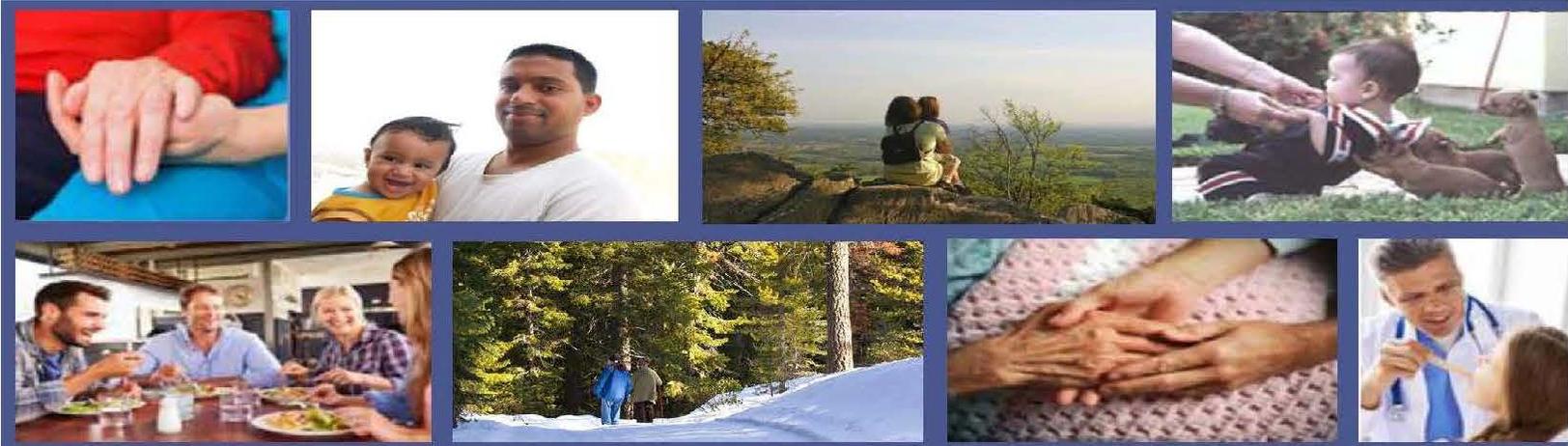


Community Health Services Network, LLC

Integrated Delivery Network Implementation Plan

July 31, 2017

New Hampshire Delivery System Reform Incentive Payment Waiver - Region 5



Enhanced Patient Experience and Provider Experience * More Effective Use of Resources * Improved Population Health

Improved Access and Availability * Reduced Preventable and Crisis Care * Improved Communication and Coordination * Whole Person Care * Family / Caregiver Involvement

Supportive Community Re-entry (C2)

- Corrections-based after-care planning blended with enhanced community care coordination
- Peer support, recovery coach mentoring
- Sustained connections to community supports and services

Expansion of Intensive SUD Tx (D3)

- Expanded IOP services
- Recovery coach intake and support
- "No wrong door" connections with EMS, ED, law enforcement and other community support organizations
- Linkage to mental health, primary care and MAT services as appropriate

Integrated Health (B1)

- Integrated Practice systems
- Patient-Centered Health Home
- Primary Care / Behavioral Health Co-location
- Multi-disciplinary, multi-sectoral community care teams

Enhanced Care Coordination for High Need Populations (E5)

- Sub-regional care coordination teams
- Inclusion of peer and recovery support workers
- Inter-agency information sharing and care plan development
- Coordinated patient assignments, peer review and mutual accountability

HIT and Data Analytics (A2)

EHR with standardized screening / assessment, Secure Communications and E-referral, Health Information Exchange, Shared Care Plans, Community Care Module, Data Analytics for Performance Monitoring and Improvement

Workforce Development (A1)

Recruitment and Retention Incentives; Training and Education Support; Use of Recovery Coaches, Patient Navigators and other care extenders; Increased awareness of community resources

Community Health Services Network, LLC
Integrated Delivery Network Implementation Plan
Table of Contents

	Page
DSRIP IDN Project Plan Implementation (PPI)	2
Project A1: Behavioral Health Workforce Capacity Development	8
Project A2: IDN Health Information Technology (HIT) to Support Integration	27
Project B1: Integrated Healthcare	43
<i>Community Project Implementation and Clinical Services Infrastructure Plans</i>	
Project C: Community Re-entry Program for Justice-Involved Adults and Youth with Substance Use Disorders or Significant Behavioral Health Issues	64
Project D: Expansion of Intensive SUD Treatment Options	78
Project E: Enhanced Care Coordination for High-Need Populations	95
DSRIP Alternative Payment Model (APM) Implementation Planning	111
Attachments	116

DSRIP IDN Project Plan Implementation (PPI)

This section includes information on implementation activities associated with overall IDN development and operations including activities for gathering ongoing Community Input, Network Development, Activities for Addressing the Opioid Crisis, IDN Governance and overall CHSN-IDN 5 Budget for network operations and projects.

PPI-1: Community Input

The initial IDN plan was informed by extensive efforts by the organizational partners of CHSN-IDN 5 to engage key community stakeholders across the region as part of a comprehensive Behavioral Health Needs Assessment. The purpose of these community engagement and assessment efforts was to identify community health concerns and solicit input and advice on priorities and opportunities for community behavioral health and behavioral health care delivery system improvements.

CHSN will continue to engage and seek input over the course of the demonstration by creating multiple opportunities for community feedback to foster learning and opportunities for performance improvement. The CHSN Executive Director will lead a committee of the CHSN membership to guide these efforts to assure ongoing consumer and caregiver representation including further developing methods and venues for ongoing assessment of progress, advice on improvement efforts, and identification of ongoing or emerging gaps. Mechanisms of community and consumer input will include:

- A client satisfaction tool will be developed to capture feedback from clients of each of the community-based projects and will be administered on an ongoing basis to assess client perceptions of effectiveness and inform quality assurance. The key partners in each of the projects will review client feedback semi-annually to make adjustments and improvements to policies and protocols to ensure goals are met, standards are maintained, and individuals receiving services are satisfied with their care.
- CHSN participation in the Annual Summit on Substance Misuse, Suicide and Behavioral Health sponsored by the Partnership for Public Health
- Collaboration with the Continuum of Care Coordinators in each Public Health Network (PHN) region for stakeholder engagement
- Periodic presentations and discussions with the Public Health Advisory Councils for each PHN region
- Facilitated discussions with clients of peer support and recovery service organizations
- Maintaining our practice of inviting community members ‘at-large’ to participate in CHSN network meetings and workgroups that will continue to guide implementation and evaluation of the initiative.
- Ongoing project communications to assure continuous information flow to key stakeholders and the overall community through written materials, presentations to agencies and municipal leaders and creative use of local resources such as radio talk shows and local cable access broadcast.

Implementation Activity/ Milestone: Community Input	Responsible Party/ Organization	Time line	Progress Measure / Notes
Conduct outreach to organizations involved in providing supportive housing	CHSN Executive Director	June 30, 2017 and ongoing	May 10 th network meeting devoted to presentations and discussions with Laconia Area Community Land Trust, Laconia Housing Authority, Laconia Salvation Army's Carey House, Belknap House in Laconia, CAP Belknap-Merrimack Counties, and Bridge House in Plymouth
Develop client satisfaction tools to capture feedback from clients of each of the community-based projects (also see community project sections)	Project Team Leads	Draft tools completed by December 31, 2017	Under development
Participation in the Annual Summit on Substance Misuse, Suicide and Behavioral Health sponsored by the Partnership for Public Health	Consumer Engagement Work Group	Nov. 2, 2017	Pending
Participation in stakeholder meetings convened by Continuum of Care Coordinators; CoC participation in SUD Expansion Leadership Team	SUD Expansion Team Lead; CoCs	Ongoing	CHSN Executive Director and CoCs currently meet on a monthly basis
Presentation and discussion with Public Health Advisory Councils	CHSN Executive Director	Semi-annual participation pending schedule of PHAC meetings	IDN-related topics are regular agenda items on PHAC meetings currently
Work with peer support and recovery service organizations to develop plans and methods for periodic group discussions with clients for ongoing assessment of needs, gaps, successes	CHSN Executive Director	Initiate planning by December 31, 2017	Pending
Maintain practice of 'at large community member' participation in CHSN governance and workgroups. Seek to increase/add number of community members	CHSN Board	Ongoing	2 community member representatives participate in CHSN network meetings
Develop plan and schedule for ongoing project communications through various media	CHSN Executive Director	Initiate planning by December 31, 2017	Pending

PPI-2: Network Development

The Community Health Services Network members and affiliated agencies are inclusive of a full set of provider and social support organizations representing the continuum of care for clinical services and broader social determinants of health in our region. Activities for continued network development are inherent in the various strategic channels of work for the IDN including the following:

- Address insufficient workforce capacity and related access and availability of care barriers by coordinated workforce recruitment and retention efforts for additional counseling capacity, expanding interagency agreements for shared staffing, shared service delivery protocols, cross-training of clinical staff and data sharing;
- Develop core competencies for Integrated Health at the practice and at the system level, such as through standardized screening and referral protocols, use of shared care plans and implementation of HIT infrastructure improvements to support integrated health care;
- Develop the network’s capacity to reduce fragmented care and avoidable utilization of higher cost services through enhanced care coordination and support for individuals and their families with complex health and psychosocial needs;
- Continue development of the network’s relationships beyond the health care community to include partners such as county corrections and recovery organizations to support effective transitions of care and community re-entry.

We will also continue to review network composition and adequacy, looking for gaps and opportunities for development or addition of new organizational members that can further the health and human service delivery goals and purpose of CHSN and the DSRIP initiative.

Implementation Activity/ Milestone: Network Development	Responsible Party/ Organization	Time line	Progress Measure / Notes
Implement workforce development and training Plan (also see workforce section)	CHSN members	Ongoing	Under development
Implement plan for HIT improvements to support integration	HIT Leadership Team, all CHSN Members	Ongoing	Under development
Implement plan for advancing practices and the overall network along a continuum of integrated health care delivery	Integrated Health Leadership team, all CHSN members	Ongoing	Under development
Implement plans for community projects that will develop capability for improved communication and coordination of patient care across the network	Community Project Leadership Teams, all CHSN members	Ongoing	Under development

Implementation Activity/ Milestone: Network Development	Responsible Party/ Organization	Time line	Progress Measure / Notes
Continue to review network composition and adequacy for gaps and opportunities for member development	CHSN Board	Ongoing	Procedures for reviewing and adding network membership specified in governance documents; Board approved three new affiliates in 2017: Farnum North/Easter Seals of NH in Franklin, Bridge House in Plymouth, and Crooked Mountain Rehabilitation in Greenfield

PPI-3: Addressing the Opioid Crisis

One of the forces of change that propelled development of the Community Health Services Network in 2015 was the need for a coordinated response to the alarming rise in substance misuse and overdose in the region. Our project design includes two strategic pathways intended in part to increase the region’s capacity to address the opioid crisis. The selection of expanded intensive outpatient treatment programs that incorporate recovery coaches as part of the team is one example of our plan’s response. This community project will also be closely linked with the community re-entry project of justice involved youth and adults with substance use disorders. Each of these channels of work will be further linked through activities to enhance care coordination and recovery supports to assure effective transitions and prevent relapse. Additionally, CHSN members have been working to expand Medication Assisted Treatment in the region, most notably through the two federally qualified health centers and the LRGH Recovery Clinic. These resources are closely connected as referral and support resources to our work on these two community projects and to the system integration efforts overall.

Implementation Activity/ Milestone: Addressing the Opioid Crisis	Responsible Party/ Organization	Time line	Progress Measure / Notes
Implement community projects that address the opioid epidemic	SUD Expansion and Community Re-entry Project Leadership Teams, all CHSN members	Ongoing	Under development
Maintain referral and practice support relationships with MAT providers	CHSN members	Ongoing	Key MAT providers are part of CHSN; Strong working relationships in place
Partner with emergency response community on awareness and education efforts and naloxone distribution	CHSN members	Ongoing	Strong working relationships in place

Implementation Activity/ Milestone: Addressing the Opioid Crisis	Responsible Party/ Organization	Time line	Progress Measure / Notes
Continue to review network composition and adequacy for gaps and opportunities for member development related to the opioid epidemic	CHSN Board	Ongoing	Identify process for reviewing and adding network membership specific in governance documents

PPI-4: Governance

Community Health Services Network (CHSN) has been established as a Limited Liability Company, which provides for a delegated model of governance. Each member organization designates an individual who serves as a Manager of the company. Meetings of the Managers are held monthly on the first Tuesday of the month, or such other time as agreed by 2/3 of the Managers. An important principle of the organization is that each Manager has one vote with respect to all matters requiring the action of the Board regardless of organization size or level of investment. Each appointed Manager holds office until the next annual meeting of the Members at which point the Board of Managers are approved for the following year by the Members.

The annual meeting of the Managers is held during the first week of April each year unless otherwise agreed by 2/3 of the Managers. At the annual meeting, the Managers review the annual operating budgets and plans of the Company. An annual meeting of CHSN members is also held during the first week of April each year at which time the member organizations appoint the Managers, review and approve the Annual Budgets, and review the strategic plans of the Network and such other matters as are typically addressed at an annual meeting.

The authority of the Board of Managers is outlined in detail in the CHSN Operating Agreement and includes the authority to: employ personnel to provide services in connection with the business of CHSN; hire and contract with accountants, attorneys, consultants and other persons necessary or appropriate to carry out the business and operations of CHSN; pay all organizational expenses and general and administrative expenses; develop Quality and Clinical Standards and Guidelines; elect Officers of the Company; develop company policies; respond to Request for Proposals on behalf of CHSN; develop the staffing structure and composition for the Company; and assign Committee membership.

The Board of Managers appoints annually three to four executive officers of the company to whom it may delegate some or all of its authority and duties under the supervision of the Board of Managers. Each individual is appointed for a one-year term and no individual can serve more than three consecutive years in any one office. Currently, the executive officers of CHSN are [REDACTED], Chair (Genesis), [REDACTED], Vice Chair (Horizons), [REDACTED], Treasurer (HealthFirst), and [REDACTED], Secretary (Lakes Region Community Services).

Implementation Activity/ Milestone: Governance	Responsible Party/ Organization	Time line	Progress Measure / Notes
Convene monthly board meetings	CHSN Chair and Executive Director	Monthly, Ongoing	Milestone met: Record of meetings minutes, % attendance monitored

Implementation Activity/ Milestone: Governance	Responsible Party/ Organization	Time line	Progress Measure / Notes
Establish and support committees as needed to guide implementation of Network plans and activities	CHSN Board	Ongoing, review committee structure as needed	Committees formed in all essential and required areas of IDN operations
Review implementation progress and outcomes; take corrective actions as needed	CHSN board and membership	Ongoing	Measures and data collection procedures currently being established (see infrastructure and community project implementation plans)
Assess member satisfaction with CHSN operations and benefits of participation	CHSN Executive Committee	Annually in April	Pending

PPI-5: Budget

The total projected budget for CHSN-IDN 5 operations is \$9,687,967 with a 10% (\$1,130,391) reserve set aside to secure for potential DHHS matching fund uncertainties and a \$485,559 reserve pending CHSN-IDN 5 achievement of performance metrics. The table below displays the budget by major budget line item. See **Attachment_A1.6** for a more detailed breakdown by project area and budget period.

Project A1: Behavioral Health Workforce Capacity Development

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

CHSN-IDN 5 has participated fully to date in Statewide Workforce Taskforce activities and completion of the Statewide Workforce Capacity Strategic Plan **Attachment_A1.1**. CHSN-IDN 5 staff and partners who have participated in the Statewide Workforce Taskforce have included [REDACTED] (Genesis Behavioral Health), [REDACTED] (Horizons Counseling Center), and [REDACTED] (CHSN Executive Director).

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

A1-2: IDN-level Workforce: Gap Analysis

Workforce capacity challenges exist throughout the continuum of care in our region for individuals with behavioral health conditions and their families. Patients and families are impacted by these challenges by way of delays in treatment, fragmented care, insufficient connection to social supports, and increased burden on family and loved ones.

While substantial behavioral health services do exist, there is inadequate capacity to meet the demand for services. Of the 33 towns within the IDN 5 region, 21 (64%) are designated primary care shortage areas and 19 (58%) are designated mental health shortage areas (Health Resources & Services Administration, Bureau of Health Workforce, <https://bhwh.hrsa.gov/shortage-designation>). These shortages result in significant delays in treatment and are a likely factor in the increased use of hospital emergency departments.

Recruitment and Retention Challenges: The difficulties of recruitment and retention of behavioral health providers and other staff are significant issues across the state, and are acutely experienced in our region. Genesis Behavioral Health reported 23 open positions as of June 2017 including a Nurse Practitioner position that has been vacant for over 9 months. The average time to fill vacant positions in Assertive Community Treatment or Supported Employment programs is about 77 days. Over the last 12 months, Genesis has experienced a staff turnover rate of 29%. Horizons Counseling Center reports a similarly high vacancy rate of 20% for licensed drug and alcohol counselors, including a MLADC position to serve the Plymouth area that has been unfilled for over a year. This circumstance is consistent with the general workforce shortage reported across New Hampshire, especially in the area of drug and alcohol counseling.

Provider turnover has significant costs to patients who experience service disruption as well as cost to the agencies that are in a continual cycle of recruiting, hiring and training new staff. Recruitment expenses have a negative effect on the fiscal health of CHSN members. For example, Genesis Behavioral Health must use recruiters to hire its providers with an average cost of [REDACTED] for physicians and [REDACTED] for APRNs. Frequently, temporary staffing agencies are used to fill open positions, resulting in additional expenses.

Relatively low pay for professional services in agencies that serve a high proportion of publicly insured and uninsured clients is a direct factor in recruitment and retention challenges. For example, professional salaries at community mental health centers are up to [REDACTED] less than in other areas of mental health. Additionally, salary increases at community mental health centers have not kept pace with inflation and cost of living adjustments are rare and staff often chooses to leave for private practice.

Education and Training: A related challenge influencing recruitment and retention is the expense of supporting staff who are working towards licensure or certification, such as social workers, alcohol and drug counselors, recovery support workers and peer support specialists. These positions require many hours of supervised clinical time that is not reimbursable. Frequently, agencies will invest time and resources to support young professionals as they work towards their licensure, but then the agencies are unable to retain their services for long due to low pay relative to the private marketplace.

Workforce capacity limitations such as these contribute to lost opportunities to integrate services at the agency and inter-agency levels. The ability of individual providers and provider organizations to effectively collaborate with other health care providers and community-based social support organizations is severely limited by pressure to generate billable services which leaves limited time for collaboration and coordination activities that are non-billable. Furthermore, community partners across the system of care such as first responders, schools, and human service organizations experience inconsistent communication, disruption of connections, and uncertainties around referrals due to limited availability of service providers.

While assessments of workforce capacity in this area tend to focus on specialty behavioral health settings (e.g. CMHCs and SUD treatment organizations), workforce capacity and competencies in primary care practice settings are similarly important. The majority of individuals with mild to moderate behavioral health conditions can be more readily identified through standardized screening protocols, diagnosed and, in many cases, provided treatment in primary care. Strengthening the workforce in these settings through strategies such as continuing education on topics including team-based care and medication management, supporting consistent specialty referral relationships with consulting psychiatric clinicians, and increasing awareness of community-based resources will be crucial to the success of this initiative.

The table below displays information from a recent survey of CHSN-IDN 5 partner agencies regarding workforce recruitment and retention challenges and training needs associated with community care coordinator (CC) staffing for the Enhanced Care Coordination community project.

E5- AGENCY WORKFORCE SURVEY RESULTS

Agency	Current CC Position to Fill	If Yes, Barriers to use Current Staff	Anticipated Costs Incurred	Barriers to Fill New Position	Challenges to Retain	Training Challenges	Comments
Mid-State Health Center	Maybe		Maybe	Finding a highly-qualified individual with knowledge of the project (if they need to hire)	No	* Making a cohesive group, working the CC's of the entire region to ensure consistency.	*depends on demand of CC services and what is required to manage their work load **Recommends CHSN consider specific training for CC group when they're hired
Riverbend	Yes-current case manager	How long it would take for new hire to be ready to be hired and ready to meet clients, ex. in comments.	Yes- *Advertising, interviewing, supervision, mandatory trainings, administrative costs, Wi-Fi and laptop for CC	Workforce for this field is very limited, have a CM willing to take over this role, but she will need to be replaced	Finding the right person to fill this role is important, need to comfortable to engaging with challenging people and going to client's homes.	Be sure that they are given the correct support and supervision that is needed to be successful.	*Dollar amount would depend on the time it takes to rehire and fill that Case Manager Position. Example, one month of a vacancy equals a program loss of approximately \$10,000 per month.
HealthFirst	No		Advertising \$500, salary and benefits, laptop, software license, cell phone and account	Shortages of RN's and behavior health professionals	Once someone is hired we anticipate to keep them long-term	Train all CC's together	
LRGHealthcare	No- have staff in CC roles but none that work towards what the E5 process intends	A part-time ECC (Embedded Care Coordinator*) RN would cost the organization approx. \$40,000+ per year.	If their role is a significant expansion to what the ECC team already does then YES. (Minimal Cost)	RN shortage, difficult to hire qualified RNs in the current market	Fortunate with the ECC retention rate- minimal turnover (2 in the last 4.5 years)	Training comes from previous roles and involves learning community team members and what is offered for support.	*ECC's keep our high risk, chronically ill patients stable, at home, which is a benefit to the patient and a financial benefit to the hospital
Central NH VNA & Hospice	No		Unknown	Workforce shortage, amount of hours available, limited benefits	Requesting Job Description Before Answering This Question		

Agency	Current CC Position to Fill	If Yes, Barriers to use Current Staff	Anticipated Costs Incurred	Barriers to Fill New Position	Challenges to Retain	Training Challenges	Comments
Horizons Counseling Center	No		Yes- advertising, interviewing time for staff, possible signing bonus	Part-time position to be made into a full-time position by combining, offering a salary/benefits package to attract qualified applicants	Retaining existing staff who are currently making less than the potential anticipated pay of this position	Training expenses for both the new and the position potentially being replaced	Potential to have to recruit staff to fill existing positions
Lakes Region Community Services	Yes	Wages for replacement	No		No		
Granite State Independent Living	No		Yes	Commitment on funding this person's salary/benefits	Yes	Funding commitment to keep this position staffed long-term	
Lakes Region VNA	Yes	Wage increase for current employee	No	Money	Yes	Staff person having enough time to learn and fulfill the role	
ServiceLink Grafton	Yes	\$ to cover position @ 20 hrs/wk (see note)	No	barrier to hire or increase hrs of another staff to reassign job responsibilities	No		Salary [REDACTED]
Speare Memorial Hospital and Speare Primary Care	No		Yes- potentially referral bonus	We already have a Case Manager position to fill and there's a shortage of qualified applicants	Yes	They will need clinical supervision, good training and Support	They will need EDM, Motivational interview training, safe training (DHHS)
Genesis Behavioral Health	Yes	Training and scheduling	accounted \$ in budget	currently has 1.5 FTE vacant	Yes	See comment	Need training in hospital language
Pemi-Baker Community Health	Yes - has a part-time social worker	Will need to increase them to full-time and looking for LICSW	Recruiting costs *would prefer a stipend instead of 0.25 FTE	Shortage of MSW in NH	Yes- burn out rate higher to work with this challenging population		Current focus pop.- frail elders w/multiple rehosp., palliative care of hospice, BH support for some homebound pts. *concern this population may displace others due to high need

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

The table below outlines the key activities, milestones and timelines, responsible party, and progress measures for the Workforce Capacity Development Implementation plan. Following this table is the Master training plan for CHSN-IDN 5 to support Workforce Capacity Development. Additional workforce development and training plans specific to other strategic pathways for accomplishing the goals of the IDN, such as specific community-driven projects, are included in later sections of this document. Smartsheet detail and timeline is included as a graphic at the end of this section and included as **Attachment_A1.3A**

Implementation Activity/ Milestone	Responsible Party/ Organization	Time line	Progress Measure / Notes
Participate with representatives of other IDNs in developing and implementing state level policy improvements and other strategies for strengthening the BH workforce and develop Statewide Workforce Capacity Plan	CHSN Executive Director; Workforce Lead – Executive Director Genesis	By June 30, 2017	Milestone Met: regular participation; statewide workforce plan developed
Identify and update workforce training needs assessment	CHSN Executive Director, MSLC	By July 31, 2017	Milestone met: Facilitated meetings convened to assess workforce training needs with 3 segments of the IDN: BH/SUD Providers; Hospitals/Primary Care/FQHC's/Home Health agencies; and other Community Service Agencies
Develop a training matrix of CHSN-IDN 5 training needs and area resources	CHSN Project Manager	By September 30, 2017 with ongoing updates	In progress; on track
Implement IDN-specific training plan (see plan outline following this table)	CHSN Project Manager	Initiate by November 1, 2017 and ongoing	In progress; on track
Initiate recruitment of Training Coordinator	CHSN Executive Director	Initiate by October 1, 2017	Job description under development; on Track
Develop criteria and obtain board approval for providing employee retention incentive payments to participating agencies	CHSN Executive Director	By November 15, 2017	Criteria under development; on track
Develop and communicate policies and procedures for agencies to achieve employee retention incentive payments	CHSN Executive Director	Initiate by December 15, 2018 and ongoing	Pending

Implementation Activity/ Milestone	Responsible Party/ Organization	Time line	Progress Measure / Notes
Provide employee retention incentive payments to participating agencies and monitor effect on recruitment and retention	CHSN Executive Committee	Initiate payments upon receipt of IDN incentive payout (mid-Sept. 2018) and ongoing	Pending
Develop criteria and obtain board approval for providing financial support for IDN-related staff pursuing licensure or certification in their fields	CHSN Executive Director	By December 15, 2017	Criteria under development
Develop and communicate policies and procedures for agencies to request licensure / certification support on behalf of staff	CHSN Executive Director	Initiate by January 15, 2017 and ongoing	Pending
Provide reimbursement to staff pursuing licensure / certification and monitor effect on recruitment and retention	CHSN Executive Committee	Initiate by February 1, 2018 and ongoing	Pending
Research NH's loan repayment program and develop IDN specific criteria to model after this.	CHSN Executive Director	By December 31, 2017	Pending
Present criteria and obtain board approval for providing loan repayment for key IDN-related staff	CHSN Executive Director	By January 31, 2018	Pending
Develop and communicate policies and procedures for key agencies to request loan repayment support on behalf of staff	CHSN Executive Director	Initiate by February 28, 2018 and ongoing	Pending
Provide loan repayment to key staff and monitor effect on recruitment and retention	CHSN Executive Committee	Initiate by April 1, 2018 and ongoing	Pending

Workforce Professional Development Training and Evaluation Plan: Improve quality of health care for BH/SUD high-needs population by increasing the understanding and education of direct and non-direct health care workforce that serve this Medicaid population. Note - specific milestones are captured on Smartsheet timeline(s).

CHSN-IDN 5 TRAINING & EDUCATION STRATEGIC PLAN

Goal 1 <i>Reference Statewide Workforce Implementation Plan</i>	Align with the Statewide Workforce plan (A1- goal 4) that NH will have a pool of qualified behavioral Health workforce applicants adequate to integrated primary and behavioral health care need through training and education
---	---

Objective 1	(4a) An increase in licensed BH staff trained to provide integrated primary and behavioral health care and addiction care			
Strategy 1: Training and Education	Support and utilize current and future training opportunities both locally and statewide to promote additional education, credentialing, and expertise in the delivery of health care for the BH/SUD population			
Activities	Timeframe	Accountable Person(s)	Evaluation	Outcomes
Convene 3 meetings with IDN partners to assess training needs and gaps	June 2017	CHSN Executive Director, MSLC	Subjective feedback from participants	<ul style="list-style-type: none"> Comprehensive set of data collected based on SAMHSA 9 core competencies for CHSN-IDN 5's training implementation plans Resource list of regional and state trainings Grow partnerships through collaborative work Compile list of IDN 5 experts in specific training topics that could be shared with other IDNs
Develop project specific training matrix of CHSN-IDN 5 training needs by provider types	July 14, 2017-ongoing	CHSN Project Manager	Application to project implementation plans	<ul style="list-style-type: none"> Global perspective of CHSN-IDN 5 specific training needs by provider type Tracking mechanism per practice/agency Proposed timelines and budget considerations
Utilize local experts for training opportunities	Initial training to begin Q4 2017	CHSN-IDN 5 Training Team and Local Experts/IDN Partners	Pre/post tests, participant surveys	<ul style="list-style-type: none"> Increase knowledge and professional development of IDN providers for target population Improve quality of care for target population
Combine training opportunities with other IDNs	September 2017 begin joint IDN committee work	CHSN-IDN 5 Training Team	Subjective feedback on benefits of the collective efforts	<ul style="list-style-type: none"> Reduction in redundancy of trainings across IDNs Cost containment of training dollars used per IDN Expand offering modalities

Begin collaboration with AHEC, NHTI, and NAMI NH and others for developing training opportunities	Begin Q3 2017-ongoing	CHSN-IDN 5 Training Team and others TBD	Online evaluation tool- Survey Monkey, Pre and Post training survey, Exit Training survey	<ul style="list-style-type: none"> • Increase knowledge and professional development of IDN providers for target population • Improve quality of care for target population • Strengthen relationships with agencies that are working on similar initiatives to expand the collaborative efforts
Explore options offered through the BRSS TAC in conjunction with the statewide efforts (project A1)	Begin Q4 2017	CHSN-IDN 5 Training Team, Statewide Training & Education Subcommittee	Subjective feedback on benefits of the collective efforts	<ul style="list-style-type: none"> • Report and recommendations

Objective 2	(4e) Reduce barriers to delivering evidence-based substance use disorder treatment in primary care settings			
Strategy 2: Training and Education	Increase training opportunities for primary care in substance abuse and addiction team-based approaches to care			
Activities	Timeframe	Accountable Person(s)	Evaluation	Outcomes
Review the identified training opportunities provided in the Statewide Workforce implementation plan	June 2017-ongoing	CHSN-IDN 5 Training Team	Effectiveness and application to IDN 5 specific training needs	<ul style="list-style-type: none"> • Resource list to address training gaps and reduce duplicative efforts • Training curriculum and schedule from committee work at state level
Collaborate with the Statewide Training & Education committee	Begin September 2017	CHSN-IDN 5 Training Team, Statewide Training & Education Subcommittee	Subjective feedback on benefits of the collective efforts	<ul style="list-style-type: none"> • Opportunities to expand training offerings and pool funds to reduce cost
Offer trainings to primary care providers on a variety of topics related to best practices for the BH/SUD population	Begin training phase Q4 2017	CHSN-IDN 5 Training Team, regional partners, and others TBD	Post training surveys	<ul style="list-style-type: none"> • Increase primary care providers knowledge of the specific needs of BH/SUD population • Reduce stigma and discrimination of target population • Improve working relationships between providers across agencies who serve BH/SUD population • Improve recognition of BH/SUD needs and awareness of available resources

Objective 3	(4h) Encourage individuals to enter the behavioral health field			
Strategy 3: Training and Education	Collaborate with educational institutions to promote careers in behavioral health and substance abuse			
Activities	Timeframe	Target Audience	Evaluation	Outcomes
Align with the Statewide efforts to identify opportunities to promote career paths in BH/SUD	Begin January 2018	CHSN-IDN 5 Training Team, Statewide Training & Education Subcommittee	Subjective feedback on benefits of the collective efforts	<ul style="list-style-type: none"> Report and recommendations Increase collective work and networking opportunities across the state
Network with local high schools and institutions of higher education of strategies to promote careers in SUD/BH to students	Begin August 2018	CHSN-IDN 5 Training Team and others TBD	Subjective feedback on benefits of the collective efforts	<ul style="list-style-type: none"> Increase the pool of potential BH/SUD applicants Reduce the stigma around the BH/SUD population Initiate collective efforts across regions and institutions to address the BH/SUD workforce Needs
Engage with higher education institutions to offer potential sites for internships, practicums, and preceptor opportunities, as well as expanded electives	Begin January 2019	CHSN-IDN 5 Training Team and others TBD	Post training surveys	<ul style="list-style-type: none"> Expand awareness of BH/SUD career opportunities in NH Address the workforce gaps for various BH/SUD settings without financially burdening the individual agencies Provided valuable “working experiences” for potential BH/SUD providers

Goal 2 <i>Reference A2, B1, C2, D3, and E5 Implementation Plans</i>	Enhance BH/SUD patient experience through care coordination efforts and comprehensive assessment and screenings
---	---

Objective 1	Improve providers ability to access essential healthcare information at point of care for BH/SUD patients			
Strategy 1: Training and Education (A2)	Promote usage of shared care plan software across network of partners in IDN 5			
Activities	Timeframe	Accountable Person(s)	Evaluation	Outcomes

Training clinical staff that are part of the Care Coordination team(s) in use of CMT PreManage shared care plan software	Begin Q4 2017	IDN 5 HIT Committee, CMT	CMT's evaluation method	<ul style="list-style-type: none"> • Increased provider's access to real-time data • Improve communication between providers of separate agencies and the co-management of BH/SUD patients • Completeness and accuracy of patient data • Improve clinical decision making and quality of care • Increase effectiveness of chronic disease management and patients with co-occurring conditions
Implement and train providers in Confidentiality/Privacy-42 CFR Part 2, ethics	Begin Q4 2017	HIT Taskforce, CHSN-IDN 5 Training Team	Pre and Post test	<ul style="list-style-type: none"> • Compliance with federal and state guidelines for health information exchange of the BH/SUD population • Increased awareness of laws and ethics surrounding the protection of BH/SUD health information • Increased education of ethical implications surrounding the health records of BH/SUD Population

Objective 2	Improve access to timely and appropriate services and supports for patients with BH/SUD Conditions			
Strategy 2: Training and Education (B1, C2, D3, E5)	Support a clinical integration approach through the implementation of care coordination teams or integrated workflow systems			
Activities	Timeframe	Accountable Person(s)	Evaluation	Outcomes
Identify coordination team members from various agencies	Begin Q1 2017-ongoing	C2, D3, E5 Workgroups	Subjective feedback	<ul style="list-style-type: none"> • Increased understanding of structure of the care coordination model pertaining to each community driven project • Training needs identified of clinical and non-clinical staff involved in the care coordination team modality • The development of and/or the identification of protocols and workflows for the care coordination teams

Convene care coordination teams	Begin Q1 2018	C2, D3, E5 Workgroups	Survey done by DHHS	<ul style="list-style-type: none"> • Reduce silos that exist between regional agencies who service the BH/SUD Medicaid population • Improved provider workflow and ease of referral processes • Increased knowledge of team members roles and pathways of integrating care • Increase patient satisfaction • Reduce duplication of work efforts
Train key providers of care coordination/integration in protocols, workflows, and processes	Begin Q1 2018	C2, D3, E5 Workgroups	Evaluation tools TBD	<ul style="list-style-type: none"> • Increased knowledge of the function of the multi-disciplinary team • Progress towards securing designation of Coordinated Care Practice • Improve referral processes • Promote a “warm hand-off” in the transitions of care • Reduce recidivism rate • Reduce inappropriate use of the ED
Offer support and trainings for non-direct care providers in Mental Health First Aid	Begin Q1 2018	C2, D3, E5 Workgroups and CHSN-IDN 5 Training Team	Evaluation tool TBD	<ul style="list-style-type: none"> • Build mental health literacy of non-direct care staff • Equipping staff in their ability to identify, understand, and respond to signs of mental illness • Increase support for individuals experiencing a mental health crisis • IDN sponsored 2 instructors for region 5 (location Genesis Behavioral Health)
Cross-train corrections officers in MH/SUD topics as needed (e.g. recognizing signs and symptoms of SUD/MH, suicide prevention)	Begin Q1 2018	C2 Workgroup, CHSN-IDN 5 Training Team	Evaluation tool TBD	<ul style="list-style-type: none"> • Increase CO’s understanding and mechanisms of handling parolees needs • Improve CO’s ability to link parolees to necessary resources and respond to unanticipated crisis

Provide training for designated Care Coordination team members as appropriate in understanding EMS and law enforcement rules and protocols (e.g. for protective custody, for ED transport)	Begin Q2 2018	E5 Workgroup, CHSN-IDN 5 Training Team	Evaluation tool TBD	<ul style="list-style-type: none"> Enhance understanding of roles of public safety and emergency response services Improve collaboration among a greater network of service providers caring for the target population
Provide education for Justice System representatives in DSRIP topics as needed (e.g. project purpose/goals, MH/SUD interventions that reduce cost/recidivism)	Begin Q4 2018	C2 Workgroup, CHSN-IDN 5 Training Team	Evaluation tool TBD	<ul style="list-style-type: none"> Improve collaborative efforts between the Justice System and IDN 5 Community Re-entry Leadership team and members Enhance the understanding of key partners in the DSRIP project

Objective 3	Increase use of a Comprehensive Core Standardized Assessment process and use of required screening tools for BH/SUD and primary care providers			
Strategy 3: Training and Education	Promote professional development of BH/SUD and primary care providers to adequately equip them to provide a comprehensive approach in caring for the target Medicaid Population			
Activities	Timeframe	Accountable Person(s)	Evaluation	Outcomes
Identify current use of Comprehensive Core Standardized Assessment process	Q1-Q3 2017		NA	<ul style="list-style-type: none"> Summary of IDN 5 crosswalk Report of SSA from CHI survey
Convene Clinical Integration Practice Committee	Q3 2017	B1 Workgroup, and other IDN 5 workgroups as appropriate	Subjective feedback	<ul style="list-style-type: none"> Development of IDN 5 CSA process Education on outcome metrics and data collection needs Improvements in all domains of the Quadruple Aim Develop common terminology for job titles and descriptions of integrated practice within overall system context
Training of Primary care (including pediatrics) and BH/SUD providers in the CSA process and required screening/assessments per DHHS	Begin Q1 2018	B1 Workgroup, CHSN-IDN 5 Training Team	Evaluation process TBD	<ul style="list-style-type: none"> Increased knowledge and use of a comprehensive standardized process to treat the target population Enhanced patient experience Improved population health: prevention, early identification, and intervention Improved recognition and diagnosis of co-occurring disorders BH/SUD

Offer trainings on chronic disease management: diabetes, dyslipidemia, hypertension	Begin Q1 2018	B1 Workgroup, CHSN-IDN 5 Training Team	Post training survey	<ul style="list-style-type: none"> Improved care for patients with complex health conditions Expand providers ability to treat patients with co-morbidities
Provide C2, D3, and E5 specific trainings for support and professional development of key providers	Begin Q4 2017	CHSN-IDN 5 Training Team, regional partners, and other TBD	Evaluation process TBD	<ul style="list-style-type: none"> Provide additional and required trainings to SUD/BH providers free of cost to them Increase awareness of clinical and non-clinical staff in specific SUD/BH topics

Goal 3 <i>Reference B1, C2, D3, and E5 Implementation Plans</i>	Increase stakeholder's general knowledge of the DSRIP waiver and encourage progress of regional partners along SAMSHA's Integrated Care Continuum for primary care and behavioral health
---	--

Objective 1	Educate stakeholders and/or the public in the DSRIP waiver initiative and IDN 5 specific regional plans			
Strategy 1: Training and Education (B1, C2, D3, E5)	Promote communication with members, affiliates, and the general public about the DSRIP waiver to raise awareness and foster input			
Activities	Timeframe	Accountable Person(s)	Evaluation	Outcomes
Offer DSRIP 101 trainings	Q4 2017-ongoing as needed	CHSN-IDN 5 Training Team with optional Hope for NH Recovery and/or NAMI NH "lived experience speaker"	Subjective feedback	<ul style="list-style-type: none"> Level-set stakeholder's perception of the NH DSRIP waiver Build community engagement and stakeholder's buy-in Provide background information and clarification as needed on the waiver Strengthen member and affiliate engagement

Objective 2	Provide learning opportunities for primary care and behavioral health (mental health and substance misuse/SUD) providers that align with SAMHSAs integration of care			
Strategy 2: Training and Education (B1, C2, D3, E5)	Promote SAMHSA's Standard Framework for Levels of Integrated Healthcare for the BH/SUD population			
Activities	Timeframe	Accountable Person(s)	Evaluation	Outcomes
Site Self-Assessment	Q4 2017	UNH Citizens Health Initiative, B1 Workgroup, Clinical Integration Committee	TBD	<ul style="list-style-type: none"> Individual report for each participating agency Aggregate report/summary of data across IDN 5's region of progress on SAMHSAs Integration of Care Model

Offer trainings for Primary care and BH providers on SAMHSA's Integration of Care	Begin Q4 2018	B1 Clinical Integration Committee, CHSN-IDN 5 Training Team	TBD	<ul style="list-style-type: none"> Progress along SAMHSAs model of Integration of Care Model Increased knowledge of SAMHSA's 9 core competencies for integrated behavioral health and primary care
---	---------------	---	-----	--

Note – A comprehensive Training Resource Guide is under development, see **Attachment_A1.3B**, to identify training topics, target audience, who can provide trainings, delivery method, duration and cost. Additionally, a Training Matrix was developed for each community-driven project to identify specific number of trainees by agency and is located within each community project section.

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
Trainee satisfaction	At least 85% of training participants rate training programs as either "excellent" or "very good" in an evaluation survey			
Trainees will demonstrate knowledge and skill gains as measured by pre / post training assessment	To be determined appropriate to each specific training			
Total number of training participants	To be determined appropriate to each specific training			
Average recruitment time for key BH positions (see comprehensive list of provider types in next section - specific position types included in this measure to be determined)	Less than 90 days			
Overall key position current (point in time) vacancy rate	Less than 10% (current baseline estimated at 12%)			
Number of IDN-related staff receiving financial support to pursue licensure / certification	To be determined			
Number of IDN-related staff receiving loan repayment	To be determined			

A1-5: IDN-level Workforce: Staffing Targets

The table that follows includes information on current staffing levels as of June 2017 and projected need by key provider type. Project staffing needs include current openings (about 73 FTEs) and openings anticipated in the next 6 months (about 66 FTEs). **It is important to note that these are point in time estimates from participating CHSN partner organizations and are subject to change. The information**

on projected needs below includes new positions that are anticipated by partner agencies as well as for staffing IDN integration and community projects.

Provider Type	IDN 5 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
Social Worker (LICSW)	21.8	17.3			
Counselor (LMHC, LFMT)	25.5	23.5			
SUD counselor (MLADC)- masters level	9	2			
SUD counselor (LADC)	8.5	4			
Peer recovery support worker	15.5	6			
Clinical psychologist (MA, PsyD, PhD)	4	4			
Psychiatrist (MD)	9.1	7.1			
Psychiatric Advanced Practice Nurse (APRN)	8	6			
Psychiatric nurse (RN)	4	3			
Psychiatric Physician Assistant (PA)	0	0			
Social worker (BSW)	96.6	86.6			
Case Manager	9	7			
Medical Assistant (MA, CMA)	20	19			
Care Coordinator (RN)	15.48	7.99			
Care Coordinator (non-RN)	3	1			
Health coach	10	8			
Community Health Worker	1	1			
Direct support worker	222	188			
Health (or other) navigator	3	3			
Primary Care Physician (MD)	28.3	20.1			
Primary Care Advanced Practice nurse (APRN)	31.3	23.8			
Primary Care Physicians Assistant (PA)	2.35	2.35			
Social worker (MSW)	56.2	42.2			
Primary Care Medical Assistant (MA)	25	19			
Primary Care Nurse (RN, LNA)	61.4	48.4			
Benefit navigator/financial assist. Coordinator	8	8			

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

Funds are budgeted to support CHSN-IDN 5 participation in statewide trainings, IDN 5 specific regional trainings to support integrated practice development, licensure or certification support for recent graduates, loan repayment to support provider recruitment, and an employee retention incentive fund for CHSN member and affiliate organizations. Funding for the employee incentive fund will be connected to achievement of DSRIP / IDN metrics and level of organizational participation. Additional detail can be found in the overall CHSN-IDN 5 budget **Attachment_A1.6**.

Budget Item	Item Description	2017 Cost	2018 Cost	2019 Cost	2020 Cost	Total Project Cost
Workforce Training, Education and Recruitment Support						
Statewide Trainings	Shared costs for statewide trainings	\$ 11,428.58	\$ 22,857.14	\$ 22,857.14	\$ 22,857.14	\$ 80,000
IDN 5 Trainings	Regional Trainings for Agency Needs related to Integration	\$ 7,500	\$ 15,000	\$ 15,000	\$ 15,000	\$ 52,500
Licensure / Certification support	Licensure / Certification support for project / agency staff associated with community projects (C2, D3, E5)	\$ 1,500	\$ 3,000	\$ 3,000	\$ 3,000	\$ 10,500
Loan repayment	Funding to support staff recruitment and retention (supplementing state's existing plan)	\$ 21,428.57	\$ 42,857.14	\$ 42,857.14	\$ 42,857.14	\$ 150,000
IDN Member and Affiliate 'Employee Retention' Incentive Fund						
Employee Retention Incentive Fund	Tiered incentive fund tied to achievement of metrics for network partners		\$ 535,000	\$ 535,000	\$ 535,000	\$ 1,605,000
WORKFORCE CAPACITY BUILDING TOTAL		\$ 41,854.15	\$ 618,715.28	\$ 618,715.28	\$ 618,715.29	\$ 1,898,000

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

Key organizations and providers participating in the IDN to support workforce development are displayed on the table below.

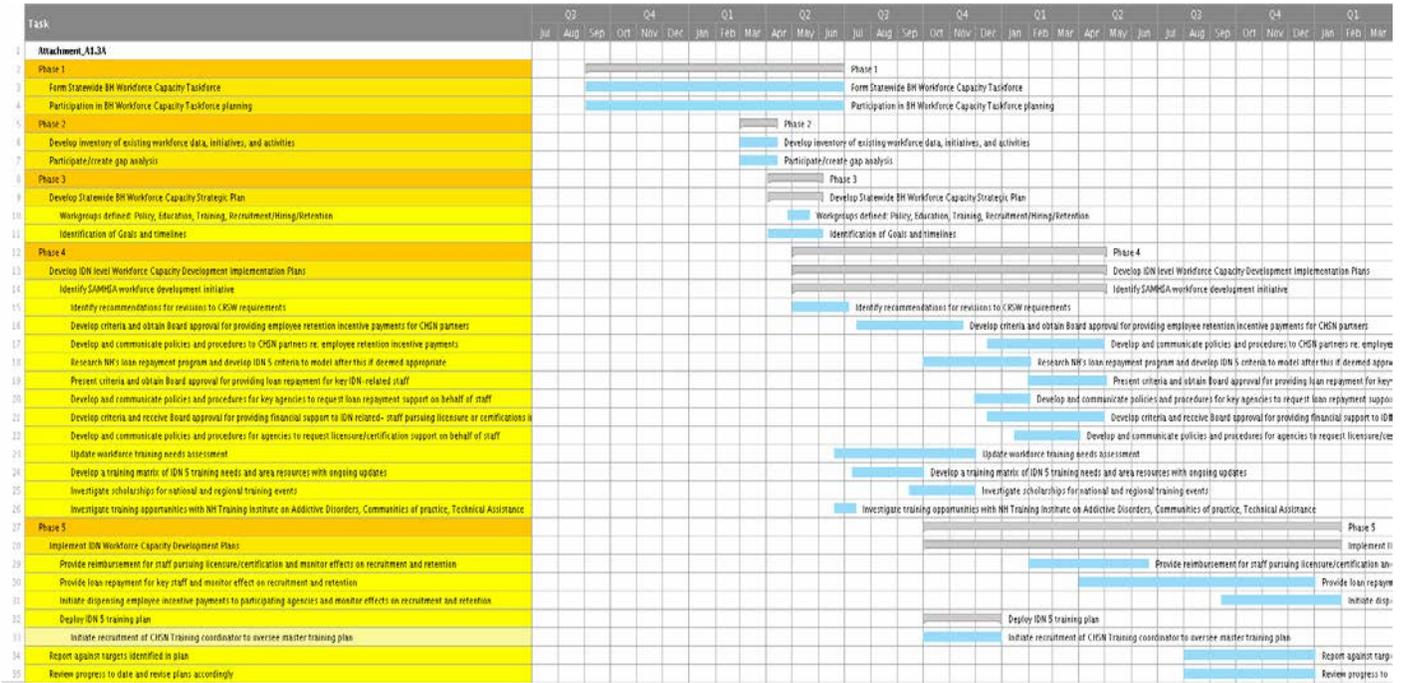
Organization Name	Organization Type	Associated with IDN Projects (A1, A2, B1, C, D, E)
LRGHealthcare	Hospital System	A1, A2, B1, C, D, E
Franklin Regional Hospital	Hospital System	A1, A2, B1, C, D, E
Speare Memorial Hospital	Hospital System	A1, A2, B1, C, D, E
Mid-State Health Center	FQHC	A1, A2, B1, C, D, E
HealthFirst Family Care Center	FQHC	A1, A2, B1, C, D, E
Genesis Behavioral Health Center	CMHC	A1, A2, B1, C, D, E
Horizons Counseling Center	SUD treatment provider	A1, A2, B1, C, D, E
Lakes Region Community Services	Social Services Organization	A1, A2, B1, C, D, E
Partnership for Public Health	Public Health Agency	A1, A2, B1, C, D, E
Pemi-Baker Community Health	Home Health Agency	A1, A2, B1, E
CAP Belknap-Merrimack Counties	Community Action Program	A1, A2, B1, C, E
Central NH VNA & Hospice	Home Health Agency	A1, A2, B1, E
Communities for Alcohol & Drug-free Youth (CADY)	SUD Prevention Agency	A1, A2, B1, C
Franklin VNA & Hospice	Home Health Agency	A1, A2, B1, E
Newfound Area Nursing Association (NANA)	Home Health Agency	A1, A2, B1, E
Ascentria	Social Services Organization	B1, E
Belknap County	Corrections	B1, C
Bridge House	Homeless Shelter	C, D, E
Community Bridges	Peer Support Agency	A1, A2, B1, E
Cornerbridge	Peer Support Agency	A1, A2, B1, E
Crotched Mountain Foundation	Disability Services and Support	E
Easter Seals/Farnum North	SUD Treatment Agency	A1, A2, B1, D
Grafton County	Corrections	B1, C
Granite State Independent Living	Disability Services and Support	E
HOPE for NH Recovery	Recovery Support Organization	A1, A2, B1, C, D, E

Organization Name	Organization Type	Associated with IDN Projects (A1, A2, B1, C, D, E)
Merrimack County	Corrections	B1, C
National Alliance on Mental Illness - NH	Peer Support Agency	B1, C, E
Navigating Recovery of the Lakes Region	Recovery Support Organization	A1, A2, B1, C, D, E
NH Alcohol and Drug Abuse Counselors	Professional Association and Training	A1
NH Veterans Home	Long term care	A1, A2, B1, E
Northern Human Services	CMHC	A1, A2, B1
Plymouth Area Resource Connection	Recovery Support Organization	A1, A2, B1, C, D, E
Riverbend Community Mental Health	CMHC	A1, A2, B1, C, D, E

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

A signed attestation of the IDN’s review and acceptance of the statewide workforce capacity development strategic plan has been signed by [REDACTED], Executive Director of the Partnership for Public Health, IDN 5 Administrative Lead and is included as **Attachment_A1.8**

A1 Statewide BH Workforce (IDN 5)



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

A2-1: IDN Participation in Statewide HIT Taskforce

CHSN-IDN 5 has participated fully to date in Statewide HIT Taskforce activities including vendor review and selection and completion of the Statewide HIT Plan. CHSN-IDN 5 staff and partners who have participated in the Statewide HIT Taskforce have included [REDACTED] (HealthFirst Family Care Center) and [REDACTED] (CHSN Executive Director). Plans developed at the state level, and vendor information associated with various applications under consideration, have been reviewed at the regional level by the CHSN HIT Committee.

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

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

Efforts by CHSN-IDN 5 to improve HIT/HIE infrastructure and functional capabilities are intended to:

1. reduce unnecessary use of inpatient and ED services, reduce unplanned hospital readmissions, and wait times;
2. facilitate integration of primary care, behavioral providers and community based organizations;
3. support care transitions; and
4. generate information that informs development of alternative payment models.

To accomplish these objectives, CHSN's HIT/HIE development activities will address improvements in organizational capacity, technology capacity and clinical workflow and related patient care systems and procedures. Organizational capacity challenges to be addressed by CHSN include providing financial resources and technical assistance, particularly to smaller agencies, to acquire and maintain HIT applications to facilitate improved clinical performance and patient care.

Technology capacity challenges to be addressed by the IDN include implementation and training in use of a new application (PreManage) to facilitate coordinated information flow across diverse health and human service settings. This work also includes establishment of common database, privacy and security standards. A key requirement for HIT development through the IDN is the support of measurable and attainable improvements in quality of care and the overall effectiveness and efficiency of the Network. Technical assistance to primary care and behavioral health practices will support modifications of clinical workflow and patient care practices to facilitate:

- Ability to access essential data at the point of care;
- Completeness and accuracy of patient data;

- Patient-centered care perspective including a) providing patients access to their clinical records and contextually appropriate educational materials, b) providing a focus on the coordination and transitions of care across different settings, and c) enabling the electronic exchange of health information to improve clinical decision making and quality of care;
- Effective clinical decision support tools;
- Patient registries to support effective chronic disease management and coordination of care for patients with co-occurring conditions; and
- High quality data reporting in support of program monitoring and reporting requirements including accurate and sufficient information to support development of alternative payment models.

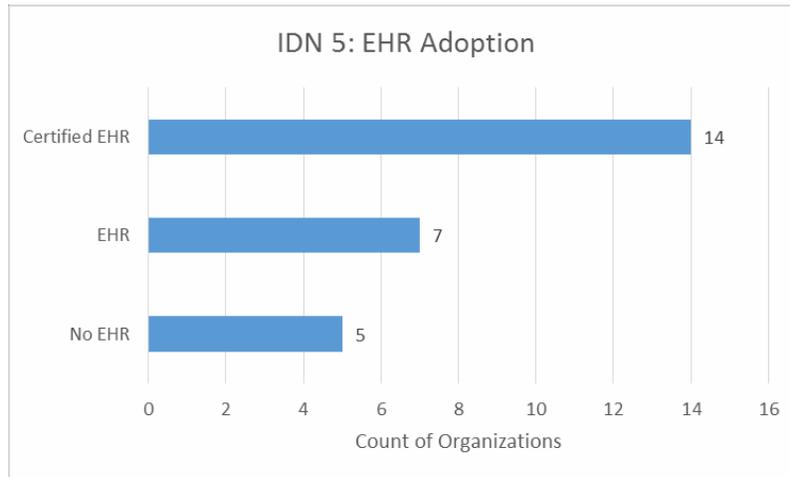
These HIT/HIE development efforts will directly and indirectly support achievement of the four objectives as follows:

1. Reduction in unnecessary use of inpatient and ED services, unplanned hospital readmissions, and wait times will be supported by implementation of PreManage including the use of a shared care plan and event notification features. These applications (as well as the Enhanced Care Coordination projects) are specifically intended to support identification of and care planning for patients at highest risk of unnecessary inpatient, ED utilization including unplanned readmissions.
2. Similarly, the shared community care plan module of PreManage is also a fundamental element of the IDN's implementation activities to facilitate integration of primary care, behavioral providers and community based organizations, particularly for practices where primary care and behavioral health are not already co-located and using a common electronic health record.
3. The risk identification and shared care plan features of PreManage also will directly support care transitions through more timely and efficient information exchange and collaborative care plan development. This focus is again also central to the substantial activities that CHSN will be implementing through the Enhanced Care Coordination initiative.
4. The activities described above will support improvements in cost and quality of care such that network member organizations can be successful in an alternative payment environment. A more specific HIT development activity that will inform development of alternative payment models will be implementation of a Data Aggregator application. CHSN will continue to work with the statewide HIT workgroup on selection and implementation of such an application that can facilitate collection and reporting of patient care data describing performance on specific quality metrics at the provider and network level.

CHSN-IDN 5 participated in a Health IT Assessment using a tool developed by Myers and Stauffer to assess the current health IT environment of all IDNs. Results as of February 2017 are described in the following text and charts.

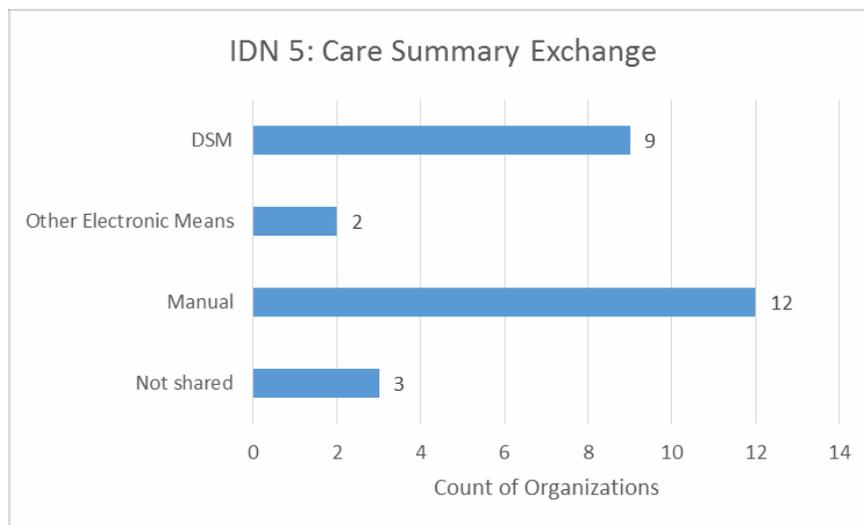
Based on the final version of the HIT Data Supplement for our region there was a total of twenty-six (n=26) organizations that completed the HIT Assessment tool. From the results, fourteen (n=14) organizations attested to having a certified EHR system and seven (n=7) organizations attested to having a non-certified EHR system. To be noted, five (n=5) organizations stated that they had no EHR system at all. Organizations with no EHR systems are important to identify in order to determine what further assistance they need to meet the State's DSRIP initiative objectives and our region's goals.

Figure 1. EHR Adoption



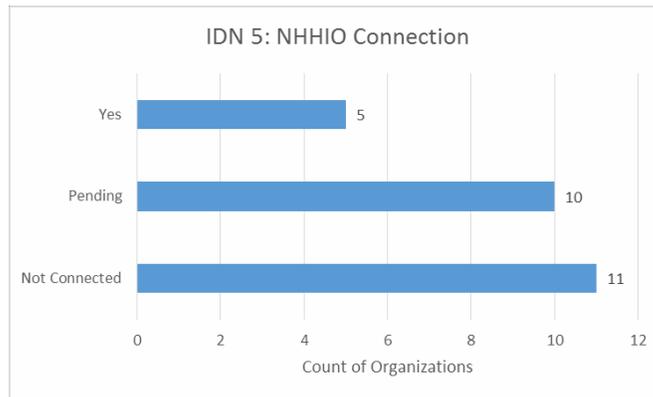
Limitations in electronic health data sharing among New Hampshire’s providers exist, due in part to legislative restrictions. Because of these limitations, Direct Secure Messaging (DSM) is used through the New Hampshire Health Information Organization (NHHIO). NHHIO serves as a Health Information Service Provider (HISP) with a statewide Healthcare Provider Directory (HPD) to support Transfers of Care. NHHIO provides a secure network option for small providers with fewer resources across the care continuum, such as community-based organizations.

Figure 2. Direct Secure Messaging



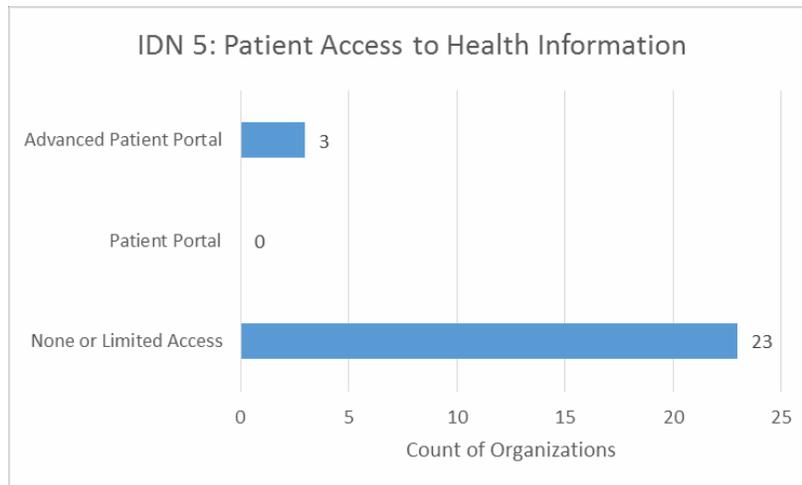
All organizations that completed the HIT Assessment tool were cross referenced with the NHHIO’s official list of organizations that are connected. In summary, for our region, five (n=5) organizations are connected to NHHIO with an additional ten (n=10) organizations that are in the process of connecting. Eleven (n=11) organizations are not connected or are not planning on connecting to NHHIO. While progressing through the DSRIP initiative, it will be important to ensure organizations that are not connected to NHHIO adopt a basic sharing protocol like direct secure messaging.

Figure 3. Electronic Health Data Sharing



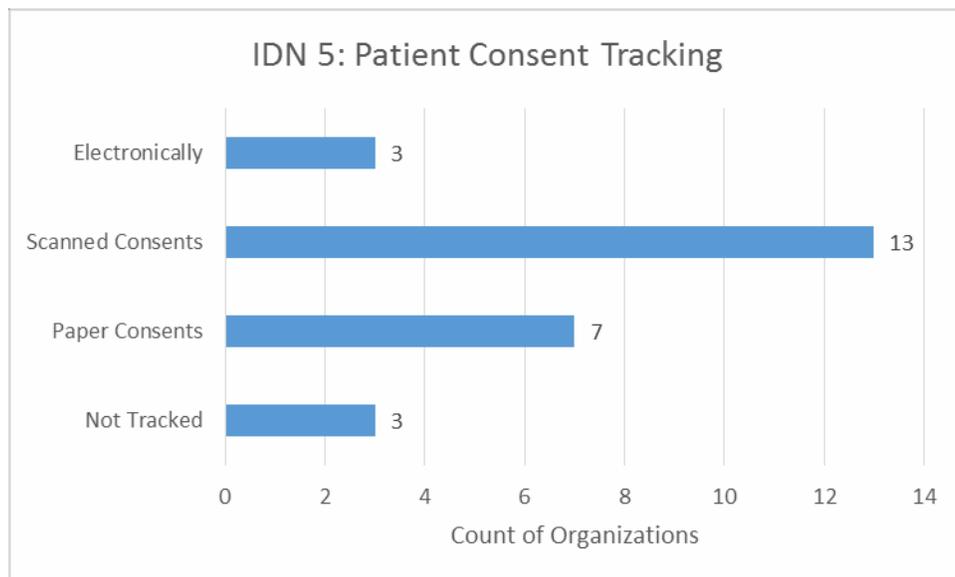
From the HIT Assessment results, a question was asked about patient access to health information. In general, most organizations do not provide easy access to their patient’s information. For our region, only three (n=3) organizations provide an advanced patient portal with at least three of the following features: lab results, appointment scheduling, billing, links to health information websites, prescription refills, referrals, or secure messaging. This compares to twenty-three (n=23) organizations that do not provide a patient portal at all and provide limited access to their patient’s information. It will be important to create infrastructure to allow the sensitive substance abuse patients access to their health information.

Figure 4. Patient Access to Health Information



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. Thirteen (n=13) organizations scan paper consents into an electronic system while another seven (n=7) organizations only capture consents on paper. Three (n=3) 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. This work has proceeded through consultation with UNH (Hodder) resulting in a draft consent form that can be configured in an electronic record or the shared care plan application under development.

Figure 5. Patient Consent Tracking



A2-3: IDN HIT/HIE Requirements and Timeline

Major activities and milestones in this strategic pathway for IDN development to support integration at the practice and community level are intended to include:

- Assisting all CHSN members to achieve the minimum HIT Standards as specified by the Statewide HIT Workgroup and as applicable to their service array by the end of 2017 (see below for excerpt from the Statewide HIT Workplan for description of these minimum standards). Ongoing assistance will include supporting CHSN partners with their selection and use of ONC Certified Technologies and functions adhering to the ONC’s 2016 Interoperability Standards Advisory and subsequent guidance.
- Assisting selected organizations to achieve desired and / or optional HIT standards with particular emphasis on providers with a significant proportion of Medicaid clients, such as

FQHCs, and key behavioral health care providers (also see below for excerpt from the Statewide HIT Workplan for description of the desired and optional standards)

- Installation, training and support of a shared application for event notification, patient risk identification, and inter-agency shared care planning (CMT PreManage)
- Assistance in establishing and supporting interfaces outside CHSN-IDN 5 partner organizations including capability for information exchange with NH Hospital (current plan if for this to be accomplished through CMT);
- Selection, installation, training and support of a data aggregation application to facilitate clinical and financial analytics across the network.

The CHSN-IDN5 HIE integration plan includes establishing and supporting an interface with NH Hospital. It is our understanding that the current plan for this HIE interface is to be accomplished through the CMT application in coordination with the efforts of the Statewide HIT workgroup. CHSN member and affiliate organizations will also be connected through the CMT-PreManage application in order to participate in the shared community care plan efforts. In particular, capability for health information exchange and shared care planning will be established with Belknap County Corrections and Lakes Region Community Services (developmental services provider) as part of the Community Re-entry and Enhanced Care Coordination projects. It is our plan to phase in improved HIE capability with other community organizations such as Belknap County Nursing Home over time in support of the IDN’s efforts to improve care transitions, reduce unnecessary ED use and unplanned hospitalreadmissions.

The CHSN-IDN5 HIT implementation plan includes developing increased capability across the network for population health management including standardized assessment, risk identification and patient recall, care coordination and care management, health care transitions support, and quality measurement. As described above, it is anticipated that these capabilities will be supported through implementation and training on use of electronic applications for risk identification, event notification, shared care planning and data aggregation. Increased capability for population health management will also be a product of practice level technical assistance and EHR enhancement to facilitate implementation of standardized screening and assessment tools and procedures, clinical decision support tools, patient registries, and patient / caregiver engagement tools and procedures.

<i>Health IT Minimum Standards</i>					
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
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
Internet Connectivity	Securely connected to the internet	All	Determine if they have it, do they need it	All	
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

Health IT 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
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.
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.
Shared Care Plan	Ability to access and/or contribute to an electronic shared care plan for an individual Patient	Community Mental Health Center, Community-Based Organization Direct Patient Care, County Nursing Facility, Federally Qualified Health Center, Home and Community-Based Care, Hospital Facility, Other Organization Type Direct Patient Care, Primary Care Practice, Rural Health Clinic, Substance Use Disorder Treatment	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.
Event Notification Service	Ability to receive notifications as a minimum for all organizations.	Community Mental Health Center, Community-Based Organization Direct Patient Care, County Nursing Facility, Federally Qualified Health Center, Home and Community-Based Care, Hospital Facility, Other Organization Type Direct Patient Care, Primary Care Practice, Rural Health Clinic, Substance Use Disorder Treatment	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.
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

Health IT Desired Standards

Desired Definition: Applies to only some IDN participants

Capability & Standard	Description	Role of IDN	DSRIP Project
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
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
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

Health IT Optional Standards

Optional Definition: Applies to only some IDN participants

Capability & Standard	Description	Role of IDN	DSRIP Project(s)
Closed Loop eReferrals	Ability to send referrals electronically in a closed loop system	To be determined if standard is adopted	All
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
Data Analysis / Validation	Ability to analyze data to generate non-required organizational or IDN level reporting	To be determined if standard is adopted	All
Population Health Tool	Ability to identify high utilizers within populations at organizational or IDN level	To be determined if standard is adopted	All
Capacity Management Tools	Ability to see utilization and availability.	To be determined if standard is adopted	All, except C2, D3
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

The table below outlines the key activities, milestones and timelines, responsible party, and progress measures for the HIT/HIE Capacity Development Implementation plan. Smartsheet detail and timeline is included as a graphic at the end of this section and included as **Attachment_A2.3**

Implementation Activity/ Milestone	Responsible Party/ Organization	Time line	Progress Measure / Notes
HIT-related Policy and Procedures			
Participate with representatives of other IDNs in developing and implementing state level plans and coordinated investments for strengthening the statewide HIT/HIE infrastructure	CHSN Executive Director; HIT Lead – [REDACTED]	Ongoing	Milestone Met: regular participation; statewide HIT plan developed
Maintain standing CHSN HIT Committee with responsibility for making recommendations to the Board on investments and technical enhancements to support development of network-wide HIT capabilities.	HIT Committee Lead	Meets monthly, ongoing	Milestone Met: regular meetings occurring with documentation of minutes; board approval for CMT investment
Maintain CHSN Data Analytics subcommittee of the HIT committee to establish data sharing standards / processes and procedures for collecting and monitoring performance data	HIT Committee Lead	Meets monthly, ongoing	Pending; work occurring at state level with regard to performance metrics and data aggregation
Develop forms and procedures for informed patient consent to share information	HIT Committee Lead	By December 31, 2017	In progress; on track; worked with UNH (Hodder) to complete activity
Develop inter-agency data sharing agreements addressing requirements for data security, storage, maintenance and exchange	HIT Committee Lead	By December 31, 2017	Pending; anticipate working with State workgroup as part of CMT and Data Aggregator implementation process
Train providers in HIPAA, Confidentiality/Privacy-42 CFR Part 2	CHSN-IDN 5 Training Committee, HIT Taskforce	Begin Q4 2017	Pending; links to Workforce/Training Plan and Community Projects.
Continue to assess capabilities of all CHSN members to meet and sustain minimal HIT standards	HIT Committee	By December 31, 2017 and ongoing	In progress; on track
HIT Infrastructure Improvements / Applications to Facilitate Integrated Care			
Support specific CHSN members to achieve minimum HIT standards; install capabilities for data encryption and Direct Secure Messaging (e.g. Kno2); applies to Horizons, NANA and PPH	HIT Committee	By December 31, 2017	In progress; on track

Implementation Activity/ Milestone	Responsible Party/ Organization	Time line	Progress Measure / Notes
Execute agreement with Collective Medical Technologies (CMT) on behalf of CHSN-IDN 5 partners for installation and support of PreManage application for shared care plan and event notification	CHSN Executive Director, Board	By September 30, 2017	In progress; on track
Initiate PreManage Primary Implementation with FQHCs and BH provider organizations <ul style="list-style-type: none"> • Send list of prioritized clinics to CMT • CMT contact prioritized agencies / practices • Agency / Practice implementation steps <ol style="list-style-type: none"> 1. View Video Demo of PreManage 2. Set up Q&A meeting with CMT 3. Set up eligibility file discussion 4. Complete On-Boarding packet 5. Train Users on PreManage Primary 	CHSN Executive Director; CMT; HIT Committee	Initiate implementation October 1, 2017; test / 'soft' go live with first agency by November 1 2017	In progress; Wave 1 = HealthFirst, Midstate, Horizons, Riverbend, Genesis
Initiate PreManage ED Implementation with hospitals <ul style="list-style-type: none"> • IT steps: <ol style="list-style-type: none"> 1. Establish VPN Connectivity 2. ADT Feed/Messages – receive ADT feed from Hospital 3. Historical File – 12-24 Months of patient enrollment and encounter data prior to go live 4. Notification Return Type – can support a print or electronic type notification. Coordinate with each hospital as to what will work best for their workflows. • Clinical steps: <ol style="list-style-type: none"> 1. Clinical Workflow discussion with clinical team 2. User Provisioning 3. Train Providers 4. Train Users 	CHSN Executive Director; CMT; HIT Committee	Initiate implementation October 1, 2017; test / 'soft' go live with first hospital by January 15 2018	In progress; Wave 2 = LRGH, FRH, Speare
Initiate PreManage Primary Implementation with hospital affiliated primary care practices <ul style="list-style-type: none"> • Send list of prioritized clinics to CMT • CMT contact prioritized agencies / practices • Agency / Practice implementation steps <ol style="list-style-type: none"> 1. View Video Demo of PreManage 2. Set up Q&A meeting with CMT 3. Set up eligibility file discussion 4. Complete On-Boarding packet 5. Train Users on PreManage Primary 	CHSN Executive Director; CMT; HIT Committee	Initiate implementation January 1, 2018; test / 'soft' go live with first practice by February 15, 2018	In progress; Wave 3 = home health, social service, recovery and peer support, housing and homeless organizations, and county facilities
Monitor PreManage utilization, troubleshoot; provide ongoing support and training	CMT; HIT Committee	Initiate November 1, 2017; ongoing	Pending installation of application
Initiate development of capacity for intra-network data aggregation for quality, utilization and cost measurement and reporting	Statewide HIT Workgroup; CHSN HIT Committee	Initiate September 1, 2017	Initial discussion underway

Implementation Activity/ Milestone	Responsible Party/ Organization	Time line	Progress Measure / Notes
Review and select vendor for data aggregation / intra-network quality reporting	Statewide HIT Workgroup; CHSN HIT Committee	Selection by November 1, 2017	Pending
Facilitate agreements with participating agencies / practices to build interfaces with the data aggregator (DA) application	Data aggregator vendor; HIT Committee; CHSN Board	Initiate by December 1, 2017; ongoing	Pending
Configure data aggregator <ul style="list-style-type: none"> define CCSA tracking requirements / definitions; configure other DSRIP measure tracking requirements / definitions Verify patient privacy requirements met;	Data aggregator vendor; HIT Committee	Initiate by January 1, 2018	Pending
Test / initiate clinical quality measures reporting	Data aggregator vendor; HIT Committee; Data Analyst	Initiate by March 1, 2018	Pending
Provide ongoing support and training on use of data aggregator functions; Provide consultation on use of reports for performance improvement	Data aggregator vendor; HIT Committee; Practice Transformation Specialist	Initiate July 1, 2018; ongoing	Pending installation of application
Initiate development of tracking and reporting of utilization and cost to inform development of alternative payment models	Data aggregator vendor; HIT Committee; CHSN Board	Initiate by January 1, 2019; ongoing	Pending

A2-4: IDN HIT Evaluation Project Targets

From the IDN HIT Implementation Plan, use the format below to identify the measurable targets, or goals, that the plan 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
Number of IDN participants achieving minimum HIT standards as appropriate to provider type (refer to Statewide HIT Implementation for description of minimum standards)	15			
Number of IDN participants utilizing ONC Certified Technologies	15			
Number of IDN participants capable of conducting ePrescribing	7 of the CHSN members that prescribe			
Number of IDN participants capable of conducting other core functions such as registries, standardized patient assessments, collection of social determinants, treatment and care transition plans	12 of the CHSN members that maintain a health record			

Performance Measure Name	Target	Progress Toward Target		
Number of IDN participants utilizing Certified Electronic Health Record Technology (CEHRT)	12 of the CHSN members that maintain a health record			
Number of IDN participants able to exchange relevant clinical data with each other and with statewide facilities such as New Hampshire Hospital via health information exchange (HIE) standards and protocols.	To be determined			
Number of IDN participants able to protect electronically-exchanged data in a secure and confidential manner meeting all applicable State and Federal privacy and security laws (e.g., HIPAA, 42 CFR Part 2).	15 CHSN Members			
Number of IDN participants able to use comprehensive, standardized physical and behavioral health assessments.	15 CHSN Members			
Number of IDN participants able to share a community-wide care plan to support care management, care coordination, patient registries, population health management, and quality measurement.	To be determined			
Number of IDN participants able to directly engage with their patients through bi-directional secure messaging, appointment scheduling, viewing care records, prescription management, and referral management.	To be determined			

A2-5: IDN HIT Workforce Staffing

The table below includes information on current staffing levels as of June 2017 and projected HIT Workforce need. It is important to note that these are point in time estimates of positions (not FTEs; in some cases CIOs have more than one role in an organization) from participating CHSN-IDN 5 partner organizations and are subject to adjustment. The information on projected need includes new positions that are anticipated for supporting HIT-related IDN work.

Staff Type	IDN Workforce (positions)				
	Projected Total Need	Baseline Staffing on 6/30/17	Staffing on 12/31/17	Staffing on 6/30/18	Staffing on 12/31/18
Health Data Analyst	1	0			
Practice Transformation Specialist	1	0			
Chief Information Officers (agency-based)	10	12			

A2-6: IDN HIT Budget

Funds are budgeted to support HIT development including staff salary and wages, software implementation and license fees, and implementation and software costs to support individual agencies to achieve minimum HIT standards.

Budget Item	Item Description	2017 Costs	2018, 2019, 2020 (Costs Equally Distributed over 3 years)	Total Project Cost
Salary and Wages	Data Analyst (part-time)	██████	██████	██████
Consultants / Subcontracts	UNH (██████) – development of client consent for inter-agency data sharing document documents	██████		██████
Software License and Fees				
Community Care Module	CMT PreManage and Event Notification @ ██████ per year plus individual ER physician user licenses ██████ x 40 licenses	██████	██████	██████
Data Aggregator	Vendor selection in process – costs are estimated at ██████ for initial installation plus ██████ per year license	██████	██████	██████
Agency-specific support	Costs to bring agencies up to HIT "Minimum standards", e.g. installation of capability for data encryption and secure messaging	██████	██████	██████
HIT CAPACITY BUILDING TOTAL		\$ 172,750	\$ 379,500	\$ 552,250

A2-7 IDN HIT Key Organizational and Provider Participants

Key organizations and providers participating in the IDN to support workforce development are displayed in the table below. It is our expectation that all participating organizations will achieve minimum HIT standards as applicable to their organizational context and participate in the CMT- PreManage shared care module as appropriate to their service array.

Organization Name	Organization Type
LRGHealthcare	Hospital System
Franklin Regional Hospital	Hospital System
Speare Memorial Hospital	Hospital System
Mid-State Health Center	FQHC
HealthFirst Family Care Center	FQHC
Genesis Behavioral Health Center	CMHC
Horizons Counseling Center	SUD treatment provider
Lakes Region Community Services	Social Services Organization
Partnership for Public Health	Public Health Agency
Pemi-Baker Community Health	Home Health Agency
CAP Belknap-Merrimack Counties	Community Action Program
Central NH VNA & Hospice	Home Health Agency
Communities for Alcohol & Drug-free Youth (CADY)	SUD Prevention Agency
Franklin VNA & Hospice	Home Health Agency
Newfound Area Nursing Association (NANA)	Home Health Agency
Community Bridges	Peer Support Agency
Cornerbridge	Peer Support Agency
Easter Seals/Farnum North	SUD Treatment Agency
HOPE for NH Recovery	Recovery Support Organization
Navigating Recovery of the Lakes Region	Recovery Support Organization
NH Veterans Home	Long term care
Northern Human Services	CMHC
Plymouth Area Resource Connection	Recovery Support Organization
Riverbend Community Mental Health	CMHC

A2-8: IDN HIT Data Agreement

Inter-agency data sharing agreements will be developed as part of the work with vendors for the shared care plan and data aggregation. Participants in the Statewide HIT Workgroup have indicated interest in collaborating on this task to develop a common data sharing agreement that can be tailored to different contexts. It is anticipated that this work will be completed by the end of December 2017.

Organization Name	Data Sharing Agreement Signed Y/N
LRGHealthcare	No
Franklin Regional Hospital	No
Speare Memorial Hospital	No
Mid-State Health Center	No
HealthFirst Family Care Center	No
Genesis Behavioral Health Center	No
Horizons Counseling Center	No
Lakes Region Community Services	No
Partnership for Public Health	No
Pemi-Baker Community Health	No
CAP Belknap-Merrimack Counties	No
Central NH VNA & Hospice	No
Communities for Alcohol & Drug-free Youth (CADY)	No
Franklin VNA & Hospice	No
Newfound Area Nursing Association (NANA)	No
Community Bridges	No
Cornerbridge	No
Easter Seals/Farnum North	No
HOPE for NH Recovery	No
Navigating Recovery of the Lakes Region	No
NH Veterans Home	No
Northern Human Services	No
Plymouth Area Resource Connection	No
Riverbend Community Mental Health	No

Project B1: Integrated Healthcare

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

The Integrated Healthcare strategic channel for delivery system transformation will support and incentivize primary care and behavioral health providers to progress along a path from their current state of practice toward a higher level of integrated care as feasible and appropriate to practice context. The overarching framework for assessing progress will be informed by SAMHSA's Standard Framework for Levels of Integrated Healthcare.

In addition to addressing integration at the individual practice level, it is important to recognize that progress toward integration at an organizational practice level also occurs within a wider systemic and environmental context across the CHSN-IDN 5 network where the health care needs and preferences of individual patients are at the center. As such, the attributes of integrated practice may vary to some extent across agencies as influenced by variation in type and intensity of health care and psychosocial needs of patients. Nevertheless, there are fundamental underlying characteristics of integration that are applicable across practices and systems and these characteristics will form the basis for monitoring progress toward greater integration. Ultimately, anticipated outcomes of this work are improvements in enhanced patient experience, improved population health, reduced costs, and enhanced provider experiences.

CHSN-IDN5 will support its primary care practices, community mental health centers, and outpatient SUD treatment agency in becoming a "Coordinated Care Practice" or an "Integrated Care Practice," depending on what is practical given the practice's current level of integration, patient panel size and risk profile, and available resources. Different practices are currently at varying levels of integration and the pace at which these practices can move towards greater integration will vary. Technology to support integration ranges from no EHR (i.e. Horizons except the state Bureau of Drug and Alcohol Services WITS system) to more advanced EHR capabilities (HealthFirst and Mid-State FQHCs). There is variation in capability to make electronic referrals, use of patient registries, use of standardized assessments specific to or inclusive of behavioral health and social determinants of health, sharing of care plan documents, intra- and inter-organizational case conferencing, capacity for care coordination, and existence of inter-agency information and referral agreements. Practices are also at different levels of integration readiness within their respective workforces including staffing levels available to support integrated practice, staff proficiencies, education levels, competing priorities and primary care/behavioral health care co-location characteristics.

We are still awaiting results of a site self-assessment survey being administered with support from UNH/Institute for Health Policy and Practice. The self-assessment will provide updated results on levels of integration for each participating practice relative to the SAMHSA framework and will inform targeted technical assistance and training for assisting practices to move along the continuum of integrated practice. However, we can anticipate that the following steps and resources will be applied to assist practices in achievement of higher levels of integrated practice characteristics. The primary focus throughout the project period will be on increasing the level of integrated practice by the organizations with the greatest number of Medicaid clients.

The implementation process will include development of individualized integration plans for each practice along with staged implementation to take into consideration practice/provider readiness level for change. Steps taken to assist achievement of higher levels of practice integration will include:

1. Confirm regional goals and timeline for Coordinated Care Practice development
2. Develop practice specific technical assistance and training plans

3. Develop Comprehensive Core Standardized Assessment process and preliminary procedures for inter-agency data collection to ensure capture of required domains
4. Assess practice workflows and create plan for introduction / modification of assessment tools and shared care plan as appropriate to each practice
5. Implement Comprehensive Core Standardized Assessment process for aggregating information across multiple assessment domains and from multiple providers
6. Facilitate adoption of evidenced based screening & assessment tools / procedures including SBIRT, PHQ 2 & 9, and developmental / behavioral assessment
7. Develop / Identify core team meeting protocols and relevant workflows for communication among core teams and other patient providers, including case conferences
8. Document roles and responsibilities for core team members and other members as needed
9. Specify / implement training plan for core team members and extended team as needed
10. Develop / Identify mechanisms (e.g. patient registries) to track patients and adherence to evidence based care recommendations
11. Install Shared Care Plan (PreManage) to support inter and intra organizational communication and coordination of care
12. Map participating partner workflows, introduce / train on shared care plan use
13. Implement Intake procedures to include consent to share information among providers
14. Develop / modify referral protocols as needed to/from PCPs, BH providers, community care coordination teams, social service support providers, Hospitals, and EDs
15. Develop / modify protocols as needed to ensure safe, supported care transitions from institutional settings to primary care, behavioral health, social support service providers and family/friend caregivers as appropriate
16. Implement workforce plan to recruit and retain multi-disciplinary care team members
17. Provide consultation on selection / use of certified EHR and related technology to support integrated care
18. Confirm regional goals and timeline for Integrated Practice development
19. Assess opportunities and challenges for integration of Medication-assisted treatment (MAT) in CHSN-IDN 5 primary care and BH practice settings
20. Facilitate training / technical assistance as needed for integration of MAT practice within CHSN-IDN 5 practices moving to Integrated Care Practice level
21. Assess opportunities and challenges for adoption of evidence-based treatment of mild-to-moderate depression within CHSN-IDN 5 practices moving to Integrated Care Practice level
22. Facilitate training / technical assistance as needed for adoption of evidence-based treatment of mild-to-moderate depression within CHSN-IDN 5 practices moving to Integrated Care Practice level
23. Provide consultation on enhanced use of HIT to support integrated care including use of the technology for identifying at risk patients, to plan care, to monitor/manage patient progress toward goals and ensure closed loop referrals.
24. Develop or modify as needed workflows, joint service protocols and communication channels

with community based social support service providers

25. Periodically assess designated practices for progress along the SAMHSA Integrated Care continuum

26. Participate in DHHS pilot of EHR-dependent measures

27. Monitor and report measures of integrated practice outcomes as defined in the DSRIP measures

Resources to support the Integrated Health core competency work will include the activities of four task teams supported by CHSN. These resources and task teams are described in the next section: B1-2: IDN Integrated Healthcare: Implementation Plan, Timeline, Milestones and Evaluation Project Plan.

Network activities in this strategic channel are closely aligned with work through the Enhanced Care Coordination community project. This alignment includes a focus on creating an overarching system of health care that improves the outcomes, experience, and coordination of care across a continuum of physical and mental health for individuals with behavioral health conditions or at risk for such conditions. The goal of integrating these services is to build a delivery system that effectively and efficiently prevents, treats, and manages acute and chronic behavioral health and physical illnesses across multiple providers and sites of service.

The table below displays information from a preliminary assessment of integrated care by organization (see **Attachment B1.1**). This information will be updated with the assessment of integration levels using the SAMHSA framework that is currently underway (roll out of results anticipated early October 2017).

Organization Name	EMR in Use	Capability to do e-Referrals through EMR	Patient registries in use	Core standardized assessment in use	Care plans documented electronically or paper, and shared with care team	Universal screening for depression and SUD in place	Regularly scheduled patient case conferences for high-risk patients	Formal consulting arrangements with BH (for PCP) or PCP (for BH) providers	Physically co-located MH or SUD and PC services	Formalized multi-disciplinary care teams that include care coordinator or Community Health Worker	Documented description of multi-disciplinary care team roles and responsibilities	Patient panels established/maintained for each care team	Formalized cross-training of clinical staff in chronic care, mental health, and substance use issues	Evidence-based guidelines established and shared	MOU and documented referral protocols with social service support agencies
HealthFirst	Y	Y	Y	Y	Y	Y	Some	Y	Y	Some	Y	Y	Y	Y	Y
Mid-State	Y	Y	Y	Y	Y	Some	Y	Y	Y	Y	Y	Y	Some	Y	Y
Speare	Y	Y, between Speare practices	In Devel	Limited	Y	Y-depression	Y	PT Psychiatrist sees pts. In PC, consults on med mgmt	Limited	N, not formalized	N	In Devel	N	Y, but not built into EMR prompts	Y
LRGH Practices	Y*	Y, limited to practices on EMR currently	N	Y, but very limited for BH	N	Y**	Y, new initiative in 2016	N	N	In Devel, not formalized	N	Some practices	N	In Devel	Y
PRH Practices	Y*	Y, limited to practices on EMR currently	N	Y, but very limited for BH	N	Y**	Limited	N	Worksite only	In Devel, not formalized	N	Some practices	N	In Devel	Y
Genesis	Y	Internally	Y	Y	Internally	Y	N	Limited	Limited	Limited	Limited	Internally	N	Y	Some
Horizons	Y	N	Y	Y	Y	Y	Y	Depends	MH, SUD	N	N	N	Y	Y	Some
Riverbend Frim. OTHER NETWORK ORGANIZATION RESIDENTS' NOTICE OR BH	Y	N	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
NANA	Y	Y	Y	Y	Y	Y	Y	N	N	N	N	N/A	Y	Y	Y
Grafton Cty Doc	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	N	N/A	N	Y	N
Lakes Region CS	N	N	N	Y	N	Y	N/A	N	Y	Y	N	N/A	N/A	N/A	Y
Lakes Region VNA	Y	N	Y	Y	Y	Y	Y	N	N	N	Y	N	N	Y	Internal
Penn Baker	Y	Y	N	Y	Y	Y	Y	N	N	N	Y	N	N	Y	Y
Northern HS	Y				Y	Y	Y	Y	Y					Y	Y
PPH			Y		Y		Y		Y	Y					
NAMI													Y	Y	
SUBTOTAL YES	13	8	8	10	11	12	10	5	6	5	6	2	5	10	9

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

The implementation process will include development of individualized integration plans for each practice along with staged implementation to take into consideration practice/provider readiness level for change. Practice involvement at the outset will vary where some practices may only participate in basic information sharing and training activities in the beginning, while others may be involved with technology enhancements and workflow modifications from the start. An important timing consideration is that practices associated with LRGH and Speare Memorial are currently involved in a continuing roll out of a new health information system (Cerner). The timing of implementation efforts

for the IDN-related integration work will need to fit within and adapt to the significant changes and learning that will be occurring with implementation of this new system across the major hospital systems. The primary focus throughout the project period will be on increasing the level of integrated practice by the organizations with the greatest number of Medicaid clients.

Resources to support the Integrated Health core competency work will include the activities of four task teams supported by CHSN-IDN 5 including:

- The Clinical Integration Committee will develop protocols for comprehensive core standardized assessment (CCSA), treatment, management, communication and referral. This Committee will build on the assessment results by reviewing current practices, protocols and procedures used by participating practices in more depth, drawing on standards and guidelines such as those associated medical or health homes. The team will determine protocols based on what practices are doing now, what works, what does not work, and incorporating best practices in a collaborative manner. The Committee will also assist in the development of common terminology for job descriptions of integrated practice within the overall system context and existing assets of the region.
- The CHSN-IDN 5 Training Team that will draw on personnel among the IDN partners to build individual and organizational level capabilities for integrated practice. The training team will design and develop relevant training sessions based on the results of more in-depth individual practice assessments. Training methods will include “Train the Trainer” sessions to build practice-based leadership, Network-wide educational opportunities, and one on one practice- based consultation focused on workflow and visit design. As an example of work in this area, the Training Team may draw on the local expertise found in the FQHCs on SBIRT implementation to provide consultation to other Network practices in order to facilitate broader and more consistent adoption of this evidence-based practice.
- The Health Information Technology Team established for the overall IDN will be essential for assisting participating practices and agencies with the information technology aspect of the project including installation of and training on technology to support shared care plans and the multi-disciplinary case management/care coordination aspects of each of the network’s community projects. The new applications to be purchased and implemented in conjunction with the other IDNs statewide are specific examples of new resources to be applied in support of practice and community level integration to include functionality for risk identification, event notification, shared care planning and data aggregation.
- The Data Analytics team will convene staff from participating practices that will work to identify common terminology, existing reporting capabilities and procedures, and challenges for collecting data across the Network associated with the DSRIP project outcome metrics. This aspect of the HIT/Data Analytics work will be guided by the Clinical Integration Committee to assure common understanding of information inputs and outputs. As part of this area of work, CHSN-IDN 5 will also support QI/QA staff from member agencies to consult with Network members lacking sufficient internal QI/QA resources on approaches to collecting and applying information to support performance improvement.

To enable the work to be accomplished through these task teams, the network will be implementing agreements with collaborating providers and organizations for inter-agency data sharing and patient information release. As previously described, this work has already progressed with technical assistance from UNH and broad participation by network members. Smartsheet detail and timeline is included as a graphic at the end of this section and included as **Attachment_B1.2**

Implementation Activity/ Milestone	Responsible Party/ Organization	Time line	Progress Measure / Notes
Planning phase			
Identify / obtain Commitment from key organizational/provider participants	CHSN Executive Director; CHSN Board	By June 30, 2017	Milestone met
Organizational leaders sign-off	CHSN Executive Director; CHSN Board	By July 31, 2017	Milestone met
Complete Workforce plan to support integrated practice	Workforce Team Lead	By July 31, 2017	Milestone met
Complete Training plan to support integrated practice	CHSN Project Manager	By July 31, 2017	Milestone met
Complete HIT plan to support integrated practice	HIT Team Lead	By July 31, 2017	Milestone met
Complete Site Self-Assessments for updated information on level of integration	CHSN Executive Director; UNH	By Sept. 15, 2017	In progress; results pending
Implementation Plan for Coordinated Care Practices			
Complete DSRIP CSA Gap Analysis	CHSN Project Manager	By March 31, 2017	Assessment of currently used assessment instruments and domains completed
Confirm regional goals and timeline for Coordinated Care Practice development	CHSN Executive Director; Clinical Integration Committee	By October 31, 2017	Overall goals and participating practices identified; more individualized plans and timelines pending results of site self-assessments in Sept.
Develop practice specific technical assistance and training plans	Clinical Integration Committee; Training Coordinator; Practice Transformation Specialist	By December 31, 2017	Pending self-assessment results; develop plans in consultation with practice managers
Develop Comprehensive Core Standardized Assessment tools and preliminary procedures for inter-agency data collection to ensure capture of required domains	Clinical Integration Committee	By December 31, 2017	Under development
Assess practice workflows and create plan for introduction / modification of assessment tools and shared care plan as appropriate to each practice	Clinical Integration Committee; HIT Team; Practice Transformation Specialist	By December 31, 2017	In progress; work to proceed in conjunction with HIT Team activities
Implement Comprehensive Core Standardized Assessment process for aggregating information across multiple assessment domains and from multiple providers	Clinical Integration Committee; HIT Team; Practice Transformation Specialist	Initiate by January 31, 2018	Pending; work to proceed in conjunction with HIT Team activities
Facilitate adoption of evidenced based screening & assessment tools / procedures including SBIRT, PHQ 2 & 9, and developmental / behavioral assessment	Clinical Integration Committee; Training Coordinator; Practice Transformation Specialist	Initiate by December 31, 2017	Pending; work to proceed in conjunction with HIT Team / EHR enhancement activities

Implementation Activity/ Milestone	Responsible Party/ Organization	Time line	Progress Measure / Notes
Develop / identify core team meeting protocols and relevant workflows for communication among core teams and other patient providers, including case conferences	Clinical Integration Committee; Practice Transformation Specialist	Initiate by December 31, 2017	Pending; work to proceed in conjunction with Enhanced Care Coordination Team
Document roles and responsibilities for core team members and other members as needed	Clinical Integration Committee; Practice Transformation Specialist	Initiate by December 31, 2017	Pending; work to proceed in conjunction with Enhanced Care Coordination Team
Specify / implement training plan for core team members and extended team as needed	Clinical Integration Committee; Training Coordinator	Initiate by December 31, 2017	Pending
Develop / identify mechanisms (e.g. patient registries) to track patients and adherence to evidence based care recommendations	Clinical Integration Committee; HIT Team; Practice Transformation Specialist	Initiate by January 31, 2018	Pending; work to proceed in conjunction with HIT Team activities
Install Shared Care Plan to support inter and intra organizational communication and coordination of care	Clinical Integration Committee; HIT Team; Practice Transformation Specialist	Initiate September 2017	Pending; work to proceed in conjunction with HIT Team activities
Map participating partner workflows, introduce / train on shared care plan use	Clinical Integration Committee; HIT Team; CMT	Initiate 1 st tier (B1) partners October 2017, all others February 2018	Pending; work to proceed in conjunction with HIT and Enhanced Care Coordination Team activities
Implement Intake procedures to include consent to share information among providers	Clinical Integration Committee; HIT Team; CMT	Initiate October 2017; ongoing 2018	Pending; work to proceed in conjunction with HIT and Enhanced Care Coordination Team activities
Develop / modify referral protocols as needed to/from PCPs, BH providers, community care coordination teams, social service support providers, Hospitals, and EDs	Clinical Integration Committee; Enhanced Care Coordination Team	Initiate by January 31, 2018	Pending; work to proceed in conjunction with Enhanced Care Coordination Team activities
Develop / modify protocols as needed to ensure safe, supported care transitions from institutional settings to primary care, behavioral health, social support service providers and family / friend caregivers as appropriate	Enhanced Care Coordination Team; Community Re-entry team	Initiate by January 31, 2018	Work to proceed in conjunction with Enhanced Care Coordination Team activities; some protocols already in place
Implement workforce plan to recruit and retain multi-disciplinary care team members	CHSN Executive Director; CHSN member agencies	Initiate by January 31, 2018; ongoing	Pending; see Workforce plan

Implementation Activity/ Milestone	Responsible Party/ Organization	Time line	Progress Measure / Notes
Provide consultation on selection / use of certified EHR and related technology to support integrated care	HIT Team; Practice Transformation Specialist	Initiate by January 31, 2018; ongoing	Pending
Implementation Plan for Integrated Care Practice			
Confirm regional goals and timeline for Integrated Practice development	CHSN Executive Director; Clinical Integration Committee	By September 30, 2017	Overall goals and participating practices identified; more individualized plans and timelines pending results of site self-assessments
Assess opportunities and challenges for Integration of Medication-assisted treatment (MAT) in CHSN-IDN 5 primary care and BH practice settings	Clinical Integration Committee	By December 31, 2017	
Facilitate training / technical assistance as needed for integration of MAT practice within CHSN-IDN 5 practices moving to Integrated Care Practice level	Clinical Integration Committee; Training Coordinator	Initiate by January 31, 2018	Pending
Assess opportunities and challenges for adoption of evidence-based treatment of mild-to-moderate depression within CHSN-IDN 5 practices moving to Integrated Care Practice level	Clinical Integration Committee; Practice Transformation Specialist	Initiate by January 31, 2018	Pending
Facilitate training / technical assistance as needed for adoption of evidence-based treatment of mild-to-moderate depression within CHSN-IDN 5 practices moving to Integrated Care Practice level	Clinical Integration Committee; Training Coordinator	Initiate by January 31, 2018	Pending
Provide consultation on enhanced use of HIT to support integrated care including use of the technology for identifying at risk patients, to plan care, to monitor/manage patient progress toward goals and ensure closed loop referrals.	Clinical Integration Committee; HIT Team; Practice Transformation Specialist	Initiate by January 31, 2018	Pending; (Note: It is anticipated that CMT PreManage will included features in at least the first 3 of these areas – risk identification, care plan development and patient monitoring. Direct referral management is a feature of Cerner currently in roll out across many practices in the region)

Implementation Activity/ Milestone	Responsible Party/ Organization	Time line	Progress Measure / Notes
Develop or modify as needed workflows, joint service protocols and communication channels with community based social support service providers	Clinical Integration Committee; Enhanced Care Coordination Team	Initiate by January 31, 2018	Pending; work to proceed in conjunction with Enhanced Care Coordination Team activities
Periodically assess designated practices for progress along the SAMHSA Integrated Care continuum	CHSN Executive Director; Practice Transformation Specialist	By June 30, 2018 and then semi-annually	Baseline assessment pending; update semi-annually
Participate in DHHS pilot of EHR-dependent measures	CHSN Executive Director; Data Analyst	By December 31, 2018	Specific tasks and timeline pending with DHHS
Monitor and report measures of integrated practice outcomes as defined in the DSRIP measures	CHSN Executive Director; Data Analyst	Initiate by January 31, 2018	Pending establishment of methods, procedures, capability for inter-agency data collection / aggregation

Evaluation Plan

The Data Analytics team will lead the Network in aligning data collection and reporting capabilities to match the comprehensive set of state specified outcome measures, as well as other Network-defined measures of integration process and system development outcomes. The latter measures are necessary to inform Network participants on progress toward coordinated and integrated practice designations and to facilitate modification and adaptation of project activities as needed. Process evaluation of the Integrated Healthcare efforts will entail documenting the presence or occurrence of core characteristics of integrated healthcare. Custom measures may be added at any time as identified by the Clinical Integration Committee in conjunction with the Data Analytics team. The CHSN Executive Director and Project Manager will have overall responsibility for internal evaluation of this core activity area. Data systems and procedures to support integration-related evaluation measures of this community project will be established in conjunction with the CHSN Health Information Technology (HIT) work group and the Enhanced Care Coordination community project.

The primary evaluation activity in this area will be to periodically compare progress across the Network against the updated baseline site self-assessment. In addition to measuring practice/ organization/ system attributes related to integration, an essential element of monitoring outcomes will be continued patient, provider and community engagement to assess perspectives on what is working and what is not. Procedures for ongoing assessment and engagement are included in the state level evaluation process through the Consumer Assessment of Healthcare Providers & Systems survey process. The Network will also support participating organizations that do not currently have resources for periodic assessment of their own patient, family and provider experiences and satisfaction to implement simple procedures for collecting and analyzing this information. Another important aspect of outcome monitoring over time will be the need to understand the impact of integrated work on cost of care and associated value of the work to inform alternative payment models.

The table below displays the measures and data sources that will be used to evaluate integration process and outcomes. All of the outcome metrics listed in the CMS approval protocol for the NH DSRIP project are associated with the Integrated Health core competency and will not be repeated here in their entirety. Selected State-defined outcome measures (the priority statewide measures) are indicated by an asterisk. The primary focus of evaluation activities throughout the project period will be on assessing the level of integrated practice by organizations with the greatest number of Medicaid clients.

Evaluation Measure	Source	Frequency of Collection / Reporting	Results / Notes
Developmental Measures			
Percent of practices (or agencies) adopting a common protocol for release of patient / client information	Care Coordination Team conference Records	Monitor quarterly; report semi-annually	Pending
Percent of practices that can communicate through secure email	Practice assessment	Monitor quarterly; report semi-annually	Updated baseline assessment report expected September 2017
Percent of practices that can send and receive electronic referrals	Practice assessment	Monitor quarterly; report semi-annually	Updated baseline assessment report expected September 2017
Percent of practices adopting standardized assessment tools and procedures	Practice assessment	Monitor quarterly; report semi-annually	Updated baseline assessment report expected September 2017
Percent of practices with EHRs; with EHRs that include evidence-based guideline prompts	Practice assessment	Monitor quarterly; report semi-annually	Updated baseline assessment report expected September 2017
Percent of practices adopting use of a common Shared Care Plan	Practice assessment	Monitor quarterly; report semi-annually	Updated baseline assessment report expected September 2017
Percent of practices/providers reporting adequate time and resources for care coordination	Practice assessment	Monitor quarterly; report semi-annually	Updated baseline assessment report expected September 2017
Percent of practices/providers with multidisciplinary teams and case conferences for complex or high risk patients	Practice assessment	Monitor quarterly; report semi-annually	Updated baseline assessment report expected September 2017
Percent of practices using patient registries to track complex or high risk patients; to track referrals to and from community service and support agencies	Practice assessment	Monitor quarterly; report semi-annually	Updated baseline assessment report expected September 2017
Percent of practices with sufficient access to specialist consultation	Practice assessment	Monitor quarterly; report semi-annually	Updated baseline assessment report expected September 2017

Evaluation Measure	Source	Frequency of Collection / Reporting	Results / Notes
Percent of practices with co-location of primary care, mental health staff and / or substance use treatment (including the various possible permutations of co-location)	Practice assessment	Monitor quarterly; report semi-annually	Updated baseline assessment report expected September 2017
Percent of practices with information strategies and materials to engage patients as participants in integrated care practice	Practice assessment	Monitor quarterly; report semi-annually	Updated baseline assessment report expected September 2017
Outcome Measures			
*Readmission to Hospital for Any Cause (Excluding Maternity, Cancer, Rehab) at 30 days for the Adult (18+) behavioral health population	Medicaid Claims	Monitor quarterly; report semi-annually	Pending
*Comprehensive and consistent use of standardized core assessment framework including screening for substance use and depression for age 12+ by IDN providers	EHR aggregate reports	Monitor quarterly; report semi-annually	Pending
*Potentially Preventable ER Visits for the BH Population and Total Population	Medicaid Claims	Monitor quarterly; report semi-annually	Pending
*Initiation of Alcohol and Other Drug Dependence Treatment (1 visit within 14 days)	EHR aggregate reports	Monitor quarterly; report semi-annually	Pending

B1-3: IDN Integrated Healthcare: Evaluation Project Targets

While we have established targets that are inclusive of all primary care and behavioral health practices, it is important to note that some practices will inevitably be more engaged than others at different points in time. In order to achieve the greatest impact, we anticipate placing the greatest emphasis for system improvement efforts on those organizations with the greatest number of Medicaid clients.

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
Number of primary care and BH practices with all characteristics of a Coordinated Care Practice	16			
Number of primary care and BH practices with all characteristics of an Integrated Care Practice	To be determined pending SSA results			
*Readmission to Hospital for Any Cause (Excluding Maternity, Cancer, Rehab) at 30 days for the Adult (18+) behavioral health population	To be determined			
*Comprehensive and consistent use of standardized core assessment framework including screening for substance use and depression for age 12+ by IDN providers	To be determined			
*Potentially Preventable ER Visits for the BH Population and Total Population	To be determined			

Performance Measure Name	Target	Progress Toward Target		
*Initiation of Alcohol and Other Drug Dependence Treatment (1 visit within 14 days)	To be determined			

B1-4: IDN Integrated Healthcare Workforce Staffing

CHSN anticipates hiring or contracting for two functional areas to support the integrated healthcare development activities. A practice transformation specialist will provide consultation to practices for performance improvement in the areas of patient visit design, workflows, efficient screening and assessment procedures, and EHR use for reporting and quality improvement. A training coordinator will work in conjunction with each practice and the CHSN team to develop individualized training plans and provide logistical support to training activities. Additional staff related to integration activities includes CHSN executive staff, data analyst and practice-based workforce. These positions are already listed in other areas of the implementation and budget and are not duplicated here. Additionally, staff at the organizational / practice level to support integrated health care are enumerated in Section A-1, Workforce Development and are also not duplicated here.

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
CHSN Executive Director, Project Manager, Administrative Asst.	2.5	2.5			
Data Analyst	1 FTE staff or consultant	0			
Practice Transformation Specialist	0.5 FTE staff or consultant	0			
Training Coordinator	0.5 FTE staff or consultant	0			

B1-5: IDN Integrated Healthcare Budget

Funds are budgeted to support Integrated Healthcare including for the clinical director, consulting psychiatrist, practice transformation specialist, and training coordinator. Please note, significant investments in Integrated Healthcare are reflected in other sections of the Implementation Plan including Workforce recruitment and retention, HIT infrastructure and staffing of community projects. These budgeted expenditures are not duplicated here.

Budget Item	Item Description	2017 Cost	2018 Cost	2019 Cost	2020 Cost	Total Project Cost
Clinical Director Stipend	Stipend for Director (MD) of the Clinical Integration Team @ [REDACTED]		[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]

Consulting Psychiatrist	Psychiatrist stipend for support of B1 multi-disciplinary care team @ [REDACTED]		[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
Practice Transformation Specialist	0.5 FTE for 2 years; consultation / coaching to facilitate integrated care development at the practice level		[REDACTED]	[REDACTED]		[REDACTED]
Training Coordinator	0.5 FTE for 2 years to develop and support practice-specific training plans	[REDACTED]	[REDACTED]	[REDACTED]		[REDACTED]
Technical Assistance	Contract with UNH for BH Integration Site Self-Assessment Survey	[REDACTED]				[REDACTED]
Training and Educational Resources	Repository of resources, educational materials and online trainings to support integrated healthcare	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
INTEGRATED HEALTHCARE TOTAL*						\$ 227,000

*Note: Significant investments to support integrated care are included in the A2–Workforce training/education and C2/D3/E5 community project sections.

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

The following list includes all the community health centers, hospital-affiliated primary practices and behavioral health provider organizations in the CHSN-IDN 5 region participating in the Integrated Healthcare initiative.

Organization/Provider	Agreement Executed (Y/N)
HealthFirst Family Care Center	Yes
Mid-State Health Center	Yes
Speare Primary Care	Yes
Westside Healthcare (FRH)	Yes
Newfound Family Practice (FRH)	Yes
Moultonboro Family Health (LRGH)	Yes
Laconia Clinic (LRGH)	Yes
Belknap Family Health – Meredith (LRGH)	Yes
Lakes Region Family Practice (LRGH)	Yes
Belknap Family Health – Belmont (LRGH)	Yes

Organization/Provider	Agreement Executed (Y/N)
Laconia Internal Medicine (LRGH)	Yes
New Hampton Family Practice (LRGH)	Yes
Hillside Family Medicine (LRGH)	Yes
Genesis Behavioral Health	Yes
Horizons Counseling Center	Yes
Riverbend Community Mental Health	Yes

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

Name	Title	Organization	Sign Off Received (Y/N)
[REDACTED]	Executive Director	Genesis Behavioral Health	Y
[REDACTED]	Executive Director	Horizons Counseling Center	Y
[REDACTED]	President, CEO	HealthFirst Family Care Center	Y
[REDACTED]	Executive Director	Lakes Region Community Services	Y
[REDACTED]	CEO	Mid-State Health Center	Y
[REDACTED]	Executive Director	Partnership for Public Health	Y
[REDACTED]	CEO	LRGHealthcare	Y
[REDACTED]	Executive Director	Pemi-Baker Community Health	Y
[REDACTED]	Executive Director	Lakes Region Visiting Nurse Association	Y
[REDACTED]	Executive Director	CAP Belknap-Merrimack Counties	Y
[REDACTED]	Interim CEO	Central NH VNA & Hospice	Y
[REDACTED]	President, CEO	Spere Memorial Hospital	Y
[REDACTED]	Executive Director	Communities for Alcohol and Drug Free Youth	Y
[REDACTED]	Executive Director	Franklin VNA & Hospice	Y
[REDACTED]	Executive Director	Newfound Area Nursing Association	Y

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

B1-8a - Comprehensive Core Standardized Assessment (CCSA): CHSN-IDN 5 completed a ‘gap analysis’ in early 2017 that involved collecting information from participating agencies on assessment tools currently in use and their inclusion of the DHHS required CCSA domains, including: Demographic information, Physical health review, Substance use review, Housing assessment, Family and support services, Educational attainment, Employment or entitlement, Access to legal services, Suicide risk assessment, Functional status assessment, Universal screening using depression screening (PHQ 2 & 9), Universal screening using SBIRT, validated developmental screening for all children and developmental evaluation as indicated following recommendations of the American Academy of Pediatrics. The results of this gap analysis are included as **Attachment_B1.8A**

B1-8b - Multi-disciplinary core team members: Specific information on multi-disciplinary core team members for each practice is pending results of the site self-assessment and further practice specific integration plan development. Members of the existing core teams for inter-agency care coordination / case management are shown below.

LRGH Care Coordination team

LRGH/Franklin Hospital	[REDACTED]	Director of Care Coordination Care Manager Transitional Care Coordinator Social Worker Social Worker Social Worker Embedded Care Coordinator
ServiceLink	[REDACTED]	ServiceLink Director, Belknap/Carroll Care Transition Specialist, Belknap
HealthFirst	[REDACTED]	Patient Care Coordinator Clinical Quality Assurance Manager
Genesis	[REDACTED]	ACT Clinical Coordinator Clinical Operations Officer Director of Long Term Services
Laconia Police	[REDACTED]	Prevention Enforcement and Treatment Coordinator
Laconia Fire	[REDACTED]	Deputy Chief
Horizons Counseling	[REDACTED]	Executive Director
Riverbend	[REDACTED]	Program Director & Adult Team Coordinator
LRCS	[REDACTED]	Executive Vice President
GSIL	[REDACTED]	Pulmonary Specialist, RN
NAMI NH	[REDACTED]	Supervisor of Training and Prevention

Sppeare Memorial Hospital / Plymouth Area Transitions Team (PATT)

Sppeare Memorial Hospital	[REDACTED]	MSW Case Manager
---------------------------	------------	---------------------

Mid-State Health Center	██████████	RN
Speare Primary Care	██████████	Nurse Supervisor
EMTs	██████████	
Pemi-Baker Home Health	██████████	Hospice Program Manager
NANA	██████████	Clinical Hospice Director
Comfort Keepers	██████████	Owner
ServiceLink	██████████	ServiceLink Director, Grafton County

B1-8c - Multi-disciplinary core team training for service providers, including topics such as Diabetes hyperglycemia, Dyslipidemia, Hypertension, Mental health and SUD are in the planning stages. Below is an excerpt from the CHSN-IDN 5 Training and Education Strategic Plan found on p. 14. A Master Training Matrix is under development which has more granular detail and identifies trainings required by provider type and will include targeted practices / agencies and number of trainees, see **Attachment_B1.8C**

Activities	Timeframe	Accountable Person(s)	Evaluation	Outcomes
Offer trainings on chronic disease management: diabetes, dyslipidemia, hypertension	Begin Q1 2018	B1 Workgroup, CHSN-IDN 5 Training Team	Post training survey	<ul style="list-style-type: none"> Improved care for patients with complex health conditions Expand providers ability to treat patients with co-morbidities

B1-8d – Non-direct care staff training: CHSN-IDN 5 training plans include training for non-direct care staff on topics such as knowledge and beliefs about behavioral health disorders and mental health first aid.

B1-8e - Core team case conferences: Specific information on core team case conference protocols and schedules for each practice is pending results of the site self-assessment and further practice specific integration plan development. Members of the multi-disciplinary core teams for inter-agency care coordination / case management (listed above) meet monthly (1st Thursday of each month in both Laconia and Plymouth) on behalf of patients with significant behavioral health conditions and/or chronic conditions.

B1-8f - Secure messaging: As described in the HIT section, three CHSN-IDN 5 participating agencies do not have Direct Secure Messaging capability currently. These agencies will be assisted by CHSN-IDN 5 resources to install this capability (using Kno2) by December 31, 2017.

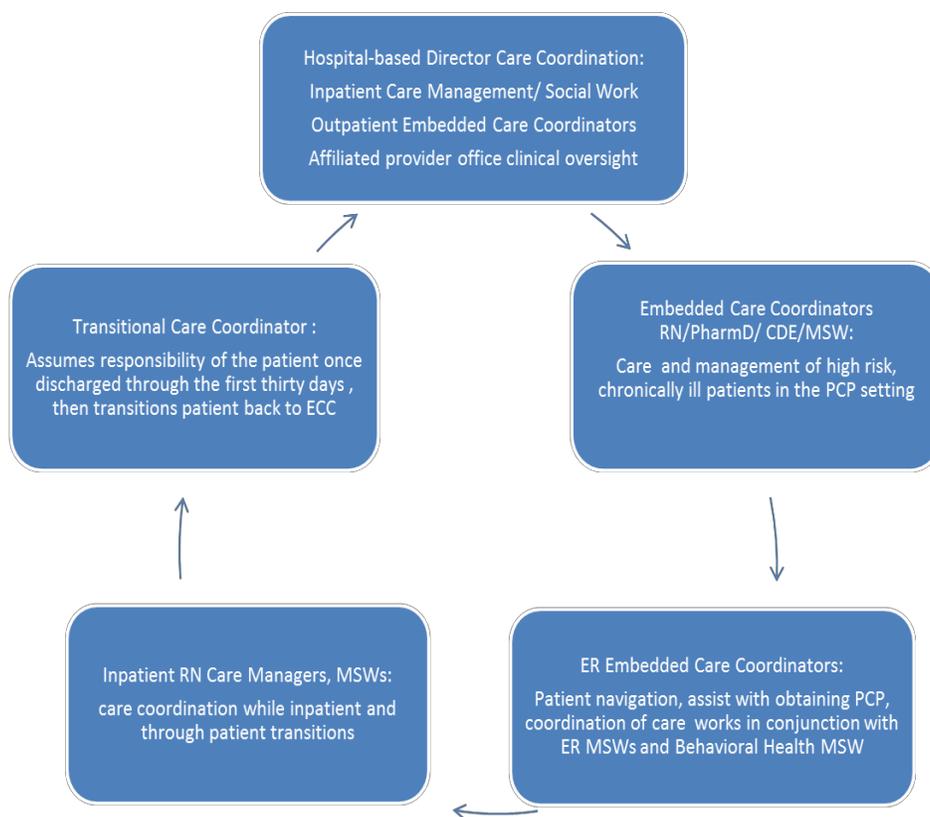
B1-8g - Closed loop referrals: As described previously, direct referral management is a feature of Cerner which is currently in roll out across many practices in the region. Direct secure messaging is also used in some cases for facilitating closed loop referrals, although DSM is not directly a management referral tool and does not inherently require ‘closing the loop’ on the actual referral process. Opportunities for expanding use of Cerner or other referral management applications will be explored by CHSN-IDN 5.

B1-8h - Documented work flows and/or protocols including interactions between providers and community based organizations; timely communication; privacy, including limitations on information for communications with treating provider and community based organizations; coordination among case managers (internal and external to IDN); safe transitions from institutional settings back to primary care,

behavioral health and social support service providers; intake procedures that include systematically soliciting patient consent to confidentially share information among providers; and adherence to NH Board of Medicine guidelines on opioid prescribing are each in progress to varying degrees. Practice specific protocols will be identified as individualized practice integration consultation plans are developed.

As has been described previously, CHSN-IDN 5 has been working on developing privacy, confidentiality and patient consent for information sharing policies, procedures and documents for use across the network. **Figure B-1** below displays the workflow for coordination between case managers, including supported transitions from a hospital setting, currently in place in the Laconia area through the LRGHealthcare Embedded Care Coordination team. The team includes a pharmacist and behavioral health specialists that support both patients and practices. The Enhanced Care Coordination Team is working on expanding on this workflow and establishing related protocols for the work of community care coordinators who will support individuals and families with complex health and social service needs by working across agencies to develop a shared care plan and connect clients across the service continuum. **Figure B-2** on page 59 displays a process map displaying information pathways between participating agencies and restrictions on types of information that can be shared related to inter- agency, system level integration and enhanced care coordination activities.

Figure B-1



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

B1-9a - Coordinated Care Practice designation: Section B1-12 lists the CHSN-IDN 5 related practices and agencies that will be assisted to achieve coordinated care practice designation. The project

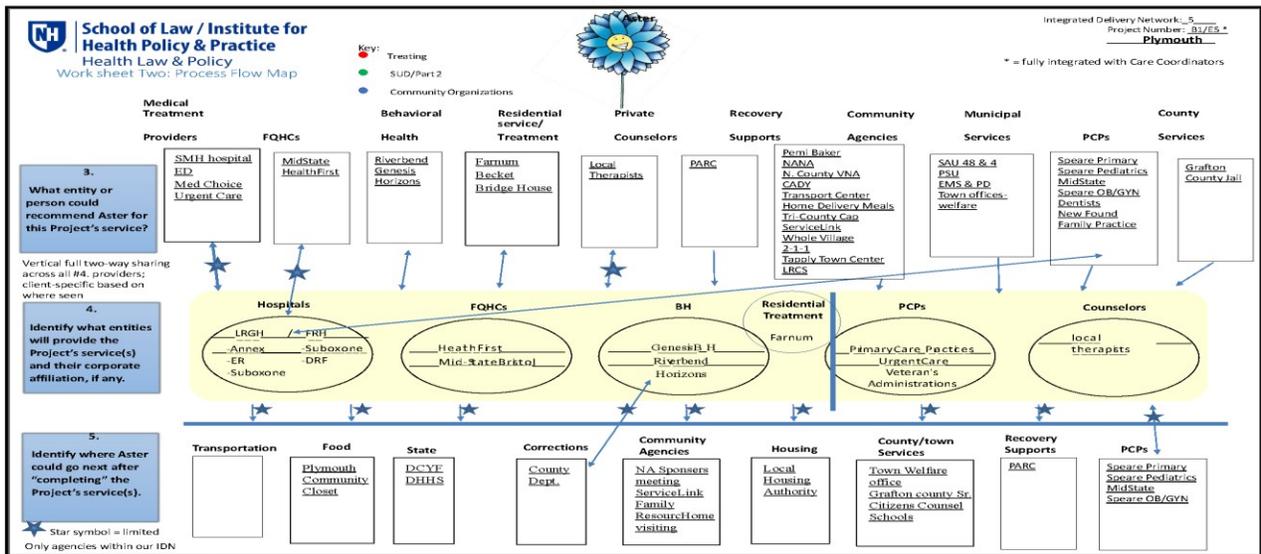
implementation plan outlines the strategies, activities and timeline for reaching this goal. A baseline assessment was completed in the fall of 2016 and is currently being updated using a Site Self- Assessment tool built on the SAMHSA framework for integrated practice.

B1-9b - Additional Integrated Practice designation requirements: Section B1-11 lists the CHSN-IDN 5 related practices and agencies that will be assisted to achieve integrated care practice designation. Several practices in the region are already Medication-assisted treatment (MAT) providers. **Attachment_B1.9B** is a buprenorphine clinic protocol from HealthFirst. We are currently in the process of gathering information on evidence-based models currently in use for treatment of depression in the primary care setting.

B1-9c – Enhanced use of technology: As previously noted, it is anticipated that CMT PreManage will include features in the areas of patient risk identification, shared care plan development and patient monitoring. Use of technology to support closed loop referrals was discussed in section B1-8g. Additional practice specific detail is pending results of the site self-assessment and practice workflow assessments related to installation of CMT PreManage. Future semi-annual report submissions will report progress on these items by practice in table format.

B1-9d - Documented workflows with community based social support service providers: Workflows with community based social support service providers are being developed / modified in conjunction with the Enhanced Care Coordination project. Workflows, communication channels and joint service protocols will be submitted in future progress reports as they are developed. **Attachment_B1.9D** below depicts a process flow map / communication channels for a hypothetical patient in the Plymouth region of CHSN-IDN 5 including community-based service and support organizations.

Figure B-2



B1-11: IDN Integrated Healthcare Project, Achievement of Coordinated Care Practice and Integrated Care Practice Designation

The tables below identify the targeted, total goal, number of practices/agencies expected to achieve designation as a Coordinated Care Practice or Integrated Care Practice.

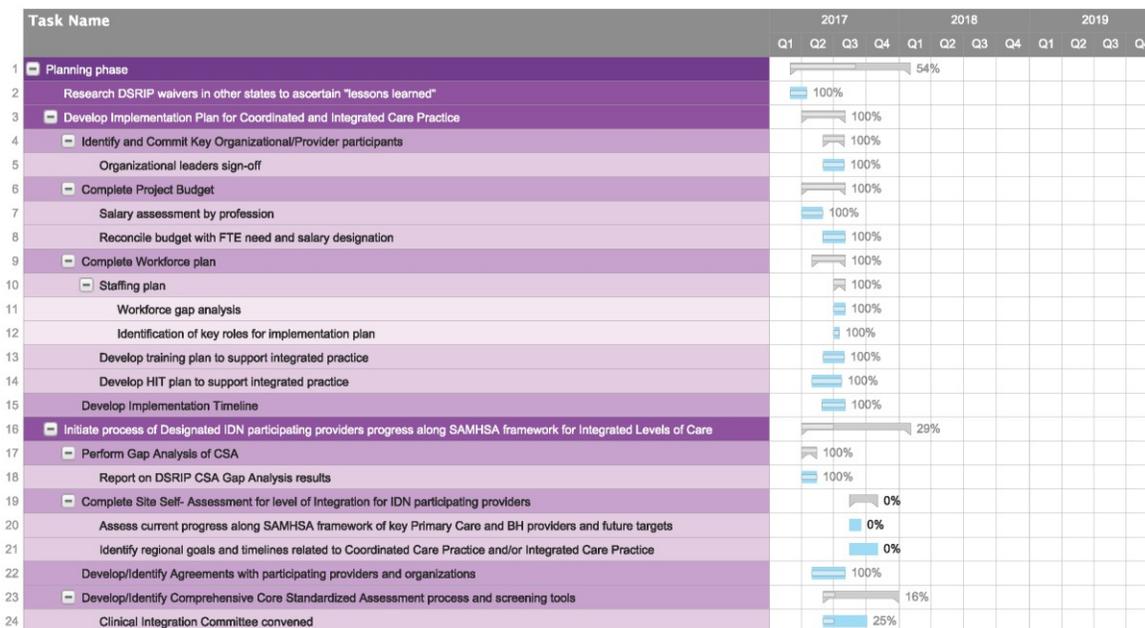
Note - Though seven practices have been identified as moving towards integration and are likely already practicing as a coordinated care practices, there have been no “formal” designations assigned at this time. CHSN-IDN 5 has opted to leave its current designation at ‘baseline’ at “0” until we receive results of the site self-assessment at which time we will confirm and assign those designations.

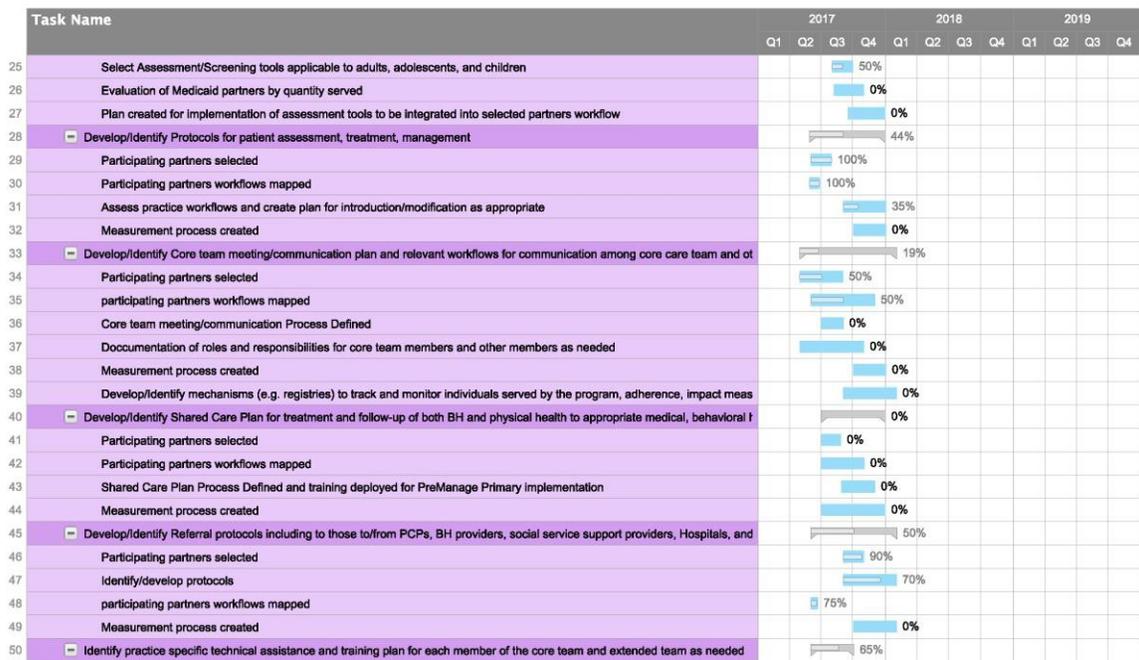
	Total Goal Number Designated	Baseline Designated 6/30/17*	Number Designated 12/31/17	Number Designated 6/30/18	Number Designated 12/31/18
Coordinated Care Practice	16	0			
Integrated Care Practice	7	0			

Coordinated Care Practice	List of providers identified to make progress toward Coordinated Care Practice designation	12/31/17	6/30/18	12/31/18
	Speare Primary Care			
	Moultonboro Family Health			
	Laconia Clinic			
	Belknap Family Health – Meredith			
	Lakes Region Family Practice			
	Belknap Family Health – Belmont			
	Laconia Internal Medicine			
	New Hampton Family Practice			
	Hillside Family Medicine			

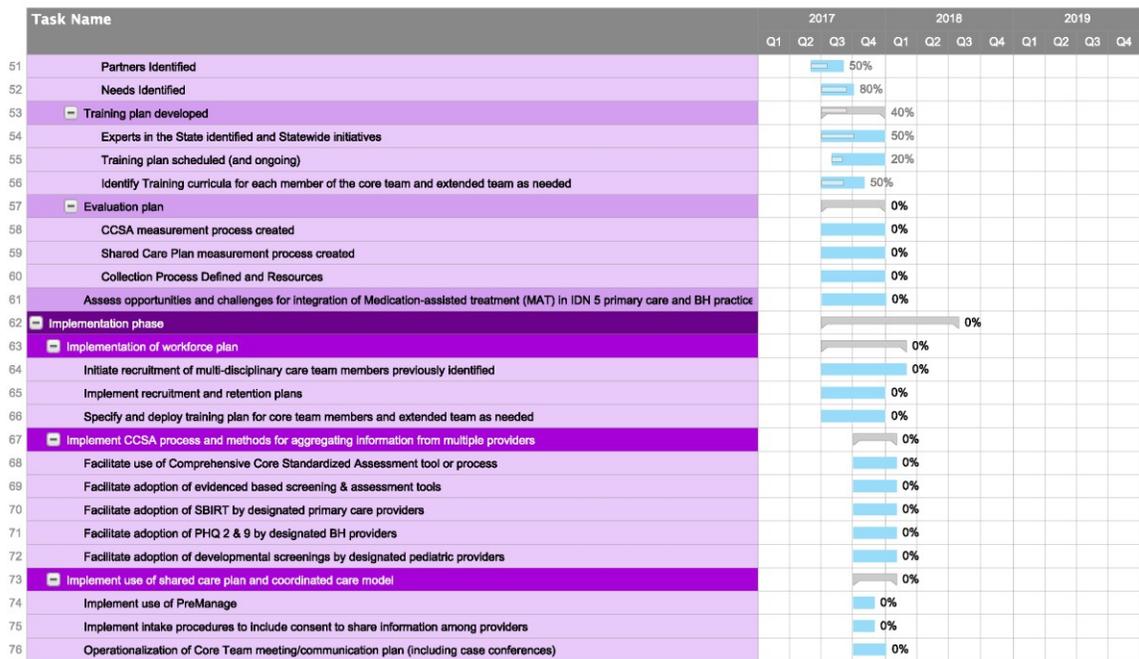
Integrated Care Practice	List of providers identified to make progress toward Integrated Care Practice designation	12/31/17	6/30/18	12/31/18
	HealthFirst Family Care Center			
	Mid-State Health Center			
	Westside Healthcare			
	Newfound Family Practice			
	Genesis Behavioral Health			
	Horizons Counseling Center			
	Riverbend Community Mental Health			

B1 Integrated Healthcare (IDN 5)





Page 2 of 5



Page 3 of 5

Task Name	2017				2018				2019			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
77 Review and modify protocols and workflows as needed				0%								
78 Develop process for designated Primary Care and Behavioral Health practices to show progress towards Integrated Care Practice de				0%								
79 Provide consultation on selection/use of certified EHR and related technology to support integrated care				0%								
80 Facilitate training/technical assistance as needed for integration of MAT within IDN 5 practices moving to Integrated Care Practice Le				0%								
81 Assess opportunities and challenges for adoption of evidenced based treatment of mild-to-moderate depression within IDN 5 practice				0%								
82 Facilitate training /technical assistance as needed for adoption of evidenced based treatment of mild-to-moderate depression for prac				0%								
83 Initiation of Data Reporting				0%								
84 Participate in Pilot reporting of 2 outcome measures with DHHS				0%								
85 Number of Medicaid beneficiaries receiving annual Comprehensive Core Standardized assessment for period & cumulative vs. pr				0%								
86 Number of Medicaid beneficiaries scoring positive on screening tools				0%								
87 Number of Medicaid beneficiaries positive on screening tools and referred for additional intervention				0%								
88 Number of new positions recruited and trained for reporting period & cumulative vs. projected				0%								
89 Impact indicator measures as defined in evaluation plan, including annual evaluation of fidelity to evidence-supported program ele				0%								
90 Reporting period Jan-Jun 2018				0%								
91 Collect data from designated agencies for progress along SAMHSA Integrated Care Continuum				0%								
92 Number of Medicaid beneficiaries receiving annual Comprehensive Core Standardized assessment for period & cumulative vs. pr				0%								
93 Number of Medicaid beneficiaries scoring positive on screening tools				0%								
94 Number of Medicaid beneficiaries positive on screening tools and referred for additional intervention				0%								
95 Number of new positions recruited and trained for reporting period & cumulative vs. projected				0%								
96 New staff position vacancy and turnover rate for period & cumulative vs. projected				0%								
97 Impact indicator measures as defined in evaluation plan				0%								
98 Reporting period Jul-Dec 2018				0%								
99 Collect data from designated agencies for progress along SAMHSA Integrated Care Continuum				0%								
100 Number of Medicaid beneficiaries receiving annual Comprehensive Core Standardized assessment for period & cumulative vs. pr				0%								
101 Number of Medicaid beneficiaries scoring positive on screening tools				0%								
102 Number of Medicaid beneficiaries positive on screening tools and referred for additional intervention				0%								

Page 4 of 5

Task Name	2017				2018				2019			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
103 Number of new positions recruited and trained for reporting period & cumulative vs. projected								0%				
104 New staff position vacancy and turnover rate for period & cumulative vs. projected								0%				
105 Impact indicator measures as defined in evaluation plan, including annual evaluation of fidelity to evidence-supported program ele								0%				
106 Periodically assess designated practices for progress along the SAMSHA Integrated Care continuum								0%				

Community Project Implementation and Clinical Services Infrastructure Plans

Project C: Community Re-entry Program for Justice-Involved Adults and Youth with Substance Use Disorders or Significant Behavioral Health Issues

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

Project Overview

The Supportive Community Re-Entry Program will improve health and social outcomes for adjudicated Medicaid-eligible youth and adults transitioning from correctional facilities to home communities and community-based services. The project approach will bridge continuing care planning efforts that occur within corrections with enhanced case management, treatment, peer support and recovery mentoring to improve access to sustained community supports and services. Through this approach, re-entering individuals will be more likely to access needed supports and services resulting in lower recidivism into the corrections system, reduced use of high cost care such as emergency room care, reduced relapse of SUD and BH conditions, and improved health outcomes and social and economic stability for individuals and their families.

Supportive Re-Entry Continuing Care Coordination and Transitional Supportive Case Management will involve a team of staff from multiple community organizations and county corrections who will establish and maintain referral mechanisms for all inmates with a SUD and/or other behavioral health problems who have met the criteria for the community corrections program. The Supportive Re-Entry Care Coordination team will assign and monitor re-entry responsibilities for inmates individually and as a whole. For example, the team will establish when SUD and other behavioral health assessments are conducted, how they are shared with team agencies and their staff, and how they are used in developing after-care plans. Supportive Re-Entry Care Coordination will be initiated at 3 months prior to re-entry to the community and carry through the probation period or approximately 12 months after release.

Current Challenges and Implementation Alternatives

A component of the model as envisioned includes additional counselors and case managers to be employed by the Belknap County Department of Corrections. The Department has applied for a Second Chance grant to support these positions. Should this application not be funded, the Community Health Services Network has made alternative plans to fund two additional positions beyond the staffing model described later in this section – a counselor and a case manager – who will be out-stationed to the Department of Corrections.

The initial focus of this project is with the Belknap County Department of Corrections. CHSN is also in the process of engaging Grafton County Department of Corrections. Once the Belknap County aspect of this project area is well established, we anticipate working with Grafton County through their Plymouth area Field Services office to identify individuals who could benefit from similar care coordination and transitional care management services.

The table on the next page outlines the key activities, milestones and timelines, responsible party, and progress measures for implementation. Smartsheet detail and timeline is included as a graphic at the end of this section and included as **Attachment_C.1A**

Implementation Activity/ Milestone	Responsible Party/ Organization	Time line	Progress Measure / Notes
Establish and support Re-Entry Leadership Team	CHSN Executive Director; Team Lead – Executive Director of Horizons Counseling Center	Within 30 days of plan approval; meet bi-monthly	Milestone Met: Leadership Team established; regular meetings occurring with documentation of minutes
Initiate recruitment process for identified staffing needs		Initiate by December 31, 2017	Milestone Met: Leadership Team identified staffing needs on April 30, 2017
Develop case management approach and protocols including: <ul style="list-style-type: none"> - Assessment, supports, services, after-care planning in correctional facility via team approach - Recovery coach pairing before release - Primary care appointments made before release - MH/SUD service appointments made before release - Transportation to primary care and BH set up before release - After-care plans include appropriate supports and services before release with connections with staff of those supports and services made before release - After-care plans include incentives for sustained participation in plan, including connections with probation/parole and supportive court involvement as appropriate - Family/friend engagement and communication as appropriate - Identification of case manager (based on assessment) for check-ins and one-on-one communications (e.g. choice of recovery coach, family support worker, clinical service staff) - Application to Medicaid/Health Insurance program upon release - Patient confidentiality and privacy assurances and releases established before release - Housing and employment supports before release - Other components of re-entry supports and services 	Re-Entry Leadership Team	By December 31, 2017	Protocol development in progress

Implementation Activity/ Milestone	Responsible Party/ Organization	Time line	Progress Measure / Notes
Develop inter-organizational care coordination protocols, including shared decision-making and crisis management	Re-Entry Leadership Team and CHSN members	By December 31, 2017	Protocol development in Progress
Develop and implement procedures for data collection and sharing	Re-Entry Leadership Team and CHSN Board	By December 31, 2017	Development of data sharing procedures in Progress
Establish data sharing agreements with participating organizations	CHSN ED, Board and participating organizations	By December 31, 2017	Data sharing agreements in development
Establish and implement all NH DHHS and CHSN data collection and reporting requirements	CHSN ED and CHSN members	By December 31, 2017 and ongoing	Data collection procedures in Development
Initiate recruitment of required staff	CHSN ED and participating organizations	By October 1, 2017	Pending
Provide cross-training to all staff and organizations involved in the project (see training plan)	Re-Entry Leadership Team	By December 31, 2017 and ongoing	Training plans in development
Initiate referral mechanisms and Continuing Care Coordination and Transitional Supportive Case Management	All participating organizations	By January 1, 2018 and ongoing	Pending completion of development Activities
Identify, develop and implement licensure and certification pathway support for project staff to meet requirements as needed (see workforce development plan)	Re-Entry Leadership Team	By June 30, 2018 and ongoing	Funds budgeted to support staff pursuing licensure / certification; supervision relationships in place
Continue to develop relationship with Grafton County Department of Corrections	Re-Entry Leadership Team	By June 30, 2018 and ongoing	In progress
Initiate referral mechanisms and Continuing Care Coordination and Transitional Supportive Case Management in partnership with Grafton County	Re-Entry Leadership Team	By January 1, 2019 and ongoing	Progress pending
Develop long-range project sustainability plan	CHSN Board	Initiate the development of a plan by September 30, 2019	Pending project implementation

Training Plan

Training activities specifically related to the Community Re-entry project will focus on team and partnership building, skill development for recovery coaches, cross-training for corrections officers and education for individuals working in the court system. Specific training activities and target trainees are specified below for C2 and also in **Attachment C.1B**. The attachment also has separate tabs for training by agency.

Project-Related Training Activities	Target Trainees	Time line	Progress Measure / Notes
New project staff orientation, team building, partner building	Project Staff (8 FTEs) and supervisors	By December 31, 2017 and ongoing	Pending staff hiring / assignment of existing staff
Supervision of recovery coaches for maintenance of certification	CRSWs based at Recovery Support Organizations	By December 31, 2017 and ongoing	Weekly supervision meetings are happening now. Activity to be connected more specifically to the Re-entry project Implementation
Cross-training for corrections officers – understanding roles, recognizing signs and symptoms of SUD / MH for non-clinicians, suicide prevention for corrections staff	Corrections Officers	Identify staff and initiate training by January 1, 2018 and ongoing (significant staff turnover)	Horizons staff provide training now. Activity to be connected more specifically to the Re-entry project Implementation
Education for Justice System on project purpose and goals; understanding relationship of SUD / MH intervention and reducing costs / recidivism; understanding value of longer term monitoring in exchange for shorter incarceration	Judges, other court personnel and attorneys	Identify trainees and initiate training by December 31, 2018	To be developed

Attachment_C.1B

TOTAL TRAINING NUMBERS

2. Community Re-entry for Justice-Involved Adults and Youth

Project	Topic/subject	BI clinicians UICW, LJM/I, LOMHC, clinical psychologists, masters level clinicians	SUD counselor MLADC, LADC, LOMHC, UICW, Masters level clinicians	Re-entry Care Coordinator, Case manager	Recovery support worker/coach (SUD)	BI Peer Support	Health Coach, Community Health worker	benefit navigator, financial assistant	HR/Data collections individual at each agency	Correction Officers	Parole officers, probation officers	Judges	Defense Bar and Prosecution	non-direct care staff/program staff receptionists, van drivers, family support staff, etc.
All	DSRIP 101- Introduction to the 1115 waiver	6	11	6	7	2	2	4					4	
All	Privacy and Confidentiality: CFR 42 part 2, HIPPA	6	11	8	7	3	3	4					4	
All	Outcome Metrics & data collection		6	4	7		3							1
All	CMT shared care plans, event notification	6	11	4	7									
All	Data aggregator trainings						4							1
B1, C2, D3, ES	Trauma Informed treatment	6	11	7	7	3		4						4
B1, C2, D3, ES	Co-occurring disorders	6	11	7	7			4						4
A1, B1, C2, D3, ES	Recognition of other providers roles	6	11	7	7		2	4						4
B1, C2, D3, ES	Motivational Interviewing	6	11	7	7	1								4
B1, C2, D3, ES	Suicide prevention	6	11	9	7	2		4						4
B1, C2, D3, ES	Ethical competency	6	11	3	7			4						4
B1, C2, D3, ES	MH First Aid (non-clinicians)			3	7	1								4
B1, C2, D3, ES	Cultural Competency	6	11	9	7			4						4
B1, C2, D3, ES	Basic training on Addiction & Recovery	6	11	9	7									4
B1, C2, D3, ES	Home visit safety			1										4
B1, C2, D3, ES	Best practices in care transitions	6	11	4	7									4
C2, D3	HIV, Hep C, STDs	6	11	6	7									4

Evaluation Plan

Process evaluation of the Community Re-entry project will entail documenting the presence or occurrence of key features of the model, as well as specific outcome metrics. Data describing process and outcome measures associated with this community project will be collected from participating organizations on a quarterly basis including data associated with training and workforce development activities, and de-identified client data to track care coordination and case management activities and monitor project goals. In addition, a client satisfaction tool will be identified to capture client feedback to assess client perceptions of effectiveness and inform on-going quality assurance. The key partners in the project will review client feedback semi-annually to make adjustments and improvements to policies and protocols to ensure goals are met, standards are maintained, and individuals receiving services are satisfied with their care.

We anticipate serving approximately 60 individuals per year through the Supportive Re-Entry Care Coordination project once fully operational. The socio-demographic characteristics of the population served through this community project will be tracked to include housing, economic and employment stability; further criminal justice system involvement; and social and family supports.

The CHSN Executive Director and Project Manager will have overall responsibility for internal evaluation of this community project. Data systems to support evaluation of this community project will be established in conjunction with the CHSN Health Information Technology (HIT) work group and the Enhanced Care Coordination community project. Leveraging these and emerging data systems that may be developed to support the IDN's re-entry work, the following measures and data sources will be used to evaluate project process and outcomes (selected State-defined outcome measures are indicated by an asterisk).

Evaluation Measure	Source	Frequency of Collection / Reporting	Results / Notes
Process Measures			
Percent of referred clients for whom assessment and continuing care plan development in correctional facility is completed	DOC (number of referred clients) and Horizons (assessment / care plan)	Monitor quarterly / report semi-annually	Pending
Percent for whom care Coordinator pairing before release is completed	DOC / Horizons	Monitor quarterly / report semi-annually	Pending
Percent for whom recovery coach pairing before release is completed	DOC / Horizons	Monitor quarterly / report semi-annually	Pending
Percent for whom Primary care appointments are made before release	DOC / Horizons	Monitor quarterly / report semi-annually	Pending

Evaluation Measure	Source	Frequency of Collection / Reporting	Results / Notes
Percent for whom appropriate Behavioral Health service appointments are made before release	DOC / Horizons	Monitor quarterly / report semi-annually	Pending
Percent for whom Transportation to primary care and BH is set up before release	DOC / Horizons	Monitor quarterly / report semi-annually	Pending
Percent for whom after-care plans include incentives for sustained participation in plan, including connections with probation/parole and supportive court involvement as appropriate	DOC / Horizons	Monitor quarterly / report semi-annually	Pending
Percent for whom family/friend engagement and communication as appropriate	DOC / Horizons	Monitor quarterly / report semi-annually	Pending
Percent for whom application to Medicaid/Health Insurance program is made upon release	DOC / Horizons	Monitor quarterly / report semi-annually	Pending
Percent for whom patient confidentiality and privacy assurances and releases are established before release	DOC / Horizons	Monitor quarterly / report semi-annually	Pending
Percent for whom housing and employment supports are arranged before release	DOC / Horizons	Monitor quarterly / report semi-annually	Pending
Outcome Measures			
Recidivism rate; currently defined as re-booking within 1 year of program completion. Working with County Corrections to further define measure definitions and feasibility of data collection).	DOC	Monitor quarterly / report semi-annually	Pending; work with DOC to further define measure and data definitions / sources
Self-report of improved status of employment, housing, arrest, relapse, interpersonal relationships, family interaction, community connectedness and other measures of recovery stability; develop questionnaire based on national Transition from Jail to Community toolkit / guidance.	Client self-report; instrument to be administered by care coordinator; de-identified aggregate data collected and analyzed by CHSN	Monitor quarterly / report semi-annually	Pending

Evaluation Measure	Source	Frequency of Collection / Reporting	Results / Notes
*Initiation of SUD Treatment (1 visit within 14 days)	SUD treatment agency records	Monitor quarterly / report semi-annually	Pending
Retention in SUD/COBHD treatment for recommended duration per ASI/ASAM evaluation	SUD treatment agency records	Monitor quarterly / report semi-annually	Pending
*Number / percentage of frequent (4+ per year) ER Visit Users	Hospital ED data	Monitor quarterly / report semi-annually	Pending
*Number / percentage of Potentially Preventable ER Visits	Hospital ED data	Monitor quarterly / report semi-annually	Pending
Percent Abstinent from Alcohol / Drugs at 30 days, 6 months and 1 year post community re-entry (NOMS measure)	WITS / SUD treatment agency records	Monitor quarterly / report semi-annually	Pending
Percent employed or in school / job training at 30 days, 6 months and 1 year post community re-entry (NOMS measure)	WITS / SUD treatment agency records	Monitor quarterly / report semi-annually	Pending
Percent in stable housing situation at 30 days, 6 months and 1 year post community re-entry (NOMS measure)	WITS / SUD treatment agency records	Monitor quarterly / report semi-annually	Pending
Percent participating in peer support activities at 30 days, 6 months and 1 year post community re-entry (NOMS measure)	WITS / SUD treatment agency records	Monitor quarterly / report semi-annually	Pending

C-2: Community Project Evaluation Targets

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
Number of individuals served	Approximately 60 per year once fully operational			
Percent of referred clients for whom assessment and continuing care plan development in correctional facility is completed	To be determined			
Percent for whom care coordinator pairing before release is completed	To be determined			
Percent for whom recovery coach pairing before release is completed	To be determined			

Performance Measure Name	Target	Progress Toward Target		
Percent for whom Primary care appointments are made before release	To be determined			
Percent for whom appropriate Behavioral Health service appointments are made before release	To be determined			
Percent for whom Transportation to primary care and BH is set up before release	To be determined			
Percent for whom after-care plans include incentives for sustained participation in plan, including connections with probation/parole and supportive court involvement as appropriate	To be determined			
Percent for whom family/friend engagement and communication as appropriate	To be determined			
Percent for whom application to Medicaid/Health Insurance program is made upon release	To be determined			
Percent for whom patient confidentiality and privacy assurances and releases are established before release	To be determined			
Percent for whom housing and employment supports are arranged before release	To be determined			
Criminal Recidivism rate	Reduce by 10% from baseline			
*Initiation of SUD Treatment (1 visit within 14 days)	To be determined			
Retention in SUD/COBHD treatment for recommended duration per ASI/ASAM evaluation	To be determined			
*Number / percentage of frequent (4+ per year) ER Visit Users	To be determined			
*Number / percentage of Potentially Preventable ER Visits	To be determined			
Percent Abstinent from Alcohol at 30 days, 6 months and 1 year post community re-entry (NOMS measure)	To be determined			
Percent Abstinent from other drugs at 30 days, 6 months and 1 year post community re-entry (NOMS measure)	To be determined			
Percent employed or in school / job training at 30 days, 6 months and 1 year post community re-entry (NOMS measure)	To be determined			
Percent in stable housing situation at 30 days, 6 months and 1 year post community re-entry (NOMS measure)	To be determined			
Percent participating in peer support activities at 30 days, 6 months and 1 year post community re-entry (NOMS measure)	To be determined			

C-3: Community Project Workforce Staffing

A total of 8 FTEs across four organizations are projected for new workforce staffing for the Community Re-Entry Project. The types of staff are shown by organization in the table below. CHSN-IDN 5 opted to leave its staffing at “0” at baseline for all projects though it is possible that existing staff may fill some of these roles, they have not been assigned to this project until plans have been approved.

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
Re-entry Care Coordinator (Horizons)	1	0			
Re-entry Care Coordinator (Genesis)	1	0			
Peer recovery support workers -future CRSW (Navigating Recovery)	2	0			
CRSW/Peer recovery workers (HOPE for NH Recovery)	0.5	0			
SUD Counselor (non-reimbursable; positioned at jail) (Horizons)	1	0			
SUD/ Co-occurring (Horizons)	1	0			
SUD/Co-occurring counselor (Horizons – Plymouth)	0.5	0			
Case Manager or clinician, shared float (Horizons)	0.5	0			
Case manager or Clinician (masters level) (Genesis)	0.5	0			

C-4: Community Project Budget

Funds are budgeted for the Community Re-Entry project to support salaries and benefits of project as outlined in the previous section. Salaries are budgeted based on prevailing wages by position type. Fringe benefits are budgeted uniformly across all partner organizations at 31% of salary.

Budget Item	Item Description	2017 Cost	2018, 2019, 2020 (Costs Equally Distributed over 3 years)	Total Project Cost
Salaries and Wages				
Project Staff Salaries / Wages (subcontracted)	Salaries for counselors, case managers, care coordinators, and recovery support workers	██████	██████	██████
Project Staff Benefits	31% of salary / wages	██████	██████	██████
		<i>SUB-TOTAL</i>		<i>\$1,448,860</i>
Other Direct Costs				

Supplies	Miscellaneous expenses over waiver period			██████
PROJECT TOTAL				\$1,450,860

C-5: Key Organizational and Provider Participants

The following organizations are the key participants in the Community Re-Entry Program with representatives of each organization forming the Community Re-Entry Program Leadership Team.

Organization/Provider	Agreement Executed (Y/N)
Horizons Counseling Center	Y
Belknap County Corrections	Y
Navigating Recovery	Y
Genesis Behavioral Health	Y
LRGHealthcare	Y
Lakes Region Community Services Family Resource Center	Y
Community Health Services Network	Y

C-6: Standard Assessment Tools

The table describes the Assessment and Screening tools that we anticipate using in the Community Re-entry Project.

Standard Assessment Tool Name	Brief Description
Addiction Severity Index (ASI)	The ASI is a semi-structured interview designed to address seven potential problem areas in substance-abusing patients: medical status, employment and support, drug use, alcohol use, legal status, family/social status, and psychiatric status.
American Society of Addiction Medicine (ASAM) criteria	The ASAM criteria provide guidelines for assessment, service planning, level of care placement, continued stay and transfer/discharge of patients with addiction and co-occurring conditions.
Adult Needs and Strengths Assessment (ANSA)	The ANSA is a multi-purpose tool developed for adult's behavioral health services to support decision making.
Clinical Interview for DSM-5	The Structured Clinical Interview for DSM-5 is a semi-structured interview guide for making DSM-5 diagnoses. It is administered by a clinician or trained mental health professional that is familiar with the DSM-5 classification and diagnostic criteria.

Standard Assessment Tool Name	Brief Description
Case Management (CM) Assessment	The CM Assessment assesses for certain health and behavioral health conditions (chronic illness, mental health, substance use), lifestyle and living conditions (employment, religious affiliation, living situation) to determine risk factors, establishes risk categories and hierarchy, severity, and level of need

C-7: Protocols for Patient Assessment, Treatment, Management, and Referrals

Protocols for patient assessment, treatment, management and referral specific to the Community Re-entry Project are under development. Horizons Counseling Center has a long history of working closely with the Belknap County Department of Corrections and has a manual of protocols and procedures that will be adopted / modified to support this project.

Protocol Name	Brief Description	Use (Current/Under development)
Client Identification and Referral	Protocols and workflows for working with the corrections on timely identification of individuals who are within 3 months of release	Anticipated completion December 2017
Screening, assessment, treatment, and care plan development	Protocols and workflows for application and frequency of screening and assessment tools and treatment planning; care plan development and review	Identified assessment tools completed. Protocols to be completed December 2017
Team-based care coordination and case management	Protocols and workflows for communication and case conferencing by community re-entry project staff including CRSWs	Anticipated completion Q1 2018
Data collection and evaluation	Protocols and workflows for collection, reporting and analysis of client data for program monitoring and improvement	Anticipated completion Q1 2018

C-8: Member Roles and Responsibilities

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

Project Team Member	Roles and Responsibilities
Horizons Counseling Center	Re-entry Leadership Team, Provide SUD/BH clinical services Employ care coordinators, Coordinate services with SUD and primary care services as appropriate
Belknap County Corrections	Re-entry Leadership Team, Coordinate inmate referral to Supportive Re-Entry Care Coordination, Administer SUD/BH assessments, Share client data with transitional care team as permitted, Provide compliance incentives

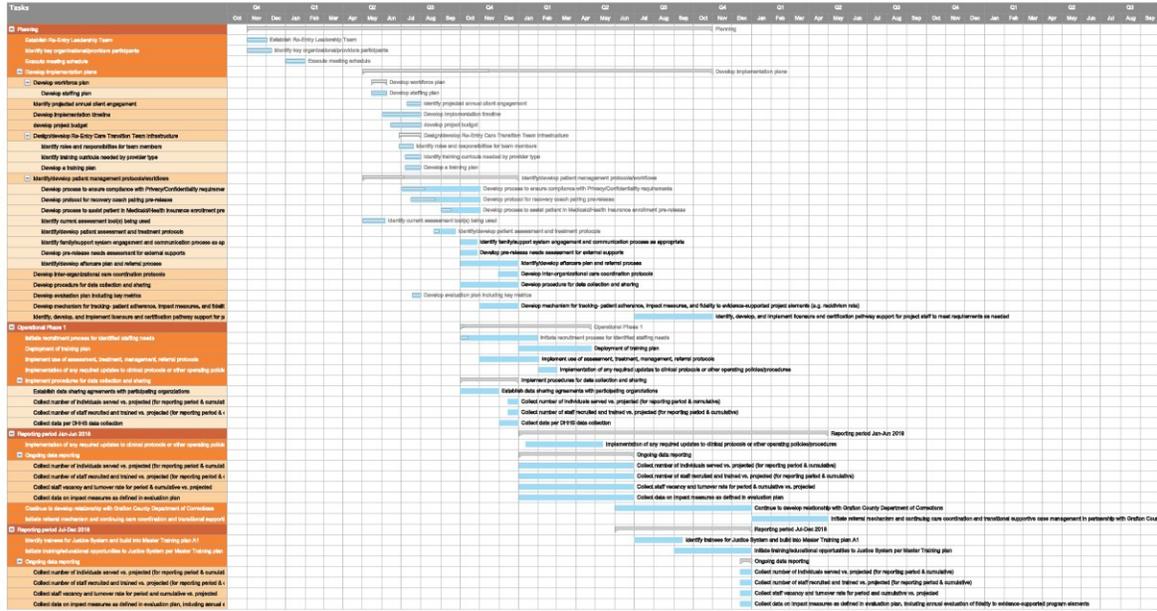
Grafton and Merrimack County Corrections	Coordinate inmate referral to Supportive Community Re-Entry project. Share client data with re-entry care team as permitted, Work with these counties will be phased in over time and coordinated through Field Services for geographic areas applicable to CHSN-IDN 5
Navigating Recovery	Re-entry Leadership Team, Employ/provide trained recovery coaches/mentors for pairing with re-entering population, Coordinate services with SUD and primary care services as appropriate, Liaison with ancillary supports in community, including housing, education/training, employment, child care and transportation
Lakes Region Community Services Family Resource Center	Re-entry Leadership Team, Provide family education and other support services to referred individuals, Employ/provide care coordinators
CADY, Belknap County Juvenile Diversion/Restorative Justice Programs	Provide family education, community service, opportunities to referred individuals and their families
Genesis Behavioral Health	Re-entry Leadership Team, Provide integrated behavioral health services, Coordinate services with SUD and primary care services as appropriate
Riverbend Community Mental Health	Provide integrated behavioral health services, Coordinate services with SUD and primary care services as appropriate. Coordinate activities with Capital Area IDN and Merrimack County Corrections.
LRGHealthcare	Re-entry Leadership Team, Provide services in county jails, Assertive Community Treatment Team, integrated care
Health First Family Care Center	Provide integrated primary care services, Coordinate services with SUD and primary care services as appropriate
Mid-State Health Center	Provide integrated primary care services, Coordinate services with SUD and primary care services as appropriate
Laconia Area Community Land Trust	Provide access to transitional and affordable housing
Laconia Housing Authority	Provides access to subsidized and supportive housing
Central NH VNA & Hospice	Provide referrals and home care services to infants, families
Franklin VNA & Hospice	Provide referrals and home care services to infants, families
Lakes Region Visiting Nurse Association	Provide referrals and home care services to infants, families
Newfound Area Nursing Association	Provide referrals and home care services to infants, families
Pemi-Baker Community Health	Provide referrals and home care services to infants, families
Lakes Region Community College	Participate in referral network for re-entry individuals
University of New Hampshire Cooperative Extension	Participate in referral network for re-entry individuals
Partnership for Public Health	Membership participates in referral network for re-entry individuals
Community Health Services Network	Administrative home for the program; funding of sub-recipients for program; Long-range infrastructure and sustainability planning and implementation for the program, Serve on Re-entry Leadership Team, Membership participates in referral network for re-entry individuals

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

See below from Section C-1 and also refer to the CHSN-IDN 5 Training and Education Strategic Plan found on p. 14.

Project-Related Training Activities	Target Trainees	Time line	Progress Measure / Notes
New project staff orientation, team building, partner building	Project Staff (8 FTEs) and supervisors	By October 31, 2017 and ongoing	Pending staff hiring / assignment of existing staff
Supervision of recovery coaches for maintenance of certification	CRSWs based at Recovery Support Organizations	By November 30, 2017 and ongoing	Weekly supervision meetings are happening now. Activity to be connected more specifically to the Re-entry project implementation
Cross-training for corrections officers – understanding roles, recognizing signs and symptoms of SUD / MH for non-clinicians, suicide prevention for corrections staff (3 hour training)	Corrections Officers	Identify staff and initiate training by January 1, 2018 and ongoing (significant staff turnover)	Horizons staff provide training now. Activity to be connected more specifically to the Re-entry project implementation
Education for Justice System on project purpose and goals; understanding relationship of SUD / MH intervention and reducing costs / recidivism; understanding value of longer term monitoring in exchange for shorter incarceration	Judges, other court personnel and attorneys	Identify trainees and initiate training by December 31, 2018	To be developed

C2 Community Re-entry (IDN 5)



Project D: Expansion of Intensive SUD Treatment Options

D-1: Core Components, Process Milestones, Training and Evaluation Project Plans

Project Overview

The focus of the project will be on expansion of Intensive Outpatient Program (IOP) services to include expansion of services during evening hours for those working or caring for children/families during the day and expansion of populations served including those with co-occurring mental illness. Expansion activities will aim to ensure that there is 'no wrong door' to IOP services. For individuals presenting in an emergency room through contact with local police, EMS or recovery centers, the first response will be a call to a recovery coach who will conduct an initial interview with the person and help him/her schedule an assessment with a licensed clinician to determine the level of SUD or Co-occurring behavioral health disorder (COBHD) treatment needed. For individuals presenting first at a behavioral health treatment agency, a clinician will conduct the initial level of care assessment and, if the IOP level of care is indicated, will refer the client directly to the IOP.

Expanded IOP features include client services and activities over two phases of treatment. Phase I will generally entail group counseling sessions three hours per day, three days per week over the course of 4 to 6 weeks. Phase I clients will also be required to attend at least five community based, sober peer support meetings or activities and will have the benefit of meeting individually with a counselor once per week to monitor progress, work on problem solving and address co-occurring behavioral health issues not directly addressed through the group process. Phase II clients will be involved in community-based peer and attend one, two-hour group session per week for twelve weeks. Phase II clients are also required to be actively involved in community based peer support activities 5 days per week, or as recommended in the individual's treatment plan.

An expanded IOP service array with integrated peer support and recovery coaching and other ancillary services will address several specific infrastructure gaps that result in limited service capacity:

- Effective, comprehensive assessment conducted within and/or in concert with a variety of referral pathways to ensure placement in an appropriate level of care;
- Care coordination to support adults with SUDs or COBHDs, supporting the integration of physical, SUD and BH care needs and community assets available to support recovery goals as well as supporting access to health insurance coverage;
- Workforce development in the form of supervision of clinical treatment providers and peer recovery support workers working toward licensure / certification;
- Cross-training of clinical service staff, peer support and recovery workers, and care managers;
- Expanded IOP capacity including evening hours in Belknap County, a new morning program serving greater Plymouth, and coordination with Riverbend to assure availability of IOP services in the Franklin area;
- Support for new transportation resources providing access to IOP services for the Plymouth area.

As previously described, the focus of the Expansion of Intensive SUD Treatment Options project will be on expansion of Intensive Outpatient Program (IOP) services (higher intensity service) to include expansion of services in a currently underserved area of our region, as well as expansion of services during evening hours for those working or caring for children/families during the day and expansion of populations served including those with co-occurring mental illness. However, it is important to note that additional activities to expand SUD treatment options will occur in conjunction with this focus and will be supported through closely related activities occurring through other channels of our integration work such as the Community Re-Entry and Enhanced Care Coordination efforts.

With respect to ambulatory and non-hospital inpatient medically monitored residential services and hospital inpatient medically managed withdrawal management services, we are currently working with LRGHealthcare and Speare Memorial Hospital to establish protocols and increase access to medically managed withdrawal in both inpatient and outpatient settings. Currently, these services are available mostly on an emergency basis only. Admission for detox typically happens when medical need is established and not necessarily when the social need is presented. To address this gap, the IDN is working to make detox beds available on a more planned basis so that people in need of Medically Managed Inpatient Detox as determined by ASAM Criteria could access admission before they are fully symptomatic. These services can be reimbursable by Medicaid and private health insurance. The resources and supports necessary to facilitate this service expansion are described in other areas of our implementation plan, most notably in the substantial expansion of enhanced care coordination and care management resources available for post-release care planning and supportive patient follow-up. Similarly, the expansion of care coordination and care management, along with the expansion of intensive SUD treatment services, will provide primary care practices with the necessary system-level support and structure around the patient through the detox process and ensure the availability of continuing care once the detox process is completed. This work is also tied to the broader workforce training efforts associated with the core behavioral health and primary care integration efforts of our overall plan by increasing physicians' awareness of: the resources available to their patients; how to access those resources; how to integrate these services in their practice, and; the enhanced care coordination resources to be made available community-wide.

While these efforts are proceeding, it is important to note that one goal of expanded IOP services connected to Medication Assisted Treatment (MAT) is to reduce the need for costly inpatient detox. Expanded IOP services will provide the social supports and structure as well as early access to treatment that can make outpatient medically managed detox more realistic for many individuals who would otherwise require more expensive hospital based medical management. In addition, IOP with MAT that is community based will reduce the emergent need for inpatient detox for many individuals with opioid use disorders, facilitate earlier entry into intensive SUD treatment, and support those individuals in remaining active in their families and employment situations to the extent possible. It is also a goal of the IDN to build on the expansion of IOP services in the fourth year of this service delivery transformation project by building on the IOP by adding a partial hospital component to further cut down on the need for more expensive inpatient treatment.

CHSN-IDN 5 is also working with Farnum Center North in Franklin (the only residential treatment provider in our region that accepts Medicaid) to increase access to residential treatment locally. Farnum Center (Easter Seals) has joined as an affiliate member of CHSN and is participating in efforts to expand access. Treatment providers within the IDN have built strong relationships with the existing residential treatment system statewide and are working on protocols for mutual assessment procedures to improve inter-agency communication and more timely interagency referrals.

Correctional facilities within the region also do medically managed detox for all offenders who are admitted to the facility who meet criteria for either ambulatory or non-ambulatory detox. The Community Re-entry project designed by the IDN, which is closely connected to the SUD treatment expansion work, will: 1) free up currently available counselor and case manager staff dedicated to offender re-entry planning to begin intervention and post detox level of care assessment with those inmates receiving this medical service without the benefit of aftercare planning, and 2) facilitate and coordinate referral and access to the appropriate post release level of care for offenders being released from confinement shortly after detox or prior to this medical intervention being completed.

In support of these efforts, Horizons in conjunction with Navigating Recovery, LRGH and other IDN agency partners are pursuing alternative funding sources for developing a non-hospital based residential withdrawal management and stabilization center that would enable individuals who do not have strong sober supports outside of the treatment and recovery community arenas to have a safe and stable short-term residential situation while they begin IOP treatment (including MAT when indicated). Specifically, Horizons is working with the Laconia Area Community Trust as well as with a number of town Welfare Officers in the region to identify potential resources for this initiative. The expansion of regular outpatient services, IOP treatment and, eventually partial hospitalization, along with Recovery Support Services addressed throughout our plan, are intended to assure timely access to community based SUD and co-occurring disorders treatment that, in conjunction with care coordination, provide a holistic approach to care, intended to keep patients engaged in the treatment and recovery process in all life areas.

With respect to concurrent treatment of co-occurring tobacco use disorder, all clients who come in for any level or type of care are screened for tobacco use and provided with tobacco session education. All identified tobacco users in SUD services are assessed for motivation to stop using tobacco and are provided with information regarding access to smoking cessation programs including the DHHS Tobacco Prevention and Control Program and certified tobacco cessation counselors available through the NH QuitLine. Clients involved in IOP and regular outpatient counseling services receive education on the importance of tobacco cessation including the association between tobacco dependency and other addictive patterns and reinforcing the use of SUD recovery skills to support tobacco cessation. These efforts are coordinated with tobacco education and smoking/tobacco use cessation and counseling services provided by primary care practices. It is the intention of the IDN to build on this beginning and integrate tobacco cessation efforts into all areas of IDN services.

With respect to concurrent MAT, there are over 200 clients currently enrolled in the MAT program operated in coordination between LRGH and Horizons. These two organizations have worked together to integrate care of MAT recipients with Horizons providing initial assessment and level of care recommendations to the LRGH Recovery Clinic and providing the treatment and recovery supports for MAT patients receiving medication and medical supervision through the Recovery Clinic. The Recovery Clinic has no wait for services at this time and has been adding MAT providers as needed to meet the demand. Efforts are underway to expand access to MAT with buprenorphine and Naltrexone by increasing the SUD and behavioral health network for referrals and ongoing treatment utilizing an integrated care model developed with Horizons as part of those relationships. HealthFirst (FQHC) is also in the process of training prescribers for MAT and is instituting an integrated care model within their community health center sites. The goal of these efforts is to increase access to MAT for individuals in the region with opioid use disorders and to ensure that medical and behavioral health treatment is fully coordinated / integrated. Finally, the Belknap County Department of Corrections (key partner in the Community Re-Entry project that will be connected to this SUD treatment expansion work) is exploring introducing MAT with Naltrexone / Vivitrol into their offender re-entry program beginning while they are on work release or electronic monitoring. Discussions with the DOC have resulted in a planning process for utilizing the supports provided by the IDN's Community Re-entry project to ensure immediate access to MAT services, both medical and clinical, for offenders leaving the County House of Corrections on MAT to assure that there are no gaps in the necessary services to support their ongoing recovery.

Increased access to traditional outpatient counseling will be accomplished by leveraging resources applied through the IOP expansion and through other aspects of our overall service delivery transformation plan and other sources. For example, Horizons will be able to create flexibility in job descriptions to allow SUD counselors in the IOP level of care to follow their clients through step down services in the outpatient level of care. The transformation plan also includes resources to support use of CRSWs for case management and practical supports generally required of counselors to free up professional counseling staff to see more clients without substantially increasing their workload. Furthermore, aftercare, or continuing care, is a required component of IOP treatment that will, by definition, result in expanded resources for a regular outpatient level of care supported by the IDN. Thus, as access to IOP treatment increases, access to outpatient counseling will also be increased in tandem. Horizons Counseling Center has also hired a SUD counselor to do level of care assessments and program intake to facilitate getting clients into SUD treatment services more quickly. While this position is not directly supported with IDN funding, it will work in coordination with the other partners in Region 5 and with the care managers and care coordinators from all of our member and affiliate agencies.

Clients who complete both the IOP and OP components of their treatment plan will continue to have access to outpatient treatment through Horizons or return to the outpatient aftercare program indefinitely without charge for as long as group outpatient counseling is deemed to be the appropriate level of care for their clinical needs. This approach is a cost effective means of increasing outpatient treatment access that has the added benefit to Horizons and to the community of increasing access to peer mentors who return to program post treatment to “give back” what they gained through treatment rather than because they need ongoing care for themselves.

CHSN-IDN 5’s workforce development and training efforts will also lead to increased access to outpatient counseling by supporting recruitment and retention of staff and assisting new counselors in working toward licensure, thereby increasing the availability of trained and credentialed outpatient counselors. IDN partners are also working to increase availability of SUD outpatient services through several collaborative efforts. For example, Horizons Counseling and Genesis Behavioral Health are collaborating on an effort to provide supervision and peer collaboration for MH counselors to prepare them to become SUD providers, thereby increasing the availability of SUD outpatient services within the community mental health setting. Horizons staff is also providing MLADC supervision for a HealthFirst social worker so to increase the FQHC’s ability to offer outpatient SUD counseling and integrated MAT. We anticipate continuing to support these types of efforts as part of the overall core integration work of the IDN in other areas of the health care delivery system in the region.

In a related development, Horizons has obtained grant funding from the NH Judicial Branch Drug Offender Program to support the Belknap County Drug Court program including support for increasing outpatient services directed to the offender population, which makes up a substantial percentage of clients requiring an outpatient level of care. This work highlights the importance of leveraging funding from a variety of sources, many within the criminal justice system, to increase efficiency, cross train existing staff and train new counselors to expand the workforce providing outpatient SUD counseling through traditional SUD providers as well as through other behavioral health and medical access points.

Current Challenges and Implementation Alternatives

A component of the model as envisioned includes utilizing CRSWs as an integral part of the IOP team. Capacity for CRSW services is currently slow in development in the Plymouth region. Early implementation activities may require use of CRSWs currently working primarily in Belknap County.

Horizons Counseling Center has been attempting to recruit a counselor for the Plymouth region for over a year. IDN resources for recruitment incentives may aid in this recruitment effort.

The table below outlines the key activities, milestones and timelines, responsible party, and progress measures for implementation. Smartsheet detail and timeline is included as a graphic at the end of this section and included as **Attachment_D.1A**

Implementation Activity/ Milestone	Responsible Party/ Organization	Time line	Progress Measure / Notes
Establish and support SUD Treatment Options Leadership Team	CHSN Executive Director; Team Lead – Executive Director of Horizons	Within 30 days of plan approval; meet bi-monthly	Milestone Met: Leadership Team established; regular meetings occurring with documentation of minutes
Develop Expanded IOP with care coordination and integrated recovery coaching approach and protocols including: <ul style="list-style-type: none"> - Referral pathways, assessments, care coordination - Patient confidentiality agreements - Recovery coach pairing, frequency and duration ranges - Transportation needs for non-Medicaid services - Communications protocols to support successful IOP for each client - Family/support system engagement and communication as appropriate - Assigning of care coordinators per individual client needs - Application to Medicaid/Health Insurance program - Patient confidentiality and privacy assurances and releases established before release - Housing and employment supports - Other community supports 	SUD Treatment Options Leadership Team	By December 31, 2017	Protocol development in progress
Initiate recruitment of staff for evening IOP in Belknap County	Hiring organization; SUD Treatment Options Leadership Team	By December 31, 2017	Recruitment underway
Develop inter-organizational care coordination protocols, including shared decision-making and crisis management	SUD Treatment Options Leadership Team and CHSN partners	By December 31, 2017	Protocol development in progress
Develop and implement procedures for data collection and sharing	SUD Treatment Options Leadership Team and CHSN Board	By December 31, 2017	Development of data sharing procedures in progress
Establish data sharing agreements with participating organizations	CHSN ED, Board and participating organizations	By December 31, 2017	Data sharing agreements in development
Establish and implement all NH DHHS and CHSN data collection and reporting requirements	CHSN ED and CHSN partners	By December 31, 2017 and ongoing	Data collection procedures in development

Implementation Activity/ Milestone	Responsible Party/ Organization	Time line	Progress Measure / Notes
Provide cross-training to all staff and organizations involved in the project (see training plan)	SUD Treatment Options Leadership Team	By January 31, 2018 and ongoing	Training plans in development
Initiate referrals, IOP services and care coordination for evening program in Belknap County	All participating organizations	By January 31, 2018 and ongoing	Pending completion of staff recruitment and development activities
Execute agreement with Riverbend Mental Health for IOP capacity as part of IOP expansion in the Franklin area being undertaken by the Capital Region IDN	CHSN Executive Director	By January 31, 2018	Informal agreement / joint planning in place
Publicize expanded IOP availability through communication to all PCP practices, local media (radio, newspaper, public access channel), grand opening event	SUD Treatment Options Leadership Team	By January 31, 2018	Pending completion of staff recruitment and development activities
Initiative recruitment of staff for Plymouth area IOP	Hiring organization; SUD Treatment Options Leadership Team	By June 30, 2018	Recruitment underway
Initiate recruitment of part-time driver in coordination with Genesis to operate van for IOP program	SUD Treatment Options Leadership Team and hiring organization	By June 30, 2018	Pending completion of program development
Initiate referrals, IOP services and care coordination for Plymouth area IOP	All participating organizations	By December 31, 2018 and ongoing	Pending completion of staff recruitment and development activities
Develop criteria and certification pathway support for project staff to meet requirements as needed (see workforce development plan)	SUD Treatment Options Leadership Team	By June 30, 2018 and ongoing	Funds budgeted to support staff pursuing licensure / certification; supervision relationships in place
Develop long-range project sustainability plan	CHSN Board	Initiate development by September 30, 2019	Pending project implementation

Training Plan

Training activities specifically related to the SUD Treatment Expansion project will focus on team and partnership building, skill development for recovery coaches, cross training for project staff and partner organizations. Specific training activities and target trainees for the SUD Treatment Expansion project are described below. Specific training activities and target trainees are specified below for D3 and also in **Attachment D.1B**. The attachment also has separate tabs for training by agency.

Project-Related Training Activities	Target Trainees	Time line	Progress Measure / Notes
New project staff orientation, team building, partner building	Project Staff (approximately 15 staff, 10 FTEs) and supervisors	By December 1, 2017 and ongoing	Pending staff hiring / assignment of existing staff
HIPAA and CFR 42 Part 2; Ethics and Boundaries	All new staff including recovery coaches	By January 1, 2018 and ongoing	Pending staff hiring
Supervision of recovery coaches and SUD counselors/LADCs for maintenance of certification and licensure respectively.	CRSWs based at Recovery Support Organizations and at the IOPs. SUD counselors/LADCs based at the IOPs.	By January 1, 2018 and ongoing	Weekly supervision meetings are happening now. Activity to be connected more specifically to the IOP project implementation
Cross-training for interagency team – understanding roles, recognizing signs and symptoms of SUD / MH	Counselors, care coordinators, recovery coaches, ED and PCP practice staff, other CHSN partner organizations	Identify staff and initiate training by January 1, 2018 and ongoing	Horizons staff provide training now. Activity to be connected more specifically to the IOP project implementation

Attachment_D.18

TOTAL TRAINING NUMBERS

D3 Expansion in Intensive SUD Treatment Options Trainings by provider type

Project	Topic/subject	Primary Care MD, NP, PA	BH clinicians LDCSW, LPMT, LCMHC, clinical psychologist, masters level clinicians	SUD counselor MAADC, LADC, LCMHC, LDCSW, Masters level clinicians	Care Coordinator/Case manager (RN and non-RN)	Recovery support worker/coach (SUD)	BH Peer Support	Admissions/Pre-screener	non-direct care staff/program support: receptionist, van driver, etc.	benefit navigator, financial assistant	WFT/Case collectionists Individual at each agency	Billing non-hospital	Billing hospital based
All	DSRIP 101- Introduction to the 1115 waiver		9	22	10		1					8	8
All	Privacy and liability: CFR 42 part 2, HIPAA		4	22	10		1					8	8
All	Outcome Metrics & data collection		4	22	7					2			
All	CMT shared care plans, event notification		4	22	7								
All	Data aggregator trainings												
B1, C2, D3, ES	Co-occurring disorders		5	4	20								
A1, B1, C2, D3, ES	Understanding of Provider roles			4	22	3	2	1				8	8
B1, D3, ES	Natural Supports training, Strengths based approach				22	7							
B1, C2, D3, ES	Motivational Interviewing			4	24	7							
B1, C2, D3, ES	Suicide prevention		10	4	18	10	2	1					
B1, D3, ES	Narcotic Awareness		10	4	5	10	2	1					
B1, C2, D3, ES	Ethical competency			4	22	3	1						
B1, C2, D3, ES	MH First Aid (non-clinicians)					3	1						
B1, C2, D3, ES	Cultural Competency			4	22	10	1						
B1, C2, D3, ES	Basic training on Addiction & Recovery				20	10							
B1, C2, D3, ES	Home visit safety				18								
B1, C2, D3, ES	Trauma informed treatment			4	21	7							
D3	Addiction Severity Index		5	4									
B1, ES, C2, D3	Best practices in care transitions				21								
C2, D3	HIV, Hep C, STDs			4	21	10							

Evaluation Plan

Process evaluation of the SUD Treatment Expansion project will entail documenting the presence or occurrence of key features of the model, as well as specific outcome metrics. Data describing process and outcome measures associated with this community project will be collected from participating organizations on a quarterly basis including data associated with training and workforce development activities, and de-identified client data to track IOP participation, case management and referral activities and monitor project goals. In addition, a client satisfaction tool will be developed to capture client feedback (see also Community Input plan) to assess client perceptions of effectiveness and inform ongoing quality assurance. The key partners in the project will review client feedback semi-annually to make adjustments and improvements to policies and protocols to ensure goals are met, standards are maintained, and individuals receiving services are satisfied with their care.

We anticipate serving 50 individuals per year once expanded IOP services are fully operational through the SUD Treatment Expansion project. The socio-demographic characteristics of the population served through this community project will be tracked to include housing, economic and employment stability, and social and family supports.

The CHSN Executive Director and Project Manager will have overall responsibility for internal evaluation of this community project. Data systems to support evaluation of this community project will be established in conjunction with the CHSN Health Information Technology (HIT) work group and the Enhanced Care Coordination community project. Leveraging these and emerging data systems that may be developed to support the IDN’s re-entry work, the following measures and data sources will be used to evaluate project process and outcomes (selected State-defined outcome measures are indicated by an asterisk).

Evaluation Measure	Source	Frequency of Collection / Reporting	Results / Notes
Process Measures			
Referral numbers and sources by type / location	SUD treatment and recovery agency records	Monitor quarterly/ report semi-annually	Pending
Percent of referred clients for whom assessment occurs within 48 hours	SUD treatment and recovery agency records	Monitor quarterly/ report semi-annually	Pending
Percent of referred clients placed in appropriate level of care per ASAM criteria	SUD treatment agency records	Monitor quarterly/ report semi-annually	Pending
Waiting list for treatment services, number of clients and wait time	SUD treatment agency records	Monitor quarterly/ report semi-annually	Pending

Evaluation Measure	Source	Frequency of Collection / Reporting	Results / Notes
Percent for whom recovery coach pairing is completed	SUD treatment and recovery agency records	Monitor quarterly/ report semi-annually	Pending
Percent for whom family/friend engagement and communication is established as appropriate	SUD treatment agency records	Monitor quarterly/ report semi-annually	Pending
Percent of clients reporting transportation as an access barrier who are connected to a transportation resource for IOP participation	SUD treatment agency records	Monitor quarterly/ report semi-annually	Pending
Community services and support referrals made from the IOP by number, type and location	SUD treatment agency records	Monitor quarterly/ report semi-annually	Pending
Outcome Measures			
*Initiation of SUD Treatment (1 visit within 14 days)	SUD treatment agency records	Monitor quarterly/ report semi-annually	Pending
Retention in SUD/COBHD treatment for recommended duration per ASI/ASAM evaluation	SUD treatment agency records	Monitor quarterly/ report semi-annually	Pending
Self-report of improved status of employment, housing, arrest, relapse, interpersonal relationships, family interaction, community connectedness and other measures of recovery stability	Client self-report; instrument to be administered by care coordinator; de-identified aggregate data collected and analyzed by CHSN	Monitor quarterly/ report semi-annually	Pending
*Number / percentage of frequent (4+ per year) ER Visit Users	Hospital ED data	Monitor quarterly/ report semi-annually	Pending
*Number / percentage of Potentially Preventable ER Visits	Hospital ED data	Monitor quarterly/ report semi-annually	Pending
Percent Abstinent from Alcohol at intake and 30 days, 6 months and 1 year post treatment discharge (NOMS measure)	WITS / SUD treatment agency records	Monitor quarterly/ report semi-annually	Pending
Percent Abstinent from other drugs at intake and 30 days, 6 months and 1 year post treatment discharge (NOMS measure)	WITS / SUD treatment agency records	Monitor quarterly/ report semi-annually	Pending

Evaluation Measure	Source	Frequency of Collection / Reporting	Results / Notes
New criminal justice involvement (NOMS measure)	WITS / SUD treatment agency records	Monitor quarterly/ report semi-annually	Pending
Percent employed or in school / job training at intake and 30 days, 6 months and 1 year post treatment discharge (NOMS measure)	WITS / SUD treatment agency records	Monitor quarterly/ report semi-annually	Pending
Percent in stable housing situation at intake and 30 days, 6 months and 1 year post treatment discharge (NOMS measure)	WITS / SUD treatment agency records	Monitor quarterly/ report semi-annually	Pending
Percent participating in peer support group at intake and 30 days, 6 months and 1 year post treatment discharge (NOMS measure)	WITS / SUD treatment agency records	Monitor quarterly/ report semi-annually	Pending

D-2: Community Project Evaluation Targets

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
Number of individuals served	50 additional IOP clients per year once fully operational in all 3 sub-regions			
Percent of referred clients for whom assessment occurs within 48 hours	To be determined			
Percent of referred clients placed in appropriate level of care per ASAM criteria	To be determined			
Waiting list for treatment services, number of clients and wait time	To be determined			
Percent for whom recovery coach pairing is completed	To be determined			
Percent for whom family/friend engagement and communication is established as appropriate	To be determined			
*Initiation of AOD Dependence Treatment (1 visit within 14 days)	To be determined			
Retention in SUD/COBHD treatment for recommended duration per ASI/ASAM evaluation	To be determined			
*Number / percentage of frequent (4+ per year) ER Visit Users	To be determined			
*Number / percentage of potentially preventable ER Visits	To be determined			
Percent Abstinent from Alcohol at intake and 30 days, 6 months and 1 year post treatment discharge (NOMS measure)	To be determined			

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
Percent Abstinent from other drugs at intake and 30 days, 6 months and 1 year post treatment discharge (NOMS measure)	To be determined			
New criminal justice involvement (NOMS measure)	To be determined			
Percent employed or in school / job training at intake and 30 days, 6 months and 1 year post treatment discharge (NOMS measure)	To be determined			
Percent in stable housing situation at intake and 30 days, 6 months and 1 year post treatment discharge (NOMS measure)	To be determined			
Percent participating in peer support group at intake and 30 days, 6 months and 1 year post treatment discharge (NOMS measure)	To be determined			

D-3: Community Project Workforce Staffing

A total of 9.7 FTEs across four organizations are projected for new workforce staffing for the Community Re-Entry Project. The types of staff are shown by organization in the table below. CHSN-IDN 5 opted to leave its staffing at “0” at baseline for all projects though it is possible that existing staff may fill some of these roles, they have not been assigned to this project until plans have been approved.

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
MD (Horizons)	0.1 (increase to 0.2 when expand to Plymouth)	0			
SUD Counselor/ Co-occurring counselor (Horizons)	4	0			
Admin. Assistant (Horizons)	0.5	0			
Recovery support worker (Horizons)	1	0			
Benefit Navigator (LRGHealthcare)	0.1	0			
Benefit Navigator (HealthFirst)	0.1	0			
Case Manager / Care Coordinator (Genesis)	0.4	0			
Transportation Driver (Genesis)	0.5	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
Recovery Support Worker (Navigating Recovery)	1	0			
Recovery Support Worker (PARC)	2	0			

D-4: Community Project Budget

Funds are budgeted for the SUD Treatment Expansion project to support salaries and benefits of project as outlined in the previous section. Salaries are budgeted based on prevailing wages by position type. Fringe benefits are budgeted uniformly across all partner organizations at 31% of salary.

Budget Item	Item Description	2017 Cost	2018, 2019, 2020 (Costs Equally Distributed over 3 years)	Total Project Cost (3.5 years)
Salaries and Wages				
Project Staff Salaries / Wages (subcontracted)	Salaries for clinicians, recovery support workers, case managers, benefit navigators, admin support and driver as outlined in the previous section	██████	██████	██████
Project Staff Benefits	31% of salary / wages	██████	██████	██████
IOP subcontract	Stipend for Treatment slot with Riverbend IOP serving Franklin		██████	██████
		SUB-TOTAL		\$ 1,672,428.59
Other Direct Costs				
Transportation van	Reimbursement for travel @ .535 p/mile (estimated @100 miles p/week x 50 weeks		██████	██████
Supplies	Miscellaneous expenses over waiver period			██████
PROJECT TOTAL				\$ 1,679,478.59

D-5: Key Organizational and Provider Participants

The following organizations are the key participants in the SUD Treatment Expansion Program with representatives of each organization forming the SUD Treatment Options Leadership Team.

Organization/Provider	Agreement Executed (Y/N)
Horizons Counseling Center	Y
Navigating Recovery	Y
Genesis Behavioral Health	Y
LRGHealthcare	Y
Plymouth Area Resource Connection	Y
HealthFirst	Y
Community Health Services Network	Y

D-6: Standard Assessment Tools

The table describes the Assessment and Screening tools that will be used for the Community Re-entry Project.

Standard Assessment Tool Name	Brief Description
Addiction Severity Index (ASI)	The ASI is a semi-structured interview designed to address seven potential problem areas in substance-abusing patients: medical status, employment and support, drug use, alcohol use, legal status, family/social status, and psychiatric status.
American Society of Addiction Medicine (ASAM) criteria	The ASAM criteria provide guidelines for assessment, service planning, level of care placement, continued stay and transfer/discharge of patients with addiction and co-occurring conditions.
Clinical Interview for DSM-5	The Structured Clinical Interview for DSM-5 is a semi-structured interview guide for making DSM-5 diagnoses. It will be administered by a clinician or trained mental health professional that is familiar with the DSM-5 classification and diagnostic criteria.

D-7: Protocols for Patient Assessment, Treatment, Management, and Referrals

Protocols for patient assessment, treatment, management and referral specific to the Community Re-entry Project are under development. Horizons Counseling Center has a long history of working with the SUD population through IOP and other recovery support services and has a manual of protocols and procedures that will be adopted / modified to support this project.

Protocol Name	Brief Description	Use (Current/Under development)
Client Identification and Referral	Protocols and communication procedures timely identification and referral from primary care, emergency departments, and other health and human service providers of individuals who may benefit from SUD-related assessment, evaluation and connection to appropriate treatment	Existing Horizons protocols / modifications Under development as necessary
Screening, assessment and care plan development	Protocols and workflows for application and frequency of screening and assessment tools; care plan development and review	Existing Horizons protocols / modifications Under development as necessary
IOP procedures	Protocols and workflows for appropriate group placement, core and enhance program content, client progress assessment, discharge and connection to community services and supports	Existing Horizons protocols / modifications Under development as necessary
Data collection and evaluation	Protocols and workflows for collection, reporting and analysis of client data for program monitoring and improvement	Under development

D-8: Member Roles and Responsibilities

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

Project Team Member	Roles and Responsibilities
Horizons Counseling Center	SUD Treatment Options Leadership Team, Provide integrated SUD/COBHD clinical services including expanded IOP, Coordinate services with primary care services, MH, MAT and Recovery services as appropriate
LRGHealthcare	SUD Treatment Options Leadership Team, provide integrated primary care services including MAT, benefits navigation / enrollment assistance, Coordinate services with SUD, MH and Recovery services as appropriate
HealthFirst	SUD Treatment Options Leadership Team, Provide MAT services, benefits navigation / enrollment assistance Coordinate services with SUD, MH and Recovery services as appropriate
Navigating Recovery	SUD Treatment Options Leadership Team, Employ/provide trained recovery coaches/mentors for pairing with IOP population, Coordinate services with SUD and primary care services as appropriate, Liaison with ancillary supports in community, including housing, education/training, employment, child care and transportation

Genesis Behavioral Health	SUD Treatment Options Leadership Team, Provide integrated behavioral health services, Coordinate services with SUD and primary care services as appropriate
Riverbend Community Mental Health	IOP service expansion in Franklin area, Provide integrated behavioral health services, Coordinate services with SUD and primary care services as appropriate
Farnum North / Easter Seals	Coordinate services, Participate in referral network
Plymouth Area Recovery Connection (PARC)	Employ/provide trained recovery coaches/mentors for pairing with IOP population, Coordinate services with SUD and primary care
Hope for NH Recovery	Employ/provide trained recovery coaches/mentors for pairing with IOP population, Coordinate services with SUD and primary care
Central NH VNA & Hospice	Provide referrals and home care services to infants, families
Franklin VNA & Hospice	Provide referrals and home care services to infants, families
Lakes Region Visiting Nurse Association	Provide referrals and home care services to infants, families
NANA	Provide referrals and home care services to infants, families
Pemi-Baker Community Health	Provide referrals and home care services to infants, families
Partnership for Public Health	Membership participates in referral network for re-entry individuals
Community Health Services Network	Administrative home for the program; funding of sub-recipients for program; Long-range infrastructure and sustainability planning and implementation for the program, Serve on SUD Treatment Options Leadership Team, Membership participates in referral network for re-entry individuals

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

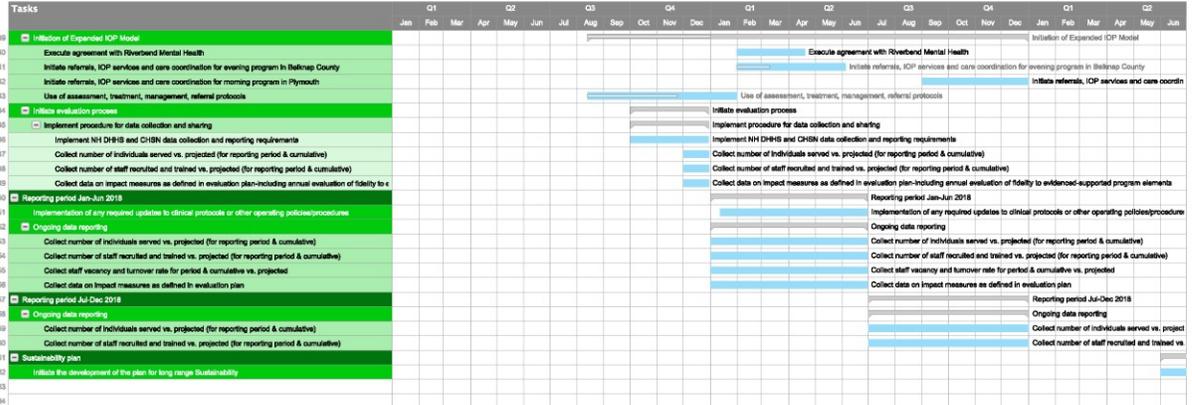
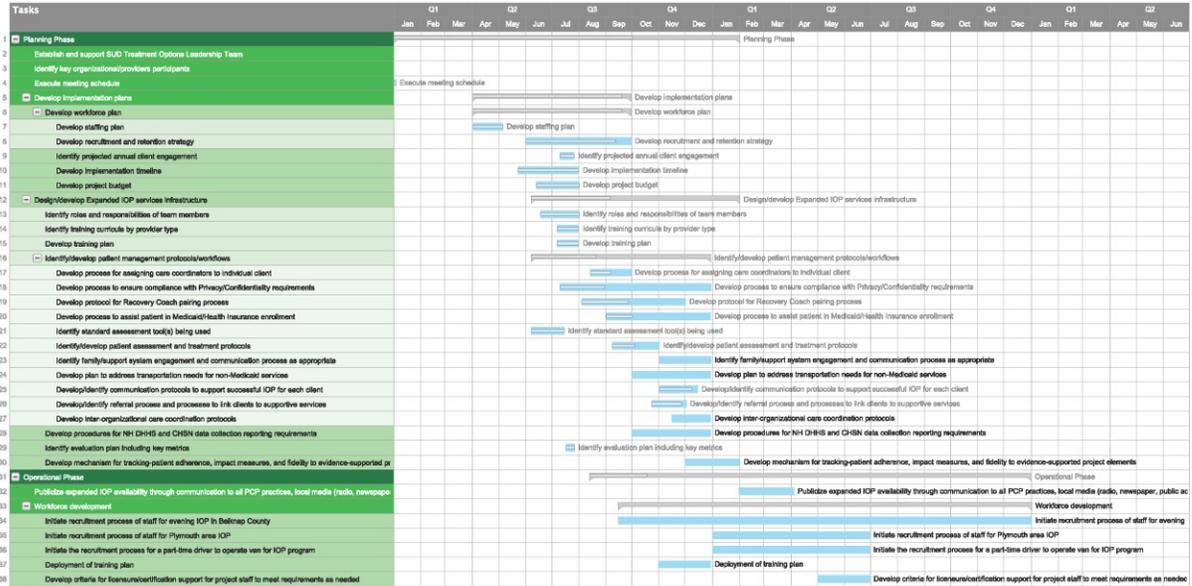
See below from Section D-1 and also refer to the CHSN-IDN 5 Training and Education Strategic Plan found on p. 14.

Project-Related Training Activities	Target Trainees	Time line	Progress Measure / Notes
New project staff orientation, team building, partner building	Project Staff (approximately 15 staff, 10 FTEs) and supervisors	By December 1, 2017 and ongoing	Pending staff hiring / assignment of existing staff

HIPAA and CFR 42 Part 2; Ethics and Boundaries	All new staff including recovery coaches	By January 1, 2018 and ongoing	Pending staff hiring
Supervision of recovery coaches and SUD counselor/LADCs for maintenance of certification and licensure respectfully	CRSWs based at Recovery Support Organizations and SUD counselors/LADCs based at the IOPs	By January 1, 2018 and ongoing	Weekly supervision meetings are happening now. Activity to be connected more specifically to the IOP project implementation
Cross-training for interagency team – understanding roles, recognizing signs and symptoms of SUD / MH	Counselors, care coordinators, recovery coaches, ED and PCP practice staff, other CHSN partner organizations	Identify staff and initiate training by January 1, 2018 and ongoing	Horizons staff provide training now. Activity to be connected more specifically to the IOP project implementation

D3 Expansion in IOP (IDN 5)

D3 timeline



Project E: Enhanced Care Coordination for High-Need Populations

E-1: Core Components, Process Milestones, Training and Evaluation Project Plans

Project Overview

The Enhanced Care Coordination for High-Need Populations project is intended to address challenges experienced by patients, families and providers resulting from fragmented care through multiple health and human service agencies and programs; challenges that contribute to poorer health outcomes and costly patterns of service utilization for individuals with complex behavioral health care needs.

Current needs and gaps to be addressed through this initiative include:

- Patient and family caregiver difficulties with accessing appropriate and timely care and support, as well as experiences with limited collaboration and information sharing between physical health care, behavioral health care, and community services and supports;
- Related provider experiences of having limited information and communication beyond their own organizations, and in some cases duplication of efforts for complex, high need patients leading to frustration, dissatisfaction and burnout;
- Limited staff capacity and high turnover of case management staff among partner agencies contributing to time constraints on participation in inter-agency care coordination and case management activities outside of each agencies' scope of services;
- Inconsistent linkages between hospital emergency and inpatient care, primary care, behavioral health care, and home and community-based care leading to increased likelihood of insufficient transitions of care, unstable social circumstances, and unintended care patterns such as frequent emergency department utilization and unplanned hospital readmissions.

The conceptual framework for this project will seek to incorporate elements of Care Management – whole person focused activities intended to ensure that individuals at high risk get the care and services they need – and Care Coordination – system focused activities intended to ensure that care is seamless and consistent across providers and transitions of care. To accomplish these related goals, we will seek a balance between assigning care coordinators to work with individual providers and assigning clients to work with case management teams with the highest likelihood of success in engagement and follow through with prescribed and recommended services.

Key elements of the implementation approach include:

- The project will build on an inter-agency, multi-disciplinary wraparound team that has been operating out of the Lakes Regional General Hospital campus over the past year. The team's focus is improving case management and coordination of services for specific patients identified as high utilizers of the Emergency Department. This existing wraparound team will serve as an important foundation for expanding the care coordination and case management team structure and processes to the two other hospital service areas within the IDN (Franklin Regional Hospital and Speare Memorial Hospital) ensuring access for all geographic areas.
- There will be 10.3 Community Care Coordinators either hired or designated / embedded from existing positions within the key organizations involved in or needing to be involved in enhanced care coordination activities (links to Workforce Development). The organizations include primary care practices, behavioral health providers, hospitals, and home health organizations to comprehensively support our region.
- Additionally, one Coordinated Care Team Leader will be hired / designated to provide logistical support to each of the Community Care Coordinators, including facilitating regular inter-agency

case conferences and training activities, building relationships and awareness of community resources, identifying best practices, assigning care coordinators to clients, monitoring implementation progress and tracking client outcomes, and collecting data to assure metrics are supported and reported on with high fidelity.

- Inclusion of peer and recovery support workers as part of the care coordination team as appropriate to help with patient activation, coaching and advocacy to better connect the different parts of the system;
- Development of common responsibilities and standardized team descriptions with cross-training such that care coordinators can support each other's work, thereby helping to address limited capacity of each agency to assure patients can get the same support across the care system;
- Implementation of common tools and procedures for risk identification, standardized screening and assessment, patient and family engagement, development and follow up of care plans, transitional care procedures, promotion of self-management skills, and monitoring patient and provider satisfaction and outcomes.
- Development / updating of inter-agency policies, agreements and forms for data sharing and patient consent for information release;
- Development of common terminology, formats and capacity for shared care plans, with patient consent and proper safeguards for protected information (links to HIT / CMT and practice-based Integration efforts);
- Improved data sharing and data analytics to support risk identification, event notification, and performance monitoring (links to HIT). Through use of shared care plan software (CMT) care coordinators will have access to real time information allowing for seamless transitions and coordination of care for high need populations;
- Coordinated patient assignments, peer review and mutual accountability.

Current Challenges and Implementation Alternatives

As mentioned above, a significant historical challenge in this area has been the recruitment of experienced health care professionals which impacts the entire workforce and contributes to the recent rise in turnover in positions including case management. Along with other northern and rural regions of New Hampshire, provider organizations in CHSN-IDN 5 are challenged to provide competitive salaries and sustain a similar array of services compared to the southern, more populated areas of our state. Of particular relevance to this project, our IDN has seen significant turnover of some key individuals involved in planning efforts for the enhanced care coordination project. IDN partner organizations are taking much longer to fill their vacant positions than they have experience historically, creating increasing demands on the current workforce.

The table below outlines the key activities, milestones and timelines, responsible party, and progress measures for implementation. Smartsheet detail and timeline is included as a graphic at the end of this section and included as **Attachment_E.1A**

Implementation Activity/ Milestone	Responsible Party/ Organization	Time line	Progress Measure / Notes
Establish and support Enhanced Care Coordination Leadership Team	CHSN Executive Director; Team Lead – Executive Director Genesis	Meet twice monthly until implementation of Care Coordination Teams established; bi-monthly thereafter	Milestone Met: Leadership Team established; regular meetings occurring with documentation of minutes
Research model practices from other states; present findings to Enhanced Care Coordination planning group	CHSN Project Manager and Leadership Team	By June 30, 2017	Milestone met: April 2017 - reviewed / presented information from Kentucky- ER SMART; Alaska- Nuka Model; Minnesota- Stratis Health
Develop Enhanced Care Coordination approach and protocols including: <ul style="list-style-type: none"> - Referral pathways, assessments, care coordination - Patient confidentiality agreements - Communications protocols to support successful care coordination for each client - Family/support system engagement and communication as appropriate - Assigning of care coordinators per criteria blending individual patient/family needs and choice - Patient confidentiality and privacy assurances and releases established before release - Housing and employment supports - Other community supports 	Enhanced Care Coordination Leadership Team	By December 31, 2017	Protocol development in progress
Finalize common job descriptions for care coordinators, metrics, standardized process for notetaking, assignment of cases	Enhanced Care Coordination Leadership Team	By December 31, 2017	Draft job descriptions have been developed for care coordinators and Lead care coordinator
Execute agreements with participating agencies for support of project-related positions	CHSN Executive Director	By November 30, 2017	MOUs in place
Initiate recruitment of Coordinated Care Team Leader, Community Care Coordination staff; transportation driver (Genesis) in conjunction with Expanded SUD project	Enhanced Care Coordination Leadership Team	By December 31, 2017	Recruitment underway
Develop inter-organizational care coordination protocols, including shared care plan, decision-making and crisis management	Enhanced Care Coordination Leadership Team	By December 31, 2017	Protocol development in progress
Develop standardized procedures for case conferencing including assignment of cases, presentation of cases, notetaking and charting in the shared care plan	Enhanced Care Coordination Leadership Team	By December 31, 2017	Under development

Implementation Activity/ Milestone	Responsible Party/ Organization	Time line	Progress Measure / Notes
Train project staff on case management and care coordination protocols and information systems	Enhanced Care Coordination Leadership Team	Initiate by December 31, 2017 and ongoing	Training has begun and ongoing training schedule identified
Finalize criteria for identifying clients for enhanced care coordination and team notification process	Enhanced Care Coordination Leadership Team	By December 31, 2017	Preliminary criteria developed based on high ED utilization
Establish caseload parameters and criteria for discharge from enhanced care coordination	Enhanced Care Coordination Leadership Team	By December 31, 2017	Under development
Develop and implement procedures for data collection and sharing	Enhanced Care Coordination Leadership Team	By December 31, 2017	Development of data sharing procedures in progress
Establish data sharing agreements with participating organizations	CHSN ED, Board and participating organizations	By December 31, 2017	Data sharing agreements in development
Establish and implement all NH DHHS and CHSN data collection and reporting requirements	CHSN ED and CHSN members	By December 31, 2017 and ongoing	Data collection procedures in development
Provide cross-training to all staff and organizations involved in the project (see master training plan)	Enhanced Care Coordination Leadership Team	By January 31, 2018 and ongoing	Training plans in development
Initiate referrals and enhanced care coordination services in Laconia area	All participating organizations	By January 31, 2018 and ongoing	Pending completion of staff recruitment and development activities
Initiate referrals and enhanced care coordination services in Plymouth and Franklin areas	All participating organizations	By July 1, 2018 and ongoing	Pending completion of staff recruitment and development activities
Develop long-range project sustainability plan	CHSN Board	Initiate development of by September 30, 2019	Pending project implementation

Training Plan

Training activities specifically related to the Enhanced Care Coordination project will focus on team and partnership building, skill development and information system user training for care coordinators, cross-training for project staff and partner organizations. Specific training activities and target trainees for the Enhanced Care Coordination project are described below. See also the CHSN-IDN 5 Training and Education Strategic Plan found on p. 14. Specific training activities and target trainees are specified below for D3 and also in **Attachment E.1B**. The attachment also has separate tabs for training by agency.

Project-Related Training Activities	Target Trainees	Time line	Progress Measure / Notes
New project staff orientation, team building, partner building, DSRIP 101; education of Medicaid; knowledge of Peer recovery support and benefits to patients; family support services available	Project Staff and supervisors	By December 31, 2017 and ongoing	Pending staff hiring / assignment of existing staff
HIPAA and CFR 42 Part 2; Ethics and Boundaries; familiarity with patient consent to interagency data sharing form and procedures	All new staff	By January 1, 2018 and ongoing	Pending staff hiring
Cross training for care coordination stakeholders to increase shared knowledge base; e.g. understanding chronic physical health conditions for behavioral health-based care coordinators; understanding mental health conditions for primary care and home health based care coordinators	Project Staff and supervisors	By January 31, 2018 and ongoing	Pending staff hiring / assignment of existing staff
Understanding EMS and law enforcement rules and protocols; e.g. for protective custody; for ED transport	All staff and community-based Partners	By June 30, 2018 and ongoing	Pending staff hiring / assignment of existing staff

Attachment_E.1B

TOTAL TRAINING NUMBERS

E5 Enhanced Care Coordination for High Needs Populations

Project	Topic/subject	Primary Care MD, NP, PA	Pediatric care providers	BH practitioners: Psychiatrist, ANNP	BH clinicians: LCSW, LMT, LCMHC, clinical psychologist-masters level and non-RN)	Care Coordinator/ Case manager (RN and non-RN), Healthcoach, BSW	ED staff RN, Medic, Tech	ED providers- MD, NP, PA	Primary care RN, MA, LNA	BH Peer Support, Peer Recovery Support worker (SUD)	Home care staff- RN, LNA, PCA	Community Health worker	Benefit/Health navigator, Financial assistant coordinator	Admissions pre-screener	non-direct staff/Program support staff: receptionist, van driver, etc.	MT/Data Collections individual	Billing hospital	Billir
All	DSRIP 101- Introduction to the 1115 waiver	36	12	5	39	66	22	48	9	12	16	2	31	3	6	7		
All	Privacy and liability: CFR 42 part 2, HIPAA	36	12	5	27	66	22	48	9	12	16	2	31	3	6	7		
All	Outcome Metrics & data collection	11	7	5	27	26	7	23	7	5	4	2	31	5	6	7		
All	CMT shared care plans, event notification	36	12	5	27	66	22	48	9	9				3				
All	Data aggregator trainings									3				2				
B1, E5	Treatment planning	11	7	5	29	26	7	23	7	20								
B1, E5	The Basics of Medicaid				27				2	20								
A1, B1, E5	New opioid prescribing regulations, chronic pain and opioids	36	12				22			20								
A1, B1, E5	Patient Centered care	36	12	5	24	66	22	48	7	20		2						
A1, B1, C2, D3, E5	Referral Process and Understanding Provider roles	30	12		27	66	22	35	9	20		1	4					
A1, B1, E5	Interpersonal communication/sensitivity and stigma training/reflective listening	30	12	1	24	26	22	35	9	52	14	2	20					
B1, D3, E5	Natural supports training, Strengths based approach			5	21				9	20								
B1, C2, D3, E5	Suicide prevention	30	12	15	24	66	22	48	9	28	16	3	21					
B1, E5	Best practices in care transitions				25				9	20								
B1, C2, D3, E5	Co-occurring disorders	36	12	10	24	66	22	48		20	16	2	20					
B1, C2, D3, E5	Ethical competency	36	12	5	26	66	22	48	9	54		2						
B1, C2, D3, E5	MH First Aid (non-clinicians)				23				9	6	16	2	20					2

B1, C2, D3, E5	Cultural Competency	31	5		5	26	40	22	43	9	52		15	2	31				2
B1, C2, D3, E5	Basic Training on Addiction & Recovery	25	5			25				2	8		14	2					
B1, D3, E5	Narcan Awareness	25	5		11	22	40	15	35	7	28		14	3	21	2	1	2	
B1, C2, D3, E5	Trauma informed treatment	30	12		1	19		22			50								
B1, C2, D3, E5	Home visit safety				1	36				2	24								
B1, C2, D3, E5	Motivational interviewing	25	5		1	6	40	15	25	7	50								
B1, E5	Targeted Care Planning (R49)					24					20								
E5	CC team model- Intake procedures, workflows, available resources, roles and responsibilities, crisis management					29				2	26								
E5	CC team model- case conferencing, assignment of cases, how to relay system issues					29				2	26								
E5	Understanding law enforcement and EMS protocols					26				2	20								

Evaluation Plan

Process evaluation of the Enhanced Care Coordination for High-Need Populations project will entail documenting the presence or occurrence of key features of the model, as well as specific outcome metrics. Data describing process and outcome measures associated with this community project will be collected from participating organizations on a quarterly basis including data associated with training and workforce development activities, and de-identified client data to track caseloads and participation, case management and referral activities and monitor project goals. In addition, a client satisfaction tool will be developed to capture client feedback (see also Community Input plan) to assess client / caregiver perceptions of effectiveness and inform on-going quality assurance. The key partners in the project will review client feedback quarterly to make adjustments and improvements to policies and protocols to ensure goals are met, standards are maintained, and individuals receiving services are satisfied with their care.

We anticipate serving 400 individuals per year once enhanced care coordination services are fully operational throughout the entire region (estimated case load of 20 to 40 patients per full-time care coordinator depending on complexity of needs). The socio-demographic characteristics of the population served through this community project will be tracked to include behavioral health status, housing, economic and employment stability, and social and family supports.

The CHSN Executive Director and Project Manager will have overall responsibility for internal evaluation of this community project. Data systems to support evaluation of this community project will be established in conjunction with the CHSN Health Information Technology (HIT) work group and the Enhanced Care Coordination community project. Leveraging these and emerging data systems that may be developed to support the IDN's Enhanced Care Coordination work, the following measures and data sources will be used to evaluate project process and outcomes (selected State-defined outcome measures are indicated by an asterisk).

Evaluation Measure	Source	Frequency of Collection / Reporting	Results / Notes
Process Measures			

Evaluation Measure	Source	Frequency of Collection / Reporting	Results / Notes
Documentation of Process Improvements: new workflows, referral and communication relationships; use of standardized assessment tools and shared care plans; procedures for peer review and feedback	Care Coordination Team conference records	Monitor quarterly; report semi-annually	Pending
Referral numbers by type / source / location	Care Coordination Team records / shared care plan reports	Monitor quarterly; report semi-annually	Pending
Number of enrollments, refusals, and discharges from the enhanced care coordination project	Care Coordination Team records / shared care plan reports	Monitor quarterly; report semi-annually	Pending
Time interval from first referral and care coordination team contact	Care Coordination Team records / shared care plan reports	Monitor quarterly; report semi-annually	Pending
Caseload; total, by care coordinator and location	Care Coordination Team records / shared care plan reports	Monitor quarterly; report semi-annually	Pending
Number of care coordination team contacts	Care Coordination Team records / shared care plan reports	Monitor quarterly; report semi-annually	Pending
Follow-up after an emergency department visit or hospitalization by enrolled client	Care Coordination Team records / shared care plan reports	Monitor quarterly; report semi-annually	Pending
Percent for whom caregiver engagement and communication is established as appropriate	Care Coordination Team records / shared care plan reports	Monitor quarterly; report semi-annually	Pending
Percent of clients reporting transportation as an access barrier who are connected to a transportation resource for enhanced care coordination	Care Coordination Team records / shared care plan reports	Monitor quarterly; report semi-annually	Pending
Community services and support referrals made from the care coordination teams by number, type and location	Care Coordination Team records / shared care plan reports	Monitor quarterly; report semi-annually	Pending
Documentation and reporting of gaps / inadequate referral resources in the system of care	Care Coordination Team records / shared care plan reports	Monitor quarterly; report semi-annually	Pending
Outcome Measures			
*Initiation of AOD Dependence Treatment (1 visit within 14 days) if indicated	SUD treatment agency records	Monitor quarterly; report semi-annually	Pending

Evaluation Measure	Source	Frequency of Collection / Reporting	Results / Notes
Self-report of improved status of employment, housing, criminal justice involvement, interpersonal relationships, family interaction, community connectedness and other quality of life measures	Client self-report; QoL instrument to be administered by care coordinator; de-identified aggregate data collected and analyzed by CHSN	Monitor quarterly; report semi-annually	Pending
*Percent of new patient referral for CMHC intake appointment if indicated within 7 calendar days	MH agency records	Monitor quarterly; report semi-annually	Pending
*Number / percentage of frequent (4+ per year) ER Visit Users	Hospital ED data	Monitor quarterly; report semi-annually	Pending
*Number / percentage of Potentially Preventable ER Visits	Hospital ED data	Monitor quarterly; report semi-annually	Pending
Percent employed or in school / job training at intake and 30 days, 6 months and 1 year post intake (NOMS measure)	Care Coordination Team records / shared care plan reports	Monitor quarterly; report semi-annually	Pending
Percent in stable housing situation at intake and 30 days, 6 months and 1 year post intake (NOMS measure)	Care Coordination Team records / shared care plan reports	Monitor quarterly; report semi-annually	Pending
Percent participating in peer support activities if indicated at intake and 30 days, 6 months and 1 year post intake (NOMS measure)	Care Coordination Team records / shared care plan reports	Monitor quarterly; report semi-annually	Pending

E-2: Community Project Evaluation Targets

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
Number of individuals served	400 clients per year once fully operational in all 3 service areas			
Time interval from referral and to first care coordination team contact	To be determined			
Time interval for follow-up by care coordination team after an emergency department visit or hospitalization by enrolled client	To be determined			

Performance Measure Name	Target	Progress Toward Target		
*Initiation of AOD Dependence Treatment (1 visit within 14 days) if indicated	To be determined			
Self-report of improved status of employment, housing, criminal justice involvement, interpersonal relationships, family interaction, community connectedness and other quality of life measures	To be determined			
*Number / percentage of frequent (4+ per year) ER Visit Users	To be determined			
*Number / percentage of Potentially Preventable ER Visits	To be determined			
Percent employed or in school / job training at intake and 30 days, 6 months and 1 year post intake (NOMS measure)	To be determined			
Percent in stable housing situation at intake and 30 days, 6 months and 1 year post intake (NOMS measure)	To be determined			
Percent participating in peer support activities if indicated at intake and 30 days, 6 months and 1 year post intake (NOMS measure)	To be determined			

E-3: Community Project Workforce Staffing

A total of 11.3 FTEs across twelve organizations are projected for new workforce staffing for the Enhanced Care Coordination project. The types of staff are shown by organization in the table below. CHSN-IDN 5 opted to leave its staffing at “0” at baseline for all projects though it is possible that existing staff may fill some of these roles, they have not been assigned to this project until plans have been approved.

Provider Type	IDN Workforce (FTEs)				
	Projected Total Need	Baseline Staffing on 6/30/17	Staffing on 12/31/17	Staffing on 6/30/18	Staffing on 12/31/18
Care Coordinator (LRGHealthcare)	1.5 (0.5 shared with Riverbend)	0			
Care Coordinator (Horizons)	1.0	0			
Care Coordinator (ServiceLink)	0.75 (Two positions, .5 in Laconia and .25 in Plymouth)	0			
Care Coordinator (HealthFirst)	1.5 (0.5 shared with Riverbend)	0			
Care Coordinator (Genesis)	1.5 (Two positions, 1 in Laconia and .5 in Plymouth)				

Provider Type	IDN Workforce (FTEs)			
Transportation Driver (Genesis)	0.25	0		
Care Coordinator (Riverbend)	1.0 (Two, 0.5 positions shared with LRGH and Healthfirst)	0		
Care Coordinator (Speare Memorial)	0.5	0		
Care Coordinator (Speare Primary Care)	0.5			
Care Coordinator (Mid-State)	1.0 (Two 0.5 positions for Plymouth and Bristol)	0		
Care Coordinator (NANA)	0.15	0		
Care Coordinator (Lakes Region VNA)	0.15	0		
Care Coordinator (Central NH VNA)	0.2	0		
Care Coordinator (Pemi-Baker Community Health)	0.15	0		
Care Coordinator (Franklin VNA & Hospice)	0.15	0		
Coordinated Care Team Leader (TBD)	1.0	0		

E-4: Community Project Budget

Funds are budgeted for the Enhanced Care Coordination project to support salaries and benefits of project staff as outlined in the previous section. Salaries are budgeted based on prevailing wages by position type. Fringe benefits are budgeted uniformly across all partner organizations at 31% of salary.

Budget Item	Item Description	2017 Cost	2018, 2019, 2020 (Costs Equally Distributed over 3 years)	Total Project Cost
Salaries and Wages				
Project Staff Salaries / Wages (subcontracted)	Salaries for lead care coordinator, agency-based care coordinators and transportation driver	██████	██████	██████
Project Staff Benefits	31% of salary / wages	██████	██████	██████
		SUB-TOTAL		\$2,599,695

Other Direct Costs				
Hardware	Laptop Computers and cell phones for Care Coordinators @ [REDACTED] (2017 only)	[REDACTED]		[REDACTED]
Software	Internet, software license fees and cell phone service plan @ [REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
Transportation van	Reimbursement for travel @ .535 p/mile (estimated @100 miles p/week x 50 weeks x 3 years)		[REDACTED]	[REDACTED]
Mileage	Reimbursement for care coordinator travel @ .535 p/mile (estimate only, actual unknown)	[REDACTED]	[REDACTED]	[REDACTED]
Supplies	Miscellaneous expenses over waiver period			[REDACTED]
PROJECT TOTAL				\$2,970,750

E-5: Key Organizational and Provider Participants

As described previously, there will be three geographically-based care coordination / case management teams that are multi-agency and multi-disciplinary in nature. This set of organizations includes not only those that have intensive contact with high-need patients for clinical services, but also organizations that can help to address broader social determinants of health. The table below lists the 'key' organizations that will have lead roles / funded care coordinator positions. Section D-8 lists a more complete set of organizations that will have roles in the project.

Organization/Provider	Agreement Executed (Y/N)
LRGHealthcare (LRGH, FRH)	Y
Sppeare Memorial Hospital	Y
HealthFirst	Y
Mid-State Health Center	Y
Genesis Behavioral Health	Y
Horizons Counseling Center	Y

Organization/Provider	Agreement Executed (Y/N)
PPH / ServiceLink	Y
Riverbend	Y
NANA	Y
Lakes Region VNA	Y
Central NH VNA	Y
Pemi-Baker Home Health	Y

E-6: Standard Assessment Tools

The table describes the Assessment and Screening tools that will be used for the Enhanced Care Coordination Project.

Standard Assessment Tool Name	Brief Description
Case Management (CM) Assessment	The CM Assessment assesses for certain health and behavioral health conditions (chronic illness, mental health, substance use), lifestyle and living conditions (employment, religious affiliation, living situation) to determine risk factors, establishes risk categories and hierarchy, severity, and level of need
Comprehensive Core Standardized Assessment (CCSA)	A comprehensive assessment process which includes demographic information, physical health review, substance use review, housing, family and support services, educational attainment, employment or entitlement, access to legal services, suicide risk assessment, functional status assessment, depression screening and SBIRT. Under Development.

E-7: Protocols for Patient Assessment, Treatment, Management, and Referrals

Protocols for patient assessment, treatment, management and referral specific to the Enhanced Care Coordination Project are under development. Several key organizations have existing protocols and procedures that will be adopted / modified to support this project.

Protocol Name	Brief Description	Use (Current/Under development)
Client Identification and Referral	Protocols and communication procedures timely identification and referral from primary care, emergency departments, and other health and human service providers of individuals who may benefit from assessment, evaluation and connection to appropriate Enhanced Care Coordination	Under development

Protocol Name	Brief Description	Use (Current/Under development)
Screening, assessment and care plan development	Protocols and workflows for application and frequency of screening and assessment tools; care plan development, shared care plan charting and review	Existing BH, hospital and FQHC protocols / modifications under development as necessary
Enhanced Care Coordination procedures	Protocols and workflows for appropriate care coordinator assignment, care plan development and presentation, client monitoring and progress assessment, connection to community services and supports, and discharge	Under development
Data collection and evaluation	Protocols and workflows for collection, reporting and analysis of client data for program monitoring and improvement	Under development

E-8: Member Roles and Responsibilities

Participating organizations in this initiative are a broad and inclusive set of organizations from across the region representing a full range of physical health care, behavioral health care, social services, and community support organizations. Organizations involved in specific care coordination activities will vary according to client needs.

Project Team Member	Roles and Responsibilities
Lakes Region General Hospital	Coordinating entity for Laconia area enhanced care coordination team
Speare Memorial Hospital	Coordinating entity for Plymouth area enhanced care coordination team
Franklin Regional Hospital	Coordinating entity for Franklin area enhanced care coordination team
HealthFirst Family Care Center	Staff participation on care coordination teams; participation in activities to improve interagency care coordination capabilities
Mid-State Health Center	Staff participation on care coordination teams; participation in activities to improve interagency care coordination capabilities
LRGHealthcare Practices	Staff participation on care coordination teams; participation in activities to improve interagency care coordination capabilities
Speare Memorial Hospital Practices	Staff participation on care coordination teams; participation in activities to improve interagency care coordination capabilities
Genesis Behavioral Health	Staff participation on care coordination teams; participation in activities to improve interagency care coordination capabilities
Horizons Counseling Center	Staff participation on care coordination teams; participation in activities to improve interagency care coordination capabilities
Riverbend Community Mental Health	Staff participation on care coordination teams; participation in activities to improve interagency care coordination capabilities

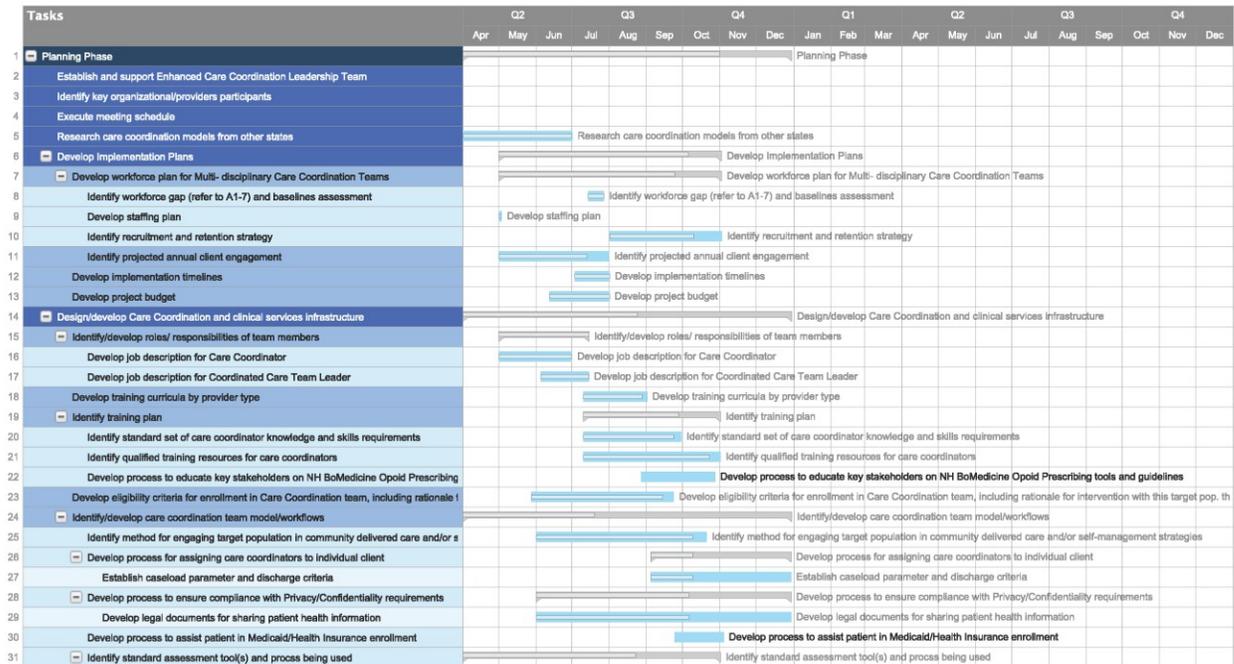
Central NH VNA & Hospice	Staff participation on care coordination teams; participation in activities to improve interagency care coordination capabilities
Franklin VNA & Hospice	Staff participation on care coordination teams; participation in activities to improve interagency care coordination capabilities
Lakes Region Visiting Nurse Association	Staff participation on care coordination teams; participation in activities to improve interagency care coordination capabilities
Newfound Area Nursing Association	Staff participation on care coordination teams; participation in activities to improve interagency care coordination capabilities
Pemi-Baker Community Health	Staff participation on care coordination teams; participation in activities to improve interagency care coordination capabilities
Community Action Program Belknap-Merrimack Counties	Staff participation on care coordination teams; participation in activities to improve interagency care coordination capabilities
Lakes Region Community Services	Staff participation on care coordination teams; participation in activities to improve interagency care coordination capabilities
Partnership for Public Health	Staff participation on care coordination teams; participation in activities to improve interagency care coordination capabilities
Ascentria Care Alliance	Staff participation on care coordination teams; participation in activities to improve interagency care coordination capabilities
Granite State Independent Living	Staff participation on care coordination teams; participation in activities to improve interagency care coordination capabilities
Community Bridges	Staff participation on care coordination teams; participation in activities to improve interagency care coordination capabilities
Navigating Recovery of the Lakes Region	Staff participation on care coordination teams; participation in activities to improve interagency care coordination capabilities
National Alliance on Mental Illness-NH	Staff participation on care coordination teams; participation in activities to improve interagency care coordination capabilities
Cornerbridge	Staff participation on care coordination teams; participation in activities to improve interagency care coordination capabilities
Hope for NH Recovery	Staff participation on care coordination teams; participation in activities to improve interagency care coordination capabilities
Plymouth Area Recovery Connection	Staff participation on care coordination teams; participation in activities to improve interagency care coordination capabilities
Multiple municipalities	EMS / Law Enforcement Staff participation on care coordination teams as appropriate; participation in activities to improve interagency care coordination capabilities

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

See below from Section E-1 and also refer to the CHSN-IDN 5 Training and Education Strategic Plan found on p. 14.

Project-Related Training Activities	Target Trainees	Time line	Progress Measure / Notes
New project staff orientation, team building, partner building, DSRIP 101; understanding Medicaid	Project Staff and supervisors	By December 31, 2017 and ongoing	Pending staff hiring / assignment of existing staff
HIPAA and CFR 42 Part 2; Ethics and Boundaries; familiarity with patient consent to interagency data sharing form and procedures	All new staff	By January 1, 2018 and ongoing	Pending staff hiring
Cross training for care coordination stakeholders to increase shared knowledge base; e.g. understanding chronic physical health conditions for behavioral health-based care coordinators; understanding mental health conditions for primary care and home health based care coordinators	Project Staff and supervisors	By January 31, 2018 and ongoing	Pending staff hiring / assignment of existing staff
Understanding EMS and law enforcement rules and protocols; e.g. for protective custody; for ED transport	All staff and community-based partners	By June 30, 2018 and ongoing	Pending staff hiring / assignment of existing staff

E5 Enhanced Care Coordination (IDN 5)



Tasks	Q2			Q3			Q4			Q1			Q2			Q3			Q4		
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
32 Identify by agency current assessments used and gaps for DSRIP																					
33 Develop/Identify Comprehensive Core Standardized Assessments (10 domains)																					
34 Review results from Self Site Assessment																					
35 Identify process for family/support system engagement and communication as appropriate																					
36 Develop/Identify referral process and processes to link clients to supportive services																					
37 Develop inter-organizational care coordination protocols																					
38 Develop standardized procedures for case conferencing																					
39 Develop procedures for NH DHHS and CHSN data collection reporting requirement																					
40 Identify evaluation plan including key metrics																					
41 Secure MOU agreements with participating agencies including community-based social supports																					
42 Develop evaluation plan																					
43 Identify evaluation plan including key metrics (e.g. number of successful linkages to social support services, change in utilization of ED and																					
44 Review Matrix of key metric requirements and reporting dates																					
45 Develop mechanism for tracking- patient adherence, impact measures, and fidelity to evidenced-supported project																					
46 Operational Phase																					
47 Workforce Development																					
48 Initiate recruitment process for care coordinators																					
49 Initiate recruitment process for Coordinated Care Team Leader																					
50 Initiate other staff for care coordination team (e.g. van driver)																					
51 Deployment of training plan																					
52 Initiation of Care Coordination Model in Laconia																					
53 Use of assessment, treatment, management, referral protocols																					
54 Implementation of any required updates to clinical protocols or other operating policies/																					
55 Initiate evaluation process for Laconia																					
56 Implement procedures for data collection and sharing																					
57 Collect number of Individuals served vs. projected (for reporting period & cumulative)																					
58 Collect number of staff recruited and trained vs. projected (for reporting period & cumulative)																					
59 Collect data on impact measures as defined in evaluation plan-including annual evaluation of fidelity																					
60 Implement NH DHHS and CHSN data collection and reporting requirements																					
61 Reporting Period Jan-Jun 2018																					
62 Initiation of care coordination model in Plymouth and Franklin																					
63 Use of assessment, treatment, management, referral protocols																					
64 Implementation of any required updates to clinical protocols or other operating policies/																					

Tasks	Q2			Q3			Q4			Q1			Q2			Q3			Q4		
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
65 Initiate evaluation process for Plymouth and Franklin																					
66 Implement procedures for data collection and sharing																					
67 Collect number of Individuals served vs. projected (for reporting period & cumulative)																					
68 Collect number of staff recruited and trained vs. projected (for reporting period & cumulative)																					
69 Collect data on impact measures as defined in evaluation plan-including annual evaluation of fidelity																					
70 Implement NH DHHS and CHSN data collection and reporting requirements																					
71 Ongoing data reporting																					
72 Collect number of Individuals served vs. projected (for reporting period & cumulative)																					
73 Collect number of staff recruited and trained vs. projected (for reporting period & cumulative)																					
74 Collect staff vacancy and turnover rate for period & cumulative vs. projected																					
75 Collect data on impact measures as defined in evaluation plan																					
76 Reporting Period Jul-Dec 2018																					
77 Ongoing data reporting																					
78 Collect number of Individuals served vs. projected (for reporting period & cumulative)																					
79 Collect number of staff recruited and trained vs. projected (for reporting period & cumulative)																					
80 Collect staff vacancy and turnover rate for period and cumulative vs. projected																					
81 Collect data on impact measures as defined in evaluation plan, including annual evaluation of fidelity																					
82 Evaluation of data and																					
83 Sustainability Plan																					
84 Initiate the development of the long range sustainability Plan																					
85																					

DSRIP Alternative Payment Model (APM) Implementation Planning

Several CHSN member organizations have experience with Alternative Payment Models (APM) ranging from developmental activities to many years of experience. The Table below contains information from a preliminary baseline assessment of current use of capacity to use APMs among partners by organization and organizational type, Alternative Payment Model descriptions, and approximate estimates for the percent of provider payments currently made through these arrangements.

Organization	Alternative Payment Model (APM) Description	Estimated Percent of Payments
HOSPITAL SYSTEMS		
LRGHealthcare (LRGH)	<p>Participates in a shared savings Accountable Care Organization (ACO) with CIGNA through Granite Health</p> <p>Expects to participate in a shared savings ACO with Harvard Pilgrim through Granite Health starting 1/1/17</p> <p>Owns a 12% stake in Granite Health Holding Company that owns a 49% stake in Tufts Health Freedom Plan</p> <p>Participates in a Primary Care Shared Savings Program with Anthem</p>	<p>CIGNA is about 8% of Net Revenue</p> <p>Harvard Pilgrim is about 13% of Net Revenue</p> <p>LRGH takes full risk for the premium amount</p> <p>Anthem is about 21% of Net Revenue</p>
Speare Memorial Hospital (SMH)	<p>Has an agreement with Anthem based on incentive payments if SMH scores enough points on their Hospital Improvement Initiative, which essentially measures systems and processes to ensure high quality care, as well as some outcome measures</p> <p>No risk agreements</p>	<p>Anthem makes up about 20% of payer mix</p>
Federally Qualified Health Centers		

Organization	Alternative Payment Model (APM) Description	Estimated Percent of Payments
<p>HealthFirst Family Care Center</p>	<p>Bundled payment rate for all of Medicaid work</p> <p>Involved in developing a limited liability corporation with BiState Primary Care Association and the other community health centers in southern NH that has contracts for special shared risk fee-for-service alternative payments structured with incentives based on clinical quality outcomes.</p> <p>Eligible for quality bonuses through federal FQHC program</p> <p>Also eligible for clinical quality outcome incentive payments through Anthem Blue Cross Blue Shield, Harvard Pilgrim, Cigna, and Martin's Point</p>	<p>Medicaid is about 52% of revenue</p> <p>Quality incentive payments in total are about 2% of annual revenue</p>
<p>Mid-State Health Center</p>	<p>The State of NH utilizes a bundled payment APM to reimburse federally qualified health centers for all of Medicaid medical and behavioral health encounters</p> <p>Mid-State also participates with Anthem Blue Cross on upside shared savings</p> <p>Helped form North Country ACO, a first cohort Medicare Advanced Payment / Shared Savings model in 2013</p> <p>Currently part of the NH Accountable Care Partners ACO</p> <p>As an FQHC, eligible each year for quality bonuses based on Uniform Data System (UDS) quality performance outcomes</p>	<p>Medicaid represents about 19% of revenue</p> <p>Amounts to 3% of revenue</p> <p>Federal Bureau of Primary Health Care quality bonuses are about 1% of revenue</p>
<p>Community Mental Health Centers (CMHC)</p>		
<p>Genesis Behavioral Health Riverbend Community Health</p>	<p>CMHCs are currently in a fee for service payment environment, but are moving to a capitated MCO rate with quality indicators. Payments are still based on fee for service rates with a revenue cap</p>	
<p>Home Health Care</p>		

Organization	Alternative Payment Model (APM) Description	Estimated Percent of Payments
Franklin VNA & Hospice	<p>Currently involved with the Medicare Prospective Payment System (PPS), which reimburses services based on clients' severity of need in 3 domains. Scores are based on the responses to a standardized assessment (OASIS).</p> <p>Value Based Purchasing (VBP) is currently being piloted by Medicare for Home Health Agencies in nine states. It is anticipated that all states will be involved in such a payment system by January 2018.</p>	Approximately 65% of clients are paid via PPS
Central New Hampshire VNA & Hospice	Participates in a bundled payment pilot with Wentworth Douglas Hospital for patients with lower extremity joint replacement	It is < 1.5% of total home health revenue; all Medicare Patients; about 38 Medicare patients on this pilot in 2016 to date

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

As part of our IDN's participation development of the Statewide APM Implementation Plan and completion of our IDN-specific APM Implementation Plan, we will update this assessment with information on current activities and capacity using criteria and definitions to be developed in collaboration with statewide stakeholders. We will also participate fully in upcoming Statewide APM Taskforce activities, completion of a Statewide APM Implementation Plan, and completion of an IDN-specific APM Implementation Plan.

Statewide APM Taskforce and Implementation Plan Activity	Progress		
	As of 12/31/17	As of 6/30/18	As of 12/31/18
Conduct IDN Baseline assessment of current use of capacity to use APMs among partners (Responsible party: CHSN Executive Director)	Preliminary assessment completed Fall 2016; updated assessment to be completed by 12/31/17		
Participate in development of statewide APM roadmap through workgroups and stakeholder meetings	Development of workgroup underway with state leadership; CHSN-IDN 5 is committed to full participation in workgroups and stakeholder meetings; schedule pending		
Identify IDN representatives for participation in workgroups and stakeholder meetings (Responsible Party: CHSN Executive Director)	Pending determination of meeting schedule		

Statewide APM Taskforce and Implementation Plan Activity	Progress		
	As of 12/31/17	As of 6/30/18	As of 12/31/18
Completion of the Statewide APM Implementation Plan	Per state communication, draft DSRIP APM Roadmap is currently under CMS review; CHSN-IDN 5 is committed to full participation in the process for completion of the Statewide APM Implementation Plan		
Form IDN APM Plan development leadership team (Responsible Party: CHSN Executive Committee)	Leadership team identified by 12/31/17		
Participation in the creation of the IDN APM Implementation Plan		Pending statewide plan development and IDN-specific plan guidance	

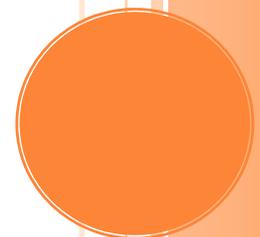
NH DSRIP DEMONSTRATION PROGRAM

Behavioral Health Workforce Capacity Strategic Plan

This plan is in fulfillment of the New Hampshire (NH) Delivery System Reform Incentive Payment (DSRIP) Demonstration Project A1, phases 1 -4. The collective Integrated Delivery Networks (IDNs) will use this plan as a road map to address statewide and regional workforce capacity needs.

Collaborative work of the NH Department of Health and Human Services (DHHS) and the statewide IDNs

6/30/17



NH DSRIP DEMONSTRATION PROGRAM

Behavioral Health Workforce Capacity Strategic Plan

TABLE OF CONTENTS

Introduction	2
Taskforce Members	3
Resource Development	
Existing Initiatives and Documents.....	4
Core Competencies	17
Training	23
Workforce Needed to Meet Demonstration Goals	25
Challenges to Meeting Workforce Capacity.....	26
Plan to Address Challenges	27
Structure and Timeframe	35

NH DSRIP DEMONSTRATION PROGRAM

Behavioral Health Workforce Capacity Strategic Plan

INTRODUCTION

On January 5, 2016, New Hampshire (NH) secured a five-year, \$150 million Medicaid 1115 waiver to transform the state's delivery system for Medicaid beneficiaries with behavioral health disorders (including mental health and substance use). Known as the "Building Capacity for Transformation Waiver," this five-year Delivery System Reform Incentive Program (DSRIP) is a demonstration project, the goals of which are to:

- ┆ Build greater behavioral health capacity
- ┆ Improve integration of physical and behavioral health
- ┆ Improve care transitions for Medicaid beneficiaries

The seven NH Integrated Delivery Networks (IDNs) are to pursue performance goals by implementing a set of six projects. One of these projects, A1: Behavioral Health Workforce Capacity Development, is intended to increase community based behavioral health service capacity through the education, recruitment, and training of a professional, allied-health, and peer workforce with knowledge and skills to provide and coordinate the full continuum of behavioral health services.

The Statewide Behavioral Health Workforce Capacity Taskforce, with representation from IDNs and other stakeholders across the state, through a process facilitated by NH Department of Health and Human Services (DHHS), conducted the following activities:

- ┆ Developed the infrastructure for its work
- ┆ Developed a statewide inventory of relevant in-process, completed, or proposed future behavioral health workforce initiatives and documents
- ┆ Assessed the current behavioral health workforce gaps across the state and IDN regions
- ┆ Surveyed the IDNs about potential causes for those gaps and identified and agreed upon core challenges and impediments
- ┆ Researched and reviewed training opportunities available along the Substance Abuse and Mental Health Services Administration (SAMHSA)'s core competencies needed for an integrated care team
- ┆ Identified the workforce capacity and integration roles needed to meet the demonstration goals
- ┆ Developed a strategic plan to implement solutions to the identified challenges and/or to research potential solutions to provide to the Taskforce for future implementation

While each IDN will submit a regional workforce development plan related to its local and project-related staffing needs, it is agreed by all IDNs that the Statewide plan addresses common and shared needs for behavioral health workforce development.

NH DSRIP DEMONSTRATION PROGRAM

Behavioral Health Workforce Capacity Strategic Plan

TASKFORCE MEMBERS

The Statewide Behavioral Health Workforce Capacity Taskforce was established in November 2016 according to the Standard Terms and Conditions (STCs) of the DSRIP project with two members from each IDN, one voting and one non-voting as well as community stakeholders from a range of specialties relevant to the Taskforce.

Chair	[REDACTED]
Vice Chair	[REDACTED]
Alternate	[REDACTED]
IDN 1	
Voting/Primary	[REDACTED]
Secondary	[REDACTED]
IDN 2	
Voting/Primary	[REDACTED]
Secondary	[REDACTED]
IDN 3	
Voting/Primary	[REDACTED]
Secondary	[REDACTED]
IDN 4	
Voting/Primary	[REDACTED]
Secondary	[REDACTED]
IDN 5	
Voting/Primary	[REDACTED]
Secondary	[REDACTED]
IDN 6	
Voting/Primary	[REDACTED]
Secondary	[REDACTED]
IDN 7	
Voting/Primary	[REDACTED]
Secondary	[REDACTED] (email: [REDACTED])

SEE APPENDIX A - BEHAVIORAL HEALTH WORKFORCE TASKFORCE OPERATING PROCESS

NH DSRIP DEMONSTRATION PROGRAM

Behavioral Health Workforce Capacity Strategic Plan

RESOURCE DEVELOPMENT: INITIATIVES AND DOCUMENTS

New Hampshire is blessed to have several initiatives focused on behavioral health workforce development. Some of these also have published studies and plans to address. In addition, there has been good work done by other states in this area. The Taskforce felt it was important to inventory and review these initiatives and documents so that we would not duplicate efforts, but could rather collaborate with existing initiatives and learn from the published documents. The following list, while not exhaustive, reflects the current inventory. The Taskforce views this as an ongoing process over the life of the DSRIP Demonstration Program.

Initiative or Document Title:	GOVERNOR'S COMMISSION ON HEALTH CARE AND COMMUNITY SUPPORT WORKFORCE
Lead Organization:	Office of the Governor/DHHS
Electronic Citation:	http://www.governor.nh.gov/commissions-task-forces/health-care/index.htm
Description:	Governor Hassan established the Commission to bring together experts from the State's health care, developmental and long-term care services, child and elderly care, and education communities to make recommendations for addressing New Hampshire's short- and long-term health care and direct support workforce needs.
Contact:	Leslie Melby, Special Projects Administrator, Leslie.Melby@dhhs.nh.gov , 603-271-9074
Initiative or Document Title:	NH SECTOR PARTNERSHIP INITIATIVE (SPI), HEALTHCARE SECTOR/NH STATE WORKFORCE INVESTMENT BOARD
Lead Organization:	NH Works, Office of Workforce Opportunity, Department of Resources and Economic Development (DRED)
Electronic Citation:	http://www.nhworks.org/Sector-Partnership-Initiative/Overview/
Description:	The NH SPI seeks to facilitate a new, industry-driven statewide initiative to help healthcare organizations address their workforce needs, while also helping

workers prepare for and advance in careers in the industry. This innovative public/private collaboration seeks to coordinate and streamline existing efforts to minimize the time commitment of business and maximize action and workforce solutions.

Contact: Phil Pryzbyszewski, Workforce Solutions Project Director, Community College System of NH (CCSNH), ppryzbyszewski@ccsnh.edu, 603-206-8185

Initiative or Document Title: WORKFORCE DEVELOPMENT WAGE INCREASE CONTRACT AMENDMENT

Lead Organization: NH DHHS - Department of Behavioral Health (BH), Bureau of Drug and Alcohol Services (BDAS)

Electronic Citation: http://sos.nh.gov/nhsos_content.aspx?id=8589958905

Description: This initiative increased contracted provider service rates with the express requirement that these increased rates be passed on in the form of wage increases for direct services staff. The amendment applied only to the fifteen Treatment and Recovery Support Services contracts managed by BDAS.

Contact: Jaime Powers, Clinical Services Unit Administrator, DHHS-DBH-BDAS, jaime.powers@dhhs.nh.gov, 603-271-6108

Initiative or Document Title: NEW HAMPSHIRE - VERMONT RECRUITMENT CENTER

Lead Organization: Bi-State Primary Care Association

Electronic Citation: <http://www.bistaterecruitmentcenter.org/>

Description: The New Hampshire Vermont Recruitment Center, a service of Bi-State Primary Care Association, is the only non-profit recruitment resource in New Hampshire and Vermont for health care professionals. Its mission is to recruit and retain primary care providers in New Hampshire and Vermont with emphasis on the needs of medically underserved areas and populations. They recruit physicians, dentists, physician assistants and nursepractitioners.

Contact: Stephanie Pagliuca, Director, Bi-State Primary Care Association, Spagliuca@bistatepca.org, 603-228-2830 x111

Initiative or Document Title: STATE LOAN REPAYMENT PROGRAM (SLRP)

Lead Organization: NH DHHS

Electronic Citation: <http://www.dhhs.nh.gov/dphs/bchs/rhpc/repayment>

Description: The NH State Loan Repayment Program (SLRP) provides funds to health care professionals working in areas of the State designated as being medically underserved and who are willing to commit and contract with the State for a minimum of three years (or two if part-time).

Contact: Alisa Druzba, Office of Rural Health and Primary Care, Alisa.Druzba@dhhs.nh.gov, 603-271-5934

Initiative or Document Title: CORE COMPETENCIES FOR LICENSED MENTAL HEALTH PRACTITIONERS

Lead Organization: NH DHHS-DBH-BDAS

Electronic Citation: <http://www.dhhs.nh.gov/dcbcs/bdas/documents/core-competencies.pdf>

Description: DHHS worked with external stakeholders to develop a summary of core competencies for licensed mental health practitioners providing substance use disorder treatment services. In addition, through our contracted training and technical assistance provider, we are offering trainings to help these practitioners achieve the core competencies.

Contact: Alisa Druzba, Office of Rural Health and Primary Care, Alisa.Druzba@dhhs.nh.gov, 603-271-5934

Initiative or Document Title: SAMHSA/NAADAC Forums & Webinars

Lead Organization: NAADAC, Association for Addiction Professionals, and SAMHSA

Electronic Citation: <http://www.naadac.org/samhsa-naadac-workforce-forums>

Description: NAADAC and SAMHSA's Regional Administrators to their Single State Authorities (SSAs) have joined forces to reach out to build awareness and educate freshman and sophomore college/university students about the benefits and opportunities in the substance use and mental health disorder professions in the hope of increasing the number of college/university

students choosing to enter the behavioral health field and specializing in these disciplines.

- Contact:** Cynthia Moreno Tuohy, Executive Director,
NAADAC, cynthia@naadac.org, 703-741-7686 x119
- Initiative or Document Title:** [Training/TA for SUD Workforce](#)
- Lead Organization:** DHHS-DBH-BDAS
- Electronic Citation:** http://sos.nh.gov/nhsos_content.aspx?id=8589952224
- Description:** This contract provides training, technical assistance, program evaluation, data analysis, data interpretation, and support to the SUD workforce. Goals of the contract include "increasing the number of licensed and/or certified service providers who can deliver" SUD services and "assisting providers to build capacity."
- Contact:** Shannon Quinn, Contract Manager,
Shannon.Quinn@dhhs.nh.gov, 603-271-5889
- Initiative or Document Title:** [Medical Assistant \(MA\) Accelerator Program](#)
- Lead Organization:** Exeter Health Resources and Great Bay Community College
- Electronic Citation:** <http://www.exeterhospital.com/news-and-health-library/exeter-hospital-news/MA-class-partnership>
- Description:** This training program is a partnership between Exeter Health Resources (EHR) and Great Bay Community College to address the workforce shortage via their Medical Assistant (MA) Accelerator Program, an 8-week program training students who are immediately work-ready for jobs at EHR. Upon successful completion of the program, students are eligible to sit for the clinical MA certification exam. As an incentive, for those who secure employment through Exeter's Core Physicians, 60% of tuition will be paid and students will receive base pay and eligible benefits during the program. Students make a 2-year commitment of employment.
- Contact:** Chris Callahan, VP, Human Resources,
ccallahan@ehr.org, 603-778-7311

Initiative or Document Title:	Improving Child & Community Health: Addressing Workforce Challenges in Our Community Mental Health Centers
Lead Organization:	NH Endowment for Health
Electronic Citation:	http://www.endowmentforhealth.org/uploads/resources/id107/CMHC_Workforce_Full_Report_2016.pdf
Description:	The mission is to ensure highly effective, diverse workforce by building a sustainable, responsive, and effective cross-sector system of workforce development that is infused with the System of Care core values and principles and uses NH Children's Behavioral Health Core Competencies. Recently completed and disseminated a study of the children's mental health workforce.
Contact:	Kim Firth, Program Director, kfirth@endowmentforhealth.org , 603-228-2448x316
Initiative or Document Title:	COMMISSION ON PRIMARY CARE WORKFORCE ISSUES
Lead Organization:	NH House of Representatives
Electronic Citation:	http://www.gencourt.state.nh.us/statstudcomm/committees/152/
Description:	The commission plans and advocates for policy changes related to maintaining and strengthening an effective primary care workforce in NH, with special concern for rural and other underserved areas. The Commission's duties include: I. Reviewing the impact of existing policies related to strengthening NH's primary care workforce and making recommendations relative to appropriate use of funds for training, education, and recruitment; II. Assessing the degree to which insurers, managed care organizations, and state and federal payment sources present inequities and problems regarding payment for primary care services which may serve as a barrier for attracting and retaining the providers necessary for network adequacy; III. Collecting and reviewing data and information that informs decisions and planning for the primary care workforce and looking for innovative ways for expanding the state's primary care resources including, but not limited to, interstate collaboration;

IV. Assembling and including in its annual report, required under RSA 126-T:4, data on the availability, accessibility, and effectiveness of primary care in NH, with special attention to rural and underserved areas of the state.

Contact: Laurie Harding, Chair, lharding0625@gmail.com, 603-667-7734

Initiative or Document Title: **NH BEHAVIORAL HEALTH INTEGRATION LEARNING COLLABORATIVE**

Lead Organization: Citizens Health Initiative

Electronic Citation: <http://www.citizenshealthinitiative.org/reports-presentations>

Description: CHI's Behavioral Health Integration Learning Collaborative (BHI LC) focuses on the integration of behavioral health in the primary care setting with a focus on depression, anxiety, and substance use disorders as they present in primary care. The BHI LC hosts in-person, webinar, and conference calls for content, information, and data sharing, and peer support; delving into topics such as different BHI models, Payment, Health Information Technology Integration, and Using Data to Track Outcomes.

Contact: Jeanne Ryer, Director, Jeanne.Ryer@unh.edu, 603-513-5126

Initiative or Document Title: **WORKFORCE AND PROFESSIONAL DEVELOPMENT**

Lead Organization: SPARK NH

Electronic Citation: <http://sparknh.com/committees>

Description: Spark NH is an early childhood advisory council created to promote a comprehensive system of early childhood programs and services in New Hampshire. Spark NH's Workforce and Professional Development Committee develops recommendations and implementation plans to enhance NH's capacity for the recruitment, retention, advancement, and support of qualified professionals across early childhood programs via education, training, and credentialing.

Contact:	Tessa McDonnell or Farrah Deselle, Committee Chairpersons, tessamcd@comcast.net or fdeselle@CMC-NH.org , 603-226-7900
Initiative or Document Title:	ALLIANCE FOR HEALTH AGING
Lead Organization:	Center on Aging and Community Living (CACL), University of New Hampshire (UNH)
Electronic Citation:	http://www.endowmentforhealth.org/our-priorities/ensuring-the-health-and-dignity-of-elders/collaborative-approach-elders-nh
Description:	<p>The Alliance for Healthy Aging (AHA) is a statewide collaboration of numerous community partners working together to address the issues of an aging NH. AHA's vision: NH's communities advance culture, policies, and services which support older adults and their families, providing a wide range of choices that advance health, independence and dignity. AHA's workforce strategy is to: "Improve the availability of quality healthcare and social service workforces." Initial efforts are focused on the following strategies:</p> <ol style="list-style-type: none"> 1. "Policy makers and stakeholders have an awareness of direct care workforce shortage and AHA's strategic area goal"; and 2. "Connect with workforce efforts in NH and deliver AHA's messaging priorities."
Contact:	Laura Davie, Chair, Workforce Group, Alliance for Healthy Aging, laura.davie@unh.edu , 603.862.3682
Initiative or Document Title:	REWARDING WORK
Lead Organization:	Collaborative effort of the Massachusetts PCA Quality Home Care Workforce Council, Massachusetts Department of Developmental Services, University of Massachusetts Medical School, Center for Health Policy and Research, New Jersey Division of Disability Services, Connecticut Department of Developmental Services, Rhode Island Department of Human Services and Vermont Department of Disabilities, Aging and Independent Living. It has been funded, in part, by New England States Consortium Systems Organization.
Electronic Citation:	http://www.rewardingwork.org/about-rewarding-work

Description:	The goal of Rewarding Work is to give people who need support with daily activities choice and control in finding personal assistants. The Rewarding Work Website and related recruitment campaign has been cited as a "Promising Practice" by the Centers for Medicare and Medicaid Services.
Contact:	Elenore M. Parker, President, 1-866-212-9675
Initiative or Document Title:	ASSESSING THE WORKFORCE FOR THE INTEGRATION OF BEHAVIORAL HEALTH AND PRIMARY CARE IN NH
Lead Organization:	Center for Behavioral Health Innovation, Antioch University, Keene.
Electronic Citation:	http://www.antiochne.edu/wp-content/uploads/2016/09/EFH-128-Integrated-Care-RPT-final.pdf
Description:	This study fills knowledge gaps about the integrated primary care workforce in NH. Surveyed safety net clinics for workforce roles and needs. Surveyed academic and certificate programs about current and future commitment to training the primary care behavioral health workforce. Assesses workforce and training needs for Behavioral Health Clinicians, Consulting Psychiatric Clinicians, Primary Care Clinicians, and Care Enhancers. Meeting for discussion involving clinics, academic programs, and other players. Leading to the development of an ongoing forum for PCBH workforce planning.
Contact:	Sandy Blount, Co-Director, ablount@antioch.edu , 603-283-2194
Initiative or Document Title:	INTEGRATED CARE PRACTICUM GRANT
Lead Organization:	Center for Behavioral Health Innovation, Antioch University, Keene
Electronic Citation:	http://www.antiochne.edu/wp-content/uploads/2016/06/GPE-press-release.pdf
Description:	In September 2016, the Antioch GPE (Graduate Psychology Education) program received federal funding from the Health Research and Services Administration under a three-year grant fund for multiple primary care sites and two dozen student

stipends to develop integrated care practicum training opportunities.

Contact: Sandy Blount, Co-Director, ablount@antioch.edu, 603-283-2194

Initiative or Document Title: **INTERACTIVE CAREER LATTICE**

Lead Organization: Center on Aging and Community Living

Electronic Citation: <http://chhs.unh.edu/cacl/interactive-career-lattice>

Description: Through DirectConnect, an interactive career guide was created to provide awareness and career guidance to those interested in starting or growing their career in direct care. The Direct Care Career Guide is an easy-to-use interactive career resource tool for individuals interested in entering the direct-care field or advancing their career in direct care. The guide identifies direct-care career opportunities tailored to fit individual needs, preferences, and career aspirations.

Contact: cacl.chhs@unh.edu, 603.228.2084

Initiative or Document Title: **WORKFORCE FOR THE FUTURE - WORKFORCE DEVELOPMENT FORUM**

Lead Organization: NAADAC and SAMHSA

Electronic Citation: <http://www.naadac.org/samhsa-naadac-workforce-forums>

Description: Four “Workforce for the Future” forums were held across the country; Colorado, Louisiana, Ohio, and the Northeast (NH, RI, VT, ME, MA) with a goal to build awareness and educate freshman and sophomore college/university students about the benefits and opportunities in the substance use and mental health disorder professions in the hope of increasing the number of college/university students choosing to enter the behavioral health field and specializing in these disciplines. The Northeast forum broadened our audience by including the recovery community in an effort to reach more individuals who may be interested in learning more about these fields, but who may not currently be enrolled in a college program. NH, RI, VT, ME, and MA partnered for this event with help from the New England Institute of

Addiction Studies (NEIAS) to host the Northeast Event at SNHU on Sept14, 2016. The is available online for use in future workforce development discussions at colleges and other venues.

Contact:	Shannon Quinn, NH DHHS - Division for Behavioral Health, Shannon.Quinn@dhhs.nh.gov , 603.271.5889
Initiative or Document Title:	MONADNOCK REGION HEALTHCARE WORKFORCE GROUP
Lead Organization:	Cheshire County
Electronic Citation:	http://www.naadac.org/samhsa-naadac-workforce-forums
Description:	Cheshire/Monadnock area initiative was created to increase the pool of individuals available for healthcare positions in the Monadnock region and NH and to reduce barriers to their successful employment. Concerns include the loss of LPN programs throughout the state and nursing licensure delays.
Contact:	Cathy Gray, Chair, Monadnock Initiative and President/CEO, Cedarcrest Center for Children with Disabilities, cgray@cedarcrest4kids.org , 603.358.3384
Initiative or Document Title:	NH AREA HEALTH EDUCATION CENTER
Lead Organization:	NH Area Health Education Center (AHEC)
Electronic Citation:	http://nhahec.org
Description:	AHECs play a significant role in building workforce while collaborating with community partners to continually improve the quality of the healthcare system for the future. NH AHECs aim to: 1. Meet the increasing demands for an adequate healthcare workforce; particularly in primary care; 2. Improve the distribution of health professions workforce particularly in rural and underserved areas; 3. Foster a diverse health professions workforce; 4. Prepare health professionals to expand collaborative practice and team-based models of care; and 5. Promote innovative care delivery models that achieve more efficient and effective patient-centered care, improve professional satisfaction and retention of providers, and improve workforce capacity and care quality.

Contact:	Kristina Fjeld-Sparks, Director, NH AHEC, Kristina.E.Fjeld-Sparks@Dartmouth.edu , 603.646.3315
Initiative or Document Title:	PEER RECOVER SUPPORT COMMUNITY OF PRACTICE
Lead Organization:	NH BDAS
Electronic Citation:	http://nhcenterforexcellence.org/resources/community-of-practice-resources/peer-recovery-support-services-community-of-practice
Description:	A community of practice (COP) convenes a group of individuals interested in a similar topic to share knowledge, information and experiences in an effort to learn more about a topic and to improve current practices. The Peer Recovery Support Services (PRSS) COP is focused on identifying standards for PRSS, implementing the systematic application of these standards and improving quality of services. This COP is managed by the Center for Excellence and all of the Recovery Community Organizations in contract with BDAS or sub-contracted with the PRSS Facilitating Organization are required to participate in it.
Contact:	Lindy Keller, Resources and Development Administrator, Bureau of Drug and Alcohol Services, Lindy.Keller@dhhs.nh.gov , 603.271.6114
Initiative or Document Title:	THE IMPACT OF STATE HEALTH POLICIES ON INTEGRATED CARE AT HEALTH CENTERS
Lead Organization:	National Association of Community Health Centers
Electronic Citation:	http://www.nachc.org/wp-content/uploads/2016/11/NACHC-BHI-Impact-of-State-Health-Policies-on-Integrated-Care-at-Health-Ctrs-FINAL-102816.pdf
Description:	This paper explores the myriad opportunities and barriers at the federal, state, payer, and provider levels around the adoption of an integrated health care model. The discussion identifies state initiatives that have either enabled or discouraged the implementation of an integrated care approach, as

well as recommendations based on feedback from the field and literature.

Initiative or Document Title: **THE STATE OF THE BEHAVIORAL HEALTH WORKFORCE: A LITERATURE REVIEW**

Lead Organization: American Hospital Association (AHA)

Electronic Citation: <http://www.aha.org/content/16/stateofbehavior.pdf>

Description: A broad, systematic literature review on the state of the behavioral health workforce in order to better understand the challenges and opportunities facing hospitals and health systems, and begin to find new ways to build capacity for the future. This literature review underscored a critical issue and revealed new findings – that is, in order to meet the growing need and demand for behavioral health care, hospitals and health systems must rethink, then redesign, the delivery of behavioral health care across the care continuum.

Initiative or Document Title: **WHO WILL PROVIDE INTEGRATED CARE: ASSESSING THE WORKFORCE FOR THE INTEGRATION OF BEHAVIORAL HEALTH AND PRIMARY CARE IN NH**

Lead Organization: Antioch University New England and the Center for Behavioral Health Innovation

Electronic Citation: <http://www.endowmentforhealth.org/uploads/resources>

Description: This project was designed to fill IBH workforce-related knowledge gaps, to inform a NH IBH workforce development plan. First, they sought to better understand the current and future workforce needs of primary care settings, with a focus on safety net providers (i.e., Federally Qualified Health Centers, Rural Health Clinics). Second, they assessed the extent to which NH-based training institutions are preparing their students for IBH roles in primary care. Finally, they leveraged the scholarly literature, the Cherokee report, and their findings to develop a NH-based IBH workforce development plan.

Initiative or Document Title: **CENTER FOR INTEGRATED HEALTH SOLUTIONS (CIHS)**

Lead Organization:

SAMHSA-HRSA

Electronic Citation:

<http://www.integration.samhsa.gov/>

Description:

Center for Integration Health Solutions (CIHS) promotes the development of integrated primary and behavioral health services to better address the needs of individuals with mental health and substance use conditions, whether seen in specialty behavioral health or primary care provider settings. CIHS provides training and technical assistance to community behavioral health organizations, community health centers, and other primary care and behavioral health organizations.

NH DSRIP DEMONSTRATION PROGRAM

Behavioral Health Workforce Capacity Strategic Plan

RESOURCE DEVELOPMENT: CORE COMPETENCIES

The Taskforce plans to use the SAMHSA-HRSA Core Competencies for Integrated Behavioral Health and Primary Care (January 2014) as a model on which to shape job descriptions, develop orientation programs, provide supervision, and conduct performance reviews for workers delivering integrated care.

Core Competency Categories

1. INTERPERSONAL COMMUNICATION

The ability to establish rapport quickly and to communicate effectively with consumers of healthcare, their family members, and other providers. Examples include: active listening; conveying information in a jargon-free, non-judgmental manner; using terminology common to the setting in which care is delivered; and adapting to the preferred mode of communication of the consumers and families served.

2. COLLABORATION & TEAMWORK

The ability to function effectively as a member of an interprofessional team that includes behavioral health and primary care providers, consumers and family members. Examples include: understanding and valuing the roles and responsibilities of other team members, expressing professional opinions and resolving differences of opinion quickly, providing and seeking consultation, and fostering shared decision-making.

3. SCREENING & ASSESSMENT

The ability to conduct brief, evidence-based and developmentally appropriate screening and to conduct or arrange for more detailed assessments when indicated. Examples include screening and assessment for: risky, harmful or dependent use of substances; cognitive impairment; mental health problems; behaviors that compromise health; harm to self or others; and abuse, neglect, and domestic violence.

4. CARE PLANNING & CARE COORDINATION

The ability to create and implement integrated care plans, ensuring access to an array of linked services, and the exchange of information among consumers, family members, and providers. Examples include: assisting in the development of care plans, whole health, and wellness recovery plans; matching the type and intensity of services to consumers' needs; providing patient navigation services; and implementing disease management programs.

5. INTERVENTION

The ability to provide a range of brief, focused prevention, treatment and recovery services, as well as longer-term treatment and support for consumers with persistent illnesses. Examples include: motivational interventions, health promotion and wellness services, health education, crisis intervention, brief treatments for mental health and substance use problems, and medication assisted treatments.

6. CULTURAL COMPETENCE & ADAPTATION

The ability to provide services that are relevant to the culture of the consumer and their family. Examples include: identifying and addressing disparities in healthcare access and quality, adapting services to language preferences and cultural norms, and promoting diversity among the providers working in interprofessional teams.

7. SYSTEMS ORIENTED PRACTICE

The ability to function effectively within the organizational and financial structures of the local system of healthcare. Examples include: understanding and educating consumers about healthcare benefits, navigating utilization management processes, and adjusting the delivery of care to emerging healthcare reforms.

8. PRACTICE-BASED LEARNING & QUALITY IMPROVEMENT

The ability to assess and continually improve the services delivered as an individual provider and as an interprofessional team. Examples include: identifying and implementing evidence-based practices, assessing treatment fidelity, measuring consumer satisfaction and healthcare outcomes, recognizing and rapidly addressing errors in care, and collaborating with other team members on service improvement.

9. INFORMATICS

The ability to use information technology to support and improve integrated healthcare. Examples include: using electronic health records efficiently and effectively; employing computer and web-based screening, assessment, and intervention tools; utilizing telehealth applications; and safeguarding privacy and confidentiality.

A sub-committee of the Taskforce researched online resources along the Core Competencies to be used for self-paced learning opportunities and as reference for those seeking to better understand Integrated Care. The chart on the next page contains that research.

1. INTERPERSONAL COMMUNICATION

SAMHSA Resources Link	http://www.integration.samhsa.gov/workforce/interpersonal-communication
Motivational Interviewing	https://www3.thedatabank.com/dpg/423/donate.asp?formid=meetb&c=4821302
Using Plain Language	https://health.gov/communication/literacy/plainlanguage/PlainLanguage.htm
Having Clear Responsibilities	http://www.integration.samhsa.gov/operations-administration/IBHP_Interagency_Collaboration_Tool_Kit_2013.pdf
Terminology	http://www.integration.samhsa.gov/glossary
Health Literacy	https://www.hrsa.gov/publichealth/healthliteracy/
Health Literacy Care Model	https://health.gov/communication/interactiveHLCM/resources.asp
Managing Personal Biases	http://www.integration.samhsa.gov/EnhancedCLASStandardsBlueprint.pdf

2. COLLABORATION AND TEAMWORK

Team Structure	https://aims.uw.edu/collaborative-care/team-structure
Training Needs in Integrated Care	http://www.ibhpartners.org/wp-content/uploads/2015/12/Training-Needs-IBHP-brief.pdf
Considerations for Hiring and Retention in	https://www.resourcesforintegratedcare.com/sites/default/files/Workforce%20Dev_Hiring%20and%20Recruitment.pdf
Integration Efforts	
Essential Elements	http://www.integration.samhsa.gov/workforce/team-members/Essential_Elements_of_an_Integrated_Team.pdf
For PCPs - working in an integrated practice	http://www.improvingprimarycare.org/work/behavioral-health-integration
For PCPs - working with behavioral health staff on the team	http://www.improvingprimarycare.org/team/behavioral-health-specialist
For PCPs - improving care	http://www.improvingprimarycare.org/work/improving-care-through-teamwork

through teamwork



Working with Peers	https://www.resourcesforintegratedcare.com/peer-support/stigma
--------------------	---

Warm Handoff	https://my.mmc.org/Media/MaineHealth/MHIPC/
--------------	---

Engaging Staff in Integration Efforts	https://www.resourcesforintegratedcare.com/sites/default/files/Workforce%20Dev_Culture%20and%20Staff%20Engagement.pdf
---------------------------------------	---

Considerations for Training and Orientation in Integration	https://www.resourcesforintegratedcare.com/sites/default/files/Workforce%20Dev_Training%20and%20Orientation.pdf
--	---

3. SCREENING AND ASSESSMENT

SAMHSA Resource Link	http://www.integration.samhsa.gov/workforce/screening-and-assessment
----------------------	---

Screening Tools	http://www.integration.samhsa.gov/clinical-practice/screening-tools
-----------------	---

Trauma	http://www.integration.samhsa.gov/clinical-practice/trauma
--------	---

Medical Co-Morbidity	http://www.integration.samhsa.gov/workforce/mental_disorders_and_medical_comorbidity.pdf
----------------------	---

SBIRT	http://www.integration.samhsa.gov/resource/sbirt-resource-page
-------	---

Maine Health	http://www.mainehealth.org/mh_body.cfm?id=3018
--------------	---

PAM Survey	http://www.insigniahealth.com/products/pam-survey
------------	---

4. CARE PLANNING AND COORDINATION

SAMHSA Resource Link	http://www.integration.samhsa.gov/workforce/care-planning-care-coordination
----------------------	---

Health & Wellness	http://www.integration.samhsa.gov/health-wellness
-------------------	---

Shared Decision Making	http://www.integration.samhsa.gov/clinical-practice/shared-decision-making
------------------------	---

Care Coordination - Chronic Illness	http://www.improvingchroniccare.org/index.php?p=Care_Coordination&s=326
--	---

Roles and Responsibilities	http://www.ibhpartners.org/get-started/roles-and-responsibilities/
-------------------------------	---



5. INTERVENTION

SBIRT	http://www.integration.samhsa.gov/clinical-practice/sbirt/brief-interventions
Motivational Interviewing	http://www.integration.samhsa.gov/clinical-practice/motivational-interviewing
Searchable Registry of EBPs	http://nrepp.samhsa.gov/01_landing.aspx
Mindfulness	http://legacy.nreppadmin.net/ViewIntervention.aspx?id=238
Mindfulness	http://www.umassmed.edu/cfm
Trauma-Informed Treatment	http://www.integration.samhsa.gov/clinical-practice/SAMSA_TIP_Trauma.PDF
Medicated Assisted Treatment (MAT)	http://www.integration.samhsa.gov/clinical-practice/mat/mat-overview
Trauma-Informed Care in the Primary Care Setting	https://www.nationalcouncildocs.net/trauma-informed-care-learning-community/tic-in-primary-care
Suicide Prevention in Primary Care	http://resource-center.yourvoicecounts.org/content/training-resource-guide-suicide-prevention-primary-care-settings

6. CULTURAL COMPETENCE

CLAS	https://www.thinkculturalhealth.hhs.gov/clas
Partnerships	http://www.integration.samhsa.gov/workforce/partnerships
Guide to Cultural and Spiritual Traditions	https://www.mercymaricopa.org/assets/pdf/providers/Guide-to-Cultures-and-Spiritual-Traditions.pdf
Southern NH AHEC	http://www.snhahec.org/culture.cfm
NH Health & Equity	http://www.healthynh.com/nhhealthequitypartnership.html
Partnership	
NH Office of Health Equity	http://www.dhhs.nh.gov/omh/

7. SYSTEMS ORIENTED PRACTICE

SAMHSA Link <http://www.integration.samhsa.gov/workforce/systems-oriented-practice>

Billing in NH http://www.integration.samhsa.gov/financing/New_Hampshire_.pdf



Business case	http://www.integration.samhsa.gov/integrated-care-models/The_Business_Case_for_Behavioral_Health_Care_Monograph.pdf
ACA expanded coverage	https://www.samhsa.gov/health-financing
Team integration	http://www.integration.samhsa.gov/workforce/team-members/Essential_Elements_of_an_Integrated_Team_Summary.pdf
CMS BH billing	https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/behavior-billing-booklet.pdf?utm_campaign=enews11032016&utm_medium=email&utm_source=govdelivery
Interdisciplinary Professionalism	http://nationalacademies.org/hmd/~media/files/activity%20files/global/innovationhealthprofeducation/2013-may-14/mcdaniel.pdf
Medicare Payment	http://www.nejm.org/doi/full/10.1056/NEJMp1614134#t=article
Coding/billing MH encounter in PCP	https://www.federalregister.gov/documents/2016/11/15/2016-26668/medicare-program-revisions-to-payment-policies-under-the-physician-fee-schedule-and-other-revisions#h-111

8. PRACTICE BASED LEARNING - QI

SAMHSA Link	http://www.integration.samhsa.gov/workforce/practice-based-learning-and-quality-improvement
Research	http://www.integration.samhsa.gov/research
Practice Guidelines	http://www.integration.samhsa.gov/integrated-care-models/behavioral-health-in-primary-care
Medical Terms	http://www.integration.samhsa.gov/clinical-practice/PBHCI_H_Indicator_Cutoffs_Final.pdf

9. INFORMATICS

SAMHSA Link	http://www.integration.samhsa.gov/workforce/informatics
Change Management	added pp to the folder - change management is key for both this and QI training
Electronic Health Record	http://www.integration.samhsa.gov/operations-administration/hit#EHR
Telehealth	http://www.integration.samhsa.gov/operations-

Privacy &
Security

administration/telebehavioral-health

<https://www.healthit.gov/providers-professionals/your-mobile-device-and-health-information-privacy-and-security>



NH DSRIP DEMONSTRATION PROGRAM

Behavioral Health Workforce Capacity Strategic Plan

RESOURCE DEVELOPMENT: TRAINING

The Taskforce sub-committee identified distant, regional, and local training opportunities for Integrated Care Core Teams including online, in-person, free, and fee-based opportunities.

AdCare Educational Institute

<http://www.adcare-educational.org/>

Agency for Healthcare Research and Quality

<http://integrationacademy.ahrq.gov/education-workforce/workforce>

American Academy of Addiction Psychiatry

<http://www.aaap.org/education-training/cme-opportunities/>

American Society for Addiction Medicine

<https://www.asam.org/education>

Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS)

<https://www.samhsa.gov/sites/default/files/brss-tacs-tta-brochure.pdf>

BRSS TACS Webinars

<https://www.samhsa.gov/brss-tacs/webinars>

Center for Excellence

<http://nhcenterforexcellence.org/nh-training-institute/>

Center for Health and Learning

<http://healthandlearning.org/professional-development/>

Community Anti-Drug Coalitions of America

<http://learning.cadca.org/available-courses>

Dartmouth-Hitchcock

http://careers.dartmouth-hitchcock.org/resources/education_training.html

HealthKnowledge

<http://healthknowledge.org/>

Intentional Peer Support

<http://www.intentionalpeersupport.org/>

Mental Health First Aid

<https://www.mentalhealthfirstaid.org/cs/>

National Council for Behavioral Health

<https://thenationalcouncil.academy.reliaslearning.com/online-education-courses-discount-subscription.aspx>

National Register of Health Service Psychologists

<https://www.nationalregister.org/ihts/>

New England Addiction Technology Transfer Center

<http://attcnetwork.org/regional-centers/?rc=newengland>

New England Institute of Addiction Studies

<http://www.neias.org/>

NH Care Path

<http://www.nhcarepath.dhhs.nh.gov/partner-resources/training.htm>

NH Children's Behavioral Health Workforce Development Network

<http://www.nh4youth.org/resources/online-training>

NH Training Institute on Addiction Disorders

<https://www.dhhs.nh.gov/dcbcs/bdas/training.htm>

NHADACA

<http://www.nhadaca.org/training-events/>

Providers' Clinical Support System for MAT

<http://pcssmat.org/>

SAMHSA

<http://www.integration.samhsa.gov/workforce/education-training>

<http://www.integration.samhsa.gov/about-us/webinars>

School of Social Work University of Michigan

<https://ssw.umich.edu/offices/continuing-education/certificate-courses/integrated-behavioral-health-and-primary-care>

Southern NH Area Health Education Center

<http://www.snhahhec.org/>

UMass Medical School Center for Integrated Primary Care

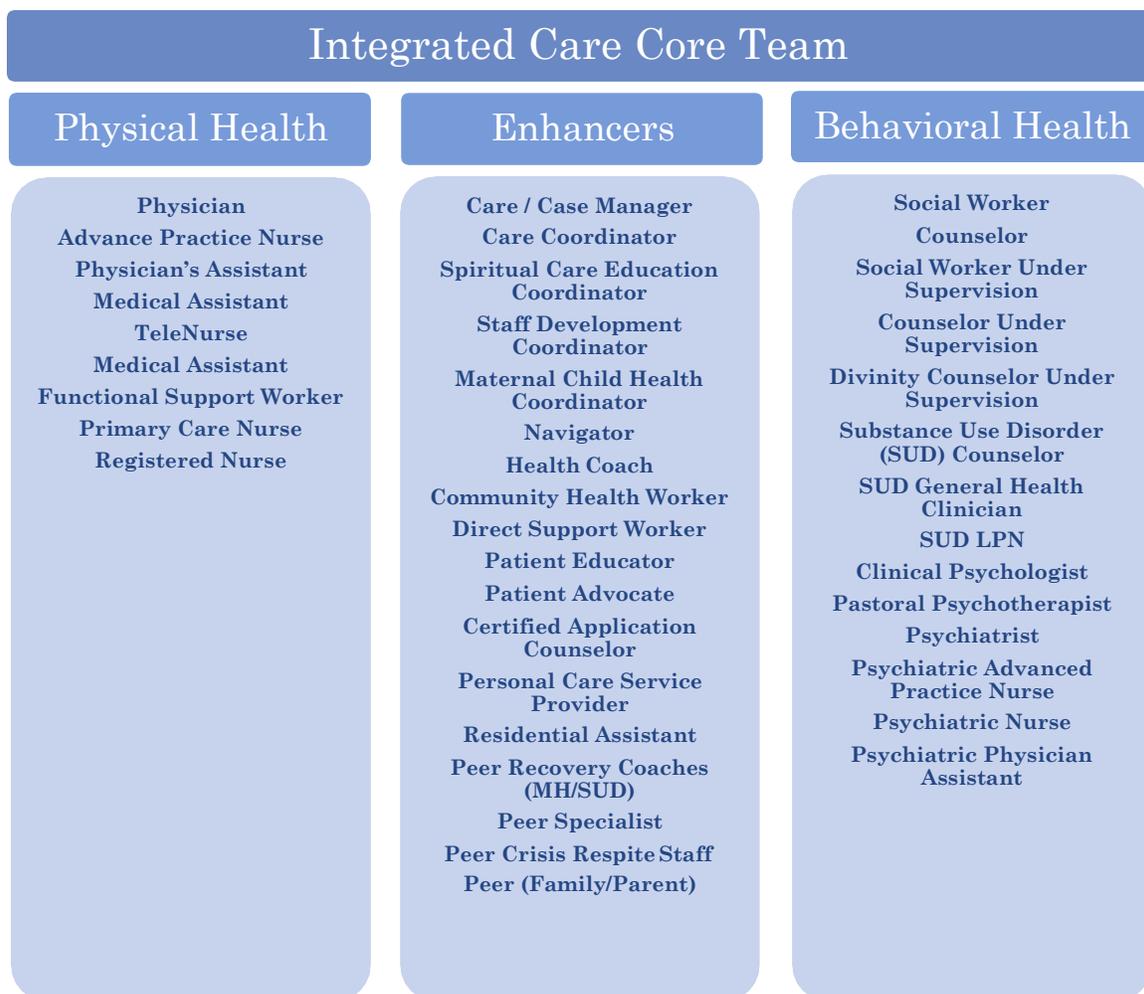
<http://www.umassmed.edu/cipc/>

NH DSRIP DEMONSTRATION PROGRAM

Behavioral Health Workforce Capacity Strategic Plan

WORKFORCE NEEDED TO MEET DEMONSTRATION GOALS

The Taskforce surveyed each IDN regarding roles in an Integrated Care Team. We found, as did the team conducting research for “Who will provide integrated care? Assessing the workforce for the integration of behavioral health and primary care in New Hampshire” (Blount, Alexander et al, 2016), “a dizzying array of staff roles and titles are in use by our respondents, with considerable variation in how these roles and titles are perceived and filled across sites.” The chart below is a sample of those in use.



NH DSRIP DEMONSTRATION PROGRAM

Behavioral Health Workforce Capacity Strategic Plan

CHALLENGES TO MEETING WORKFORCE CAPACITY

In 2015, the NH Behavioral Health Association (the Association) began to collect human resources posting data for nine NH Community Mental Health Centers (Northern, West Central, Genesis, Riverbend, Nashua, Manchester, Seacoast, Community Partners, CLM). Initially, the goal was to better understand workforce vacancy trends related to the Community Mental Health Agreement (CMHA), specifically the Assertive Community Treatment (ACT) and Supported Employment (SE) programs. It was decided that since these data were being collected, that all posting data from each Center should be collected monthly to help better understand the overall workforce picture. After each month's data collection, summary reports are created for the Association by Patrick Miller, MPH, Pero Consulting Group LLC. Below are figures from the May 2017 report:

Vacant Postings	162
Overall Vacancy Rate	7.52%
Mean Days to Fill Open Postings	104 days
Mean Days to Fill MD Vacancies	318 days
Mean Days to Fill APRN Vacancies	204 days
12-Month Rolling Turnover Rate	24.59%

The Taskforce identified the following challenges leading to these statistics.

Recruitment/Hiring

- Compensation offerings below market levels
- Arcane license reciprocity agreements with other States
- Onerous licensing requirements
- Devalued profession/patients/clients

Education/Training

- Lack of marketing about career opportunities.
- Lack of pipeline from higher education
- Integrated care competencies needed
- Cultural differences across primary and behavioral health domains
- Costs

Retention/Sustainability

- High workloads
- Paperwork burden
- Billing for integration/supervision unclear

In addition, the Taskforce noted that there are several federal and state policies and procedures that unwittingly add to these challenges.

SEE APPENDIX B - SURVEY RESULTS

NH DSRIP DEMONSTRATION PROGRAM

Behavioral Health Workforce Capacity Strategic Plan

PLAN TO ADDRESS IMPEDIMENTS TO CAPACITY

Goal 1: One comprehensive New Hampshire Behavioral Health Workforce Development Plan

Objective 1a: Identify opportunities for alignment with other behavioral health workforce development plans

Activity: Create crosswalk between other behavioral health workforce development plans and the IDN statewide plan to ensure there is no duplication of efforts

Result: Crosswalk document

Responsible: Steering Committee

Goal 2: A multi-organizational approach to address behavioral health workforce issues related to policy, education, recruitment, hiring, training, and retention.

Objective 2a: Collaborate with organizations and individuals who are working on or interested in behavioral health workforce development efforts

Activity: Identify lead organizations and individuals of all existing NH-based behavioral health workforce development initiatives; Determine interest in convening as a workgroup to address common goals and strategies

Result: List of lead organizations and individuals

Responsible: Steering Committee

Goal 3: Changes in policies encourage development, retention, and sustainability of integrated primary and behavioral health workforce

Objective 3a: APRNs can sign treatment plans at CMHCs

Activity: Request DHHS assistance with federal agency to amend rule

Result: Policy report

Responsible: Policy Committee

Objective 3b: Billing is allowed for unlicensed providers who are supervised by licensed providers including providers of different disciplines

Activity: For mental health, research appropriate pathway (state or federal requirement)

Result: Policy report

Responsible: Policy Committee

Objective 3c: Fewer barriers to billing for services and inconsistencies among carriers regarding supervision requirements

Activity: Meet with NHID to address coding problems, and professional licensure and supervision requirements

Result: Policy report

Responsible: Policy Committee

Objective 3d: There is single and uniform credentialing among NH carriers

Activity: Meet with NHID to request credentialing reforms to include more timely decisions

Result: Policy report

Responsible: Policy Committee

Objective 3e: Defray the cost of a behavioral health education

Activity: Advocate for increased funding for State Loan Repayment Program; develop Loan Forgiveness programs

Result: Policy report

Responsible: Policy Committee

Objective 3f: Increase the pool of providers coming to NH from other states

Activity: Research NH's reciprocity licensing statutes (see SB 54); meet with OPLC and Boards to advocate for alignment with other states' requirements; Advocate for increasing reciprocity arrangements

Result: Policy report

Responsible: Policy Committee

Objective 3g: Reduce restrictions on supervision to allow providers of different disciplines to supervise; remove physical location requirement

Activity: Meet with OPLC and appropriate Boards to educate them about barriers to integrated care; advocate for flexible supervisory requirements to reflect current workforce and demands.

Result: Policy report

Responsible: Policy Committee

Objective 3h: Align educational requirements for licensure with Masters programs

Activity: Meet with OPLC and Boards; meet with colleges to explore affordable track; research how NH credit programs compare to other states; consider a combined MH/SUD credential;

Result: Policy report

Responsible: Policy Committee

Objective 3i: Reduce professional licensure and associated (background checks, exams) fees

Activity: Explore reduced fees for practitioners working with Medicaid and uninsured

Result: Policy report

Responsible: Policy Committee

Objective 3j: Streamline OPLC and boards functions; improve customer service

Activity: Meet w/OPLC to streamline and simplify application requirements; eliminate delays in application processing

Result: Policy report

Responsible: Policy Committee

Objective 3k: Remove/reduce limit on units (currently at 6) for psychiatric emergencies

Activity: Request DHHS to amend rule

Result: Policy report

Responsible: Policy Committee

Objective 3l: Allow CMHCs to bill for in-reach or community transition services for patients in IMDs

Activity: Work with DHHS to obtain a waiver from CMS

Result: Policy report

Responsible: Policy Committee

Objective 3m: Consistency between Medicaid MCOs; remove delays for credentialing

Activity: Work with DHHS to address in new MCO contracts

Result: Policy report

Responsible: Policy Committee

Objective 3n: Allow billing for Medicare covered services at CMHCs with MD/APRN available by tele video vs physically within the suite of offices as currently defined by CMS

Activities

- ┆ Present to DHHS the financial implications of the change
- ┆ Present to our Federal representative (Senate and Congress) language and justification for change
- ┆ Lobby for change with invested partners identified through National organizations

Result: Policy report

Responsible: Policy Committee

Objective 3o: Increase education and training offerings for credentialing

Activity: Partner with higher education leaders to tailor trainings to meet credentialing criteria of related board and hospitals etc.; Request state funding to DHHS Divisions for education and training.

Result: Policy report

Responsible: Policy Committee

Objective 3p: Expand reimbursement for delivering services using emerging technology

Activity: Research and advocate for expansion of reimbursement for delivering services using emerging technology, such as telehealth/tele-psychiatry

Result: Policy report

Responsible: Policy Committee

Objective 3q: Expand reimbursement for alternative members of integrated team, including Community Health Workers.

Activity: Research reimbursement models.

Result: Policy report

Responsible: Policy Committee

Objective 3r: Pay a competitive rate to behavioral health staff

Activity: Commission a rate/salary study based on role, licensure, and competencies within NH/outside of NH; Continue to advocate for the adjustment of reimbursement rates to allow for more competitive pay.

Result: Policy report

Responsible: Policy Committee

Goal 4: NH has a pool of qualified behavioral health workforce applicants adequate to the integrated primary and behavioral health care need**Objective 4a:** An increase in licensed behavioral health staff trained to do integrated primary and behavioral health care and addiction care**Activities:**

- ┆ Utilize local experts for training opportunities
- ┆ Combine training opportunities with other IDNs using a variety of modalities
- ┆ Utilize established training entities (i.e. AHEC) to deliver statewide, customized trainings
- ┆ Explore options for a Technical Assistance center with programs and support for the statewide behavioral health workforce and integrated care
- ┆ Create a list of strategies used by other states to encourage in-state training of licensed behavioral health staff.

Result: Report and recommendations

Responsible: Education/Training Committee

Objective 4b: Educators and students have greater knowledge of the integrated primary and behavioral health field.

Activity: Identify and distribute common definitions and principles for integrated care team roles, job descriptions, and functions.

Result: Common definitions and principles report

Responsible: Education/Training Committee

Objective 4c: Behavioral health applicants have a clearer understanding of the roles and responsibilities of integrated care team members.

Activity

- ┆ Collect and compile a shared repository of integrated care job description samples.
- ┆ Statewide usage of similar language both verbally and in written documents to mitigate confusion and improve understanding
- ┆ **Result:** Job descriptions, language guide
- ┆ **Responsible:** Recruitment/Hiring Committee

Objective 4d: Existing behavioral health workforce feels empowered and valued for the work they are doing and stay longer in their positions.

Activity

- ┆ Explore opportunities to publicly recognize and support behavioral health workforce in ways that also educate the broader community
- ┆ Explore strategies to address job stress and safety concerns.

Result: Report and recommendations

Responsible: Retention/Sustainability Committee

Objective 4e: Overcome barriers to delivering evidence-based substance use disorder treatment in primary care settings

Activity: Train primary care providers in substance abuse and addiction team -based approaches to care

Result: Training curriculum and schedule

Responsible: Education/Training Committee

Objective 4f: Increase incentives for behavioral health workforce (both within state and from outside of state)

Activity:

- ┆ Investigate the reimbursement of licensing fees upon the hire of LNAs who complete medical certification programs and/or complete mental health/SUD specialty programs
- ┆ Research changes in reciprocity rules to make it easier to hire from other states (90-day rule)

- ┆ Investigate the use of the NH Statewide Loan Repayment Program (SLRP) in combination with other loan repayment or forgiveness programs for degrees and certification, including company matches and IDN resources.
- ┆ Investigate the reimbursement of licensing fees upon the hire of those who complete medical certification programs and/or complete mental health/SUD specialty programs

Result: Report and recommendations

Responsible: Recruitment/Hiring Committee

Objective 4g: Identify and remove some impediments to entering the field

Activity:

- ┆ Explore the use of statewide and/or IDN wide recruitment opportunities that identify potential applicants for an “integrated healthcare delivery” workforce versus for organizations.
- ┆ Identify priority categories of shortage by licensure. Determine if alternatively-licensed workforce options exist to perform Core Competencies in a value based environment.
- ┆ Create a list of strategies used by other states to encourage early career licensed behavioral health staff to settle in NH doing needed functions
- ┆ Partner with healthcare and non-healthcare employers to identify opportunities for "trailing spouses/partners"
- ┆ Identify strategies used by In-State efforts and initiatives (e.g. "The New Hampshire Advantage") and other workforce retention efforts in-state that are outside of BH workforce efforts (Stay-Work-Play)

Result: Report and recommendations

Responsible: Recruitment/Hiring Committee

Objective 4h: Encourage individuals to enter the behavioral health field

Activity:

- ┆ Promote middle- and high school training that educates students about various BH careers with emphasis on 9 SAMHSA Core Competencies
- ┆ Investigate opportunities to promote behavioral health careers to undeclared college students
- ┆ Engage with community colleges and universities to offer potential sites for internships, practicums, and preceptor opportunities, as well as expanded electives
- ┆ Work with vocational educational centers in each IDN to grow awareness of existing programs and support further development of behavioral health workforce offerings
- ┆ Investigate the use of social media to achieve this objective

Result: Report and recommendations

Responsible: Education/Training Committee

Objective 4i: Increase the number of peers in the behavioral health workforce**Activity**

- ┆ Work with peer organizations to develop career pipelines
- ┆ Through partnerships with community-based organizations, offer job fairs in the community to educate about the roles and potential training opportunities to become a peer (adult and youth), family and recovery support specialists, as well as Community Health Workers (CHWs) and navigators
- ┆ Educate community members that personal life experiences can be part of the training needed for a behavioral health career

Result: Report and recommendations

Responsible: Recruitment/Hiring Committee

Goal 5: NH's behavioral health workforce positions are filled and there is less frequent turnover in staffing

Objective 5a: Explore medical and retirement benefit options for all providers

Activity: Advocate for medical and retirement benefits for behavioral health providers; investigate developing consortiums of small practices so group of practices can leverage a better rate for benefits

Result: Advocacy and recommendations report.

Responsible: Retention/Sustainability Committee

Objective 5b: Reduce stigma associated with the behavioral health (mental health and substance use disorder) field**Activity**

- ┆ Develop a communications and outreach plan about behavioral health and integrated care.
- ┆ Plan for statewide celebration of behavioral health staff and explore other opportunities to publicly recognize and support behavioral health workforce
- ┆ Offer MH First Aid in the community and to staff not delivering behavioral health services
- ┆ Research and compile information about workplace culture elements known to increase retention

Result: Information, plans, record of MHFA attendance

Responsible: Retention/Sustainability Committee

Objective 5c: Expand billing opportunities**Activity**

- ┆ Explore options for expanding routes of service delivery that can be included in billing
- ┆ Research and compile integrated care billing by role and service
- ┆ Research if relief from liability coverage requirement to drive clients to appointments and run errands is possible

- ┆ Create billing opportunities for supervision of staff and interns working toward licensure or certification
- ┆ Research expansion of reimbursement for telehealth/tele-psychiatry, and other technology options including video, email, apps, and wearables
- ┆ Research and compile integrated care billing by role and service including but not limited to roles/models created by other transformative/APM-VBR/1115 waiver initiatives that include social service/non-traditional/non-enrolled providers

Result: Research report and recommendations

Responsible: Retention/Sustainability Committee

Objective 5d: Explore other ways of delivering services using emerging technology and other technology options including video, email, apps, and wearables

Activity

- ┆ Compile list of current usages of telehealth across NH.
- ┆ Compile list of technological advancements that have improved process and outcomes

Result: Research report and recommendations

Responsible: Retention/Sustainability Committee

NH DSRIP DEMONSTRATION PROGRAM

Behavioral Health Workforce Capacity Strategic Plan

STRUCTURE AND TIMEFRAME

STEERING COMMITTEE

- Chair, Peter Evers (Region 2); Co-Chair, Nancy Frank (Region 7)
- Comprised of two representatives of each IDN, as determined by the individual IDN
- Will meet quarterly on the third Wednesday of the month, beginning September 27, 2017, to monitor progress of activities toward meeting objectives
- In the fourth quarter of each year, will review and revise overall plan, as needed

COMMITTEES

- Structured around objectives/activities
 - Recruitment/Hiring
 - ✦ Chair (Region 3)
 - ✦ Co-Chair (Region 4)
 - Education/Training
 - ✦ Chair (Region 7)
 - ✦ Co-Chair (Region 1)
 - Retention/Sustainability
 - ✦ Chair (Region 2)
 - ✦ Co-Chair (Region 6)
 - Policy
 - ✦ Chair (Region 5)
 - ✦ Co-Chair (Region 6)
- Comprised of no less than 7 and no more than 11 members
- Will meet monthly to create and review to-do lists for activities
- └ Each Region's representative is responsible for tasking to-do items to individuals in their region, as needed, to complete activities on time

TIMEFRAME TO BEGIN ADDRESSING EACH OBJECTIVE

CY 2017	
Q3	<p>Objective 1a: Identify opportunities for alignment with other behavioral health workforce development plans - <i>Steering Committee</i></p> <p>Objective 2a: Collaborate with organizations and individuals who are working on or interested in behavioral health workforce development efforts - <i>Steering Committee</i></p> <p>Objective 4a: An increase in licensed behavioral health staff trained to do integrated primary and behavioral health care and addiction care - <i>E/T Committee</i></p> <p>Objective 4c: Behavioral health applicants have a clearer understanding of the roles and responsibilities of integrated care team members. <i>R/H Committee</i></p>
Q4	<p>Objective 4d: Existing behavioral health workforce feels empowered and valued for the work they are doing and stay longer in their positions. <i>R/S Committee</i></p> <p>Objective 4e: Overcome barriers to delivering evidence-based substance use disorder treatment in primary care settings - <i>E/T Committee</i></p> <p>Objective 4f: Increase incentives for behavioral health workforce (both within state and from outside of state) - <i>R/H Committee</i></p> <p>Objective 4h: Encourage individuals to enter the behavioral health field - <i>E/T Committee</i></p> <p>Objective 5c: Expand billing opportunities - <i>R/S Committee</i></p> <p>Objective 3a: APRNs can sign treatment plans at CMHCs - <i>Policy</i></p> <p>Objective 3g: Reduce restrictions on supervision to allow providers of different disciplines to supervise; remove physical location requirement - <i>Policy</i></p>
CY 2018	
Q1	<p>Objective 3c: Fewer barriers to billing for services and inconsistencies among carriers regarding supervision requirements - <i>Policy</i></p> <p>Objective 3j: Streamline OPLC and boards functions; improve customer service - <i>Policy</i></p> <p>Objective 3l: Allow CMHCs to bill for in-reach or community transition services for patients in IMDs - <i>Policy</i></p> <p>Objective 3r: Pay a competitive rate to behavioral health staff - <i>Policy</i></p> <p>Objective 4g: Identify and remove some impediments to entering the field - <i>R/H Committee</i></p>
Q2	<p>Objective 3f: Increase the pool of providers coming to NH from other states - <i>Policy</i></p> <p>Objective 3k: Remove/reduce limit on units for psychiatric emergencies - <i>Policy</i></p> <p>Objective 3m: Consistency between Medicaid MCOs; remove delays for credentialing - <i>Policy</i></p> <p>Objective 4b: Educators and students have greater knowledge of the integrated primary and behavioral health field. - <i>E/T Committee</i></p> <p>Objective 4i: Increase the number of peers in the behavioral health workforce - <i>R/H Committee</i></p> <p>Objective 5b: Reduce stigma associated with the behavioral health (mental health and substance use disorder) field - <i>R/S Committee</i></p>
Q3	<p>Objective 3h: Align educational requirements for licensure with Masters programs - <i>Policy</i></p> <p>Objective 3q: Expand reimbursement for alternative members of integrated team, including Community Health Workers - <i>Policy</i></p> <p>Objective 5d: Explore other ways of delivering services using emerging technology and other technology options including video, email, apps, and wearables - <i>R/S Committee</i></p> <p>Objective 5a: Ensure all providers have medical and retirement benefits - <i>R/S Committee</i></p>
Q4	<p>Objective 3b: Billing is allowed for unlicensed providers who are supervised by licensed providers including providers of different disciplines - <i>Policy</i></p> <p>Objective 3d: There is single and uniform credentialing among NH carriers - <i>Policy</i></p> <p>Objective 3e: Defray the cost of a behavioral health education - <i>Policy</i></p> <p>Objective 3i: Reduce professional licensure and associated fees - <i>Policy</i></p> <p>Objective 3n: Allow billing for Medicare covered services at CMHCs with MD/APRN available by tele video vs physically within the suite of offices as currently defined by CMS - <i>Policy</i></p> <p>Objective 3p: Expand reimbursement for delivering services using emerging technology</p> <p>Objective 3o: Increase education and training offerings for credentialing - <i>Policy</i></p> <p><i>The Steering Committee will convene to review all plan products and develop slate of goals, objectives, and activities for 2019 and 2020</i></p>



New Hampshire Delivery System Reform Incentive Payment(DSRIP) Program

Workforce Taskforce

Charter & Standard Operating Procedures

November 2016

FINAL -- November 18, 2016
New Hampshire Workforce Taskforce Charter &
Standard Operating Procedures for Meetings

Charter

The Statewide Behavioral Health Workforce Capacity Taskforce, also referred to as Workforce Taskforce, function, as part of the statewide Workforce Project, per the *New Hampshire Building Capacity for Transformation Section 1115(a) Medicaid Demonstration* goals, is to increase community-based behavioral health capacity through the education, recruitment and training of a professional, allied-health, and peer workforce with knowledge and skills to provide and coordinate the full continuum of substance use disorder and mental health services. Under this project, each IDN will develop and implement a strategy for addressing its workforce gaps using a framework established by a Statewide Behavioral Health Workforce Capacity Taskforce.

Per the waiver Special Terms and Conditions (STCs) approved by CMS (see pages 66-67 of the STCs), the effectiveness of this statewide project is dependent on active coordination across IDNs, and as such IDNs will begin with a statewide planning effort that includes representatives from across New Hampshire. In short order, however, the project will require that each IDN to take action to expand capacity for behavioral health services to support effective care for Medicaid beneficiaries affected by behavioral health concerns. All IDNs will be required to participate in this project through a collaborative statewide work group with members drawn from across the mental health and substance use disorder provider communities in each IDN, as well as other subject matter experts and stakeholders.

Under this project, each IDN will develop and implement a strategy for addressing its workforce gaps using a framework established by a Statewide Behavioral Health Workforce Capacity Taskforce. The Workforce Taskforce will be composed of:

- One (1) mental health-focused representative from each IDN
- One (1) SUD-focused representative from each IDN
- Ten (10) additional specialized taskforce members with representation across at least ten (10) of the following types of organizations:
 - Primary Care Physicians serving the Medicaid population
 - SUD Providers—including recovery providers, serving the Medicaid population
 - Regional Public Health Networks
 - Community Mental Health Centers
 - Governor's Commission Treatment Taskforce
 - Addiction recovery support services
 - Hospitals
 - Federally qualified health centers, community health centers or rural health clinics
 - Community based organizations that provide social and support services (transportation, housing, employment, community supports, legal assistance, etc.)
 - County Organizations

Through a process *facilitated* by the State or its delegate, the Taskforce will spearhead the following activities:

- An assessment of the current workforce gaps across the state and IDN regions, informed by an inventory of existing workforce data/initiatives and data gap analysis
- Identification of the workforce capacity needed to meet the demonstration goals and development of a state vision and strategic plan to efficiently implement workforce solutions, for approval by the state

Based on this statewide planning effort, its own community needs assessments, and the community-driven projects it has selected, *each IDN will then develop and implement its own workforce capacity plan*. The plan must be approved by the state and executed over the course of the demonstration.

Please see Attachment A, Metrics, for expected deliverables from each IDN.

For the Taskforce, per the STCs and Metrics (see Attachment A), the major deliverables are:

- *Workforce Initiative Inventory*—Catalog workforce efforts in the state that could inform statewide efforts or IDN specific efforts.
- *Gap Analysis Framework*—Agree upon a standard format for workforce gap analysis for IDNs to use that can inform not on only IDN specific efforts, but statewide efforts, for baseline and follow-on data analysis.
- *Statewide Plan*—Taskforce is responsible for recommending what will be worked on at a statewide level versus an IDN specific level. IDNs vote on what is included in a statewide plan that is developed by the Taskforce, versus what is included in an IDN specific plan. For example, elements that might be included in a statewide plan might include, per IDN input to date, policy issues (i.e. reciprocity, licensing, and credentialing), taxonomy, recruitment/retention (i.e. statewide peer registry, data analysis approach for workforce gaps and predictive modeling), training (i.e. taking advantage of other initiatives in play in state for training for integrated care teams, etc.), and scope of work (i.e. peer supports work scope, changes in other job work scopes, etc.).
- *Reporting Templates*--Development and consensus agreement (see Attachment A, Metrics).
- *IDN Plan Framework*—Consensus-driven framework for IDN specific workforce capacity plan that takes into consideration the IDN's community needs assessment and community driven projects. The framework must be informed by all Taskforce members and approved by the Taskforce voting members.

1. [Introduction](#)

The purpose of this document is to acknowledge the charter, inclusive of metrics, for the New Hampshire Workforce Taskforce, and to describe the protocols for conducting and participating in New Hampshire Workforce Taskforce ("taskforce") meetings for the Delivery System Reform Incentive Payment (DSRIP) Program. To promote efficiency and coordination across the state, all Integrated Delivery Networks (IDNs) will be required to participate in such meetings, the goal of which are to achieve consensus on statewide workforce projects for the IDNs to pursue ensuring alignment with many other on-going and in-development workforce initiatives in the Granite State. These protocols are offered as a way to focus the Taskforce Work, be mindful of the deliverables and metrics, and maximize the productivity of the discussions and meetings.

2. [Structure and Decision Making Process](#)

2.1 [Chair/Vice Chair Election, Advisory Members, and Subcommittees:](#)

- ┌ IDN members will be given the opportunity to submit nominations for Taskforce Chair and Vice Chair; nominees must be members of an IDN. The New Hampshire Department of Health and Human Services (DHHS) may also reserve the right to select the Chair and Vice Chair.
- ┌ The Workforce Taskforce IDN members will add up to 10 advisory members (per the STCs) to the Workforce Taskforce.
- ┌ If the taskforce would like to establish additional *ad hoc* subcommittees, this may be done at any time. Subcommittees will present any suggestions to the Taskforce for a formal decision. Subcommittee membership can be inclusive of stakeholders that are not part of the Workforce Taskforce in either a voting or advisory capacity. Subcommittee membership shall not exceed to 11 individuals. Subcommittees will establish charters with deliverables in alignment with the Taskforce charter and make recommendations to the Taskforce for statewide efforts.

2.2 [Decision Making Process:](#)

- ┌ The taskforce will strive for consensus (a majority vote of taskforce members), but will adopt a decision-making process that requires a resolution or other formal action to be passed if a consensus cannot be reached.

- ┆ Prior to a vote, each IDN must be notified, with 5 working days advance notice, via email by the Chair or Vice Chair; allowing each IDN to dialog the topic with their IDN Workforce voting member prior to the vote.
- ┆ Six of the seven IDNs must be present at the meeting in person or by teleconference to represent a quorum before the taskforce can vote on an issue within its authority.
- ┆ In the event of an absence, an absentee vote may be submitted to the Chair in advance (24 hours prior) of the meeting or the IDN may name a representative with permission to cast a vote.
- ┆ In the event of a conflict of interest, a member may abstain his or her vote. In such case, the required approval is six of seven IDN representatives of the appointed commission excluding abstaining voters.
- ┆ Member voting may be conducted via open ballot, voice voting, or show of hands.
- ┆ Advisory members do not vote.
- ┆ The voting notice and process is the responsibility of the Chair in collaboration with the Vice Chair.

It is important to note, per the STCs, that IDN Taskforce members are exclusively agreeing upon, through consensus, any statewide efforts that are built into a Statewide Workforce Project Plan. In addition, each IDN will develop and implement a strategy for addressing its specific workforce gaps using a framework established by a Statewide Behavioral Health Workforce Capacity Taskforce and meet specific workforce metrics (see Attachment A).

3. Standard Procedures

3.1 Meeting Announcements and Participation:

- ┆ Seventy-two (72) hours prior to the meeting, agenda will be sent to members of the taskforce.
- ┆ A copy of the agenda will be made available on eStudio on the [DSRIP Statewide Projects eStudio](#).
- ┆ Please provide notice to the Chair regarding substitute IDN participants (within 24 hours of the meeting start time).
- ┆ Call in capacity will be available for all monthly Taskforce meetings, but on site attendance is strongly encouraged.
- ┆ Taskforce meetings will not exceed 90 minutes in length.

3.2 Meeting Minutes:

- ┆ Minutes will be captured at each meeting by the Department and will be posted within five (5) working days.
- ┆ Minutes and meeting materials will be retained on the [DSRIP Statewide Projects eStudio](#) as the complete and accurate record of taskforce proceedings.
- ┆ Minutes from the previous meeting will be sent to the taskforce with the agenda and meeting packet for the current meeting 72 hours prior.

4. Meeting Protocol

4.1 Meeting times:

- ┆ Meeting will commence at the scheduled time.

4.2 Meeting Procedures

- ┆ Each meeting will begin a roll call, acceptance of minutes, and a review of the agenda and end with a review of decisions made and a discussion for future meeting topics.

4.3 Adherence to timeline:

- ┆ For the most efficient use of all participants' time, follow agenda items and limit tangential discussion.

4.4 Productive Participation:

- ┆ Participants shall refrain from feedback until agenda item is discussed and item is opened up for questions or comments.

- ┆ Participants shall state their names and organization or IDN Number to identify themselves to the entire group when speaking.
- ┆ Participants shall identify those asking questions by name, and direct questions to an individual when possible.
- ┆ If joining a call after it has begun, wait to be welcomed before joining the discussion. A tone will indicate when a participant has joined the group.

4.5 Minimize Disruptions:

- ┆ Please avoid environments with potential distractions or interruptions. For that reason, landlines are preferred whenever possible and cell phones are discouraged because of static and potential for “cross talk.” Please also avoid the speaker option unless using a headset.
- ┆ Attendees should mute their phones when not speaking.
- ┆ Avoid the hold options as music may play.

4.6 Maintain Respect:

- ┆ Mutual respect is essential. All questions, ideas, comments will be treated openly and fairly.

5. Taskforce Commitment

The time commitment for the Voting/Primary member and Secondary member each month is estimated to be 3.5 hours. The time commitment for Subcommittee members is estimated to be on average 5 hours per month. The Chairperson and Vice Chairperson of the Workforce Taskforce can anticipate additional time commitment. Subcommittee Chairpersons can also expect additional time commitments.

To maximize the productivity of the taskforce in reaching our shared goals, we must create a constructive and collaborative environment. Therefore, all taskforce members commit to:

- ┆ Consider the opinion of others, along with your own;
- ┆ Promote consensus building and joint responsibility;
- ┆ Relate to others with an open mind by assuming good intent;
- ┆ React calmly when in disagreement and engage respectfully to resolve conflict;
- ┆ Engage in creative problem solving while assuming that there is more than one “right” way of moving forward.

Attachment A See
Following/Page Intentionally Left Blank "Deliverables
Reporting on Process Measures" 9-6-2016

Deliverables Reporting
on Process Measures

September 16, 2016

Project ID	Requirement ID	Reporting Period	Process Milestone	Required Components	Submission Format
A1: Statewide Workforce	A1.Y2.1H.1	Jan-Jun 2017	Participation in formation and kick-off of Statewide Behavioral Health Workforce Capacity Taskforce	<input type="checkbox"/> List of taskforce meeting attendees and meetings attended	Excel template
	A1.Y2.1H.2	Jan-Jun 2017	Workforce data/initiative inventory assessment	<input type="checkbox"/> Inventory assessment developed by Workforce Capacity Taskforce	TBD by Workforce Project team
	A1.Y2.1H.3	Jan-Jun 2017	Participation in Development of Statewide Workforce Capacity Strategic Plan	<input type="checkbox"/> List of taskforce meeting attendees and meetings attended	Excel template
	A1.Y2.1H.4	Jan-Jun 2017	Development, submission, and approval of IDN Workforce Capacity Development Implementation Plan	<input type="checkbox"/> IDN Workforce Capacity Development Plan as defined by Workforce Project Team (see example in detail below)	TBD by Workforce Project team
	A1.Y2.2H.1	Jul-Dec 2017	Implementation of IDN Workforce Capacity Development Plan: ongoing semi-annual reporting against targets identified in plan	<input type="checkbox"/> Reporting against IDN Workforce Capacity Development Plan (TBD)	Templates TBD by Workforce Project team
	A1.Y3.1H.1	Jan-Jun 2018	Implementation of IDN Workforce Capacity Development Plan: ongoing semi-annual reporting against targets identified in plan	<input type="checkbox"/> Reporting against IDN Workforce Capacity Development Plan (TBD)	Templates TBD by Workforce Project team
	A1.Y3.1H.2	Jul-Dec 2018	Implementation of IDN Workforce Capacity Development Plan: ongoing semi-annual reporting against targets identified in plan	<input type="checkbox"/> Reporting against IDN Workforce Capacity Development Plan (TBD)	Templates TBD by Workforce Project team

Deliverables Reporting on Process Measures

ADDITIONAL DETAIL ON REPORTING GUIDELINES

Requirement A1.Y2.1H.4 Example Detail: Project A1 IDN Workforce Capacity Development Plan Components

Plan Component	Detailed Requirements	Submission Format
Implementation Plan	<ul style="list-style-type: none"> ┌ List of key milestones in addressing areas of workforce capacity need identified in the IDN's workforce gap analysis, including: <ul style="list-style-type: none"> ○ Recruitment ○ Hiring ○ Training ○ Retention ┌ Sub-milestone tasks necessary to achieve milestones ┌ Status of milestones and tasks ┌ Expected milestone and task start and end dates ┌ <i>Note: Workforce capacity development plans must align with guidelines and targets established by the statewide plan, the IDN's community needs assessment, and the community-driven projects selected by the IDN</i> 	Word document
Project Budget	<ul style="list-style-type: none"> ┌ Brief budget narrative outlining expected costs, major funding allocations, and expenditure timeline ┌ Detailed budget for chosen project, including the following cost categories, as applicable: <ul style="list-style-type: none"> ○ Recruitment and hiring ○ Retention of existing staff ○ Staff salaries ○ Materials needed for staff training ○ Materials needed for project implementation ○ Other, as needed 	Word document Excel template
Workforce Plan	<ul style="list-style-type: none"> ┌ Gap analysis of needed staff and hiring areas ┌ Description of staffing plan, including recruitment and retention strategies and implementation timing 	Word document
Key Organizational and Provider Participants	<ul style="list-style-type: none"> ┌ List of organizations and providers participating in project with IDN 	Excel template

Workforce Plan



- List of current staff assigned to project, including titles, roles, and responsibilities
- Gap analysis of needed staff and hiring areas
- Description of staffing plan, including recruitment and retention strategies and implementation timing

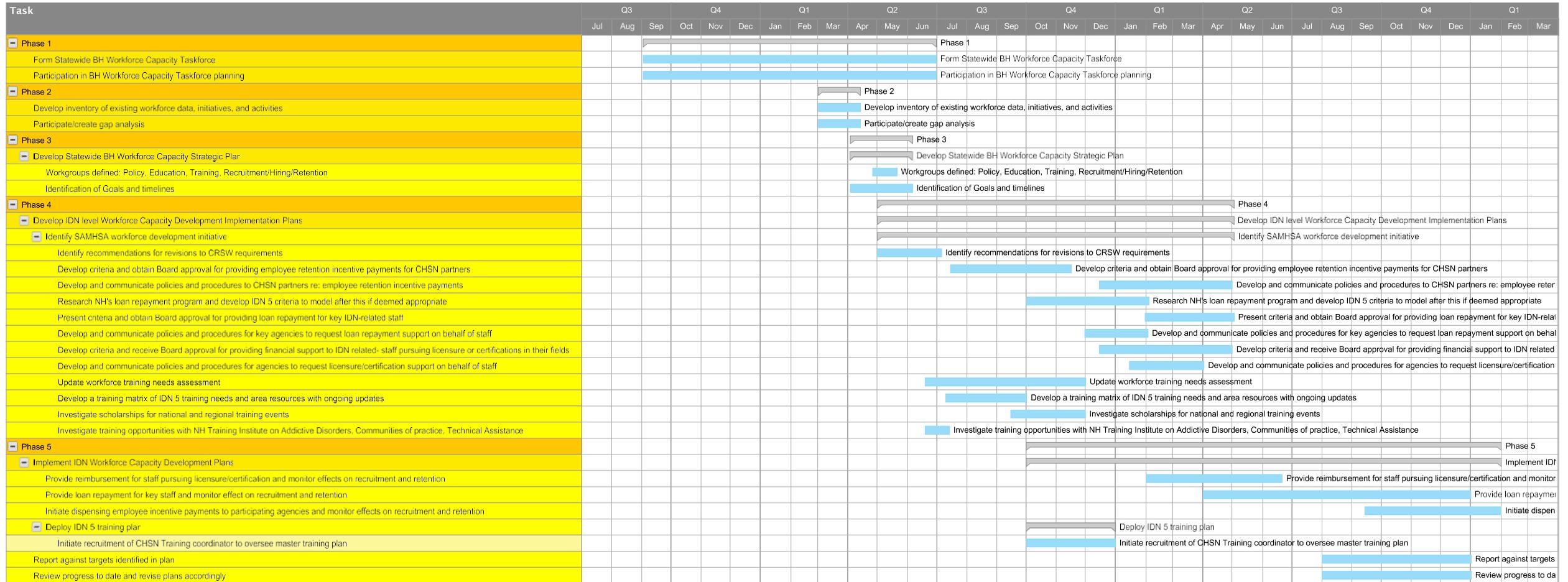
Word document

Challenges	1	2	3	4	5	6	7
Recruitment - Rural issues	x						
Recruitment - High demand because of opioid use, lack of electives or practicum at local colleges, lack of marketing for BH careers, lack of diversity among professionals			x				
Recruitment - Lack of available BH staff statewide							x
Recruitment - Numbers of BH staff required for IDN plans	x						
Recruitment - Overly restrictive and bureaucratic licensing requirements and limitations			x	x		x	
Retention - Low pay, lack of ongoing adjustments to Medicaid reimbursement rates tied to medical inflation rate, unbillable time spent supervising staff working toward licensure or certification	x		x	x	x	x	
Retention - High workloads, Pressure to generate billable hours			x		x		
Retention - Poaching from one organization to larger, better funded organizations						x	
Retention - Behavioral health stigma leads to undervalued workforce			x	x			
Retention - Burdensome regulatory practice requirements				x			
Training - Integration needs and cross training of staff in PC, MH, SUD, Peer, and Recovery				x		x	x

Strategies	1	2	3	4	5	6	7
Recruitment - Pipeline program							x
Recruitment - Broaden definition and concept of workforce roles in this sector				x		x	
Recruitment - Develop peer workforce		x	x	x	x		
Recruitment - Relief from overly restrictive and bureaucratic licensing requirements and limitations; lower or waive fees for fulfilling requirements			x	x		x	
Recruitment - Coordinated recruitment efforts					x		x
Recruitment - Explore and better utilize telehealth/tele-psychiatry			x			x	
Recruitment - Expand the use of the Statewide Loan Repayment Program to incent MH/SUD sector				x	x	x	x
Recruitment - Address licensing and reciprocity rules			x	x		x	
Recruitment - Shared BH workforce database with resumes			x				
Recruitment and Retention - Continuous public education to combat stigma, Statewide “celebration” of staff in the sector, Market BH careers			x	x			
Retention - Integrated settings with well-developed care coordination lead to greater retention	x						
Retention - Adjust reimbursement rates to allow for more competitive pay			x	x			
Training - Comprehensive (and varied in delivery system) training opportunities for integration workforce in science based best practices shared across IDNs (Region 1 to use Geisel School of Medicine at Dartmouth College and Antioch University New England; Region 2 developing resource list; Region 6 recommends engaging the CCSNH + local schools for new paths and rapid development/deployment of skills; Region 7 to use NNHAHEC); Shared training efforts	x	x	x	x	x	x	x
Retention - Sufficient post-training supervision				x			
Retention - Expand state liability coverage for mental health/SUD professionals, FSS workers, PCSPS and LNAs to drive clients to appointments and run errands			x				
Training - Statewide BH Workforce Technical Assistance Center/Program	x		x				
Engage private sector in the solution						x	

A1 Statewide BH Workforce (IDN5)

Attachment_A1.3A



Attachment_A1.3B

CHSN-IDN 5 Training Resource Guide

Project	Course/Topic	Target audience	Who can provide	Delivery Method	Duration	total number to train	Target implementation date/date offered	cost
All	DSRIP 101 (and potentially speaker of "lived experience")	All as needed	IDN, speaker- Hope for NH Recovery or NAMI	In person	1-2 hrs	TBD	Initiate monthly starting Sept 2017	Free
All	Privacy and liability (42 CFR part 2)	ALL	Horizons	In person, resource portal	6 hrs	TBD	Begin Q4 2017 then quarterly as needed	
All	Outcome metrics and QI	Care coordinators, Primary care and BH providers, SUD counselors	IDN	In person, resource portal	2+ hrs	TBD	ongoing	Free
All	CMT and working with the care plan, clinical documentation, registry	Care Coordinators, primary care providers, BH providers, SUD counselors, peer recovery workers, homecare staff, others	CMT	In person	refer to CMT training plans	TBD	Begin 10/1/17	built into CMT contract
B1	NH BH Integration Learning Collaborative: Integration in the Practice (also has part II)	Primary care and BH providers	NH AHEC		3.25 hrs	TBD		
B1	SBIRT	Primary care and BH providers	Healthfirst			TBD		
B1	PHQ 2, 9	Primary care and BH providers				TBD	Initiate by 1/31/18	
B1	Chronic Disease Management: Diabetes	Primary care and BH providers				TBD		
B1	Chronic Disease Management: Dyslipidemia	Primary care and BH providers	NNH AHEC		1 hr	TBD		
B1	Chronic Disease Management: Hypertension	Primary care and BH providers				TBD		
B1	Practice Changes/HEDIS measure data collection	Primary care providers, BH providers				TBD		
B1	Core Standard assessment process	Primary care, BH providers				TBD		
B1	Integration of MAT for practices moving towards integrated care designation	Primary care, BH providers				TBD	Initiate by 1/31/18	

Attachment_A1.3B

B1, C2, D3, E5	Referral process and procedures	receptionist, care coordinators				TBD			
B1, C2, D3, E5	Best practices in care transitions	Care coordinators	NAMI			TBD			
B1, C2, D3, E5	Natural Supports Training	primary care and BH providers, Care coordinators, SUD Counselors, Peer recovery workers, family/Caregiver	NAMI		2+ hrs	TBD			
B1, C2, D3, E5	Lethal means reduction/CALM Suicide prevention	primary care and BH providers, Care coordinators, SUD counselors, Peer recovery workers, family/Caregiver	Horizons (also has specific to C2-crimiminal justice system) Riverbend NAMI SNH AHEC		6+ hrs hrs	2	TBD		
B1, C2, D3, E5	Established treatment programs for: borderline personality disorder	Care coordinators, primary care providers, SUD counselors					TBD		
B1, C2, D3, E5	Trauma informed treatment/PTSD and SUDs	Care coordinators, primary care providers, SUD counselors	Horizons	In person			TBD		
B1, C2, D3, E5	Substance Use & Trauma, Trauma Informed Treatment	Primary care providers, BH providers, Care coordinators, peer recovery workers	Horizons, NHTI	In person	All day (8:30-4)		TBD	9/14/2017	
B1, C2, D3, E5	Adverse Childhood Events (ACE)	Primary care providers, BH providers, Care coordinators, peer recovery workers	Maine Quality Counts, NHTI	Online webinar, In person	1 hr, All day (8:30-4)		TBD	Initiate by 1/31/18, 10/12/17	Free, \$60/person
B1, C2, D3, E5	Narcan administration	family/care givers, homehealth staff, care coordinators	PPH? SNH/NNH AHEC		1-2 hrs		TBD		
B1, C2, D3, E5	MH First Aid	receptionist?, caregivers, SUD counselors, peer recovery workers	Genesis Riverbend SNH AHEC NHTI	In person-Concord	2-8 hrs all day (8:30-6)		TBD	8/8/2017	\$125/person
B1, C2, D3, E5	Motivational interviewing	Care coordinator, SUD counselors, peer recovery workers?, non-direct care staff	NNH AHEC	In person, online	2 days		TBD	Oct.-Dec. 2017	\$950/person

Attachment_A1.3B

B1, C2, D3, E5	Ethical competency/Ethics in BH/Ethical Issues	SUD worker, Peer recovery workers	NHTI		2 day for Recovery support workers 2 hrs	TBD	8/2-8/2/17	Free
B1, C2, D3, E5	Cultural competency	non-direct care staff	SNH/NNH AHEC		1-8 hrs	TBD		
B1, C2, D3, E5	Reflective listening	non-direct care staff				TBD		
B1, C2, D3, E5	Addiction severity index	Peer recovery workers, Care coordinators				TBD		
B1, C2, E5	Initial training on Addiction & Recovery	Care Coordinators, SUD counselors, peer recovery workers	NH DHHS- Bureau of Drug & Alcohol Services	In person, Concord. Preregistration required, limited	all day (8:30-4)	TBD	11/15/2017	Free
B1, E5	Making sense of the new Opioid prescribing regulations Chronic pain & Opioids	primary care and BH providers	NHH AHEC NHH AHEC		1 hr 3 hrs	TBD		
B1, E5	ED Utilization	ED providers- MD, PA, NP, other	https://www.mainequalitycounts.org/articles/161-1590/august-15th-webinar-impact-of-high-ed/3	Online webinar	1 hr		fall 2017	Free
B1, E5	Interpersonal Communication/Sensitivity and Stigma training	Primary care and ED providers	NAMI	In person on site	1.5 hrs	TBD		
B1, E5	Interpersonal Communication	Primary care, BH providers	http://healthcarecomm.org/training/continuing-education-workshops/clinician-patient-communication-to-enhance-health-outcomes/			TBD		Free
B1, E5	Patient-Centered care	Primary care, BH providers	https://resourcesforintegratedcare.com/MemberEngagement/2017_ME_Webinar_Series/Person_Centered_Culture	Online	1.5 hrs	TBD		Free
B1, E5	Treatment planning and Targeted Case Management	Primary care, BH providers, Care coordinators?	Riverbend			TBD		
B1, E5	Addressing challenges of coding	billing staff				TBD		
B1, E5	Understanding public safety and emergency response services rules and protocols (e.g. ED transport, protective custody)	Care Coordinators				TBD	Begin 4/1/18	
C2	Recognizing signs & symptoms of SUD/MH, suicide prevention, other topics as identified	Correction officers	Horizons	In person		TBD	Begin 1/1/18	

Attachment_A1.3B

C2	DSRIP 101 and MH/SUD interventions to reduce recidivism	Judges, other court personnel and attorneys		In person		TBD	Begin 1/18	
C2, D3	Licensing LADC and MLADC, Administrative Rules	SUD counselors (LADC/MLADC)	NHTI	In person	3 hrs 25 hrs (in last phase of licensure)	TBD	9:00-12:00 pm	\$25/person
C2, D3, E5	Behavioral Activation	Care Coordinator?, peer recovery workers				TBD		
C2, D3, E5	Problem solving treatment	Care Coordinator Peer recovery workers				TBD		
D3	Self care, Vital Signs for self care, Compassion fatigue	Care Coordinators, Peer recovery workers	NHTI	In person	8:30-3	TBD	10/13/2017	\$60/person
D3	Connecticut Community for Addiction (CCAR) Recovery coach Academy, CRSW Administrative Rules Overview	Peer recovery workers	NNH AHEC, NHTI	In person	30 hrs, 3 hrs (9:00-12:00 pm)	TBD	10/11/2017	\$25/person
D3, E5	Understanding Medicaid: dual payer, coverage, benefits, enrollment	Care Coordinators	DHHS	In person	2-3 hrs	TBD		
D3	Chain of Custody for Urine collection	Care Coordinators, benefit navigators	NHTI					
D3, E5	HIV	Care Coordinators, benefit navigators	NHTI	In person	All day (8:30-4)	TBD	12/1/2017	\$45/person +\$5 NBCC contact hrs
E5	Wraparound team model- Workflow responsibilities and resources available, team roles, ACT team, how to relay system issues of gaps	Care Coordinators, benefit navigators	https://www.integration.samhsa.gov/about-us/pbhci			TBD		

can receive contact hours

To become a Recovery Coach at Navigating, a person must complete the following:

5-day CCAR Academy

Ethical Issues for Recovery Support Workers

(And then over time I ask that they also complete):

HIV Update for Substance Use Professionals

Connect: Suicide Prevention

To become a CRSW (Certified Recovery Support Worker - can bill Medicaid) the person must have:

46 hrs of coursework, with 16 being Ethics, 6 Suicide, and 6 HIV

500 Hrs supervised coaching
CRSW exam
Application

Extras that are "nice" include:

CRSW Performance Domains

ASAM

SBIRT

Understanding & Responding to Basic Mental Health Concerns

CHSN/IDN 5

Project Design and Capacity Building	100% Process (Project Plan approval)		90% Process / 10% Outcome Perf			75% Process / 25% Outcome Perf		100% Outcome Performance				
	(Design/capacity bldg funds)	Year 1/pymt 2	YTD Expenditures (thru 6/30/17)	Year 2/pymt 1 (Jan-Jun 2017)	Year 2/pymt 2 (Jul-Dec 2017)	Year 3/pymt 1 (Jan-Jun 2018)	Year 3/pymt 2 (Jul-Dec 2018)	Year 4/pymt 1 (Jan-Jun 2019)	Year 4/pymt 2 (Jul-Dec 2019)	Year 5/pymt 1 (Jan-Jun 2020)	Year 5/pymt 2 (Jul-Dec 2020)	
Distributed to Each IDN	\$ 1,392,857											
Funds Allocated by Attribution of 9.17%	\$ 900,630											
Capacity Building Funds avail as of 6/30/17	\$ 2,293,487	\$ 495,603	\$ 2,789,090	\$ 1,238,010	\$ 1,238,010	\$ 1,238,010	\$ 1,238,010	\$ 1,238,010	\$ 1,238,010	\$ 1,283,862	\$ 1,283,862	\$ 12,784,874
ADMINISTRATIVE EXPENSE: IDN staff/benefits/Admin Lead operating budget thru 2020 (ending June 2021)												\$ 1,480,957
STATEWIDE PROJECTS												\$ 11,303,917
A1 - Workforce	STATEWIDE Trainings (Shared with other IDNs)											\$ 80,000
	REGIONAL Trainings for IDN agencies and staff needs related to Integration											\$ 52,500
	Licensure / Certification support for project staff (C2, D3, E5)											\$ 10,500
	Loan repayment plan (TBD - build off state's plan) Estimate											\$ 150,000
IDN Network "Employee Retention" Incentive Payment Plan												\$ 525,000
												\$ 540,000
												\$ 540,000
A2 - H.I.T.												\$ 182,000
												\$ 131,250
												\$ 225,000
												\$ 8,500
												\$ 5,500
CORE COMPETENCY PROJECT												\$ 552,250
B1 - Integrated Healthcare												\$ 15,000
												\$ 12,000
												\$ 5,000
												\$ 60,000
												\$ 100,000
												\$ 35,000
COMMUNITY PROJECTS												\$ 227,000
C2 - Community Re-Entry												\$ 1,448,860
D3 - Expansion in IOP												\$ 1,607,749
												\$ 64,680
E5 - Enhanced Care Coordination												\$ 2,599,695
												\$ 41,030
All Community projects D3/E5												\$ 16,050
E5 Care Coordinator Mileage												\$ 320,000
All community projects												\$ 6,000
OTHER EXPENSES												\$ 6,104,064
Remaining IDN Discretionary Grant Fund												\$ 31,153
CONSULTING:												\$ 15,000
LEGAL FEES:												\$ 5,500
REIMBURSEMENTS:												\$ 105,000
Unknown Staffing, project needs, etc:												\$ 750,000

DSRIP Funds Avail.

\$ 9,687,967
\$ 1,130,391.68
\$ 485,559

DSRIP projected expenses
10% reserve for DHHS matching Reserve for IDN achievement of performance metrics

A2 Statewide HIT (IDN 5)

Attachment_A2.3

Task	Q4			Q1			Q2			Q3			Q4			Q1			Q2			Q3			Q4													
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
Phase 1- Initiation	Phase 1- Initiation																																					
Participate in Statewide HIT Taskforce	Participate in Statewide HIT Taskforce																																					
Participate in State assessment of HIT for participating members of IDNs	Participate in State assessment of HIT for participating members of IDNs																																					
Assist in developing standardized current-state assessment tool	Assist in developing standardized current-state assessment tool																																					
Conduct an IDN-member assessment of existing and scheduled HIT efforts and develop a statewide report.	Conduct an IDN-member assessment of existing and scheduled HIT efforts and develop a statewide report.																																					
Assist taskforce in conducting an updated review of pertinent State and Federal Privacy laws	Assist taskforce in conducting an updated review of pertinent State and Federal Privacy laws																																					
Review HIT assessment and create gap analysis for both IDN and State levels	Review HIT assessment and create gap analysis for both IDN and State levels																																					
Phase 2 Building Consensus of minimal, desired, and optional HIT requirements for IDN infrastructures	Phase 2 Building Consensus of minimal, desired, and optional HIT requirements for IDN infrastructures																																					
Maintain standing CHSN HIT committee with responsibility to make recommendations to the board	Maintain standing CHSN HIT committee with responsibility to make recommendations to the board																																					
Alignment of goals designed to help close the gaps in HIT that will support the DSRIP demonstration	Alignment of goals designed to help close the gaps in HIT that will support the DSRIP demonstration																																					
Development of acceptable levels of ONC certified Technology adoption and electronic health record functionality	Development of acceptable levels of ONC certified Technology adoption and electronic health record functionality																																					
Identify transaction sets, methods, and mechanisms for health information exchange (HIE) between IDN participants	Identify transaction sets, methods, and mechanisms for health information exchange (HIE) between IDN participants																																					
Evaluate requirements for a shared care record across the care continuum	Evaluate requirements for a shared care record across the care continuum																																					
Engage in discussion to enable clinical outcomes and financial performance measurement and reporting functions	Engage in discussion to enable clinical outcomes and financial performance measurement and reporting functions																																					
Discuss adoption of electronic Clinical Quality Measures (eCQMs)	Discuss adoption of electronic Clinical Quality Measures (eCQMs)																																					
Discuss utilization reporting	Discuss utilization reporting																																					
Discuss financial performance reporting	Discuss financial performance reporting																																					
Discuss managing reporting between IDNs and the State using a Stat-approved standardized format for the electronic interface	Discuss managing reporting between IDNs and the State using a Stat-approved standardized format for the electronic interface																																					
Discuss availability of State-approved standardized data sets to be provided by the State and MCO partners	Discuss availability of State-approved standardized data sets to be provided by the State and MCO partners																																					
Consensus Report Published	Consensus Report Published																																					
Phase 3 Develop IDN specific HIT Implementation Plan	Phase 3 Develop IDN specific HIT Implementation Plan																																					
Develop a HIT implementation plan and timeline	Develop a HIT implementation plan and timeline																																					
Ensure inclusion of IDN provider(s): hospital, CMHC, community mental health providers, primary care, SUD, and DRF participants.	Ensure inclusion of IDN provider(s): hospital, CMHC, community mental health providers, primary care, SUD, and DRF participants.																																					
Initiate recruitment of Health Data Analyst	Initiate recruitment of Health Data Analyst																																					
Develop IDN 5 Privacy forms	Develop IDN 5 Privacy forms																																					
Meet with leads on form development	Meet with leads on form development																																					
Consult with Legal about forms	Consult with Legal about forms																																					
Develop/identify procedures for gaining informed patient consent	Develop/identify procedures for gaining informed patient consent																																					
Develop inter-agency data sharing agreements	Develop inter-agency data sharing agreements																																					
Execute agreement with CMT (Collective Medical Technologies)	Execute agreement with CMT (Collective Medical Technologies)																																					
Review applications and select vendor for data aggregation	Review applications and select vendor for data aggregation																																					
Identify key Network partners for participation in a Data Analytics team and invite to first meeting	Identify key Network partners for participation in a Data Analytics team and invite to first meeting																																					
Install capabilities for partners without existing secure messaging based on minimum standards	Install capabilities for partners without existing secure messaging based on minimum standards																																					
Phase 4 Implementation of IDN-specific Plan	Phase 4 Implementation of IDN-specific Plan																																					
Convene CHSN Data Analytics subcommittee	Convene CHSN Data Analytics subcommittee																																					
Initiate development of capacity for intra-network data aggregation	Initiate development of capacity for intra-network data aggregation																																					
Initiate PreManage Primary Implementation with FQHCs and BH Providers	Initiate PreManage Primary Implementation with FQHCs and BH Providers																																					
Send list of prioritized clinics to CMT	Send list of prioritized clinics to CMT																																					
CMT contacts prioritized agencies/practices	CMT contacts prioritized agencies/practices																																					
Agency/Practices implementation steps	Agency/Practices implementation steps																																					
View video demo of PreManage	View video demo of PreManage																																					
Set up Q & A meeting with CMT	Set up Q & A meeting with CMT																																					
Set up eligibility file discussion	Set up eligibility file discussion																																					
Complete onboarding packet	Complete onboarding packet																																					
Train users on PreManage Primary	Train users on PreManage Primary																																					
Train providers in Confidentiality/Privacy	Train providers in Confidentiality/Privacy																																					

NH DSRIP Waiver IDN Application: Supplemental Excel Worksheet Template



12.F, Project B1: Integrated Health (Core Competency) Implementation Approach and Timing

Using the below table, for each of the required project process milestone groups, please provide a short description of the IDN's planned approach to accomplishing these project requirements. Please see Appendix C for additional instructions.

Time Period	Core Competency Project Milestone	General description of IDN approach to accomplishing requirements	Resources to be deployed to support participating organizations	Individual(s) accountable for success at IDN and participating organization level	Any anticipated barriers/challenges and IDN tactics to address them (i.e. social determinants of health)
January – June 2017	Development of detailed implementation plan, including: <ul style="list-style-type: none"> Implementation timeline Project budget Workforce plan (including staffing, recruitment, retention) Key organizational/provider participants 	CHSN will support the activities of four related task teams to further develop the implementation plan including timeline and budget for the Integrated Health core competency project. The Community Health Services Network (CHSN) has identified ten primary care and behavioral health practices that are key to the success of our integrated project. To establish a baseline, each of the ten core practices will be assisted to complete a self-inventory of existing practice characteristics associated with integrated care and PCMH tailored to the context of their patient population. As gaps are identified at the practice level, the Network will develop technical assistance resources and specific tools to elevate each of those practices to a higher degree of capability for coordination and/or integration, customized to their practice environment.	CHSN central staff (Executive Director [REDACTED], Project Manager TBD) will support the work of four Committees/Project Teams: Clinical Integration Committee, Training Team, HIT Team, and Data Analytics Team). CHSN Co-Medical Directors [REDACTED] will chair the Clinical Integration Committee. One Data Analytics expert will be sourced from within the Network to measure and report on ongoing progress.	Each Committee/Project team established will identify a Team Lead to continue logistical support of the work completed to date: 1. Clinical Leadership Team Lead [REDACTED] (Health First), 2. Training Team Lead TBD 3. Health Information Technology Team Lead [REDACTED] 4. Data Analytics Team Lead TBD	It will be essential to engage clinical leadership early in the demonstration project to get buy in and identify practice-based champions for integration efforts.
	Identification or development of: <ul style="list-style-type: none"> Comprehensive Core Standardized Assessment and screening tools applicable to adults, adolescents and children Shared Care Plan for treatment and follow-up of both behavioral and physical health to appropriate medical, behavioral health, community, and social services 	CHSN has identified assessment and screening tools that are being implemented in certain Network practice sites already (e.g., adult and youth Screening Brief Intervention and Referral to Treatment (SBIRT); PHQ2 and 9; Oasis; Global Assessment Scale; CANS) Opportunities for expanded use and additional synchronization will be explored as part of the plan refinement phase (To be completed by end of February 2017). The E5 Care Coordination Committee will identify components needed to execute a Shared Care Plan reviewed by HIT (To be completed by June 2017). Standardized definitions and protocols used by each practice will be gathered, and a new protocol for Closed Loop Referrals will be developed (To be completed by June 2017).	Skilled in adult SBIRT, Network member HealthFirst will contribute expertise and/or training. Network member IT professionals will bring knowledge of their practices' systems, available care plan modules and capability for coordination. The Clinical Integration Team will be responsible for creating standardized definitions and protocols used by each practice.	[REDACTED] are responsible for identification and/or development of comprehensive core standardized assessment and screening tools. Team leads for C2, D3, E5, B1 and A2 to work closely on screening tools to support integration and cross-agency information exchange.	Competing requirements of individual agencies' funding streams for types of documents and data gathered.
	Identification or development of: <ul style="list-style-type: none"> Core team meeting/communication plan and relevant workflows for communication among core care team and other patient providers 	Core teams will be established within each practice, and workflows will be assessed for possible redesign (Timeline TBD). A Network Resource will be developed to support practices in achieving practice standards such as Patient Centered Medical Home and Behavioral Health Home (To be decided by June 30, 2017). Each key practice will develop roles and responsibilities for	A consultant with expertise in workflow analysis and practice redesign will be hired by the Network to assist the practices.	Clinical Integration Committee	Important to have sufficient flexibility to allow clinic teams to design approaches that works best for them

Time Period	Core Competency Project Milestone	General description of IDN approach to accomplishing requirements	Resources to be deployed to support participating organizations	Individual(s) accountable for success at IDN and participating organization level	Any anticipated barriers/challenges and IDN tactics to address them (i.e. social determinants of health)
	<ul style="list-style-type: none"> Written roles and responsibilities for core team members and other members 	their core team members in collaboration with and with assistance from the Clinical Integration Committee.			
	Development of training plan and training curricula for core team members and extended team as needed	The training team will develop the training plan and curricula to include train the trainer activities at practice sites and cross-network training activities	An external consultant will be hired to assist the training team to design and develop relevant training sessions as well as "Train the Trainers" at each practice site	In-house trainers will receive training from the Consultant to aid in deploying training sessions onsite at each practice and with each core team (To be completed by June 2018)	Important to design training activities that are not disruptive to clinic operations and that recognize financial costs of training time
	Identification or development of: <ul style="list-style-type: none"> Evaluation plan Mechanisms to track and monitor individuals served by program 	The Data Analytics/Quality Assurance team will establish measures and methods for collection and reporting of data and progress against project objectives (To be completed by June 2017).	Member agency representatives will serve on the Data Analytics/QA/QI Team; CHSN will look to contract with a member agency to build local capacity for population health measurement	TBD, Data Analytics Team Lead	Need to understand different information system capabilities and practice level personnel capabilities for data reporting
	Identification or development of agreements with collaborating providers and organizations	Network Participation, Data Sharing, and Interagency Affiliate Agreements will be developed and implemented (To be completed by June 2017).	Data analysts' assistance will be retained under contract, as will an attorney to review and approve as HIPAA-compliant Network members' interagency agreements on data sharing.	CHSN Board, Agency Directors	Examples are already in place between some network partners. Build on these.
July – December 2017	Implementation and deployment of <ul style="list-style-type: none"> Workforce plan (staffing, recruitment, retention) Training plan 	Implementation in this area will be synchronized with the Workforce Development task area and with the community driven project implementation teams, all of which have workforce staffing and recruitment aspects that are directly related to broader integration capacity and competency development.	CHSN will target resources for workforce recruitment and retention including training subsidies, salary incentives and support of unlicensed, unreimbursable personnel working under supervision as they pursue licensure or certification	CHSN Board, Agency Directors	Given our status as an underserved region, it is historically difficult to recruit skilled mental health and SUD treatment providers to meet population demand. CHSN will seek to address this strategies identified through the IDN workforce development team (see plan narrative)
	Operationalization of: <ul style="list-style-type: none"> Comprehensive Core Standardized Assessment Shared Care Plan Core Team meeting/communication plan 	CHSN will operationalize adult and youth SBIRT, PHQ2 and 9 (2017 - Ongoing). Shared Care Plan to be launched in 2018. Core Team meeting/communication plan to be underway ASAP in 2016.	Resources to facilitated incorporation of assessments and care plans into EHR applications	Agency Directors, Clinical Directors	Important to distinguish between purpose and goals of shared care plan and team meetings within a practice versus system level whole person care plan and inter-agency enhanced care coordination / case management of complex patients.
	Use of share EHR, electronic coordinated care management system, or other documented work flow	Using the baseline and periodic practice assessments, the clinical integration and HIT teams will prioritize assistance activities that the Network can pursue on behalf of each practice.	Resources to facilitate wider availability and use of EHRs across the network	Agency Directors, Clinical Directors	Practices are at varying stages of EHR development and capability. Network leadership will assess priorities for funding and development in this area
	Initiation of data reporting, including: <ol style="list-style-type: none"> Number of Medicaid beneficiaries receiving Comprehensive Core Standardized Assessment (during reporting period and cumulative), vs. projected Number of Medicaid beneficiaries scoring positive on screening tools 	Data team will work on review of needed fields of data and methods to collect and report (December 2017). Data team will work on method to gather and report Medicaid beneficiaries scoring positive on screening tools (December 2017). Data team will work on method to gather and report usage of Medicaid beneficiaries screening positive on	Contracted Data manager with data analytics/QA and clinical integration teams.	CHSN Board, CHSN ED, Agency Directors, Data Analytics Team	Because of differences between participating agencies across the continuum of care and because of different information system capabilities, it will be important to establish clear definitions, common terminology at the outset and be prepared to problem solve data reporting issues

Time Period	Core Competency Project Milestone	General description of IDN approach to accomplishing requirements	Resources to be deployed to support participating organizations	Individual(s) accountable for success at IDN and participating organization level	Any anticipated barriers/challenges and IDN tactics to address them (i.e. social determinants of health)
	<p>c. Number of Medicaid beneficiaries scoring positive on screening tools and referred for additional intervention</p> <p>d. Number of new staff positions recruited and trained (during reporting period and cumulative), vs. projected</p> <p>e. Impact measures as defined in evaluation plan, including annual evaluation of fidelity to evidence-supported program elements</p>	<p>screening tools and referred for additional intervention (December 2017). Data team will work on method to gather and report usage of impact measures as defined in evaluation plan (December 2017).</p>			<p>or inconsistencies at the individual practice level.</p>

B1 Integrated Healthcare (IDN5)

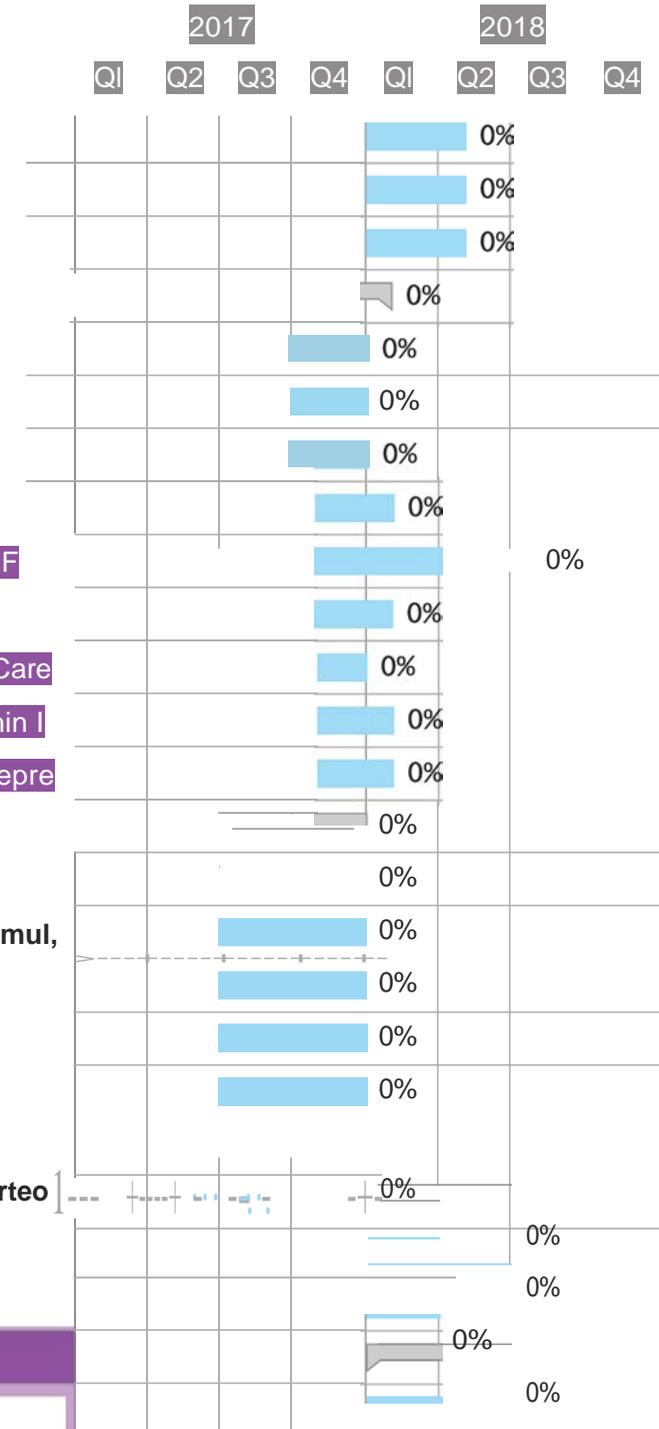
Attachment_B1.2

Task Name	2017				2018			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Planning phase					53%			
Research DSRIP waivers in other states to ascertain "lessons learned"					100%			
Develop Implementation Plan for Coordinated and Integrated Care Practice					83%			
Identify and Commit Key Organizational/Provider participants					100%			
Organizational leaders sign-off					100%			
Complete Project Budget					100%			
Salary assessment by profession					100%			
Reconcile budget with FTE need and salary designation					100%			
Complete Workforce plan					65%			
Staffing plan					100%			
Workforce gap analysis					100%			
Identification of key roles for implementation plan					100%			
Develop training plan to support integrated practice					80%			
Initiate recruitment of Practice Transformation Specialist					0%			
Develop HIT plan to support integrated practice					100%			
Develop Implementation Timeline					100%			
Initiate process of Designated IDN participating providers progress along SAMHSA framework for Integrated Levels of Car					24%			
Perform Gap Analysis of CSA					100%			
Develop report on DSRIP CSA Gap Analysis results					100%			
Complete Site Self- Assessment for level of Integration for IDN participating providers					54%			

Task Name	2017				2018			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Assess current progress along SAMHSA framework of key Primary Care and BH providers and future targets			80%					
Identify regional goals and timelines related to Coordinated Care Practice and/or Integrated Care Practice			35%					
Develop/Identify Agreements with participating providers and organizations		100%						
Develop/Identify Comprehensive Core Standardized Assessment process and screening tools				23%				
Clinical Integration Committee convened		25%						
Select Assessment/Screening tools applicable to adults, adolescents, and children			50%					
Evaluation of Medicaid partners by quantity served			30%					
Plan created for implementation of assessment tools to be integrated into selected partners workflow				0%				
Develop/Identify Protocols for patient assessment, treatment, management				33%				
Participating partners selected			80%					
Participating partners workflows mapped			30%					
Assess practice workflows and create plan for introduction/modification as appropriate				35%				
Measurement process created				0%				
- Develop/Identify Core team meeting/communication plan and relevant workflows for communication among core care				21%				
Participating partners selected				0%				
participating partners workflows mapped				50%				
Core team meeting/communication Process Defined				0%				
Documentation of roles and responsibilities for core team members and other members as needed				0%				
Measurement process created							0%	
Develop/Identify mechanisms (e.g. registries) to track and monitor individuals served by the program, adherence, i							0%	
- Develop/Identify Shared Care Plan for treatment and follow-up of both BH and physical health to appropriate medical,				10%				
Participating partners selected				0%				
Participating partners workflows mapped							0%	
Shared Care Plan Process Defined and training deployed for PreManage Primary implementation for Tier 1				40%				
Measurement process created							0%	

Task Name	2017				2018			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
- Develop/Identify Referral protocols including to those to/from PCPs, BH providers, social service support providers, H						16%		
Participating partners selected				40%				
Identify/develop protocols				40%				
Measurement process created				0%				
participating partners workflows mapped								0%
- Identify practice specific technical assistance and training plan for each member of the core team and extended team				0%				
Partners Identified				0%				
Needs Identified				0%				
Training plan developed				35%				
Experts in the State identified and Statewide initiatives				30%				
Training plan scheduled (and ongoing)				10%				
Identify Training curricula for each member of the core team and extended team as needed				75%				
- Evaluation plan				0%				
CCSA measurement process created				0%				
Shared Care Plan measurement process created								0%
Collection Process Defined and Resources				0%				
Assess opportunities and challenges for integration of Medication-assisted treatment (MAT) in ION S primary care and				0%				
1:1 Implementation phase								4%
1:1 Implementation of workforce plan								24%
Initiate recruitment of multi-disciplinary care team members previously identified								60%
Implement recruitment and retention plans								0%
Specify and deploy training plan for core team members and extended team as needed								0%
1:1 Implement CCSA process and methods for aggregating information from multiple providers								0%
Facilitate use of Comprehensive Core Standardized Assessment tool or process								0%
Facilitate adoption of evidence based screening & assessment tools								0%

Task Name



Number of Medicaid beneficiaries receiving annual Comprehensive Core Standardized assessment for period & cumul,

_____ 0%

Task Name

- Number of Medicaid beneficiaries scoring positive on screening tools
- Number of Medicaid beneficiaries positive on screening tools and referred for additional intervention
- Number of new positions recruited and trained for reporting period & cumulative vs. projected
- New staff position vacancy and turnover rate for period & cumulative vs. projected
- Impact indicator measures as defined in evaluation plan

1:1 Reporting period Jul-Dec 2018

1:1 Collect data from designated agencies for progress along SAMHSA Integrated Care Continuum

- Number of Medicaid beneficiaries receiving annual Comprehensive Core Standardized assessment for period & cumul,
- Number of Medicaid beneficiaries scoring positive on screening tools
- Number of Medicaid beneficiaries positive on screening tools and referred for additional intervention
- Number of new positions recruited and trained for reporting period & cumulative vs. projected
- New staff position vacancy and turnover rate for period & cumulative vs. projected
- Impact indicator measures as defined in evaluation plan, including annual evaluation of fidelity to evidence-supported

Periodically assess designated practices for progress along the SAMSHA Integrated Care continuum

2017				2018			
Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
						0%	
						0%	
						0%	
						0%	
						0%	

Attachment_B1.8A

CCSA Gap Analysis

CCSA Domain	LRGH Healthcare	Speare Hosp.	HealthFirst	Mid-State	Franklin VNA	LR- VNA	Genesis	Lakes Region Com. Ser	Horizons	Riverbend	Pemi-Baker	ServiceLink	NAMI NH	GSIL	CAP	NANA	CNH VNA	CADY
Demographic Information		Intake	Intake Demographic form		OASIS C-2	OASIS	Intake Assessment, CM, CSR											PPH
Physical Health Review, Med. Management, smoking	*DAFT (preganancy status) r/t SUD	Past Med. History and review, questioning, *referral for smoking	Medicare annual wellness visit, Med history/review in EMR, GAF		OASIS C-2	OASIS	Intake assessment CM, CANS, medical questionnaire, InSHAPE	SIS, HRST	COWS									no Medication
Functional Status- ADL's, mobility			ADL's		OASIS C-2	OASIS, TUG	Intake assessment ANSA, CM, CANS, InSHAPE A	SIS, SIB-R		ANSA, CANS			MEA, SCFE					
Substance Use Review Housing Assessment		ORT (Opioid Risk Assessment tool), SBIRT in adolescents	SBIRT, AUDIT, DAST, CRAFT, CAGE, UNCOPE	CRAFFT FOR 12-17 years, CAGE-AID for 18+	OASIS C-2	OASIS	Intake, DAST, AUDIT, ANSA, CANS	SIS	ASAM, CIWA, OOWS	CRAFT, CAGE								
Family and Support Services			Family & Social history		OASIS C-2	OASIS	Intake assessment, ANSA, CM, CANS											
Educational Attainment			Social history		OASIS C-2		Intake assessment, CM, CANS	SIS										
Employment or Entitlement			Social history		OASIS C-2		Intake assessment, CM, CANS	SIS, SIB-R										
Access to legal services			Social determinants of health		OASIS C-2		Intake assessment, ANSA, CM, CANS											
Suicide Risk Assessment	C-SSRS (used in ED)		Suicide risk assessment, PHQ-9	PHQ-2 & 9	OASIS C-2	OASIS	Intake assessment, ANSA, ES evaluation Columbia suicide, CANS	SIS, SIB-R	C-SSRS, SAFE-T				AMSR, CALM, Zero suicide					
Mental Health, Depression Screening (PHQ 2 & 9)	PHQ-2	PHQ-2 & 9 (post partum)	GAD, PHQ-2 & 9	PHQ-2	OASIS C-2	OASIS, PHQ-2	Intake, ANSA		DSM-5, Beck, PTSD, GAD7 PHQ- 9	PHQ- 9	PHQ- 2							

SBIRT screening	YES and BOOST	YES for adolescent only- Youth SBIRT	YES	YES			YES											
Developmental screening for children (ASQ:3 and/or ASQ SE @ 9, 18, and 24/30 month pediatric visits, Bright Futures)	YES- Bright Futures	YES- Bright Futures, MCHAT (autism)	YES- developmental screening in EMR	YES- Bright Futures			YES- Intake											
Transportation (add on)			ADL's			OASIS	Intake, CM Assessment, CANS	SIS, SIB-R										
Other									ASAM			CTI-coaching						
There an established referral system for patients who need further intervention	*referral for this specific question only	24 hr. resource for intervention for Immediate risk identified	Required domains in STCs	referral for only some of the questions asked	Crosswalk was not completed by agency		BOLD- SAMHSA screenings on Core Competencies website											

SAMSHA Recognized Screenings

- Depression- PHQ 9, GLAD
- Drug and Alcohol use- DAST- 10, AUDIT-C, CAGE, NIDAMED, AUDIT, SBIRT, SBIRT youth
- Bipolar- STABLE, MDQ
- Suicide- C-SSRS, SAFE-T
- Anxiety- GAD7, PC-PTSD
- Trauma-LEC, PCL-C (shortened version of PTSD)

HEALTH FIRST

FAMILY CARE CENTER

Department : Clinical	Policy Number: 5300
Policy: Buprenorphine/Naloxone Management	Implementation Date : 01/2016
Review Date:	Revision Date:
Approved By: Steven Youngs Medical Director  2/5/16	Approved By: Jim Wells Chair, Board of Directors

1) Introduction

These policies are specific to HealthFirst and will follow all Federal and State requirements and regulations in regards to medication assistant for opioid addiction.

12.1 Practice Philosophy

- HealthFirst practices medication assistance under the provisions of the Drug Addiction Treatment Act of 2000 which allows physicians to offer outpatient addiction treatment. HealthFirst is here to assist patients who are serious about getting better and fully participating in our treatment program. Outpatient treatment is only appropriate for patients who are motivated, willing and self-determined to make a life style change.

2) Program requirements

2.1 Healthfirst Primary Care Provision.

- Patients receiving buprenorphine/naloxone management from HealthFirst Family Care shall be enrolled as patients for all other primary care purposes. Failure to participate in recommended general primary care practice shall be grounds for dismissal from the buprenorphine/naloxone management program.

2.1.1 NewPatients

- Patients transferring primary care to HealthFirst with the intent of being considered for the buprenorphine/naloxone program shall not be seen for buprenorphine/naloxone management until available records from prior primary care providers are received by Healthfirst.

2.2 Addiction Management Provision

- Buprenorphine/naloxone may be provided for the management of symptoms related to opioid withdrawal and addiction. While it is recognized that buprenorphine/naloxone may have additional benefits (e.g. in the management of chronic pain), if it becomes clear that a patient is using buprenorphine/naloxone primarily for other purposes, buprenorphine/naloxone management shall be suspended.

2.3 Chronic Management Limitation

- The purpose of buprenorphine/naloxone management as practiced by HealthFirst Family Care is active treatment of opioid addiction problems with the goal of long-term recovery rather than simply stabilization and maintenance. Treatment is therefore intended to be of limited time duration. Patients who feel they need open-ended or "lifetime" management with buprenorphine/naloxone shall be directed to other management agencies.

2.4 Opioid Addiction Limitation

- Buprenorphine/naloxone management at HealthFirst is solely for the purpose of managing opioid addiction issues. Patients with substantial issues with addiction around other substances (e.g. cocaine, amphetamines, etc.) as identified during initial consultation for buprenorphine management shall not be considered suitable candidates for buprenorphine/naloxone management from our offices.

2.5 Medication Specification

- HealthFirst Providers will not prescribe stand-alone buprenorphine (aka Subutex) for the purpose of opioid addiction management except if the patient is pregnant. In all other cases the prescribed medication for this purpose shall be the buprenorphine/naloxone combination known as buprenorphine/naloxone.

2.6 Counseling Specification

- Substance abuse counseling is required. Patients must be enrolled in a counseling program that is administered by a licensed counselor to receive on-going prescriptions. Counseling may either be "on-site" with HealthFirst employed counseling staff or "off-site" with a licensed LADAC counselor. In the latter case the patient shall present proof of participation in the form of a letter signed by the counselor stating that the patient is attending counseling sessions related to substance abuse treatment. At a minimum such counseling shall take place on a monthly basis for the duration of buprenorphine/naloxone management. If for financial reasons such counseling is not available to the patient, the provider may, at their discretion, consider proof of attendance in Narcotics Anonymous or Alcoholics Anonymous (in the form of attendance tokens) as an acceptable substitute.

3) Standard Start up Protocol

3.1 Initial Evaluation

- Patients shall have an initial consultation visit during which the patient's substance abuse history and suitability for buprenorphine/naloxone management shall be assessed. The expectations for the program shall be reviewed. If the patient is considered suitable for buprenorphine/naloxone dosing will be issued. The patient will then be scheduled for an induction appointment.

3.1.1 Examples of Patient who should not be enrolled into the program

- Patients who have been to multiple providers within 1 year. This time I suggest drug seeking behaviors rather than an active attempt at resolving underlying addiction issues.
- Patient who have been on 16mg or more of buprenorphine/naloxone for more than 2 years. This suggests that the patient is not actively interested in reducing medication loads *over* time as required by the HealthFirst buprenorphine/naloxone management program.
- Patient who have received buprenorphine/naloxone but have gone back to prescription or non-prescription opioids. This kind of relapse is suggestive that these patients require more intense therapy and a controlled environment where they cannot obtain opioids.

3.2 Buprenorphine/Naloxone Induction

The patient shall bring in medications for opioid induction visit the time and place specified by HealthFirst staff.

- Patients are expected to be free of opioids for approximately 48 hours prior to the time of the induction visit.
- The patient will be evaluated on arrival. It is expected that the patient will be exhibiting withdrawal symptoms at the time of presentation.
- A pill count will be performed to verify that the patient has not made use of the prescription buprenorphine/naloxone prior to the induction appointment.
- Patient will take initial buprenorphine/naloxone dose of an amount determined by the managing provider.
- The patient will be evaluated by withdrawal symptoms scoring in approximately half hour intervals with additional doses of buprenorphine/naloxone being taken as directed by the managing provider.
- The scoring and medication administration should continue until the patient's withdrawal symptoms are largely controlled. The total dose required to obtain this stability shall be set as initial stabilizing buprenorphine/naloxone dose.

3.3 Maintenance Phase: Dose prescribed and tapering schedule

The general pattern of prescription shall be initial period of stabilization (typically approximately 6 months) during which the patient will establish a stable counseling and monitoring schedule. After this initial stabilization, there shall be a gradual weaning of buprenorphine/naloxone at a rate to be determined by the managing provider.

4.0 Patient Expectations

The following provisions are a requirement for ongoing participation in the HealthFirst buprenorphine/naloxone program

- The patient is expected to maintain a current contact address and phone number at all times while under treatment.
- Patient is expected to bring medications to all buprenorphine/naloxone management appointments.
- The patient is expected to remain free of non-opioid controlled and habituating substances (e.g. Benzodiazepines)
- Because Marijuana may make buprenorphine metabolism less predictable, patients are expected to remain free of marijuana during the course of treatment.
- Patient is expected to meet all other provisions stated in the controlled substance management agreement except as described elsewhere in this protocol.

4.1 Opioid Relapse

- It is to be expected that relapse with respect to non-prescribed opioids may occur during the initial stabilization. Such relapses shall not automatically be considered grounds for discharge from the program, but shall form the basis of discussion around modifications to the treatment protocol such as changes in counseling frequency or possible adjustments of medication. However, after the initial stabilization period, relapses with non-prescribed opioid use may indicate that buprenorphine/naloxone management is not appropriate for this patient and may be grounds for discontinuation from the program and referral to an alternative more comprehensive program.

4.2 Immediate Discontinuation:

The following behaviors shall be grounds for immediate discontinuation of buprenorphine/naloxone management:

- Evidence of deliberate falsification attempts with respect to urine drug screening
- Evidence of diversion of prescribed medications

4.3 Drug Testing

- Drug testing either by urine drug analysis or saliva cheek swab will be contacted on a routine basis at approximate monthly intervals for patients on buprenorphine/naloxone management. Intermittent, random request for drug testing should also be conducted. The patient is expected to bear the cost of this drug testing. Urine drug samples should be collected directly into the sample container to be sent to the lab. The patient should hand urine sample directly to the *staff* assigned to collect samples and should be sealed and labeled in sight of the patient to minimize any risk of sample origin confusion.

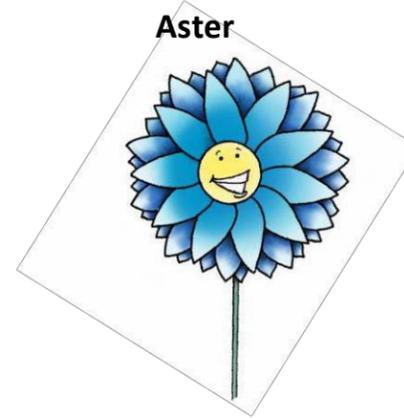
If called for random drug testing and/or pill counts patient is expected to respond within 48 hours.

4.4 No-Show or Canceled Appointments

- Limitations on no-show and canceled appointments shall be a provided in the controlled substance management agreement. The limitation shall apply to all appointments at HealthFirst and are not limited to those with the managing provider.

* = fully integrated with Care Coordinators

- Key:
- Treating
 - SUD/Part2
 - Community Organizations



Medical

Treatment

Behavioral

Residential service/

Private

Recovery

Community

Municipal

County

Providers

FQHCs

Health

Treatment

Counselors

Supports

Agencies

Services

PCPs

Services

SMH hospital
ED
Med Choice
Urgent Care

MidState
HealthFirst

Riverbend
Genesis
Horizons

Farnum
Becket
Bridge House

Local
Therapists

PARC

Pemi Baker
NANA
N. County VNA
CADY
Transport Center
Home Delivery Meals
Tri-County Cap
ServiceLink
Whole Village
2-1-1
Tapply Town Center
LRCS

SAU 48 & 4
PSU
EMS & PD
Town offices-
welfare

Speare Primary
Speare
Pediatrics
MidState
Speare OB/GYN
Dentists
New Found
Family Practice

Grafton
County Jail

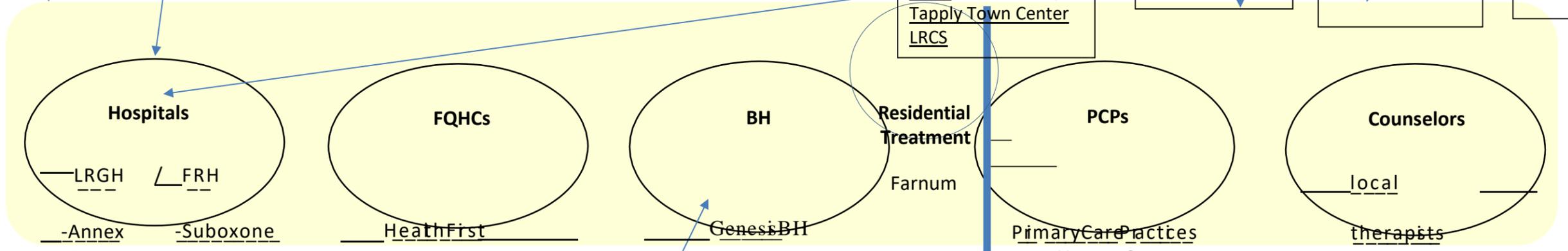
3.
What entity or person could recommend Aster for this Project's service?

Vertical full two-way sharing across all #4. providers; client-specific based on where seen

4.
Identify what entities will provide the Project's service(s) and their corporate affiliation, if any.

5.
Identify where Aster

could go next after "completing" the Project's service(s).



Hospitals: LRGH, FRH, -Annex, -ER, -Suboxone
FQHCs: Suboxone, DRF, HealthFirst, MidState Bristol
BH: Genesis BH, Riverbend, Horizons
Residential Treatment: Farnum
PCPs: Primary Care Practices, Urgent Care, Veteran's Administrations
Counselors: local therapists

Transportation
Food
State symbol = limited
Corrections Only agencies within
Community Agencies our IDN
Housing Plymouth Community Closet
County/town Services Town Welfare office Grafton county Sr. Citizens Council Schools
Recovery Supports PARC
PCPs DCYF DHHS

Star limited s within

County Dept.

NA
Sponsors
meeting
ServiceLin
k Family
ResourcHo
me visiting

Local
Housi
ng
Author
ity

Speare Primary
Speare
Pediatrics
MidState _
Speare OB/GYN

TOTAL TRAINING NUMBERS

C2 Community Re-entry for Justice-Involved Adults and Youth

Project	Topic/subject	BH clinicians LICSW, clinical psychologists, masters level	SUD counselor MLADC, LAC/MC/MAC/MCAL	Re-entry Case Manager	Recovery support worker/coach	BH Peer Support	Health Coach, Community Health benefit navigator, financial coach, assistant	HIT/Data collection	Individual at Correctional	Probation officers, probation officers	Defense Bar and non-direct care staff, probation, family support, etc.
All	DSRIP 101- Introduction to the 1115 waiver	6	11	6	7	2	2	4			4
All	Privacy and Confidentiality: CFR 42 part 2, HIPPA	6	11	8	7	3	3	4			4
All	Outcome Metrics & data collection		6	4	7		3				1
All	CMT shared care plans, event notification	6	11	4	7						
All	Data aggregator trainings						4				1
B1, C2, D3, E5	Trauma Informed treatment	6	11	7	7	3		4			4
B1, C2, D3, E5	Co-occurring disorders	6	11	7	7			4			4
A1, B1, C2, D3, E5	Recognition of other providers roles	6	11	7	7		2	4			4
B1, C2, D3, E5	Motivational Interviewing	6	11	7	7	1					4
B1, C2, D3, E5	Suicide prevention	6	11	9	7	2		4			4
B1, C2, D3, E5	Ethical competency	6	11	3	7			4			4
B1, C2, D3, E5	MH First Aid (non-clinicians)			3	7	1					4
B1, C2, D3, E5	Cultural Competency	6	11	9	7			4			4
B1, C2, D3, E5	Basic training on Addiction & Recovery	6	11	9	7						4
B1, C2, D3, E5	Home visit safety			1							4
B1, C2, D3, E5	Best practices in care transitions	6	11	4	7						4
C2, D3	HIV, Hep C, STDs	6	11	6	7						4

Project Key-

- A1 Behavioral Health Workforce Capacity Development
- A2 Health Information Technology (HIT) to Support Integration
- B1 Integrated Healthcare
- C2 Community Re-entry for Justice Involved Adults and Youth
- D3 Expansion in Intensive SUD Treatment Options
- E5 Enhanced Care Coordination for High-Need Populations

Horizons

C2 Community Re-entry for Justice-Involved Adults and Youth

Project	Topic/subject	BH clinicians, clinical psychologists, SUD counselor, LCMHC, LSW, masters level	Re-entry Case Manager	Recovery support worker/coach	BH Peer support	benefit avigator, case manager	HIT/Data collections	Correction Officers	Parole officers, Probation	Defense Bar and Prosecution
All	DSRIP 101- Introduction to the 1115 waiver	6	3			1				
All	Privacy and Confidentiality: CFR 42 part 2, HIPPA	6	3			1				
All	Outcome Metrics & data collection	6	3			1				
All	CMT shared care plans, event notification	6	3							
All	Data aggregator trainings					1				
B1, C2, D3, E5	Trauma Informed treatment	6	3							
B1, C2, D3, E5	Co-occurring disorders	6	3							
B1, C2, D3, E5	Recognition of other providers roles/Communication & Confidentiality	6	3			1				
B1, C2, D3, E5	Motivational Interviewing	6	3							
B1, C2, D3, E5	Suicide prevention	6	3							
B1, C2, D3, E5	Ethical competency	6	3							
B1, C2, D3, E5	MH First Aid (non-clinicians)									
B1, C2, D3, E5	Cultural Competency	6	3							
B1, C2, D3, E5	Basic training on Addiction & Recovery (non-clinical)	6	3							
B1, C2, D3, E5	Home visit safety									
B1, C2, D3, E5	Best practices in care transitions	6	3							
C2, D3	HIV, Hep C, STDs	6	3							

C2 Community Re-entry for Justice-Involved Adults and Youth

Project	Topic/subject	BH clinicians LICSW, LFMT, LCMHC, psychologists, masters level clinicians	SUD counselor MLADC, LADC, LCMHC, Masters level	Re-entry Care Coordinator, Case manager	Recovery support worker/coach (SUD)	BH Peer support	benefit navigator, financial coordi assistant	HIV/data collections individual at each agency	Correction Officers	Probation officers	Defense Bar and Prosecution
All	DSRIP 101- Introduction to the 1115 waiver			2							
All	Privacy and Confidentiality: CFR 42 part 2, HIPPA			4							
All	Outcome Metrics & data collection										
All	CMT shared care plans, event notification										
All	Data aggregator trainings										
B1, C2, D3, E5	Trauma Informed treatment			3							
B1, C2, D3, E5	Co-occurring disorders			3							
B1, C2, D3, E5	Recognition of other providers roles/Communication & Confidentiality			3							
B1, C2, D3, E5	Motivational Interviewing			3							
B1, C2, D3, E5	Suicide prevention			5							
B1, C2, D3, E5	Ethical competency										
B1, C2, D3, E5	MH First Aid (non-clinicians)			3							
B1, C2, D3, E5	Cultural Competency			5							
B1, C2, D3, E5	Basic training on Addiction & Recovery (non-clinical)			5							
B1, C2, D3, E5	Home visit safety										
B1, C2, D3, E5	Best practices in care transitions										
C2, D3	HIV, Hep C, STDs			2							

C2 Community Re-entry for Justice-Involved Adults and Youth

Project	Topic/subject	BH clinicians LICSW, LFMFT, psychologists, marriage and family therapists, clinical social workers	SUD counselor MLADC, LADC, Master's level clinicians	Re-entry Care Coordinator, Case manager	Recovery support worker/coach (SUD)	BH Peer support benefit navigator	HIT/Data collector, financial coordinator	Correction agency	Juvenile officers, probation officers	Defense Bar and Prosecution
All	DSRIP 101- Introduction to the 1115 waiver							4		
All	Privacy and Confidentiality: CFR 42 part 2, HIPPA							4		
All	Outcome Metrics & data collection									
All	CMT shared care plans, event notification									
All	Data aggregator trainings									
B1, C2, D3, E5	Trauma Informed treatment							4		
B1, C2, D3, E5	Co-occurring disorders							4		
B1, C2, D3, E5	Recognition of other providers roles/Communication & Confidentiality							4		
B1, C2, D3, E5	Motivational Interviewing									
B1, C2, D3, E5	Suicide prevention							4		
B1, C2, D3, E5	Ethical competency							4		
B1, C2, D3, E5	MH First Aid (non-clinicians)									
B1, C2, D3, E5	Cultural Competency							4		
B1, C2, D3, E5	Basic training on Addiction & Recovery (non-clinical)									
B1, C2, D3, E5	Home visit safety									
B1, C2, D3, E5	Best practices in care transitions									
C2, D3	HIV, Hep C, STDs									

C2 Community Re-entry for Justice-Involved Adults and Youth

Project	Topic/subject	BH clinicians psychiatrists, psychologists, clinical social workers, nurses	BH clinicians LCSW, LFMT, MA, CMC, etc.	SUD counselor MLADC, LADC, CMT, etc.	Recovery Care Coordinator, Case manager	BH Peer support worker/coach	Peer navigator, financial coach	IT/Data collections	Correction agency	Juvenile officers, probation officers	Defense Bar and Prosecution
All	DSRIP 101- Introduction to the 1115 waiver	1	1								
All	Privacy and Confidentiality: CFR 42 part 2, HIPPA	1	1								
All	Outcome Metrics & data collection										
All	CMT shared care plans, event notification	1	1								
All	Data aggregator trainings						1				
B1, C2, D3, E5	Trauma Informed treatment	1									
B1, C2, D3, E5	Co-occurring disorders	1	1								
B1, C2, D3, E5	Recognition of other providers roles/Communication & Confidentiality	1	1								
B1, C2, D3, E5	Motivational Interviewing	1	1								
B1, C2, D3, E5	Suicide prevention	1	1								
B1, C2, D3, E5	Ethical competency	1	1								
B1, C2, D3, E5	MH First Aid (non-clinicians)										
B1, C2, D3, E5	Cultural Competency	1	1								
B1, C2, D3, E5	Basic training on Addiction & Recovery (non-clinical)	1	1								
B1, C2, D3, E5	Home visit safety		1								
B1, C2, D3, E5	Best practices in care transitions	1	1								
C2, D3	HIV, Hep C, STDs	1	1								

C2 Community Re-entry for Justice-Involved Adults and Youth

Project	Topic/subject	BH clinicians clinicians	LCSW, LFMFT, Magist, masters level	UD counselor MLADC, LCSW, LMSW, masters level	Re-entry Care Coordinator, Case worker/coach	Recovery support worker/coach	BH Peer support	benefit navigator, financial coordinator	HIT/Data collections agency	Individual at Correction Officers	Parole officers, probation officers	Defense Bar and Prosecution
All	DSRIP 101- Introduction to the 1115 waiver	5	5					12	1			
All	Privacy and Confidentiality: CFR 42 part 2, HIPPA	5	5	16					1			
All	Outcome Metrics & data collection			16								
All	CMT shared care plans, event notification	5	5	16								
All	Data aggregator trainings							1				
B1, C2, D3, E5	Trauma Informed treatment	5	5	16								
B1, C2, D3, E5	Co-occurring disorders	5	5	16								
B1, C2, D3, E5	Recognition of other providers roles	5	5	16								
B1, C2, D3, E5	Motivational Interviewing	5	5	16								
B1, C2, D3, E5	Suicide prevention	5	5	16								
B1, C2, D3, E5	Ethical competency	5	5	16								
B1, C2, D3, E5	MH First Aid (non-clinicians)											
B1, C2, D3, E5	Cultural Competency	5	5	16								
B1, C2, D3, E5	Basic training on Addiction & Recovery (non-clinical)	5	5	16								
B1, C2, D3, E5	Home visit safety											
B1, C2, D3, E5	Best practices in care transitions	5	5	16								
C2, D3	HIV, Hep C, STDs	5	5	16								

C2 Community Re-entry for Justice-Involved Adults and Youth

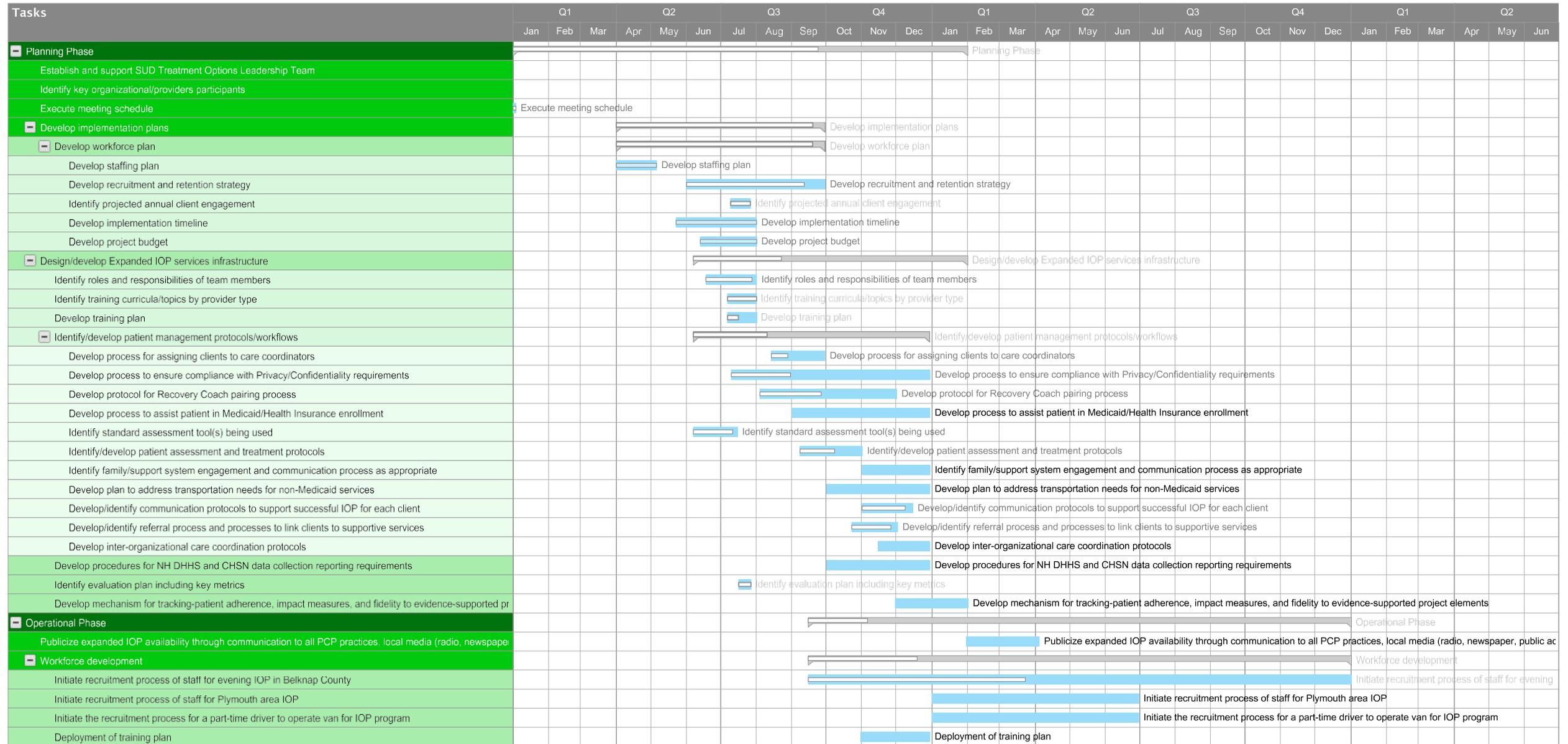
Project	Topic/subject	BA clinicians, LICSW, LHMHA, LCSW, masters level	SUD counselor, LICSW, MEd, MHC, clinicians	Re-entry Care Coordinator	Recovery Support Worker/coach (SUD)	BA Peer Support	Benefit navigator, financial coach, assistant	HIV/Data collection coordinator	Correctional Officers	Parole officers, probation officers	Defense Bar and Prosecution
All	DSRIP 101- Introduction to the 1115 waiver				7 (same staff as other projects)		1				
All	Privacy and Confidentiality: CFR 42 part 2, HIPPA				7 (same staff as other projects)		2				
All	Outcome Metrics & data collection				7 (same staff as other projects)		2				
All	CMT shared care plans, event notification				7 (same staff as other projects)						
All	Data aggregator trainings						2				
B1, C2, D3, E5	Trauma Informed treatment				7 (same staff as other projects)						
B1, C2, D3, E5	Co-occurring disorders				7 (same staff as other projects)						
B1, C2, D3, E5	Recognition of other providers roles/Communication & Confidentiality				7 (same staff as other projects)		1				
B1, C2, D3, E5	Motivational Interviewing				7 (same staff as other projects)						
B1, C2, D3, E5	Suicide prevention				7 (same staff as other projects)						
B1, C2, D3, E5	Ethical competency				7 (same staff as other projects)						
B1, C2, D3, E5	MH First Aid (non-clinicians)				7 (same staff as other projects)						
B1, C2, D3, E5	Cultural Competency				7 (same staff as other projects)						
B1, C2, D3, E5	Basic training on Addiction & Recovery (non-clinical)				7 (same staff as other projects)						
B1, C2, D3, E5	Home visit safety										
B1, C2, D3, E5	Best practices in care transitions				7 (same staff as other projects)						
C2, D3	HIV, Hep C, STDs				7 (same staff as other projects)						

C2 Community Re-entry for Justice-Involved Adults and Youth

Project	Topic/subject	BH clinicians clinicians	LCSW, LFMFT, Masters level	MSUD counselor MLADC, Masters level	Re-entry Care Coordinator, Case worker/coach	BH Peer support	benefit navigator, financial coordinator	HIT/Data collections agency	Correction Officers	Parole officers, probation officers	Defense Bar and Prosecution
All	DSRIP 101- Introduction to the 1115 waiver	5	5				12	1			
All	Privacy and Confidentiality: CFR 42 part 2, HIPPA	5	5	16				1			
All	Outcome Metrics & data collection			16							
All	CMT shared care plans, event notification	5	5	16							
All	Data aggregator trainings						1				
B1, C2, D3, E5	Trauma Informed treatment	5	5	16							
B1, C2, D3, E5	Co-occurring disorders	5	5	16							
B1, C2, D3, E5	Recognition of other providers roles	5	5	16							
B1, C2, D3, E5	Motivational Interviewing	5	5	16							
B1, C2, D3, E5	Suicide prevention	5	5	16							
B1, C2, D3, E5	Ethical competency	5	5	16							
B1, C2, D3, E5	MH First Aid (non-clinicians)										
B1, C2, D3, E5	Cultural Competency	5	5	16							
B1, C2, D3, E5	Basic training on Addiction & Recovery (non-clinical)	5	5	16							
B1, C2, D3, E5	Home visit safety										
B1, C2, D3, E5	Best practices in care transitions	5	5	16							
C2, D3	HIV, Hep C, STDs	5	5	16							

D3 Expansion in IOP (IDN 5)

Attachment_D.1A



Attachment_D.1B

TOTAL TRAINING NUMBERS

D3 Expansion in Intensive SUD Treatment Options Trainings by provider type

Project	Topic/subject	Primary Care MD, NP, PA, BH clinicians	LICSW, LPMFT, counselors, clinicians	SUD counselor MLADC, LADC, LICSW, MHCs level	Care Coordinator/Case manager (RN and no)	Recovery support worker/coach (SUD)	BH Peer support	Admissions/Pre-screener	non-direct care staff/program recep/transport van driver, etc.	benefit navigator, financial coordi	HTU/Data collections individual at each	Billing non-hospital	Billing hospital based
All	DSRIP 101- Introduction to the 1115 waiver		9	22	10		1					8	8
All	Privacy and liability: CFR 42 part 2, HIPPA		4	22	10		1					8	8
All	Outcome Metrics & data collection		4	22	7					2			
All	CMT shared care plans, event notification		4	22	7								
All	Data aggregator trainings												
B1, C2, D3, E5	Co-occurring disorders	5	4	20									
A1, B1, C2, D3, E5	Understanding of Provider roles		4	22	3	2	1					8	8
B1, D3, E5	Natural Supports training, Strengths based approach			22	7								
B1, C2, D3, E5	Motivational Interviewing		4	24	7								
B1, C2, D3, E5	Suicide prevention	10	4	18	10	2	1						
B1, D3, E5	Narcan Awareness	10	4	5	10	2	1						
B1, C2, D3, E5	Ethical competency		4	22	3	1							
B1, C2, D3, E5	MH First Aid (non-clinicians)				3	1							
B1, C2, D3, E5	Cultural Competency		4	22	10	1							
B1, C2, D3, E5	Basic training on Addiction & Recovery			20	10								
B1, C2, D3, E5	Home visit safety			18									
B1, C2, D3, E5	Trauma informed treatment		4	21	7								
D3	Addiction Severity Index	5	4										
B1, E5, C2, D3	Best practices in care transitions			21									
C2, D3	HIV, Hep C, STDs		4	21	10								

D3 Expansion in Intensive SUD Treatment Options Trainings by provider type

Project	Topic/subject	BH clinicians, LCSW, LEMT, psychologists, counselors	MLADC, LADC, LSW, MHCs level 1	Re-entry Care Coordinator, Case Manager	Recovery support worker/coach (SUD)	BH Peer Support	Health Coach, Community Worker	Substance Abuse Treatment Staff	Staff navigator, financial counselor	Data collection individual at each	Correction Officers	Probation officers	Defense Bar and Prosecution
All	DSRIP 101- Introduction to the 1115 waiver					2							
All	Privacy and Confidentiality: CFR 42 part 2, HIPPA					3							
All	Outcome Metrics & data collection												
All	CMT shared care plans, event notification												
All	Data aggregator trainings												
B1, C2, D3, E5	Trauma Informed treatment					3							
B1, C2, D3, E5	Co-occurring disorders												
B1, C2, D3, E5	Recognition of other providers roles/Communication & Confidentiality												
B1, C2, D3, E5	Motivational Interviewing					1							
B1, C2, D3, E5	Suicide prevention					2							
B1, C2, D3, E5	Ethical competency												
B1, C2, D3, E5	MH First Aid (non-clinicians)					1							
B1, C2, D3, E5	Cultural Competency												
B1, C2, D3, E5	Basic training on Addiction & Recovery (non-clinical)												
B1, C2, D3, E5	Home visit safety												
B1, C2, D3, E5	Best practices in care transitions												
C2, D3	HIV, Hep C, STDs												

D3 Expansion in Intensive SUD Treatment Options Trainings by provider type

Project	Topic/subject	Primary Care MD, NP, PA BH clinicians LICSW, LEMT, LCMHC, psychologists/therapists clinicians	SUD counselor MLADC, LADC, LICSW, MHCs level EMTs/paramedics Care Coordinator/Case manager (RN and and)	Recovery support worker/coach (SUD)	BH Peer Support	Admissions/Pre- screener non-direct care staff/program receptionist etc.	benefit navigator, financial coordinator, driver, etc.	HIT/Data ag	Billing non- hospital based	Billing hospital based
All	DSRIP 101- Introduction to the 1115 waiver		2							
All	Privacy and liability: CFR 42 part 2		2							
All	Outcome Metrics & data collection		2				2			
All	CMT shared care plans, event notification		2							
All	Data aggregator trainings									
B1, C2, D3, E5	Childhood trauma		2							
B1, C2, D3, E5	Co-occurring disorders (clinical)	5								
B1, C2, D3, E5	Recognition of other providers roles/Communication & Confidentiality		2		1	1				
B1, C2, D3, E5	Natural Supports training, Strengths based approach		2							
B1, C2, D3, E5	Motivational Interviewing		4							
B1, C2, D3, E5	Suicide prevention (clinical)	10								
B1, C2, D3, E5	Suicide prevention (non-clinical)				1	1				
B1, C2, D3, E5	Narcan Administration	10	5		1	1				
B1, C2, D3, E5	Ethical competency		2							
B1, C2, D3, E5	MH First Aid									
B1, C2, D3, E5	Cultural Competency		2							
B1, C2, D3, E5	Challenges of coding									
B1, C2, D3, E5	Basic training on Addiction & Recovery (non- clinical)		2							
B1, C2, D3, E5	Home visit safety									
B1, D3, E5	Trauma informed treatment (clinical)		2							
B1, D3, E5	Addiction Severity Index	5								
B1, E5, D3	Best practices in care transitions		2							
C2, D3, E5	HIV, Hep C, STDs									

D3 Expansion in Intensive SUD Treatment Options Trainings by provider type

Project	Topic/subject	BH clinicians LICSW, LEMT, psychologists, LCMHC, clinicians	SUD counselor MLADC, LADC, LCMHC, Masters level clinicians	Re-entry Care Coordinator, Case manager	Recovery support worker/coach (SUD)	BH Peer support	benefit navigator, financial coordinator	HIT/Data collections, financial agency	Correction Officers individual at each agency	Juvenile officers, probation officers	Defense Bar and Prosecution
All	DSRIP 101- Introduction to the 1115 waiver				1						
All	Privacy and Confidentiality: CFR 42 part 2, HIPPA				1						
All	Outcome Metrics & data collection				1						
All	CMT shared care plans, event notification				1						
All	Data aggregator trainings										
B1, C2, D3, E5	Trauma Informed treatment				1						
B1, C2, D3, E5	Co-occurring disorders				1						
B1, C2, D3, E5	Recognition of other providers roles/Communication & Confidentiality				1						
B1, C2, D3, E5	Motivational Interviewing				1						
B1, C2, D3, E5	Suicide prevention				1						
B1, C2, D3, E5	Ethical competency				1						
B1, C2, D3, E5	MH First Aid (non-clinicians)				1						
B1, C2, D3, E5	Cultural Competency				1						
B1, C2, D3, E5	Basic training on Addiction & Recovery (non-clinical)				1						
B1, C2, D3, E5	Home visit safety										
B1, C2, D3, E5	Best practices in care transitions				1						
C2, D3	HIV, Hep C, STDs				1						

D3 Expansion in Intensive SUD Treatment Options Trainings by provider type

Project	Topic/subject	Primary Care MD, NP, PA, BH clinicians	LCSW, LMFT, clinical social workers, clinical psychologists	SUD counselor MLADC, LADC, LCSW, MHCs clinicians	Care Coordinator/Case manager (RN and no)	Recovery support worker/coach (SUD)	BH Peer support	Admissions/Pre-screener non-direct care staff/program receptionist, driver, etc.	benefit navigator, financial coordi assistant	IT/Data collections individual at each	Billing non-hospital based
All	DSRIP 101- Introduction to the 1115 waiver					2					
All	Privacy and liability: CFR 42 part 2					2					
All	Outcome Metrics & data collection										
All	CMT shared care plans, event notification										
All	Data aggregator trainings										
B1, C2, D3, ES	Childhood trauma					2					
B1, C2, D3, ES	Co-occurring disorders (clinical)					2					
B1, C2, D3, ES	Recognition of other providers roles/Communication & Confidentiality					2					
B1, C2, D3, ES	Natural Supports training, Strengths based approach					2					
B1, C2, D3, ES	Motivational Interviewing										
B1, C2, D3, ES	Suicide prevention (clinical)					2					
B1, C2, D3, ES	Suicide prevention (non-clinical)					2					
B1, C2, D3, ES	Narcan Administration					2					
B1, C2, D3, ES	Ethical competency					2					
B1, C2, D3, ES	MH First Aid					2					
B1, C2, D3, ES	Cultural Competency					2					
B1, C2, D3, ES	Challenges of coding										
B1, C2, D3, ES	Basic training on Addiction & Recovery (non-clinical)					2					
B1, C2, D3, ES	Home visit safety										
B1, D3, ES	Trauma informed treatment (clinical)										
B1, D3, ES	Addiction Severity Index										
B1, E5, D3	Best practices in care transitions										
C2, D3, ES	HIV, Hep C, STDs					2					

D3 Expansion in Intensive SUD Treatment Options Trainings by provider type

Project	Topic/subject	Primary Care MD, NP, PA	BH clinicians LICSW, clinical psychologists, masters level	SUD counselor MLADC, LICSW, MA, etc.	Care Coordinator/Case manager (RN and non)	Recovery support worker/coach (SUD)	BH Peer support	Admissions/Pre-screener	non-direct care staff/program receptionist-van driver, etc.	benefit navigator, financial coordinator	HIT/Data collections individual at each	Billing non-hospital based
All	DSRIP 101- Introduction to the 1115 waiver			10-1	1	3		1			1	
All	Privacy and liability: CFR 42 part 2			10-6	1	3		1			1	
All	Outcome Metrics & data collection			10-6	1						1	
All	CMT shared care plans, event notification			10-6	1						1	
All	Data aggregator trainings											
B1, C2, D3, E5	Co-occurring disorders			10-6	1							
B1, C2, D3, E5	Understanding of other providers roles			10-6	1	3		1			1	
B1, C2, D3, E5	Natural Supports training, Strengths based approach											
B1, C2, D3, E5	Motivational Interviewing			10-6	1							
B1, C2, D3, E5	Suicide Prevention			10-6	1	3						
B1, C2, D3, E5	Narcan Awareness			10-6	1	3		1			1	
B1, C2, D3, E5	Ethical competency			10-6	1	3		1				
B1, C2, D3, E5	MH First Aid					3		1				
B1, C2, D3, E5	Cultural Competency			10-6	1	3		1				
B1, C2, D3, E5	Challenges of coding										1	
B1, C2, D3, E5	Basic Training on Addiction and Recovery					3						
B1, C2, D3, E5	Home visit safety											
B1, D3, E5	Trauma Informed Treatment			10-6	1							
B1, D3, E5	Addiction Severity Index			10-6								
B1, E5, D3	Best practices in care transitions				1							
C2, D3, E5	HIV, Hep C, STDs			10-6	1	3						

D3 Expansion in Intensive SUD Treatment Options Trainings by provider type

Project	Topic/subject	25	Primary Care MD, NP, PA, BH clinicians LICSW, LFMFT, psychologists, clinical level clinicians	4	SUD counselor MLADC, LADC, Master's level clinicians	16	Care Coordinator/Case manager (RN and non-)	Recovery support worker/coach (SUD)	BH Peer support	Admissions/Pre-screener non-direct care staff/program receptionist/program driver, etc.	benefit navigator, financial coordi assistant	HIT/Data aggregator	Billing non-hospital	Billing individual at hospital	Billing hospital based
All	DSRIP 101- Introduction to the 1115 waiver	25		4	16						8	1	8	8	
All	Privacy and liability: CFR 42 part 2	25		4	16						8	1	8	8	
All	Outcome Metrics & data collection	25		4	16							1			
All	CMT shared care plans, event notification	25		4	16							1			
All	Data aggregator trainings											1			
B1, C2, D3, E5	Co-occurring disorders	25		4	16										
B1, C2, D3, E5	Recognition of other providers roles	25		4	16						8	1	8	8	
B1, C2, D3, E5	Natural Supports training, Strengths based approach	25		4	16										
B1, C2, D3, E5	Motivational Interviewing	25		4	16										
B1, C2, D3, E5	Suicide prevention	25		4	16										
B1, C2, D3, E5	Narcan Awareness	25													
B1, C2, D3, E5	Ethical competency	25		4	16										
B1, C2, D3, E5	MH First Aid														
B1, C2, D3, E5	Cultural Competency	25		4	16										
B1, C2, D3, E5	Basic training on Addiction & Recovery (non-clinical)	25		4	16										
B1, C2, D3, E5	Home visit safety				16										
B1, D3, E5	Trauma informed treatment	25		4	16										
B1, D3, E5	Addiction Severity Index			4											
B1, E5, D3	Best practices in care transitions				16										
C2, D3, E5	HIV, Hep C, STDs	25		4	16										

E5 Enhanced Care Coordination (IDN 5)

Attachment_E.1A

Tasks	Q2			Q3			Q4			Q1			Q2			Q3			Q4		
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Planning Phase	Planning Phase																				
Establish and support Enhanced Care Coordination Leadership Team																					
Identify key organizational/providers participants																					
Execute meeting schedule																					
Research care coordination models from other states	Research care coordination models from other states																				
Develop Implementation Plans	Develop Implementation Plans																				
Develop workforce plan for Multi- disciplinary Care Coordination Teams	Develop workforce plan for Multi- disciplinary Care Coordination Teams																				
Identify workforce gap (refer to A1-7) and baselines assessment	Identify workforce gap (refer to A1-7) and baselines assessment																				
Develop staffing plan	Develop staffing plan																				
Identify recruitment and retention strategy	Identify recruitment and retention strategy																				
Identify projected annual client engagement	Identify projected annual client engagement																				
Develop implementation timelines	Develop implementation timelines																				
Develop project budget	Develop project budget																				
Design/develop Care Coordination and clinical services infrastructure	Design/develop Care Coordination and clinical services infrastructure																				
Identify/develop roles/ responsibilities of team members	Identify/develop roles/ responsibilities of team members																				
Develop job description for Care Coordinator	Develop job description for Care Coordinator																				
Develop job description for Coordinated Care Team Leader	Develop job description for Coordinated Care Team Leader																				
Develop training curricula by provider type	Develop training curricula by provider type																				
Identify training plan	Identify training plan																				
Identify standard set of care coordinator knowledge and skills requirements	Identify standard set of care coordinator knowledge and skills requirements																				
Identify qualified training resources for care coordinators	Identify qualified training resources for care coordinators																				
Develop process to educate key stakeholders on NH BoMedicine Opioid Prescribing tools and guidelines	Develop process to educate key stakeholders on NH BoMedicine Opioid Prescribing tools and guidelines																				
Develop eligibility criteria for enrollment in Care Coordination team, including rationale for intervention with this target pop. th	Develop eligibility criteria for enrollment in Care Coordination team, including rationale for intervention with this target pop. th																				
Identify/develop care coordination team model/workflows	Identify/develop care coordination team model/workflows																				
Identify method for engaging target population in community delivered care and/or self-management strategies	Identify method for engaging target population in community delivered care and/or self-management strategies																				
Develop process for assigning care coordinators to individual client	Develop process for assigning care coordinators to individual client																				
Establish caseload parameter and discharge criteria	Establish caseload parameter and discharge criteria																				
Develop process to ensure compliance with Privacy/Confidentiality requirements	Develop process to ensure compliance with Privacy/Confidentiality requirements																				
Develop legal documents for sharing patient health information	Develop legal documents for sharing patient health information																				
Develop process to assist patient in Medicaid/Health Insurance enrollment	Develop process to assist patient in Medicaid/Health Insurance enrollment																				
Identify standard assessment tool(s) and procss being used	Identify standard assessment tool(s) and procss being used																				

Tasks	Q2			Q3			Q4			Q1			Q2			Q3			Q4		
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Identify by agency current assessments used and gaps for DSRIP				Identify by agency current assessments used and gaps for DSRIP																	
Develop/identify Comprehensive Core Standardized Assessments (10 domains) process				Develop/identify Comprehensive Core Standardized Assessments (10 domains) process																	
Review results from Self Site Assessment				Review results from Self Site Assessment																	
Identify process for family/support system engagement and communication as appropriate				Identify process for family/support system engagement and communication as appropriate																	
Develop/identify referral process and processes to link clients to supportive services				Develop/identify referral process and processes to link clients to supportive services																	
Develop inter-organizational care coordination protocols				Develop inter-organizational care coordination protocols																	
Develop standardized procedures for case conferencing				Develop standardized procedures for case conferencing																	
Develop procedures for NH DHHS and CHSN data collection reporting requirements				Develop procedures for NH DHHS and CHSN data collection reporting requirements																	
Identify evaluation plan including key metrics				Identify evaluation plan including key metrics																	
Secure MOU agreements with participating agencies including community-based social supports				Secure MOU agreements with participating agencies including community-based social supports																	
- Develop evaluation plan				Develop evaluation plan																	
Identify evaluation plan including key metrics (e.g. number of successful linkages to social support services, change in				Identify evaluation plan including key metrics (e.g. number of successful linkages to social support services, change in																	
Review Matrix of key metric requirements and reporting dates				Review Matrix of key metric requirements and reporting dates																	
Develop mechanism for tracking- patient adherence, impact measures, and fidelity to evidenced-supported project ele				Develop mechanism for tracking- patient adherence, impact measures, and fidelity to evidenced-supported project ele																	
1:1 Operational Phase													Operational Phase								
1:1 Workforce Development													Workforce Development								
Initiate recruitment process for care coordinators				Initiate recruitment process for care coordinators																	
Initiate recruitment process for Coordinated Care Team Leader				Initiate recruitment process for Coordinated Care Team Leader																	
Initiate other staff for care coordination team (e.g. van driver)				Initiate other staff for care coordination team (e.g. van driver)																	
Deployment of training plan				Deployment of training plan																	
Hold a mock wrap around meeting for CC team				Hold a mock wrap around meeting for CC team																	
1:1 Initiation of Care Coordination Model in Laconia													Initiation of Care Coordination Model in Laconia								
Use of assessment, treatment, management, referral protocols				Use of assessment, treatment, management, referral protocols																	
Implementation of any required updates to clinical protocols or other operating policies/procedures				Implementation of any required updates to clinical protocols or other operating policies/procedures																	
1:1 Initiate evaluation process for Laconia				Initiate evaluation process for Laconia																	
- Implement procedures for data collection and sharing				Implement procedures for data collection and sharing																	
Collect number of individuals served vs. projected (for reporting period & cumulative)				Collect number of individuals served vs. projected (for reporting period & cumulative)																	
Collect number of staff recruited and trained vs. projected (for reporting period & cumulative)				Collect number of staff recruited and trained vs. projected (for reporting period & cumulative)																	
Collect data on impact measures as defined in evaluation plan-including annual evaluation of fidelity to evidenced-sup				Collect data on impact measures as defined in evaluation plan-including annual evaluation of fidelity to evidenced-sup																	
Implement NH DHHS and CHSN data collection and reporting requirements				Implement NH DHHS and CHSN data collection and reporting requirements																	
1:1 Reporting Period Jan-Jun 2018													Reporting Period Jan-Jun 2018								
1:1 Initiation of care coordination model in Plymouth and Franklin													Initiation of care coordination model in Plymouth								
Use of assessment, treatment, management, referral protocols				Use of assessment, treatment, management, referral protocols																	
Implementation of any required updates to clinical protocols or other operating policies/procedures				Implementation of any required updates to clinical protocols or other operating policies/procedures																	
1:1 Initiate evaluation process for Plymouth and Franklin				Initiate evaluation process for Plymouth and Franklin																	
1:1 Implement procedures for data collection and sharing				Implement procedures for data collection and sharing																	
Collect number of individuals served vs. projected (for reporting period & cumulative)				Collect number of individuals served vs. projected (for reporting period & cumulative)																	

Tasks	Q2			Q3			Q4			Q1			Q2			Q3			Q4			
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
Collect number of staff recruited and trained vs. projected (for reporting period & cumulative)																						
Collect data on impact measures as defined in evaluation plan-including annual evaluation of fidelity to evidenced-sup																						
Implement NH DHHS and CHSN data collection and reporting requirements																						
CI Ongoing data reporting																						
Collect number of individuals served vs. projected (for reporting period & cumulative)																						
Collect number of staff recruited and trained vs. projected (for reporting period & cumulative)																						
Collect staff vacancy and turnover rate for period & cumulative vs. projected																						
Collect data on impact measures as defined in evaluation plan																						
CI Reporting Perrod Jul-Dec 2018																						
CI Ongoing data reporting																						
Collect umber of individuals served vs. projected (for reporting period & cumulative)																						
Collect number of staff recruited and trained vs. projected (for reporting period & cumulative)																						
Collect staff vacancy and turnover rate for period and cumulative vs. projected																						
Collect data on impact measures as defined in evaluation plan, including annual evaluation of fidelity to evidenced-support																						
Evaluation of data and																						
CI Sustainability Plan																						
Initiate the development of the long range sustainability Plan																						

E5 Enhanced Care Coordination for High Needs Populations

Project	Topic/subject	Primary Care MD, NP, PA, Pediatric care providers, BH practitioners, BH clinician- Psychiatric, ARNP clinical Licensure, LICSW, LFMFT, clinicians, MM, MHC, masters, Case Manager, CADC, (RN) coordinator/Case manager, ED staff RN, Medic, Healthcoach, Peer, NP, PA, Primary care MD, BH Peer care RN, Support, Home care staff- RN, LNA, PCA, Community Health, Benefit Health assessment, Admissions navigator, screener, non-direct staff/Program staff, HIT/Data analyst, van driver, etc. individual @ Billing hospital based Billing non-hospital																	
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
All	DSRIP 101- Introduction to the 1115 waiver	36	12		5	39	66	22	48	9	12		16	2	31	3	6	7	
All	Privacy and liability: CFR 42 part 2, HIPPA	36	12		5	27	66	22	48	9	12		16	2	31	3	6	7	
All	Outcome Metrics & data collection	11	7		5	27	26	7	23	7	5		4	2	31	5	6	7	
All	CMT shared care plans, event notification	36	12		5	27	66	22	48	9	9					3			
All	Data aggregator trainings															2			
B1, E5	Treatment planning	11	7		5	29	26	7	23	7	20								
B1, E5	The Basics of Medicaid					27				2	20								
A1, B1, E5	New opioid prescribing regulations, chronic pain and opioids	36	12					22			20								
A1, B1, E5	Patient Centered care	36	12		5	24	66	22	48	7	20			2					
A1, B1, C2, D3, E5	Referral Process and Understanding Provider roles	30	12			27	66	22	35	9	20			1	4				
A1, B1, E5	Interpersonal communication/sensitivity and stigma training/reflective listening	30	12		1	24	26	22	35	9	52		14	2	20				
B1, D3, E5	Natural supports training, Strengths based approach				5	21				9	20								
B1, C2, D3, E5	Suicide prevention	30	12		15	24	66	22	48	9	28		16	3	21				
B1, E5	Best practices in care transitions					25				9	20								
B1, C2, D3, E5	Co-occurring disorders	36	12		10	24	66	22	48		20		16	2	20				
B1, C2, D3, E5	Ethical competency	36	12		5	26	66	22	48	9	54			2					
B1, C2, D3, E5	MH First Aid (non-clinicians)					23				9	6		16	2	20			2	
B1, C2, D3, E5	Cultural Competency	31	5		5	26	40	22	43	9	52		15	2	31			2	
B1, C2, D3, E5	Basic Training on Addiction & Recovery	25	5			25				2	8		14	2					
B1, D3, E5	Narcan Awareness	25	5		11	22	40	15	35	7	28		14	3	21	2	1	2	
B1, C2, D3, E5	Trauma informed treatment	30	12		1	19		22			50								
B1, C2, D3, E5	Home visit safety				1	36				2	24								
B1, C2, D3, E5	Motivational interviewing	25	5		1	6	40	15	25	7	50								
B1, E5	Targeted Care Planning (R49)					24					20								
E5	CC team model- Intake procedures, workflows, available resources, roles and responsibilities, crisis management					29				2	26								
E5	CC team model- case conferencing, assignment of cases, how to relay system issues					29				2	26								
E5	Understanding law enforcement and EMS protocols					26				2	20								

E5 and D3 Training Matrix by provider type

Project	Topic/subject	Primary Care MD, BH clinicians psychiatrists MHC clinicians	SUD counselor MLADC, LADC, MLC Care Coordinator (RN)	Recovery support worker/coach (SUD)	BH Peer support	Admissions/Pre- screener non-direct care staff/program receptionist/driver, etc.	benefit navigator, financial coordinator/assistant ag	MHI/Data collections individual at each Billing non- hospital Billing hospital based
All	DSRIP 101- Introduction to the 1115 waiver			2				
All	Privacy and liability: CFR 42 part 2			2				
All	Outcome Metrics & data collection			2			2	
All	CMT shared care plans, event notification			2				
All	Data aggregator trainings							
B1, C2, D3, E5	Childhood trauma			2				
B1, C2, D3, E5	Co-occurring disorders (clinical)	5						
B1, C2, D3, E5	Recognition of other providers roles/Communication & Confidentiality			2	1	1		
B1, C2, D3, E5	Natural Supports training, Strengths based approach			2				
B1, C2, D3, E5	Motivational Interviewing			4				
B1, C2, D3, E5	Suicide prevention (clinical)	10						
B1, C2, D3, E5	Suicide prevention (non-clinical)				1	1		
B1, C2, D3, E5	Narcan Administration	10		5	1	1		
B1, C2, D3, E5	Ethical competency			2				
B1, C2, D3, E5	MH First Aid							
B1, C2, D3, E5	Cultural Competency			2				
B1, C2, D3, E5	Challenges of coding							
B1, C2, D3, E5	Basic training on Addiction & Recovery (non- clinical)			2				
B1, C2, D3, E5	Home visit safety							
B1, D3, E5	Trauma informed treatment (clinical)			2				
B1, D3, E5	Addiction Severity Index	5						
B1, E5, D3	Best practices in care transitions			2				
C2, D3, E5	HIV, Hep C, STDs							

E5 Enhanced Care Coordination for High Needs Populations

Project	Topic/subject	Primary Care MD.	N/A	Pediatric care	BH providers	BH practitioners	Psychiatrist	Psychologist	LCSW, LPMI, LCMHC	MLADC	Care Coordinator/Case manager (RN and RN)	Healthcare admin	ED/Admit	Tech	ED providers- Medic	N/A	Primary care RN	BH Peer Support	worker	Home care staff- Peer Support	Recovery	PCA	Community Health worker	Benefit/Health coordinator	admission navigator	assistant	Financial	Program support staff- drive	etc.	IT/Data van	receptionist	each	Billing hospital based	Billing non-hospital		
All	DSRIP 101- Introduction to the 1115 waiver	5	7	N/A	N/A			2	26	7	5	N/A	N/A	N/A			1	N/A	N/A			1					1	5	N/A							
All	Privacy and liability: CFR 42 part 2	5	7					2	26	7	5						1										1	5								
All	Outcome Metrics & data collection	5	7					2	26	7	5						1										1	5								
All	CMT shared care plans, event notification	5	7					2	26	7	5																1									
All	Data aggregator trainings																																			
B1, E5	Treatment planning	5	7					1	26	7	5																									
B1, E5	The Basics of Medicaid							1																												
A1, B1, E5	New opioid prescribing regulations, chronic pain and opioids	5	7									7																								
A1, B1, E5	Patient Centered care	5	7					1	26	7	5																									
A1, B1, E5	Referral Process and Provider roles	5	7					2	26	7	5																									
A1, B1, E5	Interpersonal communication/sensitivity and stigma training/reflective listening	5	7					1	26	7	5											1														
B1, C2, D3, E5	Natural supports training, Strengths based approach							1																												
B1, C2, D3, E5	Suicide prevention	5	7					1	26	7	5											1														
B1, C2, D3, E5	Best practices in care transitions																																			
B1, C2, D3, E5	Co-occurring disorders (clinical)	5	7					1	26	7	5											1														
B1, C2, D3, E5	Ethical competency	5	7					1	26	7	5																									
B1, C2, D3, E5	MH First Aid (non-clinicians)																					1														
B1, C2, D3, E5	Cultural Competency	*						1																												
B1, C2, D3, E5	Basic Training on Addiction & Recovery (non-clinical)																					1														
B1, C2, D3, E5	Narcan Awareness							1				5										1														
B1, D3, E5	Trauma informed treatment (clinical)	5	7					1				7																								
B1, D3, E5	Home visit safety							1																												
D3, E5	Motivational interviewing																																			
E5	Targeted Care Planning (R49)							1																												
E5	CC team model- Intake procedures, workflows, available resources, roles and responsibilities, crisis management							1																												
E5	CC team model- case conferencing, assignment of cases, how to relay system issues							1																												
E5	Understanding law enforcement and EMS protocols							1																												

*Already required for SMH employees

E5 Enhanced Care Coordination for High Needs Populations

Project	Topic/subject	Primary Care MD	NP PA	Pediatric care	Behavioral	Psychiatrist	MLA/DC	ADIC	Case manager (RN)	Health coach	ED staff RN, Medic, NP, PA	Primary care MD	BH Peer Support, MA, worker	Home care staff- Peer Recovery	Community Health Worker	Beneficial/Health navigator, assessor	Admissions Pre-Program driver	Program support staff- van	receptionist	Billing hospital	Billing non-hospital
All	DSRIP 101- Introduction to the 1115 waiver	25	5		4	16	40	15	25							12				8	8
All	Privacy and liability: CFR 42 part 2	25	5		4	16	40	15	25							12				8	8
All	Outcome Metrics & data collection				4	16															
All	CMT shared care plans, event notification	25	5		4	16	40	15	25												
All	Data aggregator trainings																				
B1, E5	Treatment planning				4	16															
B1, E5	The Basics of Medicaid				4	16															
A1, B1, E5	New opioid prescribing regulations, chronic pain and opioids	25	5					15													
A1, B1, E5	Patient Centered care	25	5		4	16	40	15	25												
A1, B1, E5	Referral Process and Provider roles	25	5		4	16	40	15	25												
A1, B1, E5	Interpersonal communication/sensitivity and stigma training/reflective listening	25	5		4	16		15	25							12					
B1, C2, D3, E5	Natural supports training, Strengths based approach				4	16															
B1, C2, D3, E5	Suicide prevention	25	5		4	16	40	15	25							12					
B1, C2, D3, E5	Best practices in care transitions					16															
B1, C2, D3, E5	Co-occurring disorders (clinical)	25	5		4	16	40	15	25							12					
B1, C2, D3, E5	Ethical competency	25	5		4	16	40	15	25												
B1, C2, D3, E5	MH First Aid (non-clinicians)					16										12					
B1, C2, D3, E5	Cultural Competency	25	5		4	16	40	15	25							12					8
B1, C2, D3, E5	Basic Training on Addiction & Recovery (non-clinical)	25	5			16										12					
B1, C2, D3, E5	Narcan Awareness	25	5		4	16	40	15	25							12					
B1, D3, E5	Trauma informed treatment (clinical)	25	5		4	16															
B1, D3, E5	Home visit safety				4	16		15													
D3, E5	Motivational interviewing	25	5		4	16	40	15	25												
E5	Targeted Care Planning (R49)					16															
E5	CC team model- Intake procedures, workflows, available resources, roles and responsibilities, crisis management					16															
E5	CC team model- case conferencing, assignment of cases, how to relay system issues					16															
E5	Understanding law enforcement and EMS protocols					16															

E5 and D3 TrainingMatrix

Project	Topic/subject	Primary Care MD, NP, PA	Pediatric care providers	BH Practitioner- Psychiatrist, ARNP	BH clinicians LICSW, LFMT, LADC, etc.	Case manager	ED staff RN, Medic, Tech	ED providers- MD, NP, PA	Primary care RN, MA, LNA	BH Peer Support worker	Peer Support	Home care staff- RN, LNA, PCA	Community Health worker	Benefit/Health navigator, coordinator	Admissions pre- screener	Program support staff- etc. e.g. etc.	receptionist, van @ each	Billing hospital based	Billing non-hospital
All	DSRIP 101- Introduction to the 1115 waiver																		
All	Privacy and liability: CFR 42 part 2																		
All	Outcome Metrics & data collection																		
All	CMT shared care plans, event notification																		
All	Data aggregator trainings																		
B1, E5	Treatment planning																		
B1, E5	The Basics of Medicaid																		
A1, B1, E5	New opioid prescribing regulations, chronic pain and opioids																		
A1, B1, E5	Patient Centered care																		
A1, B1, E5	Referral Process and Provider roles																		
A1, B1, E5	Interpersonal communication/sensitivity and stigma training/reflective listening																		
B1, C2, D3, E5	Natural supports training, Strengths based approach																		
B1, C2, D3, E5	Suicide prevention																		
B1, C2, D3, E5	Best practices in care transitions																		
B1, C2, D3, E5	Co-occurring disorders (clinical)																		
B1, C2, D3, E5	Ethical competency																		
B1, C2, D3, E5	MH First Aid (non-clinicians)																		
B1, C2, D3, E5	Cultural Competency																		
B1, C2, D3, E5	Basic Training on Addiction & Recovery (non-clinical)																		
B1, C2, D3, E5	Narcan Awareness																		
B1, D3, E5	Trauma informed treatment (clinical)																		
B1, D3, E5	Home visit safety																		
D3, E5	Motivational interviewing																		
E5	Targeted Care Planning (R49)																		
E5	CC team model- Intake procedures, workflows, available resources, roles and responsibilities, crisis																		
E5	CC team model- case conferencing, assignment of cases, how to relay system issues																		
E5	Understanding law enforcement and EMS protocols																		
B1, C2, D3, E5	Challenges of coding																		
B1, C2, D3, E5	Childhood trauma																		

left off

left off

E5 Enhanced Care Coordination for High Needs Populations

Project	Topic/subject	Primary Care MD	NP/PA	Pediatric care	BH practitioners	ARNP	Psychiatrist	clinical LMSW, LSW, LMT, etc	Case manager	ADAC	non-RN Health coach, g	BSW	ED staff RN, Medic, etc	ED providers- MD, NP, PA	Primary care RN, MA, worker	Peer Support	Home care staff- RN, CNA, P, etc	Community Health Worker	Beneficiary	Financial navigator	Admission navigator	Program support staff- driver, etc	Program support staff- van	HTU/Data Collections	receptionist	Billing hospital	each	Billing non-hospital
All	DSRIP 101- Introduction to the 1115 waiver								14																			
All	Privacy and liability: CFR 42 part 2								2																			
All	Outcome Metrics & data collection								2																			
All	CMT shared care plans, event notification								2																			
All	Data aggregator trainings																											
B1, E5	Treatment planning								4																			
B1, E5	The Basics of Medicaid								2																			
A1, B1, E5	New opioid prescribing regulations, chronic pain and opioids																											
A1, B1, E5	Patient Centered care								2																			
A1, B1, E5	Referral Process and Provider roles								2																			
A1, B1, E5	Interpersonal communication/sensitivity and stigma training/reflective listening								2																			
B1, C2, D3, E5	Natural supports training, Strengths based approach								2																			
B1, C2, D3, E5	Suicide prevention								2																			
B1, C2, D3, E5	Best practices in care transitions			P					2																			
B1, C2, D3, E5	Co-occurring disorders (clinical)								2																			
B1, C2, D3, E5	Ethical competency								2																			
B1, C2, D3, E5	MH First Aid (non-clinicians)								2																			
B1, C2, D3, E5	Cultural Competency								2																			
B1, C2, D3, E5	Basic Training on Addiction & Recovery (non-clinical)								2																			
B1, C2, D3, E5	Narcan Awareness								2																			
B1, D3, E5	Trauma informed treatment (clinical)								2																			
B1, D3, E5	Home visit safety								14																			
D3, E5	Motivational interviewing																											
E5	Targeted Care Planning (R49)								2																			
E5	CC team model- Intake procedures, workflows, available resources, roles and responsibilities, crisis management								2																			
E5	CC team model- case conferencing, assignment of cases, how to relay system issues								2																			
E5	Understanding law enforcement and EMS protocols								2																			

E5 Enhanced Care Coordination for High Needs Populations

Project	Topic/subject	Primary Care MD	NPRN	Pediatric care	OBH providers	Psychiatrist	Behavioral Health clinicians	CSW/IE/MH clinical	MA/DA/DrCe	Pharmacist	ED staff RN	Tech	EU providers	NE PA	Primary care RN	MA/PA	BI Peer Support, Peer Support worker	Home care staff- Peer Support	Community Health	Behavioral Health	Financial Health	Administrative assistant	scribes	program	QA/IE/IEC	analyst, van	Data Collections	individual @	Billing hospital	Billing non-hospital
All	DSRIP 101- Introduction to the 1115 waiver								2																					
All	Privacy and liability: CFR 42 part 2								2																					
All	Outcome Metrics & data collection								2																					
All	CMT shared care plans, event notification								2																					
All	Data aggregator trainings																													
B1, E5	Treatment planning								2																					
B1, E5	The Basics of Medicaid								2																					
A1, B1, E5	New opioid prescribing regulations, chronic pain and opioids																													
A1, B1, E5	Patient Centered care								2																					
A1, B1, E5	Referral Process and Provider roles								2																					
A1, B1, E5	Interpersonal communication/sensitivity and stigma training/reflective listening								2																					
B1, C2, D3, E5	Natural supports training, Strengths based approach								2																					
B1, C2, D3, E5	Suicide prevention								2																					
B1, C2, D3, E5	Best practices in care transitions								2																					
B1, C2, D3, E5	Co-occurring disorders (clinical)																													
B1, C2, D3, E5	Ethical competency								2																					
B1, C2, D3, E5	MH First Aid (non-clinicians)																													
B1, C2, D3, E5	Cultural Competency								2																					
B1, C2, D3, E5	Basic Training on Addiction & Recovery (non-clinical)								2																					
B1, C2, D3, E5	Narcan Awareness																													
B1, D3, E5	Trauma informed treatment (clinical)																													
B1, D3, E5	Home visit safety								2																					
D3, E5	Motivational interviewing								2																					
E5	Targeted Care Planning (R49)								2																					
E5	CC team model- Intake procedures, workflows, available resources, roles and responsibilities, crisis management								2																					
E5	CC team model- case conferencing, assignment of cases, how to relay system issues								2																					
E5	Understanding law enforcement and EMS protocols								2																					

E5 Enhanced Care Coordination for High Needs Populations

Project	Topic/subject	Primary Care MD,	Pediatric care provider	Practitioner-physicians APRN, nurse practitioner, LCSW, LADC, Psychologist, marriage level	Case manager (RN)	ED staff RN,	TECH	PA	Primary care RN,	MA/NA	Peer Support, Peer Educator	Home care staff- RN,	Behavioral Health	assisted health navigator,	ORCA/HRSA	SPC/SPR	Program support staff- receiver,	HIT/Data Collections	individual @ hospital	Billing hospital	non-hospital
All	DSRIP 101- Introduction to the 1115 waiver	6		4	5				13				2	11 (front desk)							5
All	Privacy and liability: CFR 42 part 2	6		4	5				13				2	11 (front desk)							5
All	Outcome Metrics & data collection	6		4	5				13				2	11 (front desk)							5
All	CMT shared care plans, event notification	6		4	5				13												
All	Data aggregator trainings																				
B1, E5	Treatment planning	6		4	5				13												
B1, E5	The Basics of Medicaid				5																
A1, B1, E5	New opioid prescribing regulations, chronic pain and opioids	6																			
A1, B1, E5	Patient Centered care	6		4	5				13												
A1, B1, E5	Referral Process and Provider roles				5										3 (LK,MM,SL)						
A1, B1, E5	Interpersonal communication/sensitivity and stigma training/reflective listening				5								2								
B1, C2, D3, E5	Natural supports training, Strengths based approach			4																	
B1, C2, D3, E5	Suicide prevention	6		4	5				13				2								
B1, C2, D3, E5	Best practices in care transitions				5																
B1, C2, D3, E5	Co-occurring disorders (clinical)	6		4	5				13				2								
B1, C2, D3, E5	Ethical competency	6		4	5				13												
B1, C2, D3, E5	MH First Aid (non-clinicians)				5								2								
B1, C2, D3, E5	Cultural Competency	6		4	5				13				2	11 (front desk)							
B1, C2, D3, E5	Basic Training on Addiction & Recovery (non-clinical)				5																
B1, C2, D3, E5	Narcan Awareness																				
B1, D3, E5	Trauma informed treatment (clinical)																				
B1, D3, E5	Home visit safety				5																
D3, E5	Motivational interviewing																				
E5	Targeted Care Planning (R49)				5																
E5	CC team model- Intake procedures, workflows, available resources, roles and responsibilities, crisis management				5																
E5	CC team model- case conferencing, assignment of cases, how to relay system issues				5																
E5	Understanding law enforcement and EMS protocols				5																

E5 Enhanced Care Coordination for High Needs Populations

Project	Topic/subject	Primary Care MD,	Pediatric care	Primary Care MD,														
All	DSRIP 101- Introduction to the 1115 waiver	0	0	0	1	14	0	0	5	0	0	0	1	2	20	2	1	2
All	Privacy and liability: CFR 42 part 2	0	0	0	1	14	0	0	5	0	0	0	1	2	20	2	1	2
All	Outcome Metrics & data collection	0	0	0	1	14	0	0	5	0	0	0	1	2	20	2	1	2
All	CMT shared care plans, event notification	0	0	0	1	14	0	0	5	0	0					2		
All	Data aggregator trainings															2		
B1, E5	Treatment planning	0	0	0	1	14	0	0	5	0	0	0						
B1, E5	The Basics of Medicaid					14												
A1, B1, E5	New opioid prescribing regulations, chronic pain and opioids	0	0	0				0										
A1, B1, E5	Patient Centered care	0	0	0	1	14	0	0	5	0	0	0		2				
A1, B1, E5	Referral Process and Provider roles	0	0	0	1	14	0	0	5	0	0	0						
A1, B1, E5	Interpersonal communication/sensitivity and stigma training/reflective listening	0	0	0	1	14	0	0	5	0	0	0	1	2	20			
B1, C2, D3, E5	Natural supports training, Strengths based approach				1	14				0								
B1, C2, D3, E5	Suicide prevention	0	0	0	1	14	0	0	5	0	0	0	1	2	20			
B1, C2, D3, E5	Best practices in care transitions					14												
B1, C2, D3, E5	Co-occurring disorders (clinical)	0	0	0	1	14	0	0	5	0	0	0	1	2	20			
B1, C2, D3, E5	Ethical competency	0	0	0	1	14	0	0	5	0	0	0		2				
B1, C2, D3, E5	MH First Aid (non-clinicians)					14				0		0	1	2	20			2
B1, C2, D3, E5	Cultural Competency	0	0	0	1	14	0	0	5	0	0	0	1	2	20			2
B1, C2, D3, E5	Basic Training on Addiction & Recovery (non-clinical)					14				0	0	0	1	2				
B1, C2, D3, E5	Narcan Awareness	0	0	0	1	14	0	0	5	0	0	0	1	2	20	2	1	2
B1, D3, E5	Trauma informed treatment (clinical)	0	0	0	1	14		0										
B1, D3, E5	Home visit safety				1	14				0	0	0						
D3, E5	Motivational interviewing				1													
E5	Targeted Care Planning (R49)					14												
E5	CC team model- Intake procedures, workflows, available resources, roles and responsibilities, crisis management					14												
E5	CC team model- case conferencing, assignment of cases, how to relay system issues					14												
E5	Understanding law enforcement and EMS protocols					14												

E5 Enhanced Care Coordination for High Needs Populations

Project	Topic/subject	Primary Care MD	Pediatric care	Public Health	Behavioral Health	Case Manager													
All	DSRIP 101- Introduction to the 1115 waiver	15	2	5	2	3	15	0	3	2	0	0	2	0	12	1	0	4	
All	Privacy and liability: CFR 42 part 2	15	2	5	2	3	15	0	3	2	0	0	2	0	12	1	0	4	
All	Outcome Metrics & data collection	15	2	5	2	3	15	0	3	2	0	0	2	0	0	1	0	4	
All	CMT shared care plans, event notification	15	2	5	2	3	15	0	3	2	0					1			
All	Data aggregator trainings															1			
B1, E5	Treatment planning	15	2	5	2	3	15	0	3	2	0	0							
B1, E5	The Basics of Medicaid					3													
A1, B1, E5	New opioid prescribing regulations, chronic pain and opioids	15	2	5	2		0												
A1, B1, E5	Patient Centered care	15	2	5	2	3	15	0	3	2	0	0		0					
A1, B1, E5	Referral Process and Provider roles	15	2	5	2	3	15	0	3	2	0	0							
A1, B1, E5	Interpersonal communication/sensitivity and stigma training/reflective listening	15	2	5	2	3	15	0	3	2	0	0	0	0	12				
B1, C2, D3, E5	Natural supports training, Strengths based approach				2	3				2									
B1, C2, D3, E5	Suicide prevention	15	2	5	2	3	15	0	3	2	0	0	0	0	0				
B1, C2, D3, E5	Best practices in care transitions					3													
B1, C2, D3, E5	Co-occurring disorders (clinical)	15	2	5	2	3	15	0	3	2	0	0	0	0	0				
B1, C2, D3, E5	Ethical competency	15	2	5	2	3	15	0	3	2	0	0		0					
B1, C2, D3, E5	MH First Aid (non-clinicians)					3			2		0	0	0	0	2			4	
B1, C2, D3, E5	Cultural Competency	15	2	5	2	3	15	0	3	2	0	0	0	0	2			4	
B1, C2, D3, E5	Basic Training on Addiction & Recovery (non-clinical)					3			2	0	0	0	0	0					
B1, C2, D3, E5	Narcan Awareness	15	2	5	2	3	15	0	3	2	0	0	0	0	12	1	0	4	
B1, D3, E5	Trauma informed treatment (clinical)	15	2	5	2	3		0											
B1, D3, E5	Home visit safety				0	3			2	0	0								
D3, E5	Motivational interviewing				0														
E5	Targeted Care Planning (R49)					3													
E5	CC team model- Intake procedures, workflows, available resources, roles and responsibilities, crisis management					3													
E5	CC team model- case conferencing, assignment of cases, how to relay system issues					3													
E5	Understanding law enforcement and EMS protocols					3													

