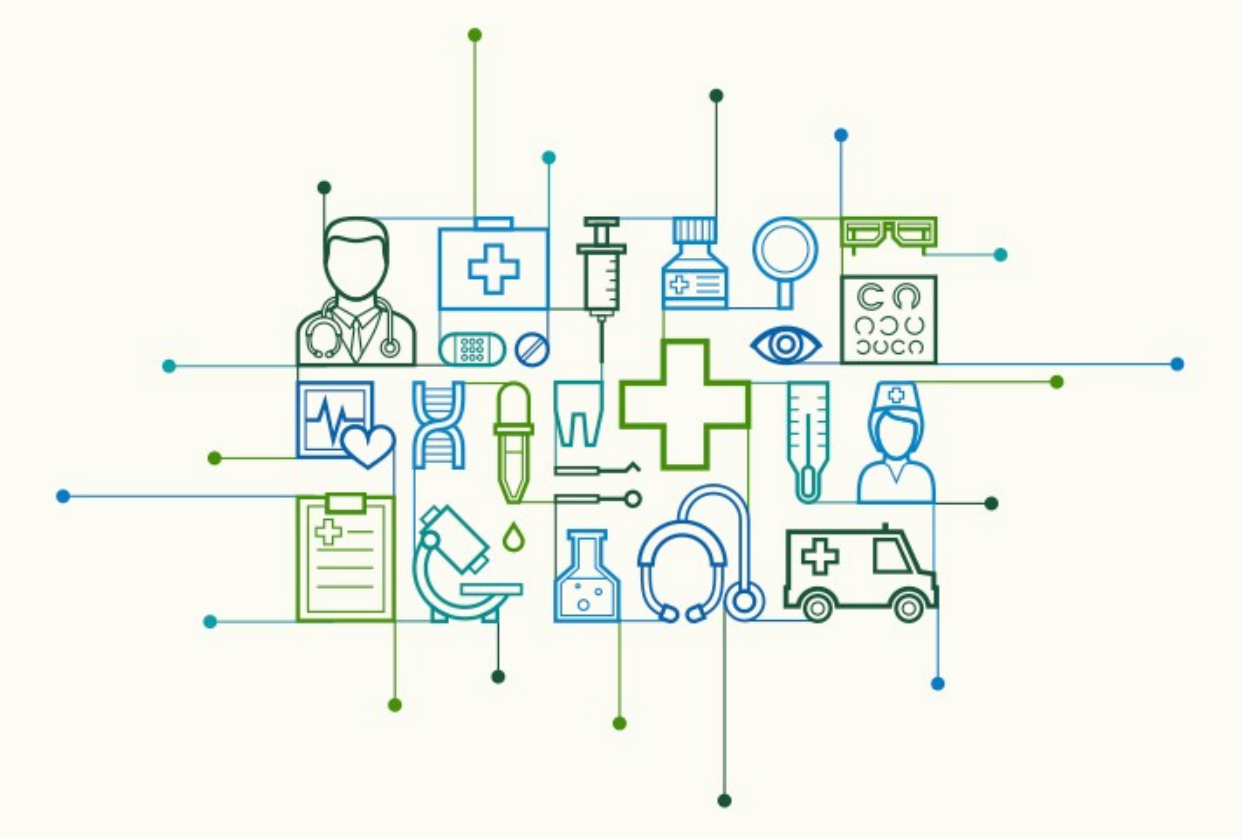
Capital Area Integrated Delivery Network (IDN2)

Concord Hospital, Administrative Lead

Capital Region Health Care (CRHC), Primary lead

Semi-Annual Report Jan - Jun 2019



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 at the administrative level and activity related to Community Input, Network Development, Addressing the Opioid Crisis, Governance, and Budget.

Community Input

IDN2 uses governance committees, project meetings, ad hoc workgroups, and full IDN2 member meetings to solicit input from its members. Site visits and self-assessments are also used to share information and gather input. During this period of time, IDN2 solicited feedback from staff involved with IDN2 projects through questionnaires and interviews. IDN2 maintains a website and Facebook presence and receives community input through these. In addition, IDN2 presents to the larger community about IDN2 activities in order to solicit regional input.

Governance Committees

- Steering - Meets quarterly
- Executive - Meets quarterly. In 2019, the executive and finance committee meetings were combined
- Finance - Meets quarterly. In 2019, the executive and finance committee meetings were combined
- Oversight & Sustainability - Meets monthly. This was combined with Sustainability in 2019.

Project Meetings

- Integration - Concord Hospital Medical Group (CHMG)
- Integration - Dartmouth Hitchcock Concord (DHC)
- Integration - Riverbend Community Mental Health (Riverbend)
- Medicated Assisted Treatment (MAT)
    - Primary Care Provider (PCP) MAT providers
    - Choices for Families (CFF)
- Enhanced Care Coordination (ECC)
- Complex Care Coordination (CCC) planning / CCC case review
- Project Managers
- Integrated Behavioral Health Clinicians (IBHC) - meet weekly for Riverbend supervision and monthly across all sites.

Ad hoc Workgroups (this period)

- Billing & Coding for Integration - meeting every two weeks with all IDNs and NH DHHS
- Data collection, reporting, validation (various as needed with HIT, data, vendor, and project staff)

Full IDN2 Member Meetings

- March - Project Updates with a Focus on MAT

- May - "Working Within A System of Care" - *Please see attachment 1*

Integrated Care Site Self-Assessments - *Please see attachment 2*

- Penacook Family Physicians
- Family Physicians of Pembroke
- Epsom Family Medicine
- Family Health Center
- Riverbend Integrated Center for Health (RICH)

Internet Presence

- www.region2idn.com
- https://www.facebook.com/CapitalAreaIntegratedCare

Community Presentations

- January 2 - Presentation of IDN 2 Projects to Rockingham County Executive Meeting
- January 29 - Presentation to Wellsense MCO on IDN Care Management
- February 5 - Present to Concord Hospital Trustees on IDN 2 projects
- February 28 - Meeting with Work Ready to plan Community College course for Peers (Workforce Taskforce)
- March 11 - Presentation to Merrimack County Commissioners
- April 1 - Meeting with AmeriHealth Caritas re LCME
- April 12 - Advisory Panel on Enhanced Care Coordination at NH BH for Childhood Trauma Recovery
- May7 - Testimony on Workforce Bill SB 308
- May 20 - Presentation to Capital Region Health Care Board of Trustees
- May 22 - Panel discussion Granite News Collaborative
- June 13 - Meeting with all County Administrators
- June 21 - Meet with all MCO's re: Local Care Management
- June 28 - Meeting with County Commissioners (Merrimack)

Network Development

There have been no changes to membership in IDN2.

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
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					Referral
NHADACA	Community based organization							Training
NH DOC (Prison)	Correctional Facility	x	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					Referral
UNH Institute on Disability	University	x					x	Training
Waypoint - (Formerly CFS)	Community based organization	x	x			x	x	
Youth Move NH	Community based organization	x					x	Peers

Addressing the Opioid Crisis

IDN2 addressed the Opioid Use Disorder (OUD) this period in the following ways:

- Supported 16 MAT providers at the following sites:

Location	MAT Providers
Internal Medicine at Horseshoe Pond	1
Concord Hospital Family Health Center	2
Pleasant Street Family Medicine	2
Dartmouth Hitchcock Concord	1
Concord Family Medicine	3
Concord Hospital Substance Use Services	1
Dartmouth Hitchcock Concord and Concord Hospital OB-GYN	2
CHOICES at Riverbend	4

- IDN2's psychiatric nurse received her X-Waiver
- MAT providers met 6 times to share best practices, review cases, and address challenges
- Provided MAT presentations to 9 community groups
- Provided SUD-focused education/trainings for behavioral health staff
    - Cognitive Behavioral Therapy for Substance Use Disorders
    - HIV for Substance Use Professionals
    - Effects of Substance Use on Young Children
    - New England Summer School of Addiction (4 days, multiple courses)
- Provided SUD-focused training for PCPs
    - IDN2 PCP MAT providers participated in Project ECHO's Northern New England Network of PCP MAT providers 8 monthly case-based learning sessions.
- Commitment to building a network of peers focused on providing recovery support services. Additional peers were hired to support OUD/SUD efforts. IDN2 peers are working toward their CRSW. In addition, IDN2 contracts with NAMI NH and Youth Move for family- and youth- focused peers.

In addition, IDN2 has been closely involved in implementing The Doorway. The Directors of IDN2's HUBs (Riverbend Choices and Concord Hospital Substance Use Services) are supervising the project manager of The Doorway.

The former SUD Coordinator of Care (under the BDAS program) joined the IDN2 team a year ago after that funding ran out. She continues to act as an SUD facilitator and care coordinator in the region. Here work during this period of time included:

Capital Area Leadership Team: Facilitate the SUD Capital Area Leadership Team of approximately 35 behavioral health leaders, SUD providers, First Responders, Governor's office advisors, policy and legislative individuals, City of Concord officials and others to ensure on-going integration and communications across the SUD continuum. Hold Monthly meetings at Concord Hospital. Efforts this past 6 months included presentations by:

- The Recovery Friendly Workplace Initiative – (Governor's Office) by Shannon Bresaw, Director.
- 2-1-1 Presentation to the Team to introduce the new SUD statewide Crisis Line number and promote the opening of The Doorways in the Capital area and around the State.
- The NH Department of Corrections gave a detailed presentation on the programs and SUD initiatives being initiated for incarcerated inmates. The NH Information and Analysis Center (DMI) gave an overview by Ryan Nix, for the statewide snapshot of SUD trends in central NH counties.
- The NH Recovery Task Force – A thorough presentation was given about the role of the RTF in the Capital Region as well as statewide, by RTF Co-Chair Keith Howard.
- Tom Donovan, Manager of The Doorway-Concord gives a brief update each month of the number of calls received, individuals assisted and trends across the clients being seen - at the request of the Team.
- Identify additional stakeholders who may assist in building a robust Capital Area Leadership Team and continue to shape an Integrated Delivery Model of care and supports for Substance Use Disorders. Two additional personnel from DHMC-Concord have been added to the Leadership Team this Spring.

- Conduct monthly meetings with SUD providers, stakeholders, and subject matter experts to gather further information and build stronger relationships across the region.

Mental Health First Aid- Certified Instructor: Conducted 3 8-hour Mental Health First Aid trainings across the region this past Spring. Completed a full training for the City of Concord employees, including the City Manager in January 2019. Completed full training for the public at the Center for Health Promotion in February and a full class for Riverbend employees in April 2019.

"The Doorway"

- Continue on-going collaboration with The Doorway -Concord Team to build a current SUD resource database for the Capital Region including all SUD treatment providers, MAT providers, Recovery resources and extended services within a 60-mile radius.
- Provide stakeholders, providers and the public with information and referral regarding The Doorway -Concord and assist in communication and support of this initiative.
- Identify and collaborate with new providers to inform them of 211 information crisis line and regional resources.
- Attend Information sessions and workshops on The Doorway when possible to stay informed of initiatives and processes being implemented to share with Leadership Team.

Riverbend Community Education Group

- Attend monthly meetings of the CEG and assist in community-wide activities to educate the public on mental health as a disease.
- Launched a successful month-long set of events, presentations and information sessions for Mental Health Awareness Month (May) to build awareness of mental Illness/SUD and provide recovery information programs for the public, First Responders, LGBTQ populations, High School populations, Veterans, Providers and Stakeholders across the Capital Region.

The Governor's Commission Recovery Task Force

- Attend and take part in the Governor's Commission Recovery Task Force monthly meetings on issues pertaining to recovery resources throughout the State. Current activities include certifying Recovery Houses in the State of NH and working with NHCORR to assist in this process.
- Contribute information from the Capital Area Leadership Team to help ensure consistent communication across the region and assist with Recovery-related events and policy initiatives.
- Leading Initiatives, events and presentations for Recovery Month 2019 for Choices (RB) and statewide. Working with the Governor's Commission Recovery Task Force to promote recovery initiatives, education and wellness across the Region.

Please see more detail under A1 for training descriptions.

Governance

The IDN2 Committee is the "steering" committee that approves any actions and the budget. Its 15 members meet quarterly 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: Concord Regional Visiting Nurse Association (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. It is comprised of the CFOs of CRVNA, Riverbend, and Concord Hospital as well as IDN2s Managing CEO, Project Director, and Accountant.

The Oversight & Sustainability Committee is the quality control branch of IDN2's governance structure. Its charter is to 1) Review and understand all process and performance metrics required by the DSRIP project, 2) Receive reports from Project Management Team about process and performance metrics achieved to date and those to be achieved in the future, 3) Identify and evaluate any potential obstacles to achieving process and performance metrics, and 4) Make recommendations for action. This Committee is comprised of clinical, technology, compliance, and QI/QA decision-makers and leaders from Riverbend, Concord Hospital, Concord Hospital Medical Group, and Dartmouth Hitchcock-Concord.

This committee is also addressing sustainability for the IDN projects after DSRIP funding ends Dec. 31, 2020. IDN2 governance has approved a Sustainability Planning process. *Please see attachment 3*.

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).

Please see five-year budget and actuals for IDN2 on next page.

	2016	2017	2018	2019	Jan-Jun 2019	July-Dec 2019	2020
	Actual	Actual	Actual	Budget	Actual	Remaining	Budget
PPI - Admin							
Salaries/Wages	$ 11,858	$ 55,108	$ 26,877		$ 14,005		
Employee Benefits	$ 617	$ 2,129	$ 1,876		$ 1,007		
Services/Prof	$ -	$ 107,620	$ 362,327		$ 190,615		
Consulting Fees	$ 107,177	$ 204,134	$ 145,350		$ 80,559		
Subtotal Admin Staff	**$ 119,652**	**$ 368,991**	**$ 536,430**	**$ 613,499**	**$ 286,186**	**$ 327,313**	
Travel and Mileage	$ 765	$ 2,778	$ 11,973		$ 3,897		
Meeting Supplies	$ -	$ 261	$ 4,751		$ 2,338		
Office Supplies	$ 692	$ 7,181	$ 7,124		$ 3,536		
Minor Equipment	$ 1,326	$ -	$ -		$ -		
Malpractice	$ -	$ 5,000	$ 9,999				
Advertising	$ -	$ 33,481	$ 28,053		$ -		
Consulting Fees	$ -	$ -	$ -		$ -		
Project Supplies	$ 281	$ 486	$ -		$ -		
Total Admin	**$ 122,716**	**$ 418,178**	**$ 598,330**	**$ 695,799**	**$ 295,957**	**$ 399,842**	**$ 696,000**
A2 BH WF Dev							
Services/Prof		$ 90,325	$ 134,890		$ 132,128		
Training		$ 16,449	$ 5,297		$ 14,859		
Minor Equipment		$ 1,376	$ -		$ -		
Office Supplies		$ 161	$ 988		$ 853		
Travel and Mileage		$ 487	$ 2,880		$ 2,605		
Recruitment		$ -	$ -		$ 1,045		
Total BH WF Dev	**$ -**	**$ 108,798**	**$ 144,055**	**$ 333,220**	**$ 151,490**	**$ 181,730**	**$ 334,000**
A1 HIT							
Services/Prof		$ 9,833	$ 105,536		$ 44,602		
Minor Equipment		$ -	$ -		$ -		
Software - Contracts		$ 16,516	$ 154,906		$ 42,821		
Total HIT	**$ -**	**$ 26,349**	**$ 260,442**	**$ 317,106**	**$ 87,423**	**$ 229,683**	**$ 300,000**
B2 Integration							
Services/Prof (RB)		$ 18,360	$ 803,934		$ 548,756		
Services/Prof (CH)		$ 293,640	$ -		$ -		
Services/Prof (DHC)		$ -	$ 27,885		$ 27,885		
Outside Training		$ 449	$ 11,757		$ 1,488		
Malpractice		$ 23,950	$ -		$ 5,000		
Total Integration	**$ -**	**$ 336,399**	**$ 843,576**	**$ 1,724,118**	**$ 583,129**	**$ 1,140,989**	**$ 1,600,000**
C2 Reentry							
Services/Prof		$ 113,287	$ 234,926		$ 100,853		
Consulting Fees		$ 40,004	$ -		$ -		
Testing supplies		$ 4,367	$ 143		$ 1,118		
Total Re-entry	**$ -**	**$ 157,658**	**$ 235,069**	**$ 289,862**	**$ 101,971**	**$ 187,891**	**$ 260,000**
D1 MAT							
Services/Prof (RB)		$ -	$ 257,465		$ 158,871		
Services/Prof (CH)		$ 5,520	$ 37,416				
Outside Training		$ -	$ 728				
Services/Professional		$ 26,957	$ -				
Contract (Waypoint)							
Flex Funds					$ 4,000		
Incentives		$ -	$ -		$ 27,956		
Total MAT	**$ -**	**$ 32,477**	**$ 295,609**	**$ 683,123**	**$ 190,827**	**$ 492,296**	**$ 680,000**
E5 ECC							
Services/Prof		$ 74,341	$ 185,085		$ 59,927		
Travel		$ 388	$ 2,956		$ 2,804		
Flex Funds		$ -	$ 3,256		$ 4,919		
Total ECC	**$ -**	**$ 74,729**	**$ 191,297**	**$ 164,237**	**$ 67,650**	**$ 96,587**	**$ 165,000**
Total Expenses	**$ 122,716**	**$ 1,154,588**	**$ 2,568,378**	**$ 4,207,465**	**$ 1,478,447**	**$ 2,729,018**	**$ 4,035,000**

July-Dec 2018 Budget Detail for PPI - Administration

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

Salaries/Wages, Employee Benefits, Services/Prof, Consulting Fees: This includes salary, fees, and/or benefits for 5.15 FTE administrative staff as follows:

- Managing CEO .3
- Project Director 1
- Associate Medical Director .35
- CTO .2
- Project Coordinator (RB and all community projects) .8
- Project Manager - (Concord Hospital) .2
- Human Resources 1
- Accountant .4
- Bookkeeper .5
- Financial Data Analyst .5

Travel and Mileage: For administrative and project staff

Meeting Supplies: For refreshments at meetings

Office Supplies: Supplies for administrative and project staff

Minor Equipment: Was used for start-up equipment while building staff

Malpractice: Moved to B1

Advertising: This is for recruitment of behavioral health staff including using a "head hunter" to find psychiatric staff. Moved to A1

Consulting Fees: Held for potential legal and audit needs.

Project Supplies: For supplies directly tied to project/client needs

DSRIP IDN Process Milestones

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

Process Milestone Number	Process Detail	Submission Format	Results (Met/Not Met)				
			6/30/17	12/31/17	6/30/18	12/31/18	6/30/19
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

IDN2 leads the statewide Behavioral Health Workforce Taskforce (BHWFTF) and participates in committees related to education, hiring, training, retention, and policy. In June 2019 this committee met to identify and communicate a clear process, structure and timeline for the WFTF and its subcommittees to meet the objectives of the DSRIP demonstration. *Please see attachment 4*.

In this period of time, IDN2 addressed these needs in its region by:

- Providing meetings, by project and/or role, for all IDN2 staff, whereby they can discuss and receive support for challenges and successes.
- Distributing learning opportunities to all IDN2 staff and encouraging participation, including through the availability of scholarships.
- Hiring persons with the right mix of interest, experience, and skills and providing them with additional educational and training opportunities to advance their knowledge.
- Hiring at the top of the credential. For example, hiring APRNs to fill psychiatrist roles.
- Building a network of peers who can delivery recovery support services.
    - IDN2 now has 9.25 peers, all of who are CRSW or working toward CRSW
    - 7.25 peers are hired by and based at Riverbend and 2 are contracted from NAMI NH and Youth Move to address family- and youth-focused needs.
    - A peer navigator oversees and manages peer deployment to IDN2 partner sites including:
        - Emergency room
        - Primary and specialty care practices
        - In the community

IDN2 will continue to work with other IDNs and BHWFTF committee members to accomplish the deliverables developed by the BHWFTF according to that timeline. Regionally, IDN2 will continue to work on the bullets listed above.

IDN2 workforce training received during this period

Training	Location/Source	Attendees	Description
January			
Project ECHO NNE MAT TeleECHO Sessions	Northern New England Network	PCP MAT Providers	Didactic presentation on risk factors of overdose and overdose prevention; two case presentations.
Hoarding: Outpatient Perspective	Riverbend	IBHCs	This training will discuss the role and effectiveness of the outpatient therapist in dealing with hoarding. The clinical definition of hoarding juxtaposed to its meaning personally.

NH's Connect Suicide Prevention and Intervention	NAMI/Riverbend	IBHCs	Module 1: Recognize risk factors and warning signs for suicide Module 2: Connect with individuals at risk for suicide Module 3: Mental health provider prevention protocols
NH Wraparound Training		ECC Staff	
February			
Myers and Stauffer Learning Collaborative on Population Health	Myers and Stauffer	IDN2 Staff	The goal of this learning collaborative is to help State leaders, IDN leads and administrators, community partner administrators, public health network managers, population health administrators, community health workers / navigators / care coordinators, project managers, and practice managers to learn and apply evidence-based strategies to make the case to advance population health and health equity. As a result of the learning collaborative, participants will be able to: • Recognize both the challenges and the importance of building public will to address population health • Rethink how they are currently making the case for population health • Identify areas where their casemaking could be leveraged to strengthen public support using evidence-based strategies • Describe methods of using data to build public support for population health programs and health system transformation
March			
Asthma Training	Network4Health	IBHC	

COPD Training	Network4Health	IBHC	Network4Health (IDN 4) in partnership with Rivier University's Family Nurse Practitioner program will again be offering a series of 45 minute chronic condition lunch and learn webinars this spring. The series will support mental health, substance use disorder and social services staff in better understanding these common medical diagnoses, and also serves as a good refresher for any primary care team members.
Project ECHO NNE MAT TeleECHO Sessions	Northern New England Network	PCP MAT Providers	Didactic presentation on managing pain in patients being treated for SUD/OUD; two case presentations.
April			
MSLC Learning Collaborative - Population Health	MSLC	IDN2 Staff	
Project ECHO NNE MAT TeleECHO Sessions	Northern New England Network	PCP MAT Providers	Didactic presentation on opioid use in special populations; two case presentations.
8-Hour MAT X-Waiver Course	Providers Clinical Support System - New England ATTC American Psychiatric Nurses Association	Psychiatric Staff	This training enables APRNs with prescriptive authority to meet the education requirement for obtaining a MAT waiver under CARA 2016. This training is tailored specifically to nurses to support their efforts in treating opioid use disorder. This training is available in two parts: an 8-hour training and a 16-hour training. Both are eligible for continuing nursing education contact hours and 21 of those hours are in pharmacology.
May			

16-Hour MAT X-Waiver Course	Providers Clinical Support System - New England ATTC American Psychiatric Nurses Association	PCP MAT Providers	This training enables APRNs with prescriptive authority to meet the education requirement for obtaining a MAT waiver under CARA 2016. This training is tailored specifically to nurses to support their efforts in treating opioid use disorder. This training is available in two parts: an 8-hour training and a 16-hour training. Both are eligible for continuing nursing education contact hours and 21 of those hours are in pharmacology.
MSLC Learning Collaborative - The New Normal: Enhanced Care Coordination	MSLC	IDN2 Staff	
CHW/Resource Specialist Festival	Dartmouth Hitchcock	DHC Resource Specialist	Best practice sharing, trauma-informed care didactic and workshop, heartmath, stigma training.
Cognitive Behavioral Therapy: How to Change Thinking to Change Lives	UNH Professional Development	IBHC	Appreciate CBT as a contemporary psychotherapy modality applicable to adults in diverse populations and myriad settings. Gain a working knowledge of basic CBT principles. Learn techniques most commonly used in CBT. Acquire CBT strategies for reducing stress, tackling relationship and work issues, and addressing depression and anxiety.
Facing Our Fears: Treating Suicidal Clients and Their Families		Waypoint ECC staff	
Behavioral Management Lunch and Learn	Dartmouth Hitchcock	DHC BH Staff	Reviews documentation of behaviors, how to set expectations with patients, how to handle various disruptive or inappropriate scenarios and learn what their role is in being the front line staff person.

Solutions from the Frontlines: A Behavioral Health Conversation		Waypoint ECC staff	
Mindfulness in Recovery	NAADC, The Association for Addiction Professionals	DHC Resource Specialist	The techniques taught in mindfulness play a critical role in relapse prevention. The core mindfulness skills, taken from Dialectical Behavior Therapy (DBT), enhance a client's ability to increase awareness of the present moment, increase the time spent in the present, and be in control of his or her mind. This then decreases the amount of mood dependent behaviors, such as using drugs and alcohol and there addictive behaviors. The concepts of mindfulness can also be found all throughout the 12 step program. This presentation will offer education of mindfulness skills found in DBT and give exercises to implement in treatment and recovery to assist clients with understanding how these skills can help them with continued sobriety.
NH NASW Conference	NASW - New Hampshire Chapter	BH Staff	Trauma-informed Primary Care from the patient's point of view.
Cognitive Behavioral Therapy for Substance Use Disorders	IRETA Webinar	BH Staff	Review of the CBT model of substance use, as well as practical treatment strategies and tools in order to best help individuals affected by SUDs.
DBT	Concord Hospital	SUD Staff	
Post Intervention Suicide	Concord Hospital	SUD Staff	
Trauma-Informed Care	Citizens Health Initiative	IBHC, BH Manager	
Essentials of Project Management	Granite State College	Administrative staff	
HIV for Substance Use Professionals		SUD Staff	
Recovery Coaching (CRSW)		SUD Staff	

Effects of Substance Abuse on Young Children		Choices for Families MAT provider	
June			
New England Summer School of Addiction	50th New England School of Addiction and Prevention Studies	ECC	Four-day intensive experience to further knowledge, skills, and experience in the field of substance use disorder services. The school is appropriate for all who recognize the impact of alcohol, tobacco and other drugs on individuals, families, and communities. Individuals may select topic specific tracks where similar topic courses have been grouped together or, if a participant would like to tailor their experiences even more, they may select specific courses from different focus areas. These focus areas have been designed to meet the needs of various audiences. Programming is intended for many different partners in substance use disorder prevention, treatment, intervention and recovery. Whether you are a new addiction counselor, a juvenile probation officer, a recovery coach, a prevention specialist, an experienced licensed clinician, or in another discipline,
Psychotropic Medications and Older Adults: Update on Safety Considerations	American Psychiatric Associations	Psychiatric Staff	
Riverbend Mobile Crisis Unit	Riverbend	Primary Care Nursing Staff, Care Coordinators, Behavioral Health Clinician, Practice Manager LPN Supervisor	

Mental Health and Wellness in the Workplace: Strategies to Support Patients and Providers Living with Mental Illness	Dartmouth Hitchcock	Care Coordinators	

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

Performance Measure Name	2020 Target	Cumulative Progress Toward Target			
		As of 12/31/17	As of 6/30/18	As of 12/31/18	As of 6/30/19
Train PCPs in behavioral health needs	28	30	30	40	46
Train BH staff in chronic medical disease	9	20	20	30	32
Train non-clinical staff in behavioral health needs	14	15	34	75	87
Staff turnover	<15%	14% (5/36)	12% (6/49)	8% (4/49)	12% (5/41)
PCPs are providing MAT in PCP settings	18	10	11	14	16

The first four performance measures were achieved and exceeded. The numbers of PCPs providing MAT in PCP settings is a Dec. 31, 2020 goal. In a 2018 change from what we originally proposed, in 2017, IDN2 went to a HUB & SPOKE model for delivering MAT. This allows the current MAT providers (SPOKEs) and their patients to be better supported and for those practices without a MAT provider to have access to the Substance Use Disorder Continuum of Care sites (HUBs) for induction and follow-up care.

A1-5. IDN-level Workforce: Staffing Targets

Provider Type	IDN Workforce (FTEs)					
	Total Need	6/30/17	12/31/17	6/30/18	12/31/18	6/30/19
A2 - Tech Support (.7)	1	1	1	1	1	1
A2 - Data Analyst (.5)	1	0	0	1	1	1
B1 - IBHC	6	6	7.4	4.4	6	5
B1 - IC Manager	2	1	1	1	2	2
B1 - Psychiatrist / APRN	2	0	0	1	2	2
B1 - MA	1	1	1	1	1	1
B1 - IBHC Supervisor	1	1	1	1	1	1
B1 - Case Manager	1	0	0	0	1	1
C2 - Case Manager	1	1	1	1	1	1
C2 - Psychiatric APRN (.3)	1	0	1	1	1	1
C2 - MLADC	0	1	1	1	1	0
C2 - BH Clinician	1	1	0	1	1	1
D1 - MAT Co-Coordinators (.2)	2	2	2	2	2	2
D1 - SUD Counselor	1	N/A	0	1	1	1
D1 - Peer Engagement Specialist	1	N/A	0	1	1	1
D1 - Clinical Manager	1	N/A	0	1	1	1
D1 - Clinical Counselor	1	0	0	0	0	1
D1 - CFF MAT Providers (.4)	2	2	2	2	2	2
D1 - CFF MA (.4)	1	N/A	0	0	1	1
D1 - CFF Wrap/PE Providers	2.1	0	1.6	1.6	2.1	1.1

E5 - ECC Supervisors (.15)	2	2	2	2	2	2
E5 - ECC Intake (.05)	1	N/A	1	2	1	1
E5 - ECC Coordinators	1	0	3	3.5	1	1
All – Peers	5.75	4	2	5	5.75	9.25

On June 30, 2019, we had one vacant B1 IBHC position in the process of being re-hired. The work is covered by other IBHCs. In addition, the work of the MLADC position for C2 was absorbed by the D1 counselor position so that position is no longer needed.

A1-6. IDN-level BH Workforce Development Budget

Year	2016	2017	2018	2019	Jan-Jun 2019	July-Dec 2019	2020
A1 Line Item	**Actual**	**Actual**	**Actual**	**Budget**	**Actual**	**Remaining**	**Budget**
Services/Prof		90,325	134,890		132,128		
Training		16,449	5,297		14,859		
Minor Equipment		1,376					
Office Supplies		161	988		853		
Travel & Mileage		487	2,880		2,605		
Recruitment					1,045		
Total A1		**108,798**	**144,055**	**$333,220**	**151,490**	**181,730**	**334,000**

Jan-June 2019 Budget Detail for A1 BH Workforce Development

Services/Prof: Represents 9.25 Peers including the following:

- Peer Recovery Support Workers 6.25
- Family Support Specialist 1
- Youth Peer 1
- Peer Navigator/Manager 1

Training: With the 2019 budget, now inclusive of all IDN2 training.

Office Supplies and Travel & Mileage: With the 2019 budget, moved to PPI and included with all IDN2 travel

Recruitment: Moved from PPI to A1. Includes all advertising, head hunting, and recruitment efforts.

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	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

Process Milestone Number	Process Detail	Submission Format	Results (Met/Not Met)				
			6/30/17	12/31/17	6/30/18	12/31/18	6/30/19
A1-3	Workforce Capacity Dev. Implementation Plan	Narrative & Microsoft Project or similar platform					
A1-4	Evaluation Project Targets	Table					
A1-5	Staffing	Table					
A1-6	Budget	Narrative and Spreadsheet					
A1-7	Key Organizational and Provider Participants	Table					

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

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

For the reporting period of January 1, 2019 through June 30, 2019, continued progress was achieved with IDN2's partners in implementing and expanding their HIT objectives and goals.

The configuration change of the MAeHC portal for the CHMG practices and Concord Hospital went live in January, changing the view in the portal from an Enterprise level view to being broken out by CHMG practice and Concord Hospital separately. This configuration change was necessary and vital both from a partner data validation capability to ensure accurate data collection, improving patient outcomes, and for IDN reporting. Riverbend also changed their MAeHC portal view to be broken out by their program areas.

After many workflow process meetings and ongoing configuration and testing on Dartmouth Hitchcock's side with their primary project team at their Lebanon site and status meetings with IDN2 HIT staff, Dartmouth Hitchcock-Concord went live with their iPad integrated CCSA at the end of April.

There was significant progress achieved with CMT activities. All 8 of the CHMG B1 sites, with the exception of CH-SUS, went live with CMT event notifications. An IDN wide Complex Care CMT portal was implemented as a key goal from IDN2's Complex Care Committee workgroup.

Technology Update for period January 1-June 30, 2019

During this timeframe, the primary HIT related focus was centered around MAeHC portal data validation and CMT implementation/ continued usage by all submitting partners.

IDN2 HIT project managers conducted both one on one and group training sessions with the CHMG practices to review MAeHC portal data and specifically, the approach to validating their data as captured in Cerner and ensuring clinical staff are fully trained in documenting the DSRIP measures criteria correctly and consistently.

ADT Feed Activity: Now that all CHMG practices have gone live with CMT event notifications, they have access to the data that is being submitted to CMT via the ADT Feed from Concord Hospital.

CHMG sites: The 7 remaining CHMG primary practices went live with event notifications by the end of May. They are all receiving event notifications on IP Discharges, 3 ED visits in 3 months, and SNF discharges but these could change once each site has had time to incorporate their new processes around event notifications into their existing clinical workflows and have had time to evaluate accordingly on the most appropriate action to take. Some may choose to only use the built- in reports vs. receiving daily notifications via fax as well.

CH-Substance Use Services: They have attended a CMT demo overview and do attend the monthly CHMG Integration Meetings where CMT usage by the other sites in IDN2 to date has been reviewed. They will be going live once their 42CFR specific consent agreement is finalized by Concord Hospital's Privacy Department. IDN2 has plans to devise an implementation plan for both the CHMG practices and CH-Substance Use Services. In the meantime, some practices have already implemented new, clinical processes of their CMT event notifications by reviewing them in their morning staff huddles.

IDN2 CMT Complex Care Program: IDN2 went live in June with a Complex Care portal based on referrals that the Complex Care Coordinator receives and has obtained client consent on. The Coordinator uploads a manual file to CMT. The portal is designated in CMT's systems as "NH IDN2 Complex Care". As of this report, 2 clients have been uploaded to this portal. Ongoing workflows continue to be discussed in each Complex Care Committee meeting, with various members from both clinical and non-clinical IDN members, including EMS providers. Event notifications are sent for all ED visits, all inpatient visits, 3+ ED visits in 3 months, 5+ ED visits in 12 months, and 3 ED locations in 90 days for those specified clients. The Complex Care Coordinator than reaches out and collaborates with the appropriate providers, both clinical and community- based, as needed.

DH-Concord:

- Internal workflow processes reviewed, defined and documented
- CMT demo attended
- Patient attribution data being submitted to CMT for all DH-sites including Concord
- Portal configured
- Anticipated go live mid-August

Both Riverbend and CRVNA continue to utilize CMT in meeting their care coordination goals for their clients and patients, based on their established and existing cohorts and event notifications.

CMCC: Crotched Mountain had no changes in technology deployments reported.

NAMI NH: NAMI NH has completed an agreement form with CMT and has established accounts for staff who will be uploading data and/or receiving event notifications. NAMI NH is in the process of preparing an initial client file for upload to the CMT system.

CMT-Shared Care Plan

As of June 30, 2019, since going live with the shared care plan pilot in the fall of 2018, Riverbend has entered 144 shared care plans across four of their 4 programs: Children's Intervention Program, CHOICES, Community Support Program, and Riverbend Counseling Associates. 107 shared care plans were entered Jan-Jun 2019.

CMT set up a custom report for Riverbend, accessible in their portal, that lists those patients that triggered the ED high utilizer cohort and documents if a shared care plan was entered and the date. This report is being used for QA purposes to ensure that shared care plans are being entered appropriately.

Due to how Riverbend's program-based portals were configured on CMT's side, any shared care plan that has been authored by Riverbend cannot be viewed or printed by any CMT member. CMT has a fix for this technical issue, and it will be deployed soon. This technical issue has delayed all care collaboration efforts in IDN2 as they relate to the shared care plan, particularly with the Concord Hospital ED Department. This has also delayed CRVNA's goals to implement shared care plans for those patients that are frequent fallers as referred by EMS providers. Once this issue is resolved, we can then start to explore the viability of entering shared care plans at the CHMG practices.

DH-Concord is planning to implement entering shared care plans in the 2nd half of 2019, after they go live with event notifications in August.

Table 4. Providers in Scope

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

- In the 2nd half of 2019, IDN2's HIT support person will query those IDN2 members who have current referral processes in place and don't already have DSM installed.

IDN2 Member Organizations		Data Extraction	Internet Connectivity	Secured Data Storage	Electronic Data Capture	DSM	Shared Care Plan	Event Notification Service	Transmit Event Notification	
Name of Organization	PHI	1	2	3	4	5	6	7	8	Site Visit Done
Ascentria Care Alliance	Yes	×	E	×	×	E	×	×	×	
Bhutanese Community of NH	Yes	×	E	×	×	E	×	×	×	
Boys & Girls Clubs of Greater Concord	Non-PCP/BH	×	×	×	×	×	×	×	×	
Capital Area Public Health Network	Non-PCP/BH	×	×	×	×	×	×	×	×	
CATCH Neighborhood Housing	No	×	E	×	×	E	×	×	×	
Community Action Program / ServiceLink	Yes	×	I	I	I	✓	✓	✓	×	YES
Concord Coalition to End Homelessness	Yes	×	I	I	I	✓	✓	✓	×	YES
Concord Family YMCA	No	×	I	I	I	×	×	×	×	YES
Concord Hospital	Yes	✓	I	I	I	I	I	IC	IC	
CHMG Primary Care Practices										
Concord Family Medicine	Yes	IC	I	I	I	I	I	IC	IC	
Concord Hospital OBGYN	Yes	×	I	I	I	I	I	×	×	
Epsom Family Medicine	Yes	IC	I	I	I	I	I	IC	IC	
Family Health Center Concord	Yes	IC	I	I	I	I	I	IC	IC	
Family Health Center Hillsboro	Yes	IC	I	I	I	I	I	IC	IC	
Family Physicians of Pembroke	Yes	IC	I	I	I	I	I	IC	IC	
Internal Medicine at Horseshoe Pond	Yes	IC	I	I	I	I	I	IC	IC	
Pelvic Medicine	Yes	×	I	I	I	I	I	×	×	
Penacook Family Physicians	Yes	IC	I	I	I	I	I	IC	IC	
Pleasant Street Family Medicine	Yes	IC	I	I	I	I	I	IC	IC	
Substance Use Services/Fresh Start	Yes	IC	I	I	I	I	I	✓	✓	
Concord Human Services	Non-PCP/BH	×	E	×	×	E	×	×	×	
Concord Regional VNA	Yes	×	I	I	I	I	✓	IC	✓	
Crotched Mountain	Yes	✓	I	I	I	I	✓	IC	✓	YES
Dartmouth Hitchcock-Concord	Yes	IC	I	I	I	I	✓	✓	✓	YES
Dartmouth Hitchcock-OBGYN	Yes	×	I	I	I	I	×	×	×	
Families in Transition	Yes	×	I	I	I	✓	×	×	×	YES
Fellowship Housing Opportunities, Inc.	Yes	IC	I	I	I	I	×	×	×	YES
Granite Pathways	Non-PCP/BH	×	E	×	×	E	×	×	×	
Granite United Way	Non-PCP/BH	×	I	I	I	×	×	×	×	YES
Granite State Independent Living	Yes	×	I	I	I	I	×	×	×	YES
Life Coping, Inc.	Yes	×	E	×	×	E	×	×	×	
Merrimack County House of Corrections	Yes	×	I	I	I	I	E	E	×	YES
NAMI New Hampshire	Yes	×	I	I	I	IC	✓	✓	×	YES
NH Alcohol/Drug Abuse Counselors	Service	×	×	×	×	×	×	×	×	
New Hampshire Hospital	Yes	×	I	I	I	✓	✓	✓	✓	YES
NH DOC	Yes	×	I	I	I	E	E	E	×	YES
Riverbend CMHC, Inc.	Yes	IC	I	I	I	IC	IC	IC	✓	YES
Sununu Youth Services Center	E	×	E	×	×	E	×	×	×	
UNH Institute on Disability	Non-PCP/BH	×	×	×	×	×	×	×	×	
Waypoint	Yes	×	I	I	I	✓	E	E	×	YES
Youth Move NH	Non-PCP/BH	×	×	×	×	×	×	×	×	YES

Data Vendor/Data Aggregator

Bi-weekly meetings continue in this reporting period with MAeHC and Concord Hospital's data analyst and Riverbend's data reporting analyst, with IDN2's HIT support person in attendance to review the ongoing, monthly metric submissions for Assess 01, Assess 02, and Assess 04 as well as the new yearly measures; Assess 03, Care 03 A&C, and Hosp Inp 02.

As requested by Riverbend, MAeHC re-configured their portal view to be broken out by their program areas including Children's Intervention Program, CHOICES, Community Support Program, and Riverbend Counseling Associates. This took effect starting with January 2019 DSRIP data reporting.

Concord Hospital's data analyst successfully submitted to MAeHC the first reporting for the new measures of 2018 that apply to the CHMG B1 sites and Concord Hospital; Assess Screen 03, Care 03 A&C, and Hosp_Inp. 02.

Monthly files are now queued automatically to be sent to MAeHC for all semi- annual and annual measures.

As a result of Dartmouth Hitchcock enterprise level, DSRIP measure analytics review meetings that took place in June where they identified a need for standardized data collection and screening assessments for both adults and adolescents, they will be re-submitting Jan-June measures data for Assess 01, Assess 02, and Assess 04 prior to the Aug. 15 deadline.

MAeHC workflow status: As of June 2019, all pre-implementation steps including data agreements, portal configuration and user set up and access have been completed for all IDN2 providers who are submitting DSRIP measures data. Two integral steps that will be maintained regularly going forward are measure validation and ongoing reporting.

CCSA

DH-Concord: DH-Concord successfully implemented the CCSA to all primary care teams on 4/29/19 once they were able to accomplish the necessary EMR modifications, workflow confirmations, and staff trainings along with the procurement of the necessary hardware. DH-Concord will be re-submitting Jan-June 2019 data to MAeHC to reflect newly updated, CCSA administration data collection to age 12+, not just 18+, as a result of recent standardized data collection review meetings that now incorporate updated Epic templates for all DH- sites that pertain to the DSRIP measures.

Riverbend: Riverbend engaged in a PDSA cycle to evaluate the effectiveness of current CCSA processes and determine a need for further action. Previously, Riverbend had planned to create a CCSA "form" in the EHR, pulling data points from multiple electronic sources to create a single summary document. It was theorized that this would support the completion of screening across all CCSA domains and thereby, the achievement of associated metrics. Upon review of MAeHC portal data, it has become clear that Riverbend's existing processes are sufficient, eliminating the need for the creation of a single form. Currently, the CCSA data elements are fully integrated in the EHR for the two largest programs (ChIP and CSP). At RCA and CHOICES, the CCSA form is scanned into the EHR and tracking of completion and upcoming due dates is incorporated into the EHR.

Table 11. Metrics for Individual Projects

C2 - Reentry

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

D1 MAT/PCP

- # of MAT Providers
- Total patients seen - New? continuing?
    - Disposition of those who left
    - Opioid status?

D1 MAT/CFF/Providers

- Number served during this period of time
    - Did not return after first visit
- Delivered during this period of time
    - Opioid free at delivery
    - Transferred to another MAT provider after delivery
    - Scheduled to be transferred to another MAT provider
    - Weaned off treatment
    - Did not follow up with transfer plans
- Delivered earlier time period but sill in service
    - Transferred to another MAT provider
    - Did not follow up with transfer plans
- Still pregnant

D1 MAT/CFF/Wraparound Services

- Individuals served during this period of time - New? Continuing?
    - # of client contacts
    - # attending parent education
    - Discontinued service with linkage to other resources
    - Discontinued service without linkage to other resources
    - How many delivered
        - Of those that delivered, # retained custody
        - Placement outside the home

E5 ECC

- Individuals served over during this period of time - New? Continuing?
- Newly placed outside the home
- Returned to home from placement
- Improved academic performance
- New psychiatric hospitalizations
- New juvenile offenses
- CANS/ANSA

Secure Texting

No new developments reported during this period.

Closed Loop Referrals

These are accomplished at the CH Integrated Care Sites in the following way:

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.

In addition, the CH Integrated Care Sites 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.

At the CH Integrated Care Sites, IBHCs are noting referrals to Community Based Organizations (CBO) within Cerner and then adding them to an excel spreadsheet. The ICM who works across practices is using the excel spreadsheet to track the referrals and ensure that the loop is closed. She then communicates this back to the IBHCs, who document the activity within Cerner.

At DHC, the RSS or IBHC documents all connections made to community agencies, specialists, etc. in the Research Electronic Data Capture (REDCap) database following standardized pathways. There is a check point at 90 days post-linkage to resource to ensure connection is successful and that the patient is following the plan.

At Riverbend, Case Managers at the Community Support Program and the Children's Intervention Program are using a Targeted Case Management note in TIER to document social determinants of health needs and referrals made. These are updated monthly and when a client follows through with a referral, this is documented. The new Riverbend Counseling Associates /CHOICES Addition Recovery Services Case Manager will use the same Targeted Case Management note to document referrals and follow-through.

Direct Messaging

NAMI NH: NAMI NH has established an agency account with Kno2 and has provided access to all staff with roles that may require the use of secure messaging. To date NAMI NH has not needed to employ Kno2 to exchange data with other providers. The family peers support model NAMI NH staff follow encourages "nothing about us without us" in reference to the families being served. Because of this NAMI NH staff has limited contact with other providers without

the presence of the individual being served. When such contact is required, it is done after obtaining a signed release from the individual.

Riverbend: Riverbend is still planning to pursue implementing the CareConnect platform.

Concord Hospital/CHMG and Dartmouth Hitchcock utilize their EMR based DSM platforms.

Crotched Mountain: CMCC communicates via secured messaging using Kno2 since May 2018.

New Hampshire Hospital: Meetings were held between Jan-June 2019 with testing being performed between NHH, CRVNA, Riverbend, and Concord Hospital. The CareConnect project will resume once a planned, hosted environment system migration is completed, to allow for the CareConnect capabilities to be implemented.

Table 5

Step	Direct	12/31/17	6/30/18	12/31/18	6/30/19
1.	**Identify agencies for direct implementation**	Completed	Completed	NA	NA
2.	**Engage with Kno2 to assist with product demos and implementation**	Completed	Completed	NA	NA
3.	**Contracting for Product**		Completed	NA	NA
4.	**Account set up**		Completed	NA	NA
5.	**Web training**		Completed	NA	NA
6.	**Process flow evaluation**		Completed	NA	NA
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
	18	Any remaining participation to be confirmed in next reporting period	In next reporting period, 2019	9

PreManage Community Project Plan	Responsible Party	12/31/17	06/30/18	12/31/18	6/30/19
Contract Executed with IDN	IDN Lead	Completed			
Agreements signed by organizations	Each Organization	Each organization signs as they enroll	Completed	Completed (CH-ED and Epsom Family Medicine)	Completed for remaining CHMG sites. Pending for DH-C.
Project Kickoff Call			Completed	Completed	Completed
IT Implementation					
SFTP Setup	CMT/Organization		Completed	Completed	Completed
Eligibility File					
Eligibility Design	Organization		Completed	Completed	Completed

Upload to SFTP	Organization		Completed	Completed	Completed
Test (Validate)	CMT		Completed	Completed	Completed
Process to Production	CMT		Completed	Completed	Completed
Automatic Pickup from SFTP Setup	CMT		Completed	Completed	Completed
Evaluate other organizations that have capability to send ADT feed	CRVNA, Riverbend, Crotched Mountain		Exploring with EMR vendors	To explore in 2019	Will explore in 2019
Follow steps 7-13 for each organization					
Clinical Implementation					
Onboarding Packet	CMT/Organization		Completed	Completed	Completed
User Set up (Provisioning)	CMT		Completed	Completed	Completed
Identify List of Initial Users	Organization		Completed	Completed	Completed
Cohorts Set up					
Notification Destination Set Up	CMT		Completed	Completed	Completed for all except DH-C
Reports Set up	CMT		CRVNA-complete	To be implemented for CHMG practices and Riverbend	Completed for Riverbend.
Training					
Account Managers/IT	CMT		Completed	Completed	Completed
Clinical Staff	CMT		Completed	Completed	Completed except for DH-C

Table 6 CMT PreManage ED (Only Concord Hospital)

EDIE Project	Responsible Party	12/31/2017	06/30/18	12/31/18	06/30/19
VPN Connectivity	CMT/Concord Hospital	**Delayed due to Cerner upgrade**	Implemented	Completed and ongoing	Ongoing
ADT Feed / Messages	CH Hospital/CHMG	**Feed has been built but not released by Privacy**	Implemented and live	Implemented and live for CH-ED and all CHMG	Completed and ongoing
Test	CMT	**Delayed due to Cerner upgrade**	Completed	Completed	Completed
Mappings	CMT/Hospital	**Delayed due to Cerner upgrade**	Completed	Completed	Completed
Prod	Hospital	**Delayed due to Cerner upgrade**	Implemented	Completed	Completed

EMR			TBD	TBD	TBD
Cerner Return	CMT		TBD	TBD	TBD
EMR Build	CH Hospital		TBD	TBD	TBD
Configure	Concord Hospital		TBD	TBD	TBD
Validation	Concord Hospital		TBD	TBD	TBD
Historical File					
Build	Concord Hospital		In progress	Completed	Complete
IT Implementatio					

Active Directory /					
Investigate	CMT/Hospital		In progress	TBD	TBD
Identify	CMT/Hospital		In progress	TBD	TBD
Implement	CMT/Hospital		In progress	TBD	TBD
Clinical Kick			Completed	Completed	
User			Completed	Completed	
Identify list of	Hospital		Completed	Completed	
Set up initial	CMT		8/7/18	Completed	
Training			8/7/18	Completed	
ED providers	CMT		8/8/18	Completed	
Clinical/Project Go Live			Week of 8/6/18	Completed	

Data Analytics/APM/Population Health

Once the MAeHC portal access was set up and granted to each CHMG practice and MAeHC portal trainings and Cerner workflow guidance meetings were conducted, significant resources and time has been and continues to be devoted to validating their data with particular emphasis around their measure specific workflows as they pertain to what and where data is being entered in Cerner. Ongoing education to the clinical staff at each site continues and with each monthly MAeHC portal report, we are seeing improvements in the numerator "Pass" level data.Numerous hands-on data validation meetings have been conducted; both as group meetings and one on one with each practice. Concord Hospital management level practice staff continue to be part of these meetings as well as the core data reporting team to ensure compliance and thorough understanding and in supporting ongoing education to the staff responsible for entering and updating the DSRIP measures data in Cerner. In March, MAeHC added the encounter date to the portal-based encounter level data, allowing for all sites that are performing data validation to directly go to those listed encounters in their respective EMR's. Detailed, step by step documentation guides have been updated with Cerner screenshots, disseminated and reviewed in extensive detail at both the practice level data validation meetings and the CHMG Integration and 1115 Waiver meetings. The practice managers continue to review with their direct clinical staff to ensure compliance. Each practice has been consistently reviewing their MAeHC portal-based data, comparing to their EMR documented data and making corrections as needed on the EMR side. As a result of these data validation meetings, missing and incorrect documentation was discovered for all 3 measures for the CHMG sites and corrections were made at the practice level; allowing for the Concord Hospital data analyst to submit a one-time overwrite file of the

previously submitted monthly files to MAeHC for the timeframe of January through April, 2019 which resulted in higher numerator "Pass" results. A Cerner report has been requested for the CHMG practices that will mimic the denominator and numerator criteria of the 3 measures that can be provided to the practices on a weekly basis where they could perform more frequent data validation. As of this report writing, this report has not been started. Once the analytics process runs on MAeHC's side at the end of each month, summary reports are being disseminated to the practice managers, Concord Hospital management level practice staff, and IDN level staff and are being reviewed in the monthly Oversight Committee meetings. We do plan to explore using the analyzed MAeHC data to date as a crosswalk for Concord Hospital's and CHMG's data as a comparison to the data they maintain in their Population Health Tool. DH-Concord's practice manager transitioned to a new Population Health/Project Manager role in late June to oversee the HIT related projects at DH-Concord. As a result, she is now reviewing and analyzing the MAeHC portal data and becoming familiar with the DSRIP measures criteria.

CMT sends manually compiled activity recap reports every other month to IDN2's HIT support person who reviews with the other Project Managers and the results will be reviewed in the monthly CHMG 1115 Integration Meetings starting with June's report (please see below example of some of the information that is included).

Facility Name	Eligibility File Size	Date	Total Active SCPs to date	# of SCPs AUTHORED This Month	# of SCPs UPDATED This Month	Notifications	Total ED Visits
Concord Family Medicine		Jun-19				91	
Epsom Family Medicine		Jun-19				43	
FHC - Concord		Jun-19					
FHC - Hillsboro		Jun-19				32	
Family Phys. Pembroke		Jun-19				53	
Internal Medicine - HSP		Jun-19				65	
Penacook Family Phys.		Jun-19				71	
Pleasant Street Fam. Med.		Jun-19					
Concord Hospital		Jun-19				238	4000
Concord Regional VNA	1206	Jun-19				547	
RB - ChIP	414	Jun-19	18	2		5	
RB - CHOICES	154	Jun-19	42			20	
RB - CSP	514	Jun-19	62	5		24	
RB - RCA	265	Jun-19				6	
RB (Master Portal)	602	Jun-19	9				
IDN2 - Complex Care	2	Jun-19				10	10

Once CMT automates these reports, planned for some time in the 3rd quarter, IDN2 will receive monthly recap reports. CMT hopes to also include these data elements in future reports:

- A breakdown of each of the different types of notifications sent to each facility and the number of each of those notifications
- A breakdown of how many SUD or BH patients have consented to share their information at each SUD or BH facility
- A breakdown of how many notifications were also sent to facilities w/in their portal (currently still showing only notifications that were sent via fax/printer/email/text/ or through the EMR)

Now that all the CHMG practices are live with CMT, we now have access to seeing their notification data and can perform QA processes by site and make any necessary cohort notification/workflow process modifications as needed. Riverbend and CRVNA continue to utilize the built in CMT reports for patient care coordination. IDN2 Project Managers plans to work with each practice to review the built-in report capabilities and explore any necessary custom reports with CMT. These reports can help to maximize the time spent reviewing event notifications and the frequency/timing i.e.-practices can run reports on Monday to view event notifications that took place over the weekend.

Table 12. IDN Specific Project Participation

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
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					Referral
NHADACA	Community based organization							Training
NH DOC (Prison)	Correctional Facility	x	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					Referral
UNH Institute on Disability	University	x					x	Training
Waypoint - (Formerly CFS)	Community based organization	x	x			x	x	
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	As of 6/30/19
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.	Achieved	Achieved
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. Secure Messaging exists at all sites.	Achieved	Achieved
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.	Achieved	Achieved
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	Achieved	Achieved
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 1st report submission of 4/1/18	Achieved	Achieved
Minimum standards assessment	Assess all organizations (41) for baseline status regarding the 8 minimum standards.	Met with 7 organizations	Met with 7 additional organizations. Not all partners collect PHI, so this was prioritized to only include those that do.	Achieved	Achieved
Direct messaging	All identified agencies will implement direct messaging	8 organizations have DSM to date	2 organizations implemented new Kno2 accounts. All B1 organizations have access to secure messaging.	Achieved	Achieved
Standards Education	Provide Education / guidance to identified agencies (14) for standards 2-4	Met with 7	Met with 7 additional organizations	Achieved	Achieved

Performance Measure Name	Target	Progress Toward Target			
		As of 12/31/17	As of 6/30/18	As of 12/31/18	As of 6/30/19
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. Epsom Family Medicine to go live 12/18. ADT Feed for all CHMG practices to go live 12/18.	Achieved	Achieved
Shared Care Plan	All identified organizations will implement shared care plan	0	Workflow discussions have been and continue to take place. Riverbend to begin with CMT/ED pilot 11/18. To include Epsom and all CHMGs.	Achieved	Achieved
PreManage Ed	Implement PreManage ED	0	Planned for week of 8/6/2018	Achieved	Achieved
Equipment	All identified primary care practices will have designated equipment for integration	8	Equipment is purchased as staff are hired for 1115 Waiver related roles	Achieved	Achieved
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. RB-planned for 2/19	In progress.	Achieved

A2-5. IDN HIT: Workforce Staffing

Provider Type	IDN Workforce (FTEs)					
	Projected Total Need	6/30/17	12/31/17	6/30/18	12/31/18	06/30/19
A2 - Tech Support (.7)	1	1	1	1	1	1
A2 - Data Analyst (.5)	1	0	0	1	1	1

A2-6. IDN HIT: Budget

Year	2016	2017	2018	2019	Jan-Jun 2019	July-Dec 2019	2020
HIT Line Item	**Actual**	**Actual**	**Actual**	**Budget**	**Actual**	**Remaining**	**Budget**
Services/Prof		9,833	105,536		44,602		
Minor Equipment							
Software - Contracts		16,516	154,906		42,821		
Total HIT		**26,349**	**260,442**	**317,106**	**87,423**	**229,683**	**300,000**

Jan-June 2019 Budget Detail for A2 - HIT

Services/Prof is for staff listed above

Minor Equipment is for technology supplies for IDN2 staff

Software - Contracts is for CMT and MAeHC

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

Organization Name	Organization Type
Concord Hospital	Hospital
Concord Family Medicine	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

Data Sharing Agreements

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	Y-Signed with IDN

Project Scoring: IDN HIT Process Milestones

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

Process #	Process Detail	Submission Format	Results (Met/Not Met)				
			6/30/17	12/31/17	6/30/18	12/31/18	6/30/19
A2-3	IDN HIT/HIE Implementation Plan and Timeline	Narrative & Spreadsheet (Microsoft Project or similar platform)					
A2-4	Evaluation Project Targets	Table					
A2-5	IDN HIT Workforce Staffing	Table					
A2-6	IDN HIT Budget	Narrative and Spreadsheet					
A2-7	IDN HIT Key Organizational and Provider Participants	Table					
A2-8	IDN HIT Data Agreement	Table					

Project B1: Integrated Healthcare

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

IDN2 timeline through 2020, with Jan-Jun 2019 updates.

IDN2 Timeline	Jul-Dec 2018	Jan-Jun 2019	July-Dec 2019	Jan-Jun 2020	Jul-Dec 2020
CCSA					
CCSA in use at all Integrated Care sites.	x	All sites are using the CCSA, and each has it available electronically.	survey & update as needed	survey & update as needed	survey & update as needed
Core Team Hiring & Training					
PCP, BH including Psych, Care Coordinator / Manager at all B1 sites	x	One vacancy	re-hire as needed	re-hire as needed	re-hire as needed
Metabolic Disorder training for BH staff	x	Completed with all hires.	New hires	New hires	New hires
SUD / MH / Integrated Care focused trainings for all IBHCs & PCPs	x	See A1	ongoing	ongoing	ongoing
Stigma reduction training for nonclinical staff	x	Available online.	New hires	New hires	New hires
Information Sharing					
Closed Loop Referrals					
At Integrated Care CH sites, inclusive of IBHCs and referrals to CBO to address social determinants of health	EHR + excel	EHR + excel	Research electronic options	Pilot	Expand
RB closed loop process	Pilot use in TIER	TIER upgrades continue	Review & modify as needed	Review & modify as needed	Review & modify as needed
Direct Messaging					
At Integrated Care CH sites	Cerner	Cerner	Cerner	Cerner	Cerner
At DHC	Epic	Epic	Epic	Epic	Epic
At RB	Limited Kno2	Exploring CareConnect. Meeting with NHH and others	Pilot CareConnect	CareConnect	CareConnect
Event Notifications					
CH ED using CMT for event notifications	Pilot	x	Review & modify as needed	Review & modify as needed	Review & modify as needed

RB using CMT for event notifications	Pilot for high utilizers	x	Expand	Review & modify as needed	Review & modify as needed
IDN2 partners using CMT for event notifications	Meetings to introduce CMT	Working on privacy and permissions	Review & modify as needed	Review & modify as needed	Review & modify as needed
Integrated Care CH sites using CMT for event notifications	Pilot for high utilizers / Epsom	x	Expand	Review & modify as needed	Review & modify as needed
Shared Care Plan					
"Crisis" shared care plan (ED, Epsom, RB)	Pilot for high utilizers	Expanded to CHMG. Working with DHC to implement.	Expand	Review & modify as needed	Review & modify as needed
RB (for local core team)	Tier	Tier	Review & modify as needed	Review & modify as needed	Review & modify as needed
Integrated Care CH sites (for local core team)	Cerner	Cerner	Review & modify as needed	Review & modify as needed	Review & modify as needed
EBPs: Depression Management & MAT					
Depression Management	All IBHCs trained in "IMPACT" - Protocol distributed to B1 sites	Researching AIMS Center Collaborative Care model that grew out of IMPACT.	Review & modify as needed	Review & modify as needed	Review & modify as needed
MAT HUB (Choices & CH SUS) and SPOKES (MAT providers)					
HUB: Oversee IDN2 MAT programs / coordinate with regional HUB and other SUD initiatives and programs / provide SUD continuum of care services / provide mentoring & support to SPOKES through Fusion	x	Conducted review: Project growing and coordinating / collaborating with The Doorway, Mobile Crisis, ED, and inpatient care. Focusing on close attention to communication and coordination of services and ongoing education to partners of available services.	Review & modify as needed	Review & modify as needed	Review & modify as needed
SPOKES: Participate in bi-monthly meetings & case conferences / provide support to other MAT providers or those considering / Refer to IBHCs and HUB for continuum of care services for patients	x	Conducted review: PCPs find MAT work satisfying and want greater connection to IBHCs. Director of Integrated Healthcare met with PCPs to develop plan for use of IBHCs.	Review & modify as needed	Review & modify as needed	Review & modify as needed

CHOICES FOR FAMILIES: MAT at OBGYN then transfer to MAT HUBs / Enhanced Care Coordination: Home visiting, wraparound supports and services / Parent Education / Flex Funds	x	Conducted review: Tightened referral process, bringing Waypoint in to meet client earlier in process, flex funds being used appropriately. Lower OBGYN MAT numbers might reflect more availability statewide as most clients in past were from out of IDN2's area.	Review & modify as needed	Review & modify as needed	Review & modify as needed
Expand access to MAT in IDN2	Developed protocol for hospitalists, ED, and CHMG to access MAT in IDN2 - sent out; developed proposals for BDAS Mobile Crisis Response Team, CFF, and Regional HUB	Submitted proposals mentioned Jul-Dec 2018 and received awards. Mapped a "system of care" and ensuring that all entities are aware of each other and the services available. IDN2 integral to the system. Concord Hospital planning large scale X-Waiver course for October, which will expand number of providers available.	Ongoing efforts	Ongoing efforts	Ongoing efforts
Use of Technology to Identify, Plan, Manage					
"Crisis" shared care plan (ED, CHMG, RB)	Pilot for high utilizers	Project is implemented and in use at RB, CHMG, and ED. Developing privacy and information sharing protocols to expand to CBOs.	Expand	Review & modify as needed	Review & modify as needed
Complex Care Project (ED, CHMG, RB, CFS, First Responders, CBOs, others)	Define / Hire	Project is implemented. See E5	Review & modify as needed	Review & modify as needed	Review & modify as needed
CCSA in DHC Epic	Add form in Epic	This is in use.	Review & modify as needed	Review & modify as needed	Review & modify as needed
CCSA in RB TIER	Implement TIER 8	Accomplished. Please see B1 8A CCSA narrative	Review & modify as needed	Review & modify as needed	Review & modify as needed
CCSA in CHMG Cerner	Research	Paper form is scanned into Cerner, where it is available electronically	Make determination	Implement if needed	Review & modify as needed

Data Collection and Reporting					
Collect and report required metrics	x	Data IDN2 is collecting is expanding beyond that required by DHHS as a way to evaluate success of projects and to plan for sustainability.	x	x	x
Monthly NH DHHS Reports	6	6 reports submitted	6	6	6
Quarterly NH DHHS Reports	2	2 reports submitted	2	2	2
Semi-Annual NH DHHS Reports	1	1 report submitted	1	1	1
B1 Site Self-Assessments & reports	x	See attachment 2	x	x	x
Oversight Committee review and evaluate reports and processes / recommend changes	6	6 meetings. Expanded to include sustainability.	6	6	6
Communication / Outreach					
IDN2 member meetings	2	See PPI.	2	2	2
Community presentations about IDN2 / Integration / Projects	4	See PPI.	4	4	4
Educational Presentations / Visits to Integrated Care Sites	5	These are ongoing. The Director of Integrated Healthcare and the supervisors of the MAT project conduct regular site visits to provide education and support to IDN2 staff.	5	5	5
Brochures and other forms of client outreach	2	A brochure was developed for Choices for Families.	2	2	2
Protocols - Guidance for Best Practices					
Timely communication	document	All protocols have been shared with IDN2 staff, as applicable.	Review & modify as needed	Review & modify as needed	Review & modify as needed
Privacy, including limitations on information for communications with treating provider and community-based organizations	document	All protocols have been shared with IDN2 staff, as applicable.	Review & modify as needed	Review & modify as needed	Review & modify as needed
Coordination among case managers -	document	All protocols have been shared with IDN2 staff, as applicable.	Review & modify as needed	Review & modify as needed	Review & modify as needed

IBHCs (internal and external to IDN)					
Safe transitions from institutional settings back to primary care, behavioral health, and social support service providers	document	All protocols have been shared with IDN2 staff, as applicable.	Review & modify as needed	Review & modify as needed	Review & modify as needed
Intake procedures that include systematically soliciting patient consent to confidentially share information among providers	document	All protocols have been shared with IDN2 staff, as applicable.	Review & modify as needed	Review & modify as needed	Review & modify as needed
Adherence to NH Board of Medicine guidelines on opioid prescribing	document	All protocols have been shared with IDN2 staff, as applicable.	Review & modify as needed	Review & modify as needed	Review & modify as needed
Treatment of mild to moderate depression - IMPACT	document	All protocols have been shared with IDN2 staff, as applicable.	Review & modify as needed	Review & modify as needed	Review & modify as needed
Joint services and communication channels (shared care plan)	document	All protocols have been shared with IDN2 staff, as applicable.	Review & modify as needed	Review & modify as needed	Review & modify as needed
Assessment, management, and referrals (using technology)	document	All protocols have been shared with IDN2 staff, as applicable.	Review & modify as needed	Review & modify as needed	Review & modify as needed
Referrals (closed loop)	document	All protocols have been shared with IDN2 staff, as applicable.	Review & modify as needed	Review & modify as needed	Review & modify as needed
Sustainability					
IDN2 Sustainability Committee					
Population Health Management	Pilot crisis shared care plan for high utilizers; draft Complex Care Coordinator proposal	Complex Care Coordinator hired. High Utilizer project implements. See E5.	Define & expand through research by complex care coordinator; CH meetings; IDN2 meetings	Define & expand through research by complex care coordinator; CH meetings; IDN2 meetings	Define & expand through research by complex care coordinator; CH meetings; IDN2 meetings

Funding (Billing, Resource Allocation, Grants)	Research, reach out, and define need.	Working with all IDNs & DHHS to identify and use Medicaid billing codes for integrated care; reached out to AIM Center for technical assistance for financial modeling, which is next step for IDN2.	Feasibility and strategic planning to sustain IDN2 programs; research & submit grants to support IDN2 programs	Ongoing work	Ongoing work
APM (requirement of NH DHHS)	Participate in statewide developme nt of roadmap	Working closely with DHHS and MCOs to determine next steps.	IDN2 plan to implement statewide roadmap; develop the financial, clinical, and legal infrastructure to support APM	Implement statewide and IDN2 roadmap	Implement statewide and IDN2 roadmap

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	As of 6/30/19
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.	Achieved	Achieved
Secure Texting	Evaluate each project for need and implement	To be determined/revie wing 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. Secure Messaging exists at all sites.	Achieved	Achieved
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.	Achieved	Achieved

Performance Measure Name	Target	Progress Toward Target			
		As of 12/31/17	As of 6/30/18	As of 12/31/18	As of 6/30/19
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	Achieved	Achieved
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 1st report submission of 4/1/18	Achieved	Achieved
Minimum standards assessment	Assess all organizations (41) for baseline status regarding the 8 minimum standards.	Met with 7 organizations	Met with 7 additional organizations. Not all partners collect PHI, so this was prioritized to only include those that do.	Achieved	Achieved
Direct messaging	All identified agencies will implement direct messaging	8 organizations have DSM to date	2 organizations implemented new Kno2 accounts. All B1 organizations have access to secure messaging.	Achieved	Achieved
Standards Education	Provide education/guidance to identified agencies (14) for standards 2-4	Met with 7	Met with 7 additional organizations	Achieved	Achieved
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. Epsom Family Medicine to go live 12/18. ADT Feed for all CHMG practices to go live 12/18.	Achieved	Achieved
Shared Care Plan	All identified organizations will implement shared care plan	0	Workflow discussions have been and continue to take place. Riverbend to begin with CMT/ED pilot 11/18. To include Epsom and all CHMGs.	Achieved	Achieved
PreManage Ed	Implement PreManage ED	0	Planned for week of 8/6/2018	Achieved	Achieved

Performance Measure Name	Target	Progress Toward Target			
		As of 12/31/17	As of 6/30/18	As of 12/31/18	As of 6/30/19
Equipment	All identified primary care practices will have designated equipment for integration	8	Equipment is purchased as staff are hired for 1115 Waiver related roles	Achieved	Achieved
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. RB-planned for 2/19	In progress; delayed at RB due to EMR upgrades	Achieved

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	**6**	6	7.4	4.4	5
B1 - IC Manager	**2**	1	1	1	2
B1 - Psychiatrist/APRN	2	0	0	1	2
B1 - MA	**1**	1	1	1	1
B1 - IBHC Supervisor	1	1	1	1	1
B1 - Case Manager	**1**	0	0	0	1
All - Peers (shared across projects)	**5.75**	**4**	**2**	5	9.25

B1-5. IDN Integrated Healthcare: Budget

Year	2016	2017	2018	2019	Jan-Jun 2019	July-Dec 2019	2020
B1 Line Items	**Actual**	**Actual**	**Actual**	**Budget**	**Actual**	**Remaining**	**Budget**
Services/Prof (RB)		18,360	803,934		548,756		
Services/Prof (CH)		293,640					
Services/Prof (DHC)			27,885		27,885		
Outside Training		449	11,757		1,488		
Malpractice		23,950			5,000		
Total Integration		**336,399**	**843,576**	**1,724,118**	**583,129**	**1,140,989**	**1,600,000**

Purchase Services / Professional (RB) and (CH): This represents the embedded IBHCs hired by Riverbend and working within the CHMG primary care practices and the MA and ICM hired by Concord Hospital to work with the Riverbend RICH program and the FHC-Concord. These are combined after 2017.

Outside Training: Moved to A1 with all IDN2 training.

Malpractice: Moved from PPI to B1.

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.

B1-8A Comprehensive Core Standardized Assessment

CCSA Domains in Place	Concord Hospital B1 Sites									DHC	RB
	CH SUS	FHC - C	FHC - H	Epsom	CFM	IMED HSP	Penacook	Pembroke	PSMF		
Demographic information	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Physical health review	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Substance use review	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Housing assessment	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Family and support services	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Educational attainment	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Employment or entitlement	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Access to legal services	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Suicide risk assessment	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Functional status assessment	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Depression screening (PHQ 2 & 9)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Universal screening using SBIRT	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Validated developmental screening for all children, such as the ASQ 3 and/or ASQ SE at 9, 18- and 24/30-month pediatric visits	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Developmental Screening using Bright Futures or other American Academy of Pediatrics recognized	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y

All sites are using the CCSA, and each has access to the information electronically. For DHC, it is built into Epic. For CH PCP and SUS practices, it is scanned into Cerner. Riverbend engaged in a PDSA cycle to evaluate the effectiveness of current CCSA processes and determine a need for further action. Previously, Riverbend had planned to create a CCSA "form" in the EHR, pulling data points from multiple electronic sources to create a single summary document. It was

theorized that this would support the completion of screening across all CCSA domains and thereby, the achievement of associated metrics. Upon review of MAeHC data, it has become clear that Riverbend's existing processes are sufficient, eliminating the need for the creation of a single form. Currently, the CCSA data elements are fully integrated in the EHR for the two largest programs (ChIP and CSP). At RCA and CHOICES, the CCSA form is scanned into the EHR and tracking of completion and upcoming due dates is incorporated into the EHR.

B1-8b Core Team Members

Key to charts:

RICH - Riverbend Integrated Center for Health
CH - Concord Hospital
FTE - Full Time Equivalent
APRN - Advanced Practice Registered Nurse
IBHC - Integrated Behavioral Health Clinician
MH - Mental Health
SUD - Substance Use Disorder
RSS - Resource Support Specialist
ICM - Integrated Care Manager

Organization/Provider	PCP	Psych	BH	Care Coord	MAT
Dartmouth Hitchcock Concord	Y	Y	IBHC	RSS	1
Riverbend	Through RICH	Y	MH + SUD	CM	4
Family Health Center Concord	Y	Y	IBHC	ICM	2
Family Health Center Hillsboro	Y	Y	IBHC	ICM	
Concord Family Medicine	Y	Sharing 2 FTE psychiatric APRN	IBHC	Dual role for IBHCs An ICM is shared across practices	3
Family Physicians of Pembroke	Y		IBHC		
Penacook Family Physicians	Y		IBHC		
Epsom Family Medicine	Y		IBHC		
CH Substance Use Services	Through CH		SUD		1
Pleasant Street Family Medicine	Y		IBHC		2
IMED Horseshoe Pond	Y		IBHC		1

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

Site	# PC Providers	Trained Goal	Actual to date	# BH Providers	Trained Goal	Actual to date
Dartmouth Hitchcock Concord	62	47	62	2	2	2
Riverbend	2	2	2	>200	>200	>200
Family Health Center Hillsboro	82	60	82	10	10	10
Family Health Center Concord						
Concord Family Medicine						
Family Physicians of Pembroke						
Penacook Family Physicians						
Epsom Family Medicine						
CH Substance Use Services						
Pleasant Street Family Medicine						
IMED Horseshoe Pond						

All CH and DHC IBHCs as well as Riverbend Community Support Program staff were trained in metabolic syndrome (Metabolic syndrome is a cluster of conditions or risk factors - 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. DHC PC and BH staff were trained in treating individuals with co-morbidities (including increased blood pressure, high blood sugar, excess body fat around the waist, abnormal cholesterol or triglyceride levels, chronic pain, depression) through a collaborative care effort. CH Integrated Care Site PCPs attended 2019 NH Academy of Family Physicians Conference and NH Medical Society Meetings and attended modules relevant to behavioral health integration.

In addition, B1 staff attended the following trainings during this period of time:

Month	Training	Location	Description
Feb	Myers and Stauffer Learning Collaborative on Population Health	Myers and Stauffer	The goal of this learning collaborative is to help State leaders, IDN leads and administrators, community partner administrators, public health network managers, population health administrators, community health workers / navigators / care coordinators, project managers, and practice managers to learn and apply evidence-based strategies to make the case to advance population health and health equity. As a result of the learning collaborative, participants will be able to: • Recognize both the challenges and the importance of building public will to address population health • Rethink how they are currently making the case for population health • Identify areas where their case-making could be leveraged to strengthen public support using evidence-based strategies • Describe methods of using data to build public support for population health programs and health system transformation
April	MSLC Learning Collaborative - Population Health	MSLC	
May	MSLC Learning Collaborative - The New Normal: Enhanced Care Coordination	MSLC	
May	Essentials of Project Management	Granite State College	
Jan	Hoarding: Outpatient Perspective	Riverbend	This training will discuss the role and effectiveness of the outpatient therapist in dealing with hoarding. The clinical definition of hoarding juxtaposed to its meaning personally.
Jan	NH's Connect Suicide Prevention and Intervention	NAMI/Riverbend	Module 1: Recognize risk factors and warning signs for suicide Module 2: Connect with individuals at risk for suicide Module 3: Mental health provider prevention protocols
March	Asthma Training	Network4Health	

March	COPD Training	Network4Health	Network4Health (IDN 4) in partnership with Rivier University's Family Nurse Practitioner program will again be offering a series of 45-minute chronic condition lunch and learn webinars this spring. The series will support mental health, substance use disorder and social services staff in better understanding these common medical diagnoses, and also serves as a good refresher for any primary care team members.
May	8-Hour MAT X-Waiver Course	Providers Clinical Support System - New England ATTC - American Psychiatric Nurses Association	This training enables APRNs with prescriptive authority to meet the education requirement for obtaining a MAT waiver under CARA 2016. This training is tailored specifically to nurses to support their efforts in treating opioid use disorder. This training is available in two parts: an 8-hour training and a 16-hour training. Both are eligible for continuing nursing education contact hours and 21 of those hours are in pharmacology.
May	CHW/Resource Specialist Festival	Dartmouth Hitchcock	Best practice sharing, trauma-informed care didactic and workshop, heartmath, stigma training.
May	Cognitive Behavioral Therapy: How to Change Thinking to Change Lives	UNH Professional Development	Appreciate CBT as a contemporary psychotherapy modality applicable to adults in diverse populations and myriad settings. Gain a working knowledge of basic CBT principles. Learn techniques most commonly used in CBT. Acquire CBT strategies for reducing stress, tackling relationship and work issues, and addressing depression and anxiety.
May	Behavioral Management Lunch and Learn	Dartmouth Hitchcock	Reviews documentation of behaviors, how to set expectations with patients, how to handle various disruptive or inappropriate scenarios and learn what their role is in being the frontline staff person.
May	Mindfulness in Recovery	NAADC, The Association for Addiction Professionals	The techniques taught in mindfulness play a critical role in relapse prevention. The core mindfulness skills, taken from Dialectical Behavior Therapy (DBT), enhance a client's ability to increase awareness of the present moment, increase the time spent in the present, and be in control of his or her mind. This then decreases the amount of mood dependent behaviors, such as using drugs and alcohol and their addictive behaviors. The concepts of mindfulness can also be found all throughout the 12-step program. This presentation will offer education of mindfulness skills found in DBT and give exercises to implement in treatment and recovery to assist clients with understanding how these skills can help them with continued sobriety.
May	NH NASW Conference	NASW - New Hampshire Chapter	Trauma-informed Primary Care from the patient's point of view.
May	Cognitive Behavioral Therapy for Substance Use Disorders	IRETA Webinar	Review of the CBT model of substance use, as well as practical treatment strategies and tools in order to best help individuals affected by SUDs.
May	Trauma-Informed Care	Citizens Health Initiative	

June	Psychotropic Medications and Older Adults: Update on Safety Considerations	American Psychiatric Associations	
June	Riverbend Mobile Crisis Unit	Riverbend	
June	Mental Health and Wellness in the Workplace: Strategies to Support Patients and Providers Living with Mental Illness	Dartmouth Hitchcock	

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

Site	# Non-Clinical Staff	Goal	Actual
Riverbend	93	93	93
Dartmouth Hitchcock Concord	9	9	9
Family Health Center Concord	As of 1/5/17 - CHMG had 152 non-clinical staff members	75	93 received SBIRT and MI 79 received Stigma Reduction Training
Family Health Center Hillsboro			
Concord Family Medicine			
Family Physicians of Pembroke			
Penacook Family Physicians			
Epsom Family Medicine			
IMED Horseshoe Pond			
Pleasant Street FM			

IDN2 developed a self-paced training for B1 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 staff members. DHC provides stigma reduction training through the DH Lebanon array of available trainings.

B1-8e Core Team Case Conferences

Riverbend has weekly multidisciplinary case conferences between its Community Services Program (CSP) for seriously and persistently mentally ill clients 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.

CH Integrated Care Sites have weekly case conferences through the IDN2 Psychiatric consultants. A psychiatrist was added to the team in January which expanded the capacity of the consultant beyond chart reviews and provider consultation to direct patient evaluation (and consultation to the PCP) when clinically indicated. All sites have twice weekly conferences with

the psychiatric consultants except for IMED HSP which is monthly due to low volume of Medicaid patients. All referrals to consultants are triaged and distributed between the consultants based on need; chart reviews are primarily managed by the APRN whereas face-to-face or emergency consultations are primarily managed by the psychiatrist. *Please see attachment 6* for updated schedule.

DHC MDCT meetings were started 3/27/19 and are held on a monthly basis. Staff representation includes Primary Care Provider, MAT provider, BHC's & resource specialists. PC leadership attends as needed.

B1-8f Secure Messaging

This is accomplished at the CH Integrated Care Sites and DHC through the use of their EHRs, Cerner and Epic. Riverbend has set up KNO2 and is exploring the use of CareConnect.

B1-8g Closed Loop Referrals

These are accomplished at the CH Integrated Care Sites in the following way:

9. The primary care physician orders a referral.
10. The primary care physician or a designated staff person communicates the referral to the subspecialist.
11. The referral is reviewed and authorized.
12. An appointment is scheduled.
13. The consult appointment occurs.
14. The subspecialist communicates the plan to the patient.
15. The subspecialist communicates the plan to the primary care physician.
16. The primary care physician acknowledges receipt of information from the subspecialist.

In addition, the CH Integrated Care Sites 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.

At the CH Integrated Care Sites, IBHCs are noting referrals to Community Based Organizations (CBO) within Cerner and then adding them to an excel spreadsheet. The ICM who works across practices is using the excel spreadsheet to track the referrals and ensure that the loop is closed. She then communicates this back to the IBHCs, who document the activity within Cerner.

At DHC, the RSS or IBHC documents all connections made to community agencies, specialists, etc. in the Research Electronic Data Capture (REDCap) database following standardized pathways. There is a check point at 90 days post-linkage to resource to ensure connection is successful and that the patient is following the plan.

At Riverbend, Case Managers at the Community Support Program and the Children's Intervention Program are using a Targeted Case Management note in TIER to document social determinants of health needs and referrals made. These are updated monthly and when a client

follows through with a referral, this is documented. The new Riverbend Counseling Associates /CHOICES Addition Recovery Services Case Manager will use the same Targeted Case Management note to document referrals and follow-through.

B1-8h Documented Work Flows and/or Protocols

DHHS Minimum Documented Protocols	DH-C	RB	CH Integrated Care Practices
Intake procedures that include systematically soliciting patient consent to confidentially share information among providers	x	x	x
Interactions between providers & community-based organizations	x	x	x
Timely communication	x	x	x
Coordination among case managers (internal & external to IDN)	x	x	x
Safe transitions from institutional settings back to primary care, behavioral health, and social support service providers	x	x	x
Privacy, including limitations on information for communications with treating provider and community-based organizations	x	x	x
NH Board of Medicine guidelines on opioid use prescribing	x	x	x

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	6/30/2019
B1-2	IDN Integrated Healthcare: Implementation Plan, Timeline, Milestones and Evaluation Project Plan	Narrative & Spreadsheet (Microsoft Project or similar platform)					
B1-3	IDN Integrated Healthcare: Evaluation Project Targets	Table					
B1-4	IDN Healthcare Integration Workforce Staffing	Table					
B1-5	IDN Healthcare Integration: Budget	Narrative and Spreadsheet					
B1-6	IDN Integrated Healthcare: Key Organizational and Provider Participants	Table					
B1-7	IDN Integrated Healthcare: Organizational leadership sign-off	Table					
B1-8a	All of the following domains must be included in the CCSA: • Demographic information • Physical health review • Substance use review • Housing assessment • Family and support services • Educational attainment	CCSAs (Submit all that are in use) Table listing all providers by domain indicating Y/N on progress for each process detail					

Process Milestone Number	Process Detail	Submission Format	Results (Met/Not Met)				
			6/30/17	12/31/17	6/30/18	12/31/18	6/30/2019
	• 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						
	For pediatric providers, the CCSA must also include: • Validated developmental screening for all children, such as the ASQ:3 and/or ASQ SE at 9, 18- and 24/30-month pediatric visits; • Developmental Screening using Bright Futures or other American Academy of Pediatrics recognized developmental	Table listing all providers by domain indicating Y/N on progress for each process detail					
B1-8b	List of multi-disciplinary core team members that includes, at minimum: • PCPs • Behavioral health providers (including a psychiatrist) • Assigned care managers or community health worker	Table listing names of individuals or positions within each provider practice by core team					
B1-8c	Multi-disciplinary core team training for service providers on topics that includes, at minimum: • Diabetes hyperglycemia • Dyslipidemia • Hypertension • Mental health topics (multiple)	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					

Process Milestone Number	Process Detail	Submission Format	Results (Met/Not Met)				
			6/30/17	12/31/17	6/30/18	12/31/18	6/30/2019
	• SUD topics (multiple)	indicate # of people trained in each practice by provider type for each reporting period for each training.					
B1-8d	Training for staff not providing direct care that at minimum includes knowledge and beliefs about mental disorders that can aid in recognition and management	Training schedule and table listing all staff indicating progress on each process detail					
B1-8e	Monthly (or more frequent) core team case conferences on behalf of patients with significant behavioral health conditions or chronic conditions	Conference schedule and Table					
B1-8f	Secure messaging	Narrative					
B1-8g	Closed loop referrals	Narrative					
B1-8h	Documented work flows and/or protocols that include, at minimum: • Interactions between providers and community-based organizations • Timely communication • Privacy, including limitations on information for communications with treating provider and community-based organizations • Coordination among case managers (internal and external to IDN) • Safe transitions from institutional settings back to primary care, behavioral health and social support service providers • Intake procedures that include systematically	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	6/30/2019
	soliciting patient consent to confidentially share information among providers • Adherence to NH Board of Medicine guidelines on opioid prescribing						

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

IDN2 sites have met all coordinated care practice designations.

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

Narrative is in B1 8a-h above

Coordinated Care Practice Designations:	DHC	Riverbend	CH Integrated Care Sites
CCSA in use	Y	Y	Y
Core Team	Y	Y	Y
Training for PCP/BH	Y	Y	Y
Training for non-clinical staff	Y	Y	Y
Case Conferences	Y	Y	Y
Secure Messaging	Y	Y	Y
Closed Loop Referral	Y	Y	Y
Documented Work Flows	Y	Y	Y

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

Medication Assisted Treatment

In addition to a critical aspect of Integration, IDN2 has D1 Medication Assisted Treatment (MAT) as a community project. IDN2's HUB & SPOKE model provides:

- Access to MAT through CHOICES for all B1 sites without a MAT provider.
- Mentoring support to B1 MAT providers.
- Community of practice whereby existing MAT providers support each other and those interested in receiving their x-waiver and participate in group educational opportunities (like Project ECHO listed in A1).
- Recovery support services for patients/clients through CHOICES and CH Substance Use Services.
- Monthly case conference meetings.
- Integrated behavioral health support for MAT patients at B1 sites.

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

All of IDN2's IBHCs were trained in the use of an expanded collaborative care model based on the AIMS Center's IMPACT model. The following protocol for mild-moderate depression is in use at the B1 sites:

1. PCP identifies depressive symptoms via CCSA or patient report or within visit
2. PCP/MA engages IBHC (ideally brought into visit) to provide further assessment
3. IBHC engages and assesses patient:
    a. Ensures baseline PHQ-9 has been completed
    b. Evaluates symptoms and determines diagnosis
    c. Identifies existing supports, including formal behavioral health providers
        i. Obtains releases and requests records when indicated
    d. Assesses for co-occurring disorders that may indicate need for specialty behavioral health referral (SUD, PTSD, IPV, chronic stressors)
        i. Facilitates referral to external outpatient provider when indicated
    e. Assesses for case management needs impacting symptoms
        i. Facilitates referral to Integrated Case Manager when indicated
    f. Educates patient about depression and treatment
    g. Documents encounter and plan
4. IBHC consults with PCP
    a. IBHC initiates brief intervention (1-5 sessions of behavioral activation)
    b. PCP updates diagnosis on problem list
    c. PCP considers adding/making changes to medication
    d. If additional complexity is identified, PCP considers referral to consulting psychiatric provider
5. IBHC reassesses level of depression (includes re-administration of PHQ-9)
    a. If no change/worsened:
        i. PCP considers adding/making changes to medication
        ii. IBHC begins Problem-Solving Treatment
    b. If improved:
        i. IBHC supports patient in creating relapse prevention plan

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

	DHC	Riverbend	CH Integrated Care Sites
Identify at Risk Patients	Through CCSA, which is built in to eDH (EPIC EMR). This is administered on iPads in reception room or via MyDH patient portal.	Intakes, through TIER, is done on all clients, to determine risk level. In addition, Riverbend emergency services staff are embedded at Concord Hospital and document emergency assessments in TIER. This allows for the monitoring of high-risk patients.	Concord Hospital utilizes claims and clinical data to identify high risk patients in a variety of medical conditions including, but not limited to, congestive heart failure, COPD, asthma, diabetes, depression, obesity, chronic kidney disease, and many other conditions. They use analytic tools through Cerner Health-e Intent to identify high risk and high utilizer patients. With the B1 project, at risk patients for MH, SUD, and SDOH

			are identified through the CCSA.
Plan Care	Patients with "positive" responses will be elevated to Share Care Plan status and uploaded to CMT.	Following intake, a therapist develops a preliminary treatment plan. In addition, identification of high risk medical / non-PCP patients are referred to the RICH program. These are recorded in TIER.	This is done through Cerner's shared care plan, which is used by the B1 team.
Monitor/Manage Patient Progress Toward Goals	SharePoint registry is used for population management of patients. REDCap database and standardized pathways is used for population management of patients with SDOH needs.	A more developed treatment plan is made with a Case Manager within the first 90 days that includes client-centered goals. This is recorded in TIER. The treatment plan is reviewed every 90 days.	Cerner's Health-e Registries product puts clinical and claims data together and places it in the providers workflow for gap closure. Concord Hospital is also utilizing electronic reporting to alert primary care practices of any patients who have been recently discharged from the hospital and getting them in to see their primary care physician within 7 days. For SDOH, IBHCs use an excel spreadsheet to track patient goals and the ICM monitors these.
Ensure Closed Loop Referral	RSS and/or IBHC documents connections made to community agencies, specialists, etc. in REDCap database following standardized pathways. Check point at 90 days post linkage to resource to ensure connection is successful and patient is following plan.	Case Managers at the Community Support Program and the Children's Intervention Program use a Targeted Case Management note in TIER to document social determinants of health needs and referrals made. These are updated monthly and when a client follows through with a referral, this is documented. The new Riverbend Counseling Associates /CHOICES Addition Recovery Services Case Manager will use the same Targeted Case Management note to document referrals and follow-through.	Cerner's dashboard reports and CH's nurse navigation program identify care gaps or risks and closes or mitigates those risks. The ICM monitors the SDOH excel spreadsheet and follows up to ensure that the follow up plan has been completed and/or that any obstacles are addressed.

In addition to the above, IDN2 has implemented two important projects.

ED/CMT Shared Care Plan

When one of the B1 receives notification of a Medicaid or Medicaid-eligible patient/client with 3 ED visits within 90 days, they use CMT to share information with the CH emergency department that can support decision making for that patient/client to include some/all of the following:

- Care team
- Patient goals
- Health concerns - BH diagnosis, social determinants of health, triggers
- Plan of treatment - care guidelines, recommendations, services they are already receiving

The attachments part of the CMT form can then be used for sharing supplemental background information.

Complex Care Coordination

IDN2 hired a Complex Care Coordinator (see E5) to identify, plan for, and structure interventions for high-utilizing behavioral/medical populations in the Capital Area, particularly those receiving services in Concord Hospital's Emergency Department. The Complex Care Coordinator is facilitating regular communication across projects and teams to ensure mutual understanding of goals, avoid duplication of services and/or service silos, and to ensure that all clients are served in the least restrictive settings according to their needs. She is also facilitating two meetings each month with providers and responders. One is a case review meeting to:

- Address and respond to individuals identified as having complex care needs.
- Improve transitions of care and communication across teams and organizations.
- Reduce the frequency of unnecessary emergency department use.

The other is a planning meeting to continue evaluating and fine tuning the project.

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

Sent with the last SAR.

B1-10. 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.

Table One

	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

Table Two - Coordinated Care

List of providers identified to make progress toward Coordinated Care Practice designation	6/30/18	12/31/18	6/30/19

ONLY			
None - all will meet integrated care			See below

Table Three - Integrated Care

List of providers identified to make progress toward Integrated Care Practice designation inclusive of Coordinated Care	6/30/18	12/31/18	6/30/19
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 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	Protocols developed and distributed. Use of technology defined. Ongoing trainings.	• Reviewing workflows, billing for potential move to collaborative care model. • Ongoing trainings and team meetings. • Psychiatric referral process and capture in Cerner was evaluated and updated. (*Please see attachment 5*. • Reviewing MAeHC portal data and working with site to improve workflows that result in data. • Reviewing CMT shared care plan use, benefits to ER, and other possible uses. • Focusing on improving smoking cessation metrics. *Please see attachment 6*. • Where MAT is present, visiting and educating these providers about what's available for recovery support services. • Where MAT is not present, visiting and educating these providers about where MAT is available and how to access. • Ongoing IBHC meetings for case and workflow review.
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	Protocols developed and distributed. Use of technology defined. Ongoing trainings.	• Ongoing trainings and team meetings. • Reviewing and updating CCSA form • Reviewing CMT shared care plan use, benefits to ER, and other possible uses. • Focusing on upgrading smoking cessation processes. *Please see attachment 6*.

	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		• Ongoing IBHC meetings for case and workflow review. • Planning for sustainability of Riverbend's Integrated Center for Health (RICH) ("reverse integration" with FHC providers at RB) now that SAMHSA funding is running out. IDN2 partially supports the project and will provide bridge funding, as needed. Concord Hospital and Riverbend working on details of continuing project.
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	Protocols developed and distributed. Use of technology defined. Ongoing trainings.	• Ongoing trainings and team meetings. • Reviewing and updating CCSA form • Reviewing CMT shared care plan use, benefits to ER, and other possible uses. • Focusing on upgrading smoking cessation processes. *Please see attachment 6*. • Ongoing IBHC meetings for case and workflow review. • Planning for sustainability of Riverbend's Integrated Center for Health (RICH) ("reverse integration" with FHC providers at RB) now that SAMHSA funding is running out. IDN2 partially supports the project and will provide bridge funding, as needed. Concord Hospital and Riverbend working on details of continuing project.
Concord Hospital Substance Use Services	Defining need for this site as it was recently added to the list.	Core team established. CCSA implemented. Trainings for core team completed. Depression, MAT, and all other workflows and protocols in place (all same as for other CH B1 sites)	• Reviewing workflows, billing for potential move to collaborative care model. • Ongoing trainings and team meetings. • Psychiatric referral process and capture in Cerner was evaluated and updated. (*Please see attachment 6*. • Reviewing MAeHC portal data and working with site to improve workflows that result in data. • Reviewing CMT shared care plan use, benefits to ER, and other possible uses. • Focusing on improving

			smoking cessation metrics. *Please see attachment 6*. • Working with RB Choices to oversee and manage MAT projects. Providing education to other B1 sites about available services. • Ongoing IBHC meetings for case and workflow review.
Dartmouth Hitchcock Concord	Working on a DHH wide approach to implementing integrated care across all IDNs that will satisfy internal and external (B1) requirements. 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.	All aspects of integrated care met as of this date with the exception of the CCSA and high need case conferences. Those are implemented as of the writing of this update.	• All DHC Primary Care Teams implemented CCSA on 4/29/19 • Scheduled for a CMT implementation Mtg on 7/11/19. Roll out mid-Aug for event notification • DH MDCT meetings were started 3/27/19 and are held on a monthly basis. Staff representation includes Primary Care Provider, MAT provider, BHC's & resource specialists. PC leadership attends as needed. • Added 1 additional MAT prescriber • DH BHC's supporting State Hub and Spoke model • The Pediatric Dart screen (CCSA for children starting at age 12) has been approved as a valid and reportable assessment tool. DH will be resubmitting IDN report data for the period of Jan through June of 2019 to update our metrics.
Epsom 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; 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	Protocols developed and distributed. Use of technology defined. Ongoing trainings. Participating in ED/CMT shared care plan pilot.	• Reviewing workflows, billing for potential move to collaborative care model. • Ongoing trainings and team meetings. • Psychiatric referral process and capture in Cerner was evaluated and updated. (*Please see attachment 5*. • Reviewing MAeHC portal data and working with site to improve workflows that result in data. • Reviewing CMT shared care plan use, benefits to ER, and other possible uses.

	identify, plan, and monitor at risk patients		• Focusing on improving smoking cessation metrics. *Please see attachment 6*. • Where MAT is present, visiting and educating these providers about what's available for recovery support services. • Where MAT is not present, visiting and educating these providers about where MAT is available and how to access. • Ongoing IBHC meetings for case and workflow review.
Family Physicians of Pembroke	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	Protocols developed and distributed. Use of technology defined. Ongoing trainings.	• Reviewing workflows, billing for potential move to collaborative care model. • Ongoing trainings and team meetings. • Psychiatric referral process and capture in Cerner was evaluated and updated. (*Please see attachment 5*. • Reviewing MAeHC portal data and working with site to improve workflows that result in data. • Reviewing CMT shared care plan use, benefits to ER, and other possible uses. • Focusing on improving smoking cessation metrics. *Please see attachment 6*. • Where MAT is present, visiting and educating these providers about what's available for recovery support services. • Where MAT is not present, visiting and educating these providers about where MAT is available and how to access. • Ongoing IBHC meetings for case and workflow review.
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	Protocols developed and distributed. Use of technology defined. Ongoing trainings.	• Reviewing workflows, billing for potential move to collaborative care model. • Ongoing trainings and team meetings. • Psychiatric referral process and capture in Cerner was evaluated and updated. (*Please see attachment 5)*.

	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		• Reviewing MAeHC portal data and working with site to improve workflows that result in data. • Reviewing CMT shared care plan use, benefits to ER, and other possible uses. • Focusing on improving smoking cessation metrics. *Please see attachment 6*. • Where MAT is present, visiting and educating these providers about what's available for recovery support services. • Where MAT is not present, visiting and educating these providers about where MAT is available and how to access. • Ongoing IBHC meetings for case and workflow review.
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	CCSA implemented. Protocols developed and distributed. Use of technology defined. Ongoing trainings.	• Reviewing workflows, billing for potential move to collaborative care model. • Ongoing trainings and team meetings. • Psychiatric referral process and capture in Cerner was evaluated and updated. (*Please see attachment 5*. • Reviewing MAeHC portal data and working with site to improve workflows that result in data. • Reviewing CMT shared care plan use, benefits to ER, and other possible uses. • Focusing on improving smoking cessation metrics. *Please see attachment 6*. • Where MAT is present, visiting and educating these providers about what's available for recovery support services. • Where MAT is not present, visiting and educating these providers about where MAT is available and how to access. • Ongoing IBHC meetings for case and workflow review.

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	CCSA implemented. Protocols developed and distributed. Use of technology defined. Ongoing trainings.	• Reviewing workflows, billing for potential move to collaborative care model. • Ongoing trainings and team meetings. • Psychiatric referral process and capture in Cerner was evaluated and updated. (*Please see attachment 5*. • Reviewing MAeHC portal data and working with site to improve workflows that result in data. • Reviewing CMT shared care plan use, benefits to ER, and other possible uses. • Focusing on improving smoking cessation metrics. *Please see attachment 6*. • Where MAT is present, visiting and educating these providers about what's available for recovery support services. • Where MAT is not present, visiting and educating these providers about where MAT is available and how to access. • Ongoing IBHC meetings for case and workflow review.
Riverbend Community Mental Health	Core team hired and trained; CCSA in place at most programs and being worked 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	CCSA implemented. Protocols developed and distributed. Use of technology defined. Ongoing trainings.	• Ongoing trainings and team meetings. • Reviewing CMT shared care plan use, benefits to ER, and other possible uses. • Planning for sustainability of Riverbend's Integrated Center for Health (RICH) ("reverse integration" with FHC providers at RB) now that SAMHSA funding is running out. IDN2 partially supports the project and will provide bridge funding, as needed. Concord Hospital and Riverbend working on details of continuing project. • Director of Integrated Healthcare expanding role beyond B1 to integrate all projects and sites, whether co-located or not. Greater focus on education of what's available to all providers and

			how entities can work together. • Setting up meetings with NHH to discuss CareConnect

IDN2 is collected data regarding how IBHCs are spending their time at B1 sites. This is being evaluated for staffing and work flow decisions as well as sustainability planning. Here is the most recent report. *Please see attachment 8*.

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

Process #	Section	Process Detail	Submission Format	Results (Met/Not Met)				
				6/30/17	12/31/17	6/30/18	12/31/18	6/30/19
B1-9a	Coordinated Care Practice designation	Achievement of all of the requirements of a Coordinated Care Practice	Progress towards Coordinated Care Practice Designations					
B1-9b	Additional Integrated Practice designation requirements	Adoption of both of the following evidence-based interventions: • Medication-assisted treatment (MAT) • Evidence-based treatment of mild-to-moderate depression within the Integrated Practice setting	Protocols (Submit all in use)					
• B1-9c		Use of technology to identify, at minimum: • At risk patients • Plan care • Monitor/manage patient progress toward goals • Ensure closed loop referral	Table listing all providers indicating progress on each process detail					
B1-9d		Documented work flows with community based social support service providers including, at minimum: • Joint service protocols • Communication channels	Work flows (Submit all in use)					

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

As noted in the monthly reports to NH DHHS, there have been ongoing challenges with the reentry program at MCDOC. A meeting in October 2018 focused on developing a framework for understanding the value differences that drive each organization/profession's decision making. IDN2 reached out to MSLC for assistance in understanding and working through these differences. The report was helpful to a degree but didn't really provide concrete information or steps for moving forward. IDN2s administrative lead and the MCDOC director continue conversations to address these challenges. In addition, the two organizations collaborated on developing and submitting a grant to BJA for reentry funding. By agreement, and due to a very small caseload, the case manager doesn't spend a full day at New Hampshire Department of Corrections (NHDOC) anymore but goes there on an as needed basis. In addition, IDN2 is not working with Sununu Youth Services (SYS) due to a very small percentage of youth who are released going back to the Capital Area.

Pre-Release Services

Entry into IDN2's MCDOC Reentry Program is for those participating in the Successful Offender Adjustment and Reentry program (SOAR). In addition, all individuals identified to receive reentry services 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.

The PROXY is completed during 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.

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. 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.

SOAR participants benefit from 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.

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.

Post-release services - up to 12 months

Participants receive an individualized combination of the following:

- Intensive case management
- Substance Use Disorder (SUD) services to include Medication Assisted Treatment (MAT), Intensive Outpatient Programming (IOP), individual and group therapy
- Mental Health services to include 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.
- Individual Placement and Support (IPS)
- Benefits assistance
- The continuation of evidence-based curriculums begun during incarceration

The Reentry Case manager 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.

C-2. IDN Community Project: Evaluation Project Targets

Performance Measure Name	2020 target	12/31/17	6/30/18	12/31/18	6/30/2019	Total
Clients served pre-release?	**250**	**52**	**23**	**45**	**36**	**156**
Of these, how many were new?			15	21	26	
Of these, how many were continuing?			8	17	10	
Clients served post-release?	**250**	**16**	**21**	**36**	**39**	**112**
Of these, how many were new?			10	12	28	
Of these, how many were continuing?			11	24	11	
How many received case management?			9	36	39	
How many received group therapy?			21	36	33	
Referred to SUD Services			7	21	18	
Follow through rate			57%	67%	60%	
Referred to MH Services			13	22	19	
Follow through rate			38%	59%	58%	
Referred to Primary Care			5	15	18	
Follow through rate			60%	73%	39%	
Clients completing 12 months?	**200**	**0**	**7**	**4**	**8**	**19**

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)					
	Total Need	Staffing on 6/30/17	Staffing on 12/31/17	Staffing on 6/30/18	Staffing on 12/31/18	Staffing on 6/30/19
C2 - Case Manager	1	1	1	1	1	1
C2 - Psychiatric APRN (.3)	1	0	1	1	1	1
C2 - MLADC	1	1	1	1	1	0
C2 - BH Clinician	1	1	0	1	1	1
ALL - Peer Recovery Coaches	1	1	0	3	5.75	9.25

C2 MLDAC's work has been replaced by D2 Counselor.

C-4. IDN Community Project: Budget

	2016	2017	2018	2019	Jan-Jun 2019	July-Dec 2019	2020
C2 Line Items	**Actual**	**Actual**	**Actual**	**Budget**	**Actual**	**Remaining**	**Budget**
Services/Prof		113,287	234,926		100,853		
Consulting Fees		40,004					
Testing supplies		4,367	143		1,118		
Total Re-entry		**157,658**	**235,069**	**289,862**	**101,971**	**187,891**	**260,000**

Consulting Fees: IDN2 used a reentry consultant 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
Merrimack County DOC	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)	Integrates case planning and risk management into the assessment process.
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.
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.
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.

Month	Training	Location	Description
Feb	Myers and Stauffer Learning Collaborative	Myers and Stauffer	The goal of this learning collaborative is to help State leaders, IDN leads and administrators, community partner administrators, public health network managers, population health administrators, community health workers / navigators / care coordinators, project

	on Population Health		managers, and practice managers to learn and apply evidence-based strategies to make the case to advance population health and health equity. As a result of the learning collaborative, participants will be able to: • Recognize both the challenges and the importance of building public will to address population health • Rethink how they are currently making the case for population health • Identify areas where their case-making could be leveraged to strengthen public support using evidence-based strategies • Describe methods of using data to build public support for population health programs and health system transformation
April	MSLC Learning Collaborative - Population Health	MSLC	
May	MSLC Learning Collaborative - The New Normal: Enhanced Care Coordination	MSLC	

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

Process #	Process Detail	Submission Format	Results (Met/ Not Met)				
			6/30/17	12/31/17	6/30/18	12/31/18	6/30/2019
C-1	Timeline, Key Milestones and Evaluation Project Plan	Spreadsheet (Microsoft Project or similar platform)					
C-2	Evaluation Project Targets	Table					
C-3	Workforce Staffing	Table					
C-4	Budget	Narrative and Spreadsheet					
C-5	Key Organizational and Provider Participants	Table					
C-6	Clinical Infrastructure: \Standard Assessment Tools	Table					
C-7	Clinical Infrastructure: 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

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

Through the SUD continuum of care centers (Riverbend CHOICES and Concord Hospital Substance Use Services)

- 5 MAT providers at HUBs
    - 4 at Riverbend and 1 at Concord Hospital Substance Use Services
- On-call mentoring and support to SPOKES (PCP and OBGYN sites)
- Care coordination and navigation between HUBs and SPOKEs
- On site urine testing
- Individual and group counseling
- Mental health services and support by through embedded IBHCs and Riverbend
- Connect clients with PCPs for general care
- Provide educational resources and leadership in the community
- Provide on-site and phone consultation to medical and psychiatric providers
- Train providers about SUD
- Refer to next level of care and residential programs for higher need patients

Through the primary care practices (PCPs)

- 9 MAT providers at B1 sites (3 CFM, 1 DHC, 2 FHC, 1 IMED HSP, 2 PSFM)
- IDN2 supports and incentivizes PCPs to become SPOKEs
    - Induct, stabilize, and/or maintain patients on MAT at their practice
    - Participate in a community of practice
        - Mentor other PC MAT providers or those interested in becoming MAT providers
        - Attend IDN2 MAT meetings/case reviews
    - Collect and provide data
- Through the B1 Integration Project, IDN2 embeds IBHCs 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.

For pregnant and parenting women with opioid use disorders (OUD) or SUD

- IDN2 provides a Choices for Families (CFF) project for pregnant and/or parenting individuals. Services include:
    - 2 MAT providers at DHC and CH OBGYN practices
    - NH Wraparound Model Case Management

- Counseling
- Home visiting
- Parent education
- Emergency financial assistance
- All SUD continuum of care services through the HUBs

D-2. IDN Community Project: Evaluation Project Targets

PCP MAT Providers

PCP MAT Performance Measure Name	2020 Target	Jun-Dec 2017	Jan-Jun 2018	Jul-Dec 2018	Jan-Jun 2019	Cumulative Total
# of MAT Providers (not including OBGYN below)	18	10	13	14	Please see below for a change in data collection beginning Jan. 2019. After a review or earlier data and the flow of new/continuing clients, it was felt that the new data was more relevant to showing results.	14
Total patients	300	31	117	142		450
Of these, how many new?		N/A	73	44		N/A
Of these, how many continuing?		N/A	38	98		N/A
How many engaged 3 months	240	13	39	88		N/A
Of these how many remained opioid free during this time?	210	11	34	83		N/A
How many engaged 6 months?	210	1	37	82		N/A
Of these how many remained opioid free during this time?	180	1	34	82		N/A
How many engaged over 6 months?	180	0	37	68		N/A
Of these how many remained opioid free during this time?	150	0	40	63		N/A
How many relapsed and returned to treatment?		N/A	1	1		N/A

Jan-Jun 2019		
Total # of MAT providers	14	
Total patients treated with MAT	160	
New this period of time	82	51%
Continuing this period of time	78	49%
Still in Service	138	86%
Still in Service / Opioid Free	128	93%
Not in Service	22	14%
Tx to MAT or higher level of care	3	14%
Self-discharged	4	18%
Incarcerated	3	14%
Discharged non-compliant	1	5%
Unknown	11	50%

CFF - OBGYN MAT Providers

CFF MAT Performance Measure Name	2020 Target	Jul-Dec 2017	Jan-Jun 2018	Jul-Dec 2018	Jan-Jun 2019	To Date
Number served during this period of time	60	20	22	23	16	62
Did not return after first visit	<10	3	2	0	See below monthly data for this period of time.	
Delivered during this period of time	60	3	15	12		
Opioid free at delivery	New	New	New	11		
Transferred to another MAT provider after delivery	New	New	New	6		
Scheduled to be transferred to another	New	New	New	3		

MAT provider						
Weaned off treatment	New	New	New	1		
Did not follow up with transfer plans	New	New	New	2		
Delivered earlier time period but sill in service	New	New	New	6		
Transferred to another MAT provider	New	New	New	5		
Did not follow up with transfer plans	New	New	New	1		
Still pregnant	New	New	New	5		
Attended all scheduled OB-GYN appointments	38	17	15	N/A		
Attended all scheduled MAT appointments	45	17	18	N/A		
Remained engaged in program	35	1	13	N/A		

Monthly Data

CFF MAT Performance Measure Name - 2019	Jan	Feb	Mar	Apr	May	Jun
Number served during this period of time	10	6	5	5	6	6
Did not return after first visit	2	0	0	0	1	0
Delivered during this period of time	1	0	0	1	1	0
Opioid free at delivery	1	N/A	N/A	1	1	
Transferred to another MAT provider after delivery	2	1	1	1	0	1
Scheduled to be transferred to another MAT provider	2	N/A	1	1	2	1
Weaned off treatment	0	0	0	0	1	0
Did not follow up with transfer plans	0	0	0	0	0	0
Delivered earlier time period but sill in service	3	1	2	1	1	2
Transferred to another MAT provider	2	0	1	1	0	0
Did not follow up with transfer plans	0	N/A	0	0	0	N/A
Still pregnant	6	5	3	3	4	4

CFF - Wraparound Services

CFF Wraparound Services Performance Measure Name	2020 Target	Jul-Dec 2017	Jan-June 2018	Jul-Dec 2018	Jan-Jun 2019	Cumulative : To Date
Individuals served during this period of time	33	10	9	14	19	35
Of these, how many new?	Was initially part of E5 ECC project and was moved to D1 to become a part of "Choices for Families" for pregnant and parenting women with SUD/OUD, some of whom are receiving MAT			6	10	
Of these, how many continuing?				8	9	
# of client contacts				191	103	
# attending parent education				6	22	
Discontinued service with linkages				2	3	
Discontinued service without linkages				3	4	
How many delivered				5	3	
Of those that delivered, # retained custody				5	3	
Placement outside the home				0	0	

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-Coordinators (.2)	2	2	2	2	2
D1 - SUD Counselor	1	N/A	0	1	1
D1 - Peer Engagement Specialist	1	1	0	1	1
D1 - Clinical Manager	1	N/A	0	1	1
D1 - Clinical Counselor	1	0	0	0	1

D1 - CFF MAT Providers (.4)	2	2	2	1	2
D1 - CFF MA (.4)	1	1	1	1	1
D1 - CFF Wrap/PE Providers	2.1	N/A	0	1	1.1
ALL – Peers	5.75	0	0	4	9.25

One of the CFF Wraparound BH staff left and they are in the process of replacing her.

D-4. IDN Community Project: Budget

	2016	2017	2018	2019	Jan-Jun 2019	July-Dec 2019	2020
D1 Line Items	**Actual**	**Actual**	**Actual**	**Budget**	**Actual**	**Remaining**	**Budget**
Services/Prof (RB)			257,465		158,871		
Services/Prof (CH)		5,520	37,416				
Outside Training			728				
Services/Professional		26,957					
Contract (Waypoint)							
Flex Funds					4,000		
Incentives					27,956		
Total MAT		**32,477**	**295,609**	**683,123**	**190,827**	**492,296**	**680,000**

Services / Professional: This for all of the staff listed above except CFF Wrap/PE Providers.

Contract (Waypoint): This line item is for CFF Wrap/PE Providers.

Flex Funds: For urgent financial needs where there is no other avenue of support and without the support, the individual would have extreme difficulty remaining in the program.

Incentives: For PCP MAT providers who participate in IDN2 as a community of practice.

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
Waypoint (Formerly CFS)	Y
NAMI NH	Y

D-6. IDN Community Project: Standard Assessment Tools

Name	Brief Description
Core Standardized Assessment (CCSA)	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.

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.

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

Protocol Name	Brief Description	Use
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 Workflows	Clinical workflows for administering MAT	Current

D-9. Provide the training plan and curricula for each Community Driven Project

Month	Training	Location	Description
Feb	Myers and Stauffer Learning Collaborative on Population Health	Myers and Stauffer	The goal of this learning collaborative is to help State leaders, IDN leads and administrators, community partner administrators, public health network managers, population health administrators, community health workers / navigators / care coordinators, project managers, and practice managers to learn and apply evidence-based strategies to make the case to advance population health and health equity. As a result of the learning collaborative, participants will be able to: • Recognize both the challenges and the importance of building public will to address population health • Rethink how they are currently making the case for population health • Identify areas where their case-making could be leveraged to strengthen public support using evidence-based strategies • Describe methods of using data to build public support for population health programs and health system transformation
April	MSLC Learning Collaborative - Population Health	MSLC	
May	MSLC Learning Collaborative - The New Normal: Enhanced Care Coordination	MSLC	
Jan	Project ECHO NNE MAT TeleECHO Sessions	Northern New England Network	Didactic presentation on risk factors of overdose and overdose prevention; two case presentations.
March	Project ECHO NNE MAT TeleECHO Sessions	Northern New England Network	Didactic presentation on managing pain in patients being treated for SUD/OUD; two case presentations.

April	Project ECHO NNE MAT TeleECHO Sessions	Northern New England Network	Didactic presentation on opioid use in special populations; two case presentations.
May	16-Hour MAT X-Waiver Course	Providers Clinical Support System - New England ATTC - American Psychiatric Nurses Association	This training enables APRNs with prescriptive authority to meet the education requirement for obtaining a MAT waiver under CARA 2016. This training is tailored specifically to nurses to support their efforts in treating opioid use disorder. This training is available in two parts: an 8-hour training and a 16-hour training. Both are eligible for continuing nursing education contact hours and 21 of those hours are in pharmacology.
May	DBT	Concord Hospital	
May	Post Intervention Suicide	Concord Hospital	
May	HIV for Substance Use Professionals		
May	Recovery Coaching (CRSW)		
May	Effects of Substance Abuse on Young Children		

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

Process #	Process Detail	Submission Format	Results (Met/ Not Met)				
			6/30/17	12/31/17	6/30/18	12/31/18	6/30/19
D-1	IDN Community Project Timeline, Key Milestones and Evaluation Project Plan	Spreadsheet (Microsoft Project or similar platform)					
D-2	IDN Community Project Evaluation Project Targets	Table					
D-3	IDN Community Project Workforce Staffing	Table					
D-4	IDN Community Project Budget	Narrative and Spreadsheet					
D-5	IDN Community Project Key Organizational and Provider Participants	Table					
D-6	Clinical Infrastructure: IDN Community Project Standard Assessment Tools	Table					
D-7	Clinical Infrastructure: IDN Community Project Protocols for Patient Assessment, Treatment, Management, and Referrals	Table					
D-9	Provide the training plan and curricula for 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. That has expanded to also address parenting individuals with SUD.

IDN2's current ECC program is for:

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

Most referrals come from Riverbend's Children's Intervention Program and are children/young adults who are aging out of children's mental health services but still need an additional layer of support as they transition to the adult world. Some refused adult mental health services but accepted services from ECC.

Individuals Identified as Needing Complex Care Coordination

The Complex Care Coordinator was hired 3/11/19 and is working to identify, plan for, and structure interventions for high-utilizing behavioral/medical populations in the Capital Area, particularly those receiving services in Concord Hospital's Emergency Department. She plans and facilitates regular communication across projects and teams to ensure mutual understanding of goals, avoid duplication of services and/or service silos, and to ensure that all clients are served in the least restrictive settings according to their needs. She also facilitates a regular meeting of providers and responders to:

- Address and respond to individuals identified as having complex care needs.
- Improve transitions of care and communication across teams and organizations.
- Reduce the frequency of unnecessary emergency department use.

E-2. IDN Community Project: Evaluation Project Targets

IDN2's ECC Renew program reports data on a quarterly basis. This is proscribed through their work with the NH Wraparound program at UNH IOD. Therefore, we've submitted quarterly data for most of the metrics and semi-annual data for the individuals served.

ECC - Renew Data	Jan	Feb	Q1	Apr	May	Q2	Jan-Jun 2019
Individuals served over during this period of time			12			12	15
New intake			2			1	7
Continuing in program			10			11	2
Left program			3			3	6
Newly placed outside the home			0			0	
Returned to home from placement			0			1	
Number enrolled in academic program			5			8	
Improved or sustained academic performance			5			5	
New psychiatric hospitalizations			0			1	
New legal offenses			0			1	
CANS/ANSA # youth where actionable items increased			1			4	
CANS/ANSA # youth where actionable items decreased			4			0	
CANS/ANSA # youth where actionable items stayed the same			1			4	
CANS/ANSA # youth with initial CANS completed			3			3	
# unable to gather data on for this period			3			1	

The Complex Care Coordination project began 3/11/19 and was still in its implementation phase through April 2019. They had two planning meetings - April and May 2019. They had two client-centered meetings in May 2019 and none in June. Data for the project will commence with the next semiannual period.

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	Staffing on 6/30/19
E5 - ECC Supervisors (.15)	2	2	2	2	2	2
E5 - ECC Intake (.05)	1	N/A	1	1	1	1
E5 - ECC Coordinators	2	0	3	2	1	2
E5 - ALL Peers	5.75	0	2	2	5.75	7.25

E-4. IDN Community Project: Budget

	2016	2017	2018	2019	Jan-Jun 2019	July-Dec 2019	2020
E5 Line Items	**Actual**	**Actual**	**Actual**	**Budget**	**Actual**	**Remaining**	**Budget**
Services/Prof		74,341	185,085		59,927		
Travel		388	2,956		2,804		
Flex Funds			3,256		4,919		
Total ECC		**74,729**	**191,297**	**164,237**	**67,650**	**96,587**	**165,000**

Purchase Services / Professional (non-CH staff): This line item is for staffing for the project.

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

Organization/Provider	Agreement Executed (Y/N)
Concord Hospital	Y
Concord Hospital Medical Group	Y
Dartmouth Hitchcock Concord	Y
Waypoint	Y
UNH Institute on Disability	Y
NAMI NH	Y
Granite United Way	Y
Youth Move	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. 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	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.
	• 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.
	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:
	• Individual services/goods for the child;
	• Services/goods for the family or extended family;
	• Services/goods to help strengthen the "natural" system of care/ support of a child and their family.
	• Some examples of use may include:
	  o family support and sustenance which would enable the guardian/family to participate in treatment
	  o or improve the support for the youth
	  o educational and vocational services not otherwise available or mandated by the local school system
	  o medical services not otherwise covered (for example: eating disorder evaluation)
	  o independent living services/supports
	  o interpersonal and recreational
		In Use

	skill development o additional rein forcers determined by the ECC Coordinator	

E-9. Provide the training plan and curricula for each Community Driven Project

Month	Training	Location	Description
Feb	Myers and Stauffer Learning Collaborative on Population Health	Myers and Stauffer	The goal of this learning collaborative is to help State leaders, IDN leads and administrators, community partner administrators, public health network managers, population health administrators, community health workers / navigators / care coordinators, project managers, and practice managers to learn and apply evidence-based strategies to make the case to advance population health and health equity. As a result of the learning collaborative, participants will be able to: • Recognize both the challenges and the importance of building public will to address population health • Rethink how they are currently making the case for population health • Identify areas where their case-making could be leveraged to strengthen public support using evidence-based strategies • Describe methods of using data to build public support for population health programs and health system transformation
April	MSLC Learning Collaborative - Population Health	MSLC	
May	MSLC Learning Collaborative - The New Normal: Enhanced Care Coordination	MSLC	
Jan	NH Wraparound Training	NH IOD	
May	Facing Our Fears: Treating Suicidal Clients and Their Families		
May	Solutions from the Frontlines: A Behavioral Health Conversation		
June	New England Summer School of Addiction	50th New England School of Addiction and Prevention Studies	Four-day intensive experience to further knowledge, skills, and experience in the field of substance use disorder services. The school is appropriate for all who recognize the impact of alcohol, tobacco and other drugs on individuals, families, and communities. Individuals may select topic specific tracks where similar topic courses have been grouped together or, if a participant would like to tailor their experiences even more, they may select specific courses from different focus areas. These focus areas have been designed to meet the needs of various audiences. Programming is intended for many different partners in substance use disorder prevention, treatment, intervention and recovery. Whether you are a new addiction counselor, a juvenile probation officer, a recovery coach, a prevention specialist, an experienced licensed clinician, or in another discipline

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

Process #	Process Detail	Submission Format	Results (Met/Not Met)				
			6/30/17	12/31/17	6/30/18	12/31/18	6/30/19
E -1	Timeline, Key Milestones and Evaluation Project Plan	Spreadsheet					
E -2	Workforce Staffing	Table					
E -3	Evaluation Project Targets	Table					
E -4	Budget	Narrative and Spreadsheet					
E -5	Key Organizational and Provider Participants	Table					
E -6	Standard Assessment Tools	Table					
E -7	Clinical Infrastructure: Protocols for Patient Assessment, Treatment, Management, and Referrals	Table					
E-9	Provide the training plan and curricula for each Community Driven Project as required in A-1.3	Training schedule and table					

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

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	As of 6/30/19
Participate in development of statewide APM roadmap through workgroups and stakeholder meetings	x	x	x	x
Develop an IDN-specific plan for implementing the roadmap which will contain IDN-specific outcome measures		N/A	N/A	x
Develop the financial, clinical, and legal infrastructure required to support APMs		N/A	x	x
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	N/A	x

The Oversight & Sustainability Committee is the quality control branch of IDN2's governance structure. Its charter is to 1) Review and understand all process and performance metrics required by the DSRIP project, 2) Receive reports from Project Management Team about process and performance metrics achieved to date and those to be achieved in the future, 3) Identify and evaluate any potential obstacles to achieving process and performance metrics, and 4) Make recommendations for action. This Committee is comprised of clinical, technology, compliance, and QI/QA decision-makers and leaders from Riverbend, Concord Hospital, Concord Hospital Medical Group, and Dartmouth Hitchcock-Concord.

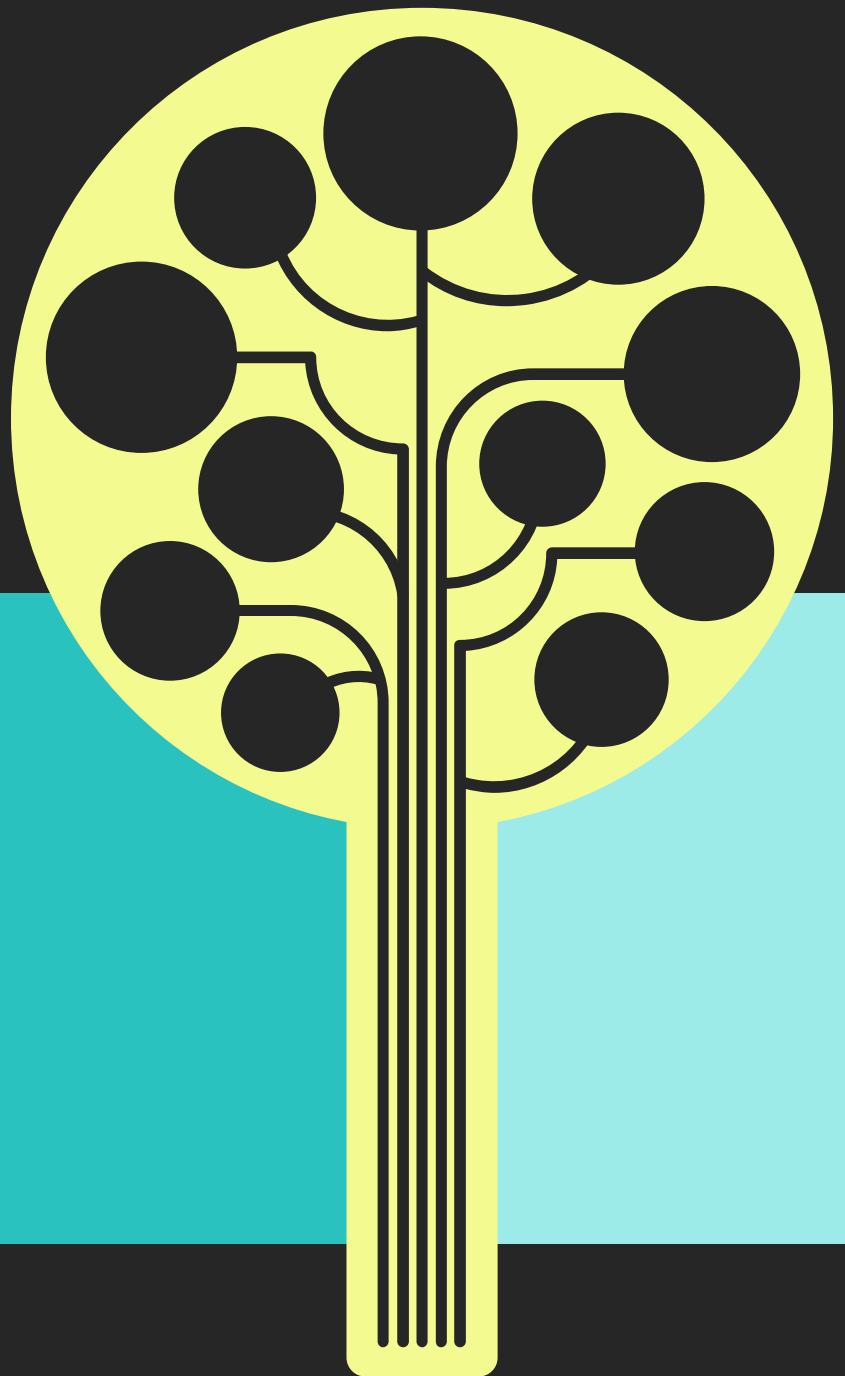
This committee is also charged with addressing sustainability for the IDN projects after DSRIP funding ends Dec. 31, 2020. IDN2 governance has approved a Sustainability Planning process and is well under way to completing the steps involved. *Please see attachment 3.* As part of the planning process, IDN2 is:

- Working with all IDNs & DHHS to identify and use Medicaid billing codes for integrated care.
- Reaching out to the AIMS Center for technical assistance for financial modeling, which is a next step for IDN2.
- Meeting with MCOs, along with other IDNs, and has had multiple internal discussions about the potential use and benefits of IDN2 providing Licensed Care Manager Entity (LCME) services to the MCOs.

Working Within a System of Care

Capital Area Integrated Delivery Network (IDN2)

Caveat: This is, by necessity, a limited view of all that is available within the state and region to address behavioral health needs and is based primarily on four plans and their subsequent or planned projects.



System of Care

A coordinated network of services and supports that is person-centered and helps individuals, families, and communities achieve improved health, wellness, and quality of life.

State and Regional Plans

New Hampshire 10-Year Mental Health Plan

2019-2029

Governor's Commission on Alcohol and Other Drugs Strategic Plan

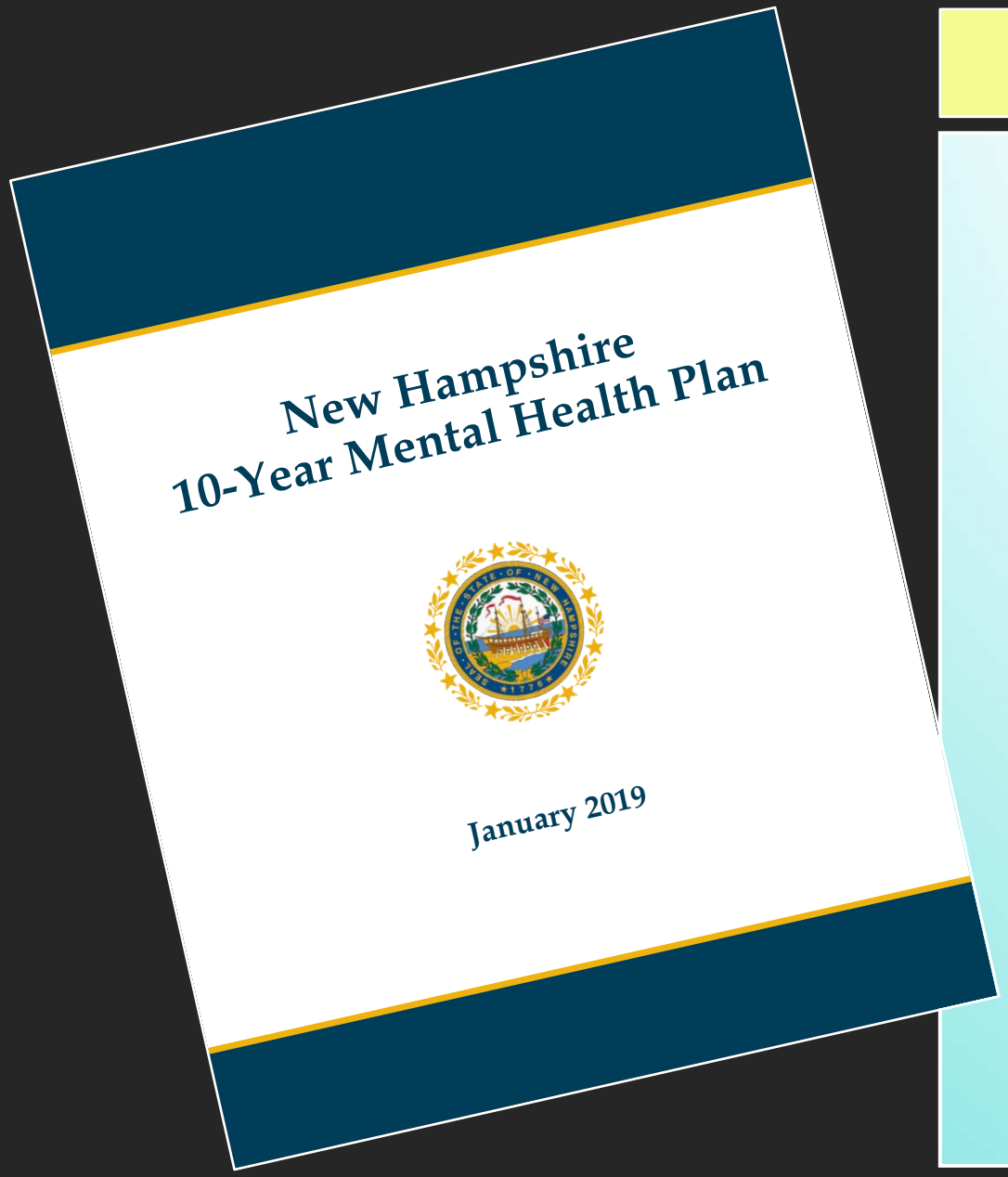
2019-2022

Capital Region Health Needs Assessment

2018

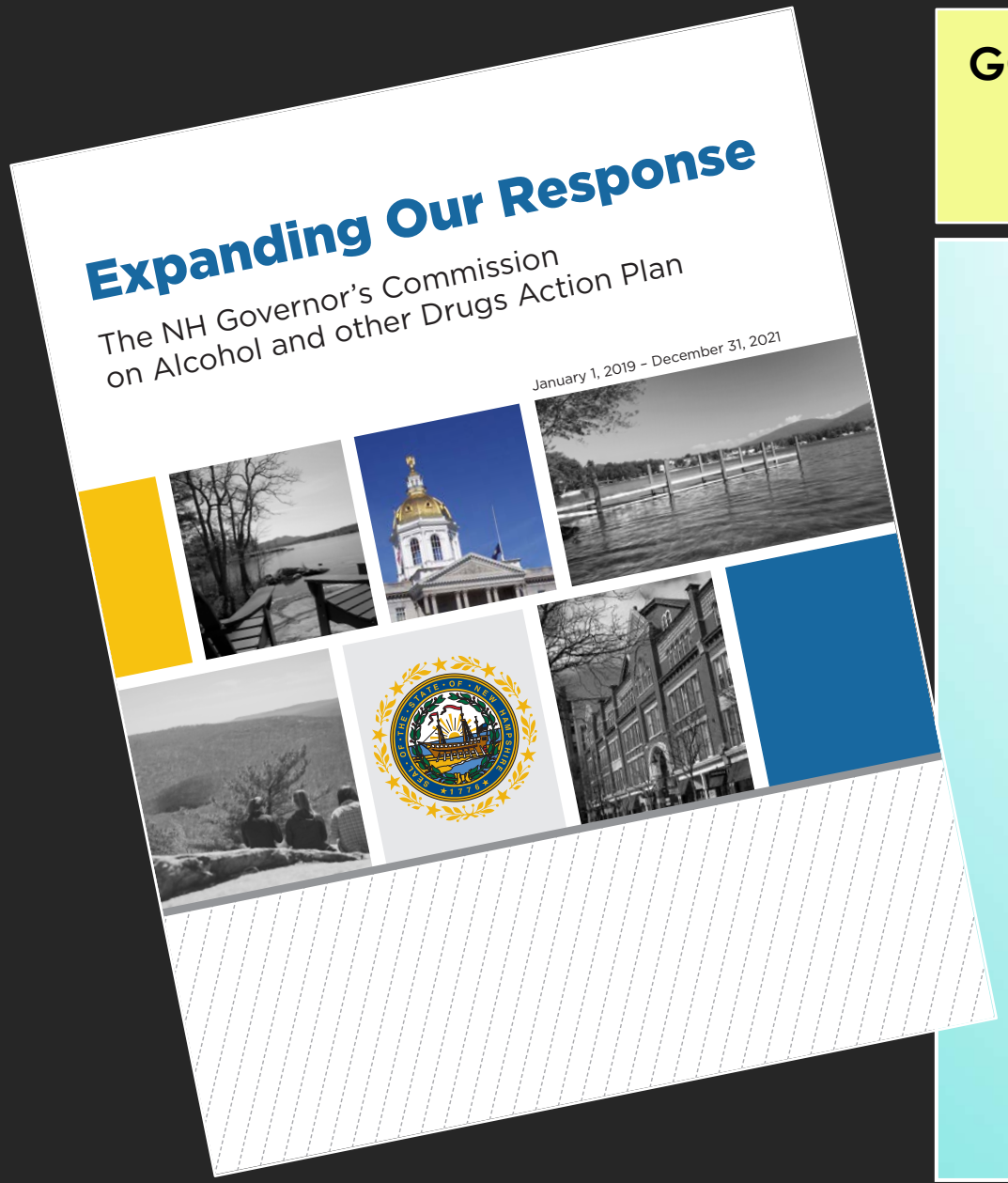
Delivery System Reform Incentive Payment (DSRIP) Program & IDN2

2016-2020



Recommendations

- Medicaid Rates for Mental Health Services
- Action Steps to Address Emergency Department Waits
- Renewed and Intensified Efforts to Address Suicide Prevention
- Enhanced Regional Delivery of Mental Health Services
- Community Services and Housing Supports
- Step-up/Step-down Options
- Integration of Peers and Natural Supports
- Establish a Commission to Address Justice Involved Individuals
- Community Education
- Prevention & Early Intervention
- Workforce Coordination
- Quality Improvement & Monitoring/DHHS Capacity
- Streamlining Administrative Requirements
- Reporting on Implementation



GOAL: *To reduce the misuse of alcohol and other drugs across the lifespan through the implementation of effective programs, practices, and policies.*

STRATEGIES INCLUDE WORK IN THE AREAS OF:

- Law enforcement
- Prevention
- Substance Use Disorder Delivery System & Early Identification
- Harm Reduction
- Treatment
- Recovery Support Services
- Family Supports and Services
- Reimbursement
- Workforce Capacity & Professional Development
- Public Awareness
- Data Utilization

Prioritized Community Need #2: Mental Health & Substance Misuse

- Mental health prevalence among the Medicare population represent specific higher-level needs
- Prevention, screening, and early intervention efforts
- Mental health services – outpatient, psychiatric, inpatient – for youth, higher-risk adults, seniors, and New Americans
- Crisis services to address co-occurring medical and mental health conditions
- Youth mental health education, stigma, early intervention services
- Substance misuse treatment and intervention for veterans, patients prescribed pain medication, and others
- Opioid intervention, crisis care, and treatment

Building Capacity for Transformation

New Hampshire seeks to transform its behavioral health delivery system through:

- Integrating physical and behavioral health to better address the full range of beneficiaries' needs;
- Expanding provider capacity to address behavioral health needs in appropriate settings; and
- Reducing gaps in care during transitions through improved care coordination for individuals with behavioral health issues.

DSRIP funding enabled the state to make performance-based funding to regionally-based IDNs.

Capital Area Integrated Delivery Network (IDN2)

- Integrated care at 11 primary and behavioral health care sites
- Medication Assisted Treatment (MAT) at primary, behavioral health, and OB-GYN care sites
- Pre- and post-release services for those reentering the community from incarceration
- Enhanced care coordination for transitional aged youth, pregnant and parenting women with OUD/SUD, and those with complex care needs
- Behavioral health workforce development and training
- Expanding the role of technology in identifying, planning, and managing care needs
- Sustainability planning

These are the top words from the combined text of these plans.

There is general agreement about need and strategy within the system.

We can organize approaches to addressing behavioral health needs in this way:

- Entryway
- Location
- Coordination

Doorways
24/7 in-person or telephone access to screening, assessment, evaluation, care coordination, and financial support.

Comprehensive Core Standardized Assessment
DSRIP requirement for all integrated care sites that includes mental health, substance use, and social determinants of health screening, which triggers a follow up plan.

Riverbend 24/7 Crisis Treatment Center
- Walk-in
- First responder drop-off
- Diversion and/or step-down from ED

Riverbend 24/7 Mobile Crisis Team
- Telephone and field response throughout central NH
- Available to assist first responders, healthcare providers and community-based agencies

Riverbend Crisis Stabilization Apartments
- Supervised accommodations and crisis stabilization services for adults (18+) who require short-term intensive treatment.

Entryways

Medical Facilities

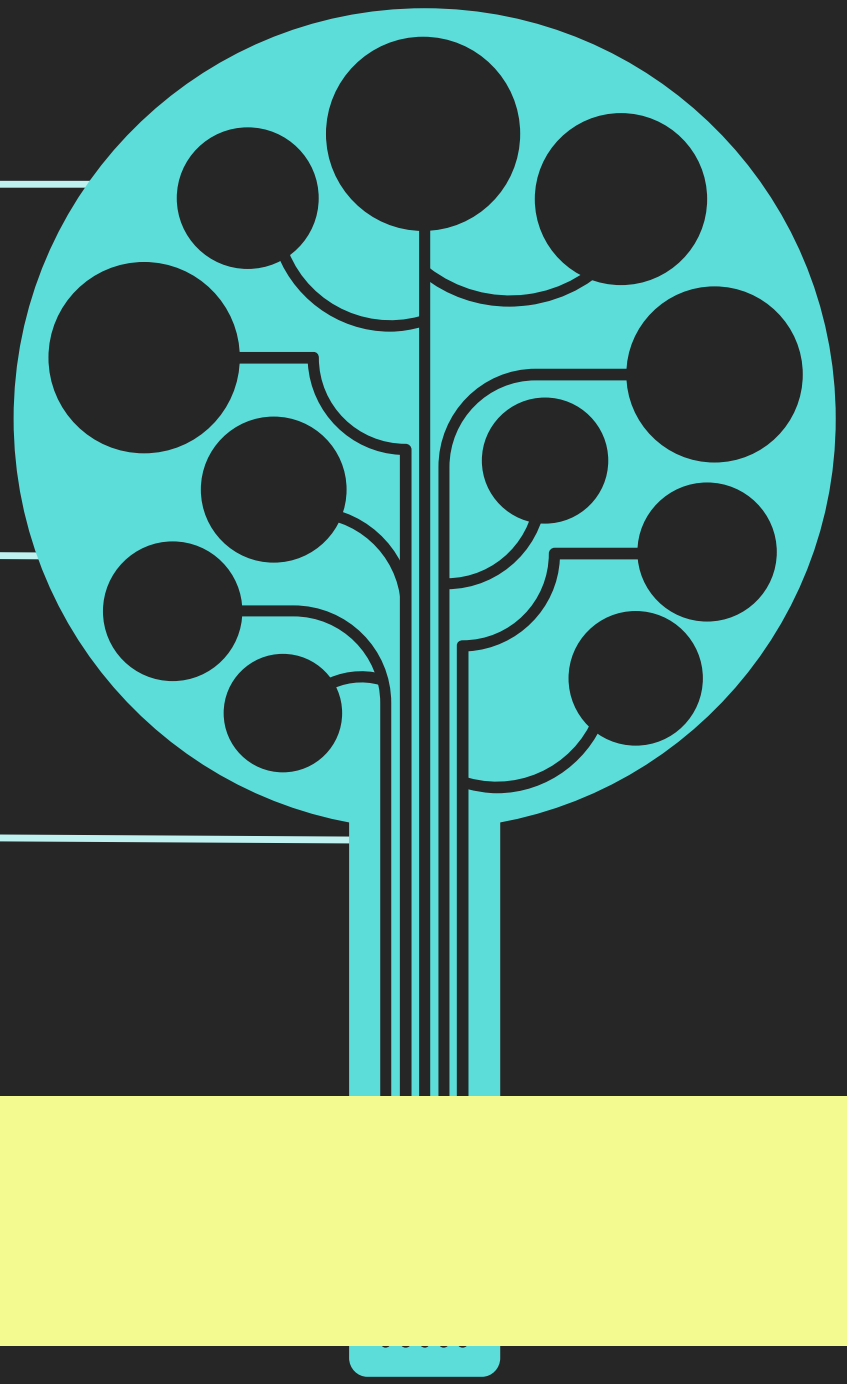
- Riverbend psychiatrists and masters level clinicians at Concord Hospital Emergency Department
- Riverbend psychiatrists at Concord Hospital 5 West inpatient care
- IDN2 Complex care coordination for high utilizers
- IDN2 Integrated health care primary care sites
- MAT at primary care and OB-GYN sites
- Concord Hospital Substance Use Services

Community Sites

- CRVNA
- Waypoint
- Riverbend Community Mental Health
- Other IDN2 partner organizations

Other

- Merrimack County House of Corrections
- Home visiting
- Community meet-ups

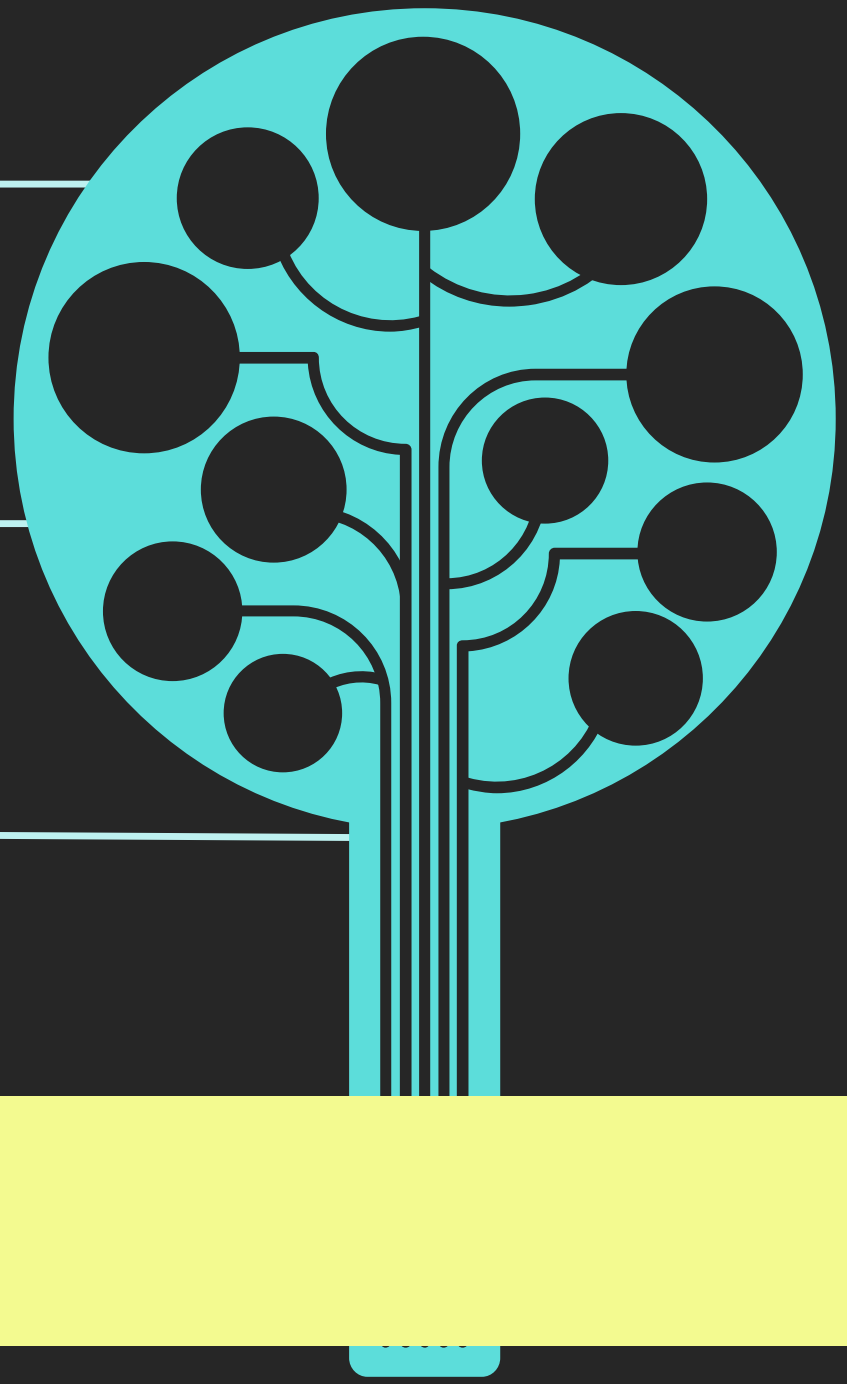


Locations

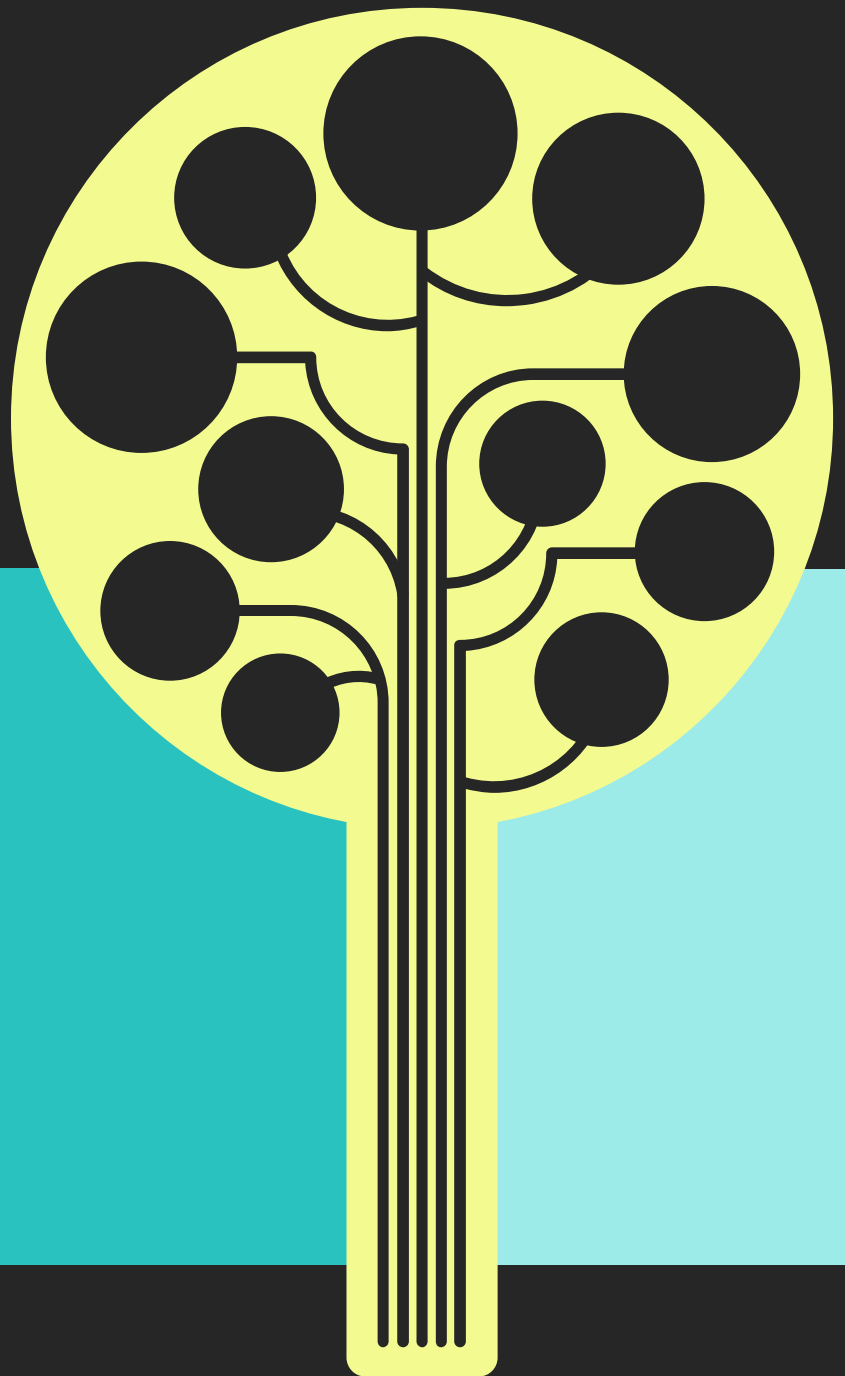
Peers
- NAMI NH Family Peer Support
- YouthMove
- IDN2 Peer Navigator
- Site specific peers

Case Managers
- Riverbend
- CRVNA
- Waypoint
- Merrimack County House of Corrections
- Other IDN2 partners

Care Coordinators
- IDN2 Enhanced Care Coordination
- IDN2 Complex Care Coordination
- Integrated Behavioral Health Clinicians
- Concord Hospital Nurse Navigators



Coordinators



and improve

How do we sustain the system?

- Matching funding requirements to gaps/needs
- Education & awareness of strategies, plans, projects
- Data & technology
  - Sharing information
  - Tracking outcomes
- Legislative needs
- Changes in billing & coding
- Workforce development
- Braiding social determinants of health in to the system
- Other?

Site Self-Assessment

CHMG Site	Epsom Family Medicine
Date Completed	3/28/19
Date of Previous Assessment	7/19/18
Next Assessment Due	9/28/19
Participants	Katie Lipp, Director Integrated Care; Chris Allen, Resource Provider; Michele Underwood, Practice Manager; Sandra Sattler, Clinical Leader; Karen Wilber, Practice Administrator

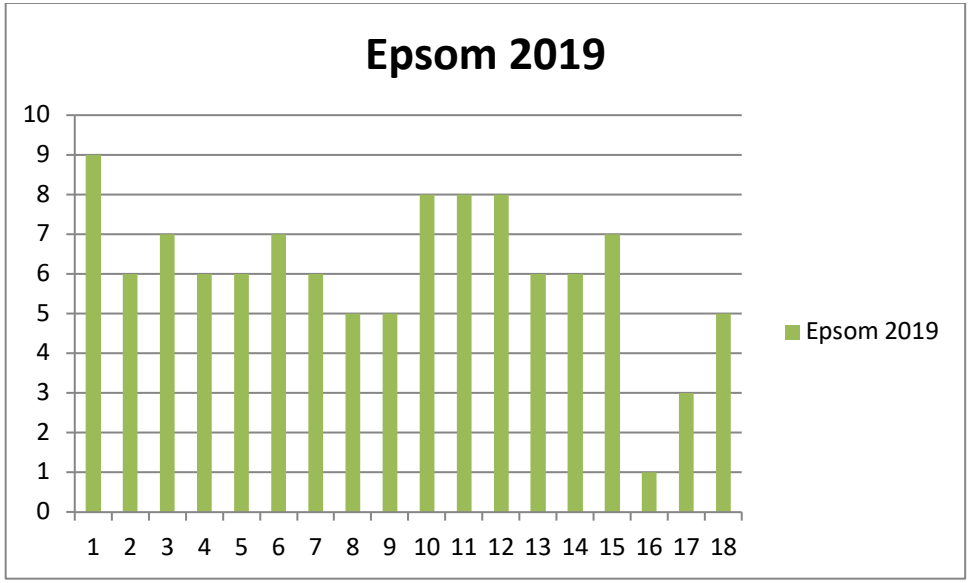
Introduction:
The Epsom Family Medicine practice has been recognized as a National Committee for Quality Assurance's Patient-Centered Medical Home for embracing the Medical Home concept and implementing evidence-based procedures that improve quality and lower costs, while constantly striving to help patients understand and manage their health. The Integrated Behavioral Health Clinician (IBHC) works as an integral member of the team to further these concepts- providing screening, assessment, brief intervention, and referral for social determinants of health in support of overall patient wellbeing. The additions of the consulting psychiatric nurse practitioner (April 2018) and psychiatrist (February 2019) have further enhanced the practice's ability to treat behavioral health conditions within the primary care environment. These integrated resources have supported an integrated, whole-person approach to primary health care, reducing stigma associated with addressing behavioral health needs and reserving scarce specialty behavioral health services for patients with chronic or complex needs.
The purpose of the Site Self Assessment is to identify the practice's current status along several dimensions of integrated care and to stimulate conversation about where the practice would like to be. The tool, provided by the Citizens Health Initiative, asks participants to choose a numeric rating for each item using a 1-10 scale with 10 being the highest level of integration. This is the third recorded administration of this tool at Epsom Family Medicine.

Discussion:

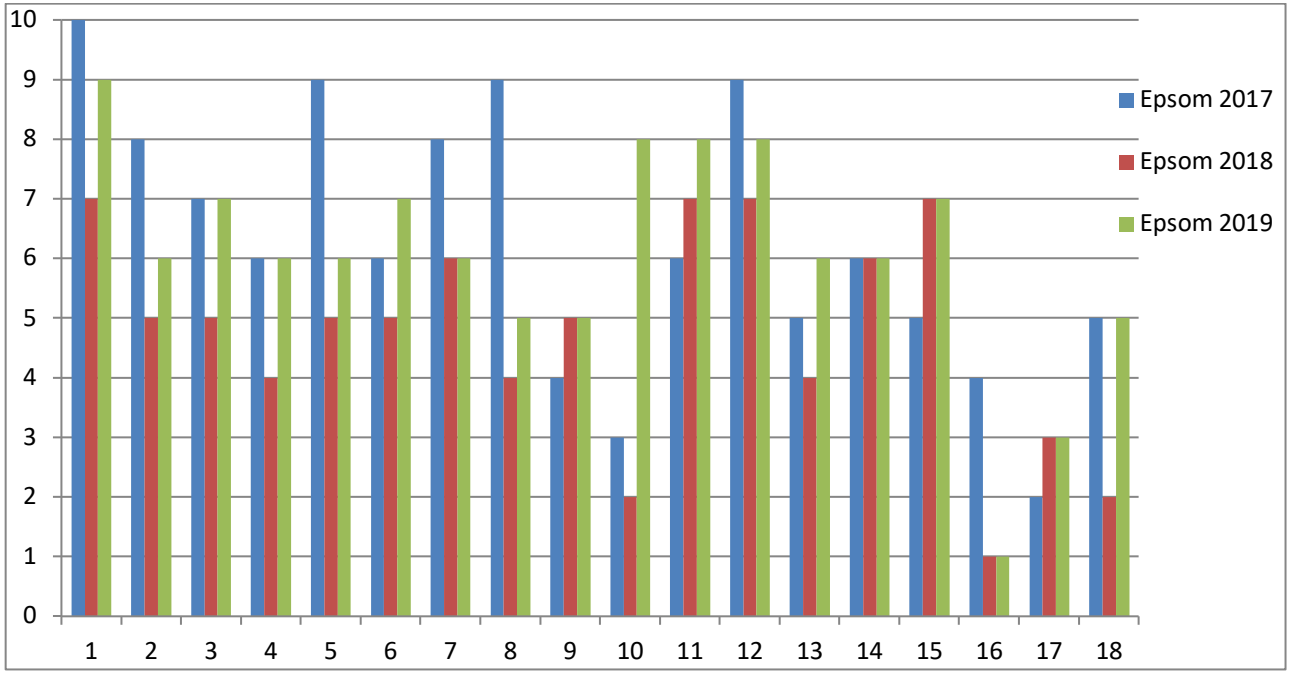
I. Integrated Services and Patient and Family-Centeredness		
Characteristic	**Score**	**Discussion**
1. Level of integration: primary care and mental/behavioral health care	9	Increase in IBHC appointment volume since last review. Appointments are jointly scheduled whenever possible; however, IBHC manages own schedule as well as that of psychiatric consultant which differs from clinic flow. Shared electronic health record. Frequent warm hand-offs and regular participation in team meetings. Prompts for integration could be more systematic.
2. Screening and assessment for emotional/behavioral health needs (e.g., stress, depression, anxiety, substance abuse)	6	CCSAs facilitate more comprehensive screening but include only Medicaid patients. Recent change to workflow, wherein MA identifies positives on CCSA and engages IBHC in visit prior to provider visit, has further improved screening and assessment processes. PHQs are completed regularly but there is no uniform application of the tools, especially when to repeat administration.
3. Treatment plan(s) for primary care *and* behavioral/mental health care	7	Behavioral health notes are routed when indicated. Mental health diagnoses are generally listed on the problem list; when a diagnosis needs to be added or clarified, a psychiatry referral is made. It was noted that progress notes have a helpful level of depth to support coordination of care.
4. Patient care that is based on (or informed by) best practice evidence	6	Several providers attended a conference in the last six months that has contributed to medication management being more aligned with evidence-based guidelines. The practice would welcome further training and

for BH/MH and primary care		guidance to improve in this area.
5. Patient/family involvement in care plan	6	Patient/family involvement is viewed as dependent on provider style. More acute cases, such as those involving IBHC or Nurse Navigator, tend to be more collaborative. Providers are very aware of the geographical and cultural nuances of their practice and are adept at considering access to resources in their provision of care. This is particularly true with regard to food insecurity.
6. Communication with patients about integrated care	7	Participants described feeling as though integrated care is always mentioned when indicated including during triage calls. Written materials would be welcomed and might be included in the new patient packet.
7. Follow-up of assessments, tests, treatment, referrals and other services	6	No change. Providers feel confident about their follow-up efforts; however, these processes are not yet built into the Cerner system and rely on individualized approaches. As reporting improves, the practice expects that Cerner can be leveraged to ensure patients don't "fall through the cracks".
8. Social support (for patients to implement recommended treatment)	5	No change in processes; however, volume of patients benefiting has increased. Patients completing the CCSA, working with IBHC, or who have certain diagnoses are screened for social support needs; however, this is not currently systematic or widespread.
9. Linking to Community Resources	5	No change. Most referrals go through IBHC which is ideal. IBHC is able to spend time identifying need, barriers, and providing follow-up. Process will be enhanced by Integrated Case Manager that will work in coordination with IBHC and will be available to the practice this fall.
II. Practice/Organization		
Characteristic	**Score**	**Discussion**
10. Organizational leadership for integrated care	8	Participants felt that the initiative is moving forward and gaining strength. Team members noted that expansion (additional resources) makes the initiative feel less like a project and more like a permanent change in service delivery; however, describing integrated care initiatives as "the 1115 waiver" or "the project" reinforces a perception that it is a time-limited effort. Participants felt that they had sufficient time in their schedules to support change associated with integration.
11. Patient care team for implementing integrated care	8	IBHC is included in all huddles. Team members felt valued and understood by one another. Roles are well defined and well-communicated. Practice Improvement Meetings facilitate regular management of these processes. IBHC has become more adept at matching to provider work style by seeking them out to provide important or timely patient updates.
12. Providers' engagement with integrated care ("buy-in")	8	Nearly all providers are utilizing the IBHC and psychiatric consultation. Increased exposure to these resources have facilitated increased trust and thereby, utilization.
13. Continuity of care between primary care and behavioral/mental health	6	Participants agreed that continuity of care for patients that work with IBHC is strong; however, this area is still lacking for the typical patient. IBHC has supported connectivity to outside resources, especially those on the Riverbend continuum of care such as CHOICES or RCA.
14. Coordination of referrals and specialists	6	The team collaborates to recommend and make referrals. Cerner continues to lack capacity to coordinate fully. This is especially true of referrals outside of CHMG.
15. Data systems/patient records	7	No change. A shared patient record now exists in Cerner; however, aggregate data is not available. Team would benefit from opportunities to identify trends or gaps in care or to conduct case finding.
16. Patient/family input to integration management	1	No change. Participants are not aware of any way in which patients are engaged in integration planning or management.
17. Physician, team and staff	3	The team received SBIRT, Motivational Interviewing, and CCSA training as well as brief overview of the

education and training for integrated care		1115 waiver initiative. No significant follow-up. Participants identified several opportunities for further training: evidence-based guidelines for treatment of mild to moderate depression, when to consider reducing/tapering off medication, evidence-based guidelines for treatment of ADHD in children, diagnostic criteria and screening for Bipolar Disorder, treatment of psychotic disorders, and de-escalation of agitated patients.
18. Funding sources/resources	5	Some overhead costs are shared across organizations, such as office space for IBHC. Integrated care services are not being billed and are provided with the single funding source of the 1115 waiver.



X Axis = Characteristic
Y axis = Score



X Axis = Characteristic
Y axis = Score

Summary/Recommendations:
This was the third administration of the SSA at Epsom; while most ratings decreased in the second administration- hypothesized as a function of an improved understanding of the full continuum of integrated care and with that, a renewed sense of ideal state- this administration saw significant improvement. Based on discussion, it seems that the team has developed a vision for integrated care at the practice and has thoughtfully and purposefully worked towards this vision through quality improvement initiatives.
Overall, participants felt that the practice is doing well with regard to level of integration, provider buy-in, organizational leadership for integrated are, and a well-defined and coordinated integrated care team. Those items that received lower ratings and/or generated the most discussion include further work towards standardized, evidence-based approach to screening and medication management of behavioral health needs, the development of written materials to communicate with patients about integrated care, and training opportunities to support the work (detailed in item 17 above). The group further discussed potential benefits to a monthly or quarterly case review, perhaps using patients identified as “high utilizers” via CMT PreManage. It was discussed that this could be used both to support treatment of patients who are not responding to treatment as well as a training tool for staff.

Site Self-Assessment

CHMG Site	Family Health Center- Concord & Hillsboro
Date Completed	6/11/19
Date of Previous Assessment	September through November 2018
Next Assessment Due	12/11/19
Participants	Katie Lipp, Director Integrated Care; Joni Haley, Behavioral Health Manager; Angela Phillips, IBHC; Lori Pelletier, IBHC; Lauren Kennedy, IBHC; Gwen Whitney-Gill, Integrated Case Manager

Introduction:
The Family Health Center (FHC) was the first of the Concord Hospital Medical Group primary care sites to adopt an integrated care model and has been practicing in this capacity for over a decade. The practice incorporates a full range of integrated care providers including case management, integrated behavioral health clinicians assigned to each pod, co-located therapists, and consulting psychiatry. As part of the Dartmouth Family Medicine Residency Program, the FHC also plays a crucial role in training new cohorts of family medicine physicians the importance of and skills required of an integrated approach to care. Integrated Care services are provided at both the Concord location as well as the satellite location in Hillsboro. These integrated resources have supported an integrated, whole-person approach to primary health care, reducing stigma associated with addressing behavioral health needs and reserving scarce specialty behavioral health services for patients with chronic or complex needs.
The purpose of the Site Self Assessment is to identify the practice's current status along several dimensions of integrated care and to stimulate conversation about where the practice would like to be. The tool, provided by the Citizens Health Initiative, asks participants to choose a numeric rating for each item using a 1-10 scale with 10 being the highest level of integration. Previously, the tool was completed separately by each pod; this administration included representation from all pods. Due to considerable variability across pods as well as the subjectivity of the instrument itself, the group decided to focus the conversation on qualitative data rather than pinpointing a score for each item.

Discussion:

I. Integrated Services and Patient and Family-Centeredness	
Characteristic	**Discussion**
1. Level of integration: primary care and mental/behavioral health care	Appointments are jointly scheduled whenever possible. Shared electronic health record. Frequent warm hand-offs and regular participation in daily huddles and team meetings. Some provider notes detail the plan of care for behavioral health needs; however, this is provider-specific.
2. Screening and assessment for emotional/behavioral health needs (e.g., stress, depression, anxiety, substance abuse)	PHQ-2s and SBIRT are administered at every visit. If reason for visit is anxiety, GAD-7s are routinely administered. CCSAs facilitate more comprehensive screening but include only Medicaid patients. There is no uniform application of the tools as they relate to pharmacotherapy, especially when to repeat administration.
3. Treatment plan(s) for primary care *and* behavioral/mental health care	IBHCs participate in many patient-specific and general collaborative team meetings including twice daily huddles. The group highlighted a liaison relationship with Riverbend's CSP, the Family Place at CH, and the impact the Integrated Case Manager role has had on communication with outside sources. No formal shared Treatment Plan exists; however, participants felt confident that providers are aware of one another's work.

4. Patient care that is based on (or informed by) best practice evidence for BH/MH and primary care	The group felt confident that the IBHC role is adherent to the model of brief intervention or long-term intermittent intervention. Participants identified SBIRT and smoking cessation protocols as fairly systematic. The group discussed the lack of evidence-based structure for the IBHC role but felt that they are taking advantage of that which exists.
5. Patient/family involvement in care plan	Patient/family involvement is viewed as dependent on provider style. The group identified a "continuum of collaboration", pointing to those groups which tend to have high collaboration such as prenatal, end of life, or refugee. Participants felt that they make efforts to foster a sense of self-reliance in their work with patients and include relevant family members based on patient preference.
6. Communication with patients about integrated care	Participants described feeling as though integrated care is always mentioned when indicated; however, it is not universally advertised. At times, IBHCs are pulled in for introductory warm hand-offs such as "I'm not hearing a specific need today but I want to introduce you to a member of your care team". The Hillsboro site does include IBHC information in the New Patient Packet.
7. Follow-up of assessments, tests, treatment, referrals and other services	These processes are not yet built into the Cerner system and rely on individualized approaches. This is particularly true of IBHC work and there are limited options for tracking a caseload. Some team members are utilizing the Dynamic Worklist which has added some value. No-show letters are routinely sent; previously, IBHCs were also providing a follow-up phone call but this was found to be an ineffective use of time.
8. Social support (for patients to implement recommended treatment)	Comprehensive screening of Medicaid patients is accomplished via the CCSA. Patients receive follow-up by the Integrated Case Manager. Beyond the CCSA, screening and integration of social supports is provider-specific.
9. Linking to Community Resources	Integrated Case Manager receives many referrals. New residents in particular tend to link patients to the ICM. Providers take access to resources into account when making treatment recommendations.
II. Practice/Organization	
Characteristic	**Discussion**
10. Organizational leadership for integrated care	Participants felt that integrated care is within the core mission and philosophy of the FHC. The FHC is currently working through a restructuring of the vision; participants felt that the importance of integrated care has been reinforced in this process. One participant stated "it's clunky because it's hard not because we don't want to do it".
11. Patient care team for implementing integrated care	IBHCs are included in all huddles and relevant team meetings. Team members felt valued and understood by one another. Roles are well defined and well-communicated with the exception of the newest role, Integrated Case Manager, simply because it is new. This role is now incorporated into the Population Health rotation for new residents to gain exposure.
12. Providers' engagement with integrated care ("buy-in")	Participants agreed that those providers who are exposed most to their work are the most "bought-in", with those who spend less time in the clinic less bought-in. The group discussed a spectrum of engagement with 1-2 providers/pod referring to the IBHC on nearly every case and 1-2 providers/pod seldom making referrals.
13. Continuity of care between primary care and behavioral/mental health	At minimum, participants identified that progress notes are routed. Beyond that, curbside consultations, huddles, and more formal meetings foster continuity of care. Work is particularly coordinated across the ICM, IBHC, and Nurse Navigator.
14. Coordination of referrals and specialists	Cerner continues to lack capacity to coordinate fully. This is especially true of referrals outside of CHMG. The group noted that some specialties feel more coordinated than others such as Infectious Disease and Neurology.
15. Data systems/patient records	A shared patient record now exists in Cerner; however, aggregate data is not available. Team would benefit from opportunities to identify trends or gaps in care or to conduct case finding.
16. Patient/family input to integration management	Last year, Dr. Aimee Valeras conducted a project on patient's perception of integrated care; however, participants are not aware of results. One participant identified wanting to do more at a committee level to involve patients.

17. Physician, team and staff education and training for integrated care	The ICM is included in the population health rotation for new residents to orient to community resources. New hires and residents meet with the IBHCs to review role. Integrated Care is a part of the resident's course work. Pod agendas are kept in the break room in Hillsboro and staff can add items as needed. The group agreed that training on physical health conditions for the IBHCs is "on the job" and they would welcome further opportunities to learn about physical health.
18. Funding sources/resources	The FHC does not bill at all for behavioral health services. All resources are shared among physical health and behavioral health providers.

Summary/Recommendations:

Overall, participants described a high level of integration at the FHC. The group felt that integration is woven into the mission and philosophy of the FHC such that IBHCs are viewed simply as another member of the care team. New staff, including residents, are oriented to the integrated system of care and it is built into the resident education structure. IBHCs are routinely included in care planning meetings and receive a high volume of referrals and warm hand-offs.
As a well-established site, the FHC presents an opportunity to pilot new initiatives that could enhance sustainability efforts and deepen the work. One recommendation is to incorporate guidelines for the use of validated screening and assessment tools to support treating to target with pharmacotherapy. Another recommendation, that is in the early stages of implementation, is to work with Informatics and Systems Education to find ways to better leverage Cerner to support IBHC work. This can also serve as a step towards initiating billing for those services for which codes are available now. Finally, FHC might benefit from increasing the formal orientation and ongoing training of IBHCs specific to physical health conditions and treatments.

Site Self-Assessment

CHMG Site	Family Physicians of Pembroke
Date Completed	3/15/19
Date of Previous Assessment	9/25/17
Next Assessment Due	9/15/19
Participants	Katie Lipp, Director of Integrated Care; Kathryn Mullaney, Integrated Behavioral Health Clinician; Michelle Goodnow, Nurse Navigator; Bob Niegisch, Resource Provider; Jen Martinez, Practice Manager

Introduction:
The Family Physicians of Pembroke practice has been recognized as a National Committee for Quality Assurance's Patient-Centered Medical Home for embracing the Medical Home concept and implementing evidence-based procedures that improve quality and lower costs, while constantly striving to help patients understand and manage their health. The Integrated Behavioral Health Clinician (IBHC) works as an integral member of the team to further these concepts- providing screening, assessment, brief intervention, and referral for social determinants of health in support of overall patient wellbeing. The addition of the consulting psychiatric nurse practitioner in April 2018 has further enhanced the practice's ability to treat behavioral health conditions within the primary care environment. An IBHC was initially placed in this practice in July 2017; however the practice experienced a vacancy from June through August which delayed full implementation of integrated care. Over the past six months, the practice has worked hard to understand the roles of the IBHC and psychiatric consultant including how they best interfaces with nurse navigation and the existing pod dynamic.
The purpose of the Site Self Assessment is to identify the practice's current status along several dimensions of integrated care and to stimulate conversation about where the practice would like to be. The tool, provided by the Citizens Health Initiative, asks participants to choose a numeric rating for each item using a 1-10 scale with 10 being the highest level of integration. This is the second recorded administration of this tool at Family Physicians of Pembroke.

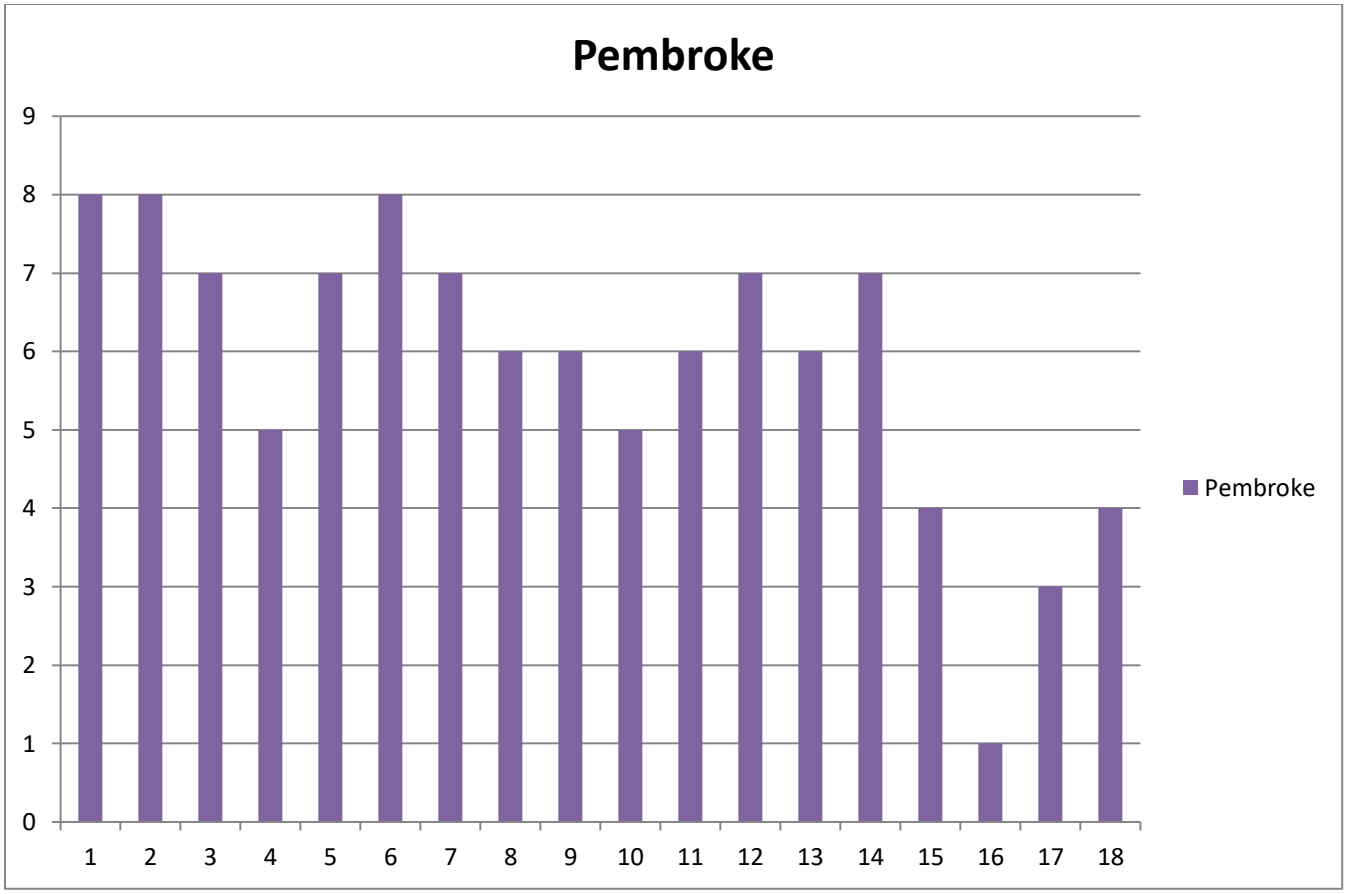
Discussion:

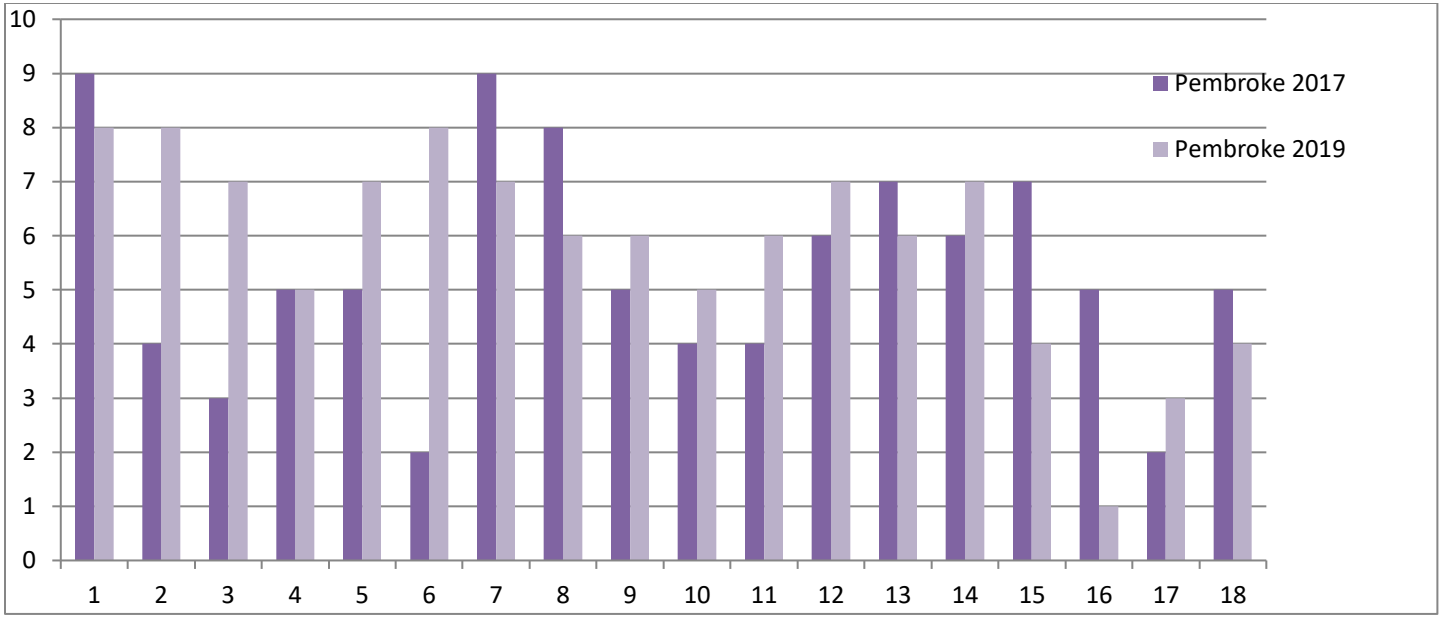
I. Integrated Services and Patient and Family-Centeredness		
Characteristic	**Score**	**Discussion**
1. Level of integration: primary care and mental/behavioral health care	8	Integrated care resources are included in staff meetings, huddles, and provider operations meetings whenever indicated. Warm hand-offs occur regularly, including via nurse triage for crisis situations. Shared electronic health record. Processes for engaging with integrated care resources could be more standardized. Improved coordination of appointments (e.g. visit with PCP immediately following evaluation by consulting psychiatry) would be helpful.
2. Screening and assessment for emotional/behavioral health needs (e.g., stress, depression, anxiety, substance abuse)	8	High performing practice with regard to administering PHQs. CCSAs facilitate more comprehensive screening but include only Medicaid patients.
3. Treatment plan(s) for primary care *and* behavioral/mental health care	7	Behavioral health progress notes identify treatment goals and are available for viewing by rest of medical team. The practice is working through ideal frequency and method of communication. Future improvements might include incorporating IBHC in care team section (Nurse Navigator does this) and ensuring behavioral health diagnoses are included in problem list. Discussed how to make involvement of nurse navigator and

		IBHC more visible in chart.
4. Patient care that is based on (or informed by) best practice evidence for BH/MH and primary care	5	Use of evidence-based practices seems to be dependent on provider preference. It would be helpful if technology could be leveraged to prompt use of specific EBPs. The group would also like to see more screening tools built into the EMR, such as screening for ADHD and Bipolar Disorder.
5. Patient/family involvement in care plan	7	Patient involvement is an integral part of the system of care. Adult children and partners are included when indicated, particularly when the IBHC or Nurse Navigator is involved.
6. Communication with patients about integrated care	8	Patients are made aware of integrated care via CCSA and otherwise when indicated. Written materials have been shared with providers and are available to patients at time of warm hand-off. More providers are thinking about the additional resources but is not yet "at the forefront of the brain".
7. Follow-up of assessments, tests, treatment, referrals and other services	7	Providers feel confident about their follow-up efforts, particularly for missed primary care appointments; however, these processes are not yet built into the Cerner system and rely on individualized approaches. As reporting improves, the practice expects that Cerner can be leveraged to ensure patients don't "fall through the cracks". A report that shows outstanding referrals/orders is forthcoming.
8. Social support (for patients to implement recommended treatment)	6	The CCSA form prompts providers to connect with IBHC for additional resources. Otherwise, discussion of social supports is generally prompted by patient. IBHC discussed ways she can support this by clarifying with providers the types of resources she is familiar with.
9. Linking to Community Resources	6	Most referrals go through IBHC which is ideal. IBHC is able to spend time identifying need, barriers, and providing follow-up. Presence of IBHC has encouraged providers that there are resources to meet many needs.
II. Practice/Organization		
Characteristic	**Score**	**Discussion**
10. Organizational leadership for integrated care	5	Participants felt that the resources within the practice have maximized the opportunities afforded by this initiative; however, discussed feeling frustrated by the amount of time (and impact on productivity) support of integrated care takes. Discussed a desire for more dedicated time to support the success of this initiative.
11. Patient care team for implementing integrated care	6	Participants discussed the gray area experienced by providers with regard to the IBHC and Nurse Navigator. These two roles coordinate well with one another but the other team members lack clarity.
12. Providers' engagement with integrated care ("buy-in")	7	Provider engagement differs across providers; however, most are supportive. Standard prompts and associated work flows might support engagement.
13. Continuity of care between primary care and behavioral/mental health	6	Participants agreed that the record shows clear documentation of each team member's involvement with a patient; however, the practice would benefit from developing standard processes for communicating information (e.g. routing certain types of notes, chart identifiers)
14. Coordination of referrals and specialists	7	The team collaborates to recommend and make specialty referrals. Participants would like a structured time to coordinate care of difficult to treat patients.
15. Data systems/patient records	4*	A shared patient record now exists in Cerner; however, aggregate data is not available. Team would benefit from opportunities to identify trends or gaps in care or to conduct case finding.
16. Patient/family input to integration management	1*	Not aware of any way in which patients are engaged in integration planning or management.
17. Physician, team and staff education and training for integrated	3	The team received SBIRT, Motivational Interviewing, and CCSA training as well as brief overview of the 1115 waiver initiative. No significant follow-up. Participants would like to see more screening tools

care		available in Cerner and more time dedicated to learning. Discussed frustration with the flow of information and expressed a desire for more "real-time" communication around developments and changes.
18. Funding sources/resources	4*	Some overhead costs are shared across organizations, such as office space for IBHC. Integrated care services are not being billed and are provided with the single funding source of the 1115 waiver.

*Scores denoted by an asterisk were not discussed as a whole group due to time and are therefore are not representative of the whole group.





X Axis: Characteristic
Y axis= Score

Summary/Recommendations:
While some items were rated at a lower level this administration as compared to 2017, most items were rated higher; this discrepancy is most likely due to an improved understanding of the full continuum of integrated care and with that, a renewed sense of what would constitute ideal state. This administration also included several different participants in the SSA process, suggesting that changes associated with integration are not being experienced uniformly across all team members.
This practice has made great improvements since last administration of the SSA, particularly in its willingness to embrace the opportunities the integrated care resources offer both patients and providers. Overall, participants felt that the practice is doing well with regard to screening for behavioral health needs, developing treatment plans that address the whole person, and communicating with patients about the integrated care resources. Those items that received the lowest ratings and that were discussed by the whole group include use of EBPs, organizational leadership for integrated care, and provider education and training for integrated care. In general, participants thought highly of integration on a conceptual level and frustrated by the lack of devoted time to support its success. Several ways to improve efficiency of communication were discussed by the group including creating standard prompts and workflows for consideration of an IBHC referral, chart identifiers to mark patients that are working with the Nurse Navigator or IBHC, and finding a way to routinely communicate more frequently about shared patients (such as via a complex care planning meeting). It is recognized that working through any of these challenges will require time which was experienced as a barrier in and of itself by the group.

Site Self-Assessment

CHMG Site	Penacook Family Physicians
Date Completed	3/27/19
Date of Previous Assessment	7/20/18
Next Assessment Due	9/27/19
Participants	Katie Lipp, Director of Integrated Care; Carol Niegisch, Resource Provider; Kyle Savage, Practice Manager; Rebecca Daoust, Nurse Navigator

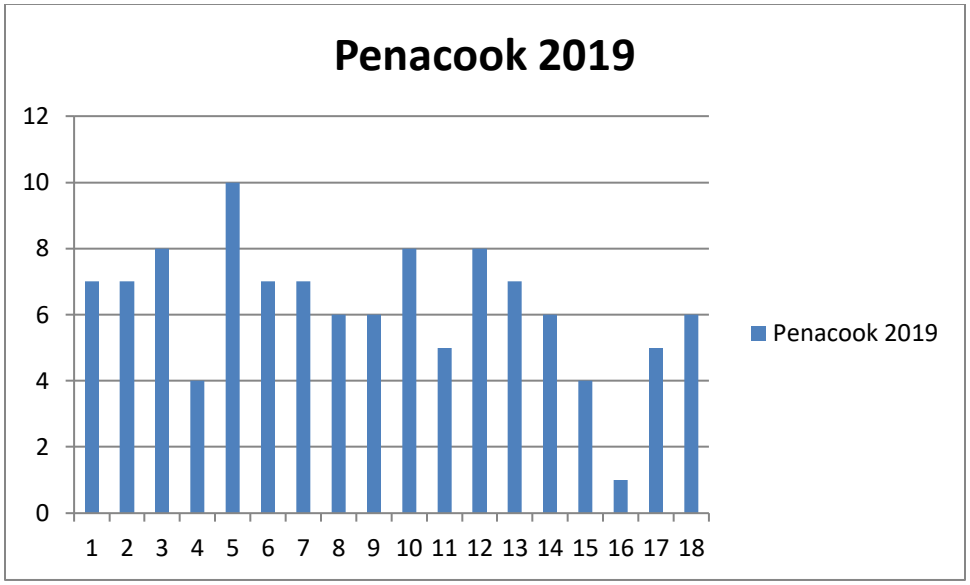
Introduction:
The Penacook Family Physicians practice has been recognized as a National Committee for Quality Assurance's Patient-Centered Medical Home for embracing the Medical Home concept and implementing evidence-based procedures that improve quality and lower costs, while constantly striving to help patients understand and manage their health. The Integrated Behavioral Health Clinician (IBHC) works as an integral member of the team to further these concepts- providing screening, assessment, brief intervention, and referral for social determinants of health in support of overall patient wellbeing. The addition of the consulting psychiatric nurse practitioner (April 2018) and psychiatrist (February 2019) have further enhanced the practice's ability to treat behavioral health conditions within the primary care environment. These added resources have supported an integrated, whole-person approach to primary health care, reducing stigma associated with addressing behavioral health needs and reserving scarce specialty behavioral health services for patients with chronic or complex needs. The purpose of the Site Self Assessment is to identify the practice's current status along several dimensions of integrated care and to stimulate conversation about where the practice would like to be. The tool, provided by the Citizens Health Initiative, asks participants to choose a numeric rating for each item using a 1-10 scale with 10 being the highest level of integration. This is the third recorded administration of this tool at Penacook Family Physicians.

Discussion:

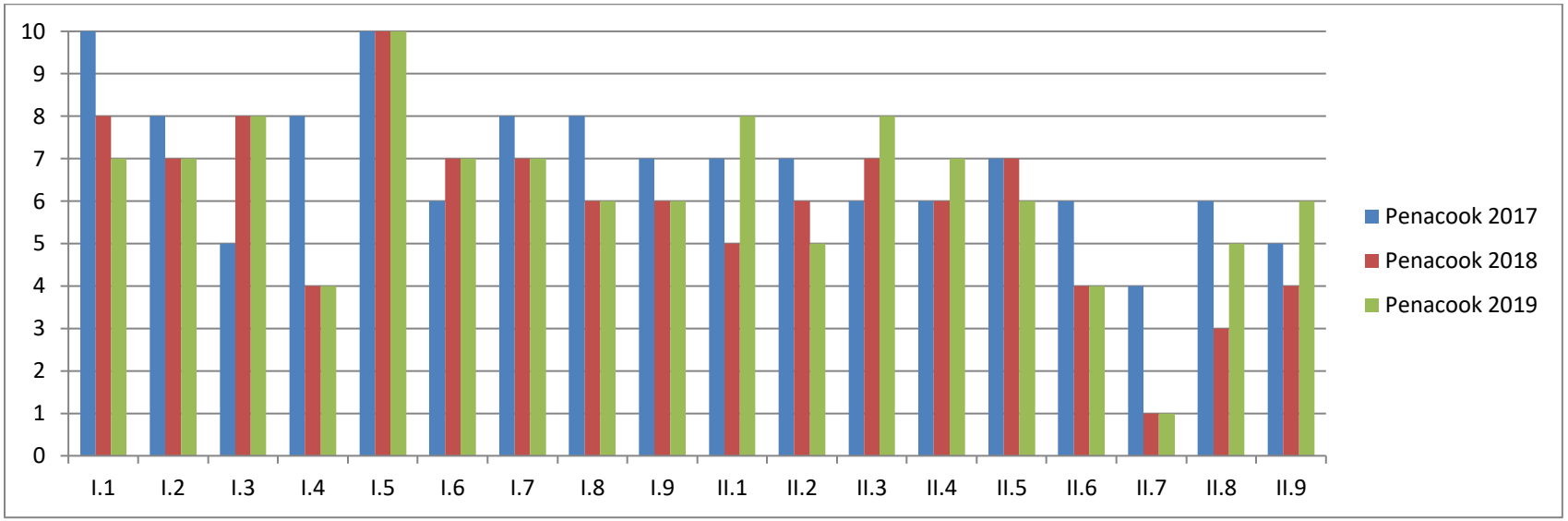
I. Integrated Services and Patient and Family-Centeredness		
Characteristic	**Score**	**Discussion**
1. Level of integration: primary care and mental/behavioral health care	7	Shared electronic health record. Frequent warm hand-offs and regular participation in team meetings. Prompts for integration could be more systematic. Appointments are jointly scheduled whenever possible; however, IBHC manages own schedule and that of psychiatric providers which differs from clinic flow. Integration of psychiatric providers challenged by lack of clarity specific to role, communication, and workflows. Dependency on one person to support a domain of patient care means role goes unfilled when staff is out of office.
2. Screening and assessment for emotional/behavioral health needs (e.g., stress, depression, anxiety, substance abuse)	7	No change. High performing practice with regard to administering PHQs. CCSAs facilitate more comprehensive screening but include only Medicaid patients. Discussed wanting to better understand current cycle time of needs identified via CCSA being met to allow for practice improvement.
3. Treatment plan(s) for primary care *and* behavioral/mental health care	8	No change. Behavioral health and nurse navigation progress notes identify treatment goals and are available for viewing by rest of medical team. When content is particularly complex/high-risk or indicative of worsening of symptoms, note is routed to providers. Future improvements might include incorporating behavioral health team in care team section and ensuring behavioral health diagnoses are included in problem

		list.
4. Patient care that is based on (or informed by) best practice evidence for BH/MH and primary care	4	Use of evidence-based practices seems to be dependent on provider preference. PHQs are used to establish baseline but not consistently used at follow-up or to manage chronic depression. Vanderbilts, MOCAs, and mini-mentals are also heavily utilized. The team feels that they have been increasingly exposed to the behavioral health system which has helped them better understand their patients' presentation on a continuum of care, recognize resources available to support them, and connect as needed. Providers would welcome more exposure to training and opportunities to identify specific ways to integrate learning into practice.
5. Patient/family involvement in care plan	10	No change. Patient/family involvement is an integral part of the system of care. Adult children and partners are included when indicated, particularly when the IBHC or Nurse Navigator is involved.
6. Communication with patients about integrated care	7	No change. Patients are made aware of integrated care via CCSA and otherwise when indicated. Practice would welcome written materials.
7. Follow-up of assessments, tests, treatment, referrals and other services	7	Providers feel confident about their follow-up efforts; however, these processes are not yet built into the Cerner system and rely on individualized approaches. While no quantitative data is available, participants felt that response speed to positive CCSA screens could be improved.
8. Social support (for patients to implement recommended treatment)	6	No change. The annual physical and CCSA forms both prompt providers to explore resources needed and available. Questioned what percent of panel attends annual physical. Participants felt confident that patients are screened but not that the referral loop is closed. Discussed having handouts available in filing cabinets in exam rooms.
9. Linking to Community Resources	6	No change. Most referrals go through IBHC which is ideal. IBHC is able to spend time identifying need, barriers, and providing follow-up. Providers would welcome regular updates to printed resource materials.
II. Practice/Organization		
Characteristic	**Score**	**Discussion**
10. Organizational leadership for integrated care	8	Participants felt that administration recognizes the value of integrated care and has been instrumental in bringing in resources and fostering partnerships to support the work. Participants felt optimistic that the increase in resources is indicative of a more permanent change in delivery strategy.
11. Patient care team for implementing integrated care	5	Participants identified a need for additional role clarity specific to the IBHC, specifically relative to the Nurse Navigator. There was confusion about whether patients referred to IBHC must have a mental health diagnosis and which role can best support "heavy social work needs".
12. Providers' engagement with integrated care ("buy-in")	8	Nearly all providers are using all components of integrated care.
13. Continuity of care between primary care and behavioral/mental health	7	Participants agreed that continuity of care for patients that work with IBHC is strong; however, this area is still lacking for the typical patient.
14. Coordination of referrals and specialists	6	Participants identified that there is no specific procedure to close loop of referrals to IBHC and Nurse Navigator. A common practice is to route the initial note to the provider or to route documentation of a final outreach attempt. Discussed benefits to having more specialists available and on site (psychiatry) and identified continued difficulty resourcing needed providers in the community.
15. Data systems/patient records	4	No change. A shared patient record now exists in Cerner; however, aggregate data is not available. Team would benefit from opportunities to identify trends or gaps in care or to conduct case finding.

16. Patient/family input to integration management	1	No change. Participants are not aware of any way in which patients are engaged in integration planning or management.
17. Physician, team and staff education and training for integrated care	5	The team received SBIRT, Motivational Interviewing, and CCSA training as well as brief overview of the 1115 waiver initiative. The team has also had several opportunities to learn about behavioral health resources in the community. Providers identified a need for additional training specific to diagnoses (Bipolar Disorder, Schizophrenia, and treatment-resistant Depression), newer medications, and further detail specific to how to manage these conditions on-going. Providers would like these trainings to be formal with written materials provided.
18. Funding sources/resources	6	Some overhead costs are shared across organizations, such as office space for IBHC. Integrated care services are not being billed and are provided with the single funding source of the 1115 waiver. Provider training is offered in-kind.



X Axis: Characteristic
Y axis= Score



X Axis: Characteristic
Y axis= Score

Summary/Recommendations:
As indicated by the chart above, there has been considerable variability in scores across the three administrations of the SSA. Noted in the 2018 summary, many items were rated lower than in 2017 which was viewed by this writer as the result of an improved understanding of the full continuum of integrated care and with that, a renewed sense of what would constitute ideal state. This administration of the SSA found most items to have improved or stayed the same since the previous administration which seems to further support this argument. Overall, participants identified improvements in organizational leadership's support of integrated care, provider engagement, and team training. Those areas that received the most discussion and/or lowest ratings included lack of role clarity of IBHC (especially relative to Nurse Navigator), use of evidence-based guidelines and tools for behavioral health care, and data systems to support the work. Newly implemented processes to provide IBHC coverage and standardize work flows and scheduling for psychiatric providers will likely improve this practice's experience. It is recommended that the IBHC and Nurse Navigator meet with their counterparts at Epsom Family Medicine where the two roles have developed a collaborative, synergistic relationship. Additional recommendations include standardizing the process of routing initial notes to the provider to close the loop of IBHC/Nurse Navigation referrals, distributing written materials to clarify the role of IBHC, and finding a way to identify the electronic records of those patients working with IBHC/Nurse Navigation more clearly.

Site Self-Assessment

CHMG Site	Riverbend Integrated Center for Health
Date Completed	4/15/19
Next Assessment Due	10/15/19
Participants	Katie Lipp, Director of Integrated Care; Kyle Boston, RICH Clinical Manager; Denise Fairbank, Nurse Care Coordinator; Carly Marquis Henson, Primary Care Provider; Liane Tobin, Medical Assistant; Jenn Drechsler-Fuller, Integrated Care Manager; Lene McCarthy, Integrated Care Manager; Sue Pratley, Peer Wellness Coach; Rebecca Cote, Program Assistant

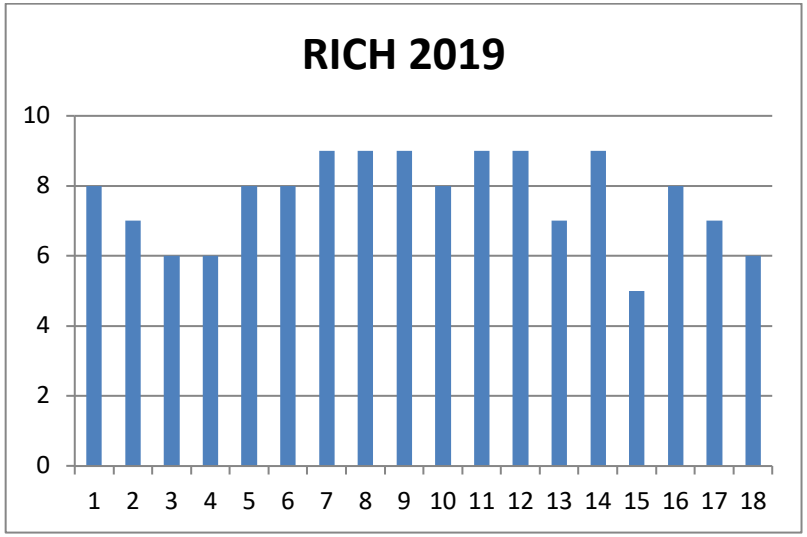
Introduction:
Riverbend Integrated Center for Health (RICH) was established in September 2016 as a "reverse integration" site which integrates primary care into Riverbend's Community Support Program for adults with Severe and Persistent Mental Illness. Primary care services are provided in partnership with Concord Hospital's Family Health Center, exclusively at the Community Support Program site. The integrated care team consists of a Primary Care Provider, Medical Assistant, Nurse Care Coordinator, Program Assistant, Peer Wellness Coach, and Integrated Care Managers in addition to the traditional behavioral health team consisting of psychiatric provider, psychiatric nurse, and case manager.
The purpose of the Site Self Assessment is to identify the practice's current status along several dimensions of integrated care and to stimulate conversation about where the practice would like to be. The tool, provided by the Citizens Health Initiative, asks participants to choose a numeric rating for each item using a 1-10 scale with 10 being the highest level of integration.

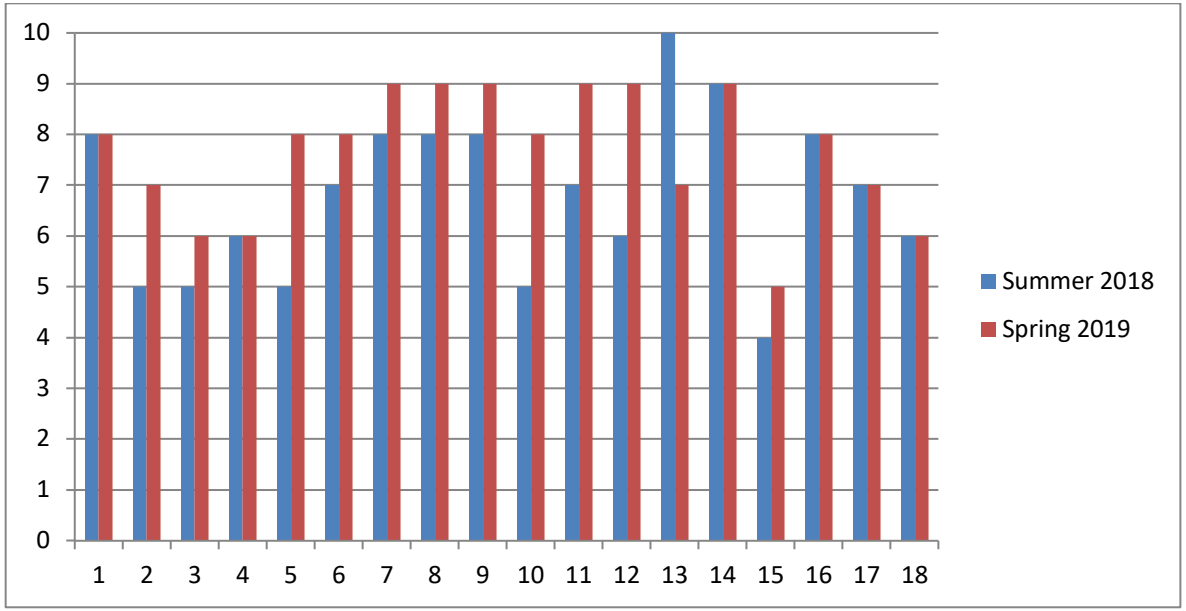
Discussion:

I. Integrated Services and Patient and Family-Centeredness		
Characteristic	**Score**	**Discussion**
1. Level of integration: primary care and mental/behavioral health care	8	Participants felt that behavioral health and primary care have successfully integrated to the extent that limitations in technology have allowed. Staff from each discipline are present at one another's team meetings, notes are shared, and warm hand-offs occur on a regular basis. Medical providers feel updated with regard to mental health symptoms at the time of the visit and vice versa. The lack of a shared record and related limitations to who can access the medical record in real time have created a need for several work arounds to ensure these processes can take place. Since upgrades to both records, some functionality has been lost. Recently applied for EMR access for Care Managers.
2. Screening and assessment for physical health needs	7	All RICH enrollees are screened for physical health needs at least biannually; however, this represents only a pilot population of the larger program enrollment. A new policy wherein a psychiatric enters an order for a nursing assessment between psychiatry visits has improved screening. Participants also noted that psychiatry is approaching primary care prior to ordering labs to limit redundancy and multiple client appointments. PHQs, GADs, and MOCAs are routinely administered but not always entered into the record in a highly visible, trackable manner.
3. Treatment plan(s) for primary care *and* behavioral/mental health care	6	The team recognized that treatment plans are more integrated than in "care as usual" but remain far from ideal state. All RICH patients have updated, accurate behavioral health diagnoses listed in their medical chart and medications are reconciled at every medical visit with reference to the behavioral health chart.

		Behavioral health progress notes identify treatment goals and are available for viewing by rest of medical team, albeit in a separate record. An upgrade to TIER has inadvertently removed RICH-related goals and objectives from the treatment plan, which is scheduled to be fixed soon. The Care Team is updated regularly in Cerner. CMT PreManage has supported some Shared Care Planning and sharing of provider data.
4. Patient care that is based on (or informed by) best practice evidence for BH/MH and primary care	6	No change. Use of evidence-based practices seems to vary by provider. It was noted that Cerner has a health promotion component that has not yet been activated. While there are policies in place to support evidence based care, such as monitoring HbA1c when a patient is being prescribed atypical anti-psychotics, there is no data or reporting available to evaluate this policy on a large scale. It would be helpful if technology could be leveraged to prompt use of specific EBPs and assess prescribing trends.
5. Patient/family involvement in care plan	8	Participants identified that there seems to be significant variation within the RICH program and outside of it. Within RICH, explicit informed consent is obtained prior to initiating integrated care and clients are encouraged to self-manage their chronic conditions through evidence-based programs like Whole Health Action Management. All treatment plans must be signed by clients on an annual basis and clients must be granted a Client-Centered Conference when requested; family members are often involved in these meetings. Staff routinely take into account family, work, and community barriers when care planning.
6. Communication with patients about integrated care	8	All new clients are assessed for Integrated Care immediately following determination of eligibility. Integrated Care is advertised in the waiting room. Psychiatric providers and nurses often provide warm hand-offs to integrated care team (volume increased since last administration) and the approach to engagement is highly tailored to the needs and presentation of the client. Relationships are being built across community providers via IBHCs and staff on 5-West.
7. Follow-up of assessments, tests, treatment, referrals and other services	9	Participants feel that follow-up efforts are very high priority for the integrated care team. There are workflows in place for follow up on labs, referrals, and missed appointments; however these processes are highly manualized. Normal values are often not communicated when ordered by the psychiatric provider; however, abnormal results are. This process will be further supported by ICM's access to the EMR.
8. Social support (for patients to implement recommended treatment)	9	Efforts are made at least annually and as indicated to engage natural supports in care. Supports often attend medical visits and are invited to attend certain groups and wellness promotions. Case Managers assess for this monthly.
9. Linking to Community Resources	9	All clients receive case management services at least monthly which assess and link to resource needs.
II. Practice/Organization		
Characteristic	**Score**	**Discussion**
10. Organizational leadership for integrated care	8	Participants identified feeling as though integrated care has gained some momentum and support since last administration of SSA. FHC has functioned more as a partner, including offering acute visits on-site. IT has supported RICH initiatives and Director of Integrated Care is often included in meetings to represent the integrated perspective. Vague sustainability plans continue to contribute to unease among staff.
11. Patient care team for implementing integrated care	9	The team felt confident that roles are clearly defined and staff are cross-trained to fully understand one another's roles. The small size of the team reinforces the value of each role when someone is out of the office. Psychiatric nurses and case managers are functioning in an increasingly cross-trained manner. In May, ICMs will present to all CSP staff about care management.
12. Providers' engagement with integrated care ("buy-in")	9	The group agreed that while the concept of integration has been met with enthusiasm by all providers, they have struggled with implementation largely due to technical difficulties. Since last review, OrderConnect

		has been implemented which has supported interoperability. The team has experienced psychiatric providers as increasingly engaged in the work.
13. Continuity of care between primary care and behavioral/mental health	7	Within this pilot subpopulation, continuity of care is very high. Visit preparation includes documentation of medication changes, the last visit the client attended with a member of their team, and any updates provided by the other team via the Integrated Care Manager. Urgent needs or updates are communicated in real time and have even resulted in co-visits. Outside of the program, transitions of care lack support due to delayed information exchange. CMT PreManage has supported this for those clients who have opted in.
14. Coordination of referrals and specialists	9	The team collaborates to recommend and make referrals. Cerner continues to lack capacity to track and measure; however, a robust manual system has been implemented to track referrals. The team has worked to train common recipients of referrals in how best to work with and process a RICH referral. The ICMs are on track to gain Cerner access to further support this process.
15. Data systems/patient records	5	A shared patient record now exists in Cerner; however, aggregate data is not available. This record is fully separate from the behavioral health record, though several team members have access to both. Systems are in place to share certain information regularly; however, it is often not available in real time except to staff that have access to both records. Team would benefit from opportunities to identify trends or gaps in care or to conduct case finding. OrderConnect has improved access to records, particularly for clients who have transferred care to the Franklin site.
16. Patient/family input to integration management	8	Clients are invited to attend a project oversight board where their voice carries equal weight to non-client members. Every six months, clients are systematically asked for feedback on their experience in the program; this data is monitored by the team bimonthly and changes are made to promptly address trends. Clients presented at an all-CSP meeting to share their experiences as testimonials.
17. Physician, team and staff education and training for integrated care	7	No change. The pilot team engages in frequent and regular training opportunities. The broader staff received training on metabolic syndrome, chronic pain, and diabetes and have been provided regular updates demonstrating the effectiveness of integrated care via data. All new staff meet with the Clinical Manager to orient to the program.
18. Funding sources/resources	6	No change. Some overhead costs are shared across organizations. Integrated care services are not being billed and are provided with the funding from SAMHSA and the 1115 waiver.





X Axis = Characteristic
Y axis = Rating

Summary/Recommendations:

As compared to the last administration of the SSA in Summer 2018, this site has maintained or improved on 17 out of 18 items. This is particularly remarkable in comparison to other sites evaluated where change has been more variable across each item. It seems that the staffing consistency and overall tenure of this team may contribute to a more consistent sense of strengths and weaknesses as they relate to integrated care.

Overall, participants felt that the clinic is operating in as integrated a manner as technology allows. Common themes across the group included frustration with technology (and its impact on coordination of care) as well as an acknowledgment that the impact of the integration achieved by this clinic is limited to a pilot group. Those items that scored highest include coordination of follow-up and referrals, social and resource support, provider engagement, and a patient care team with clearly defined roles. Those which received the lowest ratings include data systems, care based on best practice evidence, and integrated treatment plans. Of note, the team decided on a lower rating specific to continuity of care between primary care and behavioral health than previous administration due to acknowledgment that the processes developed by the integrated care team are not practiced universally across the program.

This team expends a significant amount of time and resources to implement manual processes to track and monitor patient care. The resulting effect is impressive; however, the processes are not sustainable over time or with growth of the panel. This program would benefit from continued efforts to engage IT as well as the CSP program at-large to spread out some of these tasks across roles, with the aid of technology.

IDN2 Sustainability Planning Worksheet

1. The IDN2 executive and finance committee members (CH, VNA, and RB CEOs; CH, VNA, RB CFOs; VNA CIO; RB MD; CH AMD) will review recommendations made by those with expertise from among the committee members. The IDN2 project director will work with IDN2 staff and partners to develop the work for committee review.
2. Define long-term goal or vision within a state and regional system of care - In process
    a. Review vision from IDN2 2016 application for Project Plan: *The Region 2 (Capital Area) Integrated Delivery Network upholds and supports the goal of the Capital Area Public Health Network to "improve access to a comprehensive, coordinated continuum of behavioral health care services in the Capital Area by 2020." Further our vision includes improving outcomes and increasing access to care for adult and youth populations (including those reentering from incarceration, pregnant women, and youth with developmental disabilities) across the capital area in a service-integrated continuum of care that addresses mental health, substance use disorders, and chronic/primary health care needs.*
    b. Identify and review needs assessments - done
    c. Identify and review long-term planning documents for state and region - done
    d. Identify and review similar state or regional projects - done
3. Determine which elements of current project outcomes and operations (first, second, third tier in priority), including HIT/Data need to be maintained, eliminated, or adapted to support the long-term goal or vision
    a. Define current project outcomes and operations
        i. Evaluate strengths, weaknesses, and relevance to long-term goal - In process
    b. Establish operations to be sustained ("the project")
        i. Develop outcomes and evaluation measures for the project
4. Define the 2020-2025 costs of sustaining the project
5. Identify resources to support costs
    a. Investments in capacity already paid for by DSRIP funds
    b. Unallocated DSRIP 2021 payments
    c. Continued financial support from NH DHHS/BDAS
        i. APMs
    d. Existing partners' operations
    e. Fee for services
        i. All insurance not just Medicaid
    f. Fundraising
        i. Application to federal and state agencies under identified RFRs
        ii. Corporate support
        iii. Individual support

	New Hampshire Delivery System Reform Incentive Payments (DSRIP) **Workforce Taskforce Minutes** **June 26, 2019**
LOCATION:	Brown Building, Rm 468
CALL:	**Dial-in Number**: 1-866-304-8625 **Conference Code Number**: 645 580 0197
DATE:	June 26, 2019
TIME:	**2:00 -3:30 pm**
MEETING PURPOSE	Identify and communicate a clear process, structure and timeline for the WFTF and its subcommittees to meet the objectives of the DSRIP demonstration.
ATTENDEES:	**DHHS:** Kelley Capuchino, Leslie Melby, Jaime Powers, Kerri Swenson **Myers and Stauffer LC (MSLC):** Val Brown **Bi-State:** Michele Petersen **IDN 1:**, Jessica Powell **IDN 2:** Peter Evers **IDN 3:** Beth Sheehan **IDN 4:** Peter Janelle **IDN 5:** Maggie Pritchard, Audrey Goudie **IDN 6:** No attendees **IDN 7:** April Mottram

I.	**Introduction/Announcements** • P Evers opened the meeting with updates • Updates from Subcommittee • Discussion of future meetings and other projects	**Peter Evers, Chair**

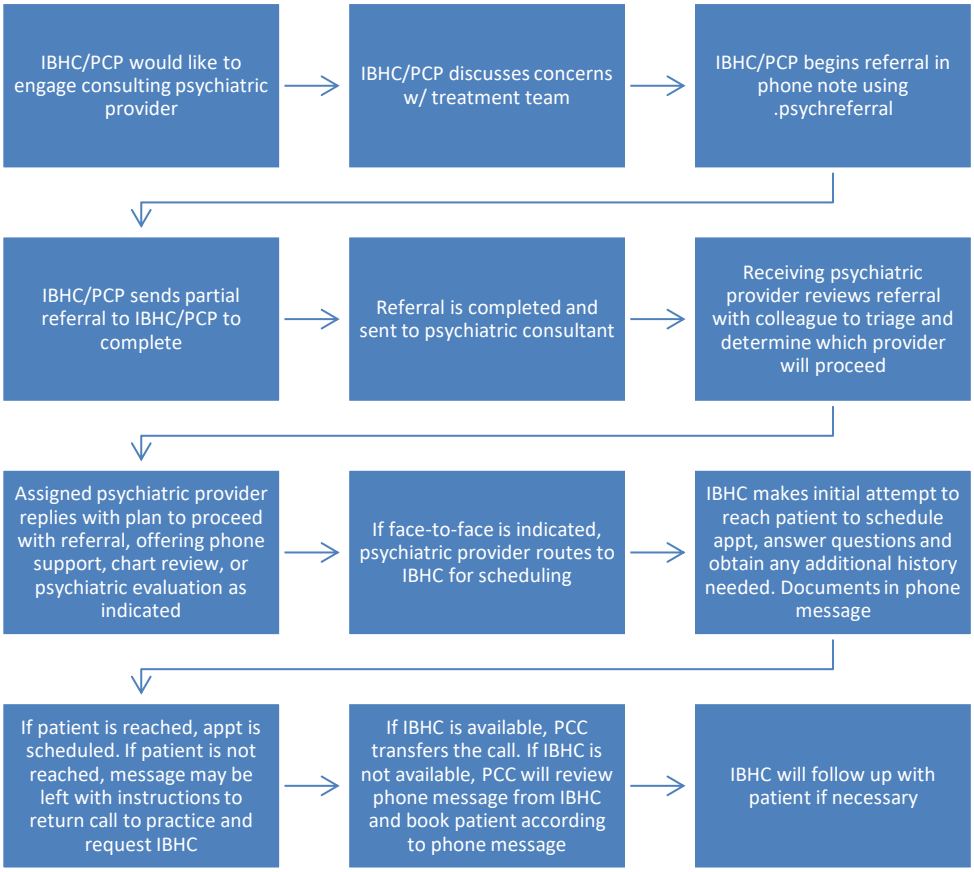
II.	**Workforce Legislative Wrap-Up**
	• Legislative update distributed.
	• Joint meeting with Legislative Commission on Primary Care Workforce on June 27 to discuss SB 180, SB 80, HB 113, SB 308 and other workforce bills.
	• M Pritchard explained these bills.
	• Looking for a volunteer that is either a LICMH or LICSW to put forward to the Governor to sit on the Board of Mental Health Practice. **ACTION ITEM**
	• P Evers stated that they have someone who may be interested.
	• SB 308 – workforce legislation
	  ○ Requested 5-7% per year for Medicaid rate increase.
	  ○ Received 3.1% per year for 2 years
	  ○ Student Loan Repayment Program (SLRP) was appropriated $3.25 M per year for 2 years
	  ○ Electronic background checks approved and will make the process easier. This is a huge win.
	  ○ HB 127 requires certain health care professionals to complete a survey collecting data on the primary care workforce.
		M Pritchard

○ SB 14 requires DHHS to establish one or more case management entities as part of the system of care for children's mental health and expands home and community-based BH services for children to include mobile crisis response and stabilization services. There are concerns with hiring individuals for this. ○ SB 11 authorizes surplus funds for DRFs and for voluntary inpatient psychiatric admissions. ○ K. Capuchino requested information regarding workforce pipelines. P. Evers reported that IDN4 is working with schools, and UNH has an advisory primary care group. • Next policy subcommittee meeting is in July.	
III. Billing and Coding • IDN2 is coordinating a Billing and Coding group. • Retention and Sustainability group is focusing on billing and coding. • Focus on leveraging Medicaid Fee for Service codes that are currently billable. Will need to lobby to increase rates for codes with low rates and to cover codes not currently covered. • K Capuchino requested J. Powers (BDAS) review SUD codes on matrix and identify which provider types can provide the services. **ACTION ITEM** • K Capuchino will include all Community Mental Health Center (CMHC) Codes and crosswalk which codes are reimbursable to FQHCs. **ACTION ITEM** • J Powers will share a memo she received that identifies which codes can be billed as part of the FQHC encounter rate and those billed outside the encounter rate. **ACTION ITEM** • P Evers asked if this will increase Medicaid expenditures and if so, a Fiscal Note will be needed • K Capuchino explained the process and budget neutrality. • P Evers noted that the BH Integration codes all fit what the IBHCs are doing at Riverbend and Concord Hospital Medical Group. • K Capuchino explained the Local Care Management Entities (LCME) - If some of the services are inherently administrative care coordination activities, and the MCOs are already paid to do this, it is expected the MCOs will purchase these services through contracts. This affects whether to turn on the Fee for Service codes.	**P Evers**
IV. Telehealth • SB 258- Adds definitions to and clarifies the statute governing telemedicine and Medicaid coverage for telehealth services. • An amendment to SB 258 includes Medicaid coverage definitions so that Medicaid and private insurance are aligned. • Telehealth definitions were added to the insurance Managed Care state, RSA 415-J. • P Evers noted this is a game changer in terms of sustainability. • A pilot at Riverbend (2-3 months) starts July 1. DOXC.me product will be used. • Will report results back to the WF TF. • J Powers stated that BDAS is getting inquiries on telehealth licensure restrictions for SUD. • They are restricted other than for methadone clinics. • Licensing statute restricts prescribing for SUD to face-to-face unless through an opioid treatment program or CMHC. • P Janelle stated IDN 4 is having problems standing up an MAT program at Rockingham County Jail. • K Capuchino remarked that M. Pritchard has done a good job with OPLC. M. Pritchard to reach out to J. Powers for more information. **ACTION ITEM**	**P Evers**

V.	**Subcommittee Reports: Education; Policy; Recruitment/Hiring; Retention/Sustainability**
	• **Recruitment/Hiring- B. Sheehan**
	  ○ Sent IDN Admin Leads information on peer organizations and career pipelines.
	  ○ Created a peer careers path document to be distributed to appropriate peer organizations within each region.
	  ○ Community colleges - Return to Work course is offered through CAP in Nashua. It is similar to the work they do on workforce re-entry with a peer component. P. Janelle will get an update from G Vercauteren. **ACTION ITEM**
	  ○ Working with Bi-State on a Trailing Spouse program.
	  ○ G Vercauteren is compiling a shared repository of integrated jobs.
	  ○ G Vercauteren is working with AHEC on the Health Careers Catalog, which will include integrated roles. The Catalog will be published this fall. IDNs should have received a bill for this work.
	• **Education Subcommittee - A Mottram**
	  ○ IDN discussions on creating a centralized training calendar have taken place
	  ○ IDN7 will develop a webpage for this purpose. This site will link to existing sites so that there is one place to go.
	  ○ The IDNs will send their training schedule to be included on the calendar along with registration links to IDN7.
	  ○ Conversations are under way as to whether to have a separate IDN track at the BH Summit.
	  ○ The next subcommittee meeting is in July.
		M Pritchard, B Sheehan, P Evers, A Mottram

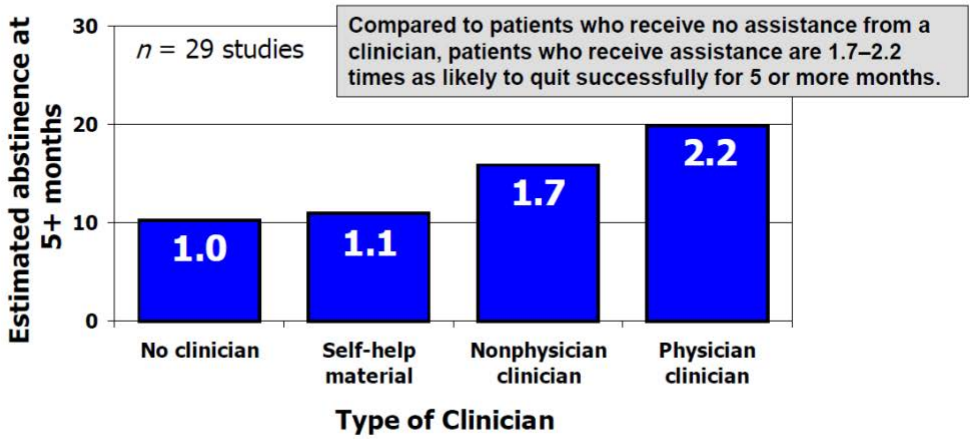
VI.	**Other Business** • P Evers stated that the Workforce Taskforce has been meeting for 3½ years. • He asked if the WF TF should revisit its Charter with only 1½ years remaining in the DSRIP Waiver. • B Sheehan remarked that perhaps the efforts should focus on current projects such as the pipeline rather than adding new projects. • P Evers requested that all Taskforce members review their projects and score them in terms of impact. This action item will be moved to the IDN Leads meeting. **ACTION ITEM** **VII.** Meeting adjourned.	**Members**

Work Flow: Referring to the Integrated Psychiatric Provider



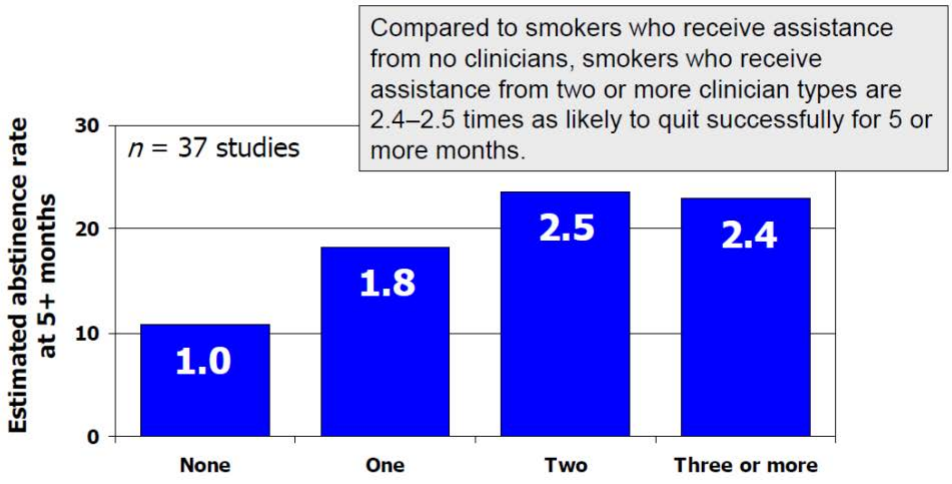
EFFECTS of CLINICIAN INTERVENTIONS

With help from a clinician, the odds of quitting approximately doubles.



Fiore et al. (2008). *Treating Tobacco Use and Dependence: 2008 Update. Clinical Practice Guideline*. Rockville, MD: USDHHS, PHS, May 2008.

The NUMBER of CLINICIAN TYPES CAN MAKE a DIFFERENCE, too



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PSYCHIATRY SCHEDULE

Monday

	LOIS	NICOLE
8:00	Supervision w/ Dr. Fetter	Supervision w/ Dr. Fetter
9:00	OFFICE	OFFICE DAY
10:00	OFFICE	
11:00	OFFICE	
12:00		
1:00	Concord Family Medicine	
2:00	Concord Family Medicine	
3:00	Concord Family Medicine	
4:00	Concord Family Medicine	

Tuesday

	LOIS	NICOLE
8:00	OFFICE	Pleasant Street
9:00	OFFICE	Pleasant Street
10:00	OFFICE	Pleasant Street
11:00	OFFICE	Pleasant Street
12:00	Yoga	
1:00	Epsom Family Medicine	OFFICE*
2:00	Epsom Family Medicine	OFFICE*
3:00	Epsom Family Medicine	OFFICE*
4:00	Epsom Family Medicine	OFFICE*

Wednesday

	LOIS	NICOLE
8:00	OFFICE DAY	OFFICE
9:00		OFFICE
10:00		OFFICE
11:00		OFFICE
12:00		OFFICE
1:00		Penacook
2:00		Penacook
3:00		Penacook
4:00		Penacook

Thursday

	LOIS	NICOLE
8:00	Pembroke	Concord Family Medicine
9:00	Pembroke	Concord Family Medicine
10:00	Pembroke	Concord Family Medicine
11:00	Pembroke	Concord Family Medicine
12:00		
1:00	Pleasant Street	Pembroke
2:00	Pleasant Street	Pembroke
3:00	Pleasant Street	Pembroke
4:00	Pleasant Street	Pembroke

Friday

	LOIS	NICOLE
8:00	IBHC Group Supervision	IBHC Group Supervision
9:00	Travel	Travel
10:00	Penacook	Epsom Family Medicine
11:00	Penacook	Epsom Family Medicine
12:00	Penacook	Epsom Family Medicine
1:00	Penacook	Epsom Family Medicine
2:00	OFFICE	OFFICE
3:00	OFFICE	OFFICE
4:00	OFFICE	OFFICE

*Internal Medicine-Horseshoe Pond 3rd Tuesday of the month

Sites	Concord Family Medicine					Penacook Family Physicians					Epsom Family Medicine					Family Physicians of Pembroke					Pleasant Street Family Medicine					Five-Month Total
2019	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	
IBHC Days in Office	**18**	**18**	**24**	**12**	**17**	**19**	**18**	**22**	**5**	**0**	**20**	**12**	**24**	**16**	**20**	**19**	**20**	**22**	**19**	**17**	**18**	**20**	**22**	**9**	**14**	**425**
Type of Client Interaction																										
Scheduled	30	63	69	30	62	55	52	42	4	N/A	81	44	91	49	56	22	29	28	45	36	49	63	88	26	30	1144
No Show	37%	16%	26%	27%	32%	31%	23%	17%	0%	N/A	25%	43%	21%	24%	21%	23%	24%	18%	18%	36%	27%	24%	33%	15%	33%	24% AVG
Warm hand-off	9	15	19	6	9	14	8	11	1	N/A	19	5	13	7	10	8	4	7	16	11	13	12	16	2	5	240
Unscheduled	5	6	11	4	2	3	5	3	7	N/A	1	1	4	0	3	13	8	16	6	9	2	0	4	8	1	122
Totals																										
VISITS TOTAL	**33**	**74**	**81**	**32**	**73**	**66**	**53**	**49**	**12**	N/A	**81**	**31**	**89**	**44**	**69**	**38**	**34**	**46**	**59**	**56**	**51**	**60**	**79**	**32**	**36**	**1278**
TEAM CONSULTS	**57**	**89**	**111**	**55**	**75**	**48**	**39**	**67**	**7**	N/A	**51**	**27**	**71**	**24**	**25**	**43**	**47**	**51**	**43**	**39**	**10**	**5**	**21**	**9**	**3**	**1017**
PHONE CHECK-INS	**7**	**17**	**20**	**14**	**10**	**135**	**125**	**218**	**11**	N/A	**10**	**10**	**20**	**9**	**11**	**33**	**38**	**20**	**27**	**32**	**29**	**24**	**36**	**14**	**16**	**886**
RESOURCE CALLS	**3**	**22**	**14**	**4**	**5**	**21**	**25**	**19**	**24**	N/A	**1**	**1**	**8**	**3**	**1**	**6**	**87**	**53**	**22**	**99**	**6**	**14**	**15**	**6**	**13**	**472**
Notes						Low IBHC attendance in May. June covered by Epsom and Pembroke and reflected in those numbers.															Low IBHC attendance in May. Missing one week of data in June.					
Key	**Scheduled Visits:** visits that were pre-planned in any capacity, even if that means that they were scheduled an hour prior **Warm hand-offs:** introductions to the patient by another team member lasting less than 15 minutes. A warm hand-off may turn into an unscheduled visit in which case it will count for both. **Unscheduled Visits:** any visit longer than 15 minutes that was not pre-planned **Team Consults:** in-person or phone consultation about a patient with a member of the team (provider, Nurse Navigator, Psychiatric consultant, IBHC, etc) **Phone Check Ins:** calls made to a patient or natural support wherein clinical conversation takes place (not just to schedule/reschedule) **Resource Calls:** Calls to collaterals or resources, including referrals																										