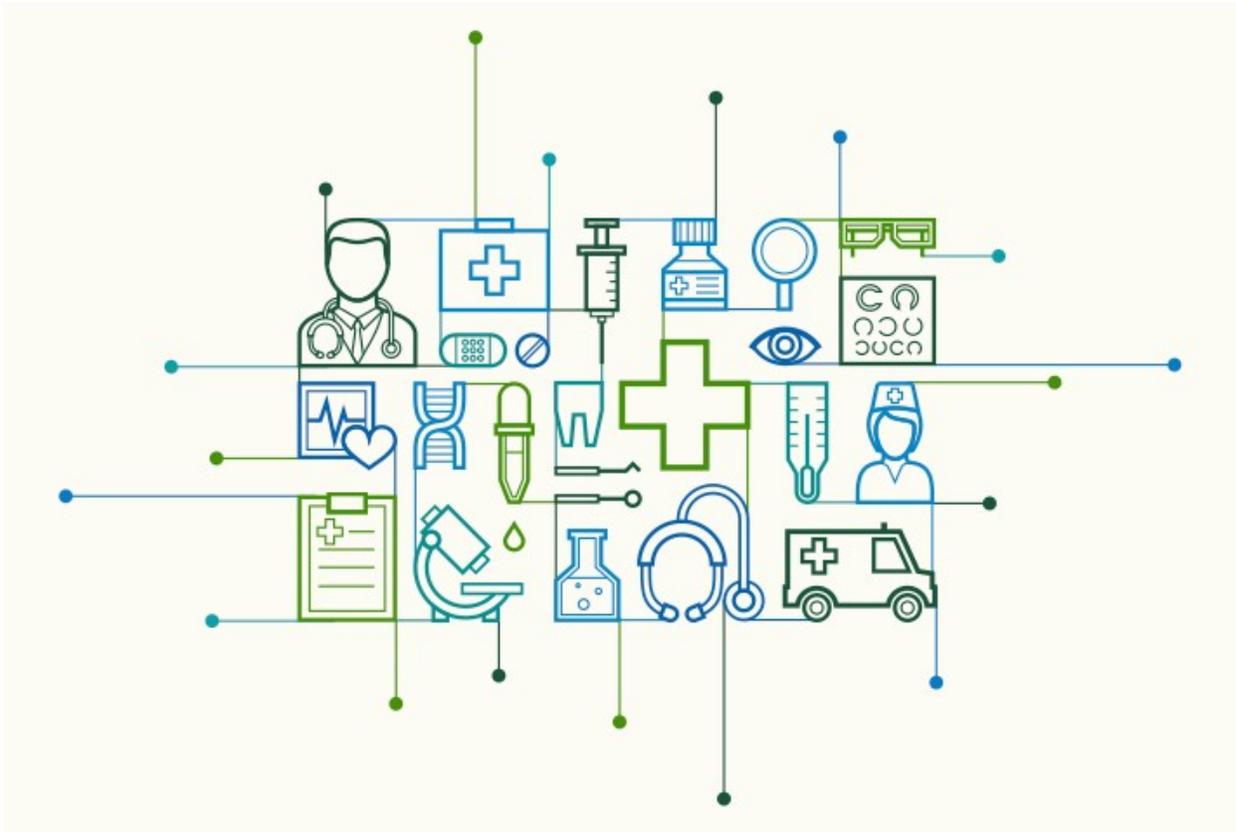


Capital Area Integrated Delivery Network (IDN2)

Concord Hospital, Administrative Lead

Capital Region Health Care (CRHC), Primary lead

Semi-Annual Report January - June 2018



Capital Region Health Care, a charitable health delivery system committed to the concept of community-based healthcare, is the parent company of:

Concord Hospital

Concord Regional Visiting Nurse Association

Riverbend Community Mental Health, Inc.

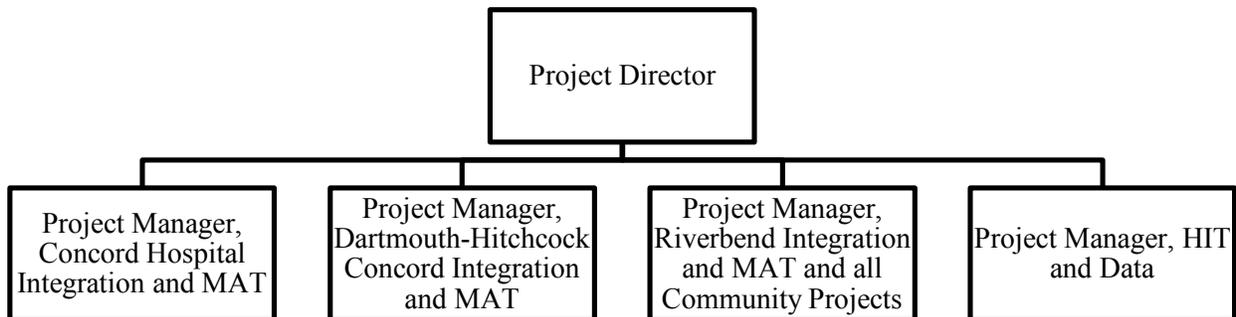
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DSRIP IDN Project Plan Implementation (PPI)

Below is narrative regarding the progress made on required activities, timelines, key milestones, progress assessment check points, and evaluation metrics. **Changes to the previous PPI timeline are indicated in bold text.**

IDN2 has implemented a new project management structure.



The team, with the exception of Dartmouth-Hitchcock Concord (DH-C), meets every other week and uses *Smartsheets* to manage project implementation. The Project Director meets directly with the DH-C project manager, as needed, or by attending the DH monthly project meetings for all DH sites.

The Project Director is the designated liaison with IDN2 CEOs, Committees (Steering, Executive, Finance, Oversight, Sustainability), Meyers & Stauffer Learning Community (MSLC), NH DHHS, and other IDNs. The Project Managers oversee the implementation of projects by site and report to the Project Director.

Soliciting Community Input

During the planning and initial implementation process, IDN2 required that all members participate fully in at least one of IDN2's workgroups, committees, and/or governance groups that meet monthly as well as the quarterly full IDN meeting. IDN2 has now evolved the workgroups into clinical meetings, attended by staff of the projects and the IDN2 project **managers** for the purposes of **implementing required components and tracking outcomes**. Rapid cycle evaluation is used, as needed. Communication about outcomes, potential course corrections, and etc. is then done **from the project managers to the project director**, and from the project director to the IDN2 ~~steering~~ committees, NH DHHS, MSLC, other IDNs, and the full IDN2 partners at the quarterly meetings.

Workgroups and Oversight Committees

- Integration - Concord Hospital Medical Group (CHMG)
- Integration - Dartmouth Hitchcock Concord (DHC) - This workgroup is being led by a Project Manager hired by DH Lebanon. IDN2 participates, as needed, and receives required information from the Project Manager for tracking and reporting.
- Integration - Riverbend Community Mental Health (Riverbend)

- Integration - Concord Hospital (CH) Family Health Center (FHC) - **This is now rolled in to the CHMG Integration meeting.**
- Medicated Assisted Treatment (MAT) inclusive of Perinatal Addiction Treatment (PAT)
- Enhanced Care Coordination (ECC)
- ~~PAT + ECC Committees – This is a case management group now for direct care staff to discuss client care and transitions.~~ **This is considered to be one project now: PAT. It is overseen by MAT.**
- Health Information Technology (HIT)
- ~~HIT + Clinical Oversight~~ - This is the complete oversight group for IDN2, attending to process and outcome metrics.
- Finance
- Executive
- Steering
- Sustainability - Includes Alternate Payment Model (APM) planning and discussion. **This group is aligned with the triple aim and has breakout committees for Resource Allocation (including billing), Population Health, and Patient Satisfaction.**

Timeline **with updates:**

July - Dec 2017

- Develop 6 template presentations to be updated as needed (IDN2 projects x 3, Integration x 4, DSRIP/IDN2 Overview, Outcome Measures) - This was accomplished
- 10 visits to CHMG practices to discuss the Integration & MAT projects with Q & A - This was delayed.
 - IDN2 did implement the Maine Site Self-Assessment in person at the first 4 sites where an Integrated Behavioral Health Clinician has been embedded. We see this as an effective outreach and communication tool in addition to a way to track the process of integration.
- 2 quarterly presentations to the full IDN with Q & A - This was accomplished.
 - Rapid Cycle Evaluation - Aug 2017
 - Social Determinants of Health - Nov 2017
- 3-5 weekly IDN2 Facebook posts on topics relevant to the DSRIP projects - This was accomplished.
- 4 presentations to community members about one or more of the IDN2 community projects with Q & A - This was accomplished.
 - Integration project presented to Concord Hospital Senior Leadership - Aug. 2017
 - Perinatal Addiction Treatment (PAT) of the MAT project presented to the Riverbend board of directors - Sept. 2017
 - Two full community partner presentations with an overview of all projects (Aug. 2017 and Nov. 2017)
- 13 monthly workgroup/committee meetings with Q & A - This was accomplished.
- 6 distributions of IDN Committee agendas and minutes - This was accomplished.

Jan - June 2018

- ~~5~~ **10 visits** to CHMG practices to discuss the Integration & MAT projects with Q & A - **This was accomplished.**
 - **Materials to support Integration and MAT project communication with**

- **primary care practices were developed**
 - **The Director of Integration visited DHC, Family Health Center, Riverbend, Pembroke, Penacook, Epsom, and Concord Family Medicine.**
 - **The new Peer Engagement Specialist and SUD Counselor visited DHC, Family Health Center, Riverbend, Pembroke, Penacook, Epsom, and Concord Family Medicine.**
- 2 quarterly presentations to the full IDN with Q & A - **This was accomplished**
 - **February 2018 - Perinatal Addiction Treatment and Enhanced Care Coordination**
 - **May 2018 - Combined with the MSLC quarterly meeting on *Engaging Community Partners Using Social Determinants of Health***
- 3-5 weekly IDN2 Facebook posts on topics relevant to the DSRIP projects - **This was accomplished**
- 4 presentations to community members about one or more of the IDN2 community projects with Q & A - **This was accomplished**
 - **CRHC Annual Meeting - Jan. 29**
 - **Psychiatry Presentation for CHMG Practice Managers - Feb. 13**
 - **CHMG PCPs Tri-Annual Presentation - May 10**
 - **Merrimack County Delegation - May 25**
- 6 distributions of IDN Committee agendas and minutes - **This was accomplished**
- Communication plan
 - Website - **This was accomplished.**
 - www.region2idn.com
 - Email identity - **Delayed**
 - ECC and MAT project brochures - **Delayed**
- 4-6 Maine Site Self-Assessment visits - **Delayed until July 2018**

July - Dec 2018

- 5 visits to CHMG practices to discuss the Integration & MAT projects with Q & A
- 2 quarterly presentations to the full IDN with Q & A
- 3-5 weekly IDN2 Facebook posts on topics relevant to the DSRIP projects
- **Project brochures**
- 4 presentations to community members about one or more of the IDN2 community projects with Q & A
- 6 distributions of IDN Committee agendas and minutes
- 4-6 Maine Site Self-Assessment visits

Network Development

This is the list of IDN2's 41 partners and each's role in the IDN and its projects:

Name of Organization	Type	A 1	A 2	B 1	C 2	D 1	E 5	Other
Ascentria Care Alliance	Community based organization							Steering
Bhutanese Community of NH	Community based organization							Steering
Boys & Girls Clubs Greater Concord	Community based organization							Referral
Capital Area Public Health Network	Public Health Network							Steering

CATCH Neighborhood Housing	Community based organization								Steering
Child & Family Services	Community based organization	x	x			x	x		
Community Action Program	Community based organization								Referral
Concord Coalition End Homelessness	Community based organization								Steering
Concord Family Medicine	Primary Care Practice	x	x	x		x			
Concord Family YMCA	Community based organization								Steering
Concord Hospital	Hospital	x	x			x	x		Steering
Concord Hospital OBGYN	Specialty Care Practice	x				x			
Concord Human Services	State Agency								Steering
Concord Regional VNA	Community based organization	x	x						Steering
Crotched Mountain	Community based organization								Referral
Dartmouth Hitchcock Concord	Primary Care Practice	x	x	x		x			
Dartmouth Hitchcock OB-GYN	Specialty Care Practice	x				x			
Epsom Family Medicine	Primary Care Practice	x	x	x		x			
Families in Transition	Community based organization								Referral
Family Health Center Concord	Primary Care Practice	x	x	x		x			
Family Health Center Hillsboro	Primary Care Practice	x	x	x		x			
Family Physicians of Pembroke	Primary Care Practice	x	x			x			
Fellowship Housing Opportunities	Community based organization								Referral
Granite Pathways	Community based organization								Referral
Granite State Independent Living	Community based organization								Referral
Granite United Way	Community based organization					x	x	x	Training
Internal Medicine at Horseshoe Pond	Primary Care Practice	x	x	x		x			
Life Coping, Inc.	Community based organization								Referral
Merrimack County DOC (Jail)	Correctional Facility	x	x			x			Steering
NAMI New Hampshire	Community based organization	x				x	x	x	Steering
New Hampshire Hospital	Hospital		x				x		Referral
NHADACA	Community based organization								Training
NH DOC (Prison)	Correctional Facility	x	x			x			
Pelvic Medicine	Specialty Care Practice	x							
Penacook Family Physicians	Primary Care Practice	x	x	x		x			
Pleasant Street Family Medicine	Primary Care Practice	x	x	x		x			
Riverbend Community Mental Health	Behavioral Health Provider	x	x	x	x	x	x		Steering
Substance Use Services / Fresh Start	Behavioral Health Provider	x	x	x		x			
Sununu Youth Services	Correctional Facility	x	x				x		Referral
UNH Institute on Disability	University	x					x		Training
Youth Move NH	Community based organization	x					x		Peers

Timeline with Updates

July - Dec 2017

- Develop a presentation about Social Determinants of Health to be delivered at a quarterly IDN meeting - This was accomplished.

- Survey at least 20 IDN2 CBOs about the services they provide and identify any potential gaps - Moving this to Jan - Jun
- Work with [REDACTED]/Granite United Way to develop a contract between IDN2 and NH-211 for 2018 - This was accomplished.
- Develop a forum including schedule, list of presenters, and attendee list for IDN2 CBOs to present to IDN2 project staff about the services they provide
 - We had 4 of our CBO partners present at the November “All Partner” meeting and will continue to include at least 2 CBO presentation on that quarterly agenda.

Jan - June 2018

- Contract with Granite United Way to provide expanded NH-211 services - Signed in January. **This contract was put on hold due to the services being offered not necessarily meeting the needs of IDN2. IDN2 sought clarification from MSLC regarding the requirements of “closed loop referrals” and a meeting was set to review the contract July 2018.**
- Survey at least 20 IDN2 CBOs about the services they provide and identify any potential gaps - **This was accomplished with a survey sent March 2018.**
- CBOs will present at least 2 times to IDN2 partners - **This was accomplished at the February 2018 quarterly meeting.**

July - Dec 2018

- CBOs will present at least 2 times to IDN2 partner

Addressing the Opioid Crisis

IDN2 continues to partner with the Capital Area SUD Continuum of Care (CoC) project in establishing its community projects and continues to meet with the representative of that project on a regular basis. IDN2 is addressing SUD and Opioid Use Disorder (OUD) in NH directly through its MAT and PAT projects and indirectly, by providing education and stigma reduction training for clinical and nonclinical providers, throughout all of its projects. IDN2 has expanded the MAT project into a HUB & SPOKE model, which we feel will result in greater numbers of individuals with OUD being able to access treatment. The PAT project is working very closely with IDN2’s Enhanced Care Coordination (ECC) project so that women engaged in PAT have wraparound supports and services for them and their unborn and newly born children. There is a high demand for this combined project, and we are already overfull and need to allocate more staffing to the project.

Timeline **with updates:**

July - Dec 2017

- Provide mentoring support to 6 existing MAT providers - During this report period, the MAT provider at Riverbend’s CHOICES Substance Use Services and the MAT provider from Concord Hospital’s Program for Addictive Disorders provided mentoring support to 10 IDN2 MAT providers based in the following locations:
- Convene existing MAT providers and IBHC each month to share best practices, review cases, and address challenges - This happened in an ad hoc fashion through phone calls and emails but did not materialize into a monthly meeting. MAT/PC providers are finding it difficult to attend monthly meetings. IDN2 is exploring other ways to exchange this kind of information and work cohesively as a regional team.

- Develop workflows for introducing MAT into 6 CHMG and DHC locations - Workflows are done and will be used to introduce the practices to MAT.
- Attend 6 CoC meetings as a representative of the IDN2 - This was accomplished by the IDN2 Managing CEO.
- Distribute recruitment materials to at least 25 primary care providers about getting their x waiver and participating in the IDN2 MAT project - This recruitment material was sent out.
- Provide training for 10 non-clinical staff in “See the Person; not the Illness” - This particularly curriculum was not used during this time frame. Finding the time and space to accomplish the training proved to be insurmountable. IDN2 is developing a self-paced training for non-clinical staff at the CHMG and DHC practices to be available April 2018. Riverbend non-clinical staff received:
 - Ethics for Non-Clinical Staff - Nov. 2017
- Provide MAT presentations to 3 community groups - This was accomplished
 - PAT/MAT was presented to Riverbend’s board of directors
 - Framing Addiction Care Effectively by Understanding Pathways, Uniting People, Undoing Prejudice, and Utilizing (best) Practices (FACE-UP) is a monthly community of practice meeting at Concord Hospital attended by MAT providers, PC providers, BH providers, peers, and interested community partners.
- Provide SUD-focused education/trainings for 6 IBHCs - All 6 IBHCs attended:
 - Implementing Medication-Assisted Treatment (MAT) Organizational Considerations and Workflows - May 2017
 - MAT + Buprenorphine Training for Behavioral Health Staff - October 2017
 - FACE-UP - Monthly
- Provide SUD-focused education/training for 12 medical providers - The following trainings occurred during this time frame and reached more than 50 medical providers:
 - Opioid use disorders in hospitalized patients June 22
 - Audience: Hospitalist physicians at Concord Hospital
 - Goals/objectives: understand the neurobiology of addictive disorders; identify the criteria of substance/opioid use disorders; review opioid withdrawal signs and symptoms and treatment options; understand best practices or continuum of care for patients with opioid use disorders
 - Opioid Use Disorders: Identification and Management in Primary Care August 30
 - Audience: Concord Hospital Internal Medicine (physicians, nursing and providers)
 - Goals/objectives: understand the neurobiology of addictive disorders; identify the criteria of substance/opioid use disorders; review the efficacy and evidence around using medications in the treatment of opioid use disorders; understand best practices and continuum of care for patients with opioid use disorders
 - Response to Opioid Epidemic: Naloxone July 23 and September 4
 - Audience: Penacook Family Medicine #1: providers and physicians; #2: RN, MAs

- Goals: Review physiology of an opioid overdose; Understand the use of naloxone in the setting of an opioid overdose; Understand the benefits and risks of using naloxone in the setting of an opioid overdose.

Jan - June 2018

Location	Number of MAT Providers
Internal Medicine at Horseshoe Pond	1
Concord Hospital Family Health Center	1
Pleasant Street Family Medicine	2
Dartmouth Hitchcock Concord	1
Concord Family Medicine	3
Concord Hospital Substance Use Services	1
IDN2 PAT providers for DHC and CH OB-GYN	2
CHOICES at Riverbend	4

- Communicate HUB & SPOKE model to all primary care practices in IDN2 and provide template workflows and protocols - **This was accomplished**
- Provide HUB & SPOKE (induction through full continuum of care) and mentoring support to **11** MAT providers - **This was accomplished through a contract with Fusion MAT providers.**
- Develop workflows for introducing MAT into 4 additional CHMG locations - **Accomplished earlier**
- Attend 6 CoC meetings as a representative of the IDN2 - **This was accomplished**
- Distribute recruitment materials to all CHMG and DHC primary care providers about getting their x waiver and participating in the IDN2 MAT HUB & SPOKE model project. - **This was delayed in order to solidify the current HUB & SPOKE process.**
- Operationalize the use of SBIRT and provide training in it for primary care providers through the New Hampshire SBIRT IPE Training Collaborative - **This was accomplished through the NH Center for Excellence for all PCP providers at CHMG practices.**
- Provide self-paced training and follow-up survey for 50 non-clinical staff - **The training materials development was delayed and went live in April 2018. 19 staff have received training as of the time of this report.**
- Provide 3 MAT presentations - **This was accomplished.**
- Provide SUD-focused education/trainings for all IDN IBHCs (12) -**This was accomplished.**
- Provide SUD-focused education/training for 12 medical providers - **This was accomplished**

July - Dec 2018

- Provide HUB & SPOKE (induction through full continuum of care) and mentoring support to **11** MAT providers
- Convene existing MAT providers and IBHC each month to share best practices, review cases, and address challenges

- Attend 6 CoC meetings as a representative of the IDN2
- Distribute recruitment materials to at least 25 primary care providers about getting their x waiver and participating in the IDN2 MAT project
- Provide stigma reduction training for 10 non-clinical staff
- Provide MAT presentations to 3 community groups
- Provide SUD-focused education/trainings for 6 IBHCs
- Provide SUD-focused education/training for 12 medical providers

Governance

The IDN2 Committee is the “steering” committee that approves any actions and the budget. Its 15 members meet monthly and represent an array of provider and organization types.

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

The Finance Committee develops the budget and provides financial reports.

The HIT Committee oversees all of the technology needs of IDN2.

The Clinical + HIT Committee: **Renamed Oversight Committee**

- The quality control branch of IDN2’s governance structure
- Ensures that IDN2 understands how to collect, interpret, and report outcomes
- Ensures that processes and protocols exist in IDN2 to meet the required outcomes
- Oversees the implementation of clinical processes and protocols in IDN2 to meet outcomes
- Oversees the implementation of technology processes and protocols in IDN2 to meet outcomes
- Tracks outcomes to ensure IDN2’s compliance with NH DHHS incentive payment structure
- Comprised of clinical, technology, compliance, and QI/QA decision-makers and leaders from these key IDN2 clinical partners: Riverbend, Concord Hospital, Concord Hospital Medical Group, Dartmouth Hitchcock-Concord.

Timeline **with updates**:

July - Dec 2017

- 6 IDN2 Committee Meetings - This was accomplished
- 6 IDN2 Executive Committee Meetings - This was accomplished
- 6 Finance Committee Meetings - This was accomplished
- 6 Clinical + HIT Meetings - This was accomplished
- 6 HIT Meetings - This was accomplished
- Evaluate membership of Clinical + HIT sub-committee and recruit any missing areas of

expertise - This was accomplished

- 19 members sit on this committee. We added QA and Compliance individuals from Concord Hospital and Riverbend.
- Define and document role of Clinical + HIT sub-committee - This was accomplished; see above.
- Recruit for any new IDN2 Committee members needed for vacancies - This was accomplished; added Capital Area Public Health Network and Concord Hospital Medical Group

Jan - June 2018

- 6 IDN2 Committee Meetings - **This was accomplished.**
- 6 IDN2 Executive Committee Meetings - **This was accomplished.**
- ~~6~~ 2 Finance Committee Meetings - **Went to meeting quarterly this period.**
- 6 Clinical + HIT Meetings - **This was accomplished.**
- 6 HIT Meetings - **This was accomplished as site meetings.**
- Review governance charter and update, if necessary - N/A
- Develop reporting mechanism for **Oversight Committee - Delayed until after July 2018 meeting with MAeHC to review reporting capabilities.**
- Recruit for any new IDN2 Committee members needed for vacancies - N/A

July - Dec 2018

- 6 IDN2 Committee Meetings
- 6 IDN2 Executive Committee Meetings
- 2 Finance Committee Meetings
- 6 **Oversight** Meetings
- 6 HIT Meetings
- Recruit for any new IDN2 Committee members needed for vacancies

Budget

IDN2's finance committee oversees revenue and expenses and provides reports to the IDN Committee. The Project Director manages the day to day budget and approves invoices and expenses. IDN2 also has an accountant who processes accounts payable and receivable and prepares financial reports. The process for developing the annual budget is that the Project Director and Managing CEO prepare a draft with input from project staff (October). That draft is presented to the Executive Committee (October) for approval. Once they have approved and/or any requested changes have been made, it goes to the Finance Committee (November) and is finalized for IDN Committee approval (November).

July - Dec 2017

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

Jan - June 2018

- ~~6~~ 2 Finance Committee Meetings - **This was accomplished**
- Develop and present quarterly budget report for the IDN Committee - **This was**

accomplished in January 2018 and April 2018

July - Dec 2018

- 6 Finance Committee Meetings
- Draft, review, and approve 2019 budget
- Other Direct Expense - Travel, supplies, as needed

Please see IDN2 budget on next page

	ACTUALS			PROJECTED			
	2016	2017	Jan-Jun 2018	Jul-Dec 2018	2018	2019	2020
Administration							
Salaries / Wages (CH)	\$ 11,858	\$ 55,108	\$ 14,741				
Employee Benefits (CH)	617	2,129	1,115				
Purchase Services / Professional	-	107,620	159,501				
Consulting Fees	107,177	204,134	73,950				
Subtotal Admin Staff	\$ 119,653	\$ 368,992	\$ 249,308	\$ 250,000	\$ 499,308	\$ 633,419	\$ 650,000
Travel and Mileage	\$ 765	\$ 2,778	\$ 6,642				
Meeting Supplies / Refreshments	-	261	957				
Office Supplies	692	7,181	4,397				
Minor Equipment	1,326	-	-				
Insurance / Other (Malpractice)	-	5,000	5,833				
Advertising	-	33,481	1,317				
Other Direct Expense	281	486	-				
Total Administration	\$ 3,064	\$ 49,186	\$ 268,454	\$ 275,000	\$ 543,454	\$ 700,719	\$ 725,000
Behavioral Health Workforce Development							
Purchase Services / Professional		\$ 90,325	\$ 52,896				
Outside Training		16,449	40				
Minor Equipment		1,376	-				
Office Supplies		161	-				
Travel and Mileage		487	-				
Total Behavioral Health/Peers		\$ 108,798	\$ 52,936	\$ 146,500	\$ 199,436	\$ 333,220	\$ 350,000
HIT							
Purchase Services / Professional		\$ 9,833	\$ 31,450				
Network Software (Software Applications)		16,516	90,199				
Total Health Info Tech		\$ 26,349	\$ 121,650	\$ 172,656	\$ 294,306	\$ 317,106	\$ 325,000
Integration							
Purchase Services / Professional (RB)		\$ 18,360	\$ 409,213				
Purchase Services / Professional (CH)		293,640	-				
Consulting (Pediatric MH)		-	22,308				
Outside Training		449	6,802				
Other Direct		23,950	-				
Total Integrated Health		\$ 336,399	\$ 438,322	\$ 864,329	\$ 1,302,651	\$ 1,337,102	\$ 1,350,000
Re-entry							
Purchase Services / Professional		\$ 113,287	\$ 136,843				
Consulting Fees		40,004	-				
Other Direct Expense (Includes testing supplies)		4,367	-				
Total Community Re-entry		\$ 157,658	\$ 136,843	\$ 131,382	\$ 268,225	\$ 279,197	\$ 325,000
Medicated Assisted Treatment							
Purchase Services / Prof (RB)		\$ -	\$ 136,307				
Purchase Services / Prof (CH)		5,520	14,791				
Purchase Services / Professional		26,957	329				
Total Medicated Assisted Treatment		\$ 32,477	\$ 151,427	\$ 196,785	\$ 348,212	\$ 479,948	\$ 525,000
Enhanced Care Coordination							
Purchase Services / Professional		\$ 74,341	\$ 135,970				
Training (NH Wraparound & Renew & Coaching)		3,396	6,200				
Travel		388	1,246				
Other Direct Expense		-	1,123				
Total Enhanced Care		\$ 78,126	\$ 144,540	\$ 125,163	\$ 269,703	\$ 104,237	\$ 125,000
Total Operating Expenses	\$ 122,716	\$ 1,157,985	\$ 1,314,172	\$ 1,911,815	\$ 3,225,987	\$ 3,551,529	\$ 3,725,000

Budget Detail

IDN2 is re-doing its budget categories within the larger project categories for 2019 and this makes it impossible to provide detail for these areas at this point. Our 2019 budget will be approved November 2018 and we can submit it at that time or with the Jan. 2019 SAR.

Budget Detail for A1, A2, B1, C2, D1, and E5 are listed under each of their sections, immediately under their portion of the budget.

Administration

- Salaries & Benefits (CH) and Payroll Taxes (CH) - This is for a .4 accountant hired by Concord Hospital to oversee and manage expenses as well as 1 FTE Project Manager and 1 FTE Data Analyst.
- Purchase Services / Professional (non-CH staff) and Consulting Fees - This is for the following positions:
 - CTO - .15
 - Managing CEO - .25
 - Bookkeeper - .5
 - Financial Data Analyst - .5
 - Human Resources - 1
 - Project Director - 1
 - Project Specialist - .8
- Travel - As needed
- Meeting Supplies - Conference and meeting costs
- Office Supplies - Office supplies for newly hired staff
- Office Minor Equipment - Office equipment for newly hired staff
- Insurance / Other - Malpractice Insurance - For behavioral health staff
- Legal Services - Held if needed
- Auditing Services - Held if needed
- Advertising and Staff Recruitment - For staff recruitment efforts

DSRIP IDN Process Milestones

DHHS will use the tool below to review and document each IDN's Implementation activity. A score of "Met" will be scored for a timely and complete submission. A score of "Not Met" will be scored for late and/or incomplete information.

Process Milestone Number	Process Detail	Submission Format	Results (Met/Not Met)			
			6/30/17	12/31/17	6/30/18	12/31/18
PPI	Project Plan Progress, including: Community Input, Network, Opioid Crisis Update, Governance, and Budget	Narrative and budget spreadsheet				

Project A1: Behavioral Health Workforce Capacity Development

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

Below is narrative regarding the progress made on required activities, timelines, key milestones, progress assessment check points, and evaluation metrics. **Changes to the previous A1 timeline are indicated in bold text:**

Timeline **with updates:**

July - Dec 2017

A1. BH Workforce Development

- Hire and train mental health peers through Riverbend - Deferred to next time period due to taking the time to meet with all peer supervising staff / peers within IDN2 to identify needs, capacity, and to ensure consistency in training and expectation across the peer workforce. Developed new job description. Made decision to have cross-trained peers in both SUD and mental health. IDN2 had originally been working with HOPE for NH Recovery through a contract that was deemed not favorable to IDN2 and which HOPE for NH Recovery was unable to renegotiate. The contract paid for full-time employees instead of a per diem or hourly rate for services actually provided and had a start date that was in advance of when IDN2 was actually able to use peers. In addition, IDN2's primary contact at HOPE for NH Recovery was unavailable to us for over a month without explanation. IDN2 parted amicably with HOPE for NH Recovery and will refer to them in the future if they maintain a Concord site. They closed and Riverbend provide the peer services ..2 Peers added to Choices
- Riverbend to conduct a market analysis of its pay scale - This was accomplished
 - In 2017 Riverbend committed to analyzing the New Hampshire labor market in human service to determine the level of competition for various disciplines in the Behavioral Health workforce. There were two objectives: how much do wages and salaries need to be adjusted to maintain competitive position for the Agency in the current labor market, and how do the Agency's benefits match up with what is available in the region and beyond? As background the Community Mental Health Center's struggle to hire for vacant positions in all disciplines. At present, there are 200 clinical positions open in the system, 20 of those are at Riverbend. In line with the Statewide Workforce Taskforce goal of evaluating wages, salaries and benefits across the State, Riverbend matched that objective on a local level. In addition, as background, Medicaid Fee Schedules for the Community Mental health system have not been raised since 2006, in fact they have been reduced twice since then. A review of wages and benefits showed that the Agency was behind significantly with its Regional competitors and as a consequence staff that had benefitted from supervision for independent licensure were leaving once they obtained that status and were taking employment with school systems, hospitals and ironically with Managed Medicaid Organizations who pay the rates that the CMHC's receive. The result of the review was that Riverbend gave its employees two cost of living adjustments in 2017 and two bonuses which amounted to around \$750 000. This has done a number of things; it has started to improve turnover in the agency, from 22% to around 18% over the past quarter. It has

made Riverbend a fair \$15 employer with the exception of 5 employees who will be raised to \$15 this year and it has maintained differentials across the workforce will raising the remuneration of every disciple and every staff.

A2. HIT

- Hire HIT Support Person - This was accomplished
- Evaluate need for Data Analyst position - This was accomplished

B1. INTEGRATION

- IBHCs complete nine-month Learning Collaborative: SAMHSA-HRSA Center for Integrated Health Solution's (CIHS) "Innovation Community Circle of Support - Engaging Loved Ones in Health and Wellness." - This was accomplished
- Hire and train 2 additional IBHCs
- 7 IBHCs receive 3 trainings related to integrated health - This was accomplished. IBHCs attended:
 - Implementing Medication-Assisted Treatment (MAT) Organizational Considerations and Workflows - May 2017
 - MAT + Buprenorphine Training for Behavioral Health Staff - October 2017
 - FACE-UP - Monthly
- Identify and schedule future training opportunities for PCPs - This was accomplished
 - 2 Primary care practice providers received motivational interviewing training
 - Motivational Interviewing
 - Epsom Family Medicine - August 2017
 - Internal Medicine Pillsbury - September 2017
- Develop plan for CHMG practices with low Medicaid numbers (staffing, coordinated/integrated) - Instead of making one plan, IDN2 is taking the approach of continually assessing and guiding what works. Expansion to other CHMG sites was halted during this period of time to allow for the Cerner implementation.
- Contract with NAMI NH to provide "See the Person, Not the Illness" for non-clinical staff in integrated sites - This particularly curriculum was not used during this time frame. Finding the time and space to accomplish the training proved to be insurmountable. IDN2 is developing a self-paced training for non-clinical staff at the CHMG and DHC practices to be available April 2018. Riverbend non-clinical staff received:
 - Ethics for Non-Clinical Staff - Nov. 2017
- 8 IBHCs meet monthly with the Concord Hospital Family Health Center (FHC) IBHCs to share best practices and support each other - This was accomplished

C2. REENTRY

- Hire Case Manager - This was accomplished December 2017
- Train Reentry staff in: - This was accomplished November 2017
 - Review of the Client Flow System: Orientation to the pathways through the reentry system from initial screening and assessment through post release programming. This process includes two major meetings: May 2017 and July 2017. The initial meeting was to discuss the need for a flow system from initial assessment to post release services; what is expected from whom; and how assessment tools, case management services, pre- and post-release programming,

transitional case management, and support services are managed. The second meeting is to review the case flow system and responsibilities with all reentry staff.

- Case Management Training: A review of evidence based case management strategies for offenders as they re-enter the community. This will include the process of coordinated case planning, transition services, use of a universal case plan, and evidence based chain of case planning and services.
- Overview of Evidence Based Practices: Discussion of the best practice models in criminal justice and correctional settings including methodology for clients with substance use and mental health disorders. This review will include the National Transition from Jail to Community Model, the Risk Need Responsivity Model, Criminogenic Risk and Need, and other successful evidence based systems.
- Outcome Data: This is designed to review the performance measures agreed to in reentry meeting and the methodology of collecting and reviewing that data for continuous quality improvement including:
 - Public Safety Indicators and Outcomes
 - Reduced re-offending, returns to jail, and length of jail stays for returning individuals
 - Reintegration Indicators and Outcomes
 - Reduced substance abuse and homelessness
 - Increased employment
 - Improved housing stability and improved mental health/health
 - Process Measures
 - Screening
 - Assessment
 - Referrals
 - Engagement
 - Service utilization
 - Completion
 - Assessments are the key to understanding your clients' needs
 - Make intelligent decisions based on evidence
 - Understand gaps in data collection and work toward building a better data infrastructure
 - Leverage existing resources

D1. MAT

- Extend FACE-UP Forum to IDN2 community - Ongoing forum at CH for anyone in the hospital or IDN including physicians, RNs, social workers, and etc. to come discuss cases or situations which involve patients with substance use disorders. The "FACE" portion of the name stands for "Framing Addiction Care Effectively" and the "UP" portion is alternately "Utilizing Best Practices", "Undoing Prejudice", and "Understanding Pathways". This was accomplished. Flyer was emailed in advance to all IDN2 partner organizations and SUD community organizations.
- Extend monthly Opioid meeting to IDN2 community - Existing meeting of pharmacists, supervising RNs, providers, and senior leadership at CH to educate around prescribing opioids as well as other potentially addicting medications. This was accomplished.
 - The following trainings occurred during this time frame and reached more than 50

medical providers and IDN2 IBHCs:

- Opioid use disorders in hospitalized patients June 22
 - Audience: Hospitalist physicians at Concord Hospital
 - Goals/objectives: understand the neurobiology of addictive disorders; identify the criteria of substance/opioid use disorders; review opioid withdrawal signs and symptoms and treatment options; understand best practices or continuum of care for patients with opioid use disorders
- Opioid Use Disorders: Identification and Management in Primary Care August 30
 - Audience: Concord Hospital Internal Medicine (physicians, nursing and providers)
 - Goals/objectives: understand the neurobiology of addictive disorders; identify the criteria of substance/opioid use disorders; review the efficacy and evidence around using medications in the treatment of opioid use disorders; understand best practices and continuum of care for patients with opioid use disorders
- Response to Opioid Epidemic: Naloxone July 23 and September 4
 - Audience: Penacook Family Medicine #1: providers and physicians; #2: RN, MAs
 - Goals: Review physiology of an opioid overdose; Understand the use of naloxone in the setting of an opioid overdose; Understand the benefits and risks of using naloxone in the setting of an opioid overdose.

E5. ECC

- Hire 3 ECC Coordinators - This was accomplished
- Train 3 ECC Coordinators in Cultural and Linguistic Competency - This was deferred to the next time period as the wraparound and renew training was pretty intensive and time consuming. We are going to contract with Ascentria for this training.
- Provide 3 ECC Coordinators with wraparound and renew coaching through UNH IOD - This was accomplished

Jan - June 2018

A1. BH Workforce Development

- Hire and train mental health peers through Riverbend by June 30, 2018 - **This was accomplished.**
 - **Riverbend hired three FTE peers as well as a Peer Recovery Engagement Specialist. One of the peers was already in the process of completing Certified Recovery Specialist Worker (CRSW) training and the other two are to begin next quarter. Next year, all will receive Intentional Peer Support training. These Peers are supervised by the CHOICES substance use continuum of care HUB and are deployed for all of the projects, as needed.**

A2. HIT

- Hire Data Analyst, ~~if needed~~ - **This was accomplished**
 - **Concord Hospital allocated these funds to existing data analysts who had been hired to implement Cerner and were transferred to working with MAeHC and CMT.**

B1. INTEGRATION

- IDN2 staff will receive pay adjustments - **This was accomplished.**
- Hire 2 psychiatrists - **We were only able to hire one psychiatrist this period of time.**
- Hire and train 3 additional IBHCs - **A decision was made not to expand the integration project during this period of time. Instead, we hired an Integrated Care Manager to provide backup support to IBHCs on vacation, out sick, or during times of turnover.**
- Hire APRN MA (Medical) - **This was accomplished.**
- Hire ICM - **This was accomplished.**
- 30 PCPs receive 1 training related to behavioral health including SBIRT and/or MI to be offered through the NH Center for Excellence or other technical assistance center. - **This was accomplished.**
- ~~7~~ **19** nonclinical staff receive 1 training related to behavioral health - **This was accomplished through an online self-pace training.**

C2. REENTRY

- Staff receive 1 additional training module - **This was accomplished.**

D1. MAT

- **A Peer Engagement Support Specialist was hired to coordinate and help with transitions between HUB & SPOKES.**
- **An SUD Counselor was hired to support increased numbers being referred to HUB from SPOKES for continuum of SUD care.**
- 12 IDN2 members attend 1-3 MAT educational meetings ~~per month~~ - **This was accomplished.**
- 2 PCPs attend NH Buprenorphine Waiver Training - **We had no additional MAT providers trained this period** as we focused on staffing and implementing the HUB & SPOKE model.
- 2 PCPs complete the NP and PA 24-hour training requirement established by the Comprehensive Addiction and Recovery Act (CARA). - **We had no additional MAT providers trained this period** as we focused on staffing and implementing the HUB & SPOKE model.

E5. ECC

- 3 Coordinators receive coaching from UNH IOD - **This was accomplished.**

PLANNED FOR July - Dec 2018

B1. INTEGRATION

- 11 IBHCs receive 3 trainings related to integrated health
- ~~30 PCPs receive 1 training related to behavioral health including SBIRT to be offered through the New Hampshire SBIRT IPE Training Collaborative and/or Motivational Interviewing~~ - **This occurred Jan - June 2018**
- 7 nonclinical staff receive 1 training related to behavioral health

C2. REENTRY

- Staff receive 1 additional training module

D1. MAT

- ~~12 IDN2 members attend 1-3 MAT educational meetings~~
- **IDN2’s MAT site-based teams (Providers, BH staff, other practice staff) will participate in Project ECHO Medication Assisted Treatment: Building Competency and Capacity for Primary Care Teams in Northern New England. This program seeks to improve the lives of patients and families living with SUD by enhancing the capacity and quality of services available to patients in their communities through their primary care practices. The program will work to establish a primary care culture that understands addiction as a chronic disease and is prepared and capable to address the range of issues, including underlying trauma and mental health conditions that emerge during the process of treatment. Specifically, this program will focus on supporting primary care based MAT services provided by prescribing providers, behavioral health clinicians, and teams. The team will meet once per month for eight months.**

E5. ECC

- 3 Coordinators receive coaching from UNH IOD

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

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
Train PCPs in behavioral health needs	28	30	30	
Train BH staff in chronic medical disease	9	20	20	
Train non-clinical staff in behavioral health needs	14	15 (at RB)	19 (at CHMG)	
Staff turnover	<15%	14% (5/36)	12% (6/49)	
PCPs are providing MAT in primary care Settings	18	10	11	

A1-5. IDN-level Workforce: Staffing Targets

IDN2’s current number of full-time equivalent (FTE) staff hired and trained by the date indicated. **Projected total need updates in bold.**

Provider Type	IDN Workforce (FTEs)				
	Projected Total Need	Baseline Staffing on 6/30/17	Staffing on 12/31/17	Staffing on 6/30/18	Staffing on 12/31/18
A2 - Tech Support (.5)	1	1	1	1	
A2 - Data Analyst (.5)	1	0	0	1	
B1 - IBHC	8.4	6	7.4	4.4	
B1 - IC Manager	1	1	1	1	
B1 - Psychiatrists	2	0	0	1	
B1 - MA	1	1	1	1	
B1 - IBHC Supervisor	1	1	1	1	
C2 - Case Manager	1	1	1	1	
C2 - Psychiatric APRN (.3)	1	0	1	1	
C2 - MLADC	1	1	1	1	
C2 - BH Clinician	1	1	0	1	

D1 - MAT Co-Coordination (.2)	2	2	2	2	
D1 - SUD Counselor	1	N/A	0	1	
D1 - Peer Engagement Specialist	1	N/A	0	1	
D1 - Clinical Coordinator	1	N/A	0	1	
D1 - PAT Providers (.4)	2	2	2	2	
D1 - PAT MA (.4)	1	N/A	0	0	
E5 - ECC Supervisors (.2)	2	2	2	2	
E5 - ECC Intake	1	N/A	1	2	
E5 - ECC Coordinators	3.5	0	3	3.5	
All – Peers	5	4	2	5	

A1-6. IDN-level BH Workforce: Building Capacity Budget with Updates

	ACTUALS			PROJECTED			
	2016	2017	Jan-Jun 2018	Jul-Dec 2018	2018	2019	2020
Behavioral Health Workforce Development							
Purchase Services / Professional		\$ 90,325	\$ 52,896				
Outside Training		16,449	40				
Minor Equipment		1,376	-				
Office Supplies		161	-				
Travel and Mileage		487	-				
Total Behavioral Health/Peers		\$ 108,798	\$ 52,936	\$ 146,500	\$ 199,436	\$ 333,220	\$ 350,000

Purchase Services / Professional (non-CH staff) - For NAMI NH, YouthMove, and Riverbend to provide peers for the IDN2 projects

Outside Training (IPS) - Training the Trainer in Intentional Peer Support and Peer Recovery Coach Training

IDN2 Trainings January - June 2018

Date	Training	Location	Attendees	Description
1/5/18	Half and Half X-Waiver: Office Based Treatment for Opioid Use Disorders	Co-Occurring Collaborative Serving Maine	PAT Clinicians	The presentation and online course are designed to train qualified physicians, physician assistants and nurse practitioners in dispensing or prescribing specifically approved Schedule III, IV, and V narcotic medications for the treatment of opioid addiction in an office-based setting. The goal of this training is to acquire the knowledge and skills needed to provide optimal care to opioid use disorder patients.
1/18/18	Harm Reduction in an Opioid Era	New England Institute of Addiction Studies	PAT Staff	Learning Objectives: 1. Articulate the rationale for and principles of evidence-based harm reduction strategies 2. Identify two policies that incorporate harm reduction principles and practices 3. Describe three harm reduction interventions that will effectively integrate harm reduction approaches into the healthcare continuum or the community
1/30/18	Workforce Development Part 2: Making the connection through integrated	SAMHSA	IBHCs	Participants will learn to: - Recognize the role of behavioral health providers as leaders and key agents in working with other disciplines - Examine methods for involving new staff in continuous quality improvement cycles

	behavioral health workflows (Webinar)			and monitoring - Identify commonly used protocols and procedures for effective and efficient clinic workflows while also avoiding provider burnout - Map workflow processes to support key evidence-based practices such as motivational interviewing and cognitive behavioral therapies
All	NH Wraparound and RENEW	NH IOD	ECC staff	Ongoing training and coaching in the NH Wraparound and RENEW models
2/2/18	Metabolic Syndrome in clients with Serious Mental Illness re: symptoms, etiology, treatment, co-morbidities, and health disparities	Concord Hospital	IBHCs (Presenting at monthly IBHC meetings)	This training covered the definition, symptoms, etiology, treatment, co-morbidities, and health disparities
2/5/18	Consumer Substance Use: Ethical Considerations	Riverbend	IBHCs BH staff ECC Staff	Overall application of NASW CODE of Ethics to this topic. - Substance use and how it contributes to CMHC consumer deaths - A brief overview of the Office of Chief Medical Examiner and how drug deaths are classified as Suicide, Accidental, or Undetermined - Review of the NASW Standards for Social Work Practice with clients with substance use disorders - Suicide risk in individuals with substance use - Strategies to referring consumers to treatment using motivational techniques - Local resources for services
2/19/18	Illness Management and Recovery (IMR)	Riverbend	ECC staff	Total of 16 hours, split between 4 days: Illness Management and Recovery (IMR) is a psycho-educational program designed for clients and their support systems to learn and work collaboratively with specially trained staff. IMR aims to empower clients to learn about and manage their illness, develop recovery focused goals, and make informed decisions about their treatment to improve their quality of life. IMR can be done individually or in a group. The time frame is client driven, usually lasting between 6 and 12 months.
2/23/18	Clinical Aspects of SBIRT	National Council for Behavioral Health	Medical staff	Webinar highlighting the clinical implementation of SBIRT within primary care settings, including a strong focus on Motivational Interviewing.
All	NH Wraparound	NH IOD	ECC staff	Ongoing training and coaching in the NH

	and RENEW			Wraparound and RENEW models
3/14 and 3/23	Your Money, Your Goals	Hosted by Granite United Way	ECC Staff IBHCs	Your Money, Your Goals was created by the Consumer Financial Protection Bureau to train case managers and other staff from social service agencies and other organizations working with individuals and families with low income or limited resources.
3/21/18	Diagnosis of Major Depressive Disorder	Riverbend	BH Clinical Staff	This presentation will provide a review of the diagnostic criteria of Major Depressive Disorder; Discussion of what else it could be when your client is struggling with depressive symptoms; treatment options.
3/23/18	Adult Lethality	Riverbend	BH Clinical Staff	This training will discuss suicide and violence risk factors, assessment strategies and standards of care, as well as legal and ethical concerns.
3/30/18	Working Respectfully with Transgender Clients: What Every Clinician Needs to Know	Riverbend	IBHCs ECC Staff	This workshop will prepare clinicians to work knowledgeably with transgender adults. It will cover the developmental progression of gender dysphoria, varieties of transgender identities, the gender transition process, and medical and non-medical treatment options available. Special attention will be paid to establishing and maintaining a collaborative therapeutic alliance.
March 2018	Autism Spectrum Disorders and Substance Use Disorders	Riverbend	ECC Staff	
March 2018	Engaging and Supporting Families in Suicide Prevention	SAMHSA	ECC Staff	Focus on engaging families whose loved ones are in suicidal crisis or have attempted suicide, and their crucial role in suicide prevention
All	NH Wraparound and RENEW	NH IOD	ECC staff	Ongoing training and coaching in the NH Wraparound and RENEW models
4/11/18	Driving Change: A Roadmap to Whole Population Integrated Care	NH BHI Learning Collaborative	IBHCs and PCPs	
4/12/18	Management of Aggressive Behavior	Concord Hospital	IBHCs	MOAB is an in-depth training program which teaches individuals how to recognize, reduce, and manage violent and aggressive behavior. MOAB goes beyond the strategies for preventing and diffusing a crisis. It addresses the multitude of crises and the stages of conflict.
4/18/18	Impact of ACEs and Adoption of Trauma-Informed Approaches in	SAMHSA Webinar	IBHCs	Webinar to learn more about trauma and its impact, hear the case for adopting trauma-informed approaches, and take back to your organization a methodology for implementing trauma-informed care.

	Integrated Settings			
4/20/18	Simulated Experience of Hearing Distressing Voices	Riverbend	BH Clinical staff	This presentation will include a 60-minute video lecture by Patricia Deegan, Ph.D., The Director of Training for the National Empowerment Center and an experienced voice-hearer who was diagnosed with Schizophrenia as a teenager. There will then be an audio (CD) simulation of auditory hallucinations. Consenting participants will wear headphones and experience the simulation as they engage in a variety of activities. The simulation focuses on a selected range of voice-hearing experiences in the hopes of creating a more intensive and real situation.
4/23-27/18	Mental Health First Aid		From IDN 2: 3 BH non-clinical 1 BH clinical Representation from other IDNs	Mental Health First Aid is a national program to teach the skills to respond to the signs of mental illness and substance use.
4/23/18	SBIRT and MI Training	Center for Excellence	Integration Approx. 6 PC Providers Approx. 9 non-clinical staff Approx. 10 other medical staff	This introductory training aims to increase providers' competence and confidence across the practice to routinely screen patients on their substance use and provide an appropriate Brief Intervention using motivational interviewing techniques. 1. Describe the four components of SBIRT and its benefits. 2. Review brief intervention techniques that utilize motivational interviewing skills. Instructors will provide a menu of motivational interviewing tools. 3. Share resources in New Hampshire for providers and patients to seek help with assessment and referral to treatment.
4/25/18	Post-Traumatic Stress Disorder	Riverbend	BH Clinical staff	This presentation will provide a review of the diagnostic criteria of PTSD, and discuss the experience of trauma and why some people are diagnosed with PTSD while others are not.
4/27/18	The Role of Nutrition in Mental Health	Riverbend	BH Clinical staff	This program will discuss general tenants of nutrition and brain health, mental illnesses that are particularly exacerbated by poor nutrition, assessment that is patient centered to improve mental health outcomes through improved nutrition, resources for wellness activities/complimentary therapies to target wellness as it pertains to nutrition for mental stability, and various medical conditions/psychiatric medication side effects that are red flags and should be referred out.

4/30/18	Addressing Intimate Partner Violence in Integrated Care Settings	SAMHSA	BH Clinical staff	Objectives: <ul style="list-style-type: none"> • Know the prevalence and symptoms of intimate partner violence and the connection to poor behavioral health outcomes • Learn best practices for prevention, identification, and response to intimate partner violence in primary care, behavioral health, and integrated care settings • Understand how to offer a supported referral to community-based programs who can assist with safety planning and support • Become familiar with resources to support clients
All	NH Wraparound and RENEW	NH IOD	ECC staff	Ongoing training and coaching in the NH Wraparound and RENEW models
5/3/18	Meeting the Needs of Children in the Opioid Epidemic	Massachusetts Association for Infant Mental Health	ECC Staff	A panel discussion of what we know (and don't know) about the effects of opioid exposure on newborns and young children, and an example of a clinical practice model.
5/4/18	Metabolic Disorder Training	Riverbend	BH Staff IBHCs	This training covered the definition, symptoms, etiology, treatment, co-morbidities, and health disparities
5/24/18	The Brave New World of Queer and Questioning Youth	Anne Boedecker	IBHCs	Focus on ages 12-24, information about the new language of sexual and gender diversity, and insight into queer youth culture.
5/24/18	Partners in the Exam Room: A Model of Integrated Behavioral Health in Primary Care	Joni Haley - Concord Hospital	IBHCs, FHC PCP	How the Family Health Center applies integrated care in their setting for a more effective and comprehensive identification, engagement, and support of complex patients.
5/25/18	An Introduction to the Ethics of Self Care	NASW NH - Susan Stibler	IBHCs	Introduce the ethical concerns around self-care, and the universality of vicarious traumatization, compassion fatigue and burnout. Participants will be introduced to and experience embodied and mindful practices that substantially reduce negative effects, increase well-being and resiliency, and improve stress reaction and symptoms of depression and anxiety.
5/16, 21, 23, 25, and 30	SBIRT and MI Training	Center for Excellence	Integration Approx. 64 PC Providers Approx. 72 non-clinical staff Approx. 115 other medical staff 3 IBHCs (Concord Family, Epsom, Penacook)	This introductory training aims to increase providers' competence and confidence across the practice to routinely screen patients on their substance use and provide an appropriate Brief Intervention using motivational interviewing techniques. <ol style="list-style-type: none"> 1. Describe the four components of SBIRT and its benefits. 2. Review brief intervention techniques that utilize motivational interviewing skills. Instructors will provide a menu of motivational interviewing tools. 3. Share resources in New Hampshire for

				providers and patients to seek help with assessment and referral to treatment.
All	NH Wraparound and RENEW	NH IOD	ECC staff	Ongoing training and coaching in the NH Wraparound and RENEW models
6/6 and 7	SBIRT and MI Training	Center for Excellence	Integration Approx. 11 PC Providers Approx. 12 non-clinical staff Approx. 20 other medical staff	This introductory training aims to increase providers' competence and confidence across the practice to routinely screen patients on their substance use and provide an appropriate Brief Intervention using motivational interviewing techniques.
6/14/18	Understanding MAT for Recovery Support	NHADACA	MAT and BH Clinical staff	This course will provide an updated version of the NIDA and SAMHSA's Blending Initiative product, originally entitled "Buprenorphine Treatment: A Training for Multidisciplinary Professionals". The primary goal of this training package is to create awareness among recovery coaches about medications currently approved by the FDA and used in the treatment of opioid dependence. The course includes information about what to expect when someone is treated with medication, information about the legislation that permits office based buprenorphine treatment, the science of addiction, the mechanism of each medication, patient selection criteria and associated patient counseling and therapeutic issues.
6/19/18	Medication Adherence in Integrated Care Settings	SAMHSA	Integration BH Staff	
6/22/18	Addressing Pain Bio- psychosocially	SAMHSA	Integration BH Staff	
6/23/18	Caring for Substance-Exposed Infants	NHADACA	PAT and BH Clinical staff	This training will examine Neonatal Abstinence Syndrome (NAS), address the nature of the problem and review the epidemiology of substance use in pregnancy/NAS regionally versus nationally. The NAS scoring process and what it means will be reviewed. The benefits of non-pharmacologic interventions to minimize NAS and need for pharmacologic treatment will be examined. The issue of mandated reporting will be discussed along with developing safe plans of care utilizing both medical and community resources. The concept of safe sleep will also be addressed.
6/28/18	Criminal Justice and Serious Mental Illness	SAMHSA sponsored webinar	Reentry Staff	Attendees of this webinar will learn about the factors contributing to the current situation, gaps in the systems, how to

		developed under contract by the National Council for Behavioral Health		improve access to care in the community and the role of diversion programs such as Mental Health Courts and Drug Courts in decreasing criminalization of serious mental illness and substance use disorders.
6/30/18	Working in an Integrated Primary Care Practice	IDN2	Non-clinical integration staff (21)	Developed by IDN2 to provide an overview of integration and address stigma
All	NH Wraparound and RENEW	NH IOD	ECC staff	Ongoing training and coaching in the NH Wraparound and RENEW models

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

Name of Organization	Type	A 1	A 2	B 1	C 2	D 1	E 5	Other
Ascentria Care Alliance	Community based organization							Steering
Bhutanese Community of NH	Community based organization							Steering
Boys & Girls Clubs Greater Concord	Community based organization							Referral
Capital Area Public Health Network	Public Health Network							Steering
CATCH Neighborhood Housing	Community based organization							Steering
Child & Family Services	Community based organization	x	x			x	x	
Community Action Program	Community based organization							Referral
Concord Coalition End Homelessness	Community based organization							Steering
Concord Family Medicine	Primary Care Practice	x	x	x		x		
Concord Family YMCA	Community based organization							Steering
Concord Hospital	Hospital	x	x			x	x	Steering
Concord Hospital OBGYN	Specialty Care Practice	x				x		
Concord Human Services	State Agency							Steering
Concord Regional VNA	Community based organization	x	x					Steering
Crotched Mountain	Community based organization							Referral
Dartmouth Hitchcock Concord	Primary Care Practice	x	x	x		x		
Dartmouth Hitchcock OB-GYN	Specialty Care Practice	x				x		
Epsom Family Medicine	Primary Care Practice	x	x	x		x		
Families in Transition	Community based organization							Referral
Family Health Center Concord	Primary Care Practice	x	x	x		x		
Family Health Center Hillsboro	Primary Care Practice	x	x	x		x		
Family Physicians of Pembroke	Primary Care Practice	x	x	x		x		
Fellowship Housing Opportunities	Community based organization							Referral
Granite Pathways	Community based organization							Referral
Granite State Independent Living	Community based organization							Referral
Granite United Way	Community based organization				x	x	x	Training
Internal Medicine at Horseshoe Pond	Primary Care Practice	x	x	x		x		
Life Coping, Inc.	Community based organization							Referral
Merrimack County DOC (Jail)	Correctional Facility	x	x		x			Steering

NAMI New Hampshire	Community based organization	x				x	x	x	Steering
New Hampshire Hospital	Hospital		x					x	Referral
NHADACA	Community based organization								Training
NH DOC (Prison)	Correctional Facility	x	x			x			
Pelvic Medicine	Specialty Care Practice	x							
Penacook Family Physicians	Primary Care Practice	x	x	x			x		
Pleasant Street Family Medicine	Primary Care Practice	x	x	x			x		
Riverbend Community Mental Health	Behavioral Health Provider	x	x	x	x	x	x	x	Steering
Substance Use Services / Fresh Start	Behavioral Health Provider	x	x	x			x		
Sununu Youth Services	Correctional Facility	x	x					x	Referral
UNH Institute on Disability	University	x						x	Training
Youth Move NH	Community based organization	x						x	Peers

A1-9. Project Scoring: IDN Workforce Process Milestones

DHHS will use the tool below to review and document each IDN’s Workforce Project activities. Grayed areas indicate that no submission is expected for the time frame. A score of “Met” will be scored for a timely and complete submission. A score of “Not Met” will be scored for late and/or incomplete information.

Process Milestone Number	Process Detail	Submission Format	Results (Met/Not Met)			
			6/30/17	12/31/17	6/30/18	12/31/18
A1-3	IDN-level Workforce Capacity Development Implementation Plan	Narrative & Microsoft Project or similar platform				
A1-4	Evaluation Project Targets	Table				
A1-5	IDN-level Workforce Staffing Targets	Table				
A1-6	IDN-level Workforce Capacity Budget	Narrative and Spreadsheet				
A1-7	IDN Workforce Key Organizational and Provider Participants	Table				

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

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

IDN2 continues to make significant progress toward the short and long-term goals of its implementation plan. The 3 organizations submitting metrics, the CHMG practices, Riverbend, and DHMC-Concord, successfully submitted their required metrics on time for the first metric reporting requirement of April 1, 2018. The CCSA was implemented at Riverbend and at most of the CHMG practices with 2 to be implemented no later than Dec. 31, 2018. DHMC-Concord has scheduled workflow discussions for the end of July to finalize their CCSA template with planned integration into their EMR, Epic, starting in August of this year.

CMT event notification is up and running at Concord Hospital via the ADT feed. Riverbend, Crotched Mountain, and Concord Regional VNA are all live with CMT submitting their active patient files on a regular basis to CMT and receiving event notifications on their respective patients.

IDN2 has a dedicated Project Management Team to oversee and manage all of IDN2's Implementation Projects; IDN2's Project Director, IDN2's HIT Support staff who is a CRVNA employee, Concord Hospital's designated PM for IDN related HIT projects, and IDN2's Project Specialist, a Riverbend employee.

Technology Update for period January 1, 2018-June 30, 2018

As of June 30, 2018, IDN2 performed 7 additional organization site visits:

- Concord YMCA
- Fellowship Housing
- Child & Family Services
- FIT NH
- NH Dept. of Corrections
- Merrimack County Dept. of Corrections
- Granite United Way

As with the past 7 site visits, one of the main takeaways from these visits, in reviewing the foundation and collaborative standards with each organization, was the need to share necessary client/patient information in real time and in more of an integrated and streamlined manner but without having to "dual document" aka entering information in a current system and a new system.

IDN2's HIT related focus during this timeframe was to work with Concord Hospital and Riverbend in establishing their data metric processes to enable them to submit their required metrics in a timely fashion to MAeHC for the first reporting submission that was due 4/1/18. Now that these processes are in place and ongoing for the next reporting requirement as well as future reporting requirements, we can transition our efforts to setting up a plan to visit the other remaining support service based organizations in the coming months.

Table 4. Providers in Scope

**E=Further Evaluation Need ✓ = Implement X= Will Not Implement
I=Already Installed IC=Implementation Complete**

Name of Organization		Data Extraction	Internet Connectivity	Secured Data Storage	Electronic Data Capture	DSM	Shared Care Plan	Event Notification Service	Transmit Event Notification	
	PHI	1	2	3	4	5	6	7	8	Site Visit Done
Ascentria Care Alliance	Yes	x	✓	✓	✓	E	E	E	E	
Bhutanese Community of NH	Yes	x	✓	✓	✓	E	E	E	E	
Boys & Girls Clubs of Greater Concord	Non-PCP/BH	x	x	x	x	x	x	x	x	
Capital Area Public Health Network	Non-PCP/BH	x	x	x	x	x	x	x	x	
CATCH Neighborhood Housing	Non-PCP/BH	x	x	x	x	x	x	x	x	
Community Action Program / ServiceLink	Yes	x	I	I	I	✓	✓	✓	✓	Yes
Concord Coalition to End Homelessness	Yes	x	I	I	I	✓	✓	✓	✓	Yes
Concord Family YMCA	Non-PCP/BH	x	✓	✓	✓	x	x	x	x	Yes
Concord Hospital	Yes	x	I	I	I	IC	✓	✓	IC	
Child and Family Services	Non-PCP/BH	x	I	I	I	✓	✓	✓	✓	Yes
CHMG Primary Care Practices										
Concord Family Medicine	Yes	IC	I	I	I	E	✓	✓	✓	
Concord Hospital OBGYN	Yes	IC	I	I	I	E	✓	✓	✓	
Epsom Family Medicine	Yes	IC	I	I	I	E	✓	✓	✓	
Family Health Center Concord	Yes	IC	I	I	I	E	✓	✓	✓	
Family Health Center Hillsboro	Yes	IC	I	I	I	E	✓	✓	✓	
Family Physicians of Pembroke	Yes	IC	I	I	I	E	✓	✓	✓	
Internal Medicine at Horseshoe Pond	Yes	IC	I	I	I	E	✓	✓	✓	
Pelvic Medicine	Yes	x	E	E	E	E	E	E	E	
Penacook Family Physicians	Yes	IC	I	I	I	E	✓	✓	✓	
Pleasant Street Family Medicine	Yes	IC	I	I	I	E	✓	✓	✓	
Substance Use Services / Fresh Start	Yes	✓	I	I	I	E	E	E	E	
Concord Human Services	Non-PCP/BH	E	E	E	E	E	E	E	E	
Concord Regional VNA	Yes	x	I	I	I	IC	I	IC	IC	
Crotched Mountain	Yes	x	I	I	I	IC	✓	IC	IC	Yes
Dartmouth Hitchcock	Yes	IC	✓	✓	✓	IC	✓	✓	✓	
Families in Transition	Yes	x	I	✓	✓	E	✓	✓	✓	Yes
Fellowship Housing Opportunities	Yes	IC	✓	✓	✓	✓	✓	✓	✓	Yes
Granite United Way	Non-PCP/BH	x	I	I	I	x	x	x	x	Yes
Granite State Independent Living	Yes	x	I	I	I	IC	✓	✓	✓	Yes
Life Coping, Inc.	Yes	x	E	E	E	E	E	E	E	
Merrimack County House of Corrections	Yes	x	✓	✓	✓	✓	✓	✓	✓	Yes
NAMI New Hampshire	Yes	x	I	I	I	IC	✓	✓	✓	Yes
New Futures	Non-PCP/BH	x	x	x	x	x	x	x	x	
NH Alcohol/Drug Abuse Counselors	Non-PCP/BH	x	x	x	x	x	x	x	x	
New Hampshire Hospital	Yes	x	I	I	I	✓	✓	E	E	Yes
NH DOC	Yes	x	I	I	I	I	✓	✓	✓	Yes
Riverbend	Yes	IC	I	I	I	IC	✓	IC	IC	Yes
Sununu Youth Services Center	Yes	x	E	E	E	E	E	E	E	
UNH Institute on Disability	Non-PCP/BH	x	x	x	x	x	x	x	x	
Youth Move NH	Non-PCP/BH	x	x	x	x	x	x	x	x	

Status as of June 30, 2018

Data Vendor/Data Aggregator

MAeHC, the chosen data vendor and data aggregator, conducted many metric specific meetings with Concord Hospital’s data analysts and Riverbend’s data reporting analyst with IDN2’s HIT support person in attendance to review their flat file specifications in conjunction with the DSRIP Outcome Measure Guide to fully understand the necessary reporting requirements.

The MAeHC portal access was granted at the end of June and portal training for IDN2 admin level staff is scheduled for Monday, July 30th. These admin users will be the “super users” and will train their appropriate staff as needed. The next step to portal usage is determining how each metric reporting organization will utilize the portal, which will determine what roles and access will need to be set up.

Workstream	Dec. 2017	Jan. 2018	Feb. 2018	Mar. 2018	Apr. 2018	May 2018	June 2018	July 2018	Aug. 2018	Sept. 2018	Oct. 2018	Nov. 2018
	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Participant contracting	x											
Finalize requirements		X										
Set-up IDN QDC environment		X										
Portal Access Set up and ready to use							x					
Validate measures												
Ongoing reporting												

On May 30, 2018, representatives from Child & Family Services met with DHHS staff regarding their participation role in IDN2 and IDN4. It was decided and agreed to by all parties that they are to be considered as a community service organization, and not a Behavioral Health Provider. They are not required to submit metrics but will still be listed as a B1 provider and will be considered as a participant in our workforce, HIT, closed loop referral, and training workflow practices and any associated community projects.

Fellowship Housing submits their metrics directly via Riverbend, who is submitting to MAeHC. DHMC-Concord will be able to submit CCSA measure data once they have completed their EMR integration of the CCSA domain components, slated for August-October 2018 timeframe.

Below are the metrics that are currently being manually collected for each project and each organization involved and being manually submitted to MAeHC. Now that Concord Hospital is using one EMR, we are exploring the option and viability of automating the manual reporting of the MAT specific metrics, at least for the CHMG practices.

Table 11. Metrics for Individual Projects

C2 - Reentry

- Clients served pre-release
 - Of these, how many were new?
 - Of these, how many were continuing?
- Clients served post-release?
 - Of these, how many were new?
 - Of these, how many were continuing?
 - How many received case management?
 - How many received individual therapy?
 - How many received group therapy?
 - Referred to SUD Services
 - Follow through rate
 - Referred to MH Services
 - Follow through rate
 - Referred to Primary Care
 - Follow through rate
- Clients completing 12 months of service?

D1 MAT

- # of MAT Providers
- Total patients seen
 - Of these, how many new?
 - Of these, how many continuing?
 - How many engaged 3 months
 - Of these how many remained opioid free during this time?
 - How many engaged 6 months?
 - Of these how many remained opioid free during this time?
 - How many engaged over 6 months?
 - Of these how many remained opioid free during this time?
 - How many relapsed and returned to treatment?

D1 PAT

- Number served over life of project
 - Did not return after first visit
 - Delivered - outside of IDN2 region
 - Delivered - within IDN2 region
 - Attended all scheduled OB-GYN appointments
 - Attended all scheduled MAT appointments
 - Remained engaged through pregnancy & delivery
- Transferred to MAT provider after delivery

D1 ECC

- Individuals served over the life of the project
 - Intake to determine eligibility
 - Successfully connected to other resources
 - Decided not to participate
 - Placement outside the home

E5 ECC

- Individuals served over the life of the project
 - Intake to determine eligibility
 - Successfully connected to other resources
 - Decided not to participate
 - Newly placed outside the home
 - Returned to home from placement
 - Improved Academic performance
 - New psychiatric hospitalizations
 - New juvenile offenses

Secure Texting

In evaluating 2 organization's communication processes where texting is used with their clients/patients, at Riverbend and Child & Family Services, secure texting was determined to not be a viable option for their Medicaid clients as the phones they are provided from Medicaid are not smart phones and are not compatible with the texting platform, TigerText. We are considering looking at other options.

Closed Loop Referrals

IDN2 vetted several models and tools related to closed loop referral during this reporting period. IDN2 also reached out to MSLC for assistance in defining what constituted "closed loop referrals" and received a TA report on 5/9/18. At its conclusion, it outlined best practices for closed loop referrals and a nine-step closed loop EHR process:

1. The primary care physician orders a referral.
2. The primary care physician or a designated staff person communicates the referral to the subspecialist.
3. The referral is reviewed and authorized.
4. An appointment is scheduled.
5. The consult appointment occurs.
6. The subspecialist communicates the plan to the patient.
7. The subspecialist communicates the plan to the primary care physician.
8. The primary care physician acknowledges receipt of information from the subspecialist.
9. The primary care physician communicates the plan to the patient and the family.

All of these except Step 9 are implemented already at the CHMG practices. PCPs do not communicate plans with patients that are developed as part of the specialist referral; the specialists do that directly with the patient.

In addition, the CHMG practices have all achieved Level 3 accreditation with the National Committee for Quality Assurance (NCQA) Patient Centered Medical Home (PCMH). To achieve accreditation, organizations MUST PASS on "Referral tracking and Follow-Up". The practice coordinates including implementing these elements:

- Providing reason for referral and relevant clinical information.
- Tracking referral status.
- Following up to obtain specialist's report.
- Documenting agreements with specialists for co-management.
- Providing electronic exchange of patient information.

As a next step, the CHMG practices will ensure that its shared care plan and embedded BH roles are part of this process.

Riverbend evaluated, by program area, its capacity to provide closed loop referrals and will implement these next reporting period.

Dartmouth-Hitchcock Concord will implement closed loop referrals next reporting period.

Data Sharing Agreements

After attending the 2 Data and Privacy Meetings in March at the UNH School of Law, where IDN specific workflows around 42 CFR Part 2 were discussed in great detail, Concord Hospital’s Audit and Compliance Department created and disseminated to IDN2 legally vetted QSO and BAA agreement forms.

Data sharing agreements were signed with IDN2 by the CEO’s of Concord Hospital, Riverbend, and Concord Regional VNA. Dartmouth Hitchcock Medical Center-Concord is still having their legal department review their agreement as they want to change some of the language in the agreements.

Direct Messaging

- 2 organizations set up new Kno2 accounts; NAMI NH, and Riverbend for their Concord-based offices, completing steps 1-6 below.
- Crotched Mountain continues to increase their day to day usage of their Kno2 account, which was originally set up under the former, NHHIO platform.
- DHMC-Concord is reviewing existing workflows at their Lebanon site to set up new ones at their Concord practice. Ongoing planned workflow from June-September, 2018.
- New Hampshire Hospital is in the early stages of executing Direct Secure Messaging using their EMR vendor’s product, CareConnect. Once this is completed, they will be piloting with Riverbend and Concord Hospital on exchanging information, particularly addressing their current patient referral workflows, which are now processed via phone and fax.
- Riverbend is also reviewing Kno2’s Cloud-based Faxing solution; a platform that integrates directly within their Direct Messaging Kno2 portal. Direct Secure Messaging and Faxing will be managed from one, web-based portal.

Table 5

Step	Direct	12/31/17	6/30/18	12/31/18	6/30/18
1.	Identify agencies for direct implementation	Completed	Completed		
2.	Engage with Kno2 to assist with product demos and implementation	Completed	Completed		
3.	Contracting for Product		Completed		
4.	Account set up		Completed		
5.	Web training		Completed		
6.	Process flow evaluation		Completed		
7.	Ongoing Process flow/use evaluation				
	Target for total completion 6/30/18				
	Has Direct Messaging	Will Implement	To be evaluated		N/A for Implementation
	10	1	17		9

Event Notification

- Concord Hospital released their ADT feed to CMT on 6/4 for all patients.
- Concord Regional VNA, Crotched Mountain, and Riverbend are all live with the CMT platform in receiving event notifications. They have developed and implemented new workflows in processing these event notifications allowing them to proactively follow up with the patient identified in the event notification in real time and make any patient related changes as needed (scheduled visit changes based on event type, calling/meeting with the patient by social workers, liaisons if at the ED, etc.)
 - These organizations are receiving CMT event notifications from various Massachusetts-based hospitals as well as from NH-based ones; Catholic Medical Center, Dartmouth-Hitchcock Medical Center-Lebanon, Valley Regional, and Elliot Hospital.
- IDN2 project managers are now working together to start the event notification rollout to the CHMG practices. A survey is being created to send to each practice manager to learn about their existing processes relating to current patient event notifications.
- We need to determine how we will incorporate the support service organizations into utilizing CMT such as Concord Coalition to End Homelessness, and GSIL-who has offices statewide and have limited to no legal resources available to assist them with the privacy and consent requirements unique to them where they do not collect PHI. IDN2 has added this topic to the agenda for the Data Meeting on August 3, 2018. IDN2 has also discussed this with the new NH-based CMT General Manager, particularly if CMT can be configured with limited data views based on the type of organization. We feel this is an IDN statewide concern and need to discuss with other IDN partners in more detail.

PreManage Community Project Plan	Responsible Party	12/31/17	06/30/18
Contract Executed with IDN	IDN Lead	Completed	
Agreements signed by organizations	Each Organization	Each organization signs as they enroll	Completed
Project Kickoff Call			Completed
IT Implementation			
SFTP Setup	CMT/Organization		Completed
Eligibility File			
Eligibility Design	Organization		Completed
Upload to SFTP	Organization		Completed
Test (Validate)	CMT		Completed
Process to Production	CMT		Completed
Automatic Pickup from SFTP Setup	CMT		Completed
Evaluate other organizations that have capability to send ADT feed	CRVNA, Riverbend, Crotched Mountain		Exploring with EMR vendors
Follow steps 7-13 for each organization			
Clinical Implementation			
Onboarding Packet	CMT/Organization		Completed

User Set up (Provisioning)	CMT		Completed
Identify List of Initial Users	Organization		Completed
Cohorts Set up			
Notification Destination Set Up	CMT		Completed
Reports Set up	CMT		CRVNA-complete
Training			
Account Managers/IT	CMT		Completed
Clinical Staff	CMT		Completed

Shared Care Plan

The planned focus with CMT was to approach the rollout in phases; get the ADT feed implemented at Concord Hospital, determine and set up required workflows and necessary training to start receiving the event notifications, and once all organizations that are live with event notifications are comfortable with their new event notification processes, discussions and meetings can take place to determine the steps needed to implement and start using the shared care plan platform of CMT at each organization.

For high risk patients at DHMC-Concord, their new workflow consists of the Care Team Coordinator to facilitate the composition of the Shared Care Plan and will conduct monthly case conferences with the patient's multi-disciplinary care team accordingly.

Riverbend has conducted initial workflow discussions directly related to how they will implement the shared care plan component of CMT, based on Emergency Department specific event notifications. Once more organizations go live with CMT, they will pursue these discussions in greater detail internally and with fellow CMT member organizations.

CMT PreManage ED

Table 6 PreManage ED (Only Concord Hospital)

EDIE Project Plan	Responsible Party	12/31/2017	06/30/18
VPN Connectivity	CMT/Concord Hospital	Delayed due to Cerner upgrade	Implemented
ADT Feed / Messages	CH Hospital/DHMC-Lebanon	Feed has been built but not released by Privacy	Implemented and live
Test	CMT	Delayed due to Cerner upgrade	Completed
Mappings	CMT/Hospital	Delayed due to Cerner upgrade	Completed
Prod	Hospital	Delayed due to Cerner upgrade	Implemented
EMR Integration			TBD
Cerner Return Message	CMT		TBD
EMR Build	CH Hospital		TBD
Configure Icon	Concord Hospital		TBD
Validation	Concord Hospital		TBD

Historical File			
Build Historical File	Concord Hospital		In progress
IT Implementation Go Live			
Active Directory / SSO (Optional)			
Investigate Issue	CMT/Hospital		In progress
Identify Solution	CMT/Hospital		In progress
Implement Solution	CMT/Hospital		In progress
Clinical Kick Off Meeting			Completed
User Provisioning			
Identify list of initial users	Hospital		Completed
Set up initial users	CMT		8/7/18
Training			8/7/18
ED providers on EDIE	CMT		8/8/18
Clinical/Project Go Live			Week of 8/6/18

As previously stated, Concord Hospital approached their CMT rollout in phases, especially as their IT staff were still very consumed with day to day tasks during this reporting period that were attributed to the Cerner implementation that took place in December.

Getting the ADT feed implemented at Concord Hospital was not only the first and most important CMT task to get implemented for IDN2, but would affect other IDN organizations as well as they worked to go live with CMT.

Now that the feed has been implemented and is live, the Concord Hospital IT resources can now focus on rolling out the event notification program in the Emergency Department and at the CHMG practices. The required testing of printing the event notifications to a printer in the Emergency Department at Concord Hospital has been completed, the CMT cohorts (criteria on what types of event notifications they will receive) have been confirmed, and a CMT training has been scheduled with the appropriate ED staff at Concord Hospital for August 7th. Go live in the ED can commence immediately thereafter.

Equipment

As staff are hired, the appropriate hardware is being purchased and provided to them to enable them to perform their 1115 Waiver related job responsibilities.

Integration

- The behaviorists are documenting directly in their respective EMR's-Cerner at the CHMG practices and Tier at Riverbend.
- Crotched Mountain is piloting Telehealth within their Community Care program bringing Nurse Case Managers together with Social Workers/Psych to integrate medical & behavioral components to managing client's care. They are in discussions with Counseling Associates, a medium size behavioral health practice that has offices in New London, Newport, Claremont, and Hanover in regard to submission of a pilot for telehealth through the DSRIP program under the B1 Integrated Case Management project. NH Medicaid reimbursement for "home

site” for telehealth remains a major obstacle for all of us and we will be looking to connect with the individuals who can help us change this for the success of telehealth and the DSRIP program as it relates to the application of Integrated Case Management via telehealth.

- IDN2 is pursuing the feasibility with CMT of having an IDN-based portal where we can view all of our CMT members’ event notification information in one location.
- Concord Hospital, CRVNA, Riverbend, and Crotched Mountain are all discussing and considering EMR integration approaches for metric related and/or CMT patient upload file processes.

Data Analytics/APM/Population Health

Once the portal training with MAeHC is completed on 7/30/18, each admin user will be able to see dashboards for submitted metric data for CHMG, Riverbend, and DHMC, with the capability to drill into each measure by practice site and by patient. This data will be used in conjunction with the attribution files that DHHS sends to the IDN. Concord Hospital has a Population Health Tool that we hope to incorporate into our Data Analytic projects.

CMT also has the capability of creating organizational level summary reports, based on the event notifications; depicting patient name, date, time, facility location, and visit type. These are viewable and downloadable via each organization’s CMT web-based portal. CMT configures and sets up these reports for each organization.

Concord Hospital has assigned a Project Manager from their IT department to oversee the HIT related projects of the 1115 Waiver as they relate to Concord Hospital and the CHMG practices. They will manage the reporting requirements for the CHMG practices, with IDN admins overseeing the approach to what reports will be used, criteria, format, etc.

Once we determine what types of reports and what data they will contain, we will provide ongoing, summary reports to the newly transitioned, Oversight Committee (formally the HIT/Clinical Committee).

Table 12. IDN Specific Project Participation

Name of Organization	Type	A1	A2	B1	C2	D1	E5	Other
Ascentria Care Alliance	Community based organization							Steering
Bhutanese Community of NH	Community based organization							Steering
Boys & Girls Clubs of Greater Concord	Community based organization							Referral
Capital Area Public Health Network	Public Health Network							Steering
CATCH Neighborhood Housing	Community based organization							Steering
Child & Family Services	Community based organization	x	x	x		x	x	
Community Action Program	Community based organization							Referral
Concord Coalition to End Homelessness	Community based organization							Steering
Concord Family YMCA	Community based organization							Steering

Concord Hospital	Hospital	x	x			x	x	Steering
CHMG Practices:								
Concord Family Medicine	Primary Care Practice	x	x	x		x		
Concord Hospital OBGYN	Specialty Care Practice	x				x		
Epsom Family Medicine	Primary Care Practice	x	x	x		x		
Family Health Center Concord	Primary Care Practice	x	x	x		x		
Family Health Center Hillsboro	Primary Care Practice	x	x	x		x		
Family Physicians of Pembroke	Primary Care Practice	x	x			x		
Internal Medicine at Horseshoe Pond	Primary Care Practice	x	x	x		x		
Pelvic Medicine	Specialty Care Practice	x						
Penacook Family Physicians	Primary Care Practice	x	x	x		x		
Pleasant Street Family Medicine	Primary Care Practice	x	x	x		x		
Substance Use Services / Fresh Start	Behavioral Health Provider	x	x	x		x		
Concord Human Services	State Agency							Steering
Concord Regional Visiting Nurse Association	Community based organization	x	x					Steering
Crotched Mountain	Community based organization							Referral
Dartmouth Hitchcock Concord	Primary Care Practice	x	x	x		x		
Dartmouth Hitchcock OB-GYN	Specialty Care Practice	x				x		
Families in Transition	Community based organization							Referral
Fellowship Housing Opportunities	Community based organization							Referral
Granite Pathways	Community based organization							Referral
Granite State United Way	Community based organization							Referral
Granite State Independent Living	Community based organization							Referral
Life Coping, Inc.	Community based organization							Referral
Merrimack County Dept of Corrections (Jail)	Correctional Facility	x	x		x			Steering
NAMI New Hampshire	Community based organization	x			x	x	x	Steering
New Hampshire Hospital	Hospital		x				x	Referral
NH Alcohol/Drug Abuse Counselors Assoc.	Community based organization							Training
NH Dept of Corrections (Prison)	Correctional Facility	x	x		x			
Riverbend Community Mental Health	Behavioral Health Provider	x	x	x	x	x	x	Steering

Sununu Youth Services	Correctional Facility	x	x				x	Referral
UNH Institute on Disability	University	x					x	Training
Youth Move NH	Community based organization	x					x	Peers

A2-4. IDN HIT: 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
Data Vendor	Data vendor will be selected to assist in collecting project metrics for the state and individual IDN projects	MAeHC was chosen	MAeHC has and is actively working with IDN2's organizations in receiving the required metric file submissions.	
Secure Texting	Evaluate each project for need and implement	To be determined/reviewing with providers at site mtgs and f/u	After careful review, secure texting is not an option due to Medicaid clients utilizing non-smart type phones that are incompatible with our preferred texting program, TigerText. We are exploring other vendors/options.	
Closed loop referrals	Evaluate and implement referral process	To be determined	All but step 9 per MSLC TA report are implemented at CHMG practices. Riverbend & DHMC will implement next reporting period.	
Data Sharing Agreements Signed	Develop agreement for sharing data within the IDN and obtain signatures	2 with MAeHC directly	3-CH/CHMG, Riverbend, CRVNA. DHMC-Concord-Pending	
Data Vendor Implementation	Data vendor will be implemented to all organizations that must report metrics in order to achieve first reporting requirement	Planned: 3	MAeHC successfully collected the required metrics from our 3 reporting organizations: CH/CHMG, Riverbend, DHMC-Concord for 1 st report submission of 4/1/18	
Minimum standards assessment	Assess all organizations (41) for baseline status regarding the 8 minimum standards.	Met with 7 organizations	Met with 7 additional organizations	
Direct messaging	All identified agencies will implement direct messaging	8 organizations have DSM to date	2 organizations implemented new Kno2 accounts	
Standards Education	Provide education/guidance to identified agencies (14) for standards 2-4	Met with 7	Met with 7 additional organizations	
Event Notification	All identified organizations will be sending ADT event notifications	0	Concord Hospital went live with ADT feed to CMT on 6/4/18	
Measure Name		As of 12/31/17	As of 6/30/18	As of 12/31/18

Performance	Target	Progress Toward Target		
Shared Care Plan	All identified (23) organizations will implement shared care plan	0	Workflow discussions have been and continue to take place	
PreManage Ed	Implement PreManage ED	0	Planned for week of 8/6/2018	
Equipment	All identified (8) primary care practices will have designated equipment for integration	8	Equipment is purchased as staff are hired for 1115 Waiver related roles	
Integration	EMR will have fields built for data collection. Epic, Cerner, Tier	0	1-RB for ASSESS Screen 4 in Tier EMR Cerner-CCSA-done Epic-planned for Aug-Oct 2018	

A2-5. IDN HIT: Workforce Staffing

Concord Hospital will provide staffing by utilizing existing staff and the funds allocated for the Data Analyst position will be applied accordingly.

Overall IDN activities

1. Oversee/coordinate IDN 2 metric submissions with member organizations required to submit metrics (DH Concord, Riverbend, CH/CHMG)
2. Work/coordinate with Maehe on IDN 2 metric submission which may include developing interfaces
3. Create/deliver reports as requested by IDN
4. Assist with developing most efficient way to extract/report on metrics for individual projects with member organizations

CH/CHMG activities

1. Coordinate implementation of CMT PreManage Community for CHMG
2. Coordinate implementation of CMT PreManage ED for CH

The above would include all aspects-interfaces, user management, roll out, process flow

Staff Type	IDN Workforce (FTEs)				
	Projected Total Need	Baseline Staffing on 6/30/17	Staffing on 12/31/17	Staffing on 6/30/18	Staffing on 12/31/18
IT Support	.5	0	.5	.5	
Data Analyst	.5	0	0	.5	

A2-6. IDN HIT: Budget

	ACTUALS			PROJECTED			
	2016	2017	Jan-Jun 2018	Jul-Dec 2018	2018	2019	2020
HIT							
Purchase Services / Professional		\$ 9,833	\$ 31,450				
Network Software (Software Applications)		16,516	90,199				
Total Health Info Tech		\$ 26,349	\$ 121,650	\$ 172,656	\$ 294,306	\$ 317,106	\$ 325,000

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

Organization Name	Organization Type
Concord Hospital	Hospital
Concord Family Medicine	Primary Care
Concord Hospital OBGYN	Primary Care
Epsom Family Medicine	Primary Care
Family Health Center-Concord	Primary Care
Family Health Center-Hillsboro	Primary Care
Family Physicians of Pembroke	Primary Care
Internal Medicine at Horseshoe Pond	Primary Care
Penacook Family Physicians	Primary Care
Pleasant Street Family Medicine	Primary Care
Substance Use Services/Fresh Start	Behavioral Health Provider
Concord Regional VNA	Home Health and Hospice
Dartmouth Hitchcock Concord	Primary Care Practice
Riverbend Community Mental Health	Behavioral Health Provider

A2-8. IDN HIT: Data Agreement

Organization Name	Data Sharing Agreement Signed Y/N
Concord Hospital/CHMG	Y-Signed with IDN
Riverbend	Y-Signed with IDN
Concord Regional VNA	Y-Signed with IDN
DHMC-Concord	Pending

Project Scoring: IDN HIT Process Milestones

Process Milestone Number	Process Detail	Submission Format	Results (Met/Not Met)			
			6/30/17	12/31/17	6/30/18	12/31/18
A2-3	IDN HIT/HIE Implementation Plan and Timeline	Narrative & Spreadsheet (Microsoft Project or similar platform)				
A2-4	Evaluation Project Targets	Table				
A2-5	IDN HIT Workforce Staffing	Table				
A2-6	IDN HIT Budget	Narrative and Spreadsheet				
A2-7	IDN HIT Key Organizational and Provider Participants	Table				
A2-8	IDN HIT Data Agreement	Table				

Project B1: Integrated Healthcare

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

Timeline with updates in bold. Past is greyed out. Present and future is in blue shading.

Dartmouth Hitchcock Concord	
Jan -Jun 2017	<ul style="list-style-type: none"> • Budget - This was accomplished • Workforce gap analysis and plan - This was accomplished • Assessment of current state of integration - This was accomplished • Assessment of ability to collect outcome measures 1 & 2 - This was accomplished • HIT assessment and plan - This was accomplished • Implementation plan and timeline for semi-annual report - This was accomplished
July - Dec 2017	<ul style="list-style-type: none"> • 1 BH staff hired, trained, credentialed, & co-located - This person resigned in Dec. 2017 and it has been decided that DHC will hire the person and IDN2 will fund the position. DHC is following a DH model not an IDN2 model and it becomes too difficult to have an embedded IBHC that is following a separate model. This may have contributed to the previous IBHC resigning. • 1 BH staff hired, trained, credentialed, & co-located - Only 1 BH staff person will be at DHC due to their not focusing on Medicaid lives. The amount of Medicaid lives they expect to serve can be covered by 1 BH staff person. • PCP, BH, & non-clinical trainings identified and documented - BH Training for flow staff completed Nov 15. MH Training for all staff completed 1/26/18 and additional BH training for providers scheduled 2/21/18 • Identify and develop any new protocols/processes required for integration Introduce/train staff in use of protocols/processes - In progress not completed. Awaiting available system resources to automate and operationalize workflows. • Clinical workflows finalized - See response above • Begin data collection for outcome measures 1 & 2 - All DH entities are reporting 0 at this time • Assessment of ability to collect outcome measures 3 & 4 - This was accomplished. • Introduce CMT (shared care plan/event notification) - This was accomplished through a presentation by CMT • Provide CMT training for users - This was accomplished through a series of presentations by CMT. • Provide data for semi-annual report - This was accomplished
Jan - Jun 2018	<ul style="list-style-type: none"> • Begin data collection for outcome measures 3 & 4 • CCSA in use • PCP, BH, & non-clinical trainings scheduled • Monthly high need case conferences established/in use • HIT + Clinical Committee monthly process & outcome review <p>From DH Project Manager (for all IDN DH sites):</p> <ul style="list-style-type: none"> • Due to challenges around project support, recruitment of needed positions & procurement needed hardware for screening, little has been accomplished between January and June. • During the month of May this author was tasked with organizing a system's approach to implementing integrated care across the organization that will satisfy internal and external (B1) requirements.

	<ul style="list-style-type: none"> • To this end, D-HH has established biweekly Thursday meetings for primary care teams across our organization and IDN partners to come together for shared learning and information exchange. • An internal D-HH workgroup continues to meet on “opposite” Thursdays to prioritize activities and mitigate challenges.
<p>July - Dec 2018</p>	<ul style="list-style-type: none"> • Monthly high need case conferences established/in use • CMT in use • Closed loop referrals in use • Coordinated Care Practice status achieved • Data collection outcome measures 1-4 • Monthly case review meetings • Annual cross training of BH, PCP, and non-clinical staff • HIT + Clinical Committee monthly process & outcome review • Provide data for semi-annual report <p>From DHH Project Manager (for all IDN DH sites):</p> <p><u>CCSA</u> - D-H hosting workshop 7/25 with leaders/delegates to gain consensus on questionnaire content for D-HH’s version CCSA; CCSA then needs to be built into EMR (August-October; new hardware required for administration (October-November).</p> <p><u>Core Team Members</u> - Approval to recruit core team members in process effective 6/21; positions posted for embedded IBHC (x2) and resource support specialist; interview being scheduled for 1 IBHC candidate.</p> <p><u>Training for Core Team Members</u> - Training for existing primary care teams to be held 7/27; training for new recruit(s) to commence upon offer/acceptance post interview process; strong candidate identified; will confirm interview schedule July-August</p> <p><u>Monthly core team case conferences for high need populations</u> - To commence upon recruitment of new hires & training July-September.</p> <p><u>Secure Messaging</u> - Learning from B1 in Lebanon to inform best practice across sites (June-September)</p> <p><u>Closed loop referrals</u> - As above for external BH services, as per workflows developed for community health workers & as per internal processes for referral from PCP to embedded IBHC.</p> <p><u>Documented work flows and/or protocols</u> - To be determined after workshop and education session (7/25 & 7/27).</p> <p><u>EBP to address mild-to-moderate depression</u> - Expanded collaborative care model based on AIMS Center IMPACT model; to be implemented upon recruitment and training of needed staff.</p> <p><u>Use of technology to identify, plan for, and monitor at-risk patients</u> - CCSA will be built in eDH (Epic EMR) and administered for target population on iPads in reception area or via MyDH patient portal; patients elevated to Shared Care Plan status will be uploaded to CMT; sharepoint registry will be used for population management of patients enrolled in Collaborative Care.</p>

Riverbend

Jan -Jun 2017	<ul style="list-style-type: none"> • Budget - This was accomplished • Workforce gap analysis and plan - This was accomplished • Assessment of current state of integration - This was accomplished • Assessment of ability to collect outcome measures 1 & 2 • HIT assessment and plan - This was accomplished • Implementation plan and timeline for semi-annual report - This was accomplished
July - Dec 2017	<ul style="list-style-type: none"> • Hired a Director of Integration - When the IBHC supervisor resigned, IDN2 made the decision to support the Integration project with a Director of Integration to focus on all areas of Integration across the primary care, mental health, and substance use provider sites in IDN2 and underscore IDN2's commitment to sustaining these Integration efforts long-term. • Hire MA and APRN - As described in the BH Workforce Development section, these hires were delayed while Concord Hospital and Riverbend conduct a business analysis of the Integrated Center for Care at Riverbend and determine how best to staff and sustain it. • PCP, BH, & non-clinical trainings identified and documented - As described in the BH Workforce Development section, PCPS are going to receive Motivational Interviewing (MI) and Screening, Brief Intervention, and Referral to Treatment (SBIRT) training; BH have/will receive Metabolic Syndrome training (Metabolic syndrome is a cluster of conditions — increased blood pressure, high blood sugar, excess body fat around the waist, and abnormal cholesterol or triglyceride levels — that occur together, increasing one's risk of heart disease, stroke and diabetes); and IDN2 is developing a self-paced training for non-Clinical staff focused on stigma reduction. • Identify and develop any new protocols/processes required for integration Introduce/train staff in use of protocols/processes - Riverbend developed a new protocol for collecting the CCSA. It is attached as Appendix A. This will be in use when the CCSA is launched May 1, 2018. • Clinical workflows finalized - Riverbend, as a multi-service CMHC also providing substance use disorder services, has workflows for each of its key clinical programs (Children's Services, CHOICES addiction services, Integrated Center for Health, Community Support Program, Riverbend Counseling Associates, Residential, Psychiatric Emergency Services, Community Wellness). It is in the process of determining how best to work as an integrated whole with the least disruption to client experience and while maintaining what's needed to accomplish the goals of each specific service. • Begin data collection for outcome measures 1 & 2 - Riverbend will be sending data to MAeHc • Assessment of ability to collect outcome measures 3 & 4 - This was accomplished. There are questions for NH DHHS regarding measure 3 and which of these needs to be done at a CMHC and under what circumstances. • Introduce CMT (shared care plan/event notification) - This was accomplished through a presentation by CMT • Provide CMT training for users - This was accomplished through a series of presentations by CMT. • Provide data for semi-annual report - This was accomplished

Jan - Jun 2018	<ul style="list-style-type: none"> • Begin data collection for outcome measures 3 & 4 - Accomplished. As a behavioral health site, Riverbend will not be collecting Assess 03. It is collecting Assess 04. The collecting and reporting of these metrics is in progress with MAeHC. • PCP, BH, & non-clinical trainings scheduled - Accomplished. Riverbend provides stigma reduction and metabolic disorders training to its staff on an ongoing basis as part of their onboarding. Medical staff in the RICH program are employees of Concord Hospital and participated in the Motivational Interviewing/SBIRT training provided by the NH Center for Excellence. • High need case conference meetings established/in use - Accomplished. These case conferences are an ongoing practice at Riverbend. • CMT in use - Accomplished. CMT is “live” and available as an event notification and shared care plan tool. • Closed loop referrals in use - Deferred to next report period as Riverbend moves to HIT TIER 8. • Use of technology to identify, plan, and manage high risk needs - Deferred to next report period as Riverbend moves to HIT TIER 8. • Develop referral protocols for CBOs - Deferred to next report period as Riverbend moves to HIT TIER 8. • HIT + Clinical Committee - monthly process & outcome review - Accomplished. • MAT & Depression EBP protocols in place - Accomplished. Riverbend offers MAT through CHOICES and all integrated staff at RICH are trained in the IMPACT model. • Provide data for semi-annual report - Accomplished.
July - Dec 2018	<ul style="list-style-type: none"> • Clinical processes in place to support all outcome measures • Data collection outcome measures • Closed loop referrals in use • Use of technology to identify, plan, and manage high risk needs • Monthly case review meetings • Annual cross training of BH, PCP, and non-clinical staff • Oversight Committee - monthly process & outcome review • Provide data for semi-annual report

Family Health Center Concord (FHC-C) Family Health Center Hillsboro (FHC-H) Concord Family Medicine (CFM) Family Physicians of Pembroke (FPP) Penacook Family Physicians (PFP) Epsom Family Medicine (EFM)	
Jan - Jun 2017	<ul style="list-style-type: none"> • Budget - This was accomplished • Workforce gap analysis and plan - This was accomplished • Assessment of current state of integration - This was accomplished • Assessment of ability to collect outcome measures 1 & 2 - This was accomplished • HIT assessment and plan - This was accomplished • Implementation plan and timeline for semi-annual report - This was accomplished

<p>July - Dec 2017</p>	<ul style="list-style-type: none"> • All BH staff hired & co-located in the first wave of CHMG sites - These are the practices that have an integrated IBHC: <ul style="list-style-type: none"> ○ Family Health Center Concord ○ Family Health Center Hillsboro-Deering ○ Concord Family Medicine ○ Family Physicians of Pembroke ○ Penacook Family Physicians ○ Epsom Family Medicine • PCP, BH, & non-clinical trainings identified and documented - As described in the BH Workforce Development section, PCPS are going to receive Motivational Interviewing (MI) and Screening, Brief Intervention, and Referral to Treatment (SBIRT) training; BH have/will receive Metabolic Syndrome training (Metabolic syndrome is a cluster of conditions — increased blood pressure, high blood sugar, excess body fat around the waist, and abnormal cholesterol or triglyceride levels — that occur together, increasing one’s risk of heart disease, stroke and diabetes); and IDN2 is developing a self-paced training for non-Clinical staff focused on stigma reduction. • Identify and develop any new protocols/processes required for integration Introduce/train staff in use of protocols/processes - Reviewed; Privacy forms to be updated January 2018 • Site Self Assessments begin / every 6 months - This was accomplished in November. Report is Attachment A. • Clinical workflows finalized - This was accomplished. Workflow is Attachment B. • Develop mechanisms for collecting/reporting data in Cerner - Cerner went live December 2017 and this is in progress. 99% of the elements exist in Cerner and CH wants to create a user-friendly portal to collect them in one place. • Assessment of ability to collect outcome measures 3 & 4 - This was accomplished. Ability exists. • Introduce CMT (shared care plan/event notification) - This was accomplished through a presentation by CMT • Provide CMT training for users - This was accomplished through a series of presentations by CMT. • Provide CMT training for users - This was accomplished through a series of presentations by CMT. • Provide data for semi-annual report - This was accomplished
<p>Jan - Jun 2018</p>	<ul style="list-style-type: none"> • Begin data collection for outcome measures 1-4 - Accomplished. <ul style="list-style-type: none"> ○ Working with MAeHC to collect and report measures • PCP, BH, & non-clinical trainings scheduled - Accomplished. <ul style="list-style-type: none"> ○ BH staff received metabolic training; PCP received MI/SBIRT training, non-clinical staff received stigma reduction training. • Hire psychiatrist - Accomplished. • CCSA in use - Accomplished. <ul style="list-style-type: none"> ○ In use as a paper form across all sites. • High need case conference meetings established/in use. Accomplished. <ul style="list-style-type: none"> ○ These are occurring weekly with the psychiatrist according to the following schedule: <ul style="list-style-type: none"> ▪ Concord Family Medicine: Monday afternoon session ▪ Epsom Family Medicine: Tuesday afternoon session ▪ Pembroke Family Physicians: Weds afternoon session ▪ Penacook Family Physicians: Friday morning session • Shared Care Plan in use - Accomplished. <ul style="list-style-type: none"> ○ Cerner is in use as the shared care plan and will be further developed

	<ul style="list-style-type: none"> • MAT EBP protocols in place - Accomplished <ul style="list-style-type: none"> ○ MAT is available onsite at Concord Family Medicine and the Family Health Centers ○ MAT is available through the HUB for other practices • Oversight Committee - monthly process & outcome review - Accomplished. • Provide data for semi-annual report - Accomplished.
July - Dec 2018	<ul style="list-style-type: none"> • Data collection and reporting outcome measures 1-4 • Closed loop referrals in use • Further develop shared care plan • Depression protocols in place • Use of technology to identify, plan, and manage high risk needs • Outcome Committee - monthly process & outcome review • Provide data for semi-annual report
Pleasant Street Family Medicine (PSFM) Internal Medicine Horseshoe Pond (IMED HP) CH Substance Use Services (CH SUS)	
July - Dec 2018	<ul style="list-style-type: none"> • Data collection and reporting outcome measures 1-4 • Core Team in Place • PCP, BH, and non-Clinical staff trainings • Link to psychiatrist • CCSA in use • High need case conferences established • Shared care plan in use • MAT and depression EBP protocols in place • Closed loop referrals in use • Use of technology to identify, plan, and manage high risk needs • Outcome Committee - monthly process & outcome review • Provide data for semi-annual report

B1-3. IDN Integrated Healthcare: 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
Data Vendor	Data vendor will be selected to assist in collecting project metrics for the state and individual IDN projects	MAeHC was chosen	MAeHC has and is actively working with IDN2's organizations in receiving the required metric file submissions.	
Secure Texting	Evaluate each project for need and implement	To be determined/reviewing with providers at site meetings and f/u	After careful review, secure texting is not an option due to Medicaid clients utilizing non-smart type phones that are incompatible with our preferred texting program, TigerText. We are exploring other vendors/options.	

Performance	Target	Progress Toward Target		
Closed loop referrals	Evaluate and implement referral process	To be determined	All but step 9 per MSLC TA report are implemented at CHMG practices. Riverbend & DHMC will implement next reporting period.	
Data Sharing Agreements Signed	Develop agreement for sharing data within the IDN and obtain signatures	2 with MAeHC directly	3-CH/CHMG, Riverbend, CRVNA. DHMC-Concord-Pending	
Data Vendor Implementation	Data vendor will be implemented to all organizations that must report metrics in order to achieve first reporting requirement	Planned: 3	MAeHC successfully collected the required metrics from our 3 reporting organizations: CH/CHMG, Riverbend, DHMC-Concord for 1 st report submission of 4/1/18	
Minimum standards assessment	Assess all organizations (41) for baseline status regarding the 8 minimum standards.	Met with 7 organizations	Met with 7 additional organizations	
Direct messaging	All identified agencies will implement direct messaging	8 organizations have DSM to date	2 organizations implemented new Kno2 accounts	
Standards Education	Provide education/guidance to identified agencies (14) for standards 2-4	Met with 7	Met with 7 additional organizations	
Event Notification	All identified organizations will be sending ADT event notifications	0	Concord Hospital went live with ADT feed to CMT on 6/4/18	
Shared Care Plan	All identified (23) organizations will implement shared care plan	0	Workflow discussions have been and continue to take place	
PreManage Ed	Implement PreManage ED	0	Planned for week of 8/6/2018	
Equipment	All identified (8) primary care practices will have designated equipment for integration	8	Equipment is purchased as staff are hired for 1115 Waiver related roles	
Integration	EMR will have fields built for data collection. Epic, Cerner, Tier	0	1-RB for ASSESS Screen 4 in Tier EMR Cerner-CCSA-done Epic-planned for Aug-Oct 2018	

B1-4. IDN Integrated Healthcare: Workforce Staffing

Provider Type	IDN Workforce (FTEs)				
	Projected Total Need	Baseline Staffing on 6/30/17	Staffing on 12/31/17	Staffing on 6/30/18	Staffing on 12/31/18
B1 - IBHC	8.4	6	7.4	4.4	

B1 - IC Manager	1	1	1	1	
B1 - Psychiatrists	2	0	0	1	
B1 - MA	1	1	1	1	
B1 - IBHC Supervisor	1	1	1	1	
All - Peers (shared across projects)	5	4	2	5	

B1-5. IDN Integrated Healthcare: Budget

	ACTUALS				PROJECTED		
	2016	2017	Jan-Jun 2018	Jul-Dec 2018	2018	2019	2020
Integration							
Purchase Services / Professional (RB)		\$ 18,360	\$ 409,213				
Purchase Services / Professional (CH)		293,640	-				
Consulting (Pediatric MH)		-	22,308				
Outside Training		449	6,802				
Other Direct		23,950	-				
Total Integrated Health		\$ 336,399	\$ 438,322	\$ 864,329	\$ 1,302,651	\$ 1,337,102	\$ 1,350,000

Purchase Services / Professional (RB)

This represents the embedded IBHCs hired by Riverbend and working within the CHMG primary care practices.

Purchase Services / Professional (CH)

This line items is to represent the embedded Medical Assistant (MA) hired by Concord Hospital and working within Riverbend's Integrated Center for Health as well as an Integrated Care Manager (ICM) hired by Concord Hospital to work within the Family Health Center. For this reporting period, it is included in Purchase Services / Professional (RB).

Outside Training

This represents training provided to Integrated Healthcare staff (please see A1 for the list of trainings attended this reporting period). It is also intended to cover the required training for PC and BH providers and non-Clinical staff within the integrated sites as well as additional training for IBHCs.

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

Organization/Provider	Agreement Executed (Y/N)
Concord Family Medicine	Y
Concord Hospital FHC Concord	Y
Concord Hospital FHC Hillsboro	Y
Concord Hospital Substance Use Services	Y
Dartmouth Hitchcock Concord	Y
Epsom Family Medicine	Y
Family Physicians of Pembroke	Y
Penacook Family Physicians	Y
Internal Medicine at Horseshoe Pond	Y
Pleasant Street Family Medicine	Y
Riverbend Community Mental Health	Y

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

Done in past.

B1-8A Comprehensive Core Standardized Assessment

CCSA Domain	DHC	FHC-C, FHC-H, Penacook, Pembroke, Epsom, CFM	PSFM, IMED HP, CH SUS	RB
Demographic information	Dec. 2018	Y	Dec. 2018	Y
Physical health review	Dec. 2018	Y	Dec. 2018	Y
Substance use review	Dec. 2018	Y	Dec. 2018	Y
Housing assessment	Dec. 2018	Y	Dec. 2018	Y
Family and support services	Dec. 2018	Y	Dec. 2018	Y
Educational attainment	Dec. 2018	Y	Dec. 2018	Y
Employment or entitlement	Dec. 2018	Y	Dec. 2018	Y
Access to legal services	Dec. 2018	Y	Dec. 2018	Y
Suicide risk assessment	Dec. 2018	Y	Dec. 2018	Y
Functional status assessment	Dec. 2018	Y	Dec. 2018	Y
Universal screening using depression screening (PHQ 2 & 9)	Dec. 2018	Y	Dec. 2018	Y
Universal screening using SBIRT	Dec. 2018	Y	Dec. 2018	Y
Validated developmental screening for all children, such as the ASQ 3 and/or ASQ SE at 9, 18 and 24/30 month pediatric visits	Dec. 2018	Y	Dec. 2018	N/A
Developmental Screening using Bright Futures or other American Academy of Pediatrics recognized	Dec. 2018	Y - MCHAT	Dec. 2018	Y-CANS

Riverbend is pulling the CCSA from a variety of sources, including CANS and ANSA, that already exist and plans to incorporate it into its HIT system, TIER 8, when that is developed (October 2018).

The Family Health Centers (Concord and Hillsboro), Penacook, Pembroke, Epsom, Concord Family Medicine, and Riverbend are all using the CCSA. It is in a paper form that is then scanned into Cerner and forms the basis for the shared care plan. Please see next page for CHMG CCSA form and workflow in current use.

Dartmouth-Hitchcock Concord, CH Substance Use Services, Pleasant Street Family Medicine, and Internal Medicine Horseshoe Pond will be using the CCSA no later than Dec. 31, 2018.

Name:
Date:
Comprehensive Core Standardized Assessment

We are trying to understand the impact of stresses and supports on our patients' health. Your answers will be shared with your care team, and we will make every effort to help you access resources in the community if you would like us to. This form will be scanned into your medical record. As with all your records, only those involved directly in your care will read your answers.

Substance Use

The following questions are about substance use. We ask in order to better care for you and to identify community services that may be available to help you.

Tobacco: Which of the following describes you?

- Never smoker
- Current some day smoker
- Current every day smoker
- Former smoker: quit more than one year
- Former smoker: quit less than one year

Type Used:

- Cigarettes
- Pipe
- Cigars
- Smokeless Cigarettes
- Oral
- Smokeless Spit Tobacco
- Other: _____

Alcohol: Which of the following describes you?

- Never used
- Past user
- Current user

Type Used:

- Beer
- Wine
- Liquor
- Other: _____

How often do you do drink alcohol?

- 1-2 times per week
- 3-5 times per week
- Daily
- Binge
- 1-2 times per month
- 1-2 times per year
- Occasional use
- Several times per day
- Regular use

Which of the following describes you?

- Never used illegal or illicit drugs
- Current use of illegal or illicit drugs
- Past use of illegal or illicit drugs

Type Used:

- Amphetamines
- Heroin
- Prescription medications
- Cocaine
- Inhalants/Glues/Solvents
- Opioids
- Ecstasy
- Marijuana
- IV drug use
- Hallucinogens/LSD
- Methamphetamines
- Other: _____

How often do you do use illegal or illicit drugs?

- 1-2 times per month
- 3-5 times per week
- Several times per day
- 1-2 times per week
- Daily

In the past two weeks, have you experienced:
Little interest or pleasure in doing things:

- Yes No

Feeling down, depressed or hopeless:

- Yes No

Please use the following to describe your physical activity

Minutes per day: _____

Days per week: (circle one) 1 2 3 4 5 6 7

Physical Activity Level:

- Light
- Moderate
- Vigorous
- Other: _____

Have you ever served in the military?

- Never served in the military
- Yes

Branch of Military

- Air Force
- Marines
- Army
- Navy
- National Guard
- Coast Guard
- Other: _____
- Do not want to answer

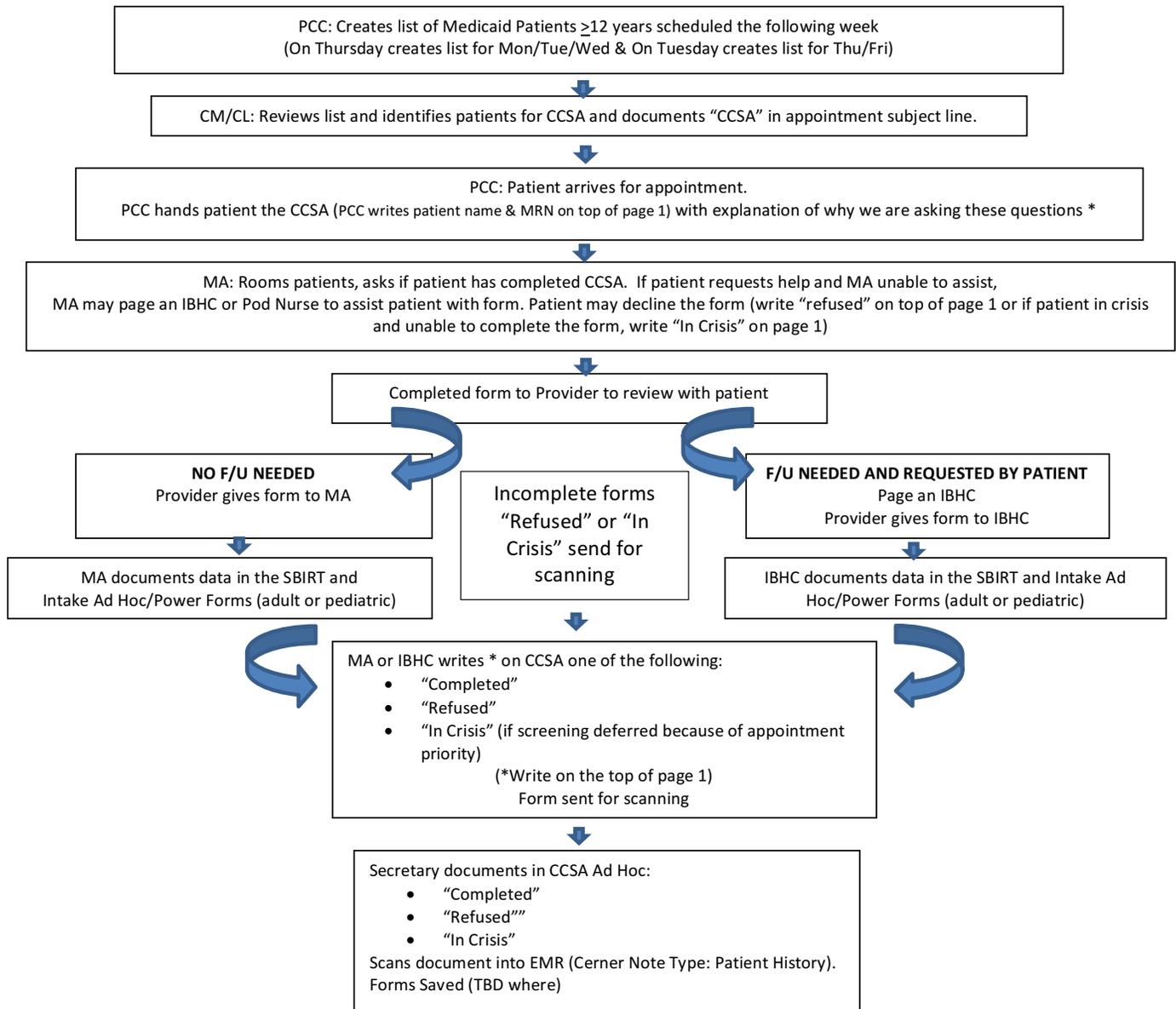
Current Military Status

- Active duty
- Discharge honorable
- Retired
- Discharge dishonorable
- Non-active duty
- Discharge general
- Reserves
- Other: _____
- Do not want to answer

**CCSA Roll-Out
Proposed Work Flow May 2018**

Who: Medicaid Patients 12 and above

When: Once annually at 40+-minute medical and BH appointments (excluding dental and procedure appointments)



** Here is a survey we would like for you to fill out. We are trying to understand the impact of stresses and supports on our patients' health. Your answers will be shared with your care team, and we will make every effort to help you access resources in the community if you would like us to. Please give this to the person who comes to get you in the waiting room, and they will share it with your medical provider.*

FHC 5/2018

B1-8b Core Team Members

Organization/Provider	PCP	Psych	IBHC	ICM	MAT
Dartmouth Hitchcock Concord	Y	Y	N		1
Riverbend	Y	Y	Y	Y	4
Family Health Center Concord	Y	Y	Y	Y	2
Family Health Center Hillsboro	Y	Y	Y	Y	
Concord Family Medicine	Y	Y, sharing 1 FTE psychiatric APRN; 1 TBH	Y	Y, sharing 1 FTE ICM	3
Family Physicians of Pembroke	Y		Y		
Penacook Family Physicians	Y		Y		
Epsom Family Medicine	Y		Y		
CH Substance Use Services	N		BH - Y		Pending
Pleasant Street Family Medicine	Y		N		2
IMED Horseshoe Pond	Y		N		1

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

Site	# PCP	Goal/Actual	MH Training	SUD Training	# IDN BH	Med Training
Dartmouth Hitchcock Concord	62	47	Dec 2018	Dec 2018	1	Dec 2018
Riverbend	2	Goal -2 Actual - 2 to date	Jun 2018	Jun 2018	At CHMG	June 2018
Family Health Center Hillsboro	82	Goal 60 Actual - 81 to date	Jun 2018	Jun 2018	1	Oct 2017
Family Health Center Concord			Jun 2018	Jun 2018	1	May 2018
Concord Family Medicine			Jun 2018	Jun 2018	1	May 2018
Family Physicians of Pembroke			Jun 2018	Jun 2018	1	Jul 2017
Penacook Family Physicians			Jun 2018	Jun 2018	1	Jul 2017
Epsom Family Medicine			Jun 2018	Jun 2018	1	Jul 2017
CH Substance Use Services						
Pleasant Street Family Medicine			Jun 2018	Jun 2018	1 TBH	Dec 2018
IMED Horseshoe Pond	Jun 2018	Jun 2018	1 TBH	Dec 2018		

All behavioral health staff hired for the IDN (as well as Riverbend’s Community Support Program staff) were trained in metabolic syndrome by (Metabolic syndrome is a cluster of conditions -- increased blood pressure, high blood sugar, excess body fat around the waist, and abnormal cholesterol or triglyceride levels — that occur together, increasing one’s risk of heart disease, stroke, and diabetes.) The training covered definition, symptoms, etiology, treatment, co- morbidities, and health disparities.

81 CHMG site PCPs received SBIRT and Motivational Interviewing training through the NH Center for Excellence. In addition, 145 other medical staff and 93 non-clinical staff received this training.

In addition, PCPs and IBHCs received a training about working together as a core team, which included the following information for PCPs in referring their patients to an IBHC:

Optimizing the Effectiveness of Integrated Behavioral Health Clinicians

- **IBHCs are available to support the behavioral health of your Medicaid patients by addressing**
- **health behaviors and their contribution to chronic medical illnesses, life stressors and crises, stress related physical symptoms, and ineffective patterns of health care utilization. Care might include assessment, collaboration with you and the consulting psychiatric prescriber to support medication management, provision of focused interventions, and referral and linkage to specialty behavioral health and other supportive services.**
- **The referral to an IBHC should be as directive as you would normally make a referral to any other service. There should not be a discernable difference in content or tone between a referral to an IBHC and a referral to a cardiologist. Patients will pick up the importance a provider implies regarding a referral and respond accordingly.**
- **Unless a patient has used a diagnostic term themselves (“I feel depressed”; “I had a panic attack”; “I’m addicted”) it is more effective to use general terms like ‘stress’ to refer to behavioral health problems. IBHCs have the time and the skill to assess patients’ readiness to identify themselves as having particular problems and can work with patients on de-stigmatizing these terms when necessary.**
- **It is more effective to use general terms such as ‘colleague’ or ‘someone who specializes’ instead of ‘counselor’ or ‘therapist’ or ‘social worker’. For many patients these terms evoke stigma, fear, and misunderstanding, and may keep a patient from seeing the IBHC. Along the same lines, asking about or offering a patient ‘counseling’ is less effective than offering them ‘education’, ‘ideas’, or even ‘support’.**
- **The opportunity for a warm hand-off should trump any pre-scheduled appointments the IBHC might have. Go ahead and knock on their closed door!**
- **Do not imply that you are referring the patient for extended mental health treatment. Instead, emphasize that the IBHC is a part of the medical team working together to provide good medical care. The IBHC is not designed to provide traditional therapy (though we can arrange this when needed), rather he/she provides short-term or targeted longitudinal consultation as part of comprehensive healthcare.**

Sample Scripts for Warm Hand-offs to IBHCs

Emotional Difficulties

“It sounds like you’re dealing with a lot of stress/sadness/worries/anger right now. I work with someone who specializes in helping with these issues, and I would like you to speak with them today to better help me help you. Is it alright with you if I introduce you to her/him?”

“As part of your overall health care, I’m concerned about your stress/sadness/worries. I have a member of our team who helps me assess these types of problems so that I can provide you with the best care. Together we can develop a plan to deal with this. May I introduce you?”

Prompted by Screening

“From some of your answers on this questionnaire, it looks as if you may be feeling down/worried/stressed lately. I have a colleague who I work with who can give you some ideas of ways to help with this. Her/His office is just down the hall; is it okay with you if my MA walks you there after we are done so you can talk for a minute?”

Chronic Pain

“One thing we know about chronic pain is that it can’t be solved or eliminated by the use of medications alone, which can cause many people to feel helpless or hopeless. I have a colleague who can help you to learn specific strategies for managing pain and reducing your risk of pain. I’d like to introduce him to you today; would that be okay?”

Chronic Diseases

“Having a chronic disease can feel really overwhelming. In order to keep it well managed, it asks you to change certain behaviors—that’s hard! We have someone on our team who can help you through this process. I’d like to go grab her right now and have her join our visit. Would you be okay with that?”

Health Risk Factors

“Making a change, like _____ (e.g. quitting smoking/losing weight/incorporating a new medication into your routine) can be much more difficult than it seems as it requires you to change habits that you have acquired over many years of practice. There is a member of our health team who is really skilled at helping people come up with and work on a plan to tackle this. I’d like to introduce her to you today; would that be okay?”

Somatic Complaints

“Our bodies are really incredible in the way that our physical health can trigger an emotional response and our emotions can trigger a physical response. It can sometimes be really hard to figure out which causes which! Regardless of what is causing your symptoms, it is stressful in and of itself to be dealing with them. I think the next step in addressing these symptoms is to work with a member of our team who can help you learn methods for managing the stress you experience in relation to your symptoms. My treatment recommendation is that you meet with her today so we can work as a team to help you feel better.”

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

Site	# Non-Clinical Staff	Goal and Actual	BH Training
Riverbend / ICH	93	93 Actual to date - 93	Upon hire
Dartmouth Hitchcock Concord	9	9	Dec 2018
Family Health Center Concord	As of 1/5/17 - CHMG had 152 non-clinical staff members	75 Actual to date- 93 received SBIRT and MI 21 received Stigma Reduction Training	Jun 2018
Family Health Center Hillsboro			Jun 2018
Concord Family Medicine			Jun 2018
Family Physicians of Pembroke			Jun 2018
Penacook Family Physicians			Jun 2018
Epsom Family Medicine			Jun 2018
IMED Horseshoe Pond			Dec 2018
Pleasant Street FM			Dec 2018

IDN2 developed a self-paced training for non-clinical staff and made it available May 2018. *Working in an Integrated Primary Care Practice* provides an overview of integration as well as information about identifying and avoiding or reducing stigma. Riverbend non-clinical staff receive *Customer Service in a Mental Health Setting* as part of their new employee training. It includes customer service, triaging emergency calls, the basics of mental health diagnoses/symptoms, and the use of appropriate language, giving context to what they're seeing. Riverbend also provides Mental Health First Aid for all staff members.

B1-8e Core Team Case Conferences

Riverbend has weekly multidisciplinary case conferences between CSP (seriously and persistently mentally ill services) and RICH (integrated primary and behavioral health care services).

The Family Health Centers have a weekly multidisciplinary Plan of Care Committee meeting to whom referrals are made regarding patients with complex needs. This Committee includes members from both FHCs: nursing, risk management, behavioral health, clinic management and physicians.

CHMG began weekly case conferences at Penacook (Friday), Pembroke (Wednesday), Concord Family Medicine (Monday), and Epsom (Tuesday) the week of April 30, 2018. This will extend to CH Substance Use Services, Pleasant Street, and IMED Horseshoe Pond by Dec. 2018.

Dartmouth-Hitchcock Concord will have these by Dec. 2018.

B1-8f Secure Messaging

Secure Texting:

In evaluating 2 organization's communication processes where texting is used with their clients/patients, at Riverbend and Child & Family Services, secure texting was determined to not be a viable option for their Medicaid clients as the phones they are provided from Medicaid are not smart phones and are not compatible with the texting platform, TigerText. We are considering looking at other options.

Direct Messaging:

- **2 organizations set up new Kno2 accounts; NAMI NH, and Riverbend for their Concord-based offices, completing steps 1-6 below.**
- **Crotched Mountain continues to increase their day to day usage of their Kno2 account, which was originally set up under the former, NHHIO platform.**
- **DHMC-Concord is reviewing existing workflows at their Lebanon site to set up new ones at their Concord practice. Ongoing planned workflow from June-September 2018.**
- **New Hampshire Hospital is in the early stages of executing Direct Secure Messaging using their EMR vendor's product, CareConnect. Once this is completed, they will be piloting with Riverbend and Concord Hospital on exchanging information, particularly addressing their current patient referral workflows, which are now processed via phone and fax.**
- **Riverbend is also reviewing Kno2's Cloud-based Faxing solution; a platform that integrates directly within their Direct Messaging Kno2 portal. Direct Secure Messaging and Faxing will be managed from one, web-based portal.**

B1-8g Closed Loop Referrals

IDN2 vetted several models and tools related to closed loop referral during this reporting period. IDN2 also reached out to MSLC for assistance in defining what constituted “closed loop referrals” and received a TA report on 5/9/18. At its conclusion, it outlined best practices for closed loop referrals and a nine-step closed loop EHR process:

- 1. The primary care physician orders a referral.**
- 2. The primary care physician or a designated staff person communicates the referral to the subspecialist.**
- 3. The referral is reviewed and authorized.**
- 4. An appointment is scheduled.**
- 5. The consult appointment occurs.**
- 6. The subspecialist communicates the plan to the patient.**
- 7. The subspecialist communicates the plan to the primary care physician.**
- 8. The primary care physician acknowledges receipt of information from the subspecialist.**
- 9. The primary care physician communicates the plan to the patient and the family.**

All of these except Step 9 are implemented already at the CHMG practices. PCPs do not communicate plans with patients that are developed as part of the specialist referral; the specialists do that directly with the patient.

In addition, the CHMG practices have all achieved Level 3 accreditation with the National Committee for Quality Assurance (NCQA) Patient Centered Medical Home (PCMH). To achieve accreditation, organizations MUST PASS on “Referral tracking and Follow-Up”. The practice coordinates including implementing these elements:

- **Providing reason for referral and relevant clinical information.**
- **Tracking referral status.**
- **Following up to obtain specialist's report.**
- **Documenting agreements with specialists for co-management.**
- **Providing electronic exchange of patient information.**

As a next step, the CHMG practices will ensure that its shared care plan and embedded BH roles are part of this process.

Riverbend evaluated, by program area, its capacity to provide closed loop referrals and will implement these next reporting period.

Dartmouth-Hitchcock Concord will implement closed loop referrals next reporting period.

B1-8h Documented Work Flows and/or Protocols

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

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

Process Milestone Number	Process Detail	Submission Format	Results (Met/Not Met)			
			6/30/17	12/31/17	6/30/18	12/31/18
B1-2	IDN Integrated Healthcare: Implementation Plan, Timeline, Milestones and Evaluation Project Plan	Narrative & Spreadsheet (Microsoft Project or similar platform)				
B1-3	IDN Integrated Healthcare: Evaluation Project Targets	Table				
B1-4	IDN Healthcare Integration Workforce Staffing	Table				
B1-5	IDN Healthcare Integration: Budget	Narrative and Spreadsheet				

Process Milestone Number	Process Detail	Submission Format	Results (Met/Not Met)			
			6/30/17	12/31/17	6/30/18	12/31/18
B1-6	IDN Integrated Healthcare: Key Organizational and Provider Participants	Table				
B1-7	IDN Integrated Healthcare: Organizational leadership sign-off	Table				
B1-8a	<p>All of the following domains must be included in the CCSA:</p> <ul style="list-style-type: none"> • Demographic information • Physical health review • Substance use review • Housing assessment • Family and support services • Educational attainment • Employment or entitlement • Access to legal services • Suicide risk assessment • Functional status assessment • Universal screening using depression screening (PHQ 2 & 9) and • Universal screening using SBIRT 	<p>CCSAs (Submit all that are in use)</p> <p>Table listing all providers by domain indicating Y/N on progress for each process detail</p>				
	<p>For pediatric providers, the CCSA must also include:</p> <ul style="list-style-type: none"> • Validated developmental screening for all children, such as the ASQ:3 and/or ASQ SE at 9, 18 and 24/30 month pediatric visits; • Developmental Screening using Bright Futures or other American Academy of Pediatrics recognized developmental 	<p>Table listing all providers by domain indicating Y/N on progress for each process detail</p>				
B1-8b	List of multi-disciplinary core team members that	Table listing				

Process Milestone Number	Process Detail	Submission Format	Results (Met/Not Met)			
			6/30/17	12/31/17	6/30/18	12/31/18
	<p>includes, at minimum:</p> <ul style="list-style-type: none"> • PCPs • Behavioral health providers (including a psychiatrist) • Assigned care managers or community health worker 	<p>names of individuals or positions within each provider practice by core team</p>				
B1-8c	<p>Multi-disciplinary core team training for service providers on topics that includes, at minimum:</p> <ul style="list-style-type: none"> • Diabetes hyperglycemia • Dyslipidemia • Hypertension • Mental health topics (multiple) • SUD topics (multiple) 	<p>Training schedule and Table listing all provider practice sites and number of individuals by provider type to be trained, PCP or BH. Ongoing reporting shall indicate # of people trained in each practice by provider type for each reporting period for each training.</p> <p>OR you may provide a list of names of all individual providers to be trained in each provider practice. Ongoing reporting would indicate Y/N for participating individuals on progress for</p>				

Process Milestone Number	Process Detail	Submission Format	Results (Met/Not Met)			
			6/30/17	12/31/17	6/30/18	12/31/18
		each training				
B1-8d	Training for staff not providing direct care that at minimum includes knowledge and beliefs about mental disorders that can aid in recognition and management	Training schedule and table listing all staff indicating progress on each process detail				
B1-8e	Monthly (or more frequent) core team case conferences on behalf of patients with significant behavioral health conditions or chronic conditions	Conference schedule and Table				
B1-8f	Secure messaging	Narrative				
B1-8g	Closed loop referrals	Narrative				
B1-8h	<p>Documented work flows and/or protocols that include, at minimum:</p> <ul style="list-style-type: none"> • 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 	Work flows and/or Protocols (submit all in use)				

Process Milestone Number	Process Detail	Submission Format	Results (Met/Not Met)			
			6/30/17	12/31/17	6/30/18	12/31/18
	<ul style="list-style-type: none"> Adherence to NH Board of Medicine guidelines on opioid prescribing 					

B1-9. Additional Documentation as Requested in B1-9a - 9d

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

See details of accomplishments this reporting period above. This chart illustrates met (Yes) or timing to achieve these requirements.

Coordinated Care Practice Designations:	DH-C	Riverbend	FHC H/C, Epsom, Penacook, Pembroke, CFM	Pleasant St Family Medicine, IMED HP, CH SUS
CCSA in use	Dec. 2018	Yes	Yes	Dec. 2018
Core Team	Dec. 2018	Yes	Yes	Dec. 2018
Training for PCP/BH	Dec. 2018	Yes	Yes	Yes
Training for non-clinical staff	Dec. 2018	Yes	Yes	Dec. 2018
Case Conferences	Dec. 2018	Yes	Yes	Dec. 2018
Secure Messaging	Dec. 2018	Dec. 2018	Dec. 2018	Dec. 2018
Closed Loop Referral	Dec. 2018	Dec. 2018	Yes	Yes
Documented Work Flows	Dec. 2018	Yes	Yes	Yes

B1-9b Adoption of both of the following evidence-based interventions:

Medication Assisted Treatment

IDN2 has D1 Medication Assisted Treatment (MAT) as a community project. We are using a HUB & SPOKE model that provides access to MAT and substance use disorder continuum of care services at all B1 sites including CHMG, Riverbend, Dartmouth-Hitchcock Concord, and CH SUS. Protocols in use are those sent with the July 31, 2017 report. Please see description of model and its implementation under D1 MAT.

Evidence-based treatment of mild-to-moderate depression within the Integrated Practice setting either through the use of IMPACT or another evidence-supported model

Riverbend BH staff were trained in IMPACT 5/1/2018. IBHCs who are embedded at Epsom, Penacook, Pembroke, Concord Family Medicine and those working for the Family Health Centers in Concord and Hillsboro will be trained on 7/27/18.

Pleasant Street Family Medicine, IMED Horseshoe Pond, CH Substance Use Services, and Dartmouth-Hitchcock Concord will implement IMPACT by 12/31/2018.

B1-9c Use of Technology to, at a minimum: Identify at Risk Patients, Plan Care, Monitor/Manage Patient progress toward goals, and Ensure Closed Loop Referral

IDN2 is reviewing population health management plans at Riverbend and Concord Hospital to ensure that they meet the intent of the DSRIP STCs. In addition, IDN2 has

gathered stakeholders from around the region, including first responders, medical providers, behavioral health providers, and community based organizations to review how each uses technology in this way to address the needs of “high utilizers” and to create a region-wide plan. We are looking at CMT as a possible tool to support this purpose and will work on the creation of privacy documentation that extends to community based organizations and first responders.

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

Similarly to B1-9c, IDN2 is in the process of meeting with community based providers, determining their needs, and creating work flows for greater integration of care.

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

Process Milestone Number	Section	Process Detail	Submission Format	Results (Met/Not Met)			
				6/30/17	12/31/17	6/30/18	12/31/18
B1-9a	Coordinated Care Practice designation	Achievement of all of the requirements of a Coordinated Care Practice	Progress towards Coordinated Care Practice Designations				
B1-9b	Additional Integrated Practice designation requirements	Adoption of both of the following evidence-based interventions: <ul style="list-style-type: none"> • Medication-assisted treatment (MAT) • Evidence-based treatment of mild-to-moderate depression within the Integrated Practice setting either through use of the IMPACT or other evidence-supported model 	Protocols (Submit all in use)				
• B1-9c	•	<ul style="list-style-type: none"> • Use of technology to identify, at minimum: • At risk patients • Plan care • Monitor/manag 	<ul style="list-style-type: none"> • Table listing all providers indicating progress on each 				

Process Milestone Number	Section	Process Detail	Submission Format	Results (Met/Not Met)			
				6/30/17	12/31/17	6/30/18	12/31/18
		e patient progress toward goals <ul style="list-style-type: none"> • Ensure closed loop referral 	process detail				
B1-9d		Documented work flows with community based social support service providers including, at minimum: <ul style="list-style-type: none"> • Joint service protocols • Communication channels 	Work flows (Submit all in use)				

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

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

	Total Goal Number Designated	Baseline Designated 6/30/17	Number Designated 12/31/17	Number Designated 6/30/18	Number Designated 12/31/18
Coordinated Care Practice	0	0	0	0	0
Integrated Care Practice	11	0	0	0	11

Coordinated Care Practice	List of providers identified to make progress toward Coordinated Care Practice designation ONLY	12/31/17	6/30/18	12/31/18
	None - all will meet integrated care			

Integrated Care Practice	List of providers identified to make progress toward Integrated Care Practice designation inclusive of Coordinated Care	12/31/17	6/30/18	12/31/18
	Concord Family Medicine		Core team hired and trained; CCSA a combination of paper and Cerner; monthly core team case conferences scheduled and occurring; shared care plan in Cerner with CMT being explored as future option; workflows documented; MAT provider	x

			at location; IBHC trained in IMPACT; closed loop referrals a combination of Cerner and paper; working on documented protocols and using technology to identify, plan, and monitor at risk patients	
	Concord Hospital FHC Concord		Core team hired and trained; CCSA a combination of paper and Cerner; monthly core team case conferences scheduled and occurring; shared care plan in Cerner with CMT being explored as future option; workflows documented; MAT provider at location; IBHC trained in IMPACT; closed loop referrals a combination of Cerner and paper; working on documented protocols and using technology to identify, plan, and monitor at risk patients	X
	Concord Hospital FHC Hillsboro		Core team hired and trained; CCSA a combination of paper and Cerner; monthly core team case conferences scheduled and occurring; shared care plan in Cerner with CMT being explored as future option; workflows documented; MAT provider at location; IBHC trained in IMPACT; closed loop referrals a combination of Cerner and paper; working on documented protocols and using technology to identify, plan, and monitor at risk patients	X
	Concord Hospital Substance Use Services		Defining need for this site as it was recently added to the list.	X
	Dartmouth Hitchcock Concord		Working on a DHH wide approach to implementing	X

		<p>integrated care across all IDNs that will satisfy internal and external (B1) requirements.</p> <p>Hosting biweekly meetings for primary care teams across all IDNs to come together for shared learning and information exchange. An internal D-HH workgroup continues to meet on “opposite” Thursdays to prioritize activities and mitigate challenges.</p>	
	Epsom Family Medicine	<p>Core team hired and trained; CCSA a combination of paper and Cerner; monthly core team case conferences scheduled and occurring; shared care plan in Cerner with CMT being explored as future option; workflows documented; Access to MAT provider through HUB; IBHC trained in IMPACT; closed loop referrals a combination of Cerner and paper; working on documented protocols and using technology to identify, plan, and monitor at risk patients</p>	x
	Family Physicians of Pembroke	<p>Core team hired and trained; CCSA a combination of paper and Cerner; monthly core team case conferences scheduled and occurring; shared care plan in Cerner with CMT being explored as future option; workflows documented; Access to MAT provider through HUB; IBHC trained in IMPACT; closed loop referrals a combination of Cerner and paper; working on documented protocols and using technology to identify,</p>	x

			plan, and monitor at risk patients	
	Penacook Family Physicians		Core team hired and trained; CCSA a combination of paper and Cerner; monthly core team case conferences scheduled and occurring; shared care plan in Cerner with CMT being explored as future option; workflows documented; Access to MAT provider through HUB; IBHC trained in IMPACT; closed loop referrals a combination of Cerner and paper; working on documented protocols and using technology to identify, plan, and monitor at risk patients	X
	Internal Medicine at Horseshoe Pond		Core team hired with PCP and non-clinical training completed; CCSA and all other aspects of integrated care not documented below being introduced; workflows documented; MAT provider on site; working on documented protocols and using technology to identify, plan, and monitor at risk patients	X
	Pleasant Street Family Medicine		Core team hired with PCP and non-clinical training completed; CCSA and all other aspects of integrated care not documented below being introduced; workflows documented; MAT provider on site; working on documented protocols and using technology to identify, plan, and monitor at risk patients	X
	Riverbend Community Mental Health		Core team hired and trained; CCSA in place at most programs and being worked	X

			out at others; monthly core team case conferences scheduled and occurring; shared care plan through CMT being piloted; workflows documented; MAT providers on site; staff at RICH trained in IMPACT; closed loop referrals a combination of TIER and paper; working on documented protocols and using technology to identify, plan, and monitor at risk patients	
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**Projects C: Care Transitions-Focused
IDN Community Project Implementation and Clinical Services Infrastructure Plan**

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

Project C2 Reentry Updates in Bold

Merrimack County Department of Correction (MCDOC)

Entry into IDN2's MCDOC Reentry Program is for those participating in the Successful Offender Adjustment and Reentry program (SOAR). Existing MCDOC staff participating in the reentry project include two Case Managers, the Program Director, LADC, **Reentry Coordinator**, and other reentry staff members. **In the next reporting period, eligibility for re-entry services will expand to all individuals housed at the Edna McKenna Community Corrections Center.**

The PROXY is completed in booking on all MCDOC offenders. Once sentenced, all offenders are screened using ORAS to determine risk level. High and medium risk offenders are offered intensive treatment services. Sentenced inmates serving 120 days, or more are targeted for the full continuum of in jail and transitional services. The program is designed around treatment services that address the criminogenic risks as assessed by the ORAS Ohio Risk Assessment System, the clinician, and the Texas Christian University (TCU) substance use screener, which has been validated in NH. Both of these instruments are administered within 7 days of entry into the facility. In the next reporting period, all individuals identified to receive reentry services will participate in a full mental health assessment conducted by a Riverbend clinician. Those who are assessed to have a mental health diagnosis or diagnoses will be offered individual therapy and case management services both prior to and post-release, regardless of whether or not they are involved with SOAR.

All inmates **in the re-entry program** are required to participate in treatment, which includes substance abuse and cognitive behavioral components, work in a supervised setting on/off site, and the option of increasing vocational skills through mock interviewing and job placement assistance. Prior to release, those identified for reentry services participate in the following curricula:

- Thinking for a Change 4.0 (T4C) is an integrated cognitive behavioral change program authored by Jack Bush, Ph.D., Barry Glick, Ph.D., and Juliana Taymans, Ph.D., under a cooperative agreement with the National Institute of Corrections (NIC). T4C incorporates research from cognitive restructuring theory, social skills development, and the learning and use of problem solving skills.
- Helping Women Recover is a 17 session, evidence-based treatment model that integrates theories of addiction, women's psychological development, and trauma. This curriculum is strengths-based and responsive to women's gender-specific needs for healing and support.
- Helping Men Recover is the first gender-responsive and trauma informed treatment curriculum for men. This 18-session program addresses male socialization in recovery, the relational needs of men, and abuse and trauma.

- Seeking Safety is an evidence-based model that can be used in group or individual counseling. It was specifically developed to help survivors with co-occurring trauma and SUD and, crucially, in a way that does not ask them to delve into emotionally distressing trauma narratives.
- Education classes are offered to men and women in the SOAR program who are working towards their High School Equivalency Assessment (HISET) with the goal to increase learning and, in some cases, work toward passing the HISET certification
- The Habits of Mind are an identified set of 16 problem solving, life related skills, necessary to effectively operate in society and promote strategic reasoning, insightfulness, perseverance, creativity and craftsmanship. The understanding and application of these 16 Habits of Mind serve to provide the individual with skills to work through real life situations that equip that person to respond using awareness (cues), thought, and intentional strategy in order to gain a positive outcome.

In addition to the groups listed above, participants have access to case management services, individual counseling on substance use or co-occurring disorders, and psychiatric evaluation and management.

The MCDOC case manager is assigned to the individual at booking and begins to develop a transition plan. Once the individual has engaged with re-entry services, the transition plan is taken over by the Riverbend Case Manager who is available to provide ongoing support for up to a year post release.

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

Aftercare is required of all SOAR participants in order to successfully graduate from the program. Aftercare involves weekly gender-specific psychotherapy groups facilitated by Riverbend clinicians. Some participants are also involved with Probation/Parole. In these instances, Probation/Parole can invoke the use of graduated responses to violations, collaborate with MCDOC and Riverbend staff on the case plans, and have access to the ORAS assessment results for community supervision determinants. All SOAR participants are subject to random and ongoing urine screens through the MCDOC, who is responsible for the scheduling, collection, and analysis of the drug screens and reporting back to Riverbend staff on the results.

All other re-entry services offered post-release are available on a voluntary basis and include case management, individual therapy, and psychiatric evaluation and management. Efforts are made to engage and motivate individuals during their incarceration to support their ongoing involvement with these services. For those in need of longer-term mental health and/or substance use services, re-entry services are provided as a bridge and discontinue at the time the individual has successfully engaged with their new provider.

New Hampshire Department of Corrections (NHDOC)

Entry into IDN2's NHDOC Reentry Program is for those **with an identified substance use or mental health disorder** participating in the program pre-release from custody and returning to

Region 2. Other offenders already participating in transition programs at the NHDOC will be provided treatment by NHDOC to avoid duplication of services.

All NHDOC sentenced offenders are screened using ORAS to determine risk level. High and medium risk offenders are offered intensive treatment services. They also receive an educational assessment and Mental health assessment at entry and the case manager develops a plan. NHDOC offers a variety reentry programming to all individuals in their custody.

- NHDOC case management offers services to all individuals including but not limited to:
 - Finding suitable housing in the community
 - Assisting individuals in the application process for community behavioral health programs, substance abuse programs, mental health, and sexual offender treatment.
 - Helping individuals apply for social services in the community, Medicaid health insurance, Supplemental Nutrition Assistance Program
 - Assisting individuals to obtain a new copy of vital records while incarcerated, a NH Non-Driver's ID, Birth Certificate, or Social Security Card.
- NHDOC Reentry Program - NHDOC reentry program helps teach individuals life skills such as, balancing a checkbook, resume writing, and job searching and interviewing. The NHDOC reentry program covers NHDOC policies regarding programs such as administrative home confinement and earned time credit. The reentry program also reviews how individuals can get involved in treatment programs such as behavioral health services, educational and vocational programs. In addition, the reentry program teaches individuals life skills from balancing a checkbook to resume writing. Each individual will have a reentry plan developed that determines what needs they have that are potential barriers to their reentry and what interventions they will participate in prior to reentry to give them a better chance at a successful release.
- Thinking for a Change (T4AC) - On an individual basis each inmate is assessed for Thinking for a Change, a cognitive behavior therapy program that focuses on learning Social skills, Cognitive Self-Change, and Problem-Solving Skills.
- Religious Services- Religious services and programming is available at all locations within the NHDOC.
- Transitional Work Center – Minimum Security facility, preparation for Transitional Housing Units. At the Transitional Work Center (TWC) individuals going into the community on work crews, learning new skills and being provided on the job training. Programming such as Family Connections Center (FCC), T4AC and LADC services are also available.
- Transitional Housing Units - NHDOC offers three Transitional Housing Unit (THU) programs in the Concord and Manchester Area. THUs are work release programs where an individual is allowed to work for employers in the community. Individuals participating in THU programs are assigned “phases” based on their successful progress in the program and are given community based privileges to aid in their transition to eventual reentry to the community.

- Education - NHDOC offers a Corrections Special School District where individuals can earn a HiSet, High School diploma, and take College Correspondence courses. NHDOC also offers a Career Technical Institute that offers certificate courses in business education, auto-mechanics, and building trades.
- Family Connections Center (FCC)- NHDOC offers a Family Connections Center where individuals can take parenting classes, healthy relationship classes, read books on tape to send to their children, and participate in video visits.
- LADC Services - NHDOC offers LADC services such as assessment of needs, individualized treatment planning, intensive group treatment, other group therapy, individualized therapy sessions, and FOCUS unit. FOCUS unit conducts treatment for males with substance use disorders; it is an intensive clinical treatment that is conducted within a wellness community environment that addresses SUD issues.
- Mental Health Services – Mental Health programming and treatment is available at all locations within the NHDOC. Many different programs and treatment offerings are available to all individuals with mental health diagnosis. Programs include sexual offender treatment (SOT) and Residential Treatment Unit (RTU).

The IDN case manager goes to the men’s and women’s prisons on a weekly basis, alternating genders each week. Upon her arrival, she receives a list of clients that have been identified as needing more intensive case management services along with their current transition plans. She meets with each client bi-weekly, beginning around 4 weeks pre-discharge.

Post-release services for both MHDOC and NHDOC - up to 12 months

Participants can receive an individualized combination of the following:

- Intensive case management
- Substance Use Disorder (SUD) supports and services to include, as needed, Medication Assisted Treatment (MAT), Intensive Outpatient Programming (IOP), counseling, and group therapy
- Mental Health services to include, as needed, psychiatric services and medication management, counseling, group therapy and an array of evidence-based practices that include:
 - Assertive Community Treatment (ACT) is an EBP for delivering comprehensive, effective and highly individualized services to clients who have needs that have not been well met by traditional approaches.
 - Dialectical Behavior Therapy (DBT) is a SAMHSA/CMHS/NREPP recognized cognitive-behavioral treatment approach that emphasizes balancing behavioral change, problem-solving, and emotional regulation with validation, mindfulness, and acceptance.
 - Illness Management and Recovery (IMR) is an EBP that combines motivational, educational, and cognitive behavioral strategies to teach people with severe mental illness how to manage their disorder in collaboration with professionals and significant others in order to achieve personal recovery goals.

- Integrated Dual Diagnosis Treatment (IDDT) is a widely accepted EBP that focuses on treatment for people with Co-Occurring Mental Health and Substance Use Disorders (COD). IDDT integrates treatment modalities for both, allowing persons with COD to receive support and services from the same providers.
- Cognitive Behavioral Therapy (CBT) is a SAMHSA/CMHS/NREPP recognized structured, short-term, present-oriented psychotherapy for depression, directed toward solving current problems and modifying dysfunctional (inaccurate and/or unhelpful) thinking and behavior.
- Motivational Enhancement Therapy (MET) is an adaptation of Motivational Interviewing (MI) that includes normative assessment feedback to clients. A therapist trained in MET can often help an individual to view behaviors more objectively, and through MET, that individual may become empowered to begin the process of change; and
- New Direction, a cognitive-behavioral treatment curriculum for justice involved individuals with COD.
- Identification of health issues and linkage to primary health care through the IDN2 Integration Project
- Individual Placement and Support (IPS)
- Benefits assistance
- The continuation of evidence-based curriculums begun in jail including education classes, Thinking for a Change, The Habits of Mind, and Community Supervision.

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

Sununu Youth Services Center (SYSC)

When a youth is committed to SYSC, a systematic process is used to classify and assign youths to a secure residential unit where they participate in a prescribed behavioral program. The program encompasses academia, cottage life, and group sessions. Progress in all three spheres is measured using a rating system with progress regularly communicated to the youth. Program completion and ultimate eligibility for release and parole from SYSC is determined by the youth's progress in addressing identified problem areas and program goals based on assessment by the youth's Program Team. The Program Team is comprised of a unit clinical coordinator, resident house leader, youth counselor, education representative, juvenile services officer, parent or guardian and the youth. The average length of stay prior to initial release from SYSC is 8-12 months. A NH juvenile may be committed to the SYSC after being adjudicated as delinquent by a NH District Court.

All youth intakes in the Sununu center are given the following range of assessments:

- Depression Anxiety Stress Scales (DASS)
- Spiritual Assessment
- Career Scopes
- Revised Children's Manifest Anxiety Scale (RCMAS)
- Substance Abuse Subtle Screening Inventory (SASSI)
- Prison Rape Elimination Act (Vulnerability Assessment)
- Becks Depression Inventory/ SI
- University of California Los Angeles (UCLA) PTSD
- Personal Safety Plan (PSP)
- Child Adolescent Needs and Strengths (CANS)

The following is the school programming:

NH Sununu Youth Services Center is composed of two programs for male and female students:

- SYSC has been approved by the NH DOE for 108 students.
- Youth Detention Services Unit (YDSU) program, the only secure pre-adjudication / predisposition detention facility in New Hampshire serving youth ages 11 to 17 in grades 6 through 12 that has been approved by the NH DOE for 24 students.

The SYSC program is approved by NHDOE, Bureau of Special Education to serve students in all disability categories. The YDSU program has previously been approved to serve students in the disability categories of Emotional Disturbance, Other Health Impairments, and Specific Learning Disabilities.

The school is part of a very well-designed facility that includes both academic and vocational classroom areas as well as a gymnasium and library/media center and interior courtyards to allow for access to secure outdoor areas for student gardening and recreation.

Most youth have a combination of disorders and will utilize and require a combination of therapies individualized to their needs. For the sake of organization, types of therapeutic modalities are grouped by primary diagnosis.

- Oppositional Defiant Disorder: Evidence based treatments utilized are parent management training (via Family Therapy) and problem-solving skills training (individual and group). In addition, behavior therapy via group and individual contingency management programs. All youth with ODD are evaluated for concurrent conditions such as ADHD, Bipolar Disorder, PTSD and depression as well as physical and sexual abuse which may exacerbate their conduct disorder or mimic symptoms of ODD. If present evidence based medication interventions and disorder specific cognitive behavior and family therapy is provided.
- Conduct Disorder: Treated with the components of Multisystemic therapy which involves 1) Family Therapy 2) prosocial skills training and development 3) Educational and vocational training and support 4) development of an outpatient support network to continue MST interventions in community at transition. We also utilize cognitive behavioral therapy directed at distorted cognitions and value system in gang involved and crime involved youth. All youth with Conduct Disorder are evaluated for concurrent

conditions such as ADHD, Bipolar Disorder, PTSD, and depression which may exacerbate their conduct disorder or mimic the symptoms. If present evidence based medication intervention and disorder specific cognitive behavior and family therapy is provided.

- Substance Abuse: Youth with substance abuse receive EBT interventions of Motivational Interviewing, and individual and group CBT regarding changing patterns, distorted cognitions and coping skills associated with substance use. The SAMHSA EBT workbook for youth substance use is specifically utilized. If indicated youth also receive medication intervention such as campral or naltrexone. As above, all youth are also evaluated for concurrent disorders or traumatic experiences that need to be treated in order to reduce their risk of relapse.

As noted above, all youth in the building are evaluated for concurrent mental health conditions and receive EBT interventions specific to that condition for example:

- Post-Traumatic Stress Disorder: Trauma focused Cognitive Behavior Therapy
- Major Depression: Cognitive Behavior Therapy (Thinking for a Change)
- Anxiety Disorder: Cognitive Behavior Therapy
- Intermittent Explosive Disorder: Mood regulation training and Anger Management Training (SAMHSA approach)
- Borderline Personality Disorder: Dialectical Behavior Therapy

Post Release Programming

They receive an individualized combination of the following:

- Intensive case management
- Substance Use Disorder (SUD) supports and services to include, as needed, Medication Assisted Treatment (MAT), Intensive Outpatient Programming (IOP), counseling, and group therapy
- Mental Health services to include, as needed, psychiatric services and medication management, counseling, group therapy and an array of evidence-based practices that include:

All Sununu youth are provided a release plan which is coordinated with the Juvenile Probation and Parole officer.

High risk clients are referred to the IDN2 Enhanced Care Coordination project for Rehabilitation for Empowerment, Natural Supports, Education & Work (RENEW) wrap around services. This project includes an enhanced care coordinator, a NAMI NH family support person, and a YouthMove peer support person. Please see more under the IDN2 ECC Care Coordination project.

Timeline with updates in bold. Past is greyed out and current/future is blue:

Reentry	
2017	
Jan - June	<ul style="list-style-type: none"> • Implementation Plan Timeline & budget Workforce plan - This was accomplished • Projected client engagement - This was accomplished • Key organizational providers - This was accomplished • R&R of team members - This was accomplished • Clinical Services Infrastructure - This was accomplished <ul style="list-style-type: none"> ○ Assessment tools ○ Protocols, Processes, & Workflow ○ Develop training plan & curricula ○ Agreements ○ Evaluation plan ○ Hire 3 staff (LADC, CM, BH Clinician) - Delayed in hiring CM during this period of time
July - Dec	<ul style="list-style-type: none"> • Operationalize program - This was accomplished <ul style="list-style-type: none"> ○ Hire 1 additional staff - Hired case manager, turnover in BH clinician position ○ Begin training schedule ○ Develop and convene monitoring and improvement team ○ Initiate data reporting • Project budget review for 2018 - This was accomplished • Employ rapid cycle evaluation - This was accomplished • Participate in semi-annual report writing - This was accomplished
2018	
Jan - June	<ul style="list-style-type: none"> • Hire peers - This was accomplished • 4 staff trained - This was accomplished • Monthly progress and data reporting - This was accomplished • Employ rapid cycle evaluation - N/A • Participate in semi-annual report writing - This was accomplished
July - Dec	<ul style="list-style-type: none"> • Monthly progress and data reporting • Employ rapid cycle evaluation • Participate in semi-annual report writing • Project budget review for 2019

C-2. IDN Community Project: Evaluation Project Targets

Performance Measure Name	5-year target	As of 12/31/17	As of 6/30/18
Clients served pre-release	250	52	23
Of these, how many were new?			15
Of these, how many were continuing?			8
Clients served post-release?	250	16	21
Of these, how many were new?			10
Of these, how many were continuing?			11
How many received case management?			9
How many received individual therapy?			0

How many received group therapy?			21
Referred to SUD Services			7
Follow through rate			57%
Referred to MH Services			13
Follow through rate			38%
Referred to Primary Care			5
Follow through rate			60%
Clients completing 12 months of service?	200	0	7

Quality and volume of post-release services expected to improve now that team is full, mental health assessments will be conducted on all participants, and participants have the opportunity to meet/engage with the team prior to release. It is very difficult to engage someone post-release without having had a relationship prior.

C-3. IDN Community Project: Workforce Staffing

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

Provider Type	IDN Workforce (FTEs)				
	Projected Total Need	Baseline Staffing on 6/30/17	Staffing on 12/31/17	Staffing on 6/30/18	Staffing on 12/31/18
C2 - Case Manager	1	1	1	1	
C2 - Psychiatric APRN (.3)	1	0	1	1	
C2 - MLADC	1	1	1	1	
C2 - BH Clinician	1	1	0	1	
ALL - Peer Recovery Coaches	1	1	0	3	

C-4. IDN Community Project: Budget

	ACTUALS			PROJECTED			
	2016	2017	Jan-Jun 2018	Jul-Dec 2018	2018	2019	2020
Re-entry							
Purchase Services / Professional		\$ 113,287	\$ 136,843				
Consulting Fees		40,004	-				
Other Direct Expense (Includes testing supplies)		4,367	-				
Total Community Re-entry		\$ 157,658	\$ 136,843	\$ 131,382	\$ 268,225	\$ 279,197	\$ 325,000

Consulting Fees

IDN2 used a reentry consultant to work with the three correctional sites and to provide training to reentry staff in 2017.

Purchase Services

These are salaries and benefits for the staff listed.

Other Direct Expenses

This is testing supplies for substance use.

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

Organization/Provider	Agreement Executed
Riverbend Community Mental Health	Y
Concord Hospital	Y
Concord Hospital Medical Group	Y

Organization/Provider	Agreement Executed
NH DOC	Y
Merrimack County DOC	Y
Sununu Youth Services Center	Y
NAMI NH	Y
Ascentria	Y
Granite United Way	Y

C-6. IDN Community Project: Standard Assessment Tools

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

Adult Needs and Strengths Assessment (ANSA)	A multi-purpose tool developed for adult's behavioral health services to support decision making, including level of care and service planning, to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services.
American Society of Addiction Medicine (ASAM) Criteria	The ASAM criteria explores six dimensions to create a holistic, biopsychosocial assessment of an individual for treatment across all services and levels of care.

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

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

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

C2 Reentry Training Jan-June 2018		
3/21/18	Diagnosis of Major Depressive Disorder	This presentation will provide a review of the diagnostic criteria of Major Depressive Disorder; Discussion of what else it could be when your client is struggling with depressive symptoms; treatment options.
3/23/18	Adult Lethality	This training will discuss suicide and violence risk factors, assessment strategies and standards of care, as well as legal and ethical concerns.
4/20/18	Simulated Experience of Hearing Distressing Voices	This presentation will include a 60-minute video lecture by Patricia Deegan, Ph.D., The Director of Training for the National Empowerment Center and an experienced voice-hearer who was diagnosed with Schizophrenia as a teenager. There will then be an audio (CD) simulation of auditory hallucinations. Consenting participants will wear headphones and experience the simulation as they engage in a variety of activities. The simulation focuses on a selected range of voice-hearing experiences in the hopes of creating a more intensive and real situation.
4/25/18	Post-Traumatic Stress Disorder	This presentation will provide a review of the diagnostic criteria of PTSD, and discuss the experience of trauma and why some people are diagnosed with PTSD while others are not.
4/27/18	The Role of Nutrition in Mental Health	This program will discuss general tenants of nutrition and brain health, mental illnesses that are particularly exacerbated by poor nutrition, assessment that is patient centered to improve mental health outcomes through improved nutrition, resources for wellness activities/complimentary therapies to target wellness as it pertains to nutrition for mental stability, and various medical conditions/psychiatric medication side effects that are red flags and should be referred out.
6/26/18	Community Justice and Serious Mental Illness	Attendees of this webinar will learn about the factors contributing to the current situation, gaps in the systems, how to improve access to care in the community and the role of diversion programs such as Mental Health Courts and Drug Courts in decreasing criminalization of serious mental illness and substance use disorders.

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

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

Number						
C-1	IDN Community Project Timeline, Key Milestones and Evaluation Project Plan	Spreadsheet (Microsoft Project or similar platform)				
C-2	IDN Community Project Evaluation Project Targets	Table				
C-3	IDN Community Project Workforce Staffing	Table				
C-4	IDN Community Project Budget	Narrative and Spreadsheet				
C-5	IDN Community Project Key Organizational and Provider Participants	Table				
C-6	Clinical Infrastructure: IDN Community Project Standard Assessment Tools	Table				
C-7	Clinical Infrastructure: IDN Community Project Protocols For Patient Assessment, Treatment, Management, and Referrals	Table				
C-9	Provide the training plan and curricula for each Community Driven Project as required in A-1.3	Training schedule and table				

Projects D: Capacity Building Focused

IDN Community Project Implementation and Clinical Services Infrastructure Plan

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

Project D1 MAT Updates in Bold

IDN2 **moved** to a HUB & SPOKE model of care for delivery MAT in the region. IDN2's goal remains to successfully treat more individuals with SUD in the capital area by increasing access to MAT:

- For pregnant women with opioid use disorders (OUD)
- Through the primary care practices (PCPs)
- Through the SUD continuum of care (Riverbend CHOICES and Concord Hospital Substance Use Services)

We will accomplish this:

- Through the Integrated Health Care project:
 - Provide ongoing information to primary care providers (PCPs) about SUD and MAT
 - Train PCPs in SUD Screening, Brief Intervention, and Referral to Treatment (SBIRT) **and Motivational Interviewing for use as the Brief Intervention**
 - Embed Integrated Behavioral Health Clinicians (IBHC) in the primary care practices to provide coordinated care, brief treatment, and closed loop referrals to community based treatment.
 - IBHCs are licensed, master level clinicians.
 - In addition to training specific to determining appropriate levels of care and brief interventions for treating substance use disorder, IBHCs have received instruction in integrated care, medication assisted treatment (MAT), confidentiality, drug testing in clinical addiction medicine, metabolic syndrome, and engaging loved ones in health and wellness. They will receive ongoing training to sharpen their skills.
- Through the MAT project:
 - Establish Continuum of Care HUBS to provide:
 - **On-call mentoring and support to SPOKES**
 - **Care coordination and transitional navigation between HUBS and SPOKES through hiring a Peer Navigation Specialist and Clinical Coordinator.**
 - MAT inductions
 - Induct, stabilize, maintain, and transfer on buprenorphine
 - Open access to services
 - On site urine testing
 - On site counseling and groups through hiring an **IDN2 dedicated SUD counselor**

- Mental health services and support **by working closely with embedded IBHCs**
 - Connect patients with primary care providers (PCP) for general care
 - Provide educational resources and leadership to the community
 - Provide on-site and phone consultation to medical and psychiatric providers
 - Train providers about substance use disorders
 - Refer to next level of care-residential programs-for higher need patients
 - Support and incentivizing PCPs to become SPOKES (Induct, stabilize, and/or maintain patients on MAT at their practice; mentor other PCP MAT providers; participate in a community of practice:
 - Financial incentives for full participation in the project* - \$2,750 semi-annually (July for period Jan-June, January for period Jul-Dec) after training and obtaining a DATA 2000 X Waiver. *Participation includes attending IDN2 meetings and/or case reviews (if meeting attendance is impossible, check in with the MAT co-coordinators on a monthly basis to discuss any questions/concerns), following NH DHHS approved IDN2 protocols, acting as a peer mentor for other MAT providers or those interested in becoming MAT providers, and participating in the collection and reporting of process and outcome data to NH DHHS.
- Provide Perinatal Addiction Treatment (PAT) at OBGYN practices
 - **Moved** the supervision of PAT to CHOICES
 - **Having PAT more closely connected with MAT and the HUB makes it possible to assist more women in making the transition to MAT with another provider after delivery. It also makes the Peer Navigation Specialist and Substance Use Counselor more readily available to this population.**
 - **Added** a Medical Assistant to the Concord Hospital practice because of increasing numbers of individuals seeking support
 - **This is a very high need population and we have successfully combined a portion of the ECC project to PAT.**
 - **In addition to the .1 director and 1 FTE enhanced care coordinator, hired an additional .5 person enhanced care coordinator**
 - **Added a parent education component to PAT with incentives and child care**
 - **NAMI NH family peer support person works closely with PAT.**

Timeline with updates in bold. Past is in grey and current/future in blue:

MAT/PAT Timeline	
2017	
Jan - June	<ul style="list-style-type: none"> • Implementation Plan Timeline & budget - This was accomplished • Workforce plan - This was accomplished • Projected client engagement - This was accomplished • Key organizational providers - This was accomplished • R&R for team members - This was accomplished • Clinical Services Infrastructure - This was accomplished <ul style="list-style-type: none"> ○ Assessment tools ○ Protocols, Processes, & Workflow ○ Training plan & curricula ○ Agreements ○ Evaluation plan ○ Education & Recruitment & Mentoring
July - Dec	<ul style="list-style-type: none"> • Provide mentoring support to 6 MAT providers - This was accomplished with 10 providers • Develop workflows for introducing MAT into 6 CHMG and DHC locations - This was accomplished • Distribute recruitment materials to at least 25 primary care providers - This was accomplished • Monthly case reviews with existing MAT providers - Change in project • Monthly FACE UP presentations Project budget review for 2018 - This was accomplished • Develop monitoring and improvement team - This was accomplished • Employ rapid cycle evaluation - This was accomplished • Participate in semi-annual report writing - This was accomplished
2018	
Jan - June	<ul style="list-style-type: none"> • Communicate HUB & SPOKE model to all CHMG and DHC providers - This was accomplished • Add staffing to PAT project - This was accomplished • Add parenting group to PAT project - This was accomplished • Hire peer recovery coach - This was accomplished • Ongoing progress and data reporting - This was accomplished • Monitor project - This was accomplished • Employ rapid cycle evaluation - This was accomplished • Participate in semi-annual report writing - This was accomplished
July - Dec	<ul style="list-style-type: none"> • Monthly FACE UP presentations • Monthly MAT/PAT meetings • Ongoing progress and data reporting • Monitor project • Employ rapid cycle evaluation • Project budget review for 2019 • Participate in semi-annual report writing

D-2. IDN Community Project: Evaluation Project Targets

MAT Performance Measure Name	5-Year Target	Jun-Dec 2017	DHC Jan-Jun 2018	Choices Jan-Jun 2018	CHMG Jan-Jun 2018	TOTAL Jan-June 2018
# of MAT Providers	18	10	1	4	8	13
Total patients seen	300	31	25	46	46	117
Of these, how many new?		N/A	20	34	19	73
Of these, how many continuing?		N/A	5	6	27	38
How many engaged 3 months	240	13	5	17	17	39
Of these how many remained opioid free during this time?	210	11	3	15	16	34
How many engaged 6 months?	210	1	4	12	21	37
Of these how many remained opioid free during this time?	180	1	3	10	21	34
How many engaged over 6 months?	180	0	4	10	23	37
Of these how many remained opioid free during this time?	150	0	3	9	18	40
How many relapsed and returned to treatment?		N/A	1	0	N/A	1
PAT Performance Measure Name	5-Year Target	Jul-Dec 2017	Jan-June 2018			
Number served over life of project	60	20	22			
Did not return after first visit	<10	3	2			
Delivered - outside of IDN2 region	40	2	2			
Delivered - within IDN2 region	20	1	13			
Attended all scheduled OB-GYN appointments	38	17	15			
Attended all scheduled MAT appointments	45	17	18			
Remained engaged through pregnancy & delivery	35	1	13			
Transferred to MAT provider after delivery	N/A	N/A	12			
ECC for PAT Mothers & Infants Performance Measure Name	5-year Target	Jan-June 2018				
Individuals served over the life of the project	33	24				
Intake to determine eligibility		16				
Successfully connected to other resources		6				
In process of engagement eligibility		5				
Decided not to participate		7				
Placement outside the home		1				

D-3. IDN Community Project: Workforce Staffing

Provider Type	IDN Workforce (FTEs)				
	Projected Total Need	Baseline Staffing on 6/30/17	Staffing on 12/31/17	Staffing on 6/30/18	Staffing on 12/31/18
D1 - MAT Co-Coordination (.2)	2	2	2	2	
D1 - SUD Counselor	1	N/A	0	1	
D1 - Clinical Coordinator	1	N/A	0	1	
D1 - PAT Providers (.4)	2	2	2	1	

D1 - PAT Social Worker (.4)	1	1	1	1	
D1 - PAT MA (.4)	1	N/A	0	1	
D1 - Peer Navigation Specialist	1	1	0	1	
ALL – Peers	4	0	0	4	

D-4. IDN Community Project: Budget

	ACTUALS			PROJECTED			
	2016	2017	Jan-Jun 2018	Jul-Dec 2018	2018	2019	2020
Medicated Assisted Treatment							
Purchase Services / Prof (RB)		\$ -	\$ 136,307				
Purchase Services / Prof (CH)		5,520	14,791				
Purchase Services / Professional		26,957	329				
Total Medicated Assisted Treatment		\$ 32,477	\$ 151,427	\$ 196,785	\$ 348,212	\$ 479,948	\$ 525,000

Purchase Services / Professional (RB)

This line item is for Project Coordinator, Peer Navigation Specialist, and Clinical Coordinator.

Purchase Services / Professional (CH)

This line item is for Project Coordinator

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

Organization/Provider	Agreement Executed (Y/N)
Riverbend Community Mental Health	Y
Concord Hospital	Y
Concord Hospital Medical Group (inclusive of the OB-GYN practice)	Y
Dartmouth Hitchcock Concord (inclusive of the OB-GYN practice)	Y

D-6. IDN Community Project: Standard Assessment Tools

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

American Society of Addiction Medicine (ASAM) Treatment Criteria	ASAM Placement criteria provides a guide to assist in matching patients to appropriate treatment settings. Adolescent and adult treatment criteria are unique. The criteria rest on the concept of enhancing the use of multidimensional assessments in placement decisions in specified levels of care, which exist along a continuum.
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D-7. IDN Community Project: Protocols for Patient Assessment, Treatment, Management, and Referrals

Protocol Name	Brief Description	Use (Current/Under Development)
NH Board of Medicine Opioid Prescribing Rules	Final rules for opioid prescribing for the management or treatment of non-cancer and non-terminal pain, as well as requirements to use the state prescription drug monitoring program (PDMP).	Current
42 CFR part 2 Agreements	To be signed by patients	Current
MAT and PAT Workflows	Clinical workflows for administering MAT & PAT	Current
MAT Adherence and Prevention of Diversion	Developed as recommendations by Concord Hospital Addiction Physician	Current

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

1/5/18	Half and Half X-Waiver: Office Based Treatment for Opioid Use Disorders	The presentation and online course are designed to train qualified physicians, physician assistants and nurse practitioners in dispensing or prescribing specifically approved Schedule III, IV, and V narcotic medications for the treatment of opioid addiction in an office-based setting. The goal of this training is to acquire the knowledge and skills needed to provide optimal care to opioid use disorder patients.
1/18/18	Harm Reduction in an Opioid Era	Learning Objectives: 1. Articulate the rationale for and principles of evidence-based harm reduction strategies 2. Identify two policies that incorporate harm reduction principles and practices 3. Describe three harm reduction interventions that will effectively integrate harm reduction approaches into the healthcare continuum or the community
2/5/18	Consumer Substance Use: Ethical Considerations	Overall application of NASW CODE of Ethics to this topic. - Substance use and how it contributes to CMHC consumer deaths - A brief overview of the Office of Chief Medical Examiner and how drug deaths are classified as Suicide, Accidental, or Undetermined - Review of the NASW Standards for Social Work Practice with clients with substance use disorders - Suicide risk in individuals with substance use - Strategies to referring consumers to treatment using motivational techniques - Local resources for services
3/30/18	Working Respectfully with Transgender Clients: What Every Clinician	This workshop will prepare clinicians to work knowledgeably with transgender adults. It will cover the developmental progression of gender dysphoria, varieties of transgender identities, the gender transition process, and medical and non-medical treatment options available. Special attention will be paid to establishing and maintaining a collaborative therapeutic alliance.

	Needs to Know	Objectives: At the completion of this program participants will know how to: 1) Identify the particular needs of transgender clients, 2) Establish a collaborative working relationship with transgender clients, 3) Guide transgender clients through the transition process, if appropriate, 4) Address co-existing conditions often associated with being transgender.
March 2018	Autism Spectrum Disorders and Substance Use Disorders	
March 2018	Engaging and Supporting Families in Suicide Prevention	Focus on engaging families whose loved ones are in suicidal crisis or have attempted suicide, and their crucial role in suicide prevention
5/3/18	Meeting the Needs of Children in the Opioid Epidemic	A panel discussion of what we know (and don't know) about the effects of opioid exposure on newborns and young children, and an example of a clinical practice model.
6/14/18	Understanding MAT for Recovery Support	This course will provide an updated version of the NIDA and SAMHSA's Blending Initiative product, originally entitled "Buprenorphine Treatment: A Training for Multidisciplinary Professionals". The primary goal of this training package is to create awareness among recovery coaches about medications currently approved by the FDA and used in the treatment of opioid dependence. The course includes information about what to expect when someone is treated with medication, information about the legislation that permits office based buprenorphine treatment, the science of addiction, the mechanism of each medication, patient selection criteria and associated patient counseling and therapeutic issues.
6/23/18	Caring for Substance-Exposed Infants	This training will examine Neonatal Abstinence Syndrome (NAS), address the nature of the problem and review the epidemiology of substance use in pregnancy/NAS regionally versus nationally. The NAS scoring process and what it means will be reviewed. The benefits of non-pharmacologic interventions to minimize NAS and need for pharmacologic treatment will be examined. The issue of mandated reporting will be discussed along with developing safe plans of care utilizing both medical and community resources. The concept of safe sleep will also be addressed.
All	NH Wraparound and RENEW	Ongoing training and coaching in the NH Wraparound and RENEW models

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

Process Milestone Number	Process Detail	Submission Format	Results (Met/ Not Met)			
			6/30/17	12/31/17	6/30/18	12/31/18
D-1	IDN Community Project Timeline, Key Milestones and Evaluation Project Plan	Spreadsheet (Microsoft Project or similar platform)				
D-2	IDN Community Project Evaluation Project Targets	Table				
D-3	IDN Community Project Workforce Staffing	Table				
D-4	IDN Community Project Budget	Narrative and Spreadsheet				

Process	Process Detail	Submission	Results (Met/ Not Met)			
D-5	IDN Community Project Key Organizational and Provider Participants	Table				
D-6	Clinical Infrastructure: IDN Community Project Standard Assessment Tools	Table				
D-7	Clinical Infrastructure: IDN Community Project Protocols For Patient Assessment, Treatment, Management, and Referrals	Table				
D-9	Provide the training plan and curricula for each Community Driven Project as required in A-1.3	Training schedule and table				

Projects E: Integration Focused

IDN Community Project Implementation and Clinical Services Infrastructure Plan

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

Project E5 Enhanced Care Coordination (ECC) for High Need Populations Updates

Please see D1 MAT for the portion of this program previously dedicated to infants born to women receiving MAT during pregnancy.

Children/Adolescents 0-17 with a diagnosable serious emotional disturbance (SED) and who meet two of the following criteria:

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

Despite multiple attempts to engage NH Hospital, the project has not received any referrals from them to the project. It was expected that most of the clients for this age group would come from NH Hospital. The ECC Supervisor submitted her resignation in July 2018 and we are undergoing a thorough evaluation of this project based on identified community needs.

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

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

The primary source of referral for this project was planned to be NH Hospital and Sununu Youth Services (SYS). Most of the referrals are coming from SYS and none are coming from NH Hospital.

There were two significant events during the last reporting period that led to disruption in this project. A 19-year-old client in the program died by suicide in a very public manner

and the Renew Coach for the project died in a car accident, leaving behind a wife and two young children. These two events happened in close proximity to each other. Riverbend brought in counselors to work with staff.

Timeline with updates in bold. Past is greyed out and current/future is in blue.

ECC Timeline	
Jan - June 2017	<ul style="list-style-type: none"> • Implementation Plan - This was accomplished • Timeline & budget - This was accomplished • Workforce plan - This was accomplished • Projected client engagement - This was accomplished • Key organizational providers - This was accomplished • R&R for team members - This was accomplished • Clinical Services Infrastructure - This was accomplished <ul style="list-style-type: none"> ○ Define target population ○ Assessment tools ○ Protocols, Processes, & Workflow ○ Training plan & curricula ○ Agreements ○ Evaluation plan ○ Hire EC Supervisors
July - Dec 2017	<ul style="list-style-type: none"> • Hire 3 EC Coordinators - This was accomplished • Operationalize Program (develop forms, protocols, referral process, workflow) Training in Wraparound (2 staff + 2 sup) and Renew (1 staff + 1 sup) - This was accomplished • Initiate data reporting - This was accomplished • Project budget review for 2018 - This was accomplished • Develop monitoring and improvement team - This was accomplished • Employ rapid cycle evaluation - This was accomplished • Participate in semi-annual report writing - This was accomplished • Contract with YouthMove for PEER services - This was accomplished • Contract with NAMI NH for PEER services - This was accomplished
Jan - June 2018	<ul style="list-style-type: none"> • Monthly progress and data reporting - This was accomplished • Monitor project - This was accomplished • Employ rapid cycle evaluation - This was accomplished • Participate in semi-annual report writing - This was accomplished
July - Dec 2018	<ul style="list-style-type: none"> • Monthly progress and data reporting • Monitor project • Employ rapid cycle evaluation • Participate in semi-annual report writing

E-2. IDN Community Project: 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
Individuals served over the life of the project	99	14	14	
Intake to determine eligibility		14	16	
Not eligible		1	1	
Left program		4	1	
Participant satisfaction (Youth Progress Scale and Team Meeting Rating Scale)	High	N/A	N/A	
Newly placed outside the home	Improvement	N/A	0	
Returned to home from placement	Improvement	N/A	3	
Improved Academic performance	Improvement	N/A	7	
New psychiatric hospitalizations	Improvement	N/A	0	
New juvenile offenses	Improvement	N/A	1	

E-3. IDN Community Project: Workforce Staffing

Provider Type	IDN Workforce (FTEs)				
	Projected Total Need	Baseline Staffing on 6/30/17	Staffing on 12/31/17	Staffing on 6/30/18	Staffing on 12/31/18
E5 - ECC Supervisors (.2)	2	2	2	2	
E5 - ECC Intake	1	N/A	1	1	
E5 - ECC Coordinators	3	0	3	2	
E5 - NAMI NH/YouthMove Peers	2	0	2	2	

E-4. IDN Community Project: Budget

	ACTUALS			PROJECTED			
	2016	2017	Jan-Jun 2018	Jul-Dec 2018	2018	2019	2020
Enhanced Care Coordination							
Purchase Services / Professional		\$ 74,341	\$ 135,970				
Training (NH Wraparound & Renew & Coaching)		3,396	6,200				
Travel		388	1,246				
Other Direct Expense		-	1,123				
Total Enhanced Care		\$ 78,126	\$ 144,540	\$ 125,163	\$ 269,703	\$ 104,237	\$ 125,000

Purchase Services / Professional (non-CH staff)

This line item is for staffing for the project.

Training & Coaching

This pays for NH Wraparound and RENEW training and coaching, NAMI NH training, and any other training for staff.

Travel

This project includes home visiting.

Other Direct Expense (Flex Funds)

Flex Funds are described under **E-7. Protocols**. They are for short term needs related to the family being able to stay in the project.

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

Organization/Provider	Agreement Executed (Y/N)
Riverbend Community Mental Health	Y
Concord Hospital	Y
Concord Hospital Medical Group	Y
Dartmouth Hitchcock Concord	Y
Sununu Youth Services Center	Y
Child and Family Services	Y
UNH Institute on Disability	Y
NAMI NH	Y
Granite United Way	Y
Youth Move	Y
New Hampshire Hospital	Y

E-6. IDN Community Project: Standard Assessment Tools

Standard Assessment Tool Name	Brief Description
Child and Adolescent Needs and Strengths (CANS)	Multi-purpose tool developed for children’s services to support decision making, including level of care and service planning, to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services. Will be used by ECC Coordinators.
Ages & Stages Questionnaire (ASQ)	ASQ screens and assesses the developmental performance of children in the areas of communication, gross motor skills, fine motor skills, problem solving, and personal-social skills. It is used to identify children that would benefit from in-depth evaluation for developmental delays.
RENEW Strengths and NEEDS Checklist	List of factors associated with a high risk of failing to make a successful transition to adult life, and protective factors that are helpful despite the challenges. To be used by Sununu Youth Services
The North Carolina Family Assessment Scale (NCFAS)	Designed to examine family functioning in the domains of Environment, Parental Capabilities, Family Interactions, Family Safety, and Child Well-being. The NCFAS has 36 subscales in 5 domains. Each of the NCFAS scales provides an organizing framework for social workers and other family practitioners to conduct a comprehensive family assessment intended to inform the construction of a service plan and subsequently document changes in family functioning that represent outcomes of the service plan. It is completed by the practitioner after gathering information necessary for the practitioner to confidently assign ratings of the level of functioning on each subscale, and when all subscales are complete then assigning a rating of family functioning to each of the overarching domains that comprise the subscales. Conducting assessments both at the beginning and end of the service (intermediate assessment at 90-day intervals) provides workers with the opportunity to prioritize goals and services and to compute change scores between pre-service and post-service levels of functioning.

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

Protocol Name	Brief Description	Use (Current/Under development)
Intake and Needs Based Eligibility Form	Used to determine eligibility for services	In Use
RENEW Process Checklist	To be used with RENEW	In Use
RENEW Integrity Tool	Used by RENEW Coach and Facilitator as primary fidelity of implementation assessment	In Use
Wraparound Coaching Model	To be used with Wraparound program	In Use
NH Wraparound Framework	To be used with youth 0-17	In Use
System of Care (SOC) Model	A spectrum of effective, community-based supports, that is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs, in order to help them to succeed at home, in school, in the community, and throughout life.	Will be imbued throughout the program through training, practice, and collaboration with NH's Statewide SOC.
Wraparound Plan of Care Coaching Tool	Primary Tool for measuring fidelity of implementation	In Use
Use of Flex Funds	<p>Flex Funds are intended as a one-time urgent supplement to these resources that will improve the family's ability to address and/or manage the parent / child's mental health or substance use disorder needs.</p> <ul style="list-style-type: none"> • Use of Flex Funds should be time-limited and cost-efficient. • All other sources of available revenues, i.e., Medicaid, Emergency Assistance, community partners, etc. • must be ruled out and documented as ruled out, before Flex Funds may be accessed. • The need for "Flex" Funds must be specifically documented and state how the use of Flex Funds is related to the child/family's service needs and will address the parent/child's mental health or substance use recovery needs. <p>A Flex Funds request may include the following, as long as the proposed services / goods are directly related to the parent/child's mental health or substance use needs:</p> <ul style="list-style-type: none"> • Individual services/goods for the child; • Services/goods for the family or 	In Use

	<p>extended family;</p> <ul style="list-style-type: none"> • Services/goods to help strengthen the “natural” system of care/ support of a child and their family. • Some examples of use may include: <ul style="list-style-type: none"> ○ family support and sustenance which would enable the guardian/family to participate in treatment or improve the support for the youth ○ educational and vocational services not otherwise available or mandated by the local school system ○ medical services not otherwise covered (for example: eating disorder evaluation) ○ independent living services/supports ○ interpersonal and recreational skill development ○ additional reinforcers determined by the ECC Coordinator 	
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E-9. Provide the training plan and curricula for each Community Driven Project as required in A-1.3

2/5/18	Consumer Substance Use: Ethical Considerations	<p>Overall application of NASW CODE of Ethics to this topic.</p> <ul style="list-style-type: none"> - Substance use and how it contributes to CMHC consumer deaths - A brief overview of the Office of Chief Medical Examiner and how drug deaths are classified as Suicide, Accidental, or Undetermined - Review of the NASW Standards for Social Work Practice with clients with substance use disorders - Suicide risk in individuals with substance use - Strategies to referring consumers to treatment using motivational techniques - Local resources for services
2/19/18	Illness Management and Recovery (IMR)	<p>Total of 16 hours, split between 4 days: Illness Management and Recovery (IMR) is a psycho-educational program designed for clients and their support systems to learn and work collaboratively with specially trained staff. IMR aims to empower clients to learn about and manage their illness, develop recovery focused goals, and make informed decisions about their treatment to improve their quality of life. IMR can be done individually or in a group. The time frame is client driven, usually lasting between 6 and 12 months.</p> <p>Objectives:</p> <ul style="list-style-type: none"> - Participants will learn the history of IMR and the importance of hope and recovery for adults with severe and persistent mental illness - Participants will be able to have an open dialogue with clients regarding their experiences with symptoms, recovery focused goals, and collaborating with their support systems - Participants will gain experience with IMR materials by completing hands on projects and assignments

		- Participants will be able to complete documentation required in TIER for billing purposes
March 2018	Autism Spectrum Disorders and Substance Use Disorders	
March 2018	Engaging and Supporting Families in Suicide Prevention	Focus on engaging families whose loved ones are in suicidal crisis or have attempted suicide, and their crucial role in suicide prevention
3/14 and 3/23	Your Money, Your Goals	Your Money, Your Goals was created by the Consumer Financial Protection Bureau to train case managers and other staff from social service agencies and other organizations working with individuals and families with low income or limited resources.
3/30/18	Working Respectfully with Transgender Clients: What Every Clinician Needs to Know	This workshop will prepare clinicians to work knowledgeably with transgender adults. It will cover the developmental progression of gender dysphoria, varieties of transgender identities, the gender transition process, and medical and non-medical treatment options available. Special attention will be paid to establishing and maintaining a collaborative therapeutic alliance. Objectives: At the completion of this program participants will know how to: 1) Identify the particular needs of transgender clients, 2) Establish a collaborative working relationship with transgender clients, 3) Guide transgender clients through the transition process, if appropriate, 4) Address co-existing conditions often associated with being transgender.
All	NH Wraparound and Renew	Ongoing training and coaching in the NH Wraparound and RENEW models

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

Process Milestone Number	Process Detail	Submission Format	Results (Met/Not Met)			
			6/30/17	12/31/17	6/30/18	12/31/18
E -1	IDN Community Project Timeline, Key Milestones and Evaluation Project Plan	Spreadsheet (Microsoft Project or similar platform)				
E -2	IDN Community Project Workforce Staffing	Table				
E -3	IDN Community Project Evaluation Project Targets	Table				
E -4	IDN Community Project Budget	Narrative and Spreadsheet				
E -5	IDN Community Project Key Organizational and Provider Participants	Table				
E -6	Clinical Infrastructure: IDN Community Project Standard Assessment Tools	Table				
E -7	Clinical Infrastructure: IDN Community	Table				

Process	Process Detail	Submission	Results (Met/Not Met)			
	Project Protocols For Patient Assessment, Treatment, Management, and Referrals					
E-9	Provide the training plan and curricula for each Community Driven Project as required in A-1.3	Training schedule and table				

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

APM-1. Project APM Scoring: IDN Participation in Statewide APM Taskforce and Implementation Plan Development and IDN 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
Participate in development of statewide APM roadmap through workgroups and stakeholder meetings	x	x	
Develop an IDN-specific plan for implementing the roadmap which will contain IDN-specific outcome measures		N/A	
Develop the financial, clinical, and legal infrastructure required to support APMs		N/A	
Meet IDN-specific measures identified in the roadmap that measure progress toward meeting APM goals, including financial, legal, and clinical preparedness and engagement with MCOs		N/A	

IDN2’s newly established Sustainability Committee is using the Triple Aim (resource allocation, population management, customer satisfaction) to develop a sustainability plan for Integration after the DSRIP project funds have disappeared. APM is a sub-focus under resource allocation and the committee has received and reviewed APM materials from a variety of sources.

This committee will develop an IDN-specific plan for implementing the statewide APM roadmap once it is developed. The committee will also be responsible for meeting the measures identified in the roadmap toward APM goals, including financial, legal, and clinical preparedness and engagement with MCOs.

IDN2’s managing director has taken the lead in providing feedback relating to the NH DHHS Medicaid Care Management Procurement that recently went out for public review and listening sessions.

IDN2 was not present at the 3/29/18 Stakeholder Meeting: Medicaid Alternate Payment Model Strategy presented by Lucy Hodder et al due to an error in the email address of our designated APM representative. IDN2 is in receipt of the slides and handouts from that meeting, updated 4/5/18, and have reviewed them.

In addition, IDN2 has reviewed the NH DHHS Alternate Payment Model Strategy Design Summary draft of 4/23/18, prepared by Lucy Hodder et al.

DSRIP Outcome Measures for Years 2 and 3

Each IDN may earn up to 10% of the total IDN performance funding in Year 2 (CY 2017) and 25% of the total performance funding in Year 3 (CY 2018). The Table below, provided for information only, includes the DSRIP Outcome Measures that will be used for incentive payments for Years 2 and 3. For Years 2 and 3, use the current DSRIP Outcome Measures that must be reported as indicated in the Table below; cross reference to the final DSRIP Outcomes Measures documentation, located in eStudio. For additional information regarding Years 2-5 incentive payment mechanics, see the STCs, Attachment D, located in eStudio. For Years 4 and 5, CY 2019 and 2020, 100% of the performance funding will be based on the DSRIP Outcomes Measures. See the DSRIP Outcomes Measures, available on the DSRIP website, for more information.

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