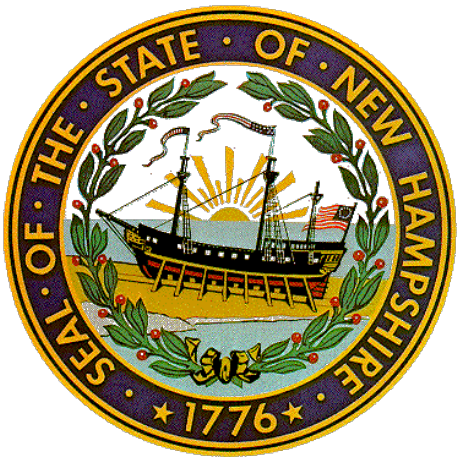

New Hampshire Building Capacity for Transformation 1115 Medicaid Waiver IDN PROCESS MEASURES SEMI-ANNUAL REPORTING GUIDE

For

Year 4 (CY2019)

2019-12-31 v.27

Region 6 IDN (Seacoast/Strafford)

WRITEBACK SUBMISSION #1

April 4, 2020

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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.

Soliciting Community Input:

As described in previous reports, IDN Region 6 has steadfastly pursued our commitment to soliciting meaningful input and promoting meaningful engagement of a broad representation of community stakeholders in all our DSRIP design and implementation efforts. IDN 6 contracted with the Continuum of Care Facilitator from the Seacoast Public Health Network to execute our 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 "consumer" member to our Executive Committee regularly contributes highly valuable insights into our collective efforts.

During the reporting period we continued our practice of hosting and facilitating Work Groups related the Community Projects in IDN 6, comprised of multiple clinical and non-clinical stakeholders throughout the Region. 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.

All Partner Meetings continued 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. All Partner meetings were conducted 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 Managed Care, the Doorways, the Mental Health 10-Year Plan, and APM/VBP development on DSRIP and on partner agencies more generally. IDN partner representatives and Operations staff have and will continue to participate on the Statewide HIT, Workforce, and APM Workgroups and subcommittees. And likewise, we continue to participate in numerous opportunities throughout the region to inform, engage and solicit input from groups in every sector.

Our Clinical Advisory Team (CAT) met monthly to provide expert input on operational considerations and problem-solving related to the care integration objectives across IDN projects (with emphasis on B.1). CAT membership was further expanded with clinical leaders from multiple sectors throughout our region.

The initiation of a Case Manager networking and support quarterly meeting to bring clinical case management and Social Determinants of Health case management conversations into better alignment and identify professional / workforce development opportunities in integrated / collaborative settings. This "boots-on the-ground" group has been instrumental in providing timely insights on the experiences of multiple programs and initiatives.

IDN 6 staff also conducted warming shelter trainings to support shelters in three cities with high number of Medicaid clients. Our approach with the Warming Shelters is a vehicle to reach people when they are most vulnerable. The mix of professional, para-professional and lay people attending shelter trainings and providing services, supports and feedback to IDN staff and partners agencies has been a valuable conduit for community input.

The following table reflects the community, partner, and public meetings attended and/or presented by the IDN 6 Operations team during the reporting period.

Public Meeting/Engagement	Brief Description	Date	IDN Member(s) Attending
Home for All Coalition Meetings	Monthly Coalition Meetings	Jun 26, Aug 20; typically, monthly	Operations Team; Care Coordination Team Members
Commission on Mental Health Workforce	Monthly meeting to address mental health workforce issues	July 19 & third Friday of every month	Nick Toumpas, Executive Director
Addiction: Disease or Choice? Dr. Tom Brophy	Meeting held at Exeter High School on Opioid Addiction	August 13	Christine Alibrandi, Director of Solutions Integration
CHW Coalition Meeting	Statewide Coalition of Community Health Workers. Sandi / Director of Care Coordination is an ongoing member.	Aug 21	Sandi Denoncour, Director of Care Coordination
BH Coalition/ Networking Meet & Greet		Aug 21	Bill Gunn, Director of Clinical Integration
SYS: 20th Anniversary Open House	Seacoast Youth Services: Regional partner public event	Aug 28	Christine Alibrandi, Director of Solutions Integration
Case Managers Support Group	NEW ongoing, quarterly regional meeting convened by Connections for Health to discuss various Case Management / Care Coordination models and regional initiatives to address unmet needs. Tammy, CTI Team Lead facilitates with Operations Team support.	Sep 3	Tammy Whalen, CTI Team Lead; Sandi Denoncour, Director of Care Coordination
Exeter High School: EH, WDH, MGH	Public meeting regarding regional hospital affiliations / mergers	Sep 9	Operations Team Members
Public hearing for State's Ten-Year Transportation Plan	Public meeting	Sep 10	Tory Jennison, Director of Population Health
UNH Coop Extension Advisory Council Meeting	Ongoing	Sep 12 Oct 17	Tory Jennison, Director of Population Health
TriCity Mayors Homelessness Task Force	Ongoing	Sep 12	Tory Jennison, Director of Population Health
Community Opioid Forum with Senator Tom Sherman, M.D.	Forum addressing opioid crisis	Sep 16	Bill Gunn, Director of Clinical Integration; Nick Toumpas, Executive Director
Seacoast Public Health Network Meeting (Lamprey Health Care)			Tory Jennison, Director of Population Health
United Way Meeting - CE help	Collaborative meeting by invitation from the Leadership Team of Home for All to hear about strategies for project development and regional unmet needs.	Sep 25	Sandi Denoncour, Director of Care Coordination; Tammy Whalen, CTI Team Lead
LEAD Policy Workgroup	Multi-sector workgroup to inform project development, implementation, and service delivery	Sep 26	Tory Jennison, Director of Population Health; and/or Christine Alibrandi, Director of Solutions Integration
Aloft Open House	Open house in Exeter – partner addressing children's mental health issues	Sep 26	Nick Toumpas, Executive Director
Dover's Response to	Public Meeting	Sep 28	Tory Jennison, Director

Opioid Epidemic			of Population Health
NH Public Health Association Conference	Description: "Team Up, Take Action: A Conference on Partnering to Improve Community Health" CONFERENCE PRESENTATION: Sandi, Director of Care Coordination and Tory, Director of Public Health presented "Community Care Teams" as part of a panel discussion on successful regional partnerships.	Oct 2	Sandi Denoncour, Director of Care Coordination; Tory Jennison, Director of Population Health
Seacoast Mental Health Center Panel / Annual Meeting	Panel Presentation: "Creating a safety net for the vulnerable in our communities" by invitation from Seacoast Mental Health Center. Partner's community event.	Oct 9	Sandi Denoncour, Director of Care Coordination; Bill Gunn, Director of Clinical Integration; Nick Toumpas
Community Health Workers Meeting	This was a training and regional discussion that was attended by partners and members of the public. Discussion of Community Health Worker potential roles in our region. Convened by Connections for Health.	Oct 11	Operations and CTI Team Members
CFHA Conference (Denver)	Collaborative Family Healthcare Association annual conference. Bill Gunn, Director of Clinical Services and Sandi, Director of Care Coordination presented in collaboration with Citizens Health Initiative / UNH Institute of Healthcare Policy & Practice. Conference Presentation: Maximizing Partnerships for Integration Success: A Quality Improvement Approach for Engaging Practices	Oct 17-20	Sandi Denoncour, Director of Care Coordination; Bill Gunn, Director of Clinical Integration
NHID Annual Hearing - Mental Health Services Focus	Focus on insurance coverage and access to mental health care services, the agency said. The hearing will include a report on 2018 data submitted by health insurance companies in New Hampshire. Richard G. Frank, health economics professor in the Department of Health Care Policy at Harvard Medical School, will speak on “The Evolution of Mental Health Policy and Realizing the Aims of Improved Mental Health Care.” There will also be a conversation about mental health care policymaking with NH Reps. John Hunt, R-Rindge, and Rep. Ed Butler, D-Harts Location.	Oct 25	Christine Alibrandi, Director of Solutions Integration
NH Behavioral Health Education Roundtable		Oct 25	Bill Gunn, Director of Clinical Integration
Workforce Housing Coalition Seacoast	2019 Greater Seacoast Housing Summit	Nov 8	Christine Alibrandi, Director of Solutions

Housing Summit	This annual event is designed to examine solutions to the region's housing affordability crisis. The theme for this year's summit is "What Can We Learn from Other Communities?" Panelists for this solutions-oriented event include Sarah Marchant, director of the City of Nashua's Community Development Division; Jeff Gowan, planning director for the Town of Pelham; Steve Whitman, Resilience Planning & Design, LLC.; and Carol Ogilvie, land use consultant. The summit will be moderated by Elissa Margolin, director of Housing Action New Hampshire.		Integration
Community Partners Annual Meeting	Community partners annual meeting	Nov 12	Bill Gunn, Director of Clinical Integration; Sandi Denoncour, Director of Care Coordination
Endowment for Health - Health Equity workgroup	Workgroup on health equity	Nov 13	Christine Alibrandi, Director of Solutions Integration
Rockingham Corrections Wrap - Brentwood	Monthly meeting at Rockingham County Corrections to discuss resources for transitions from incarceration to community. And for best practice service while incarcerated.	Nov 15	Tammy Whalen, CTI Team Lead and/or Sandi Denoncour, Director of Care Coordination
SOS Open House	SOS Recovery Support Organization: Public meeting / open house with regional partners and community members	Nov 21	Operations Team Members
NH Oral Health Fall Forum		Nov 22	Christine Alibrandi, Director of Solutions Integration
Haven Info Meeting	Partner Presentation: Tammy, CTI Team Lead and Sandi presented by invitation of HAVEN on IDN and CTI programs. Also, discussions of unmet needs for their clients / community members.	Nov 22	Sandi Denoncour, Director of Care Coordination; Tammy Whalen, CTI Team Lead
Case Managers Support Group Meeting	Convening by IDN Region 6 to support regional case managers with a community of practice model to collectively share ideas, resources, and program development	Sept 3, Dec 3; Quarterly	Christine Alibrandi, Director of Solutions Integration; Tammy Whalen, CTI Team Lead, Sandi Denoncour, Director of Care Coordination
MCAC mtg		Dec 9	Tory Jennison, Director of Population Health
Shelter Training - Manchester	Training for emergency shelter operational volunteers	Dec 10	Tory Jennison, Director of Population Health
Prevention Board	Community Presentation: Sandi presented by invitation to the Strafford County Prevention Board, a multi-partner learning collaborative. Presentation on IDN programming	Dec 11	Sandi Denoncour, Director of Care Coordination; Tory Jennison, Director of Population Health

	and focus on unmet needs in the community.		
Strafford CAP Annual Meeting	Partner Annual Meeting	Dec 12	Tory Jennison, Director of Population Health; Nick Toumpas
Concord Chamber of Commerce: Connected Crisis		Dec 12	Christine Alibrandi, Director of Solutions Integration
Fidelity Committee - CAP		Dec 12	Tory Jennison, Director of Population Health
Rockingham County Board of Commissioners	Quarterly Update for Rockingham County Board of Commissioners.	ongoing	Nick Toumpas, Executive Director

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. Fortunately, our Integrated Delivery Network has not lost one participating partner agency. In fact, during this reporting period we began the process of adding another, New Generations, which is a shelter for homeless pregnant and parenting women. We are initiated agreements to support two new initiatives for New Generations (homeless shelter for women and children).

The Region 6 IDN has continued our outreach and engagement strategy. We have continued to visit, participate in, and provide IDN updates to several multi-stakeholder initiatives throughout the region. These include the Regional Behavioral Health Work Group, Opioid Taskforce; our E5 Work Group; Home For All (Homeless Coalition); Public Health Network meetings, and more. We use these opportunities to keep a broad range of agencies informed, learn about and support existing collaborative initiatives in the region, invite input, and generally build community readiness for change/implementation. In addition to these activities, the Region continues to cultivate the relationships at the Executive levels of our key partners including meetings with hospital CEOs, CMHC CEOs, FQHC CEOs as well as meetings with the leadership of both Counties making up our Region.

One of the most impactful of those engagement opportunities continues to be our Community Care Team (CCT), which continues to grow and thrive, including the newest team in Exeter. 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, discussed in the previous section, have continued to be a key staple of network development, and will continue to serve as our largest and most diverse in-person network audience.

In this period we observed and heard from many clinical partners increasing concern about continued gaps in the continuity of mental health services for adults in our region, particularly in Strafford County, both in terms of the availability of appropriate levels of care for patient acuity, as well as transitions between service providers and sectors. In response, we convened primary stakeholders in this space specifically with the aim of identifying and reconciling these gaps. By request of partner agencies, the IDN facilitated / hosted a regional BH provider Meet & Greet including inpatient, outpatient hospital-based, private, and FQHC providers. This group continues to define collaborative care opportunities. One recent success was an agreement to increase training / access to services for DBT between the CMHC and a hospital-based practice.

Relatedly, we assisted one of our hospital-affiliated Primary Care practices to transfer the MAT-related care for most of their current patients to a partner that specializes in SUD treatment (while maintaining their status as Primary Care Provider).

IDN 6 network participation continued to grow for our bi-weekly Pediatric Telepsychiatry consultations and learning collaborative; supported by IDN and facilitated by a pediatric practice partner with Dartmouth-Hitchcock psychiatry. Likewise, we continued facilitation of the Enhanced Care Coordination workgroup with monthly meetings to discuss sustainability of services to both transition-aged youth, adults, and family systems.

During the reporting period, seven pediatric and family practice partner teams ***completed*** a Certificate in Pediatric and Behavioral Health Integration. This 6-month course provided 21 CEU/CME credits and is designed to develop practitioners' skills related to their patients' mental health needs. The course also focuses on developing systems to support effective, sustainable integrated behavioral health care. The participants will be supported by the IDN in development of a Community of Practice to facilitate continued implementation, regional collaboration, and network-building

With IDN support during this report period, eight practice partners initiated 12-month B1 Integration Projects being facilitated by Citizen's Health Initiative with first quarter outcome data anticipated during the next reporting period.

The Region 6 IDN has been actively engaged in convening regional partners to address significant changes and related gaps in recent changes to Coordinated Entry for homeless and housing insecure people in our region.

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.

The following narratives are examples of network success in collaboration and improved service delivery:

"A" is a young man in his 20's referred from Rockingham County Corrections in 2018 at release to a Portsmouth address. The home was a Section 8 apartment of a family member, so he could not stay long-term. He ended up leaving the home and living outside. Due to past issues, he was ineligible for admission at any group shelter. With an IDN Care Coordinator's help, he was provided gear to live outside as safely as possible. As he worked on his immediate goals, the Care Coordinator helped him to follow up on benefits enrollment, connect with mental health services, continue his medication-assisted recovery, and start a job. With an IDN Care Coordinator's help, he connected with Seacoast Mental Health Center.

Seacoast Mental Health Center's PATH worker and the IDN Care Coordinator worked hard to keep "A" connected during a substance use relapse, the loss of his job, and a period of little communication. During this time, he did utilize the Emergency Room once for a chronic health condition, but the IDN team stayed connected with him in the woods.

After a few months of support, "A" was able to successfully restart his medication-assisted therapy program. He reapplied for benefits and reconnected with his primary care provider and mental health provider. Since June 2019, "A" has remained stable, although he still lives outside. He has applied for housing and APTD, sees his doctors, and remains engaged with the IDN Care Coordination team 15 months after the initial referral.

"J" is a mom in late 40's who supports her family of four. She was referred to the IDN from Exeter High School. The two children remained at Exeter High School, although the family had been homeless for eight months in various parts of Rockingham County. "J" has a spouse with chronic health needs who is unable to work and needs regular care. The family was in a seasonal hotel rental with little food or ability to meet their needs. "J" was struggling with the anxiety and overwhelming burdens she faced, making it difficult for her to make new connections.

With support from an IDN Care Coordinator, they connected with city welfare, Community Action Partnership of Rockingham County, and food pantry support for immediate help. Over the past few months, "J" has been able to connect with her own primary care provider to start treating her deepening and overwhelming depression. Her spouse has also applied for Social Security Disability, which will provide additional income in the future. "J" has completed multiple housing applications and the family hopes to find local housing and work with the school to allow both children to graduate high school in the next two years in Exeter.

In addition to direct support, the IDN Care Coordinator has provided support to the school to demonstrate how to help other families / students in need. There continue to be collaborative meetings with school and family to support everyone's learning about local resources.

Mom / young adult daughter: A Core Physicians practice referred "D", a young woman in her 20's due to concern for her mental health and the complexity of her social needs. She is an undergraduate student at a local university at risk of losing her housing, struggling to eat regularly, and trying to care for her mother who lives in Section 8 housing in Rockingham County. "D" cannot live with her mother, but she has become her primary caretaker with no idea how to connect her mother to appropriate supports. Her IDN Care Coordinator is working with her to identify resources for both her and her mother. "D" has made connections with behavioral health services. She is working on budgeting her limited income and connecting her mother with extended services.

"J" is a man in his 40s who has worked with the IDN for 18 months total to date. He is an example of how a regional approach and collaboration can benefit homeless residents and reduce burden on multiple county systems. "J" was released from Strafford County Corrections with a plan for transitional housing. It's unclear why this was not successful, but he was connected to the IDN after he made his first stop at Families First Health Care van. "J" had significant mental health needs but was reluctant to engage in formal counseling or evaluation. He had no community connections.

With IDN support, "J" found shelter at Crossroads House in Rockingham County. "J" chose to stay with Families First as his new primary care provider. Crossroads House asked the IDN Care Coordinator to remain involved with "J" to support his success in shelter. "J" struggled to remain in the shelter but was helped to work with the Crossroads House staff whenever problems arose.

The IDN remained involved for the 12 months that "J" was at Crossroads. He connected with benefits, healthcare, and some community supports. Working together, "J" and his Care Coordinator secured transitional / supported housing via a Section 8 voucher. "J" has now been housed for four months. Since being housed, "J" started counseling at Seacoast Mental Health Center – something he had been reluctant to do while homeless.

After a meeting with Corrections last week, "J" told his Care Coordinator, "I feel happy." This was the first time he had expressed such positive emotions. His Care Coordinator continues to support his growing self-sufficiency and resilience when faced with new challenges. His relative stability with IDN support has prevented recurrence of behavioral health issues which led to his incarceration and kept him in the community and out of jail.

R is a gentleman in his early 70's and long-term resident of Rockingham County. He had been staying with his partner and family at a local hotel for many months. He was referred to the IDN by town welfare due to the long-standing dependence on welfare help for housing payments and his declining health.

"R" has chronic health conditions that prevented him from continuing work. Due to his decline in health and the impact on him of family members' ongoing substance use and instability, he ended up with no real caretaker. He was admitted to the hospital. After discharge, community-based caregivers found others in the home made it very difficult to provide "R" the care and services he needed to prevent unnecessary admission to a nursing facility.

In collaboration with his IDN Care Coordinator, HAVEN, and a Seacoast Mental Health Center team member, "R" was able to leave his abusive partner and get into Crossroads House. Once a restraining order was obtained, multiple service providers were able to start seeing him. He now has Visiting Nurses, CFI Case Management when he gets into housing, a primary care provider, a behavioral health provider, and has remained out of the hospital since starting his work with the IDN Care Coordinator. Due to his disability, "R" is close to the top of the housing waiting list. He looks forward to being housed with his community supports early next year.

Addressing the Opioid Epidemic:

Stimulated by recent legal findings, we are experiencing increasing demand for the capacity to deliver Medication Assisted Treatment for people living with Opioid Use Disorder in Corrections settings in both County systems (Strafford and Rockingham) in our region. The recent focus on MAT/Recovery and supports in Corrections has highlighted the fact that this has been a considerable unmet need for many years that has placed those involved at risk as well as diminishing efforts to reduce recidivism. Region 6 IDN is actively supporting efforts to implement MAT/Recovery services into the Corrections settings of both Rockingham and Strafford Counties.

The untimely death of solo practitioner and MAT provider, based in Rochester, posed an immediate and significant risk of lapse in services continuity to over 100 patients for who he was providing MAT. Within 24 hours, IDN 6 led an effort to identify and coordinate the transitioning of care for all of Dr. Bennett's MAT patients and placement with new providers throughout the region. The rapid mobilization coordinated by IDN 6 to engage existing relationships with MAT clinicians throughout the Region no doubt prevented numerous potential negative consequences for this vulnerable population.

IDN 6 funded two full time staff in support of SOS Recovery Community Organization to open a new Recovery Community Center in Hampton. We also revised funding agreement with Southeastern New Hampshire Services to fund a CRSW Case Manager position in their residential treatment program. IDN 6 has continued to support the facilitation of Doorway / HUB and spokes workgroup and networking support meetings,

The Region 6 Operations Team continues to benefit 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. These have all been described in previous reports. 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, New Hampshire Harm Reduction Coalition, Hand-Up Health Services, and more.

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. There was one change in membership in the

Substance Use Treatment Sector Seat. There were no significant changes to governance structure or stability during the reporting period. The Operations Team has especially engaged the Executive Committee to assist in strategic planning of IDN priorities and activities in anticipation of the sunset of the DSRIP, and in consideration of multiple, concurrent initiatives throughout the state.

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. This report reflects 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. We are making contingency plans in respect to additional adjustments that 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 has made 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.

Strengthening Network Partner Readiness for DSRIP Initiatives:

During this reporting period, the IDN Operations team continued execution of 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:

- Launch of our Workforce Capacity-building funding opportunity for IDN partners. Six $50,000 awards were approved to support the implementation of agency-level, and cross-agency investments and activities aimed at strengthening workforce stability, retention, readiness and capacity.
- Continued the 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, now standing at 60.
- Continued collaborative relationship with Southern NH AHEC to oversee and administer regional training efforts including design and delivery of trainings across the IDN projects portfolio.
- Assisted Community Partners to embed primary care services through ProHealth model.
- Eight B1 partner Integrated Behavioral Health projects reported on progress for the first quarter of funding. Projects are being facilitated by Citizens Health Initiative and first reported outcome data expected with next quarterly report from each partner.
- Sponsored 13 partners providers for two-day Collaborative Family Healthcare Association Conference in Denver Colorado, including preparatory, on-site and follow-up cross-site learning inputs.
- The IDN has supported the development and standing up of ALOFT – an innovative model of wellness-based integration in a triad model between hospital (ED and Pediatrics), a private behavioral health provider, and a Community Mental Health Center. Our team will be collecting data and seeking

opportunities to identify enhancements in payor billing that could make this model more attractive to other regional partners.

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

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.
- 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 includes 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.

PPI Budget

Connections for Health									
IDN Region 6									
PPI Project									
Project	CY 2016 Actuals	CY 2017 Actuals	Jan-Jun 2018 Actuals	July-Dec 2018 Actuals	Jan-Jun 2019 Actuals	Jul-Dec 2019 Actual	CY 2020 Projected Spend Budget	CY 2021 Projected Spend Budget	Total Actual and Spend Budget
Expense Items									
Staffing									
Direct Staff	$ 43,843	$ 190,929	$ 103,694	$ 135,762	**$ 150,458**	$ 154,228	$ 320,000	$ 320,000	$ 1,418,915
Indirect Staff	$ 12,692	$ 59,000	$ 29,500	$ 29,500	**$ 29,500**	$ 29,500	$ 65,000	$ 65,000	$ 319,691
Benefits	$ 15,976	$ 76,902	$ 37,368	$ 60,242	**$ 69,363**	$ 87,560	$ 170,000	$ 170,000	$ 687,411
Contracted Staffing	$ 60,000	$ 165,000	$ 96,000	$ 111,000	**$ 170,957**	$ 270,768	$ 450,000	$ 450,000	$ 1,773,725
								$ -	$ -
Project Infrastructure								$ -	$ -
Equipment	$ 3,970	$ -	$ -	$ -	**$ -**	$ 3,104	$ 5,000	$ 5,000	$ 17,074
Operations	$ 486	$ 7,820	$ 2,425	$ 6,971	**$ 6,600**	$ 6,686	$ 20,000	$ 20,000	$ 70,988
								$ -	$ -
Workforce								$ -	$ -
Fees/Outside Placement	$ 7,147	$ 62,703	$ 79,441	$ 40,663	**$ -**	$ -	$ 80,000	$ 80,000	$ 349,954
Recruiting/Retention	$ -	$ -	$ -	$ -	**$ -**	$ -	$ -	$ -	$ -
Training	$ -	$ 915	$ -	$ -	**$ -**	$ -	$ -	$ -	$ 915
Other	$ -	$ -	$ -	$ -	**$ -**	$ -	$ -	$ -	$ -
							$ -	$ -	$ -
Technology	$ -	$ -	$ -	$ -	**$ -**	$ -	$ -	$ -	$ -
							$ -	$ -	$ -
									$ -
Totals	$ 144 114	$ 563 268	$ 348 429	$ 384 138	**$ 426,877**	**$ 551,847**	$ 1 110 000	$ 1 110 000	$ 4,638,673
DY 2019						**$ 978,724**			

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.

Progress on the IDN's plan to fill gaps and reduce barriers to utilizing and connecting existing SUD and BH resources continued and was expanded in several ways. Expansion efforts included continued development of a third Community Care Team meeting site at Exeter Hospital, where area partner agency representatives now come together monthly. In Community Care Team meetings, representatives from SUD, BH, Social Service/Support, and Medical partner agencies come together to share information and 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 four 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. Organizations that have joined the Care Team table during the reporting period include AmeriHealth Caritas.

A second strategy the IDN continues to focus on to connect existing SUD and BH resources is the facilitation of the Clinical Advisory Team (CAT), 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. During this reporting period, participants shared questions and best practices with each other around their organizational efforts to

improve billing for integrated health, define the best skill sets for integrated health behavioral health workers, and motivate/incent clinical providers to pursue advanced addiction medicine training beyond X-waivers. These discussions led to additional IDN investment in billing and coding training and facilitation of job-description sharing during the reporting period.

A third example of the region's expanding efforts to bridge gaps and reduce barriers to connect enrolled beneficiaries (and unenrolled but eligible residents) to existing SUD and BH resources during the reporting period was the facilitation of public-private partnerships to improve access for homeless residents in the region to safe shelter during life-threatening temperatures. The Region 6 IDN, in collaboration with key partner agencies and the Strafford County Commissioners, planned and operated a series of overnight warming centers during the 2018-2019 Winter season.

One result of that successful collaborative was the TriCity Mayor's Commission, a panel that included representatives from the 3 largest cities in Strafford County, who convened to craft a "Master Plan" to address homelessness that would align the cities' respective efforts to improve housing related services for the homeless and housing insecure. This plan included strategies to address many elements of housing policy. It also encouraged regional discussion between municipal leaders and community agencies about sharing resources to create a new system of support for Emergency Warming Centers to provide overnight space in the community for homeless neighbors to shelter safely during extreme temperatures. The IDN operations team developed and delivered a series of training events to encourage and prepare citizen volunteers to participate in these efforts. During the reporting period, citizen volunteers staffed 2 separate warming centers – one at a municipal space and one at a city church. This effort allowed 31 unique individuals to connect with IDN care coordination and homeless outreach staff. These connections resulted in 6 new referrals to the Doorway @ Wentworth Douglass, 2 individuals requested assistance obtaining ID's, referral of 2 individuals to Waypoint services, and submission of 3 new applications for Medicaid. Additional referrals were made to Welfare offices in 3 communities.

The Region 6 IDN planned and provided several professional development opportunities for partners during the reporting period. These opportunities ranged from providing scholarship support for conferences to procuring custom designed and delivered agency level trainings to facilitating the delivery of professional development sessions open to all regional partners. These can be reviewed in Attachment B1-8C and associated SAR Community Project sections. Region 6 IDN partner agencies also sent providers/teams to several Community Health Institute Behavioral Health Integration and MSLC Learning Collaboratives during the reporting period, further increasing workforce capacity to adopt integration strategies.

Additional progress during the reporting period includes execution of funding commitments to partners in projects including:

- Expansion at a new site for the SOS Community Recovery Organization in an underserved part of the region (Hampton) – D3.
- Addition of Aftercare Enhanced Care Coordination for women and children moving to permanent housing from New Generation, Inc in Greenland – E5.
- Addition of clinical staff and plans for Enhanced Care Coordination with ALOFT; a project involving private BH clinicians, Core Pediatrics, Dartmouth-Hitchcock Pediatric Psychiatry, and SAU-16 – E5.
- Addition of Clinical Care Coordinator support with the Somersworth Ready Together ACERT project; a collaboration between United Way of the Greater Seacoast, Somersworth Police Department, Strafford County Child Advocacy Center, and Strafford County Family Justice Center – E5.
- Approved expansion of BH Clinician staffing with Exeter Health Resources and Hope on Haven Hill – B1. The additional staff are projected to be hired in CY2020.

- Development and implementation of a regional Case Manager Support Group with quarterly meetings to promote professional development, retention, and resource-sharing for Case Managers spanning multiple projects – B1, C1, D3, E5. This group has met twice and is defining goals and objectives for CY2020.

- Continuation funding for the Community Resource Network, a regional resource-sharing event facilitated by Families First / Greater Seacoast Community Health – benefits all projects. The facilitator explains, *"Our free networking meetings and workshops provide space and time for your staff to learn more about programs and services and stay up to date on resources available in our region. Everyone gets something out of these meetings; your staff may learn about a new program or forge a relationship with a new contact to coordinate with on behalf of individuals your organization serves. It helps your staff members be better at their jobs."*

WRITEBACK RESPONSE: Funding for the A1 investment at Lamprey Health Care to support an X-Waivered Nurse Practitioner Fellow in the Fellowship program ended during this reporting period. The MOU for support of the position spanned September 1, 2018 – August 31, 2019. Lamprey Health Care submitted the following narrative to highlight the impact of this investment:

"The IDN's investment in the Nurse Practitioner Fellowship allowed Lamprey Health Care to add a third Fellow to this year's Cohort. This NP Fellow is a waivered MAT provider and has completed 9 months of her Fellowship. She had built skills in assessment, teamwork, and professionalism and gained experience in working in an integrated primary care and behavioral health environment. She is finalizing her quality improvement project that involves curriculum development on an educational program on MAT for nurses and medical assisting staff…Lamprey's goal is to recruit and retain a qualified workforce that can manage acute and chronic behavioral health and physical conditions. In the past month Lamprey Health Care interviewed and made an offer to the NP Fellow to stay on at Lamprey Health Care as a nurse practitioner. Negotiations are underway and we are hopeful that she will accept the offer. The IDN's support of this NP Fellow has been instrumental in assisting Lamprey to recruit and possibly retain our own waivered Integrated Health Provider."

The Region 6 IDN maintained a contract with the Citizen's Health Initiative to provide 2.0 FTE staff to support B1 Integration Coaching efforts at up to 8 partner sites. 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.

Progress in support of the 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: Bill Gunn

- Retention/Sustainability: (Nick Toumpas, co-chair-IDN)

- Recruitment/Hiring: ad hoc participation

During this reporting period, the Region 6 IDN made substantial progress executing the A1 Workforce Project Implementation Plan. Impacts from investments in recruitment and retention support, training, and participation in the state-wide workforce taskforce were identified. Significant progress in the area of recruitment and retention was observed in the 6 proposals returned by IDN network partners in response to an RFP published to support Comprehensive Agency-level plans to strengthen and retain a high-performing workforce. (See Attachment A1.3a: Agency Workforce Capacity RFP).

The RFP was distributed widely to all IDN network partners providing direct service to Medicaid enrollees, regardless of Medicaid receipts. The Workforce Engagement RFP produced six responses from regional partners. Responses were scored by multiple reviewers. Good quantitative interrater reliability was found. Summary scores ranged from 70-94 out of 100. (see Attachment A1.3b: Agency Workforce Capacity Proposal Scoring Template). Each respondent was provided with feedback collected from the review team with a request for additional/clarifying information. 100% of initial respondents provided the requested writebacks and were assessed as eligible for funding.

Attachment A1.3a: Agency Workforce Capacity RFP

AGENCY WORKFORCE CAPACITY-BUILDING PLANS

REQUEST FOR PROPOSALS

WHAT: Funding opportunity to Partner Agencies in the Region Six Integrated Delivery Network.

Up to 10 awards of up to $50,000 available to meritorious proposals

WHO: IDN6 Partner Agencies with fewer than 500 employees are eligible to apply for these funds.

WHEN:	Full Proposals are Due:	Friday, May 10
	Provisionally Approved Proposals Returned:	Wednesday, May 22
	Final Proposals Due:	Friday, June 7
	Award Letters:	Friday, June 14

OBJECTIVES: Connections for Health seeks to support Comprehensive Agency-level plans to strengthen and retain a high-performing workforce. Proposals should describe how DSRIP investments will directly support a well-conceived **Agency Workforce Strategy.** The types of activities may include, but are not limited to:

Education/Certification Programs	Specific Trainings
Clinical Supervision	Peer Support
Enhanced Recruitment	Enhanced Retention
Enabling Technology	Case Consultation

This funding is a **One-Time Award**, and **NOT** intended to pay or subsidize salaries or new positions. Proposals should clearly articulate how these funds will strengthen the agency/organization workforce recruitment, retention and services quality capacity beyond the funding period. Please describe any opportunities in the plan to coordinate efforts with other IDN partners.

NARRATIVE SECTIONS (1-4)

Proposals will be evaluated based on the following criteria:

1. Describe your overall Comprehensive Agency Workforce Strategy (25 points)
2. Describe where you will target, and the rationale for those investments (30 points)
    a. Why will this work?
    b. How do you know this is what employees want?
    c. How can this be replicated/sustained?
3. Describe the alignment of these investments with the Aims of the DSRIP (15 points)
4. Describe the coordination of activities with other specific IDN Partners (15 points)
5. Break down simple budget and deliverables in the tables below (15 points)

PROPOSAL COMPONENTS:

A. EXECUTIVE SUMMARY:

Provide a summary description of your proposal (not to exceed 300 words)

B. WORK PLAN:

Please use the table below to enter the main objectives of the plan, the specific deliverables associated with each objective, and a target date for launch or completion. Feel free to modify the table cells to enter as much text as needed. Add rows if needed.

OBJECTIVE	DELIVERABLE	TARGET DATE

Consulting with Connections for Health Operations Team is welcome and encouraged

C. BUDGET:

Awards of up to $50,000 are available to IDN-6 Partners delivering direct services to Medicaid Members in the Region. Please provide a simple line item budget with a narrative describing the basis for each figure.

For questions or quick consultation please contact: Kevin Irwin kirwin@co.strafford.nh.us

Attachment A1.3b: Agency Workforce Capacity Proposal Scoring Template

Agency:_____	**Max Points**	**Proposal Score**
Describe your overall Comprehensive Agency Workforce Strategy	25	
Describe where you will target, and the rationale for those investments • Why will this work? • How do you know this is what employees want? • How can this be replicated/sustained?	30	
Describe the alignment of these investments with the Aims of DSRIP	15	
Describe the coordination of activities with other specific IDN Partners	15	
Break down simple budget and deliverables in the tables below	15	
Total	100	
Executive Summary Comments:		
Work Plan Comments:		
Other Comments (Alignment?):		

Strong themes were noted across proposals in three areas. In the first, support for educational advancement, several partners focused on strategies to help staff obtain Master's degrees. In the second, staff appreciation, a few partner proposals focused on the value of developing and celebrating staff mindfulness through a variety of protective retention strategies. The third theme reflected in several proposals was workforce development to serve service expansion – most often through a new model of (or population) for programming. Key strategies from the proposal are identified in Table A1.3c, illustrating the significant themes and strategies in each Workforce Capacity proposal received.

Table A1.3c illustrates the key themes and strategies in each Workforce Capacity proposal received.

Agency Workforce Capacity RFP Responses		
Funded Partner Agency	Proposal Themes	Primary Workforce Impacted
Strafford County Community Action Partnership	Expand agency capacity to retain staff qualified to serve complex clients via: • Supporting workforce needs around training, professional development and client services for the Whole Family model & trauma informed care with expansive deployment for clients impacted by substance use.	MLADCs Case management staff receiving Recovery Coach training
Community Partners	Increase agency capacity to recruit, retain & serve dual-diagnosis clients by: • Cross-training Behavioral Health and Disability Support staff • Expanding All-staff appreciation/wellness/self-care programming • Implementing an Applicant Tracking System to: - more quickly fill open positions - identify talent for hard to fill positions - minimize the time from application to hire - improve hiring manager engagement	Applied Behavior Analysts Behavioral therapists Hiring managers Human resources staff
Hope on Haven Hill	Grow and retain staff via: • Professional Development in trauma informed care and step-down level of care areas • Clinical Supervision • CARF Accreditation • Providing enhanced incentives to staff for retention	MLADCs LADCs CRSWs LICSWs
Lamprey Health Care	Expand implementation of the Agency's Comprehensive Workforce Support Strategy including: • Psychiatric Consultation • Clinical Supervision • Peer support/ one-on-one mentoring • Mindfulness Training • Team Building • Healthstream Modules	Behavioral Health Clinicians Clinical staff All agency staff

Seacoast Mental Health Center	Provide incentives for a Bachelor's to Master's level pathway through: • Partnership with New England College for cost savings/on-site education • Creation of an internship coordinator position to manage opportunities for development with the agency • Consideration of feasibility of cohort training model with partner agencies	Bachelor's level aspiring clinicians Master's level staff participating in agency succession planning
SOS Community Recovery Organization	Focus on retention and professional development for service expansion by: • Incenting/supporting staff professional development for Leadership skills • Supporting/incenting staff to pursue CRSW certification • Providing community awareness of roles to increase potential workforce	SOS managers SOS non-management staff SOS volunteers

As indicated in the table above, partner proposals reflected a strong commitment to developing current staff into more advanced clinical roles and preparing current staff for roles in expanded programming. Investment in this theme of workforce retention strengthens partner organizations because it results in increased horizontal and vertical agency capacity. Partner agencies can bring new projects and service models to implementation more quickly and reliably by re-distribution of organization-experienced staff. They can also operate more efficiently when qualified internal staff can be developed through succession planning. Both dimensions are important attributes in an organizational culture that prioritizes staff engagement and in a resilient network that must continually learn to become more responsive.

This ongoing initiative reflects an effort to build partner agency capacities to retain workforce and identify best-practices that can be shared across the region. This level of simultaneous investment across agencies illustrates the IDN's confidence in its growing role as convener and expediter of information exchange.

Attachment A1.3d

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 in CAPACITY BUILDING SUPPORT

IDN Partners requesting 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.

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.

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	As of 6/30/19	As of 12/31/19
# of participating partner agencies who receive recruitment and/or retention support from the IDN.	10	0	6	12	12	14
% of participating partner agencies receiving recruitment and/or retention support from the IDN who report positive	70%	0	100%	100%	100%	100%
# of participating partner agency staff who receive IDN sponsored training.	150	0	350	380	406	448
# of participating partner agency staff who receive IDN sponsored training who report positive impact on knowledge or practice.	75% (or 113)	0	97%	90%	94%	95%
# of eligible participating provider agencies who were offered a stipend for staff participation on the Clinical Advisory Team	15	0[1]	15	15	15	15

# of Members Demonstrating Initiation of Alcohol and Other Drug Dependence Treatment	Target Pending Baseline Measurement –**TARGET UPDATED FOR 12/2019 SUBMISSION, SEE BELOW**
~~# and % of new patient calls or referrals from other providers for CMHC intake appointment within 7 calendar days~~	Target Pending Baseline Measurement- **MEASURE AND TARGET REVISED FOR 12/2019 SUBMISSION, SEE BELOW**
~~# and % of new patients for whom time between intake and first follow - up visit was 7 days or less.~~	Target Pending Baseline Measurement **- MEASURE AND TARGET REVISED FOR 12/2019 SUBMISSION, SEE BELOW**
~~# and % of new patients for whom time between intake and first psychiatrist visit was 30 days or less~~	Target Pending Baseline Measurement- **MEASURE AND TARGET REVISED FOR 12/2019 SUBMISSION, SEE BELOW**

Performance Measure Name	Target	As of 12/31/19
# of Members Demonstrating Initiation of Alcohol and Other Drug Dependence Treatment ***scored in performance metrics Care.05**	**13.94%*** **target in Care.05**	**Actual performance for last available DHHS review (Jan-June 2019) was MET at 18.43% = 176 out of 995**
# of patients completing a CMHC intake appointment (noted below as Updated Measure #1)		50% of CMHCs reporting: 2019 Q1: 431 Q2: 384 Q3: 390 Q4: 477
# and % of patients with CMHC appointment within 7 days of hospital discharge (noted below as Updated Measure #2)		50% of CMHCs reporting: 2019 Q1: 97 (22.5%) Q2: 76 (19.8%) Q3: 84 (21.5%) Q4: 138 (28.9%)
# and % of patients with CMHC appointment within 30 days of hospital discharge (noted below as Updated Measure #3)		50% of CMHCs reporting: 2019 Q1: 176 (40.8%) Q2: 152 (39.5%) Q3: 161 (41.2%) Q4: 178 (37.3%)

Evaluation targets met or exceeded all measurable metrics in the A1: Workforce project. Performance exceeded previously reported scores in two metrics – the number of participating partner agency staff who received IDN sponsored training (380 v. 406) and the number of participating partner agency staff who receive IDN sponsored training who report positive impact on knowledge or practice (90%-95%).

The Region 6 IDN Operations team continues to work with network partners to collect data for the following metrics:

# of patients completing a CMHC intake during the reporting period (quarter).

and % of patients with CMHC appointment within 7 days of hospital discharge

and % of patients with CMHC appointment within 30 days of hospital discharge

The Region 6 IDN and partners believe these metrics are valuable measures of system of care performance because they reflect timeliness of client engagement and activation. Both CMHCs in Region 6 undertook efforts to offer open access scheduling to clients during the last reporting period. The IDN will

continue these efforts to help the participating agencies identify and utilize this critical data as the open access schedule model is implemented and refined.

WRITEBACK RESPONSE: referring to the UPDATED portion of Table A1.4 above

Three performance measures were revised during this report period after discussion with DHHS and CMHC project partners. The goal for each of the revised measures is that ≥ 50% of reporting CMHCs provide it. This goal was met for Dec 2019.

The June 2019 metrics for *# (and %) of new patients for whom time between intake and first follow-up visit was 7 days or less* and *time between first intake and first psychiatric visit was 30 days or less* were tabled because investigation into coding and labeling of visits at our CMHC partners revealed that these metrics did not provide actionable data for them to meaningfully discuss transformation.

For example, the inclusion of a qualifier in the June 2019 SAR for "new" clients was incompatible with the refined goal of the metric. The updated goal was to determine how many of the highest risk clients (post-hospitalization) were being seen in a timely manner. The past measures did not capture the post-hospital capture rates of follow-up for existing clients. The Dec 2019 measure adjustment allows a logic model to unfold that considers both the # of successful intakes AND the rates and timeliness of capture for the CMHC's self-defined highest risk populations: new and existing clients leaving hospitalization.

Updated Measure #1:

Measure *"# of patients completing a CMHC intake appointment*" was added because discussion with CMHC partner agencies in the process of B1 project work revealed a previously unknown data point: CMHC belief that approximately 50% of referrals were not actually qualified clients for CMHC services. Therefore, using the number of *referred patients* as a denominator for any measure inaccurately implies that ALL referred patients SHOULD receive services. No previous measure assessed how many of the patients seen at intake ever received service, so an evaluation adjustment to collect data establishing successful intake as the baseline was necessary.

Updated Measure #2:

The June 2019 # and % of new patient calls or referrals with CMHC intake appointment within 7 calendar days metric was adjusted for Dec 2019 to capture the *"# and % of patients with a CMHC appointment within 7 days of hospital discharge"* because our partner agencies reported that the post-hospitalization clients were the highest risk population for them to care for and they weren't sure how they were doing getting those clients into care. As a result, the biggest difference between the June and December metrics is the added specificity of '7 days from hospital discharge' as a qualifier in Dec 2019.

Updated Measure #3:

Agencies were encouraged to also look at the number of patients referred to their agency after hospital discharge compared to those who completed an intake and those who showed up for an appointment at 7 days and at 30 days because that series of measures can offer insight into how many of these highest risk clients are actually engaging with CMHC treatment as part of their hospital discharge planning. The goal for both the 7 and 30-day appointment after hospital discharge measures was that 50% of reporting CMHCs provide data. That goal was met.

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.

Staffing targets, where adjusted since the start of the project, are marked with ~~strikethrough~~ and new targets are added. Each of the targets adjusted is also reflected in the appropriate project section staffing narrative and table. Targets are projections through December 2020.

Table A1-5 reflects expanded staffing during the report period in the following projects. Please see the project sections for more detail:

- Expansion at a new site for the SOS Community Recovery Organization in an underserved part of the region (Hampton) – D3.
- Addition of Aftercare Enhanced Care Coordination for women and children moving to permanent housing from New Generation, Inc in Greenland – E5.
- Addition of clinical staff and plans for Enhanced Care Coordination with ALOFT; a project involving private BH clinicians, Core Pediatrics, Dartmouth-Hitchcock Pediatric Psychiatry, and SAU-16 – E5.
- Addition of Clinical Care Coordinator support with the Somersworth Ready Together ACERT project; a collaboration between United Way of the Greater Seacoast, Somersworth Police Department, Strafford County Child Advocacy Center, and Strafford County Family Justice Center – E5.

All B1 staffing was retained during the reporting period except for one position at a hospital-based primary care practice that turned over. The position was successfully filled within the reporting period. Project C1 had turnover in one position, again successfully filled withing the reporting period. Project D3 experienced growth and all previous positions were retained. Project E5 had two resignations that were not successfully filled during the report period and growth in new projects with the addition of 3.1 FTEs total.

WRITEBACK RESPONSE: Funding for the A1 investment at Lamprey Health Care to support an X-Waivered Nurse Practitioner in the Fellowship program ended during this reporting period. The MOU for support of the position spanned September 1, 2018 – August 31, 2019. (further narrative, report page 16)

In reference to positions correlating with section B1-4 of this report, *Behavioral Health Clinician* is used to include billable clinicians working at B1 partner practices. For IDN 6, current positions specifically include: LICSW, FMT, MLADC/LADC, and dually licensed providers.

Behavioral Health Coordinator **is inclusive of various roles embedded in B1 partner practices as part of their Behavioral Health (including SUD) teams and responsible for coordination of behavioral health care plans, clinical care plans, and/or social determinant of health coordination. These roles also provide direct service to patients but are not directly billable at this time. For IDN 6, current positions specifically include: BSW, MSW, and MSW working toward LICSW and/or MLADC status under direct supervision with a MLADC.**

In reference to positions correlating with section D-3 of this report, the following is offered for clarity. The terms *Behavioral Health provider* and *substance use provider* are used simultaneously in DSRIP program reporting. In December 2018, the partner status of Hope on Haven Hill was discussed extensively with DHHS. It was determined that Hope on Haven Hill would be moved from our D3 Project, where it was originally conceived as an SUD partner, and designated as a B1 Project Behavioral Health partner. Staff members supported at Hope on Haven Hill are now reported in the B1 Project following the definitions above. One staff member at Greater Seacoast Community Health – Families First has been consistently reported in B1 and highlighted to reflect the 1.0FTE investment in increasing MLADC /LADC services in the primary care setting.

Table A1.5: Workforce Staffing Targets

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	Staffing on 6/30/19	Staffing on 12/31/19
Executive Director (I)	1	1	1	1	1	1	1
Director of Operations (I/B1/C1/D3/E5)	~~Up to 1~~ **0.8**	0	0	.8	.8	.8	.8
Director or Population Health (I/B1/C1/D3/E5)	1	1	1	1	1	1	1
Director of Clinical Integration (I/B1/C1/D3/E5)	0.4	0	0	0.4	0.4	0.4	0.4
Director of Care Coordination (I/B1/C1/D3/E5)	1	0	0	1	1	1	1
Director of Solutions Integration (I/A2)	1	0	0	1	1	1	1
Program Coordinator (I/B1/E5)	Up to 1.0	0	0	0.8	0.8	~~0.25~~ **0.75**	0.5
Administrative Assistant (I)	~~Up to 2~~ **0.5**	0	0	.5	.5	0.5	0.5
School/Youth Mental Health Integration Clinician (I/E5)	~~Up to 1~~ **0.7**	0	.05	.1	.1	**0.7**	**0.7**

Waivered Nurse Practitioner (A1)	Up to 1	0	0	1	1	1	1
Integration Coach (B1)	2	0	0	0	3	5	2
Behavioral Health Clinician (B1)	~~Up to 6~~ **6.4**	0	0	1	2.8	~~5.4~~ **6.4**	6.4
Behavioral Health Coordinator (B1)	~~Up to 6~~ **4**	0	0	1	2	3	4
Pediatric Psychiatry Consultation (I)	~~Up to 1~~ **0.03**	0	0	0.03	0.03	0.03	0.03
Masters Level Team Leader (C1)	~~Up to 2~~ **1**	0	0	1	1	1	1
CTI Case Manager (C1)	~~Up to 6~~ **4.8**	0	3	4	4.8	4.8	4.8
Master Licensed Alcohol and Drug Counselor Navigators (D3)	~~Up to 1~~ **0.35**	0	0	1	1	**0.1**	**0.125**
CRSW/Case Manager (D3)	~~Up to 6~~ **4**	0	0	1	3	~~2~~ **3**	~~4~~
Clinical Care Coordinator (E5)	~~Up to 6~~ **2.5**	0	0	1	1	1	2.6
Enhanced Care Coordination Case Manager (E5)	~~Up to 2~~ **2.5**	0	0	1	2	0.75	~~2.5~~ **3.0**
Clinical Supervision Consultation (D3/E5)	~~Up to 2~~ **0.25**	0	0	.05	0.25	0.25	**0.3**

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	Jan-Jun 2019 Actuals	Jul-Dec 2019 Actual	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	$ 70,000
								$ -	$ -
Project Infrastructure								$ -	$ -
Equipment	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Operations	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
								$ -	$ -
Workforce								$ -	$ -
Fees/Outside Placement	$ -	$ -	$ 74,326	$ 20,361	$ 77,091	$ 164,817	$ 300,000	$ 300,000	$ 936,595
Retention	$ -	$ -	$ -	$ -	$ -	$ 100,000	$ 150,000	$ 150,000	$ 400,000
Training	$ -	$ -	$ -	$ 18,856	$ 31,716	$ 53,069	$ 60,000	$ 60,000	$ 223,641
Recruiting	$ -	$ -	$ -	$ 2,500	$ -	$ -	$ 75,000	$ 75,000	$ 152,500
Technology	$ -	$ -	$ -	$ -	$ -	$ -	$ 50,000	$ 50,000	$ 100,000
								$ -	$ -
									$ -
Totals	$ -	$ -	$ 74 326	$ 41 717	$ 108,807	$ 317,886	$ 670 000	$ 670 000	$ 1,882,736
DY 2019						$ 426,693			

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.

- 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.

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.*

Table A1-7: Key Organizational and Provider Participants

Organization Name	Organization Type	Associated with IDN Projects (A1, A2, B1, C, D, E)
Appledore Family Medicine	HBPC	A1, A2, B1
ALOFT Integrated Wellness	BH Private Practice	A1, E5
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, E5
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
Homeless Center for Strafford County	**Soc Service**	**E5**
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
Lee Family Practice	HBPC	A1, A2, B1
New Generation, Inc	Soc Service	A1, 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
Somersworth Ready Together / United Way of Greater Seacoast	Soc Service	A1, E5
Southeastern NH Services	SUD	A1, A2, B1, C1, D3
SOS Recovery Community Organization / LEAD	Peer Recovery	A1, A2, C1, D3, E5
Strafford County Corrections	Corrections	A1, A2, C1, D3, E5
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 Medical 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 TO DECEMBER 2019 KEY A2 ACHIEVEMENTS FOR REGION 6 IDN:

- Data Aggregator (Quality Reporting Service):
  - All fourteen (14) B1 partners reporting data to the Quality Reporting Service data aggregator engaged in quality improvement review of their data submitted, supported by IDN-6 staff and MAeHC consultant. This prompted the desired conversations between partners' data teams and clinical providers on using the information received for evaluations of work flows, protocols, capturing data in EMRs, and inter-departmental communications, resulting in better data and improved performance.
  - One more partner is successfully reporting CCSAs.
  - Two hospital partners, Exeter and Wentworth Douglass, that did not report on the full-year metrics for 2018 worked through limited resources issues and an EHR conversion in order to prepare to submit data for 2019 on the full-year metrics.
- Shared Care Plan:
  - Shared care plan platforms were researched and evaluated, resulting in the choice to replace our originally selection Care Director with UniteUs as IDN-6's shared care plan tool, as well as our closed loop referral tool.
- Event Notification Services:
  - Exeter Hospital approved the sharing of its Admissions, Discharges, Transfers (ADT) data via IDN-6's Event Notification Service (ENS) during this reporting period. Discussions began with Exeter's current ENS vendor to map out the how the sharing would occur via existing interfaces with MAeHC, and full implementation is planned for Q1 of 2020.
  - Work that began in early 2019 with a community mental health center partner (Seacoast Mental Health Center) to evaluate the ability of its care records system to accept an ADT data feed resulted in an alternative solution which will allow SMHC to receive ADT data and utilize it in care coordination.
- Additional technology support for partners:
  - An investment was made in Lamprey Health Services to purchase an electronic solution to the communication challenges that partner was having due to its lack of an effective messaging service between its multiple locations and multiple buildings at each location.

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

Fourteen (14) B1 partners continue to submit production data. Some will report data on the full-year metrics for the first time for the 2019 reporting period and others started reporting on more 6-month measures during this period. Data reported below is inclusive of the B1 practice-level partners.

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

NARRATIVE ON A2.3:

Data Aggregator:

Building on the significant progress made in the first half of 2019 to have 14 B(1) partners and practices report data to the QRS, work done in this period resulted in more partners reporting more data. Our primary focus then shifted to quality review and improvement. Monthly or bi-monthly meetings were held with partners to review each reported metric's processed data to identify instances when the reported performance on a metric (e.g., the percentage of people who screened positive for depression and had an appropriate follow-up plan documented on day of screening) varied from the partner's expectation or goal. Several partners engaged in detailed reviews with their clinical staff leadership to understand the causes of the variances. Some partners identified responsive data in their EHR that was not being pulled into their data reports, corrected those omissions, and saw their performance improve. For example, SMHC initially reported a "pass" rate for Assess Screen 1's Comprehensive Core Standardized Assessments (CCSA) in the teens. Review by the CIO and clinical representative of the data fields in SMHC's case record system being pulled identified data not being included in the reporting; once included, performance on that measure improved 30% immediately from that one change to the data pull. Other partners had one experience quality review is specifically intended to address: inconsistency following work protocols or work flows that result in patients not receiving an assessment or recommended evaluations, etc., and/or inconsistency in where or how providers report that patient information in their EHR. Several partners with that experience used their performance information to address those inconsistencies, with an eye to seeing performance improve going forward.

Two partners that had not reported any CCSAs being performed in earlier reporting periods looked more closely at their specialized units to confirm what had been suspected; that some units were doing CCSAs but related data was being captured in disparate sections of the EHR and not being aggregated to report a "pass". Lamprey Health Care found that to be the case and is now seeing "confirmed passes" for CCSAs; Greater Seacoast Community Health Center is engaged in that review currently.

One metric that will not see all partners reporting a high confirmed pass rate before the end of the DSRIP project is Assess Screen 4, "Smoking and Tobacco Cessation Screening and Counseling for Tobacco Users by IDN Primary Care and BH Providers". While all of our SUD provider partners do screen for tobacco use, most of them do not routinely introduce or encourage a tobacco cessation intervention for their clients. According to their clinical teams, in the treatment of a substance or alcohol disorder, smoking is often a coping mechanism that supports a patient's recovery; those partners see tobacco use as not desirable, but a useful tool in the overall picture of a patient's recovery.

Finally, Exeter and Wentworth Douglass hospitals, which were unable to provide data on the full-year metrics for 2018, are now prepared to do so for 2019 as the result of work done in the reporting period. Testing of files on those metrics has already occurred with Exeter, and Wentworth Douglass staff are actively working with their Partners Healthcare IT colleagues to develop the reports that will pull and report the full-year metrics data from EPIC, their recently implemented EHR.

Shared Care Plan:

[Some repeated background information from last SAR for new DHHS staff's benefit.] As the result of several proposed non-IDN state-wide electronic integration efforts, partners' use of Care Director was paused [in Jan-June 2019 reporting period] in order to evaluate other Shared Care Plan solutions or equivalent/connected technologies being considered around the state. Our goal remains to utilize electronic solutions that IDN partners want to and will use and that can be sustained after DSRIP. Thus, a reevaluation of the solutions introduced in the market since Care Director was chosen is under way. Use of Care Director

was paused so as not to ask partners to invest more time into a solution that may be replaced with one that will meet more partner needs (like SCP, closed loop referral, DSM, etc.) on one platform like the UniteUs solution, which is under review by other state-wide programs our partner agencies participate in. The goal of this pause was to avoid as much duplication of functionality as possible while interoperability was evaluated.

Another reason for the pause in further implementation was that subsequent to our purchase of Care Director, the vendor removed a key function from the Care Director platform, resulting in its inability to provide a patient-matching service, as called for in its contract with the IDN. That function was specifically needed to handle ADT data as Care Director was to be a platform on which our social services partners (and clinical partners, if they so choose) would also access ADT data for care coordination purposes in the shared care planning process. Our discovery of this change in 2019 and uncertainty that the vendor would be able to provide a solution to that change in function, combined with an awareness of newer products on the market that could now meet multiple IDN partner needs (shared care plans and closed loop referrals), prompted exploration of those new products.

The review of other platforms was completed in this reporting period and UniteUs was determined to be a solution that could meet IDN-6's partner's shared care plan functionality needs, as well as provide a closed loop referral function. Currently, multiple key entities, including "211", several IDNs, and DHHS, are negotiating the purchase of UniteUs for statewide use.

Event Notification Services:

Exeter Hospital approved the sharing of its Admissions, Discharges, Transfers (ADT) data via IDN-6's Event Notification Service during this reporting period. Discussions began with Exeter's current ENS vendor to map out the how the sharing will occur via existing interfaces between MAeHC and Patient Ping, the IDN's and Exeter's ENS vendors, respectively.

Work that began in early 2019 with a community mental health center partner (Seacoast Mental Health Center) to evaluate the ability of its care records system to accept an ADT data feed continued. This is data SMHC has expressed strong interest in receiving. Once a determination was made that its system could not do so, a work-around utilizing another feature of the ENS was identified which will allow SMHC to receive ADT data and utilize it in care coordination.

Three Region 6 hospitals have expressed interest in sharing ADT data regionally. As reported in earlier SARs, two of those hospitals were unable to dedicate IT resources to setting up an electronic interface for ADT data sharing in 2019 while they were converting to a new EHR (Wentworth Douglass Hospital) or seeking acquisition by another health system (Frisbie Memorial Hospital). With its EHR conversion now implemented, Wentworth-Douglass actively engaged during the reporting period in discussions to approve sharing ADT data with IDN-6's partners. Approval is now a more lengthy process, as WDH is now part of Partners Healthcare, which has more bureaucratic levels to navigate. That said, the desire to share ADT data has been expressed clearly and may be an easier process given an existing relationship between the IDN's and Partners Healthcare's ADT vendors. It is still hoped that a successful acquisition of Frisbie Memorial Hospital by Portsmouth Regional Hospital, which remains pending, will lead to a decision to share ADT within the region; however, it is unknown how likely the hospitals are to provide any IT support to this effort in 2020, given how complex this merger will be, if approved.

Additional Technology Support:

Additional technology support was provided by IDN-6, in conjunction with IDN-3, to Lamprey Health Services to allow for timely and secure messaging between and among staff. An investment was made in Lamprey to purchase an electronic solution ("TigerText") to the communication challenges it has had historically that are largely due to it having multiple buildings at multiple locations. Tracking down a provider who practices in multiple locations has often been time-consuming for Lamprey staff and has resulted at times in critical communications being delayed. For example, a Nashua provider was working with a patient who needed a warm handoff to someone in behavioral health for an ultimate MAT referral. There wasn't a behavioral health provider in Nashua that day, so they ended up calling a site manager's cell phone, and she ended up walking to another building to find the MAT nurse in Newmarket to complete the referral and schedule an intake appointment. The IDNs jointly funded the purchase of 120 licenses for TigerText, a cloud-based healthcare messaging application that can be downloaded onto desktop computers and mobile devices to allow authorized users to access Protected Health Information and communicate PHI to other authorized users within a private network. This purchase enables secure, HIPAA-compliant, instant messaging in and between Lamprey's clinics.

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.

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.

WRITEBACK RESPONSE: There are no substantive updates to report.

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	*As of 6/30/19	As of 12/31/19
1	# of participating partners reporting access to a shared care plan solution	25	0	10	0	17(12)	17(12)
2	# of participating partners reporting meaningful use of a shared care plan solution	20	0	7	0	10(7)	10(7)
3	# of eligible participating partners utilizing ONC Certified EHRs (CEHRT)	8	5	8	9	19(10)	19(10)
4	# of participating partners reporting contributions to data aggregator	10	0	2	5	20(13)	20(13)
5	# of participating partners reporting access to event notification solution	10	0	0	0	4(1)	4(1)
6	# of participating partners reporting meaningful use of event notification solution	10	0	0	0	4(1)	4(1)
7	# of participating partner hospitals reporting ADT submissions to IDN associated event notification	4	0	0	0	0	0
8	# of eligible participating partners utilizing ONC Certified technologies	10	5	8	9	21(14)	21(14)

9	# of eligible participating partners capable of conducting e-prescribing	**8**	**2**	**8**	**9**	**17(**10**)**	**17(**10**)**
10	# of eligible participating partners capable of creating and managing registries	**10**	**0**	**7**	**7**	**20(**13**)**	**20(**13**)**
11	# of eligible participating partners able to electronically exchange relevant clinical data w/ others incl. NH Hospital	**8**	**0**	**5**	**5**	**16(**9**)**	**16(**9**)**
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**	**52**	**52**
13	# of eligible participating partners reporting client access to bi-directional secure messaging, records, apt scheduling, prescription & referral management	**8**	**0**	**4**	**4**	**16(**9**)**	**16(**9**)**
14	# of eligible participating partners identified to report via the dataaggregator	**10**	**1**	**3**	**13**	**21(**14**)**	**21(**14**)**

* *[Repeating for the new DHHS staff benefit] The explanation of numbers in parenthesis in narrative immediately below.*

For Example,

Where the metric is reported as X, (Y)

X = 4: Recalibrated partner count inclusive of enterprise and multiple sites (i.e. Wentworth Douglas Hospital AND Wentworth Health Partners Internal Medicine and Lee Family Practice and Hilltop Family Practice)

Y = 1: Previously reported partner counts that did NOT distinguish between enterprise entity and unique partner sites (i.e. Wentworth Douglas Hospital System inclusive of hospital and primary care practices)

Progress toward Evaluation Targets identified in Table A2.4:

When the A2-4 targets for the various Health Information Technology efforts were selected early in the DSRIP planning process, the targets were selected based on the information available at the time and with reasonable assumptions tied to that information. A factor that was not known at the time was the number of primary practices of each IDN partner that would engage in IDN-lead integration efforts. Many of the initial targets were based on a count of partners, not the number of primary practice offices at each partner. Consequently, as the IDN gained greater knowledge of each partner's organizational structure and was invited to do integration work with their primary practices, the number of IDN efforts with an IDN partner grew to one, two, or even three primary practice sites, along with the work being done with some partners at the enterprise level, too. That new information, plus other factors, led to a recalibration of how the partners are counted for A2-4 measures to more accurately reflect the extensive IDN work being done in the region.

Note that none of the targets have changed, just how we count the partners and their practices has. And, this recalibration does not cause the IDN to meet targets we would not have met under the old counting system; in all instances where our targets are met in this reporting period, they are met regardless of whether they are counted the old way (partners at the enterprise level) or the new way (partners at the enterprise level plus the number of primary practices we are working with).

Performance Measure Name:

1.**Partners accessing a shared care plan solution**: target is not met. The utilization of Care Director, IDN-6's shared care plan platform, was paused in 2019, due to concerns it was not going to be the solution hoped for when it was selected. Subsequent to our implementation of the program with partners, the vendor removed a key functionality from the Care Director platform, resulting in its inability to provide the patient-matching service, which was specifically needed to handle ADT data, as called for in its contract with the IDN; Care Director was to be a platform on which our social services partners (and clinical partners, if they so choose) would access ADT data for care coordination purposes in the shared care planning process. Our uncertainty that the vendor would be able to provide a solution to that change in function, combined with an awareness of newer products on the market that could meet multiple IDN partner needs (shared care plans and closed loop referrals), prompted exploration of those new products. The result was a preliminary decision to proceed with the purchase of UniteUs to provide the shared care planning and closed loop referral functions, a decision that will become final upon confirmation of the adoption of UniteUs by statewide entities, such as "2-1-1" and DHHS. Access by our social service partners to patient/client's ADT data now may be via our ENS vendor's portal exclusively.

2. **Meaningful use of a shared care plan solution**: target is not met. IDN staff members are utilizing Care Director; IDN partners are not. Our goal remains to utilize electronic solutions that IDN partners want to and will use and that can be sustained after DSRIP. Thus, a reevaluation of the solutions introduced in the market since Care Director was chosen resulted in the selection of UniteUs as our new shared care plan tool. With the previously reported interventions across partner agencies in the last SAR, the IDN has furthered the meaningful use of shared care plans, with more to come with the implementation of UniteUs.

3. **Utilizing ONC certified EHRs**: Previously met.

4. **Contributing to data aggregator**: Previously met.

5. **Access to event notification solution**: target is not met. As reported in previous SARs, an ENS vendor (MAeHC) was selected, is prepared to go live as of the reporting period, and is discussing with IDN

partners the EMR system specs required to receive an ADT feed. IDN staff discussions with Exeter Health Resources (EHR) in this reporting period resulted in their agreement to share their ADT data so full implementation of our ENS will happen in Quarter 1 2020. As reported previously, two of the region's four hospitals were unable to dedicate IT resources to setting up an ADT feed to MAeHC in 2019 while they were converting to a new EHR (Wentworth Douglass Hospital) or merging with another health system (Frisbie Hospital). That said, during the last quarter of 2019, Wentworth Douglass expressed anew its interest in sharing ADT data so work toward that end continues. Frisbie Hospital, which may be acquired by Portsmouth Regional Hospital, has remained noncommittal while its focus is on its acquisition. Portsmouth Regional Hospital itself has not been responsive to requests to discuss sharing ADT data

6. **Meaningful use of event notification solution**: target is not met. Please also see response to #5 above. Our work to implement the IDN's ENS is expected to be complete in the next reporting period. While the IDN's ENS was not implemented in the reporting period, the work IDN staff has done, as reported in the last SAR, has furthered the meaningful use of by Exeter's hospital and three practices of its existing ENS.

7.**Hospitals reporting ADT submissions to IDN-associated ENS**: target is not met. Explanation provided in #5 above.

8.**Partners utilizing ONC Certified technologies**: Previously met.

9.**Partners capable of conducting e-prescribing**: Previously met.

10. **Partners capable of creating and managing registries**: Previously met.

11.**Partners able to electronically exchange relevant clinical data w/others including NH Hospital**: Previously met.

12.**Partners able to protect electronically exchanged data in a secure and confidential manner**: Previously met.

13. **Partners reporting client access to bi-directional secure messaging, records, appointment scheduling, prescription and referral management**: Previously met.

14. **Eligible participating partners identified to report via the data aggregator**: Previously met.

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

	IDN Workforce (FTEs)						
Staff Type	**Projected Total Need**	**Baseline Staffing on 6/30/17**	**Staffing on 12/31/17**	**Staffing on 6/30/18**	**Staffing on 12/31/18**	**Staffing on 6/30/19**	**Staffing on 12/31/19**
Director of Solutions Integration	1	0	0	0	1	1	1

A Director of Solutions Integration was hired and started with Region 6 IDN in August 2018. 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	Jan-Jun 2019 Actuals	Jui-Dec 2019 Actual	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	$ -	$ -	$ -	$ -	$ -	$ -	$ 150,000	$ 150,000	$ 300,000
								$ -	$ -
Project Infrastructure								$ -	$ -
Equipment	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Operations	$ -	$ -	$ 2,036	$ -	$ -	$ -	$ -	$ -	$ 2,036
								$ -	$ -
Workforce								$ -	$ -
Fees/Outside Placement	$ -	$ -	$ 19,500	$ -	$ 18,914	$ 49,299	$ 80,000	$ 90,000	$ 257,713
Recruiting/Retention	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Training	$ -	$ -	$ 3,411	$ -	$ 1,509	$ 1,320	$ 5,000	$ 5,000	$ 16,240
Other	$ -	$ -	$ -	$ -	$ -	$ 1,097	$ -	$ -	$ 1,097
									$ -
Technology	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Data Agg	$ -	$ -	$ 96,195	$ 81,730	$ 115,100	$ (20,423)	$ 60,000	$ 60,000	$ 392,602
ENS	$ -	$ -	$ -	$ 46,215	$ -	$ -	$ 100,000	$ 25,000	$ 171,215
SCP	$ -	$ -	$ 33,417	$ 232	$ -	$ -	$ 125,000	$ 100,000	$ 258,649
CLR Platform	$ -	$ -	$ -	$ -	$ -	$ -	$ 100,000	$ 75,000	$ 175,000
Other	$ -	$ -	$ -	$ 21,845	$ -	$ -	$ 72,000	$ 72,000	$ 165,845
								$ -	$ -
Totals	$ -	$ -	$ 154 559	$ 150 022	$ 135,523	$ 31,293	$ 692 000	$ 577 000	$ 1,740,397
DY 2019						$ 166,816			

A2 Budget Narrative:

- The budget details the actual and projected spend for the three key technology projects, as well as additional projects that are supporting DSRIP goals, closed loop referrals, and improved care coordination communications.
- Fees and outside services are 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.

The Region 6 IDN projected budget for 2020-2021 reflects scheduled payments per vendor contracts for MAeHC's Quality Reporting Service and Event Notification Service and Allscripts' Care

Director solution.* As explained elsewhere in this report, as implementation of Care Director progressed in 2019, IDN staff realized that Allscripts had removed a key function from Care Director after it was purchased. Developing a work-around for the missing function, a key deliverable, was going to result in additional IDN expense and human resources for a "fix" that was not as effective as the original function promised in the Allscripts contract. As such, payments to Allscripts were stopped and negotiations to reach a fair settlement for the breach of contract are ongoing. However, since we cannot predict how much of the projected payments called for under the contract will be negotiated away, they have not been removed from the budget.

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 via CMT. The GIS mapping project is active 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.

As partners deepen their understanding of and involvement in systems integration, greater technology needs requiring investments have surfaced. Those resources have been used to support Lamprey Health Care's purchase of 120 licenses for TigerText, a cloud-based healthcare messaging application that can be downloaded onto desktop computers and mobile devices to allow authorized users to access Protected Health Information and communicate PHI to other authorized users within a private network. This purchase enables secure, HIPAA-compliant, instant messaging in and between Lamprey's clinics, as well as to other providers on the network.

Funding has also been budgeted to accommodate any HIT/HIE solutions, training or equipment necessary to meet DSRIP performance expectations.

** Note: A week before the deadline for this report's submission, MAeHC announced it is terminating its QRS contract with the IDNs and is also ceasing to provide an ENS product. This will impact IDN-6 on both fronts and we are still evaluating that impact. Because we do not yet know what related changes will result to our HIT budget, we have not amended it for this submission. We do know that budgeted amounts that were to be paid to MAeHC will now become available for other technology solutions, and it is possible that our next approach to providing an ENS to our partners will cost less; however, we do not know what further QRS reporting will cost. The impact of MAeHC's departure, combined with the Allscripts' payment dispute, means our HIT budget will remain fluid until more information on how both will be resolved is available.*

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 Region 6 IDN B1 partners, except 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 workflows, expected uses of shared care plan platforms, and the ADT feed. All B1 partners will be invited to participate in shared care plan opportunities and to access the ENS in any of the three paths described elsewhere in this section.

Table A2-7: Key Organizational and Provider Participants

Organization Name	Organization Type	Associated with IDN Projects
Appledore Family Medicine	HBPC	A1, A2, B1
ALOFT Integrated Wellness	BH Private Practice	A1, 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
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
Homeless Center for Strafford County	**Soc Service**	**E5**
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
Lee Family Practice	HBPC	A1, A2, B1
New Generation, Inc	Soc Service	A1, 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
Somersworth Ready Together / United Way of Greater Seacoast	Soc Service	A1, E5
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, E5
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 Medical 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.

Table A2.8 – Data Agreement Status

Organization Name	Data Sharing Agreement / Business Associate Agreement Status
Community Partners CMHC	EXECUTED
Dover Pediatrics	EXECUTED
Exeter Hospital - Core Family & Internal Medicine - Seacoast Family Practice	EXECUTED
Frisbie Hospital - Rochester Pediatrics - Skyhaven Internal Medicine - White Mountain Medical Center	EXECUTED EXECUTED
Greater Seacoast Community Health Center- Families First	EXECUTED
Greater Seacoast Community Health Center- Goodwin Community Health	EXECUTED
Greater Seacoast Community Health Center- Lilac Pediatrics	EXECUTED
Hope on Haven Hill	EXECUTED
Lamprey Health Care CHC- Newmarket	EXECUTED
Lamprey Health Care CHC- Raymond	EXECUTED
Portsmouth Hospital - Appledore	EXECUTED
Seacoast Youth Services	EXECUTED
Seacoast Mental Health Center	EXECUTED
SENHS	EXECUTED
Wentworth Douglass Hospital - Wentworth Health Partners - Hilltop Family Practice - Lee 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

B1-2. 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 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.

B1-2 Narrative

Many IDN 6 regional practice partners have made significant progress towards Coordinated Care practice designation during this report period. To date, Region 6 has ***six Coordinated Care practices*** and ***five Integrated Care Practices***. Essential elements of both Coordinated Care and Integrated Care Practice designations have been successfully implemented or further developed by multiple partners. A narrative summary of each practice's progress is below. Information about *regional* projects and support efforts are discussed in more detail following the practice narratives.

All regional B1 partners have identified Multi-Disciplinary Core Teams and the three models for MDCT case reviews are further explained in section B1-8e. IDN 6 supports multiple ongoing trainings and Community of Practice models to support both MDCT members and partner practice staff. All MDCTs have been trained in the core DSRIP trainings and have access to ongoing training in these essential areas.

All practice partner Site Self-Assessments with strategy meetings were complete during this reporting period. The SSA remains a valuable tool in support of the organization-level change that the DSRIP is designed to impact. Partners report that the SSA process, with the introduction of the SAMHSA levels of integration, helped create common language and motivation among staff with varying levels of experience in integration work and integrated practice settings. The Blueprint tool introduced by Citizens Health Initiative (CHI), combined with expert facilitation, helped practices set realistic goals that continue to inform their B1 integration work. A repeat round of SSAs for all partners is planned for July - August 2020. Regional themes are highlighted below.

Table B1-2a: Site Self-Assessment Themes

SSA Regional Themes/Sub-Themes	Examples
Referrals/Connections Supports	Connecting with PCPs; Routing Patients to MH services; SUD Services; Connecting with University supports; Coordination with community resources;
Screening and Workflow Supports	SDOH; SUD tools; Triaging patients with MH issues; intake process/criteria; scheduling
Training	BHI; Interdisciplinary
Team-Based Care	Huddles; Role Definitions; Multi-disciplinary Team Meetings; Care coordination meetings; Connecting across disciplines
Workforce Support	Dedicated Care Managers; Filling open positions;
Quality Improvement Support	Communication within practice; Data collection and reporting; data; access redesign
Reimbursement/Payment	Leveraging MCO services; budget

Eight practice partners initiated Behavioral Health Integration Enhancement projects during this reporting period. Kick-off meetings and further project development took place in July and August 2019 with a project end date of July 31, 2020. These projects are specifically designed to facilitate practice progress on the Coordinated Care and/or Integrated Practice continuum, leveraging the work of the practices in their Site Self-Assessments. Project details are listed in Table B1-2b – project final design may vary slightly based on facilitated project discussion during the next report period.

Table B1-2b: B1 project approved Behavioral Health Integration Enhancement Projects

B1 Practice Partner	Behavioral Health Integration Enhancement Project work area
Community Partners & Goodwin Community Health	Expand capacity of current ProHealth / SAMHSA project: • Increase co-located services created via the ProHealth grant. Goal: Adjust the current service model for shared clients to receive Goodwin Community Health services at the Community Partners location in Rochester. This will allow clients with SPMI age 35+ and those clients who cannot qualify for the ProHealth project to receive Primary Care services at their CMHC. • Creation of joint services protocols for this expanded population
Dover Pediatrics	Provide immediate, effective same day intervention, utilizing a midlevel mental/behavioral provider, as well as short term follow up care for minor or moderate BH problems and appropriate timely referrals for BH services: • Develop special referral procedure to outside community members to ensure quick referral turn arounds. This will include tracking outcomes of referrals • Develop warm hand offs protocol for providers and mental health providers • Work with computer company PCC to make sure our chart can have a special behavioral health component • Develop protocol for the medical assistants who triage phone calls as it applies to mental/behavioral health • Ensure billing department bills appropriately for services • Modify consent forms to include mental/behavioral health • Provide timely appointments for patients in crisis • Screen all ages for mental/behavioral health issues • Warm hand offs to in-house mental/behavioral health provider • Develop time slots for mental/behavioral health provider to follow up with identified patients • Further develop screening protocols; evaluate different screening tools for different age groups
Lamprey Health Care - Newmarket	Develop a multi-faceted approach to our integrated Behavioral Health Services, utilizing the Innovative Care for Chronic Conditions Model. • MDCT daily huddles to review the day's schedule and pro-actively identify patients who may benefit from a behavioral health intervention • Refine workflows and protocols for continuity and coordination of care, • organizing and equipping the health care team, and utilization of information systems to coordinate care • Promote consistent funding through strengthened MDCT collaboration with the billing/finance department
Lamprey Health Care - Raymond	Develop a multi-faceted approach to our integrated Behavioral Health Services, utilizing the Innovative Care for Chronic Conditions Model. • MDCT daily huddles to review the day's schedule and pro-actively identify patients who may benefit from a behavioral health intervention • Refine workflows and protocols for continuity and coordination of care, • organizing and equipping the health care team, and utilization of information systems to coordinate care • Promote consistent funding through strengthened MDCT collaboration with the billing/finance department
Core Family & Internal	The CFIME team would like to engage the resources available through the IDN and Citizen's Health Initiative to assist with standardizing and spread of a highly reliable

Medicine Exeter	huddle process. • Create comprehensive interdisciplinary patient care plans for patients with behavioral health needs as the capacity does not exist within our current electronic medical record. • Develop in-person and electronic workflows to increase effective, timely and reliable knowledge transfer
Seacoast Family Practice	The Seacoast Family Practice team would like to engage the resources available through the IDN and Citizen's Health Initiative to assist with standardizing and spread of a highly reliable huddle process. • Create comprehensive interdisciplinary patient care plans for patients with behavioral health needs as the capacity does not exist within our current electronic medical record. • Develop in-person and electronic workflows to increase effective, timely and reliable knowledge transfer
Wentworth Health Partners – Internal Medicine	The goal of the project is to identify and standardize workflow and referral process for patients who have been administered a PHQ-2 / PHQ-9 at the PCP level. • Workflows for collaboration with members of the PCP team including MD, BHC, SW and Case Manager • Benchmark scores on PHQ-9 will be identified and a standardize response will be developed • Standardize PCP response to PHQ scores across practices with IBHC's • Metrics will include PHQ-9 scores at annual PCP visit and follow up score at conclusion of intervention for those patients receiving IBH services, number of warm handoff's requested, length of stay with IBH services and provider satisfaction • Increase primary care providers' confident and capacity operating in an integrated behavioral health practice with guidelines for responses to PHQ-9 scores to minimize outside referrals for generalized behavioral health conditions.
Hilltop and/or Lee Family Practices	The goal of the project is to identify and standardize workflow and referral process for patients who have been administered a PHQ-2 / PHQ-9 at the PCP level. • Workflows for collaboration with members of the PCP team including MD, BHC, SW and Case Manager • Benchmark scores on PHQ-9 will be identified and a standardize response will be developed • Standardize PCP response to PHQ scores across practices with IBHC's • Metrics will include PHQ-9 scores at annual PCP visit and follow up score at conclusion of intervention for those patients receiving IBH services, number of warm handoff's requested, length of stay with IBH services and provider satisfaction • Increase primary care providers' confident and capacity operating in an integrated behavioral health practice with guidelines for responses to PHQ-9 scores to minimize outside referrals for generalized behavioral health conditions.

Practice Partner Narrative

Independent Practice Partners

Dover Pediatrics

Dover Pediatrics became a B1 practice partner in December 2018. The practice has achieved NCQA Level III Patient-Centered Medical Home designation. Their priority was hiring an embedded MSW Care Coordinator. IDN 6 Clinical Director provided technical assistance developing a job description for this 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 are also part of the multidisciplinary core team and initiate and follow up with referrals made to specialty behavioral health services in the community.

The IDN has funded clinical supervision for the new BHC to work toward licensure. She achieved licensure as an LICSW in January 2020, significantly impacted the practice's ability to bill for her work. They participated in the Site Self-Assessment to further define which elements of integrated practice they want to develop. Dover Pediatrics has identified a goal to enhance their NCQA Level III Medical Home status by applying for the Distinction in Behavioral Health Integration. This will reflect their ability to provide comprehensive care in the practice to children, adolescents, and their families identified as having complex medical, behavioral and/or social service needs.

Dover Pediatrics completed the SSA process in December 2018, identifying the following goals:

1. Creating a BH Protocol
2. Express/Communicate Value of BHC to Team
3. Psychiatry at WDH, what can they provide to the team? Consults, Look at different models
4. Follow Up on ER/ED Utilization

In service of these goals and their alignment with the DSRIP goals, Dover Pediatrics' MDCT members have quickly become involved in regional support efforts including:

- Certificate in Pediatric and Behavioral Health Integration: March 2019-September 2019
- Pediatric Psychiatry for MDCTs
- Peer Support and Supervision Project for integrated BHCs
- B1 Behavioral Health Integration Enhancement Initiative

In addition, Dover Pediatrics recently executed an MOU with Great Bay Mental Health / Wentworth Health Partners for 2 hours per month of psychiatric consult. Workflows to enhance their use of this time are included in their B1 Behavioral Health Integration Enhancement Initiative work.

Hospital Based Primary Care Partners

Portsmouth Regional Hospital (PRH) / HCA is currently involved in acquisition negotiations with Frisbie Memorial Hospital, which began during this reporting period. It is the IDN's expectation that regional impact of this acquisition will be to strengthen the service delivery in Strafford County and allow for increased collaborative care planning and service delivery between Rockingham and Strafford-based service entities. IDN 6 obtained a Data Sharing Agreement with PRH / HCA during this reporting period. To date, one HCA-affiliated practice has become a B1 practice partner.

Strong collaborative work with the PRH Behavioral Health Unit (BHU) continues with PRH hosting the Portsmouth / Seacoast Community Care Team and active referral relationships from both the practice partner and the BHU to the IDN 6 Care Transitions team.

The Director of Nursing from the newly established PRH Emergency Room in Dover has joined the Strafford County Community Care Team. The Strafford CCT also includes Wentworth-Douglass Hospital and Frisbie Memorial Hospital's ED and inpatient Case Managers, allowing for enhanced direct collaboration and shared care planning for ED utilizers and patients with frequent hospitalizations.

The IDN 6 Clinical Director has met regularly during this reporting period with the Program Director for the Portsmouth Family Medicine Residency program to establish participation by partners in the new residency programs that will begin in the next two years. These are in family medicine, internal medicine, and psychiatry.

PRH/HCA participates in the following regional efforts in addition to the practice-level engagement, each is discussed in more detail in the appropriate reporting section:

Regional BH service provider collaboration

Portsmouth, Exeter, and Strafford County CCT

Appledore Family Practice / HCA

Appledore Family Practice became a B1 practice partner in October 2018. The practice affiliation with HCA / Portsmouth Regional Hospital and their service to both pediatric and adult Medicaid recipients makes them an important primary care service provider in our region. During the site self-assessment strategy meetings, the practice priorities were identified as:

1. Routing patients appropriately to BH services
2. SDoH screening and support
3. PHQ-2/PHQ-9 screening workflow with Medical Assistants

The practice first chose to hire a Nurse Care Coordinator / Case Manager to facilitate SDoH support needs and track appropriate BH referrals. This position was filled in May 2019. Recent meetings with Appledore and IDN 6 have informed the start of their work in development of workflows and protocols regarding:

- 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)

Ongoing quarterly meeting are planned to further develop their current screening and referral workflows for PHQ2/9 and substance use.

Work will continue to support Appledore's MDCT – the practice currently participates in the following regional MDCT support opportunities:

- Pediatric Psychiatry for MDCTs
- Community Care Team in Exeter, Portsmouth, and Strafford

E**xeter Hospital / Exeter Health Resources (EHR)** have entered into a merger agreement with Massachusetts General Hospital with the conversion of the EMR to Epic pending. Exeter Hospital / Exeter Health Resources and the B1 practice partners joined the IDN 6 primary care integration project in May 2018 and November 2018 respectively. Since that time, they have been highly engaged.

Exeter Hospital / Exeter Health Resources established an IDN Project working group that meets quarterly. This regular structure and communication have allowed for significant progress in project development and regional collaborative efforts. The leadership recognizes the IDN as a key strategic partner in supporting primary care development on the Coordinated Care practice continuum.

Exeter Hospital hosts the newly formed Exeter County Community Care Team (CCT). Case Managers have become active with the CCT and provide referrals regularly. The Exeter CCT distribution list includes Portsmouth Regional Hospital's ED and BHU Case Managers, allowing for direct collaboration and shared care planning for ED utilizers and patients with frequent hospitalizations.

Exeter Health Resources has been approved for additional support to increase the number of Behavioral Health Clinicians and Care Coordinators in their primary practice settings in CY2020.

Exeter Hospital / Exeter Health Resources also participate in the following regional efforts in addition to the practice-level engagement:

Community Care Team in Exeter and Portsmouth

Clinical Advisory Team

Core Family and Internal Medicine Exeter / EHR

Core Family and Internal Medicine Exeter (CFIME) is a primary care practice with six providers and a new LICSW. EHR identified a need for a behavioral health specialist in the practice to help with screening and referrals for both psychological and social support. They felt that a Licensed Independent Social Worker was the role they needed to perform these functions. All roles in the multidisciplinary team were included in the hiring of this position with the IDN paying the startup costs.

During the Site Self-Assessment strategy meetings, the practice priorities were identified as:

1. Improved communication within practices
2. Role definitions
3. SUD Services/Tools – MAT / MAR services are provided at this practice

The practice goals for their B1 Behavioral Health Integration Enhancement Initiative align well with their SSA goals and the DSRIP elements.

CFIME's MDCT members have quickly become involved in regional support efforts including:

- Pediatric Psychiatry for MDCTs
- Peer Support and Supervision Project for integrated BHCs
- B1 Behavioral Health Integration Enhancement Initiative
- Community Care Team in Exeter and Portsmouth

Seacoast Family Practice / EHR

Seacoast Family Practice is a small practice with four providers and a new MSW. The team at this practice participated in the Site Self-Assessment and established priorities for the coming year. EHR identified a need for a behavioral health specialist in the practice to help with screening and referrals for both psychological and social support. They chose to hire an MSW at this practice, in contrast to a LICSW. The different models (LICSW vs MSW) will help inform EHR of the viability of each role for potential development in additional practices in the EHR system. All roles in the multidisciplinary team were included in the hiring of this position with the IDN paying the startup costs.

During the Site Self-Assessment strategy meetings, the practice priorities were identified as:

1. Improved communication within practices
2. Role definitions
3. SUD Services/Tools

The practice goals for their B1 Behavioral Health Integration Enhancement Initiative align well with their SSA goals and the DSRIP elements.

Seacoast Family Practice's MDCT members have quickly become involved in regional support efforts including:

- Pediatric Psychiatry for MDCTs
- Peer Support and Supervision Project for integrated BHCs
- B1 Behavioral Health Integration Enhancement Initiative
- Community Care Team in Exeter and Portsmouth

Wentworth-Douglass Hospital (WDH) and Wentworth Health Partners (WHP) *are now a subsidiary of* Massachusetts General Hospital. This merger will resulted in an EMR change to Epic October 2019. While this has impacted the entity's ability to enhance their data reporting, the new EMR system will allow for more local reporting capacity. This will give participating practice-level partners increased ability to use local electronic tools to identify at-risk patient panels and the IDN remains ready to assist with development of these tools.

There are three WHP-affiliated B1 practice partners with primary care behavioral health clinicians embedded. Recently a fourth practice, Adult and Children's Medicine of Dover added a BHC which is supported by the IDN, although not a formal B1 partner due to late entry to the project.

The Behavioral Health medical director has encouraged the use of the e-consult function within the EMR with primary care providers to begin to increase the consultative capacity of psychiatry which is a limited (two psychiatrists and four psych NP's) resource in the system. Providers have begun to use this process and report satisfaction with the ease and quickness of the response. Even though they would like to refer their more complex patients to psychiatry to manage, the lack of available access makes this difficult. It is feasible for more complex patients to be referred. The goal of the e-consult is to reduce the number of patients who could be managed by a PCP from being placed on a waitlist, therefore improving access to more complex patients in a shorter period. They do have a well-managed waitlist for patients needing medication management. The primary care physicians can treat more patients with the introduction of consultative psychiatry services.

On June 17, 2019, WDH provided a waiver training program which several providers from WDH and across the region attended. The goal was to train WHP primary care providers to receive patients into their practice who were started in the emergency room on buprenorphine. The ED efforts are discussed further in the D Project section of this report.

WDH remains an active participant in the Strafford County Community Care Team. The Strafford CCT also includes Frisbie Memorial Hospital's ED and inpatient Case Managers and the PRH Dover ED Nursing Coordinator allowing for direct collaboration and shared care planning for ED utilizers and patients with frequent hospitalizations.

WDH / WHP also participate in the following regional efforts in addition to the practice-level engagement:

Regional BH service provider collaboration

Strafford County CCT

Wentworth Health Partners Internal Medicine

Wentworth Health Partners Internal Medicine practice is the result of three outpatient practices merging to form one PCMH practice. The CMO of the ambulatory practices is one of the medical providers in this practice and has been a champion for integrated care embedded in the team. One of the Great Bay Mental Health clinicians was brought into the practice and began to work as an embedded integrated behavioral health resource. They also have other related resources in the form of nurse care coordination and social work referral services.

The IDN supported and was part of an internal quality improvement process that led to the development of processes and workflows to ensure the right level of service is provided to patients by all these resources working together. This practice is large and could support 3-4 embedded primary care behavioral health clinicians. At this point a second position was added and has begun to work in the practice. The Site Self-Assessment goals included:

1. Looking at BHCs schedule
2. Budget
3. Making connections across physical health – MH/BH

Work will continue to support Wentworth Partners Internal Medicine's MDCT – the practice currently participates in the following regional MDCT support opportunities:

- Peer Support and Supervision Project for integrated BHCs
- B1 Behavioral Health Integration Enhancement Initiative
- Community Care Team in Strafford County

Hilltop Family Practice / WHP

Hilltop Family Practice is a smaller family practice with two providers and one LICSW. The practice had turn-over of one provider during the report period but has remained engaged in project initiatives as time and capacity allow. The practice went through the Site Self- Assessment process and identified strategic initiatives they would like to work on for a defined population that would benefit most by using integrated care services.

1. Care coordination meetings
2. Huddles
3. Training support

The practice goals for their B1 Behavioral Health Integration Enhancement Initiative align well with their SSA goals and the DSRIP elements. We look forward to working more concretely with this practice in the next report period.

Work will continue to support Hilltop Family Practice's MDCT – the practice currently participates in the following regional MDCT support opportunities:

- Pediatric Psychiatry for MDCTs
- Peer Support and Supervision Project for integrated BHCs
- B1 Behavioral Health Integration Enhancement Initiative
- Community Care Team in Strafford County

Lee Family Practice / WHP

Lee Family Practice has five providers and one LICSW. The practice has had a behavioral health provider as part of their team for years. This position is partially supported by the IDN. The practice recently went through the Site Self-Assessment process and identified strategic initiatives they would like to work on for a defined population that would benefit most by using integrated care services.

1. Training (just in time training, MH First Aid, De-escalation)
2. Add Measurement pieces to track BH patients with chronic conditions
3. Patient feedback survey
4. Make notes available to all providers

The practice goals for their B1 Behavioral Health Integration Enhancement Initiative align well with their SSA goals and the DSRIP elements. We look forward to working more concretely with this practice in the next report period.

Work will continue to support Lee Family Practice's MDCT – the practice currently participates in the following regional MDCT support opportunities:

- Pediatric Psychiatry for MDCTs
- Peer Support and Supervision Project for integrated BHCs
- B1 Behavioral Health Integration Enhancement Initiative
- Community Care Team in Strafford, Portsmouth, and Exeter

Frisbie Memorial Hospital (FMH) and Frisbie Physician Practices has recently entered acquisition negotiations with Portsmouth Regional Hospital/Hospital Corporation of America (HCA). New projects at Frisbie have been curtailed as the process to make this acquisition official takes up to a year.

IDN team members met with the CEO of Frisbie in early Spring 2019. While she said they remain supportive of the mission of the NH DSRIP, they could not devote additional staff and time to new projects given the current situation. Accordingly, there are no FMH practices participating in formal B1 Behavioral Health Integration Enhancement Initiative projects starting in this report period. Progress of the three FMH-affiliated practices toward Coordinated Care practice designation is detailed below.

FMH hosts the Strafford County Community Care Team (CCT). Inpatient and ED Case Managers remain active with the CCT and provide active referrals regularly. The Strafford CCT also includes Wentworth-Douglass Hospital's ED and inpatient Case Managers, allowing for direct collaboration and shared care planning for ED utilizers and patients with frequent hospitalizations.

Frisbie Memorial Hospital (FMH) and Frisbie Physician Practices also participate in the following regional efforts in addition to the practice-level engagement:

Rochester Pediatrics / FMH

Rochester Pediatrics has five primary care providers and an FMT working toward licensure. The IDN 6 continues to provide embedded behavioral health clinician (BHC) support. This clinician is accessible to the providers and provides short term focused interventions to children and their families seen in the practice. She averages 3 "warm handoffs" a day in the practice and can provide immediate follow up to acute behavioral health issues. The BHC also is the link to specialty behavioral health providers when needed and will connect and bridge those patients to a higher level of service. Workflow and protocol development have focused on response to PHQ-2/ 9 screenings and CCSA-identified needs.

The BHC at Rochester Pediatrics is also the coordinator of psychiatry consultation services from Dartmouth. This is an ECHO like project designed to increase the skills of the primary care providers in the region as well as develop a multidisciplinary team for chronic and more severe cases. Apart from the twice a month tele-consultation calls, the psychiatric team is available for emails and phone calls for more immediate consultation. The IDN continues to support this effort to address the need for more psychiatric support for the primary care providers in the region.

The practice completed the Site Self-Assessment process and identified strategic initiatives they would like to work on for a defined population that would benefit most by using integrated care services.

1. Explore opportunities to engage patients and families in the design of program materials and development of service delivery
2. Improve connections with outside community-based orgs and services
3. ID an age-appropriate screening for SUD
4. ID strategies to improve communication with pts on integrated care
5. Explore preventative BH screening services
6. Look toward building resilience before a BH referral

This practice has developed workflows to connect with CBOs and is working on pilot efforts to implement age-appropriate SUD screenings with brief intervention and referrals (SBIRT). The BHC is receiving supervision toward licensure from the IDN 6 Clinical Director. Successful licensure will allow for new billing opportunities and enhance sustainability of services at the practice.

Rochester Pediatrics' MDCT currently participates in the following regional MDCT support opportunities:

- Pediatric Psychiatry for MDCTs
- Certificate in Pediatric and Behavioral Health Integration: March 2019-September 2019
- Peer Support and Supervision Project for integrated BHCs

Skyhaven Internal Medicine / FMH

Skyhaven Internal Medicine is an internal medicine practice that was providing MAT services to patients in the Frisbie system and was interested in also placing a BHC in the practice during their SSA discussions. Due to the acquisition situation described above they have discontinued MAT currently and are not able to support a BHC in the practice. The practice declined to participate in a facilitated SSA strategy session during this report period. IDN 6 will continue to support efforts as the practice is prepared to move forward.

White Mountain Medical Center / FMH

White Mountain Medical Center (WMMC) 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. WMMC 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 WMMC has a high Medicaid attributed population and many behavioral and social needs identified in their Community Needs Assessment.

WMMC is already participating in a grant project to test an EHR based program that captures social determinant data. The IDN contracted with the practice and Frisbie to provide the startup cost support for a BHC position there. 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.

The IDN support during the report period included SSA Strategy meeting with CHI facilitation to identify practice goals:

1. Create an implementation team
2. Scale up the use of the SDoH screener
3. Have BHC attend the provider meeting
4. Incorporate community outreach in this integrated work

IDN 6 assisted in writing the job description for an embedded behavioral health provider to help meet the practice goals. This role was envisioned be the conduit to make sure the CCSA is completed and appropriate follow up occurs. They would be responsible for providing brief treatment in the office and making referrals outside as indicated.

Given the current workforce shortage, it was hard to recruit and identify an appropriate person for this position. However, the lengthy recruitment process resulted in hiring a clinician during this reporting period who had had experience working in primary care. Unfortunately, when this person began working there were issues identified that made it clear this was not a good fit for the practice and the clinician is not going to continue in that role. Given the context described above, the decision by the practice organization is to hold off on hiring another person in this role.

White Mountain Medical Center's MDCT currently participates in the following regional MDCT support opportunities:

- Pediatric Psychiatry for MDCTs

FQHC Partners

Greater Seacoast Community Health (GSCH) is a merger of two existing B1-partner FQHCs; Goodwin Community Health (GCH) and Families First (FF). Some providers and support staff are now working in both locations and/or supporting teams as needed for continued service delivery. The IDN has continued to work with both practices to sustain multi-disciplinary teams as both are advanced on the Integrated Care practice continuum.

Following the merger, 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.

GSCH has worked diligently to maintain high-quality services in both Rockingham and Strafford counties throughout its merger process. Both Goodwin Community Health and Families First are NCQA Level

III Patient- Centered Medical Homes. The IDN is available to be involved in the strategic plan to help GSCH, as needed, to bring their high-quality services into high need areas.

GSCH acquired Lilac City Pediatrics during this project period and the practice joined as a partner late in 2018. This added support to a well-established pediatric practice has allowed for BH service expansion in Strafford County and an important collaboration of service providers.

GSCH also has important divisions working collaboratively with multiple B1 and Community Project partners. These include SOS Recovery Community Support and Healthcare for the Homeless / Low Income Mobile Medical Clinic. IDN 6 is providing support for the collaborative work of GSCH and Community Partners through the B1 Behavioral Health Integration Enhancement Initiative with Community Partners.

Both Goodwin Community Health and Families First have had embedded Behavioral Health Services that predate the DSRIP project timeline. IDN 6 support has facilitated maintenance of these services, additional program support and development, and opportunities for significant regional collaboration and MDCT support. Both practices' successful BH Integration and MAT service programs support their designation as Integrated Care Practices.

GSCH received IDN 6 support for provision of primary care services to residents at Southeastern NH Services, another B1 project partner. This collaboration allows GSCH and Southeastern New Hampshire Services (SENHS) to provide primary care services at the SENHS residential program. For the reporting period of July 1, 2018-June 30, 2019, the Families First team saw 73 individual patients at SENHS, for a total of 157 patient visits. Patients were seen at SENHS by the Families First team, which included a Provider, Nurse, and Care Coordinator/Social Worker. The IDN 6 has recommitted funding support to this collaboration for the period October 2019-October 2020.

Lilac City Pediatrics / GSCH

Lilac City Pediatrics is a two-provider pediatric practice with over two decades of service delivery in Rochester. They do not yet share an EMR with GSCH, but workflows for communication and administrative support are significantly developed with GSCH. With the added support provided by becoming a division of GSCH, the practice has successfully onboarded a BHC. IDN 6 participated in their successful recruitment process and executed an MOU to provide support for the embedded LICSW January 2019.

To increase the practice capacity for SDoH support and to provide team-based care for mild / moderate depression, the LICSW has been awarded a scholarship by the IDN to attend the Modular Approach to Therapy for Children (MATCH) training for September 2019. Combined with the practice participation in the Certificate in Behavioral Health Integration program, the practice is anticipated to make significant progress in the DSRIP elements over the next reporting period.

IDN support during the report period included SSA Strategy meeting with CHI facilitation to identify practice goals:

1. Looking at intake process and criteria
2. Balancing the triage for MH/BH services
3. Coordination with community resources

Lilac City Pediatrics' MDCT currently participates in the following regional MDCT support opportunities:

- Pediatric Psychiatry for MDCTs
- Certificate in Pediatric and Behavioral Health Integration: March 2019-September 2019
- Community Care Team in Strafford County

Goodwin Community Health / GSCH

Goodwin Community Health is a large family practice with integrated primary care and BH services. They are a critical service provider in Strafford County with an established MAT/MAR and IOP program. The practice model includes extensive support for SDoH needs, extensive community engagement programs for families, prenatal/postpartum/newborn care, a critical dental care program, and collaborations with multiple B1 and Community Project partners.

Goodwin Community Health's MAT and IOP services are recognized as a critical resource for another regional partner, Hope on Haven Hill. Combined with well-established prenatal and postpartum programs, Goodwin Community Health helps to care for and support pregnant women with SUD as part of a collaborative model. Goodwin Community Health has also executed an MOU with the Doorway at WDH, enhancing collaborative services in the region.

IDN support during the report period included SSA Strategy meeting with CHI facilitation to identify practice goals:

1. Data collection and reporting
2. Team Meetings – Multi-disciplinary
3. Dedicated Care Managers

Staffing limitations and the necessary focus on maintenance of essential services has limited the in-depth work on the practice goals. Continued refinement of Integrated Care practice elements remains the goal for the IDN 6 work with Families First.

Goodwin Community Health's MDCT currently participates in the following regional MDCT support opportunities:

- Pediatric Psychiatry for MDCTs
- B1 Behavioral Health Integration Enhancement Initiative with Community Partners
- Community Care Team in Strafford

Families First / GSCH

Families First has a large family practice with integrated primary care and BH services. They are a critical service provider in Rockingham County with an established MAT/MAR and IOP program. The practice model includes extensive support for SDoH needs, extensive community engagement programs for families, prenatal/postpartum/newborn care, mobile health care with outreach, a critical dental program, and collaborations with multiple B1 and Community Project partners.

During the previous reporting period, the newly hired Director of Behavioral Health at Families First 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 Families First. The IDN helped the Families First behavioral health manager develop a communication strategy to let other agencies and the general public know how to refer patients to the program.

Updated training:

MATCH (Modular Approach to Therapy for Children) attended by four staff Sep 5-11, 2019

IDN support during has included SSA Strategy meeting with CHI facilitation to identify practice goals:

1. Grow/Expand Psych Consult
2. Continue to increase availability/access between PCP and BHC
3. Edu/Training re: Integration @ Provider meetings

Staffing limitations and the necessary focus on maintenance of essential services has limited the in-depth work on the practice goals. Continued refinement of Integrated Care practice elements remains the goal for the IDN 6 work with Families First.

Families First's MDCT currently participates in the following regional MDCT support opportunities:

- Community Care Team in Exeter and Portsmouth

Lamprey Health Care (LHC) participates in IDN projects in both Region 6 and Region 3. Two practices in Region 6, located in Newmarket and Raymond, are IDN 6 practice partners. Lamprey Health Care has well-established primary care and Behavioral Health services at each practice. Their service model also includes extensive support for SDoH needs, extensive community engagement and health literacy programming, a critical transportation service, and collaborations with multiple B1 and Community Project partners.

Lamprey Health Care successfully developed an innovative Nurse Practitioner Fellowship Program that is helping to build the workforce in the region. While the Fellowship is housed in the Newmarket practice, the Fellows receive clinical and didactic training at all LHC sites and in specialty placements. IDN 6 is supporting one NP Fellow with X-waiver training to facilitate enhanced MAT services and develop training tools for practice support.

LHC has implemented MAT/ MAR in the Newmarket and Raymond practices with. This successful extension of services into Raymond represents a critical service delivery model in an area with currently limited MAT/MAR service options.

Both LHC practice partners are NCQA Level III Patient-Centered Medical Homes. LHC has worked with the IDN 6 to identify CCSA data-reporting strategies that will allow for enhanced reporting by all CHAN-affiliated FQHCs in future reporting periods.

Lamprey Health Care – Newmarket

Lamprey Health Care – Newmarket is a large family practice with integrated primary care and BH services. They have maintained high-quality integrated care while the practice has experienced significant turn over in the BH staffing during the current reporting period. LHC has taken the opportunity to thoughtfully approach a rebuild of its BH services with both the assistance of a consultant and the IDN 6. The practice's B1 Behavioral Health Integration Enhancement Initiative seeks to leverage what they have learned to build a stronger, more resilient BH program.

LHC – Newmarket's MAT / MAR program started in early 2019 and is serving both their prenatal and primary care populations. Their MAT policies are well-developed and in active use.

LHC – Newmarket's MDCT currently participates in the following regional MDCT support opportunities:

- B1 Behavioral Health Integration Enhancement Initiative
- Community Care Team in Portsmouth and Exeter
- Peer Support and Supervision Project for integrated BHCs

Lamprey Health Care - Newmarket has also executed an MOU with the Doorway at WDH, enhancing collaborative services in the region.

Lamprey Health Care - Raymond

Lamprey Health Care – Raymond is a large family practice with integrated primary care, BH services, and new MAT/MAR services. The BH clinicians practicing at the Raymond site have not experienced the same level of turn over as in Newmarket, but the practice does share the impact of reduced provider hours and the motivation to participate in a redesign of the integrated BH services. The practice's B1 Behavioral Health Integration Enhancement Initiative seeks to leverage the shared learning of the practices and refine workflows to effect improved service delivery.

LHC-Raymond has recently hired an LICSW whose role will involve work at both partner sites initially. Her role will be further defined through the B1 project work in the next reporting period. She will quickly join the peer support group being facilitated by IDN 6.

LHC – Raymond's MDCT currently participates in the following regional MDCT support opportunities:

- B1 Behavioral Health Integration Enhancement Initiative
- Community Care Team in Exeter
- Peer Support and Supervision Project for integrated BHCs

Lamprey Health Care - Raymond has also executed an MOU with the Doorway at WDH, enhancing collaborative services in the region.

CMHC Partners

Community Partners

Community Partners (CP) is a well-established CMHC in Strafford County. As the mental health center and the area agency for developmental disabilities, CP has extensive service programs including SPMI treatment, case management, functional support, early intervention and family support services, emergency response services, and residential services. CP is also the DHHS contractor for ServiceLink, contributing to the impact of their extensive services.

During this report period, CP maintained a ProHealth reverse integration project with Goodwin Community Health. The IDN is supporting this project and the Director of Clinical Integration is working with the project director to provide ideas and outside expertise to make this ProHealth project successful.

The ProHealth project partners received IDN 6 funding to expand the ProHealth project beyond the age restricted 16-35 to include adults over 35 and those shared patients who may not otherwise qualify for the ProHealth grant program. This will allow more patients to receive integrated care services to better coordinate physical and mental health care plans. The IDN 6 is supporting this expansion with a focus on the integrated workflows and protocols that will allow for shared care planning.

CP is participating with the regional BH service provider collaboration to look for ways to improve communication with local partners. They are also participating in the twice monthly consultation calls to build child psychiatry expertise and to coordinate with local partners on child and family cases.

CP is a key participant in the Strafford County Community Care Team. Their participation facilitates the coordination of complex primary care, behavioral health, and social service care plans among regional partners.

Community Partners' MDCT currently participates in the following regional MDCT support opportunities:

- B1 Behavioral Health Integration Enhancement Initiative with Goodwin Community Health
- Community Care Team in Strafford
- Pediatric Psychiatry for MDCTs
- Regional BH service provider collaboration

Seacoast Mental Health Center

Seacoast Mental Health Center (SMHC) is a well-established CMHC in Rockingham County. SMHC services include including SPMI treatment for adults and children in multiple settings, case management, functional support, family support services, emergency response services, and MAT/MAR outpatient SUD services.

SMHC has strong joint service relationships with regional partners. SMHC provides Emergency Service response to Exeter Hospital's ED. They provide crisis services in the emergency room and facilitate timely follow-up with outpatient services. SMHC has co-located services in the CORE pediatric practices and Lamprey Health Care in both Newmarket and Raymond for pediatric counseling.

SMHC employs a transitional youth Care Coordinator as part of the IDN 6 Enhanced Care Coordination Community Project. Seacoast Mental Health has also executed an MOU with the Doorway at WDH, enhancing collaborative services in the region.

SMHC participated in the Site Self-Assessment process and identified the following practice priorities:

1. Workforce; needing positions filled
2. Access Redesign process
3. Data

In service of the need for increased access to services, SMHC is launching an Open Access model during the next report period.

Seacoast Mental Health's MDCT currently participates in the following regional MDCT support opportunities:

- Community Care Teams in Portsmouth and Exeter
- Certificate in Pediatric and Behavioral Health Integration: March 2019-September 2019

SUD Treatment /Recovery Support Partners

Seacoast Youth Services (SYS)

Seacoast Youth Services is a B1 partner as of December 2018. Seacoast Youth Services is a 20-year old program providing services to adolescents and young adults. The IDN 6 is helping SYS to continually explore opportunities to expand services into Rochester. The IOP program for high risk youth in the Rochester area closed. 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. The IDN is paying for the services of the Clinical Director of SYS. The IDN continues to work with SYS to identify and address barriers to service expansion.

SYS has identified work on policies and protocols as a priority for further development of IOP services. The Director of Care Coordination is working with the SYS Clinical Director on this effort. Primary areas of ongoing development are:

- 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)
- Joint service protocol development with collaborating providers and CBO's

Seacoast Youth Services does not currently participate in regional MDCT support opportunities but is an active participant on the Clinical Advisory Team and D3 Workgroup.

Hope on Haven Hill

Hope on Haven Hill (HHH) is a level 3.5 substance use treatment organization serving homeless, pregnant and newly parenting mothers who are in recovery. Hope on Haven Hill has an eight-bed residential facility and outpatient services. Hope on Haven Hill provides group and individual counseling services, case management services, and an IOP program.

Hope on Haven opened a residential program in Rochester. The new eight-bed has a mission to provide a safe, supportive place for mothers and their babies once they graduate from the high-intensity treatment at Hope on Haven Hill.

HHH experienced turn over in the Executive Director role during this report period. The position was permanently filled by the Chief Operating Officer and Co-Founder and resulted in no disruption to services.

Hope on Haven Hill's MDCT participates in the following MDCT regional supports:

- Community Care Team in Strafford County

Hope on Haven Hill also executed an MOU with the Doorway at WDH, enhancing collaborative services in the region.

Southeastern NH Services

Southeastern NH Services (SENHS) provides critical SUD services in the region. SENHS experienced turnover of the Executive Director position twice since the DSRIP timeline began, in both in the current and previous reporting periods. The last ED left in the first week of May 2019 and the position remains to be filled as of the writing of this report.

During this period, SENHS also re-assigned all their residential beds to ASAM Level 3.1 Low Intensity Treatment. This functionally eliminated all capacity of ASAM Level 3.5 High Intensity Treatment beds (28-Day program) in our region, except for the eight Level 3.5 beds at Hope on Haven Hill, which are only for pregnant and post-partum women.

SENHS continues to provide essential services in residential and outpatient SUD services, including the residential treatment program for adults 18+ (both men & women) who have completed a 28-day high-

intensity treatment program. Clients are given the opportunity to further enhance and strengthen their recovery for up to 90 days. Outpatient counseling and IOP programs for women and for drug-court participants remain active.

SENHS participated in a Site Self-Assessment and strategy meeting with CHI facilitation. They identified the following goals:

Connecting with University for Support (re: OT students/interns/research/etc.)

Outpatient Referrals and connection with PCP

Leveraging MCO services for patients and communicating this to staff and patients

To support enhanced PCP connection, IDN 6 funded a collaboration between SENHS and GSCH to provide primary care services at the SENHS residential program. For the reporting period of July 1, 2018-June 30, 2019, the Families First team saw 73 individual patients at SENHS, for a total of 157 patient visits. Patients were seen at SENHS by the Families First team, which included a Provider, Nurse, and Care Coordinator/Social Worker. The IDN 6 has recommitted funding support to this collaboration for the period October 2019-October 2020.

Due to limited resources and Executive Director turnover, the MDCT at SENHS has been limited in ability to make significant progress on further goals. The IDN 6 will continue to support progress in the essential DSRIP elements as partner capacity allows.

Regional B1 Partner Support Projects

Ongoing initiatives to support multiple B1 partners:

Peer Support and Supervision Project - To provide direct support group to the embedded Behavioral Health Coordinators and Clinicians in our region.

Need: There is a unique set of competencies and skills that are necessary to practice as a team member in a primary care setting. It also can be a role that is isolating, and the clinician can experience feeling marginalized as a result.

Method: There have been many individual BHC's hired in various practices in our region. All these clinicians are new to the role. The IDN identified that this group would greatly benefit from the development of a collaborative community that meets monthly and is facilitated by a more senior clinician with direct experience in primary care. We identified a person who is available to facilitate the group and the process will begin in August 2019. In June 2019, there were meetings to discuss the format and logistics for this group.

Initial members will be from Core Seacoast Family Practice, Core Family and Internal Medicine of Exeter, Dover Pediatrics, Greater Seacoast Community Health- Lilac City Pediatrics, Rochester Pediatrics, and Lamprey Health Care. The facilitator will be Elizabeth Tracy.

Evaluation: There will be six participants in this process, and they will meet for 90 minutes once a month. Each month there will be someone in the group who presents a case that provides the stimulus for discussion. There will be an independent evaluation performed by the IDN staff at six and twelve months to evaluate the groups effectiveness and the participants satisfaction level with the process.

Update: the contract for this small group learning collaborative with new integrated behavioral health

providers continues through June 30, 2020. A licensed social worker/psychologist meets twice a month to talk about the knowledge, skills, and attitudes needed to be successful in working in primary care. All group members describe this as being very helpful in the development of their positions.

Exeter, Portsmouth, and Strafford County Community Care Team

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 61 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.

Note on 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 multiple pediatric and family practices.*

Certificate in Pediatric and Behavioral Health Integration: March 2019-September 2019 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 focuses 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.cfm?cssearch=26042_1

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

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

Pediatric Psychiatry for MDCTs: Pediatric Psychiatry Telehealth utilizing Dartmouth-Hitchcock for didactic and case-based learning

Pediatric and family practices were identified as missing key support in pediatric psychiatry during IDN 6 environmental scanning. Barriers to effect multidisciplinary care team implementation 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 response to the need for support in multiple partner practices, the IDN initiated and funded completely an ECHO-like program starting in July 2018. This group continues to meet twice monthly 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. In June 2019, the group met in person for a full day of didactic learning and case review.

The target group served by 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)*

Regional BH service provider collaboration

The IDN *joined a regional collaborative group* of BH providers with representatives from Wentworth Douglass Hospital / Wentworth Health Partners, Community Partners, Greater Seacoast Community Health (Goodwin site), and Chestnut Hill Counseling, a large private practice group in Dover.

This group has identified ways to communicate more easily with each other to be able to triage complex patients to receive the right level of services. They also identified issues in communication with Portsmouth Regional Hospital where about 90% of inpatient admissions from the area go for acute level services. The director of PRH inpatient unit has now joined this community collaborative and areas where communication and care transitions can happen more easily with the full information provided about the patient or family in a timely way.

During the reporting period, IDN 6 worked with this regional collaborative group to create and submit a response to the DHHS RFI request for Mobile Crisis Response.

Collaborative Family Healthcare Association – Annual Conference October 2019

The Collaborative Family Healthcare Association held an annual conference in October 2019. IDN 6 supported attendance by multiple B1 partners including: Lamprey Health Care, Greater Seacoast Community Health, Rochester Pediatrics, Dover Pediatrics, and Exeter Health Resources. Feedback from the conference was gathered from participants and continues to inform training development. Threaded throughout all the feedback was the sentiment that the participants appreciated the opportunity to learn how to integrate behavioral health in a more efficient, meaningful way. Participants felt that many of the tools and skills presented would help them make the integration process less frustrating for both patients and providers.

Summary of Feedback from CFHA Conference

October 2019

Overall, feedback received was positive. Most attendees felt that the content was refreshing, motivational, and beneficial to their current practices.

Toolkit for Disruptive Behaviors	**Behavioral keys** and **behavioral themes** were noted in almost all of the feedback. Participants were especially enthusiastic about how useful these would be to implement within their practices. Other standouts from this segment: • **Behavior mapping** • **Review of functions of behavior** • **ABCs – back to basics** • **PRIDE**

"ABC's great reminder to come back to basics as behavior of any kind is driven by motive. Working with parents and school supporting analysis of the events and triggers.

Love the behavior keys and lock. I can see using this visual within a short term intervention with families. Will be working on implementing some form of this…"

"'Behavioral Health Theme of the Month' - hands outs, brochures, bulletin boards in the office?"

"Love the idea of doing a Behavioral health theme a few times a year in our office. Would love to work with other BHC's on sharing ideas for this in our offices.

The younger a child is diagnosed with a behavioral issue, the higher risk they are for it to turn to ODD or Conduct Disorder.

- How do we do a better job in pediatrics addressing these problems? Many are not straightforward behavioral issues and have significant social factors...many due to trauma or family stressors (parents incarcerated, messy parent separation, parent drug abuse or mental illness, etc.)

Parent Management Programs

- Our area is very limited in good Parent Management training programs for families with kids with ADHD or other behavioral issues (the #1 recommended first line of treatment for these kids). There needs to be more support for these families. Outside of Occupational Therapy or Psychotherapy there are few options and 1:1 therapy, particularly for young children, has significant limitations. How can we implement "bite size pieces" of this in Peds? One idea…
- Model of using "behavioral keys" as a 20min intervention with parents/kids in Primary Care. Would love to work on this intervention with other Peds BHC's and use this."

- *"Assessment scales in primary care (Connors, Child Behavior Checklist, Vonderbilt, Overt Aggression Scale)*
- *Always examine the function of the child's behavior: Functional Analysis*
- *Involve parent, teach parent strategies*
- *Behavior plan = preventative strategies, instructive strategies, consequence strategies*

- *Behavior keys as way to illustrate to parents*
- *PRIDE (praise, reflect, imitate, describe appropriate behavior, enthusiasm)"*

- "The younger a child is at the onset of disruptive behaviors (ODD), the more likely it is that they present with a Conduct Disorder later in life
- Important assessment scales that are used for disruptive behaviors. Often schools or developmental peds will discuss these tools so it was great to discuss them more. (Connors, Child behavior checklist, Overt Aggression Scale, Eyeberg Child Behavior Inventory and the Vanderbilt)
- Review of the functions of behavior was helpful
- Active ingredients for Behavior change;
    - Predictability and Consistency
    - Differential Reinforcement
    - Practice/Repetition
    - Proximity of consequences/ reinforcers to behaviors (I talk about this with families all the time now since this session)
- Behavior Mapping
- BEHAVIORAL KEYS!! This was so helpful to add to my own clinical tool box. I have already used this and think it works great. It is a great metaphor for helping parents visualize which behaviors are being positively and negatively reinforced.
- Discussion of time outs for multiple ages. I had not heard of job cards before so this was another great addition to my tool box."

From Bill's notes: Alyssa liked the idea of honing down a theme of the month. Able to focus on a bulletin board and they would get a handout on nutrition or diabetes. All are educating the team and the patients on a regular basis. They have set up organizational meetings with staff. Trauma informed care is the next one.

Assessment Tools/Prolonged Trauma	Participants thought that it was helpful to learn when **assessment tools** are most useful and in which circumstances they should be used. **Many participants were disappointed that the curriculum from the VA was not available for use and would like to know if there is a way to access this training.*

- *"Using assessment tools each visit to track progress. For example, PHQ9 or GAD7 to see numbers decrease.*
- ***Audit and Audit-C for alcohol screening to be used at assessments and not just the DAST.***
- *Each IBH site assesses/evaluates different. Let the area and the current needs of Exeter NH trigger what should be evaluated.*
- *Using the ACE's assessment and PCL5- screening for PTSD. – PROLONGED EXPOSURE -5-6 SESSIONS. CURRICULUM FROM VA AND NOT OFFERED OUTSIDE? HOW CAN BHC'S GET TRAINED IN THIS? If Trauma is treated first, a patient is more likely to address and work on other medical conditions*
- *QLES-SF Quality of Life assessment- https://depts.washington.edu/uwcssc/sites/default/files//hw00/d40/uwcssc/sites/default/files/WHO%20Quality%20of%20Life%20Scale.pdf*
- *AAQ-11 Acceptance and Action questionnaire http://personal.kent.edu/~dfresco/Resources/mindfulness_sig/documents/AAQ_I_and_%20II.pdf"*

"Using assessment tools is essential to measure outcomes = have structures in place to have these

completed ahead of time (MA, hand at check-in, etc), have structure in EMR"

"I learned:

- *That trauma work can be effective in the brief setting. Similar to all cases, it can be evaluated at the end of the treatment and if the patient needs more treatment, they can be referred*
- *How PE-PC worked. I had no experience with prolonged exposure so this was a great brief introduction*
- *Assessment tools like the PHQ-9, Quality of life, psychological flexibility, PTSD symptom check list are helpful in measuring progress*
- "Including other screening tools in addition to behavior only screenings and assessments (PHQ9, GAD7, etc.)
    - Screening for family dynamics captures behaviors and may be less threatening than screening for mental health symptoms
    - Family Assessment Device – has the most research and evidence to support its use https://isucounselingresources2017.weebly.com/uploads/1/1/3/4/11344496/family_assessment_device.pdf
        - It's super long – the presenters mentioned a shortened version, but I'm not sure where/how to find that
    - This can be standardized – "we ask all families these questions"
    - We talked about screening burnout/fatigue for patients – we ask them so much!
    - Charting issues – once these relational screeners are completed, whose chart do they go in? (parent, child, etc.)
    - These screeners can normalize burden on the family when it comes to chronic conditions
        - "We ask every family these questions and may families with x diagnosis struggle with these things.""

From Bill's notes:

- *ACES screening is a process that is starting at Frisbee and there was a focused workshop on how to do this.*
- *Alyssa - looking at brief models to treat trauma, treating primary care PTSD. Looking for a VA grant to look for ways to have access to that model.*

Telehealth	**Telehealth** was mentioned by some of participants to be something that would be very helpful in their practices.

"I feel that Telehealth could really make an amazing difference for patients and I plan to push for this as an option because of our patients who suffer from SDOH barriers. "

*"**Integration of BH Telehealth**- Our agency is actively looking at integrating BH Telehealth. The speaker and BH specialist discussed the workflow. It does appear to add about 4-5 mins of MA _me to each BH Telehealth consult. This is of course a concern as the MA _me is already stretched beyond thin currently. I was impressed at the satisfaction surveys completed with a similarity between in person and Telehealth consults. My other concern is with connection issues. In our building now we experience lag*
time with internet and I wonder how this may interact with a consult."

Ways to Integrate More Effectively	The sentiment that participants are seeking ways to integrate behavioral health with primary care more effectively was expressed in a variety of ways.

"I'm very curious and hopeful to learn more about how I can use short term specific treatment

modalities/ interventions with our patients. Brief treatment models and curriculums are going to be VERY important so that we can continue to offer our services and not have long waits for patients to get in to see us and most people coming in new to BHC work have not been trained in brief treatment modalities for specific diagnosis."

*"**Plenary Session: Building Integrated Care at the Statewide Level – The Colorado Story***
- The how is not as important as the why; don't let the how keep you from remembering why you are doing the work
- Transformation and change lift us up

Translating Therapy Skills into IBH
- Additional Assessments: SCOFF, ESP, PARS
- Very similar to Cherokee model training
- Brief models (problem solving therapy, behavior activation)
- Make it part of provider's review if they refer patients to BH

Building Shields against Trauma Monsters
- Do providers/interpreters/care coordinators know their triggers?
- How to promote resiliency among staff
- TIC = parallel process for patients and health center staff

- Paying attention to workload and lifestyle balance of staff, have supports in place, staff appreciation. In an integrated model of care it is important to include ALL team members (interpreters, care coordinators, PSRs, etc.)
- Keeping the employer's and own vision in mind to remind of WHY we are doing the work will facilitate change (as opposed to focus too much on HOW)
- A lot of classic therapy models can be utilized in brief interventions by adjusting them"

"CFHA provided tremendous validation of the work we are doing and confirmation that we are on the right track towards integration.

Sue Durkin and I both found great insight learning about the Collaborative Care model of integration, especially since these codes are currently active in New Hampshire. We are working on developing a pilot to work towards this model."

"I Learned: (referring to Translating Therapy Skills to Primary care B1)

- *How to better implement MI!!!*
- *How I can address time management issues in the clinic by not having families recap what they already shared with the doctor. This was a big deficit with my practice"*

"PCBH ETHICS SIG WITH DR. STACY OSGOOD

Refreshing to hear others having similar difficulties applying mental health ethic practice to PCBH within our ethical code of discipline. There was discussion on orientation of new employees and the standard; not treating family within the practice. Sharing resources with co-workers seeking support which could include one consult appointment, document clearly, and referral to EAP.

Utilization Opportunities FOR YOU! • What are common barriers with BH Integration in your clinic and patient population? • What is your vision for your Integration program and what are practical next steps? • Who is on your team? Who makes the next steps with you? Love this!!! It's coming up on a year within LCP and I have shined the light on, a year in review, how are we doing? I got their attention as some seem unclear with IBH model. To review this information more in depth I can present the vision if they are open. How can I be an extension to be helpful not add extra?"

"Facilitated Group Discussion:

I joined the "Warm Handoffs" lunch discussion on Friday. I found this conversation to be beneficial as we explored both commonalities and differences in how Warm Handoffs are introduced and received. In particular, the discussion focused on how to introduce BH to patients in Integrated programs. We explored introducing a BHS to every new clinic patient, in hopes of "normalizing" and highlighting BH as part of the patient's team."

From Bill's notes:

- Focused Acceptance and Commitment Therapy This is a model that focuses on values and focus and work on issues of pain.
- Outcome Based performance - they were feeling the pressure of trying to have their own work evaluated. Discussed the importance of them learning what is being measured for their own metrics for the practice. Better they look to see where they could add value to the practice rather than independently. Other value added is reimbursement and doing screeners that add value both to quality and from a financial benefit.
- Big question is how to build up our services, bring it up in small ways or keep people talking about it.
- Also wanted to continue to bring up more and more of their prolonged exposure protocols. How do you work on both the medical and the psychological issues.
- Data is key and still not sure if I am documenting enough and gathering the right data for how to demonstrate value and success.
- Jess talked about how to get quicker about assuming there is a relationship.
- Tonya – have to think about how we get the buy in and getting the right people at the table before we start doing something.
- Lot of talk about obtaining and working with data and outcomes
- Coreen talked about dental health care and how this can be applied at FF

From Sandi's notes:

- *Shared evaluation tools – Sarah P.*
- *Collaborative Care Model – Sue D.*
- *Outcome measurement and registries – Karen*
    - *Think about patient defined registry measures*
- *Bridging the dental/BH gap, asking about PCP status – Coreen*

Favorite sessions/topics of discussion	Some sessions/topics of discussion were noted as favorites by at least one participant: • Integrated Behavioral Health in a Women's Care Clinic • Intimate Partner Violence in Primary Care • Servicing the LGBTQIA+ Community

Servicing the LGBTQIA+ community – I was excited to attend this session as this is a passion of mine. I was very pleased to know that we are ahead of the curve in many areas here. We do need assistance in our EMR however. Addition of pronouns, Sex assigned at birth along with identified gender. Billing name vs Identified Name, Anatomical genitalia for appropriate office visit types. I am currently working on setting up meetings with the sales repos for GE to discuss how we can make

necessary changes to CHAN to better serve our LGBTQIA+ community."

Integrated Health in a Women's Care Clinic
- Screening for MH and SA = essential aspect of prenatal and post- partum care
- Unrealistic expectations/pressure from media and societal standards
- Educating patients what "normal" is
- Routine BHC check-ins as part of prenatal and post -partum care

"My two favorite sessions were:

1. *Integrated Behavioral Health in a Women's Care Clinic*
2. *Intimate Partner Violence in Primary Care*

It's difficult for me to boil these down because I loved everything about them and got so much out of it! I guess the take home message is that we all need to do a WAY better job of screening pregnant women and mothers for mental health issues, and screening for intimate partner violence (not just for women, and not just when we suspect something)."

"Translating Therapy Skills into Integrated BH in Primary Care:
Enjoyed this workshop and left w/resources to share w/my team. I currently supervisor 3 new clinicians and will use the PowerPoint provided by the presenters as a training/supervision tool.

Measurement Based Care:
Probably the most impactful (though hard to say, as I enjoyed all of the workshops I attended) workshop that I attended. It certainly raised my awareness of the importance of measuring outcomes in Behavioral Health. Since the workshop, I have shared this information w/the BH team and am working toward the development of a systematic administration of rating scales. I was also interested in the use of a Registry, although this was in a different workshop. I was curious if people use a Registry in addition to their EMR reports?"

From Bill and Sandi's notes: Intimate Partner violence - Angel talked about a screening process that goes into assessment for this issue. Big deal is how do you have a process where there are questions asked about this but it's important to have a follow program.

Additional Training Requested or Noted	Participants noted that there is interest in additional training in these topics: • VA Curriculum for Prolonged Exposure/PTSD (as noted above) • Focused Acceptance and Therapy • More skill building sessions in general • Brief symptom management • Biofeedback • MAs as Health Coaches • Diabetes Training through APA

*"**MA's as health coaches**- This was a brief breakout session and I was hoping it would be more in depth than it was but the speakers did offer that the MA's were given specialized training in areas such as Diabetes educators and HTN. They met with patients one on one and in group settings to offer education. A reduction in areas such as A1c and BP were noticed. The main obstacle that was discovered was that the MAs that were chosen to be coaches were not backfilled therefor the burden of added duties was noticeable. I have been very interested in utilizing the MAs in a different way however the need for more staff is imperative to make this model work."*

- "Training in Diabetes through APA? https://www.apa.org/health/emphasis/diabetes

- Brief symptom management – Any curriculums?
- Biofeedback? Need more information on this!
- Focused Acceptance and Commitment Therapy (Pain acceptance, disability, depression, emotional functioning) Can we have access to training/curriculum?"

"We did come away with questions about where to go for clarity when it comes to billing and coding. To really get a sense of what codes are available to us as an FQHC with a psychiatrist on board would be of great value for us. For example, could Sue Nichols be billing her psych med management visits differently now that we have Dr. Mitchell?

Several of our team attended a workshop on treating PTSD with brief interventions in the VA system, and are eagerly hoping they receive funding to expand that treatment outside of the VA as it would be of great benefit for our patients."

"Unfortunately, this *(VA curriculum)* is not a resource that is available to the public at this time as it is owned by the DOD.

I would have appreciated more sessions on skill building like the ones I recapped above as I got the most out of those and left feeling excited."

"I also thought that Focused Acceptance and Commitment Therapy (FACT) was an interesting modality and I'd love to learn more about this!"

From Bill's notes:

- The more practical the better. Sometimes the sessions were too quick and would have wanted more.
- Reminder that there is a set of webinars from CFHA that are accessible to everyone.

Other Takeaways	Miscellaneous topics noted

"Medically unexplained symptoms - if it's not a structure problem, if it's not an organ problem, then it's psychological. PPDassociation.org. Metabolic syndrome?

APP called 'Curable' for doctor's ad BHC's to prescribe in addition to getting BHC.

Wagner's approach- chronic pain model -> patient centered"

"Pain is… A primer on Using FACT to Reframe the Meaning and Experience of Pain
- Focus on functioning and barriers, accept distress, choose life path based on values, take actions
- increasing psychological flexibility
- OPEN AWARE ENGAGED

Most integrated models are based on Cherokee's Behavioral Health Consultant model =having new behavioral health clinicians train in Cherokee's model seems almost essential

Leadership Workshop for Behavioral Health Directors
- What are our biggest fears and who can we share them with?
- Are there other ways that we can provide value to an organization?
- What is realistic and unrealistic for us as a work load?
- Adjust career and work-life balance to current circumstances
- Look at your own avoidance behaviors, then values (ACT)
- What is my vision in regards to work/career, home/family, community/society, mind/body/spirit?

Plenary Session: Improvisation and the Art of Medicine
- AAA model: Attune, Affirm, Advance

- 'Yes, but' versus 'yes, and'
- 'I appreciate you said that, because…'

Conversations that connect
- Micro-behaviors and how this impacts what is being received by others
- Guessing another person's emotion through body language
- Empathy through inquiry

"It's really important we look at evaluation of both our PCBH and reverse integration models to help determine efficacy and patient outcomes. While we can anecdotally tell the story of why integration is important, we need to have the numbers to back up these programs as well."

"Measures helpful in IPC program evaluation:

- Measures across all levels – not just the patient
- What are you most interested in? outcomes, cost, etc.
- Implementation related outcomes
    - % of providers adhering
    - % clinical that are delivering
    - Population penetration rate
    - % patient who *should* be receiving an intervention
    - Fidelity- are we delivering the care as intended
        - PCBH provider adherence questionnaire
        - PCBH model
        - CCM model
        - Administrative data through the EMR: length of visits, same day visits, episodes of care
    - AIM, IAM, FIM (acceptability, appropriateness, feasibility)
- Patient outcomes
    - PHQ, GAD etc., BHM, Duke, QOL measures, functioning (WSAS, ORS), DM control, etc.
- Access measures
    - # days to next apt, open access (appointments open throughout the day), BHC productivity
- Continuity of care measures
    - Are we following up on our screenings?
    - Patient engagement (are patients showing up for appts)
- Patient experience measures (CAHPS)
- Provider level- burnout (Maslach inventory- proprietary); national academy of medicine has many tools
- Job satisfaction, retention, admin support
- Team functioning (team development measure)
- Relational coordination scale
- Medical home coordination survey
- Provider-level process outcomes
    - Referral #, # of intervention, barriers and facilitators to adopting IBH

PROMIS repository for measures
AHRQ measure repositories across a variety of domains
GEM (grid enabled measures)

QI for collaborative care
RAND

Step 1: what is the specific question you want to ask and which data is best to answer it? Not always what data is the easiest
What type of data will be best
Step 2: how have others done it?
Step 3: can I make it feasible and how?"

Focused Groups
Warm hand offs DC 18
Enjoyed hearing feedback with how to introduce myself to patients, screening tools used and how to implement the practice within LCP. Mapping tool assessment (Engle handout) great tool for evaluating hot spots in the practice. How/What measurement as tool during well-checks and or warm welcomes?
How can we get the message to patients that BHC is in the house? Where and how to advertise? Parent Support groups.

Lastly, I enjoyed hearing the opportunity of mentorship and have contacted those supporting this track. I will keep you posted, very exciting.

Thank you again for the opportunity to attend this great conference. "

"Caregiver support

- Do better at informing caregivers about what information we need (blood pressure, weight, sugars, etc.)
- Always ask these questions:
    - "What's the hardest decision you are facing in how to care for your loved one?"
    - "Can you complete a checklist of all the ADL's for which you provide assistance to your loved one?"
- Also look at the POSITIVE impacts of caregiving – fulfillment, purpose, etc.
- Screen for burden
    - Where is your line in the sand/your limit on what you're willing to do?
- Assess for self-care and coping
    - How have you and your family navigated other difficult times?
- The CARE Act – I wasn't familiar with this! Requires:
    - Identification of caregiver in the patient's hospital chart
    - Notifying the caregiver of discharge
    - In person training to family for tasks they will need to provide at home
- Patient centered > patient centric
    - We ignore the patient within the family context
- Should we be completing MoCA's (Montreal Cognitive Assessment) on all patients over a certain age at yearly physicals? I don't think this is routinely done…"

"What an incredible experience! It was so energizing to be with so many people who love the model

on integrated care and understand it."

From Bill's notes:

- Special Interest Groups are also a valuable resource. There is a pediatric one that several people went to. There are ongoing resources through the SIG that can be helpful.
- Karen – measuring outcomes using a registry
- McArthur website – registry on the depression scale

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, are reporting data and can report a denominator in the CCSA implementation reporting. 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.

There are no updated values to report related to the Evaluation Project Targets as reported for 12/31/2018. Updated data for the two targets below will be available after the 8/15/19 data submission by our partners. Those values are submitted for the 12/31/2019 reporting period.

Increase number of Medicaid beneficiaries receiving ComprehensiveCoreStandardized Assessment (period & cumulative)
Increase number of Medicaid beneficiaries scoring positive on screening tools who are referred for additional intervention

TABLE B1-3: 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	As of 12/31/2019
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)	15
Selected IDN partners complete CHI Integration Self-Assessment	Up to 25 practices complete CHI Integration Practice Self- Assessment	16 *(See Above)*	17 *to repeat Fall 2018*	20 (See table below)	20
Partners/Practices Use Dashboard in Integration Planning *(defined 12/2018 as active B1 partners having completed*	Dashboard template is developed by Clinical Advisory Team	*(See Above)*	*Rollout with 2ND Round*	20 Current B1 partners	20
(defined 12/2018 as SSA baseline, f/u, and STRATEGY review and implementation meeting completed or scheduled)	105 Partners/Practices/Provider Report using Dashboard	*(in Process)*	*64*	115	115
Participating Practices report data on IDN Outcome Performance Measures	10 participating practices meet reporting standards for IDN Outcome Performance Measures	--	1	19	19
Increase number of Medicaid beneficiaries receiving ComprehensiveCore Standardized Assessment (period & cumulative)	Increase by 10% each reporting period	0	342	1,113 cumulative/ 771 period	**3,791 / 2,678 period Jan-Dec 2019**
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	**8,622 cumulative/ 6,310 period Jan-Dec 2019**
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%	11/13= 85%
Age 12-17:	**75% of family and pediatric practice partners by 12/31/18**	0	0	11/13= 85%	11/13= 85%
Age 18-64:	**75% of family and internal medicine practice partners by 12/31/18**	0	0	11/12 =92%	11/12 =92%
Age 65:	**75% of family and internal medicine practice partners by 12/31/18**	0	0	11/12 =92%	11/12 =92%

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 B1 partners to provide recruitment and retention support for integrated care positions at the practice level. During this report period, the B1 workforce staffing has remained consistent for primary care integrated BH services.

Direct investments in positions at Wentworth Health Partners practices has facilitated the onboarding of an *additional* 2.0 FTEs of Behavioral Health Clinician support. With IDN 6 support, CORE Physicians hired one BH Clinician at CORE Family and Internal Medicine and one BH Coordinator at Seacoast Family Practice. IDN 6 has agreed to support two additional positions with Exeter Health Resources practices in CY2020.

Staffing targets refined during the last reporting period and are updated below. The total current Workforce FTEs in the chart below are individually identified as follows:

Behavioral Health Clinicians:

Rochester Pediatrics / FMH:	1.0 FTE
CORE Family and Internal Medicine:	1.0 FTE
WHP / Lee Family Practice:	0.4 FTE
WHP /Adult & Children's Medicine:	1.0 FTE
Hope on Haven Hill:	1.0 FTE *also noted in D3
Lilac City Pediatrics:	1.0 FTE
Seacoast Youth Services:	1.0 FTE

Behavioral Health Coordinators:

Greater Seacoast Community Health-Families First:	1.0 FTE *also noted in D3
CORE Seacoast Family Practice	1.0 FTE
Dover Pediatrics:	1.0 FTE
Hope on Haven Hill:	1.0 FTE
~~Skyhaven Internal Medicine / FMH:~~	~~1.0 FTE MAT Program Coordinator~~

Integration Coaches:

Citizens Health Initiative	2.0 FTE
~~*Wentworth Douglass Hospital**~~	~~*1.0 FTE*~~
~~*Frisbie Memorial Hospital**~~	~~*1.0 FTE*~~
~~*Exeter Hospital**~~	~~*1.0 FTE*~~

**supported as of July 1, 2019 via B1 Behavioral Health Integration Enhancement Project funding for new TEAMS vs. coaches.*

IDN 6 has contracted with Citizens Health Initiative to provide 12 months of Integration Enhancement support to up to 8 B1 partner practices. This is the equivalent of 2 FTEs starting July 1, 2019. Wentworth Douglass Hospital, Frisbie Memorial Hospital, and Exeter Hospital had previously identified internal implementation coaches to support the work of multiple practices affiliated with each facility. The identified staff continue to meet with Dr. Bill Gunn, Sandra Denoncour, and additional IDN 6 team members regularly. The structure of each implementation team varies.

TABLE B1-4: 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	Staffing on 6/30/19	Staffing on 12/31/19
Implementation Coaches	2.0	0	0	Paused	3	5	2
Behavioral Health Clinician	~~Up to 6~~ 6.4	0	0	0.4	3.8	6.4	6.4
Behavioral Health Coordinator	~~Up to 6~~ 4	0	0	0.5	2	3	4

B1 Workforce collaborations of note:

The IDN 6 has provided financial support for Greater Seacoast Community Health - Families First to co-locate primary care services at Southeastern NH Services (SUD provider) for one half-day per week starting July 2018. This was a one-time, 12-month 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. The MOU for this support has been approved for continued support and/or additional needs to maintain this important collaboration.

IDN 6 had extensive discussions with Skyhaven Internal Medicine during the current report period. It was anticipated that the result would be IDN 6 support for expanded MAT services at the practice, including the MAT Program Coordinator / Behavioral Health Coordinator ~~marked~~ in the list above. Due to program stability concerns and pending acquisition of the Frisbie Memorial Hospital, the practice decided to maintain limited services. IDN 6 remains available to support expanded services in the future.

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	Jan-Jun 2019 Actuals	Jul-Dec 2019 Actual	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	$ -	$ -	$ -	$ -	$ -	$ -	$ 150,000	$ 150,000	$ 300,000
								$ -	$ -
Project Infrastructure								$ -	$ -
Equipment	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Operations	$ -	$ -	$ -	$ -	$ -	$ 4,994	$ -	$ -	$ 4,994
								$ -	$ -
Workforce								$ -	$ -
Fees/Outside Placement	$ -	$ -	$ 24,235	$ 40,888	$ 142,734	$ 431,370	$ 400,000	$ 400,000	$ 1,439,227
Recruiting	$ -	$ -	$ -	$ 8,500	$ -	$ -	$ 50,000	$ 50,000	$ 108,500
Retention	$ -	$ -	$ -	$ -	$ -	$ -	$ 150,000	$ 50,000	$ 200,000
Training	$ -	$ -	$ 2,385	$ 5,941	$ 45,947	$ -	$ 25,000	$ 25,000	$ 104,273
Other	$ -	$ -	$ -	$ -	$ -	$ -	$ 200,000	$ 200,000	$ 400,000
					$ -	$ -		$ -	$ -
Technology	$ -	$ -	$ -	$ -	$ -	$ -	$ 25,000	$ 25,000	$ 50,000
								$ -	$ -
Totals	$ -	$ -	$ 26 620	$ 55 328	$ 188,681	$ 436,364	$ 1 000 000	$ 900 000	$ 2,606,993
DY 2019						$ 625,045			

Budget Narrative:

- 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.
- 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 current 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 partners listed below.

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. The IDN 6 will not be adding B1 partners.

Table B1-6: Key Organizational and Provider Participants

Organization/Provider	Agreement Executed (Y/N)	Date of COA with enterprise - *Date of Onboarding to IDN at practice level based on SSA #1 completion*
Frisbie Memorial Hospital	**Yes**	**10/2016**
Rochester Pediatrics	*yes*	***SSA # 1 11/29/2018***
Skyhaven Internal Medicine	*yes*	***SSA #1 completed***
White Mountain Medical 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**
Exeter Health Resources/CORE	**Yes**	**5/2018**
Seacoast Family Practice - Stratham	*yes*	***SSA #1 11/5/2018***
Core Family and Internal Medicine - Exeter	*yes*	***SSA #1 11/5/2018***
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*	***SSA #1 completed***
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*	***SSA #1 10/30/2018***
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.

B1 partners are represented by sector on the Executive Committee as listed below. Additional participation and planning representation occur through the Clinical Advisory Team.

Two previous Executive Committee members; CEOs from two substance use treatment partners, Hope on Haven Hill and Southeastern NH Services, left their positions in 2019. These short-term vacancies on the Executive Committee were successfully filled by IDN 6 with the new Executive Director of Hope on Haven Hill and Program Director of Addictions Recovery Services in representation of this critical sector.

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
Kerry Norton	Executive Director	Hope on Haven Hill	Yes
Chris Kozak	Chief Operating Officer	Community Partners	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, Inc	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
John Iudice	Program Director	Addiction Recovery 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.

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 / The Doorway
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
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
Sarah Fetras	Clinical Director	Seacoast Youth Services
Sarah Plante	Director of Population Health	Exeter Health Resources

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: CCSA Implementation By Practice Partners

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.*

WRITEBACK RESPONSE: There are no substantive updates to report.

There are two active models for CCSA implementation in the region. During the reporting period, IDN 6 partners have demonstrated significant progress in implementation of additional CCSA domains and remain actively engaged in work to create workflows to address the needs identified in their expanded assessments. A total of nine practice partners are currently collecting full CCSAs. The remaining practices have demonstrated progress as described below.

MODEL 1: CCSA single formats are assessed at a minimum of annually and available in the EMR for review by providers, and other care team members, in creation of ongoing treatment and care plans within the assessing agency. For partners with established CCSAs, ongoing work includes development of the Coordinated Care Practice elements to address needs identified in the CCSA that require internal or external collaboration and/or referrals.

CCSA single-format implementation and reporting status:

IDN Region 6 CMHC and SUD 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)

Reporting a numerator for the CCSA implementation with a single format data source has been successful for the following B1 practice partners:

1. Seacoast Mental Health Center
2. Community Partners
3. Hope on Haven Hill
4. Seacoast Youth Services

5. Southeastern NH Services

MODEL 2: CCSA multiple interaction format. In this model, domains of the CCSA are collected at multiple points in the course of the patient's interaction with the practice. Four B1 partners currently include templated interactions such as intake forms combined with elements of their routine office visit templates that include all the screening and assessment elements of the CCSA. The interactions that build the complete CCSA may include intake, clinical visit documentation, and additional forms created for use by non-billable clinical support staff such as Care Coordinators, Social Workers, and Care Managers.

CCSA multiple interaction format implementation and reporting status:

IDN Region 6 FQHC partners currently use multiple interaction formats.

During this report period, the IDN 6 Director of Care Coordination worked with Lamprey Health Care to identify opportunities to add domain questions to their current EMR templates to create a complete CCSA format. The result is that Lamprey Health Care proposed to change their clinical templates. Those changes were reviewed by the clinical teams at Lamprey Health Care, proposed to CHAN (the regional EMR network administrator for FQHCs), and the proposed changes were approved by the CHAN user group. This allows for the collection of all CCSA domains by the following partners:

1. Lamprey Health Care, Newmarket
2. Lamprey Health Care, Raymond
3. Greater Seacoast Community Health, Goodwin Community Health
4. Greater Seacoast Community Health, Families First

Reporting a denominator for CCSA eligible Medicaid members is possible for all FQHC partners. Reporting a ***numerator*** for the CCSA implementation with a multiple interaction data sources is now possible for Lamprey Health Care, Newmarket and Lamprey Health Care, Raymond. These partners will be newly reporting a numerator for August 15, 2019 reporting. Greater Seacoast Community Health's reporting capacity does not currently allow for collection from a multiple interaction format but remains an open conversation for future reporting.

IDN Region 6 HBPC and Independent Practice partners currently collect partial CCSAs.

Partners including Hospital based primary care (HBPC) and independent practices (IP) do not currently capture all elements of the CCSA. They have indicated that they are not able to add a single format CCSA to their currently workflows. Each of these 11 practice partners does collect information under many of the necessary domains as part of their intake, clinical visit documentation, and additional forms created for use by billable and non-billable clinical support staff such as Care Managers and newly integrated BH Clinicians and BH Coordinators. 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 progressive implementation of the CCSA domains by HBPC and IP partners. 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. Strategy and technical assistance meetings are used as opportunities to discuss progress on CCSA development and workflows to address needs identified in CCSA domains.

The status of each partner's CCSA implementation is listed in Table B1-8.

Table B1.8 CCSA Domains By Partner at practice level

CCSA Domains	Rochester Pediatrics	White Mountain Medical Center	Skyhaven Internal Medicine	Wentworth Health Partners / Internal Medicine	Wentworth Health Partners / Hilltop Family Practice	Wentworth Health Partners / Lee Family Practice	Seacoast Mental Health Center
Demographic information	YES	YES	YES	YES	YES	YES	YES
Physical health review	YES	YES	YES	YES	YES	YES	YES
Substance use review	YES	YES	YES	YES	YES	YES	YES
Housing assessment	YES	YES	YES	progress	progress	progress	YES
Family and support services	YES	YES	YES	progress	progress	progress	YES
Educational attainment	YES	YES	YES	progress	progress	progress	YES
Employment or entitlement	progress	progress	progress	progress	progress	progress	YES
Access to legal services	progress	progress	progress	progress	progress	progress	YES
Suicide risk assessment	YES	YES	YES	progress	progress	progress	YES
Functional status assessment	progress	progress	progress	progress	progress	progress	YES
Universal screening using depression screening (PHQ 2 & 9) and	YES	YES	YES	YES	YES	YES	YES
Universal screening using SBIRT	progress	progress	progress	progress	progress	YES	YES
Pediatric provider CCSA:							
Validated developmental screening for all children, such as the ASQ:3 and/or ASQ SE at 9, 18- and 24/30mth month pediatric visits	YES	YES	N/A	N/A	YES	YES	N/A
Developmental Screening using Bright Futures or other American Academy of Pediatrics recognized developmental tool	YES	YES	N/A	N/A	YES	YES	N/A

CCSA Domains	Lamprey Health Care - Newmarket	Lamprey Health Care - Raymond	Community Partners	Seacoast Family Practice - Stratham	Core Family and Internal Medicine - Exeter
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	YES	YES	YES
Employment or entitlement	YES	YES	YES	YES	YES
Access to legal services	YES	YES	YES	progress	progress
Suicide risk assessment	YES	YES	YES	YES	YES
Functional status assessment	YES	YES	YES	progress	progress
Universal screening using depression screening (PHQ 2 & 9) and	YES	YES	YES	YES	YES
Universal screening using SBIRT	YES	YES	YES	YES	YES
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	N/A	YES	YES
Developmental Screening using Bright Futures or other American Academy of Pediatrics recognized developmental tool	YES	YES	N/A	YES	YES

CCSA Domains	Greater Seacoast Community Health - Families First	Greater Seacoast Community Health - Goodwin Community Health	Greater Seacoast Community Health – Lilac Pediatrics	Southeastern NH Services	Hope on Haven Hill	Seacoast Youth Services
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	YES	YES	YES	YES
Family and support services	YES	YES	YES	YES	YES	YES
Educational attainment	YES	YES	YES	YES	YES	YES
Employment or entitlement	YES	YES	YES	YES	YES	YES
Access to legal services	YES	YES	YES	YES	YES	YES
Suicide risk assessment	YES	YES	YES	YES	YES	YES
Functional status assessment	YES	YES	YES	YES	YES	YES
Universal screening using depression screening (PHQ 2 & 9) and	YES	YES	YES	YES	YES	YES
Universal screening using SBIRT	YES	YES	YES	YES	YES	YES
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	N/A	N/A
Developmental Screening using Bright Futures or other American Academy of Pediatrics recognized developmental tool	YES	YES	YES	N/A	N/A	N/A

CCSA Domains	Appledore Family Medicine	Dover Pediatrics
Demographic information	**YES**	**YES**
Physical health review	**YES**	**YES**
Substance use review	progress	**YES**
Housing assessment	progress	progress
Family and support services	progress	progress
Educational attainment	progress	**YES**
Employment or entitlement	progress	progress
Access to legal services	progress	progress
Suicide risk assessment	progress	**YES**
Functional status assessment	progress	progress
Universal screening using depression screening (PHQ 2 & 9) and	progress	**YES**
Universal screening using SBIRT	progress	progress
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**
Developmental Screening using Bright Futures or other American Academy of Pediatrics recognized developmental tool	**YES**	**YES**

B1-8b

List of multi-disciplinary core team members that includes, at minimum:

- *PCPs*
- *Behavioral Health Providers (including a psychiatrist)*
- *Assigned care managers or community health worker*

Multidisciplinary core teams have been identified at all primary care and behavioral health partners. Bold entries are additions during the report period. All the MDCT models and minimum monthly case review meetings with all-partner and/or partner-specific access are detailed in Section B1-8e.

Table B1-8b: Multidisciplinary Core Teams at partner level

Organization/Provider	MDCT roles identified	Roles included in MDCT / *external component
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 Health Partners / Internal Medicine	YES	PCPs, Behavioral health provider, BH Care Manager, Psychiatrist via internal e-consult
Hilltop Family Practice	YES	PCPs, Behavioral health provider, RN Care Manager, Psychiatrist via internal e-consult
Lee Family Practice	YES	PCPs, Behavioral health provider, RN Care Manager, Psychiatrist via internal 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 via ProHealth colocation**, 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
Appledore Family Medicine	YES	PCPs, RN Care Manager, *behavioral health provider, *psychiatrist
Dover Pediatrics	YES	PCPs, Behavioral health provider, BH Care Manager, **Psychiatrist via consultation with GBMH**

B1-8c

Multi-disciplinary core team training for service providers on topics that includes, at minimum:

- *Diabetes hyperglycemia*
- *Dyslipidemia*
- *Hypertension*
- *Mental health topics (multiple)*
- *SUD topics (multiple)*

Implemented trainings from the current reporting period are included in the attachment B1-8c.a. The regional multi-disciplinary core teams have all been trained in the five essential areas: diabetes, hypertension, dyslipidemia, MH, and SUD recognition and support.

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.

To serve this need, the IDN6 continues to develop a web-based training link. The website link is available at**: https://www.cfhnh.org/training.** The structure directly reflects 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.

During the reporting period, the IDN 6 has taken steps to ensure that staff at all partner practices have received training and have continued access to core training resources, including those to aid in recognition and management of mental health disorders. It is a priority for our region that partners have access to the training resources to use in adaptable ways. The IDN 6 is encouraging the training of:

- **New hires** to the organization as part of an onboarding training protocol by providing web-based trainings for MH recognition and support.
- **Ongoing staff training** by providing updated training resources and encouraging partners to make MH and SUD trainings part of the annual competencies for all staff.
- **Organization-level** by developing training protocols and modular training packages that can be used to promote practice-level responsiveness. (e.g. *Trauma-Informed practices* vs. trauma-informed direct care providers only)

Ongoing training notes:

1. Ongoing topics for all Pediatrics practices via **Pediatric Psych Teleconference monthly call** with psychiatric case consultation and didactic sessions from Dr. Craig Donnelly, Dartmouth Hitchcock.

2. **Modular Approach to Therapy for Children (MATCH)** – February 2019 and September 2019**.** IDN 6 offers scholarships for partner providers. 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.

The decision to invest in future MATCH training was based on the positive feedback and high level of implementation success from the four providers who attended the training with IDN 6 scholarships. Partners from Seacoast Youth Services, Seacoast Mental Health, Hope on Haven Hill, and Dover Pediatrics attended in February 2019. Feedback from one attendee is included below.

- ***Was this a useful training?*** Yes! I found the training to be incredibly useful. I have encouraged other Behavioral Health Clinicians in Region 6 to be part of this training because I found it so useful. MATCH address anxiety, depression, conduct, and trauma. These are the top problems we are dealing with in Pediatrics with few resources and brief interventions to utilize. I love MATCH because it can be done as a whole treatment plan (~25 session) OR I can use one single module with a patient. I have been using their conduct module and handout with parents often at our office as well as the anxiety protocol which helped one of our patients with a fear of needles get a vaccine.
- ***How have you implemented MATCH in your organization?*** As previously mentioned, I was able to use the anxiety protocol to do needle exposures with one of our patients who is terrified of needles. I found this patient in the hallway hyperventilating when a nurse tried to give her a vaccine. I worked with her for about 6 sessions and she successfully got a vaccine. I also use the conduct protocols and handouts with parents inquiring about what to do with their child's defiance. I also use the depression modules to teach skills like problem solving, activity selection, and challenging negative thoughts. The handouts and agendas are great.
- ***If you have not yet implemented MATCH in your organization, what are the barriers/challenges to doing so?*** I have used the trauma protocol once due to my context in integrated care not being the best place to treat trauma. I have one patient I have used it with as I made an exception to see them, but otherwise I typically refer out trauma cases as they typically need more regular and on-going treatment.

1. **IDN track core training sessions from the BH Summit of December 2018** have been made available as webinars with CEUs for all MDCT members and partner staff via the Connections For Health website.
2. **Certificate in Pediatric and Behavioral Health Integration: February 2019 – August 2019**

   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.cfm?cssearch=13765_1

   The IDN has funded the 6-month course and there are 21 CEU/CME credits attached to it. **B1 and E5 pediatric partners attending:**

   - **Lilac City Pediatrics / Greater Seacoast Community Health**
     - Rima Sutton (LICSW), Rebecca Searles (LICSW)
   - **Rochester Pediatrics**

- Alexa Randall (FMT), Pam Udomprasert, Erica Boheen / Leadership - Emily Garland, Deb Harrigan, MD

- **Core Pediatrics (E5)**
  - Marjorie Darmody (RN Care Coordinator), Jodie Lubarsky, Pediatrician / Leadership - Sarah Plante
- **Seacoast Mental Health Center (B1 and E5)**
- **Dover Pediatrics**
  - Dr. Rachel Laramee, Jessica Foye MSW, Joe Pagnotta / Practice Leadership
- **Private Practice consultants**
  - Ben Hillyard, Jessica Lyons

Table B1-8c: MDCT Training Status

MDCT Training Domains	Rochester Pediatrics	Skyhaven Internal Medicine	White Mountain Medical Center	Wentworth Health Partners / Internal Medicine	Hilltop Family Practice	Lee Family Practice	Seacoast Mental Health Center
Diabetes	YES	YES	YES	YES	YES	YES	YES
Dyslipidemia	YES	YES	YES	YES	YES	YES	YES
Hypertension	YES	YES	YES	YES	YES	YES	YES
Mental Health / Behavioral Health (multiple options)	YES	YES	YES	YES	YES	YES	YES
SUD / Substance Use (multiple options)	YES	YES	YES	YES	YES	YES	YES
Additional Training							
Integration Model (general, coding/billing, etc..)	YES	NO	NO	YES	YES	YES	YES
Cherokee Integration Model	YES	NO	NO	YES	YES	YES	YES
SBIRT / S2BI	IMPLEMENTED	IMPLEMENTED	IMPLEMENTED	IMPLEMENTED	IMPLEMENTED	IMPLEMENTED	IMPLEMENTED
Regional Training							
Child Psychiatry Telehealth w/ training session	YES	YES	YES	n/a	YES	YES	n/a
Certificate in Pediatric and Behavioral Health Integration (2/2019)	YES	NO	NO	n/a	NO	NO	YES

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

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

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

Attachment B1-8c.a

IDN REGION 6 TRAINING Q3 / Q4 2019

Training	Date	Project Impacted	Brief Description	Total Attendance	Agencies Attending	IDN Role
CTI Fidelity Train the Trainer	Jul 18	C1	Training for CTI Project staff to conduct a program fidelity review	2	IDN Region 6	IDN 6 CTI Team Lead and Director of Care Coordination attended as part of CACTI contract
State Immunization Conference	Sep 26	A1	Scholarships for two NP fellows from the NP Fellowship program at Lamprey Health Care	2	Lamprey Health Care	IDN 6 agreed to provide scholarships for 2 NP fellows from Lamprey Health Care's NP Fellowship program to attend the conference.
Behavioral Health / SUD						
Harvard Judge Baker Children's Center's Modular Approach to Therapy for Children (MATCH)	Sep 5 - 11	A1, B1, E5	5 day training An evidence based treatment for children ages 6-15 with emotional or behavioral challenges including anxiety, depression, trauma or conduct problems.	4	Families First/Goodwin Community Health/Lilac City Pediatrics	IDN 6 provided scholarships to attend
SOS Recovery Bootcamp	Oct 11 – Dec 13	A1, B1, D3	CCAR Advanced Recovery Coach Boot Camp is training to better handle the variety of scenarios and situations generated from recoverees who frequent the centers. Includes engagement and communication skills. Subjects include: Ethical Considerations for Recovery Support, Suicide Prevention, HIV, AIDS, & Hepatitis Prevention, Motivational Interviewing, and Recovery Coaching	19	SOS, Greater Seacoast Community Health	IDN 6 provided scholarships to 19 people for the recovery coaching bootcamp curriculums and 5 of the first 11 who received these funds are now employed by SOS and Greater Seacoast Community Health. SOS was able to stretch the educational dollars in this farther for the Drug Policy Alliance, International Drug Policy Conference in St. Louis. 2 attendees from our region http://www.drugpolicy.org/event/2019-international-drug-policy-reform-conference This impacts education and knowledge of current developments in the field of harm reduction which impacts our service and program delivery.
Collaborative Family Healthcare Association	Oct 17-19	A1, B1, D3	Annual Conference "Our Generation: Integration"	12	Families First/Goodwin Community	IDN 6 provided scholarships to 10 B1 partner staff to attend. IDN 6 Clinical Director and Director of Care Coordination presented in

Annual Conference					Health/Lilac City Pediatrics, Lamprey Health Care, Rochester Pediatrics, Dover Pediatrics, Exeter Health Resources	collaboration with CHI.
Foundational Training in Trauma Responsive Systems	Nov 18 & Dec 6	A1, B1, C1, D3	**Target Audience**: This workshop is an advanced professional development opportunity for professionals seeking to become "trauma competent" and to develop trauma-informed systems of care in their own agencies/organizations. **Learning Objectives:** 1. Realize the widespread impact of trauma and understand potential paths for recovery; 2. Recognize the signs and symptoms of trauma in clients, families, staff, and others involved with the system; 3. Respond by fully integrating knowledge about trauma into policies, procedures, and practices; and 4. Seek to actively resist re-traumatization.	21/15	Lamprey Health Care, Rockingham VNA & Hospice, Connections for Health, Greater Seacoast Community Health/Goodwin Community Health, regional medical providers, regional SAU staff,	IDN 6 fully funded training
2019 Strafford County Addiction Summit	Nov 20	A1, B1, C1, D3, E5	Educate and provide community members with the knowledge, skills and tools to address challenges such as adverse childhood experiences (ACE) by utilizing trauma-informed care (TIC) principles in their everyday lives and work. By hearing concrete examples, learning about funding opportunities, and listening to experts across fields, attendees will learn how to cultivate resilient communities that are built on a foundation of trauma-informed care		C1 Care Transitions / IDN 6, multiple B1, E5 and D3 partners	IDN 6 marketing support to partners
ONGOING						
Child Psychology Telehealth Calls	Twice Monthly; 1st and 3rd Tuesdays	A1, B1, E5	Clinical psychology case review and training with Dartmouth-Hitchcock Pediatric Psychology Department.	Child Psych Telehealth	multiple B1 and E5 partners, full list embedded in SAR section B-8e	IDN 6 funds the contract for DHMC psychiatry services

BEHAVIORAL HEALTH

Training provided	Date	Project Impacted	Total Attendance**		Agencies attending**	Sectors/Key Organizational Participants Attending**	IDN Role
Stigma Across Cultures The impact of stigma on clients accessing BH and SUD services	1/24/2019	A1, B1, C1	9		Seacoast Public Health Network, Bridging the Gap, Community Partners, Exeter Health Resources	Recovery Support Organization, Hospital Administration, Primary Care, Social Work, Substance Use Prevention, Public Health	Provided via AHEC contract
Harvard Judge Baker Children's Center's Modular Approach to Therapy for Children (MATCH) An evidence based treatment for children ages 6-15 with emotional or behavioral challenges including anxiety, depression, trauma or	2/215-3/1/2019	A1, B1, E5	4		Seacoast Youth Services, Hope on Haven Hill, Seacoast Mental Health Center, Rochester Pediatrics	SUD Treatment & Recovery, Behavioral Health, Community Mental Health Center, Pediatric	Provided scholarships to attend

conduct problems.						Primary Care	
Harvard Medical School: Young Adults with Chronic Conditions - Optimizing Treatment and Transition from Pediatric to Adult Care Optimizing the transition from pediatric to adult care to ensure the highest levels of care for pediatric patients transferring or onboarding into adult care.	3/4-6/2019	A1, B1, E5	3		Center for Collaborative Change, Dover Pediatrics, Seacoast Mental Health Center	Behavioral Health, Pediatric Primary Care, Enhanced Care Coordination	Provided scholarships to attend
Foundations in 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.	4/16-17/2019	A1, B1, C1, D3, E5	22		Healthcentric Advisors, SOS RCO, Region 6 IDN, Families First, Lamprey Health Care, Community Action Partnership of Strafford County, Cross Roads House, Dover Housing Authority, Seacoast Public Health Network, Goodwin Community Health, St. Vincent de Paul Society, individual mental health therapists	IDN CTI; SUD assessment, treatment & recovery; FQHC; Social Services; Individual Behavioral Health Services; Schools	Provided via AHEC contract
Northern New England Nurse Practitioner Conference	4/11-12/2019	A1, B1	3		Addiction Recovery Services, Riverside	SUD treatment and recovery,	Provided scholarships

Scholarship recipients attended sessions that included Integrating Behavioral Health in Primary Care, Motivational Interviewing, Getting Ready for Delivering Medication Assisted Treatment for Opioid Use Disorder, and Lessons Learned: Challenges for Advance Practice Leaders in Integrated Care Settings				Rest Home/Hyder Hospice House, Lamprey Health Care	geriatric primary care/palliative & hospice care, QI & nursing	to attend
ACT Now: An Introduction to Acceptance Commitment Therapy Powerful brief intervention model. Training addresses: the rationale for using acceptance and commitment therapy (ACT) for chronic pain and other behavioral health concerns, how avoidance contributes to suffering, ACT strategies to improve functioning in primary care patients, and resources to further develop skills.	5/3/2019	A1, B1, C1, D3, E5	17	Information not available	BA, MSW, PhD, RN, BSW, LADC, APRN, LCMHC, MSCJ, M.Ed, Ed.D,	

NH National Assn of Social Workers Annual Conference	5/23-24/2019	A1, B1, C1, D3,	8	Community Partners, Region 6 IDN, Dover	Behavioral Health,	Provided scholarships

Scholarship recipients attended sessions that included Trauma-informed Primary Care, Peer Recovery Work in NH: Ethical Considerations, Strengthening Your Dual Diagnosis Assessment and Treatment Skills and Neuropsychological approaches to reduce anxiety and suicidality in youth.		E5			Pediatrics	Pediatric Primary Care, Care Coordination	to attend
Trauma Informed Care for Paraprofessionals Incorporate trauma-informed care as a strengths-based approach to caring for patients and clients. Includes basics of brain function and development, components of Trauma Informed Care, and strategies to address challenging behaviors.	5/28/19	A1, B1, C1, D3, E5	31	_____	Lamprey Health Care - Newmarket	BA, MA, APRN, RN, BS, Patient Service Rep, Medical records, Community Health Worker, PA,	
Trauma Informed Care for Paraprofessionals See description above.	5/30/19	A1, B1, C1, D3, E5	32	_____	Lamprey Health Care - Raymond	BA, MA, APRN, RN, BS, Patient Service Rep, Medical records, Community Health Worker, PA, LCMHC	

Dartmouth Hitchcock Child and Adolescent Psychiatry Meeting Teleconference attendees meeting bi-monthly for the past year gathered with Pediatric Psychiatrist, Craig Donnelly, for further training and case consultation including: the latest updates in psychopharmacology for children with ADHD, how to engage families around developmental issues in behavioral compliance and sleeping; a Psychoeducational prelude to formal referral to mental health services, and discussion of how to format the calls for the coming year.	6/25/2019	A1, B1, E5	25		Barrington Family Practice, Rocehster Pediatrics, Rochester Hill Family Practice, Frisbie Hospital Pediatric Occupational Therapy, Wentworth Douglass Hospital Dept of Psychiatry and Behavioral Health, Dover Pediatrics, Lilac City Pediatrics, Oyster River School District, Goodwin Community Health, Community Partners Youth & Family Services Department	Primary Pediatric Care, Community Mental Health Center, Behavioral Health, Psychiatry and Psychology, Hospitals, Schools,	IDN Provided

SUBSTANCE USE DISORDER

Training provided	Date	Project Impacted	Total Attendance**		Agencies attending**	Sectors/Key Organizational Participants Attending**	IDN Role
Enhancing Provider Skills in Serving Active Substance Users (Harm Reduction) Collaborative learning, conversation, and case discussion to identify opportunities to	4/23/2019	A1, B1, D3	31		Lamprey Health Care, Newmarket	Physicians, Nurse Practitioners, Nurses, BH Therapists, Patient Services Reps, Social	Provided via AHEC contract

engage clients in setting goals. The session focuses on provider acceptance of 'where a person is at' as a precursor to supporting client driven goal setting. Evidence related to harm reduction approaches and goal setting will be discussed and harm reduction best practices, evidence, and current local and national resources will be provided.						Workers, Community Health Workers, Medical Records, LPNs	
Enhancing Provider Skills in Serving Active Substance Users (Harm Reduction) See description above.	4/25/2019	A1, B1, D3	28		Lamprey Health Care, Raymond	Physicians, Nurse Practitioners, Nurses, BH Therapists, Patient Services Reps, Social Workers, Community Health Workers, Medical Records, LPNs	Provided via AHEC contract

INTEGRATION SUPPORT

Training provided	Date	Project Impacted	Total Attendance**	Agencies attending**	Sectors/Key Organizational Participants Attending**	IDN Role
Integrated Care: Practical Applications in the Seacoast Region-Model: The Integrated	2/27/2019	A1, B1	26 total, 9 from	Region 6: Wentworth Douglass Hospital, Lamprey Health Care,	Behavioral Health, Care Coordination,	IDN Provided in partnership

Model Introduction to the embedded integrated care clinical Model (as opposed to “silos” of co-location or referral models) to familiarize group with the model, its advantages and challenges and team-based care (primary care providers and behaviorists). "Open Floor" discussion & Q&A including clarification of key concepts and model challenges			Region 6		Region 6 IDN, Hope on Haven Hill, Dover Pediatrics, Frisbie Memorial Hospital, Exeter Health Resources/Core Physicians	SUD Treatment and Recovery, Clinical Quality, Population Health	with Regions 1, 3 and 4

Integrated Care: Practical Applications in the Seacoast Region-Method: The Integrated Care Team Method Introduction to the Method of team-based integrated care, specifically how primary care providers, nurses, behaviorists, front desk staff, operations staff and others with “face-to-face” patient contact work together using evidence-based team methods and skills to provide increased access and improved quality for patients. "Open Floor" discussion & Q&A including implications for staffing, training, schedules, EHRs, documentation, fast turnaround, productivity and improved quality for patients.	3/19/2019	A1, B1	29 total, 5 from Region 6		Region 6: Lamprey Health Care, Region 6 IDN, Hope on Haven Hill, Exeter Health Resources/Core Physicians	Behavioral Health, Care Coordination, SUD Treatment and Recovery, Population Health	IDN Provided in partnership with Regions 1, 3 and 4

Integrated Care: Practical Applications in the Seacoast Region-Money: Long-term Financial Sustainbility of Integrated Care Fee-for-service and value-based contracting and how they provide the financial undergirding for integrated care. "Open Floor" discussion & Q&A regarding coding, billing, revenue cycle, MCO negotiations and contract provisions.	4/16/2019	A1, B1	32 total, 5 from Region 6		Region 6: Lamprey Health Care, Region 6 IDN, Hope on Haven Hill, Exeter Health Resources/Core Physicians, Frisbie Memorial Hospital	Behavioral Health, Care Coordination, SUD Treatment and Recovery, Population Health	IDN Provided in partnership with Regions 1, 3 and 4
Community Health Worker Course Community Health Worker training in team-based care.	April-June 2019	A1, B1	2		Greater Seacoast Community Health	Community Health Worker	Provided scholarships to attend
Cherokee Health Systems Integrated Care Training Workshop for Region 6 IDN B1 clinical partners to bring a multidisciplinary team together to develop strategies to address internal progress towards full integration.	6/12/2019	A1, B1	64		Center for Collaborative Change, Community Partners, Region 6 IDN, Exeter Health Resources/Core Physicians, DHHS, Dover Pediatrics, Families First, Frisbie Memorial Hospital/Rochester Pediatrics, Goodwin Community Health, Lilac City Pediatrics,	Physicians, Administration, Finance, Social Work, Behavioral Health, Care Coordination, Nursing, SUD Treatment and Recovery	IDN Provided in partnership with Regions 4 and 7

					Lamprey Health Care, Seacoast Mental Health Center, Wentworth Douglass Hospital/Wentworth Health Partners		

OTHER

Training provided	Date	Project Impacted	Total Attendance**		Agencies attending**	Sectors/Key Organizational Participants Attending**	IDN Role
Culturally Effective Organizations Using the Culturally Effective Organizations Framework to move towards an inclusive workplace.	1/15/2019	A1, B1, C1, D3, E5	3		Lamprey Health Care, Raymond Coalition for Youth	FQHC, Youth Prevention	Provided via AHEC contract
Ready to Rent Four sessions, 2-hours each, to learn resources, skills, attitudes and behaviors for procuring and maintaining housing in their communities.	4/1/2019	C1, E5	6		Rockingham County Corrections	Inmates	IDN Staff led training
Addressing Public Benefits Questions and Problems in NH	5/22/2019	C1, D3, E5	15		Farmington Welfare Dept, Southern NH	Municipal welfare, FQHC,	IDN Provided

Presented by NH Legal Assistance, this training focused on how to contest federal, state and local public benefits decisions, how to seek free legal aid with public benefit questions, the duties of municipal welfare, and the Medicaid work requirement.			Services, Cross Roads House, Families First, Waypoint, Seacoast Mental Health Center, Lamprey Health Care,	CMHC, Social Services,

**** When available**

B1-8d Training For Non Direct-Care Staff

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

During the reporting period, the IDN 6 has taken steps to ensure that staff providing indirect care at partner practices have received training and have continued access to training resources to aid in recognition and management of mental health disorders. *(in-person sessions in Attachment B1-8c.a*) It is a priority for our region that partners have access to the training resources to use in adaptable ways. The IDN 6 is encouraging the training of:

- **New hires** to the organization as part of an onboarding training protocol by providing web-based trainings for MH recognition and support.
- **Ongoing staff training** by providing updated training resources and encouraging partners to make MH and SUD trainings part of the annual competencies for all staff.
- **Organization-level** by developing training protocols and modular training packages that can be used to promote practice-level responsiveness. (e.g. *Trauma-Informed practices* vs. trauma-informed direct care providers only)

In addition, we have provided ongoing coding and billing training to all B1 partners with the webinar and resources available on the Connections for Health website (cfhnh.org). The IDN clinical director is participating in a statewide billing/coding workgroup coordinated by Region 2 and DHHS. There are ongoing 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.

Additional training strategies:

- ***Online access*** to BH / MH disorder recognition and management for current partner staff to include core trainings
- Promotion of essential core trainings as part of ***onboarding*** **for non-direct care staff**
- Development of training formats that can be **added to partner training platforms** (e.g. HealthStream) for practice-wide distribution

B1-8e MDCT Case Conferences

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

Table B1-8e: MDCT case conference schedule / PPT= Pediatric Psych Telehealth*, CCT= 1 or more Community Care Team*

Organization/Provider	MDCT identified	Roles included in MDCT / *external component	MDCT Conference schedule
Rochester Pediatrics	YES	PCPs, Behavioral health provider, RN Care Manager, *psychiatrist	**PPT, 1st & 3rd Tuesday of each month CCT- Strafford**
Skyhaven Internal Medicine	YES	PCPs, Behavioral health provider, RN Care Manager, *psychiatrist	**CCT - Strafford**
White Mountain Community Health Center	YES	PCPs, Behavioral health provider, RN Care Manager, *psychiatrist	**PPT, 1st & 3rd Tuesday of each month**
Wentworth Health Partners / Internal Medicine	YES	PCPs, Behavioral health provider, BH Care Manager, **Psychiatrist via internal e-consult**	**CCT: Strafford Internal – schedule in narrative**
Hilltop Family Practice	YES	PCPs, Behavioral health provider, RN Care Manager, **Psychiatrist via internal e-consult**	**PPT, 1st & 3rd Tuesday of each month Internal – schedule in narrative**
Lee Family Practice	YES	PCPs, Behavioral health provider, RN Care Manager, **Psychiatrist internal via e-consult**	**PPT, 1st & 3rd Tuesday of each month Internal – schedule in narrative**
Seacoast Mental Health Center	YES	*PCPs, Behavioral health providers, Assigned care managers, psychiatrist	**CCT - Exeter and Portsmouth**
Lamprey Health Care - Newmarket	YES	PCPs, Behavioral health providers, Assigned care managers, psychiatrist	**PPT, 1st & 3rd Tuesday of each month Internal – schedule in narrative**
Lamprey Health Care - Raymond	YES	PCPs, Behavioral health providers, Assigned care managers, psychiatrist	**PPT, 1st & 3rd Tuesday of each month Internal – schedule in narrative**
Community Partners	YES	***PCPs**, Behavioral health providers, Assigned care managers, psychiatrist	**PPT, 1st & 3rd Tuesday of each month CCT: Strafford Internal – schedule in narrative**
Seacoast Family Practice - Stratham	YES	PCPs, Behavioral health providers, Assigned care managers, *psychiatrist	**PPT, 1st & 3rd Tuesday of each month CCT: Exeter**
Core Family and Internal Medicine - Exeter	YES	PCPs, Behavioral health providers, Assigned care managers, *psychiatrist	**PPT, 1st & 3rd Tuesday of each month CCT: Exeter**
Greater Seacoast Community Health - Goodwin Community Health	YES	PCPs, Behavioral health providers, Assigned care managers, *psychiatrist	**PPT, 1st & 3rd Tuesday of each month**
Greater Seacoast Community Health - Families First	YES	PCPs, Behavioral health providers, Assigned care managers, *psychiatrist	**CCT – Exeter, Portsmouth**
Greater Seacoast Community Health – Lilac City Pediatrics	YES	PCPs, Behavioral health providers, Assigned care managers, *psychiatrist	**PPT, 1st & 3rd Tuesday of each month**
Southeastern NH Services	YES	PCPs (on-site from Families First), Behavioral health providers, Assigned care managers, *psychiatrist	**CCT - Strafford**
Hope on Haven Hill	YES	*PCPs, behavioral health provider, RN Care Manager, *psychiatrist	**CCT - Strafford**
Seacoast Youth Services	YES	*PCPs, behavioral health provider, Care Manager, *psychiatrist	**PPT, 1st & 3rd Tuesday of each month**

Appledore Family Medicine	YES	PCPs, RN Care Manager, *behavioral health provider, *psychiatrist	**PPT, 1st & 3rd Tuesday of each month CCT – Portsmouth, Exeter, Strafford**
Dover Pediatrics	YES	PCPs, Behavioral health provider, BH Care Manager, **Psychiatrist consult with GBMH**	**PPT, 1st & 3rd Tuesday of each month Internal – schedule in narrative**

The IDN 6 has developed and/or supported **three models for MDCT case conferences** on behalf of pediatric, adolescent, and adult patients with significant behavioral health conditions or chronic conditions. These models are listed below with more comprehensive narrative to follow.

1. Pediatric psychiatry *all-partner accessible* teleconference and didactic learning sessions
2. Community Care Team *all-partner accessible* case review
3. 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.

MODEL 1: Child and Adolescent Psychiatry telehealth case conferences and didactic learning for MDCTs

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.

The Pediatric Psychiatry Telehealth group was formed in response to challenges identified by pediatric and family practice partners in development of their MDCTs. The challenges identified during the development of the DSRIP 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. While the DSRIP efforts are supporting an increase in co-located and integrated behavioral health providers, the remaining challenges required a creative approach.

The participant list for this group continues to expand (*distribution list and referral for case review follow*). All B1 partners have access to this resource in service of their applicable pediatric populations. In addition to these calls, Dr. Donnelly has been available to respond to emails or phone calls. 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:

- Screening, diagnosing, and managing bipolar in Primary Care
- Benefits of Occupational Therapy and what PCP's may refer for
- Barriers between schools and healthcare
- How healthcare systems can better communicate with schools
- Complex comorbidity and when to refer for neuropsych/psych testing
- Trauma's influence on affective disorders
- Resources for 3-5 year olds (Aged out of early intervention, too young for school)
- The job of the Psychiatrist
- Depression screening in primary care
- ADHD in preschoolers
- Autism screening resources
- Approaches to substance use in teens in primary care
- Newest medical approaches and devices for ADHD and depression
- Impact of Technology on children's mental health
- 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

Child and Adolescent Psychiatry Telehealth Distribution List

Facilitator: Alexa Randall

Psychiatrist / Facilitator: Dr. Craig Donnelly

1. [redacted]

36. [redacted]

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!

MODEL 2: Adult Community Care Team (CCT) case conferences for MDCTs

During the report period, the IDN 6 continued to facilitate three regional Community Care Teams with a total of four monthly meetings. The membership in the CCT is now over 60 agencies / partners, including all three New Hampshire Managed Care Organizations. The full list of partners is available in embedded attachment B1-8e.6.

The CCT model has been presented by members of the Operations team at two statewide conferences. These efforts have led to requests from hospitals and community agencies outside Region 6 to attend CCT meetings and learn more about opportunities to develop similar models in their regions. We have welcomed visitors and shared development resources with them directly and supported connections with their IDN representatives.

CCT Ongoing meeting schedules are:

- **Seacoast CCT: 2nd Monday of each month**
- **Exeter CCT: 2nd Wednesday of each month**
- **Strafford CCT: 1st and 3rd Mondays of each month**

One missing component of the multidisciplinary team for adult and family practices consistently identified by multiple partners is lack of access to psychiatry providers for immediate referral 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.

Partner agencies in Rockingham County expressed interest in an additional Community Care Team meeting of key organizational partners. The Exeter CCT was established during this report period and the first meeting of this new CCT was held March 6, 2019.

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

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.

Updates during reporting period:

- IDN Region 6 successfully onboarded AmeriHealth Caritas to the CCT membership.
- The secure email system used by the CCT Administrative Coordinator has proved to be an unreliable platform for communicating referrals and announcements to CCT members. The IDN 6 has identified, **Flock**, an SOC2 compliant communication platform for use by the CCT in 2020. First test messages and announcements were sent January 2020 and full implementation is anticipated February 2020. *Flock is not intended as an ENS, DSM, or*

shared care plan platform for the region. It is a regional tool for the facilitation of the CCT that remains independent of other platforms.

- Changes to the CCT manual and any needed User Agreements for the use of Flock will be implemented in the first quarter of 2020.

IDN Region 6 Community Care Team meetings

Seacoast / Portsmouth CCT Meetings Jul - Dec 2019	Strafford County CCT Meetings Jul - Dec 2019	Exeter CCT Meetings Jul - Dec 2019
July 8, 2019	July 1 & 15, 2019	July 10, 2019
August 12, 2019	August 5 & 19, 2019	August 14, 2019
September 9, 2019	September 2 & 16, 2019	September 11, 2019
October 14, 2019	October 7 & 21, 2019	October 16, 2019
November 11, 2019 – cancelled, holiday	November 4 & 18, 2019	November 13, 2019
December 9, 2019	December 2 & 16, 2019	December 11, 2019

Region 6 Integrated Delivery Network

Seacoast, Exeter, 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.

Attachment B1-8e.6

COMMUNITY CARE TEAM / CARE COORDINATION
AUTHORIZATION TO RELEASE / OBTAIN PROTECTED INFORMATION

Patient name: _____ Date of Birth: _____

I, _____ authorize the Connections for Health
(patient name)
Community Care Team (CfH CCT), 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 CFH CCT 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 CFH CCT sign confidentiality statements and promise to keep my information private. However, if a CFH CCT 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 CFH CCT** or by notifying **Connections for Health at cct@CfHnh.com**, and my health information will no longer be shared at the CFH CCT. The cancellation will not apply to information that has already been disclosed. If I do not want to participate with the CFH CCT, 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 CFH CCT member listed on page 2.)

1

* Managed Care Organizations will only be present during discussions of their members.

Updated 1/17/2020

Connections for Health
Integrated Health Services

Connections for Health CCT members:

Amedisys
AmeriHealth Caritas*
Beacon Health Strategies*
Community Action Partnership of Strafford County Community Partners
Connections for Health
Connections Peer Support Center
Core Physicians
Cornerstone VNA
Cross Roads House
Crotched Mountain Community Care
Dover Housing Authority
Easter Seals of NH
Exeter Hospital
Exeter Housing Authority
Families First of the Greater Seacoast
Families in Transition (FIT)
Frisbie Memorial Hospital
Goodwin Community Health
Granite State Independent Living
Haven
Home for All
Homeless Center for Strafford County
Hope on Haven Hill
The Homemakers Services
Lamprey Health Care
My Friend's Place
NH DHHS Bureau of Elderly and Adult Services
NH Healthy Families*
NH Housing Finance Authority
OASIS Senior Advisors
OneSky Community Services
Portsmouth Housing Authority
Portsmouth Regional Hospital
Raymond Baptist Church
Rochester Housing Authority
Rockingham VNA
Safe Harbor Recovery Center
Salvation Army, Portsmouth
Seacoast Mental Health Center
Seacoast Pathways/Granite Pathways
ServiceLink of Rockingham County
ServiceLink of Strafford County
SNHS/Rockingham Community Action
Somersworth Housing Authority
SOS Recovery Community Organization
Southeastern NH Services
St. Vincent dePaul Society, Exeter
St. Vincent dePaul Society, Hampton
TASC-Transportation Assistance for Seacoast Citizens
Tri-City Consumers' Action Co-operative
Veterans, Inc.
Waypoint
Welfare Department, City of Dover
Welfare Department, City of Portsmouth
Welfare Department, City of Rochester
Welfare Department, City of Somersworth
WellSense Healthplan*
Wentworth-Douglass Hospital
Wentworth Home Care and Hospice/Amedisys
Womenaid of Greater Portsmouth

Other organizations you wish to add to this release:

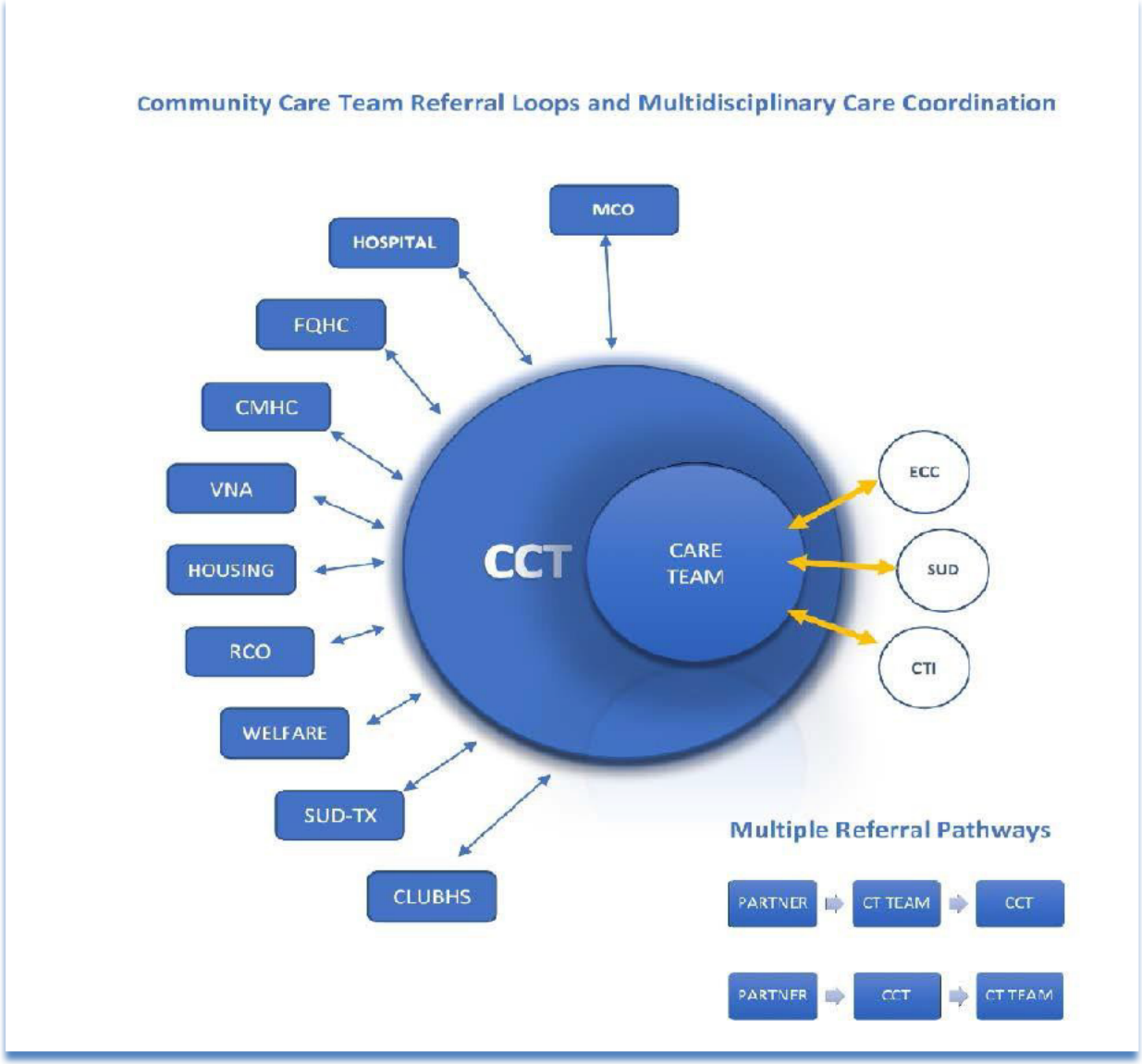
For IDNCCT use only

Date revoked: Name & Organization of IDNCCT member receiving revocation:

* Managed Care Organizations will only be present during discussions of their members.

Updated 1/17/2020

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



<u>MODEL 3:</u> Partner-specific Internal case conference for MDCTs:

Dover Pediatrics signed an MOU in Quarter 2 2019 with Wentworth Health Partners / Great Bay Mental Health for 2 hours per month of psychiatric case consultation to support their MDCT in care planning. The monthly meetings are currently held during a provider meeting with dates being solidified. Expanding the workflows around this model are part of the integration enhancement project that Dover Pediatrics started August 2019.

Wentworth Health Partners – Internal Medicine, Lee Family Practice, and Hilltop Family Medicine utilize the psychiatry services of their Great Bay Mental Health practice for psychiatry consults via electronic communication between providers. There is not a set time for these interactions to occur each month but are available continuously for provider access. The consultation informs the availability of access to BH services and the primary care provider's care plan reviews with the MDCT. Expanding the workflows around this model are part of the integration enhancement project that the three practices started August 2019.

Community Partners and Greater Seacoast Community Health – Goodwin Community Health are collaborators on a ProHealth SAMHSA grant to establish reverse-integration at the Community Partners site in Rochester. The project began during this reporting period. The colocation of primary care and BH services allows for enhanced MDCT engagement to serve their shared patient panel. Expanding the panel served and developing workflows around this model are part of the integration enhancement project that Community Partners began August 2019.

Lamprey Health Care - Newmarket and Lamprey Health Care - Raymond have a fully functioning internal MDCT case review model, including psychiatry. To achieve this model, Lamprey Health Care previously contracted time with Seacoast Mental Health. A psychiatrist attends case review meeting monthly. He is also available by phone for consults for the MDCT. Lamprey Health Care recently hired a part-time psychiatrist who will become part of their MDCT model.

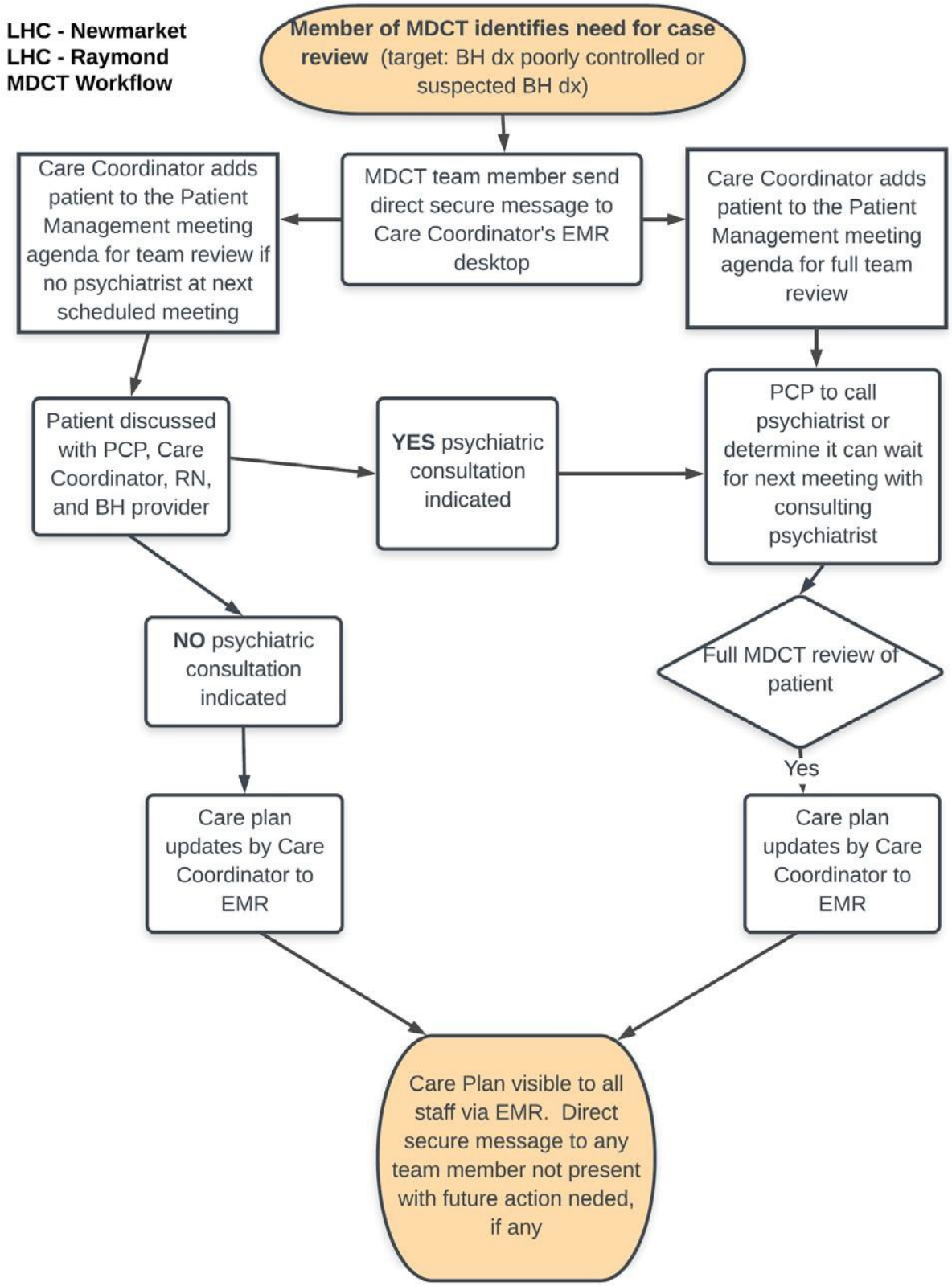
The IDN 6 supports this intact MDCT case review model by providing training to the team members, retention funding for key BH provider staff, and support from the CCT and child psychiatry case reviews, as needed. Indirect support is provided via the IDN 6 support at the partner agency, Seacoast Mental 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 2019 meeting schedule for this MDCT:

- January 16, 2019
- February 22, 2019
- March 12, 2019
- April 26, 2019
- May 15, 2019
- June 18, 2019
- July 23, 2019
- August 20, 2019
- September 17, 2019
- October 15, 2019
- November 19, 2019
- December 17, 2019

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

Attachment B1-8e.8



B1-8f

Secure Messaging

Region 6 IDN partners report using direct secure messaging (DSM) in several ways. The primary work of the Region 6 IDN DSRIP has been to support these partners to use their tools in new ways to support new project work by facilitating discussion of workflow and policy design or re-engineering. In a few cases part of that facilitation has resulted in partner agencies selecting a new or different solution than anticipated by their organization's HIT timeline prior to engaging with the IDN. For the vast majority of the rest of the partners, they use DSM to communicate internally or externally in ways their other suite of technology solutions does not accommodate, which results in very different product and use profiles across the region, because the technology portfolios of our regional partners are very different. (See Table B1-8f: Secure Messaging)

Most B1 partners use their DSM capabilities in the interest of care planning, but those uses can vary, even toward the same goal. For example, for one FQHC, the DSM solution SureScripts functions as their patient portal so clients can communicate with the practice regarding refill requests, appointments, and other relevant simple messaging. That same practice has procured Kno2 for clinician to outside agency clinician DSM and is refining their implementation plan for the solution. That same organization has been approved for IDN 6 funding support and purchased TigerText as an internal DSM option for communication among members of the internal care team.

A partner community mental health agency has recently implemented the CareConnect Inbox DSM solution. Because the implementation is new, there are not yet standard workflows. Primary care practices affiliated with one of the Region 6 Hospital systems use their NextGen EHR product, Direct, for DSM with external partners only. The robust EHR provides ample tools for messaging internally and connecting with clients through an EHR based portal.

IDN 6 partners report accessing DSMs through a Health Internet Service Provider (HISP) or a solution that already has an embedded HISP as part of the product. In a previous reporting period, IDN 6 assisted one partner agency to procure access to a HISP when their scope and review of available products with embedded HISPs could not identify a solution/vendor that met their needs and would work cost-effectively with their current other HIT solutions. They then worked with their EHR vendor and internal quality improvement team to tweak workflows to use the less costly HISP effectively to meet their priority communication needs. No partner agencies identified a need for new or alternative HISP during the reporting period.

An emerging theme across our B1 partners is the market availability of solutions that do more than one critical DSRIP function – especially DSM solutions that also provide closed loop referral and/or ADT/SIU event notification functionality. The rapid evolution of the HIT market is one reason the Region 6 IDN has cancelled implementation of the region's previously selected shared care plan solution, procured in 2017. Regional partners reported a request to evaluate their current communication needs in the context of other statewide information technology planning efforts, especially those underway or anticipated to be adopted by 211 (Granite United Way), the NH State Opioid Response (SOR)-funded Doorway teams, and evolving Medicaid Managed Care contracts. During the reporting period, the Region 6 IDN explored procurement of UniteUs, a closed loop referral and care coordination electronic solution, as the most appropriate and cost-effective way to meet partners' identified needs.

It is clear that partners want a minimal number of solutions – they will not accept one IT solution for shared care plan, another for event notification, a third for closed loop referrals, and a fourth for direct secure messaging of records, especially when a fifth might be indicated to ensure clients/patients can communicate with providers and staff. The Region 6 IDN continues to assess the current state of IT across our partner agencies. These assessments' help us to ensure investments will be available to support only

those technologies that contribute to enhancing communication and connection with other partner agencies and appropriately expanding communication/access to knowledge across disciplines within agencies. During the previous reporting period, for example, the Region 6 IDN supported Crossroads House Homeless Shelter with almost $40,0000 in funding to rearchitect the organization's IT network to ensure rolling blackouts would be a thing of the past and shelter staff would be able to access NH HIMMS data and organizational records in a timely fashion, two critical needs of this sector.

Workflow review and coaching for each B1 partner is available via SSA & B1 project development to ensure that robust use of the tools currently available is part of each partner's enhancement plan.

Table B1-8f: Secure Messaging

Organization/Provider	Direct Secure Messaging enabled		IDN enhanced / impacted
Rochester Pediatrics	YES	Meditech	workflow review incorporated in B1 project via SSA & coaching
Skyhaven Internal Medicine	YES	Meditech	workflow review and coaching available
White Mountain Medical Center	YES	Meditech	workflow review and coaching available
Wentworth Health Partners (WHP): *Internal Medicine*	YES	Direct (NextGen)	workflow review incorporated in B1 project via SSA & coaching
(WHP): *Hilltop Family Practice*	YES	Direct (NextGen)	workflow review and coaching available
(WHP): *Lee Family Practice*	YES	Direct (NextGen)	workflow review and coaching available
Seacoast Mental Health Center	YES	Care Connect Inbox	*IDN reimbursed SCMH for contracted services With HISP (Health Information Service Provider)
Lamprey Health Care - *Newmarket*	YES	SureScripts – Pt Portal Kno2 – C2C, TigerText	workflow review incorporated in B1 project via SSA & coaching
Lamprey Health Care - *Raymond*	YES	SureScripts – Pt Portal Kno2 – C2C, TigerText	workflow review incorporated in B1 project via SSA & coaching
Community Partners	YES	Echo	workflow review and coaching available
CORE: Seacoast Family Practice - *Stratham*	YES	Voltair	workflow review incorporated in B1 project via SSA & coaching
CORE: Family and Internal Medicine - *Exeter*	YES	Voltair	workflow review incorporated in B1 project via SSA & coaching
Greater Seacoast Community Health: *Goodwin Community Health*	YES	SureScripts – Pt Portal	workflow review incorporated in B1 project via SSA & coaching
Greater Seacoast Community Health: *Lilac City Pediatrics*	YES	SureScripts – Pt Portal	workflow review and coaching available
Greater Seacoast Community Health: *Families First*	YES	SureScripts – Pt Portal	workflow review incorporated in B1 project via SSA & coaching
Southeastern NH Services	YES	WITS	workflow review and coaching available
Hope on Haven Hill	n/a	none	workflow review and coaching available
Seacoast Youth Services	n/a	none	workflow review and coaching available
Appledore Family Medicine	YES	MyHealthOne	workflow review and coaching available
Dover Pediatrics	YES	PCC	workflow review incorporated in B1 project via SSA & coaching

B1-8g

Closed Loop Referrals

The internal work processes and workflows for IDN 6 practice partners vary within or across agencies regarding patient population or types of referrals that are included in closed loop consideration. In consultation with the regional Clinical Advisory Team, the Region 6 IDN operations team identified the following essential elements of closed loop referral and incorporated them into guiding protocols for CAT members, B1 project members, and for closed loop referral solution scoping.

- Coordination among case managers (internal and external to IDN)
- Timely communication
- Safe transitions from community and institutional settings back to primary care, behavioral health and social support service providers

The majority of Region 6 IDN partners still report completing at least one component of closed loop referrals (generate referral, receive referral, confirm/closeout sent referral) manually. For some partners, sending a referral between providers/staff internally is done via a warm-hand-off, a phone note, or a flag/message/communication document for consideration.

Many partners report that referrals to outside partner agencies are still sent and received manually via secure fax. While partners report having the technical capability to execute electronic referral sharing, many still identify data silos and imperfect workflows as barriers to using technology more fully.

One successful strategy has been to encourage each MDCT to identify a smaller, priority population (e.g. BH referrals to one outside entity) for which they will fully develop a closed loop referral process. The goal is to identify the most persistent barriers to completing the referral loop (e.g. staff time, lack of response from outside entities, training needs for full electronic tool use). Based on their experience with this approach, partners have identified that there is significant need for both extensive committed staff time AND development of more electronic tools that do not negatively impact and/or distract the direct service delivery (i.e. “too many systems” does not make it easier).

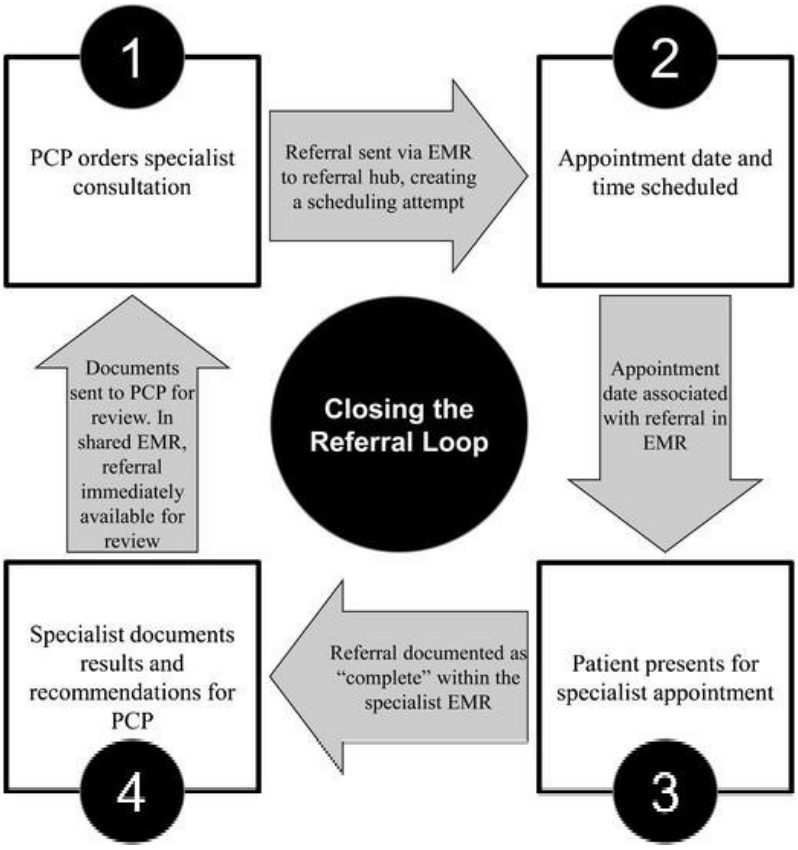
The Region 6 IDN is currently in what could be termed an aggressive pause with regard to implementation of a standardized shared care plan solution because partners have advised that closed loop referrals are a more important tool to them than the elements of a shared care plan that were initially identified by IDN stakeholders 24 months ago. There are several new solutions on the market that can function as both closed loop referral systems *and* shared care plans.

Several IDN stakeholders report expectations from DHHS that they use one or more of these newer solutions as a function of their DHHS project/funding contracts (e.g. the Doorways, the Community Mental Health Centers). This combination of new products and new expectations demanded the IDN reevaluate the best strategy moving forward to meet partners’ needs in the context of the DSRIP goals and the regional priorities.

The IDN anticipates continuing to develop workflows and protocols with partner agencies through B1 coaching, Clinical Advisory Team reviews, and A1 workforce investment plans with the knowledge that those efforts will prepare partners to participate in any/all closed loop and shared care plan communication exchange solutions they may participate in individually or across the region.

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 support partner progress to more electronic participation on this standard will remain an active priority.

Closed Loop Referral in Primary Care Ideal Type



B1-8h

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*
- *Intake procedures that include systematically soliciting patient consent to confidentially share information among providers*
- *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.*

Guidance protocols in all the required content areas have been developed and reviewed by the Clinical Advisory Team (CAT). The IDN 6 CAT felt strongly that protocol guidance should inform content areas that may be most challenging in a coordinate care / integrated care setting. Many partners had previously developed protocols / workflows in some content areas. The CAT advised that guidelines to enhance protocol / workflow development should not be prescriptive, but prompt discussion and be used as a tool for each practice to develop best practices in a setting moving toward Coordinate Care or Integrated Practice designation.

During this reporting period, the Operations team continued to share the Policy / Protocol Guidance Document (*embedded to follow*) with each B1 practice partner. Site visits and facilitated reviews of practice protocols / policies have been provided to help each partner complete an attestation form *(embedded to follow*). Each partner understands that policies / protocols / workflows will need to be available for audit, if required.

Table B1-8h illustrates attested status by practice partner of the current state of their protocol / workflow development. Many of the B1 partners will work directly on enhancing current policy / protocol / workflows in these areas as part of their 12-month Behavioral Health Integration Enhancement Project previously discussed.

Partners not engaged in a formal Behavioral Health Integration Enhancement Project will continue to receive Operations team support in progressive policy / protocol / workflow development. The regional 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. The IDN 6 Operations team can share examples of established protocols and workflows amongst regional partners. Attachment B1-8h.1 is an example of an MOU between one of our regional CBO partners and multiple B1 partners.

The Clinical Advisory Team's guidance will be made available to all regional partners in all projects via a website link.

Connections for Health IDN Region 6

Clinical Advisory Team Protocol / Policy Development Guidance

Connections for Health IDN Region 6

Connections for Health
IDN Region 6

Clinical Advisory Team Protocol / Policy Development Guidance

The following guidance is provided by the Clinical Advisory Team whose members include representation from Connections for Health partner practices including primary care, hospital-based practices, mental health, and substance use disorder treatment providers.

This guidance represents collective recommendations for development of policies and protocols in an integrated care setting.

Guidance: This protocol describes the process for documentation of interactions between providers and community-based organizations (CBOs). The protocol may be adapted for paper or electronic health record, as needed.

Rationale: Provider-to-provider interactions help to ensure coordinated care for patients. Well-coordinated care improves patient outcomes and reduces health care costs by reducing redundancy and unnecessary costs associated with duplication of care.

Localized Adoption Considerations:

1. *Patient Registries*: Clearly define patient groupers to facilitate future data extraction, including, but not limited to, payor-type, disease based, and demographic.
2. *Care Team Documentation*: Whether using paper or electronic health record, the patient chart should include documentation of the patient care team. Patient care team documentation should include a field for "provider type" to facilitate future data extraction.
3. *Workflow documentation*: Documentation, training, and quality assurance activities for localized workflows are essential to ensuring fidelity to care coordination activities and facilitating accurate data extraction.

Process Considerations:

1. Interaction Documentation
    a. How will care calls be routed in your organization?
        i. Example: Patient service associate (PSA) answers call and routes to a care coordinator (CC). If care coordinator is not available, PSA documents the call and routes to CC for call back. *In this workflow, all calls are documented. Quality assurance activities can include measuring first-call resolution and time-to-return call. This workflow requires training of two groups of employees.*
        ii. Example: Service-providers call the care coordinator directly. If the CC is not available, the service provider leaves a message. *In this workflow, calls cannot be tracked, but only one group of employees will need training.*
    b. How will care calls be documented?
        i. *Subject of call:* If you have an electronic medical record, choose a "structured" subject. This will facilitate future data extraction.
        ii. *Call facts:* If you have an electronic record develop a template to ensure thorough call documentation, include time and date of call, name of caller, call back number.
        iii. *Follow up activities:* Workflow should include documentation of follow-up activities, for example, "will route to PCP for advice" or "care plan has been updated." If possible, these activities will be structured fields to facilitate data extraction.

2. Quality assurance activities allow you to monitor the process to determine if the workflow is effective, when staff may need additional training, or when more (or less) staff may be needed.
    a. What process measures will you monitor? Examples include:
        i. Number of care calls
        ii. Time-to-care call resolution
        iii. Number of health record interactions and/or phone calls needed to resolve the care call
        iv. Number of care plan updates generated
        v. Number of follow up patient appointments generated

Attachments

1. **Patient Registries**
2. **Care Team Documentation**
3. **Workflow Documentation**

Patient Registries

Patient Registries track patients on the basis of age, disease, sex, risk for disease, or insurance payor, and many other criteria and risk factors. Patient registries enable health care providers to plan for patient care and to ensure appropriate care and follow up.

Patient registries include, for example:

- Sex
- Gender
- Age
- Ethnicity
- Language
- Chronic Disease
- Insurance Payor

Registries may also include answers from risk-based screening, or social or work history data, for example:

- At-risk alcohol and drug use
- At-risk sexual behavior
- Legal status
- DCF status
- Lead level

Resources are available to help you develop or to improve your patient registries:

Implementing a Plan of Care Registry (AMA)
https://jamanetwork.com/SsoTokenHandler.ashx?returnUrl=https%3a%2f%2fedhub.ama-assn.org%2fsteps-forward%2fmodule%2f2702745&instSigninUrl=&referralUrlKey=

Registries Made Simple (AAFP)
https://www.aafp.org/fpm/2011/0500/p11.html

Using Computerized Registries in Chronic Disease Care (CHCF)
https://www.chcf.org/wp-content/uploads/2017/12/PDF-ComputerizedRegistriesInChronicDisease.pdf

Care Team Documentation

Effective care coordination relies on having accurate documentation of the patient's care team and service providers.

If you are using an electronic health record, your record may include fields for recording the care team. You may be able to work with your health record vendor to customize fields to support your patient care registry.

Recommendations for care team documentation:

- Provider or Service Agency Name
  - Note: your health record vendor may be able to upload specialists and service providers in your area to facilitate data entry promote accurate data capture.
- Provider or Service Agency Type
  - Note: Structured data is ideal, for example:
    - Skilled Nursing
    - Home Health Aid
    - Family Member
    - Caregiver
    - Department of Children and Families
    - Cardiology
    - Social Work
    - Therapist
- Address
- Fax
- Phone number

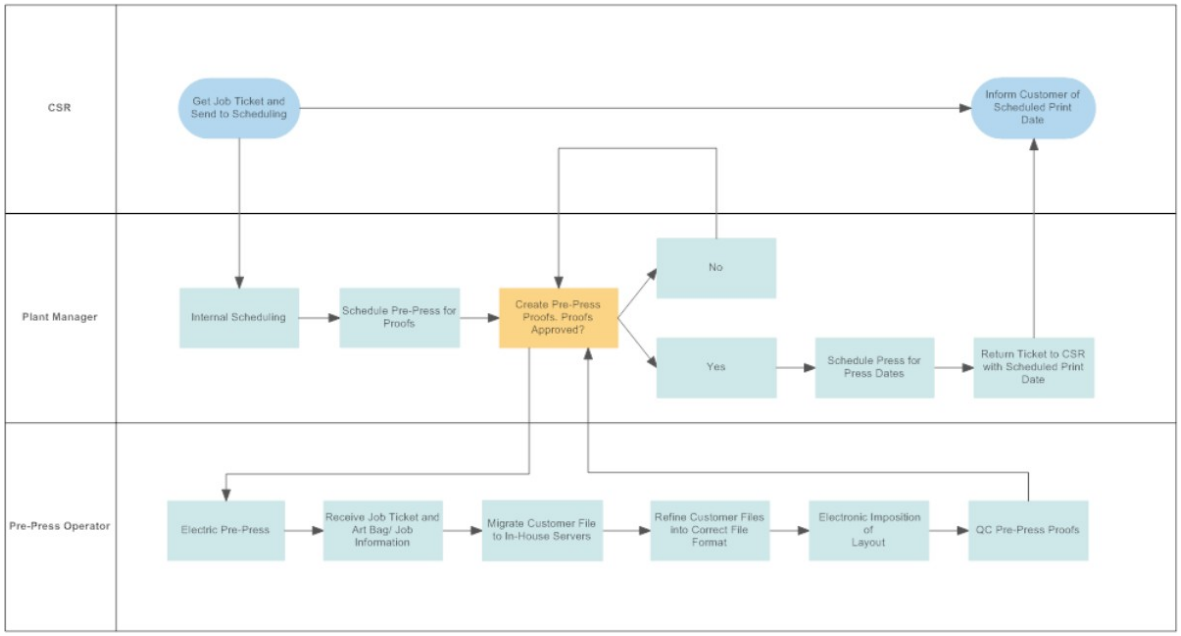
Workflow Documentation

Developing a workflow "map" of your localized process is essential for training and quality assurance activities.

Common tools used for workflow documentation include Visio, which can be quite complex and expensive if a number of team members are responsible for developing and documenting workflows. As an alternative, you can use a program like PowerPoint to document simple workflows.

Swim Lane workflow charts are helpful when there are number of different "roles" responsible for a workflow.

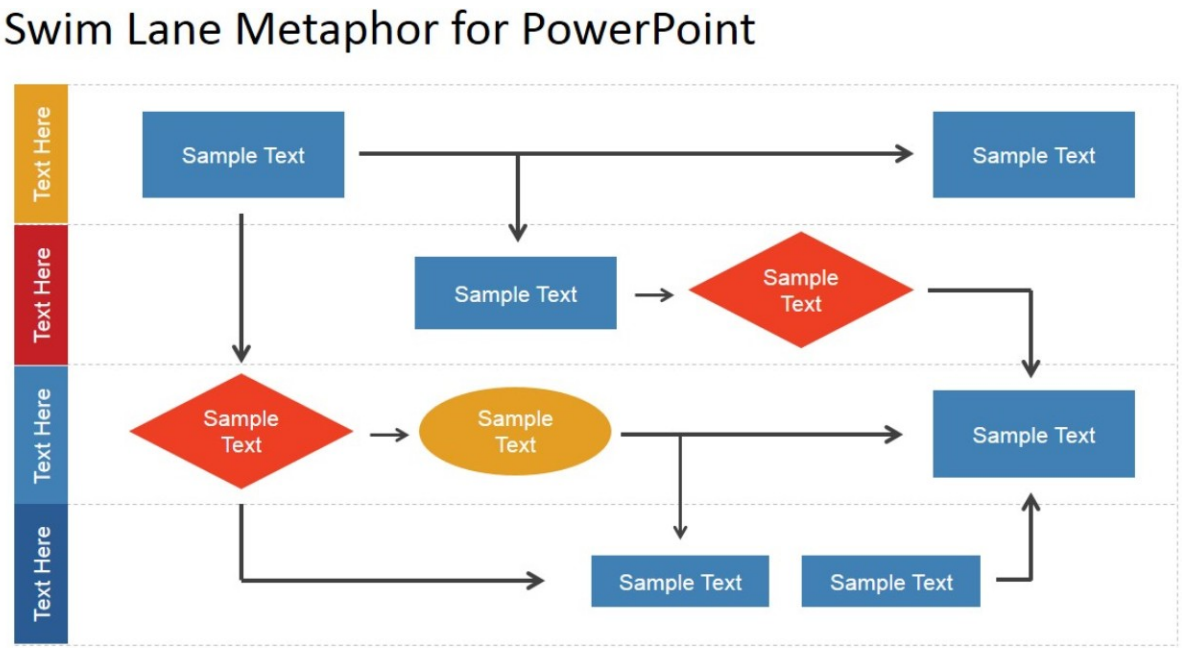
Example: Swim Lane Workflow in Visio



Using "SmartArt" in PowerPoint, you can also develop basic workflows and "swim lane" type workflows.

Example: SmartArt in PowerPoint

Subscribing to a service like SlideModel can also reduce the time spent on creating workflow diagrams. https://slidemodel.com



Guidance: This protocol defines timely communication and describes the process for documentation of outreach activities.

Rationale: Timely follow up with patients during a care transition can improve care quality, reduce health care costs, and reduce morbidity and mortality.

Localized Adoption Considerations:

1. *Care Transitions*: It is important to "define" care transitions in your organization and educate all levels of staff on the importance of recognizing a care transition and scheduling appropriate telephonic or in-person follow up during a care transition.

Generally, a care transition is defined as any movement of a patient from level of care to another level of care, an insurance coverage change, or a housing change which may have altered the patient's access to care-giver assistance, air-conditioning, or refrigeration.

2. *Care Team Documentation*: Whether using paper or electronic health record, the patient chart should include documentation of the care transition, outreach attempts, and the outcomes of outreach. When able, develop templates to ensure all necessary data is collected.
3. *Medication Reconciliation*: Define when, how, and who should perform medication reconciliation during a care transition.
4. *Workflow documentation*: Documentation, training, and quality assurance activities for localized workflows are essential to ensuring fidelity to care coordination activities and facilitating accurate data extraction.

Process Considerations:

1. Define care transitions in your organization.
2. Define who is responsible for outreach?
3. Will outreach be telephonic or home visiting?
4. How will outreach be documented?
5. What data will be collected during outreach to assist with clinical care decisions?
6. Can timepoints be captured in your electronic health record?
7. How can other software (i.e., MS Excel) help you to track outreach?

Attachments

1. Care Transitions Grid (examples)

Transition	Number of Contact Attempts	Responsible for Outreach	Call & Scheduling Guidelines
ED Visit	3, at different times of the day. If no response, send a letter. Call Emergency Contact if needed. Document all contact attempts, outcomes, and follow up.	Nurse	• Education on ED use. • Schedule follow up in 24-72 hours if issue not resolved.
Hospital Visit		Nurse	• Have all results been received? • Have specialty appointments been scheduled? • Any questions about medications? • Schedule follow up within 24-72 hours with Provider. • Perform medication reconciliation.
SNF Discharge		Nurse	• Update the care team. • Are VNA services in place, if needed? • Are there unmet ADL needs. • Schedule follow up as needed. • Perform medication reconciliation.
Housing Status		Care Coordinator	• Link patient with social work services. • Are there medications requiring refrigeration (HIV, Insulin)? • Are there medications requiring electricity (nebulizers)? • Can the patient safely store medications? • Schedule follow up with Nurse or Provider.
VNA discharge		Nurse	• Have care plan needs been met? • Are there unmet ADLS? • Schedule follow up with Nurse or Provider, if needed.
Insurance Coverage		Care Coordinator	• How many days' supply of medication does the patient have on hand? • Are there upcoming medical appointments that may not be covered? • Schedule patient with enrollment and eligibility if an insurance loss or underinsurance. • Schedule patient with medication access nurse, if needed. • Assist with "free bed funds" enrollment if upcoming hospital-based specialty appointments.

Guidance: This protocol will highlight some common misconceptions around data sharing that may serve as barriers to providing integrated care to patients.

Rationale: Patient privacy protection is required for all workflows implemented under the NH 1115 Waiver, and partner organizations should follow their established policies and procedures as defined by HIPAA and 42 CFR Part 2. Re-educating staff and partner organizations on "allowable" communications under HIPAA and 42 CFR Part 2 Regulations may reduce barriers to care integration.

Localized Adoption Considerations:

1. Community Health Center partner organizations have access to excellent resources that will provide assistance with policy revisions and staff education, including:
    a. The ECRI Institute provides risk management services at no charge to health centers on the behalf of HRSA https://www.ecri.org/clinical-risk-management-services
    b. The National Association of Community Health Centers (NACHC) provides webinars and community sharing through its Learning Center http://mylearning.nachc.com/diweb/home as well as the Health Center Resource Clearing House https://www.healthcenterinfo.org
    c. On a fee-for-service basis Feldman, Tucker, Leifer, Fidell will provide consultations on health law https://www.feldesmantucker.com/health-law/
2. Other non-FQHC partners should seek further advice from their internal legal counsel.

Privacy: Barriers and Misconceptions*:

1. State laws may be more stringent than federal laws; it is helpful to have legal review of current and future privacy-related policies and procedures.
2. HIPAA has broad exceptions for treatment and related care management activities and is not an impediment to data share among physical and mental health providers.
3. Records relating to substance abuse diagnosis or treatment provided in a general hospital emergency room or inpatient department, in a mental health facility, or in a primary care provider office, are *not* subject to Part 2 regulations.
4. Because of restrictive requirements for Part 2 providers, a general consent authorizing disclosure to all providers is not sufficient, and this poses a barrier for communication among Part 2 and non-Part 2 providers.

More information can be found in the policy brief "Integrating Physical and Behavioral Health: Strategies for Overcoming Legal Barriers to Health Information Exchange," prepared by Manatt, Phelps & Phillips – Robert Belfort, William Bernstein, and Susan Ingargiola for the Robert Wood Johnson Foundation (January 2014).

https://www.manatt.com/uploadedFiles/Content/4_News_and_Events/Newsletters/IntegratingPhysicalandBehavioralHealth.pdf

Attachments:
Examples of Common Provider Misconceptions About Health Privacy - selected content from above referenced article. As stated by the authors, these examples are not exhaustive. This chart is provided to counter common misconceptions generally and is not to be construed as legal advice."

Misconception	Actual Legal Rule
HIPAA requires patient authorization for disclosures for treatment purposes.	No patient authorization is required.
HIPAA's minimum necessary provision forces providers to determine which part of the medical record they can share with other providers for treatment purposes.	The minimum necessary rule does not apply to disclosures for treatment purposes.
A provider may not disclose information to another provider for treatment purposes unless the receiving provider has a pre-existing relationship with the patient.	No pre-existing relationship is required to receive information for treatment purposes. (A prior relationship is required to receive information for quality improvement purposes.)
HIPAA's restriction on the disclosure of psychotherapy notes applies to all notes of counseling sessions that are part of the patient's medical record.	A clinician's notes qualify as psychotherapy notes under HIPAA only if they are maintained separately from the patient's medical record.
The Part 2 regulations restrict the disclosure of all substance abuse treatment information.	The Part 2 regulations apply only to specialized substance abuse providers, not general medical providers who deliver substance abuse services.
A consent for the release of a Part 2 provider's records must be a separate document and cannot be combined with any other type of patient consent.	A Part 2 consent can be combined with another patient consent form if the form contains all of the elements required under the Part 2 regulations.

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Guidance: This protocol describes best practices in care transition management.

Rationale: Managing care transitions can help to ensure patient safety, improve care quality, reduce health care costs, and reduce morbidity and mortality.

Localized Adoption Considerations:

1. *This protocol should be developed in conjunction with "timely communication" protocols.*

Process Considerations:

1. Define care transitions in your organization.
2. Define who is responsible for outreach?
3. Will outreach be telephonic or home visiting?
4. How will outreach be documented?
5. What data will be collected during outreach to assist with clinical care decisions?
6. Can timepoints be captured in your electronic health record?
7. How can other software (i.e., MS Excel) help you to track outreach?

Attachments

1. **Care Transitions Activities Grid (Eric Coleman & Project Red)**
2. **Medication Discrepancy Tool**

CARE TRANSITIONS ACTIVITIES

Materials/components of transition plan (combination of Project RED and Coleman)

	STAFF ACTIVITIES: INPATIENT	PATIENT ACTIVITIES: INPATIENT	STAFF ACTIVITIES: AMBULATORY [translates into key assessment questions]	PATIENT ACTIVITIES: AMBULATORY
Medications	-Medication reconciliation	-Understand meds: how to take them, how to obtain them, side effects	-Medication reconciliation -Reinforce medication teaching -Ask if patient filled prescription -Discuss system for taking meds	-Fills prescription -Has a system for storage, reminders, refills -Takes meds appropriately -Asks questions
Discharge plan/ Care plan at home	-Written discharge plan -Reconcile discharge plan with national guidelines -Post-discharge services -Discharge summary sent to PCP	-Knows why ended up in hospital, chief problem -Been involved in decisions -Know where I am going and what will happen when I arrive -My family/friend know that I am going home and what I need -Care partner knows also -Has post-d/c appointment or knows how to make one	-Office visit within time period based on risk -Make follow-up phone call, possibly home visit -Reviews discharge plan -Assess status of discharge plan: is it in place, working, etc? Is care partner involved?	-Can answer: what's my problem, what can I do, why that's important -Involves care partner -Asks appropriate questions about plan
Follow-up appointment	Make follow-up appointments	-Know when appointment is/will make appointment when I get home -Have transportation to get	-Makes sure patient has appointment, emphasize its importance -Ask if patient has	-Keeps appointment
		there	transportation	

Thanks to Kathleen Thies, RN, PhD (pg. 1)

Outstanding tests	Outstanding tests			
Red Flags	Patient teaching: What to do if problem arises	-understands red flags ("red, yellow, green" zones for intervention) -has phone number of person/PCP to call -has a plan for what to do	-Remind patient about red flags during follow-up phone call -Reinforce red flags during visit	-can state red flags and what to do (could be related to red, yellow and green zones) -calls PCP office appropriately for red flags
Patient education and self-management	-Assess patient understanding Patient education -Discuss patient goals	-Patient indicates understanding of teaching, e.g., diet, daily weights, etc. -Care partner indicates understanding of teaching -Knows who to call with further questions/need for assistance -Knows "red, yellow, green" zones for intervention	-Discuss patient goals -Assess if patient is following through with teaching; do Teachback -Reinforce teaching -Reinforce about calling with questions/need for assistance -Assess functional status (e.g., ADLs) -Assess self-care/efficacy for self-management (Stanford model)	-Articulates goals -Follows through with teaching -Calls PCP office appropriately with questions/need for assistance -Confident that he/she can: --keep fatigue from interfering --keep pain/discomfort from interfering --keep emotional distress from interfering --keep symptoms from interfering with life --can do what need to do to manage illness --can do things other than take meds to manage illness (Stanford model)

Thanks to Kathleen Thies, RN, PhD (pg. 2)

MEDICATION DISCREPANCY TOOL (MDT)

MDT is designed to facilitate reconciliation of medication regimen across settings and prescribers

Medication Discrepancy Event Description: *Complete one form for each discrepancy*

✓ Causes and Contributing Factors :: Check all that apply

:: *Italicized text suggests patient's perspective and/or intended meaning*

Patient Level _____

1. ☐ Adverse Drug Reaction or side effects
2. ☐ Intolerance
3. ☐ Didn't fill prescription
4. ☐ Didn't need prescription
5. ☐ Money/financial barriers
6. ☐ Intentional non-adherence *"I was told to take this but I choose not to."*
7. ☐ Non-intentional non-adherence (ie: Knowledge deficit) *"I don't understand how to take this medication."*
8. ☐ Performance deficit *"Maybe someone showed me, but I can't demonstrate to you that I can."*

System Level _____

9. ☐ Prescribed with known allergies/intolerances
10. ☐ Conflicting information from different informational sources *For example, discharge instructions indicate one thing and pill bottle says another.*
11. ☐ Confusion between brand & generic names
12. ☐ Discharge instructions incomplete/inaccurate/illegible *Either the patient cannot make out the hand- writing or the information is not written in lay terms.*
13. ☐ Duplication. *Taking multiple drugs with the same action without any rationale.*
14. ☐ Incorrect dosage
15. ☐ Incorrect quantity
16. ☐ Incorrect label
17. ☐ Cognitive impairment not recognized
18. ☐ No caregiver/need for assistance not recognized
19. ☐ Sight/dexterity limitations not recognized

✓ Resolution :: check all that apply

- ☐ Advised to stop taking/start taking/change administration of medications
- ☐ Discussed potential benefits and harm that may result from non-adherence
- ☐ Encouraged patient to call PCP/specialist about problem
- ☐ Encouraged patient to schedule an appointment with PCP/specialist to discuss problem at next visit
- ☐ Encouraged patient to talk to pharmacist about problem
- ☐ Addressed performance/knowledge deficit
- ☐ Provided resource information to facilitate adherence
- ☐ Other _____

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Guidance: This protocol will highlight the importance of obtaining the patient's consent to engage in care coordination, case management, or care management activities.

Rationale: Comprehensive intake processes ensure the development of a complete care plan and/or case management plan. Obtaining patient consent for participation serves as a mutual agreement to the care plan, including frequency of contact and consent to contact other care providers, family members, and other caregivers for care and case management purposes.

Localized Adoption Considerations:

1. Intake into a formal care or case management program differs from a routine comprehensive history; comprehensive intake is generally performed by a nurse or social worker after the patient has been identified or referred for care or case management services.
2. The goal of the comprehensive intake is to establish strengths and opportunities, identify care gaps or concrete needs, and to facilitate the patient and family in meeting mutually agreed upon goals. A gap identified by the PCP (for example, over-due for routine cancer screenings) may be a part of that care plan, if the patient shares that goal.
3. A comprehensive intake may occur in person or over the phone. Intakes may take 45-90 minutes, or more.
4. Developing a standard intake tool, or template if you have an electronic health record, will assist in complete data capture, as well as case-review with the local care team.
5. The content of the intake will vary based on the service being delivered: medical intake for a care transition versus intake for psycho-social services. Below are suggestions for intake domains.

Examples Intake Domains for Medical Intake

- Follow up appointments
  - Does the patient have routine follow up with PCP and with Specialists?
  - If yes, what is the frequency, when is the next visit(s)?
  - *Goal (1): Identify patient's circle of care.*
  - *Goal (2): Identify if any challenges exist: transportation, copays, interpreter services, etc.*
- Psychosocial
  - Does the patient have help at home? If yes, who?
  - Who lives in your home?
  - Housing status
  - Violence at home: use a standard, evidence-based screener)
  - Food security: use a standard screener
  - Utilities: Any issues paying bills?
  - Transportation needs
  - Interpreter services needs
  - Substances use: use a standard, evidence base screener

  - Weapons in the home
  - DCF involvement
  - Incarceration (self, or close family)
  - *Goal (1): The interviewer learns more about what factors support and what may undermine the patient's mental and physical well-being.*
  - *Goal (2): The interviewer uses these findings to establish a care plan with the patient for linkages to concrete and social services.*
- Respiratory
  - Inhaler use
  - Nebulizer use
  - O2 use now, or prescribed, but not using?
  - Smokers in the house
  - CPAP use now, or prescribed, but not using?
  - *Goal (1): Establish if there are unmet educational needs*
  - *Goal (2): Establish if the patient is able to secure and to use the medications prescribed.*
  - *Goal (3): Establish if there are safety issues in the home related to O2 use.*
- Transitions
  - Has there been a recent care transition (ED, hospital, SNF)?
  - Admission date
  - Admission reason
  - Discharge date
  - Referrals made: VNA, Specialists
  - Medication changes
  - Falls during admission
  - Falls in home before the admission
  - *Goal (1): Establish if the patient is at risk for readmission.*
  - *Goal (2): Establish the patient's level of understanding regarding their health, their admission, follow up instructions, etc.*
  - *Goal (3): Identify transition needs related to referrals, overdue results, medication questions.*
  - *Goal (4): Identify if the patient may be a risk for falls and if patient is in need of a falls assessment (in office, and in home).*
- VNA Care
  - Is the patient currently receiving care from the VNA, including PT, OT, PCA services?
  - What type of services, how frequent, names/phone numbers of providers?
  - *Goal (1): Establish patient's circle of care.*
  - *Goal (2): Identify unmet needs.*
- Medications
  - The nurse manually reviews the patient's medication, with bottles.
  - RN performs a complete medication reconciliation.
  - Are there medications the patient regularly skips, or modifies the dosage?

    - Does the patient understand the need for each medication?
    - Does the patient use vitamins, supplements, or herbals?
    - Does the patient have trouble remembering to take medications?
    - Is medication diversion a concern for the patient?
    - *Goal (1): Identify safety issues.*
    - *Goal (2): Identify educational needs.*
- Care Process Review
    - *The goal of these questions is to discover if there are unmet educational needs around disease self-management: does the patient have the right tools in their home to monitor and manage their disease? Do they know when to call their PCP if their "numbers" are out of range?*
    - Glucometer if diabetes?
    - Home BP cuff if hypertension?
    - Scale if heart failure and/or COPD?
    - Medical alert bracelet?
    - Living will?
- Clinical Assessment
    - *If the interviewer is able, they may stratify the patient, enroll in a specific program, or refer to care team for review.*
- Patient Consent
    - Depending on the stratification/assessment, the interviewer should provide informed consent for participation.
    - Documentation of informed consent conversations can be done on a paper form, or an electronic medical record template. This consent may take place in a number of ways:
        - Establishing mutually agreed upon care goals, timelines, and follow up phone calls/meetings.
        - Setting self-management goals.
        - Enrolling in a dedicated care or case management program that may include group and/or 1:1 follow up, phone calls, journaling, etc.
        - Establishing how long the "focused" care will last: weeks, months, etc, and if the patient will receive ongoing support after "discharged" from the program.
    - As appropriate, patient may be asked to sign releases of information.

Guidance: This protocol will provide guidance on adherence to New Hampshire Board of Medicine Opioid Prescribing Regulations (NH BOM OPR).

Rationale: Enacting policies and procedures within your organization can ensure adherence and consistent enforcement of NH BOM OPR.

Questions for Organizational Assessment:

1. Does your organization of an existing policy and procedure in place for prescribers?
2. Is a review of the OPR a part of prescriber orientation and annual risk management activities?
3. Are patient registries and provider dashboards a part of your procedure?
4. Are templates available for prescribers to help with compliance to regulations?
5. Are nurse/ma standing orders in place to assist with opioid agreements, urine toxicology, pill counts, and prescription drug monitoring program checks?
6. Are OPR a part of annual provider peer review?

Examples Practice Tools to Facilitate Adherence to OPR: Attached to this guidance are two tools that can be adopted by your organization.

- Nurse Standing Order
  - With appropriate training, nurses can assist providers with adhering to BOM regulations.
  - Nurse care management of patients using chronic opioids for pain can be a part of the comprehensive treatment plan for chronic pain.
  - This standing order can be modified for your organization.
  - Nurse visits can be templated into your health record to ensure adequate data collection, and adherence to standing order guidelines.
- Provider Peer Review Tool
  - Peer review serves as an opportunity to:
    - Reinforce organizational policy and procedures.
    - Provider continuing education.
    - Provider collegiality and community.
- Technical assistance with adoption and implementation is available.

Policy: **Standing Order for Nurse Visit for Opioid Management**
Location: **Provision of Care Treatment and Services Department: Medical, Behavioral Health**
Date:
Revision:

Policy: Understanding order of the Chief Medical Officer, nurses may conduct independent visits for opioid management according to the following guidelines.

Rationale: All medical and behavioral health providers licensed to prescribe controlled substances in New Hampshire are required to adhere to the New Hampshire Board of Medicine's Administrative Rule Med 502 Opioid Prescribing. Opioids are commonly prescribed for pain in the United States, and the increase in "prescribed opioids" has been linked to the rise in opioid use disorders and overdose deaths. This public health emergency has lead both federal and state governments to ramp up their efforts to educate the public and prescribers on safer opioid prescribing and use. Nurses, as a part of comprehensive team-based care, play an important rule in assisting patients with the management of chronic pain, and the use of chronic opiates for pain.

Procedure for Nurse Visit

1. Collect full set of vital signs, including pain score.
2. Perform PHQ2 screener if not performed in the past 12 months.
3. Perform SBIRT if not performed in the past 12 months.
4. Perform functional assessment screener.
5. Verify/update Allergies.
6. Perform medication reconciliation.
7. If patient has been called in for pill count, document pill count.
8. If patient has been called for random urine toxicology, order and collect urine.
9. If patient is due, check PDMP, and reference findings in patient record.
10. Assess side effects and adverse effects of opioid therapy.
11. Assess opioid storage.
12. Document how patient is taking opioid medication, and how patient manages "breakthrough pain."
13. Review referrals with patient, assess compliance and/or barriers to receiving specialty care.
14. Review patient's treatment plan. Discuss success and barriers, modify and update plan as needed.
15. Establish or update self-management goal with patient.
16. Ensure routine follow up is scheduled with PCP.

Treatment and Plan

1. Before patient discharge, review red flags with PCP or provider of the day.
    a. Adverse effects from medication
    b. Medication diversion
    c. Need for early refills
    d. Side-effects that cannot be managed through lifestyle modifications.
2. Provide patient with updated medication list and after visit summary which includes updates to treatment plan, including referrals, side-effect management, and self-management goals.

	PEER REVIEW: Controlled Substances													
	DATE	Chart#	Chart#	Chart#	Chart#	Chart#	Chart#	Chart#	Chart#	Chart#	Chart#	Chart#	Chart#	
	REVIEWER													
	PROVIDER/SITE													
	ANSWER MAY BE NUMERICAL, YES, NO, or NA													Total
1*	History documentation?													
2*	Physical Exam documentation?													
3*	Rationale for opioid prescribing?													
4*	Complete treatment plan, including non-opioid modalities?													
5*	Risks and benefits discussed (informed consent)?													
6*	Documentation of PDMP Query?													
7^	Documentation of education provided?													
8^	Risk for opioid misuse, abuse, diversion documented?													
9^	Lowest effective dose, shortest duration prescribed?													
10^	Appropriate follow up, in office, before refilling?													
11#	Prescribed for lowest effective dose, limited duration?													
12#	Documentation of treatment goals?													
13#	Written/signed treatment agreement?													
14#	Documentation of consultation/consideration for consultation with specialist?													
15#	Documentation of evaluation of treatment plan, at least twice per year?													
16#	Random and periodic urine drug testing at least annually for chronic use >90 days?													

Definitions:
Chronic: Prescribed for more than 90 days.
Controlled Substances: Any Schedule 2, 2N, 3, 3N, 4, 5 medication.
Aberrant behavior: abuse, diversion, early refills, escalating doses without evidence of improvement of functional status.

INSTRUCTIONS

1. **CHART NUMBERS, BY PRESCRIBER SHOULD BE RANDOMLY GENERATED FOR "OPIOID GROUPER" BY A MEMBER OF INFORMATION TECHNOLOGY, BUSINESS INTELLIGENCE, OR QI/QA TEAM.**
    a. **Exclude cancer patients, terminal pain patients, and patients that have supervised administration of opioids in a health care setting.**
2. **A MINIMUM OF 10 CHARTS SHOULD BE REVIEWED BY A PEER MEMBER OF THE TEAM.**
3. **QUESTIONS 1-6 (MARKED WITH *) SHOULD BE ANSWERED FOR <u>ALL</u> PATIENTS, ACUTE AND CHRONIC.**
    a. **Q1: Documentation should include onset, location, duration, characteristics, alleviating and aggravating factors, radiation, time and severity. Physical exam should be appropriate for documented history.**
    b. **Q2: Approved risk assessment tools include:**
        i. **Opioid Risk Assessment Tool (ORT)**
        ii. **SOAPP 5**
        iii. **SOAPP 14**
    c. **Q3: Rationale should include why an opiate versus non opiate was selected**
    d. **Q4: Nonopioid modalities may include:**
        i. **Non-opioid medications (eg, NSAIDs, TCAs, SNRIs, anti-convulsants)**
        ii. **Physical treatments (eg, exercise therapy, weight loss)**
        iii. **Behavioral treatment (eg, CBT)**
        iv. **Procedures (eg, intra-articular corticosteroids)**
        v. **Referral to alternative medicine: chiropractor, acupuncture**
    e. **Q5: Informed consent may be structured text or documented in a patient hand out or after visit summary.**
    f. **Q6: NH PDMP queries should be "referenced" in the patient record. Queries may be performed by a delegate.**
4. **QUESTIONS 7-10 (MARKED WITH ^) SHOULD BE ANSWERED FOR ALL <u>ACUTE</u> PAIN PATIENTS.**
    a. **Q7: Education provided includes (handout given, structured data in chart)**
        i. **Risk of side effects, including addiction and overdose resulting in death**
        ii. **Risks of keeping unused medications**
        iii. **Options for safely securing and disposing of unused medication**
        iv. **Danger in operating a motor vehicle or heavy machinery**
    b. **Q8: This can be a standard screener implemented at your organization. Known risk factors include:**
        i. **Illegal drug use; prescription drug use for nonmedical reasons**
        ii. **History of substance use disorder or overdose**
        iii. **Mental health conditions (eg, depression, anxiety)**
        iv. **Sleep-disordered breathing**
        v. **Concurrent benzodiazepine use**
    c. **Q9: Prescriptions from Emergency Departments/Urgent Care/Walk-In Care: In most cases, a prescription of 3 or fewer days is sufficient, but no more than 7 days. If a prescription is necessary to exceed the board approved limit, the medical condition and rationale must be documented.**
    d. **Q10: For unresolved acute pain where continuity of care is anticipated: No obligation to prescribe opioids for more than 30 days; however, if unresolved acute pain persists beyond 30 days, requires an in-office, follow-up appointment prior to issuing a new script.**
5. **QUESTIONS 11-16 (MARKED WITH #) SHOULD BE ANSWERED FOR ALL <u>CHRONIC</u> PAIN PATIENTS.**
    a. **Q11: Prescribe short-acting opioids using lowest dosage on product labeling; match duration to scheduled reassessment.**
    b. **Q12: Treatment Plan, includes but not limited to:**
        i. **Goals of treatment in terms of pain management**

ii. **Restoration of function**
iii. **Safety**
iv. **Time course of treatment**
v. **Consideration of non-pharmacological modalities and non-opioid therapy**

c. **Q13: Written Treatment Agreement** The treatment agreement shall address, at a minimum:**
    i. **Requirement for safe medication use and storage**
    ii. **Requirement for obtaining opioids from only one prescriber or practice**
    iii. **Consent to periodic and random drug testing**
    iv. **Prescriber's responsibility to be available or to have clinical coverage**
    v. ****Not required for patients with episodic intermittent pain receiving no more than 50 dose units in a 3-month period**
d. **Q14: Consideration of consultation with an appropriate specialist for patients:**
    i. **Receiving 100mg morphine equivalent daily dose > 90 days;**
    ii. **At high risk for abuse or addiction; or**
    iii. **Have a co-morbid psychiatric disorder**
e. **Q15: Re-evaluation of treatment plan may should be at documented patient visits. PDMP checks may be conducted by nurse/MA with appropriate delegated authority.**
f. **Q16: Urine toxicology is not required for patients with episodic intermittent pain receiving no more than 50 dose units in a 3-month period. Urine toxicology may be conducted at nurse/MA visits with appropriate training and delegated authority.**

RESOURCES

Boston University School of Medicine. Safer/Competent Opioid Prescribing Education (SCOPE of Pain). https://www.scopeofpain.org Centers for Disease Control and Prevention (CDC). Safe Prescribing Saves Lives. https://www.nhms.org/resources/opioid
New Hampshire Medical Society Opioid Prescribing Resources. https://www.nhms.org/resources/opioid

Guidance: This document provides guidance to IDN members for establishing joint service protocols, communication channels, and other expectations of partners in an integrated delivery network.

Rationale: Integrating care and services requires clearly outlining expectations and deliverables between partners, or among multiple partners to ensure quality patient care and services, reduce duplications of care and services, outline payment and billing, ensure fidelity to federal and state regulations, and/or funding agencies.

Localized Adoption Considerations: It's likely that these partnerships already exist in your organization and may not have been formalized with documented and mutually agreeable standard operating procedures.

Process Considerations:

1. *Inventory existing partnerships*:
    a. What services or staff are being delivered or shared?
    b. Are billing arrangements clearly defined?
    c. Are communication channels established?
    d. Do you currently have MOUs in place?
2. *Quality and Performance*:
    a. Have you established measurable quality and performance goals?
    b. Does reporting meet the needs of partner organizations?
    c. Are partner meetings occurring?
    d. Are reports and outcomes shared with leadership and boards of directors?
3. *Workflow documentation*:
    a. Do existing MOU clearly outline how and where work is done?
    b. Do you have business associate agreements (BAA) in place if partner agency staff have access to your health record?
    c. Do you have policies and procedures in place to on-board partner staff at your organization to meet federal privacy regulations?

Resources: SAMHSA-HRSA Center for Integrated Health Solutions has resources available to help at https://www.integration.samhsa.gov/operations-administration/contracts-mous

1. Mutual care management agreements for transitions of care, access, collaborative care management, patient communication.
2. Assessing and addressing legal barriers to integration
3. Do's and Don'ts of contracting behavioral health services
4. Sample documents
    a. Memorandum of understanding
    b. Partnership agreements
    c. Affiliation agreements

Guidance: This document is intended to help IDN partners perform an organizational assessment on Case Management Services. Individual partner organizations may use this tool to help craft their policies and procedures the process for coordination and documentation of interactions among case managers internal and external to the integrated delivery network.

Rationale: Well-coordinated care is facilitated by case management activities to ensure patient safety, improve patient outcomes, and reduce health care costs by reducing missed opportunities, avoiding redundancy and unnecessary costs associated with duplication of care.

Localized Adoption Considerations:

1. *Define Case Management in Your Organization*: Case management functions may be performed by various levels of staff at your organization; some services may be performed/delivered by organizations external to your organization. It is important to define what types of case management (CM) your organization offers, who providesthe CM service, and the levels of CM (intermittent, intensive, etc).
2. *Care Team Documentation*: Whether using paper or electronic health record, the patient chart should include documentation of the patient care team and "touches" with both the patient, and other members of the care team.
3. *Workflow documentation*: Documentation, training, and quality assurance activities for localized workflows are essential to ensuring fidelity to care coordination activities and facilitating accurate data extraction.

Process Considerations:

1. How will patient be stratified and how will case management services be delivered at each level of acuity? *Example: A 45-year old woman with an abnormal mammogram. How would case management activities be different if . . .*
    a. *The woman is insured, in a stable relationship, and has her own transportation.*
    b. *The woman is homeless, has no reliable transportation. She frequently runs out of "prepaid cell phone minutes" by the middle of the month.*
    c. *The woman is severely and persistently mentally ill; she lives in a group home setting.*
2. Who performs case management services in your organization? Are roles clearly defined? Does work "fall through the cracks?"

Attachments

1. **Organizational Assessment: Case Management**

Case Management: Who does it now?		
Activity	Who does it now?	Notes
Abnormal Results Management	☐ Office Assistant ☐ Medical Assistant ☐ CHW ☐ BSW ☐ LICSW ☐ LPN ☐ RN ☐ APN ☐ MD/DO ☐ Other	
Referral Management • Scheduling according to acuity • Results Retrieval • Following up for patients who do not attend appointment	☐ Office Assistant ☐ Medical Assistant ☐ CHW ☐ BSW ☐ LICSW ☐ LPN ☐ RN ☐ APN ☐ MD/DO ☐ Other	
Concrete Services • Housing • Food • Utilities • Transportation • Clothing	☐ Office Assistant ☐ Medical Assistant ☐ CHW ☐ BSW ☐ LICSW ☐ LPN ☐ RN ☐ APN ☐ MD/DO ☐ Other	
Social Services Coordination • Unemployment • DCF • Elder Affairs • Intimate Partner Violence • Legal • Custody/guardianship • Schools	☐ Office Assistant ☐ Medical Assistant ☐ CHW ☐ BSW ☐ LICSW ☐ LPN ☐ RN ☐ APN	

Case Management: Who does it now?		
Activity	Who does it now?	Notes
	☐ MD/DO ☐ Other	
Medication Assistance • MAP applications for uninsured and underinsured • Medication reconciliation • Medication checks/Pill Counts • Medication Education	☐ Office Assistant ☐ Medical Assistant ☐ CHW ☐ BSW ☐ LICSW ☐ LPN ☐ RN ☐ APN ☐ MD/DO ☐ Other	
Coordination of Care Activities • Attends team meetings • Updates patient care team • Proactively outreaches to patient and caregivers • Responsible for ensuring patient health record is up to date	☐ Office Assistant ☐ Medical Assistant ☐ CHW ☐ BSW ☐ LICSW ☐ LPN ☐ RN ☐ APN ☐ MD/DO ☐ Other	
Does your organization have policies defining how case management activities get done?		
Are there formal policies/procedures on case management documentation?		
Are there formal guidelines on the management of abnormal results?		
Are there formal guidelines on the management of routine, intermediate, and high priority referrals?		
Are there organized times during the week/month/quarter for care team meetings/case review?		

Case Management: Who does it now?		
Activity	Who does it now?	Notes
Are there members of the care team who spend hours "after hours" performing case management activities?		
How "easy" or how "hard" is it to "refer" a patient for a social service need? Describe some cases you've encountered.		
Describe how/if supervisors are involved in budgeting discussions if work/staff is shared between departments?		

Below is the attestation form to be completed by each partner and kept on file with IDN 6. Table B1-8h illustrates the partners' level of protocol / workflow development as of the end of the current reporting period.

B1-8h Practice Partner Workflow Attestation Form

Practice Name:		
Person Completing Form:		
Signature:	**Date:**	
Instructions: Please indicate if the practice has an **Active = A, In Development=ID, or To Be Developed=TBD** policy, protocol, or workflows in each of the following content areas.	***Please list status as: A, ID, TBD, or n/a***	***Guidance from the IDN 6 Clinical Advisory Team (CAT) is attached. Please add a check mark below to indicate review of the CAT documents.***
POLICY/PROTOCOL CONTENT	**STATUS**	**IDN 6 GUIDANCE REVIEWED**
1. Interactions between providers and community-based organizations		
2. Timely communications		
3. Privacy, including limitations on information for communications with treating provider and community-based organizations		
4. Coordination among Case Managers		
5. Safe transitions from institutional settings back to primary care, behavioral health, and social support service providers		
6. Intake procedures that include systematically soliciting patient consent to confidentially share information among providers		
7. Adherence to NH Board of Medicine guidelines on opioid prescribing		
8. Medication Assisted treatment		
9. Treatment of mild to moderate depression		*USPSTF guidance recommended for both children and adults*
10. Joint Service protocols		
11. Communication channels		.

Table B1-8h: practice has an **Active = A, In Development=ID, or To Be Developed=TBD** policy, protocol, or workflows in each of the following content areas. **n/a = not applicable to the practice**

Documented Workflows / protocols:	Rochester Pediatrics	Skyhaven Internal Medicine	White Mountain Community Health Center	Wentworth Internal Medicine	Hilltop Family Practice	Lee Family Practice	Seacoast Mental Health Center	Lamprey Health Care – Newmarket	Lamprey Health Care- Raymond	Community Partners	Seacoast Family Practice	Core Family & Internal Medicine
B1-8h												
Interactions between providers and community-based organizations	**ID**	**ID**	**ID**	**ID**	**ID**	**ID**	**A**	**A**	**A**	**A**	**ID**	**ID**
Timely communications	**ID**	**ID**	**ID**	**A**	**A**	**A**	**A**	**A**	**A**	**A**	**TBD**	**TBD**
Privacy, including limitations on information for communications with treating provider and community-based organizations	**ID**	**ID**	**ID**	**A**	**A**	**A**	**A**	**A**	**A**	**A**	**A**	**A**
Coordination among Case Managers (internal and external to IDN)	**ID**	**ID**	**ID**	**ID**	**ID**	**ID**	**A**	**A**	**A**	**A**	**ID**	**ID**
Safe transitions from institutional settings back to primary care, behavioral health, and social support service providers	**A**	**A**	**A**	**ID**	**ID**	**ID**	**A**	**A**	**A**	**A**	**ID**	**ID**
Intake procedures that include systematically soliciting patient consent to confidentially share information among providers	**A**	**A**	**A**	**A**	**A**	**A**	**A**	**A**	**A**	**A**	**ID**	**ID**
Adherence to NH Board of Medicine guidelines on opioid prescribing	**A**	**A**	**A**	**A**	**A**	**A**	**n/a**	**A**	**A**	**n/a**	**A**	**A**

Documented Workflows / protocols:	GSCH – Goodwin Community Health	GSCH – Families First	GSCH – Lilac City Pediatrics	Southeastern New Hampshire Services	Hope on Haven Hill	Seacoast Youth Services	Appledore Family Medicine	Dover Pediatrics
B1-8h								
Interactions between providers and community-based organizations	**A**	**A**	**ID**	*Attestation pending*	*Attestation pending*	**ID**	**TBD**	**ID**
Timely communications	**A**	**A**	**ID**	*Attestation pending*	*Attestation pending*	**ID**	**TBD**	**ID**
Privacy, including limitations on information for communications with treating provider and community-based organizations	**A**	**A**	**ID**	*Attestation pending*	*Attestation pending*	**ID**	**TBD**	**ID**
Coordination among Case Managers (internal and external to IDN)	**A**	**A**	**ID**	*Attestation pending*	*Attestation pending*	**ID**	**TBD**	**ID**
Safe transitions from institutional settings back to primary care, behavioral health, and social support service providers	**A**	**A**	**ID**	*Attestation pending*	*Attestation pending*	n/a	**TBD**	**ID**
Intake procedures that include systematically soliciting patient consent to confidentially share information among providers	**A**	**A**	**A**	*Attestation pending*	**A**	**A**	**A**	**A**
Adherence to NH Board of Medicine guidelines on opioid prescribing	**A**	**A**	**A**	*Attestation pending*	**n/a**	**n/a**	**A**	**A**

Attachment B1-8h.1 *(B1 partners are bolded)*

MEMORANDUM OF AGREEMENT

Service Linkages Supporting Runaway and Homeless Youth in NH's Seacoast Region

As community stakeholders and organizations, we recognize the importance of providing supportive services and resources to meet the needs of our runaway and homeless youth in New Hampshire's Seacoast Region. The undersigned system-of-care providers have coordinated to support runaway, homeless and at-risk youth for 10+ years. Our organizations support the request being made by Waypoint for Street Outreach Program funding from the Family and Youth Services Bureau. The Street Outreach Program and Outreach Van has consistently provided outreach, gateway services, assessment, harm reduction, access to emergency shelter, and crisis stabilization to run away, homeless, and at-risk youth throughout the Seacoast Region. We agree, as summarized below, to support the efforts of Waypoint to provide services to run away, homeless, and at-risk youth in a coordinated way. Waypoint will engage youth through outreach, respond to urgent needs, conduct assessments, create and implement case plans and aftercare plans with youth, refer youth to appropriate external resources, provide counseling to youth and their families, and support youth as they transition from uncertain circumstances to safety, stability, well-being, and self-sufficiency. As outlined in separate agreements, when needed, shelter will be provided by Cross Roads House, My Friend's Place, and New Generations through the Seacoast Coordinated Entry System and the Waypoint Basic Center Program.

SERVICE LINKAGES		
Agency by Category	**Services**	**Name & Signature**
Government and Continuums of Care		
Home for All	Coordinates a community-wide collaborative, strategic plan to prevent and end homelessness. Waypoint Program Manager participates in general coalition meetings and participates in the advocacy work group to represent the youth voice.	
NH Bureau of Housing Supports	Works with NH communities to develop programs and services for NH's homeless population. Waypoint is a funded partner and is an entry point in the State of NH Coordinated Entry system.	
Balance of State	Provides Coordinated Entry (CE) system; coordinates a community-wide collaborative, strategic plan to prevent	

Continuum of Care.	and end homelessness. Waypoint is the entry point for youth in CE and is a funded partner providing youth focused Rapid Rehousing in the Seacoast and Concord areas.	
Balance of State Continuum of Care – Youth Subcommittee	Developing and implementing a state-wide strategic plan to prevent and end youth homelessness. Waypoint Program Director co-chairs this committee.	
Seacoast Youth on Their Own	Seacoast regional meeting which provides youth workers, child welfare, educators, healthcare professionals, advocates, other professionals, and community members a space to develop and implement plans to decrease barriers to services, identify in-risk youth, strategize, identify gaps in services, and educate the community at large. Waypoint Program Manager facilitates and will act as a liaison between regional and state efforts to end youth homelessness.	
Physical and Mental Health Providers		
Families First - Portsmouth	Provide (a) Healthcare for the Homeless - mobile comprehensive health services delivered to people at about 10 locations in 5 communities without stable housing and access to a regular medical provider; and (b) office based medical and dental services, pregnancy counseling, reproductive health and STI services. Waypoint SOP staff outreaches the mobile health services vans to connect with youth, as well as the office based center, and consistently links youth to staff at the health center to access the aforementioned services.	
Seacoast Mental Health Center – Portsmouth, Exeter	Provide adolescent and young adult mental health services. This includes assessment and evaluation, crisis intervention, individual and family counseling, school-, community- and home-based services, and wraparound services. SOP staff coordinates with the PATH worker at Seacoast Mental Health to engage in outreach activities together. SOP staff also refers youth to the center by way of the PATH worker to decrease barriers and enhance access to mental health supports and services.	
Endurance Behavioral Health	Endurance Behavioral Health provides mental health treatment for adolescents in the Seacoast Region by way of two programs: a six-hour Partial Hospitalization Program (PHP) and an Intensive Outpatient Program (IOP). SOP staff refer youth to Endurance as needed and accept referrals from Endurance Behavioral Health staff accordingly.	
Connections For Health Portsmouth , Rochester, Exeter	SOP staff participate and regularly refer youth and young adults to the Community Care Teams, a function of the Connections For Health regional initiative. The primary objectives are to 1) Improve care transitions between providers. 2) Promote integrated physical and behavioral health. 3) Build mental health and substance use disorder treatment capacity	

Goodwin Community Health - Somersworth-based, serve Strafford County residents	Provide adolescent and young adult primary care, dental care, prenatal care, and behavioral and mental health services. This includes teen specific health care and supports. SOP staff maintains intentional relationships with critical staff members at Goodwin Community Health center in an effort to connect youth to critical services at the health center.	
Waypoint – Family Counseling Program	SOP staff directly connects youth to Family Counseling Clinicians for outpatient counseling services.	
Health Insurance		
New Hampshire Healthy Families	Health plan selected by the State of New Hampshire to offer high-quality healthcare coverage to Medicaid enrollees throughout NH. SOP assists youth in applying for Medicaid through the NH Easy Application, comparing health plans once accepted and navigating benefits. .	
Well Sense	Health plan selected by the State of New Hampshire to offer high-quality healthcare coverage to Medicaid enrollees throughout NH. SOP assists youth in applying for Medicaid through the NH Easy Application, comparing health plans once accepted and navigating benefits.	
Substance Abuse Treatment Centers		
Live Free Recovery Consultants- Rockingham and Strafford Counties	Adolescent (13-17) and Young People (18-25) Intensive Outpatient Programming. Provides transportation, mentoring, clinical peer recovery supports, academic tutoring, job assistance, relapse prevention planning, and after-care supports. Waypoint SOP staff assist clients access supports and services as needed.	
SOS Recovery Community Organization Rochester, Dover	Peer based recovery support communities. Provides recovery coaching, recovery phone coaching, meetings and workshops, harm reduction, pro-social engagement, crisis response, and professional trainings. Waypoint SOP staff intermittently outreaches the community centers, shares Waypoint SOP outreach calendars and events with SOS staff, and helps youth access SOS Recovery Community services and supports.	
Law Enforcement		
Dover Police Department	Collaboration with department as needed, pertaining to referrals for youth in need; SOP to participate in National Night Out: a nationwide community police awareness raising event; and on-going referrals, support, and collaboration between SOP and the Dover Teen Center- a police sponsored drop-in center to support pro-social community involvement and prevention programming.	
Rochester Police Department	Collaboration with department as needed, pertaining to referrals for youth in need; SOP to participate in National Night Out; a nationwide community police awareness raising event; and on-going participation in teen night a monthly police sponsored activity to	

	support safe and pro-social engagement amongst youth, community members, the recreation department, and police department.	
Rockingham Department of Corrections – Corrections Wrap	SOP staff attend WRAP meetings at the DOC to assist in transition planning for young adults exiting corrections into housing instability and/or homelessness.	
Juvenile Justice		
New Hampshire Department of Health and Human Services – Juvenile Justice Services	Provide oversight of youth involved in juvenile justice. SOP connects with JJS when a youth is identified as having run from that system in order to coordinate safe return. Youth who are aging out of system care and may be at risk for homelessness are referred to SOP.	

Child Welfare		
New Hampshire Department of Health and Human Services – Division of Children, Youth, and Families	Provide child protective services and oversight of youth involved in child protection or foster care. SOP connects with DCYF when a youth is identified as having run from that system in order to coordinate safe return and when abuse or neglect of a minor is suspected. Youth who are aging out of system care and may be at risk for homelessness are referred to SOP.	
School Systems		
Dover School Department	Provide education to all students including alternative education options when appropriate; provide McKinney-Vento sanctioned services to homeless and unaccompanied youth. SOP receives referrals from the McKinney-Vento Homeless Liaisons and unaccompanied youth under age 18 are connected to the Basic Center Program. SOP and BCP staff will connect with those youth in any safe, comfortable location youth identify. SOP connects youth to the homeless liaisons when re-engagement/re-enrollment in education is needed.	
Exeter School Department		
Somersworth School Department		
Hampton School Department		
Portsmouth School Department		
Rochester School District		
Employment Services/ Job Training		
NH Job Corps – Manchester	A free education and training program that helps young people at least 16 years of age learn a career, earn a high school diploma or GED, and find and keep a good job. SOP bring youth on tours weekly, provide referral and follow-up on intake appointments, and provide aftercare services to youth who enter the program. Youth who are being discharged from the program and may be at risk of homelessness are referred to the SOP Drop-in Center.	
NH Vocational Rehabilitation	Assist eligible NH citizens with disabilities secure suitable employment and financial and personal independence. SOP connect youth who have identified disabilities and who are struggling with employment in order to be assessed and	

	connected to the appropriate services.	
Community Action Partnership of Strafford County - Workplace Success	Provides TANF recipients skills, knowledge, experience, and support to obtain paid employment. SOP connects youth who receive TANF to support the youth employment and vocational objectives.	
My Turn Incorporated	My Turn helps in-risk youth develop their skills, goals, and self-confidence through alternative education, post-secondary planning, career exploration, and employment training. Waypoint SOP collaborates with My Turn Incorporated staff to help youth directly connect to their supports and services.	
Safe, Stable Housing		
Waypoint-Transitional Living Program	Provide 12-18 months of safe, stable housing and intensive case management focused on independent living skills for youth ages 18-21. The SOP and TLP exist in a continuum of RHY services at Waypoint which allows for effective referral into TLP.	
Families in Transition – Dover, Concord, and Manchester locations	The diverse array of housing options provided at Families in Transition does meet the need of some SOP youth, staff refer accordingly. FIT residential buildings in Manchester, Concord, and Dover New Hampshire house more than 180 individuals and families on any given night. They offer clean, safe, affordable living to the many residents who come to call FIT home. Waypoint SOP staff assist with the application and interviewing process and collaborate with the intake coordinator to decrease barriers and support access to services.	
Welfare Personnel		
City of Dover Public Welfare	Provides emergency assistance for individuals who lack adequate resources. Waypoint SOP staff assists youth access supports and navigate local welfare systems.	
City of Portsmouth Public Welfare		
Town of Farmington General Assistance		
City of Rochester Municipal Welfare Department		
Somersworth City Welfare		
Domestic Violence		
HAVEN	Provide crisis intervention, support services, education and advocacy to domestic violence survivors, their families and the community. 24 hour advocacy and support for victims, survivors, and others impacted by sexual violence. SOP connect youth to HAVEN when they have been victims of domestic or sexual violence and want to connect with advocacy, support, emergency shelter, or civil legal services.	
Services for Victims of Human Trafficking		
New Hampshire Human Trafficking Collaborative Task Force	A coordinated multi-sector effort to develop a strategic plan to respond to human trafficking through investigations and service provision. Waypoint was a founding member of the Task Force and remains a core partner representing the needs of RHY.	

Manchester Police Department	Is the statewide law enforcement contact for Human Trafficking needs including investigation and prosecution for victims of human trafficking. SOP connect youth to Detective Eric Tracy (assigned to Human Trafficking) when youth want to pursue prosecution of traffickers.	
Homeland Security Investigations	Provide law enforcement needs including investigation and prosecution for victims of human trafficking. SOP connect youth to Resident Agent in Charge Michael Posanka (assigned to Human Trafficking) when youth want to pursue prosecution of traffickers.	
Waypoint – Human Trafficking Program	Provides intensive case management services to victims of human trafficking including crisis intervention, victim advocacy, and support. SOP connects youth who have experienced trafficking (both sex and labor) to the Human Trafficking Program when youth want to access services specific to their trafficking.	

Confidentiality
All parties agree that they shall be bound by and shall abide by all Federal or State statutes or regulations pertaining to the confidentiality of client records or information.

Amendment
This agreement may be amended by any party but shall be done so in writing.

Execution
This agreement was executed in May of 2018 and shall be renewed annually thereafter.

_____ _____

Borja Alvarez de Toledo
President and CEO
Child and Family Services

Date

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

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

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

	assessment ● Universal screening using depression screening (PHQ 2 & 9) and ● Universal screening using SBIRT					
	For pediatric providers, the CCSA must also include: ● Validated developmental screening for all children, such as the ASQ:3 and/or ASQ SE at 9, 18 and 24/30 month pediatric visits; ● Developmental Screening using Bright Futures or other American Academy of Pediatrics recognized developmental	Table listing all providers by domain indicating Y/N on progress for each process detail				
B1-8b	List of multi-disciplinary core team members that includes, at minimum: ● PCPs ● Behavioral health providers (including a psychiatrist) ● Assigned care managers or community health worker	Table listing names of individuals or positions within each provider practice by core team				
B1-8c	Multi-disciplinary core team training for service providers on topics that includes, at minimum: ● Diabetes hyperglycemia ● Dyslipidemia ● Hypertension ● Mental health topics (multiple) ● SUD topics (multiple)	Type to be trained, PCP or BH. Ongoing reporting shall indicate # of people trained in each practice by provider type for each reporting period for each training. OR you may provide a list of names of all individual providers to be trained in each provider practice. Ongoing reporting would indicate Y/N for participating				

		individuals on progress for each training				
B1-8d	Training for staff not providing direct care that at minimum includes knowledge and beliefs about mental disorders that can aid in recognition and management	Training schedule and table listing all staff indicating progress on each process detail				
B1-8e	Monthly (or more frequent) core team case conferences on behalf of patients with significant behavioral health conditions or chronic conditions	Conference schedule and Table				
B1-8f	Secure messaging	Narrative				
B1-8g	Closed loop referrals	Narrative				
B1-8h	Documented work flows and/or protocols that include, at minimum: ● Interactions between providers and community based organizations ● Timely communication ● Privacy, including limitations on information for communications with treating provider and community based organizations ● 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	Workflows and/or Protocols (submit all in use)				

	opioid prescribing					

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

Achievement of all the requirements of a Coordinated Care Practice

Partners in IDN Region 6 continue to progress steadily on the continuum toward Coordinated Care practice designation. The chart below illustrates each practice partner's current status. Based on partners with all CCSA domains, MDCTs operationalized, successful development of workflows and protocols in the essential NH DSRIP components, and the ability to share care / treatment plans, the IDN 6 identifies six practice partners who have achieved Coordinated Care Practice designation.

Partner listings below are based on partner attestation and discussions at strategy sessions.

Partners listed below as:

Table B1-9a: Achievement of all the requirements of a Coordinated Care Practice

Organization / Provider	CCSA all domains	MDCT	Information sharing - care plans, treatment plans, case conferences	Standardized workflows and protocols via review and attestation
Rochester Pediatrics	No	Yes	Yes	*Progress*
White Mountain Medical Center	No	Yes	Yes	*Progress*
Skyhaven Internal Medicine	No	Yes	Yes	*Progress*
Wentworth Health Partners / Internal Medicine	No	Yes	Yes	*Progress*
Hilltop Family Practice	No	Yes	Yes	*Progress*
Lee Family Practice	No	Yes	Yes	*Progress*
Seacoast Mental Health Center	Yes	Yes	Yes	Yes
Lamprey Health Care - Newmarket	Yes	Yes	Yes	Yes
Lamprey Health Care - Raymond	Yes	Yes	Yes	Yes
Community Partners	Yes	Yes	Yes	Yes
Seacoast Family Practice - Stratham	No	Yes	Yes	*Progress*
Core Family and Internal Medicine -	No	Yes	Yes	*Progress*

Exeter				
Greater Seacoast Community Health - Families First	**Yes**	**Yes**	**Yes**	**Yes**
Greater Seacoast Community Health- Lilac Pediatrics	**Yes**	**Yes**	**Yes**	***Progress***
Greater Seacoast Community Health-Goodwin Community Health	**Yes**	**Yes**	**Yes**	**Yes**
Southeastern NH Services	**Yes**	**Yes**	**Yes**	*pending*
Hope on Haven Hill	**Yes**	**Yes**	**Yes**	*pending*
Seacoast Youth Services	**Yes**	**Yes**	**Yes**	***Progress***
Appledore Family Medicine	**No**	**Yes**	**Yes**	***Progress***
Dover Pediatrics	**No**	**Yes**	**Yes**	***Progress***

B1-9b

Adoption of both of the following evidence-based interventions:

- *Medication-assisted treatment (MAT)*
- *Evidence-based treatment of mild-to-moderate depression within the Integrated Practice setting either through use of the IMPACT or other evidence-supported model*

IDN 6 has guiding protocols and workflow development tools ("roadmaps") which guide our discussions with B1 partners as they move implementation or further refine their MAT/MAR programs and treatment protocols for mild to moderate depression. In addition to guiding protocol development, the IDN 6 offers connections to larger community of practice and training opportunities.

During the reporting period:

- Lamprey Health Care – Raymond successfully implemented MAT / MAR.
- Dover Pediatrics further developed treatment protocols and workflows for evidence-based treatment of mild-to-moderate depression as part of their B1 Integration facilitated project.
- Wentworth Health Partners / Internal Medicine further developed treatment protocols and workflows for evidence-based treatment of mild-to-moderate depression as part of their B1 Integration facilitated project.

Table B1-9b - MAT Program and Mild/Moderate Depression Treatment at practice level

Organization/Provider	MAT implemented	MAT/MAR integrated protocols Yes = completed ID = In development	Evidence-based treatment for mild/moderate depression
Rochester Pediatrics	**No**	**No**	**Yes**
White Mountain Medical Center	**No**	**No**	**Yes**
Skyhaven Internal Medicine*	**Yes**	**Yes**	**Yes**
Wentworth Health Partners / Internal Medicine	**No**	**No**	**Yes**
Hilltop Family Practice	**No**	**No**	**Yes**
Lee Family Practice	**No**	**No**	**Yes**
Seacoast Mental Health Center*	**Yes**	**Yes**	**Yes**

Lamprey Health Care – Newmarket*	Yes	Yes	Yes
Lamprey Health Care – Raymond*	Yes	Yes	Yes
Community Partners	No	No	Yes
Seacoast Family Practice -Stratham	No	ID	Yes
Organization/Provider	**MAT implemented**	**MAT/MAR integrated protocols Yes = completed ID = In development**	**Evidence-based treatment for mild/moderate depression**
Core Family and Internal Medicine-Exeter*	Yes	Yes	Yes
Greater Seacoast Community Health - Goodwin Community Health*	Yes	Yes	Yes
Greater Seacoast Community Health - Families First*	Yes	Yes	Yes
Greater Seacoast Community Health – Lilac Pediatrics	No	No	Yes
Southeastern NH Services	No	No	Yes
Hope on Haven Hill	No	No	No
Seacoast Youth Services	No	No	Yes
Appledore Family Medicine	No	No	Yes
Dover Pediatrics	No	No	Yes

**indicates practice with implementation of both required elements*

TREATMENT OF MILD TO MODERATE DEPRESSION

The Clinical Advisory Team's guidance for the development of evidence-based treatment protocols for mild to moderate depression includes adherence to the US Preventative Services Task Force (USPSTF) published guidelines for both pediatric / adolescent and adult populations. The USPSTF guidelines inform the treatment plan. The IDN 6 B1 partners need little support in this level of treatment decision-making. The primary need is in the development of *practice-specific integrated protocols / workflows* that progress from assessment (PHQ/9) -> intervention and/or referral to include internal BH staff and external providers -> multidisciplinary treatment care planning.

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.

B1 practice partners who have included further development of their integrated protocols / workflows for treatment of mild to moderate depression as a ***priority*** of their integration enhancement project starting August 2019 include:

1. Lamprey Health Care, Newmarket
2. Lamprey Health Care, Raymond
3. Dover Pediatrics

4. Wentworth Health Partners – Internal Medicine
5. Hilltop Family Practice
6. Lee Family Practice

MEDICATION ASSISTED TREATMENT (MAT) / MEDICATION ASSISTED RECOVERY (MAR)

The NH Bureau of Drug and Alcohol Services (BDAS) published "NH Guidance Document on Medication Assisted Treatment Best Practices", April 2018, is the foundational guidance document used by the IDN 6 and regional partners in development and implementation of MAT/MAR service programs. To access this document electronically, visit:
https://www.dhhs.nh.gov/dcbcs/bdas/documents/matguidancedoc.pdf

The MAT/MAR roadmap *(embedded to follow as Attachment B1-9b.2)* is used as a Technical Assistance tool to guide partners through the implementation phases of MAT/MAR programs and develop integrated programs that are *unique to their individual practice and enterprise needs*. Technical assistance includes recommendations for development of collaborative and community of practice connections between MAT/MAR providers. The IDN 6 team provides technical assistance during the development process based on the practice partner's needs and resources.

IDN support of progress for partner movement on this continuum

Increasing MAT/MAR services in Region 6: ***(available protocols in use immediately follow***

- **Lamprey Health Care** successfully implemented MAT / MAR services in their Raymond practice during the current reporting period. This follows successful implementation in their Newmarket location that is now providing MAT/MAR services for both prenatal and primary care patients. IDN 6 has supported participation in the MAT ECHO project and supports funding for hiring / retention of X-waivered providers at Lamprey Health Care.
- **CORE Physicians** has two active MAT prescribing providers in primary care at **Core Family and Internal Medicine - Exeter**. Protocols and workflows are in place at this practice. IDN 6 continues to provide technical assistance in development of workflows and protocols for their extended practice(s). CORE Physicians has expressed a goal to have a prescriber in each of their primary care locations. The IDN 6 is providing active technical assistance in this development phase.
- **SMHC** has an established MAT program. There has been no direct financial support for this service from IDN 6. Development of workflows and protocols in the areas of collaboration, case management, and joint services continue to inform further development of this service area.
- **Frisbie Memorial Hospital** practices / Skyhaven had expressed interest in assistance to increase the MAT / MAR services provided in their outpatient primary care practices. Due to enterprise-level changes pending, this work is paused at this time. IDN 6 remains in contact with clinical directors to reinforce the availability of support when the practice(s) are prepared to expand the service and/or work on integrated workflow design.

Support for partners in Community of Practice:

The IDN-6 has supported and confirmed Lamprey Health Care and CORE's ongoing attendance in the NH-based Project ECHO with case-based learning on Medications for Addiction Treatment (MAT). Both

partners have recently enrolled in the **Project ECHO – AMPLIFI**, is a one-year program that serves as an extension of the Partnership for Academic-Clinical Telepractice (PACT)-MAT ECHO program that will provide monthly onsite facilitation and practice support provided through evidence-based QI for MAT. It will provide participants with access to a toolkit of research and evaluation QI methods to expand practice knowledge and performance in the delivery of evidence-based MAT and PACT-MAT modules. This grant-funded project is of no cost to participants, and free CME/CNE are available.

The IDN-6 continues to provide opportunities to support both the MAT/MAR direct service teams and their indirect staff with training and professional development opportunities to enhance their work with patients with substance use disorders.

Attachment B1-9b.1 Partner-provided MAT/MAR protocols in use:

PARTNER #1 MAT/MAR PROTOCOL IN USE

Scenarios for SUD referrals

1. Internal referral from prescriber for client who is meds only and has primary diagnosis of SUD:
   Prescriber: Sends SUD referral to SUD Program Manager (PM)
   Diane: Schedules SUD Intake (either with herself or SUD clinician); once client shows for SUD intake, PM or SUD clinician sends referral to Mary C so she can open the client to SUD program.

2. Internal referral from clinicians: if a MH clinician does an intake and determines with client has SUD as primary (could have MH dx as secondary or just only SUD); they send a SUD referral to PM. Client is then scheduled for SUD Assessment. Once the assessment is completed and/or during SUD treatment, if MH issues become more evident and need attention, Diane will consult with the Team Leader/clinician who made the initial referral or Patty to develop an appropriate plan for the client.

3. Co-Occurring Clients:
   - Client has an intake with a MH clinician and is diagnosed with COD: if SUD is primary (or sole dx), clinician's send SUD referral to PM. It's important for the MH clinician who did the intake to consult with PM and their supervisor re: the client's mental health needs. Diane and the supervisor will discuss appropriate services (ie. Clients sees SUD clinician and attends COD group).

   - Client has an intake with a MH clinician and is diagnosed with COD with MH primary and SUD secondary: If the SUD is opiates/heroin, etc and client is asking for or may benefit from Suboxone, the clinician will send an SUD referral to PM who will schedule (or transfer to SUD clinician to schedule) an SUD Assessment. At the end of the assessment, the SUD clinician will schedule with client with a Suboxone prescriber for a Pre-Induction E&M (if appropriate). If a referral is not appropriate, the SUD clinician will inform the referring clinician and send the referral back.

   - Client has an intake with an ITCOD clinician (or a clinician with SUD experience) and Suboxone is indicated, the clinician will complete the SUD Assessment and if warranted, will send the MAT referral to Jan for her to schedule with Pre-induction E&M with the Suboxone prescriber. This clinician will also need to inform Mary C so she can open the client to the SUD program.

   *N**ote:** COD clients with primary MH who are in the Suboxone program will be mandated to attend a group but will be offered to attend a SUD or COD group. It will be encouraged that the client attend a COD group if one exists.

In cases where major Anxiety D.O. is presence and client is unable to tolerate a group setting, weekly individual therapy can be substituted for the mandatory group requirement.

Suboxone Treatment Program

What to Expect on Induction Day

- Please do not drink any alcohol or use any other non-approved drugs for 48-72 hours prior to induction appointment as this could interfere with your induction.
- Participants **should NOT drive** themselves to the initial induction appointment; participants should inform those that are providing transportation that they will call to notify them when they are ready for pick up. Friends and relatives are not allowed in the "induction room."
- Participants will be monitored by medical staff who will administer the Clinical Opiate Withdrawal Scale (COWS).
- Participants will be arriving with active withdrawal symptoms and may be experiencing discomfort.
- Medical staff will take steps to assist with managing this discomfort by administering small doses of the medication in half hour (1/2) increments until the symptoms improve.
- Please be prepared to be at SMHC for three (3) to four (4) hours for the induction process.
- Participants will be expected to provide a urine sample prior to being induced.
- If a participant is initially unable to provide a sample, they will be asked again to provide a sample prior to leaving.
- Participants **must stay** in the designated induction room(s) and not be walking around or hanging out in other areas of the building.
- Respect and politeness toward all staff and other participants is requested.
- Please **bring a pillow or blanket and snack food**, if desired.
- Please bring a book, newspaper, or other item(s) to keep you occupied while waiting. Consideration for others who are also in the induction process or for other SMHC business that is being conducted that day should be taken into account.
- Participants are expected to have their first follow up appointment with the doctor scheduled within a week after the induction.
- At the conclusion of the induction process participants will have a prescription sent to the pharmacy that will include enough medication until their next scheduled appointment.

Smoking Policy

- Smoking will be allowed in short breaks (3 to 5 minutes) between designated evaluations.
- Participants must be in the designated smoking area (picnic tables by white building) or in their own vehicle.
- Participants must return immediately to the building and to the designated induction room(s).
- After the initial dose is taken participants must remain in the designated induction room for a minimum of 15 minutes prior to taking a break, and also must return immediately after 5 minutes to have their vital signs checked again.

- Anytime a participant leaves the building for a smoke break they must hold their own prescription.

SUD Protocol for communication of pertinent information

UA results given to clients

- Doctor First
- Therapist second
- Avoid giving at MA office due to potential for crisis
- Pregnancy results – doctor, therapist, team

Notification of client death/overdose/other critical situation:

- Death – Next Business day –
  - Doctor First
  - Program Manager second
  - Therapist and team third
  - Do not disclose during off hours or to those not working directly with client
- Overdose/**other critical** situation – non death related:
  - Use of Alert system

SUD Program Structuring of groups

Groups will be tailored to stage of change and individualized to client's treatment needs.

- An introductory group that consists of 8 sessions.
  - Curriculum generated by Ari for ITCOD groups
  - Group will need to be completed prior to moving forward in program
  - Attendance will be taken regularly and given to prescribing doctors to ensure open communication regarding treatment.
  - 3 – 4 groups per week will operate on the same scheduled curriculum so that if a client misses one group, they can make it up on another day/time.
- Proposed:
  - If a MAT client misses 2 sessions, they will be given a warning that a 3rd absence may begin a taper of their prescription until they are group compliant (exception if hospitalized or in jail).
  - Clients will be expected to attend weekly until group is complete prior to reducing expectation to bi-weekly appointments.
  - Upon completion of initial 8 CBT group sessions, clients will be transitioned to other individualized groups to help continue sobriety.

- Will build upon existing groups and times initially.
- After induction, or beginning MAT, clients will attend an orientation (group or individual) with a CRSW.
- Orientation will include all aspects and expectations of the program.
- Intake staff may be asked to give a brief explanation of SUD Program expectations to clients making a SUD intake appointment.

SUD Protocol for Termination from Program

The following could result in a participant's termination from the MAT Program. The final decision to terminate a participant from the program will be at the discretion of the MAT Team. If terminated from the MAT program one may be eligible for other services.

1. Failure to comply with the drug testing policy.
2. Falsifying urine tests.
3. Multiple positive urine tests.
4. Selling or attempting to sell drugs or encourage drug or alcohol use by other participants.
5. Multiple situations in which a participant is requesting new refills due to their medication being
    a. "lost," "stolen," or another form of diversion.
6. Use of any synthetic substances.
7. Use of violence or threats of violence directed at SMHC staff, participants in the MAT Program,
    a. or any other SMHC client.
8. Assessed as needing a higher Level of Care (LoC) not available at SMHC. (Clinician will help facilitate move into higher LoC as needed).
9. Illegal activities on the grounds of SMHC.

Re-Entry Requirements: Proof of one or more of the following

- Completed a minimum of 90 days IOP program successfully
- Completed a minimum of 28 days residential tx program successfully
- Minimum of 6 months since termination and evidence of episodes of overdose or other near-death experience from use that has caused a significant adjustment in motivation toward recovery – and/or evidence of other stabilization on medication or living situation that was not previously present, and,
    - Expected to provide negative UA within 2 weeks of entry and
        - Provide 4 consecutive negative UA's within 60 days of re-entry

***Re-Entry guidelines may not apply to all – the MAT and psychiatric team will make a final decision regarding one's ability to re-enter services on an individual basis.**

PARTNER #2 MAT/MAR PROTOCOL IN USE

Policy

Policy Title:	Medication Assisted Treatment (MAT) Guidelines		
Manual:	Clinical	**Policy #:**	C.5.26
Latest Revision #	**Revision Date**	**Revised By:**	
Reason for revision:			
Developed By:	[redacted]	**Effective Date:**	01/2019
Reviewed By:	[redacted]	**Reviewed Date**	01/2019
Approved By:	Board of Directors	**Approved Date:**	01/23/19
Approval Signature:	[redacted]		

Cross References		
☐ **Other Policy (# & name)**	Medication Assisted Treatment (MAT) Nurse Intake Procedures Medication Assisted Treatment (MAT) Guideline Procedures	
☐ **Risk Management Manual**	☐ **New Hire Orientation**	☐ **Nurse Training Manual**

Sources / Standards	
☐ **NCQA (standard, element, factor)**	
☐ **Statutes / Regulations**	
☐ **Other Citations:**	Boston Medical Center Nurse Care Manager Model of Office Based Addiction Treatment: Clinical Guidelines 2018. http://www.nnepqin.org/wp-content/uploads/2018/08/A-Toolkit-for-the-Perinatal-Care-of-Women-with-Substance-Use-Disorders-COMPLETE-PRINT-VERSION-rev08.29.18-1-2.pdf This policy is MAT related.

Policy Statement

[redacted] will address substance use disorders as chronic medical conditions within the MAT program by using evidence-based, patient-centered comprehensive medical care in an effort to cease or reduce harmful substance craving and use; engage patients in treatment; restore patients' normal physiologic functioning; and improve patients' quality of life.

Protocol/Procedure:	Medication Assisted Treatment (MAT) Guideline Procedures

Developed By:	[redacted]	**Effective Date:**	01/2019
Reviewed/Revised By:	[redacted]	**Reviewed/Revised Date:**	01/2019
Reason for Revision:			
Approved By:	[redacted]	**Approved Date:**	3/5/19
Approval Signature:	[redacted]		

Cross References

Manual:	Clinical	**Policy #:**	C.5.26 Medication Assisted Treatment (MAT) Guidelines Policy

☐ **Risk Management Manual**	☐ **New Hire Orientation**	☐ **Nurse Training Manual**

Sources/Standards

☐ **NCQA (standard, element, factor)**	
☐ **Statutes/Regulations**	
☒ **Other Citations:**	Boston Medical Center Nurse Care Manager Model of Office Based Addiction Treatment: Clinical Guidelines 2018 http://www.nnepqin.org/wp-content/uploads/2018/08/A-Toolkit-for-the-Perinatal-Care-of-Women-with-Substance-Use-Disorders-COMPLETE-PRINT-VERSION-rev08.29.18-1-2.pdf This procedure is MAT related.

Protocol/Procedure

Purpose: To provide consistency in the scope of treatment provided within [redacted] Medication Assisted Treatment Program.

Admission Criteria:

Eligible patients for the MAT program must receive primary care at [redacted]. Prenatal patients must also receive primary care at [redacted] and if requiring induction, must be prior to 23 weeks gestation (confirmed by dating ultrasound) and without the following risk factors: acute medical or surgical conditions, significant polysubstance use, and/or use of long acting opioids.

Patients must be age 21and over.

Patient must have a phone with an active phone number.

Patient must have a *DSM-5* diagnosis of Opioid Use Disorder.

Patient must be able to come to visits during office hours of operation.

Patient must not have acute/chronic pain issues requiring opioid management.

Patient must be able to be treated in an office- based setting safely without harm to self or others.

Patient should be willing to address use of other harmful and/or illicit substances.

Patient must be assessed by the MAT team and deemed appropriate for Medication Assisted Treatment in an office- based setting.

Program Structure:

The MAT Nurse will notify the patient's PCP when there is a MAT referral, if referral did not originate from the PCP.

Regular communication will be maintained through the EMR between the patient's PCP and the MAT Treatment Team and is an integral part of the treatment plan.

Patients will be assigned a primary MAT provider, yet they may receive treatment from a covering MAT provider through [redacted] if their primary provider is unavailable.

If determined to be appropriate through the MAT nurse intake, behavioral health intake, and team determination process, patients commit to an individualized treatment plan involving behavioral health and medical office visits.

Confidentiality will be maintained according to Federal Confidentiality Rules (42C.F.R. Part 2).

Guideline for Buprenorphine- Naloxone Treatment:

Prior to Induction:

The patient discontinues use of illicit opioids prior to buprenorphine/naloxone induction to avoid risk of precipitated withdrawal.

Timeline for opioid discontinuation to be determined as part of the induction treatment plan and should be based upon patient's medical status, current opioid use, and opioid dependency.

Short-acting opioids: typically discontinue 8-24 hours prior to scheduled induction.

Long-acting opioids: typically discontinue 12-24 hours prior to scheduled induction.

Day 1: Induction:

The patient arrives at clinic in early withdrawal, with prescription medication in hand.

For patients who are actively using opioids other than buprenorphine, the MAT nurse assesses symptoms with the Clinical Opioid Withdrawal Scale (COWS). If the COWS score is > 12, the MAT nurse instructs the patient to take the buprenorphine/naloxone as prescribed.

The MAT nurse/provider will not initiate induction if COWS score is less than 12.

For patients who are self-maintaining with buprenorphine, assessment using COWS may not be necessary. Use of clinical judgment and reference to recent urine toxicology will be utilized by MAT provider.

The MAT nurse supervises medication administration and educates the patient about the appropriate administration technique. Administration of buprenorphine/naloxone sublingual film requires the medication to be kept in the mouth for a sustained period of time for appropriate absorption.

An initial dose of 2mg/0.5 mg buprenorphine/naloxone will be used as induction dose. This dose may be titrated upwards in 2 or 4 mg increments of buprenorphine, at approximately 2-hour intervals, under supervision, to maximum dose of 8 mg/2 mg buprenorphine/naloxone based on the control of acute withdrawal symptoms.

Buprenorphine/naloxone 2mg/0.5mg sublingual film is removed from a sealed, child-resistant foil pouch by the patient using proper technique as guided by the MAT nurse. The patient places the film under the tongue as instructed and observed by the MAT nurse.

The MAT nurse reassesses the patient after 30-60 minutes and updates the MAT provider.

The MAT provider will continue to titrate the prescription dose and instructions based on the patient response, until symptoms of withdrawal subside. Typically patients will titrate to 8 mg/2 mg by the end of day one; however, this dose may be less or could be higher, and will vary according to a patient's level of physical opioid dependence at the onset of treatment.

Adjunctive therapy may be used with or without buprenorphine/naloxone induction for the treatment of opioid withdrawal symptoms:

Clonidine 0.1mg q 6 hrs (hold if SBP <105mmHg)
Dicyclomine 20 mg q 6 hrs prn abdominal cramps
Loperamide 2 mg q 6 hrs prn diarrhea
Acetaminophen 650 mg prn q 4 hrs mild-moderate pain
Acetaminophen 1000mg q 6 hrs moderate-severe pain
Hydroxyzine HCL 50 mg q 6 hrs prn anxiety
Diphenhydramine 50 mg prn sleep

Day 2 through Day 7:

The patient is instructed to take the total dose equivalent to day one upon awakening. The patient is then required to check in with the MAT nurse by phone in a few hours. If increased symptoms throughout the day, the MAT provider may increase dose up to 16mg. The patient is to return to [redacted] within one week, or sooner if needed.

Week 1-6

The patient returns to the clinic after one week for assessment, prescription renewal, toxicology screening, counseling, education, support, and evaluation of medical, mental health and social needs.

No prescriptions lasting longer than one week are to be given during this phase.

Refills are permitted, but prescriptions are faxed or sent electronically to the appointed pharmacy (Rite Aid-[redacted]).

The patient sees the MAT nurse/provider weekly for four to six weeks until medication dose is stable, toxicology screens are appropriate, and the patient is adherent to the treatment plan.

Buprenorphine/Naloxone Stabilization:

Goal: Stabilization of dosing, elimination or reduction in use of illicit opioids and other substances, and patient engagement in the treatment plan.

The patient sees the MAT provider weekly until stable, then every other week, and progresses to monthly as clinically indicated. If a patient requires more support, they may present in person for more frequent visits.

Target buprenorphine dose should eliminate opioid cravings and withdrawal, with minimal to no side-effects.

The [redacted] MAT program will prescribe buprenorphine/naloxone sublingual film dose up to 16mg/day.

Narcotic blockade is typically reached at 16mg and is recommended in the early stages of recovery. (http://www.naabt.org/education/pharmacoloy_of_buprenorphine.cfm)

Divided dosing is especially helpful for patients with chronic pain for dual effectiveness and avoidance of narcotic medications.

The majority of patients take buprenorphine twice daily; the prescription may need to be specifically written as twice daily dosing to allow some patients to receive it twice daily while engaged in the MAT program.

Buprenorphine/Naloxone Maintenance:

Goal: monthly visits; ultimately, random visits if appropriate for patient; random is more effective in assisting patients (ASAM, White Paper, 2013).

Once stable, clinic visits every two to four weeks, with refills that coincide with visits.

Many patients will continue making visits more frequently than monthly as patients find these visits important to their recovery process.

Each decrease in visit frequency requires MAT treatment team review.

MAT Office Visits to Include:

Collection of urine sample for toxicology screen.

Assessment of status: medication dose, adherence, tolerance, side effects, cravings and withdrawal. Education on safe storage, recovery, relapse, as well as medical, social and psychiatric issues should all be addressed as indicated.

Review of treatment plan: visit frequency, counseling, and assess need for additional support.

The MAT nurse and provider notes should be documented in the EMR and available to the entire clinical team, including all waivered providers.

Lab testing: if LFTs were elevated at induction, consider rechecking within one to two months or sooner depending on degree of elevation, and regularly monitor thereafter. Elevations are more common in patients with Hepatitis C and HIV infection.

In cases of co-occurring alcohol use disorder, address concerns with patient and consider monitoring with urine EtG (ethyl glucuronide).

Contact other MAT team members as needed, including MAT provider and PCP if different and warranted.

Review contact information and phone number at each visit.

Clinical Decision-Making in the Event of Substance Use During Treatment:

[redacted] MAT program embraces a harm reduction approach to care and therefore does not recommend automatic discharge for patients who struggle with substance use while engaged in treatment, but rather will work to increase supports to patients in an effort to stabilize them.

Illicit substance use is typically reported by the patient during a MAT office visit and then later confirmed by toxicology screening. When substance use is reported during an encounter, the treatment plan can be adjusted at the time of the visit.

When a patient discloses substance use, the MAT nurse or provider will assess the circumstances surrounding the incident(s) (i.e. home environment, work environment, role of support persons and persons close to the patient). These details are necessary to effectively adjust the treatment plan to meet the evolving needs of the patient.

Clinical decisions to augment the treatment plan will be based upon the patient's overall well-being and standing within the MAT program, and therefore based upon multiple data points including: patient engagement with the treatment plan, recent toxicology screens, and status of physical, mental, and social health.

The MAT team communication via in-person team meetings, telephone calls, and the electronic medical record is essential to ensure consistent, high-quality patient care.

When a patient is struggling with ongoing substance use during treatment, the MAT nurse and providers will review the case specifics and utilize shared decision making to adjust the treatment plan to best meet the needs of the patient.

If illicit or harmful substance use occurs, the treatment plan should first be revised to increase supports and monitoring.

If the patient complies with an intensified treatment plan and is able to be stabilized, the MAT team will restructure treatment and continue with medication for addiction treatment within an office based setting.

In a case of continued substance use despite an intensified treatment plan, a patient may be referred to a higher level of care for added support and safety. When possible, ensure a "warm handoff" to where the patient has been referred.

Clinicians will always carefully weigh the risk versus benefit of continuing treatment in an office based setting prior to referring to another level of care.

In every instance that the treatment plan is augmented, careful documentation will occur in the electronic medical record to support either continuing the patient in the current treatment program or referring to another level of care.

Potential situations in which the risk of continuing treatment may outweigh the benefit:

- Inability to stabilize a patient on buprenorphine treatment within an office-based setting (i.e. ongoing opioid use despite adequate buprenorphine/naloxone dosage).
- Multiple negative buprenorphine UDS results for buprenorphine prescribed patients.
- Ongoing use of benzodiazepines, cocaine/stimulants, alcohol or other harmful/illicit substances causing impairment, sedation, overdose, medical events, and/or hazardous unsafe behaviors despite interventions by the MAT team.

Repeated incidents of presenting intoxicated, overdose, or hospitalization related to substance use.

Patients who are referred to a higher level of care or discharged will be reconsidered for MAT treatment in the future.

Revision of treatment plan may include:

- More frequent visits
- Shortened prescription intervals
- Loss of refills
- Confirmation of counseling and team engagement with counselor
- MAT treatment team meeting with patient
- Referral to relapse prevention groups or individual therapy
- Referral to intensive outpatient program (IOP)
- Psychiatric evaluation and treatment per psychiatric assessment
- Residential treatment
- Involvement of social services
- Increased collaboration with community providers
- Increased engagement with law enforcement
- Family/support involvement

Referral to higher level care may include:

- Detoxification/crisis stabilization services/transitional support services
- Residential treatment
- Methadone maintenance
- Directly observed buprenorphine/naloxone daily dosing in outpatient treatment program.
- Dual Diagnosis treatment

Buprenorphine/Naloxone: Aberrant Urine Drug Screen Results:

Illicit substance use is typically reported by the patient during a MAT visit and then later confirmed by toxicology screening. When substance use is reported during an encounter, the treatment plan will be adjusted at the time of the visit.

If a patient does not disclose substance use or inappropriate medication management during the office visit, and the toxicology screen is inappropriate (i.e. positive for illicit substances not reported or negative for buprenorphine), the patient is called by the MAT nurse within 24 hours of UDS result in an effort to address a potential relapse or medication issue.

Negative Buprenorphine: Buprenorphine adherence is necessary for successful treatment. Nonadherence may be self- reported or found on a toxicology screen that is negative for buprenorphine.

There are a variety of reasons why a patient may be non-adherent to buprenorphine and/or have a negative buprenorphine toxicology screen, including:

Self-increasing buprenorphine dose or a lost/stolen/destroyed medication, and therefore running out of medication early.

Forms of diversion. Diversion may be well intended, such as sharing of medication with a friend, or more salacious such as selling medication for profit.

If a patient's dose is less than 4-6mg, the toxicology sample may need to be sent for confirmatory testing due to the test cut-off limits and therefore an inability to react positive to buprenorphine despite adherence to treatment.

In all cases of reported nonadherence to buprenorphine/naloxone, the MAT nurse and provider will assess and reinforce medication adherence, including total daily buprenorphine/naloxone dose, dosing schedule, proper administration, and safe storage.

The MAT treatment team will consider that the patient's buprenorphine/naloxone dose may need to be adjusted (i.e. increased if struggling, decreased if taking less than prescribed).

Clinical decisions to augment the treatment plan will be based upon the patient's overall wellbeing and standing within the MAT program, and therefore based upon multiple data points including: patient engagement with the treatment plan, recent toxicology screens, and status of physical, mental, and social health.

If the patient provides an adequate explanation regarding a negative buprenorphine/naloxone result to the MAT treatment team, the MAT nurse and provider will establish a follow-up plan that may include a return to weekly clinic visits and weekly prescriptions.

If the patient is unable to provide an adequate explanation regarding a negative buprenorphine/naloxone result, they should return to the clinic within 24 hours.

At return visit, a repeat toxicology screen will be obtained and sent for confirmatory testing that includes checking for the presence of buprenorphine and buprenorphine's metabolite, norbuprenorphine.

MAT team members may consider calling the patient between scheduled clinic visits for a "random call back" visit that includes patient assessment, medication count and toxicology screen.

If patient denies any reason for negative buprenorphine result, and repeat is again negative, the entire MAT team should meet to discuss the next best steps.

If diversion is likely or if the risk outweighs the benefit of continuing treatment in a MAT setting, the patient may be referred to a higher level of care.

Positive Opioids:

Report of opioid use or positive opioid toxicology screen result is addressed by MAT nurse during visit or through subsequent phone conversation and the treatment plan is intensified accordingly to meet the needs of the patient.

If patient has a positive opioid UDS and does not report opioid use at the visit and denies use when addressed on the phone with the MAT

nurse, the patient will be asked to return to the clinic for a repeat visit as soon as possible for assessment, within 24-48 hours.

A report of opioid use or a positive opioid UDS will result in intensification of the treatment plan potentially including: increased frequency of clinic visits, confirm attendance and increase frequency of counseling, encourage meetings, provide education on relapse prevention and overdose. This also includes the patient returning to weekly clinic visits until stable.

If the patient has ongoing reports of opioid use or positive opioid screens, and the MAT team determines that the risk outweighs the benefit of continuing treatment in [redacted] MAT program, the patient will be assisted with transfer to higher level of care. The patient may return to [redacted] MAT program at a later date after the MAT team and patient meet to assess how to assist them differently in their treatment moving forward.

Polysubstance Use:

Cocaine

Report of cocaine use or positive cocaine UDS result is addressed by the MAT team members during a visit or through subsequent phone conversations and the treatment plan is intensified accordingly to meet the needs of the patient.

If patient has a positive UDS and does not report cocaine use at the visit and denies use when addressed on the phone with the MAT team member, the patient should return to the clinic for repeat visit for assessment as soon as possible, within 24-48 hours.

A report of cocaine use or a positive cocaine UDS will result in intensification of the treatment plan, relapse prevention education and support. This includes the patient returning to weekly clinic visits until stable.

Contingency management combined with psychosocial support (CBT, counseling) has been shown to be an effective strategy for decreasing stimulant misuse and should be considered when possible.

Amphetamines

Report of illicit amphetamine use or positive amphetamine UDS result is addressed by MAT team members during a visit or through subsequent phone conversations and the treatment plan is intensified accordingly to meet the needs of the patient.

If patient has a positive UDS and does not report amphetamine use at visit and denies use when addressed on the phone with the MAT team members, the patient must return to clinic for a repeat as soon as possible, within 24-48 hours.

If a patient denies amphetamine use, the MAT team will send the toxicology screen for confirmatory testing to identify specific metabolites as false positive amphetamine results are common and can occur due to cross-reactivity from commonly prescribed and over-the-counter medications.

A report of illicit amphetamine use or a positive amphetamine UDS will result in intensification of the treatment plan, relapse prevention education and support. This includes the patient returning to weekly clinic visits until stable.

If the patient reports struggling with attention deficit and/or hyperactivity, offer the patient referral to psychiatry for evaluation.

If patient reports diagnosis of ADHD and is requesting amphetamine medications, patient should undergo neuro-psych evaluation for a proper diagnosis.

Check prescription drug monitoring program (PDMP) to search for prescription(s) not reported.

Contingency management combined with psychosocial support has been shown to be an effective strategy for decreasing stimulant misuse and should be considered.

Benzodiazepines

Report of illicit benzodiazepine use or positive benzodiazepine UDS result is addressed by MAT team members during a visit or through subsequent phone conversations and the treatment plan is intensified accordingly to meet the needs of the patient.

If patient has a positive UDS and does not report benzodiazepine use at visit and denies use when addressed on the phone with the MAT team members, the patient must return to clinic for repeat as soon as possible, within 24-48 hours.

A report of illicit benzodiazepine use or a positive benzodiazepine UDS will result in intensification of the treatment plan, relapse prevention education and support. This includes the patient returning to weekly clinic visits until stable.

If the patient reports struggling with anxiety, offer patient referral to psychiatry for evaluation.

Providers will make every effort to avoid medications with potential for misuse.

Check prescription drug monitoring program (PDMP) to search for prescription(s) not reported.

Contingency management combined with psychosocial support has been shown to be an effective strategy for decreasing stimulant misuse and should be considered.

Toxicology samples will be sent for confirmatory testing and identification of the medication in instances of ongoing positive benzodiazepine screens.

Ongoing benzodiazepine misuse despite an intensified treatment plan may result in referral to a higher level of care. Patient may return to [redacted] MAT program at a later date after the MAT team and patient meet to assess how to assist them differently in their treatment moving forward.

Alcohol

In addition to frequent office visits, patients with concerning alcohol use or comorbid alcohol use disorder should be monitored via urine EtG testing.

A report of risky alcohol use or positive urine EtG result is addressed by MAT team members during a visit or through subsequent phone conversation and the treatment plan is intensified accordingly.

Patients presenting to clinic impaired from recent alcohol use or with a positive Etg screen will require treatment plan revision. Additionally, a safety assessment should be completed, which may include ability to care for any accompanying children or alternate transportation home.

Ongoing alcohol misuse, presenting to clinic impaired or noted ED visits or hospital events for ETOH intoxication/use may result in referral to a higher level of care.

Patient may return to [redacted] MAT program at a later date after the MAT team and patient meet to assess how to assist them differently in their treatment moving forward.

Buprenorphine/Naloxone Tapering:

A substance use disorder is a chronic and complex condition, therefore enforcing a predefined treatment duration is not recommended or advised.

Some patients may choose to taper off buprenorphine/naloxone. These patients will continue to be supported by the MAT team and receive assistance with dose decreases, and management of withdrawal symptoms. The taper duration is individualized to the patient and will be continually adjusted to meet the patient's needs.

Buprenorphine/naloxone should be tapered over days, weeks, or months, depending on the patient's tolerance of symptoms.

Upon abrupt buprenorphine discontinuation, withdrawal syndrome may occur.

Subjective withdrawal symptoms typically begin within the first three days. Autonomic withdrawal signs, including: lacrimation, rhinorrhea, tremors, chills, gooseflesh. General complaints include: restless leg, insomnia, anxiety, abdominal distress.

Protracted abstinence syndrome can occur and persist for months or years following discontinuation of the medication. It is important to respond to the patient's protracted withdrawal symptoms to support their recovery process and avoid relapse.

Tapering/discharge from the MAT program or initiation of an intensive treatment plan should be considered for the following cases:

Negative buprenorphine screens.

Ongoing opioid use or use of other illicit drugs which makes the risk of continuing treatment outweigh the benefit.

Patient presents to the [redacted] MAT program impaired, incidence of overdose, or hospitalization related to substance use and the risk of continuing treatment outweighs the benefit.

Multiple missed appointments or inability to contact patient will be addressed with treatment team and documented in EMR. If unable to reach the patient, refills should be canceled in an effort to engage the patient back in to care.

Patients who are referred to a higher level of care or discharged will be reconsidered for MAT treatment in the future.

Pregnancy Considerations:

The [redacted] MAT Program will use buprenorphine/naloxone (Suboxone) in pregnancy. The use of buprenorphine monotherapy (Subutex) in pregnancy has contributed to injection abuse, diversion, or even victimization of pregnant patients, such as theft of medication or coercion to share or sell medication since their acquaintances were aware that pregnant women had access to buprenorphine monotherapy, which has a much higher street value and abuse potential than buprenorphine/naloxone. Further, the immediate postpartum period can be a difficult time for women to tolerate change from buprenorphine monotherapy to buprenorphine/naloxone.

Pregnant women will be counseled regarding the use of buprenorphine/naloxone and the risk of neonatal opioid withdrawal syndrome (NOWS)/ neonatal abstinence syndrome (NAS) in their infant.

Patients will be counseled that buprenorphine/naloxone is considered safe with lactation, and women stable on buprenorphine/naloxone who are not using other substances should be encouraged to breastfeed their infants. Breastmilk levels of buprenorphine and metabolites are low, and buprenorphine is poorly bioavailable when ingested orally, leading to minimal drug exposure for breastfeeding infants. Naloxone is not orally bioavailable and is unlikely to affect a breastfeeding infant.

Attachment B1-9b.2

ROADMAP TO

MAR PROGRAM

FISCAL

- Trainings
- EHR modifications
- Billing
- Supports
  - Toxicology
  - Co-Pays

CQI

- Data/Evaluation Plan
- ECHO/Peer Support
- Curbside Consults
- Case Conferencing
- Community of Practice

ADMINISTRATION

- MOUs/BAAs
- Billing
- EHR
- Regulations/Licensing
- Evaluation

PROGRAMMING

PARTNERS

- Identify Stakeholders
- Methadone
- CMHCs
- Peer Support

STAFFING

- Admin Lead
- MD and Nurse Leaders
- Invite Staff
- Waivered Providers
- Full Staff Training

April 4, 2020

What are MAT/MAR Programs?

Medication-Assisted Treatment (MAT), or Medication-Assisted Recovery (MAR) is "the use of medications, in combination with counseling and behavioral therapies, to provide a whole-patient approach to the treatment of substance use disorders." (SAMHSA)

Research has consistently demonstrated the effectiveness of methadone and buprenorphine (Suboxone®, Subutex®) effectiveness for opioid use disorder (OUD) treatment, with increasing support for extended-release naltrexone (Vivitrol®).

- Reduced drug use/misuse
- Reduced risk of overdose
- Reduced transmission of infectious diseases
- Reduced criminal behavior

Some Core Tenets about MAT/MAR

- OUD is a chronic condition that benefits from treating it as such
- It is critical to treat the person, not the disorder
- Medication alone will not cure the problem
- You can make an impact simply by asking if the patient wants help
- People will fluctuate on a spectrum of change – be there when they are ready for treatment

OUD has been successfully treated and managed in Primary Care settings in the United States since it was permitted through the passage of The Drug Addiction Treatment Act of 2000 (DATA 2000), Title XXXV, Section 3502 of the Children's Health Act. Practically every Primary Care practice in the United States has patients who would benefit from MAT/MAR.

Persistent myths and misconceptions about buprenorphine treatment serve as barriers. These include:

- MAT/MAR is more dangerous than other health interventions
- MAT merely replaces one addiction with another
- MAT delivery is burdensome and time-consuming for PCPs
- Abstinence-based treatment is more effective for treating addiction, and
- Clinicians should simply stop prescribing so many opioids to help curb opioid misuse

Successful delivery of MAT/MAR in Primary Care settings is characterized by:

- Treating OUD as other chronic conditions for which every patient presents different needs and responses to treatment and support, characterized by:
  - Unique bio-psycho-social profile and supports
  - Co-occurring health conditions and treatment history
  - Variations on scale of readiness for change
- Harm reduction in Primary Care. Expecting abstinence after Suboxone induction is not realistic. As with diabetes, hypertension and asthma, learning to coach patients for longer periods of symptoms-free lifestyle is more the goal in chronic illness care.

Key domains for implementation of MAT/MAR services include:

A. Staffing/Workforce Readiness
B. Key Partnership Development
C. Administrative/Organizational Readiness
D. Programming
E. Continuous Quality Improvement Processes
F. Fiscal/Regulatory Readiness

A. Staffing/Workforce Readiness

- Identify Administrative Leadership to drive requisite processes
- Physician and Nurse Leaders are key to success
- Invite and engage ALL Staff in the process of preparedness from the outset. Regardless of who is an x-waivered provider, all staff come into contact with patients.
- Work together to collectively Define the Goals of the Program
- Support Providers to obtain x-waivers (at least one in each location)
- Full Staff Training (in-person whenever possible)
- Part of the overall Integrated Behavioral Health plan at CORE/EHR

B. Key Partnership Development

- Identify Key Stakeholders, including:
- Internal (e.g. Emergency Department referral protocol)
- Connect to Methadone Clinics (for appropriate transfers)
- Community Mental Health Centers
- Other Behavioral Health providers
- Peer Support Agencies
- Community Care Team

C. Administrative/Organizational Readiness

- Execute MOUs/BAAs with Key Partner Agencies
- Establish Billing and Coding Needs
- Electronic Health Record changes
- Relevant Regulations/Licensing
- Craft a Continuous Evaluation Plan

D. Programming

- Select Screening Tools:
  - Audit C
  - DSM 5: Opioid Use Disorder criteria
  - COWS (Clinical Opioid Withdrawal Scale): severity of withdrawal
  - Patient Readiness Questionnaire: readiness for MAT program
  - TNQ (Treatment Needs Questionnaire): appropriate level of treatment
  - OBH bio-psycho-social assessment, eases the burden of receiving clinic capacity
  - Liver function test – possibly recommend methadone
  - Assessments for Polysubstance use
- Current medications or other substance use
- History of MAT services – currently on/coming off methadone
- Policies/Protocols
  - Induction Policies/Practice Guidance (not one rigid policy)
  - UDS Policy Guidance
- Referrals Workflow
- Staff Management
  - Regular Multi-Disciplinary Team Meetings
  - Site and Cross-Site
- Special Populations
  - Pregnancy
  - Juveniles

E. Continuous Quality Improvement

- Operationalize Data/Evaluation Plan
- ECHO/Peer Support (including Pain Tx)
- Telephone Consults availability
- Case Conferencing (Teams, Cross-Teams)
- Community of Practice

F. Fiscal/Regulatory Readiness

- Funding for Trainings, TA

- EHR modifications
- Billing Lines established
- Supportive services funding, such as
  - Toxicology Screening
  - Patient supports (i.e. Co-Pays, Transportation, etc.)

Draw from features and successes of existing programs, such as:

- Medical Home
- Chronic Disease Management
- Zero Suicide
- Collaborative Care Model[1]

More Tips:

- Keep in mind that MAT/MAR clinicians can experience stigma similar to people struggling with OUD and may be reluctant to willingly subject themselves to criticism by peers, media, and scrutiny by law enforcement (i.e. DEA).
- Some clinicians did not want to be known as the "go to" for referrals of addicted patients from their colleagues.
- Clinicians considering prescribing buprenorphine often are unsure about the course of the illness and clinical features of medication induction, maintenance and the many "what ifs"
- Need assistance/support available including curbside consults and referrals for complex patients where buprenorphine was ineffective

[1] Alford DP, LaBelle CT, Kretsch N, etal. Collaborative Care of Opioid-Addicted Patients in Primary Care using Buprenorphine. Arch Intern Med, Mar 2011; 171(3):425-437.

B1-9c

Use of technology to identify, at minimum:

- *At risk patients*
- *Plan care*
- *Monitor/manage patient progress toward goals*
- *Ensure closed loop referral*

Partner agencies in the B1 project have identified capacity to identify at-risk clients. 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. Table B1-9c illustrates where known tools are in place and in use. This information continues to be refined as B1 projects develop. For the practices designated as Integrated Practices during this report period, a combination of methods is used to meet this DSRIP element.

The FQHC partners work with CHAN / Community Health Access Network as a shared resource for development and processing of standardized reports that are approved by multiple practices for major content and customizable to identify at-risk patients and referral status reports. The Integrated Care practices (Lamprey Health Care – Newmarket, Goodwin Community Health, and Families First) are also able to access practice-specific queries of their EMR encounters. They have well-developed templates for establishing and monitoring patient-centered goals and progress toward those goals. Care plans are generated from EMR templates and produced for patient disbursement, which can be printed or posted to the patient portal.

Lamprey Health Care has access to Collective Medical ADT data via the CM portal. They have not chosen to integrate the data feed into their EMR at this time. The contributing facilities are not the primary hospitals in Region 6, so development of workflows will depend on the needs of the local practices.

These FQHC partners and SMHC (the four Integrated Practice designees) had started work on these elements as tied to their engagement with NCQA Patient-Centered Medical Home achievement and/or Meaningful Use measures. The IDN 6 has pursued opportunities to help augment the current resources and adapt successful tools to achieve increased coordination of primary care, behavioral health, and SUD treatment care plans within partner practices and across agencies.

As discussed in sections B1-f and B1-g, the IDN 6 anticipates additional electronic tools will be available and facilitated by the IDN within the next reporting period as multiple provider sectors make decisions about regional platform preferences and compatibility with multiple partner needs.

Table B1-9c

Organization/Provider	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
Rochester Pediatrics	**Electronic**	**Electronic-EHR**		**Electronic-EHR**
Skyhaven Internal Medicine	**Electronic**			
White Mountain Medical Center	**Electronic**			
Wentworth Health Partners / Internal Medicine	**Electronic**	**Electronic-EHR**		**Electronic-EHR**
Hilltop Family Practice	**Electronic**	**Electronic-EHR**		**Electronic-EHR**
Lee Family Practice				
Seacoast Mental Health Center	**Electronic**	**Electronic-EHR**		**Electronic-EHR**
Lamprey Health Care - Newmarket	Currently using EMR for MAT panel management, ED and hospital utilization reports, BH panels, hypertension, diabetes, care management and monitoring	Centricity EMR with care plan elements that create clinical visit documentation for patient and care team review. DSM to patient portal, DSM to care team	EMR templates for managing patient goals including PCMH forms to track progress	Ability to send / receive referrals via DSM, run report of referrals outstanding, and close the referral in the EMR
Lamprey Health Care - Raymond	Currently using EMR for ED and hospital utilization reports, BH panels, hypertension, diabetes, care management and monitoring	Centricity EMR with care plan elements that create clinical visit documentation for patient and care team review. DSM to patient portal, DSM to care team	EMR templates for managing patient goals including PCMH forms to track progress	Ability to send / receive referrals via DSM, run report of referrals outstanding, and close the referral in the EMR
Community Partners	**Electronic**	**Electronic-EHR**		**Electronic-EHR**
Seacoast Family Practice - Stratham	**Electronic**	**Electronic-EHR**		**Electronic-EHR**
Core Family and Internal Medicine - Exeter	**Electronic**	**Electronic-EHR**		**Electronic-EHR**

Greater Seacoast Community Health – Goodwin Community Health	**Electronic**	Centricity EMR with care plan elements that create clinical visit documentation for patient and care team review. DSM to patient portal, DSM to care team	EMR templates for managing patient goals including PCMH forms to track progress	Ability to send / receive referrals via DSM, run report of referrals outstanding, and close the referral in the EMR
Greater Seacoast Community Health - Families First	**Electronic**	Centricity EMR with care plan elements that create clinical visit documentation for patient and care team review. DSM to patient portal, DSM to care team	EMR templates for managing patient goals including PCMH forms to track progress	Ability to send / receive referrals via DSM, run report of referrals outstanding, and close the referral in the EMR
Greater Seacoast Community Health – Lilac Pediatrics				
Southeastern NH Services	**Electronic**	**Electronic-EHR**		**Electronic-EHR**
Hope on Haven Hill	**Electronic**	**Electronic-EHR**		
Seacoast Youth Services	**Electronic**	**Electronic-EHR**		
Appledore Family Medicine	**Electronic**	**Electronic-EHR**		**Electronic-EHR**
Dover Pediatrics	**Electronic**	**Electronic-EHR**		**Electronic-EHR**

B1-9d

Documented work flows with community based social support service providers including, at minimum:

- *Joint service protocols*
- *Communication channels*

The IDN 6 Clinical Advisory Team (CAT) guidance for the development of joint service protocols and communication channels is embedded to follow. The CAT recommends that these protocols be based on established MOUs, partnership agreements, or affiliation agreements.

Table B1-9d demonstrates the active MOUs in place between B1 project partners. The joint service types covered by the MOUs noted in Table B1-9d include:

MOU joint service PCP/BH	MOU joint service between SUD /Doorway and PCP or BH	MOU for Emergency Services or co-located BH services	MOU for Emergency Services or reverse integration site	MOU / contract for ED and hospital response for recovery support

The MOU developed by WDH / The Doorway is discussed in more detail in the D Project section of this report. 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 for 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.

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 membership and workflow is a robust example of communication channel workflow between primary care, behavioral health, and social service agency partners across the region. Attachment B1-9d.a and B1-9d.b illustrate the robust membership and the agreements reached regarding joint service and communication among the members in service of their mutual patients / clients.

Attachment B1-9d.a CAT Guidance

Integrated Delivery Network	Region 6
Integrated Healthcare Delivery Guidance	Joint Service Protocols and Communication Channels
Page - 1 -	

Guidance: This document provides guidance to IDN members for establishing joint service protocols, communication channels, and other expectations of partners in an integrated delivery network.

Rationale: Integrating care and services requires clearly outlining expectations and deliverables between partners, or among multiple partners to ensure quality patient care and services, reduce duplications of care and services, outline payment and billing, ensure fidelity to federal and state regulations, and/or funding agencies.

Localized Adoption Considerations: It's likely that these partnerships already exist in your organization and may not have been formalized with documented and mutually agreeable standard operating procedures.

Process Considerations:

1. *Inventory existing partnerships*:
    a. What services or staff are being delivered or shared?
    b. Are billing arrangements clearly defined?
    c. Are communication channels established?
    d. Do you currently have MOUs in place?
2. *Quality and Performance*:
    a. Have you established measurable quality and performance goals?
    b. Does reporting meet the needs of partner organizations?
    c. Are partner meetings occurring?
    d. Are reports and outcomes shared with leadership and boards of directors?
3. *Workflow documentation*:
    a. Do existing MOU clearly outline how and where work is done?
    b. Do you have business associate agreements (BAA) in place if partner agencystaff have access to your health record?
    c. Do you have policies and procedures in place to on-board partner staff at your organization to meet federal privacy regulations?

Resources: SAMHSA-HRSA Center for Integrated Health Solutions has resources available to help at https://www.integration.samhsa.gov/operations-administration/contracts-mous

1. Mutual care management agreements for transitions of care, access, collaborative care management, patient communication.
2. Assessing and addressing legal barriers to integration
3. Do's and Don'ts of contracting behavioral health services
4. Sample documents
    a. Memorandum of understanding
    b. Partnership agreements
    c. Affiliation agreements

Table B1-9d: Joint service MOUs in place between B1 DSRIP project partners

	Wentworth Douglass Hospital	Seacoast Mental Health Center	Community Partners	Greater Seacoast Community Health - Goodwin Community Health	Greater Seacoast Community Health - Families First		MOU joint service PCP/BH	MOU joint service between SUD /Doorway and PCP or BH	MOU for Emergency Services or co-located BH services	MOU for Emergency Services or reverse integration site	MOU / contract for ED and hospital response for recovery support
Frisbie Memorial Hospital			*								
White Mountain Medical Center											
Wentworth Douglass Hospital			*	*							
Seacoast Mental Health Center	*										
Lamprey Health Care - Newmarket	*	*									
Lamprey Health Care - Raymond	*	*									
Community Partners	*										
Exeter Health Resources/CORE		*									
Seacoast Family Practice - Stratham		*									
Core Family and Internal Medicine - Exeter		*									
Greater Seacoast Community Health - Goodwin Community Health	*		*								
Greater Seacoast Community Health - Families First	*										
Greater Seacoast Community Health - Lilac Pediatrics											
Southeastern NH Services	*			*							
Hope on Haven Hill	*			*							
Dover Pediatrics	*										.

REGION 6 INTEGRATED DELIVERY NETWORK COMMUNITY CARE TEAM

CONFIDENTIALITY AGREEMENT and POLICY AND PROCEDURES ACKNOWLEDGMENT

As a member of the Region 6 Integrated Delivery Network Community Care Team I, _ _____(name), of_____(member organization) have a legal and ethical responsibility to protect the privacy of individuals and families referred ("consumer") to the Region 6 Integrated Delivery Network Community Care Team (IDN CCT) and to protect the confidentiality of their health information.

By signing this document, I understand and agree to the following:

1. "Confidential Information" means any and all non-public, medical, financial and personal information in whatever form (written, oral, visual or electronic) held or received by any member of the IDN CCT. Confidential Information shall include all information which (i) has been labeled in writing as confidential, (ii) is identified at the time of disclosure as confidential, (iii) is commonly regarded as confidential in the health care industry, or (iv) is Protected Health Information as defined by HIPAA.

2. I agree to obey all applicable laws and regulations, including HIPAA and the HITECH Act, to the extent applicable, in meeting their obligations under this Agreement.

3. I agree to only use or disclose the minimum necessary information needed for the mission of the IDN CCT (as required by the HIPAA Privacy and Security Rule 164.502, 164.514d).

4. I agree not to share or discuss any consumer health or other confidential information with others, including friends or family, who do not have a need-to-know. I understand that consumer information includes, but is not limited to, the medical records of my family, friends, co-workers, and myself.

5. I shall not disclose to unauthorized personnel, inside or outside the organization whether an individual is a patient.

6. I agree not to discuss any consumer health or other confidential information where others can overhear the conversation, e.g. in hallways, on elevators, in the cafeteria, on shuttle buses, on public transportation, at restaurants, or at social events. It is not acceptable to discuss clinical information in public areas, even if a consumer's name is not used.

7. I understand when utilizing or interacting with others regarding consumer health or other confidential information, this must be limited to authorized personnel.

8. I will not use, disclose, or in any way reveal or disseminate to unauthorized parties any information I gain through contact with materials or documents that are made available through IDN CCT.

9. I will not disclose or in any way reveal or disseminate any information pertaining to the consumer that comes to my attention as a result of participating in the IDN CCT.

SAMPLE

10. This Agreement may be modified or amended only with the written consent of all IDN CCT Members.

11. No waiver of any provision of this Agreement, including this paragraph, shall be effective unless the waiver is in writing and signed by the party making the waiver.

12. I understand that should I no longer be employed with the IDN CCT member listed on this agreement all of the information to which I have been exposed remains confidential.

13. I have read and agree to comply with the IDN CCT Policy and Procedures

My signature below indicates I have read this agreement, understand its terms, and I agree to abide by this agreement.

_____

Signature of IDN CCT Member Date

_____

Name and Title of IDN CCT Member (Please print)

_____

Organization of IDN CCT Member (Please print)

APLE

Attachment B1-9d.c: CCT membership

Connections for Health CCT members:

Amedisys
AmeriHealth Caritas*
Beacon Health Strategies*
Community Action Partnership of Strafford County Community Partners
Connections for Health
Connections Peer Support Center
Core Physicians
Cornerstone VNA
Cross Roads House
Crotched Mountain Community Care
Dover Housing Authority
Easter Seals of NH
Exeter Hospital
Exeter Housing Authority
Families First of the Greater Seacoast
Families in Transition (FIT)
Frisbie Memorial Hospital
Goodwin Community Health
Granite State Independent Living
Haven
Home for All
Homeless Center for Strafford County
Hope on Haven Hill
The Homemakers Services
Lamprey Health Care
My Friend's Place
NH DHHS Bureau of Elderly and Adult Services
NH Healthy Families*
NH Housing Finance Authority
OASIS Senior Advisors
OneSky Community Services
Portsmouth Housing Authority
Portsmouth Regional Hospital
Raymond Baptist Church
Rochester Housing Authority
Rockingham VNA
Safe Harbor Recovery Center
Salvation Army, Portsmouth
Seacoast Mental Health Center
Seacoast Pathways/Granite Pathways
ServiceLink of Rockingham County
ServiceLink of Strafford County
SNHS/Rockingham Community Action
Somersworth Housing Authority
SOS Recovery Community Organization
Southeastern NH Services
St. Vincent dePaul Society, Exeter
St. Vincent dePaul Society, Hampton
TASC-Transportation Assistance for Seacoast Citizens
Tri-City Consumers' Action Co-operative
Veterans, Inc.
Waypoint
Welfare Department, City of Dover
Welfare Department, City of Portsmouth
Welfare Department, City of Rochester
Welfare Department, City of Somersworth
WellSense Healthplan*
Wentworth-Douglass Hospital
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:

2

* Managed Care Organizations will only be present during discussions of their members.

Updated 1/17/2020

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 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: • Medication-assisted treatment (MAT) • Evidence-based treatment of mild-to-moderate depression within the Integrated Practice setting either through use of the IMPACT or other evidence-supported model	Protocols (Submit all in use)				
B1-9c		• Use of technology to identify, at minimum: • At risk patients • Plan care • Monitor/manage patient progress toward goals • Ensure closed loop referral	Table listing all providers indicating progress on each process detail				
B1-9d		Documented work flows with community based social support service providers including, at minimum: • Joint service protocols • Communication channels	Workflows (Submit all in use)				

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

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

Coordinated Care Practice Designation

As supported by documentation in section B1-8 and B1-9 of this report, IDN 6 has six practices who have successfully implemented all the Coordinated Care DSRIP elements. Those practices are highlighted by practice name in Table B1-10.b. All the B1 partner practices listed are expected to make progress toward Coordinated Care designation during the next reporting period.

Integrated Care Practice Designation

IDN 6 has five practices who have successfully implemented all the additional Integrated Care Practice DSRIP elements. They are highlighted by practice name in Table B1-10.c. **This is including the addition of Lamprey Healthcare, Raymond with successful implementation of MAT / MAR during this reporting period.** Additional practices are listed in the table if it is anticipated that they will make progress on ALL the elements required for designation.

We anticipate many additional practices will make progress on developing evidence-based treatment plans for mild / moderate depression and will produce joint service and communication workflows with CBOs. Many will also successfully progress on the use of technology to identify at-risk patients, plan care, and monitor/manage patient progress toward goals and ensure closed loop referrals.

The list of practices anticipated to implement MAT / MAR in addition to the elements above is much smaller, resulting in a smaller list of practices anticipated to reach Integrated Practice designation.

WRITEBACK RESPONSE: There are no substantive updates to report for the tables B1-10a to B1-10c.

Table B1-10.a Target Goals

	Total Goal Number to be Designated	Baseline Designated 6/30/17	Number Designated 12/31/17	Number Designated 6/30/18	Number Designated 12/31/18	Number Designated 6/30/19	**Number Designated 12/31/19**
Coordinated Care Practice	**14**	0	5	11	*10** *Clarified for the 6/2019 report*	6	**6**
Integrated Care Practice	**3**	0	0	0	*5** *Clarified for the 6/2019 report*	4	**5**

Table B1-10.b Coordinated Care Practice Designation

List of providers identified *to make progress* toward Coordinated Care Practice designation	12/31/17	6/30/18	12/31/18	06/30/19	12/31/19
• Lamprey Health Care - Newmarket Site • Lamprey Health Care - Raymond Site	2	2	2	2	2
Wentworth Douglass Hospital • Hilltop Family Practice • Wentworth Health Partners Int Med • Lee Family Practice	2	2	3	3	3
Frisbie Memorial Hospital • Rochester Pediatrics • Skyhaven Internal Medicine • White Mountain Medical Center	0	0	3	3	3
Community Partners Mental Health Center	1	1	1	1	1
Seacoast Mental Health Center	1	1	1	1	1
• Greater Seacoast Community Health - Families First • Greater Seacoast Community Health - Goodwin Community Health • Greater Seacoast Community Health – Lilac Pediatrics	2	2	3 *2 Care Coordinated this report period	3 *2 Care Coordinated this report period	3 *2 Care Coordinated this report period
Exeter Health Resources / CORE • Seacoast Family Practice • Core Family and Internal Medicine	n/a	0	2	2	2
Southeastern NH Services	n/a	n/a	1	1	1
Hope on Haven Hill	n/a	n/a	1	1	1
Seacoast Youth Services	n/a	n/a	1	1	1
Portsmouth Regional Hospital • Appledore Family Medicine	0	0	1	1	1
Dover Pediatrics	n/a	n/a	1	1	1

Table B1-10.c Integrated Care Practice Designation

List of providers identified *to make progress* toward Integrated Care Practice designation	12/31/17	6/30/18	12/31/18	06/30/19	12/31/19
Lamprey Health Care - Newmarket	n/a	n/a	1	1	1
Lamprey Health Care – Raymond • ***Current reporting period implementation of MAT/MAR***	n/a	1	1	1	1
Greater Seacoast Community Health - Families First	n/a	1	1	1	1
Greater Seacoast Community Health - Goodwin Community Health	n/a	1	1	1	1
Seacoast Mental Health Center	1	1	1	1	1
Seacoast Family Practice • MAR/MAT implementation anticipated. • Further development of treatment models for mild / moderate depression anticipated.	n/a	1	1	1	1
Core Family and Internal Medicine • Limited implementation of MAR/MAT to date. Expanded implementation anticipated. • Further development of treatment models for mild / moderate depression anticipated.	n/a	1	1	1	1
Skyhaven Internal Medicine • May resume MAT/MAR services • Further development of treatment models for mild / moderate depression anticipated.	1	1	1	1	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 3.8 CTI Case Managers. The team had turnover in one position with a resignation in August 2019 and successful onboarding of a replacement in October 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, although staffing targets were adjusted to reflect that a second team in unlikely to be successfully built during the DSRIP project period.

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 has 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 28 clients into CTI within the team. The CTI program has graduated 37 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 all three of the regional CCT meetings; hosted at Frisbie Memorial Hospital (Strafford County), Portsmouth Regional Hospital (Rockingham County), and Exeter Hospital (Rockingham County).

The Care Transitions team have been engaged with the IDN6 Shared Care Plan, Care Director. All 276 clients referred as of June 30, 2019 are reported in Care Director with a standard list of inputs to establish the framework for implementation of Care Director across our partner network. As discussed earlier in this report, the implementation of Care Director was put on hold while other options were being considered. The team will be trained to participate in any new platforms developed for enhanced regional care coordination.

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 provided the training for the two new Case Managers in the first quarter of 2019 and one new Case Manager in the fourth quarter of 2019.

Internal training plans include encompassing 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 Narrative: We are including an update on a previous narrative with this submission. P's experience and work with the Care Transitions team highlights the intersecting needs of complex clients. **Updates are in bold below**.

"P": The IDN first connected with P through a referral from Lisa, a social worker at Hospital #1 in late July/early August 2018. He had been inpatient for an extended stay with medical issues complicated by acute alcohol withdrawal. Lisa was concerned that his discharge plans were to return to living in a broken vehicle parked on his friend's property. P had lost his job due to lack of transportation. The car was going into repo status, as he was unable to make the monthly payments without the ability to access work.

P was without income for supplies and food, and unable to follow up with medical providers. The IDN connected with him via telephone with the intent to foster connections to resources within his community (city welfare, Community Action). The IDN continued to make frequent contact, encouraging him to make the tough decision to access shelter and be out of the elements.

The IDN made sure he had phone minutes so he could remain in touch with Lisa at Hospital #1, the IDN, as well as new supports and resources. Towards the end of August 2018, he was becoming open to shelter and made the decision to go to a shelter in Portsmouth. A friend had given him his old car with the agreement he would get it registered and established in his name within a month of entering shelter.

Living in a shelter for the first time was an adjustment for P. He is a very independent, hardworking "country boy" (his description). He wasn't used to the realities of community living and living within a set of shelter policies. Portsmouth, itself, was a tough transition for P, having lived out in the country his whole life and now in his early 50's, the city was overwhelming. P is a very kind, funny, engaging individual and shelter staff connected with him right away and community providers found him a pleasure to work with.

Once sheltered, P immediately connected with NH Employment Security and found multiple employment opportunities and chose employment at a wholesale store. He connected with his case worker at the shelter, re-enrolled in health insurance and utilized a mobile health van, registered his vehicle and visited a peer support program once with his IDN care coordinator. Attempts to connect P with recovery supports to were unsuccessful. P had remained abstinent from alcohol since his hospital discharge.

In October 2018, P had an overnight pass to leave the shelter and drank alcohol. He left the shelter when confronted and chose to stay in his car. He remained employed, and the IDN looped in another care coordinator to provide more connection/ support in the community. His medical needs were still unmet. He needed and endoscopy and all attempts to support that to happen while living in his car failed, as hospital policy states he would need a driver. Plans were made for him to connect with the mobile health van for support to receive procedure. During this time, he continued to drink and became disengaged until mid- December 2018, although the IDN continued to reach out weekly.

P re-engaged in mid-December 2018. He was drinking regularly and had lost his job. He was still living in his car, utilizing a propane heater as an unsafe heat source in his vehicle, and was access the YMCA for showers. Over this week or two of engagement, he became open to exploring treatment for his alcohol use and was referred to the IDN D3 project. P became overwhelmed by the process of calling

treatment centers and was in a state of active withdrawal. He was hospitalized at hospital #2 during this time when experiencing acute alcohol withdrawals. There were two admissions to the ER within 24 hours.

After those hospitalizations, he decided to access a treatment program and the IDN connected him with resources to access treatment. P made plans to attend IOP vs. inpatient programming so he could find employment and stay temporarily with a friend.

While getting plans in place to start IOP, he received a call with an employment opportunity. Encouraged by his friend to choose employment, he traveled back to the area with plans to live in his car. He returned to the area with receipts for all the purchases he made with the gift cards provided by his supports.

After much encouragement, swallowing his pride, P connected with City Welfare who made an agreement with him that once he was employed, they could connect him with assistance for car repairs and gas cards. P was hired and qualified for the help. He was incredibly grateful to the city and the program as they provided resources to repair his car for it to pass inspection. His first pay period, P surprised the offices by returning to begin repayments, feeling as though it was the right thing to do.

P continued to work the overnight shifts at a retail store, living in his vehicle, using improper sources for heat and lacking nutritional foods. Very isolated, he continued live in his vehicle for the next two months until his drinking caused him to lose his job. A combination of his substance use, lack of sleep and losing his job led P down a more complicated road. He remained engaged with the IDN and we continued to address his substance use. P was in a place where he would be unable to move forward until this issue was addressed.

P's drinking led to inpatient hospitalization at Hospital #2. He was discharged from Hospital #2 still extremely sick and weak. Post discharge he chose to drive to Hospital #1 and met his IDN care coordinator at the emergency department. He was assessed and discharged. He slept in his vehicle in the parking lot. Still sick the next morning, P and IDN care coordinator accessed the Doorway. He was too ill for assessment and needed medical release in order to access treatment options. P chose to seek care at the mobile health van as it was nearby. The IDN care coordinator transported and accompanied him. It was determined he needed emergent care. The provider on the Van called ahead to Hospital #3, and IDN care coordinator transported and accompanied him to the Emergency Department He received a CT, MRI and admitted.

P was able to connect with the Doorway upon discharge to complete an assessment to get enrolled in an IOP. He remained in his vehicle and began his IOP in April 2019. He began attending sessions, opened a checking account and was able to begin working out and showering at a gym and was doing laundry regularly. P was finally feeling better and his motivation was visible. He was working with NH Employment Security and IDN coordinator to seek employment and submitted his resume for multiple employment opportunities.

After two weeks, P disengaged with his IOP and was drinking again. He was connected with IDN care coordinators who discussed safety planning and encouraged his connection with peer recovery and re-connecting with his IOP supports for referrals. Within a few weeks, P connected with peer recovery and IDN supports and discussed detox at Hospital #2 and entering a 28-90 day program.

Nervous and anxious, he was ready to access detox. He connected with The Doorway, peer recovery and a treatment center and decided he wanted treatment. He delayed his entry to treatment and reached out to the IDN to report that a family member had died, he had received a Driving Under the Influence, and spent his first night in jail. He was then transported to Hospital #4 upon release due to

active alcohol withdrawal. His car was impounded with all his belongings and his license suspended. He was discharged from Hospital #4 and taxied to his vehicle in a retail store parking lot, whereas he was sick, hallucinating, and eventually passed out and was transported by ambulance to Hospital #2 where he went through detox and was discharge to treatment.

In May 2019, P was able to connect with peer recovery, IDN coordinator and a treatment center to get insurance re-activated and paperwork submitted. He secured a temporary bed space at a residential treatment program. He completed the daily phone calls, and everything asked of him to get a bed at a residential treatment center. He was sick and tired, but he was also motivated and ready.

From there, P worked to complete applications with additional treatment centers until a bed space opened. We worked together to complete an updated assessment through The Doorway while P was in touch with treatment centers daily and worked closely with peer recovery to get to where he was at this point. He was so tired, but he did not give up. P called daily for the continued support from the IDN as he moved through his plan. The IDN was able to connect P with all these recovery supports, something P could not navigate all on his own. P did all the hard work, and the IDN was right behind him ensuring these supports did not fall through and his situation continued to improve.

A bed space opened for P on May 14th. P did well in treatment, so well that he graduated early. Upon graduation, he secured a bed at a longer-term residential program. At first, P hated it. He expressed his stubbornness, which can be difficult in an environment that is very strict. About a week into the longer program, his attitude shifted. He has found support with the staff, as well as the other residents. P calls weekly to stay in touch and to discuss his daily tasks/assignments. He is motivated to keep moving forward, to phase up in the program and to secure steady employment. P is hoping to look for sober living upon leaving his current program to maintain his sobriety, as well as live in a supportive environment to ensure his supports do not fall through. P is still closely connected with the IDN.

As of December 2019, P is working full time, reports that he enjoys his job and recently received a raise. He is living at a rooming house in Dover. P is still connected with SENHS for support. He has been out of the SENHS residential program for a few months. He is successfully navigating the bus system as he is not driving.

P lost his health insurance a few months ago and seems to have fallen out of routine care. He reports that he is working on time management. He finds it hard to follow up with care AND commit to his full-time job which 'comes first'. P is maintaining recovery with supports that the CTI Care Transitions team would consider tenuous – ongoing support has been offered. Since P initiated SUD treatment, he has had no ED visits or hospitalizations.

Additional narrative:

D: D is a CTI graduate who had successful found housing with a local Housing Authority. D had previously been homeless for 35 years. The team was contacted by one of our partners about 6 months after D graduated due to concern that he was leaving his housing due to some conflict /concerns. The CTI Case Manager who had worked with D was able to intervene and provide support for him to remain in housing. Together, they found a connection at the Housing Authority to facilitate future resolution strategies. D is still housed – and has been successfully housed for over 15 months.

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

Performance Measure Name	Target	Progress Toward Target				
		As of 12/31/17	As of 6/30/18	As of 12/31/18	As of 6/30/2019	As of 12/31/2019
# clients **referred to Care Transitions Team (cumulative)**	≥50 per year per team	0	133	210	278	356
# clients **Screened (cumulative)**	90% of referrals	n/a	133	210/210= 100%	278/278= 100%	356/356= 100%
# new clients referred to Care Transitions Team **during 6-month report period**	≥25 per team	n/a	133	77 dispositions below	68 dispositions below	78 Disposition below
• # new clients screened to **CCT only**	>20%	n/a	n/a	30/77=39%	14/68=26%	30/80= 36%
• # new clients screened to **Pre-CTI/ Extended Phase 1 CTI**	<50%	n/a	n/a	22/77=29%	34/68=50%	36/80= 40%
• # new clients screened to **CTI**	>10%	n/a	n/a	8/77=10%	11/68=16%	11/80= 14%
• # new clients screened to **ECC**	<10%	n/a	n/a	2/77=3%	1/68=1%	0/80= 0%
• # new clients **screened to Coordinated Entry** only	>10%	n/a	n/a	15/77=19%	8/68=12%	1/80= 0%**

LEVEL OF SERVICE PROVIDED	Target per team	As of 12/31/17	As of 6/30/18	As of 12/31/18	As of 6/30/19	As of 12/31/19
# clients **served Extended Phase 1 CTI (cumulative)**	35	0	10	32	66	102
# clients **Extended Phase 1 Pre-CTI moved to Phase 2 (cumulative)**	10% of Pre-CTI	n/a	n/a	10/32=31%	22/66=33%	28/102= 27%
# clients **enrolled in CTI (cumulative)**	70	0	15	33	99	116
# clients **graduated / completed CTI (cumulative)**	35	0	0	4	15 ***37 minimum total graduates by 12/2019**	37
Increase enrollment for eligible benefits for Pre-CTI and/or CTI enrolled clients* (cumulative)	>10%	n/a	n/a	35/77=45%	73/145=50%	134/223 = 60%
TRANSITION IDENTIFIED AFFECTING CLIENT AT REFERRAL OR WITHIN 30 DAYS PRECEDING REFERRAL (n=223)	>50%	n/a	n/a	51/77=66% Listed below	92/145=63% Listed below	128/223= 57% Listed below
• Hospital discharge / inpatient medical/ inpatient behavioral health		n/a	n/a	8	14	10
• SUD treatment discharge/residential program		n/a	n/a	0	0	0
• Corrections release		n/a	n/a	7	9	4
• Unstable housing / Homeless		n/a	n/a	36	69	22

*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. *Many of the target measures below are now actively reported / tracked via the project performance measures, which can be used to measure regional impact.*

Performance Measure Name	Target	Progress Toward Target				
		As of 12/31/17	As of 6/30/18	As of 12/31/18	As of 6/30/19	As of 12/31/19
Total # clients served	70 per CTI team	0 – See Above	133	210	278	356
ED Admissions	Reduce by 10%	N/A	Data Pending	Data Pending	*Tracking update*	*Tracking update*
ED Utilization for PC treatable conditions	Reduce by 10%	N/A	Data Pending	Data Pending	*Tracking update*	*Tracking update*
Hospitalization Frequency & Duration	Reduce by 10%	N/A	Data Pending	Data Pending	*Tracking update*	*Tracking update*
Psych Hospitalization Freq. & Duration	Reduce by 10%	N/A	Data Pending	Data Pending	*Tracking update*	*Tracking update*
Incarceration Nights	Reduce by 10%	N/A	Data Pending	Data Pending	*Tracking update*	*Tracking update*
Increase enrollment for eligible benefits	Increase 10%	N/A	Data Pending	45% of new referrals	50% of new referrals	60% of new referrals
Reduce Crisis Response Services	Reduce by 10%	N/A	Data Pending	Data Pending	*Tracking update*	*Tracking update*

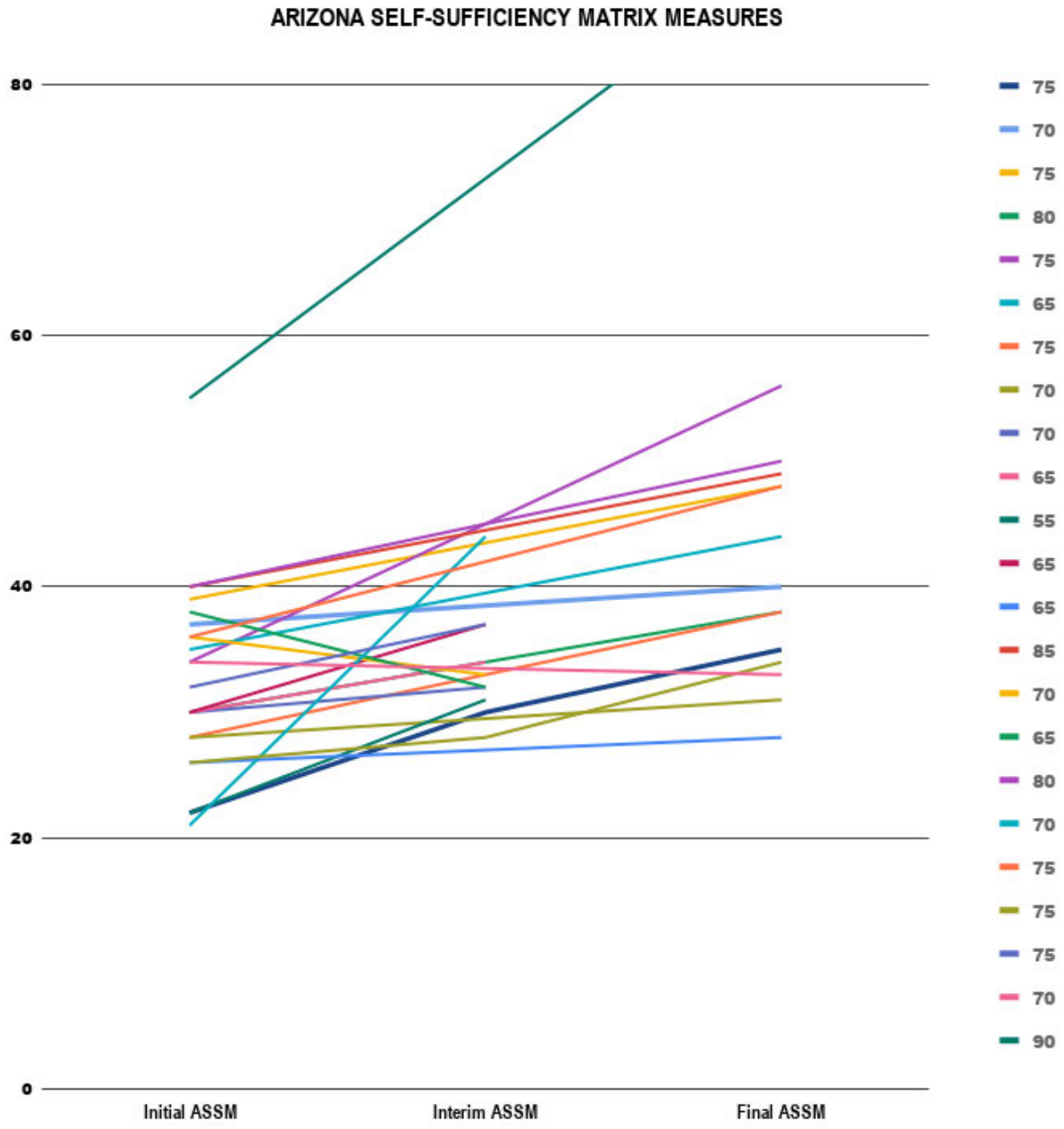
The IDN 6 has additionally adopted self-sufficiency as an outcome measured by the Arizona Self-Sufficiency Matrix (ASSM). Self-sufficiency is the ability to carry out activities of daily living independently. These activities of daily living pertain to different domains. For example, daily life requires 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. **Updated data from the team's ASSM tracking is included below:**



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 3.8 CTI Case Managers who have collaboratively achieved the Evaluation Project Targets reported to date. Turnover in one position during the reporting period.

The IDN6 has explored opportunities to replicate or expand this model in the community with embedded CTI Case Managers and/or a team with a partner agency or practice. At 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, but regional partner capacity does not allow for the development of further staffing before the end of the project period. The staffing targets are adjusted in Table C-3a below.

Table C-3a: Workforce Staffing ***target adjusted to projected total need for remainder of DSRIP implementation***

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	Staffing On 6/30/19	Staffing on 12/31/19
Team Leader / Supervisor (Masters Level)	~~Up to 2~~ ***1**	0	1	1	1	1	1
CTI Worker (Case Manager)	~~Up to 6~~ ***4.8**	0	2	4	4.8	4.8	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	Jan-Jun 2019 Actuals	Jul-Dec 2019 Actual	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	**$ 126,887**	$ 126,154	$ 260,000	$ 260,000	$ 927,197
Indirect Staff	$ -	$ -	$ -	$ -	**$ -**	$ -	$ -	$ -	$ -
Benefits	$ -	$ 403	$ 19,772	$ 46,706	**$ 56,140**	$ 62,607	$ 125,000	$ 125,000	$ 435,628
Contracted Staffing	$ -	$ -	$ -	$ -	**$ -**	$ -	$ 50,000	$ 50,000	$ 100,000
								$ -	$ -
Project Infrastructure								$ -	$ -
Equipment	$ -	$ 4,800	$ 1,981	$ 1,215	**$ -**	$ -	$ -	$ -	$ 7,996
Operations	$ -	$ 137	$ 9,617	$ 21,512	**$ 14,585**	$ 35,956	$ 60,000	$ 60,000	$ 201,807
					$ -			$ -	$ -
Workforce								$ -	$ -
Fees/Outside Placement	$ -	$ 250	$ 200	$ 38	**$ 2,829**	$ 4,159	$ 20,000	$ 20,000	$ 47,476
Recruiting/Retention	$ -	$ -	$ -	$ -	**$ -**	$ -	$ -	$ -	$ -
Training	$ -	$ -	$ -	$ 6,287	**$ 5,818**	$ 4,041	$ 15,000	$ 15,000	$ 46,146
Other	$ -	$ -	$ -	$ -	**$ -**	$ 22,139	$ 50,000	$ 50,000	$ 122,139
								$ -	$ -
Technology	$ -	$ -	$ -	$ -	**$ 3,960**	$ 2,398	$ 15,000	$ 15,000	$ 36,358
								$ -	$ -
									$ -
Totals	$ -	$ 7 586	$ 83 933	$ 175 556	**$ 210,219**	**$ 257,454**	$ 595 000	$ 595 000	$ 1,924,748
DY 2019						**$ 467,673**			

Budget Narrative

- Direct staff actuals include a supervisor and 4.8 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.

Table C-5: Key Organizational and Provider Participants

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 *(attachment C-6a)*	Domains assessed to determine appropriate project disposition (CCT, Pre-CTI, CTI, ECC, or Coordinated Entry)
CTI Self-Assessment Tool *(attachment C-6b)*	For assessment of CTI Model Fidelity

Attachment C-6a

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

Attachment C-6b

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

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.

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.

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

DOCUMENTATION

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) came 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. 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

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

Eligibility	**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***	**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***	**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	**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.	**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
Program Goals	**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	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	**Time limited case management** provides intensive bridging and enhances client engagement with their support network and long-term resources	**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	Engages with clients to link with long term intensive supports; CM collaborates with partner agencies frequently for PCP/MH/SUD and housing support services.
Referral Process	CCT release signed; presentation template completed by CCT team provider	CCT release signed; task list assessed with referral information	CCT release and referral form for transitioning from: shelters, hospitals, psychiatric hospitals, jails, and/or in-patient recovery treatment programs	PHA, CE, 211, shelters, CCT, and welfare make referrals for tenants transitioning into or needing support to maintain housing	CCT referrals are internally screened and evaluated for ECC

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:

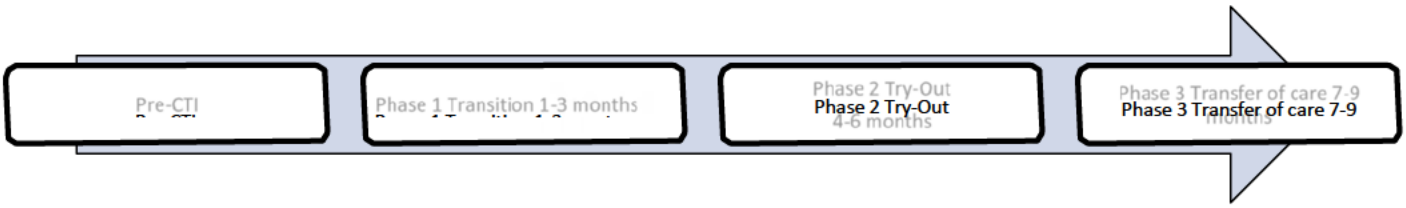
Pre-screening received Date:_____CTI Screening Completed Date:_Eligible: Yes ☐ No

☐

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 **Food**	No income. No food or means to prepare it. Relies to a significant degree on other sources of free or low-cost food.	Inadequate income and/or spontaneous or inappropriate spending. Household is on food stamps.	Can meet basic needs with subsidy; appropriate spending. Can meet basic food needs but requires occasional assistance.	Can meet basic needs and manage debt without assistance. Can meet basic food needs without assistance.	Income is sufficient, well managed; has discretionary income and is able to save. 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 **Adult Education**	One or more school-aged children not enrolled in school. Literacy problems and/or no high school diploma/GED are serious barriers to employment.	One or more school-aged children enrolled in school, but not attending classes. Enrolled in literacy and/or GED program and/or has sufficient command of English to where language is not a barrier to employment.	Enrolled in school, but one or more children only occasionally attending classes. Has high school diploma/GE D.	Enrolled in school and attending classes most of the time. Needs additional education/training to improve employment situation and/or to resolve literacy problems to where they are able to function effectively in society.	All school-aged children enrolled and attending on a regular basis. 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 **Mobility**	Lack of necessary support form family or friends; abuse (DV, child) is present or there is child neglect. No access to transportation, public or private; may have car that is inoperable.	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. Transportation is available, but unreliable, unpredictable, unaffordable; may have care but no insurance, license, etc.	Some support from family/friends; family members acknowledge and seek to change negative behaviors; are learning to support and communicate Transportation is available and reliable but limited and/or inconvenient; drivers are licensed and minimally insured.	Strong support from family or friends. Household members support each other's efforts. Transportation is generally accessible to meet basic travel needs.	Has healthy/expanding support network; household is stable, and communication is consistently open. 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/par ole 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 on 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.

Table C-8a: Member Roles and Responsibilities

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
[redacted]	CTI Supervisor / Team Lead
[redacted]	CTI Case Manager
[redacted]	CTI Case Manager focused on Pre-CTI clients
[redacted]	CTI Case Manager
[redacted]	CTI Case Manager
[redacted]	CTI Case Manager

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

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 directly trains in CTI. One CTI Case Manager position turned over during this report period. The new hire has been trained by the CTI Supervisor who is a certified CTI trainer.

The Care Transitions team members are an integral part of the Multi-disciplinary Core Team within the Community Care Team. Each member of the team is required to complete a core competency training.

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.

ALL NEW C1 STAFF members hired during the report period have been trained in Chronic Disease management: Diabetes, Hypertension, Dyslipidemia. They have also participated in CTI Worker training, SUD and BH awareness trainings, Motivational Interviewing, and Trauma-Informed Care. The Care Transitions team has also worked to establish trainings and attend learning sessions with our community project partners.

The Care Transitions team pursued advance SUD service training starting with a one-day overview of the CRSW training domains. This training was held at one of our B1 partner sites, Southeastern NH Services, and funded by IDN Region 6. For those CTI Case Managers interested in pursuing further training, the IDN Region 6 supported their enrollment in the New Hampshire Training Institute course listed in the table below.

*ADCL 230C The Four Domains of the Certified Recovery Support Worker (CRSW) 3-0-3
This eight-week online course includes detailed and comprehensive information on the educational components required by the NH Licensing Board for Alcohol and Other Drug Use Professional as well as education in the Four Domains of the CRSW credential. This course meets the educational requirements for the CRSW. To receive the CRSW certification, however, students must contact the Licensing Board and meet additional requirements which include 500 hours of paid or volunteer work, completion of the IC&RC exam, and any other conditions as required by the Board. This Credential is ideal for anyone seeking a career in the substance use disorder profession, specifically pertaining to the recovery of individuals suffering from the disease of addiction

The IDN Region 6 is reviewing opportunities for the CTI Case Managers to pursue CRSW certification to enhance their role and service delivery to clients with complex clinical needs.

Table C-9a: Ongoing C1 Training Schedule

Projected C1 Training Schedule	PROJECTS IMPACTED	# ATTENDING	REPORTING PERIOD		
TOPIC			**06/30/19**	**12/31/19**	**06/30/20**
HIPAA training for CTI and Community Care Team	C1, D3, E5	10-15	Jan 9	**Oct 15**	
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	**Dec 13**	
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	5	March	-	
BH updates and services	C1, E5, D3	5	April	-	
BH - Foundations In Trauma Informed Care	C1, E5, D3	4	April	-	
Chronic Disease / Part II - further discussion of chronic disease management's impact on BH and SUD co-occurring conditions	C1, E5, D3	8	May	-	
CTI Project Fidelity and Program Metrics	C1	7-10	-	**July 18**	
CRSW training in domains 1-4	C1, D3	8		**Oct 17**	
ADCL 230C LZZ online course through NHTI*	C1, D3, E5	3	_	**Oct 21-Dec 20**	
Foundational Training in Trauma Responsive Systems	C1, D3, E5	4	_	**Nov 18, Dec 6**	

Wentworth-Douglass / PHN Addiction Summit	C1, D3, E5	3	_	**Nov 20**	
Beyond Self-Care	C1	1	_	**Dec 5**	
Greater Seacoast Housing Summit	C1, E5	4	_	**Nov 8**	

Table C-9b: Previous C1 Training Schedule

Attended C1 Training Schedule	PROJECTS IMPACTED	# ATTENDED	REPORTING PERIOD		
TOPIC			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 -> Sep 12	ongoing	ongoing
*Web-based: Program Fidelity Assmt	C1	4			
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	

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 IDN6 Team secured an agreement with Southeastern New Hampshire Services (SENHS) in January 2018 to employ and provide clinical supervision to the D3 Services Team. Following an extensive search, two staff were recruited and hired, one MLADC Navigator and one Case Manager (CRSW). The MLADC completed 78 level of care evaluations with referrals directly to the CRSW / Case Manager.

SENHS experienced turnover of the Executive Director position twice, in both in the current and previous reporting periods. The last ED left in the first week of May and the position remains to be filled as of the writing of this report. During this period, SENHS also re-assigned all their residential beds to ASAM Level 3.1 Low Intensity Treatment. This functionally eliminated all capacity of ASAM Level 3.5 High Intensity Treatment beds (28-Day program) in our region, except for the eight Level 3.5 beds at Hope on Haven Hill, which are only for pregnant and post-partum women.

In March 2019, internal changes at SENHS led to a discussion of SENHS ability to continue to manage the embedded D3 program and staff. After multiple discussions, the contract was not renewed and ended 4/30/2019. In preparation for this change, the IDN 6 Operations team surveyed partners to find a new option to house the MLADC and CRSW for community-based assessments. There was not a regional partner prepared to host this team. The resulting changes in regional staffing are reflected in Table D-3

Some of the impact of this change is offset by the availability of the HUB / The Doorway services and the IDN 6 is closely collaborating with The Doorway at WDH to facilitate getting clients / residents in need of support to their facility for evaluation and Case Management. The Doorway reflects much of IDN 6 efforts that are aimed at building capacity for intensive SUD services in the region, which are most often not achieved through the hiring of SUD provider staff to deliver those specific services, but rather ancillary and supportive staff, navigators and connectors, uncovered costs associated with administering programs, and strengthening organizational and inter-agency capacity that is so critical to system efficiency.

During the current reporting period, Wentworth Douglass Hospital maintained a limited volume of patients receiving initiation of withdrawal management in the ED. During the past reporting period, collaboration efforts with Wentworth Douglass Hospital and The Doorway at Wentworth Douglass Hospital resulted in the development draft workflows for ED initiation of withdrawal management and limited implementation. 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.

IDN 6 continually pursues conversations with D3 project partners to find opportunities for both staffing and project development to expand regional capacity for intensive SUD services, including but not limited to community based MLADC assessments and CRSW services. Among those efforts are:

- Upon agreeing to serve as the Hub in our region, Wentworth Douglas Hospital staff immediately reached out to the IDN 6 for assistance. The IDN staff convened and facilitated the HUB and Spoke (The Doorway) workgroup meetings throughout the reporting period, supporting the development of this key effort to build SUD treatment and recovery capacity in the region.
- The IDN 6 has also connected the Strafford County Community Corrections and Public Defenders with SENHS for SUD assessments that are necessary for court compliance. The IDN has provided funding for these assessments to be provided by SENHS if the client is Medicaid eligible, but does not have active coverage. The goal of this collaboration is to reduce the burden on the clients and the corrections system due to a client's inability to obtain a Medicaid covered service. The impact of this investment is a stronger collaboration and timely workflow between Corrections and SENHS to facilitate Medicaid applications and referral for evaluations much earlier in the Corrections process, reducing the number of court appearances and potential days in jail.
- The Region 6 IDN Operations team is providing technical assistance to Strafford County Corrections in the development of expanded MAT / MAR services. "A Primer for Implementation of Overdose Education and Naloxone Distribution in Jails and Prisons" is one model of program development used by the team to introduce programming development to accompany clinical services. The entire document can be found at:

  https://harmreduction.org/wp-content/uploads/2019/09/Naloxone-Prison-Primer_v2.pdf
- The funding of a full time IOP Director at Seacoast Youth Services to expand capacity to meet the high demand of SUD services for youth across the region. The SYS Coordinator is intended to be dually based in Seabrook in Rockingham County, as well as Rochester in Strafford County. ***This position is reflected in the B1 staffing table.***
- The funding of a full time Behavioral Health / IOP Director at Families First / Greater Seacoast Community Health to expand capacity to meet the high demand of IOP and SUD support services across the region. ***This MLADC position is reflected in the B1 staffing table.***

- IDN 6 funded Strafford County Community Corrections to support a full time Case Manager position in the E5 project to directly serve and support people in the court system who are experiencing serious and persistent mental illness, many of whom live with SUD complications.
- Likewise, IDN 6 continues to fund the position of a CRSW for the LEAD program in Strafford County, providing CRSW staffing who take referrals primarily, but not exclusively from the Dover and Farmington Police Departments as a larger effort to divert community members in need of SUD services away from legal interventions and towards intensive SUD services.
- IDN continued to fund, in this reporting period, two full time positions at Hope on Haven Hill (B1 partner), a level 3.5 residential and outpatient SUD treatment provider for pregnant and post-partum women. These positions covered billable and non-billable services, including MLADC evaluations, care coordination, IT infrastructure building and facilities development and management. All of which are critical to the SUD infrastructure and capacity of HHH to offer these critical SUD services. ***The clinical positions are reflected in the B1 staffing table.***
- Continuing our support of the SOS Recovery Community Organization to expand Recovery Capital and Recovery-oriented services and supports in our region, the IDN approved the funding of a full time Capacity Building Specialist. This position will serve as the Site Director of the new SOS Recovery Community Center in Hampton, opening July 29, 2019. RCCs have been critical partners in lowering the threshold and increasing access and support to people in the region who are seeking SUD services and ongoing supports. IDN 6 funds the MLADC providing supervision for the CRSWs at SOS through a subcontract with Addiction Recovery Services.
- IDN 6 has been working closely with Wentworth Douglass Hospital/Wentworth Health Partners, Lamprey Health Care and Exeter Hospital/CORE Physicians on their plans to implement and expand implementation of Medication Assisted Treatment and recovery supports, through training, technical assistance, and funding of program start-up costs.
- IDN 6 attended several meetings during this reporting period (along with our colleagues from Region 4) with the Rockingham County Corrections staff, in support of their efforts to build a full continuum of MAT/MAR treatment and support for inmates.

The following **client narrative** demonstrates the value of the integrated network of providers, including D3 partners, working in the IDN 6 region.

"M" is a referral from a partner hospital #1 concerned that M would be unable to follow up with her appointments and make connects with her community mental health center. Prior to M's hospitalization, her partner and roommate tragically took her life in their shared apartment. M struggled with her own suicidal ideation and went to her local ED #2 for help. She was hospitalized for psychiatric care at hospital #3.

Shortly after M returned home, the grief from losing her partner was too much and she returned to the ED of hospital #1. This cycle repeated itself two more times before M was referred to the IDN 6 CTI team (C1 project). Case management first met M during her admission at hospital #1, worked with M after discharge 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 M needed to go back to the hospital, case management arranged for a foster dog mom, so M didn't rack up expensive fees from kenneling her dog long term. M had been very anxious about this during previous admissions.

Just before the holidays in 2018, M expressed readiness to address her underlying substance use disorder. CTI case management coordinated with the D3 project who met with M at hospital #1. The team was able to get M into a 28-day treatment program. Thanks to these coordinated efforts, M 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.

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.*

Data from the MLADC and CRSW team employed at Southeastern NH Services (SENHS) through 4/30/19 provides the foundation for the target measures reported to date. Patients were referred to the D3 staff at Southeastern NH Services from the following sources:

- Portsmouth Regional Hospital
- Portsmouth Regional Hospital Behavioral Health Unit
- Frisbie Memorial Hospital
- Wentworth Douglass Hospital
- Tri-City Co-Op
- Crossroads House / shelter
- SOS Recovery Community Supports
- Bonfire Recovery
- Strafford and Rockingham County Corrections
- Care Transitions Care Coordination team (C1)

Measures from current project partners:

Data from the recently revised agreement with **SENHS** to support a CRSW in their residential treatment program is pending currently. The data anticipated from the IDN 6 supported staff will positively impact the following performance measures:

patients referred to CRSWs / Case Managers
referrals made and completed by Case Managers / CRSWs
clients who **complete** a defined treatment program
clients who leave treatment in the first 7 days

Updated client service data from **SOS / Hampton** team is pending currently. The data anticipated from their IDN 6 supported staff will positively impact the following performance measures:

patients referred to CRSWs / Case Managers
referrals made and completed by Case Managers / CRSWs

Data from the **Law Enforcement Assisted Diversion (LEAD) / SOS** program to date represents 20 total additional referrals to CRSWs this reporting period. Of the 20, nine have attended / are currently in some sort of inpatient or intensive outpatient care. 80 additional community members with active bench warrants have been identified as potential 'social contact' referrals, so if they are contacted in the community, they will be offered the same program. Although it won't affect their outstanding bench warrant, it is a way to offer targeted support to at-risk individuals prior to an arrest-able crime being committed. Discussion is underway to expand the LEAD program to Portsmouth and Seabrook.

Ongoing data from the IDN 6 supported staff will continue to positively impact the following performance measures:

patients referred to CRSWs / Case Managers
referrals made and completed by Case Managers / CRSWs
clients who **complete** a defined treatment program

TABLE D-2a: 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	As of 6/30/19	As of 12/31/19
# patients engaged with MLADC Navigator	30 by 12/31/18	n/a	11	>60	>78	>78
# patients received MLADC evaluation in community setting	30 by 12/31/18	n/a	n/a	60	78	78
# patients referred to CRSWs / Case Managers	20 by 12/31/18	n/a	n/a	62	97	>117
# referrals made and completed by Case Managers / CRSWs	20 by 12/31/18	0	5	45	63	>72
# clients who **complete** a defined treatment program	15 by 12/31/18	0	TBD	15	30	30
# clients who leave treatment in the first 7 days	<50%	0	TBD	unknown	2/30=7%	2/30=7%
# clients in supportive services 30 days after completion	>50%	0	TBD	10/15=67%	20/30= 67%	20/30= 67%
# Providers trained in SBIRT	20 by 12/31/18	0	0	21	24	24
# Providers employing SBIRT*	10 by 12/31/18	N/A	N/A	>30	>30	>30

**inclusive of partners in all projects, does not indicate universal screening. (GSCH, LHC, WDH/WHP, CP, SMHC, SYS, Hope on Haven Hill, Dover Pediatrics, 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) in January 2018 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 78 level of care evaluations with referrals directly to the SENHS CRSW / Case Manager.

In March 2019, internal changes at SENHS led to a discussion of their ability to continue to manage the embedded D3 program and staff. After multiple discussions, the contract was not renewed and ended 4/30/2019. In preparation for this change, the IDN 6 Operations team surveyed partners to find a new option to house the MLADC / CRSW team for community-based assessments. There was not a regional partner prepared to host this team. The resulting changes in regional staffing are reflected in the table below.

Some of the impact of this change is offset by the availability of the HUB / The Doorway services and the IDN 6 is closely collaborating with The Doorway at WDH to facilitate getting clients / residents in need of support to their facility for evaluation and Case Management.

Progress has been made in work toward an IDN-supported MAT / MAR program with Strafford County Corrections. An MOU was anticipated during the reporting period to include a minimum of 0.25 FTE MLADC and 1.0 FTE Case Manager. Those staffing goals are included in the adjusted targets in Table D-3a. The project plans are still in development and IDN 6 remains open to funding these efforts during the DSRIP period.

IDN 6 continues to pursue conversations with D3 project partners to find opportunities for both staffing and project development to expand community based MLADC assessments and CRSW services.

Current Staffing

Southeastern NH Services

IDN 6 did convert funding for the 1.0 FTE CRSW Case Manager from a community-based position to be utilized in the SENHS residential recovery program.

The IDN 6 has also connected the Strafford County Community Corrections / Public Defenders with SENHS for SUD assessments that are necessary for court compliance. The IDN has offered funding, if needed, for these assessments to be provided by SENHS if the client is Medicaid eligible, but does not have active coverage. This resource commitment removes a barrier to timely evaluation and reduces the time / burden on both clients and the County in the drug court system. A 0.1 FTE MLADC at SENHS is included in the staffing targets in Table D-3a.

SOS / Greater Seacoast Community Health

In October 2018, an agreement was secured to support SOS Recovery Community Support (SOS) in hiring additional CRSW / Case Managers, total 2.0 FTE. As 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. SOS

recently opened a new Peer Recovery Support center in Hampton. Region 6 IDN is supporting a new 1.0 FTE Case Manager at that location.

During this report period, IDN 6 newly funded MLADC supervision for the CRSW staff employed by SOS / Greater Seacoast Community Health through a subcontract with John Iudice from Addictions Recovery Services, Inc will provide 4 hours total per month, 0.025 FTE MLADC supervision from October 1, 2019 through June 30, 2020 or another suitable MLADC to allow staff and volunteers to gain and maintain Certified Recovery Support Worker (CRSW) credentials to enhance and further workforce in the treatment and recovery support services in the Hampton and Seacoast area.

IDN 6 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.

WRITEBACK RESPONSE:

Reduction of MLADC staffing targets in section D-3: Hope on Haven Hill staff positions were removed from the D3 project reporting for December 2018, resulting in a discussion with DHHS and understanding that there would be a corresponding target reduction in section D-3 from 2 MLADCs to 1. It was not anticipated that IDN 6 would hire additional MLADCs in the D3 project.

In the June 2019 SAR, IDN 6 reported the following in section A1-5 (emphasis added), "Revision of key elements of the D3 Community Project resulted in the loss of two partner agency staff assigned to the D3 project, an MLADC navigator and a CRSW. *Staffing to the new target of 0.35 FTE MLADC and 3 Case Manager / CRSW is anticipated by 12/31/19*…."

In the June 2019 SAR, further detail was provided in section D-4; "In March 2019, internal changes at SENHS led to a discussion of their ability to continue to manage the embedded D3 program and staff. After multiple discussions, the contract was not renewed and ended 4/30/2019. In preparation for this change, the IDN 6 Operations team surveyed partners to find a new option to house the MLADC / CRSW team for community-based assessments. There was not a regional partner prepared to host this team. *The resulting changes in regional staffing are reflected in the table below."* The current goal of 0.35FTE reflects the loss of the 1.0FTE at SENHS and the anticipation of limited MLADC onboarding to follow.

We feel it is important to note that the targets were adjusted to reflect expectations *at the time of each report* for staff that would be prospectively hired and trained exclusively in the D3 Project. Historical positions have been hired / trained and adjusted as explained above. It would be inaccurate to interpret the new target of 0.35FTE MLADC as the total of the staff successfully hired, trained, and operating in this role during the project period.

TABLE D-3: Workforce Staffing ***targets adjusted to projected total need for remainder of DSRIP implementation***

**Please Note: 2.0 FTE MLADCs are hired and trained with IDN support at Hope on Haven Hill and Families First / Greater Seacoast Community Health. These organizations are B1 project partners and the positions are reported in the B1 staffing table but are work originally envisioned in the D3 project.*

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	Staffing on 06/30/19	Staffing on 12/31/19
MLADC Navigator	~~1~~ **0.35**	0	0	1	1	0.1	0.125
Case Manager / CRSW	~~6~~ **4**	0	0	1	3	~~2~~ **3**	4
Staffing support of note							
MLADC Navigators* (reported in B1)	~~1~~ **0.35**					2	2

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	Jan-Jun 2019 Actuals	Jul-Dec 2019 Actual	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	**$ 566**	$ 1,154	$ 3,500	$ 3,500	$ 13,340
								$ -	$ -
Workforce								$ -	$ -
Fees/Outside Placement	$ -	$ -	$ 154,000	$ 154,792	**$ 151,760**	$ (11,994)	$ 350,000	$ 350,000	$ 1,148,558
Recruiting/Retention	$ -	$ -	$ -	$ -	**$ -**	$ -	$ -	$ -	$ -
Training	$ -	$ -	$ 340	$ -	**$ 70**	$ -	$ 5,000	$ 5,000	$ 10,410
Other	$ -	$ -	$ -	$ -	**$ -**	$ -	$ -	$ -	$ -
								$ -	$ -
Technology	$ -	$ -	$ -	$ -	**$ -**	$ -	$ 15,000	$ 15,000	$ 30,000
								$ -	$ -
									$ -
Totals	$ -	$ -	$ 158 122	$ 155 631	**$ 152,395**	**$ (10,839)**	$ 373 500	$ 373 500	$ 1,202,309
DY 2019						**$ 141,556**			

Budget Narrative

- Outside placements included 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. The IDN expects to allocate resources in support of this, but at this point, the details are not yet finalized.

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 host for the D3 project has been 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. During the past report period, the contract with SENHS to host D3 staff ended, as discussed in the section D-1 narrative. IDN 6 remains in close contact with SENHS and is supportive of efforts to retain essential services, including funding a CRSW position in their residential program. Current collaboration continues regarding ongoing staff trainings.

IDN 6 is working closely with The Doorway at Wentworth Douglass Hospital and actively reconvened the IDN 6 D3 Workgroup following the establishment of the Doorway in our region. The workgroup met during the reporting period on September 10, 2019. Smaller workgroups continued project work as defined at that meeting. Partners who provide valuable SUD services in the region and those who are formally partnered with our B1 projects also participate in the D3 Workgroup; including Seacoast Mental Health Center, Seacoast Youth Services, Hope on Haven Hill, ROAD to a Better Life and Addiction Recovery Services.

D3 Workgroup Objectives:

- Create a Regional Partner Collaborative to build SUD Treatment and Recovery Capacity through existing and new resources.
- Review current state of SUD Treatment Modalities Availability and Accessibility in the Seacoast Region
- Facilitate Mapping Exercise of Regional (and extra-regional) Resources (includes visual of Hub-and-Spokes)
- Layer existing Referral and Transitional Workflows on Mapping (reconcile with Hub-and-Spokes)
- Identify Investment Needs and Opportunities in Workflow efficiencies, Staffing, Trainings, Agreements, Technology, and other Capacity-Building
- Identify data points for tracking and Continuous Quality Improvement of Workflows

Organization/Provider	Agreement Executed (Y/N)
Southeastern New Hampshire Services	Yes
Wentworth Douglass Hospital	Yes
Frisbie Memorial Hospital	Yes
Portsmouth Regional Hospital / HCA	Yes
Hope on Haven Hill	Yes
Rockingham County Corrections	Yes
Seacoast Youth Services	Yes
SOS Recovery Community Support	Yes
Safe Harbor Recovery Community Organization/ Granite Pathways/Seacoast Pathways	Yes
Strafford County Community Corrections	Yes
Tri-City Co-Op	Yes
Bridging the Gaps - Rochester's Substance Misuse Prevention Coalition	Yes
Addiction Recovery Services, Inc	Yes

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 used the ASSM to compliment the assessments completed by the Care Transitions team (C1).

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

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

Attachment D-6b

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 *Measured after patient is sitting or lying for one minute* 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 piloerrection of skin can be felt or hairs standing up on arms 5 prominent piloerrection
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	Total Score _____ The total score is the sum of all 11 items Initials of person completing assessment: _____

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

Attachment D6-c

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):

First or second session after screening/diversion	***Third session or later after screening/diversion***

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

☐ Non-prescribed 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

☐ Non-prescribed 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☐ 3-5 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)
☐ Choose not to answer ☐ Don't Know

For billing purposes (if enrolling in billable Recovery Coaching or Telephone Recovery) What is your Insurance Group Number:_____Member ID Number _____

VETERAN: ☐ YES ☐ N O **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 note 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 ☐1st - 6th Grade ☐ 7th- 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.

During the report period, The IDN 6 has supported the development of HUB / Doorway MOUs by holding regular meetings with the Doorway and regional spoke partners. MOUs set the foundation for the referrals and shared tracking of community members seeking Doorway and treatment services. The MOU serves as a referral and management protocol for this regional work. MOUs have been executed with 8 of the IDN 6 B1 partners (discussed further in B1-8h and B1-9d). In addition, they have executed MOUs with the following D3 partners:

- SOS Recovery Community Support
- Safe Harbor Recovery Community Organization / Granite Pathways / Seacoast Pathways
- Strafford County Community Corrections
- ROAD to a Better Life

The IDN team and SENHS worked closely with key partners (Wentworth Douglass Hospital, Frisbie Memorial Hospital, Portsmouth Regional Hospital) and 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 received 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.

UPDATED Table D-7: Protocols for Patient Assessment, Treatment, Management, and Referrals

Protocol Name	Brief Description	Use (Current/Under Development)
NEW: WDH / Doorway Memorandum of Understanding	MOU between Regional HUB and identified spoke / treatment partners	Current
WDH ED buprenorphine for Opioid Withdrawal Protocol *(attachment D-7a)*	Protocol for ambulatory detox started in Emergency Department	Current
National Institute on Drug Abuse (NIDA) Guidelines *(attachment D-7b)*	Protocol for ambulatory detox started after ED discharge	Current
Addiction Severity Index (ASI) *(attachment D-6a)*	Level of Care assessment for SUD	Current
American Society of Addiction Medicine (ASAM) Criteria *(attachment D-7c)*	Biopsychosocial assessment for SUD treatment planning	Current
SBIRT	Screening tool for SUD	Current
Referral to D3 services *(attachment D-7d)*	Referral form to MLADC / CRSW	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/OUD. 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, <u>buprenorphine without naloxone (Subutex</u>), may be used.

   b. Do not administer buprenorphine until patient objectively demonstrates signs andsymptoms 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)

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

  - **o 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

Resting Pulse Rate: _____beats/minute *Measured after patient is sitting or lying for one minute* 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 piloerrection of skin can be felt or hairs standing up on arms 5 prominent piloerrection
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	Total Score _____ The total score is the sum of all 11 items Initials of person completing assessment: _____

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

Attachment D-7b

A Guide for Patients Beginning Buprenorphine Treatment at Home

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

It should be at least . . .

- **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

You should feel at least three of these symptoms . . .

- 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

DAY 1:
8-12mg of buprenorphine

Most people feel better the first day after 8-12mg. (Dosing depends on how early on the first day you started)

Step 1.

Take the first dose

4mg

Wait 45 minutes

45 minutes

- 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

Step 2.

Still feel sick? Take next dose

4mg

Wait 6 hours

6 hours

Most people feel better after two doses = 8mg

Step 3.

Still uncomfortable? Take last dose

4mg

Stop

Stop

- Stop after this dose
- Do not exceed 12mg on Day 1

DAY 2:
16mg of buprenorphine

Take one 16mg dose

Most people feel better with a 16mg dose

16mg

Repeat this dose until your next follow-up appointment

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?
2. Do any emotional, behavioral or cognitive problems appear to be an expected part of addictive disorder or do they appear to be autonomous?
3. Even if connected to the addiction, are they severe enough to warrant specific mental health treatment?
4. Is the patient able to manage the activities of daily living?
5. 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 of 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).

Connections for Health
Integrated Health Services

Connections for Health / Referral Form

Please send via secure email only

IDN Referral date: _____ D*3 Referral Date*: _____
Client name: _____DOB: _____ Male ☐ Female ☐ Transgender ☐
Mailing Address: _____Phone number: _____
Income? Yes ☐ No ☐ Stable Housing? Yes ☐ No ☐
Insurance Provider: _____ ***PCP***: _____***MH Provider***: _____
Case Management Status:

☐ Client has verbally agreed to meet with MLDAC for an assessment
☐ Client has a CCT release form signed
☐ Client is *not* consistently attending appointments for PCP or referrals for specialized health care treatment
☐ Client has been assessed and has a care plan with the Connections for Health team

Current status:

☐ Client is currently a patient/resident at _____ facility; or the client is at the following address: _____
☐ Client's formal and informal supports/connections: _____

D3 Report Back to referral source:

- **The client above has been seen – please call directly for detailed information, if needed.**

Assessment Date: _____
Client to follow up with: _____ > **Referral made: Yes No (circle one)**
Next Steps (brief summary of care plan): _____

_____

- **The client above HAS NOT BEEN seen – please call directly for detailed information, if needed. Reason (brief explanation of contact attempts or client declination of service):**

_____
_____

Form Completed by: _____ **Contact phone number:** _____

Attachment D-7e

Memorandum of Understanding

Between

Wentworth-Douglass Hospital

and

[Name of Organization Here]

This Memorandum of Understanding ("MOU"), effective as of March 19, 2019 (the "Effective Date") sets forth the terms and understanding between

Wentworth-Douglass Hospital ("WDH") and [Name of Organization Here] (the "Spoke").

This MOU represents a voluntary agreement to processes and procedures governing leveraging and sharing resources, referral relationships, and roles related to care coordination and shared care planning for substance use disorder patient treatment and recovery.

Background

Pursuant to that certain Agreement dated [October 18, 2018] by and between the State of New Hampshire, Department of Health and Human Services (the "Agreement") and WDH, the State of New Hampshire has selected WDH (operating under the trade name "The Doorway Operated by Wentworth-Douglass Hospital") to serve as the "HUB" under the Agreement and to provide a complete needs assessment in addition to ongoing support services including care coordination and continuous recovery monitoring for all patients presenting at the HUB. This MOU between Spoke and WDH is required to accomplish the following: (1) delivery of the best continuum of care for our patients; (2) reducing duplication of services; (3) assuring the patient is at the correct level of care for his or her needs; and (4) providing ongoing support for all patients on their journey in recovery.

Responsibilities of WDH

WDH will provide the services in accordance with Scope of Work described under the Agreement and at the direction of the State thereunder on behalf of patients presenting at the HUB including the following for:

Responsibilities of Spoke

- List Services/duties here.

Spoke will provide the following services:

- List Services/duties here.

Funding

There will be no transfer of funds between WDH and Spoke for services rendered within this agreement. Spoke is required to bill third party payers for the services provided to patients referred to Spoke in its role as the HUB under the Agreement.

Representations and Warranties of Spoke

Spoke represents and warrants to WDH that it will provide the services described in this Agreement in compliance with all applicable laws, including, without limitation, as applicable, the Health Insurance Portability and Accountability Act, Public Law 104-191 ("HIPAA") and the associated Standards for Privacy and Security of Individually Identifiable Health Information, 45 CFR Parts 160, 162 and 164, and the federal regulations regarding the Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2 ("Part 2").

Term; Survival of Obligations

The Term of this Memorandum of Understanding shall commence on the Effective Date, and shall continue in effect for so long as the Agreement is in effect between the State and WDH, or until either party provides written notice of its termination to the non-terminating party. Termination of this Agreement does not alleviate either party of its obligations to continue to provide treatment services to patients with whom the parties have established relationship with pursuant to applicable state law and standards of professional ethics. Additionally, any obligations of the parties to continue to provide reports to the State of New Hampshire of data with respect to Naloxone distribution or the services provided hereunder shall continue following the termination of this Agreement.

State as Contracting Party

Spoke acknowledges and agrees that, pursuant to the Agreement, as it may be modified from time to time, WDH's obligations related to the scope and content of its services are directed exclusively by the State, and WDH's contractual responsibilities in connection with delivery of services is exclusively with the State and not with Spoke.

Indemnification

Spoke shall defend, indemnify and hold harmless WDH and its officers, directors, trustees, employees, agents, successors and permitted assigns (each, a "WDH Indemnitee") from and against all losses, damages, liabilities, deficiencies, actions, judgments, interest, awards, penalties, fines, costs or expenses of whatever kind, including reasonable attorneys' fees and the cost of enforcing any right to indemnification hereunder

and the cost of pursuing any insurance providers (collectively, "Losses") arising out of or resulting from any third party claim, suit, action or proceeding (each, an "Action") arising out of or resulting from: (a) bodily injury, death of any person or damage to real or tangible, personal property resulting from the willful, fraudulent or grossly negligent acts or omissions of Spoke; or (b) Spoke's material breach of any representation, warranty or obligation of Spoke set forth in this MOU.

WDH shall defend, indemnify and hold harmless Spoke and its officers, directors, trustees, employees, agents, successors and permitted assigns from and against all Losses arising out of or resulting from an Action arising out of or resulting from: (a) bodily injury, death of any person or damage to real or tangible, personal property resulting from the grossly negligent or willful acts or omissions of WDH; or (b) WDH's material breach of any representation, warranty or obligation of WDH in this MOU.

The party seeking indemnification hereunder shall promptly notify the indemnifying party in writing of any action and cooperate with the indemnifying party at the indemnifying party's sole cost and expense. The indemnifying party shall immediately take control of the defense and investigation of such action and shall employ counsel of its choice to handle and defend the same, at the indemnifying party's sole cost and expense. The indemnifying party shall not settle any Action in a manner that adversely affects the rights of the indemnified party without the indemnified party's prior written consent, which shall not be unreasonably withheld or delayed. The indemnified party's failure to perform any obligations under this Section shall not relieve the indemnifying party of its obligations under this Section except to the extent that the indemnifying party can demonstrate that it has been materially prejudiced as a result of such failure. The indemnified party may participate in and observe the proceedings at its own cost and expense.

LIMITATION OF LIABILITY

EXCEPT AS OTHERWISE PROVIDED IN THIS MOU, IN NO EVENT WILL EITHER PARTY BE LIABLE TO THE OTHER FOR ANY LOSS OF USE, REVENUE OR PROFIT OR FOR ANY CONSEQUENTIAL, INCIDENTAL, INDIRECT, EXEMPLARY, SPECIAL OR PUNITIVE DAMAGES WHETHER ARISING OUT OF BREACH OF CONTRACT, TORT (INCLUDING NEGLIGENCE) OR OTHERWISE, REGARDLESS OF WHETHER SUCH DAMAGE WAS FORESEEABLE AND WHETHER OR NOT SUCH PARTY HAS BEEN ADVISED OF THE POSSIBILITY OF SUCH DAMAGES.

Insurance

At all times during the Term of this MOU and for a period of three years thereafter, Spoke shall procure and maintain, at its sole cost and expense, at least the following types and amounts of insurance coverage:

(a) Commercial General Liability with limits no less than $1,000,000 per occurrence and $3,000,000 in the aggregate which policy will include contractual liability coverage insuring the activities of Spoke under this MOU; [and] [NTD: including subsection (b) will depend on the identity of the Spoke]

[(b) Errors and Omissions/Professional Liability with limits no less than $1,000,000 per occurrence and $3,000,000 in the aggregate.]

All insurance policies required pursuant to this Section shall provide that such insurance carriers give WDH at least 30 days' prior written notice of cancellation or non-renewal of policy coverage; provided that, prior to such cancellation, the Spoke shall have new insurance policies in place that meet the requirements of this Section. Upon the written request of WDH, Spoke shall provide WDH with copies of the certificates of

insurance and policy endorsements for all insurance coverage required by this Section, and shall not do anything to invalidate such insurance. This Section shall not be construed in any manner as waiving, restricting or limiting the liability of either party for any obligations imposed under this MOU (including but not limited to, any provisions requiring a party hereto to indemnify, defend and hold the other harmless under this MOU).

Federal Health Care Program Participation

WDH and Spoke each represents and warrants to the other that neither (i) is currently excluded, debarred, or otherwise ineligible to participate in any Federal health care program as defined in 42 USC § 1320a-7b(f) ("Federal health care programs"); (ii) has been convicted of a criminal offense related to the provision of health care items or services but not yet been excluded, debarred, or otherwise declared ineligible to participate in any Federal health care program; and (iii) is under investigation or otherwise aware of any circumstances which may result in being excluded from participation in any Federal health care program. The foregoing shall be an ongoing representation and warranty during the term of this MOU, and each party shall immediately notify the other of any change in the status of the representation and warranty. Any breach of this Section shall give the non-breaching party the right to terminate this Agreement immediately for cause.

Entire Agreement; Counterparts

This MOU contains the entire agreement of the parties hereto and supersedes all prior agreements, contracts and understandings, whether written or otherwise, between the parties relating to the subject matter hereof. This MOU may be executed in one or more counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument.

Partial Invalidity

In the event, any provision of this MOU is found to be legally invalid or unenforceable for any reason, the remaining provisions of the MOU shall remain in full force and effect provided the fundamental rights and obligations remain reasonably unaffected.

Assignment

Neither party may assign any of its rights or obligations hereunder without the prior written consent of the other party. This MOU shall inure to the benefit of and be binding upon the parties hereto and their respective successors and permitted assigns.

Relationship of Parties

WDH and Spoke are performing services and duties as independent contractors and not as employees, agents, partners of, or joint ventures of each other. Spoke shall not be considered an employee of WDH for any purpose. In rendering professional services, practitioners are acting in their capacity as independent medical staff members of either WDH or Spoke, as applicable. Spoke shall be responsible for determining the manner in which services to its patients are provided and ensuring that such services are rendered in a manner consistent with applicable law and ethical standards.

Regulatory Requirements

The parties expressly agree that nothing contained in this MOU shall require Spoke to refer or admit any patients to, or order any goods or services from WDH, or require WDH to refer or admit any patients to, or order any goods or services from, Spoke. Notwithstanding any unanticipated effect of any provision of this MOU, neither party will knowingly or intentionally conduct itself in such a manner as to violate the prohibition against fraud and abuse in connection with the Medicare and Medicaid programs (42 USC § 1320a-7b).

Medicare Access to Records

Insofar as Section 952 of PL 96-499 (42 U.S.C. 1395x(v)(1)(I)) is applicable to this MOU, Spoke agrees as follows: (a) Until the expiration of four (4) years after the furnishing of services pursuant to this MOU or any greater length of time as may be required by applicable federal statute or regulation, Spoke shall make available, upon written request, to the Secretary of the Federal Department of Health and Human Services or upon request to the Comptroller General of the United States, or any of their duly authorized representatives, this MOU, and books, documents and records that are necessary to certify the nature and extent of such costs; and (b) If Spoke carries out any of the duties of this MOU through a subcontract with a value of $10,000 or more over a 12-month period, such subcontract shall contain a clause to the effect that until the expiration of four years after the furnishing of such services pursuant to such subcontract or any greater length of time as may be required by applicable federal statute or regulation, the related organization shall make available, upon written request, to the Secretary of the Federal Department of Health and Human Services or the Comptroller General of the United States, or any of their duly authorized representatives, the subcontract, and books, documents and records of such organization that are necessary to verify the nature and extent of such costs. No attorney-client, accountant-client, or other legal privilege will be deemed to have been waived by WDH or Spoke by virtue of this MOU.

Third Party Beneficiaries

This MOU is entered into for the sole benefit of WDH and Spoke. Nothing contained herein or in the parties' course of dealings shall be construed as conferring any third party beneficiary status on any person or entity not a party to this MOU.

Governing Law

This MOU shall be governed by the laws of the State of New Hampshire.

[Signature page follows].

Wentworth-Douglass Hospital
Kellie Mueller, MEd
Director of Behavioral Health
789 Central Avenue
Dover, N.H. 03820
Telephone Fax:
E-mail

BY: _____ DATE: _____

[INSERT SIGNATORY NAME & TITLE]

[Name of Organization Here]
Spoke representative
Position
Address
Telephone
Fax
E-mail

BY: _____ DATE: _____

[INSERT SIGNATORY NAME & TITLE]

WDH Memorandum of Understanding / Appendix A:

Gender	Insurance Type	# of Previous OD's	# of times Naloxone used	Primary reason why client used opioids	Where did client get first use?

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

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

Project Team Member	Roles and Responsibilities
Kevin Irwin	Administrative and Operations Support, Workgroup Facilitator
Tory Jennison	Data and HIT TA and Support
Sandra Denoncour	Administrative and Operations Support
Bill Gunn	Clinical Integration Support
[redacted]	Case Manager / CRSW, SOS Recovery Community Support & LEAD
[redacted]	Case Manger / CRSW, Southeaster NH Services

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, 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.

Scholarships to the SOS Recovery Bootcamp were supported by IDN 6.

The CRSW Case Managers from both SENHS and SOS have been 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: D3 Training Schedule

Attended D3 Training Schedule	PROJECTS IMPACTED	# ATTENDED	REPORTING PERIOD				
TOPIC			12/31/17	6/30/18	12/31/18	6/30/19	12/31/19
CORE TRAININGS							
Trauma-Informed Care	C1, D3, E5	4		Jun 1	Aug 2		Nov 8, Dec 6
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			Oct 17-19
Initial Training on Addiction and Recovery	A1, B1, C1, D3, E5	25			Sept 26		Oct 11 – Dec 13
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			
Strafford County Addiction Summit	A1, B1, C1, D3, E5	15					Nov 20

***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.

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 continues to facilitate a E5 Project Workgroup that meets monthly to discuss successes, barriers, and opportunities to enhance care for complex clients and populations in our region. This workgroup developed the early priorities for the E5 project. More recent initiatives and executed MOUs were identified through continued review of regional opportunities and as a result of significant, prolonged engagement by multiple partners.

The E5 Project / Enhanced Care Coordination Workgroup membership and meeting schedule for the report period are below. New project partners are invited to join the workgroup and guests are often invited to discuss specific topics.

Ongoing meetings are scheduled the second Thursday of each month. The monthly Zoom meetings are 11AM-12:00noon. In-person quarterly meetings are 11AM -12:30PM.

- July 2019 – no meeting per group decision
- August 8, 2019 – In person / Exeter Hospital Conference Room
- September 12, 2019 - Zoom
- October 10, 2019 – Zoom
- November 14, 2019 – In person / Exeter Hospital Conference Room
- December 12, 2019 – Zoom

The E5 project has been 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.

Early success of the At-Risk Youth focused Enhanced Care Coordination model is highlighted in the narratives below. These were submitted by the Nurse Care Coordinator at a collaborating pediatric practice who is a primary referral source:

- I referred a 19-year-old mother of 2 (ages 2 ½ and 9 months) with housing, food and clothing needs to the Enhances Care Coordinator. Children are patients of our pediatric practice. Mom with Medicaid insurance. The Care Coordinator and I met with Mom in our office for soft handoff. We all discussed the needs of the family. The Care Coordinator was able to assist with housing. WIC appointment was scheduled so Mom could get formula. Through IDN help, the Care Coordinator was able to assist with clothing for family. It was helpful that the Care Coordinator met with the family at temporary home they were staying in.
- 14- year- o l d 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 the Care Coordinator 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 in Maine. PCP reported they had cancelled or no showed several appointments with PCP and concerned Mom would not follow up with Metabolism Clinic. Referred to the Care Coordinator, to assess for barriers were preventing follow-up with specialist. She accompanied family to the appointments in Maine. In addition, one child had been seeing a therapist in Exeter who reported this client had informed him of limited food in the home. The Care Coordinator 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 the Care Coordinator 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, all positions hired and trained to date in the E5 project have worked closely with the Community Care Teams. Consistent with the true nature of network building, all the B1, C1, E5, and D3 partners and services are visible to each other and are resources in support of each other. The E5 workgroup has considered development of a Community Care Team (CCT) for transition-aged youth and young adults. IDN 6 remains available to facilitate the development of a dedicated CCT for our region.

The development of protocols and agreements in this area is 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.

Early E5 workgroup documents explain the goal of the project as: *"This project will create and continually develop an ECC model that combines the development and deployment of Clinical Care Coordinators with Team-based care coordination. The initial target population will be specifically focus on transition-aged youth with an aim to develop a model for serving other age groups and extend the model to serve highly complex populations across the region."*

Implementation of the E5 Enhanced Care Coordination project for both populations has achieved considerable momentum, with delays during this reporting period due to staffing changes. In discussion with the E5 workgroup and in service to the goal to extend the model, changes to the two previously filled positions are being made.

First, the job description and title for the 1.0 FTE Clinical Care Coordinator are being updated to better reflect the role of the position with the current host agency, Seacoast Mental Health Center. The workgroup believes these updates will attract appropriate candidates and facilitate successful hiring. The additional 1.6 FTE Clinical Care Coordinator roles will be hosted at ALOFT and Somersworth Ready Together. Both projects are further discussed below.

Second, the role of the 1.0 FTE Adult Enhanced Care Coordinator staffed with the IDN 6 is being reviewed. The role requires prolonged and consistent direct-service engagement with clients. At this time in the DSRIP project period, redefining the role to facilitate work with partner agencies instead of direct client engagement is being considered. The IDN 6 remains committed to funding ECC Care Coordinators with both ALOFT and New Generation, Inc. Both projects are further discussed below.

Additionally, significant effort has been made to widen the scope of the enhanced care coordination definition in this project and increase the number of active demonstration partnerships in order to maximize the impact of the DSRIP demonstration potential. New partnerships are explained in more detail below, but serve these complex populations:

- Youth and families experiencing Adverse Childhood Experiences with police involvement
- Youth and families with positive screenings for behavioral health intervention as part of a multi-disciplinary team with primary care, behavioral health, psychiatric consult, and enhanced care coordination
- Women and children transitioning from shelter to permanent housing
- Adults with mental health diagnoses engaged with the criminal justice system

Ongoing partner updates and significant changes during the reporting period:

Seacoast Community Mental Health Center's full-time bachelor's level trained Clinical Care Coordinator resigned in August 2019 due to the need to move out of the region. The position is advertised, and funding is available to hire, train, and maintain the role. This position was the primary staff role coordinating services for the at-risk youth population in this project to date. Seacoast Mental Health Center has remained fully engaged in the E5 project workgroup, leading to progressive definition of the role within the agency and the region.

Seacoast Community Mental Health project partners consistently engaged in workgroup discussions as the primary referral sources for the Clinical Care Coordinator; including Core Pediatrics in Exeter, Waypoint, SAU-16 (Exeter and area) schools, and DCYF.

The IDN 6 Adult Enhanced Care Coordinator resigned in September 2019. Before rehiring, the IDN 6 and the E5 workgroup decided to reconsider the role's scope at this point in the project plan. These conversations have allowed for a wider view of partner opportunities and new MOUs and partnerships have been created.

Openings in both roles has impacted progress in measure tracking with a slight increase in measures during this reporting period. The anticipated impact of new projects is highlighted in section E-2 to follow.

New Partnerships during reporting period:

1. Somersworth Ready Together (SRT) Early Childhood Coalition was approved as a project partner during this reporting period. Their project proposal includes development of an **Adverse Childhood Experience Response Team (ACERT)** in Somersworth. This exciting project involves four key collaborative partners: United Way of the Greater Seacoast, Somersworth Police Department, Strafford County Child Advocacy Center, and Strafford County Family Justice Center. IDN 6 is a member of the Leadership Group informing the project work plan (embedded in section E-7). IDN 6 funds will directly support 1.0 FTE Clinical Care Coordinator and 0.05 FTE Clinical Supervision.

As a multidisciplinary approach, the ACERT Project will connect children exposed to violence and other trauma with an Advocate and provide timely referral and access to services that would be most beneficial in reducing the negative impact of the trauma experienced by those children; including primary and behavioral health care. Since this project is being implemented by the SRT Coalition, the ACERT Response Team will have ready access to all the major service providers who make up the Coalition's membership. Not only will this increase children's ***and families'*** access to services, it will also greatly increase the coordination and alignment of these services. Through the implementation of a collaborative release form that includes several organizations on one form and shared formal agreements, we will be able to track children and families' use of services across organizations, which is currently not possible. This will allow us to get a better understanding of the impact and efficacy of a comprehensive approach to serving families rather than providing singular, siloed services.

ACERT Background and supporting project information (see workplan embedded in section E-7): Somersworth is a small city of 11,765 residents with a strong sense of community pride and an unwavering commitment to its future. It is also a community that suffers from several socio-economic factors that put children at risk for adverse childhood experiences and negatively impact their healthy social-emotional development that is essential for success in school <u>and lifelong health</u>:

- According to a recent Community Health Needs Assessment completed by the Wentworth Douglass Health System, the rate of violent crime in Somersworth is higher than all other cities and towns served by the health system and is 75% worse than the state's overall rate. Recent data from the Somersworth Police Department shows that from January to August of 2019, there were 307 cases in which children were witness to a crime such as domestic violence, drug overdose or other disturbance. Currently there are no systems in place to address the impact that this violence has on Somersworth's children. Without a comprehensive response, this violence will continue to have devastating effects on the community.

- The poverty rate for families with children in Somersworth is 16.4% (compared to 10.5% for all New Hampshire families with children) with 42% of children 5 years old and younger living in low income families and 60% of elementary age students in Somersworth qualifying for free or reduced lunch.
- The opioid epidemic has reached crisis levels in New Hampshire, and the community of Somersworth has not been immune. While city specific data is not available for Somersworth, Strafford County, in which Somersworth is located, has the second highest rate of suspected drug use leading to overdose deaths in the state and the effects have been felt in Somersworth. A local school administrator stated that four elementary school children have lost a parent to drug overdose this past year.
- A recent article highlights the project: https://www.fosters.com/news/20200122/somersworth-taking-on-childhood-trauma---heres-how

2. ALOFT Integrated Wellness is a project led by two providers in private practice in Exeter; Ben Hillyard, M.Ed., LCMHC and Jessica Lyons, LFMT P.L.L.C. The regional partners in the project include; CORE Pediatrics in Stratham, Dartmouth-Hitchcock Psychiatry Department, SAU-16, and expansion to SAU-21. IDN 6 funding will support the 1.0 FTE Enhanced Care Coordination Case Manager, 1.0 FTE Clinical Care Coordinator, and 0.1 FTE Clinical Supervision.

With the goal of being a fully integrated behavioral health service Aloft has developed five specific but complementary components:

1) Integrated and embedded behavioral health services including an enhanced care coordinator and behavioral health providers.
2) Telehealth connection with Dartmouth Child Psychiatry Department to provide consultation, evaluations and training services.
3) A treatment management and intervention tracking IT solution built to leverage additional billing opportunities and increase office visit billing for medical providers.
4) A Sub Emergency Department quick response service for schools, concerned parents and pediatricians.
5) A complimentary office-based staff of clinicians to receive referrals for longer term care and to provide effective referrals to other community services.

The primary project goal is to respond to the needs of medical providers, help families respond to needs in a caring way and help prepare children for future stressors. We will do this with two unique methodologies. One, changing Well Child Visits into Whole Child Visits that include a mental health check that tracks a child's mental health in the same way that a pediatrician tracks developmental progress and physical wellness. Second, we will use an iterative model, Agile Scrum, commonly used in the business world, to offer multiple entry points to wellness and respond early rather than just be left to react to crisis.

Ben Hillyard recently presented a TEDx talk on the concept of Whole Child Visits, you can view it here: TedxPortsmouth (9/13/19): https://youtu.be/gpeyA7zXf5A.

The multidisciplinary approach to Whole Child Visits involves early (ages 4-18) assessment for mental health concerns or rising risk as part of pediatric and adolescents primary care visits. The ALOFT clinicians will screen Core Pediatrics patients prior to scheduled physical exams and present the findings to the Primary Care Physicians as an integrated EMR assessment and collaborative care plan. Screening assessment tools will be evidence-based and age-appropriate (PHQ-2, PHQ-9, etc.)

Supportive services will include psychiatric consultation for the PCPs and ALOFT team, a real-time referral protocol for urgent assessment from the PCP or school / SAU-16. The project involves multiple partners and will allow for data tracking and progressive care planning.

Enhanced care coordination for young adults *and the families* of younger clients will be a collaborative effort between ALOFT and the partners. The E5 project workgroup acknowledges the challenges or working with family systems; the medical care plan directly relates to the child, while the care coordination needs, and social support needs are provided in collaboration with the adult family members. The ALOFT project embraces that complexity and strives to demonstrate that clinical outcome improvement can be achieved by early and repeat screenings, interventions, and family support. In many ways, this project mirrors the efforts in the B1 DSRIP projects and is a compliment to that work.

The ALOFT project will begin to draw data from CORE Pediatrics pilot group of 50 client and families, prioritizing Medicaid-eligible or enrolled patients, receiving integrated care through Aloft including Mental Health Well Child Check, compare to control group of 50 non-participants. The ALOFT and Core teams will track statistics around school attendance, ER utilization, measure of parental concern, and extent to which parents feel supported/informed. Similar statistics will be gathered from pediatric providers including nurses: establish a baseline prior to start of program and then again at 30-day, 60-day, 90-day marks. In addition, the project itself will include a focus on measuring the "extent to which providers feel they are adequately able to assess mental health needs in context of a medical practice" utilizing 1-5 Likert Scale.

Essential measures for ALOFT will include: (further discussed in section E-2)

- ↓ In-School Suspensions
- ↓ Out of School Suspension
- ↓ Absences
- ↑ Families reporting ↓ crisis/conflict @ Home
- ↑ Family engagements w/ HC & Social Service Providers
- ↓ ED Visits
- ↑ HC Provider Satisfaction

Update on ALOFT Project Development December 20, 2019:

<u>MOU with Dartmouth-Hitchcock pending</u>: IDN 6 has been working with us to move forward in our communication with Dartmouth Hitchcock Psychiatry Department including review of contract or MOU we are waiting to receive. We are in the process of scheduling a follow up with this team for a target date of early January 2020.

<u>MOU with CORE Pediatrics pending</u>: The MOU has been reviewed by Core's legal team and has been presented for suggested changes by both ALOFT and CORE. We already have an assigned and dedicated Aloft Behavioral Health Treatment room at the Stratham site and have been spending time there participating in team huddles and studying workflow. We have also been given another work location side by side with the physicians. We have also worked to create marketing documents with CORE including a letter to parents directing them to a video of Ben/Jessica explaining the process and next steps of the Whole Child Visit.

<u>Working with key regional partners / SMHC</u>: We have another meeting with CORE and Seacoast Mental Health Center booked for January 28, 2020 to continue to discuss opportunities for collaboration and coordination as key players in the community. SMHC has embedded services at Core Pediatrics and will continue to provide services in that location.

<u>Hiring</u>: We have job descriptions for Enhanced Care Coordinator and additional Integrated Care Clinicians and are ready to post for these positions once we get the MOU finalized with CORE. Insurance

credentialing will occur as soon as offer letters are accepted by employees and we have positioned to be able to execute this in a timely manner.

Technology: We have extensively researched and had meetings with several technology companies offering Measured Based Care and automated screening tools. We have concluded that Mirah will likely be the best match for our model moving forward. It is a HIPPA complaint process which sends scheduled screening assessments to clients at various intervals and typically can be integrated/received back to many EHR systems, specifically Simple Practice.

Whole Child Visits / Billing: The whole child visit methodology is being refined to complement integrated care, workflow considerations and will include the necessary registry requirements for collaborative care billing codes.

Schools: We have a meeting booked with representatives from SAU16 to further explore our model integrated into school settings.

3. New Generation, Inc is a shelter for women and young children (age 10 and under) in Greenland, NH. New Generation was approved as a project partner during this reporting period. IDN 6 funds support 0.5 FTE Enhanced Care Coordination Case Manager effective December 2019 and support to a unique transportation funding project that began in November 2019.

Background and supporting project information: In 2019, New Generation helped 45 women and children – a record for New Generation in over 30 years of operation here in the Seacoast. They are proud of their impact on homelessness in our many surrounding communities and the assistance provided to women and children in crisis.

Approximately 85 percent of those families that lived at New Generation were successfully placed into permanent housing, another record and important accomplishment in a state that has a tremendous problem with homelessness. ***Each of these families need critical Aftercare services that will prevent their fall back into homelessness.*** The Aftercare program allows the women who leave New Generation to continue their successful transition to independent, sustainable living.

Due to a limited staffing budget, New Generation has been struggling to provide on-going Aftercare services to the women who have found permanent housing. Without supportive services, many of these women are highly likely to fall back into homelessness. The priority supportive services are case management and parenting education. These vulnerable single mothers need support while getting their lives back on track with their babies and children. The continuous approach to support and education at New Generation has proven effective time and again in helping women break the generational cycle of poverty and become self-sufficient.

The transportation project grew out of concern for the regional, limited transportation options for families at New Generation. There is no public transportation available servicing Greenland, NH. Many women arrive with no car and no local support system. CTS is used for non-emergency medical appointments whenever possible and Medicaid reimbursement used if transportation can be provided by a family member to medical appointments, IOP programs, and other eligible services. New Generation has one van, but limited funding for dedicated staff for rides, no contract with CTS as a vendor, and the real challenge that one van cannot be used by multiple families with different destinations at the same time. Residents with cars would often provide car-pooling to shared destinations, but this is not a reliable option to serve all families. IDN 6 has also supported New Generation ongoing connections to local resources for volunteer-based transportation programs.

Despite those options, many families at New Generation were being educated about resource connections (daycare, work opportunities, parenting groups, recovery supports, etc.) with no way to get to them. In some cases, women arrived at New Generation from other towns with jobs, connections to daycare providers, and other protective social supports in place but inconsistent transportation options to get them back to their previous community. This leads to having to "start all over" once arriving at New Generation. The positive and protective impact on health and well-being of children and women with consistent caregivers, medical care providers, and social supports is well documented. IDN 6 hopes to help New Generation demonstrate the impact of transportation funding with an ambitious goal**: *to get every family everywhere they need to be every day.*** This includes rides to CTS eligible destinations when a CTS vendor is unavailable or cancels.

New Generation has been able to use the funding from IDN 6 to increase hours for a driver and has worked on arranging rides to make the best use of their van services. Early tracking (spreadsheet embedded to follow) demonstrates that families are maintaining or making new connections to medical care providers, but also in many of the social determinant of health domains. It is early in this project, but New Generation's ability to quickly begin to demonstrate the impact the funds is encouraging and will impact the target measures for the E5 project.

The ECC Case Manager at New Generation provided this narrative feedback after 30 days of transportation support:

> "As I reflect on the impact that this transportation funding has made it becomes multi-dimensional. The immediate impact on clients has been significant. Women have been able to get to social programs to help build parenting skills and resiliency. Medical appointments have not been missed due to a lack of CTS transportation. Clients have been able to go on job interviews knowing that they would have transportation if offers were made. It has opened a new perspective to move forward because the transportation will no longer be a barrier.
>
> As a staff member, the unexpected ability to work with the clients that need more intensive case management was created. Now that the clients that can secure employment are not at the house during the day, we can work more closely with the ones that are here. This was a benefit I did not originally see with what was designed as transportation funds.
>
> A direct impact on the client's mental health is also a visible gain. People are feeling better about themselves as they move quicker towards their self-sufficiency goals at this point. They have a plan, and a purpose for the day. They have been able to open bank accounts and begin to have money to buy needed things for their children which has become a great source of pride for many of them."

The tracking spreadsheet embedded to follow is organized to reflect the domains of the Arizona Self-Sufficiency Matrix used by New Generation, and approved by the E5 workgroup, to measure self-sufficiency. It also captures impact on other target measures, when possible. IDN 6 is working with New Generation to pull longitudinal, meaningful data from this tracking tool.

New Generation Transportation Tracking

NEW GENERATION CLIENT	DATE	DESTINATION / DESCRIPTION	RESOURCE (C)ONNECTION or (M)AINTENANCE	Mobility / Transportation vendor	Housing	Food	Safety	Income/Finances	Employment	Mental Health	Life Skills	Substance Abuse	Family / Social Relations	Health Care Coverage / Access	Disabilities	Child Care	Children's Education	Adult Education	Parenting Skills	Community Involvement	Legal / Criminal Justice	Life Management	Access to Services		Avoided ED / Urgent Care visit	Avoided loss of benefits	Other
(JD03) = Jane Doe 3 total family members																M											
AE5	11/1/2019	Families First	C	New Gen van							c		c				c	C	c	c							
MA2	11/1/2019	Convient MD	M	New Gen van																			M				
SH3	11/2/2019	Convient MD	M																				m				
SH3	11/4/2019	Rye School, Market Basket	M	New Gen van		M										M											
EM2	11/4/2019	NH WORKS	C	New Gen van					C																	C	
SH3	11/4/2019	Rye School	M	New Gen van												M											
SH3	11/4/2019	NH WORKS	C	New Gen van					C																		
SH3	11/5/2019	HEAD START	C	New Gen van												C											
MA2	11/5/2019	Families First, Work	M	New Gen van					M				M						M	M							
EM2	11/5/2019	Families First	C	New Gen van						C	C	C	C									C					
SH3	11/5/2019	Rye School	M	New Gen van												M	M										
SH3	11/6/2019	Target	C	New Gen van				C	C		C									C							
SH3	11/7/2019	Rye School	M	New Gen van												M	M										
MA2	11/7/2019	SMH	C	New Gen van			C			C	C											C					
SH3	11/7/2019	Greenland Elementary	M	New Gen van													M										
SH3	11/8/2019	Children's Museum	M	New Gen van							M						M		M	M							
EM2	11/9/2019	Dover Bowl	M	New Gen van							M								M	M							
SH3	11/9/2019	Dover Bowl	M	New Gen van							M								M	M							
EM2	11/11/2019	Families First	M	New Gen van												M											
MA2	11/11/2019	Families First	M	New Gen van							M		M					M	M	M							
SH3	11/14/2019	Rye School	M	New Gen van												M	M										
SH3	11/15/2019	HEAD START	M	New Gen van												M	M										
EM2	11/15/2019	Families First	M	New Gen van						M	M	M	M														
MA2	11/15/2019	Families First	M	New Gen van								M	M							M							
SH3	11/18/2019	Families First	M	New Gen van												M	M										
EM2	11/18/2019	Families First	M	New Gen van						M	M	M	M														
SH3	11/19/2019	HEAD START	M	New Gen van												M	M										
EM2	11/19/2019	Families First	M	New Gen van												M											
MA2	11/19/2019	SMH	M	New Gen van						M													M				
SH3	11/20/2019	HEAD START	M	New Gen van												M	M										
MA2	11/21/2019	WDH	C	New Gen van										C					C			C	C		X		
EM2	11/21/2019	RITE AID	M	New Gen van								M		M													
SH3	11/21/2019	HEAD START	M	New Gen van												M	M										
EM2	11/21/2019	Target	C	New Gen van				C	C																		
EM2	11/22/2019	Families First	M	New Gen van												M	M										
SH3	11/22/2019	HEAD START	M	New Gen van												M	M										
SH3	11/25/2019	HEAD START	M	New Gen van												M	M										
EM2	11/25/2019	Families First	M	New Gen van												M	M										
EM2	11/26/2019	RITE AID	M	New Gen van								M		M													
EM2	11/26/2019	Families First	M	New Gen van												M	M										
SH3	11/26/2019	Families First	M	New Gen van												M	M										
SH3	11/27/2019	Families First	M	New Gen van												M	M										
EM2	11/27/2019	Families First	M	New Gen van												M	M										
SH3	11/14/2019	ASPEN	C	New Gen van										C									C				
MA2	11/14/2019	Families First	C	New Gen van							C		C						C	C		C					
EM2	12/4/2019	Families First	M	New Gen van												M	M										
KW3	12/4/2019	Portsmouth	M	New Gen van													M										
AF3	12/4/2019	GATHER	C	New Gen van		C																	C				
EM2	12/5/2019	Families First	M	New Gen van												M	M										
EM2	12/5/2019	Target	M	New Gen van				M	M																		
SH3	12/5/2019	Families First	M	New Gen van												M	M										
EM2	12/6/2019	Families First	M	New Gen van												M	M										
EM2	12/6/2019	RITE AID	M	New Gen van										M													
SH3	12/6/2019	HEAD START	M	New Gen van												M	M										
EM2	12/6/2019	Target	M	New Gen van				M	M																		
MA2	12/10/2019	Families First	C	New Gen van							C		C						C	C							
DM2	12/11/2019	MAT	M	New Gen van								M															
MA2	12/12/2019	Families First	C	New Gen van							C		C						C	C							
DM2	12/12/2019	MAT	M	New Gen van								M															
				New Gen van																							

4. Strafford County Community Corrections became a partner in the E5 project during this reporting period. A Case Manager was hired to assist criminal justice involved persons who are diagnosed with a severe and persistent mental illness. The role of the position is ongoing coordination of mental health and primary care, monitoring compliance with court orders, and ensuring engagement in treatment. The county anticipates a reduction in recidivism from this population, increase in healthy productive members of the community, and an increase in community safety. IDN 6 funds directly support 1.0 FTE Enhanced Care Coordination Case Manager.

Background and supporting project information: From the project proposal, "As we move further into New Hampshire's post bail reform era, we are seeing an increase in our Community Supervision - Mental Health caseloads. In addition to an increase in numbers, people are being released from custody prior to their initial arraignment or immediately after. This doesn't give us time to prepare for their release and coordinate services prior to. That means that a lot of work is being done by case managers ranging from finding shelter, applying for health insurance and other benefits, and coordinating mental health and substance abuse treatment. When our case managers are stretched so thin, it is impossible to truly help this population in need.

While bail supervision, at its core, is not meant to be a treatment program, in our county it has certainly become one. More and more often, the orders and conditions of bail require case managers to put an immense amount of time into each client. I've found that our case managers enjoy this responsibility, but frequently voice frustrations that they cannot do as much as they'd like due to time limitations and high caseloads. Warrant requests, court appearances, and violation drafting are prioritized which forces meaningful case management to fall by the wayside. There is great work that can be done during the pre-trial period to assist persons while they are court ordered to engage in treatment."

The ECC Case Manager contributed to an increased ability to provide the comprehensive case management support that is difficult with current caseloads. IDN 6 is working with Strafford County Community Corrections to define tracking measures and further refine assessment and referral tools where needed.

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

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 continued to track established clients and began tracking performance measures under the new MOU with New Generation. Data is not yet available for three of the newer projects. Anticipated data is identified below and will be incorporated into future reporting as it is available.

The Adult ECC Case Manager at **New Generation** has initiated use of the Arizona Self-Sufficiency Matrix at intake, 3 months, 6 months, and 12 months of engagement in the Care Coordination / Aftercare program. We do not yet have longitudinal progress to report for these 10 enrollees as the project was implemented in December 2019. The data anticipated from the IDN 6 supported staff will positively impact the following performance measures:

Individuals served
Continued participation in care
Client-generated achievable goals met
Improved Functional status

ALOFT: data pending. The data anticipated from the IDN 6 supported staff will positively impact the following performance measures:

Individuals served
Continued participation in care
Client-generated achievable goals met
Improved Functional status
Reduced Crisis services utilization
Reduced School attendance/truancy

Somersworth Ready Together / ACERT: data pending. The data anticipated from the IDN 6 supported staff will positively impact the following performance measures:

Individuals served
Client-generated achievable goals met
Improved Functional status
Reduced Crisis services utilization
Reduced School attendance/truancy

Strafford County Community Corrections: data pending. The data anticipated from the IDN 6 supported staff will positively impact the following performance measures:

Individuals served
Client-generated achievable goals met
Improved Functional status
Reduced Crisis services utilization

Table E-2a: 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	As of 6/30/19	As of 12/31/19
# Individuals served	20 by 12/31/18	N/A	7	**25**	41	**45 (SMHC)** **10 (New Generation) = 55 total**
Continued participation in care	60% 6+months	N/A	Ongoing	16/25=64%	27/41=66%	**37/55 = 67%**
Client-generated achievable goals met	50% met	N/A	Ongoing	18/25 =72%	28/41=68%	**38/55 = 67%**
Improved Functional status	50%enrolled	N/A	Ongoing	22/25=88%	35/41=85%	**49/55 =** **89%**
Reduced Crisis services utilization	15% reduction	N/A	Ongoing	3/8 clients with past crisis service utilization = 38%	5/10 clients with past crisis service utilization = 50%	**5/10 clients with past crisis utilization = 50%**
Reduced School attendance/truancy	10% reduction	N/A	Ongoing	5/12 Youth = 42%	6/15 Youth =40%	**6/15 Youth = 40%**

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.

Over the past two reporting periods, staffing needs for the Enhanced Care Coordination project have been refined. Multiple newer efforts now have established MOUs and staffing in place. The targets below reflect active, IDN supported positions.

There have been changes in the E5 project staff during this report period. Staff with each partner is discussed in detail below.

Seacoast Mental Health Center:

1.0 FTE Clinical Care Coordinator for Transition-aged youth and young adults was employed by Seacoast Mental Health Center (SMHC) during this reporting period. The Clinical Care Coordinator resigned in August 2019 due to the need to relocate out of the region. **The position was successfully filled with SMHC in March 2020.**

The IDN6 maintains an MOU with SMHC for this position to support employment and provision of 0.1 FTE clinical supervision at 3-4 hour/week.

IDN Region 6 / Strafford County:

1.0 FTE adult-focused Enhanced Care Coordination (ECC) Case Manager was directly employed by IDN 6. This ECC Case Manager worked co-located with our Care Transitions Team. The staff member in this position resigned in October 2019 and the position has not been rehired. The ECC Case Manager was serving adults who were referred to the CCT but whose needs were too complex and acute to be enrolled in the CTI protocol. ~~At this point in the project, the IDN 6 is considering whether rehiring in a position that requires a long-term commitment to direct client service is appropriate~~. **The 1.0 FTE position was filled in March 2020. The ECC Case Manager is directly employed by IDN 6.**

Somersworth Ready Together (SRT) Early Childhood Coalition / ACERT:

The 0.6 FTE Project Director / MSW (listed below as Clinical Care Coordinator and currently filled) provides oversight of the project including data collection and quality improvement as well as efforts to expand the services available to families referred through the ACERT Project based on data gathered during the pilot and implementation phases. The Project Director will also explore the possibility of implementing the ACERT Model in additional communities.

0.1 FTE clinical supervision will be provided by a subcontracting partner.

IDN 6 funds will also support one, four-hour overtime shift per week for one officer of the Somersworth Police Department to serve on the ACERT Response Team from April through December of 2020.

ALOFT

1.0 FTE Clinician Care Coordinator with ALOFT, providing services to Core Pediatrics and two regional school systems. Hired.

0.1 FTE clinical supervision to be provided via subcontract with Dartmouth-Hitchcock Pediatric Psychiatry Department. MOU pending.

1.0 FTE Enhanced Care Coordination Case Manager with ALOFT, providing case management to youth and families. MOU in place; actively recruiting.

New Generation

0.5 FTE Enhanced Care Coordination Case Manager to provide post-shelter case management to promote housing stability. MOU executed; position is filled.

Strafford County Community Corrections

1.0 FTE Enhanced Care Coordination Case Manager, working directly with adults with court-ordered MH services to ensure service access and court compliance for complex population. MOU executed; position is filled.

Homeless Center for Strafford County (new March 2020)

0.5 FTE Enhanced Care Coordination Case Manager to provide post-shelter case management to promote housing stability. MOU executed; position is filled.

WRITEBACK RESPONSE:

The staffing target change from 6 to 2.5 FTE in the role of Clinical Care Coordinator was made in the June 2019 report after discussions with DHHS of what were anticipated as realistic goals for the remaining project period. In concert with that reduction, there was an increase in the target for Enhanced Care Coordination Case Manager from "Up to 2" to 2.5 FTE. This combination resulted in a commitment of 5 FTE in the combined roles. Previous SAR submission explain that the MOU with Seacoast Mental Health (SMHC) for 2.0 FTE in the Clinical Care Coordinator role was changed to 1.0 FTE during discussion about renewal of the first 12-month MOU as SMHC felt that they could not successfully hire / support two positions. This results in the overall reduction of 1.0FTE in the project targets.

Table E-3a: Workforce Staffing ***target adjusted to projected total need for remainder of DSRIP implementation***

	IDN Workforce (FTEs)						
Provider Type	**Projected Total Need**	**Baseline Staffing on 6/30/17**	**Staffing on 12/31/17**	**Staffing on 6/30/18**	**Staffing on 12/31/18**	**Staffing on 6/30/19**	**Staffing on 12/31/19**
Clinical Care Coordinator	~~6~~ **2.5***	0	0	1	1	2	2.6
Enhanced Care Coordination Case Manager	~~Up to 2~~ **2.5***	0	0	1	**2**	0.75	~~**2.5**~~ **3.0** *1 currently open with ALOFT*

Clinical Supervision (3 hrs/week per CCC)	~~Up to .5 FTE~~ **0.25***	0	ready	0.2	0.2	0.2	~~**0.2**~~ **0.3**

WRITEBACK: Staffing values updated to current date of report. Increases are attributed to: 0.5 FTE Enhanced Care Coordination Case Manager hired under a new MOU with Homeless Center for Strafford County. A 0.1 FTE Clinical Supervisor for the ACERT program was formalized March 2020.

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	Jan-Jun 2019 Actuals	Jul-Dec 2019 Actual	CY 2020 Projected Spend Budget	CY 2021 Projected Spend Budget	Actual and Projected Spend
Expense Items									
Staffing									
Direct Staff	$ -	$ -	$ -	$ -	**$ 18,955**	$ 18,058	$ 70,000	$ 70,000	$ 177,013
Indirect Staff	$ -	$ -	$ -	$ -	**$ -**	$ -	$ -	$ -	$ -
Benefits	$ -	$ -	$ -	$ -	**$ 4,271**	$ 2,378	$ 37,100	$ 37,100	$ 80,849
Contracted Staffing	$ -	$ -	$ -	$ -	**$ -**	$ -	$ -	$ -	$ -
								$ -	$ -
Project Infrastructure								$ -	$ -
Equipment	$ -	$ -	$ -	$ -	**$ 4,966**	$ -	$ 5,000	$ 5,000	$ 14,966
Operations	$ -	$ -	$ -	$ -	**$ 6,013**	$ (2,574)	$ 10,000	$ 10,000	$ 23,439
								$ -	$ -
Workforce								$ -	$ -
Fees/Outside Placement	$ -	$ -	$ 132	$ 31,100	**$ 47,467**	$ 80,651	$ 300,000	$ 300,000	$ 759,350
Recruiting/Retention	$ -	$ -	$ -	$ -	**$ -**	$ -	$ 25,000	$ 25,000	$ 50,000
Training	$ -	$ -	$ -	$ -	**$ 92**	$ 615	$ 5,000	$ 5,000	$ 10,707
Other	$ -	$ -	$ -	$ -	**$ -**	$ 7,621	$ -	$ -	$ 7,621
								$ -	$ -
Technology	$ -	$ -	$ -	$ -	**$ -**	$ -	$ 14,000	$ 14,000	$ 28,000
								$ -	$ -
									$ -
Totals	$ -	$ -	$ 132	$ 31 100	**$ 81,764**	**$ 106,749**	$ 466 100	$ 466 100	$ 1,151,945
DY 2019						**$ 188,513**			

Budget Narrative

- Direct staff include positions for ECC Case Manager work in the two counties in the region.
- Outside placement includes embedded supports in community mental health and health centers and recently executed MOUs for new projects discussed in E-2.
- 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.

E5 Workgroup Membership July 1, 2019- December 31, 2019

Organization/Provider	Workgroup Member (Y/N)
Seacoast Community Mental Health	Yes
CORE Pediatrics via Exeter Health Resources	Yes
SAU-16	Yes
One Sky Services	Yes
Center for Collaborative Change	Yes
Waypoint (formerly Child and Family Services)	Yes
Seacoast Youth Services	Yes
Exeter Health Resources	Yes
Seacoast Public Health Network	Yes
DCYF (Division for Children, Youth, and Families)	Yes
Wellsense	Yes

Key Organizational and Provider Participants

Organization/Provider	Agreement Executed (Y/N)
Seacoast Community Mental Health	Yes
CORE Pediatrics via Exeter Health Resources	Yes
Crossroads House Homeless Shelter	Yes
New Generation, Inc	Yes
SAU-16	Yes
Somersworth Ready Together / United Way of the Greater Seacoast	Yes
Greater Seacoast Community Health - Families First	Yes
ALOFT Integrated Wellness	Yes
Strafford County Community Corrections	Yes
Greater Seacoast Community Health - Goodwin Community Health	Yes
Homeless Center for Strafford County	**Yes**
OneSky Services	Yes
Frisbie Memorial Hospital	Yes
Lamprey Health Care - Raymond	Yes
Lamprey Health Care - Newmarket	Yes
Center for Collaborative Change	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 ANSA (Adult Needs and Strengths Assessment) or Arizona Self- Sufficiency Matrix (ASSM) as an initial assessment tool for Adults.

Implementation of the CANS by the Clinical Care Coordinator at SMHC went in effect in June 2019. The IDN 6 Adult ECC Case Manager initiated use of the Arizona Self-Sufficiency Matrix in November 2018. The New Generation ECC Case Manager initiated use of the ASSM in December 2019. **The Homeless Center of Strafford County ECC Case Manager initiated use of the ASSM in April 2020.** The ASSM will be assessed at Intake, 3 months, 6 months, and 12 months of engagement.

Assessment tools will be identified for ALOFT, Somersworth Ready Together, and Strafford County Community Corrections during further project development.

Standard Assessment Tool Name	Brief Description	
CANS (Child and Adolescent Needs and Strengths) *(attachment B1-8a.2)*	Standard BH Functional Assessment for CMHCs	Current
ANSA (Adult Needs and Strengths Assessment) *(attachment B1-8a.1)*	Standard BH Functional Assessment for CMHCs	Current
Arizona Self Sufficiency Matrix *(attachment C-7c)*	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. Protocols currently adopted in the project are listed in Table E-7.

For At-risk youth referrals, the Clinical Care Coordinator can augment their 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.

IDN 6 is providing ongoing technical assistance to the ALOFT, New Generation, and Somersworth Ready Together, and Strafford County Community Corrections teams around project development to develop consent forms, partner MOUs, and referrals where needed. ***Embedded documents below demonstrate that development of client-specific assessment and treatment plans, management protocols, and referral workflows are a significant part of ongoing project development.***

New protocols will be incorporated into future reporting as they become available and are adopted for use by the project.

Connections for Health; IDN Region 6 Funding Request
Somersworth Ready Together ACERT Project
Work Plan

Objective 1	**Task**	**Timeline**	**Responsible Party**	**Outcome**
Finalize Planning Stage for Implementing ACERT in Somersworth	Identify agencies able to staff ACERT Response Team during pilot period and establish MOU's regarding staffing commitments and information sharing	Oct-Nov 2019	United Way Strafford County Child Advocacy Center Strafford County Family Justice Center Somersworth Police Department	ACERT Response Team for Pilot Phase (April-Jun 2020)
	Convene the ACERT Leadership Team to oversee and inform pilot and full implementation processes including referral and CQI processes	Form Nov 2019-January 2020; meet ongoing	United Way	Dedicated Leadership Group that meets at least monthly to oversee pilot and implementation.
	Secure funding for calendar year 2020 to support initial pilot	Oct-Nov 2019 (Connections for Health funding)	United Way as lead with support from ACERT Leadership Team	Secure one year of funding from Connections for Health to support final planning and pilot stages and to provide additional coordination support through year 1
	Inventory existing services aimed at building resilience and protective factors for children and families who have been referred to ACERT; and establish MOU's and releases to facilitate referrals	Present-January 2020	United Way ACERT Leadership Team ACERT Partners	Established referral system that enables families to access needed services quickly and effectively

Connections for Health; IDN Region 6 Funding Request
Somersworth Ready Together ACERT Project
Work Plan

Objective 1	**Task**	**Timeline**	**Responsible Party**	**Outcome**
Finalize Planning Stage for Implementing ACERT in Somersworth (cont.)	Train Somersworth Police Department Staff and other ACERT Response Team members on ACERT Model and Trauma informed/asset informed approaches	Jan-March 2020	United Way Somersworth PD and other partners to participate in training Cassie Yackley, PhD as trainer	At least 75% of SPD staff and other staff serving on Response Team trained on ACERT
	Finalize work flow for referral from Somersworth Police to other ACERT Response Team agencies for coordination	March 2020	United Way Somersworth Police Department Strafford County Family Justice Center Strafford County Child Advocacy Center	Steps for referring children and families are finalized and ready to put into practice in April

Objective 2	Task	Timeline	Responsible Party	Outcome
Conduct 3 month Pilot of ACERT in Somersworth	Launch Pilot: referrals from Somersworth Police Department initiated; ACERT Response Coordinator begins outreach to referred families; Response Team meets with families and provides referrals to services that build resilience and protective factors	April -June 2020	United Way ACERT Leadership Team ACERT Response Team (Somersworth Police Department; Strafford County Family Justice Center; Strafford Child Advocacy Center) ACERT Referral Partners	ACERT Response Team makes initial contact with an average of families 4 families per week ACERT Coordinator refers children and families to services resulting in 50% referral success rate
	Launch data collection process to track number of families contacted and referred to services through ACERT	April-June 2020	United Way ACERT Leadership Team ACERT Referral Partners	Data on families reached and children and families connected to services will inform CQI efforts
	Use data from pilot to identify gaps in existing services available to children and families and resources needed to fill those gaps	May-June 2020	United Way ACERT Leadership Team ACERT Referral Partners	Strategies and a defined plan to expand resources and services available to families referred through ACERT

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Objective 3	Task	Timeline	Responsible Party	Outcome
Fully implement ACERT Model with expanded response and service capacity	Secure funding for full implementation of ACERT	Oct 2019-June 2020 (VOCA and other funding)	United Way ACERT Leadership Team	Secure two years of funding, starting July 2020 to support full implementation
	Determine staffing needs for post –pilot period and establish formal contracts to facilitate funding for positions	June 2020-July 2020	United Way Strafford County Child Advocacy Center Strafford County Family Justice Center Somersworth Police Department	ACERT Response Team for full implementation phase (July 2020 and beyond)
	Expand services, especially non-traditional therapies for children referred to ACERT.	July 2020-June 2022	United Way ACERT Leadership Team ACERT Partners	Increased availability of services for families including non-traditional therapies and other family support services

Aloft is the combined vision of Jessica Lyons, MS, LMFT and Ben Hillyard, M.Ed., LCMHC and comes from their combined five decades of experience. With the goal of being a fully integrated behavioral health service Aloft has developed five specific but complementary components:

1) Integrated and embedded behavioral health services including an enhanced care coordinator and behavioral health providers.
2) Telehealth connection with Dartmouth Child Psychiatry Department to provide consultation, evaluations and training services.
3) A treatment management and intervention tracking IT solution built to leverage additional billing opportunities and increase office visit billing for medical providers.
4) A Sub Emergency Department quick response service for schools, concerned parents and pediatricians.
5) A commentary office-based staff of clinicians to receive referrals for longer term care and to provide effective referrals to other community services.

Our goal is to respond to the needs of medical providers, help families respond to needs in a caring way and help prepare children for future stressors. We will do this with two unique methodologies. One, changing Well Child Visits into Whole Child Visits that include a mental health check that tracks a child's mental health in the same way that a pediatrician tracks developmental progress and physical wellness. Second, we will use an iterative model, Agile Scrum, commonly used in the business world, to offer multiple entry points to wellness and respond early rather than just be left to react to crisis.

Table E-7a: Protocols for Patient Assessment, Treatment, Management, and Referrals

Protocol Name	Brief Description	Use (Current/Under Development)
Enhanced Care Coordination Eligibility Criteria *(attachment E-7a)*	Notification to partners of referral criteria and reference for eligibility upon referral to the project	Current
Enhanced Care Coordination Referral Form *(attachment E-7b)*	Referral between partners	Current
Enhanced Care Coordination Release Form *(attachment E-7c)*	Release of Information between partners	Current
Care Director / Allscripts	Shared Care Plan	Current

Attachment E7-a

Region 6 Integrated Delivery Network

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	

Attachment E7-c

COMMUNITY CARE TEAM / CARE COORDINATION
AUTHORIZATION TO RELEASE / OBTAIN PROTECTED INFORMATION

Patient name: _____ Date of Birth: _____

I, _____ authorize the Connections for Health
(patient name)
Community Care Team (CfH CCT), 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 CFH CCT 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 CFH CCT sign confidentiality statements and promise to keep my information private. However, if a CFH CCT 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 CFH CCT** or by notifying **Connections for Health at cct@CfHnh.com**, and my health information will no longer be shared at the CFH CCT. The cancellation will not apply to information that has already been disclosed. If I do not want to participate with the CFH CCT, 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 CFH CCT member listed on page 2.)

* Managed Care Organizations will only be present during discussions of their members.

Updated 1/17/2020

Connections for Health
Integrated Health Services

Connections for Health CCT members:

Amedisys
AmeriHealth Caritas*
Beacon Health Strategies*
Community Action Partnership of Strafford County Community Partners
Connections for Health
Connections Peer Support Center
Core Physicians
Cornerstone VNA
Cross Roads House
Crotched Mountain Community Care
Dover Housing Authority
Easter Seals of NH
Exeter Hospital
Exeter Housing Authority
Families First of the Greater Seacoast
Families in Transition (FIT)
Frisbie Memorial Hospital
Goodwin Community Health
Granite State Independent Living
Haven
Home for All
Homeless Center for Strafford County
Hope on Haven Hill
The Homemakers Services
Lamprey Health Care
My Friend's Place
NH DHHS Bureau of Elderly and Adult Services
NH Healthy Families*
NH Housing Finance Authority
OASIS Senior Advisors
OneSky Community Services
Portsmouth Housing Authority
Portsmouth Regional Hospital
Raymond Baptist Church
Rochester Housing Authority
Rockingham VNA
Safe Harbor Recovery Center
Salvation Army, Portsmouth
Seacoast Mental Health Center
Seacoast Pathways/Granite Pathways
ServiceLink of Rockingham County
ServiceLink of Strafford County
SNHS/Rockingham Community Action
Somersworth Housing Authority
SOS Recovery Community Organization
Southeastern NH Services
St. Vincent dePaul Society, Exeter
St. Vincent dePaul Society, Hampton
TASC-Transportation Assistance for Seacoast Citizens
Tri-City Consumers' Action Co-operative
Veterans, Inc.
Waypoint
Welfare Department, City of Dover
Welfare Department, City of Portsmouth
Welfare Department, City of Rochester
Welfare Department, City of Somersworth
WellSense Healthplan*
Wentworth-Douglass Hospital
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.

Updated 9/23/2019

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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 (roles in BOLD are reflected in E-3 staffing table)
Kevin Irwin	Administrative and Operations Support
Tory Jennison	Data and HIT TA and Support
Sandra Denoncour	Administrative and Operations Support, Workgroup Facilitator
Bill Gunn	Clinical Support and TA
[redacted]	**Clinical Care Coordinator**, SMHC
[redacted]	**Clinical Supervision**, SMHC
[redacted]	**Clinical Supervision** (via subcontract) **and Clinical Care Coordinator**, ALOFT Integrated Wellness
[redacted]	**Enhanced Care Coordination Case Manager**, ALOFT Integrated Wellness
[redacted]	**Enhanced Care Coordination Case Manager**, New Generation
[redacted]	**Clinical Care Coordinator**, Somersworth Ready Together / United Way of Greater Seacoast
[redacted]	**Enhanced Care Coordination Case Manager**, Strafford County Community Corrections
[redacted]	**Clinical Supervision,** Somersworth Ready Together (via subcontract)
[redacted]	**Enhanced Care Coordination Case Manager**, IDN 6

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

The ACERT Project training plan for CY2020 includes:

- A trainer who developed a training specifically for ACERT and worked with several communities to successfully implement the model will provide a four-hour training for all Somersworth Police Department staff plus other members of the ACERT Response Team. This training will expand the capacity of the Somersworth Police Department staff to better understand the effects of trauma they encounter regularly when answering calls within the community, including calls that are not an appropriate referral to the ACERT Program.

- To ensure the participation of all members of the Somersworth Police Department in the four-hour ACERT training, IDN 6 funds will also cover the overtime costs of staff who are not on duty to attend the training.

Additional project training needs are being identified and trainings attended and scheduled will be incorporated into future reporting. The E5 workgroup continues to revise recommended trainings for the E5 project staff as project grow and reflect work with multiple complex populations. The following list remain the priorities currently.

CORE TRAININGS
Trauma-Informed Care
Core Standardized Assessment
Integration in Practice
Initial Training on Addiction and Recovery

Trauma Informed Care in Health & Social Services
Behavioral Health Summit - multiple topics, multiple attendees *
SUPPLEMENTAL TRAINING
Human Trafficking
Cultural Competence
Motivational Interviewing
Stigma Across Cultures
ACES in Early Childhood Education

Table E-9a: Attended E5 Training Schedule

Attended E5 Training Schedule	PROJECTS IMPACTED	# ATTENDED	REPORTING PERIOD		
TOPIC			12/31/17	6/30/18	12/31/18
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)			
			6/30/17	12/31/17	6/30/18	12/31/18
E -1	IDN Community Project Timeline, Key Milestones and Evaluation Project Plan	Spreadsheet (Microsoft Project or similar platform)				
E -2	Staffing IDN Community Project Evaluation Project Targets	Table				
E -3	IDN Community Project Workforce	Table				
E -4	IDN Community Project Budget	Narrative and Spreadsheet				
E -5	IDN Community Project Key Organizational and Provider Participants	Table				
E -6	Clinical Infrastructure: IDN Community Project Standard Assessment Tools	Table				
E -7	Clinical Infrastructure: IDN Community Project Protocols For Patient Assessment, Treatment, Management, and Referrals	Table				
E -8	Clinical Infrastructure: IDN Community Project Roles and Responsibilities	Table				
E-9	Provide the training plan and curricula for each Community Driven Project as required in A-1.3	Training schedule and table				

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

As a part of the DSRIP demonstration, the state has committed to value-based health services reimbursements. The DSRIP APM Roadmap articulates the process by which the state will work with the IDNs, Medicaid Managed Care Organizations (MCO), and other Medicaid services stakeholders to develop a statewide APM workgroup for the completion of the DSRIP APM Implementation Plan. The goal of the DSRIP APM Implementation Plan is to achieve 50% Medicaid provider payments in an APM by 12/31/2020.

IDNs will be evaluated on their engagement with the state and managed care plans in support of the APM goals consistent with Special Terms and Conditions (STC) 24, Project Milestones; STC 33 MCO and Medicaid Service Delivery Contracting Plan; and STC Attachment C: DSRIP Planning Protocol IV Project Stages, Milestones, and Metrics.

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

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

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

The Region 6 IDN participated in development of a statewide APM roadmap during the reporting period. 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 further 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. Region 6 continues participation in statewide efforts, such as previous 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. 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 most active APM development efforts during the reporting period were centered on IDN efforts to partner with MCOs in the context of Local Care Management Entities (LCME).
- Several meetings were held in the reporting period between combinations of the IDN Teams, the three MCOs and the DHHS in an effort to operationalize the structure, functions and terms of agreement between the contractual LCME standards and contractual obligations to which MCOs will be held, and the specific roles that IDNs could play as LCME partners.
- LCME language, terms and timeline were altered in MCO contracts towards the end of the reporting period in such a way that may facilitate more clear opportunities for IDNs to partner with MCOs in LCM in efforts that may ostensibly lead to the basis for APMs.
- A subset of IDNs have agreed with one of the MCOs to develop a pilot project as a proof of concept. The pilot project concept with be shared with all IDNs and all three MCOs to create opportunities for input and participation.
- The IDN 6 continued 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 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.
- The IDN has continued 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.
- 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 operational resource for bringing social services 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.