New Hampshire Building Capacity for Transformation 1115 Medicaid Waiver

IDN PROCESS MEASURES SEMI-ANNUAL REPORTING GUIDE

For

Year 3 (CY2018) 2017-12-10 v.27

Region 7 IDN

Revised 04/05/2018

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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.

Submission of the semi-annual report shall be a single pdf document which includes all attachments. In addition, due to printing and size constraints your attachments should also be uploaded separately in the original file version as well (ms project, ms excel, etc.) Attachments should use the naming convention identified in the weekly update dated week ending July 7, 2017. The naming convention shall correlate with the project deliverable for which it is being submitted. See below for illustration of attachment for project B1 deliverable 2A:

Attachment_B1.2A

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

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

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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 and evaluation metrics. Using Microsoft Project or similar platform update your project timeline.

Governance:

Steering Committee:

The Steering Committee has been focusing on the IDN Implementation plan, partner proposals, partner concept papers, and IDN workgroup progress over the months of July-December 2017. The Committee is dedicated to providing comprehensive feedback in all areas of the project. The essential function of its members is to provide input that will ensure the progress of the plan, partners, and all four workgroups. In July, signatures were obtained from the Committee for the implementation plan. The plan was reviewed at the September meeting and its approval was discussed in October. The Committee reviewed the funding process and will continue to refer to the plan throughout the project to ensure the achievement of project metrics for the IDN.

The Committee discussed the finalization of the Workforce Strategic Plan and the need of review, so it can be put into a regional perspective. An update on the HIT Statewide Taskforce was provided, communicating that CMT (Collective Medical Technologies) was selected as the shared care plan vendor. A contract was provided in late July for the Committee to review; where there were no oppositions to signing the contract, however they suggested a renewal clause in the contract. The Committee was reassured that the contract can be terminated at the end date of the project, with the hope being hat the savings from the demonstration project will supplement the cost of continued use of this technology. The Committee will continue to discuss components of the Shared Care Plan, as to what it looks like and what it includes. This information will also be relayed to partners as they are onboarded, for those that don't have EHR there will still be a way to utilize it by logging into a portal to make connections.

The Data Aggregator vendor options were discussed in July and revisited in September. Vendor demo opportunities were shared during this period and the Committee and Data workgroup looked to see how this can be helpful with evaluation data. Statewide IDN's suggested that all IDN's use one aggregator across the state. The Data workgroup worked vigorously to determine the final Data Aggregator, as MAEHC, which will be discussed further as it pertains to the Data Workgroup.

In October, a 30-day extension was granted on third round concept papers, pushing the due date to 12/15/2017; this would allow for partners to read the full implementation plan and to submit a concept paper that will best meet the needs of the IDN. The second round of proposals were due on September 6, 2017 including evaluation and work plan. The Committee reviewed them and chose to fully fund 8 of the 9 proposals. The Committee requested further information from one proposal. The Committee oversaw the second round of funds being awarded in December of 2017. IDN partners were sent a Memorandum of understanding in November/December of 2017. The first 50% of funds will be distributed once the signed MOU is produced, not all of which have been received back yet. The next installment of 25% will be distributed with the interim report and the last 25% will be distributed with the final report. This 6-month cycle will involve the following organizations and funds:

Tri-County Community Action Program (TCCAP): The partner was awarded $100,904 to implement the Critical Time Intervention Model to address supportive housing across Region 7 IDN.

White Mountain Community Health Center (WMCHC): The partner was awarded $52,391.01 for salary costs to contract for part-time LADC services, add a community-health worker to support MAT patients, and to help support 2 staff in getting psychiatric nurse certification.

Carroll County Corrections: The partner was awarded $42,560 to use the Critical Time Intervention model for people in corrections as they transition back to the community.

Northern Human Services: The partner was awarded $213,453.69 to partner with Coos County Family Health Services (CCFHS) in Berlin to create a primary care office within the Berlin location of NHS that can be used by CCFHS providers to treat SMI, SPMI, and dually diagnosed patients.

Memorial Hospital collaborative proposal: Memorial Hospital, Saco River Medical Group, Children's Unlimited, and Visiting Nurse Home Care and Hospice was awarded $156,275 to collaborate with each other and other partners in Carroll County to create a workforce which will address complex behavioral health and substance use in the region, enhance care coordination in the region by adding staff capacity at partner organizations, increase the number of MAT providers in the region, improve behavioral health access, and address community outreach and education.

North Country Healthcare: The partner was awarded $50,000 to support the development of a regional call center and a cloud based schedule of health care resources; an affiliate of this partner, Weeks Medical Center, was awarded $90,290 for three components; a care coordination supervisor who will oversee care coordination and collaborate with external partners totaling $50,000; a care coordinator assistant to coordinate functions associated with inpatient and outpatient services totaling $20,000; and continuation funding for behavioral health case manager position totaling $20,290.

Whitehorse Addiction Center: The partner was awarded $115,800 to add 2 new behavioral health clinicians, preferably CRSWs who will work their way up towards becoming a LADC.

Ammonoosuc Community Health Services (ACHS): The partner was awarded $98,638.36 to support a 4 prong approach – 1) to expand capacity to address SUD, two LICSW and 2 patient navigators will obtain additional training in SUD and be deployed to different ACHS sites in the region; 2) one LICSW will provide student assistance at Haverhill Cooperative Middle School on a part-time basis to offer evidence-based substance abuse prevention and counseling services, 3) positioning a psychiatric nurse practitioner and physician assistant at Friendship House on a part-time basis to prescribe for clients with dual diagnoses and address screening and treatment of chronic disease; 4) ACHS will improve follow up of patients seen in LRH ED for behavioral health conditions by reviewing the LRH ED report, and reaching out to the patients to arrange for follow up care.

Community Engagement Workgroup :

The Community Engagement Workgroup has been focusing on community education, community feedback mechanisms, the IDN Region 7 website, and the IDN's central message. The workgroup's continued efforts throughout this period have led to important progress of the project. The workgroup works closely with the community to provide information regarding the IDN and has been dedicated to developing a comprehensive way to receive and interpret community feedback. The Community Engagement Workgroup continues to advise the IDN Steering committee on ways to engage the entire Region 7 IDN community to gather input and feedback on improving patient outcomes in the region. These suggestions will continue to reflect the consideration of various community goals, issues, and concerns, and find the appropriate balance among competing interests.

A major project the workgroup is developing is, Community Education through Storytelling. There have been two people who have volunteered to share their stories. The community members are connected to Community Engagement members and IDN partners, Granite United Way and Northern Human Services. There is support from Huggins that will provide guidance on next steps. There will be interviews with the community member's volunteering their stories to help write the piece. Discussion about how to roll this out to the community is ongoing. Ideas involve, creating a series that the IDN would write and offer to newspapers or engage a paper or two to have their reporters write the story.

The workgroup has also been developing and updating the Region 7 IDN website content to allow for a user/community friendly avenue to access IDN information and updates. The workgroup has been discussing ways to use the website to link individuals to services instead of just providing IDN information. There have been discussions about the design of the 'Main page/about page' to encourage readers to look further. The group developed a website review sub-committee that will continuously meet to go through the its contents. The website and story articles will provide information on how to get involved and what comes not for the Region.

The Region 7 IDN central message or "elevator speech" has been worked on through this period. The workgroup has been considering what the message needs to be There are many avenues the message could go down however it is important to the workgroup to inform the community about the project by taking all the "heady" information our and utilizing a real person's experience to illustrate the project. The message should also stress that substance use disorders and mental health issues can happen to anyone, recovery is possible, and weave in the applicable plans for Region 7. Once the implementation plan was reviewed the group looked at key points they wanted to educate the community on. The implementation plan will also be used to determine a "workplan" for community engagement workgroup as the project moves forward.

Data Workgroup:

The Data Workgroup has been responsible for the daunting tasks of choosing the Regional data aggregator, shared care plan vendor, and reporting mechanisms for the IDN project outcome measures. This period the workgroup has had multiple discussions regarding the logistics of all HIT and Data needs. The workgroup has also been working with multiple IDN partners to information, education, and implement the new technologies. The Data workgroup has been working closely with the other groups to assure a smooth transition for the Region and IDN partners as many begin to use the technologies.

This period the group spent time determining the data aggregator, Massachusetts E-Health Collaborative (MAEHC). IDN Region 7 and the Data Workgroup participated fully in the vendor demos and reviews organized at the state level to ensure that the correct vendor was selected for this important task. The regional HIT leads and data/HIT representatives of 3 partner organizations all participated in this process, which resulted in the selection of MAEHC to fulfill this need. In order to conduct proper legal review of the MAEHC contract, IDN Region 7 needed to delay its signing of this contract until the New Year pushing back many preparatory actions until this document was in place. IDN Region 7 Partners were exposed to frequent messaging about the upcoming reporting deadline on HIT/Data Workgroup phone calls throughout the reporting period and updates to all partners at our September and December quarterly meetings. This messaging focused on the data to be captured and the timelines involved. In addition, MAEHC graciously agreed to begin laying the framework for participation by holding a regional kickoff call in mid-November, allowing partners from the various IDN partners to understand their role in this reporting and began outreach to partners in late December. The decision was made to concentrate our initial outreach only to those providers needed for the initial round of reporting (being primary care and behavioral health Medicaid-billing settings). Other settings, such as hospitals, will be brought in for later reporting when necessary. In order to support the proper exchange of data, IDN Region 7, has begun a parallel process of gathering signed business associate agreements and user agreements for the MAEHC software with 4 partners as of this writing having signed BAAs on record with the remainder being expected by the reporting deadline. In addition, the IDN and MAEHC have begun to prepare outreach in February to guide partners in advance of the August reporting deadline, which contains several other measures across a wider range of settings.

The Data Workgroup also worked with the Statewide HIT Taskforce, to select Collective Medical Technologies as a regional vendor to fulfill the shared care plan, event notification (send) and event notification (receive), components through their PreManage Community and PreManage ED products. CMT is a national company with numerous large-scale implementations similar to the New Hampshire

DSRIP project in its portfolio. Their software was selected out of a field of 3 separate vendors who were reviewed as being the best fit for the state. The workgroup has been working with the region's seven hospital facilities and vendor Collective Medical Technologies to set up Health Level 7 (HL7) Admit, Discharge and Transfer (ADT) linkages with their software solution, PreManage ED. A stretch goal of 12/31/2017 had been targeted for all regional hospitals sending ADT information to PreManage. Work began in August and continued through December to accomplish this goal. The workgroup has been guiding each hospital facility through the onboarding process.

The Data workgroup connected with the other workgroups to determine the best way to capture the upcoming project measures to be reported in the next period. Discussions have focused on what should count for certain measures, CCSA, and criteria regarding event notification triggers. The efforts of this group have developed a strong foundation for the remainder of the project and future of IDN partners.

Clinical Workgroup

The Clinical Workgroup has focused on the development of many essential aspects of the Region 7 IDN project. The group began to think about the development of a regional training schedule and comprehensive project toolkits for partners to utilize throughout the project. The workgroup has also been collaborating with the Data workgroup to finalize logistics around the region's Shared Care Plan and Data Aggregator. An essential function of the workgroup has been to provide feedback and recommendations regarding the use of the Comprehensive Core Standardized Assessment, the Multidisciplinary team, and the IDN project measures. The group has continued to advise the Steering Committee regarding clinical pathway standards, and how to monitor fidelity, performance, and patient outcomes of the Region 7 IDN.

The workgroup was involved in a discussion with a representative from Collective Medial Technologies to go over the customization of PreManage Shared Care Plan/Event Notification Solution to meet clinical workflow concerns and goals. The group had ongoing discussions about what criteria should be used for reporting purposes and event notifications. Criteria from other states that have implemented the same system were reviewed and discussed. The workgroup determined suitable criteria to follow and report on. The Data aggregator decision was discussed and reporting mechanisms as they relate to MAEHC were also covered. The on boarding process of both began to roll out to some IDN partners with the help of the Clinical and Data Workgroups.

North Country Health Consortium hired a Program Specialist to help with administrative duties, training/meeting logistics, and the development of toolkits for the Region. A toolkit for each project was created during this period and will continue to be updated throughout the remaining periods. The vision of these toolkits is to provide IDN partners with a packet of Best-Practice tools, resources, and recommendations to use as they begin implementing the various IDN projects. The Clinical Workgroup will review and provide feedback on the contents of these toolkits in the upcoming period.

The Workgroup continued to determine the training needs of the region and discussion on what could be most beneficial to partners. There has been discussion about Regional Trainings vs. Agency Trainings, partner feedback regarding their specific training needs, and team-based care training options. The workgroup also focused their attention on how to develop a regional Multidisciplinary team instead of allowing every practice to have one, since the team needs to have a psychiatrist on it. The group looked at possibilities through Dartmouth Hitchcock Medical Center during this period. The CCSA was also a major topic discussed by the workgroup, efforts were used to determine how to capture all 12 domains.

Financial Workgroup

The Financial Workgroup has continued to be a valued asset to the IDN project. The group spent this period reviewing implementation budgets, indirect rates, and IDN proposals. The Financial Workgroup worked closely with the Steering Committee to develop comprehensive budgets for the project and financial feedback to partner proposals. The group worked with the Data Workgroup to determine cost and choice for the data aggregator. The regional HIT funds were held until all estimates were in and finalized. The group also discussed regional funds for two new IDN positions to provide technical assistance to region 7 partners around development of clinical workflows, multidisciplinary teams, and integration.

Opioid crisis

IDN Region 7 has been vigorously involved in efforts aiming to reduce the mortality and morbidity of the Opioid crisis in the North Country. This period has brought significant events, trainings, and resources to the Region. The IDN continues to work closely with North Country Health Consortium's, Substance Misuse Prevention Program and their Continuum of Care Facilitator to provide the North Country with the opportunity of recovery and support. The progress of the region has been directly related to many partner projects and successes during this period.

The Substance Misuse Prevention Program and NCHC helped facilitate a recovery tent for a Grateful Dead inspired music festival in Bath, NH during the month of July. It encouraged individuals in recovery to stay in recovery during the event. They also had an informative meeting about the start of a Lancaster/Groveton Coalition on July 11th, which developed into the first inaugural meeting held in August 2017.

In July and October 2017, Be An Opportunity trainings were provided to approximately 50 people in Woodsville, Lancaster, Colebrook, and Littleton by Bernadette Gleeson, a national motivational speaker. She delivered messaging on how to interact with people who have substance use disorders. In September and October 2017, Peer Recovery Coach Academy trained xxx people in Woodsville, NH and in December 2017-January 2018 they will train xxx people in Lancaster, NH. The Recovery Coach Academy is a 5-day intensive training academy focusing on providing individuals with the skills needed to guide, mentor and support anyone who would like to enter or sustain long-term recovery from an addiction to alcohol or other drugs. These trainings will provide Region 7 with skilled individuals to assist in the communities recovering population. The region has also held 15 Narcan Education trainings and distributed 129 Narcan kits during the reporting period.

A major event relating to the Opioid crisis was the Friendship House groundbreaking on September 29th, 2017. The projected open date is May 2018, when at that point the organization will be a 28-bed residential facility and a 4-bed detox facility. There was a seamless transition for clients as well as staff as the North Country Health Consortium took over the organization. There were a few complications in regards to confidentiality laws that are still being worked out as the clients were transferred from Tri County Community Action Program's care.

IDN Region 7 also witnessed the development and distribution of the North Country Regional Community Compass, created by the NCHC Continuum of Care Facilitator. The booklet serves as a regional SUD resource and educational piece for the North Country. The product helps the community navigate local resources for substance use disorders and provides educational materials about healthy living, addiction services, and recovery. IDN Region 7 will continue to combine efforts with SMP and CoC to combat the Opioid crisis that still exists in the North Country. The activities from July-December 2017 will continue to evolve as we move forward into the next reporting period, with a vision of decreasing the burden this crisis has caused Region 7's community.

Community Input:

On November 15th, 2017 the "Resiliency in Our Back Yard: Your Ideas on Substance Misuse Prevention, Treatment and Recovery" event was put on by the North Woods Addiction Coalition and North Country Listens. It was held in the Colebrook Elementary School and had over 60 participants. The event was an interactive community conversation with North Coos County about substance misuse prevention, treatment, and recovery in the community. The event was used for community to share perspectives, experiences, and ideas for local solutions for the issue that affects the whole community.

On December 7th, 2017, NCHC held an event at the Mountain View Grand, that supported the Community Health Improvement Plan (CHIP). This event brought together representatives from each of the 5 coalitions in our region. The attendees shared knowledge and worked towards improving the CHIP.

SMP has been continuously working with Marty Boldin, the Governor's advisor on prevention, treatment and recovery, who visits the North Country monthly to meet with various SUD facilities, staff, and clients. He visited NCHC, NCCA, Weeks medical and a women's recovery center that is preparing to open in Center Conway. They provided valuable assistance to move the process along. SMP was also able to organize "Drug Recognition Expert" presentations to educators, through a connection made at the Littleton coalition. These presentations developed into Drug Recognition Trainings that will help school personnel identify the latest trends in substance misuse as well as help to identify youth in crisis. A meeting with Indian Stream Medical Center resulted in the collaboration of the "North Woods Addiction Coalition" and Health professionals for the medical center. They generously invited NCHC SMP to share their booth at the well-attended "Moose Festival" in Canaan and Colebrook for 2017. The SMP is also working towards getting a prescription drug "Drop Box" in towns across the North Country. These efforts will lead to the limiting of access to harmful drugs. Local law enforcement was interviewed about the needs and challenges associated with a permanent "Drop Box" and "Drug Take Back Day". SMP has also been meeting with Weeks Medical Center to discuss how to better serve our first responders and create a smooth transition on the new pathway to recovery that is being piloted through our work with Weeks Medical staff. This is directly related to the new MAT program being offered at Weeks. A representative from New Hampshire Teen Institute spoke with the Little ATOD Coalition about a free ten-hour class for parents that need help communicating with their teens.

In 2017 Huggins Hospital established the Eastern Lakes Region Coalition for Healthy Families Youth Prevention Coalition

Network Development:

Region 7 IDN partners continue to work well and have learned a lot from one another already. The IDN quarterly meetings have been very valuable to give the partners a chance to talk and see what each other is doing. NCHC has structured these meetings to facilitate these collaborative conversations and will continue to do so. An example of this is creating a seating plan so partners get the chance to talk with someone new.

Region 7 IDN Total Project Budget

Budget Period:	**01/01/2017-12/31/2020**	**07/01/2017-12/31/2017**	**07/01/2017-12/31/2017**	**01/01/2018-12/31/2020**	
	IDN Region 7 Budget Total	**IDN Region 7 Budget (6 months)**	**IDN Region 7 Actual Expense (6 months)**	**IDN Region 7 Budget Projection (remaining project period)**	
Line Item	**Total**	**Total**	**Total**	**Total**	**NARRATIVE:**
1. Total Salary/Wages					
2. Employee Benefits					
3. Consultants					
5. Supplies:					
Educational					
Office	$239,892	$29,987	$7,093	$179,919	**YR2-YR5:** Org.-Wide Office Supply Allocation & New Hire Set ups
6. Travel	$272,880	$34,110	$2,019	$204,660	**YR2-YR5:** Travel expenses for regional & conference/training expenses. **Additional Notes:** IDN Quality Improvement team not yet fully staffed to absorb travel budget. Partners requesting less in Travel than originally estimated. Continued Travel expected in next reporting period.
7. Occupancy					
8. Current Expenses					
Telephone					
Postage					
Subscriptions	$674,923	$84,365	$15,086	$506,192	**Additional Notes:** Delayed vendor invoicing and timed payment options contribute to under-budget status.
Audit and Legal					
Insurance					

Board Expenses					
9. Software	$22,740	$2,843		$17,055	**Additional Notes:** NCHC continues with manual submission process, and evaluating future computerized options.
10. Marketing/Communications	$209,256	$26,157	$8,497	$156,942	**YR2-YR5:** Org.-Wide Marketing/Communications Allocation & Outreach materials
11. Staff Education and Training	$355,881	$44,485	$4,038	$266,911	**YR2-YR5:** Training $20,000, **Additional Notes:** Increased expense trend anticipated with future training and LLP participation.
12. Subcontracts/Agreements					
13. Other (specific details mandatory):					
Current Expenses: Administrative Lead Organizational Support	$107,424	$13,428	$12,534	$80,568	**YR2-YR5:** Telephone/Postage/Audit& Legal/Insurance
Support Payments to Partners	$7,880,060	$985,008	$348,573	$5,910,045	**YR2-YR5**: Budget line item to cover workforce related requests submitted by Region 7 IDN partners in future funding cycles. **Additional Notes:** RFPs awarded. Payment in various stages pending MOU execution and reporting deliverables. Represents a portion of the $715,250 for Round 1 funding and additional $1,000,601 pending for Round 2 funding.
Indirect	$406,257	$50,782.13	$21,658	$304,693	
TOTAL	**$11,210,036**	**$1,401,255**	**$562,645.95**	**$8,407,527**	

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

A1-1. IDN Participation in Statewide Behavioral Health Workforce Capacity Development Taskforce Strategic Plan Activity

Use the format below to identify the IDN's participation in Statewide Workforce Taskforce activities and completion of a Statewide Workforce Capacity Strategic Plan. Of note, *all* IDNs must participate in the development and writing of the Statewide Workforce Capacity Strategic Plan. Should the Statewide Workforce Capacity Strategic Plan not be received by DHHS, *all* IDNs will receive a "No" for this effort.

Statewide BH Workforce Capacity Taskforce Strategic Plan Activity	Yes/No
Participation in taskforce meetings - 1 BH representative	Y
Participation in taskforce meetings - 1 SUD representative	Y
Participation in assessment of current workforce gaps across the state	Y
Participation in the creation of the statewide gap analysis	Y
Participation in the creation of the Statewide Workforce Capacity Strategic Plan	Y
Completion of the Statewide Workforce Strategic Plan	Y

A1-2. IDN-level Workforce: Gap Analysis

Provide a narrative summarizing the results of your IDN's analysis of workforce gaps in your region informed by the Statewide Behavioral Health Workforce Capacity Development Strategic Plan, the IDN's community needs assessment, and selected community-driven projects. The narrative should include identified workforce gaps in education, recruitment, training, and retention of specific behavioral health providers to include but not be limited to:

- Master Licensed Alcohol and Drug Counselors;
- Licensed Mental Health Professionals;
- Peer Recovery Coaches; and
- Other Front Line Providers.

Provide a narrative summarizing the results of your IDN's analysis of workforce gaps in your region informed by the Statewide Behavioral Health Workforce Capacity Development Strategic Plan, the IDN's community needs assessment, and selected community-driven projects. The narrative should include identified workforce gaps in education, recruitment, training, and retention of specific behavioral health providers to include but not be limited to:

- Master Licensed Alcohol and Drug Counselors;
- Licensed Mental Health Professionals;
- Peer Recovery Coaches; and
- Other Front Line Providers.

IDN-level Workforce: Gap Analysis

In mid-February 2017, workforce surveys were sent to 17 behavioral health and primary care agencies in Region 7 IDN, and 14 of those agencies completed the survey. The results of this survey were shared with the state behavioral health taskforce, so the information could be compiled with the results from the other 6 regional IDNs, and the results were then incorporated into the statewide strategic plan. This

survey serves as the foundation for the workforce gaps analysis of Region 7 IDN. The information gleaned from this survey, along with information obtained from regional community health needs assessment, and workforce needs for selected community-driven projects was collected and analyzed to create the Region 7 IDN gap analysis. The goal of this gap analysis is to identify workforce gaps in recruitment, hiring, training, and retention of specific behavioral health providers including but not limited to Master Licensed Alcohol and Drug Counselors; Licensed Mental Health Professionals; Peer Recovery Coaches; and Other Front-Line Providers.

Numerous challenges related to behavioral health workforce capacity shortages were identified in the region, but the challenges which rose to the top were related to recruitment and training. The main problem identified related to recruitment was a lack of available behavioral health workforce statewide. Region 7 IDN sees existing behavioral staff move from organization to organization, but there is not much expansion of the behavioral health workforce in Region 7 IDN. There is a significant shortage of psychiatrists both at the regional level and statewide, so Region 7 IDN will need to be innovative to get psychiatrists to be part of the multi-disciplinary core teams. NCHC will research the options for contracting psychiatric services for practices within the region and will share this information with IDN partners. The other challenge that rose to the top in the survey was related to training. Survey respondents felt the region needs to have trainings on integrated healthcare, and felt it was very important to cross train staff from partner agencies so all agencies had an understanding of the intersection of primary care, mental health, substance use disorders, and peer recovery support services.

Region 7 IDN identified recruitment and training as the top strategies to address the regional challenges. Survey respondents selected the pipeline program, expansion of the Statewide Loan Repayment Program (SLRP) to incentivize mental health and Substance Use Disorder (SUD) professionals, along with the need for coordinated recruitment efforts as the top strategies to address as a region. NNH AHEC was identified as a strategy to address the training needs of the region. The regional gap analysis needed to tie into the statewide strategic plan which was finalized at the end of June 2017, so in early July Region 7 IDN formed a regional workgroup to look at the goals and objectives of the statewide plan to prioritize how Region 7 wants to move forward to address the challenges related to behavioral health workforce capacity in the region. Region 7 IDN will be working on strategies for utilizing and connecting existing SUD and behavioral health resources, strategies to address gaps in educational preparation of SUD and behavioral health providers to ensure workforce readiness upon graduation, strategies to support training of non-clinical IDN staff in Mental Health First Aid, and strategies for strengthening the workforce in specific areas of expertise such as Master Licensed Alcohol and Drug Counselors (MLADCs), licensed mental health professionals, Peer Recovery Coaches, and other front line providers. The region will work to ensure the regional plan aligns with guidelines and targets established by the statewide plan, the IDN's community needs assessment, the IDN's workforce assessment survey and the community-driven projects selected by the IDN.

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. Using Microsoft Project or similar platform update your project timeline.

At a minimum provide detail on the progress made on the strategies to address identified workforce gaps in:

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

The Behavioral Health Workforce Capacity Project, referred to as project A1, is a statewide project designed to establish the workforce required to meet the objectives of the DSRIP demonstration. It will increase community-based behavioral health service capacity through the education, recruitment and training of a professional, allied-health, and peer workforce with knowledge and skills to provide and coordinate the full continuum of substance use disorder and mental health services. Region 7 IDN has been actively involved in all phases of creating the statewide strategic plan to date and used this document as a road map to address regional workforce capacity needs. Region 7 IDN's Chief Executive Officer, Nancy Frank, serves as the vice-chair of the Behavioral Health Workforce Taskforce, as well as Co-Chair for the Training & Education subcommittee of the Behavioral Health Workforce Taskforce. The Statewide Behavioral Health Taskforce created 4 subcommittees: Training & Education, Retention & Sustainability, Recruitment & Hiring, and Policy. Each of the subcommittees has goals and objectives they are addressing to get deliverables met, and then this progress gets incorporated into the strategic plan of the Statewide Behavioral Health Taskforce. Region 7 IDN members have been actively participating in both the quarterly meetings of the Behavioral Health Workforce Taskforce and monthly meetings of the Training & Education Subcommittee.

The Chairperson from each of the Behavioral Health Workforce Taskforce subcommittees were asked to create a document reflecting the progress and recommendations for the period of 7/1-12/31/2017 and submit this document to the Chairperson of the Behavioral Health Workforce Taskforce, so all 4 reports can be compiled into one document and shared with NH DHHS and the Behavioral Health Taskforce. Voting members of the Behavioral Health Taskforce will vote on subcommittees' recommendations for the Statewide Behavioral Health Workforce Strategic Plan on January 24, 2018.

During the reporting period of 7/1-12/31/2017 Region 7 IDN had 1 new member agency, North Country Serenity Center, a Recovery Community Center join the network, and no members leave.

Region 7 IDN has seen success when it comes to recruiting new staff in the region along with a few challenges:

- Weeks Medical Center has hired a psychiatric nurse practitioner, a LCMHC, and a behavioral health team leader/MAT Coordinator. They had hired a behavioral health case manager, but the position is vacant again
- Northern Human Services has hired two new clinicians, both are getting ready to be dually licensed, but also lost one clinician. In addition, they have hired one care manager for their Drug Court program and 2 other staff to assist with Drug Court. They have hired an intern who will graduate in May and have made an offer to another clinician who is working toward licensure
- White Mountain Community Health Center has added a community health worker position and has sent a medical assistant to become a community health worker as well. They have 2 nurse practitioners who will be finishing their final semester to become psychiatric nurse practitioners in May 2018
- Huggins Hospital has added three staff directly focused on IDN work: a population health nurse, a LICSW embedded in primary care, and a senior community health officer
- Ammonoosuc Community Health Services hired a Behavioral Health Care Coordinator and a behavioral health community health worker
- Whitehorse Addiction Center hired a CRSW in training, and just had 2 staff complete their CRSW. In addition, they hired a LADC/CMH (a New York Clinical Mental Health license – it is a 48 credit Masters and is working to get additional credits
- Cottage Hospital lost a social worker and had a behavioral health APRN retire
- Saco River Medical Group has hired a care coordinator who will monitor and navigate patients with behavioral health and SUD problem as they go through the referral process
- Friendship House has hired a part-time LADC eligible clinician, and 2 intake coordinators
- Coos County Family Health Services hired an RN Coordinator to coordinate their new MAT program

To ensure front line staff have an understanding about the knowledge and beliefs about mental disorders that can aid in recognition and management of these disorders, NCHC coordinated 2 Mental Health First Aid trainings during the reporting period of 7/1/-12/31/17. One was held at Littleton Regional Healthcare on 11/30 for 26 participants, and one on 12/18 at Cottage Hospital for 28 participants. NCHC currently has one certified Mental Health First Aid trainer on staff, and the organization plans to send another staff member to be trained at Riverbend Mental Health Center in April 2018. Having 2 staff members trained in this model will help the region meet the deliverable of having 4 Mental Health First Aid trainings offered in each year 2018-2020. Currently, NCHC is working with Memorial Hospital to coordinate a training for March 2018.

To meet workforce goals and address the challenges identified the region will be primarily addressing four workforce projects: 1) grow our own mental health providers, 2) petition mental health licensing boards regarding supervision rules, 3) shared use of existing mental health professionals, and 4) create a central coordinating agency for recovery support services

<u>Grow Our Own Mental Health Provider Workforce:</u>

Region 7 IDN has created a regional workforce team that has met three times during the reporting period of 7/1-12/31/17. The group has been instrumental in helping the region think through strategies to increase the behavioral health provider capacity in the region. The Grow Your Own Workforce idea came out of these discussions. The primary focus of the grow-your-own model is to support existing staff as they work to advance from one level of certification to another. The region has been trying to

determine how many LADCs and MLADCs are in the region, and this number fluctuates as staff move from one agency to another. In addition, so many mental health professionals are working on certifications that is difficult to accurately capture what level of certification they are at. Region 7 IDN wanted to offer educational trainings for the mental health workforce in the region, but first needed to conduct an educational needs assessment to see what was needed for trainings. A training needs survey was sent out late in 2017, which was designed to capture participants credentials as well as training needs. 145 people completed the survey, but the region would like to get additional feedback from mental health professionals, so will work to follow up with these professionals early in 2018. However, based on preliminary results, the region has moved forward to arrange for numerous trainings for the upcoming year:

- March 8, 2018 – IDN Regional Quarterly meeting: care coordination panel discussion in the morning, followed by Medication Assisted Treatment (MAT) training during the afternoon session presented by Peter Mason, MD. The program is designed to demonstrate how to overcome barriers to MAT expansion in a primary care practice. AMC Highland Center, Crawford Notch
- March 19, 2018 - Drug Recognition Training - identify the latest trends in substance misuse, as well as recognize individuals in crisis. North Country Health Consortium, Littleton
- March 2018 Mental Health First Aid training at Memorial Hospital, North Conway
- April 12, 2018 - Co-Occurring Medical Conditions within Behavioral Health, Danielle Moreggi, PhD - This session is focused on providing behavioral health and substance abuse treatment professionals with an increased understanding for circumstances when medical conditions are related to behavioral health. AMC Highland Center, Crawford Notch
    - Objectives:
        - Provide a review of the most common medical conditions diagnosed among substance addicted and mental health clients.
        - Help clinicians identify “key” symptoms during the assessment process that may co-occur; and, remain within the scope of practice.
        - Provide an understanding of how medical symptoms can overlap, interact and vail psychological symptoms which effects treatment planning.
- April 13, 2018- Co-Occurring Psychological Conditions within Primary Care, Danielle Moreggi, PhD - Designed for medical professionals to better understand evidenced- based screening tools for common mental and behavioral health conditions as well as a plan for treatment planning and follow up. AMC Highland Center, Crawford Notch
    - Objectives:
        - Provide a review of most common psychological symptoms presenting in primary care
        - Assist medical professionals with proper screening and diagnosing for depression, PTSD, addiction and suicide risks
        - Provide an understanding of how standardized data collection can assist with comprehensive treatment planning and follow up.
        - May 1-2, 2018 Motivational Interviewing Workshop, AMC Highland Center, Crawford Notch
- May 23, 2018 – Behavioral and Medical Professionals Working Together to Address Co-Occurring Conditions, Danielle Moreggi, PhD. Designed to bring primary care and behavioral health professionals together to discuss feedback from the first two sessions and work on an

interprofessional team-based approach to provide comprehensive care to patients with medical, behavioral health and substance abuse treatment needs. AMC Highland Center, Crawford Notch
    - Objectives:
        - Provide a review of the importance working together with proper diagnosis and treatment strategies; common co-occurrences
        - Review of screening, assessment and proper referral processes
        - Discussion of policies and procedures to improve standardization of care
- September 13, 2018 IDN Regional Quarterly Meeting, Trauma Informed Care - participants will understand the effects of childhood trauma as it relates that could trigger patients in their own health care setting and describe three interventions or skills that can be used to decrease the trauma response in patients. AMC Highland Center, Crawford Notch

In addition to the trainings already scheduled the regions has been in communication with NH DHHS to offer a training titled *Initial Training on Addiction & Recovery*. This introductory workshop on addiction and recovery is designed to raise awareness and understanding of the dynamics and impact of addiction on people whom we serve. It will cover the neurological basis of addiction; mental, behavioral, emotional and spiritual dimensions; stages of change; recovery; motivational techniques; and resources. Region 7 IDN will also work with the New Hampshire Alcohol & Drug Abuse Counselors Association to arrange for a training on ethics and HIV for the region.

In addition to this, the region plans to identify local mental health subject matter experts in the region who would be willing to utilize these skills for training purposes. NCHC had planned to reach out to the region in the fall of 2017 to see who was interested in being a trainer, but then decided more work needed to be done to assess training needs before looking for trainers. However, part of the IDN Training & Education subcommittee work is to come up with a Speakers Bureau, a list of names of people who will be willing to train others in the state. NCHC will continue to work on this effort as the project moves forward. The region is committed to getting local experts to train current workforce.

The region is also committed to connecting local subject matter experts to training programs at Plymouth State University, Springfield College, White Mountains Community College, and Granite State College as a way for them to become adjunct faculty. The subject matter experts will develop learning objectives and curriculum content which will be approved by the academic institution. The organizations where the subject matter experts are employed could agree to serve as a mentor for students from these academic institutions in exchange for a reduced cost in tuition for professionals in Region 7 IDN looking to enter the mental health field or advance their current level of certification. In addition, IDN funds can be used as scholarships for behavioral health trainings and for organizations to help support staff as they advance their level of certification. NCHC has had a very promising conversation with Springfield College in December 2017 regarding this concept and looks forward to additional conversations in the upcoming months. NCHC will continue to engage other academic institutions in similar conversations and will participate on a statewide level as academic institution are brought together to discuss behavioral health workforce capacity in the state.

Another part of the Grow Your Own Workforce relates to the use of IDN funds for an organization to support a staff person interested in advancing their education, as a way to retain existing staff. Agencies can use the region's proposal process to apply for funds to help offset the costs associated with this training, including the loss of revenue due to non-billable hours. Region 7 IDN already has

agencies using IDN funds to support this, including White Mountain Community Health Center in Conway, NH. This agency currently has 2 nurse practitioners, and they have asked for some IDN funds to help support these 2 professionals obtain their psychiatric nurse certification, which should be completed by May of 2018. NCHC will actively encourage partner agencies to look at their existing staff to see who has both the interest and potential to seek out professional development and work towards advancing their current certification.

The grow-your-own model ties in directly with the Northern New Hampshire Area Health Education Center (NNH AHEC), a program of the North Country Health Consortium. NNH AHEC has been involved with grow-your-own models related to health care professionals for many years and will use this expertise to position the region for success regarding this grow-your-own model. Through "Live, Learn, Play in Northern NH", a program of the Northern NH AHEC/North Country Health Consortium, health professional students receive quality training experiences in rural medically underserved areas throughout northern New Hampshire. In addition, students will experience New Hampshire's most awe-inspiring scenery, outdoor recreation and complete a community service project. This is an important part of introducing health professional students to the rural nature of the region and works into recruitment and retention strategies. This model will be used to bring mental health professional students to the area as the region explores collaborating with academic institutions offering education in the mental health field. Region 7 IDN met their goal of having 3 mental health professional students enrolled in the program by the end of 2017. Northern Human Services is serving as a preceptor site for 2 of these students, and Friendship House is serving as a preceptor site for the third student. Region 7 IDN will continue to recruit for additional students to join this program with a goal of adding 3 additional students to the program each year. NCHC also had conversations with Rivier College about student places for psychiatric nurse practitioners, and these conversations will continue into 2018, and has had preliminary conversations with the University of NH about potential student placements.

<u>Petition mental health licensing boards regarding supervision rules</u>

Current rules state supervision of mental health professional staff needs to be in a face-to-face format, which is difficult given the large distances between practice sites in Region 7. There have been significant changes and advancements in the practice in behavioral health field over the past 10 years. The laws in NH and the Federal government have expanded as the use of telemedicine and electronic medical records have become more prevalent in practice settings. Insurance companies now pay for services delivered by tele-video equipment. The Centers for Medicare and Medicaid rules allow for billing of psychotherapy while using tele-video equipment by physician and other health care providers. Region 7 IDN is going to ask the Board for a waiver to pilot a model of long-distance supervision on a limited basis. The premise of this waiver will be since patients can receive care virtually, so mental health practitioners should be able to use the same platform to receive supervision. Improvements in technology have made it so video connections are very high quality and electronic medical records can be accessed simultaneous by the supervisor and the supervisee in real time, as well as encrypted communications by email and by Jabber can allow instant communications between formal supervision sessions. The petition is also going to request that very experienced staff be grandfathered in as supervisors, and Region 7 IDN will ask the Board to consider shared group supervision as a potential option. All these strategies would allow mental health professionals to advance to the next level of certification and help Region 7 IDN expand behavioral health workforce capacity.

Region 7 IDN will continue to create a petition as outlined above, even though some of this is also being looked at by the Behavioral Health Taskforce. In addition, in December 2017, the NH Board of Mental

Health Practice approved a waiver submitted by Northern Human Services which will allow them to be able to do supervision using tele-video equipment due to the obstacles associated with providing quality services in a very rural and large geographic area. It is the hope that this can serve as a pilot, and other agency will be able to apply for a waiver as well.

Shared Use of Resources

Region 7 IDN has made progress on addressing workforce capacity issues during the reporting period of 7/1-12/31/17, although the region still faces numerous workforce shortages related to the DSRIP project, the most challenging being recruitment of psychiatrists, LADCs, MLADCs, and certified peer recovery support workers. The region has been working together on strategies which go beyond normal organizational recruitment strategies to expand the behavioral health workforce and position the region to meet the DSRIP goals. To address the lack of psychiatrists in the region, and the need to have psychiatrists as part of the multi-disciplinary team, NCHC has reached out to both Northern Human Services, the area's community mental health center, and the Department of Psychiatry at Geisel School of Medicine at Dartmouth to explore the feasibility of one of the organizations providing consulting psychiatric services to support the monthly case conference requirement of the core competency project. NCHC has asked these 2 agencies to put together a quote for what it will cost to purchase psychiatric consulting time to cover the needs of the region to meet the DSRIP requirements. These cost proposals will be discussed with both the IDN Steering Committee and IDN partners, and NCHC will ensure a decision is made so the region can be ready to move forward with its first multi-disciplinary case conference in March 2018.

The region said they would explore shared use of resources as a region. NCHC and Weeks Medical Center have started to engage in preliminary conversations related to shared staff resources, especially as it relates to coverage schedules. These conversations will continue to evolve as the region moves forward in implementing DSRIP projects. Another example of shared staff resources includes the region's plan to use mobile LADCs. The region is positioned to work with Friendship House, the only residential treatment facility in region 7 IDN service area, to support the growth of LADCs in the organization. Friendship House will have a process in place to deploy mobile LADCs to the hospitals in the region on an as needed basis. This approach will be a phased approach, based on the three counties, or sub-regions in Region 7 IDN. There will be an agreement in place with to have mobile LADC services in place for Grafton County by 12/31/18; Coos County 12/31/19; and Carroll County by 12/31/2020.

NCHC started this preliminary discussion with the NCHC Board of Directors, most of which represent Region 7 IDN agencies, on 9/8/17 when OneDigital Health & Benefits presented an employee benefit presentation. The presentation covered group purchasing options for health insurance, life & disability insurance, and voluntary benefits such as Accident Insurance and supplemental life insurance. Those listening to the presentation completed a survey to see assess interest in moving forward with additional conversations. Although the overall response rate was low, for those completing the survey 100% of the respondents said they would be interested in exploring group purchasing options for insurance, and 80% of the respondents said they would be interested in exploring group life insurance and short-term disability. The region will look at this information and continue to explore options.

Centralized Peer Recovery Support

Region 7 IDN would benefit from the creation of a central coordinating agency for recovery support services. Currently, there is some forward movement to get people trained as peer recovery coaches,

but there is not an infrastructure in place to coordinate and support this process. For example, although there are trainings happening in the area, many in the region do not know where these trainings are happening, and then how to access peer recovery coaches. If the region had one central agency coordinating the trainings, and helping to deploy recovery coaches, it will lead to more coordinated approach to getting recovery services to patients in a timely manner which will lead to better health outcomes. NCHC has been working to promote the idea of a centralized peer support recovery organization for the region and received 2 concept papers in December 2017 from peer recovery support agencies in the region. The IDN Steering Committee will review these concept papers in January 2018 and decide if the organizations will be invited to submit a full proposal which will be due in March 2018. In addition, NCHC will create a survey to identify existing care coordinators in the region and create a training plan to enhance their skills related to peer recovery support services by March of 2018.

The region had 2 Peer Recovery Coach Academies during the reporting period, one in August 2017 in Whitefield where 9 people were trained, and one in December 2017 at the Northwoods Training Center in Whitefield, where 11 people were trained. There is another Peer Recovery Coach Academy scheduled for March 2018 in Lancaster, NH. There is momentum in the Weeks Medical Center catchment area to find ways to connect patients to peer recovery coaches, and the region hopes to share lessons learned from this work to help other towns implement similar initiatives.

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

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

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
# of mental health professional students completing Live, Learn Play program in northern NH	6 by 2018	3		
# of new preceptor sites (practice site accepting students into practice settings for students to work with providers to gain clinical experience) receiving mental health professional students	2 by 2018	1		
# of mobile LADCs ready to deploy to Region 7 IDN partners	1 by 2018	0		
Expanded supervision for masters level clinicians	1 by 2018	0		
# contracts in place in Region 7 for consultation with psychiatrists as member of multidisciplinary teams	1 by 2018	0		

A1-5. IDN-level Workforce: Staffing Targets

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

Provider Type*	IDN Workforce (FTEs)				
	Projected Total Need	Baseline Staffing on 6/30/17	Staffing on 12/31/17	Staffing on 6/30/18	Staffing on 12/31/18
Master Licensed Alcohol and Drug Counselors	16 by 2018	11	11		
Licensed Mental Health Professionals	23 by 2018	14	18		
Peer Recovery Coaches	6 by 2018	2	22		
CTI Workers	15 by 2018	0	11		
CTI Supervisors	3 by 2018	0	3		
Community Health Workers	4 by 2018	0	13		
Psych Nurse Practitioners (round 1 funds)	3 by 2018	1	2		
Care Advocates	15 by 2018	0	0		
Other Front Line Provider	1 by 2018	0	10		
Care Advocate Supervisors	1 by 2018	0	0		
Community based clinician (round 1 funds for baseline 6/30/17)	1	1	1		
Physician assistant (round 1 funds for baseline 6/30/17)	1	1	1		
Community nurse coordinator (round 1 funds for baseline 6/30/17)	1	1	1		
Behavioral health assistant (round 1 funds for baseline 6/30/17)	1	1	1		
Behavioral health case managers (round 1 funds for baseline 6/30/17)	5	2	4		

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
LICSW (round 1 funds for baseline 6/30/17)	3	1	2		
IDN QI Coach	1	0	0		
HIT Integration Coach	1	0	1		
IDN Data Specialist (NCHC)	1	0	0		
Data Specialists for IDN partners	Up to 3	0	0		

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

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

Budget Period:	**01/01/2017-12/31/2020**	**07/01/2017-12/31/2017**	**07/01/2017-12/31/2017**	**01/01/2018-12/31/2020**	
	Workforce Budget	**Workforce Budget (6 months)**	**Workforce Actual Expense (6 months)**	**Workforce Budget Projection (remaining project period)**	
Line Item	**Total**	**Total**	**Total**	**Total**	**NARRATIVE:**
1. Total Salary/Wages					
2. Employee Benefits					
3. Consultants					
5. Supplies:					
Educational					

Office	$100,622	$12,578	$1,780	$75,467	**YR2-YR5:** Org.-Wide Office Supply Allocation & New Hire Set ups; actual expenses not as anticipated - anticipate expenses in future budget period
6. Travel	$68,220	$8,528	$508	$51,165	**YR2-YR5:** Travel expenses for regional & conference/training expenses
7. Occupancy					
8. Current Expenses					
Telephone					
Postage					
Subscriptions			$3,782		
Audit and Legal					
Insurance					
Board Expenses					
9. Software	$3,790	$474	$5	$2,843	
10. Marketing/Communications	$95,516	$11,940	$2,134	$71,637	**YR2-YR5:** Org.-Wide Marketing/Communications Allocation & Outreach materials
11. Staff Education and Training	$134,166	$16,771	$1,011	$100,625	**YR2-YR5:** Training $20,000, Three LLP students $1,500 each & Preceptor Support $500 each; **Additional Notes:** Increased expense trend anticipated with future training and LLP participation.
12. Subcontracts/Agreements					
13. Other (specific details mandatory):					
Current Expenses: Administrative Lead Organizational Support	$17,904	$2,238	$3,145	$13,428	**YR2-YR5:** Telephone/Postage/Audit&Legal/Insurance
Support Payments to Partners	$1,983,499	$247,937	$87,209	$1,487,624	**YR2-YR5**: Budget line item to cover workforce related requests submitted by Region 7 IDN partners; **Additional Notes:** RFP awarded. Payment in various stages pending MOU execution and reporting deliverables.
TOTAL	**$2,705,611**	**$338,201**	**$135,511**	**$2,029,208**	

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

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

Organization Name	Organization Type	Associated with IDN Projects (A1, A2, B1, C, D, E)
Northern Human Services	Substance Use Disorder Provider; Community Mental Health Center (CMHC); Community-Based Organization Providing Social and Support Services	A1, A2, B1, C1, D3, E5
White Mountain Community Health Center	Non-FQHC Community Health Partner	A1, A2, B1, D3, E5
Memorial Hospital	Hospital Facility	A1, A2, B1, C1, D3, E5
Huggins Hospital	Primary Care Practice; Hospital Facility	A1, A2, B1, C1, D3, E5
Crotched Mountain Foundation	Hospital Facility; Community-based organization providing social and support services	A1, E5
Life Coping, Inc.	Community-based	A1, E5
Saco River Medical Group	Rural Health Clinic	A1, B1,
White Horse Addiction Center	Addiction & Recovery	A1, A2, B1, D3
Carroll County Department of Corrections	County Corrections Facility	A1, A2, C1
Androscoggin Valley Hospital	Hospital Facility	A1, A2, B1, E5
Coos County Family Health Services	Federally Qualified Health Center (FQHC)	A1, A2, B1, D3, E5
Weeks Medical Center	Primary Care Practice; Hospital Facility; Rural Health Clinic	A1, A2, B1, D3, E5
Indian Stream Health Center	Federally Qualified Health Center (FQHC); Substance Use Disorder; Non-CMHC Mental Health Provider; Community-based Organization providing social and support services	A1, A2, B1, D3, E5
Upper Connecticut Valley Hospital	Hospital Facility	A1, A2, B1, C1, D3, E5

Ammonoosuc Community Health Services	Federally Qualified Health Center (FQHC)	A1, A2, B1, C1, D3, E5
Littleton Regional Healthcare	Hospital Facility; Rural Health Clinic	A1, A2, B1, C1, E5
Cottage Hospital	Hospital Facility	A1, A2, B1, C1, E5
Rowe Health Center	Rural Health Clinic	A1, A2, B1, C1, D3, E5
North Country Health Consortium/Friendship House	Substance Use Disorder Treatment (After 10/01/2017)	A1, B1, D3
Mount Washington Valley Supports Recovery	Peer Recover, Transitional Housing	D3
North Country Serenity Center	Peer Recover, Transitional Housing	D3
Tri-County Community Action Program	Community-Based Organization	A1, C1, E5

A1-8. Signed Attestation of IDN Review and Acceptance of the Statewide Workforce Capacity Development Strategic Plan

Submit a signed attestation of the IDN's review and acceptance of the statewide workforce capacity development strategic plan.

Integrated Delivery Network Administrative Lead Contract

Attestation Form

I, Nancy Frank, a representative of Region # 7, attest that I have reviewed and am in acceptance on behalf of Region 7 of the Statewide Workforce Capacity Development Strategic Plan as outlined in the New Hampshire Building Capacity for Transformation 1115 Medicaid Waiver, IDN Process Measures Semi-Annual Reporting Guide for year 2 (CY2017) and Year 3 (CY2018), 2017-03-22 v.23

(Signature)

STATE OF NEW HAMPSHIRE

County of Grafton

The forgoing instrument was acknowledged before me this 31st day of July, 2017

Tracy A Page

(Notary Public/Justice of the Peace)

TRACY A PAGE
Notary Public - New Hampshire
My Commission Expires September 18, 2018

(NOTARY SEAL)

Commission Expires: 09/18/2018

A1-9. 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
A1-1	Participation in Statewide BH Workforce Capacity Taskforce Strategic Plan Activity	Table				
A1-2	IDN-level Workforce Gap Analysis	Narrative				
A1-3	IDN-level Workforce Capacity Development Implementation Plan	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				
A1-8	Review and Acceptance of Statewide BH Workforce Capacity Strategic Plan	Signed Attestation				

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

A2-1. IDN Participation in Statewide HIT Taskforce

In addition to the overall goals of the demonstration project, an HIT Task Force including representatives for each IDN was formed to support the statewide planning effort. All IDNs were required to participate in the monthly, in-person HIT Task Force meetings. Facilitated by Myers and Stauffer, the HIT Task Force was charged with[i]:

- Assessing the current health IT infrastructure gaps across the state and IDN regions.
- Coming to consensus on statewide health IT implementation priorities given the demonstration objectives.
- Identifying the statewide and local IDN health IT infrastructure requirements to meet demonstration goals, including:
    - Minimum standards required of every IDN
    - "Desired" standards that are strongly encouraged but not required to be adopted by every IDN
    - A menu of optional requirements

In addition to the monthly HIT Task Force meetings, work sessions were established and conducted via WebEx and facilitated jointly by the elected Chairs of the HIT Task Force and Myers and Stauffer, LC. These work sessions were scheduled to occur weekly (if necessary) with the exception of the weeks in which an in-person HIT Task Force meeting was held. IDN Region 7 participated in these sessions.

Statewide HIT Taskforce Participation	Yes/No
Participation in HIT Taskforce meetings	Yes
Participation in current state assessment	Yes
Completion of IDN member assessment of existing and scheduled HIT efforts and statewide report	Yes
Participation in the review of pertinent State and Federal laws	Yes
Participation in the creation of the gap analysis	Yes
Participation on work to achieve consensus on a set of minimally required, desired, and optional IT HIE infrastructure projects for IDNs to pursue	Yes

A2-2. IDN HIT/HIE: Assessment and Gap Analysis

Provide a narrative summarizing the results of the IDN's analysis of the current HIT infrastructure gaps obtained through the Statewide HIT Taskforce's current state assessment efforts, current HIT capacity, and community needs assessment. At a minimum, include in the narrative how HIT will support meeting the following objectives:

- *Reduce unnecessary use of inpatient and ED services, hospital readmissions and wait times*

- *Promote the integration of primary care, behavioral providers (mental health and SUD providers) and community-based organizations*
- *Support care transitions*
- *Support alternative payment models*

Myers and Stauffer was engaged to develop a Health IT Assessment tool to assess the current health IT environment of all IDNs. The HIT Assessment tool is an essential component in the design of the HIT infrastructure needed to support the health care integration project of New Hampshire's DSRIP initiative. The assessment measured both the business and technical aspects of the HIT capabilities and gaps of providers, hospitals, and other consumer-focused entities. The results facilitated discussions on defining required, optional, and desired statewide HIT implementation priorities by the HIT Task Force and will inform the HIT Implementation Plan below.

Myers and Stauffer developed the HIT Assessment tool specifically designed to align with New Hampshire's DSRIP objectives and informed by its HIT experience from similar engagements, research on other states and additional resources, including the Office of the National Coordinator for Health Information Technology's (ONC) Interoperability Standards Advisory (ISA)[ii] (and the Substance Abuse and Mental Health Services Administration's (SAMHSA) behavioral and mental health screening tools.[iii]

The HIT Assessment tool was divided into seven distinct sections that focused on different subject areas. Each section provided a unique set of questions that addressed the requirements of the DSRIP program requirements. The sections included:

1. **Base** – 12 questions: for the organization to provide basic contact information.
2. **Assessment** – 20 multiple choice questions: to assess HIT maturity and provide a corresponding score.
3. **Software** – 20 free response questions: to list EHR systems, consumer support systems, and other state systems.
4. **Patient Record** – 19 dropdown questions: to identify patient information captured and shared by organizations.
5. **Security** – 20 dropdown questions: to assess compliance with Health Insurance Portability and Accountability Act (HIPAA) standards.
6. **Behavioral** – 29 dropdown questions: to identify behavioral health assessments by provider organizations.
7. **HIT** – Four dropdown and three free response questions: to assess barriers, standards, and planned initiatives.

A final comprehensive statewide assessment report was completed in December 2016 based on the HIT Assessments submitted by member organizations. Individual HIT Data Supplements based on the HIT Assessments were provided to each IDN with the final version being received by our region in March 2017.

Statewide Key Findings

Key areas of HIT maturity were analyzed for every IDN region and included Electronic Health Record (EHR) adoption, Health Information Exchange (HIE) adoption, patient access to their health information,

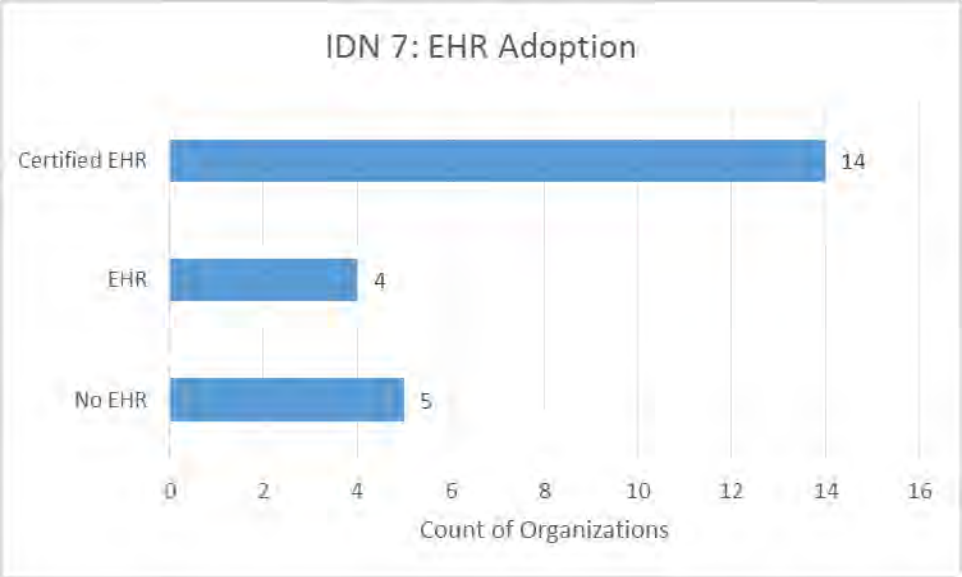
and the ability to track patient consents electronically. While HIT adoption was high for many traditional providers such as hospitals, many community-based organizations had limited HIT infrastructure.

Key findings from the New Hampshire health IT assessment include:

1. **Electronic health data capture capabilities are not widespread among IDN members.** While New Hampshire benefits from a high number of providers having adopted electronic health records (EHRs) at 74% of IDN members, there are a several key provider types that have less than 60% adoption rate including SUD treatment organizations at 57%, community-based organizations at 48%, and public health organizations at only 33%.
2. **Limited capabilities for electronic health data sharing throughout the state, but IDN members use available option.** Despite the limitations in electronic health data sharing among New Hampshire's providers, due in part to legislative restrictions, 48% of IDN member organizations are using or have plans to use Direct Secure Messaging (DSM) through New Hampshire Health Information Organization (NHHIO).
3. **Low rate of patient consents are captured electronically.** The ability to electronically capture patient consents still appears to be in its infancy among IDN members with only 21% of all responding organizations doing so. High adopters of health IT such as hospitals, community mental health centers, and federally qualified health centers (FQHCs) are all below 50% for collecting and storing patient consents by electronic means.
4. **Patient referrals are mostly manual processes.** Sixty-one percent of IDN members responding to the assessment stated that patient referrals are performed manually by either fax, U.S. mail, or telephone. Only a small percentage of organizations, just 15%, are using DSM for referrals.
5. **Patients have limited options to access their health information electronically.** Currently, only 28% of all IDN members responding to the Assessment Tool have a patient portal.
6. **A higher than expected number of IDN members capture at least one social determinant of health data element.** While collection of social determinants of health data is fragmented and inconsistent across the health care continuum[iv], 62% of all IDN member respondents electronically capture at least one area of social determinants of health such as economic stability, education, food, community, and social context.
7. **Funding is available to advance health IT in New Hampshire.** Several of the health IT-related needs identified by IDN members during the assessment and information gathering process may be funded through the Health Information Technology for Economic and Clinical Health (HITECH) Act administrative matching funds or other grant opportunities identified in this report.

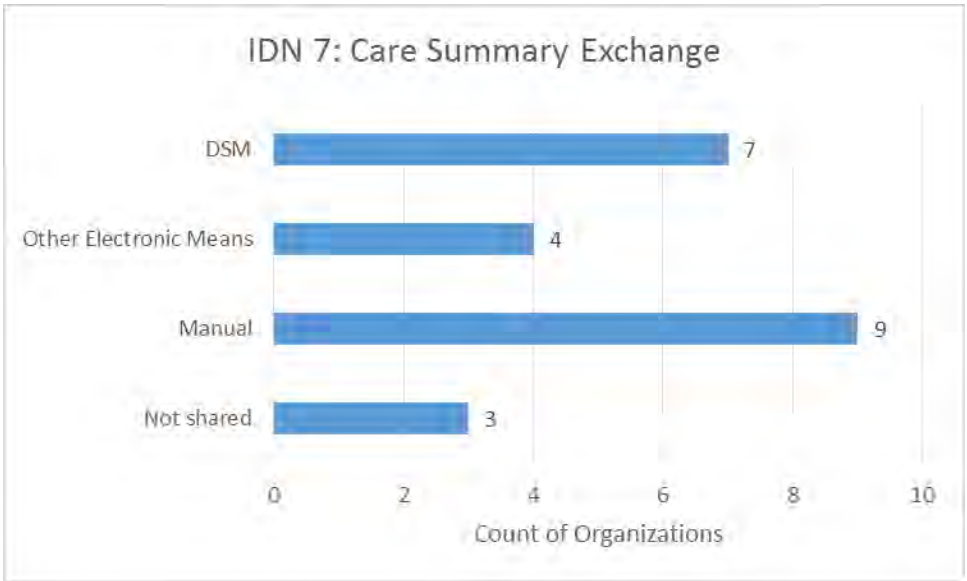
2.2 IDN-7 Specific Findings

Figure 1. EHR Adoption



Based on the final version of the HIT Data Supplement for our region there was a total of eighteen (n=23) organizations that completed the HIT Assessment tool. From the results, fourteen (n=14) organizations attested to having a certified EHR system and four (n=4) organizations attested to having a non-certified EHR system. To be noted, five (n=5) organizations stated that they had no EHR system at all. Organizations with no EHR systems are important to identify in order to determine what further assistance they need to meet the State's DSRIP initiative objectives and our region's goals.

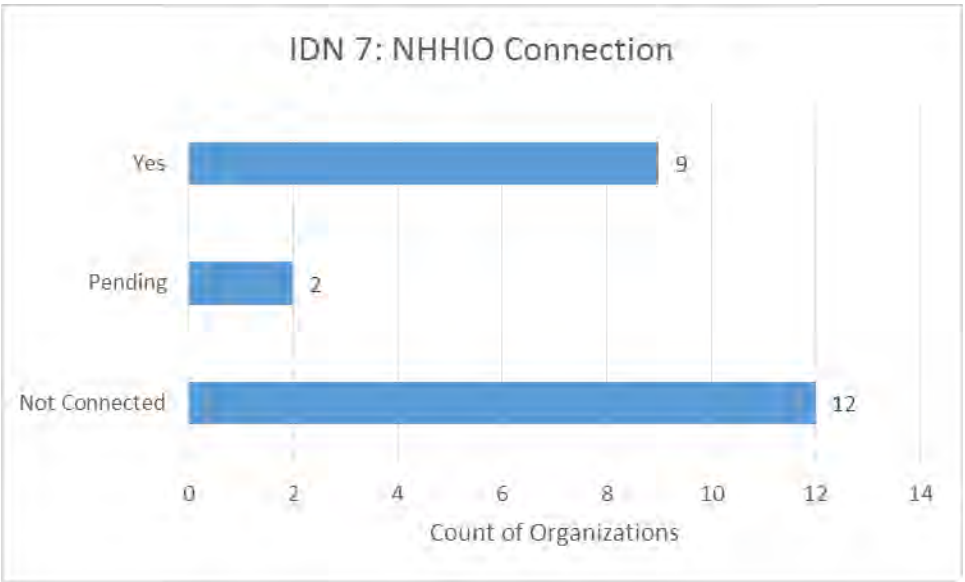
Figure 2. Direct Secure Messaging



Limitations in electronic health data sharing among New Hampshire's providers exists, due in part to legislative restrictions. Because of these limitations, Direct Secure Messaging (DSM) is used through the New Hampshire Health Information Organization (NHHIO). NHHIO serves as a Health Information

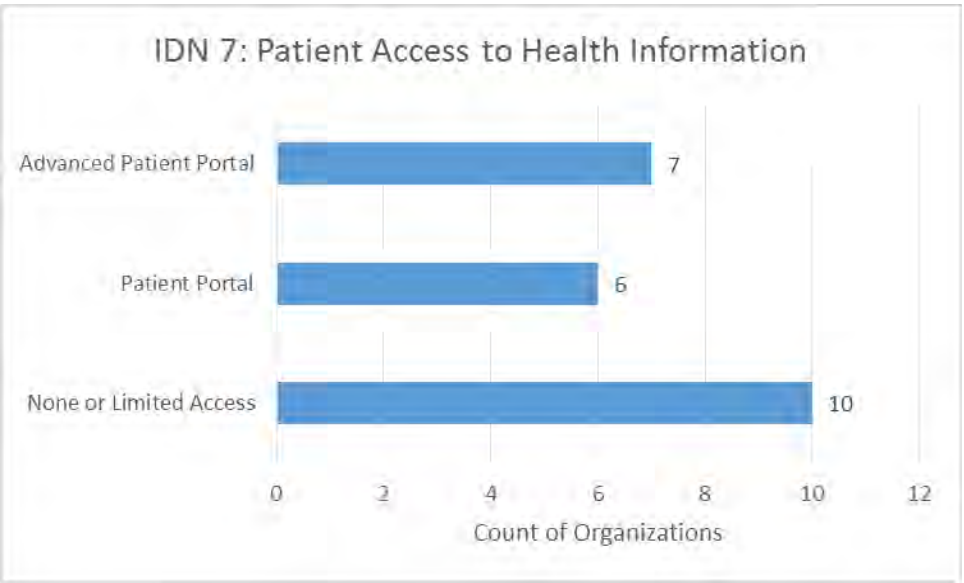
Service Provider (HISP) with a statewide Healthcare Provider Directory (HPD) to support Transfers of Care. NHHIO provides a secure network option for small providers with fewer resources across the care continuum, such as community-based organizations.

Figure 3. Electronic Health Data Sharing



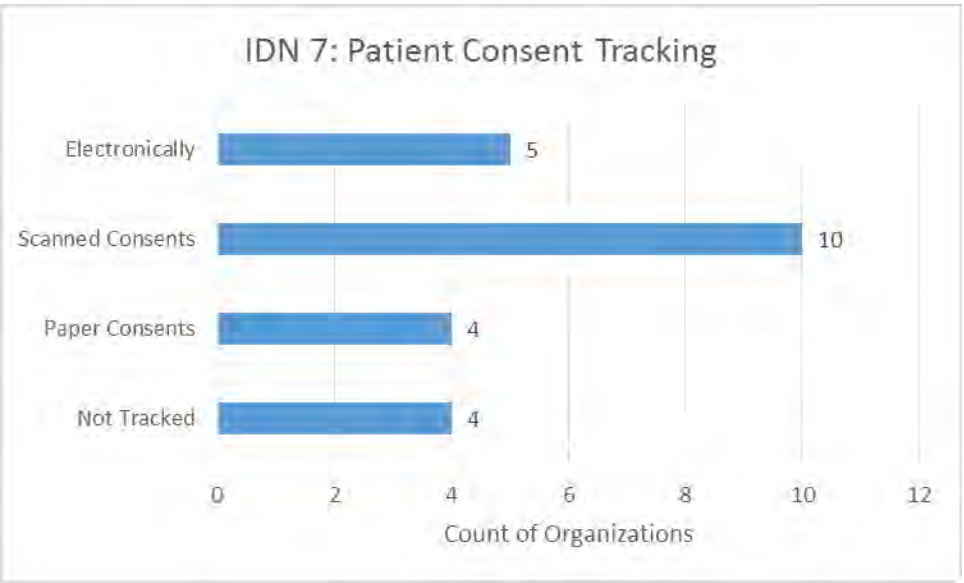
All organizations that completed the HIT Assessment tool were cross referenced with the NHHIO's official list of organizations that are connected. In summary, for our region, nine (n=9) organizations are connected to NHHIO with an additional two (n=2) organizations that are in the process of connecting. Twelve (n=12) organizations are not connected or are not planning on connecting to NHHIO. While progressing through the DSRIP initiative, it will be important to ensure organizations that are not connected to NHHIO to adopt a basic sharing protocol like direct secure messaging.

Figure 4. Patient Access to Health Information



From the HIT Assessment results, a question was asked about patient access to health information. In general, most organizations do not provide easy access to their patient's information. For our region, only seven (n=7) organizations provide an advanced patient portal with at least three of the following features: lab results, appointment scheduling, billing, links to health information websites, prescription refills, referrals, or secure messaging. This compares to ten (n=10) organizations that do not provide a patient portal at all and provide limited access to their patient's information. It will be important to create infrastructure to allow the sensitive substance abuse patients access to their health information.

Figure 5. Patient Consent Tracking



Another critical area for the waiver program is how patient consents are tracked and processed. With patients being shared across multiple regions, it is imperative to define a standardized process. In our region, five (n=5) organizations capture patient consent information entirely electronically in an EHR system. Ten (n=10) organizations scan paper consents into an electronic system while another four (n=4) organizations only capture consents on paper. Four (n=4) organizations do not track patient consents at all. The HIT Taskforce determined that defining a statewide consent form and process should be a priority but it will require additional work outside the scope of HIT. If a statewide standard is defined it will be up to the HIT leads within each region to implement the infrastructure to make sharing easier.

The Challenge of Geography and A Diverse Providers

IDN region 7 encompasses a large geographic area and a sparse population concentrated in approximately seven "sub regions", mostly centered around the hub towns of Berlin, Colebrook, Conway, Lancaster, Littleton, North Haverhill and Wolfeboro. These sub-regions each have their own provider set, including a hospital, primary care, behavioral health, and social determinant providers. Service utilization between these sub regions does happen but most care happens in a patient's sub-region or with region-wide providers such as Northern Human Services (the community mental health center for the region) or Tri-County Community Action Program (a provider of both behavioral health services and social determinant services). This vast geography and smaller pockets of care presents a unique challenge from a care coordination standpoint as well a reduces overall resources for projects such as IT infrastructure, since individual smaller providers have smaller IT budgets.

Addressing Gaps/Needs

In Fall 2016, IDN Region 7 selected the following three community driven projects with the overall goal being to address the following goals:

- Reduce unnecessary use of inpatient and ED services, hospital readmissions and wait times
- Promote the integration of primary care, behavioral providers (mental health and SUD providers) and community-based organizations
- Support care transitions
- Support alternative payment models

IDN 7's regional Health Information Technology/Data Workgroup quickly recognized that that health information technology is a means to an end rather than a goal unto itself and that the well-defined goals outlined above would be accomplished through the HIT-enabled success of the other projects. They committed to the core concept that the HIT project needed to act in support of these three community driven and one mandatory competencies in order to achieve success in its overall goal. The directive for this group, like that of the statewide work group, became focused on finding solutions that would support an effective implementation of the core competency and community driven projects region-wide.

The priorities focused on will include:

- Institute a secure, EHR-compatible electronic shared care plan tool for all direct service providers (both physical and behavioral health, region-wide, to better enable cross-site care coordination.

- Enable event notification triggered by specific patient actions to better enable care coordination and appropriate use of services across a wide region.

- Assist all agencies who could be involved in a patient's care in acquiring a direct secure messaging service allowing for secure transmission of appropriate information, when enabled by patient consent.

- Use data warehouse/data aggregation technologies to satisfy all internally-derived and state-directed reporting requirements of the project.

- Use data aggregation tools to better enable population health management and improve outcomes through better direction of resources.

For specifics on project details please see below:

- **C1: Care Transition Teams**
  - **Project Description:** This project will follow the evidence-based ''Critical Time Intervention'' (CTI) approach to providing care at staged levels of intensity to patients with serious mental illness during transitions from the hospital setting to the community.

- **HIT Support of C1**: Utilization of the region-wide electronic shared care plan tool PreManage ED will allow for portability of patient data from the hospital setting to their primary care doctor for ongoing support, allowing a care manager or community health worker to better manage the care of the patient and make sure that patient care is taking place at the correct provider, preventing unnecessary use of the emergency department. Event notification services will assist similarly in care management of the patient as they transition. Utilization of direct secure messaging will allow secure and timely methods for appropriate involvement of community-based providers when necessary for the ongoing support of the patient. Population health tools enabled through a data aggregator will help care teams identify patients for involvement with the program, better allowing providers to predict which patients would benefit most from a CTI-style care plan.

- **D3: Expansion in Intensive Substance Use Disorder Treatment Options, including Partial Hospital and Residential Care**
  - This project is aimed at expanding capacity within an IDN for delivery of partial intensive outpatient, partial hospital, or residential treatment options for SUD, in conjunction with expansion of lower acuity outpatient counseling.
  - **HIT Support for D3:** Electronic shared care plans will allow better patient flow both in and out of the expanded services, helping to assure proper utilization of services based on the patient's level of need and support their ongoing recovery in a secure manner compliant with privacy regulations. Direct secure messaging between would allow involvement of recovery organizations and social determinant providers such as housing agencies, employment programs and other agencies central to an patient's recovery.
- **E5: Enhanced Care Coordination for High-need Populations**
  - This project aims to develop comprehensive care coordination/management services for high need adult and child populations with multiple physical health and behavioral health chronic conditions.
  - **HIT Support for E5:** Population health analytics will help in identifying the patients who would fall into a high-risk category and help track outcomes. An electronic shared care plan and event notification system will assist care coordinators and community health workers in bringing their skills to bear in support of this population.

All three of these projects were in addition to the core competency project:

- **B1: Integrated Health Care**
  - Primary care providers, behavioral health providers, and social services organizations will partner to implement an integrated care model that reflects the highest possible levels of collaboration/integration as defined within the Substance Abuse and Mental Health Services Administration (SAMHSA) Levels of Integrated Healthcare.
  - **HIT Support for B1:** A shared care plan and electronic sharing of data will be a key component in the formation of multi-disciplinary core teams across agencies in sub-regions and event notification will allow all members of the core team to stay up to date in real time. Direct

secure messaging will allow these teams to effectively communicate with social determinant providers necessary to their patient care. A data aggregator will help assure that a comprehensive core standardized assessment is being delivered to all patients.

By tying HIT components as tightly as possible to the other IDN projects, the IDN can realize a great deal of efficiency in marking sure that its other deliverables are spread throughout the region and that HIT does not become, from a provider perspective, a project unto itself – but rather something that will assist in overcoming the challenges of implementation.

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.

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

During the reporting period of 7/1-12/31/2017 Region 7 IDN had 1 new member agency, North Country Serenity Center, a Recovery Community Center join the network, and no members leave.

Project Component 1: Support Care Coordination

A Note on Vendor Selection:

Working with the Statewide HIT Taskforce, IDN Region 7 has selected Collective Medical Technologies as a regional vendor to fulfill the shared care plan, event notification (send) and event notification (receive), components through their PreManage Community and PreManage ED products.

CMT is a national company with numerous large-scale implementations similar to the New Hampshire DSRIP project in its portfolio. Their software was selected out of a field of 3 separate vendors who were reviewed as being the best fit for the state. The statewide HIT taskforce has selected CMT as the vendor of choice and 5 other regions have also indicated that CMT will provide service moving forward. This is a positive development which will enable an event notification to be passed inter-region, a step important to the success of the program given the flow of patients between regions.

A vendor of choice has not been selected for direct secure messaging, since this capability exists within many certified EHRs already in place. In addition, where on site EHRs do not exist or do not possess such capabilities, New Hampshire Health Information Organization (NHHIO) has been working with providers to successfully deploy direct secure messaging standalone solutions to these. NHHIO's vendor of choice Kno-2 may be the correct vendor to deploy out to community based providers who do not currently have such capabilities, however given the growth in this field, IDN Region 7's HIT Workgroup will continue to work with its participant organizations to select a vendor of choice for this solution.

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

Given the demonstrated needs of providers involved in the B1, C1, D3 and E5 projects (see the assessment and gaps section) to receive real time notifications of patient interactions at hospitals, IDN Region 7 will work with its 7 hospital facilities and vendor Collective Medical Technologies to set up Health Level 7 (HL7) Admit, Discharge and Transfer (ADT) linkages with their software solution, PreManage ED. This tool, in turn, interfaces with the shared care plan tool PreManage Community (the rollout of which is covered in the next component section).

IDN Region 7 had targeted a stretch goal of all regional hospitals sending ADT information to PreManage by 12/31/2017. Work began in August and continued through December to accomplish this goal. As this (along with statewide outcome reporting) has been one of the areas of focus for the early project, find below a facility by facility breakdown for each hospital (the North Country Healthcare affiliation hospitals) were addressed as a group:

North Country Health Care (Androscoggin Valley Hospital, Littleton Regional Healthcare Upper Connecticut Valley Hospital, Weeks Medical Center): The hospitals of the North Country Affiliation have reported that IT resources at their various sites are heavily invested in tasks related to the new affiliation, meaning that they would not be able to dedicate resources in the fall to a full implementation of PreManage ED in their emergency departments. A presentation by the Region 7 HIT Lead and the Region 7 IDN Director on October 31st to the affiliation's presidents was met with great interest but they reiterated that IT resources could not be reassigned until 2018 at the earliest.

A mid-December offer by Dartmouth Hitchcock Medical Center, which already receives ADT data from Androscoggin Valley Hospital, Upper Connecticut Valley Hospital and Weeks Medical Center, to send this information on their behalf to CMT was met with interest and work has proceeded to set up these feeds to go live. However, such a move would still require approval from the executives. This proposal is being presented to the hospital presidents, with the expectation that they will approve and sign all appropriate documents to turn ADT feeds for these three hospitals. The target date for these feeds to go live is now 03/01/2018. ADTs for Littleton Regional Healthcare, as well as PreManage ED implementations for all four hospitals are being targeted for 06/30/2018

Huggins Hospital (Wolfeboro): With the able assistance of Patrick Brown, CIO Of Huggins Hospital and a member of the Statewide IDN HIT Taskforce, Collective Medical Technologies has configured the HL7 ADT feed for Huggins and it is now active. A implementation of PreManage ED on site is now ongoing

Cottage Hospital (Woodsville): After vendor presentations to their Hospital Administrator and CIO, Cottage has expressed interest in going live with PreManage ED. A meeting is slated to be held involving the aforementioned stakeholders, as well as the compliance officer and the ED director in the New Year with the expectation that they will move forward with a target date of 03/01/2018.

Memorial Hospital: Staff at Memorial have indicated that all IT resources are being dedicated to an EMR migrations at their various sites and has asked that we hold off until the New Year to begin engagement. In the New Year, a disaster situation involving flooding of certain facilities has caused this meeting to be delayed again. Contact was re-established with the Director of Population Health and a presentation to her and the Chief Medical Officer will be scheduled to establish stakeholder buy-in. A target date of 06/30/2018 for this hospital to go live with ADT feeds has now been established.

Criteria Selection: In concert with working with region 7s hospital facilities to establish ADT feeds, the IDN Clinical Workgroup has been tasked with approving baseline event notification criteria for all facilities to utilize the ADTs once active. In a meeting held in late December 2017 presented several options for

this criteria and a vote was held in January 2018 to adopt the New Mexico Standards as the baseline for IDN Region 7 on a preliminary basis. The New Mexico criteria are:

- *5 ED Visits in 12 Months*
- *3 ED Visits in 3 different facilities in a 90 day period.*
- *Any patient with an established Care Guideline, either by hospital or Managed Care Organization.*
- *Patients that are within 30 days of discharge from an in-patient stay.*
- *Any patient with a documented Security Event.*

The workgroup has selected these as the baseline, but it is worth noting that individual facilities, once live in PreManage Primary, can make modifications to these criteria or even add criteria of their own to act as match their own use cases. Support will be available both at the IDN 7 and vendor levels to assist with this modification.

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

Recognizing the physical geography of Region 7 and the existence of no less than 7 distinct hospital service areas involving no less than 18 direct care providers, IDN region 7 has selected a phased rollout into three distinct sub regions for CMT's PreManage Community and ED Products. This product will enable not only the shared care plan technologies but also for users to receive event notifications. This product has been successfully used by other large scale healthcare implementations to integrate providers and reduce avoidable emergency department visits. The three sub regions include Carroll County, Northern Grafton Count and Coos County.

The first of these trainings slated to start at a 2 day training scheduled for March 29th and 30th 2018 with providers located in or serving Carroll County. Two separate hour long PreManage Primary trainings will be surrounded by other integration training, with a focus on making the use case for PreManage primary clear to attendees as well as instilling knowledge of the benefits.

In preparation for this regional rollout, IDN Region 7 Providers and Staff have participated in three shared care plan discussions held by Region 1 in October and November in order to prepare for protocols and privacy practices necessary to utilize the shared care plan tool in a diverse, multi-organization environment. Region 7 also coordinated a vendor presentation entitled "the Value of the Shared Care Plan" at the December 2017 quarterly meeting, which generated a great deal of interest from our partners in attendance.

In addition, IDN Region 7 has hired a Health Information Technology (HIT) Integration Coach to assist with the rollout. This staff member will begin in the new year and will spend his first several weeks becoming familiar with the PreManage primary tool and meeting local partners. The goal is to have this individual ready and able to support the rollout when it begins in March.

Finally, IDN Region 7's lead agency, North Country Health Consortium, has agreed to pilot the use of the shared care plan tool prior to the March training with their cadre of community health workers, whose focus is on coordinating the care of a high needs population being served by several local providers. The goal of this implementation is to 1) enhance the ability of these Community Health Workers to serve their target population and 2) build a core of "power users" of the tool within the lead agency and 3) demonstrate the value of the shared care plan tool to the partner agencies with whom these workers interface.

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

In order to allow for the passing of consent-enabled information between disparate sites, IDN Region 7 will be promoting the use and deployment of direct secure messaging to all IDN participants. The HIT Assessment conducted between November of 2016 and February 2017, found that only 7 of 23 responding organizations utilized direct secure messaging for some element of data exchanged- the remainder used a manual process instead or simply did not exchange information. By making direct secure messaging a priority goal for HIT in Region 7, the IDN will ensure that a secure line of communication for all IDN participants enabling integration opportunities for all participants – including those social determinant providers that may lack the HIT infrastructure to accommodate a more robust solution.

An interim HIT capability Census conducted to support the statewide outcome measures reporting conducted in October found that 15 of our 24 direct service medical providers had at least the capability to send via a direct protocol (either native to their EHR or provided by a third party HISP). However, many of these organizations originally gained direct secure messaging capability through the New Hampshire Health Information Organization (NHHIO) are now exploring other alternatives. Meaning they are now looking for IDN support and guidance on either continuing with Kno2 (the NHHIO vendor of choice) or exploring other options.

Because of the varied need for DSM solutions throughout the region, this project will be accomplished by phased rollout enabled through a request for proposal process. Assessment of use cases will be handled by the Region 7 Integration team.

To support this, in the fall IDN Region 7 instituted a streamlined RFP process for HIT-focused projects under $5000. Several providers have already availed themselves of this opportunity and have received funds to respond to IT challenges preventing them from interfacing with others in their region.

To date, no proposals have been received to fund direct. However, with the change to the NHHIO structure in the state and the rollout of the shared care plan that is slated to begin in our region in Q2 2018, our organizations will begin to search for solutions in this area.

Project Component 1/4 Ongoing Assessment Follow Up And Support of Adopted Sub Regions

Recognizing the complexity of the systems involved and the need for ongoing support in the face of a changing care landscape and other challenges, IDN Region 7 commits to the ongoing support of its network as it moves towards meeting the criteria for integrated care and begins the transition into an advanced payment model. To accomplish this on the HIT side, ongoing assessment and follow up will be necessary.

Upon graduation of a sub-region from the initial integration trainings (which include utilization of HIT tools), the team will begin the process of a six-month monitoring and assessment period, using the following methods to assess performance

Individual Interview-Style Follow Up With Sites
Vendor utilization data
HIT Utilization Survey (developed by the HIT working group and conducted at the end of the assessment period)

Following this six-month assessment period, the regional team will convene the original trainees from IDN direct care participants as well as community-based providers from the area in a learning collaborative environment to present the results of their assessment. The group will emerge from this learning collaborative with recommendations for follow-up. The regional team will take these recommendations to form a 6 month follow up plan and work to close the gaps identified through the assessment.

Given that the initial integration trainings are not scheduled to begin until late March 2018, only preparatory actions have been taken by the IDN at this point, including the hiring of a Health Information Technology Integration Coach and messaging to the providers about the value of shared care planning and event notification components.

Project Component #2: Data Management

HIT Capabilities and Standards Addressed	Minimum/Desired Optional	For Whom	By When
Data Extraction / Validation	Minimum	All Participants	By 03/01/2018
Data Analysis / Validation	Optional	Regional Lead	By 03/01/2018
Population Health Tool	Optional	Regional Lead, Selected Participants	By 08/01/2018

A project with the scope and complexity of the DSRIP requires extensive data management for the purposes of reporting to funders and internal evaluation for process improvement. In addition, many of the projects, such as E5 and C1 would benefit from a comprehensive population health analytics solution, which could be enabled through the same infrastructure. Therefore IDN Region 7 is proposing pursuit of a regional data management infrastructure as an HIT project component.

Project Component 2/1: Regional Data Infrastructure Buildout

The most pressing need for data management is to create a regional structure that will accommodate reporting on outcome measures for all 6 DSRIP projects in a regional manner. Though the nature of phased project rollouts means that the 12/31/2017 reporting period will involve numerous process measures that can be handled through existing methods of communication, the 04/01/2018 deadline for reporting on statewide outcome measures means that a more robust and integrated solution is required, at least for the Medicaid-billing participants.

IDN Region 7 participated fully in the vendor demos and reviews organized at the state level to ensure that the correct vendor was selected for this important task. The regional HIT leads and data/HIT representatives of 3 partner organizations all participated in this process, which resulted in the selection of Massachussets Area E-Health Collaborative (MAEHC) to fulfill this need. A combination of MAEHC's success in similar initiatives and a demonstrated ability to report crosss-platform made them the consensus selection of Region 7 respondents as well as the state.

In order to conduct proper legal review of the MAEHC contract, IDN Region 7 needed to delay its signing of this contract until the New Year pushing back many preparatory actions until this document was in place.

However, IDN Region 7 Partners were exposed to frequent messaging about the upcoming reporting deadline on HIT/Data Workgroup phone calls throughout the reporting period and updates to all partners at our September and December quarterly meetings. This messaging focused on the data to be captured and the timelines involved. In addition, MAEHC graciously agreed to begin laying the framework for participation by holding a regional kickoff call in mid-November, allowing partners from the various IDN partners to understand their role in this reporting and began outreach to partners in late December. The decision was made to concentrate our initial outreach only to those providers needed for the initial round of reporting (being primary care and behavioral health Medicaid-billing settings). Other settings, such as hospitals, will be brought in for later reporting when necessary.

IDN Region 7, in order to support the proper exchange of data has begun a parallel process of gathering signed business associate agreements and user agreements for the MAEHC software with 4 partners as of this writing having signed BAAs on record with the remainder being expected by the reporting deadline.

In addition, the IDN and MAEHC have begun to prepare outreach in February to guide partners in advance of the August reporting deadline, which contains several other measures across a wider range of settings.

Project Component 2/2: Population Health Analytics

Though the primary purpose for the selection of a data aggregator is to ease the burden of reporting on both the participant organizations and the administrative lead, all vendors reviewed to date have demonstrated elements of population health analytics within their solutions. Since all three community driven projects and the core competency will require some examination of population health, either for the purposes of quality improvement above and beyond the regional and statewide outcome measures or for tracking of individual high risk patients for purpose of implementation, IDN Region 7 commits to a trial period of population health analytics.

This will be accomplished first through an exploration of the selected tools capabilities in this area, a process targeted for completion by 06/30/2018. Once this has been determined, IDN Region 7 will work to create a trial population health protocols, enabled through the aggregator, that will support project E5 (Enhanced Care Coordination for High Needs Populations). Though this exploration has yet to be done, possible areas to address would be the identification of high needs populations that may be otherwise be going unseen and determining shared characteristics of successful patients already in the population.

Once these protocols have been outlined, Region 7 will seek a volunteer organization already involved in the E5 project that would be willing to trial them in late 2018. A joint presentation will be made to the Region 7 Steering committee before the end of the year, highlighting the successes and lessons from this process. From here, the steering committee will determine whether to expand this tool to other practices.

This project still lies in the future, however to prepare for its rollout, IDN Region 7 is considering engaging an outside data analytics firm to assist with this task, providing advice on protocols and practices to utilize existing resources to give our providers great information about their populations. Several potential firms have been interviewed and IDN Region 7 is in the process of reviewing them for best fit.

Project Component 3: Support HIT Improvement Throughout the Region Through RFP Process

Potential HIT Capabilities and Standards Addressed	Minimum/Desired Optional	For Whom
Secured Data Storage	Minimum	All Participants
Electronic Data Capture	Minimum	All Participants
Internet connectivity	Minimum	All Participants
Discrete Electronic Data Capture	Desired	All Participants
Integrated Direct Messaging	Desired	All Participants
Patient Engagement Technology	Optional	All Participants
Capacity Management Tools	Optional	All Participants

Throughout the capacity building period, IDN Region 7 has sought to allow for local innovation on the part of providers, trusting in the natural resourcefulness of Northern New Hampshire providers who have historically operated in this challenging environment to bring forward solutions best suited to their local conditions. Region 7 plans to continue this in the implementation period, giving participants a chance to seek funding for their own innovative project components s above and beyond the region-wide projects outlined above. This will be handled through a request for proposal process offered on a semi-annual basis.

For HIT Project funding, preference will be given to participant organizations seeking funding to do the following (from highest priority to lowest)

Create, improve or expand current health information exchange (HIE) infrastructure
Create or improve their ability to store or transmit patient data in a secure manner
Assure stable and secure internet connectivity
Create or enhance ability to capture and transmit patient consents electronically
Offer innovative technology-enabled patient engagement solutions
Other HIT capabilities supportive of DSRIP integration of care goals

HIT Proposals funded in the reporting period 07/01/2017-12/31/2017 which fall into the general IT categories include:

Northern Human Services - $2000 computer and printer to support integration of behavioral and physical health

Partner Organization	Funding Allocated	Project Description	HIT Component
North County Healthcare	$50,000	For software communication platform and provider directory to ensure that patients accessing an online call center are directed appropriately to providers across the physical health/behavioral health continuum.	Patient Engagement Technology/ Capacity Management Tools
Memorial Hospital/Saco River Medical Group/Visiting Nurse Home Care and Hospice of Carroll County/Children Unlimited Inc.	$3,434	For EHR licenses and workstations to support data capture in an integrated settings involving primary care, behavioral health, home health and social determinant providers.	Discrete Electronic Data Capture/ Secured Data Storage
Carroll County Corrections	$2,060	IT needs related to the implementation of Critical Time Intervention	Discrete Electronic Data Capture/ Secured Data Storage
Tri County Community Action Program	$4,481	IT Support to develop and track Critical Time Intervention Components	Discrete Electronic Data Capture/ Secured Data Storage
White Mountains Community Health Center	$1,811	Purchase of electronic prescribing module, training and IT support	Discrete Electronic Data Capture/ Secured Data Storage
Northern Human Services/Coos County Family Health Services	$2,000	Hardware purchases to support collocation of behavioral and physical health services in a single setting.	Discrete Electronic Data Capture/ Secured Data Storage
Total	$63,786		

A2-4. IDN HIT: Evaluation Project Targets

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

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
Participant sites with at least one staff member trained in use of PreManage Primary	18	0		
Number of Participants Exchanging Information Via Shared Care Plan Tool	18	0		
Hospitals Sending Event Notifications To PreManage ED	7	1		
Number of Participants Exchanging Information Via Direct Secure Messaging (By 2020)	35	15 (presence of capabilities only)		
Reporting Periods Successfully Completed (By 2020)	20	0		
Pilot Participants Using Population Health Tool (By 2020)	5	0		
Region 7 Patient Lives In PreManage Primary (By 2020)	19601	0		
Participant HIT Projects Addressing Minimum/Desired/Optional Capabilities Funded and Completed (By 2020)	5	0		

A2-5. IDN HIT: Workforce Staffing

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

Staff Type	IDN Workforce (FTEs)				
	Projected Total Need	Baseline Staffing on 6/30/17	Staffing on 12/31/17	Staffing on 6/30/18	Staffing on 12/31/18
HIT Lead	1	1	1		
HIT Integration Coach	1	0	0		
Data Specialist (at NCHC)	1	0	0		
Data Aggregator Specialists in community (through proposal process)	Up to 3	0	0		

A2-6. IDN HIT: Budget

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

Budget Period:	**01/01/2017-12/31/2020**	**07/01/2017-12/31/2017**	**07/01/2017-12/31/2017**	**01/01/2018-12/31/2020**	
	HIT Budget	**HIT Budget (6 months)**	**HIT Actual Expense (6 months)**	**HIT Budget Projection (remaining project period)**	
Line Item	**Total**	**Total**	**Total**	**Total**	**NARRATIVE:**
1. Total Salary/Wages					
2. Employee Benefits					
3. Consultants					
5. Supplies:					
Educational					
Office	$55,142	$6,893	$984	$41,357	**YR2-YR5:** Org.-Wide Office Supply Allocation & New Hire Set ups
6. Travel	$90,960	$11,370	$281	$68,220	**YR2-YR5:** Travel expenses for regional & conference/training expenses
7. Occupancy					
8. Current Expenses					
Telephone					
Postage					
Subscriptions	$674,923	$84,365	$2,091	$506,192	**Additional Notes:** Delayed vendor invoicing and timed payment options contribute to under-budget status.
Audit and Legal					
Insurance					

Board Expenses					
9. Software	$3,790	$474	$3	$2,843	**YR2-YR5:** Proposal Software
10. Marketing/Communications	$4,556	$570	$1,180	$3,417	**YR2-YR5:** Org.-Wide Marketing/Communications Allocation & Outreach materials
11. Staff Education and Training	$113,700	$14,213	$559	$85,275	**YR2-YR5**: anticipated trainings/conferences
12. Subcontracts/Agreements					
13. Other (specific details mandatory):					
Current Expenses: Administrative Lead Organizational Support	$17,904	$2,238	$1,739	$13,428	**YR2-YR5:** Telephone/Postage/Audit&Legal/Insurance
Support Payments to Partners	$145,000	$18,125	$48,309	$108,750	**YR2-YR5**: Supplies/Travel/Shared Care Plan; **Additional Notes:** RFPs awarded. Payment in various stages pending MOU execution and reporting deliverables.
TOTAL	**$1,495,962**	**$186,995**	**$75,015**	**$1,121,972**	

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

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

Organization Name	Organization Type
Affordable Housing Education and Development (AHEAD)	Community-Based Organization providing social and support services; Other- Affordable Housing Organization
Ammonoosuc Community Health Services	Federally Qualified Health Center (FQHC)
Androscoggin Valley Home Care Services	Home and Community- Based Care Provider
Androscoggin Valley Hospital	Hospital Facility
Carroll County Coalition for Public Health	Community-Based Organization providing social and support services
Carroll County Department of Corrections	Country Corrections Facility
Central New Hampshire Visiting Nurse Association & Hospice	Home and Community- Based Care Provider

Organization Name	Organization Type
Children Unlimited	Community-Based Organization providing social and support services
Coos County Family Health Services	Federally Qualified Health Center (FQHC)
Cottage Hospital	Hospital Facility
Crotched Mountain Foundation	Hospital Facility; Community-based organization providing social and support services
Grafton County Department of Corrections	County Corrections Facility
Grafton County Nursing Home	County Nursing Facility
Granite State Independent Living	Home and Community- Based Care Provider
Hope for NH Recovery	Community-based organization - recovery center
Huggins Hospital	Primary Care Practice; Hospital Facility
Indian Stream Health Center	Federally Qualified Health Center (FQHC); Substance Use Disorder; Non-CMHC Mental Health Provider; Community-based Organization providing social and support services
Life Coping, Inc.	Community-based
Littleton Regional Healthcare	Hospital Facility; Rural Health Clinic
Memorial Hospital	Hospital Facility
MWV Supports Recovery	Peer Support Agency
National Alliance on Mental Illness	Community-based organization providing social and support services
North Country Health Consortium	Substance Use Disorder Treatment (After 10/01/2017)
North Country Healthcare	North Country Hospital Affiliation
Northern Human Services	Substance Use Disorder Provider; Community Mental Health Center (CMHC); Community-Based Organization Providing Social and Support Services
Rowe Health Center	Rural Health Clinic
Saco River Medical Group	Rural Health Clinic

Organization Name	Organization Type
ServiceLink Resource Center of Carroll County and Grafton County	Community-Based Organization providing social and support services
Tri-County Community Action Program, Inc.	Substance Use Disorder Provider (until 10/01/2017); Community-Based Organization Providing Social and Support Services; Home and Community-Based Care Provider
Upper Connecticut Valley Hospital	Hospital Facility
Visiting Nurse Home Care and Hospice of Carroll County	Home and Community- Based Care Provider
Weeks Medical Center	Primary Care Practice; Hospital Facility; Rural Health Clinic
White Horse Addiction Center	Addiction & Recovery
White Mountain Community Health Center	Non-FQHC Community Health Partner

A2-8. IDN HIT. Data Agreement

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

Organization Name	Data Sharing Agreement Signed Y/N
Affordable Housing Education and Development (AHEAD)	N
Ammonoosuc Community Health Services	N
Androscoggin Valley Home Care Services	N
Androscoggin Valley Hospital	N
Carroll County Coalition for Public Health	N
Carroll County Department of Corrections	N
Central New Hampshire Visiting Nurse Association & Hospice	N
Children Unlimited	N
Coos County Family Health Services	N
Cottage Hospital	N
Crotched Mountain Foundation	N
Grafton County Department of Corrections	N

Organization Name	Data Sharing Agreement Signed Y/N
Grafton County Nursing Home	N
Granite State Independent Living	N
Hope for NH Recovery	N
Huggins Hospital	N
Indian Stream Health Center	N
Life Coping, Inc.	N
Littleton Regional Healthcare	N
Memorial Hospital	N
MWV Supports Recovery	N
National Alliance on Mental Illness	N
North Country Healthcare	N
Northern Human Services	N
Rowe Health Center	N
Saco River Medical Group	N
ServiceLink Resource Center of Carroll County and Grafton County	N
Tri-County Community Action Program, Inc.	N
Upper Connecticut Valley Hospital	N
Visiting Nurse Home Care and Hospice of Carroll County	N
Weeks Medical Center	N
White Horse Addiction Center	N
White Mountain Community Health Center	N

Region 7 IDN has not signed a contract with MAeHC as of 12/31/2017. As a result, NCHC has not moved forward to get executed data use agreements with IDN partner agencies yet. Once the MAeHC contract has been reviewed by the IDN's legal counsel NCHC will move forward to get data use agreements executed. NCHC anticipates the legal review to be finalized in January 2018 and will work to get data use agreements in place with behavioral health and primary care organizations ahead of the MAeHC reporting requirement deadline of 2/28/2018. NCHC will not be asking for these documents from 42CFR Part 2 providers until later in 2018 to allow for more time to figure out data sharing with 42CFR Part 2 providers.

A2-9. 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
A2-1	IDN Participation in Statewide HIT Taskforce	Table				
A2-2	IDN HIT/HIE Assessment and Gap Analysis	Narrative				
A2-3	IDN HIT/HIE Implementation Plan and Timeline	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				

Project B1: Integrated Healthcare

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

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

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

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

To assess the current level of behavioral health integration existing in participating behavioral health and primary care practices, and to demonstrate progress over time, NCHC contracted with Citizens Health Initiative (CHI) and UNH Institute for Health Policy and Practice (IHPP) to electronically administer a Site Self-Assessment (SSA) Survey to behavioral health and primary care practices. The baseline assessment was conducted in June 2017, and the first 6 month follow up survey was administered in December 2017. The next survey is scheduled to be deployed in June 2018, and then on a yearly basis to quantitatively and qualitatively measure the progress of these practices as they move along the continuum of integrated healthcare. When the SSA is quantified, it can be trended over time and compared across organizations by question or in aggregate.

The SSA is based on the Maine Health Access Foundation Site Self-Assessment (MeHAF SSA) and asks respondents to answer 9 questions related to characteristics about integrated services and patient and family services, and 9 questions related to characteristics about their respective practice or organization. Once partner agencies complete the surveys CHI compiled and analyzed the scores, and cross walked the results using the SAMHSA/SSA Crosswalk Guide. The crosswalk is intended to be used as a guide to assist practices with applying the principals of integration and quality improvement science.

Staff from CHI analyzed the survey results and then presented the results to NCHC, making sure to point out where practices landed along the continuum of integration, which sites were high and low performers, and areas for improvement. As predicted during the baseline assessment process, a few practices had scores which dropped, this may be because they initially rated themselves too high to begin with. Since the surveys are a self-assessment some of the results may be a bit skewed based on how the questions are interpreted and who fills out the survey, especially if the same people ae not involved in the process as the surveys are repeated. Even though the Region's IDN Quality Improvement team wasn't fully established during the reporting period, the region still saw an overall improvement in scores for the 6 month follow up surveys. CHI explained that the survey itself is a quality improvement intervention. The survey and the process to complete it gets staff talking and thinking about integration, and how they will work together to improve their scores on the next survey.

Region 7 IDN had 19 practices complete the baseline survey and 17 practices complete the 6 months follow up survey. One of these practices completed the survey for the first time, so these results will become their baseline information. CHI reported to NCHC that this was great follow up for a survey of this type and shows the commitment of the region as they work to improve the level of integrated healthcare. Overall, for the reporting period of 7/1-12/31/17 the region scored 125 points out of 180

points, up from 119 points scored for the baseline assessments, as depicted in the image below. These findings are very similar to what for agencies participating in CHIs Behavioral Health Integration Learning Collaborative, and when the state of Maine started using the Maine Health Access Foundation Site Self-Assessment.

Below are the survey results based on SAMHSA/SSA Crosswalk Guide. Currently the site self-assessment scores for Region 7 IDN reflect that the region is functioning at a Level IV on the SAMHSA Six Levels of Integration scale. This is the same category that the region reported in June 2017, but the region is on the cusp of moving to the next level. Many IDN partners have made significant strides to become patient centered medical homes and participate in both accountable care organizations and community care organizations. This, in conjunction with IDN partners having a strong history of collaborating for a variety of reasons, has positioned Region 7 IDN to have a great foundation for the DSRIP program.

SAMHSA/SSA Crosswalk

SAMHSA Six Levels of Integration					
COORDINATED CARE		CO-LOCATED CARE		INTEGRATED CARE	
I Minimal Coordinated Care, Silos	II Basic Collaboration at a Distance	III Basic Onsite Collaboration	IV Close Collaboration On Site with Some Systems Collaboration	V Close Collaboration Approaching a Fully Integrated Practice	VI Fully Collaboration Merge Transformed Integrated Practice
Separate systems Separate culture Limited communication	Separate systems Separate culture Communication mostly written	Separate systems Separate culture Same facilities Occasional face-to-face meetings General role appreciation Communication occasionally face-to-face	Some shared systems Face-to-face consultation Coordinated treatment plans Basic appreciation of each other's role and cultures Collaborative routines difficult time and operation barriers Influence sharing	Shared systems and facilities Consumers and providers have same expectations In-depth appreciation of roles and culture Collaborative routines Conscious influence	Single transformed practice, treats the whole patient

MeHAF Site Self-Assessment Score Levels									
1	2	3	4	5	6	7	8	9	10
INTEGRATED SERVICES AND PATIENT AND FAMILY-CENTEREDNESS and PRACTICE/ORGANIZATION DOMAIN TOTAL									
0-18	*19-46*		*47-82*		*83-126*		*127-162*		*163-180*

The image below depicts the breakdown of the 2 domains used in the site self-assessment survey: Integrated Services and Patient and Family Centeredness and the Practice/Organization. When looking closely at these numbers you will see slight changes in numerous categories. One of the significant increases occurs within Domain Two – Funding Sources/Resources. This increase is most likely due to Region 7 IDN has been successful in getting funds out to partners for both capacity building and project implementation.

IDN Region: 7

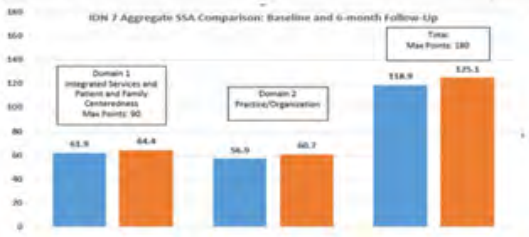
Site Self-Assessment (SSA) Roll-Up Report

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

	BL	F/U 1
1. Level of integration: primary care and mental/behavioral health care	5.8	6.0
2. Screening and assessment for emotional/behavioral health needs (e.g. stress, depression, anxiety, substance abuse)	7.7	8.0
3. Treatment plan(s) for primary care and behavioral/mental health care	6.3	6.8
4. Patient care that is based on (or informed by) best practice evidence for BH/MH and primary care	7.2	7.9
5. Patient/family involvement in care plan	7.3	7.6
6. Communication with patients about integrated care	6.6	6.6
7. Follow-Up of assessments, tests, treatment, referrals and other services	7.7	7.7
8. Social support (for patients to implement recommended treatment)	6.6	6.8
9. Linking to community resources	6.8	6.9

Average Scores: Domain Two
Practice/Organization

	BL	F/U..
1. Organizational leadership for integrated care	7.8	8.0
2. Patient care team for implementing integrated care	5.5	6.6
3. Providers' engagement with integrated care ("buy-in")	6.5	6.9
4. Continuity of care between primary care and behavioral/mental health	6.1	6.3
5. Coordination of referrals and specialists	6.8	6.9
6. Data systems/patient records	6.9	6.9
7. Patient/family input to integration management	4.9	5.4
8. Physician, team and staff education and training for integrated care	5.6	6.1
9. Funding sources/resources	6.9	7.5



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

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Institute for Health Policy & Practice
Maine Health Access Foundation. Site Self-Assessment. Updated 2016

CITIZENS HEALTH INITIATIVE

Region 7 IDN used the baseline survey results from June 2017 and targeted the following areas for improvement: level of integration - primary care and mental/behavioral health care; patient care team for implementing integrated care; patient/family input to integration management; and physician, team and staff education and training for integrated care. It is encouraging to see some improvement in all of these areas in the 6 month follow up survey, and shows the commitment of partner agencies as they work to improve integration.

Maine Health Access Foundation Site Self-Assessment categories	Baseline survey results June 2017	6 month follow up survey results December 2017
level of integration - primary care and mental/behavioral health care	5.8	6.0
patient/family input to integration management;	4.9	5.4
physician, team and staff education and training for integrated care	5.6	6.1

patient care team for implementing integrated care	5.5	6.6

The information shared below highlights suggested opportunities for improvement as the region works to advance along the continuum of integrated healthcare. This information in this chart can be used as agencies work on quality improvement plans and will be useful as IDN staff reach out to partner agencies to discuss DSRIP requirements and improving health outcomes in the region.

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

SSA No.	1. Level of integration: primary care and mental/ behavioral health care	3. Treatment plan(s) for primary care and behavioral/ mental health care	6. Communication with pati e..	7. Follow-Up of assessments, tests, treatment, referrals and other services	9. Linking to community resources	8. Social support (for patients to implement recommended treatment)	4. Patient care that is based on (or informed by) best practice evidence for BH/MH and primary care	5. Patient/family involvement in care plan	2. Screening and assessment for emotional/ behavioral health needs (e.g. stress, depression, anxiety, substance ab..
F/U 1	6.0	6.8	6.6	7.7	6.9	6.8	7.9	7.6	8.0
BL	5.8	6.3	6.6	7.7	6.8	6.6	7.2	7.3	7.7

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

SSA No.	9. Funding sources/ resources	8. Physician, team and staff education and training for integrated ca..	6. Data systems/ patient records	7. Patient/family input to integration management	4. Continuity of care between primary care and behavior..	5. Coordination of referrals and specialists	2. Patient care team for implementing integrated care	1. Organizational leadership for integrated care	3. Providers' engagement with integrated care ("buy-in")
F/U 1	7.5	6.1	6.9	5.4	6.3	6.9	6.6	8.0	6.9
BL	6.9	5.6	6.9	4.9	6.1	6.8	5.5	7.8	6.5

Below is a chart reflecting composite scores by practice site for both the baseline assessment and the 6-month follow up survey.

Composite scores by Practice		
Practice Site	**June 2017 Baseline Results**	**December 2017 Follow – Up Results**
	153	153
	124	120
	103	115
	91	125
	145	150
	109	123
	132	127
	154	174
	86	105

	116	136
	118	127
	121	121
	121	121
	117	119
	117	119
	124	120
	N/A	86

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 to complement the project plan or provide further explanation.

The *Coordinated Care Practice* must include:

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

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

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

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

During the reporting period of 7/1-12/31/2017 Region 7 IDN had 1 new member agency, North Country Serenity Center, a Recovery Community Center join the network, and no members leave.

Region 7 IDN's implementation plan states that the region will build a delivery system that prevents, treats, and manages acute and chronic behavioral health and physical illnesses across multiple providers and sites of service to meet DSRIIP goals: reduce avoidable acute care admissions and ED utilization, and measurably improve the health status for Medicaid beneficiaries and other state residents. The center of the DSRIP program is the required Core Competency Project which focuses on the integration of care across primary care, behavioral health (mental health and substance misuse/substance use disorder (SUD)) and social support service providers. This project, in conjunction with working to improve care transitions, enhance care coordination for the high needs population, and expand SUD treatment options, will lead to an integrated behavioral health delivery system. The region will address behavioral health workforce shortages and develop an HIT infrastructure to support integrated healthcare. The region's implementation plan outlines the following process to achieve this:

- Utilize the Maine Health Access Foundation Site Self-Assessment (MeHAF SSA) to assess the level of behavioral health integration existing in participating behavioral health and primary care practices, and to demonstrate progress over time.
- Hire a quality improvement team
- Use a three-pronged approach to help transform the delivery of behavioral health care in the region:
    - adequately train the workforce to meet SAMHSA's 9 Core Competencies, by designing a comprehensive training plan
    - follow a continuum of care model which addresses prevention, early intervention, treatment, and recovery support services;
    - focus on transitional services.
- Provide training, support and financial incentives for the primary care and behavioral health providers in the region to progress along a path from their current state of practice toward the highest feasible level of integrated care.
- Develop a Region 7 Core Competency Integration Toolkit to help practices advance along the continuum of integrated healthcare
- Assist participating behavioral health and primary care practices as they work to implement the 5 following components required to reach a level of coordinated care by December 31, 2018:
    - Comprehensive Core Standardized Assessment
    - Multi-Disciplinary Core Team
    - Standardized Workflows and Protocols
    - Information Sharing: Care Plans, Treatment Plans, Case Conferences

Maine Health Access Foundation Site Self-Assessment:

Region 7 IDN has made great progress under the Core Competency project during the reporting period of 7/1-12/31/17. As previously mentioned, 17 behavioral health and primary care practices across the region completed the 6-month Maine Health Access Foundation Site Self-Assessment. The region scored 125 points out of 180 points, up from 119 points scored for the baseline assessments. This shows the region is starting to see some progress as participating agencies work to advance along the continuum of integrated healthcare.

Quality Improvement Team:

Region 7 IDN's implementation plan stated that NCHC would recruit for a full-time Integration Coach and a Quality Improvement Coach to help the region advance along the continuum of integrated health

care. NCHC did recruit for both positions, and hired an Integration Coach, although only part-time to start. The Integration Coach hired has a behavioral health background, has experience in implementation of electronic health records, and has worked with agencies developing integrated care programs using SAMHSA's Primary Care Behavioral Health Integration funding. This vast amount of experience will lend itself well to work with IDN partners as the region works to implement the shared care plan. The IDN Integration Coach will start to engage with IDN partners in January 2018.

The Quality Improvement Coach has been a more challenging position to fill, so currently the region has decided to leverage the expertise of the NCHC practice facilitators working with the Practice Transformation Network (PTN) and shift a portion of their time to provide guidance to the IDN. The PTN is designed to promote broad payment and practice reform in primary care and specialty care, promote care coordination between providers of services and suppliers, establish community-based health teams to support chronic care management, and promote improved quality and reduced cost by developing a collaborative of institutions that support practice transformation.

NCHC practice facilitators work with 3 practices which are also members of Region 7 IDN: Northern Human Services (NHS), Huggins Hospital, and White Mountain Community Health Center (WMCHC). NCHC has been having cross-collaboration discussion with these 3 agencies and staff from both the PTN and IDN since June 2017 as the agencies expressed questions and concerns about the overlap of the 2 programs. There are numerous goals within the PTN which align very closely with IDN deliverables such as engaging the patient and family in collaborative goal setting, self-management, and decision making; conducting patient screenings and assessments; ensuring roles and responsibilities are in place for providers and care teams; and that clear communication and a closed loop referral process is in place. However, one PTN goal connects the two programs unequivocally: practices encourage care which addresses the whole person, including mental and physical health, by ensuring access to behavioral health services is in place. The three agencies have agreed to work with the NCHC practice facilitators to pilot a model which will use the IDN requirements of integrated healthcare to meet this PTN goal. The workflows and protocols that get developed because of this work will be shared with other Region 7 IDN partners.

The practice transformation facilitator working with Northern Human Services has been reviewing workflows related to communication with primary care providers, and how closed loop referrals are addressed. They have developed baseline work flows for new patient referrals and provider communication and are ready to modify to include shared care planning. Discussions have begun regarding warm handoffs, direct secure messaging, and communication with the referring provider. In addition, staff at all NHS locations have received training in quality improvement and how to implement PDSAs to improve workflows. This work will serve as a foundation to help the practice meet the IDN requirements, including the use of the shared care plan.

The Manager of Population Health & Care Coordination at Huggins Hospital staff has been actively working with the NCHC practice transformation facilitator to implement a hypertension management project, develop the care coordination process to include behavioral health integration, and work on quality improvement trainings for the staff. The licensed clinical social worker at Huggins Hospital has been included in discussions as the group works to draft a workflow that documents the current care coordination processes in place, and then incorporate the IDN core competencies related to behavioral health integration into the new workflow. The NCHC practice transformation facilitator plans to observe the current process and make suggestions for improvement as the new workflow is

implemented, which includes a work plan for each step of the workflow that identifies needed policies, procedures, and trainings for staff.

The Director of Operations at White Mountain Community Health Center(WMCHC) is also willing to work with the NCHC practice transformation facilitator to create a workflow that meets both the IDN and PTN competencies/milestones. WMCHC has 2 staff members currently attending a community health worker training offered through NCHC. The CHWs will be instrumental as WMCHC works to create a care coordination department. The NCHC practice facilitator has been working with the agency to outline the process and workflow to get this care coordination department developed during the first half of 2018. They are outlining processes for establishment of new patient, shared decision making shared care plan, core standardized assessment, risk stratification, and referrals, and connecting to social service providers and multi-disciplinary core team as necessary.

The willingness of these 3 agencies to work together to figure out the intersection of the IDN/PTN deliverables is exciting because all 3 of these agencies serve patients in Carroll County, and Region 7 IDN stated it would roll out the shared care plan, multidisciplinary core teams, and the regional care coordination approach in the Carroll County sub-region first. Having these 3 agencies serve as a pilot model for the development of workflows and protocols will lay a solid foundation for the rest of the Region 7 IDN partners as they work to improve behavioral health integration. The 3 agencies are working to schedule a time to meet to discuss workflows and processes as patients move from agency to agency across the region. The work that occurs because of this meeting will help set the agenda for the first regional care coordination training scheduled for March 2018.

Three-pronged approach to help transform the delivery of behavioral health care in the region:
Region 7 IDN is utilizing a three-prong approach to help the region advance along the continuum of integrated healthcare. The region is implementing the Critical Time Intervention model to help reduce gaps in care during transitions across care settings. This model is currently being used at the Carroll County Department of Corrections to provide support to incarcerated people as they transition into the community. The model is also being used at Tri-County Community Action Program to help patients in their Homeless Intervention and Outreach Supportive Housing Care Coordination Project. Tri-County Community Action serves the entire region, and it is exciting that they are addressing supportive housing, an issue that is a priority for the state. Eleven Region 7 IDN partners participated in the CTI Worker training on 11/15-11/16 and 3 partners participated in the CTI Supervisor Training on 12/18/17. To increase capacity for this project there will be another CTI worker training scheduled sometime during February-April 2018. Additional details about this project are discussed in the Care Transitions section of this report.

The region is working closely with 2 Continuum of Care Facilitators to ensure the IDN work incorporates a continuum of care model which addresses prevention, early intervention, treatment, and recovery support services. This region has made substantial progress in the expansion of medication assisted treatment programs and has had 2 Peer Recovery Coach Academies during the reporting period of 7/1-12/31/17. Additional details about this project are discussed in the Care Transitions section of this report.

A comprehensive training plan is the third prong the region is using to help transform the delivery of behavioral health care in the region. The master training plan is designed to train the workforce to meet SAMHSA's 9 Core Competencies using a cross-training approach. The cross-training approach is designed to bring agencies together and learn the same information as they work on different IDN

projects. This approach will enable agencies to learn from one another, share resources, improve communication, and collaborate on team-based care to improve the delivery of behavioral health across Region 7 IDN. Below is the master training plan which was submitted with the implementation plan in July 2017. The table lists all the trainings, both required and optional that may be needed for projects associated with implementation of the DSRIP program.

Region 7 IDN Master Training Table		
Training	**Description**	**Project Reference**
Core Competency Integration Toolkit	Participants will receive on overview of all Tools in the Core Competency Integration Toolkit	B1
Community Resources	The newest and up to date Community Resource guide created by the Continuum of Care Coordinators in Grafton, Coos and Carroll counties will be shared. Participants will be asked to share their community resources.	B1
42 CFR Part 2 Introduction	Overview of the updated 42 CFR Part 2	B1, C1, D3, E5
Multi-Agency Consent Forms and Shared Care Plan	Participants will learn how to use Region 7 IDN's multi-agency consent form as a tool to help drive the utilization of the shared care plan	B1, C1, D3, E5
Co-occurring Mental Illness and Substance Use Disorder	Participants will gain an understanding of co-occurring disorders, the prevalence of co-occurrence and recommendations for assessment and treatment	B1, E5
Anti-Stigma Training	The course is designed to provide participants with an opportunity to recognize attitudes and behaviors that could potentially lead to stigma. Participants will examine attitudes, beliefs and behaviors toward persons with mental health problems, and become comfortable addressing mental health patients	B1
Core Standardized Assessment Tools	Participants will learn how to use the core standardized assessment tool to capture information regarding all of the required domains in the DSRIP program	B1
Cultural Competency	Cultural Competency- Class: A Hidden Culture of socioeconomic class relates to many aspects of the work in health care. This interactive	B1, E5

	workshop draws from the work of Ruby Payne, in Hidden Rules of Class, Bridges out of Poverty, and Framework for Understanding Poverty. Participants will engage in activities that illuminate some ways in which class acts as culture, determining assumptions, expectations, and conclusions about interactions	
Change Management	Participants will learn how to get both organizational and employee buy-in of new initiatives, how to deal with culture change, how to implement new processes as efficiently as effectively as possible, and how to identify risks and develop system to mitigate those risks and monitor progress	B1
Integration 101	Understand the rationale for integrated care and how it leads to improved health outcomes Describe "integrated care," and the SAMHSA levels of integration,	B1
Health Literacy	Introduction to Health Literacy: Increasing awareness of how health literacy may impact practice. 18% of NH residents have never graduated high school and the majority read at a 7th & 8th grade level	B1
Mental Health First Aid	An international evidence-based practice designed for all audiences that teaches how to help someone who may be experiencing a mental health or substance use challenge. The training helps identify, understand and respond to signs of addictions and mental illnesses.	B1
Suicide Prevention	Connect Suicide Prevention: A national model that uses a socio-ecological model and best practices around Zero Suicide and suicide prevention	B1
Verbal De-Escalation Training	Ensure the safety of the patient, staff, and others in the area; help the patient manage his emotions and distress and maintain or regain	B1

	control of his behavior; avoid the use of restraint when at all possible; and avoid coercive interventions that escalate agitation.	
Medication Assisted Treatment (MAT) Best Practices	American Society of Addiction Medicine (ASAM) criteria	D3
Community Health Worker (CHW) training	Participants will learn how community health workers serve as the link between health and social services and the community to facilitate access to services and improved quality and cultural competence of care. Skills learned include communication, advocacy, interpersonal issues, service coordination, organization, teaching, capacity building, motivational interviewing and knowledge in specific health issues, such as cervical cancer screenings, behavioral health, and oral health	E5, B1
Motivational Interviewing (MI) training	Understanding the basics of MI Practice applying Motivational Interviewing concepts and skills Recognize the four elements of MI-MI Spirit (PACE), MI Principles (RULE), MI Skills and Strategies (OARS), and MI Tools and Change talk (DARN	B1, C1, E5
Critical Time Intervention training	Participants will learn the three-phased, time-limited approach of the evidence-based CTI model, including pre-CTI, crisis intervention, and clinical supervision. They will be able to define the CTI core skills and principles needed to engage persons who are experiencing mental health, substance use disorder and other chronic diseases and that are making a significant transition, such as from homelessness, hospitalization or incarceration. The training covers the key principles of the CTI model, evidence for its effectiveness, and the tools that teams need to implement it and maintain fidelity to it.	C1

Peer Recovery Coach training	Training provides participants with a basic understanding of substance use and mental disorders, crisis intervention and how to respond in crisis situations. In addition, skills and tools on effective communication, motivational enhancement strategies, recovery action planning, cultural competency and recovery ethics.	D3
Health Equity	Providers Linking Patient With Community Programs- Why improving the social determinants of health will help eliminate population-based health disparities; health-impacting choices that individuals make which are shaped by community environment and context; things health providers can do to strengthen the community knowledge base on population-based health disparities	B1
Self-Management and Recovery Training (SMART) program-	Participants get motivated to address substance use disorders, and learn how to cope with urges and drug use behaviors. SMART Recovery 4-Point Program, Building and Maintaining Motivation; Coping with Urges; Managing Thoughts, Feelings and Behaviors; Living a Balanced Life	D3
Virtual Collective Medical Technologies (CMT) training	NCHC will work with Collective Medical Technologies (CMT) to create a training program which can be virtually accessed by team members, IT staff, and other pertinent agency staff.	B1, C1, D3, E5
Engaging and Leveraging Family and Natural Supports in the Recovery Process	Family and natural supports can play a critical role in recovery success. NAMI NH offers training for providers on understanding the realities of living with mental illness and its effect on families; and how those natural supports can be engaged to promote recovery and enhance the treatment process.	D3

Trauma Informed Care and Health Professionals	Participants will understand the effects of childhood trauma as it relates to physical, mental and emotional health, identify possible procedures, policies, or physical structures that could trigger patients in their own health care setting, describe three interventions or skills that can be used to decrease the trauma response in patients.	D3, E5
Screening, Brief Intervention, and Referral to Treatment (SBIRT)	The NH Youth SBIRT Initiative is committed to expanding SBIRT as a standard practice of care across primary care settings in NH. To facilitate this growth, the Initiative is offering many educational and workforce developmental opportunities throughout the state. Monthly webinars, core training, SBIRT model and validated screening tools, case examples and design flow within a clinical setting, Motivational interviewing techniques.	B1, D3, E5
Telehealth and mHealth Use in Integrated Care	The purpose of this training is to augment learner knowledge about existing telehealth and mHealth technology applications available to support behavioral health integration. Participants will be able to distinguish the differences between types of telehealth and mHealth technologies and applications as applied to integrated behavioral health; discover how clinical practices, researchers, and payers are defining the use and payment of telehealth and mHealth technologies to support integrated behavioral health; compare and contrast payer reimbursement models and understand their direct-to-consumer (DTC) model implications; describe the regulatory and legal frameworks governing mHealth technologies and practice impacts.	B1
Integration in the Practice - Part II: Coordination with Community and Re-visiting Payment	The purpose of this training is to increase learner capacity to 1) operationalize linkages with organizational as well as community resources with a focus on diverse populations to improve care quality and outcomes and 2) understand an alternative payment model	B1

	structure to support behavioral health integration delivery. Learning Objectives include identify practical strategies to coordinate and monitor patient/family linkage to physical health, mental health/substance misuse, and enabling support services (organizational and community-based); describing models for shared care planning involving physical, mental/substance misuse, and community support providers; Identifying mechanisms to address the unique needs of diverse populations in integrated care settings; recalling results of a fiscal analysis to develop a payment model to support the cost of care delivery in integrated care settings.	
Naloxone (Narcan)	Training provides step by step instructions for administration of Naloxone including signs and symptoms of overdoes, protocol for calling 911 and rescue breathing.	B1, C1, D3, E5
TeamSTEPPS Training Series for Hypertension Management	The purpose of this activity is to enable the learner to identify common communication barriers between team members in a healthcare setting and become familiar with TeamSTEPPS 2.0® tools that can be implemented to improve communication. Participants will be able to describe how communication affects team processes and outcomes; define effective communication and identify communication challenges; and identify TeamSTEPPS Tools and Strategies that can improve a teams' communication.	B1
New Lipid Guidelines	The purpose of this training is to enable providers to understand the components of the new lipid guideline recommendations and the current evidence to support the transition.	B1
Expanding Tobacco Treatment Among High-Risk Populations for Value-Based Integrated Care	Participants will be able to describe the short and long-term consequences of tobacco use for individuals who have a mental health issue (MHI) or substance use disorder (SUD),	D3

	describe the return on investment of helping patients quit smoking, discuss strategies to help individuals who have a mental health issue or substance use disorder quit using tobacco, understand how to make a referral to the NH Tobacco Helpline via QuitWorks-NH.	
Supervising a Peer Recovery Workforce	Are the supervisory needs in a peer-based recovery support service any different than in any other service, and how? What needs to be considered in developing the supervisor's role as well as the certified recovery support worker's role? As peer support services become more prevalent in substance use disorder recovery and mental health services, it is important to address these questions as peer roles can present unique challenges to existing supervision structures and	D3
HIV Update for Substance Use Professionals	This training is geared toward substance use professionals and will provide participants with basic and updated information about HIV other STDs. This includes risk factors, modes of transmission, signs and symptoms, prevention, the relationship between HIV and other STDs.	D3
Care Advocate Training	This training will be specifically designed for the Care Advocates in Project E5. This two-day training will provide instruction on all the Assessment, Treatment and Referral Protocols, Engagement strategies, Gap analysis, Communication skills and Tracking and Reporting required.	E5
The Metabolic Triad: Diabetes, **Cardiovascular Disease, and Inflammation**	Participants will be able to explain the burden of cardiovascular risk factor in patients with diabetes, define inflammation and its role as a risk factor for CVD, list 4 lifestyle modifications to reduce heart disease, review evidence based guidelines for diet, lipid disorders and hypertension, explain positive approach to nutrition education, describe a Heart Healthy Diet	B1

Mental Health Provider Diabetes Education Program	This program will teach mental health providers about diabetes management, the daily struggles people face, as well as effective interventions to treat people with diabetes experiencing mental health issues	B1

Region 7 IDN held numerous trainings during the reporting period of 7/1/2017-12/31/2017 based on the suggested training list in the region's master training. Although June 2017 is out of the reporting window, it is pertinent to mention that Alexander Blount, EdD, Professor of Clinical Psychology, Director, Major Area of Study in Behavioral Health Integration and Population Health, Antioch University, New England presented for Region 7 IDN at the June 22, 2017 quarterly meeting. His Integration 101 training titled "*Levels of Integration: What's All the Fuss?*" was useful information to help level set the region. 35 people attended this training.

9/28/2017 Region 7 IDN Quarterly Meeting – 38 participants

- *Rule Changes of 42 CFR Part 2 and What That Means for You*: Lucy C. Hodder, JD, Director Health Law and Policy, Professor of Law, University of New Hampshire, IHPP, and Stephen Noyes LICSW, Director of Integrated Behavioral Health, Ammonoosuc Community Health Services, Inc.

Region 7 IDN has decided to use the IDN quarterly meetings as training opportunities. It is the intention to have a keynote speaker at each meeting, and then offer additional training hours during the afternoon session.

12/7/2017 Region 7 IDN Quarterly Meeting – 38 participants

- *Value of the Shared Care Plan* – Tristan Van Horne – VP of Network Development, Collective Medical Technologies, Inc.
- *Implementing Organizational Culture Change* – William B. Gunn, Jr., PhD - Director of Clinical Integration Strafford/Seacoast Integrated Network of Care
- *Integrating Community Health Workers into the IDN* – Annette Carbonneau – Program Manager with North Country Health Consortium, Amber Culver and Jennifer Goulet – Community Health Workers with NCHC – 20 participants
- *Who is Driving the Bus of Integrated Healthcare?* – Jill Gregoire, RN, MSN – Practice Facilitator, North Country Health Consortium - 20 participants

Other Trainings in Region 7 IDN during the reporting period 7/1-12/31/17:

- Sept-October 2017 – Peer Recovery Coach Academy for 9 people, Woodsville, NH
- 8/28 – Myers & Stauffer Learning Collaborative: Behavioral Health Integration, Concord, NH
- Oct. 2017-Jan. 2018 – Community Health Worker training, NCHC for 11 people
- October 2017 – Motivational Interviewing, NCHC for 18 people
- 11/1 - Alternative Payment Model Myers & Stauffer Learning Collaborative, Plymouth, NH
- 11/15-11/16 – CTI Worker Training for 11 Region 7 IDN participants
- 11/30 -Mental Health First Aid at Littleton Regional Healthcare for 26 people
- 12/18 – Mental Health First Aid at Cottage Hospital for 28 people
- 12/18 – CTI Supervisor training for 3 Region 7 IDN participants
- December 2017 Peer Recovery Coach Academy for 11 people, Lancaster, NH

The region has held 15 Narcan Education trainings and distributed 129 Narcan kits during the reporting period.

After the submission of the implementation plan, NCHC realized they still needed additional information to prioritize the training needs within the master training plan to assist the region in meeting the DSRIP deliverables. The region also stated in the implementation plan that they would continue to assess the training needs of the region. For example, the project metrics and specification criteria states that partners need to be trained on substance use disorder topics, but our region didn't really know what SUD topics needed to be covered during a training. In addition, the region felt it was important to get additional input on training needs from direct care staff versus just an administrative perspective on what it needed for trainings. Northern New Hampshire Area Health Education Center (NNHAHEC), a program of NCHC, worked in conjunction with the IDN Clinical Workgroup to create a more detailed training needs survey, based from the region's master training table, and this survey was sent to the main clinical contact person at the behavioral health and primary care organizations in the region during the reporting period of 7/1-12/31/17. The survey also asked participants to identify their credentials because the region continues to work on assessing workforce capacity. The main clinical point of contact at IDN partner agencies was asked to forward the survey to direct care staff at their agencies. When the survey period ended, NCHC had responses from 149 direct care providers in the region. Responses to the survey are below:

Region 7 Priorities (Based on Survey) in order of priority by percentage of those answering the question	
Topic	*Percentage rating
The Metabolic Triad: Diabetes, Cardiovascular Disease, and Inflammation: Participants will be able to explain the burden of cardiovascular risk factor in patients with diabetes, define inflammation and its role as a risk factor for CVD, list 4 lifestyle modifications to reduce heart disease, review evidence-based guidelines for diet, lipid disorders and hypertension, explain positive approach to nutrition education, describe a Heart Healthy Diet.	62%
Mental Health Provider Diabetes Education Program: This program will teach mental health providers about diabetes management, the daily struggles people face, as well as effective interventions to treat people with diabetes experiencing mental health issues	60%
Trauma Informed Care and Health Professionals: Participants will understand the effects of childhood trauma as it relates to physical, mental and emotional health, identify possible procedures, policies, or physical structures that could trigger patients in their own health care setting, describe three interventions or skills that can be used to decrease the trauma response in patients	59%
TeamSTEPS: Identify common communication barriers between team members in a healthcare setting and become familiar with TEAMSTEPPS 2.0 tools that can be implemented to improve communication. Goals of the session are to understand how communication affects team processes and outcomes; define effective communication and communication challenges; and the tools and strategies that will improve a teams' communication	56%

Co-Occurring Mental Illness and Substance Use Disorder: Participants will gain an understanding of co-occurring disorders, the prevalence of co-occurrence and recommendations for assessment and treatment.	54%
Street Recognition Drugs: Recognize common street drugs, their symptoms and effects on the body and how to best treat patients' using them.	51%
Ethical Communications & Decision Making in an Integrated Care Environment: Understand the roles of all partners in the integrated care environment and how they relate to each other. Addresses how varied communication and confidentiality requirements impact one another and our patients and identify strategies to reduce those barriers in order to provide the best care possible.	51%
Crisis Management of Co-Occurring Patients: Strategies to use with persons with mental illness and emotional disorders, and or are experiencing a crisis, including techniques for defusing potential volatile interactions, and identifying resources to assist in making a disposition.	49%
De-escalation Best Practices for Severe Mental Health: Ensure the safety of the patient, staff, and others in the area; help the patient manage their emotions and distress to maintain or regain control of their behavior; avoid the use of restraint when possible; and avoid coercive interventions that escalate agitation.	49%
Motivational Interviewing (MI) training: Understanding the basics of MI Practice applying Motivational Interviewing concepts and skills. Recognize the four elements of MI-MI Spirit (PACE), MI Principles (RULE), MI Skills and Strategies (OARS), and MI Tools and Change talk (DARN)	47%
Change Management: Understand how to get both organizational and employee buy-in with culture change, how to implement new processes as efficiently and effectively as possible, and how to identify risks and systems to mitigate those risks and monitor progress	44%
Suicide Prevention Connect Suicide Prevention: A national model that uses a socio-ecological model and best practices around Zero Suicide and suicide prevention	41%
Cultural Competency: - Participants will engage in activities that illuminate some ways in which class acts as culture, determining assumptions, expectations, and conclusions about interactions	40%
Understanding Adverse Childhood Experiences & Working with Complex Trauma:- Trauma informed practice implies a working knowledge of not only what signs and symptoms exist with trauma but also, how trauma impacts brain function, coping, and client well-being. This session will cover the basics of trauma definition and symptomology, with special focus the impact of multiple adverse childhood experiences (ACES) on brain process and its impact on coping and substance use. Special attention will be given to the exploration of a variety of prevention strategies in working with individuals, families and communities.	39%

MH First Aid: An international evidence-based practice designed for all audiences that teaches how to help someone who may be experiencing a mental health or substance use challenge. The training helps identify, understand and respond to signs of addictions and mental illnesses.	34%
Competent Caring: When Mental Illness Becomes A Traumatic Event: NAMI and the Hospital Corporation of America have collaborated to create Competent Caring: When Mental Illness Becomes a Traumatic Event, a DVD for continuing education training for health care staff. The DVD highlights the experience of an individual living with a mental illness, as well as the staff response when he seeks treatment for a mental health crisis in an emergency room setting. collaborated to create Competent Caring: When Mental Illness Becomes a Traumatic Event, a DVD for continuing education training for health care staff. The DVD highlights the experience of an individual living with a mental illness, as well as the staff response when he seeks treatment for a mental health crisis in an emergency room setting.	32%
Screening, Brief Intervention, and Referral to Treatment (SBIRT): Short brief interventions and referral to treatment for alcohol and substance abuse is an evidenced base practice that can be integrated into a primary care or other health setting. Validated screening tools, design flows for clinical settings and motivational interviewing techniques are taught in this session	32%
MAT Best Practice America Society of Addiction Medicine	32%
Critical Time Intervention: Participants will learn the three-phased, time-limited approach of the evidence-based CTI model, including pre-CTI, crisis intervention, and clinical supervision. They will be able to define the CTI core skills and principles needed to engage persons who are experiencing mental health, substance use disorder and other chronic diseases and that are making a significant transition, such as from homelessness, hospitalization or incarceration. The training covers the key principles of the CTI model, evidence for its effectiveness, and the tools that teams need to implement it and maintain fidelity to it.	31%
Team STEPPS Series for Hypertension Management: The purpose of this training is to enable the learner to identify common communication barriers between team members in a healthcare setting and become familiar with TeamSTEPPS 2.0 tools that can be implemented to improve communication. Participants will be able to describe how communication affects team processes and identify communication challenges; and the TeamSTEPPS Tools and Strategies that can improve a teams' communication.	24%
Learning Collaborative of Behavioral Health and Primary Care: Best -practice and evidence-based integration recommendations and supports for those seeking more integration. Peer support, sharing of strategies and networking cross clinical and behavioral health staff.	29%
Integration 101: Understand the rationale for integrated care and how it leads to improved health outcomes. Describe "integrated care," and the SAMHSA levels of integration	29%

Integration in the Practice - Part II: Coordination with Community and Re-Visiting Payment: The purpose of this training is to increase learner capacity to 1) operationalize linkages with organizational as well as community resources with a focus on diverse populations to improve care quality and outcomes and 2) understand an alternative payment model structure to support behavioral health integration delivery. Learning Objectives: Identify practical strategies to coordinate and monitor patient/family linkage to physical health, mental health/substance misuse, and enabling support services (organizational and community-based); describing models for shared care planning involving physical, mental/substance misuse, and community support providers; Identifying mechanisms to address the unique needs of diverse populations in integrated care settings; recalling results of a fiscal analysis to develop a payment model to support the cost of care delivery in integrated care settings.	27%
Best Practices for Severe Mental Health Beyond the Scope of the Primary Care Practice	24%
Expanding Tobacco Treatment Among High Risk Populations for Value-Based Integrated Care: Describe the short and long- term consequences of tobacco use for individuals who have a mental health issue or substance use disorder. Describe strategies to help those individuals quit and how to make a referral to the NH Tobacco Helpline.	20%
Anti-Stigma Training: The course is designed to provide participants with an opportunity to recognize attitudes and behaviors that could potentially lead to stigma. Participants will examine attitudes, beliefs and behaviors toward persons with mental health problems, and become comfortable addressing mental health patients.	22%
Naloxone (Narcan) Training: Provides step by step instructions for administration of Naloxone including signs and symptoms of overdoes, protocol for calling 911 and rescue breathing.	20%
Home Visitor Safety	18%
New Lipid Guidelines: Understand the components of the new lipid guideline recommendations and the current evidence to support the transition. Understand the methodology upon which the new lipid guidelines were based. Identify the new components of the lipid guidelines in comparison to the Adult Treatment Panel (ATP) III revised guidelines. Discuss common misconceptions and recall current expert consensus guidelines for non-statin medication.	16%

NCHC will use the results of the survey to help the region prioritize their training schedule for 2018. The region is planning to offer chronic illness trainings related to hypertension, dyslipidemia, and diabetes via a webinar platform, and will use in person trainings to focus on trainings related to team based care and how to work on an interprofessional level to improve health outcomes in the region. NCHC is cognizant of using participants time in the most efficient manner and is working to develop a training calendar which will be the least intrusive on provider time. For instance, NCHC is working to schedule in person trainings, but trying to eliminate numerous in person trainings in the same month. In addition, NCHC is trying to offer trainings in a timely fashion so the region can use the knowledge to improve the care delivery system. NCHC will ensure continuing education credits are offered for eligible trainings and participants. The tentative training schedule to date for 2018 is as follows:

- February 13, 2018 - Be the Change: Approaches and Tools to Successfully Manage Change All-Partner Statewide Learning Collaborative meeting. Concord, NH
- March 8, 2018 – IDN Regional Quarterly meeting: care coordination panel discussion in the morning, followed by Medication Assisted Treatment (MAT) training during the afternoon session presented by Peter Mason, MD. The program is designed to demonstrate how to overcome barriers to MAT expansion in a primary care practice. AMC Highland Center, Crawford Notch
- March 19, 2018 - Drug Recognition Training - identify the latest trends in substance misuse, as well as recognize individuals in crisis. North Country Health Consortium, Littleton
- March 19-24, 2018 Recovery Coach Academy offered through NHADACA at Northwoods Center for Continuing Education, Whitefield
- March 29-30, 2018 2-day regional care coordination training for Carroll County (other regions may participate if they would like to). AMC Highland Center, Crawford Notch
- March 2018 Mental Health First Aid training at Memorial Hospital, North Conway
- April 12, 2018 - Co-Occurring Medical Conditions within Behavioral Health, Danielle Moreggi, PhD - This session is focused on providing behavioral health and substance abuse treatment professionals with an increased understanding for circumstances when medical conditions are related to behavioral health. AMC Highland Center, Crawford Notch
    - Objectives:
        - Provide a review of the most common medical conditions diagnosed among substance addicted and mental health clients.
        - Help clinicians identify "key" symptoms during the assessment process that may co-occur; and, remain within the scope of practice.
        - Provide an understanding of how medical symptoms can overlap, interact and vail psychological symptoms which effects treatment planning.
- April 13, 2018- Co-Occurring Psychological Conditions within Primary Care, Danielle Moreggi, PhD - Designed for medical professionals to better understand evidenced- based screening tools for common mental and behavioral health conditions as well as a plan for treatment planning and follow up. AMC Highland Center, Crawford Notch
    - Objectives:
        - Provide a review of most common psychological symptoms presenting in primary care
        - Assist medical professionals with proper screening and diagnosing for depression, PTSD, addiction and suicide risks
        - Provide an understanding of how standardized data collection can assist with comprehensive treatment planning and follow up.
- May 1-2, 2018 Motivational Interviewing Workshop, AMC Highland Center, Crawford Notch
- May 23, 2018 – Behavioral and Medical Professionals Working Together to Address Co-Occurring Conditions, Danielle Moreggi, PhD. Designed to bring primary care and behavioral health professionals together to discuss feedback from the first two sessions and work on an interprofessional team-based approach to provide comprehensive care to patients with medical, behavioral health and substance abuse treatment needs. AMC Highland Center, Crawford Notch
    - Objectives:
        - Provide a review of the importance working together with proper diagnosis and treatment strategies; common co-occurrences
        - Review of screening, assessment and proper referral processes

        - Discussion of policies and procedures to improve standardization of care
- June 14, 2018 IDN Regional Quarterly Meeting, AMC Highland Center, Crawford Notch
- June 2018 2nd regional care coordination training, location to be determined
- September 13, 2018 IDN Regional Quarterly Meeting, Trauma Informed Care - participants will understand the effects of childhood trauma as it relates that could trigger patients in their own health care setting and describe three interventions or skills that can be used to decrease the trauma response in patients. AMC Highland Center, Crawford Notch
- TBD: Initial Training on Addiction & Recovery: Through NH DHHS - This introductory workshop on addiction and recovery is designed to raise awareness and understanding of the dynamics and impact of addiction on people whom we serve. It will cover the neurological basis of addiction; mental, behavioral, emotional and spiritual dimensions; stages of change; recovery; motivational techniques; and resources. Region 7 IDN will collaborate with other IDNs to secure a date and location
- TBD: Ethics and HIV trainings through NHADACA. Location to be determined
- TBD: Management of Aggressive Behavior - training presents principles, techniques, and skills for recognizing, reducing, and managing violent and aggressive behavior both in and out of the workplace. Location to be determined.

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

Region 7 IDN had numerous partners submit full proposals for funding related to the Core Competency project during the reporting period of 7/1-12/31/2017. Memorandums of agreements went out in early December 2017, so although there is not a lot of progress yet, there will be significant momentum in 2018. Northern Human Services (NHS), the only community health center in the entire region, submitted a proposal for co-located services which was approved for funding by the IDN. Through this proposal NHS and Coos County Family Health Services (CCFHS) plan to pilot an Integrated Health Home, to be located within the NHS site in Berlin. Providers from CCFHS will go to NHS and provide services to patients suffering from severe mental illness or severe and persistent mental illness, and dually diagnosed patients who would otherwise potentially go without medical care. NHS has started to procure bids from contractors to do some necessary renovations and has posted the project manager position. CCFHS is working on getting staff licensed to work at a different location.

White Mountain Community Health Center also submitted a proposal to help them advance along the continuum of integrated healthcare. The agency will use these funds to contract for part-time LADC services, add a community-health worker to support patients in a medication assisted treatment program, and offer some tuition reimbursement for 2 staff members who are working to complete their psychiatric nurse certification by May of 2018.

Region 7 Core Competency Integration Toolkit:

NCHC has been working to compile a Core Competency Integration Toolkit to assist the primary care and behavioral health practices in the region as they advance along the continuum of integrated healthcare. The toolkit will include sample forms, policies, and procedures, will be reviewed by various work groups in the region and finalized in late summer/early fall of 2017, and then they will be introduced at the September 2017 quarterly regional meeting, and then rolled out to partner agencies starting in October 2017 during various training opportunities. The toolkits will be measured for effectiveness using the PDSA approach, and partner feedback will be used to edit the tools to fit the needs of partners in the region. The region intends for the toolkit to contain the following:

- Multi-agency consent form packet;
- Sample job descriptions for members of the multi-disciplinary core team;
- NH Board of Medicine Guidelines on opioid prescribing;
- Comprehensive Core Standardized Assessment form;
- Sample screening tools for adults, adolescents and children;
- Sample protocols for patient assessment, treatment, and management;
- Sample referral protocols including those to/from PCPs, BH providers, social service support providers, Hospitals, and EDs;
- Sample communication plans, relevant workflows and case conference templates to be used by the multi-disciplinary core team and Community Care Teams;
- Samples of contracts or MOUs that can be used between participating providers and organizations including social support providers to outline the roles and responsibilities for both organizations, including, but not limited to compliance, liability, insurance, coverage schedules, consultant report turnaround time, referral processes; and
- Tools related to SAMHSA 9 Core Competencies: quality improvement resource guide, guide to shared care plan, guide to data aggregation, Integration 101 guide, team building activities, templates to define roles & responsibilities of core team members, information on co-occurring disorders, information regarding shared decision making, guide to Systems Oriented Practice, tool to develop patient & family education brochure, information on cultural competency, information on Active Listening, Reflective Response, protocols for patient interaction, protocols for internal communication, communication protocols to share the information learned with treatment, transitional care and social service providers will be defined.

The region has made significant progress on this toolkit, but staffing transitions, and busy clinical provider schedules have delayed the toolkit being finalized. NCHC staff is working with the IDN Clinical Workgroup to get this toolkit finalized early in 2018. Once finalized, the effectiveness of the tools will be reviewed on an on-going basis, and changes will be made to meet the needs of the providers.

B1-3. IDN Integrated Healthcare: Evaluation Project Targets

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

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
# of partner organizations using comprehensive core standardized assessment	18 as of 2018	0		
# of partner agencies using shared care plan	18 as of 2018	0		
# of partner agencies using multi-disciplinary core team	18 as of 2018	0		

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
# of partner agencies using standardized workflow and protocols	18 as of 2018	0		
# of partner organizations which have implemented MAT services	5 as of 2018	2		
# of psychiatric nurse practitioners	3 as of 2018	2		
# of MLDACs	16 as of 2018	16		
# Licensed Mental Health Professionals	23 as of 2018	18		
# of Peer Recovery Coaches	6 as of 2018	22		
# of Community Health Workers	4 as of 2018	11		
# CTI Workers	15 as of 2018	11		
# CTI Supervisors	3 as of 2018	3		
# Care Advocates	15 as of 2018	0		
# Care Advocate Supervisors	1 as of 2018	0		
# Community based clinicians (staffing from first round of capacity)	1 as of 2018	1		
# Physician assistant clinicians (staffing from first round of capacity)	1 as of 2018	1		
Community nurse coordinator clinicians (staffing from first round of capacity)	1 as of 2018	1		
Behavioral health assistant clinicians (staffing from first round of capacity)	1 as of 2018	1		
Behavioral health case managers clinicians (staffing from first round of capacity)	5 as of 2018	4		

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
LICSW clinicians (staffing from first round of capacity)	3 as of 2018	2		
IDN QI Coach	1 as of 2018	0		
HIT Integration Coach	1 as of 2018	1		
IDN Data Specialist (NCHC)	1 as of 2018	0		
Data Specialists for IDN partners	Up to 3 as of 2018	0		

B1-4. IDN Integrated Healthcare: Workforce Staffing

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

Provider Type*	IDN Workforce (FTEs)				
	Projected Total Need	Baseline Staffing on 6/30/17	Staffing on 12/31/17	Staffing on 6/30/18	Staffing on 12/31/18
Master Licensed Alcohol and Drug Counselors	16 by 2018	11	16		
Licensed Mental Health Professionals	23 by 2018	14	18		
Peer Recovery Coaches	6 by 2018	2	22		
CTI Workers	15 by 2018	0	11		
CTI Supervisors	3 by 2018	0	3		
Community Health Workers	4 by 2018	0	13		
Psych Nurse Practitioners (round 1 funds)	3 by 2018	1	2		
Care Advocates	15 by 2018	0	0		
Other Front Line Provider	1 by 2018	0	10		
Care Advocate Supervisors	1 by 2018	0	0		
Community based clinician (round 1 funds for baseline 6/30/17)	1	1	1		
Physician assistant (round 1 funds)	1	1	1		
Community nurse coordinator (round 1 funds for baseline 6/30/17)	1	1	1		
Behavioral health assistant (round 1 funds for baseline 6/30/17)	1	1	1		
Behavioral health case managers (round 1 funds for baseline 6/30/17)	5	2	4		
LICSW (round 1 funds for baseline 6/30/17)	3	1	2		
IDN QI Coach	1	0	0		
HIT Integration Coach	1	0	1		

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

B1-5. IDN Integrated Healthcare: Budget

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

Budget Period:	**01/01/2017 - 12/31/2020**		**07/01/2017-12/31/2017**		**07/01/2017 - 12/31/2017**		**01/01/2018-12/31/2020**		
	Core Competency Budget		**Core Competency Budget (6 months)**		**Core Competency Actual Expense (6 months)**		**Core Competency Budget Projection (remaining project period)**		
Line Item	**Total**		**Total**		**Total**		**Total**		**NARRATIVE:**
3. Consultants									
5. Supplies:									
Educational									
Office	$55,142		$6,893		$2,632		$41,357		**YR2-YR5:** Org.-Wide Office Supply Allocation & New Hire Set ups
6. Travel	$113,700		$14,213		$751		$85,275		**YR2-YR5:** Travel expenses for regional & conference/training expenses
7. Occupancy									
8. Current Expenses									
Telephone									
Postage									
Subscriptions					$5,594				
Audit and Legal									
Insurance									
Board Expenses									
9. Software	$3,790		$474		$8		$2,843		
10. Marketing/Communications	$95,516		$11,940		$3,157		$71,637		**YR2-YR5:** Org.-Wide Marketing/Communications Allocation & Outreach materials
11. Staff Education and Training	$90,960		$11,370		$1,495		$68,220		**YR2-YR5**: anticipated trainings/conferences; **Additional Notes:** IDN 7

									will be implementing training in coming year
12. Subcontracts/Agreements									
13. Other (specific detail mandatory):									
Current Expenses: Administrative Lead Organizational Support	$17,904		$2,238		$4,652		$13,428		**YR2-YR5:** Telephone/Postage/Audit& Legal/Insurance
Support Payments to Partners	$3,509,565		$438,696		$129,061		$2,632,174		**YR2-YR5**: Personnel/Supplies/Software; **Additional Notes:** RFPs awarded. Payment in various stages pending MOU execution and reporting deliverables.
TOTAL	**$4,001,393**		**$500,174**		**$200,495**		**$3,001,045**		

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

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

Organization/Provider	Agreement Executed (Y/N)
Coos County Family Health Services	Y
Cottage Hospital/Rowe Health Center	Y
Littleton Regional Healthcare	Y
Friendship House/North Country Health Consortium	Y
Northern Human Services	Y
Ammonoosuc Community Health Services	Y
Androscoggin Valley Hospital	Y
North Country Healthcare	Y
White Mountain Community Health Center	Y
Weeks Medical Center	Y
Memorial Hospital	Y
Huggins Hospital	Y
Indian Stream Health Center	Y
Whitehorse Addiction Center	Y
Saco River Medical Group	Y
North Country Health Consortium	Y

NCHC removed Upper Connecticut Valley Hospital, Crotched Mountain Foundation, Carroll County Department of Corrections, and Life Coping from the Key Organizational and Provider Participants list under B1 because these agencies do not offer primary care services.

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

If all IDN Governance sign-off's were YES in the July 2017 submission and there are no changes, then a resubmission of this section is not required. If any sign-offs were NO, then resubmission of this information is required with the signatures noted as received.

Name	Title	Organization	Sign Off Received (Y/N)
Jebb Curelop	Financial Manager	Life Coping	Y
Monika O'Clair	Vice President of Strategy & Community Relations	Huggins Hospital	Y
Emily Benson	C3PH PHAC Coordinator	Carroll County Coalition for Public Health	Y
Rona Glines	Director of Physician Services	Weeks Medical Center	Y
Ken Gordon	Chief Executive Officer	Coos County Family Health Services	Y
Suzanne Gaetjens-Oleson	Regional Mental Health Administrator	Northern Human Services	Y
Jeanne Robillard	Chief Operating Officer	Tri-County Community Action Program	Y
Bernie Seifert	Coordinator of Older Adult Programs	NAMI NH	Y
Russ Keene	President and Chief Executive Officer	North Country Healthcare	Y
Karen Woods	Administrative Director	Cottage Hospital	Y
Sue Ruka	Director of Population Health	Memorial Hospital	Y
Jason Henry	Superintendent	Carroll County Corrections	Y

B1-8. Additional Documentation as Requested in B1-8a-8h of the Project Scoring Tool in B1-9

B1- 8a: Core Comprehensive Standardized Assessment:

NCHC staff have been working with Region 7 IDN partners to assess which domains they currently capture when seeing patients. The list below reflects what is currently known at the end of 2017.

Site	Demographic	Physical Health	Substance Use	Housing	Family & Support	Educational attainment	Employment	Access to legal services	Suicide Risk	Functional Status	Universal Screening	SBIRT
Saco River Medical Group	Y	Y	Y	N	N	N	N	N	Y	N	Y	N
Littleton Regional Healthcare	Y	Y	Y	?	Y	some times	some times	?	Y	Y	Y	Y
Memorial Hospital	Y	Y	Y	N	N	N	N	N	Y	N	Y	N
Huggins Hospital	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N
White Mountain Community Health Center	Y	Y	Y	Y	N	Y	Y	N	Y	N	Y	Y
Weeks Medical Center	Y	Y	Y	N	N	N	N	N	Y	Y	Y	Y
Coos County Family Health Services	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Rowe Health Center	Y	Y	limited	Y	Y	Y	Y	Y	Y	Y	Y	N

B1-8a pediatric provider: The table below reflects what NCHC currently knows regarding comprehensive core standardized assessments for pediatric providers at the end of 2017. There is no additional new information, although NCHC is working on another assessment process in January 2018.

Site	Validated developmental screening for all children, ASQ:3, and/or ASQ SE at 9, 18, 24/30 months	Developmental Screening using Bright Futures or other American Academy of	Other tool

		Pediatrics recognized screening	
Ammonoosuc Community Health Services			**Y**
Coos County Family Health Services	**Y**	**Y**	
Weeks Medical Center	**Y**	**Y**	**Y (MCHAT)**
White Mountain Community Health Center	**N**	**N**	**Y (MCHAT)**
Huggins Hospital	**Y**	**Y**	**Y (Teen screen)**
Memorial Hospital	**Y**		
Littleton Regional Healthcare	**Y**		
Saco River Medical Group	**Y**	**Y**	**Y (MCHAT)**

The region planned to have an IDN Quality Improvement Team to work with IDN partner organizations to create a plan to capture all the required domains. The B1 toolkit will have a sample core standardized assessment which will contain questions related to each domain. Due to a slower than anticipated recruitment process, additional staffing transitions, and busy provider schedules the IDN QI team has not been able to engage with IDN partners as much as was originally planned. The IDN Clinical Director has suggested that NCHC reassess the region to see where partners are at with the core standardized assessment process, and this process will happen early in 2018. The following table will be made into a form and sent to primary care and behavioral health providers in January 2018 to get an update on progress as it relates to the domains of the CCSA, including the pediatric screening components.

DOMAIN	IS THIS CURRENTLY IN YOUR ASSESSMENT?	IF NO, WHEN WILL YOU ADD THIS COMPONENT?	WHAT ARE THE BARRIERS TO INCLUDING THIS DOMAIN? DO YOU NEED IDN ASSISTANCE TO COMPLETE THIS?
Demographic	☐ **YES** ☐ **NO**		
Medical	☐ **YES** ☐ **NO**		
Substance use	☐ **YES** ☐ **NO**		

Housing	☐ **YES** ☐ **NO**		
Family and support services	☐ **YES** ☐ **NO**		
Education	☐ **YES** ☐ **NO**		
Employment and entitlement	☐ **YES** ☐ **NO**		
Legal	☐ **YES** ☐ **NO**		
Risk assessment including suicide risk	☐ **YES** ☐ **NO**		
Functional status (ADL, instrumental ADL, cognitive functioning)	☐ **YES** ☐ **NO**		
PHQ2 and PHQ9	☐ **YES** ☐ **NO**		
SBIRT	☐ **YES** ☐ **NO**		
For pediatric providers, developmental screening at 9, 18, and 24/30 month pediatric visits	☐ **YES** ☐ **NO**		**Which screening tool do you use?** ☐ **ASQ:3** ☐ **ASQ SE** ☐ **Other** _____

The table is designed to find out when providers plan to incorporate the required domains of the CCSA if they are not already them in place. In addition, the table is asking organizations to identify the barriers for adding the domains to the CCSA process. NCHC will review the barriers and work with the IDN Steering Committee to strategize ways to overcome these barriers. Once solutions have been identified, Region 7 IDN HIT Integration Coach and Quality Improvement Coach will offer assistance to IDN partner agencies as they work to incorporate the missing domains into the CCSA approach. To accomplish this, IDN Staff have a list of questions that can be shared with organizations to help them capture a specific domain that they aren't currently capturing. Examples of these questions include the following:

FINANCIAL STRAIN

1. **How hard is it for you to pay for the very basics like food, housing, heating, medical care and medications?**
   - ❑ **Not hard at all**
   - ❑ **Somewhat hard**
   - ❑ **Very hard**

Education:

Do you ever need help reading health related materials?

- ❑ **Yes**
- ❑ **No**

Transportation:

In the past 12 months, has a lack of transportation kept you from medical appointments, meetings, work or from getting things needed for daily living? Check all that apply:

- ❑ **Yes, it has kept me from medical appointments or getting medications.**
- ❑ **Yes, it has kept me from non-medical meetings, appointments, work or getting things that I need.**
- ❑ **No**

Region 7 IDN staff will be working to reassess IDN partners during the first four months of 2018, and then use this information to work with IDN partner organizations to create a plan on how and when each of the required domains will be added to their CCSA, so practices can reach coordinated care designation by 12/31/2018. IDN staff will follow up with partner agencies on an on-going basis from May-December 2018 to offer support and guidance as agencies work to implement the CCSA.

B1-8b Multi-disciplinary core team members

Region 7 IDN's implementation plan states that NCHC will work with organizations which already have elements of a multi-disciplinary core team and expand these teams to include providers from other agencies, with the purpose to come together and discuss mutual high needs patients. NCHC convened a meeting with Ammonoosuc Community Health Services, Weeks Medical Center, and White Mountain Community Health Center on November 13, 2017 to discuss the regional approach for the multidisciplinary teams. The agencies participating in the call expressed concerns about the value of monthly case conferences due to the lag time in getting necessary information to treat patients. The agencies participating on the call suggested a hybrid model for the case conferences. If the monthly case conference was scheduled in a timely manner to address the needs of a specific patient, then the care team would discuss the patient. However, if too much time had elapsed for a patient, and their care was plan was already determined, then the team would use a retrospective look at patients as a learning model for the case conferences. The team could discuss the patient, and the processes involved in care of the patient, and how to improve these processes moving forward. The region will continue to discuss how to create a multi-disciplinary core team which brings the most value to Region 7 IDN partners. Region 7 IDN has not identified who will participate on each multi-disciplinary team, but the region plans to have 3 teams in place by the end of 2018. The teams will be established in waves, following the roll out of the shared care plan; Carroll County by March 2018, Coos County by June 2018, and northern Grafton County by September 2018. Rolling out the teams in a staggered approach will allow for rapid cycle evaluation to see what works the best and share best practices with the other teams as they get established. NCHC will work with organizations within each core team region to find representation to make up these teams to meet the DSRIP requirements and approach the Region 7 IDN Steering Committee about incentivizing these teams if it becomes necessary.

The core team will be comprised of primary care providers, behavioral health providers, care managers, or community health workers, and consulting psychiatrists. In addition, Region 7 IDN is following the Community Care Team model, so depending on patient needs, social service providers will often be added to the multi-disciplinary core team meetings. Tri-County Community Action Program (TCCAP), Affordable Housing, Education and Development (AHEAD), and ServiceLink cover all of Region 7 IDN and will have a standing seat on the MDCT as needed. Other social service agencies or organizations like corrections, home health, or schools will be included based on need.

IDN staff has reached out to the Department of Psychiatry at the Geisel School of Medicine at Dartmouth and Northern Human Services to receive a cost proposal of what it will cost to cover the psychiatrist component of the multi-disciplinary core team. Region 7 IDN will discuss these cost proposals with the IDN Steering Committee and the IDN region at the March 2018 quarterly meeting.

Carroll County Multi-Disciplinary core team

Provider Type	Organization
Primary Care Provider	Huggins or Memorial Hospital

Behavioral Health Provider	Northern Human Services
Care Manager or Community Health Worker	Huggins Hospital
Care Manager or Community Health Worker	Memorial Hospital
Care Manager or Community Health Worker	White Mountain Community Health Center
Care Manager or Community Health Worker	Saco River Medical Group
Psychiatrist	Northern Human Services or consulting contract with Dartmouth Hitchcock or other entities

Coos County Multi-Disciplinary core team

Provider Type	Organization
Primary Care Provider	Weeks Medical Center or Indian Stream Health Center
Behavioral Health Provider	Northern Human Services and/or Indian Stream Health Center
Care Manager or Community Health Worker	Indian Stream Health Center
Care Manager or Community Health Worker	Weeks Medical Center
Care Manager or Community Health Worker	Coos County Family Health Services
Psychiatrist	Northern Human Services or consulting contract with Dartmouth Hitchcock or other entities

Northern Grafton County Multi-Disciplinary core team

Provider Type	Organization
Primary Care Provider	Ammonoosuc Community Health Services
Behavioral Health Provider	Ammonoosuc Community Health Services and/or Northern Human Services
Care Manager or Community Health Worker	Rowe Health Center
Care Manager or Community Health Worker	Littleton Regional Healthcare
Psychiatrist	Northern Human Services or consulting contract with Dartmouth Hitchcock or other entities

B1-8c Multi-disciplinary core team training

Master Tracking Table of Regional Trainings						
Reporting Period: July 1, 2017-December 31, 2017			# of Individuals trained			
			Core Team Disciplines	Non-Direct Staff	Other Staff	Total
Date	Training Title	Training Category				
11/30/17 12/18/17	Mental Health First Aid	Mental Health Recognition, Treatment, Management, and Specialty Referral	22	5	22	49
09/28/17 AM Session	42 CFR Part 2	Substance Use Disorder Recognition, Treatment, Management, and Specialty Referral				38
12/07/17 AM Session	Value of the Shared Care Plan	Team-based Care Trainings (IDN Quarterly Meeting)				34
12/07/17 PM Session	Implementing Organizational Culture Change	Team-based Care Trainings (IDN Quarterly Meeting)				24
12/07/17 PM Session	Integrating Community Health Workers into the IDN	Team-based Care Trainings (IDN Quarterly Meeting)				24

During the July-December reporting period IDN Region 7 held two Mental Health First Aid Trainings and two Quarterly meetings. The quarterly meetings consisted of a variety of presentations that educated partners on team-based care and substance use disorder confidentiality regulations and standards. The table below represents the quantity of participants trained during the period.

The 42 CFR Part 2 presentation was provided at the September 28th quarterly meeting to 38 participants during the morning session. The Value of the Shared Care Plan presentation was provided at the December 7th quarterly meeting to 34 participants during the morning session. The afternoon session of the December 7th quarterly meeting consisted of two presentations, Implementing Organizational Culture Change and Integrating Community Health Workers into the IDN, where 24 participants were trained. The participants were guided through an activity to determine a work process that needs better coordination within the region. This provided partners with the opportunity to critically think about what gaps need to be filled in order to develop a team-based care system. The participants were also educated about the essential role of Community Health Workers and how they can be integrated into existing practices. This provided partners with a vision and practical option on how to fill in the gaps of providing quality care.

The IDN team envisions the ability to capture the separate disciplines being trained as described in the table below.

Core Team Disciplines		Non-Direct Staff	Other Staff
MD/DO	MSW	Patient Service Reps.	Any other staff member that does not directly relate to the defined disciplines or a staff member with unreported credentials/job title.
PA	MLADC	Registrar	
APRN	LADC	Medical Secretary	
RN	CRSW	Front Desk Personnel	
LPN	Care Coordinator	Any staff member who is indirectly involved with a patient's care.	
MA			
Psy.D.			
LICSW			

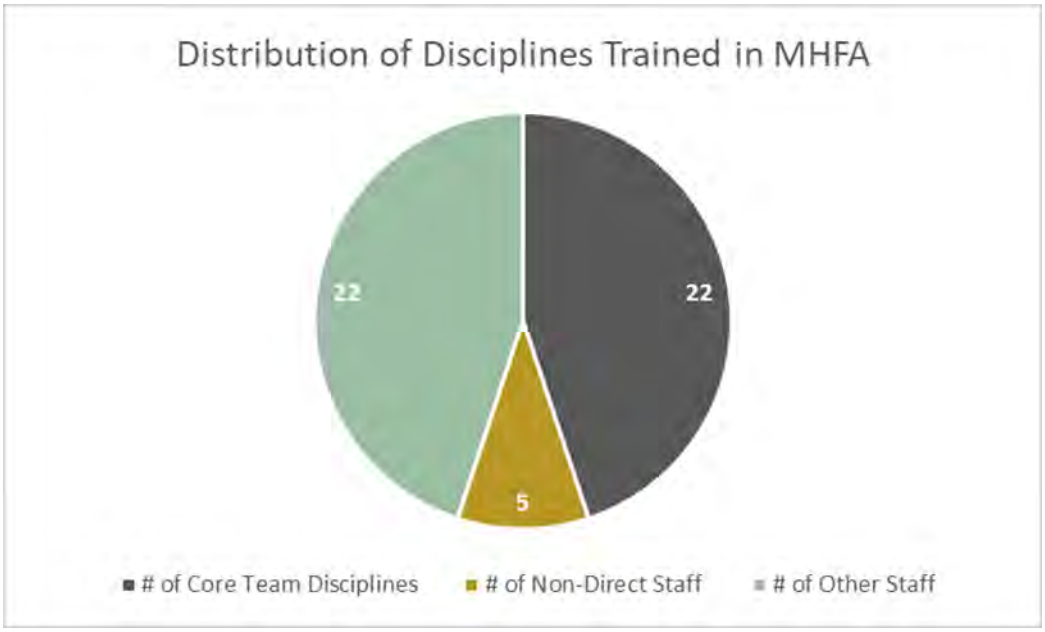
The team will develop a comprehensive process to ensure all credentials and job titles are reported for all trainings and meetings going forward. It is crucial to have the ability to report not just how many partners are being trained but what disciplines are being trained across the region. The goal is to be able to report on all disciplines as shown in the Mental Health First Aid row in the previous Master Tracking Table of Regional Trainings. IDN Region 7 team will work with the partners to stress the importance of this information as they continue to register for trainings and meetings.

B1-8d: Training for non-direct staff: To ensure front line staff have an understanding about the knowledge and beliefs about mental disorders that can aid in recognition and management of these disorders, NCHC will be working with IDN partners to coordinate Mental Health First Aid trainings. The following table reflects what Region 7 IDN partners to identified as training needs for their agencies. NCHC stated they would roll out this training on a regional level, with 2 trainings being offered in 2017, and 4 training being offered in each year 2018-2020, spread throughout the region.

Progress during the 7/1/-12/31/17 reporting period includes 2 Mental Health First Aid trainings, one at Littleton Regional Healthcare on 11/30 for 26 participants, and one on 12/18 at Cottage Hospital for 28 participants. NCHC currently has one certified Mental Health First Aid trainer on staff, and the organization plans to send another staff member to be trained at Riverbend Mental Health Center in April 2018. Having 2 staff members trained in this model will help the region meet the deliverable of having 4 Mental Health First Aid trainings offered in each year 2018-2020. Currently, NCHC is working with Memorial Hospital to coordinate a training for March 2018. Below is a table reflecting what was reported in the region's implementation plan regarding number of front-line staff who needed to be trained in Mental Health First Aid.

Mental Health First Aid Training Plan	
Saco River Medical Group	3 (reception, phone support, medical records)
Littleton Regional Healthcare	35 (medical secretaries and hospital registrars)
Memorial Hospital	8 (front desk, medical records, registration)
Huggins Hospital	19 (front desk, PATH, billing, medical records)
White Mountain Community Health Center	5 (front desk, billing, medical records)

Weeks Medical Center	8 (front desk)
Northern Human Services	20 (front desk, medical records, billing)
Coos County Family Health Services	12 (front desk staff)
Rowe Health Center	10 (patient service representatives, certified medical assistants)
Ammonoosuc Community Health Services	38 (front desk, medical records, scheduling, billing, facilities, human resources, finance, administration



This pie chart reflect the people trained at Littleton Regional Healthcare and Cottage Hospital for the 2 trainings referenced above.

B1-8e Monthly Core Team Case Conferences

Members of the Multi-Disciplinary Core Team will meet monthly on behalf of patients with significant behavioral health conditions or chronic conditions. Region 7 IDN will have a total of 3 teams which will start meeting in a phased approach:

Carroll County Multi-disciplinary core team	Monthly starting March 2018
Coos County Multi-disciplinary core team	Monthly starting June 2018
Grafton County Multi-disciplinary core team	Monthly starting September 2018

Meeting dates will be determined based on the best fit for team members. NCHC staff will assist with establishing meeting dates and times, and ensures the team has all the necessary resources in place to make the meetings as successful as possible.

B1-8f - Secure Messaging

To allow for the passing of consent-enabled information between disparate sites, IDN Region 7 will be promoting the use and deployment of direct secure messaging to all IDN participants. The HIT Assessment conducted between November of 2016 and February 2017, found that only 7 of 23 responding organizations utilized direct secure messaging for some element of data exchanged- the remainder used a manual process instead or simply did not exchange information.
An interim HIT capability Census conducted to support the statewide outcome measures reporting conducted in October 2017 found that 15 of our 24-direct service medical providers had at least the capability to send via a direct protocol (either native to their EHR or provided by a third party HISP). However, many of these organizations originally gained direct secure messaging capability through the New Hampshire Health Information Organization (NHHIO) are now exploring other alternatives, including looking for IDN support and guidance on either continuing with Kno2 (the NHHIO vendor of choice) or exploring other options.

To support the use of direct secure messaging, in the fall of 2017 Region 7 IDN implemented a streamlined RFP process for HIT-focused projects under $5000 to make it easier for IDN partners to implement this technology. It is anticipated that with the change to the NHHIO structure in the state, and with the rollout of the shared care plan in the second quarter of 2018, IDN agencies may reach out to request funds to incorporate direct secure messaging.

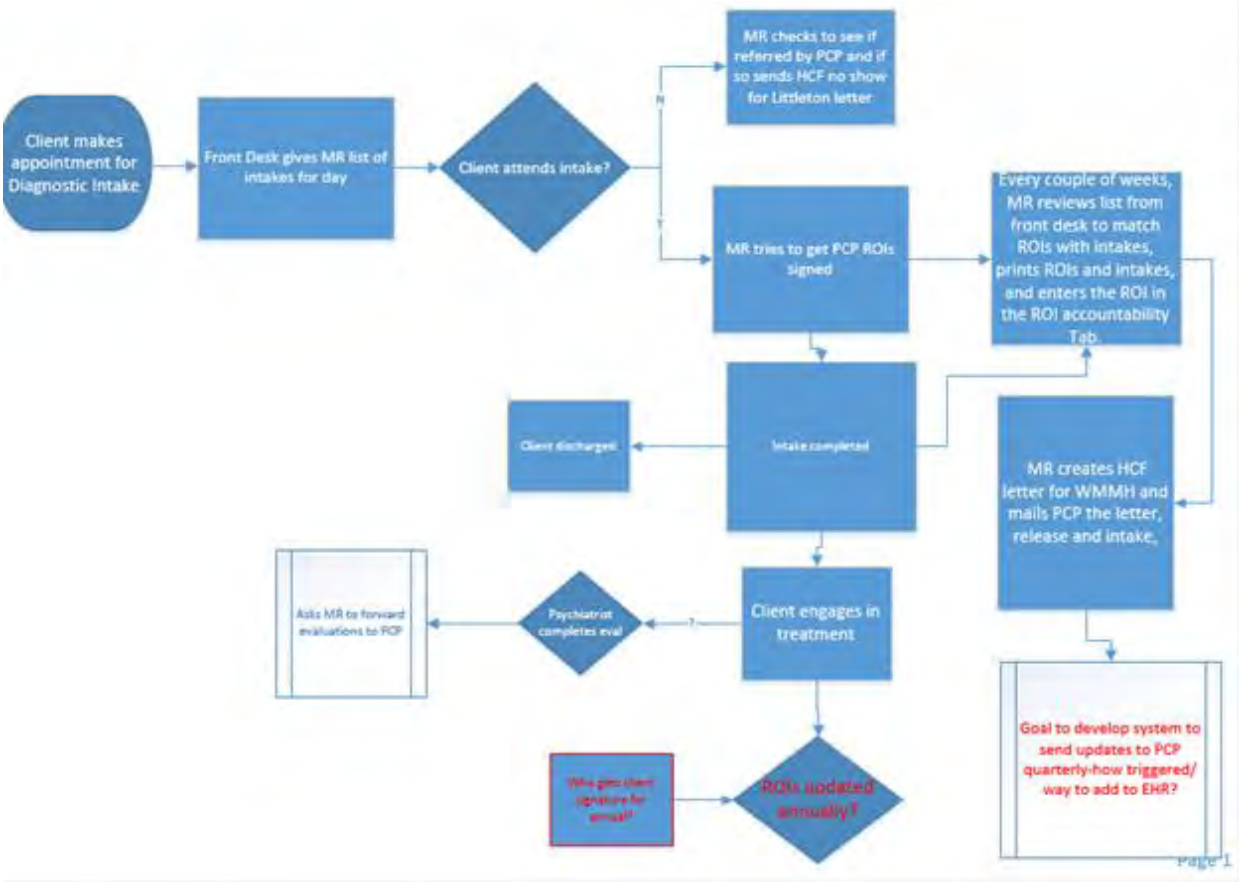
B1-8g - Closed Loop Referrals

Region 7 IDN's implementation plan states that the IDN Quality Improvement Coach and HIT Integration Coach will work with IDN partners to assess if they have workflows in place which support a closed loop referral process, whether it be via electronic, or non-electronic means. These workflows will ensure that the referring provider has a way to track a referral, monitor the referral process, receive the consultant's report, and communicate with the patient. The IDN Quality Improvement Coach and HIT Integration Coach will share best practices related to closed loop referrals and assist provider practices with creating workflows to incorporate a closed loop referral process if they do not have one in place. Provider teams will decide how to measure their success by choosing from the following types of measures:

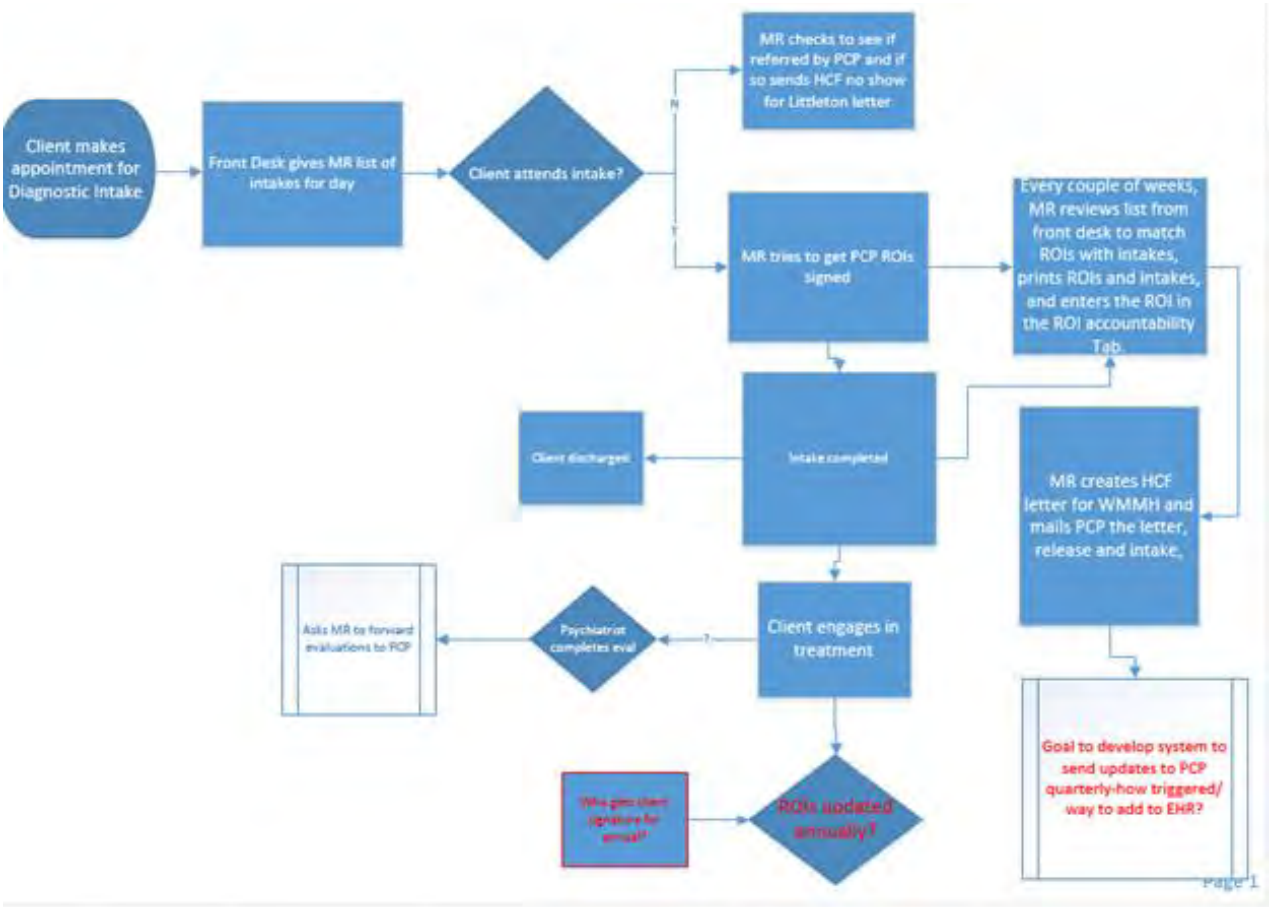
- % decrease in number of open referrals
- % increase in number of closed referrals
- % decrease in the number of days from referral created to referral sent
- % of complete summary of care records sent with referral to specialist
- % decrease # of total days from referral created to referral closed
- Provider satisfaction with the referral process
- Patient satisfaction with the referral process

As previously mentioned, Northern Human Services, Huggins Hospital, and White Mountain Community Health Center have been at various stages of discussions related to closed loop referral protocols through their work in the Practice Transformation Network. Northern Human Services has created a communication workflow for all 5 sites and workflows from 2 of these sites are shared below. Northern Human services is eager to engage in shared care plan discussions and incorporate the use of shared care planning tool into their communication workflow. They are due to meet with NCHC on 1/31/18 to discuss this process in detail, and then will be meeting with NCHC, Huggins Hospital, and White Mountain Community Health Center to work on regional sharing of information. The NCHC HIT Integration Coach will start to meet with these practices as they work to incorporate the shared care plan into their workflows.

Example community mental health center/primary care communication workflow:



Additional example community mental health center/primary care communication workflow



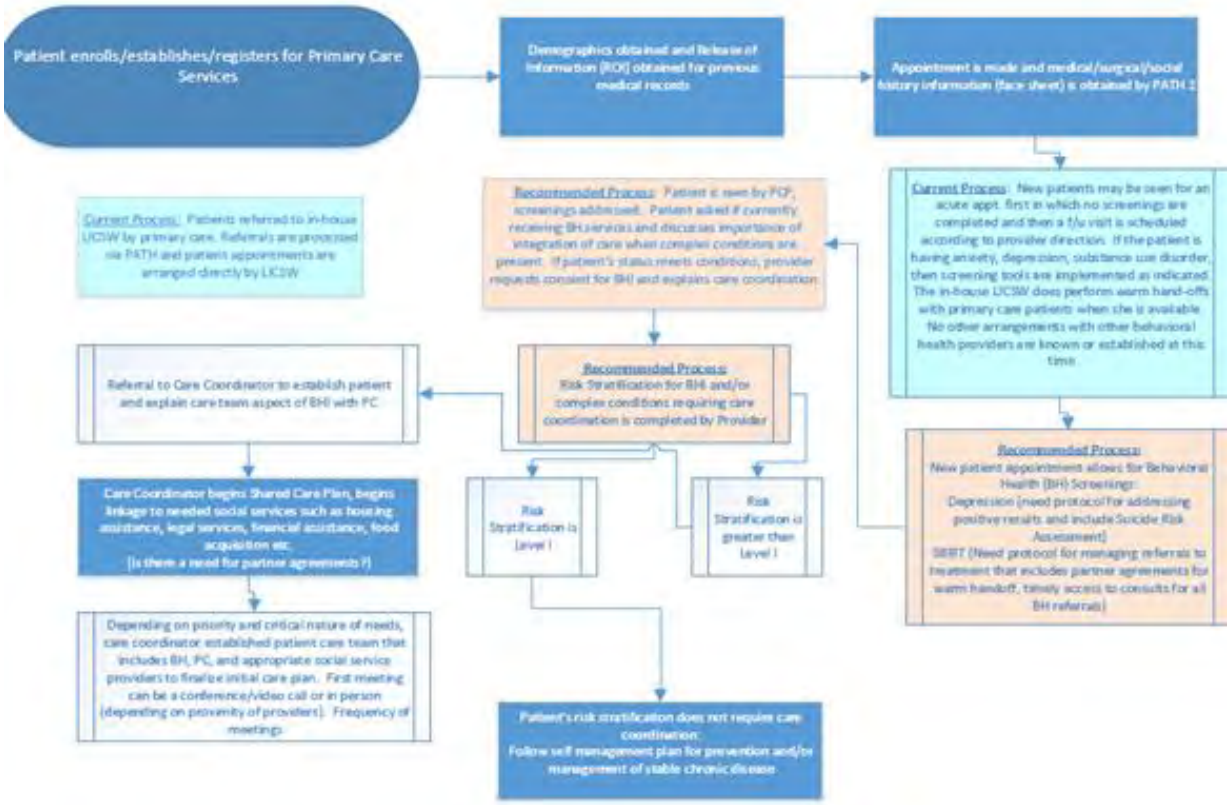
B1-8h – Documented work flows and/or protocols

Region 7 IDN's implementation plan stated that NCHC staff would work with the Region 7 IDN Clinical workgroup to Core Competency Integration toolkit based on best practices to ensure safe care transitions from institutional settings back to primary care, behavioral health and social support service providers. The Clinical Workgroup has identified SAMHSA-HRSA Center for Integrated Health Solutions, Agency for Healthcare Research and Quality (AHRQ) Academy for Integrating Behavioral Health and Primary Care Integration Playbook, Institute for Health Improvement, Advancing Integrated Mental Health Solutions (AIMS) Center, and Partners in Health Interagency Toolkit will serve as the main resources for the development of the Region 7 Core Competency Integration Toolkit. The B1 toolkit was scheduled to be completed by October 2017, and then used within practices throughout 2018 until all participating primary care and behavioral health sites have documented workflows and protocols in place. NCHC staffing transition and busy provider schedules has delayed work on the document, but the region has a version of the toolkit that will be shared with IDN partners early in 2018. The toolkit will be modified on an as needed basis based on feedback from IDN partners.

Region 7 IDN included examples of workflows and protocols that were being utilized when the July 2017 implementation plan was submitted. Since then, Huggins Hospital and White Mountain Community Health Center have been working on workflows and protocols related to care coordination and behavioral health integration. Both agencies are collaborating with Northern Human Services to discuss regional care coordination, and this level of communication, along with the implementation of the

shared care plan will lead to advances along the continuum of integrated healthcare for the agencies and the patients in the region. The work happening at these 3 agencies will be used as a pilot model, and information will be shared with other practices in Region 7 IDN.

Example Behavioral Health Integration Draft Workflow



Example Workplan for Behavioral Health Integration

Objective	Workflow steps	Tasks to be completed
New Patient Establish	• Register patient • Get Release of Information for previous medical records	1. Identify Demographic information needed 2. Create welcome letter/packet
New Patient Coordinator	• Make appt. for in-person or telephone visit with New Patient Coordinator • NPC enters all assessment data into EMR prior to establish visit	1. Create role description for NPC 2. Establish calendar/time available for new patient assessment 3. Establish Comprehensive Standardized Health Assessment that meets IDN requirements

New Patient Office Visit to Establish	• Support staff assist patient with SBIRT and Depression Screenings • Support staff reviews patient's PMH/FMH/SH	1. SBIRT, Depression screening procedures 2. Risk Stratification procedures 3. Rooming procedures for new patient appointment.
Provider establishes Shared Decision Making and Shared Care Plan	• Provider reviews screenings • Provider assigns risk stratification level • Provider Refers to appropriate levels of care based on stratification • Provider and patient develop initial self-management goals	1. Schedule provider training/information meeting 2. Establish shared decision making and self- management plans that match risk stratification level 3. Establish medical neighborhood for referrals to behavioral health and social services that includes partner agreements for integration of care
Care Coordination	• Referral to care coordination indicates risk level and patient self-management goals • Shared care plan	1. Care Coordination policy and procedures 2. Develop process on implementing risk stratification and patient self - management plans 3. Develop process for integration of behavioral health and social service organizations into shared care plans 4. Develop process for multidisciplinary care team for high risk patients.

B1-9. 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
B1-1	IDN Integrated Healthcare: Assessment and Ongoing Reporting of Current State of Practice Against SAMHSA Framework for Integrated Levels of Care and Gap Analysis	Narrative				
B1-2	IDN Integrated Healthcare: Implementation Plan, Timeline, Milestones and Evaluation Project Plan	Spreadsheet (Microsoft Project or similar platform)				

Process Milestone Number	Process Detail	Submission Format	Results (Met/Not Met)			
			6/30/17	12/31/17	6/30/18	12/31/18
B1-3	IDN Integrated Healthcare: Evaluation Project Targets	Table				
B1-4	IDN Healthcare Integration Workforce Staffing	Table				
B1-5	IDN Healthcare Integration: Budget	Narrative and Spreadsheet				
B1-6	IDN Integrated Healthcare: Key Organizational and Provider Participants	Table				
B1-7	IDN Integrated Healthcare: Organizational leadership sign-off	Table				
B1-8a	All of the following domains must be included in the CCSA: • Demographic information • Physical health review • Substance use review • Housing assessment • Family and support services • Educational attainment • Employment or entitlement • Access to legal services • Suicide risk assessment • Functional status assessment • Universal screening using depression screening (PHQ 2 & 9) and • Universal screening using SBIRT	CCSAs (Submit all that are in use) Table listing all providers by domain indicating Y/N on progress for each process detail				

Process Milestone Number	Process Detail	Submission Format	Results (Met/Not Met)			
			6/30/17	12/31/17	6/30/18	12/31/18
	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)	Training schedule and Table listing all provider practice sites and number of individuals by provider type to be trained, PCP or BH. Ongoing reporting shall indicate # of people				

Process Milestone Number	Process Detail	Submission Format	Results (Met/Not Met)			
			6/30/17	12/31/17	6/30/18	12/31/18
		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				

Process Milestone Number	Process Detail	Submission Format	Results (Met/Not Met)			
			6/30/17	12/31/17	6/30/18	12/31/18
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 opioid prescribing	Work flows and/or Protocols (submit all in use)				

B1-10. Additional Documentation as Requested in B1-9a - 9d of the Project Scoring Table in B1-11 below.

B1-9a Coordinated Care Practice designation progress
For a participating behavioral health or primary care practices to reach a level of coordinated care by December 31, 2018 they must work to implement the following:

- Comprehensive Core Standardized Assessment
- Multi-Disciplinary Core Team
- Standardized Workflows and Protocols
- Information Sharing: Care Plans, Treatment Plans, Case Conferences

Comprehensive Core Standardized Assessment
Region 7 IDN has made progress on the required Coordinated Care components referenced above. The region has not adopted the use of a single comprehensive core standardized assessment tool. Instead, providers are encouraged to use existing assessment tools to capture the required domain information. If a provider agency doesn't currently capture a specific domain during the assessment process, then they will be able to use the region's Core Competency Integration Toolkit to get suggestions on questions to include in the assessment process which will capture the required domains. Although it is a work in progress, the toolkit will include examples of questions used to capture the domains of a comprehensive core standardized assessment.

Upon the suggestion of the IDN Medical Director, during the first four months of 2018 NCHC will reassess the assessment and screening tools being utilized by the behavioral health and primary care providers in the region. Once the assessment process is complete, Region 7 IDN HIT Integration Coach and Quality Improvement Coach will meet with partner agencies by June 30, 2018 to create a plan outlining when the DSRIP required domains will be added to the CCSA process to ensure practices reach coordinated care designation by 12/31/2018. IDN staff will work with practices from June-December 2018 to help them develop protocols for the CCSA process, and identify the training needs of the practices related to the implementation of the CCSA.

Multi-Disciplinary Core Team
To help the region prepare for the multi-disciplinary core team requirement NCHC convened a meeting with Ammonoosuc Community Health Services, Weeks Medical Center, and White Mountain Community Health Center on November 13, 2017 to discuss the regional approach for the multidisciplinary teams. NCHC is working with IDN partner agencies to create a multidisciplinary team model that will bring value to providers and patients in the region while meeting DSRIP requirements. Region 7 IDN has not identified who will participate on each multi-disciplinary team, but the region plans to have 3 teams in place by the end of 2018. The teams will be established in waves, following the roll out of the shared care plan; Carroll County by March 2018, Coos County by June 2018, and northern Grafton County by September 2018. Rolling out the teams in a staggered approach will allow for rapid cycle evaluation to see what works the best and share best practices with the other teams as they get established. NCHC will work with partner agencies to ensure the regional multi-disciplinary core team incorporates a Community Care Team on an as needed basis.

IDN staff has reached out to the Department of Psychiatry at the Geisel School of Medicine at Dartmouth and Northern Human Services to receive a cost proposal of what it will cost to cover the psychiatrist component of the multi-disciplinary core team. Region 7 IDN will discuss these cost

proposals with the IDN Steering Committee and the IDN region at the March 2018 quarterly meeting. Region 7 IDN has selected a phased rollout into three distinct sub regions for CMT's PreManage Community and ED Products. This product will enable not only the shared care plan technologies but also for users to receive event notifications. The three sub regions include Carroll County, Northern Grafton Count and Coos County. The first of these trainings slated to start at a 2-day training scheduled for March 29th and 30th, 2018 with providers located in or serving Carroll County. Two separate hour long PreManage Primary trainings will be surrounded by other integration training, with a focus on making the use case for PreManage primary clear to attendees as well as instilling knowledge of the benefits.

Standardized Workflows and Protocols

NCHC is working closely with Northern Human Services, Huggins Hospital, White Mountain Community Health Center, Ammonoosuc Community Health Services, Friendship House, Weeks Medical Center, and Coos County Family Health Services on many projects which also intersect with the IDN. Examples of these intersecting projects include the Practice Transformation Network, the Community Health Worker Program, and clinical services for SUD treatment needs. Region 7 IDN is looking at the convergence of these programs and will use these practices as a pilot model to create documented workflows and protocols.

Information sharing:

In preparation for a regional rollout of the shared care plan, IDN Region 7 Providers and Staff have participated in three shared care plan discussions held by Region 1 in October and November to prepare for protocols and privacy practices necessary to utilize the shared care plan tool in a diverse, multi-organization environment. Region 7 also coordinated a vendor presentation entitled "the Value of the Shared Care Plan" at the December 2017 quarterly meeting, which generated a great deal of interest from our partners in attendance.

In addition, IDN Region 7 has hired a Health Information Technology (HIT) Integration Coach to assist with the rollout. This staff member will begin in the new year and will spend his first several weeks becoming familiar with the PreManage primary tool and meeting local partners. The goal is to have this individual ready and able to support the rollout when it begins in March.

Finally, IDN Region 7's lead agency, North Country Health Consortium, has agreed to pilot the use of the shared care plan tool prior to the March training with their cadre of community health workers, whose focus is on coordinating the care of a high needs population being served by several local providers. The goal of this implementation is to 1) enhance the ability of these Community Health Workers to serve their target population and 2) build a core of "power users" of the tool within the lead agency and 3) demonstrate the value of the shared care plan tool to the partner agencies with whom these workers interface.

B1-9b Additional Integrated Practice designation requirements

In addition to all the requirements for the Coordinated Care Practice designation above, the Integrated Care Practice must include incorporate Medication-assisted treatment (MAT) and Evidence-based treatment of mild-to-moderate depression within the Integrated Practice setting either (e.g., IMPACT or other evidence-supported model) and have an enhanced use of technology. Region 7 IDN has numerous IDN partners working to either implement MAT programs or expand existing programs. These agencies include: Weeks Medical Center, Ammonoosuc Community Health Services, White Mountain Community Health Center, Coos County Family Health Services, Saco River Medical Group, Memorial Hospital, and Huggins Hospital. The region's Expansion in SUD Treatment Option Toolkit has numerous screening and assessment tools and includes MAT best practices and protocols. In addition, the region's Core

Competency Integration toolkit contains protocols related to evidence-based treatment of mild-to-moderate depression within an integrated practice setting. IDN staff will be working to get these toolkits out to the IDN members in early 2018 and follow up with partners to offer technical assistance with meeting DSRIP deliverables.

B1-9c Use of technology to identify, at minimum: at risk patients, plan care, monitor/manage patient progress toward goals, ensure closed loop referrals

The IDN Clinical workgroup is continuing to work in conjunction with the IDN Data workgroup to assess the level of technology at participating provider sites, and the capabilities of this technology to identify patients at risk, plan care, monitor/manage patient progress towards goals, and have a closed loop referral process. The plan to do this is below:

Provider List		Process Details			
Provider	**Provider Type**	**Identify At Risk Patients**	**Plan Care**	**Monitor/Manage Patient Progress Towards Goal**	**Ensure Close Loop Referrals**
Northern Human Services	Substance Use Disorder Provider; Community Mental Health Center (CMHC); Community-Based Organization Providing Social and Support Services	Region will pilot use of data aggregator to perform population health tasks by 12/31/2018	Targeted for rollout of CMT PreManage 03/01/2018	Targeted for rollout of CMT PreManage 03/01/2018	Targeted for rollout of CMT PreManage 03/01/2018
White Mountain Community Health Center	Non-FQHC Community Health Partner	Region will pilot use of data aggregator to perform population health tasks by 12/31/2018	Targeted for rollout of CMT PreManage 03/01/2018	Targeted for rollout of CMT PreManage 03/01/2018	Targeted for rollout of CMT PreManage 03/01/2018
Memorial Hospital	Hospital Facility	Region will pilot use of data aggregator to perform population health tasks by 12/31/2018	Targeted for rollout of CMT PreManage 03/01/2018	Targeted for rollout of CMT PreManage 03/01/2018	Targeted for rollout of CMT PreManage 03/01/2018
Huggins Hospital	Primary Care Practice; Hospital Facility	Region will pilot use of data aggregator to perform population health tasks by 12/31/2018	Targeted for rollout of CMT PreManage 03/01/2018	Targeted for rollout of CMT PreManage 03/01/2018	Targeted for rollout of CMT PreManage 03/01/2018
Crotched Mountain Foundation	Hospital Facility; Community-based organization providing social	Region will pilot use of data aggregator to perform	Targeted for rollout of CMT	Targeted for rollout of CMT PreManage 03/01/2018	Targeted for rollout of CMT

	and support services	population health tasks by 12/31/2018	PreManage 03/01/2018		PreManage 03/01/2018
Life Coping, Inc.	Community-based	Region will pilot use of data aggregator to perform population health tasks by 12/31/2018	Targeted for rollout of CMT PreManage 03/01/2018	Targeted for rollout of CMT PreManage 03/01/2018	Targeted for rollout of CMT PreManage 03/01/2018
Saco River Medical Group	Rural Health Clinic	Region will pilot use of data aggregator to perform population health tasks by 12/31/2018	Targeted for rollout of CMT PreManage 03/01/2018	Targeted for rollout of CMT PreManage 03/01/2018	Targeted for rollout of CMT PreManage 03/01/2018
White Horse Addiction Center	Addiction & Recovery	Region will pilot use of data aggregator to perform population health tasks by 12/31/2018	Targeted for rollout of CMT PreManage 03/01/2018	Targeted for rollout of CMT PreManage 03/01/2018	Targeted for rollout of CMT PreManage 03/01/2018
Carroll County Department of Corrections	County Corrections Facility	Region will pilot use of data aggregator to perform population health tasks by 12/31/2018	Targeted for rollout of CMT PreManage 03/01/2018	Targeted for rollout of CMT PreManage 03/01/2018	Targeted for rollout of CMT PreManage 03/01/2018
Androscoggin Valley Hospital	Hospital Facility	Region will pilot use of data aggregator to perform population health tasks by 12/31/2018	Targeted for rollout of CMT PreManage 06/01/2018	Targeted for rollout of CMT PreManage 06/01/2018	Targeted for rollout of CMT PreManage 06/01/2018
Coos County Family Health Services	Federally Qualified Health Center (FQHC)	Region will pilot use of data aggregator to perform population health tasks by 12/31/2018	Targeted for rollout of CMT PreManage 06/01/2018	Targeted for rollout of CMT PreManage 06/01/2018	Targeted for rollout of CMT PreManage 06/01/2018
Weeks Medical Center	Primary Care Practice; Hospital Facility; Rural Health Clinic	Region will pilot use of data aggregator to perform population	Targeted for rollout of CMT PreManage 06/01/2018	Targeted for rollout of CMT PreManage 06/01/2018	Targeted for rollout of CMT PreManage 06/01/2018

		health tasks by 12/31/2018			
Indian Stream Health Center	Federally Qualified Health Center (FQHC); Substance Use Disorder; Non-CMHC Mental Health Provider; Community-based Organization providing social and support services	Region will pilot use of data aggregator to perform population health tasks by 12/31/2018	Targeted for rollout of CMT PreManage 06/01/2018	Targeted for rollout of CMT PreManage 06/01/2018	Targeted for rollout of CMT PreManage 06/01/2018
Upper Connecticut Valley Hospital	Hospital Facility	Region will pilot use of data aggregator to perform population health tasks by 12/31/2018	Targeted for rollout of CMT PreManage 06/01/2018	Targeted for rollout of CMT PreManage 06/01/2018	Targeted for rollout of CMT PreManage 06/01/2018
Ammonoosuc Community Health Services	Federally Qualified Health Center (FQHC)	Region will pilot use of data aggregator to perform population health tasks by 12/31/2018	Targeted for rollout of CMT PreManage 09/01/2018	Targeted for rollout of CMT PreManage 09/01/2018	Targeted for rollout of CMT PreManage 09/01/2018
Littleton Regional Healthcare	Hospital Facility; Rural Health Clinic	Region will pilot use of data aggregator to perform population health tasks by 12/31/2018	Targeted for rollout of CMT PreManage 09/01/2018	Targeted for rollout of CMT PreManage 09/01/2018	Targeted for rollout of CMT PreManage 09/01/2018
Cottage Hospital	Hospital Facility	Region will pilot use of data aggregator to perform population health tasks by 12/31/2018	Targeted for rollout of CMT PreManage 09/01/2018	Targeted for rollout of CMT PreManage 09/01/2018	Targeted for rollout of CMT PreManage 09/01/2018
Rowe Health Center	Rural Health Clinic	Region will pilot use of data aggregator to perform population health tasks by 12/31/2018	Targeted for rollout of CMT PreManage 09/01/2018	Targeted for rollout of CMT PreManage 09/01/2018	Targeted for rollout of CMT PreManage 09/01/2018
North Country Health Consortium	Substance Use Disorder Treatment (After 10/01/2017	Region will pilot use of data aggregator to perform	Targeted for rollout of CMT	Targeted for rollout of CMT PreManage 09/01/2018	Targeted for rollout of CMT

		population health tasks by 12/31/2018	PreManage 09/01/2018		PreManage 09/01/2018

The table below reflects progress made between July 1, 2017-December 31, 2017 as Region 7 IDN works to use technology to identify at risk patients, plan care, monitor/manage patient progress toward goals, and ensure closed loop referrals. A significant amount of this progress relates to learning about 42CFR Part 2 which will be necessary to plan care and ensure a closed loop referral process. In addition, contracting with CMT will provide IDNs with a platform to plan patient care and manage patient progress towards goals.

Timeline	Activity
July 2017	Finished 42 CFR Part 2 Privacy Bootcamp – privacy workbook created, including draft consent forms and qualified service organization agreements – all documents that will be needed for information sharing including the shared care plan
August 2017	PreManage demos for Region 7 IDN partners
September 2017	CMT and NCHC started outreach to the seven hospitals in Region 7 IDN to get the hospitals' Admission, Discharge, Transfer (ADT) feeds sent to CMT because theses will help power PreManage Community, the shared care plan.
September 11, 2017	NCHC signed CMTs contract so CMT could start working with agencies in Region 7 IDN.
September 19, 2017	CMT presented to Region 7 IDN Clinical Workgroup to start discussions on regional event notification criteria.
September 28, 2017	42 CFR Part 2 presentation at Region 7 IDN quarterly meeting
October 27, 2017	Shared Care Plan Data Convention discussion with all IDNs implementing CMT
October 31, 2017	Met with North Country Hospital Board Presidents (Upper Connecticut Valley Hospital, Androscoggin Valley Hospital, Weeks Medical Center, Littleton Regional Healthcare) to discuss implementation of shared care plan
November 3, 2017	Shared Care Plan Privacy Policy Guiderails with all IDNs implementing CMT
November 10, 2017	Shared Care Plan Privacy Guiderails continued, with all IDNs implementing CMT
December 7, 2017	CMT present at Region 7 IDN quarterly meeting to discuss implementation of ADTs, PreManage ED, and PreManage Community
December 2017	Hired Region 7 IDN HIT Integration Coach

December 2017	HL7 ADT feed for Huggins and is now active

B1-9d Documented work flows with community based social support service providers
IDN staff will continue to work with the IDN partners to assess for workflows related to communication with social support service providers and will incorporate examples of these workflows within the regions Core Competency Integration Toolkit. NCHC still has not seen any examples of documented workflows within the region as they relate to community based social support providers.

B1-11. Project Scoring: IDN Integrated Healthcare Process Milestones, Achievement of *Integrated Care Practice* Designation Requirements

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

Process Milestone Number	Section	Process Detail	Submission Format	Results (Met/Not Met)			
				6/30/17	12/31/17	6/30/18	12/31/18
B1-9a	Coordinated Care Practice designation	Achievement of all of the requirements of a Coordinated Care Practice	Progress towards Coordinated Care Practice Designations				
B1-9b	Additional Integrated Practice designation requirements	Adoption of both of the following evidence-based interventions: • 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	Table listing all providers indicating progress on each				

Process Milestone Number	Section	Process Detail	Submission Format	Results (Met/Not Met)			
				6/30/17	12/31/17	6/30/18	12/31/18
		• Monitor/manage patient progress toward goals • Ensure closed loop referral	process detail				
B1-9d		Documented work flows with community based social support service providers including, at minimum: • Joint service protocols • Communication channels	Work flows (Submit all in use)				

B1-12. Project Scoring: 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.

	Total Goal Number Designated	Baseline Designated 6/30/17	Number Designated 12/31/17	Number Designated 6/30/18	Number Designated 12/31/18
Coordinated Care Practice	12	0	0		
Integrated Care Practice	8	0	0		

Coordinated Care Practice	List of providers identified to make progress toward Coordinated Care Practice designation	12/31/17	6/30/18	12/31/18
	Saco River White Mountain Community Health Rowe LRH Whitehorse Huggins ISHC ACHS Memorial Weeks Northern Human Services Coos County Family Health Services Friendship House	None are considered coordinated care designation because none have a CCSA in place which captures all 12 domains		

Integrated Care Practice	List of providers identified to make progress toward Integrated Care Practice designation	12/31/17	6/30/18	12/31/18
	ISHC ACHS Memorial Weeks CCFHS NHS Friendship House White Mountain Community Health Center	None are considered integrated care practice		

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.

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.

During the reporting period of 7/1-12/31/2017 Region 7 IDN had 1 new member agency, North Country Serenity Center, a Recovery Community Center join the network, and no members leave.

Region 7 IDN submitted a CTI implementation plan that stated the region would create a robust training program that equips workers with the necessary tools and soft skills to effectively serve a more complex patient; offer ongoing complimentary training and professional development to learn new skills; and offer strong supervision that guides, receives input from CTI workers, provides problem solving expertise and processes experiences that could lead to worker burnout. NCHC also reported that Region 7 IDN would partner with IDNs from region 1, 3, 4 and 6 to offer an initial statewide CTI worker training in November 2017, and a statewide CTI Supervisor training will be held within 6 weeks following the initial training. In addition, NCHC reported that a CTI Learning Collaborative would be formed which is inclusive of all statewide CTI program staff. Region 7 IDN will also have a CTI toolkit which contains assessment tools, protocols, crisis planning tools, monitoring tools, care transition plans, CTI worker guidelines, and roles and responsibilities for CTI workers.

Region 7 IDN has seen forward movement in the implementation of the CTI program during the July – December 2017 reporting period. As planned, the region has continued to partner with regions 1, 3, 4 and 6 to offer CTI training programs for the region through The Center for Advancement of Critical Time Intervention (CACTI) at Hunter College. The first statewide CTI worker training was held on November 15-16 for 45 participants, 11 of which were from Region 7 IDN. The participants from Region 7 came from

Weeks Medical Center, Northern Human Services, Tri-County Community Action Program (TCCAP), and Carroll County Department of Corrections. There was also participation from Crotched Mountain, a statewide agency. The first CTI Supervisor training was held on December 18th for 16 participants, 3 of which were from Region 7. To help support these new workers the group has established a Community of Practice which met on December 20th for the first time. This learning collaborative model is designed to be a platform for information sharing along with getting technical assistance from CACTI. The CTI Community of Practice will meet monthly over phone, and the attendees will meet in person on a quarterly basis.

Region 7 IDN had 2 agencies actively working to implement the CTI model during the July-December 2017 reporting period, TCCAP and Carroll County Department of Corrections. Carroll County Department of Corrections will be using the CTI model to improve transitional services for offenders as they reentry the community. Their model will focus on a coordinated case plan, including input from key community based providers to allow for a seamless transition into the community including access to behavioral health services including inpatient and outpatient services. The agency has trained one staff person as both a CTI worker and supervisor. They are currently advertising for a correctional case manager who will be trained in the CTI curriculum upon hire. Agency staff have also completed trainings in Prime for Life, Prime Solutions, and Thinking for a Change during the reporting period. The agency has completed 45 case management assessments, and referred 18 patients to residential and/or intensive outpatient treatment programs. In addition, through funding from the Bureau of Justice Carroll County Department of Corrections is currently recruiting for a Mental Health/Substance Abuse Clinician which will be a partnership with Northern Human Services.

TCCAP is using the Critical Time Intervention model for their Homeless Intervention/Prevention Programs. Progress for the reporting period of 7/1/2017 through 12/31/2017 includes 4 staff members being trained as CTI workers, and 2 staff members being trained as CTI Supervisors. Agency staff have presented their project to NH's Bureau of Homeless and Housing's Balance of State Continuum of Care, and have connected with Littleton Regional Healthcare Transitions in Care group to share information about their CTI program. TCCAP was asked to present about the CTI model for the State of NH Employment Program. The agency has begun conversations related to marketing materials, and identified individuals applying for grants and loan programs as potential participants in CTI. TCCAP has hired 3 new case managers who will serve in the role as Intervention/Prevention staff members. To better serve the project's needs TCCAP has signed a lease for new office space within Mt. Eustis Commons.

The region's CTI toolkit has been compiled and will be sent to agencies implementing the CTI program. The toolkit will be revised as feedback is received from the CTI workers.

C-2. IDN Community Project: Evaluation Project Targets

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

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

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
# of individuals served by CTI	120 by 12/31/2018	0		

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
# of partner organizations implementing CTI	3 by 12/31/2018	2		
# of CTI workers positioned in Region 7 IDN	15 by 12/31/2018	11		

C-3. IDN Community Project: Workforce Staffing

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

Provider Type	IDN Workforce (FTEs)				
	Projected Total Need	Baseline Staffing on 6/30/17	Staffing on 12/31/17	Staffing on 6/30/18	Staffing on 12/31/18
CTI Workers	15 by 12/31/2018	0	11		
CTI Field Work Coordinator/clinical supervisor	3 by 12/31/2018	0	3		

C-4. IDN Community Project: Budget

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

Budget Period:	**01/01/2017-12/31/2020**	**07/01/2017-12/31/2017**	**07/01/2017-12/31/2017**	**01/01/2018-12/31/2020**	
	Care Transition Budget	**Care Transition Budget (6 months)**	**Care Transition Actual Expense (6 months)**	**Care Transition Budget Projection (remaining project period)**	
Line Item	**Total**	**Total**	**Total**	**Total**	**NARRATIVE:**
1. Total Salary/Wages					
2. Employee Benefits					
3. Consultants					
5. Supplies:					
Educational					

Office	$9,662	$1,208	$797	$7,247	**YR2-YR5:** Org.-Wide Office Supply Allocation
6. Travel			$227		
7. Occupancy					
8. Current Expenses					
Telephone					
Postage					
Subscriptions			$1,693		
Audit and Legal					
Insurance					
Board Expenses					
9. Software	$3,790	$474	$66	$2,843	
10. Marketing/Communications	$4,556	$570	$955	$3,417	**YR2-YR5:** Org.-Wide Marketing/Communications Allocation & Outreach materials
11. Staff Education and Training	$17,055	$2,132	$453	$12,791	
12. Subcontracts/Agreements					
13. Other (specific details mandatory):					
Current Expenses: Administrative Lead Organizational Support	$17,904	$2,238	$1,408	$13,428	**YR2-YR5:** Telephone/Postage/Audit&Legal/ Insurance
Support Payments to Partners	$747,332	$93,417	$39,109	$560,499	**YR2-YR5**: Personnel/Supplies/Travel/Software/Mrktg/Training. **Additional Notes:** RFPs awarded. Payment in various stages pending MOU execution and reporting deliverables.
TOTAL	**$1,210,950**	**$151,369**	**$60,791**	**$908,213**	

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

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

Organization/Provider	Agreement Executed (Y/N)
Tri- County Cap	y
Carroll County Corrections	y
Northern Human Services	N
Memorial Hospital	N

C-6. IDN Community Project: Standard Assessment Tools

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

Standard Assessment Tool Name	Brief Description
Abbreviated Assessment	Only required if client has not had a comprehensive clinical assessment within the previous 12 months, contains basic assessment information.

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

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

Protocol Name	Brief Description	Use (Current/Under development)
Identification	Criteria to identify	Under development, will be completed by March 2018
Sequential Intercept Model	Illustrated flow chart of points of interception with potential clients	Is complete
Referral/Consent Form	Protocol for referring clients to the CTI program and obtaining client consent	Under development, will be completed by March 2018
Phase Plan	Outlines Client goals, is created with client input	Is complete
Standardized Care Transition Plan (Treatment Protocol)	Outline of processes and actions for all three phases of the CTI model; Transition to the Community, Try Out & Transfer of Care	Is completed

Protocol Name	Brief Description	Use (Current/Under development)
Crisis Plan	Actions to be taken, and contacts to be made if there is a client crisis	Is complete
CTI Closing Note	Summary of interventions, impact on client, closing status, next steps and recommendations.	Complete

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

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

Project Team Member	Roles and Responsibilities
CTI Worker	To initiate contact with client; be the primary contact person for up to 20 clients, provide access or referral to recovery support services; assist clients in navigating resources and obtaining additional benefits; maintain client files follow CTI Worker guidelines that Includes location of time spent with client; goals setting process, minimum of client meetings per phase. Follow all of the pre-determined steps of the CTI model and meet all of the required Supervision and Documentation requirements. Provide CTI services that meet the quality, performance and fidelity methods of the program, meet the needs of the client and the stakeholders, develop and maintain constructive working relationships with the community.
CTI Supervisor	Provide supervision, assure quality of all services provided, assure all team members are maintaining fidelity to the program, share strategies and problem-solving techniques, maintain documentation, complete CTI Caseload Review form and CTI Supervision forms, oversee the status and completion of the CTI cycle.

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

The Region 7 IDN plan for CTI program implementation is inclusive of recruitment, training, implementation, oversight and evaluation processes. Eligible organizations will recruit internal or external candidates that meet the criteria for a CTI worker. CTI positions to be filled include a Fieldwork Coordinator/Clinical Supervisor, who has a least 2 years of experience with the population to be served and CTI Workers who may be Alcohol/Mental Health professionals, licensed or paraprofessional staff. Optional is a Peer Support Specialist with a min of two years working with the mental health population. The CTI team must be a minimum of 2, and recommended maximum of 5. CTI team members do not need to be located at the same organization, teams will be developed in 3 regions; Northern Grafton; Carroll County and Coos County.

Partnering with 4 other state IDN regions an initial statewide CTI training was held in November 2017, and the Statewide CTI Supervisor training was held on 12/18/2017. A second round of statewide CTI worker training will be held in March, 2018. A Train-the-Trainer training will be held at the end of the first 9 month cycle of the program, in August 2018. In addition, the CTI Community of Practice, a Statewide Learning Collaborative has been formed, and the first call was held on 12/20/2018. The Learning Collaborative will meet monthly via remote technology and quarterly in person. All training, Technical Assistance/Mentoring and Learning Collaborative leadership will be provided by National CTI experts from (CACTI) The Center for Advancement of Critical Time Intervention. A Technical Assistance/Mentoring schedule will provide guidance and assure fidelity to the program.

Participants will learn the three-phased, time-limited approach of the evidence-based CTI model, including pre-CTI, crisis intervention, and clinical supervision. They will be able to define the CTI core skills and principles needed to engage persons who are experiencing mental health, substance use disorder and other chronic diseases, and that are making a significant transition, such as from homelessness, hospitalization or incarceration. The training covers the key principles of the CTI model, evidence for its effectiveness, and the tools that teams need to implement and maintain fidelity.

C-10. 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-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.

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.

During the reporting period of 7/1-12/31/2017 Region 7 IDN had 1 new member agency, North Country Serenity Center, a Recovery Community Center join the network, and no members leave.

Region 7 IDN submitted a plan for expansion of substance use disorder (SUD) services which included expansion of the workforce and SUD treatment services; prevention and early intervention to reduce the number of individuals in need of services; and improved and expanded transition and care coordination services to prevent relapse. Specifically, the region said they would work on the following:

- Increase supportive BH therapy
- Increase MAT
- Expand IOP
- Expand outpatient counseling
- Increased evidence-based screening and identification of high-risk patients in primary care settings
- Institute a "no wrong door" program
- Community, patient and family education on mental health and substance use disorders
- Expand SUD education, outreach and prevention
- Strengthen peer supports
- Compile a D3 toolkit

The information below speaks to the significant progress that Region 7 IDN has made on their D3 project, Expansion in Intensive Substance Use Disorder (SUD) Treatment Options during the period of July 1 – December 31, 2017. Effective 10/1/2017 NCHC assumed operations of Friendship House, a residential treatment facility in Bethlehem, and the alcohol and other drug treatment and recovery services that were previously under the umbrella of Tri-County Community Action Program. NCHC has worked to incorporate Friendship House, outpatient services, peer recovery support services and the impaired driver

care management program into NCHC's Substance Use Disorder Program, which is part of its Substance Misuse Prevention-Continuum of Care Program. A key component of this transition includes building a new 32-bed, 17,588-square-foot center treatment and recovery center facility and tearing down the old building. It is anticipated that the new facility will be ready by October 2018. AHEAD (Affordable Housing Education and Development) will maintain ownership and then lease the facility to North Country Health Consortium. The new Friendship House treatment and recovery center, the region's only residential treatment facility, will be designed to treat addiction as a chronic disease with a medical model. This medical model includes eventually opening a 4-bed medical detoxification unit at Friendship House and providing mobile LADC services to the IDN region over the course of the demonstration.

Ammonoosuc Community Health Services (ACHS) will be an integral part of the medical model for Friendship House because the federally qualified health center will be providing medical staff on a part-time basis to perform physicals to patients which are needed for medical clearance prior to admission to Friendship House. In addition, ACHS medical staff will prescribe for clients with dual diagnoses, address screening and treatment of chronic disease, assist with medication management, and arrange for lab orders. ACHS will also work to expand capacity to address substance use disorders by training 2 LICSWs and 2 patient navigators in intensive SUD treatment, and then have these employees serve as resources for the ACHS sites in the region. Parallel to this approach, ACHS will embed one LICSCW into the Haverhill Cooperative Middle School on a part-time basis to offer evidence-based substance abuse prevention and counseling services, and they will improve follow up of patients seen in Littleton Regional Healthcare(LRH) emergency department for behavioral health conditions by reviewing the LRH ED report and reaching out to the patients to arrange for follow up care. The shared care plan should help facilitate some of this process. Waiting to hear more about their MAT program

Weeks Medical Center has demonstrated significant progress with their North Country Recovery Center (NCRC), a Medication Assisted Treatment (MAT) program for individuals struggling with substance use during the period of July-December 2017. Weeks Medical Center started their MAT program in mid-May 2017. Staffing needs, location, policies, protocols, consent forms, and flowcharts were established before the opening date. They started with 6 patients who were identified by their prescriber and M-LADC for the pilot program. In October 2017 Weeks Medical Center moved the North Country Recover Center to a permanent location in their Lancaster office, which required some construction to include an observation area for urine collections, an area for pill counts, and a separate private conference room for the interdisciplinary team meetings. In November 2017 they opened the clinic to accept referrals from all of Weeks primary care providers and by the end of 2017 they had 21 patients receiving MAT services at the North Country Recovery Center. Their MAT program is going so well, that they are currently planning to expand the program to the Littleton Regional Healthcare and Ammonoosuc Community Health Services catchment area in 2018. In addition to the MAT program, Weeks Medical Center is also an active participant in the Lancaster Safe Pathways Program. This program is in the early stages of development and is designed to connect SUD patients to a peer recovery support worker, even if they receive Naloxone and refuse additional medical treatment.

Another exciting project within Region 7 IDN is the opening of Endeavor House, a new program of Mount Washington Valley Supports Recovery Coalition (MWVSRC) in Center Conway. Endeavor House is a female sober transitional living house that has been renovated and is slated to open on January 15, 2018. The house will have 9 beds for women in the region and will combine transitional sober living with continued treatment services. This facility will help women transition to a sober lifestyle after completing primary or extended residential treatment. To support these women in their recovery MWVSRC offers numerous peer support services including counseling services, Families Advocating Substance Treatment, Education

& Recovery (FASTER) meetings, Grief Recovery After A Substance Passing (GRASP) meetings, and Medication Assisted Treatment meetings. MWVSRC educates, encourages and involves family and significant others in the recovery process to help break the generational cycle of addiction. In addition, the organization focuses on social support services to help clients successfully "re-socialize," or transition to an alcohol and drug free lifestyle that supports recovery, and they address specific issues to help clients avoid relapse and take accountability for sustaining recovery. In addition, the agency has plans to expand its offerings and collaborate with both Memorial Hospital and White Horse Addiction Center.

Coos County Family Health Services (CCFHS) in Berlin has reported significant progress in the development of their new MAT program. CCFHS is working in collaboration with Androscoggin Valley Hospital for this program, and they have formed a multidisciplinary team comprised of staff from both agencies. They have established an MAT team within the organization that includes physicians, nurses, a clinical social worker, MLDAC and medical social worker. In the fall of 2017 they hired a RN coordinator to coordinate the MAT program. During the fall of 2017 CCFHS expanded the number of hours contracted for drug and alcohol services from the local community mental health services from 8 to 16 hours per week. To prepare to implement the MAT program CCFHS partnered with the local state correctional facility who shared policies, practices and insights gained from their work offering MAT programs for the past several years. CCFHS Medical Director visited an FQHC in upstate New York that has offered MAT services for many years to learn more about how their program operates. The agency worked with the MaineGeneral Health System who provided them with technical assistance on establishing an MAT program, and staff participated in a MAT learning collaborative sponsored by the Bi-State Primary Care Association. The agency reached out to community leaders such as police, corrections officials, and city council members to let them all know the program was being developed. CCFHS has developed MAT workflows and EHR templates to support the MAT program and has had their MAT policies and procedures approved by their board of Directors. Four agency providers have obtained DEA waivers to prescribe MAT medications and are positioned to start offering MAT services in conjunction with Androscoggin Valley Hospital on 1/15/2018. Initially, the program will serve pregnant mothers, new mothers, and their partners. The first six months of 2018 will be spent implementing the program, revising policies as required, and adding additional waivered providers.

Saco River Medical Group (SRMG) has been actively working to expand their existing MAT program. The practice has two clinicians providing MAT services for 40 patients currently and has space for 80 patients by the end of 2018. SRMG has employed a new care coordinator who will monitor and navigate patients with behavioral health and SUD problems through the referral process, and the practice is increasing their formal use of behavioral health screening tools. They are actively seeking a part-time LADC to work within the practice.

White Mountain Community Health Center(WMCHC) has made progress on their new MAT program during the reporting period and have reached their full capacity of 30 patients. The organization has worked hard to get a good counseling system in place to support the MAT program, and this has been challenging due to the lack of LADCs in the area. WMCHC continues to revise processes as it relates to program compliance monitoring and wants to collaborate more with the Mount Washington Valley Supports Recovery Program previously mentioned.

Memorial Hospital, a newly approved Rural Health Center, has been working to expand their "New Life" program for pregnant and post-partum women with SUD. This comprehensive program provides a range of services during the prenatal and postpartum period, including medication assisted treatment, and ongoing weekly support and education to women in the program. Memorial has provided care for 16

women in the program prenatally and postpartum with good clinical outcomes. A licensed clinical social worker was hired for 2 hours a week in December 2017 for group counseling sessions instead of having to rely on a contracted employee for this service. As Memorial Hospital works to expand their program though radio and print campaigns, 3 midwives will work to be credentialed to prescribe MAT. Memorial Hospital is also in the process of expanding their MAT services in primary care, and effective 1/1/2018 will have a behavioral health department within primary care, with a behavioral health nurse practitioner serving as the director of the department. The agency intends to hire a patient care coordinator for this team as well, and the agency is recruiting for a LICSW to offer counseling services to support the MAT program. They have one APRN who has received credentialing to prescribe for MAT services, and she will see first patient in January. Two additional APRNs are in the process of being credentialed to prescribe for MAT. This means that Memorial will have a total of 6 nurse practitioners in different phases of receiving their MAT waiver, but all should be done by March 2018. To streamline efforts, avoid duplication and coordinate care for all patient within the Primary Care and Women's Health New Life program, staff have formed an interdisciplinary work team with representation from both departments. In addition, Memorial Hospital has taken on a lead role to form a multi-agency group within the Mount Washington Valley (MWV) for 4 organizations that are addressing SUD needs. The goal is to coordinate care, share resources, and improve communications among Memorial Hospital, Saco River Medical Group, Visiting Nurse Home Care & Hospice, and Children Unlimited. The Continuum of Care Facilitator for the Carroll County Coalition for Public Health will help to coordinate these efforts, and integrate this work with other agencies in the area including, but not limited to, White Horse Addiction Center, White Mountain Community Health Center, and MWV Supports Recovery,

Huggins Hospital has hired a full-time Licensed Social Worker whose objective is to integrate behavioral health into their primary care practices. She is currently seeing patients to provide behavioral health services on a "warm handoff" and works with patients within the primary care sites associated with the hospital. The agency is preparing to establish an MAT program in their primary care practices in 2018.

Strong working relationships with the Carroll County Public Health Network and North County Public Health Network have proven to be very beneficial to Region 7 IDN. Both public health networks have a Continuum of Care Facilitator (CoC) who has been very active with IDN initiatives. The North Country CoC works in Coos and northern Grafton County. In late summer/early fall of 2017 she worked to create a Continuum of Care Resource Guide full of information related to prevention, intervention, treatment and recovery resources in the region. 26000 copies of this document were directly inserted into 4 major North Country newspapers, 200 were made available for local distribution, and the document was posted on the NCHC website and shared electronically throughout the region. This document served as the foundation for a more comprehensive guide, called the Community Compass which was completed at the end of October 2017. There were 400 copies printed of this booklet, and they were distributed throughout the region to serve as a substance use disorder resource guide. This document is also on the NCHC website, and will be updated electronically as services change, and will be reprinted on an annual basis. As previously mentioned, the Carroll County CoC has been working with the Memorial Hospital collaborative proposal, and participates in the IDN Community Engagement Workgroup, and attends other IDN meetings as possible.

Whitehorse Addiction Center has been actively talking with agencies in their service area to discuss ways to collaborate on IOP and other counseling services. The organization has been working to secure pertinent trainings for staff and working to expand peer recovery services. Whitehorse Addiction Center has 2 recently certified CRSWs who are now working toward LADC licensure, and 6 recovery coaches, 3 of

which are working towards CRSW certification. The organization recently hired a LADC, but also had a LADC move to a different organization within the region.

The region also had 2 Peer Recovery Coach Academies during the reporting period, one in August 2017 in Whitefield where 9 people were trained, and one in December 2017 at the Northwoods Training Center in Whitefield, where 11 people were trained. 5 of these participants have also been trained as Community Health Workers. There is another Peer Recovery Coach Academy scheduled for March 2018 in Lancaster, NH.

Region 7 IDN has had numerous community education programs during the reporting period of July-December 2017.

- **Be An Opportunity**: 10/12 Woodsville, July 2017 in Lancaster, Colebrook, and Littleton – Bernadette Gleeson, a national motivational speaker delivered messaging on how to interact with people who have substance use disorders. Trained approximately 50 people
- **Resiliency in our Backyard**: 11/15/17 Colebrook interactive community conversation about substance misuse prevention, treatment and recovery in the community – 25 participants

NCHC staff, in partnership with the IDN Clinical Workgroup and clinicians from Friendship House, have been compiling the D3 toolkit, which contains treatment protocols, referral protocols, team roles and responsibilities, and a monitoring plan. This toolkit is still a work in progress but will be shared with IDN partners early in 2018.

D-2. IDN Community Project: Evaluation Project Targets

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

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

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
# of new MAT services in Region 7	3 by 12/31/2018	1		
# of individuals to be served with new MAT services in Region 7	35 by 12/31/2018	0		
# of new sites offering intensive outpatient (IOP) services	1 by 12/31/2018	0		
# of individuals to be served with IOP services	144 by 12/31/2018	25		
# of existing IOP providers expanding services	3 by 12/31/2018	0		
# trained Peer Recovery Coaches	6 by 12/31/2018	22		
# of individuals served by Peer Recovery Coaches	50 by 12/31/2018	0		

D-3. IDN Community Project: Workforce Staffing

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

Provider Type	IDN Workforce (FTEs)				
	Projected Total Need	Baseline Staffing on 6/30/17	Staffing on 12/31/17	Staffing on 6/30/18	Staffing on 12/31/18
Community Health Workers	4	0	13		
Psychiatric Nurse Practitioners	3	1	2		
Peer Recovery Coaches	6	2	22		
MLADC	3	0	0		
Case Management	2	2	4		

D-4. IDN Community Project: Budget

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

Budget Period:	**01/01/2017-12/31/2020**	**07/01/2017-12/31/2017**	**07/01/2017-12/31/2017**	**01/01/2018-12/31/2020**	
	Expansion in SUD Budget	**Expansion in SUD Budget (6 months)**	**Expansion in SUD Actual Expense (6 months)**	**Expansion in SUD Budget Projection (remaining project period)**	
Line Item	**Total**	**Total**	**Total**	**Total**	**NARRATIVE:**
1. Total Salary/Wages					
2. Employee Benefits					
3. Consultants					
5. Supplies:					
Educational					
Office	$9,662	$1,208	$591	$7,247	**YR2-YR5:** Org.-Wide Office Supply Allocation

6. Travel			$169		
7. Occupancy					
8. Current Expenses					
Telephone					
Postage					
Subscriptions			$1,255		
Audit and Legal					
Insurance					
Board Expenses					
9. Software	$3,790	$474	$2	$2,843	**YR2-YR5:**
10. Marketing/Communications	$4,556	$570	$708	$3,417	**YR2-YR5:** Org.-Wide Marketing/Communications Allocation & Outreach materials
11. Staff Education and Training			$337		
12. Subcontracts/Agreements					
13. Other (specific details mandatory):					
Current Expenses: Administrative Lead Organizational Support	$17,904	$2,238	$1,046	$13,428	**YR2-YR5:** Telephone/Postage/Audit&Legal/Insurance
Support Payments to Partners	$747,332	$93,417	$28,032	$560,499	**YR2-YR5**: Personnel/Supplies/Travel/Software/Mrktg/Training. **Additional Notes:** RFPs awarded. Payment in various stages pending MOU execution and reporting deliverables.
TOTAL	**$898,060**	**$112,258**	**$44,079**	**$673,545**	

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

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

Organization/Provider	Agreement Executed (Y/N)
Friendship Houses	y
White Horse Addiction Services	y
Northern Human Services	y
Indian Stream Healthcare	N
Huggins Hospital	N

Organization/Provider	Agreement Executed (Y/N)
Coos County Family Health	N
White Mountain Community Health	Y
Memorial Hospital	Y
Weeks Medical Center	Y
North Country Serenity Center	N
MWV Recovery	N
Ammonoosuc Community Health Services	y

D-6. IDN Community Project: Standard Assessment Tools

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

Standard Assessment Tool Name	Brief Description
SBIRT	Screening, Brief Intervention, and Referral to Treatment (**SBIRT**) is an evidence-based practice used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs.
Mental Health Screening Form	A comprehensive 12-page screening tool designed to gather the client's mental health experiences and screen for symptoms.

Standard Assessment Tool Name	Brief Description
(MAST)Michigan Drug Screening Test	The Michigan Alcohol Screening Test (MAST) is one of the oldest and most accurate alcohol screening tests available, effective in identifying dependent drinkers with up to 98 percent accuracy.
Stages of Readiness and Treatment Eagerness scale (SOCRATES 8D)	SOCRATES is an experimental instrument designed to assess readiness for change in alcohol abusers. The instrument yields three factorially-derived scale scores: Recognition (Re), Ambivalence (Am), and Taking Steps (TS)
Addiction Evaluation ASI Addiction	ASI is a semi-structured interview for substance abuse assessment and treatment planning. The ASI is designed to gather valuable information about areas of a client's life that may contribute to their substance-use problems.

Standard Assessment Tool Name	Brief Description
Addiction Severity Index (ASI) assessment tool	(ASI) is a semi-structured interview for substance abuse assessment and treatment planning. The ASI is designed to gather valuable information about areas of a client's life that may contribute to their substance-abuse problems.
DSM V Diagnostic Tool	The Diagnostic and Statistical Manual of Mental Disorders (DSM) is the handbook used by health care professionals as the authoritative guide to the diagnosis of mental disorders. *DSM* contains descriptions, symptoms, and other criteria for diagnosing mental disorders.
American Society of Addiction Medicine (ASAM) placement criteria tool	The ASAM criteria is most widely used and comprehensive set of guidelines for placement, continued stay and transfer/discharge of patients with addiction and co-occurring conditions.

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

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

Protocol Name	Brief Description	Use (Current/Under Development)
Assessment and Screening Protocol	The six assessment dimensions outlined by ASAM for making placement decisions	The ASAM six dimension assessment and screening tool is in place and adopted. Toolkit will be deployed by 3/29/18
Patient Treatment Protocol	Protocol to include coordination of medical care, therapeutic alternatives, safety, co-morbidity, social support networks and mutually agreed upon plan of action	Components of protocol are in place and adopted, additional research and review underway. Toolkit to be deployed by 3/29/18
Patient Management Protocol	Protocol includes oversight of patient care and medications, assessment of clinical progress, continuity in addiction care.	Components of protocol are in place and review underway. Toolkit will be deployed by 3/29/18
Referral Protocol	Protocol includes coordination of treatments, confidentiality, referral process, matching level of care with patient's preferences and history	Components of protocol are in place and review underway. Toolkit will be deployed by 3/29/18

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

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

Project Team Member	Roles and Responsibilities
Community Based Clinician	Based at Carroll County Corrections, this position supports inmates before and after release with behavioral health issues
Case Managers white horse	Providing case management for patients receiving IOP
Licensed social worker- Huggins	Addressing the behavioral health needs of patients and providing consult to physicians
Peer Recovery Coaches	Recovery support services for individuals with substance use disorder
Psych Nurse Practitioner	Behavioral Health, including MAT services
Physician’s Assistant	Assisting providing Behavioral health services at Friendship House
Community Nurse Care Coordinator	Assisting behavioral health patients connect with needed services
Behavioral Health Assistant	Providing support to behavioral health staff at community health center
Behavioral Health APRN	Providing behavioral health services at hospital

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

Training Plan and Curricula

In looking at the Region 7 overall implementation plan and recognizing the complimentary nature of the B1 and the regional plans, NCHC has created a master Training Plan that is divided into tracks. The main tracks are trainings specific to deliverables under B1 Integrated Health/Core Competencies, C1 Care Transitions, D3 Expansion in Substance Use Disorder Treatment, E5 Enhanced Care Coordination. In addition, Region 7 developed a list of supplemental trainings to promote professional development and provide community education and engagement. Most of the trainings listed can be useful in any or all of the IDN projects. Please see Training Plan below with Curricula descriptions

Region 7 IDN Master Training Table		
Training	**Description**	**Project Reference**
Core Competency Integration Toolkit	Participants will receive on overview of all Tools in the Core Competency Integration Toolkit	B1
Community Resources	The newest and up to date Community Resource guide created by the Continuum of Care Coordinators in Grafton, Coos and Carroll counties will be shared. Participants will be asked to share their community resources.	B1
42 CFR Part 2 Introduction	Overview of the updated 42 CFR Part 2	B1, C1, D3, E5
Multi-Agency Consent Forms and Shared Care Plan	Participants will learn how to use Region 7 IDN's multi-agency consent form as a tool to help drive the utilization of the shared care plan	B1, C1, D3, E5
Co-occurring Mental Illness and Substance Use Disorder	Participants will gain an understanding of co-occurring disorders, the prevalence of co-occurrence and recommendations for assessment and treatment	B1, E5
Anti-Stigma Training	The course is designed to provide participants with an opportunity to recognize attitudes and behaviors that could potentially lead to stigma. Participants will	B1

	examine attitudes, beliefs and behaviors toward persons with mental health problems, and become comfortable addressing mental health patients	
Core Standardized Assessment Tools	Participants will learn how to use the core standardized assessment tool to capture information regarding all of the required domains in the DSRIP program	B1
Cultural Competency	Cultural Competency- Class: A Hidden Culture of socioeconomic class relates to many aspects of the work in health care. This interactive workshop draws from the work of Ruby Payne, in Hidden Rules of Class, Bridges out of Poverty, and Framework for Understanding Poverty. Participants will engage in activities that illuminate some ways in which class acts as culture, determining assumptions, expectations, and conclusions about interactions	B1, E5
Change Management	Participants will learn how to get both organizational and employee buy-in of new initiatives, how to deal with culture change, how to implement new processes as efficiently as effectively as possible, and how to identify risks and develop system to mitigate those risks and monitor progress	B1
Integration 101	Understand the rationale for integrated care and how it leads to improved health outcomes Describe "integrated care," and the SAMHSA levels of integration,	B1
Health Literacy	Introduction to Health Literacy: Increasing awareness of how health literacy may impact practice. 18% of NH residents have never graduated high school and the majority read at a 7th & 8th grade level	B1

Mental Health First Aid	An international evidence-based practice designed for all audiences that teaches how to help someone who may be experiencing a mental health or substance use challenge. The training helps identify, understand and respond to signs of addictions and mental illnesses.	B1
Suicide Prevention	Connect Suicide Prevention: A national model that uses a socio-ecological model and best practices around Zero Suicide and suicide prevention	B1
Verbal De-Escalation Training	Ensure the safety of the patient, staff, and others in the area; help the patient manage his emotions and distress and maintain or regain control of his behavior; avoid the use of restraint when at all possible; and avoid coercive interventions that escalate agitation.	B1
Medication Assisted Treatment (MAT) Best Practices	American Society of Addiction Medicine (ASAM) criteria	D3
Community Health Worker (CHW) training	Participants will learn how community health workers serve as the link between health and social services and the community to facilitate access to services and improved quality and cultural competence of care. Skills learned include communication, advocacy, interpersonal issues, service coordination, organization, teaching, capacity building, motivational interviewing and knowledge in specific health issues, such as cervical cancer screenings, behavioral health, and oral health	E5, B1
Motivational Interviewing (MI) training	Understanding the basics of MI Practice applying Motivational Interviewing concepts and skills Recognize the four elements of MI-MI Spirit (PACE), MI Principles	B1, C1, E5

	(RULE), MI Skills and Strategies (OARS), and MI Tools and Change talk (DARN	
Critical Time Intervention training	Participants will learn the three-phased, time-limited approach of the evidence-based CTI model, including pre-CTI, crisis intervention, and clinical supervision. They will be able to define the CTI core skills and principles needed to engage persons who are experiencing mental health, substance use disorder and other chronic diseases and that are making a significant transition, such as from homelessness, hospitalization or incarceration. The training covers the key principles of the CTI model, evidence for its effectiveness, and the tools that teams need to implement it and maintain fidelity to it.	C1
Peer Recovery Coach training	Training provides participants with a basic understanding of substance use and mental disorders, crisis intervention and how to respond in crisis situations. In addition, skills and tools on effective communication, motivational enhancement strategies, recovery action planning, cultural competency and recovery ethics.	D3
Health Equity	Providers Linking Patient With Community Programs- Why improving the social determinants of health will help eliminate population-based health disparities; health-impacting choices that individuals make which are shaped by community environment and context; things health providers can do to strengthen the community knowledge base on population-based health disparities	B1

Self-Management and Recovery Training (SMART) program-	Participants get motivated to address substance use disorders, and learn how to cope with urges and drug use behaviors. SMART Recovery 4-Point Program, Building and Maintaining Motivation; Coping with Urges; Managing Thoughts, Feelings and Behaviors; Living a Balanced Life	D3
Virtual Collective Medical Technologies (CMT) training	NCHC will work with Collective Medical Technologies (CMT) to create a training program which can be virtually accessed by team members, IT staff, and other pertinent agency staff.	B1, C1, D3, E5
Engaging and Leveraging Family and Natural Supports in the Recovery Process	Family and natural supports can play a critical role in recovery success. NAMI NH offers training for providers on understanding the realities of living with mental illness and its effect on families; and how those natural supports can be engaged to promote recovery and enhance the treatment process.	D3
Trauma Informed Care and Health Professionals	Participants will understand the effects of childhood trauma as it relates to physical, mental and emotional health, identify possible procedures, policies, or physical structures that could trigger patients in their own health care setting, describe three interventions or skills that can be used to decrease the trauma response in patients.	D3, E5
Screening, Brief Intervention, and Referral to Treatment (SBIRT)	The NH Youth SBIRT Initiative is committed to expanding SBIRT as a standard practice of care across primary care settings in NH. To facilitate this growth, the Initiative is offering many educational and workforce developmental opportunities throughout the state. Monthly webinars, core	B1, D3, E5

	training, SBIRT model and validated screening tools, case examples and design flow within a clinical setting, Motivational interviewing techniques.	
Telehealth and mHealth Use in Integrated Care	The purpose of this training is to augment learner knowledge about existing telehealth and mHealth technology applications available to support behavioral health integration. Participants will be able to distinguish the differences between types of telehealth and mHealth technologies and applications as applied to integrated behavioral health; discover how clinical practices, researchers, and payers are defining the use and payment of telehealth and mHealth technologies to support integrated behavioral health; compare and contrast payer reimbursement models and understand their direct-to-consumer (DTC) model implications; describe the regulatory and legal frameworks governing mHealth technologies and practice impacts.	B1
Integration in the Practice - Part II: Coordination with Community and Re-visiting Payment	The purpose of this training is to increase learner capacity to 1) operationalize linkages with organizational as well as community resources with a focus on diverse populations to improve care quality and outcomes and 2) understand an alternative payment model structure to support behavioral health integration delivery. Learning Objectives include identify practical strategies to coordinate and monitor patient/family linkage to physical health, mental health/substance misuse, and enabling support services (organizational and community-based); describing models for shared care planning involving physical,	B1

	mental/substance misuse, and community support providers; Identifying mechanisms to address the unique needs of diverse populations in integrated care settings; recalling results of a fiscal analysis to develop a payment model to support the cost of care delivery in integrated care settings.	
Naloxone (Narcan)	Training provides step by step instructions for administration of Naloxone including signs and symptoms of overdoes, protocol for calling 911 and rescue breathing.	B1, C1, D3, E5
TeamSTEPPS Training Series for Hypertension Management	The purpose of this activity is to enable the learner to identify common communication barriers between team members in a healthcare setting and become familiar with TeamSTEPPS 2.0® tools that can be implemented to improve communication. Participants will be able to describe how communication affects team processes and outcomes; define effective communication and identify communication challenges; and identify TeamSTEPPS Tools and Strategies that can improve a teams' communication.	B1
New Lipid Guidelines	The purpose of this training is to enable providers to understand the components of the new lipid guideline recommendations and the current evidence to support the transition.	B1
Expanding Tobacco Treatment Among High-Risk Populations for Value-Based Integrated Care	Participants will be able to describe the short and long-term consequences of tobacco use for individuals who have a mental health issue (MHI) or substance use disorder (SUD), describe the return on investment of helping patients quit smoking, discuss	D3

	strategies to help individuals who have a mental health issue or substance use disorder quit using tobacco, understand how to make a referral to the NH Tobacco Helpline via QuitWorks-NH.	
Supervising a Peer Recovery Workforce	Are the supervisory needs in a peer-based recovery support service any different than in any other service, and how? What needs to be considered in developing the supervisor's role as well as the certified recovery support worker's role? As peer support services become more prevalent in substance use disorder recovery and mental health services, it is important to address these questions as peer roles can present unique challenges to existing supervision structures and	D3
HIV Update for Substance Use Professionals	This training is geared toward substance use professionals and will provide participants with basic and updated information about HIV other STDs. This includes risk factors, modes of transmission, signs and symptoms, prevention, the relationship between HIV and other STDs.	D3
Care Advocate Training	This training will be specifically designed for the Care Advocates in Project E5. This two-day training will provide instruction on all the Assessment, Treatment and Referral Protocols, Engagement strategies, Gap analysis, Communication skills and Tracking and Reporting required.	E5
The Metabolic Triad: Diabetes, Cardiovascular Disease, and Inflammation	Participants will be able to explain the burden of cardiovascular risk factor in patients with diabetes, define inflammation and its role as a risk factor for CVD, list 4 lifestyle modifications to reduce heart	B1

	disease, review evidence based guidelines for diet, lipid disorders and hypertension, explain positive approach to nutrition education, describe a Heart Healthy Diet	
Mental Health Provider Diabetes Education Program	This program will teach mental health providers about diabetes management, the daily struggles people face, as well as effective interventions to treat people with diabetes experiencing mental health issues	B1

D-10. 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-9	Provide the training plan and curricula for	Training schedule and table				

Process Milestone Number	Process Detail	Submission Format	Results (Met/ Not Met)			
			6/30/17	12/31/17	6/30/18	12/31/18
	each Community Driven Project as required in A-1.3					

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.

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.

During the reporting period of 7/1-12/31/2017 Region 7 IDN had 1 new member agency, North Country Serenity Center, a Recovery Community Center join the network, and no members leave.

Region 7 IDN selected to work on Enhanced Care Coordination for the High Needs Population, otherwise known as Project E5. The region's implementation plan stated the region would:

- Conduct a detailed analysis of the current care coordination workforce and their skill levels;
- Analyze high utilizers of both behavioral health, medical and emergency services;
- Create a robust training program that equips workers with the necessary tools and soft skills to effectively serve complex patients, and offer ongoing training and professional development to support this staff;
- Expand the Community Health Worker (CHW) workforce;
- Create a Care Advocate Workgroup to serve in an advisory capacity;
- Approach the project using a regional care coordination training model to train Care Advocates;

- Create an Enhanced Care Coordination Toolkit to be shared with partners implementing this project. The toolkit will contain many tools to assist with coordination of services, including:
- Utilize an outreach tool to define the program and services in simple and easy to understand language, free from medical jargon and suggest ways to approach candidates for this service;
- Develop an assessment tool that will be utilized to assess the individual's level of need for services and coordination;
- Use a template for creating a person-centered care plan that is inclusive of input from the patient and family/caregivers;
- Implement a process and criteria for identifying the members of the multi-disciplinary care team of providers that will represent the clinical, behavioral health, long term services and supports, social services including social determinants of health and other community resources that are needed for the individual to improve or maintain their functional status.

Region 7 IDN has made substantial progress on the E5 project during the timeframe of 7/1-12/31/17. The region has convened a Care Advocate workgroup which has met in November and December 2017. The purpose of the Care Advocate workgroup is to offer input in the development of a detailed process to identify the target population and conduct an analysis of the need for program thresholds such as # of Emergency Department visits or inpatient hospitalizations in 6 months. The target population will be those individuals who are heavy utilizers of Medicaid and emergency services including inpatient services. This population may include those with complex behavioral health and medical illnesses including serious mental illness and/or substance use disorders including opioid addiction, with or without poorly managed or uncontrolled co-morbid chronic physical and/or social factors that are barriers to community living and well-being.

In addition, the Care Advocate workgroup will help the region create a seamless process to guide the referral process and ensure the Medicaid population receives enhanced care coordination services. The region will have an outreach plan to educate and engage medical, behavioral health, social services and community resources. The Region 7 Care Advocate Workgroup will review and assess the progress of this plan on a regular basis and make recommendations to improve the plan. The members of the Care Advocate workgroup have discussed tools to incorporate into the region's Enhanced Care Coordination toolkit and started to discuss workflows and processes related to care coordination in the region. As the conversation around workflows evolved, the members of the workgroup discussed the value of having a panel of care coordinators at one of the region's quarterly IDN meetings, to discuss the barriers and challenges of care coordination in the region from their own perspective. NCHC used the input from Care Advocate workgroup and set the agenda for the region's March 2018 quarterly meeting, which will include a panel of care coordinators talking about care coordination in the region. This panel will consist of care coordinators representing various sectors such as emergency departments, inpatient services, outpatient services, primary care offices, behavioral health providers, and community-based organizations. The panel will be facilitated, and the panelists will discuss the care coordination delivery system from their own perspective. The panelists will be asked to identify gaps and barriers in the current process as agencies work together and patients move from one organization to another. These issues will be documented and following this discussion the panelists and participants at the meeting will be presented with a solution to address the gaps and barriers. This solution will be the shared care plan, use of the multidisciplinary team, and using Care Advocates to improve care coordination across the region.

The region is also moving along with their plan to train Care Advocates to improve care coordination. Care Advocates will be staff from partner agencies who come together to receive intensive care coordination training and learn how to utilize regional resources in the most efficient manner possible. NCHC will

arrange for 3 regional care coordination trainings, one within each county of the region to train Care Advocates. These Care Advocates will then come together on a regular basis for additional training opportunities, and to share successes, new ideas, strategies to overcome barriers, and resources. The first regional care coordination training has been scheduled for March 29-30, 2018. The purpose of this training is to bring agencies from Carroll County together to discuss the shared care plan in detail, and to provide partners with an opportunity to discuss workflows and processes, and how to incorporate the use of a regional multidisciplinary team into these processes. The agenda is still evolving, but the plan is to have a presentation from Collective Medical Technologies focused on their past experiences as states have worked to incorporate the shared care plan tool into workflows. They have been asked to share lessons learned, and best practices on the implementation and utilization of the shared care plan. Other topics which will be covered during this 2-day training will include discussions on the different roles of providers on an integrated care team, and how HIPAA and CFR 42 Part 2 needs to be addressed, especially as they relate to the use of the multidisciplinary team. There will also be time for a work session where partners will use the region's Enhanced Care Coordination Toolkit and discuss the flow of patients in the region. It is the intention that these conversations will lead to the creation of new workflows designed to help improve care coordination services across agencies.

The North Country Health Consortium has a Community Health Worker Program designed to increase chronic disease self-management, improve patient access to services by addressing social determinants of health, reduce healthcare costs for public and private payers, and close the gaps in understanding that can occur between provider visits and patients' homes. NCHC started this program with 2 community health workers, and recently added a third community health worker as the program has expanded. Part of the work of the CHWs at NCHC is to educate the medical community on the value of the community health workers and their role in the continuum of care.

IDN partners from across the region expressed an interest in learning more about the role of CHWs in care coordination, so the CHW team from NCHC presented their work at a regional IDN meeting in December 2017. This educational outreach has been instrumental as IDN partners address the need for additional care coordinators to achieve integrated healthcare and realize that CHWs can fill a vital role in care coordination. IDN partners in Carroll County have been discussing the use of CHWs in the area, and White Mountain Community Health Center sent 2 staff members to be trained during the 2017 fall CHW training offered by NCHC. In addition, Tri-County Community Action sent 3 staff to be trained. Six additional people participated in the fall 2017 training, so overall 11 CHWs were trained during this time. In addition to these 11 people being trained in the region, Ammonoosuc Community Health Services and NCHC both added a Community Health Worker to their staff. Another goal of the region is to train community health workers as peer recovery coaches, and at the end of 2017 Region 7 IDN had 5 people cross-trained.

Two of Region 7 IDN partners, Weeks Medical Center and Coos County Family Health Services, are participating in the *Ways2Wellness CONNECT Program*. *Ways2Wellness CONNECT* is designed to incorporate Community Health Workers into care coordination teams to improve quality and health care delivery in the North Country for patients with chronic diseases. The program will lead to enhanced patient and family engagement in the patient's health care management through Community Health Worker interaction and educational materials. Another anticipated outcome of the program will be a 30-day hospital readmission rates and inappropriate emergency department use by patients with chronic illnesses. CHWs have provided services for 11 Medicaid patients through the *Ways2Wellness CONNECT Program.*

NCHC has worked with the participating provider agencies to create a referral process, and to establish eligibility criteria for the program. Current criteria includes a chronic disease diagnosis such as diabetes, pre-diabetes, kidney or liver disease, and chronic obstructive pulmonary disease. Additional referral criteria includes patients experiencing barriers to self-management of their chronic disease, substance use disorder that is co-occurring with their chronic disease, and patients having mental illness that is co-occurring with chronic disease. Business associate agreements and memorandums of understandings have been executed with Weeks Medical Center and Coos County Family Health Services to clarify roles and responsibilities of both the provider and NCHC CHW program and define the criteria for patient referral.

Referral processes have been established to allow providers and other network partners to easily refer patients through a secure web link. The referral will then trigger an email alert to the CHW staff allowing them to begin the intake process for the individual. The CHW will make initial contact with eligible patients within 3 business days to discuss and introduce the CHW program and to schedule an intake, if agreeable to the patient. The CHW will communicate status updates to the Weeks Care Management Team, including whether the patient has been deemed eligible for the program. The CHW will secure a signed release from the patient which will enable information sharing with the provider agency and/or additional provider or social service organizations. NCHC CHWs will track and enter all patient contact, progress, and other notes into the secured client database for ease of sharing with the Weeks Care Management Team. The provider agency will provide the assigned CHW with the patients' last doctor's note, medication list and care plan, as needed, and will provide CHWs with information related to changes or updates for referred patients. The CHWs will continue to provide updates to the patient's primary care team, including sharing all patient care coordination information once a patient case has closed.

The 3 CHWs working on the *Ways2Wellness CONNECT Program* utilize Apricot, a web-based platform designed for case management, client, tracking, and outcomes management. The Apricot system tracks enrollment criteria, program start dates, and exit dates all in one place, to ensure that your program is enrolling those who it intends to serve. It creates well-defined pathways, for the patient which includes individualized goals that can be tracked and monitored for completion. The platform provides a place to document case notes and progress toward each goal at every intervention, a way to record referrals, the and ability to track fulfillment of referred services from external providers to ensure that participants receive quality services. Apricot uses state of the art equipment and technology to safeguard the system data, Data is automatically encrypted while in transit between user computers and their server. All traffic to and from the Apricot server are monitored. Virus scans, automated system checks, and other measures are taken to safeguard data. Additionally, data is backed up in three different physical locations. Securing messaging is being integrated for on-going communication with referring agencies and providers.

Systems and processes developed for the *Ways2Wellness CONNECT Program* will serve as a model for IDN work as both the shared care plan and enhanced care coordination project get implemented. The referral process and web-based platform will be used to create the framework for the regional care coordination approach, and development of the shared care plan. There are numerous components of this project which coordinate directly with IDN deliverables: mechanism to identify the target population, memorandum of understanding in place which outlines roles and responsibilities, referral process, secure transmission of information, and a closed loop referral process. Preliminary conversations are underway with the staff of the *Ways2Wellness CONNECT Program* asking them to pilot Collective Medical Technologies shared care plan tool and incorporate it into workflow with existing agencies to learn about the tool, and then share this information with Region 7 IDN partner agencies as a testimonial.

The NCHC Program Manager working with the *Ways2Wellness CONNECT Program* participates in the Littleton Regional Healthcare Care Transition monthly meetings and participates in discussions related to high ED utilizers at Weeks Medical Center. There are discussions underway to provide a list of high ED utilizers to the staff working on the *Ways2Wellness CONNECT Program.* This CHWs working on this program will be able to follow up directly with patients enrolled in their program, and work with these patients to address their needs so they do not need to access ED services as often. This process is directly in line with IDN goals to decrease ED utilization in the region. The IDN will use some of this work as a model to replicate similar programs with other IDN partners.

Several agencies submitted proposals during the reporting period that were funded to help the region meet the deliverables of the Enhanced Care Coordination project. Memorandums of Understanding did not go out until late November or early December of 2017, so although there is not significant progress to report yet, these funds are paving the way for improved care coordination in the region. Memorial Hospital took the lead to submit a collaborative proposal which includes Memorial Hospital, Saco River Medical Group, Children's Unlimited, and Visiting Nurse Home Care and Hospice to collaborate with other partners in Carroll County to create a workforce which will address complex behavioral health and substance use in the region, enhance care coordination in the region by adding staff capacity at partner organizations, increase the number of MAT providers in the region, improve behavioral health access, and address community outreach and education.

North Country Healthcare (NCH), the affiliation of Androscoggin Valley Hospital, Littleton Regional Healthcare, North Country Home Health & Hospice, Upper Connecticut Valley Hospital, and Weeks Medical Center received IDN funds to support the development of a regional call center and a cloud-based schedule of health care resources. The call center will have the capability to provide the region with an immediate response system that connects care providers and delivery teams to available resources and facilitate expedited treatment. Through a universally accessible directory and on-call schedule, providers, clinical staff, and other supportive health care individuals will have immediate knowledge of resources available at any facility.

Weeks Medical Center received IDN funds to support its newly restructured care coordination department Previously, their care management teams were divided into two groups, inpatient care management and outpatient care management, working under the direction of separate department heads. In evaluating the effectiveness of their teams, they determined that by consolidating they would strengthen their care coordination efforts, avoid duplicative care management services, and promote a more cost-effective method of care management. Weeks Care Coordination department will be comprised of a behavioral

E-2. IDN Community Project: Evaluation Project Targets

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

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

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
# of individuals served	45 by 12/31/2018	0		

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
Reduced hospital inpatient readmissions for patients with BH indicators	20% decrease in annual 30 day hospital readmission s rate for patients with behavioral health indicators rate per 1,000 population from 9.1 in 2015 to 7.2 by 2020	0		
# of ED visits for patients with BH indicators	20% decrease in annual emergency department visits for patients with behavioral health indicators rate per 1,000 from 1073 in 2015 to 858 by 2020.	0		
# of sub-recipient proposals received which are related to Enhanced Care Coordination	5 by 12/31/2018	3		
Convene 1 Care Advocate Workgroup	1 by 12/31/2017	1		
# regional care coordination trainings	3 by 12/31/2018	0		
# Community Health Worker Trainings	3 by 12/31/2018	1		
# of CHW cross trained as Peer Recovery Coaches	8 by 12/31/2018	5		

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
# of Region 7 IDN agencies with embedded Community Health Workers	5 by 12/31/2018	4		
# of agencies working on Enhanced Care Coordination as defined by DSRIP metrics	3 by 12/31/2018	0		
# of trained Care Advocates	15 by 12/31/2018	0		
# of partner organizations that have agreements in place for referral process	4 by 12/31/2018	0		

E-3. IDN Community Project: Workforce Staffing

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

Provider Type	IDN Workforce (FTEs)				
	Projected Total Need	Baseline Staffing on 6/30/17	Staffing on 12/31/17	Staffing on 6/30/18	Staffing on 12/31/18
Care Advocate	15 by 12/31/2018	0	0		
Regional Care Advocate Supervisors	1 by 12/31/2018	0	0		

Region 7 IDN is using a regional care coordination training approach for the Enhanced Care Coordination project. This approach includes training Care Advocates in Carroll, Coos, and northern Grafton County who will work to identify the highest need patients in the region, and then work to coordinate their care so the patients see improved health outcomes. Region 7 IDN will train care coordinators to become Care Advocates in a phased approach, with the first phase being individuals from Carroll County who will be trained on March 29-30, 2018. The goal is to have at least 5 trained Care Advocates in Carroll County after the March 2018 training, representing the various primary care and behavioral health agencies in the sub-region. Care Advocates will be trained in Coos County in June 2018, and in September 2018 for those working in northern Grafton organizations. The Region has identified the need for a Regional Care Advocate Supervisor, who will serve as a technical assistance resource, and ensure the Care Advocates follow fidelity to the DSRIP requirements for enhanced care coordination. NCHC will leverage the work of Jill Gregoire, RN, MSN, NCHC Practice Facilitator, to serve as the Regional Care Advocate Supervisor. The Regional Care Advocate Supervisor will provide leadership, support, and guidance for the Care Advocates, and work with both the NCHC Program Coordinator and the IDN Program Manager to assure all performance metrics and deliverables related to enhanced care coordination are completed. The main responsibilities of this position will include:

- Offering technical assistance as it relates to care coordination to ensure Care Advocates follow fidelity to the Enhanced Care Coordination project;
- Assisting with the identification of training needs of regional Care Advocates;
- Monitoring workflow development;

- Assisting Care Advocates with developing policies and procedures that meet the DSRIP required core components of the Enhanced Care Coordination project

The Care Advocate is a care coordinator from a Region 7 IDN partner organization who has participated in a Region 7 IDN Care Coordination Training and learned the regional care coordination approach which will include the following:

- Who's Driving the Bus to Integrated Healthcare?
- What is the Shared Care Plan and How Can It Help?
- Ethical Communication and Decision-Making in an Integrated Care Environment
- Connecting with Regional & State Resources
- Patient Advocacy & Cultural Humility
- Health Literacy
- Enhanced Care Coordination for High Needs Population DSRIP components

After completing the training, the Care Advocate will have a better understanding of the DSRIP project and the requirements of the Enhanced Care Coordination project. The Care Advocate will work in collaboration with high-risk patients and their family/caregiver(s), clinic/hospital/specialty providers and staff, and community resources in a team approach to:

- Promote timely access to appropriate care;
- Increase utilization of preventative care;
- Reduce emergency room utilization and hospital readmissions;
- Increase comprehension through culturally and linguistically appropriate education;
- Create and promote adherence to a care plan, developed in coordination with the patient, primary care provider, and family/caregiver(s);
- Increase continuity of care by managing relationships with tertiary care providers, transitions-in-care, and referrals;
- Increase patients' ability for self-management and shared decision-making;
- Connect patients to relevant community resources, with the goal of enhancing patient health, addressing social determinant needs, increasing patient satisfaction, and reducing health care costs;
- Participate on the multi-disciplinary core team as needed;
- Provide comprehensive care coordination/management services for individuals across the lifespan with complex health/behavioral health needs.

E-4. IDN Community Project: Budget

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

Budget Period:	**01/01/2017-12/31/2020**	**07/01/2017-12/31/2017**	**07/01/2017-12/31/2017**	**01/01/2018-12/31/2020**	
	Care Coordination Budget	**Care Coordination Budget (6 months)**	**Care Coordination Actual Expense (6 months)**	**Care Coordination Budget Projection (remaining project period)**	
Line Item	**Total**	**Total**	**Total**	**Total**	**NARRATIVE:**
1. Total Salary/Wages					
2. Employee Benefits					
3. Consultants					
5. Supplies:					
Educational					
Office	$9,662	$1,208	$591	$7,247	**YR2-YR5:** Org.-Wide Office Supply Allocation
6. Travel			$169		
7. Occupancy					
8. Current Expenses					
Telephone					
Postage					
Subscriptions			$1,254		
Audit and Legal					
Insurance					
Board Expenses					
9. Software	$3,790	$474	$1,735	$2,843	**YR2-YR5:**
10. Marketing/Communications	$4,556	$570	$707	$3,417	**YR2-YR5:** Org.-Wide Marketing/Communications Allocation & Outreach materials
11. Staff Education and Training			$336		
12. Subcontracts/Agreements					

13. Other (specific details mandatory):					
Current Expenses: Administrative Lead Organizational Support	$17,904	$2,238	$1,042	$13,428	**YR2-YR5:** Telephone/Postage/Audit&Legal/ Insurance
Support Payments to Partners	$747,332	$93,417	$29,009	$560,499	**YR2-YR5**: Personnel/Supplies/Travel/Software/Mrktg/Training. **Additional Notes:** RFPs awarded. Payment in various stages pending MOU execution and reporting deliverables.
TOTAL	**$898,060**	**$112,258**	**$46,753**	**$673,545**	

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

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

Organization/Provider	Agreement Executed (Y/N)
Tri- County Cap	N
Northern Human Services	N
Weeks Hospital	Y
Rowe Health Center	N
Life Coping	N
White Mountain Health Services	N
Ammonoosuc Community Health Services	N
Crotched Mountain	N
Memorial Hospital	Y
Huggins Hospital	N

Organization/Provider	Agreement Executed (Y/N)
*(This list is subject to change based on Region 7 IDN's sub-recipient Proposal process. NCHC anticipates other organizations to join the E5 Project through the proposal process over the course of the DSRIP Demonstration. Agencies which may join the E5 work include Coos County Family Health Services, Cottage, Huggins, Indian Stream Health Center Littleton Hospital, and Upper Connecticut Valley Hospital. The region will work With the first cohort to assess program effectiveness, and will then work to expand E5)	

E-6. IDN Community Project: Standard Assessment Tools

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

Standard Assessment Tool Name	Brief Description
Care Transition Risk Assessment	An assessment of the patient's current and past medical and behavioral health, social supports and social determinants of health.
Screening for Health-Related Social Needs	Accountable Health Communities Core Health-Related Social Needs Screening: identify patient's needs in 5 domains: housing, food, transportation, utility assistance needs, interpersonal safety.

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

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

Protocol Name	Brief Description	Use (Current/Under Development)
Assessment Protocol	Protocol includes: gathering input from Multi-Disciplinary care team, patient and family, communication techniques, relationship building with patient/family; patient's culture, past experience, health literacy, priorities, fears, HIPAA & 42 CFR part 2 consent process ; on-going reassessment	Researched components of the Assessment Protocol are to be reviewed by Care Transitions Workgroup. Written protocol containing these elements will be finalized and deployed by 3/29/18

Protocol Name	Brief Description	Use (Current/Under Development)
Crisis Planning	Actions to be taken, and contacts to be made if there is a client crisis	Crisis Planning Protocol to be reviewed by Care Transitions Workgroup. Will be deployed by 3/29/18
Patient Treatment Protocol	Protocol includes process of identifying patient need, connecting to provider(s), shared care plan, coordination of logistics, changes to care plan, communication. Protocol includes process for acute care situations.	Researched components of the Patient Treatment Protocol are to be reviewed by Care Transitions Workgroup. Written protocol containing these elements will be finalized and deployed by 3/29/18
Management Protocol	Cyclical process of care plan review with Multi-disciplinary care team, and patient and family, supports and service connects, positive/negative occurrence, care plan adjustment, re-assessment, Gap analysis, review with multi-disciplinary care team	Researched components of the Management Protocol are to be reviewed by Care Transitions Workgroup . Written protocol containing these elements will be finalized and deployed by 3/29/18.
Referral Protocol	Protocol includes: Accountability, no wrong door, patient support, connections, agreements on referring, outreach	Researched components of the Referral Protocol are to be reviewed by Care Transitions Workgroup. Written protocol containing these elements will be finalized and deployed by 3/29/18.

E-8. IDN Community Project Member Roles and Responsibilities

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

Project Team Member	Roles and Responsibilities
Care Advocate (CA)	The role of the CA as a member of the Multidisciplinary team is to take the lead to provide comprehensive care coordination/management services for individuals across the lifespan with complex health/behavioral health needs. As described in the protocols, the CA is the patient's advocate for: timely, accessible treatment and management of illness, access to the social determinants of health, the patient and family's health literacy and education, in order to maintain or improve the patient's health and functional status.
Care Advocate Supervisor	The Care Advocate Supervisor will offer technical assistance as it relates to care coordination to ensure Care Advocates follow fidelity to the Enhanced Care Coordination project. This will include assisting with the identification of the training needs of the regional Care Advocates, monitoring workflow development, assisting Care Advocates with developing policies and procedures that meet the DSRIP required core components of the Enhanced Care Coordination project.
Multi-disciplinary Care Team	Multidisciplinary teams may include: physicians, physician assistants, nurse practitioners, nurses, medical assistants, licensed clinical social workers, psychologists, and other bachelor-level providers. Roles and responsibilities include following determined communication, team interaction and decision-making protocols; identification of competencies and qualifications of each member of the team and role mapping to clearly define the specific roles of each member of the team. The Multidisciplinary team has the responsibility of assessment and diagnosis, creation of a treatment plan, referrals to providers/social services, evaluation of safety, addressing co-morbidity concurrently, involving family and social supports, care re-assessment and care management.
NCHC Program Coordinator	Works closely with the Care Advocate Supervisor and IDN Program Manager to coordinate and support the work of the Enhanced Care Coordination project. This includes coordinating training needs, coordinating funding proposals, and follow up on identified needs of the Care Advocates as they work to ensure the DSRIP requirements of the project are met.
IDN Program Manager	Works closely with the Care Advocate Supervisor and NCHC Program Coordinator to ensure all the DSRIP requirements of the Enhanced Care Coordination are met, including reporting requirements.

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

The region is also moving along with their plan to train Care Advocates to improve care coordination. Care Advocates will be staff from partner agencies who come together to receive intensive care coordination training and learn how to utilize regional resources in the most efficient manner possible. NCHC will arrange for 3 regional care coordination trainings, one within each county of the region to train Care Advocates. These Care Advocates will then come together on a regular basis for additional training opportunities, and to share successes, new ideas, strategies to overcome barriers, and resources. The first regional care coordination training has been scheduled for March 29-30, 2018. The purpose of this training is to bring agencies from Carroll County together to discuss the shared care plan in detail, and to provide partners with an opportunity to discuss workflows and processes, and how to incorporate the use of a regional multidisciplinary team into these processes. The agenda is still evolving, but the plan is to have a presentation from Collective Medical Technologies focused on their past experiences as states have worked to incorporate the shared care plan tool into workflows. They have been asked to share lessons learned, and best practices on the implementation and utilization of the shared care plan. Other topics which will be covered during this 2-day training will include discussions on the different roles of providers on an integrated care team, and how HIPAA and CFR 42 Part 2 needs to be addressed, especially as they relate to the use of the multidisciplinary team. There will also be time for a work session where partners will use the region's Enhanced Care Coordination Toolkit and discuss the flow of patients in the region. It is the intention that these conversations will lead to the creation of new workflows designed to help improve care coordination services across agencies.

Region 7 IDN Master Training Table		
Training	**Description**	**Project Reference**
Core Competency Integration Toolkit	Participants will receive on overview of all Tools in the Core Competency Integration Toolkit	B1
Community Resources	The newest and up to date Community Resource guide created by the Continuum of Care Coordinators in Grafton, Coos and Carroll counties will be shared. Participants will be asked to share their community resources.	B1
42 CFR Part 2 Introduction	Overview of the updated 42 CFR Part 2	B1, C1, D3, E5
Multi-Agency Consent Forms and Shared Care Plan	Participants will learn how to use Region 7 IDN's multi-agency consent form as a tool to help drive the utilization of the shared care plan	B1, C1, D3, E5
Co-occurring Mental Illness and Substance Use Disorder	Participants will gain an understanding of co-occurring disorders, the prevalence of co-occurrence and recommendations for assessment and treatment	B1, E5, D3
Anti-Stigma Training	The course is designed to provide participants with an opportunity to recognize attitudes and behaviors that could potentially lead to	B1

	stigma. Participants will examine attitudes, beliefs and behaviors toward persons with mental health problems, and become comfortable addressing mental health patients	
Core Standardized Assessment Tools	Participants will learn how to use the core standardized assessment tool to capture information regarding all of the required domains in the DSRIP program	B1
Cultural Competency	Cultural Competency- Class: A Hidden Culture of socioeconomic class relates to many aspects of the work in health care. This interactive workshop draws from the work of Ruby Payne, in Hidden Rules of Class, Bridges out of Poverty, and Framework for Understanding Poverty. Participants will engage in activities that illuminate some ways in which class acts as culture, determining assumptions, expectations, and conclusions about interactions	B1, E5
Change Management	Participants will learn how to get both organizational and employee buy-in of new initiatives, how to deal with culture change, how to implement new processes as efficiently as effectively as possible, and how to identify risks and develop system to mitigate those risks and monitor progress	B1
Integration 101	Understand the rationale for integrated care and how it leads to improved health outcomes Describe "integrated care," and the SAMHSA levels of integration,	B1
Health Literacy	Introduction to Health Literacy: Increasing awareness of how health literacy may impact practice. 18% of NH residents have never graduated high school and the majority read at a 7th & 8th grade level	B1
Mental Health First Aid	An international evidence-based practice designed for all audiences that teaches how to help someone who may be experiencing a mental health or substance use challenge. The training helps identify, understand and respond to signs of addictions and mental illnesses.	B1
Suicide Prevention	Connect Suicide Prevention: A national model that uses a socio-ecological model and best practices around Zero Suicide and suicide prevention	B1

Verbal De-Escalation Training	Ensure the safety of the patient, staff, and others in the area; help the patient manage his emotions and distress and maintain or regain control of his behavior; avoid the use of restraint when at all possible; and avoid coercive interventions that escalate agitation.	B1
Medication Assisted Treatment (MAT) Best Practices	American Society of Addiction Medicine (ASAM) criteria	D3
Community Health Worker (CHW) training	Participants will learn how community health workers serve as the link between health and social services and the community to facilitate access to services and improved quality and cultural competence of care. Skills learned include communication, advocacy, interpersonal issues, service coordination, organization, teaching, capacity building, motivational interviewing and knowledge in specific health issues, such as cervical cancer screenings, behavioral health, and oral health	E5, B1
Motivational Interviewing (MI) training	Understanding the basics of MI Practice applying Motivational Interviewing concepts and skills Recognize the four elements of MI-MI Spirit (PACE), MI Principles (RULE), MI Skills and Strategies (OARS), and MI Tools and Change talk (DARN	B1, C1, E5
Critical Time Intervention training	Participants will learn the three-phased, time-limited approach of the evidence-based CTI model, including pre-CTI, crisis intervention, and clinical supervision. They will be able to define the CTI core skills and principles needed to engage persons who are experiencing mental health, substance use disorder and other chronic diseases and that are making a significant transition, such as from homelessness, hospitalization or incarceration. The training covers the key principles of the CTI model, evidence for its effectiveness, and the tools that teams need to implement it and maintain fidelity to it.	C1
Peer Recovery Coach training	Training provides participants with a basic understanding of substance use and mental disorders, crisis intervention and how to respond in crisis situations. In addition, skills and tools on effective communication, motivational enhancement strategies, recovery action	D3

	planning, cultural competency and recovery ethics.	
Health Equity	Providers Linking Patient With Community Programs- Why improving the social determinants of health will help eliminate population-based health disparities; health-impacting choices that individuals make which are shaped by community environment and context; things health providers can do to strengthen the community knowledge base on population-based health disparities	B1
Self-Management and Recovery Training (SMART) program-	Participants get motivated to address substance use disorders and learn how to cope with urges and drug use behaviors. SMART Recovery 4-Point Program, Building and Maintaining Motivation; Coping with Urges; Managing Thoughts, Feelings and Behaviors; Living a Balanced Life	D3
Virtual Collective Medical Technologies (CMT) training	NCHC will work with Collective Medical Technologies (CMT) to create a training program which can be virtually accessed by team members, IT staff, and other pertinent agency staff.	B1, C1, D3, E5
Engaging and Leveraging Family and Natural Supports in the Recovery Process	Family and natural supports can play a critical role in recovery success. NAMI NH offers training for providers on understanding the realities of living with mental illness and its effect on families; and how those natural supports can be engaged to promote recovery and enhance the treatment process.	D3
Trauma Informed Care and Health Professionals	Participants will understand the effects of childhood trauma as it relates to physical, mental and emotional health, identify possible procedures, policies, or physical structures that could trigger patients in their own health care setting, describe three interventions or skills that can be used to decrease the trauma response in patients.	D3, E5
Screening, Brief Intervention, and Referral to Treatment (SBIRT)	The NH Youth SBIRT Initiative is committed to expanding SBIRT as a standard practice of care across primary care settings in NH. To facilitate this growth, the Initiative is offering many educational and workforce developmental opportunities throughout the state. Monthly	B1, D3, E5

	webinars, core training, SBIRT model and validated screening tools, case examples and design flow within a clinical setting, Motivational interviewing techniques.	
Telehealth and mHealth Use in Integrated Care	The purpose of this training is to augment learner knowledge about existing telehealth and mHealth technology applications available to support behavioral health integration. Participants will be able to distinguish the differences between types of telehealth and mHealth technologies and applications as applied to integrated behavioral health; discover how clinical practices, researchers, and payers are defining the use and payment of telehealth and mHealth technologies to support integrated behavioral health; compare and contrast payer reimbursement models and understand their direct-to-consumer (DTC) model implications; describe the regulatory and legal frameworks governing mHealth technologies and practice impacts.	B1
Integration in the Practice - Part II: Coordination with Community and Re-visiting Payment	The purpose of this training is to increase learner capacity to 1) operationalize linkages with organizational as well as community resources with a focus on diverse populations to improve care quality and outcomes and 2) understand an alternative payment model structure to support behavioral health integration delivery. Learning Objectives include identify practical strategies to coordinate and monitor patient/family linkage to physical health, mental health/substance misuse, and enabling support services (organizational and community-based); describing models for shared care planning involving physical, mental/substance misuse, and community support providers; Identifying mechanisms to address the unique needs of diverse populations in integrated care settings; recalling results of a fiscal analysis to develop a payment model to support the cost of care delivery in integrated care settings.	B1
Naloxone (Narcan)	Training provides step by step instructions for administration of Naloxone including signs and symptoms of overdoes, protocol for calling 911 and rescue breathing.	B1, C1, D3, E5
TeamSTEPPS Training Series for Hypertension Management	The purpose of this activity is to enable the learner to identify common communication	B1

	barriers between team members in a healthcare setting and become familiar with TeamSTEPPS 2.0® tools that can be implemented to improve communication. Participants will be able to describe how communication affects team processes and outcomes; define effective communication and identify communication challenges; and identify TeamSTEPPS Tools and Strategies that can improve a teams' communication.	
New Lipid Guidelines	The purpose of this training is to enable providers to understand the components of the new lipid guideline recommendations and the current evidence to support the transition.	B1
Expanding Tobacco Treatment Among High-Risk Populations for Value-Based Integrated Care	Participants will be able to describe the short and long-term consequences of tobacco use for individuals who have a mental health issue (MHI) or substance use disorder (SUD), describe the return on investment of helping patients quit smoking, discuss strategies to help individuals who have a mental health issue or substance use disorder quit using tobacco, understand how to make a referral to the NH Tobacco Helpline via QuitWorks-NH.	D3
Supervising a Peer Recovery Workforce	Are the supervisory needs in a peer-based recovery support service any different than in any other service, and how? What needs to be considered in developing the supervisor's role as well as the certified recovery support worker's role? As peer support services become more prevalent in substance use disorder recovery and mental health services, it is important to address these questions as peer roles can present unique challenges to existing supervision structures and	D3
HIV Update for Substance Use Professionals	This training is geared toward substance use professionals and will provide participants with basic and updated information about HIV other STDs. This includes risk factors, modes of transmission, signs and symptoms, prevention, the relationship between HIV and other STDs.	D3
Care Advocate Training	This training will be specifically designed for the Care Advocates in Project E5. This two-day training will provide instruction on all the	E5

	Assessment, Treatment and Referral Protocols, Engagement strategies, Gap analysis, Communication skills and Tracking and Reporting required.	
The Metabolic Triad: Diabetes, Cardiovascular Disease, and Inflammation	Participants will be able to explain the burden of cardiovascular risk factor in patients with diabetes, define inflammation and its role as a risk factor for CVD, list 4 lifestyle modifications to reduce heart disease, review evidence based guidelines for diet, lipid disorders and hypertension, explain positive approach to nutrition education, describe a Heart Healthy Diet	B1
Mental Health Provider Diabetes Education Program	This program will teach mental health providers about diabetes management, the daily struggles people face, as well as effective interventions to treat people with diabetes experiencing mental health issues	B1

E-10. Project Scoring: IDN Community Project Process Milestones

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

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

Project APM: DSRIP Alternative Payment Model (APM) Implementation Planning

As a part of the DSRIP demonstration, the state has committed to value-based health services reimbursements. The DSRIP APM Roadmap articulates the process by which the state will work with the IDNs, Medicaid Managed Care Organizations (MCO), and other Medicaid services stakeholders to develop a statewide APM workgroup for the completion of the DSRIP APM Implementation Plan. The goal of the DSRIP APM Implementation Plan is to achieve 50% Medicaid provider payments in an APM by 12/31/2020.

IDNs will be evaluated on their engagement with the state and managed care plans in support of the APM goals consistent with Special Terms and Conditions (STC) 24, Project Milestones; STC 33 MCO and Medicaid Service Delivery Contracting Plan; and STC Attachment C: DSRIP Planning Protocol IV Project Stages, Milestones, and Metrics.

APM-1. Project APM Scoring: IDN Participation in Statewide APM Taskforce and Implementation Plan Development and IDN APM Implementation Plan

Provide a brief narrative describing the current use of APMs among partners.

Use the format below to: identify the IDNs participation in workgroups for the development of the DSRIP APM Implementation Plan; assess the current use and/or capacity for engaging APMs amount IDN participants; develop an IDN-specific plan for implementing the roadmap to include IDN-specific outcome measures; and develop the financial, clinical and legal infrastructure required to support APMs.

Region 7 IDN has been actively involved in alternative payment model discussions on a statewide level. 11 individuals from the region participated in the November 2017 Alternative Payment Model Learning Collaborative hosted by Myers & Stauffer. In addition, NCHC's Chief Executive Officer attended the December 15, 2017 APM stakeholder meeting to discuss moving forward with the State of NH APM Roadmap. To prepare for this meeting attendees were asked to question IDN partner agencies regarding the following issues. Below are some of the responses from Region 7 IDN partners.

1. How does Medicaid impact your organization's sustainability and mission?
    - As a Rural Health Clinic, we receive an encounter rate for Medicaid patients which allows us a better reimbursement rate for these patients
    - Medicaid plays a critical role to the sustainability of our organization – we would not be able to fulfill our mission without it
    - Medicaid is essential to the health and well-being of the pregnant women, children, disabled adults and frail elders we serve
    - Medicaid is our primary source of funding as we bill for services

2. What are your organization's key goals for positively impacting Medicaid patients and their health outcomes?
    - Medical home model, integrated care, MAT program and care management
    - Goal is to provide high quality, accessible care in a medical home environment to all patients served; build an integrated model that allows for a holistic approach
    - We to not differentiate our Medicaid patients from the other patients we serve
    - For all of our patients, we are working to promote their optimal health and well being
    - We want to improve Mental Health Symptoms as well as Physical illness that our clients have
    - Beginning work on an integrated delivery system at one of our clinics but hope to have this

be something we can offer at every clinic

3. What work are you doing in Alternative Payment Models now for Medicaid, Medicare, and commercial carriers?
   - Track 1 ACO – working toward an APM
   - Enrolled in an ACO for Medicare patients; have a quality agreement with a major commercial insurer where we can earn incentive payments to our rates
   - Medicaid : NH 1115 Waiver
   - ACO: Medicare Shared Savings Program
   - Commercial Insurance: PMPM for Care Management; Shared Savings Arrangements
   - We do not have any APMs per se; but doing a capitated system and are not paid fee for service by the MCOs for certified clients
   - Allotted specific amount of money depending on certification and must work within those limits to deliver services

4. How would you change or realign the objectives or incentives to make your APM a "win win win" for beneficiaries, the MCOs, and your organization?
   - Making sure we are providing cost effective, high quality care, keeping them healthier and of the ED and hospital
   - Current APMs are a win win because we can receive incentive payments based on quality metrics that ultimately focus on promoting health
   - Provide incentives to encourage patients to adopt healthy behaviors
   - Allow patients to benefit in shared savings arrangements
   - In a perfect world, Mental Illness and Substance Use Disorder and its treatment would be seen in the same way as physical illness
   - CMHCs in this state have not received a rate increase in over 10 years so unable to pay staff as much as medical facilities – much inequity in the system – need less disparity between the systems

5. What are your hopes for Medicaid APM models?
   - Expanding Medicaid to those in need and reimburse for cost, not less than cost
   - To mirror Medicare's approach as reflected in ACO
   - Reasonable reporting requirements that align with existing measures
   - No down-side risk
   - CMHCs and others who treat MI and SUD can receive an equitable amount of funding so that they can afford to pay service providers what they deserve

6. What is your organization ready to contribute in an APM environment? What does it need?
   - Care management, chronic disease management, integrated behavioral health, medical home
   - Reasonable reimbursements, a deficit is not sustainable
   - Transportation, availability of inpatient beds for voluntary admits, crisis stabilization units, more resources for acutely mentally ill patients, long waiting to get into community mental health center
   - Facility is focused on quality and is able to offer low cost healthcare
   - Acclimated to the needs of being involved in an APM
   - Recognize the importance of preventive care and care coordination, and meeting quality

metrics
- Support for Care Coordinators is valuable
- Strong RN Care Management infrastructure
- Integrated Behavioral, MAT and Oral Health Programs
- Robust population health delivery capacity
- Patient Centered Medical Home
- CMHC ready to contribute long standing willingness to come to the table and collaborate with other providers

The responses to the questions above reflect that Region 7 IDN member agencies are willing to engage in discussions related to alternative payment models, and work at both the state and regional level to find a solution that works.

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	Y		
Develop an IDN-specific plan for implementing the roadmap which will contain IDN-specific outcome measures			
Develop the financial, clinical and legal infrastructure required to support APMs			
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			

DSRIP Outcome Measures for Years 2 and 3

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

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

DSRIP Outcome Measures		
Year 2 (CY 2017) Incentive Payment for Reporting Measures	Year 3 (CY 2018)	
	Incentive Payment for Reporting Measures	Incentive Payment for Performance Improvement Measures
Use of Comprehensive Core Standardized Assessment by Medicaid Billing IDN Providers	Recommended U.S. Preventive Services Task Force (USPSTF) A&B Services Provided for Behavioral Health Population by IDN Providers (reporting)	Physical Health-Focused HEDIS Measures for BH Population: Summary Score (reporting)
Appropriate Follow-Up by Medicaid Billing IDN Providers for Positive Screenings for Potential Substance Use Disorder and/or Depression	Smoking and Tobacco Cessation Screening and Counseling for Tobacco Users by Medicaid Billing IDN Providers (reporting)	Experience of Care Survey: Summary Score
Conduct IDN Baseline assessment of current use of capacity to use APMs among partners	Timely Transmission of Transition Record After Hospital Discharge (reporting)	Frequent (4+ per year) Emergency Department Use in the Behavioral Health Population
Participate in development of statewide APM roadmap through workgroups and stakeholder meetings	Develop an IDN-specific roadmap for using APMs	Potentially Avoidable Emergency Department Visits
		Follow-up After Emergency Department Visit for Mental Illness Within 30 Days
		Follow-up After Emergency Department Visit for Alcohol and Other Drug Dependence Within 30 Days
		Follow-up After Hospitalization for Mental Illness Within 7 Days
		Follow-up After Hospitalization for Mental Illness Within 30 Days
		Extended Daily Dosage of Opioids Greater Than 120mg Morphine Equivalent Dose

[i] New Hampshire Building Capacity for Transformation Section 1115(a) Medicaid Demonstration, dated July 20, 2016; Attachment C: DSRIP Planning Protocol, page 67.
[ii] https://www.healthit.gov/standards-advisory/2016
[iii] http://www.integration.samhsa.gov/clinical-practice/screening-tools
[iv] http://www.rwjf.org/en/library/research/2010/01/a-new-way-to-talk-about-the-social-determinants-of-health.html