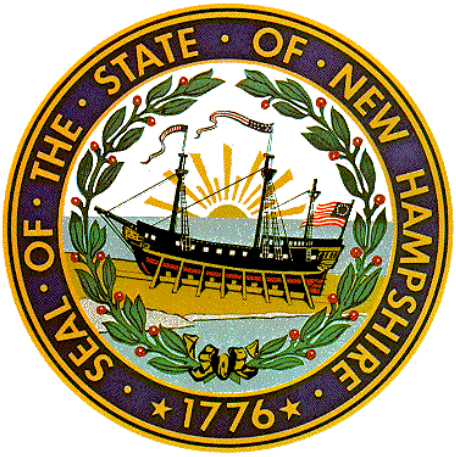

New Hampshire Building Capacity for Transformation 1115 Medicaid Waiver

IDN PROCESS MEASURES SEMI-ANNUAL REPORTING GUIDE

For

Year 4 (CY2019)

Redacted April 2020

Region 7 IDN

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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.

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

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DSRIP IDN Project Plan Implementation (PPI)

Each IDN was required to develop implementation plans for the July 2018 submission. Provide a detailed narrative which describes the progress made on required activities, timelines, key milestones, progress assessment check points, evaluation metrics, and Community Input, IDN Network changes, Opioid Crisis Update, Governance, and Budget narrative accompanied by a budget spreadsheet.

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

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

Narrative

December 31, 2018

Governance Section:

Steering Committee:

Members of the Region 7 IDN Steering Committee continue to leverage their combined expertise and experience to provide guidance and oversight to IDN partner agencies as the region works to achieve the project metrics associated with the DSRIP project. Members of the committee have been actively involved in reviewing concept papers and providing guidance on what feedback should be given to IDN partner agencies to ensure full proposal submissions align with IDN goals to help the region meet performance metrics as it works to transform the delivery of behavioral health care. After full proposals are received, the IDN Steering Committee convenes to discuss the submission and make final funding decisions, taking into consideration the input from individuals involved with the proposal scoring process.

The committee met with the three governance workgroups in July at the Strategic Funding Meeting to design a new funding process which aligns with the shifting of incentive funds to a pay for performance methodology. The group reviewed the deliverables that the region is expected to achieve and discussed the importance of meeting established performance metrics to continue receiving incentive funding for the remaining DSRIP project. They talked about challenges that make the current process difficult and expressed options for improvement. The workgroups felt that more technical support is needed to execute the majority of IDN deliverables. They also identified the need for coordination of projects to avoid duplication of services and inefficient use of funds. Standardized data collection was discussed as a challenge because many partners have different systems that measure different things. The group made recommendations to improve the funding process which included the elimination of concept papers.

The Steering Committee met in August to review the results of the July Strategic Funding Meeting. The group stressed the importance of funding only being allocated to proposals that will clearly help the region meet DSRIP deliverables and requested that funds only be approved for projects that tie into existing projects or expand projects, instead of funding brand new initiatives. The committee agreed to eliminate the concept paper process. Agencies who submit a proposal will now be asked to prepare a 10-15-minute presentation for the Steering Committee to explain their proposal intentions and address any questions or concerns. The proposal scoring system was updated to encourage the workgroup review panel to focus on providing comments and questions instead of a numeric rating because this is

more valuable information for the Steering Committee to consider as funding decisions are made. The group also discussed expanding the training and technology form to include additional categories if the request will help an agency meet DSRIP deliverables and not exceed $10,000. This process will start in early 2019 if there are available DSRIP funds to support the requests.

The 4th round of proposals were due in October. The Region 7 IDN team received a total of fifteen proposals. The Steering Committee looked at the reviewers' feedback and listened to new presentations in November to help guide funding decisions. The following projects were approved contingent on the region receiving funding:

- *Tri-County Community Action Program* submitted a proposal to continue their Supportive Housing project to deliver a coordinated system of care utilizing The Critical Time Intervention (CTI) model. The primary goal of their project is to improve the participant's capability to remain housed beyond program participation by effectively connecting them with critical community supports and aiding them to achieve greater economic stability. TCCAP aims to support a successful transition into permanent housing by maximizing available resources and supports. TCCAP Prevention Programs is proactively exploring future options for delivery of some components of the program through secured teleconferencing equipment. As caseloads increase the ability to utilize technology to reduce the burden of travel time and expense would be vital.
- *North Country Health Consortium Clinical Services (Friendship House):* Submitted a proposal for continuation funds to continue focusing on enhancing care coordination and service delivery. Friendship house with continue researching best-practices clinical treatment curriculum to purchase, which will in turn enhance their ability to provide comprehensive care for co-occurring disorders. The organization also plans to expand case management availability by integrating a trained Community Health Worker/Recovery Coach to assist clients with addressing treatment and recovery issues, social determinants of health, affordable housing, transportation barriers, and navigating availability of mainstream resources. This proposal demonstrates collaboration and program enhancement, which will bring great things to the Region.
- *Memorial Hospital* submitted a proposal on behalf of four organizations in Mount Washington Valley (Memorial Hospital, Saco River Medical Group (SRMG), Children's Unlimited (CU) and Visiting Nurse Home Care & Hospice (VNHCH)) to expand their Collaborative Community Program Addressing Behavioral Health & Substance Use in Carroll County project. Each agency will build on and expand the collaborative work already begun. Memorial's patient care coordinators will continue collaboration of behavioral health, IMAT and A New Life prenatal substance abuse program. Memorial will also expand their IMAT program to full capacity of providers with waivers, provide staff education and training, and expand outreach and connections with other community partners particularly addressing social determinants of health. VNHCH will expand its "Crossings" Program which provides free facilitated peer support groups for children ages 3-18 and their families and ensure all resources in its multi-media library are available to the community. CU will continue to support the "Parenting from Prison" Program, provide training to support "children from hard places", and continue to provide comprehensive support services through its "Bridges" Program. SRMG will expand its current MAT program and continue coordinating transitions of care for all patients, including those with mental health and substance use disorders. They continue to improve integrated behavioral

health care and are investing in their infrastructure by building a suite to be used for psychiatric care, mental health counseling and substance use disorder counseling.

- *North Country Healthcare (NCH)* submitted a proposal for a Regional Care Coordination Project involving ACO Care Coordinators from affiliates Littleton Regional Healthcare and Weeks Medical Center who will divide time between NCH care management activities and each affiliate organization's obligations. The Regional Care Coordinators will be responsible for establishing a Critical Time Intervention program to effectively transition patients from one setting to another. They will also provide a unified team-based approach with shared control of tasks, phases, and deliverables of population health and clinical initiatives, promoting a culture of coordination and integration between physical, behavioral health, and social service systems throughout the North Country. Weeks Medical Center, an NCH affiliate, submitted a proposal to expand Medication Assisted Treatment and behavioral health services to Upper Connecticut Valley Hospital and Indian Stream Health Center. These agencies will work together to ensure patients who are referred to Weeks Medical Center's North Country Recovery Center (NCRC) will have access to behavioral health specialists for counseling services as well as behavioral health case management/care coordinators to identify social determinants and assist patients in obtaining support services.
- *Weeks Medical Center* also submitted a proposal to support their Care Management department due to the increasing volume of patients needing care coordination management services. Weeks Medical Center's Behavioral Health Case Manager provides much needed support for the behavioral health department and MAT program, allowing the behavioral health providers to focus on services within their scope of practice. The Care Coordination Assistant helps to coordinate functions that are associated with both inpatient and outpatient services and helps to provide case management teams with added support, which allows them to concentrate on preventing unnecessary admissions, readmissions, and over utilization of the healthcare delivery system.
- *Huggins Hospital* submitted a proposal to expand their "Huggins Health Neighborhood Care Coordination and Integration Services" project. The project would expand Huggins Hospital's integration of behavioral health and primary care and address the social determinants through expanded care coordination, adoption of assessment and screening related to the IDN project, and support for expanded MAT services.
- *North Country Serenity Center (NCSC)* requested funds to expand their "Substance Use Disorder Treatment" project. NCSC plans to expand services using recovery coaching, telephone recovery supports, and the closed loop coordinated cares systems model that is currently being developed with Ammonoosuc Community Health Services. This model will impact an individual's quality of health and address the unique needs of each individual as it relates to their social determinants of health. NCSC also plans to develop a regional partnership with other Recovery Community Organization and share processes and protocols with them that have been developed.
- *Northern Human Service (NHS)* submitted a proposal to implement Critical Time Intervention to assist patients who are transitioning from inpatient psychiatric units to their home communities. The goal of this program is to make needed community support connections over a prescribed nine-month period for the person being discharged to assure their successful transition back into the community. NHS also submitted a proposal to partner with Ammonoosuc Community Health Services (ACHS) to expand their existing Integrated Health Care Clinic project to the Littleton service area. The existing project in Berlin led to the opening of CrossRoads Clinic, a

partnership between Coös County Family Health Services and Northern Human Services, offering a co-located primary care office embedded within a Community Mental Health Center. NHS and ACHS will address the needs of the IDN's target population by developing a second Integrated Health Home, to be located at White Mountain Mental Health Center in Littleton and operated by ACHS.

- *White Mountain Community Health Center* submitted a funding request to continue an existing project including care coordination, risk stratification, closed-loop referrals, and case conferences.
- *Ammonoosuc Community Health Services* submitted a proposal to continue and expand their "Integrated Behavioral Health/Substance Use Disorder Services across Settings" project. ACHS will continue to formally coordinate behavioral health and primary care between ACHS and Friendship House (FH); place Mental Health Clinicians at local area schools to provide substance use preventive and counseling services; and utilize its work flow to notify ACHS behavioral health staff when clients are seen in the EDs for behavioral health or substance use reasons. ACHS plans to expand internal Medication Assisted Treatment (MAT), as well as establish and maintain close coordination with recovery support organizations. They also plan to ensure clients served by ACHS behavioral health providers are assessed and referred to in-house patient navigator staff as appropriate to address social determinants of health.
- *White Horse Addiction Center, Inc. and MWV Supports Recovery (MWVSR)* submitted a joint proposal to provide 24/7 emergency recovery support services for those struggling with substance use disorders. White Horse will set up the on-call services in their Recovery Support Center in North Conway and plan to be the lead agency providing a full-time Coordinator of Services. White Horse will also provide a CRSW to supervise, train and directly support recovery coaches who will make weekly recovery support phone calls and introduce clients to recovery resources. Recovery coaches from both organizations will provide 24/7 coverage for emergency situations on a rotational basis. MWVSR will provide a part-time Peer Recovery Coordinator and be on call the last two weeks of each six-week period.

NCHC had hoped to enter new MOUs for these proposals in December, but due to funding uncertainties that hasn't occurred yet. It is likely that the Steering Committee will need to meet again to have additional discussions on prioritizing the funding decisions related to these proposals once the region knows the total amount of its incentive payment for the period. Region 7 IDN staff continues to update the Steering Committee regarding funding as updates come in from NH DHHS. IDN staff have also been increasingly involved in county and state level conversations over the past six-months to encourage the counties to contribute to IDN funding. Members of the IDN team have presented at multiple county delegation and commissioner meetings to help secure funding for these projects and will continue to inform the Steering Committee and partners regularly.

Community Engagement Workgroup:

The Community Engagement Workgroup continued to work together to develop strategies of communicating IDN messages to the community and partners. The group determined a new monthly meeting schedule to increase attendance, which seemed to work for most members during the first few months. The group continues to struggle with participation, resulting in a quarterly meeting model to be implemented in 2019. The core group of partners that have been in attendance regularly will continue to collaborate more often as necessary to prepare for the community engagement quarterly meetings moving forward. The IDN team continues to update the workgroup on funding and discussed the new request for funds process that will be utilized.

The IDN 7 Partners will continue to work on engaging patients and families to assure that IDN work is done with their feedback and insight which is critical to the work of creating and embedding evidence-based systems of integrated care. The community engagement workgroup has continuously discussed effective strategies of capturing patient and family input and community outreach activities to be reported on as the region shifts to pay for performance. The Chair of the workgroup came up with the following list of questions that the group will use to help guide further conversations as the project continues:

1. Do you feel you have the information/communication needed to successfully participate in the IDN project? If no, what are ways that communication could be improved or made more informative for you/your agency?
2. Do you feel you have a good understanding of other partners' work?
3. How, if at all, are you communicating with your Medicaid population about IDN work?
4. What kinds of communications are happening with your Medicaid population regarding new practices/services resulting from IDN work?
5. Have you requested and/or received feedback from your Medicaid population (or their support networks) regarding IDN work?
6. How would you like to see our partners share info and receive feedback from each other and with the Medicaid population?

The workgroup was encouraged to like and share the Region 7 IDN Facebook page and submit posts from their agencies to be shared. The NCHC media team has expressed the importance of partner engagement through their agency Facebook pages and the IDN Facebook. The media team reiterated the value of sharing the IDN Facebook page with those who manage IDN partner agency pages to help grow the IDN's social media presence. Aside from partner engagement, the IDN team shared that a post about the opening of Crossroads Clinic reached over 7,000 users, showing the impact of the new social media approach. The Facebook page has been proven to be a valuable resource to share relevant information, events, and help Region 7 acknowledge partners on their progress.

The IDN team has continued to update the workgroup on trainings and encouraged members to promote these trainings to appropriate staff to ensure the right audience is reached. The IDN team moved forward and developed the Region 7 IDN Webinar Series that was briefly mentioned during the last reporting period. The HIT Integration Coach worked diligently with IDN staff and the Community Engagement workgroup to decide the most effective approach to delivering relevant trainings that providers could attend or easily watch as a recording during their spare time. The workgroup provided valuable feedback and ideas for webinar topics and will continue to be part of program development as the project continues. The group discussed promotion strategies and the IDN team asked members to share webinar links as they become available. The workgroup discussed the idea of an IDN rack card that could explain integrated care to patients and help them understand the changes that are occurring. The core group will continue to brainstorm the most effective way to create this and share ideas with the rest of the Community Engagement Workgroup at the first quarterly meeting in 2019.

Data Workgroup:

The Data workgroup met less as a group this reporting period due to the increase in individual meetings with MAeHC regarding reporting. Members did attend the Strategic Funding Meeting in July, providing valuable feedback about funding and data collection strategies. The group met in September to participate in a Shared Care Plan presentation from the IDN HIT Integration Coach. The team has decided to include this work to broaden the audience of the workgroup and seek ideas and topics that

can be helpful to the group. The workgroup was educated on basic features of the shared care plan including PreManage ED, PreManage Primary, and Event Notifications. Admission Discharge Transfer feeds were also discussed; the workgroup was notified that a high percentage of IDN 7 hospitals are submitting this data to Collective Medical Technologies. The workgroup was updated on the partners that have been actively engaged in implementing the Shared Care Plan and encouraged to reach out to the HIT Integration Coach to discuss the process.

Monthly technical integration calls and quality measure meetings took place during this reporting period with the following agencies:

- Cottage Hospital
- White Mountain Community Health Center
- Ammonoosuc Community Health Services
- Coös County Family Health Services
- Huggins Hospital
- Weeks Medical Center
- North Country Healthcare
- Indian Stream Health Center
- Saco River Medical Group

The IDN team has been having conversations with partners to determine how to align various agency measures such as HEDIS, ACO, and IDN measures. The group was informed that the historical lookback to 2015 will be due in October 2018 to establish a baseline. It was stressed that data reporting will become increasingly important in 2019 due to the shift to pay for performance.

Clinical Workgroup:

Clinical Workgroup members attended the Strategic Funding Meeting in July to help brainstorm efficient ways to allocate funds moving forward. The workgroup was essential to the discussion and has continued developing strategies to meet IDN deliverables. They continued discussing the core comprehensive standardized assessment, Multi-Disciplinary Core Teams, and protocols and workflows. The expertise within the clinical workgroup has been crucial in the development of the region's sample protocols and strategies to implement the deliverables mentioned above.

The workgroup also spent the period discussing workforce updates, shared care plan updates, training schedules, IDN funding, and reporting. The IDN Team updated the Clinical Workgroup on the Site Self-Assessment survey from June 2018 to illicit feedback and develop strategies to increase scores in the keys areas that were lacking. The primary area the workgroup discussed was patient and family input to integration management; the partners explained current practices at capturing this information and ways to improve and implement the process at other agencies. The group determined that barriers to involving patients and family include stress and increased demands of staff member. In addition, the large region makes it difficult to get full representation of the population being served. The Clinical and Community Engagement workgroups will continue strategizing on ways to involve the Medicaid population throughout the remainder of the waiver.

Workforce discussions mainly revolved around the lack of behavioral health workforce and the need for more trainings in the area to help maintain certifications and licensure. The Region 7 IDN team has worked diligently to provide an array of trainings that count towards certification and licensure and have called on the clinical workgroup for training recommendations as they begin to develop the region's

2019 training plan. The workgroup strongly suggested bringing more LADC specific trainings to the region to encourage more individuals to work in this field and in the North Country.

Implementation of the CCSA continued to be a main topic on the agenda each month, the group worked to clarify the specific requirements regarding the deliverable and discussed ways to effectively document the completion of the process for each patient. Multiple partners have been working to integrate this in their EMR's and intake workflows, setting an example for the entire region. The sample protocol has been shared region wide and the IDN team has been working with remaining agencies to help them adapt it to their specific processes. The IDN Quality Improvement Coach and the IDN Medical Director spent the reporting period developing more protocols around various topics such as closed-looped referrals, depression management, and collaborative care agreements. These draft protocols will be shared with the clinical workgroup for feedback and then disseminated to the region for adaptation across partner agencies. Members of the clinical workgroup continued to discuss the formation of Multi-Disciplinary Core Teams, and the IDN team solicited the group for ways to expand the use of the Multi-Disciplinary Core Team at additional partner agencies across the region.

The Clinical Workgroup revisited the topic of collaborating with Managed Care Organizations to enhance care coordination and avoid duplication. New Hampshire Healthy Families (NHHF) representatives joined a clinical workgroup meeting in October to explain opportunities that their MCO could provide. The MCO mentioned that they provide report cards to providers regarding patient progress and a provider/patient analytic tool to look at population health within that provider group, including looking at information at the individual provider level. This allows access to look at high complex patients to identify gaps in care. The workgroup suggested further follow up with NHHF and the second NH MCO, Well Sense, to learn more about each program. The IDN team met with both individually to learn about potential trainings and demonstrations and discuss collaborative opportunities for delivering trainings to IDN partner agencies.

The Clinical Workgroup also spoke about the Cherokee Health System training that IDN staff attended in October. The IDN team mentioned using this model to guide them as they assist partners with advancing along the continuum of integrated healthcare. The Clinical Workgroup will continue to work together to finalize protocols, assess training needs, improve communication, increase provider involvement and move the region towards integrated care.

Financial Workgroup:

The Financial Workgroup participated in the proposal review process and provided feedback related to the budgets submitted from IDN partner agencies. The NCHC Chief Financial Officer, a member of the Financial Workgroup, assisted IDN staff in reviewing budgets to help the Steering Committee understand the status of funds available to the region. The workgroup was invited to the Strategic Funding Meeting in July to participate in the discussion regarding allocation of funds as the region moves to pay for performance. The group will continue to be a resource to the region as necessary and review proposals and budgets regularly.

Opioid Crisis:

Region 7 IDN has continued to work collaboratively with partners and existing initiatives to address the opioid crisis. These relationships have proven foundational to impacting the crisis, expanding services, and improving prevention strategies across all counties. The Carroll County Coalition for Public Health and North Country Health Consortium's Substance Misuse Prevention Program have continued to be crucial in helping the region to address the opioid epidemic. NCHC has also received grants to address the opioid crisis further, their Wellness and Recovery Model will help bring more peer recovery coach

services to the north country and help involve EMS, Law enforcement and emergency departments in the initiative. The region is excited to see two Hubs stood up in Coös and Northern Grafton county; Androscoggin Valley Hospital and Littleton Regional Healthcare will develop their HUB models while Region 7 IDN works to collaborate with all initiatives to determine the best use of resources. Region 7 IDN will continue to leverage these new state initiatives and projects to avoid duplication and build collaborative relationships to address the opioid epidemic.

During the last reporting period, a new residential treatment facility opened its doors in Bethlehem to accommodate twenty-eight clients and provide improved treatment strategies. The Friendship House held its official Ribbon Cutting on October 16, 2018. The opening of the new Friendship House reflects the commitment, hard work and resourcefulness of the many stakeholders invested in addressing the opioid crisis locally. The community celebrated having effective, evidence-based treatment for substance use disorder and other addictions brought to fruition.

The availability of peer to peer services to augment and enhance the aforementioned model of care is a priority of the four Recovery Community Organizations of Region 7 IDN. They have participated in collaborative conversations to develop a peer recovery support network for people suffering from substance use disorder. Region 7 has provided multiple trainings to help partner staff become recovery coaches and certified recovery support workers. The region has expanded its capacity to increase recovery support and treatment services and is developing projects to continue building the network.

The North Country Substance Misuse Prevention (SMP) team planned and carried out multiple events during the last period that have positively impacted the opioid crisis. The team saw the Community Anti-Drug Coalitions of America's (CADCA) Youth Leadership take place on August 8 & 9, 2018 for ten Haverhill/Woodsville Middle & High School Students at Haverhill Cooperative Middle School. CADCA's National Youth Leadership Initiative (NYLI) works to engage youth to become involved in community coalitions, develop their skills and character to be strong, capable, and visionary leaders through training, and inspire them to create lasting change. The Drug Enforcement Agency organizes two Drug Take Back Days each year, one in April and the other in October. In October, the state of New Hampshire collected a total of 11,880 pounds of unneeded or expired prescription drugs. More than 600 pounds of these drugs came from North Country communities where they were collected at local police departments. The SMP Coordinator also worked with Upper Connecticut Valley Hospital to secure a permanent drop box at their agency.

The SMP Coordinator has also been working hard on the Recovery Friendly Workplace Initiative that Governor Sununu launched statewide. This initiative creates a safe recovery environment for employees by opening the line of communication between the employee and employer when the employee is struggling. The employer helps to remove barriers and stigma associated with getting help for a substance misuse disorder. Tender Corp, Gen-foot America, North Country Health Consortium and Phlume Media have all signed on to become a Recovery Friendly Workplace in the North Country to date.

The Granite Youth "UP" Conference was attended by 140 youth in the North Country on September 21, 2018 at the Mountain View Grand in Whitefield. Students were encouraged to show up, stand up, and speak up to promote healthy school culture. The conference welcomed national speaker Tony Hoffman who shared an incredibly inspiring recovery story. Also, in September 2018, The North Country Health Consortium (NCHC) & the NH Oral Health Coalition hosted "*Putting the Mouth Back in the Body: The Role of Oral Health in Addiction, Treatment and Recovery*." Participants learned about local community

oral health programs and partners, low cost solutions to caries management, payment sources for dental and oral health, and community-based public health hygienists.

The SMP team has also been involved with Law Enforcement Against Drugs (LEAD), an organization that supports local law enforcement officers by training them to teach students in the classroom about drugs, bullying, and violence prevention. LEAD uses the only K-12 evidence-based program by partnering with the Mendez Foundation to use their 'Too Good For' curriculum. NCHC has two initiatives focused on the region's young adult population, ages 18-25: Young Adult Strategies and Young Adult Leadership.

NCHC sent two staff to the NAMI Young Adult Prevention Training on Mental Health, Substance Use & Suicide Risk to become young adult trainers, as a strategic plan to repeat the training across the Region during 2019. The two young adult leaders also attended a film screening event of Kevin Hines: "Suicide: The Ripple Effect" on October 30, 2018. This event served as a starting point for a conversation with other young adult trainers around the state on how to address substance use disorder and suicide prevention moving forward. The young adult trainer program will focus on bringing substance use disorder and suicide risk awareness to 18-25-year-olds. Carroll County Coalition for Public Health also held the NAMI Young Adult Prevention Training on Mental Health, Substance Use & Suicide Risk training for community members to participate in. NAMI staff and the two NCHC staff traveled to train participants on the subject to increase capacity to prevent suicide and the burden of mental health and substance use issues among the region's young adults.

C3PH participated in multiple activities relating to fighting the opioid crisis and has been a pivotal player in many collaborations. The partner's CoC participated in a newly formed meeting designed for treatment providers and recovery coach volunteers to come to share updates, resources and build collaboration. At this Medication Assisted Treatment Providers meeting at Mount Washington Valley Supports Recovery the CoC was able to meet providers and coaches in person and offer the support of the public health network. The partner has also been a crucial participant in the Peer Recovery Support Network meetings to help facilitate the collaboration between the region's Recovery Community Organization as they work to set up emergency response dispatch systems that would link recovery coaches to individuals in need at emergency departments. C3PH was also a major participant in the development of a local video that was produced highlighting the work happening in northern Carroll County to respond to the needs of individuals and families impacted by SUD across the continuum. The video was shared with NH BDAS, NH DHHS and featured at the quarterly regional meeting of the IDN Region 7, and well received by audiences in those offices across the state.

Region 7 IDN will continue collaborating to strategically address the opioid crisis and leverage each other's work to avoid duplication. The programs will continue to provide education, raise awareness, and prevent substance use disorders. The regions' coalitions will continue to work together to be a community voice and youth groups will be used to help reach the school-aged population. Statewide and local initiatives coming to the region will complement these efforts and help move the region toward recovery.

Community Input:

The Region 7 IDN is diverse with significant geographic barriers between the communities it serves. The IDN works closely with partners to understand the unique characteristics and needs that their local areas present individually and collectively. This requires active and ongoing engagement with representative stakeholder groups to identify, target and address needs in a meaningful and effective way. The goal of these conversations is to help agencies create sustainable systems which promote integrated healthcare and enable the region to articulate the impact the IDN project.

The IDN's community engagement workgroup gathers input from the community regarding needs and IDN activities within the Region. The community engagement workgroup also strategizes and plans with partners how to best present the IDN to the community and ensure visibility of the IDN's work. This has included maintaining a Region 7 IDN Facebook page that shares relevant information with partners and community members as well as refreshing the IDN website. In addition, the IDN webinar series aids in creating community awareness of the IDN and its mission. The discussions and questions that occur during these webinars assists the IDN team to better understand the needs of the community.

IDN 7 Partners recognize how important it is to engage patients and families on multiple levels to assure that IDN work is done with their feedback as well as their insight and investment. Critical to the work of creating and embedding evidence-based systems of integrated care is the assurance that patient and family provide feedback as systems and polices are developed. Partners play a key role in engaging patients and families to provide feedback about specific services. Ammonoosuc Community Health Services Board of Directors is comprised of multiple representatives and disciplines, including patients. Northern Human Services also has patients and family members on their Board of Directors and has continued to use their annual patient satisfaction survey to assess quality of care.

Currently, Coös County and Northern Grafton County have five coalitions combined, made up of community members who are doing their part to fight the opioid epidemic. North Country Health Consortium's Substance Misuse Prevention Coordinator helps facilitate and provide direction for the coalitions who are dedicated to reducing the incidence and effects of alcohol, tobacco, and other drug use in their communities. Regional coalitions include Littleton Alcohol, Tobacco & Other Drugs Coalition (ATOD), Lancaster/Groveton Coalition, Haverhill Area Substance Misuse Prevention Coalition (HASMPC), Stand Up Androscoggin Valley (SUAV), and North Woods Action Committee (NWAC).

In August 2018, NCHC hosted the Bi-Annual Coalition Learning Collaborative at Echo Lake attended by twenty-five participants including members from all five regional coalitions as well as neighboring Vermont Coalitions. Multiple presenters including Staff Sergeant Rick Frost of the N.H. National Guard Counterdrug Task Force, IDN 7 staff, and staff from the Teen Institute presented on topics related to drug recognition, harm reduction strategies, local substance misuse prevention efforts, and youth engagement topics.

The Carroll County Coalition for Public Health (C3PH) continues to be an active partner in the region and have staff who routinely participate in the IDN Community Engagement Workgroup. C3PH staff coordinate and attend a variety of community forums focused on assessing public health needs and priorities in order to inform their community health improvement plan and are instrumental in sharing DSRIP related information.

The hospitals in Region 7 IDN play a key role in aggregating community input through their Community Health Needs Assessment process and related public documents. As part of the Memorial Hospital Community Health Needs Assessment, C3PH Continuum of Care (CoC) facilitator participated in a public forum held by Memorial Hospital to share data about current health trends in the region as well as to collect community input about perceived top priorities in health issues.

Carroll County has done impressive work to engage the community to participate in many initiatives to express their support. The Carroll County CoC had an opportunity to meet a newly relocated trained recovery coach. This recovery coach became a new member of the SMP/CoC Stakeholder workgroup. C3PH held bi-monthly SMP/CoC meetings in October and December 2018. The detailed minutes with follow up links and action items are shared not only with the average of twenty regular participants but

with a larger email list of 190 subscribers throughout the community. The combined SMP/CoC Stakeholders Workgroup included participation of twenty-nine community members representing twenty-two different agencies, including state legislature candidates and concerned citizens. The C3PH bi-monthly workgroup attracted the first-time participation of three state legislature candidates who became more informed about local SUD public health issues before the November election. All have stayed engaged regardless of the outcome of their personal bid for office. Carroll County Coalition for Public Health continues to be an asset to the region regarding community outreach, input and engagement. They will continue to work with stakeholders and community members to improve systems and services throughout the county.

Network Development:

Region 7 IDN continued to foster relationships between partners over the past six months, improving current partnerships and creating new ones. The region held two quarterly meetings that continued to allow partners to participate in collaborative conversations and update the region on their progress. IDN partners have expressed how valuable these meetings have been in coalescing their understanding of IDN goals and reinforcing their shared commitment to learning what is happening in the region and facilitating ideas for further collaboration.

The partnerships that have stemmed from this DSRIP funding continue to flourish and impact the region. An IDN funded project involving Memorial Hospital, Saco River Medical Group, Children Unlimited, and Visiting Nurse Home Care & Hospice has made great progress in the Carroll County area. The project has strengthened relationships between the four agencies and community partners throughout the region. The project has resulted in the creation of a nine-minute video explaining the IDN and the work that the agencies have been doing to improve the health of the community. The video was shared with Region 7 IDN at the December quarterly meeting and Carroll county partners have been sharing it region wide in hopes of reaching all levels of the community.

White Horse Addiction Center and Mount Washington Valley Supports Recovery submitted a proposal to develop an 24/7 emergency peer recovery support service program for Carroll County. The request was approved contingent on the results of the Strength, Weakness, Opportunity, Threat (SWOT) analysis for White Horse Addiction Center and available funding. The four recovery community organizations in the region have also been working together throughout this period to develop a strategy to implement a Regional Peer Recovery Support Service Network. The agencies will continue to have conversations on how to proceed with developing coordinated systems which will be sustainable and not duplicative of other initiatives in the region.

North Country Serenity Center continues to collaborate with Ammonoosuc Community Health Services to help their clients receive medical care. Conversely, they agree to provide recovery support services to ACHS patients who have been seen in the ED. The partners have developed a referral process and are working to develop strategies to close the loop during the process. ACHS enjoys collaborative relationships with local schools to provide students with behavioral health services. They also have an agreement with Friendship House to provide clients with physicals required for admission.

Northern Human Services and Coös County Family Health Services opened their CrossRoads Clinic in July and have seen an improvement in the care of patients from both agencies due to this collaboration. NHS submitted a proposal to replicate this integrated health clinic in Littleton with ACHS. Weeks Medical Center, Indian Stream Health Center and Upper Connecticut Valley Hospital have also partnered with the aim of expanding the Medication Assisted Treatment program to Northern Coös County.

Huggins Hospital received funding from Health Resources and Services Administration to be a Rural Health Network. Huggins launched the project in 2018 to create a strategic partnership to promote optimal community health and well-being by delivering screening, referral and navigation services to address the community's social determinants of health. They are building a Rural Health Network of multi-sector stakeholders to identify and pinpoint community needs, identify unmet needs and gaps in services, and develop a collaborative plan to build capacity and improve services. The goal of their planning grant is to build a strong and sustainable Network, which depends on including the right partners. The Network's programmatic focus areas are (1) integrated mental/behavioral health and substance abuse services, including needs arising from the opioid epidemic, and (2) the needs of the aging rural population including those related to chronic disease and healthy aging. The first activities of this Planning Grant are to mature the Network infrastructure and vision, as well as to conduct a service gap analysis and strategic planning. The next activities of this Planning Grant are to establish a "no wrong door" system of social needs screening, referral and navigation of residents to health and social services to address the social determinants of health, and a system of "Hotspotting" services to geographic areas and residents of greatest need. The social determinants model is guided by the promising practices of the CMS Accountable Health Communities demonstration model that screens, refers and navigates residents to services to address unmet health-related social needs. The evidence-based Healthcare Hotspotting program designed by the Camden Coalition in Camden, NJ, will ensure that data are used strategically to allocate resources and services where they are needed most in the community to promote optimal health outcomes. This program is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS), Grant number P10RH-31838.

The collaborations within our region help partners on many levels, from cementing professional relationships, to building trust and social capital necessary to begin thinking of patients as common consumers of care, rather than in separate and discrete "billing" encounters. This is seen as integral to moving not just toward but into the integration of behavioral health with primary care services, as a real paradigm shift in healthcare. The vision of enhanced treatment that is effective and accessible for all, of better outcomes that last and build one onto the other, of a healthy and vibrant community, this vision is the center of the work that brings the partners together.

June 30, 2019 Update

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

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

Network Membership

During the reporting period of January 1 through June 30, 2019, Region 7 IDN had no members join or leave the network. The information below speaks to the progress that Region 7 IDN has made on the DSRIP as a whole during this reporting period

Improvements to Region 7 Performance Monitoring Process

As Region 7 IDN adopted the new DHHS Monthly Update reporting format this spring, efforts were expended to verify the total number of individuals served by each Region 7 IDN partner to date and leverage the State's reporting tool as a mechanism to help partners report monthly totals for the remainder of the DSRIP. By utilizing the State's new monthly reporting mechanism as the backbone of a

high-integrity data management process, the Region 7 IDN team hopes to ease the reporting burden for partners while retaining the ability to collect, aggregate and analyze data for the region as a whole. This revised process is anticipated to allow the region to evaluate progress on performance evaluation targets more frequently and help the Region 7 IDN team provide more timely feedback and support to the region's partners. Partner specific updates in this section reflect narrative regarding their progress along the continuum of the project, and their total number of unique individuals served during the DSRIP period through June 30, 2019.

Governance:

Steering Committee

As the Region 7 IDN works to achieve evaluation targets associated with the DSRIP project, its Steering Committee continues to leverage members' combined expertise and experience to provide guidance and oversight to partner agencies. Members of the Committee have been actively involved in strategic conversations related to a targeted funding approach to maximize the incentive payments earned by the region by focusing on projects that will further the region's success in meeting unmet performance targets. In anticipation of these discussions, the Region 7 IDN team presented information to the Steering Committee regarding key metrics that were linked to incentive payments. Those performance metrics not yet met by the region were highlighted for and discussed by the Committee. This included discussion of targeted funding for efforts to successfully convene monthly case conferences by Multi-Disciplinary Core Teams, supporting partners' data reporting efforts, and establishing a regional contract for psychiatrist consultants. The Committee determined that the previous proposal process and 6-month funding cycle will not be an effective mechanism for the remainder of the DSRIP project due to the time consuming nature of the application and approval process, misalignment between the 6-month sub-recipient cycles and partner budgeting schedules, and release of funds from NH DHHS. Members of the Steering Committee also discussed ways to leverage the Training and Technology funding process to support partners' ability to meet specific IDN deliverables more effectively. This discussion resulted in a decision by the Steering Committee to increase the maximum Training and Technology award from $5000 to $10,000. Partners can apply for these funds on a yearly basis.

The Steering Committee has discussed at length the importance of communicating the impact of IDN work to county officials to address their concerns related to the DSRIP funding mechanism at the county level. The Committee was also introduced to the State's new monthly reporting process, and the Region 7 IDN team shared a partner-level reporting tool developed to help capture data from partners more efficiently for this new process.

The fourth round of sub-recipient proposals that were received by partner agencies in October 2018 were revisited in April 2019 following the receipt of partial funding from NH DHHS. The following projects were discussed during the April meeting, with focus on the most appropriate use of available funds.

- *Ammonoosuc Community Health Services (ACHS)* submitted a proposal to continue expanding their *Integrated Behavioral Health/Substance Use Disorder Services across Settings* project. ACHS will continue to formally coordinate behavioral health and primary care between ACHS and Friendship House (FH), place Mental Health Clinicians at local area schools to provide substance use preventive and counseling services, and utilize its work flow to notify ACHS behavioral health staff when clients have behavioral health or substance use disorder related Emergency Room visits. ACHS plans to expand internal Medication Assisted Treatment (MAT), as well as establish and maintain close coordination with recovery support organizations. They also plan to ensure clients served by ACHS

behavioral health providers are assessed and referred to in-house patient navigator staff as appropriate to address social determinants of health.

- *Friendship House (North Country Health Consortium Clinical Services)* submitted a proposal for continuation funds to focus on enhancing care coordination and service delivery and purchasing new best-practice clinical treatment curriculum. The organization also requested funds to expand case management availability by integrating a trained Community Health Worker/Recovery Coach to assist clients with addressing treatment and recovery issues, social determinants of health, affordable housing, transportation barriers, and navigating availability of mainstream resources. This proposal demonstrates collaboration and program enhancement, which will improve the residential services provided to community members in the Region.
- *Huggins Hospital* submitted a proposal to expand their Huggins Health Neighborhood Care Coordination and Integration Services project. The project would expand Huggins Hospital's integration of behavioral health and primary care and address the social determinants through expanded care coordination, adoption of assessment and screening related to the IDN project, and support for expanded MAT services.
- *Memorial Hospital* submitted a proposal on behalf of four partner organizations in Carroll County (Memorial Hospital, Saco River Medical Group (SRMG), Children's Unlimited (CU) and Visiting Nurse Home Care & Hospice (VNHCH)) to expand their *Collaborative Community Program Addressing Behavioral Health & Substance Use in Carroll County* project. Each agency will build on and expand the collaborative work already begun. Memorial's patient care coordinators will continue collaboration of behavioral health, IMAT and A New Life prenatal substance abuse program. Memorial will also expand their IMAT program to full capacity of providers with waivers, provide staff education and training, and expand outreach and connections with other community partners particularly addressing social determinants of health. VNHCH will expand its "Crossings" Program which provides free facilitated peer support groups for children ages 3-18 and their families and ensure all resources in its multi-media library are available to the community. CU will continue to support the "Parenting from Prison" Program, provide training to support "children from hard places," and continue to provide comprehensive support services through its "Bridges" Program. SRMG will expand its current MAT program and continue coordinating transitions of care for all patients, including those with mental health and substance use disorders. They continue to improve integrated behavioral health care and are investing in their infrastructure by building a suite to be used for psychiatric care, mental health counseling and substance use disorder counseling.
- *North Country Healthcare (NCH)* submitted a proposal for a Regional Care Coordination Project involving ACO Care Coordinators from affiliates Littleton Regional Healthcare and Weeks Medical Center. These partners proposed that the ACO Care Coordinators will divide time between NCH care management activities and the obligations of their home affiliates. The Regional Care Coordinators will be responsible for establishing a Critical Time Intervention program to effectively transition patients from one setting to another. They will also provide a unified team-based approach with shared control of tasks, phases, and deliverables of population health and clinical initiatives, promoting a culture of coordination and integration between physical, behavioral health, and social service systems throughout the North Country.
- *North Country Serenity Center (NCSC)* requested funds to expand their substance use disorder treatment project. NCSC plans to expand services using recovery coaching, telephone recovery supports, and the closed loop coordinated cares systems model that is currently being developed with Ammonoosuc Community Health Services. This model will impact an individual's quality of health and address the unique needs of each individual as it relates to their social determinants of

health. NCSC also plans to develop a regional partnership with other Recovery Community Organizations and share processes and protocols with them that have been developed.

- *Northern Human Services (NHS)* submitted a proposal to implement Critical Time Intervention to assist patients who are transitioning from inpatient psychiatric units to their home communities. The goal of this program is to make needed community support connections over a prescribed 9-month period for the person being discharged to assure their successful transition back into the community.
- *Northern Human Services (NHS)* also submitted a proposal to partner with Ammonoosuc Community Health Services (ACHS) to expand their existing reverse integration project, embedding primary care into a community mental health center, to the Littleton service area. The existing project in Berlin led to the opening of CrossRoads Clinic, a partnership between Coös County Family Health Services (CCFHS) and NHS, offering a co-located primary care office embedded within a Community Mental Health Center. NHS and ACHS will address the needs of the IDN's target population by developing a second Integrated Health Home, to be located at White Mountain Mental Health Center in Littleton and operated by ACHS.
- *Tri-County Community Action Program (TCCAP)* submitted a proposal to continue their Supportive Housing project to deliver a coordinated system of care utilizing The Critical Time Intervention (CTI) model. The primary goal of their project is to improve the participant's capability to remain housed beyond program participation by effectively connecting them with critical community supports and aiding them to achieve greater economic stability. TCCAP aims to support a successful transition into permanent housing by maximizing available resources and supports. TCCAP Prevention Programs is proactively exploring future options for delivery of some components of the program through secured teleconferencing equipment. As caseloads increase the ability to utilize technology to reduce the burden of travel time and expense would be vital.
- *Weeks Medical Center (WMC),* an NCH affiliate, submitted a proposal to expand Medication Assisted Treatment and behavioral health services to Upper Connecticut Valley Hospital and Indian Stream Health Center. These agencies will work together to ensure patients who are referred to WMC's North Country Recovery Center (NCRC) will have access to behavioral health specialists for counseling services as well as behavioral health case management/care coordinators to identify social determinants and assist patients in obtaining support services.
- *Weeks Medical Center (WMC),* also submitted a proposal to support their Care Management department as it expands to address an increasing volume of patients needing care coordination management services. WMC's Behavioral Health Case Manager provides much needed support for the behavioral health department and MAT program, allowing the behavioral health providers to focus on services within their scope of practice. The Care Coordination Assistant helps to coordinate functions that are associated with both inpatient and outpatient services and helps to provide case management teams with added support, which allows them to concentrate on preventing unnecessary admissions, readmissions, and over utilization of the healthcare delivery system.
- *White Horse Addiction Center, Inc. (WHAC)* and *Mount Washington Valley Supports Recovery (MWVSR)* submitted a joint proposal to provide 24/7 emergency recovery support services for individuals in the Conway area who are struggling with substance use disorders. WHAC will set up the on-call services in their Recovery Support Center in North Conway and plan to be the lead agency, providing a full-time Coordinator of Services. WHAC will also provide a CRSW to supervise, train and directly support recovery coaches who will make weekly recovery support phone calls and introduce clients to recovery resources. Recovery coaches from both organizations will provide 24/7

coverage for emergency situations on a rotational basis. MWVSR will provide a part-time Peer Recovery Coordinator and be on call the last two weeks of each 6-week period.

- *White Mountain Community Health Center (WMCHC)* submitted a funding request to continue an existing project including care coordination, risk stratification, closed-loop referrals, and case conferences.

NCHC had hoped to enter new MOUs for these proposals in December, but this distribution was delayed until DHHS was able to release incentive payments tied to the January – June 2018 performance period. These funds were received in late April, though in an amount lower than anticipated. The funds received reflected a 16.8% decrease in incentive payments because the region fell short of targets for several performance metrics. Additionally, NH DHHS received 30.9% of the anticipated Coös County contribution to the IDN for this period and allocated the full shortage to Region 7. Following discussion about the reduced incentive payment, the Steering Committee agreed that all partner projects approved for funding would be subject to a 16.8% reduced award to reflect the performance-related reduction in incentive payments for the January-June 2018 reporting period. Additionally, just as Region 7 was subject to the full reduction in funding resulting from the partial Coös County contribution, those sub-recipient proposals that included work done in Coös County were initially asked to further reduce their budgets by a proportional amount of 69.1%. In the interim, Coös County submitted the remainder of its anticipated contribution, and the Coös-involved projects have been asked to provide budgets that only reflect the performance adjustment. In response to the reduced Coös County contribution, Weeks Medical Center retracted their Care Coordination proposal and the NCH Regional Care Coordination proposal to prioritize funding for the MAT expansion into the Colebrook Community.

The Steering Committee has spent time during this reporting period discussing ways to deliver more information to the county legislators that illustrates the impact of the IDN and reinforce the value of the project to the region. The Committee proposed holding a Legislative Breakfast at which this information could be shared with County Commissioners and Delegates, and several Steering Committee members convened a subcommittee to plan the event. A robust agenda was developed by the subcommittee and approved by the Steering Committee. Unfortunately, lower than anticipated registration for this event prompted the Steering Committee to cancel the breakfast and move key agenda items to the Region 7 IDN Annual Meeting held on June 27, 2019. County officials were invited to attend this meeting as well, and both Northern Grafton and Coös had representation in attendance.

The Steering Committee has also dedicated time to the topic of sustainability as NH DHHS has provided additional information regarding Local Care Management Entities (LCME) and the Managed Care Organization contract language related to the potential relationship between LCMEs and IDNs. Members of the Region 7 IDN team and the Steering Committee continue to participate in discussions within several statewide forums regarding the topics of sustainability, LCMEs and potential future applications of the IDN infrastructure after the DSRIP ends.

Community Engagement Workgroup

During this reporting period, the Community Engagement Workgroup continued working to ensure that IDN information is correctly delivered to the community, IDN partners and key stakeholders. A core group of regular attendees agreed that it would be more efficient to meet quarterly instead of monthly during this reporting period, meeting in March and June. The shift resulted in increased attendance by other members of the workgroup and improved productivity of this workgroup. Members have spent this reporting period developing a rack card that can be used by Region 7 IDN partners to inform healthcare consumers and the community at large about the integrated care made possible through IDN

projects. The overarching goal of this communications tool is to explain integrated care and provide individual partners the opportunity to highlight their efforts towards the delivery of integrated healthcare to their existing and potential patients/clients.

In March, the workgroup discussed how to collaborate with the NH Doorway locations that opened across the state. Specifically, *Carroll County Coalition for Public Health (C3PH)* encouraged the creation of effective communication pathways between Substance Use Disorder providers and the Doorways to allow for collaboration, making the argument that the Doorway goals are aligned with the integrated care goals of the IDN. Carroll County has had a large voice within the region over the last six months as the Doorways have engaged agencies and organizations to serve as spoke providers for the Doorway initiative. C3PH has played a significant role in connecting SUD service providers and Doorway coordinators to allow for effective collaboration and avoid inefficient duplication of efforts.

The Community Engagement Workgroup members also spent time this reporting period seeking the most effective and efficient way to gather data that shows the impact of IDN work. The group agreed that one of the best ways to capture the value of IDN efforts is to collect and share the stories and feedback from the people receiving services. This approach helps to validate the efforts of the staff providing services, resulting in a workforce that is more engaged and committed to the work. These patient driven impact statements can be challenging to collect but the Workgroup agreed that a story of quality care is valuable to share. The Workgroup also discussed the value of bringing all Region 7 IDN care coordinators together on a routine basis. The purpose of these gatherings would be twofold, with attendees engaging in shared learning experiences and gathering stories and data that show the impact of enhanced care coordination efforts in the region.

In the coming months, the Community Engagement Workgroup will finalize the rack card and develop additional strategies to collect and share impact statements from patients and providers throughout the region. The Workgroup is also committed to discussing impact with county delegates and commissioners whenever possible to ensure that county contributions continue to support this work for the remainder of the DSRIP period. With the guidance of this Workgroup, the Region 7 IDN team will continue to regularly engage in sharing these impact stories through the Region 7 IDN Facebook page. The Workgroup will continue to encourage partners to submit content that can be shared easily on this platform.

HIT & Data Workgroup

The HIT & Data Workgroup met throughout the reporting period to discuss Statewide Outcome Reporting, shared cared plan implementation and the technical aspects of other IDN performance metrics. The Workgroup was informed that thirteen Region 7 IDN partners would be reporting in the third reporting period, with four of them being newly engaged partners. The members focused on sharing data abstraction strategies and discussing challenges involved in abstracting specific data points. This led to conversations in which partners helped each other by sharing techniques and tactics for mitigating abstraction challenges.

During this reporting period, members received information about a new Clinical Collaboration Call hosted by Collective Medical, designed to help partners review shared care plan functionality, implementation steps, best-use recommendations and success stories. The HIT & Data Workgroup has dedicated a considerable portion of their meeting time to discussions about shared care plan implementation and the challenges experienced by some partners. The Region 7 IDN team have reinforced that these meetings are a venue in which partners can seek guidance on shared care plan implementation and utilization when needed. Shared care plan updates from the Region 7 IDN's Health

Information Technology Integration Coach have enriched Workgroup discussion and helped partners progress past implementation challenges. Partners share their progress on adoption of the shared care plan at these meetings, allowing agencies not yet using this technology to explore strategies for adoption.

The HIT & Data Workgroup also dedicated a full meeting this reporting period to the technical aspects of Comprehensive Core Standardized Assessments used at partner sites. The members discussed the rationale behind this Coordinated Care Practice requirement and the specific domains required for this IDN process metric. Partners shared their individual implementation status, copies of the tools in use by clinical and support staff to query responses from patients, and provided reflection, feedback, and suggestions on the process. Additionally, they explored the data points that are abstracted to meet performance metric reporting requirements of Statewide Outcomes measures being extracted for the third round of reporting. Partners shared that this was a valuable discussion not only for those who had not completely implemented a CCSA, but also those agencies who have had one in place for some time but recognized opportunities to finetune their current use. The discussion also helped the Region 7 IDN team better understand what technical supports partners will need as the region continues in the pay for performance period of the DSRIP.

This Workgroup continues to serve as a venue for partners' IT staff members to share information about technical barriers and challenges related to the implementation of IDN initiatives. Partners newly engaging in IDN projects have expressed appreciation for value that these discussions provide, and the meetings appear to be keeping partners informed and on track for Statewide Data Reporting.

Clinical Workgroup

The Clinical Workgroup has dedicated their meetings this reporting period to discussions regarding protocol development, workforce updates, integrated care communication and meeting IDN performance metric targets. The Workgroup has used their expertise to strategize ways to meet unmet targets and develop comprehensive workflows and protocols that will help bring high quality integrated care to patients. Members have had discussed ways to communicate with clients about integrated care and *Northern Human Services (NHS)* was asked to present their communication approach in the context of implementing the shared care plan with a portion of their client population at the region's quarterly meeting in March. NHS shared the importance of creating a shared vision for integrated care which includes the patient and their families. The Workgroup has reinforced that patient and family engagement is crucial to positive health outcomes.

Staffing remains a challenge in the region and the Clinical Workgroup has regularly discussed staffing turnover and ways to recruit more behavioral health staff to the area. Considerable discussion time has been dedicated to the topic of trainings, both as a mitigator of workforce shortages and a means to ensure the delivery of high-quality integrated care by keeping staff well-informed of changes in practice standards. The Clinical Workgroup has discussed the paradox of staff needing trainings but due to staffing shortages the staff cannot find time to participate in the needed trainings. Region 7 IDN has focused on expanding educational offerings in on-demand formats like webinar recordings as a tactic to improve access for providers, who can then receive content at a time that is convenient, both for themselves and the operations of their practices.

Workgroup members were also encouraged to attend the newly formed Clinical Collaboration Call hosted by Collective Medical to ensure that both clinical and technological voices are engaged in those discussions. The call is intended to bring clinical stakeholders together to show how the shared care plan technology can be leveraged to enhance the delivery of clinical care. The meeting allows partners

to see the depth of nation-wide implementation of this technology and provides education into the efficacy of HIT adoption by highlighting case studies from within the Collective Medical client community. Workgroup members were receptive to the information and conveyed that this meeting will likely be helpful in encouraging new providers to adopt the shared care plan.

Clinical Workgroup members dedicated portions of their meetings to the review of IDN process and outcome measures and developed strategies that could help the region meet performance metric targets that have not been met yet. The Workgroup included consideration of the opportunity to recoup money associated with metrics not met in the prior reporting periods in their discussions. Following DHHS' release of preliminary outcome measure results in March, the Workgroup performed an analysis of the HOSP_INP.03: Follow-up After Hospitalization for Mental Illness within 7 days measure, which was one of the unmet performance metric targets for the region. Members had anticipated that, based on the work being done in the region to improve post-hospitalization follow-up, the region would have met or exceeded the target for this measure. The Workgroup produced a list of possible reasons that performance on this measure was lower than anticipated, so that an improvement plan could be developed. Feedback indicated that some follow-up appointments at primary care offices with behavioral health providers were not being captured due to coding methods in use at those sites. The Workgroup discussed ways that these follow-ups could be captured in coding so that they are counted for the measure. Members expressed concern that coding for both a primary care provider and behavioral health provider during the same visit may lead to the denial of claims, and asked the Region 7 IDN team to inquire about potential tactics that could both allow the metric to be met and mitigate claim denials during statewide IDN discussions. The Workgroup also agreed that more collaboration with NH Hospital will be necessary to increase the rate of timely follow-ups throughout the region. This discussion also produced a suggestion that developing a webinar about how to access behavioral health services in the region could potentially increase the follow-up rate.

The April Clinical Workgroup meeting was dedicated to discussing strategies related to the use of Multi-Disciplinary Core Teams across the region in an efficient way. The Workgroup considered both independent teams functioning at separate partner sites and the need to provide access to MDCTs for those partners that lack the resources to stand up an MDCT within their agencies. The Clinical Workgroup members discussed that the lack of buy-in has hindered the region's progress in meeting this goal, and researched evidence-based MDCT outcomes and the value of MDCT monthly case conferences. The group agreed that it will be important to highlight the Triple Aim and the importance of structured workflows and protocols to drive MDCT functionality as the region discusses the value of this resource. The concept of implementing a regional MDCT that provides all Region 7 IDN partners with access to a consultative body that meets MDCT requirements has resurfaced among the Clinical Workgroup and the Steering Committee as more partners express interest in having access to a team but are not able to stand one up at their own location due to lack of workforce capacity.

The Clinical Workgroup also spent time during this reporting period providing updates on the implementation of required workflows and protocols across the region. Templates for the required workflows and protocols remain available to all partners through Basecamp but the Workgroup has identified that the challenge to completely meeting this requirement is in partners having the bandwidth to adopt and adapt templates to meet their organizational needs and workflows. The Workgroup has worked to identify tactics that can help the region meet this performance measure and will continue to meet and guide the region in these crucial areas as the last year of the DSRIP approaches. The IDN team continues to remind partner agencies that members of the IDN team can work directly with their agencies to help meet these IDN deliverables.

Financial Workgroup

The Financial Workgroup has remained available to be deployed to advise the Region 7 IDN team and the region's other workgroups as progress on IDN initiatives continues across the region. The members were not called upon during this last reporting period because delayed funding halted the sub-recipient proposal process. Although the Workgroup did not convene as a whole, communication remained open between all members to allow for financial consultation if necessary, as the Steering Committee addressed the distribution of the funding received in April.

Community Input

The Region 7 IDN Community Engagement Workgroup and Region 7 IDN team continue to work with IDN 7 partners to collect input from the community and consumers regarding IDN activities and services throughout the region. Changes in monthly reporting requirements this spring resulted in an improved process for gathering patient impact stories that show the value of IDN efforts across the region. Most partners continue to gather patient experience data through existing survey processes and in this reporting period several have reported that they have begun to solicit and receive more meaningful verbal feedback from patients in their programs.

Specifically, Carroll County Department of Corrections has received calls from past clients who expressed gratitude for services that helped to address daily struggles that challenged them prior to incarceration. Tri County Community Action program has had similar feedback from a client served by their Homeless Intervention and Prevention team. This client agreed to have his story recorded in order to show how the agency's Critical Time Intervention program had a positive impact on his life. These are just two of several examples of patient impact Region 7 IDN partners have shared during this reporting period. The Region 7 IDN team plans to continue collaborating with the Community Engagement Workgroup to strategize more efficient ways to solicit and gather this data moving forward. The team will also continue to utilize the newly developed monthly reporting templates to capture patient stories from partners.

Network Development

In response to the launch of the NH Doorway project in January 2019, Region 7 IDN partners have worked vigorously during the reporting period to establish collaborative and effective relationships with the local Doorway locations in the region to ensure efficient delivery of services and reduce duplication of efforts under the two initiatives. Region 7 IDN partners *Littleton Regional Hospital (LRH)* and *Androscoggin Valley Hospital (AVH)* were named as the two Doorway partners operating sites within Region 7, one in Littleton (Northern Grafton County) and the other in Berlin (Coös County). Unlike some of the other Doorway sites in the state, both North Country sites have contracted with *Weeks Medical Center (WMC)* to provide Medication Assisted Treatment services on site. The Doorways have also identified *Upper Connecticut Valley Hospital (UCVH)* as an important spoke to these service hubs, and IDN funding was awarded to WMC in June to begin providing MAT in the Northern parts of Coös County, with services expected to begin in the summer or early fall.

Region 7 IDN partners in Carroll County have expended significant effort during this period to establish relationships with the Doorways because there is not a Doorway site located within Carroll County. It has been crucial to identify spokes throughout Carroll County and establish referral procedures with the Doorway sites proximal to the county in order to ensure that Carroll County residents in need of services are able to receive them. *Carroll County Coalition for Public Health (C3PH)* has been actively involved in this process as a convener and facilitator of meetings between community providers and the Doorway coordinators, supporting the development and deepening of these important relationships throughout

the region. C3PH hosted the Doorway sites that serve Carroll County at a provider meeting on April 2 which multiple Region 7 IDN partners attended.

C3PH continues to convene meetings within the community to bring partners together and enhance collaboration across the region. On May 22, C3PH brought partners together for a professional development opportunity and community conversation about adverse childhood experiences. Ninety-nine community members representing a cross section of providers from sectors including education, healthcare, mental health, and peer-support attended this event. The Community Health Collaborative led by Memorial Hospital met on May 16. This collaborative group is working to better align efforts of Substance Use Disorder and Mental Health treatment providers. Huggins Hospital's Rural Health Network met on May 13. This group includes healthcare, mental health, homelessness intervention, and aging service partners in southern Carroll County, all of whom are IDN 7 partners. C3PH has also remained dedicated to keeping county commissioners and legislators informed about the value of the IDN to the region. This partner presented information regarding critical health issues in the region at the Carroll County delegation meeting on May 3.

C3PH also partnered with NAMI NH and Carroll Academy to bring a Young Adult Leaders in Prevention Connect Training to the area to help raise awareness about mental health, substance use disorder and suicide prevention. The goals of the training were for participants to return to their communities as young adult leaders able to recognize risk factors, protective factors and warning signs for addiction and suicide. The training was also designed to prepare these young adult leaders to be more comfortable connecting peers at risk with helpful resources in their community. Young Adult trainers from *North Country Health Consortium (NCHC)* also provided this training staff of Region 7 IDN partners in the North Country. The training is a proven asset to the region and both populations shared positive feedback about the offerings.

NCHC's Wellness and Recovery Model (WARM) team has offered multiple trainings and hosted several events throughout the North Country aimed at growing the local recovery workforce, raising awareness about Substance Use Disorders, and reducing stigma. The WARM team has expanded outreach efforts to include the Haverhill and Littleton communities as they work across Coös and Northern Grafton Counties. During the reporting period, the WARM team worked with the Lancaster and Littleton police departments to begin developing recovery-oriented policing models in the North Country. The WARM team presented information about the model to Coös and Grafton County Drug Treatment Courts, staff at Northern Human Services, representatives from the Doorway site in Littleton and the Director of the Emergency Department at Upper Connecticut Valley Hospital. Private service providers and civic organizations throughout the region have also received the WARM team's presentations.

The WARM team continues to help develop the Peer Recovery Coach Network throughout the region. The program has developed a volunteer database that the trained recovery coaches can opt into if interested in deploying into the region as needed. Recovery coaches throughout the region responded positively to this opportunity. The WARM team has also worked to build the network by participating in multiple conferences during this reporting period. In March 2019 WARM program staff and others from NCHC participated in the Bi-Annual Learning Collaborative Conference with a group of 27 participants from various community partners and coalitions. These participants encompass the Coös County and Upper Grafton County areas; one participant was from the Caledonia County in Vermont. The conference's goal was to gather community wide information about the Gaps/Needs and Opportunities/Resources in relation to Treatment, Intervention, Recovery and Prevention. The Peer

Recovery Network is an important piece to both the IDN and the WARM program so collaboration between program staff will continue as they implement training plans across the region.

The WARM team and other members of the NCHC staff also were part of the 2019 Drug Summit in April hosted by NH Representative Linda Massimilla, with 95 participants in attendance. Among the attendees were various community professionals, educators, students, law enforcement officers, legislators, county attorneys, physicians, business members, community members and representatives from the area's faith-based organizations. Most participants were from Coös, Grafton, and Carroll Counties, along with representation from the State of NH. The summit was value-added to the region as it convened multiple stakeholders to discuss local solutions to address the opioid crisis sweeping the nation. The group identified significant progress made in decreasing SUD stigma and increasing access to SUD treatment resources in the region. Lack of transportation and housing, along with the need for more treatment programs and recovery resources, were some of the unmet needs identified at the summit. Those in attendance left the summit reassured that the State and stakeholders had a plan to collaborate moving forward.

December 31, 2019 Update

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

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

Network Membership

During the reporting period of July 1 through December 31, 2019, no partners have left the network. The Region 7 IDN had one new member join the network – Coös County Department of Corrections – bringing the total number of partners in the Region 7 IDN to thirty-nine (39).

The information below speaks to the progress that Region 7 IDN has made on the DSRIP during this reporting period

Improvements to Region 7 Performance Monitoring Process

Following on a plan developed during the last reporting period, the Region 7 IDN team has continued to ask partners to complete a modified version of the DHHS Monthly Update template each month in order to inform the regional aggregate reports. Despite this more efficient reporting process, as the reporting period progressed, fewer and fewer partners contributed to the reports. During a number of conversations in the last quarter of the year, partners expressed concerns of initiative fatigue and a lack of bandwidth to respond to multiple reporting requests that were similar but not aligned and therefore demanded significant investment of staff time abstracting near-redundant information.

These partner concerns were expressed again when the region rolled out a new targeted funding approach tied to completion of key process measures, but the funding was only accepted by about 50% of the agencies who were eligible to receive these funds. Most of these agencies who accepted these funds had limited reporting burden from other sources. Larger organizations associated with the Core Competency project were hesitant to accept funding tied to the completion of process measures. These agencies remained supportive of the work of the DSRIP, and continued to progress as they could, but would not guarantee that their organizations could make progress at the speed necessary to reach the region's process targets by the end of the reporting period.

These partners shared that there were a number of payer-related projects underway (including participation in Medicare ACOs, commercial insurance plan incentive programs and federal quality monitoring programs) that each requested similar, but not exactly identical, data sets. More often than not, the variance in data measure specifications, combined with older electronic medical record systems that had not been implemented with an eye to this level of data output, resulted in partner organizations having to expend hundreds of staff hours per year to meet these commitments. And often, the staff members engaged in those existing payer-based initiatives are the same staff members needed to implement new initiatives under the Region 7 IDN implementation plan. Partner organizations feel obligated to prioritize work that supports existing reimbursement mechanisms over the work of the demonstration, with its continued funding uncertainties.

One other monitoring trend that has become evident in this first year of wholly performance-based incentive payments is the need to further support and develop a workforce that has deep understanding and application skills of data governance and quality improvement. In larger organizations that have a dedicated person or persons responsible for quality assurance and performance improvement (QAPI), there is large variance in the amount of QAPI training completed by each member of the workforce. In smaller organizations, there is often no internal staff person dedicated to the work of ensuring that records are structured in such a way that reporting can be performed in an efficient manner with verifiable data integrity, and abstraction functions are outsourced to a third party with little to no knowledge of the local variation in data handling. Most partner organizations are working towards better analytics maturity, but struggle with aging medical records systems and the need to balance data governance changes with keeping existing platforms in working order so as not to disrupt patient care.

Although the statewide workforce capacity project is focused on increasing the number of licensed clinicians involved in the delivery of integrated healthcare, this feedback from Region 7 IDN partners makes clear that, as delivery system reform takes place, there is also a strong need to develop and maintain a workforce that provides the administrative support necessary to prove that these clinicians are providing integrated care. Under current reimbursement models, however, there is little to no consideration for the expense of this administrative work, which is best performed by individuals with specific QAPI knowledge and training. Without adequate financial support for data controls and analytics, this work falls to existing staff in smaller partner organizations who struggle to complete it due to a lack of experience and training. In larger partner organizations, some level of overhead absorbs the cost of these efforts, but it is often diffused across many staff, compromising efficiency and data integrity.

As partner organizations prepare for Alternative Payment Models under the NH Medicaid program and other payer initiatives, the Region 7 IDN team will work with its partners to identify opportunities to deepen the skills of their existing workforce and ways to structure workflows such that the reporting requirements of these programs are less burdensome.

Governance:

Steering Committee

During this reporting period, the Steering Committee spent a considerable amount of time developing a new targeted funding approach aimed at ensuring that incentive payments already on hand in the region were used to achieve process measure targets set under the region's implementation plan. At the start of the reporting period, there were approximately $1 million available for use in the region, and the Steering Committee had determined that the project-based request for proposal process used in previous rounds of incentive payment distribution was a model that would not meet the region's

needs as the end of the demonstration approached, and instead the funding distribution should be focused on supporting partners in hardwiring their existing work or meeting specific DSRIP program deliverables to improve integrated healthcare in the region. A tiered funding approach based on overall regional projects and the continuation of partner projects was adopted. $200,000 was retained in a "rainy day fund" pending further clarity on future incentive payments and county funding mechanisms. $50,000 was retained to support the existing training & technology request fund.

Lump-sum funding was offered to partners engaged on key projects, in a tiered fashion based on the partner type and its direct correlation to performance-based funding metrics. Partners were offered a Memorandum of Understanding (MOU) for the tiered amounts in exchange for a commitment to complete key project targets set under the region's implementation plan. A MOU was developed for each partner with an attachment that outlined clear deliverables each partner would have to meet in exchange for the amount offered. For Integrated Healthcare partners this included engaging with the regional Multi-Disciplinary Core Team, ensuring that the organization had a Core Comprehensive Standardized Assessment in place that included all required domains, the use of direct secure messaging technology, formalizing communication channels with social service agencies, engaging with the Collective Medical network, committing at least one care coordinator to participate in the Regional Care Coordination Network, ensuring that all staff training requirements were met and meeting all reporting obligations under the DSRIP. Funding was offered to partner organizations in a tiered fashion as follows:

- $45,000 was offered to eleven primary care partners connected to the Core Competency/Integrated Healthcare project;
- $35,000 was offered to two Substance Use Disorder treatment organizations connected to the Core Competency/Integrated Healthcare project;
- $25,000 was offered to two partners implementing Critical Time Intervention under the Care Transitions project;
- $20,000 was offered to three Recovery Community Organizations connected to the Expansion in Intensive Substance Use Disorder project;

The Steering Committee also approved two separate funding distributions through the new performance-based funding mechanism. Northern Human Services received $10,000 to supply Behavioral Health staff for the newly developed Regional Multidisciplinary Core Team. After signing a Certificate of Authorization to become a formal partner of the Region 7 IDN, the Coös County Department of Corrections was awarded $35,000 to implement a Medication Assisted Treatment (MAT) program and provide intensive case management for incarcerated individuals with known release dates. The Steering Committee felt that the work proposed by the Superintendent of the Coös County Department of Corrections was consistent with the goals of the DSRIP, the work would meet a great need in northern Coös, and this new partner was willing to engage with existing partners in order to implement these programs efficiently. The Steering Committee is optimistic about the potential impact of the project in Coös County.

The county funding challenge was discussed with the Steering Committee throughout the reporting period to keep all members informed on progress. Members were regularly encouraged to engage with county officials to share impact stories of what is needed in the community and how the IDN has helped. The Region 7 IDN team responded to several requests for county information during the reporting period and made presentations to both Coös and Carroll County Commissioners and Delegation.

County delegates, commissioners and administrators were regularly included on invitations to IDN quarterly meetings and Grafton County requested that a member of their administrative team be included in monthly Steering Committee meetings.

During this reporting period the Steering Committee revisited the strategy of implementing a Regional Multidisciplinary Core Team after multiple partners expressed the difficultly of standing up separate team, and ultimately approved the approach for further development. As previously noted, the Steering Committee also approved the funding support for Northern Human Services (NHS) to supply the behavioral health professionals to staff the core team. The Region 7 IDN team is working diligently with NHS to hold the first regional case conference in early 2020.

The Region 7 IDN team continued to take part in multiple statewide conversations including billing and coding work, Local Care Management Entities, Pathways Hub model, data reporting and a closed-loop referral platform. The team and multiple Region 7 partners continued to be involved in discussions about each of these topics to gain clarity for the region. It has become clear to the Steering Committee that more partner engagement and support will be necessary for these approaches to be sustainable as the end of the demonstration approaches.

In December, the focus of the Steering Committee's meeting was an update from the Region 7 IDN team on the status of performance funding MOUs and the lack of uptake from key partners across the region. With only half of the offers being accepted, $375,000 remained unclaimed. As noted in earlier sub-sections above, multiple partners expressed initiative and staff fatigue as reasons for not stepping into this round of funding, being concerned that the specific deliverables and deadlines were too burdensome to their organization. This resulted in a discussion among steering committee members about how to move forward with remaining funds and how to plan for funds that are predicted to arrive as late as the end of 2021. Much of this conversation was focused on the importance of program sustainability moving forward.

During the region's December quarterly workshop the IDN team facilitated a Ripple Mapping Exercise to look at the impact of IDN work in the region. Partners voiced the ongoing concern about the reporting burden from multiple projects, each focused on different populations, reporting requirements and standards of care. The region continues to face a shortage of skilled professionals to provide necessary services to the region. The Steering Committee used this information to discuss priority focus areas for the remainder of the DSRIP program and is prepared to have further discussion regarding sustainability throughout 2020.

Community Engagement Workgroup

The Community Engagement Workgroup was designed to engage the entire Region 7 IDN community as work was done to gather input and feedback on improving patient outcomes in the region. During this reporting period, the group struggled with participation and holiday schedules, resulting in a shift of the quarterly cadence to one October meeting and one scheduled for early in January 2020. The region has a core group of partners who have been involved in this work and are available to provide guidance and feedback when they are asked, even between scheduled meetings.

The IDN team continues to update the workgroup on funding and has called upon the workgroup to brainstorm effective ways to capture IDN impact regularly. Workgroup members continued to work on a rack card designed as a communications tool to explain integrated care and provide individual partners the opportunity to highlight their efforts towards the delivery of integrated healthcare to their existing and potential patients/clients. The workgroup also continued efforts to develop additional strategies to

collect and share impact statements from patients and providers throughout the region. Messaging about the IDN and integrated healthcare remained a challenge during this period.

The Community Engagement Workgroup discussed ways to message the impact of the IDN work to help with county funding conversations. During this reporting period the workgroup shifted away from the direct development of communication materials and instead focused on developing communication strategies as partners continue to work on an integrated healthcare delivery system. In the coming months the Community Engagement Workgroup will focus on determining their role during the last year of the DSRIP and provide support to the region in capturing impact for consumers, partners and county officials.

HIT & Data Workgroup

The Data/HIT Workgroup continued to gather monthly to review Statewide outcome reporting, shared care plan technology implementation and data extraction burdens throughout the region. The Region 7 IDN team continued to work diligently to remind partners about the importance of their participation in data reporting to help the region meet performance metrics.

The group reviewed the results of 6-month and 12-month measures for 2018 data and were updated on goals rates for the next reporting period. Partners seemed confident that they would meet the next performance threshold for the 6 month measures (ASSESS_SCREEN.01, .02 and .04) however, due to measure complexity and EHR system limitations, the 12-month measures have created an increased burden on partner staff to extract. Because of this, some partners are concerned about their ability to report fully on the next round of these measures. The workgroup continued to discuss the status of the claims-derived measures Follow-up After Hospitalization for Mental Illness within 7 days (HOSP_INP.03) and Follow-up within 30 days (HOSP_INP .04). Region 7 has consistently met HOSP_INP .04 however HOSP_INP .03 remains unmet by a hand full of patients. Partners in the workgroup have discussed the barriers to meeting this metric, and perceive that it relates to the difficulty in billing for the correct services during a follow-up, specifically in an integrated medical center setting. The workgroup has advocated for clarification on how the measure is captured to help the region meet it during upcoming reporting periods. Separately, the Region 7 IDN team continues to monitor the work of the state level Billing & Coding Workgroup in order to share updates on reimbursement policy changes and clarifications that can assist Region 7 partners with accurate billing practices that may positively impact these scores.

The workgroup has remained an asset to the region as partners work to capture data to show performance outcomes. The feedback provided by this workgroup has been instrumental to the Region 7 IDN team, and this information is often shared with NH DHHS.

Clinical Workgroup

The Clinical Workgroup was originally formed to help develop integrative workflows & protocols for partners across the region to adopt. Since the development of these workflows & protocols has been streamlined and partners now have access to an array of samples through the region's Policy & Protocol Clearinghouse, the workgroup has transitioned into a more consultative role. The workgroup has been called on throughout this reporting period to provide feedback and guidance regarding the development of the Regional Multidisciplinary Core Team, Regional Care Coordinator Network, training gaps that exist for providers and how to mitigate the challenges that remain around implementing core processes of integrated care. During this reporting period, the workgroup also dedicated their meetings to workforce discussions, Shared Care Plan progress, and integrated care gaps among the region. The workgroup has supplied valuable feedback and asked thought-provoking questions about how the new components

within the region will complement each other and help create sustainability as the last year of the DSRIP approaches. The workgroup is committed to determining what their role will be during 2020 as the region works to advance along the continuum of integrated healthcare.

The standing agenda topic of workforce during the Clinical Workgroup meeting has helped the Region 7 IDN team capture real-time information related to staffing transitions. The workgroup has also been actively involved in discussions about the regional Multi-Disciplinary Core Team (MDCT) as the Region 7 IDN team worked with the Steering committee to gain approval to pursue the concept since previously partners wanted their own MDCT. During the reporting period partners in the region became more receptive to the idea of a regional team that can take referrals from each partner. The governance bodies and Region 7 IDN team have worked to determined how to sponsor a team that will effectively collaborate to consider the needs of the most challenging patients' needs. The Clinical Workgroup provided feedback on the draft workflow and protocol developed by Region 7 IDN's Quality Improvement Coach and recommended it be piloted in early 2020.

The workgroup also provided insight around regional training needs. These ideas were brought to the Statewide Training & Education Subcommittee where it was decided that Region 7 IDN team would lead the way in the development of a statewide Integrated Training website as a database for statewide trainings. Closed-loop referral software technology was briefly discussed with the workgroup and members expressed concerns about potential duplicative features between the suggested technology and Collective Medical Shared Care plan. Regional updates on Shared Care Plan uptake were regularly provided to the workgroup and partners were encouraged to share success stories to help with buy-in across the region.

The Clinical Workgroup is dedicated to determining their role as the region shifts into the last year of the DSRIP. The workgroup will gather in early 2020 to determine priority focus areas, including sustainability of key initiatives moving forward.

Financial Workgroup

The Financial Workgroup is still available to be utilized as progress on IDN initiatives continues across the region. Due to the change from project-based requests for proposal to a performance-based funding mechanism in round 5, the committee did not meet during this last reporting period. It is expected that the workgroup will be called upon in 2020 as the region looks at sustainability and distribution of incentive payments post DSRIP.

Network Development

During this reporting period, Region 7 IDN welcomed Coös County Department of Corrections as a new partner. After finalizing their membership, the agency submitted a proposal for sub-recipient funding aimed at providing enhanced case management and MAT services to inmates of the Coös County jail. The proposal was awarded and preliminary work towards their deliverables began. This work included collaboration with Region 7 IDN partners Northern Human Services and Carroll County Department of Corrections. Coös County Department of Corrections is working to formalize agreements, workflows, and protocols to provide enhanced case management and MAT services to individuals with a known release date, and the agency is contracting with Northern Human Services to provide these case management service. This case manager has joined Region 7 IDN's newly developed Regional Care Coordinator Network to help improve knowledge of available resources and collaborate with local partners who provide care coordination to the population. The case manager has also been in communication with the Program Director at Carroll County Department of Corrections to seek guidance on how to effectively implement a case management model within the jail.

Littleton Regional Healthcare (LRH) and North Country Healthcare (NCH) continue to adjust to LRH's separation from the NCH affiliation over the summer. Weeks Medical Center has a contract with LRH to provide Medication Assisted Treatment and support to the Doorway at LRH. On December 1, Weeks Medical Center exercised the 30-day withdrawal clause of this contract and their provision of staff and clinical services to the LRH Doorway ended on December 30, 2019. LRH used the 30-day notice to actively recruit staff and clinicians to ensure that client services are not impacted by the transition. Weeks Medical Center continues to support the Doorway at Androscoggin Valley Hospital.

Carroll County residents have the choice between four Doorway sites surrounding but not located within the county. However, partners have shared that the local geography is a significant barrier for accessing these Doorways and it has been challenging for the population to initiate an intake at any of the Doorway sites. Region 7 IDN partner Carroll County Coalition for Public Health (C3PH) has dedicated time and efforts during the reporting period to coordinating more local supports throughout the county. The organization has helped strengthen and create partnerships within the recovery community to increase the amount of spoke services available to provide immediate support until the transportation challenges related to distance and geography can be overcome for clients to reach a Doorway site for intake.

C3PH has continued working with a community health collaborative between four Region 7 partner agencies: Visiting Nursing Home Care and Hospice of Carroll County, Memorial Hospital, Saco River Medical Group (SRMG), and Children Unlimited. The group meets every other month as a collaborative to review programmatic updates. The group's focus has been on an integrated Medication Assisted Treatment program at SRMG and helping to build MAT capacity for the entire region. The collaborative also supports a parenting program for incarcerated individuals at Carroll County Department of Corrections and expansion of the Crossings Program which focuses on childhood grief and loss, particularly related to the Opioid epidemic.

C3PH has been working closely with White Horse Addiction Center and Mount Washington Valley Supports Recovery during the implementation stage of the 24/7 recovery support services, acting as an important supporter of the relationship between the two RCOs and Memorial Hospital's Emergency Department. The new relationship has been beneficial to the community and expansion to other local hospitals and collaboration with local health centers is on the horizon.

C3PH reports a strengthened partnership with Huggins Hospital as the hospital has worked to implement their new Medication Assisted Treatment Program. The Huggins Rural Health Network has also been an important asset to the community and partnerships throughout the region since its inception in 2018. This program is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS), Grant number P10RH-31838.

C3PH has also been involved in multiple initiatives working to address the transportation gaps that exist in the county. The organization continues to work on an array of community engagement activities and collecting input from the region about ongoing needs.

North Country Health Consortium's Wellness and Recovery Model (WARM) team continued to offer trainings and host events throughout the North Country aimed at growing the local recovery workforce, raising awareness about Substance Use Disorders, and reducing stigma. The WARM team continued to travel throughout the region to provide resources to local partners about services and opportunities that are available through the program. During this reporting period, Littleton Police Department was the first law enforcement agency to step into a formal agreement to begin implementing the recovery-

oriented policing model developed last period. The WARM team continued to attend local coalition and resource meetings to learn about regional activities and promote collaborative relationships.

The WARM team continued to help develop the trained Recovery Coach Network throughout the region, ensuring training opportunities were offered to recovery coaches who were interested in becoming Certified Recovery Support Workers. The WARM program has also started a "North Country Trainer's Collaborative" to bring together trained trainers from the Family Resource Center, North Country Serenity Center, and Hope for NH Recovery to discuss the development of a training plan for the region. The group is in the early stages of developing and examining opportunities for the training model and will continue meeting in 2020 to determine next steps in implementing a structured Recovery Coach/CRSW training plan and trainer schedule.

In partnership with a local acupuncturist, WARM staff developed a collaborative opportunity for local holistic practitioners and healers to support individuals in recovery. A Healer's Forum was held on December 10, 2019 to bring an array of holistic practitioners together including a nutritionist/herbalist, a shaman, artists, acupuncturists, a psychic medium, energy workers, reiki practitioners, RNs and a local MAT-waivered nurse practitioner. At this meeting, practitioners expressed interest in moving forward on a proposal to provide free services for the recovery community at North Country Serenity Center on one Saturday morning each month. The group is dedicated to helping people in a creative and artistic way to facilitate a sense of connectedness, inspiration for self-healing, and healing in the community. The attendees expressed their desire to become more organized and establish themselves as a group, and scheduled a follow-up meeting for January 23, 2020.

The WARM team continues to identify and address gaps throughout multiple communities. During this period EMS professionals voiced their need for more training on Methamphetamine use and how to deal with it from both law enforcement and recovery perspectives. The team also received feedback from the EMS community about its concerns and questions regarding safely delivering Narcan in the field. The WARM team has observed that not addressing these concerns continues to feed stigma around substance use disorders. The team found that, while current Narcan training is focused on how to use Narcan, it does not adequately address safety concerns. The team at NCHC will work throughout 2020 to address this concern and research Narcan safety training options to bring to the region. The WARM team continued to address stigma through virtual outreach on Facebook and movie screenings of Pleasure Unwoven, to bring the community together to learn the facts about Substance Use Disorder and provide access to local resources through a follow-up panel discussion.

Community Input

The Region 7 IDN Community Engagement Workgroup and Region 7 IDN team continue to work with IDN 7 partners to collect input from the community and consumers regarding IDN activities and services throughout the region. The updated monthly reporting tool is helpful to gather patient and partner impact stories to show the value of IDN efforts across the region. Partners continue to administer patient surveys and there has been continued focus on soliciting more meaningful verbal feedback from patients in their programs.

NCHC's WARM program spent a considerable amount of time out in community during this reporting period working to gather community input about pathways to recovery. The team hosted a community event in front of the local bookstore to capture reasons why community members support recovery. The event was a great way to bring the community together to look at stigma related to substance use disorders and access to quality treatment. The group also partnered with Ammonoosuc Community Health Services and North Country Serenity Center to host a vigil on International Overdose Awareness

day, the event was virtual and in-person which allowed for a Narcan training on site. The WARM team participated in multiple coalition meetings around the region to help make connection within the community and continues to strengthen relationships to help lessen the burden of the opioid crisis in the North Country.

Carroll County Department of Corrections and Tri County Community Action program continue to receive powerful thank you letters from clients who have had sustainable success because of their Critical Time Intervention programs. The partners have expressed a reduced rate of revolving patients due to the model and have been thrilled to receive the positive feedback from past clients. The Region 7 IDN team plans to continue collaborating with the Community Engagement Workgroup to strategize more efficient ways to solicit and gather input from the community and front-line staff at partner agencies moving forward.

Region 7 IDN Total Project Budget – PPI

December 31, 2018

Project	CY 2016 Actuals	CY 2017 Actuals	Jan-June 2018 Actuals	July-Dec 2018 Actuals	CY 2019 Projected	CY 2020 Projected	CY 2021 Projected
PPI	$ 66,115	$ 1,148,128	$1,156,435	$878,004	$2,653,647	$2,653,647	$1,326,824
A1	$15,956	$277,087	$229,443	$194,706	$646,563	$646,563	$323,282
A2	$8,822	$153,205	$332,433	$179,030	$332,228	$332,228	$166,114
B1	$25,576	$444,143	$367,152	$310,449	$1,030,999	$1,030,999	$515,499
C	$5,254	$91,231	$75,802	$64,607	$214,619	$214,619	$107,309
D	$5,254	$91,231	$75,802	$64,607	$214,619	$214,619	$107,309
E	$5,254	$91,231	$75,802	$64,607	$214,619	$214,619	$107,309

Consistent with all prior reporting, report begins with January 1, 2017 utilizing capacity building funds to maintain infrastructure.
IDN 7 projects the additional amount approved at June 2017 quarterly meeting to absorb future anticipated line item variances in Salary, Benefits, Software and Training.

June 30, 2019 Update

Consistent with the write-back request made for the last reporting period, this report reflects all five years of the DSRIP, beginning with CY 2016 actuals and moving through 2021 Projected budgets.

Project	CY 2016 Actuals	CY 2017 Actuals	CY 2018 Actuals	Jan-June 2019 Actuals	July - Dec 2019 Projected	CY 2020 Projected	CY 2021 Projected
PPI	$ 66,115.00	$ 1,148,128.40	$ 2,034,438.48	$ 734,855.30	$ 734,855.58	$ 1,301,120.00	$ 543,137.00
A1	$ 15,956.00	$ 277,087.34	$ 424,148.79	$ 152,736.24	$ 152,736.24	$ 276,626.00	$ 112,490.00
A2	$ 8,822.00	$ 153,204.63	$ 511,463.27	$ 186,549.65	$ 186,549.65	$ 308,062.00	$ 139,309.00
B1	$ 25,576.00	$ 444,143.15	$ 677,601.04	$ 243,529.71	$ 243,529.71	$ 441,071.00	$ 179,360.00
C	$ 5,254.00	$ 91,231.09	$140,409	$50,680	$50,680	$91,787	$37,326
D	$ 5,254.00	$ 91,231.09	$140,409	$50,680	$50,680	$91,787	$37,326
E	$ 5,254.00	$ 91,231.09	$140,409	$50,680	$50,680	$91,787	$37,326

December 31, 2019 Update

Consistent with previous reporting periods, this report reflects all five years of the DSRIP, beginning with CY 2016 actuals and moving through 2021 Projected budgets.

Project	CY 2016 Actuals	CY 2017 Actuals	CY 2018 Actuals	CY 2019 Actuals	Jan-June 2020 Projected	July-Dec 2020 Projected	CY 2021 Projected
PPI	$66,115	$1,148,128	$2,034,438	$1,584,807	$697,216	$1,137,216	$925,282
A1	$15,956	$277,087	$424,149	$339,150	$146,597	$252,813	$199,704
A2	$8,822	$153,205	$511,463	$367,294	$170,949	$229,645	$208,359
B1	$25,576	$444,143	$677,601	$540,758	$233,742	$403,098	$318,420
C	$5,254	$91,231	$140,409	$112,535	$48,644	$83,888	$66,267
D	$5,254	$91,231	$140,409	$112,535	$48,644	$83,888	$66,266
E	$5,254	$91,231	$140,409	$112,535	$48,644	$83,888	$66,266
(Rounding may slightly impact totals by no more than $3)							

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	6/30/19	12/31/19
PPI	Project Plan Progress, including: Community Input, Network, Opioid Crisis Update, Governance, and Budget	Narrative and budget spreadsheet						

Project A1: Behavioral Health Workforce Capacity Development

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

December 31, 2018

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

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

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

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

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

During the reporting period of July 1, 2018-December 31, 2018, Region 7 IDN had no new members join the network, and no members leave.

Region 7 IDN continues to make progress on Project A1, the statewide Behavioral Health Workforce Capacity Project during the reporting period of January-June 2018. The Executive Director for Region 7 IDN continues to be involved with numerous workforce related initiatives which is beneficial to the region as work is being done to increase workforce capacity without duplicating efforts happening with initiatives. Examples of these initiatives include: Northern New Hampshire Area Health Education Center, Bi-State Primary Care Association, Primary Care Workforce Commission, New England Rural Health Roundtable, North County Community Care Organization, NH Behavioral Health Roundtable, Statewide Behavioral Health Workforce Taskforce, and the IDN Training and Education Subcommittee. Participation in these various initiatives has been instrumental to the region addressing workforce issues, specifically those related to education, training, recruitment, and retention. Region 7 IDN's Executive Director continues to serve as the Vice-Chairperson of the Behavioral Health Workforce Taskforce, as well as Co-Chairperson for the Training & Education subcommittee. Region 7 IDN

members have continued to actively participate in both the quarterly meetings of the Behavioral Health Workforce Taskforce, and monthly meetings of the Training & Education Subcommittee.

As of September 2018, the Statewide IDN Training and Education workgroup made the decision to start meeting bimonthly. The September and November meetings focused primarily on workshop topics and presenters appropriate for a clinical track at the annual New Hampshire Behavioral Health Summit. This led to the partnership between North Country Health Consortium/ IDN 7 and Northern Vermont Area Health Education Center to provide a Continuing Medical and Continuing Nursing Education track at the annual NH Behavioral Health Summit on December 10 & 11, 2018 in Manchester, NH. This state-wide conference targets behavioral healthcare providers and organizations including mental health and substance use disorders. This year, planners felt it was important to encourage more providers and nurses to attend by providing a continuing education track for them. Over the course of the 2-day event, up to nine continuing education credits were available for providers and nurses. From the live event, six – 90-minute sessions were recorded and will be available online for continuing education credits through an online Moodle platform that the North Country Health Consortium administers. Each of the 7 Integrated Delivery Networks agreed to support this clinical track; the sessions are available at no charge across the state to the IDN partner members.

The webinar topics soon to be available online include:

- The Community Care Team: A Model Strategy for Systems Alignment
- Understanding and Addressing Substance Use Disorders as Chronic Medical Conditions
- Enhanced Care Coordination for High Needs Populations from Multiple Perspectives
- Core Competencies for Primary Care Behavioral Health Integration: Knowledge, Skills and Attitudes
- Chronic Disease information for Behavioral Health Providers
- Facilitated Integrated Care Success with Co-Occurring Disorders: A Case Study

Other discussions included the possibly of creating and utilizing a centralized state-wide training calendar and an update on the progress of the next Health Career Catalog with the integration of behavioral health professionals from the NH AHEC. IDN 7 Team members and Northern AHEC staff at NCHC have been working closely with Southern AHEC to edit and develop content for the 5th edition Health Career Catalog. The seven IDN's have agreed to support the development of this catalog to allow creators to incorporate more behavioral health careers and emerging careers that are blossoming throughout the region.

Staffing

For the reporting period of July-December 2018, below is what Region 7 IDN partners have reported for workforce capacity:

- *Ammonoosuc Community Health Services* hired a new patient coordinator and a school-based Licensed Independent Clinical Social Worker.
- *Cottage Hospital* hired a Licensed Clinical Social Worker to work thirty-two Hours per week. They also hired a Certified Medical Assistant and a Chronic Care Management Nurse for the Internal Medicine department. Cottage also hired two APRNs in Primary Care/Internal Medicine. The partner los one Chronic Care Nurse and two APRN's during this period.
- *Friendship House* hired five Recovery Support Staff and an intake coordinator. They lost five Recovery support staff and a program advisor.

- *Huggins Hospital* hired a new nurse care coordinator, a Rural Health Program Coordinator, and a family nurse practitioner.
- *Indian Stream Health Center* hired three new nursing staff, two for ISHC and one for school health. They also hired two medical assistants with one later leaving. One pharmacy tech and one medical provider was hired as well. ISHC has been actively recruiting for one LICSW and one Pharmacist.
- *Littleton Regional Healthcare* hired a Behavioral Health Counselor who is a social worker currently working through supervision in order to get their LICSW. They also hired a registered nurse for and a medical assistant float for adult primary care, along with a per diem medical secretary. LRH lost a pediatric RN, a RN/Patient Care Coordinator for the ACO, a physician for adult primary care, a practice manager for the ACO and a per diem Physician for pediatrics. The practice shifted staff to mitigate these losses resulting in an adult primary care RN moving to an ACO RN/Patient Care Coordinator, an ACHO RN/Patient Care Coordinator moving to an ACO Practice Manager and an Adult primary care medical assistant to a primary care/ACO clinical team leader.
- *Memorial Hospital* hired a Psychiatric Nurse Practitioner, a MAT waiver PCP, and a general PCP. They had one primary care nurse practitioner leave the agency.
- *Northern Human Services* hired five case managers, two Licensed Mental Health Clinicians and one psychiatrist. The agency lost four case managers and nine LMHCs.
- *Saco River Medical Group* hired a new primary care physician who is MAT waivered and two nurses. The agency lost on nurse and three reception staff.
- *Weeks Medical Center* hired four receptionists, a specialty medicine practice manager, two medical assistants, a behavioral health APRN, a primary care APRN, a social worker (BSW), a communications assistant, an office coordinator the MAT program, a behavioral health case manager, a new physician, and one RN.
- *White Horse Addiction Center* hired two administration staff to support billing and RCO. They also hired two LADC candidates, three CRSW candidates. The executive director resigned resulting in a transformation of their leadership structure mentioned in D3.
- *Tri County Community Action Program* hired a Director of Compliance, trained four individuals in CTI, one trained as a CTI trainer and three staff members completed the Community Health Worker course. The agency lost their Carroll County CTI specialist due to unforeseen family emergency. The partner will begin actively recruiting for the CTI program once IDN funding is secured.
- *North Country Serenity Center* lost two employees during this period. In their place the RCO hired one new CRSW, a new volunteer coordinator, and one administrative assistant.
- We have been able to recruit and enroll three behavioral health students in the *Live, Learn, Play in Northern New Hampshire (LLP-NNH)* Program for late fall and into early 2019. They include:
    - A Master's Level Social Worker interning at *Northern Human Services* August 2018 through May 2019.
    - A Bachelor level Psychology major interning at *White Horse Addiction Center* May 2018 to March 2019.
    - A Master level Social Worker interning at *Rowe Health Center*, starting in January of 2019 through August 2019.

These students will receive an educational stipend in the amount of $1000 each after successful completion of a community service project as part of the program requirements.

In addition to these students, we are anticipating more behavioral health students at different Northern Human Service sites and a new student at Friendship House interested in the program in upcoming 2019. Follow up is planned with our partners at Memorial Hospital in early January for planned UNH psychiatric nurse practitioner students.

Northern NH Area Health Education Center also has four medical students from the University of New England enrolled in the Live, Learn and Play Northern NH clinical program. The Northern NH AHEC Workforce and Education Coordinator has provided multiple resources to the medical students to help them better understand the Integrated Delivery Network system of New Hampshire. At least two of the medical students are planning projects related to integrated health; one on the topic of opioid Infant Neonatal Abstinence Syndrome. The second on patient education related to overall holistic approach to wellness integrating healthy eating, exercise and education related to diabetes management.

Mental Health First Aid

NCHC's two Mental Health First Aid trainers continued to work together to bring more trainings to the region between July-December 2018. The trainers were able to bring a third MHFA training to Huggins Hospital in Wolfeboro to train an additional 21 staff members. The training took place on October 26, 2018, bringing the number of MHFA trainings to four for 2018. The region was successful in training a total of 93 partners for 2018; this period has helped Huggins exceed their targeted number of staff members trained. The region plans to work with remaining partners that expressed need previously to help them achieve this goal during the next six months. On the evaluation survey participants expressed two changes they would make as a result of the session. A participant expressed that they plan to "be a better listener without judgement" and another participant explained that the training gave them "more confidence and tools to use as a nurse to help my patients with mental illness or drug/alcohol abuse." These quotes demonstrate the impact this training has on one the staff members and how it will begin to impact the care they give to patients.

Shared Use of Resources

North Country Healthcare continue to be the champions regarding shared use of resources. NCH has put significant effort in enhancing their regional care coordination department that spans across the entire affiliation. Affiliates Weeks Medical Center, Littleton Regional Hospital, Androscoggin Valley Hospital and Upper Connecticut Valley Hospital all share care coordinators and processes for care coordination. The partners have also worked to build capacity for the HUB funding that is coming into LRH and AVH from the state to address the opioid epidemic. NCH plans to leverage IDN resources to bring enhanced services to the region through care coordination and HUB services.

Northern Human Services continues to be an asset to the region as the region's only community mental health center. NHS has worked with NCHC IDN staff to finalize an agreement to provide psychiatric consultation throughout the region to stand up MDCT's with other partners. NHS has continued to work closely with Huggins Hospital and White Mountain Community Health Center on their MDCT. NHS has many shared patients with fellow partners and shares resources regularly throughout the region. NHS has been working with Coös County Family Health Services to provide integrated care to mutual patients and plans to replicate this project with Ammonoosuc Community Health Services.

Region 7 IDN team will continue to share resources and opportunities to partners via Basecamp and Constant Contact to help improve collaboration throughout the region. Basecamp will allow partners to share resources they have created and request guidance to appropriate resources as needed. The new Policy and Protocol Clearinghouse will be exceptionally useful for sharing resources between partners as they all work toward integration.

Centralized Peer Recovery Support

The Centralized Peer Recovery Support Network has been discussion at length throughout this reporting period. The IDN team has facilitated two collaborative planning meetings with the four Recovery Community Centers of Region 7 to strategize the most effective way to develop the Peer Recovery Support Network. The group met in August and October to discuss models that will be the most effective, efficient, and sustainable between all agencies. The four RCO's have worked to build capacity to create this network together over the past six months, which includes increasing staff and adding more services.

A tentative model was suggested which will involve creating two hubs, one for Carroll County and one for Northern Grafton and Coös with each hub containing two RCOs. The hubs would be overseen by an advisory board to provide guidance for all four RCOs which will include help with the development of systems and processes for referrals and establishing a peer recovery workforce that is equipped to be deployed to clients in their time of need. The RCOs felt it was important to leverage existing initiatives as the model is developed. The group plans to reconvene in early 2019 to learn more about the implementation of NCHC's WARM model and the NH Doorway hub model, and then discuss next steps in the implementation of this regional approach.

The Recovery Coach Academy training plan started in July 2018 with the following trainings held throughout the reporting period:

- 7/25/2018: Ethical Considerations for Recovery Coaches; trained 13
- 8/9/2018: HIV/AIDS; trained 13
- 8/23/2018: Suicide Prevention; trained 16
- 9/13/2018: Recovery Coach Academy; trained 8
- 10/11/2018: Recovery Coach Academy Train the Trainer, trained 6
- 11/5/2018: Ethics Training; trained 13
- 11/7/2018: Ethics Train the Trainer; trained 4
- 11/14/2018: Suicide Prevention Training; trained 26

The trainings had impressive participation and helped build the region's peer recovery network substantially. Multiple participants have taken all or most of the trainings required to become a Certified Recovery Support Worker, which will help create sustainability in the Region. Currently, eight partner staff have been trained in three out of the four topics needed to move forward in becoming a CRSW and several partner staff have taken more than one training to move toward CRSW.

Region 7 IDN plans to continue the Recovery Coach Academy training plan through 2019 to increase the workforce and more Recovery Coaches toward CRSW certification. The remainder of the original 2018 PRCA Training plan is below:

- HIV/AIDS, March 2019
- Peer Recovery Coach Academy, April 2019
- Peer Recovery Coach Academy, September 2019
- Suicide Prevention, October 17, 2019
- Ethics, November 2019
- HIV/AIDS, December 14, 2019

June 30, 2019 Update

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

Provide a detailed narrative to reflect progress made toward recruitment, retention, hiring and training during this reporting period.

Network Membership

During the reporting period of January 1 through June 30, 2019, Region 7 IDN had no members join or leave the network. The information below speaks to the progress that Region 7 IDN has made on the A1 project "IDN-Level Workforce Capacity Development" during this reporting period

Region 7 IDN Data Governance

As Region 7 IDN adopted the new DHHS Monthly Update reporting format this spring, efforts were expended to verify the total number of individuals served by each Region 7 IDN partner to date and leverage the State's reporting tool as a mechanism that will help partners report monthly totals for the remainder of the DSRIP. By utilizing the State's new monthly reporting mechanism as the backbone of a high-integrity data management process, the Region 7 IDN team hopes to ease the reporting burden for partners while retaining the ability to collect, aggregate and analyze data for the region as a whole. This revised process is anticipated to allow the region to evaluate progress on performance evaluation targets more frequently and help the Region 7 IDN team provide more timely feedback and support to the region's partners. Partner specific updates in this section reflect narrative regarding their progress along the continuum of the project, and their total number of unique individuals served during the DSRIP period through June 30, 2019.

Statewide Workforce Capacity Development Collaboration

Workforce Taskforce

Region 7 IDN has continued to be actively involved with multiple Statewide Workforce Taskforce initiatives, including the Statewide Training & Education Subcommittee. The workgroup met twice during this reporting period, having previously determined that the work the group was engaged in during this time could be conducted more efficiently by meeting less frequently. In January, the group met to discuss training opportunities throughout the state and how to best circulate information about these training schedules across the seven IDN regions. This conversation continued in the May meeting, where the group decided a centralized online training calendar would be the most efficient route to keeping the entire state informed. The group was clear in making sure no duplication would occur, encouraging the centralized page to link to other training pages that already exist rather than expending unnecessary time and effort recreating the postings on the centralized page. NCHC has volunteered to lead this effort and will share some webpage design options at the group's next meeting in September.

The group also received updates on the activity of the Behavioral Health Higher Education Roundtable, which continues to focus efforts on the expansion of the Behavioral Health workforce. The Roundtable met in February and April, and agenda topics including a conversation with the Cherokee Health System to help academic institutions learn how to implement curricula that includes the value and delivery of integrated healthcare models. The Roundtable continues to encourage the involvement of academic institutions and state agencies in these curricula development discussions so that all stakeholders remain informed of changes. The group also discussed the development of programs throughout the state that provide high school students with exposure to careers in Behavioral Health.

Retention of Licensed Mental Health Professionals

Northern Human Services (NHS) has shared that staffing turnover is significant for this Community Mental Health Center and notes that CMHCs are challenged with recruiting and retaining new workforce members, despite being directly engaged in the mentoring, precepting and supervision of their clinical skills development. NHS reports that this workforce is difficult to retain because CMHCs in this state do not have Federally Qualified status. This results in the CHMCs having to charge and be reimbursed at lower rates than other clinics offering the same types of Behavioral Health services in the region. This lower revenue directly translates to fewer financial resources being available to support competitive salary and benefit packages offered to potential hires – a significant barrier to successful staff recruitment and retention. NHS has tried to ameliorate this issue by engaging in a state-wide initiative by NH CMHCs to encourage the State to approve their application for Federally Qualified status, the first step in the process and an approval that has not been granted in the past. These factors, coupled with increased demands for reporting that resulted from recent settlement agreements focused on inadequate support of behavioral health patients across the state, are indirect yet compelling pressure points on CMHCs that hamper their ability deliver essential services with a stable workforce able to respond to intakes and referrals in a timely manner.

Investment in Education for Integrated Healthcare Professions

Health Career Catalog

Region 7 IDN team members continue to assist Southern and Northern AHEC staff with the development of the 5th Edition AHEC Health Career Catalog. The Catalog team has solicited feedback from academic and workforce communities to inform the final revisions of this edition, which will include graphics of various career pathways. These visual tools are being developed to provide a clear picture of the processes available for individuals to pursue a health career field. The group has also developed an Emerging Careers section of the catalog inspired by several discrete professions that have been created during DSRIP Workforce Capacity Building initiatives. The catalog is anticipated to go to print by the end of August 2019.

Live, Learn, Play in Northern NH

During this period, there were 3 Live Learn, Play in Northern NH behavioral health students completing rotations and community service projects within Region 7:

- A student working on a Master of Social Worker degree at the University of New Hampshire continues their internship at *Northern Human Services'* Conway site from August 2018 to May 2019. This student's community service project included doing research and a report on the topic of Workforce Retention in Community Mental Health. This North Conway resident is scheduled to graduate in May 2020 and plans to seek employment in the area after graduation.
- A student concurrently earning a bachelor's degree in Psychology from Southern New Hampshire University and Licensed Alcohol and Drug Counseling accreditation interned at *White Horse Addiction Center (WHAC)* from January through March 2019. Their community service project included organizing family nights and a creating community garden to support clients in recovery at WHAC.
- A Master of Social Work student completing a distance degree from Louisiana State University is participating in a rotation at Rowe Health Center from January to August 2019. Their community service project promotes the benefits of mindfulness and meditation practices in elementary schools. This student is scheduled to graduate in May 2020.

Behavioral Health Preceptor Sites

During this reporting period, the Region 7 IDN team confirmed that a total of seven partners are currently serving as preceptor sites for behavioral health programs, with one new partner, Huggins Hospital, engaging in this workforce development during this reporting period. At this time, there are students actively deployed at five partner agencies.

- *Ammonoosuc Community Health Services* continues to intentionally seek out Behavioral Health interns to help staff their IDN-funded project focused on integrating behavioral health services in the school setting.
- *Huggins Hospital* began the process of becoming a preceptor site during this reporting period. This partner reported that they contracted to provide an internship for an LICSW student with an anticipated start date in July 2019.
- *Rowe Health Center* continues its role as an experiential learning site by hosting a Social Work intern that is being precepted by the behavioral health team as this partner works to enhance the integration of behavioral health and mindfulness practices in the clinic's new pain management program.
- *Indian Stream Health Center's* behavioral health team also continues to serve as an experiential learning site for behavioral health students and is currently precepting an LICSW intern.
- *Northern Human Services* continues to leverage existing staff to precept and mentor several interns pursuing licensed mental health professional careers, including LMCHC and LADC candidates. Additionally, they have encouraged existing staff to pursue dual LMCHC/LADC licensure, utilizing supervision resources among their NHS peers so that they can remain engaged in their current practice while expanding their treatment capacity.

Ongoing Care Coordinator Skills Development

At the recommendation of the Community Engagement Workgroup and the request of several partner organizations, the Region 7 IDN team has begun the process of establishing a monthly virtual Care Coordinator/Care Advocate cohort meeting. The purpose of this meeting is to provide an opportunity to come together and learn from one another about what is working and what may need to be improved related to care coordination in the region. It is proposed that this group will have quarterly in-person meetings to allow for an extended time for educational offerings. In the upcoming reporting period, the Region 7 IDN team will work with the Clinical and Community Engagement Workgroups to stand up these monthly Care Advocate meetings.

Staffing

Workforce Calculation Process

As the Region 7 IDN team spent time this reporting period assessing the progress made on process measures and their potential impact on the performance metrics that will drive incentive payments in DSRIP years 4 and 5, questions arose regarding the rate of change for some workforce categories in the context of narrative reports of significant improvements in access to treatment for behavioral health diagnoses was improving. Specifically, the rates of change for Licensed Mental Health Professionals and Master Licensed Alcohol and Drug Counselors were scrutinized because neither target was met in the previous reporting period.

During the collection of data for this report, the Region 7 IDN team focused on verifying the current state of workforce in the region as it compared to the baseline reported in the Region's Implementation Plan published July 2017. This included a level-setting of workforce numbers and the number of individuals served under each of the DSRIP projects. The team was successful in capturing current

workforce levels for all partners specifically engaged in the DSRIP projects, as well as the turnover specific to this reporting period. As the Region 7 IDN team analyzed this latest data, four variances were found, all occurring with the introduction of the June 30, 2019 staffing levels contributed by the region's Community Mental Health Center, *Northern Human Services (NHS)*, as demonstrated in the A1-5 table extract below.

Workforce Category	2018 Target	Baseline 6/30/17	As of 12/31/18	As of 6/30/19
Behavioral Health Case Managers	5	2	7	49
Case Management	2	2	15	67
Licensed Mental Health professionals	23	14	9	49
Master Licensed Alcohol and Drug Counselors	16	11	14	17

Further examination of data collection processes and findings from prior reporting periods suggests that the Region 7 IDN team was unable to ascertain NHS baseline staffing levels in June 2017 for these professions as the region's workforce inventory was compiled and used to set the targets for the region's implementation plan. Once the baseline staffing levels were determined, workforce calculations in subsequent periods were made by applying the net gains/losses of partner-reported turnover data to the previous period's total. Starting in December 2017, the Region 7 IDN team was able to determine the staffing turnover at NHS for every reporting period after the implementation plan was published. As a result, NHS turnover data impacted the region's aggregate workforce totals, but not their baseline staffing levels. This analysis of workforce data has also identified that the number of MLADCs in the region was reported inconsistently across projects in prior periods, likely due to the manual calculation of the impact that partner turnover data has on the regional workforce aggregate.

This process has highlighted the difficulty that the IDN faces in accurately capturing workforce capacity changes over time. It is common for a single partner to report that they lost a member of their workforce to another partner agency. Partners attribute the contrast between high local partner turnover rates and a relatively lower change in regional workforce totals to the dynamic recruitment and retention efforts employed by partner organizations in the face of workforce shortages within our rural region. Together these factors incentivize skilled workforce members living in the area to seek higher compensation packages without being encumbered by the inconvenience of moving their families. In future reporting periods, the Region 7 IDN team will work to capture both current staffing and turnover data from all project-engaged partners to ensure accurate updating to both tables and regional narrative. In this way, the region will be better positioned to show workforce capacity levels as a snapshot in time and local workforce turbulence impact on the delivery of integrated care.

Community Health Workers

North Country Health Consortium (NCHC) suspended Community Health Worker (CHW) trainings during this reporting period as the training curriculum was updated to reflect national core competencies that were released at the beginning of the year. After the curriculum was updated, newly branded training materials were developed and produced. During this update to the curriculum, the training team also revisited the mode of course delivery. In prior periods, the decision had been made to offer the bulk of didactic training online to improve access to learners in the North Country. Newly released research and an analysis of participant evaluations has shown that dedicating up to 75% of course time for face-to-face interactive sessions with the remainder of the course designed for online learning is the recommended mode of delivery because the work of CHWs is so relational. The new training curriculum has been designed to incorporate not only national core competencies but also these national recommendations for the mode of training by breaking the 80-hour course into eight 6-hour classroom

sessions, a two-day (12-hour) training in Motivational Interviewing and 20 hours of online homework assignments which align with the classroom time. At this time, NCHC has scheduled two trainings for the last half of 2019, one starting in August and a second in late fall.

The primary goal of this redesign is to produce a quality product that aligns with anticipated certification process requirements at both the state and national level as a steppingstone to reimbursement possibilities. In furtherance of this goal, NCHC's CHWs also dedicated time this period to leading and participating in the NH Community Health Worker Coalition. This state coalition is focused on building relationships throughout the state and creating a pathway to state certification for Community Health Workers with an eye toward future reimbursement models for the services provided by CHWs.

Mobile LADC

During this reporting period, *Weeks Medical Center* reported that a Mobile LADC has been hired as part of this partner's staffing of the two Doorway sites under a sub-contract with the hosting agencies *Littleton Regional Healthcare* and *Androscoggin Valley Hospital*. This partner's expansion of LADC services in the region has helped Region 7 IDN meet this previously unmet workforce metric.

Quality & Data Specialist Workforce

During this reporting period several partners reported that, while they do not have any staff directly tasked and budgeted for DSRIP data management, they have allocated significant time from existing staff members to meet the reporting requirements of the DSRIP. Consistently, partners have indicated that the increasing demand for the use of data to drive care, and the need to validate data for payer performance metrics is increasing. Separate from the dedicated data aggregator specialists accounted for in the evaluation target table above, this reporting period the Region 7 IDN team estimates that the thirteen partners engaged in the Core Competency project are dedicating an aggregate total in excess of 9 FTE engaged across the region in these data governance and reporting activities. This is based on partner feedback to targeted questions regarding their current allocation of staff resources to meet reporting requirements, including participation in calls with MAeHC and the IDN HIT Lead, abstraction of data, and alterations to EMR systems in order to have claims data accurately represent the care provided to their patients.

Care Advocates

As part of the continuous improvement process for performance metrics under the DSRIP, the Region 7 IDN team analyzed those metrics not yet met following the submission of final writebacks on the December 2018 SAR. One unmet target listed in several areas of the Region 7 Implementation Plan that remained unmet was the number of Care Advocates working in the Region. Region 7 IDN describes a Care Advocate as a person who coordinates care between the complex patient's multiple providers, has a strong understanding of the principles of integrated healthcare, can effectively leverage technology to ensure that the patient's complex needs are consistently met by all members of the care circle, and has received supplemental education beyond the development of traditional case management/utilization review skills in order to meet the needs of this complex patient population. Care Advocates can work at either clinical facilities or community-based organizations, and often their work includes helping patients to address social determinants of health as part of the patient care coordination process.

In previous rounds of reporting, Region 7 IDN staff only counted a care coordinator as a Care Advocate if they participated in one of the IDN sponsored care coordinator trainings. the Region 7 IDN team was prepared to offer another Care Advocate training during this reporting period because targets for this workforce capacity went unmet in the last reporting period. Prior to expending efforts to host a training, the Region 7 IDN team engaged IDN partner agencies in deeper discussions regarding their

capacity to provide this higher-level care coordination. The conversations included the partners' perception of what training their care coordination staff have received that may qualify them as effective Care Advocates for the most complex patients. During these conversations it became clear that several partners who concurrently participated in a Medicare Shared Savings Program Accountable Care Organization (ACO) and the DSRIP had access to additional training for their care coordinators and case managers through their contract with the ACO Administrator, Caravan Health. Several partners indicated that they did not feel it was necessary for their staff members to also engage in the IDN 7 Care Advocate trainings because they were perceived as redundant, and confirmed that their staff members continued to use the skills gained under the ACO despite the fact that the ACO contract ended on December 31, 2018. Partners also confirmed that the enhanced care coordination processes adopted under the ACO are evidence-based clinical interventions based on patient risk factors, so were applied across their entire patient populations rather than adding payer-based layers of complexity to enhanced care coordination.

These partners provided the Region 7 IDN team with agendas and curricula from the trainings offered to Care Coordinators under the ACO. They also confirmed that these Care Coordinators participated in monthly care coordination quality improvement calls and had ready access to a Care Coordinator Coach that continued to help them improve their coordination and advocacy skills. The Region 7 IDN team is confident that the ongoing training and support provided to the Care Coordinators under the ACO is comparable to the training and support offered by the IDN during the same period. Based on this added information, partners were asked to include their ACO-trained Care Coordinators in the number of Care Advocates in place at their organizations. As a result of revisiting who can be counted as a Care Advocate, Region 7 IDN can report a total of 21 Care Advocates at the end of the January-June 2019 reporting period. Not only does this revisited count ensure that Region 7 met this target during the current reporting period, partners were able to confirm that these staff members received this training and acted in this capacity in the previous reporting periods as well. Rather than convening another live training, the Region 7 IDN team began a process of identifying on-demand training resources and assembling a virtual training program that partners can access as they experience local turnover in their care coordination teams. The team anticipates that this will be available during the next reporting period.

Additionally, *Weeks Medical Center* has reported that they have one staff member serving in a Care Advocate Supervisor role. This individual facilitates regular meetings with Care Coordinators who are employed by agencies partnering under a Collaborative Care Organization (CCO) in the region, many of whom are ACO-trained Care Coordinators. These meetings are focused on strengthening the relationships between Care Coordinators and standardize care coordination processes across the CCO. Because this individual is engaged in regional Care Coordination efforts, she has been counted as a second Care Advocate supervisor for the region.

December 31, 2019 Update

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

Provide a detailed narrative to reflect progress made toward recruitment, retention, hiring and training during this reporting period.

Network Membership

During the reporting period of July 1 through December 31, 2019, no partners have left the network. The Region 7 IDN had one new member join the network – Coös County Department of Corrections – bringing the total number of partners in the Region 7 IDN to thirty-nine (39).

The information below speaks to the progress that Region 7 IDN has made on the A1 project "IDN-Level Workforce Capacity Development" during this reporting period.

Region 7 IDN Data Governance

Following on a plan developed during the last reporting period, the Region 7 IDN team has continued to ask partners to complete a modified version of the DHHS Monthly Update template each month in order to inform the regional aggregate reports. Despite this more efficient reporting process, as the reporting period progressed, fewer and fewer partners contributed to the reports. During a number of conversations in the last quarter of the year, partners expressed concerns of initiative fatigue and a lack of bandwidth to respond to multiple reporting requests that were similar but not aligned and therefore demanded significant investment of staff time abstracting near-redundant information. As the end of the reporting period for this Semi-Annual Report approached, the Region 7 IDN team spent time connecting with project-involved partners to obtain final staffing counts and turnover data for the entire reporting period, thereby ensuring that the numbers offered in the reports tables were as accurate as possible, despite the fact that the streamlined monthly reporting process was not as successful as intended.

One monitoring trend that has become evident in this first year of wholly performance-based incentive payments is the need to further support and develop a workforce that has deep understanding and application skills of data governance and quality improvement. In larger organizations that have a dedicated person or persons responsible for quality assurance and performance improvement (QAPI), there is large variance in the amount of QAPI training completed by each member of the workforce. In smaller organizations, there is often no internal staff person dedicated to the work of ensuring that records are structured in such a way that reporting can be performed in an efficient manner with verifiable data integrity, and abstraction functions are outsourced to a third party with little to no knowledge of the local variation in data handling. Most partner organizations are working towards better analytics maturity, but struggle with aging medical records systems and the need to balance data governance changes with keeping existing platforms in working order so as not to disrupt patient care.

Although the statewide workforce capacity project is focused on increasing the number of licensed clinicians involved in the delivery of integrated healthcare, this feedback from Region 7 IDN partners makes clear that, as delivery system reform takes place, there is also a strong need to develop and maintain a workforce that provides the administrative support necessary to prove that these clinicians are providing integrated care. Under current reimbursement models, however, there is little to no consideration for the expense of this administrative work, which is best performed by individuals with specific QAPI knowledge and training. Without adequate financial support for data controls and analytics, this work falls to existing staff in smaller partner organizations who struggle to complete it due to a lack of experience and training. In larger partner organizations, some level of overhead absorbs the cost of these efforts, but it is often diffused across many staff, compromising efficiency and data integrity.

As partner organizations prepare for Alternative Payment Models under the NH Medicaid program and other payer initiatives, the Region 7 IDN team will work with its partners to identify opportunities to

deepen the skills of their existing workforce and ways to structure workflows such that the reporting requirements of these programs are less burdensome.

Statewide Workforce Capacity Development Collaboration

Workforce Taskforce

The Statewide Training & Education Workgroup met in September to update members on the status of multiple initiatives throughout the state. The group was informed that IDN leads opted not to create an IDN-specific training track for the 2019 Behavioral Health Summit, as it felt unnecessary since all regions were so far into separate training plans during the reporting period. As an alternative, several regions opted to instead sponsor slots for partner staff to attend the Behavioral Health Summit so they could participate in the sessions most meaningful and useful to their own agency. The summit was held on December 16-17, 2019 and provided the NH workforce an opportunity for continued learning and professional development on behavioral health topics.

During the reporting period, the workgroup agreed to trial an online directory of upcoming educational opportunities focused on the delivery of integrated health. Region 7 IDN developed and launched www.integrated-trainings.com – the New Hampshire Integrated Healthcare Training Directory – and provided a process for workgroup members to submit material to be posted to the site. Although workgroup members agreed that the design met the basic functions and budget of their goal, there have not been many content submissions. The Region 7 IDN team continues to search and request training opportunities across the state and will update the directory frequently. In addition to the training directory, Myers and Stauffer continues to maintain the CPAS website, which serves as an archive for collateral from former trainings as opposed to upcoming trainings.

Training opportunities were the focus of the workgroup during this reporting period, with each region having an opportunity to update the group on upcoming offerings across the state. Representation from the New Hampshire Alcohol & Drug Addiction Counselors Association (NHADACA) joined the September meeting and provided an update on their professional development programs. NHADACA shared that the organization has recently begun offering virtual attendance as an option for learners, but has started with low virtual enrollment caps as they adjust to this new format of content delivery and learner participation. Additionally, they have opted to hold off on offering this option for full-day trainings until presenters have had the opportunity to familiarize themselves with this format and become comfortable with delivery that remains engaging for the virtual attendees. NHADACA agreed to provide updates to the IDNs as this pilot becomes fully implemented.

Retention of Licensed Mental Health Professionals

The December Quarterly Meeting shed light on the challenges the entire region continues to face regarding the retention of Licensed Mental Health Professionals. Northern Human Services continues to be a key partner to experience this burden due to low reimbursement rates of a Community Mental Health Center. This creates a challenge for NHS to offer competitive salary and benefit packages to potential hires, leading to the significant barrier to successfully recruit and retain LMHCs. As a direct impact of this barrier, the agency has seen multiple clinicians stay with NHS through the training and certification process, only to then relocate to a federally qualified health center that has the capacity to pay more.

North Human Services continues to advocate for CMHCs to receive Federally Qualified status, which will allow them to receive higher reimbursement rates and in turn offer more competitive salaries to staff as a retention strategy. As the region continues to discuss sustainability of IDN projects and what focus the IDN should have in the last year, recruitment and retention remains a high priority for all partners.

Mental Health First Aid

During the reporting period, the Region 7 IDN team identified a barrier to training non-direct staff in Mental Health First Aid, due to the training taking 8 hours to complete. Region 7 IDN Partners expressed the difficulty in freeing up staff time to allow for the training. To mitigate this barrier a Behavioral Health Awareness Webinar was created and is scheduled to be delivered to partners using an on-demand method in February 2020. The IDN team has also created an attestation form to accompany this training that partners can utilize to show proof of non-direct staff education on this and other topics related to the delivery of integrated healthcare services.

Investment in Education for Integrated Healthcare Professions

Health Career Catalog

Region 7 IDN team members continued to assist Southern and Northern NH AHEC staff with the development of the 5th Edition AHEC Health Career Catalog during this reporting period. The Catalog team spent the majority of the period proofing the final copy and submitting edits to the designer, which included graphics of various career pathways. The team believes that this new edition provides a clearer picture of the pathways available for individuals to pursue a health career. The Catalog was approved for printing at the end of this reporting period, and were delivered to program offices in early January 2020.

Live, Learn, Play in Northern NH

During this period, there were 3 *Live Learn, Play in Northern NH* behavioral health students completing rotations and community service projects within Region 7IDN:

- A student working on a master's in clinical mental health counseling started a rotation at White Mountain Mental Health (Northern Human Services) on September 1, 2019. The student's project was the White Mountain Parent Outreach; a support group for parents/caregivers of children with mobility issues. The student hopes to continue working on this project beyond the end of their rotation on December 31, 2019.
- Another student started a rotation on August 1, 2019, at Northern Human Services. This student, an MSW degree candidate from the University of New Hampshire, selected a project that involves compiling resources to support the agency's as it explores the use of Mobile Crisis Units in rural areas. The student's rotation will continue through May 2020.
- Another MSW student from UNH started an internship at Huggins Hospital from August 1 through November 30, 2019. The project topic focused on developing a resource guide for individuals diagnosed with SUD and includes Carroll County and Huggins-connected resources to assist with recovery. The final guide was distributed to Carroll County Coalition for Public Health and Huggins Hospital staff.

Behavioral Health Preceptor Sites

During this reporting period, the Region 7 IDN team confirmed that a total of seven partners are currently serving as preceptor sites for behavioral health programs. At this time, there are students actively deployed at six partner agencies.

- *Ammonoosuc Community Health Services* continued a previous preceptorship with the LMHC that started in December 2018 and ended in December 2019. ACHS also supported a current employee through an LMHC internship between September and December 2019. This grow-your-own process was slightly challenging for the partner and posed potential conflicts that ACHS is dedicated to overcoming during the next reporting period so this option can continue to be offered to staff internally. ACHS plans to seek guidance from Northern Human Services regarding the success of

their grow-your-own program to gain insight on ways to address the logistics of supporting an employee internship.

- *Huggins Hospital* hosted an LICSW student who started in July 2019 and practiced with their current Social Worker. The partner saw an increase in capacity for behavioral health case management services with the student on the team.
- *Indian Stream Health Center's* behavioral health team also continues to serve as an experiential learning site for behavioral health students and is currently precepting an MSW student. This student is helping with case management of high-risk patients and will likely begin coordinating warm hand offs for the health center in the beginning of 2020.
- *Memorial Hospital* supported a student to follow the current Psychiatric Nurse Practitioner during this reporting period. The student is leveraging their master's degree to expand into a Psychiatric Nurse Practitioner role. Memorial anticipates this student to return as an employee once the transition is complete.
- *Northern Human Services* continues to utilize the grow-your-own model to train behavioral health staff for the agency. This reporting period NHS supported several students at multiple locations including three clinical interns at White Mountain Mental Health, two working towards LCMHC and one working towards a Master's in Social Work. The agency also supported three staff members in their bid for licensure, including two social workers (one of whom will become dual licensed with a LADC) and one Licensed Clinical Mental Health Counselor.
- *White Mountain Community Health Center (WMCHC)* contracted with NHS to host a Social Worker student who saw WMCHC clients and complete a care coordination project for the organization. The student assessed the current care coordination workflows and provided recommendations for improvement based on a survey of the entire staff. During this process, the student also evaluated the Comprehensive Core Standardized Assessment process in use at WMCHC and provided feedback regarding other stakeholders that could be included in the process. WMCHC reports that this analysis has been valuable to the organization and the resulting recommendations are now under consideration as future process improvements to be adopted.
- *White Horse Addiction Center (WHAC)* has served as an experiential learning site in past reporting periods, but did not hold any preceptorships during this reporting period. Instead, the organization has begun conversations with higher education institutions regarding support of their interns in the future with an eye toward the agency building the capacity to operate an education center that trains and certifies MLADC, LADC and LICSW candidates. There are currently licensed professionals on staff at WHAC that are qualified to provide oversite and supervision to these behavioral health candidates as soon as formalized relationships and shared processes with the institutions can be finalized.

Ongoing Care Coordinator Skills Development

The Region 7 IDN Regional Care Coordinator Network (RCCN) was established in September 2019. It is intended to serve as a vehicle for the strengthening of the Care Coordinators and Care Advocates in the region by establishing a peer cohort that networks regularly, shares ongoing continuing education opportunities, and convenes to discuss trends in care coordination and shared patients/clients in a confidential setting. The RCCN is facilitated by the Region 7 Care Advocate Supervisor, and topics of discussion are selected based on regularly solicited feedback from members regarding educational needs and trends seen in care coordination across the region. Members of the RCCN serve in both clinical (i.e. RN Case Manager, LICSW) and non-clinical (i.e. Community Health Worker, Peer Recovery Coach) capacities across the region, allowing for shared learning from multiple perspectives of care coordination taking place in a broad selection of care settings. The RCCN will also serve as the primary

vehicle for ongoing training on topics related to Enhanced Care Coordination. This live education, in conjunction with enduring material from previous Care Advocate trainings available on the Region 7 IDN website, will serve to maintain the level of training in place for Care Advocates as turnover occurs within partner organizations.

Community Health Workers

North Country Health Consortium's Ways2Wellness CONNECT staff dedicated much of 2019 to the revision of the Community Health Worker curriculum. Changes included delivery methods that are more consistent with adult learning styles, a significant increase in in-person training and reduction in online content, the opportunity to practice skills learned and exposure to professionals currently working as or with Community Health Workers. The new curriculum was launched with a course that was offered in the last quarter of 2019. All eight registrants completed the course and are actively working or volunteering in ways that leverage the CHW training. The Ways 2 Wellness Connect staff utilized participant feedback to further customize the curriculum and delivery before scheduling the next four sessions of the course, being offered in March and October of 2020 and 2021.

Peer Recovery Workforce

The peer recovery workforce and recovery community organizations continued to grow during this reporting period. North Country Health Consortium's Wellness and Recovery Model (WARM) team hosted a number of learning opportunities, including Recovery Coach Academy trainings, to increase workforce capacity throughout the region. The Region 7 IDN partners were targeted recipients of the trainings. Multiple trainings and events were offered during this reporting period to strengthen the recovery workforce and improve community awareness. Over 230 people participated in the list of trainings and events provided below:

- July 18-19 & 25-26, 2019: Recovery Coach Academy
- August 3, 2019: Addiction Hurts Panel Discussion
- August 12-13 & 19-20, 2019: Recovery Coach Academy
- August 26-28, 2019: Ethical Considerations for Recovery Coaches
- August 27, 2019: Recovery Friendly Workplace panel
- September 13-14 & 28-29, 2019: Recovery Coach Academy
- September 12, 2019: Mental Health First Aid for First Responders
- September 25, 2019: Mental Health First Aid
- September 28, 2019: Holistic Wellness Fair
- October 3 & 4, 2019: OUD in the 603
- October 7, 2019: WARM resource table NHS Employee Wellness Fair
- October 16,2019: Pleasure Unwoven Movie Screening w/ Panel Discussion
- October 23, 2019: WARM resource table at Health Rocks! LRH Health Fair
- November 13, 2019: Pleasure Unwoven Movie Screening w/ Panel Discussion
- November 25, 2019: Suicide Prevention
- December 4-5 & 11-12: Recovery Coach Academy
- December 10, 2019: North Country Healer's Forum

The WARM program also focused efforts during this reporting period on strengthening relationships between the region's recovery community organizations. Stakeholders were convened to discuss effective strategies to train workforce across the region as it works to address the ongoing opioid crisis. In December 2019, the development of a comprehensive training plan for 2020 began and stakeholders hope to have if finalized in early 2020.

North Country Serenity Center (NCSC) has continued to collaborate with the Family Resource Center to provide the Sober Parenting Journey program to individuals in the region. NCSC has also deepened collaborations with NCHC, White Mountains Recovery Homes, Weeks Medical Center's North Country Recovery Center, Ammonoosuc Community Health Services, and several other area partners to effectively leverage workforce to establish a network of resources that provide an increased level of service to the recovery community. These partners continue to refer to one another and have dedicated efforts during this reporting period to formalizing and strengthening referral processes. Hope for NH Recovery in Berlin has also worked to expand services in Coos County during this period collaborating with multiple area partners throughout the region.

White Horse Addiction Center (WHAC) focused efforts during this reporting period to improving the organization's business model and workforce infrastructure. A consultant helped the agency as it worked to formalize clinical and service protocols and workflows as the organization expands its service offerings, with an eye towards adoption of evidence-based practices and process standardization. WHAC also hired a design professional to help rebrand the organization following a decision to increase the behavioral health workforce so that mental health services can be offered to a broader population, in addition to the SUD treatments and recovery supports that are the core of WHAC programming. The partner decided to adopt a new front facing name of White Horse Recovery & Behavioral Health Services to better encompass the array of programs they currently provide and plan to expand in the future. The organization's trade name has not yet changed, but that is expected to occur in mid 2020. While work continues to formally register a new trade name for the organization, it has already begun using White Horse Recovery & Behavioral Health Services as its front-facing name on marketing materials.

WHAC and *Mount Washington Valley Supports Recovery (MWVSR)* teamed up during this reporting period to establish 24/7 Recovery Support Services in Carroll County. The partners ensured that peer recovery coaches in both organizations were trained to respond to emergency departments, and began the pilot by developing a relationship with Memorial Hospital. Over the first half of the reporting period, a collaborative group representing both recovery organizations worked to build policies and protocols for the program, while executives executed the necessary agreements with Memorial Hospital to support the project. Peer recovery coaches began serving in an on-call capacity during the second half of the reporting period and have successfully provided support to individuals through the program, which has been recognized in both social and mainstream media as a strategy underway in Carroll County. WHAC and MWVSR plan to expand the project during 2020 to include collaboration with Huggins Hospital in the southern part of the county.

Quality & Data Specialist Workforce

As discussions with partners have progressed during the reporting period, it has become evident in this first year of wholly performance-based incentive payments that there is a need to further support and develop a workforce that has deep understanding and application skills of data governance and quality improvement. In partner organizations large and small there is large variance in the amount of training and experience workforce members have in data governance and performance improvement. This includes ensuring that records are structured in such a way that reporting can be performed in an efficient manner with verifiable data integrity, and data collection, analysis and reporting activities are meaningfully and effectively carried out in accordance with nationally developed quality improvement standards and competencies. Most partner organizations are working towards better analytics maturity, but struggle with aging medical records systems and striking the balance of making improvements to data governance and health information systems without disrupting patient care.

Although the statewide workforce capacity project is focused on increasing the number of licensed clinicians involved in the delivery of integrated healthcare, this feedback from Region 7 IDN partners makes clear that, as delivery system reform occurs, the development of a quality/data management workforce is as important as the development of the service provider workforce. As partner organizations prepare for Alternative Payment Models under the NH Medicaid program and other payer initiatives, the Region 7 IDN team will work with its partners to identify opportunities to increase data governance and performance improvement capacity.

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	3	6
# 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	1	2
# of mobile LADCs ready to deploy to Region 7 IDN partners	1 by 2018	0	0	0

December 31, 2018

Statewide workforce shortages related to LADCs has made it challenging for the region to meet the metric of having mobile LADCs ready to deploy to area agencies as needed. Despite extensive advertising efforts to recruit LADCs Friendship House still has vacancies for these positions, and as a result does not have staff readily available to deploy to agencies as needed. NCHC will continue recruitment efforts and will work with other area agencies to see if there are any LADCs in the area who could be deployed on an as needed basis. In addition, Region 7 IDN will continue to leverage the work of NCHC's new Wellness and Recovery Model (WARM) and the two NH Doorways in the region to develop a network of mobile LADCs throughout the region.

Friendship House was able to expand supervision for master's level clinicians by shifting around responsibility of an existing MLADC so their role now includes supervision of LADC staff and providing peer collaboration for newly licensed MLADCs. Clinical Supervision training will be offered to applicable staff at Friendship House through NCHC's Relias Learning Management System as a way to augment their supervisory skillset.

June 30, 2019 Update

Region 7 IDN Data Governance

As Region 7 IDN adopted the new DHHS Monthly Update reporting format this spring, efforts were expended to verify the total number of individuals served by each Region 7 IDN partner to date and leverage the State's reporting tool as a mechanism that will help partners report monthly totals for the

remainder of the DSRIP. By utilizing the State's new monthly reporting mechanism as the backbone of a high-integrity data management process, the Region 7 IDN team hopes to ease the reporting burden for partners while retaining the ability to collect, aggregate and analyze data for the region as a whole. This revised process is anticipated to allow the region to evaluate progress on performance evaluation targets more frequently and help the Region 7 IDN team provide more timely feedback and support to the region's partners. Partner specific updates in this section reflect narrative regarding their progress along the continuum of the project, and their total number of unique individuals served during the DSRIP period through June 30, 2019.

Performance Measure Name	Target	Progress Toward Target			
		As of 12/31/17	As of 6/30/18	As of 12/31/18	As of 6/30/19
Number of mental health professional students completing Live, Learn Play program in northern NH	6 by 2018	3	3	6	9
Number 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	1	2	3
Number of mobile LADCs ready to deploy to Region 7 IDN partners	1 by 2018	0	0	0	1

December 31, 2019 Update

As noted earlier in this section, regional support of workforce development continues through expanded preceptor sites and the use of the Live, Learn, Play program in Region 7. All targets for this section continue to be met as partner organizations see value in their role as contributors to workforce capacity development and retention.

Performance Measure Name	Target	Progress Toward Target				
		As of 12/31/17	As of 6/30/18	As of 12/31/18	As of 6/30/19	As of 12/31/19
Number of mental health professional students completing Live, Learn Play program in northern NH	6 by 2018	3	3	6	9	12
Number 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	1	2	3	3
Number of mobile LADCs ready to deploy to Region 7 IDN partners	1 by 2018	0	0	0	1	1

A1-5. IDN-level Workforce: Staffing Targets

December 31, 2018

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 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	13	14
Licensed Mental Health Professionals	23 by 2018	14	18	16	9
Peer Recovery Coaches	6 by 2018	2	22	59	67
CTI Workers	15 by 2018	0	11	24	37
CTI Supervisors	3 by 2018	0	3	3	3
Community Health Workers	4 by 2018	0	13	13	13
Psych Nurse Practitioners (round 1 funds)	3 by 2018	1	2	5	7
Care Advocates	15 by 2018	0	0	5	11
Other Front-Line Provider	1 by 2018	0	10	16	52
Care Advocate Supervisors	1 by 2018	0	0	1	1
Case Management	2	2	4	6	15
Community based clinician (round 1 funds for baseline 6/30/17)	1	1	1	1	1
Physician assistant (round 1 funds for baseline 6/30/17)	1	1	1	3	3
Community nurse coordinator (round 1 funds for baseline 6/30/17)	1	1	1	1	1
Behavioral health assistant (round 1 funds for baseline 6/30/17)	1	1	1	2	4
Behavioral health case managers (round 1 funds for baseline 6/30/17)	5	2	4	5	7
LICSW (round 1 funds for baseline 6/30/17)	3	1	2	2	4
IDN QI Coach	1	0	0	1	2
HIT Integration Coach	1	0	1	1	1
IDN Data Specialist (NCHC)	1	0	0	0	1
Data Specialists for IDN partners	Up to 3	0	0	0	3

Region 7 IDN continues to struggle with recruitment and retention for MLADCs and other licensed mental health professions. The region has experienced increased turnover of licensed mental health clinicians and Master Licensed Alcohol and Drug Counselors assumingly due to provider burnout and compassion fatigue. There is a considerable amount of work being done in the region to address compassion fatigue by the North Country Task Force on Improving Opioid Treatment Outcomes. This is a group of individuals and provider agencies who are coming together to discuss how to identify core competencies for addiction professionals that effectively addresses self-care as a risk management and quality assurance measure for patient care.

Region 7 has also continued to be actively involved in the Statewide IDN Training and Education Workgroup which discusses the Behavioral Health Higher Education Roundtable regularly. The two groups have been working together to help increase BH workforce and help providers with recruitment and retention strategies. Organizations and educational institutions have continued to collaborate to align employment requirements with education requirements to streamline the transition between school and actual practice.

Region 7 IDN held two Regional Care Coordination trainings during 2018. This was a shift from the original three that were planned, one for each county. The northern Grafton and Coös County training was combined into one training to better fit IDN partner needs, specifically those of North Country

Healthcare affiliate organizations. North Country Healthcare only sent two staff instead of one from each affiliate agency, and other partner agencies chose not to send staff because of the need to serve patients, so the region did not meet metrics for the number of care coordinators trained. The Carroll County training had two individuals who were partially trained during the two-day training that were not counted in this measure, however they received valuable content from the day they attended. Region 7 IDN staff will adapt the care coordination training into webinar modules to make the training easier to access.

After initiation of the project, the data specialist was deemed to be redundant with services already provided by MAeHC and the HIT lead at NCHC. In lieu of hiring additional staff to handle data aggregation and funding them through IDN request for proposal funding, three agencies (White Mountain Community Health Center, Saco River Medical Group and Coös County Family Health Service) have elected to contract for these services instead. WMCHC has contracted with a third-party expert, while Saco and Coös County have contracted directly with MAeHC for data abstraction services. All three have been able to leverage these resources into better reporting results.

June 30, 2019 Update

Provide the IDN's **current number of full-time equivalent** (FTE) staff needed to address the gaps identified in the IDN's Workforce Capacity Development Implementation Plan **include workforce related to the IDN HIT Infrastructure, IDN Integrated Healthcare, and the IDN selected community-driven projects**.

Region 7 IDN Data Governance

As Region 7 IDN adopted the new DHHS Monthly Update reporting format this spring, efforts were expended to verify the total number of individuals served by each Region 7 IDN partner to date and leverage the State's reporting tool as a mechanism that will help partners report monthly totals for the remainder of the DSRIP. By utilizing the State's new monthly reporting mechanism as the backbone of a high-integrity data management process, the Region 7 IDN team hopes to ease the reporting burden for partners while retaining the ability to collect, aggregate and analyze data for the region as a whole. This revised process is anticipated to allow the region to evaluate progress on performance evaluation targets more frequently and help the Region 7 IDN team provide more timely feedback and support to the region's partners. Partner specific updates in this section reflect narrative regarding their progress along the continuum of the project, and their total number of unique individuals served during the DSRIP period through June 30, 2019.

Provider Type	IDN Workforce (FTEs)					
	Project(s)	Projected Total Need By 12/31/18	Staffing on 12/31/18	Staffing on 6/30/19	Staffing on 12/31/19	Staffing on 6/30/20
Master Licensed Alcohol and Drug Counselors	A1, B1, D3	16	14	17		
Licensed Mental Health Professionals	A1, B1	23	9	49		
Peer Recovery Coaches	A1, B1, D3	6	67	88		
Other Front-Line Provider	A1, B1	1	52	42		
Behavioral health assistant (round 1 funds for baseline 6/30/17)	A1, B1	1	4	4		
Behavioral health case managers (round 1 funds for baseline 6/30/17)	A1, B1	5	7	49		
Care Advocate Supervisors	A1, B1, E5	1	1	2		

Provider Type	IDN Workforce (FTEs)					
	Project(s)	Projected Total Need By 12/31/18	Staffing on 12/31/18	Staffing on 6/30/19	Staffing on 12/31/19	Staffing on 6/30/20
Care Advocates	A1, B1, E5	15	11	21		
Case Management	A1, D3	2	15	67		
Community based clinician (round 1 funds for baseline 6/30/17)	A1, B1	1	1	1		
Community nurse coordinator (round 1 funds for baseline 6/30/17)	A1, B1	1	1	1		
Community Health Workers	A1, B1, D3, E5	4	13	18		
CTI Supervisors	A1, B1, C1	3	3	5		
CTI Workers	A1, B1, C1	15	37	37		
Data Specialists for IDN partners	A1, B1	Up to 3	3	9.4 FTE[1] + 3 contracted data aggregators		
HIT Integration Coach	A1, A2, B1	1	1	1		
IDN Data Specialist (NCHC)	A1, B1	1	1	1		
IDN QI Coach	A1, B1	1	2	2		
LICSW (round 1 funds for baseline 6/30/17)	A1, B1	3	4	13		
Physician assistant (round 1 funds for baseline 6/30/17)	A1, B1	1	3	17		
Psych Nurse Practitioners (round 1 funds)	A1, B1, D3	3	7	11		

Workforce Calculation Process

As the Region 7 IDN team spent time this reporting period assessing the progress made on process measures and their potential impact on the performance metrics that will drive incentive payments in DSRIP years 4 and 5, questions arose regarding the rate of change for some workforce categories in the context of narrative reports of significant improvements in access to treatment for behavioral health diagnoses was improving. Specifically, the rates of change for Licensed Mental Health Professionals and Master Licensed Alcohol and Drug Counselors were scrutinized because neither target was met in the previous reporting period.

During the collection of data for this report, the Region 7 IDN team focused on verifying the current state of workforce in the region as it compared to the baseline reported in the Region's Implementation Plan published July 2017. This included a level-setting of workforce numbers and the number of individuals served under each of the DSRIP projects. The team was successful in capturing current workforce levels for all partners specifically engaged in the DSRIP projects, as well as the turnover specific to this reporting period. As the Region 7 IDN team analyzed this latest data, four significant variances were found, all occurring with the introduction of the June 30, 2019 staffing levels contributed

[1] During this reporting period several partners reported that, while they do not have any staff directly tasked and budgeted for DSRIP data management, they have diverted significant staff time to meet the reporting requirements of the DSRIP. Consistently, partners have indicated that the increasing demand for the use of data to drive care and the need to validate data for payer performance metrics is increasing. Separate from the dedicated data aggregator specialists accounted for in December 2018, this reporting period the Region 7 IDN team estimates that the thirteen partners engaged in the Core Competency project are dedicating an aggregate total in excess of 9 FTE engaged across the region in these data governance and reporting activities.

by the region's Community Mental Health Center, *Northern Human Services (NHS)*, as demonstrated in the A1-5 table extract below.

Workforce Category	2018 Target	Baseline 6/30/17	As of 12/31/18	As of 6/30/19
Behavioral Health Case Managers	5	2	7	49
Case Management	2	2	15	67
Licensed Mental Health professionals	23	14	9	49
Master Licensed Alcohol and Drug Counselors	16	11	14	17

Further examination of data collection processes and findings from prior reporting periods suggests that the Region 7 IDN team was unable to ascertain NHS baseline staffing levels in June 2017 for these professions as the region's workforce inventory was compiled and used to set the targets for the region's implementation plan. Once the baseline staffing levels were determined, workforce calculations in subsequent periods were made by applying the net gains/losses of partner-reported turnover data to the previous period's total. Starting in December 2017, the Region 7 IDN team was able to determine the staffing turnover at NHS for every reporting period after the implementation plan was published. As a result, NHS turnover data impacted the region's aggregate workforce totals, but not their baseline staffing levels. This analysis of workforce data has also identified that the number of MLADCs in the region was reported inconsistently across projects in prior periods, likely due to the manual calculation of the impact that partner turnover data has on the regional workforce aggregate.

This process has highlighted the difficulty that the IDN faces in accurately capturing workforce capacity changes over time. It is common for a single partner to report that they lost a member of their workforce to another partner agency. Partners attribute the contrast between high local partner turnover rates and a relatively lower change in regional workforce totals to the dynamic recruitment and retention efforts employed by partner organizations in the face of workforce shortages within our rural region. Together these factors incentivize skilled workforce members living in the area to seek higher compensation packages without being encumbered by the inconvenience of moving their families. In future reporting periods, the Region 7 IDN team will work to capture both current staffing and turnover data from all project-engaged partners to ensure accurate updating to both tables and regional narrative. In this way, the region will be better positioned to show workforce capacity levels as a snapshot in time and local workforce turbulence impact on the delivery of integrated care.

December 31, 2019 Update

Provide the IDN's **current number of full-time equivalent** (FTE) staff needed to address the gaps identified in the IDN's Workforce Capacity Development Implementation Plan **include workforce related to the IDN HIT Infrastructure, IDN Integrated Healthcare, and the IDN selected community-driven projects**.

Region 7 IDN Data Governance

Historically, Region 7 IDN has reported the number of individuals recruited and trained for each of the workforce roles listed in the table below. During this reporting period, efforts were undertaken to clarify with partners that an FTE count was also valuable at the state level. Values reported in the table below reflect actually staffing at partner agencies. It should be noted that this table reflects true workforce deployment throughout the region, most of which is not currently supported by the use of DSRIP incentive payments. Although several project proposals from Region 7 IDN partners requested the use of distributed incentive payments for the purposes of standing up new positions, proposals

included a long-term sustainability plan so that increased workforce capacity would exist after the demonstration has ended. As a result, this table reflects the total workforce levels as reported by Region 7 IDN partners and is not limited solely to those positions financed with DSRIP monies.

During this reporting period, Region 7 IDN continued to meet all previously established staffing targets. While some staffing totals for this period are lower than those of the previous reporting period, the variances are small, and indicative in most cases of the change from reporting employees to reporting full time equivalents, resulting in per diem or very part time positions no longer being reflected in the table. Despite continued increases in the number of MLADCs in the region, partners report that there is still a significant need for individuals to provide supervision to CRSW, LADC and MLADC candidates.

Provider Type	IDN Workforce (FTEs)					
	Project(s)	Projected Total Need By 12/31/18	Staffing on 12/31/18	Staffing on 6/30/19	Staffing on 12/31/19	Staffing on 6/30/20
Master Licensed Alcohol and Drug Counselors	A1, B1, D3	16	14	17	18	
Licensed Mental Health Professionals	A1, B1	23	9	49	45	
Peer Recovery Coaches	A1, B1, D3	6	67	88	88	
Other Front-Line Provider	A1, B1	1	52	42	39	
Behavioral health assistant (round 1 funds for baseline 6/30/17)	A1, B1	1	4	4	5	
Behavioral health case managers (round 1 funds for baseline 6/30/17)	A1, B1	5	7	49	51	
Care Advocate Supervisors	A1, B1, E5	1	1	2	2	
Care Advocates	A1, B1, E5	15	11	21	18	
Case Management	A1, D3	2	15	67	66	
Community based clinician (round 1 funds for baseline 6/30/17)	A1, B1	1	1	1	1	
Community nurse coordinator (round 1 funds for baseline 6/30/17)	A1, B1	1	1	1	1	
Community Health Workers	A1, B1, D3, E5	4	13	18	19	
CTI Supervisors	A1, B1, C1	3	3	5	4	
CTI Workers	A1, B1, C1	15	37	37	36	
Data Specialists for IDN partners	A1, B1	Up to 3	3	9.4 FTE + 3 contracted data aggregators	8.65 FTE + 3 contracted data aggregators	
HIT Integration Coach	A1, A2, B1	1	1	1	1	
IDN Data Specialist (NCHC)	A1, B1	1	1	1	1	
IDN QI Coach	A1, B1	1	2	2	1	
LICSW (round 1 funds for baseline 6/30/17)	A1, B1	3	4	13	10.5	
Physician assistant (round 1 funds for baseline 6/30/17)	A1, B1	1	3	17	18	
Psych Nurse Practitioners (round 1 funds)	A1, B1, D3	3	7	11	11	

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

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

December 31, 2018

Region 7 IDN has numerous positions listed within A1-5 that don't impact the budget in A1-6 because most of these positions are existing care coordinators at our partner agencies who are not supported by IDN funds, or agencies request for funds to support salaries through the regions' subrecipient process.

Budget Period:	01/01/2017-12/31/2017	01/01/2018-06/30/2018	07/01/2018-12/31/2018	01/01/2019-12/31/2019	01/01/2020-12/31/2020	01/01/2021-06/30/2021
Workforce	CY 2017 Actuals	CY 2018 January to June Actual	CY 2018 July to Dec. Actual	CY 2019 Projected	CY 2020 Projected	CY 2021 Projected
1. Total Salary/Wages						
2. Employee Benefits						
3. Consultants			$0	$0	$0	$0
5. Supplies:			$0	$0	$0	$0
Educational			$0	$0	$0	$0
Office	$ 2,916	$105	$229	$26,751	$26,751	$13,376
6. Travel	$ 2,233	$1,108	$873	$17,883	$17,883	$8,942
7. Occupancy			$0	$0	$0	$0
8. Current Expenses			$0	$0	$0	$0
Telephone			$0	$0	$0	$0
Postage			$0	$0	$0	$0
Subscriptions			$0	$0	$0	$0
Audit and Legal			$0	$0	$0	$0
Insurance			$0	$0	$0	$0
Board Expenses			$0	$0	$0	$0
9. Software		$1,334	$0	$1,011	$1,011	$505
10. Marketing/Communications	$ 3,272	$1,722	$5,416	$23,554	$23,554	$11,777
11. Staff Education and Training		$1,547	$1,786	$35,145	$35,145	$17,573
12. Subcontracts/Agreements			$0	$0	$0	$0
13. Other (specific details mandatory):			$0	$0	$0	$0
Current Expenses: Administrative Lead Organizational Support	$ 4,923	$2,790	$1,276	$4,323	$4,323	$2,161
Support Payments to Partners	$ 198,135	$181,979	$130,609	$476,689	$476,689	$238,345
TOTAL	**$ 211,479**	**$190,586**	**$140,189**	**$585,357**	**$585,357**	**$292,678**

Consistent with all prior reporting, report begins with January 1, 2017 utilizing capacity building funds to maintain infrastructure.
IDN 7 projects the additional amount approved at June 2017 quarterly meeting to absorb future anticipated line item variances in Salary, Benefits, Software and Training.

June 30, 2019 Update

As noted in the last reporting period, Region 7 IDN has numerous positions listed within A1-5 that don't impact the budget in A1-6. This is primarily because most of these positions are existing employees of Region 7 partner agencies whose salaries are not supported by IDN funds.

Budget Period:	01/01/2017-12/31/2017	01/01/2018-12/31/2018	01/01/2019-06/30/2019	07/01/2019-12/31/2019	01/01/2020-12/31/2020	01/01/2021-06/30/2021
Workforce	CY 2017 Actuals	CY 2018 January to December ACTUAL	CY 2019 January to June ACTUAL	CY 2019 July to December PROJECTED	CY 2020 Projected	CY 2021 Projected
Line Item	Total					
1. Total Salary/Wages						
2. Employee Benefits						
3. Consultants		$0	$0	$0	$0	$0
5. Supplies:		$0	$0	$0	$0	$0
Educational		$0	$0	$0	$0	$0
Office	$ 2,916	$334	$350	$350	$700	$350
6. Travel	$ 2,233	$1,981	$650	$650	$1,300	$650
7. Occupancy		$0	$0	$0	$0	$0
8. Current Expenses		$0	$0	$0	$0	$0
Telephone		$0	$0	$0	$0	$0
Postage		$0	$0	$0	$0	$0
Subscriptions		$0	$0	$0	$0	$0
Audit and Legal		$0	$0	$0	$0	$0
Insurance		$0	$0	$0	$0	$0
Board Expenses		$0	$0	$0	$0	$0
9. Software		$1,334	$0	$0	$0	$0
10. Marketing/Communications	$ 3,272	$7,138	$1,257	$1,257	$2,514	$1,257
11. Staff Education and Training		$3,334	$610	$610	$1,220	$610
12. Subcontracts/Agreements		$0	$0	$0	$0	$0
13. Other (specific details mandatory):		$0	$0	$0	$0	$0
Current Expenses: Administrative Lead Organizational Support	$ 4,923	$4,066	$887	$887	$1,774	$887
Support Payments to Partners	$ 198,135	$312,588	$80,492	$80,492	$160,984	$80,492
TOTAL	**$ 277,087**	**$424,149**	**$152,736**	**$152,736**	**$275,867**	**$152,736**

Consistent with all prior reporting, report begins with January 1, 2017 utilizing capacity building funds to maintain infrastructure. IDN 7 projects the additional amount approved at June 2017 quarterly meeting to absorb future anticipated line item variances in Salary, Benefits, Software and Training.

Incentive Payments from January 2019 through December 2020 reflect a reduction based on anticipated DHHS action and county participation.

Budgets for project remainder reflect revised staffing structure in attempt to maximize funds available to partners.

December 31, 2019 Update

Please note that the bulk of positions listed within A1-5 do not impact the budget in A1-6, primarily because these positions have been added by Region 7 IDN partners sustainably without needing ongoing support of IDN funds.

Budget Period:	01/01/2017-12/31/2017	01/01/2018-12/31/2018	1/1/2019 - 6/30/2019	7/1/2019 - 12/31/2019	1/1/2019 - 12/31/2019	1/1/2020-6/30/2020	7/1/2020-12/31/2020	01/01/2020-12/31/2020	01/01/2021-12/31/2021
Workforce	CY 2017 Actuals	CY 2018 January to December ACTUAL	CY 2019 January to June ACTUAL	CY 2019 July to December ACTUAL	CY 2019 January to December ACTUAL	CY 2020 Jan to June PROJECTED	CY 2020 July to Dec PROJECTED	CY 2020 Projected	CY 2021 Projected
Line Item	Total								
1. Total Salary/Wages									
2. Employee Benefits									
3. Consultants		$0	$0	$0	$0	$0	$0	$0	$0
5. Supplies:		$0	$0	$0	$0	$0	$0	$0	$0
Educational		$0	$0	$0	$0	$0	$0	$0	$0
Office	$ 2,916	$334	$350	$286	$636	$318	$318	$636	$318
6. Travel	$ 2,233	$1,981	$650	$650	$1,300	$650	$650	$1,300	$650
7. Occupancy		$0	$0	$0	$0	$0	$0	$0	$0
8. Current Expenses		$0	$0	$0	$0	$0	$0	$0	$0
Telephone		$0	$0	$0	$0	$0	$0	$0	$0
Postage		$0	$0	$0	$0	$0	$0	$0	$0
Subscriptions		$0	$0	$0	$0	$0	$0	$0	$0
Audit and Legal		$0	$0	$0	$0	$0	$0	$0	$0
Insurance		$0	$0	$0	$0	$0	$0	$0	$0
Board Expenses		$0	$0	$0	$0	$0	$0	$0	$0
9. Software		$1,334	$0	$0	$0	$0	$0	$0	$0
10. Marketing/Communications	$ 3,272	$7,138	$1,257	$1,743	$3,000	$1,500	$1,500	$3,000	$1,500
11. Staff Education and Training		$3,334	$610	$610	$1,220	$610	$610	$1,220	$610
12. Subcontracts/Agreements		$0	$0	$0	$0	$0	$0	$0	$0
13. Other (specific details mandatory):		$0	$0	$0	$0	$0	$0	$0	$0
Current Expenses: Administrative Lead Organizational Support	$ 4,923	$4,066	$887	$828	$1,716	$858	$858	$1,716	$858
Support Payments to Partners	$ 198,135	$312,588	$80,492	$124,788	$205,280	$79,662	$185,878	$265,540	$132,770
					$0				
TOTAL	**$ 277,087**	**$424,149**	**$152,736**	**$186,074**	**$338,810**	**$146,427**	**$252,643**	**$399,070**	**$199,535**

Consistent with all prior reporting, report begins with January 1, 2017 utilizing capacity building funds to maintain infrastructure.

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)
Ammonoosuc Community Health Services	Federally Qualified Health Center (FQHC)	A1, A2, B1, D3, E5
Androscoggin Valley Hospital	Hospital Facility	A1, A2
Carroll County Department of Corrections	County Corrections Facility	A1, A2, C1
Children Unlimited	Community-based Organization providing social and support services	A1
Coos County Department of Corrections	County Corrections Facility **(NEWLY ADDED THIS REPORTING PERIOD)**	A1, D3
Coös County Family Health Services	Federally Qualified Health Center (FQHC)	A1, A2, B1, D3, E5
Cottage Hospital	Hospital Facility	A1, A2
Crotched Mountain Foundation	Hospital Facility; Community-based organization providing social and support services	A1
Family Resource Center, Gorham	Community-based Organization providing social and support services	A1, C1
Grafton County Nursing Home	Skilled nursing	A1
Hope for NH Recovery	Peer Recovery	A1, D3
Huggins Hospital	Primary Care Practice; Hospital Facility	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, E5
Life Coping, Inc.	Community-based	A1
Littleton Regional Healthcare	Hospital Facility; Rural Health Clinic	A1, A2, B1
Memorial Hospital	Hospital Facility	A1, A2, B1, D3, E5
Mount Washington Valley Supports Recovery	Peer Recovery, Transitional Housing	A1, D3
North Country Health Consortium (NCHC), NCHC Clinical Services & Friendship House	Substance Use Disorder Treatment (After 10/01/2017), Community-based Organization providing social and support services	A1, A2, B1, D3, E5
North Country Serenity Center	Peer Recovery	A1, D3
Northern Human Services	Substance Use Disorder Provider; Community Mental Health Center (CMHC); Community-Based Organization Providing Social and Support Services	A1, A2, B1, D3, E5
Rowe Health Center	Rural Health Clinic	A1, A2, B1
Saco River Medical Group	Rural Health Clinic	A1, B1
Tri-County Community Action Program	Community-Based Organization	A1, C1
Upper Connecticut Valley Hospital	Hospital Facility	A1, A2
Visiting Nurse Home Care & Hospice	Skilled nursing, home health, homemaker	A1
White Horse Addiction Center	Substance Use Disorder Provider, Therapy for co-occurring disorders (mental health and substance use disorders); Recovery Resources, Advocacy and Support.	A1, A2, B1, D3
White Mountain Community Health Center	Non-FQHC Community Health Partner	A1, A2, B1, D3, E5
Weeks Medical Center	Primary Care Practice; Hospital Facility; Rural Health Clinic	A1, A2, B1, D3, E5

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	6/30/19	12/31/19
A1-3	IDN-level Workforce Capacity Development Implementation Plan	Narrative & Microsoft Project or similar platform						
A1-4	Evaluation Project Targets	Table						
A1-5	IDN-level Workforce Staffing Targets	Table						
A1-6	IDN-level Workforce Capacity Budget	Narrative and Spreadsheet						
A1-7	IDN Workforce Key Organizational and Provider Participants	Table						

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

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

Each IDN was required to develop implementation plans for the July 2018 submission. Provide a detailed narrative which describes the progress made on required activities, timelines, key milestones, progress assessment check points and evaluation metrics.

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

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

Network Membership

December 31, 2018

During the reporting period of July 1, 2018-December 31, 2018, Region 7 IDN had no new members join the network, and no members leave.

June 30, 2019 Update

During the reporting period of January 1 through June 30, 2019, Region 7 IDN had no members join or leave the network.

December 31, 2019 Update

During the reporting period of July 1 through December 31, 2019, no partners have left the network. The Region 7 IDN had one new member join the network – Coös County Department of Corrections – bringing the total number of partners in the Region 7 IDN to thirty-nine (39).

The information below speaks to the progress that Region 7 IDN has made on the A1 project "IDN Health Information Technology (HIT) to Support Integration" during this reporting period.

Project Component 1: Support Care Coordination

Project Component 1-1: Support Event Notification Feeds from Hospital Facilities

December 31, 2018

Hospital	ADTs sending	Goal Date	PreManage ED Implementation	Goal Date
Androscoggin Valley Hospital	Yes	n/a	No	05/31/2019
Cottage Hospital	No	03/31/2019	No	05/31/2019
Huggins Hospital	Yes	n/a	Yes	n/a
Littleton Regional Hospital	No	07/01/2019	No	07/30/2019
Memorial Hospital	No	09/01/2019	No	10/31/2019
Weeks Medical Center	Yes	n/a	Pending	02/15/2019
Upper Connecticut Valley Hospital	Yes	n/a	No	05/31/2019

Update: Because of the unified manner of the approach to event notification and shared care plan utilities, the updates for hospital agencies are covered in the next section A2-3 Component 12.

Partner	Region 7 Attributed Population Emergency Department Visit Percentage (2015)	Region 7 Attributed Population Inpatient Admissions (2015)
Androscoggin Valley Hospital	18.40%	12.11%
Cottage	5.78%	1.12%
Huggins	12.81%	3.08%
Littleton Regional Healthcare	18.31%	14.92%
Memorial	15.69%	16.62%
Upper Connecticut Valley Hospital	6.05%	1.65%
Weeks Medical Center	11.30%	3.29%

June 30, 2019 Update

Hospital	ADTs sending	Goal Date	PreManage ED Implementation	Goal Date
Androscoggin Valley Hospital	Yes	n/a	No	12/31/2019
Cottage Hospital	No	10/31/2019	No	12/31/2019
Huggins Hospital	Yes	n/a	Yes	n/a
Littleton Regional Hospital	No	10/31/2019	No	12/31/2019
Memorial Hospital	No	09/01/2019	No	12/31/2019
Weeks Medical Center	Yes	n/a	Yes	N/A
Upper Connecticut Valley Hospital	Yes	n/a	No	12/31/2019

Because of the unified manner of the approach to event notification and shared care plan utilities, the updates for hospital agencies are covered in the next section A2-3 Component 1-2.

December 31, 2019 Update

Hospital	ADTs sending	Goal Date	PreManage ED Implementation	Goal Date
Androscoggin Valley Hospital	Yes	N/A	No	TBD
Cottage Hospital	No	In process	No	TBD
Huggins Hospital	Yes	N/A	Yes	N/A
Littleton Regional Hospital	No	TBD	No	TBD
Memorial Hospital	No	TBD	No	TBD
Weeks Medical Center	Yes	N/A	Yes	N/A
Upper Connecticut Valley Hospital	Yes	N/A	No	TBD

Because of the unified manner of the approach to event notification and shared care plan utilities, the updates for hospital agencies are covered in the next section A2-3 Component 1-2.

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

December 31, 2018

- *Ammonoosuc Community Health Services:* ACHS is currently not working on shared care plan implementation. IDN staff will continue to discuss how this can help the team and clients of ACHS.
- *Huggins Hospital and Outpatient Clinic:* Huggins Hospital has done the most work to adopt the SCP in the region. They have completed implementation steps with Collective Medical

Technologies for PreManage ED at the Hospital and PreManage in their Clinic. The hospital is contributing ADT feeds to the CMT network. Neither location is actively using the SCP yet as they work through adoption and workflow as well as a fix to the ADT process. Huggins works closely with the IDN Quality Improvement Coach to address the CCSA protocol, and has created a Multi-Disciplinary Core Team, supported by a psychiatrist as previously mentioned, and will be having their first monthly case conference in August 2018. Huggins Hospital will also be working on depression protocols.

- *Memorial Hospital:* Memorial is not engaged in active work on the SCP and is not contributing ADT feeds to the CMT network. The organization was recently integrated in to the MaineHealth system and they are engaged in an Epic electronic health record implementation. IDN staff have had ongoing communications and one meeting with their team that included a demo of the shared care plan, but it has been difficult to gain approval to proceed. As this hospital is near the Maine border and they are now a MaineHealth affiliate, staff have shared that not having Maine patient data in the CMT network is a barrier to using the SCP that is unique for this organization. Memorial Hospital has really focused on their behavioral health integration, and MAT expansion. They have a total of six staff divided within two departments who can prescribe for MAT services. They use the following for assessments, all provided by MaineHealth to ensure there is a standard protocol across the MaineHealth system: Guidelines for Assessing Appropriateness of Office Based Buprenorphine Treatment (this assumes the person is opioid dependent); Addiction Severity Index Lite-CF; PHQ-9; Adverse Childhood Events; MaineHealth Mental Health Assessment: Scoring and Care Planning GAD-7 Anxiety rating scale; and MDQ- mood disorder questionnaire. So far, every patient they have seen has been a patient within primary care; there is the shared electronic record that enables them to capture and share patient information. This closes the loop. Moving forward, they are going to begin accepting transfers of patients from outside providers so the closed looped referral process will become an active goal as they work on the care coordination of newly entering patients. The agency holds monthly IMAT meetings with everyone involved in IMAT, including senior leadership at the hospital.
- *North Country Healthcare:* NCH is comprised of Weeks Hospital, Androscoggin Valley Hospital, Littleton Regional Healthcare and Upper Connecticut Valley Hospital. IDN staff have worked with the affiliation to engage them on integrated healthcare initiatives although time and resources has been a constraint. In this period, Androscoggin, Upper Connecticut Valley and Weeks were able to leverage an existing ADT connection to Dartmouth-Hitchcock Medical Center to quick-start contributing ADT feeds to the CMT network. Recently, they have initiated a project to establish ADT connections for Littleton Hospital and hope that can be completed quickly. NCH has also agreed to begin implementing the shared care plan. This will occur first at the Weeks Medical Center Emergency Department. After the approach is modeled at Weeks, a rollout will occur to the other three affiliation hospitals. While no specific timeline has been established yet, it is hoped that we will see active use by the end of the next reporting cycle. Weeks Medical Center has been looking at the CCSA domains and exploring how to capture all of these domains. They will work closely with Littleton Regional Healthcare throughout this process to share information and lessons learned.
- *Cottage Hospital:* Cottage Hospital is not engaged in active work on the SCP and is not contributing ADT feeds to the CMT network. IDN staff continue to engage this partner on how the tool can help the organization and other IDN partners. Cottage Hospital has received funding to hire a behavioral health integration consultant to work with the organization on

planning for addressing IDN goals. This work is under way and the SCP is part of that discussion. They have also engaged legal help to review contributing ADT feeds to the CMT network.

- *White Mountain Community Health Center:* This organization has done significant work in developing a process to deliver integrated care including hiring a care coordinator, developing an assessment process and establishing a multidisciplinary team process. They have worked closely with a North Country Health Consortium Practice Transformation facilitator in this regard. They are actively working on a shared care plan install. IT resources are currently developing the census file upload and leadership is defining parameters for SCP users, cohorts, and notifications. WMCHC has been working on risk stratification models and a CCSA protocol. They held their first monthly case conference in June of 2018, supported by a psychiatrist. Staff at the agency feel this meeting was helpful and are looking forward to the next meeting.
- *Indian Stream Health Center:* Indian Stream has not been engaged in SCP implementation to date but at the end of this reporting cycle, IDN staff met with the organization to review progress towards IDN goals and after walking through SCP features and benefits, they agreed to a demonstration with Collective Medical. That meeting has been scheduled and it is expected that the organization will engage implementation steps in the early part of 2019.
- *Coös County Family Health Services:* IDN staff have met with the CCFHS management team, provided a personalized demonstration of the shared care plan and offered education on 42 CFR consent tracking. We are scheduling an initial project call now with Collective Medical Technologies and the organization will be moving forward with an installation of the shared care plan in the coming weeks. CCFHS provides MAT services and is working with NHS on a co-located behavioral health/primary care site. They are currently assessing some of the CCSA domains, but not consistently. As the agency continues exploration of the shared care plan, the additional DSRIP deliverables will be discussed.
- *Northern Human Services:* During this reporting period, NHS met with Collective Medical and IDN staff several times about shared care planning. They have seen a demonstration of the product and completed required pre-implementation paperwork with CM. They identified their initial cohort for using the SCP to be clients receiving services from the ACT team as this a group of complex clients with high utilization of services. NHS completed significant due diligence on consent requirements and related processes. They are working on obtaining written consent from their target population. This is a process that will require time to complete as many consumers have guardians or may not appear for appointments. NHS has also worked to develop best practices for communication about integrated care and shared care planning with staff and clients. In this reporting period they have trained all staff on this process and introduced a brochure for clients that explains collaborative care and addresses common questions asked such as: What is the CMT Network? What are EDIE and PreManage? Who is on my "Care Team"? What does "Treatment" include? Am I required to participate in EDIE/PreManage or can I opt-out? Will signing this Special Consent Form affect other consents or authorizations I have signed? Northern plans to complete an initial census upload early in 2019 and begin live use of the product at some point in the late winter or spring.
- *Saco River Medical Group:* Saco River and IDN staff have met twice to discuss the SCP. Resources to install and provider workflow and productivity impact have been concerns. Additionally, SRMG's primary hospital partner, Memorial Hospital, is not submitting ADT information and the SCP is viewed as less valuable without that information. Saco River is engaged, and willing to work with IDN staff to put systems in place to meet DSRIP deliverables, including looking at risk stratification models.

June 30, 2019 Update

- *Ammonoosuc Community Health Services (ACHS)*: During the last half of this period, ACHS signed on to the Collective Medical (CM) network. This partner's implementation included completing their census upload, training their staff, and receiving event notifications. Their current census is just over 11,000 and they have five trained users on the system.
- *Huggins Hospital and Outpatient Clinics*: Huggins Hospital has been contributing a live census to the CM network for some time and is using PreManage ED at the Hospital and PreManage Primary in their Clinics. This partner is using ADT feeds to populate census data on the CM network for both care settings. The Huggins Emergency Department is utilizing event notifications and reports that their ability to use this data in the delivery of patient care is improving timeliness of care delivery and care coordination. The ED leadership has also reported using the CM portal to retrospectively evaluate patient care for patients that have multiple ED visits at their facility and others, conducting case reviews to identify potential care gaps or opportunities for future adaptations to care protocols. This partner has also begun entering care guidelines in a limited fashion.
- *Memorial Hospital*: Memorial has not stepped into the CM network to date. Located on the Maine border in North Conway, Memorial estimates that approximately 40% of their patients are from Maine. They state that the lack of CM engagement with Maine providers remains a significant factor in this MaineHealth affiliate's perception of the value this technology will bring to their facility. The Region 7 IDN team continues to engage this partner in discussions regarding the use of this technology and the interest that surrounding IDN partners have in receiving event notifications generated by ADT feeds from Memorial's hospital units.
- *North Country Healthcare (NCH)*: During this reporting period, the NCH affiliation included *Androscoggin Valley Hospital (AVH), Littleton Regional Healthcare (LRH), Upper Connecticut Valley Hospital (UCVH),* and *Weeks Medical Center (WMC)*. Mid-way through this reporting period, LRH announced its intent to withdraw from the NCH affiliation, retaining its status as an independent Critical Access Hospital with provider-based practices but no longer utilizing NCH as its parent entity. Currently, AVH, WMC and UCVH are submitting ADT feeds to the CM network through an existing connection to Dartmouth-Hitchcock Medical Center. LRH had previously indicated that it would being to implement ADT feeds and expressed interest in using event notifications in their Emergency Department. This has not yet occurred, although this partner did re-engage in discussion about the use of this technology towards the end of the reporting period. WMC's Emergency Department is the only NCH care location currently utilizing event notifications and preliminary feedback from their clinical staff indicate that they are seeing benefit to the data within PreManage ED. The Region 7 IDN team will continue to engage NCH affiliates regarding further engagement with the CM network in the coming reporting period.
- *Cottage Hospital*: Cottage Hospital is not currently live within the CM network but did begin the implementation process during this reporting period. The agency has dedicated considerable time vetting this technology internally, including the engagement of an independent consultant to provide reassurances regarding privacy safeguards implemented by CM. Towards the end of the reporting period, this partner was engaged in regular communication with members of the Region 7 IDN team and Collective Medical representatives to outline future implementation steps. Current concerns being addressed collaboratively are primarily focused on the way the CM network will interact with their newly adopted Athena electronic medical record. The CM leadership team is working to address these concerns at this time.
- *White Mountains Community Health Center (WMCHC)*: WMCHC was one of the earliest Region 7 IDN partners to engage with the CM network. They continue to use the PreManage Primary

platform and are happy with the results it delivers to better understand their patient's care, engage other providers and reinforce their primary care relationship with their patients. WMCHC has begun to enter care guidelines on patients as well, starting with contact information for their care coordination staff. WMCHC has a CM census of approximately 2300 patients and three users of the system. In June, they received 14 event notifications.

- *Indian Stream Health Center (ISHC)*: In this reporting period, ISHC signed on to the CM network, both uploading census data and receiving event notifications. They have approximately 2,000 patients on the network and five trained users of the system.
- *Coös County Family Health Services (CCFHS)*: CCFHS also engaged with the CM network during this reporting period. They currently have a census of almost 13,000 patients and five trained users on the network. They chose not to have automated event notifications pushed to their staff, instead opting to train their care coordinators as active users of the CM portal. The care coordinators use the portal regularly to understand what is happening with their patients. April 2019 data indicated they viewed 539 events involving their patients. Their feedback is that using the CM platforms have enhanced care coordination, including improved notification of events from Androscoggin Valley Hospital, a partner with whom CCFHS already had a robust process in place to track ED visits and hospitalizations of CCFHS patients.
- *Northern Human Services (NHS)*: During this reporting period, NHS completed engagement with the CM network. They have opted to start use of this technology with the pilot population of enrollees in their Assertive Community Treatment (ACT) program, the NHS clients who are the most active consumers of services. This partner reports that their current enrollment in the CM network is comprised of 120 clients. NHS plans to continue to expand their use of CM over time and has intentionally implemented this technology in a phased approach leveraging extensive staff and client education to ensure strong buy-in of this care collaboration approach. This partner was asked to present their implementation and client engagement processes at the Region 7 IDN quarterly meeting in March and the DSRIP Learning Collaborative in May.
- *Saco River Medical Group (SRMG)*: During this reporting period, the Region 7 IDN team has engaged SRMG in several discussions regarding the adoption of this technology. This partner reports that limited HIT resources and the implementation impact on provider workflow and productivity continue to be barriers to engagement. Additionally, SRMG's primary hospital partner, Memorial Hospital, is not connected to the CM network, and SRMG reports that the return on investment for this technology is less valuable without event notifications triggered by their local hospital's ADT feeds.
- *White Horse Addiction Center (WHAC)*: The Region 7 IDN team continues to work with WHAC to identify a potential timeline for engaging with the CM network, which this partner has not had the capacity to do to date. During this reporting period, WHAC has prioritized the strengthening of their business infrastructure to maintain and expand existing services. The organization has shared that they will evaluate connection to the CM network after they implement a much-needed electronic health record. They are in the final stages of selecting an electronic health record provider and hope to begin implementation later this year. The Region 7 IDN team will continue to provide whatever support this partner finds valuable throughout this process.
- *Friendship House*: Friendship House staff have spent the reporting period devoted to the work of preparing for the Council on Accreditation for Rehabilitation Facilities (CARF) accreditation process. As a result, staff did not have the bandwidth to engage in conversations related to the implementation of Collective Medical. The Region 7 IDN team will meet with Friendship House staff during the upcoming reporting period to discuss the utilization of the Collective Medical platform.

December 31, 2019 Update

- *Ammonoosuc Community Health Services (ACHS)*: ACHS implemented Collected Medical's Shared Care plan (CM's SCP) and is currently using the system. They receive event notifications but do not enter care guidelines.
- *Coös County Family Health Services (CCFHS)*: CCFHS has been using CM's SCP for most of this year. They track a census of approximately 13,000 patients in the system and maintain this through an automated upload. CCFHS has five trained users on the network. CCFHS care coordinators have integrated the CM portal into their workflow and this is how they gather information on patient activity and event notification. Feedback continues to be positive that the system is enhancing care coordination and process efficiency.
- *Cottage Hospital*: Cottage Hospital has started working closely with both Collective Medical and their Athena electronic medical record team to contribute ADT information to the Collective Medical Network and utilize event notifications. This is still in process and has a strong focus on system interface and ensuring processes regarding 42 CFR part 2 and confidentiality are supported in the technologies. The go live date for this process is unclear, but work is ongoing at this time.
- *Friendship House*: There has been initial discussion of possible use of Collective Medical at Friendship House but at this time, no decision to implement at this facility has been made.
- *Huggins Hospital and Outpatient Clinics*: Huggins Hospital has been a leading user of CM's SCP including both PreManage ED at the Hospital and PreManage Primary in their Clinics. The organization uses ADT feeds to populate census data on the CM network for both care settings. The Huggins Emergency Department is utilizing event notifications and reports that their ability to use this data in the delivery of patient care is improving timeliness of care delivery and care coordination. The ED leadership has also reported using the CM portal to retrospectively evaluate patient care for patients that have multiple ED visits at their facility and others, conducting case reviews to identify potential care gaps or opportunities for future adaptations to care protocols. Clinics also use event notifications and enter care guidelines. The organization reports the SCP platform has developed increased efficiency and lead to stronger care coordination, notifying them of critical patient situations that they would not have known about otherwise.
- *Memorial Hospital*: During this reporting period, IDN Staff met with the Memorial Hospital Chief Medical Officer to review opportunities with Collective Medical. The system was favorably received but mention was made that implementation of the technology will require significant review by Maine Health, the parent organization for the hospital. In subsequent meetings with key executive leaders at Memorial, additional information regarding CM's SCP was shared, including the ways in which Memorial's decision making on this project can impact other regional partners. Consideration of engagement with CM's SCP is underway, and the Region 7 IDN team will continue to respond to requests for information as Memorial and Maine Health consider engagement with the network.
- *Indian Stream Health Center (ISHC)*: ISHC has engaged with CM's SCP technology during this period. This federally qualified health center is uploading census files and receiving event notifications. Although the organization experienced turnover of their primary staff on this project, it reports that the system is making a positive impact for them. The new Quality Director has been excited about the use of the SCP and the information it provides.
- *North Country Healthcare (NCH):* The hospitals of NCH contribute ADT data to the Collective Medical network including Androscoggin Valley Hospital, Upper Connecticut Valley Hospital and Weeks Memorial Hospital. Weeks is also receiving event notifications, but the other hospital partners have not yet engaged this functionality. During the reporting period, the NCH hospitals began migration to a new Electronic Medical Record system that will serve the entire affiliation.

Decisions regarding any further engagement with the CM network have been paused as staff have been wholly absorbed in the EMR implementation process.

- *Northern Human Services (NHS)*: NHS utilizes the Collective Medical platform in a limited way, with focused census uploads and event notifications for their Assertive Community Treatment and Drug Court clients.
- *Saco River Medical Group (SRMG)*: Regular meetings are held with SRMG and Shared Care Plan is frequently a topic of interest. To date, staffing and resources constraints have served as barriers to this partner's engagement with the CM network, although the organization has expressed an interest in engaging with the network should the resources necessary for implementation materialize.
- *White Horse Addiction Center(WHAC)*: White Horse has completed implementation of the organization's first electronic health record during this period. Concurrent with their go-live schedule, this partner entered into discussions with Collective Medical to begin implementation of CM's SCP and is looking forward to the value this connectivity will bring to their care coordination efforts, including the provision of 24/7 peer recovery supports to patients in Carroll County emergency departments. Implementation is expected to be complete in early 2020.
- *White Mountains Community Health Center (WMCHC)*: WMCHC was one of the first partners in Region 7 IDN to adopt CM's SCP. They continue to benefit from the event notifications and care recommendations features of the Collective Medical platform.

Project Component 1-3: Support Adoption of Direct Secure Messaging by IDN Participants

December 31, 2018

- *Ammonoosuc Community Health Services:* ACHS uses capacity in their Centricity electronic health record to send secure messages to patients. They have the functionality to send messages to other providers but currently that is not their practice.
- *Huggins Hospital:* The hospital has direct secure messaging through their patient portal for patient communications. Their EMR has HIPAA compliant DSM functionality to communicate with other providers. The organization currently uses two different EMR's for the ED and primary care. In the future, they will be transitioning to Allscripts for all EMR needs and DSM functionality will evolve at that time.
- *Indian Stream Health Center:* ISHC uses TigerConnect to facilitate secure messaging between providers and patients. They currently do not send secure messages to other providers.
- *North Country Healthcare Hospitals:* The North Country Healthcare affiliation includes Littleton Regional Hospital, Weeks Medical Center, Androscoggin Valley Hospital, and Upper Connecticut Valley Hospital. All four organizations are implementing Imprivata as a secure messaging platform. It was originally planned that this would be live by end of 2018. But it was identified that the NCH hospitals had to first finalize implementation of active directory across all four hospitals to support this platform. This has delayed rollout of the Imprivata which is now targeted for use by the end of the first quarter 2019. The organization also maintains patient portals for communications appropriate for that channel.
- *Northern Human Services:* NHS had previously installed DSM functionality, but vendor issues prohibited them from using the functionality. A new upgrade that is forthcoming for their Netsmart LWSI Essentia electronic record will include a HISP and NHS plans to take advantage of this to engage direct secure messaging. Targeted upgrade completion is February of 2019.

- *White Mountain Community Health Center:* WMCHC has a patient portal that they use to communicate with patients if the patient is registered. They do not currently have other secure messaging technology to provide email communication with other providers or clients.
- *Saco River Medical Group:* The practice is fully functional with patient portal and direct secure messaging via their EMR. They can receive and send messages. The challenge that SRMG has encountered is that many of the organizations they work with don't have DSM and can't engage them in this form of communication.
- *Coös Family Health Services:* DSM has been in place for a number of years at CFHS. They use secure messaging for patient communications as well as messaging to other organizations and providers. Changes related to NHHIO did require the implementation of a new HISP with MedAllies. The organization can send direct secure messages to anyone in the Surescripts directory or anyone who has some sort of connection to a HISP. They can also use the secure messaging platform to communicate via DSM to anyone with a valid email address. This is done via a process where the end user receives a generic notification that they have a secure message to retrieve from the CFHS Secure Message server. They then log-in to view/retrieve their message.
- *Memorial Hospital:* The hospital can communicate via direct secure messaging for patients and providers. The functionality is part of their newly installed Epic EMR. The hospital has also implemented Imprivata Cortext to perform secure text messaging.

June 30, 2019 Update

- *Ammonoosuc Community Health Services (ACHS)*: There has been is no change in DSM by this partner during the reporting period. As previously reported, ACHS uses functionality within their Centricity electronic health record to send secure messages to patients. They have the functionality to send messages to other providers but currently that is not their practice.
- *Huggins Hospital*: There has been is no change in DSM by this partner during the reporting period. As previously reported, Huggins continues to use direct secure messaging through their patient portal for patient communications. Their EMR has HIPAA compliant DSM functionality to communicate with other providers. The organization currently uses two different EMR's for the ED and primary care. In the future, they will be transitioning to Allscripts for all EMR needs and DSM functionality will evolve at that time.
- *Indian Stream Health Center (ISHC)*: There has been is no change in DSM by this partner during the reporting period. As previously reported, ISHC uses TigerConnect to facilitate secure messaging between providers and patients. They currently do not send secure messages to other providers.
- *North Country Healthcare (NCH)* Hospitals: There has been is no change in DSM by this partner during the reporting period. As previously reported, all four NCH affiliates are in the process of implementing Imprivata as a secure messaging platform. This was originally planned to be live by end of 2018, but the implementation was stalled when the affiliates learned that they would first have to complete implementation of active directory protocols across all affiliates in order to support this platform. This has delayed rollout of the Imprivata which is targeted for use by the end of 2019. All NCH affiliates also maintain patient portals for secure communications with patients and peer to peer transmission of patient information consistent with the Medicare EHR Incentive Program, otherwise known as the "Meaningful Use" requirements.
- *Northern Human Services (NHS)*: NHS had previously installed DSM functionality, but vendor issues were cited as barriers to this partner using the functionality. There was hope that a new upgrade from the vendor would make this technology more usable, but at this time NHS' evaluation of the

DSM tools from their vendor continues to raise concerns that the design of this functionality remains a barrier to its productive use.

- *White Mountain Community Health Center (WMCHC)*: There has been is no change in DSM by this partner during the reporting period. As previously reported, WMCHC has a patient portal that they use to communicate with patients if the patient has enrolled in the portal. They do not currently have other secure messaging technology to provide email communication with other providers or clients.
- *Saco River Medical Group (SRMG)*: There has been is no change in DSM by this partner during the reporting period. As previously reported, the practice has a fully functional patient portal and direct secure messaging via their EMR. They can receive and send messages. The challenge that SRMG has encountered is that many of the organizations they work with do not have DSM in place and therefore cannot engage in this form of communication.
- *Coös County Family Health Services (CCFHS)*: There has been is no change in DSM by this partner during the reporting period. As previously reported, DSM has been in place for a number of years at CCFHS. They use secure messaging for patient communications as well as messaging to other organizations and providers using compatible platforms and using the secure messaging platform to communicate via DSM to anyone who has a valid email address. This process generates a generic notification to the end user that they have a secure message, and the user then logs in to the CCFHS Secure Message server to view/retrieve their message.
- *Memorial Hospital*: There has been is no change in DSM by this partner during the reporting period. As previously reported, the hospital can communicate via direct secure messaging for patients and providers. The functionality is part of their newly installed Epic EMR. The hospital has also implemented Imprivata Cortext to send secure text messages.
- *Friendship House, Cottage Hospital* and *White Horse Addiction Center* have not yet confirmed the use of Direct Secure Messaging at this time. The Region 7 IDN team remains available to assist these partners with implementation of this technology when their unique organizational circumstances are such that they feel they have the necessary bandwidth to explore and implement a DSM option.

December 31, 2019 Update

- *Ammonoosuc Community Health Services (ACHS)*: There has been is no change in DSM by this partner during the reporting period. As previously reported, ACHS uses functionality within their Centricity electronic health record to send secure messages to patients. They have the functionality to send messages to other providers but currently that is not their practice.
- *Huggins Hospital*: There has been is no change in DSM by this partner during the reporting period. As previously reported, Huggins continues to use direct secure messaging through their patient portal for patient communications. Their EMR has HIPAA compliant DSM functionality to communicate with other providers. The organization currently uses two different EMR's for the ED and primary care. In the future, they will be transitioning to Allscripts for all EMR needs and DSM functionality will evolve at that time.
- *Indian Stream Health Center (ISHC)*: There has been is no change in DSM by this partner during the reporting period. As previously reported, ISHC uses TigerConnect to facilitate secure messaging between providers and patients. They currently do not send secure messages to other providers.
- *North Country Healthcare (NCH)* Hospitals: There has been is no change in DSM by this partner during the reporting period. As of the time of this writing, NCH has completed the process of implementing Imprivata as a secure messaging platform on a provider by provider voluntary basis, with a great deal of initial uptake, particularly in the realm of home health. All NCH affiliates also maintain patient portals for secure communications with patients and peer to peer transmission of

patient information consistent with the Medicare EHR Incentive Program, otherwise known as the "Meaningful Use" requirements.

- *Northern Human Services (NHS)*: NHS had previously installed DSM functionality, but vendor issues were cited as barriers to this partner using the functionality. There was hope that a new upgrade from the vendor would make this technology more usable, but at this time NHS' evaluation of the DSM tools from their vendor continues to raise concerns that the design of this functionality remains a barrier to its productive use.
- *White Mountain Community Health Center (WMCHC)*: There has been is no change in DSM by this partner during the reporting period. As previously reported, WMCHC has a patient portal that they use to communicate with patients if the patient has enrolled in the portal. They do not currently have other secure messaging technology to provide email communication with other providers or clients.
- *Saco River Medical Group (SRMG)*: There has been is no change in DSM by this partner during the reporting period. As previously reported, the practice has a fully functional patient portal and direct secure messaging via their EMR. They can receive and send messages. The challenge that SRMG has encountered is that many of the organizations they work with do not have DSM in place and therefore cannot engage in this form of communication.
- *Coös County Family Health Services (CCFHS)*: There has been is no change in DSM by this partner during the reporting period. As previously reported, DSM has been in place for a number of years at CCFHS. They use secure messaging for patient communications as well as messaging to other organizations and providers using compatible platforms and use the secure messaging platform to communicate via DSM to anyone who has a valid email address. This process generates a generic notification to the end user that they have a secure message, and the user then logs in to the CCFHS Secure Message server to view/retrieve their message.
- *Memorial Hospital*: There has been is no change in DSM by this partner during the reporting period. As previously reported, the hospital can communicate via direct secure messaging for patients and providers. The functionality is part of their newly installed Epic EMR. The hospital has also implemented Imprivata Cortext to send secure text messages.
- *Friendship House, Cottage Hospital* and *White Horse Addiction Center* have not yet confirmed the use of Direct Secure Messaging at this time. The Region 7 IDN team remains available to assist these partners with implementation of this technology when their unique organizational circumstances are such that they feel they have the necessary bandwidth to explore and implement a DSM option.

Project Component 1-4: Ongoing Assessment Follow Up and Support of Adopted Sub Regions

December 31, 2018

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 six-month follow up plan and work to close the gaps identified through the assessment.

Given that the initial integration trainings began in March of 2018 and that the rest of the region has come on sporadically in the intervening months, Region 7 is not ready to initiate a fully study via a HIT Utilization survey. However, the HIT Integration Coach continues to follow up directly with B1 user-organizations in the Region like CCFHS and White Mountains to discuss utilization, challenges, successes, and next steps. The Integration Coach also offers support through the coordination of the IDN 7 Webinar Series, newsletter work and Basecamp posting. As the active cohort grows, Region 7 will formalize this follow up and institute a survey as indicated above.

June 30, 2019 Update

As reported in the previous period, the Region 7 IDN team has remained available to assist partners with integration efforts. The HIT Integration Coach provided support to partners considering implementation and has encouraged heavy utilizers to share their successes and challenges through vehicles like the HIT/Data Workgroup and Quarterly meetings. While some progress has been made during this reporting period, several partners are currently either vetting or just beginning implementation of this health information technology. As a result, the Region 7 IDN team remains concerned that a full study via the HIT Utilization survey will not provide actionable results. During the upcoming reporting period, the Region 7 IDN team will continue to support partners in their integration efforts and establish a timeline for the full study.

December 31, 2019 Update

The Region 7 IDN team continues to be available to assist partners with IT-related integration efforts. During this reporting period, Region 7 IDN partners participated in regular meetings of the HIT/Data workgroup, discussing the use of IT to support integration efforts, including reporting of outcomes measures and adopting of technology solutions like Collective Medical's Shared Care Plan, consideration of state-wide activities related to potential use of the UniteUs platform for closed loop referrals, and adoption of direct secure messaging technologies. As this is the final year of the DSRIP, demonstrating value to implementing partners will be key to sustaining use of health information technology in support of integrated care delivery beyond the period of the project.

Project Component 2: Data Management

HIT Capabilities and Standards Addressed	Minimum/Desired Optional	For Whom	By When
Data Extraction/Validation	Minimum	All Participants	3/01/2018
Data Analysis/Validation	Optional	Regional Lead	3/01/2018
Population Health Tool	Optional	Regional Lead, Selected Participants	8/01/2018

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 pursues a regional data management infrastructure as a HIT project component.

Project Component 2-1: Regional Data Infrastructure Buildout

December 31, 2018

The most pressing need for data management is to create a regional structure that will accommodate reporting on outcome measures for all six DSRIP projects in a regional manner. The period covered by this report (07/01/2018-12/31/2018) contained work on two separate reporting deadlines (the first, which was due in August, and the third which will be due in February 2019) as well as a historical data request from calendar year 2015 on two of the CARE.03 measures.

The second reporting period, covering the six-month period 01/01/2018 to 06/30/2018 was successfully completed by eight of our B1 partners, up from five in the first reporting period. In addition to Huggins Hospital, Ammonoosuc Community Health Center, White Mountain Community Health Center and Indian Stream Health Center, the following newly engaged partners submitted at least denominator data in the second period: Northern Human Services, Coös County Family Health Services, Saco River Medical Group, and Cottage Hospital/Rowe Health Center. Memorial Hospital was the only partner to report in the first period but not the second.

The historical data request was fulfilled by all seven of the eight partners who reported in the second reporting period, with only Huggins unable to fulfill this request due to a lack of staff availability for some unavoidable manual extraction for this request. Memorial Hospital was also unable to engage on this request due to an ongoing I upgrade.

The remaining providers (North Country Healthcare, Friendship House, White Horse Addition Center) did not engage because of administrative hurdles, which have since been cleared and all are engaging with MAeHC and IDN Region 7 in pursuit of reporting in the third period.

Additionally, Region 7 is pleased to note that Memorial has completed their I upgrade and has re-engaged, bringing Region 7 to a full participation in reporting by appropriate partners for the first time in the project.

Please see the list below for the snapshot status of partners regarding the reporting requirement. More details are provided in the partner by partner updates later in this same section.

Provider	First Reporting Period Status	Second Reporting Period Status	Historical File Submission 10/15	Projected Status for Third Period
Ammonoosuc Community Health Services	Complete	Complete	Complete	Complete
Androscoggin Valley Hospital	*	*	*	*
Coös County Family Health Services	Did not report (held data back because of 42 CFR Part 2 concerns)	Complete	Complete	Complete
Cottage Hospital/Rowe Health Center	Did not report	Partial	Complete	Complete
Friendship House	Did Not Report	Did Not Report	No patients in sample	Complete
Huggins Hospital	Partial	Partial	Did Not Report	Complete
Indian Stream Health Center	Complete	Complete	Complete	Complete
Littleton Regional Healthcare	*	*	*	*
North Country Healthcare	Did Not Report	Did Not Report	Did Not Report	Partial
Northern Human Services	Did Not Report	Complete	Complete	Complete
Memorial Hospital	Partial	Did Not Report	Did Not Report	Partial
Saco River Medical Group	Did Not Report	Complete	Complete	Complete
Upper Connecticut Valley Hospital	*	*	*	*
Weeks Medical Center	*	*	*	*
White Horse Addiction Center	Did Not Report	Did Not Report	No patients in sample	Partial
White Mountain Community Health Center	Complete	Complete	Complete	Complete

*See entry for North Country Health Care

Partner by Partner Updates

- *Ammonoosuc Community Health Services:* ACHS has been a model partner in terms of data reporting and has satisfied all requirements on time. They appear to be on track to report successfully in the third period, and we expect numerator performance from them on CCSA, given work they have completed internally to align their screening tools to accommodate this process.
- *Androscoggin Valley Hospital:* As AVH is part of the North Country Healthcare hospital affiliation, please see the entry for North Country Healthcare.
- *Coös County Family Health Services:* Though CCFHS held back in the initial period due to concerns around 42 CFR Part 2, explaining the process to them cleared the path for them to report successfully in the second and historical requests. Staff shortages have resulted in them using IDN training and technology request funding to engage MAeHC directly for data extraction assistance. It is hoped that through this process CCFHS can create a sustainable process for reporting data to MAeHC in monthly files rather than batch reporting at the end of each reporting period.
- *Cottage Hospital:* Technical limitations prevented Cottage Hospital from reporting at all in the first reporting period, but through sustained work with MAeHC they have made great strides. They still have a gap in their reporting related to the SUD-Screening component of ASSESS_SCREEN_02 but they have fully reported in depression component and submitted denominators for ASSESS_SCREEN_01 and ASSESS_SCREEN_02. Recognizing that some of these limitations may be due to the configuration of their local I, Cottage Hospital has engaged their I vendor to work directly with MAeHC to build standard fields and reports to ease the reporting

burden in the third period and beyond. However, the late institution of these changes may mean that the third period may reflect the historical challenges with Cottage's fields, an issue they share with Memorial and others.

- *Friendship House:* A wholly covered 42 CFR Part 2 Provider, Friendship House held back reporting in the first reporting period. In the second period, a site move took vital resources away from their ability to report. The state sample for the historical request did not have any Friendship House attributed patients. Now, approaching the third reporting deadline they are engaging with MAeHC with an eye towards reporting all 2018 data at once.
- *Huggins Hospital:* An early partner who has engaged with the IDN on many levels from day one, Huggins has nevertheless encountered several challenges related to the reporting of data for the statewide outcome measures, all of which have to do with their ability to pull the data in an automated way. They have reported some data for all periods requested, excepting only the historical request, which they were not able to process due to staffing shortages. For the third period they have engaged directly with MAeHC to help solve this issue.
- *Indian Stream Health Center:* ISHC engaged early on and has reported data in all periods as requested. They are on a monthly flat file submission schedule that allows them to fulfill the requirements without the strenuous last-minute effort.
- *Littleton Regional Healthcare:* As LRH is part of the North Country Healthcare hospital affiliation, please see the entry for North Country Healthcare.
- *Memorial Hospital:* Memorial Hospital engaged with IDN Region 7 early on and was able to report some data for the pilot reporting period covering 07/01/2017-12/31/2017. However, an organization wide I migration caused them to disengage for the second and historical request periods. However, in the leadup to the third period's reporting deadline they have engaged their I vendors directly with MAeHC in order to make the ongoing reporting as seamless and automated as possible. This coincides with clinical work to begin to implement the CCSA first in behavioral health providers and then in the totality of their primary care. Though the fruits of both the I modifications and the CCSA implementation occurred well into 2018, we would expect some results to show in their reporting for the latter half of that year. We would also expect much better performance for future reporting periods.
- *North Country Healthcare (NCH):* An affiliation that combines several partners, including the four hospitals Androscoggin Valley Hospital (AVH), Littleton Regional Healthcare (LRH), Upper Connecticut Valley Hospital (UCVH) and Weeks Medical Center (Weeks), NCH accounts for a majority of Region 7 hospital partners and between Weeks and LRH, a large number of primary care patients in Region 7. However, the initiation of reporting the Statewide Outcome measures coincided with the action of affiliation by these partners, meaning that they were unable to engage directly with reporting until just recently. In recognition of their new status they asked to sign their data use agreements and engage as an affiliation rather than as individual partners. With all administrative hurdles cleared, the team assigned, led primarily by Weeks staff, have begun to approach the task of reporting. They are aided in this task by the fact that only LRH and Weeks have primary care arms, meaning that the immediate reporting period of 02/15/2019 they would be the primary focus. Region 7 is happy with the hard work being done by NCH and their team in the face of the catch-up task they are now presented with, and we are hopefully they will report fully in the third period and beyond.
- *Northern Human Services:* IDN Region 7's sole community mental health center, Northern Human Services represents a key partner for region 7, without whom many of the Behavioral Health goals of the IDN would be difficult or impossible to realize. Their novel proposal to

collocate primary care directly in one of their sites (through a partnership with Coös County Family Health Services) was met with the full support of the IDN Region 7 steering committee. Their value to the Region stretches into the reporting of statewide outcome measures as well. Though they held back first reporting period data because of concerns around 42 CFR Part 2, the system modifications by MAeHC and the modifications to the data use agreement by Region 7 allowed them to fully report in the second and historical periods. Region 7 believes they will report fully again in the third period (deadline 02/15/2019).

- *Saco River Medical Group:* Saco River was unable to engage on the first reporting period but engaged on the second. Despite being a smaller agency that lacked much in the way of traditional reporting infrastructure they were nevertheless able to report fully in both the second and historical reporting deadlines. They were able to do so because of the tireless support of their staff and their engagement of MAeHC directly in the data extraction process using IDN Training and Technology Funding request. Region 7 is hopeful that the structures set up by this investment will continue in the third period and beyond.
- *Upper Connecticut Valley Hospital:* As UCVH is part of the North Country Healthcare hospital affiliation, please see the entry for North Country Healthcare.
- *Weeks Medical Center:* As Weeks is part of the North Country Healthcare hospital affiliation, please see the entry for North Country Healthcare.
- *White Horse Addiction Center (WHAC):* A wholly covered 42 CFR Part 2 SUD-treatment provider, WHAC was not engaged in the first period. IDN Region 7 began outreaching to them over the late summer and fall, culminating in a productive face to face meeting in November that kicked off their involvement in numerous IDN initiatives including statewide outcome reporting. It is hoped that many of the lessons that are being learned working with Friendship House (use of the WITS system) can be applied here, as they are a similar provider. As of the time of this writing, they have a scheduled kickoff call for late January (the earliest time their staff could be available). It is hoped that, despite the short deadline, a small denominator may allow them to report manually for the 02/15/2019 deadline.

Summary

Overall, Region 7 is very pleased with the progress that has happened in the last six months, seeing engagement from all targeted providers for the first time. Moreover, Region 7 is pleased with the hard work of these partners to catch up and, in some cases, modify their data systems to better interface with the IDN outcome measures. Many of the newly engaged have a long way to go in terms of catching up to the early high-performers (such as Northern Human Services and Ammonoosuc Community Health Services) but Region 7's ability to fulfill the reporting requirement is in a much stronger place now than on 07/01/2018.

June 30, 2019 Update

The most pressing need for data management is to create a regional structure that will accommodate reporting on outcome measures for all six DSRIP projects in a regional manner. The period covered by this report (01/01/2019-06/30/2019) contained work on two separate reporting deadlines. The first, which was due in February was focused on reporting the 6-month measures that were the focus of previous reporting periods. The second deadline, which came due in June, was focused instead on full year measures that had an increase in reporting complexity and a different focus in terms of settings.

A complicating factor that occurred during the time period being measured was *Littleton Regional Healthcare (LRH)* beginning the process of withdrawing from the regional hospital affiliation *North Country Healthcare (NCH)*. Their departure from this affiliation meant that although the IDN had

previously been able to enjoy a single point of contact for reporting from all hospitals, new parallel contacts would have to be established at LRH, along with the signing of new user agreements and business associates agreements to establish proper data sharing with LRH.

Please see the list below for the snapshot status of partners regarding the reporting requirement. More details are provided in the partner by partner updates later in this same section.

Provider	1st Reporting Period Status	2nd Reporting Period Status	Historical File Submission 10/15	3rd Reporting Period Status	4th Reporting Period Status
Ammonoosuc Community Health Services	Complete	Complete	Complete	Complete	Complete
Androscoggin Valley Hospital	*	*	*	*	Did not report
Coös County Family Health Services	Did not report (held data back because of 42 CFR Part 2 concerns)	Complete	Complete	Complete	Complete
Cottage Hospital/Rowe Health Center	Did not report	Partial	Complete	Complete	Complete
Friendship House	Did Not Report	Did Not Report	No patients in sample	Complete	N/A
Huggins Hospital	Partial	Partial	Did Not Report	Complete	Complete
Indian Stream Health Center	Complete	Complete	Complete	Complete	Did not report
Littleton Regional Healthcare	*	*	*	*	Did not report
North Country Healthcare	Did Not Report	Did Not Report	Did Not Report	Partial	Partial
Northern Human Services	Did Not Report	Complete	Complete	Complete	Complete
Memorial Hospital	Partial	Did Not Report	Did Not Report	Complete	Complete
Saco River Medical Group	Did Not Report	Complete	Complete	Complete	Partial
Upper Connecticut Valley Hospital	*	*	*	*	*
Weeks Medical Center	*	*	*	*	*
White Horse Addiction Center	Did Not Report	Did Not Report	No patients in sample	Complete	N/A
White Mountain Community Health Center	Complete	Complete	Complete	Complete	Complete

Partner by Partner Updates

- *Ammonoosuc Community Health Services (ACHS):* ACHS has been a model partner in terms of data reporting and has satisfied all requirements on time. They have reported successfully in both the third and fourth periods.
- *Androscoggin Valley Hospital (AVH):* As AVH is part of the North Country Healthcare hospital affiliation, please see the entry for North Country Healthcare.
- *Coös County Family Health Services (CCFHS):* CCFHS has worked directly with MAeHC in a contract supported by IDN funding and has produced complete reporting for the third and fourth reporting periods.
- *Cottage Hospital:* Cottage has engaged their EMR vendor to work directly with MAeHC and has reported successfully in both the third and fourth periods.
- *Friendship House:* Leveraging onsite expertise, Friendship House used the MAeHC online portal to manually enter data for the third reporting period. Because of the different denominator inclusion criteria for the Fourth Reporting period, Friendship House did not have to report in that period.

- *Huggins Hospital:* Huggins successfully engaged MAeHC directly to assist with their reporting in the third reporting period and reported successfully. For the fourth period, they engaged a large onsite manual abstraction team in order to successfully report on the full year measures.
- *Indian Stream Health Center (ISHC):* ISHC has reported data in all 6-month periods (so far, periods 1 through 3) as requested. They are on a monthly flat file submission schedule that allows them to fulfill the requirements without the strenuous last-minute effort. However, key staff departures in early 2019 meant that they were unable to participate in reporting the full year measures in June. IDN Region 7 and MAeHC are working with the remaining onsite staff in order to come up with a plan to get them back on track for period 5.
- *Littleton Regional Healthcare (LRH):* As LRH was part of the *North Country Healthcare (NCH)* affiliation during the third reporting deadline, they were able to submit data for ASSESS_SCREEN.01. Unfortunately, as has been mentioned earlier in this section, LRH has begun the process to withdraw from NCH, meaning that by the time the proper documents were signed and staff assigned, there was not enough time for them to report on the full year measures due in June. However, such documents and staff are now in place and IDN Region 7 and MAeHC are working directly with these staff to position LRH for success in the 5th reporting period.
- *Memorial Hospital:* After engaging their EHR vendor directly with MAeHC to discuss reporting, Memorial has been able to report successfully on both the third and fourth period.
- *North Country Healthcare (NCH):* An affiliation that combines several partners, including the four hospitals *Androscoggin Valley Hospital (AVH), Littleton Regional Healthcare (LRH), Upper Connecticut Valley Hospital (UCVH)* and *Weeks Medical Center (WMC)*, NCH accounts for a majority of Region 7 hospital partners and between Weeks and LRH, a large number of primary care patients in Region 7. However, as has been mentioned before, LRH elected to leave the affiliation in March 2019. The remaining hospitals (AVH, UCVH and WMC) are remaining in the affiliation. For the 6-month measures due in February (when LRH was still a member of the affiliation), NCH reported successfully on ASSESS_SCREEN.01 for LRH and both ASSESS_SCREEN.01 and ASSESS_SCREEN.04 for WMC. In the fourth reporting period, it appears that WMC was able to report successfully on all full year measures (they are still pending a MAeHC review as of the time of this writing).
- *Northern Human Services (NHS):* Northern Human Services has been a model partner in terms of statewide outcome reporting, reporting successfully in both the third and fourth periods.
- *Saco River Medical Group (SRMG):* SRMG had previously engaged MAeHC directly for data abstraction through an IDN-funded contract. They were able to leverage this into fully reporting in the third reporting period. Because of a slowdown in funding being released, they were not able to engage MAeHC in a similar contract for the full year measures due in June. Because of this, it appears that they were only able to partially report these measures.
- *Upper Connecticut Valley Hospital (UCVH):* As UCVH is part of the North Country Healthcare hospital affiliation, please see the entry for North Country Healthcare.
- *Weeks Medical Center (WMC):* As WMC is part of the North Country Healthcare hospital affiliation, please see the entry for North Country Healthcare.
- *White Horse Addiction Center (WHAC):* Much like Friendship House, White Horse engaged an onsite team to use a manual process to fully report for the 6-month measures due in February. As with Friendship House, the different denominator inclusions for the full year measures meant that they did not have to report on the full year measures.

Summary

Overall, Region 7 is very pleased with the progress that has happened in the last six months. In this time, the region was able to report fully on a measure (ASSESS_SCREEN.01) for the first time ever. The

region has also seen challenges arising from structural changes to regional organizations (LRH/NCH), staff departures (ISHC) and funding delays (Saco) and the challenges of introducing novel and complex measures to a diverse group of organizations for the June deadline. Despite this, the region was still able to report at least partially on the full year measures with 9 out of the required 11 partners. The region, with continued hard work of partner teams, regional staff and vendors (including MAeHC) should be able to perform better on the more familiar 6th month measures in period 5.

December 31, 2019 Update

Please see the list below for the snapshot status of partners regarding the reporting requirement. More details are provided in the partner by partner updates later in this same section.

Provider	Reporting Status by Reporting Period					
	Reporting Period 1	Reporting Period 2	Historical File Submission 10/15	Reporting Period 3	Reporting Period 4	Reporting Period 5
Ammonoosuc Community Health Services	Complete	Complete	Complete	Complete	Complete	Complete
Androscoggin Valley Hospital	*	*	*	*	Did not report	*
Coös County Family Health Services	Did not report (held data back because of 42 CFR Part 2 concerns)	Complete	Complete	Complete	Complete	Complete
Cottage Hospital/Rowe Health Center	Did not report	Partial	Complete	Complete	Complete	Complete
Friendship House	Did Not Report	Did Not Report	No patients in sample	Complete	N/A	Complete
Huggins Hospital	Partial	Partial	Did Not Report	Complete	Complete	Complete
Indian Stream Health Center	Complete	Complete	Complete	Complete	Did not report	Did Not Report
Littleton Regional Healthcare	*	*	*	*	Did not report	Complete
North Country Healthcare	Did Not Report	Did Not Report	Did Not Report	Partial	Partial	Partial
Northern Human Services	Did Not Report	Complete	Complete	Complete	Complete	Complete
Memorial Hospital	Partial	Did Not Report	Did Not Report	Complete	Complete	Complete
Saco River Medical Group	Did Not Report	Complete	Complete	Complete	Partial	Complete
Upper Connecticut Valley Hospital	*	*	*	*	*	*
Weeks Medical Center	*	*	*	*	*	*
White Horse Addiction Center	Did Not Report	Did Not Report	No patients in sample	Complete	N/A	Complete
White Mountain Community Health Center	Complete	Complete	Complete	Complete	Complete	Complete

Partner by Partner Updates (5th Period, 6 Month Measures reported August 2019)

- *Ammonoosuc Community Health Services (ACHS):* ACHS Continues to report fully. Critically, they are providing one of the largest sources of ASSESS_SCREEN.01 numerators in the region, with 478 of 1196 denominator patients meeting the criteria for numerator inclusion (a raw rate of 40%). Other than Northern Human Services, this is Region 7's highest rate.

- *Androscoggin Valley Hospital (AVH):* As AVH is part of the North Country Healthcare hospital affiliation, please see the entry for North Country Healthcare.
- *Coös County Family Health Services (CCFHS):* Coos County continues to report fully. Their lack of CCSA uptake (remaining at 0%) combined with a high denominator population is a challenge for meeting regional rates. However, their rate for ASESSS_SCREEN.04 (the tobacco screening and intervention assessment) sits at 71%, helping drive positive Region 7 performance on this measure.
- *Cottage Hospital:* Cottage's transition to a new EHR (Athena) was completed during the measurement period for reporting period 5, and Cottage was able to successfully leverage Athena resources to complete their reporting requirement. Like CCFHS, their performance on ASSESS_SCREEN.01 (0%) is a challenge to regional success, but their improved data structure speaks to a better prognosis for the 6th reporting period.
- *Friendship House:* For the 5th period, Friendship House continued to report a small denominator population, and contribute high rates for ASSESS_SCREEN.02 and ASSESS_SCREEN.04 (78% and 100% respectively). While they reported a 0% for ASSESS_SCREEN.01, approval of a CCSA process used at Friendship House that occurred in September should mean that they will perform on this measure in Period 6.
- *Huggins Hospital:* After committing a great deal of resources into the reporting of the 4th period full-year measures, Huggins was able to report more easily on the more familiar 6-month measures. One of the first Region 7 partners to report CCSA implementation, they continue to report a small numerator on this measure (1%). Combined with a high denominator, they, like Coos, pose a challenge to regional compliance on the ASSESS_SCREEN.01 performance going forward. That said, the status of their CCSA as a pilot program in their behavioral health unit with the potential to expand to primary care, speaks to a possible regional pathway to compliance on this measure.
- *Indian Stream Health Center (ISHC):* Due to staffing departures and positions in their IT department remaining vacant since March, ISHC was unable to report in this period. Despite this challenge, ISHC is happy to report that a team has been assigned to report on IDN measures going forward and the Region looks forward to having the contributions of ISHC reflected in the next reporting period.
- *Littleton Regional Healthcare (LRH):* LRH, after a period of non-reporting related to their reorganization in the wake of departure from North Country Healthcare, has re-engaged with IDN reporting. While their performance on ASSESS_SCREEN.01 remains at 0, Region 7 has reason to believe that the dedication of data resources to the project on the LRH side will result in a better ability to extract data on their ongoing CCSA implementation. They demonstrated excellent performance on ASSESS_SCREEN.02 and ASSESS_SCREEN.04, indicating that once the data is encapsulated correctly in their system, they have robust capability to report.
- *Memorial Hospital:* Memorial continues to report fully, providing low but improving performance on ASSESS_SCREEN.02 and .04 (16% and 19% respectively).
- *North Country Healthcare (NCH):* An affiliation that combines several partners, including the three hospitals *Androscoggin Valley Hospital (AVH), Upper Connecticut Valley Hospital (UCVH)* and *Weeks Medical Center (WMC)*, NCH accounts for almost half of Region 7 hospital partners and WMC's rural health clinics provide primary care services to a large number of patients in Region 7. While AVH and UCVH do not have dedicated primary care and thus did not report in period 5, WMC has 4 primary care locations that all reported in the same period. All reported fully and contributed numerator and denominator data for all measures. Performance on the ASSESS_SCREEN.01 measure, a focus for Region 7 in this period, was between a low end of 1% at one site and a high end of 27% at another, reflecting the phased rollout approach that WMC has taken on CCSA implementation. Region 7 is hopeful that with another 6 months of implementation and their large

denominator contribution, WMC's performance will help drive regional performance on this measure.

- *Northern Human Services (NHS):* Region 7's only Community Mental Health Center accounts for much of the performance across the three measures that were the focus of period 5. By incorporating existing screening questions into a CCSA, they were able to perform at an extremely high rate on this measure (94%). Their performance on ASSESS_SCREEN.02 is also robust (77%) while their performance on ASSSESS_SCREEN.04 (27%) remains an opportunity for improvement but is still well higher than other partners.
- *Saco River Medical Group (SRMG):* SRMG reported fully in period 5 and while ASSESS_SCREEN.01 remains an opportunity for improvement (0%) their performance on ASSESS_SCREEN.02 and ASSESS_SCREEN.04 helped contribute to regional performance on these measures (100% and 50% respectively).
- *Upper Connecticut Valley Hospital (UCVH):* As UCVH is part of the North Country Healthcare hospital affiliation, please see the entry for North Country Healthcare.
- *Weeks Medical Center (WMC):* As WMC is part of the North Country Healthcare hospital affiliation, please see the entry for North Country Healthcare.
- *White Horse Addiction Center (WHAC):* The approval of WHAC's CCSA process prior to this reporting period allowed them to demonstrate great performance on this measure as well as ASSESS_SCREEN.02 (100% for both). ASSESS_SCREEN.04 is an opportunity for improvement.
- *White Mountain Community Health Center (WMCHC):* WMCHC has reported fully in period 5 and was one of the original test sites for CCSA implementation. WMCHC continues to provide a small numerator, reflecting that this method has not had a chance to spread beyond their pilot population. Region 7 is hopeful that this process will expand, reflecting a higher rate in the 6th period. However, WMHC's strong performance on ASSESS_SCREEN.02 (65%) contributed to regional performance on this measure.

Summary

In the wake of the often-extreme commitments of staff time and partner resources into reporting on the full year measures, Region 7 IDN partners, with the exception of Indian Stream Health Center, reported fully on the 6-month measures due August 15th. Preliminary projections have IDN Region 7 "passing" the performance thresholds for ASSSES_SCREEN.02 and .04 and failing to achieve the threshold on ASSESS_SCREEN.01. It is hoped that with another 6 months of implementation, those partners with low but measurable progress on CCSA (WMC, WMCHC and Huggins) can join those with strong performance (ACHS, WHAC and NHS) and some of those on the cusp of implementing (LRH, Saco, and Friendship House) begin to contribute meaningful data to improve overall aggregate rates for the Region.

It is worth noting that the all-or-nothing reporting constraints imposed upon the project can be a barrier to participation. Huggins Hospital has already expressed concerns about significant investments of staff time into a process that is a single point of failure for the region, either because they are unable to report, or because their rate, when added to the regional aggregate, will result in a score below target for the region. Similarly, concerns exist that the all-or-nothing reporting requirement prevents the region from demonstrating improvements in the aggregate when situations occur that are outside the control of the IDN and partners who *are* successful in reporting. This structure will be a barrier as we enter into the last year of the project and partners begin to weigh out their costs of contribution against potential benefit.

Project Component 2-2: Population Health Analytics

December 31, 2018

IDN Region 7 will continue to seek out population health solutions that can help support the processes of the E5 project and beyond. Region 7 had targeted implementation of such a tool at one partner agency by 12/31/2018. Region 7 had hoped to leverage relationships with the hospital affiliation and others who have existing ACO commitments to find and leverage population health analytics.

However, challenges based around funding uncertainty and regulatory hurdles to using existing tools like MAeHC's Quality Data Center and CMT's PreManage Community have hampered the ability of the region to move forward in this area – as has lack of desire on the part of partners – who drive the IDN through their proposal process – to engage in a Population Health-focused project.

If funding allows, Region 7 will initiate this process on the regional level by incentivizing participation by a partner or group of smaller partners in a lead-agency initiated Population Health Analytics project.

June 30, 2019 Update

IDN Region 7 will continue to seek out population health solutions that can help support the processes of the E5 project and beyond. Region 7 had targeted implementation of such a tool at one partner agency by 12/31/2018. Region 7 had hoped to leverage relationships with the hospital affiliation and others who have existing ACO commitments to find and leverage population health analytics for the DSRIP target population, however, challenges based around funding uncertainty and regulatory hurdles to using existing tools like MAeHC's Quality Data Center and CMT's PreManage Community have hampered the ability of the region to move forward to engage in a Population Health-focused project, as has lack of desire on the part of partners who drive the IDN through their proposal process.

In the course of provider meetings in June of 2019, however, the Region 7 IDN team discovered that eight Region 7 partners, Ammonoosuc Community Health Services (ACHS), Androscoggin Valley Hospital (AVH), Coös County Family Health Services (CCFHS), Cottage Hospital, Indian Stream Health Center (ISHC), Littleton Regional Healthcare (LRH), Upper Connecticut Valley Hospital (UCVH) and Weeks Medical Center (WMC), had been using a population health analytics tool for their Medicare population that was contracted as part of their Medicare Shared Savings Program ACO in calendar years 2016-2018. They reported varied levels of success in using the LightBeam population health platform, albeit not with an IDN specific population. The ACO ended 12/31/2018 and they lost access to LightBeam in February after submitting value-based purchasing performance data to the Medicare program. While not specifically focused on the DSRIP target population, access to the LightBeam platform provided these partners with the opportunity to learn how to leverage population-based data to risk stratify their population, reduce unnecessary resource utilization, improve preventative screening processes, standardize behavioral health screenings and interventions, and improve patient outcomes.

Five of these same partners (ACHS, AVH, LRH, UCVH and WMC) have joined Huggins Hospital and several other agencies in the southern half of the state to form a new ACO that launches on July 1. As part of this new ACO, they will have access to another population health tool, this time hosted by new ACO partner Catholic Medical Center. In the upcoming period, IDN Region 7 staff will engage these partners to determine whether this new platform can be used with the DSRIP target population and in support of IDN initiatives. Considering this information, the Region 7 IDN team feels comfortable reporting that eight partners piloted the use of population health software by 12/31/18, far exceeding the original target set in the region's implementation plan.

December 31, 2019 Update

This section has previously been scored as meeting established targets, as a number of Region 7 IDN partners were using Population Health Analytics as the result of having participated in a Medicare Accountable Care Organization (ACO) from January 1, 2016 through December 31, 2018. During this reporting period, Region 7 IDN partners Ammonoosuc Community Health Services (ACHS), Androscoggin Valley Hospital (AVH), Huggins Hospital, Littleton Regional Healthcare (LRH), Upper Connecticut Valley Hospital (UCVH) and Weeks Medical Center (WMC) engaged with several other partners in southern NH to form the NHValuesCare ACO, continuing the ACO work that allows them to unite and leverage population health resources. The ACO was officially launched on July 1, 2019, and much of this reporting period was spent establishing the necessary workgroups to carry out improvement initiatives, including familiarization with a new population health platform.

As EHRs with expanded population health functions begin to be implemented across the region (such as Athena), Region 7 expects this type of system to become more widespread.

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

Potential HIT Capabilities and Standards Addressed	Minimum, Desired, or 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

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

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

Potential HIT Capabilities and Standards Addressed	Minimum, Desired, or 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

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

December 31, 2018

Funding for projects is in a delayed state because of uncertainty about availability of funds. HIT Proposals provisionally funded in the reporting period 07/01/2018-12/31/2018 which fall into the general IT categories include:

Partner Organization	Funding Provisionally Allocated	Project Description	HIT Component
Saco River Medical Group	$70,399 (agency total, MAeHC budget will be a subset of this)	As part of a larger collaborative proposal, Saco has requested funding to continue to engage directly with MAeHC (for 45 hours) to shore up their reporting capabilities.	Discrete Electronic Data Capture
North Country Serenity Center	$15,550	Hire and equip one full time data admin to assist with the collection of data on clients they are assisting with recovery.	Electronic Data Capture, Secured Data Storage, Discrete Electronic Data Capture
Northern Human Services	$2,558.86	Equip technology needs (laptop, connectivity, etc.) for second of two integrated Clinics – this time located in Littleton's Ammonoosuc Community Health Services location.	Electronic Data Capture, Secured Data Storage, Discrete Electronic Data Capture, Internet Connectivity
Tri-County Community Action Program	$1,500	Equip connectivity needs (phone and mobile hotspot) for Critical Time Intervention-implementing staff to allow them to communicate and record encounters.	Internet Connectivity, Electronic Data Capture, Discrete Electronic Data Capture
Weeks Medical Center	$66,365 (entire salary line item, medical assistant position not broken out)	As part of a proposal to expand MAT services at Weeks, a medical assistant position will be funded. One of this person's primary responsibilities will be entry into the EMR of all relevant screening and encounter data for MAT patients.	Electronic Data Capture, Discrete Electronic Data Capture
Mount Washington Valley Supports Recovery	$850	Purchase of a laptop and internet connectivity to support staff engaged in a 24/7 emergency response service for people experiencing addiction crisis in their area.	Internet Connectivity, Electronic Data Capture, Discrete Electronic Data Capture

Partner Organization	Funding Provisionally Allocated	Project Description	HIT Component
White Horse Addiction Center	$2,550	Purchase of three laptops and internet connectivity to support staff engaged in a 24/7 emergency response service for people experiencing addiction crisis in their area.	Internet Connectivity, Electronic Data Capture, Discrete Electronic Data Capture
Total	**$23,008 + some portion of the $136,764**		

In addition to the traditional request for proposal process, IDN 7 has also offered its partners access to a quicker release "Training and Technology Request" of amounts of up to $5000 for training and technology needs related directly to the goals of IDN 7. In the last reporting period, the following agencies requested and received:

Partner Organization	Funding Provided	Project Description	HIT Component
Tri County Community Action Program	$779	Tri-CAP requested and was granted funding to provide a newly hired community health worker with a laptop.	Electronic Data Capture, Discrete Electronic Data Capture
Saco River Medical Group	$4,680	Saco requested and was granted funding to engage directly with MAeHC to complete requirements for the second reporting period ending August 15.	Discrete Electronic Data Capture
Coös County Family Health Services	$4,900	CCFHS requested and was granted funding to engage directly with MAeHC to complete requirements for the third reporting period due in February 2019	Discrete Electronic Data Capture

June 30, 2019 Update

Funding for projects was delayed because of uncertainty about availability of funds. As a result, all HIT Proposals provisionally funded in the reporting period 01/01/2019-06/30/2019 which fall into the general IT categories include proposals originally submitted in 2018 and reported as "provisionally funded" in the last SAR:

Partner Organization	Funding Provisionally Allocated	Project Description	HIT Component
North Country Serenity Center	$16,640	Hire and equip one full time data admin to assist with the collection of data on clients they are assisting with recovery.	Electronic Data Capture, Secured Data Storage, Discrete Electronic Data Capture
Northern Human Services	$4,700	Equip technology needs (laptop, connectivity, etc.) for second of two integrated Clinics – this time located in Littleton's Ammonoosuc Community Health Services location.	Electronic Data Capture, Secured Data Storage, Discrete Electronic Data Capture, Internet Connectivity

Partner Organization	Funding Provisionally Allocated	Project Description	HIT Component
White Horse Addiction Center	$2,550	Purchase of three laptops and internet connectivity to support staff engaged in a 24/7 emergency response service for people experiencing addiction crisis in their area.	Internet Connectivity, Electronic Data Capture, Discrete Electronic Data Capture
Total	$23,890		

In addition to the traditional request for proposal process, IDN 7 has also offered its partners access to a quicker release "Training and Technology Request" of amounts of up to $5000 for training and technology needs related directly to the goals of IDN 7. Due to the uncertainty in funding, no new training and technology requests were granted In the last reporting period, but the Steering Committee agreed to raise the maximum amount of these awards to $10,000 in anticipation of technology supports that will be required to help partners achieve DSRIP targets in the last half of the demonstration.

December 31, 2019 Update

A major development in the area of RFP support for IDN initiatives was the offer of funds by the IDN Region 7 to partners who agreed to meet the basics of becoming a coordinated care practice. Such funds could be then used to support appropriate IDN initiatives at the partner agency. To date, eleven partners have fully executed these agreements, including:

- Ammonoosuc Community Health Services
- Coös County Department of Corrections
- Friendship House
- Indian Stream Health Center
- Mount Washington Valley Supports Recovery
- North Country Serenity Center
- Northern Human Services
- Saco River Medical Group
- Tri-County Community Action Program
- White Horse Addiction Center
- White Mountain Community Health Center

As a part of their obligations under the funding Memoranda of Understanding, the above partners have agreed to adopt all necessary technology tools including engagement with the Collective Medical network and the use of direct secure messaging as applicable. They also agreed to abide by any regional or statewide outcome or process reporting pertinent to their setting. This agreement, along with funds which can be used for support of these IT projects, should go a long way in helping Region 7 achieve its DSRIP goals by the close of the project.

A2-4. IDN HIT: Evaluation Project Targets

December 31, 2018

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	13	0	1	3*
Number of Participants Exchanging Information Via Shared Care Plan Tool	13	0	0	3*
Hospitals Sending Event Notifications to PreManage ED	7	1	4	4**
Number of Participants Exchanging Information Via Direct Secure Messaging (By 2020)	35	15 (presence of capabilities only)	16 (presence of capabilities only)	10
Reporting Periods Successfully Completed (By 2020)	11	0	1	3
Pilot Participants Using Population Health Tool (By 2020)	5	0	0	0***
Region 7 Patient Lives In PreManage Primary (By 2020) – includes any patient on the census upload	19601	0	0	15,273
Participant HIT Projects Addressing Minimum/Desired/Optional Capabilities Funded and Completed (By 2020)	5	0	5 (11 funded)	8 (22 funded or provisionally funded)

Region 7 IDN has changed the target for the number of participant sites with at least one member trained in use of PreManage Primary and number of participants exchanging info via a shared care plan to be 13 agencies by 2018 to match with our B1 project. When Region 7 IDN staff first saw this measure it was thought that all sites needed to use a CCSA and shared care plan, but now it is known that it is only required for the behavioral health and primary care organizations in the region.

Region 7 IDN is still working with IDN partners regarding use of direct secure messaging (DSM). The idea behind the DSM exchange measure was that it could be a standalone solution that could be used to connect partners that lack other methods to securely receive and transmit necessary information. When the region's implementation plan was submitted the plan was to cast a wide net over the entire IDN membership because it was unknown which agencies would be key to DSRIP projects. Now that there has been further definition of who are considered B1 partners are and who is involved in the various community driven projects, and potentially need to exchange protected health information, the target for this measure may not be appropriate. IDN staff has been working to find out which agencies have direct secure messaging capabilities, and during the recent reporting period key agencies were asked about actual use of direct secure messaging, versus only capabilities. The IDN team will continue to ascertain the use of direct secure messaging across IDN partners in the region during the next reporting period and use this information to adjust targets ahead of the 2020 deadline if appropriate.

The Region 7 IDN team initially had a target of 20 "reporting periods successfully completed by 2020" in the region's implementation plan which also included the implementation plan and semi-annual reports. The target for this measure has been revised to more accurately reflect the data reporting required under project A-2. The target for this measure is 11: Seven half year measurement periods for 2nd half 2017 through 2nd half 2020; plus three full year measurement periods for 2018-2020; plus one historical look in October 2018. As of December 31, 2018, Region 7 IDN completed two reporting cycles plus one historical look back.

*Shared Care Plan rollout has been slower than expected due to a variety of factors including: concerns about the SCP impacting provider time, staff resources needed to implement, competing projects and re-alignment of current consent processes to cover the inclusion of 42 CFR Part 2 covered data.

However, those partners which have moved on this have responded very positively and the region has worked to amplify their voices by providing them a platform to discuss successes at our quarterly meetings. The reception from these presentations has been positive and several other partners are now in the process of adopting the shared care plan.

**Event notification (send) rollout has been slowed by extensive legal reviews taking place at Littleton Regional Healthcare and Cottage Hospital. The adoption of the event notification (send) functionality by four other hospitals in Region 7 within compliance with legal framework should help move this process along. Memorial Hospital implementation was delayed because of an EMR migration which was completed early this year. Additionally, as they are a member of the Maine Health affiliation, they have concerns that CMT currently does not have data for Maine hospitals which makes the system less useful to them.

***After an initial discovery process for the population health tool, IDN Region 7 has temporarily suspended activity in this area because of the expenditure of resources involved in such a tool and the and uncertainty around DSRIP funding.

June 30, 2019 Update

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

Region 7 IDN Data Governance

As Region 7 IDN adopted the new DHHS Monthly Update reporting format this spring, efforts were expended to verify the total number of individuals served by each Region 7 IDN partner to date and leverage the State's reporting tool as a mechanism that will help partners report monthly totals for the remainder of the DSRIP. By utilizing the State's new monthly reporting mechanism as the backbone of a high-integrity data management process, the Region 7 IDN team hopes to ease the reporting burden for partners while retaining the ability to collect, aggregate and analyze data for the region as a whole. This revised process is anticipated to allow the region to evaluate progress on performance evaluation targets more frequently and help the Region 7 IDN team provide more timely feedback and support to the region's partners. Partner specific updates in this section reflect narrative regarding their progress along the continuum of the project, and their total number of unique individuals served during the DSRIP period through June 30, 2019.

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/18	As of 6/30/19	As of 12/31/19
Participant sites with at least one staff member trained in use of PreManage Primary	13	3	8[2]	
Number of Participants Exchanging Information Via Shared Care Plan Tool	13	3	8[2]	
Hospitals Sending Event Notifications to PreManage ED	7	4	4[3]	
Number of Participants Exchanging Information Via Direct Secure Messaging (By 2020)	35	10	**10[4]**	
Reporting Periods Successfully Completed (By 2020)[5]	11	3	5	
Pilot Participants Using Population Health Tool (By 2020)[6]	5	0	8	
Region 7 Patient Lives in PreManage Primary (By 2020) – includes any patient on the census upload	19,601	15,273	57,998	
Participant HIT Projects Addressing Minimum/Desired/Optional Capabilities Funded and Completed (By 2020)	5	8 (22 funded or provisionally funded)	11	

[2] Shared Care Plan rollout has been slower than expected due to a variety of factors including: concerns about the SCP impacting provider time, staff resources needed to implement, competing projects and re-alignment of current consent processes to cover the inclusion of 42 CFR Part 2 covered data. However, the last period has seen greater uptake than any period to date, and Region 7 believes that CMT adoption will soon reach a point where previously reluctant partners may see greater value because peer agencies are active in the system.

[3] Event notification (send) rollout has been slowed by extensive legal reviews taking place at Littleton Regional Healthcare and Cottage Hospital. The adoption of the event notification (send) functionality by four other hospitals in Region 7 should help move this process along. Memorial Hospital implementation was delayed because of an EMR migration which was completed early this year. Additionally, as they are a member of the Maine Health affiliation, they have concerns that CMT currently does not have data for Maine hospitals which makes the system less useful to them. Region 7 hopes to have all three remaining hospitals sending ADT feeds to CMT in the next period

[4] IDN partners are already using existing secure means of communication with each another, often via fax or some other modality. The purpose of this Direct Secure Messaging metric is to monitor progress on partner adoption of more modern, flexible tools that accomplish these same transmissions more consistently and efficiently.

[5] The Region 7 IDN team initially had a target of 20 "reporting periods successfully completed by 2020" in the region's implementation plan which also included the implementation plan and semi-annual reports. The target for this measure has been revised to more accurately reflect the data reporting required under project A-2. The target for this measure is 11: Seven half year measurement periods for 2nd half 2017 through 2nd half 2020; plus three full year measurement periods for 2018-2020; plus one historical look in October 2018. As of June 2019, IDN Region 7 has had three half year measurement periods, 1 full year measurement period and 1 historical lookback period.

[6] As noted in section A2-4, during provider meetings in June 2019, the Region 7 IDN team discovered that eight Region 7 partners had been using a population health analytics tool for their Medicare population that was contracted as part of their Medicare Shared Savings Program ACO in calendar years 2016-2018. While not specifically focused on the DSRIP target population, access to the platform provided these partners with the opportunity to learn how to leverage population-based data to risk stratify their population, reduce unnecessary resource utilization, improve preventative screening processes, standardize behavioral health screenings and interventions, and improve patient outcomes.

As requested, the following table has been added to this section to aid in consideration of incentive payments based on partially met sections of this report. The Region 7 IDN team populated the table as follows:

- Event Notifications reflects partners actively receiving notifications in the Collective Medical (CM) network
- Shared Care Plan reflects partners exchanging information on the CM network, including both in feeding and receiving data to populate the event notification service
- Closed-Loop Referral reflects partners who meet the criteria for closed loop referral within the Core Competency Integrated Healthcare project. The remaining partners are all implementing closed loop referral workflows, but were not counted because their processes are either in draft or being tested with pilot locations
- Data Reporting reflects partners who have submitted Statewide Outcome Reporting data to MAeHC
- Data Sharing reflects partners who have data use agreements in place.
- Care Coordination reflects those partners who meet the criteria for electronic sharing of some clinical data related to treatment, diagnosis, and care management within the Core Competency Integrated Healthcare project. During this reporting period, the remaining partners reported using manual processes to share this information with other members of the patient/client care circle.

Performance Measure Name	# of Participating Practices	Progress Toward Target		
		As of 12/31/18	As of 6/30/19	As of 12/31/19
Event Notification Services	13	3	7	
Shared Care Plan	13	3	10	
Closed Loop Referral	13	9	10	
Data Reporting	13	13	13	
Data Sharing	13	13	13	
Care Coordination	13	10	11	

December 31, 2019 Update

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 12/31/18	As of 6/30/19	As of 12/31/19
Participant sites with at least one staff member trained in use of PreManage Primary	13	3	8	8
Number of Participants Exchanging Information Via Shared Care Plan Tool	13	3	8	8
Hospitals Sending Event Notifications to PreManage ED	7	4	4	4
Number of Participants Exchanging Information Via Direct Secure Messaging (By 2020)	35	10	10	10
Reporting Periods Successfully Completed (By 2020)	11	3	5	6
Pilot Participants Using Population Health Tool (By 2020)	5	0	8	8
Region 7 Patient Lives in PreManage Primary (By 2020) – includes any patient on the census upload	19,601	15,273	57,998	30,024*
Participant HIT Projects Addressing Minimum/Desired/Optional Capabilities Funded and Completed (By 2020)	5	8 (22 funded or provisionally funded)	11	13

*This is a provisional number received from Collective Medical in January 2020 but did not include patient lives submitted to PreManage Primary by the Huggins Outpatient Clinics. This number will be revised during the review period to reflect the true total for Region 7 IDN.

As requested, the following table has been added to this section to aid in consideration of incentive payments based on partially met sections of this report. The Region 7 IDN team populated the table as follows:

- Event Notifications reflects partners actively receiving notifications in the Collective Medical (CM) network
- Shared Care Plan reflects partners exchanging information on the CM network, including both in feeding and receiving data to populate the event notification service
- Closed-Loop Referral reflects partners who meet the criteria for closed loop referral within the Core Competency Integrated Healthcare project. The remaining partners are all implementing closed loop referral workflows, but were not counted because their processes are either in draft or being tested with pilot locations
- Data Reporting reflects partners who have submitted Statewide Outcome Reporting data to MAeHC
- Data Sharing reflects partners who have data use agreements in place.
- Care Coordination reflects those partners who meet the criteria for electronic sharing of some clinical data related to treatment, diagnosis, and care management within the Core Competency Integrated Healthcare project. During this reporting period, the remaining partners reported using manual processes to share this information with other members of the patient/client care circle.

Performance Measure Name	# of Participating Practices	Progress Toward Target		
		As of 12/31/18	As of 6/30/19	As of 12/31/19
Event Notification Services	13	3	7	7
Shared Care Plan	13	3	10	10
Closed Loop Referral	13	9	10	11
Data Reporting	13	13	13	13
Data Sharing	13	13	13	13
Care Coordination	13	10	11	12

No additional information indicating achievement on this deliverable has become available during the review period.

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.

December 31, 2018

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	1	1
HIT Integration Coach	1	0	0	1	1
Data Specialist at NCHC	1	0	0	0	1*

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
Data Aggregator specialists in the community through the RFP process	Up to 3	0	0	0	3**

*After initiation of the project, the data specialist was deemed to be redundant with services already provided by MAeHC and the HIT Lead.

**In lieu of hiring additional staff to handle data aggregation and funding them through IDN request for proposal funding, three agencies (White Mountain Community Health Center, Saco River Medical Group and Coös County Family Health Service) have elected to contract for these services instead. WMCHC has contracted with a third-party expert, while Saco and Coös County have contracted directly with MAeHC for data abstraction services. All three have been able to leverage these resources into better reporting results.

June 30, 2019 Update

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	Staffing on 6/30/18
HIT Lead	1	1	1	1	1	1
HIT Integration Coach	1	0	0	1	1	1
Data Specialist at NCHC*	1	0	0	0	1	1
Data Aggregator specialists in the community through the RFP process**	Up to 3	0	0	0	3	3

*After initiation of the project, the data specialist was deemed to be redundant with services already provided by MAeHC and the HIT Lead.

**In lieu of hiring additional staff to handle data aggregation and funding them through IDN request for proposal funding, three agencies (White Mountain Community Health Center, Saco River Medical Group and Coös County Family Health Service) have elected to contract for these services instead. WMCHC has contracted with a third-party expert, while Saco and Coös County have contracted directly with MAeHC for data abstraction services. All three agencies have been able to leverage these resources, so they have better reporting results. Consistently, partners have indicated that the increasing demand for the use of data to drive care, and the need to validate data for payer performance metrics is increasing. Separate from the dedicated data aggregator specialists in the community through the RFP process accounted for in the evaluation target table above, this reporting period the Region 7 IDN team estimates that the thirteen partners engaged in the Core Competency project are dedicating an aggregate total in excess of 9 FTE engaged across the region in these data governance and reporting activities. This is based on partner feedback to targeted questions regarding their current allocation of staff resources to meet reporting requirements, including participation in calls with MAeHC and the IDN HIT Lead, abstraction of data, and alterations to EMR systems in order to have claims data accurately represent the care provided to their patients.

December 31, 2019 Update

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	Staffing on 6/30/19	Staffing on 12/31/19
HIT Lead	1	1	1	1	1	1	
HIT Integration Coach	1	0	0	1	1	1	
Data Specialist at NCHC*	1	0	0	0	1	1	
Data Aggregator specialists in the community through the RFP process**	Up to 3	0	0	0	3	3	

*After initiation of the project, the data specialist was deemed to be redundant with services already provided by MAeHC and the HIT Lead.

**In lieu of hiring additional staff to handle data aggregation and funding them through IDN request for proposal funding, three agencies (White Mountain Community Health Center, Saco River Medical Group and Coös County Family Health Service) have elected to contract for these services instead. WMCHC has contracted with a third-party expert, while Saco and Coös County have contracted directly with MAeHC for data abstraction services. All three agencies have been able to leverage these resources, so they have better reporting results. Consistently, partners have indicated that the increasing demand for the use of data to drive care, and the need to validate data for payer performance metrics is increasing. Separate from the dedicated data aggregator specialists in the community through the RFP process accounted for in the evaluation target table above, this reporting period the Region 7 IDN team estimates that the thirteen partners engaged in the Core Competency project are dedicating an aggregate total in excess of 9 FTE engaged across the region in these data governance and reporting activities. This is based on partner feedback to targeted questions regarding their current allocation of staff resources to meet reporting requirements, including participation in calls with MAeHC and the IDN HIT Lead, abstraction of data, and alterations to EMR systems in order to have claims data accurately represent the care provided to their patients.

A2-6. IDN HIT: Budget

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

December 31, 2018

Budget Period:	01/01/2017-12/31/2017	01/01/2018-06/30/2018	07/01/2018-12/31/2018	01/01/2019-12/31/2019	01/01/2020-12/31/2020	01/01/2021-06/30/2021
	HIT Actual Funds Spent	HIT Actual Expense (6 months)				
HIT	CY 2017 Actuals	CY 2018 January to June Actual	CY 2018 July to Dec. Actual	CY 2019 Projected	CY 2020 Projected	CY 2021 Projected
1. Total Salary/Wages						
2. Employee Benefits						
3. Consultants			$0	$0	$0	$0
5. Supplies:			$0	$0	$0	$0
Educational			$0	$0	$0	$0
Office	$1,612	$138	$127	$14,660	$14,660	$7,330
6. Travel	$1,235	$613	$482	$24,085	$24,085	$12,043
7. Occupancy			$0	$0	$0	$0
8. Current Expenses			$0	$0	$0	$0
Telephone			$0	$0	$0	$0
Postage			$0	$0	$0	$0
Subscriptions		$150,322	$71,433	$154,693	$154,693	$77,347
Audit and Legal			$0	$0	$0	$0
Insurance			$0	$0	$0	$0
Board Expenses			$0	$0	$0	$0
9. Software		$738	$0	$1,011	$1,011	$505
10. Marketing/Communications	$1,809	$1,509	$2,993	$156	$156	$78
11. Staff Education and Training		$862	$987	$29,971	$29,971	$14,985
12. Subcontracts/Agreements			$0	$0	$0	$0
13. Other (specific details mandatory):			$0	$0	$0	$0
Current Expenses: Administrative Lead Organizational Support	$2,722	$1,541	$705	$4,525	$4,525	$2,262
Support Payments to Partners	$109,551	$99,342	$72,176	$9,796	$9,796	$4,898
TOTAL	**$116,929**	**$255,065**	**$148,903**	**$238,896**	**$238,896**	**$119,448**

Consistent with all prior reporting, report begins with January 1, 2017 utilizing capacity building funds to maintain infrastructure.

IDN 7 projects the additional amount approved at June 2017 quarterly meeting to absorb future anticipated line item variances in Salary, Benefits, Software and Training

June 30, 2019 Update

Budget Period:	01/01/2017-12/31/2017	01/01/2018-12/31/2018	01/01/2019-06/30/2019	07/01/2019-12/31/2019	01/01/2020-12/31/2020	01/01/2021-06/30/2021
HIT	CY 2017 Actuals	CY 2018 January to December ACTUAL	CY 2019 January to June ACTUAL	CY 2019 July to December PROJECTED	CY 2020 Projected	CY 2021 Projected
1. Total Salary/Wages						
2. Employee Benefits						
3. Consultants		$0		$0	$0	$0
5. Supplies:		$0		$0	$0	$0
Educational		$0		$0	$0	$0
Office	$1,612	$265	$194	$194	$387	$194
6. Travel	$1,235	$1,095	$696	$696	$1,392	$696
7. Occupancy		$0		$0	$0	$0
8. Current Expenses		$0		$0	$0	$0
Telephone		$0		$0	$0	$0
Postage		$0		$0	$0	$0
Subscriptions		$221,755	$102,146	$102,146	$154,293	$77,146
Audit and Legal		$0		$0	$0	$0
Insurance		$0		$0	$0	$0
Board Expenses		$0		$0	$0	$0
9. Software		$738	$397	$397	$793	$397
10. Marketing/Communications	$1,809	$4,501	$298	$298	$596	$298
11. Staff Education and Training		$1,849		$0	$0	$0
12. Subcontracts/Agreements		$0		$0	$0	$0
13. Other (specific details mandatory):		$0		$0	$0	$0
Current Expenses: Administrative Lead Organizational Support	$2,722	$2,246	$490	$490	$981	$490
Support Payments to Partners	$109,551	$171,518	$44,481	$44,481	$88,961	$44,481
TOTAL	**$153,205**	**$511,463**	**$186,550**	**$186,550**	**$306,739**	**$161,550**

Consistent with all prior reporting, report begins with January 1, 2017 utilizing capacity building funds to maintain infrastructure.
IDN 7 projects the additional amount approved at June 2017 quarterly meeting to absorb future anticipated line item variances in Salary, Benefits, Software and Training.
Incentive Payments from January 2019 through December 2020 reflect a reduction based on anticipated DHHS action and county participation.
Budgets for project remainder reflect revised staffing structure in attempt to maximize funds available to partners.

December 31, 2019 Update

Budget Period:	01/01/2018-06/30/2018	**01/01/2017-12/31/2017**	**01/01/2018-12/31/2018**	**1/1/2019 - 6/30/2019**	**7/1/2019 - 12/31/2019**	**01/01/2019-12/31/2019**	**1/1/2020-6/30/2020**	**7/1/2020-12/31/2020**	**01/01/2020-12/31/2020**	**01/01/2021-12/31/2021**
HIT		**CY 2017 Actuals**	**CY 2018 January to December ACTUAL**	**CY 2019 January to June ACTUAL**	**CY 2019 July to December ACTUAL**	**CY 2019 January to December ACTUAL**	**CY 2020 Jan to June PROJECTED**	**CY 2020 July to Dec PROJECTED**	**CY 2020 Projected**	**CY 2021 Projected**
1. Total Salary/Wages	$36,110									
2. Employee Benefits	$7,222									
3. Consultants	$0		$0			$0	$0	$0	$0	$0
5. Supplies:	$0		$0			$0	$0	$0	$0	$0
Educational	$0		$0			$0	$0	$0	$0	$0
Office	$6,127	$1,612	$265	$194	$158	$352	$176	$176	$352	$176
6. Travel	$10,107	$1,235	$1,095	$696	$884	$1,580	$790	$790	$1,580	$790
7. Occupancy	$0		$0			$0	$0	$0	$0	$0
8. Current Expenses	$0		$0			$0	$0	$0	$0	$0
Telephone	$0		$0			$0	$0	$0	$0	$0
Postage	$0		$0			$0	$0	$0	$0	$0
Subscriptions	$74,991		$221,755	$102,146	$78,070	$180,217	$90,108	$90,108	$180,217	$98,000
Audit and Legal	$0		$0			$0	$0	$0	$0	$0
Insurance	$0		$0			$0	$0	$0	$0	$0
Board Expenses	$0		$0			$0	$0	$0	$0	$0
9. Software	$421		$738	$397	$643	$1,040	$520	$520	$1,040	$520
10. Marketing/Communications	$506	$1,809	$4,501	$298	$320	$618	$309	$309	$618	$309
11. Staff Education and Training	$12,633		$1,849			$0	$0	$0	$0	$0
12. Subcontracts/Agreements	$0		$0			$0	$0	$0	$0	$0
13. Other (specific details mandatory):	$0		$0			$0	$0	$0	$0	$0
Current Expenses: Administrative Lead Organizational Support	$1,989	$2,722	$2,246	$490	$458	$948	$474	$474	$948	$474
Support Payments to Partners	$16,111	$109,551	$171,518	$44,481	$68,959	$113,440	$44,022	$102,718	$146,740	$73,370
						$0				
TOTAL	**$166,218**	**$ 153,205**	**$511,463**	**$186,550**	**$181,085**	**$367,634**	**171119.2958**	**$229,815**	**$400,935**	**$208,359**

Consistent with all prior reporting, report begins with January 1, 2017 utilizing capacity building funds to maintain infrastructure.

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
Children Unlimited	Community-Based Organization providing social and support services
Coös 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
Family Resource Center	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
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

Organization Name	Organization Type
White Horse Addiction Center	Substance Use Disorder Provider, Therapy for co-occurring disorders (mental health and substance use disorders); Recovery Resources, Advocacy and Support.
White Mountain Community Health Center	Non-FQHC Community Health Partner
North Country Serenity Center	Peer Recovery

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/A
Ammonoosuc Community Health Services	Y
Androscoggin Valley Home Care Services	N/A
Androscoggin Valley Hospital	Y*
Carroll County Coalition for Public Health	N/A
Carroll County Department of Corrections	N/A
Central New Hampshire Visiting Nurse Association & Hospice	N/A
Children Unlimited	N/A
Coös County Family Health Services	Y
Cottage Hospital	Y
Crotched Mountain Foundation	N/A
Family Resource Center	N/A
Grafton County Department of Corrections	N/A
Grafton County Nursing Home	N/A
Granite State Independent Living	N/A
Hope for NH Recovery	N/A
Huggins Hospital	Y
Indian Stream Health Center	Y
Life Coping, Inc.	N/A
Littleton Regional Healthcare	Y
Memorial Hospital	Y
MWV Supports Recovery	N/A
National Alliance on Mental Illness	N/A
North Country Healthcare	Y
Northern Human Services	Y
Rowe Health Center	Y**
Saco River Medical Group	Y
ServiceLink Resource Center of Carroll County and Grafton County	N/A
Tri-County Community Action Program, Inc.	N/A
Upper Connecticut Valley Hospital	Y*
Visiting Nurse Home Care and Hospice of Carroll County	N/A
Weeks Medical Center	Y*
White Horse Addiction Center	Y
White Mountain Community Health Center	Y

N/A: As a partner for whom no data for the statewide reporting measures is gathered (because of their type), these partners do not need a data use agreement.

*Included in the overarching North Country Healthcare data use agreement

**Included in the overarching Cottage Hospital use agreement

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	6/30/19	12/31/19
A2-3	IDN HIT/HIE Implementation Plan and Timeline	Narrative & Spreadsheet (Microsoft Project or similar platform)						
A2-4	Evaluation Project Targets	Table						
A2-5	IDN HIT Workforce Staffing	Table						
A2-6	IDN HIT Budget	Narrative and Spreadsheet						
A2-7	IDN HIT Key Organizational and Provider Participants	Table						
A2-8	IDN HIT Data Agreement	Table						

Project B1: Integrated Healthcare

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

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

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

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

The *Coordinated Care Practice* must include:

- Comprehensive Core Standardized Assessment with required domains (**Note:** applies only to primary care, behavioral health and substance use disorder practitioners.)
- Use of a Multi-Disciplinary Core Team
- 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

December 31, 2018

Network Membership

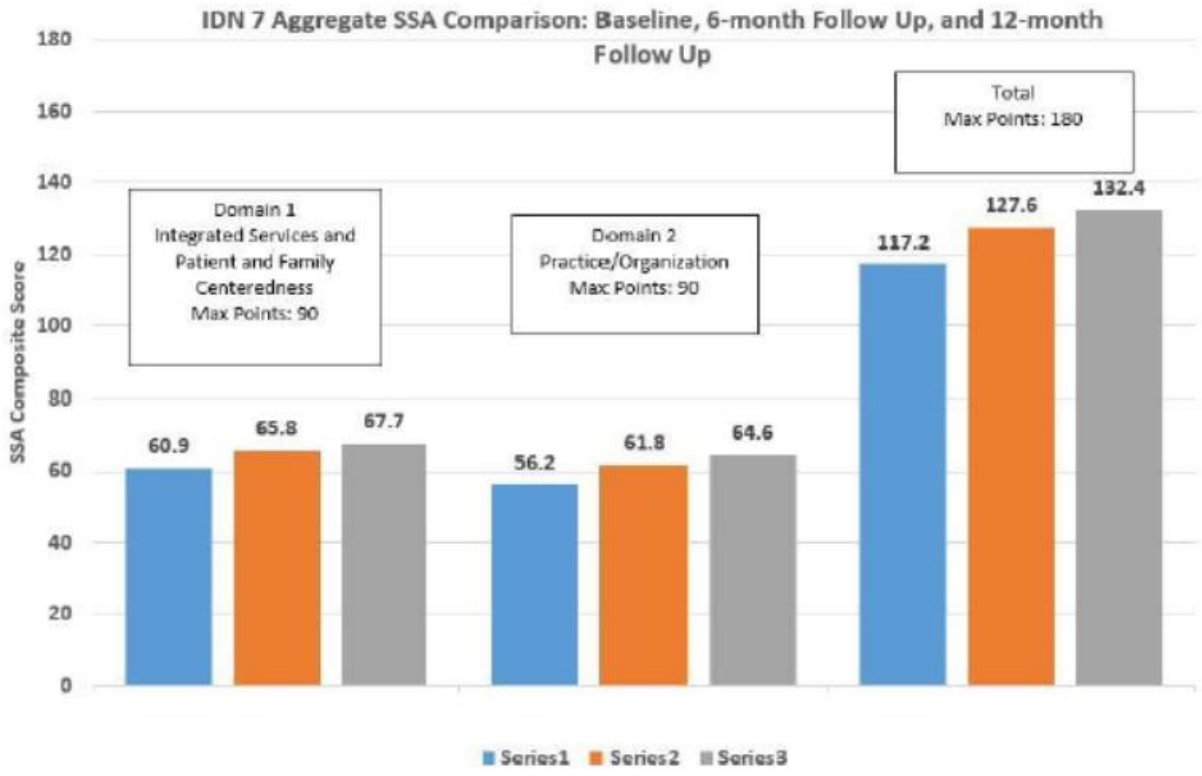
During the reporting period of 07/01/2018-12/31/2018 Region 7 IDN had no members join or leave the network.

Maine Health Access Foundation Site Self-Assessment:

Partner agencies in Region 7 IDN have made significant progress as they have worked to advance along the continuum of integrated healthcare during the reporting period of July-December 2018. The region has a contract with Citizens Health Initiative (CHI) and UNH Institute for Health Policy and Practice (IHPP) to administer a Site Self-Assessment (SSA) Survey to the behavioral health and primary care practices

within the region to assess their level of behavioral health integration. The survey is based on the on the Maine Health Access Foundation Site Self-Assessment.

To date, practices have completed a baseline survey in June 2017, a follow up survey in December 2017, and a second follow up survey in June 2018. The region's implementation plan states that moving forward the survey will be administered on a yearly basis, so the partners in the region are not expected to complete another survey until June 2019, and then one more in 2020. The region's SSA score results through June 2018 are reflected below. According to SAMSHA's Six Levels of Integration the region is at a level 5 out of 6. As agencies continue to refine workflows, develop written protocols, and incorporate additional technologies into their systems, these scores should continue to rise over the remaining DSRIP period. When the IDN team met with CHI to discuss the June 2018 SSA results they suggested that Region 7 IDN explore using Tanya Lord's skills to increase patient/family input to integration management. Ms. Lord was the main speaker at NCHC's annual meeting in November 2018 and the IDN team will continue to strategize on how to best incorporate her information to help improve patient and family engagement within the region.



note: Series 1: Baseline; Series 2: Follow-up 1; Series 3: Follow-up 2

Figure 1 IDN7 Site Self-Assessment Results over time

Quality Improvement Team:

The region's Quality Improvement team has evolved based on the needs of the region. NCHC continues to leverage the expertise of one of the organization's Practice Transformation Network (PTN) Facilitators to serve as a part-time IDN Quality Improvement Coach. She bills some of her time to the IDN and works with a few of the IDN partners directly to help them develop and implement workflows and protocols designed to improve integration of behavioral health and primary care services. These

resources are shared with the IDN team who then shares the tools with the remaining IDN partners in the region and encourages the agencies to adapt the tools to meet the needs of their agencies. In addition, the IDN Quality Improvement Coach serves as the region's Care Advocate Supervisor by offering training and technical assistance for care coordinators. During this reporting period she has created a number or draft workflows and protocols, presented at the regional care coordination training, delivered a webinar on risk stratification, and delivered a webinar on the region's available protocols.

The IDN team has seen significant progress from the agencies that the IDN QI Coach works directly with and is excited that they have been able to hire an addition part-time QI coach who will work with additional practices in the region. The new QI coach previously worked for the Practice Transformation Network and has strong ties in the region so she will be an asset to the region when she joins the team in January 2019. The part-time QI coach will work closely with the region's HIT Integration Coach to offer technical assistance to IDN partners.

The IDN team lost a full-time coordinator during the reporting period but was able to transition an existing IDN team member into a full-time coordinator role. The IDN Program Manager transitioned to a Director level position at NCHC during the reporting period but will continue to work with the IDN team on an ongoing basis. This will ensure a seamless transition for the new IDN Program Manager who will be starting in February 2019. The new manager has a lot of experience in quality initiatives and is a Certified Professional in Healthcare Quality which is great for the IDN. NCHC will be looking at the skill sets of all the IDN team members and relying on those skills and expertise to advance the region along the continuum of integrated healthcare.

Three-pronged approach to help transform the delivery of behavioral health care in the region:

The IDN team has continued using a three-pronged approach to help transform the delivery of behavioral health care in the region: adequately train the workforce utilizing a comprehensive training plan; follow a continuum of care model which addresses prevention, early intervention, treatment, and recovery support services; and focus on transitional services. Each of these areas are discussed in more detail in the sections that follow in the report, starting with training. Below is a table depicting the region's comprehensive master training plan for the core competency project and the 3 community-driven projects. The trainings were placed in one table because there is so much overlap in training needs among the various DSRIP associated projects.

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, Coös 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	B1

Region 7 IDN Master Training Table		
Training	**Description**	**Project Reference**
	potentially lead to 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

Region 7 IDN Master Training Table		
Training	**Description**	**Project Reference**
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	B1

Region 7 IDN Master Training Table		
Training	**Description**	**Project Reference**
	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.	
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 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 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.	D3
HIV Update for Substance Use Professionals	This training is geared toward substance use professionals and will provide participants with basic and updated information	D3

Region 7 IDN Master Training Table		
Training	**Description**	**Project Reference**
	about HIV other STDs. This includes risk factors, modes of transmission, signs and symptoms, prevention, the relationship between HIV and other STDs.	
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 four 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 07/1/2018-12/31/2018 based on the suggested trainings in the region's master training list. There were two quarterly meetings held during this period to bring the region together to discuss the IDN projects, partner progress, and collaborate to develop strategies to meet deliverables in 2019. Thirty-nine people attend the September 2018 to participate in the following presentations:

- *XY Exercise (Collaboration team building activity)* – Facilitated by Joe Viger, IDN HIT Integration Coach, North Country Health Consortium
- *IDN Updates & Incentive Funding Process* – Nancy Frank, CEO, North Country Health Consortium
- *Data Aggregation & Shared Care Plan Update* – Drew Brown, Management Information Systems Administrator, North Country Health Consortium & Joe Viger, IDN Integration Coach, North Country Health Consortium
- *Trauma Informed Care* – Linda Douglas, M.Ed., CTSS, Trauma Informed Services Specialist, NH Coalition Against Domestic & Sexual Violence

The December 2018 Quarterly meeting served as a partner forum to prepare agencies for the shift to pay for performance and strategize on meeting deliverables in 2019. Approximately thirty-one people were in attendance to discuss the following topics:

- *Funding, Alternative Payment Models, Granite Advantage Healthcare Program* – Henry D. Lipman, Medicaid Director, New Hampshire Department of Health and Human Services
- *Vision for Integrated Care* – Joe Viger, IDN HIT Integration Coach, North Country Health Consortium
- *IDN and Partner Updates* – Nancy Frank, CEO, North Country Health Consortium and IDN Partners

Other trainings for Region 7 IDN during the reporting period 07/01/18-12/31/18 include:

- 7/25/2018: Ethical Considerations for Recovery Coaches trained 13
- 8/9/2018: HIV/AIDS Training trained 13
- 8/23/2018: Suicide Prevention trained 16

- 8/23/2018: Critical Time Intervention Train the Trainer trained 2
- 9/13/2018: CCAR Recovery Coach Academy trained 8
- 9/13/2018: Trauma Informed Care Training (Quarterly Meeting) trained 39
- 9/17/2018: Introduction to Management of Aggressive Behavior trained 10
- 9/17/2018: Introduction to Managing Physical Confrontation trained 6
- 9/20/2018: Addiction 101 trained 9
- 9/27/2018: Co-Occurring Medical and Psychological Conditions trained 23 total and 16 from IDN 7
- 10/1/2018: Introduction to Management of Aggressive Behavior, trained 14
- 10/1/2018: Introduction to Managing Physical Confrontation, trained 14
- 10/11/2018: Recovery Coach Academy Train the Trainer, trained 6
- 10/24/2018: Motivational Interviewing, trained 11
- 10/26/2018: Mental Health First Aid –Huggins Hospital, trained 21
- 10/31/2018: Stigma and Language Webinar, trained 10, 46 views of YouTube recording
- 11/1/2018: Critical Time Intervention, trained 17
- 11/5/2018: Ethical Considerations for Recovery Coaches Training, trained 13
- 11/7/2018: Ethics Train the Trainer, trained 4
- 11/14/2018: Suicide Prevention Training, trained 26
- 11/16/2018: NCHC Annual Meeting: Patient and Family Engagement Training
- 11/28/2018: Risk Stratification Webinar, trained 7, 12 views of YouTube recording
- 11/28/2018 – 11/29/2018: Regional Care Coordination, trained 6
- 12/4/2018 – 12/5/2018: Motivational Interviewing, trained 12

The North Country Health Consortium held their Annual Meeting in November 2018, at which Tanya Lord, Director of Patient and Family Engagement at Foundation for Health Communities presented about the importance of engaging the patient and family during care. She explained that collaborative patient and family engagement is a strategy to build a patient and family centered health care system. In a patient and family centered health system, patients and families are encouraged and supported as essential members of the health care team and there are meaningful opportunities for them to serve as advisors and partners in quality improvement efforts, patient safety initiatives and health care design. The presentation was very well received by NCHC staff, board members and community members.

The Region 7 IDN team has developed a Peer Recovery Coach training plan that will continue into 2019, along with multiple other trainings listed below:

- Policy & Protocol Clearinghouse Webinar: January 16, 2019
- Peer Recovery Coach Academy: April 2019
- Peer Recovery Coach Academy: September 2019
- Suicide Prevention: October 17, 2019
- Ethics: November 2019
- HIV/AIDS: December 5, 2019

The region has multiple trainings which will be offered on an as needed or recurring basis including:

- Mental Health First Aid
- Community Health Worker Training
- Introduction to Management of Aggressive Behavior

- Introduction to Managing Physical Confrontation
- Critical Time Intervention
- Regional Care Coordination

In addition to the training plan above, IDN staff have engaged in conversations with the Managed Care Organization, New Hampshire Healthy Families (NHHF), to potentially deliver additional trainings to the region using the partner connections the MCO currently has in place. NHHF staff are routinely prepared to train in multiple areas including, SBIRT, social determinants of health and social supports, integrated care for healthcare providers, cultural competence, and other topics based on identified needs. IDN staff have continued conversations with the New England Addiction Technology Transfer Center to learn more about their training opportunities and potentially partnering with them to bring some of the these to the IDN region.

The IDN team has been working closely with the other IDN regions across the state to sponsor an IDN training track at the December 2018 NH Behavioral Health Summit entitled*, "Alignment of Systems: Improving Behavioral Health Outcomes*." There were six sessions created as part of the track to help participants meet the training requirements of the DSRIP project. The sessions were recorded and will be available as webinars with continuing education options in early 2019. The sessions were as follows:

- Community Care Team: A Model Strategy for Systems Alignment: Tory Jennison PhD, RN and Sandi Denoncour BS, ASN, RN
- Understanding and Addressing Substance Use Disorders as Chronic Medical Conditions: Mary Brunette, MD and Seddon R. Savage MD, MS
- Enhanced Care Coordination for High Needs Population from Multiple Perspectives: Jennifer Seher, B.S., CIRS A/D; Glenn Lawrence, MA; Maryann Evers, LICSW; Marie Macedonia, MS Psychology, PsyD; Annette Carbonneau
- Core Competencies for Primary Care Behavioral Health Integration: Knowledge, Skills & Attitudes: William Gunn PhD
- Chronic Disease Information for Behavioral Health Providers: Tracy Tinker, RN, MSN, CDE, CNL
- Facilitated Integrated Care Success with Co-Occurring Disorders: A Case Study: David Ferruolo, EdD., LICSW, MLADC

IDN staff have been working to promote the newly developed Region 7 IDN webinar series that has brought two trainings to the region in October and November 2018. The webinars included, *Reducing Stigma in SUD Treatment* and *Risk Stratification to Drive Care Coordination.* Both were recorded for participants to have access to the material on their own time and to assist in addressing training of new staff. The team plans to deliver a webinar monthly addressing topics germane to the IDN and partner feedback. The January 2019 webinar will be focused on policy and protocol development.

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 has not engaged in new memorandum of understandings with IDN partners in this reporting period due to the IDN funding uncertainties associated with the county funding methodology. The region did receive fifteen new proposals in October but has not been able to execute agreements until final DSRIP funding levels are solidified. The following agencies submitted proposals to help their agencies improve the integration of primary care and behavioral health and are anxiously waiting to receive agreements and subsequent funds.

- *Memorial Hospital* submitted a proposal on behalf of four organizations in Mount Washington Valley (Memorial Hospital, Saco River Medical Group (SRMG), Children's Unlimited (CU) and Visiting Nurse Home Care & Hospice (VNHCH)) to expand their Collaborative Community Program Addressing Behavioral Health & Substance Use in Carroll County project;
- *Huggins Hospital* submitted a proposal to expand their "Huggins Health Neighborhood Care Coordination and Integration Services" project. The project would expand Huggins Hospital's integration of behavioral health and primary care and address the social determinants through expanded care coordination, adoption of assessment and screening related to the IDN project, and support for expanded MAT services;
- *Northern Human Services* submitted a proposal to partner with Ammonoosuc Community Health Services to develop an Integrated Health Home, to be located at White Mountain Mental Health Center in Littleton and operated by ACHS.

Region 7 IDN Core Competency Integration Toolkit:

The Core Competency Integration Toolkit remains available to partners as they work to implement new systems and B1 deliverables into their agencies. The toolkit has proven to be an effective and valuable tool to the partners. The IDN team continues to encourage the use of the toolkit and updates the content as necessary.

CCSA implementation:

Region 7 IDN has made significant progress towards all B1 partners implementing the Comprehensive Core Standardized Assessment (CCSA). The Sample CCSA Protocol drafted by the IDN Quality Improvement Coach, and submitted in the last reporting period, was pivotal to the momentum the region experienced during this reporting period.

The IDN team prepared for multiple meetings over the past six months where the focus was the implementation of the CCSA. The Strategic Funding Meeting with all workgroups held in July 2018 provided a great opportunity to discuss the importance of meeting IDN deliverables, and how they equate to incentive payments. The CCSA was a major agenda item that was discussed at length between the IDN team and partners in attendance. The two quarterly meetings in September and December were strategically planned to continue helping partners understand the value and importance of the CCSA. Partners were very receptive at these meetings and many agencies are now capturing domains they had not before.

B1 partners have been working to embed the twelve domains into their EMR and create systems to gather the information from patients. Multiple partners have been successful in launching this technique, while others continue to adjust a process to fit their internal needs. The IDN team plans to continue working with all partners to finalize protocols and procedures relating to the CCSA. Partners who do not currently capture all domains will be the focus of the IDN team moving into the next six months. The providers of multiple agencies have begun to see value in gathering this data and are more comfortable with how to address positive screenings.

Multi-Disciplinary Core Team:

The IDN team has worked with partner agencies to encourage them work with a Multi-Disciplinary Core Team which meets DSRIP requirements. Some of the partner agencies had a system in place which could be adapted to meet the requirements, while other agencies didn't have the staffing needed to form these teams. The IDN team helped the agencies assess what was in place and worked to make connections to psychiatrists for those agencies who didn't have access. This is still a work in progress for some of the agencies in the region, but the IDN team will focus efforts on these agencies to help connect

them to a Multi-Disciplinary Core Team. The IDN team will research more on telepsychiatry services to support the multi-disciplinary teams in the region. Additional efforts will be made to ensure partner agencies are using the multi-disciplinary team meetings to discuss high risk patients versus talking about system level concerns.

Standardized Workflows and Protocols:

Members of the IDN team have worked diligently to research and create draft workflows and protocols for partners in the region to adapt to meet their needs. These draft protocols have been shared in the region's toolkits and have been posted in Basecamp. In addition, the team has scheduled a webinar for January 2019 to have open discussions related to these workflows and protocols.

June 30, 2019 Update

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

Integrated Care Practice must include:

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

Network Membership

During the reporting period of January 1 through June 30, 2019, Region 7 IDN had no members join or leave the network. The information below speaks to the progress that Region 7 IDN has made on the B1 Core Competency project "Integrated Healthcare" during this reporting period.

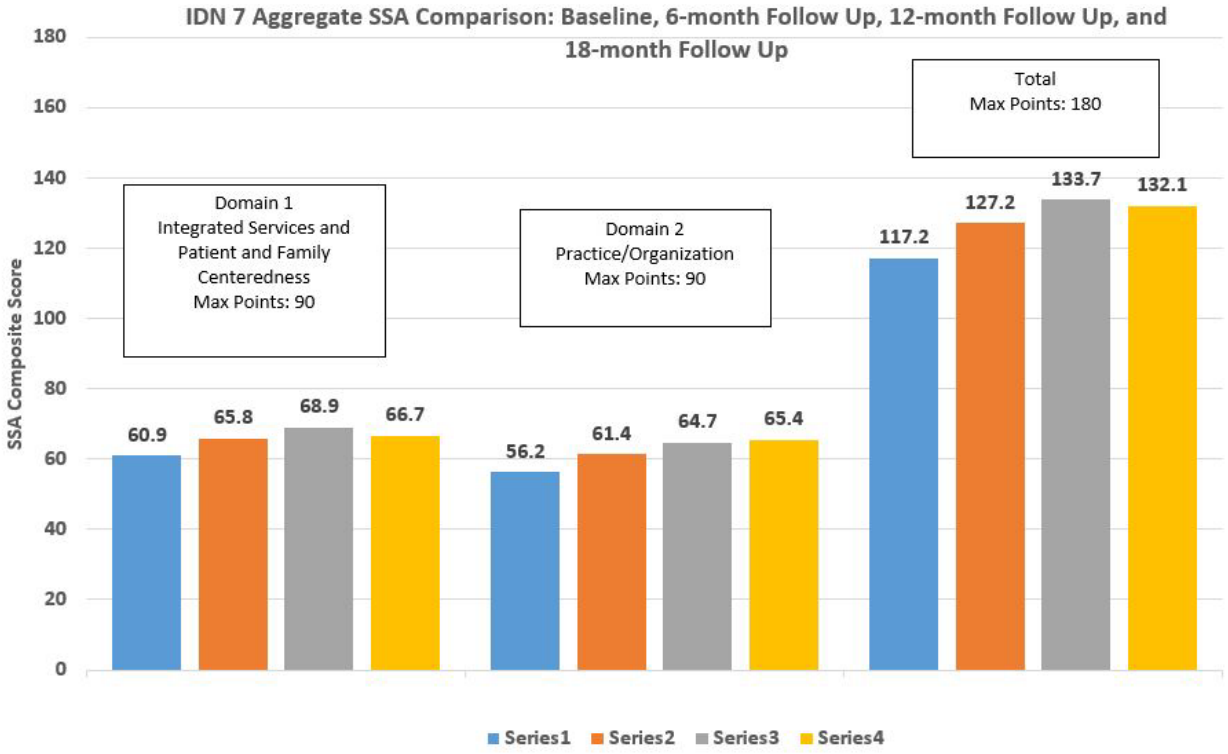
Region 7 IDN Data Governance

As Region 7 IDN adopted the new DHHS Monthly Update reporting format this spring, efforts were expended to verify the total number of individuals served by each Region 7 IDN partner to date and leverage the State's reporting tool as a mechanism that will help partners report monthly totals for the remainder of the DSRIP. By utilizing the State's new monthly reporting mechanism as the backbone of a high-integrity data management process, the Region 7 IDN team hopes to ease the reporting burden for partners while retaining the ability to collect, aggregate and analyze data for the region as a whole. This revised process is anticipated to allow the region to evaluate progress on performance evaluation targets more frequently and help the Region 7 IDN team provide more timely feedback and support to the region's partners. Partner specific updates in this section reflect narrative regarding their progress along the continuum of the project, and their total number of unique individuals served during the DSRIP period through June 30, 2019.

Maine Health Access Foundation Site Self-Assessment:

Partner agencies in Region 7 IDN have continued to make progress in many areas as they have worked to advance along the continuum of integrated healthcare during the reporting period of January-June 2019. The region has a contract with Citizens Health Initiative (CHI) and UNH Institute for Health Policy and Practice (IHPP) to administer a Site Self-Assessment (SSA) Survey to the behavioral health and primary care practices within the region designed to assess their level of behavioral health integration. The survey is based on the Maine Health Access Foundation Site Self-Assessment. To date, practices have completed a baseline survey in June 2017, a follow up survey in December 2017, a second follow up survey in June 2018 and a third follow-up survey in June 2019. The region's implementation plan

states that moving forward the survey will be administered on a yearly basis, so the partners in the region are not expected to complete another survey until late 2020. The region's SSA score results through June 2019 are reflected below.



The chart below reflects composite scores by practice site for the baseline assessment and subsequent follow-up surveys. The slight dip in the region's scores, specifically in Domain 1: Integrated Services and Patient and Family Centeredness is not unexpected, and the IDN team has been reminding partner agencies that this may be a possibility. Explanations for this variance include staffing turnover which can impact who may complete a survey, and workflows and protocols which have been communicated but not yet fully adopted by partner agencies. Despite the minor variation evidenced in this follow-up survey, the region remained on Level 5 of SAMSHA's Six Levels of Integration scale. As agencies continue to refine workflows, develop written protocols, and incorporate additional technologies into their systems of care, these scores should continue to rise over the remaining DSRIP period.

During a meeting with CHI staff to review the scores of the region, the IDN team was encouraged to reinforce organized approaches with partner agencies, recognizing that many of the current processes in place are newly implemented and need continual evaluation and reinforcement in order to hardwire these new processes into the practices. The CHI staff also recommended preparing for sustainability throughout the Region, reinforcing the active involvement of Region 7 IDN partners in several statewide taskforces addressing the sustainability of various DSRIP initiatives. The strong collaborative relationships that have developed across the region will serve as the foundation for continued work toward total integration as defined by SAMHSA's Six Levels of Integration. The Region 7 IDN team is prepared to assist partner agencies with efforts to address challenges as agencies work to continue advancement along the continuum of integrated healthcare.

The table below reflects survey results for each of the SSAs conducted to date, showing that most Region 7 IDN partners showed mild to moderate improvement in their scores. Results for two partners,

Littleton Regional Healthcare and White Horse Addiction Center, showed a significant regression in scores. In the coming reporting period, the Region 7 IDN team will work with these partners to identify the factors contributing to their team having scored the agencies lower on the self-assessment than in prior periods and offer supports to address any integration gaps.

SSA Composite Scores by Practice				
Practice Site	**June 2017 Baseline Results**	**December 2017 Follow-Up Results**	**June 2018 Follow-Up Results**	**June 2019 Follow-Up Results**
7-101 Ammonoosuc Community Health Services	153	153	N/A	**N/A**
7-102 Coös County Family Health Services Family Medicine, Pleasant Street	124	120	126	**137**
7-123 Coös County Family Health Services, OB/Gyn	124	120	126	**137**
7-119 Coös County Family Health Services Family Medicine, Page Hill	121	121	126	**136**
7-120 Coös County Family Health Services Family Medicine, Gorham	121	121	126	**136**
7-121 Coös County Family Health Services Pediatrics, Pleasant Street	117	119	122	**134**
7-122 Coös County Family Health Services Pediatrics, Gorham	117	119	122	**134**
7-103 Northern Human Services	103	115	N/A	**N/A**
7-105 Littleton Regional Healthcare	91	125	135	**81**
7-106 Weeks Medical Center	145	150	152	**153**
7-107 White Mountains Community Health Center	109	123	143	**159**
7-108 Rowe Health Center	132	127	113	**138**
7-109 Memorial Hospital	154	174	169	**180**
7-111 Huggins Hospital	86	105	117	**126**
7-113 Saco River Medical Group	80	109	117	**125**
7-115 Indian Stream Health Center	116	136	121	**126**
7-118 White Mountain Community Health Center	118	127	140	**156**
7-104 Friendship House	N/A	86	N/A	**N/A**
7-114 White Horse Addiction Center	129	119	146	**55**

The table below reflects Region 7 IDN progress in the four specific SSA categories identified as opportunities for improvement in the analysis of the baseline survey results in 2017. As shown below, each category has reflected ongoing improvement apart from the category, "Physician, Team and Staff Education and Training for Integrated Care." While work will continue in all these focus categories so that progress continues, this result demonstrates the need for additional integrated healthcare training opportunities within the region. Recorded on-demand trainings will remain available to partners and the Region 7 IDN team will focus efforts in the coming reporting period on ensuring that staff at partner agencies continue to enhance their understanding of the delivery and value of integrated care.

Maine Health Access Foundation Site Self-Assessment Categories	**June 2017 Baseline Results**	**December 2017 Follow-Up Results**	**June 2018 Follow-Up Results**	**June 2019 Follow-Up Results**
Level of Integration - Primary Care and Mental/Behavioral Health Care	5.8	6.0	6.4	7.4
Patient/Family Input to Integration Management;	4.9	5.4	6.0	6.3
Physician, Team and Staff Education and Training for Integrated Care	5.6	6.1	7.3	6.6
Patient Care Team for Implementing Integrated Care	5.5	6.6	7.0	7.1

Quality Improvement Team:

The region's Quality Improvement team continues to evolve based on the needs of the region. NCHC continues to leverage the expertise of one of the organization's Practice Transformation Network (PTN) Facilitators to serve as a part-time IDN Quality Improvement Coach. In addition, the IDN Quality Improvement Coach serves as the region's Care Advocate Supervisor by offering training and technical assistance for care coordinators. During this reporting period she has continued to provide focused guidance to several IDN partners who worked to develop and implement workflows and protocols. In particular, she worked closely with Friendship House as they worked to enhance the codification of their processes in anticipation of the CARF accreditation process.

The IDN team also added a part-time QI coach in January who will work with additional practices in the region. The new QI coach previously worked for the Practice Transformation Network and has strong ties in the region. Her time was primarily dedicated during this reporting period to the support of the region's partners implementing Critical Time Intervention services. During the coming reporting period, the Region 7 IDN team hopes to deploy the part-time QI coach and the region's HIT Integration Coach directly into partner care settings where they can offer technical assistance to IDN partners in real-time.

The IDN team also welcomed a new Program Manager in February 2019, replacing the previous Program Manager who moved into a Program Director role within NCHC and continues to provide oversight of IDN activities. The new Program Manager is a Certified Professional in Healthcare Quality (CPHQ) and has extensive experience in quality improvement, systems design and data analysis in the partner setting. As the reporting period progressed, the Region 7 IDN team began the process of reassessing the skill sets of all the IDN team members and realigning their skills and expertise to assist partners as they work to advance along the continuum of integrated healthcare.

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

As incentive payments were received in the latter half of this reporting period, Region 7 IDN team began the process of executing new memoranda of understanding with IDN partners based on the projects approved in October 2018. After learning of the approximate 16.8% decrease in available incentive payments resulting from several performance evaluation targets not met by June 2018, the following partners opted to adjust their proposal budgets to reflect the regional loss of 16.8% and move ahead with the funding process to aid in deepening their integration of physical and behavioral health services:

- *Ammonoosuc Community Health Services (ACHS)* plans to continue expanding their *Integrated Behavioral Health/Substance Use Disorder Services across Settings* project. ACHS will continue to formally coordinate behavioral health and primary care between ACHS and Friendship House (FH), place Mental Health Clinicians at local area schools to provide substance use preventive and counseling services, and utilize its work flow to notify ACHS behavioral health staff when clients have behavioral health or substance use disorder related Emergency Room visits. ACHS plans to expand their internal Medication Assisted Treatment (MAT), as well as establish and maintain close coordination with recovery support organizations. They also plan to ensure clients served by ACHS behavioral health providers are assessed and referred to in-house patient navigator staff as appropriate to address social determinants of health.
- *Huggins Hospital* will expand their *Huggins Health Neighborhood Care Coordination and Integration Services* project. The project will enhance Huggins Hospital's integration of behavioral health and primary care and address the social determinants through expanded care

coordination, adoption of assessment and screening related to the IDN project, and support for expanded MAT services.

- *Northern Human Services (NHS)* is partnering with *Ammonoosuc Community Health Services (ACHS)* to expand their existing reverse integration project, embedding primary care into a community mental health center, into the Littleton service area. The 2 agencies will work closely together to so ACHS can deliver primary care services at Northern Human Service's site in Littleton.

Core Comprehensive Standardized Assessment (CCSA) implementation:

Region 7 IDN has continued to make considerable progress towards all partners participating in the core competency integrated healthcare project implementing the Comprehensive Core Standardized Assessment (CCSA). During this reporting period, the Region 7 IDN team was able to ascertain that all thirteen partners have some version of a CCSA underway. Of those thirteen partners, nine have a CCSA in place that meets all requirements, including the 10 CCSA domains, pediatric screenings for pediatric primary care, and universal screenings. Many of these partners have used the Sample CCSA Protocol drafted by the IDN Quality Improvement Coach. Partners report that they have been working to embed the findings from CCSA domains into their EMRs so that the data is actionable and reportable.

Several partners report that they have conducted rapid-cycle quality improvement processes during this reporting period, changing their data collection processes to maximize the usability of information gathered from patients. Some partners invite patients to enter their own responses directly in the EMR by using a connected tablet while waiting for their appointment to start. Other partners give paper tools to patients and then use staff time to populate the corresponding fields within the EMR. Additionally, several partners have indicated that they are dedicating efforts to reinforcing CCSA process and the value of these screenings with providers and support staff.

In the coming reporting period, the Region 7 IDN team will continue to offer targeted support to partners who are not yet meeting all CCSA requirements and will consider ways to include education regarding the importance of CCSA implementation in the region.

Access to a Multi-Disciplinary Core Team (MDCT):

Region 7 IDN has acknowledged that access to a Multi-Disciplinary Core Team which meets DSRIP requirements is one of the primary barriers that prevents many practices in the region from achieving Coordinated Care Practice designation. Although six partners have successfully implemented a MDCT at their individual sites, the rest of the Region 7 IDN partners continue to struggle with the composition of the team. In particular, the lack of a psychiatrist at most locations is a significant barrier to full MDCT composition. Several members have indicated that they have psychiatric nurse practitioners already participating in multidisciplinary case conferences, and express a frustration that this specially trained healthcare provider who is able to practice independently according to the licensing rules of NH and many other states is not considered qualified to provide the necessary psychiatric guidance to a MDCT.

Philosophically, partners taking part in the core competency integrated healthcare project have expressed an interest in having a MDCT readily available to their providers for regular case consultations. In practice, however, more than half of these partners feel they do not have the internal bandwidth necessary to dedicate provider time to these regular meetings. These partners report the cost of a psychiatrist and the non-billable time MDCT members would spend on these activities is a barrier to successful implementation.

During the reporting period, the Region 7 IDN team facilitated discussions with workgroups and the partner agencies working on the core competency integrated healthcare project to assess their willingness to use a regional Multi-Disciplinary Core Team in such a way as to meet all DSRIP requirements. Partners who do not yet have access to a MDCT expressed an interest in having such a consultative body available to them for guidance on their most complex cases. As these conversations progressed it has become clear that there was some misunderstanding about the nature and functionality of a MDCT. To address this misperception, the Region 7 IDN team has spent a significant amount of time during this reporting period clarifying the purpose, functionality, and requirements of the MDCT.

Even for partner agencies who have been able to successfully establish a Multi-Disciplinary Core Team at their own locations, confirming that the members of this team have met the DSRIP training requirements continues to be challenging. The Region 7 IDN team has corroborated this challenge with administrative leads from other regions who share that they are facing similar barriers in determining whether adequate training of MDCT members has occurred. Region 7 IDN has discussed the best way to verify that MDCT members have adequate training in the five topic areas. The consensus is that primary care providers have received adequate training in all five topic areas as part of their scope of practice. In individual partner calls and Clinical Workgroup meetings, partners have expressed that some providers receive regular CME in the areas of integrated care, chronic disease management and the importance of behavioral health as a component of whole person wellness. Partners with functioning MDCTs also report their existing case consultation process organically provides ongoing education about the topic area as a byproduct of the case review process.

The Steering Committee has dedicated time during meetings in the last half of the reporting period to discussing the use of targeted funding in support of a regional MDCT, and these conversations will continue to evolve during the next reporting period. In the coming reporting period, the IDN team will collaborate closely with partner agencies and governance workgroups to develop workflow and protocol templates that can be adapted by partner agencies to ensure that their providers have access to the regional MDCT.

Standardized Workflows and Protocols:

In prior reporting periods, the Region 7 IDN team worked diligently to research and create draft workflows and protocols for partners in the region to adapt to meet their needs. These draft protocols populate the region's toolkits and are accessible on Basecamp. In January, partners were invited to participate in a live webinar where these tools were presented, and partners had the opportunity to engaged in open discussions related to these workflows and protocols.

During this reporting period, the Region 7 IDN team has supported partners' adoption of the protocols and workflows required to progress along the continuum of Coordinated and Integrated Care Practice designations. At this time, twelve of the thirteen partner agencies taking part in the core competency integrated healthcare project have made progress in codifying the work done by their practices within these focus areas, and seven have put all required workflows and protocols in place. In the coming months, the Region 7 IDN team will support and assist partner agencies as they continue to implement the required protocols.

Ongoing Integrated Healthcare Educational Opportunities

During this reporting period, the Region 7 IDN team focused efforts on evaluating the current library of on-demand training across the region and considering the best ways in which to make this content available to Region 7 IDN partners. Additionally, the Region 7 IDN team engaged partners to discuss the

training that Care Advocates and MDCT members have received and identify gaps in that education which can be addressed through regional training opportunities. An analysis of this feedback is currently underway, and results will be used as future trainings are planned.

December 31, 2019 Update

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

Integrated Care Practice must include:

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

Network Membership

During the reporting period of July 1 through December 31, 2019, no partners have left the network. The Region 7 IDN had one new member join the network – Coös County Department of Corrections – bringing the total number of partners in the Region 7 IDN to thirty-nine (39).

The information below speaks to the progress that Region 7 IDN has made on the B1 Core Competency project "Integrated Healthcare" during this reporting period.

Maine Health Access Foundation Site Self-Assessment:

The region has a contract with Citizens Health Initiative (CHI) and UNH Institute for Health Policy and Practice (IHPP) to administer a Site Self-Assessment (SSA) Survey to the behavioral health and primary care practices within the region designed to assess their level of behavioral health integration. During this reporting period, Region 7 IDN partners utilized the Site Self-Assessment Survey (SSA) results from June 2019 to continue working along SAMSHA's integrated healthcare continuum. The survey is based on the Maine Health Access Foundation Site Self-Assessment. To date, practices have completed a baseline survey in June 2017, a follow up survey in December 2017, a second follow up survey in June 2018 and a third follow-up survey in June 2019. The region's implementation plan states that moving forward the survey will be administered on a yearly basis, so the partners in the region are not expected to complete another survey until late 2020.

The table below reflects Region 7 IDN progress as of June 2019 in the four specific SSA categories identified as opportunities for improvement in the analysis of the baseline survey results in 2017. As shown below, each category has reflected ongoing improvement apart from the category, "Physician, Team and Staff Education and Training for Integrated Care." This result demonstrated the need for additional integrated healthcare training opportunities within the region. The Region 7 IDN team focused on providing training opportunities to partners that met these needs during this reporting period, including ensuring that partner agencies had access to recorded on-demand trainings to enhance partner staff understanding of the delivery and value of integrated care. In addition, the Regional Care Coordinator Network was established, in part, to provide ongoing educational and skills development opportunities to Care Advocates throughout the region.

A key approach to mitigating this challenge was the Region 7 IDN Quarterly Workshop held in September 2019. The structure of this regional meeting was designed to provide a more interactive

learning experience for attendees. Activities focused on key components of coordinated and integrated care and the ways that specific DSRIP process deliverables contribute to the ultimate success of the region. Feedback from attendees indicated that they found the exercise valuable in opening up more conversation regarding opportunities to collaborate on efforts which move the region closer to a delivery system that provides truly integrated care.

The Region 7 IDN team will continue to engage with partners on these focus categories so progress on the coordinated/integrated care continuum continues.

Maine Health Access Foundation Site Self-Assessment Categories	June 2017 Baseline Results	December 2017 Follow-Up Results	June 2018 Follow-Up Results	June 2019 Follow-Up Results
Level of Integration - Primary Care and Mental/Behavioral Health Care	5.8	6.0	6.4	7.4
Patient/Family Input to Integration Management;	4.9	5.4	6.0	6.3
Physician, Team and Staff Education and Training for Integrated Care	5.6	6.1	7.3	6.6
Patient Care Team for Implementing Integrated Care	5.5	6.6	7.0	7.1

Quality Improvement Team:

The region's Quality Improvement team continues to evolve based on the needs of the region. NCHC continues to leverage the expertise of their Quality Improvement Manager to work part-time as the IDN Quality Improvement Coach and Care Advocate Supervisor who offers training and technical assistance in the region.

As the reporting period progressed, the Region 7 IDN team continued the process of reassessing the skill sets of all the IDN team members, and realigning workload to best leverage skills and expertise to assist partners as they work to advance along the continuum of integrated healthcare.

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

During the reporting period, multiple partners continued work on projects funded through Round 4 of the request for proposal process. Interim reports providing updates on project status were received from the following agencies:

- *Northern Human Services (NHS):* NHS submitted two proposals for Round 4. Their proposal to stand up a second Integrated Clinic in collaboration with Ammonoosuc Community Health Services in Littleton was awarded and the project was implemented during this reporting period. The second integrated clinic opened in September 2019 and has been a valuable addition to the clients of both

agencies. The partner decided to rescind their second proposal to implement Critical Time Intervention in July due to competing priorities within the agency.

- *Tri County Community Action Program:* TCCAP used IDN funds to continue providing Critical Time Intervention services to the region, with a focus on the transition from homelessness to permanently housed. The agency has focused the bulk of their pre-CTI efforts on clients of the Tyler Blain homeless shelter and continue intensive phased case management with clients of higher need to achieve sustainable housing. TCCAP reports that this model has been so successful, however, that they have adopted it as the preferred model for case management with all clients served by the Homelessness Intervention and Prevention specialists. Of note, the project has helped eliminate the "revolving door" of repeat clients and allowed staff to help new clients. Multiple clients that have graduated the CTI program have later sent letters expressing their gratitude to the agency and staff who helped them through their struggles.
- *Friendship House:* Friendship House was awarded funds to continue enhancing their care coordination department and improving the curriculum for the residential program. During the reporting period the partner worked with the regions quality improvement coach to finalize workflows and protocols to achieve project goals. The new systems in place have been implemented and are being monitored in an ongoing fashion to track progress.
- *Weeks Medical Center:* WMC spent this reporting period expanding their existing Medication Assisted Treatment program to the Colebrook area to provide services for Upper Connecticut Valley Hospital and Indian Stream Health Center. The funding has allowed Weeks to hire a new Psychiatric NP and MLADC to staff the new location. From 07/15/2019 to 08/28/2019 Weeks Medical Center had 134 patients referred to behavioral health providers, with 133 screening positive for SUD.
- *North Country Serenity Center:* NCSC was awarded funds to continue expanding recovery support staff to ensure appropriate capacity to serve the additional influx of visits the agency has begun to experience. The funds helped bring the agency to be fully staffed and improve collaboration throughout the region. NCSC has focused on continuing their collaboration with ACHS and began collaborating with the Family Resource Center to provide the Sober Parenting Journey program. NCSC reports that their new focus is to work towards sustainability by achieving CRSW status for all staff, allowing them to bill for services.
- *White Mountain Community Health Center:* WMCHC was awarded funds to continue improving care coordination services at the agency. During this period, IDN funds have helped WMCHC continue utilizing the CCSA to identify risks related to social determinants of health and a risk stratification tool to identify patients who would benefit from care coordination. The funds have also allowed the agency to continue collaborating with Northern Human Services to hold monthly MDCT meetings for high-risk patients.
- *Huggins Hospital:* Huggins Hospital used IDN funds this period to hire two RN care coordinators to strengthen care coordination services and increase patients served by coordinated and integrated care services. The partner has also been able to move forward with a training plan as they work to implement the CCSA in more primary care offices. Huggins also focused on the final stages of development of their new MAT program, intended to formally launch in early 2020.
- *Ammonoosuc Community Health Services (ACHS):* ACHS continued a long-standing project to provide behavioral health services integrated in the school setting and to collaborate with local partners to provide quality SUD care throughout the region. ACHS continues to provide LICSW/LCMHC support to Lafayette Regional school, Blue Mountain Union School, Bethlehem Elementary school, Profile High School, and K-12 grades in Lisbon. During the reporting period ACHS formed an agreement with local Boys and Girls Club to allow enrolled students to continue treatment at the club when the schools are closed during breaks and vacations. ACHS has also been utilizing a behavioral health

master's degree intern to help with delivering services to students and school staff for the last 9 months, primarily in Lisbon. As of September 2019, ACHS expanded its behavioral health support to the Bath Village School, Woodsville Elementary and High Schools, Haverhill Cooperative Middle School, and schools in Piermont and Warren. ACHS is actively recruiting one Licensed Clinical Social Worker (LICSW) to increase capacity for these services and actively advertising for a licensed mental health professional to fulfill requests for counseling services at Littleton area schools and The White Mountain School, a private boarding school in Bethlehem.. ACHS has also identified the Linwood school district located in the southern portion of their catchment area as an underserved community for mental health and SUD services, and has begun talks with the White Mountains Regional School District covering five towns in Southern Coös County regarding similar service expansion. Collaboration with North Country Serenity Center and Friendship House has continued, increasing all partners' ability to provide quality SUD treatment to clients through improved referral systems and access to services.

- *Memorial Collaborative:* Memorial Hospital, Saco River Medical Group, Visiting Nurse Home Care and Hospice of Carroll County and Children Unlimited used IDN funding this period to continue their collaborative care coordination efforts within Carroll County. The funds continued to help foster more valuable relationships throughout the region, support expansion of MAT services, and provide supportive services for families and clients of all agencies. The group continues to work on a collaboration with the Carroll County jail to provide support to families impacted by SUD and the judicial system using the "Parenting from Prison" curriculum.
- *White Horse Addiction Center (WHAC) & Mount Washington Valley Supports Recovery (MWVSR):* IDN funding supported WHAC & MWVSR as they worked to secure staff, space and equipment required to provide 24/7 on call recovery supports to patients in local emergency departments. Their work also included obtaining specialized training for peer recovery coaches working in emergency departments. As these partners formalized their policies, workflows and workforce for this initiative, they engaged with Memorial Hospital to enter into a Memorandum of Understanding for the provision of on call recovery supports to individuals who present at their facility. The relationship has proven beneficial to the expansion of recovery services throughout the region.

During this reporting period, the Steering Committee spent a considerable amount of time developing a new targeted funding approach aimed at ensuring that incentive payments already on hand in the region were used to achieve process measure targets set under the region's implementation plan. A tiered funding approach based on overall regional projects and the continuation of partner projects was adopted. Lump-sum funding was offered to partners engaged on key projects in a tiered fashion based on the partner type and its direct correlation to performance-based funding metrics. Partners were offered a Memorandum of Understanding (MOU) for the tiered amounts in exchange for a commitment to complete key project targets set under the region's implementation plan. A MOU was developed for each partner with an attachment that outlined clear deliverables each partner would have to meet in exchange for the amount offered. For Integrated Healthcare partners this included engaging with the regional Multi-Disciplinary Core Team, ensuring that the organization had a Core Comprehensive Standardized Assessment in place that included all required domains, the use of direct secure messaging technology, formalizing communication channels with social service agencies, engaging with the Collective Medical network, committing at least one care coordinator to participate in the Regional Care Coordination Network, ensuring that all staff training requirements were met and meeting all reporting obligations under the DSRIP. Funding was offered to partner organizations in a tiered fashion as follows:

- $45,000 was offered to eleven primary care partners connected to the Core Competency/Integrated Healthcare project;
- $35,000 was offered to two Substance Use Disorder treatment organizations connected to the Core Competency/Integrated Healthcare project;
- $25,000 was offered to two partners implementing Critical Time Intervention under the Care Transitions project;
- $20,000 was offered to three Recovery Community Organizations connected to the Expansion in Intensive Substance Use Disorder project;

The Steering Committee also approved two separate funding distributions through the new performance-based funding mechanism. Northern Human Services received $10,000 to supply Behavioral Health staff for the newly developed Regional Multidisciplinary Core Team, and new partner Coös County Department of Corrections was awarded $35,000 to implement a Medication Assisted Treatment (MAT) program and provide intensive case management for incarcerated individuals with known release dates. The following partners entered into the proposed MOUs by December 31, 2019:

- Ammonoosuc Community Health Services
- Coös County Department of Corrections
- Friendship House/NCHC Clinical Services
- Indian Stream Health Center
- Mt. Washington Valley Supports Recovery
- North Country Serenity Center
- Northern Human Services
- Saco River Medical Group
- Tri-County Community Action Program
- White Horse Addiction Center
- White Mountain Community Health Center

Due to competing priorities and agency concerns about meeting the deliverables required within the MOU, the following partners opted not to accept the performance funding offer:

- Carroll County Department of Corrections
- Coös County Family Health Services
- Hope for NH Recovery
- Huggins Hospital
- Littleton Regional Healthcare
- Memorial Hospital
- Rowe Health Center/Cottage Hospital
- Weeks Medical Center

The Region 7 IDN Steering Committee has begun discussion to determine how remaining incentive payments, including those not claimed under the performance-based MOUs and any earned in future evaluation periods, are distributed to the region through the remainder of the demonstration.

Core Comprehensive Standardized Assessment (CCSA) implementation:

In the coming reporting period, the Region 7 IDN team will continue to offer targeted support to partners who are not yet meeting all CCSA requirements and will consider ways to include education regarding the importance of CCSA implementation in the region.

Access to a Multi-Disciplinary Core Team (MDCT):

Region 7 IDN has developed access to a multidisciplinary core team (MDCT) by contracting with Northern Human Services for provision of a psychiatrist, behavioral health therapist, and MDCT coordinator. Additionally, the case coordinator will ensure that there is always a primary care provider present for sharing care plan options for managing primary care challenges with chronic disease management. The following gives an overview of the program being developed.

Purpose: To provide a multidisciplinary team forum for complex patient case presentation and assistance with planning of care.

Policy: Maintaining the strictest standards of confidentiality, the Region 7 Integrated Delivery Network (IDN) Multi-Disciplinary Core Team (MDCT) will meet on a monthly basis to provide consultation and person-centered care planning that will improve outcomes for the most complex and vulnerable patients in the region.

Membership: The Region 7 IDN MDCT is comprised of health and human service organizations serving Coös, Carroll and Northern Grafton Counties. Each MDCT member organization is responsible for developing and providing employee education about the MDCT operations at their organization.

Structure: The core part of the team will include a psychiatrist, behavioral health provider, behavioral health coordinator and primary care provider. Referrals to the team will occur from Region 7 IDN partners who need to access the MDCT for complex patient management. These partners will provide case presentation information and identify priority participants.

The IDN7 Regional MDCT is intended to be a collaborative and consensus-driven consultative body, that will be convened for the purpose of planning patient/client care. Its primary goal is to share information and knowledge in general to improve service delivery across the region and specifically to:

1. Engage priority participants as indicated by referrals received;
2. Recognize patient/client's self-identified needs/goals as indicated in referral paperwork;
3. Identify gaps to meeting those needs and goals (historical, current, and anticipated);
4. Identify strategies to remove barriers and meet those goals;
5. Identify partner agents/points of contact responsible for coordinating and facilitating next steps/strategies;
6. Communicate strategies via a shared care plan to the patient's circle of care; and
7. Create a closed-loop communication plan that includes the patient/client/family.

The IDN7 Regional MDCT will meet a minimum of once each month. Core team members are not required to be physically co-located or be part of the same organization. Teams may also include peer specialists, pharmacists, social support service providers and pediatric providers as appropriate to individual needs.

The IDN7 Regional MDCT team will meet in February 2020 and a case will be presented by an IDN partner. Once the process has been evaluated using the plan, do, study, act (PDSA) method, the IDN7 Regional MDCT will start meeting monthly, and partners will have access to a MDCT.

Standardized Workflows and Protocols:

During this reporting period Region 7 IDN partners continued to have access to the region's Policy and Protocol Clearing house that was developed in early 2019. The clearinghouse holds an array of draft policies, protocols and workflows for partners to adapt and implement into their unique practices. Region 7 IDN partners have been continuously encouraged to browse the library of policies and

protocols to help move the region further toward integrated care. The Collaborative Care agreement has been an essential asset to many partners throughout the region, helping ensure improved care transitions and referral process across agencies. The Region 7 IDN Quality Improvement Coach has also spent this period helping partners identify the most efficient use of the protocols and workflows available.

Ongoing Integrated Healthcare Educational Opportunities

During this reporting period, the Region 7 IDN team focused on closing training gaps partners continued to help identify. Concerns about the availability of staff time continues to be a major barrier for all partners when it comes to trainings. This is due to the loss of billable hours and simply the lack of additional staff to cover daily functions while the primary staff are away. This lead IDN staff to search for remote ways to deliver trainings utilizing on demand webinars. The Region 7 IDN team ensured all partners had access to the online library of on demand webinars and began developing new webinars to satisfy specific DSRIP requirements, such as the awareness of behavioral health among non-direct staff. The team worked to develop a webinar on this topic and plans to record and release it to the region in early 2020.

During the reporting period, Region 7 IDN partners had access to an array of trainings sponsored by multiple initiatives. The trainings helped develop the peer recovery workforce, community health worker workforce, and enhance the awareness of many other topics among Region 7 providers. The following trainings were offered:

- July 18-19 & 25-26, 2019: Recovery Coach Academy- 22 trained
- August 3, 2019: Addiction Hurts Panel Discussion
- August 12-13 & 19-20, 2019: Recovery Coach Academy- 15 trained
- August 26-28, 2019: Ethical Considerations for Recovery Coaches - 11 trained
- August 27, 2019: Recovery Friendly Workplace panel
- September 8, 2019: Psychological First Aid
- September 2019: Community Health Worker Training- 8 trained
- September 12, 2019: Mental Health First Aid for First Responders- 8 trained
- September 25, 2019: Mental Health First Aid- 21 trained
- September 28, 2019: Holistic Wellness Fair
- October 2, 2019: LNA Day of Learning
- October 3 & 4, 2019: OUD in the 603- 22 trained
- October 4 & 5, 2019: Motivational Interviewing- 10 trained
- October 7, 2019: NHS Employee Wellness Fair
- October 16,2019: Pleasure Unwoven Movie Screening w/ Panel Discussion- 24 trained
- October 23, 2019: Health Rocks! LRH Health Fair
- November 4-6, 2019: Ethical Considerations for Recovery Coaches- 12 trained
- November 13, 2019: Pleasure Unwoven Movie Screening w/ Panel Discussion- 31 trained
- November 25, 2019: Suicide Prevention- 25 trained
- December 4-5 & 11-12, 2019: Recovery Coach Academy-21 trained
- December 10, 2019: Healer's Forum – 18 participants

The Region 7 IDN team, Northern NH Area Health Education Center, and NCHC's Wellness and Recovery Model program have begun developing a training plan for 2020, focusing on reducing duplication and increasing access to high demand trainings that are usually offered out of the area. The following trainings have been scheduled and promoted to the region during this reporting period:

- January 9, 2020: HIV/AIDS Training
- January 22, 2020: Pleasure Unwoven Movie Screening w/ Panel Discussion
- February 5-7, 2020: Ethical Consideration for Recovery Coaches
- February 27, 2020: Mental Health First Aid
- April 2020: Pleasure Unwoven Movie Screening w/ Panel Discussion

The North Country Health Consortium plans to continue developing necessary resources and education for the current workforce and will look closely at the sustainability of initiatives that have resulted from IDN work.

Region 7 IDN also held two Quarterly Meetings during this reporting to bring partners together to think about what the project has accomplished and what should be focused on during 2020 to support sustainability. The meetings were held on:

- September 13, 2019: Region 7 IDN Quarterly Workshop: Moving Along the Continuum of Integrated Healthcare
- December 12, 2019: Region 7 IDN Quarterly Meeting: Integrated Care 2020 & Beyond

The September Quarterly Workshop was designed to engage partners in an activity to show the true functionality and potential that integrated care has for their patients. The partners were walked through an integration modeling exercise to help them gain a better understanding of the key components of integrated care. The Region 7 IDN team then spent time tying these processes to the statewide outcome metrics to show partners the impact their work has had thus far and the importance of improvement moving forward. At the December Quarterly Workshop, attendees continued the regional assessment of successes and barriers by participating in a Ripple Effect Mapping activity and then rank order identified trends to help the region strategize efforts in the final year of the project.

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.

December 31, 2018

Performance Measure Name	2018 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 **December 31, 2018:** Region 7 IDN partners have worked closely with IDN staff toward capturing all 12 CCSA domains and putting a protocol in place for the assessment process. Multiple partners have made excellent progress and continue to adapt the sample CCSA protocol to meet their specific needs. Saco River Medical Group is still in the process of developing ways to implement tools and workflows to capture missing domains. Coös County Family Health Services is still working to capture all 12 domains and the IDN team continues to provide workflow and protocol templates to assist CCFHS with the implementation process. White Horse Addiction Center and Friendship House have been focusing on building capacity to treat	13	0	0	8

Performance Measure Name	2018 Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
SUD patients. Memorial Hospital has been working to build the CCSA domains into their new EPIC platform. The IDN team will continue to focus efforts on assisting partner agencies to capture the 12 domains and implement a CCSA protocol, including the identification of specific barriers and realities, and implementing PDSA's as needed to hone workflows.				
# of partner agencies using shared care plan (care guidelines feature) **December 31, 2018:** While Region 7 IDN do not have any organizations using care guidelines at this time, there has been continued expansion of all other areas of CMT utilization. This includes White Mountain Community Health doing additional census work as part of their go-live (it is anticipated they will use care guidelines in the next quarter), Northern Human Services starting implementation, Huggins Hospital starting to receive faxed event notifications in the ED and presentations to Indian Stream Health Center.	13	0	0	0
# of partner agencies using Multi-Disciplinary Core Team	5	0	0	7
# of partner agencies using standardized workflow and protocols: **December 31, 2018:** The IDN engaged consulting and education resources to develop and implement a Protocol Clearinghouse on the IDN Basecamp site. Here, partners can see examples of all required protocols that they can either adopt or use as guideline to develop their own version. Region 7 IDN team have communicated this to partners and will also be doing a webinar in January to review the platform and specific policies. IDN staff are working to develop a new partner reporting tool which will help address gaps in workflow and protocol development.	13	0	0	7
# of partner organizations which have implemented MAT services	5	2	6	7
# of psychiatric nurse practitioners	3	2	5	6
# of MLDACs **December 31, 2018:** Region 7 IDN continues to struggle with recruitment and retention for MLADCs and other licensed mental health professions. The region has experienced increased turnover of licensed mental health clinicians and Master Licensed Alcohol and Drug Counselors assumingly due to provider burnout and compassion fatigue. There is a considerable amount of work being done in the region to address compassion fatigue by the North Country Task Force on Improving Opioid Treatment Outcomes. This is a group of individuals and provider agencies who are coming together to discuss how to identify core competencies for addiction professionals that effectively addresses self-care as a risk management and quality assurance measure for patient care. Region 7 has also continued to be actively involved in the Statewide IDN Training and Education Workgroup which discusses the Behavioral Health Higher Education Roundtable regularly. The two groups have been working together to help increase BH workforce and help providers with recruitment and retention strategies. Organizations and educational institutions have continued to collaborate to align employment	16	16	19	20

Performance Measure Name	2018 Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
requirements with education requirements to streamline the transition between school and actual practice.				
# Licensed Mental Health Professionals **December 31, 2018:** Region 7 IDN continues to struggle with recruitment and retention for MLADCs and other licensed mental health professions. The region has experienced increased turnover of licensed mental health clinicians and Master Licensed Alcohol and Drug Counselors assumingly due to provider burnout and compassion fatigue. There is a considerable amount of work being done in the region to address compassion fatigue by the North Country Task Force on Improving Opioid Treatment Outcomes. This is a group of individuals and provider agencies who are coming together to discuss how to identify core competencies for addiction professionals that effectively addresses self-care as a risk management and quality assurance measure for patient care. Region 7 has also continued to be actively involved in the Statewide IDN Training and Education Workgroup which discusses the Behavioral Health Higher Education Roundtable regularly. The two groups have been working together to help increase BH workforce and help providers with recruitment and retention strategies. Organizations and educational institutions have continued to collaborate to align employment requirements with education requirements to streamline the transition between school and actual practice.	23	18	16	9
# of Peer Recovery Coaches	6	22	59	67
# of Community Health Workers	4	11	13	13
# CTI Workers	15	11	24	37
# CTI Supervisors	3	3	3	3
# Care Advocates **December 31, 2018:** The region initially planned to train five Care Advocates in each of the three subregions by December 31,2018. As the project moved into the implementation phase it became apparent that it would be beneficial to combine Coös and northern Grafton County agencies together for the regional care coordination training. The reasoning behind this decision was due to the structure of North Country Healthcare, and their efforts to coordinate care across the region. Due to North Country Healthcare's regional care coordination approach they only sent two staff members to the training versus one from each of the five affiliate agencies. NCHC plans to offer additional care coordination training modules via webinar to reach additional care coordinators moving forward.	15	0	7	11
# Care Advocate Supervisors	1	0	1	1
# Community based clinicians (staffing from first round of capacity)	1	1	1	1
# Physician assistant clinicians (staffing from first round of capacity)	1	1	3	3
Community nurse coordinator clinicians (staffing from first round of capacity)	1	1	1	1
Behavioral health assistant clinicians (staffing from first round of capacity)	1	1	2	3
Behavioral health case managers clinicians (staffing from first round of capacity)	5	4	5	11
LICSW clinicians (staffing from first round of capacity)	3	2	2	4

Performance Measure Name	2018 Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
IDN QI Coach	1	0	1	2 (both part-time)
HIT Integration Coach	1	1	1	1
IDN Data Specialist (NCHC)	1	0	0	1
Data Specialists for IDN partners	Up to 3	0	0	3

After initiation of the project, the data specialist was deemed to be redundant with services already provided by MAeHC and the HIT lead at NCHC. In lieu of hiring additional staff to handle data aggregation and funding them through IDN request for proposal funding, three agencies (White Mountain Community Health Center, Saco River Medical Group and Coös County Family Health Service) have elected to use IDN funds to contract for these services instead. WMCHC has contracted with a third-party expert, while Saco and Coös County have contracted directly with MAeHC for data abstraction services. All three have been able to leverage these resources into better reporting results.

Region 7 IDN does not believe that all B1 partner agencies will be connected to a Multi-Disciplinary Core Team. Because the region has shifted away from the regional core team model, it will be difficult to get full participation with this component, so now the region would like to stand up five teams by the end of 2018.

June 30, 2019 Update

Workforce Calculation Process

As the Region 7 IDN team spent time during this reporting period assessing the progress made on process measures, questions arose regarding the rate of change for some workforce categories in the context of narrative reports of significant improvements in access to treatment for behavioral health diagnoses was improving. During the collection of data for this report, the Region 7 IDN team focused on verifying the current state of workforce in the region as it compared to the baseline reported in the Region's Implementation Plan published July 2017. This included a level-setting of workforce numbers and the number of individuals served under each of the DSRIP projects. The team was successful in capturing current workforce levels for all partners specifically engaged in the DSRIP projects, as well as the turnover specific to this reporting period. As the Region 7 IDN team analyzed this latest data, four significant variances were found, all occurring with the introduction of the June 30, 2019 staffing levels contributed by the region's Community Mental Health Center, *Northern Human Services (NHS)*, as demonstrated in the A1-5 table extract below.

Workforce Category	2018 Target	Baseline 6/30/17	As of 12/31/18	As of 6/30/19
Behavioral Health Case Managers	5	2	7	49
Licensed Mental Health professionals	23	14	9	49
Master Licensed Alcohol and Drug Counselors	16	11	14	17

Further examination of data collection processes and findings from prior reporting periods suggests that NHS turnover data has impacted the region's aggregate workforce totals since December 2017, but their baseline staffing levels were not included in the June 2017 regional baseline aggregate. This analysis of workforce data has also identified that the number of MLADCs in the region was reported inconsistently

across projects in prior periods, likely due to the manual calculation of the impact that partner turnover data has on the regional workforce aggregate. This process has highlighted the difficulty that the IDN faces in accurately capturing workforce capacity changes over time. It is common for a single partner to report that they lost a member of their workforce to another partner agency. Partners attribute the contrast between high local partner turnover rates and a relatively lower change in regional workforce totals to the dynamic recruitment and retention efforts employed by partner organizations in the face of workforce shortages within our rural region. Together these factors incentivize skilled workforce members living in the area to seek higher compensation packages without being encumbered by the inconvenience of moving their families. In future reporting periods, the Region 7 IDN team will work to capture both current staffing and turnover data from all project-engaged partners to ensure accurate updating to both tables and regional narrative. In this way, the region will be better positioned to show workforce capacity levels as a snapshot in time and local workforce turbulence impact on the delivery of integrated care.

Performance Measure Name	2018 Target	Progress Toward Target			
		As of 12/31/17	As of 6/30/18	As of 12/31/18	As of 6/30/19
Partner organizations using comprehensive core standardized assessment	13	0	0	8	**11****
Partner agencies using shared care plan (care guidelines feature)	13	0	0	0	2
Partner agencies using Multi-Disciplinary Core Team	5	0	0	7	6
Partner agencies using standardized workflow and protocols:	13	0	0	7	**13*****
Partner organizations which have implemented MAT services	5	2	6	7	9
Psychiatric nurse practitioners	3	2	5	6	11
Master Licensed Drug & Alcohol Counselors	16	11	13	14	17
Licensed Mental Health Professionals	23	18	16	9	49
Peer Recovery Coaches	6	22	59	67	88
Community Health Workers	4	11	13	13	18
CTI Workers	15	11	24	37	37
CTI Supervisors	3	3	3	3	5
Care Advocates	15	0	7	11	21
Care Advocate Supervisors	1	0	1	1	2
Community based clinicians (staffing from first round of capacity)	1	1	1	1	1
Physician assistants (staffing from first round of capacity)	1	1	3	3	17
Community nurse coordinators (staffing from first round of capacity)	1	1	1	1	1
Behavioral health assistants (staffing from first round of capacity)	1	1	2	3	4
Behavioral health case managers (staffing from first round of capacity)	5	4	5	11	49
LICSWs (staffing from first round of capacity)	3	2	2	4	13
IDN QI Coach	1	0	1	2	2
HIT Integration Coach	1	1	1	1	1
IDN Data Specialist (NCHC)	1	0	0	1	1
Data Specialists for IDN partners*	Up to 3	0	0	3	9.4 FTE

*During this reporting period several partners reported that, while they do not have any staff directly tasked and budgeted for DSRIP data management, they have allocated significant time from existing staff members to meet the reporting requirements of the DSRIP. Consistently, partners have indicated that the increasing demand for the use of data to drive care, and the need to validate data for payer

performance metrics is increasing. Separate from the dedicated data aggregator specialists accounted for in the evaluation target table above, this reporting period the Region 7 IDN team estimates that the thirteen partners engaged in the Core Competency project are dedicating an aggregate total in excess of 9 FTE engaged across the region in these data governance and reporting activities. This is based on partner feedback to targeted questions regarding their current allocation of staff resources to meet reporting requirements, including participation in calls with MAeHC and the IDN HIT Lead, abstraction of data, and alterations to EMR systems in order to have claims data accurately represent the care provided to their patients.

****During review period, partners White Horse Addiction Center and Saco River Medical Group were able to verify that they are currently assessing all required domains within their CCSA process. Though Saco River Medical Group was not able to complete this process in time to submit data for the CCSA performance measures in the first half of this year, staff have continued to work on making sure it is integrated in the new electronic medical record system currently being implemented. The Region 7 IDN team continues to make support available to these partners for the development of protocols that codify their current practice. Only two partners, Coös County Family Health Services and Memorial Hospital, remain as partners that have implemented most, but not all, of the required domains. The Region 7 IDN team continues to provide support and resources to these partners as they consider the addition of those domains not yet included in their regular screenings and assessments.**

*****During the review period, the Region 7 IDN team had the opportunity to compare the list of required workflows and protocols for Core Competency Integrated Healthcare partners against the extensive list of policies, procedures and protocols adopted by the Friendship House/NCHC Clinical Services Program as this partner prepared for and received accreditation from the Commission on Accreditation of Rehabilitation Facilities. This extensive body of work not only ensured that this partner began meeting this DSRIP metric, but that the clients of their clinical programs are receiving consistently high-quality services. In the remainder of the current reporting period, the Region 7 IDN team will assist this partner in implementing the remaining DSRIP-required workflows and protocols.**

December 31, 2019 Update

Performance Measure Name	2018 Target	Progress Toward Target				
		As of 12/31/17	As of 6/30/18	As of 12/31/18	As of 6/30/19	As of 12/31/19
Partner organizations using comprehensive core standardized assessment	13	0	0	8	11	11
Partner agencies using shared care plan (care guidelines feature)	13	0	0	0	2	2
Partner agencies using Multi-Disciplinary Core Team	5	0	0	7	6	9
Partner agencies using standardized workflow and protocols:	13	0	0	7	13	13
Partner organizations which have implemented MAT services	5	2	6	7	9	11
Psychiatric nurse practitioners	3	2	5	6	11	11
Master Licensed Drug & Alcohol Counselors	16	11	13	14	17	18
Licensed Mental Health Professionals	23	18	16	9	49	45
Peer Recovery Coaches	6	22	59	67	88	88
Community Health Workers	4	11	13	13	18	19
CTI Workers	15	11	24	37	37	36
CTI Supervisors	3	3	3	3	5	4

Performance Measure Name	2018 Target	Progress Toward Target				
		As of 12/31/17	As of 6/30/18	As of 12/31/18	As of 6/30/19	As of 12/31/19
Care Advocates	15	0	7	11	21	18
Care Advocate Supervisors	1	0	1	1	2	2
Community based clinicians (staffing from first round of capacity)	1	1	1	1	1	1
Physician assistants (staffing from first round of capacity)	1	1	3	3	17	18
Community nurse coordinators (staffing from first round of capacity)	1	1	1	1	1	1
Behavioral health assistants (staffing from first round of capacity)	1	1	2	3	4	5
Behavioral health case managers (staffing from first round of capacity)	5	4	5	11	49	51
LICSWs (staffing from first round of capacity)	3	2	2	4	13	10.5
IDN QI Coach	1	0	1	2	2	1
HIT Integration Coach	1	1	1	1	1	1
IDN Data Specialist (NCHC)	1	0	0	1	1	1
Data Specialists for IDN partners*	Up to 3	0	0	3	9.4 FTE	8.65 FTE

Targets not yet met

During the reporting period, the Region 7 IDN partners dedicated significant efforts to meeting process metrics related to the Core Competency project. All staffing targets have been met or exceeded at this time. The implementation of specific processes related to the delivery of coordinated and integrated care has proven more challenging, however, with many of the partners directly connected to this project having experienced the turnover of staff critical to the success of process implementation and/or the migration of the organizations' records from one health information system to another during the demonstration period. Despite these challenges, Region 7 IDN partners continue to progress along the continuum of coordinated and integrated care practices, implementing initiatives at a slower pace than originally anticipated, but in sustainable ways that are meaningful to both patients and providers.

Core Comprehensive Standardized Assessment (CCSA)

Eleven of the thirteen Core Competency project partners have fully implemented the required domains of the CCSA, and then remaining two have implemented most of them. Coös County Family Health Services (CCFHS) has the electronic capacity to collect the missing domains and does so on specific sub-populations of their patient panel based on condition, but has shared that they do not currently have the staffing bandwidth to adjust clinical and support staff workflows to implement those domains across the patient population as a whole. Memorial Hospital has dedicated effort during this reporting period to restructuring their data collection process to ensure capture of all domains for their patient population, and suspect that the missing domains are being assessed on many patients, but not in a way that is easy to collect.

Use of the Shared Care Plan Care Guidelines feature

Although eight partner agencies have staff trained in the use of PreManage Primary, at this time, only two of the Region 7 IDN partners connected to this core competency project are actively using the care guidelines feature of the Collective Medical Shared Care Planning software. Uptake of this technology has been slow to progress in the region. Many primary care partners have shared that their electronic medical record systems already have a care coordination module that their staff are using effectively, and they have concerns about requiring staff to document in a redundant fashion. The remaining partners are not yet connected to the Collective Medical network. They have shared that their

organizations lack the staff resources necessary to begin the implementation project at this time, prioritizing more immediate operational needs above this DSRIP initiative, but continue to monitor progress within the region and the state as they consider moving forward.

No additional information indicating achievement on this deliverable has become available during the review period.

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 **December 31, 2018:** Region 7 IDN continues to struggle with recruitment and retention for MLADCs and other licensed mental health professions. The region has experienced increased turnover of licensed mental health clinicians and Master Licensed Alcohol and Drug Counselors assumingly due to provider burnout and compassion fatigue. There is a considerable amount of work being done in the region to address compassion fatigue by the North Country Task Force on Improving Opioid Treatment Outcomes. This is a group of individuals and provider agencies who are coming together to discuss how to identify core competencies for addiction professionals that effectively addresses self-care as a risk management and quality assurance measure for patient care. Region 7 has also continued to be actively involved in the Statewide IDN Training and Education Workgroup which discusses the Behavioral Health Higher Education Roundtable regularly. The two groups have been working together to help increase BH workforce and help providers with recruitment and retention strategies. Organizations and educational institutions have continued to collaborate to align employment requirements with education requirements to streamline the transition between school and actual practice.	16	11	16	18	19
Licensed Mental Health Professionals **December 31, 2018:** Region 7 IDN continues to struggle with recruitment and retention for MLADCs and other licensed mental health professions. The region	23	14	18	16	9

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
has experienced increased turnover of licensed mental health clinicians and Master Licensed Alcohol and Drug Counselors assumingly due to provider burnout and compassion fatigue. There is a considerable amount of work being done in the region to address compassion fatigue by the North Country Task Force on Improving Opioid Treatment Outcomes. This is a group of individuals and provider agencies who are coming together to discuss how to identify core competencies for addiction professionals that effectively addresses self-care as a risk management and quality assurance measure for patient care. Region 7 has also continued to be actively involved in the Statewide IDN Training and Education Workgroup which discusses the Behavioral Health Higher Education Roundtable regularly. The two groups have been working together to help increase BH workforce and help providers with recruitment and retention strategies. Organizations and educational institutions have continued to collaborate to align employment requirements with education requirements to streamline the transition between school and actual practice.					
Peer Recovery Coaches	6	2	22	59	67
CTI Workers	15	0	11	27	37
CTI Supervisors	3	0	3	3	3
Community Health Workers	4	0	13	13	13
Psych Nurse Practitioners (round 1 funds)	3	1	2	5	7
Care Advocates **December 31, 2018:** Region 7 IDN held two Regional Care Coordination trainings during 2018. This was a shift from the original 3 planned for each county. Northern Grafton and Coös County training were combined into one fall training to allow partners to prepare staff. Due to staffing transition and lack of staff time the measure was missed by two. The Carroll County training had two individuals who were partially trained during the two-day training that were not counted in this measure, however they received valuable content from the day they attended. The Region 7 IDN team is exploring more efficient ways to train current care coordination staff throughout the region. The Region 7 IDN webinar series seems to be a good platform to achieve this goal.	15	0	0	7	13
Other Front-Line Provider	1	0	10	16	52

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 Supervisors	1	0	0	0	1
Community based clinician (round 1 funds for baseline 6/30/17)	1	1	1	1	1
Physician assistant (round 1 funds)	1	1	1	3	3
Community nurse coordinator (round 1 funds for baseline 6/30/17)	1	1	1	1	1
Behavioral health assistant (round 1 funds for baseline 6/30/17)	1	1	1	2	4
Behavioral health case managers (round 1 funds for baseline 6/30/17)	5	2	4	5	7
LICSW (round 1 funds for baseline 6/30/17)	3	1	2	2	4
IDN QI Coach	1	0	0	1	2
HIT Integration Coach	1	0	1	1	1
IDN Data Specialist (NCHC)	1	0	0	0	1
Data Specialists for IDN partners	Up to 3	0	0	0	3

December 31, 2018

After initiation of the project, the data specialist was deemed to be redundant with services already provided by MAeHC and the HIT lead at NCHC. In lieu of hiring additional staff to handle data aggregation and funding them through IDN request for proposal funding, three agencies (White Mountain Community Health Center, Saco River Medical Group and Coös County Family Health Service) have elected to contract for these services instead. WMCHC has contracted with a third-party expert, while Saco and Coös County have contracted directly with MAeHC for data abstraction services. All three have been able to leverage these resources into better reporting results.

June 30, 2019 Update

Workforce Calculation Process

As the Region 7 IDN team spent time during this reporting period assessing the progress made on process measures, questions arose regarding the rate of change for some workforce categories in the context of narrative reports of significant improvements in access to treatment for behavioral health diagnoses was improving. During the collection of data for this report, the Region 7 IDN team focused on verifying the current state of workforce in the region as it compared to the baseline reported in the Region's Implementation Plan published July 2017. This included a level-setting of workforce numbers and the number of individuals served under each of the DSRIP projects. The team was successful in capturing current workforce levels for all partners specifically engaged in the DSRIP projects, as well as the turnover specific to this reporting period. As the Region 7 IDN team analyzed this latest data, four significant variances were found, all occurring with the introduction of the June 30, 2019 staffing levels contributed by the region's Community Mental Health Center, *Northern Human Services (NHS)*, as demonstrated in the A1-5 table extract below.

Workforce Category	2018 Target	Baseline 6/30/17	As of 12/31/18	As of 6/30/19
Behavioral Health Case Managers	5	2	7	**49**
Licensed Mental Health professionals	23	14	9	**49**
Master Licensed Alcohol and Drug Counselors	16	11	14	**17**

Further examination of data collection processes and findings from prior reporting periods suggests that NHS turnover data has impacted the region's aggregate workforce totals since December 2017, but their baseline staffing levels were not included in the June 2017 regional baseline aggregate. This analysis of workforce data has also identified that the number of MLADCs in the region was reported inconsistently across projects in prior periods, likely due to the manual calculation of the impact that partner turnover data has on the regional workforce aggregate. This process has highlighted the difficulty that the IDN faces in accurately capturing workforce capacity changes over time. It is common for a single partner to report that they lost a member of their workforce to another partner agency. Partners attribute the contrast between high local partner turnover rates and a relatively lower change in regional workforce totals to the dynamic recruitment and retention efforts employed by partner organizations in the face of workforce shortages within our rural region. Together these factors incentivize skilled workforce members living in the area to seek higher compensation packages without being encumbered by the inconvenience of moving their families. In future reporting periods, the Region 7 IDN team will work to capture both current staffing and turnover data from all project-engaged partners to ensure accurate updating to both tables and regional narrative. In this way, the region will be better positioned to show workforce capacity levels as a snapshot in time and local workforce turbulence impact on the delivery of integrated care.

Provider Type*	IDN Workforce (FTEs)					
	Projected Total Need	Baseline Staffing on 6/30/17	Staffing on 12/31/17	Staffing on 6/30/18	Staffing on 12/31/18	Staffing on 6/30/19
Master Licensed Alcohol and Drug Counselors	16	11	11	13	14	**17**
Licensed Mental Health Professionals	23	14	18	16	9	**49**
Peer Recovery Coaches	6	2	22	59	67	**88**
CTI Workers	15	0	11	27	37	**37**
CTI Supervisors	3	0	3	3	3	**5**
Community Health Workers	4	0	13	13	13	**18**
Psych Nurse Practitioners (round 1 funds)	3	1	2	5	7	**11**
Care Advocates	15	0	0	7	13	**21**
Other Front-Line Provider	1	0	10	16	52	**37**
Care Advocate Supervisors	1	0	0	0	1	**2**
Community based clinician (round 1 funds for baseline 6/30/17)	1	1	1	1	1	**1**
Physician assistant (round 1 funds)	1	1	1	3	3	**17**
Community nurse coordinator (round 1 funds for baseline 6/30/17)	1	1	1	1	1	**1**
Behavioral health assistant (round 1 funds for baseline 6/30/17)	1	1	1	2	4	**4**
Behavioral health case managers (round 1 funds for baseline 6/30/17)	5	2	4	5	7	**49**
LICSW (round 1 funds for baseline 6/30/17)	3	1	2	2	4	**13**

Provider Type*	IDN Workforce (FTEs)					
	Projected Total Need	Baseline Staffing on 6/30/17	Staffing on 12/31/17	Staffing on 6/30/18	Staffing on 12/31/18	Staffing on 6/30/19
IDN QI Coach	1	0	0	1	2	**2**
HIT Integration Coach	1	0	1	1	1	**1**
IDN Data Specialist (NCHC)	1	0	0	0	1	**1**
Data Specialists for IDN partners	Up to 3	0	0	0	3	**9.4 FTE***

*During this reporting period several partners reported that, while they do not have any staff directly tasked and budgeted for DSRIP data management, they have allocated significant time from existing staff members to meet the reporting requirements of the DSRIP. Consistently, partners have indicated that the increasing demand for the use of data to drive care, and the need to validate data for payer performance metrics is increasing. Separate from the dedicated data aggregator specialists accounted for in the evaluation target table above, this reporting period the Region 7 IDN team estimates that the thirteen partners engaged in the Core Competency project are dedicating an aggregate total in excess of 9 FTE engaged across the region in these data governance and reporting activities. This is based on partner feedback to targeted questions regarding their current allocation of staff resources to meet reporting requirements, including participation in calls with MAeHC and the IDN HIT Lead, abstraction of data, and alterations to EMR systems in order to have claims data accurately represent the care provided to their patients.

December 31, 2019 Update

Provider Type	IDN Workforce (FTEs)						
	Projected Total Need	Baseline Staffing 6/30/17	Staffing on 12/31/17	Staffing on 6/30/18	Staffing on 12/31/18	Staffing on 6/30/19	Staffing on 12/31/19
Master Licensed Alcohol and Drug Counselors	16	11	11	13	14	17	18
Licensed Mental Health Professionals	23	14	18	16	9	49	45
Peer Recovery Coaches	6	2	22	59	67	88	88
CTI Workers	15	0	11	27	37	37	36
CTI Supervisors	3	0	3	3	3	5	4
Community Health Workers	4	0	13	13	13	18	19
Psych Nurse Practitioners (round 1 funds)	3	1	2	5	7	11	11
Care Advocates	15	0	0	7	13	21	18
Other Front-Line Provider	1	0	10	16	52	37	39
Care Advocate Supervisors	1	0	0	0	1	2	2
Community based clinician (round 1 funds for baseline 6/30/17)	1	1	1	1	1	1	1
Physician assistant (round 1 funds)	1	1	1	3	3	17	18
Community nurse coordinator (round 1 funds for baseline 6/30/17)	1	1	1	1	1	1	1
Behavioral health assistant (round 1 funds for baseline 6/30/17)	1	1	1	2	4	4	5
Behavioral health case managers (round 1 funds for baseline 6/30/17)	5	2	4	5	7	49	51
LICSW (round 1 funds for baseline 6/30/17)	3	1	2	2	4	13	10.5
IDN QI Coach	1	0	0	1	2	2	1
HIT Integration Coach	1	0	1	1	1	1	1

Provider Type	IDN Workforce (FTEs)						
	Projected Total Need	Baseline Staffing 6/30/17	Staffing on 12/31/17	Staffing on 6/30/18	Staffing on 12/31/18	Staffing on 6/30/19	Staffing on 12/31/19
IDN Data Specialist (NCHC)	1	0	0	0	1	1	1
Data Specialists for IDN partners	Up to 3	0	0	0	3	9.4 FTE*	8.65 FTE*

*As in the prior reporting period, during this reporting period partners continued to reported that, while they do not have any staff directly tasked and budgeted for DSRIP data management, they have allocated significant time from existing staff members to meet the reporting requirements of the DSRIP. Consistently, partners have indicated that the increasing demand for the use of data to drive care, and the need to validate data for payer performance metrics is increasing. Separate from the dedicated data aggregator specialists accounted for in the evaluation target table in section B1-3, this reporting period the Region 7 IDN team estimates that the thirteen partners engaged in the Core Competency project are dedicating an aggregate total of close to 9 FTE engaged across the region in these data governance and reporting activities. This is based on partner feedback to targeted questions regarding their current allocation of staff resources to meet reporting requirements, including participation in calls with MAeHC and the IDN HIT Lead, abstraction of data, and alterations to EMR systems in order to have claims data accurately represent the care provided to their patients.

B1-5. IDN Integrated Healthcare: Budget

December 31, 2018

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

Budget Period:	01/01/2017-12/31/2017	01/01/2018-06/30/2018	07/01/2018-12/31/2018	01/01/2019-12/31/2019	01/01/2020-12/31/2020	01/01/2021-06/30/2021
	Core Competency Actual Funds Spent	Core Competency Actual Expense (6 months)				
Core Competency	CY 2017 Actuals	CY 2018 January to June Actual	CY 2018 July to Dec. Actual	CY 2019 Projected	CY 2020 Projected	CY 2021 Projected
1. Total Salary/Wages						
2. Employee Benefits						
3. Consultants			$0	$0	$0	$0
5. Supplies:			$0	$0	$0	$0
Educational			$0	$0	$0	$0
Office	$4,650	$341	$365	$14,575	$14,575	$7,288
6. Travel	$3,560	$1,767	$1,391	$29,827	$29,827	$14,914
7. Occupancy			$0	$0	$0	$0
8. Current Expenses			$0	$0	$0	$0
Telephone			$0	$0	$0	$0
Postage			$0	$0	$0	$0
Subscriptions			$0	$0	$0	$0
Audit and Legal			$0	$0	$0	$0
Insurance			$0	$0	$0	$0
Board Expenses			$0	$0	$0	$0
9. Software		$2,127	$0	$1,011	$1,011	$505
10. Marketing/Communications	$5,218	$4,351	$8,635	$22,414	$22,414	$11,207
11. Staff Education and Training		$2,487	$2,848	$27,796	$27,796	$13,898
12. Subcontracts/Agreements			$0	$0	$0	$0
13. Other (specific detail mandatory):			$0	$0	$0	$0
Current Expenses: Administrative Lead Organizational Support	$7,851	$4,469	$2,034	$4,054	$4,054	$2,027
Support Payments to Partners	$315,939	$290,152	$208,250	$852,584	$852,584	$426,292
TOTAL	**$337,218**	**$305,695**	**$223,524**	**$952,262**	**$952,262**	**$476,131**

Consistent with all prior reporting, report begins with January 1, 2017 utilizing capacity building funds to maintain infrastructure.
IDN 7 projects the additional amount approved at June 2017 quarterly meeting to absorb future anticipated line item variances in Salary, Benefits, Software and Training.
(Budget reflects correction from previous reports. Inadvertently switched Care Transition total with Core Competency total.)

Figure 2 B1-5 Integrated Healthcare Budget 12/31/2018

June 30, 2019 Update

Budget Period:	01/01/2017-12/31/2017	01/01/2018-12/31/2018	01/01/2019-06/30/2019	07/01/2019-12/31/2019	01/01/2020-12/31/2020	01/01/2021-06/30/2021
Core Competency	CY 2017 Actuals	CY 2018 January to December ACTUAL	CY 2019 January to June ACTUAL	CY 2019 July to December PROJECTED	CY 2020 Projected	CY 2021 Projected
1. Total Salary/Wages (Budget reflects correction from previous reports. Inadvertently switched Care Transition total with Core Competency total.)						
2. Employee Benefits (Budget reflects correction from previous reports. Inadvertently switched Care Transition total with Core Competency total.)						
3. Consultants		$0		$0	$0	$0
5. Supplies:		$0		$0	$0	$0
Educational		$0		$0	$0	$0
Office	$4,650	$707	$558	$558	$1,117	$558
6. Travel	$3,560	$3,159	$2,008	$2,008	$4,016	$2,008
7. Occupancy		$0		$0	$0	$0
8. Current Expenses		$0		$0	$0	$0
Telephone		$0		$0	$0	$0
Postage		$0		$0	$0	$0
Subscriptions		$0		$0	$0	$0
Audit and Legal		$0	$912	$912	$1,824	$912
Insurance		$0	$503	$503	$1,006	$503
Board Expenses		$0		$0	$0	$0
9. Software		$2,127	$1,144	$1,144	$2,288	$1,144
10. Marketing/Communications	$5,218	$12,986	$860	$860	$1,720	$860
11. Staff Education and Training		$5,335		$0	$0	$0
12. Subcontracts/Agreements		$0		$0	$0	$0
13. Other (specific detail mandatory):		$0		$0	$0	$0
Current Expenses: Administrative Lead Organizational Support	$7,851	$6,503		$0	$0	$0
Support Payments to Partners	$315,939	$498,402	$128,340	$128,340	$256,680	$128,340
				$0		
TOTAL	**$444,143**	**$677,601**	**$243,530**	**$243,530**	**$439,855**	**$243,530**

Consistent with all prior reporting, report begins with January 1, 2017 utilizing capacity building funds to maintain infrastructure.
IDN 7 projects the additional amount approved at June 2017 quarterly meeting to absorb future anticipated line item variances in Salary, Benefits, Software and Training.
Incentive Payments from January 2019 through December 2020 reflect a reduction based on anticipated DHHS action and county participation.
Budgets for project remainder reflect revised staffing structure in attempt to maximize funds available to partners.

December 31, 2019 Update

Budget Period:	01/01/2017-12/31/2017	01/01/2018-12/31/2018	1/1/2019 - 6/30/2019	7/1/2019 - 12/31/2019	01/01/2019-12/31/2019	1/1/2020 - 6/30/2020	7/1/2020 - 12/31/2020	01/01/2020-12/31/2020	01/01/2021-12/31/2021
Core Competency	CY 2017 Actuals	CY 2018 January to December ACTUAL	CY 2019 January to June ACTUAL	CY 2019 July to December ACTUAL	CY 2019 January to December ACTUAL	CY 2020 Jan to June PROJECTED	CY 2020 July to Dec PROJECTED	CY 2020 Projected	CY 2021 Projected
1. Total Salary/Wages									
2. Employee Benefits									
3. Consultants		$0			$0	$0	$0	$0	$0
5. Supplies:		$0			$0	$0	$0	$0	$0
Educational		$0			$0	$0	$0	$0	$0
Office	$4,650	$707	$558	$456	$1,014	$507	$507	$1,014	$507
6. Travel	$3,560	$3,159	$2,008	$2,551	$4,559	$2,280	$2,280	$4,559	$2,280
7. Occupancy		$0			$0	$0	$0	$0	$0
8. Current Expenses		$0			$0	$0	$0	$0	$0
Telephone		$0			$0	$0	$0	$0	$0
Postage		$0			$0	$0	$0	$0	$0
Subscriptions		$0			$0	$0	$0	$0	$0
Audit and Legal		$0	$912	$859	$1,771	$886	$886	$1,771	$886
Insurance		$0	$503	$462	$964	$482	$482	$964	$482
Board Expenses		$0			$0	$0	$0	$0	$0
9. Software		$2,127	$1,144	$1,855	$2,999	$1,500	$1,500	$2,999	$1,500
10. Marketing/Communications	$5,218	$12,986	$860	$923	$1,784	$892	$892	$1,784	$892
11. Staff Education and Training		$5,335			$0	$0	$0	$0	$0
12. Subcontracts/Agreements		$0			$0	$0	$0	$0	$0
13. Other (specific detail mandatory):		$0			$0	$0	$0	$0	$0
Current Expenses: Administrative Lead Organizational Support	$7,851	$6,503			$0	$0	$0	$0	$0
Support Payments to Partners	$315,939	$498,402	$128,340	$198,969	$327,309	$127,017	$296,373	$423,390	$211,695
					$0				
TOTAL	$ 444,143	$ 677,601	$ 243,530	$ 297,228	$ 540,758	$ 233,742	$ 403,098	$ 636,839	$ 318,420

Consistent with all prior reporting, report begins with January 1, 2017 utilizing capacity building funds to maintain infrastructure.

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)
Ammonoosuc Community Health Services	Y
Coös County Family Health Services	Y
Cottage Hospital/Rowe Health Center	Y
Friendship House/North Country Health Consortium	Y
Huggins Hospital	Y
Indian Stream Health Center	Y
Littleton Regional Healthcare	Y
Memorial Hospital	Y
Northern Human Services	Y
Saco River Medical Group	Y
Weeks Medical Center	Y
White Horse Addiction Center	Y
White Mountain Community Health Center	Y

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

If all IDN Governance signoffs were YES in a prior submission and there are no changes, then a resubmission of this section is not required. If any signoffs were NO or Governance Leadership has changed, then a full 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

Name	Title	Organization	Sign Off Received (Y/N)
Monika O'Clair	Vice President of Strategy & Community Relations	Huggins Hospital	Y
Caleb Gilbert	Public Health Advisory Council Coordinator	Carroll County Coalition for Public Health	Y
Rona Glines	Director of Physician Services	Weeks Medical Center	Y
Ken Gordon	Chief Executive Officer	Coös 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
Karen Woods	Administrative Director	Cottage Hospital	Y
Sue Ruka	Director of Population Health	Memorial Hospital	Y
Jason Henry	Superintendent	Carroll County Corrections	Y
Kevin Kelly	Chief Executive Officer	Indian Stream Health Center	Y

Region 7 IDN has seen changes to the membership of the region's Steering Committee due to staffing turnover, but NCHC has worked to ensure the composition still encompasses the required participating agency representation and has a broad geographic distribution. All current Steering Committee members have signed charters for the DSRIP project.

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

a. All of the following domains must be included in the CCSA:
   - Demographic information
   - Physical Health Review
   - Substance Use Review
   - Housing Assessment
   - Family and Support Services
   - Educational Attainment
   - Employment or entitlement
   - Access to Legal Services
   - Suicide Risk Assessment
   - Functional Status Assessment
   - Universal screening using depression screening (PHQ 2 & 9)
   - Universal screening using SBIRT
   - For pediatric providers, the CCSA must also include:
     - Validated developmental screening for all children, such as the ASQ:3 and/or ASQ SE at 9, 18- and 24/30-month pediatric visits
     - Developmental screening using Bright Futures or other American Academy of Pediatrics recognized screening

b. List of Multi-Disciplinary Core Team members that includes, at minimum:
   - PCPs
   - Behavioral Health Providers (including a psychiatrist)
   - Assigned care managers or community health worker

c. Multi-Disciplinary Core Team training for service providers on topics that includes, at minimum:

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

d. Training for staff not providing direct care that at minimum includes knowledge and beliefs about mental disorders that can aid in recognition and management
e. Monthly (or more frequent) core team case conferences on behalf of patients with significant behavioral health conditions or chronic conditions
f. Secure Messaging
g. Closed Loop Referrals
h. Documented workflows and/or protocols that include, at minimum:
    - Interactions between providers and community-based organizations
    - Timely communication
    - Privacy, including limitations on information for communications with treating provider and community-based organizations
    - Coordination among case managers (internal and external to IDN)
    - Safe transitions from institutional settings back to primary care, behavioral health, and social support service providers
    - Adherence to NH Board of Medicine guidelines on opioid prescribing

B1-8a: All of the following domains must be included in the CCSA:

December 31, 2018

Site	Demographic	Medical	Substance Use	Housing	Family & Support	Education	Employment	Legal	Risk assessment including suicide risk	Functional Status	Universal Screening	SBIRT
Saco River Medical Group	Y	Y	Limited	N	N	N	N	N	Y	N	Y	Used for adolescents
Littleton Regional Healthcare	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Memorial Hospital	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Huggins Hospital Behavioral Health	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Huggins Primary Care	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Limited use
White Mountain Community Health Center	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Weeks Medical Center	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Coös County Family Health Services	Y	Y	Y	Y	Y	N	Y	N	N	N	Y	Y
Rowe Health Center	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Northern Human Services	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N

Ammonoosuc Community Health Services	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Indian Stream Health Center	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
White Horse Addiction Center	Gathering data											N
Friendship House	Y	Y	Y	Y	Y	Y	Y	Y	Y	Unknown	Y	Unknown

Region 7 IDN partners have worked closely with IDN staff towards capturing all twelve CCSA domains and putting a protocol in place for the assessment process. Multiple partners have made excellent progress towards this deliverable and continue to adapt the sample CCSA protocol to meet the agencies specific needs.

- *Littleton Regional Healthcare* has worked to add the domains that were lacking during this last reporting period. Currently the CCSA is fully templated and live in their ambulatory clinics' EMR. Staff and providers are receiving education on its use, and they have recently shared a Primary Care staffing plan with the head of the Physician Practices that includes a deeper care coordination bench including, among other things, a Population Health Coordinator whose role encompasses monitoring care gap reports, assisting patients in completing assessments like these and coordinating referrals to the appropriate community resources for the most needy patients with multiple comorbidities. The agency is hopeful that in early 2019, they will have the staffing plan finalized and begin the hiring process so that they see this and other assessments charted at least annually on most of their primary care patients.
- *White Mountain Community Health Center* has fully implemented the CCSA survey process with their Medicaid population of 18 years and older and are tracking through a checklist system in their health maintenance flowsheet of the EMR for monitoring and reporting purposes. The care coordination team is responsible for tracking compliance and ensuring patients with identified needs are addressed with care coordination follow up. They have implemented ASQ-3 developmental screenings as part of their CCSA process as well. The agencies protocol was submitted during the last reporting period.
- *Saco River Medical Group* continues to work toward implementing the CCSA however does not currently capture all twelve domains. They are still in the process of developing ways to implement tools and workflows to capture the missing domains. SRMG does use SBIRT routinely for adolescents with positive screens during well checkups. They do not use it in the older population however they do have templates written. Currently, there is no written process for CCSA patient completion. SRMG will continue to seek out guidance from IDN team to work toward CCSA implementation.
- *Indian Stream* continues to capture all twelve domains through the nurses and provider in the exam room. Currently there is no formal process however the subject has been discussed with the team. ISHC has entertained the idea to have patients answer questions on paper before the visit that can then be transcribed into the EMR. Currently, when domains are collected the SDoH are flagged in the EMR.
- Huggins Hospital made significant progress around the CCSA, now capturing all domains, and piloting the assessment with a small sample of patients; one patient completed the CCSA during the reporting period. Due to the pressure of the rapid implementation, Huggins is planning to use PSDA to massage the process. The agency has been using SBIRT in their behavioral health department, however providers do not use it routinely. One primary care provider has only

used it in a limited way. Huggins staff has expressed the need of SBIRT training as the project moves forward.

- *Cottage Hospital/Rowe Health Center* has made exceptional progress in implementing the CCSA. Currently, they have a documented protocol in place that was adapted from the sample protocol released to the region. They now capture all twelve domains and use SBIRT regularly. The PCP does have an SBIRT process that consists of AUDIT and DAST regarding high risk behaviors. If indicated, a referral is made to internal or external BH services.
- *Weeks Medical Center* made great strides to implement the CCSA in September 2018. To capture the twelve domains, they have put the process on tablets to give to patients at annual visits. Weeks has also developed a formal protocol for collecting the domains. Overall it is going well, however there is some pushback from patients who do not want to provide certain information. To mitigate this, Weeks adapted the questionnaire to allow a patient to opt out of a specific question versus skipping the survey entirely. Providers feel that they are getting some useful information from this process.
- *Memorial Hospital* conducts an Assessment for Appropriateness for Office Based Buprenorphine Treatment, found in the IMAT clinical guidelines distributed by MaineHealth, that could be considered a form of SBIRT. *Coös County Family Health Services* has experienced some barriers to capturing all twelve domains and developing a protocol to implement the CCSA process. The IDN team will continue to work with CCFHS as they work towards full CCSA implementation. *White Horse Addiction Center* and *Friendship House* have been focusing on building capacity to treat SUD patients, resulting in slow progress towards CCSA implementation. The treatment centers will continue to enhance services and work with the IDN team to capture the twelve domains and implement a CCSA protocol.
- *Northern Human Services* and *Ammonoosuc Community Health Services* continue to capture all domains within the CCSA. ACHS has implemented the process within tablets given to patients before visits. While processes are active and clear for staff, written protocol for CCSA has not yet been finalized. Protocol for follow-up is in place and guides the role of the Patient Navigators. NHS has embedded the twelve domains into their EMR and are moving toward using the Columbia for a suicide risk assessment. The agency has completed a CCSA protocol and plans a mass roll-out to all open and incoming patients to be assessed by the end of January 2019. While NHS does not follow SBIRT protocol and the table above shows a “No” response, they do perform significant screening on substance use disorder that likely exceeds the requirements as defined by SBIRT given the nature of their organization as a behavioral health provider.

The table below reflects what NCHC currently knows regarding comprehensive core standardized assessments for pediatric providers in the region.

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 Pediatrics recognized screening	Other tool
Ammonoosuc Community Health Services	N	N	Y Developmental Milestones and M-CHAT-R
Coös County Family Health Services	Y ASQ:SE	Y	N
Weeks Medical Center	Y ASQ:3	Y	Y (MCHAT)
White Mountain Community Health Center	Y ASQ:SE	N	Y (MCHAT)
Huggins Hospital	Y	Y	Y (Teen screen)
Memorial Hospital	Y	N	Hoping to integrate ACEC
Littleton Regional Healthcare	Y ASQ:3	N	N
Saco River Medical Group	Y ASQ:3	Y	Y (MCHAT)
Indian Stream Health Center	Y ASQ:3	N	N

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Site	Demographic	Medical	Substance Use	Housing	Family & Support	Education	Employment	Legal	Risk assessment including suicide risk	Functional Status	Universal Screening	SBIRT
Saco River Medical Group	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Littleton Regional Healthcare	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Memorial Hospital	Y	Y	Y	Y	Y	N	N	N	Y	Y	Y	Y
Huggins Hospital Behavioral Health	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Huggins Primary Care	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
White Mountain Community Health Center	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Weeks Medical Center	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Coös County Family Health Services **Used only for OB patients*	Y	Y	Y	*	Y	Y	Y	*	Y	Y	Y	Y
Rowe Health Center *Some domains disconnected due to EMR change*	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Northern Human Services	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Ammonoosuc Community Health Services	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Indian Stream Health Center	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
White Horse Addiction Center	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	**Y**
Friendship House	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y

Most partners participating in the core competency integrated healthcare project in the region have reported that they have implemented a Comprehensive Core Standardized Assessment (CCSA) that incorporates all required domains and screenings. Many of those partners report that they have had a CCSA in place long enough to now be in the process of renewing the annual screens and are taking this opportunity to perform rapid cycle continuous quality improvement on their CCSA process. For some partners this has meant changing the mode of delivery to patients (i.e. moving from paper to an electronic format or vice versa). For others, this has meant revising the questions asked of the patient in order to make them more understandable by the patients and/or easier for clinical staff to record in the medical record for review and action. One partner noted that it wasn't until this annual review of the CCSA process that they realized the question regarding education was halfway through the assessment, and therefore a patient with low literacy/health literacy may not be answering any of the questions properly because they were given a tool too complex for them to understand.

All pediatric primary care providers have confirmed that they use some form of American Academy Pediatrics approved screening process for both developmental and behavioral screenings. During this reporting period, the Region 7 IDN team also had an opportunity to begin engaging with Coös Coalition for Young Children and Families, which is actively engaged in collaborative efforts in Coös County to standardize an approach in the educational sector to promote social-emotional wellness in children, and particularly interventions for very young children. They have suggested redundancies between sectors such as healthcare, education and early childcare can be eliminated through a process of information sharing, preferably via direct secure messaging or other electronically secured means.

Partners who do not currently use an electronic record have found that current assessments cover most domains, but the information is not centralized and proving that the findings are integrated in the treatment plan is a cumbersome process that requires manual chart review.

The Region 7 IDN team continues to work closely with primary care and behavioral health providers to support processes for all ten CCSA domains, universal screening and (when applicable) developmental and behavioral screening for pediatric primary care patients. Multiple partners have made excellent progress towards this deliverable and continue to adapt the sample CCSA templates to meet the agencies specific needs.

- *Ammonoosuc Community Health Services (ACHS)* continues to capture all domains within the CCSA. ACHS shared that they have found that some patients struggled with using tablets to complete the survey, so during this reporting period they built a process which allows patients to choose between completing the survey on a tablet or a paper tool.
- *Coös County Family Health Services (CCFHS)* captures most CCSA domains, with the exception of regular assessment of housing and legal issues for the broader Medicaid population. These two domains are currently only asked of obstetrical patients as part of their intake process. All required pediatric and universal screenings have been in place for some time at CCFHS clinics. The Region 7 IDN team will continue to be available to this partner regarding screening tools in use in the region.
- *Cottage Hospital/Rowe Health Center* continued their conversion to the Athena EMR during this reporting period. Although the EMR migration has been a positive step for this partner, it has delayed the implementation of the CCSA until the IT team can verify the best process for integrating the assessment into the record so that it can be used meaningfully by providers in their care planning and reported against for DSRIP performance metrics. Cottage expects to have a process in place within the next reporting period.
- *Friendship House (FH)*: During this reporting period, the Friendship House has confirmed that this agency utilizes the American Society of Addiction Medicine (ASAM) Continuum Decision Engine as their CCSA tool. The ASAM Decision Engine is a computerized, structured interview and clinical decision support system that allows providers to systematically examine co-occurring addiction and Mental health conditions. The decision engine uses research-based quality questions such as Addiction Severity Index (ASI), Clinical Institute Withdrawal Assessment (CIWA) and Clinical Institute Narcotic Assessment (CINA). Continuum Design Engine assists the interviewer in distinguishing each symptom's perceived relationship to substance use and whether the patient believes the symptom is related to substance use and intoxication, related to substance withdrawal, unrelated or independent of substance use. Suicidality is systematically assessed as are depression screening, SBIRT, and other social determinants of health. This partner feels that this assessment aspect of this system is more in-depth and therefore goes a step beyond the screening requirements of the CCSA.
- *Huggins Hospital* continues to include all domains in its collection of CCSA data from the patients who are seen at the one primary care practice utilizing the form in a pilot process. Huggins reported that they expected to have more practices implementing the CCSA during this reporting period, but continuing staffing shortages in the care coordination department have challenged them to do this successfully in the current period.
- Indian Stream Health Center (ISHC) reports that, while their CCSA captures all domains, they did not pilot the process as expected. They started collecting data on the domains in a paper format. After the patient completed the survey, the RN would review it and consult with the provider. Then RN was to input into the system for reference. The hope was for IT to integrate the form into the medical record, but his has yet to come to fruition due to staffing challenges. As a result, the

manual work process to collect and input data manually was too burdensome in the context of their staffing shortages, so completed screenings are not being recorded electronically. ISHC has suspended this part of their pilot until they complete implementation of a new EMR later this year and the CCSA can be wholly integrated there.

- *Littleton Regional Healthcare (LRH)* invested significant effort at the end of 2018 to ensure that all domains were fully templated and live in their ambulatory clinics' EMR. Staff and providers were provided education on its use, and the agency was hopeful that in early 2019, they would see this and other assessments charted at least annually on their primary care patients. During this reporting period, however, providers minimally used the templates. The practice management and quality teams collaborated with providers and the IT team to redesign the templates so that they were more user friendly and the data generated from the assessments could be more easily incorporated into treatment plans and captured in DSRIP reporting processes. This partner expects to fully roll-out this revised process in early July
- *Memorial Hospital* conducts several in-depth assessments as part of their integrated approach to primary and behavioral care. During this reporting period, they identified that there are still several CCSA domains that are not captured consistently for all patients and are primarily used in the assessment and treatment of patients enrolled in their Integrated Medication Assisted Treatment (IMAT) program for individuals diagnosed with a substance use disorder. The Region 7 IDN team will continue to provide support to this partner as they adopt DSRIP-related initiatives like the full CCSA. **During the reporting period, this partner engaged the assistance of several IDN resources to begin the process of adding the missing domains into the assessment process. The Region 7 IDN team anticipates that this partner will fully meet this requirement by the end of the current reporting period.**
- *Northern Human Services (NHS)* shared during this reporting period that CCSA adoption has been a huge improvement for their agency and has enhanced their case management assessment process. Prior to adopting the CCSA model, most domains were queried but were located in many different parts of the client record. NHS' team moved all domains and screenings to a single section of the EMR, and report that the agency has rolled out the CCSA adoption to dovetail with the agency's mandate to do quarterly reviews after the intake process is completed, and use this data for care plan adjustments accordingly. In so doing, they have ensured that the full CCSA is actually conducted on a quarterly, rather than annual basis, for all their clients.
- Saco River Medical Group (SRMG) has successfully developed a tool during this reporting period that captures all domains of the CCSA, pediatric screenings and universal screening protocols. The questionnaire and protocols are completed, and this partner will begin piloting the new process in early July. **During the reporting period, this partner reported that the new process is now in use and they are collecting CCSA data.**
- *Weeks Medical Center (WMC)* reports that their CCSA process continues to evolve following the initial implementation at the end of 2018. The initial work on the CCSA was primarily managed by the EMR administrator as a technical workflow designed to meet DSRIP reporting requirements, so significant focus was placed during this reporting period on orienting the clinical staff to the value of this enhanced assessment process. Providers and care coordinators at WMC now report that the CCSA is very valuable for real time care coordination. Care Coordinators have a special box that messages get sent to for follow up of positive findings and share that, "we are definitely intervening based on the results of some of those questions on the CCSA." In the beginning of this roll-out, some patients were unwilling to share information that they feel is private. Based on this feedback, the WMC team has added a statement to the tablet-based CCSA tool that patients receive prior to

rooming. The statement explains that WMC providers want to provide the best care to their patients and understand that there may be circumstances in their lives that might make it difficult to maintain their health. WMC has also provided means for patients to opt out of individual questions they find invasive in order to capture as much of the CCSA data on the tablets as possible, with a process for staff to follow-up on any unaddressed domains during care interactions.

- *White Horse Addiction Center (WHAC)*: This partner remains challenged by the lack of an electronic health record but reports that they are currently evaluating products and plan to implement one later this fall. In the interim, they use a paper assessment process that does capture all ten CCSA domains and an evidence-based practice for the assessment of depression. Because they do not provide primary care (only counseling services) to patients under 18, they do not conduct the pediatric screenings. Additionally, there is not a formalized process that is reflective of SBIRT adoption, but this partner reports an intent to reassess their screening processes after an EHR is in place, at which point they will re-engage the IDN team for assistance in establishing a core comprehensive standardized assessment process that meets IDN requirements. **During the reporting period, this partner's process, which includes a combination of their "Psychological Assessment" form and their "Case Management Plan," was clarified and reassessed. The use of their two tools together, which currently happens through a manual, paper-driven process, does cover all required domains of the CCSA. (Pediatric screenings are not required, because this partner does not provide care to the age range targeted by the developmental screens of interest.) During the current reporting period, this partner reports anticipating the implementation of an Electronic Medical Records system that will help them collect this data more efficiently. The Region 7 IDN team will provide support to WHAC during this process as they develop a protocol for assessing each domain and using the information obtained to inform the delivery the Behavioral Health services offered by this partner.**
- White Mountain Community Health Center (WMCHC) has fully implemented the CCSA survey process and during this reporting period began the annual reassessment of their Medicaid population. This partner reported that the biggest barrier identified was that the CCSA was another work burden added to front office staff responsibilities, and that level of staff is not always comfortable deciding which tool to give to specific patients, and when. WMCHC opted to perform continuous quality improvement assessments and revisions to the CCSA process as the screenings were being renewed and have identified system improvements to educate staff and help them navigate the process better. Additionally, they assessed the CCSA tool using a patient perspective, and realized that literacy is a significant issue for many patients in the target sub-population. Use of tablets was also a bit problematic for some patients who do not have sophisticated technology skills. WMCHC has moved to the use of a paper tool because it is the most practical approach for the patient, and has engaged the Region 7 IDN team to provide success stories from other Region 7 partners in order to inform further process revisions. Additionally, WMCHC is considering the use of the CCSA for all patients, regardless of their Medicaid eligibility, because their providers are recognizing the value of this information in the care planning process and see its applicability as being payer agnostic.

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Site	Demographic	Medical	Substance Use	Housing	Family & Support	Education	Employment	Legal	Risk assessment including suicide risk	Functional Status	Universal Screening	SBIRT
Ammonoosuc Community Health Services	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Coös County Family Health Services **Used only for OB patients*	Y	Y	Y	*	Y	Y	Y	*	Y	Y	Y	Y
Cottage Hospital/Rowe Health Center – Hospital Provider-based Primary Care Practice	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Friendship House	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Huggins Hospital – Hospital Provider-based Primary Care Practice[7]	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Indian Stream Health Center	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Littleton Regional Healthcare – Hospital Provider-based Primary Care Practice	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Memorial Hospital – Hospital Provider-based Primary Care Practice	Y	Y	Y	Y	Y	N	N	N	Y	Y	Y	Y
Northern Human Services	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Saco River Medical Group	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Weeks Medical Center – Hospital Provider-based Primary Care Practice	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
White Mountain Community Health Center	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
White Horse Addiction Center	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	**Y**
Ammonoosuc Community Health Services	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y

The table above reflects the status for all thirteen B1 provider partners. Hospital partners are listed because the Critical Access Hospital owns and operates a provider-based primary care practice. Prior reports separated practice sites for Huggins Hospital because this partner was piloting a CCSA process and did not have it in place across all sites. At this time, all partners with multiple sites are implementing their CCSA processes consistently across all sites. Coös County Family Health Services does not capture Housing and Legal domains for individuals unless they are at-risk obstetrical patients referred to the clinic's social worker for additional assistance. Memorial Hospital is in the process of adding the missing domains of the CCSA to their process following migration to a new Electronic Medical Record platform in 2019. No additional information indicating achievement on this deliverable has become available during the review period.

The Region 7 IDN team continues to work closely with primary care and behavioral health providers to support processes for all ten CCSA domains, universal screening and (when applicable) developmental and behavioral screening for pediatric primary care patients. Multiple partners have continued to make

[7] Prior reports separated practice sites for Huggins Hospital in this table because this partner was piloting a CCSA process at specific locations. At this time, Huggins Hospital has implemented this process across all locations, so there is no longer a breakout of pilot sites in this table.

progress towards this deliverable and continue to adapt the sample CCSA templates to meet the agencies specific needs.

- *Ammonoosuc Community Health Services (ACHS)*: ACHS continues to utilize the processes developed in previous reporting periods to administer the CCSA to all patients, capturing all domains and providing enhanced supports to patients with identified needs.
- *Coös County Family Health Services (CCFHS):* CCFHS continues to capture most CCSA domains, with the exception of regular assessment of housing and legal issues for the broader Medicaid population. These two domains remain only asked of obstetrical patients as part of their intake process. While CCFHS has the electronic capacity to collect the missing domains and does so on specific sub-populations of their patient panel based on condition, they have shared that they do not currently have the staffing bandwidth at this time to adjust clinical and support staff workflows to implement those domains across the patient population as a whole.
- *Cottage Hospital/Rowe Health Center (RHC):* RHC and Cottage Hospital continue to capture all twelve domains through the EMR. Although the conversion to the Athena platform temporarily disrupted this partner's CCSA collection process in the prior reporting period, they have confirmed that this platform works efficiently to capture patient information in the social history section during visits. The partner continues to use a workflow adapted from the sample protocol released to the region.
- *Huggins Hospital:* Huggins Hospital spent this reporting period preparing to implement the CCSA process they previously piloted in a single practice across their remaining practice locations. A training plan for staff was developed to help ease the remaining primary care practices into use of the CCSA. Full implementation and tracking compliance remain a high priority, the partner anticipates launching the process practice wide in early 2020.
- *Indian Stream Health Center (ISHC):* ISHC continues to capture all domains of the CCSA. The partner experienced a rapid EMR transition during this reporting period, converting to the Meditech platform several months earlier than planned as functionality in their legacy system began sunsetting early. The team focused on incorporating all CCSA domains into Meditech templates to eliminate the need for a paper assessment tool. A portion of the process was created in the care management template and will continue to be utilized by providers and the care management team moving forward.
- *Littleton Regional Healthcare (LRH):* LRH continues to have systems in place to allow all 12 domains to be captured. The partner is still working to mitigate challenges around administering the assessment by training staff and having key providers review the protocol to provide recommendations for improvement.
- *Memorial Hospital:* The partner has dedicated effort during this reporting period to restructuring their data collection process within the Epic EMR to ensure capture of all domains for their patient population, and suspect that the missing domains are being assessed on many patients, but not in a way that is easy to report against. They anticipate completion of the domains in early 2020.
- *Weeks Medical Center (WMC):* WMC continues to capture all 12 domains through the process implemented in 2018. The process continues to work well, and providers/staff involved are clear on the expectations. The domains are not all captured in one visit, however staff ensure all are captured within the required timeframe, and positive screens trigger notification to the outpatient care management department in real time to activate the care management team to engage immediately with the patient to address identified needs.
- *Northern Human Services (NHS):* NHS has successfully implemented the CCSA into the agency's daily workflow. All patients are receiving the assessment at intake and providers are responding to needs

found through the documented referral process. The partner continues to use a variety of supplemental assessments in conjunction with the CCSA including the CANS/ANSA, PHQ-9 and the Columbia lethality assessment.

- *White Mountain Community Health Center (WMCHC):* WMCHC continues to utilize the CCSA process in place and during this reporting period WMCHC collaborated with Huggins Hospital to revise their tool into a more user-friendly format. The partner also hosted a student from Northern Human Services who conducted a care coordination project that included an analysis of the current CCSA workflow and protocol. The student gathered staff feedback about the process and provided recommendations on how to improve it moving forward.
- *Saco River Medical Group (SRMG):* SRMG has progressed to capturing all 12 domains of the CCSA. The transition to a new EMR during the reporting period has helped with this task. The partner is dedicated to codifying a clear protocol for staff to ensure consistent use of the CCSA in the coming months.
- *Friendship House:* Friendship House worked diligently during the CARF accreditation process to implement the CCSA process and currently captures all 12 domains on all residential clients by leveraging the ASAM continuum. An accompanying protocol was developed and approved by the quality improvement team to provide guidance to staff.
- *White Horse Addiction Center (WHAC):* WHAC sought guidance from the Region 7 IDN Quality Improvement Coach in the beginning of the reporting period to confirm that all domains were captured through their paper process in use, and following implementation of an electronic medical record platform in the last half of the reporting period, that all domains were still being captured. In both instances, the Quality Improvement Coach determined all domains were captured by leveraging the ASAM continuum.

B1-8b: List of Multi-Disciplinary Core Team members that includes, at minimum: PCP, Behavioral Health Providers (including a psychiatrist), assigned Care Managers or Community Health Workers:

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In the early stages of the demonstration, Region 7 IDN B1 partners expressed a preference for developing site-specific Multi-Disciplinary Core Teams over the development of a regional Multi-Disciplinary Core Team. Several partners have been successful in implementing a Multi-Disciplinary Core Team within their agencies, while others have struggled to formalize this process. In future reporting periods Region 7 IDN will explore alternatives that ensure that all B1 partners have access to a Multi-Disciplinary Core Team. Alternatives to be explored include, but are not limited to, the possibility of leveraging existing Multi-Disciplinary Core Teams as consulting bodies for partners in need of a Multi-Disciplinary Core Team, as well as revisiting the possibility of convening a regional group to hold monthly case conferences in a virtual setting.

- Huggins Hospital

Provider Type	Position
Primary Care Provider	Huggins Primary Care Provider (DO)
Behavioral Health Provider	LICSW, Huggins Hospital
Care Manager or Community Health Worker	RN Care Coordinator, Huggins Hospital
Psychiatrist	Northern Human Services

- White Mountain Community Health Center

Provider Type	Position
Primary Care Provider	APRN, WMCHC
Primary Care Provider	APRN, WMCHC
Behavioral Health Provider	Care Coordinator/Social Worker, WMCHC
Care Manager or Community Health Worker	Community Health Worker, WMCHC
Psychiatrist	Northern Human Services

- Ammonoosuc Community Health Services – the table below shows MDCT members that attend monthly patient care case conferences at ACHS.

Provider Type	Position
Primary Care Provider	Primary Care Provider (MD), ACHS
Behavioral Health Provider	LICSW, ACHS
Care Manager or Community Health Worker	Behavioral Health/SUD Case Manager, ACHS
Care Coordination	RN Care Coordinator, ACHS Behavioral Health Community Health Worker, ACHS Patient Navigator, ACHS
Psychiatrist	Pathways Psychiatric Consulting, Dr Erinn Fellner & Dr Stacey Charron
Additional Members	
Pharmacist	RPh, ACHS

- Cottage Hospital/Rowe Health Center – the partner has an Integrated Care Team (ICT) and a Multi-Disciplinary Core Team (MDCT) which consists of similar staff members on both teams as shown below.

Provider Type	Position
Primary Care Provider	Internal Medicine Provider Primary Care Provider, Rowe Health Center (ICT)
Behavioral Health Provider	Licensed Social Worker Behavioral Health Providers, Rowe Health Center (ICT)
Care Manager or Community Health Worker	Chronic Care Management RN Certified Medical Assistant, Rowe Health Center (ICT)
Psychiatrist	Ray of Hope Psychiatric Department, Cottage Hospital Behavioral Health APRN with access to psychiatrist consultation, Cottage Hospital

- Weeks Medical Center – Weeks employs multiple forums to communicate about patients. Behavioral Health is embedded in daily interdisciplinary team meetings that involve real time review of all inpatients. The BH team meets on a regular basis and sets up regular case conferences that include the PCP, as needed. If psychiatric input is needed the patient is put on the psychiatrist schedule. In the monthly provider meetings, BH is also present for case discussion.

Provider Type	Position
Primary Care Provider	Rotating Primary Care Providers, Weeks Medical Centers 4 DOs 2 MDs 5 APRNs 3 PA-Cs
Behavioral Health Provider	BH Providers, Weeks Medical Center 2 Psych NP 2 LDACs 2 Social Workers 2 LICSW

Provider Type	Position
Care Manager or Community Health Worker	1 BH Case Manager, Weeks Medical Center 5 Care Coordinators (RNs & MAs)
Psychiatrist	Available if necessary, with consulting psychiatrist Erin Fellner

- Indian Stream Health Center – ISHC has a long-standing integrated provider meeting with providers from across disciplines where a variety of issues are discussed including patient issues. The organization is working on developing this meeting to address MDCT requirements including case conference. They have recently transitioned a staff person to be a behavioral health care manager and as of the end of 2018, staffing is in place for the MDCT.

Provider Type	Position
Primary Care Provider	Rotating Primary Care Providers, ISHC 1 DO 1 MD 1 PA-C 1 APRN
Behavioral Health Provider	LICSW, ISHC MSW, ISHC
Care Manager or Community Health Worker	Behavioral Health Case Worker, ISHC
Psychiatrist	Contracted psychiatrist

- Northern Human Services – Northern Human Services actively participates on Huggins and WMCHC teams. They have also agreed to provide psychiatric consultation for agencies in the region to support the Multi-Disciplinary Core Team approach.

Provider Type	Position
Primary Care Provider	Huggins and WMCHC primary care provider
Behavioral Health Provider	LICSW, Huggins Hospital and APRN, WMCHC
Care Manager or Community Health Worker	RN Care Coordinator, Huggins Hospital and Community Health Worker and social worker from WMCHC
Psychiatrist	Northern Human Services

- Memorial Hospital – Memorial does not have a structured MDCT in place. However, as part of their I-MAT program they are regularly involved in a learning collaborative forum that has primary care providers, psychiatrists, and any other necessary staff to discuss difficult cases/complex patients. In addition, behavioral health providers are embedded within the primary care pods at the agency, which gives primary care providers direct access to behavioral health staff. The agency has access to psychiatrists through MaineHealth.

Provider Type	Position
Primary Care Provider	Not Yet Identified
Behavioral Health Provider	Not Yet Identified
Care Manager or Community Health Worker	Not Yet Identified
Psychiatrist	Not Yet Identified

- Littleton Regional Healthcare – LRH does not have a structured team in place. Currently, their level of integration is collegial interaction with providers through a shared EMR. Behavioral health notes are integrated with primary care records. PCPs can refer to psychiatric APRN or psychiatrist who provide co-located services when they are at LRH.

Provider Type	Position
Primary Care Provider	Not Yet Identified
Behavioral Health Provider	Not Yet Identified
Care Manager or Community Health Worker	Not Yet Identified
Psychiatrist	Not Yet Identified

- Saco River Medical Group (SRMG) – Saco River Medical Group does not currently have a Multi-Disciplinary Core Team in place, however they are searching for a psychiatrist to consult on difficult cases, once per month as a start. They have been communicating with Northern Human Services to address this need and plan to craft a solid team moving forward. The IDN team will continue to follow up with SRMG to see how they can support these efforts.

Provider Type	Position
Primary Care Provider	Not Yet Identified
Behavioral Health Provider	Not Yet Identified
Care Manager or Community Health Worker	Not Yet Identified
Psychiatrist	Not Yet Identified

- Coös County Family Health Services – Coös County Family Health Services does not currently have a MDCT or case conference in place, but staff does participate in care transition meetings which includes several provider agencies from across the region. The IDN team will work closely with this partner to offer assistance in finding a solution to which meets DSRIP requirements.

Provider Type	Position
Primary Care Provider	Not Yet Identified
Behavioral Health Provider	Not Yet Identified
Care Manager or Community Health Worker	Not Yet Identified
Psychiatrist	Not Yet Identified

- Friendship House and White Horse Addiction Center – Friendship House and White Horse Addiction Center continue to build capacity to deliver services to the region's SUD population and will work closely with the IDN team to develop a process and structure for their MDCTs.

Provider Type	Position
Primary Care Provider	Not Yet Identified
Behavioral Health Provider	Not Yet Identified
Care Manager or Community Health Worker	Not Yet Identified
Psychiatrist	Not Yet Identified

June 30, 2019 Update

Partner status on Multi-Disciplinary Core Team composition is outline below for each of the partners listed in table B1-6 as Integrated Healthcare Key Organizational and Provider Participants.

- *Ammonoosuc Community Health Services (ACHS)* – ACHS continues to convene monthly patient care conferences. The table below reflects the MDCT members in attendance for these meetings.

Provider Type	Position, Organization
Primary Care Provider	Primary Care Provider (MD), ACHS
Behavioral Health Provider	LICSW, ACHS
Care Manager or Community Health Worker	Behavioral Health/SUD Case Manager and Behavioral Health CHW, ACHS
Care Coordination	RN Care Coordinator and Patient Navigator, ACHS

Provider Type	Position, Organization
Psychiatrist	Pathways Psychiatric Consulting, Dr Erinn Fellner & Dr Stacey Charron
Additional Members	ACHS Pharmacist

- *Cottage Hospital/Rowe Health Center (RHC)* – RHC continues to convene weekly Inter-Disciplinary Team meetings, but no longer meets the MDCT composition requirements following the loss of a psychiatrist from Ray of Hope Psychiatric Department at Cottage Hospital who served as a supervisor and consultant for the Psychiatric APRN at RHC.

Provider Type	Position, Organization
Primary Care Provider	Internal Medicine and Primary Care Providers, RHC
Behavioral Health Provider	Licensed Social Worker and Psychiatric APRN, RHC
Care Manager or Community Health Worker	Chronic Care Management RN and Certified Medical Assistant, RHC
Psychiatrist	None at this time

- *Coös County Family Health Services (CCFHS)* – Coös County Family Health Services does not currently have a MDCT or monthly case conference in place, as defined within the DSRIP program. Nonetheless, multiple staff, including case managers, social workers and providers, participate in a community care transition team that meets regularly and includes several provider agencies from across the region. In the current reporting period, Region 7 is working to develop and launch a regional MDCT that will be accessible by this partner. The IDN team will work closely with this partner to develop workflow and protocol templates explaining how to access the regional MDCT.

- *Friendship House* – Friendship House continues to build capacity to deliver services to the region's SUD population. This partner does not have the internal capacity to stand up their own MDCT. In the current reporting period, Region 7 IDN is working to develop and launch a regional MDCT that will be accessible by this partner. The IDN team will work closely with this partner develop workflow and protocol templates explaining how to access the regional MDCT.

- *Huggins Hospital* – Huggins continues to convene monthly patient care conferences. The table below reflects the MDCT members in attendance for these meetings.

Provider Type	Position, Organization
Primary Care Provider	Huggins Primary Care Provider (DO)
Behavioral Health Provider	LICSW, Huggins Hospital
Care Manager or Community Health Worker	RN Care Coordinator, Huggins Hospital
Psychiatrist	Northern Human Services

- *Indian Stream Health Center (ISHC)* – ISHC has a long-standing integrated provider meeting with providers from across disciplines where a variety of issues are discussed including patient care coordination needs. The organization has developed additional processes in order to leverage this meeting to address MDCT requirements, including case conferences.

Provider Type	Position, Organization
Primary Care Provider	Rotating PCPs, including 1 DO, 1 MD, 1 PA-C, and 1 APRN, ISHC
Behavioral Health Provider	LICSW and MSW, ISHC
Care Manager or Community Health Worker	Behavioral Health Case Worker, ISHC
Psychiatrist	Contracted psychiatrist

- *Littleton Regional Healthcare (LRH)* – LRH does not have a structured team in place. Currently, their level of integration is collegial interaction with providers through a shared EMR. Behavioral health notes are integrated with primary care records. PCPs can refer to psychiatric APRN or psychiatrist who provide co-located services when they are at LRH.

- *Memorial Hospital* – Memorial does not have a structured MDCT in place. However, as part of their I-MAT program they are regularly involved in a learning collaborative forum that has primary care providers, psychiatrists, and any other necessary staff to discuss difficult cases/complex patients. In addition, behavioral health providers are embedded within the primary care pods at the agency, which gives primary care providers direct access to behavioral health staff. The program is staffed with multiple Psychiatric APRNs who have access to psychiatrists through MaineHealth. In the current reporting period, Region 7 IDN is working to develop and launch a regional MDCT that will be accessible by this partner. The IDN team will work closely with this partner to develop workflow and protocol templates explaining how to access the regional MDCT.

- *Northern Human Services* – Northern Human Services actively participates on Huggins' and White Mountain Community Health Center's (WMCHC) Multi-Disciplinary Core Teams. They have also agreed to provide psychiatric consultation for agencies in the region to support the Multi-Disciplinary Core Team approach. During the review period, this partner agreed to provide essential behavioral health staff, including a psychiatrist, to the regional MDCT currently being developed by the Region 7 IDN. Additionally, during the review period, they successfully partnered with Ammonoosuc Community Health Services to open a new integrated clinic located in Littleton. This clinic is the second reverse integration site in the region. These integrated clinics primarily serve clients of this community mental health center who were otherwise not accessing primary care services in part because of the challenges created by their complex behavioral health needs. Clients within this high-needs population report that they are now accessing primary care services because they are conveniently offered in a familiar and trusted environment; providers in the integrated clinic work closely to ensure that the client's behavioral and physical health needs are met in an integrated fashion.

Provider Type	Position, Organization
Primary Care Provider	Multiple PCPs, Huggins and WMCHC
Behavioral Health Provider	LICSW, Huggins Hospital and APRN, WMCHC
Care Manager or Community Health Worker	RN Care Coordinator, Huggins Hospital and Community Health Worker and social worker from WMCHC
Psychiatrist	Northern Human Services

- *Saco River Medical Group (SRMG)* – Saco River Medical Group does not currently have a Multi-Disciplinary Core Team in place, however they are searching for a psychiatrist to consult on difficult cases, once per month as a start. They have been communicating with Northern Human Services to address this need. In the current reporting period, Region 7 IDN is working to develop and launch a regional MDCT that will be accessible by this partner. Saco has expressed a strong interest in utilizing this regional resource, acknowledging that they do not have the internal capacity at this time to stand up their own MDCT. The IDN team will work closely with this partner to develop workflow and protocol templates explaining how to access the regional MDCT.

- *Weeks Medical Center (WMC)* – Weeks employs multiple forums to communicate about patients. Behavioral Health is embedded in daily interdisciplinary team meetings that involve real time review of all inpatients. The BH team meets on a regular basis and sets up regular case conferences that

include the PCP, as needed. If psychiatric input is needed the patient is put on the psychiatrist schedule. In the monthly provider meetings, BH is also present for case discussion.

Provider Type	Position
Primary Care Provider	Rotating Primary Care Providers including 4 DOs, 2 MDs, 5 APRNs and 3 PA-Cs, WMC
Behavioral Health Provider	All BH providers including 2 Psychiatric NPs, 2 LDACs, 2 Social Workers and 2 LICSWs, WMC
Care Manager or Community Health Worker	1 BH Case Manager and 5 Care Coordinators (RNs & MAs), WMC
Psychiatrist	Available by contract with consulting psychiatrist Erin Fellner

- *White Horse Addiction Center (WHAC)* –White Horse Addiction Center continues to build capacity to deliver services to the region's SUD population, and added mental health counseling to their service list during the review period. This partner does not have the internal capacity to stand up their own MDCT. In the current reporting period, Region 7 IDN is working to develop and launch a regional MDCT that will be accessible by this partner. The IDN team will work closely with this partner develop workflow and protocol templates explaining how to access the regional MDCT.

- *White Mountain Community Health Center* – Huggins continues to convene monthly patient care conferences. The table below reflects the MDCT members in attendance for these meetings.

Provider Type	Position
Primary Care Provider	APRN, WMCHC
Primary Care Provider	APRN, WMCHC
Behavioral Health Provider	Care Coordinator/Social Worker, WMCHC
Care Manager or Community Health Worker	Community Health Worker, WMCHC
Psychiatrist	Northern Human Services

Region 7 IDN has acknowledged that access to a Multi-Disciplinary Core Team (MDCT) which meets DSRIP requirements is one of the primary barriers preventing several practices in the region from achieving Coordinated Care Practice designation. Although several partners have successfully established a MDCT at their individual sites that meets the requirements, many partners continue to struggle with the composition of the team. In particular, the lack of a psychiatrist at most locations, is a significant barrier to full MDCT composition. Several members have indicated that they have psychiatric nurse practitioners readily available to participate in multidisciplinary case conferences, and express a frustration that this specially trained healthcare provider who is able to practice independently according to the licensing rules of NH and many other states is not considered qualified to provide the necessary psychiatric guidance to a MDCT.

In general, partners participating in the core competency integrated healthcare project have expressed an interest in having a MDCT readily available to their providers for regular case consultations. However, many feel they do not have the bandwidth necessary to set providers up in these meetings with regularity and report the cost of a psychiatrist and the non-billable time for the MDCT members to participate in the case conference process is a barrier to successful implementation. During the reporting period, the Region 7 IDN team facilitated discussions with workgroups and the partner agencies working on the core competency integrated healthcare project to assess their willingness to use a regional MDCT in such a way as to meet all DSRIP requirements. Many partners who do not yet have a MDCT available expressed an interest in having such a consultative body available to them for guidance on their most complex cases. The IDN team will spend the next reporting period trying to

formalize a regional MDCT team to support IDN partner agencies working to reach the status of a Coordinated Care Practice.

During conversations with partners it has become clear that there was some misunderstanding about the nature of a MDCT so the IDN team has spent a significant amount of time during this reporting period clarifying the purpose, functionality, and requirements of the MDCT. The Region 7 IDN team has also sought additional information from Region 6 IDN about their Community Care Team model in an effort to begin conceptualizing a regional body that could provide access to a MDCT for all agencies working on the core competency integrated healthcare project regardless of what they have available within their own sites. The Steering Committee has dedicated time during meetings in the last half of the reporting period to discuss the use of targeted funding to support a regional MDCT, and these conversations will continue to evolve during the next reporting period. The IDN team will work closely with partner agencies and governance workgroups to develop workflow and protocol templates explaining how to access the regional MDCT.

The Steering Committee has dedicated time during meetings in the last half of the reporting period to discussing the use of targeted funding in support of a regional MDCT, and these conversations will continue to evolve during the next reporting period. In the coming reporting period, the IDN team will collaborate closely with partner agencies and governance workgroups to develop workflow and protocol templates that can be adapted by partner agencies to ensure that their providers have access to the regional MDCT.

December 31, 2019 Update

Partner status on Multi-Disciplinary Core Team composition is outline below for each of the partners listed in table B1-6 as Integrated Healthcare Key Organizational and Provider Participants.

- *Ammonoosuc Community Health Services (ACHS)* – ACHS continues to convene monthly patient care conferences. The table below reflects the MDCT members in attendance for these meetings.

Provider Type	Position, Organization
Primary Care Provider	Primary Care Provider (MD), ACHS
Behavioral Health Provider	LICSW, ACHS
Care Manager or Community Health Worker	Behavioral Health/SUD Case Manager and Behavioral Health CHW, ACHS
Care Coordination	RN Care Coordinator and Patient Navigator, ACHS
Psychiatrist	Pathways Psychiatric Consulting, Dr Erinn Fellner & Dr Stacey Charron
Additional Members	ACHS Pharmacist

- *Cottage Hospital/Rowe Health Center (RHC)* – RHC

Provider Type	Position, Organization
Primary Care Provider	Internal Medicine and Primary Care Providers, RHC
Behavioral Health Provider	Psychiatric APRN, RHC
Care Manager or Community Health Worker	Chronic Care Management RN and Certified Medical Assistant, RHC
Psychiatrist	Psychiatrist contracted to provide oversight to APRN

- *Coös County Family Health Services (CCFHS)* – This partner does not have a MDCT in place at this time, but does participate in a large interdisciplinary Transitions in Care team for their catchment area that regularly discusses and addresses barriers that patients with complex needs encounter as they navigate the healthcare system. A key participant in this initiative is a care coordinator whose

position is shared between CCFHS and Androscoggin Valley Hospital, thereby providing consistency of practice for patients transitioning from one setting to another. As the idea of a regional MDCT was presented to Region 7 IDN partners, CCHFS voiced the potential willingness to adopt policies related to the use of the Regional MDCT at some point in the future, but the organization has shared that they do not feel they have the staff resources to take on any additional initiatives at this time.

- *Friendship House (FH)* – This partner does not have an MDCT in place at this time, but has begun preparations to adopt policies and protocols that will allow them to access the Region 7 MDCT for case consultations on the most complex cases receiving treatment in their rehabilitation facility. They do anticipate minimal referrals to the MDCT directly from FH due to the limited scope of services offered, and instead suspect that clients' primary care providers are more likely to make referrals but FH will be involved as a member of the client's circle of care.

- *Huggins Hospital* – Huggins continues to convene monthly patient care conferences. The table below reflects the MDCT members in attendance for these meetings.

Provider Type	Position, Organization
Primary Care Provider	Huggins Primary Care Provider (DO)
Behavioral Health Provider	LICSW, Huggins Hospital
Care Manager or Community Health Worker	RN Care Coordinator, Huggins Hospital
Psychiatrist	Northern Human Services

- *Indian Stream Health Center (ISHC)* – ISHC has a long-standing integrated provider meeting with providers from across disciplines where a variety of issues are discussed including patient care coordination needs. The organization has developed additional processes in order to leverage this meeting to address MDCT requirements, including case conferences and participant training in required chronic health conditions. Despite turnover in key positions at ISHC during this reporting period, the MDCT has continued to hold case conferences at least monthly.

Provider Type	Position, Organization
Primary Care Provider	Rotating PCPs, including 1 DO, 1 MD, 1 PA-C, and 1 APRN, ISHC
Behavioral Health Provider	LICSW and MSW, ISHC
Care Manager or Community Health Worker	Behavioral Health Case Worker, ISHC
Psychiatrist	Contracted psychiatrist

- *Littleton Regional Healthcare (LRH)* – This partner does not have an MDCT in place at this time, but has expressed an interest in adopting policies and protocols that will allow them to access the Region 7 MDCT for case consultations on their most complex cases. The partner anticipates further progress on this coordinated care practice requirement in early 2020.

- *Memorial Hospital* – This partner has begun implementing mini team huddles on a biweekly basis from each care team. Other disciplines are regularly invited to participate in the discussion, which includes focus on specific patients and ways to improve care and reduce emergency department utilization. Huddles are attended by members of the behavioral health team, and the Psychiatric NP has regular supervisory and consultative discussions regarding complex patient care with a Psychiatrist from Maine Health, Memorial's parent organization.

Provider Type	Position, Organization
Primary Care Provider	Care team PCP
Behavioral Health Provider	Psychiatric APRN, Memorial

Provider Type	Position, Organization
Care Manager or Community Health Worker	Care Coordinator and LICSW
Psychiatrist	Maine Health psychiatrist

- *Northern Human Services* – Northern Human Services actively participates on Huggins' and White Mountain Community Health Center's (WMCHC) Multi-Disciplinary Core Teams. They have also agreed to provide psychiatric consultation for agencies in the region to support their Multi-Disciplinary Core Teams. During the review period, this partner agreed to provide essential behavioral health staff, including a psychiatrist, to the Regional MDCT currently being developed by the Region 7 IDN and entered into an MOU for those services. Additionally, during the review period, their successful partnering with Ammonoosuc Community Health Services was realized with the opening of a new integrated clinic located in Littleton. This clinic is the second reverse integration site in the region. These integrated clinics primarily serve clients of the community mental health center who were otherwise not accessing primary care services in part because of the challenges created by their complex behavioral health needs. Clients within this high-needs population report that they are now accessing primary care services because they are conveniently offered in a familiar and trusted environment; providers in the integrated clinic work closely to ensure that the client's behavioral and physical health needs are met in an integrated fashion.

Provider Type	Position, Organization
Primary Care Provider	Multiple PCPs, Huggins and WMCHC
Behavioral Health Provider	LICSW, Huggins Hospital and APRN, WMCHC
Care Manager or Community Health Worker	RN Care Coordinator, Huggins Hospital and Community Health Worker and social worker from WMCHC
Psychiatrist	Northern Human Services

- *Saco River Medical Group (SRMG)* – – This partner does not have an MDCT in place at this time, but has expressed an interest in adopting policies and protocols that will allow them to access the Region 7 MDCT for case consultations on their most complex cases. The partner anticipates further progress on this coordinated care practice requirement in early 2020.

- *Weeks Medical Center (WMC)* – Weeks employs multiple forums to communicate about patients. Behavioral Health is embedded in daily interdisciplinary team meetings that involve real time review of all inpatients. The BH team meets on a regular basis and sets up regular case conferences that include the PCP, as needed. If psychiatric input is needed the patient is put on the psychiatrist schedule. In the monthly provider meetings, BH is also present for case discussion.

Provider Type	Position
Primary Care Provider	Rotating Primary Care Providers including 4 DOs, 2 MDs, 5 APRNs and 3 PA-Cs, WMC
Behavioral Health Provider	All BH providers including 2 Psychiatric NPs, 2 LDACs, 2 Social Workers and 2 LICSWs, WMC
Care Manager or Community Health Worker	1 BH Case Manager and 5 Care Coordinators (RNs & MAs), WMC
Psychiatrist	Available by contract with consulting psychiatrist Erin Fellner

- *White Horse Addiction Center (WHAC)* — This partner does not have an MDCT in place at this time, but has already adopted the policies and protocols that provide their clinicians access to the Region 7 MDCT for case consultations on their most complex cases. Additionally, this partner has identified a clinician to serve as the primary point of contact for all care coordination and MDCT activities involving external partners.

Provider Type	Position
Primary Care Provider	Region 7 MDCT Primary Care Provider
Behavioral Health Provider	WHAC Licensed Mental Health Provider, Care Coordinator
Care Manager or Community Health Worker	Northern Human Services Care Manager
Psychiatrist	Northern Human Services Psychiatrist

- *White Mountain Community Health Center (WMCHC)* – WMCHC continues to convene monthly patient care conferences. The table below reflects the MDCT members in attendance for these meetings.

Provider Type	Position
Primary Care Provider	APRN, WMCHC
Primary Care Provider	APRN, WMCHC
Behavioral Health Provider	Care Coordinator/Social Worker, WMCHC
Care Manager or Community Health Worker	Community Health Worker, WMCHC
Psychiatrist	Northern Human Services

With the challenges of standing up individual partner MDCTs, Region 7 IDN is supporting a base team that includes a psychiatrist, behavioral health provider and behavioral health case manager. As noted above, Northern Human Services has contracted to provide MDCT access to Region 7 partners on a monthly basis to present their complex cases and invite their team members to participate in the development of shared care plans that will provide patient-centered care guidelines to the team and patient/family. The Regional MDCT is intended to be a collaborative and consensus-driven consultative body, that will be convened for the purpose of planning patient/client care. Its primary goal is to share information and knowledge in general to improve service delivery across the region and specifically to:

1. Engage priority participants as indicated by referrals received;
2. Recognize patient/client's self-identified needs/goals as indicated in referral paperwork;
3. Identify gaps to meeting those needs and goals (historical, current, and anticipated);
4. Identify strategies to remove barriers and meet those goals;
5. Identify partner agents/points of contact responsible for coordinating and facilitating next steps/strategies;
6. Communicate strategies via a shared care plan to the patient's circle of care; and
7. Create a closed-loop communication plan that includes the patient/client/family.

During the reporting period, policies and protocols for the Regional MDCT, as well as policies and protocols for partner agencies to access the Regional MDCT, have been developed by the IDN Quality Improvement Coach and approved by the Regional Care Coordinator Network and the Clinical Workgroup. The Regional MDCT will test these processes during its first meeting in February 2020 with a case presented by a Region 7 IDN partner organization. Once the process has been evaluated with a formal plan, do, study, act (PDSA) review, monthly meetings will be open for referrals from all Region 7 IDN partners. Although the Region had hoped to convene the first meeting by the end of this reporting period, partners opted to favor the development of processes that will be sustainable after the demonstration over processes that could be adopted quickly with diminished likelihood of success.

No additional information from individual partners indicating achievement on this deliverable has become available during the review period. Separate from individual partner teams, Northern Human Services identified a case manager, behavioral health provider and psychiatrist to serve as the primary members of the Regional Multi-Disciplinary Team during the review period. The Core Team will be rounded out by the presence of the primary care provider(s) caring for the case(s) presented at the

scheduled monthly case conferences. At this time, the Regional MDCT is available to all Region 7 IDN partners, and the Region 7 MDCT Policy & Protocol has been provided to care coordinators at each partner location so that they have a means to access this resource.

B1-8c: Multi-Disciplinary Core Team training:

December 31, 2018

Master MDCT Training Tracking Table						
Staff	**Target**	**Mental Health**	**Substance Use Disorder**	**Diabetes**	**Dyslipidemia**	**Hypertension**
Cottage Hospital/Rowe Health Center	7	0	0	0	0	0
Huggins Hospital	4	2	0	0	0	0
ACHS	8	2	0	0	0	0
Indian Stream Health Center	8	0	0	0	0	0
Weeks Medical Center	28	0	0	0	0	0
White Mountain Community Health Center	4	1	0	0	0	0
Northern Human Services	2	-	0	0	0	0

The table above reflects the five DSRIP required training topics for Multi-Disciplinary Core Team members. Region 7 IDN has worked diligently to develop a comprehensive training plan to target the MDCT members and other essential staff involved in patient care. Despite the team's best efforts, it has been evident that the consistent barrier to training the MDCT members is directly related to lost billable hours for providers to attend; workforce shortages so staff cannot get time off to participate in required trainings; and provider hesitancy to take trainings they feel are unnecessary for re-licensure. The Region 7 IDN team will continue developing a strategy to reach the MDCT members specifically, potentially using their monthly case conference schedule as a platform to deliver trainings.

Region 7 IDN is working to offer trainings on diabetes/hyperglycemia and hypertension to meet DSRIP requirements. The region partnered with the other IDNs in the state to sponsor an IDN training track at the Behavioral Health Summit in December 2018. Chronic Disease Management for Behavioral Health Providers was one of the sessions offered, and the session was approved for continuing education credits. The Region 7 IDN team will work to promote this training over the remaining course of the DSRIP program. The Region 7 IDN webinar series will also be used as an option to bring additional required trainings to the MDCT members in an efficient way to avoid lost staff time. Multiple trainings have been held over the past year that relate to mental health and SUD including; Stigma & Language Webinar, Addiction 101, Co-Occurring Medical and Psychological Conditions, Ethical Considerations, Suicide Prevention and Mental Health First Aid.

The Region 7 IDN team will expand this training table once it is determined how the six remaining B1 partners in the region will be connected to a MDCT. The team will continue working to connect the MDCT members to these webinars and available trainings throughout the state to help meet the DSRIP training requirement.

During the July-December 2018 reporting period, IDN Region 7 held several other trainings for IDN partners including MDCT team disciplines, non-direct staff, and many other staff. The Peer Recovery Coach Academy training track began in July of 2018 and provided multiple trainings, mostly to community service partners and recovery community organizations. The region also sponsored one

Critical Time Intervention Training, two Management of Aggressive Behavior trainings and Managing Physical Confrontation were offered, along with one Mental Health First Aid training which has been determined as one training that meets the mental health topic required by DSRIP. The region also developed two webinars during this period; one focused on Stigma and Language and the other on Risk Stratification. The Stigma and Language training addressed the Substance Use Disorder topic required by DSRIP. These trainings and webinars reached a variety of partners and are now available on demand for the MDCT team members in the region. The second Regional Care Coordination training was delivered to partners from Coös and Northern Grafton, training key members of partner MDCTs.

Region 7 also held two quarterly meetings for IDN partners, with a Trauma Informed Care training at the September meeting; this trained a portion of the thirty-nine people that attended the meeting and was very valuable to the region. The December quarterly meeting focus on informing the partners on funding updates, reporting requirements, Medicaid programs, and workforce policy movements. Region 7 IDN is working diligently to train the team members of all partner Multi-Disciplinary Core Teams and plans to develop another strategic training plan for 2019.

Multiple Region 7 IDN partners were trained over the July-December reporting period in the main eight IDN sponsored trainings of this period. The table below showcases the number of individuals trained by organization for each training across all disciplines.

Partner	CTI Worker Training	Regional Care Coordination	Motivational Interviewing	Mental Health First Aid	Introduction to Management of Aggressive Behavior	Introduction to Managing Physical Confrontation
Ammonoosuc Community Health Services		1			17	12
Northern Human Services	2	1	3		2	2
Family Resource Center	8				2	1
Huggins Hospital				21		
Saco River Medical Group						
White Mountain Community Health Center			1			
Carroll County Department of Corrections						
Tri-County Community Action Program	4		1			
Crotched Mountain						
White Horse Addiction Center						
North Country Health Consortium			3			
NCHC Friendship House			5			
Memorial Hospital						

Partner	CTI Worker Training	Regional Care Coordination	Motivational Interviewing	Mental Health First Aid	Introduction to Management of Aggressive Behavior	Introduction to Managing Physical Confrontation
Carroll County Coalition for Public Health						
Granite State Independent Living						
Littleton Regional Healthcare	2	2	1			
Weeks Medical Center		1				
Cottage Hospital/Rowe Health Center		1	1		2	1
Mount Washington Valley Supports Recovery			2			
Grafton County Department of Corrections			2			
North Country Serenity Center			3			
Town of Conway			1			
GCNH					1	1
Coös County Family Health Services						
Indian Stream Health Center						

The IDN team has been working to capture the separate disciplines being trained throughout the region 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			

June 30, 2019 Update

Even for partner agencies who have been able to successfully establish a Multi-Disciplinary Core Team (MDCT) at their own locations, confirming that the members of this team have met the DSRIP training requirements continues to be challenging. Several conversations have occurred with the Region 7 IDN Medical Director, the clinical work group, and individual partners during partner status calls about the best way to verify that MDCT members have adequate training in the five topic areas. The consensus is that primary care providers have received adequate training in all five topic areas as part of their scope of practice. Several partners have expressed that their existing MDCT meetings have resulted in behavioral health providers and care coordinators receiving additional education about the topics as an organic byproduct of the MDCT case consultation process.

The Region 7 IDN team has corroborated this challenge with administrative leads from other regions who share that they are facing similar barriers in determining whether adequate training of MDCT members has occurred. The Steering Committee and Clinical Workgroup have briefly discussed whether an attestation would be sufficient for MDCT team members, and during the most recent round of partner status call, the Region 7 IDN team has asked primary contacts at each partner site to query their providers for additional information about what education the providers feel they have received that would meet this requirement. Several partners have expressed that some providers undergo regular CME that address integrated care, chronic disease management and the importance of behavioral health in whole person wellness. These partners feel it may be possible to produce a provider's CME log used for their licensure renewal and payer credentialing that could prove such as education has occurred.

One partner, Indian Stream Health Center (ISHC) , reports that the care coordinator who prepares cases for consultation has begun attaching information from Up-To-Date to the case review forms in order to ensure that each MDCT member has baseline information about key diagnoses for each patient as part of the preparation for the case conferences. ISHC feels that this has been a value-added process that does not require significant effort on the part of the care coordinator and results in all members of the multi-disciplinary team having the necessary information to make an effective care plan. Indian Stream Health Center has agreed to allow NCHC to share information about this technique with other partners in the region to make education about key topic areas easy to obtain and consistent throughout the region.

The Steering Committee has dedicated time during meetings in the last half of the reporting period to discussing the use of targeted funding in support of a regional MDCT, and these conversations will continue to evolve during the next reporting period. In the coming reporting period, the Region 7 IDN team will collaborate closely with partner agencies and governance workgroups to develop workflow and protocol templates that can be adapted by partner agencies to ensure that their providers have access to the regional MDCT. Efforts will also be made to continue promoting the training webinars from the 2018 Behavioral Health Summit since these modules were designed to meet DSRIP training requirements. As the region continues conversations related to a targeted funding approach the IDN team will ensure that the required training component will remain part of these discussions.

No additional information indicating achievement on this deliverable has become available during the review period.

December 31, 2019 Update

As noted above, even for partner agencies who have been able to successfully establish a Multi-Disciplinary Core Team (MDCT) at their own locations, confirming that the members of local teams have met the DSRIP training expectations for the required chronic conditions continues to be a challenge. Several conversations have occurred with the Region 7 IDN Medical Director, the Clinical Workgroup, and individual partners during partner status calls about the best way to verify that MDCT members have adequate training in the five topic areas. As in previous reporting periods, partner consensus is that primary care providers have received adequate training in all five topic areas as part of their scope of practice. It is increasingly common for partners with existing MDCTs to identify that all members of the MDCT receiving ongoing education regarding chronic conditions, including those outlined in the Special Terms and Conditions, in the course of conducting their case consultations – an organic byproduct of the MDCT case consultation process.

As the Regional IDN7 Multi-Disciplinary Core Team has been developed, consideration has been given to processes that will ensure that the Region 7 MDCT members can demonstrate adequate training on the required topics. During the reporting period, the Region 7 IDN team has also reminded partner organizations that on-demand content is available to their behavioral health providers on the Region 7 IDN website that can help broaden their knowledge regarding chronic conditions.

No additional information from individual partners indicating achievement on this deliverable has become available during the review period. Separately, as noted in section B1-8b a plan was put in place during the review period to provide all Region 7 IDN partner agencies with access to the Region 7 MDCT. Northern Human Services has reported that all staff at all sites have participated in the Chronic Conditions for Behavioral Health Providers module of the 2018 Behavioral Health Summit, thereby ensuring that the staff engaged in Regional MDCT activities have the training requirement. Additionally, the Region 7 Medical Director has advised that the five conditions required in the MDCT training are all within the scope of a primary care provider, thereby assuring that the primary care provider(s) caring for the case(s) presented at the scheduled monthly case conferences will also have adequate education to identify, treat and refer these key conditions. At this time, the Regional MDCT is available to all Region 7 IDN partners, and the Region 7 MDCT Policy & Protocol has been provided to care coordinators at each partner location so that they have a means to access this resource.

B1-8d: Training for non-direct staff

December 31, 2018

The region used the two trainers embedded at NCHC to deliver the last MHFA training for 2018, totaling four trainings for the year. This training was held at Huggins Hospital in Wolfeboro for twenty-one staff members on October 26th. Region 7 IDN staff will work to coordinate at least four Mental Health First Aid trainings for 2019 to meet the deliverable of having four Mental Health First Aid trainings offered in each year 2018-2020.

Below is a table reflecting what was reported in the region's implementation plan regarding number of front-line staff members who needed to be trained in Mental Health First Aid. Mental Health First Aid training was determined to be the main training given to staff not providing direct care to ensure they have an understanding about mental disorders that can aid in recognition and management of these disorders. The training is also open to the Core Team disciplines and other staff. During this reporting period, one training was offered on 10/26/18. A variety of Huggins staff members participated in this training, reaching a wide range of disciplines. Below is a table reflecting the region's progress regarding number of front-line staff members trained in Mental Health First Aid. Region 7 IDN team is working with the remaining partners that have not met their target for this training to schedule opportunities during 2019. It is anticipated to offer four more Mental Health First Aid trainings with a focus on Northern Grafton, Coös County and all other partners who still require the training.

Mental Health First Aid Training Plan	Target based on need	Trained as of 12/31/18
Saco River Medical Group	3 (reception, phone support, medical records)	0
Littleton Regional Healthcare	35 (medical secretaries, facility directors, administration, and hospital registrars)	11
Cottage Hospital	N/A	11
Memorial Hospital	8 (front desk, medical records, registration)	18
Huggins Hospital	19 (front desk, PATH, billing, medical records)	64
White Mountain Community Health Center	5 (front desk, billing, medical records)	0

Mental Health First Aid Training Plan	Target based on need	Trained as of 12/31/18
Weeks Medical Center	8 (front desk)	0
Northern Human Services	20 (front desk, medical records, billing)	2
Coös County Family Health Services	12 (front desk staff)	0
Rowe Health Center	10 (patient service representatives, certified medical assistants)	3
Ammonoosuc Community Health Services	38 (front desk, medical records, scheduling, billing, facilities, human resources, finance, administration)	0

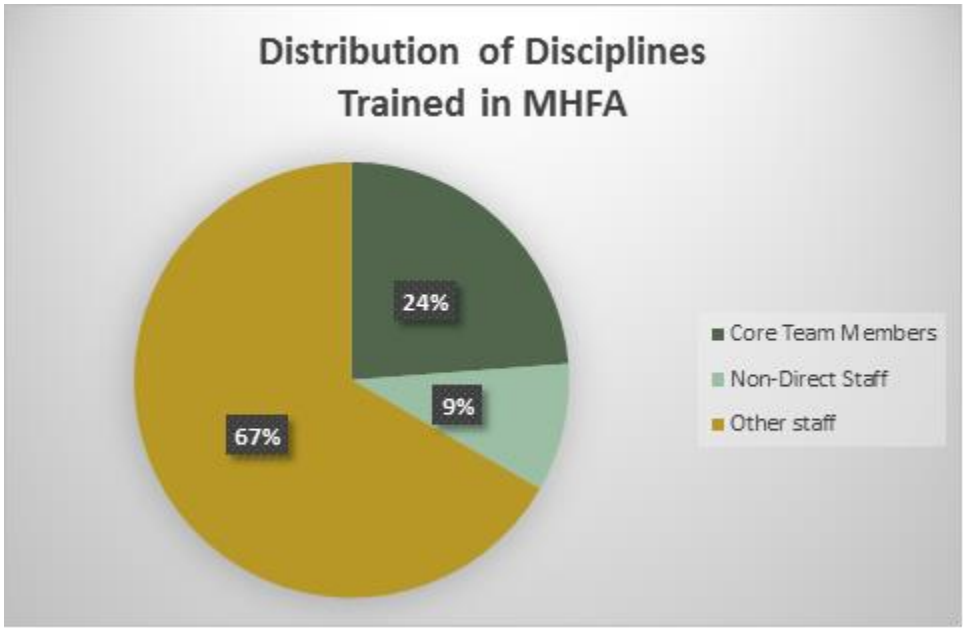

Figure 3: B1-8d Disciplines Trained in Mental Health First Aid

The pie chart above shows the distribution of disciplines that have been trained in Mental Health First Aid out of a total of 109 individuals, as of December 31, 2018. The "Core Team" and "Other" categories consist of a variety of disciplines that are in the Mental Health First Aid Training table above.

Additionally, ACHS has been encouraging all its staff to attend de-escalation training. Currently twelve ACHS employees have attended the Introduction to Management of Aggressive Behavior Series sponsored by IDN 7. More will be scheduled for 2019. ACHS also plans to participate in a 42 CFR Part 2 training in early 2019.

June 30, 2019 Update

Region 7 IDN partners agree that Mental Health First Aid remains an important training for their non-direct staff members to access. Despite the recognized value of this training, partners have shared that it is challenging to send staff to this training due to the intensive 8-hour day format. Limited staffing throughout the region prohibits partners from sending staff to a full-day training in high-volume numbers because of the negative impact on clinic operations. As a result, it has become challenging to train the original target populations developed by partners at the beginning of the project.

North Country Health Consortium has two trainers embedded in the organization that are prepared to provide this training to non-direct staff, and the table below will continue to be used in the process of scheduling targeted trainings in the next reporting period based on anticipated need by agency. The Region 7 IDN team has targeted outreach to partners in an effort to begin scheduling trainings in the last

half of 2019 and will work with trainers and partners to identify the best way to deliver this content to non-direct staff. Two trainings have already been scheduled for fall 2019, and the IDN team will work to coordinate additional sessions before the end of the year.

During the review period, partner organizations were queried to see if there were any other training options being offered to their non-direct staff that address this training requirement. Many partners shared that no other training mechanism was currently in place that would meet the DSRIP requirements. Universally, partners listed in the table below confirmed that the primary barrier to uptake on the Mental Health First Aid offerings was the amount of staff time the training consumed. Particularly for partners who are struggling to maintain adequate staffing levels for their current clinic volumes, the primary challenge is in finding the necessary coverage in order to free a staff member to attend the full-day training. Partners have expressed a strong interest in having on-demand, web-based learning content available, and feel confident that they would be able to task staff to engage in a shorter training, or one that could be completed over time, allowing staff to use periodic downtime to meet this training requirement.

During the review period calls, Ammonoosuc Community Health Services (ACHS) shared a staff education mechanism in place at their organization that bears highlighting because it underscores the value of using ongoing messaging to support and strengthen an organizational culture of compassion and focus on whole-patient care. As this FQHC partner has opened service lines that allow them to provide integrated dental, vision, and behavioral health services within the primary care setting, they have also created public-facing promotional videos that demonstrate their commitment to providing integrated care in an environment that is compassionate, supportive and trustworthy. The videos from this partner can be viewed at https://www.youtube.com/channel/UC9tthMFiYCkoqE8j9F-JdLQ/featured and while brief in length, many narrate the integrated care from the patient/client perspective. If the patient/client frame is not used, the videos either highlights the provider perspective or the value to the community at large of offering integrated services.

Before these videos are shared broadly within the ACHS catchment area, the management team at ACHS requires all staff to view the videos. In doing this, they ensure that the entire employee population is aware of the expectations being set for their patient population, and the expectation that the entire organization will work together to meet those expectations. Secondarily, the staff are asked to personally distribute the links to the videos to their friends and family. Use of staff at all levels of the organization to share this messaging with the catchment area further promotes a sense of trust and openness, subtly combatting the stigma of behavioral health needs – the primary purpose of the non-direct staff training required under the DSRIP.

In the current reporting period, the Region 7 IDN team is continuing to collaborate with partners to identify training options for their non-direct staff that meet both the intent of this requirement and the workflows of our partners.

Organization	Mental Health First Aid Training Plan Targets (targeted staff populations, based on need)	Trained as of 12/31/18
Ammonoosuc Community Health Services	38 (front desk, medical records, scheduling, billing, facilities, human resources, finance, administration)	0
Coös County Family Health Services	12 (front desk staff)	0
Cottage Hospital/Rowe Health Center	10 (patient service representatives, certified medical assistants)	14
Huggins Hospital	19 (front desk, PATH, billing, medical records)	64
Littleton Regional Healthcare	35 (medical secretaries, facility directors, administration, and hospital registrars)	11

Organization	Mental Health First Aid Training Plan Targets (targeted staff populations, based on need)	Trained as of 12/31/18
Memorial Hospital	8 (front desk, medical records, registration)	18
Northern Human Services	20 (front desk, medical records, billing)	2
Saco River Medical Group	3 (reception, phone support, medical records)	0
Weeks Medical Center	8 (front desk)	0
White Mountain Community Health Center	5 (front desk, billing, medical records)	0

December 31, 2019 Update

During the reporting period, the Region 7 IDN team worked to develop an on-demand, web-based training designed to improve behavioral health awareness among non-direct staff in the region. This offering was developed in response to partner feedback regarding the challenges of releasing staff members to attend in-person, full-day sessions of Mental Health First Aid training, the curriculum originally identified in the Region 7 IDN Project Plan as the vehicle to broaden cultural sensitivity around behavioral health needs in the community, reduce stigma and improve access to services. The on-demand content is expected to be released in February 2020, and after participating in the activity learners will be able to:

- Understand that the only difference between mental illnesses and physical illnesses is the body part affected
- Understand and identify personal preconceptions and misconceptions about mental illness
- Understand the impact that mental illness has on an individual and society
- Identify symptoms of common mental illnesses

The training will be available to partners on the Region 7 IDN YouTube channel, and via the Region 7 IDN Moodle platform for those individuals interested in earning continuing education credit for the one-hour module. To assist partners with demonstration of staff participation in the module, the Region 7 IDN team has also developed attestation forms and completion logs to be used at partner organizations. Partner organizations have expressed strong interest in this training alternative for non-direct staff, and the IDN 7 team anticipates broad participation across the region.

During the review period, the on-demand Mental Health Awareness module was developed and recorded by Region 7 IDN staff. It has been released to partners at https://youtu.be/aHb6Y34ObA8 and they have been encouraged to share it broadly amongst their staff. The Region 7 IDN team also has the ability to share this module in MP4 format to partners who want to mount it in their online learning platforms.

Several partners have expressed an interest in having all staff members at their location participate in this training and are pleased to have a more consumable learning option that is available on demand and consumes less staff time. Within hours of its release, the CEO of partner Ammonoosuc Community Health Services shared the link for this training to all senior leaders and board members, encouraging them to serve as force multipliers by first watching the module and then sharing with three friends in community, and encouraging those friends to do the same.

The Region 7 IDN staff also shared forms for tracking staff participating in the training with the Region 7 IDN partners via the region's Basecamp site, images of which are pasted below.

Mental Health Awareness Training
Region 7 IDN
Partner Organization: _____

The following employees attest that they have viewed the Mental Health Awareness training for non-direct staff, available at: https://youtu.be/aHb6Y34ObA8, a module designed to increase cultural sensitivity and reduce stigma when working with individuals who have mental health needs.

Date Completed	Name	Title	Signature

Please return this completed attestation to: Region 7 IDN Team at idn7@nchcnh.org

Mental Health Awareness Training
Region 7 IDN
Individual Attestation

I hereby attest that the demographic information provided below is true and factual, and that my organization is a partner organization within the Region 7 IDN. I further attest that I have viewed the Mental Health Awareness training for non-direct staff, available at https://youtu.be/aHb6Y34ObA8, a module designed to increase cultural sensitivity and reduce stigma when working with individuals who have mental health needs.

Individual information	Organizational information
Print Name	Organization Name
Title	Street Address
Date of Completion	City, State, Zip Code
Signature	

Please return this completed attestation to: Region 7 IDN Team at idn7@nchcnh.org

B1-8e: Monthly Core Team Case Conferences

December 31, 2018

This section should include a schedule of case conferences for the, minimally monthly, MDCT.

The partners of the Region 7 IDN have worked very hard to expand integrated and coordinated care in the region. Many partners have developed the capacity to deliver primary care and behavioral health care under one roof. They enjoy staff relationships that are fluid and collegial. In the words of staff at Memorial Hospital, “we’re in each other’s offices all the time.” Teams at many partner organizations work together every day, crossing disciplines to address patient centered goals.

As a result, structured and scheduled case conferences are not occurring in some organizations. But Region 7 IDN is still seeing a high level and growing amount of collaboration between primary care and behavioral health staff. In some cases, this results in more case specific discussion albeit less formal. And some providers feel this is done more efficiently and at a lower cost than convening a full monthly case conference.

In the early stages of the demonstration, Region 7 IDN B1 partners expressed a preference for developing site-specific Multi-Disciplinary Core Teams over the development of a regional Multi-Disciplinary Core Team. Several partners have been successful in implementing a Multi-Disciplinary Core Team within their agencies, while others have struggled to formalize this process. In future reporting periods, Region 7 IDN will explore alternatives that ensure that all B1 partners have access to a Multi-Disciplinary Core Team. Alternatives to be explored include, but are not limited to, the possibility of leveraging existing Multi-Disciplinary Core Teams as consulting bodies for partners in need of a Multi-Disciplinary Core Team, as well as revisiting the possibility of convening a regional group to hold monthly case conferences in a virtual setting.

Northern Human Services: Northern Human Services actively participates on Huggins and WMCHC teams and meets with these agencies on a monthly basis. They have met with Huggins Hospital four times during the reporting period and with WMCHC five times. They have also agreed to provide psychiatric consultation for agencies in the region to support the Multi-Disciplinary Core Team approach.

Indian Stream Health Center: ISHC has a long-standing integrated provider meeting with providers from across disciplines where a variety of issues are discussed including patient issues. The organization is working on developing this meeting to address MDCT requirements including case conferencing. They have recently transitioned a staff person to be a behavioral health care manager and as of the end of 2018, staffing is in place for the MDCT. The ISHC team is now working on developing protocols and policy that will structure the MDCT meeting. They hope to roll this out in 2019. The Team has agreed to begin a more formal process for case conferences during their scheduled integrated provider meetings (both BH and medical). ISHC will be looking into executing BAAs with other local organizations such as Upper Connecticut Valley Hospital and Northern Human Services to be able to include them in those discussions. The organization is familiar with meetings facilitated by NHS with school health, and ISHC will reach out about releases for their staff. Monthly update dashboard will help to focus the effort to implement regular monthly meetings of the MDCT.

Ammonoosuc Community Health Services: ACHS has held four MDCT meetings during this reporting period, including contracted psychiatric representation. Roles and responsibilities have been written for MDCT members, and these along with the purpose of the team has been documented. The agency has held a structured meeting to strategize the most effective way to continue using the MDCT. In response, it has been arranged for providers to have a 15-minute block to participate in the care planning case conference in person or by phone. Cases presented are high utilizing or complicated patients selected at provider discretion. A barrier to implementation of the MDCT has been provider buy-in due to lack of time, referral processes, and the uncertain benefit for patients. Evidence-based articles have been provided to the team to support the MCDT process. At their last case conference, the team discussed 2-3 referrals which was proven to be helpful for providers. In addition to this progress, roles and responsibilities have been written for MDCT members, and these along with the purpose of the team has been documented. Below is an example of MDCT Purpose, Roles and Responsibilities developed by ACHS:

- **Purpose**: Multidisciplinary care involves a team approach to planning treatment and providing care for patients as they move along the pathway of services they need. The Multi-Disciplinary Core Team (MDT) provides improved patient care and outcomes through the development of an agreed treatment plan, streamlined treatment pathways and reduction in duplication of services, improved coordination of care, and educational opportunities for health professionals.
- **Roles and Responsibilities:** The multidisciplinary team includes providers, Case managers, nurses, pharmacists, and patient navigators. Other members may be present as appropriate to the patient group. All members of the team should have the opportunity to actively interact as part of the MDT process. Possible roles for each team member on a multidisciplinary round are outlined below:
    - **Integrated Behavioral Health (IBH) Director –** Is the primary leadership for MDT. Is the focal point for MDT related issues. Schedules and facilitates MDT meetings. Ensures all team members are resourced to perform MDT functions. Makes recommendations pertaining to Behavioral issues.
    - **Psychiatrist –** Provides psychiatric recommendations on referred patients

- **Primary Care –** Leads the round and introduces patient to the team. Provides update of recent history, clinical examination, and review of the patient. Reviews medications.
- **Medical Case Manager –** Case Manager for patients whose primary needs are medical in nature. Ensures patients are prepared for next care setting. Coordinates transitioning the care plan from one setting to a next setting. Case manager works during the health care encounter with the patient/family and next level of care. Case manager should advise care coordinator of potential care coordination needs in the home setting.
- **Pharmacist –** Plays a key role in medication management, with the goal to minimize patient attrition (going without a needed medication) and to minimize to the extent possible prescriber and pharmacy disruption.
- **Behavioral Health Case Manager –** Case Manager for patients whose primary needs are behavioral in nature. Ensures patients are prepared for next care setting. Coordinates transitioning the care plan from one setting to a next setting. Case manager works during the health care encounter with the patient/family and next level of care. Case manager should advise care coordinator of potential care coordination needs in the home setting.
- **Community Health Worker (CHW) –** Ensures patients get needed care services to keep health stable and reduce risk of further expensive care services. Coordinates health-related needs for patients at home. CHW works with patient prior to and after any given health care encounter.
- **Patient Navigator –** Reviews and makes recommendations on social determinants of health.

Huggins Hospital: Huggins Hospital has scheduled Multi-Disciplinary Core Team (MDCT) meetings on a monthly basis since August. Dr. Murray, a psychiatrist from Northern Human Services (NHS), attends as the psychiatric consultant. They have limited the primary care involvement at this time, due to capacity of care coordination at this time. They are unable to handle large volumes of complex case management at this time due to staffing constraints but are evaluating how IDN funding opportunities can assist in expanding capacity. As the CCSA process implementation is spread throughout the organization, it will be imperative to have dedicated care coordination staff for this purpose.

White Mountain Community Health Center: WMCHC had their first case conference with their established MDCT in June 2018. The team meets monthly and has discussed five cases in this reporting period. All meetings have included WMCHC's provider team, social worker/care coordinator and contracted psychiatrist. The team explains that the meeting is very beneficial in caring for the patient and developing a care plan. They found the toolkit forms exceptionally valuable for/ during the planning process and execution of the meeting.

Cottage Hospital/Rowe Health Center (RHC): RHC has a weekly Integrated Care Team meeting with primary care, care coordinator, social worker, and behavioral health APRN to discuss patients. The behavioral health APRN then takes any patient cases that need additional consideration by the psychiatrist to a meeting between the APRN and psychiatrist. Once this consult is complete the APRN brings feedback to the next weekly meeting. All providers necessary are involved in this process. They also have a more formal MDCT that will meet quarterly, guided by the ICT, to discuss targeted high-risk patients experiencing significant barriers, challenges and/or complex situations requiring a larger discussion. The MDCT consists of Rowe Health Center providers from Internal Medicine, Rowe Health Center Behavioral Health, Rowe Health Center Chronic Care RN, and the Cottage Hospital Psychiatric Department (Ray of Hope). Goals of this team are to support patients at high risk for or diagnosed with high risk behavioral

health conditions and/or chronic health conditions. The partner has a documented Integrated and Multi-Disciplinary Core Team Protocol that explains each team's purpose, members, roles, communication, format, and logistics.

Weeks Medical Center: Although Weeks Medical Center does not currently schedule regular case conferences with a structured MDCT behavioral health is embedded in daily interdisciplinary team meetings for real time review of all inpatients. The BH team meets on a regular basis and sets up regular case conferences that include the PCP as needed. The patient cases that need psychiatric input are specifically put on the psychiatrist schedule. BH is also present for case discussion at monthly provider meetings. The IDN team will continue to work with Weeks to identify a standard case conference **format and monthly schedule** for the MDCT to discuss complex patient cases.

Saco River Medical Group: SRMG does not currently have a Multi-Disciplinary Core Team in place or case conferences scheduled. The IDN team plans to facilitate discussion between SRMG and NHS to help them build a team that will include a psychiatrist. The IDN team will also continue to provide SRMG the tools to develop the team and schedule **monthly** case conferences moving forward. **The first step in this process is to connect with the Practice Transformation Facilitator at SRMG to ascertain work currently in progress through the Transforming Clinical Practice Initiative ending in September 2019, particularly as it relates to agreements in place with outside providers co-managing patients and/or consulting in their care.**

Memorial Hospital: Memorial does not have a structured MDCT in place however, BH staff is imbedded in primary care and involved in the staff meetings with primary care. The BH staff are in a "specialty pod" within the same practice and both share MA's and nursing. They have a seamless system in place to help transition patients from primary care to BH services and discuss complex cases as necessary.

Memorial also participates in a learning collaborative as part of their I-MAT program that regularly meets with representation from primary care providers, psychiatrists and any other necessary staff. They discuss difficult patients, changes in protocols, difficulty in implementing new protocols, and also solicit insight and guidance from other providers as necessary.

Coös County Family Health Services: As previously mentioned, Coös County Family Health Services does not currently have a MDCT or case conference in place. The IDN team will work closely with this partner to establish a team and help them move towards holding monthly case conferences.

Littleton Regional Health Care: LRH does not have a structured team in place. Currently, their level of integration is collegial interactions with providers through a shared EMR. The IDN will continue to work with LRH to determine an effective **way to formalize** case conferences **and to schedule them monthly for optimal, integrated care management**.

Friendship House and White Horse Addiction Center: As mentioned previously, Friendship House and White Horse Addiction Center continue to build capacity to deliver services to the region's SUD population and will work closely with the IDN team to develop a process and structure for their MDCT's and **monthly** case conference schedule.

June 30, 2019 Update

As previously reported, the partners of the Region 7 IDN have worked very hard to expand integrated and coordinated care in the region. Many partners have developed the capacity to deliver primary care and behavioral health care under one roof. They enjoy staff relationships that are fluid and collegial. Teams at many partner organizations work together every day, crossing disciplines to address patient centered goals. As a result, scheduled case conferences are not occurring in some organizations on a monthly basis, because multiple interdisciplinary meetings are occurring more frequently at which the highest-risk patients and heaviest utilizers of services are being discussed. Region 7 IDN continues to

see a growing amount of collaboration between primary care and behavioral health staff. In some cases, this is resulting in more case-specific discussions across disciplines and some providers feel this is done more efficiently and at a lower cost than convening a full monthly case conference.

In the early stages of the demonstration, Region 7 IDN partner agencies involved in the core competency integrated healthcare project expressed a preference for developing site-specific Multi-Disciplinary Core Teams (MDCT) over the development of a regional MDCT. Several partners have been successful in implementing a MDCT within their agencies, while others have struggled to formalize this process. As noted elsewhere in this report, Region 7 IDN dedicated time during this reporting period exploring alternatives that can ensure that all agencies implement the core competency integrated healthcare project have access to a MDCT. During the reporting period, the Region 7 IDN team facilitated discussions with workgroups and the partner agencies to assess their willingness to use a regional MDCT in such a way as to meet all DSRIP requirements. Many partners who do not yet have a MDCT available expressed an interest in having such a consultative body available to them for guidance on their most complex cases.

During conversations with partners it has become clear that there was some misunderstanding about the nature of a MDCT. The Region 7 IDN team has spent a significant amount of time during this reporting period clarifying the purpose, functionality, and requirements of the MDCT. The team has also sought additional information from Region 6 IDN about their Community Care Team model in an effort to begin conceptualizing a regional body that could provide access to a MDCT for all agencies working on the core competency integrated healthcare project regardless of what they have available within their own sites.

The Steering Committee has dedicated time during meetings in the last half of the reporting period to discussing the use of targeted funding in support of a regional MDCT, and these conversations will continue to evolve during the next reporting period. In the coming reporting period, the IDN team will collaborate closely with partner agencies and governance workgroups to develop workflow and protocol templates that include monthly case conferences and can be adapted by partner agencies to ensure that their providers have access to the regional MDCT.

December 31, 2019 Update

During the reporting period, protocols and procedures for the Region 7 IDN Multi-Disciplinary Core Team were developed by the IDN Quality Improvement Coach and approved by the Regional Care Coordinator Network and the Clinical Workgroup. Members of the Region 7 MDCT have been identified, and the Regional Care Coordinator Network will join the Team for their first test case in February 2020.

The Region 7 MDCT format for case conferences will be as follows:

- Two weeks prior to each MDCT case conference, the MDCT Case Manager will email all member organizations to request referrals for the next meeting.
- Referring organizations will complete a Case Referral Form and send to the MDCT Case Manager using secure communication methods.
- The MDCT Case Manager will provide MDCT members with referral information for each case to review one week prior to the meeting.
- In order to ensure that all organizations within the patient/client circle of care have the opportunity to participate in the case conference, even if they are not the referring organization, the MDCT case manager will then compile the list of patients/clients to be discussed and email Regional Care Coordination Network members with the list of cases to be

reviewed. The email will contain ONLY basic, non-PHI (protected health information), limited to the patient/client name, date the Release of Information for the MDCT was signed, and the presenting organization.

- A representative from the referring organization will present the case at the meeting.
- The case presentation at the meeting should be concise and follow the format outlined in the Region 7 MDCT Case Referral Form shown below.

Communication/PHI:

- All communication related to cases referred for MDCT consultation will be conducted in ways that are consistent with requirements of state and federal privacy regulations.
- Due to the inability to have all agencies on a secure server, it is imperative that patient/client information be limited to the name of a patient/client only and no other identifying information during case consultations and interagency communications that occur outside a secure communication pathway.

An example of the case referral form:

IDN7 Regional Multi-Disciplinary Core Team

Case Referral Form

The case presentation should be concise, presenting only known relevant information and generally including:

Referring Person and Organization: _____

MDCT Meeting Date: _____

- New Referral
- Existing Referral, Date First Presented: _____

Reason for case presentation to the MDCT:

- Report (to provide anticipatory/supportive situational awareness)
- Action (to request a collaborative care plan or assistance addressing a barrier/gap)

Patient/Client details:

Name	
PCP and visit history	
Emergency Dept. History	
Known providers/circle of care	

Presenting medical/psychosocial issues and any significant health and social determinant status and/or history.
Care plan from earlier referrals

As noted in section B1-8b, , the Regional MDCT is available to all Region 7 IDN partners, and the Region 7 MDCT Policy & Protocol has been provided to care coordinators at each partner location so that they have a means to access this resource. Starting in January, time has been held on the calendar each month for case consultations by the Region 7 MDCT. The Region 7 IDN Care Advocate Supervisor has worked with the members of the Regional Care Coordinator Network (RCCN) to identify a case that could be used to test the Region 7 MDCT Policy & Protocol, with the intent to perform rapid cycle improvement on the process.

Despite multiple attempts to identify and prepare a case for one of the scheduled monthly case conferences, care coordinators across the region encountered barriers to the process of identifying and obtaining consent to present cases to the Regional MDCT. As a result, no cases have been reviewed by the members of the Region 7 MDCT to date.

In early March, members of the RCCN were surveyed to determine the primary barriers to their use of the case referral and consultation process. The RCCN discussed the findings of this survey during their March 11 meeting. The general consensus is members feel strongly that they are empowered by their leaders to advocate for their patients by using the Region 7 MDCT as a resource for enhanced care coordination, and feel knowledgeable about the process in place to access the MDCT.

Survey results and discussion regarding the lack of uptake for this process clearly identified, however, that the Care Coordinators generally lack the bandwidth necessary to prepare cases for consultation. A deeper discussion of daily duties reflected that Care Coordinators are generally relied upon to perform a myriad of duties for their organizations that range from processing referrals and prior authorizations to annual wellness visits and screenings, in addition to providing enhanced care coordination to the most complex patients. Members agreed that it may be valuable to examine staffing ratios through the use of productivity assessment tools for care coordination which may exist under pay for performance programs like Medicare Accountable Care Organizations (ACOs) or commercial payer incentive programs.

Finally, in light of the recent retasking of clinical staff under the current COVID-19 pandemic, members of the RCCN have voiced concern that they are even less able to engage in a new initiative at this time. The Region 7 IDN staff will continue to monitor the needs of Region 7 partners and provide supports as necessary to ensure the needs of complex patients are met during this time of strained healthcare resources.

B1-8f: Secure Messaging

December 31, 2018

The narrative should speak to the progress made with Secure Message Exchange that was not already in place prior to the IDN. If participating partners already have the technology, the narrative should speak to what the IDN is doing to enhance the use of Secure Messaging to promote Integrated Care.

Ammonoosuc Community Health Services: ACHS uses capacity in their Centricity electronic health record to send secure messages to patients. They have the functionality to send messages to other providers but currently that is not their practice.

Huggins Hospital: The hospital has direct secure messaging through their patient portal for patient communications. Their EMR has HIPAA compliant DSM functionality to communicate with other providers. The organization currently uses two different EMR's for the ED and primary care. In the

future, they will be transitioning to Allscripts for all EMR needs and DSM functionality will evolve at that time.

Indian Stream Health Center: ISHC uses TigerConnect to facilitate secure messaging between providers and patients. They currently do not send secure messages to other providers.

North Country Healthcare Hospitals: Littleton Regional Healthcare, Weeks Medical Center, Androscoggin Valley Hospital, and Upper Connecticut Valley Hospital are all implementing Imprivata as a secure messaging platform. It was originally planned that this would be live by end of 2018. But it was identified that the NCH hospitals had to first finalize implementation of active directory across all four hospitals to support this platform. This has delayed rollout of the Imprivata which is now targeted for use by the end of the first quarter 2019. The organization also maintains patient portals for communications appropriate for that channel.

Northern Human Services: NHS had previously installed DSM functionality, but vendor issues prohibited them from using the functionality. A new upgrade that is forthcoming for their Netsmart LWSI Essentia electronic record will include a HISP and NHS plans to take advantage of this to engage direct secure messaging. Targeted upgrade completion is February of 2019.

White Mountain Community Health Center: WMCHC has a patient portal that they use to communicate with patients if the patient is registered. They do not currently have other secure messaging technology to provide email communication with other providers or clients.

Saco River Medical Group: The practice is fully functional with patient portal and direct secure messaging via their EMR. They can receive and send messages. The challenge that SRMG has encountered is that many of the organizations they work with don't have DSM and can't engage them in this form of communication.

Coös County Family Health Services: DSM has been in place for a number of years at CCFHS. They use secure messaging for patient communications as well as messaging to other organizations and providers. Changes related to NHHIO did require the implementation of a new HISP with MedAllies. The organization can send direct secure messages to anyone in the Surescripts directory or anyone who has some sort of connection to a HISP. They can also use the secure messaging platform to communicate via DSM to anyone with a valid email address. This is done via a process where the end user receives a generic notification that they have a secure message to retrieve from the CCFHS Secure Message server. They then log-in to view/retrieve their message.

Memorial Hospital: The hospital can communicate via direct secure messaging for patients and providers. The functionality is part of their newly installed Epic EMR. The hospital has also implemented Imprivata Cortext to perform secure text messaging.

Littleton Regional Healthcare: LRH uses a peer-to-peer protocol in the clinics EMR and has consolidated clinical document architecture documents in the hospital EMR. This is a standard for the creation of electronic documents that facilitates data sharing in healthcare. These documents are sent by DSM services that are also part of the EMR; the system meets HIPPA guidelines and scores high in meaningful use evaluations. The partner also uses patient portal to communicate with patients which is unidirectional.

Cottage Hospital/Rowe Health Center: The hospital and health center have a system in place for provider-to-provider and staff-to-provider communication. Their EHR is utilized to develop patient cases, to outline patient needs, concerns, etc. These are assigned to staff/providers as appropriate and all

documentation/responses are timestamped and e-signed. These cases can be marked as urgent. The partner has not reported capability to use DSM with patients however the IDN team will continue to work with them to implement this feature into their practice.

Friendship House: The IDN team will work to assess for the availability of direct secure messaging at Friendship House.

White Horse: The IDN team will work to assess for the availability of direct secure messaging at White Horse Addiction Center.

December 31, 2019 Update

The narrative should speak to the progress made with Secure Message Exchange that was not already in place prior to the IDN. If participating partners already have the technology, the narrative should speak to what the IDN is doing to enhance the use of Secure Messaging to promote Integrated Care.

- *Ammonoosuc Community Health Services (ACHS)*: There has been is no change in DSM by this partner during the reporting period. As previously reported, ACHS uses functionality within their Centricity electronic health record to send secure messages to patients. They have the functionality to send messages to other providers but currently that is not their practice.
- *Huggins Hospital*: There has been is no change in DSM by this partner during the reporting period. As previously reported, Huggins continues to use direct secure messaging through their patient portal for patient communications. Their EMR has HIPAA compliant DSM functionality to communicate with other providers. The organization currently uses two different EMR's for the ED and primary care. In the future, they will be transitioning to Allscripts for all EMR needs and DSM functionality will evolve at that time.
- *Indian Stream Health Center (ISHC)*: There has been is no change in DSM by this partner during the reporting period. As previously reported, ISHC uses TigerConnect to facilitate secure messaging between providers and patients. They currently do not send secure messages to other providers.
- *North Country Healthcare (NCH)* Hospitals: There has been is no change in DSM by this partner during the reporting period. As of the time of this writing, NCH has completed the process of implementing Imprivata as a secure messaging platform on a provider by provider voluntary basis, with a great deal of initial uptake, particularly in the realm of home health. All NCH affiliates also maintain patient portals for secure communications with patients and peer to peer transmission of patient information consistent with the Medicare EHR Incentive Program, otherwise known as the "Meaningful Use" requirements.
- *Northern Human Services (NHS)*: NHS had previously installed DSM functionality, but vendor issues were cited as barriers to this partner using the functionality. There was hope that a new upgrade from the vendor would make this technology more usable, but at this time NHS' evaluation of the DSM tools from their vendor continues to raise concerns that the design of this functionality remains a barrier to its productive use.
- *White Mountain Community Health Center (WMCHC)*: There has been is no change in DSM by this partner during the reporting period. As previously reported, WMCHC has a patient portal that they use to communicate with patients if the patient has enrolled in the portal. They do not currently have other secure messaging technology to provide email communication with other providers or clients.
- *Saco River Medical Group (SRMG)*: There has been is no change in DSM by this partner during the reporting period. As previously reported, the practice has a fully functional patient portal

and direct secure messaging via their EMR. They can receive and send messages. The challenge that SRMG has encountered is that many of the organizations they work with do not have DSM in place and therefore cannot engage in this form of communication.

- *Coös County Family Health Services (CCFHS)*: There has been is no change in DSM by this partner during the reporting period. As previously reported, DSM has been in place for a number of years at CCFHS. They use secure messaging for patient communications as well as messaging to other organizations and providers using compatible platforms and using the secure messaging platform to communicate via DSM to anyone who has a valid email address. This process generates a generic notification to the end user that they have a secure message, and the user then logs in to the CCFHS Secure Message server to view/retrieve their message.
- *Memorial Hospital*: There has been is no change in DSM by this partner during the reporting period. As previously reported, the hospital can communicate via direct secure messaging for patients and providers. The functionality is part of their newly installed Epic EMR. The hospital has also implemented Imprivata Cortext to send secure text messages.
- *Friendship House, Cottage Hospital* and *White Horse Addiction Center* have not yet confirmed the use of Direct Secure Messaging at this time. The Region 7 IDN team remains available to assist these partners with implementation of this technology when their unique organizational circumstances are such that they feel they have the necessary bandwidth to explore and implement a DSM option.

B1-8g: Closed Loop Referrals

December 31, 2018

The narrative should speak to the progress the IDN has made with participating partners for a closed loop referral process and the movement to electronic closed loop referrals.

Ammonoosuc Community Health Services: ACHS has an approved policy and procedure for tracking outstanding test orders and referral orders. They have an electronic means of creating referrals and a monthly report that tracks all open referrals for follow-up. The organization has a procedure for closing referrals which is as follows, but does not have a formal protocol.

Huggins Hospital: Huggins utilized orders tracking functionality in their electronic record as the basis of their closed loop referral process. Referrals are entered as orders. Once a referral is complete and a patient has been seen, Huggins receives a note from the specialty provider which is attached to the order in the EMR. The order status is modified to returned. This information goes back to Huggins referring provider for review and the referral loop is closed. Huggins staff also update the "visit date seen" in referral management which provides additional tracking that the referral loop has been closed. Below is the Huggins internal and external referral workflow they have documented.

Indian Stream Health Center: ISHC has a formalized protocol and workflow regarding closed loop referral. Referrals are handled by the care management staff that includes two referral coordinators and they work towards a goal of never closing a referral without patient contact. They recently introduced a new algorithm that ensures closed loop process. This includes tracking reports for referrals with no patient contact with-in seven days and reaching out to the specialty provider to see why. If they cannot establish patient contact, then the organization sends the patient a certified letter to inquire about why the referral wasn't fulfilled before closing out the referral. ISHC has multiple protocols to explain the process, procedure and tracking of their referrals.

NCH – Littleton Regional Hospital: LRH has a dedicated group of staff work that referrals. They are responsible for sending medical records via DSM and manage reminders in the EMR to look for referral reports coming back to LRH and the loop being closed. This process is all part of their EMR managed through orders functionality for the referral and direct messaging. The EMR manages the responsibility for follow-up.

Northern Human Services: NHS uses a referral workflow (shown below) to describe how referrals are processed. Policies are in place on how to transfer to another mental health center. Depression Management protocol is outlined in multiple documents with eligibility assessment protocol guides to define needs and to specify level of service.

White Mountain Community Health Center: WMCHC operates a closed-loop referral process that is based on their EMR's order entry system. The process includes a written protocol.

Memorial Hospital: Referrals are made through the Hospitals new Epic EMR. Referrals are entered and tracked via the systems order entry feature. The hospital has a staff person who works to help manage the referral process. Memorial will be working to adjust workflows and protocols as the agency continues with the adoption of the Epic platform.

Cottage Hospital/Rowe Health Center: Cottage/RHC currently has an Internal Medicine to Behavioral Health Referral Process documented at their agency. Below is the documented process followed by the agency, and the IDN team engage with the partner to see how the plan to close the loop for external partner agencies.

The organization's closed loop referral procedure relies on their electronic medical record's ability to enter the required referral with appropriate information about the identified need and relevant dates of entry and follow-up. This data is the basis of tracking performed by staff in the EMR and related reporting to ensure a closed loop process.

NCH – Weeks Medical Center: WMC has a comprehensive referral protocol and referral policy flow in place to direct providers and staff through the referral process. This protocol and policy acts as a guide for both internal and external referrals, with directions for each referral type. Weeks' EMR, eClinicalWorks, is utilized to record referrals to WMC specialists and non-WMC specialists, at which time actions related to the referral are tracked. Once the referral is entered into the system it is labeled as "referral, scheduled" to await the receipt of report; once this report is received the referral is marked as reviewed. The protocol has instructions on how to manage referrals which include processing requests, managing pending referrals and managing pending report.

Coös County Family Health Services: CCFHS has established closed loop referral protocols in place.

Saco River Medical Group: The IDN team will continue to engage with staff at Saco River Medical Group to learn more about their closed loop referral process and aid with protocol development if it is needed.

Friendship House: The IDN team will continue to engage with staff at Friendship House to learn more about their closed loop referral process and aid with protocol development if it is needed.

White Horse Addiction Center: The IDN team will continue to engage with staff at White Horse Addiction Center to learn more about their closed loop referral process and aid with protocol development if it is needed.

December 31, 2019 Update

The narrative should speak to the progress the IDN has made with participating partners for a closed loop referral process and the movement to electronic closed loop referrals

The following Region 7 IDN partners continue utilizing previously implemented referral protocols during daily operations:

- Ammonoosuc Community Health Services (ACHS)
- Coös County Family Health Services (CCFHS)
- Cottage Hospital/Rowe Health Center
- Huggins Hospital
- Indian Stream Health Center (ISHC)
- Littleton Regional Healthcare (LRH)
- Northern Human Services (NHS)
- White Mountain Community Health Center (WMCHC)

Region 7 IDN partners listed below continued to work with Region 7 IDN team and collaborating partners to develop effective workflows and protocols to ensure closed loop referral systems are in place.

- *Memorial Hospital:* Currently, Memorial Hospital embeds referral processes in their patient care policy and protocol.
- *Saco River Medical Group (SRMG):* This partner has not yet adopted a formal closed loop referral process, although it does have mechanisms in place to coordinate care for patients being discharged from institutions back into community-based care and is working to formalize those processes.
- *Friendship House (FH):* FH implemented multiple new policies and protocols during the reporting period that will directly improve the referral process moving forward. The partner has implemented a coordination of care protocol to ensure care transitions remain efficient. Referrals to outside agencies continue through the care management services offered at the facility.
- *White Horse Addiction Center (WHAC):* WHAC worked diligently during this reporting period to develop and implement multiple workflows and protocols. The agency contracted with a part-time consultant to help streamline this process and ensure efficiency and has engaged the services of the IDN Quality Improvement Coach to ensure that adopted protocols are well aligned with DSRIP requirements. Timely communication is made possible through the adoption of the National Patient Safety Foundation's closed loop referral protocol.

The Region 7 IDN team continues to encourage partners to implement the collaborative care agreement available to all partners via the Policy & Protocol Clearinghouse on Basecamp. The collaborative care agreement will help partners expand their capacity to collaborate and refer to surrounding agencies within the region.

Region 7 IDN has also been involved in statewide conversations regarding the potential use of UniteUs, a platform that could be used to streamline the closed-loop referral process between all agencies connected to the network. This software could allow more interactions between medical providers and social service agencies to improve the referral process to community-based supports. Region 7 IDN has decided to monitor ongoing discussions at the statewide level regarding potential engagement of the UniteUs platform to augment the IDN infrastructure in place across the state, rather than engaging as an early adopter of the platform. Locally, concerns regarding duplication of resources and processes already implemented by Region 7 IDN partners – including modules within their existing Health

Information Systems and the Collective Medical network – still need to be addressed before partners in the region are prepared to undertake implementation of another technology tool.

B1-8h: Documented workflows

This section should represent the submission of the required workflows/protocols. Minimally, it should represent the IDN's plan to train and disseminate the workflows/protocols that address the requirements.

December 31, 2018

The IDN has developed a Protocol Clearinghouse that is housed on the Region 7 IDN Basecamp site. This area accessible by any IDN partner and is for the sharing of sample and draft policies and protocols to assist with the educating partners on protocols, defining requirements and promoting efficiency in the development of protocols. The IDN worked closely with IDN Quality Improvement Coach to coordinate the development a set of sample protocols and policies and these are the basis of the Clearinghouse. The sample set includes:

- Care Coordination Documentation and Plan TCM
- Care Coordination Documentation Referral and Plan
- Collaborative Care Agreement
- Referrals Process Workflow Sample
- Sample Closed Loop Referral Guidelines
- Sample Process for MDCT and Complex Case Management Teams
- Sample Protocol for Comprehensive Core Standardized Assessment
- Sample SBIRT Screening Policy
- Sample Suicide Risk Assessment Procedure
- Sample Transitional Care Management Policy and Procedure
- Transition of Care Spreadsheet

Education on these protocols and the Clearinghouse will be delivered by the IDN Quality Improvement Coach at a Region 7 IDN Webinar in January. The IDN team encourage sharing and ask partners to contribute appropriate sample protocols to the Clearinghouse as they see fit.

IDN 7 partners have done considerable work in implementing multiple documented workflows throughout this reporting period. Several workflows and protocols are highlighted in the corresponding section (MAT, Referrals, MDCT, CCSA, etc.) with remaining documents highlighted below.

White Mountain Community Health Center continues to work with IDN Quality Improvement Coach to develop and revise workflows and protocols. They have finalized their CCSA during the reporting period.

Cottage Hospital has been progress developing and documenting workflows throughout the hospital and Rowe Health Center. Cottage has made significant progress implementing the CCSA and has a comprehensive protocol similar to the sample protocol drafted by the IDN team in the previous reporting period.

Huggins has also continued to work with NCHC Quality Improvement Program Manager to develop and revise workflows and protocols.

December 31, 2019 Update

The IDN Protocol Clearinghouse that is housed on the Region 7 IDN Basecamp site continues to be an asset to the region. The Region 7 IDN Team regularly encourages partners to utilize the sample and draft

policies and protocols to improve the delivery of integrated care by their organizations. The sample set continues to grow and currently includes:

- Care Coordination Documentation and Plan TCM
- Care Coordination Documentation Referral and Plan
- Collaborative Care Agreement
- Referrals Process Workflow Sample
- Sample Closed Loop Referral Guidelines
- Sample Process for MDCT and Complex Case Management Teams
- Sample Protocol for Comprehensive Core Standardized Assessment with multiple partner versions available for review
- Sample SBIRT Screening Policy
- Sample Suicide Risk Assessment Procedure
- Sample Transitional Care Management Policy and Procedure
- Transition of Care Spreadsheet
- Sample Policy and Procedure Integrated Healthcare and MDCT Utilization
- Region 7 IDN MDCT Policy and Procedure
- Risk Stratification Procedure Sample
- Patient Risk Stratification Policy Sample
- Depression Screening Management Policy Sample
- Mapping Workflows Resource

Education on these protocols and the Clearinghouse is available to partners through enduring presentation materials delivered by the IDN Quality Improvement Coach during a Region 7 IDN Webinar in 2018. The IDN team continues to encourage sharing and ask partners to contribute appropriate sample protocols to the Clearinghouse as they see fit.

Partners participating in the Core Competency project have continued to adopt and implement the required workflows and protocols for coordinated and integrated care practice.

- *Ammonoosuc Community Health Services (ACHS)*: ACHS continues to use all required workflows and protocols to ensure quality care is delivered to their patients.
- *Coös County Family Health Services (CCFHS):* CCFHS has implemented almost all of the required workflows and protocols. At this time, the only required protocol still pending is one that reflects the process for coordination among Case Managers. Despite the lack of formal written protocol, CCFHS has a long-standing practice of strong collaboration between agencies in their catchment area, and actually shares a care coordinator with Androscoggin Valley Hospital to ensure that patient care is well coordinated across multiple settings.
- *Cottage Hospital/Rowe Health Center:* Cottage Hospital/RHC continues to use all required workflows and protocols to ensure quality care is delivered to their patients.
- *Huggins Hospital:* Huggins Hospital continues to use all required workflows and protocols to ensure quality care is delivered to their patients.
- *Indian Stream Health Center (ISHC):* ISHC continues to use all required workflows and protocols to ensure quality care is delivered to their patients. The partner has experienced multiple transitions during this reporting period which have required adaptation and improvement, however the systems in place are proving to be effective to the delivery of care.

- *Littleton Regional Healthcare (LRH):* LRH has implemented almost all of the required workflows and protocols. At this time, the required protocols still pending are related to interactions with community-based organizations, timely communications and coordination among case managers. The partner currently has a team of providers dedicated to working together to review policies and procedures to identify improvements and strategies for developing new documents. The Region 7 IDN has encouraged the partner to take advantage of the Region 7 IDN Policy and Protocol Clearinghouse to use samples adaptable to their agency.
- *Memorial Hospital:* Memorial Hospital has implemented almost all of the required workflows and protocols. At this time, the required protocols still pending are those that reflects the process for coordination among Case Managers and privacy. Despite the lack of formal written protocol, Memorial follows processes to deliver care coordination and ensure privacy of all patients. Region 7 IDN will work with the partner to help document these processes more clearly moving forward.
- *Weeks Medical Center:* WMC continues to use all required workflows and protocols to ensure quality care is delivered to their patients.
- *Northern Human Services (NHS):* NHS continues to use all required workflows and protocols to ensure quality care is delivered to their patients.
- *White Mountain Community Health Center (WMCHC):* WMCHC continues to use all required workflows and protocols to ensure quality care is delivered to their patients.
- *Saco River Medical Group (SRMG):* SRMG continues to be dedicated to implementing the remaining workflows and protocols needed to meet DSRIP requirements. The partner follows processes for timely communications and coordination among case managers however a clear and documented workflow/protocol has not yet been implemented. The Region 7 IDN team has encourage SRMG to utilize the region's Policy and Protocol Clearinghouse to find a sample document to adapt to their practice. The partner is also focusing on increasing and strengthening interactions between providers and community-based organizations, which will require documented processes. Region 7 IDN will continue to support the partner as they determine what protocols will work best at their agency.
- *Friendship House:* FH spent a considerable amount of time developing and implementing new workflows and protocols as part of their recent CARF accreditation process, and the IDN Quality Improvement Coach has continued to help draft new policies and protocols and improve existing documents to meet DSRIP requirements.
- *White Horse Addiction Center (WHAC):* WHAC has worked with the IDN Quality Improvement Coach to leverage templates in the region's policy and protocol clearinghouse to implement multiple workflows and protocols to meet DSRIP requirements. The collaborative care agreement helps the partner regarding multiple different workflows essential for integrated care. The partner contracted with a consultant during this reporting period to help develop more comprehensive policies and protocols as the agency grows its service capacity. The consultant will continue working to implement all pending protocols/workflow moving forward. Currently, WHAC staff do not prescribe opioids, leaving this protocol not applicable.

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	6/30/19	12/31/19
B1-2	IDN Integrated Healthcare: Implementation Plan, Timeline, Milestones and Evaluation Project Plan	Narrative & Spreadsheet (Microsoft Project or similar platform)						
B1-3	IDN Integrated Healthcare: Evaluation Project Targets	Table						
B1-4	IDN Healthcare Integration Workforce Staffing	Table						
B1-5	IDN Healthcare Integration: Budget	Narrative and Spreadsheet						
B1-6	IDN Integrated Healthcare: Key Organizational and Provider Participants	Table						
B1-7	IDN Integrated Healthcare: Organizational leadership sign-off	Table						
B1-8a	All of the following domains must be included in the CCSA: Demographic information Physical health review Substance use review Housing assessment Family and support services Educational attainment 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	6/30/19	12/31/19
	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						

Process Milestone Number	Process Detail	Submission Format	Results (Met/Not Met)					
			6/30/17	12/31/17	6/30/18	12/31/18	6/30/19	12/31/19
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 trained in each practice by provider type for each reporting period for each training. OR you may provide a list of names of all individual providers to be trained in each provider practice. Ongoing reporting would indicate Y/N for participating individuals on progress for each training						
B1-8d	Training for staff not providing direct care that at minimum includes knowledge and beliefs about mental disorders that can aid in recognition and management	Training schedule and table listing all staff indicating progress on each process detail						
B1-8e	Monthly (or more frequent) core team case conferences on behalf of patients with significant behavioral health conditions or chronic conditions	Conference schedule and Table						
B1-8f	Secure messaging	Narrative						
B1-8g	Closed loop referrals	Narrative						

Process Milestone Number	Process Detail	Submission Format	Results (Met/Not Met)					
			6/30/17	12/31/17	6/30/18	12/31/18	6/30/19	12/31/19
B1-8h	Documented workflows and/or protocols that include, at minimum: Interactions between providers and community-based organizations Timely communication Privacy, including limitations on information for communications with treating provider and community-based organizations 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	Workflows and/or Protocols (submit all in use)						

B1-9. Additional Documentation as Requested in B1-9a - 9d: Achievement of all the requirements of a Coordinated Care Practice:

B1- 9a: Progress towards Coordinated Care

December 31, 2018

This section should consist of the progress toward Coordinated Care Practice designation of your partners to include the NH Plus requirements. For example, speak to your rollout of the CCSA.

The current status of IDN partners most likely to adopt the Shared Care Plan is outlined below:

Ammonoosuc Community Health Services: ACHS is currently not working on shared care plan implementation. IDN staff will continue to discuss how this can help the team and clients of ACHS.

Huggins Hospital and Outpatient Clinic: Huggins Hospital has done the most work to adopt the SCP in the region. They have completed implementation steps with Collective Medical Technologies for PreManage ED at the Hospital and PreManage in their Clinic. The hospital is contributing ADT feeds to the CMT network. Neither location is actively using the SCP yet as they work through adoption and workflow as well as a fix to the ADT process. Huggins works closely with the IDN Quality Improvement Coach to address the CCSA protocol, and has created a Multi-Disciplinary Core Team, supported by a psychiatrist as previously mentioned, and will be having their first monthly case conference in August 2018. Huggins Hospital will also be working on depression protocols.

Memorial Hospital: Memorial is not engaged in active work on the SCP and is not contributing ADT feeds to the CMT network. The organization was recently integrated in to the MaineHealth system and they are engaged in an Epic electronic health record implementation. IDN staff have had ongoing communications and one meeting with their team that included a demo of the shared care plan, but it has been difficult to gain approval to proceed. As this hospital is near the Maine border and they are now a MaineHealth affiliate, staff have shared that not having Maine patient data in the CMT network is a barrier to using the SCP that is unique for this organization. Memorial Hospital has really focused on their behavioral health integration, and MAT expansion. They use the following for assessments, all provided by MaineHealth to ensure there is a standard protocol across the MaineHealth system: Guidelines for Assessing Appropriateness of Office Based Buprenorphine Treatment. This assumes the person is opioid dependent; Addiction Severity Index Lite-CF; PHQ-9; Adverse Childhood Events; MaineHealth Mental Health Assessment: Scoring and Care Planning GAD-7 Anxiety rating scale; and MDQ- mood disorder questionnaire. So far, every patient they have seen has been a patient within primary care there is the shared electronic record that enables us to capture and share patient information. This closes the loop. Moving forward, they are going to begin accepting transfers of patients from outside providers so the closed looped referral process will become an active goal as they work on the care coordination of newly entering patients. The agency holds monthly IMAT meetings with everyone involved in IMAT including senior leadership at the hospital.

North Country Health Care: NCH is comprised of Weeks Medical Center, Androscoggin Valley Hospital, Littleton Regional Healthcare and Upper Connecticut Valley Hospital, and North Country Home Health and Hospice Agency. IDN staff have worked with the affiliation to engage them on integrated healthcare initiatives although time and resources has been a constraint. Androscoggin Valley Hospital, Upper Connecticut Valley Hospital and Weeks were able to leverage an existing ADT connection to Dartmouth-Hitchcock Medical Center to quick-start contributing ADT feeds to the CMT network. The IDN team continues to work with Littleton Regional Healthcare to establish ADT connections for that agency.

NCH has also agreed to begin implementing the shared care plan. This will occur first at the Weeks hospital emergency department. After the approach is modeled at Weeks, a rollout will occur to the other three affiliation hospitals. While no specific timeline has been established yet, it is hoped that we will see active use by the end of the next reporting cycle. Weeks Medical Center has been looking at the CCSA domains and explore how to capture all of these domains. They will work closely with Littleton Regional Healthcare throughout this process to share information and lessons learned.

Cottage Hospital: Cottage Hospital is not engaged in active work on the SCP and is not contributing ADT feeds to the CMT network. IDN staff continue to engage this partner on how the tool can help the organization and other IDN partners. Cottage Hospital has received funding to hire a behavioral health integration consultant to work with the organization on planning for addressing IDN goals. This work is under way and the SCP is part of that discussion. Cottage is considering contributing ADT information to the CMT network and this is under legal review.

White Mountain Community Health Center: This organization has done significant work in developing a process to deliver integrated care including hiring a care coordinator, developing an assessment process and establishing a multidisciplinary team process. They have worked closely with a North Country Health Consortium Practice Transformation facilitator in this regard. They are actively working on a shared care plan install. IT resources are currently developing the census file upload and leadership is defining parameters for SCP users, cohorts and notifications. WMCHC has been working on risk stratification models, and a CCSA protocol. They held their first monthly case conference in June of 2018, supported by a psychiatrist. Staff at the agency feel this meeting was helpful and are looking forward to the next meeting.

Indian Stream Health Center: Indian Stream has not been engaged in SCP implementation to date. But at the end of this reporting cycle, IDN staff met with the organization to review progress towards IDN goals and after walking through SCP features and benefits, they agreed to a demonstration with Collective Medical. That meeting has been scheduled and it is expected that the organization will engage implementation steps in the early part of 2019.

Coös County Family Health Services: IDN staff have met with the CCFHS management team, provided a personalized demonstration of the shared care plan and offered education on 42 CFR consent tracking. We are scheduling an initial project call now with Collective Medical Technologies and the organization will be moving forward with an installation of the shared care plan in the coming weeks. CCFHS provides MAT services and is working with NHS on a co-located behavioral health/primary care site. They are currently assessing some of the CCSA domains, but not consistently. As the agency continues exploration of the shared care plan, the additional DSRIP deliverables will be discussed.

Northern Human Services: During this reporting period, NHS met with Collective Medical and IDN staff several times about shared care planning. They have seen a demonstration of the product and completed required pre-implementation paperwork with CM. They identified their initial cohort for using the SCP to be clients receiving services from the ACT team as this a group of complex clients with high utilization of services. NHS completed significant due diligence on consent requirements and related processes. They are working on obtaining written consent from their target population. This is a process that will require time to complete as many consumers have guardians or may not appear for appointments. NHS has also worked to develop best practices for communication about integrated care and shared care planning with staff and clients. In this reporting period they have trained all staff on this process and introduced a brochure for clients that explains collaborative care and addresses common questions asked such as: What is the CMT Network? What are EDIE and PreManage? Who is on my “Care Team”? What does “Treatment” include? Am I required to participate in EDIE/PreManage

or can I opt-out? Will signing this Special Consent Form affect other consents or authorizations I have signed? Northern plans to complete an initial census upload early in 2019 and begin live use of the product at some point in the late winter or spring.

Saco River Medical Group: Saco River and IDN staff have met twice to discuss the SCP. Resources to install and provider workflow and productivity impact have been concerns. Additionally, SRMG's primary hospital partner, Memorial Hospital, is not submitting ADT information and the SCP is viewed as less valuable without that information. Saco River is engaged, and willing to work with IDN staff to put systems in place to meet DSRIP deliverables, including looking at risk stratification models.

Friendship House: Friendship House staff have not participated in conversations related to the implementation of the shared care plan to date due to 42CFR Part 2 concerns and their primary focus has been the opening of the new facility to serve patients. The IDN team will continue to engage in conversations with the staff at Friendship House during the upcoming reporting period related shared care plan implementation.

White Horse Addiction Center: White Horse has been active in quarterly meetings and IDN communications. Near the end of this reporting period, the IDN team joined discussions with White Horse leadership about the opportunities that exist for expanding coordinated care efforts with the shared care plan. The IDN team is working with the agency to determine how the shared care plan can work for White Horse and assess readiness for implementation.

The current status of IDN partners working to capture all twelve domains of the Comprehensive Core Standardized Assessment is outlined below:

Ammonoosuc Community Health Services: ACHS captures all required CCSA domains utilizing tablets for patients to answer the assessment questions as well as other admit information. Answers are automatically brought in to the visit note and are looked at by patient navigators. The organization has four patient navigators (one per three providers) that follow up on patient responses to the CCSA. Tablets are working on a Visual Signature Capture form and linked to their Centricity EHR. The agency is reviewing the appropriateness of this process for adolescents as they feel some aspects of the assessment should be framed differently for that population. The organization uses several assessments in conjunction with the CCSA including the PHQ-2 and PHQ-9. ACHS had planned to finalize their CCSA protocol before the end of 2019. While processes are active and clear for staff, written protocol for CCSA has not yet been finalized because ACHS has chosen to implement the CCSA process and use the PDSA cycle to determine if adjustments need to be made to the process before finalizing their protocol. However, the organization has seen the region's CCSA protocol template and participates in conversations related to workflow and protocol development.

Huggins Hospital: Huggins Hospital has completed a Comprehensive Core Standardized Assessment protocol that has included all required domains for patients 18 years and older. This protocol has been reviewed by appropriate committees and approved for use. The CCSA survey has been reviewed by the forms committee and has been approved for use. The checklist for documentation of completion of each domain will be developed in the health maintenance flowsheet of the EMR. This will allow tracking of completion of the CCSA process. There is a plan to pilot implementation at Wolfeboro Family Medicine with Dr. Jamison Costello's Medicaid patients that started December 18, 2019. Staff have been trained and full implementation continues to be a high priority. A process review will take place early in 2019.

Wolfeboro Pediatric Medicine does complete age appropriate developmental screenings using the Ages and Stages Questionnaire, Third Edition (ASQ-3). They are currently working on documenting that

process workflow for consistency in training staff and tracking compliance. They anticipate having that completed by February 1, 2019.

Indian Stream Health Center (ISHC): All CCSA domains have been added to the organization's electronic health record and providers have access to the data as part of medical history. CCSA data fields are also synchronized from the Indian Stream record to the electronic record at their partner Upper Connecticut Valley Hospital. ISHC is working on finalizing written protocol for the CCSA and confirming process for annual update. The organization will begin the CCSA process via paper utilizing the following process... Patients who are coming in for annual visits will receive the CCSA from the nurse during the "rooming" process. They will be given time to complete the CCSA during their wait for the provider or immediately following the appointment if the provider is running on schedule/early. The provider will briefly examine the CCSA for any "red flags" and refer as appropriate. The nurse will enter the CCSA information into the EMR upon close of the appointment and has an opportunity to catch any "red flags" that the provider may have missed.

Littleton Regional Healthcare: The CCSA is fully templated and live in the electronic health record used by LRH's ambulatory clinic. Staff and providers are receiving education on its use. A barrier to completion of the CCSA at LRH has been staffing to apply the assessment but also to provide adequate follow-up on identified needs. A new Primary Care staffing plan is under consideration that would deepen care coordination resources including, among other things, a Population Health Coordinator whose role encompasses monitoring care gap reports, assisting patients in completing assessments like the CCSA and coordinating referrals to the appropriate community resources for our most needy patients with multiple comorbidities. The goal is to finalize this plan in early 2019 and begin hiring to facilitate primary care patients getting annual assessment and proper follow-up. The agency has seen the region's draft CCSA protocol and the IDN team will continue to work with staff at LRH to ensure they complete a written protocol.

Northern Human Services: NHS has adopted a full roll out of the CCSA format. They are moving through the administration of this tool to all clients and anticipate completing that process by the end of January 2019. Based on the nature of their population, NHS is updating this information quarterly. They use a variety of supplemental assessments in conjunction with the CCSA including the CANS/ANSA, PHQ-9 and the Columbia lethality assessment.

White Mountain Community Health Center (WMCHC): WMCHC has fully implemented the CCSA survey process with their Medicaid population of 18 years and older and are tracking through a checklist system in their health maintenance flowsheet of the EMR for monitoring and reporting purposes. The care coordination team is responsible for tracking compliance and ensuring patients with identified needs are addressed with care coordination follow up. They have implemented ASQ-3 developmental screenings as part of their CCSA process as well. The agencies protocol was submitted during the last reporting period.

Weeks Medical Center: Weeks Medical Center implemented the CCSA in September of 2018. They have developed a formal protocol for collecting the data which is captured during the patient's annual visit and completed by the patient on a tablet. Staff report that this process is going well although they do have a challenge that sometimes patients do not want to provide the information.

Saco River Medical Group: This practice does not collect all domains of the CCSA at this time. They do not have a structured process to complete this task.

Coös Family Health Services: CFHS is currently collecting a majority of the CCSA domains including: Demographic, medical, substance abuse screenings/referrals, housing, education, employment, and

depression screening. They are not collecting Family & Support services, Legal (other than advance directives & power of attorney), risk assessment and functional status. CFHS has communicated that will continue to evaluate the implementation of the CCSA and IDN staff will remain in communication with them on this.

White Horse Addiction Center: White Horse Addiction Center has had a very active year which included opening a new treatment location in North Conway. Near the end of this reporting period, the IDN team joined discussions with White Horse leadership about the opportunities that exist for expanding coordinated care efforts by implementing the CCSA, and the team will continue to engage in additional conversations with agency regarding this deliverable. The agency does create care plans for clients and part of this care plan address social determinants of health. The IDN team will work to learn more about this process to see what questions are asked of clients, and if those meet the DSRIP requirements for the CCSA process.

Memorial Hospital: Memorial Hospital went live with a new Epic EMR in this reporting period. They report all domains of the CCSA are captured in the system. They do not currently have a CCSA reporting procedure in place but are working to address that.

Cottage Hospital/Rowe Health Center: RHC and Cottage hospital have made significant progress in implementing the CCSA. As mentioned previously they have a documented protocol in place that was adapted from the sample protocol released to the region. They now capture all twelve domains and use SBIRT regularly. The PCP does have an SBIRT process that consists of AUDIT and DAST regarding high risk behaviors. If indicated, a referral is made to internal or external BH services.

Friendship House: Staff at Friendship House use the Continuum Narrative Report during the intake process for clients at Friendship House. Patients are asked questions related to medical, employment, alcohol, drug, legal, family/social and psychiatric involvement and/or problems. The answers to these questions assist in the development of the client's treatment plan. The IDN team will continue to engage with the agency to learn more about this intake process and to see if it meets DSRIP requirements for the CCSA.

The current status of IDN partners working with a Multi-Disciplinary Core Team is outlined below:

Huggins Hospital has continued to build their MDCT and conduct regular case conferences. They have been scheduling Multi-Disciplinary Core Team (MDCT) meetings on a monthly basis since August. A psychiatrist from Northern Human Services (NHS) attends these meetings as the psychiatric consultant. At this time, they have limited the primary care involvement, due to capacity of care coordination. They are unable to handle large volumes of complex case management but are looking to bolster their staffing in the near future with IDN funding opportunities.

White Mountain Community Health Center has also had success in implementing their MDCT. WMCHC had monthly case conferences with a psychiatrist from NHS and primary care providers for approximately ten years. During the last reporting period the MDCT meet four times, one each month and as of June 2018, they have now included the care coordinator who is presenting shared cases and/or complex cases that need assistance with development of the plan of care. WMCHC has two psychiatric nurse practitioners that are on staff who participate in the MDCT meetings as well.

Ammonoosuc Community Health Services: ACHS has made progress in developing their MDCT during this reporting. They have a structured team with psychiatric consultation in place and have documented roles and responsibilities written for MDCT members, along with the purpose of the team. ACHS has held four MDCT meetings during this reporting period, including contracted psychiatric representation. The agency has held a structured meeting to strategize the most effective way to continue using the MDCT. In response, it has been arranged for providers to have a 15-minute block to participate in the

care planning case conference in person or by phone. Cases presented are high utilizing or complicated patients selected at provider discretion. A barrier to implementation of the MDCT has been provider buy-in due to lack of time, referral processes, and the uncertain benefit for patients. Evidence-based articles have been provided to the team to support the MCDT process. At their last case conference, the team discussed 2-3 referrals which was proven to be helpful for providers.

Indian Stream Health Center: ISHC is working on developing a long-standing integrated provider meeting into a meeting to address MDCT requirements including case conference. This meeting has been conducted with providers from across disciplines where a variety of issues are discussed including patient issues. They have recently transitioned a staff person to be a behavioral health care manager and as of the end of 2018, staffing is in place for the MDCT. The ISHC team is now working on developing protocols and policy that will structure the MDCT meeting and hope to roll this out in 2019. The ISHC team has agreed to begin a more formal process for case conferences during their scheduled integrated provider meetings (both BH and medical). The agency will look into executing business associate agreements with other local organizations such as Upper Connecticut Valley Hospital and Northern Human Services to be able to include them in those discussions. The organization is familiar with meetings facilitated by NHS with school health, and ISHC will reach out about releases for their staff.

Weeks Medical Center: Currently Weeks has Behavioral Health embedded in daily interdisciplinary team meetings that involve real time review of all inpatient patients. The BH team meets on a regular basis and sets up regular case conferences that include the PCP, as needed. Weeks does not currently schedule regular case conferences with a structure MDCT. If psychiatric input is needed the patient is put on the psychiatrist schedule. In the monthly provider meetings, BH is also present for case discussion. Weeks does not currently schedule regular case conferences with a structure MDCT. BH is also present for case discussion at monthly provider meetings. The IDN team will continue to work with Weeks to identify a standard case conference for the MDCT to discuss complex patient cases.

Cottage Hospital/Rowe: Cottage Hospital and Rowe Health Center have made significant progress in standing up a MDCT. The partners have developed and Integrated Care Team and a standard Multi-Disciplinary Core Team to provide effective and efficient collaboration of treatment interventions and care for those patients identified as experiencing behavioral health and/or complex chronic medical needs compounded by social determinants of health issues. The teams have similar staff attend as described in previous sections with the Integrated Care Team meeting weekly as part of the broader Provider Meeting. This meeting focuses on the following:

- New Patients: Risk Stratification and Concerns
- Existing Patients: Specific Goals for resolution through the discussion
- Anticipated BH and/or CCM Discharges in the next 1-2 months.

All patient cases which are discussed are documented via a new patient case or complex care management documentation protocol within the EHR.

Memorial Hospital: Memorial does not have a structured MDCT in place or hold monthly case conference however, BH staff are imbedded in primary care and involved in staff meetings with primary care. As part of their I-MAT program, Memorial participates in a learning collaborative that regularly meets with representation from primary care providers, psychiatrists and any other necessary staff to discuss difficult patients, change in protocols or difficulty in implementing new protocols, and soliciting insight and guidance from other providers as necessary.

Littleton Regional Healthcare: Currently, LRH's level of integration is collegial interactions with providers through a shared EMR with behavioral health notes integrated with primary care records. PCPS can refer to psychiatric APRN or psychiatrist who are co-located. LRH does not have a structured

MDCT team in place or case conferences to discuss complex patients. The IDN will continue to work with LRH to determine an effective case conference schedule and solidify their MDCT.

Saco River Medical Group: As mentioned previously throughout B1, SRMG does not currently have a Multi-Disciplinary Core Team in place, however they are searching for a psychiatrist to consult on difficult cases, once per month as a start. They have been communicating with Northern Human Services to address this need and plan to crafting a solid team moving forward. The IDN team plans to help facilitate discussion with SRMG and NHS to help them build a team that will include a psychiatrist. The IDN team will also continue to provide SRMG the tools to develop the team and schedule regular case conferences moving forwards.

Northern Human Services: Northern Human Services continues to sit on Huggins and WMCHC MDCT's, as well as the early childhood team at CCFHS.

Coös County Family Health Services: As previously mentioned, Coös County Family Health Services does not currently have a MDCT or case conference in place. They do however hold meetings for their early childhood team that Northern Human Services attend regularly and participate in care transition meetings which are attending by numerous provider agencies in the region. The IDN team will work closely with CCFHS to try to connect the agency to a MDCT.

Friendship House and White Horse Addiction Center: Friendship House and White Horse Addiction Center continue to build capacity to deliver services to the region's SUD population and will work closely with the IDN team to develop a process and structure for their MDCT's.

December 31, 2019 Update

This section should consist of the progress toward Coordinated Care Practice designation of your partners to include the NH Plus requirements. For example, speak to your rollout of the CCSA.

The current status of IDN partners most likely to adopt the Shared Care Plan is outlined below:

- *Cottage Hospital/Rowe Health Center:* Cottage is working with their electronic health record vendor and Collective Medical on pre-implementation system integration issues.
- *Littleton Regional Healthcare (LRH):* LRH has expressed interest in the Shared Care Plan but various internal projects have kept any concrete discussion from moving forward.
- *Memorial Hospital:* Meetings and presentations have occurred but there has been no additional internal discussion to authorize or discount the project.
- *North Country Healthcare Hospitals (NCH):* There is currently no process related to NCH hospitals taking additional steps to implementation the shared care plan
- *Saco River Medical Group (SRMG):* SRMG is interested in the system and hopes to find resources to engage in the project.
- *Friendship House:* There has been no confirmation that a Share Care Plan project can proceed at Friendship House, but conversations are continuing.
- *White Horse Addiction Center (WHAC):* WHAC began the process of implementing the Shared Care Plan at the end of the reporting period as they completed implementation of their first Health Information System. They are expected to complete engagement with the Shared Care Plan in early 2020.

The current status of IDN partners working to capture all twelve domains of the Comprehensive Core Standardized Assessment is outlined below:

- *Ammonoosuc Community Health Services (ACHS)*: Fully implemented
- *Coös County Family Health Services (CCFHS):* In progress
- *Cottage Hospital/Rowe Health Center (RHC):* Fully implemented

- *Huggins Hospital:* Fully implemented
- *Indian Stream Health Center (ISHC):* Fully implemented
- *Littleton Regional Healthcare (LRH):* Fully implemented
- *Memorial Hospital:* In progress
- *Weeks Medical Center (WMC):* Fully implemented
- *Northern Human Services (NHS):* Fully implemented
- *White Mountain Community Health Center (WMCHC):* Fully implemented
- *Saco River Medical Group (SRMG):* Fully implemented
- *Friendship House:* Fully implemented
- *White Horse Addiction Center (WHAC):* Fully implemented

The current status of IDN partners working with a Multi-Disciplinary Core Team is outlined below:

- *Ammonoosuc Community Health Services (ACHS)*: Fully implemented
- *Coös County Family Health Services (CCFHS):* In progress
- *Cottage Hospital/Rowe Health Center:* Fully implemented
- *Friendship House:* In progress
- *Huggins Hospital:* Fully implemented
- *Indian Stream Health Center (ISHC):* Fully implemented
- *Littleton Regional Healthcare (LRH):* In progress
- *Memorial Hospital:* Fully implemented
- *North Country Healthcare Hospitals (NCH):*
- *Northern Human Services (NHS):* Fully implemented
- *White Mountain Community Health Center (WMCHC):* Fully implemented
- *Saco River Medical Group (SRMG):* In progress
- *White Horse Addiction Center (WHAC):* Fully implemented

B1-9b: Adoption of both of the following evidence-based interventions:

This section should speak to protocols for MAT and treatment of mild to moderate depression.

December 31, 2018

Medication-assisted treatment (MAT)

White Mountain Community Health Care: WMCHC has an active MAT program that is at capacity. And despite this growth of the service, they still feel demand is significant. The organization has written protocols in place for the program that are highlighted in the D3 project.

Saco River Medical Group: SRMG continues to expand their capacity to deliver MAT with their agency. SRMG added one new MAT certified prescriber who is performing SUD treatment as part of her regular schedule; this is a total of two MAT providers with a third contracted to start April 15, 2019. The agency reports a current total of 97 active MAT patients, 30 of which are new patients that have started treatment between 7/1/18-12/31/18. The partner has multiple protocols and documents in place to ensure program success.

Coös County Family Health Services: CCFHS has an active MAT program that started in 2018 with a focus on prenatal patients. They have started to reach out to their primary care patients and now serve 25 individuals with a wait list of 32. They are working towards an expansion of 50 MAT patients in a very structured program that includes group sessions. CCFHS has five waivered prescribers and the program also includes the work of an RN, Recovery Coach and Women's Health staff. CCFHS using a

comprehensive MAT Policy & Procedure document that totals fifteen pages. The document explains the population eligible for treatment, the purpose of the program, enrollment requirements, referral management, provider training requirements, and several other detailed sections to ensure 42 CFR Part 2 compliance. CCFHS using multiple assessment strategies including the CAGE assessment for alcohol abuse and the Drug Abuse Screening Test DAST-10 for the program.
Ammonoosuc Community Health Services: ACHS continues to build capacity to deliver MAT services to internal patients with hopes to expand outside their walls in the future and attained their Drug Enforcement Agency credentialing in September 2018. Policies and workflows are continually being executed and assessed using the Plan, Do, Study, Act cycle (PDSA).

Huggins Hospital: Huggins has worked to build capacity for MAT in this reporting period. They have been working with consultants who have been on site multiple times assisting them with assessment tasks. The hospital has two waivered providers, this is an addition of one provider during this period. They have not seen a patient yet and will continue working to develop workflows and protocol specific to their MAT program.

Memorial Hospital: Memorial Hospital has continued to offer SUD services through their Integrated Medication Assisted Treatment Program (I-MAT) and the "A New Life" Prenatal Program. The I-MAT program served 45 new patients during the reporting period, making a total of 97 active patients between the three providers. In addition, Memorial's "New Life" Prenatal Program treated four patients during the reporting period.

Weeks Medical Center: WMC has continued to enhance and expanded their MAT program throughout the region. Weeks currently has two MAT waivered providers and two more completing certification. Their current estimate is a total of 60 patients enrolled in the program. The partner continues to use multiple workflows and protocols (new documents shown below) to ensure program success and quality care.

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

Northern Human Services: NHS is a community mental health center and does not have a formal MAT program although they do have a waivered prescriber on staff. NHS has positioned itself to be a behavior health provider working to integrate care in support of other providers who provide MAT. They don't do significant amounts of this work as frequently, health centers and other providers with MAT programs have developed their own behavioral health services.

Saco River Medical Group: SRMG does not have a formal depression workflow or protocol in place however they have a draft outline of a depression screening protocol shown below. The IDN team will continue working with SRMG to provide information on the IMPACT model and other model options.

The IDN team will continue to work with the remaining partners designated to adopt evidence-based treatment of mild-to-moderate depression by utilizing the Policy and Protocol Clearinghouse to share sample templates of common models, specifically the Collaborative Care Model which is discussed in detail under the joint service provider protocol session.

B1-9C Use of Technology to identify, at a minimum:

- At Risk Patients
- Plan Care

- Monitor/Manage Patient progress toward goals
- Ensure Closed Loop Referral

This table should include all partners at the practice level and their progress on the Use of Technology for At-risk, Plan of care, Monitor care and Closed loop referrals. If the provider already has the ability, speak to the IDNs plan to enhance the use of technology to promote Integrated Care.

Provider List		**Process Details**			
Provider	**Provider Type**	**Identify At-Risk Patients**	**Plan of Care**	**Monitor/Manage Patient Progress Towards Goal**	**Ensure Close Loop Referrals**
Northern Human Services	Community Mental Health Center	Alert system in EMR	Mass roll-out of SCP info to staff, clients. Initial census upload 1/2019 Goal all clients in system Need CMT-specific training High PHQ-9: staff now to do suicide assessment (Columbia in mid-January)	Focus on honing workflows, referral tracking and closing referral loop.	DSM in mid-January, will ease burden of calling to determine patient status and place in the referral process.
White Mountain Community Health Center	Community Health Center	Event notifications being sent from Memorial, shared throughout office for cross coverage/care management.	Fully implemented the CCSA survey process with their Medicaid population of 18 years and older.	Tracking through a checklist system in their health maintenance flowsheet of the EMR for monitoring and reporting purposes	The basis of CLR tracking is the order entry system of their EMR.
Memorial Hospital	Hospital	Implementation of new EMR, Epic this past year featuring significant provider alerts at the point of service and care documentation. These prompts alert providers to situations that present risk for the patient and protocols that may assist or additional	MaineHealth standard protocols for its system: Guidelines for Assessing Appropriateness of Office Based Buprenorphine Treatment. Addiction Severity Index Lite-CF; PHQ-9; Adverse Childhood Events; MaineHealth Mental Health Assessment: Scoring and Care Planning GAD-7 Anxiety rating	Internal patients to MaineHealth, through EMR	Shared EMR assures closed loop referral for in-system MaineHealth patients only. Working on CLR for patients referred from

Provider List		Process Details			
Provider	**Provider Type**	**Identify At-Risk Patients**	**Plan of Care**	**Monitor/Manage Patient Progress Towards Goal**	**Ensure Close Loop Referrals**
		documentation to be completed. Has enabled closed loop referrals on patients who are part of the hospital primary care practices.	scale; and MDQ- mood disorder questionnaire.		outside the system.
Huggins Hospital	Hospital	The checklist for documentation of completion of each CCSA domain will be developed in the health maintenance flowsheet of the EMR. This will allow tracking of completion of the CCSA process and referencing for risk factors.	Completed implementation steps with Collective Medical Technologies for PreManage ED at the Hospital and PreManage in their Clinic. The hospital is contributing ADT feeds to the CMT network.	Huggins works closely with the IDN Quality Improvement Coach to address the CCSA protocol, and has created a Multi-Disciplinary Core Team, supported by a psychiatrist as previously mentioned, and has implemented monthly case conferences	*Focus on building Care Coordination staff, hopefully with IDN funds to assure f/u. MDCT meets with BH staff, seek to engage PCPs next as capacity to support complex cases allows.
Coös County Family Health Services	Community Health Center	* CCFHS collects majority of domains in CCSA, not yet risk assessment domain. * MAT services expanding to include new moms and partners. *Continue work with NHS on a co-located BH and PCP. *Transitions of care tracked by care mgmt team as indicator of risk, through EMR.C	*Completed installation of the shared care plan through CMT, use to track patient movement through other users of CMT system. *Patient transitional info from AVH Care Management team sends discharge plan and care plan to CCFHS for follow-up. Enhanced care management also through private insurance companies.	Strong care coordination for high risk patients. Care managers access ADT information as part of their follow-up of high utilizers and complex/chronic care patients on CMT portal every day.	Two nurses and care coordinator on CMT are shared positions by CCFHS and AVH. Actively exploring community care plan with local partners, would better communications, timeliness, assure closed loop.

Provider List		Process Details			
Provider	**Provider Type**	**Identify At-Risk Patients**	**Plan of Care**	**Monitor/Manage Patient Progress Towards Goal**	**Ensure Close Loop Referrals**
Rowe Health Center	Community Health Center	Rowe and Cottage Hospital demo on CMT, shared care plan and prospect of sending/receiving ADT data for risk identification of high utilizers.	Major step taken in conjunction with Cottage Hospital was to adopt and implement the same EMR.	Working to finalize how they will best utilize shared care plan going forward. IDN metrics examined for integration into processes.	
Saco River Medical Group	Community Health Center	*Use technology to identify at risk patients, plan their care, monitor their goals and ensure a closed loop referral thro patient registries on EHR. This is monitored by MAT providers and our Care Coordinator	Decision support built into EMR; using as conditional logic model for patients who should have specific follow-up at next appt. Working to stratify COPD, CHF.	Currently using EMR for SUD, developmental screen, hypertension, diabetes, care management and monitoring	Using EMR to check on referral out information (once back in record).
White Horse Addiction Center	Substance Use Disorder Treatment	IDN team will continue to gather additional information	IDN team will continue to gather additional information	IDN team will continue to gather additional information	IDN team will continue to gather additional information
Weeks Medical Center	Hospital	*Implemented the CCSA in September of 2018, formal protocol in place for collecting the data. Patient completes with annual visit using a tablet.	Weeks hospital emergency department to begin implementing SCP, the first hospital in the NCH network. After the approach is modeled at Weeks, a rollout will occur to the other three affiliation hospitals. Active use by the end of the next reporting cycle, also work to capture all CCSA domains, aligning with Littleton Regional Healthcare on pilot.	Able to leverage an existing ADT connection to Dartmouth-Hitchcock Medical Center to quick-start contributing ADT feeds to the CMT network Strong care coordination department and technology to identify high risk patients and document care	Formal written protocol in place for closed loop referral process.

Provider List		Process Details			
Provider	**Provider Type**	**Identify At-Risk Patients**	**Plan of Care**	**Monitor/Manage Patient Progress Towards Goal**	**Ensure Close Loop Referrals**
Littleton Regional Healthcare	Hospital	EMR, eClinical Works, has built in registries for diabetes, heart failure, COPD. Await SUD. Chronic care management. CCSA seen as critical to risk ID. Opioid risk assessment tool. Screen for PPD in new moms.	Weeks hospital emergency department to begin implementing SCP, the first hospital in the NCH network which includes LRH. After the approach is modeled at Weeks, a rollout will occur to the other affiliation hospitals, with active use by the end of the next reporting cycle. Working to capture all CCSA domains Littleton Regional Healthcare will partner with Weeks on second phase of pilot.	Initiated project with IDN/CMT to establish ADT connections for Littleton Hospital, expect work completed next cycle. Open EMR system between BH and PCP to monitor and manage care	Ticklers built into the EMR for referral reports arriving back from outside. Specific staff dedicated to tracking.
Indian Stream Health Center	Community Health Center	The AAFP model is used and six levels of risk are possible. Risk assessment is done directly in EMR on a separate tab with the ability to electronically indicate needed care management.	Exploring SCP implementation in early 2019 with demonstration of the product and articulated next steps.	Collecting all domains in the CCSA, with access of this information available to all providers for their care planning with patients and care management. BH and PCP meet weekly for MDCT meetings. Director of Quality developing clear written guidelines and CLR process. EMR documentation to monitor	CLR is currently tracked using a spreadsheet with reports indicating needed follow-up.
NCHC Friendship House	Substance Use Disorder Treatment	Not sure her IDN team will continue to gather additional information	IDN team will continue to gather additional information	IDN team will continue to gather additional information	IDN team will continue to gather additional information

Provider List		Process Details			
Provider	**Provider Type**	**Identify At-Risk Patients**	**Plan of Care**	**Monitor/Manage Patient Progress Towards Goal**	**Ensure Close Loop Referrals**
Ammonoosuc Community Health Services	Community Health Center	CCSA used for adult patients, all domains on a tablet while pt waits for appt. Synced into EMR for reference and use by patient navigator. BMI, Suicide Risk, Lead in children, Hypertension, Tobacco, Depression screens and assessments/follow-up.	Not yet addressed shared care plan priority, though IDN focus on how to assist in next reporting cycle.	Rigorous attention to MAT service development and provision. Electronic EMR system used to document patient treatment plans Policies and workflows are continually being executed	Electronic order sent out for referrals, clinical summary or note scanned into chart. Reports out of EMR can track whether loop generate a follow-up form to work on closing the loop.

The three agencies (Carroll County Department of Corrections, Life Coping Inc., Crotched Mountain) included in this table as it is shown in the implementation plan are not required B1 partners so Region 7 IDN team will continue to talk with them as necessary. The IDN team decided to focus on required B1 partners to highlight their progress towards coordinated and integrated care.

B1-9D Documented Workflows including at a minimum: Joint service protocols and Communication channels

Submit all workflows for Joint service protocols and communication channels. At a minimum, provide a narrative describing the IDN's plan to develop/train partners and a timeframe for completion.

Further movement with joint service protocols and communication channels continues with several partners throughout the region to improve integration of behavioral health and primary care.

Ammonoosuc Community Health Services has been working with North Country Serenity Center to provide Recovery Support Services for 24 patients/clients with SUDs since August 2018. During the last reporting period, ACHS proposed formalizing agreements and procedures with North Country Serenity Center (NCSC) to provide medical, dental, vision, behavioral health, substance misuse, nutrition, and patient navigation services, while utilizing NCSC's peer support and recovery support services for ACHS patients. ACHS will gain the ability to provide complete wrap-around services for persons with behavioral health and substance use disorders, and by using its internal capacities, in addition with NCSC for persons that exit corrections' institutions, residential programs, or hospitals. This formalized agreement will enable ACHS to provide services that will ultimately reduce recidivism, relapse rates, and expand behavioral health services.

Currently the proposed formal agreements and procedures or written protocols are not in place with NCSC. ACHS leadership has been encouraged to construct a Qualified Service Organization Agreement (QSOA) with no success. ACHS is currently reviewing its HIPPA and CFR 42 Part 2 compliance and has decided to have their lawyers present to the staff compliance education and training meeting in early 2019. It was decided to discuss specific relationships such as NCSC at that presentation. In the meantime, the partners have been using Release of Information (ROI) as authorization to discuss patients and have case management meetings bi-weekly to discuss mutual client goals and progress.

ACHS also has a comprehensive feedback loop documented with Littleton Regional Healthcare ED to allow them to track high utilizers within their patient population. This relationship is explained in greater detail within the D3 project including a snapshot of their feedback loop workflow.

The Region 7 IDN team is also excited to help partners develop joint service protocols and communication channels using a newly developed Collaborative Care Agreement. The IDN Quality Improvement Coach worked throughout the reporting period to draft the agreement for partners to use as templates to provide a framework for better communication and safe transitions of care between primary care and behavioral health care providers. White Mountain Community Health Center and Northern Human Services have adapted this template to fit the needs of the communications they currently have between each other and plan to use this system to improve care across both agencies. All IDN 7 partners have access to this document through the new Policy and Protocol Clearinghouse folder on Basecamp. The complete draft is included below.

Collaborative Care Agreement

The primary care practice of (Primary Care Practice Name) and (Specialty Practice Name) has developed a Collaborative Care Agreement. This agreement is based on the following agreed upon collaborative care guidelines.

Collaborative Guidelines

I. **Purpose**

- To provide optimal health care for our patients
- To provide a framework for better communication and safe transitions of care between primary care and behavioral health care providers

II. **Principles**

- Safe, effective and timely patient care is our central goal.
- Effective communication between primary care and behavioral health care is essential to providing optimal patient care and to eliminate the waste and excess costs of health care.
- Mutual respect is essential to building and sustaining a professional relationship and working collaboration.
- A high functioning medical system of care provides patients with access to the 'right care at the right time in the right place'

III. **Definitions**

Primary Care Physician (PCP) – a generalist whose broad medical knowledge provides first contact, comprehensive and continuous medical care to patients.

Specialist (Psychiatrist) – a physician with advanced, focused knowledge and skills who provides care for patients with complex problems in a specific organ system, class of diseases or type of patient.

Prepared Patient – an informed and activated patient who has an adequate understanding of their present health condition in order to participate in medical decision-making and self-management.

Care Manager – An APN who uses evidence based guidelines and assessment tools to identify high risk patients in the primary care practice. The CM then facilitates patient care through the complex health system according to PCMH principals including but not limited to:

i. Whole person orientation
ii. Coordinated and/or integrated care
iii. Quality and safety
iv. Enhanced access

Behavioral Health Navigator – a social worker who works as a team member with a Nurse Navigator and the patients primary care provider to assist the patient in negotiating the complex health care system

Nurse Navigator – an RN who works as a team member with the Behavioral Health Navigator and the patients primary care provider to assist the patient in negotiating the complex health care system

Patient-Centered Medical Home –a community-based and culturally sensitive model of primary care that ensures every patient has a personal physician who guides a team of health professionals to provide the patient with accessible, coordinated, comprehensive and continuous health care across all stages of life.

Patient Goals – health goals determined by the patient after thorough discussion of the diagnosis, prognosis, treatment options, and expectations taking into consideration the patient's psychosocial and personal needs.

- *Medical Neighborhood* – a system of care that integrates the PCMH with the medical community through enhanced, bidirectional communication and collaboration on behalf of the patient.

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IV. **Types of Transitions of Care**

- *Pre-consultation exchange* – communication between the PCP and Health Options Social Worker to
  - i Answer a clinical question and/or determine the necessity of a formal consultation.
  - ii Facilitate timely access and determine the urgency of referral to specialty care.
  - iii Facilitate the diagnostic evaluation of the patient prior to a specialty assessment.

Formal Consultation (Advice) – a request for an opinion and/or advice on a discrete question regarding a patient's diagnosis, diagnostic results, procedure, treatment or prognosis with the intention that the care of the patient will be transferred back to the PCP after one or a few visits. The specialty practice would provide a detailed report on the diagnosis and care recommendations and not manage the condition. This report may include an opinion on the appropriateness of co-management.

Complete transfer of care to specialist for entirety of care (Specialty Medical Home Network) – due to the complex nature of the disorder or consuming illness that affects multiple aspects of the patient's health and social function, the specialist assumes the total care of the patient and provides first contact, ready access, continuous care, comprehensive and coordinated medical services with links to community resources.

Co-management – where both primary care and specialty care providers actively contribute to the patient care for a medical condition and define their responsibilities including first contact for the patient, drug therapy, referral management, diagnostic testing, patient education, care teams, patient follow-up, monitoring, as well as, management of other medical disorders.

- i *Co-management with shared management for the disease* – the specialist shares long-term management with the primary care physician for a patient's referred condition and provides expert advice, guidance and periodic follow-up for one specific condition. Both the primary care and specialty practice are responsible to define and agree on mutual responsibilities regarding the care of the patient. In general, the specialist will provide expert advice, but will not manage the condition day to day.
- ii *Co-management with Principal Care for the Disease (Referral)* – the specialist assumes responsibility for the long-term, comprehensive management of a patient's referred medical/surgical condition. The primary care practice continues to receive consultation reports and provides input on secondary referrals and quality of life/treatment decision issues. The PCP continues to care for all other aspects of patient care and new or other unrelated health problems and remains the first contact for the patient.
- iii *Co-management with Principal Care for the Patient (Consuming illness)* – this is a subset of referral when for a limited time due to the nature and impact of the disease, the specialist practice becomes first contact for care until the crisis or treatment has stabilized or completed. The primary care practice remains active in bi-directional information, providing input on secondary referrals and other defined areas of care.
- iv *Emergency Care* – medical or surgical care obtain on an urgent or emergent basis.

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V. **Mutual Agreement for Care Management**

Review tables and determine which services you can provide.

The *Mutual Agreement* section of the tables reflects the core element of the PCMH and Medical Neighborhood and outline expectations from both primary care and specialty care providers.

- The *Expectations* section of the tables provides flexibility to choose what services can be provided depending on the nature of your practice and working arrangement with PCP or Behavioral Health.
- The *Additional Agreements/Edits* section provides an area to add, delete or modify expectations.
- After appropriate discussion, the representative provider checks each box that applies to the commitment of their practice.

When patients self-refer to Behavioral Health, processes should be in place to determine the patient's overall needs and reintegrate further care with the primary care practice, as appropriate.

The agreement is waived during emergency care or other circumstances that preclude following these elements in order to provide timely and necessary medical care to the patient.

- Each provider should agree to open dialogue to discuss and correct real or perceived breaches

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of this agreement, as well as, on the format and venue of this discussion.
- Optimally, this agreement should be reviewed every 2 years.

Primary Care – Behavioral Health Compact

Transition of Care	
Mutual Agreement	
• Maintain accurate and up-to-date clinical record. • When available and clinically practical, agree to standardized demographic and clinical information format such as the Continuity of Care Record (CCR) or Continuity of Care Document (CCD). • Ensure safe and timely transfer of care of a prepared patient.	
Expectations	
Primary Care	Behavioral Health
- PCP maintains complete & up-to-date record including demographics - Transfers information as outlined in Patient Transition Record - Orders appropriate studies that would facilitate the Behavioral Health visit - Provides patient with Behavioral Health contact information & expected time frame for appointment - PCP Care Manager facilitates the Transition of Care by communicating directly with the Behavioral Health Social Worker to plan a strategy for the transition. - Patient/family are in agreement with the referral, type of referral & selections of specialist	- Determines &/or confirms insurance eligibility - Identifies a specific referral contact person to communicate with in the PCP office - Assist PCP prior to the appointment regarding appropriate pre-referral work-up - Informs patient of need, purpose, expectations & goals of transfer

Addendum
Additional Agreement/Edits

Primary Care – Behavioral Health Compact

Access
Mutual Agreement

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- Be readily available for urgent help to both the physician and patient
- Provide adequate visit availability
- Be prepared to respond to urgencies
- Offer reasonably convenient office facilities and hours of operation
- Provide alternate back-up when unavailable for urgent matters
- When available and clinically practical, provide a secure email option for communication with established patients and/or providers

Expectations

Primary Care	Behavioral Health
Communicate with patients who miss appointments to Behavioral Health Determines reasonable time frame for specialist appointment	Notifies PCP of missed appointments or other actions that place patient jeopardy Schedule patient's first appointment with requested provider Provide PCP with a list of practice physicians who agree to agreement principles

Addendum

Additional Agreement/Edits

Primary Care – Behavioral Health Compact

Patient Communication

Mutual Agreement

- Consider patient/family choices in care management, diagnostic testing & treatment plan
- Provide information to & obtain consent from patient according to community standards
- Explore patient issues on quality of life in regards to their specific medical condition & shares this information with the care team

Expectations

Primary Care	Behavioral Health
Explains, clarifies, & secures mutual agreement with patient on recommended care plan Assists patient in identifying their treatment goals Engages patient in the PCMH concept and identifies whom the patient wishes to be included in their care team	Informs patient of diagnosis, prognosis & follow-up recommendations Provides educational material & resources to patient when appropriate Recommends appropriate follow-up with PCP Be available to the patient to discuss questions or concerns regarding the consultation of their care management Participates with patient care team

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Addendum
Additional Agreement/Edits

Primary Care – Behavioral Health Compact

Collaborative Care Management	
Mutual Agreement	
• Define responsibilities between PCP, Behavioral Health, and patient • Clarify who is responsible for specific elements of care (drug therapy, referral management, diagnostic testing, care teams, patient calls, patient education, monitoring, and follow-up • Maintain competency and skills within scope of work & standard of care • Give & accept respectful feedback when expectations, guidelines or standards of care are not met • Agree on type of care that best fits the patient's needs	
Expectations	
Primary Care	Behavioral Health
Follows principles of PCMH Manages Behavioral Health problem to the extent of the PCP's scope of practice, abilities & skills Follows standard practice guidelines related to evidence-based guidelines Resumes care of the patient as outlined by Behavioral Health & incorporates care plan recommendations into overall care of the patient Shares data with Behavioral Health in a timely manner including data from other providers	Review information sent by PCP; address provider & patient concerns Confer with PCP & establish protocol before ordering additional services outside of practice guidelines Confers with PCP before referring to other specialists; uses preferred provider list Sends timely reports to PCP; shares data with care team Notifies PCP of major interventions, emergency care, & hospitalizations

Addendum
Additional Agreement/Edits

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December 31, 2019 Update

Medication Assisted Treatment

- *Ammonoosuc Community Health Services (ACHS)*: ACHS continues to staff 5 prescribers, 2 LICSWs, Patient Navigators and a BH/SUD case manager as internal resources for SUD matters in the Woodsville and Littleton locations. This structure has also helped the partner expand the delivery of Medication Assisted Treatment services to internal patients at their Littleton and Woodsville office, serving 14 patients during the reporting period. The policies and workflows of these services are continually being studied, reviewed and modified.
- *Coös County Family Health Services (CCFHS):* CCFHS continues to offer MAT to their patients while adjusting the program as more is learned about patients and collaborating providers. CCFHS is committed to balancing harm reduction and patient engagement in response to lack of compliance from patients. The agency has served 21 new patients with their MAT program during this reporting period. CCFHS has seen less enrollment of pregnant women which was the original target population however the program has experienced overall growth resulting in the addition of another half day to offer services.
- *Cottage Hospital/Rowe Health Center:* The partner continues to provide their patients with access to MAT services through an MOU with Little Rivers Health Care. The collaborative approach continues to be valuable to the patients and both agencies.
- *Huggins Hospital:* Huggins Hospital worked to finalize workflows and protocols for the new MAT program during this reporting period. The partner implemented a soft launch with a new provider who came to Huggins with an MAT waiver and was followed by several patients from her previous practice so they could have uninterrupted care. This new provider was integral in the final stage of implementation for the program, providing valuable feedback about the policies, workflows and protocols. The partner plans to formally launch the program by the end of January 2020.
- *Indian Stream Health Center (ISHC):* ISHC continues to provide behavioral health services to patients of a local MAT provider and has an internal protocol in place to provide Vivitrol to eligible patients. For further MAT services related to substances other than Alcohol, works to refer patients to other MAT programs in the Colebrook community as slots are available.
- *Littleton Regional Healthcare (LRH):* LRH contracted with Weeks Medical Center to provide MAT services to the Doorway for most of the reporting period. On December 1st, Weeks exercised the 30-day withdrawal clause of the contract and stopped providing services at LRH on December 31, 2019. During the final month of the reporting period, LRH recruited staff to maintain delivery of clinical services at the Littleton Doorway site so the program could continue to function without interruption of services to current patients.
- *Memorial Hospital:* This partner continues to offer MAT services through their IMAT program embedded in the primary care clinic and the New Life Prenatal Program for mothers with SUD. The programs did not experience major changes during the reporting period.
- *Weeks Medical Center (WMC):* Weeks Medical Center (WMC) continues to provide MAT services through their North Country Recovery Center (NCRC) program at multiple sites throughout the region. During the reporting period, NCRC services were expanded into the Colebrook area, initially using space at Upper Connecticut Valley Hospital. Initial reports of this expansion project indicate that need in Colebrook was higher than anticipated, and NCRC is currently seeking larger accommodations for their Colebrook site. WMC continued to provide contracted MAT services to both North Country Doorways at AVH and LRH during the reporting period. In December, Weeks exercised the 30-day withdrawal clause of this contract and stopped providing services to the LRH Doorway as of December 31, 2019. Following withdrawal from the Littleton Doorway contract, WMC

developed a plan to serve the Littleton area, securing space in the Mt. Eustis Commons building on Cottage Street.

- *Northern Human Services (NHS):* As the region's only Community Mental Health Center, NHS continues to provide essential behavioral health services to local MAT providers and programs. The partner does not offer MAT internally, but does have a mechanism in place to refer behavioral health clients to appropriate programs when clients present a need. General intake and referral policies are used to ensure efficient transitions of care.
- *White Mountain Community Health Center (WMCHC):* WMCHC continues to provide MAT services to their patients. During this reporting period the agency served 12 new patients, totaling 106 since the beginning of the program. The staff structure and procedures of the program have not changed during this reporting period.
- *Saco River Medical Group (SRMG):* SRMG continues to offer MAT services to their patients, having served a total of 155 patients since the beginning of the program in 2016. During this reporting period, the agency lost a primary care provider who was MAT waivered, however the remaining 2 waivered providers were able to absorb those patients without an issue. SRMG is considering providing MAT education to other PCPs as a way to increase capacity for this service. At the end of November, a pediatric provider went through the waiver course but ultimately decided not to move forward with the wavier process due to the patient population this provider serves. Currently the agency has not seen a need in the pediatric population for this service, but it has noticed SUD presenting in young adults, leading the agency to question whether more screening and intervention in the pediatric population is warranted.
- *Friendship House (FH):* FH does not currently offer Medication Assisted Treatment services however the partner continues to refer clients to the Doorways in Littleton and Berlin. Quality improvement staff is beginning to work on a closed-loop referral protocol to enter in the Web Information Technology System (WITS) to allow the Bureau of Drug and Alcohol Services easy access to information about client referrals to Doorway services. Currently there is a process in place, but it is not codified in a formal policy or protocol. Friendship House hopes to offer MAT internally in the future.
- *White Horse Addiction Center (WHAC):* WHAC began collaborating with Better Life Partners (BLP) to provide patients with access to MAT services. BLP rents space from WHAC to hold weekly MAT group sessions and provides an overseeing physician, a care coordinator available for the BLP patient for questions and weekly drug tests via UAs, weekly curriculum for the group, patient intake and screening, along with advertising. BLP contracts with WHAC for a counselor to facilitate the weekly group session. WHAC provides individual counseling to group participants interested in the extra help, separate from BLP. As of December 2019, the program served 4 clients. The program started in Conway and is expected to expand into Ossipee during 2020.

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

- *Ammonoosuc Community Health Services (ACHS)*: ACHS utilizes the PHQ-9 to capture depression status, this assessment links to depression treatment guidelines in the EMR which provide next steps for providers.
- *Coös County Family Health Services (CCFHS):* CCFHS providers use UpToDate practice guidelines embedded within the EMR to help direct them to evidenced based treatment protocols when patients screen positive for depression. The providers utilize this feature to determine the best treatment options for patients based on assessment results.

- *Cottage Hospital/Rowe Health Center:* The partner utilizes the PHQ-2 and PHQ-9 during routine depression screenings for patients. The process for assessing for and treating depression are embedded in the CCSA protocol.
- *Huggins Hospital:* Huggins Hospital follows an internal screening process for identifying and managing depression in their patients. The PHQ-2 and PHQ-9 are used during the screening process to help determine the level of treatment necessary. Once a score is determined the treating provider is notified and follows the policy to continue care.
- *Indian Stream Health Center (ISHC):* ISHC has been administering a Patient Health Questionnaire (PHQ-9) for Adults and the Patient Health Questionnaire (PHQ-A) for Adolescents. Once a score is determined the provider enters it into the EMR which has embedded software to recommend treatment options for the patient.
- *Littleton Regional Healthcare (LRH):* LRH utilizes embedded versions of the PHQ-2 and PHQ-9 to screen for depression in an effort to determine the best treatment options for patients. LRH providers have access to UpToDate practice guidelines, which are embedded in their EMR, but the practice has not formally adopted a workflow that prompts providers to follow those evidence-based guidelines.
- *Memorial Hospital:* Memorial Hospital reports that their current internal PHQ-9 workflow is structured to ensure quality assessment and treatment of depression.
- *Weeks Medical Center:* WMC continues to administer the PHQ-9 to patients which help determine level of depression treatment necessary moving forward. The score is recorded into the patient's chart and staff follow the depression protocol which indicates if a patient has a positive PHQ-9 for mild to moderate depression the provider or RN team leader is notified, and interventions are put in place. Interventions include but are not limited to, a referral to behavioral health for evaluation, medication start or adjustments, and real time referrals to a behavioral health provider while in the office.
- *Northern Human Services (NHS):* As the Region's Community Mental Health Center, NHS is positioned to provide assessment and treatment of depression as a standard of care using evidence-based practices. Due to the nature of their patient population, the partner does not often treat mild or moderate depression, instead more frequently treating severe depression commonly associated with psychosis. NHS follows standardized referral protocols to provide treatment access to clients with mild to moderate depression seeking treatment.
- *White Mountain Community Health Center (WMCHC):* WMCHC has embedded assessment and treatment guidelines for depression in their CCSA workflow and protocol.
- *Saco River Medical Group (SRMG):* SRMG utilizes a depression screening protocol to ensure patients receive quality treatment of mild to moderate depression.
- *Friendship House:* FH utilizes an internal Screening Assessment and Access to Services protocol and residential screening and intake process protocol to ensure the delivery of quality treatment for mild to moderate depression.
- *White Horse Addiction Center (WHAC):* WHAC utilizes internal mental health counselors to ensure the treatment of mild to moderate depression. Screening tools and evidence-based treatment recommendations are embedded in the EMR to help guide providers to the appropriate treatment plan for patients who screen positive.

B1-9c: Use of Technology to identify, at a minimum:

- At Risk Patients
- Plan Care
- Monitor/Manage Patient progress toward goals
- Ensure Closed Loop Referral

This table should include all partners at the practice level and their progress on the Use of Technology for At-risk, Plan of care, Monitor care and Closed loop referrals. If the provider already has the ability, speak to the IDNs plan to enhance the use of technology to promote Integrated Care.

December 31, 2018

Provider List		**Process Details**			
Provider	**Provider Type**	**Identify At-Risk Patients**	**Plan of Care**	**Monitor/Manage Patient Progress Towards Goal**	**Ensure Close Loop Referrals**
Northern Human Services	Community Mental Health Center	Alert system in EMR	Mass roll-out of SCP info to staff, clients. Initial census upload 1/2019 Goal all clients in system Need CMT-specific training High PHQ-9: staff now to do suicide assessment (Columbia in mid-January)	Focus on honing work flows, referral tracking and closing referral loop.	DSM in mid January, will ease burden of calling to determine patient status and place in the referral process.
White Mountain Community Health Center	Community Health Center	Event notifications being sent from Memorial, shared throughout office for cross coverage/care management.	Fully implemented the CCSA survey process with their Medicaid population of 18 years and older.	Tracking through a checklist system in their health maintenance flowsheet of the EMR for monitoring and reporting purposes	The basis of CLR tracking is the order entry system of their EMR.
Memorial Hospital	Hospital	Implementation of new EMR, Epic this past year featuring significant provider alerts at the point of service and care documentation. These prompts alert providers to situations that present risk for the patient and protocols that may assist or additional documentation to be completed. Has enabled closed loop referrals on patients who are part of the hospital primary care practices.	MaineHealth standard protocols for its system: Guidelines for Assessing Appropriateness of Office Based Buprenorphine Treatment. Addiction Severity Index Lite-CF; PHQ-9; Adverse Childhood Events; MaineHealth Mental Health Assessment: Scoring and Care PlanningGAD-7 Anxiety rating scale; and MDQ- mood disorder questionnaire.	Internal patients to MaineHealth, through EMR	Shared EMR assures closed loop referral for in-system MaineHealth patients only. Working on CLR for patients referred from outside the system.
Huggins Hospital	Hospital	The checklist for documentation of completion of each CCSA domain will be developed in the health maintenance flowsheet of the EMR. This will allow tracking of completion of the CCSA process and referencing for risk factors.	Completed implementation steps with Collective Medical Technologies for PreManage ED at the Hospital and PreManage in their Clinic. The hospital is contributing ADT feeds to the CMT network.	Huggins works closely with the IDN Quality Improvement Coach to address the CCSA protocol, and has created a multi-disciplinary core team, supported by a psychiatrist as previously mentioned, and has implemented monthly case conferences	*Focus on building Care Coordination staff, hopefully with IDN funds to assure f/u. MDCT meets with BH staff, seek to engage PCPs next as capacity to support complex cases allows.
Coos County Family Health Services	Community Health Center	* CCFHS collects majority of domains in CCSA, not yet risk assessment domain. * MAT services expanding to include new moms and partners. *Continue work with NHS on a co-located BH and PCP.	*Completed installation of the shared care plan through CMT, use to track patient movement through other users of CMT system. *Patient transitional info from AVH Care Management team sends discharge plan and care plan to CCFHS for follow-up.	Strong care coordination for high risk patients. Care managers access ADT information as part of their follow-up of high utilizers and complex/chronic care patients on CMT portal every day.	2 nurses and care coordinator on CMT are shared positions by CCFHS and AVH. Actively exploring community care plan with local partners, would

Provider List		Process Details			
Provider	**Provider Type**	**Identify At-Risk Patients**	**Plan of Care**	**Monitor/Manage Patient Progress Towards Goal**	**Ensure Close Loop Referrals**
		*Transitions of care tracked by care mgmt team as indicator of risk, through EMR.C	Enhanced care management also through private insurance companies.		better communications, timeliness, assure closed loop.
Rowe Health Center	Community Health Center	Rowe and Cottage Hospital demo on CMT, shared care plan and prospect of sending/receiving ADT data for risk identification of high utilizers.	Major step taken in conjunction with Cottage Hospital was to adopt and implement the same EMR.	Working to finalize how they will best utilize shared care plan going forward. IDN metrics examined for integration into processes.	
Saco River Medical Group	Community Health Center	*Use technology to identify at risk patients, plan their care, monitor their goals and ensure a closed loop referral thro patient registries on EHR. This is monitored by MAT providers and our Care Coordinator	Decision support built into EMR; using as conditional logic model for patients who should have specific follow up at next appt. Working to stratify COPD, CHF.	Currently using EMR for SUD, developmental screen, hypertension, diabetes, care management and monitoring	Using EMR to check on referral out information (once back in record).
White Horse Addiction Center	Substance Use Disorder Treatment	IDN team will continue to gather additional information	IDN team will continue to gather additional information	IDN team will continue to gather additional information	IDN team will continue to gather additional information
Weeks Medical Center	Hospital	*Implemented the CCSA in September of 2018, formal protocol in place for collecting the data. Patient completes with annual visit using a tablet.	Weeks hospital emergency department to begin implementing SCP, the first hospital in the NCH network. After the approach is modeled at Weeks, a rollout will occur to the other three affiliation hospitals. Active use by the end of the next reporting cycle, Also work to capture all CCSA domains, aligning with Littleton Regional Healthcare on pilot.	Able to leverage an existing ADT connection to Dartmouth-Hitchcock Medical Center to quick-start contributing ADT feeds to the CMT network Strong care coordination department and technology to identify high risk patients and document care	Formal written protocol in place for closed loop referral process.
Littleton Regional Healthcare	Hospital	EMR, eClinical Works, has built in registries for diabetes, heart failure, COPD. Await SUD. Chronic care management. CCSA seen as critical to risk ID. Opioid risk assessment tool. Screen for PPD in new moms.	Weeks hospital emergency department to begin implementing SCP, the first hospital in the NCH network which includes LRH. After the approach is modeled at Weeks, a rollout will occur to the other affiliation hospitals, with active use by the end of the next reporting cycle. Working to capture all CCSA domains Littleton Regional Healthcare will partner with Weeks on second phase of pilot.	Initiated project with IDN/CMT to establish ADT connections for Littleton Hospital, expect work completed next cycle. Open EMR system between BH and PCP to monitor and manage care	Ticklers built into the EMR for referral reports arriving back from outside. Specific staff dedicated to tracking.
Indian Stream Health Center	Community Health Center	The AAFP model is used and 6 levels of risk are possible. Risk assessment is done directly in EMR on a separate tab with the ability to electronically indicate needed care management.	Exploring SCP implementation in early 2019 with demonstration of the product and articulated next steps.	Collecting all domains in the CCSA, with access of this information available to all providers for their care planning with patients and care management. BH and PCP meet weekly for MDCT meetings. Director of Quality developing clear written guidelines and CLR process. EMR documentation to montior	CLR is currently tracked using a speadsheet with reports indicating needed follow-up.
NCHC Friendship House	Substance Use Disorder Treatment	Not sure her IDN team will continue to gather additional information	IDN team will continue to gather additional information	IDN team will continue to gather additional information	IDN team will continue to gather additional information
Ammonoosuc Community Health Services	Community Health Center	CCSA used for adult patients, all domains on a tablet while pt waits for appt.	Not yet addressed shared care plan priority, though IDN focus on how to assist in next reporting cycle.	Rigorous attention to MAT service development and provision.	Electronic order sent out for referrals, clinical

Provider List		Process Details			
Provider	**Provider Type**	**Identify At-Risk Patients**	**Plan of Care**	**Monitor/Manage Patient Progress Towards Goal**	**Ensure Close Loop Referrals**
		Synch'd into EMR for reference and use by patient navigator. BMI, Suicide Risk, Lead in children, Hypertension, Tobacco, Depression screens and assessments/followup.		Electronic EMR system used to document patient treatment plans Policies and workflows are continually being executed	summary or note scanned into chart. Reports out of EMR can track whether loop generate a followup form to work on closing the loop.

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Provider	Provider Type	Identify At-Risk Patients	Plan of Care	Monitor/Manage Patient Progress Towards Goal	Ensure Close Loop Referrals
Northern Human Services	Community Mental Health Center	Alert system in EMR; use of Collective Medical	Use of Collective Medical and CCSA process to drive care plans that are updated quarterly and communicated to PCP	Use of quarterly assessment process to monitor care plan progress	Automated process in place for transmitting quarterly updates to referring PCPs
White Mountain Community Health Center	Community Health Center	Use of Collective Medical platform and alerts in EMR system	WMCHC was one of the first IDN 7 partners to adopt the Collective Medical SCP. They continue to benefit from the Collective Medical platform's event notifications and care recommendations features.	Tracking through a checklist system in their health maintenance flowsheet of the EMR for monitoring and reporting purposes	The basis of CLR tracking is the order entry system of their EMR.
Memorial Hospital	Hospital	Implementation of new EMR, Epic, featuring significant provider alerts at the point of service and care documentation. These prompts alert providers to situations that present risk for the patient and protocols that may assist or additional documentation to be completed.	MaineHealth standard protocols for its system: Guidelines for Assessing Appropriateness of Office Based Buprenorphine Treatment. Addiction Severity Index Lite-CF; PHQ-9; Adverse Childhood Events; MaineHealth Mental Health Assessment: Scoring and Care PlanningGAD-7 Anxiety rating scale; and MDQ- mood disorder questionnaire.	Internal patients to MaineHealth, through EMR	Shared EMR assures closed loop referral for in-system MaineHealth patients; working on CLR for patients referred from outside the system .
Huggins Hospital	Hospital and outpatient practices	Utilizing event notifications and is able to use this data in the delivery of patient care is improving timeliness of care delivery and care coordination. The ED leadership has also reported using the CM portal to retrospectively evaluate patient care for patients that have multiple ED visits at their facility and others, conducting case reviews to identify potential care gaps or opportunities for future adaptations to care protocols.	Completed implementation steps with Collective Medical Technologies for PreManage ED at the Hospital and PreManage in their Clinic. The hospital is contributing ADT feeds to the CMT network.	Huggins works closely with the IDN Quality Improvement Coach to address the CCSA protocol, and has created a multi-disciplinary core team, supported by a psychiatrist as previously mentioned, and has implemented monthly case conferences	Uses EMR technology to track referrals
Coos County Family Health Services	Community Health Center	* CCFHS collects majority of domains in CCSA, not yet risk assessment domain. *Transitions of care tracked by care mgmt	Use of Collective Medical event notifications to trigger care plan development as necessary. *Patient transitional info from AVH Care Management team sends discharge plan and care plan to CCFHS for follow-up.	Strong care coordination for high risk patients. Care managers access ADT information as part of their follow-up of high utilizers and complex/chronic care patients on CMT portal every day.	2 nurses and care coordinator on CMT are shared positions by CCFHS and AVH. Actively exploring community care

Provider	Provider Type	Identify At-Risk Patients	Plan of Care	Monitor/Manage Patient Progress Towards Goal	Ensure Close Loop Referrals
		team as indicator of risk, through EMR.C	Enhanced care management also through private insurance companies.		plan with local partners, would better communications, timeliness, assure closed loop.
Rowe Health Center	Community Health Center	Rowe and Cottage Hospital demo on CMT, shared care plan and prospect of sending/receiving ADT data for risk identification of high utilizers. Implementation in progress	Shares an EMR platform with Cottage Hospital, allowing for coordination of care across settings	Use of care coordination templates within the EMR	Processes established across care settings to track receipt of referral follow-up
Saco River Medical Group	Community Health Center	*Use technology to identify at risk patients, plan their care, monitor their goals and ensure a closed loop referral thro patient registries on EHR. This is monitored by MAT providers and our Care Coordinator	Decision support built into EMR; using as conditional logic model for patients who should have specific followup at next appt. Working to stratify COPD, CHF.	Currently using EMR for SUD, developmental screen, hypertension, diabetes, care management and monitoring. In this period, SMRG made the decision to begin a migration process to a new EHR, that has expanded features.	Using EMR to check on referral out information (once back in record).
White Horse Addiction Center	Substance Use Disorder Treatment	Features embedded in newly adopted Health information system	Care plan developed within the EMR based on intake assessment findings	White Horse recently completed migration onto a EHR offered through The Echo Group. This should afford greater opportunities for patient outcome tracking.	Now that they are situated on a new EHR, White Horse is targeting electronic closed loop referral features
Weeks Medical Center	Hospital	*Implemented the CCSA in September 2018, formal protocol in place for collecting the data. Patient completes with annual visit using a tablet. Weeks is receiving event notification through Collective Medical's PreManage	Weeks hospital emergency department receiving event notifications; use of care coordination modules in ambulatory EMR to develop care plans	Able to leverage an existing ADT connection to Dartmouth-Hitchcock Medical Center to quick-start contributing ADT feeds to the CMT network Strong care coordination department and technology to identify high risk patients and document care	Formal written protocol in place for closed loop referral process.
Littleton Regional Healthcare	Hospital	EMR, eClinical Works, has built in registries for diabetes, heart failure, COPD. Await SUD. Chronic care management. CCSA seen as critical to risk ID. Opioid risk assessment tool. Screen for postpartum depression in new moms.	Identified diagnoses trigger care plan items in the ambulatory record.	Open EMR system between BH and PCP to monitor and manage care	Ticklers built into the EMR for referral reports arriving back from outside. Specific staff dedicated to tracking.
Indian Stream Health Center	Community Health Center	The AAFP model is used and 6 levels of risk are possible. Risk assessment is done directly in EMR on a separate tab with the ability to electronically	ISHC has gone live with the Collective Medical Shared Care Plan technology during this period. They are uploading census files and receiving event notifications. The organization experienced turnover of their	Collecting all domains in the CCSA, with access of this information available to all providers for their care planning with patients and care management.	CLR is currently tracked in the EMR

Provider	Provider Type	Identify At-Risk Patients	Plan of Care	Monitor/Manage Patient Progress Towards Goal	Ensure Close Loop Referrals
		indicate needed care management. ISHC also receives event notifications through Collective Medical's PreManage.	primary staff on this project, but feel that the system is making a positive impact for them. The new Quality Director has been excited about the use of the SCP and the information it provides.	BH and PCP meet weekly for MDCT meetings. Director of Quality developing clear written guidelines and CLR process. EMR documentation to monitor	
Friendship House	Substance Use Disorder Treatment	Use of a CCSA to identify areas of risk	Protocol in place for person centered treatment plan; tracking information in WITS	Use of screening and ongoing assessments to monitor progress	IDN team will continue to gather additional information
Ammonoosuc Community Health Services	Community Health Center	Receives event notification through CMT CCSA used for adult patients, all domains on a tablet while pt waits for appt. Synched into EMR for reference and use by patient navigator. BMI, Suicide Risk, Lead in children, Hypertension, Tobacco, Depression screens and assessments/follow up.	ACHS implemented Collected Medical's Shared Care plan (CM's SCP) and is currently using the system. They receive event notifications but do not enter care guidelines.	Electronic EMR system used to document patient treatment plans Policies and workflows are continually being executed	Electronic order sent out for referrals, clinical summary or note scanned into chart. Reports out of EMR can track whether loop generate a follow up form to work on closing the loop.

B1-9d Documented Workflows including at a minimum: Joint service protocols and Communication channels

Submit all workflows for Joint service protocols and communication channels. At a minimum, provide a narrative describing the IDN's plan to develop/train partners and a timeframe for completion.

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Further movement with joint service protocols and communication channels continues with several partners throughout the region to improve integration of behavioral health and primary care.

Ammonoosuc Community Health Services has been working with North Country Serenity Center to provide Recovery Support Services for 24 patients/clients with SUDs since August 2018. During the last reporting period, ACHS proposed formalizing agreements and procedures with North Country Serenity Center (NCSC) to provide medical, dental, vision, behavioral health, substance misuse, nutrition, and patient navigation services, while utilizing NCSC's peer support and recovery support services for ACHS patients. ACHS will gain the ability to provide complete wrap-around services for persons with behavioral health and substance use disorders, and by using its internal capacities, in addition with NCSC for persons that exit corrections' institutions, residential programs, or hospitals. This formalized agreement will enable ACHS to provide services that will ultimately reduce recidivism, relapse rates, and expand behavioral health services.

Currently the proposed formal agreements and procedures or written protocols are not in place with NCSC. ACHS leadership has been encouraged to construct a Qualified Service Organization Agreement

(QSOA) with no success. ACHS is currently reviewing its HIPPA and CFR 42 Part 2 compliance and has decided to have their lawyers present to the staff compliance education and training meeting in early 2019. It was decided to discuss specific relationships such as NCSC at that presentation. In the meantime, the partners have been using Release of Information (ROI) as authorization to discuss patients and have case management meetings bi-weekly to discuss mutual client goals and progress.

ACHS also has a comprehensive feedback loop documented with Littleton Regional Healthcare ED to allow them to track high utilizers within their patient population. This relationship is explained in greater detail within the D3 project including a snapshot of their feedback loop workflow.

The Region 7 IDN team is also excited to help partners develop joint service protocols and communication channels using a newly developed Collaborative Care Agreement. The IDN Quality Improvement Coach worked throughout the reporting period to draft the agreement for partners to use as templates to provide a framework for better communication and safe transitions of care between primary care and behavioral health care providers. White Mountain Community Health Center and Northern Human Services have adapted this template to fit the needs of the communications they currently have between each other and plan to use this system to improve care across both agencies. All IDN 7 partners have access to this document through the new Policy and Protocol Clearinghouse folder on Basecamp.

December 31, 2019 Update

During this reporting period, multiple partners worked to implement and develop joint service protocols and communication channels throughout the region to improve integration of behavioral health and primary care.

Ammonoosuc Community Health Services continues to work with *North Country Serenity Center* to provide joint services to mutual clients. Due to staff transition during the reporting period the development of formalized protocols was delayed however the agencies are committed to finalizing these documents in early 2020. Patient services and mutual referrals continue to function effectively with frequent communication between partners.

White Horse Addiction Center and *Mount Washington Valley Supports Recovery* began a joint service collaboration to bring 24/7 emergency recovery support to the Carroll County area. The partners worked to develop comprehensive workflows and protocols to implement the new services while focusing on creating clear communication channels between themselves and surrounding partners in the region. The project resulted in an invaluable relationship between the two recovery agencies and *Memorial Hospital*, as the pilot was rolled out first to Memorial's Emergency Department, formalized in an Memorandum of Understanding among the three partners.

The Region 7 IDN team continues to help partners develop joint service protocols and communication channels encouraging the use/adaptation of the Collaborative Care Agreement (CCA) developed in early 2019. The IDN Quality Improvement Coach continues to be available for individual consults with partners as necessary and all IDN 7 partners have access to the CCA document through the Policy and Protocol Clearinghouse folder on Basecamp.

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	6/30/19	12/31/19
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 requirement	Adoption of both of the following evidence-based interventions: Medication-assisted treatment (MAT) Evidence-based treatment of mild-to-moderate depression within the Integrated Practice setting either through use of the IMPACT or other evidence-supported model	Protocols (Submit all in use)						
B1-9c		Use of technology to identify, at minimum: At risk patients Plan care Monitor/manage patient progress toward goals Ensure closed loop referral	Table listing all providers indicating progress on each process detail						
B1-9d		Documented workflows with community based social support service providers including, at minimum: Joint service protocols Communication channels	Workflows (Submit all in use)						

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

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

B1-10 Table 1: B1 partners who have achieved Coordinated Care designation to include NH Plus requirements or partners who have achieved Integrated Care designation

December 31, 2018

Achieved	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	13	0	0	0	7
Integrated Care Practice	9	0	0	0	0

The Region 7 IDN team feels that 7 out of 13 agencies in the region have achieved Coordinated Care Practice Designation as reflected by their progress above and in the documents below: Northern Human Services, Weeks Medical Center, Huggins Hospital, White Mountain Community Health Center, Indian Stream Health Center, Ammonoosuc Community Health Services, and Rowe Health Center. Coös County Family Health Services, Memorial Hospital, and Saco River Medical Group are still working on processes to capture all of the domains of the CCSA for a variety of reasons. For example, Memorial Hospital has the ability to capture the domains in their new Epic platform but have not created the processes to do so yet. Friendship House and White Horse Addiction Center have had to work around 42CFR Part 2 which has delayed some of the engagement with these two agencies. Littleton Regional Healthcare was able to get a system in place to capture all of the required CCSA domains, but the agency is still working to get formal protocols in place and a formal system in place for a Multi-Disciplinary Core Team.

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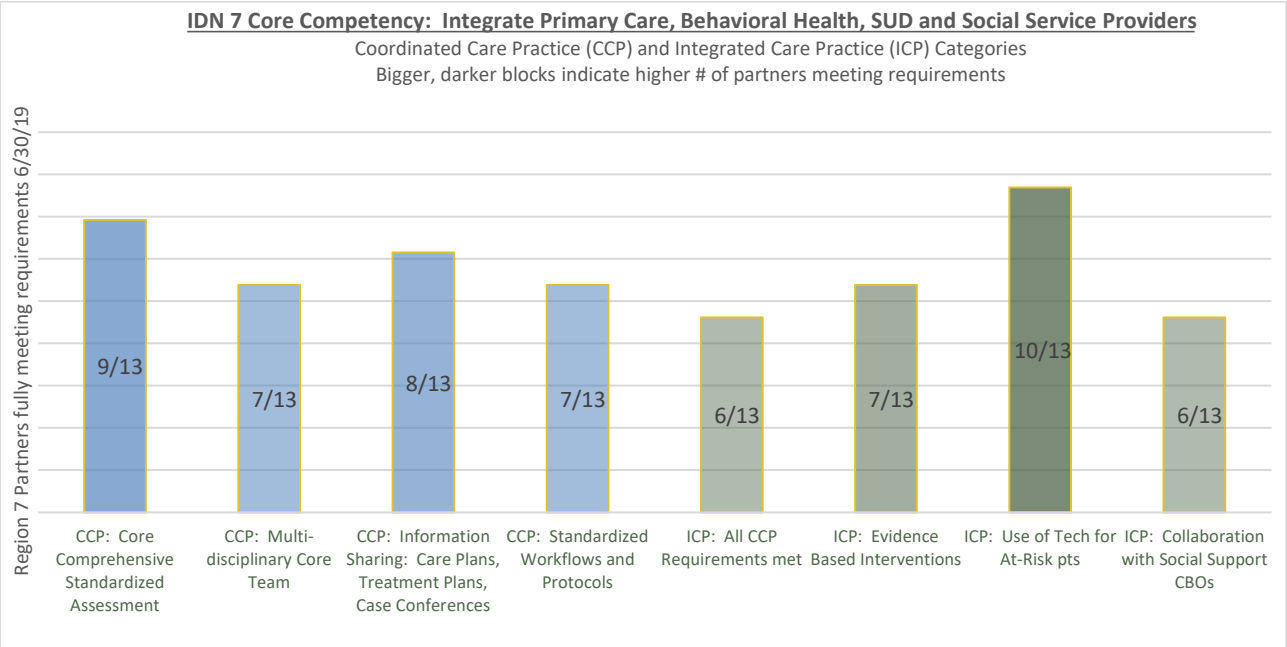
Achieved	Total Goal Number Designated	Baseline Designated 6/30/17	Number Designated 12/31/17	Number Designated 6/30/18	Number Designated 12/31/18	Number Designated 6/30/19
Coordinated Care Practice	13	0	0	0	7	6
Integrated Care Practice	9	0	0	0	0	5

The Region 7 IDN team feels that 6 out of 13 agencies in the region are currently meeting the requirements for Coordinated Care Practice status as reflected by their progress in the two tables below: *Ammonoosuc Community Health Services, Huggins Hospital, Indian Stream Health Center, Northern Human Services, Weeks Medical Center,* and *White Mountain Community Health Center*. *Cottage Hospital* had previously been reported as also meeting the Coordinated Care Practice designation, but during this period an EMR migration resulted in the suspension of their CCSA process as new templates are being built, and funding delays led to the suspension of psychiatrist consultations for the MDCT. The Region 7 IDN team will continue to support this partner as they reinstitute these two practices. Of the six partners meeting Coordinated Care Practice designation, the Region 7 IDN team feels that five have also met the requirements for Integrated Care Practice status.

The remaining seven partners engaged in the Core Competency project have met many of the requirements for both designations, and in most cases have processes in progress but not yet fully implemented. The graph below provides a snapshot of the current state of the Region 7 IDN partners' progress on each of the requirements of Coordinated and Integrated Care Practice status. Partner-specific details are embedded in tables 2 and 3 of this section.

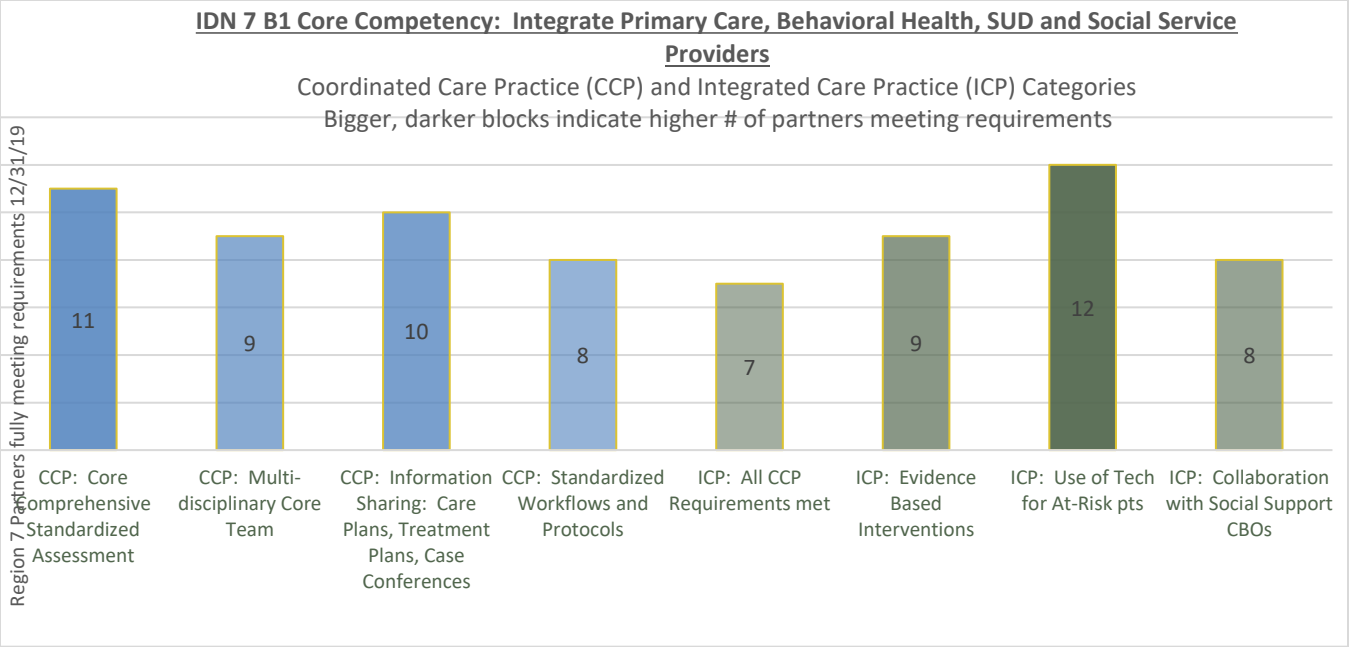


December 31, 2019 Update

Status	Total Goal Number Designated	Baseline Designated 6/30/17	Number Designated 12/31/17	Number Designated 6/30/18	Number Designated 12/31/18	Number Designated 6/30/19	Number Designated 12/31/19
Coordinated Care Practice	13	0	0	0	7	6	7
Integrated Care Practice	9	0	0	0	0	5	5

The Region 7 IDN team feels that 7 out of 13 agencies in the region are currently meeting the requirements for Coordinated Care Practice status as reflected by their progress in the two tables below: *Ammonoosuc Community Health Services, Huggins Hospital, Indian Stream Health Center, Northern Human Services, Rowe Medical Center, Weeks Medical Center,* and *White Mountain Community Health Center*. *Rowe Medical Center/Cottage Hospital* had previously been reported as not meeting the Coordinated Care Practice designation, but during this period they completed EMR migration and resumed their CCSA process, and resumed psychiatrist consultations for the MDCT. Of the seven partners meeting Coordinated Care Practice designation, the Region 7 IDN team feels that five have also met the requirements for Integrated Care Practice status.

The remaining six partners engaged in the Core Competency project have met many of the requirements for both designations, and in most cases have processes in progress but not yet fully implemented. The graph below provides a snapshot of the current state of the Region 7 IDN partners' progress on each of the requirements of Coordinated and Integrated Care Practice status. Partner-specific details are embedded in tables 2 and 3 of this section.



No additional information indicating achievement on this deliverable has become available during the review period.

B1-10 Table 2: Progress Toward Coordinated Care Practice Designation

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

December 31, 2018

Agencies with an asterisk are the ones that Region 7 IDN feels have achieved Coordinated Care Practice designation

Providers Progressing toward Coordinated Care Practice designation	12/31/17	6/30/18	12/31/18
*Northern Human Services		CCSA & SCP including NH Plus: • Actively engaged in shared care plan conversations Multi-Disciplinary Core Team: • Finalizing a contract with NCHC to provide psychiatric services for developing MDCT's across the region • Finalizing CrossRoads clinic, a co-located site with CCFHS supplying primary care providers • Part of a Multi-Disciplinary Core Team meeting with WMCHC and soon to be with Huggins Hospital • Staff member attended Regional Care Coordinator training Information Sharing: • Working on consent requirements and related	CCSA & SCP including NH Plus: • Developed best practices for communication about integrated care and shared care planning with staff and clients • CCSA now in EMR, expect all patients to be using by end of January • Use Dartmouth SDoH assessment, like it Multi-Disciplinary Core Team: • Trained all staff on Integrated care process and introduced a brochure for clients that explains collaborative care. • Can opt for on-site to FQHC's, see patients, then bill

Providers Progressing toward Coordinated Care Practice designation	12/31/17	6/30/18	12/31/18
		processes relating to the shared care plan	• Practice transformation work addressing MDCT work done by psychiatrist with Huggins and WMCH • Participates on MDCT at WMCHC and Huggins Hospital Information Sharing: • On site mtg with IDN HIT coach and CMT demonstration for SCP; First client population to be Assertive Community TX clients • To complete an initial census upload early in 2019 and begin live use early spring • Opt-out and consent/authorizations explained • Event notifications soon, up and running in some locations • Mid-January, upgrade with Esscentia for DSM • Consent requirements being finalized Workflows & Protocols: • Workflow chart sent on referrals • Risk stratification built into procedures
*White Mountain Community Health Center		CCSA & SCP including NH Plus: • Developed a CCSA assessment process • Actively working to install shared care plan Multi-Disciplinary Core Team: • Hired a care coordinator • Staff member attended Regional Care Coordination Training Information Sharing: • Held first case conference June 2018, and establish a MDCT process • Has a MAT program in place, has held a case conference with a full MDCT and have taken a pilot patient through the CCSA process Workflows & Protocols: • Working closely with Region 7 IDN Quality Improvement Coach to develop risk stratification processes	CCSA & SCP including NH Plus: • Developed an assessment process • Developing protocols for care guidelines in SCP • Fully implemented CCSA with Medicaid population 18 yo and over; tracking through Health Maintenance Flowsheet on EMR, use for reporting by Care Coordination Team. Multi-Disciplinary Core Team: • Established a multidisciplinary team process • Hired a care coordinator • MDCT monthly case conference with NHS psychiatrist and WMCHC primary care, behavioral health, and care managers • MDCT case conferences in grand rounds style, care coordinator began presenting complex cases and consults for med prescribing. Information Sharing: • Implemented CMT PreManage • Receiving Event Notifications, circulated to all staff to assure

Providers Progressing toward Coordinated Care Practice designation	12/31/17	6/30/18	12/31/18
			coverage of patient follow-up; see this as critical to care coordination and decreasing ED use Workflows & Protocols: • Working on risk stratification models using PDSA approach on CCSA protocol
Memorial Hospital		CCSA & SCP including NH Plus: • Met with key staff to discuss IDN deliverables; their affiliation with MaineHealth and time being spent on an EHR upgrade has played into the timing of meeting IDN deliverables Multi-Disciplinary Core Team: • nurse practitioners have received certification in MAT and have a robust behavioral health integration project underway through MaineHealth • Looking into connecting to psychiatric services through MaineHealth; • Staff attended a Mental Health First Aid training Information Sharing: • Taken the lead on a four-agency collaborative proposal in Region 7 IDN to improve care coordination in the North Conway area	CCSA & SCP including NH Plus: • Six standardized assessments used across the system for SUD and BH Multi-Disciplinary Core Team: • Memorial does not have a structured MDCT in place. However, as part of their I-MAT program they are regularly involved in a learning collaborative forum that has primary care providers, psychiatrists and any other necessary staff to discuss difficult cases/complex patients. In addition, behavioral health providers are embedded within the primary, the agency has access to psychiatrists through MaineHealth. Information Sharing: • SCP and ADT feeds to CMT next priority for IDN Workflows & Protocols: • Epic EMR migration focus, so IDN team will continue to engage on CCSA protocol. Domains being built within EPIC • Closed loop for internal patients, look to expand and focus on this for external referrals they receive • Focused on behavioral health integration, and MAT expansion
*Huggins Hospital		CCSA & SCP including NH Plus: • Staff have been working closely with the IDN Quality Improvement Coach to ensure they have a CCSA and a CCSA protocol which meets DSRIP requirements by the end of 2018 • Plans to roll out the CCSA for their entire patient population, not just the Medicaid population Multi-Disciplinary Core Team: • Have received funds to stand up a MAT program during this period and have been shaping a	CCSA & SCP including NH Plus: • CCSA protocol reviewed and approved, includes all domains per DSRIP • Piloting CCSA at Wolfeboro Family Medicine starting Dec. 18th; staff trained, patients to pilot chosen, results to be documented to inform upcoming full implementation Multi-Disciplinary Core Team: • Hosted one more Mental Health First Aid training

Providers Progressing toward Coordinated Care Practice designation	12/31/17	6/30/18	12/31/18
		MDCT to use in the upcoming reporting period • Hosted two Mental Health First Aid trainings • Staff attended Regional Care Coordinator training Information Sharing: • Hospital is contributing ADT feeds to the CMT network • Completed implementation steps with Collective Medical Technologies for PreManage ED at the Hospital and PreManage in the Clinic • Neither location is actively using the SCP yet as they work through adoption and workflow as well as a fix to the ADT process	• Care guidelines in process, as is consent process for contributing to patient goals and treatment plan • MDCT meets monthly, with NHS psychiatrist, only limited PCP involvement due to care coordination capacity issues • Hope to bolster staffing with IDN funding for care coordination of CCSA identified issues Information Sharing: • Pre-Manage ED in both hospital and clinic completed • Hospital sending ADT's to the CMT network • Event notifications being sent to ED via dedicated printer • Outpatient SW staff using CMT portal Workflows & Protocols: • CMT-Related workflows created • Sample policies and consents being amended for Huggins format
Saco River Medical Group		CCSA & SCP including NH Plus: • Saco River Medical Group is looking at the CCSA process and is working to address the IDN domains Multi-Disciplinary Core Team: • Staff attended Regional Care Coordinator training Information Sharing: • Saco River and IDN staff have met twice to discuss the SCP; resources to install and provider workflow and productivity impact have been concerns Workflows & Protocols: • Staff are working on care coordination processes	CCSA & SCP including NH Plus: • SCP discussions continue but there are concerns because Memorial Hospital is not yet submitting ADT feeds Multi-Disciplinary Core Team: • IDN team will continue to engage with Saco River Medical Group regarding MDCT Information Sharing: • Continue to engage on Coordinated care initiatives with local partners and shared care plan implementation Workflows & Protocols: • IDN team will continue to engage on protocol development
Coös County Family Health Services		CCSA & SCP including NH Plus: • CCFHS addresses most of the domains in the CCSA and conversations continue about the CCSA process and shared care plan Multi-Disciplinary Core Team: • Providing staff to CrossRoads clinic, a co-located site with Northern Human Services Information Sharing: • IDN staff have met with the CCFHS management team,	CCSA & SCP including NH Plus: • Assessing some of the CCSA domains, but not consistently • Shared care plan work continues, the additional DSRIP deliverables considered in this context Multi-Disciplinary Core Team: • No MDCT currently in place but do hold meetings for their early childhood team that Northern Human Services attend regularly and participate in care transition

Providers Progressing toward Coordinated Care Practice designation	12/31/17	6/30/18	12/31/18
		provided a personalized demonstration of the shared care plan and offered education on 42 CFR consent tracking	meetings which are attending by numerous provider agencies in the region. The IDN team will continue to engage CCFHS on MDCT Information Sharing: • Implemented event notifications, working to understand patient utilization of services • Care Coordinators log in daily to CMT, get info re: ADTs and find this very helpful, though not if patient seen at other sites that don't use CMT Workflows & Protocols: referral protocols in place. IDN team will continue engagement on CCSA protocol
*Weeks Medical Center		CCSA & SCP including NH Plus: • Weeks plans to move forward to implement a CCSA during the next six months and use lessons learned to share with Littleton Regional Healthcare as they implement the CCSA Multi-Disciplinary Core Team: • As part of the affiliation Weeks has been addressing regional care coordination which includes working with Community Health Workers from the North Country Health Consortium Information Sharing: • Weeks was able to leverage an existing ADT connection to Dartmouth-Hitchcock Medical Center to quick-start contributing ADT feeds to the CMT network • NCH has also agreed to begin implementing the shared care plan; this will occur first at the Weeks Emergency Department Workflows & Protocols: • Weeks is an affiliate of North Country Health Care; IDN staff have worked with the affiliation to engage them on integrated healthcare initiatives although time and resources has been a constraint	CCSA & SCP including NH Plus: • CCSA implemented in September, use tablet to collect info from patients • Patient opt out possible question by question, rather than for whole survey Multi-Disciplinary Core Team: • Registries run based on real time data, e.g. diabetes • MDCT is embedded in IDT daily meetings • Working closely with LRH and AVH to help staff NH Doorway hubs • Peer Recovery Coach Academy training to be attended by two MAs and a case manager in early 2019 Information Sharing: • BH team meets regularly and as needed for case conferencing • DSM through Imprivata for all hospitals and partners slated to be completed first quarter, 2019 Workflows & Protocols: • Risk stratification through EMR, flags two or more chronic conditions as well as identified through private insurers
*Indian Stream Health Center		CCSA & SCP including NH Plus: • ISHC is engaged in conversations related to CCSA and are currently revising their assessment process	Multi-Disciplinary Core Team: • MDCT meets weekly, includes psychiatry;

Providers Progressing toward Coordinated Care Practice designation	12/31/17	6/30/18	12/31/18
		• Staff is interested in shared care plan and IDN staff will engage them in additional conversations in the next six months Multi-Disciplinary Core Team: • Have a contract with a psychiatrist, and do have provider meetings, just not a formal case conference process in place – IDN staff will continue discussions about this	• Care management process now inclusive of BH and Primary care, recruiting for third Social Worker Information Sharing: • Many changes, including interim and new CEO's, EMR upgrade, new QI Director, loss of IT Director, have slowed progress this period • Care coordination remains paramount; IDN HIT Coach met with team early December, slating SCP implementation early Jan 2019 • Project engagement pending Workflows & Protocols: • Referrals tracked, honing closed loop referral process and form • Structured case review protocol pending
*Ammonoosuc Community Health Services		CCSA & SCP including NH Plus: • Creating a form capturing all required CCSA domains, and this form will be embedded within the agency's tablets • The agency plans to finalize their CCSA protocol once they have finished embedding a form into their tablets/EMR and anticipate they will have this completed before the end of 2018 • Modifying CCSA for adolescents Workflows & Protocols: • ACHS is working on a process to route the document to a patient navigator once it is completed for review and action if needed • Working on development of various protocols required	CCSA & SCP including NH Plus: • Continue to capture all domains within the CCSA. ACHS has implemented the process within tablets given to patients before visits. • Written protocol for CCSA has not yet been finalized but is in process. Protocol for follow-up is in place and guides the role of the Patient Navigators. Multi-Disciplinary Core Team: • Structured team with psychiatric consultation in place • Documented roles and responsibilities written for MDCT members, along with the purpose of the team. • ACHS has held four MDCT meetings during this reporting period Information Sharing: • Working with North Country Serenity Center to provide Recovery Support Services for 24 patients/clients with SUDs since August 2018 Workflows & Protocols: • Implemented feedback loop to increase identification and

Providers Progressing toward Coordinated Care Practice designation	12/31/17	6/30/18	12/31/18
			timeliness of appointments for patients seen in ED for BH related issues. 7% of ED pts were there for BH reasons, 5% were seen by ACHS for follow-up
Littleton Regional Healthcare		CCSA & SCP including NH Plus: • LRH will work to capture domains required in IDN CCSA and will work closely with Weeks Medical Center to help with this process • LRH is an affiliate of North Country Health Care. IDN staff have worked with the affiliation to engage them on integrated healthcare initiatives including rollout of shared care plan. Weeks will start this process and then work with other affiliates on implementation. Information Sharing: • ADT feeds should be live in next reporting period	CCSA & SCP including NH Plus: • CCSA templated in EMR, including all domains for adults and pediatric patients • EMR captures SBIRT • Protocol not finalized Multi-Disciplinary Core Team: • Six days a month, two contracted psychiatrists are on site for diagnostic and medication management services; they recommend care plan to PCP via a shared EMR • Two social workers, one fully licensed and the other finalizing supervision requirements, provide full time counseling services to patients in the primary care practice • Practice also leases space to Weeks so that their Psychiatric APRN can provide satellite services to LRH patients one day per week (records are kept in WMC EMR) • Three waivered MAT providers at LRH, no MAT program yet • OB/GYN providers working with Dartmouth using CARPP to support moms that are addicted • Plans to work on implementation of MDCT when care coordination staffing filled out Information Sharing: • Co-located PCPs and BH providers work within a shared EMR so BH notes are readily available to PCPs; psychotherapy notes are not part of record per HIPAA rules, but the full BH consult note is available to PCP and Care Coordinators Workflows & Protocols: • Focus on written workflows and protocols for CCSA and closed loop referral tracking
*Rowe Health Center		CCSA & SCP including NH Plus:	CCSA & SCP including NH Plus:

Providers Progressing toward Coordinated Care Practice designation	12/31/17	6/30/18	12/31/18
		• Conversations continue around the CCSA and shared care plan Multi-Disciplinary Core Team: • The health center continues to build capacity to implement integrated healthcare	• Documented protocol in place adapted from the sample protocol released to the region. • Capture all twelve domains and use SBIRT regularly. T • PCP has an SBIRT process that consists of AUDIT and DAST regarding high risk behaviors. If indicated, a referral is made to internal or external BH services. • IDN team still engaging agency on SCP implementation Multi-Disciplinary Core Team: • Weekly Integrated Care Team meeting with primary care, care coordinator, social worker and behavioral health APRN to discuss patients. • Behavioral health APRN then takes any patient cases that need additional consideration by the psychiatrist to a meeting between the APRN and psychiatrist. APRN brings feedback to the next weekly meeting. • Documented Integrated and Multi-Disciplinary Core Team Protocol that explains each team's purpose, members, roles, communication, format, and logistics. Information Sharing: • Significantly advanced care coordination efforts by unifying EMR between hospital and health clinic Workflows & Protocols: • CCSA, MDCT and referral protocols in place. Agency working with IDN team to adapt regional protocols
White Horse Addiction Center		CCSA & SCP including NH Plus: • Not engaged in active work on the shared care plan – IDN staff will engage with White Horse about the shared care plan in the next reporting period; Multi-Disciplinary Core Team: • Working with a consultant to build capacity and implement processes to work toward coordinated care	CCSA & SCP including NH Plus: • Discussing opportunities that exist for expanding coordinated care efforts by implementing the CCSA. • The IDN team will work to learn more about this process to see what questions are asked of clients, and if those meet the DSRIP requirements for the CCSA process.

Providers Progressing toward Coordinated Care Practice designation	12/31/17	6/30/18	12/31/18
			• IDN team is working with the agency to determine how the shared care plan can work for White Horse and assess readiness for implementation. Multi-Disciplinary Core Team: • IDN team will engage White Horse Addiction Center leadership to determine how to involve agency in area MDCTs Information Sharing: • 42 CFR Part 2 has been a barrier. IDN staff working closely with agency to determine best processes to address this Workflows & Protocols: IDN team working with agency staff to determine protocols and workflows in place
NCHC Clinical Services – Friendship House		CCSA & SCP including NH Plus: • Not engaged in active work on the shared care plan due to 42CFR Part 2 constraints – IDN staff will engage with staff at Friendship House about the shared care plan in the next reporting period; Workflows & Protocols: • Working to improved treatment curriculum to enhance the treatment of co-occurring mental and SUD disorders.	CCSA & SCP including NH Plus: Multi-Disciplinary Core Team: IDN team will work with Friendship House staff to determine how to involve agency in area MDCTs Information Sharing: • 42 CFR Part 2 has been a barrier. IDN staff working closely with agency to determine best processes to address this • Agreements with ACHS and CCFHS for preadmission physicals Workflows & Protocols: • IOP Matrix Model, focus on education and awareness of symptoms r/t addiction, relapse prevention, community connections, and other needs as identified • CARF accreditation in progress

June 30, 2019 Update

Provider	Progress Toward Coordinated Care Practice as of 6/30/18	Progress Toward Coordinated Care Practice as of 12/31/18	Progress Toward Coordinated Care Practice as of 6/30/19
Ammonoosuc Community Health Services ***Meets CCP requirements as assessed by Region 7 IDN team***	Core Comprehensive Standardized Assessment: • Creating a form capturing all required CCSA domains, and this form will be embedded within the agency's tablets • The agency plans to finalize their CCSA protocol once they have finished embedding a form into their tablets/EMR and anticipate they will have this completed before the end of 2018 • Modifying CCSA for adolescents Standardized Workflows/Protocols: • ACHS is working on a process to route the document to a patient navigator once it is completed for review and action if needed • Working on development of various protocols required	Core Comprehensive Standardized Assessment: • Continue to capture all domains within the CCSA. ACHS has implemented the process within tablets given to patients before visits. • Written protocol for CCSA has not yet been finalized but is in process. Protocol for follow-up is in place and guides the role of the Patient Navigators. Multi-Disciplinary Core Team: • Structured team with psychiatric consultation in place • Documented roles and responsibilities written for MDCT members, along with the purpose of the team. • ACHS has held four MDCT meetings during this reporting period Information Sharing: • Working with North Country Serenity Center to provide Recovery Support Services for 24 patients/clients with SUDs since August 2018 Standardized Workflows/Protocols: • Implemented feedback loop to increase identification and timeliness of appointments for patients seen in ED for BH related issues. 7% of ED pts were there for BH reasons, 5% were seen by ACHS for follow-up	Core Comprehensive Standardized Assessment: • Continues to utilize all required components of the CCSA • Now offering paper and tablet options to patients Multi-Disciplinary Core Team for High-Risk Patients • The structured MDCT continues to meet monthly for case reviews • Documented purpose for the MDCT as well as roles and responsibilities written for members • Working to develop a more structured patient referral process Information Sharing • Engaged with Collective Medical platform this period; sending census files and using event notifications Standardized Workflows/Protocols • Uses all required workflows and protocols to meet CCP status

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Coös County Family Health Services	Core Comprehensive Standardized Assessment: • CCFHS addresses most of the domains in the CCSA and conversations continue about the CCSA process and shared care plan Multi-Disciplinary Core Team: • Providing staff to CrossRoads clinic, a co-located site with Northern Human Services Information Sharing: • IDN staff have met with the CCFHS management team, provided a personalized demonstration of the shared care plan and offered education on 42 CFR consent tracking	Core Comprehensive Standardized Assessment: • Assessing some of the CCSA domains, but not consistently • Shared care plan work continues, the additional DSRIP deliverables considered in this context Multi-Disciplinary Core Team: • No MDCT currently in place but do hold meetings for their early childhood team that Northern Human Services attend regularly and participate in care transition meetings which are attending by numerous provider agencies in the region. The IDN team will continue to engage CCFHS on MDCT Information Sharing: • Implemented event notifications, working to understand patient utilization of services • Care Coordinators log in daily to CMT, get info re: ADTs and find this very helpful, though not if patient seen at other sites that don't use CMT Standardized Workflows/Protocols: • referral protocols in place. IDN team will continue engagement on CCSA protocol	Core Comprehensive Standardized Assessment: • Has adopted most CCSA domains; housing and legal status only assessed for OB patients; pediatric and universal screenings in place • IDN 7 team will continue to support this partner as they consider expanding housing and legal screenings to a broader patient population Multi-Disciplinary Core Team for High-Risk Patients • No structured MDCT however continues to have internal case conferences with their Psychiatric NP • Region 7 IDN team will continue engaging CCFHS in conversation about the possibility of utilizing a regional MDCT for high-risk patients Information Sharing • Engaged with Collective Medical platform this period; sending census files and using event notifications Standardized Workflows/Protocols • Uses all required workflows and protocols to meet CCP status

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Friendship House	Core Comprehensive Standardized Assessment: • Not engaged in active work on the shared care plan due to 42CFR Part 2 constraints – IDN staff will engage with staff at Friendship House about the shared care plan in the next reporting period; Standardized Workflows/Protocols: • Working to improved treatment curriculum to enhance the treatment of co-occurring mental and SUD disorders	Multi-Disciplinary Core Team: • IDN team will work with Friendship House staff to determine how to involve agency in area MDCTs Information Sharing: • 42 CFR Part 2 has been a barrier. IDN staff working closely with agency to determine best processes to address this • Agreements with ACHS and CCFHS for preadmission physicals Standardized Workflows/Protocols: • IOP Matrix Model, focus on education and awareness of symptoms r/t addiction, relapse prevention, community connections, and other needs as identified • CARF accreditation in progress	Core Comprehensive Standardized Assessment: • Has all domains of CCSA in place, including Universal Screening; no pediatric primary care population Multi-Disciplinary Core Team for High-Risk Patients • No structured MDCT in place; Region 7 IDN team will continue engaging this partner regarding the possibility of utilizing a regional MDCT for high-risk patients Information Sharing and Standardized Workflows/Protocols • Extensive work has been done during this reporting period to codify practice at FH to support compliance with CARF accreditation requirements. In the coming reporting period, the Region 7 IDN team will work with the FH team to determine how these policies, protocols and workflows align with DSRIP requirements for Coordinated Care Practices and provide assistance with furthering this partner's progress along the continuum.

Huggins Hospital ***Meets CCP requirements as assessed by Region 7 IDN team***	Core Comprehensive Standardized Assessment: • Staff have been working closely with the IDN Quality Improvement Coach to ensure they have a CCSA and a CCSA protocol which meets DSRIP requirements by the end of 2018 • Plans to roll out the CCSA for their entire patient population, not just the Medicaid population Multi-Disciplinary Core Team: • Have received funds to stand up a MAT program during this period and have been shaping a MDCT to use in the upcoming reporting period • Hosted two Mental Health First Aid trainings • Staff attended Regional Care Coordinator training Information Sharing: • Hospital is contributing ADT feeds to the CMT network • Completed implementation steps with Collective Medical Technologies for PreManage ED at the Hospital and PreManage in the Clinic • Neither location is actively using the SCP yet as they work through adoption and workflow as well as a fix to the ADT process	Core Comprehensive Standardized Assessment: • CCSA protocol reviewed and approved, includes all domains per DSRIP • Piloting CCSA at Wolfeboro Family Medicine starting Dec. 18th; staff trained, patients to pilot chosen, results to be documented to inform upcoming full implementation Multi-Disciplinary Core Team: • Hosted one more Mental Health First Aid training • Care guidelines in process, as is consent process for contributing to patient goals and treatment plan • MDCT meets monthly, with NHS psychiatrist, only limited PCP involvement due to care coordination capacity issues • Hope to bolster staffing with IDN funding for care coordination of CCSA identified issues Information Sharing: • Pre-Manage ED in both hospital and clinic completed • Hospital sending ADT's to the CMT network • Event notifications being sent to ED via dedicated printer • Outpatient SW staff using CMT portal Standardized Workflows/Protocols: • CMT-Related workflows created • Sample policies and consents being amended for Huggins format	Core Comprehensive Standardized Assessment: • This partner has all domains of the CCSA designed, including pediatric and universal screening; currently being used at one of seven primary care sites as the partner undergoes an EMR migration and temporary staffing shortages in the care coordination department • Using pilot of CCSA to address opportunities to improve the process based on patient and provider feedback • Intends to implement across all clinics when the care coordination department returns to full staffing and has better capacity to address positive screens Multi-Disciplinary Core Team for High-Risk Patients • The agency has enhanced their MDCT this period to include consistent PCP involvement and have 3 care coordinators involved in the process • Continue to meet monthly using a psychiatrist from NHS Information Sharing • Fully engaged in Collective Medical platform, with Care coordinators leveraging event notifications to help drive better patient care • Beginning to utilize the care guidelines feature in PreManage primary and leveraging event notification data in ED for quality reviews • Conducting monthly case conferences with the MDCT Standardized Workflows/Protocols

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			• Uses all required workflows and protocols to meet CCP status
Indian Stream Health Center ***Meets CCP requirements as assessed by Region 7 IDN team***	Core Comprehensive Standardized Assessment: • ISHC is engaged in conversations related to CCSA and are currently revising their assessment process • Staff is interested in shared care plan and IDN staff will engage them in additional conversations in the next six months Multi-Disciplinary Core Team: • Have a contract with a psychiatrist, and do have provider meetings, just not a formal case conference process in place – IDN staff will continue discussions about this	Core Comprehensive Standardized Assessment: • MDCT meets weekly, includes psychiatry; • Care management process now inclusive of BH and Primary care, recruiting for third Social Worker Information Sharing: • Many changes, including interim and new CEO's, EMR upgrade, new QI Director, loss of IT Director, have slowed progress this period • Care coordination remains paramount; IDN HIT Coach met with team early December, slating SCP implementation early Jan 2019 • Project engagement pending Standardized Workflows/Protocols: • Referrals tracked, honing closed loop referral process and form • Structured case review protocol pending	Core Comprehensive Standardized Assessment: • Has all domains of the CCSA in place, including pediatric and universal screening • Currently collecting CCSA data on paper forms for review by RN Care Coordinator; was planning to upload the survey into the EMR however IT capacity has decreased, and the agency has decided to put this on hold until the new EMR is implemented Multi-Disciplinary Core Team for High-Risk Patients • The MDCT continues to meet regularly to review cases. Have changed the structure of the meeting slightly to make case presentation more objective • Including regular education regarding key diagnoses in the case presentation forms in order to provide ongoing education on required topics to MDCT members Information Sharing • Engaged in Collective Medical platform during this reporting period with regular census uploads and use of event notifications on a daily basis for follow up purposes • Planning to implement care guideline feature in the next period Standardized Workflows/Protocols • Uses all required workflows and protocols to meet CCP status

Littleton Regional Healthcare	Core Comprehensive Standardized Assessment: • LRH will work to capture domains required in IDN CCSA and will work closely with Weeks Medical Center to help with this process • LRH is an affiliate of North Country Health Care. IDN staff have worked with the affiliation to engage them on integrated healthcare initiatives including rollout of shared care plan. Weeks will start this process and then work with other affiliates on implementation. Information Sharing: • ADT feeds should be live in next reporting period	Core Comprehensive Standardized Assessment: • CCSA templated in EMR, including all domains for adults and pediatric patients • EMR captures SBIRT • Protocol not finalized Multi-Disciplinary Core Team: • Six days a month, two contracted psychiatrists are on site for diagnostic and medication management services; they recommend care plan to PCP via a shared EMR • Two social workers, one fully licensed and the other finalizing supervision requirements, provide full time counseling services to patients in the primary care practice • Practice also leases space to Weeks so that their Psychiatric APRN can provide satellite services to LRH patients one day per week (records are kept in WMC EMR) • Three waivered MAT providers at LRH, no MAT program yet • OB/GYN providers working with Dartmouth using CARPP to support moms that are addicted • Plans to work on implementation of MDCT when care coordination staffing filled out Information Sharing: • Co-located PCPs and BH providers work within a shared EMR so BH notes are readily available to PCPs; psychotherapy notes are not part of record per HIPAA rules, but the full BH consult note is available to PCP and Care Coordinators Standardized Workflows/Protocols: • Focus on written workflows and protocols for CCSA and closed loop referral tracking	Core Comprehensive Standardized Assessment: • Used Performance Improvement processes this reporting period to identify barriers to use of the CCSA template built in 2018 • CCSA has been rebuilt in the EMR and education on its use will be shared with providers and support staff through the summer Multi-Disciplinary Core Team for High-Risk Patients • No structured MDCT in place for the primary care clinic; the inpatient units do hold a daily interdisciplinary team that includes behavioral health and the primary care RN Care Coordinator • Does not currently have the bandwidth to implement a local MDCT but reports being interested in being involved in a regional MDCT approach Information Sharing • This partner is continuing discussions with the Region 7 IDN team regarding engagement with the Collective Medical Platform; further conversations will be necessary to finalize logistics Standardized Workflows/Protocols • Has many of the required workflows and protocols for CCP status in place • The Region 7 IDN team will continue to support this partner's development and adoption of CCP required protocols and workflows

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Memorial Hospital	Core Comprehensive Standardized Assessment: • Met with key staff to discuss IDN deliverables; their affiliation with MaineHealth and time being spent on an EHR upgrade has played into the timing of meeting IDN deliverables Multi-Disciplinary Core Team: • nurse practitioners have received certification in MAT and have a robust behavioral health integration project underway through MaineHealth • Looking into connecting to psychiatric services through MaineHealth; • Staff attended a Mental Health First Aid training Information Sharing: • Taken the lead on a four-agency collaborative proposal in Region 7 IDN to improve care coordination in the North Conway area	Core Comprehensive Standardized Assessment: • Six standardized assessments used across the system for SUD and BH Multi-Disciplinary Core Team: • Memorial does not have a structured MDCT in place. However, as part of their I-MAT program they are regularly involved in a learning collaborative forum that has primary care providers, psychiatrists and any other necessary staff to discuss difficult cases/complex patients. In addition, behavioral health providers are embedded within the primary, the agency has access to psychiatrists through MaineHealth Information Sharing: • SCP and ADT feeds to CMT next priority for IDN Standardized Workflows/Protocols: • Epic EMR migration focus, so IDN team will continue to engage on CCSA protocol. Domains being built within EPIC • Closed loop for internal patients, look to expand and focus on this for external referrals they receive • Focused on behavioral health integration, and MAT expansion	Core Comprehensive Standardized Assessment: • This partner has most of the required CCSA domains, including pediatric and universal screenings in place. • This partner has recently engaged the Region 7 IDN team to assess outstanding DSRIP requirements following a resource consuming EMR migration and begin implementation of missing requirements Multi-Disciplinary Core Team for High-Risk Patients • Does not have a structured MDCT in place for all high-risk patients; has expressed interest in assistance developing a policy for referring cases to a regional resource Information Sharing • This partner has begun new discussions regarding engagement with the Collective Medical platform and how their participation will benefit agencies within the region that are already using the platform • This partner reports that they are hesitant to engage due to the high percentage of patients who live in Maine, where CM does not have a strong presence • Region 7 IDN will continue conversations with the agency to encourage implementation Standardized Workflows/Protocols • Uses all required workflows and protocols to meet CCP status

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Northern Human Services ***Meets CCP requirements as assessed by Region 7 IDN team***	Core Comprehensive Standardized Assessment: • Actively engaged in shared care plan conversations Multi-Disciplinary Core Team: • Finalizing a contract with NCHC to provide psychiatric services for developing MDCT's across the region • Finalizing CrossRoads clinic, a co-located site with CCFHS supplying primary care providers • Part of a Multi-Disciplinary Core Team meeting with WMCHC and soon to be with Huggins Hospital • Staff member attended Regional Care Coordinator training Information Sharing: • Working on consent requirements and related processes relating to the shared care plan	Core Comprehensive Standardized Assessment: • Developed best practices for communication about integrated care and shared care planning with staff and clients • CCSA now in EMR, expect all patients to be using by end of January • Use Dartmouth SDoH assessment, like it Multi-Disciplinary Core Team: • Trained all staff on Integrated care process and introduced a brochure for clients that explains collaborative care. • Can opt for on-site to FQHC's, see patients, then bill • Practice transformation work addressing MDCT work done by psychiatrist with Huggins and WMCH • Participates on MDCT at WMCHC and Huggins Hospital Information Sharing: • On site mtg with IDN HIT coach and CMT demonstration for SCP; First client population to be Assertive Community TX clients • To complete an initial census upload early in 2019 and begin live use early spring • Opt-out and consent/authorizations explained • Event notifications soon, up and running in some locations • Mid-January, upgrade with Esscentia for DSM • Consent requirements being finalized Standardized Workflows/Protocols: • Workflow chart sent on referrals • Risk stratification built into procedures	Core Comprehensive Standardized Assessment: • This partner reports that implementing the CCSA has enhanced their case management assessment process, so all patients have it completed now, with quarterly renewals Multi-Disciplinary Core Team for High-Risk Patients • Continues to actively provide psychiatrist to MDCT within the region and is open to exploring the opportunity to participate in a regional MDCT model Information Sharing • Engaged with the Collective Medical platform with regular census uploads and use of event notifications • Plans to begin piloting the se of care guidelines for ACT and Drug Court clients later this year Standardized Workflows/Protocols • Uses all required workflows and protocols to meet CCP status

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Rowe Health Center	Core Comprehensive Standardized Assessment: • Conversations continue around the CCSA and shared care plan Multi-Disciplinary Core Team: • The health center continues to build capacity to implement integrated healthcare	Core Comprehensive Standardized Assessment: • Documented protocol in place adapted from the sample protocol released to the region. • Capture all twelve domains and use SBIRT regularly. T • PCP has an SBIRT process that consists of AUDIT and DAST regarding high risk behaviors. If indicated, a referral is made to internal or external BH services. • IDN team still engaging agency on SCP implementation Multi-Disciplinary Core Team: • Weekly Integrated Care Team meeting with primary care, care coordinator, social worker and behavioral health APRN to discuss patients. • Behavioral health APRN then takes any patient cases that need additional consideration by the psychiatrist to a meeting between the APRN and psychiatrist. APRN brings feedback to the next weekly meeting. • Documented Integrated and Multi-Disciplinary Core Team Protocol that explains each team's purpose, members, roles, communication, format, and logistics. Information Sharing: • Significantly advanced care coordination efforts by unifying EMR between hospital and health clinic Standardized Workflows/Protocols: • CCSA, MDCT and referral protocols in place. Agency working with IDN team to adapt regional protocols	Core Comprehensive Standardized Assessment: • Previously reported as meeting CCP status requirements, an EMR migration this reporting period has resulted in the loss of several CCSA domains; currently assessing the best way to rebuild the CCSA in the new EMR Multi-Disciplinary Core Team for High-Risk Patients • Continue to have weekly meetings for case conferences with the Psych NP in place, but delays in sub-recipient funding during this reporting period resulted in the suspension of psychiatrist consults for the MDCT Information Sharing • Initial meetings with Collective Medical have begun as this partner prepares to engage with the CM platform during the next reporting period • Working on a protocol that will codify their current practice of assisting patients with safe transitions from institutional care back into community Standardized Workflows/Protocols • Working with Region 7 IDN team to ensure that all required workflows and protocols have been developed and implemented

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Saco River Medical Group	Core Comprehensive Standardized Assessment: • Saco River Medical Group is looking at the CCSA process and is working to address the IDN domains Multi-Disciplinary Core Team: • Staff attended Regional Care Coordinator training Information Sharing: • Saco River and IDN staff have met twice to discuss the SCP; resources to install and provider workflow and productivity impact have been concerns Standardized Workflows/Protocols: • Staff are working on care coordination processes	Core Comprehensive Standardized Assessment: • SCP discussions continue but there are concerns because Memorial Hospital is not yet submitting ADT feeds Multi-Disciplinary Core Team: • IDN team will continue to engage with Saco River Medical Group regarding MDCT Information Sharing: • Continue to engage on Coordinated care initiatives with local partners and shared care plan implementation Standardized Workflows/Protocols: • IDN team will continue to engage on protocol development	Core Comprehensive Standardized Assessment: • This partner dedicated efforts this reporting period developing a CCSA questionnaire covering all required domains and workflows and protocols to implement it. It will begin pilot phase in July 2019. **During the review period, this partner fully implemented the CCSA.** Multi-Disciplinary Core Team for High-Risk Patients • The agency shared that they do not have the bandwidth to stand up a structured MDCT of their own, and has expressed an interest in referring cases another team or a regional team if one is developed Information Sharing • This partner has an interest in engaging with the Collective Medical platform, but expresses concern that the value of the technology without their local hospital, Memorial, contributing to the network Standardized Workflows/Protocols • Has many of the required workflows and protocols for CCP status in place • The Region 7 IDN team will continue to support this partner's development and adoption of CCP required protocols and workflows

Provider	Progress Toward Coordinated Care Practice as of 6/30/18	Progress Toward Coordinated Care Practice as of 12/31/18	Progress Toward Coordinated Care Practice as of 6/30/19
Weeks Medical Center ***Meets CCP requirements as assessed by Region 7 IDN team***	Core Comprehensive Standardized Assessment: • Weeks plans to move forward to implement a CCSA during the next six months and use lessons learned to share with Littleton Regional Healthcare as they implement the CCSA Multi-Disciplinary Core Team: • As part of the affiliation Weeks has been addressing regional care coordination which includes working with Community Health Workers from the North Country Health Consortium Information Sharing: • Weeks was able to leverage an existing ADT connection to Dartmouth-Hitchcock Medical Center to quick-start contributing ADT feeds to the CMT network • NCH has also agreed to begin implementing the shared care plan; this will occur first at the Weeks Emergency Department Standardized Workflows/Protocols: • Weeks is an affiliate of North Country Health Care; IDN staff have worked with the affiliation to engage them on integrated healthcare initiatives although time and resources has been a constraint	Core Comprehensive Standardized Assessment: • CCSA implemented in September, use tablet to collect info from patients • Patient opt out possible question by question, rather than for whole survey Multi-Disciplinary Core Team: • Registries run based on real time data, e.g. diabetes • MDCT is embedded in IDT daily meetings • Working closely with LRH and AVH to help staff NH Doorway hubs • Peer Recovery Coach Academy training to be attended by two MAs and a case manager in early 2019 Information Sharing: • BH team meets regularly and as needed for case conferencing • DSM through Imprivata for all hospitals and partners slated to be completed first quarter, 2019 Standardized Workflows/Protocols: • Risk stratification through EMR, flags two or more chronic conditions as well as identified through private insurers	Core Comprehensive Standardized Assessment: • CCSA process is going well and has proven valuable for real time care coordination • Currently working to address provider and patient resistance to participate in the full screening, including improving internal workflows and providing patients with education regarding the intent behind the CCSA Multi-Disciplinary Core Team for High-Risk Patients • MDCT continues to be embedded in the daily IDT meetings with the BH team meeting with a Psychiatrist once a month for consultation • This partner also reports that there are several medical staff committees that meet at least monthly which are attended by members of the BH team and at which case consultations occur Information Sharing • This partner has engaged with Collective Medical and reports that they receive event notifications in the ED, where there is a process in place to respond to the data • Region 7 IDN will continue engaging in conversation with the Weeks team regarding implementation of PreManage Primary in the ambulatory setting Standardized Workflows/Protocols • Uses all required workflows and protocols to meet CCP status

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White Horse Addiction Center	Core Comprehensive Standardized Assessment: • Not engaged in active work on the shared care plan – IDN staff will engage with White Horse about the shared care plan in the next reporting period; Multi-Disciplinary Core Team: • Working with a consultant to build capacity and implement processes to work toward coordinated care	Core Comprehensive Standardized Assessment: • Discussing opportunities that exist for expanding coordinated care efforts by implementing the CCSA • The IDN team will work to learn more about this process to see what questions are asked of clients, and if those meet the DSRIP requirements for the CCSA process. • IDN team is working with the agency to determine how the shared care plan can work for White Horse and assess readiness for implementation. Multi-Disciplinary Core Team: • IDN team will engage White Horse Addiction Center leadership to determine how to involve agency in area MDCTs Information Sharing: • 42 CFR Part 2 has been a barrier. IDN staff working closely with agency to determine best processes to address this Standardized Workflows/Protocols: • IDN team working with agency staff to determine protocols and workflows in place	Core Comprehensive Standardized Assessment: • Currently has almost all components of the CCSA embedded in their paper intake process, though it currently does not appear to include adoption of SBIRT. **During the review period, this partner's process of assessment was determined to include all domains of the CCSA. The Region 7 IDN team will work with this partner to codify their assessment process in a protocol by the end of the current reporting period.** Multi-Disciplinary Core Team: • This partner reports that the agency does not have the staffing or bandwidth to stand up their own structured MDCT, and expressed an interest in having a regional resource to which cases could be referred Information Sharing: • 42 CFR Part 2 remains a barrier, as does the lack of technology in place for this partner. They report that EMR products are currently being vetted, with the hopes of beginning implementation later this year. At that time, this partner is interested in additional support from the Region 7 IDN team in implementing additional DSRIP initiatives. Standardized Workflows/Protocols: • The Region 7 IDN team will continue to provide support and assistance to this partner as they develop and implement required workflows and protocols

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White Mountain Community Health Center ***Meets CCP requirements as assessed by Region 7 IDN team***	Core Comprehensive Standardized Assessment: • Developed a CCSA assessment process • Actively working to install shared care plan Multi-Disciplinary Core Team: • Hired a care coordinator • Staff member attended Regional Care Coordination Training Information Sharing: • Held first case conference June 2018, and establish a MDCT process • Has a MAT program in place, has held a case conference with a full MDCT and have taken a pilot patient through the CCSA process Standardized Workflows/Protocols: • Working closely with Region 7 IDN Quality Improvement Coach to develop risk stratification processes	Core Comprehensive Standardized Assessment: • Developed an assessment process • Developing protocols for care guidelines in SCP • Fully implemented CCSA with Medicaid population 18 yo and over; tracking through Health Maintenance Flowsheet on EMR, use for reporting by Care Coordination Team. Multi-Disciplinary Core Team: • Established a multidisciplinary team process • Hired a care coordinator • MDCT monthly case conference with NHS psychiatrist and WMCHC primary care, behavioral health, and care managers • MDCT case conferences in grand rounds style, care coordinator began presenting complex cases and consults for med prescribing. Information Sharing: • Implemented CMT PreManage • Receiving Event Notifications, circulated to all staff to assure coverage of patient follow-up; see this as critical to care coordination and decreasing ED use Standardized Workflows/Protocols: • Working on risk stratification models using PDSA approach on CCSA protocol	Core Comprehensive Standardized Assessment: • Continues to utilize all required components of the CCSA, and reports that they have begun an annual quality review of the process to identify improvement opportunities • Now offering paper and tablet options to patients • Querying other IDN partners for best practices • Working on systems to educate staff and help them navigate the CCSA process Multi-Disciplinary Core Team for High-Risk Patients • Continue meeting monthly with the full MDCT put in place • PCP's have been cross trained in DSRIP required topics; trying to determine what the minimum requirement of training is for people who are not experts in some domains Information Sharing • This partner continues to leverage the Collective Medical platform to delivery care and coordinate quality reviews. • During this reporting period, this partner began using care guidelines to enter care coordinator information for reference by ED and other providers Standardized Workflows/Protocols • Uses all required workflows and protocols to meet CCP status

December 31, 2019 Update

Provider	Progress Toward Coordinated Care Practice as of 6/30/18	Progress Toward Coordinated Care Practice as of 12/31/18	Progress Toward Coordinated Care Practice as of 6/30/19	Progress Toward Coordinated Care Practice as of 12/31/19
Ammonoosuc Community Health Services ***Meets CCP requirements as assessed by Region 7 IDN team***	Core Comprehensive Standardized Assessment: • Creating a form capturing all required CCSA domains, and this form will be embedded within the agency's tablets • The agency plans to finalize their CCSA protocol once they have finished embedding a form into their tablets/EMR and anticipate they will have this completed before the end of 2018 • Modifying CCSA for adolescents Standardized Workflows/Protocols: • ACHS is working on a process to route the document to a patient navigator once it is completed for review and action if needed • Working on development of various protocols required	Core Comprehensive Standardized Assessment: • Continue to capture all domains within the CCSA. ACHS has implemented the process within tablets given to patients before visits. • Written protocol for CCSA has not yet been finalized but is in process. Protocol for follow-up is in place and guides the role of the Patient Navigators. Multi-Disciplinary Core Team: • Structured team with psychiatric consultation in place • Documented roles and responsibilities written for MDCT members, along with the purpose of the team. • ACHS has held four MDCT meetings during this reporting period Information Sharing: • Working with North Country Serenity Center to provide Recovery Support Services for 24 patients/clients with SUDs since August 2018 Standardized Workflows/Protocols: • Implemented feedback loop to increase identification and timeliness of appointments for patients seen in ED for BH related issues. 7% of ED pts were there for BH reasons,	Core Comprehensive Standardized Assessment: • Continues to utilize all required components of the CCSA • Now offering paper and tablet options to patients Multi-Disciplinary Core Team for High-Risk Patients • The structured MDCT continues to meet monthly for case reviews • Documented purpose for the MDCT as well as roles and responsibilities written for members • Working to develop a more structured patient referral process Information Sharing • Engaged with Collective Medical platform this period; sending census files and using event notifications Standardized Workflows/Protocols • Uses all required workflows and protocols to meet CCP status	Core Comprehensive Standardized Assessment: • Continues to utilize all required components of the CCSA Multi-Disciplinary Core Team for High-Risk Patients • The structured MDCT continues to meet monthly for case reviews Information Sharing • Engaged with Collective Medical platform; sending census files and using event notifications Standardized Workflows/Protocols • Uses all required workflows and protocols to meet CCP status

Provider	Progress Toward Coordinated Care Practice as of 6/30/18	Progress Toward Coordinated Care Practice as of 12/31/18	Progress Toward Coordinated Care Practice as of 6/30/19	Progress Toward Coordinated Care Practice as of 12/31/19
		5% were seen by ACHS for follow-up		
Coös County Family Health Services	Core Comprehensive Standardized Assessment: • CCFHS addresses most of the domains in the CCSA and conversations continue about the CCSA process and shared care plan Multi-Disciplinary Core Team: • Providing staff to CrossRoads clinic, a co-located site with Northern Human Services Information Sharing: • IDN staff have met with the CCFHS management team, provided a personalized demonstration of the shared care plan and offered education on 42 CFR consent tracking	Core Comprehensive Standardized Assessment: • Assessing some of the CCSA domains, but not consistently • Shared care plan work continues, the additional DSRIP deliverables considered in this context Multi-Disciplinary Core Team: • No MDCT currently in place but do hold meetings for their early childhood team that Northern Human Services attend regularly and participate in care transition meetings which are attending by numerous provider agencies in the region. The IDN team will continue to engage CCFHS on MDCT Information Sharing: • Implemented event notifications, working to understand patient utilization of services • Care Coordinators log in daily to CMT, get info re: ADTs and find this very helpful, though not if patient seen at other sites that don't use CMT Standardized Workflows/Protocols: • referral protocols in place. IDN team will continue engagement on CCSA protocol	Core Comprehensive Standardized Assessment: • Has adopted most CCSA domains; housing and legal status only assessed for OB patients; pediatric and universal screenings in place • IDN 7 team will continue to support this partner as they consider expanding housing and legal screenings to a broader patient population Multi-Disciplinary Core Team for High-Risk Patients • No structured MDCT however continues to have internal case conferences with their Psychiatric NP • Region 7 IDN team will continue engaging CCFHS in conversation about the possibility of utilizing a regional MDCT for high-risk patients Information Sharing • Engaged with Collective Medical platform this period; sending census files and using event notifications Standardized Workflows/Protocols • Uses all required workflows and protocols to meet CCP status	Core Comprehensive Standardized Assessment: • Has adopted most CCSA domains; housing and legal status only assessed for OB patients; pediatric and universal screenings in place Multi-Disciplinary Core Team for High-Risk Patients • No structured MDCT however continues to have internal case conferences with their Psychiatric NP • Region 7 IDN team will continue engaging CCFHS in conversation about the possibility of utilizing a regional MDCT for high-risk patients Information Sharing • Engaged with Collective Medical platform this period; sending census files and using event notifications Standardized Workflows/Protocols • Uses all required workflows and protocols to meet CCP status

Provider	Progress Toward Coordinated Care Practice as of 6/30/18	Progress Toward Coordinated Care Practice as of 12/31/18	Progress Toward Coordinated Care Practice as of 6/30/19	Progress Toward Coordinated Care Practice as of 12/31/19
Friendship House	Core Comprehensive Standardized Assessment: • Not engaged in active work on the shared care plan due to 42CFR Part 2 constraints – IDN staff will engage with staff at Friendship House about the shared care plan in the next reporting period; Standardized Workflows/Protocols: • Working to improved treatment curriculum to enhance the treatment of co-occurring mental and SUD disorders	Multi-Disciplinary Core Team: • IDN team will work with Friendship House staff to determine how to involve agency in area MDCTs Information Sharing: • 42 CFR Part 2 has been a barrier. IDN staff working closely with agency to determine best processes to address this • Agreements with ACHS and CCFHS for preadmission physicals Standardized Workflows/Protocols: • IOP Matrix Model, focus on education and awareness of symptoms r/t addiction, relapse prevention, community connections, and other needs as identified • CARF accreditation in progress	Core Comprehensive Standardized Assessment: • Has all domains of CCSA in place, including Universal Screening; no pediatric primary care population Multi-Disciplinary Core Team for High-Risk Patients • No structured MDCT in place; Region 7 IDN team will continue engaging this partner regarding the possibility of utilizing a regional MDCT for high-risk patients Information Sharing and Standardized Workflows/Protocols • Extensive work has been done during this reporting period to codify practice at FH to support compliance with CARF accreditation requirements. In the coming reporting period, the Region 7 IDN team will work with the FH team to determine how these policies, protocols and workflows align with DSRIP requirements for Coordinated Care Practices and provide assistance with furthering this partner's progress along the continuum.	Core Comprehensive Standardized Assessment: • Has all domains of CCSA in place, including Universal Screening; no pediatric primary care population Multi-Disciplinary Core Team for High-Risk Patients • No structured MDCT in place; Region 7 IDN team will continue engaging this partner regarding the possibility of utilizing a regional MDCT for high-risk patients Information Sharing • Considering engagement with Collective Medical Standardized Workflows/Protocols • Uses all required workflows and protocols to meet CCP status
Huggins Hospital ***Meets CCP requirements as assessed by Region 7 IDN team***	Core Comprehensive Standardized Assessment: • Staff have been working closely with the IDN Quality Improvement Coach to ensure they have a CCSA and a CCSA	Core Comprehensive Standardized Assessment: • CCSA protocol reviewed and approved, includes all domains per DSRIP	Core Comprehensive Standardized Assessment: • This partner has all domains of the CCSA designed, including pediatric and universal screening; currently being used	Core Comprehensive Standardized Assessment: • This partner has all domains of the CCSA implemented in the EMR; fully implemented in one practice and training

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	protocol which meets DSRIP requirements by the end of 2018 • Plans to roll out the CCSA for their entire patient population, not just the Medicaid population Multi-Disciplinary Core Team: • Have received funds to stand up a MAT program during this period and have been shaping a MDCT to use in the upcoming reporting period • Hosted two Mental Health First Aid trainings • Staff attended Regional Care Coordinator training Information Sharing: • Hospital is contributing ADT feeds to the CMT network • Completed implementation steps with Collective Medical Technologies for PreManage ED at the Hospital and PreManage in the Clinic • Neither location is actively using the SCP yet as they work through adoption and workflow as well as a fix to the ADT process	• Piloting CCSA at Wolfeboro Family Medicine starting Dec. 18th; staff trained, patients to pilot chosen, results to be documented to inform upcoming full implementation Multi-Disciplinary Core Team: • Hosted one more Mental Health First Aid training • Care guidelines in process, as is consent process for contributing to patient goals and treatment plan • MDCT meets monthly, with NHS psychiatrist, only limited PCP involvement due to care coordination capacity issues • Hope to bolster staffing with IDN funding for care coordination of CCSA identified issues Information Sharing: • Pre-Manage ED in both hospital and clinic completed • Hospital sending ADT's to the CMT network • Event notifications being sent to ED via dedicated printer • Outpatient SW staff using CMT portal Standardized Workflows/Protocols: • CMT-Related workflows created • Sample policies and consents being amended for Huggins format	at one of seven primary care sites as the partner undergoes an EMR migration and temporary staffing shortages in the care coordination department • Using pilot of CCSA to address opportunities to improve the process based on patient and provider feedback • Intends to implement across all clinics when the care coordination department returns to full staffing and has better capacity to address positive screens Multi-Disciplinary Core Team for High-Risk Patients • The agency has enhanced their MDCT this period to include consistent PCP involvement and have 3 care coordinators involved in the process • Continue to meet monthly using a psychiatrist from NHS Information Sharing • Fully engaged in Collective Medical platform, with Care coordinators leveraging event notifications to help drive better patient care • Beginning to utilize the care guidelines feature in PreManage primary and leveraging event notification data in	staff across all others in its use Multi-Disciplinary Core Team for High-Risk Patients • The agency continues monthly meetings monthly using a psychiatrist from NHS Information Sharing • Fully engaged in Collective Medical platform, with Care coordinators leveraging event notifications to help drive better patient care • Using the care guidelines feature in PreManage primary and leveraging event notification data in ED for quality reviews • Conducting monthly case conferences with the MDCT Standardized Workflows/Protocols • Uses all required workflows and protocols to meet CCP status

Provider	Progress Toward Coordinated Care Practice as of 6/30/18	Progress Toward Coordinated Care Practice as of 12/31/18	Progress Toward Coordinated Care Practice as of 6/30/19	Progress Toward Coordinated Care Practice as of 12/31/19
			ED for quality reviews • Conducting monthly case conferences with the MDCT Standardized Workflows/Protocols • Uses all required workflows and protocols to meet CCP status	
Indian Stream Health Center ***Meets CCP requirements as assessed by Region 7 IDN team***	Core Comprehensive Standardized Assessment: • ISHC is engaged in conversations related to CCSA and are currently revising their assessment process • Staff is interested in shared care plan and IDN staff will engage them in additional conversations in the next six months Multi-Disciplinary Core Team: • Have a contract with a psychiatrist, and do have provider meetings, just not a formal case conference process in place – IDN staff will continue discussions about this	Core Comprehensive Standardized Assessment: • MDCT meets weekly, includes psychiatry; • Care management process now inclusive of BH and Primary care, recruiting for third Social Worker Information Sharing: • Many changes, including interim and new CEO's, EMR upgrade, new QI Director, loss of IT Director, have slowed progress this period • Care coordination remains paramount; IDN HIT Coach met with team early December, slating SCP implementation early Jan 2019 • Project engagement pending Standardized Workflows/Protocols: • Referrals tracked, honing closed loop referral process and form • Structured case review protocol pending	Core Comprehensive Standardized Assessment: • Has all domains of the CCSA in place, including pediatric and universal screening • Currently collecting CCSA data on paper forms for review by RN Care Coordinator; was planning to upload the survey into the EMR however IT capacity has decreased, and the agency has decided to put this on hold until the new EMR is implemented Multi-Disciplinary Core Team for High-Risk Patients • The MDCT continues to meet regularly to review cases. Have changed the structure of the meeting slightly to make case presentation more objective • Including regular education regarding key diagnoses in the case presentation forms in order to provide ongoing education on required topics to MDCT members Information Sharing	Core Comprehensive Standardized Assessment: • Has all domains of the CCSA in place, including pediatric and universal screening • Currently collecting CCSA in new EMR Multi-Disciplinary Core Team for High-Risk Patients • The MDCT continues to meet regularly to review cases, including regular education regarding key diagnoses in the case presentation forms in order to provide ongoing education on required topics to MDCT members Information Sharing • Engaged in Collective Medical platform • Planning to implement care guideline feature in the next period Standardized Workflows/Protocols • Uses all required workflows and protocols to meet CCP status

Provider	Progress Toward Coordinated Care Practice as of 6/30/18	Progress Toward Coordinated Care Practice as of 12/31/18	Progress Toward Coordinated Care Practice as of 6/30/19	Progress Toward Coordinated Care Practice as of 12/31/19
			• Engaged in Collective Medical platform during this reporting period with regular census uploads and use of event notifications on a daily basis for follow up purposes • Planning to implement care guideline feature in the next period Standardized Workflows/Protocols • Uses all required workflows and protocols to meet CCP status	
Littleton Regional Healthcare	Core Comprehensive Standardized Assessment: • LRH will work to capture domains required in IDN CCSA and will work closely with Weeks Medical Center to help with this process • LRH is an affiliate of North Country Health Care. IDN staff have worked with the affiliation to engage them on integrated healthcare initiatives including rollout of shared care plan. Weeks will start this process and then work with other affiliates on implementation. Information Sharing: • ADT feeds should be live in next reporting period	Core Comprehensive Standardized Assessment: • CCSA templated in EMR, including all domains for adults and pediatric patients • EMR captures SBIRT • Protocol not finalized Multi-Disciplinary Core Team: • Six days a month, two contracted psychiatrists are on site for diagnostic and medication management services; they recommend care plan to PCP via a shared EMR • Two social workers, one fully licensed and the other finalizing supervision requirements, provide full time counseling services to patients in the primary care practice • Practice also leases space to Weeks so that their Psychiatric APRN can provide satellite services to	Core Comprehensive Standardized Assessment: • Used Performance Improvement processes this reporting period to identify barriers to use of the CCSA template built in 2018 • CCSA has been rebuilt in the EMR and education on its use will be shared with providers and support staff through the summer Multi-Disciplinary Core Team for High-Risk Patients • No structured MDCT in place for the primary care clinic; the inpatient units do hold a daily interdisciplinary team that includes behavioral health and the primary care RN Care Coordinator • Does not currently have the bandwidth to implement a local MDCT but reports being interested in	Core Comprehensive Standardized Assessment: • CCSA has been rebuilt in the EMR and education on its is ongoing Multi-Disciplinary Core Team for High-Risk Patients • No structured MDCT in place for the primary care clinic; the inpatient units do hold a daily interdisciplinary team that includes behavioral health and the primary care RN Care Coordinator • interested in being involved in a regional MDCT approach Information Sharing • This partner is continuing discussions with the Region 7 IDN team regarding engagement with the Collective Medical Platform; further conversations will be necessary to finalize logistics

Provider	Progress Toward Coordinated Care Practice as of 6/30/18	Progress Toward Coordinated Care Practice as of 12/31/18	Progress Toward Coordinated Care Practice as of 6/30/19	Progress Toward Coordinated Care Practice as of 12/31/19
		LRH patients one day per week (records are kept in WMC EMR) • Three waivered MAT providers at LRH, no MAT program yet • OB/GYN providers working with Dartmouth using CARPP to support moms that are addicted • Plans to work on implementation of MDCT when care coordination staffing filled out Information Sharing: • Co-located PCPs and BH providers work within a shared EMR so BH notes are readily available to PCPs; psychotherapy notes are not part of record per HIPAA rules, but the full BH consult note is available to PCP and Care Coordinators Standardized Workflows/Protocols: • Focus on written workflows and protocols for CCSA and closed loop referral tracking	being involved in a regional MDCT approach Information Sharing • This partner is continuing discussions with the Region 7 IDN team regarding engagement with the Collective Medical Platform; further conversations will be necessary to finalize logistics Standardized Workflows/Protocols • Has many of the required workflows and protocols for CCP status in place • The Region 7 IDN team will continue to support this partner's development and adoption of CCP required protocols and workflows	Standardized Workflows/Protocols • Has many of the required workflows and protocols for CCP status in place • The Region 7 IDN team will continue to support this partner's development and adoption of CCP required protocols and workflows
Memorial Hospital	Core Comprehensive Standardized Assessment: • Met with key staff to discuss IDN deliverables; their affiliation with MaineHealth and time being spent on an EHR upgrade has played into the timing of meeting IDN deliverables Multi-Disciplinary Core Team: • nurse practitioners have received	Core Comprehensive Standardized Assessment: • Six standardized assessments used across the system for SUD and BH Multi-Disciplinary Core Team: • Memorial does not have a structured MDCT in place. However, as part of their I-MAT program they are regularly involved in a learning collaborative forum	Core Comprehensive Standardized Assessment: • This partner has most of the required CCSA domains, including pediatric and universal screenings in place. • This partner has recently engaged the Region 7 IDN team to assess outstanding DSRIP requirements following a resource consuming EMR migration and begin	Core Comprehensive Standardized Assessment: • This partner has most of the required CCSA domains, including pediatric and universal screenings in place. Multi-Disciplinary Core Team for High-Risk Patients • Has a structured MDCT in place for all high-risk patients; has expressed interest in assistance

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	certification in MAT and have a robust behavioral health integration project underway through MaineHealth • Looking into connecting to psychiatric services through MaineHealth; • Staff attended a Mental Health First Aid training Information Sharing: • Taken the lead on a four-agency collaborative proposal in Region 7 IDN to improve care coordination in the North Conway area	that has primary care providers, psychiatrists and any other necessary staff to discuss difficult cases/complex patients. In addition, behavioral health providers are embedded within the primary, the agency has access to psychiatrists through MaineHealth Information Sharing: • SCP and ADT feeds to CMT next priority for IDN Standardized Workflows/Protocols: • Epic EMR migration focus, so IDN team will continue to engage on CCSA protocol. Domains being built within EPIC • Closed loop for internal patients, look to expand and focus on this for external referrals they receive • Focused on behavioral health integration, and MAT expansion	implementation of missing requirements Multi-Disciplinary Core Team for High-Risk Patients • Does not have a structured MDCT in place for all high-risk patients; has expressed interest in assistance developing a policy for referring cases to a regional resource Information Sharing • This partner has begun new discussions regarding engagement with the Collective Medical platform and how their participation will benefit agencies within the region that are already using the platform • This partner reports that they are hesitant to engage due to the high percentage of patients who live in Maine, where CM does not have a strong presence • Region 7 IDN will continue conversations with the agency to encourage implementation Standardized Workflows/Protocols • Uses all required workflows and protocols to meet CCP status	developing a policy for referring cases to a regional resource Information Sharing • This partner has begun new discussions regarding engagement with the Collective Medical platform and how their participation will benefit agencies within the region that are already using the platform • This partner reports that they are hesitant to engage due to the high percentage of patients who live in Maine, where CM does not have a strong presence • Region 7 IDN will continue conversations with the agency to encourage implementation Standardized Workflows/Protocols • Uses all required workflows and protocols to meet CCP status
Northern Human Services ***Meets CCP requirements as assessed by Region 7 IDN team***	Core Comprehensive Standardized Assessment: • Actively engaged in shared care plan conversations Multi-Disciplinary Core Team:	Core Comprehensive Standardized Assessment: • Developed best practices for communication about integrated care and shared care	Core Comprehensive Standardized Assessment: • This partner reports that implementing the CCSA has enhanced their case management assessment process,	Core Comprehensive Standardized Assessment: • This partner reports that implementing the CCSA has enhanced their case management assessment process,

Provider	Progress Toward Coordinated Care Practice as of 6/30/18	Progress Toward Coordinated Care Practice as of 12/31/18	Progress Toward Coordinated Care Practice as of 6/30/19	Progress Toward Coordinated Care Practice as of 12/31/19
	• Finalizing a contract with NCHC to provide psychiatric services for developing MDCT's across the region • Finalizing CrossRoads clinic, a co-located site with CCFHS supplying primary care providers • Part of a Multi-Disciplinary Core Team meeting with WMCHC and soon to be with Huggins Hospital • Staff member attended Regional Care Coordinator training Information Sharing: • Working on consent requirements and related processes relating to the shared care plan	planning with staff and clients • CCSA now in EMR, expect all patients to be using by end of January • Use Dartmouth SDoH assessment, like it Multi-Disciplinary Core Team: • Trained all staff on Integrated care process and introduced a brochure for clients that explains collaborative care. • Can opt for on-site to FQHC's, see patients, then bill • Practice transformation work addressing MDCT work done by psychiatrist with Huggins and WMCH • Participates on MDCT at WMCHC and Huggins Hospital Information Sharing: • On site mtg with IDN HIT coach and CMT demonstration for SCP; First client population to be Assertive Community TX clients • To complete an initial census upload early in 2019 and begin live use early spring • Opt-out and consent/authorizatio ns explained • Event notifications soon, up and running in some locations • Mid-January, upgrade with Esscentia for DSM • Consent requirements being finalized	so all patients have it completed now, with quarterly renewals Multi-Disciplinary Core Team for High-Risk Patients • Continues to actively provide psychiatrist to MDCT within the region and is open to exploring the opportunity to participate in a regional MDCT model Information Sharing • Engaged with the Collective Medical platform with regular census uploads and use of event notifications • Plans to begin piloting the se of care guidelines for ACT and Drug Court clients later this year Standardized Workflows/Protocols • Uses all required workflows and protocols to meet CCP status	so all patients have it completed now, with quarterly renewals Multi-Disciplinary Core Team for High-Risk Patients • Continues to actively provide psychiatrist to MDCT within the region and is open to exploring the opportunity to participate in a regional MDCT model Information Sharing • Engaged with the Collective Medical platform with regular census uploads and use of event notifications • Plans to begin piloting the se of care guidelines for ACT and Drug Court clients later this year Standardized Workflows/Protocols • Uses all required workflows and protocols to meet CCP status

Provider	Progress Toward Coordinated Care Practice as of 6/30/18	Progress Toward Coordinated Care Practice as of 12/31/18	Progress Toward Coordinated Care Practice as of 6/30/19	Progress Toward Coordinated Care Practice as of 12/31/19
		Standardized Workflows/Protocols: • Workflow chart sent on referrals • Risk stratification built into procedures		
Rowe Health Center	Core Comprehensive Standardized Assessment: • Conversations continue around the CCSA and shared care plan Multi-Disciplinary Core Team: • The health center continues to build capacity to implement integrated healthcare	Core Comprehensive Standardized Assessment: • Documented protocol in place adapted from the sample protocol released to the region. • Capture all twelve domains and use SBIRT regularly. T • PCP has an SBIRT process that consists of AUDIT and DAST regarding high risk behaviors. If indicated, a referral is made to internal or external BH services. • IDN team still engaging agency on SCP implementation Multi-Disciplinary Core Team: • Weekly Integrated Care Team meeting with primary care, care coordinator, social worker and behavioral health APRN to discuss patients. • Behavioral health APRN then takes any patient cases that need additional consideration by the psychiatrist to a meeting between the APRN and psychiatrist. APRN brings feedback to the next weekly meeting. • Documented Integrated and Multi-Disciplinary Core Team Protocol that	Core Comprehensive Standardized Assessment: • Previously reported as meeting CCP status requirements, an EMR migration this reporting period has resulted in the loss of several CCSA domains; currently assessing the best way to rebuild the CCSA in the new EMR Multi-Disciplinary Core Team for High-Risk Patients • Continue to have weekly meetings for case conferences with the Psych NP in place, but delays in sub-recipient funding during this reporting period resulted in the suspension of psychiatrist consults for the MDCT Information Sharing • Initial meetings with Collective Medical have begun as this partner prepares to engage with the CM platform during the next reporting period • Working on a protocol that will codify their current practice of assisting patients with safe transitions from institutional care back into community Standardized Workflows/Protocols • Working with Region 7 IDN team to ensure that all required	Core Comprehensive Standardized Assessment: • Reinstated CCSA in new EMR; fully functional Multi-Disciplinary Core Team for High-Risk Patients • Continue to have weekly meetings for case conferences with the Psych NP in place; reinstated psychiatrist consults for the MDCT Information Sharing • Initial meetings with Collective Medical have begun as this partner prepares to engage with the CM platform during the next reporting period • Working on a protocol that will codify their current practice of assisting patients with safe transitions from institutional care back into community Standardized Workflows/Protocols • All required workflows and protocols have been developed and implemented

Provider	Progress Toward Coordinated Care Practice as of 6/30/18	Progress Toward Coordinated Care Practice as of 12/31/18	Progress Toward Coordinated Care Practice as of 6/30/19	Progress Toward Coordinated Care Practice as of 12/31/19
		explains each team's purpose, members, roles, communication, format, and logistics. Information Sharing: • Significantly advanced care coordination efforts by unifying EMR between hospital and health clinic Standardized Workflows/Protocols: • CCSA, MDCT and referral protocols in place. Agency working with IDN team to adapt regional protocols	workflows and protocols have been developed and implemented	
Saco River Medical Group	Core Comprehensive Standardized Assessment: • Saco River Medical Group is looking at the CCSA process and is working to address the IDN domains Multi-Disciplinary Core Team: • Staff attended Regional Care Coordinator training Information Sharing: • Saco River and IDN staff have met twice to discuss the SCP; resources to install and provider workflow and productivity impact have been concerns Standardized Workflows/Protocols: • Staff are working on care coordination processes	Core Comprehensive Standardized Assessment: • SCP discussions continue but there are concerns because Memorial Hospital is not yet submitting ADT feeds Multi-Disciplinary Core Team: • IDN team will continue to engage with Saco River Medical Group regarding MDCT Information Sharing: • Continue to engage on Coordinated care initiatives with local partners and shared care plan implementation Standardized Workflows/Protocols: • IDN team will continue to engage on protocol development	Core Comprehensive Standardized Assessment: • This partner dedicated efforts this reporting period developing a CCSA questionnaire covering all required domains and workflows and protocols to implement it. It will begin pilot phase in July 2019. **During the review period, this partner fully implemented the CCSA.** Multi-Disciplinary Core Team for High-Risk Patients • The agency shared that they do not have the bandwidth to stand up a structured MDCT of their own, and has expressed an interest in referring cases another team or a regional team if one is developed Information Sharing • This partner has an interest in engaging	Core Comprehensive Standardized Assessment: • fully implemented CCSA in use Multi-Disciplinary Core Team for High-Risk Patients • The agency shared that they do not have the bandwidth to stand up a structured MDCT of their own, and has expressed an interest in referring cases another team or a regional team if one is developed Information Sharing • This partner has an interest in engaging with the Collective Medical platform, but expresses concern that the value of the technology without their local hospital, Memorial, contributing to the network Standardized Workflows/Protocols • Has many of the required workflows

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			with the Collective Medical platform, but expresses concern that the value of the technology without their local hospital, Memorial, contributing to the network Standardized Workflows/Protocols • Has many of the required workflows and protocols for CCP status in place • The Region 7 IDN team will continue to support this partner's development and adoption of CCP required protocols and workflows	and protocols for CCP status in place • The Region 7 IDN team will continue to support this partner's development and adoption of CCP required protocols and workflows
Weeks Medical Center ***Meets CCP requirements as assessed by Region 7 IDN team***	Core Comprehensive Standardized Assessment: • Weeks plans to move forward to implement a CCSA during the next six months and use lessons learned to share with Littleton Regional Healthcare as they implement the CCSA Multi-Disciplinary Core Team: • As part of the affiliation Weeks has been addressing regional care coordination which includes working with Community Health Workers from the North Country Health Consortium Information Sharing: • Weeks was able to leverage an existing ADT connection to Dartmouth-Hitchcock Medical Center to quick-start	Core Comprehensive Standardized Assessment: • CCSA implemented in September, use tablet to collect info from patients • Patient opt out possible question by question, rather than for whole survey Multi-Disciplinary Core Team: • Registries run based on real time data, e.g. diabetes • MDCT is embedded in IDT daily meetings • Working closely with LRH and AVH to help staff NH Doorway hubs • Peer Recovery Coach Academy training to be attended by two MAs and a case manager in early 2019 Information Sharing: • BH team meets regularly and as	Core Comprehensive Standardized Assessment: • CCSA process is going well and has proven valuable for real time care coordination • Currently working to address provider and patient resistance to participate in the full screening, including improving internal workflows and providing patients with education regarding the intent behind the CCSA Multi-Disciplinary Core Team for High-Risk Patients • MDCT continues to be embedded in the daily IDT meetings with the BH team meeting with a Psychiatrist once a month for consultation • This partner also reports that there are several medical	Core Comprehensive Standardized Assessment: • CCSA process is fully implemented Multi-Disciplinary Core Team for High-Risk Patients • MDCT continues to be embedded in the daily IDT meetings with the BH team meeting with a Psychiatrist once a month for consultation Information Sharing • This partner has engaged with Collective Medical and reports that they receive event notifications in the ED, where there is a process in place to respond to the data • Region 7 IDN will continue engaging in conversation with the Weeks team regarding implementation of

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	contributing ADT feeds to the CMT network • NCH has also agreed to begin implementing the shared care plan; this will occur first at the Weeks Emergency Department Standardized Workflows/Protocols: • Weeks is an affiliate of North Country Health Care; IDN staff have worked with the affiliation to engage them on integrated healthcare initiatives although time and resources has been a constraint	needed for case conferencing • DSM through Imprivata for all hospitals and partners slated to be completed first quarter, 2019 Standardized Workflows/Protocols: • Risk stratification through EMR, flags two or more chronic conditions as well as identified through private insurers	staff committees that meet at least monthly which are attended by members of the BH team and at which case consultations occur Information Sharing • This partner has engaged with Collective Medical and reports that they receive event notifications in the ED, where there is a process in place to respond to the data • Region 7 IDN will continue engaging in conversation with the Weeks team regarding implementation of PreManage Primary in the ambulatory setting Standardized Workflows/Protocols • Uses all required workflows and protocols to meet CCP status	PreManage Primary in the ambulatory setting Standardized Workflows/Protocols • Uses all required workflows and protocols to meet CCP status
White Horse Addiction Center	Core Comprehensive Standardized Assessment: • Not engaged in active work on the shared care plan – IDN staff will engage with White Horse about the shared care plan in the next reporting period; Multi-Disciplinary Core Team: • Working with a consultant to build capacity and implement processes to work toward coordinated care	Core Comprehensive Standardized Assessment: • Discussing opportunities that exist for expanding coordinated care efforts by implementing the CCSA • The IDN team will work to learn more about this process to see what questions are asked of clients, and if those meet the DSRIP requirements for the CCSA process. • IDN team is working with the agency to determine how the shared care plan can	Core Comprehensive Standardized Assessment: • Currently has almost all components of the CCSA embedded in their paper intake process, though it currently does not appear to include adoption of SBIRT. **During the review period, this partner's process of assessment was determined to include all domains of the CCSA. The Region 7 IDN team will work with this partner to codify their assessment**	Core Comprehensive Standardized Assessment: • Fully implemented Multi-Disciplinary Core Team: • This partner has fully adopted policies and protocols to access the Region 7 MDCT Information Sharing: • New EMR fully implemented • Engaged in Collective Medical implementation proces. Standardized Workflows/Protocols: • All required workflows and protocols have been adopted

Provider	Progress Toward Coordinated Care Practice as of 6/30/18	Progress Toward Coordinated Care Practice as of 12/31/18	Progress Toward Coordinated Care Practice as of 6/30/19	Progress Toward Coordinated Care Practice as of 12/31/19
		work for White Horse and assess readiness for implementation. Multi-Disciplinary Core Team: • IDN team will engage White Horse Addiction Center leadership to determine how to involve agency in area MDCTs Information Sharing: • 42 CFR Part 2 has been a barrier. IDN staff working closely with agency to determine best processes to address this Standardized Workflows/Protocols: • IDN team working with agency staff to determine protocols and workflows in place	**process in a protocol by the end of the current reporting period.** Multi-Disciplinary Core Team: • This partner reports that the agency does not have the staffing or bandwidth to stand up their own structured MDCT, and expressed an interest in having a regional resource to which cases could be referred Information Sharing: • 42 CFR Part 2 remains a barrier, as does the lack of technology in place for this partner. They report that EMR products are currently being vetted, with the hopes of beginning implementation later this year. At that time, this partner is interested in additional support from the Region 7 IDN team in implementing additional DSRIP initiatives. Standardized Workflows/Protocols: • The Region 7 IDN team will continue to provide support and assistance to this partner as they develop and implement required workflows and protocols	
White Mountain Community Health Center ***Meets CCP requirements***	Core Comprehensive Standardized Assessment: • Developed a CCSA assessment process	Core Comprehensive Standardized Assessment: • Developed an assessment process	Core Comprehensive Standardized Assessment: • Continues to utilize all required components of the	Core Comprehensive Standardized Assessment: • Continues to utilize all required

Provider	Progress Toward Coordinated Care Practice as of 6/30/18	Progress Toward Coordinated Care Practice as of 12/31/18	Progress Toward Coordinated Care Practice as of 6/30/19	Progress Toward Coordinated Care Practice as of 12/31/19
as assessed by Region 7 IDN team	• Actively working to install shared care plan Multi-Disciplinary Core Team: • Hired a care coordinator • Staff member attended Regional Care Coordination Training Information Sharing: • Held first case conference June 2018, and establish a MDCT process • Has a MAT program in place, has held a case conference with a full MDCT and have taken a pilot patient through the CCSA process Standardized Workflows/Protocols: • Working closely with Region 7 IDN Quality Improvement Coach to develop risk stratification processes	• Developing protocols for care guidelines in SCP • Fully implemented CCSA with Medicaid population 18 yo and over; tracking through Health Maintenance Flowsheet on EMR, use for reporting by Care Coordination Team. Multi-Disciplinary Core Team: • Established a multidisciplinary team process • Hired a care coordinator • MDCT monthly case conference with NHS psychiatrist and WMCHC primary care, behavioral health, and care managers • MDCT case conferences in grand rounds style, care coordinator began presenting complex cases and consults for med prescribing. Information Sharing: • Implemented CMT PreManage • Receiving Event Notifications, circulated to all staff to assure coverage of patient follow-up; see this as critical to care coordination and decreasing ED use Standardized Workflows/Protocols: • Working on risk stratification models using PDSA approach on CCSA protocol	CCSA, and reports that they have begun an annual quality review of the process to identify improvement opportunities • Now offering paper and tablet options to patients • Querying other IDN partners for best practices • Working on systems to educate staff and help them navigate the CCSA process Multi-Disciplinary Core Team for High-Risk Patients • Continue meeting monthly with the full MDCT put in place • PCP's have been cross trained in DSRIP required topics; trying to determine what the minimum requirement of training is for people who are not experts in some domains Information Sharing • This partner continues to leverage the Collective Medical platform to delivery care and coordinate quality reviews. • During this reporting period, this partner began using care guidelines to enter care coordinator information for reference by ED and other providers Standardized Workflows/Protocols • Uses all required workflows and protocols to meet CCP status	components of the CCSA • Working on process improvements Multi-Disciplinary Core Team for High-Risk Patients • Continue meeting monthly with the full MDCT put in place Information Sharing • This partner continues to leverage the Collective Medical platform to delivery care and coordinate quality reviews; use of care guidelines in place Standardized Workflows/Protocols • Uses all required workflows and protocols to meet CCP status

B1-10 Table 3: Progress toward Integrated Care Practice Designation

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

December 31, 2018

Region 7 IDN has identified nine agencies to work towards Integrated Care Practice Designation: Ammonoosuc Community Health Services, Memorial Hospital, Weeks Medical Center, Coös County Family Health Services, Northern Human Services, Friendship House, White Mountain Community Health Center, Huggins Hospital, and Saco River Medical Group.

June 30, 2019 Update

Provider	Progress Toward Integrated Care Practice as of 6/30/18	Progress Toward Integrated Care Practice as of 12/31/18	Progress Toward Integrated Care Practice as of 6/30/19
Ammonoosuc Community Health Services ***Meets CCP & ICP requirements as assessed by Region 7 IDN team***	Coordinated Care Practice Designation • met as of 6/30/18 according to Region 7 IDN Evidence Based Interventions: • Provides MAT services Technology for at-risk patients • ACHS is working on a process to route the document to a patient navigator once it is completed for review and action if needed. The agency plans to finalize their CCSA protocol and once they have finished embedding a form into their tablets and anticipate they will have this completed before the end of 2018; Collaboration with Community Based Supports: • Agreements in place with North Country Serenity Center • Agreements in place with NCHC Friendship House to provide medical care to residential patients as needed	Coordinated Care Practice Designation • met as of 6/30/18 according to Region 7 IDN Evidence Based Interventions: • Provides MAT services Collaboration with Community Based Supports: • Implemented feedback loop to increase identification and timeliness of appointments for patients seen in ED for BH related issues (7% of ED pts were there for BH reasons, 5% were seen by ACHS for follow-up) • Working with North Country Serenity Center (NCSC) to provide Recovery Support services for 24 patients/clients with SUD since August 2018 while ACHS provides medical, dental, vision, BH, SUD, nutrition and patient navigation services with a goal to reduce recidivism, relapse rates, and expand BH services	Coordinated Care Practice Designation • Met according to Region 7 IDN Evidence based interventions (MAT & Depression) • Provides MAT services to internal patients • Follows standardized procedures for the treatment of depression Technology for at-risk patients • Engaged with the Collective Medical network during this reporting period; actively receiving event notifications • This partner has trained staff and is developing standardized procedures for use Collaboration w/ Community Based Supports • Continues to use feedback loop with LRH to track ED visits of patients • Continues to collaborate with North Country Serenity Center about mutual patients • Provides medical assessments to Friendship House patients • Positioned to collaborate with other CBOs as necessary

Provider	Progress Toward Integrated Care Practice as of 6/30/18	Progress Toward Integrated Care Practice as of 12/31/18	Progress Toward Integrated Care Practice as of 6/30/19
Coös County Family Health Services	Coordinated Care Practice Designation • in progress according to Region 7 IDN Evidence Based Interventions: • MAT program in place Technology for at-risk patients: • IDN staff have met with the CCFHS management team, provided a personalized demonstration of the shared care plan and offered education on 42 CFR consent tracking Collaboration with Community Based Supports: • Providing staff to CrossRoads clinic, a co-located site with Northern Human Services	Coordinated Care Practice Designation • in progress according to Region 7 IDN Evidence Based Interventions: • Provides comprehensive MAT services • Expansion MAT program to accept referrals from primary care providers; five waivered prescribers and the program includes an RN, Recovery Coach and Women's Health staff • Seven BH staff attended Cherokee training and agency is working to implement BH services in a similar fashion to the Cherokee model Technology for at-risk patients: • Implemented event notifications, working to understand patient utilization of services • Care Coordinators log in daily to CMT, get info re: ADTs and find this very helpful, though not if patient seen at other sites that don't use CMT	Coordinated Care Practice Designation • In progress according to Region 7 IDN Evidence based interventions (MAT & Depression) • This partner has recently expanded their existing MAT program to increase capacity within the community • Currently developing a formal protocol for the treatment of depression; the Region 7 IDN team will support this agency in these efforts Technology for at-risk patients • Continues to use event notifications in the care coordination department; care coordinators login daily and have found the system valuable • Uses a closed-loop referral system to monitor services ordered for patients Collaboration w/ Community Based Supports • Continue to develop joint service protocols with outside agencies • Regularly engaged in collaborative efforts with healthcare providers and CBSs to address needs of high-risk patients in their census

Provider	Progress Toward Integrated Care Practice as of 6/30/18	Progress Toward Integrated Care Practice as of 12/31/18	Progress Toward Integrated Care Practice as of 6/30/19
Friendship House	Coordinated Care Practice Designation • in progress according to Region 7 IDN Evidence Based Interventions: • Working to improved treatment curriculum to enhance the treatment of co-occurring mental and SUD disorders. Technology for at-risk patients: • Not engaged in active work on the shared care plan due to 42CFR Part 2 constraints; IDN staff will engage with staff at Friendship House about the shared care plan in the next reporting period	Coordinated Care Practice Designation • in progress according to Region 7 IDN Evidence Based Interventions: • IOP Matrix Model, focus on education and awareness of symptoms r/t addiction, relapse prevention, community connections, and other needs as identified • Barriers to patient fidelity are transportation and lack of resources • CARF accreditation in progress • Agency working to implement MAT program Collaboration with Community Based Supports: • Agreements with ACHS and CCFHS for preadmission physicals • Working with agency staff regarding SCP implementation	Coordinated Care Practice Designation • In progress according to Region 7 IDN Evidence based interventions (MAT & Depression) • Focusing on building strong relationships with the Doorway NH sites rather than pursuing an internal MAT program to prevent duplication of services • Using new treatment curricula for clients – Seeking Safety focuses on co-occurring PTSD and SUD, and the agency is using the latest IOP Matrix Model • Follows standardized processes for treatment of depression Technology for at-risk patients • Updated multiple systems throughout the agency to prepare for CARF accreditation • IDN Team will reengage partner in the next reporting period to discuss engagement with the Collective Medical network Collaboration w/ Community Based Supports • Agreements continue to be in place with ACHS and CCFHS for preadmission physicals • Continue to collaborate with NCSC • Working to build relationships with LRH and AVH Doorway NH sites

Provider	Progress Toward Integrated Care Practice as of 6/30/18	Progress Toward Integrated Care Practice as of 12/31/18	Progress Toward Integrated Care Practice as of 6/30/19
Huggins Hospital	Coordinated Care Practice Designation • in progress according to Region 7 IDN Evidence Based Interventions: • They have received funds to stand up a MAT program during this period and have been shaping a MDCT to use in the upcoming reporting period;	Coordinated Care Practice Designation • met according to Region 7 IDN Evidence Based Interventions: • MAT program under development Technology for at-risk patients: • Completed implementation steps with Collective Medical Technologies for PreManage ED at the Hospital and PreManage in their Clinic. The hospital is contributing ADT feeds to the CMT network. • Works closely with the IDN Quality Improvement Coach to address the DSRIP deliverables, has created a Multi-Disciplinary Core Team, supported by a psychiatrist as previously mentioned, and has implemented monthly case conferences • Focus on building Care Coordination staff to assure f/u. MDCT meets with BH staff, seek to engage PCPs next as capacity to support complex cases allows	Coordinated Care Practice Designation • Met according to Region 7 IDN Evidence based interventions (MAT & Depression) • During this reporting period this partner has dedicated significant effort to the development of their MAT program, predicting go-live in October 2019 • Utilizes standard screening and treatment protocols for depression Technology for at-risk patients • Fully engaged with the Collective Medical network and using it for both direct care delivery and quality improvement processes. Collaboration w/ Community Based Supports • Has standard systems in place to collaborate with Community Based Organizations

Provider	Progress Toward Integrated Care Practice as of 6/30/18	Progress Toward Integrated Care Practice as of 12/31/18	Progress Toward Integrated Care Practice as of 6/30/19
Indian Stream Health Center ***Meets CCP & ICP requirements as assessed by Region 7 IDN team***	Coordinated Care Practice Designation • in progress according to Region 7 IDN	Coordinated Care Practice Designation • met according to Region 7 IDN Evidence Based Interventions: • Behavioral Health Team in place; provides therapy for clients of a local MAT program Technology for at-risk patients: • The AAFP model is used and six levels of risk are possible. Risk assessment is done directly in EMR on a separate tab with the ability to electronically indicate needed care management. • Exploring SCP implementation in early 2019 with demonstration of the product and articulated next steps. • BH and PCP meet weekly for MDCT meetings. Director of Quality developing clear written guidelines and CLR process. • EMR documentation to monitor • CLR is currently tracked using a spreadsheet with reports indicating needed follow-up	Coordinated Care Practice Designation • Met according to Region 7 IDN Evidence based interventions (MAT & Depression) • Has processes in place to refer patients to MAT prescribers and provides behavioral health services for patients receiving MAT • Follows a standardized depression treatment policy throughout practice Technology for at-risk patients • Engaged in the Collective Medical network and receiving event notifications; working to embed system into daily staff processes Collaboration w/ Community Based Supports • This partner has a long history of collaborating with Community Based Organizations • Actively collaborating with Doorway NH and North Country Recovery Center to be • involved in SUD treatment services in the state's northernmost region

Provider	Progress Toward Integrated Care Practice as of 6/30/18	Progress Toward Integrated Care Practice as of 12/31/18	Progress Toward Integrated Care Practice as of 6/30/19
Littleton Regional Healthcare	Coordinated Care Practice Designation • in progress according to Region 7 IDN • IDN staff have worked with the affiliation to engage them on integrated healthcare initiatives including rollout of shared care plan. • LRH will work to capture domains required in IDN CCSA and will work closely with Weeks Medical Center to help with this process; • ADT feeds should be live in next reporting period	Coordinated Care Practice Designation • in progress according to Region 7 IDN Evidence Based Interventions: • January 2019 NH Doorway will open at LRH Technology for at-risk patients: • CCSA in place. Need additional care coordination staff to address social determinants of health • EMR, eClinicalWorks, has built in registries for diabetes, heart failure, COPD. Await SUD. Chronic care management; CCSA seen as critical to risk ID; Opioid risk assessment tool; Screen for PPD in new moms • Open EMR system between BH and PCP to monitor and manage care • Ticklers built into the EMR for referral reports arriving back from outside. Specific staff dedicated to tracking.	Coordinated Care Practice Designation • In progress according to Region 7 IDN Evidence based interventions (MAT & Depression) • This partner refers patients to MAT services at their Littleton Doorway NH site, where they have subcontracted these services from Weeks Medical Center • Working with the Region 7 IDN team to implement a protocol for the treatment of depression Technology for at-risk patients • Continuing to investigate ways in which the current EMR can be used to identify and coordinate care for high-risk patients; anticipating EMR changes in the coming year that may enhance these abilities • Collaborating with several commercial payers to also use their patient care opportunity portals to this end Collaboration w/ Community Based Supports • Has dedicated significant efforts this reporting period under the Doorway NH project to the development of strong relationships throughout the community

Provider	Progress Toward Integrated Care Practice as of 6/30/18	Progress Toward Integrated Care Practice as of 12/31/18	Progress Toward Integrated Care Practice as of 6/30/19
Memorial Hospital	Evidence Based Interventions: • New nurse practitioner has received certification in MAT • Have a robust BH integration project underway through MaineHealth	Coordinated Care Practice Designation • in progress according to Region 7 IDN Evidence Based Interventions: • Provides comprehensive MAT services • Focused on behavioral health integration, and MAT expansion • Six standardized assessments used across the system for SUD and BH Technology for at-risk patients: • SCP and ADT feeds to CMT next priority for IDN Collaboration with Community Based Supports: • Closed loop for internal patients, look to expand and focus on this for external referrals they receive	Coordinated Care Practice Designation • In progress according to Region 7 IDN Evidence based interventions (MAT & Depression) • Continues to provide comprehensive Integrated MAT services • Using standardized policies and procedures for assessing and treating mild to moderate depression Technology for at-risk patients • Recently migrated to a new EMR that has enhanced their ability to use technology to coordinate care; also using DSM and Imprivata Cortext to perform secure text messaging Collaboration w/ Community Based Supports • Recently began conversations with the recovery community to offer 24/7 emergency support services • Continue to use closed loop for internal patients • The Region 7 IDN team will continue to collaborate with this partner as they work to meet the DSRIP deliverables

Provider	Progress Toward Integrated Care Practice as of 6/30/18	Progress Toward Integrated Care Practice as of 12/31/18	Progress Toward Integrated Care Practice as of 6/30/19
Northern Human Services ***Meets CCP & ICP requirements as assessed by Region 7 IDN team***	Technology for at-risk patients: • Have been working on consent requirements and related processes relating to the shared care plan; • Actively engaged in shared care plan conversations	Technology for at-risk patients: • On site mtg with IDN HIT coach and CMT demonstration for SCP; first client population to be Assertive Community TX clients • To complete an initial census upload early in 2019 and begin live use early spring • Mid-January, upgrade with Esscentia for DSM • Event notifications soon, up and running in some locations • Risk stratification built into procedures Collaboration with Community Based Supports: • Developed best practices for communication about integrated care and shared care planning with staff and clients • Trained all staff on Integrated care process and introduced a brochure for clients that explains collaborative care • Consent requirements being finalized	Coordinated Care Practice Designation • Met according to Region 7 IDN Evidence based interventions (MAT & Depression) • Embedded treatment for mild to moderate depression in assessment processes following a standard protocol • Follows a standard referral protocol to provide clients with access to MAT services Technology for at-risk patients • Engaged with the Collective Medical network to enhance their use of technology to care for the highest-risk clients • Leveraged CCSA implementation to improve their quarterly screening process to enhance information shared with primary care providers Collaboration w/ Community Based Supports • Implemented best practices for communication about integrated care and shared care planning with staff and clients; all staff have received training and distributed client brochures at all sites • Implemented consent requirements throughout agency that incorporate collaboration with Community Based Organizations

Provider	Progress Toward Integrated Care Practice as of 6/30/18	Progress Toward Integrated Care Practice as of 12/31/18	Progress Toward Integrated Care Practice as of 6/30/19
Rowe Health Center	***Coordinated Care Practice Designation in progress according to Region 7 IDN*** • The health center continues to build capacity to implement integrated healthcare. They received IDN funding to hire a consultant to help them work toward this goal. Conversations continue around the CCSA and shared care plan	***Coordinated Care Practice Designation met according to Region 7 IDN*** Evidence Based Interventions: • IDN staff will continue to engage with Rowe Health Center on evidence-based interventions • Technology for at-risk patients: • Demo on CMT, shared care plan and prospect of sending/receiving ADT data for risk identification of high utilizers. • Major step taken in conjunction with Cottage Hospital was to adopt and implement the same EMR. •	Coordinated Care Practice Designation • In progress according to Region 7 IDN Evidence based interventions (MAT & Depression) • This partner does not currently offer MAT services • The Region 7 IDN team will continue to support his partner in their efforts to codify existing processes related to the treatment of depression and referral to MAT Technology for at-risk patients • This partner leverages technology to identify and deliver care to at-risk patients; has piloted population health tools under a Medicare ACO and is currently engaging in the Collective Medical network. Collaboration w/ Community Based Supports • In process of formalizing systems to collaborate with outside agencies • The Region 7 IDN team will continue to assist this partner as it develops tools to enhance collaboration with community-based supports

Provider	Progress Toward Integrated Care Practice as of 6/30/18	Progress Toward Integrated Care Practice as of 12/31/18	Progress Toward Integrated Care Practice as of 6/30/19
Saco River Medical Group	***Coordinated Care Practice Designation in progress according to Region 7 IDN*** Evidence Based Interventions: • Saco River Medical Group has a MAT program in place	***Coordinated Care Practice Designation in progress according to Region 7 IDN*** Evidence Based Interventions: • Provides MAT services and has multiple protocols and documents in place to ensure program success. • Does not have a formal depression workflow or protocol in place however they have a draft outline of a depression screening protocol and are working with IDN team to explore IMPACT model and other models Technology for at-risk patients: • Decision support built into EMR; using as conditional logic model for patients who should have specific follow-up at next appt. and Working to stratify COPD, CHF • Currently using EMR for SUD, developmental screen, hypertension, diabetes, care management and monitoring • Using EMR to check on referral out information (once back in record)	Coordinated Care Practice Designation • In progress according to Region 7 IDN Evidence based interventions (MAT & Depression) • During this reporting period, this partner expanded existing MAT services • formal depression treatment protocol in place Technology for at-risk patients • Continues to leverage EMR features to check on referral status, SUD, and developmental screenings • This partner also works within a Medicare ACO and with incentivized payer contracts – programs that have helped them leverage technology to enhance care delivery for high-risk patients Collaboration w/ Community Based Supports • Actively dedicating efforts to building strong relationships with outside agencies, including an interest in joining Northern Human Services to stand up an integrated clinic in their community • The Region 7 IDN team continues to support this partner's efforts in formalizing these referral relationships as they are developed

Provider	Progress Toward Integrated Care Practice as of 6/30/18	Progress Toward Integrated Care Practice as of 12/31/18	Progress Toward Integrated Care Practice as of 6/30/19
Weeks Medical Center ***Meets CCP & ICP requirements as assessed by Region 7 IDN team***	Evidence Based Interventions: • Weeks has a robust MAT program Technology for at-risk patients: • Weeks was able to leverage an existing ADT connection to Dartmouth-Hitchcock Medical Center to quick-start contributing ADT feeds to the CMT network. • NCH has also agreed to begin implementing the shared care plan; this will occur first at the WMC Emergency Department	Coordinated Care Practice Designation met according to Region 7 IDN Evidence Based Interventions: • Provides comprehensive MAT services • Working closely with AVH and LRH to stand up NH Doorway hubs • Peer Recovery Coach Academy training to be attended by two MAs and a case manager in early 2019 • DSM through Imprivata for all hospitals and partners slated to be completed first quarter, 2019 Technology for at-risk patients: • Risk stratification through EMR, flags two or more chronic conditions as well as identified through private insurers	Coordinated Care Practice Designation • Met according to Region 7 IDN Evidence based interventions (MAT & Depression) • Continue to offer comprehensive MAT and behavioral health services through the North Country Recovery Center and as a sub-contractor of MAT services for the Berlin and Littleton Doorway NH sites • Follows standardized protocols for the treatment of mild to moderate depression Technology for at-risk patients • Continues to use risk stratification system through EMR and the Collective Medical network (PreManage ED) to coordinate care for at-risk patients Collaboration w/ Community Based Supports • Have structured processes to collaborate with Community-Based Organizations • Has a strong relationship with NCHC Community Health Workers, who are used to provide community-based care coordination for at-risk patients

Provider	Progress Toward Integrated Care Practice as of 6/30/18	Progress Toward Integrated Care Practice as of 12/31/18	Progress Toward Integrated Care Practice as of 6/30/19
White Horse Addiction Center	Coordinated Care Practice Designation in progress according to Region 7 IDN • IDN team will continue to gather additional information on required aspects of integrated care destination	Coordinated Care Practice Designation in progress according to Region 7 IDN • IDN team will continue to gather additional information on required aspects of integrated care destination	Coordinated Care Practice Designation • In progress according to Region 7 IDN Evidence based interventions (MAT & Depression) • In the process of developing an MAT program to align with the recent onboarding of an MAT waivered nurse practitioner • Has expressed an interest in assistance from the Region 7 IDN team in codifying depression treatment protocols Technology for at-risk patients • In the process of selecting an electronic health record platform in order to begin leveraging technology to coordinate patient/client care. Collaboration w/ Community Based Supports • WHAC is collaborating with Mount Washington Valley Supports Recovery to develop protocols for their new 24/7 emergency peer recovery support • The Region 7 IDN team will continue to provide support to this partner as it works to meet DSRIP requirements

Provider	Progress Toward Integrated Care Practice as of 6/30/18	Progress Toward Integrated Care Practice as of 12/31/18	Progress Toward Integrated Care Practice as of 6/30/19
White Mountain Community Health Center ***Meets CCP & ICP requirements as assessed by Region 7 IDN team***	Evidence Based Interventions: • Has a MAT program in place, has held a case conference with a full MDCT and have taken a pilot patient through the CCSA process Technology for at-risk patients: • Actively working to install shared care plan; • Working closely with Region 7 IDN Quality Improvement Coach to develop risk stratification processes	Coordinated Care Practice Designation met according to Region 7 IDN Evidence Based Interventions: • Provides comprehensive MAT services; active MAT program at capacity, working to expand and prescriber waiver increased to 100 to accommodate Technology for at-risk patients: • Working on risk stratification models	Coordinated Care Practice Designation • Met according to Region 7 IDN Evidence based interventions (MAT & Depression) • Provides comprehensive MAT services with the program currently operating at practice capacity • Waiting for Depression protocol Technology for at-risk patients: • Fully engaged with the Collective Medical network, including recently beginning to enter care guideline information • Continues to strengthen the use of risk stratification models within the practice Collaboration w/ Community Based Supports • Follows comprehensive referral coordination guidelines and care coordination workflow to collaborate with community-based supports

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Provider	Progress Toward Integrated Care Practice as of 6/30/18	Progress Toward Integrated Care Practice as of 12/31/18	Progress Toward Integrated Care Practice as of 6/30/19	Progress Toward Integrated Care Practice as of 12/31/19
Ammonoosuc Community Health Services ***Meets CCP & ICP requirements as assessed by Region 7 IDN team***	Coordinated Care Practice Designation • met as of 6/30/18 according to Region 7 IDN Evidence Based Interventions: • Provides MAT services Technology for at-risk patients • ACHS is working on a process to route the document to a patient navigator once it is completed for review and action if needed. The agency plans to finalize their CCSA protocol and once they have finished embedding a form into their tablets and anticipate they will have this completed before the end of 2018; Collaboration with Community Based Supports: • Agreements in place with North Country Serenity Center • Agreements in place with NCHC Friendship House to provide medical care to residential patients as needed	Coordinated Care Practice Designation • met as of 6/30/18 according to Region 7 IDN Evidence Based Interventions: • Provides MAT services Collaboration with Community Based Supports: • Implemented feedback loop to increase identification and timeliness of appointments for patients seen in ED for BH related issues (7% of ED pts were there for BH reasons, 5% were seen by ACHS for follow-up) • Working with North Country Serenity Center (NCSC) to provide Recovery Support services for 24 patients/clients with SUD since August 2018 while ACHS provides medical, dental, vision, BH, SUD, nutrition and patient navigation services with a goal to reduce recidivism, relapse rates, and expand BH services	Coordinated Care Practice Designation • Met according to Region 7 IDN Evidence based interventions (MAT & Depression) • Provides MAT services to internal patients • Follows standardized procedures for the treatment of depression Technology for at-risk patients • Engaged with the Collective Medical network during this reporting period; actively receiving event notifications • This partner has trained staff and is developing standardized procedures for use Collaboration w/ Community Based Supports • Continues to use feedback loop with LRH to track ED visits of patients • Continues to collaborate with North Country Serenity Center about mutual patients • Provides medical assessments to Friendship House patients • Positioned to collaborate with other CBOs as necessary	Coordinated Care Practice Designation • Met according to Region 7 IDN Evidence based interventions (MAT & Depression) • Provides MAT services to internal patients • Follows standardized procedures for the treatment of depression Technology for at-risk patients • Engaged with the Collective Medical network Collaboration w/ Community Based Supports • Continues to use feedback loop with LRH to track ED visits of patients • Continues to collaborate with North Country Serenity Center about mutual patients • Provides medical assessments to Friendship House patients • Positioned to collaborate with other CBOs as necessary
Coös County Family Health Services	Coordinated Care Practice Designation	Coordinated Care Practice Designation	Coordinated Care Practice Designation	Coordinated Care Practice Designation

Provider	Progress Toward Integrated Care Practice as of 6/30/18	Progress Toward Integrated Care Practice as of 12/31/18	Progress Toward Integrated Care Practice as of 6/30/19	Progress Toward Integrated Care Practice as of 12/31/19
	• in progress according to Region 7 IDN Evidence Based Interventions: • MAT program in place Technology for at-risk patients: • IDN staff have met with the CCFHS management team, provided a personalized demonstration of the shared care plan and offered education on 42 CFR consent tracking Collaboration with Community Based Supports: • Providing staff to CrossRoads clinic, a co-located site with Northern Human Services	• in progress according to Region 7 IDN Evidence Based Interventions: • Provides comprehensive MAT services • Expansion MAT program to accept referrals from primary care providers; five waivered prescribers and the program includes an RN, Recovery Coach and Women's Health staff • Seven BH staff attended Cherokee training and agency is working to implement BH services in a similar fashion to the Cherokee model Technology for at-risk patients: • Implemented event notifications, working to understand patient utilization of services • Care Coordinators log in daily to CMT, get info re: ADTs and find this very helpful, though not if patient seen at other sites that don't use CMT	• In progress according to Region 7 IDN Evidence based interventions (MAT & Depression) • This partner has recently expanded their existing MAT program to increase capacity within the community • Currently developing a formal protocol for the treatment of depression; the Region 7 IDN team will support this agency in these efforts Technology for at-risk patients • Continues to use event notifications in the care coordination department; care coordinators login daily and have found the system valuable • Uses a closed-loop referral system to monitor services ordered for patients Collaboration w/ Community Based Supports • Continue to develop joint service protocols with outside agencies • Regularly engaged in collaborative efforts with healthcare providers and CBSs to address needs of high-risk patients in their census	• In progress according to Region 7 IDN Evidence based interventions (MAT & Depression) • This partner has recently expanded their existing MAT program to increase capacity within the community • Uses treatment guidelines embedded in EMR Technology for at-risk patients • Continues to use event notifications in the care coordination department; care coordinators login daily and have found the system valuable • Uses a closed-loop referral system to monitor services ordered for patients Collaboration w/ Community Based Supports • Continue to develop joint service protocols with outside agencies • Regularly engaged in collaborative efforts with healthcare providers and CBSs to address needs of high-risk patients in their census
Friendship House	Coordinated Care Practice Designation • in progress according to Region 7 IDN Evidence Based Interventions:	Coordinated Care Practice Designation • in progress according to Region 7 IDN Evidence Based Interventions:	Coordinated Care Practice Designation • In progress according to Region 7 IDN Evidence based interventions (MAT & Depression)	Coordinated Care Practice Designation • In progress according to Region 7 IDN Evidence based interventions (MAT & Depression)

Provider	Progress Toward Integrated Care Practice as of 6/30/18	Progress Toward Integrated Care Practice as of 12/31/18	Progress Toward Integrated Care Practice as of 6/30/19	Progress Toward Integrated Care Practice as of 12/31/19
	• Working to improved treatment curriculum to enhance the treatment of co-occurring mental and SUD disorders. Technology for at-risk patients: • Not engaged in active work on the shared care plan due to 42CFR Part 2 constraints; IDN staff will engage with staff at Friendship House about the shared care plan in the next reporting period	• IOP Matrix Model, focus on education and awareness of symptoms r/t addiction, relapse prevention, community connections, and other needs as identified • Barriers to patient fidelity are transportation and lack of resources • CARF accreditation in progress • Agency working to implement MAT program Collaboration with Community Based Supports: • Agreements with ACHS and CCFHS for preadmission physicals • Working with agency staff regarding SCP implementation	• Focusing on building strong relationships with the Doorway NH sites rather than pursuing an internal MAT program to prevent duplication of services • Using new treatment curricula for clients – Seeking Safety focuses on co-occurring PTSD and SUD, and the agency is using the latest IOP Matrix Model • Follows standardized processes for treatment of depression Technology for at-risk patients • Updated multiple systems throughout the agency to prepare for CARF accreditation • IDN Team will reengage partner in the next reporting period to discuss engagement with the Collective Medical network Collaboration w/ Community Based Supports • Agreements continue to be in place with ACHS and CCFHS for preadmission physicals • Continue to collaborate with NCSC • Working to build relationships with LRH and AVH Doorway NH sites	• Focusing on building strong relationships with the Doorway NH sites rather than pursuing an internal MAT program to prevent duplication of services • Follows standardized processes for treatment of depression Technology for at-risk patients • Updated multiple systems throughout the agency to prepare for CARF accreditation • Interested in engagement with the Collective Medical network Collaboration w/ Community Based Supports • Agreements continue to be in place with ACHS and CCFHS for preadmission physicals • Continue to collaborate with NCSC • Established relationships with Doorway sites
Huggins Hospital ***Meets CCP & ICP requirements***	Coordinated Care Practice Designation	Coordinated Care Practice Designation • met according to Region 7 IDN	Coordinated Care Practice Designation • Met according to Region 7 IDN	Coordinated Care Practice Designation • Met according to Region 7 IDN

Provider	Progress Toward Integrated Care Practice as of 6/30/18	Progress Toward Integrated Care Practice as of 12/31/18	Progress Toward Integrated Care Practice as of 6/30/19	Progress Toward Integrated Care Practice as of 12/31/19
as assessed by Region 7 IDN team	• in progress according to Region 7 IDN Evidence Based Interventions: • They have received funds to stand up a MAT program during this period and have been shaping a MDCT to use in the upcoming reporting period;	Evidence Based Interventions: • MAT program under development Technology for at-risk patients: • Completed implementation steps with Collective Medical Technologies for PreManage ED at the Hospital and PreManage in their Clinic. The hospital is contributing ADT feeds to the CMT network. • Works closely with the IDN Quality Improvement Coach to address the DSRIP deliverables, has created a Multi-Disciplinary Core Team, supported by a psychiatrist as previously mentioned, and has implemented monthly case conferences • Focus on building Care Coordination staff to assure f/u. MDCT meets with BH staff, seek to engage PCPs next as capacity to support complex cases allows	Evidence based interventions (MAT & Depression) • During this reporting period this partner has dedicated significant effort to the development of their MAT program, predicting go-live in October 2019 • Utilizes standard screening and treatment protocols for depression Technology for at-risk patients • Fully engaged with the Collective Medical network and using it for both direct care delivery and quality improvement processes. Collaboration w/ Community Based Supports • Has standard systems in place to collaborate with Community Based Organizations	Evidence based interventions (MAT & Depression) • Soft launch of MAT program during this reporting period • Utilizes standard screening and treatment protocols for depression Technology for at-risk patients • Fully engaged with the Collective Medical network and using it for both direct care delivery and quality improvement processes. Collaboration w/ Community Based Supports • Has standard systems in place to collaborate with Community Based Organizations
Indian Stream Health Center ***Meets CCP & ICP requirements as assessed by Region 7 IDN team***	Coordinated Care Practice Designation • in progress according to Region 7 IDN	Coordinated Care Practice Designation • met according to Region 7 IDN Evidence Based Interventions: • Behavioral Health Team in place; provides therapy for clients of a local MAT program Technology for at-risk patients: • The AAFP model is used and six levels of	Coordinated Care Practice Designation • Met according to Region 7 IDN Evidence based interventions (MAT & Depression) • Has processes in place to refer patients to MAT prescribers and provides behavioral health services for patients receiving MAT	Coordinated Care Practice Designation • Met according to Region 7 IDN Evidence based interventions (MAT & Depression) • Has processes in place to refer patients to MAT prescribers and provides behavioral health services for patients receiving MAT

Provider	Progress Toward Integrated Care Practice as of 6/30/18	Progress Toward Integrated Care Practice as of 12/31/18	Progress Toward Integrated Care Practice as of 6/30/19	Progress Toward Integrated Care Practice as of 12/31/19
		risk are possible. Risk assessment is done directly in EMR on a separate tab with the ability to electronically indicate needed care management. • Exploring SCP implementation in early 2019 with demonstration of the product and articulated next steps. • BH and PCP meet weekly for MDCT meetings. Director of Quality developing clear written guidelines and CLR process. • EMR documentation to monitor • CLR is currently tracked using a spreadsheet with reports indicating needed follow-up	• Follows a standardized depression treatment policy throughout practice Technology for at-risk patients • Engaged in the Collective Medical network and receiving event notifications; working to embed system into daily staff processes Collaboration w/ Community Based Supports • This partner has a long history of collaborating with Community Based Organizations • Actively collaborating with Doorway NH and North Country Recovery Center to be • involved in SUD treatment services in the state's northernmost region	• Follows a standardized depression treatment policy throughout practice Technology for at-risk patients • Engaged in the Collective Medical network and receiving event notifications; working to embed system into daily staff processes Collaboration w/ Community Based Supports • This partner has a long history of collaborating with Community Based Organizations • Actively collaborating with Doorway NH and North Country Recovery Center to be involved in SUD treatment services in the state's northernmost region
Littleton Regional Healthcare	Coordinated Care Practice Designation • in progress according to Region 7 IDN • IDN staff have worked with the affiliation to engage them on integrated healthcare initiatives including rollout of shared care plan. • LRH will work to capture domains required in IDN CCSA and will work closely with Weeks Medical Center to help with this process;	Coordinated Care Practice Designation • in progress according to Region 7 IDN Evidence Based Interventions: • January 2019 NH Doorway will open at LRH Technology for at-risk patients: • CCSA in place. Need additional care coordination staff to address social determinants of health • EMR, eClinicalWorks, has built in registries for diabetes, heart failure, COPD. Await	Coordinated Care Practice Designation • In progress according to Region 7 IDN Evidence based interventions (MAT & Depression) • This partner refers patients to MAT services at their Littleton Doorway NH site, where they have subcontracted these services from Weeks Medical Center • Working with the Region 7 IDN team to implement a protocol for the treatment of depression Technology for at-risk patients	Coordinated Care Practice Designation • In progress according to Region 7 IDN Evidence based interventions (MAT & Depression) • This partner continues to refer patients to MAT services at their Littleton Doorway site • Working with the Region 7 IDN team to implement a protocol for the treatment of depression Technology for at-risk patients • Continuing to investigate ways in

Provider	Progress Toward Integrated Care Practice as of 6/30/18	Progress Toward Integrated Care Practice as of 12/31/18	Progress Toward Integrated Care Practice as of 6/30/19	Progress Toward Integrated Care Practice as of 12/31/19
	• ADT feeds should be live in next reporting period	SUD. Chronic care management; CCSA seen as critical to risk ID; Opioid risk assessment tool; Screen for PPD in new moms • Open EMR system between BH and PCP to monitor and manage care • Ticklers built into the EMR for referral reports arriving back from outside. Specific staff dedicated to tracking.	• Continuing to investigate ways in which the current EMR can be used to identify and coordinate care for high-risk patients; anticipating EMR changes in the coming year that may enhance these abilities • Collaborating with several commercial payers to also use their patient care opportunity portals to this end Collaboration w/ Community Based Supports • Has dedicated significant efforts this reporting period under the Doorway NH project to the development of strong relationships throughout the community	which the current EMR can be used to identify and coordinate care for high-risk patients; anticipating EMR changes in the coming year that may enhance these abilities • Collaborating with several commercial payers to also use their patient care opportunity portals to this end Collaboration w/ Community Based Supports • Has dedicated significant efforts this reporting period under the Doorway NH project to the development of strong relationships throughout the community
Memorial Hospital	Evidence Based Interventions: • New nurse practitioner has received certification in MAT • Have a robust BH integration project underway through MaineHealth	Coordinated Care Practice Designation • in progress according to Region 7 IDN Evidence Based Interventions: • Provides comprehensive MAT services • Focused on behavioral health integration, and MAT expansion • Six standardized assessments used across the system for SUD and BH Technology for at-risk patients: • SCP and ADT feeds to CMT next priority for IDN	Coordinated Care Practice Designation • In progress according to Region 7 IDN Evidence based interventions (MAT & Depression) • Continues to provide comprehensive Integrated MAT services • Using standardized policies and procedures for assessing and treating mild to moderate depression Technology for at-risk patients • Recently migrated to a new EMR that has enhanced their ability to use technology to	Coordinated Care Practice Designation • In progress according to Region 7 IDN Evidence based interventions (MAT & Depression) • Continues to provide comprehensive Integrated MAT services • Using standardized policies and procedures for assessing and treating mild to moderate depression Technology for at-risk patients • Recently migrated to a new EMR that has enhanced their ability to use technology to

Provider	Progress Toward Integrated Care Practice as of 6/30/18	Progress Toward Integrated Care Practice as of 12/31/18	Progress Toward Integrated Care Practice as of 6/30/19	Progress Toward Integrated Care Practice as of 12/31/19
		Collaboration with Community Based Supports: • Closed loop for internal patients, look to expand and focus on this for external referrals they receive	coordinate care; also using DSM and Imprivata Cortext to perform secure text messaging Collaboration w/ Community Based Supports • Recently began conversations with the recovery community to offer 24/7 emergency support services • Continue to use closed loop for internal patients • The Region 7 IDN team will continue to collaborate with this partner as they work to meet the DSRIP deliverables	coordinate care; also using DSM and Imprivata Cortext to perform secure text messaging • Contemplating engagement with Collective Medical Network Collaboration w/ Community Based Supports • Recently contracted with RCOs to offer 24/7 emergency recovery supoprt services • Continue to use closed loop for internal patients
Northern Human Services ***Meets CCP & ICP requirements as assessed by Region 7 IDN team***	Technology for at-risk patients: • Have been working on consent requirements and related processes relating to the shared care plan; • Actively engaged in shared care plan conversations	Technology for at-risk patients: • On site mtg with IDN HIT coach and CMT demonstration for SCP; first client population to be Assertive Community TX clients • To complete an initial census upload early in 2019 and begin live use early spring • Mid-January, upgrade with Esscentia for DSM • Event notifications soon, up and running in some locations • Risk stratification built into procedures Collaboration with Community Based Supports: • Developed best practices for communication about integrated care and shared care planning with staff and clients	Coordinated Care Practice Designation • Met according to Region 7 IDN Evidence based interventions (MAT & Depression) • Embedded treatment for mild to moderate depression in assessment processes following a standard protocol • Follows a standard referral protocol to provide clients with access to MAT services Technology for at-risk patients • Engaged with the Collective Medical network to enhance their use of technology to care for the highest-risk clients • Leveraged CCSA implementation to improve their quarterly screening	Coordinated Care Practice Designation • Met according to Region 7 IDN Evidence based interventions (MAT & Depression) • Embedded treatment for mild to moderate depression in assessment processes following a standard protocol • Follows a standard referral protocol to provide clients with access to MAT services Technology for at-risk patients • Engaged with the Collective Medical network to enhance their use of technology to care for the highest-risk clients • Leveraged CCSA implementation to improve their quarterly screening

Provider	Progress Toward Integrated Care Practice as of 6/30/18	Progress Toward Integrated Care Practice as of 12/31/18	Progress Toward Integrated Care Practice as of 6/30/19	Progress Toward Integrated Care Practice as of 12/31/19
		• Trained all staff on Integrated care process and introduced a brochure for clients that explains collaborative care • Consent requirements being finalized	process to enhance information shared with primary care providers Collaboration w/ Community Based Supports • Implemented best practices for communication about integrated care and shared care planning with staff and clients; all staff have received training and distributed client brochures at all sites • Implemented consent requirements throughout agency that incorporate collaboration with Community Based Organizations	process to enhance information shared with primary care providers Collaboration w/ Community Based Supports • Implemented consent requirements throughout agency that incorporate collaboration with Community Based Organizations
Rowe Health Center	***Coordinated Care Practice Designation in progress according to Region 7 IDN*** • The health center continues to build capacity to implement integrated healthcare. They received IDN funding to hire a consultant to help them work toward this goal. Conversations continue around the CCSA and shared care plan	***Coordinated Care Practice Designation met according to Region 7 IDN*** Evidence Based Interventions: • IDN staff will continue to engage with Rowe Health Center on evidence-based interventions • Technology for at-risk patients: • Demo on CMT, shared care plan and prospect of sending/receiving ADT data for risk identification of high utilizers. • Major step taken in conjunction with Cottage Hospital was to adopt and implement the same EMR. •	Coordinated Care Practice Designation • In progress according to Region 7 IDN Evidence based interventions (MAT & Depression) • This partner does not currently offer MAT services • The Region 7 IDN team will continue to support his partner in their efforts to codify existing processes related to the treatment of depression and referral to MAT Technology for at-risk patients • This partner leverages technology to identify and deliver care to at-risk patients; has piloted population health tools under a	Coordinated Care Practice Designation • Met according to Region 7 IDN Evidence based interventions (MAT & Depression) • Offers MAT to patients through MOU with Little Rivers Technology for at-risk patients • This partner leverages technology to identify and deliver care to at-risk patients; has piloted population health tools under a Medicare ACO and is currently engaging in the Collective Medical network. Collaboration w/ Community Based Supports

Provider	Progress Toward Integrated Care Practice as of 6/30/18	Progress Toward Integrated Care Practice as of 12/31/18	Progress Toward Integrated Care Practice as of 6/30/19	Progress Toward Integrated Care Practice as of 12/31/19
			Medicare ACO and is currently engaging in the Collective Medical network. Collaboration w/ Community Based Supports • In process of formalizing systems to collaborate with outside agencies • The Region 7 IDN team will continue to assist this partner as it develops tools to enhance collaboration with community-based supports	• In process of formalizing systems to collaborate with outside agencies • The Region 7 IDN team will continue to assist this partner as it develops tools to enhance collaboration with community-based supports
Saco River Medical Group	***Coordinated Care Practice Designation in progress according to Region 7 IDN*** Evidence Based Interventions: • Saco River Medical Group has a MAT program in place	***Coordinated Care Practice Designation in progress according to Region 7 IDN*** Evidence Based Interventions: • Provides MAT services and has multiple protocols and documents in place to ensure program success. • Does not have a formal depression workflow or protocol in place however they have a draft outline of a depression screening protocol and are working with IDN team to explore IMPACT model and other models Technology for at-risk patients: • Decision support built into EMR; using as conditional logic model for patients who should have specific follow-up at next appt. and Working to stratify COPD, CHF	Coordinated Care Practice Designation • In progress according to Region 7 IDN Evidence based interventions (MAT & Depression) • During this reporting period, this partner expanded existing MAT services • formal depression treatment protocol in place Technology for at-risk patients • Continues to leverage EMR features to check on referral status, SUD, and developmental screenings • This partner also works within a Medicare ACO and with incentivized payer contracts – programs that have helped them leverage technology to enhance care delivery for high-risk patients	Coordinated Care Practice Designation • In progress according to Region 7 IDN Evidence based interventions (MAT & Depression) • Provides MAT services • Formal depression treatment protocol in place Technology for at-risk patients • Continues to leverage EMR features to check on referral status, SUD, and developmental screenings • This partner also works within a Medicare ACO and with incentivized payer contracts – programs that have helped them leverage technology to enhance care delivery for high-risk patients Collaboration w/ Community Based Supports

Provider	Progress Toward Integrated Care Practice as of 6/30/18	Progress Toward Integrated Care Practice as of 12/31/18	Progress Toward Integrated Care Practice as of 6/30/19	Progress Toward Integrated Care Practice as of 12/31/19
		• Currently using EMR for SUD, developmental screen, hypertension, diabetes, care management and monitoring • Using EMR to check on referral out information (once back in record)	Collaboration w/ Community Based Supports • Actively dedicating efforts to building strong relationships with outside agencies, including an interest in joining Northern Human Services to stand up an integrated clinic in their community • The Region 7 IDN team continues to support this partner's efforts in formalizing these referral relationships as they are developed	• Actively dedicating efforts to building strong relationships with outside agencies, including an interest in joining Northern Human Services to stand up an integrated clinic in their community • The Region 7 IDN team continues to support this partner's efforts in formalizing these referral relationships as they are developed
Weeks Medical Center ***Meets CCP & ICP requirements as assessed by Region 7 IDN team***	Evidence Based Interventions: • Weeks has a robust MAT program Technology for at-risk patients: • Weeks was able to leverage an existing ADT connection to Dartmouth-Hitchcock Medical Center to quick-start contributing ADT feeds to the CMT network. • NCH has also agreed to begin implementing the shared care plan; this will occur first at the WMC Emergency Department	Coordinated Care Practice Designation met according to Region 7 IDN Evidence Based Interventions: • Provides comprehensive MAT services • Working closely with AVH and LRH to stand up NH Doorway hubs • Peer Recovery Coach Academy training to be attended by two MAs and a case manager in early 2019 • DSM through Imprivata for all hospitals and partners slated to be completed first quarter, 2019 Technology for at-risk patients: • Risk stratification through EMR, flags two or more chronic conditions as well as identified through private insurers	Coordinated Care Practice Designation • Met according to Region 7 IDN Evidence based interventions (MAT & Depression) • Continue to offer comprehensive MAT and behavioral health services through the North Country Recovery Center and as a sub-contractor of MAT services for the Berlin and Littleton Doorway NH sites • Follows standardized protocols for the treatment of mild to moderate depression Technology for at-risk patients • Continues to use risk stratification system through EMR and the Collective Medical network (PreManage ED) to coordinate care for at-risk patients	Coordinated Care Practice Designation • Met according to Region 7 IDN Evidence based interventions (MAT & Depression) • Continue to offer comprehensive MAT and behavioral health services through the North Country Recovery Center and as a sub-contractor of MAT services for the Berlin and Littleton Doorway NH sites • Follows standardized protocols for the treatment of mild to moderate depression Technology for at-risk patients • Continues to use risk stratification system through EMR and the Collective Medical network (PreManage ED) to coordinate care for at-risk patients

Provider	Progress Toward Integrated Care Practice as of 6/30/18	Progress Toward Integrated Care Practice as of 12/31/18	Progress Toward Integrated Care Practice as of 6/30/19	Progress Toward Integrated Care Practice as of 12/31/19
			Collaboration w/ Community Based Supports • Have structured processes to collaborate with Community-Based Organizations • Has a strong relationship with NCHC Community Health Workers, who are used to provide community-based care coordination for at-risk patients	Collaboration w/ Community Based Supports • Have structured processes to collaborate with Community-Based Organizations • Has a strong relationship with NCHC Community Health Workers, who are used to provide community-based care coordination for at-risk patients
White Horse Addiction Center	Coordinated Care Practice Designation in progress according to Region 7 IDN • IDN team will continue to gather additional information on required aspects of integrated care destination	Coordinated Care Practice Designation in progress according to Region 7 IDN • IDN team will continue to gather additional information on required aspects of integrated care destination	Coordinated Care Practice Designation • In progress according to Region 7 IDN Evidence based interventions (MAT & Depression) • In the process of developing an MAT program to align with the recent onboarding of an MAT waivered nurse practitioner • Has expressed an interest in assistance from the Region 7 IDN team in codifying depression treatment protocols Technology for at-risk patients • In the process of selecting an electronic health record platform in order to begin leveraging technology to coordinate patient/client care. Collaboration w/ Community Based Supports	Coordinated Care Practice Designation • In progress according to Region 7 IDN Evidence based interventions (MAT & Depression) • Implemented MAT program to align with the recent onboarding of an MAT waivered nurse practitioner • Has expressed an interest in assistance from the Region 7 IDN team in codifying depression treatment protocols Technology for at-risk patients • Implemented an EMR this period that provides all required technology Collaboration w/ Community Based Supports • Collaborating with Mount Washington Valley Supports Recovery to provide 24/7 emergency peer recovery support

Provider	Progress Toward Integrated Care Practice as of 6/30/18	Progress Toward Integrated Care Practice as of 12/31/18	Progress Toward Integrated Care Practice as of 6/30/19	Progress Toward Integrated Care Practice as of 12/31/19
			• WHAC is collaborating with Mount Washington Valley Supports Recovery to develop protocols for their new 24/7 emergency peer recovery support • The Region 7 IDN team will continue to provide support to this partner as it works to meet DSRIP requirements	
White Mountain Community Health Center ***Meets CCP & ICP requirements as assessed by Region 7 IDN team***	Evidence Based Interventions: • Has a MAT program in place, has held a case conference with a full MDCT and have taken a pilot patient through the CCSA process Technology for at-risk patients: • Actively working to install shared care plan; • Working closely with Region 7 IDN Quality Improvement Coach to develop risk stratification processes	Coordinated Care Practice Designation met according to Region 7 IDN Evidence Based Interventions: • Provides comprehensive MAT services; active MAT program at capacity, working to expand and prescriber waiver increased to 100 to accommodate Technology for at-risk patients: • Working on risk stratification models	Coordinated Care Practice Designation • Met according to Region 7 IDN Evidence based interventions (MAT & Depression) • Provides comprehensive MAT services with the program currently operating at practice capacity • Waiting for Depression protocol Technology for at-risk patients: • Fully engaged with the Collective Medical network, including recently beginning to enter care guideline information • Continues to strengthen the use of risk stratification models within the practice Collaboration w/ Community Based Supports • Follows comprehensive referral coordination guidelines and care coordination workflow to collaborate with	Coordinated Care Practice Designation • Met according to Region 7 IDN Evidence based interventions (MAT & Depression) • Provides comprehensive MAT services with the program currently operating at practice capacity • Has adopted evidence based practices for the treatment of depression Technology for at-risk patients: • Fully engaged with the Collective Medical network, including recently beginning to enter care guideline information • Continues to strengthen the use of risk stratification models within the practice Collaboration w/ Community Based Supports • Follows comprehensive referral coordination guidelines and care

Provider	Progress Toward Integrated Care Practice as of 6/30/18	Progress Toward Integrated Care Practice as of 12/31/18	Progress Toward Integrated Care Practice as of 6/30/19	Progress Toward Integrated Care Practice as of 12/31/19
			community-based supports	coordination workflow to collaborate with community-based supports

Projects C: Care Transitions-Focused

IDN Community Project Implementation and Clinical Services Infrastructure Plan

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

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

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

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

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

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

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

December 31, 2018

During the reporting period of 07/01/2018-12/31/2018 Region 7 IDN had no members join or leave the network.

Region 7 IDN chose Care Transition Teams as the C1 Community Project and has been consistently making progress to grow the Critical Time Intervention (CTI) network in the region. CTI's evidence-based approach to serving vulnerable populations when supports are critical by providing focused care at staged levels of decreasing intensity is helping clients overcome barriers as they make major transitions. Region 7 has been working to implement CTI Teams to address many different transitions and currently has teams for homelessness to housing, incarceration to community, and SUD issues to treatment. Plans are in the works to stand up teams for discharge from both medical and psychiatric hospitals to the community. This comprehensive approach of embedding CTI Teams in agencies to address many different transitions is taking longer to implement than the approach of utilizing one team that grows larger; however, it is setting the region up well for sustainability. Region 7 IDN was also faced with another setback after losing their NCHC project coordinator whose main focus was convening the CTI partners to move the project forward.

The five IDNs that are working on the C1 project held a CTI Train-the-Trainer training in August 2018 in Plymouth, NH for fourteen participants and two facilitators from the Center for the Advancement of CTI (CACTI). Two of those participants were from Region 7. NCHC, as the Region 7 IDN lead agency, took responsibility for planning the location, travel details, and registration process for the event. The training objectives stated that participants would be able to describe three best practices for trainers, present a 5-7 minute overview of the basics of CTI, explain team members' roles and responsibilities in

each CTI phase, facilitate discussion about challenges and opportunities in each CTI phase, demonstrate a "tell, show, do, apply" approach to training, and enhance skillfulness as a trainer through practice with feedback. This training now allows all five regions to adapt the training to their needs; whether it be a one-hour presentation to partners, a one-day training within an agency, or a two-day training for people from agencies who are new to CTI.

Trainers from IDN Region 6 & 7 worked closely with staff from CACTI to plan and conduct a two-day CTI Worker Training for 23 participants at the beginning of November 2018. One CTI Worker from Region 1 and one from Region 4 were able to join the other two regions on Day 1 at Plymouth State University. The topics included CTI Model & Essentials, Practical Strategies useful in CTI, and Getting Started with CTI – Case Scenarios. On Day 2, Region 6 met in Dover to continue with training specific to their region while the 15 participants from Region 7 met in Littleton. Topics for Region 7 were Community Partners Activity, CTI Team Structure & Teamwork, Fidelity Monitoring & Quality Assurance, and How to Implement a New Team/Strengthen an Existing Team. The day also included a virtual visit from Kim Livingstone of CACTI for technical assistance and additional questions. Evaluation from both days were very positive.

The CTI-NH Community of Practice continued with monthly virtual meetings and quarterly in-person meetings with logistical support from Region 7 IDN. These meetings provided the five regions an opportunity to share new information about CTI work including successes and challenges with the contribution of feedback from others with similar experiences. Some commonalities that arose were issues with receiving timely and appropriate referrals, thoughts of moving to electronic tracking and documentation, problems with finding housing, and feelings of gratification when clients made gains. Participants have expressed that the collaboration and knowing they are not alone in their experiences has been beneficial. The September in-person meeting in Concord included the updates from each region as well as a Harm Reduction Training for 19 participants, three of whom were from Region 7 IDN. Due to scheduling complications, all regions agreed that the December in-person meeting would be postponed until January. The plan is to widen the scope of experiences beyond NH by reaching out to the CTI Global Network and inviting their participation in the CTI-NH Community of Practice in the coming year. New and updated materials are continuously being added to the CTI Project on Basecamp for new and existing CTI Workers to access. Basecamp is a platform managed by Region 7 IDN as a vehicle for communication and documentation sharing; an updated distribution list for CTI-NH CoP is also stored there.

The five IDNs working on CTI agreed to extend the contract with Hunter College for another year to include the following tasks; supervisor training, Community of Practice meeting facilitation, program level coaching support, fidelity training, and fidelity consultation to assist local staff to carry out fidelity assessments. Every region expressed the value of this relationship and looks forward to continued guidance from the Center for the Advancement of Critical Time Intervention (CACTI). Region 7 IDN had planned to have a supervisor training in 2018, but after discussions with the other IDNs participating in the project, the decision was made to postpone the supervisor training until 2019 to maximize the number of participants across the state.

Region 7 IDN currently has thirty-seven trained CTI Workers and three CTI Supervisors. Four CTI Workers left their positions in the last reporting period leaving twenty in the region of the twenty-four previously trained. One of the attendees at the CTI Training in November had previously attended a training, so that leaves fourteen newly trained CTI Workers for this reporting period. The previous twenty added to the seventeen newly trained brings the total to thirty-seven. One previously trained CTI worker left one agency but joined another one in the region which did not affect the total. It did increase the number of agencies in the region with trained CTI Workers by one. The training in November increased the number by an additional one bringing the total of agencies with CTI Workers and/or CTI Supervisors to eleven. These agencies will be referenced below.

Carroll County Department of Corrections (CCDoC) still has two CTI Workers one of whom is also a CTI Supervisor. In September 2018, CCDoC had their first client (and the first for Region 7) complete all three phases of the CTI program (nine months total) and get discharged. CCDoC served five clients with CTI services and connected all five to community resources during this reporting period. This agency does not have a need for outside referrals since their clientele come directly from the incarcerated individuals who are transitioning to the community. The CTI workers at CCDoC have expressed that transportation remains a barrier because they are not able to transport individuals in their own vehicles. Having the extended time for Pre-CTI helps to build relationships and encourage client engagement. The partner does not have agreements in place between collaborating organizations because the region is still working to get additional agencies to participate. CCDoC continues to have challenges with regards to executing the CTI model with fidelity. Region 7 IDN team plans to engage with CCDoC more during this next reporting period to help enhance their program further.

The Family Resource Center at Gorham (FRC) is using CTI with their clients engaged in their new Strength to Succeed program. The agency has eleven staff trained as CTI Workers. One previously trained worker left the agency in the last reporting period, but six were newly trained in the same time frame. The clients in Strength to Succeed are involved with the Division of Children, Youth, and Families (DCYF) and have a substance use disorder. Originally, it only included those who already had children removed from the home but has since expanded to include those at risk of having children removed. Parent partners who have lived experience similar to the referred population work with the clients using the Critical Time Intervention approach. The focus is on connecting the parents to SUD treatment along with linking them to other community services that will support them in recovery. FRC served ten clients with the CTI model during this last period, connecting all ten clients to community resources. The agency does not currently have agreements in place between collaborating organizations. They do have a LICSW who is the clinical supervisor to oversee CTI fidelity. FRC hired a Program Administrator and Recovery/Prevention Specialist who will be managing the expansion of the Strength to Succeed program and enhance the implementation of CTI.

Tri-County Community Action Program (TCCAP) has struggled with unexpected staff turnover which has slowed the implementation of CTI. However, they have taken that opportunity to restructure job roles and assign responsibilities to complement skill sets creating capacity to fully execute the CTI program to fidelity. All positions (see the staffing chart below) have now been filled bringing their total number of trained CTI Workers to seven including one who is also trained as a CTI Supervisor and one as a CTI Trainer. Of the four employees that left during this reporting period, two had not yet attended a training and one moved to Huggins Hospital which is another partner in Region 7. Four of the five new employees from this reporting period attended the CTI Worker Training in November while the fifth employee had attended the training in November of 2017.

TCCAP is positioned in all three counties included in Region 7 IDN and addresses the homeless or at risk of homelessness to housing transition. They had been providing Pre-CTI services prior to this reporting period but are now moving eligible clients into the other three phases of CTI. During this period, they have provided CTI services to ten clients, eight with Pre-CTI and two in Phase 1, all of which were connected to community resources. This soft roll-out will allow for process improvement prior to accepting referrals from partner agencies. The agency has obtained verbal commitments from outside referring agencies and will fully execute MOU's upon the approval of continuation of program funding. The plan was to finalize agreements with area providers and begin accepting referrals from external partners beginning 1/3/19. Due to the uncertainty of funding to reimburse for the period of 12/17/18-6/30/19, the agency has postponed execution of agreements until continuation of funding for the program is confirmed.

TCCAP is also proactively exploring future options for delivery of some components of the program through secured teleconferencing equipment. As caseloads increase the ability to utilize technology to

reduce the burden of travel time and expense will be vital. They are currently researching programs located in rural US, one specifically in New Mexico, utilizing technology and evaluating whether the model would meet the unique needs of Region 7 while preserving program fidelity.

TCCAP created quality assurance tools to test and monitor both the fidelity of the model and staff competency. Supervision is conducted weekly through both individual sessions and group-peer collaboration. Current Pre-CTI and CTI clients are discussed during supervision. Client level data, including transition and review dates are tracked and monitored on an internal spreadsheet; with reminder notifications set using Microsoft outlook shared calendars.

The manager of the Homeless Intervention Program Manager and the Director of Compliance will be conducting monthly QA reviews beginning the third week of January and monthly thereafter; this coincides with the initial 30-day period following enrollment of our initial CTI Phase 1 client. Non-compliance to the fidelity of the model or necessary alterations will be addressed during the monthly QA reviews accompanied by a plan of correction when necessary. These staff members are also working to develop a 6-week follow-up survey for clients that graduate from the program to capture outcomes.

Northern Human Services (NHS) lost a staff member during the last reporting period that was trained in CTI but was able to get two employees trained in November. Littleton Regional Healthcare (LRH) also sent two people to the same training. As mentioned earlier, Huggins Hospital hired a new employee who was previously trained. The remainder of agencies also have workers who were previously trained; one at Weeks Medical Center, five at Crotched Mountain (statewide partner), one at White Mountain Community Health Center, one at White Horse Addiction Center, and one at North Country Health Consortium. Many of these agencies plan to implement CTI once IDN funds are secured for the region. Staff from these various agencies have been engaging in CTI meetings throughout this period and plan to continue participating as the project moves forward.

The 5 IDN Regions plan to meet with CACTI staff at the end of January to develop a 2019 training plan and discuss the best use of resources to increase the adoption of CTI throughout the state.

June 30, 2019 Update

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

Network Membership

During the reporting period of January 1 through June 30, 2019, Region 7 IDN had no members join or leave the network. The information below speaks to the progress that Region 7 IDN has made on the C1 “Care Transitions” Community Project during this reporting period.

Region 7 IDN Data Governance

As Region 7 IDN adopted the new DHHS Monthly Update reporting format this spring, efforts were expended to verify the total number of individuals served by each Region 7 IDN partner to date and leverage the State’s reporting tool as a mechanism that will help partners report monthly totals for the remainder of the DSRIP. By utilizing the State’s new monthly reporting mechanism as the backbone of a high-integrity data management process, the Region 7 IDN team hopes to ease the reporting burden for partners while retaining the ability to collect, aggregate and analyze data for the region as a whole. This revised process is anticipated to allow the region to evaluate progress on performance evaluation targets more frequently and help the Region 7 IDN team provide more timely feedback and support to the region’s partners. Partner specific updates in this section reflect narrative regarding their progress along the continuum of the project, and their total number of unique individuals served during the DSRIP period through June 30, 2019.

Region 7 CTI Partner Specific Updates

Region 7 IDN partner agencies involved with the implementation of Critical Time Intervention (CTI) have maintained momentum in their care transition projects over the past 6 months despite delays in funding for some of these projects. Kim Livingstone, a consultant from the Center for the Advancement of Critical Time Intervention (CACTI), confirmed that the intensive pre-CTI work done with clients could be counted when tallying individuals served by Region 7 CTI projects. This important foundational work represents the most substantial portion of care coordination activities performed by Region 7 CTI teams, especially with incarcerated individuals at Carroll County Department of Corrections (CCDoC) and sheltered guests being served by the Tri-County Community Action Program (TCCAP)'s Housing Intervention and Prevention program. This clarification allowed Region 7 IDN to recalculate the number of individuals served by all CTI programs in the region regardless of phase. As a result, Region 7 IDN met or exceeded all Performance Evaluation Targets for this Community Driven Project by December 31, 2018. Updates for the Region 7 IDN Care Transitions Project include:

- *Carroll County Department of Corrections (CCDoC):* Carroll County Department of Corrections reported that they continued to use a strong pre-CTI focus during incarceration as part of their ongoing Transitional Reentry Under Supportive Treatment (TRUST) Program, performing in-depth assessments within the first 48 hours of incarceration and working intensively with individuals in the 90 days prior to release to connect them to community-based supports for needs identified at intake. Following release, the TRUST program continues aftercare through the remaining CTI phases for up to a year. During this reporting period CCDoC shared that their TRUST program has driven down their recidivism rates to almost a quarter of the national average. They have also identified that completion of the program is a compelling factor when requests are made of the courts to shorten probation sentences, further decreasing the burden of corrections expense on the county. The agency would like to establish an arrangement with a community-based CTI team at some point, because there are limitations to the work that jail employees can perform in community, particularly if an individual is released outside Carroll County. During the reporting period of January-June 2019 CCDoC served 84 TRUST candidates using the CTI model.
- *Family Resource Center (FRC):* This reporting period, the Family Resource Center sent one staff person to the statewide CTI Supervisor Training on May 6. This partner reported that their CTI team meets on a weekly basis, and for most of the reporting period those meetings were convened and overseen by an LICSW. The FRC also reported that their Parent Partners are co-trained as both CTI workers and Peer Recovery Coaches who are working towards Certified Recovery Support Worker (CRSW) status. This partner is using the CTI model as part of their Strength to Succeed program and has identified the CRSW status as an important part of their sustainability plan for their Strengths to Succeed program so that the work will be billable as a recovery support service when their current grant funding expires next year. To further this goal, toward the end of this reporting period the FRC added an MLADC to the team who can provide the necessary supervision of CRSWs in the future. This partner has indicated that they have concerns about expending efforts to meet CTI fidelity requirements after the end of the DSRIP without further clarity from the State about reimbursement for CTI services. They report that they will instead likely use a CTI-informed approach in the delivery of reimbursable recovery support services as the primary means of sustaining their program. Family Resource Center reported serving 37 new clients during the reporting period of January-June 2019.
- *Tri-County Community Action Program (TCCAP):* This partner continues to maintain a strong pre-CTI focus with guests at Tyler Blain House while they work toward securing permanent housing in the community. TCCAP reported that the shelter's average length of stay has decreased from over 12

months per guest to 4.5 month increasing access to shelter for others in crisis. Although delays in funding impacted this partner's ability to accept new applicants during this reporting period because staff salaries were supported by IDN funds, the agency did continue serving the 3 active clients they had and reported ten more clients served by their CTI workforce. At the region's Annual Meeting in June, TCCAP also shared a testimonial video from a client who was served by the CTI program at the Tyler Blain House. He reflected on how the agency helped him to overcome barriers that might have otherwise derailed him from securing permanent housing and helped him to form connections to recovery treatment and support providers in the community. TCCAP continues to demonstrate strong commitment to operating their CTI program to fidelity and noted that internal resources would be reallocated to expand the program as soon as IDN funding was received to support these efforts. In the interim, TCCAP supported sending the Manager of their Homeless Intervention and Prevention Program to the CTI Supervisor Training on May 6 and the upcoming Fidelity Training in July.

- *Re-invigoration of the Region 7 CTI Mini Learning Collaborative:* The Region 7 IDN team continued efforts to bring together representatives from the 3 unique CTI projects administered by community-based organizations in the region. While each of these IDN partners has expressed a willingness to participate in this regional peer learning opportunity, finding a mutually convenient meeting time has proven challenging. Attendance on the monthly calls has also been challenged by delays in funding, as some partners were unable to support staff time spent outside the direct delivery of CTI services to individuals already enrolled in their programs. The IDN 7 team continued to engage Region 7 CTI partners in program status update conversations, encouraged partners to participate in the NH Community of Practice calls, and is working to establish a new meeting schedule that will garner better regional attendance.

Coordination of Statewide CTI Activities

The Region 7 IDN Team continued to serve as the coordinator of statewide CTI activities for the five IDN regions implementing CTI programs (Regions 1, 3, 4, 6, and 7), convening NH Community of Practice meetings and statewide CTI trainings. The NH Community of Practice met monthly during this reporting period, including two in-person gatherings in January and April. These meetings continue to provide CTI teams across the state with an opportunity to share successes and challenges; participants share that this collaborative learning opportunity is value-added, particularly the quarterly in-person gatherings. Additional statewide activities during this reporting period focused on three primary subject areas:

- *Ongoing workforce training opportunities:* The Region 7 IDN team coordinated a statewide CTI Supervisor training on May 6 for CTI partners from Regions 3, 4 and 7. The training was taught by CACTI Consultant Janice Bainbridge and focused on the role of a CTI Supervisor, an overview of case studies, the relationship between CTI supervision and case management, and the importance of building strong relationships with community resources working with CTI clients. A total of seven people participated in this training, three of which were from Region 7 IDN.
- *Sustainability of CTI through NH Medicaid reimbursement:* At the request of the NH CTI Community of Practice, Region 7 IDN worked with CACTI consultant Kim Livingstone to convene a facilitated call on May 29 with stakeholders from State of NH DHHS, CACTI, IDN Team Leads from the five regions implementing the CTI model and representatives from several CTI programs. Discussion focused on determining the value of CTI activities (both face-to-face and outside patient/client interactions) and coordinating coverage of CTI as a reimbursable service under Alternative Payment Models in general and by the NH Medicaid Managed Care Organizations specifically. The group agreed that methodologies for performance-based reimbursement could be addressed by the statewide Billing

and Coding Workgroup, though the discussions would likely need to be informed by those working directly on the CTI project.

- *Fidelity of CTI projects:* The NH CTI Community of Practice identified program fidelity as an important component in securing sustainable funding for this model, particularly in the context of discussions regarding payer reimbursement for care coordination at critical transition points. During this reporting period, Region 7 IDN arranged for a CTI Fidelity Training to occur on July 18 for the five IDN Regions implementing the CTI model. Sally Conover, fidelity consultant for CACTI, will be providing this education with an eye toward preparing a cadre of experts in the state that could be deployed regularly to assess CTI programs. It is anticipated that more than 20 participants representing all five regions will participate in the training, where they will learn how to use evidence-based measurement tools to ascertain whether programs using the CTI model of transitional care have implemented the model to fidelity, lending credence to each program's ability to meet outcome targets for successful care coordination during transitions.

December 31, 2019 Update

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

Network Membership

During the reporting period of July 1 through December 31, 2019, no partners have left the network. The Region 7 IDN had one new member join the network – Coös County Department of Corrections – bringing the total number of partners in the Region 7 IDN to thirty-nine (39).

The information below speaks to the progress that Region 7 IDN has made on the C1 "Care Transitions" Community Project during this reporting period.

Region 7 CTI Partner Specific Updates

Partner specific updates in this section reflect narrative regarding their progress along the continuum of the project, and their total number of unique individuals served during the DSRIP period through December 31, 2019.

Having previously been scored as meeting all targets in this community-based project, Region 7 IDN partner agencies involved with the implementation of Critical Time Intervention (CTI) continued to operate their transitions programs as previously reported, adding additional individuals served and working towards sustainability of their case management services during the current reporting period. Partner-specific updates for the Region 7 IDN Care Transitions Project include:

- *Carroll County Department of Corrections (CCDoC):* CCDoC reports that they continue to use CTI methods in serving the population at the Carroll County jail, primarily in the pre-CTI phase due to the constraints of the team being directly employed by the facility and therefore unable to follow incarcerated individuals into community post-release. Their staffing has remained stable, with one CTI worker and one CTI supervisor. Although the team's clinician/CTI Supervisor does hold regular group meetings in community for follow-up with individuals released into Carroll County, the bulk of inmates currently in the program did not originate in Carroll County and return to communities in other counties around the state. Most notably, CCDoC houses a number of female inmates originally sentenced in Rockingham County because that county does not have a women's facility. CCDoC has been collaborating with the Superintendent of Coös County Department of Corrections during this reporting period as that facility works to provide enhanced case management services to their population of incarcerated individuals with known release dates. Central to Coös' approach is

the use of an external case manager who has better flexibility to follow released individuals into the community locally, and provide warm handoffs to case managers in other New Hampshire communities when the individuals are released to counties other than Coös. Although CTI is not being implemented at the Coös facility, their staffing model was adopted, in part, based on the feedback from CCDoC about the challenges of using jail staff to coordinate case management.

- *Family Resource Center (FRC):* FRC reports that they continue to move their Strengths to Succeed staff to Certified Recovery Support Worker status so their services can be billed and reimbursed in a sustainable fashion. The team continues to use a CTI-informed approach to their case management services when working with families in the Strength to Succeed program, where the transition of interest is in moving these parents from "poorly connected to resources" to "well connected to resources" as they work to reunify their families under the oversight of DCYF. The process of achieving CRSW status for staff was challenged by a lack of necessary MLADC supervision, but FRC has contracted with a local person in private practice and their staff are now progressing along that career path. The FRC continues to share stories of the progressive success of their clients as they gain the skills necessary to enter and maintain sobriety, satisfy requirements of reunification, and strengthen the health and wellbeing of their families. FRC continues to remain engaged in a number of initiatives in Coös County aimed at improving the protective factors for North Country residents.
- *Tri-County Community Action Program (TCCAP):* Despite getting a slow start on the launch of their CTI program due to delays in the release of project funding at the beginning of 2019, the TCCAP team of Homelessness Intervention and Prevention (HIP) specialists has fully adopted the CTI model, using it with clients in all three Region 7 IDN counties. Initially, TCCAP reported great success of the program evidenced by a significant reduction in length of staff at their homeless shelter, the Tyler Blain House in Lancaster, from over 12 months to just over 4 months per individual served. As the year ended, TCCAP also noted that they were seeing a significant decrease in the number of clients who returned for additional services after completing the phases of CTI. TCCAP's CTI Supervisor credits this success to the intensive supports offered at the beginning of their work with clients. In particular, they note that CTI workers are able to role model the development and maintenance of healthy relationships with landlords, neighbors and utility companies – skills that many clients do not have well developed at the start of their work together. Similarly, during the CTI process, HIP specialists use motivational interviewing techniques to help clients identify long-term goals and indicators of successful independence, and then hold those goals and thoughts about success central to their decision making. TCCAP credits the rapport that HIP specialists are able to develop with clients during the intensive supports provided in pre-CTI and Phase 1 as the foundation to being able to have difficult conversations which ultimately can lead to behavioral change. For example, many clients lack the necessary skills and confidence to set long-range goals and meet them. The HIP specialists at TCCAP use the CTI model to first help the clients give voice to their vision of success, and then establish goals to reach those visions. When decisions are made, the HIP specialists are able to challenge clients to evaluate their options more closely when they appear to be making choices that are not aligned with those goals. TCCAP reports that this is an action historically perceived by clients as confrontational when done by other case managers, but is received as helpful guidance when carried out by the HIP specialist with whom they've worked so closely. They also report that a secondary key to their success is the ability of their HIP specialists to collaborate with other Region 7 IDN partners who provide other services necessary to address the client needs identified through the initial intake assessment performed by CTI workers. They report that "knowing our lane and staying in it" is important in terms of using their limited resources most effectively. TCCAP staff have shown that this case management model is having significant positive

effects in the region and have adopted the method for use with all clients, regardless of their Medicaid status. They look forward to forthcoming reimbursement models that may allow them to continue this work.

- *Region 7 CTI Mini Learning Collaborative:* Despite multiple attempts to convene regular meetings of the Region 7 CTI community of practice for shared learning, it has not been possible to make this mini learning collaborative a successful undertaking. The significant variation in implementation methods and populations served, in addition to perpetual scheduling conflicts, have led the teams in Region 7 to the conclusion that this is not a value-added undertaking. Rather than continuing efforts to convene the learning collaborative, teams have been happy utilizing the Region 7 IDN team and the Center for the Advancement of Critical Time Intervention (CACTI) supports available to them as resources for information and assistance on an as-needed basis. Teams continue to be looped in to the greater NH CTI Community of Practice activities and membership.

Coordination of Statewide CTI Activities

The Region 7 IDN Team continued to serve as the coordinator of statewide CTI activities for the five IDN regions implementing CTI programs (Regions 1, 3, 4, 6, and 7), convening NH Community of Practice meetings and statewide CTI trainings. The NH Community of Practice met monthly via Zoom connection through the end of the CACTI contract in September, as well as in person on July 23. These meetings continue to provide CTI teams across the state with an opportunity to share successes and challenges; participants share that this collaborative learning opportunity is value-added, particularly the quarterly in-person gatherings. Additional statewide activities during this reporting period included:

- *Ongoing workforce training opportunities:* The Region 7 IDN team coordinated a statewide CTI Fidelity training on July 18 for CTI partners from Regions 1, 3, 4, 6 and 7. The training was taught by CACTI Consultant Sally Conover and focused on the processes developed by CACTI for assessing a CTI team's implementation of the model as designed. A total of eighteen people representing all five regions participated in this training, three of which were from Region 7 IDN.
- *Fidelity of CTI projects:* Following the fidelity training mentioned above, CTI regions discussed possible ways to carry out fidelity assessments across the state in the context of supporting a bid for reimbursement of the model as the Billing & Coding workgroup develops coding policy recommendations to submit to NH DHHS. At this time, teams have discussed the value of self-assessments for ongoing quality improvements, and potentially coordinating the use of the statewide community of practice to form a team of external fidelity assessors, but no formal arrangements have been made at this time.
- *Continuation of CACTI support:* As the contract with CACTI came to an end in October, stakeholders from the five CTI regions were polled to identify what, if any, supports from CACTI would be valuable to their teams through the end of the demonstration. Based on feedback from both regional leads and CTI team members, a contract addendum was executed to extend CACTI facilitation of quarterly in-person NH Community of Practice meetings through December 31, 2020. Regional leads agreed that if any local team determined that they would like additional support from CACTI, they could contract individually for those services. The NH Community of Practice met on November 22, 2019 at the Audubon Society's McLane Center in Concord NH. Representation from IDN Regions 1, 3, 4 and 7 were in attendance. Discussion included establishing a plan for the quarterly in-person meetings, a sharing of updates from each region, the challenges teams face when clients pass away, and the individual supports that will be most beneficial for sustainability of CTI in the state post-DSRIP.

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.

December 31, 2018

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 12/31/18	0	12	196
# of partner organizations implementing CTI	3 by 12/31/18	2	2	3
# of CTI workers positioned in Region 7 IDN	15 by 12/31/18	11	24	37

Members of the Region 7 IDN team conducted calls with each of the Region's three CTI partners (Carroll County Department of Corrections, the Family Resource Center and Tri-County CAP) in March 2019 as part of an effort to reinvigorate the Region 7 CTI Community of Practice. The calls were intended to garner updates regarding program progress and inform a Mini Learning Collaborative plan for the year. During the calls, partner organizations each expressed concern that they had received information at various trainings that suggested their programs were not operating to fidelity. In previous reporting periods, these partners provided limited counts of individuals served by their programs due to these fidelity concerns.

A CACTI facilitator was engaged to review program implementation with the partners in response to these concerns. Following overview of each program's current format, discussion regarding previous feedback that had informed their concerns regarding fidelity and review of a program self-assessment tool, the CACTI facilitator affirmed on April 11, 2019 that, despite serving radically different populations at disparate points of transition, the partners currently appeared to be meeting the minimum program requirements. She stated that, although in early stages of implementation, the three partners should be credited for all persons served by their various CTI programs.

With the validation from CACTI that was received in April 2019, the programs agreed to recalculate their totals to include all individuals served by their programs. Partners were queried for revised counts, both through 12/31/18 and from 1/1/19 through 4/15/19. In particular, Tri County CAP and Carroll County Department of Corrections had previously under-reported the number of individuals served in the Pre-CTI phase of the project, citing information received that led them to believe that individuals who did not follow through all phases of the CTI program could not be counted. Both partners' CTI teams provide the bulk of their services to individuals during the pre-transition (or Pre-CTI) phase. Counting additional persons served in this window has allowed the Region to better depict the number of lives impacted by this service.

The table above has been corrected to reflect that the total number of persons served by CTI programs in Region 7 through 12/31/18 is 196, not the 37 individuals previously reported. Further, partners were able to confirm that an additional 84 individuals have been served by their programs between January 1 and April 15, 2019, bringing the total number of persons served by Region 7 CTI programs to 280 as of this report revision.

Funding delays and staff turnover have made partners hesitant to start and/or expand the CTI model locally. Northern Human Services submitted a proposal to implement the model across the region.

Funding delays have now jeopardized the implementation of this project, as well as expansion of TCCAP's program. Despite best efforts, the evolving fiscal picture has created significant challenges in Region 7 IDN being successful at meeting client engagement targets. Of note, The Family Resource Center was able to implement CTI without funding support from the IDN in their Strength to Succeed program, and this agency has contributed significantly to the client engagement numbers reported.

Although the region exceeded the projected number of CTI workers, many agencies have expressed concerns about being able to implement the model to fidelity. There are also concerns about the sustainability of the model after the DSRIP program ends; agencies want to know if CTI will be a Medicaid reimbursable service. Despite having staff trained in the model, the lack of clarity on future reimbursement has left partners hesitant to expend current resources on reaching fidelity of a model that will not be sustainable at the end of the demonstration period. In many cases, partners feel they are now able to address the needs of their patients/clients using a "CTI-informed approach" without the burden of reaching and sustaining fidelity of a program in the context of uncertain reimbursement.

June 30, 2019 Update

Performance Measure Name	Target (by 12/31/18)	Progress Toward Target			
		As of 12/31/17	As of 6/30/18	As of 12/31/18	As of 6/30/19
# of individuals served by CTI	120	0	12	196	**344**
# of partner organizations implementing CTI	3	2	2	3	**3**
# of CTI workers positioned in Region 7 IDN	15	11	24	37	**37**

While two sub-recipient funding proposals approved in October 2018 including the possibility of establishing additional CTI programs in the region, neither project was implemented during this reporting period because delays in incentive payments for the January – June 2018 reporting period resulted in subsequent delays in Region 7 IDN subrecipient awards being distributed. When incentive payments were received in the region, both partners opted to withdraw the CTI-related proposals in favor of focusing sub-recipient work on other DSRIP initiatives. The number of CTI trained staff in the region has remained stable during this reporting period, allowing all three programs to provide services to fidelity as assessed by consultants from CACTI.

During this reporting period, the number of Region 7 IDN Partners implementing CTI remained constant, with services being provided by Carroll Country Department of Corrections (CCDoC), the Family Resource Center (FRC), and Tri-County Community Action Program (TCCAP). The most substantial portion of care transition activities performed by Region 7 CTI teams continues to occur in the Pre-CTI phase, especially with incarcerated individuals at CCDoC and sheltered guests being served by TCCAP's Housing Intervention and Prevention program. These two programs are responsible for the largest populations of CTI-served individuals in the region.

During this reporting period, CCDoC served an additional 84 individuals using the CTI model. Despite a slow-down of their CTI program from January to June in the absence of sub-recipient funds, TCCAP reported that they maintained full CTI services for three shelter guests and CTI-trained staff served an additional ten individuals. The Family Resource Center also continued to use the CTI model to serve and additional 37 individuals through their Strengths to Succeed program during this reporting period. Concurrently, FRC reports that they are also seeking CRSW status for their CTI-trained staff working with Strengths to Succeed families. The nature of their work with families is such that FRC believes the services provided by parent partners is a billable and reimbursable recovery support service, lending a sustainability plan to this program when the grants currently funding it expire.

December 31, 2019 Update

CTI work in Region 7 continues to be stable across all three partner organizations, each of which has found a workflow that meets the needs of the population it serves. Workforce has also remained stable, with only a single position at TCCAP having been opened during the reporting period. TCCAP has indicated that they are able to handle their current client load without refilling this position.

Performance Measure Name	Target (by 12/31/18)	Progress Toward Target				
		As of 12/31/17	As of 6/30/18	As of 12/31/18	As of 6/30/19	As of 12/31/19
# of individuals served by CTI	120	0	12	196	344	**482**
# of partner organizations implementing CTI	3	2	2	3	3	**3**
# of CTI workers positioned in Region 7 IDN	15	11	24	37	37	**36**

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	Staffing on 6/30/19	Staffing on 12/31/19
CTI Workers	15 by 12/31/2018	0	11	24	37	37	36
CTI Field Work Coordinator/clinical supervisor	3 by 12/31/2018	0	3	3	3	4	4

C-4. IDN Community Project: Budget

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

December 31, 2018

Budget Period:	01/01/2017-12/31/2017	01/01/2018-06/30/2018	07/01/2018-12/31/2018	01/01/2019-12/31/2019	01/01/2020-12/31/2020	01/01/2021-06/30/2021
	Care Transition Actual Funds Spent	Care Transition Actual Expense (6 months)				
Care Transition	CY 2017 Actuals	CY 2018 January to June Actual	CY 2018 July to Dec. Actual	CY 2019 Projected	CY 2020 Projected	CY 2021 Projected
1. Total Salary/Wages						
2. Employee Benefits						
3. Consultants			$0	$0	$0	$0
5. Supplies:			$0	$0	$0	$0
Educational			$0	$0	$0	$0
Office	$968	$71	$76	$2,550	$2,550	$1,275
6. Travel		$368	$0	$0	$0	$0
7. Occupancy			$0	$0	$0	$0
8. Current Expenses			$0	$0	$0	$0
Telephone			$0	$0	$0	$0
Postage			$0	$0	$0	$0
Subscriptions			$0	$0	$0	$0
Audit and Legal			$0	$0	$0	$0
Insurance			$0	$0	$0	$0
Board Expenses			$0	$0	$0	$0
9. Software		$443	$0	$1,011	$1,011	$505
10. Marketing/Communications	$1,086	$572	$1,797	$579	$579	$289
11. Staff Education and Training		$522	$0	$0	$0	$0
12. Subcontracts/Agreements			$0	$0	$0	$0
13. Other (specific details mandatory):			$0	$0	$0	$0
Current Expenses: Administrative Lead Organizational Support	$1,634	$930	$1,306	$4,312	$4,312	$2,156
Support Payments to Partners	$65,766	$59,987	$43,338	$181,953	$181,953	$90,977
TOTAL	**$69,454**	**$62,893**	**$46,517**	**$190,405**	**$190,405**	**$95,202**

Consistent with all prior reporting, report begins with January 1, 2017 utilizing capacity building funds to maintain infrastructure.
IDN 7 projects the additional amount approved at June 2017 quarterly meeting to absorb future anticipated line item variances in Salary, Benefits, Software and Training.
(Budget reflects correction from previous reports. Inadvertently switched Care Transition total with Core Competency total.)

June 30, 2019 Update

Budget Period:	01/01/2017-12/31/2017	01/01/2018-12/31/2018	01/01/2019-06/30/2019	07/01/2019-12/31/2019	01/01/2020-12/31/2020	01/01/2021-06/30/2021
Care Transition	CY 2017 Actuals	CY 2018 January to December ACTUAL	CY 2019 January to June ACTUAL	CY 2019 July to December PROJECTED	CY 2020 Projected	CY 2021 Projected
1. Total Salary/Wages (Budget reflects correction from previous reports. Inadvertently switched Care Transition total with Core Competency total.)						
2. Employee Benefits (Budget reflects correction from previous reports. Inadvertently switched Care Transition total with Core Competency total.)						
3. Consultants		$0.00		$0	$0	$0
5. Supplies:		$0.00		$0	$0	$0
Educational		$0.00		$0	$0	$0
Office	$968	$147.07	$116	$116	$232	$116
6. Travel		$368.16	$418	$418	$836	$418
7. Occupancy		$0.00		$0	$0	$0
8. Current Expenses		$0.00		$0	$0	$0
Telephone		$0.00		$0	$0	$0
Postage		$0.00		$0	$0	$0
Subscriptions		$0.00		$0	$0	$0
Audit and Legal		$0.00	$190	$190	$379	$190
Insurance		$0.00	$105	$105	$209	$105
Board Expenses		$0.00		$0	$0	$0
9. Software		$442.82	$238	$238	$476	$238
10. Marketing/Communications	$1,086	$2,368.58	$179	$179	$358	$179
11. Staff Education and Training		$521.66		$0	$0	$0
12. Subcontracts/Agreements		$0.00		$0	$0	$0
13. Other (specific details mandatory):		$0.00		$0	$0	$0
Current Expenses: Administrative Lead Organizational Support	$1,634	$2,236.13		$0	$0	$0
Support Payments to Partners	$65,766	$103,325.43	$26,708	$26,708	$53,417	$26,708
TOTAL	**$91,231**	**$140,409**	**$50,680**	**$50,680**	**$91,536**	**$50,680**

Consistent with all prior reporting, report begins with January 1, 2017 utilizing capacity building funds to maintain infrastructure.
IDN 7 projects the additional amount approved at June 2017 quarterly meeting to absorb future anticipated line item variances in Salary, Benefits, Software and Training.
Incentive Payments from January 2019 through December 2020 reflect a reduction based on anticipated DHHS action and county participation.
Budgets for project remainder reflect revised staffing structure in attempt to maximize funds available to partners.

December 31, 2019 Update

Budget Period:	01/01/2017–12/31/2017	01/01/2018–12/31/2018	1/1/2019 – 6/30/2019	7/1/2019 – 12/31/2019	1/1/2019 – 12/31/2019	1/1/2020 – 6/30/2020	7/1/2020 – 12/31/2020	01/01/2020–12/31/2020	01/01/2021–12/31/2021
Care Trans	CY 2017 Actuals	CY 2018 January to December ACTUAL	CY 2019 January to June ACTUAL	CY 2019 July to December ACTUAL	CY 2019 January to December ACTUAL	CY 2020 Jan to June PROJECTED	CY 2020 July to Dec PROJECTED	CY 2020 Projected	CY 2021 Projected
1. Total Salary/Wages									
2. Employee Benefits									
3. Consultants		$0.00			$0	$0	$0	$0.00	$0
5. Supplies:		$0.00			$0	$0	$0	$0.00	$0
Educational		$0.00			$0	$0	$0	$0.00	$0
Office	$968	$147.07	$116	$95	$211	$106	$106	$211.08	$106
6. Travel		$368.16	$418	$531	$949	$474	$474	$948.85	$474
7. Occupancy		$0.00			$0	$0	$0	$0.00	$0
8. Current Expenses		$0.00			$0	$0	$0	$0.00	$0
Telephone		$0.00			$0	$0	$0	$0.00	$0
Postage		$0.00			$0	$0	$0	$0.00	$0
Subscriptions		$0.00			$0	$0	$0	$0.00	$0
Audit and Legal		$0.00	$190	$179	$369	$184	$184	$368.57	$184
Insurance		$0.00	$105	$96	$201	$100	$100	$200.70	$100
Board Expenses		$0.00			$0	$0	$0	$0.00	$0
9. Software		$442.82	$238	$386	$624	$312	$312	$624.20	$312
10. Marketing/Communications	$1,086	$2,368.58	$179	$192	$371	$186	$186	$371.17	$186
11. Staff Education and Training		$521.66			$0	$0	$0	$0.00	$0
12. Subcontracts/Agreements		$0.00			$0	$0	$0	$0.00	$0
13. Other (specific details mandatory):		$0.00			$0	$0	$0	$0.00	$0
Current Expenses: Administrative Lead Organizational Support	$1,634	$2,236.13			$0	$0	$0	$0.00	$0
Support Payments to Partners	$65,766	$103,325.43	$26,708	$41,407	$68,115	$26,433	$61,677	$88,110.00	$44,055
					$0				
TOTAL	$ 91,231	$140,409	$ 50,680	$ 61,855	$ 112,535	$ 48,643	$ 83,887	$ 132,530	$ 66,265

Consistent with all prior reporting, report begins with January 1, 2017 utilizing capacity building funds to maintain infrastructure.

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)
Carroll County Department of Corrections	Y
Family Resource Center at Gorham	Y
Tri- County Community Action Program	Y

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	Is complete
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	Is complete
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 complete
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.	Is 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 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.

Project Team Member	Roles and Responsibilities
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.

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, Coös 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 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

Region 7 IDN Master Training Table		
Training	**Description**	**Project Reference**
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,	D3

Region 7 IDN Master Training Table		
Training	**Description**	**Project Reference**
	recovery action 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 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	B1

Region 7 IDN Master Training Table		
Training	**Description**	**Project Reference**
	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.	
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 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 strategies to help individuals who have a mental health issue or substance use disorder quit using tobacco, understand how to	D3

Region 7 IDN Master Training Table		
Training	**Description**	**Project Reference**
	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

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	6/30/19	12/31/19
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						

Process Milestone Number	Process Detail	Submission Format	Results (Met/ Not Met)					
			6/30/17	12/31/17	6/30/18	12/31/18	6/30/19	12/31/19
C-3	IDN Community Project Workforce Staffing	Table						
C-4	IDN Community Project Budget	Narrative and Spreadsheet						
C-5	IDN Community Project Key Organizational and Provider Participants	Table						
C-6	Clinical Infrastructure: IDN Community Project Standard Assessment Tools	Table						
C-7	Clinical Infrastructure: IDN Community Project Protocols for Patient Assessment, Treatment, Management, and Referrals	Table						
C-8	Clinical Infrastructure: IDN Community Project Roles and Responsibilities	Table						
C-9	Provide the training plan and curricula for each Community Driven Project as required in A-1.3	Training schedule and table						

Projects D: Capacity Building Focused

IDN Community Project Implementation and Clinical Services Infrastructure Plan

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

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

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

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

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

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

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

December 31, 2018

During the reporting period of 07/01/2018-12/31/2018 Region 7 IDN had no members join or leave the network.

The information below speaks to the progress that Region 7 IDN has made on the D3 project, Expansion in Intensive Substance Use Disorder (SUD) Treatment Options during the period of July 1- December 31, 2018. IDN Partners involved with this project collaborated with each other to address expansion in intensive substance use disorder treatment options.

NCHC's Clinical Services Program, comprised of in-patient high-intensity and low-intensity services at Friendship House (FH), intensive outpatient services, outpatient services, peer recovery support services and the impaired driver care management has continued to evolve during the reporting period. The most significant event during this time period was the completion and subsequent grand opening of Friendship House, the region's only residential treatment facility within a 65-mile radius. Nearly 80 people attend the October 19th ribbon cutting ceremony at the new facility including Executive Councilor Joe Kenney, U.S. Rep. Annie Kuster, U.S. Sen. Maggie Hassan, and U.S. Sen. Jeanne Shaheen. NCHC staff have been working with a consultant to complete the process for the Commission on Accreditation of Rehabilitation Facilities (CARF®) accreditation process for Friendship House, NCHC's outpatient clinical services, and the agency's Intensive Outpatient Program (IOP). Receiving CARF® accreditation is an important element to the sustainability of these programs since third-party payers, governmental agencies, and the public at-large recognize CARF accreditation as a demonstration of accountability and conformance to internationally accepted standards that promote excellence in services. The new facility has had an average daily patient census of 23 patients, and often has a wait list for men wanting to receive services at the facility.

Friendship House has contracted with a nurse practitioner who can write medication orders for patients and provide trainings for agency staff. She has a Medication Assisted Treatment (MAT) waiver and will be able to prescribe detox medications once Friendship House moves forward with this part of their program. Friendship House staff have had conversations with staff from Weeks Medical Center and the North Country Recovery Center related to these services and will continue conversations with partners in the area as the program evolves. In addition, the new facility has a four-bed detoxification unit which has not opened yet. Staffing transitions have occurred at the Friendship House during this reporting period, the partner lost their operations coordinator and program advisor, along with five recovery support staff. However, FH hired multiple positions including a new intake coordinator and five new recovery support staff. They currently staff four Master Licensed Alcohol and Drug Counselor's, two Licensed Alcohol and Drug Counselor's, two Licensed Eligible Master's Level Councilors, one Certified Recovery Support Worker, ten Recovery Support Staff currently working toward CRSW certification, and three employees enrolled in behavioral health programs – two working on a master's in counseling and one working on an associate degree in human services.

Friendship House currently operates one Intensive Outpatient Program (IOP) which meets Tuesday, Wednesday, and Thursday mornings from 9:00-12:00 at the Bethlehem location. IOP staff have determined that this time works well and accommodates the client's ability to find and sustain employment while in the program. Since July 1, 2018 there have been 29 participants in IOP. Of those participants fourteen completed the program; five were discharged for noncompliance with attendance policies; four were transferred to higher level of care (at Friendship House); one was referred to an outside agency, and five are still currently enrolled in the program. The IOP at Friendship House utilizes the Matrix Model which is an evidenced based curriculum in order to provide participants with education and awareness of symptoms related to addiction; develop effective relapse prevention strategies and coping skills; provide insight and connection to community resources; and fulfill other needs as they apply to the individuals. This curriculum is implemented with over nine clinical group hours and one hour of 1:1 counseling each week over a period of twelve weeks. The program operates under an open enrollment status which allows staff to provide treatment without delay to individuals seeking help, usually within a few days of the initial phone call. Participants are often self-referred however referral sources also include internal referrals from Friendship House, NH Probation/Parole, Division for Children, health care providers, Youth and Families (DCYF), North Country Serenity Center, and various other programs throughout the state.

Current barriers to the IOP program include lack of transportation and lack of choices for participants. Often people are unable to obtain adequate transportation to be consistent to the fidelity of the IOP attendance policy. Although the time change mentioned above has helped with attendance, the lack of a second IOP with differing hours does leave some people with the decision to work or attend IOP. Friendship House staff have been working to incorporate updated evidence-based curriculum into their programming to better meet the needs of clients. In addition, staff continue to look at options of expanding the IOP to additional service areas, especially the Berlin area.

Friendship House has established a relationship with Ammonoosuc Community Health Services to provide physicals and follow up medical appointments for patients staying at the treatment facility. Although it would be helpful to have these services provided at the Friendship House location that isn't currently possible, so clients are transported to ACHS. In addition, Friendship House staff have worked with Coös County Family Health Services to develop a similar relationship so CCFHS can serve their patient population. Friendship House staff have started referring clients from the Berlin area to CCFHS to receive a physical during the week prior to their admission. The Friendship House case manager instructs the client to call CCFHS and then notifies CCFHS that a client will be calling to schedule the physical. They plan to continue building this relationship to help CCFHS patients remain getting services there if they are

already an established patient; referral processes will be enhanced to allow for timely execution of all necessary Friendship House admission procedures.

NCHC has received a *Rural Health Opioid Program* grant from the Health Resources and Services Administration, Federal Office of Rural Health Policy, which will be used in conjunction with the agency's *Rural Health Care Services Outreach Program* grant to expand its portfolio of programs addressing Substance Misuse issues in the North Country. Both of these grants offer three years of funding which will jointly be used to design and implement a new "warm handoff" model in Emergency Departments for patients presenting with an opioid use disorder; improve knowledge and understanding by educating clinicians, patients, families, law enforcement and the public about the need for access to unbiased long-term approach to recovery; and to implement care coordination practices by integrating Community Health Workers/Recovery Coaches into opioid use disorder treatment teams. These funds will help to ensure the region is addressing the full the full continuum of care— ranging from prevention, intervention, treatment and recovery.

In addition to these funds, NCHC has received a one-year *Rural Communities Opioid Response Program* – planning grant from the Federal Office of Rural Health Policy to implement a comprehensive planning process that will result in an effective, accessible, coordinated system of service delivery that reduces morbidity and mortality associated with opioid overdoses in Northern New Hampshire. NCHC staff will work closely with provider agencies in the North Country to improve understanding of accessible treatment and recovery options, gaps in services, and feasibility of systematically increasing capacity and care coordination; implement an Opioid Use Disorder Learning Collaborative that enhances cross-sector community partnerships and explores new, innovative, evidence-based models of care; and integrate a model of care which utilizes a comprehensive approach to address overdose reduction, treatment and recovery support, and criminal justice reforms. This planning grant will be used to assess services and resources related to substance misuse treatment and recovery in the region to help ensure collaboration, non-duplicative services, and identify gaps.

Although the federal funds from these programs do not cover agencies in Carroll County, the infrastructure created as a result of these programs will be leveraged to help expand SUD programming is this part of the IDN region. NCHC staff and the IDN team are working diligently to ensure all these programs align with other SUD initiatives in the region, included *The Doorway-NH initiative,* NH's hub and spoke model designed to transform the system serving individuals with a substance use disorder (SUD). NCHC staff meet on a regular basis with the coordinator of the Littleton and Berlin HUBs to discuss collaboration and integration of programs and services in the region. Littleton Regional Healthcare and Androscoggin Valley Hospital will both serve as hubs in the region which will greatly expand access to MAT in the region starting in 2019. The strategic level of involvement of NCHC's CEO is pivotal to ensure the alignment of these programs to avoid duplication of services and utilize resources efficiently.

In July of 2018 NCHC was awarded the contract for the Grafton County Drug Treatment Court (DTC) and added a new LADC to their staff to serve as the Drug Treatment Program Clinician. This program is an Alternative Sentencing Program designed to help adult offenders whose substance use disorder has led to criminal behavior. The mission of the Drug Treatment Court Sentencing Program for Grafton County is to assist criminal offenders in breaking the cycle of crime and substance misuse, while improving community safety, and decreasing financial costs currently incurred by the criminal justice system. Within an 18- to 36-month window, each part of the multi-phase intervention program focuses on key concepts of addiction recovery, from stabilization to continuing care. DTC works with its participants to determine the appropriate level of care needed, collaborating between several agencies to provide substance use disorder treatment, psycho-educational programs, and consistent supervision—including swift sanctions for violations and rewards for positive behavior— aimed at supporting participants to maintain a drug-free lifestyle. NCHC's involvement with DTC significantly impacts the timeliness of getting participants

into the appropriate level of substance use disorder services. On several occasions, Friendship House staff was able to expedite the intake process for DTC participants when the court mandated in-patient services.

Agency staff at Friendship House are currently working to develop a volunteer policy which would then pave the way for recovery coaches from the Recovery Community Organizations (RCOs) to come into the agency and establish relationships with clients. This would provide an opportunity for the clients to learn more about resources available to them upon discharge and help create a smooth transition back to the community. The case manager at Friendship House works diligently to set up client referrals to outside community services agencies before clients are discharged from the agency. This is an important part of the discharge process which can be very time intensive since many of the clients come from areas outside of the Region 7 IDN service area. Once relationships with the RCOs are solidified the peer recovery coaches will be able to assist with connections to other peer recovery coaches outside of the service area.

North Country Serenity Center (NCSC) is one of the four recovery community organizations in the region. The RCO has continued to expand their capacity to deliver an array of recovery services over the past six months. The local recovery community has expressed appreciation for the events hosted by NCSC, and this has led to new agencies engaging in peer recovery services and signing on to be active volunteers at the RCO. Examples of community events offered during the reporting period include the Recovery and Community Field Day in September which had approximately 60 participate in the event. The agency now offers two evening All Recovery Meetings which average approximately 15-20 people in attendance, and a weekly evening Family Support Group which has an average attendance of 5-7 participants. The center is seeing more individuals come in during the afternoon and engaging in the coloring café and socializing with peers. Moving forward, the agency will continue to offer center activities to meet the needs of the growing recovery community.

NCSC staff have been working hard to expand services, and part of this outreach included a staff person visiting Webster Place and Farnum treatment facilities to discuss peer recovery support services offered by North Country Serenity Center. Individuals living in recovery homes in the region have heard about the services provided by NCSC staff and have started to utilize these services. Due to the expansion of services and staffing, NCSC staff have spent the last several months looking for a larger location for a new center, and just recently found a new location a few short blocks from the current location. The building will undergo renovations and NCSC will share space with an up and coming recovery home.

North Country Serenity Center lost their administrative assistant and volunteer coordinator during the reporting period but were able to rehire the positions within the same timeframe. The agency also hired a Certified Recovery Support Worker. The current staffing level at the agency will provide NCSC with the infrastructure to expand their peer recovery support services to include activities such as meditation groups, creative writing sessions, and coffee after hours to welcome the f recovery community to gather and share experiences to gain strength and hope.

NCSC has five staff members, three of which are full-time, and two which are part-time. The agency also has nine volunteers filling out paperwork to participate in volunteer activities at the center. Two of the agency's staff are CRSWs and the remaining staff are working towards CRSW certification. NCSC staff attended numerous trainings during this reporting period, including:

- HIV/AIDS Training: 4 attended
- Recovery Coach Academy: 1 attended
- Suicide Prevention: 2 attended
- Recovery Coach Academy Train the Trainer: peer lead attended
- Recovery housing trainings: 2 attended
- Ethics Training 2 attended

- Ethics Train-the-Trainer: 1 attended
- Community Health Worker Training: 4 staff will complete the training in early 2019

NCSC has served approximately 131 unique participants through their Telephone Recovery Support and Recovery Coaching programs since their inception in 2017, 64 of which are new to the reporting period of July 1-December 31, 2018. North Country Recovery Center continues to build relationships with external partners and has developed a closed loop mutual referral process with ACHS. The two agencies refer individuals in need of peer recovery support services and those in need of medical, vision, or dental services to one another as appropriate. During the reporting period of July 1 – December 31 the agencies used this system to refer 17 patients. They have not executed formal agreements for this arrangement yet, but conversations continue about the process and system.

North Country Serenity Center was awarded the Sober Parenting Journey contract which should begin in March 2019. Sober Parenting Journey is a 14-week evidence-based group program specifically designed for parents in recovery. The program is designed to help parents and caregivers in recovery begin to understand and experience healing new and old wounds, address the impact of triggers that lead to relapse, learn about local resources in the area, learn how to effectively communicate with children, become more confident and optimistic about maintaining recovery, learn to overcome emotional shame and guilt and learn to stop justifying consequences related to substance use and create new possibilities for parents/caregivers and their children.

NCSC has been working to foster relationships so they can provide peer recovery support services to individuals in hospitals, the workplace and the community. The agency has seen forward momentum in their work which includes a local hospital contacting them about individuals needing recovery support information and sending a coach to sit and provide information to a patient until the patient was able to make an informed choice. North Country Serenity Center staff provide peer recovery support services for Friendship House's Intensive Outpatient Program, meeting bi-weekly with participants to provide education and information on services offered by the agency. During these sessions, participants are encouraged to sign up for telephone recovery support and to work with a NCSC coach to assist in transition from treatment to their home recovery community. The center is accepting referrals from Weeks Medical Center MAT program and provides MAT support to groups for recovery. NCSC entered into a formal agreement with MAT provider Better Life Partners (BLP) to provide peer recovery support services to clients on the BLP MAT program. In addition to these collaborations, the Executive Director of NCSC has been meeting with the CEO of NCHC to discuss coordination of services for NCHC's warm handoff model program, including opportunities to provide extensive coverage of Recovery Coaches for individuals presenting in emergency departments.

NCSC and White Mt Recovery Homes, a men's sober living home, continue their collaborative partnership. The RCO attends several treatment programs to educate about NCSC and WMRH and WMRH clients attend meetings, receive coaching and participate in community service and volunteer with NCSC. NCSC staff also engage in many other outreach initiatives, including presenting to the local high school to explain and educate students about peer recovery support services. Additionally, the Good Samaritan Network invited NCSC to attend a round table discussion to address the opioid crisis impact in the region. As a result of the Recovery Friendly Workplace initiative NCSC has received a referral from an employer, and the RCO is in the process of developing referral systems and protocols to handle community requests for peer recovery support services.

Ammonoosuc Community Health Services continues to provide primary care and behavioral health/SUD services at Friendship House. ACHS has been meeting monthly with the Friendship House staff to refine services provided by ACHS and documentation required by ACHS. Between April 2018 and December 2018, ACHS has provided physicals and comfort medication to at least 93 patients. ACHS has also worked

with Friendship House to provide after care for patients discharged that remain in the ACHS operational area in northern Grafton County, and southern Coös County.

ACHS continues to improve services to provide enhanced behavioral health services to the region. ACHS has proposed to formalize agreements and procedures with North Country Serenity Center (NCSC) to provide medical, dental, vision, behavioral health, substance misuse, nutrition, and patient navigation services, while utilizing NCSC's peer support and recovery support services. ACHS is currently reviewing HIPPA and 42CFR Part 2 regulations to determine the best way to move forward with the formalized agreements, and in the meantime the agencies are relying on Release of Information forms as authorization to discuss mutual patients. These two agencies have been meeting biweekly since August 2018, and to date have provided services for twenty-four mutual patients. The collaborative relationship between these agencies will ultimately reduce recidivism, relapse rates, and expand behavioral health services in the region.

ACHS has worked with Grafton and Coös County Corrections to provide primary care and behavioral health services for individuals. The agency has established relationships with Grafton County Corrections, Grafton County Alternative Sentencing, Grafton County Department of Corrections Focused Intentional Re-Entry and Recovery Program (FIRRM) and Federal Alternative Sentencing (Laser Docket) programs to provide immediate services for those convicted of SUD related crimes. Through these efforts ACHS has provided wrap-around services to twenty-one individuals exiting Corrections programs since February 2018. Staff from ACHS and Grafton County Corrections meet weekly to conduct treatment team meetings on all patients.

ACHS has formalized a workflow to notify behavioral health staff when clients are seen in an Emergency Department (ED) for behavioral health or substance use reasons. This feedback loop provides ACHS staff the opportunity to provide services to patients in a time appropriate manner. During the period of February 8, 2018 – December 14, 2018 ACHS reviewed 2615 emergency room reports and identified 188 (7%) patients with a behavioral health related diagnosis. ACHS has flagged providers and/or conducted follow up on all of these patients. 108 (4%) of these patients resulted in actual contact with ACHS behavioral health providers.

IDN staff will continue to engage with ACHS staff regarding the utilization of Collective Medical event notifications to potentially help with this process.

The partner has continued providing mental health clinician support to Lafayette Regional school, Bethlehem Elementary school, Profile High School, Lisbon Elementary School, and Blue Mountain Union School in Landaff. ACHS has provided behavioral health support throughout the summer for identified students that desired it. ACHS is in the beginning stages of expanding its behavioral health support to Woodsville and Warren schools. They have attained one intern who will start in January 2019 and hired one LICSW to work within the schools.

ACHS has expanded their MAT program identifying four prescribers, two LICSWs, and two Patient Navigators to become internal resources for SUD matters in the Woodsville and Littleton locations. As of this date two additional prescribers have completed MAT waiver training to bring their MAT waivered prescribers to four. The agency is not actively promoting this service but will treat existing patients as the need arises. ACHS is currently treating one patient in their MAT program. These providers and ACHS support staff have been attending addictions counseling courses to increase their knowledge about substance use disorder. The agency is working to refine MAT policies and workflows using the Plan, Do, Study, Act cycle (PDSA).

Coös County Family Health Services has expanded their MAT program. When the program first started it focused on prenatal patients and their partners. Now primary care providers can refer patients to the

MAT program. They currently have a total of 25 MAT patients and a wait list of 32 and hope to expand their patient capacity to 50. The MAT program currently has an RN coordinator, recovery coach and a Women's Health nurse practitioner working on MAT one day per week. CCFHS has five waivered prescribers on staff and will be starting a fourth MAT group session early in 2019. During the period of July 1-December 31, 2018 the agency hired a LCMHC/MLDAC and one LPN who will fill the role of Behavioral Health Clinical Support and will works toward LADC certification. CCFHS is looking forward to collaborating with Androscoggin Valley Hospital as part of the NH Doorway hub and spoke model once their plan is developed.

Weeks Medical Center has continued to increase its capacity to treat behavioral health and substance use disorders and has an integrated physical and behavioral health facility operating concurrently. In 2017 Weeks opened the North Country Recovery Center, their medication assisted treatment program for opioid use, offering services in the hospital setting and outpatient services in four office locations. The agency has expanded services to the Littleton area and has a psychiatric mental health nurse practitioner providing behavioral health services for Littleton Regional Healthcare (LRH) and Ammonoosuc Community Health Services (ACHS) every Monday.

Currently, Weeks Medical Center has two prescribers with waivers to deliver MAT services and is in the process of obtaining a waiver for two more providers. The North Country Recovery Center enrolled 17 new patients in their MAT program and currently have 59 active participants in the program. Weeks Medical Center continued to expand their behavioral health department during the reporting period by adding a LICSW, a Psychiatric Nurse Practitioner, an office coordinator for their MAT program, and a Behavioral Health Case Manager. Future plans for the agency include hiring two additional psychiatric nurse practitioners and expanding MAT services to the Colebrook area to allow the underserved area an opportunity to have direct access to MAT services and counseling regardless of their primary care provider. In addition, Weeks Medical Center will help to provide staff for the two NH Doorway hubs in the region starting in 2019 and will be sending staff to the next Peer Recovery Coach Academy starting in January 2019.

White Mountain Community Health Center (WMCHC) continues to offer MAT services based on their capacity. The MAT provider recently got waivered to service up to 100 patients, however the agency does not yet have the capacity to accept that number of patients. The provider is currently capping her services at 35-40 patients. WMCHC served seven new patients in their MAT program from 7/1/2018-12/31/2018 and currently have 32 total patients enrolled; this makes a total of 62 patients served since its inception in June 2017.

WMCHC uses a comprehensive protocol for MAT intakes to determine patient eligibility for the program. Once the patient is accepted into the program treatment proceeds using the phase system of progress.

During the reporting period of July 1-December 31, 2018 Saco River Medical Group (SRMG) hired a new primary care physician who also has a MAT waiver and sees SUD patients as part of his regular practice. With the addition of this provider the agency now has two waivered prescribers. SRMG has recently contracted with a new family practice nurse practitioner who has a MAT waiver and is slated to start in April 2019. This will increase capacity to provide MAT services to the region and reduce the workload of currently providers. During the reporting period they served 30 new patients in their MAT program creating a total of 97 active MAT patients.

SRMG has multiple policies in place to provide information about the program to patients looking to receive their services. The agency utilizes a similar phase system as WMCHC mentioned above. They also use the following documents:

- Explanation of program and patient expectations for prospective patients requesting acceptance into the MAT program (See below)
- Informed Consent
- Consent for the Release of Confidential Information
- Understand Opioid Dependence
- Treatment Options for Opioid Dependence
- Patient Consent and Release Form for Buprenorphine Treatment during Pregnancy
- Treatment Agreement for Suboxone Therapy Program Requirements and Patient Responsibilities
- Warning Statement: Suboxone Treatment will Lead to Loss of Tolerance

Memorial Hospital has continued to offer SUD services through their Integrated Medication Assisted Treatment Program (I-MAT) and the "A New Life" Prenatal Program. The I-MAT program served 45 new patients during the reporting period, making a total of 97 active patients between the three providers. This is an increase of one provider as a new waivered PCP was hired during this reporting period. Memorial also hired a new Psychiatric Nurse Practitioner to work in their Behavioral Health Department, along with a new general PCP. One of the current waivered providers will be leaving the practice in early 2019 resulting in only two waivered providers moving forward. The program is currently not accepting new patients due to this transition and the lack of suboxone induction capacity. Memorial has been referring patients to external MAT programs due to this. The hospital is actively recruiting for a nurse practitioner to increase capacity to deliver services. Through MaineHealth, Memorial has access to a Learning Collaborative forum that meets regularly to present cases on difficult patients. This meeting is specifically for I-MAT programs within the Maine Health system for the providers to discuss how their programs are doing and ask for advice on complex patients. The meeting has helped providers illicit insight and guidance on these patients and discuss challenges and barriers to the IMAT program. Memorial sends I-MAT staff to this meeting and has access to the psychiatrists on the line when needed.

Although two nurse midwives have left Memorial's "New Life" Prenatal Program the remaining staff are able to maintain the program and the population it serves. The program allows patients to stay in the program for up to a year however some stay longer due to lack of other treatment options. The number of patients enrolled in the program hasn't changed much, but during the July-December reporting period the New Life program was able to transition three patients into Memorial's I-MAT program after determining the patients were stable enough to make the transition. The program has two providers who are waivered and one waivered nurse midwife and has provided MAT services for four patients in the reporting period. in 2018 the program delivered 19 opiate exposed newborns out of 221 births. This means that 8.6% of the births were opiate exposed. Of the 19 opiate exposed babies, only seven of their mothers were involved in New Life prenatally. Memorial was able to enroll two additional mothers post-delivery. There were an additional three mothers who joined late in 2018 early in their pregnancies and will deliver in 2019. This totals twelve new patients for the entire year of 2018.

Huggins Hospital has spent the last six months developing a new MAT program. The agency has been working to change the culture for MAT dispensing by creating a "change team" to help with implementation. Currently, Huggins has two MAT waivered providers since hiring a new provider during this reporting period. A system wide MAT training for providers and outpatient staff was held in November 2018, that included a 90-minute overview of the MAT program, including the evidence for incorporating MAT into practice, and case discussions aimed to teach providers that change is possible. Approximately 25 staff people participated in the training. The Change Management team has not created any workflows or protocols yet; however, they will be working on this in early 2019, and they anticipate that patients will be provided MAT services by March of 2019. The team has been working to identify a pilot practice site

for MAT services to be implemented and believe they will start offering these services at the Ossipee location first.

In January 2019 Huggins will start a waiver training for providers and will include some ancillary staff in the training so they have education on the MAT program. There is a goal to have five additional prescribers trained during this time so Huggins will have capacity of seven waivered prescribers total. Huggins staff have been able to engage contracted ED provider staff into the MAT conversation and some ED staff are interested in participating in waiver training.

As a result of the multiple new and expanding MAT programs throughout the region IDN 7 was able to serve an impressive number of patients. Among all partners offering MAT services within the region a total of 121 new patients were served during this reporting period.

White Horse Addiction Center (WHAC) continued to provide outpatient treatment services including IOP, individual counseling, LADC evaluation, and DUI aftercare at both their Conway and Ossipee locations in Carroll County. The agency refers to the RCO in North Conway as the Shed North which provides 1-on-1 peer recovery meetings, transportation assistance, and volunteer opportunities. Additional services that have been added include life skills groups, AA and NA meetings, recovery support groups, parenting classes and more. White Horse staff participated in multiple trainings over the past six months including:

- Narcan Training: 12 participants
- Parenting Training: 4 participants
- Nami Family Support Facilitators training: 15 participants
- Kingswood Youth Center Prevention training: 50 participants

WHAC continues to provide Intensive Outpatient Programs in the region. During the reporting period of July-December 2018 the agency ran two IOP groups in Center Ossipee, one Christian and one secular session; and they started a new IOP in the North Conway location in August. The three IOPs provided a structure to offer a total of 198 IOP sessions which served 36 new clients. The agency had 11 new clients complete an IOP in the last six months.

Peer Recovery Coaches have provided services to 19 new clients, all of which have been assessed to determine level of readiness. There have also been some staff changes during the reporting period including the addition of two administration staff to support the RCO and billing, two LADC candidates with target licensure of 2019, three CRSW candidates, and a Chief Financial Officer/Controller. The agency's Executive director resigned resulting in the restructuring of leadership.

WHAC also spent the reporting period working with a consultant to perform a Strength, Weakness, Opportunity, Threat (SWOT) Analysis. The agency reviewed the results with the Board of Directors and the consultant, as well has held multiple sessions with staff to educate them on executing a more cohesive business approach. The SWOT analysis revealed multiple strengths, weaknesses and threats; however, it came with many opportunities and recommendations to pursue as the agency works to integrate services in the region. The SWOT analysis highlights that organizations in the region are willing to partner with White Horse and they feel that White Horse has passionate and committed staff who work with clients.

As a result of the SWOT analysis, White Horse Addiction Center added a strategic planning committee to the Board of Directors and restructured leadership and management teams to be more proactive and collaborative within the region. The partner utilized their SWOT results to develop work strategies and communications with outside providers including the IDN and developed a complete marketing strategy for 2019 that will help them to promote their services to partners in the region. WHAC had meetings

with Region 7 IDN staff, Memorial Hospital and Mount Washington Valley Supports Recovery to discuss collaborative opportunities. As a result of this new collaboration strategy, WHAC and MWVSR requested funds for a project to provide 24/7 emergency peer recovery support services to Carroll County and plan to partner with Memorial Hospital and surrounding partners, to roll out the proposed model.

Mount Washington Valley Supports Recovery has increased their capacity to collaborate more effectively throughout the region and bring services to the population. In the last six months MWVSR hired a Director of Programs using IDN funds to help have more presence at project and community meetings. Since then they have attended DN meetings, two bi-monthly meetings with C3PH, and held a Peer Recovery Support Services meeting at their facility. They continue to meet with WHAC regularly to discuss crisis intervention in the ER and develop a strategy to bring 24/7 emergency peer recovery support services to Carroll County. MWVSR held a provider's discussion meeting in December 2018 to discuss harm reduction. There were three nurse practitioners, one MLADC, an AA representative, a Licensed Social Worker and a psychologist as well as five recovery coaches that were engaged in the conversation.

MWVSR continues to have good relationships with surrounding partners which has led to WMCHC referring their MAT patients to the center for recovery coaching and meetings. Additionally, MWVSR raised $700 at a collaborative fundraiser they held with Memorial Hospital's New Life Program.

The partner currently has one full-time employee, one part time administrative assistant and three part time recovery coaches. During the reporting period the peer recovery coaches engaged 18 new clients for services. MWVSR continues to run two weekly peer support meetings that are regularly attended, as well as weekly collaborative/oversite work sessions with their recovery coaches and contracted MLADC. The two weekly peer support meetings are known as Medication-Assisted Recovery Anonymous (MARA) and FASTER which is a model that follows the acronym below

- Finished - What has been completed since the last meeting?
- Acknowledgements - Who made their job easier?
- Still outstanding - What are they working on now?
- Trouble spots - What difficulties are they encountering?
- Enlightenment - What have they learned?
- Requests - What do they need?

MWVSR had 63 attendees at these meetings through the reporting period and 48 calls or inquires for services. They had 58 in-person inquires and 127 encounters with recovery phone/in-person check ins. The partner plans to collaborate with local agencies and the other RCO's in the region to build the Peer Recovery Support Network and help provide services.

Hope for NH Recovery, one of the four RCO's in the region, continued to build capacity to expand services throughout the region. In the past six months Hope has begun a complete reorganization of the center. They have hired all new staff, including a new center manager, a new peer lead and a recovery coach. The peer lead has had recovery coach training and is now participating in IDN trainings that will help move them towards CRSW certification. In addition, the peer lead has been trained as a Community Health Worker. The agency is looking forward to greatly expanding their capacity and range of services. Hope has been working with the Family Resource Center (FRC) to provide a space for a Parenting Class. They also work with FRC's parent partners to provide a safe supportive environment for their client visits as well as having several supervised visitation sessions. The RCO has been working with Tri-County CAP's homeless intervention and prevention worker, and collaboration has begun with Coös County Family Health Center to assist with their MAT program.

The center has increased capacity to implement SBIRT by hiring fully trained Recovery Coaches and a Community Health Worker who have been made familiar with the SBIRT practice modules. During this reporting period Hope served 12 new individuals with Peer Recovery Coaching. The agency is eager to participate in the Regional Peer Recovery Support Network and expand their services to those in need.

The four Recovery Community Centers of Region 7 have continued meeting to strategize the most effective way to develop the Peer Recovery Support Network. The group met in August and October to discuss the development of a sustainable peer recovery network. The four RCO's have worked to build capacity to create this network together over the past six months, which includes increasing staff and adding more services. One model that was suggested was to create two hubs, one for Carroll County and one for Northern Grafton and Coös. Each hub would be comprised of two RCOs. The idea is to have an advisory board to provide guidance for all four RCOs which will include help with the development of systems and processes for referrals and establishing a peer recovery workforce that is equipped to be deployed to clients in their time of need. Each hub would have one of the RCOs serve as a lead agency which would have additional reporting and fiduciary responsibilities for the hub. The RCOs felt it was important to leverage existing initiatives as the model is developed. The group plans to reconvene in early 2019 to learn more about the implementation of NCHC's WARM model and the NH Doorway hub model, and then discuss next steps in the implementation of this regional approach.

The Recovery Coach Academy training plan started in July 2018 with the following trainings held throughout the reporting period:

- 7/25/2018: Ethical Considerations for Recovery Coaches; trained 13
- 8/9/2018: HIV/AIDS; trained 13
- 8/23/2018: Suicide Prevention; 16
- 9/13/2018: Recovery Coach Academy; 8
- 10/11/2018: Recovery Coach Academy Train the Trainer, trained 6
- 11/5/2018: Ethics Training; trained 13
- 11/7/2018: Ethics Train the Trainer; trained 4
- 11/14/2018: Suicide Prevention Training; 26

The trainings had impressive participation and helped build the region's peer recovery network substantially. Multiple participants have taken all or most of the trainings required to become a Certified Recovery Support Worker, which will help create sustainability in the Region. Currently, eight partner staff have been trained in three out of the four topics needed to move forward in becoming a CRSW. Several partner staff have taken more than one training to move toward CRSW and five recovery coaches have been cross trained as Community Health Workers. The current Community Health Worker training began in November 2018 and is expected to graduate ten participants in February 2019.

Region 7 IDN plans to continue the Recovery Coach Academy training plan through 2019 to increase the workforce and more Recovery Coaches toward CRSW certification. The remainder of the original 2018 PRCA Training plan is below:

HIV/AIDS	March 2019
Peer Recovery Coach Academy	April 2019
Peer Recovery Coach Academy	September 2019
Suicide Prevention	October 17, 2019
Ethics	November 2019
HIV/AIDS	December 14, 2019

June 30, 2019 Update

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

Network Membership

During the reporting period of January 1 through June 30, 2019, Region 7 IDN had no members join or leave the network. The information below speaks to the progress that Region 7 IDN has made on the D3 "Expansion in Intensive Substance Use Disorder (SUD) Treatment Options" community project during this reporting period.

Region 7 IDN Data Governance

As Region 7 IDN adopted the new DHHS Monthly Update reporting format this spring, efforts were expended to verify the total number of individuals served by each Region 7 IDN partner to date and leverage the State's reporting tool as a mechanism that will help partners report monthly totals for the remainder of the DSRIP. By utilizing the State's new monthly reporting mechanism as the backbone of a high-integrity data management process, the Region 7 IDN team hopes to ease the reporting burden for partners while retaining the ability to collect, aggregate and analyze data for the region as a whole. This revised process is anticipated to allow the region to evaluate progress on performance evaluation targets more frequently and help the Region 7 IDN team provide more timely feedback and support to the region's partners. Partner specific updates in this section reflect narrative regarding their progress along the continuum of the project, and their total number of unique individuals served during the DSRIP period through June 30, 2019.

Region 7 IDN Partner Specific Updates

Androscoggin Valley Hospital and *Littleton Regional Healthcare* were named as the two northernmost entities responsible for opening NH Doorway sites in Berlin and Littleton, respectively, under the State Opioid Response grant. Region 7 IDN partners across the region focused efforts during this reporting period on identifying effective ways to leverage infrastructure and treatment capacity developed by the IDN to support the "hub and spoke model" utilized by the NH Doorway sites. This was particularly true in Carroll County, the only NH county without a Doorway site located within its borders. The Berlin and Littleton Doorway sites have been making connections as needed and have collaborated with the Doorway site in Laconia to participate in discussions with Carroll County's community resources to develop strong ties between spokes in this county and the Doorways which are located in neighboring counties. In addition to these conversations, part of the agenda at the region's March 2019 quarterly meeting was spent talking about the intersection of the IDN and the Doorway model. There was good dialogue among the attendees at the meeting and follow up conversations have occurred between the Doorways and IDN partners as a result of the session.

Because the two host hospitals were both North Country Healthcare (NCH) affiliates, the entity assigned a single management team to administer the Doorway program at both sites for consistency. The sites have sub-contracted with Weeks Medical Center to offer MAT services onsite. This has allowed for efficient staffing of the Doorway sites and provided immediate access to MAT services for eligible clients. Additionally, it has allowed the sites to utilize the same electronic systems for documenting care and recording services rendered. The two Doorway sites in Region 7 have provided 149 individuals with MAT services in the first six months of this program.

Both sites are also working diligently to make connections with the recovery community in Region 7 IDN, and the recovery community organizations in the region are eager to be involved in the initiative. While the initial focus of the Doorway sites was standing up the hub and spoke model with SUD-related

resources, the administrative team has identified that there is a clear need to connect better to medical resources for preventative care and non-SUD healthcare needs. They look forward to focusing more efforts in the coming months on developing and hardwiring referral and joint service protocols with primary care providers in the area.

Weeks Medical Center (WMC) continues to provide MAT services through the North Country Recovery Center, serving 107 new patients during this reporting period. WMC continues to limit enrollment in the MAT program to those individuals who are established as primary care patients within their Rural Health Clinic. The counseling component of the MAT program continues to be crucial, and admission to the program is restricted to established WMC primary care patients due to the amount of counseling available at the clinic, which is limited by the size of their existing Behavioral Health team. Under WMC's contract with the Doorway sites in Berlin and Littleton for MAT services, there is no requirement for Doorway clients to be established WMC primary care patients. Weeks Medical Center was awarded IDN funding to expand their North Country Recovery Center services into the Colebrook area during this reporting period. This is separate from and in addition to their extensive work with the 2 Doorway programs in the region. Once established, WMC has stated an intent to leverage their expansion into the Colebrook community to partner with Upper Connecticut Valley Hospital and Indian Stream Health Center as part of the Doorway hub and spoke model in the northernmost reaches of the State.

Friendship House (FH), the only residential SUD treatment provider in Region 7 and the largest component of the Clinical Services Program at North Country Health Consortium (NCHC), has continued to strengthen the foundations of services and programs during the reporting period. The NCHC Clinical Services Program is comprised of inpatient high-intensity and low-intensity services at FH, an Intensive Outpatient (IOP) program, outpatient services, and an Impaired Driver Care Management Program. The agency has invested considerable time and effort during this reporting period preparing for an accreditation survey by the Commission on Accreditation of Rehabilitation Facilities (CARF). As part of this preparation, NCHC and Friendship House staff worked together to develop and enhance systems and policies to address CARF requirements for residential services and other treatment options. While formal survey results were not made available to NCHC by the end of this reporting period, the accreditation survey of the NCHC Clinical Services Program was conducted in June and preliminary feedback from the survey team at the exit conference was positive. As the organization awaited final notification of the accreditation decision, additional work was conducted to further align protocols and practices with best-practice recommendations from the survey team.

NCHC has identified accreditation as an essential step in being able to credential the Friendship House and its clinical programs with insurance plans, thereby increasing access to these critical services for potential clients who are otherwise unable to afford these services. To further this goal, a significant area of focus during CARF survey preparation was building the infrastructure to assess and improve upon the quality of service delivery. This included evaluation of clinical, financial, client experience and staff experience data points. Several components of these assessments also furthered FH's progress on DSRIP requirements, especially as they relate to the Core Comprehensive Standardized Assessment process. Additionally, FH was able to fill the Administrative Director position, contract with a Nurse Practitioner to serve as the agency's Medical Director and relocate the Berlin office to a larger and more prominent location on that city's main street in preparation of expanded IOP services later this year.

During this reporting Friendship House implemented a new curriculum, Seeking Safety. The new curriculum is an integrated treatment program aimed at addressing co-occurring PTSD and Substance Use Disorder and covers more than two dozen topics. The curriculum helps providers engage clients

with these dual diagnoses, teaching them the skills necessary to reduce the risk of self-harm and develop healthy relationships. Clients are working both in group sessions and individually with their counselors on treatment goals, using curriculum-specific tools and assignment sheets to develop goals and monitor progress. Additionally, the agency purchased and implemented the Matrix Model Intensive Outpatient Program, further strengthening the integrity of their IOP services. The Friendship House Intensive Outpatient Program has served 31 IOP clients during this reporting period.

This spring, several staff members at FH received training in Dialectical Behavioral Therapy, an evidence-based form of cognitive behavioral therapy designed to affect changes in behavioral patterns such as self-harm and substance misuse. FH will continue the spread of this evidence-based practice by scheduling a second training for staff in the fall of this year. The agency is working to train their recovery support staff to become CRSWs and will train agency staff in the Management of Aggressive Behaviors.

At this time, FH has opted to focus on strengthening its relationship with the Doorway sites instead of pursing a MAT program to avoid inefficient duplication of services in the region. As the Doorway sites generate data regarding the need for MAT services among their focus population and their ability to meet those needs, FH will remain engaged in conversations regarding the possible implementation of additional MAT services and the importance of hardwiring systems to ensure that MAT clients are connected to adequate BH services. Friendship House had one LADC on staff achieve MLADC status during this reporting period.

North Country Health Consortium (NCHC)'s Wellness and Recovery Model (WARM) team has offered multiple trainings and hosted several events throughout the North Country aimed at growing the local recovery workforce, raising awareness about Substance Use Disorders, and reducing stigma. The WARM team has expanded outreach efforts to include the Haverhill and Littleton communities as they work across Coös and Northern Grafton Counties. During the reporting period, the WARM team worked with the Lancaster and Littleton police departments to begin developing recovery-oriented policing models in the North Country. The WARM team presented information about the model to Coös and Grafton County Drug Treatment Courts, staff at Northern Human Services, representatives from the Doorway site in Littleton and the Director of the Emergency Department at Upper Connecticut Valley Hospital. Private service providers and civic organizations throughout the region have also received the WARM team's presentations.

The WARM team continues to help develop the Peer Recovery Coach Network throughout the region. The program has developed a volunteer database that the trained recovery coaches can opt into if interested in deploying into the region as needed. Recovery coaches throughout the region responded positively to this opportunity. The WARM team has also worked to build the network by participating in multiple conferences during this reporting period. In March 2019 WARM program staff and others from NCHC participated in the Bi-Annual Learning Collaborative Conference with a group of 27 participants from various community partners and coalitions. These participants encompass the Coös County and Upper Grafton County areas; one participant was from the Caledonia County in Vermont. The conference's goal was to gather community wide information about the Gaps/Needs and Opportunities/Resources in relation to Treatment, Intervention, Recovery and Prevention. The Peer Recovery Network is an important piece to both the IDN and the WARM program so collaboration between program staff will continue as they implement training plans across the region.

The WARM team and other members of the NCHC staff also were part of the 2019 Drug Summit in April hosted by NH Representative Linda Massimilla, with 95 participants in attendance. Among the attendees were various community professionals, educators, students, law enforcement officers, legislators,

county attorneys, physicians, business members, community members and representatives from the area's faith-based organizations. Most participants were from Coös, Grafton, and Carroll Counties, along with representation from the State of NH. The summit was value-added to the region as it convened multiple stakeholders to discuss local solutions to address the opioid crisis sweeping the nation. The group identified significant progress made in decreasing SUD stigma and increasing access to SUD treatment resources in the region. Lack of transportation and housing, along with the need for more treatment programs and recovery resources, were some of the unmet needs identified at the summit. Those in attendance left the summit reassured that the State and stakeholders had a plan to collaborate moving forward.

During this reporting period, the bulk of community education and engagement has been focused on the Colebrook community, with the WARM team hosting a kick-off event in May and a screening and panel discussion of the movie Pleasure Unwoven in June. The panel included the Medical Director of the Doorway sites in Berlin and Littleton, a licensed drug & alcohol counselor, representation from the recovery community, and a member of the WARM team representing recovery support services. Additionally, the WARM team hosted Recovery Coach Academy trainings in January and April, both of which included Narcan training for participants. In June, the WARM team also launched the North Country Recovery Chronicle – a scheduled newsletter that will provide information about recovery supports in the region. The June edition focused on meeting basic needs for individuals in recovery. In the coming reporting period, the WARM team will be conducting outreach activities in the Haverhill and Lancaster communities, meeting with community and clinical groups in Haverhill and hosting a Recovery Coach Academy training and community engagement activities in Lancaster.

The WARM team is currently receiving referrals from Northern Human Services, the Littleton Regional Healthcare Doorway site and Emergency Department, Coös County's Drug Treatment Court, local employers, and the HOPE Center. They are currently serving five active clients, three of whom have high needs and two who are in the maintenance phase of support services. Co-occurring conditions are common to all WARM clients and needs often include safe and reliable access to housing and food, connections to medical and dental care, SUD recovery supports and treatments, parenting supports and care for victims of domestic violence. Clients have been successfully placed at the Tyler Blain House, a safe domestic violence shelter, motels, and permanent housing. The WARM team reports that two clients have entered treatment, one has obtained employment and three are receiving services from Doorway sites.

Coös County Family Health Services (CCFHS) continues to provide MAT to their patients using updated policies and procedures as shown below. During this reporting period, the agency added one additional prescriber to the MAT team and is currently training another to be waivered in the upcoming months. This results in five MAT prescribers with one in training to staff the agency's MAT program. CCFHS has served 44 new patients with their MAT program during this reporting period. The agency reports that they have focused efforts during this reporting period on learning how to coexist with the Doorway at Androscoggin Valley Hospital since both entities serve patients from the same catchment area. This partner shared that anecdotal feedback from patients indicates that some patients perceive a difference in the level of restrictions and structure between the two programs. CCFHS shares that they will continue to collaborate with other MAT programs in the area, believing that the benefit of increased access to evidence-based treatment outweighs variations in individual program requirements, provided the long-term impact on the region's SUD population is positive.

CCFHS also reports that the agency has engaged in conversations with the NH Correctional Facility in Berlin regarding their MAT program for incarcerated individuals. The current prison model has opted to use an injectable medication to minimize the diversion of MAT medications, which occurs more frequently with medications in strip form. The Department of Corrections is interested in partnering with community MAT prescribers to ensure that individuals successfully treated with injectable medication can continue this regimen post-release. CCFHS uses a harm reduction model and has an interest in collaborating with Corrections to offer this injectable treatment option but reports that current pricing and reimbursement for this agent is cost-prohibitive for the clinic. CCFHS states an interest in offering this treatment option as soon as it is financially feasible.

North Country Serenity Center (NCSC) has significantly expanded their service offerings in the last six months. They moved to a new location on April 15 that has more space than their previous site. Since opening the new location, NCSC has seen a dramatic increase in visits to their organization, totaling over 500 visits in this reporting period and serving 211 unique individuals since opening in May 2017. NCSC continues to offer in-person and telephone-based Recovery Supports with six employed Recovery Coaches on staff and an additional Recovery Coach in place as an AmeriCorps volunteer. The Center also adjusted their hours based on the recovery community needs, adding Saturdays to the schedule of programming offered. NCSC's new offerings include meetings such as:

- Narcotics Anonymous,
- Three Principles,
- Youth Expressions,
- Coffee and Acoustic Jam,
- Family Support,
- Woman's Recovery,
- Exploring Spirituality,
- NAR A-NON, and
- Sober Parenting Journey

North Country Serenity Center has focused efforts during this reporting period on preparing to have their programs accredited by the Council on Accreditation of Peer Recovery Support Services (CAPRSS). This has required the development of policies, procedures, and systems to ensure that all items on the CAPRSS program inventory checklist are met. NCSC continues to collaborate with White Mountain Recovery Homes (WMRH), encouraging the clients of WMRH to attend meetings and join the peer advisory board for the Center. NCSC also continues to work the Ammonoosuc Community Health Center through a mutual referral process to provide collaborative care to shared patients. A CRSW from the Center and a Community Health Worker from ACHS meet bi-weekly to discuss the Recovery Wellness Plans of their mutual patients. A closed-loop referral protocol is under development to codify this effective relationship between these two Region 7 IDN partners.

Ammonoosuc Community Health Services (ACHS) continues to engage in the collaborative relationship with North Country Serenity Center to provide appropriate services to their mutual clients despite the loss of their Behavioral Health Case Manager early this year. ACHS reports that their Community Health Worker has stepped in to fill the role of their Behavioral Health Case Manager. This vacancy has created an increased case load and decreased follow-up rates for the CHW, but the agency has maintained the biweekly meeting plan with NCSC to ensure that their mutual patients are connected to appropriate services as needed. The agency plans to fill the Behavioral Health Case Manager vacancy as soon as possible. ACHS has also continued to provide Medication Assisted Treatment services to their own

primary care patients. Their evidence-based model requires patients to comply with guidelines for both therapy and medication management. The ACHS MAT program has served 18 new patients since starting as a new MAT service within the IDN. Currently, ACHS' four waivered MAT prescribers use a standardized protocol for screening and educating patients regarding the treatment.

White Mountain Community Health Center (WMCHC) continues to provide MAT services to their patients, serving 94 patients since beginning their program, which was in place prior to the start IDN activities. Although their single MAT prescriber is waivered to serve up to 100 patients, WMCHC reports that the clinic does not currently have the capacity to support a case load that large because the prescriber carries a full primary care panel and would need to decrease primary care hours in order to accommodate a larger MAT population. This prescriber continues to devote one day per week to the delivery of MAT services, maintaining a case load consistent with that of prior reporting periods. WMCHC reports that this agency has continued to foster strong connections with peer recovery supports in their catchment area of Northern Carroll County, including Mount Washington Valley Supports Recovery, rather than expanding their own internal workforce.

Saco River Medical Group (SRMG) continues to offer MAT services and feels that their program is functioning well. During the reporting period, the agency hired a new MAT waiver provider who is eager to grow the service at the agency. The addition of another provider has resulted in a total of three prescribers at the agency, who have delivered services to 132 individuals during the DSRIP period. SRMG currently refers patients out for LADC services and is in the process of recruiting a LADC to their team within the next reporting period.

Memorial Hospital continues to provide services to residents of Carroll County and neighboring communities in Maine through their Integrated Medication Assisted Treatment (I-MAT) and Prenatal New Life programs. The behavioral health team has regular interdisciplinary meetings and case reviews for patients in both programs. This partner invested a significant amount of time in an Electronic Medical Record (EMR) installation in the previous reporting periods, resulting in minimal capacity to engage in DSRIP reporting, but has completed this work and reengaged with the Region 7 IDN team during this reporting period to re-establish the flow of information regarding their efforts at providing integrated healthcare services to their patients. During this period, Memorial has also engaged in discussions with White Horse Addiction Center and Mount Washington Valley Supports Recovery regarding their new 24/7 Recovery Support Services project. In the coming reporting period, Memorial will collaborate with representatives from these Region 7 IDN partners to establish protocols that support the engagement of community-based recovery support workers in the Emergency Department setting.

Huggins Hospital reports that they continue the development of their MAT program, which will utilize integrated Primary Care and Emergency Department services. The agency reports that they have convened a Change Team for this project that includes Primary Care and ED providers, the ED Director, Care Coordination, Physician practice management, and revenue cycle. Drafts have been developed for policy, procedures, and protocols for MAT inductions in the ED and primary care, as well as assessment tools, financial assistance plans, MAT consent forms, and patient reference tools. They are currently researching where documentation of these services will be maintained, as their current EMR does not have the ability to segregate notes, thereby making compliance with SUD-related privacy rules a concern. Huggins also reports that the change team is in the process of scheduling site visits with LRGHealthcare Recovery Clinic and other community partners to collaborate resources. They have arranged for contracted Psychiatric NP services from Northern Human Services two days per week and

continue to research other options for another LICSW or MLADC for individual and group counseling. The revenue cycle team is reviewing billing and coding for counseling, as well as reimbursement for acupuncture services because one of their providers is interested in offering this option as part of treatment. This partner reports that the providers and some clinical support staff have completed Stigma Training. The change team is working on a plan for more comprehensive training, including web-based training for ED providers and staff, and workflow training for providers and staff this August and September. Huggins anticipates going live with their MAT program in October 2019.

White Horse Addiction Center (WHAC) has continued expansion throughout the Carroll County region to provide an array of services to the community. The Center is currently running two Intensive Outpatient (IOP) programs, one in North Conway and one in Ossipee. WHAC reports that enrollment in North Conway has dropped during this reporting period to three clients, potentially due to competing MAT programs in the area and the successful graduation of several clients earlier in the year. WHAC reports that they are carefully considering continuation of IOP in Conway because volume has been low during this reporting period. This partner shared that the agency is hopeful that their plan to provide MAT services in that community will result in an increase in referrals to and participation in the IOP program. The Ossipee IOP is currently serving 8-10 clients and WHAC is positioned to add another IOP if the need arises. During this reporting period, WHAC served an additional 26 individuals with IOP services.

Currently, WHAC refers clients to the Laconia Doorway site for MAT services. During the reporting period WHAC was able to recruit a MAT waivered APRN who is slated to start later this summer and may be able to initiate an inhouse MAT program. This partner continues to offer regular outpatient services including intervention, individual counseling, family counseling and recovery support services. WHAC has expended efforts this reporting period to expand their services by offering acupuncture as a recovery intervention, expanding behavioral health services to pediatric clients six years and older, and collaborating with Mount Washington Valley Supports Recovery (MWVSR) to provide emergency recovery support services to local Emergency Departments. The two agencies have dedicated time during this reporting period to the development of workflows and protocols for the upcoming 24/7 ER Recovery Support Service project that received funds through the IDN 7 Subrecipient Proposal process in May.

WHAC continues to offer recovery support services with twelve Recovery Coaches on staff, four of whom were hired during this reporting period. This partner continues to provide Recovery Coach Academy trainings and supplemental recovery coach trainings to keep their workforce thriving. WHAC reports that they have a Recovery Coach Academy scheduled to take place later this summer. The agency is also sending a senior staff member to the Connecticut Community for Addiction Recovery (CCAR) Recovery Coaching in the Emergency Department training, which includes a train-the-trainer component, in preparation of the new program being developed with MWVSR.

Mount Washington Valley Supports Recovery (MWVSR) has been actively involved throughout the community during the reporting period, delivering services and participating in resource meetings. The recovery community organization is collaborating on the 24/7 Recovery Support Service project with WHAC. The 2 agencies are working together to develop a program model and collaborate with local hospitals to ensure that patients in local emergency departments have access to peer recovery support services. Referral processes and service delivery protocols are being developed and workforce is ready to be deployed as soon as these steps are complete. MWVSR believes they can make a significant impact on how people who overdose in the ED are treated through the new 24/7 Recovery Supports program, and that the program will help to reduce stigma around addiction among hospital staff and

throughout the community. The team has participated in CCAR's Recovery Coaching in the Emergency Department training and is ready to engage with professional services and emergency responders in this new project.

MWVSR continues to provide recovery supports within the Carroll County region with four staff members, three of whom are CRSWs and one who is waiting to take the CRSW exam. The agency also hired one new volunteer into their volunteer recovery coach program. Two staff members were trained in Harm Reduction in June and another two were trained to be Self-Management and Recovery Training (SMART) facilitators for one of their current program models. The agency continues to run their Families Advocating Substance, Treatment, Education, and Recovery (FASTER) group and has trained another family member to become a facilitator for the group to increase capacity. The agency has had 475 interactions and served 144 clients during the DSRIP period.

Hope for NH Recovery (Hope) reports that they currently have three recovery coaches on staff who have served at least 60 individuals during the DSRIP period. During this reporting period, they have worked to become a spoke for the Berlin Doorway site. Through the new Monthly Update reporting mechanism, this partner has shared several stories that demonstrate the impact of the collaborative relationships being fostered through the Doorway's use of the hub and spoke model. Hope reports that they have seen an improvement in care delivery since they began working more closely with other service providers in the region.

North Country Health Consortium (NCHC) and the *Carroll County Coalition for Public Health (C3PH)* continue to engage the recovery community organizations within the region to encourage interagency collaboration. The agencies are also working in partnership with administrators of the Doorway sites within and proximal to the region to develop referral pathways between Region 7 IDN partners and the Doorway sites. C3PH has spent a substantial amount of time both convening and participating in various resource meetings across Carroll County to ensure the community is able to be served with SUD programs effectively in light of the fact that no Doorway sites were established in the county. NCHC continues to promote Recovery Coach Academy Trainings throughout the region and has been leveraging the work of NCHC's WARM program to ensure that IDN partners are aware of and have access to the educational opportunities hosted by the WARM team. As part of these efforts, NCHC held a community-wide Recovery Coach Academy (RCA) in January 2019, training 17 individuals from the region. The WARM program held a Recovery Coach Academy in April 2019 at which 4 participants were trained. Region 7 IDN also hosted an HIV/AIDS training for Recovery Coaches on March 27th, training 20 individuals from the region. The WARM program has two RCAs scheduled for upcoming months, one in July and another in August 2019. The NCHC WARM program and Region 7 IDN team meet regularly to coordinate trainings and determine the most effective way to reach the community. The programs are planning to provide trainings in Suicide Prevention, Ethical Considerations for Recovery Coaches, and HIV/AIDS in the upcoming months.

December 31, 2019 Update

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

Network Membership

During the reporting period of July 1 through December 31, 2019, no partners have left the network. The Region 7 IDN had one new member join the network – Coös County Department of Corrections – bringing the total number of partners in the Region 7 IDN to thirty-nine (39).

The information below speaks to the progress that Region 7 IDN has made on the D3 "Expansion in Intensive Substance Use Disorder (SUD) Treatment Options" community project during this reporting period.

Region 7 IDN Partner Specific Updates

Partner specific updates in this section reflect narrative regarding their progress along the continuum of the project, and their total number of unique individuals served during the DSRIP period through December 31, 2019.

Coös County Department of Corrections joined Region 7 IDN in October 2019 and was awarded funding to support Medication Assisted Treatment services and implement enhanced case management for inmates of the Coös County jail. The proposal was approved by the Steering Committee and preliminary work towards project deliverables began in late 2019. Coös County DoC has been offering MAT services to inmates previous to becoming a Region 7 IDN member and is currently treating 1 inmate in the program. The additional funds will help support the initiation of more inmates and strengthen the sustainability of the services. The partner has continuously used an authorized policy to determine the administration of MAT.

Coös County Department of Corrections plans to continue developing their MAT program and enhanced case management services throughout 2020 to increase quality care for inmates requiring increased supports in their recovery. It will be crucial for the agency to collaborate with partners throughout Region 7 IDN, most importantly Northern Human Services as that partner works to provide essential Behavioral Health services for the MAT program and has a plan for warm handoffs to providers that will maintain therapies post-release. Region 7 IDN is excited to welcome this new partner and assist in the growth of the supports they provide to incarcerated individuals.

Androscoggin Valley Hospital (AVH) and Littleton Regional Healthcare (LRH) continue to serve as the two Doorway sites for the North Country Region. LRH and North Country Healthcare (NCH) continued to adjust to LRH's separation from the NCH affiliation over the summer. During this quarter, Weeks Medical Center (WMC) was contracted with LRH to provided Medication Assisted Treatment and support to the Doorway at LRH. On December 1, WMC exercised the 30-day withdrawal clause of this contract and their provision of staff and clinical services to the LRH Doorway ended on December 30, 2019. LRH used the 30-day notice to actively recruit staff and clinicians in order to ensure that client services are not disrupted by the transition. WMC continues to support the Doorway at AVH.

Weeks Medical Center (WMC) saw substantial expansion during the reporting period including new sites offering MAT in Colebrook and Littleton. IDN funds were distributed to the agency in August of 2019 to expand into Colebrook and the program has already filled their entire panel and outgrown the space they had at Upper Valley Connecticut Hospital. The partner is actively looking to relocate to a different facility in the Colebrook area. WMC also spent time this reporting period preparing to open a new site in Littleton area for their North Country Recovery Center. The new office opened its doors to clients at the end of December.

Friendship House (FH) continued to grow and enhance their residential treatment and outpatient services while finalizing necessary policies and protocols developed as the program worked to earn accreditation from the Council on Accreditation for Rehab Facilities (CARF) earlier in the year. In mid-July, the facility learned that they had successfully earned full three-year accreditation (highest CARF accreditation status) on their first attempt. As the reporting period progressed, the FH team has continued diligent efforts to ensure that the CARF standards are maintained, providing ongoing

education and feedback to staff and clients. Reaching this milestone positions the facility to complete credentialing requirements for a number of commercial payers, thereby expanding access to treatment services.

The facility is committed to staff development and is working to train recovery support staff so they can become certified recovery support workers. Despite this commitment to staff development, the process of advancing staff to CRSW status is challenging due to staffing schedules and supervision requirements. FH leadership continue to work to find solutions to address workforce needs as they move into 2020.

During the reporting period, NCHC's Substance Use Disorder Clinical Services expanded their intensive outpatient program (IOP) to start providing services in the Berlin area. The program has served 36 new patients between July 1 and December 31, 2019. FH staff continue to build relationships with social service agencies in order to smooth the referral process for social support services for clients transitioning residential programing. FH has also continued to strengthen relationships with North Country Serenity Center and Ammonoosuc Community Health Services, two Region 7 IDN partners that provide FH residents with access to recovery meetings and primary care services.

Although FH hopes to offer Medication Assisted Treatment internally in the future, the facility does not currently offer MAT. In the interim, FH continues to refer clients out to both Doorway sites in Littleton and Berlin. Quality improvement staff are beginning to work on a closed-loop referral protocol to enter in WITS that will allow BDAS better insight regarding when clients are referred to HUB services. Currently there is a process in place, and FH is working to develop policies and protocol to solidify these processes. FH is also beginning work to implement Collaborative Care Agreements with several local partners to strengthen referral pathways across all settings.

North Country Health Consortium (NCHC)'s Wellness and Recovery Model (WARM) team has offered multiple trainings and hosted several events throughout the North Country aimed at increasing the recovery support services workforce and engaging the community around recovery awareness. Over 230 people participated in the listed trainings and events below:

- July 18-19 & 25-26, 2019: Recovery Coach Academy
- August 3, 2019: Addiction Hurts Panel Discussion
- August 12-13 & 19-20, 2019: Recovery Coach Academy
- August 26-28, 2019: Ethical Considerations for Recovery Coaches
- August 27, 2019: Recovery Friendly Workplace panel
- September 13-14 & 28-29, 2019: Recovery Coach Academy
- September 12, 2019: Mental Health First Aid for First Responders
- September 25, 2019: Mental Health First Aid
- September 28, 2019: Holistic Wellness Fair
- October 3 & 4, 2019: OUD in the 603
- October 7, 2019: WARM resource table NHS Employee Wellness Fair
- October 16,2019: Pleasure Unwoven Movie Screening w/ Panel Discussion
- October 23, 2019: WARM resource table at Health Rocks! LRH Health Fair
- November 13, 2019: Pleasure Unwoven Movie Screening w/ Panel Discussion
- November 25, 2019: Suicide Prevention
- December 4-5 & 11-12: Recovery Coach Academy
- December 10, 2019: North Country Healer's Forum

The team also completed planning for trainings that are being offered in early 2020. These upcoming trainings that will be available to Region 7 IDN partners and the community include:

- January 9, 2020: HIV/AIDS for Recovery Support Workers Training
- January 22, 2020: Pleasure Unwoven Movie Screening w/ Panel Discussion
- February 5-7, 2020: Ethical Consideration for Recovery Coaches
- February 27, 2020: Mental Health First Aid
- April 2020: Pleasure Unwoven Movie Screening w/ Panel Discussion

During the reporting period the WARM team developed a new 3-hour Recovery Boot Camp course to help educate multiple sectors across the region about recovery. The curriculum is intended to serve as a general education to populations interacting with those in recovery but not necessarily serving in a recovery coach capacity as a stigma reduction effort. Secondarily, it is also intended to serve as an introduction to recovery coach training for those who are contemplating that type of service. Development of the curriculum occurred in response to feedback from regional partners and collaborators that the 4-day Recovery Coach Academy created a significant staffing challenge for local organizations – one with limited return on investment if their primary intent was to provide introductory education to their staff. The curriculum was first developed for use with the Littleton Police Department, the first North Country law enforcement agency working to pilot a recovery-oriented policing model in collaboration with the WARM program. The team plans to offer the course to medical professionals, educators, legal system staff and any other sector with interest in the material.

The WARM program has expanded their program by hiring two new cross trained CHW/RC staff in the fall, serving 21 new clients during the reporting period. As the winter approached, the team focused on gathering cold weather resources for clients and creating supply backpacks to distribute to those in need. The team distributed 30 back packs to the homeless outreach agency, 12 back packs to Littleton PD and 4 backpacks to active clients during the reporting period. Referrals have been received from local partner agencies throughout the reporting period however volume remains low and further collaboration is necessary. The team plans to focus on strengthening collaborative relationships with partners and implementing formal agreements to improve transitions of care.

Coös County Family Health Services (CCFHS) continues to provide MAT to their patients while adjusting the program as more is learned about patients and collaborating providers. The agency continued to engage in conversations with the Doorway at AVH to strengthen collaboration and look for vulnerabilities in the program that could be addressed. The discussion was valuable and helped educate staff on a different perspective of harm reduction. CCFHS is committed to balancing harm reduction and patient engagement following past episodes of patient non-compliance with the CCFHS program. During this reporting period, CCFHS has served 21 new patients with their MAT program. Although the agency has seen less enrollment of pregnant women, the original target population of the program, the program has experienced overall growth and has required the addition of another half day of service offerings.

CCFHS continues to build relationships with local community partners including Hope for NH Recovery. During the reporting period, these two partners cohosted a meeting for local providers to come together to discuss prevention, treatment and aftercare as it relates to recovery. About 20 people attended the event and the group is interested in meeting on a quarterly basis to help move the area forward by better coordinating their services. CCFHS is also working to strengthen connections to the new Friendship House and Northern Human Services IOP programs serving the Berlin area. The strength

of these relationships will be crucial to providing quality care and ensuring smooth transitions for the patients in recovery.

North Country Serenity Center (NCSC) has seen significant growth during the past reporting period with over 2,700 visits to the center in the 6-month time period. NCSC completed renovations over the summer that improved the ability for the agency to offer in house meetings and recovery services to the community from their new location on Union Street in Littleton. The location of the center is now more central, and easier to recognize. This change in location has allowed NCSC to raise awareness within the community, resulting in increased need for the services provided. The agency continues to be dedicated to increasing capacity and quality of services for the region through innovative collaboration with community partners.

NCSC continues to employ six direct staff members, all trained as recovery coaches and working towards becoming Certified Recovery Support Workers. One center leadership staff member is dually trained as a Community Health Worker/Recovery Coach and is currently in the final stages of supervision needed to be a CRSW. NCSC built a new relationship with a local private practice MLADC to provide this supervision in order to help all employees towards final certification. The MLADC is also providing leadership supervision to the two leadership employees. Engaging this provider of supervision has been identified by NCSC as a key component of the center's sustainability plan. NCSC also has fifteen volunteers helping with programing within the center on an as needed basis. Volunteers are not required to be trained as peer recovery coaches, but if an interest is expressed by a volunteer who donates 100 or more hours of volunteer time to the center, NCSC has committed to helping them receive formal training in the field. The center reports that such dedicated volunteers have been an asset to community engagement and the overall operations of the center.

North Country Serenity Center continues to have a strong relationship with the local Doorway sites, including a verbal agreement for mutual referrals. The agency has reached out to Doorway staff to discuss entering into more formal agreements, however that has not yet been accomplished. NCSC is dedicated to keeping communication on this topic flowing to help improve the system moving forward. The same mutual referral relationships continue to exist with Weeks Medical Center's North Country Recovery Center, the NCHC Clinical Services Program and White Mountain Recovery Homes. Additionally, the center continues to collaborate with The Family Resource Center to offer the Sober Parenting Journey Program to clients, this relationship has been valuable for both agencies.

North Country Serenity Center reports that it will continue working to formalize agreements with local partners and update internal policies and procedures as necessary. NCSC intends to pursue Council on Accreditation of Peer Recovery Support Services (CAPRSS) accreditation as another means to sustain the programming they provide to the community. The agency's peer advisory board spent the reporting period evaluating the current NCSC policy and procedure manual and working diligently to align it with the CAPRSS standards for Recovery Community Organizations. The peer advisory board reviews and makes recommendations for edits which are then shared with NCSC leadership staff and passed on to NCSC's Board of Directors for final approval.

The relationship between NCSC and Ammonoosuc Community Health Services continues to develop despite transitions in key staff roles during the reporting period. The agencies continue to share clients and work towards formal joint service agreements for shared clients. The new ACHS BH/SUD case manager has communicated the option to connect clients to case management within a shorter timeframe to help the transition into primary care from being a barrier to treatment and recovery

progress. The BH/SUD case manager continues to visit the center once a week for an hour to provide support and resources to NCSC clients and staff.

Ammonoosuc Community Health Services (ACHS) continues to collaborate closely with North Country Serenity Center as mentioned above. The collaboration of formalizing agreements and procedures with NCSC to provide medical, dental, vision, behavioral health, and substance misuse treatments along with nutrition and patient navigation services while utilizing NCSC's peer support and recovery support services for ACHS patients was briefly tabled during staffing transition at ACHS in summer 2019. Once a new BH/SUD case manager was hired, the agencies resumed work to revisit the terms of the agreement proposed. By using its internal capacities and leveraging its relationship with NCSC, this agreement will allow ACHS the ability to provide complete wrap-around services for patients with mental illness and substance use disorders, and for individuals that exit correctional facilities, residential programs, or hospitals. The goal of this collaborative effort is to ultimately reduce recidivism and relapse rates and expand behavioral health services. Since August 2018, ACHS has been working with North Country Serenity Center to provide Recovery Support Services for 24 patients/clients with SUD.

ACHS has continued to provide admission physicals as requested and has also worked with FH to establish primary care services for FH clients who remain in the ACHS operational area of Northern Grafton and Southern Coös counties after discharge. Disruptions in staffing at ACHS have also necessitated a pause in the manual process that provided daily notification to ACHS behavioral health staff when clients were seen in an Emergency Department (ED) for behavioral health or substance use reasons. Regardless, as a user of the Collective Medical network, ACHS continues to receive event notifications and that information continues to reach providers through the CM integration with the ACHS medical record system.

ACHS continues to staff five prescribers, two LICSWs, a BH/SUD case manager and Patient Navigators as internal resources for patients with SUD in the Woodsville and Littleton locations. This structure has also helped the partner expand the delivery of Medication Assisted Treatment services to internal patients at their Littleton and Woodsville office, serving 14 patients during the reporting period. ACHS continues to periodically assess the policies and workflows related to these services to ensure that they remain consistent with best practices.

ACHS continues to work with Grafton and Coös County offices to provide medical, dental, vision, mental health and substance misuse treatment as well as nutrition and patient navigator services to persons as part of alternative sentencing plans. ACHS provides re-entry and recovery support to individuals released into ACHS' support area of northern Grafton and southern Coös counties. ACHS has established relationships with the Grafton County Corrections, Grafton County Alternative Sentencing, and Federal Alternative Sentencing (Laser Docket) programs to provide immediate services for those convicted of SUD related crimes.

White Mountain Community Health Center (WMCHC) continues to provide MAT services to their patients. During this reporting period the agency served 12 new patients, totaling 106 since the beginning of the program. The staff structure and procedures of the program have not changed during this reporting period and the partner continues to foster strong connections with peer recovery supports in their catchment area of Northern Carroll County, including Mount Washington Valley Supports Recovery, rather than expanding their own internal workforce.

Saco River Medical Group (SRMG) continues to offer MAT services to their patients, having served a total of 155 patients since the beginning of the program in 2016. The agency lost a primary care provider who

was MAT waivered, but the two remaining waivered providers had bandwidth to manage the existing MAT population and the practice will continue to provide MAT services at this reduced staffing level. SRMG is considering providing MAT education to other PCPs to increase MAT capacity in the future. At the end of November, a pediatric provider went through the waiver course but ultimately made the decision not to move forward with the waiver process due to the patient population they serve. Currently the agency has not seen a need for this service in the pediatric population but has noted an increased need for these services in the young adult population, leading SRMG to question whether more pediatric screening and intervention opportunities are warranted. SRMG continues to collaborate with local recovery resources throughout the region and has been in communication with White Horse Addiction Center to begin conversations about using a collaborative care agreement to formalize their relationship.

Memorial Hospital continues to offer MAT services through their IMAT and New Life Prenatal programs. There have not been significant changes to either program during this reporting period and the agency reports that they review related policies and procedures regularly to ensure continued utilization of evidence-based practices. The New Life Prenatal program continues to promote a centralized care approach linking Midwifery/Obstetric care and treatment for SUD with a goal of improving the coordination of care, ongoing maternal success, newborn health, and patient experience. As of September 2019, there were 9 mothers participating in the weekly programing that includes education on various topics related to pregnancy, well-being and infant care. The mothers also participate in group substance misuse counseling sessions with the psychologist, social work support services (housing, transportation), prenatal care visits with Certified Nurse Midwife, physician visits for pharmacologic management of opioid dependence, and healthcare coordination and follow up by an RN coordinator. The program offers complementary therapies to support mental wellness and referrals to other community support services.

The IMAT program continues to be fully integrated into the primary care department and is staffed by two waivered providers, two psychiatric nurse practitioners, a behavioral health navigator, four medical assistants, one RN, and administrative support staff. A third provider is also working to obtain a waiver in order to contribute to overall capacity for the practice. All IMAT patients who screen positive for depression or score at least a 4 on their ACE questionnaire are referred to behavioral health services for treatment of dual diagnoses and/or trauma. Patients are seen monthly and there is availability to be seen 4 days a week. At last report in September, Memorial reported that there were a total of 99 patients served by their IMAT program.

Huggins Hospital worked diligently during this reporting period to finalize the details of their new MAT program, which was funded during the fourth round of Region 7 IDN project-based proposals. The program is close to a formal launch, which is anticipated to occur by the end of January 2020. They have had a soft launch of processes as they added a new provider who came to the practice already MAT waivered. Thirteen of this provider's MAT patients followed her to the Huggins practice, and she has been an asset to the development of the program's workflows and protocols, lending her experience to provide guidance to the project implementation team. As Huggins approaches the formal program launch, they are finalizing some of the tools for in-office urine drug screening and establishing a process for having distributable Narcan in the office rather than having to send people home with prescriptions to be filled. The newly waivered providers have not started offering MAT yet as the implementation team worked to answer process-oriented questions and address provider concerns about the program. The implementation team reports that additional stigma reduction training and provider education seems to have left the providers feeling more confident about the program launch.

White Horse Addiction Center (WHAC) experienced ongoing growth during the reporting period, including continued work on marketing and development of the organization which has helped with a complete rebranding of the organization. Although formal trade name changes are not yet complete, the agency is now using White Horse Recovery and Behavioral Health Services as their organizational identity on outward facing communications in order to better showcase the expansion of their behavioral health services in addition to the SUD treatments and recovery supports that they initially provided to the community. The trade name White Horse Addiction Center is anticipated to change in 2020, after careful attention has been paid to ensure that all partner agreements and contracts are revised accordingly.

WHAC has worked with a consultant to help rewrite protocols to create an integrated multi-disciplinary care environment. The consultant is employed part-time by WHAC and holds a PhD and MLADC. His focus is on helping WHAC formalize relationships with key stakeholders to collaborate on the provision of quality care for clients. The agency has also been working to formalize agreements with primary care and residential programs to further this goal. As part of their ongoing sustainability plan, WHAC hopes to expand the organization's capacity to grow their own clinicians and offer preceptorships to students by developing collaborative relationships with University of New Hampshire and other key stakeholders. As 2020 progresses, WHAC is evaluating alternate business lodgings that will accommodate an educational center for individuals in Carroll County who are interested in pursing CRSW, MLADC and LCMHC credentials.

WHAC currently has an LICSW/LADC candidate taking part in supervision. Once these requirements have been met, the provider will be duel licensed – a goal that WHAC has for all clinicians on staff. In addition, WHAC has an LCMHC on staff who is also an MLADC candidate waiting for certification approval from the licensing board. The agency also employs three CRSWs, one who serves as a behavioral health case manager, and three MLDACs to provide SUD, mental health, behavioral health, case management, peer recovery and newly developed MAT services. The MAT services began in December 2019 and the agency served four clients during that time. Currently WHAC has eight peer recovery coaches who provide essential one-on-one recovery supports and staff the newly developed 24/7 Emergency Department recovery support services in partnership with Mount Washington Valley Supports Recovery (MWVSR). To date, WHAC has served 235 clients with recovery coaching.

During the reporting period, WHAC and MWVSR worked diligently to develop their 24/7 recovery support model, servicing individuals in the Memorial Hospital emergency department. By December 2019, the new project had served 6 patients and word of the service started to spread on both social and traditional media platforms. Broader interest in this type of on-call recovery support is growing, and the program expects to serve many more individuals in the coming months. WHAC has begun working with Memorial on a revised MOU for long-term support and exploring primary care involvement in addition to the ED. Expansion into southern Carroll county is anticipated as WHAC's relationship with Huggins Hospital is strengthened and the project makes progress in early 2020.

WHAC is dedicated to expanding their service lines and capacity to address ongoing challenges throughout the county, including homelessness and transportation. The agency's long-range goals include plans to develop options to reduce these barriers in the next few years. The agency has deepened relationships with residential treatment centers throughout the country that are proving to be valuable resources in assisting WHAC with the development and implementation of a sustainable business plan and vision for the future. Sustainability remains a focal point for this partner as they investigate funding sources, including grants, fostering relationships with private investors and the

development of enduring endowments. Additionally, seeking licensure and credentialing for staff and programs will provide WHAC with the means to be reimbursed by multiple payers for the services they provide.

Mount Washington Valley Supports Recovery (MWVSR) continues to be an asset to the region as a key stakeholder in the Carroll County recovery community. The agency continues to offer one-on-one and telephone recovery coaching. MWVSR is working to ensure that staff members receive the necessary education to become CRSWs, including sessions of the three core courses: HIV/AIDS, Suicide Prevention, and Ethical Considerations.

MWVSR spent the reporting period preparing to launch a new syringe service program in early January 2020. The service will provide participants with two clean syringes, a clean set of rubber gloves, alcohol and wipes and literature on where to get HIV/Hepatitis C testing and Pre-Exposure Prophylaxis (PrEP) medication. This new service will be valuable to the region's harm reduction efforts, and staff are taking courses related to this new service line to ensure it is delivered in accordance with the rules established by the NH Department of Health & Human Services.

As noted above, MWVSR stepped into a formal agreement with WHAC to develop a 24/7 recovery support services program for individuals in the Memorial Hospital emergency department. Although the program was slow to launch, the focus of MWVSR and WHAC to ensure that the program was well developed and that appropriate contracts were in place was important to the successful implementation of the program. Initial use was low, but the center noted that calls did increase through the holiday period and initial goals of the program have been met, including the deepening of collaborative relationship between the three parties. The project has seen strong support from Memorial Hospital and is expected to expand during 2020.

During the reporting period there was no staff turnover, although this partner has seen the need for their services increase and as a result there is now the need to add one more volunteer recovery coach and possibly a part-time CRSW. The agency continues to have volunteers complete six months of service before offering to bring them onto payroll. MWVSR credit the increase in services provided to their ongoing collaboration with Region 7 IDN Partners Memorial Hospital, Saco River Medical Group and White Mountain Community Health Center. These three primary care partners have been making referrals to MWVSR in the hopes that the RCO can help address social service needs of their shared clients.

During a recent reporting call, MWVSR stated they believe the RCOs in Carroll County have emerged as pseudo-Doorway NH sites in the care coordination process, because the four Doorway sites located proximal – but not in – Carroll County are difficult for clients to access as a result of distance and geography in a county with limited to no public transportation. MWVSR noted that they do work with the Doorways, but often fill service needs for clients in the space between their immediate referral for Doorway intervention and their ability to actually get to an intake appointment. This perception was echoed during discussions with the Carroll County Coalition for Public Health, who noted that the recovery community in Carroll County has really pulled together in 2019 to be sure that residents needing recovery services are well served and supported.

Hope for NH Recovery (Hope) reports that they currently have three recovery coaches on staff who have served at least 13 new individuals during this reporting period. One of these three recovery coaches is cross trained as a Community Health Worker and is currently employed as the Center Manager at the Berlin location. The remaining recovery coaches serve in a volunteer capacity at this time. All staff are

working towards becoming Certified Recovery Support Workers, but still require the necessary 25 hours of supervision to complete the certification process. The center is exploring options for contracting out for supervision including the potential of using the services of an MLADC from White Horse Addiction Center.

During this reporting period, the agency continued to work with the Berlin Doorway site for mutual referrals. Center staff noted that there is a gap in understanding – both at a community level and among the population served – between harm reduction and recovery maintenance. The center is also collaborating with Coös County Family Health Services for mutual referrals and beginning a relationship with The Family Resource Center at Gorham to develop necessary recovery programing for the area. Currently the center offers multiple meetings, along with one-on-one recovery coaching and social supports.

Hope for NH Recovery has been actively searching for a new building to improve accessibility of services and meetings. The current location is difficult for clients to travel to due to lack of transportation, a consistent challenge throughout the region. The center has also seen a continued need for resources to address homelessness within the recovery community, which is hampered by a significant lack of housing options in the region and the state as a whole. The center works to help walk-in clients find sober housing to move them forward in their recovery, but notes that many sober houses do not accept clients on Medication Assisted Treatment programs, specifically synthetic medications such as Suboxone. In a region with insufficient temporary housing options for the general population, this has surfaced as a serious barrier in the North Country for those entering recovery, and is compounded by inadequate transportation resources to move individuals to sober housing that will accept individuals on MAT when a bed is available.

As Hope for NH Recovery solidifies relationships within the area through formal agreements, they will be able to provide quality recovery maintenance services through one-on-one recovery coaching to help address these challenges. This will become more structured as collaboration continues and center staff obtain CRSW status. The certification of CRSWs will allow for increased sustainability as the center becomes able to bill and be reimbursed for recovery support services. The center also continues to search for grant opportunities and philanthropic support to their sustainability.

Northern Human Services (NHS) In December 2019, Northern Human Services (NHS) worked to implement a new Intensive Outpatient Program for justice-involved clients, including those engaged in open cases with the courts, DCYF, drug court, and/or probation programs. NHS is also willing to take referrals for individuals outside of this target population if there is space available. The program is offered to Coos and Carroll County residents through NHS' Berlin and Conway offices, using two providers at each site and utilizing video for group session 3 days per week for 3 hours at a time.

The *Carroll County Coalition for Public Health (C3PH)* continue to support the Recovery Community Organizations and facilitate the development of collaborative relationships across the region. C3PH has been working closely with White Horse Addiction Center and Mount Washington Valley Supports Recovery during the implementation of their 24/7 recovery support services. C3PH has been an important supporter of the relationship between the two RCOs and Memorial Hospital's Emergency Department. C3PH has also seen strengthening of the partnership with Huggins Hospital in the southern part of the county as they finalize the implementation of their new Medication Assisted Treatment Program.

As noted above, Carroll County partners have the choice between multiple Doorways proximal but not located within the county. C3PH reports that the distance and geography between Carroll County population centers and these Doorway sites, combined with a lack of public transportation in this rural county, has proven to be a significant barrier to access for the population. In response to this identified barrier, C3PH has focused efforts during the reporting period on coordinating more local supports throughout the county. The organization has helped strengthen and create partnerships within the recovery community to increase the amount of spoke services available to provide immediate support until the transportation challenges related to distance and geography can be overcome for clients to reach a Doorway site for intake.

Changes under the State Opioid Response grant have resulted in Narcan distribution being the responsibility of the Doorway sites, so C3PH has stopped providing this service. Any distribution to area Recovery Community Organizations comes from the Doorways, however C3PH has noted that there have been several public events during this reporting period that included Narcan distribution and training.

C3PH has also expended efforts during this reporting period to support the delivery of MAT services to individuals incarcerated at the Carroll County jail. Early in the fall, the Carroll County Department of Corrections Superintendent presented a policy and procedure for the delivery of MAT treatment to the County Commissioners. There have been a number of follow up meetings to discuss whether MAT can be inducted during the period of incarceration, and C3PH has provided testimony and letters of support for the MAT program to include both continuation and induction of the treatment in accordance with best practices. At this time, incarcerated individuals who have been participating successfully in MAT prior to incarceration are continuing to receive this treatment at an outpatient clinic in the region, and no MAT services are being provided by the MAT waivered providers serving the jail.

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.

December 31, 2018

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	2	3
# of individuals to be served with new MAT services in Region 7	35 by 12/31/2018	0	10	28
# of new sites offering intensive outpatient (IOP) services	1 by 12/31/2018	0	0	0
# of individuals to be served with IOP services	144 by 12/31/2018	25	66	156
# of existing IOP providers expanding services	3 by 12/31/2018	0	0	1
# trained Peer Recovery Coaches	6 by 12/31/2018	22	59	67
# of individuals served by Peer Recovery Coaches	50 by 12/31/2018	0	109	222

Although Region 7 IDN has seen significant growth in MAT services in the region the metric for "number of individuals to be served with new MAT services"" was not met because currently there are only three agencies being included for this measure: Coös County Family Health Services, Ammonoosuc Community Health Services, and Huggins Hospital. These are the three agencies which established MAT programs after the submission of the region's implementation plan and therefore are being considered as new MAT programs for the region. Huggins Hospital is still working to stand up their MAT program and get providers trained to delivery MAT services, which delayed their ability to start seeing patients before December 31st, 2018. Their program is anticipated to be completely stood up within the first few months of the next reporting period, which will help increase these numbers. ACHS hasn't seen much growth to date in their program due to their model of only accept existing patients and push back from these patients related to the MAT program requirements. However, CCFHS has expanded their program to include prenatal patients, new moms and partners of new moms, and then adding patients referred to the program by CCFHS primary care providers. The region anticipates meeting this metric in the next reporting period due to the two NH Doorways at Littleton Regional Healthcare and Androscoggin Valley Hospital.

Due to workforce shortages Region 7 IDN has not been successful thus far with new or expanded IOP services. When the region's implementation plan was submitted it was hoped that Indian Stream Health Center may expand their IOP, but the agency has stopped providing the service due to staff turnover.

Friendship House is still working to expand IOP services and will do so once the agency has adequate staffing in place. NCHC will work closely with IDN partners in the region to investigate the feasibility of another agency establishing a new IOP in the region.

June 30, 2019 Update

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

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

Performance Measure Name	Target (by 12/31/18)	Progress Toward Target		
		12/31/18	6/30/19	12/31/19
New MAT services in Region 7	3	3	5	
Individuals served with new MAT services in Region 7	35	28	211	
New sites offering intensive outpatient (IOP) services	1	0	1	
Individuals served with IOP services	144	156	189	
Existing IOP providers expanding services	3	1	**2**	
Trained Peer Recovery Coaches	6	67	88	
Individuals served by Peer Recovery Coaches	50	222	480	

The addition of two Doorway NH sites to the region during this reporting period provided an opportunity to for new MAT sites to be introduced. This has resulted in a significant increase in the number of individuals being served by new MAT services in the region. Region 7 IDN partners did not expand IOP services during this reporting period, instead focusing on the strengthening of existing program infrastructure as preparation for further expansion efforts. Region 7 IDN has verified that, since the start of the DSRIP, 88 individuals within the region have been trained as Peer Recovery Coaches. The Region 7 IDN team has been able to confirm that 35 of these individuals are actively employed by Region 7 IDN partners. The region saw increased engagement of clients being supported by Peer Recovery Coaches, evidenced by more than a doubling of individuals served by Peer Recovery Coaches in the January to June timeframe. It is clear that the region had need for and is benefitting from this component of SUD treatment services.

In the coming reporting period, the Friendship House plans to work with Region 7 IDN partners in the Berlin area to expand IOP services to that community. The Region 7 IDN team will continue to offer support to SUD treatment partners throughout the region to support sustainable expansion of IOP and MAT programs and deepen connections between service providers across the recovery community.

During the review period, the Friendship House successfully began providing IOP services in Berlin, adding another existing IOP provider to the list of those expanding services in the region. Ahead of this launch, the Friendship House, Coös County Family Health Services and Northern Human Services, among other Region 7 IDN partners, met extensively to ensure that this expansion of IOP services was established with a strong understanding of community need, available resources, and likely referral patterns. While still not meeting the target of three existing providers expanding this service, this is reflective of the collaborative work among Region 7 IDN partners to thoughtfully deploy resources in areas where they are needed while maintaining a focus on sustainability.

December 31, 2019 Update

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

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

Performance Measure Name	Target (by 12/31/18)	Progress Toward Target		
		12/31/18	6/30/19	12/31/19
New MAT services in Region 7	3	3	5	7
Individuals served with new MAT services in Region 7	35	28	211	591
New sites offering intensive outpatient (IOP) services	1	0	1	4
Individuals served with IOP services	144	156	189	280
Existing IOP providers expanding services	3	1	2	4
Trained Peer Recovery Coaches	6	67	88	88
Individuals served by Peer Recovery Coaches	50	222	480	975
Staff recruited and trained vs. projected	31	116	148	148
Individuals served vs. projected	229	406	880	1594

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	Staffing on 6/30/19	Staffing on 12/31/19
Community Health Workers	4	0	13	13	13	18	19
Psychiatric Nurse Practitioners	3	1	2	5	7	11	11
Peer Recovery Coaches	6	2	22	59	67	88	88
MLADC	3	0	0	3	4	14	16
Case Management	2	2	4	6	15	67	66
Staff recruited and trained vs. projected	31	16	52	96	116	148	148

D-4. IDN Community Project: Budget

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

December 31, 2018

Budget Period:	01/01/2017-12/31/2017	01/01/2018-06/30/2018	07/01/2018-12/31/2018	01/01/2019-12/31/2019	01/01/2020-12/31/2020	01/01/2021-06/30/2021
	Expansion in SUD Actual Funds Spent	Expansion in SUD Actual Expense (6 months)				
SUD	CY 2017 Actuals	CY 2018 January to June Actual	CY 2018 July to Dec. Actual	CY 2019 Projected	CY 2020 Projected	CY 2021 Projected
1. Total Salary/Wages						
2. Employee Benefits						
3. Consultants			$0	$0	$0	$0
5. Supplies:			$0	$0	$0	$0
Educational			$0	$0	$0	$0
Office	$968	$71	$76	$2,550	$2,550	$1,275
6. Travel		$368	$0	$0	$0	$0
7. Occupancy			$0	$0	$0	$0
8. Current Expenses			$0	$0	$0	$0
Telephone			$0	$0	$0	$0
Postage			$0	$0	$0	$0
Subscriptions			$0	$0	$0	$0
Audit and Legal			$0	$0	$0	$0
Insurance			$0	$0	$0	$0
Board Expenses			$0	$0	$0	$0
9. Software		$443	$0	$1,011	$1,011	$505
10. Marketing/Communications	$1,086	$572	$1,797	$579	$579	$289
11. Staff Education and Training		$522	$0	$0	$0	$0
12. Subcontracts/Agreements			$0	$0	$0	$0
13. Other (specific details mandatory):			$0	$0	$0	$0
Current Expenses: Administrative Lead Organizational Support	$1,634	$930	$1,306	$4,312	$4,312	$2,156
Support Payments to Partners	$65,766	$59,987	$43,338	$181,953	$181,953	$90,977
TOTAL	**$69,454**	**$62,893**	**$46,517**	**$190,405**	**$190,405**	**$95,202**

Consistent with all prior reporting, report begins with January 1, 2017 utilizing capacity building funds to maintain infrastructure.

IDN 7 projects the additional amount approved at June 2017 quarterly meeting to absorb future anticipated line item variances in Salary, Benefits, Software and Training.

June 30, 2019 Update

Budget Period:	01/01/2017-12/31/2017	01/01/2018-12/31/2018	01/01/2019-06/30/2019	07/01/2019-12/31/2019	01/01/2020-12/31/2020	01/01/2021-06/30/2021
SUD	CY 2017 Actuals	CY 2018 January to December ACTUAL	CY 2019 January to June ACTUAL	CY 2019 July to December PROJECTED	CY 2020 Projected	CY 2021 Projected
1. Total Salary/Wages						
2. Employee Benefits						
3. Consultants		$0		$0	$0	$0
5. Supplies:		$0		$0	$0	$0
Educational		$0		$0	$0	$0
Office	$968	$147	$116	$116	$232	$116
6. Travel		$368	$418	$418	$836	$418
7. Occupancy		$0		$0	$0	$0
8. Current Expenses		$0		$0	$0	$0
Telephone		$0		$0	$0	$0
Postage		$0		$0	$0	$0
Subscriptions		$0		$0	$0	$0
Audit and Legal		$0	$190	$190	$379	$190
Insurance		$0	$105	$105	$209	$105
Board Expenses		$0		$0	$0	$0
9. Software		$443	$238	$238	$476	$238
10. Marketing/Communications	$1,086	$2,369	$179	$179	$358	$179
11. Staff Education and Training		$522		$0	$0	$0
12. Subcontracts/Agreements		$0		$0	$0	$0
13. Other (specific details mandatory):		$0		$0	$0	$0
Current Expenses: Administrative Lead Organizational Support	$1,634	$2,236		$0	$0	$0
Support Payments to Partners	$65,766	$103,325	$26,708	$26,708	$53,417	$26,708
TOTAL	**$91,231**	**$140,409**	**$50,680**	**$50,680**	**$91,536**	**$50,680**

Consistent with all prior reporting, report begins with January 1, 2017 utilizing capacity building funds to maintain infrastructure.

IDN 7 projects the additional amount approved at June 2017 quarterly meeting to absorb future anticipated line item variances in Salary, Benefits, Software and Training.

Incentive Payments from January 2019 through December 2020 reflect a reduction based on anticipated DHHS action and county participation.

Budgets for project remainder reflect revised staffing structure in attempt to maximize funds available to partners.

December 31, 2019 Update

Budget Period:	01/01/2017-12/31/2017	01/01/2018-12/31/2018	1/1/2019 - 6/30/2019	7/1/2019 - 12/31/2019	1/1/2019 - 12/31/2019	1/1/2020 - 6/30/2020	7/1/2020 - 12/31/2020	01/01/2020-12/31/2020	01/01/2021-12/31/2021
SUD	CY 2017 Actuals	CY 2018 January to December ACTUAL	CY 2019 January to June ACTUAL	CY 2019 July to December ACTUAL	CY 2019 January to December ACTUAL	CY 2020 Jan to June PROJECTED	CY 2020 July to Dec PROJECTED	CY 2020 Projected	CY 2021 Projected
1. Total Salary/Wages									
2. Employee Benefits									
3. Consultants		$0			$0	$0	$0	$0	$0
5. Supplies:		$0			$0	$0	$0	$0	$0
Educational		$0			$0	$0	$0	$0	$0
Office	$968	$147	$116	$95	$211	$106	$106	$211	$106
6. Travel		$368	$418	$531	$949	$474	$474	$949	$474
7. Occupancy		$0			$0	$0	$0	$0	$0
8. Current Expenses		$0			$0	$0	$0	$0	$0
Telephone		$0			$0	$0	$0	$0	$0
Postage		$0			$0	$0	$0	$0	$0
Subscriptions		$0			$0	$0	$0	$0	$0
Audit and Legal		$0	$190	$179	$369	$184	$184	$369	$184
Insurance		$0	$105	$96	$201	$100	$100	$201	$100
Board Expenses		$0			$0	$0	$0	$0	$0
9. Software		$443	$238	$386	$624	$312	$312	$624	$312
10. Marketing/Communications	$1,086	$2,369	$179	$192	$371	$186	$186	$371	$186
11. Staff Education and Training		$522			$0	$0	$0	$0	$0
12. Subcontracts/Agreements		$0			$0	$0	$0	$0	$0
13. Other (specific details mandatory):		$0			$0	$0	$0	$0	$0
Current Expenses: Administrative Lead Organizational Support	$1,634	$2,236			$0	$0	$0	$0	$0
Support Payments to Partners	$65,766	$103,325	$26,708	$41,407	$68,115	$26,433	$61,677	$88,110	$44,055
					$0				
TOTAL	**$91,231**	**$140,409**	**$50,680**	**$61,855**	**$112,535**	**$48,643**	**$83,887**	**$132,530**	**$66,265**

Consistent with all prior reporting, report begins with January 1, 2017 utilizing capacity building funds to maintain infrastructure.

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)
Ammonoosuc Community Health Services	Y
Coös County Department of Corrections	Y
Coös County Family Health Services	Y
Friendship House	Y
Hope for NH Recovery	Y
Huggins Hospital	Y
Memorial Hospital	Y
Mount Washington Valley Supports Recovery	Y
North Country Serenity Center	Y
Northern Human Services	Y
Weeks Medical Center	Y
White Horse Addiction Center	Y
White Mountain Community Health Center	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.
(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

Project Team Member	Roles and Responsibilities
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

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, Coös 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 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	B1

	practices around Zero Suicide and suicide prevention	
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	C1

	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.	
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	B1, C1, D3, E5

	members, IT staff, and other pertinent agency staff.	
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	B1

	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.	
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	B1, C1, D3, E5

	for calling 911 and rescue breathing.	
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 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	D3

	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	
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

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	6/30/19	12/31/18
D-1	IDN Community Project Timeline, Key Milestones and Evaluation Project Plan	Spreadsheet (Microsoft Project or similar platform)						
D-2	IDN Community Project Evaluation Project Targets	Table						
D-3	IDN Community Project Workforce Staffing	Table						
D-4	IDN Community Project Budget	Narrative and Spreadsheet						
D-5	IDN Community Project Key Organizational and Provider Participants	Table						
D-6	Clinical Infrastructure: IDN Community Project Standard Assessment Tools	Table						
D-7	Clinical Infrastructure: IDN Community Project Protocols for Patient Assessment, Treatment, Management, and Referrals	Table						
D-8	Clinical Infrastructure: IDN Community Project Roles and Responsibilities	Table						
D-9	Provide the training plan and curricula for each Community Driven Project as required in A-1.3	Training schedule and table						

Projects E: Integration Focused

IDN Community Project Implementation and Clinical Services Infrastructure Plan

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

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

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

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

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

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

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

December 31, 2018

During the reporting period of 07/01/2018-12/31/2018, Region 7 IDN had no new agencies join the IDN network and no members leave.

Region 7 IDN continued to make progress on Project E5, Enhanced Care Coordination for the High Needs Population, during the reporting period of July-December 2018. Region 7 IDN partner agencies had opportunities to attend trainings to improve care coordination services, participate in the new Region 7 IDN Webinar Series to learn more about risk stratification, and participate in new Multi-Disciplinary Core Team meeting within their agencies to discuss high risk patients.

Region 7 IDN staff repeated the two-day Regional Care Coordination training in November 2018 for partner agencies in Coös and northern Grafton Counties so staff could learn how to improve care coordination services for the high needs population as these patients transition between agencies. The region's implementation plan focused on training five Care Advocates in each subregion in 2018, but it has become apparent that Coös and Northern Grafton are acting as one subregion instead of two in regard to this project, largely due to collaborative relationships within North Country Healthcare affiliation. For example, North Country Healthcare has been working on a regional care coordination approach and only sent two staff members to the training versus one from each of the five affiliate agencies. As a result, six participants attended the training, representing Weeks Medical Center, Littleton Regional Healthcare, Northern Human Services, Ammonoosuc Community Health Services, and Rowe Health Center/Cottage

Hospital. The training agenda structure was adapted using feedback from the first Regional Care Coordination training held in March 2018, but the topics of the training remained the same. This was an important aspect of the training since the region is focused on a regional training approach to deliver enhanced care coordination. The agenda for the training is shown below:

Day 1: Thursday, November 29

- Who's Driving the Bus to Integrated Healthcare?
- What is the Shared Care Plan and How Can It Help?
- Patient Advocacy & Cultural Humility
- Ethical Communication and Decision-Making in an Integrated Care Environment

Day 2: Friday, November 30

- Enhanced Care Coordination for High Needs Population
    - Toolkit review and how to utilize it
    - Sample workflows
    - Breakout sessions for workflow development
- Health Literacy
- Connecting with Regional & State Resources
- Risk Stratification Workflows & Multi-Disciplinary Core Teams
- Closed Loop Referrals and Collaborative Care Agreements

Region 7 IDN HIT Integration Coach joined staff from Collective Medical Technologies to highlight the value of CMT's shared care plan platform in improving care coordination particularly when patients receive services from multiple provider agencies. The team updated participants on the current status of shared care plan implementation throughout the region and what the plan is for moving forward. A focus on the care guidelines feature of the platform was presented to help care coordinators understand their role in using the system. A vital aspect of the care coordination process is sharing of information, but this is challenging due to the variety of providers and organizations involved in the process as patients transition from one agency to another. IDN partners have continued to express concerns that 42CFR Part 2 has created a barrier to information sharing. To address this barrier, Region 7 IDN staff invited Jacqui Abikoff, the Executive Director from Horizons Counseling Center, to deliver a presentation titled *Ethical Communication and Decision-Making in an Integrated Care Environment.* This group of care coordinators were very engaged in this presentation and brought some great questions to the table. They left with knowledge and advice to bring back to their agencies to put into practice. Their understanding of substance use and consent increased, and additional training on the complicated subject will continue to help move the region toward integrated care.

The Region 7 IDN team coordinated a regional resource panel specific to northern Grafton and Coös County to provide participants with an opportunity to make connections with local social service providers and gain an understanding of what services they provide throughout the region. The IDN team recruited eleven agencies to speak on the panel, including representation from Waypoint, North Country Health Consortium, Hope for NH Recovery, North Country Serenity Center, Response, NH Legal Assistance, Affordable Housing Education and Development, Family Resource Center, ServiceLink Coös County, Tri County Community Action Program, and Affordable Housing Education and Development.

The care coordinators enjoyed the networking opportunities and the overview of each agency. The social service agencies provided business cards and brochures for participants to bring back to their organizations and reference when necessary. New relationships were formed during the panel presentation which will help partner agencies as they work to improve the coordination of care across treatment settings.

The care coordinators were also trained on topics such as cultural humility, patient advocacy and health literacy to keep them up to date on best-practices. Participants did understand all topics but agreed that it is important to reflect on that knowledge and refresh their skills. The care coordinators were very engaged in each presentation and left with action items to complete while providing services to their patients. The region's E5 toolkit continues to be updated as necessary and shared with partners to allow them to adapt the sample workflows, forms and best practices into their current work. The care coordinators were provided with pieces of the toolkit to bring back to their agency to put into practice and encouraged to access the entire toolkit on Basecamp for additional information.

The IDN team plans to offer additional care coordination trainings as the DSRIP project continues to account for staffing turnover. After debriefing from the most recent training the team has decided to utilize the Region 7 IDN Webinar Series as a platform to replicate presentations from the Regional Care Coordination training. This will allow for partners to have on demand access to the recorded session so they can learn on their own time and reduce the burden of the time needed to attend an in-person full two-day training. This strategy will help the region reach its goal of training at least 15 care advocates throughout the region. The Care Advocate workgroup that was convened earlier in the year hasn't needed to continue to meet because the region has seen some positive movement in this project thanks to the Regional Care Coordination training and the November 2017 Risk Stratification Webinar which is available as a recording as well.

In addition to the care coordination trainings available within Region 7 IDN there have been other training opportunities addressing this topic during the reporting period. MSLC hosted a monthly learning collaborative in July which focused on care coordination and included a care coordinator panel discussion. The 7 IDNs worked together to sponsor an IDN training track at the December 2018 Behavioral Health Summit and one of the sessions was an enhanced care coordinator panel discussion. These sessions were recorded and will be available as webinars with continuing education credits attached to the them.

North Country Healthcare (NCH) has continued to grow their care coordination program across all five affiliates, Androscoggin Valley Hospital, Littleton Regional Healthcare, Upper Connecticut Valley Hospital, Weeks Medical Center, and North Country Home Health & Hospice. NCH has continued to use the two ACO coordinators from affiliates Littleton Regional Healthcare and Weeks Medical Center who share responsibility for regional care coordination, which is a 40-hour per week position. Coordinator's responsibilities are divided between NCH care management activities and each of their respective affiliate obligations. During the past six months the ACO coordinators have overseen several initiatives mentioned below.

North Country Healthcare also collaborates with three Federally Qualified Health Clinics: Ammonoosuc Community Health Services in Littleton, Coös County Family Health Services in Berlin, and Indian Stream Health Center in Colebrook. All these agencies together form the North Country Community Care Organization (CCO) which meets on a regular basis to address population health and improve the health indicators for all of the residents of the North Country. NCH regional care coordinators leverage these established meetings to discuss:

<u>Methods to reduce ED utilization</u>:

- Recommendation to review ED reports to determine those patients who frequently have ED visits and who may need care coordination support;
- Implementation of ED rack cards explaining appropriate and inappropriate visits to the ED available at each affiliate and FQHC locations;
- Weekend hours offered at Weeks Medical Center's hospital to help avoid non-emergent visits to the ED;

- Effective use of home health services

Reduction in hospital readmissions:

- AVH has a Cardiac Rehab Nurse who provides in-depth education to patients admitted with congestive heart failure (CHF). AVH has zero readmissions for CHF. Other facilities are looking into implementing a similar CHF program and regional care coordinators are currently working with the provider group to standardize the CHF process using best practice;
- Shared processes to improve transitions in care

Annual Wellness Visits (AWV):

- Information sharing from affiliates and FQHC's on effective approaches to increase annual wellness visits.

Diabetes Education:

- Connecting with an endocrinologist interested in providing education to facilities. One of the regional care coordinators will organize diabetic educational sessions.

Behavioral Health:

- The CCO committee was informed that Weeks Medical Center is providing MAT services in the Whitefield Office as part of its Littleton expansion plan and providing a psychiatric mental health nurse practitioner for behavioral health counseling services at Littleton Regional Healthcare.
- The CCO group is discussing ways in which to improve services for psychiatric patients. Many affiliates and partners are experiencing a 10-day wait period for psychiatric beds.

The regional care coordinators and CCO committee are working towards standardizing processes among affiliates and partners with the goal of improving transitions of care and ensuring patients are connected to appropriate support services. Monthly meetings are held with representation from partners to discuss concerns and/or share processes that have been proven successful. The leadership of NCH regional care coordinators helps the CCO team effectively develop methods to improve communication across the agencies in the region.

Although still in its infancy, the Regional Care Coordinators and CCO committee have made concerted efforts towards integration, communication, and cost reduction to improve valued-based care spanning Coös and northern Grafton Counties. The team continues to identify high-risk and complex patients and brainstorming ideas to decrease ED and hospital utilization and help improve healthcare outcomes. The CCO has experienced challenges in consolidating data from various reporting systems into one reportable result.

Weeks Medical Center has made significant progress with their internal care coordination efforts connecting patients within their primary care practice to services offered through their North Country Recovery Center. Weeks Medical Center behavioral health case manager & care coordination team are working together to reduce expenses through utilization reviews, assessing appropriate cost-effective services, educating patients on self-management skills, and overseeing proper handoffs. The team is helping to improve quality and patient health outcomes with focus on avoiding unnecessary hospital and ED visits.

The development of North Country Healthcare's regional call center, or connection center as they refer to it, is progressing. The Connection Center's development and implementation team will continue to oversee the Connection Center project to include reviewing system productivity, determining

provider/staff/patient satisfaction, developing procedures & policies, etc. The committee is comprised of managers with associated responsibilities in operations, information technology, provider services, and care management. The Connection Center offers an effective method of connecting providers, staff, and patients to available physical and behavioral health care through a direct link. With one 24/7 access directory for affiliates and partners, individuals can quickly be connected to an appropriate provider and/or service within the region. This system will help avoid delays in finding an on-call provider particularly for specialty services.

As with any project of this size managing time between demanding daily schedules and the Connection Center project development/implementation has been challenging. The partner experienced some delays due to a vendor change, information collection for the provider directory, and an integration issue with logins. The regional CCO group members and Connection Center team have worked together over these past several months to create an all-inclusive provider directory. The directory will soon be available on-line.

NCHC's Ways2Wellness Connect program experienced some staffing transition during the last reporting period which included one staff person leaving the agency and another staff person who transitioning to a new program at the organization where they will serve as a CHW/peer recovery coach. NCHC was able to add a new CHW to their Ways2Wellness Connect program, to bring them to a current total of three. The partner is actively looking to fill two more CHW slots to expanded capacity as the program grows. The target population for this program has shifted slightly to be patients over 55 with chronic health problems and no SUD problems. During this reporting period the program served four Medicaid clients. NCHC CHW's currently have relationships with all affiliates of North Country Healthcare, Indian Stream Health Center, Coös County Family Health, and Ammonoosuc Community Health Services. ACHS and NCH affiliate, North Country Home Health and Hospice, are two of these eight referring agencies to have increased their engagement with NCHC CHW's during this reporting period. The CHW team and referring agencies continue to use the same efficient process to provide patients with services and continue to refine processes and add to protocols as necessary. Weeks Medical Center has begun sending a referral check back sheet once a month to act as a closed-loop referral process. When this sheet is received at NCHC the CHW looks at the patient names to see the status of their care and/or referral. The CHW communicates the status of the referral to Weeks to allow them to manually close the referral in their system. NCHC CHW staff have been attending Weeks' Emergency Room readmission committee meetings that occur twice a month. The CHW's get a list high ED utilizes and high readmission patients who will be discussed at the meeting to allow them to follow up and participate in the discussion. CHW staff also attend process and system meetings and meet with care transitions staff to continue to improve strategies of care. The CHW Program is looking to have a similar relationship with CCFHS when staffing has increased.

Currently, the NCHC CHW team is strategizing on how to get data out of Weeks Medical Center system to assess impact and prove sustainability and return on investment. The team plans on looking at dollars saved by engaging CHW's in the course of treatment for clients and implementing client surveys to get treatment feedback. NCHC held one community health worker training which started in November 2018 and will end in February 2019; the trainer anticipates graduating eight participants. The organization will continue to hold one-two CHW trainings per year to expand the CHW workforce.

The CHW Program launched their Brown Bag webinar which includes a presentation by a chronic care transitions team manager at Weeks Medical Center who explains the positive impact on clients. The one-hour webinar offers CEU and covers conception and history of community health workers, training, implementation, role of CHW, how it fills the gaps that other positions do not, how it is different and return on investment. The webinar has been uploaded to NCHC's Moodle platform to be accessed by community partners on demand, allowing for increased exposure to the content. NCHC CHW's continue to participate in the NH CHW Coalition to work to standardize a Community Health Worker training for

the state and educate providers about CHW's. The group elected a steering committee for the first time and are working to develop a strategic plan to explore CHW certification to work towards sustainability. The NCHC CHW program was chosen to present to twenty-two clinics that are involved in the Breast and Cervical Cancer Screening project across the state to educate providers about CHW's.

The CHW staff held Diabetes Self-Management Education Class series in Lancaster in July and August. The objectives of the class were how to manage diabetes, how to create an action plan and stick to it, how to problem solve, how to deal with stress, how to select healthy choices, and when to contact the doctor. Better Choices, Better Health classes were also held at Androscoggin Valley Hospital in August & September. Within this class the Chronic Disease Self-Management Program (diabetes, arthritis, high blood pressure, heart disease, COPD, chronic pain, and anxiety) was completed to help participants gain to manage their health.

White Mountain Community Health Center (WMCHC) and Huggins Hospital both made significant progress on services related to enhanced care coordination for the high needs population. The partners have continued working with the IDN Quality Improvement Coach to improve care coordination systems, develop workflows, and document policies and protocols. Care coordination staff at both agencies have been pivotal in the implementation of the CCSA protocol and risk stratification processes. The IDN Quality Improvement Coach presented a draft risk stratification policy and procedure for review.

Huggins staff worked to determine where risk levels will be documented in the new Allscripts EMR platform. The agency is working to have this be embedded in the health maintenance flowsheet with a 1-6 drop down level to select the assigned risk level. The NCHC PTN team hosted a provider training in December that included risk stratification, SBIRT, screening tools, depression screening documentation and other relevant topics.

As mentioned in project B1, White Mountain Community Health Center has fully implemented the CCSA survey process with their Medicaid population of 18 years and older and are tracking through a checklist system in their health maintenance flowsheet of the EMR for monitoring and reporting purposes. The care coordination team is responsible for tracking compliance and ensuring patients with identified needs are addressed with care coordination follow up. Once the CCSA profile is initiated when the patient arrives it is determined if they need further care coordination, if they are determined a high-risk patient, they are referred to the Social Worker, who then prepares their cases for the Multi-Disciplinary Core Team meetings. If they are a low risk patient that only need simple services the Community Health Worker providers community outreach, helps fill out applications for social services and Medicaid and handles the follow-up of these patients. During the reporting period of July-December 2018 WMCHC enrolled 58 individuals with behavior health disorders, with or without poorly managed or uncontrolled co-morbid chronic physical and/or social factors into care coordination services. Additionally, WMCHC has 23 prenatal patients who are receiving care coordination, several having substance misuse risks. They do not currently have any children (<18 years) who meet the criteria of having been diagnosed with chronic serious emotional disturbance seeing a care coordinator.

The Memorial Collaborative Project continues to bring four organizations in northern Carroll County together to improve coordination of services and care for the population. Memorial Hospital, Saco River Medical Group, Visiting Nurse Home Care & Hospice, and Children Unlimited, continue to work collaboratively to enhance care coordination and address substance use disorder needs. These agencies meet routinely to ensure they are working cohesively and avoiding duplication. They continue to work closely with Carroll County Coalition for Public Health (C3PH) relying heavily on the Continuum of Care (CoC) facilitator to assist on convening and playing a key role in developing the plan as it relates to SUD. They finalized a short video highlighting services in place and demonstrating collaboration among agencies in northern Carroll County. The video can be found at the link below:

https://www.youtube.com/watch?v=3z2JKm8hzIs&feature=youtu.be

This video was an exceptional example of innovative collaboration and community outreach. The staff from the four organizations and Carroll County Coalition for Public Health spoke about the impact the opioid crisis has had on the region and how they have come together to improve the health of the community. The video was a powerful representation of how collaboration and commitment can change the way people communicate with others. This group intends to create a second video, highlighting testimonials of people receiving services from these agencies in 2019. Each of the four agencies participating in the collaboration have made significant achievements to help with the coordination of services in Carroll County:

Children Unlimited: IDN funding has provided support to allow the addition of one staff person who started in Fall 2018. This has given the agency the capacity to increase outreach into the community affected by SUD. The partner has developed two series of parent support/education groups on site of the local domestic violence shelter and SUD treatment center.

Memorial Hospital: Care coordination has remained their major focus during this project. Memorial's Patient Care Coordinator has continued to help coordinate services and assist patients in navigating the system and obtain needed services. Community outreach and education to inform the public and other agencies about the services available for patients with SUD and families has been essential during this project. Community education and outreach included presentations with discussion in multiple venues including:

- Carroll County Coalition of Public Health Advisory Committee meeting
- SAU 9 Wellness Committee
- Carroll County Visiting Nurse Association Board of Directors
- Memorial Hospital Strategic Planning Committee
- Memorial Care Transitions Committee
- Mount Washington Valley Community Health Collaborative
- Mount Washington Valley Regional Health Collaborative
- Mount Washington Valley Future Leaders Chamber of Commerce

Visiting Nurse Home Care and Hospice of Carroll County: This partner has worked to expand their Crossings Bereavement service by increasing coordinator hours for program development. The agency has been able to invest in outreach, resulting in the establishment of solid networks for partnering and referrals. There are no other peer support bereavement services for families in Carroll county, and IDN funding is helping to develop these programs.

Saco River Medical Group: SRMG continues to work to secure behavioral health services for their patients and has been having discussions with a local therapist who has significant experience working with SUD patients. The agency continues to work on the development of risk stratification models.

The four organizations working together have been able to share information regarding resources including community supports, availability of counseling, and peers support groups. This project has fostered stronger partnerships and provided a structure to sustain collaboration.

June 30, 2019 Update

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

Network Membership

During the reporting period of January 1 through June 30, 2019, Region 7 IDN had no members join or leave the network. The information below speaks to the progress that Region 7 IDN has made on the E5 "Enhanced Care Coordination" community project during this reporting period.

Region 7 IDN Data Governance

As Region 7 IDN adopted the new DHHS Monthly Update reporting format this spring, efforts were expended to verify the total number of individuals served by each Region 7 IDN partner to date and leverage the State's reporting tool as a mechanism that will help partners report monthly totals for the remainder of the DSRIP. By utilizing the State's new monthly reporting mechanism as the backbone of a high-integrity data management process, the Region 7 IDN team hopes to ease the reporting burden for partners while retaining the ability to collect, aggregate and analyze data for the region as a whole. This revised process is anticipated to allow the region to evaluate progress on performance evaluation targets more frequently and help the Region 7 IDN team provide more timely feedback and support to the region's partners. Partner specific updates in this section reflect narrative regarding their progress along the continuum of the project, and their total number of unique individuals served during the DSRIP period through June 30, 2019.

Partner Specific Updates

Region 7 IDN continued to make progress on Project E5, Enhanced Care Coordination for the High Needs Population, during the reporting period of January-June 2019. Region 7 IDN partner agencies had opportunities to attend trainings to improve care coordination services, participate on demand risk stratification webinar, and participate in new Multi-Disciplinary Core Team meeting within their agencies to discuss high risk patients. Additionally, as partners have continued developing their processes for risk stratifying patients, they have also built mechanisms for recording the enhanced care coordination services they provide so that they can report against this data. This enhanced reporting capacity has allowed several partners to report the total number of individuals served for the first time, allowing the Region 7 IDN team to include the total number of individuals served by these partners in the regional aggregate total for the first time. Of note, most partners are not currently able to report specifically on the Medicaid population, so the totals reported by individual partners represent all patients receiving enhanced care coordination, regardless of payer source.

Ammonoosuc Community Health Services (ACHS) continues their expansion of school-based behavioral health integration in the region. This program provides students with access to behavioral health services that may be difficult to access outside their school routine. The ACHS continues to embed Behavioral Health counselors in area schools to mitigate the disruption to learning that students experience when they have a behavioral health appointment. The program has continued to show great benefit to the population, allowing teachers to focus on educating rather than deescalating behavioral issues. The program is also helping to combat the stigma of mental illness and contributing to a wraparound service for high need/high-risk students. ACHS spent time this period developing a comprehensive video to summarize their enhanced School-Based Care for Kids program which can be viewed at this link: https://ammonoosuc.org/behavioral-health/behaviorial-health-for-kids/. The agency will use continuation funds into next period to continue and enhance these services.

ACHS also continues to strengthen their relationship with North Country Serenity Center (NCSC), collaborating on the delivery of services to shared patients. ACHS's Community Health Worker has stepped into the BH/SUD Case Manager role while the agency works to refill that position, vacated early in this reporting period. This temporary substitution in staff has allowed ACHS to continue providing

enhanced care coordination to NCSC clients, a process that is supported through bi-weekly meetings between ACHS and NCSC staff to review and update care plans for their shared patient population. The agency also continues providing their Transitional Care Management and Chronic Care Management Programs initially started under their last Medicare ACO. During this reporting period, this partner has been able to report the number of individuals served by their enhanced care coordination efforts for the first time, confirming they have serviced 389 individuals to date since the start of the IDN 7 implementation plan on 7/1/17.

Coös County Family Health Services (CCFHS) reports that they have added a new Psychiatric NP to replace a departing staff person during this period and will be brining another on board in the coming months. These additions will enable CCFHS to have a Psychiatric NP in each of their three sites in the Berlin/Gorham area, thereby enhancing their care coordination capabilities for the behavioral health population. Since one of these new providers is also MAT waivered, the agency anticipates further expanding their MAT program as the practice adapts to the addition of a Doorway site in their catchment area this year and the need to successfully co-exist with this community resource. This partner shared that their enhanced care coordination services are regularly reassessed through the lens of changes in the population of the region, the funding environment and the reality of balancing patient and population needs with administrative pressures. They have engaged in discussions with the corrections sector during this period to provide further supports to recently incarcerated individuals while minimizing the risk of MAT medications being diverted in the community – an activity that directly relates to the dynamic of poverty in the region. This partner also reports an interest in focusing on the sub-population of self-neglecting elders in the area, many living without family supports and on fixed incomes, who are not faring well in their bid to live independently in the community. CCFHS believes that this patient cohort requires particular attention from an enhanced care coordination perspective, because without additional work to address their Social Determinants of Health, these fragile elders frequently decline to the point that require long-term residential care.

Huggins Hospital reports that they hired two staff members for their enhanced care coordination program during this reporting period, filling all seven budgeted positions which include three care coordinators, three PCP's and a social worker. One Community Health Worker is budgeted, and that position is filled. They report using the CM technology every day for Transitional Care Management callbacks and are gradually entering information on care guidelines so that ED and medical practices can receive this information easily. Event notifications are being used for real time care and quality purposes. Staff turnover continues to be identified as a challenge to adoption of the CM technology at all clinic sites, so the hospital-based staff are monitoring event notifications for the entire organization. Additionally, this partner is in the process of migrating to a new electronic health record, so has paused any further local implementation of the CM technology until the new EHR is fully implemented.

Huggins has continued working with IDN Team staff to solidify their risk stratification process used to determine what level of care coordination is needed. Their Care Coordination Policy and Procedure highlights how to determine and update care coordination needs. Using these processes, they report having added another fifty patients to the enhanced care coordination program during this reporting period, bringing their overall total of individuals served by their team during the DSRIP period to 124.

Indian Stream Health Center (ISHC) has addressed challenges in creative ways as they work to meet DSRIP deliverables. The agency has leveraged the ingenuity of their staff to maximize the utilization of their internal and community-based resources to meet numerous needs of their patients. This partner has struggled with significant staff turnover during this reporting period, and reports that they have

been especially challenged by the lack of qualified candidates applying for open positions, particularly for quality and IT positions essential to the data management activities of the DSRIP and other payer-based incentive programs. Though these staffing vacancies have caused stress on their systems, ISHC's ability to maintain effective use of CCSAs and Multi-Disciplinary Core Team consultations has remained intact and the agency has also engaged with the CM network during this reporting period. As part of their MDCT process, this partner has revised their strong existing risk stratification process to meet DSRIP requirements. The IDN champion at ISHC reports that they have also made recent changes to their MDCT process to integrate discussion of evidence-based practices specific to the key diagnoses of patients whose cases are presented. The process begins with a formal chart audit and development of a case summary for MDCT members to review before the meeting. Up-To-Date articles are attached to the case summaries, objectively presenting the material for provider consideration, and level-setting the team's understanding of the diagnoses complicating the patient's picture and evidence-based practices that could be leveraged to enhance their care plans. The Region 7 IDN team continues to offer support for these processes as ISHC works through staffing and technology resource challenges, including the migration to a new EMR platform in the upcoming reporting period.

Memorial Hospital continues to collaborate with *Saco River Medical Group, Visiting Nurse Home Care & Hospice,* and *Children Unlimited* in furtherance of the Memorial Collaborative Project. These four organizations in northern Carroll County continue to work collaboratively to enhance care coordination and address needs for families affected by Substance Use Disorders. Memorial Hospital will continue to enhance activities of their patient care coordination department and use IDN funds to bring a second Psychiatric NP onboard. Children Unlimited will use these funds to offset the salary of a staff person hired in Fall 2018 for community outreach, which they report as an enhancement to several of their programs. Funding will also be used to continue support of the "Parenting from Prison" Program, offer training to support "Children from Hard Places" program, and continue to provide comprehensive support services through its "Bridges" Program. Visiting Nurse Home Care and Hospice of Carroll County will use funding to make enhancements and expansions to their Crossings bereavement service. Saco River Medical Group will use this funding to support a Patient Care Coordinator position designed to enhance care coordination for patients living with mental illness and substance use disorders, expand the current MAT and Behavioral Health provider teams, and purchase additional training to deepen staff capacity to gather and report IDN performance data. Continuation funds were distributed to support this project in May 2019.

Memorial's Patient Care Coordinator has continued to focus on the integration of the patient experience by helping high-risk/at-risk patients navigating systems. Providers report that the role is a major asset to the way the organization delivers care. These patient care coordinators help their agency's behavioral health, IMAT and A New Life prenatal substance abuse programs collaborate as they deliver care to shared patients. Memorial aims to use leverage enhanced care coordination activities to expand the IMAT program so that MAT-waivered providers are carrying caseloads consistent with the capacity of their MAT waivers in the upcoming reporting period. They also plan to provide staff education and training that will further expand outreach and connections with community partners addressing social determinants of health in the coming months.

North Country Health Consortium (NCHC)'s Ways 2 Wellness Connect program continued enhancing their services and engaging with the Community Health Worker workforce at both a statewide and national level during this period. NCHC Ways 2 Wellness Connect began conversations to engage with two new agencies this period, anticipating that MOUs will be signed in early July to work with Cottage Hospital's Rowe Health Center and Androscoggin Valley Home Care. Both new partners reporting being

ready to send referrals as soon as the necessary agreements are executed. In addition to their normal client caseload, three of the NCHC CHWs prepared to attend the 2019 Unity Conference for and About Community Health Workers in Las Vegas – a conference intended to further the development of the Community Health Worker role nationwide. The CHWs developed information boards to include in the conferences poster presentations that highlighted the model of care they have been using in the program. The CHWs reported that they found immense value in the sessions and information provided during the conference, and experienced positive feedback from teams in several states who are trying to achieve the same outcomes realized by the NCHC Ways 2 Wellness Connect team. NCHC's CHWs also dedicated time this period to leading and participating in the NH Community Health Worker Coalition. This state coalition is focused on building relationships throughout the state and creating a pathway to state certification for Community Health Workers with an eye toward future reimbursement models for the services provided by CHWs. The Ways 2 Wellness Connect CHWs have served 24 NH Medicaid beneficiaries with enhanced care coordination services at the request of Region 7 IDN partners during the DSRIP demonstration.

North Country Healthcare (NCH) hospitals continue to take part in a regional community care organization (CCO) with the three Federally Qualified Health Clinics in their catchment area (*Ammonoosuc Community Health Services, Coös County Family Health Services,* and *Indian Stream Health Center*). Members from the North Country Community Care Organization agencies meet on a regular basis to address population health initiatives with a focus on improving the health indicators for all the residents of the North Country. The Regional Care Coordination workgroup has evolved into a CCO workgroup that continues to enhance and standardize processes across the region to improve transitions of care and ensure patients connections to appropriate support services. The head of NCH affiliate Weeks Medical Center's care coordination team is serving in a Care Advocate Supervisor capacity as she facilitates these regional care coordination meetings. These agencies have also focused their efforts on ways to identify high-risk/at-risk patients and implement effective Enhanced Care Coordination interventions to address the needs of this sub-population. Collaboration between the CCO's care coordinators includes discussion and partnered work to address the needs of specific patients shared by CCO partners. NCH's sub-recipient proposal to use IDN funding for continuation of the Regional Care Coordination work was approved in October 2018, but distribution of funds was delayed by statewide funding uncertainties. When the region received a decreased incentive payment in April 2019 resulting from unmet performance targets, NCH made the decision to rescind this continuation request to ensure enough IDN funding was available to support their expansion of MAT services. The organization finds value in continuing this project, though, and has decided to seek other funding sources and work toward cost reductions to continue this work. They are hopeful that cost savings realized through decreased ED utilization resulting from enhanced care coordination will also offset the cost of this work.

NCH hospitals joined fellow Region 7 IDN partners *Ammonoosuc Community Health Services* and *Huggins Hospital*, along with several agencies in the southern part of the state, during this reporting period in the formation of an Accountable Care Organization (ACO) under the Medicare Shared Savings Program. The NHValuesCare ACO is slated to go live on July 1, 2019 and as this initiative gets underway, the Region 7 IDN team will engage these partners to support alignment between ACO and DSRIP activities.

Northern Human Services (NHS) decided to hold off on their original plan to stand up a Critical Time Intervention program under the C-1 Care Transitions Project during this reporting period. Their plan was to use this model to augment the enhanced care coordination being provided to clients as they are

discharged from the institutional setting back into community. NHS reports that their decision to not implement this model as part of their Enhanced Care Coordination process is directly related to staffing, most especially the anticipated retirement of several key staff members in the organization who collectively represent nearly 100 years of institutional and regional knowledge. Despite these workforce challenges, NHS continues to provide enhanced care coordination services to several of their patient populations and provide psychiatrist resources to several Multi-Disciplinary Core Teams operation throughout Region 7 IDN. During this reporting period, NHS confirmed that they have served 120 individuals with Enhanced Care Coordination through their Assertive Community Treatment program since the start of the Region 7 IDN Implementation Plan on 7/1/17.

Saco River Medical Group (SRMG) reports that, in addition to their participation in the Memorial Collaborative, they have hired a new MAT waivered Nurse Practitioner during this reporting period and are exploring a promising opportunity to collaborate with a LADC in the region later this summer. Their goal is to expand behavioral health services available to their patient population. SRMG continues to be actively involved in a Medicare ACO and leverage data from commercial payer incentive programs to enhance risk stratification of covered beneficiaries, targeting high-risk/at-risk patients covered by those payers for enhanced care coordination interventions. During this reporting period, the agency also worked to implement an improved comprehensive risk stratification process for identifying high risk-patients within their entire patient population, regardless of payer source. SRMG will use this enhanced risk stratification process to support the expansion of its MAT program and improve the coordination of transitions in care for all patients, including those with mental health and substance use disorders. They are also investing in their infrastructure by building a suite to be used for psychiatric care, mental health counseling and substance use disorder counseling.

Weeks Medical Center (WMC) reports use of both Collective Medical and LightBeam platforms (LightBeam is a population health tool in use during their time as an Accountable Care Organization in calendar years 2016 – 2018) to identify and coordinate care for their high-risk populations. WMC reports that they are still challenged by staff perception that these tools are redundant to mechanisms already in place for sharing information electronically, so have not yet begun entering care guidelines and are instead leveraging event notifications to inform care coordination activities. Weeks Medical Center has robust systems in place to connect with care coordinators in real time at Littleton Regional Healthcare (LRH), Androscoggin Valley Hospital (AVH) and Upper Connecticut Valley Hospital (UCVH), which has been helpful in the care coordination of high utilizers. Additionally, WMC has continued to refine the structure of their case management team to ensure that the flow of information between hospital units and the Rural Health Clinic supports the patient during times of transition. Weeks Medical Center has also been the most significant utilizer of Community Health Workers from North Country Health Consortium's Ways2Wellness Connect Program, viewing them as an essential member of the care team for high-risk patients. NCHC's Community Health Workers participate in meetings of the WMC Readmissions Team as standing members. During this reporting period, WMC was able to share their number of individuals served by enhanced care coordination for the first time, reporting that they have served 275 individuals since July 1, 2017.

White Mountain Community Health Center (WMCHC) continues with their robust enhanced care coordination process. Successes stemming from their engagement with the Collective Medical (CM) network were highlighted by their IDN champion at the Region 7 IDN Quarterly meeting in March. This partner has also shared information with other partners regarding their workflows and processes for conduction the Core Comprehensive Standardized Assessment, risk stratification and coordinating care for high risk patients, including referral to a Multi-Disciplinary Core Team for case consultation. Their

use of CM platforms as a base for enhanced care coordination and retrospective safety, quality and staff/patient satisfaction reviews has also been significant. WMCHC reports that their work continues to evolve as staff grapples with learning which tools to use for screening and assessment, for which patients, and when to use these tools. This educational process is balanced with a consideration of staff roles and responsibilities as well as staff workload. The issue of patient literacy has also come into focus because of an annual review of the CCSA process this spring. To address the patient literacy concerns WMCHC decided to provide paper copies of the CCSA to patients as an alternative to a tablet and reordered their evaluation questions to identify patient literacy challenges at the beginning of the tool so that assistance completing the CCSA could be offered.

December 31, 2019 Update

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

Network Membership

During the reporting period of July 1 through December 31, 2019, no partners have left the network. The Region 7 IDN had one new member join the network – Coös County Department of Corrections – bringing the total number of partners in the Region 7 IDN to thirty-nine (39).

The information below speaks to the progress that Region 7 IDN has made on the E5 "Enhanced Care Coordination" community project during this reporting period.

Regional Care Coordinator Network

The IDN 7 Regional Care Coordinator Network (RCCN) was established in September 2019. Partner agencies were invited to send their care coordinators to a special session held after the September All-Partner Quarterly Meeting, and those in attendance created the following mission statement for the group:

> "To provide a supportive, professional environment for Region 7 Care Coordinators that allows for collaboration and sharing of resources; provide opportunities for education and professional development in the field of care coordination, which will ultimately improve quality and cost-effective outcomes for patients/clients and organizations."

The development of the Regional Care Coordinator Network (RCCN) has provided care advocates across the region with a peer cohort that serves as a vehicle for sustainable communication, support and access to resources that further enhances care coordination within the region. This cohort has convened twice in person and twice virtually during the reporting period, and feedback from members as their work gets underway has been positive. The RCCN has been established, in part, to provide ongoing training to care advocates throughout the region. This continuing education model, in conjunction with enduring formats of previous care coordination trainings, has been adopted by Region 7 IDN partners as the most sustainable pathway to ensuring that the region maintains a trained care coordinator workforce.

The RCCN has established a schedule of meetings that includes two one-hour monthly web meetings and one two-hour in person meeting each quarter. The in-person meetings will follow the region's All Partner Quarterly Meetings and meeting content will be such that continuing education credits will be offered. The web meeting agenda is open for case presentations as needed and prioritized topics established by the group. The web meetings are held on the 2nd Wednesday of the month and members have participated in a survey to identify and prioritize meeting topics. The following tables demonstrate

the scoring of member survey results that helped to prioritize topics to present at the meetings and indicates which topics have been covered in RCCN meetings to date.

Resource-related Topics	Score	Date Covered
Transportation Resources	4.33	
Process Navigation and Follow Through with Referrals	4.22	
Prescription Assistance Resources	4.11	
Cold weather Resources	4	10/9/2019
Children and Family Resources	4	
Alzheimer's	3.89	1/8/2020
Homeless Shelter/Low Income Housing Resources	3.89	10/9/2019
Bureau of Elderly and Adult Services	3.89	
Diabetes Education and self-management planning	3.78	
CHW Resources/Access	3.78	
Service Link	3.67	11/13/2019
Nursing Homes and Long-term care planning	3.67	
Assisted Living Resources	3.56	
Doorway and SUD Resources	3.44	
Third Party Payer Resources (MCOs, Anthem)	3.33	
Traumatic Brain Injury	3.22	
Home Health Resources	3.22	
Vermont Care Coordination Resources	2.78	

Care Coordination Educational Topics	Score	Date Covered
Goal Setting, Problem Solving, Decision Making	4.22	
Communication and Team Building	4.22	
Chronic Care Model	4	12/12/2019
Health Coaching/Counseling with self-management support	3.78	
Care Coordination and Transitions Management	3.78	
Chronic Disease Management	3.78	
Evidence Based Guidelines Across Lifespan	3.56	
Care Management Principles	3.44	
Health Literacy, Cultural Competency and End of Life Care	3.22	
Patient Centered Medical Home	3.11	

The RCCN spent time in the last quarter of the year reviewing the draft policies and procedures for the development of a Regional Multidisciplinary Core Team (MDCT). The IDN7 Regional MDCT will be a collaborative and consensus-driven consultative body, which will be convened for the purpose of planning patient/client care for the complex population. Its primary goal is to share information and knowledge to improve service delivery across the region and specifically to:

1. Engage priority participants as indicated by referrals received;
2. Recognize patient/client's self-identified needs/goals as indicated in referral paperwork;
3. Identify gaps to meeting those needs and goals (historical, current, and anticipated);
4. Identify strategies to remove barriers and meet those goals;

5. Identify partner agents/points of contact responsible for coordinating and facilitating next steps/strategies;
6. Communicate strategies via a shared care plan to the patient's circle of care; and
7. Create a closed-loop communication plan that includes the patient/client/family.

Partner Specific Updates

Region 7 IDN continued to make progress on Project E5, Enhanced Care Coordination for the High Needs Population, during the reporting period of July – December 2019. Region 7 IDN partner agencies had opportunities to attend trainings to improve care coordination services, access an on-demand risk stratification webinar, and participate in new Multi-Disciplinary Core Team meetings within their agencies to discuss high risk patients. Additionally, more partners continue to build mechanisms for recording the enhanced care coordination services they provide so that they can report this information, allowing the Region 7 IDN team to continue adding agency data to the total number of individuals served by these partners in the regional aggregate total. It continues to be true, however, that most partners are unable to easily report specifically on the Medicaid population, so the totals reported by individual partners represent all patients receiving enhanced care coordination, regardless of payer source.

Ammonoosuc Community Health Services (ACHS): This partner experienced turnover in care coordinator staff during this reporting period but anticipates participation in the Regional Care Coordinator Network (RCCN) as their staffing stabilizes. They have continued to provide integrated healthcare services to their patient population and use the Collective Medical network to coordinate transitions of care and follow-up for individuals receiving facility-based care.

Coös County Family Health Services (CCFHS): CCFHS participated in the initiation of the Regional Care Coordinator Network (RCCN) and continues to provide enhanced care coordination for their most complex patients, but has shared that the organization is experiencing initiative fatigue, and has limited bandwidth to dedicate staff time to additional interventions at this time. This partner continues to coordinate and provide integrated care to patients in high-risk and high utilizer populations and collaborates closely with partners in the CCFHS catchment area as part of a large, multi-sector Transitions in Care program.

Huggins Hospital: Huggins Hospital has worked to ensure that its Care Coordination department is engaged with the RCCN, often with multiple staff members in attendance. Huggins is also working to develop a Regional Health Network in Southern Carroll County, leveraging the enhanced care coordination services and deep relationships with other agencies that this partner has developed as a member of the Region 7 IDN. Huggins is also participating in a Medicare ACO that launched on July 1, 2019, in partnership with several other Region 7 IDN partners, and will continue to provide enhanced care coordination services to those members of the Medicare population identified as having higher complexity and utilization of resources.

Indian Stream Health Center (ISHC): ISHC has experienced a significant change in staffing over the reporting period, including changes to the IT, case management and quality improvement teams. They have also undergone the rapid installation of a new electronic medical record system – a project that was anticipated to occur over a longer trajectory but was accelerated when the legacy system vendor announced a shortened timeline for sunsetting the platform. Despite these significant challenges, ISHC has remained a highly engaged partner on this project, providing staff to participate in RCCN meetings and delivering enhanced care coordination for their most complex patients. While not originally a participant in the Medicare ACO undertaken by several North Country partners on July 1, 2019, ISHC has

shared that they are formally joining as a member of the NHValuesCare ACO effective January 1, 2020 and will continue their ongoing collaboration with their North Country partners on this population health initiative.

Memorial Hospital continues to collaborate with *Saco River Medical Group (SRMG), Visiting Nurse Home Care & Hospice (VNHCH),* and *Children Unlimited (CU)* in furtherance of the Memorial Collaborative Project. As reported in previous periods, this collaboration has multiple prongs, all of which continued during the reporting period. This included ongoing support of care coordination services at Memorial, further development of care coordination services and the MAT program at SRMG, and collaboration between VNHCH and CU to provide bereavement support services and parenting classes to Carroll County families impacted by Substance Use Disorders. During the reporting period, work by the collaborative included community engagement activities such as the development of new radio spots advertising these services, and participation in community events to raise awareness of the resources the collaborative can provide to the community. Additionally, SRMG and Memorial Hospital have committed to the participation of their care coordinators in the RCCN and expressed an interest in being participants of the Region 7 MDCT as both initiatives progress.

North Country Health Consortium (NCHC)'s Ways2Wellness CONNECT program continues to strengthen and increase the capacity of Community Health Workers (CHWs) across the region. Following a hiatus of CHW trainings as the team redesigned their curriculum, a successful training was held during the last quarter of 2019. All eight registrants completed the course and are actively using their skills in community – some in paid positions and others in a volunteer capacity. The new curriculum is focused on in-person training opportunities to mimic the level of face to face contact essential to the success of CHW interventions. Participants are provided the opportunity to role play, practice skills, and have the opportunity to speak with a number of professionals regarding the value that this work brings to the overall wellbeing of the individuals served. Based on the success of this first course under the new curriculum, the Ways2Wellness CONNECT team has already booked the next four sessions of the training, in March and October of 2020 and 2021.

During the December All-Partner Quarterly meeting, attendees participated in an exercise intended to identify the successes and barriers of Region 7 IDN initiatives under the DSRIP. One of the most obvious take-aways from that exercise was the value of CHWs across the region and a strong interest on the part of many partners in continuing to grow and deploy that portion of the workforce. Several partners not currently connected to the program expressed an interest in growing their own internal team of CHWs. Interestingly, though, a partner currently utilizing the Ways2Wellness CONNECT team's CHWs was emphatic that deploying an external source for this work was instrumental to the success of their enhanced care coordination efforts because the CHWs could not be absorbed by internal clinic workflows and were non-clinical members of the patients' circles of care. Partners expressed an interest in continuing to explore ways that this could become a sustainable service in the region so more organizations could add CHW support to their enhanced care coordination efforts.

The Ways2Wellness CONNECT team continues to engage at both state and national levels in efforts to develop certification pathways for CHWs as a means to support reimbursement models in an ongoing fashion. The team has been following and participating in the Billing & Coding workgroup to deepen their understanding of the current policy climate in New Hampshire and to contribute to the development of policy recommendations. As the demonstration reaches its end, the Ways2Wellness CONNECT team will continue its support of these professional and policy development activities and promote the value of CHWs as essential stakeholders in population health efforts.

North Country Healthcare (NCH) hospitals continue to take part in a regional community care organization (CCO) with the three Federally Qualified Health Clinics in their catchment area – *Ammonoosuc Community Health Services (ACHS), Coös County Family Health Services (CCFHS),* and *Indian Stream Health Center (ISHC)*. During this reporting period, NCH hospitals joined fellow Region 7 IDN partners ACHS, LRH and Huggins Hospital, along with several agencies in the southern part of the state, in the formation of an Accountable Care Organization (ACO) under the Medicare Shared Savings Program. The NHValuesCare ACO launched on July 1, 2019 and partners spent the reporting period establishing key workgroups to further their population health efforts under the new ACO. As noted above, ISHC has committed to joining the ACO as a member effective January 1, 2020. The Region 7 IDN team will engage with these partners to support alignment between ACO and DSRIP activities as this initiative gets underway.

Northern Human Services (NHS): NHS has contributed a number of staff to take part in the RCCN, and further entered into a contract to provide essential members to the Region 7 MDCT. As the region's sole Community Mental Health Center, NHS continues to provide intensive case management services to individuals with serious mental illness and support the integrated healthcare efforts of a number of physical medicine providers in the region. NHS continues to support the skills development of care advocates within the organization and across the region.

Weeks Medical Center (WMC): As noted above, WMC is actively engaged in enhanced care coordination services through their role as an NCH partner in both the CCO and ACO. WMC has continued to strengthen their care coordination department, which serves patients in both the hospital and ambulatory setting. This partner reports that there have been no significant changes in their processes during this reporting period, but they feel their team is at its best point to date in terms of having strong relationships with community partners and providing meaningful supports to the patients under their care. At this time, they are confident that they have hard-wired these services in a sustainable fashion and look forward to continuing the work that they are doing.

White Mountain Community Health Center (WMCHC): WMCHC continues to provide enhanced care coordination services to its most complex patients, leveraging the multi-faceted aspects of the Collective Medical platform for both real-time care coordination and retrospective quality reviews. They have partnered with both Mount Washington Valley Supports Recovery and White Horse Addiction Center as referral sources for recovery-related supports. While this partner learned late this year that it was not selected to receive FQHC status, it continues to operate as an FQHC look-alike practice and focuses on delivering integrated, whole-person care to its patient population.

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.

December 31, 2018

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	34	127
Reduced hospital inpatient readmissions for patients with BH indicators *This measure corresponds closely to the statewide outcome measure Hosp_ED.01 – Frequent Emergency Department Use in the Behavioral Health Population* *Once the state releases IDN Region 7s performance on this measure using claims data, we will be able to assess our performance in this area.*	20% decrease in annual 30-day hospital readmissions rate for patients with behavioral health indicators rate per 1,000 population from 9.1 in 2015 to 7.2 by 2020	0	N/A	N/A – waiting to receive claims-based data information
# of ED visits for patients with BH indicators *This measure corresponds closely to the statewide outcome measure Hosp_ED.01 – Frequent Emergency Department Use in the Behavioral Health Population* *Once the state releases IDN Region 7s performance on this measure using claims data, we will be able to assess our performance in this area.*	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	N/A	N/A - waiting to receive claims-based data information
# of sub-recipient proposals received which are related to Enhanced Care Coordination	5 by 12/31/2018	3	5	10
Convene 1 Care Advocate Workgroup	1 by 12/31/2017	1	1	1
# regional care coordination trainings	3 by 12/31/2018	0	1	2
# Community Health Worker Trainings	3 by 12/31/2018	1	0	2
# of CHW cross trained as Peer Recovery Coaches	8 by 12/31/2018	5	5	7
# of Region 7 IDN agencies with embedded Community Health Workers	5 by 12/31/2018	4	4	5
# of agencies working on Enhanced Care Coordination as defined by DSRIP metrics	3 by 12/31/2018	0	2	11
# of trained Care Advocates	15 by 12/31/2018	0	5	11
# of partner organizations that have agreements in place for referral process	4 by 12/31/2018	0	2	7

Region 7 IDN initially planned to train 15 Care Advocates by December 31,2018. To accomplish this, NCHC hosted a Risk Stratification Webinar and coordinated two Regional Care Coordination trainings during 2018. This was a shift from the original three that were planned, one for each county. The northern Grafton and Coös County training was combined into one training to better fit IDN partner needs, specifically those of North Country Healthcare affiliate organizations. North Country Healthcare only sent two staff instead of one from each affiliate agency, and other partner agencies chose not to send staff because of the need to serve patients, so the region did not meet metrics for the number of care coordinators trained. The Carroll County training had two individuals who were partially trained during the two-day training that were not counted in this measure, however they received valuable content from the day they attended. The Region 7 IDN team plans to offer additional care coordination training modules via webinar to reach additional care coordinators moving forward.

The region did not meet targets for the number of CHW trainings offered in 2018 because NCHC did not conduct a Spring 2018 training as originally planned. NCHC did hold a fall 2018 training and has counted that training in the table above because most of the sessions occurred in 2018, despite the course officially ending in January 2019. The region will be holding two more Recovery Coach Academies in January and April 2019 and will use targeted promotion to individuals who have previously completed NCHC Community Health Worker training. NCHC also plans to host two Community Health Worker trainings in 2019.

It has been challenging to capture the number of Community Health Workers trained as Peer Recovery Coaches because there are so many paths to and titles of individuals that can fall within the CHW category. Additionally, many Peer Recovery Coach trainings are offered over and above those hosted/funded/promoted by the IDN. For the purposes of this report, Region 7 IDN counts only those individuals who have completed both the NCHC (or other formal) CHW training as well as the CCAR Recovery Coach Academy in the "CHWs trained as Peer Recovery Coaches" category.

Although IDN staff are working closely with Huggins Hospital and White Mountain Community Health Center to develop Enhanced Care Coordination programs that meet DSRIP specifications, there are other partners in the region at various stages of implementing Enhanced Care Coordination models without additional IDN facilitation.

For example, Weeks Medical Center has a team that meets regularly to review high utilizers of Emergency Department services and helps identified patients establish and maintain better connections to primary care. They also have a core comprehensive standardized assessment process in place and workforce within the primary care clinic that meets the Multi-Disciplinary Core Team requirements. Weeks Medical Center also utilizes NCHC's Ways2Wellness CONNECT program, which provides Community Health Workers to patients 55 and older with unmanaged chronic disease such as hypertension, diabetes, CHF, and COPD, for some of their high-risk patients. Weeks Medical Center has also contributed to the development of a universal consent form for patients using the five NCH affiliates, and in late 2018 began implementation of the Collective Medical platform, first within the hospital side of their operations and with a goal to see the primary care side utilizing this technology in 2019.

Indian Stream Health Center is another agency which has done a lot of work on Enhanced Care Coordination. They have a strong risk stratification system in place, and the IDN team will be working closely with the agency over the next reporting period to get Collective Medical implemented. In the North Conway area, Memorial Hospital is working closely with Children Unlimited, Saco River Medical Group, and Visiting Nurse Home Care and Hospice of Carroll County to enhance care coordination

services in the area. Funding delays have impacted this work, but these four agencies hope to continue collaborative conversations focused on care coordination systems, and as the DSRIP program continues they will be encouraged to look at shared patients and develop coordinated care plans which will best serve the needs of high-risk patients.

Coös County Family Health Services and Androscoggin Valley Hospital share a community care coordinator, splitting the time of this person equally between the two agencies. The community care coordinator looks at risks related to transitions of care, as well as risks identified by the care management team. This information along with care plans and discharge plans are shared with CCFHS to ensure high risk patients are seen in a timely manner, and referrals are made as necessary. CCFHS staff look at the event notifications triggered by Collective Medical daily to determine who has been utilizing services frequently, and address patient needs appropriately.

Northern Human Services is working on enhanced care coordination, especially with their Assertive Community Treatment (ACT) clients. ACT services are customized to the individual needs of identified individuals and delivered by a team of professionals who are available 24 hours/day. ACT helps to prevent psychiatric hospitalizations and is based in the local communities of those who need intensive community support services. Northern Human Services has an identified care team to work with these clients and are utilizing the Collective Medical platform to assist with the care coordination of these clients.

NCHC has received copies of referral protocols from White Mountain Community Health Center, Huggins Hospital, Coös County Family Health Services, Weeks Medical Center, Indian Stream Health Center, Ammonoosuc Community Health Services, and Rowe Health Center. Region 7 IDN staff continue to work with other B1 agencies to ensure they have written referral agreements in place.

June 30, 2019 Update

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

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

Performance Measure Name	Target by 12/31/18	Progress Toward Target		
		12/31/18	6/30/19	12/31/19
Individuals served	45	127	1027	
ECC - Reduced hospital inpatient readmissions for patients with BH indicators as evidenced by a decrease in annual 30-day hospital readmissions rate per 1,000 population.	20% decrease (from 9.1 in 2015 to 7.2 by 2020)	N/A – waiting to receive claims-based data	N/A – waiting to receive claims-based data	
ECC - Reduced Number of ED visits for patients with BH indicators as evidenced by a decrease in annual emergency department visits for patients with behavioral health indicators rate per 1,000 population.	20% decrease (from 1073 in 2015 to 858 by 2020)	N/A - waiting to receive claims-based data	N/A - waiting to receive claims-based data	
Sub-recipient proposals received which are related to Enhanced Care Coordination	5	10	10	
Convene 1 Care Advocate Workgroup	1	1	1	

Performance Measure Name	Target by 12/31/18	Progress Toward Target		
		12/31/18	6/30/19	12/31/19
Regional care coordination trainings	3	2	**2 IDN sponsored, as well as extensive ongoing training for regional care coordinators engaged in ACOs**	
Community Health Worker Trainings	3	2	2	
CHW cross trained as Peer Recovery Coaches	8	7	**9**	
Region 7 IDN agencies with embedded Community Health Workers	5	5	7	
Agencies working on Enhanced Care Coordination as defined by DSRIP metrics	3	11	12	
Trained Care Advocates	15	11	21	
Partner organizations that have agreements in place for referral process	4	7	7	

*In previous rounds of reporting, Region 7 IDN staff only counted a care coordinator as a Care Advocate if they participated in one of the IDN sponsored care coordinator trainings. Because targets for this workforce capacity went unmet in the last reporting period the Region 7 IDN team was prepared to offer another Care Advocate training, but the Region 7 IDN team decided to engage IDN partner agencies in deeper discussions regarding their capacity to provide this higher-level care coordination. The conversations included the partners' perception of what training their care coordination staff have received that may qualify them as effective Care Advocates for the most complex patients. During these conversations it became clear that several partners who concurrently participated in a Medicare Shared Savings Program Accountable Care Organization (ACO) and the DSRIP had access to additional training for their care coordinators and case managers through their contract with the ACO Administrator, Caravan Health. Several partners indicated that they did not feel it was necessary for their staff members to also engage in the IDN 7 Care Advocate trainings because they were perceived as redundant, and confirmed that their staff members continued to use the skills gained under the ACO despite the fact that the ACO contract ended on December 31, 2018.

These partners provided the Region 7 IDN team with agendas and curricula from the trainings offered to Care Coordinators under the ACO. They also confirmed that these Care Coordinators participated in monthly care coordination quality improvement calls and had ready access to a Care Coordinator Coach that continued to help them improve their coordination and advocacy skills. The Region 7 IDN team is confident that the ongoing training and support provided to the Care Coordinators under the ACO is comparable to the training and support offered by the IDN during the same period. Based on this added information, partners were asked to include their ACO-trained Care Coordinators in the number of Care Advocates in place at their organizations. As a result of revisiting who can be counted as a Care Advocate, Region 7 IDN can report a total of 21 Care Advocates at the end of the January-June 2019 reporting period. Not only does this revisited count ensure that Region 7 met this target during the current reporting period, partners were able to confirm that these staff members received this training and acted in this capacity in the previous reporting periods as well.

As Region 7 IDN partners have continued developing their processes for risk stratifying patients, they have also built mechanisms for recording the enhanced care coordination services they provide so that they can report against this data. This enhanced reporting capacity has allowed several partners to report the total number of individuals served for the first time, allowing the Region 7 IDN team to include the data from these partners in the regional aggregate total for the first time. Of note, most partners are not currently able to report specifically on the DSRIP target population, so the totals reported by individual partners represent all patients receiving enhanced care coordination, regardless of payer source. Most notable in these counts are those received from Weeks Medical Center, Ammonoosuc Community Health Services and Northern Human Services, who reporting having served 275, 380 and 120 individuals respectively with enhanced care coordination since the start of the Region 7 IDN implementation plan on July 1, 2017.

Risk stratification continues to be a priority for the Region 7 IDN partners engaged in the Enhanced Care Coordination project. In response to the Risk Stratification webinar held in November 2018, the Region 7 IDN team hosted a webinar in January 2019 highlighting the region's Policy & Protocol Clearinghouse. This was an opportunity for Region 7 IDN partners to learn how to access an array of policies and procedures needed to develop and sustain Enhanced Care Coordination efforts. Although the webinar included information regarding the variety of protocols and policies available in the Clearinghouse, emphasis was placed on the risk stratification tools located within. The Risk Stratification process was highlighted as an essential step in determining what patients to serve through the Enhanced Care Coordination program. The Risk Stratification and Policy & Protocol Clearinghouse webinars are now available as on demand resources for all Region 7 IDN partners. The Region 7 IDN team continues to maintain the clearinghouse and encourages partners still strengthening their Enhanced Care Coordination processes to leverage these regional resources. The Region 7 IDN team will continue to provide support and assistance to Region 7 IDN partners as they implement and enhance their Enhanced Care Coordination programs.

North Country Health Consortium (NCHC) suspended Community Health Worker (CHW) trainings during this reporting period as the training curriculum was updated to reflect national core competencies that were released at the beginning of the year. After the curriculum was updated, newly branded training materials were developed and produced. During this update to the curriculum, the training team also revisited the mode of course delivery. At this time, two trainings are planned for the last half of 2019, one starting in August and a second in late fall. In prior periods, the decision had been made to offer the bulk of didactic training online to improve access to learners in the North Country. Newly released research and an analysis of participant evaluations has shown that dedicating up to 75% of course time for face-to-face interactive sessions with the remainder of the course designed for online learning is the recommended mode of delivery because the work of CHWs is so relational. The new training curriculum has been designed to incorporate not only national core competencies but also the national recommendations for the mode of training by breaking the 80-hour course into eight 6-hour classroom sessions, a two-day (12-hour) training in Motivational Interviewing and 20 hours of online homework assignments which align with the classroom time. The goal of this redesign is to produce a quality product that aligns with anticipated certification process requirements at both the state and national level as a steppingstone to reimbursement possibilities. In furtherance of this goal, NCHC's CHWs also dedicated time this period to leading and participating in the NH Community Health Worker Coalition. This state coalition is focused on building relationships throughout the state and creating a pathway to state certification for Community Health Workers with an eye toward future reimbursement models for the services provided by CHWs. The region anticipates seeing the number of CHWs trained in Region 7,

as well as the number of cross-trained CHW Peer Recovery Coaches rise as the revised training is deployed across the region in the coming reporting period.

North Country Health Consortium launched their first Community Health Worker training under the new curriculum on September 26, 2019. There are currently 9 participants enrolled to complete the 80-hour course, two of whom were recently hired by NCHC's Wellness and Recovery Model program to serve as Community Health Worker/Recovery Coaches. NCHC welcomed these two staff members at the beginning of September and they are participating in this CHW training. They have also both completed the Recovery Coach Academy, bringing the regional total for CHWs crossed trained as Recovery Coaches to nine and exceeding the intended target of eight for the Region.

At the recommendation of the Community Engagement Workgroup and the request of several partner organizations, the Region 7 IDN team has begun the process of establishing a monthly virtual Care Coordinator/Care Advocate cohort meeting. The purpose of this meeting will be to provide an opportunity to come together and learn from one another about what is working and what may need to be improved related to care coordination in the region. It is proposed that this group will have quarterly in-person meetings to allow for an extended time for educational offerings. In the upcoming reporting period, the Region 7 IDN team will work with the Clinical and Community Engagement Workgroups to stand up these monthly Care Advocate meetings and anticipates that they will provide both continuing education to existing Care Advocates and baseline training to new Care Advocates as they are onboarded.

The Region 7 IDN held a Care Coordinator Network kickoff meeting following the quarterly gathering on Thursday, September 19. The meeting was facilitated by the region's Care Advocate Supervisor and attended by fourteen care coordinators representing ten partner organizations or programs from all three counties in Region 7. The purpose of the meeting was to develop a regional network of care coordinators that meet regularly to review case studies and receive continuing education related to care coordination activities. During the session, the group developed a mission statement and developed a workplan for their meetings. The cohort has agreed to meet virtually for two months each quarter and hold a longer educational meeting in person aligned with the region's quarterly meetings. They plan to develop shared resource lists and protocols for partners to access the regional MDCT during the remainder of the current reporting period.

December 31, 2019 Update

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

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

When the inpatient readmission and Emergency Department visit measures were developed, they were based on information in Databooks provided by the State in 2016, which contained baseline data from 2015 claims. At the time that the Region 7 IDN Implementation Plan was written, these databooks represented the only baseline available for many data points, and IDNs had the impression that the databooks would be issued on some recurring basis during the demonstration period. This has not been the case and it does not appear, at this time, that any refresh of the databooks will provide an adequate measure of the efficacy of IDN interventions. As an alternative, the measures

highlighted below have been adapted to align with comparable DSRIP performance measures for which data is refreshed more regularly.

Performance Measure Name	Target by 12/31/18	Progress Toward Target		
		12/31/18	6/30/19	12/31/19
Individuals served	45	127	1027	1897
ECC - Reduced hospital inpatient readmissions for patients with BH indicators as evidenced by a decrease in annual 30-day hospital readmissions rate per 1,000 population. **As noted above, this measure was originally established using 2015 baseline data made available in the 2016 release of the State's Databook 4. Since that data source has not been refreshed regularly, this row will now contain the data available for HOSP_INP.01: Readmission to Any Hospital for Any Cause by Adult Behavioral Health Population Within 30 Days.** **At this time, target and results for the region have not yet been made available, although a release was anticipated on January 31, 2020. As soon as this information becomes available, this table will be updated.**	20% decrease (from 9.1 in 2015 to 7.2 by 2020)	N/A – waiting to receive claims-based data	N/A – waiting to receive claims-based data	N/A – waiting to receive claims-based data
ECC - Reduced Number of ED visits for patients with BH indicators as evidenced by a decrease in annual emergency department visits for patients with behavioral health indicators rate per 1,000 population. **As noted above, this measure was originally established using 2015 baseline data made available in the 2016 release of the State's Databook 2. Since that data source has not been refreshed regularly, this row will now contain the data available for HOSP_ED.01: Frequent (4+ per year) Emergency Department Use in the Behavioral Health Population.** **Consistent with information provided to Region 7 IDN by the DHHS Office of Quality Assurance and Improvement, each subsequent column lists the DHHS established target and any available results for the corresponding reporting period.**	20% decrease (from 1073 in 2015 to 858 by 2020) **Baseline Rate = 8.50%**	N/A - waiting to receive claims-based data **Target = 8.18%; Result = 6.10%**	N/A - waiting to receive claims-based data **Target = 6.99%%; Result = 6.15%**	N/A - waiting to receive claims-based data **Target = 8.18%; Result = pending**
Sub-recipient proposals received which are related to Enhanced Care Coordination	5	10	10	10
Convene 1 Care Advocate Workgroup	1	1	1	1
Regional care coordination trainings	3	2	2 IDN sponsored, as well as extensive ongoing training for regional care coordinators engaged in ACOs	3
Community Health Worker Trainings	3	2	2	3
CHW cross trained as Peer Recovery Coaches	8	7	9	11
Region 7 IDN agencies with embedded Community Health Workers	5	5	7	7
Agencies working on Enhanced Care Coordination as defined by DSRIP metrics	3	11	12	11
Trained Care Advocates	15	11	21	18

Performance Measure Name	Target by 12/31/18	Progress Toward Target		
		12/31/18	6/30/19	12/31/19
Partner organizations that have agreements in place for referral process	4	7	7	8
E5 - Individuals served vs. projected	45	127	1027	1897
E5 - Staff recruited and trained vs. projected	23	18	28	29

As noted above, the most significant developments on this community-based project during the reporting period was the implementation of the IDN 7 Regional Care Coordinator Network and the launch of the newly redesigned CHW training offered by North Country Health Consortium. At this time, the region has met all process targets for this project and continues to deepen and strengthen relationships between partners through the support of peer cohorts like the RCCN and the CHW workforce.

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.

December 31, 2018

Provider Type	IDN Workforce (FTEs)				
	Projected Total Need by 12/31/18	Baseline Staffing on 6/30/17	Staffing on 12/31/17	Staffing on 6/30/18	Staffing on 12/31/18
Care Advocate	15	0	0	5	11
Regional Care Advocate Supervisors	1	0	0	1	1

Although Region 7 IDN did not meet the Care Advocate staffing target which was established, the region has had two regional care coordinator trainings to date, one in March 2018 for Carroll County agencies and one in November 2018 for Coös and northern Grafton County agencies. Participants felt the trainings were valuable because they provided an opportunity to come together to discuss information sharing and how to improve care coordination services for the high needs population as these patients transition between agencies.

The region initially planned to train five Care Advocates in each of the three subregions by December 31,2018. As the project moved into the implementation phase it became apparent that it would be beneficial to combine Coös and northern Grafton County agencies together for the regional care coordination training. The reasoning behind this decision was due to the structure of North Country Healthcare, and their efforts to coordinate care across the region. Due to North Country Healthcare's regional care coordination approach they only sent two staff members to the training versus one from each of the five affiliate agencies. This is, in part, because NCH hospitals and primary care practices belonged to a Medicare Accountable Care Organization at the same time, so care coordinators at each local affiliate were receiving care coordination training under that demonstration project as well. Counts in this table only reflect those care coordinators trained as part of the IDN activities. NCHC plans to offer additional care coordination training modules via webinar to reach additional care coordinators moving forward.

In addition to regional care coordination trainings NCHC has also hosted a risk stratification webinar in November 2018 which was well received by participating agencies. The IDN team scheduled a Policy and Protocol webinar for January 2019.

June 30, 2019 Update

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 (by 12/31/18)	Baseline Staffing on 6/30/17	Staffing on 12/31/17	Staffing on 6/30/18	Staffing on 12/31/18	Staffing on 6/30/19
Care Advocate	15	0	0	5	11	**21**
Regional Care Advocate Supervisors	1	0	0	1	1	**1**

As part of the continuous improvement process for performance metrics under the DSRIP, the Region 7 IDN team analyzed those metrics not yet met following the submission of final writebacks on the December 2018 SAR. One unmet target under the Enhanced Care Coordination Implementation Plan that remained unmet was the number of Care Advocates working in the Region. Region 7 IDN describes a Care Advocate as a person who coordinates care between the complex patient's multiple providers, has a strong understanding of the principles of integrated healthcare, can effectively leverage technology to ensure that the patient's complex needs are consistently met by all members of the care circle, and has received supplemental education beyond the development of traditional case management/utilization review skills in order to meet the needs of this complex patient population. Care Advocates can work at either clinical facilities or community-based organizations, and often their work includes helping patients to address social determinants of health as part of the patient care coordination process.

In previous rounds of reporting, Region 7 IDN staff only counted a care coordinator as a Care Advocate if they participated in one of the IDN sponsored care coordinator trainings. Because targets for this workforce capacity went unmet in the last reporting period, the Region 7 IDN team was prepared to offer another Care Advocate training. In preparation for a new training session, the Region 7 IDN team decided to engage IDN partner agencies in deeper discussions regarding their capacity to provide higher-level care coordination. The conversations included a look into each partners' perception of what training their care coordination staff have received that may qualify them as effective Care Advocates for the most complex patients. During these conversations, it became clear that several partners who concurrently participated in a Medicare Shared Savings Program Accountable Care Organization (ACO) and the DSRIP had access to additional training for their care coordinators and case managers through their contract with the ACO Administrator, Caravan Health. Several partners indicated that they did not feel it was necessary for their staff members to also engage in the IDN 7 Care Advocate trainings because they were perceived as redundant, and confirmed that their staff members continued to use the skills gained under the ACO despite the fact that the ACO contract ended on December 31, 2018.

These partners provided the Region 7 IDN team with agendas and curricula from the trainings offered to Care Coordinators under the ACO. They also confirmed that these Care Coordinators participated in monthly care coordination quality improvement calls and had ready access to a Care Coordinator Coach that continued to help them improve their coordination and advocacy skills. These partners have also been able to speak to their process for risk stratifying their patients and using a cut off for entry into an enhanced care coordination process, which can include formally billed services like Chronic Care Management and Transitional Care Management programs covered in the Medicare fee schedule, as well as local referral patterns for engaging CHWs and collaborating across agencies to address social determinants of health identified as barriers in Comprehensive Core Standardized Assessment

screenings. The Region 7 IDN team is confident that the ongoing training and support provided to the Care Coordinators under the ACO is comparable to the training and support offered by the IDN during the same period. Based on this added information, partners were asked to include their ACO-trained Care Coordinators in the number of Care Advocates in place at their organizations. As a result of revisiting who can be counted as a Care Advocate, Region 7 IDN can report a total of twenty-one trained Care Advocates deployed across the region by the end of the January-June 2019 reporting period. Not only does this revisited count ensure that Region 7 met this target during the current reporting period, partners were able to confirm that these staff members also received this training and acted in this capacity in previous reporting periods.

At the recommendation of the Community Engagement Workgroup and the request of several partner organizations, the Region 7 IDN team has begun the process of establishing a monthly virtual Care Coordinator/Care Advocate cohort meeting. The purpose of this meeting will be to provide an opportunity to come together and learn from one another about what is working and what may need to be improved related to care coordination in the region. It is proposed that this group will have quarterly in-person meetings to allow for an extended time for educational offerings. In the upcoming reporting period, the Region 7 IDN team will work with the Clinical and Community Engagement Workgroups to stand up these monthly Care Advocate meetings and anticipates that they will provide both continuing education to existing Care Advocates and baseline training to new Care Advocates as they are onboarded.

North Country Health Consortium suspended Community Health Worker (CHW) trainings during this reporting period as the training curriculum was updated to reflect national core competencies that were released at the beginning of the year. After the curriculum was updated, newly branded training materials were developed and produced, while the training team also revisited the mode of course delivery. At this time, two trainings are planned for the last half of 2019, one starting in August and a second in late fall. In prior periods, the decision had been made to offer the bulk of didactic training online to improve access to learners in the North Country. Newly released research and an analysis of participant evaluations has shown that dedicating up to 75% of course time for face-to-face interactive sessions with the remainder of the course designed for online learning is the recommended mode of delivery because the work of CHWs is so relational. The new training curriculum has been designed to incorporate not only national core competencies but also these national recommendations for the mode of training by breaking the 80-hour course into eight 6-hour classroom sessions, a two-day (12-hour) training in Motivational Interviewing and 20 hours of online homework assignments which align with the classroom time. The goal of this redesign is to produce a quality product that aligns with anticipated certification process requirements at both the state and national level as a steppingstone to reimbursement possibilities. NCHC is increasingly involved in CHW sustainability discussions at the state and national level and plans to continue participating in these efforts moving forward.

December 31, 2019 Update

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 (by 12/31/18)	Baseline Staffing on 6/30/17	Staffing on 12/31/17	Staffing on 6/30/18	Staffing on 12/31/18	Staffing on 6/30/19	Staffing on 12/31/19
Care Advocate	15	0	0	5	11	21	18
Regional Care Advocate Supervisors	1	0	0	1	1	1	1

E-4. IDN Community Project: Budget

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

December 31, 2018

Budget Period:	01/01/2017-12/31/2017	01/01/2018-06/30/2018	07/01/2018-12/31/2018	01/01/2019-12/31/2019	01/01/2020-12/31/2020	01/01/2021-06/30/2021
	Care Coordination Actual Funds Spent	Care Coordination Actual Expense (6 months)				
Care Coordination	CY 2017 Actuals	CY 2018 January to June Actual	CY 2018 July to Dec. Actual	CY 2019 Projected	CY 2020 Projected	CY 2021 Projected
1. Total Salary/Wages						
2. Employee Benefits						
3. Consultants			$0	$0	$0	$0
5. Supplies:			$0	$0	$0	$0
Educational			$0	$0	$0	$0
Office	968	$71	$76	$2,550	$2,550	$1,275
6. Travel		$368	$0	$0	$0	$0
7. Occupancy			$0	$0	$0	$0
8. Current Expenses			$0	$0	$0	$0
Telephone			$0	$0	$0	$0
Postage			$0	$0	$0	$0
Subscriptions			$0	$0	$0	$0
Audit and Legal			$0	$0	$0	$0
Insurance			$0	$0	$0	$0
Board Expenses			$0	$0	$0	$0
9. Software		$443	$0	$1,011	$1,011	$505
10. Marketing/Communications	1,086	$572	$1,797	$579	$579	$289
11. Staff Education and Training		$522	$0	$0	$0	$0
12. Subcontracts/Agreements			$0	$0	$0	$0
13. Other (specific details mandatory):			$0	$0	$0	$0
Current Expenses: Administrative Lead Organizational Support	1,634	$930	$1,306	$4,312	$4,312	$2,156
Support Payments to Partners	65,766	$59,987	$43,338	$181,953	$181,953	$90,977
TOTAL	**69,454**	**$62,893**	**$46,517**	**$190,405**	**$190,405**	**$95,202**

Consistent with all prior reporting, report begins with January 1, 2017 utilizing capacity building funds to maintain infrastructure.
IDN 7 projects the additional amount approved at June 2017 quarterly meeting to absorb future anticipated line item variances in Salary, Benefits, Software and Training.

June 30, 2019 Update

Budget Period:	01/01/2017-12/31/2017		01/01/2018-12/31/2018	01/01/2019-06/30/2019	07/01/2019-12/31/2019		01/01/2020-12/31/2020		01/01/2021-06/30/2021	
Care Coordination	CY 2017 Actuals		CY 2018 January to December ACTUAL	CY 2019 January to June ACTUAL	CY 2019 July to December PROJECTED		CY 2020 Projected		CY 2021 Projected	
1. Total Salary/Wages										
2. Employee Benefits										
3. Consultants			$0		0.00		$0		$0	
5. Supplies:			$0		0.00		$0		$0	
Educational			$0		0.00		$0		$0	
Office	968		$147	116.21	116.21		$232		$116	
6. Travel			$368	417.87	417.87		$836		$418	
7. Occupancy			$0		0.00		$0		$0	
8. Current Expenses			$0		0.00		$0		$0	
Telephone			$0		0.00		$0		$0	
Postage			$0		0.00		$0		$0	
Subscriptions			$0		0.00		$0		$0	
Audit and Legal			$0	189.74	189.74		$379		$190	
Insurance			$0	104.64	104.64		$209		$105	
Board Expenses			$0		0.00		$0		$0	
9. Software			$443	238.11	238.11		$476		$238	
10. Marketing/Communications	1,086		$2,369	179.00	179.00		$358		$179	
11. Staff Education and Training			$522		0.00		$0		$0	
12. Subcontracts/Agreements			$0		0.00		$0		$0	
13. Other (specific details mandatory):			$0		0.00		$0		$0	
Current Expenses: Administrative Lead Organizational Support	1,634		$2,236		0.00		$0		$0	
Support Payments to Partners	65,766		$103,325	26,708.35	26,708.35		$53,417		$26,708	
TOTAL	**91,231**		**$140,409**	**$50,680**	**$50,680**		**$91,536**		**$50,680**	

Consistent with all prior reporting, report begins with January 1, 2017 utilizing capacity building funds to maintain infrastructure.
IDN 7 projects the additional amount approved at June 2017 quarterly meeting to absorb future anticipated line item variances in Salary, Benefits, Software and Training.
Incentive Payments from January 2019 through December 2020 reflect a reduction based on anticipated DHHS action and county participation.
Budgets for project remainder reflect revised staffing structure in attempt to maximize funds available to partners.

December 31, 2019 Update

Budget Period:	01/01/2017-12/31/2017	01/01/2018-12/31/2018	1/1/2019 - 6/30/2019	7/1/2019 - 12/31/2019	1/1/2019 - 12/31/2019	1/1/2020 - 6/30/2020	7/1/2020 - 12/31/2020	01/01/2020-12/31/2020	01/01/2021-12/31/2021
Care Coordination	**CY 2017 Actuals**	**CY 2018 January to December ACTUAL**	**CY 2019 January to June ACTUAL**	**CY 2019 July to December ACTUAL**	**CY 2019 January to December ACTUAL**	**CY 2020 Jan to June PROJECTED**	**CY 2020 July to Dec PROJECTED**	**CY 2020 Projected**	**CY 2021 Projected**
1. Total Salary/Wages									
2. Employee Benefits									
3. Consultants		$0			0.00	0.00	$0	$0	$0
5. Supplies:		$0			0.00	0.00	$0	$0	$0
Educational		$0			0.00	0.00	$0	$0	$0
Office	968	$147	116.21	$95	211.08	105.54	$106	$211	$106
6. Travel		$368	417.87	$531	948.85	474.43	$474	$949	$474
7. Occupancy		$0			0.00	0.00	$0	$0	$0
8. Current Expenses		$0			0.00	0.00	$0	$0	$0
Telephone		$0			0.00	0.00	$0	$0	$0
Postage		$0			0.00	0.00	$0	$0	$0
Subscriptions		$0			0.00	0.00	$0	$0	$0
Audit and Legal		$0	189.74	$179	368.57	184.28	$184	$369	$184
Insurance		$0	104.64	$96	200.70	100.35	$100	$201	$100
Board Expenses		$0			0.00	0.00	$0	$0	$0
9. Software		$443	238.11	$386	624.20	312.10	$312	$624	$312
10. Marketing/Communications	1,086	$2,369	179.00	$192	371.17	185.59	$186	$371	$186
11. Staff Education and Training		$522			0.00	0.00	$0	$0	$0
12. Subcontracts/Agreements		$0			0.00	0.00	$0	$0	$0
13. Other (specific details mandatory):		$0			0.00	0.00	$0	$0	$0
Current Expenses: Administrative Lead Organizational Support	1,634	$2,236			0.00	0.00	$0	$0	$0
Support Payments to Partners	65,766	$103,325	26,708.35	$41,407	68,114.93	26,433.00	$61,677	$88,110	$44,055
					0.00				
TOTAL	**91,231**	**$140,409**	**$50,680**	**$61,855**	**$112,535**	**$48,643**	**$83,887**	**$132,530**	**$66,265**
Consistent with all prior reporting, report begins with January 1, 2017 utilizing capacity building funds to maintain infrastructure.									

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)
Ammonoosuc Community Health Services	Y
Coös County Family Health Services	Y
Huggins Hospital	Y
Indian Stream Health Center	Y
Memorial Hospital	Y
North Country Health Consortium	Y
North Country Healthcare	Y
Northern Human Services	Y
Saco River Medical Group	Y
Weeks Medical Center	Y
White Mountain Community Health Center	Y

Region 7 IDN partners listed in the chart above are also involved with the region's B1 project in some capacity such as having identified care teams; a systematic strategy to identify and intervene with target population; a comprehensive core assessment and a care plan for each enrolled patient; care coordination services that facilitate linkages and access to needed primary and specialty health care, prevention and health promotion services, mental health and substance use disorder treatment, and long-term care services, as well as linkages to other community supports and resources; transitional care

coordination across settings; technology-based systems to track and share care plans and to measure and document selected impact measures; robust patient engagement process around information sharing consent; and coordination with other care coordination/management programs or resources that may be following the same patient. IDN staff will continue to engage with agencies working to implement enhanced care coordination to ensure these agencies are incorporating the project core components. Other agencies in the region may be actively involved in the enhanced care coordination project but their efforts are not being tracked due to projected cuts in IDN funding.

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.
Risk Stratification -	To determine the level of case management a high needs patient should be provided. The California Quality Collaborative Risk Stratification Report identifies need based on 12 domains: age, hospitalization in last 12 months for any reason, ER visits in last 12 months any reason, sever diagnosis w/in last 2 years, co-morbid diagnosis w/in last 2 years, Rx # of unique prescriptions in last 12 months, behavioral health diagnosis w/in last 2 years, hospitalization last 12 months with sever or co-morbid diagnoses, ER visits last 12 months with sever or co-morbid diagnoses, cancer diagnosis w/in last 2 years, member has LTC Aid code 23, 63, 13, 53, member is LTC institutionalized or has aid code.
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 Core 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
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

Protocol Name	Brief Description	Use (Current/Under Development)
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 Core Team, and patient and family, supports and service connects, positive/negative occurrence, care plan adjustment, re-assessment, Gap analysis, review with Multi-Disciplinary Core 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 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
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 Core 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

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, Coös 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 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 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	B1

	training helps identify, understand and respond to signs of addictions and mental illnesses.	
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 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	D3

	Motivation; Coping with Urges; Managing Thoughts, Feelings and Behaviors; Living a Balanced Life	
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 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	B1

	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 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 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

DHHS Project Scoring: IDN Community Project Process Milestones

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

Process Milestone Number	Process Detail	Submission Format	Results (Met/Not Met)					
			6/30/17	12/31/17	6/30/18	12/31/18	6/30/19	12/31/19
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 -8	Clinical Infrastructure: IDN Community Project Roles and Responsibilities	Table						
E-9	Provide the training plan and curricula for each Community Driven Project as required in A-1.3	Training schedule and table						

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

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

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

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

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

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

December 31, 2018

Region 7 IDN partners and the IDN team continue to participate in conversations related to the Alternative Payment Model. Seven people from the region participated in the August 2018 Myers and Stauffer Learning Collaborative session on Performance Measurement and Quality Outcomes and heard Henry Lipman, NH Medicaid Director, present an update on the alternative payment model. The IDN team also arranged for Henry Lipman to speak at the region's quarterly meeting in December 2018 to address funding uncertainties and alternative payment models. To date, the focus of alternative payment model conversations has been related to the re-procurement process of the managed care organizations because the MCOs have been asked to develop a strategy for moving 50% of their medical expenditures into qualifying APMs to improve cost, quality, and member experience. The MCOs are tasked with implementing cost of care models which include shared savings and align with the existing APM models used in the Medicare and commercial markets. The APMs must improve measures related to unnecessary emergency department and service utilization; preventable admissions and 30-day readmissions; and timeliness of follow-up after mental illness or substance use disorder admission, all important things related to DSRIP goals as well. DHHS expects the MCOs to provide person-centered care which addresses patients' physical health, behavioral health, and social and economic needs, all of which aligns with what the IDNs are doing. The MCOs must conduct local care management or contract with a designated care management entity for at least 50% of high-risk/high-need members. Region 7 IDN will work closely with NH DHHS as conversations evolve defining DHHS certification of IDNs as a local care management entity. In addition, members of the IDN team have had conversations with the existing MCOs and at least one of the new MCOs regarding working together to prevent duplication of services, and these conversations will continue.

The 7 IDNs and staff from NH DHHS have come together to start having conversations related to billing and coding for integration services. These conversations will continue bimonthly, and the information learned will be shared with partners in the region. The IDN team is interested in learning more about the sustainability of the Critical Time Intervention model and finding out if this could be a billable service as it is now in North Carolina. This has been a stumbling block for implementation of the model and has been brought up by numerous partners across the region and from other IDN regions in the state.

A non-binding Notice of Intent to Apply for NH Value Care has been submitted and accepted by CMS for the following participating member organizations: Catholic Medical Center, Huggins Hospital, Monadnock Community Hospital, Androscoggin Valley Hospital, Littleton Regional Healthcare, Upper Connecticut Valley Hospital Association, Weeks Medical Center, Ammonoosuc Community Health Services, Coös County Family Health Services, and Indian Stream Health Center. The Region 7 IDN team does not know if all the mentioned agencies will move forward with the submission, but the team will stay in contact with these agencies to learn more about the progress and what it means for the region.

Saco River Medical Group, the third-largest independent physician group in NH, has joined VillageMD New Hampshire ACO which is a collaboration with Derry Medical Center and Southern NH Internal Medicine Associates. The ACO is a joint venture among three independent physician groups in NH working together to remain viable as independent medical practices.

Dartmouth-Hitchcock Health (D-HH) and GraniteOne Health (GOH) have signed a non-binding letter of intent describing their intent to combine their health systems to better serve the health care needs of patients and communities throughout New Hampshire. As a combined system, Dartmouth-Hitchcock Health GraniteOne will seek to:

- Expand access to high-quality care for individuals and families throughout New Hampshire;
- Respond to growing demand for inpatient, specialty and sub-specialty services, particularly in southern New Hampshire;
- Extend and reinforce health care services in rural communities;
- Coordinate and strengthen efforts to address behavioral health and substance use disorder;
- Improve the health of populations suffering from chronic conditions such as diabetes, asthma, and obesity, leading to better long-term health and lowering long term healthcare costs;
- Address social determinants of health such as nutrition and food security, access to preventative care, and educational opportunity

There are numerous opportunities for systems alignment and potential alternative payment models in the upcoming month. The Region 7 IDN team will look for opportunities to participate in these conversations as they evolve over the coming months and attempt to leverage payer strategies to develop innovative ideas that meet IDN metrics and measures.

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	Yes	Yes	Yes
Develop an IDN-specific plan for implementing the roadmap which will contain IDN-specific outcome measures		No	No
Develop the financial, clinical and legal infrastructure required to support APMs		No	No
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		No, but trying	No

June 30, 2019 Update

Provide a brief narrative which speaks to the following:

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

During this reporting period, the Region 7 IDN team queried partner agencies working on the core competency integrated healthcare project to ascertain their readiness to enter into Alternative Payment Model (APM) contracts with payer sources. Several partners report that they have already participated in at least one round of Medicare Shared Savings Program Accountable Care Organization demonstrations. Most partners also report that they currently hold payer contracts that include some form of incentive payment program that uses HEDIS measures to evaluate the quality of preventative care and chronic disease management for covered beneficiaries. None of the partners are currently involved in any down-side risk APMs.

Partners generally report that they feel prepared to deliver clinical care that is consistent with the standards of care upon which most APM quality metrics are based and are therefore clinically prepared to enter into APM contracts. Despite confidence in the way care is delivered at partner agencies, most partners expressed a reluctance to enter into down-side risk arrangements at this time because they have not yet established the infrastructure necessary to proactively manage data that will allow them to produce and act upon reliable care opportunity reports, adequately code claims to ensure that Hierarchical Condition Category stratification is accurate for beneficiaries and validate performance metric data as required by most APM contracts. The primary reason stated by partners for not having this infrastructure in place is that billing, coding, and data governance activities are generally un- or under-compensated in current pay schedules. Members of the Region 7 IDN team have been participating in statewide conversations related to billing and coding and will work with other IDNs across the state to share this information with partner agencies in the upcoming reporting period.

Region 7 IDN has had representation at several meetings focused on Local Care Management Entities (LCMEs) during this reporting period. The Region 7 IDN team included this topic on the agenda at the region's annual meeting in June and has asked the Steering Committee to offer guidance on the feasibility of the IDN becoming a local care management entity. These conversations continue to evolve as sustainability conversations come to the forefront of the DSRIP project, and the region will continue to engage in conversations with the MCOs and NH DHHS related to this topic during the next reporting period.

Statewide APM Taskforce and Implementation Plan Activity	Progress			
	As of 12/31/17	As of 6/30/18	As of 12/31/18	As of 6/30/19
Participate in development of statewide APM roadmap through workgroups and stakeholder meetings	Yes	Yes	Yes	Yes
Develop an IDN-specific plan for implementing the roadmap which will contain IDN-specific outcome measures		No	No	No
Develop the financial, clinical and legal infrastructure required to support APMs		No	No	No
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		No, but trying	No	No

December 31, 2019 Update

Provide a brief narrative which speaks to the following:

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

Billing/Coding workgroup

As noted in previous reports, most Region7 IDN partners are participating in various payer incentive programs that have left their clinical teams well-positioned to deliver care in Alternative Payment Model environments. Despite confidence in the way care is delivered within their organizations, most partners continue to express a reluctance to enter into down-side risk arrangements because they have not yet established the infrastructure necessary to proactively manage the data that feeds reliable care opportunity reports, adequately code claims to ensure that Hierarchical Condition Category stratification is accurate for beneficiaries and validate performance metric data as required by most APM contracts. The primary reason stated by partners for not having this infrastructure in place is that billing, coding, and data governance activities are generally un- or under-compensated in current pay schedules.

During the reporting period, members of the Region 7 IDN team participated in the statewide Billing & Coding Workgroup. In response to feedback regarding billing and coding concerns, the IDN team also encouraged partners to participate in billing and coding subcommittees which were developed in the last half of the reporting period. As the next reporting period progresses, the IDN 7 team will monitor the recommendations of the subcommittees closely, sharing information with partners and assessing regional need for education regarding coding and billing guidelines and methods for communicating with the Managed Care Organizations regarding reimbursement for integrated healthcare delivery to NH Medicaid beneficiaries

Meeting reporting requirements

There is an emerging awareness of the need to further develop and strengthen data governance and quality improvement skills within the integrated healthcare workforce. Region 7 IDN partners report that there were a number of payer-related projects underway (including participation in Medicare ACOs, commercial insurance plan incentive programs and federal quality monitoring programs) that each request similar, but not exactly identical, data sets. Most Region 7 IDN partner organizations are working towards better analytics maturity, but struggle with the need to balance making improvements in health information systems data governance practices without disrupting patient care. The variance in measure specifications and use of medical record systems that were not implemented with an eye to data output lead to partners expending extensive staff time to meet reporting obligations retrospectively, rather than using data to inform real time quality improvement efforts.

Often, the staff members reporting on payer-based initiatives are the same individuals called upon to implement new initiatives that further the delivery of integrated, person-centered care. Because current reimbursement models offer little to no consideration for the cost of data handling, partner organizations feel obligated to prioritize work that furthers the delivery of quality care over the work that demonstrates that quality care has been delivered. This data handling includes system design controls that ensure that reports can be generated in an efficient manner with verifiable data integrity and is best performed by individuals who can demonstrate nationally developed quality assurance and performance improvement (QAPI) competencies and process standards. Even in larger organizations

with a dedicated person or persons responsible for quality improvement, there is significant variation in staff training and experience. In smaller organizations, it is common to outsource system maintenance and abstraction functions to separate third parties that have little to no knowledge of the local variation in data handling.

This feedback from partners makes clear that, as delivery system reform takes place, there is a need to advance data governance and analytics maturity so partners can efficiently and accurately demonstrate gains made in clinical quality, resource utilization and patient experience. Without adequate financial support for these activities, they are often diffused across many staff with varying capabilities, compromising efficiency and data integrity, and missing the opportunity to apply systems-thinking to quality improvement efforts.

As partner organizations prepare for Alternative Payment Models under the NH Medicaid program and other payer initiatives, the Region 7 IDN team will work with them to identify opportunities that deepen the skills of their existing workforce, bringing them in line with nationally developed quality improvement standards and staff competencies.

The Region 7 IDN team continues to have representation at meetings focused on Local Care Management Entities (LCMEs), and has had meetings with representatives from one of MCOs to discuss potential pilot models that can look at reimbursement options for some of the care coordination efforts in the region which are currently not reimbursed. The IDN team will join with partners across the region to continue dialogue with the MCOs and NH DHHS related to alternative payment models during the next reporting period.

Statewide APM Taskforce and Implementation Plan Activity	Progress				
	As of 12/31/17	As of 6/30/18	As of 12/31/18	As of 6/30/19	As of 12/31/19
Participate in development of statewide APM roadmap through workgroups and stakeholder meetings	Yes	Yes	Yes	Yes	Yes
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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		No, but trying	No	No	No

DSRIP Outcome Measures for Years 4 and 5

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.