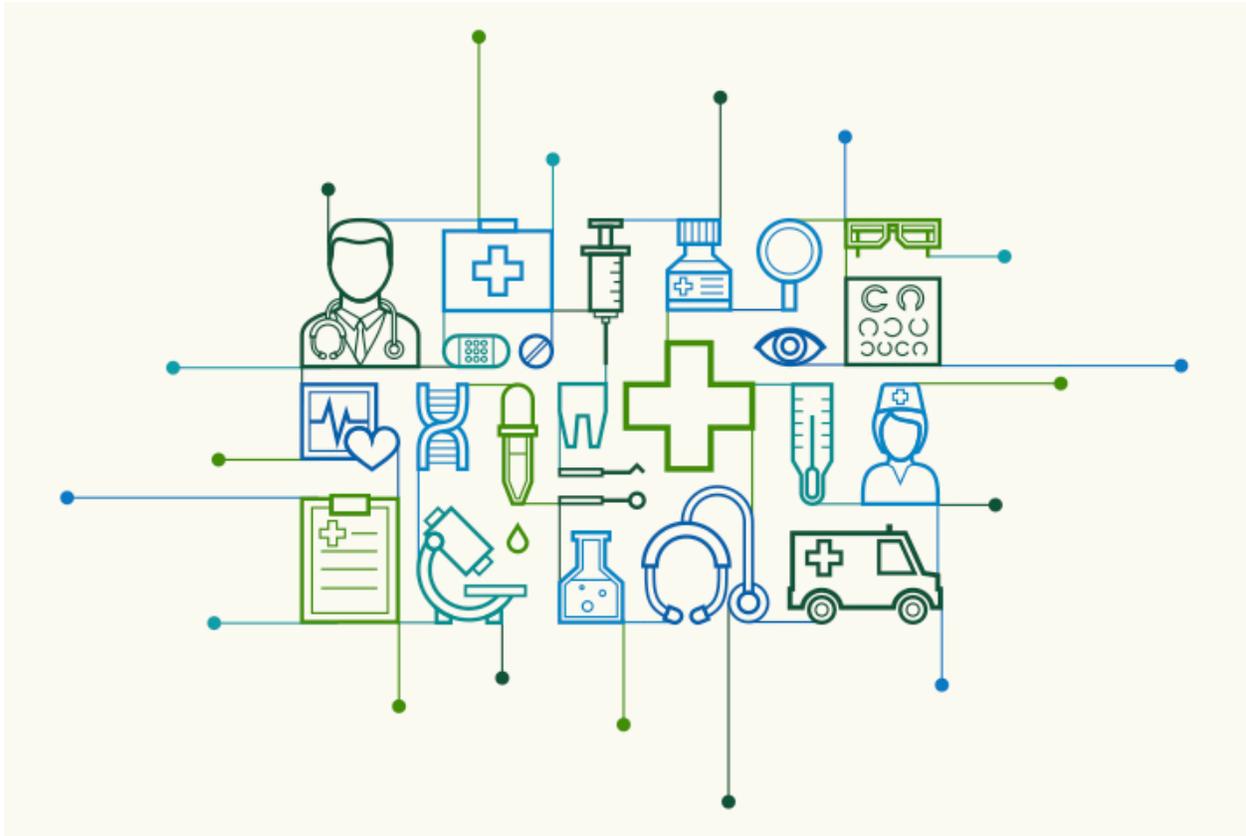


Integrated Delivery Network (IDN) for Region 2 - Capital Area

Concord Hospital, Administrative Lead
Capital Region Health Care, Primary Lead



Semi-Annual Report

To the New Hampshire Department of Health and Human Services (NH DHHS)
For the period January - June 2017

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DSRIP IDN Project Plan Implementation (PPI)

Soliciting Community Input

To date, IDN2 has conducted four community surveys to solicit input about the choice of project plans, perceptions of community need, gaps in services, and proposed training topics.

IDN2 requires that all members participate fully in at least one of IDN2's 8 workgroups, 5 committees, and/or 2 governance groups that meet monthly as well as the quarterly full IDN meeting:

Workgroups

- Integration - Concord Hospital Medical Group (CHMG)
- Integration - Dartmouth Hitchcock Concord (DHC)
- Integration - Riverbend Community Mental Health (Riverbend)
- Integration - Concord Hospital (CH) Family Health Center (FHC)
- Medicated Assisted Treatment (MAT)
- Perinatal Addiction Treatment (PAT)
- Enhanced Care Coordination (ECC)
- PAT + ECC

Committees

- Health Information Technology (HIT)
- HIT + Clinical
- Finance
- Executive
- Steering

These meetings are very successful in “getting the word out” about the status of IDN2 projects and also in “getting the word in” about how IDN2's projects are being perceived in the community as well as what is/isn't working.

The agenda and minutes of IDN2's “steering” committee (IDN Committee) are sent to the entire IDN membership.

IDN2 initially created a monthly newsletter to keep members informed and has since moved to a Facebook format. IDN2 still circulates information through newsletters distributed by two of its key partners: CH and Riverbend.

In addition, IDN2 provides presentations and speakers about the IDN2 projects to any groups that request them. It has presented to the CH and Riverbend boards of directors. It has also taken its presentations to individual CHMG practices.

Timeline for future activities:

July - Dec 2017

- Develop 6 template presentations to be updated as needed (IDN2 projects x 3, Integration x 4, DSRIP/IDN2 Overview, Outcome Measures)
- 10 visits to CHMG practices to discuss the Integration & MAT projects with Q & A
- 2 quarterly presentations to the full IDN with Q & A

- 3-5 weekly IDN2 Facebook posts on topics relevant to the DSRIP projects
- 4 presentations to community members about one or more of the IDN2 community projects with Q & A
- 13 monthly workgroup/committee meetings with Q & A
- 6 distributions of IDN Committee agendas and minutes

Jan - June 2018

- 5 visits to CHMG practices to discuss the Integration & MAT projects with Q & A
- 2 quarterly presentations to the full IDN with Q & A
- 3-5 weekly IDN2 Facebook posts on topics relevant to the DSRIP projects
- 4 presentations to community members about one or more of the IDN2 community projects with Q & A
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Network Development

To date, IDN2 has 38 partners. Of those present at the beginning, only three are no longer involved: HOPE for NH Recovery, Merrimack County Nursing Home, and Concord Pediatrics. There are 8 partners (representing 21 sites) who are participating in one or more projects, either as a service or as a key referral site: CH (including CHMG, CH Substance Use Services, and The Family Place), DHC (including its OB-GYN practice), Child & Family Services (CFS), Riverbend, Concord Regional VNA (CRVNA), NH Hospital (NHH), Merrimack County Department of Corrections (DOC), and Sununu Youth Services (SYS). Most of the other partners are community based organizations (CBO) whose role is still being developed. IDN2's IDN Committee, limited to 15 members, has representation from across all provider types and CBOs.

July - Dec 2017

- Develop a presentation about Social Determinants of Health to be delivered at a quarterly IDN meeting
- Survey at least 20 IDN2 CBOs about the services they provide and identify any potential gaps
- Work with Cary Gladstone/Granite United Way to develop a contract between IDN2 and NH-211 for 2018
- Develop a forum including schedule, list of presenters, and attendee list for IDN2 CBOs to present to IDN2 project staff about the services they provide.

Jan - June 2018

- Contract with Cary Gladstone/Granite United Way to provide expanded NH-211 services
- CBOs will present at least 3 times to IDN2 project staff

July - Dec 2018

- CBOs will present at least 3 times to IDN2 project staff

Addressing the Opioid Crisis Update

IDN2 partnered with the Capital Area SUD Continuum of Care (CoC) project in establishing its community projects and continues to meet with the representative of that project on a regular basis.

IDN2 is addressing substance use disorders (SUD) in NH, including the “Opioid Crisis,” through the development of the MAT and PAT project projects and by including a focus on SUD throughout all of its other projects. When IDN2 uses the term “behavioral health,” it includes mental illness and SUD and recognizes that co-occurring disorders are much more prevalent than either single diagnosis.

IDN2’s MAT project is recruiting and mentoring up to 18 primary care providers (PCPs) to receive their x-waiver and provide MAT within the primary care provider (PCP) setting. IDN2 structured its ECC project to address those participating in the PAT project with family wraparound services in order to prevent relapse and generational SUDs.

Timeline for future activities:

July - Dec 2017

- Provide mentoring support to 6 existing MAT providers
- Convene existing MAT providers and IBHC each month to share best practices, review cases, and address challenges
- Develop workflows for introducing MAT into 6 CHMG and DHC locations
- Attend 6 CoC meetings as a representative of the IDN2
- Distribute recruitment materials to at least 25 primary care providers about getting their x waiver and participating in the IDN2 MAT project
- Provide training for 10 non-clinical staff in “See the Person; not the Illness”
- Provide MAT presentations to 3 community groups
- Provide SUD-focused education/trainings for 6 IBHCs
- Provide SUD-focused education/training for 12 medical providers

Jan - June 2018

- Provide mentoring support to 6 additional MAT providers
- Convene existing MAT providers and IBHC each month to share best practices, review cases, and address challenges
- Develop workflows for introducing MAT into 4 additional CHMG locations
- Attend 6 CoC meetings as a representative of the IDN2
- Distribute recruitment materials to at least 25 primary care providers about getting their x waiver and participating in the IDN2 MAT project
- Provide training for 10 non-clinical staff in “See the Person; not the Illness”

- Provide MAT presentations to 3 community groups
- Provide SUD-focused education/trainings for 6 IBHCs
- Provide SUD-focused education/training for 12 medical providers

July - Dec 2018

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- Provide SUD-focused education/training for 12 medical providers

Governance

IDN2 developed its governance charter and structure in 2016 and has held monthly steering committee meetings since then. The “IDN Committee” is the steering committee that votes/approves any actions and the budget. Its 15 members meet monthly and represent an array of provider and organization types.

The IDN Executive Committee consists of six members. The three CEOs of Capital Region Health Care’s (CRHC) organizations: CRVNA, Riverbend, and Concord Hospital head the Executive Committee. CRHC split the primary responsibilities (Clinical/Riverbend, HIT/CRVNA, Financial/Concord Hospital) of IDN2 among the three organizations and the leads of those sub-committees also sit on the IDN Executive Committee. The Project Director attends these meetings and is guided in her day to day work by them.

The Financial Committee develops the budget and provides financial reports. The HIT Committee oversees all of the technology needs of IDN2. The Clinical + HIT Committee is becoming the quality control branch of the governance structure. Currently, it is becoming steeped in the required Process and Metric Outcomes.

Timeline for future activities:

July - Dec 2017

- 6 IDN2 Committee Meetings
- 6 IDN2 Executive Committee Meetings
- 6 Finance Committee Meetings
- 6 Clinical + HIT Meetings
- 6 HIT Meetings
- Evaluate membership of Clinical + HIT sub-committee and recruit any missing areas of expertise
- Define and document role of Clinical + HIT sub-committee
- Recruit for any new IDN2 Committee members needed for vacancies

Jan - June 2018

- 6 IDN2 Committee Meetings
- 6 IDN2 Executive Committee Meetings
- 6 Finance Committee Meetings
- 6 Clinical + HIT Meetings
- 6 HIT Meetings
- Review governance charter and update, if necessary
- Develop reporting mechanism for Clinical + HIT sub-committee
- Recruit for any new IDN2 Committee members needed for vacancies

July - Dec 2018

- 6 IDN2 Committee Meetings
- 6 IDN2 Executive Committee Meetings
- 6 Finance Committee Meetings
- 6 Clinical + HIT Meetings
- 6 HIT Meetings
- Recruit for any new IDN2 Committee members needed for vacancies

Budget

IDN2 has a finance committee that oversees revenue and expenses and provides reports to the IDN Committee. The Project Director manages the day to day budget and approves invoices and expenses. IDN2 also has an accountant who processes accounts payable and receivable and prepares financial reports.

It was difficult to budget accurately for 2017 with many project specifics still undecided; however, 2018 is already being drafted with the plan to have it approved at the November IDN Committee meeting.

The process for developing the budget is that the Project Director and Managing CEO prepare a draft with input from project staff. That draft is presented to the Executive Committee for approval. Once they have approved and/or any requested changes have been made, it will go to the Finance Committee to be finalized for IDN Committee approval.

July - Dec 2017

- 6 Finance Committee Meetings
- Draft, review, and approve 2018 budget

Jan - June 2018

- 6 Finance Committee Meetings

July - Dec 2018

- 6 Finance Committee Meetings
- Draft, review, and approve 2018 budget

Please see the 5-year budget as of June 30, 2017 on the next page. Changes to the 2018 budget are already underway.

Budget Narrative

Administrative Staff

Managing CEO oversees the whole of the IDN2 projects and reports to the Executive Committee (on which he also sits).

Project Director works closely with the Managing CEO to oversee the whole of the IDN2 projects as well as plans and implements processes to support the IDN2 projects. The Project Director supervises the Project Specialist, prepares and provides materials for all of the committees and workgroups, and writes all required reports. The Project Director, along with the Managing CEO, is also IDN2's liaison and "administrative lead" with NH DHHS and any other statewide entities.

The Chief Technology Officer (CTO) oversees all of the HIT and technology needs of IDN2 and leads an HIT workgroup. The CTO sits on the Executive Committee.

The Project Specialist schedules all meetings, updates all member lists, submits invoices for approval, corresponds with IDN members and the community, troubleshoots, and provides administrative and project management support.

The Accountant manages accounts payable and receivable and prepares financial reports.

The following positions reside at Riverbend due to the majority of the new positions that IDN2 created being employed there: Human Resources, Bookkeeper, and Financial Data Analyst. These positions support those employees and provide records and data required by IDN2.

Direct Expenses

Travel is primarily for the Project Director who is not located in New Hampshire. Meeting supplies and office equipment & supplies are standard expenses. Malpractice insurance is to offset the costs to Riverbend of hiring new employees who are required to carry that insurance. Legal services are a placeholder in the event those are needed. Audit services were thought to be a requirement of the DSRIP project but that line item may be removed in the future. Job advertising and promotion is high because, after trying and failing to recruit, IDN2 elected to hire a professional recruiting firm to find two psychiatrists for the projects.

BH Workforce Development

BH Workforce Development is reflected in this section through the hiring and training of peers for all of the projects. It is also reflected in "Direct Expenses" through the hiring of a professional recruiting firm and in "Integration" under "Training."

HIT/DATA

This budget reflects what is needed to meet the requirements of the Integration project (CMT, Data Vendor, Direct Messaging, Secure Texting, Interfacing Costs) and what has been well vetted and agreed to by IDN2 and other IDNs as statewide solutions to these requirements. Equipment is to provide computers for new employees. Tech Support is for a person to assist the CTO in day to day operations and troubleshooting of equipment and technology. A Data Analyst has not been hired yet and is there as a place holder for an anticipated need.

Integration

As you will see under the Integration section of this report, IDN2 plans to integrate across 11 sites in the region. Some of these sites already had co-located behavioral health staff and two were already on their way to becoming integrated. The plan is to embed Integrated Behavioral Health Clinicians (IBHC) at PCP sites. For those sites that were already integrating, we have chosen instead to augment that staff with a Medical Assistant or Integrated Care Coordinator. We are hoping to hire 2 psychiatrists to provide consultation across the integrated sites. In addition, we have a Director of Integration who supervises most of the IBHCs and who conducts site assessments and works with the providers to develop workflows and troubleshoot any difficulties. We have also included training costs for the PCPs, IBHCs, and non-clinical staff.

Medicated Assisted Treatment (MAT)

The expenses for this project are light in 2017 because the project was started with funds from the Foundation for Healthy Communities. IDN2 is augmenting that funding this year by providing another .2 mentor and offering incentives to PCPs to become x-waivered and provide MAT in their practice.

Enhanced Care Coordination (ECC)

You will see more detail in the section of the report that is about this project. Three Enhanced Care Coordinators (ECC) have been hired to serve the 0-22 population of IDN2 with wraparound services. There is a supervisor for these positions. The UNH Institute of Disability is providing training in the Wraparound and Renew models of care. Travel is for the ECCs who will visit clients. Flex funds are for the families who are receiving ECC services. Protocols for the use of those funds is under development. They are intended to support information/volunteer resources to improve the family's ability to meet their service needs. They are time-limited and cost-efficient and used only after all other sources of available revenues are ruled out. Flex funds must be related to the child/family's service needs and address the child's mental health needs.

Reentry

An outside consultant with expertise in developing reentry programs was brought in to work with Merrimack County Department of Corrections and Sununu Youth Services for this project. The reentry project includes case management and behavioral health services provided during incarceration, transitions, and in the community. The staff listed here reflect that. Testing supplies are part of the monitoring aspect of the reentry project. The Integration Director is allocated some time here to oversee the behavioral health staff in this project.

Project A1: Behavioral Health Workforce Capacity

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

IDN 2’s participation in Statewide Workforce Taskforce activities and completion of a Statewide Workforce Capacity Strategic Plan.

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

A1-2. IDN-level Workforce: Gap Analysis

Along with the other IDNs, IDN2 submitted a gap analysis to the statewide behavioral health workforce development taskforce. This included regional as well as statewide gaps:

- **RECRUITMENT and HIRING** - In the June 2017 report prepared for the NH Community Behavioral Health Association by Patrick Miller, Riverbend had the highest number of vacancies at 30. There are particularly high vacancies in these key behavioral health positions: psychiatry, licensed alcohol and drug counselors, MAT providers.
 - There is a national shortage of psychiatrists in NH and IDN2 is keenly aware of that difficulty. Data collected for the above referenced report showed that the Community Mental Health Centers (CMHC) mean to fill a psychiatric APRN position is 204 days and 318 days for an MD.
 - In NH, up until 2016, Medicaid did not offer SUD treatment as a benefit. As a consequence, there have been very few individuals who are licensed at the master’s level for alcohol and drug counseling. In fact, at the moment there are about 250 such qualified individuals in the entire State.
 - MAT providers are disproportionate to the need created by the State’s opioid epidemic.
 - Peer Recovery Support is a proven route to sustained recovery and can augment staff shortages in the field as well as assist with care coordination and transitions, two key elements of an integrated practice.
- **EDUCATION and TRAINING** - Current behavioral health staff are not trained to provide integrated care because it is a relatively new model. As such, schools are only beginning to include it in their curriculum and very few existing behavioral health staff will have direct experience in providing it. There is a need for more trained mental health peers and to overcome any barriers to having peers in the integrated workforce.
- **RETENTION** - Retention of behavioral health staff is challenging due to low pay, particularly at the Community Mental Health Centers (CMHC) like Riverbend due to Medicaid reimbursement from the State having continued over many years at the same rate. Retention is also an issue because of the stigma associated with behavioral health.

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

IDN2's primary work to address these gaps will be conducted on a statewide level using the activities and outcomes defined by the statewide behavioral health workforce development taskforce. IDN2 has addressed, and will continue to address, the regional gaps, as well as hire the workforce needed to staff IDN2 projects, in the following way:

Jan - June 2017

1. Define and develop job descriptions for all positions needed for the IDN2 projects.
(Please see A1-5)
2. Contracted with HOPE for NH Recovery for 4 peers for the IDN2 projects
3. Contracted with NAMI NH for family peer support specialists
4. INTEGRATION
 - a. Hired IBHC Supervisor
 - b. Hired 6 FTE IBHCs for Integration project
 - c. Identified training opportunities for IBHCs to expand knowledge of Integration
 - d. 6 IBHCs attend the following trainings:
 - i. Integration overview (SAMHSA oriented) and delivered by IDN staff
 - ii. SAMHSA "Implementing Medication-Assisted Treatment (MAT): Organizational Considerations and Workflows." Covered clinical pathways, staffing needs, and organizational readiness.
 - iii. NH Providers Association Annual Training - Confidentiality Training, 42 CFR Part 2: How to be Compliant and Integrate
 - iv. ASAM Appropriate Use of Drug Testing in Clinical Addiction Medicine Webinar
 - e. IBHCs applied to and were accepted to join a nine-month Learning Collaborative: SAMHSA-HRSA Center for Integrated Health Solutions (CIHS) "Innovation Community Circle of Support - Engaging Loved Ones in Health and Wellness."
 - f. 6 IBHCs were trained in chronic health disease through a presentation on Metabolic syndrome (Metabolic syndrome is a cluster of conditions — increased blood pressure, high blood sugar, excess body fat around the waist, and abnormal cholesterol or triglyceride levels — that occur together, increasing one's risk of heart disease, stroke, and diabetes.) The training covered definitions, symptoms, etiology, treatment, co-morbidities, and health disparities.
 - g. While being credentialed to work in the Concord Hospital Medical Group (CHMG) and Dartmouth Hitchcock Concord (DHC) practices, IBHCs participated in developing work flows for the practices
 - h. IDN2 IBHCs began meeting monthly with the Concord Hospital Family Health Center (FHC) IBHCs to share best practices and support each other
 - i. 25 primary care providers (PCPs) at CHMG received training in Motivational Interviewing
 - j. Contracted with a recruitment firm (Merritt Hawkins) to identify and hire 2 psychiatrists
 - k. Riverbend Medical Director began conducting professional outreach including to graduating psychiatry students

- l. Hired Medical Assistant for the Integrated Center for Health
- m. Hired Integrated Care Coordinator (ICC) for CH FHC.
5. REENTRY
 - a. Hired psychiatric APRN, Masters Level BH Clinician, and Masters Level Alcohol and Drug Counselor
6. MAT
 - a. Hired 2 mentors for project
 - b. Developed incentive program for PCPs to become X-Waivered
 - c. Reached out to 6 current MAT providers for inclusion on MAT workgroup
 - d. Involved 6 IBHCs in MAT workgroup
 - e. Provided educational presentations about MAT to 6 PCP practices
 - f. Distributed literature about the IDN2 MAT project to 25 PCPs
 - g. Hired 2 providers for Perinatal Addiction Treatment (PAT) project
 - h. Hired Social Worker for PAT project
7. ECC
 - a. Hired ECC Supervisors
 - b. Contracted with UNH IOD to provide NH wraparound and renew training to 6 ECC staff and supervisors

July - Dec 2017

- Hire and train mental health peers through Riverbend
- Riverbend to conduct a market analysis of staff pay rates and make adjustments as needed
- HIT
 - Hire HIT Support Person
 - Evaluate need for Data Analyst position
- INTEGRATION
 - IBHCs complete nine-month Learning Collaborative: SAMHSA-HRSA Center for Integrated Health Solutions (CIHS) “Innovation Community Circle of Support - Engaging Loved Ones in Health and Wellness.”
 - Hire and train 2 additional IBHCs
 - 8 IBHCs receive 3 trainings related to integrated health
 - Identify and schedule future training opportunities for PCPs
 - Develop plan for CHMG practices with low Medicaid numbers (staffing, coordinated/integrated)
 - Contract with NAMI NH to provide “See the Person, Not the Illness” for non-clinical staff in integrated sites
 - 8 IBHCs meet monthly with the Concord Hospital Family Health Center (FHC) IBHCs to share best practices and support each other
- REENTRY
 - Hire Case Manager
 - Train Reentry staff in:
 - Review of the Client Flow System: Orientation to the pathways through the reentry system from initial screening and assessment through post release programming. This process includes two major meetings: May 2017 and July 2017. The initial meeting was to discuss the need for a flow system from initial assessment to post release services; what is expected from whom; and

how assessment tools, case management services, pre- and post-release programming, transitional case management, and support services are managed. The second meeting is to review the case flow system and responsibilities with all reentry staff.

- Case Management Training: A review of evidence based case management strategies for offenders as they re-enter the community. This will include the process of coordinated case planning, transition services, use of a universal case plan, and evidence based chain of case planning and services.
- Overview of Evidence Based Practices: Discussion of the best practice models in criminal justice and correctional settings including methodology for clients with substance use and mental health disorders. This review will include the National Transition from Jail to Community Model, the Risk Need Responsivity Model, Criminogenic Risk and Need, and other successful evidence based systems.
- Outcome Data: This is designed to review the performance measures agreed to in reentry meeting and the methodology of collecting and reviewing that data for continuous quality improvement including:
 - Public Safety Indicators and Outcomes
 - Reduced re-offending, returns to jail, and length of jail stays for returning individuals
 - Reintegration Indicators and Outcomes
 - Reduced substance abuse and homelessness
 - Increased employment
 - Improved housing stability and improved mental health/health
 - Process Measures
 - Screening
 - Assessment
 - Referrals
 - Engagement
 - Service utilization
 - Completion
 - Assessments are the key to understanding your clients' needs
 - Make intelligent decisions based on evidence
 - Understand gaps in data collection and work toward building a better data infrastructure
 - Leverage existing resources
- MAT
 - Begin monthly “Didactic Call-In” with MAT mentors and subject matter experts (SME). The subject list includes Prescribing FAQs: dose, type, side effects, prior authorization, and etc.; Motivational Interviewing; Counseling strategies (IBHCs); 12 step introduction and discussion; Consent; Urine drug testing; Vivitrol/naltrexone; and Other substances (e.g. gabapentin, benzos, clonidine, anti-psychotics).
 - Extend FACE-UP Forum to IDN2 community - Ongoing forum at CH for anyone in the hospital or IDN including physicians, RNs, social workers, and etc. to come discuss cases or situations which involve patients with substance use disorders. The

“FACE” portion of the name stands for “Framing Addiction Care Effectively” and the “UP” portion is alternately “Utilizing Best Practices”, “Undoing Prejudice”, and “Understanding Pathways”.

- Extend monthly Opioid meeting to IDN2 community - Existing meeting of pharmacists, supervising RNs, providers, and senior leadership at CH to educate around prescribing opioids as well as other potentially addicting medications.
- ECC
 - Hire 3 ECC Coordinators
 - Train 3 ECC Coordinators in Cultural and Linguistic Competency
 - Provide 3 ECC Coordinators with wraparound and renew coaching through UNH IOD

Jan - June 2018

- HIT
 - Hire Data Analyst, if needed
- INTEGRATION
 - IDN staff will receive pay adjustments
 - Hire 2 psychiatrists
 - Hire and train 3 additional IBHCs
 - Hire APRN (Medical)
 - Hire ICC
 - 14 PCPs receive 1 training related to behavioral health
 - 7 nonclinical staff receive 1 training related to behavioral health
- REENTRY
 - Staff receive 1 additional training module
- MAT
 - 12 IDN2 members attend 1-3 MAT educational meetings per month
 - 3 PCPs attend NH Buprenorphine Waiver Training
 - 3 PCPs complete the NP and PA 24-hour training requirement established by the Comprehensive Addiction and Recovery Act (CARA).
- ECC
 - 3 Coordinators receive coaching from UNH IOD

July - Dec 2018

- INTEGRATION
 - 11 IBHCs receive 3 trainings related to integrated health
 - 14 PCPs receive 1 training related to behavioral health
 - 7 nonclinical staff receive 1 training related to behavioral health
- ECC
 - 3 Coordinators receive coaching from UNH IOD
- REENTRY
 - Staff receive 1 additional training module
- MAT
 - 12 IDN2 members attend 1-3 MAT educational meetings per month

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

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
Train PCPs in behavioral health needs	28			
Train BH staff in chronic medical disease	9			
Train non-clinical staff in behavioral health needs	14			
Staff turnover	<15%			
PCPs are providing MAT in primary care settings	18			

A1-5. IDN-level Workforce: Staffing Targets

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
A2 - Tech Support	1	1			
A2 - Data Analyst	1	0			
B1 - IBHC	11	6			
B1 - Case Manager	1	0			
B1 - ICC	2	1			
B1 - Psychiatrists	2	0			
B1 - MA	2	1			
B1 - APRN (Medical)	1	0			
B1 - IBHC Supervisor	1	1			
C2 - Case Manager	1	1			
C2 - Psychiatric APRN	1	0			
C2 - LADC	1	1			
C2 - BH Clinician	1	1			
D1 - MAT Provider Mentors	2	2			
D1 - PAT Providers	2	2			
D1 - PAT Social Worker	1	1			
E5 - ECC Supervisors	2	2			
E5 - ECC Coordinators	3	0			
ALL Peer Recovery Coaches	4	4			

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

	2017	2018	2019	2020
Hiring	\$1,180,853	\$2,719,650	\$3,000,432	\$3,000,432
Training	\$78,000	\$31,000	\$68,000	\$15,000
Job Advertising / Promotion	\$54,000	\$14,000	\$14,000	\$14,000
Incentives for MAT providers	\$35,000	\$50,000	\$75,000	\$100,000

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

Organization Name	Organization Type	Associated IDN Projects
Riverbend Community Mental Health	Behavioral Health	A1, A2, B1, C2, D3, E5
Concord Hospital Medical Group	Primary Care Provider	A1, A2, B1, D3, E5
Dartmouth Hitchcock Concord	Primary Care Provider	B1, D3, E5
Concord Regional VNA	Behavioral Health/CBO	A2, E5
Children and Family Services	Behavioral Health	E5
UNH Office of Disability	Education	E5
NAMI NH	CBO, Training	B1, C2, D3, E5
HOPE for NH Recovery	CBO, Peer Support	B1, C2, D3, E5
Ascentria	CBO, Training	C2

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

**Integrated Delivery Network Administrative Lead Contract
Attestation Form**

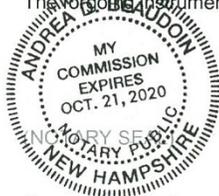
I, Peter Evers, a representative of Region #2, attest that I have reviewed and am in acceptance on behalf of Capital Region Health Care of the Statewide Workforce Capacity Development Strategic Plan as outlined in the New Hampshire Building Capacity for Transformation 1115 Medicaid Waiver, IDN Process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

Peter Evers
(Signature)

STATE OF NEW HAMPSHIRE

County of Merrimack

The above instrument was acknowledged before me this 29th day of June, 2017.



Andrea D. Beaudoin
(Notary Public/Justice of the Peace)

Commission Expires: October 21, 2020

Project A2: Health Information Technology

A2-1 HIT Participation in Statewide HIT Taskforce

To support the New Hampshire Department of Health and Human Services (DHHS) Delivery System Reform Incentive Payment (DSRIP) Building Capacity for Transformation, Section 1115 Medicaid demonstration waiver, IDN Region 2 is participating in two statewide projects as defined in the Special Terms and Conditions (STC).ⁱ The second of the two statewide projects, *A2. Health Information Technology (HIT) Infrastructure to Support Integration*, requires each IDN to develop HIT infrastructure required to support integrated, high-quality care throughout New Hampshire. This HIT Implementation Plan includes IDN-specific plans and timelines that align with the HIT Task Force's assessment and recommendations adopted on April 5, 2017. This HIT Implementation Plan is also based on the IDN's current HIT capacity and IDN-specific community needs assessments.ⁱⁱ HIT lead: Deb Mullen deb.mullen@crvna.org

HIT/Data Committee

- Provide processes and standards for data sharing among the partners in the IDN;
- Provide guidance on the approach to drafting and executing data sharing agreements;
- Develop reporting and reporting processes for the IDN;
- Develop monitoring policies and procedures;
- Determine the roles of information technology, health informatics, clinical, and administrative leadership within partner organizations will play on overall data governance.
- Provide monthly data report to IDN Committee
- Make HIT/Data recommendation to IDN Committee
- Serve as the HIT Workgroup
- The HIT Committee meets monthly.

The HIT Workgroup will:

- Participate in statewide taskforce meetings
- Lead regional assessments
- Lead the development of a regional HIT plan (April 2017 – June 2017)
- Lead the implementation of a regional HIT plan (Sep 2017 – Dec 2018)

Summary of Statewide Task Force Process Analysis

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

- Assessing the current HIT infrastructure gaps across the state and IDN regions.
- Coming to consensus on statewide HIT implementation priorities given the demonstration objectives.
- Identifying the statewide and local IDN HIT infrastructure requirements to meet demonstration goals, including:
- Minimum standards required of every IDN

- “Desired” standards that are strongly encouraged but not required to be adopted by every IDN
- A menu of optional requirements

In addition to the monthly HIT Task Force meetings, work sessions were established and conducted via WebEx and facilitated jointly by the elected Chairs of the HIT Task Force and Myers and Stauffer, LC. These work sessions were scheduled to occur weekly (if necessary) with the exception of the weeks in which an in-person HIT Task Force meeting was held. IDN Region 2 participated in these sessions.

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

A2-2 HIT Gap Analysis

Before the analysis done by Myers & Stauffer, IDN2 conducted its own survey of IDN2 partners and found that they have a wide gap of information technology capabilities and needs. Sixty-five percent use an electronic medical record. There are seven different vendors in use across the IDN of those who responded. Those that use an electronic medical record are the hospitals, physician practices, and home health. The participants that do not use an electronic medical record appear to be community service providers for substance abuse and counseling.

Out of all responding participants, only one agency has an implemented secure texting application for their staff. Secure texting allows for secure quick communication from provider to provider but also allows for secure text messages to be sent to patients.

None of the respondents have an electronic notification system in place to be alerted if their patient is admitted or discharged from the hospital or ED or from other providers.

Only fifty-five percent of respondents are able to receive referral information electronically. Fifty percent can receive electronically. When meaningful use was put into place there were no provisions required for post-acute or community providers to be able to receive documents electronically. This is an issue for those hospitals and physician practices who are trying to send electronically.

Eighty percent of respondents have staff who are mobile. Out of the eighty percent, seventy-eight percent have laptops. Twenty-two percent have mobile staff without access to data. Out of the seventy-eight percent that have laptops, eighty-eight percent can connect and receive data while out in the field.

Pagers have decreased in use over the years with forty-five percent of the respondents still using pagers. Out of the forty-five percent using a pager thirty percent are using a mobile app to receive pages.

Respondents were asked to provide their gaps in health information technology.

- Secure electronic transfer of documents
- Integration of lab and test results-ability for EMR to consume data
- E-prescribing
- Alert notifications for ADT
- Interoperability with insurance payors
- Ability to see data from all settings in one patient record
- Lack of appropriate EMR for SUD charting
- Secure communication amongst providers

Care Coordination Gaps

- Transitions of care-currently there is a great deal of faxing, phone calls and inefficient handoffs
- Lack of knowledge of where the patient is within the system
- Inability of providers to communicate securely with each other

While not specifically a gap, Concord Hospital is switching its EMR system from Centricity to Cerner. The “go live” date has been delayed several times and this hampers IDN2’s ability to electronically capture data, as it was decided earlier on, with approval from DHHS, not to develop systems for Centricity, the outgoing system.

Concord Pediatrics, with over 700 Medicaid lives in our region, has stated that they do not want to use an EMR. We are talking with them and with DHHS about how to include them in the Integration project without the use of an EMR.

IDN2 HIT Recommendations

There are several ways that identified HIT gaps can be lessened. Some require consensus amongst many and others can be implemented independent of each other.

Direct Messaging

Forty-five percent responding to our survey did not have a secure means to receive or send patient information. This technology can be implemented independently. Because there are standard protocols, each organization can select their own vendor. The vendor can have a standalone direct messaging product or it can be one integrated with the EMR. The IDN can assist in educating providers on the products that exist. The IDN can promote the need for connection and evaluate if financial or technical assistance is needed to be implemented. Once all members have implemented direct messaging, the use must be promoted and work flows evaluated.

Secure Text Messaging

Many IDN (68%) members expressed the need for secure texting. Many patients are asking to be receive text messages instead of phone calls. Text messaging is also helpful between peers managing a specific patient case. Text messaging doesn't require a consensus to select a product. But those wishing to cross over to texting staff in other organizations would need to select the same product. The IDN can assist in educating its members on the features and use of secure texting and evaluate if technical or financial support is needed to implement the product.

Admission, Discharge, Transfer alerts (ENS Notifications)

This type of product is only reliable and informative if all providers are using the same product. A statewide master patient index is also needed. Seventy-five percent of the responding IDN members identified this as a need. Understanding where the patient is, and being able to provide appropriate medical documentation can help improve outcomes and decrease cost of care.

Care Transitions

Another common theme is the need for care coordination across providers and the Emergency Department. Implementing a product that would assist in improving the Emergency departments knowledge of the patient would also improve outcomes and decrease costs. Many times, the ED is treating a patient without their medical record. As well, once discharged, the community providers do not receive enough information to provide continuity of care.

Care Coordination would also benefit from some type of statewide repository to support a query and retrieval of patient information. Currently that is not possible through the state designated HIE unless legislative changes are made. However, there are some other vendors beginning to provide services in this area such as Commonwell and Carequality.

Meaningful use mandated the use of a Continuity of Care document (CCD). This document is sent through direct messaging. However, the meaningful use did not mandate that post-acute providers be able to accept the CCD through direct messaging. NHHIO has worked over the past 18 months on expanding post-acute providers knowledge and ability to accept a CCD. It would be a goal for care transitions for all providers to have the ability to receive a CCD upon discharge from a facility. This would improve care coordination. Selecting a direct messaging vendor that has the capability to receive a CCD will assist community service providers in being able to receive referral/discharge information.

Community Referrals

There is a need to establish an electronic closed loop referral system to community resources. Often referrals are lost in the system or providers rely on the patient to initiate the community resource. A statewide community resource directory with electronic referral ability could improve patient care. This could be a statewide HIT task item.

Patient Portal

Patient portals are becoming more common but a patient may have too many to log on to, and therefore stops using them. Developing a statewide patient portal could assist in providing education and care coordination to the patient.

Education

Not all providers have equal levels of knowledge regarding interoperability, direct messaging, secure texting and other various HIT technologies. The IDN will need to provide education to its members and encourage the use of technology to streamline processes. The IDN may need to provide resources in order to assist smaller organizations with implementation.

Alternative Payment Models

Alternative Payment Models (APMs) reward providers for delivering high quality and cost-efficient care. Currently care is delivered in silos on a fee for service basis. APM requires providers to have available the entire picture/information of the patient in order to make the best decision that will impact/improve patient care. In order to shift to an APM, technology is needed to:

- Extract data, validate data integrity
- Provide data analytics regarding quality metrics, high risk patients and financial cost of care
- Provide technology to assist in care transitions
- Provide technology for adoption of a shared care plan
- Provide electronic referral system

Statewide HIT Taskforce Data

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

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

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

Base – 12 questions: for the organization to provide basic contact information.

Assessment – 20 multiple choice questions: to assess HIT maturity and provide a corresponding score.

Software – 20 free response questions: to list EHR systems, consumer support systems, and other state systems.

Patient Record – 19 dropdown questions: to identify patient information captured and shared by organizations.

Security – 20 dropdown questions: to assess compliance with Health Insurance Portability and Accountability Act (HIPAA) standards.

Behavioral – 29 dropdown questions: to identify behavioral health assessments by provider organizations.

HIT – Four dropdown and three free response questions: to assess barriers, standards, and planned initiatives.

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

Statewide Key Findings

Key areas of HIT maturity were analyzed for every IDN region and included Electronic Health Record (EHR) adoption, Health Information Exchange (HIE) adoption, patient access to their health information, and the ability to track patient consents electronically. While HIT adoption was high for many traditional providers such as hospitals, many community-based organizations had limited HIT infrastructure. Key findings from the New Hampshire HIT assessment include:

Electronic health data capture capabilities are not widespread among IDN members. While New Hampshire benefits from a high number of providers having adopted electronic health records (EHRs) at 74% of IDN members, there are a several key provider types that have less than 60% adoption rate including SUD treatment organizations at 57%, community-based organizations at 48%, and public health organizations at only 33%.

Limited capabilities for electronic health data sharing throughout the state, but IDN members use available option. Despite the limitations in electronic health data sharing among New Hampshire's providers, due in part to legislative restrictions, 48% of IDN member organizations are using or have plans to use Direct Secure Messaging (DSM) through New Hampshire Health Information Organization (NHHIO).

Low rate of patient consents is captured electronically. The ability to electronically capture patient consents still appears to be in its infancy among IDN members with only 21% of all responding organizations doing so. High adopters of HIT such as hospitals, community mental health centers, and federally qualified health centers (FQHCs) are all below 50% for collecting and storing patient consents by electronic means.

Patient referrals are mostly manual processes. Sixty-one percent of IDN members responding to the assessment stated that patient referrals are performed manually by either fax, U.S. mail, or telephone. Only a small percentage of organizations, just 15%, are using DSM for referrals.

Patients have limited options to access their health information electronically. Currently, only 28% of all IDN members responding to the Assessment Tool have a patient portal.

A higher than expected number of IDN members capture at least one social determinant of health data element. While collection of social determinants of health data is fragmented and inconsistent across the health care continuum^{vi}, 62% of all IDN member respondents electronically capture at least one area of social determinants of health such as economic stability, education, food, community, and social context.

Funding is available to advance HIT in New Hampshire. Several of the HIT-related needs identified by IDN members during the assessment and information gathering process may be funded through the Health Information Technology for Economic and Clinical Health (HITECH) Act administrative matching funds or other grant opportunities identified in this report.

IDN2-Specific Findings

Based on the final version of the HIT Data Supplement for our region there was a total of twenty-one (n=21) organizations that completed the HIT Assessment tool. From the results, two (n=2) organizations attested to having a certified EHR system and eleven (n=11) organizations attested to having a non-certified EHR system. To be noted, eight (n=8) organizations stated that they had no EHR system at all. Organizations with no EHR systems are important to identify in order to determine what further assistance they need to meet the State's DSRIP initiative objectives and our region's goals.

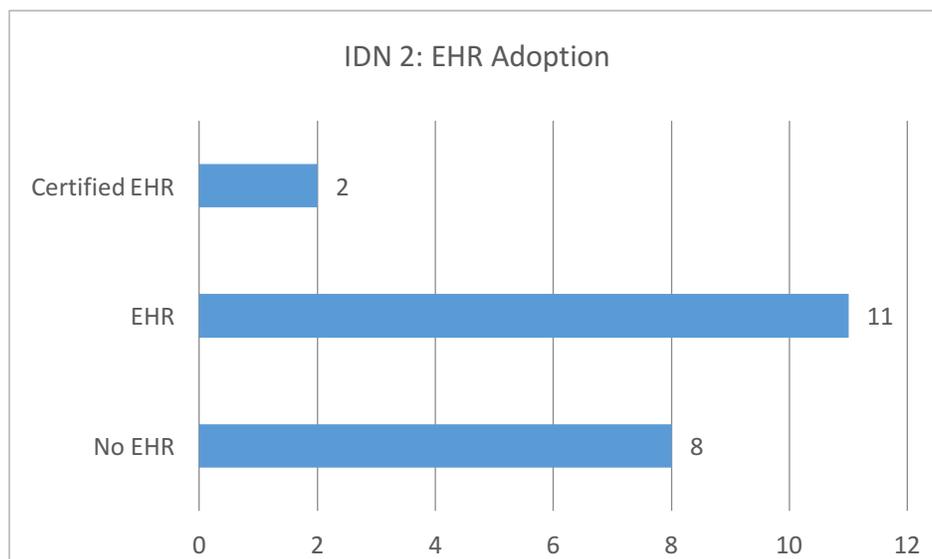


Figure 2. EHR Adoption

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

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

Direct Messaging

All organizations that completed the HIT Assessment tool were cross referenced with the NHHIO’s official list of organizations that are connected. Eleven out of 27 organizations are currently utilizing direct messaging. The remainder will be evaluated to determine if they are organizations that collect PHI or receive referrals. Those organizations that receive referrals and collect PHI will be evaluated for implementation of direct messaging.

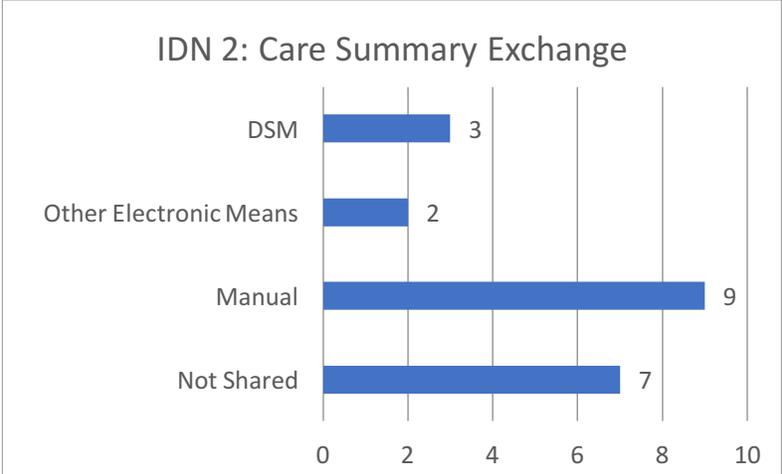


Figure 3. Direct Secure Messaging

Patient Access

From the HIT Assessment results, a question was asked about patient access to health information. In general, most organizations do not provide easy access to their patient’s information. For our region, only three (n=3) organizations provide an advanced patient portal with at least three of the following features: lab results, appointment scheduling, billing, links to health information websites, prescription refills, referrals, or secure messaging. This compares to eighteen (n=18) organizations that do not provide a patient portal at all and provide limited access to their patient’s information. It will be important to create infrastructure to allow the substance abuse patients to access to their health information.

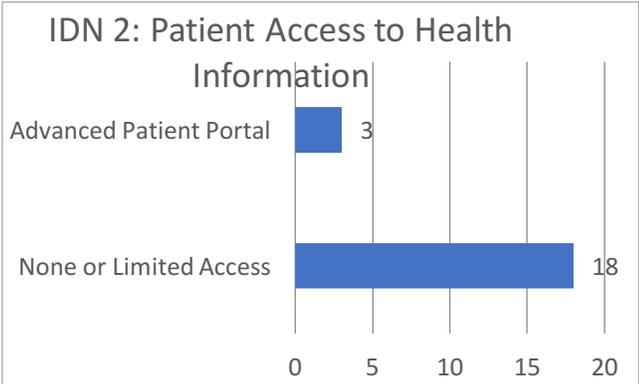


Figure 4. Patient Access to Health Information Patient Consent Tracking

Another critical area for the waiver program is how patient consents are tracked and processed. With patients being shared across multiple regions, it is imperative to define a standardized process. In our region, three (n=3) organizations capture patient consent information entirely electronically in an EHR system. Three (n=3) organizations scan paper consents into an electronic system while another nine (n=9) organizations only capture consents on paper. Six (n=6) organizations do not track patient consents at all. The HIT Taskforce determined that defining a statewide consent form and process should be a priority but it will require additional work outside the scope of HIT. If a statewide standard is defined it will be up to the HIT leads within each region to implement the infrastructure to make sharing easier.

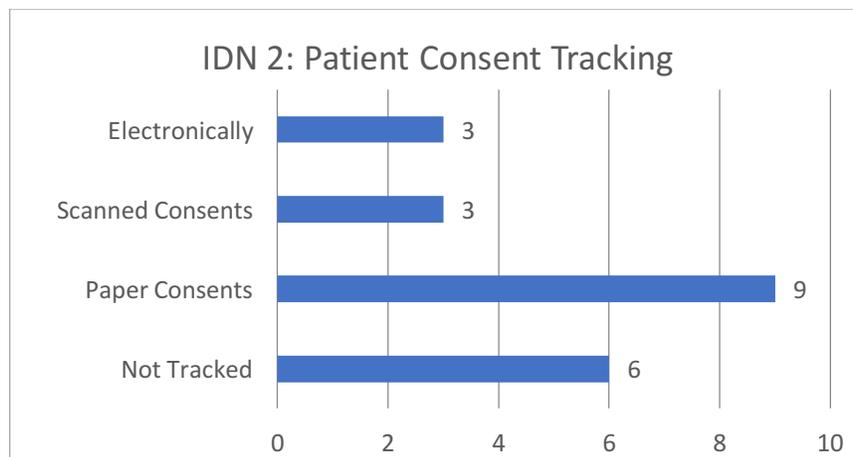


Figure 5. Patient Consent Tracking

Health Information Technology Standards

IDN Region 2 collaborated with members of the Statewide HIT Taskforce Project to define and adopt minimum, desired, and optional HIT standards required for the demonstration project. These standards are described below.

Minimum, Desired, and Optional HIT Standards Definitions

For the purposes of enabling robust technology solutions to support care planning and management and information sharing among providers and community based social support service agencies as outlined in the STCs^{vii}, the identified statewide and local HIT standards are defined as either “Minimum,” “Desired,” or “Optional.”

Minimum – standards that apply to all IDN participants except where provider type is defined in the Minimum Standards Table

- Includes minimally-required technologies to ensure all participants are at a basic level in order to meet the overall HIT goals of the program.
- Minimally-required technologies required for meeting the requirements of the statewide initiative, project B1: Integrated Health Care.
- Each IDN will keep the HIT Task Force members informed on the progress for each minimum standard, along with required reporting to the state.

Desired – standards that apply to only some IDN participants.

- Includes more advanced technologies that may only apply to certain types of organizations
- Identifies standards that are strongly encouraged but not required to be adopted by every IDN in order to meet the overall HIT goals of the program.
- Applies, in some cases, to a statewide initiative or a regional initiative but will not arrest the advancement of the initiative, project B1: Integrated Health Care.
- Each IDN will keep the HIT Task Force members informed on the progress for each desired standard, along with required reporting to the state.

Optional – standards that apply to only some IDN participants

- Not required but could better enable IDN members' ability to support the demonstration project goals.
- Each IDN will keep the HIT Task Force members informed on the progress for each optional standard, along with required reporting to the state.

HIT Standards Tables

The following tables outline the minimum, desired, and optional standards for the statewide and local HIT standards required for the demonstration projects, as agreed upon and adopted by the HIT Task Force. As described above in the Process for Reaching Consensus section, each table had extensive input from each IDN. Consensus was achieved on April 5, 2017 via an official, in-person vote with a response collected from each IDN.

Table 1. Minimum HIT Standards

New Hampshire Building Capacity for Transformation Waiver					
HIT Minimum Standards					
Minimum Definition: Standards that apply to all IDN participants except where provider type is defined					
Capability & Standard	Description	Provider Type	Role of IDN	DSRIP Project	Rationale for Standard Classification
1.Data Extraction / Validation	Using a single vendor is an option for all IDNs; reporting metrics is mandatory - the distinction will be made in the implementation plans	All	Procurement and payment of a single collector for all IDNs. Assist organizations with transmitting data	All	All IDNs are required to report metrics
2.Internet Connectivity	Securely connected to the internet	All	Determine if they have it, do they need it	All	
3.Secured Data Storage	Ability and knowledge to secure PHI through technology and training	All	Educate or assist organization with standards. Determine PHI at organization level	All	HIPAA regulations

New Hampshire Building Capacity for Transformation Waiver

HIT Minimum Standards

Minimum Definition: Standards that apply to all IDN participants except where provider type is defined

Capability & Standard	Description	Provider Type	Role of IDN	DSRIP Project	Rationale for Standard Classification
4.Electronic Data Capture	Ability to capture and convert documents to an electronic format as a minimum.	All	Education of electronic data capture solutions including EHRs, certified EHRs, and other solutions. Assist in procurement	All	Capturing discreet data is essential for sharing and analyzing data for population health, care coordination, etc.
5.Direct Secure Messaging (DSM)	Ability to use the protocol DSM to transmit patient information between providers.	All	Education of DSM to organizations including use cases, assist in procurement	All	DSM establishes standards and documentation to support pushing data from where it is to where it's needed, supporting more robust interoperability in the future.
6.Shared Care Plan	Ability to access and/or contribute to an electronic shared care plan for an individual patient	All	Education of shared care plan to organizations including use cases, assist in procurement and payment	All	A shared care plan is a patient-centered health record designed to facilitate communication and sharing data among members of the care team, including the patient. A shared plan of care combines physical and behavioral health aspects to encourage a team approach to care.

New Hampshire Building Capacity for Transformation Waiver					
HIT Minimum Standards					
Minimum Definition: Standards that apply to all IDN participants except where provider type is defined					
Capability & Standard	Description	Provider Type	Role of IDN	DSRIP Project	Rationale for Standard Classification
7.Event Notification Service	Ability to receive notifications as a minimum for all organizations.	All	Education of ENS to organizations including use cases, assist in procurement and payment	All, except B1 2017	An automated service that provides timely alert messages when patients are discharged from a hospital or emergency department. Delivers alerts about a patient's medical services encounter to an authorized recipient with an existing relationship to the patient.
8. Transmit Event Notification Service	Hospitals that have the ability to produce Admission, Discharge or Transfers (ADT) must transmit as a minimum	Hospital Facility	Ensure that organizations that produce ADTs are transmitting	All, except B1 2017	Leverage hospital generated ADT data elements for alerts to downstream clinical, behavioral and community providers

Table 2. Desired HIT Standards

New Hampshire Building Capacity for Transformation Waiver			
HIT Desired Standards			
Desired Definition: Applies to only some IDN participants			
Capability & Standard	Description	Role of IDN	DSRIP Project
9.Discrete Electronic Data Capture	Ability to capture discrete data and/or usage of a Certified Electronic Health Record Technology (CEHRT) as desired	Education of EHRs including certified EHRs, assist in procurement	All

10. Integrated Direct Secure Messaging	Ability to use the protocol DSM to transmit patient information between providers. Integration in EHR system as a desired	Education of DSM to organizations including use cases, assist in procurement	All
11. Query Based Exchange	Ability to use Inter-Vendor capabilities to share data, query, and retrieve.	Education of query-based exchange capabilities such as Carequality and Commonwell to organizations including use cases	B1 2018, D1, E4, E5

Table 3. Optional HIT Standards

New Hampshire Building Capacity for Transformation Waiver			
HIT Optional Standards			
Optional Definition: Applies to only some IDN participants			
Capability & Standard	Description	Role of IDN	DSRIP Project(s)
12. Closed Loop eReferrals	Ability to send referrals electronically in a closed loop system	To be determined if standard is adopted	All
13. Secure Text	Ability to use secure texting for patient to agency, agency to agency, or other use cases	To be determined if standard is adopted	All, except D1
14. Data Analysis / Validation	Ability to analyze data to generate non-required organizational or IDN level reporting	To be determined if standard is adopted	All
15. Population Health Tool	Ability to identify high utilizers within populations at organizational or IDN level	To be determined if standard is adopted	All
16. Capacity Management Tools	Ability to see utilization and availability.	To be determined if standard is adopted	All, except C2, D3
17. Patient Engagement Technology	Ability to better engage patients which includes telemedicine, secure texting, and others.	To be determined if standard is adopted	B1 2017, B1 2018, D1, E5

A2-3 Implementation Strategy/Plan

IDN Specific Standards

The foundation standards are required before moving to the collaborative standards. The foundation standards need to be reviewed/evaluated by IDN 2 with all member organizations. The collaborative standards would be implemented with all organizations that collect PHI. The

optional standards that IDN 2 will evaluate are closed loop referrals and population health analytics. Direct messaging can be used to send referrals which is the beginning component of a closed loop referral. The need for secure texting will be evaluated in relation to the needs of each project. Query based exchange will be beneficial only if other health providers in the state implement as well. This will be evaluated on a yearly basis to determine if enough providers in the state are engaged in use of the technology to create a benefit to implementing.

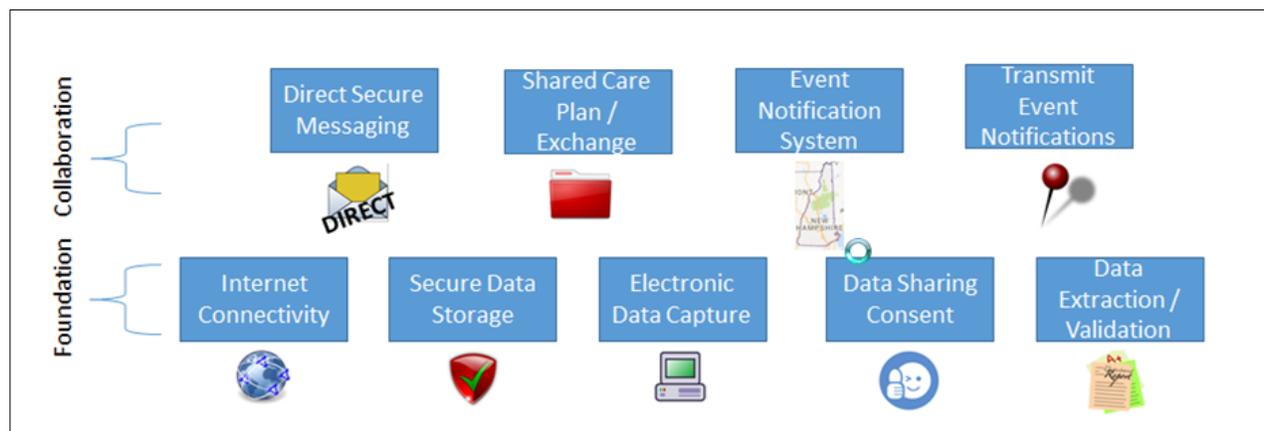


Figure 6 Standards

Future Vision

The IDN's future vision is having a patient centric communication process and shared care plan. All organizations that provide patient care will have the ability to share information across settings electronically. All organizations will have electronic access to patient information. Community service agencies will be evaluated to determine what type of information they collect and should be able to access. All organizations will be educated to secure information properly. A provider will have access to all of a patient's care team's important information including community agencies through event notification and shared care plan. This will allow providers to know where their patient has received care.

Populations and Providers in Scope

All providers that collect patient data will be included in standards. All providers that are service agencies will be excluded. Providers that may not collect PHI but do receive referrals will be included in direct messaging and will be evaluated against the foundation standards.

1. Data Extraction / Validation
2. Internet Connectivity
3. Secured Data Storage
4. Electronic Data Capture
5. Direct Secure Messaging (DSM)
6. Shared Care Plan
7. Event Notification Service
8. Transmit Event Notification Service

E = Further evaluation needed ✓ = Implement ✗ = will not implement

Table 4. Providers in Scope

Name of Organization	PHI	Standards							
		1	2	3	4	5	6	7	8
Ascentria Care Alliance	Yes	✓	✓	✓	✓	✓	✓	✓	E
Bhutanese Community of NH	Yes	✓	✓	✓	✓	✓	E	E	E
Boys & Girls Clubs of Greater Concord	Service	x	x	x	x	x	x	x	x
Capital Area Public Health Network	Service	x	x	x	x	x	x	x	x
CATCH Neighborhood Housing	No	E	E	E	E	E	E	E	E
Community Action Program	Yes	✓	✓	✓	✓	✓	✓	✓	E
Concord Coalition to End Homelessness	Yes	✓	✓	✓	✓	✓	✓	✓	E
Concord Family YMCA	No	E	E	E	E	E	E	E	E
Concord Hospital	Yes	✓	✓	✓	✓	✓	✓	✓	✓
CHMG Primary Care Practices	Yes	✓	✓	✓	✓	✓	✓	✓	✓
Child and Family Services	Yes	✓	✓	✓	✓	✓	E	E	E
Concord Human Services	E	E	E	E	E	E	E	E	E
Concord Regional VNA	Yes	✓	✓	✓	✓	✓	✓	✓	✓
Crotched Mountain	Yes	✓	✓	✓	✓	✓	✓	✓	E
Dartmouth Hitchcock	Yes	✓	✓	✓	✓	✓	✓	✓	✓
Families in Transition	Yes	✓	✓	✓	✓	✓	✓	✓	E
Fellowship Housing Opportunities, Inc.	Yes	✓	✓	✓	✓	✓	✓	✓	E
Granite State Independent Living	Yes	✓	✓	✓	✓	✓	✓	✓	E
Hope for New Hampshire Recovery	E	E	E	E	E	E	E	E	E
Life Coping, Inc.	Yes	E	E	E	E	E	E	E	E
Merrimack County House of Corrections	Yes	✓	✓	✓	✓	✓	✓	✓	E
NAMI New Hampshire	Yes	✓	✓	✓	✓	✓	✓	✓	E
New Futures	Service	x	x	x	x	x	x	x	x
NH Alcohol/Drug Abuse Counselors	Service	x	x	x	x	x	x	x	x
New Hampshire Hospital	Yes	✓	✓	✓	✓	✓	✓	E	E
Riverbend CMHC, Inc.	Yes	✓	✓	✓	✓	✓	✓	✓	E
Sununu Youth Services Center	E	E	E	E	E	E	E	E	E

Priorities

Priorities are listed below, but elements of each may be going on at the same time.

- Selection of data aggregator vendor for metric submissions
- Procurement
- Implementation
- Metrics from Cerner and Epic
- Data Sharing Agreements-required for data metric collection
- Implementation of shared care plan/event notification
- Integration into process flow
- On-site review of the foundation standards with each organization

- Implementation of direct messaging and evaluation of process flow
- Equipment for integrating behaviorist into practices
- Planning for closed loop referral process
- Assist with projects goals from each project - IT will assess the metrics from each IDN 2 project and if any EHR work is needed to capture discreet information; or if no EHR is present, a method to collect the data will be evaluated. A reporting schedule will then be developed. Reporting - capturing number served vs. projected and impact measures as defined in individual evaluation plans.

Technology

IDN2 plans to visit each organization to review internet connectivity status, data storage and data capture ability, and determine if education or assistance obtaining is needed. Due to Concord Hospital and CHMG implementing Cerner, changes that will be needed for Cerner to capture discreet data for metrics for many of the projects will occur between January and June of 2018.

Direct Messaging - All organizations that collect PHI will be reviewed for direct messaging capabilities. Organizations that do not collect PHI will also be reviewed for process flow to determine if there is a benefit to having direct messaging capabilities (referrals could be received this way). Once organizations are identified, IDN 2 will work with NHHIO to obtain a webmail product for those identified agencies. Once the webmail product is installed, organizations will be visited again to assist with recommendations for process flow changes to incorporate the use of direct messaging. Organizations that have the ability to send and receive CCD documents within their EHR will be encouraged to do so. For agencies that will use the Kno2 webmail product - it does have the capability to receive CCD but not create one.

Table 5 Direct

Direct	12/31/17	6/30/18	12/31/18	6/30/2018
Identify agencies for direct implementation				
Engage NHHIO to assist with kno2 implementation				
Contracting for Product				
Account set up				
Web training				
Process flow evaluation				
Ongoing Process flow/use evaluation				
Target for total completion 6/30/2018				

Event Notification - Organizations will be evaluated to determine if they are to send and/or receive event notifications for admission/discharge/transfer (ADT). If they are the sender of event notifications the IDN will work with the organization to assist in setting up the ADT feed with the event notification vendor. If they are an organization to receive, the IDN will work with the organization to determine/suggest work flow changes. Due to Cerner implantation, Concord Hospital will set up to send an ADT feed but will not implement premanaged ED until first quarter 2018.

Table 6 Premanaged ED

EDIE Project Plan	Responsible Party	12 31 2017	06/30/18
VPN Connectivity	CMT/Concord Hospital		
ADT Feed / Messages	CH Hospital		
Test	CMT		
Mappings	CMT/Hospital		
Prod	Hospital		
EMR Integration			
EDIE Return Message	CMT		
EMR Build	CH Hospital		
Configure Icon	Concord Hospital		
Validation	Concord Hospital		
Historical File			
Build Historial File	Concord Hospital		
CMT Historical File Processing	CMT		
IT Implementation Go Live			
Active Directory / SSO (Optional)			
Investigate Issue	CMT/Hospital		
Identify Solution	CMT/Hospital		
Implement Solution	CMT/Hospital		
Clinical Kick Off Meeting			
User Provisioning			
Identify list of initial users	Hospital		
Set up initial users	CMT		
Training			
ED providers on EDIE Report	CMT		
CM and SW on Portal	CMT		
Clinical/Project Go Live			

Shared Care plan- the statewide HIT group evaluated shared care plan vendors based upon the criteria below. Organizations that collect PHI will be evaluated for shared care plan implementation.

Table 7 Shared Care plan requirements

#	Category	Requirement-Shared Care Plan
1	<u>Market Penetration</u>	Vendor has experience with 1115 Waiver Programs, HIE and/or other large, regional implementations (number of years in business)
2	<u>Market Penetration</u>	The vendor has live clients and can provide site references
3	<u>Current Functionality</u>	The vendor demonstrated the use of Event Notifications & supporting IDN use cases/workflows
4	<u>Current Functionality</u>	The vendor demonstrated the use of Shared Care Plans & supporting IDN use cases/workflows
5	<u>Current Functionality</u>	The vendor demonstrated that the electronic shared care plan product component has the capability to integrate with data sources to send and/or receive patient data into the shared care plan
6	<u>Current Functionality</u>	The vendor demonstrated reporting capabilities (user configurable reporting engine, measures, query engine, sortable reporting, graphical display of data)
7	<u>Current Functionality</u>	The vendor demonstrated Audit Reports and role based security
8	<u>Current Functionality</u>	The vendor has the ability to interface with HIEs, MCOs, PDMPs, and other repositories
9	<u>Ease of Use</u>	The vendor discussed the ease of implementing their solution in the Community
10	<u>Ease of Use</u>	The vendor discussed the ability to implement the solution with multiple IDN members at one time
11	<u>Ease of Use</u>	The User Interface was easy to navigate
12	<u>Ease of Use</u>	The solution appears to have flexibility in how to implement
13	<u>Ease of Use</u>	The vendor has demonstrated the ability to implement their solution in organization sizes and types consistent with the planned IDN member adoption
14	<u>Future Capabilities</u>	The vendor discussed their Product Road Map and/or their Product Development
15	<u>Future Capabilities</u>	The vendor can speak to some of our 'Desired / Optional' elements (eReferrals, Secure Text, Patient Engagement, Population Health, Capacity Management)
16	<u>EHR Integration</u>	The vendor supports HL7, C-CDA, etc. (i.e., not discussed as custom)
17	<u>EHR Integration</u>	The vendor supports payload agnostic Direct Protocol (i.e., C-CDA, .pdf documents, for easy import of SCP's). Similar to a web mail product that can then attach the document to the patient's SCP
18	<u>EHR Integration</u>	The vendor has a list of EHR vendors they can integrate with (Is integration custom or out of the box)

New Hampshire PreManage IDN Implementation Plan

The first step of implementation is with the hospitals since they drive the data for the clinics. The plan is to attain sufficient hospital involvement to gain critical mass with ADT feed sharing. The second step is to engage the clinics that the IDN provides to CMT in a prioritized list. The highest priority clinics will be on boarded first and continue roll out until 100% of hospitals and clinics are connected to the PreManage network. Because Concord Hospital is implementing a new EHR, IDN2 will work with community organizations first. A future phase will be implementing to community agencies that should only have access to limited information.

Table 8 Premanged Community

PreManage Community Project Plan	Responsible Party	12/31/17	06/30/18
Contract Executed with IDN			
Agreements signed by organizations			
Project Kickoff Call			
IT Implementation			
SFTP Setup	CMT/concord Hospital		
Eligibility File			
Eligibility Design	Concord Hospital		
Upload to SFTP	Concord Hospital		
Test (Validate)	CMT		
Process to Production	CMT		
Automatic Pickup from SFTP Setup	CMT		
Evaluate other organizations that have capability to send ADT feed			
Follow steps 7-13 for each organization			
Clinical Implementation			
Onboarding Packet	CMT/Concord Hospital		
User Set up (Provisioning)	CMT		
Identify List of Initial Users	Clinic		
Cohorts Set up			
Notification Destination Set Up	CMT		
Reports Set up	CMT		
Training			
Account Managers/IT	CMT		
Clinical Staff	CMT		

Data Aggregator - The HIT statewide group would like to use one single vendor for data aggregation/metric collection for the DSRIP project. Four vendors have been selected to provide product capabilities/web demonstrations. Selection will be made down to two vendors for more intensive review of capabilities. Requirements developed by the group are listed in the table below.

Table 9 Data Requirements

#	Category	Requirement-Data Vendor
1	Market Penetration	Vendor has experience with 1115 Waiver Programs, HIE and/or other large, regional implementations
2	Market Penetration	The vendor has live clients and can provide site references for Data aggregation (Minimum Requirement)
3	Current Functionality	The vendor demonstrated the capability to report the IDN specific state outcome measures and community
4	Current Functionality	The vendor demonstrated the capability to run custom reports (Minimum Requirement)
5	Current Functionality	The vendor demonstrated the capability to extract data from multiple data sources; standard formats (CCD
6	Current Functionality	The vendor demonstrated a portal solution that allows for manually entering data, uploading of data, and
7	Current Functionality	The vendor demonstrated Audit Reports and role based security (Minimum Requirement)
8	Current Functionality	The vendor has the ability to interface with MMIS, HIEs, MCOs, PDMPs, and other repositories (Desired
9	Current Functionality	The vendor has the ability to manage attribution of members to individual IDNs and organizations. Has the
10	Ease of Use	The vendor discussed the ease of implementing their solution in the Community. Time frame to implement
12	Ease of Use	The User Interface was easy to navigate
13	Ease of Use	The solution appears to have flexibility in how to implement
14	Ease of Use	The vendor has demonstrated the ability to implement their solution in organization sizes and types
15	Future Capabilities	The vendor discussed their Product Road Map and/or their Product Development
16	Pricing	Vendor has provided a pricing model for a standard statewide configuration statewide and custom options

Below are activities that will need to take place for each organization/EMR that will be sending in data to the data vendor. For IDN 2 Concord Hospital/CHMG, Riverbend, Dartmouth Clinic will be sending in data for the required metrics.

Table 10 Data Vendor

Workstream	Months											
	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Participant contracting												
Finalize requirements												
Set-up IDN QDC environment & portal												
Custom portal development (e.g., shared care plan)												
Build test source system interfaces												
Validate measures												
Ongoing reporting												

Metrics for IDN 2 Individual Projects

Below are the metrics that will be required to be collected for each project and each organization involved. IDN2 will work with the data vendor to determine the best method to collect each metric. This will be discussed in a scoping session with the data vendor.

Reentry Performance Measure Name	Target
# served	250
# and % of clients released from jail with a psychiatric symptom management plan	190 (75%)
# and % of clients actively engaged in mental health or substance use treatment post release	200 (80%)
# and % of clients who completed core community-based services post-release	200 (80%)
# and % of clients with transition case plans	250 (100%)
# and % of clients with suitable housing post release	200 (80%)
# and % of clients with health care	250 (100%)
# and % of clients employed	175 (70%)

Sites: Merrimack County House of Corrections, Riverbend Community Mental Health

ECC Performance Measure Name	Target
Individuals served over the life of the project	81
Adherence rates	70%
Child or youth stays remains at home	Improvement
Fewer hospitalizations	Improvement
Prevention of residential placement	Improvement
Improved academic performance in school	Improvement
Improved school attendance with peers	Improvement
Fewer suspensions or office write ups at school	Improvement
Fewer (no) instances of re-offending	Improvement
Improved behavioral health indicators (CANS for children and youth) or improved performance on developmental screening/assessment for 0-5 (Ages & Stages).	Improvement

Sites: Riverbend Community Mental Health, Child & Family Services

MAT & PAT Performance Measure Name	Target
Numbers served over life of project	300
Negative urines for opioids (other than those prescribed for OUD) at 3 months	60%
Negative urines for opioids (other than those prescribed for OUD) at 6 months	70%
Negative urines for opioids (other than those prescribed for OUD) at 12 months	80%
Treatment retention at 3 months	80%
Treatment retention at 6 months	70%
Treatment retention at 12 months	60%
Retained over life of project	60%
Referral to treatment no-shows	<25%
PAT: numbers served over life of project	50
PAT: attend all scheduled OB-GYN appointments	75%
PAT: attend all scheduled MAT appointments	90%
PAT: remain engaged through pregnancy & delivery	70%
PAT: transfer care to PCP/MAT after delivery	90%

Sites: MAT = CHMG and DHC primary care practices (same as integration); PAT = DHC and CH OB-GYN

Integration - The IDN will provide equipment needed for integration of behaviorists into the designated provider practices. The behaviorists will be documenting in the EHR of the providers, therefore new software is not needed. Again, due to the implementation of Cerner additional areas that will be required for integration documentation will be in place by June 2018.

Data Analytics/APM/Population Health - As a second phase, the data aggregator will be asked to provide data analytics to the IDNs. IDNs need the ability to identify at risk patients and assess the health of the population. As well, if the data aggregator can be supplied with Medicaid and MCO data this will assist in analyzing clinical and financial outcomes to work towards an APM.

Data Sharing Agreements - Once a vendor is selected and a structure is defined for the collection of data, data sharing agreements will be developed and require signature by each IDN organization with a target date of all agreements signed by 12/31/17

Closed Loop Referrals - A closed loop referral process will reduce gaps in service by providing the mechanisms to exchange pertinent patient information at key points during the referral process. Direct messaging is a protocol that can be used to send a referral. ONC requires providers to be able to send a C-CDA (Summary of Episode or Referral Note) by direct messaging. A closed loop referral process would also include the capability to electronically transmit the request itself, request status, and result of request. Collective Medical Technologies (CMT, vendor for shared care plans) would like to convene a state group to discuss requirements for a closed loop referral as an initial plan.

Table 12. IDN Specific Project Participation

Name of Organization	Integration	MAT	ECC	Re-E
Ascentria Care Alliance			x	
Bhutanese Community of NH			x	
Boys & Girls Clubs of Greater Concord				x
Capital Area Public Health Network				
CATCH Neighborhood Housing				
Community Action Program				x
Concord Coalition to End Homelessness			x	x
Concord Family YMCA			x	
Concord Hospital	x	x	x	
CHMG Primary Care Practices	x	x	x	
Child and Family Services			x	
Concord Human Services				x
Concord Regional VNA			x	
Crotched Mountain			x	
Dartmouth Hitchcock	x	x		
Families in Transition			x	
Fellowship Housing Opportunities, Inc.			x	
Granite State Independent Living			x	
Hope for New Hampshire Recovery	x	x	x	x
Life Coping, Inc.			x	

Merrimack County House of Corrections				X
NAMI New Hampshire	X	X	X	X
New Futures				
NH Alcohol/Drug Abuse Counselors Assoc.				X
New Hampshire Hospital			X	
Riverbend CMHC, Inc.	X	X	X	X
Sununu Youth Services Center			X	X

MAT - Medication Assisted Treatment, **ECC** - Enhanced Care Coordination, **Re-E** - Community Re-Entry

A2-4 Evaluation Project Targets

Table 13

Performance Measure Name	Target	Target # organizations*	Date-total completion	Progress Toward Target		
				As of 12/31/17	As of 6/30/18	As of 12/31/18
Data Vendor	Data vendor will be selected to assist in collecting project metrics for the state and individual IDN projects	na	9/30/2017			
Secure Texting	Evaluate each project for need and implement	to be determined	3/31/2018			
Closed loop referrals	Evaluate and implement referral process	to be determined	6/30/2018			
Data Sharing Agreements Signed	Develop agreement for sharing data within the IDN and obtain signatures	27	12/31/2017			
Data Vendor Implementation	Data vendor will be implemented to all organizations that must report metrics in order to achieve first reporting requirement	17	3/31/2018			
Minimum standards assessment	Assess all organizations for baseline status regarding the 8 minimum standards.	27	12/31/2017			
Direct messaging	All identified agencies will implement direct messaging	17	2/28/2018			
Standards Education	Provide education/guidance to identified agencies for standards 2-4	17	3/31/2018			
Event Notification	All identified organizations will be sending ADT event notificaitons	1	6/30/2018			
Event Notification	All identified organizations will be sending/receiving event notificaitons	14	6/30/2018			
Shared careplan	All identified organizations will implement shared careplan	15	6/30/2018			
Premanaged Ed	Implement Premanaged ED	1	4/30/2018			
Equipment	All identified primary care practices will have designated equipment for integration	14	6/30/2018			
Integration	Emr will have fields built for data collection. Epic, cerner, tier	3	6/30/2018			

Top Risks

Identifying risks at the DSRIP program level occurred at the HIT Task Force meetings and the work sessions through discussion and the consensus building process. Potential risks already identified by the HIT leads and the HIT Task Force participants include:

- Many community-based member organizations are non-covered entities as defined by the HIPAA Omnibus Rule, meaning they are not required to be familiar with policies and procedures regarding Protected Health Information (PHI). To mitigate this risk, additional education may be required for those who may handle PHI at these organizations, or become covered entities. Not necessarily all community-based organizations will have access to PHI or other sensitive information.
- Some IDN member organizations lack any IT infrastructure today and are more susceptible to not meeting the standards.
- While many IDN member organizations from each region participated in the HIT Taskforce, not everyone was represented. A couple of regions did not have their hospitals directly participate in the HIT Taskforce.
- If the sharing of data consents is implemented, a standard outside of the scope of HIT must be realized.
- The DSRIP program has a significant budget allocated for the implementation of the IDN's projects and HIT infrastructure over the course of the program; however, there is still a risk that not all IDN member HIT infrastructure projects will be fully covered by the budget because of other project priorities. Some financial reliance will be on the individual member organizations which could hamper implementation schedules over the course of the DSRIP program.
- Because technology is constantly evolving, specifically in the shared care plan and event notification service areas, there is a risk involved when choosing a solution. Many vendors and solutions are relatively new and there is potential that more robust solutions evolve and vendors may need to change over time.
- Concord Hospital and Concord Hospital Medical Group providers are implementing Cerner. This places a risk on DSRIP because we must wait for implementation to occur in order to proceed with DSRIP implementation.
- Riverbend's Information Systems Department, in combination with the vendor, Netsmart, is currently in the process of upgrading their customized version of TIER with a projected completion of April 27, 2018.

A2-5 IDN HIT: Workforce Staffing

- Organizations that already have an EMR also have IT departments that consist of support and data analyst. Those organizations will use their staff to extract data, create additions for the EMR etc. The staffing positions being proposed are to assist with the coordination across all organizations and the 1115 project.
- IDN is budgeting for IT support at 20 hours per week and a data analyst for 20 hours per week
- These are new staff and we are in the hiring process.

Table 15 Staffing

Staff Type	Target Date for hire	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
IT support	11/30/17	.5	0			
Data Analyst	11/30/17	.5	0			

IT Support/Analyst	Target for Completion
Advertise for position	9/30/17
Interview	9/30/17
Hire	9/30/17
Onboard	10/31/17
Data Analyst	Target for completion
Advertise for position	9/30/17
Interview	10/31/17
Hire	10/31/17
Onboard	11/30/17

A2- 6 IDN HIT: Budget

- The HIT budget is based upon the selection of the two statewide vendors for data collection and shared care plan. There are costs associated to interface for the ADT feeds.
- IDN specific HIT projects will be direct messaging, secure texting, and equipment required for integration.
- Each individual project will be evaluated for the use of secure texting.
- Need to add staffing descriptions/why needed.

Table 16 Budget

	2017	2018	2019	2020
Equipment	\$60,000.00	\$25,000.00	\$10,000.00	\$75,000.00
CMT-premanage	\$10,000.00	\$30,000.00	\$30,000.00	\$30,000.00
CMT-ED	\$0.00	\$30,000.00	\$30,000.00	\$30,000.00
Data Vendor*	\$75,000.00	\$40,000.00	\$40,000.00	\$40,000.00
Direct Messaging	\$5,000.00	\$5,000.00	\$5,000.00	\$5,000.00
Secure Texting	\$2,000.00	\$6,000.00	\$6,000.00	\$6,000.00
Interfacing costs*	\$100,000.00	\$50,000.00	\$30,000.00	\$30,000.00
staffing-tech support	65000	65000	65000	65000
staffing-data analyst	\$30,000.00	65000	65000	65000
Total	\$349,017.00	\$253,018.00	\$218,019.00	\$283,020.00

A2-7-IDN HIT: Key Organization and Provider Participants

Table 17

Organization Name	Organization Type
Concord Regional VNA	Home Health and Hospice
Riverbend	Community Mental Health
Concord Hospital/CHMG	Hospital, Primary care
Ascentria	CBO
Crotched Mountain	Home and Community based care provider
Dartmouth Hitchcock	Primary Care

A2-8-IDN HIT: Key Data Agreement

The statewide HIT taskforce is evaluating vendors to assist in the collecting of the metrics for submission. Once the vendor is selected and the process that will be used is understood, a data agreement will be developed. Target is 12/31/17

Table 18

Organization Name	Data Sharing Agreement Signed
Ascentria Care Alliance	N
Bhutanese Community of NH	N
Boys & Girls Clubs of Greater Concord	N
Capital Area Public Health Network	N
CATCH Neighborhood Housing	N
Community Action Program / ServiceLink	N
Concord Coalition to End Homelessness	N
Concord Family YMCA	N
Concord Hospital	N
CHMG Medical group	N
Child and Family Services	N
Concord Human Services	N
Concord Regional VNA	N
Crotched Mountain	N
Dartmouth Hitchcock	N
Families in Transition	N
Fellowship Housing Opportunities, Inc.	N
Granite State Independent Living	N
Hope for New Hampshire Recovery	N
Life Coping, Inc.	N
Merrimack County House of Corrections	N
NAMI New Hampshire	N
New Futures	N
NH Alcohol/Drug Abuse Counselors Assoc.	N
New Hampshire Hospital	N
Riverbend CMHC, Inc.	N
Sununu Youth Services Center	N

Appendices

Projects Selected by Each IDN

The project categories and requirements are *excerpts* from the New Hampshire Building Capacity for Transformation Attachment C: DSRIP Planning Protocol^{viii}.

Table 5. DSRIP Project and Participating IDNs

IDN Selected Projects							
IDN	B1	C1	C2	D1	D3	E4	E5
1	X	X			X		X
2	X		X	X			X
3	X	X			X	X	
4	X	X			X	X	
5	X		X		X		X
6	X	X			X		X
7	X	X			X		X

Core Competency Projects

B1: Integrated Health Care (All IDNs)

Primary care providers, behavioral health providers, and social services organizations will partner to implement an integrated care model that reflects the highest possible levels of collaboration/integration as defined within the Substance Abuse and Mental Health Services Administration (SAMHSA) Levels of Integrated Healthcare.

Community Driven Projects

The community driven projects are broken down into three categories and IDNs selected one project within each of the following projects:

- (C) Care Transition Projects
- (D) Capacity Building Projects
- (E) Integration Projects

IDN 2 projects are the following:

(C) Care Transition Projects

C2: Community Re-entry Program for Justice-Involved Adults and Youth with Substance Use Disorders or Significant Behavioral Health Issues - The community re-entry project assists adults with mental health conditions and/or substance use disorders who are leaving correctional facilities in maintaining their health and recovery in the community. The program, which is initiated pre-discharge and continues for 12 months post discharge, provides them with

integrated primary and behavioral health services, care coordination, and social and family support. By promoting the stability and recovery of participants, it is designed to prevent unnecessary hospitalizations and ED usage among these individuals.

(D) Capacity Building Projects

D1: Medication Assisted Treatment (MAT) of Substance Use - This project seeks to implement evidence based programs combining behavioral and medication treatment for people with substance use disorders, with or without co-occurring chronic medical and/or mental health conditions. IDNs selecting this project will increase access to MAT programs through multiple settings, including primary care offices and clinics, specialty office-based (“stand-alone”) MAT programs, traditional addiction treatment programs, and mental health treatment programs. The project’s goal is to successfully treat more individuals with substance use disorder and to help prevent relapse and sustain recovery.

(E) Integration Projects

E5: Enhanced Care Coordination for High-need Populations - This project aims to develop comprehensive care coordination/management services for high need adult and child populations with multiple physical health and behavioral health chronic conditions.

Project B1: Integrated Healthcare - Region 2 IDN

This section is changed from what was previously submitted

Overview

Region 2 IDN is achieving the goals of the DSRIP Integrated Healthcare project at 11 primary care practices in the region. Ten of these are Concord Hospital Medical Group (CHMG) practices, one is a satellite of Dartmouth-Hitchcock, and the other is a primary care site embedded within Riverbend Community Mental Health (Riverbend). Seven of the sites will work toward integration from July 2017-June 2018 and the other 4 from January 2018-December 2018. All sites will be fully integrated by December 2018. The second group is participating in ongoing educational presentations and is invited to attend any and all integration meetings that occur July 2017-June 2018.

The behavioral health staffing for the project consists of Integrated Behavioral Health Clinicians (IBHC), Integrated Care Coordinators (ICC), Psychiatrists, and Peer Coaches. A Medical Assistant and an APRN is being hired for the Riverbend site. The IBHCs are Master Level clinicians who are also care coordinators. Most sites will have one IBHC with the largest 2 sites, Dartmouth-Hitchcock Concord (DH-C) and Concord Hospital Family Health Center (CHFHC) having two or more. Integrated Care Coordinators are Bachelor level clinicians. The smaller sites will each have a part-time IBHC and a part-time ICC. CHFHC already employs several ICCs and will be adding one more through this project to address the multicultural, multilingual needs of their population.

The integration workgroup, which has been meeting since January 2017, will continue to meet to track progress against the timeline. In addition, a new workgroup combining the Clinical and Health Information Technology (HIT) Committees has been meeting since April 2017 and will continue to meet monthly to address outcome metrics from an implementation and quality assurance/improvement perspective.

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

Region 2 IDN used the following SAMHSA “Levels of Integration” definitions alongside NH DHHS’s requirements for coordinated and integrated care to assess each practice. The chart following these definitions illustrates where each practice is on the continuum.

Coordinated Care

Level 1: Minimal Collaboration

Behavioral health and primary care providers work at separate facilities and have separate systems. Providers communicate rarely about cases. When communication occurs, it is usually based on a particular provider’s need for specific information about a mutual patient.

Level 2: Basic Collaboration at a Distance

Behavioral health and primary care providers maintain separate facilities and separate systems. Providers view each other as resources and communicate periodically about shared patients. These communications are typically driven by specific issues. For example, a primary care

physician may request copy of a psychiatric evaluation to know if there is a confirmed psychiatric diagnosis. Behavioral health is most often viewed as specialty care.

Co-Located Care

Level 3: Basic Collaboration Onsite

Behavioral health and primary care providers co-located in the same facility, but may or may not share the same practice space. Providers still use separate systems, but communication becomes more regular due to close proximity, especially by phone or email, with an occasional meeting to discuss shared patients. Movement of patients between practices is most often through a referral process that has a higher likelihood of success because the practices are in the same location. Providers may feel like they are part of a larger team, but the team and how it operates are not clearly defined, leaving most decisions about patient care to be done independently by individual providers.

Level 4: Close Collaboration with Some System Integration

There is closer collaboration among primary care and behavioral healthcare providers due to colocation in the same practice space, and there is the beginning of integration in care through some shared systems. A typical model may involve a primary care setting embedding a behavioral health provider. In an embedded practice, the primary care front desk schedules all appointments and the behavioral health provider has access and enters notes in the medical record. Often, complex patients with multiple healthcare issues drive the need for consultation, which is done through personal communication. As professionals have more opportunity to share patients, they have a better basic understanding of each other's roles.

Integrated Care

Level 5: Close Collaboration Approaching an Integrated Practice

There are high levels of collaboration and integration between behavioral and primary care providers. The providers begin to function as a true team, with frequent personal communication. The team actively seeks system solutions as they recognize barriers to care integration for a broader range of patients. However, some issues, like the availability of an integrated medical record, may not be readily resolved. Providers understand the different roles team members need to play and they have started to change their practice and the structure of care to better achieve patient goals.

Level 6: Full Collaboration in a Transformed / Merged Practice

The highest level of integration involves the greatest amount of practice change. Fuller collaboration between providers has allowed antecedent system cultures (whether from two separate systems or from one evolving system) to blur into a single transformed or merged practice. Providers and patients view the operation as a single health system treating the whole person. The principle of treating the whole person is applied to all patients, not just targeted groups.

Name of Practice	N/A to SAMHSA				SAMHSA 3				SAMHSA 4				SAMHSA 5, 6				
	NH DHHS STC Requirements																
	CSA	Depression Screen	SUD Screen	Ped Screen	Shared care plans	Co-located	Teams	Cross-Training	Case conferences	Secure Messaging	Closed Loop Referrals	Documented protocols	MAT	Tech-High Risk Patients	Tech-Plan Care	Tech-Monitor Goals	Protocols referrals to CBOs
Group One - Integration Achieved 6/30/2018																	
Dartmouth Hitchcock Concord	P	Y	Y	Y	N	Y	Y	P	N	N	N	P	Y	N	N	N	N
Integrated Center for Health - Riverbend	Y	Y	Y	Y	Y	Y	Y	P	Y	N	N	Y	Y	N	N	N	N
CH Family Health Center	P	Y	Y	Y	N	Y	Y	P	N	N	N	P	Y	N	N	N	N
Concord FM	P	Y	Y	Y	N	Y	Y	P	N	N	N	P	Y	N	N	N	N
Family Physicians of Pembroke	P	Y	Y	Y	N	Y	Y	P	N	N	N	P	N	N	N	N	N
Penacook Family Physicians	P	Y	Y	Y	N	Y	Y	P	N	N	N	P	N	N	N	N	N
Epsom FM	P	Y	Y	Y	N	Y	Y	P	N	N	N	P	N	N	N	N	N
Group Two - Integration Achieved 12/31/2018																	
Family Tree Health Care - Hopkinton	P	Y	Y	Y	N	N	N	N	N	N	N	P	N	N	N	N	N
Pleasant Street FM	P	Y	Y	Y	N	N	N	N	N	N	N	P	Y	N	N	N	N
Family Care of Concord	P	Y	Y	Y	N	N	N	N	N	N	N	P	N	N	N	N	N
Family Health Center / Hillsboro	P	Y	Y	Y	N	N	N	N	N	N	N	P	Y	N	N	N	N

P = Partial

Narrative Assessment

The Integrated Center for Health at Riverbend is a SAMHSA funded (2015-2019) Primary Behavioral Health Care Integration (PBHCI) site with primary care, provided through Concord Hospital Family Health Center, embedded into behavioral health, Riverbend's Community Support Programs for the Seriously Mentally Ill (SMI) population. Client care is coordinated through an Integrated Care Manager and a Nurse Care Coordinator. The program is overseen by a Project Director and care is augmented with a Peer Wellness Coach. The population is small, 114 Medicaid lives, but the successes have been phenomenal. Along the SAMHSA continuum, they are a level 5. Their participation in the DSRIP project allows them to improve their integration through the use of technology. They use Concord Hospital's EHR as well as the NetSmart Tier EHR from Riverbend and will benefit greatly from the integration technology enhancements planned in the region. They also serve as a microcosm of successful integration and are providing training to the IBHCs being embedded into the primary care practices.

Dartmouth Hitchcock Concord (DH-C) is a large medical center that is enthusiastic to participate in the Region 2 DSRIP integration project. They have many champions of integration at the administrative level. Dartmouth Hitchcock's (DH) home entity in Region 1 has hired an integration project manager to work with all of their satellite practices. The project manager is working closely with Region 2's project director to help DHC achieve integration. Monthly meetings are scheduled to track progress and to address any needs that arise. In addition, DH-C uses EPIC and any changes to that system will be managed through DH in Region 1. EPIC is scheduled to be fully integration compliant by June 30, 2018. DH has also just begun a DH-wide Medicated Assisted Treatment (MAT) project (separate from the DSRIP) and is reviewing Region 2's project to see how the two might coincide at DH-C. With the placement of an IBHC within the practice, DH-C is approaching a SAMHSA level 3.

Concord Hospital Medical Group is comprised of 13 primary care practices. After an analysis of the number of Medicaid lives served at each practice, as well as readiness, determined by the sites that have experience already with co-located behavioral health services, it was decided to roll-out the integration project by two groups. The first group of 6 practices will achieve integration by June 30, 2018 and the second group of 7 practices will achieve integration by December 31, 2018. The sites are listed in the chart on page 1. All of the CHMG practices are moving their EHRs from Centricity to Cerner as of December 2018. For this reason, plans to begin documenting within the EHR will happen later than previously expected. The 6 CHMG sites that have an embedded IBHC are approaching a SAMHSA level 3. The other 7 are primarily a SAMHSA level 2 due to their longstanding relationship with Riverbend. The only exception to the current integration status of the CHMG practices is The Concord Hospital Family Health Center (CHFHC). This practice has many aspects of integration already including multiple co-located behavioral health staff and integration coordinators, as well as the presence of MAT providers. For the DSRIP project, they are hiring an Integrated Care Coordinator (ICC) with a focus on serving multilingual, multicultural populations. CHFHC is also in a position to provide "lessons learned" as well as set the lead in some aspects of integration such as implementing SBIRT and having documented protocols. They have monthly IBHC meetings and the newly hired IBHCs are now participating in those meeting. CHFHC is evaluating and documenting their current processes and making those changes necessary to ensure that behavioral health is fully

integrated and so they can move toward the highest level of integration that NH DHHS has defined. They are currently at a SAMHSA level 3 with some aspects of level 4.

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

IDN2 has established a Clinical + HIT committee to monitor process and outcome metrics. This group has been meeting as a learning community, including with members of NH DHHS and Meyers & Stauffer staff, to fully understand the metric requirements and to develop clinical and technological pathways toward implementation. The Clinical + HIT committee will review progress at each monthly meeting and determine what changes, if any, need to be made to achieve better outcomes. Members of the Clinical + HIT committee are decision makers within their organizations and have the ability to influence change.

In addition, the Director of Integration (Supervisor of IBHCs) is using the Maine Health Access Foundation's (MeHAF) Site Self-Assessment (SSA) Questionnaire with each practice every three months. This is done with the IBHC and the practice manager as a way to determine how the day to day integration process is working and to address any issues that might arise.

Dartmouth Hitchcock Concord is working with a Project Manager (AJ Horvath) and Sally Kraft to implement integration in a similar fashion across the four IDNs where they have a presence (1, 2, 3, 4). IDN2's Project Director attends these weekly meetings to monitor progress and provide additional input.

Following are implementation timelines for each of the following: DHC, Riverbend, CHMG first group practices, CHMG second group of practices.

Dartmouth Hitchcock Concord		
2017		
Jan - Jun	x x x x x x	Budget Workforce gap analysis and plan Assessment of current state of integration Assessment of ability to collect outcome measures 1 & 2 HIT assessment and plan Implementation plan and timeline for semi-annual report
July - Dec	x	1 BH staff hired, trained, credentialed, & co-located 1 BH staff hired, trained, credentialed, & co-located PCP, BH, & non-clinical trainings identified and documented Identify and develop any new protocols/processes required for integration Introduce/train staff in use of protocols/processes Clinical workflows finalized Begin data collection for outcome measures 1 & 2 Assessment of ability to collect outcome measures 3 & 4 Introduce CMT (shared care plan/event notification) Provide CMT training for users Provide data for semi-annual report
2018		
Jan - Jun		Begin data collection for outcome measures 3 & 4 PCP, BH, & non-clinical trainings scheduled Monthly high need case conferences established/in use CMT in use Closed loop referrals in use Use of technology to identify, plan, and manage high risk needs Develop referral protocols for CBOs HIT + Clinical Committee - monthly process & outcome review MAT & Depression EBP protocols in place Integration status achieved Provide data for semi-annual report
July - Dec		Clinical processes in place to support all outcome measures Data collection outcome measures 1-4 Monthly case review meetings Annual cross training of BH, PCP, and non-clinical staff HIT + Clinical Committee - monthly process & outcome review Provide data for semi-annual report

Riverbend		
2017		
Jan - Jun	x x x x x x	Budget Workforce gap analysis and plan Assessment of current state of integration Assessment of ability to collect outcome measures 1 & 2 HIT assessment and plan Implementation plan and timeline for semi-annual report
July - Dec	x	Hire MA Hire APRN PCP, BH, & non-clinical trainings identified and documented Identify and develop any new protocols/processes required for integration Introduce/train staff in use of protocols/processes Clinical workflows finalized Begin data collection for outcome measures 1 & 2 Assessment of ability to collect outcome measures 3 & 4 Introduce CMT (shared care plan/event notification) Provide CMT training for users Provide data for semi-annual report
2018		
Jan - Jun		Begin data collection for outcome measures 3 & 4 PCP, BH, & non-clinical trainings scheduled High need case conference meetings established/in use CMT in use Closed loop referrals in use Use of technology to identify, plan, and manage high risk needs Develop referral protocols for CBOs HIT + Clinical Committee - monthly process & outcome review MAT & Depression EBP protocols in place Provide data for semi-annual report
July - Dec		Clinical processes in place to support all outcome measures Data collection outcome measures 1-4 Monthly case review meetings Annual cross training of BH, PCP, and non-clinical staff HIT + Clinical Committee - monthly process & outcome review Provide data for semi-annual report

Family Health Center, Concord Family Medicine, Epsom Family Medicine, Penacook Family Medicine, Family Physicians of Pembroke	
2017	
Jan - Jun	<ul style="list-style-type: none"> x Budget x Workforce gap analysis and plan x Assessment of current state of integration x Assessment of ability to collect outcome measures 1 & 2 x HIT assessment and plan x Implementation plan and timeline for semi-annual report
July - Dec	<ul style="list-style-type: none"> x All BH staff hired & co-located PCP, BH, & non-clinical trainings identified and documented Identify and develop any new protocols/processes required for integration Introduce/train staff in use of protocols/processes Site Self Assessments begin / every 3 months Clinical workflows finalized Develop mechanisms for collecting/reporting data in Cerner Assessment of ability to collect outcome measures 3 & 4 Introduce CMT (shared care plan/event notification) Provide data for semi-annual report
2018	
Jan - Jun	<ul style="list-style-type: none"> Provide CMT training for users Begin data collection for outcome measures 1 & 2 Begin data collection for outcome measures 3 & 4 PCP, BH, & non-clinical trainings scheduled High need case conference meetings established/in use CMT in use Closed loop referrals in use Use of technology to identify, plan, and manage high risk needs Develop referral protocols for CBOs HIT + Clinical Committee - monthly process & outcome review MAT & Depression EBP protocols in place Provide data for semi-annual report
July - Dec	<ul style="list-style-type: none"> Clinical processes in place to support all outcome measures Data collection outcome measures 1-4 Monthly case review meetings Annual cross training of BH, PCP, and non-clinical staff HIT + Clinical Committee - monthly process & outcome review Provide data for semi-annual report

**Family Care of Concord, Family Health Center Hillsboro/Deering,
Family Tree Health Center Hopkinton, Pleasant Street Family Medicine**

2017

Jan - Dec	<ul style="list-style-type: none"> x Budget x Workforce gap analysis and plan x Key Providers x Assessment of current state of integration x Assessment of ability to collect outcome measures 1 & 2 x HIT assessment and plan x Implementation plan and timeline for semi-annual report Site Self Assessments begin (every 3 month)
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2018

Jan - Jun	<ul style="list-style-type: none"> All BH staff hired & co-located PCP, BH, & non-clinical trainings Introduce/train staff in use of protocols/processes Clinical workflows finalized Provide CMT training for users Data collection outcome measures 1-4 Provide data for semi-annual report
July - Dec	<ul style="list-style-type: none"> Case conference meetings established/in use CMT in use Closed loop referrals in use Use of technology to identify, plan, and manage high risk needs Develop referral protocols for CBOs Monthly case review meetings Annual cross training of BH, PCP, and non-clinical staff HIT + Clinical Committee - monthly process & outcome review MAT & Depression EBP protocols in place Clinical processes in place to support all outcome measures Provide data for semi-annual report

B1-3. IDN Integrated Healthcare: Evaluation Project Targets

Performance Measure Name	Target	Target # organizations*	Date-total completion	Progress Toward Target		
				As of 12/31/17	As of 6/30/18	As of 12/31/18
Data Vendor	Data vendor will be selected to assist in collecting project metrics for the state and individual IDN projects	na	9/30/2017			
Secure Texting	Evaluate each project for need and implement	to be determined	3/31/2018			
Closed loop referrals	Evaluate and implement referral process	to be determined	6/30/2018			
Data Sharing Agreements Signed	Develop agreement for sharing data within the IDN and obtain signatures	27	12/31/2017			
Data Vendor Implementation	Data vendor will be implemented to all organizations that must report metrics in order to achieve first reporting requirement	17	3/31/2018			
Minimum standards assessment	Assess all organizations for baseline status regarding the 8 minimum standards.	27	12/31/2017			
Direct messaging	All identified agencies will implement direct messaging	17	2/28/2018			
Standards Education	Provide education/guidance to identified agencies for standards 2-4	17	3/31/2018			
Event Notification	All identified organizations will be sending ADT event notificaitons	1	6/30/2018			
Event Notification	All identified organizations will be sending/receiving event notificaitons	14	6/30/2018			
Shared careplan	All identified organizations will implement shared careplan	15	6/30/2018			
Premanaged Ed	Implement Premanaged ED	1	4/30/2018			
Equipment	All identified primary care practices will have designated equipment for integration	14	6/30/2018			
Integration	Emr will have fields built for data collection. Epic, cerner, tier	3	6/30/2018			

B1-4. IDN Integrated Healthcare: Workforce Staffing

From Project A1: Workforce Capacity Development Implementation Plan, document workforce targets and timeline milestones 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
Integrated Behavioral Health Clinicians (IBHC)	11	6			
Case Manager	1	0			
Integrated Care Coordinators	2	1			
Psychiatrists	2	0			
Medical Assistant	2	1			
APRN (Medical)	1	0			
IBHC Supervisor	1	1			

B1-5. IDN Integrated Healthcare: Budget

	Approved	Steady State	Steady State	Steady State
INTEGRATION	2017	2018	2019	2020
Staffing	\$654,612	\$1,373,430	\$1,654,212	\$1,654,212
Peers	\$116,719	\$298,625	\$298,625	\$298,625
NAMI NH	\$38,000	\$76,000	\$76,000	\$76,000
Training	\$69,000	0	\$53,000	0
INTEGRATION Total	\$878,331	\$1,764,055	\$2,081,837	\$2,028,837

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

Organization/Provider	Agreement Executed (Y/N)
Dartmouth Hitchcock Concord	Y
Concord Hospital Family Health Center Concord	Y
Concord Hospital Family Health Center Hillsboro	Y
Concord Family Medicine	Y
Family Physicians of Pembroke	Y
Penacook Family Physicians	Y
Epsom Family Medicine	Y
Family Tree Health Care - Hopkinton	Y
Pleasant Street Family Medicine	Y
Family Care of Concord	Y
Riverbend Community Mental Health	Y

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

Name	Title	Organization	Sign Off (Y/N)
[REDACTED]	Chief Executive Officers, IDN Non-voting members, IDN Committee	Concord Hospital, Concord Region VNA, Riverbend CMHC	Y
[REDACTED]	Member, IDN Committee	Ascentria Care Alliance	Y
[REDACTED]	Member, IDN Committee	Bhutanese Community of NH	Y
[REDACTED]	Member, IDN Committee	Capital Area PHN	Y
[REDACTED]	Member, IDN Committee	CATCH Neighborhood Housing	Y
[REDACTED]	Member, IDN Committee	Concord Coalition/Homelessness	Y
[REDACTED]	Member, IDN Committee	Concord Family YMCA	Y
[REDACTED]	Chief Financial Officer, IDN	Concord Hospital	Y
[REDACTED]	Member, IDN Committee	CHMG	Y
[REDACTED]	Member, IDN Committee	Concord Human Services	Y
[REDACTED]	Member, IDN Committee	Concord Peer Support	Y
[REDACTED]	Chief Technology Officer, IDN	Concord Regional VNA	Y
[REDACTED]	Member, IDN Committee	[REDACTED]	Y
[REDACTED]	Member, IDN Committee	Merrimack County DOC	Y

Name	Title	Organization	Sign Off (Y/N)
	Member, IDN Committee	NAMI New Hampshire	Y
	Chief Medical Officer, IDN	Riverbend CMHC, Inc.	Y

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

B1-8A Core Standardized Assessment

Please see copies of CSA domains in appendix.

CSA Domain Current Status	Dartmouth-Hitchcock Concord	All Concord Hospital Medical Groups	Riverbend Community Mental Health
Demographic information	Y	Y	Y
Physical health review	Y	Y	Y
Substance use review	Y	Y	Y
Housing assessment	Nov 2017	Y	Y
Family and support services	Nov 2017	Y	Y
Educational attainment	Nov 2017	Y	Y
Employment or entitlement	Y	Y	Y
Access to legal services	Nov 2017	Jun 2018	Y
Suicide risk assessment	Y	Y	Y
Functional status assessment	Y	Y	Y
Universal screening using depression screening (PHQ 2 & 9)	Y	Y	Y
Universal screening using SBIRT	Jan 2018	Jan 2018	Y
Validated developmental screening for all children, such as the ASQ 3 and/or ASQ SE at 9, 18 and 24/30 month pediatric visits	Y	Y	N/A
Developmental Screening using Bright Futures or other American Academy of Pediatrics recognized	Y - MCHAT	Y - MCHAT	N/A

B1-8b Core Team Members

Organization/Provider	PCP	Psych	IBHC	ICC	Peer	MAT
Dartmouth Hitchcock Concord	Y	Y	1 + 1 TBH		4 FTE to serve across practices	1
CH Family Health Center	Y	Y	Y	1 + 1 TBH		2
Integrated Center for Health	Y + 1 TBH	Y	Y	Y		1
Concord Family Medicine	Y	2 FTE TBH to consult across practices	1			1
Family Physicians of Pembroke	Y		1			1+ TBD
Penacook Family Physicians	Y		1			1+ TBD
Epsom Family Medicine	Y		1			1+ TBD
Family Tree Health Care - H	Y		1 TBH			1+ TBD
Pleasant Street FM	Y		1 TBH			1

Organization/Provider	PCP	Psych	IBHC	ICC	Peer	MAT
FHC Hillsboro	Y		1 TBH			
Family Care of Concord	Y		1 TBH			1+ TBD

Y = Existing (not funded by IDN)

B1-8c Multi-disciplinary core team training for service providers

Site	# PCP	Goal	MH Training	SUD Training	# IDN BH	Med Training
Dartmouth Hitchcock Concord	62	47	Jun 2018	Jun 2018	2	Oct 2017
Integrated Center for Health	1	1	Jun 2018	Jun 2018	1	Jul 2017
CH Family Health Center - C	82	60	Jun 2018	Jun 2018	2	Oct 2017
CH Family Health Center - H			Dec 2018	Dec 2018	1	Dec 2018
Concord FM			Jun 2018	Jun 2018	1	Jul 2017
Family Physicians of Pembroke			Jun 2018	Jun 2018	1	Jul 2017
Penacook Family Physicians			Jun 2018	Jun 2018	1	Jul 2017
Epsom FM			Jun 2018	Jun 2018	1	Jul 2017
Family Tree Health Care - H			Dec 2018	Dec 2018	1	Dec 2018
Pleasant Street FM			Dec 2018	Dec 2018	1	Dec 2018
Family Care of Concord			Dec 2018	Dec 2018	1	Dec 2018

All behavioral health staff hired for the IDN (as well as Riverbend’s Community Support Program staff) were trained in metabolic syndrome by [REDACTED], who works at the Integrated Center for Health at Riverbend. (Metabolic syndrome is a cluster of conditions — increased blood pressure, high blood sugar, excess body fat around the waist, and abnormal cholesterol or triglyceride levels — that occur together, increasing one’s risk of heart disease, stroke, and diabetes.) The training covered definition, symptoms, etiology, treatment, co-morbidities, and health disparities. She will train all future hired behavioral health staff. Those sites marked “Dec 2018” are slated to attain integrated status by that date. The trainings may occur sooner. IBHC staff are also receiving on-going training in Integrated care through SAMHSA and other providers identified through the Statewide Behavioral Health Workforce Development plan. These have included:

- Integration overview (SAMHSA oriented) and delivered by IDN staff
- SAMHSA “Implementing Medication-Assisted Treatment (MAT): Organizational Considerations and Workflows.” Covered clinical pathways, staffing needs, and organizational readiness.
- NH Providers Association Annual Training - Confidentiality Training, 42 CFR Part 2: How to be Compliant and Integrate
- ASAM Appropriate Use of Drug Testing in Clinical Addiction Medicine Webinar

IBHCs are also part-way through a nine-month Learning Collaborative: SAMHSA-HRSA Center for Integrated Health Solutions (CIHS) “Innovation Community Circle of Support - Engaging Loved Ones in Health and Wellness.”

Sixty-four CHMG providers attended an online Motivational Interviewing (MI) course for 8 hours over the course of one month in June. The course is being offered every month to CHMG

employees through a contract with Health Education & Training Institute (HETI) in Maine. Those who complete the course are eligible for coaching, which provides an opportunity to practice MI skills with different case scenarios and receive direct feedback from MI coaches. In addition, 85 CHMG PCPs attended an all-day training on Pediatric Mental Health Assessment and Treatment.

CHMG is building out their Organizational Development department and plans to have an array of behavioral health trainings available for CHMG and Dartmouth-Hitchcock Concord primary care providers by June 2018.

B1-8d Behavioral Health Training for Non-Clinical Staff

Site	# Non-Clinical Staff	Goal	BH Training
Integrated Center for Health	4	4	Jun 2017
Dartmouth Hitchcock Concord	9	9	Jun 2018
CH Family Health Center Concord	As of 1/5/17 - CHMG had 152 non-clinical staff members	75	Jun 2018
CH Family Health Center Hillsboro			Dec 2018
Concord FM			Jun 2018
Family Physicians of Pembroke			Jun 2018
Penacook Family Physicians			Jun 2018
Epsom FM			Jun 2018
Family Tree Health Care - H			Dec 2018
Pleasant Street FM			Dec 2018
Family Care of Concord			Dec 2018

Region 2 is contracting with NAMI NH to provide “See the Person, Not the Illness” to non-clinical staff. This training is geared to general audiences to raise the awareness of the impact of stigma. Participants explore the myths and misconceptions about emotional disorders and/or mental illness and the impact stigma has on the individual, family, and community. They are challenged to explore their personal attitudes and biases and gain new insights and knowledge that can influence their individual practices and the development of agency and/or organizational policies. Participants will learn the four components of stigma, to recognize the consequences of stigmatizing behaviors on practice and policy, the facts about emotional disorders and/or mental illness, and how to be more aware of the impact of stigma on the individual, family, and community. This training will help non-clinical staff recognize and manage symptoms of mental illness in the waiting room and during transitions.

B1-8e Core Team Case Conferences

Each practice is in the process of setting up a monthly core team case conference on behalf of patients with significant medical and behavioral health conditions. Until then, the IBHC will attend primary care practice meetings where these cases will be discussed.

CHMG Primary Care Practice Meetings				
	All Staff		Provider	
Concord Family Medicine	4th Friday	12-1pm	3/30, 4/27, 5/30, 6/26, 7/26, 8/31, 9/25, 10/30	6-8pm
Epsom Family	Every Wed	8-10am	4th Weds	8-10am
Family Care of Concord	1st and 4th Weds	12-1pm	2nd Wed	12-1pm
Family Physicians Pembroke	4th Thurs	12-1pm	4th Thurs	1-2pm
Family Tree- Hopkinton	1st Monday	12-1pm		
Penacook Family	3rd Friday	12:15-1:30pm	4th Wed	7-8:30am
Pleasant Street	Varies		1st Tues	7-8am
Family Health Center C+H			4th Monday	Varies

B1-8f Secure Messaging

From the HIT Implementation Plan: All organizations that completed the HIT Assessment tool were cross referenced with the NHHIO’s official list of organizations that are connected. Eleven out of 27 organizations are currently utilizing direct messaging. IDN2 plans to visit each organization to review internet connectivity status, data storage and data capture ability, and determine if education or assistance obtaining is needed. The need for secure texting will be evaluated in relation to the needs of each project.

Query based exchange will be beneficial only if other health providers in the state implement as well. This will be evaluated on a yearly basis to determine if enough providers in the state are engaged in use of the technology to create a benefit to implementing.

Due to Concord Hospital and CHMG implementing Cerner, changes that will be needed for Cerner to capture discreet data for metrics for many of the projects will occur between January and June of 2018.

Direct Messaging - All organizations that collect PHI will be reviewed for direct messaging capabilities. Organizations that do not collect PHI will also be reviewed for process flow to determine if there is a benefit to having direct messaging capabilities (referrals could be received this way). Once organizations are identified, IDN2 will work with NHHIO to obtain a webmail product for those identified agencies. Once the webmail product is installed, organizations will be visited again to assist with recommendations for process flow changes to incorporate the use of direct messaging. Organizations that have the ability to send and receive CCD documents within their EHR will be encouraged to do so. For agencies that will use the Kno2 webmail product - it does have the capability to receive CCD but not create one.

Event Notification - Organizations will be evaluated to determine if they are to send and/or receive event notifications for admission/discharge/transfer (ADT). If they are the sender of event notifications the IDN will work with the organization to assist in setting up the ADT feed with the event notification vendor.

B1-8g Closed Loop Referrals

From the HIT Implementation Plan: A closed loop referral process will reduce gaps in service by providing the mechanisms to exchange pertinent patient information at key points during the referral process. Direct messaging is a protocol that can be used to send a referral. ONC requires providers to be able to send a C-CDA (Summary of Episode or Referral Note) by direct messaging. A closed loop referral process would also include the capability to electronically transmit the request itself, request status, and result of request. Collective Medical Technologies (CMT, vendor for shared care plans) would like to convene a state group to discuss requirements for a closed loop referral as an initial plan.

B1-8h Documented Work Flows and/or Protocols

Please see protocols in use in appendix.

DHHS Minimum Documented Protocols	DH-C	CHMG	ICH
Intake procedures that include systematically soliciting patient consent to confidentially share information among providers	Y	Y	Y
Interactions between providers & community based organizations	Jun 2018	Jun 2018	Jun 2018
Timely communication	Nov 2018	Sep 2017	Y
Coordination among case managers (internal & external to IDN)	Jun 2018	Jun 2018	Jun 2018
Safe transitions from institutional settings back to primary care, behavioral health, and social support service providers	Jun 2018	Jun 2018	Jun 2018
Privacy, including limitations on information for communications with treating provider and community based organizations	Y	Y	Y
NH Board of Medicine guidelines on opioid use prescribing	Y	Y	N/A
Other Documented Protocols	DHC	CHMG	ICH
Hospital Discharge	Y	Y	Y
Referral	Y	Y	Y
Medication Assisted Treatment (MAT) related	Jun 2018	Nov 2017	Nov 2017
Other Documented Work Flows	DHC	CHMG	ICH @ RB
Integration Workflow	Nov 2017	Nov 2017	Nov 2017
MAT Workflow	Nov 2017	Nov 2017	Nov 2017
ECC Workflow	Nov 2017	Nov 2017	N/A
Reentry Workflow	Nov 2017	Nov 2017	N/A

B1-9. Project Scoring: IDN Integrated Healthcare Process Milestones and Achievement of Coordinated Care Practice Designation Requirements

DHHS will use a tool to assess progress made by each IDN's Integrated Healthcare Implementation Plan activities.

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

B1-9a. Coordinated Care Practice designation

Please see chart in B1-1 above.

B1-9b. Additional Integrated Practice designation requirements

- MAT - Please see protocols under MAT project
- Evidence based treatment of mild to moderate depression within the integrated practice setting - Protocols for this will be implemented June 2018 in DHC, ICH @ RB, and CHMG 1 and December 2018 in CHMG 2.

B1-9c. Use of Technology

Use of Technology to Identify	DHC	CHMG 1	CHMG 2	ICH @ RB
At risk patients	Jun 2018	Jun 2018	Dec 2018	Jun 2018
Plan care	Jun 2018	Jun 2018	Dec 2018	Jun 2018
Monitor/manage patient progress toward goals	Jun 2018	Jun 2018	Dec 2018	Jun 2018
Closed loop referrals	Jun 2018	Jun 2018	Dec 2018	Jun 2018

Page 10 of the IDN 2 HIT report outlines the minimum, desired, and optional standards for the statewide and local HIT standards required for the demonstration projects, as agreed upon and adopted by the HIT Task Force. These standards address the requirements of B1-9c.

The HIT statewide group would like to use one single vendor for data aggregation/metric collection for the DSRIP project. Four vendors have been selected to provide product capabilities/web demonstrations. Selection will be made down to two vendors for more intensive review of capabilities. The data aggregator will be asked to provide data analytics to the IDNs needed to identify at risk patients and assess the health of the population.

Concord Hospital is implementing Cerner as their electronic health record as of Dec 2018. Dartmouth-Hitchcock used EPIC. Riverbend is licensed to use Concord Hospital's EHR. Both Cerner and EPIC are capable of shared care plans and monitoring patient progress toward goals. However, the ability to do that is not in one area of the EHR or presented in a way that is intuitive to the user. Both entities' HIT departments, in cooperation with IDN2's HIT sub-committee, are working toward solutions for this and report that they will be fully functional by the integrated dates specified for each practice.

B1-9d. Documented work flows with community based social support service providers

Documented work flows with CBOs	DH-C	CHMG 1	CHMG 2	ICH @ RB
Joint service protocols	Jun 2018	Jun 2018	Dec 2018	Jun 2018
Communication channels	Jun 2018	Jun 2018	Dec 2018	Jun 2018

Once a vendor is selected and a structure is defined for the collection of data, data sharing agreements will be developed and require signature by each IDN organization. These data sharing agreements will include joint service protocols and communication channels.

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

DHHS will use a tool 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.

B1-12. Project Scoring: IDN Integrated Healthcare Project: Achievement of Coordinated Care Practice and Integrated Care Practice Designation

The targeted, total goal, number of practices/providers expected to achieve designation as a Coordinated Care Practice or Integrated Care Practice.

	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	11	0	0	6	11
Integrated Care Practice	11	0	0	6	11

Coordinated Care Practice	List of providers identified to make progress toward Coordinated Care Practice designation	12/31/17	6/30/18	12/31/18
	Dartmouth Hitchcock Concord		X	
	Concord Hospital Family Health Center Concord		X	
	Concord Hospital Family Health Center Hillsboro			X
	Concord Family Medicine		X	
	Family Physicians of Pembroke		X	
	Penacook Family Physicians		X	
	Epsom Family Medicine		X	
	Family Tree Health Care - Hopkinton			X
	Pleasant Street Family Medicine			X
	Family Care of Concord			X
	Riverbend Community Mental Health		X	

Integrated Care Practice	List of providers identified to make progress toward Integrated Care Practice designation	12/31/17	6/30/18	12/31/18
	Dartmouth Hitchcock Concord		X	
	Concord Hospital Family Health Center Concord		X	
	Concord Hospital Family Health Center Hillsboro			X
	Concord Family Medicine		X	
	Family Physicians of Pembroke		X	
	Penacook Family Physicians		X	
	Epsom Family Medicine		X	
	Family Tree Health Care - Hopkinton			X
	Pleasant Street Family Medicine			X
	Family Care of Concord			X
	Riverbend Community Mental Health		X	

Reentry Timeline	
2017	
Jan - June	Implementation Plan Timeline & budget Workforce plan Projected client engagement Key organizational providers R&R of team members Clinical Services Infrastructure Assessment tools Protocols, Processes, & Workflow Training plan & curricula - See C-9 Agreements Evaluation plan Hire 3 staff (LADC, CM, BH Clinician)
July - Dec	Operationalize program Hire 1 additional staff (APRN) Begin training schedule Develop and convene monitoring and improvement team Initiate data reporting Project budget review for 2018 Employ rapid cycle evaluation Participate in semi-annual report writing
2018	
Jan - June	4 staff trained - See C-9 Monthly progress and data reporting Employ rapid cycle evaluation Participate in semi-annual report writing
July - Dec	Monthly progress and data reporting Employ rapid cycle evaluation Participate in semi-annual report writing Project budget review for 2019

Merrimack County Department of Corrections (MCDOC) Reentry Program

Entry into Region 2’s MCDOC Reentry Program is for those participating in the Successful Offender Adjustment and Reentry program (SOAR). Existing MCDOC staff participating in the reentry project include two SOAR Case Managers, the Program Director, LADAC and reentry staff members(?)

All sentenced offenders are screened using PROXY to determine risk level. High and medium risk offenders are offered intensive treatment services. The PROXY is completed in booking. Sentenced inmates serving 120 days or more are targeted for the full continuum of in jail and transitional services. The program is designed around treatment services that address the criminogenic risks as assessed by the ORAS Ohio Risk Assessment System, the clinician, and the Texas Christian University (TCU) substance use screener, which has been validated in NH.

All inmates are required to participate in treatment, which includes substance abuse and cognitive behavioral components, work in a supervised setting on/off site, and the option of increasing vocational skills through mock interviewing and job placement assistance. MCDOC clinicians are responsible for completing the ORAS and TCU within 7 days of entry into the facility.

Prior to release, those identified for reentry services participate in the following curricula:

Thinking for a Change 4.0 (T4C) is an integrated cognitive behavioral change program authored by Jack Bush, Ph.D., Barry Glick, Ph.D., and Juliana Taymans, Ph.D., under a cooperative agreement with the National Institute of Corrections (NIC). T4C incorporates research from cognitive restructuring theory, social skills development, and the learning and use of problem solving skills.

Helping Women Recover is a 17 session, evidence-based treatment model that integrates theories of addiction, women's psychological development, and trauma. This curriculum is strengths-based and responsive to women's gender-specific needs for healing and support.

Helping Men Recover is the first gender-responsive and trauma informed treatment curriculum for men. This 18-session program addresses male socialization in recovery, the relational needs of men, and abuse and trauma.

Seeking Safety is an evidence-based model that can be used in group or individual counseling. It was specifically developed to help survivors with co-occurring trauma and SUD and, crucially, in a way that does not ask them to delve into emotionally distressing trauma narratives

Education classes are offered to men and women in the SOAR program who are working towards their High School Equivalency Assessment (HISET) with the goal to increase learning and, in some cases, work toward passing the HISET certification

The Habits of Mind are an identified set of 16 problem solving, life related skills, necessary to effectively operate in society and promote strategic reasoning, insightfulness, perseverance, creativity and craftsmanship. The understanding and application of these 16 Habits of Mind serve to provide the individual with skills to work through real life situations that equip that person to respond using awareness (cues), thought, and intentional strategy in order to gain a positive outcome.

Support groups are facilitated by Riverbend and designed to provide support at transition for SOAR participants reentering the community. The groups are separated by gender and deliver gender specific psycho-educational material on life skills and managing stressors. There are currently plans to expand the scope of these groups to include a continuation of the concepts presented in Seeking Safety and a New Direction. These are evidenced based approach to treating dually diagnosed individuals. Additional services will include ongoing case management services, individual counseling on substance use, closed loop referral to substance use disorder services when appropriate and coordination and support provided by Peer Mentors.

Transition Planning - 2-4 weeks

The MCDOC and Riverbend Case Manager begin meeting with the reentering individual prior to release to develop a transition plan.

Goals prior to release are identifying safe and sober housing, completion of in-jail intensive treatment, obtaining and maintaining a job or enrollment in an educational/vocational program, practicing good self-care including sustaining recovery and completing a 12-month transition aftercare program.

Aftercare can be required as a condition of probation. A partnership has already been established with Probation/Parole for the program, which will continue as the program expands. Probation/Parole will invoke the use of graduated responses to violations, will collaborate with MCDOC and Riverbend staff on the case plans, and have access to the ORAS assessment results for community supervision determinants. This after care plan will be monitored by Riverbend.

All aftercare participants are subject to random and ongoing urine screens through the MCDOC, who is responsible for the scheduling, collection, and analysis of the drug screens and reporting back to Riverbend staff on the results.

Post-Release - up to 12 months

Participants will receive an individualized combination of the following:

- Intensive case management
- Substance Use Disorder (SUD) supports and services to include, as needed, Medication Assisted Treatment (MAT), Intensive Outpatient Programming (IOP), counseling, and group therapy
- Mental Health services to include, as needed, psychiatric services and medication management, counseling, group therapy and an array of evidence-based practices that include:
 - Assertive Community Treatment (ACT) is an EBP for delivering comprehensive, effective and highly individualized services to clients who have needs that have not been well met by traditional approaches.
 - Dialectical Behavior Therapy (DBT) is a SAMHSA/CMHS/NREPP recognized cognitive-behavioral treatment approach that emphasizes balancing behavioral change, problem-solving, and emotional regulation with validation, mindfulness, and acceptance.
 - Illness Management and Recovery (IMR) is an EBP that combines motivational, educational, and cognitive behavioral strategies to teach people with severe mental illness how to manage their disorder in collaboration with professionals and significant others in order to achieve personal recovery goals.
 - Integrated Dual Diagnosis Treatment (IDDT) is a widely accepted EBP that focuses on treatment for people with CODs. IDDT integrates treatment modalities for both, allowing persons with COD to receive support and services from the same providers.
 - Cognitive Behavioral Therapy (CBT) is a SAMHSA/CMHS/NREPP recognized structured, short-term, present-oriented psychotherapy for depression, directed toward solving current problems and modifying dysfunctional (inaccurate and/or unhelpful) thinking and behavior.
 - Motivational Enhancement Therapy (MET) is an adaptation of Motivational Interviewing (MI) that includes normative assessment feedback to clients.

- A therapist trained in MET can often help an individual to view behaviors more objectively, and through MET, that individual may become empowered to begin the process of change; and
- A New Direction is a cognitive-behavioral treatment curriculum for justice involved individuals with Co-Occurring Mental Health and Substance Use Disorders (COD).
- Identification of health issues and linkage to primary health care through the Region 2 Integration Project
- Individual Placement and Support (IPS) Supported Employment
- Wellness Activities including InSHAPE
- Benefits assistance
- The continuation of evidence-based curriculums begun in jail including education classes, Thinking for a Change, The Habits of Mind, and Community Supervision.

The Reentry Case manager will work with clients and family members, if appropriate, to identify needs and explore community resources available to address those needs. Staff will maintain a list of resources and linkages to address needs related to food banks, transportation, homeless shelters, PCPs, apartment listings, domestic violence shelters, medication assistance, smoking cessation, pharmacies, specialty care services, dentists, nutritionists, HIV/AIDS resources, soup kitchens, NAMI, CAMI, recovery supports, peers, and etc. This list will be used in conjunction with all other services with the goal of supporting clients and their families in maintaining the highest level of health and functioning in the community.

Data to be evaluated is listed below. The MCDOC has a solid data collection system that is based in the MCDOC jail management system. This includes demographic data, screening, assessment information, and other program data. There is also a system to collect recidivism information that has been in place for well over a year. The MCDOC staff will be responsible for the pre-release data while Riverbend will collect the post release measures in NetSmart TIER. The Region 2 HIT project will work on data collection mechanisms, shared care plans, and secure messaging to support the project.

C-2. IDN Community Project: Evaluation Project Targets

Measurable targets or goals that the program intends to achieve.

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
# served	250			
# and % of clients released from jail with a psychiatric symptom management plan	190 (75%)			
# and % of clients actively engaged in mental health or substance use treatment post release	200 (80%)			
# and % of clients who completed core community-based services post-release	200 (80%)			
# and % of clients with transition case plans	250 (100%)			
# and % of clients with suitable housing post release	200 (80%)			
# and % of clients with health care	250 (100%)			

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
# and % of clients employed	175 (70%)			

C-3. IDN Community Project: Workforce Staffing

The workforce targets and timeline milestones specifically related to this project.

Provider Type	IDN Workforce (FTEs)				
	Projected Total Need	Baseline Staffing on 6/30/17	Staffing on 12/31/17	Staffing on 6/30/18	Staffing on 12/31/18
Case Manager	1	1			
Psychiatric APRN	1	0			
MLDAC	1	1			
Clinician MSW	1	1			

C-4. IDN Community Project: Budget

	Approved	Steady State	Steady State	Steady State
Reentry	2017	2018	2019	2020
Project Planning & Development	\$40,000	0	0	0
APRN .3 FTE (Psychiatric Nurse)	\$32,860	\$65,719	\$65,719	\$65,719
Clinician MSW	\$52,874	\$79,311	\$79,311	\$79,311
Case Manager	\$30,181	\$60,362	\$60,362	\$60,362
MLADC	0	\$79,311	\$79,311	\$79,311
Testing supplies	\$11,755	\$11,755	\$11,755	\$11,755
██████ Director of Integration - 10%	\$10,681	\$10,681	\$10,681	\$10,681
Reentry Total	\$178,351	\$307,139	\$307,139	\$307,139

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

The Key Organizational and Provider Participants specifically related to this project.

Organization/Provider	Agreement Executed (Y/N)
Merrimack County Department of Corrections	Y
Riverbend Community Mental Health, Inc.	Y
Sununu Youth Services	Y
Hope for NH Recovery	Y
NH NAMI	Y

C-6. IDN Community Project: Standard Assessment Tools

The Assessment and Screening tools that will be used for the IDN Community Project.

Name	Brief Description
Proxy Triage Risk Screener (Proxy)	Risk of recidivism on an 8-point scale
Ohio Risk Assessment System (ORAS)	This fourth-generation risk assessment tool integrates case planning and risk management into the assessment process. As such, the primary goal extends beyond assessing risk and focuses on enhancing treatment and supervision.
TCU Mapping Interventions	Mapping is a visual representation counseling strategy for improving communication and decision making that can enhance any therapeutic or psycho-educational exercise, either in group or individual settings. Evidence shows it significantly improves treatment engagement and client progress indicators, and helps compensate for a variety of cognitive and social deficits common among drug users in treatment
Structured Assessment of Violence Risk in Youth (SAVRY)	SAVRY includes 24 items in three risk domains (Historical Risk Factors, Social/Contextual Risk Factors, and Individual/Clinical Factors), drawn from existing research and the professional literature on adolescent development as well as on violence and aggression in youth. SAVRY helps you structure an assessment so that important factors will be emphasized when you formulate a final professional judgment about a youth's level of risk.
Substance Abuse Subtle Screening Inventory (SASSI-3)	SASSI is a brief, easily administered psychological questionnaire. It is available in both adult and adolescent versions, as well as versions for diverse cultures, including those with disabilities. The SASSI can identify people who may have a Substance Use Disorder with a high degree of accuracy – even when someone is reluctant to self-disclose.
Revised Children's Manifest Anxiety Scale (RCMAS)	RCMAS is a self-report instrument designed to measure anxiety for children and adolescents aged 6-9 years. For children over 9 and a half years of age, it can be administered in a group situation. For first and second graders, the examiner should read the items to the child. There are 37 items each of which requires a yes or no answer. (For SYS)
The Child and Adolescent Needs and Strengths (CANS) Comprehensive Assessment for Young Children	A multi-purpose tool developed to support care planning and level of care decision-making, to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services. CANS was developed from a communication perspective so as to facilitate the linkage between the assessment process and the design of individualized service plans including the application of evidence-based practices (For SYS)
Mental Health Status Examination (MSE)	A structured way of observing and describing a patient's current state of mind, under the domains of appearance, attitude, behavior, mood and affect, speech, thought process, thought content, perception, cognition, insight and judgment.
Adult Needs and Strengths Assessment (ANSA)	A multi-purpose tool developed for adult's behavioral health services to support decision making, including level of care and service planning, to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services.
American Society of Addiction Medicine (ASAM) Criteria	The ASAM criteria explores six dimensions to create a holistic, biopsychosocial assessment of an individual for treatment across all services and levels of care.

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

A list of all protocols to be utilized for patient assessment, treatment, management, and referrals for the community project.

Protocol Name	Brief Description	Use (Current/Under development)
Reentry Workflow	Documented and approved workflow for identification, assessment, SOAR curriculum, transition planning, community services & supports, data collection	Under development
HIT Protocols	Related to privacy, confidentiality, and data sharing	Under development

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

Team members and their roles and responsibilities for the project.

Project Team Member	Roles and Responsibilities
APRN .3 FTE (Psychiatric Nurse)	The Consulting APRN is responsible for supporting behavioral health care provided by the Merrimack County House of Corrections including medication management.
License Eligible Master’s Clinician	To provide treatment and education, link offenders to community services and collaborate with community-based resources.
Case Manager	To provide treatment and education, link offenders to community services and collaborate with community-based resources. The case manager is responsible for assessment of and service delivery to inmates. The case manager facilitates groups and provides individual case management for residents. The case manager is responsible for ongoing support, follow-up, and strict supervision according to program procedures.
Substance Use Treatment Master’s Clinician	To provide treatment and education, link offenders to community services and collaborate with community-based resources. Assures delivery and provision of quality substance use disorder services to residents of the Merrimack County House of Corrections. All work assignments are performed according to MCHOC policies and procedures, and federal and state guidelines.
Director of Integration 10%	Supervise Reentry Behavioral Health Staff

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

C2 Reentry		
Review of the Client Flow System	May & Jul 2017	Orientation to the pathways through the reentry system from initial screening and assessment through post release programming. This process includes two major meetings: May 2017 and July

		2017. The initial meeting was to discuss the need for a flow system from initial assessment to post release services; what is expected from whom; and how assessment tools, case management services, pre- and post-release programming, transitional case management, and support services are managed. The second meeting is to review the case flow system and responsibilities with all reentry staff.
Case Management Training	Aug & Sep 2017	A review of evidence based case management strategies for offenders as they re-enter the community. This will include the process of coordinated case planning, transition services, use of a universal case plan, and evidence based chain of case planning and services.
Overview of Evidence Based Practices	Sep & Oct 2017	Discussion of the best practice models in criminal justice and correctional settings including methodology for clients with substance use and mental health disorders. This review will include the National Transition from Jail to Community Model, the Risk Need Responsivity Model, Criminogenic Risk and Need, and other successful evidence based systems.
Outcome Data	Oct & Nov 2017	This is designed to review the performance measures agreed to in reentry meeting and the methodology of collecting and reviewing that data for continuous quality improvement including: <ul style="list-style-type: none"> • Public Safety Indicators and Outcomes • Reduced re-offending, returns to jail, and length of jail stays for returning individuals • Reintegration Indicators and Outcomes • Reduced substance abuse and homelessness • Increased employment • Improved housing stability and improved mental health/health • Process Measures • Screening • Assessment • Referrals • Engagement • Service utilization • Completion

Data-Driven Understanding of Reentry	Nov 2017	<ul style="list-style-type: none"> • Assessments are the key to understanding your clients' needs • Make intelligent decisions based on evidence • Understand your gaps in data collection and work toward building a better data infrastructure • Leverage existing resources
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Reentry staff will also have access to all trainings offered through the integration project.

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

DHHS will use a tool to assess each IDN's Community Projects activities.

Projects D: Capacity Building Focused

Region 2 - D1 Medicated Assisted Treatment (MAT)

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

In alignment with the Standard Terms and Conditions (STCs) published by NH DHHS, Region 2's MAT project seeks to implement evidence based programs combining behavioral and medication treatment for people with substance use disorders, with or without co-occurring chronic medical and/or mental health conditions, with the goal to successfully treat more individuals with substance use disorders and, for some people struggling with addiction, help sustain recovery. In fulfillment of this goal, and based on the needs assessments of the region, the Region 2 MAT project will recruit, incentivize, mentor, and support 18 primary care providers across the region to incorporate MAT into their practice. Training and curriculum is the 8-hour NH Buprenorphine Waiver Training. Following trainings, physicians who have successfully completed the course, may apply to the Substance Abuse and Mental Health Administration (SAMHSA) to obtain the waiver. Nurse Practitioners and Physicians Assistants are required to take the additional 24-hour training established by the Comprehensive Addiction and Recovery Act (CARA). These trainings are available free of charge through the Providers Clinical Support System (PCSS).

Recruitment efforts include educational presentations at the practices, one to one conversations with existing MAT providers, and a letter sent to all of the practice providers introducing the MAT project and what is available in terms of incentives, mentoring, and support. Incentives are budgeted at \$5,500 annually (pro-rated) for primary care providers who obtain a waiver, begin providing MAT at their practice, and participate in the IDN MAT project through attendance at case review and participation in data collection. Mentoring is provided by two experienced MAT providers by phone or in person on an as needed basis. Shadowing opportunities are also offered during open access hours or by appointment. Assistance with MAT inductions is available for providers at their practice or at the Mentor's practice. In addition, case review is conducted monthly with a phone-in option and there are monthly opportunities for informal education and training on a variety of MAT related topics.

This MAT project is supported by the Region 2 Integration Project. MAT providers will become a member of that practice's Integrated Care Core Team. IBHCs will provide therapeutic and care coordination support to MAT patients. The roll out of the MAT project is planned to coincide with the rollout of the Integration Project as much as possible to maximize IBHC support of the MAT provider. The chart on the next page illustrates where the IDN has already placed for the Integration project and where MAT providers also currently exist or have been recruited.

Organization Name	IBHC	MAT
To achieve Integrated Care by 6/30/2018		
Dartmouth Hitchcock - Concord	1 (+1 TBH)	1
CH Family Health Center Concord	Pre-existing - multiple	MAT Mentor + 1

Integrated Center for Health	Pre-existing - multiple	MAT Mentor
Concord Family Medicine	1	1 + 2 pending
Family Physicians of Pembroke	1	No
Penacook Family Physicians	1	No
Epsom Family Medicine	1	No
To achieve Integrated Care by 12/31/2018		
Family Tree Health Care - Hopkinton	TBH	No
Pleasant Street Family Medicine	TBH	1
Family Health Center - Hillsboro	TBH	No
Family Care of Concord	TBH	No

In addition to this Integration practices focus; the Region 2 MAT project is providing Perinatal Addiction Treatment (PAT) at Concord Hospital and Dartmouth-Hitchcock OB-GYN practices through a mobile team of MAT providers and a behavioral health clinician who provides care coordination and therapeutic interventions. Patients in the PAT program, and their children 0-5, are fully supported by the Enhanced Care Coordination (ECC) project's wraparound supports and services. PAT and ECC staff will meet monthly to review cases and participate in cross-learning opportunities.

The evaluation plan for MAT/PAT will include process measures as defined by NH DHHS and included in Region 2's MAT/PAT timeline as well as the following outcome measures for:

MAT

- # of individuals served (reporting period and cumulative) vs. projected
- Negative urines
- Treatment retention
- Length of time in treatment
- Referral follow-through

PAT

- # of individuals served (reporting period and cumulative) vs. projected
- Attendance at appointments
- Treatment retention during pregnancy and delivery
- Transfer of care post delivery

The HIT project will work on data collection mechanisms, shared care plans, and secure messaging to support the project.

MAT/PAT Timeline	
2017	
Jan - June	<ul style="list-style-type: none"> Implementation Plan Timeline & budget Workforce plan Projected client engagement Key organizational providers R&R for team members Clinical Services Infrastructure Assessment tools Protocols, Processes, & Workflow Training plan & curricula Agreements Evaluation plan Education & Recruitment & Mentoring
July - Dec	<ul style="list-style-type: none"> Provide mentoring support to 6 MAT providers Develop workflows for introducing MAT into 6 CHMG and DHC locations Distribute recruitment materials to at least 25 primary care providers Monthly case reviews with existing MAT providers Monthly FACE UP presentations Project budget review for 2018 Develop monitoring and improvement team Employ rapid cycle evaluation Participate in semi-annual report writing
2018	
Jan - June	<ul style="list-style-type: none"> Provide mentoring support to 2 additional MAT providers Develop workflows for introducing MAT into 2 additional CHMG locations Monthly case reviews with MAT providers Monthly FACE UP presentations Provide MAT presentations to 3 community groups Ongoing progress and data reporting Monitor project Employ rapid cycle evaluation Participate in semi-annual report writing
July - Dec	<ul style="list-style-type: none"> Provide mentoring support to 2 additional MAT providers Monthly case reviews with MAT providers Monthly FACE UP presentations Develop workflows for introducing MAT into 2 additional CHMG locations Distribute recruitment materials to at least 25 primary care providers Ongoing progress and data reporting Monitor project Employ rapid cycle evaluation Project budget review for 2019 Participate in semi-annual report writing

D-2. IDN Community Project: Evaluation Project Targets

The measureable targets or goals, that the program intends to achieve.

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
Numbers served over life of project	300			
Negative urines for opioids (other than those prescribed for OUD) at 3 months	180			
Negative urines for opioids (other than those prescribed for OUD) at 6 months	210			
Negative urines for opioids (other than those prescribed for OUD) at 12 months	240			
Treatment retention at 3 months	240			
Treatment retention at 6 months	210			
Treatment retention at 12 months	180			
Retained over life of project	180			
Referral to treatment no-shows	<75			
PAT: numbers served over life of project	50			
PAT: attend all scheduled OB-GYN appointments	38			
PAT: attend all scheduled MAT appointments	45			
PAT: remain engaged through pregnancy & delivery	35			
PAT: transfer care to PCP/MAT after delivery	45			

D-3. IDN Community Project: Workforce Staffing

Provider Type	IDN Workforce (FTEs)				
	Projected Total Need	Baseline Staffing on 6/30/17	Staffing on 12/31/17	Staffing on 6/30/18	Staffing on 12/31/18
MAT Provider	18	7			
MAT Mentor	.4 FTE	.4 FTE			
Medical Assistant	1	1			
Addiction Nurse	.2 FTE	0			
OB-GYN MAT Provider	.8 FTE	.8 FTE			
BH Clinician	.4 FTE	.4 FTE			

D-4. IDN Community Project: Budget

	Approved	Steady State	Steady State	Steady State
Medication Assisted Treatment	2017	2018	2019	2020
Mentors .4 FTE	\$94,382	\$115,827	\$115,827	\$115,827
Medical Assistant (1 FTE)	\$30,000	\$57,054	\$57,054	\$57,054
Addictions Nurse (.2 FTE)	\$7,000	\$15,392	\$15,392	\$15,392
Mobile OB-GYN MAT MD (.4 FTE)	\$50,000	\$99,848	\$99,848	\$99,848
Mobile OB-GYN Case Manager (.4 FTE)	\$12,000	\$23,551	\$23,551	\$23,551
Incentive (18)	\$35,000	\$50,000	\$75,000	\$100,000
MAT Total	\$228,382	\$361,672	\$386,672	\$411,672

This budget is augmented with technology, office supplies, training, travel, administrative, and peer budgets. Please see **full five-year budget with PPI document**.

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

Organization/Provider	Agreement Executed (Y/N)
Concord Hospital Medical Group	Y
Dartmouth-Hitchcock Concord	Y
Concord Hospital OB-GYN	Y
Dartmouth-Hitchcock Concord OB-GYN	Y
Riverbend Community Mental Health	Y
HOPE for NH Recovery	Y

D-6. IDN Community Project: Standard Assessment Tools

The Assessment and Screening tool(s) that will be used for the IDN Community Project.

Name	Brief Description
Core Standardized Assessment (CSA)	To include: Functional Status (Activities of Daily Living), Medical Conditions/Diagnoses, Demographics Substance Use, Housing, Family and Other Support Services, Education, Employment and Entitlement Status, Legal, and Suicide and Behavior Health Risk Assessment (PHQ2 & 9)
Screening, Brief Intervention, and Referral to Treatment (SBIRT)	SBIRT is an evidence-based practice used to identify, reduce, and prevent problematic use, misuse, and dependence on alcohol and illicit drugs.
Drug Abuse Screen Test (DAST-10)	DAST-10 yields a quantitative index of the degree of consequences related to drug abuse. The instrument takes approximately 5 minutes to administer and may be given in either a self-report or interview format. The DAST may be used in a variety of settings to provide a quick index of drug abuse problems.
Alcohol Use Disorders Identification Test (AUDIT-C)	AUDIT-C is an alcohol screen that can help identify patients who are hazardous drinkers or have active alcohol use disorders (including alcohol abuse or dependence)
American Society of Addiction Medicine (ASAM) Treatment Criteria	ASAM Placement criteria provides a guide to assist in matching patients to appropriate treatment settings. Adolescent and adult treatment criteria are unique. The criteria rest on the concept of enhancing the use of multidimensional assessments in placement decisions in specified levels of care, which exist along a continuum.

Name	Brief Description
Clinical Opiate Withdrawal Scale (COWS)	COWS is an 11-item scale designed to be administered by a clinician to reproducibly rate common signs and symptoms of opiate withdrawal and monitor these symptoms over time. The summed score for the complete scale can be used to help clinicians determine the stage or severity of opiate withdrawal.
Institute for Health and Recovery's Integrated 5 Ps Screening Tool	Based on Dr. Hope Ewing's 4 P's (Parents, Partner, Past, and Pregnancy) and designed specifically for pregnant women, this tool adds Present to include "Past and Present problems with alcohol or substances."

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

List of all protocols to be utilized for patient assessment, treatment, management, and referrals for the community project.

Protocol Name	Brief Description	Use (Current/Under Development)
NH Board of Medicine Opioid Prescribing Rules	Final rules for opioid prescribing for the management or treatment of non-cancer and non-terminal pain, as well as requirements to use the state prescription drug monitoring program (PDMP).	Current
42 CFR part 2 Agreements	To be signed by patients	Under development
MAT and PAT Workflows	Clinical workflows for administering MAT & PAT	Under development
NH Infant Safe Plan of Care	NH Division for Children, Youth and Families (DCYF) and the NH Division of Public Health Services document to satisfy the "Safe Plan of Care" for all infants born affected by substance abuse symptoms, withdrawal symptoms, or a Fetal Alcohol Spectrum Disorder mandate.	In use in beta form
MAT Adherence and Prevention of Diversion	Developed as recommendations by Concord Hospital Addiction Physician	Use

Protocol Name	Brief Description	Use (Current/Under Development)
MAT Discharge or Transfer of Care	Developed as recommendations by Concord Hospital Addiction Physician	Use
MAT Continued Substance Use While in Treatment	Developed as recommendations by Concord Hospital Addiction Physician	Use
MAT Vivitrol Work Instructions	Developed as recommendations by Concord Hospital Addiction Physician	Use
MAT Considerations for Special Populations and Situations	Developed as recommendations by Concord Hospital Addiction Physician	Use
MAT Weaning Buprenorphine	Developed as recommendations by Concord Hospital Addiction Physician	Use
MAT Urine Drug Testing	Developed as recommendations by Concord Hospital Addiction Physician	Use
MAT Induction of Buprenorphine (New)	Developed as recommendations by Concord Hospital Addiction Physician	Use
MAT Prescription Drug Monitoring Program	Developed as recommendations by Concord Hospital Addiction Physician	Use
HIT protocols	Related to privacy, confidentiality, and data sharing	Under development

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

Team members and their roles and responsibilities for the project.

Project Team Member	Roles and Responsibilities
MAT Provider in PCP Office	Provide MAT, collect data, attend case reviews, utilize mentors; Member of Core Integration Team
MAT Provider Mentor	Provide mentoring support including phone and in-person consultation, shadowing opportunities, and induction assistance; Lead case reviews
Medical Assistant	Supports mentors; Assists in the examination and treatment of patients and is able to independently perform specific treatments and procedures under the direction of a provider.
Addictions Nurse	Support for CHMG MAT Mentor and any staff throughout CHMG who request support and guidance.
OB-GYN MAT Provider	Provided MAT for pregnant women who are addicted to opioids; works closely with behavioral health clinician to provide services to meet the patient’s level of need.

Project Team Member	Roles and Responsibilities
Behavioral Health Clinician	Provide behavioral health support and referrals for pregnant women receiving MAT
INTEGRATION IBHC	Provide assessments & referrals, clinical support to MAT PCP, and behavioral health support and referrals for MAT patients; Act as primary point person for follow up of referrals for patients in MAT program

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

NH Buprenorphine Waiver Training	When a PCP agrees to participate in the MAT project - No less than 10 by Dec. 31, 2020	To obtain the waiver to prescribe, physicians are required to take eight hours of training. Following trainings, physicians who have successfully completed the course, may apply to the Substance Abuse and Mental Health Administration (SAMHSA) to obtain the waiver. These trainings are available free of charge through the Providers Clinical Support System (PCSS).
NP and PA 24-hour training requirement established by the Comprehensive Addiction and Recovery Act (CARA).	When a PCP agrees to participate in the MAT project - No less than 8 by Dec. 31, 2020	Nurse practitioners (NPs) and physician assistants (Pas) who take the 8-hour MAT waiver course will receive a certificate of completion and can apply it toward the 24-hour training requirement. These additional trainings are available free of charge through the Providers Clinical Support System (PCSS).
“Didactic Call-In”	Monthly meetings with an attendance of at least 12	With MAT mentors and subject matter experts (SME). The subject list includes Prescribing FAQs: dose, type, side effects, prior authorization, and etc.; Motivational Interviewing; Counseling strategies (IBHCs); 12 step introduction and discussion; Consent; Urine drug testing; Vivitrol/naltrexone; and Other substances (e.g. gabapentin, benzos, clonidine, anti-psychotics).
FACE-UP forum	Monthly meetings with an attendance of at least 12	Ongoing forum at CH for anyone in the hospital or IDN including physicians, RNs, social workers, and etc. to come discuss cases or situations which involve patients with substance use disorders. The “FACE” portion of the name stands for “Framing Addiction Care Effectively” and the “UP” portion is alternately “Utilizing Best Practices”, “Undoing Prejudice”, and “Understanding Pathways”. The last presentation was on harm reduction and was attended by the IBHCs.
Opioid specific meeting	Monthly meetings with an attendance of at least 12	Existing meeting of pharmacists, supervising RNs, providers, and senior leadership at CH to educate around prescribing opioids as well as other potentially addicting medications.

IBHC and PC providers will also receive cross training in chronic medical and behavioral health issues through the Integration project.

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

DHHS will use a tool below to assess each IDN's Community Projects activities.

Projects E: Integration Focused

E5: Enhanced Care Coordination for High Need Populations

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

In alignment with the Standard Terms and Conditions (STCs) published by NH DHHS, Region 2's Enhanced Care Coordination (ECC) for High-Need Populations is intended to maintain or improve functional status, increase capacity to self-manage conditions, eliminate unnecessary clinical testing, address the social determinants creating barriers to health improvement, and reduce the need for acute care services among the populations it serves.

The Region 2 ECC project will hire three Enhanced Care Coordinators and provide NH Wraparound and RENEW service to at least 81 children/adolescents/young adults over the life of the project. These are the unduplicated service numbers, by year:

YEARS	0-5 Wraparound	6-17 Wraparound	15-22 RENEW	TOTALS
Sept-Dec 2017	3	3	3	9
Jan-Dec 2018	9	9	10	28
Jan-Dec 2019	7	7	8	22
Jan-Dec 2020	7	7	8	22
TOTALS	26	26	29	81

Because Region 2 IDN has chosen two systems approach models, approximately 324 individuals, inclusive of the family members of these 81 young people, will meet the intended goals of the project. Generations of these families will also be impacted. An additional 200 individuals (50 per year), who are not found eligible for the ECC project, will be referred to applicable community supports and services offered by IDN partners.

Based on needs assessments, organizational capacities, and the desire to coordinate closely between all three community projects, Region 2 defined the **high need population** as Medicaid recipients, living in the region or going to a primary care or community mental health provider in the region, and:

Children 0-5 who are born substance exposed or whose birth mother is receiving/did receive perinatal addiction treatment (PAT) or who has a diagnosable serious emotional disturbance (SED) or is eligible for Family Centered Early Supports and Services and who meet one of the following criteria:

- diagnosed chronic physical health issue
- primary caregiver is diagnosed with serious mental illness (SMI)
- primary caregiver has a substance use history
- primary care giver is a victim of domestic abuse
- family has a significant social risk factor such as homelessness.

Children/Adolescents 6-18 with a diagnosable serious emotional disturbance (SED) and who meet two of the following criteria:

- identified co-occurring substance use disorder (COD)

- diagnosed chronic medical issue
- psychiatric hospitalization in the past 12 months
- has juvenile justice involvement
- has a history of trauma
- is experiencing significant problems in school (suspensions, absences, academic failure)
- is experiencing significant social factors that are barriers to wellbeing
- primary caregiver has SMI, significant substance abuse history, or is a victim of domestic violence

Adolescents/Young Adults 15-22 with SED or Serious Mental Illness (SMI) and who meet two of the following criteria:

- discharging from Sununu Youth Services
- identified co-occurring substance use disorder (COD)
- diagnosed chronic medical issue
- psychiatric hospitalization in the past 12 months
- has juvenile justice involvement
- has a history of trauma
- is experiencing significant problems in school (suspensions, absences, academic failure)
- is experiencing significant social factors that are barriers to wellbeing
- primary caregiver has SMI, significant substance abuse history, or is a victim of domestic violence

The 0-5 EC Coordinator will be hired, supervised, and housed at Children, Family & Services (CFS) and trained in the NH Wraparound model of care. The 6-18 and 15-22 EC Coordinators will be hired, supervised, and housed at Riverbend Community Mental Health, Inc. (Riverbend) and trained in the NH Wraparound and NH RENEW models of care. All three EC Coordinators will receive ongoing coaching and meet regularly with others across the state implementing NH Wraparound and RENEW.

Riverbend's Children's Intervention Program (ChIP) will provide intake services and make appropriate referrals to an EC Coordinator or to IDN community based organizations offering appropriate supports and services.

Concord Hospital Medical Group, NH Hospital, and Sununu Youth Services will each partner with the ECC project to identify, refer, and assist with transitions from facility to community for youth and families served by the project. The Region 2 MAT/PAT and Reentry projects will also be involved in making referrals and assisting with transitions.

NAMI NH and HOPE for NH Recovery will provide family education and peer support.

The HIT project will work on data collection mechanisms, shared care plans, and secure messaging to support the project. The HIT project will also assess the metrics from each IDN 2 project and if any HER work is needed to capture discreet information; or if no HER is present, a method to collect the data will be evaluated. A reporting schedule will then be developed.

These are the objectives:

- University of NH’s Institute on Disability (IOD) will train and coach three Enhanced Care Coordinators in NH Wraparound and RENEW as well as participate in collecting data and evaluating fidelity measures.
- EC Coordinators will provide individualized Wraparound and RENEW planning and an expanded array of services to the highest need children, youth, adolescents, and their families in our region
- Provide family peer support and training through NAMI NH and adult peer recovery support through HOPE for NH Recovery
- Work in a closely coordinated fashion including regular team meetings, shared care plans, and secure messaging with:
 - The assigned EC Coordinator and the Director of the Anna Philbrook Center to improve transitions from NH Hospital to the community
 - Region 2’s Reentry project to improve transitions into the community from Sununu Youth Services
 - Region 2’s MAT project to provide wraparound services for women receiving Perinatal Addiction Treatment (PAT) at Concord Hospital and Dartmouth-Hitchcock Concord OB-GYN clinics and their unborn, newly born, and other children up to age 5
 - Region 2’s Integrated Care project to identify and refer children, youth, and young adults to with chronic medical conditions to the ECC project

The evaluation plan for the ECC project includes:

Outcome measures:

- # of individuals served (reporting period and cumulative) vs. projected
- Project adherence rates - (service dropout rates).
- Fidelity to evidence-supported project elements - WIFI–EZ for Wraparound, RENEW Integrity Tool (RIT) for RENEW.
- Participant satisfaction - Youth Progress Scale (YPS) for 6-22, Team Meeting Rating Scale (TMRS) for team members

ECC Timeline	
2017	
Jan - June	Implementation Plan Timeline & budget Workforce plan Projected client engagement Key organizational providers R&R for team members Clinical Services Infrastructure Define target population Assessment tools Protocols, Processes, & Workflow Training plan & curricula Agreements Evaluation plan Hire EC Supervisors

July - Dec	Hire 3 EC Coordinators Operationalize Program (develop forms, protocols, referral process, workflow) Training in Wraparound (2 staff + 2 sup) and Renew (1 staff + 1 sup) Initiate data reporting Project budget review for 2018 Develop monitoring and improvement team Employ rapid cycle evaluation Participate in semi-annual report writing
2018	
Jan - June	Monthly progress and data reporting Monitor project Employ rapid cycle evaluation Participate in semi-annual report writing
July - Dec	Monthly progress and data reporting Monitor project Employ rapid cycle evaluation Project budget review for 2018 Participate in semi-annual report writing

E-2. IDN Community Project: Evaluation Project Targets

List all of the measurable targets or goals, that the program intends to achieve.

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
Individuals served over the life of the project	81			
Adherence rates	57			
The following measures are individualized against each child's baseline				
Child or youth stays remains at home	Improvement			
Fewer hospitalizations	Improvement			
Prevention of residential placement	Improvement			
Improved academic performance in school	Improvement			
Improved school attendance with peers	Improvement			
Fewer suspensions or office write ups at school	Improvement			
Fewer (no) instances of re-offending	Improvement			
Improved behavioral health indicators (CANS for children and youth) or improved performance on developmental screening/assessment for 0-5 (Ages & Stages).	Improvement			

E-3. IDN Community Project: Workforce Staffing

Provider Type	IDN Workforce (FTEs)				
	Projected Total Need	Baseline Staffing on 6/30/17	Staffing on 12/31/17	Staffing on 6/30/18	Staffing on 12/31/18
Enhanced Care Coordinators	3	0			

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
ECC Supervisors	2	2			

E-4. IDN Community Project: Budget

ECC	2017	2018	2019	2020
Enhanced Care Coordinator (3) 100% FTE	\$110,562	\$221,124	\$221,124	\$221,124
Supervisors 20% FTE	\$20,080	\$24,096	\$24,096	\$24,096
Wraparound & Renew Training & Coaching	\$9,000	\$15,000	\$15,000	\$15,000
Travel	\$1,000	\$2,500	\$2,500	\$2,500
Flex Funds	\$12,000	\$36,000	\$28,000	\$28,000
ECC Total	\$152,642	\$298,720	\$290,720	\$290,720

This budget is augmented with technology, office supplies, training, travel, administrative, and peer budgets. Please see full five-year budget with PPI document.

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

The key organizational and provider participants specifically related to this project:

Organization/Provider	Agreement Executed (Y/N)
Riverbend Community Mental Health	Y
Child and Family Services	Y
Hope for NH Recovery	Y
NH Hospital Anna Philbrook Center (NHH APC)	Y
Sununu Youth Services	Y
Concord Hospital Medical Group (CHMG)	Y
Institute on Disability (IOD) at the University of NH	Y

E-6. IDN Community Project: Standard Assessment Tools

The Assessment and Screening tool(s) that will be developed and/or used for the project:

Standard Assessment Tool Name	Brief Description
Child and Adolescent Needs and Strengths (CANS)	Multi-purpose tool developed for children's services to support decision making, including level of care and service planning, to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services. Will be used by ECC Coordinators.
Ages & Stages Questionnaire (ASQ)	ASQ screens and assesses the developmental performance of children in the areas of communication, gross motor skills, fine motor skills, problem solving, and personal-social skills. It is used to identify children that would benefit from in-depth evaluation for developmental delays.

RENEW Strengths and NEEDS Checklist	List of factors associated with a high risk of failing to make a successful transition to adult life, and protective factors that are helpful despite the challenges. To be used by Sununu Youth Services
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E-7. IDN Community Project: Protocols for Patient Assessment, Treatment, Management, and Referrals

All protocols to be utilized for patient assessment, treatment, management, and referrals for the project:

Protocol Name	Brief Description	Use (Current/Under development)
Intake and Needs Based Eligibility Form	Used to determine eligibility for services	Under development
RENEW Process Checklist	To be used with RENEW	Will be used after hire and training of ECC RENEW Coordinator
RENEW Integrity Tool	Used by RENEW Coach and Facilitator as primary fidelity of implementation assessment	Is administered 3 months after enrollment and then every 6 months
Wraparound Coaching Model	To be used with Wraparound program	Will be used after hire and training of ECC Youth Coordinators
NH Wraparound Framework	To be used with youth 0-17	Will be used after hire and training of ECC Youth Coordinators
System of Care (SOC) Model	A spectrum of effective, community-based supports, that is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs, in order to help them to succeed at home, in school, in the community, and throughout life.	Will be imbued throughout the program through training, practice, and collaboration with NH's Statewide SOC.
Wraparound Plan of Care Coaching Tool	Primary Tool for measuring fidelity of implementation	No later than 3-4 months after first Wraparound Team meeting

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

Team members and their roles and responsibilities for the project:

Project Team Member	Roles and Responsibilities
[REDACTED]	Supervision of CFS ECC staff
[REDACTED]	Screen and triage all ECC referrals, supervision of Riverbend ECC staff
EC Coordinators (TBH)	Provide wraparound and renew services

Project Team Member	Roles and Responsibilities
[REDACTED] UNH	Training & Coaching for Wraparound and Renew

E-9. Training plan and curricula

NH Wraparound training - 2 EC Coordinators and 2 Supervisors - August 2017

NH Renew training - 1 EC Coordinator and 1 Supervisor - September 2017

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

DHHS will use a tool to assess each IDN's Community Projects activities.

ⁱ New Hampshire Building Capacity for Transformation Section 1115(a) Medicaid Demonstration, dated July 20, 2016; Attachment C: DSRIP Planning Protocol, page 65.

ⁱⁱ New Hampshire Building Capacity for Transformation Section 1115(a) Medicaid Demonstration, dated July 20, 2016; Attachment C: DSRIP Planning Protocol, page 68.

ⁱⁱⁱ New Hampshire Building Capacity for Transformation Section 1115(a) Medicaid Demonstration, dated July 20, 2016; Attachment C: DSRIP Planning Protocol, page 67.

^{iv} <https://www.healthit.gov/standards-advisory/2016>

^v <http://www.integration.samhsa.gov/clinical-practice/screening-tools>

^{vi} <http://www.rwjf.org/en/library/research/2010/01/a-new-way-to-talk-about-the-social-determinants-of-health.html>

^{vii} New Hampshire Building Capacity for Transformation Section 1115(a) Medicaid Demonstration, dated July 20, 2016; Attachment C: DSRIP Planning Protocol, page 63.

^{viii} New Hampshire Building Capacity for Transformation Section 1115(a) Medicaid Demonstration, dated July 20, 2016; Attachment C: DSRIP Planning Protocol, page 69.

ADULT NEEDS & STRENGTHS ASSESSMENT (ANSA)

NEW HAMPSHIRE COMPREHENSIVE

Ages 18+

<input type="checkbox"/> Eligibility Effective Date: _____	Eligibility End Date: _____
<input type="checkbox"/> 90-Day ISP Review Dates	From: _____ To: _____

PLEASE USE "EXTENSION MODULES" TO FURTHER ASSESS *ITALICIZED* ITEMS.

MENTAL HEALTH NEEDS				
ITEM RATINGS:	0=No Evidence	1=Watch/Prevent	2=Act	3=Act Immediately/Intensively
Item	Level	Rating:	Comments:	
Psychosis	N/A			
<i>Cognition</i> ¹	N/A			
Impulse Control	N/A			
Depression	N/A			
Mania	N/A			
Anxiety	N/A			
Personality Disorder	N/A			
Antisocial Behavior	N/A			
<i>Adjustment to Trauma</i> ^{2s}	N/A			
Anger Control	N/A			
<i>Substance Use</i> ³	N/A			
Eating Disturbance	N/A			
Autism Spectrum	N/A			

LIFE FUNCTIONING				
RATINGS:	0=No Evidence	1=Watch/Prevent	2=Act	3=Act Immediately/Intensively
Item	Level	Rating:	Comments:	
Physical/Medical	B			
Intellectual Functioning	N/A			
Communication	A			
Family	N/A			
<i>Employment</i> ⁴	Employment			
<i>Cultural</i> ⁵	N/A			
Social Functioning	A			
Caregiving Role	B			
Intimate Relationships	A			
Sexuality	N/A			
Living Skills	A			
Residential Stability	A			
Legal	N/A			
Sleep	A			
ADLs/Self Care	A			
Decision-making	A			
Medication Adherence	Medication			
Transportation	N/A			
Financial Resources	N/A			
Isolation	A			

ADULT NEEDS & STRENGTHS ASSESSMENT (ANSA)

NEW HAMPSHIRE COMPREHENSIVE

Ages 18+

RISK BEHAVIORS				
RATINGS:	0=No Evidence	1=Watch/Prevent	2=Act	3=Act Immediately/Intensively
Item	Level	Rating	Comments:	
Agitation	C			
Self Injurious Behavior	C			
Other Self Harm	C			
Wandering	C			
Gambling	N/A			
Exploitation	C			
Criminal Behavior	N/A			
<i>Suicide</i> ⁶	C			
<i>Danger to Others</i> ⁷	C			
<i>Sexual Aggression</i> ⁸	C			

STRENGTHS			
0=Centerpiece	1=Useful	2=Identified	3=Not yet identified
Item	Level	Rating	Comments:
Family	N/A		
Social Connectedness	N/A		
Optimism	N/A		
Involvement in Recovery	N/A		
Educational	N/A		
Job History	N/A		
Talents/Interests	N/A		
Leisure Activities	N/A		
Meaningfulness	N/A		
Spiritual/Religious	N/A		
Community Strengths	N/A		
Volunteering	N/A		
Natural Supports	N/A		
Resiliency	N/A		
Resourcefulness	N/A		

CAREGIVER(S) STRENGTHS & NEEDS			
0=No Evidence	1= Watch/Prevent	2= Act	3= Act Immediately/Intensively
Item	Level	Rating	Comments:
Physical/Behavioral	N/A		
Involvement	N/A		
Knowledge	N/A		
Social Resources	N/A		
Family Stress	N/A		
Adult Protection	N/A		
Paid Caregiver	N/A		

ADULT NEEDS & STRENGTHS ASSESSMENT (ANSA)**NEW HAMPSHIRE COMPREHENSIVE**

Ages 18+

EXTENSION MODULES*Extension modules are required for any italicized items with ratings >0.***MODULE 1: COGNITION**

RATINGS:		0=No Evidence	1=Watch/Prevent	2=Act	3=Act Immediately/Intensively
Item	Level	Rating	Comments:		
Memory	N/A				
Planning	N/A				
Visual-Spatial Abilities	N/A				
Motor Skills	N/A				

MODULE 2: TRAUMA

RATINGS:		0=No Evidence	1=Watch/Prevent	2=Act	3=Act Immediately/Intensively
Item	Level	Rating	Comments:		
Sexual Abuse*	N/A				
Physical Abuse	N/A				
Emotional Abuse	N/A				
Medical Trauma	N/A				
Natural Disaster	N/A				
Witness to Family Violence	N/A				
Witness to Community Violence	N/A				
Witness/Victim – Criminal Acts	N/A				
*If sexual abuse >0, complete the following					
Emotional Closeness to Perpetrator	N/A				
Frequency of Abuse	N/A				
Duration	N/A				
Force	N/A				
Reaction to Disclosure	N/A				
Adjustment					
Affect Regulation	N/A				
Intrusions	N/A				
Attachment	N/A				
Dissociation	N/A				
Hyperarousal	N/A				

MODULE 3: SUBSTANCE USE

RATINGS:		0=No Evidence	1=Watch/Prevent	2=Act	3=Act Immediately/Intensively
Item	Level	Rating	Comments:		
Severity of Use	N/A				
Duration of Use	N/A				
Stage of Recovery	N/A				
Peer Influences	N/A				
Environmental Influences	N/A				
Please specify the drug(s) of choice:					

ADULT NEEDS & STRENGTHS ASSESSMENT (ANSA)**NEW HAMPSHIRE COMPREHENSIVE**

Ages 18+

MODULE 4: EMPLOYMENT

0=No Evidence **1=Watch/Prevent** **2=Act** **3=Act Immediately/Intensively**

Item	Level	Rating	Comments:
Job Performance	N/A		
Job Attendance	N/A		
Job Relations	N/A		
Career Aspirations	N/A		
Job Skills	N/A		

MODULE 5: CULTURE

RATINGS: **0=No Evidence** **1=Watch/Prevent** **2=Act** **3=Act Immediately/Intensively**

Item	Level	Rating	Comments:
Language	N/A		
Identity	N/A		
Ritual	N/A		
Cultural Stress	N/A		

MODULE 6: SUICIDE

RATINGS: **0=No Evidence** **1=Watch/Prevent** **2=Act** **3=Act Immediately/Intensively**

Item	Level	Rating	Comments:
Suicide Risk*	N/A		
*If suicide risk >0, complete the following			
Ideation	N/A		
Intent	N/A		
Planning	N/A		
History	N/A		

ADULT NEEDS & STRENGTHS ASSESSMENT (ANSA)**NEW HAMPSHIRE COMPREHENSIVE**

Ages 18+

MODULE 7: DANGER TO OTHERS				
RATINGS:	0=No Evidence	1=Watch/Prevent	2=Act	3=Act Immediately/Intensively
Item	Level	Rating	Comments:	
Frustration Management	N/A			
Hostility	N/A			
Paranoid Thinking	N/A			
Secondary Gains from Anger	N/A			
Violent Thinking	N/A			
Aware of Potential for Violence	N/A			
Response to Consequences	N/A			
Commitment to Self-Control	N/A			
Treatment Involvement	N/A			

MODULE 8: SEXUAL AGGRESSION				
RATINGS:	0=No Evidence	1=Watch/Prevent	2=Act	3=Act Immediately/Intensively
Item	Level	Rating	Comments:	
Relationship	N/A			
Physical Force/Threat	N/A			
Planning	N/A			
Age Differential	N/A			
Type of Sex Act	N/A			
Response to Accusation	N/A			
Temporal Consistency	N/A			
History of Sexual Behavior	N/A			
Severity of Sexual Abuse	N/A			

ADULT ELIGIBILITY DETERMINATION

Diagnosis*:		Diagnostic Code:	
Eligibility Effective Date:		Eligibility End Date:	
Eligibility Determination:	<input type="checkbox"/> Severe Mental Illness (SMI) < 1 year	<input type="checkbox"/> Severe & Persistent Mental Illness (SPMI) > 1 year	<input type="checkbox"/> Low Utilizer (LU)
		<input type="checkbox"/> Presumed Eligible for 10 days	<input type="checkbox"/> Not Eligible
			<input type="checkbox"/> Waiver Requested Date Approved: ____/____/____
SMI/SPMI: An adult shall be determined by a CMHP to have a severe mental illness (SMI) or severe and persistent mental illness (SPMI) if he or she meets one of each of the following criteria, as per He-M 401.05 - .06:			
<input type="checkbox"/> Criteria I (required): Eligible <u>diagnosis</u> (e.g., schizophrenia and other psychotic disorders, mood disorders, borderline personality disorder, post-traumatic stress disorder, obsessive compulsive disorder, eating disorders, panic disorder, or dementia, where the psychiatric symptoms cause functional impairments and one or more of the followings co-morbid symptoms exist: anxiety, depression, delusions, hallucinations, or paranoia) (He-M 401.02).			
<input type="checkbox"/> Criteria II (check one): The assessment of <u>functional impairment</u> demonstrates at least 1 of the following:			
<input type="checkbox"/> A "3" rating in any Level A or Level C item			
<input type="checkbox"/> 2 or more Level A items rated >1			
<input type="checkbox"/> 1 Level A item rated >1 and 1 Level B item rated >1			
<input type="checkbox"/> A "2" rating for 1 Level A item and a rating >1 for Medication Adherence			
<input type="checkbox"/> A "2" rating for 1 Level A item and a rating >1 for Employment			
<input type="checkbox"/> 2 or more Level C items rated >1			
<u>OR</u> the following exceptions apply:			
<input type="checkbox"/> Exception: The individual does not currently meet Criteria II as a result of the use of clozaril or clozapine or as a result of close supervision such as that provided in a community residence as defined in He-M 1002.02.			
Low Utilizer (LU): An adult shall be determined by a CMHP to have a severe mental illness (SMI) or severe and persistent mental illness (SPMI) with <u>low service utilization</u> if he or she meets one of the following criteria, as per He-M 401.07:			
The adult			
<input type="checkbox"/> Has a diagnosed mental illness but no longer meets all the criteria for SPMI or SMI and receives services that are designed to prevent relapse; <u>OR</u>			
<input type="checkbox"/> Has functional impairments that are due to developmental disability or receives services primarily through another agency such as a provider for persons with developmental disabilities or New Hampshire Hospital; <u>OR</u>			
<input type="checkbox"/> Meets criteria for SPMI or SMI but has refused recommended services and for whom the CMHP is providing outreach.			

The following dated signature is only needed if an electronic signature elsewhere in the clinical record is not employed.

Staff Printed Name, Credential, Title:

Staff Signature, Credential, Title _____

Date: _____

QUARTERLY REVIEW OF THE INDIVIDUAL SERVICE PLAN

Time period covered by this review:	Start Date:	End Date:
Date of quarterly review:		
Change in Status (for the last 90 days):		
Employment Status	<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Unemployed <input type="checkbox"/> Not in labor force	
Housing Status	<input type="checkbox"/> Homeless <input type="checkbox"/> Residential Care <input type="checkbox"/> Crisis Residence <input type="checkbox"/> Institutional Setting <input type="checkbox"/> Jail <input type="checkbox"/> Private Residence – Independent Living <input type="checkbox"/> Private Residence – Dependent Living <input type="checkbox"/> Private Residence – Living Arrangement Not Available <input type="checkbox"/> Other _____	
Was the client hospitalized for any psychiatric issues in the last 90 days?	<input type="checkbox"/> Yes # days hospitalized: _____	<input type="checkbox"/> No
Individual's Goals and Objectives (for the last 90 days):		
Goal & Objectives:		
Progress: <i>Note: Please describe specific progress towards goals (i.e., Client was able to go grocery shopping without anxiety 4 out of 8 times). If there is no progress, please explain why not.</i>		
Revisions:		
Goal & Objectives:		
Progress:		
Revisions:		
Goal & Objectives:		
Progress:		
Revisions:		
Goal & Objectives:		
Progress:		
Revisions:		
Services provided in the last 90 days:		
Service	Frequency	Duration
Purpose of Service <i>Note: Please describe both the appropriateness of services being provided AND the need for a participant's continued participation in services</i>		

Attachment BI - CSA Examples

<p>Please explain why any services documented in the Individual Service Plan were not provided during the past 90 days.</p>			
<p>Change(s) to the Individual Service Plan during the reporting quarter:</p>			
<p>Eligibility Category: <input type="checkbox"/> Severe Mental Illness (SMI) <input type="checkbox"/> Severe & Persistent Mental Illness (SPMI) <input type="checkbox"/> Low Utilizer (LU)</p>			

Consumer Signature: _____ **Date:** _____

Staff Signature: _____ **Date:** _____

Physician's Signature: _____ **Date:** _____

TIER 8.3.5 CR11 Client Facesheet (test, client)

ANSA (test, client)

Client ID Voided on
DOB

Page 1 Page 2 Page 3 Page 4 Page 5 Cognition/Trauma Substance Use Employment/Culture Danger to Self/Others Sexual Aggression Diagnosis Problems Identified Invisibles

Module 6 Suicide

0 = No Evidence 1 = Watch/Prevent
2 = Act 3 = Act Immediately/Intensively

0 1 2 3 Eligibility Category

Suicide Risk N/A

Comments

Module 7 Danger to Others

0 = No Evidence 1 = Watch/Prevent
2 = Act 3 = Act Immediately/Intensively

0 1 2 3 Eligibility Category

Frustration Management N/A

Hostility N/A

Paranoid thinking N/A

Secondary Gains from Anger N/A

Violent Thinking N/A

Aware of Potential for Violence N/A

Response to Consequences N/A

Commitment to Self-Control N/A

Treatment Involvement N/A

Comments

TIER 8.3.5 CR11 Client Facesheet (test, client) ANSA (test, client)

File Edit Search Help Object

Client ID Voided on
DOB

Page 1 Page 2 Page 3 Page 4 Page 5 Cognition/Trauma Substance Use Employment/Culture Danger to Self/Others Sexual Aggression Diagnosis Problems Identified Invisibles

Module 3 Substance Use

	0	1	2	3	Eligibility Category
Severity of Use	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	N/A
Duration of Use	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	N/A
Stage of Recovery	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	N/A
Peer Influences	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	N/A
Environmental Influences	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	N/A

Specify Drug Choice

Comments

0 = No Evidence
1 = Watch/Prevent
2 = Act
3 = Act Immediately/Intensively

TIER 8.3.5 CR11 Client Facesheet (test, client) ANSA (test, client)

File Edit Search Help Object

Client ID Voided on
DOB

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Risk Behaviors

	0	1	2	3	Eligibility Category
Agitation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	C
Self Injurious Behavior	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	C
Other Self Harm	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	C
Wandering	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	C
Gambling	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	N/A
Exploitation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	C
Criminal Behavior	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	N/A
Suicide	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	C
Danger to others	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	C
Sexual Aggression	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	C

0 = No Evidence
1 = Watch/Prevent
2 = Act
3 = Act Immediately/Intensively

Comments

Client ID Voided on
 DOB

Date Name DOB Gender Race
 Staff LIPP, KATHERINE LICSW Please select appropriate use Initial Reassesemnt Transition/Discharge Quarter

Mental Health Needs

Psychosis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cognition	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Impulse Control	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Depression	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Mania	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Anxiety	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Personality Disorder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Antisocial Behavior	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Adjustment to Trauma	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Anger Control	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Substance Use	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Eating Disturbance	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Autism Spectrum	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Comments				

TIER 8.3.5 CR11 Client Facesheet (test, client)

ANSA (test, client)

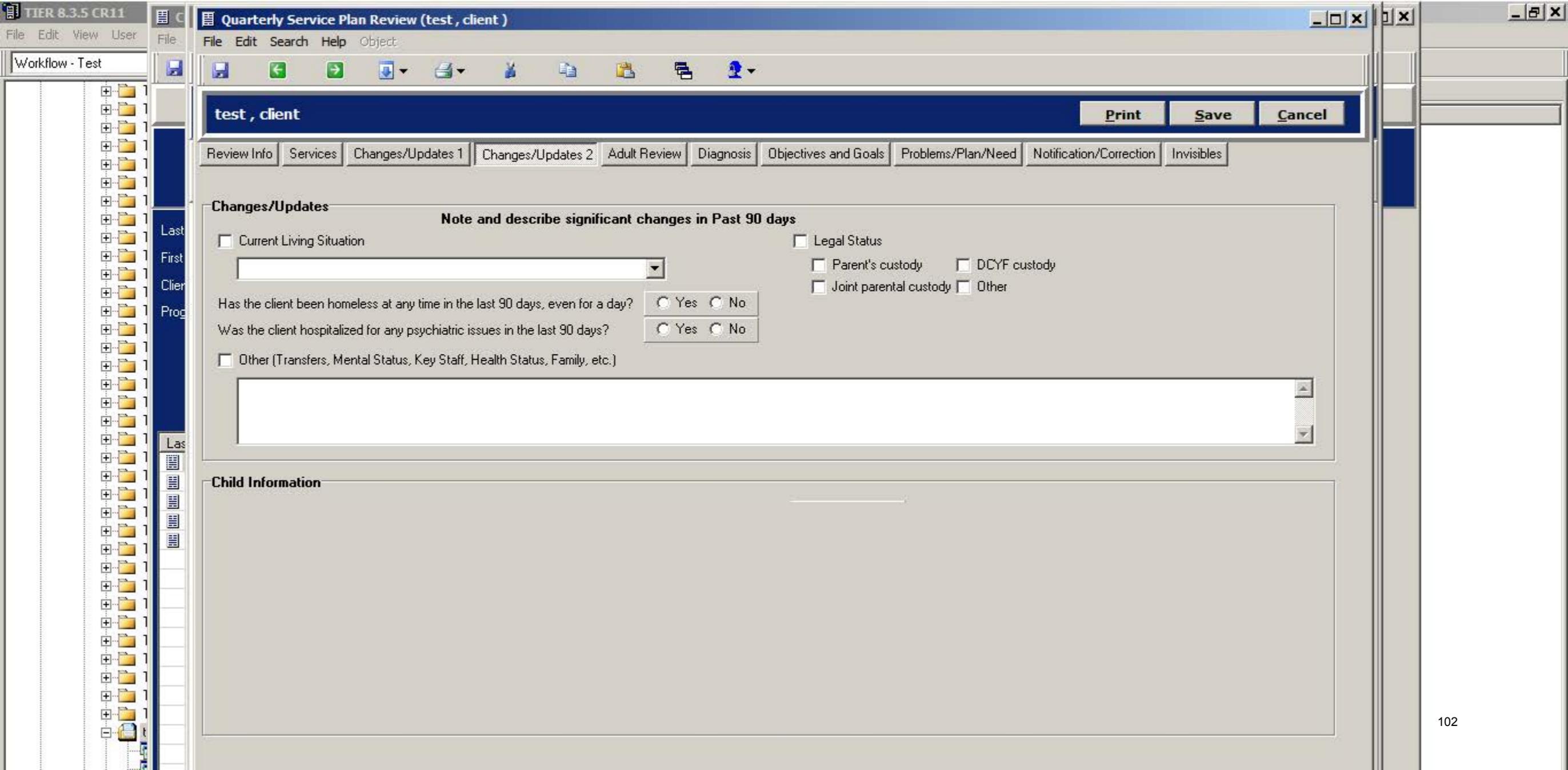
Client ID _____ Voided on _____
 DOB _____

Page 1 Page 2 Page 3 Page 4 Page 5 Cognition/Trauma Substance Use Employment/Culture Danger to Self/Others Sexual Aggression Diagnosis Problems Identified Invisibles

Strengths

	0	1	2	3	Eligibility Category
Family	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	N/A
Social Connectedness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	N/A
Optimism	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	N/A
Involvement in Recovery	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	N/A
Educational	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	N/A
Job History	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	N/A
Talents/Interests	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	N/A
Leisure activities	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	N/A
Meaningfulness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	N/A
Spiritual/Religious	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	N/A
Community Strengths	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	N/A
Volunteering	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	N/A
Natural Supports	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	N/A
Resiliency	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	N/A
Resourcefulness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	N/A
Comments					

0 = Centerpiece
 1 = Useful
 2 = Identified
 3 = Not Yet Identified



Quarterly Service Plan Review (test, client)

File Edit Search Help Object



test, client Print Save Cancel

Review Info Services Changes/Updates 1 Changes/Updates 2 Adult Review Diagnosis Objectives and Goals Problems/Plan/Need Notification/Correction Invisibles

Changes/Updates

Note and describe significant changes in Past 90 days

Current Living Situation

Legal Status

- Parent's custody DCYF custody
- Joint parental custody Other

Has the client been homeless at any time in the last 90 days, even for a day? Yes No

Was the client hospitalized for any psychiatric issues in the last 90 days? Yes No

Other (Transfers, Mental Status, Key Staff, Health Status, Family, etc.)

Child Information

TIER 8.3.5 CR11 Client Facesheet (test, client)

ANSA (test, client)

File Edit Search Help Object

Client ID Voided on
DOB

Page 1 Page 2 Page 3 Page 4 Page 5 Cognition/Trauma Substance Use Employment/Culture Danger to Self/Others Sexual Aggression Diagnosis Problems Identified Invisibles

Module 4 Employment

0 = No Evidence 1 = Watch/Prevent
2 = Act 3 = Act Immediately/Intensively

	0	1	2	3	Eligibility Category
Job Performance	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	N/A
Job Attendance	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	N/A
Job Relations	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	N/A
Career Aspirations	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	N/A
Job Skills	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	N/A

Comments

Module 5 Culture

0 = No Evidence 1 = Watch/Prevent
2 = Act 3 = Act Immediately/Intensively

	0	1	2	3	Eligibility Category
Language	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	N/A
Identity	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	N/A
Ritual	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	N/A
Cultural Stress	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	N/A

Comments

TIER 8.3.5 CR11 Client Facesheet (test , client)

File Edit Search Help Object

test , client Client ID 686365 Addendum Print Save Cancel
DOB 01/01/2000

Diagnoses/Symptoms Functional Impairments 1 Functional Impairments 2 Service Use Duration of Impairment Determination Functional Impairment Notification/Correction Invisibles

Note: When a new eligibility form is created, explanations/examples are loaded from Clinical Database. Change as needed. Functional Impairment Help

Activities of Daily Living
Activities of Daily Living (level of impairment) [dropdown] Add New

Activities of Daily Living - Significant Problems	Description, if "Other"

Explanation/Examples of Impairment [text area]

Interpersonal Functioning
Interpersonal Functioning (level of impairment) [dropdown] Add New

Interpersonal Functioning - Significant Problems	Description, if "Other"

Explanation/Examples of Impairment [text area]

808665

Riverbend Community Mental Health, Inc.

Print Date: 7/11/17

Master Treatment Plan T

Client : 686365 test , client

DOB : 01/01/2000

Effective Date of this Plan (Annual or Revision): 07/11/2017

Provider: 3948 LIPP, KATHERINE

Type: Initial

This treatment Plan is for: Adult

Eligibility Date:

Eligibility Type:

Eligibility Category:

Does client/guardian want Case Management supports ?

Yes No

Strengths: Client is motivated to improve mood and return to work.

Military Experience

Military Addendum Date: 7/11/17

Have you or a family member ever served in the military? Self Only

Branch(es) Army Navy Air Force Marines
 Coast Guard National Guard Other

Dates of Service 7/1/12 to 7/11/14

Country United States Other

Countries Assigned to: Afghanistan

/ Combat Experience Yes

Plan

1. Depression

Goal: "I want to feel better"

1.1 Client will learn and implement three new coping skills over the next three months.
 Interventions: Individual Psychotherapy Provider: Therapist Avg Freq: 1 Times
 Per: Week Avg Dur: 1:00

1.2 Client will engage in aerobic activity at least two times per week over the next three months. 7/11/17 Active 7/11/17

Interventions: FSS TBS Individual Provider: FSS InShape Avg Freq: 1 Times
 Per: Week Avg Dur: 1:00 Criterion for Discontinuing: Goal Achieved 7/11/17

1.3 Client will improve health self-management skills as evidenced by her ability to follow through with provider recommendations such as referrals, health monitoring, or tests and procedures. 7/11/17 Active 7/11/17

Interventions: RICH Medical Care Provider: RICH Primary Care Provider Avg Freq: 2 Times Per: Year Avg Dur: 0:30 Criterion for Discontinuing: Goal Achieved 7/11/17

Adult Crisis Plan

Medicare Preventive Services: SIM Lab Test

Screen Mobility **ADL** MOCA PHQ-9 UI

Show IADL scale

ADL Date of Last Patient Entered Data (ADL): 06/11/2015

Are you independent with the following activities - bathing, dressing, toileting, feeding? Yes Previous No Clear Use Pt Entered Data

View Previous or Pt Entered Data

Are you independent with the following activities - bathing? Independent Dependent

Are you independent with the following activities - dressing? Independent Dependent

Are you independent with the following activities - toileting? Independent Dependent

Are you independent with the following activities - feeding? Independent Dependent

Home environment

Are there any potential home hazards?

Instrumental Activities of Daily Living Date of Last Patient Entered Data (IADL): 06/11/2015

Print IADL scale Memory Impairment and Driving

All Independent Previous All Dependent Clear Use Pt Entered Data

View Previous or Pt Entered Data

Are you independent with the following activities?

Shopping: Independent Dependent

Transportation: Independent Dependent

Laundry: Independent Dependent

Light housework: Independent Dependent

Light meal preparation: Independent Dependent

Managing Finances: Independent Dependent

Using the telephone: Independent Dependent

Taking medications: Independent Dependent

Social Support

Who could help you in case of emergency?

Emergency contact phone number:

Geri Orders Print Caregiver Strain Survey Return to screen tab

OV2 Histories: SIM Lab Test

Hx PMH PSH FH SH OB/Gyn

(web train) Reviewed all Histories Reviewed all Histories including ob/gyn Clear

Past Medical History Reviewed, include in note (03/11/2016 8:13:53 AM) Edit PMH Reviewed, include in note

DIABETES MELLITUS- TYPE II
 DIABETES MELLITUS- TYPE II
 HYPERTENSION- BENIGN ESSENTIAL
 HYPERLIPIDEMIA

Total # CT's:

Past Surgical History Reviewed, include in note (03/11/2016 8:13:53 AM) Edit PSH Reviewed, include in note

HYPERTENSION- BENIGN ESSENTIAL

Family History Edit FH Reviewed, include in note

Patient is adopted.

Social History Edit SH Reviewed, include in note

Marital Status: Married ; Children: None ; Living Arrangement: Lives with spouse ; Education: Post graduate education ; Employment Status: Full time employment ; Occupation: CMIO
 Smoking Status: current some day smoker 27 Alcohol Use: Social drinks/day

OB/Gyn History Edit OB/Gyn Reviewed, include in note

Srvc Due
HPI
Histories
Risk
ROS
Vitals
PE
COV A/P
Pt Instr
E/M Summary
CPOE A/P

Prev Form (Ctrl+PgUp)
Next Form (Ctrl+PgDn)
Close

OV3 Risk: SIM Lab Test

Tobacco
Etoh/Drugs
Health Risk
Diet

Risk Factors

Patient: SIM Lab Test DOB: 12/07/1948, 68 Years Old Female

Date of last patient-entered data:

Smoking Status: current every day smoker ?

current some day smoker

former smoker

never smoker

smoker - current status unknown

unknown if ever smoked

Add Tobacco Use to Prob List
 Reviewed

Get Previous
Clear Previous

	Yr Started	per day	
<input type="checkbox"/> cigarettes	<input type="text"/>	<input type="text"/>	packs # Years: <input type="text"/>
	Calc Pack Years		Pack Years: <input type="text"/>
<input type="checkbox"/> cigars	<input type="text"/>	<input type="text"/>	#
<input type="checkbox"/> pipe	<input type="text"/>	<input type="text"/>	Bowls per week
<input type="checkbox"/> marijuana	<input type="text"/>	<input type="text"/>	per <input type="text"/>
<input type="checkbox"/> inhaled drugs rec	<input type="text"/>	<input type="text"/>	per <input type="text"/>

Counseled to quit/cut down: yes no

Additional Comments:

smokeless/chew

Passive smoke exposure: current previous never

of years exposed:

Passive Smoke Exposure

Additional Comments:

Counseled regarding the importance of avoiding passive smoke exposure

Methods of Smoking Cessation tried:

Smoking Cessation Program:	<input type="radio"/> Yes <input type="radio"/> No		Previous	<input type="text"/>
Nicotine Replacement:	<input type="radio"/> Yes <input type="radio"/> No			<input type="text"/>
Hypnosis/Acupuncture:	<input type="radio"/> Yes <input type="radio"/> No			<input type="text"/>
Bupropion:	<input type="radio"/> Yes <input type="radio"/> No			<input type="text"/>
Chantix:	<input type="radio"/> Yes <input type="radio"/> No			<input type="text"/>
Nortriptyline or Other TCA:	<input type="radio"/> Yes <input type="radio"/> No			<input type="text"/>
Clonidine Pill or Patch:	<input type="radio"/> Yes <input type="radio"/> No			<input type="text"/>
Other:	<input type="radio"/> Yes <input type="radio"/> No			<input type="text"/>

Prev Comment

Readiness to Change:

1. Are you thinking about stopping tobacco use? Yes No
2. Would you be interested in talking to the provider on ways? Yes No
3. Would you be willing to set a quit date after today? Yes No
4. What has happened when you tried to quit Prev.

Readiness to change stage:

Print Healthy Plan Form

Print Quitworks NH fax referral

Referred to QuitWorks-NH Quitworks NH Website

Enrollment form completed and faxed to QuitWorks-NH

Srv Due
HPI
Histories
Risk
ROS
Vitals
PE
COV A/P
Pt Instr
E/M Summary

CPOE A/P

Prev Form (Ctrl+PgUp)
Next Form (Ctrl+PgDn)
Close

OV3 Risk: SIM Lab Test

Tobacco
Etoh/Drugs
Health Risk
Diet

Alcohol use: yes no previous

Reviewed Get Previous

1 Drink = Beer (can/bottle), Wine (glass/cooler), Spirits (cocktail/shot)

Average drink(s) per day: Social Last Drink:

3+ drinks per day:

6+ drinks per day:

Type:

Has patient ever -

Felt need to cut down: yes no

Been annoyed by complaints: yes no

Felt guilty re: drinking: yes no

Needed eye opener in a.m.: yes no

Comments:

Counseled: yes no

Cage Result:

Previous Cage Result: 0 (10/25/2016 12:15:02 PM)

Get Previous

Have you ever used marijuana, cocaine, or any other recreational drugs? Yes No

If so, which drugs:

- Marijuana
- Cocaine
- Heroin
- Hallucinogens
- Stimulants
- IVDU
- pain medications
- prescription medications

Do you currently use any recreational drugs? Yes No

If so, which drugs:

- Marijuana
- Cocaine
- Heroin
- Hallucinogens
- Stimulants
- IVDU
- pain medications
- prescription medications
- Other

Counseled regarding the use of recreational drugs

Srvc Due
HPI
Histories
Risk
ROS
Vitals
PE
COV A/P
Pt Instr
E/M Summary

CPOE A/P

Prev Form (Ctrl+PgUp)
Next Form (Ctrl+PgDn)
Close

OV3 Risk: SIM Lab Test

Tobacco
Etoh/Drugs
Health Risk
Diet

Get All Previous
Clear All Previous

HIV high risk behavior: yes no

Caffeine use (drinks/day):

Exercise (times/week):

Seat Belt Use:

Does activities where helmet use is recommende Y N

Smoke detectors in home: Yes No

Firearms in home: Yes No

Sun exposure:

Have you ever used Tanning Beds or Lights?

Counseled regarding importance of Advance Directive Plar

Name of Current Dentist/Dental Provider:

Counseled Regarding the importance of flossing and brushing daily

Depression PHQ2 ? Get Prior data from 06/11/2015

Do you feel down,depressed or hopeless? yes no

Little interest or pleasure in doing things? yes no

Patient is being treated for depression

Domestic Violence

Are you concerned for your safety at home or with others? Y N

Do you feel threatened at home or with others? Y N

Have you been hit/slapped/kicked/shoved/choked at home? Y N

Patient reports no history of domestic violence

Patient reports no current domestic violence

If the patient is experiencing DV, refer to one or more of the listed resources

CH Social Services Consult
 Behavioral Health Services
 Local Law enforcement
 Domestic Violence Crisis Line: 1-800-852-3388 or 225-9000
 Refused

Additional Comments:

Screened/Counseled regarding domestic violence

Directives

PAIN MANAGEMENT CONTRACT 84 OXYCODONE EVERY 28 DAYS

Update/Add Directives

Srcv Due
HPI
Histories
Risk
ROS
Vitals
PE
COV A/P
Pt Instr
E/M Summary
CPOE A/P

Prev Form (Ctrl+PgUp)
Next Form (Ctrl+PgDn)
Close

OV3 Risk: SIM Lab Test

Tobacco Etoh/Drugs Health Risk **Diet**

Diet

Counseled to limit dietary intake of fat (<30% calories)

Counseled to limit dietary intake of cholesterol (<300 mg/day)

Counseled to limit dietary intake of sodium

Counseled to maintain caloric balance

Counseled to maximize intake of fruits; vegetables & grain products

Select All

Counseled to attain healthy weight

Counseled to increase protein intake.

Counseled to take multi-vitamin.

Referred to Nutrition Services for Dietary Consult.

History of Eating Disorder

Get Previous

Nutritional History:

Recommended Daily Calcium Intake

Adolescent/Young Adult 1200-1500m

25-50 Year Old 1000mg

Postmenopausal 1000-1500mg

One 8 ounce glass of milk contains approx. 300mg of Calcium

Advise patients who need to increase calcium intake to consume extra amounts of:

Low fat dairy: skim or 1/2% or 1% milk and nonfat yogurt

Small fish (with bones)

Tofu (bean curd)

Dark green leafy vegetables

Counseled regarding the importance of maintaining recommended a

Additional Comments:

Print Dietary Handout: **Carbs/Wgt Loss** **Calcium** **DASH Diet** **Improve Lipid** **Low Fat** **Start Wgt Loss**

Srvc Due **HPI** **Histories** **Risk** **ROS** **Vitals** **PE** **COV A/P** **Pt Instr** **E/M Summary**

CPOE A/P

POV5 Devel and Counsel 0-4: baby test

Screening Diet/Behaviors **Development** Safety Anticipatory Guidance

Development

One word III ADDITION to 'mama' or 'dada' (Ask: what words are your child saying?): Yes No

When named looks at the object: Yes No

Walks along furniture while holding on with one hand: Yes No

Pincer grasp: Yes No

Bangs toys together or plays 'Patty Cake': Yes No

Imitates dropping toy in bowl: Yes No

Finds toy hidden under cloth: Yes No

When dressing, assists by lifting foot for shoe: Yes No

Importance of literacy discussed Book Given

Additional Concerns:

Development Milestones Previously Identified as NOT Met

Fine Motor View Previous	Gross Motor View Previous	Communication View Previous
Social View Previous	Problem Solving View Previous	MCHAT View Previous

MCHAT: baby test

Modified Checklist for Autism in Toddlers (M-CHAT) / of Connecticut Department of Ps ALL "YES" ALL "NO"

1. Does your child enjoy being swung, bounced on your knee, etc.?	<input type="radio"/> YES	<input type="radio"/> NO
2. Does your child take an interest in other children?	<input type="radio"/> YES	<input type="radio"/> NO
3. Does your child like climbing on things, such as up stairs?	<input type="radio"/> YES	<input type="radio"/> NO
4. Does your child enjoy playing peek-a-boo/hide-and-seek?	<input type="radio"/> YES	<input type="radio"/> NO
5. Does your child ever pretend, for example, to talk on the phone or take care of a doll or pretend other things?	<input type="radio"/> YES	<input type="radio"/> NO
6. Does your child ever use his index finger to point, to ask for something?	<input type="radio"/> YES	<input type="radio"/> NO
7. Does your child ever use his/her index finger to point, to indicate interest in something?	<input type="radio"/> YES	<input type="radio"/> NO
8. Can your child play properly with toys (e.g., cars or bricks) without just mouthing, fiddling, or dropping them?	<input type="radio"/> YES	<input type="radio"/> NO
9. Does your child ever bring objects over to you (parent) to show you something?	<input type="radio"/> YES	<input type="radio"/> NO
10. Does your child look you in the eye for more than a second or two?	<input type="radio"/> YES	<input type="radio"/> NO
11. Does your child ever seem oversensitive to noise? (e.g., plugging ears)	<input type="radio"/> YES	<input type="radio"/> NO
12. Does your child smile in response to your face or your smile?	<input type="radio"/> YES	<input type="radio"/> NO
13. Does your child imitate you? (e.g., you make a face-will your child imitate it?)	<input type="radio"/> YES	<input type="radio"/> NO
14. Does your child respond to his/her name when you call?	<input type="radio"/> YES	<input type="radio"/> NO
15. If you point at a toy across the room, does your child look at it?	<input type="radio"/> YES	<input type="radio"/> NO
16. Does your child walk?	<input type="radio"/> YES	<input type="radio"/> NO
17. Does your child look at things you are looking at?	<input type="radio"/> YES	<input type="radio"/> NO
18. Does your child make unusual finger movements near his/her face?	<input type="radio"/> YES	<input type="radio"/> NO
19. Does your child try to attract your attention to his/her own activity?	<input type="radio"/> YES	<input type="radio"/> NO
20. Have you ever wondered if your child is deaf?	<input type="radio"/> YES	<input type="radio"/> NO
21. Does your child understand what people say?	<input type="radio"/> YES	<input type="radio"/> NO
22. Does your child sometimes stare at nothing or wander with no purpose?	<input type="radio"/> YES	<input type="radio"/> NO
23. Does your child look at your face to check your reaction when faced with something unfamiliar?	<input type="radio"/> YES	<input type="radio"/> NO

SCORE

Signed

MCHAT FAILS: CRITICAL FAILS (red questions):

A child fails the M-CHAT when 2 or more CRITICAL ITEMS are failed or when any 3 items are failed
Not all children who fail the checklist will meet criteria for a diagnosis on the autism spectrum. However, children who fail the checklist should first be evaluated in more depth by the physician or referred for a developmental evaluation with a specialist.

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If a child fails the MCHAT, the next recommended step is to do the MCHAT-R. [Launch to MCHAT-R website](#)



Integrated Center for Health

Consent for Participation in Integrated Center for Health

By enrolling in Riverbend’s Integrated Center for Health (RICH), you agree to the integration of your mental health and medical treatment. Integration means that your mental health providers work in coordination with your medical providers to provide your care. This consists of the sharing of critical information such as medication changes, new diagnoses, or lab results via phone calls, your medical record, and in-person team meetings.

If you have chosen to receive Primary Care services through RICH, you acknowledge that RICH has partnered with Concord Hospital Medical Group to provide this service. The Primary Care Provider is an employee of Concord Hospital who works in close collaboration with your team at CSP, attending team meetings, reviewing the notes that have been written in your electronic health record when appropriate, and informing your team of important medical updates. Because this provider is an employee of Concord Hospital, you acknowledge that you may receive communication, including bills, from Concord Hospital with regard to your primary care.

If you have chosen to continue to see a Primary Care Provider outside of RICH, you consent to an increased sharing of information between Riverbend and your Primary Care Provider, including biannual written updates called “Individual Wellness Reports”, which you will also receive a copy of.

Your health record will now include both mental health and medical information so that all of your providers have access to the information they need to provide your care.

Your participation in RICH is voluntary. You can choose to disenroll from RICH at any time by communicating this to your Integrated Care Manager. Your choice to disenroll will not affect the other types of treatment you receive through CSP.

Client/Guardian Signature

Date

Printed Name of Client/Guardian



RIVERBEND COMMUNITY MENTAL HEALTH, Inc.***-Parent/Guardian Annual Acknowledgements-***

Please read the following carefully. If a person or entity other than a parent is legally and financially responsible for this child, that person or entity must complete this document. "My child" refers to the child for whom the person signing this document is legally and financially responsible. If you have any questions, please discuss them with a staff member.

I CONSENT to have my child receive mental health services from Riverbend Community Mental Health, Inc. (Riverbend). I understand that I have the responsibility to actively work with my child's treatment providers and to ask questions if I need to. I understand that I have the right to receive competent oral translation of written materials if I so request. I also understand that I may terminate services at any time. I agree to contact Riverbend's Emergency Service by phone if a mental health crisis occurs and to go directly to a hospital emergency room in the event of a medical or psychiatric emergency. I understand that if my child is seen by a Riverbend Emergency Services clinician at the Concord Hospital Emergency Department, some portion of that contact may be documented in the Concord Hospital Record, and my child's PCP may have access to it.

_____ ***I Consent to Receive Services***

I UNDERSTAND that Riverbend will use my child's protected health information (PHI) to provide treatment; to secure payment for treatment and services provided to my child; and to conduct its health care operations. I understand that Riverbend will request my authorization to disclose my child's PHI for other purposes, except as required or permitted by law. I acknowledge that I have reviewed the notices on this form and have received Riverbend's Notice of Privacy Practices.

_____ ***I Have Received Riverbend's Notice of Privacy Practices***

I UNDERSTAND that under He-M 401 I have the right to request a conference for planning my child's treatment.

_____ ***I have been notified of my right to request a conference for planning my child's treatment.***

I ACCEPT responsibility to supply complete and accurate insurance information to Riverbend and to adhere to the procedures indicated in my insurance policy. I understand that if I do not adhere to such procedures I will be responsible for making full payment to Riverbend for the services which my child received. I understand that I am responsible to pay any co-payments required by my insurance at the time my child receives service. I request that payment of insurance benefits be made directly to Riverbend for services furnished to my child.

I ACCEPT responsibility to make payment to Riverbend in accordance with my Client Fee Agreement. I understand that Riverbend is not obligated to adhere to financial arrangements indicated in any divorce decree regarding payment for health care. I understand that if payment required by my Client Fee Agreement is not received within 60 days from the date of billing, Riverbend may discontinue my child's services and/or institute activity to ensure collection of the balance.

I ACCEPT responsibility to pay for any legal involvement I or my attorney or agent(s) may request from Riverbend staff, except for matters pursuant to RSA 135-C or RSA 464-A. I understand that charges for legal involvement are not discounted.

_____ ***I Accept Financial Responsibility for Treatment provided to my child.***

Riverbend may wish to contact me about whether or not I would like my child to participate in a research study. I understand that I will have the opportunity to agree or decline participation in any research and that my child's treatment will not be affected by my decision to participate or not participate in any research.

_____ ***I DO*** _____ ***I DO NOT*** ***wish to be contacted regarding research.***

Please **PRINT** Name of Client Here: _____

Signature of Parent/Guardian: _____ Date: _____

Witness: _____ Date: _____

QA 11/97; 12/01; 4/03, 6/03, 1/05, 1/08, 10/09, 5/12, 6/14, 4/15, 1/17

RIVERBEND COMMUNITY MENTAL HEALTH, Inc.

ADULT-ELDER CONSENT FORM ATTACHMENT

Information About the Service Planning Process

In the State of New Hampshire there are regulations that help assure that excellent services are available, offered, and delivered to adults who are diagnosed with a serious mental illness. The State regulation that specifically pertains to service planning is He-M 401. It lays out timelines for the process, along with the rights and responsibilities of the people involved.

Service planning is intended to be a collaborative and inclusive enterprise. Every adult, and every guardian of an adult who is served at Riverbend, is encouraged and expected to participate actively in that process and to include other individuals whom they would like to have involved.

You are being given this notice so that you can be fully informed about your rights and responsibilities, as you move forward in setting goals and planning for your services, or, if you are a guardian, for services for your ward. You have the right and the power to choose one of the following two methods for developing an individual service plan:

1. You may choose a formal, Client-Centered Conference. This option is a meeting held at a mutually convenient time and place with the psychiatrist and other involved persons as approved by you, such as family members; staff members; representatives of other, involved agencies (such as voc rehab); friends; an attorney or legal representative; a peer advocate; and/or others with relevant knowledge or expertise; or
2. You may choose a less formal method that includes one or more one-on-one or small group meetings with the psychiatrist, and/or other treatment providers and individuals of your choosing. These meetings may be face-to-face, by phone, or by some other effective means of communication.

You are welcome to consult with family/friends/advocates/etc. before deciding which of the above methods you want to use.

You have ten days from the day you sign the Consent Form and receive this attached notice, to make your decision.

This decision will be documented in the clinical record.

If you decide that you would like to have a formal, Client-Centered Conference please let your case manager or primary staff person know within the ten day timeframe.

If no one hears from you about your choice, staff will assume that you want to plan your services by the second method, and will be in touch with you about doing that.

QA 10/04, 1/14/05, 6/14

**AUTHORIZATION TO DISCLOSE
 PROTECTED
 HEALTH INFORMATION**

PATIENT LABEL

Patient's full name _____ Date of birth _____ Medical Record number (if known) _____

I authorize _____ to:

Send/Disclose information to: **Receive information from:**

Name: _____ Phone #: _____
 Address: _____ Fax #: _____

For the following purpose(s):

- Current treatment Personal records Insurance Workers' Compensation Attorney
 Provider transfer Other (specify): _____

Type of information requested:

Abstract (*includes any available documents below or check only those documents needed*):

- Discharge Summary Laboratory Report
 History & Physical Cardiology Report
 Consultation Radiology Report (Concord Hospital)
 Operative Report Radiology Report (Concord Imaging Ctr.)
 Emergency Dept. Documentation

Other health information:

- Physician Orders Assessments
 Progress Notes Nurses' Notes
 Radiology Films/CD Itemized Bill
 (CD may include final report) Telephone Notes
 Medication Records
 Other: _____

Dates of care to be released: _____ to: _____

I UNDERSTAND THAT:

- Concord Hospital will treat me even if I decline to sign this authorization.
- Upon request, I can inspect or obtain a copy of the information I am authorizing to be released. A fee for the costs of processing this request may be charged.
- Information disclosed under this authorization might be redisclosed by the recipient and this re-disclosure may no longer be protected by federal or state laws.
- Concord Hospital may utilize a trusted business associate to assist in fulfilling this request. If I have any questions about disclosure of my health information, I can contact the Release of Information staff of Health Information Management Services at Concord Hospital, 603-228-7312.
- I can revoke this authorization at any time by submitting a request in writing to the Concord Hospital Health Information Management Services or my provider's office. This will not apply to any previously released information. I understand that this will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

The following types of information WILL BE INCLUDED UNLESS indicated by you initialing below:

Drug and/or alcohol treatment	Initials: _____	Psychiatric	Initials: _____
Abuse/sexual abuse	Initials: _____	Genetic testing	Initials: _____
Sexually transmitted disease	Initials: _____	History of abortion	Initials: _____
HIV (AIDS) testing/treatment	Initials: _____		

This authorization expires six months from the date of signature, or on: _____

I have been offered a copy of this form.

Sign Here →

→ **Date/Time**

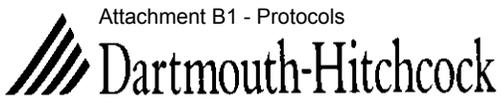
 Signature of patient or legal representative/ guardian Authority or relationship of representative

 (Attach copy of documentation of authority) Date/Time

Must be completed by hospital staff:

Date received: _____ ID verified by: _____ (Name)
 Request completed by: _____ (Name) ID method: Photo ID Personal recognition
 Date completed: _____ Demographic information match
 Delivery method: In person Mail Fax Other: _____
 Other: _____

Intake / Privacy



Attachment B1 - Protocols

MRN:

NAME:

DOB:

**Privacy Notice Acknowledgement
Consent for Treatment**

CONSENT TO TREATMENT

I consent to all treatment deemed necessary or advisable by the health care provider responsible for my care. I also understand that I have a right to be informed about all treatments given me and the right to decline any specific treatment should I so choose.

Health Care Operations: We may use and/or share your Protected Health Information (PHI) for our health care operations, which include management, planning, quality improvement activities and quality research activities that help to improve the quality and efficiency of the care that we deliver. For example, we may use your PHI to review the quality and skill of our physicians, nurses, and other health care providers or for their training. In addition, we may confidentially and securely share your PHI with outside quality improvement organizations which help us with our quality improvement and quality research activities.

ACKNOWLEDGEMENT AND CONSENT

The Dartmouth-Hitchcock Privacy Group (DHPG) Notice of Privacy Practices describes the ways in which DHPG institutions use and disclose Protected Health Information.

- I acknowledge that I have received the DHPG Notice of Privacy Practices (required by federal law), and
- I consent to DHPG's use and/or disclosure of my health information (which may include treatment for drug/alcohol abuse or mental health; HIV Status or genetic testing records, if applicable) to treat me, to obtain payment for your services, and to conduct internal health care operations, quality improvement and engage in quality research and other health care operations, as described in your Notice of Privacy Practices in accordance with federal and state law.

Signature of Patient or Personal Representative

Legal Authority of Personal Representative

Name of Patient

Printed Name of Authority / Representative

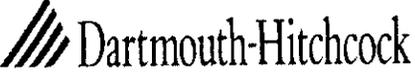
No information on file.

Date of Appointment

Department

For Internal Use only. Please check here when signature is entered into electronic system. Send original to Health Information Services Approval: 12-3-11

Intake

 Designation of Personal Representative	MRN: _____
	Name: _____
	DOB: _____

I hereby designate the following Personal Representative to assist me in exercising my health information rights under the New Hampshire Patients' Bill of Rights (NH RSA 151:19-21) and the Federal Privacy Rule (45 CFR § 164.502(g)), as indicated below.

My designated Personal Representative is: _____ Relationship: _____

Name: _____

Address: _____

Phone: _____

I request that my personal representative be allowed to assist me in exercising the following rights related to my protected health information. I understand and acknowledge that my protected health information may contain drug/alcohol abuse, mental health, HIV, and/or genetic testing information. **(please check all applicable items):**

- The right to access and obtain a copy of my medical records and other protected health information;
- The right to authorize use or disclosure of my protected health information;
- The right to request an amendment of any protected health information;
- The right to request an accounting of disclosures of my protected health information;
- The right to communicate verbally regarding my appointments;
- The right to have verbal communication with my health care team;
- The right to request a myD-H Patient Portal Proxy Access;
- Other (please specify): _____

No expiration

Expires on _____ (date)

I understand that if I no longer wish for this Personal Representative designation to be in effect, I must revoke the designation in writing to Dartmouth Hitchcock. I also understand that it is my responsibility to notify my designee that I have revoked his or her access to my protected health information.

Patient's Name

Date

Signature of Patient or Legal Guardian

Legal Guardian's Name if Applicable



 Dartmouth-Hitchcock

[Redacted]

[Redacted]

Date: January 12, 2017

RE: New Tools to Support Acute Opioid Prescribing

Following up on recent communications around opioids, the evening of January 12, we will introduce new tools in eD-H to support regulation-compliant opioid prescribing for **acute pain**:

- a) a best practice alert (BPA) which reminds you of the key steps and will link you out to...
- b) the opioid prescribing activity will contain enhancements specific to acute pain prescribing.

The new BPA will pop up during prescribing when you select a schedule II, III, IV opioid and have clicked the choice for "acute pain."

It will remind you the **4 documentation steps** the state has told us we must follow in order to comply with the new rules. It provides a link directly out to the opioid prescribing activity where you can accomplish these tasks. In order to comply with the new rules for acute opioid prescribing, you must:

1. Query the PDMP (To be done by prescriber or their delegate. The delegate must be assigned on the PDMP website)
2. Perform a risk assessment (using the opioid risk tool) (you can find a link to the tool in the Opioid Rx activity)
3. Obtain written informed consent with the Acute Opioid Therapy Consent form (you can find a link under web links → consents, in the med order or in the Opioid Rx activity)

Opioid Prescribing

Opioid Prescribing ← Previous Next →

Acute Opioid Prescribing
 New Opioid Prescribing
 Refill Opioid Prescribing

NPI/PCMP Query: New Opioid Prescribing
 Date:

VTE/PCMP Query: New Opioid Prescribing
 Date:

Risk Assessment: New Opioid Prescribing
 Category:

Acute Opioid Specific Questions New questions

Considerable abuse? New questions
 Is patient at high risk for opioid misuse/abuse? New questions
 Considered options for non-pharmacological modalities and non-opioid alternatives? New questions

Opioid Prescribing Links

[Opioid Prescribing Links](#)
[Opioid Prescribing Links](#)
[Opioid Prescribing Links](#)

Previous Home Next

Patient Level Contract:

Please note that there is a **fifth** requirement which is already built into eD-H workflow. Acute opioid prescriptions will automatically insert into the After Visit Summary certain additional information material which is required to be given to the patient; **we must ensure that the AVS is printed and given to the patient when we prescribe opioids.**

For more information, visit the Opioid Therapy intranet site located at this [link](#). We will continue to add to the Frequently Asked Questions (FAQs) as we get answers and will continue to refine our processes to meet these compliance rules.

Unhealthy Alcohol and Drug Use

Adult, Primary Care, Clinical Practice Guideline Pocket Guide

UNHEALTHY ALCOHOL AND DRUG USE GUIDELINE USE

Full Dartmouth-Hitchcock Unhealthy Alcohol and Drug Use Adult, Primary Care Clinical Practice Guideline
http://sitefinity.hitchcock.org/intranet/docs/default-source/d-h-knowledge-map-documents/uadu-guideline-final_2017.pdf?sfvrsn=8

Unhealthy Alcohol and Drug Use Adult, Primary Care Clinical Practice Guideline Brief
http://sitefinity.hitchcock.org/intranet/docs/default-source/d-h-knowledge-map-documents/sud_brief_2_6_16.pdf?sfvrsn=2

Guideline Adoption Statement Source Documents:

[MA-SBIRT \(Massachusetts Screening, Brief Intervention and Referral to Treatment\) Clinician's Toolkit](#)

[Helping Patients Who Drink Too Much: A Clinician's Guide](#)

[Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs and Health](#)

D-H Depression Management Guideline

http://sitefinity.hitchcock.org/intranet/docs/default-source/d-h-knowledge-map-documents/depression_cpg_final.pdf?sfvrsn=2

D-H Behavioral Health Integration into Primary Care Model Guideline

<http://sitefinity.hitchcock.org/intranet/docs/default-source/d-h-knowledge-map-documents/behavioral-health-integration-guideline-final.pdf?sfvrsn=2>

Definitions:

Risky Use: consumption of amounts that increase the likelihood of health consequences.

Risky Drinking¹:

For healthy men up to age 65:

- more than 4 drinks in a day or
- more than 14 drinks in a week

For all healthy women and healthy men over age 65:

- more than 3 drinks in a day or
- more than 7 drinks in a week



Copyright, citation, use, and adoption limitation/instructions:

May not be reproduced, distributed or modified for sale. May not be loaded into software platform outside of D-H in whole or in part without explicit permission.

If modified for local use, cite as:

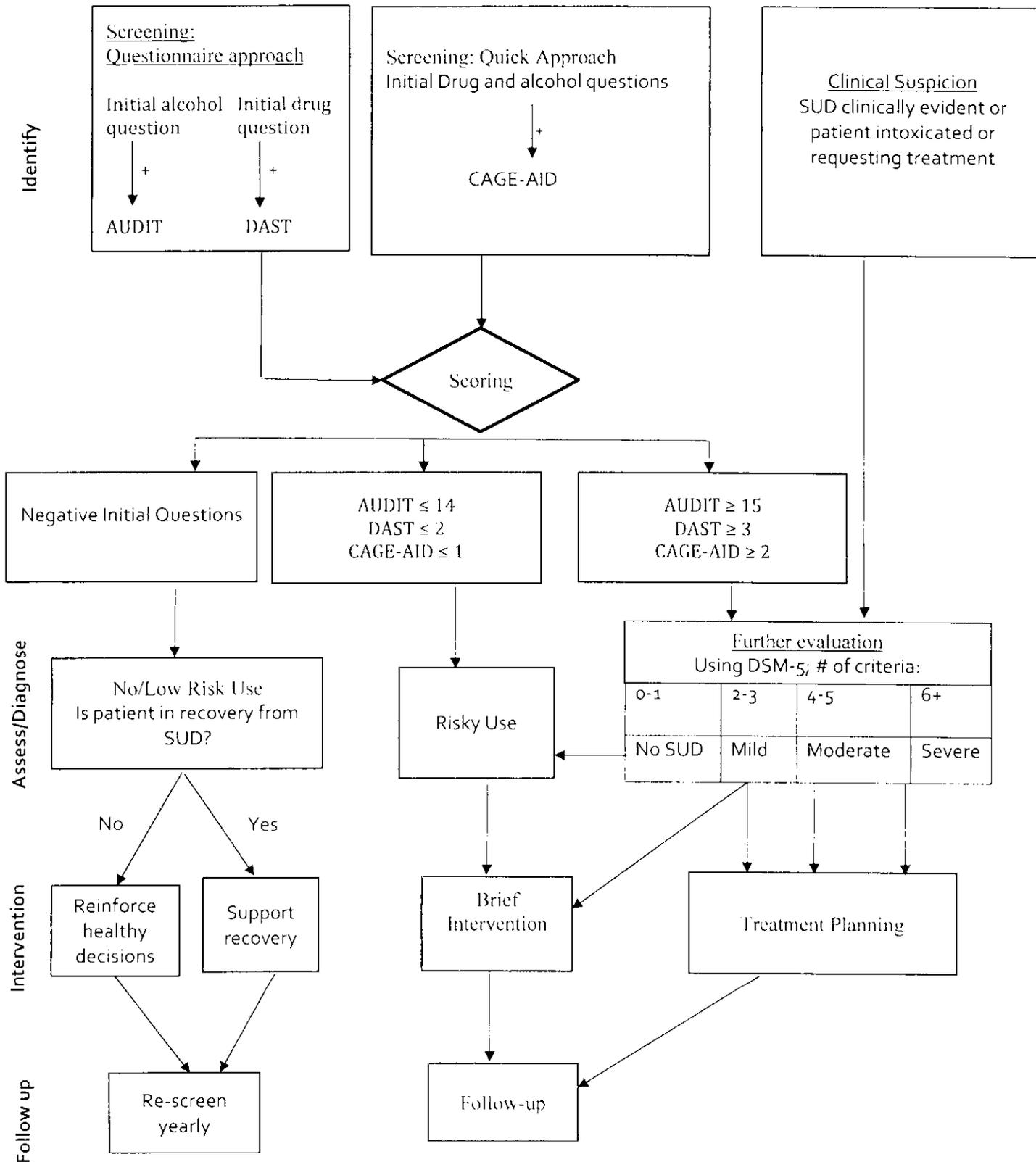
Adapted from Dartmouth-Hitchcock Knowledge Map™ Unhealthy Alcohol and Drug Use, Adult, Primary Care Clinical Practice Guideline. Copyright 2017.

Pathways & Guidelines: Clinical Practice Guideline and pathways are designed to assist clinicians by providing a framework for the evaluation and treatment of patients. This Clinical Practice Guideline outlines the preferred approach for most patients. It is not intended to replace a clinician's judgment or to establish a protocol for all patients. It is understood that some patients will not fit the clinical condition contemplated by a guideline and that a guideline will rarely establish the only appropriate approach to a problem.

Unhealthy Alcohol and Drug Use, Adult, Primary Care Clinical Practice Guideline Pocket Guide
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1

Algorithm: Recognizing and Managing Alcohol and Substance Use Disorders in Primary Care



DH Hbsp
D/C

Transitional and Chronic Care Management Codes Primary Care Service Line

Key Points

TCM

- Patient outreach call, myDH (or attempted) by nurse within 2 business days post- discharge
- Provider visit within 14 days (moderate complexity, 99495) or 7 days (high complexity) post-discharge
- Coding opportunity (99495/99496) that allows for additional billing opportunities for providers and nurses who provide services for patients who are discharged from a facility (hospital/SNF/rehab/observation)

CCM

- Identify patients meeting criteria (2+ chronic illnesses, post hospital visit)
- Coordinate goals of care with provider and patient for at least 20 minutes/month
- Document action plan

Identification

Patient Data Coordinator

- Information from facilities received daily
- Create Patient Outreach encounter (POE) with details of admission and discharge and Hospital Check visit (HCK) date if available
- Create TCM episode
- Readmission
 - a. Close previous POE encounter
 - b. Resolve TCM episode
 - c. Create new POE encounter
 - d. Create new TCM episode

Patient Outreach

Care Coordinator

- At discharge (TCM)
 - a. Run Reporting Workbench (RWB) report to ID patients who are admitted/discharged
 - b. Open POE and document using post-hospital discharge PHD template (.TCMNURSENOTE)
 - c. Introduce CCM to patient
- After hospital check visit
 - a. Run RWB report to ID consented patients
 - b. Create care plan (CCM)
 - c. Coordinate care with patient during month (at least 20 min)
 - d. Send plan to provider at end of month

Discharge from Facility

Clinical Flow

- Room patient
- Respond to BPA by linking encounter to TCM episode
- Review CCM services with patient using rack card.

Provider

- Use Template for HCK visit (.TCMPROVIDERNOTE)
- LOS speed button for billing TCM code and CCM code
- Obtain verbal consent from patient and discuss goals of care (weight loss, manage stress, increase exercise)
 - a. Click "consented" or "declined" in smart form
- Monthly, attest that there is agreement with care plan
 - a. Use smart phrase .CCMATTESTATION
 - b. Submit charge for CCM

Laliberte

DH Screenshot
for referrals

Perf

Select Referral Custom Search Recent Referrals

Patient Referral # Search Exclude auth/cert

Status: Class: Type: Service area: Decision reason: Any

Authorization number: Payor: Plan: Coverage status: Unassigned only Retro only Scheduling status:

Reason: Flags: Sensitivity: Priority:

Creation Date Service Date

From To From To

Referred To Procedure

Provider specialty Department specialty Location/POS Coded

Provider Department Vendor Free text

Diagnosis

Coded

Referred By

Provider Department Location/POS Free text

Max number returned 10 Open group

Open as read-only New Clear Cancel

Riverbend Community Mental Health, Inc. **NOTICE OF PRIVACY PRACTICES**

This notice describes how you can access your personal medical information and how we may use and disclose it to provide you with services. PLEASE REVIEW IT CAREFULLY. If you have any questions about this Notice, please contact Riverbend's Privacy Officer at (603)226-7505 x 4335 or privacy@riverbendcmhc.org.

Riverbend's Commitment to Privacy

Riverbend Community Mental Health, Inc. (Riverbend) is committed to insure the privacy and confidentiality of the personally identifiable protected health information (PHI) it creates and maintains regarding the clients that it serves. Confidence in the privacy of the sensitive information clients share with staff promotes partnership, honest and open dialogue, and facilitates appropriate clinical supports to aid the client in his or her recovery and healthy development.

Riverbend takes steps to assure that only those individuals who have a legitimate need have access to your health information to accomplish their work assignments. All staff in Riverbend's programs and offices throughout Merrimack County will follow this notice.

Riverbend is required by law to maintain the privacy of your personally identifying health information and to provide you with this Notice. We are required to comply with our current Privacy Notice. We reserve the right to change this Notice. Any revision will affect health information we already have about you as well as information we receive in the future. Any revisions to this notice will be posted in our offices and on our website and will be made available to you upon request.

How We Will Use and Disclose Your Health Information

The following describes in general different ways we may use or disclose your health information.

Treatment. We will use and disclosure your health information to provide and coordinate your health care and related services. Riverbend may disclose your health information among members of your treatment team or in programs in which you participate or to our emergency services clinicians. For example, our staff may discuss your care at a case conference.

Payment. We may use or disclose your health information so that the services you receive are billed to, and payment is collected from you, your health plan or other third party. For example, we may disclose your health information to permit your health plan to approve payment for additional visits to your therapist.

Operations. We may use and disclose health information about you as necessary to run our organization and make sure that clients receive quality care. For example, we may use or disclose your information to review the performance of our staff, train students, or develop new programs. We may combine health information of many of our consumers to decide whether new treatment approaches are effective. We may also combine health information that does not identify you with health information from other providers to compare how we are doing and see where we can make improvements.

Reminders and Follow-up. We may use and disclose your health information to contact you to remind you of your appointments or to follow up with you about your care.

Options. We may use or disclose your health information to inform you about treatment options or alternatives or health-related benefits or services that may be of interest to you. If you do not want us to provide you with such information, you must notify the Privacy Officer in writing.

Fundraising. We may use or disclose your name, address or phone number to contact you about raising money for our programs. If you do not want us to contact you for this purpose, you must notify the Privacy Officer in writing.

Business Associates. We may use or disclose your information to companies and professionals such as our accountants that assist us to run our organization. Contracts with these businesses assure that the privacy of your health information is protected.

Individuals Involved in Your Care. We may provide health information about you to someone who pays for your care. In an emergency we may use or disclose your health information to notify a family member or other person responsible for your care of your location, general condition or death. We may also use or disclose your health information to an entity assisting in disaster relief to inform your family about your condition.

Research. We may disclose your health information to researchers when you have agreed to participate in a study. We may also disclose your health information to researchers looking at medical records when adequate steps have been taken to protect the privacy of your health information and a committee for the protection of human subjects has approved the study.

Disclosure Required By Law. We will disclose health information about you when required to do so by federal, state or local law such as a court order or search warrant, or a report of abuse, neglect or exploitation.

Averting a Serious Threat to Health or Safety. We may use or disclose health information about you when necessary to prevent a serious threat to your health or safety or to the health or safety of others. For example, health information may be used or disclosed for an Involuntary Emergency Admission, to revoke a conditional discharge or to make a warning if you threaten others.

Public Health Activities. We may disclose health information about you as necessary for public health activities. For example, we may make a report to prevent or control disease or to report the abuse or neglect of a child or the abuse, neglect or exploitation of a vulnerable adult.

Health Oversight Activities. We may disclose health information about you to a state or federal health oversight agency for monitoring, licensing, auditing, inspection or investigation activities which are authorized by law.

Law Enforcement Activities. We may disclose health information to a law enforcement official for law enforcement purposes when the information is needed to identify or locate a missing person; to report a death that may be the result of criminal conduct; or to report criminal conduct occurring on our premises.

Effective 4/14/03, REV 12/07, 3/11, 6/14, 12/16

How We Will Use and Disclose Your Health Information (Continued)

Medical Examiners or Funeral Directors. We may provide health information about our clients to a medical examiner to assist in identifying deceased persons and to determine the cause of death in certain circumstances. We may also disclose health information about our clients to funeral directors as necessary to carry out their duties.

National Security. We may disclose medical information about you to authorized federal officials for intelligence and other national security activities authorized by Federal law. We may also disclose health information about you to authorized federal officials so they may conduct special investigations or protect the President or other authorized persons.

Workers' Compensation. We may disclose health information about you to comply with the state's Workers' Compensation Law.

Law Enforcement Custody. If you are in the custody of a police officer or the House of Corrections, we may disclose health information about you, such as your medications or drug allergies, to ensure your safety and continuity of treatment.

Other Uses or Disclosures you Authorize. Uses and disclosures not described in this Notice will generally only be made with your written permission, called an "authorization." You have the right to revoke an authorization at any time. If you revoke your authorization we will not make any further uses or disclosures of your health information under that authorization, except to the extent that we have already taken an action you previously authorized.

Your Rights

Right to Read and Copy. You may read or copy your health information including clinical and billing records and records from other providers included in Riverbend's records. You may submit your request to a staff member or the Privacy Officer. If you request copies, we may charge a fee for the cost of copying.

Right to Request Amendment. For as long as we keep records about you, you have the right to ask us to amend any health information used to make decisions about your care, including clinical and billing records. A request for amendment must be made in writing to Riverbend's Privacy Officer indicating what information you believe to be incorrect and why. If we grant your request, we will annotate the health information in question. Under no circumstances will we remove or destroy original documents in your clinical record.

We may deny your request if you ask us to amend health information that was not created by Riverbend, unless the person or entity that created the health information is no longer available to make the amendment; is not part of the health information we maintain to make decisions about your care; is not part of the health information that you would be permitted to inspect or copy; or is accurate and complete.

Right to an Accounting. You have the right to request that we provide you with an accounting or list of disclosures we have made after April 14, 2003, excluding disclosures you authorized or which were for treatment, payment or healthcare operations. You may submit your request in writing on a form available from our Privacy Officer. The request should state the time period for which you wish to receive an accounting, but not be longer than six years. The first accounting requested within a twelve month period will be free. For additional requests during the year, we will charge you a fee.

Right to Request Restrictions. You have the right to request a restriction on the health information we use or disclose about you for treatment, payment or health care operations. You may also ask that any part (or all) of your health information not be disclosed to family members or friends who may be involved in your care. You may request the restriction in writing to the Privacy Officer. ***We are not required to agree to a restriction that you may request.*** If we do agree, we will honor your request unless the restricted health information is needed to provide you with emergency treatment.

Right to Alternative or Confidential Communications. We will normally communicate with you in person, by phone or by first class mail. We will accommodate all reasonable requests that we communicate with you only in a certain location or method. For example, you may request that we contact you only at work or by e-mail. You may request such manner of communication in writing to a staff member or the Privacy Officer.

Right to a Paper Copy of this Notice. You can obtain a paper copy of this Notice of Privacy Practices at any time by contacting our Privacy Officer.

Confidentiality of Substance Abuse Records.

For individuals who have received treatment, diagnosis or referral treatment from our drug or alcohol abuse programs, the confidentiality of records of such programs is protected by Federal law and regulations.

Retention of Protected Health Information.

Riverbend retains client records for at least 7 years following the termination of services, unless the client was a minor during the time he/she received services in which case Riverbend retains records for at least 20 years following the client's 18th birthday. Retained records may be kept in their original format or may be transferred and stored on electronic media. Following the expiration of the retention period Riverbend may absolutely destroy all files, notes, evaluations and other client data without further notice to the client.

Questions, Concerns or Complaints.

If you have a question or believe your privacy rights have been violated you may request clarification or file a complaint with us or with the Secretary of the U.S. Department of Health and Human Services. Riverbend's Privacy Officer will assist you with your complaint, if you request such assistance. ***We will not retaliate against you for filing a complaint.***

Privacy Officer
Riverbend CMHC, Inc.
PO Box 2032
Concord, NH 03302-2032
(603) 228-1551
or 226-7505 x 4335

Consumer/Family Liaison
Riverbend CMHC, Inc.
PO Box 2032
Concord, NH 03302-2032
(603) 228-1551
or 226-7505 x 4336

Secretary, Dept of HHS
US Dept of HHS
Office of Civil Rights
200 Independence Ave SW
Rm 515 F HHH Bldg
Washington DC 20201

Effective 4/14/03, REV 12/07, 3/11, 6/14, 12/16

RIVERBEND COMMUNITY MENTAL HEALTH, Inc.

ADULT-ELDER CONSENT FORM ATTACHMENT

Information About the Service Planning Process

In the State of New Hampshire there are regulations that help assure that excellent services are available, offered, and delivered to adults who are diagnosed with a serious mental illness. The State regulation that specifically pertains to service planning is He-M 401. It lays out timelines for the process, along with the rights and responsibilities of the people involved.

Service planning is intended to be a collaborative and inclusive enterprise. Every adult, and every guardian of an adult who is served at Riverbend, is encouraged and expected to participate actively in that process and to include other individuals whom they would like to have involved.

You are being given this notice so that you can be fully informed about your rights and responsibilities, as you move forward in setting goals and planning for your services, or, if you are a guardian, for services for your ward. You have the right and the power to choose one of the following two methods for developing an individual service plan:

1. You may choose a formal, Client-Centered Conference. This option is a meeting held at a mutually convenient time and place with the psychiatrist and other involved persons as approved by you, such as family members; staff members; representatives of other, involved agencies (such as voc rehab); friends; an attorney or legal representative; a peer advocate; and/or others with relevant knowledge or expertise; or
2. You may choose a less formal method that includes one or more one-on-one or small group meetings with the psychiatrist, and/or other treatment providers and individuals of your choosing. These meetings may be face-to-face, by phone, or by some other effective means of communication.

You are welcome to consult with family/friends/advocates/etc. before deciding which of the above methods you want to use.

You have ten days from the day you sign the Consent Form and receive this attached notice, to make your decision.

This decision will be documented in the clinical record.

If you decide that you would like to have a formal, Client-Centered Conference please let your case manager or primary staff person know within the ten day timeframe.

If no one hears from you about your choice, staff will assume that you want to plan your services by the second method, and will be in touch with you about doing that.

QA 10/04, 1/14/05, 6/14

RIVERBEND COMMUNITY MENTAL HEALTH SERVICES, INC. Consent to Communication via E-Mail

It may be convenient and appropriate to communicate with a client, a guardian or a client's family member, or another third party via e-mail. Such communication shall not occur without the approval of the Program Director. If this means of communication is to be used the client or guardians shall be informed that communication by e-mail does not assure the protection of the confidentiality of such communications. If the client wishes to utilize communication by e-mail, the client or guardian's express written consent to communicate via e-mail shall be documented in the clinical record. If e-mail communication is authorized by the client or guardian, the staff member involved in the communication shall use the minimum necessary personally identifying information to effect the communication.

IMPORTANT NOTE: E-mail communication shall not be used in any situation in which there are clinical issues that need to be addressed or in any crisis or emergent situation, as it is quite possible that no one will receive or read an email for several days. If there is a crisis, contact must be made by means other than e-mail. Likewise, clinical issues should be discussed during a therapeutic contact and NOT via e-mail.

Name: _____ Date of Birth: _____

I would like to (please check all that apply):

- Utilize e-mail communication with my or my child/ward's treatment provider(s) at Riverbend.
- Authorize Riverbend to utilize e-mail communication with my insurance company.
- Other (please specify): _____

I am aware of the policies relevant to the use of e-mail and of the fact that the confidentiality of such communications cannot be assured. I am also aware that e-mail is not to be used in crisis or emergent situations, nor to discuss clinical issues.

My signature below (and that of my guardian, if applicable) indicates my consent to the use of e-mail communication.

Client's Signature

Date

Guardian's Signature (If Applicable)

Date

Program Director's Approval:

Program Director's Signature

Date

Please file this form in the client's chart, in the LEGAL section.

QA: 9/04, 5/06, 6/07, 6/14

RIVERBEND COMMUNITY MENTAL HEALTH, Inc.**-Client/Guardian Annual Acknowledgements-**

Please read the following carefully. If this document is being completed by a guardian on behalf of her/his adult ward, it is understood that consent is being granted on behalf of the ward. In such cases, the word "I" refers to the adult ward where it is used below, and financial responsibility, if not part of the guardianship order, does NOT fall to the guardian. If you have any questions, please discuss them with a staff member.

I CONSENT to receive mental health services from Riverbend Community Mental Health, Inc. (Riverbend). I understand that I have the responsibility to actively participate in treatment and to ask questions if I need to. I understand that I have the right to receive competent oral translation of written materials if I so request. I also understand that I may terminate services at any time. I agree to contact Riverbend's Emergency Service by phone if a mental health crisis occurs and to go directly to a hospital emergency room in the event of a medical or psychiatric emergency. I understand that if I am seen by a Riverbend Emergency Services clinician at the Concord Hospital Emergency Department, some portion of that contact may be documented in the Concord Hospital Record, and my PCP may have access to it.

I Consent to Receive Services

I UNDERSTAND that Riverbend will use my protected health information (PHI) to provide treatment; to secure payment for treatment and services provided to me; and to conduct its health care operations. I understand that Riverbend will request my authorization to disclose my PHI for other purposes, except as required or permitted by law. I acknowledge that I have reviewed the notices on this form and have received Riverbend's Notice of Privacy Practices.

I Have Received Riverbend's Notice of Privacy Practices

-For State-Eligible Adult/Elder Clients and/or Their Guardians Only-

I UNDERSTAND that as an adult receiving services governed by He-M 401 I have the right to choose from amongst different methods for planning treatment. I acknowledge that these options have been explained to me, and I am aware of my range of choices.

I Have Heard my options and I am aware that I have the right to request a client centered conference or a less formal method for developing my individual service plan.

I Have Received the written explanation of the methods for planning treatment and am aware that I need to contact the treatment team within ten (10) days if I decide I want to schedule a formal client-centered conference.

I ACCEPT responsibility to supply complete and accurate insurance information to Riverbend and to adhere to the procedures indicated in my insurance policy. I understand that if I do not adhere to such procedures I will be responsible for making full payment to Riverbend for the services which I have received. I understand that I am responsible to pay any co-payments required by my insurance at the time I receive service. I request that payment of insurance benefits be made directly to Riverbend for services furnished to me.

I ACCEPT responsibility to make payment to Riverbend in accordance with the Client Fee Agreement. I understand that Riverbend is not obligated to adhere to financial arrangements indicated in any divorce decree regarding payment for health care. I understand that if payment required by the Client Fee Agreement is not received within 60 days from the date of billing, Riverbend may discontinue my services and/or institute activity to ensure collection of the balance.

I ACCEPT responsibility to pay for any legal involvement I or my attorney or agent(s) may request from Riverbend staff, except for matters pursuant to RSA 135-C or RSA 464-A. I understand that charges for legal involvement are not discounted.

I Accept Financial Responsibility for Treatment provided to me.

Riverbend may wish to contact me about whether or not I would like to participate in a research study. I understand that I will have the opportunity to agree or decline to participate in any research and that my treatment will not be affected by the decision to participate or not participate in any research.

I DO **I DO NOT** wish to be contacted regarding research.

Please **PRINT** Name of Client Here: _____

I HAVE READ THE PRECEDING ITEMS WHICH PERTAIN TO ME OR TO THE PERSON FOR WHOM I AM RESPONSIBLE. I UNDERSTAND THESE CONDITIONS AND I AGREE TO ADHERE TO THEM.

Signature of Client/Guardian: _____ Date: _____

Witness: _____ Date: _____

QA 11/97; 12/01; 4/14/03, 6/03, 1/05, 1/08, 10/09, 5/12, 6/14, 4/15

**AUTHORIZATION TO DISCLOSE
 PROTECTED
 HEALTH INFORMATION**

PATIENT LABEL

Patient's full name _____ Date of birth _____ Medical Record number (if known) _____

I authorize _____ to:

Send/Disclose information to: **Receive information from:**

Name: _____ Phone #: _____
 Address: _____ Fax #: _____

For the following purpose(s):

- Current treatment Personal records Insurance Workers' Compensation Attorney
 Provider transfer Other (specify): _____

Type of information requested:

Abstract (*includes any available documents below or check only those documents needed*):

- Discharge Summary Laboratory Report
 History & Physical Cardiology Report
 Consultation Radiology Report (Concord Hospital)
 Operative Report Radiology Report (Concord Imaging Ctr.)
 Emergency Dept. Documentation

Other health information:

- Physician Orders Assessments
 Progress Notes Nurses' Notes
 Radiology Films/CD Itemized Bill
 (CD may include final report) Telephone Notes
 Medication Records
 Other: _____

Dates of care to be released: _____ to: _____

I UNDERSTAND THAT:

- Concord Hospital will treat me even if I decline to sign this authorization.
- Upon request, I can inspect or obtain a copy of the information I am authorizing to be released. A fee for the costs of processing this request may be charged.
- Information disclosed under this authorization might be redisclosed by the recipient and this re-disclosure may no longer be protected by federal or state laws.
- Concord Hospital may utilize a trusted business associate to assist in fulfilling this request. If I have any questions about disclosure of my health information, I can contact the Release of Information staff of Health Information Management Services at Concord Hospital, 603-228-7312.
- I can revoke this authorization at any time by submitting a request in writing to the Concord Hospital Health Information Management Services or my provider's office. This will not apply to any previously released information. I understand that this will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

The following types of information WILL BE INCLUDED UNLESS indicated by you initialing below:

Drug and/or alcohol treatment	Initials: _____	Psychiatric	Initials: _____
Abuse/sexual abuse	Initials: _____	Genetic testing	Initials: _____
Sexually transmitted disease	Initials: _____	History of abortion	Initials: _____
HIV (AIDS) testing/treatment	Initials: _____		

This authorization expires six months from the date of signature, or on: _____

I have been offered a copy of this form.

Sign Here →

→ **Date/Time**

 Signature of patient or legal representative/ guardian Authority or relationship of representative

 (Attach copy of documentation of authority) Date/Time

Must be completed by hospital staff:

Date received: _____ ID verified by: _____ (Name)
 Request completed by: _____ (Name) ID method: Photo ID Personal recognition
 Date completed: _____ Demographic information match
 Delivery method: In person Mail Fax Other: _____
 Other: _____

**TREATMENT AUTHORIZATION
AND ADMINISTRATIVE
ACKNOWLEDGMENT**

AUTHORIZATION FOR TREATMENT: I authorize my provider(s) or his/her designee(s) or consultant(s), in charge of my care at Concord Hospital, to administer any treatment deemed necessary or advisable in the diagnosis and treatment of my condition. I certify that no guarantee has been made as to the results that may be obtained.

I further authorize my provider(s) and their designee(s) to administer such anesthetics and perform such operation and procedures, as they deem necessary. I recognize that the need for prompt medical attention precludes authorization of a more detailed or specific nature before proceeding. Any tissues or parts surgically removed may be disposed of by Concord Hospital in accordance with the customary practice.

I recognize that I may withdraw this request for treatment, or any part of it, before a procedure, test, or medication is administered.

ELECTRONIC MEDICAL RECORD ACKNOWLEDGMENT: Concord Hospital primarily uses electronic medical record systems to capture medical information in both the inpatient and outpatient settings. These systems allow my information to be available to my healthcare providers and the staff at Concord Hospital, Concord Hospital Medical Group practices, and other providers who are treating me, including my primary care provider, specialty care providers, consulting providers, on-call providers, emergency/urgent care providers, hospitalists and other hospital-based providers. Concord Hospital is committed to protecting my privacy in accordance with applicable state and federal laws. A complete description of how my health information may be used and disclosed is contained in the *Concord Hospital Notice of Privacy Practices*, available to me upon request.

HEALTH CARE EDUCATION: I acknowledge that Concord Hospital is a teaching institution, and health care workers in training are important members of my health care team. I understand that trainees, under appropriate supervision, may perform or observe some of the health care services that I receive. Additionally, I understand that students may perform certain services under appropriate supervision.

PERSONAL VALUABLES: I understand that Concord Hospital is **not** responsible for my personal possessions. If I choose to keep personal belongings during my hospital stay, I may request that these items be stored in the hospital safe.

RECEIPT OF PATIENT INFORMATION: I acknowledge that I have been offered and/or provided a copy of the Patients' Bill of Rights.

ASSIGNMENT OF BENEFITS AND PAYMENT TERMS: I agree to assign to Concord Hospital, all insurance benefits otherwise payable to or on behalf of the undersigned for the services rendered. I agree that I am responsible to pay the balance owed if the insurance or personal information I have given is not true. I understand that I remain liable for all charges not covered by insurance or other benefits. I agree to pay Concord Hospital in accordance with its regular rates and terms for all services rendered. All amounts are due immediately, upon receipt of the bill for said services. In the event that the bill is not paid pursuant to these terms and the account is placed with an attorney or agency for collection, I agree to pay actual attorney's fees and cost of collection.

I understand that if I am presenting with a work-related injury, it is my responsibility to provide Concord Hospital with accurate information regarding my employer and my workers' compensation insurance. I further understand that I remain liable for all charges not covered by workers' compensation, health insurance, or other benefits.

I understand and acknowledge that many of the providers on the Concord Hospital medical staff are not employees or agents of Concord Hospital, but rather are independent contractors/treating providers who have been granted the privilege of using the Concord Hospital facilities for care and treatment of their patients. I understand and acknowledge that Concord Hospital cannot be held legally responsible or liable for the conduct of these providers. I further understand that I will be billed separately for the services provided by these providers. I agree to assign to my treating providers all insurance benefits otherwise payable for the services rendered and agree that I will be responsible for any amount not covered. I grant permission to my treating providers to release my medical records for the purpose of claims adjudication.

By signing below I acknowledge that I understand and agree to the terms set forth above.

Sign Here 

Date/Time 

Patient/Legal Guardian/Appropriate Authorizing Party Witness signature Date/Time

Patient is unable to personally authorize because: _____

Print name and relationship to patient

RIVERBEND COMMUNITY MENTAL HEALTH

Client Rights and Responsibilities

CLIENT RIGHTS

*These are rights to which State-eligible clients of Riverbend Community Mental Health are entitled.
These rights apply to all State-eligible clients of Riverbend.*

1. You have a right to be informed about your rights, and your treatment options. You have a right to be a full partner in planning and evaluating your treatment. You have a right to have your treatment providers listen to you and your concerns. At your request your primary clinician or case manager will arrange a conference with your treatment providers and other individuals of your choosing, to plan your care.
2. Services are available without regard to gender, race, color, religion, national origin, age, and degree of disability. You have the right to be treated with dignity and respect. Riverbend may suspend or terminate services if you no longer need them or if you endanger staff or peers. Riverbend may seek involuntary admission if you present a serious risk of harm to yourself or others due to mental illness.
3. Your records are available for your review. Copies may be obtained for a small fee. The confidentiality of your health care information is protected consistent with State and Federal law. Riverbend's records about you will be released only as you permit or as required or permitted by law.
 - Children's records may be reviewed and released by legal guardians. In cases of divorce, both parents have access to records if they maintain joint decision making.
 - In situations in which there are current court actions or disputes regarding decision-making responsibility, parenting schedule, or residential responsibility and a parent requests records, the following must be explored (including consultation from the Program Director and QA Department) before records may be released:
 - Are the parents in dispute about whether the record should be released?
 - Will releasing the requested material negatively impact the therapeutic relationship?
 - Would or does the child not want his or her records released?
 - Is the release of the requested material adverse to the child's best interest?
 - In some circumstances, depending on the answers to the questions above, Riverbend may evoke the Berg Decision. This means that the record will not be released and the parent will be advised that he or she will need to obtain a court order requiring said release in order for Riverbend to do so.
4. Riverbend offers clinically appropriate services designed to promote the healthy development of children and adolescents with emotional difficulties and to assist adults in recovery from mental illness. If you choose not to accept certain services, you will still receive the best help that Riverbend staff can provide, within those limits.
5. You have a right to be informed of the potential risks and expected benefits of medications and other treatment that may be recommended to you.
6. You have the right to second-opinion consultations, at your own expense.
7. You may withdraw from services at any time.
8. You have a right to appeal decisions Riverbend may make about your treatment and will be provided with information on how you may access the appeal process.

QUESTIONS, CONCERNS, COMPLAINTS

Your treatment team is committed to open dialogue with you. Staff will answer your questions and be as flexible as possible with you to develop a treatment program that works for you.

If you have an issue and feel that it cannot be resolved at the program level, a Complaint Manager is available at Riverbend to discuss and attempt to informally resolve concerns. The Complaint Manager may be contacted by calling 226-7505, extension 4336.

If you have a complaint and feel that it cannot be resolved at the program level or via the Complaint Manager, you have the right to request a formal investigation and resolution. You may do that by contacting the Office of Client and Legal Services, Bureau of Behavioral Health, 105 Pleasant Street, Concord, NH 03301.

CLIENT RESPONSIBILITIES:

1. You are encouraged to be as open and honest as you can be regarding your treatment. This will give us the best opportunity to assist you to reach your goals.
2. You have the responsibility to treat other clients and Riverbend staff with dignity and respect.
3. You are responsible for asking questions about any policy, procedure, or treatment which you do not understand or with which you do not agree. You should let your prescriber know about any problems you have with medications. Particularly at the beginning of treatment close monitoring is needed to make sure you get the greatest benefit with the least side effects.
4. You are responsible to read and understand any papers you may be asked to sign about your treatment.
5. You have the responsibility to honor your agreement to pay for the services you receive at the agreed-upon times and/or terms. You are also responsible for providing Riverbend with all information necessary for billing your health insurance.

Name of Client _____

Client/Parent/Guardian

Date

Witness

Date

Client was given a copy of this form.

Client declined a copy of this form.

Riverbend Community Mental Health, PO Box 2032, Concord, NH 03302, (603) 228-1600

QA:12/88 REV 8/96, 12/00, 3/01, 8/03, 1/04, 2/04, 3/11, 6/12, 4/15, 12/16



TREATMENT AUTHORIZATION AND ADMINISTRATIVE ACKNOWLEDGMENT

AUTHORIZATION FOR TREATMENT: I authorize my provider(s) or his/her designee(s) or consultant(s), in charge of my care at Concord Hospital, to provide services deemed necessary or advisable in the diagnosis and treatment of my condition(s). I understand that I may withdraw this authorization for treatment at any time before a procedure, test, or medication is administered.

In cases of emergency, I understand that the need for prompt medical attention may prevent authorization of a more detailed or specific nature before proceeding. In this circumstance, I authorize my provider(s) and their designee(s) to administer such anesthetics and perform such operation and procedures as they deem necessary.

I understand and agree to the following:

- 1) Concord Hospital may request and use my prescription medication history from other healthcare providers or third-party pharmacy benefit payors for treatment purposes;
- 2) Any tissues or parts surgically removed may be disposed of by Concord Hospital in accordance with the customary practice; and,
- 3) No guarantee has been made as to the results of care provided.

ELECTRONIC MEDICAL RECORD ACKNOWLEDGMENT: Concord Hospital primarily uses electronic medical record systems to capture medical information in both the inpatient and outpatient settings. These systems allow my information to be available to my healthcare providers and the staff at Concord Hospital, Concord Hospital Medical Group practices, and other providers who are involved in my care, which would include my primary care provider, specialty care providers, consulting providers, on-call providers, emergency/urgent care providers, hospitalists and other hospital-based providers. Concord Hospital is committed to protecting my privacy in accordance with applicable state and federal laws. A complete description of how my health information may be used and disclosed is contained in the Concord Hospital Notice of Privacy Practices, available to me upon request.

HEALTH CARE EDUCATION: I acknowledge that Concord Hospital is a teaching institution, and health care workers in training are important members of my health care team. I understand that trainees, under appropriate supervision, may perform or observe some of the health care services that I receive. Additionally, I understand that students may perform certain services under appropriate supervision.

PERSONAL VALUABLES: I understand that Concord Hospital is not responsible for my personal possessions. If I choose to keep personal belongings during my hospital stay, I may request that these items be stored in the hospital safe.

RECEIPT OF PATIENT INFORMATION: I acknowledge that I have been offered and/or provided a copy of the Patients' Bill of Rights.

ASSIGNMENT OF BENEFITS AND PAYMENT TERMS: I agree to assign to Concord Hospital, all insurance benefits otherwise payable to or on behalf of the undersigned for the services rendered. I agree that I am responsible to pay the balance owed if the insurance or personal information I have given is not true. I understand that I remain liable for all charges not covered by insurance or other benefits. I agree to pay Concord Hospital in accordance with its regular rates and terms for all services rendered.

Pursuant to NH RSA 151:12b when billing SELF-PAY patients, Concord Hospital accepts as payment in full an amount no greater than the amount generally billed and received by health carriers in a manner consistent with Section 9007 of the Patient Protection and Affordable Care Act of 2009. As such, uninsured patients will receive a discount off charges at the time of billing. Self-Pay Rates do not apply to insured patients for copayments, coinsurance, deductibles, or non-covered services.

All amounts are due immediately, upon receipt of the bill for said services. In the event that the bill is not paid pursuant to these terms and the account is placed with an attorney or agency for collection, I agree to pay actual attorney's fees and cost of collection.

I understand that if I am presenting with a work-related injury, it is my responsibility to provide Concord Hospital with accurate information regarding my employer and my workers' compensation insurance. I further understand that I remain liable for all charges not covered by workers' compensation, health insurance, or other benefits.

PHONE COMMUNICATION: I consent to receive calls to the cellular and residential telephone numbers I have provided, including calls using any type of artificial or prerecorded voice or auto-dialer technologies made by or on behalf of the Hospital, its providers, assignees, agents, servicers, debt collectors, or any owner of a receivable for unpaid services or treatment provided to me by the Hospital or any of its providers.

NON-EMPLOYED PROVIDERS: I understand and acknowledge that many of the providers on the Concord Hospital medical staff are not employees or agents of Concord Hospital, included but not limited to, specialists who provide services in anesthesiology, orthopedics, radiology, pathology, and emergency care. These independent contractors/treating providers have been granted the privilege of using the Concord Hospital facilities for care and treatment of their patients. I understand and acknowledge that Concord Hospital cannot be held legally responsible or liable for the conduct of these providers. I further understand that I will be billed separately for the services provided by these providers.

By signing below I acknowledge that I understand and agree to the terms set forth above.

Sign Here → _____
 Patient/Legal Guardian/Appropriate Authorizing Party Witness signature

Date → _____ **Time** → _____
 Date Time

 Print name and relationship to patient

Patient is unable to personally authorize because: _____