



**New Hampshire Building Capacity for Transformation 1115 Medicaid Waiver
IDN PROCESS MEASURES SEMI-ANNUAL REPORTING GUIDE**

**For
Year 3 (CY2018)
2018-12-31 v.27**

Region 6 IDN (Seacoast/Strafford)

WRITEBACK SUBMISSION #1

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Introduction

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

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

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

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

Kelley Capuchino
Senior Policy Analyst
NH Department of Health and Human Services
Division of Behavioral Health

DSRIP IDN Project Plan Implementation (PPI)

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

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

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

DHHS Final Review from previous submission:

PPI Budget

This budget is intended to be the Master Budget for the IDN which should include all funds disbursed to include operating budget, salaries, benefits and all costs associated with the planning and implementation of all of the required projects.

In the December 2018 submission, a single budget should be reported with actuals as well as projected budgets. Please submit one budget which includes actuals for the completed time frames and projected budgets in the following columns. This submission included 2 separate budgets, one for actuals and a separate one for projected. While we appreciated the amount of detail provided in the actual budget, the line items are difficult to correlate with the projected budget.

Soliciting Community Input:

IDN Region 6 has steadfastly kept our commitment to the meaningful engagement and input of a broad representation of community stakeholders in all our DSRIP design and implementation efforts. IDN 6 crafted a Consumer Engagement Work Plan intended to solicit meaningful input and foster active participation in IDN projects from all manner of individuals and family members touched by the efforts of IDN partners. The IDN contracted with Continuum of Care Facilitator from the Seacoast Public Health Network to carry out this Work Plan.

Implementation of all three of the Community Projects in IDN 6 continues to be guided by Workgroups comprised of multiple clinical and non-clinical stakeholders throughout the Region. Workgroups continue to meet at least twice per reporting period to guide implementation of respective projects. To advance the integration of resources and services that address the social determinants of health through Region 6 projects sector-specific work groups address homelessness/housing, and transportation related needs, assets and opportunities across the region. The Clinical Advisory Team continues to meet to provide expert input on operational considerations and problem-solving related to the care integration objectives across IDN projects (with emphasis on B.1).

IDN partner representatives and Operations staff have and will continue to participate on the Statewide HIT, Workforce, and APM Workgroups and subcommittees. All Partner Meetings continue to be a key aspect of network development throughout the initiative and an especially useful forum to solicit feedback from multiple perspectives, and to inform and engage new network partners. We

continued to offer All Partner meetings in the reporting period as a forum to provide detail and answer questions related to IDN updates and progress, and to serve as an information source for partners to understand the larger policy and programming landscape in which DSRIP projects operate. For example, the status and relative influence of Medicaid re-procurement, Granite Advantage logistics, the 10-Year Plan, and APM/VBP development on DSRIP and on partner agencies more generally. And likewise, we continue to participate in numerous opportunities throughout the region to inform, engage and solicit input from groups in every sector.

Network Development:

Network development continues to be a priority for the Region 6 IDN as we emphasize partner engagement opportunities in those areas that add the most value for our regional partners and our attributed members. One of the most impactful of those engagement opportunities in our region is the Community Care Team (CCT), which continues to grow and thrive in two locations. The number of partner agencies engaging with the three monthly CCT meetings continues to increase as we regularly see representatives from more than 15 agencies in attendance at every meeting. The direct support the CCT model provides for referred clients is very valuable to increasing care coordination. The knowledge transfer that attending partners receive through participation is invaluable to the care coordination work they do every day.

Our Region Six All Partner Meetings, held roughly every two months (depending on competing meetings, priorities, etc.) have been a key staple of network development since Day One, and will continue to serve as our largest and most diverse in-person network audience. These meetings are attended by a diverse range of partners. Attendees include partners participating in B1 and Community Projects and those who currently or desire to work with Medicaid beneficiaries more peripherally due to beneficiary's tendencies to need other supports related to socioeconomic risk like food pantry, area disability agency, homeless outreach, and faith community feeding programs.

Operations Team Members continue to be heavily involved in many IDN-related Network activities (e.g. seat on Strafford County and Seacoast Public Health Network Advisory Committees; Commissioner of Dover Housing Authority; advisor to TriCity Mayor's TaskForce on Homelessness; members of Greater Seacoast Coalition to end Homelessness Steering Committee and Workgroups; Strafford County Medical Reserve Corps; Recovery Community Organization Advisory Board; and many more). All together and across members, the Operations Team engages in hundreds of contacts, engagements, meetings and interactions of all types that are relevant to Network Development that are too numerous to document or predict systematically.

Of note, no partners have left the IDN network or requested to decrease participation in the Region 6 DSRIP initiative.

Addressing the Opioid Epidemic: The Region 6 Operations Team benefits from the direct involvement of staff members in several local and statewide efforts that seek to address the negative consequences of Opioid misuse in New Hampshire. One Team member sits on the Governor’s Commission for Alcohol and Substance Use Prevention, Treatment and Recovery, including serving as Chair of the Recovery Task Force, the Data Task Force, and the Policy Task Force, as well as Chair of the NH Harm Reduction Coalition, and Board Chair of Hope on Haven Hill. Two Team members were employed by our two respective Public Health Networks before joining the IDN and brought with them their extensive engagement in Continuum of Care activities throughout the region that are focused on the Opioid Epidemic and have been integrating those efforts into the IDN projects.

Members of the Operations Team have been actively involved in existing Network efforts and regularly participate in such groups as the Prevention, Treatment and Recovery Roundtable and The Opioid Taskforce, etc. Operations Team staff have also been very actively involved in providing multiple Overdose Prevention trainings before and since the inception of DSRIP. Additional trainings **to be offered include those to First Responders and other non-clinical personnel. Likewise, these team members have also been instrumental in creating one of the first Syringe Services Programs in NH that serves Region 6 and provides technical assistance and support for an emerging statewide initiative, the New Hampshire Harm Reduction Coalition.**

Toward the end of the reporting period one of our primary partners, Wentworth Douglass Hospital, was designated as a regional host agency to serve as a “Hub” for the State Opioid Response effort in New Hampshire. The WDH staff and IDN Operations staff immediately began working together to align the previous and future efforts of the IDN with the structure and functions of the “Hub and Spokes” model. These efforts are certain to build our regional capacity to reduce the negative consequences of opioid misuse through enhanced prevention, treatment and recovery-oriented services capacity.

Governance: The primary component of our governance model is the Executive Committee, which is comprised of fourteen people, each representing a different sector of the IDN. During the reporting period, the Region 6 IDN Executive Committee added 2 new members to fill recently vacated seats representing the Housing and Public Health sectors. The Executive Committee also agreed to seat 1 new member to representing the Consumer. This seat was filled during the reporting period. There were no significant changes to governance structure or stability during the reporting period.

Budget: The Master Budget was reviewed and accepted by the Executive Committee. The Executive Committee informs and accepts significant budget adjustments on a rolling basis, at least annually. The initial Master Budget assumed a 15% reduction from maximum possible funding. In this report we detail several decisions to redistribute funds that were either allocated but not expended during the reporting period, or to reflect alignment with alterations in project redesign and growth that could not be anticipated in the original project design. Most funds that were not distributed were in staff/workforce line items that were not hired due to reorganization of the agency or project they were intended to be associated with. The current master budget maintains funding at approximately 85% of maximum. Additional reduction may be necessary pending CMS/NH DHHS negotiation regarding match funding. The Director of Finance conducts monthly budget reconciliation. The master budget is comprised of the PPI budget and the A1,A2,B1,C1,D3, and E5 project budgets included in this report.

Strengthening Operational Capacity to Administer the DSRIP:

Region 6 continues to make significant investments to build and strengthen our Operations Team knowledge and capacity. Operations Team members continued to rotate attendance at IDN Administrative Lead meetings to ensure comprehensive access to evolving information. IDN Operations team members advised on and participated in knowledge exchange activities during the MSLC state-wide quarterly Learning Collaborative sessions. IDN Operations staff have also attended a variety of exercises and trainings in Integration, Transformation, and Behavioral Health improvement hosted by diverse entities across the state. Our Director of Population Health also attended a 2-day Academy that delivered training for Care Director from Allscripts, our Shared Care Plan IT solution.

Strengthening Network Partner Readiness for DSRIP Initiatives:

During this reporting period, the IDN Operations team has begun to execute several activities designed to strengthen partner readiness for DSRIP Initiatives, especially for multiple types of partner staff beyond executive level and for those agencies who do not yet have key partner role designations. These efforts include:

- Planned re-design of community projects as informed by key member workgroups to ensure operational success
- Expansion # of partner agencies participating on Release of Information for both Community Care Teams
- Use of Community Care Team expertise to define ideal scope of Shared Care Plan solution
- Use of the Clinical Advisory Team to further evaluate resources and best practices to inform development of Core Standardized Assessment protocols.
- Initiation and contracting of collaborative relationship with Southern NH AHEC to oversee and administer regional training efforts including design and delivery of trainings across the IDN projects portfolio.
- Conducted session with over 40 School Counselors and Supportive Services staff from throughout SAU-16 to provide and IDN and Enhanced Care Coordination Project overview.
- Hosted a meeting with Dr. Craig Donnelly and his associates from Dartmouth-Hitchcock Department of Psychiatry and several Youth/Pediatric stakeholders in the Rochester/Somersworth/Dover region to introduce opportunity to participate in Case Consultation of Pediatric Behavioral Health clients. Included representatives from Rochester Pediatrics; Lilac City Pediatrics; Dover Pediatrics; Rochester School System; Community Partners.

Please refer to the PPI Project timeline in the Attachment Appendix for the complete project implementation timeline

The Region 6 IDN Team is highly active and engaged throughout the region and state in numerous efforts that directly support and strengthen capacity for project implementation. Not only convening Work Groups and conducting All Partner Meetings, but the combined deep and wide participation by all members of our Operations Team in literally dozens of groups, coalitions, agencies, organizations and related health initiatives are synonymous to our outreach and engagement. Likewise, Operations Team members are engaged in virtually every aspect of efforts to address the Opioid Crisis regionally and at the state level.

Budget Narrative

- The full budget submitted for the IDN, inclusive of PPI and the six required projects is budgeted at \$16.8M or 75% of the maximum projected available funds.
- The actual spend and projected budget spend for the PPI is \$4,162,449, a decrease from the 6/30/2018 SAR.
- The IDN is rebranding itself from Seacoast Strafford Integrated Network of Care to Connections for Health. Beginning in January 2019, the IDN will roll out the new logo including an updated website.
- Direct Salaries include full time positions for Director of Population Health, Director of Care Coordination and Director of Solutions Integration. The latter position is also responsible for legal reviews especially pertaining to 45 CFR Part 2 and HIPAA.
- Indirect Staff include support from the Administrative Lead Organization—Strafford County—including Finance Director, Finance staff assistance, IT support and administrative support.
- Benefits are calculated at 22% of staff salaries.
- Contracted staffing include positions for Executive Director, Clinical Director and Director of Operations & Strategy. Prior to the period beginning CY 19, the Director of Operations was a full-time position, but is now contracted.
- Fees and Outside Placement include projected costs for community project management services and other infrastructure support functions.

UPDATED PPI Budget

Connections for Health IDN Region 6										
Project	CY 2016 Actuals	CY 2017 Actuals	Jan-Jun 2018 Actuals	July-Dec 2018 Actuals	CY 2019 Projected	CY 2020 Projected	CY 2021 Projected	Totals	Revised Target Budget	
PPI	\$ 144,114	\$ 563,268	\$ 348,429	\$ 384,138	\$ 907,500	\$ 907,500	\$ 907,500	\$ 4,162,449	\$ 4,200,000	
A1	\$ -	\$ -	\$ 74,326	\$ 41,717	\$ 1,110,000	\$ 1,110,000	\$ 1,110,000	\$ 3,446,043	\$ 3,500,000	
A2	\$ -	\$ -	\$ 154,559	\$ 150,023	\$ 298,400	\$ 382,600	\$ 392,600	\$ 1,378,181	\$ 1,500,000	
B1	\$ -	\$ -	\$ 26,620	\$ 55,328	\$ 755,000	\$ 1,030,000	\$ 1,030,000	\$ 2,896,948	\$ 3,000,000	
C1	\$ -	\$ 7,586	\$ 83,933	\$ 175,556	\$ 456,154	\$ 496,154	\$ 496,154	\$ 1,715,536	\$ 1,800,000	
D3	\$ -	\$ -	\$ 158,122	\$ 155,631	\$ 341,500	\$ 341,500	\$ 341,500	\$ 1,338,253	\$ 1,400,000	
E5	\$ -	\$ -	\$ 132	\$ 31,100	\$ 333,240	\$ 333,240	\$ 333,240	\$ 1,030,952	\$ 1,400,000	
Total	\$ 144,114	\$ 570,854	\$ 846,120	\$ 993,492	\$ 4,201,794	\$ 4,600,994	\$ 4,610,994	\$ 15,968,362	\$ 16,800,000	

DSRIP IDN Process Milestones

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

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

Project A1: Behavioral Health Workforce Capacity Development

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

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

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

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

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

Educating and training, including gaps in educational preparation of behavioral health providers' workforce readiness upon graduation;

- Recruitment of new providers and staff; and
- Retention of existing staff, including the IDN's targeted retention rates; and address:
- Strategies to support training of non-clinical IDN staff in Mental Health First Aid;
- Strategies for utilizing and connecting existing SUD and BH resources;
- Additional strategies identified in the Statewide Workforce Capacity Strategic Plan; and
- Any special considerations for workforce development related to the IDN's Community- Driven Projects, including unique training curricula and plans.

The Region 6 IDN planned and provided several professional development opportunities for partners during the reporting period. These can be reviewed in Attachments B1-8C.a and B1-8C.b. In addition, IDN staff provided training on Substance Use 101 and Narcan training to UNH nursing students to increase awareness of behavioral health practice standards and fill gaps in workforce integrated care readiness. Region 6 IDN partner agencies also sent providers/teams to a number of Community Health Institute Behavioral Health Integration Learning Collaboratives during the reporting period, further increasing workforce capacity to adopt integration strategies.

Accomplishments and progress on IDN strategies to fill gaps/reduce barriers on recruitment of new providers and staff during the reporting period include funding commitments to partners for a nurse practitioner fellowship, additional behavioral health clinicians and coordinators, and a Director of Care Coordination for the IDN operations team. These positions were all committed and hired during the reporting period. Due to a variety of MOU arrangements including quarterly and reimbursement-based billing, the costs incurred are not all yet reflected in the actual expenses for this reporting period.

The IDN staff continued to work with partner agencies to support efforts to fill gaps and reduce barriers to retention of existing staff. For most partners, the primary retention strategy they requested was training support, which is reflected in Attachments B1.8C.a and B1.8C.b. This support included regular promotion of Mental Health First Aid for non-clinical staff and concurrent orientation to elements of that training including de-escalation, therapeutic communication, and self-care/compassion fatigue.

Accomplishments and progress on the IDN's plan to fill gaps and reduce barriers to utilizing and connecting existing SUD and BH resources were realized in several ways. The first was through Community Care Team meetings, where representatives from SUD, BH, Social Service/Support, and Medical partner agencies come together to review and collaborate on support plans for individuals with complex combinations of social determinant, BH, SUD, and/or medical needs. Significant knowledge transfer happens at these thrice monthly meetings, and ongoing monitoring suggests that partner agencies are beginning to demonstrate capacity to coordinate care for more complex clients on their own that might have once been referred to the Community Care Team table as a result of the knowledge and connections they have gained from attendance.

A second strategy the IDN utilized to connect existing SUD and BH resources is the Clinical Advisory Team, a meeting of clinical providers and key organizational liaisons to inform strategic, operational, and project-based work that functions much like a community of practice, allowing mid-level providers to exchange resources, challenges, and solutions.

A third example of the region's efforts to fill gaps and reduce barriers to connecting existing SUD and BH resources includes the procurement and distribution of bus tickets to reduce transportation barriers. With IDN support, one mental health peer support agency partner was able to distribute 200 bus tickets to Medicaid enrolled or eligible clients for transport to medical appointments, many of which were SUD partners for methadone and/or suboxone treatment. These tickets created a safety net for clients, many of whom are homeless, for those occasions when their Medicaid paid (CTS) transportation was not available/reliable to meet their needs.

The Region 6 IDN identified one significant opportunity to leverage collaboration for workforce development in conjunction with the development of the Wentworth Douglass Hospital (WDH) HUB Doorway initiative. Several strategies being developed in support of the Region 6 D3 project (enhanced capacity for intensive outpatient SUD care) coalesced with HUB development during this reporting period. These strategies included IDN technical assistance to a WDH clinician-led team to implement an Emergency Department MAT Bridge program, IDN funding to leverage availability of 24/7 on-call CRSW peer coaching to the WDH Emergency Department, and IDN technical assistance for a nurse practitioner's doctoral project on increasing Emergency Department staff readiness for the MAT Bridge project. With the emergence of the HUB at WDH, the IDN was able to work with HUB leadership to develop and coordinate these parallel efforts to strengthen and solidify commitments and sustainability planning. This coordination resulted in 5 of 10 WDH Emergency Department clinicians completing their X-waiver certification during the reporting period, a tremendous indicator of increased workforce readiness.

Progress in support of development of Statewide Workforce Capacity during this reporting period includes continued participation in the Statewide Workforce Task Force and promotion of Task Force recommendations and messaging to all Regional partners. Region 6 is specifically represented on the following A1 Statewide Workforce workgroups:

- Education & Training: Kevin Irwin (IDN), Paula Smith (SNHAHEC)
- Policy: Diane Fontaneu (SMHC) for part of reporting period prior to resignation
- Retention/Sustainability: (Nick Toumpas, co-chair-IDN)
- Recruitment/Hiring: ad hoc participation

Opportunities to participate in Workforce Task Force collaborations are continually disseminated from Regional representatives to partners at-large. The Region 6 IDN looks forward to continued support for the amended Workforce Task Force Implementation plan in January 2019.

During this reporting period, the Region 6 IDN made progress on the A1 Workforce Project Implementation Plan. Please refer to the A1 Project timeline in the Attachment Appendix for the complete project implementation timeline. Milestone or deliverable dates highlighted in red in the Attachment A1 Project Timeline reflect the accompanying strategy has not yet begun or has been cancelled. Dates highlighted in yellow indicate that the strategy was started, but faced barriers or delays that prevented completion. Dates highlighted in green reflect milestones or deliverables that were met. This color legend is standard across the remaining A2, B1, C1, D3, and E5 Implementation Timelines in this document.

Attachment_A1.3b

Region 6 Integrated Delivery Network IDN Partner One-Time Investment Request

The Region 6 IDN Executive Committee granted authorization to the IDN Operations Team to invest up to \$50,000 per month to partner agencies to stabilize and/or improve regional capacity to meet DSRIP program and regional terms and goals.

This form accommodates requests for support made via **OPTION 2*** in the CAPACITY BUILDING SUPPORT: Attachment A1.3b form (attached).

IDN Partners requesting **OPTION 2** support will receive a consultation with the Region 6 IDN Operations Team to identify the following elements to enable the Region 6 IDN Operations Team to ensure investment is aligned with regional and DSRIP terms and goals. The Region 6 IDN Executive Committee will review investments on a monthly/ongoing basis and provide feedback/guidance as indicated.

**[Option 2 funding is separate from OPTION 1 funding. OPTION 1 funding is allocated via detailed project plans collaboratively crafted in a series of waves, to primary partners in the B1 & C1/D3/E5 Community Projects that will come before the Executive Committee.]*

AGENCY/ORGANIZATION	
CONTACT INFO	
AMOUNT REQUESTED	
SPECIFIC AIM(S)	
SPECIFIC OUTCOME(S)	
JUSTIFICATION	(rationale for support)
IMPACTS IN REGIONAL HEALTH NEIGHBORHOOD	
SUSTAINABILITY	(if capacity improvement is sustainable, how?)
ALIGNED WITH CORE COMPETENCIES	(refer to SAMHSA competencies)
AGENCY CAPACITY	(how does support improve agency capacity?)
REGIONAL CAPACITY	(how does support improve regional capacity?)
DIRECT FUNDING OR IDN PAYMENT?	(Does payment go to partner agency or vendor/individual?)
ACKNOWLEDGEMENT	(how will investment be identified/branded to stakeholders?)

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

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

UPDATED TABLE - Table A1.4: Evaluation Project Targets

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
# of participating partner agencies who receive recruitment and/or retention support from the IDN.	10	0	6	12
% of participating partner agencies receiving recruitment and/or retention support from the IDN who report positive	70%	0	100%	100%
# of participating partner agency staff who receive IDN sponsored training.	150	0	350	380
% of participating partner agency staff who receive IDN sponsored training who report positive impact on knowledge or practice.	75% (or 113)	0	97%	90%
# of eligible participating provider agencies who were offered a stipend for staff participation on the Clinical Advisory Team	15	0 ¹	15	15
# of Members Demonstrating Initiation of Alcohol and Other Drug Dependence Treatment	Target Pending Baseline Measurement – TARGET UNDER REVIEW FOR NEXT SUBMISSION			
# and % of new patient calls or referrals from other providers for CMHC intake appointment within 7 calendar days	Target Pending Baseline Measurement- TARGET UNDER REVIEW FOR NEXT SUBMISSION			
# and % of new patients for whom time between intake and first follow - up visit was 7 days or less.	Target Pending Baseline Measurement - TARGET UNDER REVIEW FOR NEXT SUBMISSION			
# and % of new patients for whom time between intake and first psychiatrist visit was 30 days or less	Target Pending Baseline Measurement- TARGET UNDER REVIEW FOR NEXT SUBMISSION			

INFORMATION ON STAFFING TARGETS PREVIOUSLY INCLUDED HERE HAVE BEEN MOVED TO A1-5

A1-5. IDN-level Workforce: Staffing Targets

From the IDN-level Workforce Capacity Development Implementation Plan, use the format below to provide the IDN's current number of full-time equivalent (FTE) staff needed to address the gaps identified in the IDN's Workforce Capacity Development Implementation Plan and the number of staff hired and trained by the date indicated. Include workforce related to the IDN HIT Infrastructure, IDN Integrated Healthcare and the IDN selected community-driven projects.

As discussed in A1.3, the Region 6 IDN workforce plan continues to evolve based on network and organizational learning, fundamental elements of the DSRIP initiative. Projected Total Need in Table A1.5 reflects the gaps identified by Partner agencies during project planning. It is updated during each reporting period based on summary partner projections for their own 6- and 12-month workforce development plans. It is possible that the Region 6 IDN will provide funding and/or assistance to recruit, retain, or support positions that are not included in the workforce staffing targets below because they have not yet been identified by Partner agencies as needed.

During the reporting period, two additional CRSWs were funded to support the Law Enforcement Assisted Diversion Program through an MOU with SOS Community Recovery Organization/Greater Seacoast Community Health Center. Funds were committed to support a total of 1.8 FTEs of Behavioral Health Clinician time and 1 FTE of Behavioral Health Coordinator time. (see section B1.4 for details) Additional hiring for partner positions is anticipated during Q1 & Q2 of 2019 as partners continue to implement integration strategies.

Contracted psychiatry consultation was continued from Dartmouth College to provide expert consultation and case review to Region 6 IDN providers using a Project ECHO model, beginning with the Frisbie Hospital system. The Region 6 IDN continued a contract with Ben Hillyard, M.Ed, LCMHC, of the Center for Collaborative Change, to serve as the School/Youth Mental Health Integration Clinician based on his very successful participation to date on the Clinical Advisory Team and professional experience and current practice focus. The IDN's Director of Care Coordination role was filled with the hiring of Sandi Denoncour and a contract expansion was reached with Maria Sillari, the administrative manager of both the northern and southern regional Community Care Teams.

UPDATED TABLE - Table A1.5: Workforce Staffing Targets *unmet target

Provider Type & Project Association (I = Infrastructure, B1 = Integrated Healthcare, C1/D3/E5 = Community Projects)	IDN Workforce (FTEs)				
	Projected Total Need	Baseline Staffing on 6/30/17	Staffing on 12/31/17	Staffing on 6/30/18	Staffing on 12/31/18
Executive Director (I)	1	1	1	1	1
Director of Operations (I/B1/C1/D3/E5)	Up to 1.0	0	0	.8	.8
Director or Population Health (I/B1/C1/D3/E5)	1	1	1	1	1
Director of Clinical Integration (I/B1/C1/D3/E5)	0.4	0	0	0.4	0.4
Director of Care Coordination (I/B1/C1/D3/E5)	1	0	0	1	1
Director of Solutions Integration (I/A2)	1	0	0	1	1
Program Coordinator (I/B1/E5)	Up to 1.0	0	0	0.8	0.8
Administrative Assistant (I)	Up to 2	0	0	.5	.5
School/Youth Mental Health Integration Clinician (I/E5)	Up to 1	0	.05	.1	.1
Waivered Nurse Practitioner (A1)	Up to 1	0	0	1	1
Integration Coach (B1)	2	0	0	0	3
Behavioral Health Clinician (B1)	Up to 6	0	0	1	2.8
Behavioral Health Coordinator (B1)	Up to 6	0	0	1	2
Pediatric Psychiatry Consultation (B1)	Up to 1	0	0	0.03	0.03
Masters Level Team Leader (C1)	2	0	0	1	1*
CTI Case Manager (C1)	6	0	3	4	4.8*
Master Licensed Alcohol and Drug Counselor Navigators (D3)	1 (*revised)	0	0	1	1
CRSW/Case Manager (D3)	6	0	0	1	3*
Enhanced Clinical Care Coordinator (E5)	6	0	0	1	1*
Enhanced Care Coordination Care Manager(E5)	Up to 2	0	0	1	2
Clinical Supervision Consultation (D3/E5)	Up to 2	0	0	.05	0.25

The table above has been updated to reflect all positions in all projects for the reporting period. Additional narrative on unmet staffing targets (*) is included below:

(C1) The IDN6 continues to explore opportunities to replicate or expand this model in the community with future creation of embedded CTI Case Managers and/or a team with a partner agency or practice. As this time, B1 and C1 key organizational partners have indicated that they do not feel they can adequately support a CTI team. The project plan accounted for the development of a second CTI team and this remains a goal of the IDN6.

(D3) The project plan anticipated 2 MLADC positions. The second MLADC was hired with IDN support at Hope on Haven Hill, originally envisioned as a D3 project. Now that Hope on Haven Hill is identified as a B1 partner, the MLADC position is included in the B1 workforce staffing. The Projected Total Need for the D3 MLADC has been revised to 1 and discussed with DHHS for approval.

It is anticipated that the remaining 3 CRSW / Case Manager positions will be filled in CY 2019. These positions are anticipated to be filled in support of SOS Community Recovery Support's expansion to Hampton and/or additional capacity in regional spoke partner agencies.

(E5) The IDN 6 Operations team continues to pursue opportunities to expand the number of Enhanced Clinical Care Coordinators at partner sites. To date, Seacoast Mental Health Center has felt their capacity allowed for one Care Coordinator. This is not a billable position in the current structure at SMHC, but the IDN and SMHC are working together to identify billable models for this position. Once established, the goal is to expand the number of Care Coordinators in the region.

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

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

Table A1.6: Project Budget

Connections for Health								
IDN Region 6								
Project A1								
Project	CY 2016 Actuals	CY 2017 Actuals	Jan-Jun 2018 Actuals	July-Dec 2018 Actuals	CY 2019 Projected Spend Budget	CY 2020 Projected Spend Budget	CY 2021 Projected Spend Budget	Total Actuals and Projected Spend
Expense Items								
Staffing								
Direct Staff	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Indirect Staff	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Benefits	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Contracted Staffing	\$ -	\$ -	\$ -	\$ -	\$ 35,000	\$ 35,000	\$ 35,000	\$ 105,000
Project Infrastructure								
Equipment	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Operations	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Workforce								
Fees/Outside Placement	\$ -	\$ -	\$ 74,326	\$ 20,361	\$ 300,000	\$ 300,000	\$ 300,000	\$ 994,687
Retention	\$ -	\$ -	\$ -	\$ -	\$ 600,000	\$ 600,000	\$ 600,000	\$ 1,800,000
Training	\$ -	\$ -	\$ -	\$ 18,856	\$ 50,000	\$ 50,000	\$ 50,000	\$ 168,856
Recruiting	\$ -	\$ -	\$ -	\$ 2,500	\$ 75,000	\$ 75,000	\$ 75,000	\$ 227,500
Technology								
	\$ -	\$ -	\$ -	\$ -	\$ 50,000	\$ 50,000	\$ 50,000	\$ 150,000
Totals	\$ -	\$ -	\$ 74,326	\$ 41,717	\$ 1,110,000	\$ 1,110,000	\$ 1,110,000	\$ 3,446,043

UPDATED Budget Narrative: staff for Infrastructure, B1, C1, D3, and E5 projects are NOT included in this budget. Please refer to the budget sections for each project for more information.

- The A1 Budget total actual and projected spend budget for the 12/31/2018 SAR is \$3,446,043. The 6/30/2018 SAR was projected at \$4,193,000.
- The 6/30/2018 SAR submission indicated that the IDN was not pursuing the hiring of 13 FTE positions in table A1-5.
- Contracted staffing is projected budget for support of workforce development initiatives for the SAR periods ahead.
- Retention includes a pool of funds for partners to retain positions directed at targeted clinical positions identified through collaborative design sessions, SSA work and specific efforts (e.g. a Community of Practice and a statewide conference/workshop) to support non-clinical positions intended to support community connections, navigators and coordinators. We expect that these positions will become of greater importance as Alternative Payment Models emerge from the new Managed Care Organizations.
- Training includes additional trainings raised by partners in ongoing relationship building. Also, in this line is support for Same Day or Open Access for the two Community Mental Health Centers.
- Other includes initiatives to support housing stability through the building of a community of practice as well as other initiatives to decrease eviction rates and increase the stability and availability of housing options.

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

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

UPDATED Table A1-7: Key Organizational and Provider Participants as of date of submission 4/5/19

Organization Name	Organization Type	Associated with IDN Projects (A1, A2, B1, C, D, E)
Appledore Family Medicine	HBPC	A1, A2, B1
Center for Collaborative Change / Ben Hillyard	Soc Service	E5
City of Dover Welfare	Soc Service	A1, A2
City of Portsmouth Welfare	Soc Service	A1, A2, C1
Community Partners	CMHC	A1, A2, B1, C1
CORE Family and Internal Medicine – Exeter	HBPC	A1, A2, B1, C1
CORE Seacoast Family Practice – Stratham	HBPC	A1, A2, B1, C1
Core Pediatrics	HBPC	E5
Cornerstone VNA	HomeCare	A1, A2, C1
Crossroads House Homeless Shelter	Soc Service	A1, A2, C1, E5
Dover Pediatrics	Primary Care	A1, A2, B1
Exeter Health Resources / CORE	Hospital	A2, B1, C1
Frisbie Memorial Hospital	Hospital	A2, B1, C1, D3, E5
Granite/SeacoastPathways	Peer Support	A1, A2, C1, E5
Greater Seacoast Community Health - Families First	FQHC	A1, A2, B1, C1, E5
Greater Seacoast Community Health - Goodwin Community Health	FQHC	A1, A2, B1, C1, E5

Greater Seacoast Community Health - Lilac Pediatrics	FQHC	A1, A2, B1, C1
Hilltop Family Practice	HBPC	A1, A2, B1, C1
Hope On Haven Hill	Residential SUD Treatment	A1, A2, B1, D3
Lamprey Health Care, Raymond	FQHC	A1, A2, B1, C1, E5
Lamprey Health Care, Newmarket	FQHC	A1, A2, B1, C1, E5
One Sky Community Services	Area Agency	A1, A2, E5
Portsmouth Regional Hospital / HCA	Hospital	A2, B1, C1, D3, E5
Rochester Pediatrics	HBPC	A1, A2, B1
Riverside Rest Home (Strafford County)	LTC	A1
Rockingham CAP	Soc Service	A1, A2, C1
Rockingham County Corrections	Corrections	A1, A2, C1
SAU-16	School System	E5
Safe Harbor Recovery Community Organization	Peer Recovery	A1, A2, C1, D3, E5
Seacoast Mental Health Center	CMHC	A1, A2, B1, C1, E5
Seacoast Youth Services	SUD	A1, A2, B1, C1, D3, E5
Skyhaven Internal Medicine	HBPC	A1, A2, B1, C1
Southeastern NH Services	SUD	A1, A2, B1, C1, D3
SOS Recovery Community Organization	Peer Recovery	A1, A2, C1, D3, E5
Strafford County Corrections	Corrections	A1, A2, C1, D3
Strafford CAP	Soc Service	A1, A2, C1
Wentworth Douglass Hospital	Hospital	A2, B1, C1, D3
Tri-City Consumer Action Cooperative	Peer Recovery	A1, C1, D3, E5
Wentworth Health Partners / Internal Medicine	HBPC	A1, A2, B1, C1
White Mountain Community Health Center	HBPC	A1, A2, B1, C1

Project Scoring: IDN Workforce Process Milestones

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

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

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

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

Each IDN was required to develop implementation plans for the July submission. Provide a detailed narrative which describes the progress made on required activities, timelines, key milestones, progress assessment check points and evaluation metrics. Using Microsoft Project or similar platform update your project timeline to reflect progress made during this reporting period.

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

JULY-DECEMBER 2018 KEY A2 ACHIEVEMENTS FOR REGION 6 IDN:

- Director of Solutions Integration hired.
- Data Aggregator:
 - 85% (11 of 13) of B1 partners have now executed Data Sharing Agreements/Business Associate Agreements. *(Remaining partners are Portsmouth Hospital, which has been unresponsive, and SENHS, which has agreed to sign the DSA/BAA as of this report.)* See Table A2.8.
 - 92% (12 of 13) of B1 partners have completed an orientation to MAeHC's Quality Reporting Service portal and 77% (10 of 13) of them are expected to report data by MAeHC's February 15, 2019 deadline for the April submission to DHHS. *(Portsmouth Hospital has been unresponsive to signing a DSA/BAA; Hope on Haven Hill and Seacoast Youth Services came on at the end of December and do not have enough time to make the MAeHC deadline).* See Table A2.3.

- HIT assessments have been conducted with 77% (10 of 13) B1 partners. (*Hope on Haven Hill and Seacoast Youth Services came on at the end of December, and Dover Pediatrics shortly before that.*)
- Shared Care Plan:
 - Region 6 IDN's shared care plan "Care Director" has been brought on line and implemented.
 - All five IDN Care Transitions Team and ECC Case Managers have been trained on and are using Care Director; all of their approximately 200 clients have been uploaded into Care Director.
 - New information on evolving expected uses of IDN partners prompted a redrafting of the Care Director implementation plan to accommodate IDN partners' growing understanding of the potential uses of a shared care plan; training and onboarding of partners into Care Director is planned for Q1 of 2019.
 - A four-week delay during this reporting period in Care Director implementation was caused by the vendor's internal transition (its 300+ servers were moved to another platform).
 - The interface between Care Director and MAeHC to provide a feed of Admissions, Discharge, and Transfer (ADT) data to display in Care Director is being developed and is expected to go live Q1 of 2019.
 - A legal analysis was conducted of the flow of Protected Health Information into and through Care Director to address HIPAA and 42 CFR Part 2 privacy requirements.
- Event Notification Services:
 - A contract with MAeHC was signed to provide ENS to Region 6 IDN.
 - The decision was made to provide IDN partners three means of access to the Event Notification Services' ADT data: an interface with Care Director, a MAeHC portal for provider direct access, and an interface with the CMT ENS product.

NARRATIVE ON A2.3:

Data Aggregator: Region 6 IDN made significant progress in the data aggregator work since the last reporting period. Our number of unique enterprise B1 partners has grown to 13. All but one of them has signed (or agreed to sign) the DSA/BAA, and but for that one (Portsmouth Hospital) and the two that became IDN partners in late December (*Hope on Haven Hill and Seacoast Youth Services*), all are expected to report data for the April 2019 reporting submission. Our Director of Solutions Integration is working closely with MAeHC and 12 partners on bi-weekly QRS calls to support their data reporting efforts, including identifying and obtaining answers from DHHS to their questions on the metrics. As a result of those bi-weekly discussions, partner IT staff are being prompted to interact with their clinical staff, starting conversations on how this technology and the information reports from it will further their organization's integration efforts, among other topics. Just by discussing what a comprehensive core assessment is has led to several partners asking the IDN for recommended assessment tools. The next stage of work with partners on this will be walking through the information reports they can view in the MAeHC portal and discussing how to use the information to consider practice changes or greater integration work.

Four of our B1 partners will be providing data either manually or via a manual/electronic hybrid approach due to limitations in their EHR system (WITS, for example) or their use of multiple EHRs. SENHS, Hope on Haven Hill, and Seacoast Youth Services all utilize WITS to varying extents, and pulling relevant data from WITS is still a work-in-process. Dover Pediatrics has almost a boutique EHR used exclusively by pediatric practices. They are working with their vendor to identify what data is captured

and reportable out of their EHR and what will need to be manually entered while reviewing patient hard files. Due to the additional staff time associated with the manual input of data into the MAeHC portal, Region 6 IDN has offered technical and financial support to each of those partners.

Portsmouth Hospital remains elusive in Region 6 IDN's efforts to partner with them. Despite initial conversations, Portsmouth Hospital has since been largely unresponsive to requests to discuss data reporting and signing a DSA/BAA. Elsewhere in this report is information on discussions with Appledore, Portsmouth Hospital's practice; it is hoped that those discussions will lead to greater involvement of Portsmouth Hospital in the IDN's work.

Table A2.3: Partner Status re: Reporting to Data Aggregator During Reporting Period

In the last reporting period, only Seacoast Mental Health Center had submitted data from Region 6 IDN. By the end of December 2018, five (5) partners were providing production data to MAeHC (as reflected in the table below), and by the February 15 MAeHC submission data deadline, ten (10) of our B1 partners will be submitting production data for submission to DHHS by April 1, 2019. This is great progress towards the ultimate milestone of 100% participation of all B1 partners in the data aggregation reporting work.

Partner Agency	Initial Discussion Held w/MaEHC	Data Ready For Testing	Data in Production	Data Submitted
Community Partners CMHC	X	X	X	
Dover Pediatrics	X			
Exeter Hospital				
- Core Family & Int Medicine	X	X		
- Seacoast Family Practice	X	X		
Frisbie Hospital				
- Rochester Pediatrics	X	X	X	
Greater Seacoast Community Health Center- Families First	X	X	X	X
Greater Seacoast Community Health Center- Goodwin	X	X	X	X
Hope on Haven Hill, SUD facility	X			
Lamprey Health Care- Newmarket	X	X		
Lamprey Health Care -Raymond	X	X		
Portsmouth Hospital	X			
- Appledore				
Seacoast Youth Services, SUD services	X			
Seacoast Mental Health Center	X	X	X	X
SENHS, SUD facility	X			
Wentworth Douglass Hospital				
- Wentworth Health Partners	X	X		
- Hilltop Family Practice	X	X		

Of the three B1 partners who will not be providing production data by February 15, two of them, Hope on Haven Hill and Seacoast Youth Services, became B1 partners at the end of December so they are in the early stages of working with the metrics and identifying where their relevant data is located in their EHR(s) or files. Region 6 IDN recently agreed to fund a part-time IT position at Hope on Haven Hill that will support the further data aggregation project work in 2019. Interestingly, in early conversations, it appears that Seacoast Youth Services may have the most comprehensive core assessment of all our B1 partners. Portsmouth Hospital is the only B1 partner that has not engaged in the data aggregator work beyond an initial conversation with MAeHC (and the IDN). Attempts to discuss the DSA/BAA have not been successful, with messages not answered.

Shared Care Plan: Having IDN Case Managers/staff use Care Director for IDN clients has resulted not only in more effective tracking of client information, but also staff suggestions on how to “tweak” Care Director to better meet user needs. That, along with feedback from IDN partners on their evolving understanding of a shared care plan with a holistic approach (addressing all social determinants of health) and anticipated uses of a shared care plan triggered a pause in our Care Director implementation. Because Region 6 IDN chose strategically to implement a SCP clinical providers and social service organizations serving our clients will use, the use of Care Director will further our integration goals faster and more effectively than a SCP that is limited to clinical providers. However, along with that greater utility comes greater complexity.

Region 6 IDN focused in Q4 of 2018 on making the necessary personal connections between MAeHC, Allscripts, and CMT to put in place all the interfaces needed to feed ADT data into Care Director from not only Region 6, but all the Regions. Those efforts continue and may require customized technical solutions.

Finally, a legal analysis was performed on the flow of Protected Health Information into and through Care Director to ensure compliance with all federal and state medical record privacy laws. Any shared care plan must conduct such an analysis, as CMT has also done. It was of need for Region 6 IDN because not all Region 6 IDN users are HIPAA Covered Entities (hospitals, medical or mental health providers) bound already by law to abide by those legal requirements. The goal of connecting all the organizations, clinical and social service, serving our clients/patients is best met by all such organizations having access to the information available in Care Director (the homeless shelter can see their resident who is diabetic was admitted to a hospital, a CMHC can see the IDN Case Manager has succeeded in placing their patient in stable housing, providers can alert a Case Manager to a patient’s missed appointment due to lack of transportation, etc.). Because of the heightened protections of 42 CFR Part 2 SUD information, we had to closely evaluate whether controls in our vendors’ systems can limit access appropriately to Part 2 data; fortunately, there are several system controls that will do so. Thus, the legal analysis was done to ensure all necessary patient consents are received, all legal documents are in place, and Care Director and MAeHC systems controls are in place to fully comply with federal and state privacy laws. The anticipated outcome is worthy of the additional effort.

Event Notification Services: As with our interface discussions around Care Director, so too is Region 6 IDN working with our vendors to implement three means of IDN partner access to ADT data via an event notification service. The initial feedback from our partners was little interest in receiving directly ADT data; utilizing the Care Director platform was preferred. In this reporting period, however, a couple of

partners expressed interest in a direct feed. We are encouraged by this increased interest because it appears to be prompted by CMHCs' desire to have more patient information sooner from hospitals, a sign of greater systems integration and more informed patient care.

As stated above, the ADT feed to Care Director is expected to go live Q1 of 2019. The timing of the MAeHC portal to view ADT data and the CMT/MAeHC interface for bi-directional ADT data flows is not known due to CMT internal processes, but the goal is to have all available by Q2 of 2019, if not sooner.

See Attachment A2 Project Timeline in the Appendix of Attachments for detailed timeline.

The timeline attached demonstrates the attainment or progress towards all milestones and deliverables. Each is discussed in other sections of the A2 report. A continuing effort not reflected in the timeline is the support being provided by HIT subject matter experts to the Clinical Advisory Team. The goal of including HIT expertise in the discussion is to anticipate and problem solve those scenarios at the planning table to more quickly develop feasible solutions.

A2-4. IDN HIT: Evaluation Project Targets

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

Table A2-4: Evaluation Project Targets

#	Performance Measure Name	Target	Progress Toward Target		
			As of 12/31/17	As of 6/30/18	As of 12/31/18
1	# of participating partners reporting access to a shared care plan solution	25	0	10	0*
2	# of participating partners reporting meaningful use of a shared care plan solution	20	0	7	0*
3	# of eligible participating partners utilizing ONC Certified EHRs (CEHRT)	8	5	8	9^ε
4	# of participating partners reporting contributions to data aggregator	10	0	2	5^D
5	# of participating partners reporting access to event notification solution	10	0	0	0
6	# of participating partners reporting meaningful use of event notification solution	10	0	0	0
7	# of participating partner hospitals reporting ADT submissions to IDN associated event notification solution	4	0	0	0
8	# of eligible participating partners utilizing ONC Certified technologies	10	5	8	9^ε
9	# of eligible participating partners capable of conducting e-prescribing	8	2	8	9^ε
10	# of eligible participating partners capable of creating and managing registries	10	0	7	7^ε
11	# of eligible participating partners able to electronically exchange relevant clinical data w/ others incl. NH Hospital	8	0	5	5^ε
12	# of eligible participating partners able to protect electronically exchanged data in a secure and confidential manner per state/federal and security laws	30	5	24	42
13	# of eligible participating partners reporting client access to bi-directional secure messaging, records, apt scheduling, prescription & referral management	8	0	4	4^ε
14	# of eligible participating partners identified to report via the data aggregator	10	1	3	13

* Pursuant to DHHS’s instructions, although some Region 6 IDN participating partners report access to and/or meaningful use of a shared care plan, until Q1 of 2019 when Region 6 IDN’s shared care plan is being accessed by partners, we will report “0”.

^ε Region 6 IDN’s newest partners (Dover Pediatrics, Hope on Haven Hill, Seacoast Youth Services) have not yet been assessed for these functions.

^D While 10 of Region 6 IDN’s B1 partners are expected to make contributions to the data aggregator for the 2/15/19 deadline, only five were providing production data as of 12/31/18.

Progress toward Evaluation Targets identified in Table A2.4:

Targets #1 and 2: As explained in detail in Section A2-3, Region 6 IDN hit “pause” on Care Director planning in late 2018 in response to new and evolving expected uses of B1 partners. It will be rolled out to partners in Q1 of 2019.

Target #3: This target measure was reached earlier in 2018. More partners may be added to the total tally as assessments are completed of our newest partners who joined the IDN in December.

Target #4: Up from one Region 6 partner agency reporting contributions to the data aggregator during the last reporting period, there were 5 (five) as of 12/31/18, and will be 10 (ten) as of 2/15/19. All but one of the B1 partners, Portsmouth Hospital, are expected to be reporting by the next reporting deadline.

Target #5 & #6: Until the MAeHC interface with Care Director is developed and Care Director rolled out to IDN partners in 2019, or the other two access points created to the MAeHC ADT data feed, no partners can be reported as meeting this measure, although they may have access to a non-IDN event notification solution.

Target #7: Until the MAeHC interface with Care Director is developed and Care Director rolled out to IDN partners in 2019, no partner hospitals can be reported as meeting this measure.

Target #8: Currently nine participating partners are identified as using a certified ONC technology. Region 6 IDN’s newest partners (Dover Pediatrics, Hope on Haven Hill, Seacoast Youth Services) have not yet been assessed for these functions.

Target # 9: As reported previously, the eight Region IDN partners identified as using ONC certified EHRs also reported or demonstrated the ability to utilize e-prescribing. No other Region 6 IDN partners are known to report this capability, although an assessment of our newest partners may result in a few more.

Target #10: No change from the earlier reported number of partner agencies attesting to the ability to create, share, and follow/track a client/panel in any format of electronic database (Crystal reports, Excel, EHR reports/flat files, SPSS).

Target #11: No change from earlier reported number. Five participating partners identified the ability to electronically exchange relevant clinical data w/ others. Mechanisms included direct secure messaging, secure email and some SFTP to MCOs. For the purpose of this evaluation measure, Fax transmission was not included, although all partners reported Fax as a primary transmission method for clinical data, especially to specialty clinical partners.

Target #12: 42 participating partners reported the ability to protect electronically exchanged data in a secure and confidential manner per state/federal and security laws. This measure includes capacity of agencies participating on the Community Care Team and key IDN partners as identified in other parts of this SAR. The primary mechanisms of protection and secure exchange were reported as data encryption and/or secure email.

Target #13: No change from earlier reported number. 4 eligible participating partners (3 CHCs, 1 Hospital based Primary Care partner) reported portal-based client access to bi-directional secure messaging, records, appointment scheduling, and/or prescription and referral management. That number may increase upon assessing Dover Pediatrics capacity in this area.

Target #14: Although Region 6 IDN may continue to add B1 partners, currently there are 13 B1 partners identified as eligible to report via the data aggregator.

A2-5. IDN HIT: Workforce Staffing

From Project A1: Workforce Capacity Development Implementation Plan, document the current workforce staffing specifically related to this project using the format below.

Table A2-5: Workforce Staffing

Staff Type	Projected Total Need	IDN Workforce (FTEs)			
		Baseline Staffing on 6/30/17	Staffing on 12/31/17	Staffing on 6/30/18	Staffing on 12/31/18
Director of Solutions Integration	1	0	0	0	1

A Director of Solutions Integration was hired and started with Region 6 IDN in August. She meets (virtually) with each B1 partner’s data reporting or IT staff on MAeHC’s bi-weekly QRS online meetings. Consequently, connections have been developed that allow for quick replies to partner’s technical or policy questions around the data aggregator metrics. Also, as the reporting focus progresses to include working with partners to analyze the information reports produced by MAeHC from the partner’s data reporting, those relationships will allow more room for encouraging partners to stretch toward deeper practice change or integration with others serving the same patients.

A2-6. IDN HIT: Budget

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

Table A2-6: Budget

Connections for Health								
IDN Region 6								
Project A2								
Project	CY 2016 Actuals	CY 2017 Actuals	Jan-Jun 2018 Actuals	July-Dec 2018 Actuals	CY 2019 Projected Spend Budget	CY 2020 Projected Spend Budget	CY 2021 Projected Spend Budget	Total Actual and Projected Spend
Expense Items								
Staffing								
Direct Staff	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Indirect Staff	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Benefits	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Contracted Staffing	\$ -	\$ -	\$ -	\$ -	\$ 50,000	\$ 150,000	\$ 150,000	\$ 350,000
								\$ -
Project Infrastructure								\$ -
Equipment	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Operations	\$ -	\$ -	\$ 2,036	\$ -	\$ -	\$ -	\$ -	\$ 2,036
								\$ -
Workforce								\$ -
Fees/Outside Placement	\$ -	\$ -	\$ 19,500	\$ -	\$ 39,400	\$ 49,600	\$ 59,600	\$ 168,100
Recruiting/Retention	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Training	\$ -	\$ -	\$ 3,411	\$ -	\$ -	\$ -	\$ -	\$ 3,411
Other	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
								\$ -
Technology								\$ -
MAeHC/Data Agg	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
MAeHC/ENS	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Allscripts/SCP	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Allscripts/ENS	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Other	\$ -	\$ -	\$ -	\$ 21,845	\$ 75,000	\$ 72,000	\$ 72,000	\$ 240,845
								\$ -
Totals	\$ -	\$ -	\$ 154,559	\$ 150,022	\$ 298,400	\$ 382,600	\$ 392,600	\$ 1,378,181

A2 Budget Narrative:

- Budget is \$1,378,181, up from 6/30/18 SAR of \$1,094,000.
- The budget details the actual and projected spend for the three key technology projects.
- Contracted staffing is projected to support the implementation of Event Notification System and the Shared Care Plan as well as other initiatives being considered by partners.
- Fees and outside services is increased to support partner capacity and readiness to for the planning and implementation of the Alternative Payment Model requirement in the pending Care Management program contracts.
- Other supports are focused on assisting partners to maintain or increase solutions to address HIT requirements.
- One deviation of the actual expense from the budgeted amount is the reduced payment to

Allscripts in Q3-Q4. This was due to the late presentment of their invoices that have since been paid and will be reconciled to show as 2018 expenses.

The Region 6 IDN projected budget for 2019-2021 reflects scheduled payments per vendor contracts for the MAeHC data aggregator and Event Notification Service and Allscripts Care Director solution. Also included are projected costs for a CMT/MAeHC interface to allow for the bi-directional sharing of ADT data between Region 6 IDN and the other IDNs. The GIS mapping project will see renewed focus in 2019 and is funded accordingly. Included under Fees & Outside Placement is support for B1 partners performing their data pulls for the data aggregation work manually, in whole or in part.

Contracted staffing is projected to support the implementation of Event Notification System and the Shared Care Plan as well as other initiatives being considered by partners. Fees and outside services is increased to support partner capacity and readiness for the planning and implementation of the Alternative Payment Model requirement in the pending Care Management program contracts.

As partners deepen their understanding of and involvement in systems integration, greater technology needs requiring investments are expected to surface; this accounts for the amounts in the "Other" line item under Technology. Those resources may be used for additional solution training, ergonomic equipment, hardware to support implementation, backfill for training time, or to procure enhanced security solutions, upgrade information storage/exchange capacity, and incent partner participation in minimum solution implementation. This may include optimizing information for wearable technology, alternative communication, or enabling technology. Funding has also been budgeted to accommodate any HIT/HIE solutions, training or equipment necessary to meet DSRIP performance expectations.

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

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

All the below listed entities are Region 6 IDN B1 partners. All but Portsmouth Hospital are actively engaged in the data aggregator work. All have provided feedback to the IDN (or will, in the case of newer partners) to better understand partner work flows and expected uses of Care Director and the ADT feed; that feedback is being utilized to inform the final implementation planning for Care Director's roll out to partners in Q1 of 2019. All B1 partners will be invited to participate in Care Director and to access the ENS in any of the three paths described elsewhere in this section.

UPDATED Table A2-7: Key Organizational and Provider Participants as of date of submission 4/5/19

Organization Name	Organization Type	Associated with IDN Projects
Appledore Family Medicine	HBPC	A1, A2, B1
City of Dover Welfare	Soc Service	A1, A2
City of Portsmouth Welfare	Soc Service	A1, A2, C1
Community Partners	CMHC	A1, A2, B1, C1
CORE Family and Internal Medicine – Exeter	HBPC	A1, A2, B1, C1
CORE Seacoast Family Practice – Stratham	HBPC	A1, A2, B1, C1
Cornerstone VNA	HomeCare	A1, A2, C1
Crossroads House Homeless Shelter	Soc Service	A1, A2, C1, E5
Dover Pediatrics	Primary Care	A1, A2, B1
Exeter Health Resources / CORE	Hospital	A2, B1, C1
Frisbie Memorial Hospital	Hospital	A2, B1, C1, D3, E5
Granite/Seacoast Pathways	Peer Support	A1, A2, C1, E5
Greater Seacoast Community Health - Families First	FQHC	A1, A2, B1, C1, E5
Greater Seacoast Community Health - Goodwin Community Health	FQHC	A1, A2, B1, C1, E5
Greater Seacoast Community Health - Lilac Pediatrics	FQHC	A1, A2, B1, C1
Hilltop Family Practice	HBPC	A1, A2, B1, C1
Hope On Haven Hill	Residential SUD Treatment	A1, A2, B1, D3
Lamprey Health Care, Raymond	FQHC	A1, A2, B1, C1, E5
Lamprey Health Care, Newmarket	FQHC	A1, A2, B1, C1, E5

One Sky Community Services	Area Agency	A1, A2, E5
Portsmouth Regional Hospital / HCA	Hospital	A2, B1, C1, D3, E5
Rochester Pediatrics	HBPC	A1, A2, B1
Rockingham CAP	Soc Service	A1, A2, C1
Rockingham County Corrections	Corrections	A1, A2, C1
Safe Harbor Recovery Community Organization	Peer Recovery	A1, A2, C1, D3, E5
Seacoast Mental Health Center	CMHC	A1, A2, B1, C1, E5
Seacoast Youth Services	SUD	A1, A2, B1, C1, D3, E5
Skyhaven Internal Medicine	HBPC	A1, A2, B1, C1
Southeastern NH Services	SUD	A1, A2, B1, C1, D3
SOS Recovery Community Organization	Peer Recovery	A1, A2, C1, D3, E5
Strafford County Corrections	Corrections	A1, A2, C1, D3
Strafford CAP	Soc Service	A1, A2, C1
Wentworth Douglass Hospital	Hospital	A2, B1, C1, D3
Wentworth Health Partners / Internal Medicine	HBPC	A1, A2, B1, C1
White Mountain Community Health Center	HBPC	A1, A2, B1, C1

A2-8. IDN HIT. Data Agreement

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

UPDATED Table A2.8 – Data Agreement Status as of date of submission 4/5/19

ORGANIZATION NAME	<u>DATASHARING AGREEMENT/BUSINESS ASSOCIATE AGREEMENT STATUS</u>
Community Partners CMHC	EXECUTED
Dover Pediatrics	EXECUTED
Exeter Hospital - Core Family & Int Medicine - Seacoast Family Practice	EXECUTED
Frisbie Hospital - Rochester Pediatrics	EXECUTED
Greater Seacoast Community Health Center- Families First	EXECUTED
Greater Seacoast Community Health Center- Goodwin Community Health	EXECUTED
Hope on Haven Hill	EXECUTED
Lamprey Health Care CHC- Newmarket Lamprey Health Care CHC- Raymond	EXECUTED EXECUTED
Portsmouth Hospital - Appledore	No progress- lack of communication on this item continues from partner
Seacoast Youth Services	EXECUTED
Seacoast Mental Health Center	EXECUTED
SENHS	EXECUTED
Wentworth Douglass Hospital - Wentworth Health Partners - Hilltop Family Practice	EXECUTED

Project Scoring: IDN HIT Process Milestones

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

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

Project B1: Integrated Healthcare

B1-1. IDN Integrated Healthcare: Assessment of Current State of Practice Against SAMHSA Framework* for Integrated Levels of Care and Gap Analysis

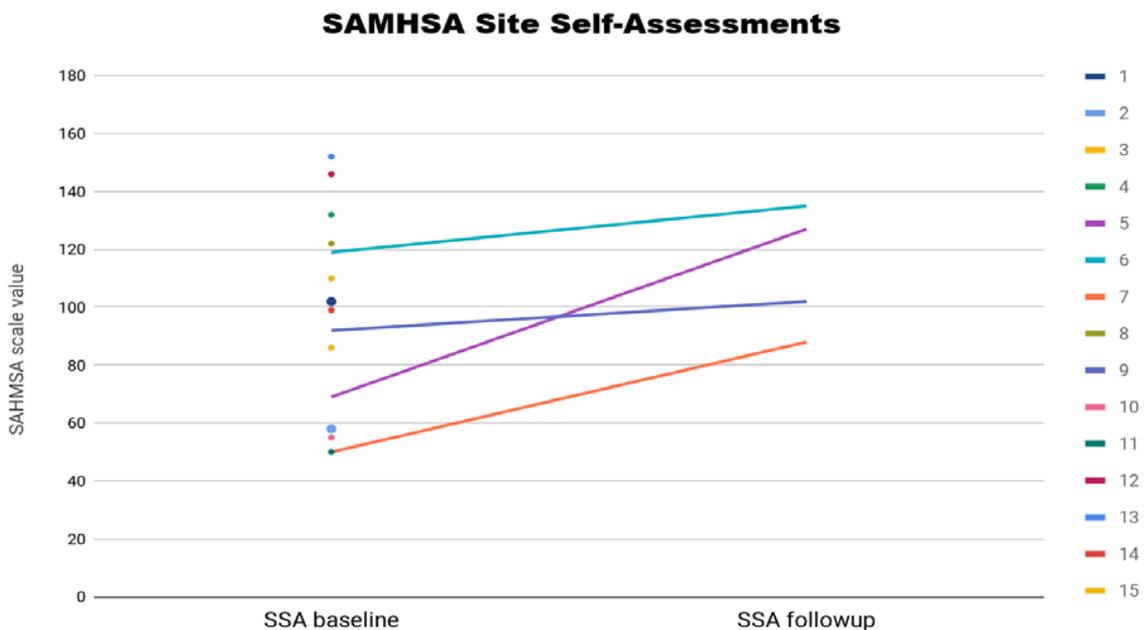
Provide a narrative summarizing the results of the IDN’s assessment and gap analysis of the primary care and behavioral health providers’ current state of practice against the SAMHSA designation requirements and the Special Terms and Conditions. At a minimum, include the following:

NH DHHS DSRIP Implementation IDN Process Measures Template 11

Identification of gaps against the SAMHSA designation* requirements, and Steps and resources needed to achieve the designation(s) judged to be feasible by the provider and the IDN during the demonstration period. (p115)

* Note: SAMHSA’s designation of “Coordinated Care” and “Integrated Care” differ from the NH DSRIP STCs. While the SAMHSA framework should be used as a guideline, the IDN will be held accountable to the NH DSRIP designations.

An update on the **15 Site Self-Assessments** completed with current B1 partners are charted below. Follow-up assessment values are charted for the four partners with follow-up assessments completed by the end of this reporting period. Remaining partners have follow-up assessments scheduled for first quarter 2019.



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

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

Provide a detailed narrative which describes the progress made on required activities, timelines, key milestones, progress assessment check points and evaluation metrics. Using Microsoft Project or similar platform update your project timeline that includes a timeline of milestones and targets for each of the Process Milestone requirements listed for reporting periods of Jan-June 2017; July-Dec 2017; Jan-June 2018; and July-Dec 2018. See the DSRIP STCs and the IDN Integrated Healthcare Coordinated Care Practice and Integrated Care Practice milestones for additional detail.

Include a detailed narrative. The narrative should relate to tables B1-3 through B1-10 and identify progress, barriers and plans to address those barriers within your IDN and reflected within your project plan and timeline.

The *Coordinated Care Practice* must include:

- Comprehensive Core Standardized Assessment with required domains (**Note:** applies only to primary care, behavioral health and substance use disorder practitioners.)
- Use of a multi-disciplinary Core Teams
- Information sharing: care plans, treatment plans, case conferences
- Standardized workflows and protocols

In addition to all of the requirements for the Coordinated Care Practice designation above, the *Integrated Care Practice* must include:

- Medication-assisted treatment (MAT)
- Evidence-based treatment of mild-to-moderate depression within the Integrated Practice setting either (e.g., IMPACT or another evidence-supported model)
- Enhanced use of technology
- Include a narrative which provides detail of Key Organizations and Providers that have been off-boarded as well as new partners.

Please see Project B1 Project Timeline Attachment in Appendix of Attachments for additional detail.

Region 6 IDN Narrative Overview

Pediatric Services: Region 6 IDN continues to receive monthly enrollment reports. The analysis of the enrollments and the environmental scans we are completing with our partners has increased focus on services for children less than 18 years of age. A full 47% of our population is in this demographic and as such has been a catalyst for integration efforts focused on children's health. The IDN 6 is supporting the integration of BH Clinicians and Care Coordinators at the following pediatric practices.

- **Rochester Pediatrics:**

The new behavioral health clinician receives clinical supervision from the IDN 6 Clinical Director to progress to licensure and being able to bill for services. She is also organizing and facilitating the multidisciplinary core team psychiatric consult referrals further described below.

- **Dover Pediatrics:**

Embedded MSW Care Coordinator. IDN 6 will support second position, if hired. IDN clinical director developed job description for embedded BH position. This position will develop an overall screening and treatment strategy to address the group of patients identified as having some degree of psychosocial distress. They will also be part of the multidisciplinary core team and initiate and follow up with referrals made to specialty behavioral health services in the community.

The IDN will fund this position and the necessary training of this individual as well as the overall practice to define what elements of integrated practice they want to develop. Dover Pediatrics has achieved the designation of a Level 3 medical home and this additional service will expand the ability to provide comprehensive care in the practice to children, adolescents, and their families identified as having complex medical, behavioral and/or social services needs.

- **Greater Seacoast Community Health - Lilac City Pediatrics: (onboarding Jan 2019)**

IDN 6 participated in their successful recruitment process and anticipates MOU for embedded BH Clinician January 2019.

Pediatric Psychiatry for MDCTs:

Key components of the multidisciplinary team for pediatric and family practices were identified as missing during environmental scanning. These included; lack of access to any child psychiatry providers in Strafford County, low confidence and competence of pediatric providers across the region, a small number of co-located behavioral health providers in pediatric / family practices overall, and lack of coordination between agencies.

In July of 2018 the IDN initiated and funded completely an ECHO like program using the expertise of Dartmouth psychiatry. Dr. Craig Donnelly facilitates a bi-monthly teleconference call in which primary care medical providers, primary care embedded behavioral health providers, school representatives, specialty mental health providers, community participants attend.

The target group for this B1 initiative is those children and families in the highest need of services including psychiatry, behavioral health, and/or social service involvement. The goals of this ECHO-like project are (1) strengthen the skills of primary care docs and (2) strengthen community capacity to take care of children and families who are at risk for no treatment or undertreatment of behavioral substance use problems, and/or social service connections.

All B1 partners have access to this resource in service of their pediatric populations. In addition, the Strafford County school systems participate in the project. *(see attachments in section B1-8b for more detail)*

Challenges for key partners during this reporting period:

Greater Seacoast Community Health - Goodwin Community Health (GCH) and Families First (FF)

GSCH recently went through a merger of two existing, B1-partner FQHCs. This merger has just been finalized in the last reporting period and partly as a result of change of culture, Families First had both medical and behavioral health providers leave. The IDN has continued to work with both practices to sustain multi-disciplinary teams as both are advanced on the integrated practice continuum. Specific progress on CCSA workflows and closed loop referrals were delayed during the merger.

Families First has an IOP program which they have provided to patients experiencing substance use issues and deemed to need an IOP level of care. The newly hired Director of Behavioral Health at FF was covering this IOP program and this kept her from expanding services in other areas and being able to manage staff. IDN intervention: The IDN clinical director met with the FF behavioral health manager in August 2018 and helped to consult around a different more accessible and sustainable model. The IDN funded a position that started in September 2018 to provide clinical services in the IOP and to expand services to patients who were not formerly medical patients at FF. The IDN helped the FF behavioral health manager develop a communication strategy to let other agencies and the general public know how to refer patients to the program.

The medical director at Goodwin Community Health was concerned about the quality of patient care given a loss of key staff and wanted to lead a team that addressed how to collectively create change in the culture. The IDN funded a consultant, Laura Montville, to survey the leadership and key staff using the Relational Coordination survey analytics and then to feed this information back to the leadership, the Board of Directors, and the IDN. The IDN plans to be involved in the strategic plan to help GSCH recruit new providers and move into high need areas, including reinvestment in the Seabrook / Hampton area of Rockingham County.

Network Capacity Building

The IDN Team continues to invest considerable time and effort into the building of Network Capacity as the foundational objective of the IDN. The facilitation and support of the Community Care Team is fundamentally a network capacity building enterprise. With 50 regional agencies on one Release of Information, the coordination work of the CCT continues to build and strengthen the connective tissue of the network across partners in practically every domain.

B1-3

Performance measures and targets are identified below. All B1 enterprise partners, except for Portsmouth Regional Hospital, will be reporting outcome data and CCSA implementation as of the next reporting date of 2/15/19.

B1-4

The IDN 6 Operations Team has continually met with partners to provide recruitment and retention support for integrated care positions. During this report period, the region has realized increases in workforce staffing for primary care integrated BH services and increased service availability for both MLADC and primary care in the SUD provider setting.

Direct investments in positions at partner agencies have facilitated the onboarding of an *additional* 1.4 FTEs of Behavioral Health Clinician support and 1.5 FTEs of additional Behavioral Health Coordinator support at our B1 partner agencies during this report period.

Anticipated B1 Workforce expansion:

Additional regional IOP service expansion with Seacoast Youth Services is being facilitated and supported by the IDN 6. The onboarding of an additional 1.0 FTE IOP provider to expand current Rockingham County services into Strafford County is anticipated in the first quarter of 2019.

An MOU for support of two integrated BH Clinicians with CORE Physicians is being signed for January 2019. This will place one BH Clinician at CORE Family and Internal Medicine and one BH Clinician at Seacoast Family Practice.

An MOU is pending for support of 1.0 FTE BH Clinician at Greater Seacoast Community Health-Lilac Pediatrics. IDN 6 has helped with recruiting for this position, which was successfully filled. The signed agreement for ongoing support is anticipated February 2019.

B1-5

Budget Narrative Update

- The total budget for the B1 project is \$2,896,948, which is an increase from \$2,559,000 in the 6/30/2018 SAR.
- The IDN had identified that we would be conducting sessions with our B1 partners in 4 waves and those were consolidated into 2 waves, which have now been completed. We expect to have additional B1 partners join the network as well as identify new opportunities for investments.
- Contracted staffing is in support of network development for PCP/family support presence in one of the region's areas.
- Outside placement contains projected spend for several initiatives currently or pending. These include support for PCP presence at a key SUD provider, a BH specialist in a hospital-based PCP focused on children, an MLDAC at a key SUD provider working with young mothers, support for an IOP in an FQHC, embedded clinicians in four PCP practices. All of these are B1 partners.
- Recruiting is a pool for partners to assist in recruiting key clinical positions.
- Retention is a pool for targeted staff retention including those for connections to the SDoH services.
- Other reflects projected spend to support housing and transportation support.
- Technology is projected spend in support of partners implementation of telehealth initiatives.

B1-6

The IDN has executed Certificates of Authorization with all Wave One and Wave Two partners listed in B1-6. During the current report period, the IDN added *new B1 enterprise partners; Dover Pediatrics and Seacoast Youth Services.*

We also added **new B1 practice level partners**; *Appledore Family Medicine, Wentworth Health Partners Internal Medicine, Hilltop Family Practice, Seacoast Family Practice (Core) in Stratham and Core Family & Internal Medicine in Exeter.*

It is the IDN 6 model to build B1 partnerships at a practice level on an ongoing basis. The date of the Site Self-Assessment is this project's measure of first engagement at the practice level. Practices within our B1 partner enterprises have expressed expanded interest in B1 project development. To highlight the IDN 6 onboarding workflow, below is a summary of our approach to new practice partner strategic planning, technical assistance, and ongoing support.

Partner Onboarding: White Mountain Health Center (WMHC) - B1 partner for January 2019.

WMHC is a primary care family practice of Frisbie Hospital. It is in Carroll County and has three medical providers and their teams. They have no embedded behavioral health services and have identified a need to serve their complex patients who have co-occurring, medical, behavioral health, substance use, and social issues. WMHC was one of three practices in the Frisbie system identified to work with the IDN by the medical director for primary care. The population served by WMHC has a high Medicaid attributed population and many behavioral and social needs identified in their Community Needs Assessment.

WMHC is already participating in a grant project to test an EHR based program that captures social determinant data. They currently do not have the clinical staff to follow up with needs that are assessed. The clinical director of the IDN met with the medical director and behavioral health director at Frisbie six times along with the practice to develop a plan to move toward Coordinated Care practice status.

This practice is working under a grant to use an EMR based tool that collects comprehensive core standardized clinical and social determinant data from patients. They are collecting this information on all patients who come to the office. They identified a need to follow up on positive screens and not having the resources to do that. The IDN support during the report period:

1. Writing the job description for an embedded behavioral health provider. This person will be the conduit to make sure the CCSA is completed and appropriate follow up occurs. They will be responsible for providing brief treatment in the office and making referrals outside as indicated.
2. Actively assisting in recruiting for that position.
3. The IDN clinical director will coordinate training to both this individual and to the medical team and staff at White Mountain Health Center.
4. Scheduling baseline Site Self-Assessment for January 2019

Anticipated Outcomes: The addition of this provider will enable the practice to move towards coordinated care as measured by both the SAMHSA and NH DSRIP requirements. The IDN will propose to bring in an integration coach to help the practice set goals and meet deadlines. The practice will identify what parts of the CCSA they can complete and provide follow up and closed loop referrals for complex patient care. While they have separate co-located care now, this will enable them to have a functioning multidisciplinary team.

Partner Onboarding: Seacoast Youth Services (SYS)

Seacoast Youth Services is a new B1 partner as of December 2018. Seacoast Youth Services is a twenty-year-old program providing services to adolescents and young adults. The IDN 6 is helping SYS to expand services into Rochester. This will occur first with the reestablishment of an IOP program for high risk youth in the Rochester area. Some of these adolescents are already in the program but are transported to Seabrook which involves a long commute and less participation than if programming were more localized. SYS will also take over an ongoing program, Bridging the Gaps, which is a preventive program involving the schools and community. IDN Clinical Director met with Executive Director of SYS to build relationships with local partners including the Rochester school leadership.

The IDN facilitated a meeting with the schools and SYS to identify other areas they could be involved with in the future. SYS, the schools, and the IDN believe SYS could bring additional supports to Rochester both as Home-Based Therapy and TDT/IOP providers. IDN 6 has planned direct support of the IOP program through D3 Community Project funds. The IDN is paying for the services of the Clinical Director of SYS to open the program in Rochester. The IDN was instrumental in identifying a good central location and helped to negotiate the agreement to use the space.

B1-7

B1 partners are represented by members sector from across all required organization types as listed in STC Section II(c) on the Executive Committee. Additional participation and planning representation occur through the Clinical Advisory Team. Between these two groups, all B1 partners are represented except for the two B1 enterprise partners added in December 2018; Seacoast Youth Services and Dover Pediatrics. New partners are notified of opportunities to participate in governance by the IDN 6 Executive Director.

B1-8

a

CCSA single-formats implemented:

IDN Region 6 CMHC partners currently use single-format CCSA tools:

- ADULT NEEDS & STRENGTHS ASSESSMENT (ANSA)
- CHILD AND ADOLESCENT NEEDS AND STRENGTHS (CANS)

IDN Region 6 FQHC partners currently use CCSAs formatted as intake forms that include all of the elements of the PRAPARE tool as endorsed by the National Association of Community Health Centers:

- PRAPARE: Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences

Partners outside of these two categories have indicated that, although they do not currently have one tool to capture all elements of the CCSA, they do collect information under the necessary domains as part of their intake, clinical visit documentation, and additional forms created for use by non-billable clinical support staff such as Care Managers. This information is integrated into care planning via multiple methods; huddles, case reviews, and EMR documentation.

It is the IDN 6 strategy to continuously promote aggregation of the CCSA domains in one consistent format whenever possible. The goal is to have all domains visible to care team members and considered in the preparation of the care plan involving the entire MDCT. SSA strategy and technical assistance meetings are used as opportunities to discuss progress on CCSA development and workflows to address needs identified in CCSA domains. As discussed in B1-4, partners have expressed renewed interest in Integration Coaching and CCSA enhancement will be a priority of that coaching. At the next report interval of 2/15/19, we anticipate at least 9 partners will be reporting on full-scope CCSA implementation numbers.

b

Multidisciplinary core teams have been identified at all primary care and behavioral health partners. The minimum monthly case review meetings with all-partner and/or partner -specific access are detailed in Section B1-8e.

c

In addition to the trainings executed and planned, partners are notified by email of additional opportunities for training issued by the Myers & Stauffer Learning Collaborative, the other IDNs in NH, the University of New Hampshire, Southern NH AHEC, partner community-based agencies, and others.

We also target outreach to specific partners when appropriate to highlight the relevance of specific training to their practice, or to offer scholarship support for their staff to attend. In any instance where the IDN can provide a scholarship or travel assistance to promote attendance, these offers are made. It is not possible to track every partner's participation in events not directly sponsored or funded by the IDN, but the email notification list for all opportunities is inclusive of all B1 partner practice contacts.

Partners have identified a significant need for on-line and/or webinar trainings that they can present to their MDCT members and support staff at their convenience. Attending scheduled events and/or leaving the practice(s) to attend trainings is a significant barrier for many partner participants.

The IDN6 has identified the creation of a web-based training link as a priority for first quarter 2019. The structure will directly reflect the IDN core competency trainings that MDCT members, and all others possible, are encouraged to take as part of their Coordinated Care practice development. In addition, development of Integrated Practice knowledge and program application will be included.

d

We have provided coding and billing training to all our B1 partners, provided by Sylvia Ronda. It is important to note that many trainings are appropriate for and attended by clinical and non-clinical staff alike. We have found it effective to offer region-wide and site-specific trainings on an ongoing basis to meet shifting partner needs and priorities shaped by flux in demands, funding opportunities, staffing turnover, staff coverage, etc. We have also found that some agencies have internal capacity to deliver these trainings and ongoing support to their own staff, *particularly where BH clinicians and BH Case Managers are embedded*. The IDN Team is diligent about informing Regional partners about training opportunities throughout the region, the state, and some in other states.

e

The IDN 6 has developed and/or supported three models for MDCT case conferences on behalf of patients with significant behavioral health conditions or chronic conditions.

- Pediatric psychiatry *all-partner accessible* teleconference
- Community Care Team *all-partner accessible* case review
- Internal partner-specific case review

All B1 partners and targeted key organizational partners are invited to attend and participate in both the Pediatric psychiatry *all-partner accessible* teleconference and the Community Care Team *all-partner accessible* case review. Not all B1 partners have chosen to participate at this time. Opportunities are reinforced at Executive Committee, Clinical Advisory, and All-Partner meetings. Additional reminders are sent to key MDCT members within the partner organization.

f

IDN 6 Operations team has discussed Direct Secure Messaging with all B1 partners. To date, partners, except for SCMH, has indicated that no new support is needed / desired to enhance their use of Direct Secure Messaging. The IDN 6 team will continue to assess partner readiness for new strategy development in this area. This remains a topic for future Executive Committee discussion should implementation strategies be identified.

Current uses among partners include only internal messaging except for:

- Direct secure email to patients via patient portals and/or EHR
- Direct secure email to outside providers in referral processes with secure document transfer

Additional potential secure message strategies will evolve through implementation planning for Allscripts (Care Director), the Region 6 vendor selected to meet the minimum standard requirements for Shared Care Plan, scheduled to commence during the next Reporting Period.

g

No significant progress has been made regarding closed loop referrals during the reporting period. The Operations Team continues to discuss the importance of closed loop referrals with partners during each strategy / integration coaching and technical assistance meeting. The status of referral tracking in each partner system varies widely.

Region 6 IDN believes that closed loop referrals are a good indication of a maturing care coordination system. Further development of this standard is a priority for the Operation Team and strategies to progress on this standard will remain an active priority.

h

Workflows and protocols have been requested from multiple B1 partners. To date, most partners have agreed to provide that information / copies to the IDN 6, but they have not been received. For example, the IDN Director of Care Coordination met directly with multiple partners upon her hire in November 2018 to discuss workflows and strategies for improving current practices regarding:

- Transitions from inpatient
- Interactions between providers and community based agencies
- closing the loop on referrals
- Privacy protocols
- Intake procedures that ensure privacy
- Guidelines on opioid prescribing

While it seems that obtaining workflow and protocol copies should not be a substantial burden for either partners or the IDN 6, we have found that not having met this requirement in the past by gathering these documents during earlier partner meetings was a barrier to going back to gather this information. We have discussed this with members of the Clinical Advisory Team to ask for their assistance in securing follow-up to our requests in this area. The need for increased documentation of active workflows is on the agenda for the next All-Partner meeting.

The development of an MDCT within each partner practice that is *inclusive of psychiatry* support has proved a challenge for the region. The combination of workforce shortage in psychiatry and the diversity of enterprise partners' current resources and limitations has necessitated the development of a unique approach to the MDCT support concept. The IDN 6 Operation Team has chosen a strategic philosophy of building region-wide resource networks to provide direct support to pediatric teams, provide support and collaboration to adult-serving teams to promote stability in complex patient care plans while often waiting for psychiatry / BH consults, and provide direct support for intact MDCTs whenever possible.

B1-9

Partners in IDN Region 6 are at varying points on the continuum toward Coordinated Care practice designation. We acknowledge and recognize that without significant further documentation of the workflows and protocols of the partners, full designation as Care Coordinated practices cannot be determined.

IDN support of progress for partner movement on this continuum:

Lamprey Health Care successfully hired a full-time MAT Nurse Coordinator during this report period and plans to implement their MAT program in January 2019. The IDN-6 has worked with Lamprey Health Care to further define the program training needs for both direct care staff and supporting staff. Southern NH AHEC has been contracted to develop the requested training.

In addition, the IDN-6 has encouraged and confirmed Lamprey Health Care's attendance in the NH-based Project ECHO with case-based learning on Medications for Addiction Treatment (MAT). The UNH Partnership for Academic-Clinical Telepractice (PACT): Medications for Addiction Treatment Program (PACT-MAT) will enroll MAT prescribers and their teams in the upcoming PACT-MAT Project ECHO. This grant-funded project is of no cost to participants, and free CME/CNE will be available. At this time, one provider and one nurse will attend. The IDN-6 is exploring opportunities to support attendance by additional Lamprey Health Care MAT care team members.

Greater Seacoast Community Health - Families First has successfully hired support for their MAT / IOP program with IDN 6 support during this reporting period. This has allowed them to maintain vital services and expand IOP services.

Greater Seacoast Community Health - Families First and Southeastern NH Services are co-located two days per week to provide primary care for residential clients of SENHS. Positive PHQ2/9 screenings can now be referred to the primary care provider for further assessment and care planning.

Dover Pediatrics, Rochester Pediatrics, Wentworth Health Partners Internal Medicine, Hilltop Family Practice, and Lamprey Health Care have all received support and funding to either hire or retain BH staff to support increased practice capacity for treatment of mild/moderate depression.

Based on the current capacity to achieve Coordinated Care practice designation* AND current implementation of MAT services and evidence-based treatment for mild / moderate depression, there are five IDN 6 partners who are on the path to Integrated Practice designation*.

**We acknowledge and recognize that without significant further documentation of the workflows and protocols of the partners, full designation as Care Coordinated practice and/or Integrated Practice cannot be determined.*

Partner agencies in the B1 project have identified capacity to identify at-risk clients. Those methods are reported as proprietary. With observation and analysis, the Region 6 team has observed elements of those methods to include electronic notification of patient Emergency Department visits, risk-scoring based on confidential agency-specific criteria and algorithms, and reports run by the agency on HEDIS measures and/or provided, in few instances, by an MCO for a panel of clients. All report the capacity to plan care and monitor progress for clinical care via the use of EHR notes, patient and provider dashboards, and reports.

While partners continue to develop the ability to assess social determinants and consider that assessment in care plan development through implementation of the CCSA domains, agency-wide ability to consistently monitor progress for social determinant interventions is still emerging. This capability will be improved when agencies begin implementation of Care Director, the Allscripts Shared Care Plan solution, during the next reporting period. Care Director will provide staff at all B1 partner agencies access to social determinant assessments and progress on interventions driven by those interventions.

B1-10

Note on newest B1 Enterprise partners / CCSA review and development on the Coordinated Care continuum:

Both Dover Pediatrics and Seacoast Youth Services became B1 partners in December 2018. As a primary care practice, Dover Pediatrics will make continued progress toward achieving Coordinated Care Practice designation. This progress has begun with significant movement over the past reporting period. Seacoast Youth Services is an SUD provider and remains engaged in development of the CCSA, as required by the STCs, as well as increasing their service availability in the region with IDN 6 support.

B1-3. IDN Integrated Healthcare: Evaluation Project Targets

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

Performance measures and targets are identified below. All B1 enterprise partners, except for Portsmouth Regional Hospital, will be reporting outcome data and CCSA implementation as of the next reporting date of 2/15/19. Narrative and supporting documentation in the areas of CCSA domains implemented, MDCT identification, MDCT training status, support staff training status, monthly core team case conferences, secure message capacity, and closed loop referral processes and workflows are discussed in sections B1-8a through B1-8h.

***In the updated table below, IDN 6 has been requested by DHHS to revise the identified performance measure name and target for report period ending 12/31/2018 to reflect progress made in the region that impacts the region's ability to assess progress toward DSRIP goals.**

UPDATED TABLE B1-3: Evaluation Project Targets as of date of submission 4/5/19

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
IDN Operations Team conducts Environmental Scan w/Key Partners	Environmental Scan Complete for 10 Key Enterprise Partners	5 (See Above)	6	15 (see table below)
Selected IDN partners complete CHI Integration Self-Assessment	Up to 25 practices complete CHI Integration Practice Self-Assessment	16 (See Above)	17 <i>to repeat Fall 2018</i>	20 (see table below)
Partners/Practices Use Dashboard in Integration Planning <i>(defined 12/2018 as active B1 partners having completed)</i>	Dashboard template is developed by Clinical Advisory Team	<i>(See Above)</i>	<i>Rollout with 2nd Round</i>	20 current B1 partners
<i>(defined 12/2018 as SSA baseline, f/u, and STRATEGY review and implementation meeting completed or scheduled)</i>	105 Partners/Practices/Provider Report using Dashboard	<i>(in Process)</i>	64	115
Participating Practices report data on IDN Outcome Performance Measures	10 participating practices meet reporting standards for IDN Outcome Performance Measures		1	19
Increase number of Medicaid beneficiaries receiving Comprehensive Core Standardized Assessment (period & cumulative)	Increase by 10% each reporting period	0	342	1,113 cumulative / 771 period
Increase number of Medicaid beneficiaries scoring positive on screening tools who are referred for additional intervention	Increase by 10% each reporting period	0	342	2,312 cumulative / 1,970 period
Increase number of regional partner practices able to report # of attributed Medicaid beneficiaries who received a preventative care visit in the previous calendar year by age	Considered as reportable to MaEHC for Regional and State-Wide Date			

Age 0-11:	75% of family and pediatric practice partners by 12/31/18	0	0	11/13= 85%
Age 12-17:	75% of family and pediatric practice partners by 12/31/18	0	0	11/13= 85%
Age 18-64:	75% of family and internal medicine practice partners by 12/31/18	0	0	11/12 =92%
Age 65:	75% of family and internal medicine practice partners by 12/31/18	0	0	11/12 =92%

Table B1-3a: Partner / practice environmental scan and SSA status

Organization/Provider	IDN Operations Team conducts Environmental Scan w/Key Enterprise Partners	Selected IDN practice partners complete CHI Integration Self-Assessment
WAVE ONE	Yes / No	Yes / No
Frisbie Memorial Hospital	Yes	No
Rochester Pediatrics	<i>n/a</i>	Yes
Skyhaven Internal Medicine	<i>n/a</i>	Yes
White Mountain Community Health Center	<i>n/a</i>	Yes
Wentworth Douglass Hospital	Yes	Yes
Wentworth Health Partners / Internal Medicine	<i>n/a</i>	Yes
Hilltop Family Practice	<i>n/a</i>	Yes
Lee Family Practice	<i>n/a</i>	Yes
Seacoast Mental Health Center	Yes	Yes
Lamprey Health Care - Newmarket	Yes	Yes
Lamprey Health Care - Raymond	Yes	Yes
Community Partners	Yes	Yes
WAVE TWO		
Exeter Health Resources/CORE	Yes	No
Seacoast Family Practice - Stratham	<i>n/a</i>	Yes
Core Family and Internal Medicine - Exeter	<i>n/a</i>	Yes
Greater Seacoast Community Health - Goodwin Community Health	Yes	Yes
Greater Seacoast Community Health - Families First	Yes	Yes
Greater Seacoast Community Health – Lilac Pediatrics	Yes	Yes
Southeastern NH Services	Yes	Yes
Hope on Haven Hill	Yes	No
Seacoast Youth Services	Yes	No
Portsmouth Regional Hospital / HCA	Yes	Yes
Appledore Family Medicine	<i>n/a</i>	Yes
Dover Pediatrics	Yes	Yes

B1-4. IDN Integrated Healthcare: Workforce Staffing

From Project A1: Workforce Capacity Development Implementation Plan, provide the current number of full-time equivalent (FTE) staff specifically related to this project using the format below.

The IDN 6 Operations Team has continually met with partners to provide recruitment and retention support for integrated care positions. During this report period, the region has realized increases in workforce staffing for primary care integrated BH services and increased service availability for both MLADC and primary care in the SUD provider setting.

Direct investments in positions at partner agencies have facilitated the onboarding of an *additional* 1.4 FTEs of Behavioral Health Clinician support and 1.5 FTEs of additional Behavioral Health Coordinator support at our B1 partner agencies during this report period.

Leveraging the IDN6 support has *affected* a total of 4 FTEs of Behavioral Health Clinician support as the two positions at 0.4 FTE each are now hired as 1.0 FTEs. The partner agencies have funded the remaining 0.6 FTE hours.

The total current Workforce FTEs in the chart below are individually identified as follows:

Behavioral Health Clinicians:

Rochester Pediatrics / FMH:	1.0 FTE
Wentworth Health Partners / Internal Medicine:	0.8 FTE (2 x 0.4 FTE)
Hope on Haven Hill:	1.0 FTE
Lilac City Pediatrics:	1.0 FTE

Behavioral Health Coordinators:

Greater Seacoast Community Health-Families First:	1.0 FTE
Dover Pediatrics:	1.0 FTE

Implementation Coaches:

Wentworth Douglass Hospital	1.0 FTE
Frisbie Memorial Hospital	1.0 FTE
Exeter Hospital	1.0 FTE

Wentworth Douglass Hospital, Frisbie Memorial Hospital, and Exeter Hospital have identified internal implementation coaches to support the work of multiple practices affiliated with each facility. The identified staff meet with Dr. Bill Gunn, Sandra Denoncour, and additional IDN 6 team members regularly. The structure of each implementation team varies.

Wentworth Douglass Hospital has one FTE dedicated to implementation of BH integration within the three primary care practice partners. She meets biweekly with Dr. Bill Gunn for coaching and with Sandra Denoncour and the BH Clinicians for each site bimonthly. The focus of the shared implementation coaching work includes standardizing internal communication, identification of target populations, and electronic psychiatry consultation model development.

Frisbie Memorial Hospital has one FTE consisting of: 0.5 FTE Care Coordination Manager, 0.3 FTE BH Clinician, and 0.2 FTE CMO for Primary Care. This team meets collectively with each person supporting an element of the integration process. The ID 6 team provides biweekly support including coaching meetings and clinical supervision.

Exeter Hospital has created a one FTE Implementation team consisting of: 0.5 FTE Director of Population Health, 0.25 FTE BH Manager, and 0.25 Provider. This team meets with the IDN 6 team quarterly to discuss multiple projects at the community and practice levels.

Based on integration strategy conversations facilitated by the IDN Operations team during this report period, we have initiated conversations with Citizens Health Initiative about their capacity to offer Implementation Coaches within the first quarter of 2019 and ongoing as needed. We are excited to find during this report period that there is new interest in implementation coaching from B1 partners without adequate current support for their growing efforts. We are actively working to identify the available resources. The potential to hire additional implementation coaches remains in the budget.

UPDATED TABLE B1-4: Workforce Staffing as of date of submission 4/5/19

Provider Type	IDN Workforce (FTEs)				
	Projected Total Need	Baseline Staffing on 6/30/17	Staffing on 12/31/17	Staffing on 6/30/18	Staffing on 12/31/18
Implementation Coaches	2.0	0	0	Paused	3
Behavioral Health Clinician	Up to 6	0	0	0.4	3.8
Behavioral Health Coordinator	Up to 6	0	0	0.5	2

Additionally, the IDN is providing financial support for Greater Seacoast Community Health - Families First to co-locate a primary care team at Southeastern NH Services (SUD provider) for one half-day per week starting July 2018. The goals for this project are discussed in more detail in B1-2. This was a one-time investment request to support any additional staffing needs that may be identified during the first year of the co-located services with the goal of developing a sustainable service model supported by primary care billable services.

Anticipated B1 Workforce expansion:

Additional regional IOP service expansion with Seacoast Youth Services is being facilitated and supported by the IDN 6. The onboarding of an additional 1.0 FTE IOP provider to expand current Rockingham County services into Strafford County is anticipated in the first quarter of 2019.

An MOU for support of two integrated BH Clinicians with CORE Physicians is being signed for January 2019. This will place one BH Clinician at CORE Family and Internal Medicine and one BH Clinician at Seacoast Family Practice.

An MOU is pending for support of 1.0 FTE BH Clinician at Greater Seacoast Community

Health- Lilac Pediatrics. IDN 6 has helped with recruiting for this position, which was successfully filled. The signed agreement for ongoing support is anticipated February 2019.

Notes on changes from previous submission:

Previously reported hours for the positions below are being reported exclusively in the PPI budget:

Clinical Director - Consultation	0.4	0	0	0.4
AdministrativeAssistant	0.5	0	0	0.5
Project Manager	0.8	0	0	0.8

Based on DHHS feedback and further review, the following previously reported position has been moved to A1 only:

Waivered Nurse Practitioner	1	0	0	1
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B1-5. IDN Integrated Healthcare: Budget

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

Table B1.5: Budget

Connections for Health								
IDN Region 6								
Project B1								
Project	CY 2016 Actuals	CY 2017 Actuals	Jan-Jun 2018 Actuals	July-Dec 2018 Actuals	CY 2019 Projected Spend Budget	CY 2020 Projected Spend Budget	CY 2021 Projected Spend Budget	Total Actual and Projected Spend
Expense Items								
Staffing								
Direct Staff	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Indirect Staff	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Benefits	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Contracted Staffing	\$ -	\$ -	\$ -	\$ -	\$ 75,000	\$ 150,000	\$ 200,000	\$ 425,000
Project Infrastructure								
Equipment	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Operations	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Workforce								
Fees/Outside Placement	\$ -	\$ -	\$ 24,235	\$ 40,888	\$ 330,000	\$ 330,000	\$ 330,000	\$ 1,055,123
Recruiting	\$ -	\$ -	\$ -	\$ 8,500	\$ 50,000	\$ 50,000	\$ 50,000	\$ 158,500
Retention	\$ -	\$ -	\$ -	\$ -	\$ 150,000	\$ 250,000	\$ 200,000	\$ 600,000
Training	\$ -	\$ -	\$ 2,385	\$ 5,941	\$ 25,000	\$ 25,000	\$ 25,000	\$ 83,326
Other	\$ -	\$ -	\$ -	\$ -	\$ 100,000	\$ 200,000	\$ 200,000	\$ 500,000
Technology								
Technology	\$ -	\$ -	\$ -	\$ -	\$ 25,000	\$ 25,000	\$ 25,000	\$ 75,000
Totals	\$ -	\$ -	\$ 26,620	\$ 55,328	\$ 755,000	\$ 1,030,000	\$ 1,030,000	\$ 2,896,948

UPDATED Budget Narrative: Expenditures for the period July – Dec 2018 have been confirmed and are listed accurately in the table above.

- The total budget for the B1 project is \$2,896,948, which is an increase from \$2,559,000 in the 6/30/2018 SAR.
- The IDN had identified that we would be conducting sessions with our B1 partners in 4 waves and those were consolidated into 2 waves, which have now been completed. We expect to have additional B1 partners join the network as well as identify new opportunities for investments.
- Contracted staffing is in support of network development for PCP/family support presence in one of the region’s areas.
- Outside placement contains projected spend for several initiatives currently or pending. These include support for PCP presence at a key SUD provider, a BH specialist in a hospital-based PCP focused on children, an MLDAC at a key SUD provider working with young mothers, support for an IOP in an FQHC, embedded clinicians in four PCP practices. All of these are B1 partners.
- Recruiting is a pool for partners to assist in recruiting key clinical positions.
- Retention is a pool for targeted staff retention including those for connections to the SDOH services.
- Other reflects projected spend to support housing and transportation support
- Technology is projected spend in support of partners implementation of telehealth initiatives.

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

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

The IDN has executed Certificates of Authorization with all Wave One and Wave Two partners listed below. During the current report period, the IDN added **new B1 enterprise partners; Dover Pediatrics and Seacoast Youth Services.**

We also added **new B1 practice level partners; Appledore Family Medicine, Wentworth Health Partners Internal Medicine, Hilltop Family Practice, Seacoast Family Practice (Core) in Stratham and Core Family & Internal Medicine in Exeter.**

It is the IDN 6 model to build B1 partnerships at a practice level on an ongoing basis. The date of the Site Self-Assessment is this project's measure of first engagement at the practice level. Practices within our B1 partner enterprises have expressed expanded interest in B1 project development.

To capture the continual progress of the IDN 6, anticipated new practice partners are listed below with **. These practices are anticipated to become practice level B1 partners with Site Self Assessments completed within the next reporting period. They include Lilac Pediatrics, White Mountain Community Health Center, Skyhaven Internal Medicine, and Lee Family Practice. They all have a first Site Self-Assessments scheduled in January 2019. **As of 4/5/19, all pending practice partners have completed Site Self-Assessments and have been updated in the table below.**

The IDN 6 does not anticipate additional B1 partners after the practices above are added early 2019. The exception to this will be any SUD provider who enters the project. The IDN 6 is working closely with The Doorway at Wentworth Douglass Hospital. This is further discussed in Community Project Section D. We will continue to pursue opportunities to develop formal collaborations with ROAD to a Better Life and Addiction Recovery Services. They provide valuable SUD services in the region.

UPDATED Table B1-6: Key Organizational and Provider Participants as of submission date 4/5/19

Organization/Provider	Agreement Executed (Y/N)	Date of COA with enterprise - Date of Onboarding to IDN at practice level based on SSA #1 completion
WAVE ONE		
Frisbie Memorial Hospital	Yes	10/2016
Rochester Pediatrics	yes	SSA # 1 11/29/2018
Skyhaven Internal Medicine	yes	SSA #1 completed
White Mountain Community Health Center	yes	SSA #1 completed
Wentworth Douglass Hospital	Yes	10/2016
Wentworth Health Partners / Internal Medicine	yes	SSA #1 11/15/2018
Hilltop Family Practice	yes	SSA #1 11/28/2018
Lee Family Practice	yes	SSA #1 completed
Seacoast Mental Health Center	Yes	9/2016
Lamprey Health Care - Newmarket	Yes	11/2016, SSA #1 11/14/2017
Lamprey Health Care - Raymond	Yes	11/2016, SSA #1 11/14/2017
Community Partners	Yes	9/2016
WAVE TWO		

Exeter Health Resources/CORE	Yes	5/2018
Seacoast Family Practice - Stratham	yes	<i>SSA #1 11/5/2018</i>
Core Family and Internal Medicine - Exeter	yes	<i>SSA #1 11/5/2018</i>
Greater Seacoast Community Health - Goodwin Community Health	yes	9/26/2016, SSA #1 11/21/2017
Greater Seacoast Community Health - Families First	yes	9/26/2016 SSA #1 11/21/2017
Greater Seacoast Community Health - Lilac Pediatrics	yes	<i>SSA #1 completed</i>
Southeastern NH Services	Yes	9/2016
Hope on Haven Hill	Yes	10/2016
Seacoast Youth Services	Yes	12/2018
Portsmouth Regional Hospital / HCA	Yes	10/2016
Appledore Family Medicine	yes	<i>SSA #1 10/30/2018</i>
Dover Pediatrics	Yes	12/2018

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

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

Note: Core Pediatrics is not a B1 partner, they are represented in our discussion of E5 projects.

B1 partners are represented by sector on the Executive Committee as listed below. Additional participation and planning representation occur through the Clinical Advisory Team. Between these two groups, all B1 partners are represented except for the two B1 enterprise partners added in December 2018; Seacoast Youth Services and Dover Pediatrics.

Executive Committee:

Monthly meetings with representation from across all required organization types as listed in STC Section II (c)

Table B1-7a: Executive Committee

Name	Title	Organization	Sign Off Received
George Maglaras	Executive Council Chair	Strafford County Commissioners	Yes
John Burns	Assoc. Dir, Strategic Partnerships	SOS Recovery/Goodwin Health Center	Yes
Carrie Conway	Criminal Justice Programming Coordinator	Strafford County Community Corrections	Yes
Jay Couture	Executive Director	Seacoast Mental Health Center	Yes
Kathy Crompton	Director, Strategic Initiatives	Strafford Community Action Partnership	Yes
Sharon Drake	Chief Executive Officer	Hope on Haven Hill	Yes
Chris Kozak	Chief Operating Officer	Community Partners	Yes
Cathy Smith	Chief Operating Officer	Goodwin Community Health	Yes
Bernie Seifert	Older Adult Services Coordinator	NAMI - NH	Yes
Helen Taft	Executive Director	Families First Health & Support Center	Yes
Greg White	Chief Executive Officer	Lamprey Health Care	Yes
Steve Woods	Administrator	Rockingham County Nursing Home	Yes
Paige Farmer	Director	Home For All / Greater Seacoast Coalition to End Homelessness	Yes
Sandra Rose	Consumer	-----	Yes
Nick Pfeifer	Chief Executive Officer	Southeastern NH Services	Yes
Kellie Mueller	Director of Behavioral Health Services	Wentworth Douglass Hospital	Yes

Clinical Advisory Team (CAT):

Meets minimum of quarterly (4 meetings/year)

Each CAT representative provides subject matter expertise, facilitation, or master training in clinical, health care hospital and/or practice management, behavioral, social, or integrated healthcare. Participation will inform the strategic, operational and project based work being undertaken by the Region 6 IDN. The Partner Agency will make every effort to ensure continuity of participation from the identified representative.

CAT 2018 Meeting Dates:

January 16, 2018
February 15, 2018
June 20, 2018

August 9, 2018
September 12, 2018
November 14, 2018
December 12, 2018

Table B1-7b: Clinical Advisory Team

Name	Title	Organization
Ben Hillyard	Consultant	Private Practice
Bobby Kelly	Family Physician	Exeter Health Resources
Peter Fifield	Behavioral Health	Wentworth Douglass Hospital / HUB
Patty Driscoll	Director of Adult Services	Seacoast Mental Health
John Iudice	Director	NH Provider Services
Deb Harrigan	Director of Primary Care	Frisbie Hospital
Susan Nichols	Physician Assistant / BH provider	Lamprey Health Care
Darren Guy	Population Health Director	Exeter Health Resources
Skip Homicz	Dentist	Families First Health Center
Rosalyn Moriarty	Special Services	SAU 16
Nancy Pettinari	Medical Director	Wentworth Douglass Hospital
Melanie Lanier	Medical Director	Exeter Health Resources
Kellie Mueller	Director of Behavioral Health	Wentworth Douglass Hospital
Jay Sawler	Special Services	SAU 16
Valerie Brown	Senior Consultant	Myers and Stauffer
Steve Curtis	Inpatient Director	HCA Healthcare
Nick Pfeifer	CEO	Southeastern NH Services

All-Partner Meetings: Invitation to all B1 and community partners

All-Partner 2018 Meeting dates: January 25, 2018 & June 7, 2018. Next planned All-Partner meeting for February 21, 2019 - will include new partners Dover Pediatrics and Seacoast Youth Services.

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

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

For pediatric providers, the CCSA must also include:

- Validated developmental screening for all children, such as the ASQ:3 and/or ASQ SE at 9, 18 and 24/30 month pediatric visits
- Developmental screening using Bright Futures or other American Academy of Pediatrics recognized screening.
- b. List of multi-disciplinary core team members that includes, at minimum:
 - PCPs
 - Behavioral Health Providers (including a psychiatrist)
 - Assigned care managers or community health worker
- c. Multi-disciplinary core team training for service providers on topics that includes, at minimum:
 - Diabetes hyperglycemia
 - Dyslipidemia
 - Hypertension
 - Mental health topics (multiple)
 - SUD topics (multiple).
- d. Training for staff not providing direct care that at minimum includes knowledge and beliefs about mental disorders that can aid in recognition and management.
- e. Monthly (or more frequent) core team case conferences on behalf of patients with significant behavioral health conditions or chronic conditions.
- f. Secure Messaging
- g. Closed Loop Referrals
- h. Documented workflows and/or protocols that include, at minimum:
 - Interactions between providers and community based organizations
 - Timely communication
 - Privacy, including limitations on information for communications with treating provider and community based organizations
 - Coordination among case managers (internal and external to IDN)
 - Safe transitions from institutional settings back to primary care, behavioral health and social support service providers
 - Adherence to NH Board of Medicine guidelines on opioid prescribing.

B1-8a

DHHS Final Review from previous submission:

CCSA single-formats implemented:

IDN Region 6 CMHC partners currently use single-format CCSA tools:

- ADULT NEEDS & STRENGTHS ASSESSMENT (ANSA) (*attachment B1-8a.1*)
- CHILD AND ADOLESCENT NEEDS AND STRENGTHS (CANS) (*attachment B1-8a.2*)

IDN Region 6 FQHC partners currently use CCSAs formatted as intake forms that include all the elements of the PRAPARE tool as endorsed by the National Association of Community Health Centers:

- PRAPARE: Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences (*attachment B1-8a.3*)

Partners outside of these two categories have indicated that, although they do not currently have one tool to capture all elements of the CCSA, they do collect information under the necessary domains as part of their intake, clinical visit documentation, and additional forms created for use by non-billable clinical support staff such as Care Managers (*see attachment B1-8a.4*). This information is integrated into care planning via multiple methods; huddles, case reviews, and EMR documentation.

It is the IDN 6 strategy to continuously promote aggregation of the CCSA domains in one consistent format whenever possible. The goal is to have all domains visible to care team members and considered in the preparation of the care plan involving the entire MDCT. SSA strategy and technical assistance meetings are used as opportunities to discuss progress on CCSA development and workflows to address needs identified in CCSA domains. As discussed in B1-4, partners have expressed renewed interest in Integration Coaching and CCSA enhancement will be a priority of that coaching. At the next report interval of 2/15/19, we anticipate at least 9 partners will be reporting on full-scope CCSA implementation numbers.

Note on newest B1 Enterprise partners / CCSA development:

Both Dover Pediatrics and Seacoast Youth Services became B1 partners in December 2018. As a primary care practice, Dover Pediatrics will make continued progress toward achieving Coordinated Care Practice designation. This progress has begun (see description of engagement to date below) with significant movement over the past reporting period. Seacoast Youth Services is an SUD provider and remains engaged in development of the CCSA, as required by the STCs, as well as increasing their service availability in the region with IDN 6 support.

Please see the Appendix of Attachments for B1.8a.1-B1.8a.3.

Attachment B1.8a.4 CCSA Domains By Partner TABLE follows

Attachment B1.8a.4 CCSA Domains By Partner

CCSA Domains	Frisbie Hospital	Rochester Pediatrics	Wentworth Douglass Hospital	Wentworth Health Partners / Internal Medicine	Hilltop Family Practice	Seacoast Mental Health Center (CANS / ANSA)
Demographic information	YES	YES	YES	YES	YES	YES
Physical health review	YES	YES	YES	YES	YES	YES
Substance use review	SOME	@ Age Appropriate*	SOME	SOME	SOME	YES
Housing assessment	SOME	YES	SOME	SOME	SOME	SOME
Family and support services	SOME	YES	SOME	SOME	SOME	YES
Educational attainment	RARELY	YES	SOME*	SOME*	SOME*	YES
Employment or entitlement	RARELY	SOME	SOME*	SOME*	SOME*	YES
Access to legal services	RARELY	RARELY	SOME*	SOME*	SOME*	SOME
Suicide risk assessment	RARELY	@Age Appropriate*	YES*	YES*	YES*	YES
Functional status assessment	SOME	NO	SOME	SOME	SOME	YES
Universal screening using depression screening (PHQ 2 & 9) and	RARELY	@Age Appropriate*	YES	YES	YES	YES
Universal screening using SBIRT	RARELY	NO *	SOME	SOME	SOME	NO*
Pediatric provider CCSA:						
Validated developmental screening for all children, such as the ASQ:3 and/or ASQ SE at 9, 18- and 24/30-month pediatric visits	YES	YES	YES	N/A	YES	YES
Developmental Screening using Bright Futures or other American Academy of Pediatrics recognized developmental tool	YES	YES	YES	N/A	YES	YES

CCSA Domains	Lamprey Health Care - Newmarket (SBIRT)	Lamprey Health Care - Raymond (SBIRT)	Community Partners (CANS / ANSA)	Exeter Hospital	Seacoast Family Practice - Stratham	Core Family and Internal Medicine - Exeter
Demographic information	YES	YES	YES	YES	YES	YES
Physical health review	YES	YES	YES	YES	YES	YES
Substance use review	YES	YES	YES	YES	YES	YES
Housing assessment	YES	YES	SOME	SOME	SOME	SOME
Family and support services	YES	YES	YES	SOME	SOME	SOME
Educational attainment	YES	YES	YES	SOME	SOME	SOME
Employment or entitlement	YES	YES	YES	SOME	SOME	SOME
Access to legal services	YES	YES	SOME	SOME	SOME	SOME
Suicide risk assessment	YES	YES	YES	SOME	SOME	SOME
Functional status assessment	YES	YES	YES	SOME	SOME	SOME
Universal screening using depression screening (PHQ 2 & 9) and	YES	YES	YES	YES	YES	YES
Universal screening using SBIRT	YES	YES	NO *	NO *	NO *	NO *
Pediatric provider CCSA:						
Validated developmental screening for all children, such as the ASQ:3 and/or ASQ SE at 9, 18- and 24/30-month pediatric visits	YES	YES	YES	YES	YES	YES
Developmental Screening using Bright Futures or other American Academy of Pediatrics recognized developmental tool	YES	YES	YES	YES	YES	YES

CCSA Domains	Greater Seacoast Community Health - Families First (SBIRT & S2BI)	Greater Seacoast Community Health - Goodwin Community Health (SBIRT & S2BI)	Southeastern NH Services	Hope on Haven Hill	Seacoast Youth Services
Demographic information	YES	YES	YES	YES	YES
Physical health review	YES	YES	YES	YES	YES
Substance use review	YES	YES	YES	YES	YES
Housing assessment	YES	YES	YES	YES	YES
Family and support services	YES	YES	YES	YES	YES
Educational attainment	YES	YES	SOME	YES	YES
Employment or entitlement	YES	YES	YES	YES	YES
Access to legal services	YES	YES	SOME	YES	YES
Suicide risk assessment	YES	YES	YES	YES	YES
Functional status assessment	YES	YES	SOME	YES	YES
Universal screening using depression screening (PHQ 2 & 9) and	YES	YES	YES	YES	YES
Universal screening using SBIRT	YES	YES	YES	YES	YES
<i>Pediatric provider CCSA:</i>					
Validated developmental screening for all children, such as the ASQ:3 and/or ASQ SE at 9, 18- and 24/30-month pediatric visits	YES	YES	N/A	N/A	N/A
Developmental Screening using Bright Futures or other American Academy of Pediatrics recognized developmental tool	YES	YES	N/A	N/A	N/A

CCSA Domains	Portsmouth Hospital	Appledore Family Medicine	Dover Pediatrics
Demographic information	YES	YES	YES
Physical health review	YES	YES	YES
Substance use review	SOME	SOME	YES
Housing assessment	SOME	SOME	<i>pending</i>
Family and support services	SOME	SOME	<i>pending</i>
Educational attainment	RARELY	RARELY	<i>pending</i>
Employment or entitlement	RARELY	RARELY	<i>pending</i>
Access to legal services	RARELY	RARELY	<i>pending</i>
Suicide risk assessment	RARELY	RARELY	YES
Functional status assessment	SOME	SOME	<i>pending</i>
Universal screening using depression screening (PHQ 2 & 9) and	RARELY	SOME*	YES
Universal screening using SBIRT	RARELY	RARELY	<i>pending</i>
Pediatric provider CCSA:			
Validated developmental screening for all children, such as the ASQ:3 and/or ASQ SE at 9, 18- and 24/30-month pediatric visits	YES	YES	YES
Developmental Screening using Bright Futures or other American Academy of Pediatrics recognized developmental tool	YES	YES	YES

B1-8b

Multidisciplinary core teams have been identified at all primary care and behavioral health partners. The minimum monthly case review meetings with all-partner and/or partner-specific access are detailed in Section B1-8e.

UPDATED Table B1-8b: Multidisciplinary Core Teams as of submission date 4/5/19

Organization/Provider	MDCT roles identified	Roles included in MDCT / *external component
WAVE ONE		
Frisbie Memorial Hospital	YES	PCPs, Behavioral health providers, Assigned care managers, *psychiatrist
Rochester Pediatrics	YES	PCPs, Behavioral health provider, RN Care Manager, *psychiatrist
Skyhaven Internal Medicine	YES	PCPs, Behavioral health provider, RN Care Manager, *psychiatrist
White Mountain Community Health Center	YES	PCPs, Behavioral health provider, RN Care Manager, *psychiatrist
Wentworth Douglass Hospital	YES	PCPs, Behavioral health provider, BH Care Manager, Psychiatrist via e-consult
Wentworth Health Partners / Internal Medicine	YES	PCPs, Behavioral health provider, BH Care Manager, Psychiatrist via e-consult
Hilltop Family Practice	YES	PCPs, Behavioral health provider, RN Care Manager, Psychiatrist via e-consult
Lee Family Practice	YES	PCPs, Behavioral health provider, RN Care Manager, Psychiatrist via e-consult
Seacoast Mental Health Center	YES	*PCPs, Behavioral health providers, Assigned care managers, psychiatrist
Lamprey Health Care - Newmarket	YES	PCPs, Behavioral health providers, Assigned care managers, psychiatrist

Lamprey Health Care - Raymond	YES	PCPs, Behavioral health providers, Assigned care managers, psychiatrist
Community Partners	YES	*PCPs, Behavioral health providers, Assigned care managers, psychiatrist
WAVE TWO		
Exeter Health Resources/CORE	YES	PCPs, Behavioral health providers, Assigned care managers, *psychiatrist
Seacoast Family Practice - Stratham	YES	PCPs, Behavioral health providers, Assigned care managers, *psychiatrist
Core Family and Internal Medicine - Exeter	YES	PCPs, Behavioral health providers, Assigned care managers, *psychiatrist
Greater Seacoast Community Health - Goodwin Community Health	YES	PCPs, Behavioral health providers, Assigned care managers, *psychiatrist
Greater Seacoast Community Health - Families First	YES	PCPs, Behavioral health providers, Assigned care managers, *psychiatrist
Greater Seacoast Community Health – Lilac City Pediatrics	YES	PCPs, Behavioral health providers, Assigned care managers, *psychiatrist
Southeastern NH Services	YES	PCPs (on-site from Families First), Behavioral health providers, Assigned care managers, *psychiatrist
Hope on Haven Hill	YES	*PCPs, behavioral health provider, RN Care Manager, *psychiatrist
Seacoast Youth Services	YES	*PCPs, behavioral health provider, Care Manager, *psychiatrist
Portsmouth Regional Hospital / HCA	YES	PCPs, Behavioral health providers, Assigned care managers, psychiatrist
Appledore Family Medicine	YES	PCPs, RN Care Manager, *behavioral health provider, *psychiatrist
Dover Pediatrics	YES	PCPs, Behavioral health provider, BH Care Manager, *psychiatrist

B1-8c

Training strategy has been a focus of direct discussion with our B1 partners during the past reporting period. Implemented and planned trainings are included in the attachments B1-8c.a and B1-8c.b, and B1-8a.c. In addition to the trainings executed and planned, partners are notified by email of additional opportunities for training issued by the Myers & Stauffer Learning Collaborative, the other IDNs in NH, the University of New Hampshire, Southern NH AHEC, partner community-based agencies, and others.

We also target outreach to specific partners when appropriate to highlight the relevance of specific training to their practice, or to offer scholarship support for their staff to attend. In any instance where the IDN can provide a scholarship or travel assistance to promote attendance, these offers are made. It is not possible to track every partner's participation in events not directly sponsored or funded by the IDN, but the email notification list for all opportunities is inclusive of all B1 partner practice contacts.

Partners have identified a significant need for on-line and/or webinar trainings that they can present to their MDCT members and support staff at their convenience. Attending scheduled events and/or leaving the practice(s) to attend trainings is a significant barrier for many partner participants.

The IDN6 has identified the creation of a web-based training link as a priority for first quarter 2019. The structure will directly reflect the IDN core competency trainings that MDCT members, and all others possible, are encouraged to take as part of their Coordinated Care practice development. In addition, development of Integrated Practice knowledge and program application will be included.

Future / ongoing training notes:

- MAT training for LHC - Newmarket primary care nurses (5) in support of MAT services
- SBIRT / S2BI for Rochester Pediatrics
- Ongoing topics for all Pediatrics practices vis Psych Teleconference monthly call
- Modular Approach to Therapy for Children (MATCH) Feb 25-Mar 1, 2019. Delivered by Harvard Judge Baker Children's Center, this is a high quality, evidence-based counseling program for children experiencing multiple problems related to anxiety, depression, post-traumatic stress, and disruptive conduct, including conduct problems associated with ADHD.
- IDN track core training sessions from the BH Summit of December 2018 will be made available as webinars for all MDCT members and partner staff.

- Upcoming February 2019

Certificate in Pediatric and Behavioral Health Integration: *for pediatric health practitioners, mental health practitioners and practice administrators seeking to develop an integrated approach to behavioral health in their practices.* The certificate program will focus on developing practitioners' skills related to their patients' mental health needs, but will also focus on developing systems to support effective, sustainable integrated behavioral health care. https://www.williamjames.edu/academics/lifelong/ce/pediatric-and-behavioral-health-integration-on.cfm?cssearch=13765_1

The IDN will fund the 6-month course and there are 21 CEU/CME credits attached to it. **B1 and E5 pediatric partners anticipated to attend:**

1. **Lilac City Pediatrics / Greater Seacoast Community Health**
Rima Sutton (LICSW), Rebecca Searles (LICSW)
2. **Rochester Pediatrics**
Alexa Randall (FMT), Pam Udomprasert, Erica Boheen / Leadership - Emily Garland, Deb Harrigan, MD
3. **Core Pediatrics (E5)**
Marjorie Darmody (RN Care Coordinator), Jodie Lubarsky, Pediatrician / Leadership - Sarah Plante
4. **Seacoast Mental Health Center (B1 and E5)**
5. **Dover Pediatrics**
Dr. Rachel Laramée, Jessica Foye MSW, Joe Pagnotta / Practice Leadership
6. **Private Practice consultants**
7. Ben Hillyard, Jessica Lyons

Ben Hillyard will then be supported by the IDN 6 to lead a **Community of Practice** after the course is done and help to facilitate the learnings and the NH Seacoast region group through the program.

BEHAVIORAL HEALTH

Training provided	Date	Project Impacted	Total Attendance**	Agencies attending**	Sectors/Key Organizational Participants Attending**	IDN Role
Trauma Informed Care Advanced professional development for professionals seeking to become “trauma competent” and to develop trauma-informed systems of care in their own agencies/organizations.	8/2/2018	A1, B1, C1, D3, E5	25	Dondero Elementary School; Region 6 IDN; Lamprey Health Care; Families First Health Center; Southern NH Services; Tri-City Consumers Action Cooperative; Easter Seals NH & Military/Veterans Services; Southeastern NH Services; AIDS Response Seacoast; WIC; Rochester Pediatric Associates; HAVEN; New Franklin Elementary School; Frisbie Hospital; Goodwin Community Health Center; Wentworth Douglass Hospital	Schools; IDN CTI; SUD assessment, treatment & recovery; FQHC; MH Peer Support; Hospitals; DV/sexual assault; Social Services; Pediatric Primary Care	Provided via AHEC contract
CTI Community of Care Training on the CTI Model	Aug. 2018	C1	29	Mental Health Center of Greater Manchester; Easter Seals NH; Region 6 IDN; SOS Recovery Community Organization; Tri-City Consumers Action Cooperative; Family Resource Center at Gorham; Monadnock Family Services; Littleton Regional Health Care/North Country Primary Care; North Country Health Consortium; Northern Human Services; Tri-County Community Action Program	CMHC; IDN; Human Services Homeless Services; Primary Care; SUD Peer Recovery	Region 6 IDN staff led

<u>A Taste of Motivational Interviewing</u>	8/31/2018	A1, B1, C1, D3, E5	11	Child & Family Services of NH; Appledore Medical Group; Seacoast Mental Health Center; Dover Housing Authority	Primary Care; Social Services; SUD; CMHC; Public Housing	Provided via AHEC contract
Introductory training on Motivational Interviewing.						
<u>Lynn Lyons webinars</u>	Sept 2018	B1	1	Rochester Pediatric Associates	Pediatric Primary Care	Paid for webinar participation
Lynn Lyons is a specialist on children with ADHD and how to talk to parents of anxious children						
<u>A Taste of Motivational Interviewing</u>	9/7/2018	A1, B1, C1, D3, E5	9	Rochester School Dept; Exeter Health Resources; Rochester Youth Reach; Seacoast Mental Health Center; Child & Family Services of NH	Primary Care; Schools; Social Services; SUD; Community Health Center; CMHC	Provided via AHEC contract
Introductory training on Motivational Interviewing.						
<u>Trauma Informed Care in Health & Social Services</u>	9/25/2018	A1, B1, C1, E5	8	Strafford County Community Corrections; Community Partners; Cross Roads House; Child & Family Services	Community Corrections; CMHC; Homeless Services; Social Services	Provided via AHEC contract
Incorporating trauma-informed care as a strengths-based approach to caring for patients and clients.						
<u>Clubhouse International Conference</u>	10/14-16/2018	A1, C1	3	Granite Pathways staff attended Clubhouse International Conference	Mental Health Peer Recovery	Paid for three staff to attend national conference

<p><u>Mental Health First Aid</u> An 8-hour course that teaches how to identify, understand and respond to signs of mental illnesses and substance use disorders. The training provides the necessary skills to reach out and provide initial help and support to someone who may be developing a mental health or substance use problem or experiencing a crisis.</p>	10/26/2018	A1, B1, C1	7	St. Vincent de Paul, St. Michael's Parish; Exeter Hospital; SAU 15	Faith community; Social Services; Schools; Hospitals	Provided via AHEC contract
<p><u>Trauma Informed Care in Health & Social Services</u> Incorporating trauma-informed care as a strengths-based approach to caring for patients and clients.</p>	10/30/2018	A1, B1, C1, E5	17	Families First; Community Partners; Rochester Schools; Cross Roads House; Seacoast Mental Health Center; Frisbie Hospital; Goffstown High School	Schools; Hospitals; FQHC; Homeless Services; CMHC; Goodwin Community Health	Provided via AHEC contract
<p><u>Stigma Across Cultures</u> The impact of stigma on clients accessing BH and SUD services</p>	11/8/2018	A1, B1, C1	6	Cross Roads House, Easter Seals NH, Seacoast Mental Health Center	Homeless Services, Social Services, CMHC	Provided via AHEC contract

SBIRT Training provides information on integrating Screening Brief Intervention and Referral to Treatment (SBIRT) into primary care practice.	11/13/2018	A1, D3	5	Provided to staff of Joan G Lovering Health Center	Administration, RN, APRN	Provided via AHEC contract
NH Behavioral Health Summit	12/10/18 and 12/11/18	A1, B1, C1, D3, E5	35	Bridging the Gaps; Families First; Frisbie Hospital; Skyhaven Internal Medicine; Goodwin Community Health; Granite Pathways; Lamprey Health Care; Region 6 IDN; Rochester Pediatrics; Center for Collaborative Change; Rockingham County Corrections; Safe Harbor; Southeastern NH Services; SOS Recovery Community Organization; Strafford County Community Corrections; Strafford County Public Health Network; Wentworth Douglass Hospital	Hospitals; FQHCs; IDN; Primary Care; SUD Assessment, Treatment, Recovery & Prevention; Mental Health Peer Recovery; Corrections; Public Health;	Provided scholarships

<p><u>Core Competencies for Primary Care Behavioral Health Integration: Knowledge, Skills & Attitudes (NH Behavioral Health Summit)</u></p>	<p>12/10/18 and 12/11/18</p>	<p>A1, B1</p>	<p>50</p>	<p>Registration roster maintained by NH Providers' Association</p>	<p>IDN Staff conducted training</p>
<p>Overview of the key competencies needed to practice as a behavioral health clinician in primary care.</p>					

<p><u>The Community Care Team: A Model Strategy for Systems Alignment (NH Behavioral Health Summit)</u></p>	<p>12/10/18 and 12/11/18</p>	<p>A1, B1, C1, D3, E5</p>	<p>50</p>	<p>Registration roster maintained by NH Providers' Association</p>	<p>IDN Staff conducted training</p>
<p>Understanding the CCT model, how to start and develop a CCT, and understanding the value of a CCT for coordinated and integrated care models across a network of clinical/non-clinical entities and for network development and systems alignment.</p>					

**SUBSTANCE USE
DISORDER**

Training provided	Date	Project Impacted	Total Attendance**	Agencies attending**	Sectors/Key Organizational Participants Attending**	IDN Role
<p><u>Initial Training on Addiction and Recovery</u></p> <p>An introductory training on addiction designed to raise awareness and understanding of the dynamics and impact of addiction including the neurological basis of addiction; mental, behavioral, emotional and spiritual dimensions; stages of change; recovery; and motivational techniques and resources.</p>	9/26/2018	A1, B1, C1, D3, E5	22	Rochester Schools; Frisbie Memorial Hospital; Life Coping; Lamprey Health Care; Granite Pathways; Cross Roads House; Strafford County Corrections; Goodwin Community Health; Seacoast Mental Health Center; Bridging the Gaps; Homeless Center for Strafford County; Southeastern NH Services	Schools; Hospitals; SUD Recovery and Treatment; FQHC; SUD Peer Support; Homeless Services; Corrections; CMHC; SUD Prevention	IDN Provided, BDAS staff led training

<p><u>Stigma Across Cultures</u></p> <p>The impact of stigma on clients accessing BH and SUD services</p>	11/8/2018	A1, B1, C1, D3	6	Cross Roads House, Easter Seals NH, Seacoast Mental Health Center	Homeless Services, Social Services, CMHC	Provided via AHEC contract
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CHRONIC DISEASE

Training provided	Date	Project Impacted	Total Attendance**	Agencies attending**	Sectors/Key Organizational Participants Attending**	IDN Role
<u>Better Choices, Better Health - Chronic Pain Self-Management Leaders Training</u> Training in leading groups on Chronic Disease Self Management	9/26-27/18	A1, B1	3	Lamprey Health Care	Social work	Provided via AHEC contract
<u>Better Choices, Better Health - Chronic Pain Self-Management Crossover Training</u> Crossover training for those already trained to lead groups on Chronic Disease Self Management	11/2/2018	A1, B1	2	Lamprey Health Care	FQHC	Provided via AHEC contract

INTEGRATION SUPPORT

Training provided	Date	Project Impacted	Total Attendance**	Agencies attending**	Sectors/Key Organizational Participants Attending**	IDN Role
<u>Clinical Integration</u> Integrating behavioral health and primary care, led by Cherokee Systems	9/27/18 and 9/28/2018	A1, B1	26	Frisbie Hospital & Physician Practices; Region 6 IDN; Exeter Health Resources; Wentworth Health Partners; Seacoast Mental Health Center; Families First; Goodwin Community Health; Rochester Pediatrics; Lamprey Health Care;	Hospitals; Primary Care; FQHCs; CMHCs	Sponsored in partnership with Regions 1 and 4

Billing & Coding for FQHCs	10/3/2018	A1, B1	8	Lamprey Health Care; Families First; Catholic Medical Center; Manchester CHC	FQHCs; Healthcare for the Homeless	Provided
Billing and coding for Integrated Behavioral Health with a focus on ensuring payments.						

Billing & Coding for FQHCs	10/4/2018	A1, B1	16	Exeter Health Resources; Wentworth Douglass Hospital; Frisbie Memorial Hospital; Dover Pediatrics	Hospitals; Primary Care	Provided
Billing and coding for Integrated Behavioral Health with a focus on ensuring payments.						

OTHER

Training provided	Date	Project Impacted	Total Attendance**	Agencies attending**	Sectors/Key Organizational Participants Attending**	IDN Role
Ready to Rent	9/1/2018	C1, E5	10	Rockingham County Corrections	Inmates	IDN Staff led training
Four sessions, 2-hours each, to learn resources, skills, attitudes and behaviors for procuring and maintaining housing in their communities.						

**** When available**

Please see Attachment B1-8c.c in the Appendix of Attachments for Cherokee Integrated Care Training IDN 6 Attendance List – September 27/28, 2018

Attachment B1-8c.b

IDN REGION 6 PROPOSED TRAINING 2019

<u>BEHAVIORAL HEALTH</u>					
PLANNED Training	Date	Potential Project(s) Impacted	Projected Attendance**	Anticipated Audience	IDN Role
<p><u>Stigma Across Cultures</u></p> <p>Cultural effectiveness training focused on SUD and mental illness</p>	1/24/2019	A1, B1, C1, D3, E5	8-12	IDN Partners; Health and Human Service Agencies	Provided via AHEC contract
<p><u>Modular Approach to Therapy for Children (MATCH)</u></p> <p>Delivered by Harvard Judge Baker Children’s Center, this is a high quality, evidence-based counseling program for children experiencing multiple problems related to anxiety, depression, posttraumatic stress, and disruptive conduct, including conduct problems associated with ADHD.</p>	Feb 25- Mar 1	A1, B1, E5	3-5	IDN Partners	Providing scholarships for 3-5 clinicians, particularly pediatric BH specialists, to attend.
<p><u>The Impact of Compassion Fatigue in Human Service Work</u></p> <p>Define compassion fatigue, identify signs and symptoms, apply self-care practices, build a self-care plan.</p>	Feb 5 or Feb 16	A1, C1, D3, E5	6-10	IDN Care Coordinators	Paying for staff to attend.

Foundations in Trauma Informed Care – Day 1 Advanced professional development opportunity for professionals seeking to become “trauma competent” and to develop trauma-informed systems of care in their own organizations.	4/16/2019	A1, B1, C1, D3, E5	25	IDN Partners; Health and Human Service Agencies; Schools	Provided via AHEC contract
Foundations in Trauma Informed Care – Day 2 Implementing learning from Day 1. Also open to participants of August Day 1 training	4/17/2019	A1, B1, C1, D3, E5	25	IDN Partners; Health and Human Service Agencies; Schools	Provided via AHEC contract
Mental Health First Aid An 8-hour course that teaches how to identify, understand and respond to signs of mental illnesses and substance use disorders. The training provides the necessary skills to reach out and provide initial help and support to someone who may be developing a mental health or substance use problem or experiencing a crisis.	TBD	A1, B1, C1	6-10	IDN Partners; Health and Human Service Agencies; Schools	Provided via AHEC contract
MAT for Nurses	TBD	A1, B1, D3		IDN Partners	
<u>SUBSTANCE USE DISORDER</u>					
PLANNED Training	Date	Potential Project(s) Impacted	Projected Attendance**	Anticipated Audience	IDN Role
Stigma Across Cultures Cultural effectiveness training focused on SUD and mental illness	1/24/2019	A1, B1, C1, D3, E5	8-12	IDN Partners; Health and Human Services Agenices	Provided via AHEC contract

<u>SBIRT/Pediatric SBIRT</u> Integrating SBIRT into primary care practice.		A1, B1	Rochester Pediatrics on-site for providers, BH Clinician, and support staff	Provided via AHEC contract
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<u>Partnership for Academic-Clinical Telepractice</u> Case-based learning opportunity on MAT for MAT prescribers and their teams.	April 17 and ongoing	A1, B1, D3	5-10	MAT Rxers, practice teams	Series is free. Promoting to partners to encourage participation
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<u>Enhancing Provider Skills in Serving Active Substance Users (Lunch & Learn)</u> How health care providers can engage and support clients who use drugs in setting and attaining health related goals.	April TBD	A1, B1, D3	4-6	Lamprey Health Care staff	Provided via AHEC contract
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<u>CHRONIC DISEASE</u>					
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PLANNED Training	Date	Potential Project(s) Impacted	Projected Attendance**	Anticipated Audience	IDN Role
<u>Managing Chronic Disease in Behavioral Health Patients</u> Define the latest guidelines for diabetes, hypertension and dyslipidemia; Understand the intersection of BH and chronic disease management; ID barriers to the integration of BH and CDM and strategies to overcome those barriers.	TBD; possibly via webinar	A1, B1	15-20	B1 Partners	TBD

<p><u>Managing Chronic Disease in Behavioral Health Patients</u></p> <p>Define the latest guidelines for diabetes, hypertension and dyslipidemia; Understand the intersection of BH and chronic disease management; ID barriers to the integration of BH and CDM and strategies to overcome those barriers.</p>	February	B1, C1	5-10	Care Transitions Team, B1 Partners	Presentation and facilitation
<p><u>Diabetes and Behavioral Health</u></p>	TBD	A1, B1		B1 Partners	
<u>INTEGRATION SUPPORT</u>					
<p>PLANNED Training</p>	Date	Potential Project(s) Impacted	Projected Attendance**	Anticipated Audience	IDN Role
<p><u>Certificate in Pediatric and Behavioral Health Integration</u></p> <p>Intended for pediatric health and mental health practitioners and practice managers seeking to develop an integrated approach to behavioral health in their practices. Focuses on developing practitioners' skills related to their patients mental health needs as well as on developing systems to support effective, sustainable integrated behavioral health care. The curriculum is customized to meet the needs of each professional group.</p>	Feb 23- Aug 4	A1, B1	10	B1 Partners	Providing scholarships for 10 participants followed by an IDN-led Community of Practice

<u>Model, Methods and Money – Cherokee Systems</u> 3-part Zoom series presenting brief integrated care content and then focusing on engagement with participants through discussion and Q&A regarding integrated care, its methodology and long-term sustainability.	Feb 27, March & April	A1, B1	15-20	B1 Partners	Sponsored in partnership with other IDN Regions
<u>Cherokee Health Systems, Integrated Care Training – JUNE 2019</u> Continuation of "Model, Methods and Money" as well as previous Cherokee trainings to build on prior learning.	June TBD	A1, B1	25-30	B1 Partners	Sponsored in partnership with other IDN Regions
<u>Billing and Coding in Integrated Care</u> Enhancing knowledge of billing and coding, including around coding for care coordination, to maximize revenue	TBD	A1, B1	3-10	Dover Pediatrics and additional B1 partners	IDN Role & Sylvia Ronda
<u>OTHER</u>					
PLANNED Training	Date	Potential Project(s) Impacted	Projected Attendance**	Anticipated Audience	IDN Role
<u>Culturally Effective Organizations</u> Learning forum on CEO framework and opportunity to provide TA to practices.	1/15/2019	A1, B1	3-5	IDN Partners; Health and Human Services Agenices	Provided via AHEC contract
<u>NH Legal Assistance</u> How to address Public Benefits Notices of Decision and Notices of Eviction, and working with municipal welfare	1/22/2019	A1, C1, E5	6-10	IDN staff - CTI & Care Coordinators, Operations	Provided by IDN, led by NHLA Director of Litigation

<u>NH Legal Assistance</u> How to address Public Benefits Notices of Decision and Notices of Eviction, and working with municipal welfare	TBD	A1, C1, D3, E5	15-20	IDN Partners; Health and Human Services Staff	Provided by IDN, led by NHLA Director of Litigation
<u>Working in an Ethical Environment</u> Ethics training	TBD	A1, B1, C1, D3, E5	10-15	IDN Partners; Health and Human Services Staff	Provided via AHEC contract
<u>HIPAA Training</u>	TBD		15	CTI Staff and Community Care Team Members	Presenting
AVAILABLE LUNCH AND LEARNS					
Training		Potential Project(s) Impacted	Anticipated Audience		IDN Role
<u>Trauma Informed Care in Health & Social Services</u> Incorporating trauma-informed care as a strengths-based approach to caring for patients and clients.		A1, B1, C1, E5	IDN Partners; Health and Human Services Agencies		Provided via AHEC contract
<u>Enhancing Provider Skills in Serving Active Substance Users</u> How health care providers can engage and support clients who use drugs in setting and attaining health related goals.		A1, B1, D3	IDN Partners		Provided via AHEC contract
<u>SBIRT</u> Integrating SBIRT into primary care practice.		A1, B1	IDN Partners		Provided via AHEC contract

Strafford County Prevention Board Agenda Outline

2018-2019

Meetings are the second Wednesday of each month 8:30-10:00am / McConnell Center Room 305

	Topic/Person Responsible	Agency Spotlight/Person Responsible
September 2018	Anxiety	Community Partners
October	Special Education Rules	Seacoast Youth Services
November	Trauma Informed Systems	Beckett Family of Services
December	Social Media	Haven
January 2019	Diversity Awareness	Somersworth Ready Together
February	Non-Parent Caregivers	DCYF
March	Homeless Youth	Greater Seacoast Coalition on Homelessness
April	Suicide Prevention	Fast Forward
May	Immigration Update	Strafford County Community
June	Wrap-up and Evaluation	

Strafford County Prevention Board

January 9, 2019

8:30-10:00

Agenda

1. Welcome and Introductions

- 2. Facilitated discussion related to the topic/theme:** The meeting facilitator will lead a discussion related to this month's theme, "**Diversity Awareness**".

What questions do we have about this topic?

What perspective could youth or family members offer about this topic?

Are there existing coalitions already addressing this issue?

Is this an issue we should be focusing on as a Prevention Board?

Is there one thing each of us could do in the short term to address this issue?

- 3. Agency/Coalition spotlight:** To offer a more in-depth look at participating organizations, each month one agency/coalition will have an opportunity to spotlight their work. This month we will highlight "**Somersworth Ready Together**".
- 4. Additional Updates/Announcements:** Recognizing that some updates might not fit into the theme, Prevention Board members will have an opportunity to share other updates and announcements.

Table B1-8c.f: MDCT Training Status

MDCT Training Domains	Frisbie Hospital	Rochester Pediatrics	Wentworth Douglass Hospital	Wentworth Health Partners / Internal Medicine	Hilltop Family Practice	Seacoast Mental Health Center
Diabetes	YES	YES	YES	YES	YES	
Dyslipidemia	YES	YES	YES	YES	YES	
Hypertension	YES	YES	YES	YES	YES	
Mental Health / Behavioral Health (multiple options)	YES	YES	YES	YES	YES	YES
SUD / Substance Use (multiple options)	YES	YES	YES	YES	YES	YES
Integration Model (general, coding/billing, etc..)	YES	YES	YES	YES	YES	YES
Cherokee Integration Model	YES	YES	YES	YES	YES	YES
SBIRT / S2BI		planned				
Child Psychiatry Telehealth w/ training session	YES	YES				
Strafford County Prevention Board trainings		YES				
Certificate in Pediatric and Behavioral Health Integration (2/2019)		YES				YES

MDCT Training Domains	Lamprey Health Care - Newmarket	Lamprey Health Care - Raymond	Community Partners	Exeter Hospital	Seacoast Family Practice - Stratham	Core Family and Internal Medicine - Exeter
Diabetes	YES	YES				
Dyslipidemia	YES	YES				
Hypertension	YES	YES				
Mental Health / Behavioral Health (multiple options)	YES	YES		YES	YES	YES
SUD / Substance Use	YES	YES				
Integration Model (general, coding/billing, etc..)	YES	YES	YES	YES	YES	YES
Cherokee Integration Model	YES	YES	NO	YES	YES	YES
SBIRT / S2BI	IMPLEMENTED	IMPLEMENTED				
Child Psychiatry Telehealth w/ training session			YES			
Strafford County Prevention Board trainings	n/a	n/a	YES	n/a	n/a	n/a
Certificate in Pediatric and Behavioral Health Integration (2/2019)			n/a			YES *Core Peds (E5)

MDCT Training Domains	Greater Seacoast Community Health - Families First	Greater Seacoast Community Health - Goodwin Community Health	Southeastern NH Services	Hope on Haven Hill	Seacoast Youth Services
Diabetes	YES	YES	n/a	n/a	n/a
Dyslipidemia	YES	YES	n/a	n/a	n/a
Hypertension	YES	YES	n/a	n/a	n/a
Mental Health / Behavioral Health (multiple options)	YES	YES	YES	n/a	n/a
SUD / Substance Use		YES	YES	n/a	n/a
Integration Model (general, coding/billing, etc..)	YES	YES	YES	NO	NO
Cherokee Integration Model	YES	YES	YES	NO	NO
SBIRT / S2BI	IMPLEMENTED	IMPLEMENTED	n/a	n/a	n/a
Child Psychiatry Telehealth w/ training session		YES	n/a	n/a	n/a
Strafford County Prevention Board trainings		YES		n/a	n/a
Certificate in Pediatric and Behavioral Health Integration (2/2019)		YES *Lilac Peds (future B1)	n/a	n/a	n/a

	Portsmouth Hospital	Appledore Family Medicine	Dover Pediatrics
MDCT Training Domains			
Diabetes			
Dyslipidemia			
Hypertension			
Mental Health / Behavioral Health (multiple options)			
SUD / Substance Use			
Integration Model (general, coding/billing, etc..)	YES	NO	YES
Cherokee Integration Model	NO	NO	NO
SBIRT / S2BI			
Child Psychiatry Telehealth w/ training session			
Stafford County Prevention Board trainings			
Certificate in Pediatric and Behavioral Health Integration (2/2019)			YES

B1-8d

We have provided coding and billing training to all of our B1 partners, provided by Sylvia Ronda. The IDN clinical director is participating in a statewide billing/coding workgroup coordinated by Region 2 and the DHHS. There have been two initial meetings to look at Medicaid billing codes and ways to maximize reimbursement.

It is important to note that many trainings are appropriate for and attended by clinical and non-clinical staff alike. We have found it effective to offer region-wide and site-specific trainings on an ongoing basis to meet shifting partner needs and priorities shaped by flux in demands, funding opportunities, staffing turnover, staff coverage, etc. We have also found that some agencies have internal capacity to deliver these trainings and ongoing support to their own staff, *particularly where BH clinicians and BH Case Managers are embedded*. The IDN Team is diligent about informing Regional partners about training opportunities throughout the region, the state, and some in other states.

Future training strategies:

- ***Online access*** to BH / MH disorder recognition and management for current partner staff
- Promotion of essential core trainings as part of *onboarding* for non-direct care staff
- Development of integration support training for a larger community of practice amongst the support staff who are the connective contacts and organizational staff with significant patient contact. The Director of Operations and Director of Care Coordination are developing the concept for this type of training / conference for discussion with the Executive Committee before June 2019.

B1-8e

UPDATED NARRATIVE is included at the end of this section with the addition of the MDCT meeting dates for Lamprey Health Care – Newmarket and Lamprey Health Care – Raymond.

The IDN 6 has developed and/or supported three models for MDCT case conferences on behalf of patients with significant behavioral health conditions or chronic conditions.

- Pediatric psychiatry *all-partner accessible* teleconference
- Community Care Team *all-partner accessible* case review
- Internal partner-specific case review

All B1 partners and targeted key organizational partners are invited to attend and participate in both the Pediatric psychiatry *all-partner accessible* teleconference and the Community Care Team *all-partner accessible* case review. Not all B1 partners have chosen to participate at this time. Opportunities are reinforced at Executive Committee, Clinical Advisory, and All-Partner meetings. Additional reminders are sent to key MDCT members within the partner organization.

Pediatric Psychiatry case conferences for MDCTs:

Key components of the multidisciplinary team for pediatric and family practices were identified as missing during environmental scanning. These included; lack of access to any child psychiatry providers in Strafford County, low confidence and competence of pediatric providers across the region, a small number of co-located behavioral health providers in pediatric / family practices overall, and lack of coordination between agencies.

In July of 2018 the IDN initiated and funded completely an ECHO-like program using the expertise of Dartmouth Hitchcock psychiatry. Dr. Craig Donnelly facilitates a *bi-monthly* teleconference call in which primary care medical providers, primary care embedded behavioral health providers, school representatives, specialty mental health providers, and community participants attend.

The target group for this B1 initiative is those children and families in the highest need of services including psychiatry, behavioral health, and/or social service involvement. The goals of this ECHO-like project are (1) strengthen the skills of primary care docs and (2) strengthen community capacity to take care of children and families who are at risk for no treatment or undertreatment of behavioral substance use problems, and/or social service connections.

All B1 partners have access to this resource in service of their applicable pediatric populations. There were 10 calls during the reporting period with an average of 10 individuals on each call. In addition to these calls, Dr. Donnelly has been available to respond to emails or phone calls. There have been 15 phone and 7 email consultations. In addition, educational sessions are included in each call. Dr. Donnelly and Alexa Randall work with Dr. Bill Gunn from the IDN 6 to identify guest professionals to present topics. Topics chosen by the group to date are:

- ★ ADHD
- ★ Young children with aggressive behaviors
- ★ Young children with disruptive behaviors
- ★ Trauma Informed Systems
- ★ Eating Disorders
- ★ Ethics around working with patients with an ongoing sexual abuse investigation
- ★ Barriers between schools and healthcare
- ★ Diagnosing Bipolar in children

Region 6 Integrated Delivery Network

Child and Adolescent Psychiatry Telehealth

Call Distribution List

Facilitator: Alexa Randall

Psychiatrist / Facilitator: Dr. Craig Donnelly

Frisbie Memorial Hospital

Emily Garland, Director of Behavioral Health
and Geropsychiatry

Rochester Pediatrics

Alexa Randall, Behavioral Health Clinician
(Coordinator of Call)

Dr. Erica Boheen, MD

Dr. Pam Udomprasert, MD

Joe Miller, NP

Megan Gregoire, Practice Manager

Skyhaven Medical Center

Deb Harrigan, MD

White Mountain Medical Center

Tara McKenna, NP

J. Ball, Medical Provider

K. Woo, Medical Provider

R. Wilt, Medical Provider

T. Fraser, Medical Provider

Tamara Schilling

Community Partners

S. Johnson, NP

R. Allister, MD

Lucy Putnam, LMFT

Amanda Seavey, LICSW Youth and Family
Services Program Manager

Greater Seacoast Community Health -

Goodwin Community Health

Rima Sutton, LCSW

Nicole Bates, LSW

J. Buonomano, Medical Provider

Greater Seacoast Community Health - Lilac City Pediatrics

Dr. Mitch Pivor, MD

Dr. Walter Horeman, MD

Rebeka Balok-Searles, LMHC

Dover Pediatrics

Joe Pagnotta, Practice Manager

Jessica Foye, MSW

Rachel Laramee, MD

COMMUNITY ORGANIZATIONS / PARTNERS

Private Practice Clinician

Ben Hilyard, LMHC

Erisbie Rehabilitation

Melissa Grenier, OT

SCHOOL SYSTEMS

Rochester School District

Christiane Allison, Director of Student Services

Kyle Repucci, Superintendent of Rochester School District

Dover School District

Erica Helm, Special Education Director

Oyster River School District

Ryan Long, School Psychologist

Carina Dolcino

JoAn Saxe

Jean Wons

Dagmar Lamberts

Rheanna Cote

Eileen Moran

Brittany Morley

Felicia Sperry, School Psychologist

Andrea Biniszkiewicz

Heather Machanoff

David Geschwendt

Catherine Plourde

Region 6 Integrated Delivery Network

Child and Adolescent Psychiatry Telehealth

Education Session Summary

7/16/2018

- CASE: Dr. Boheen re: encopresis

8/6/2018

- CASE: Dr. Pivor re: developmental disorder and disruptive behaviors

8/20/2018

- Topic: ADHD in young children and the nuances of med management, therapies, and diagnosing

9/4/2018

- CASE: Dr. Donnelly and Dr. Tappan re: young child with disruptive behaviors
- Topics:
 - Patients choice in provider
 - Ethics around race/religion/small community
 - Trauma informed approaches

9/18/2018

- CASE: Dr. Boheen re: behavioral issues and family support or child
- Topics:
 - Trauma Informed Systems

10/2/2018

- CASE: Dr. Donnelly re: young aggression
- Alexa and Dr. Pam re: disruptive behaviors
- Topics: resources, medication, therapeutic interventions, and parent coaching around young children with behavioral issues

10/16/2018

- CASE: Alexa and Dr. Pruette re: encopresis and sensory issues
- CASE: Dr. Pivor re: med consult for child with ASD
- CASE: Rima Sutton re: child with disruptive behaviors
- TOPIC: Heard from Kay Jankowski, PHD, who is doing research around the impacts of parenteral substance abuse on kids in the state of NH.

11/6/2018

- CASES: Ben Hilyard re: OCD
- TOPIC: Working with pts with an on-going sexual abuse investigation

11/27/2018

- CASE: Tammy Whalen: Young man with substance abuse issues, homeless, and potential neurological disorder.
- CASE: Ben Hilyard: anxiety
- CASE: Nicole from Goodwin: PTSD

12/2018

- CASE: Dr. Pivor re: ADHD/ODD and hospitalizations
- CASE: Dr. Pivor re: Eating Disorder
- Topic: Eating Disorder treatment

1/8/2019

- CASE: NP at Goodwin: When to diagnose with Bipolar
- Topic: OT by Melissa Grenier
- Topic: Barriers between school and healthcare

Total case presentations: 15

Topics:

- ADHD
- Young children with aggressive behaviors
- Young children with disruptive behaviors
- Trauma Informed Systems
- Eating Disorders
- Ethics around working with pts with an ongoing sexual abuse investigation
- Barriers between schools and healthcare
- Diagnosing Bipolar in children

Region 6 Integrated Delivery Network

**Child & Adolescent Psychiatry Telehealth - Dartmouth Hitchcock Medical Center
REFERRAL FORM**

Today's Date: Referring name/contact info:

Patient name: DOB: MRN:

Contact Name: Contact #: Is this legal guardian? Y N

If no, legal guardian name: Contact #:

Referral question/problem:

Are you looking for (check all that apply)?

Psychiatric evaluation and treatment recommendations. **Please note that we are unable to take on medication management for most of the patients we see, and will send recommendations back to PCP or other designated provider.**

- Therapy
- Neuropsychological evaluation*
- Autism/developmental evaluation**

*Please note that neuropsychological evaluation for academic purposes is only considered if problems persist despite the school having already completed testing and implementing a plan. Further, neuropsychological evaluation is not considered for disorders which are primarily behavioral and evidence-based interventions have not yet been tried.

**For these patients, all prior assessments must be noted in history, and evaluations sent in so that we may triage to the appropriate subspecialty clinic.

Psychiatric Diagnoses:

Medical Diagnoses:

Current treatment (incl. medications and therapies):

Are there any concerns with substance abuse? Y_ N___:

Additional history/information that will help us triage and serve this patient:

PLEASE FAX THIS COMPLETED FORM WITH RECENT PROGRESS NOTES TO 603-676-4080. THANK YOU!

Adult Community Care Team (CCT) case conferences for MDCTs:

One missing component of the multidisciplinary team for pediatric and family practices identified during environmental scanning was lack of access to psychiatry providers and lack of coordination between agencies. While the IDN 6 actively seeks to increase the available psychiatry services in the region and directly impact the availability of psychiatric consults via teleconference such as the one described above, creating this connection for every partner is not currently possible.

In the absence of direct psychiatric consult, PCPs and hospital partners managing clients with significant co-occurring BH needs, SDoH needs, SUD diagnoses, and chronic medical conditions continue to need real-time support. The Community Care Team design reinforces the network of support to keep complex patients *as stable as possible* pending full psychiatric consult or service availability.

Core team case conferences for patients with significant behavioral health conditions or chronic conditions were also conducted by both the Seacoast and Strafford County Community Care Teams during the reporting period. The CCT in Strafford County has increased in frequency to twice monthly. The Seacoast CCT meets at least once monthly and occasionally more frequently if case load or acuity indicate a need for increased frequency.

Partner agencies in Rockingham County have expressed interest in an additional CCT meeting of key organizational partners to be hosted either at Lamprey Health Care or Exeter Hospital. The first meeting of this new CCT is planned for February 2019.

The Community Care Teams have established a manual of operations. Members work with established workflows, referral processes, release forms, and a secure email communication / messaging system. See attachment for further details.

Seacoast CCT Meetings Q3/4 2018	Strafford County CCT Meetings Q3/4 2018
July 9	July 2 & July 16
August 13	August 6 & August 20
September 10	September 17
October 8	October 1 & October 15
November 12	November 5 & November 19
December 10	December 3 & December 17

Seacoast CCT Members/*B1 Partner

Amedisys Home Care
 Beacon Health Strategies
 Community Action Partnership of Strafford County

 Child & Family Services
 Cornerstone VNA
 Cross Roads House
 Crotched Mountain Community Care
 Exeter Health Resources*
 Families First of the Greater Seacoast*
 Granite State Independent Living
 Greater Seacoast Coalition to End Homelessness

 Haven
 Hope on Haven Hill*
 NH DHHS Bureau of Elderly and Adult Services
 NH Healthy Families MCO
 One Sky Community Services
 Portsmouth Housing Authority

 Portsmouth Regional Hospital*
 Region 6 Integrated Delivery Network
 Rockingham Community Action
 Rockingham VNA
 Safe Harbor Recovery Center
 Salvation Army, Portsmouth
 Seacoast Mental Health Center*
 Seacoast Pathways (Granite Pathways)
 ServiceLink of Rockingham County
 St. Vincent dePaul Society
 Veterans, Inc.
 Welfare Department, City of Portsmouth
 WellSense Healthplan

Strafford CCT Members/*B1 Partner

Beacon Health Strategies
 Child & Family Services
 Community Action Partnership of Strafford
 County
 Community Partners*
 Cornerstone VNA
 Cross Roads House
 Dover Housing Authority
 Families First of the Greater Seacoast*
 Frisbie Memorial Hospital*
 Goodwin Community Health*
 Granite State Independent Living
 Greater Seacoast Coalition to End
 Homelessness
 Haven
 Homeless Center for Strafford County
 Hope on Haven Hill*
 The Homemakers Services
 My Friend's Place

 NH DHHS Bureau of Elderly and Adult
 Services
 NH Healthy Families MCO
 Region 6 Integrated Delivery Network
 Rochester Community Recovery Center
 Rochester Housing Authority
 ServiceLink of Strafford County
 Somersworth Housing Authority
 SOS Recovery Community Organization
 Southeastern NH Services*
 Tri-City Consumers' Action Co-operative
 Veterans, Inc.
 Welfare Department, City of Dover
 Welfare Department, City of Rochester
 Welfare Department, City of Somersworth
 WellSense Healthplan
 Wentworth-Douglass Hospital*
 Wentworth Home Care and Hospice -
 Amedisys



Region 6 Integrated Delivery Network



Seacoast and Strafford County Community Care Team Workflow

One week prior to meeting

Secure Email CCT members to remind them of meeting date/time/place and request new referrals or names of existing referrals for discussion be sent to me.

Thursday prior to Monday meeting

Send new referral summaries and names to CCT members **via secure email**
Prep document for note-taking
Prep sign in sheet for meeting

Monday meeting

Have any guests / individuals new to the meeting sign the Confidentiality Agreement
Take notes per discussion

Post-meeting

Update my master referral list with new names and new info on existing referrals
Follow up after meeting with action items **via secure email** to MDCT members involved in specific client's care planning

Start date: November 2018:

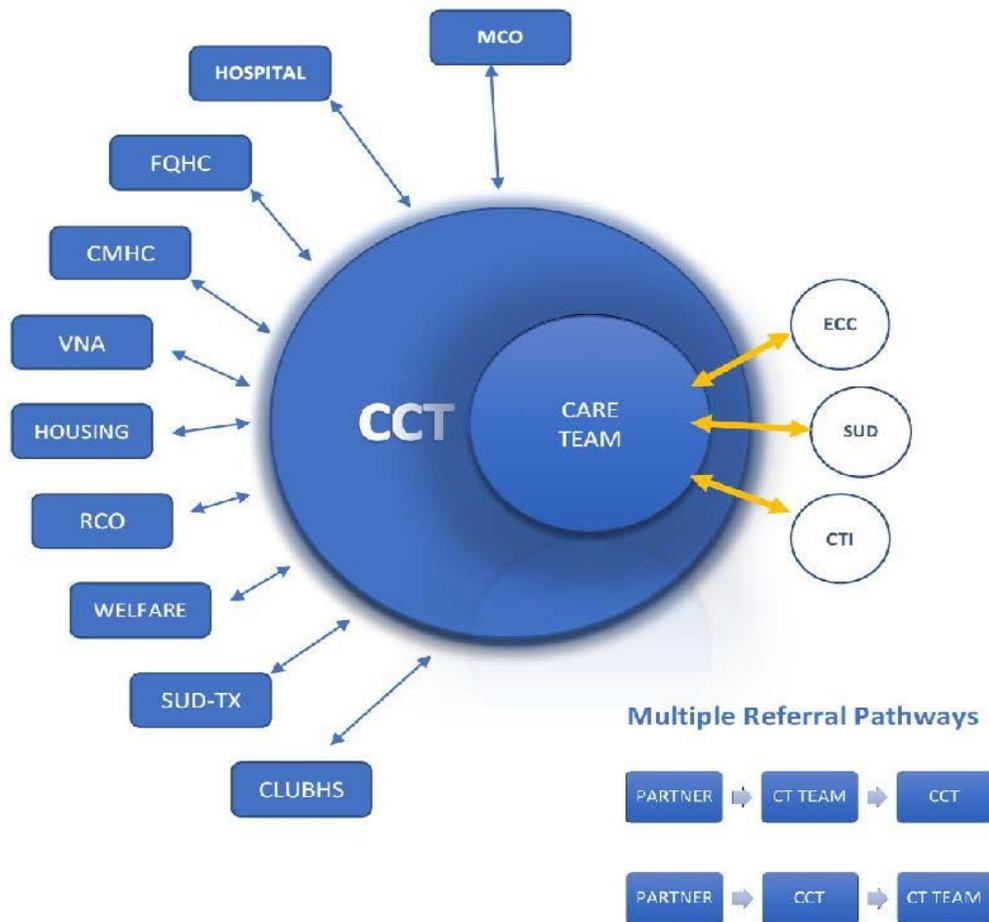
Enter all referrals into Care Director shared care plan tool.

Please see Attachment B1-8e.5 in the Appendix of Attachments for the complete Community Care Team manual.

Please see Attachment B1-8e.6 in the Appendix of Attachments for the Community Care Team Release of Information.

Attachment B1-8e.7 – Community Care Team Diagram of Coordination

Community Care Team Referral Loops and Multidisciplinary Care Coordination



Partner-specific Internal case conference for MDCTs:

Lamprey Health Care - Newmarket and Lamprey Health Care - Raymond are the only B1 partners with a fully-functioning internal MDCT case review model, including psychiatry. To achieve this model, Lamprey Health Care contracts time with Seacoast Mental Health. **A psychiatrist attends case review meetings monthly. He is also available by phone for consults for the MDCT.**

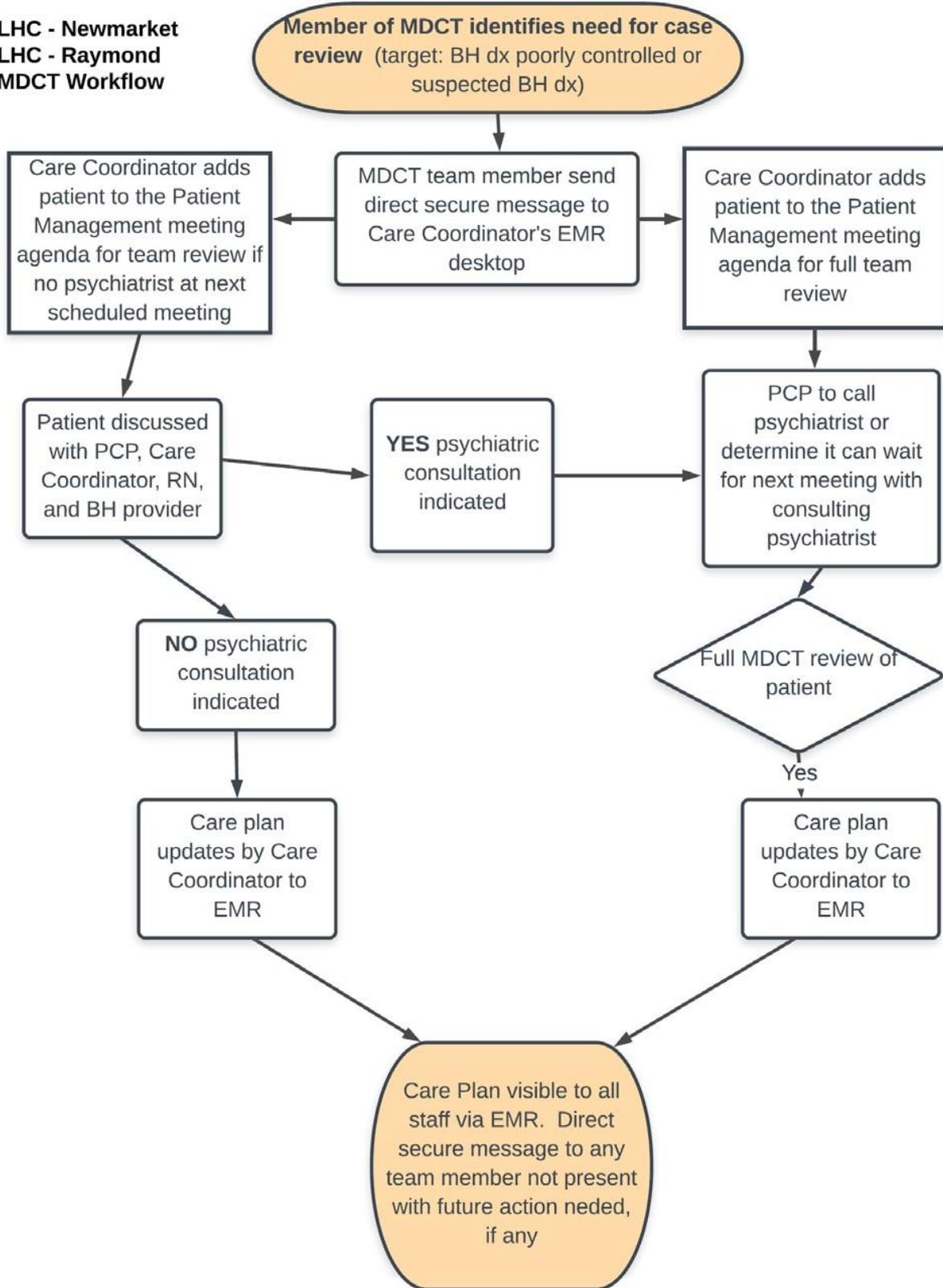
The IDN 6 supports this intact MDCT case review model by providing training to the team members, retention funding for key BH provider staff, and support from the CCT and child psychiatry case reviews, as needed. Indirect support is provided via the IDN 6 support at the partner agency, Seacoast Mental Health. The Lamprey Health Care workflow for this meeting demonstrates the use of internal direct secure messaging, case review, care management and shared care planning.

The 2018 meeting schedule for this MDCT:

- January 16, 2018
- February 22, 2018
- March 12, 2018
- April 26, 2018
- May 15, 2018
- June 28, 2018
- July 17, 2018
- August 23, 2018
- September 18, 2018
- October 25, 2018
- November 20, 2018
- December 27, 2018

Attachment B1-8e.8 on the next page outlines the LHC workflow.

LHC - Newmarket
LHC - Raymond
MDCT Workflow



B1-8f

IDN 6 Operations team has discussed Direct Secure Messaging with all B1 partners. To date, partners, with the exception of SCMH, has indicated that no new support is needed / desired to enhance their use of Direct Secure Messaging. There is no single product or vendor to serve the diverse B1 partner cohort of IDN Region 6. Challenges to any implementation / updated workflows include enterprise partner anticipated EMR changes during the project period. For example, WDH and Wentworth Health Partners will be changing to a new EMR due to their merger with Massachusetts General Hospital. The IDN 6 team will continue to assess partner readiness for new strategy development in this area. This remains a topic for future Executive Committee discussion should implementation strategies be identified.

Current uses among partners include only internal messaging with the exception of:

- Direct secure email to patients via patient portals and/or EHR
- Direct secure email to outside providers in referral processes with secure document transfer

Additional potential secure message strategies will evolve through implementation planning for Allscripts (Care Director), the Region 6 vendor selected to meet the minimum standard requirements for Shared Care Plan, scheduled to commence during the next Reporting Period.

Table B1-8f: Secure Messaging

Organization/Provider	Direct Secure Messaging enabled	IDN enhanced / impacted
WAVE ONE		
Frisbie Memorial Hospital	YES	EHR Enabled
Rochester Pediatrics	YES	EHR Enabled
Wentworth Douglass Hospital	YES	EHR Enabled
Wentworth Health Partners / Internal Medicine	YES	EHR Enabled
Hilltop Family Practice	YES	EHR Enabled
Seacoast Mental Health Center	YES	EHR Enabled *IDN reimbursed SCMh for contracted services With HISP (Health Information Service Provider)
Lamprey Health Care - Newmarket	YES	EHR Enabled
Lamprey Health Care - Raymond	YES	EHR Enabled
Community Partners	YES	EHR Enabled
WAVE TWO		
Exeter Health Resources/CORE	YES	EHR Enabled
Seacoast Family Practice - Stratham	YES	EHR Enabled
Core Family and Internal Medicine - Exeter	YES	EHR Enabled
Greater Seacoast Community Health - Goodwin Community Health	YES	EHR Enabled
Greater Seacoast Community Health - Families First	YES	EHR Enabled
Southeastern NH Services	YES	EHR Enabled
Hope on Haven Hill	n/a	n/a
Seacoast Youth Services	n/a	n/a
Portsmouth Regional Hospital / HCA	YES	EHR Enabled
Appledore Family Medicine	YES	EHR Enabled
Dover Pediatrics	YES	EHR Enabled

B1-8g

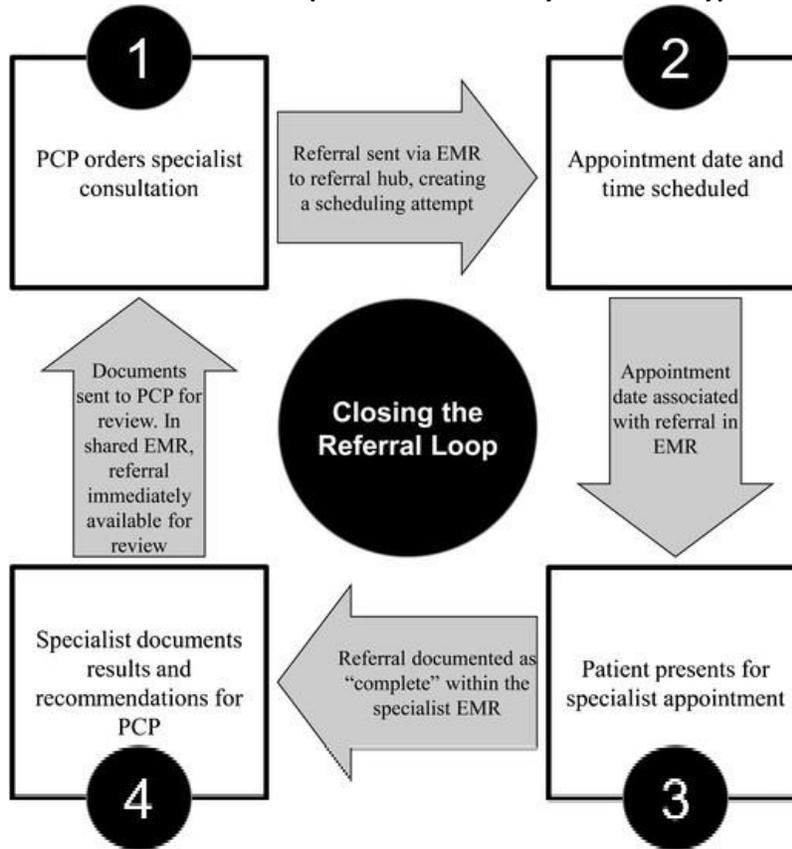
No significant investment has been made regarding closed loop referrals during the reporting period. The Operations Team continues to discuss the importance of closed loop referrals with partners during each strategy / integration coaching and technical assistance meeting. The status of referral tracking in each partner system varies widely. We continue to discuss the Closed Loop Referral in Primary Care Ideal Type (diagram below) as a goal with each partner.

To date, Hope on Haven Hill is the only partner to identify technical or staffing resource support that would move them toward their goals in this area. Region 6 IDN recently agreed to fund a part-time IT position at Hope on Haven Hill that will support further data aggregation and closed loop referral project work with funding to begin in 2019.

Referral gaps, pathways, processes and protocols were assessed via guided exercises at 2 regional All Partner meetings. For those partners who do use electronic means to conduct closed loop referrals, the technology is not a barrier. The internal work processes and workflows are not consistent within or across agencies with regard to patient population or types of referrals that are included in closed loop consideration. For those partner agencies who express willingness to dialogue with the Region 6 IDN regarding the development of closed loop protocols, the IDN Operations team has provided recommendations.

Region 6 IDN believes that closed loop referrals are a good indication of a maturing care coordination system. Further development of this standard is a priority for the Operation Team and strategies to progress on this standard will remain an active priority.

Closed Loop Referral in Primary Care Ideal Type



B1-8h

Shared Care Plan: During the reporting period, the setup of the All Scripts, Care Director, IDN 6's shared care plan, was finalized. Internal training for staff, provided by the vendor, was scheduled for delivery in October 2018. The plan for the rollout of the Care Director called for testing of the system by the Care Transitions Team through December 2018 with workflows and best practices identified to build the training resources needed for introduction to the B1 partners and CCT team members. The training and rollout to partners and CCT members is anticipated by April 2019.

Workflows and protocols have been requested from multiple B1 partners. To date, most partners have agreed to provide that information / copies to the IDN 6, but they have not been received. For example, the IDN Director of Care Coordination met directly with multiple partners upon her hire in November 2018 to discuss workflows and strategies for improving current practices regarding:

- Transitions from inpatient
- Interactions between providers and community-based agencies
- closing the loop on referrals
- Privacy protocols
- Intake procedures that ensure privacy
- Guidelines on opioid prescribing

IDN 6 is aware that many partners have evidence of extensive workflow and protocol development. All FQHC partners and Dover Pediatrics are recognized as NCQA Level III Medical Homes. To achieve this designation, they are required to maintain protocols and workflows in essential areas such as: transitions from inpatient care, referral tracking, and chronic disease population management.

While it seems that obtaining workflow and protocol copies should not be a substantial burden for either partners or the IDN 6, we have found that not having met this requirement in the past by gathering these documents during earlier partner meetings was a barrier to going back to gather this information. We have discussed this with members of the Clinical Advisory Team to ask for their assistance in securing follow-up to our requests in this area. The need for increased documentation of active workflows is on the agenda for the next All-Partner meeting.

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

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

Process Milestone Number	Process Detail	Submission Format	Results (Met/Not Met)			
			6/30/17	12/31/17	6/30/18	12/31/18
B1-2	IDN Integrated Healthcare: Implementation Plan, Timeline, Milestones and Evaluation Project Plan	Narrative & Spreadsheet (Microsoft Project or similar platform)				
B1-3	IDN Integrated Healthcare: Evaluation Project Targets	Table				
B1-4	IDN Healthcare Integration Workforce Staffing	Table				
B1-5	IDN Healthcare Integration: Budget	Narrative and Spreadsheet				
B1-6	IDN Integrated Healthcare: Key Organizational and Provider Participants	Table				
B1-7	IDN Integrated Healthcare: Organizational leadership sign-off	Table				
B1-8a	All of the following domains must be included in the CCSA: <ul style="list-style-type: none"> • Demographic information • Physical health review • Substance use review • Housing assessment • Family and support services • Educational attainment 	CCSAs (Submit all that are in use) Table listing all providers by domain indicating Y/N on progress for each process detail				

	<ul style="list-style-type: none"> • Employment or entitlement • Access to legal services • Suicide risk assessment • Functional status assessment • Universal screening using depression screening (PHQ 2 & 9) and • Universal screening using SBIRT 					
	<p>For pediatric providers, the CCSA must also include:</p> <ul style="list-style-type: none"> • Validated developmental screening for all children, such as the ASQ:3 and/or ASQ SE at 9, 18 and 24/30 month pediatric visits; • Developmental Screening using Bright Futures or other American Academy of Pediatrics recognized developmental 	Table listing all providers by domain indicating Y/N on progress for each process detail				
B1-8b	<p>List of multi-disciplinary core team members that includes, at minimum:</p> <ul style="list-style-type: none"> • PCPs • Behavioral health providers (including a psychiatrist) • Assigned care managers or community health worker 	Table listing names of individuals or positions within each provider practice by core team				
B1-8c	<p>Multi-disciplinary core team training for service providers on topics that includes, at minimum:</p> <ul style="list-style-type: none"> • Diabetes hyperglycemia • Dyslipidemia • Hypertension • Mental health topics (multiple) 	Training schedule and Table listing all provider practice sites and number of individuals by provider				

	<ul style="list-style-type: none"> SUD topics (multiple) 	<p>type to be trained, PCP or BH. Ongoing reporting shall indicate # of people trained in each practice by provider type for each reporting period for each training.</p> <p>OR you may provide a list of names of all individual providers to be trained in each provider practice. Ongoing reporting would indicate Y/N for participating individuals on progress for each training.</p>				
B1-8d	Training for staff not providing direct care that at minimum includes knowledge and beliefs about mental disorders that can aid in recognition and management	Training schedule and table listing all staff indicating progress on each process detail				
B1-8e	Monthly (or more frequent) core team case conferences on behalf of patients with significant behavioral health conditions or chronic conditions	Conference schedule and Table				

B1-8f	Secure messaging	Narrative				
B1-8g	Closed loop referrals	Narrative				
B1-8h	<p>Documented work flows and/or protocols that include, at minimum:</p> <ul style="list-style-type: none"> ● Interactions between providers and community based organizations ● Timely communication ● Privacy, including limitations on information for communications with treating provider and community based organizations ● Coordination among case managers (internal and external to IDN) ● Safe transitions from institutional settings back to primary care, behavioral health and social support service providers ● Intake procedures that include systematically soliciting patient consent to confidentially share information among providers ● Adherence to NH Board of Medicine guidelines on opioid prescribing 	Work flows and/or Protocols (submit all in use)				

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

- a. Achievement of all the requirements of a Coordinated Care Practice
 - Adoption of both of the following evidence-based interventions: Medication Assisted Treatment
 - Evidence-based treatment of mild-to-moderate depression within the Integrated Practice setting either through the use of IMPACT or another evidence-supported model
- b. Use of Technology to identify, at a minimum:
 - At Risk Patients
 - Plan Care
 - Monitor/Manage Patient progress toward goals
 - Ensure Closed Loop Referral
- c. Documented Workflows including at a minimum: Joint service protocols and Communication channels

B1-9a

Partners in IDN Region 6 are at varying points on the continuum toward Coordinated Care practice designation. The chart below illustrates the IDN 6 Operations teams understanding of partners current status. *We acknowledge and recognize that without significant further documentation of the workflows and protocols of the partners, full designation as Care Coordinated practices cannot be determined.* Based on partners with all CCSA domains, MDCTs available, and moderate to advanced development of workflows and protocols in the essential NH DSRIP components, the IDN 6 identifies 10 partners who can be *potentially designated* as Coordinated Care Practices.

Partner listings below are based on partner meetings and discussions at strategy sessions. Partners listed below as:

advanced - partners known to have robust internal workflow and protocol development. All FQHC partners and Dover Pediatrics are recognized as NCQA Level III Medical Homes. To achieve this designation, they are required to maintain protocols and workflows in essential areas such as: transitions from inpatient care, referral tracking, and chronic disease population management.

moderate - partners known to have some internal workflow and protocol development accomplished based on partner meetings and project collaborations to date. Unable to identify specific written protocols for some essential NH DSRIP components.

minimal - partners who are either newer to IDN 6 partnership or have few known protocols or workflows for essential NH DSRIP components.

Highlight of newer B1 partner successfully engaged during the last reporting period:

Dover Pediatrics is a long-standing independent practice with 5 medical providers. One pediatrician in the practice engaged the IDN Clinical Director to request assistance in *facilitating referrals* and providing *direct brief BH treatment* through the IDN. The IDN conducted two coaching sessions to help providers see the possibilities of having a behavioral health partner in the practice. The practice has identified significant unmet needs providing screening and effective interventions in behavioral health.

To address the need for behavioral health services, IDN 6 Clinical Director met with Medical Director of Practice Manager to plan an integration strategy. The practice hired a Social Worker Care Manager during this reporting period. IDN 6 Clinical Director participated in interviews and in meetings with staff to develop a plan for what an integrated position would look like. The practice level Site Self-Assessment is scheduled for February 12, 2019. The practice is participating in the Certificate in Pediatric and Behavioral Health Integration early 2019 with IDN 6 funding. A multidisciplinary core team has been identified with an administrative leader, medical provider champion, the newly hired care coordinator, and the resources of the Child and Adolescent Psychiatry Telehealth consultations.

Organization/Provider	CCSA all domains	MDCT available	Information sharing - care plans, treatment plans, case conferences	Standardized workflows and protocols
WAVE ONE			Requires additional IDN 6 clarification and documentation	Requires additional IDN 6 clarification and documentation
Frisbie Memorial Hospital	No	Yes	moderate	moderate
Rochester Pediatrics	No	Yes	moderate	moderate
Wentworth Douglass Hospital	Yes	Yes	<i>advanced</i>	<i>advanced</i>
Wentworth Health Partners / Internal Medicine	Yes	Yes	<i>advanced</i>	<i>advanced</i>
Hilltop Family Practice	Yes	Yes	<i>advanced</i>	<i>advanced</i>
Seacoast Mental Health Center	Yes	Yes	moderate	moderate
Lamprey Health Care - Newmarket	Yes	Yes	<i>advanced</i>	<i>advanced**</i>
Lamprey Health Care - Raymond	Yes	Yes	<i>advanced</i>	<i>advanced**</i>
Community Partners	Yes	Yes	moderate	moderate
WAVE TWO				
Exeter Health Resources/CORE	No	Yes	moderate	moderate
Seacoast Family Practice - Stratham	No	Yes	moderate	moderate
Core Family and Internal Medicine - Exeter	No	Yes	moderate	moderate
Greater Seacoast Community Health -	Yes	Yes	<i>advanced</i>	<i>advanced</i>

Goodwin Community Health				
Greater Seacoast Community Health - Families First	Yes	Yes	<i>advanced</i>	<i>advanced</i>
Southeastern NH Services	Yes	Yes	moderate	moderate
Hope on Haven Hill	Yes	Yes	minimal	minimal
Seacoast Youth Services	Yes	Yes	minimal	minimal
Portsmouth Regional Hospital / HCA	No	Yes	minimal	minimal
Appledore Family Medicine	No	Yes	minimal	minimal
Dover Pediatrics	No	Yes	moderate	moderate

** See Attachments B1-9a.a & B1-9a.b for protocol and procedure documentation

B1-9b

Practices noted “Yes” for evidence-based treatment of mild/moderate depression are actively using the PHQ2/9 with management by one of two models:

- Positive screens reviewed by PCP and managed with their integrated BH clinicians and PCP teams, if indicated.
- Positive screens identified and communicated to PCP and/or integrated BH Clinician for patient contact and further assessment / referral if indicated.

The legacy terms “IMPACT Care” or “IMPACT Model” is largely synonymous with collaborative care. The terms originate from the IMPACT study, the first large randomized controlled trial of treatment for depression. The IMPACT study demonstrated that collaborative care more than doubled the effectiveness of depression treatment for older adults in primary care settings.

IDN support of progress for partner movement on this continuum:

Lamprey Health Care successfully hired a full-time MAT Nurse Coordinator during this report period and plans to implement their MAT program in January 2019. The IDN-6 has worked with Lamprey Health Care to further define the program training needs for both direct care staff and supporting staff. Southern NH AHEC has been contracted to develop the requested training.

In addition, the IDN-6 has encouraged and confirmed Lamprey Health Care's attendance in the NH-based Project ECHO with case-based learning on Medications for Addiction Treatment (MAT). The UNH Partnership for Academic-Clinical Telepractice (PACT): Medications for Addiction Treatment Program (PACT-MAT) will enroll MAT prescribers and their teams in the upcoming PACT-MAT Project ECHO. This grant-funded project is of no cost to participants, and free CME/CNE will be available. At this time, one provider and one nurse will attend. The IDN-6 is exploring opportunities to support attendance by additional Lamprey Health Care MAT care team members.

Greater Seacoast Community Health - Families First has successfully hired support for their MAT / IOP program with IDN 6 support during this reporting period. This has allowed them to maintain vital services and expand IOP services.

Greater Seacoast Community Health - Families First and Southeastern NH Services are co-located two days per week to provide primary care for residential clients of SENHS. Positive PHQ2/9 screenings can now be referred to the primary care provider for further assessment and care planning.

Dover Pediatrics, Rochester Pediatrics, Wentworth Health Partners Internal Medicine, Hilltop Family Practice, and Lamprey Health Care have all received support and funding to either hire or retain BH staff to support increased practice capacity for treatment of mild/moderate depression.

Based on the current capacity to achieve Coordinated Care practice designation* AND current implementation of MAT services and evidence-based treatment for mild / moderate depression, there are five IDN 6 partners who are on the path to Integrated Practice designation*.

**We acknowledge and recognize that without significant further documentation of the workflows and protocols of the partners, full designation as Care Coordinated practice and/or Integrated Practice cannot be determined.*

Table B1-9b

Organization/Provider	MAT implemented	Evidence-based treatment for mild/mod depression	Use of technology to Identify at-risk patients Plan Care Monitor/ manage patient goals Ensure closed loop referrals	Documented workflows/protocols/ communication channels with community-based social services
WAVE ONE			Requires additional IDN 6 clarification and documentation	
Frisbie Memorial Hospital	No	Yes	<i>IDN 6 to provide further information</i>	<i>IDN 6 to provide further information</i>
Rochester Pediatrics	No	Yes	<i>IDN 6 to provide further information</i>	<i>IDN 6 to provide further information</i>
Wentworth Douglass Hospital	No	Yes	<i>IDN 6 to provide further information</i>	<i>IDN 6 to provide further information</i>
Wentworth Health Partners / Internal Medicine	No	Yes	<i>IDN 6 to provide further information</i>	<i>IDN 6 to provide further information</i>
Hilltop Family Practice	No	Yes	<i>IDN 6 to provide further information</i>	<i>IDN 6 to provide further information</i>
Seacoast Mental Health Center	Yes	Yes	<i>IDN 6 to provide further information</i>	<i>IDN 6 to provide further information</i>
Lamprey Health Care - Newmarket	Yes	Yes	<i>IDN 6 to provide further information</i>	<i>IDN 6 to provide further information</i>
Lamprey Health Care - Raymond	No	Yes	<i>IDN 6 to provide further information</i>	<i>IDN 6 to provide further information</i>
Community Partners	No	Yes	<i>IDN 6 to provide further information</i>	<i>IDN 6 to provide further information</i>
WAVE TWO				
Exeter Health Resources/CORE	No	Yes	<i>IDN 6 to provide further information</i>	<i>IDN 6 to provide further information</i>
Seacoast Family Practice - Stratham	No	Yes	<i>IDN 6 to provide further information</i>	<i>IDN 6 to provide further information</i>
Core Family and Internal Medicine - Exeter	No	Yes	<i>IDN 6 to provide further information</i>	<i>IDN 6 to provide further information</i>
Greater Seacoast Community Health - Goodwin Community Health	Yes	Yes	<i>IDN 6 to provide further information</i>	<i>IDN 6 to provide further information</i>
Greater Seacoast Community Health - Families First	Yes	Yes	<i>IDN 6 to provide further information</i>	<i>IDN 6 to provide further information</i>
Southeastern NH Services	Yes	Yes	<i>IDN 6 to provide further information</i>	<i>IDN 6 to provide further information</i>
Hope on Haven Hill	Yes	No	<i>IDN 6 to provide further information</i>	<i>IDN 6 to provide further information</i>
Seacoast Youth Services	Yes	No	<i>IDN 6 to provide further information</i>	<i>IDN 6 to provide further information</i>
Portsmouth Regional Hospital / HCA	No	No	<i>IDN 6 to provide further information</i>	<i>IDN 6 to provide further information</i>
Appledore Family Medicine	No	No	<i>IDN 6 to provide further information</i>	<i>IDN 6 to provide further information</i>
Dover Pediatrics	No	Yes	<i>IDN 6 to provide further information</i>	<i>IDN 6 to provide further information</i>

B1-9c

Table B1-9c

Organization/Provider	Data Agreement	Use of technology to ID At risk patients	Use of technology to Plan care	Use of technology to Monitor/ manage patient goals	Use of technology to Ensure closed loop referrals	IDN 6 supported or IDN managed tool in use
WAVE ONE						
Frisbie Memorial Hospital	Yes	Electronic	Electronic-EHR	Care Director* pending IDN implementation	Electronic-EHR	Care Director*
Rochester Pediatrics	Yes	Electronic	Electronic-EHR	Care Director*	Electronic-EHR	Care Director*
Wentworth Douglass Hospital	Yes	Electronic	Electronic-EHR	Care Director*	Electronic-EHR	Care Director*
Wentworth Health Partners / Internal Medicine	Yes	Electronic	Electronic-EHR	Care Director*	Electronic-EHR	Care Director*
Hilltop Family Practice	Yes	Electronic	Electronic-EHR	Care Director*	Electronic-EHR	Care Director*
Seacoast Mental Health Center	Yes	Electronic	Electronic-EHR	Care Director*	Electronic-EHR	Care Director*
Lamprey Health Care - Newmarket	Yes	Electronic	Electronic-EHR	Care Director*	Electronic-EHR	Care Director*
Lamprey Health Care - Raymond	Yes	Electronic	Electronic-EHR	Care Director*	Electronic-EHR	Care Director*
Community Partners	Yes	Electronic	Electronic-EHR	Care Director*	Electronic-EHR	Care Director*
WAVE TWO						
Exeter Health Resources/CORE	Yes	Electronic	Electronic-EHR	Care Director*	Electronic-EHR	Care Director*
Seacoast Family Practice - Stratham	Yes	Electronic	Electronic-EHR	Care Director*	Electronic-EHR	Care Director*
Core Family and Internal Medicine - Exeter	Yes	Electronic	Electronic-EHR	Care Director*	Electronic-EHR	Care Director*

Greater Seacoast Community Health - Goodwin Community Health	Yes	Electronic	Electronic-EHR	<i>Care Director*</i>	Electronic-EHR	<i>Care Director*</i>
Greater Seacoast Community Health - Families First	Yes	Electronic	Electronic-EHR	<i>Care Director*</i>	Electronic-EHR	<i>Care Director*</i>
Southeastern NH Services	Yes	Electronic	Electronic-EHR	<i>Care Director*</i>	Electronic-EHR	<i>Care Director*</i>
Hope on Haven Hill	Yes	Electronic	Electronic-EHR	<i>Care Director*</i>		<i>Care Director YES, added HIT funding to support data aggregation</i>
Seacoast Youth Services	Yes	Electronic	Electronic-EHR	<i>Care Director*</i>		<i>Care Director*</i>
Portsmouth Regional Hospital / HCA	No	Electronic	Electronic-EHR	<i>Care Director*</i>	Electronic-EHR	<i>Care Director*</i>
Appledore Family Medicine	No	Electronic	Electronic-EHR	<i>Care Director*</i>	Electronic-EHR	<i>Care Director*</i>
Dover Pediatrics	Yes	Electronic	Electronic-EHR	<i>Care Director*</i>	Electronic-EHR	<i>Care Director*</i>

Partner agencies in the B1 project have identified capacity to identify at-risk clients. Those methods are reported as proprietary. With observation and analysis, the Region 6 team has observed elements of those methods to include electronic notification of patient Emergency Department visits, risk-scoring based on confidential agency-specific criteria and algorithms, and reports run by the agency on HEDIS measures and/or provided, in few instances, by an MCO for a panel of clients. All report the capacity to plan care and monitor progress for clinical care via the use of EHR notes, patient and provider dashboards, and reports.

While partners continue to develop the ability to assess social determinants and consider that assessment in care plan development through implementation of the CCSA domains, agency-wide ability to consistently monitor progress for social determinant interventions is still emerging. This capability will be improved when agencies begin implementation of Care Director, the Allscripts Shared Care Plan solution, during the next reporting period. Care Director will provide staff at all B1 partner agencies access to social determinant assessments and progress on interventions driven by those interventions.

B1-9d

Accurate workflow representation of Joint Service Protocols has been challenging to obtain from our partners because they are either continually in flux or considered proprietary. We continue to work with our partners to reduce what has been considered administrative burden while still meeting DSRIP reporting expectations. The Community Care Team workflow is a robust example of communication channel workflow between primary care, behavioral health, and social service agency partners across the region. Additional examples of Joint Service Protocols are anticipated as IDN funded collaborative initiatives in the region mature and partnerships are built. The Region 6 IDN anticipates provision of additional workflows for this section during the next reporting period for recently funded/developing projects like an FQHC primary care team serving a residential/outpatient SUD partner's clients on-site one day a week, CRSW on call 24/7 for hospital and emergency department clients at one hospital partner, and an embedded Behavioral Health provider in a different hospital partner's emergency department.

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

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

Process Milestone Number	Section	Process Detail	Submission Format	Results (Met/Not Met)			
				6/30/17	12/31/17	6/30/18	12/31/18
B1-9a	Coordinated Care Practice designation	Achievement of all of the requirements of a Coordinated Care Practice	Progress towards Coordinated Care Practice Designations				
B1-9b	Additional Integrated Practice designation requirements	Adoption of both of the following evidence-based interventions: <ul style="list-style-type: none"> ● Medication-assisted treatment (MAT) ● Evidence-based treatment of mild-to-moderate depression within the Integrated Practice setting either through use of the IMPACT or other evidence-supported model 	Protocols (Submit all in use)				
B1-9c		<ul style="list-style-type: none"> ● Use of technology to identify, at minimum: ● At risk patients ● Plan care ● Monitor/manage patient progress toward goals ● Ensure closed loop referral 	Table listing all providers indicating progress on each process detail				
B1-9d		Documented work flows with community based social support service providers including, at minimum:	Work flows (Submit all in use)				

		<ul style="list-style-type: none"> ● Joint service protocols ● Communication channels 					
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B1-10. IDN Integrated Healthcare Project: Achievement of Coordinated Care Practice and Integrated Care Practice Designation

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

Note on newest B1 Enterprise partners / CCSA review and development on the Coordinated Care continuum:

Both Dover Pediatrics and Seacoast Youth Services became B1 partners in December 2018. As a primary care practice, Dover Pediatrics will make continued progress toward achieving Coordinated Care Practice designation. This progress has begun (see description of engagement to date below) with significant movement over the past reporting period. Seacoast Youth Services is an SUD provider and remains engaged in development of the CCSA, as required by the STCs, as well as increasing their service availability in the region with IDN 6 support.

Dover Pediatrics is a long-standing independent practice with 5 medical providers. One pediatrician in the practice engaged the IDN Clinical Director to request assistance in *facilitating referrals* and providing *direct brief BH treatment* through the IDN. The IDN conducted two coaching sessions to help providers see the possibilities of having a behavioral health partner in the practice. The practice has identified significant unmet needs providing screening and effective interventions in behavioral health.

To address the need for behavioral health services, IDN 6 Clinical Director met with Medical Director of Practice Manager to plan an integration strategy. The practice hired a Social Worker Care

Manager during this reporting period. IDN 6 Clinical Director participated in interviews and in meetings with staff to develop a plan for what an integrated position would look like. The practice level Site Self-Assessment is scheduled for February 12, 2019. The practice is participating in the Certificate in Pediatric and Behavioral Health Integration early 2019 with IDN 6 funding. A multidisciplinary core team has been identified with an administrative leader, medical provider champion, the newly hired care coordinator, and the resources of the Child and Adolescent Psychiatry Telehealth consultations.

	Total Goal Number Designated	Baseline Designated 6/30/17	Number Designated 12/31/17	Number Designated 6/30/18	Number Designated 12/31/18
Coordinated Care Practice	14	0	5	11	10* <i>pending IDN 6 improved documentation</i>
Integrated Care Practice	3	0	0	0	5* <i>pending IDN 6 improved documentation</i>

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

Chart updated from last submission to indicate practices that have shown demonstrable progress toward Coordinated Care Practice designation as detailed in earlier sections of this report.

Coordinated Care Practice	List of providers identified to make progress toward Coordinated Care Practice designation	12/31/17	6/30/18	12/31/18
	<ul style="list-style-type: none"> Lamprey Health Care - Newmarket Site Lamprey Health Care - Raymond Site 	2	2	2
	Wentworth Douglass Hospital <ul style="list-style-type: none"> Hilltop Family Practice Wentworth Health Partners Int Med 	2	2	3
	Frisbie Memorial Hospital <ul style="list-style-type: none"> Rochester Pediatrics 	0	0	0
	Community Partners Mental Health Center	1	1	1
	Seacoast Mental Health Center	1	1	1
	<ul style="list-style-type: none"> Greater Seacoast Community Health - Families First Greater Seacoast Community Health - Goodwin Community Health 	2	2	2
	Exeter Health Resources / CORE <ul style="list-style-type: none"> Seacoast Family Practice Core Family and Internal Medicine 	n/a	0	0

	Southeastern NH Services	n/a	n/a	1
	Hope on Haven Hill*	n/a	n/a	n/a
	Seacoast Youth Services*	n/a	n/a	n/a
	Portsmouth Regional Hospital <ul style="list-style-type: none"> Appledore Family Medicine 	0	0	0
	Dover Pediatrics	n/a	n/a	0

**per STC guidance, only primary care and behavioral health practices are required to achieve Coordinated Care Practice designation requirements. SUD providers noted where primary care services are co-located during this report period.*

Integrated Care Practice	List of providers identified to make progress toward Integrated Care Practice designation	12/31/17	6/30/18	12/31/18
	Lamprey Healthcare - Newmarket	n/a	n/a	1
	Greater Seacoast Community Health - Families First	n/a	1	1
	Greater Seacoast Community Health - Goodwin Community Health	n/a	1	1
	Seacoast Mental Health Center	1	1	1
	Southeastern NH Services	n/a	n/a	1

Projects C: Care Transitions-Focused

IDN Community Project Implementation and Clinical Services Infrastructure Plan

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

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

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

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

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

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

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

The IDN-6 C1 Care Transitions project implementation continues to progress the most quickly among the three community projects. This is due, in part, to the fact that the staffing of this project is internal to the IDN/Strafford County organizational structure and does not require outside contractual agreements.

The Care Transitions team consists of 1 Team Leader / Supervisor, 1 Pre-CTI Case Manager, and 3 CTI Case Managers. This team will grow with the addition of 2 CTI Case Managers in January and February of 2019.

The IDN6 continues to explore opportunities to replicate or expand this model in the community with future creation of embedded CTI Case Managers and/or a team with a partner agency or practice. As this time, B1 and C1 key organizational partners have indicated that they do not feel they can adequately support a CTI team. The project plan accounted for the development of a second CTI team and this remains a goal of the IDN6.

During the report period, the Care Transitions team has continued to use a shared Release of Information and Referral Form used amongst the members of the Community Care Team. In addition, the project team identified and implemented CTI direct referral forms, intake checklist, periodic self-sufficiency assessment tool, CTI phase-planning, and fidelity tracking workflow.

Evaluation project targets were also further defined during this report period. Significant barriers to analysis of evaluation of ED and hospital utilization remain. The IDN6 continues to work on strategies to collect meaningful data in these areas. Managed Care partners continue to refer IDN staff requests for data back to DHHS. DHHS reports inadequate workforce capacity to provide custom data reports on ED utilization.

In the interest of working to the top of the team's capacity, referrals to the project have not been limited to specific referring entities to date. Referring sources have diversified as the team's work matures, indicated in C-7. Screening outcome targets reflect the expectation that effective engagement by the Care Transitions team with its network of collaborating partners will allow for screening into established programs (Coordinated Entry, Community Care Team) for a significant portion of referred clients. This avoids service duplication within the network.

Outcome measures and targets identified to date reflect the aspects of SDoH status, use of the Arizona Self-Sufficiency Matrix, benefit enrollment, and specific healthcare utilization measures when possible. Metrics regarding movement between the Pre-CTI and CTI case management models are also reported.

The primary criteria for engagement in the CTI model with this team is stable housing. The Pre-CTI clients and those screened to our Enhanced Care Coordination project are generally not in stable housing or are not prepared to engage in work with supports in recovery, behavioral health, or primary care. Those who can secure stable housing and indicate readiness to participate in the CTI model are moved into the 9-month CTI supportive case management model. To date, the team has successfully leveraged the Pre-CTI and ECC work and transitioned 13 clients into CTI within the team. The CTI program has graduated 4 clients who successfully completed the 9-month model.

The Care Transitions CTI team is a key partner of the regional Community Care Teams and participates in and facilitates both the CCT hosted at Frisbie Memorial Hospital (Strafford County) and Portsmouth Regional Hospital (Rockingham County). One of the CTI Case Managers newly hired for February 2019 will focus efforts on increasing collaborations in Rockingham County and support the initiation of an additional CCT hosted by Lamprey Health Care or Exeter Hospital (both B1 partners).

A key milestone of this report period was the engagement of the Care Transitions team with the IDN6 Shared Care Plan, Care Director. All 210 clients referred to date are reported in Care Director with a standard list of inputs to establish the framework for implementation of Care Director across our partner network. Development of best-use practices remains an iterative process and will continue to be informed by the needs of our project partners.

All Care Transition / CTI Case Managers, as well as several IDN Partners, have participated in trainings delivered by the Center for the Advancement of Critical Time Intervention (CACTI). The Care Transitions Supervisor is also certified to instruct CTI and will provide the training for the two new Case Managers in the first quarter of 2019.

Internal training plans include a training series from January 2019-June 2019 to include the core set of competency training for the entire Care Transitions team. For additional description of training activities, see Section C-9.

The Care Transitions CTI team participates monthly in the New Hampshire wide Community of Practice teleconferences and quarterly in-person trainings facilitated by Kim Livingstone.

Protocols for the team have been formalized and now include assessment with the Arizona Self-Sufficiency Matrix within 30 days of referral for all clients. Interim values measured at 3 months intervals of engagement if not in CTI. If enrolled in CTI, the final value is at CTI graduation. Initial measurements demonstrate consistent increases in client self-sufficiency as measured over length of involvement with the team and CTI model. The ASSM puts the client at the center of identifying and prioritizing efforts that may lead to real outcomes.

Client Narratives:

“Mary” is a referral from a partner hospital concerned that Mary would be unable to follow up with her appointments and make connects with her community mental health center. Prior to Mary’s hospitalization, her partner and roommate tragically took her life in their shared apartment. Mary struggled with her own suicidal ideation and went to her local ED for help. She was hospitalized for psychiatric care.

Shortly after Mary returned home, the grief from losing her partner was too much and she returned to the ED. This cycle repeated itself two more times before Mary was referred to the CTI team. Case management worked with Mary to help get her connected with her community mental health center by taking her to appointments and advocated for an affordable medication plan with her primary provider. When Mary needed to go back to the hospital, case management arranged for a foster dog mom, so Mary didn’t rack up expensive fees from kenneling her dog long term. Mary had been very anxious about this during previous admissions.

Just before the holidays in 2018, CTI case management coordinated with the D3 project to get Mary into a 28-day treatment program. Thanks to CTI, Mary has met with her prescribing psychiatrist and is in line for a therapist and a new functional support worker. *She has stayed out of the ED for almost 2 months* and has set goals for her to engage in SMD treatment and MH counseling so she can return to work, using her master’s degree in computer science.

“Clint” became known to the CTI team when he was a warming shelter resident at the National Guard Armory in early January 2018. He returned to living in the woods and was an active user of heroin and methamphetamine. Any community partner interactions with Clint usually ended with Clint being asked to leave for aggravating and intimidating behaviors. Case managers believed Clint had a serious mental illness and he talked about conspiracy theories, hallucinated voices and was known to have violent outbursts.

Months later, the CTI team heard through the CCT that Clint was in the hospital for endocarditis. Pre-CTI case management went to see Clint in the hospital, and he was a different person. After hospital-based detoxification and nearly 8 weeks of antibiotics, Clint was motivated to change his life. He was referred to the D3 team, and with his new motivation, the team coordinated arrangements for him to go to The Farnham Center. Unfortunately, when Clint was discharged, he no longer met the criteria for admission into a 28 day treatment center as he had been sober too long.

The alternative plan was for Clint to enter an MAT program with outpatient counseling and go to Cross Roads House shelter. Because Clint’s hospital discharge was approved very quickly and on a Friday afternoon, the CTI team heavily advocated for Clint to remain as an inpatient until after the weekend when supportive shelter arrangements could be made.

IDN Care Coordination staff worked throughout the weekend to support Clint in his safety plan, as his precipitous hospital discharge left him without formal support for his maintaining sobriety and he was at great risk of using substances. The D3 team continued to work on getting Clint an appointment for MAT. After 3 days of calling the intake office, Clint was granted an intake appointment but needed a valid ID. All of Clint’s belongings were stolen by looters in his tenting area while he was hospitalized. Case managers drove Clint to the DMV for his replacement ID for the intake appointment. However, the dosing doctor for MAT wasn’t available until the following week. Clint’s hospital discharge medications only included a 5-day supply of narcotics that would leave Clint detoxing for several days before his MAT treatment began.

Case managers spoke to the hospital and were instructed to bring Clint to the ED. Clint returned with the support of his Pre-CTI case manager and after 10 hours of waiting, Clint was told he could only get the narcotic refills if he were admitted to the behavioral health unit. Clint was frustrated with hospitals and declined that care plan. IDN case managers worked with the Cross Roads House staff to provide support, arrange for back-up comfort medication access if necessary, and deliver continual encouragement for Clint to maintain sobriety. He did and has been safely housed at Cross Roads, receives MAT treatment daily and has been working part time.

“Bob” is an 81-year-old man that has been living in the woods of Exeter for over a year. He was introduced to the CTI team through the CCT meeting at PRH. His current supports were struggling to get Bob engaged in treatment and had concerns about his safety living in the woods during the winter. His MH health outreach worker managed to get Bob to agree to stay in a hotel over the holidays with the financial backing from welfare, BEAS, and Community Action Partnership, while long term housing was explored.

CTI provided care coordination among his current supports and brought into conversation additional supports for Bob to maintain housing and access MH and PCP support. Bob has moved into housing in Newmarket and will receive CTI services for ongoing intensive support: getting established with housing essentials, managing health care needs and being an advocate for Bob as he adjusts to his new surroundings.

C-2. IDN Community Project: Evaluation Project Targets

From the Evaluation Project Plan, use the format below to provide a list of the progress toward targets or goals that the program has achieved. Targets required by the STCs, include but should not be limited to:

- Number of individuals served (during reporting period and cumulative)
- All performance measures identified in the evaluation project plan.

UPDATED Table C-2a: Evaluation Project Targets as of submission date 4/5/19

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
# clients referred to Care Transitions Team (cumulative)	≥ 50 per year per team	0	133	210
# clients Screened (cumulative)	90% of referrals	n/a	133	210/210=100%
# new clients referred to Care Transitions Team during 6-month report period	≥ 25 per team	n/a	133	77 dispositions below
• # new clients screened to CCT only	>20%	n/a	n/a	30/77=39%
• # new clients screened to Pre-CTI	< 50%	n/a	n/a	22/77=29%
• # new clients screened to CTI	> 10%	n/a	n/a	8/77=10%
• # new clients screened to ECC	< 10%	n/a	n/a	2/77=3%
• # new clients screened to Coordinated Entry only	>10%	n/a	n/a	15/77=19%

LEVEL OF SERVICE PROVIDED	Target per team	As of 12/31/17	As of 6/30/18	As of 12/31/18
# clients served Pre-CTI phase	35	0	10	32
# clients moved Pre-CTI to CTI enrolled	10% of Pre-CTI	n/a	n/a	10/32=31%
# clients enrolled in CTI	70	0	15	33
# clients <u>graduated / completed CTI</u>	35	0	0	4
Increase enrollment for eligible benefits for Pre-CTI and/or CTI enrolled clients*	>10%	n/a	n/a	35/77=45%
TRANSITION IDENTIFIED AFFECTING CLIENT AT REFERRAL OR WITHIN 30 DAYS PRECEDING REFERRAL (n=77)	>50%	n/a	n/a	51/77=66% Listed below
<ul style="list-style-type: none"> Hospital discharge / inpatient medical/ inpatient behavioral health 		n/a	n/a	8
<ul style="list-style-type: none"> SUD treatment discharge/residential program 		n/a	n/a	0
<ul style="list-style-type: none"> Corrections release 		n/a	n/a	7
<ul style="list-style-type: none"> Unstable housing / Homeless 		n/a	n/a	36

*one or more: Medicaid, SNAP, SSI, SSDI, NH Easy accounts

The Performance Measures below were included in original project planning and past reporting. Significant barriers to evaluation of ED and hospital utilization remain. The IDN6 continues to work on strategies to collect meaningful data in these areas. The client narratives reflect the impact on these measures for those individuals discussed.

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
Total # clients served	70 per CTI team	0 – See Above	133	210
ED Admissions	Reduce by 10%	N/A	Data Pending	Data Pending
ED Utilization for PC treatable conditions	Reduce by 10%	N/A	Data Pending	Data Pending
Hospitalization Frequency & Duration	Reduce by 10%	N/A	Data Pending	Data Pending
Psych Hospitalization Freq. & Duration	Reduce by 10%	N/A	Data Pending	Data Pending

Incarceration Nights	Reduce by 10%	N/A	Data Pending	Data Pending
Increase enrollment for eligible benefits	Increase 10%	N/A	Data Pending	45% of new referrals
Reduce Crisis Response Services	Reduce by 10%	N/A	Data Pending	Data Pending

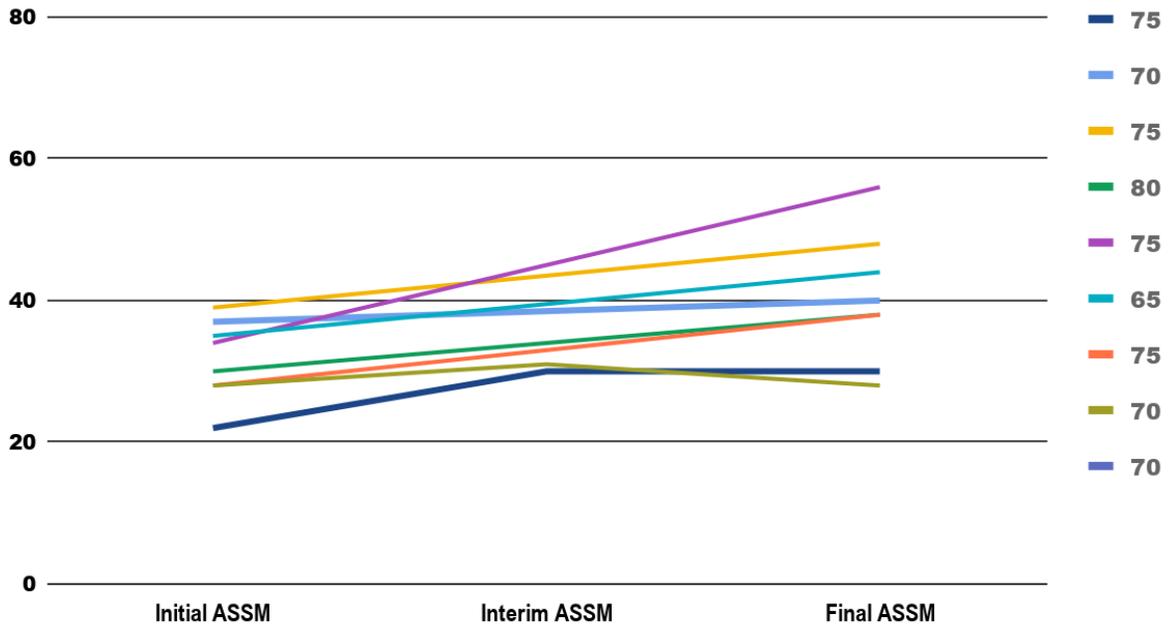
The IDN6 has additionally adopted self-sufficiency as an outcome measured by the Arizona Self-Sufficiency Matrix (ASSM). Self-sufficiency is the ability to carry out activities of daily living independently. These activities of daily living pertain to different domains. For example, daily life requires actions to provide for an income, to remain physically and mentally healthy or to maintain a supportive social network.

Activities of living also include organizing the right help when a need arises that cannot be met by the person themselves. For example, going to the doctor in time in case of illness or accessing BH or SUD treatment services.

The degree of self-sufficiency is therefore an outcome of personal characteristics, such as skills, personality and motivation and environmental characteristics, such as culture, economy and infrastructure that enable a person to provide for their own basic life needs to a greater or lesser extent. The team's first set of Arizona Self-Sufficiency Matrix measures are charted below. Each line indicates one client who has been engaged with the Care Transitions team for 6 or more months. Each client is listed as the total possible value achievable for their identified domains on the ASSM.

Current protocol for the team is to measure ASSM within 30 days of referral for all clients. Interim values measured at 3 months intervals of engagement if not in CTI. If enrolled in CTI, the final value is measured at CTI graduation. The team has found this assessment to be a useful tool for goal development with clients and a benchmark that reflects real progress made by clients in a complex project. The ASSM puts the client at the center of identifying and prioritizing efforts that may lead to real outcomes.

ARIZONA SELF-SUFFICIENCY MATRIX MEASURES



C-3. IDN Community Project: Workforce Staffing

From Project A1: Workforce Capacity Development Implementation Plan, document the current workforce staffing specifically related to this project using the format below.

The Care Transitions team consists of: 1 Team Leader / Supervisor, 1 Pre-CTI Case Manager, and 3 CTI Case Managers. This team will grow with the addition of 2 CTI Case Managers in January and February of 2019.

The IDN6 continues to explore opportunities to replicate or expand this model in the community with future creation of embedded CTI Case Managers and/or a team with a partner agency or practice. As this time, B1 and C1 key organizational partners have indicated that they do not feel they can adequately support a CTI team. The project plan accounted for the development of a second CTI team and this remains a goal of the IDN6.

UPDATED Table C-3a: Workforce Staffing as of submission date 4/5/19

Provider Type	IDN Workforce (FTEs)				
	Projected Total Need	Baseline Staffing on 6/30/17	Staffing on 12/31/17	Staffing on 6/30/18	Staffing on 12/31/18
Team Leader / Supervisor (Masters Level)	2	0	1	1	1
CTI Worker (Case Manager)	6	0	2	4	4.8

C-4. IDN Community Project: Budget

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

Table C-4: Budget

Connections for Health								
IDN Region 6								
Project C1								
Project	CY 2016 Actuals	CY 2017 Actuals	Jan-Jun 2018 Actuals	July-Dec 2018 Actuals	CY 2019 Projected Spend Budget	CY 2020 Projected Spend Budget	CY 2021 Projected Spend Budget	Actual and Projected Spend
Expense Items								
Staffing								
Direct Staff	\$ -	\$ 1,996	\$ 52,363	\$ 99,797	\$ 259,880	\$ 259,880	\$ 259,880	\$ 933,796
Indirect Staff	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Benefits	\$ -	\$ 403	\$ 19,772	\$ 46,706	\$ 57,174	\$ 57,174	\$ 57,174	\$ 238,402
Contracted Staffing	\$ -	\$ -	\$ -	\$ -	\$ 25,000	\$ 50,000	\$ 50,000	\$ 125,000
								\$ -
Project Infrastructure								
Equipment	\$ -	\$ 4,800	\$ 1,981	\$ 1,215	\$ -	\$ -	\$ -	\$ 7,996
Operations	\$ -	\$ 137	\$ 9,617	\$ 21,512	\$ 49,100	\$ 49,100	\$ 49,100	\$ 178,566
								\$ -
Workforce								
Fees/Outside Placement	\$ -	\$ 250	\$ 200	\$ 38	\$ 30,000	\$ 50,000	\$ 50,000	\$ 130,488
Recruiting/Retention	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Training	\$ -	\$ -	\$ -	\$ 6,287	\$ 15,000	\$ 15,000	\$ 15,000	\$ 51,287
Other	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
								\$ -
Technology	\$ -	\$ -	\$ -	\$ -	\$ 20,000	\$ 15,000	\$ 15,000	\$ 50,000
								\$ -
								\$ -
Totals	\$ -	\$ 7,586	\$ 83,933	\$ 175,556	\$ 456,154	\$ 496,154	\$ 496,154	\$ 1,715,536

Budget Narrative

- The Projected Budget for C1 is \$1,715,536, the 6/30/2018 SAR budget was \$3,878,500.
- Direct staff actuals include a supervisor and 5 case managers.
- Benefits are calculated at 22% of salaries.
- Contracted staffing is in support of expected work in support of the requirements for the local care management entity as part of Managed Care.
- Operations includes costs for offices in the community to enable staff to build and maintain community relationships and work closely with clients and providers in existing and targeted areas in the region.
- Fees and Outside placement are projected costs for expanding presence in the lower Rockingham County area.
- Technology includes projected costs in support of the shared care plan as well as partner requested innovative technologies to support client communications.

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

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

UPDATED Table C-5: Key Organizational and Provider Participants as of date of submission 4/5/19

Organization/Provider	Agreement Executed (Y/N)
Frisbie Memorial Hospital, Rochester, NH (*host org)	Yes
Portsmouth Regional Hospital / HCS (*host org)	Yes
City of Portsmouth Welfare	Yes
Crossroads House Shelter, Portsmouth, NH	Yes
CORE Family and Internal Medicine - Exeter	Yes
CORE Seacoast Family Practice - Exeter	Yes
Dover Pediatrics	Yes
Exeter Health Resources / CORE	Yes
Community Partners CMHC, Rochester, NH	Yes
Seacoast Mental Health - CMHC	Yes
Greater Seacoast Community Health - Goodwin Community Health (FQHC)	Yes
Greater Seacoast Community Health - Families First (FQHC)	Yes
Greater Seacoast Community Health – Lilac City Pediatrics	Yes
Cornerstone VNA	Yes
Granite Pathways / Seacoast Pathways	Yes
Hilltop Family Practice	Yes
SOS Recovery Community Organization	Yes
Lamprey Health Care - Newmarket	Yes
Lamprey Health Care - Raymond	Yes
Portsmouth Housing Authority	Yes
Rochester Community Recovery	Yes
Rochester Housing Authority	Yes
Rockingham CAP	Yes
Rockingham County Corrections	Yes
Safe Harbor Recovery Center	Yes
Seacoast Mental Health Center	Yes
Seacoast Youth Services	Yes
Southeastern NH Services	Yes
Tri-City Consumer Action Cooperative	Yes
Wentworth Douglass Hospital	Yes
Wentworth Health Partners - Internal Medicine	Yes

C-6. IDN Community Project: Standard Assessment Tools

Use the format below to identify and briefly describe the Assessment and Screening tool(s) that will be developed and/or used for the IDN Community Project. NOTE: Project C1: Care Transitions does not *require the* use of standardized assessment tools. If the IDN chooses to use any standardized assessment tools, please list them.

Screening, assessment, and management tools have been defined and are actively used as described below. The tools have been developed with close consideration of other tools under development through the IDN, including the Core Standardized Assessment.

Standard Assessment Tool Name	Brief Description
Pre-CTI Screening Task List (<i>attachment C-6a</i>)	Domains assessed to determine appropriate project disposition (CCT, Pre-CTI, CTI, ECC, or Coordinated Entry)
CTI Self-Assessment Tool (<i>attachment C-6b</i>)	For assessment of CTI Model Fidelity



Region 6 Integrated Delivery Network



Pre-CTI Task List

➤ **Documentation**

- Photo I.D./Driver's License
- Birth Certificate
- Social Security Card

➤ **NH Easy Account**

- Email
- Username
- Password
- Security Questions

➤ **Housing**

- Current Waitlists:

- Application Packet(s)
- Income Verification (bank statement, pay stub, assistance/benefits verification letter)

➤ **Benefits**

- Medicaid
- SNAP
- SSI
- SSDI
- DHHS
- ADPT
- TANF

➤ **Connections**

- Primary Care Provider
- Dental Provider
- Mental Health Services
- Treatment/Recovery Support
- Peer/Social Support
- Case Management
- Transportation
- Communication (phone, email)

CTI Implementation Self-Assessment

Never or rarely	Sometimes	About half the time	Most of the time	Always
1	2	3	4	5

MAIN COMPONENTS **Score**

Time-Limited

1. CTI workers provide no more than nine months of CTI after the date a client starts Phase 1. *For a 6-month CTI program, they provide no more than six months.*

Three Phases

2. The intervention takes place in three phases, each phase having the same duration. *(e.g., for a 9-month CTI program, each phase lasts 3 months)*

Focused

3. One to three areas of focus for each phase are selected from your program’s list of CTI areas.

Small caseload size

4. Each FTE CTI worker has no more than 20 clients on his/her caseload.

Community-based During

Phase 1:

- 5. CTI workers have at least 3 community-based meetings with the client.
- 6. CTI workers have at least 2 community-based meetings with a client’s providers and/or informal supports.

Weekly team supervision

7. The team has weekly team supervision meetings, led by the clinical supervisor, who is a psychiatrist, MSW, or other master’s level clinician and who has been trained in CTI.

Decreasing contact

8. CTI workers have fewer meetings and calls with a client in Phase 2 than in Phase 1, and fewer in Phase 3 than in Phase 2.

No drop-outs

9. The CTI program does not stop the intervention for a client before nine months. *For a 6-mo CTI program, it does not drop a client before the end of six months.*

ENGAGEMENT

10. CTI workers at least 2 meetings or calls with a client during the first month to establish rapport and build trust as early as possible.

INITIAL ASSESSMENT

11. CTI workers gather client information that is most relevant to your CTI program’s particular transition, population and setting. *(e.g., client’s interests, skills, strengths, vulnerabilities, aspirations; and client’s history, such as education, jobs, housing, treatment).*

CTI Implementation Self-Assessment

Never or rarely	Sometimes	About half the time	Most of the time	Always	
1	2	3	4	5	
LINKING PROCESS					
<u>During Phase 1:</u>					
12. CTI workers assess the strength of a client’s current connections to service providers and informal supports in areas that are relevant to the aim of your CTI program.					
13. CTI workers begin to connect client to providers and informal supports where needed.					
<u>During Phase 2:</u>					
14. CTI workers mediate between a client and his/her support network, especially for new linkages.					
<u>During Phase 3:</u>					
15. CTI workers encourage direct communication between different members of a client’s support network (e.g., a family member and a provider), as well as between the client and his/her providers and informal supports.					
<u>Before a case is closed:</u>					
16. CTI workers have a transfer-of-care meeting or call with each of the client’s providers and informal supports.					
17. CTI workers have a final meeting each client					
<i>They talk about client’s experience with CTI and relationship with CTI worker; discuss client’s expectations for the future; and review the long-term support network’s contact information.</i>					
CTI WORKER ROLE					
18. CTI workers carry cell phones when they are in the field.					
19. CTI workers reflect the recovery perspective in their interactions with clients. (e. g., they relate to clients in a genuine way; ask about topics not related to treatment; share their own experiences as a way to normalize client’s feelings, etc).					
20. CTI workers take a harm-reduction approach to planning with clients how to decrease their risky behaviors. (e. g., at client’s own pace; goal of reducing behavior; non-judgmental)					
CLINICAL SUPERVISION					
21. The team uses supervision to reinforce practices that are in alignment with the CTI model and to correct staff practices that are not in alignment.					
22. CTI workers give a case presentation at the supervision meeting for each new client.					
FIELDWORK COORDINATION					
23. The fieldwork coordinator selects some (~6-8) high priority clients prior to each supervision meeting for in-depth discussion by the team.					
24. The fieldwork coordinator monitors the CTI workers’ documentation to ensure high quality and timeliness.					
25. The fieldwork coordinator meets at least once a month with the CTI workers to briefly review the entire caseload.					

CTI Implementation Self-Assessment

Never or rarely	Sometimes	About half the time	Most of the time	Always
1	2	3	4	5

DOCUMENTATION

Score

Phase Plan form

26. CTI workers complete a *Phase Plan* form close to the start of each phase. (~3 weeks before to ~3 weeks after the due date for the phase)

Progress Notes form

27. Each *Progress Note* form records only one meeting or call.

Phase-Date form

28. The *Phase-Date* form is updated and distributed to team members at weekly supervision meetings.

Team Supervision form

29. The clinical supervisor completes a *Team Supervision* form for each weekly team meeting.

Caseload Review form

30. The fieldwork coordinator completes a *Caseload Review* form for each monthly caseload review meeting.

A	Total of scores for items 1 through 30	
B	AVERAGE CTI IMPLEMENTATION SCORE (A divided by 30)	

Not implemented Poorly implemented Adequately implemented Well implemented Ideally implemented

1.0-1.4

1.5-2.4

2.5-3.4

3.5-4.4

4.5-5.0

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

Use the format below to provide a list of all protocols to be utilized for patient assessment, treatment, management, and referrals for the community project. IDNs should indicate what protocols are currently in place and which are slated for adoption. DHHS reserves the right to audit all or a selection of protocols used by the IDNs.

Critical Time Intervention is not a clinical care protocol, but rather is focused on supporting clients to align clinical and non-clinical care and support services on their own behalf. The Community Care Team Referral form serves as a universal referral mechanism for the CTI Team. In limited circumstances, a stably housed community member is referred directly to CTI, using the Critical Time Intervention (CTI) referral form.

The Care Transitions team conducts referral screening to determine appropriate case disposition following the Community Project Eligibility and Referral Process. A CCT release is obtained for clients who consent; and case planning that may include formal CTI enrollment (triggering Participation Agreement), Pre-CTI supportive services, and/or Referrals to IDN services partners for priority needs. All clients' status is tracked. Those enrolled in CTI are tracked in Phases, along with Progress notes as appropriate. *(see attachment C-7d, C-7e, and C-7f for more detail)*

Initial Arizona Self-Sufficiency Matrix measures are charted in section C-2. Protocol for the team has been formalized to measure ASSM within 30 days of referral for all clients. Interim values measured at 3 months intervals of engagement if not in CTI. If enrolled in CTI, the final value is at CTI graduation.

To build regional network capacity for serving the most vulnerable people throughout our attributed population, the staff of the C1 project work very closely with our D3 team and E5 Enhanced Care Coordinators, and the Community Care Teams. Consistent with the true nature of network building, all the C1, E5, and D3 efforts are visible to each other and are resources in support of each other. For example, most referrals to the MLADC and CRSW at Southeastern New Hampshire Services (D3) come from the Care Transitions team. Part of the C1 project intake is to assess for SUD concerns and refer directly to the D3 team for assessment. If the client is screened to Enhanced Care Coordination, a referral is made to E5 with support of D3 for assessment, if needed. Case follow-ups on shared clients occur regularly through team meetings and case conferences facilitated by the C1 Supervisor.

Protocol Name	Brief Description	Use (Current/Under development)
Eligibility and Referral Process (attachment C-7a)	Process and criteria For referrals to CT Team as well as referrals of clients to partner services	Current
CTI IDN6 Referral Form (attachment C-7b)	Intake of referral from community or practice partner	Current
Arizona Self-Sufficiency Matrix (attachment C-7c)	Domains used to assess target strategies and coordination needs	Current
CTI Program documentation (attachment C-7d)	CTI phase plan, progress note, team supervision form, closing note, caseload review form, and phase date form	Current
CTI Participation Agreement (attachment C-7e)	Client consent to participate upon CTI enrollment	Current
Care Director shared care plan protocol (attachment C-7f)	Establish standard inputs / workflow in shared care plan	Current and in development

Referrals by source	Total to date	Report Period	Referrals by source	Total to date	Report Period
Warming Center	64	0	Rockingham County Corrections	5	5
Frisbie Hospital CCT	34	10	Portsmouth Housing Authority	4	4
Crossroads House	15	3	Rochester Housing Authority	3	3
Tri-City Co-Op	17	7	Waypoint Recovery Support	2	2
SOSDover/Rochester	20	8	Cypress	4	4
Portsmouth Hospital CCT	16	11	Families First	1	1
Other (original source unclear)	13	4	Self Referrals	11	11
Strafford County Corrections	5	5	IDN 4 transfers	4	1
-----	-----	-----	TOTAL REFERRALS	210	80*

***3 referrals were referred more than once** or by more than one agency for the same client. That happened for referrals moving across counties. Care Transitions team ‘carries’ the info from one CCT to the new CCT.

Attachment C-7a IDN 6 COMMUNITY PROJECT ELIGIBILITY AND REFERRAL PROCESS

<p>Eligibility</p>	<p>CCT Team Medicaid/Medicare/ presumed eligibility; referrals are frequently seen in the ED for medical/MH issues; poor PCP attendance; experiences frequent lapses in benefit coverage; referrals are loosely connected with services, resources and supports</p>	<p>Pre-CTI Medicaid eligible; referrals may need documents, income, benefits etc, and hand holding to follow up with these tasks; can maintain, but are not living in independent housing; task list intends to prepare clients for independent housing</p>	<p>CTI Medicaid eligible; transitioning from a facility to the community and into stable housing; in need of short-term support to get connected with MH/PCP/recovery or other resources; can maintain relationship with supports independently</p>	<p>Housing Stability CTI Medicaid eligible; are at risk for eviction or in need of support with budgeting, household management skills, and navigating resources to maintain housing. Referring LL must agree to work with cm and tenant to stabilize housing.</p>	<p>ECC Medicaid eligible; referrals require more intensive supports to get connected with MH/PCP providers, and continued support to maintain connections; referrals have complex needs; frequent ED and shelter hopping</p>
<p>Program Goals</p>	<p>Develop a care plan within the CCT team; identify barriers for accessing PCP/MH/SUD treatment; Provides knowledge and information on long-term resources; this is not case management, it is brokering services between client and provider</p>	<p>Develop a rapport that can survive the moment of transition and endure for 9 months; specific tasks are tied to accessing benefits, housing, employment or treatment; provides outreach and advocates for client's needs within the community</p>	<p>Time limited case management provides intensive bridging and enhances client engagement with their support network and long-term resources</p>	<p>Time limited cm to establish long term supports, build skills and education for tenants to maintain housing if at risk of eviction, or during housing transitions</p>	<p>Engages with clients to link with long term intensive supports; CM collaborates with partner agencies frequently for PCP/MH/SUD and housing support services.</p>
<p>Referral Process</p>	<p>CCT release signed; presentation template completed by CCT team provider</p>	<p>CCT release signed; task list assessed with referral information</p>	<p>CCT release and referral form for transitioning from: shelters, hospitals, psychiatric hospitals, jails, and/or in-patient recovery treatment programs</p>	<p>PHA, CE, 211, shelters, CCT, and welfare make referrals for tenants transitioning into or needing support to maintain housing</p>	<p>CCT referrals are internally screened and evaluated for ECC</p>



Region 6 Integrated Delivery Network



Critical Time Intervention (CTI) Referral Form

Referral date: _____ Referral source name: _____ Referral source phone number: _____

Client name: _____ DOB: _____ Male Female Transgender Mailing Address: _____ Phone number: _____

Hispanic Non-Hispanic White African-American Asian-American Native-American Other

Is client receiving SSI or SSDI? Yes No If no, Application Completed? Yes No

Income source: _____

Health Care Insurance Provider: _____ PCP: _____ Date last seen: _____

Mental Health Care Provider: _____ Date last seen: _____

CTI Requirements for transitions out of hospitals, incarceration, or other facilities:

- CCT participating hospital ER, inpatient, NH Hospital, or corrections facility scheduled to be discharged into community
- CCT release form signed
- Client is 18 +
- Client is *not* consistently engaged with behavioral and/or health care treatment services
 - Client is *not* consistently attending appointments for PCP or referrals for specialized health care treatment
- Insurance: current Medicaid or lapsed Medicaid If lapsed, date of expiration: _____ Medicaid application completed? Y or N Filed? Y or N (if yes, date filed: _____)

CTI Requirements for housing transitions:

- Client is currently in a NH homeless shelter transitioning to permanent housing
- Client's housing is at risk due to unmet mental health or physical health needs

Current areas of unmet need:

Housing MH/SA treatment Medical Income Family/social support Money mgmt. Independent Living

Additional information:

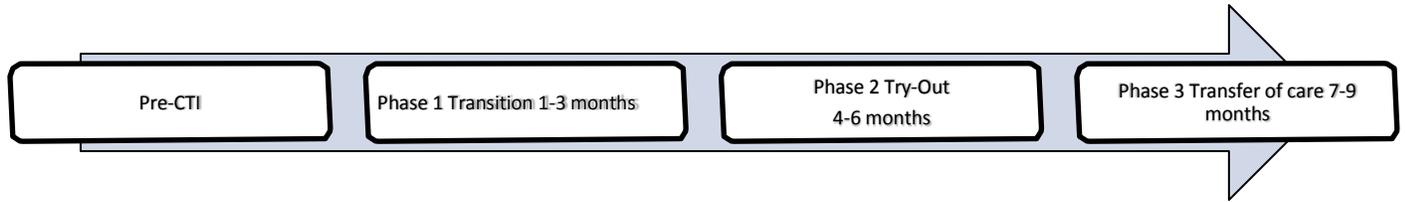
For IDN Use:

Pre-screening received Date: _____ CTI Screening Completed Date: _____ Eligible: Yes No

If not eligible, referred to IDN Provider(s): _____

Critical Time Intervention Model Service Guide and Worksheet

“(CTI) is a time-limited (9month) evidence-based practice that mobilizes support for society’s most vulnerable individuals during periods of transition. It facilitates community integration and continuity of care by ensuring that a person has enduring ties to their community and support systems during these critical periods.”



CTI Transition Planning

Pre-CTI -Prior to discharge, or moving into housing	Transition (Phase 1) -Day 1 of transition into the community or housing	Try Out (Phase 2)	Transfer Care (Phase 3)
Pre-Transition	Month 0-3 post transition	Month 4-6 post transition	Month 7-9 post transition
Assessment	Weekly + contact: Add Focus Area(s) 1 2 3	Monthly + contact: Add Focus Area(s) 1 2 3	Monthly + contact: Add Focus Area(s) 1 2 3
Phase Plan	Building connections and relationships	Increase autonomy	Wrap-up
Transition	Prioritize Needs	Strategize, plan and help maintain	Monthly check in to see that connections continue to go smoothly

Attachment C-7c

Arizona Self-Sufficiency Matrix

Participant Name _____ DOB ____/____/____ HMIS ID ____ Assessment Date ____/____/____ Intake Interim Exit
 Program Name _____

Domain	1	2	3	4	5	Score	Participant goal? (/)
Housing	Homeless or threatened with eviction.	In transitional, temporary or substandard housing; and/or current rent/mortgage payment is unaffordable (over 30% of income).	In stable housing that is safe but only marginally adequate.	Household is in safe, adequate subsidized housing.	Household is safe, adequate, unsubsidized housing.		
Employment	No job.	Temporary, part-time or seasonal; inadequate pay, no benefits.	Employed full time; inadequate pay; few or no benefits.	Employed full time with adequate pay and benefits.	Maintains permanent employment with adequate income and benefits.		
Income	No income.	Inadequate income and/or spontaneous or inappropriate spending.	Can meet basic needs with subsidy; appropriate spending.	Can meet basic needs and manage debt without assistance.	Income is sufficient, well managed; has discretionary income and is able to save.		
Food	No food or means to prepare it. Relies to a significant degree on other sources of free or low-cost food.	Household is on food stamps.	Can meet basic food needs but requires occasional assistance.	Can meet basic food needs without assistance.	Can choose to purchase any food household desires.		
Child Care	Needs childcare, but none is available/accessible and/or child is not eligible.	Childcare is unreliable or unaffordable, inadequate supervision is a problem for childcare that is available.	Affordable subsidized childcare is available but limited.	Reliable, affordable childcare is available, no need for subsidies.	Able to select quality childcare of choice.		
Children's Education	One or more school-aged children not enrolled in school.	One or more school-aged children enrolled in school, but not attending classes.	Enrolled in school, but one or more children only occasionally attending classes.	Enrolled in school and attending classes most of the time.	All school-aged children enrolled and attending on a regular basis.		
Adult Education	Literacy problems and/or no high school diploma/GED are serious barriers to employment.	Enrolled in literacy and/or GED program and/or has sufficient command of English to where language is not a barrier to employment.	Has high school diploma/GE D.	Needs additional education/training to improve employment situation and/or to resolve literacy problems to where they are able to function effectively in society.	Has completed education/training needed to become employable. No literacy problems.		

Health Care Coverage	No medical coverage with immediate need.	No medical coverage and great difficulty accessing medical care when needed. Some household members may be in poor health.	Some members (e.g. Children) have medical coverage.	All members can get medical care when needed but may strain budget.	All members are covered by affordable, adequate health insurance.		
Life Skills	Unable to meet basic needs such as hygiene, food, activities of daily living.	Can meet a few but not all needs of daily living without assistance.	Can meet most but not all daily living needs without assistance.	Able to meet all basic needs of daily living without assistance.	Able to provide beyond basic needs of daily living for self and family.		
Family/Social Relations	Lack of necessary support from family or friends; abuse (DV, child) is present or there is child neglect.	Family/friends may be supportive, but lack ability or resources to help; family members do not relate well with one another; potential for abuse or neglect.	Some support from family/friends; family members acknowledge and seek to change negative behaviors; are learning to support and communicate	Strong support from family or friends. Household members support each other's efforts.	Has healthy/expanding support network; household is stable, and communication is consistently open.		
Mobility	No access to transportation, public or private; may have car that is inoperable.	Transportation is available, but unreliable, unpredictable, unaffordable; may have car but no insurance, license, etc.	Transportation is available and reliable but limited and/or inconvenient; drivers are licensed and minimally insured.	Transportation is generally accessible to meet basic travel needs.	Transportation is readily available and affordable; car is adequately insured.		
Community Involvement	Not applicable due to crisis; in "survival" mode.	Socially isolated and/or no social skills and/or lacks motivation to become involved.	Lacks knowledge of ways to become involved.	Some community involvement (advisory group, support group), but has barriers such as transportation, childcare issues.	Actively involved in community.		
Parenting Skills	There are safety concerns regarding parenting skills.	Parenting skills are minimal.	Parenting skills are apparent but not adequate.	Parenting skills are adequate.	Parenting skills are well developed.		
Legal	Current outstanding tickets or warrants.	Current charges/trial pending, noncompliance with probation/parole.	Fully compliant with probation/parole terms.	Has successfully completed probation/parole within past 12 months, no new charges filed.	No active criminal justice involvement in more than 12 months and/or no felony criminal history.		

Mental Health	Danger to self or others; recurring suicidal ideation; experiencing severe difficulty in day-to-day life due to psychological problems.	Recurrent mental health symptoms that may affect behavior, but not a danger to self/others; persistent problems with functioning due to mental health symptoms.	Mild symptoms may be present but are transient; only moderate difficulty in functioning due to mental health problems.	Minimal symptoms that are expectable responses to life stressors; only slight impairment in functioning.	Symptoms are absent or rare; good or superior functioning in wide range of activities; no more than everyday problems or concerns.		
Substance Abuse	Meets criteria for severe abuse/dependence; resulting problems so severe that institutional living or hospitalization may be necessary.	Meets criteria for dependence; preoccupation with use and/or obtaining drugs/alcohol; withdrawal or withdrawal avoidance behaviors evident; use results in avoidance or neglect of essential life activities.	Use within last 6 months; evidence of persistent or recurrent social, occupational, emotional or physical problems related to use (such as disruptive behavior or housing problems); problems have persisted for at least one month.	Client has used during last 6 months, but no evidence of persistent or recurrent social, occupational, emotional, or physical problems related to use; no evidence of recurrent dangerous use.	No drug use/alcohol abuse in last 6 months.		
Safety	Home or residence is not safe; immediate level of lethality is extremely high; possible CPS involvement.	Safety is threatened/temporary protection is available; level of lethality is high.	Current level of safety is minimally adequate; ongoing safety planning is essential.	Environment is safe, however, future of such is uncertain; safety planning is important.	Environment is apparently safe and stable.		
Disabilities	In crisis - acute or chronic symptoms affecting housing, employment, social interactions, etc.	Vulnerable - sometimes or periodically has acute or chronic symptoms affecting housing, employment, social interactions, etc.	Safe - rarely has acute or chronic symptoms affecting housing, employment, social interactions, etc.	Building Capacity - asymptomatic - condition controlled by services or medication	Thriving - no identified disability.		
Other: (Optional)	In Crisis	Vulnerable	Safe	Building Capacity	Empowered		

Please see Attachment Appendices for full documentation of Attachment C-7d (CTI Program Documentation), Attachment C-7e (CTI Participation Agreement), and Attachment C-7f (Care Director User Guidance Tool).

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

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

UPDATED Table C-8a: Member Roles and Responsibilities as of submission date 4/5/19

Project Team Member	Roles and Responsibilities
Kevin Irwin	Administrative and Operations Support
Sandra Denoncour	Administrative and Operation Support
Tory Jennison	Data and HIT TA and Support
Bill Gunn	Clinical Support and Consultation
Tamara Whalen	CTI Supervisor
Maggie Weaver	CTI Case Manager
Katie Mackle	CTI Case Manager focused on Pre-CTI clients
Donna Harbison	CTI Case Manager
Alix Campbell	CTI Case Manager
Kimberly Nute	CTI Case Manager
Collaborating IDN Member	-----
Aimee Bouffard	ECC Case Manager focused on Complex Case (E5)
Donald McCullough	ECC Case Manager focused on Complex Case (E5)

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

DHHS Final Review from previous submission: none

All Care Transition / CTI Case Managers, as well as several IDN Partners, have participated in trainings delivered by the Center for the Advancement of Critical Time Intervention (CACTI).

The Care Transitions Supervisor has completed the CACTI Train the Trainer courses and can now directly train in CTI. Two new staff members hired January and February 2019 will be trained by the CTI Supervisor who is a certified CTI trainer. She will also be a training and support resource as the IDN6 continues to explore opportunities to replicate or expand this model in the community with future creation of embedded CTI Case Managers and/or a team with a partner agency or practice.

The Care Transitions team members are an integral part of the Multi-disciplinary Core Team within the Community Care Team. Training plans include a series from January 2019-June 2019 of core competency trainings for the entire Care Transitions team.

The Care Transitions CTI team participates in monthly CTI Community of Practice teleconferences and in-person sessions facilitated by Kim Livingstone. This Community of Practice participation provides opportunities to discuss and learn from other IDN regional projects.

Core and supplemental trainings have been attended and scheduled in alignment with other projects and organization demands. The Care Transitions Team members participated in several trainings

that are identified in the table below. Attendees also included the Enhanced Care Coordinator Case Manager (E5) and/or the embedded MLADC and CRSW (D3) whenever possible.

The Care Transitions team has also worked to establish trainings and attend learning sessions with our community project partners. Specific examples include:

- August 2018- **Rockingham County Corrections** meeting to establish “Ready to Rent” program.
- September 2018- **Rockingham County Corrections**- IDN lead “**Ready to Rent**” program to 10 RCC inmates over the course of 4 two-hour sessions each to learn resources, skills, attitudes and behaviors for procuring and maintaining housing in their communities.
- October 2018- attended **Service Link** training at **Community Partners** (2 Case Managers)
- October 2018 -attended **Understanding Adolescent Substance Misuse** training (2 Case Managers)
- November 2018 - attended **Safe Station** training (1 Case Manager)

Table C-9a: Projected C1 Training Schedule

Projected C1 Training Schedule	PROJECTS IMPACTED	# ATTENDING	REPORTING PERIOD		
			06/30/19	12/31/19	06/30/20
TOPIC					
HIPAA training for CTI and Community Care Team work	C1, D3, E5	10-15	Jan 9		
NH Legal Assistance: How to address Public Benefits Notices of Decision and Notices of Eviction, and working with municipal welfare	C1, E5	6-10	Jan 22		
Managing Chronic Disease in Behavioral Health Patients	C1, E5	8	Feb		
Compassion Fatigue in Human Service Work - 2 options	C1, E5, D3	10-15	Feb 5 and/or Feb 16		
SUD updates and services	C1, E5, D3	10-15	March		
BH updates and services	C1, E5, D3	10-15	April		
BH - Foundations In Trauma Informed Care	C1, E5, D3	10-15	April		
Chronic Disease / Part II - further discussion of chronic disease management’s impact on BH and SUD co-occurring conditions	C1, E5, D3	10-15	May		
CTI Project Fidelity and Program Metrics	C1	7-10	June	Dec	June

Table C-9b: Attended C1 Training Schedule

Attended C1 Training Schedule	PROJECTS IMPACTED	# ATTENDED	REPORTING PERIOD		
			12/31/17	6/30/18	12/31/18
*CACTI Delivered					
*One Day F2F CTI Training for Supervisors	C1	5	Nov 30		
*Two Day F2F CTI Training - All CTI Staff	C1, E5	5	Nov 30		
*CTI Train-the-Trainer	C1	1			Aug 23
*Ongoing Coaching and Implementation Support	C1, E5	6	Ongoing Nov 2017 ->	ongoing	ongoing
*Web-based: Program Fidelity Assmt	C1	4	Sep 12		
CORE TRAININGS					
Trauma-Informed Care	C1, E5	4		Jun 1	
Core Standardized Assessment	C1, E5	5		Jun 7	
Integration in Practice	C1, E5	5		Jun 14	
NADAC training	C1	1 - Supervisor			Nov
Behavioral Health Summit - multiple topics, multiple attendees **	C1, D3, E5	6			Dec 10 & Dec 11
SUPPLEMENTAL TRAINING					
Human Trafficking	C1	4		Mar 29	
Cultural Competence	C1	4		Apr 24	
Motivational Interviewing	C1	4		Jun 19	

****Behavioral Health Summit** sessions attended included the following core team training: Integrated SMD recovery practices with inpatients, SUD prevention and risk factors, Understanding and addressing SUD as a chronic medical condition, Core competencies for primary care behavioral health integration, Facilitating integrated care success with co-occurring disorders, Addressing childhood adversity and social determinants of health, Core competencies for primary care BH integration, MAT: striving for quality.

Project Scoring: IDN Community Project Process Milestones

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

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

Projects D: Capacity Building Focused

IDN Community Project Implementation and Clinical Services Infrastructure Plan

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

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

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

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

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

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

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

The IDN Region 6 D3 project is aimed at expanding capacity within the IDN region to deliver partial intensive outpatient, partial hospital, or residential treatment options for SUD in conjunction with lower acuity outpatient counseling. These services are intended to result in increased stable remission of substance misuse, reduction in hospitalizations, reduction in arrests, and a decrease in psychiatric symptoms for individuals with co-occurring mental health conditions. The target population for the Region 6 IDN's D3 project is individuals with substance use disorders. Priority populations within the target population include pregnant women, individuals who have experienced an overdose in the last 30 days, people who inject drugs, and custodial parents of minor children.

While this project was initially conceptualized to engage primary care providers (in hospital based primary care practices), early implementation efforts indicated that provider readiness in the primary care arena was not yet at critical mass to justify continued program investment. Concurrently, clients in need of the treatment and recovery supports available through this project were being identified in other areas of the healthcare continuum, specifically Emergency Department and Hospital Inpatient units. While the locations where D3 Project staff first became engaged with clients shifted from the anticipated primary care setting, the core project components (increased access to MLADC level of care assessment and referral navigation) were sustained and expanded.

The D3 Community Project continues to grow in support of primary hospital partners and clients' desire to access SUD assessment and treatment services in our community. The priorities of our IDN key partners has been expressed as the need for support in service of patients in Emergency Department and Inpatient Hospital settings, including delivery of comfort medication, withdrawal management, MAT induction as indicated, comprehensive SUD assessment, and the navigation of patients experiencing SUD-associated challenges to the most clinically appropriate and available clinical and non-clinical treatment and supports.

To date, direct investment under the D3 Community Project has increased the regional capacity and community-based access to comprehensive SUD assessment and the navigation of patients experiencing SUD-associated challenges to the most clinically appropriate and available clinical and non-clinical treatment and supports. The D3 Community Project workforce consists of one MLADC Navigator employed at Southeastern New Hampshire Services (SENHS), one CRSW Case Manager at SENHS, and two CRSW Case Managers at SOS Recovery Community Supports (SOS).

These areas of direct investment are enhanced by the IOP and MLADC services supported with B1 partners, including MAT program support with Lamprey Health Care, an MLADC hired at Hope on Haven Hill, IOP program support at Families First, and IOP expansion support for Seacoast Youth Services.

The SUD Team of 1 MLADC Navigator and 1 CRSW Case Manager were successfully on-boarded at Southeastern New Hampshire service mid-May 2018. Both the MLADC and the CSRW are *community accessible*. They are unique in the region and an addition to SENHS current services; seeing clients as quickly as possible after referral and often before the client's transition from the hospital. To date, the MLADC has completed 60 ASI Level of Care assessments in various community locations including 26 in the hospital settings of our partners; further detailed in D-7.

To build regional network capacity for serving the most vulnerable people throughout our attributed population, the staff of the D3 work very closely with our Care Transitions Team and Community Care Teams. Consistent with the true nature of network building, all of the C1, E5, and D3 efforts are visible to each other and are resources in support of each other. For example, the majority of referrals to the MLADC and CRSW at Southeastern New Hampshire Services come from the Care Transitions team. Part of the C1 and E5 project intake is to assess for SUD concerns and refer directly to

the D3 team for assessment. Case follow-ups on shared clients occur regularly through team meetings and case conferences facilitated by the C1 Supervisor.

The following client narrative was presented in Section C-1. It is repeated here to demonstrate the value of the integrated network of providers, including D3 partners, working in the IDN 6 region.

“Mary” is a referral from a partner hospital (*PRH) concerned that Mary would be unable to follow up with her appointments and make connects with her community mental health center (*Community Partners). Prior to Mary’s hospitalization, her partner and roommate tragically took her life in their shared apartment. Mary struggled with her own suicidal ideation and went to her local ED (*FMH with transfer to Cypress) for help. She was hospitalized for psychiatric care (*Cypress).

Shortly after Mary returned home, the grief from losing her partner was too much and she returned to the ED (*PRH). This cycle repeated itself two more times before Mary was referred to the CTI team. Case management first met Mary during her admission at PRH Behavioral Health Unit, worked with Mary after discharge to help get her connected with her community mental health center (*CP) by taking her to appointments and advocated for an affordable medication plan with her primary provider (*Seacoast Family Practice). When Mary needed to go back to the hospital (*PRH), case management arranged for a foster dog mom, so Mary didn’t rack up expensive fees from kenneling her dog long term. Mary had been very anxious about this during previous admissions.

Just before the holidays in 2018, Mary expressed readiness to address her underlying SUD. CTI case management coordinated with the D3 project who met with Mary at PRH BHU. The team was able to get Mary into a 28-day treatment program (*Keystone). Thanks to these coordinated efforts, Mary has completed the 28-day program and met with her prescribing psychiatrist. She is in line for a therapist and a new functional support worker. *She has stayed out of the ED for almost 2 months* and has set goals for her to engage in SMD treatment and MH counseling so she can return to work, using her Master’s degree in computer science.

In October 2018, an agreement was secured to support SOS Recovery Community Support (SOS) in hiring two additional CRSW / Case Managers. As an IDN6 Partner and lead agency for the Law Enforcement Assisted Diversion (LEAD Dover/Farmington) project , SOS agreed to hire and manage part-time/on-call/per diem Certified Recovery Support Worker(s) to supplement a comprehensive staffing plan to ensure the LEAD project has 24/7 capacity to respond to diversion referrals from Dover and Farmington NH police staff.

IDN6 funding for workforce support allowed SOS to leverage additional funding to build a sustainable 24/7 response capacity to meet LEAD and associated programming standards. Associated programs include 24/7 response capacity to deliver peer recovery coaching in the WDH Emergency Department and inpatient units and to probation and parole clients in Strafford County.

During the past reporting period, collaboration efforts with Wentworth Douglass Hospital and The Doorway at Wentworth Douglass Hospital have resulted in draft workflows for ED initiation of withdrawal management. IDN 6 provided technical assistance in protocol development by retaining Molly Rossignol, DO FASAM FAAFP, an Addiction Medicine Physician, to consult with WDH in August 2018. The workflow includes connection and referrals to community supports, including SOS Recovery Community Support whose response capacity is supported by the IDN 6.

The IDN 6 Operations Team discussions with the Director of The Doorway at Wentworth Douglass Hospital have identified a key role for the IDN 6 to support HUB and spoke development in our region. Funding to support the priorities identified by the IDN 6, WDH, and the emerging Working Group has been built into the D3 project projected budget.

The first step in support of the HUB development is a Working Group meeting organized by the IDN 6 and scheduled for February 2019. The Working Group will be focused on working together to maximize collective assets and opportunities and build a treatment and recovery-oriented system of care in the Seacoast Region. The early invitation to this workgroup includes: Wentworth Douglass Hospital, Frisbie Memorial Hospital, Seacoast Youth Services, Bonfire Recovery, ROAD to a Better Life, Seacoast Community Mental Health, Hope on Haven Hill, and SOS Recovery Community Supports.

Details of the first meeting include:

Date: Friday, Feb 15

Time: 8:00-9:30am

Place: Federal Savings Room, Garrison Wing, Wentworth Douglass Hospital

Draft Agenda:

- Introductions
- Work Group Objectives (Primary: Identify Investment Needs and Opportunities in Workflow efficiencies, Staffing, Trainings, Agreements, Technology, and other Capacity-Building).
- Hub & Spokes/Doorway Model Overview
- Review findings and recommendations of the IDN SUD Work Group
- Review/Inform Services Inventory Plan
- Review/Inform Mapping Plan
- Next Steps

D-2. IDN Community Project: Evaluation Project Targets

Use the format below to provide a list of all of the progress toward targets or goals, that the program has achieved. Targets required by the STCs include, but should not be limited to:

- Number of individuals served (during reporting period and cumulative)
- All performance measures identified in the evaluation project plan.

Patients were referred to the D3 staff from the following sources:

- Portsmouth Regional Hospital
- Portsmouth Regional Hospital Behavioral Health Unit
- Frisbie Memorial Hospital
- Wentworth Douglass Hospital = **Total 27 Hospital-based MLADC assessments**
- Tri-City Co-Op
- Crossroads House / shelter
- SOS Recovery Community Supports = **33 Community-located MLADC assessments**

UPDATED TABLE D-2a: Evaluation Project Targets as of date of submission 4/5/19

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
# patients engaged with MLADC Navigator	30 by 12/31/18	n/a	11	>60
# patients received MLADC evaluation in community setting	30 by 12/31/18	n/a	n/a	60
# patients referred to CRSWs / Case Managers	20 by 12/31/18	n/a	n/a	62
# referrals made and completed by Case Managers / CRSWs	20 by 12/31/18	0	5	45
# clients who complete a defined treatment program	15 by 12/31/18	0	TBD	15
# clients who leave treatment in the first 7 days	<50%	0	TBD	unknown
# clients in supportive services 30 days after completion	>50%	0	TBD	10/15=67%
# Providers trained in SBIRT	20 by 12/31/18	0	0	21
# Providers employing SBIRT*	10 by 12/31/18	N/A	N/A	>30

**inclusive of partners in all projects, does not indicate universal screening. (GSCH, LHC, WDH/WHP, CP, SCMH, SYS, and SENHS)*

D-3. IDN Community Project: Workforce Staffing

From Project A1: Workforce Capacity Development Implementation Plan, document the current workforce staffing specifically related to this project using the format below.

The IDN-6 Team secured an agreement with Southeastern New Hampshire Services (SENHS) to employ and provide clinical supervision to the D3 Services Team. Two staff were recruited and hired, one MLADC Navigator and one Case Manager (CRSW). The MLADC has completed 60 level of care evaluations with referrals directly to the SENHS CRSW / Case Manager.

In October 2018, an agreement was secured to support SOS Recovery Community Support (SOS) in hiring two additional CRSW / Case Managers. As an IDN6 Partner and lead agency for the Law Enforcement Assisted Diversion (LEAD Dover/Farmington) project, SOS agreed to hire and manage part-time/on-call/per diem Certified Recovery Support Worker(s) to supplement a comprehensive staffing plan to ensure the LEAD project has 24/7 capacity to respond to diversion referrals from Dover and Farmington NH police staff.

IDN6 funding for workforce support allowed SOS to leverage additional funding to build a sustainable 24/7 response capacity to meet LEAD and associated programming standards. Associated programs include 24/7 response capacity to deliver peer recovery coaching in the WDH Emergency Department and inpatient units and to probation and parole clients in Strafford County.

**An additional MLADC was hired with IDN support at Hope on Haven Hill, originally envisioned as a D3 project. Now that Hope on Haven Hill is identified as a B1 partner, the MLADC position is discussed in the B1 project narrative and details.*

UPDATED TABLE D-3a: Workforce Staffing

Provider Type	IDN Workforce (FTEs)				
	Projected Total Need	Baseline Staffing on 6/30/17	Staffing on 12/31/17	Staffing on 6/30/18	Staffing on 12/31/18
MLADC Navigator	*1 (revised)	0	0	1	1
Case Manager / CRSW	6	0	0	1	3

D-4. IDN Community Project: Budget

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

Table D-4: Budget

Connections for Health								
IDN Region 6								
Project D3								
Project	CY 2016 Actuals	CY 2017 Actuals	Jan-Jun 2018 Actuals	July-Dec 2018 Actuals	CY 2019 Projected Spend Budget	CY 2020 Projected Spend Budget	CY 2021 Projected Spend Budget	Actual and Projected Spend
Expense Items								
Staffing								
Direct Staff	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Indirect Staff	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Benefits	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Contracted Staffing	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
								\$ -
Project Infrastructure								\$ -
Equipment	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Operations	\$ -	\$ -	\$ 3,782	\$ 838	\$ 3,500	\$ 3,500	\$ 3,500	\$ 15,120
								\$ -
Workforce								\$ -
Fees/Outside Placement	\$ -	\$ -	\$ 154,000	\$ 154,792	\$ 308,000	\$ 308,000	\$ 308,000	\$ 1,232,792
Recruiting/Retention	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Training	\$ -	\$ -	\$ 340	\$ -	\$ 15,000	\$ 15,000	\$ 15,000	\$ 45,340
Other	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
								\$ -
Technology	\$ -	\$ -	\$ -	\$ -	\$ 15,000	\$ 15,000	\$ 15,000	\$ 45,000
								\$ -
								\$ -
Totals	\$ -	\$ -	\$ 158,122	\$ 155,631	\$ 341,500	\$ 341,500	\$ 341,500	\$ 1,338,253

Budget Narrative

- The projected budget for D3 project is \$1,338,253, the 6/30/2018 SAR budget was \$1,468,400.
- Outside placements include embedded staff in SUD providers including an MLDAC and CRSW's. The IDN has been working closely with the HUB in our region to convene sessions with the partners in the network who will be the spokes in the State Opioid Response program. During the coming month, the IDN expects to allocate resources in support of this, but at this point, the details are not yet finalized.

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

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

The primary organizational partner and hub for the D3 project is Southeastern New Hampshire Services (SENHS), the largest and most comprehensive SUD treatment provider in Region 6. SENHS offers a full range of low to high intensity clinically managed outpatient and inpatient residential SUD services, including specialty programs for women, Drug Court, Impaired Driver Care Management, and Community Access to Recovery Program.

IDN 6 is working with Rockingham County Corrections (RCC) to support and further develop their program to provide Narcan to inmates at release. This work is in collaboration with IDN Region 4 and SOS Recovery Community Support. To date, IDN Region 4 and IDN Region 6 have reached an agreement to share cost for the Narcan supply at Rockingham County Corrections as part of developing a structured program. Rockingham County Corrections will be working with SOS Recovery Community Support for training and education. RCC indicates that their clinical team will support standing orders and clinical oversight.

The IDNs in both regions agree to support further education for both inmates and staff as needs are identified, provide technical assistance to ensure best clinical practices are supported, and ensure program development is consistent with project goals. IDN 6 will secure the MOU for the Narcan procurement assistance in the first quarter of 2019. Both IDNs have CTI team involvement (C1 Community project) with RCC. This will be leveraged to collaborate in this new agreement.

Organization/Provider	Agreement Executed (Y/N)	Active referrals as of 12/31/2018 (Y/N)
Southeastern New Hampshire Services *host agency	Yes	Yes
Wentworth Douglass Hospital	Yes	Yes
Frisbie Memorial Hospital	Yes	Yes
Portsmouth Regional Hospital / HCA	Yes	Yes
Hope on Haven Hill	Yes	Yes
Rockingham County Corrections	Yes	No
Seacoast Youth Services	Yes	Yes
SOS Recovery Community Support	Yes	Yes
Safe Harbor Recovery Community Organization/Granite Pathways/Seacoast Pathways	Yes	Yes
Strafford County Community Corrections	Yes	No
Tri-City Co-Op	Yes	Yes
Bridging the Gaps - Rochester's Substance Misuse Prevention Coalition	Yes	No
Joan Lovering Health Center	Yes	No

D-6. IDN Community Project: Standard Assessment Tools

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

Project partners using the Addiction Severity Index include: SENHS and The Doorway at WDH.

The Clinical Opiate Withdrawal Scale (COWS) is used at WDH for inpatient and ED to assess for level of care needs while at their facility and identify substance use support and treatment needs post-discharge.

The Arizona Self-Sufficiency Matrix is used by the SOS / LEAD program for all of their program enrollees. The D3 team at SENHS uses the ASSM to compliment the assessments completed by the Care Transitions team (C1). For clients referred from the C1 project, the D3 team will collaborate on updates to the assessment during weekly team meetings.

Standard Assessment Tool Name	Brief Description
Addiction Severity Index (<i>attachment D-6a</i>)	Comprehensive SUD Assessment
Clinical Opiate Withdrawal Scale (<i>attachment D-6b</i>)	Assess a patient's level of opiate withdrawal
Arizona Self-Sufficiency Matrix (<i>attachment C-7c</i>)	Core Standardized Assessment
SOS / Lead Intake Assessment (<i>attachment D-6c</i>)	SUD use and severity assessment

Please see Attachment D-6a in the Appendix of Attachments for the full documentation of the Addiction Severity Index.

Clinical Opiate Withdrawal Scale

For each item, circle the number that best describes the patient's signs or symptom. Rate on just the apparent relationship to opiate withdrawal. For example, if heart rate is increased because the patient was jogging just prior to assessment, the increase pulse rate would not add to the score.

Patient's Name: _____ Date and Time ____/____/____:_____	
Reason for this assessment: _____	
Resting Pulse Rate: _____beats/minute <i>Measured after patient is sitting or lying for one minute</i> 0 pulse rate 80 or below 1 pulse rate 81-100 2 pulse rate 101-120 4 pulse rate greater than 120	GI Upset: over last 1/2 hour 0 no GI symptoms 1 stomach cramps 2 nausea or loose stool 3 vomiting or diarrhea 5 multiple episodes of diarrhea or vomiting
Sweating: over past 1/2 hour not accounted for by room temperature or patient activity. 0 no report of chills or flushing 1 subjective report of chills or flushing 2 flushed or observable moistness on face 3 beads of sweat on brow or face 4 sweat streaming off face	Tremor observation of outstretched hands 0 no tremor 1 tremor can be felt, but not observed 2 slight tremor observable 4 gross tremor or muscle twitching
Restlessness Observation during assessment 0 able to sit still 1 reports difficulty sitting still, but is able to do so 3 frequent shifting or extraneous movements of legs/arms 5 unable to sit still for more than a few seconds	Yawning Observation during assessment 0 no yawning 1 yawning once or twice during assessment 2 yawning three or more times during assessment 4 yawning several times/minute
Pupil size 0 pupils pinned or normal size for room light 1 pupils possibly larger than normal for room light 2 pupils moderately dilated 5 pupils so dilated that only the rim of the iris is visible	Anxiety or Irritability 0 none 1 patient reports increasing irritability or anxiousness 2 patient obviously irritable or anxious 4 patient so irritable or anxious that participation in the assessment is difficult
Bone or Joint aches If patient was having pain previously, only the additional component attributed to opiates withdrawal is scored 0 not present 1 mild diffuse discomfort 2 patient reports severe diffuse aching of joints/muscles 4 patient is rubbing joints or muscles and is unable to sit still because of discomfort	Gooseflesh skin 0 skin is smooth 3 piloerection of skin can be felt or hairs standing up on arms 5 prominent piloerection
Runny nose or tearing Not accounted for by cold symptoms or allergies 0 not present 1 nasal stuffiness or unusually moist eyes 2 nose running or tearing 4 nose constantly running or tears streaming down cheeks	<p style="text-align: right;">Total Score _____</p> <p style="text-align: center;">The total score is the sum of all 11 items</p> Initials of person completing assessment: _____

Score: 5-12 = mild; 13-24 = moderate; 25-36 = moderately severe; more than 36 = severe withdrawal



SOS Recovery Community Organization, Dover, and Farmington LEAD

Participant Full Intake Assessment Form

Instructions: This form should be completed at either the first or second session after the client is diverted and screened. The case manager should ask the client these questions and record their responses.

Information completed at (Circle One):	<i>First or second session after screening/diversion</i>	<i>Third session or later after screening/diversion</i>
---	--	---

Date Completed ___/___/_____

Name:

(Please Print) First Middle Last

Any Aliases: _____

Where can we find you? _____

Who is most likely to know where you are, if we can't find you?

Address _____ Phone Number _____

Current Physical Address: _____ City/Town _____ Zip _____

Current Mailing Address: _____ City/Town _____ Zip _____



Email: _____ @ _____ Phone Number: _____

Last 4 digits ONLY of Social Security _____ Date of Birth: ____/____/____

Children Yes No Notes on children: _____ Partner Yes No

Notes on partner _____

Emergency Contact: _____ Relation _____

Address _____ Phone Number _____

Gender: Male Female Transgender Other Prefer not to answer

Marital Status: Married Single Divorced Separated Living as Married Widowed

Race: African American/Black Native American Asian White Native Hawaiian or other Pacific Island other _____ No answer **Are you Hispanic or Latino** Yes No

May we contact you via: Email Phone If by Phone may we leave message? Yes No

In the past 30 days have you used any of the following substances:

Alcohol Cocaine/Crack Marijuana Opiates (Heroin, Fentanyl, Other prescription Opiates)
 Nonprescribed Methadone Hallucinogens/Psychedelics Methamphetamine or other
Amphetamines Other(specify) _____

What substance(s) have been most challenging to you (check all that apply)?

Alcohol Cocaine/Crack Opiates (Heroin, Fentanyl, Other prescription Opiates) Marijuana
 Nonprescribed Methadone Hallucinogens/Psychedelics Methamphetamine or other
Amphetamines Other(specify) _____

Over last 30 days how many times have you been to an Emergency Dept for substance use concerns:

Zero 1 Time 2 times 3 times More than 5 times

In the LAST YEAR have you received any treatment for substance misuse (check ALL that apply):

Withdrawal Management (Detoxification) Outpatient Counseling Intensive Outpatient (IOP)
 Inpatient/Hospital Residential Treatment Center Medically Assisted Treatment (with Suboxen/Buprenorphine, Methadone, Naltrexone or Vivitrol) I did not access Substance Use Disorder Treatment Services



In the PAST 30 DAYS have you received any treatment for substance misuse (check ALL that apply):

- Withdrawal Management (Detoxification) Outpatient Counseling Intensive Outpatient (IOP)
 Inpatient/Hospital Residential Treatment Center Medically Assisted Treatment (with Suboxen/Buprenorphine, Methadone, Naltrexone or Vivitrol) I did not access Substance Use Disorder Treatment Services

How many people are in your family including yourself? _____

Approx monthly household income: _____ (these answers will remain confidential)

Do you currently have health insurance? Yes No Don't Know Choose not to answer

What type of Insurance do you have? Medicaid: NH Healthy Families/Centapico WellSense (Beacon Health) Am better Anthem (Blue Cross) Community Health Options Harvard Pilgrim Minuteman Medicare **Veteran Insurance:** Tricare Other Private Insurance (paid by employer or individual) Other (specify) _____ Don't Know
 Choose not to answer

For billing purposes (if enrolling in billable Recovery Coaching or Telephone Recovery) What is your

Insurance Group Number: _____ Member ID Number _____

VETERAN: YES NO **SERVICE MEMBER:** YES NO

Employment: Full Time Part Time Volunteer Actively seeking work Retired
 Unemployed Disabled Student Other

Describe your living arrangements today: Homeless (includes abandoned bldg, vehicle, anywhere outside) Emergency Shelter (includes hotel/motel) Live with Family/Friends Own House Rent Recovery Housing Transitional Living Residential Treatment Psychiatric Hospital/facility Nursing Facility Foster Care/Home Other Choose not to answer
How Long Have you been living in this setting: (specify # of years/months) _____

In the Past 30 days what City/Town have you been staying in or sleeping majority of time _____



Education: Never attended 6th Grade 7-9th Grade 10th or 11th Grade 12th Grade/High School Diploma/GED 1st year college 2nd year college 3rd year college college or university completed/ BA or BS Master's Degree Doctorate's Degree Other

In the past 30 days have you been arrested: Yes If so How many times _____ No Don't Know
 Choose not to answer

In the past 60 days have you been incarcerated for 5 or more days: Yes No Don't Know Choose not to answer

Have you ever been convicted of a sex offense? Yes _____ No _____

If yes, what was the nature of this charge and when did this happen?

In the past 30 days, what services and/or supports have you engaged in (check all that apply)?

Support groups Recovery Coaching Telephone Recovery Supports Substance Use Disorder Treatment
 Spiritual Supports Other Service/Supports Not currently engaged with services/supports

Are you interested in receiving either of the following services?

Telephone Recovery Supports Recovery Coaching

I acknowledge and affirm that the information provided is complete and accurate:

(your signature)

(please print your name here)

(date)

Completed Assessment requires completion of Arizona SS Matrix

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

Use the format below to provide a list of all protocols to be utilized for patient assessment, treatment, management, and referrals for the community project. IDNs should indicate what protocols are currently in place and which are slated for adoption. DHHS reserves the right to audit all or a selection of protocols used by the IDNs.

The IDN Team and SENHS worked closely with key partners (Wentworth Douglass Hospital, Frisbie Memorial Hospital, Portsmouth Regional Hospital) and has formalized referral protocols from inpatient and ED, as well as from agencies and organizations that are included and covered by the Release of Information Agreement in the Community Care Team. The D3 team at SENHS receives direct phone calls in real time to connect with patients at the hospital and/or receive referral information for follow-up after discharge. Referrals are documented using the CCT referral form for ease of referral. Releases of information needed for specific agencies are executed as needed. The D3 team routinely asks clients to sign the ROI document for the Community Care Team to facilitate resource collaboration.

Referrals from Care Transitions Team and CCT are forwarded using the same referral form as the C1 project team. All individuals referred from these sources are listed in the Care Director shared care plan. It is anticipated that the D3 workforce staff will be trained in Care Director as it is rolled out to all partners.

Both SENHS and WDH are using the ASAM to guide care-planning and referrals. One important aspect of The American Society of Addiction Medicine (ASAM) Criteria is that it views patients in their entirety, rather than a single medical or psychological condition. This means that, when determining service and care recommendations, The ASAM Criteria pays attention to the whole patient, including all of his or her life areas, as well as all risks, needs, strengths, and goals.

Wentworth Douglass Hospital has implemented the attached protocols for ambulatory detox started in and after discharge from the Emergency Department.

Select partners have been trained in the Allscripts Care Director shared care plan, including designated users at SENHS and WDH.

UPDATED Table D-7a: Protocols for Patient Assessment, Treatment, Management, and Referrals as of submission date 4/5/19

Protocol Name	Brief Description	Use (Current/Under Development)
WDH ED buprenorphine for Opioid Withdrawal Protocol <i>(attachment D-7a)</i>	Protocol for ambulatory detox started in Emergency Department	Current
National Institute on Drug Abuse (NIDA) Guidelines <i>(attachment D-7b)</i>	Protocol for ambulatory detox started after ED discharge	Current
Addiction Severity Index (ASI) <i>(attachment D-6a)</i>	Level of Care assessment for SUD	Current
American Society of Addiction Medicine (ASAM) Criteria <i>(attachment D-7c)</i>	Biopsychosocial assessment for SUD treatment planning	Current
SBIRT	Screening tool for SUD	Current
Care Director / Allscripts <i>(attachment C-7f)</i>	Shared Care Plan	Current

(space left intentionally blank)

Attachment D-7a *Emergency Department Guideline*

Guideline:	ED buprenorphine for Opioid Withdrawal Protocol
Applies to:	Department of Emergency Medicine
Effective Date:	
Reviewed by:	
Approved by:	
Last Revision:	

Standards/Definitions:

The following guideline has been developed to manage patients’ opioid withdrawal symptoms while being treated in the Emergency Department. The guideline applies to patients who are actively going through opioid withdrawal. The active management of withdrawal symptoms is based on individual assessment and may vary based on specific clinical presentations.

Recommendations in this guideline derived from:

ASAM Clinical Practice Guideline: <https://www.asam.org/docs/default-source/practice-support/guidelines-and-consensus-docs/asam-national-practice-guideline-supplement.pdf>

NIDA-Initiating Buprenorphine Treatment in the Emergency Department:

<https://www.drugabuse.gov/nidamed-medical-health-professionals/initiating-buprenorphine-treatment-in-emergency-department>

Details:

Federal regulations permit the use of buprenorphine for a maximum of 72 hours for the purpose of relieving acute withdrawal symptoms while arranging for a patient’s referral to treatment. Patients who are eligible for the opioid withdrawal guideline must show active signs of withdrawal and be equal to or greater than 18 years old. Appropriate conditions *may* include any of the following:

1. Patients in the ED for an extensive period of time who meet Clinical Opioid Withdrawal Scale (COWS) criteria (Score > 8) for opioid withdrawal
2. Patients in moderate-severe withdrawal (COWS >8) who are seeking assistance accessing treatment for their substance use and identified to have an opioid use disorder (OUD) in the course of their ER stay
3. Pregnant women in withdrawal (COWS >8)--**an OB consult is required for any pregnant patient. Inpatient induction recommended for gestational age >20 weeks.**

Assessment

- a. Medical exam
- b. Identify patients with possible OUD (“How many times in the last year have you used heroin, fentanyl or prescription opioids for nonmedical reasons?” Any response more than “never” is a positive screen and warrants further assessment.)
- c. Assess eligibility for ED-initiated buprenorphine by meeting following criteria:
 - Recent regular opioid use (i.e. daily/almost daily use including within last 7 days)
 - Meets DSM-5 criteria for moderate to severe OUD (4 or more criteria)

- Opioids are often taken in larger amounts or over a longer period of time than intended.
- There is a persistent desire or unsuccessful efforts to cut down or control opioid use.
- A great deal of time is spent in activities necessary to obtain the opioid, use the opioid, or recover from its effects.
- Craving, or a strong desire to use opioids.
- Recurrent opioid use resulting in failure to fulfill major role obligations at work, school or home.
- Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids.
- Important social, occupational or recreational activities are given up or reduced because of opioid use.
- Recurrent opioid use in situations in which it is physically hazardous
- Continued use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by opioids.
- *Tolerance, as defined by either of the following: (a) a need for markedly increased amounts of opioids to achieve intoxication or desired effect (b) markedly diminished effect with continued use of the same amount of an opioid
- *Withdrawal, as manifested by either of the following: (a) the characteristic opioid withdrawal syndrome (b) the same (or a closely related) substance are taken to relieve or avoid withdrawal symptoms
- Needs treatment (i.e. not already engaged in formal medication treatment program)

d. Assess for signs and symptoms of withdrawal

- Opioid withdrawal symptoms include:

Signs	Symptoms
Lacrimation Rhinorrhea Dilated Pupils Piloerection Tachycardia Hypertension Diarrhea Vomiting	Yawning Sweating Anxiety Restlessness Insomnia Chills Nausea Cramping Abdominal pains Muscle aches

Utilize COWS scale (<https://www.mdcalc.com/cows-score-opiate-withdrawal> or see Appendix A) to determine if patient is in active withdrawal. If COWS score is >8, consider ED induction. If COWS<8, patient may be considered for Home Induction (See ED Buprenorphine/naloxone Home Induction Guideline).

- e. Consider: Urine tox screen, pregnancy test. Lab testing not required but urine tox can confirm opioid use and exclude recent methadone if concerned. Consider LFT's, HIV and Hep screens as these are recommended in early treatment.

- f. Patient education should be conducted, ensuring patient makes an informed decision to take buprenorphine products to manage withdrawal symptoms/OD. Provider will document that this discussion took place.
- g. **SOS recovery coach (800-864-9040) to be called in** while arranging ED induction or Home induction- Recovery Coach will offer their services to the patient while patient is in the ED. (If patient declines Recovery Coach services after coach arrives, this does not preclude patient from receiving buprenorphine or Rx at discharge.)
- h. Consider other prescribed or recreational substances and interactions as withdrawal/comfort meds are prescribed
- i. Consider complicating factors and potential contraindications:
 - Recent methadone or long-acting opioid use (risk for precipitated withdrawal)
 - Unstable alcohol, benzodiazepine or other sedative use
 - Medical, psychiatric, or surgical instability or decompensated liver/lung/heart/kidney disease
 - Prisoner- consult with jail medical staff
 - Pregnancy (buprenorphine not contraindicated **but MUST be managed with OB consult**)

Medication orders

1. Buprenorphine products (either buprenorphine (“Subutex” ®) or buprenorphine/naloxone

- a. Please Note:
 - Use with caution in patients requiring opioid analgesics for pain management
 - Do not use in patients who may require surgery in the next seven days
 - IF AFTER CONSULTATION WITH OB, a decision is made to start buprenorphine in pregnant patient, buprenorphine without naloxone (Subutex), may be used.
- b. Do not administer buprenorphine until patient objectively demonstrates signs and symptoms of opioid withdrawal (COWS score >8) or precipitated withdrawal may occur.
- c. Withdrawal typically begins:
 - 12 hours after last dose of short-acting opioid (heroin, oxycodone, Vicodin, etc.) or
 - 24-48 hours after last dose of long-acting opioid (methadone)
- d. First dose:
 - Wait until COWS score >8 before giving initial buprenorphine dose
 - Administer buprenorphine SL 4mg or buprenorphine/naloxone SL 4mg/1mg (may consider initial dose of 8mg if COWS score >12).
- e. Observe for 45-60 minutes and if no adverse reaction, administer second dose of 4mg buprenorphine or 4mg/1mg buprenorphine/naloxone.
- f. Observe for 60 minutes. If patient remains in moderate withdrawal (COWS >8), may consider adding additional 4mg buprenorphine or 4mg/1mg buprenorphine/naloxone and additional 60-minute observation. Do not exceed 16mg in first 24 hours.

2. Clonidine

- j. May be given instead of buprenorphine for opioid withdrawal or to supplement treatment (not needed if able to bridge to appointment for continued buprenorphine treatment).
- k. Administer 0.1mg every 6 hours PRN signs and symptoms of withdrawal
- l. Do not exceed 0.4mg in 24 hours
- m. Hold any doses if:
 - SBP < 90 or DBP < 50 mm Hg
 - HR < 50

- Excessive sedation
 - Orthostatic hypotension (drop of 20 mm Hg in SBP or 10 mm Hg in DBP)
2. To augment opioid withdrawal treatment, consider symptom-targeted treatment as below:
- a. Mild-moderate pain management options
 - Acetaminophen 650mg PO every 6 hours PRN, not to exceed 4000mg in 24 hours in patients with normal hepatic function or 2000mg in patients with hepatic disease/cirrhosis
 - Ibuprofen 400 – 800mg PO TID PRN, not to exceed 2400mg in 24 hours; avoid in patients with renal impairment (eGFR < 30 mL/min/1.73m²)
 - b. Abdominal cramps
 - Dicyclomine 10-20mg PO every 6 hours PRN stomach cramps
 - c. Diarrhea
 - Loperamide 4mg PO after first loose stool, then 2mg PO each additional loose stool, not to exceed 16mg in 24 hours
 - d. Nausea
 - Ondansetron 4 mg PO every 8 hours PRN or 2 mg IV every 6 hours PRN Nausea or vomiting (CAUTION: Combination of buprenorphine and ondansetron may prolong QT interval) OR
 - Promethazine (Phenergan)-25mg PO every 6 hours PRN
 - e. Dyspepsia
 - Famotidine 40mg every 8 hours PRN
 - f. Muscle cramping
 - Methocarbamol 750mg PO every 6-8 hours PRN muscle cramps
 - g. Insomnia
 - Melatonin –over the counter
 - 5-10 mg PO every night before bed
 - Trazadone – Prescription
 - 50-100mg PO every night before bed

Discharge

Buprenorphine X-Waivered providers-

Prior to prescribing buprenorphine, providers should check NH Prescription Drug Monitoring Program.

Provide short term (2-7 day Rx for buprenorphine/naloxone 8mg/2mg (tabs or films) OR buprenorphine SL 8mg tabs, take 2 tabs or films SL one time daily).

If patient was not in withdrawal (COWS <8) then follow Buprenorphine Home Induction Guideline for prescription dosing.

Take home Naloxone and Overdose prevention-

- Ensure all patients are educated on and given intranasal naloxone kit/instructions to take home.

Treatment and Harm Reduction Referral:

- RN or recovery coach will make direct phone call to one of the following **WDH community buprenorphine partners for follow up visit within 2-7 days:**
 - **Addiction Recovery Services- Intensive Outpatient Program**
Office: 603-433-6250
Fax: 603-433-6350
1145 Sagamore Ave. Portsmouth, NH 03801
Cell: 814-515-9896
Website: arsnh.com
Email: info@arsnh.com
 - **Groups**
40 Winter St., # 204, Rochester, NH
New Members: (800)683-8313
info@joinGroups.com

- Provide informational material that includes local resources for treatment and medication maintenance treatment. Provide contact information for WDH Doorway (dial 211 or 603-609-6690).

- Referral to **SOS Recovery** (603) 841-2350- if patient declined to speak to on-call recovery coach during encounter.

- Also refer to **Hand-Up Health Services-** (<http://nhhrc.org/resources/handup/>) ((207) 370-7187) for syringes/naloxone refills/other harm reduction services in case of continued use or return to use.

- As needed, involve social work services for housing/financial assistance/PCP linkage

Appendix A
COWS Score

<p>Resting Pulse Rate: _____ beats/minute <i>Measured after patient is sitting or lying for one minute</i></p> <p>0 pulse rate 80 or below 1 pulse rate 81-100 2 pulse rate 101-120 4 pulse rate greater than 120</p>	<p>GI Upset: <i>over last 1/2 hour</i></p> <p>0 no GI symptoms 1 stomach cramps 2 nausea or loose stool 3 vomiting or diarrhea 5 multiple episodes of diarrhea or vomiting</p>
<p>Sweating: <i>over past 1/2 hour not accounted for by room temperature or patient activity.</i></p> <p>0 no report of chills or flushing 1 subjective report of chills or flushing 2 flushed or observable moistness on face 3 beads of sweat on brow or face 4 sweat streaming off face</p>	<p>Tremor <i>observation of outstretched hands</i></p> <p>0 no tremor 1 tremor can be felt, but not observed 2 slight tremor observable 4 gross tremor or muscle twitching</p>
<p>Restlessness <i>Observation during assessment</i></p> <p>0 able to sit still 1 reports difficulty sitting still, but is able to do so 3 frequent shifting or extraneous movements of legs/arms 5 unable to sit still for more than a few seconds</p>	<p>Yawning <i>Observation during assessment</i></p> <p>0 no yawning 1 yawning once or twice during assessment 2 yawning three or more times during assessment 4 yawning several times/minute</p>
<p>Pupil size</p> <p>0 pupils pinned or normal size for room light 1 pupils possibly larger than normal for room light 2 pupils moderately dilated 5 pupils so dilated that only the rim of the iris is visible</p>	<p>Anxiety or Irritability</p> <p>0 none 1 patient reports increasing irritability or anxiousness 2 patient obviously irritable or anxious 4 patient so irritable or anxious that participation in the assessment is difficult</p>
<p>Bone or Joint aches <i>If patient was having pain previously, only the additional component attributed to opiates withdrawal is scored</i></p> <p>0 not present 1 mild diffuse discomfort 2 patient reports severe diffuse aching of joints/muscles 4 patient is rubbing joints or muscles and is unable to sit still because of discomfort</p>	<p>Gooseflesh skin</p> <p>0 skin is smooth 3 piloerection of skin can be felt or hairs standing up on arms 5 prominent piloerection</p>
<p>Runny nose or tearing <i>Not accounted for by cold symptoms or allergies</i></p> <p>0 not present 1 nasal stuffiness or unusually moist eyes 2 nose running or tearing 4 nose constantly running or tears streaming down cheeks</p>	<p align="right">Total Score _____</p> <p align="center">The total score is the sum of all 11 items</p> <p>Initials of person completing assessment: _____</p>

Score: 5-12 = mild; 13-24 = moderate; 25-36 = moderately severe; more than 36 = severe withdrawal

A Guide for Patients Beginning Buprenorphine Treatment at Home

Before you begin you want to feel very sick from your withdrawal symptoms

<p>It should be at least . . .</p> <ul style="list-style-type: none"> • 12 hours since you used heroin/fentanyl • 12 hours since snorted pain pills (Oxycontin) • 16 hours since you swallowed pain pills • 48-72 hours since you used methadone 	<p>You should feel at least three of these symptoms . . .</p> <ul style="list-style-type: none"> • Restlessness • Heavy yawning • Enlarged pupils • Runny nose • Body aches • Tremors/twitching • Chills or sweating • Anxious or irritable • Goose pimples • Stomach cramps, nausea, vomiting or diarrhea
--	--

Once you are ready, follow these instructions to start the medication

<p>DAY 1: 8-12mg of buprenorphine</p> <p style="font-size: small;">Most people feel better the first day after 8-12mg. (Dosing depends on how early on the first day you started)</p>			<p>DAY 2: 16mg of buprenorphine</p>
<p>Step 1.</p>	<p>Step 2.</p>	<p>Step 3.</p>	<p>Take one 16mg dose</p>
<p>Take the first dose</p> <div style="text-align: center; margin: 10px 0;">  </div> <p>Wait 45 minutes</p> <div style="text-align: center; margin: 10px 0;">  </div>	<p>Still feel sick? Take next dose</p> <div style="text-align: center; margin: 10px 0;">  </div> <p>Wait 6 hours</p> <div style="text-align: center; margin: 10px 0;">  </div>	<p>Still uncomfortable? Take last dose</p> <div style="text-align: center; margin: 10px 0;">  </div> <p>Stop</p> <div style="text-align: center; margin: 10px 0;">  </div>	<p>Most people feel better with a 16mg dose</p> <div style="text-align: center; margin: 10px 0;">  </div>
<ul style="list-style-type: none"> • Put the tablet or strip under your tongue • Keep it there until fully dissolved (about 15 min.) • Do NOT eat or drink at this time • Do NOT swallow the medicine 	<p>Most people feel better after two doses = 8mg</p>	<ul style="list-style-type: none"> • Stop after this dose • Do not exceed 12mg on Day 1 	<p>Repeat this dose until your next follow-up appointment</p>

If you develop worsening symptoms while starting buprenorphine before your scheduled outpatient appointment return to the emergency department

Attachment D-7c

The following are the six dimensions of ASAM, and how they are defined by the American Society of Addiction Medicine, (ASAM PPC-2R, ASAM Patient Placement Criteria for the Treatment of Substance Related Disorders, 2nd Edition – Revised, David Mee Lee, M.D. Editor, 2001).

ASAM Dimension 1.) Acute Intoxication and Withdrawal

1. What risk is associated with the patient's current level of acute intoxication?
2. Is there significant risk of severe withdrawal symptoms or seizures, based on the patient's previous withdrawal history, amount, frequency, chronicity and recency of discontinuation or significant reduction of alcohol or another drug use.
3. Are there current signs of withdrawal? 4. Does the patient have supports to assist in ambulatory detoxification, if medically safe?

Dimension 2.) Bio-Medical Conditions and Complications

1. Are there current physical illnesses, other than withdrawal, that need to be addressed or that may complicate treatment?
2. Are there chronic conditions that affect treatment?

Dimension 3.) Cognitive, Behavioral, and Emotional Conditions

1. Are there current psychiatric illnesses or psychological, behavioral, emotional or cognitive problems that need to be addressed because they create risk or complicate treatment? 2. Are there chronic conditions that affect treatment?
3. Do any emotional, behavioral or cognitive problems appear to be an expected part of addictive disorder or do they appear to be autonomous?
4. Even if connected to the addiction, are they severe enough to warrant specific mental health treatment?
5. Is the patient able to manage the activities of daily living?
6. Can he or she cope with any emotional, behavioral or cognitive problems?

Dimension 4.) Readiness / Motivation

1. What is the individual's emotional and cognitive awareness of the need to change?
2. What is his or her level of commitment to and readiness for change?
3. What is or has been his or her degree of cooperation with treatment?
4. What is his or her awareness of the relationship of alcohol or other drug use to negative consequences?

Dimension 5.) Relapse, Continued Use, Continued Problem

1. Is the patient in immediate danger of continued severe mental health distress and or alcohol or drug use?

2. Does the patient have any recognition of, understanding of, or skills with which to cope with his or her addictive or mental disorder in order to prevent relapse, continued use or continued problems such as suicidal behavior? How severe are the problems and further distress that may continue or reappear if the patient is not successfully engaged in treatment at this time?

3. How aware is the patient of relapse triggers, ways to cope with cravings to use, and skills to control impulses to use or impulses to harm self or others?

Dimension 6.) Recovery Environment

1. Do any family members, significant others, living situations or school or work situations pose a threat to the patients safety or engagement in treatment?
2. Does the patient have supportive friendships, financial resources, or educational/ vocational resources that can increase the likelihood of successful treatment?
3. Are there legal, vocational, social service agency or criminal justice mandates that may enhance the patient's motivation for engagement in treatment?
4. Are there transportation, child care, housing or employment issues that need to be clarified and addressed?

(ASAM PPC-2R, ASAM Patient Placement Criteria for the Treatment of Substance Related Disorders, 2nd Edition – Revised, David Mee Lee, M.D. Editor, 2001).

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

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

DHHS Final Review from previous submission: none

Project Team Member	Roles and Responsibilities
Kevin Irwin	Administrative and Operations Support
Tory Jennison	Data and HIT TA and Support
Sandra Denoncour	Administrative and Operations Support
Bill Gunn	Clinical Integration Support
Nick Pfiefer	Clinical Supervision, SENHS
Amor Irizarry	MLADC Navigator, SENHS
Justin Younger	Case Manager / CRSW, SENHS
Ashley Hurteau & Denny Freitas	Case Manager / CRSW, SOS Recovery Community Support

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

Trainings of service delivery staff and affiliated network partner staff during the report period is listed below. D3 partners are consistently invited to join Care Transitions Team members in a number of trainings that are identified in the table below, also discussed in C1 project. D3, E5, and C1 team members plan to attend trainings offered by organizational partners. For example, the C1 team will attend a Compassion Fatigue workshop facilitated at SOS Recovery Community Support. Sharing training supports efficient use of resources and helps build collaboration in the field. Training plans include a series from January 2019-June 2019 of core competency trainings for the D3 project staff with the C1 and E5 teams.

Scholarships to the Behavioral Health Summit were provided to the following D3 project partners: Safe Harbor Recovery Community Organization (part of Granite Pathways/Seacoast Pathways), Strafford County Community Corrections, Southeastern NH Services, Granite Pathways, SOS, Bridging the Gaps, and Rockingham County Corrections.

The CRSW Case Managers from both SENHS and SOS are regularly attendees of the Community Care Team meetings. These meetings provide ongoing education regarding the collaborative potential and integrated delivery of primary care, BH, SUD and social service support services in our region.

Table D-9a: Projected D3 Training Schedule

Projected D3 Training Schedule	PROJECTS IMPACTED	# ATTENDING	REPORTING PERIOD		
			06/30/19	12/31/19	06/30/20
HIPAA training	C1, D3, E5	10-15	Jan 9		
Compassion Fatigue in Human Service Work - 2 options	C1, E5, D3	10-15	Feb 5 and/or Feb 16		
SUD updates and services	C1, E5, D3	10-15	March		
BH updates and services	C1, E5, D3	10-15	April		
BH - Foundations In Trauma Informed Care	C1, E5, D3	10-15	April		

Table D-9b: Attended D3 Training Schedule

Attended D3 Training Schedule	PROJECTS IMPACTED	# ATTENDED	REPORTING PERIOD		
			12/31/17	6/30/18	12/31/18
CORE TRAININGS					
Trauma-Informed Care	C1, D3, E5	4		Jun 1	Aug 2
Mental Health First Aid	D3	2		Apr 23-27	
Core Standardized Assessment	C1, E5	5		Jun 7	
Integration in Practice	C1, E5	5		Jun 14	
Initial Training on Addiction and Recovery	A1, B1, C1, D3, E5	25			Sept 26
SBIRT	D3	5			Nov 13
Behavioral Health Summit* - multiple topics, multiple attendees **	C1, D3,E5	6			Dec 10 & Dec 11
SUPPLEMENTAL TRAINING					
Human Trafficking	C1	4		Mar 29	
Cultural Competence	C1, D3	4		Apr 24	
Motivational Interviewing	C1	4		Jun 19	

***Behavioral Health Summit** sessions attended by D3 Workforce include: Gun Violence, Understanding and Addressing SUD as a chronic medical condition, Core Competencies for Primary Care Behavioral Health Integration, Plans of Safe Care in NH, Power of Language in Strength Based Approaches, Facilitated Integrated Care Success with Co-Occurring Disorders, Ethical Communication & Confidentiality in an Integrated Care Environment, Suicide Risk, Partners in Recovery Wellness - how hospitals and recovery coaches can improve outcomes for patients with SUD, MAT -Striving for Quality.

**D3-specific Partner Attendees included: 2 Case Managers from Strafford County Community Corrections, 1 Executive Director of Seacoast Pathways, 1 Executive Director of SOS Recovery Community Support, MLADC and CRSW from SENHS, 1 Case Manager from Rockingham County Corrections, 1 RAPS specialist from Safe Harbor, 1 Bridging the Gaps Coalition Coordinator

Project Scoring: IDN Community Project Process Milestones

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

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

Projects E: Integration Focused

IDN Community Project Implementation and Clinical Services Infrastructure Plan

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

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

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

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

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

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

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

The Region 6 IDN E5 Project is focused on enhancing care for two distinct populations that were identified as especially critical priorities during our project planning work. The first population, At-Risk Youth, was identified because many stakeholders reported large gaps in continuity of care for clients transitioning between child serving systems and adult serving systems when clients 'aged-out' of one system and into another and eligibility and service standards changed, sometimes profoundly. The negative impact associated with this gap was reported by partners across developmental disability, behavioral health, education, social service and medical agencies.

The second population, adults with very complex care coordination needs, was identified during implementation of the C1 project, when it became clear that partner agencies participating on the Community Care Team needed additional support to participate in care coordination for clients who were referred to and reviewed by the Community Care Team, were found not eligible for CTI care coordination services, but were definitely in need of ongoing support/care coordination beyond what partner agencies were able to provide to meet the client's goals.

Implementation of the **E5 Enhanced Care Coordination Project** for both populations gained considerable momentum during the reporting period since all of the key partners were engaged and staff hired to implement the project. The project team includes two primary staff roles, each serving one of the priority populations:

1. Youth Transitions Clinical Care Coordinator embedded at Seacoast Mental Health
2. Adult Enhanced Care Coordination Case Manager employed by IDN 6

During the reporting period:

Seacoast Community Mental Health successfully onboarded and developed their full-time Bachelors level trained Youth Transitions Clinical Care Coordinator, the primary staff role coordinating services for the at-risk youth population in this project to date.

Exeter Health Resources, the enterprise partner over a key primary care partner (CORE Pediatrics in Exeter) finalized agreements to become a formal partner in the Region 6 IDN network.

Appropriate project partners consistently engaged in implementation work, including Child & Family Services (now Waypoint) and school partners, led by SAU-16 (Exeter and area) schools.

CORE Pediatrics and Child & Family Services made active referrals during this report period. The project engaged dedicated technical assistance from the Center for Collaborative Change.

The development of protocols and agreements in this area has been slow, due to stringent privacy concerns. To help advance progress we have included key SAU-16 staff members on our IDN Clinical Advisory Team and have contracted the services of a therapeutic mental health provider (Ben Hillyard at Center for Collaborative Change) who has facilitated care coordination and service delivery between schools and related providers in the region for many years. Through continued facilitation and IDN assistance, a referral network was developed for this project. The first referrals have been made and partners indicate successful progress toward the evaluation metrics.

Please refer to Attachment E5 Project Timeline in the Attachment Appendix for additional information.

Early success in Youth Transitions focused Enhanced Care Coordination is highlighted in the narratives below. These were submitted by the Nurse Care Coordinator at CORE Pediatrics:

- I referred a 19 year old mother of 2 (ages 2 ½ and 9 months) with housing, food and clothing needs to SCMH's Clinical Care Coordinator. Children are patients of Dr. Bonesho. Mom with Wellsense insurance. Marixa and I met with Mom in Exeter Pediatrics office for soft handoff to meet Marixa. We all discussed the needs of the family. Marixa was able to assist with housing. WIC appointment was scheduled so Mom could get formula. Through IDN Marixa was able to assist with clothing for family. Marixa met with Family at temporary home they were staying in.
- 14-year-old with diagnosis of Autism who is in middle school-transitioning to high school next year. Mom with concerns for future planning and requesting assistance with vocational training resources. Mom was able to meet Marixa at family home to address needs.
- 13 year old and 17 year old siblings with diagnosis of Classical PKU and in need of being seen by Metabolism Clinic at Maine Medical Center. PCP reported they had cancelled or no-showed several appointments with PCP and concerned Mom would not follow up with Metabolism Clinic. Referred to Marixa, Clinical Care Coordinator, to assess for barriers were preventing follow-up with specialist. Marixa accompanied family to the appointments at Maine Medical Center. In addition one child had been seeing Ben Hillyard /therapist in Exeter who reported this client had informed him of limited food in the home. Marixa was able to address those needs as well.
- 19 year old Type 1 diabetic with frequent hospitalizations for Diabetic Ketoacidosis. Patient with history of cancelling and no-shows for appointments related to endocrinology specialty follow-up. PCP with concerns for ability to follow up with care due to transportation and scheduling issues. This referral was sent to Marixa to support patient and work toward successful specialty follow-up.

To build regional network capacity for serving the most vulnerable people throughout our attributed population, the E5 Adult Enhanced Care Coordination Case Manager works very closely with our Care Transitions Team and Community Care Teams. Consistent with the true nature of network building, all of the C1, E5, and D3 efforts are visible to each other and are resources in support of each other. The C1 project intake assesses for SUD concerns and complex medical and behavioral health needs. These are assessed at regular intervals and clients who require more complex and longer-term case management are referred to the E5 Case Manager. The E5 Case Manager and Clinical Care Coordinator can refer directly to the D3 team for assessment.

Case follow-ups on shared clients occur regularly through team meetings and case conferences facilitated by the C1 Supervisor. The ECC Adult Case Manager began using the Care Director shared care plan during this report period.

E-2. IDN Community Project: Evaluation Project Targets

Use the format below to provide a list all of the progress toward targets or goals that the program has achieved. Targets required by the STCs include, but should not be limited to:

- Number of individuals served (during reporting period and cumulative)
- All performance measures identified in the evaluation project plan.

During the reporting period, the E5 project established and began tracking initial performance measures. To date, the volume of referrals has not produced significant data. SCMH delayed training the Clinical Care Coordinator in the CANS assessment model while she was familiarized with the agency and community partners. She has plans to complete the training with SCMH in the first quarter of 2019. To date, she has used an intake method and progress tracking tool that is not reportable as an evidence-based tool and this practice will change as she initiates the CANS assessment.

The Adult ECC Case Manager has initiated use of the Arizona Self-Sufficiency Matrix at intake, 3 months, 6 months, and 12 months of engagement. She does not yet have longitudinal progress to report as this was implemented in November 2018. The C1 project team implemented it first in order to assess the efficacy of the tool and it has now been adopted by the E5 staff.

UPDATED Table E-2a: Evaluation Project Targets as of date of submission 4/5/19

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
# Individuals served	20 by 12/31/18	N/A	7	25
Continued participation in care	60% 6+months	N/A	Ongoing	16/25=64%
Client generated achievable goals met	50% met	N/A	Ongoing	18/25 =72%
Improved Functional status	50% enrolled	N/A	Ongoing	22/25=88%
Reduced Crisis services utilization	15% reduction	N/A	Ongoing	3/8 clients with past crisis service utilization = 38%
Reduced School attendance/truancy	10% reduction	N/A	Ongoing	5/12 Youth = 42%

E-3. IDN Community Project: Workforce Staffing

From Project A1: Workforce Capacity Development Implementation Plan, document the current workforce staffing specifically related to this project using the format below.

There have been no changes in the E5 project staff during this report period. All staff hired as of July 1, 2018 have been retained.

The Clinical Care Coordinator is employed by Seacoast Mental Health Center (SMHC). The IDN6 maintains an MOU to support employment and provision of clinical supervision to the E5 Services Team. One position has been filled by Seacoast Community Mental Health. A second position remains open with Seacoast Mental Health and the IDN6 continues to support their recruitment efforts.

The IDN employs one adult-focused ECC Case Manager. This ECC Case Manager works co-located with our Care Transitions Team. She also works closely with the Community Care Teams. She is currently serving adults who were referred to the CCT but whose needs were too complex and acute to be enrolled in the CTI protocol.

UDPATED Table E-3a: Workforce Staffing as of submission date 4/5/19

Provider Type	Projected Total Need	IDN Workforce (FTEs)			
		Baseline Staffing on 6/30/17	Staffing on 12/31/17	Staffing on 6/30/18	Staffing on 12/31/18
Clinical Care Coordinator	6	0	0	1	1
Enhanced Care Coordination Case Manager	Up to 2	0	0	1	2
Clinical Supervision (3 hrs/week per CCC)	Up to .5 FTE	0	ready	0.2	0.2

E-4. IDN Community Project: Budget

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

Table E-4: Budget

Connections for Health								
IDN Region 6								
Project E5								
Project	CY 2016 Actuals	CY 2017 Actuals	Jan-Jun 2018 Actuals	July-Dec 2018 Actuals	CY 2019 Projected Spend Budget	CY 2020 Projected Spend Budget	CY 2021 Projected Spend Budget	Actual and Projected Spend
Expense Items								
Staffing								
Direct Staff	\$ -	\$ -	\$ -	\$ -	\$ 192,000	\$ 192,000	\$ 192,000	\$ 576,000
Indirect Staff	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Benefits	\$ -	\$ -	\$ -	\$ -	\$ 42,240	\$ 42,240	\$ 42,240	\$ 126,720
Contracted Staffing	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
								\$ -
Project Infrastructure								\$ -
Equipment	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Operations	\$ -	\$ -	\$ -	\$ -	\$ 10,000	\$ 10,000	\$ 10,000	\$ 30,000
								\$ -
Workforce								\$ -
Fees/Outside Placement	\$ -	\$ -	\$ 132	\$ 31,100	\$ 45,000	\$ 45,000	\$ 45,000	\$ 166,232
Recruiting/Retention	\$ -	\$ -	\$ -	\$ -	\$ 25,000	\$ 25,000	\$ 25,000	\$ 75,000
Training	\$ -	\$ -	\$ -	\$ -	\$ 5,000	\$ 5,000	\$ 5,000	\$ 15,000
Other	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
								\$ -
Technology	\$ -	\$ -	\$ -	\$ -	\$ 14,000	\$ 14,000	\$ 14,000	\$ 42,000
								\$ -
								\$ -
Totals	<u>\$ -</u>	<u>\$ -</u>	<u>\$ 132</u>	<u>\$ 31,100</u>	<u>\$ 333,240</u>	<u>\$ 333,240</u>	<u>\$ 333,240</u>	<u>\$ 1,030,952</u>

Budget Narrative

- The projected budget for E5 is \$1,030,952, the 6/30/2018 SAR budget was \$2,905,440.
- Direct staff include positions for housing support work in the two counties in the region.
- Outside placement includes embedded supports in community mental health and health center.
- Retention pool for non-clinicians to support community connections.
- This area is under the region’s targeted budget as the potential impact of the pending MCO contracts and the role that this team will play in the care management requirement section of the contract is not known. The region has not budgeted funds in anticipation of this activity requiring investments.

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

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

Organization/Provider	Agreement Executed (Y/N)
Seacoast Community Mental Health *host agency	Yes
CORE Pediatrics via Exeter Health Resources	Yes
Crossroads House Homeless Shelter	Yes
SAU-16	Yes
Greater Seacoast Community Health - Families First	Yes
Greater Seacoast Community Health - Goodwin Community Health	Yes
OneSky Services	Yes
Frisbie Memorial Hospital	Yes
Lamprey Health Care - Raymond	Yes
Lamprey Health Care - Newmarket	Yes
Center for Collaborative Change / Ben Hillyard	Yes
Waypoint (formerly Child and Family Services)	Yes
Portsmouth Regional Hospital / HCA	Yes
Seacoast Youth Services	Yes
Rochester School District	Yes
Granite / Seacoast Pathways	Yes
SOS Recovery Community Organization	Yes
Safe Harbor Recovery Community Organization	Yes
Tri-City Consumer Action Co-Op	Yes

E-6. IDN Community Project: Standard Assessment Tools

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

DHHS Final Review from previous submission:

The ECC Work Group supports the use of the CANS (Child and Adolescent Needs and Strengths) assessment tool for Youth. The ECC Work Group supports the use of the Arizona Self-Sufficiency Matrix as an initial assessment tool for Adults.

The Adult ECC Case Manager initiated use of the Arizona Self-Sufficiency Matrix in November 2018. The ASSM will be assessed at Intake, 3 months, 6 months, and 12 months of engagement.

During the reporting period, the E5 project workgroup, led by SMHC, evaluated a number of possible assessment/screening tools for this population based on care coordination needs. A decision was made to use the CANS assessment, and SMHC began providing training and orientation to the Clinical Care Coordinator. Implementation of the CANS by the Clinical Care Coordinator is expected in the first quarter of 2019.

Standard Assessment Tool Name	Brief Description	
CANS (Child and Adolescent Needs and Strengths) <i>(attachment B1-8a)</i>	Standard BH Functional Assessment for CMHCs	Current
Arizona Self Sufficiency Matrix <i>(attachment C-7c)</i>	Multi-domain Evidence-based Tool	Current

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

Use the format below to provide a list of all protocols to be utilized for patient assessment, treatment, management, and referrals for the community project. IDNs should indicate what protocols are currently in place and which are slated for adoption. DHHS reserves the right to audit all or a selection of protocols used by the IDNs.

Enhanced Care Coordination in IDN 6 is not contemplated to serve as a clinical care protocol, but rather is focused on supporting clients to access appropriate levels of clinical care and align clinical and non-clinical care and support services on their own behalf. Assessments inform the referrals to clinical care and appropriate levels of treatment.

The Enhanced Care Coordination (ECC) project has adopted:

- Standardized Eligibility Criteria
- Referral form
- Release of Information

Any organization not currently listed on the ECC Release for Information form is using their agency-specific release for information.

For Adult referrals from the CCT to ECC, the CTI Team conducts Pre-CTI Screening to determine appropriate case disposition and refers to the Adult ECC for those clients deemed to be appropriate candidates. All clients' status is tracked. Those enrolled in ECC are tracked along with Progress notes as appropriate.

For youth referrals, the Clinical Care Coordinator is able to augment her impact with referral to Seacoast Mental Health Child and Family Support services. This includes the Rehabilitation for Empowerment, Natural Supports, Education, & Work (RENEW) program in addition to referral for psychiatric services, if indicated.

Select partners have been trained in the Allscripts Care Director shared care plan, including designated users at Seacoast Mental Health Center.

UPDATED Table E-7a: Protocols for Patient Assessment, Treatment, Management, and Referrals as of submission date 4/5/19

Protocol Name	Brief Description	Use (Current/Under Development)
Enhanced Care Coordination Eligibility Criteria (<i>attachment E-7a</i>)	Notification to partners of referral criteria and reference for eligibility upon referral to the project	Current
Enhanced Care Coordination Referral Form (<i>attachment E-7b</i>)	Referral between partners	Current
Enhanced Care Coordination Release Form (<i>attachment E-7c</i>)	Release of Information between partners	Current
Care Director / Allscripts	Shared Care Plan	Current



Region 6 Integrated Delivery Network



Attachment E7-a

Enhanced Care Coordination Eligibility Criteria

ENHANCED CARE COORDINATION: Comprehensive care coordination/management services for high need adult and child populations with multiple physical health and behavioral health chronic conditions.

ELIGIBILITY CRITERIA

- Youth Transitions: MUST be 14-24 years of age
- ECC Adult: MUST be over 18 years
- Presumed Medicaid eligible
- Behavioral health and/or SMD diagnosis
- Experiencing one or more of the following:
 - **Youth Transitions:** School behavior or academic performance issues
 - Active IEP/504
 - Juvenile Justice or DCYF involvement
 - In foster care and close to transitioning out
 - Lack of social connections/friends
 - Inconsistent, inadequate, or no primary care
 - Family provides limited or no positive support
 - **ECC Adult:** Under resourced (no documentation, benefits, PCP/MH care)
 - Housing instability
 - Limited independent living skills
 - Needs assistance applying for and/or maintaining benefits (Medicaid, Food Stamps, etc.)

EXCLUSION CRITERIA

- Youth Transitions: Younger than 14 years of age; older than 24 years of age
- ECC Adult: Unmanaged, severe mental health diagnosis
- Resistance or non-adherent to medical/mental health treatment (This does not necessarily exclude a potential participant from being assessed or beginning to receive enhanced care coordination. However, it could be a reason to exit a participant from the program.)

Attachment E7-b

**Enhanced Care Coordination
Referral Form**

The information presented about the referral should be concise, presenting only known relevant information:

Referred By (name & organization)	
Client NAME	
Date of Birth	
Insurance	
Parent/Guardian Name	
Military Service? (Referral or Parent/Guardian)	
Primary Care Provider and Recent Visit History (if known)	
Emergency Dept History (if applicable)	
Other providers with whom patient/client is engaged	
Housing Status	
Income	
CONTACT INFO	

Presenting medical/psychosocial issues and any significant health and social determinant status and/or history.

Relevant information from former care plans

Referral Date	
Referring Person, Organization & Contact Information	

**AUTHORIZATION TO RELEASE / OBTAIN PROTECTED INFORMATION
REGION 6 INTEGRATED DELIVERY NETWORK COMMUNITY CARE TEAM**

Patient name: _____ Date of Birth: _____

I, _____ authorize the Region 6 Integrated Delivery Network Community Care Team (IDNCCT), whose members are listed below to disclose and discuss my health care information, including any mental illness, substance use disorders, HIV- related information and state benefit and housing status so that the IDNCCT may help me get assistance by making recommendations and referrals to meet my needs.

I understand that:

- Information in my health record about any alcohol and/or drug treatment is protected under federal laws. It cannot be shared without my written permission unless stated otherwise in the law *42 CFR, Part 2, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR, Parts 160 and 164.*
- This authorization form does not authorize the release of written or electronic copies of my medical records. It only authorizes discussion regarding my health and care amongst the agencies listed above.
- All members of the IDNCCT sign confidentiality statements and promise to keep my information private. However, if a IDNCCT member is not a health care provider or health plan, or is not covered under federal privacy laws, the released information may not be protected.
- I can cancel this authorization at any time by telling any member of the IDNCCT or by notifying the **Region 6 Integrated Delivery Network at (603) 305-0422 or msillari14@gmail.com**, and my health information will no longer be shared at the IDNCCT. The cancellation will not apply to information that has already been disclosed. If I do not want to participate with the IDNCCT, this will **not** limit my treatment, payment, enrollment, or eligibility for benefits.
- This permission shall expire one year from the date of my signature below.

I have read this form and have had any questions answered.

I understand the purpose of form is to authorize permission for the organizations listed above to discuss my health and personal information, including alcohol and/or drug treatment information.

I have been offered a copy of this signed release.

Patient Signature

Date

Parent/Guardians Signature (if applicable)

Name of Reviewer

Organization (Must be current IDNCCT member listed on page 2.)



* Managed Care Organizations will only be present during discussions of their members.

**AUTHORIZATION TO RELEASE / OBTAIN PROTECTED INFORMATION
REGION 6 INTEGRATED DELIVERY NETWORK COMMUNITY CARE TEAM**

IDN CCT members:

Amedisys	OneSky Community Services
Beacon Health Strategies*	Portsmouth Housing Authority
Child & Family Services of NH	Portsmouth Regional Hospital
Community Action Partnership of Strafford County	Region 6 Integrated Delivery Network
Community Partners	Rochester Community Recovery Center
Connections Peer Support Center	Rochester Housing Authority
Cornerstone VNA	Rockingham Community Action
Cross Roads House	Rockingham VNA
Crotched Mountain Community Care	Safe Harbor Recovery Center
Dover Housing Authority	Salvation Army, Portsmouth
Easter Seals of NH	Seacoast Mental Health Center
Exeter Health Resources	Seacoast Pathways (Granite Pathways)
Families First of the Greater Seacoast	ServiceLink of Rockingham County
Families in Transition (FIT)	ServiceLink of Strafford County
Frisbie Memorial Hospital	Somersworth Housing Authority
Goodwin Community Health	SOS Recovery Community Organization
Granite Pathways	Southeastern NH Services
Granite State Independent Living	St. Vincent dePaul Society
Greater Seacoast Coalition to End Homelessness Haven	Tri-City Consumers' Action Co-operative Veterans, Inc.
Homeless Center for Strafford County	Welfare Department, City of Dover
Hope on Haven Hill	Welfare Department, City of Portsmouth
The Homemakers Services	Welfare Department, City of Rochester
My Friend's Place	Welfare Department, City of Somersworth
NH DHHS Bureau of Elderly and Adult Services	WellSense Healthplan*
NH Healthy Families*	Wentworth-Douglass Hospital
NH Housing Finance Authority	Wentworth Home Care and Hospice/Amedisys
	Womenaid of Greater Portsmouth

Other organizations you wish to add to this release:

For IDNCCT use only

Date revoked: _____ Name & Organization of IDNCCT member receiving revocation: _____

* Managed Care Organizations will only be present during discussions of their members.

E-8. IDN Community Project Member Roles and Responsibilities

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

Project Team Member	Roles and Responsibilities
Kevin Irwin	Administrative and Operations Support
Tory Jennison	Data and HIT TA and Support
Sandra Denoncour	Administrative and Operations Support
Maria Sillari	Project Coordination
Bill Gunn	Clinical Support and TA
Marixa North	Clinical Care Coordinator
Jodie Lubarsky	Clinical Supervision
Aimee Bouffard	Adult Enhanced Care Coordinator
Ben Hillyard	Center for Collaborative Change, TA support for project enhancement

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

Table E-9a Projected E5 Training Schedule

Projected E5 Training Schedule	PROJECTS IMPACTED	# ATTENDING	REPORTING PERIOD		
			06/30/19	12/31/19	06/30/20
TOPIC					
HIPAA training for CTI and Community Care Team work	C1, D3, E5	10-15	Jan 9		
Compassion Fatigue in Human Service Work - 2 options	C1, E5, D3	10-15	Feb 5 and/or Feb 16		
SUD updates and services	C1, E5, D3	10-15	March		
BH updates and services	C1, E5, D3	10-15	April		
BH - Foundations In Trauma Informed Care	C1, E5, D3	10-15	April		
Chronic Disease / Part II - further discussion of chronic disease management's impact on BH and SUD co-occurring conditions	C1, E5, D3	10-15	May		

Table E-9b: Attended E5 Training Schedule

Attended E5 Training Schedule	PROJECTS IMPACTED	# ATTENDED	REPORTING PERIOD		
			12/31/17	6/30/18	12/31/18
TOPIC					
CORE TRAININGS					
Trauma-Informed Care	C1, D3, E5	4		Jun 1	Aug 2
Core Standardized Assessment	C1, E5	5		Jun 7	
Integration in Practice	C1, E5	5		Jun 14	
Initial Training on Addiction and Recovery	A1, B1, C1, D3, E5	25			Sept 26
Trauma Informed Care in Health & Social Services	E5	8			Sept 25, Oct 30
Behavioral Health Summit - multiple topics, multiple attendees *	C1, D3, E5	6			Dec 10 & Dec 11
SUPPLEMENTAL TRAINING					
Human Trafficking	C1	4		Mar 29	
Cultural Competence	C1, D3	4		Apr 24	
Motivational Interviewing	C1, E5	4		Jun 19	Aug 31, Sept 7
Stigma Across Cultures	C1, D3	2			Nov 8
ACES in Early Childhood Education	C1, D3, E5	8			Nov 19

***Behavioral Health Summit** sessions attended by E5 Workforce include: Addressing Childhood Adversity and Social Determinants of health, Core Competencies for Primary Care BH Integration, Guns and Violence

DHHS Project Scoring: IDN Community Project Process Milestones

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

Process Milestone Number	Process Detail	Submission Format	Results (Met/Not Met)			
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E -7	Clinical Infrastructure: IDN Community Project Protocols For Patient Assessment, Treatment, Management, and Referrals	Table				
E -8	Clinical Infrastructure: IDN Community Project Roles and Responsibilities	Table				
E-9	Provide the training plan and curricula for each Community Driven Project as required in A-1.3	Training schedule and table				

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

As a part of the DSRIP demonstration, the state has committed to value-based health services reimbursements. The DSRIP APM Roadmap articulates the process by which the state will work with the IDNs, Medicaid Managed Care Organizations (MCO), and other Medicaid services stakeholders to develop a statewide APM workgroup for the completion of the DSRIP APM Implementation Plan. The goal of the DSRIP APM Implementation Plan is to achieve 50% Medicaid provider payments in an APM by 12/31/2020.

IDNs will be evaluated on their engagement with the state and managed care plans in support of the APM goals consistent with Special Terms and Conditions (STC) 24, Project Milestones; STC 33 MCO and Medicaid Service Delivery Contracting Plan; and STC Attachment C: DSRIP Planning Protocol IV Project Stages, Milestones, and Metrics.

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

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

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

The Region 6 IDN participated in development of a statewide APM roadmap during the reporting period. Participation included the provision of design and development guidance to Myers & Stauffer to inform the agenda for an APM focused Learning Collaborative and the promotion of that learning opportunity to regional partners, some of whom did attend with Region 6 Operations Team representatives. The Region 6 IDN has consistently provided leadership level representation to statewide workgroups and stakeholder meetings on APM. During the reporting period, that representation was informed by IDN Executive Director led consultations with partner Agency CEOs (including hospital systems) regarding the impact of historical and future APMs on their efforts. In addition, a Special Executive Committee Meeting was convened to focus on improving partner readiness for APM planning. That session also informed Region 6 participation on statewide efforts. Partners continue to struggle to identify use cases of APM in practice.

Statewide APM Taskforce and Implementation Plan Activity	Progress		
	As of 12/31/17	As of 6/30/18	As of 12/31/18
Participate in development of statewide APM roadmap through workgroups and stakeholder meetings		IDN 6 ED attended 4 mtgs	No meeting convened
Develop an IDN-specific plan for implementing the roadmap which will contain IDN-specific outcome measures		premature	In progress
Develop the financial, clinical and legal infrastructure required to support APMs		premature	In progress
Meet IDN-specific measures identified in the roadmap that measure progress toward meeting APM goals, including financial, legal and clinical preparedness and engagement with MCOs		premature	In progress

- The IDN 6 has been reviewing criteria for the Alternative Payment Model using the Health Care Payment Learning Action Network or HCP-LAN framework. The Statewide Roadmap established the baseline for NH's Alternative Payment Models would be at the Category 2-C level.
- The model contract for the Managed Care Organizations also requires models consistent with that Category 2-C.
- The region engaged its Executive Committee and an external resource to discuss the implications of Alternative Payment Models on their operations.
- The associations supporting three of the key partner groups: hospitals, FQHCs and CMHCs each have expressed plans that they will work with the MCOs to assist in negotiations for new payment models.
- With that assumption, which will be validated in the next 6 months, the IDN is working with partners to discuss what level of supports the IDN can provide.
- The structure of the waiver and our focused investments are aligned with the Category 2-C baseline. Specifically, the IDN is enhancing care coordination and information infrastructure to implement the goal of being paid based on performance. The A-2 HIT infrastructure including the data aggregator and the shared care plan are critical elements.
- These investments are key to DSRIP year 4 when IDNs will earn funds based on reporting and performance or will be penalized for not having the capacity to report data.
- The IDN is exploring approaches and resources to assist partners in building greater awareness of the changes in organization's people, process and technology as well as the larger change in culture which will emerge with new forms of payment.
- The work of the IDN in the Community Care Team is a key element in also bringing the SDoH partners into the dialogue regarding new payment models as our experience has clearly demonstrated that the essential role that these non-Medicaid and non-clinical supports have on overall health outcomes.