

Capital Area Integrated Delivery Network (IDN2)

Concord Hospital, Administrative Lead

Capital Region Health Care (CRHC), Primary lead

Semi-Annual Report July - December 2017



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

Concord Hospital

Concord Regional Visiting Nurse Association

Riverbend Community Mental Health, Inc.

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DSRIP IDN Project Plan Implementation (PPI)

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

Soliciting Community Input

During the planning and initial implementation process, IDN2 required that all members participate fully in at least one of IDN2's 8 workgroups, 5 committees, and/or 2 governance groups that meet monthly as well as the quarterly full IDN meeting. IDN2 has now evolved the workgroups into oversight meetings. These are attended by the leads/supervisors of the projects and the IDN2 project director for the purposes of tracking progress and outcomes. Rapid cycle evaluation is used, as needed. Communication about outcomes, potential course corrections, and etc. is then done from the leads/supervisors to the direct care staff and from the project director to the IDN2 steering committee, NH DHHS, other leads/supervisors, and the full IDN2 partners at the quarterly meetings.

Workgroups - Oversight Committees

- Integration - Concord Hospital Medical Group (CHMG)
- Integration - Dartmouth Hitchcock Concord (DHC) - **This workgroup is being led by a Project Manager hired by DH Lebanon. IDN2 participates, as needed, and receives required information from the Project Manager for tracking and reporting.**
- Integration - Riverbend Community Mental Health (Riverbend)
- Integration - Concord Hospital (CH) Family Health Center (FHC)
- Medicated Assisted Treatment (MAT)
- Perinatal Addiction Treatment (PAT) - **We have folded this into the MAT oversight group.**
- Enhanced Care Coordination (ECC)
- PAT + ECC Committees - **This is a case management group now for direct care staff to discuss client care and transitions.**
- Health Information Technology (HIT)
- HIT + Clinical - **This is the complete oversight group for IDN2, attending to process and outcome metrics.**
- Finance
- Executive
- Steering
- **Sustainability - Includes Alternate Payment Model (APM) planning and discussion.**

IDN2 is in the process of finalizing a communication plan to include logo (updates to existing) Facebook (existing), a website (existing but not used), and project brochures (new). One issue to resolve is the point of contact when projects are spread out among organizations. IDN2 is therefore also looking at honing its identify and points of contact by creating and using distinct email accounts tied to its existing domain name. (e.g. projectdirector@region2idn.org)

Timeline **with updates:**

July - Dec 2017

- Develop 6 template presentations to be updated as needed (IDN2 projects x 3, Integration

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

Jan - June 2018

- 5 visits to CHMG practices to discuss the Integration & MAT projects with Q & A
 - **Materials to support Integration and MAT project communication with primary care practices**
- 2 quarterly presentations to the full IDN with Q & A
- 3-5 weekly IDN2 Facebook posts on topics relevant to the DSRIP projects
- 4 presentations to community members about one or more of the IDN2 community projects with Q & A
- ~~13 monthly workgroup/committee meetings with Q & A - These are now oversight groups~~
- 6 distributions of IDN Committee agendas and minutes
- **Website, Email identity, ECC and MAT project brochures**
- **4-6 Maine Site Self-Assessment visits**

July - Dec 2018

- 5 visits to CHMG practices to discuss the Integration & MAT projects with Q & A
- 2 quarterly presentations to the full IDN with Q & A
- 3-5 weekly IDN2 Facebook posts on topics relevant to the DSRIP projects
- 4 presentations to community members about one or more of the IDN2 community projects with Q & A
- ~~13 monthly workgroup/committee meetings with Q & A - These are now oversight~~

groups

- 6 distributions of IDN Committee agendas and minutes
- **4-6 Maine Site Self-Assessment visits**

Network Development

This is the list of IDN2’s 33 partners and each’s role in the IDN and its projects:

Name of Organization	A1	A2	B1	C2	D1	E5	Referral	Training	Steering
Ascentria Care Alliance							X	X	X
Bhutanese Community of NH							X	X	X
Boys & Girls Clubs of Greater Concord							X	X	
Capital Area Public Health Network								X	X
CATCH Neighborhood Housing							X		X
Community Action Program							X		
Concord Coalition to End Homelessness							X		X
Concord Family YMCA							X	X	X
Concord Hospital, IDN2 Admin & Finance Lead	X	X	X		X	X	X	X	X
CHMG Primary Care Practices	X	X	X		X	X	X	X	X
Concord Hospital Substance Use Services	X	X	X		X	X			
Concord Hospital Ob-Gyn					X		X		
Child & Family Services	X	X	X		X	X	X		
Concord Human Services							X		X
Concord Regional VNA, IDN2 Tech Lead	X	X					X		X
Crotched Mountain							X		
Dartmouth Hitchcock Primary Care Practice	X	X	X		X	X	X		
Dartmouth Hitchcock Concord Ob-Gyn					X		X		
Families in Transition		X	X				X		
Fellowship Housing		X	X				X		
Granite State Independent Living							X		
Granite State United Way								X	
Granite Pathways							X		
Life Coping, Inc.							X		
Merrimack County DOC				X			X		X
NAMI New Hampshire	X				X	X		X	X
NH DOC				X			X		
NHADACA								X	

New Hampshire Hospital						x	x		
Riverbend CMHC, Inc., IDN2 Clinical Lead	x	x	x	x	x	x	x	x	x
Sununu Youth Services Center				x		x	x		
UNH Institute on Disability								x	
Youth Move	x					x			

Timeline with Updates

July - Dec 2017

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

Jan - June 2018

- Contract with [REDACTED]/Granite United Way to provide expanded NH-211 services - **Signed in January.**
- Survey at least 20 IDN2 CBOs about the services they provide and identify any potential gaps
- CBOs will present at least **2** times to IDN2 **partners**

July - Dec 2018

- CBOs will present at least **2** times to IDN2 **partner**

Addressing the Opioid Crisis

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

Timeline with updates:

July - Dec 2017

- Provide mentoring support to 6 existing MAT providers - **During this report period, the MAT provider at Riverbend’s CHOICES Substance Use Services and the MAT provider from Concord Hospital’s Program for Addictive Disorders provided mentoring support to 10 IDN2 MAT providers based in the following locations:**

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

- Convene existing MAT providers and IBHC each month to share best practices, review cases, and address challenges - **This happened in an ad hoc fashion through phone calls and emails but did not materialize into a monthly meeting. MAT/PC providers are finding it difficult to attend monthly meetings. IDN2 is exploring other ways to exchange this kind of information and work cohesively as a regional team.**
- Develop workflows for introducing MAT into 6 CHMG and DHC locations - **Workflows are done and will be used to introduce the practices to MAT.**
- Attend 6 CoC meetings as a representative of the IDN2 - **This was accomplished by the IDN2 Managing CEO.**
- Distribute recruitment materials to at least 25 primary care providers about getting their x waiver and participating in the IDN2 MAT project - **This recruitment material was sent out.**
- Provide training for 10 non-clinical staff in “See the Person; not the Illness” - **This particularly curriculum was not used during this time frame. Finding the time and space to accomplish the training proved to be insurmountable. IDN2 is developing a self-paced training for non-clinical staff at the CHMG and DHC practices to be available April 2018. Riverbend non-clinical staff received:**
 - **Ethics for Non-Clinical Staff - Nov. 2017**
- Provide MAT presentations to 3 community groups - **This was accomplished**
 - **PAT/MAT was presented to Riverbend’s board of directors**
 - **Framing Addiction Care Effectively by Understanding Pathways, Uniting People, Undoing Prejudice, and Utilizing (best) Practices (FACE-UP) is a monthly community of practice meeting at Concord Hospital attended by MAT providers, PC providers, BH providers, peers, and interested community partners.**
- Provide SUD-focused education/trainings for 6 IBHCs - **All 6 IBHCs attended:**
 - **Implementing Medication-Assisted Treatment (MAT) Organizational Considerations and Workflows - May 2017**
 - **MAT + Buprenorphine Training for Behavioral Health Staff - October 2017**
 - **FACE-UP - Monthly**
- Provide SUD-focused education/training for 12 medical providers - **The following**

trainings occurred during this time frame and reached more than 50 medical providers:

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

Jan - June 2018

- **Communicate HUB & SPOKE model to all primary care practices in IDN2 and provide template workflows and protocols**
- **Provide HUB & SPOKE (induction through full continuum of care) and mentoring support to 10 MAT providers**
- ~~● Convene existing MAT providers and IBHC each month to share best practices, review cases, and address challenges~~
- **Develop workflows for introducing MAT into 4 additional CHMG locations - Accomplished earlier**
- **Attend 6 CoC meetings as a representative of the IDN2**
- **Distribute recruitment materials to all CHMG and DHC primary care providers about getting their x waiver and participating in the IDN2 MAT HUB & SPOKE model project.**
- **Operationalize the use of SBIRT and provide training in it for primary care providers through the New Hampshire SBIRT IPE Training Collaborative**
- **Provide self-paced training and follow-up survey for 50 non-clinical staff in “See the Person, not the Illness”**

- Provide 3 MAT presentations
- Provide SUD-focused education/trainings for **all IDN IBHCs (12)**
- Provide SUD-focused education/training for 12 medical providers

July - Dec 2018

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

Governance

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

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

The Finance Committee develops the budget and provides financial reports.

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

The Clinical + HIT Committee:

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

Concord Hospital Medical Group, Dartmouth Hitchcock-Concord.

Timeline **with updates:**

July - Dec 2017

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

Jan - June 2018

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

July - Dec 2018

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

Budget

IDN2 has a finance committee that oversees revenue and expenses and provides reports to the IDN Committee. The Project Director manages the day to day budget and approves invoices and expenses. IDN2 also has an accountant who processes accounts payable and receivable and prepares financial reports. The process for developing the annual budget is that the Project Director and Managing CEO prepare a draft with input from project staff (October). That draft is

presented to the Executive Committee (October) for approval. Once they have approved and/or any requested changes have been made, it goes to the Finance Committee (November) and is finalized for IDN Committee approval (November).

July - Dec 2017

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

Jan - June 2018

- 6 Finance Committee Meetings
- **Develop and present quarterly budget report for the IDN Committee**

July - Dec 2018

- 6 Finance Committee Meetings
- Draft, review, and approve 2019 budget

Please see the approved 2018 budget, 2017 actual versus expenses, and a five-year cash flow following:

IDN2	Approved 2018 Budget	Actual 2017 Expenses	Approved 2017 Budget
Administration			
Salaries & Benefits (CH)	35,647	55,108	57,282
Payroll Taxes (CH)	2,953	2,129	2,953
Purchase Services / Professional (non-CH staff)	238,485	107,620	137,796
Consulting Fees	153,000	204,134	194,304
Travel	4,000	2,778	4,000
Meeting Supplies	2,300	261	2,300
Office Supplies	5,000	486	0
Office Minor Equipment	5,000	7,181	20,000
Insurance / Other - Malpractice Insurance	15,000	5,000	5,000
Legal Services	20,000	0	20,000
Auditing Services	25,000	0	40,000
Advertising and Staff Recruitment	54,000	33,481	54,000
Total	560,385	418,178	537,635
Peers			
Purchase Services / Professional (non-CH staff)	286,000	90,325	154,719
Outside Training (IPS)	7,000	16,449	55,000
Other Direct Expense	0	2,024	0
Total	293,000	108,798	209,719
Health Information Technology			
Purchase Services / Professional (non-CH staff)	39,312	0	0
Minor Equipment	25,000	9,833	62,500
Software Applications	281,000	16,516	455,000
Total	345,312	26,349	517,500
Integrated Health Care			
Purchase Services / Professional (RB)	1,304,883	293,640	514,042
Purchase Services / Professional (CH)	378,845	18,360	75,570
Outside Training	44,750	449	30,000
Other Direct Expenses	0	23,950	0
Total	1,728,478	336,399	619,612
Community Re-Entry			
Consulting Fees	0	40,004	40,000
Purchase Services / Professional (non-CH staff)	251,009	113,287	166,252
Other Direct Expense (Includes testing supplies)	11,755	4,367	11,755
Total	262,764	157,658	218,007
Medicated Assisted Treatment			
Purchase Services / Professional (RB)	230,809	26,957	42,872
Purchase Services / Professional (CH)	82,760	5,520	5,520
Outside Training (PAT Parent Education)	25,000	0	0
Incentives - Processed thru HR	55,000	0	35,000
Total	393,569	32,477	83,392
Enhanced Care Coordination			
Purchase Services / Professional (non-CH staff)	188,826	74,341	130,642
Training & Coaching	16,500	3,396	17,500
Travel	15,000	388	0
Other Direct Expense (Flex Funds)	30,000	0	0
Total	250,326	78,126	148,142

Budget Detail

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

Administration

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

Peers

- Purchase Services / Professional (non-CH staff) - For NAMI NH, YouthMove, and Riverbend to provide peers for the IDN2 projects
- Outside Training (IPS) - Training the Trainer in Intentional Peer Support
- Other Direct Expense - Travel, supplies, as needed

Five-Year Cash Flow

Calendar Year	2016	2017	2018	2019	2020	2021	Total
Capacity Building Funds	3,063,145						
May MAX Incentive Funds (July - Dec)			1,301,927	1,301,927	1,379,017	1,379,017	
Nov MAX Incentive Funds (Jan - June)		1,301,927	1,301,927	1,379,017	1,379,017		
INCOME	3,063,145	1,301,927	2,603,854	2,680,944	2,758,034	1,379,017	13,786,921
ROLLOVER from previous year	0	2,940,429	3,084,371	1,854,391	535,335	-706,631	
Calendar year ASSETS	3,063,145	4,242,356	5,688,225	4,535,335	3,293,369	672,386	
Calendar Year EXPENSES	122,716	1,157,985	3,833,834	4,000,000	4,000,000		13,114,535
NET	2,940,429	3,084,371	1,854,391	535,335	-706,631	672,386	672,386

DSRIP IDN Process Milestones

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

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

Project A1: Behavioral Health Workforce Capacity Development

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

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

Timeline **with updates:**

July - Dec 2017

A1. BH Workforce Development

- Hire and train mental health peers through Riverbend - **Deferred to next time period due to taking the time to meet with all peer supervising staff / peers within IDN2 to identify needs, capacity, and to ensure consistency in training and expectation across the peer workforce. Developed new job description. Made decision to have cross-trained peers in both SUD and mental health. IDN2 had originally been working with HOPE for NH Recovery through a contract that was deemed not favorable to IDN2 and which HOPE for NH Recovery was unable to renegotiate. The contract paid for full-time employees instead of a per diem or hourly rate for services actually provided and had a start date that was in advance of when IDN2 was actually able to use peers. In addition, IDN2's primary contact at HOPE for NH Recovery was unavailable to us for over a month without explanation. IDN2 parted amicably with HOPE for NH Recovery and will refer to them in the future if they maintain a Concord site.**
- Riverbend to conduct a market analysis of its pay scale - **This was accomplished**
 - In 2017 Riverbend committed to analyzing the New Hampshire labor market in human service to determine the level of competition for various disciplines in the Behavioral Health workforce. There were two objectives: how much do wages and salaries need to be adjusted to maintain competitive position for the Agency in the current labor market, and how do the Agency's benefits match up with what is available in the region and beyond? As background the Community Mental Health Center's struggle to hire for vacant positions in all disciplines. At present, there are 185 clinical positions open in the system, 27 of those are at Riverbend. IN line with the Statewide Workforce Taskforce goal of evaluating wages, salaries and benefits across the State, Riverbend matched that objective on a local level. In addition, as background, Medicaid Fee Schedules for the Community Mental health system have not been raised since 2006, in fact they have been reduced twice since then. A review of wages and benefits showed that the Agency was behind significantly with its Regional competitors and as a consequence staff that had benefitted from supervision for independent licensure were leaving once they obtained that status and were taking employment with school systems, hospitals and ironically with Managed Medicaid Organizations who pay the rates that the CMHC's receive. The result of the review was that Riverbend gave its employees two cost of living adjustments in 2017 and two bonuses which amounted to around \$750 000. This has done a number of things; it has started to improve turnover in the agency, from 22% to around 18% over the past quarter. It

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

A2. HIT

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

B1. INTEGRATION

- IBHCs complete nine-month Learning Collaborative: SAMHSA-HRSA Center for Integrated Health Solution’s (CIHS) “Innovation Community Circle of Support - Engaging Loved Ones in Health and Wellness.” - **This was accomplished**
- Hire and train 2 additional IBHCs
- **7 IBHCs receive 3 trainings related to integrated health - This was accomplished.**
IBHCs attended:
 - **Implementing Medication-Assisted Treatment (MAT) Organizational Considerations and Workflows - May 2017**
 - **MAT + Buprenorphine Training for Behavioral Health Staff - October 2017**
 - **FACE-UP - Monthly**
- Identify and schedule future training opportunities for PCPs - **This was accomplished**
 - **2 Primary care practice providers received motivational interviewing training**
 - **Motivational Interviewing**
 - **Epsom Family Medicine - August 2017**
 - **Internal Medicine Pillsbury - September 2017**
- Develop plan for CHMG practices with low Medicaid numbers (staffing, coordinated/integrated) - **Instead of making one plan, IDN2 is taking the approach of continually assessing and guiding what works. Expansion to other CHMG sites was halted during this period of time to allow for the Cerner implementation. Here are the IDN2 primary care practice sites and their current and projected level of behavioral health staffing:**

IDN2 Practice	Medicaid Most to Least	IBHC and Care Coordinator Staffing Update (Psychiatric staff beginning March 2018)
Dartmouth Hitchcock Concord	1	Staff turnover. IDN2 planned for 2 IBHCs in DHC and have heard from DHC that they might not want/need 2 individuals. DHC is following an overall DH model and is not focused on Medicaid lives and IDN2 is unwilling to fund any positions that don't focus on Medicaid lives. At this point, we have decided, after discussions with DHC, that they will hire one IBHC directly and IDN2 will fund the position.
CH Family Health Center	2	IDN2 added 1 Care Manager to the 6 existing IBHCs
Concord Family Medicine	3	IBHC embedded; applied for another position in IDN; replacement already hired for no gap in service
Family Physicians of Pembroke	4	IBHC embedded

Penacook Family Physicians	5	IBHC embedded
Epsom Family Medicine	6	IBHC embedded
Family Care of Concord	7	Pending conversation with DHHS and a plan for addressing sites with low Medicaid numbers
Family Tree Warner	8	Pending conversation with DHHS and a plan for addressing sites with low Medicaid numbers
Family Tree Hopkinton	9	Pending conversation with DHHS and a plan for addressing sites with low Medicaid numbers
Pleasant Street Family Medicine	10	Pending conversation with DHHS and a plan for addressing sites with low Medicaid numbers
Internal Medicine Pillsbury	11	Pending conversation with DHHS and a plan for addressing sites with low Medicaid numbers
Family Tree Concord	12	Pending conversation with DHHS and a plan for addressing sites with low Medicaid numbers
Internal Medicine HP	13	Pending conversation with DHHS and a plan for addressing sites with low Medicaid numbers

- Contract with NAMI NH to provide “See the Person, Not the Illness” for non-clinical staff in integrated sites - **This particularly curriculum was not used during this time frame. Finding the time and space to accomplish the training proved to be insurmountable. IDN2 is developing a self-paced training for non-clinical staff at the CHMG and DHC practices to be available April 2018. Riverbend non-clinical staff received:**
 - **Ethics for Non-Clinical Staff - Nov. 2017**
- 8 IBHCs meet monthly with the Concord Hospital Family Health Center (FHC) IBHCs to share best practices and support each other - **This was accomplished**

C2. REENTRY

- Hire Case Manager - **This was accomplished December 2017**
- Train Reentry staff in: - **This was accomplished November 2017**
 - Review of the Client Flow System: Orientation to the pathways through the reentry system from initial screening and assessment through post release programming. This process includes two major meetings: May 2017 and July 2017. The initial meeting was to discuss the need for a flow system from initial assessment to post release services; what is expected from whom; and how assessment tools, case management services, pre- and post-release programming, transitional case management, and support services are managed. The second meeting is to review the case flow system and responsibilities with all reentry staff.
 - Case Management Training: A review of evidence based case management strategies for offenders as they re-enter the community. This will include the process of coordinated case planning, transition services, use of a universal case plan, and evidence based chain of case planning and services.
 - Overview of Evidence Based Practices: Discussion of the best practice models in criminal justice and correctional settings including methodology for clients with

substance use and mental health disorders. This review will include the National Transition from Jail to Community Model, the Risk Need Responsivity Model, Criminogenic Risk and Need, and other successful evidence based systems.

- Outcome Data: This is designed to review the performance measures agreed to in reentry meeting and the methodology of collecting and reviewing that data for continuous quality improvement including:
 - Public Safety Indicators and Outcomes
 - Reduced re-offending, returns to jail, and length of jail stays for returning individuals
 - Reintegration Indicators and Outcomes
 - Reduced substance abuse and homelessness
 - Increased employment
 - Improved housing stability and improved mental health/health
 - Process Measures
 - Screening
 - Assessment
 - Referrals
 - Engagement
 - Service utilization
 - Completion
 - Assessments are the key to understanding your clients' needs
 - Make intelligent decisions based on evidence
 - Understand gaps in data collection and work toward building a better data infrastructure
 - Leverage existing resources

D1. MAT

- Extend FACE-UP Forum to IDN2 community - Ongoing forum at CH for anyone in the hospital or IDN including physicians, RNs, social workers, and etc. to come discuss cases or situations which involve patients with substance use disorders. The "FACE" portion of the name stands for "Framing Addiction Care Effectively" and the "UP" portion is alternately "Utilizing Best Practices", "Undoing Prejudice", and "Understanding Pathways". **This was accomplished. Flyer was emailed in advance to all IDN2 partner organizations and SUD community organizations.**
- Extend monthly Opioid meeting to IDN2 community - Existing meeting of pharmacists, supervising RNs, providers, and senior leadership at CH to educate around prescribing opioids as well as other potentially addicting medications. **This was accomplished.**
 - **The following trainings occurred during this time frame and reached more than 50 medical providers and IDN2 IBHCs:**
 - **Opioid use disorders in hospitalized patients June 22**
 - **Audience: Hospitalist physicians at Concord Hospital**
 - **Goals/objectives: understand the neurobiology of addictive disorders; identify the criteria of substance/opioid use disorders; review opioid withdrawal signs and symptoms and treatment options; understand best practices or continuum of care for patients with opioid use disorders**

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

E5. ECC

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

Jan - June 2018

A1. BH Workforce Development

- Hire and train mental health peers through Riverbend by June 30, 2018

A2. HIT

- Hire Data Analyst, ~~if needed~~

B1. INTEGRATION

- IDN2 staff will receive pay adjustments
- Hire 2 psychiatrists
- Hire and train 3 additional IBHCs
- Hire APRN (Medical)
- Hire ICC
- **30 PCPs receive 1 training related to behavioral health including SBIRT and/or MI to be offered through the NH Center for Excellence or other technical assistance center.**
- 7 nonclinical staff receive 1 training related to behavioral health

C2. REENTRY

- Staff receive 1 additional training module

D1. MAT

- 12 IDN2 members attend 1-3 MAT educational meetings ~~per month~~
- 2 PCPs attend NH Buprenorphine Waiver Training
- 2 PCPs complete the NP and PA 24-hour training requirement established by the Comprehensive Addiction and Recovery Act (CARA).

E5. ECC

- 3 Coordinators receive coaching from UNH IOD

July - Dec 2018

B1. INTEGRATION

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

C2. REENTRY

- Staff receive 1 additional training module

D1. MAT

- 12 IDN2 members attend 1-3 MAT educational meetings ~~per month~~

E5. ECC

- 3 Coordinators receive coaching from UNH IOD

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

From the IDN Workforce Capacity Development Implementation Plan, use the format below to identify the progress toward targets or goals that the project has achieved.

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

A1-5. IDN-level Workforce: Staffing Targets

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

Provider Type	IDN Workforce (FTEs)
---------------	----------------------

	Projected Total Need	Baseline Staffing on 6/30/17	Staffing on 12/31/17	Staffing on 6/30/18	Staffing on 12/31/18
A2 - Tech Support (.5)	1	1	1		
A2 - Data Analyst (.5)	1	0	0		
B1 - IBHC	10.4	6	7.4		
B1 - Case Manager	0	0	0		
B1 - IC Manager	1	1	1		
B1 - Psychiatrists	2	0	0		
B1 - MA	1	1	1		
B1 - PC TBD	1.75	N/A	0		
B1 - IBHC Supervisor	1	1	1		
C2 - Case Manager	1	1	1		
C2 - Psychiatric APRN (.3)	1	0	1		
C2 - MLADC	1	1	1		
C2 - BH Clinician	1	1	0		
D1 - MAT Co-Coordination (.2)	2	2	2		
D1 - BH TBD	2	N/A	0		
D1 - PAT Providers (.4)	2	2	2		
D1 - PAT Social Worker (.4)	1	1	1		
D1 - PAT MA (.4)	1	N/A	0		
E5 - ECC Supervisors (.2)	2	2	2		
E5 - ECC Intake	1	N/A	1		
E5 - ECC Coordinators	3	0	3		
All - Peers	5	4	2		

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

	2017 Actual	2017 Budget	2018 Budget	2019 Budget	2020 Budget
Hiring	622,431	1,180,853	2,762,444	3,000,000	3,000,000
Training	60,298	78,000	68,250	75,000	75,000
Job Advertising / Promotion	3,3481	54,000	54,000	54,000	54,000
Incentives for MAT providers	0	35,000	55,000	75,000	100,000

Hiring - Rather than hire all of the IBHCs IDN2 originally planned for, it was decided to proceed more methodically and see what was working, or not working, in those sites where IDN2 already had an embedded IBHC. In addition, toward the end of 2017, with the introduction of Cerner to the CHMG practices, it was decided that it would be better to wait for 2018 before introducing new staffing. In addition, the person who was supervising the IBHCs for IDN2 left the position in December and a new hire was made, elevating the position to Director of Integration. Rather than have the previous supervisor make the hires, IDN2 wanted to wait for the new person to become established, weigh in on the plan, and make the hires.

Training - Training continues to be an important aspect for IDN2. Wherever possible, IDN2 provides a variety of training opportunities for staff including online, webinar, self-paced, in person, one to one, and group training. IDN2 also pursues opportunities to contract with its partners to provide training.

Job Adverting/Promotion - Even with only 14% turnover during this time period, advertising for new positions does translate to a cost. In addition, IDN2 contracts with an agency to find and recruit psychiatrists for the demonstration project.

Incentives for MAT providers - Incentives for MAT providers were first available for the July-December 2017 time period and not payable until January 2018.

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

Updated list of key organizations and providers participating in the IDN to support workforce development within this reporting period.

Organization Name	Organization Type	Associated with IDN Projects (A1, A2, B1, C, D, E)
Riverbend Community Mental Health	Behavioral Health	A1, A2, B1, C2, D3, E5
Concord Hospital	Hospital	A1, A2, B1, D3, E5
Concord Hospital Medical Group	Primary Care Provider	A1, A2, B1, D3, E5
Concord Hospital Substance Use Services	SUD provider	B1, D3
Dartmouth Hitchcock Concord	Primary Care Provider	A1, B1, D3, E5
NH DOC	Correctional Facility	C2
Merrimack County DOC	Correctional Facility	C2
Sununu Youth Services Center	Correctional Facility	C2, E5
Concord Regional VNA	CBO, Home visiting	A2
Child & Family Services	Behavioral Health	B1, E5
UNH Institute on Disability	University, Education	E5
NAMI NH	CBO, Training, Peers	C2, E5
Ascentria	CBO, Training	C2, E5
Granite United Way	CBO, Training	B1, C2, E5
Youth Move	CBO, Peers	E5
New Hampshire Hospital	Psychiatric Hospital	E5

A1-9. Project Scoring: IDN Workforce Process Milestones

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

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

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

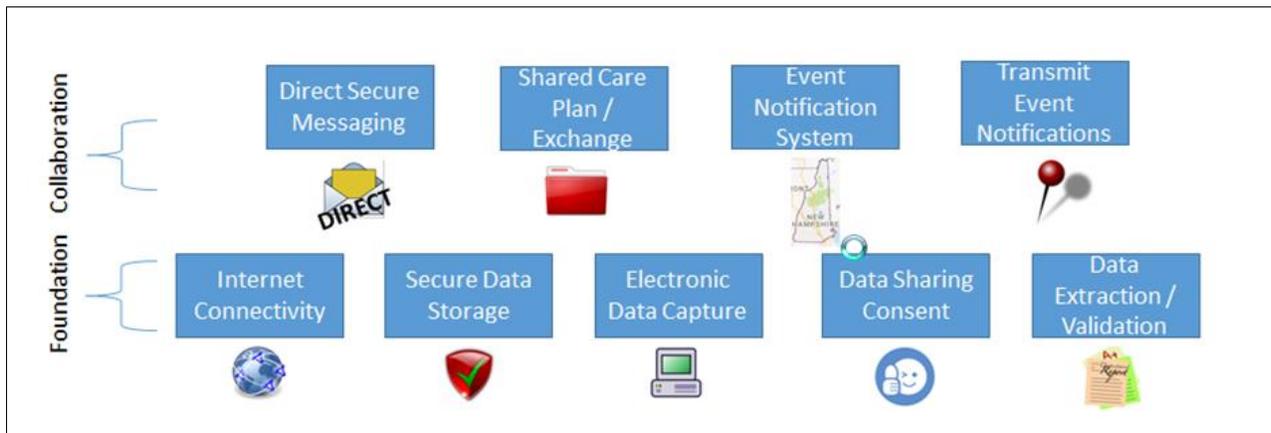
A2-3. IDN HIT/HIE: Implementation Plan: Requirements, Timeline, Milestones and Evaluation Project Plan

IDN Specific Foundations Recap

The foundation standards are required before moving to the collaborative standards. The foundation standards are being reviewed/evaluated by IDN 2 with member organizations during a site visit. Once site visits are completed, the IDN is creating action steps for appropriate implementation of the standards if required.

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

Figure 6. Standards



Technology Status

As of 12/31/17, IDN2 has performed 7 organization member site visits. Additional visits are scheduled in January, and the IDN is actively working to schedule the remaining visits. During the site visits, aspects of the foundation standards were reviewed: internet connectivity status, data storage and data capture ability, and determined if education or assistance obtaining is needed. Discussions during these visits included learning of each organizations’ day to day operations/process flow regarding how they receive new referrals, and the IT related/clinical based systems and processes they use accordingly.

IDN2 reviewed the functionalities of both the Kno2 products (including their integrated fax option) and the CMT products (event notification and the shared care plan) and how these products could interface within and streamline their current processes. Based on organizations

feedback, demos were and are being scheduled for either one or both products for the organizations' decision makers. IDN2 is currently working on following up with each of these organizations based on where they are at in the decision-making process and subsequent implementation.

Three of the 7 organizations visited to date already are a Kno2 client and use the system, but not to its full potential. IDN2 is collaborating with Crotched Mountain's IDN lead, to identify Concord area based providers to introduce the Kno2 product to them to allow for secure sharing of client information and better utilization.

IDN2 signed the CMT and MAeHC contracts. IDN2 is working with appropriate organizations to enroll in CMT and assisting with data submissions to MAeHC.

Crotched Mountain, at the time of their site visit, was submitting their CMT agreement that same week. They are upgrading their EMR in April 2018 allowing for an HL7 interface and will be starting to work with CMT and their EMR vendor right away to start mapping the necessary data requirements to enable them to immediately use an HL7 interface with CMT once their EMR update is done.

Riverbend is in the process of finishing their CMT enrollment. They are having their clinical and QA leads review and fill out the necessary forms and review current and new workflow processes.

Due to the Cerner upgrade that occurred on Dec. 1, 2017, Concord Hospital and CHMG changes needed for Cerner to capture discreet data for metrics for many of the projects will occur between March and June of 2018. They have identified the various areas where the information exists in Cerner and want to develop a one stop portal for providers to collect all of them.

CMT demonstrations are scheduled for dates in January for two of the service oriented organizations, GSIL and Fellowship Housing. A CMT representative will also attend Riverbend's Integration Workgroup in early February to assist them with rollout.

Site visits that are scheduled in January as of this report are Concord YMCA and Fellowship Housing.

Table 4. Providers in Scope

Key:

- 1. Data Extraction/Validation - Only for PCP & BH sites involved in Integration**
- 2. Internet Connectivity**
- 3. Secured Data Storage**
- 4. Electronic Data Capture**
- 5. Direct Secure Messaging**
- 6. Shared Care Plan**
- 7. Event Notification Service**
- 8. Transmit Event Notification**
- E Further evaluation needed**
- ✓ Implement**
- x will not implement**
- I already installed**
- IC Implementation Complete**

Name of Organization	PHI	Standards								Site Visit Done
		1	2	3	4	5	6	7	8	
Ascentria Care Alliance	Yes	x	✓	✓	✓	I	✓	✓	E	
Bhutanese Community of NH	Yes	x	✓	✓	✓	✓	E	E	E	
Boys & Girls Clubs of Greater Concord	Non-PCP/BH	x	x	x	x	x	x	x	x	
Capital Area Public Health Network	Non-PCP/BH	x	x	x	x	x	x	x	x	
CATCH Neighborhood Housing	Non-PCP/BH	x	E	E	E	E	E	E	E	
Community Action Program / ServiceLink	Yes	x	I	I	I	✓	✓	✓	E	✓
Concord Coalition to End Homelessness	Yes	x	I	I	I	✓	E	E	x	✓
Concord Family YMCA	Non-PCP/BH	x	✓	✓	✓	E	E	E	E	
Concord Hospital	Yes	✓	✓	✓	✓	I	✓	✓	✓	
Concord Hospital Substance Use Services	Yes	✓	E	E	E	E	E	E	E	
CHMG Primary Care Practices	Yes	✓	✓	✓	✓	I	✓	✓	✓	
Child and Family Services	Yes	✓	I	I	I	✓	✓	✓	✓	✓
Concord Human Services	E	E	E	E	E	E	E	E	E	
Concord Regional VNA	Yes	x	I	I	I	I	I	✓	✓	
Crotched Mountain	Yes	x	I	I	I	I	✓	✓	E	✓
Dartmouth Hitchcock	Yes	✓	✓	✓	✓	I	✓	✓	✓	
Families in Transition	Yes	✓	I	✓	✓	E	✓	✓	✓	
Fellowship Housing Opportunities, Inc.	Yes	✓	✓	✓	✓	✓	✓	✓	E	
Granite State Independent Living	Yes	x	I	I	I	I	✓	✓	E	✓
Life Coping, Inc.	Yes	x	E	E	E	E	E	E	E	
Merrimack County House of Corrections	Yes	x	✓	✓	✓	✓	✓	✓	E	
NAMI New Hampshire	Yes	x	I	I	I	✓	E	E	E	✓
New Futures	Non-PCP/BH	x	x	x	x	x	x	x	x	
NH Alcohol/Drug Abuse Counselors	Non-PCP/BH	x	x	x	x	x	x	x	x	
New Hampshire Hospital	Yes	✓	I	I	I	✓	✓	E	E	✓
NH DOC	Yes	x	E	E	E	E	E	E	E	
Riverbend CMHC, Inc.	Yes	✓	I	I	I	I	✓	✓	E	✓
Sununu Youth Services Center	Yes	x	E	E	E	E	E	E	E	

Priorities - Status as of 12/31/17

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

- Selection of data aggregator vendor for metric submissions
 - Procurement-MAeHC
 - Implementation-portal training starts 1/4/18
 - Metrics from Cerner-initial meetings were conducted in November and December and more detailed meetings with MAeHC and the IDN are scheduled for January 2018
- Data Sharing Agreements-required for data metric collection-IDN2 SAAS agreement signed and submitted to MAeHC
- Implementation of shared care plan/event notification-IDN Contracts signed with CMT. Further demos with CMT are scheduled for January for GSIL and Fellowship Housing and discussions will take place with Concord Hospital in January now that their Cerner implementation took place on 12/1/2017.
 - Integration into process flow-ongoing review and discussions
- On-site review of the foundation standards with each organization
 - As of 12/31/17, 7 site visits have been completed with action items in progress i.e.-Kno2/CMT demos sign up/follow up with decision makers based on site visit discussions
- Implementation of direct messaging and evaluation of process flow-ongoing
- Equipment for integrating behaviorist into practices-for any new hires, proper equipment was purchased by the organization that will manage the equipment and billed to the IDN
- Planning for closed loop referral process
- Assist with projects goals from each project - IT will assess the metrics from each IDN 2 project and if any EHR work is needed to capture discreet information; or if no EHR is present, a method to collect the data will be evaluated. A reporting schedule will then be developed. Reporting - capturing number served vs. projected and impact measures as defined in individual evaluation plans. Once Riverbend completes their EMR upgrade in June of 2018, they want to work with Netsmart, the vendor for their EMR product, TIER, in building direct interfaces to pull their metrics data for both MAeHC and CMT data requirements.

Direct Messaging - All organizations that collect PHI are being reviewed for direct messaging capabilities. Organizations that do not collect PHI will also be reviewed for process flow to determine if there is a benefit to having direct messaging capabilities (referrals could be received this way). Once organizations are identified, IDN2 will work directly with NHHIO's established vendor, Kno2, to implement their secure email product for those identified agencies.

Once the webmail product is installed, organizations will be visited again to assist with recommendations for process flow changes to incorporate the use of direct messaging. Organizations that have the ability to send and receive CCD documents within their EHR will be encouraged to do so. For agencies that will use the Kno2 webmail product - it does have the capability to receive CCD but not create one.

Table 5. Direct Messaging

Direct		12/31/17	6/30/18	12/31/18	6/30/2018
Identify agencies for direct implementation					
Engage with Kno2 to assist with product demos and implementation					
Contracting for Product					
Account set up					
Web training					
Process flow evaluation					
Ongoing Process flow/use evaluation					
Target for total completion 6/30/2018					
Has Direct Messaging	Will Implement	To be evaluated	N/A for Implementation		
8	1	8	4		

Event Notification

Organizations will be evaluated to determine if they are to send and/or receive event notifications for admission/discharge/transfer (ADT). If they are the sender of event notifications the IDN will work with the organization to assist in setting up the ADT feed with CMT. If they are an organization to receive, the IDN will work with the organization to determine/suggest work flow changes. Concord Hospital’s privacy committee will not approve the release of an ADT feed at this time. [Approval did come in January with changes made to their patient privacy statement.] Due to the Cerner implementation, Concord Hospital will not implement PreManage ED until first quarter 2018. Three of the support service based organizations visited expressed a big interest in both CMT products, especially the event notification. They shared with IDN2 how they currently do not get immediate notifications of their clients’ admissions to Hospital ER’s and could provide a much higher level of proactive client care coordination/case management if alerted to this event much sooner than they currently are.

Table 6. CMT PreManage ED (Only Concord Hospital)

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

Validation	Concord Hospital		
Historical File			
Build Historical File	Concord Hospital		
CMT Historical File	CMT		
IT Implementation Go			
Active Directory / SSO			
Investigate Issue	CMT/Hospital		
Identify Solution	CMT/Hospital		
Implement Solution	CMT/Hospital		
Clinical Kick Off			
User Provisioning			
Identify list of initial	Hospital		
Set up initial users	CMT		
Training			
ED providers on EDIE	CMT		
CM and SW on Portal	CMT		
Clinical/Project Go Live			

Shared Care Plan

The statewide HIT group evaluated shared care plan vendors based upon the criteria below and chose Collective Medical Technologies (CMT). Organizations that collect PHI are being evaluated for shared care plan implementation.

New Hampshire CMT PreManage IDN Implementation Plan

- The first step of implementation is with the hospitals since they drive the data for the clinics. The plan is to attain sufficient hospital involvement to gain critical mass with ADT feed sharing. The ADT feed was built at Concord Hospital, but is pending release from the Privacy committee.
- The second step is to engage the clinics that the IDN provides to CMT in a prioritized list. The highest priority clinics will be on boarded first and continue roll out until 100% of hospitals and clinics are connected to the PreManage network. Because Concord Hospital was focused on implementing a new EHR, IDN2 will work with community organizations first. Concord Regional VNA uploaded their active patient census file to the CMT portal in late December of 2017.
- A future phase will be to implement at community agencies that should only have access to limited information.

Table 8. PreManaged Community

PreManage Community Project Plan	Responsible Party	12/31/17	06/30/18
Contract Executed with IDN	IDN Lead	Completed	
Agreements signed by organizations	Each Organization	Each organization signs as they enroll	
Project Kickoff Call			

IT Implementation			
SFTP Setup	CMT/Concord Hospital		
Eligibility File			
Eligibility Design	Concord Hospital		
Upload to SFTP	Concord Hospital		
Test (Validate)	CMT		
Process to Production	CMT		
Automatic Pickup from SFTP Setup	CMT		
Evaluate other organizations that have capability to send ADT feed			
Follow steps 7-13 for each organization			
Clinical Implementation			
Onboarding Packet	CMT/Concord Hospital		
User Set up (Provisioning)	CMT		
Identify List of Initial Users	Clinic		
Cohorts Set up			
Notification Destination Set Up	CMT		
Reports Set up	CMT		
Training			
Account Managers/IT	CMT		
Clinical Staff	CMT		

Data Aggregator

MAeHC was chosen by all IDN's to be the data aggregator.

Below are activities that will need to take place for each organization/EMR that will be sending in data to MAeHC. For IDN 2, Child & Family Services, Concord Hospital/CHMG, Families in Transition, Fellowship Housing Opportunities (via Riverbend's EMR system reporting), NH Hospital, Riverbend, and Dartmouth Clinic will be submitting and validating their data for the required metrics. All other organizations do not qualify as they do not have providers performing office visits.

Table 10. Data Vendor - MAeHC

Workstream	Months											
	M 1	M 2	M 3	M 4	M 5	M 6	M 7	M 8	M 9	M1 0	M1 1	M1 2
Participant contracting	x											
Finalize requirements		x										
Set-up IDN QDC environment & portal			x									
Custom portal development (e.g., shared care plan)												
Build test source system interfaces												
Validate measures												
Ongoing reporting												

Metric process overview demonstrations were attended by representatives from Concord Hospital and Riverbend in December with follow up review meetings scheduled for early January 2018. Portal training is scheduled for early January 2018 as well.

Metrics for IDN 2 Individual Projects

Below are the metrics that are currently being manually collected for each project and each organization involved and being submitted to MAeHC. The future goal is to evaluate how to automate the process of retrieving and submitting these metrics in an automated, electronic format.

Table 11. Metrics for Individual Projects

Reentry Performance Measure Name	Target
# enrolled in SOAR and expected to receive reentry post-services	250
# completing 12 months of reentry post-services	200

Sites: Merrimack County DOC, NH DOC, Riverbend Community Mental Health

ECC Performance Measure Name	Target
Individuals served over the life of the project	99
Adherence rates	57
Participant satisfaction (Youth Progress Scale and Team Meeting Rating Scale)	High
Placement outside the home	Improvement
Academic performance	Improvement
School attendance	Improvement
# psychiatric hospitalizations	Improvement
# of juvenile offenses	Improvement
Improved behavioral health indicators (CANS for children and youth) or improved performance on developmental screening/assessment for 0-5 (Ages & Stages).	Improvement

Sites: Riverbend Community Mental Health, Child & Family Services

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

Sites: MAT = CHMG and DHC primary care practices (SPOKES)

and Choices at Riverbend and CH Substance Use Services (HUBS); PAT = DHC and CH OB-GYN

Integration

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

Data Analytics/APM/Population Health

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

Data Sharing Agreements

This is still currently being evaluated. Concord Hospital, as the lead agency of the IDN, has signed agreements with CMT and MAeHC as well as has a BAA with MAeHC. Dartmouth also signed the master agreement with MAeHC which covers DH clinic. The other organizations that will be submitting metrics is Child & Family Services, Families in Transition, Fellowship Housing Opportunities (via Riverbend’s Tier EMR), NH Hospital, and Riverbend. Therefore, a data sharing agreement is needed between the IDN and these organizations. At this time, reporting will be done by the IDN, therefore; individual organizations will not have the ability to see patient data from other organizations.

Table 12. IDN Specific Project Participation

Name of Organization	A1	A2	B1	C2	D1	E5	Referral	Training	Steering
Ascentria Care Alliance							x	x	x
Bhutanese Community of NH							x	x	x
Boys & Girls Clubs of Greater Concord							x	x	
Capital Area Public Health Network								x	x
CATCH Neighborhood Housing							x		x
Community Action Program							x		
Concord Coalition to End Homelessness							x		x
Concord Family YMCA							x	x	x
Concord Hospital, IDN2 Admin & Finance Lead	x	x	x		x	x	x	x	x
CHMG Primary Care Practices	x	x	x		x	x	x	x	x
Concord Hospital Substance Use Services	x	x	x		x	x			
Concord Hospital Ob-Gyn					x		x		
Child & Family Services	x	x	x		x	x	x		
Concord Human Services							x		x
Concord Regional VNA, IDN2 Tech Lead	x	x					x		x
Crotched Mountain							x		

Dartmouth Hitchcock Primary Care Practice	x	x	x		x	x	x		
Dartmouth Hitchcock Concord Ob-Gyn					x		x		
Families in Transition		x	x				x		
Fellowship Housing		x	x				x		
Granite State Independent Living							x		
Granite State United Way								x	
Granite Pathways							x		
Life Coping, Inc.							x		
Merrimack County DOC				x			x		x
NAMI New Hampshire	x				x	x		x	x
NH DOC				x			x		
NHADACA								x	
New Hampshire Hospital						x	x		
Riverbend CMHC, Inc., IDN2 Clinical Lead	x	x	x	x	x	x	x	x	x
Sununu Youth Services Center				x		x	x		
NH Institute on Disability								x	
Youth Move	x					x			

A2-4. IDN HIT: Evaluation Project Targets

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

Performance Measure Name	Target	Target # organizations*	Completion Date	Progress Toward Target		
				As of 12/31/17	As of 6/30/18	As of 12/31/18
Data Vendor	Data vendor will be selected to assist in collecting project metrics for the state and individual IDN projects	N/A	9/30/2017	MAeHC was chosen		
Secure Texting	Evaluate each project for need and implement	to be determined	3/31/2018	ongoing		
Closed loop referrals	Evaluate and implement referral process	to be determined	6/30/2018			
Data Sharing Agreements	Develop agreement for sharing data within the IDN and	7	12/31/2017	2 with MAeHC		

Signed	obtain signatures					
Data Vendor Implementation	Data vendor will be implemented to all organizations that must report metrics in order to achieve first reporting requirement	7	3/31/2018	in progress with CHMG, DH, Riverbend -others by 12/31/18		
Minimum standards assessment	Assess all organizations for baseline status regarding the 8 minimum standards.	27	12/31/2017	To date, have met with 7 organizations		
Direct messaging	All identified agencies will implement direct messaging	9	2/28/2018	1 of 7 organizations visited in process of signing up with Kno2.8 have DSM to date.		
Standards Education	Provide education/guidance to identified agencies for standards 2-4	17	3/31/2018	7		
Event Notification	All identified organizations will be sending ADT event notifications	1	6/30/2018	0		
Event Notification	All identified organizations will be sending/receiving event notifications	14	6/30/2018	0		
Shared Care Plan	All identified organizations will implement shared care plan	15	6/30/2018	0		
PreManage Ed	Implement PreManage ED	1	4/30/2018	0		
Equipment	All identified primary care practices will have designated equipment for integration	14	6/30/2018	8 have new equipment		

Integration	EMR will have fields built for data collection. Epic, Cerner, Tier, MCG	4	6/30/2018	0		
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Top Risks

Identifying risks at the DSRIP program level occurred at the HIT Task Force meetings and the work sessions through discussion and the consensus building process. These risks were discussed as they related to each organization at their completed site visits as of the end of December 2017.

Potential risks already identified by the HIT leads and the HIT Task Force participants include:

- Many community-based member organizations are non-covered entities as defined by the HIPAA Omnibus Rule, meaning they are not required to be familiar with policies and procedures regarding Protected Health Information (PHI). To mitigate this risk, additional education may be required for those who may handle PHI at these organizations, or become covered entities. Not necessarily all community-based organizations will have access to PHI or other sensitive information.
- Some IDN member organizations lack any IT infrastructure today and are more susceptible to not meeting the standards.
- While many IDN member organizations from each region participated in the HIT Taskforce, not everyone was represented. A couple of regions did not have their hospitals directly participate in the HIT Taskforce.
- If the sharing of data consents is implemented, a standard outside of the scope of HIT must be realized.
- The DSRIP program has a significant budget allocated for the implementation of the IDN's projects and HIT infrastructure over the course of the program; however, there is still a risk that not all IDN member HIT infrastructure projects will be fully covered by the budget because of other project priorities. Some financial reliance will be on the individual member organizations which could hamper implementation schedules over the course of the DSRIP program.
- Because technology is constantly evolving, specifically in the shared care plan and event notification service areas, there is a risk involved when choosing a solution. Many vendors and solutions are relatively new and there is potential that more robust solutions evolve and vendors may need to change over time.
- Concord Hospital and Concord Hospital Medical Group providers implemented Cerner on 12/01/2017. This places a risk on DSRIP because we must wait for implementation to occur in order to proceed with DSRIP implementation.
- Riverbend's Information Systems Department, in combination with the vendor, Netsmart, is currently in the process of upgrading their customized version of TIER with a projected completion of June 30, 2018.

A2-5. IDN HIT: Workforce Staffing

- Organizations that already have an EMR also have IT departments that consist of support and data analyst. Those organizations will use their staff to extract data, create additions

for the EMR etc. The staffing positions being proposed are to assist with the coordination across all organizations and the 1115 project.

- IDN is budgeting for IT support at 20 hours per week and a data analyst for 20 hours per week
- Data Analyst - As of 12/31/17, the IDN is waiting to better understand the skills that will be needed once the IDN has access to the MAeHC portal.

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

A2-6. IDN HIT: Budget

Health Information Technology	2018 Budget	2017 Actual	2017 Budgeted
Purchase Services / Professional (non-CH staff)	39,312		
Minor Equipment	25,000	9,833	62,500
Software Applications	281,000	16,516	455,000
Total	345,312	26,349	517,500

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

When IDN2 budgeted for HIT for 2017, there was no depth of knowledge regarding the data aggregation or shared care plan software requirements or when something like that might be implemented so the budget was very high to accommodate multiple potential scenarios.

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

Organization Name	Organization Type
Concord Regional VNA	Home Health and Hospice
Riverbend	Community Mental Health
Concord Hospital/CHMG	Hospital, Primary care
Ascentria	CBO
Crotched Mountain	Home and Community based care provider
Dartmouth Hitchcock	Primary Care
Child & Family Services	Non-CMHC MH provider

A2-8. IDN HIT: Data Agreement

- The statewide HIT taskforce evaluated vendors to assist in the collecting of the metrics for submission and chose MAeHC. Please note-Fellowship uses Riverbend's Tier EMR and their data will be collected and submitted by Riverbend's data reporting staff.
- Target is 12/31/17 - **this was achieved**

- **CH/CHMG has signed the agreement with MAeHC on behalf of CH, CRVNA, and RB (as CRHC). We will have Child and Family Services, Families in Transition, Fellowship Housing Opportunities, NH Hospital, and Riverbend sign with the IDN.**

Organization Name	Data Sharing Agreement Signed
Child & Family Services	To be signed with IDN
Families in Transition	To be signed with IDN
Fellowship Housing	To be signed with IDN
NH Hospital	To be signed with IDN
Concord Hospital	Y with MAeHC, to be signed with IDN
CHMG Medical group	Y with MAeHC, to be signed with IDN
Dartmouth Hitchcock	Y with MAeHC, to be signed with IDN
Riverbend CMHC, Inc.	To be signed with IDN

A2-9. Project Scoring: IDN HIT Process Milestones

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

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

Project B1: Integrated Healthcare

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

Timeline with updates

Dartmouth Hitchcock Concord	
Jan -Jun 2017	<ul style="list-style-type: none"> • Budget - This was accomplished • Workforce gap analysis and plan - This was accomplished • Assessment of current state of integration - This was accomplished • Assessment of ability to collect outcome measures 1 & 2 - This was accomplished • HIT assessment and plan - This was accomplished • Implementation plan and timeline for semi-annual report - This was accomplished
July - Dec 2017	<ul style="list-style-type: none"> • 1 BH staff hired, trained, credentialed, & co-located - This person resigned in Dec. 2017 and it has been decided that DHC will hire the person and IDN2 will fund the position. DHC is following a DH model not an IDN2 model and it becomes too difficult to have an embedded IBHC that is following a separate model. This may have contributed to the pervious IBHC resigning. • 1 BH staff hired, trained, credentialed, & co-located - Only 1 BH staff person will be at DHC due to their not focusing on Medicaid lives. The amount of Medicaid lives they expect to serve can be covered by 1 BH staff person. • PCP, BH, & non-clinical trainings identified and documented - BH Training for flow staff completed Nov 15. MH Training for all staff completed 1/26/18 and additional BH training for providers scheduled 2/21/18 • Identify and develop any new protocols/processes required for integration Introduce/train staff in use of protocols/processes - In progress not completed. Awaiting available system resources to automate and operationalize workflows. • Clinical workflows finalized - See response above • Begin data collection for outcome measures 1 & 2 - All DH entities are reporting 0 at this time • Assessment of ability to collect outcome measures 3 & 4 - This was accomplished. • Introduce CMT (shared care plan/event notification) - This was accomplished through a presentation by CMT • Provide CMT training for users - This was accomplished through a series of presentations by CMT. • Provide data for semi-annual report - This was accomplished
Jan - Jun 2018	<ul style="list-style-type: none"> • Begin data collection for outcome measures 3 & 4 • CCSA in use • PCP, BH, & non-clinical trainings scheduled • Monthly high need case conferences established/in use • HIT + Clinical Committee - monthly process & outcome review
July - Dec 2018	<ul style="list-style-type: none"> • Monthly high need case conferences established/in use • CMT in use • Closed loop referrals in use • Coordinated Care Practice status achieved • Data collection outcome measures 1-4

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

	<ul style="list-style-type: none"> • Provide CMT training for users - This was accomplished through a series of presentations by CMT. • Provide data for semi-annual report - This was accomplished
Jan - Jun 2018	<ul style="list-style-type: none"> • Begin data collection for outcome measures 3 & 4 • PCP, BH, & non-clinical trainings scheduled • High need case conference meetings established/in use • CMT in use • Closed loop referrals in use • Use of technology to identify, plan, and manage high risk needs • Develop referral protocols for CBOs • HIT + Clinical Committee - monthly process & outcome review • MAT & Depression EBP protocols in place • Provide data for semi-annual report
July - Dec 2018	<ul style="list-style-type: none"> • Clinical processes in place to support all outcome measures • Data collection outcome measures 1-4 • Monthly case review meetings • Annual cross training of BH, PCP, and non-clinical staff • HIT + Clinical Committee - monthly process & outcome review • Provide data for semi-annual report

Concord Hospital Primary Care Practices

Jan - Jun 2017	<ul style="list-style-type: none"> • Budget - This was accomplished • Workforce gap analysis and plan - This was accomplished • Assessment of current state of integration - This was accomplished • Assessment of ability to collect outcome measures 1 & 2 - This was accomplished • HIT assessment and plan - This was accomplished • Implementation plan and timeline for semi-annual report - This was accomplished
July - Dec 2017	<ul style="list-style-type: none"> • All BH staff hired & co-located in the first wave of CHMG sites - These are the practices that have an integrated IBHC: <ul style="list-style-type: none"> ○ Family Health Center Concord ○ Family Health Center Hillsboro-Deering ○ Concord Family Medicine ○ Family Physicians of Pembroke ○ Penacook Family Physicians ○ Epsom Family Medicine • PCP, BH, & non-clinical trainings identified and documented - As described in the BH Workforce Development section, PCPS are going to receive Motivational Interviewing (MI) and Screening, Brief Intervention, and Referral to Treatment (SBIRT) training; BH have/will receive Metabolic Syndrome training (Metabolic syndrome is a cluster of conditions — increased blood pressure, high blood sugar, excess body fat around the waist, and abnormal cholesterol or triglyceride levels — that occur together, increasing one’s risk of heart disease, stroke and diabetes); and IDN2 is developing a self-paced training for non-Clinical staff focused on stigma reduction. • Identify and develop any new protocols/processes required for integration Introduce/train staff in use of protocols/processes - Reviewed; Privacy forms to be updated January 2018

	<ul style="list-style-type: none"> • Site Self Assessments begin / every 3 months - This was accomplished in November. Report is Attachment A. • Clinical workflows finalized - This was accomplished. Workflow is Attachment B. • Develop mechanisms for collecting/reporting data in Cerner - Cerner went live December 2017 and this is in progress. 99% of the elements exist in Cerner and CH wants to create a user-friendly portal to collect them in one place. • Assessment of ability to collect outcome measures 3 & 4 - This was accomplished. Ability exists. • Introduce CMT (shared care plan/event notification) - This was accomplished through a presentation by CMT • Provide CMT training for users - This was accomplished through a series of presentations by CMT. • Provide CMT training for users - This was accomplished through a series of presentations by CMT. • Provide data for semi-annual report - This was accomplished
<p>Jan - Jun 2018</p>	<ul style="list-style-type: none"> • B1 workflows and core team established at the second wave of CHMG sites: <ul style="list-style-type: none"> ○ Pleasant Street Family Medicine ○ Family Care of Concord ○ Family Tree Concord ○ Family Tree Hopkinton ○ Family Tree Warner ○ Internal Medicine at Concord Hospital ○ Internal Medicine at Horseshoe Pond ○ Concord Hospital Substance Use Services • Begin data collection for outcome measures 1 & 2 • Begin data collection for outcome measures 3 & 4 • PCP, BH, & non-clinical trainings scheduled • For first wave of CHMG sites: <ul style="list-style-type: none"> ○ Hire Psychiatrist ○ CCSA in use ○ High need case conference meetings established/in use ○ Shared Care Plan in use ○ Closed loop referrals in use ○ Use of technology to identify, plan, and manage high risk needs ○ Develop referral protocols for CBOs ○ HIT + Clinical Committee - monthly process & outcome review ○ MAT & Depression EBP protocols in place • HIT + Clinical Committee - monthly process & outcome review • Provide data for semi-annual report
<p>July - Dec 2018</p>	<ul style="list-style-type: none"> • Data collection outcome measures 1-4 • For first wave of CHMG sites: <ul style="list-style-type: none"> ○ Monthly case review meetings ○ Annual cross training of BH, PCP, and non-clinical staff ○ Clinical processes in place to support all outcome measures • For second wave of CHMG sites: <ul style="list-style-type: none"> ○ CCSA in use ○ High need case conference meetings established/in use

	<ul style="list-style-type: none"> ○ CMT in use ○ Closed loop referrals in use ○ Develop referral protocols for CBOs • HIT + Clinical Committee - monthly process & outcome review • Provide data for semi-annual report
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Timeline for Child & Family Services, Families in Transition, and Fellowship Housing Opportunities (through Riverbend) to be developed Jan - Jun 2018 pending communications with DHHS and other IDNs in how to onboard organizations with statewide presence who are reluctant to commit to the B1 project.

B1-3. IDN Integrated Healthcare: Evaluation Project Targets

Performance Measure Name	Target	Target # organizations*	Completion Date	Progress Toward Target		
				As of 12/31/17	As of 6/30/18	As of 12/31/18
Data Vendor	Data vendor will be selected to assist in collecting project metrics for the state and individual IDN projects	N/A	9/30/2017	MAeHC was chosen		
Secure Texting	Evaluate each project for need and implement	to be determined	3/31/2018	ongoing		
Closed loop referrals	Evaluate and implement referral process	to be determined	6/30/2018			
Data Sharing Agreements Signed	Develop agreement for sharing data within the IDN and obtain signatures	3	12/31/2017	2 with MAeHC		
Data Vendor Implementation	Data vendor will be implemented to all organizations that must report metrics in order to achieve first reporting requirement	3	3/31/2018	in progress with all 3		
Minimum standards assessment	Assess all organizations for baseline status regarding the 8 minimum standards.	27	12/31/2017	To date, have met with 7 organizations		
Direct messaging	All identified agencies will implement direct messaging	9	2/28/2018	1 of 7 organizations visited in process of signing up with Kno2.8 have		

				DSM to date.		
Standards Education	Provide education/guidance to identified agencies for standards 2-4	17	3/31/2018	7		
Event Notification	All identified organizations will be sending ADT event notifications	1	6/30/2018	0		
Event Notification	All identified organizations will be sending/receiving event notifications	14	6/30/2018	0		
Shared Care Plan	All identified organizations will implement shared care plan	15	6/30/2018	0		
PreManage Ed	Implement PreManage ED	1	4/30/2018	0		
Equipment	All identified primary care practices will have designated equipment for integration	14	6/30/2018	8 have new equipment		
Integration	EMR will have fields built for data collection. Epic, Cerner, Tier, MCG	4	6/30/2018	0		

B1-4. IDN Integrated Healthcare: Workforce Staffing

Changes are in **bold type**.

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	10.4	6	7.4		
B1 - Case Manager	0	0	0		
B1 - IC Manager	1	1	1		
B1 - Psychiatrists	2	0	0		
B1 - MA	1	1	1		
B1 - PC TBD	1.75	N/A	0		
B1 - IBHC Supervisor	1	1	1		
B1 - Peer Recovery Coach	1	1	0		

B1-5. IDN Integrated Healthcare: Budget

Integrated Health Care	2018 Budget	2017 Actual	2017 Budget
Purchase Services / Professional (RB)	1,304,883	293,640	514,042

Purchase Services / Professional (CH)	378,845	18,360	75,570
Outside Training	44,750	449	30,000
Other Direct Expenses	0	23,950	0
Total	1,728,478	336,399	619,612

Purchase Services / Professional (RB)

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

Purchase Services / Professional (CH)

This represents the embedded primary care providers (APRN and MA) hired by Concord Hospital and working within Riverbend's Integrated Center for Health as well as an Integrated Care Manager (ICM) hired by Concord Hospital to work within the Family Health Center.

Outside Training

This represents training provided by a non-Concord Hospital employee. It is intended to cover the required training for PC and BH providers and non-Clinical staff within the integrated sites as well as additional training for IBHCs.

Other Direct Expenses

In 2017, this expense represented office expansions necessary to accommodate new employees for the integration project.

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

Organization/Provider	Agreement Executed (Y/N)
Child and Family Services	N
Concord Family Medicine	Y
Concord Hospital	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
Families in Transition	N
Family Care of Concord	Y
Family Physicians of Pembroke	Y
Family Tree Concord	Y
Family Tree Hopkinton	Y
Family Tree Warner	Y
Fellowship Housing Opportunities	N
Internal Medicine at Concord Hospital	Y
Internal Medicine at Horseshoe Pond	Y
Penacook Family Physicians	Y
Pleasant Street Family Medicine	Y
Riverbend Community Mental Health	Y

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

Not applicable.

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

B1-8A Comprehensive Core Standardized Assessment - Ability to Collect

Please see narrative below for description of work completed this report period.

CCSA Domain	DHC	1st Wave of CHMG	2nd Wave of CHMG	RB and FH	CFS, FIT
Demographic information	Y	Y	Y	Y	TBD
Physical health review	Y	Y	Y	Y	TBD
Substance use review	Y	Y	Y	Y	TBD
Housing assessment	Y	Y	Y	Y	TBD
Family and support services	Y	Y	Y	Y	TBD
Educational attainment	Y	Y	Y	Y	TBD
Employment or entitlement	Y	Y	Y	Y	TBD
Access to legal services	Y	Y	Y	Y	TBD
Suicide risk assessment	Y	Y	Y	Y	TBD
Functional status assessment	Y	Y	Y	Y	TBD
Universal screening using depression screening (PHQ 2 & 9)	Y	Y	Y	Y	TBD
Universal screening using SBIRT	Jun 2018	Jun 2018	Dec. 2018	Y	TBD
Validated developmental screening for all children, such as the ASQ 3 and/or ASQ SE at 9, 18 and 24/30 month pediatric visits	Y	Y		N/A	TBD
Developmental Screening using Bright Futures or other American Academy of Pediatrics recognized	Y - MCHAT	Y - MCHAT		Y-CANS	TBD

All sites currently have the ability to collect; however, the questions are scattered within the EHR and existing other screeners. This past period of time has been spent locating each piece of information; determining where/if it should be relocated and if so, when/where; designing a paper screener to implement before June 30, 2018; developing a method to incorporate the CCSA into the current patient workflow; testing out proposed workflows with practice managers and making adaptations; and working with IT departments to determine how best to capture information in the short term and to develop dashboards for the long term. Specifically:

The **Dartmouth Hitchcock (DH) Health System** analytics institute will be pulling data from the enterprise data warehouse for all the D-H clinics including Concord. The full CSA has not been implemented at any of the D-H clinics and they will be reporting O for this measure. They should be able to report on the # of Medicaid patients who had a PHQ-2 completed and then went on to have a PHQ-9. Currently in pilot at DH are 2 different "bundles" of screening questionnaires: behavioral health screener (alcohol, other drug, anxiety being asked in addition to the PHQ-2); Social Determinants of Health (SDoH) screener. These new screeners, which are the CCSA, are in test mode currently. The plan is to test, modify, revise, re-test, and then

disseminate and implement across all D-H clinics including Concord no later than December 31, 2018.

At the **CHMGs**, implementation of the CCSA was delayed due to a change from Centricity to Cerner EHR. During this time period, the CHMG IT department developed a crosswalk between the CCSA requirements and what currently exists in Cerner. They are currently developing a paper CCSA form. The questions already in Cerner mirror how they appear in the EHR. The additional questions will be placed into Cerner in 2019 and the entire CCSA will exist as a dashboard. The Integrated practices will begin collecting the CCSA, on paper, no later than June 30, 2018. The CCSA will be collected by the Medical Assistant (MA) during the rooming process. The CHMGs have been collecting similar information for 18 years and when an MA is hired, they learn the process by shadowing an experienced MA. The document used to describe the rooming process will now include the CCSA. Additionally, the Director of Integration is working on a “decision tree” for how the IBHCs will respond to various “positive” indicators.

Riverbend uses the Adult Needs and Strengths Assessment (ANSA) and the Child and Adolescent Needs and Strengths (CANS) as well as other screeners built into their EHR that cover all CCSA questions. They did a crosswalk between the CCSA and these documents to ensure that that was true. They are developing a way for the completion of these to activate a reportable “completed CCSA.” They also developed a protocol for completion of a “CCSA.” This will be in place no later than June 30, 2018.

B1-8b Core Team Members

Organization/Provider	PCP	Psych	IBHC	ICC	MAT
Dartmouth Hitchcock Concord	Y	Y	1 Turnover		1
CH Family Health Center	Y	Y	Y	Y	2
Riverbend / ICH	Y + 1.25 TBH	Y	Y	Y	1
Concord Family Medicine	Y	2 FTE hired to begin April - June 2018 and consult across practices	Y		2
Family Physicians of Pembroke	Y		Y		
Penacook Family Physicians	Y		Y		
Epsom Family Medicine	Y		Y		

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

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

All behavioral health staff hired for the IDN (as well as Riverbend’s Community Support Program staff) were trained in metabolic syndrome by (Metabolic syndrome is a cluster of conditions -- increased blood pressure, high blood sugar, excess body fat around the waist, and abnormal cholesterol or triglyceride levels — that occur together, increasing one’s risk of heart disease, stroke, and diabetes.) This training is also being offered to the Concord Hospital Family Health Center no later than June 2018. The training covered definition, symptoms, etiology, treatment, co- morbidities, and health disparities. PCPs and IBHCs also receiving on-going training as identified in the Behavioral Health Workforce portion of this report.

An online Motivational Interviewing (MI) course for 8 hours over the course of one month is offered every month to CHMG employees through a contract with Health Education & Training Institute (HETI) in Maine. Those who complete the course are eligible for coaching, which provides an opportunity to practice MI skills with different case scenarios and receive direct feedback from MI coaches. In addition, PCPs will receive SBIRT training no later than June 2018, most likely through the NH Center for Excellence.

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

Site	# Non-Clinical Staff	Goal	BH Training
Riverbend / ICH	93	93	Upon hire
Dartmouth Hitchcock Concord	9	9	Jan 2018
CH Family Health Center Concord / Hillsboro	As of 1/5/17 - CHMG had 152 non-clinical staff members	75	Jun 2018
Concord FM			Jun 2018
Family Physicians of Pembroke			Jun 2018
Penacook Family Physicians			Jun 2018
Epsom FM			Jun 2018
Family Tree Health Care - H/W			Jun 2018
Pleasant Street FM			Jun 2018

IDN2 is developing a self-paced training for non-clinical staff at the CHMG practices to be available April 2018. Riverbend non-clinical staff receive *Customer Service in a Mental Health Setting* as part of their new employee training. It includes customer service, triaging emergency calls, the basics of mental health diagnoses/symptoms, and the use of appropriate language, giving context to what they're seeing. Riverbend also provides Mental Health First Aid for all staff members.

B1-8e Core Team Case Conferences

CHMG Primary Care Practice Meetings				
	All Staff		Provider	
Concord Family Medicine	4th Friday	12-1pm	3/30, 4/27, 5/30, 6/26, 7/26, 8/31, 9/25, 10/30	6-8pm
Epsom Family	Every Wed	8-10am	4th Weds	8-10am
Family Care of Concord	1st and 4th Weds	12-1pm	2nd Wed	12-1pm
Family Physicians Pembroke	4th Thurs	12-1pm	4th Thurs	1-2pm

Family Tree- H/W	1st Monday	12-1pm		
Penacook Family	3rd Friday	12:15-1:30pm	4th Wed	7-8:30am
Pleasant Street	Varies		1st Tues	7-8am

B1-8f Secure Messaging

From the HIT Implementation Plan: All organizations that collect PHI are being reviewed for direct messaging capabilities. Organizations that do not collect PHI will also be reviewed for process flow to determine if there is a benefit to having direct messaging capabilities (referrals could be received this way). Once organizations are identified, IDN2 will work directly with NHHIO’s established vendor, Kno2, to implement their secure email product for those identified agencies.

Once the webmail product is installed, organizations will be visited again to assist with recommendations for process flow changes to incorporate the use of direct messaging. Organizations that have the ability to send and receive CCD documents within their EHR will be encouraged to do so. For agencies that will use the Kno2 webmail product - it does have the capability to receive CCD but not create one.

B1-8g Closed Loop Referrals

From the HIT Implementation Plan: Organizations will be evaluated to determine if they are to send and/or receive event notifications for admission/discharge/transfer (ADT). If they are the sender of event notifications the IDN will work with the organization to assist in setting up the ADT feed with CMT. If they are an organization to receive, the IDN will work with the organization to determine/suggest work flow changes. Concord Hospital’s privacy committee will not approve the release of an ADT feed at this time. [Approval did come in January with changes made to their patient privacy statement.] Due to the Cerner implementation, Concord Hospital will not implement PreManage ED until first quarter 2018. Three of the support service based organizations visited expressed a big interest in both CMT products, especially the event notification. They shared with IDN2 how they currently do not get immediate notifications of their clients’ admissions to Hospital ER’s and could provide a much higher level of proactive client care coordination/case management if alerted to this event much sooner than they currently are.

During this reporting period, Concord Hospital finalized their patient privacy statement and approved the ADT feed for CMT. This reporting period, IDN2 has participated in at least a dozen meetings within the region and with the State, other IDNs, and CMT to comprehend the implications of event notifications on patient consents. IDN2 has engaged in ongoing education about how to effectively and legally share information between IDN2 partners. This information will lead to the development of any new referral protocols that might be needed between IDN2 partners.

B1-8h Documented Work Flows and/or Protocols

DHHS Minimum Documented Protocols	DH-C	CHMG	RB
Intake procedures that include systematically soliciting patient consent to confidentially share information among providers	Y	Y	Y

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

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

DHHS will use the tool below to assess progress made by each IDN’s Integrated Healthcare Implementation Plan activities. Grayed areas indicate that no submission is expected for the time frame. A score of “Met” will be scored for a timely and complete submission. A score of “Not Met” will be scored for late and/or incomplete information.

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

Process Milestone Number	Process Detail	Submission Format	Results (Met/Not Met)			
			6/30/17	12/31/17	6/30/18	12/31/18
B1-8a	<p>All of the following domains must be included in the CCSA:</p> <p>Demographic information Physical health review Substance use review Housing assessment Family and support services Educational attainment Employment or entitlement Access to legal services Suicide risk assessment Functional status assessment Universal screening using depression screening (PHQ 2 & 9) and Universal screening using SBIRT</p>	<p>CCSAs (Submit all that are in use)</p> <p>Table listing all providers by domain indicating Y/N on progress for each process detail</p>				
	<p>For pediatric providers, the CCSA must also include:</p> <p>Validated developmental screening for all children, such as the ASQ:3 and/or ASQ SE at 9, 18 and 24/30 month pediatric visits; Developmental Screening using Bright Futures or other American Academy of Pediatrics recognized developmental</p>	<p>Table listing all providers by domain indicating Y/N on progress for each process detail</p>				
B1-8b	<p>List of multi-disciplinary core team members that includes, at minimum:</p> <p>PCPs Behavioral health providers (including a psychiatrist) Assigned care managers or community health worker</p>	<p>Table listing names of individuals or positions within each provider practice by core team</p>				
B1-8c	<p>Multi-disciplinary core team training for service providers on topics that includes, at minimum:</p> <p>Diabetes hyperglycemia Dyslipidemia Hypertension</p>	<p>Training schedule and Table listing all provider practice sites and number of individuals by provider</p>				

Process Milestone Number	Process Detail	Submission Format	Results (Met/Not Met)			
			6/30/17	12/31/17	6/30/18	12/31/18
	Mental health topics (multiple) SUD topics (multiple)	type to be trained, PCP or BH. Ongoing reporting shall indicate # of people trained in each practice by provider type for each reporting period for each training. OR you may provide a list of names of all individual providers to be trained in each provider practice. Ongoing reporting would indicate Y/N for participating individuals on progress for each training				
B1-8d	Training for staff not providing direct care that at minimum includes knowledge and beliefs about mental disorders that can aid in recognition and management	Training schedule and table listing all staff indicating progress on each process detail				
B1-8e	Monthly (or more frequent) core team case conferences on behalf of patients with significant behavioral health conditions or chronic conditions	Conference schedule and Table				
B1-8f	Secure messaging	Narrative				
B1-8g	Closed loop referrals	Narrative				

Process Milestone Number	Process Detail	Submission Format	Results (Met/Not Met)			
			6/30/17	12/31/17	6/30/18	12/31/18
B1-8h	<p>Documented work flows and/or protocols that include, at minimum:</p> <ul style="list-style-type: none"> Interactions between providers and community based organizations Timely communication Privacy, including limitations on information for communications with treating provider and community based organizations Coordination among case managers (internal and external to IDN) Safe transitions from institutional settings back to primary care, behavioral health and social support service providers Intake procedures that include systematically soliciting patient consent to confidentially share information among providers Adherence to NH Board of Medicine guidelines on opioid prescribing 	Work flows and/or Protocols (submit all in use)				

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

B1-9a. Coordinated Care Practice Designation

CCSA

As described elsewhere, Riverbend, DHC, and CHMG have been conducting crosswalks between their EHRs and the CCSA requirements. Each organization has been developing a paper CCSA document and mapping the processes required for implementing the CCSA into the practice including completion of document, review with patient, flagging items, communication between rooming staff and PCP, PCP communication with patient, methods of referral to embedded behavioral staff, behavioral health staff role in further assessment and referral to community based provider, role of NH 2-1-1, linkage to other IDN2 projects. This reporting period, each organization has met at least once per month with staff to work on the process. In addition, each organization’s leadership has met with IDN2 HIT, NH DHHS, and MAeHC at least monthly to understand how to accurately report the results of the CCSA.

Multidisciplinary Team

Though there have been a few turnovers, as described elsewhere, during this reporting period IDN2 assembled multidisciplinary teams, with the exception of a psychiatrist (hired in March 2018) at each of the locations it has flagged for Coordinated Care designation.

Cross Training

As described elsewhere, IDN2 trained both behavioral and primary care health providers during this reporting period. Behavioral health staff at the Family Health Center received the same Metabolic Disorder training this reporting period that the staff at the other CHMGs did last reporting period. New behavioral health staff were also trained this reporting period. Some CHMG PCPs received Motivational Interviewing (MI) training this period. IDN2 identified a combined MI/SBIRT training offered by the Center for Excellence to begin offering to PCPs spring 2018. In addition, IDN2 began development of a stigma reduction self-paced training for non-clinical staff this reporting period.

Case Conferences

The Integrated Center for Health at Riverbend has regular weekly case conferences for its high need patients. CHMG identified the monthly practice meetings as a way to identify these patients and have preliminary conversations about them.

Secure Messaging

During this reporting period, IDN2 has been conducting research and meeting about the use of Tiger Text for secure messaging. It was determined that in order to use Tiger Text to communicate with clients/patients, they would need to have phones capable of using SMS and Medicaid supplied phones are not SMS capable. We are discussing the possibility of using Tiger Text to communicate between providers, particularly in our PAT + ECC project, which involve four partners working with the same pool of clients/patients. Kno2 is also being reviewed for its capabilities to replace faxing and allow for secure messaging. Riverbend has a Kno2 license, which it has not used except at Franklin (in Region 5). Riverbend staff meet monthly and Kno2 is on the agenda for setting up contacts and usage policies. Concord Hospital has a product similar to Kno2 and already uses it effectively to send secure messages.

Closed Loop Referrals

IDN2 has been meeting regularly to look at how implementing CMT will assist with closed loop referrals from the integrated care sites to community based organizations. We also have a contract with NH 2-1-1 to provide case management of referrals to them, which we imagine will be plentiful. The details of workflow and protocols are still being worked out.

Documented Workflows

We have several drafts of these for Integration and MAT but none are final. They were drafted based on best practices and then shared with practice managers for a “reality check,” which resulted in changes. Some changes we also made based on final decisions about the CCSA and how the questions would be formatted on the paper document versus in Cerner. We have begun taking these drafts to the individual practices to see how they might need to be tailored even further for each’s use.

B1-9b. Additional Integrated Practice designation requirements

- MAT - Please see description of D1. MAT project
- Evidence based treatment of mild to moderate depression within the integrated practice setting - Protocols for this will be implemented June 2018 in DHC, RB, and CHMG practices.

B1-9c. Use of Technology

As described elsewhere, IDN2 has been meeting weekly with its partners, other IDNs, the state, and individual vendors to determine how best to use the available technologies including MAeHC, CMT, Kno2, and Tiger Text. IDN2’s HIT department has gone to IDN partner sites to assess their capabilities and educate them about the available technologies. CMT is in use in a few sites and is about to be implemented through Concord Hospital’s Emergency Department.

Use of Technology	DHC	CHMG	RB
Identify at risk patients	Dec 2018	Dec 2018	Dec 2018
Plan care	Dec 2018	Dec 2018	Dec 2018
Monitor/manage patient progress toward goals	Dec 2018	Dec 2018	Dec 2018
Closed loop referrals	Dec 2018	Dec 2018	Dec 2018

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

As stated above, all of these efforts to share care plans, employ secure messaging, use technology include community based service providers. During this reporting period, IDN2 HIT has worked with some of our partners to implement pieces of the eventual overall plan to use CMT.

Documented work flows with CBOs	DH-C	CHMG 1	RB
TBD	Dec 2018	Dec 2018	Dec 2018

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

DHHS will use the tool below to assess Integrated Healthcare Integrated Care Practice activities. A score of “Met” will be scored for a timely and complete submission. A score of “Not Met” will be scored for late and/or incomplete information.

Process Milestone Number	Section	Process Detail	Submission Format	Results (Met/Not Met)			
				6/30/17	12/31/17	6/30/18	12/31/18
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)	Protocols (Submit all in use)				

Process Milestone Number	Section	Process Detail	Submission Format	Results (Met/Not Met)			
				6/30/17	12/31/17	6/30/18	12/31/18
		Evidence-based treatment of mild-to-moderate depression within the Integrated Practice setting either through use of the IMPACT or other evidence-supported model					
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)				

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

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

	Total Goal Number Designated	Baseline Designated 6/30/17	Number Designated 12/31/17	Number Designated 6/30/18	Number Designated 12/31/18
Coordinated Care Practice	10	0	0	0	10
Integrated Care Practice	10	0	0	0	10

Coordinated Care Practice	List of providers identified to make progress toward Coordinated Care Practice designation ONLY	12/31/17	6/30/18	12/31/18
	Child and Family Services			x
	Concord Hospital			x
	Dartmouth Hitchcock Concord			x

	Families in Transition			X
	Family Care of Concord			X
	Family Tree Concord			X
	Family Tree Hopkinton			X
	Family Tree Warner			X
	Fellowship Housing Opportunities			X
	Internal Medicine at Concord Hospital			X

Integrated Care Practice	List of providers identified to make progress toward Integrated Care Practice designation inclusive of Coordinated Care	12/31/17	6/30/18	12/31/18
	Concord Family Medicine			X
	Concord Hospital FHC Concord			X
	Concord Hospital FHC Hillsboro			X
	Concord Hospital Substance Use Services			X
	Epsom Family Medicine			X
	Internal Medicine at Horseshoe Pond			X
	Family Physicians of Pembroke			X
	Penacook Family Physicians			X
	Pleasant Street Family Medicine			X
	Riverbend Community Mental Health			X

Projects C: Care Transitions-Focused

IDN Community Project Implementation and Clinical Services Infrastructure Plan

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

Project C2 Reentry Updates

Merrimack County Department of Correction (MCDOC)

Entry into IDN2's MCDOC Reentry Program is for those participating in the Successful Offender Adjustment and Reentry program (SOAR). Existing MCDOC staff participating in the reentry project include two SOAR Case Managers, the Program Director, LADAC, and reentry staff members

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

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

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

- Thinking for a Change 4.0 (T4C) is an integrated cognitive behavioral change program authored by Jack Bush, Ph.D., Barry Glick, Ph.D., and Juliana Taymans, Ph.D., under a cooperative agreement with the National Institute of Corrections (NIC). T4C incorporates research from cognitive restructuring theory, social skills development, and the learning and use of problem solving skills.
- Helping Women Recover is a 17 session, evidence-based treatment model that integrates theories of addiction, women's psychological development, and trauma. This curriculum is strengths-based and responsive to women's gender-specific needs for healing and support.
- Helping Men Recover is the first gender-responsive and trauma informed treatment curriculum for men. This 18-session program addresses male socialization in recovery, the relational needs of men, and abuse and trauma.
- Seeking Safety is an evidence-based model that can be used in group or individual counseling. It was specifically developed to help survivors with co-occurring trauma and SUD and, crucially, in a way that does not ask them to delve into emotionally distressing trauma narratives.
- Education classes are offered to men and women in the SOAR program who are working towards their High School Equivalency Assessment (HISET) with the goal to increase learning and, in some cases, work toward passing the HISET certification

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

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

The MCDOC and Riverbend Case Manager begin meeting with the reentering individual prior to release to develop a transition plan. This planning process takes about 2-4 weeks.

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

Aftercare can be required as a condition of probation. A partnership has already been established with Probation/Parole for the program, which will continue as the program expands.

Probation/Parole will invoke the use of graduated responses to violations, will collaborate with MCDOC and Riverbend staff on the case plans, and have access to the ORAS assessment results for community supervision determinants. This after care plan will be monitored by Riverbend.

All after care 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.

New Hampshire Department of Corrections (NHDOC)

Entry into IDN2's NHDOC Reentry Program is for those participating in the program pre-release from custody and returning to Region 2. Other offenders already participating in transition programs at the NHDOC will be provided treatment by NHDOC to avoid duplication of services

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

NHDOC offers a variety reentry programming to all individuals in their custody.

- NHDOC case management offers services to all individuals including but not limited to:
 - Finding suitable housing in the community
 - Assisting individuals in the application process for community behavioral health programs, substance abuse programs, mental health, and sexual offender treatment.

- Helping individuals apply for social services in the community, Medicaid health insurance, Supplemental Nutrition Assistance Program
- Assisting individuals to obtain a new copy of vital records while incarcerated, a NH Non-Driver's ID, Birth Certificate, or Social Security Card.
- NHDOC Reentry Program - NHDOC reentry program helps teach individuals life skills such as, balancing a checkbook, resume writing, and job searching and interviewing. The NHDOC reentry program covers NHDOC policies regarding programs such as administrative home confinement and earned time credit. The reentry program also reviews how individuals can get involved in treatment programs such as behavioral health services, educational and vocational programs. In addition, the reentry program teaches individuals life skills from balancing a checkbook to resume writing. Each individual will have a reentry plan developed that determines what needs they have that are potential barriers to their reentry and what interventions they will participate in prior to reentry to give them a better chance at a successful release.
- Thinking for a Change(T4AC) - On an individual basis each inmate is assessed for Thinking for a Change, a cognitive behavior therapy program that focuses on learning Social skills, Cognitive Self-Change, and Problem-Solving Skills.
- Religious Services- Religious services and programming is available at all locations within the NHDOC.
- Transitional Work Center – Minimum Security facility, preparation for Transitional Housing Units. At the Transitional Work Center (TWC) individuals going into the community on work crews, learning new skills and being provided on the job training. Programming such as Family Connections Center (FCC), T4AC and LADC services are also available.
- Transitional Housing Units - NHDOC offers three Transitional Housing Unit (THU) programs in the Concord and Manchester Area. THUs are work release programs where an individual is allowed to work for employers in the community. Individuals participating in THU programs are assigned “phases” based on their successful progress in the program and are given community based privileges to aid in their transition to eventual reentry to the community.
- Education - NHDOC offers a Corrections Special School District where individuals can earn a HiSet, High School diploma, and take College Correspondence courses. NHDOC also offers a Career Technical Institute that offers certificate courses in business education, auto-mechanics, and building trades.
- Family Connections Center (FCC)- NHDOC offers a Family Connections Center where individuals can take parenting classes, healthy relationship classes, read books on tape to send to their children, and participate in video visits.
- LADC Services - NHDOC offers LADC services such as assessment of needs, individualized treatment planning, intensive group treatment, other group therapy, individualized therapy sessions, and FOCUS unit. FOCUS unit conducts treatment for males with substance use disorders; it is an intensive clinical treatment that is conducted within a wellness community environment that addresses SUD issues.

- Mental Health Services – Mental Health programming and treatment is available at all locations within the NHDOC. Many different programs and treatment offerings are available to all individuals with mental health diagnosis. Programs include sexual offender treatment (SOT) and Residential Treatment Unit (RTU).

The IDN case manager can go into the prison (after ½ day training to get access) on a weekly basis. During this time, s/he will be meeting with the case managers and discussing case transfers. Also, s/he will begin to meet with the participants weekly, 4 weeks pre-discharge.

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

Participants will receive an individualized combination of the following:

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

- New Direction, a cognitive-behavioral treatment curriculum for justice involved individuals with COD.
- Identification of health issues and linkage to primary health care through the IDN2 Integration Project
- Individual Placement and Support (IPS) Supported Employment
- Wellness Activities including InSHAPE
- Benefits assistance
- The continuation of evidence-based curriculums begun in jail including education classes, Thinking for a Change, The Habits of Mind, and Community Supervision.

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

Sununu Youth Services Center (SYSC)

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

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

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

The following is the school programming:

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

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

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

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

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

- **Oppositional Defiant Disorder:** Evidence based treatments utilized are parent management training (via Family Therapy) and problem-solving skills training (individual and group). In addition, behavior therapy via group and individual contingency management programs. All youth with ODD are evaluated for concurrent conditions such as ADHD, Bipolar Disorder, PTSD and depression as well as physical and sexual abuse which may exacerbate their conduct disorder or mimic symptoms of ODD. If present evidence based medication interventions and disorder specific cognitive behavior and family therapy is provided.
- **Conduct Disorder:** Treated with the components of Multisystemic therapy which involves 1) Family Therapy 2) prosocial skills training and development 3) Educational and vocational training and support 4) development of an outpatient support network to continue MST interventions in community at transition. We also utilize cognitive behavioral therapy directed at distorted cognitions and value system in gang involved and crime involved youth. All youth with Conduct Disorder are evaluated for concurrent conditions such as ADHD, Bipolar Disorder, PTSD, and depression which may exacerbate their conduct disorder or mimic the symptoms. If present evidence based medication intervention and disorder specific cognitive behavior and family therapy is provided.
- **Substance Abuse:** Youth with substance abuse receive EBT interventions of Motivational Interviewing, and individual and group CBT regarding changing patterns, distorted cognitions and coping skills associated with substance use. The SAMHSA EBT workbook for youth substance use is specifically utilized. If indicated youth also receive medication intervention such as campral or naltrexone. As above, all youth are also evaluated for concurrent disorders or traumatic experiences that need to be treated in order to reduce their risk of relapse.

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

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

Post Release Programming

They receive an individualized combination of the following:

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

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

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

Timeline with updates:

Reentry Timeline	
2017	
Jan - June	<ul style="list-style-type: none"> • Implementation Plan Timeline & budget Workforce plan - This was accomplished • Projected client engagement - This was accomplished • Key organizational providers - This was accomplished • R&R of team members - This was accomplished • Clinical Services Infrastructure - This was accomplished <ul style="list-style-type: none"> ○ Assessment tools ○ Protocols, Processes, & Workflow ○ Develop training plan & curricula ○ Agreements ○ Evaluation plan ○ Hire 3 staff (LADC, CM, BH Clinician) - Delayed in hiring CM during this period of time

July - Dec	<ul style="list-style-type: none"> • Operationalize program - This was accomplished <ul style="list-style-type: none"> ○ Hire 1 additional staff - Hired case manager, turnover in BH clinician position ○ Begin training schedule ○ Develop and convene monitoring and improvement team ○ Initiate data reporting • Project budget review for 2018 - This was accomplished • Employ rapid cycle evaluation - This was accomplished • Participate in semi-annual report writing - This was accomplished
2018	
Jan - June	<ul style="list-style-type: none"> • Hire peers • 4 staff trained • Monthly progress and data reporting Employ rapid cycle evaluation • Participate in semi-annual report writing
July - Dec	<ul style="list-style-type: none"> • Monthly progress and data reporting Employ rapid cycle evaluation • Participate in semi-annual report writing • Project budget review for 2019

C-2. IDN Community Project: Evaluation Project Targets

Changes to the target measures were made because the list of measures currently submitted represented the minimum requirements of enrollment in the program so all participants would achieve those targets. Therefore, it wasn't felt to be useful to measuring success.

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
# in SOAR and expected to receive IDN2 reentry services	250	52		
# served (enrolled in post-services)	250	16		
# of clients who completed 12 months of treatment post-release	200	0		

C-3. IDN Community Project: Workforce Staffing

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

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

C-4. IDN Community Project: Budget

Community Re-Entry	2018	2017 Actual	2017 Budget
Consulting Fees	0	40,004	40,000
Purchase Services / Professional (non-CH staff)	251,009	113,287	166,252
Other Direct Expense (Includes testing supplies)	11,755	4,367	11,755
Total	262,764	157,658	218,007

Consulting Fees

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

Purchase Services

These are salaries and benefits for the staff listed.

Other Direct Expenses

This is testing supplies for substance use.

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

From Project A1: Workforce Capacity Development Implementation Plan document the Key Organizational and Provider Participants specifically related to this project in this reporting period using the format below.

Organization/Provider	Agreement Executed
Riverbend Community Mental Health	Y
Concord Hospital	Y
Concord Hospital Medical Group	Y
NH DOC	Y
Merrimack County DOC	Y
Sununu Youth Services Center	Y
NAMI NH	Y
Ascentria	Y
Granite United Way	Y

C-6. IDN Community Project: Standard Assessment Tools

Name	Brief Description
Proxy Triage Risk Screener (Proxy)	Risk of recidivism on an 8-point scale MCDOC only
Ohio Risk Assessment System (ORAS)	This fourth-generation risk assessment tool integrates case planning and risk management into the assessment process. As such, the primary goal extends beyond assessing risk and focuses on enhancing treatment and supervision.
TCU Mapping Interventions	Mapping is a visual representation counseling strategy for improving communication and decision making that can enhance any therapeutic or psycho-educational exercise, either in group or individual settings. Evidence shows it significantly improves treatment engagement and client progress indicators, and helps compensate for a variety of cognitive and social deficits common among drug users in treatment

Structured Assessment of Violence Risk in Youth (SAVRY)	SAVRY includes 24 items in three risk domains (Historical Risk Factors, Social/Contextual Risk Factors, and Individual/Clinical Factors), drawn from existing research and the professional literature on adolescent development as well as on violence and aggression in youth. SAVRY helps you structure an assessment so that important factors will be emphasized when you formulate a final professional judgment about a youth's level of risk.
Substance Abuse Subtle Screening Inventory (SASSI- 3)	SASSI is a brief, easily administered psychological questionnaire. It is available in both adult and adolescent versions, as well as versions for diverse cultures, including those with disabilities. The SASSI can identify people who may have a Substance Use Disorder with a high degree of accuracy – even when someone is reluctant to self-disclose.
Revised Children's Manifest Anxiety Scale (RCMAS)	RCMAS is a self-report instrument designed to measure anxiety for children and adolescents aged 6-9 years. For children over 9 and a half years of age, it can be administered in a group situation. For first and second graders, the examiner should read the items to the child. There are 37 items each of which requires a yes or no answer. (For SYS)
The Child and Adolescent Needs and Strengths (CANS) Comprehensive Assessment for Young Children	A multi-purpose tool developed to support care planning and level of care decision-making, to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services. CANS was developed from a communication perspective so as to facilitate the linkage between the assessment process and the design of individualized service plans including the application of evidence-based practices (For SYS)
Mental Health Status Examination (MSE)	A structured way of observing and describing a patient's current state of mind, under the domains of appearance, attitude, behavior, mood and affect, speech, thought process, thought content, perception, cognition, insight and judgment.
Adult Needs and Strengths Assessment (ANSA)	A multi-purpose tool developed for adult's behavioral health services to support decision making, including level of care and service planning, to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services.
American Society of Addiction Medicine (ASAM) Criteria	The ASAM criteria explores six dimensions to create a holistic, biopsychosocial assessment of an individual for treatment across all services and levels of care.

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

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

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

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

		<p>2017. The initial meeting was to discuss the need for a flow system from initial assessment to post release services; what is expected from whom; and how assessment tools, case management services, pre- and post-release programming, transitional case management, and support services are managed. The second meeting is to review the case flow system and responsibilities with all reentry staff. There was a final meeting that included all MCDOC program staff as well to finalize the flow process and clarify roles. An initial meeting was held with the NH DOC to begin on May 11th and a second meeting was held on December 1.</p>
Case Management Training	September meeting also covered in November 29 all day training	<p>A review of evidence based case management strategies for offenders as they re-enter the community. This will include the process of coordinated case planning, transition services, use of a universal case plan, and evidence based chain of case planning and services. There was an internal IDN case management flow meeting to determine flow at the MCDOC in September of 2017. There was also a case management training (separate) for the NH DOC on May 11th of 2017 and then this was followed by a full day training including 3 hours on transition planning on November 29, 2017. As noted, this included MCDOC, NHDOC and private provided including NAMI</p>
Overview of Evidence Based Practices	November 29, 2017	<p>Discussion of the best practice models in criminal justice and correctional settings including methodology for clients with substance use and mental health disorders. This review will include the National Transition from Jail to Community Model, the Risk Need Responsivity Model, Criminogenic Risk and Need, and other successful evidence based systems. This meeting was well attended with MCDOC staff, IDN staff NHDOC staff and staff from NAMI NH and Riverbend.</p>
Outcome Data	<p>Oct & Nov 2017</p> <p>There were two meetings with MCDOC followed by a review of data beginning with meetings in October and ongoing discussion of who would handle data. It was decided at the MCDOC that the reentry data measures would be collected by the MCDOC Staff while post release IDN data would be collected by the IDN case Manager. Since that position was not hired to collect the initial data it will</p>	<p>This is designed to review the performance measures agreed to in reentry meeting and the methodology of collecting and reviewing that data for continuous quality improvement including:</p> <ul style="list-style-type: none"> ● Public Safety Indicators and Outcomes ● Reduced re-offending, returns to jail, and length of jail stays for returning individuals ● Reintegration Indicators and Outcomes ● Reduced substance abuse and homelessness ● Increased employment ● Improved housing stability and improved mental health/health ● Process Measures ● Screening ● Assessment

	be collected by the MCDOC reentry manager until December 31, 2017.	<ul style="list-style-type: none"> • Referrals • Engagement • Service utilization • Completion
Outcome Data	<p>Oct & Nov 2017</p> <p>There were two meetings with MCDOC followed by a review of data beginning with meetings in October and ongoing discussion of who would handle data. It was decided at the MCDOC that the reentry data measures would be collected by the MCDOC Staff while post release IDN data would be collected by the IDN case Manager. Since that position was not hired to collect the initial data it will be collected by the MCDOC reentry manager until December 31, 2017.</p>	<p>This is designed to review the performance measures agreed to in reentry meeting and the methodology of collecting and reviewing that data for continuous quality improvement including:</p> <ul style="list-style-type: none"> • Public Safety Indicators and Outcomes • Reduced re-offending, returns to jail, and length of jail stays for returning individuals • Reintegration Indicators and Outcomes • Reduced substance abuse and homelessness • Increased employment • Improved housing stability and improved mental health/health • Process Measures • Screening • Assessment • Referrals • Engagement • Service utilization • Completion
Data-Driven Understanding of Reentry	November 29th	<ul style="list-style-type: none"> • Assessments are the key to understanding your clients' needs • Make intelligent decisions based on evidence • Understand your gaps in data collection and work toward building a better data infrastructure • Leverage existing resources

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

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

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

Process Milestone	Process Detail	Submission Format	Results (Met/ Not Met)			
	Staffing					
C-4	IDN Community Project Budget	Narrative and Spreadsheet				
C-5	IDN Community Project Key Organizational and Provider Participants	Table				
C-6	Clinical Infrastructure: IDN Community Project Standard Assessment Tools	Table				
C-7	Clinical Infrastructure: IDN Community Project Protocols For Patient Assessment, Treatment, Management, and Referrals	Table				
C-9	Provide the training plan and curricula for each Community Driven Project as required in A-1.3	Training schedule and table				

Projects D: Capacity Building Focused

IDN Community Project Implementation and Clinical Services Infrastructure Plan

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

IDN2 faced some challenges in implementing the MAT project as originally planned. We had hoped to have 2 MAT providers in each integrated practice and link those providers to mentoring and education through Concord Hospital's Program for Addiction Disorders (PAD). However, we were not having success in recruiting PCPs to get their X-Waiver or in getting current MAT providers to attend meetings. Meanwhile, there were changes being made at both Concord Hospital and Riverbend's Substance Use programs. Concord Hospital had made the decision to absorb PAD into the Concord Hospital Substance Use Services program and Riverbend hired new leadership for CHOICES, their substance use services program. At that time, IDN2 was conducting a rapid cycle evaluation of the MAT project. It was decided to use the strength of the newly invigorated continuum of care centers to create HUBs for the CHMG practices (SPOKES). This allows the current MAT providers and their patients to be better supported and for those practices without an MAT provider to have access to the HUBs for induction and follow-up care. The opportunities to create a community of practice are more plentiful as well. Below is the model we are using:

Project D1 MAT Updates

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

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

We will accomplish this:

- Through the Integrated Health Care project:
 - Provide ongoing information to primary care providers (PCPs) about SUD and MAT
 - Train PCPs in SUD Screening, Brief Intervention, and Referral to Treatment (SBIRT)
 - Embed Integrated Behavioral Health Clinicians (IBHC) in the primary care practices to provide coordinated care, brief treatment, and closed loop referrals to community based treatment.
 - IBHCs are licensed, master level clinicians.
 - In addition to training specific to determining appropriate levels of care and brief interventions for treating substance use disorder, IBHCs have received instruction in integrated care, medication assisted treatment (MAT), confidentiality, drug testing in clinical addiction medicine,

metabolic syndrome, and engaging loved ones in health and wellness. They will receive ongoing training to sharpen their skills.

- Through the MAT project:
 - Establish Continuum of Care HUBS to provide:
 - MAT inductions
 - Induct, stabilize, maintain, and transfer on buprenorphine
 - Open access to services
 - On site urine testing
 - On site counseling and groups
 - Mental health services and support
 - Connect patients with primary care providers (PCP) for general care
 - Provide educational resources and leadership to the community
 - Provide on-site and phone consultation to medical and psychiatric providers
 - Train providers about substance use disorders
 - Refer to next level of care-residential programs-for higher need patients
 - Support and incentivizing PCPs to become SPOKES (Induct, stabilize, and/or maintain patients on MAT at their practice; mentor other PCP MAT providers; participate in a community of practice:
 - Financial incentives for full participation in the project* - \$2,750 semi-annually (July for period Jan-June, January for period Jul-Dec) after training and obtaining a DATA 2000 X Waiver. *Participation includes attending IDN2 meetings and/or case reviews (if meeting attendance is impossible, check in with the MAT co-coordinators on a monthly basis to discuss any questions/concerns), following NH DHHS approved IDN2 protocols, acting as a peer mentor for other MAT providers or those interested in becoming MAT providers, and participating in the collection and reporting of process and outcome data to NH DHHS.
- Refine the Perinatal Addiction Treatment (PAT) project at OBGYN practices
 - Move the supervision of PAT to one of the MAT HUBS (CHOICES)
 - Add a Medical Assistant to the Concord Hospital practice because of increasing numbers of individuals seeking support
 - Successfully merge the PAT and Enhanced Care Coordination (ECC) projects
 - Add a % of an ECC Coordinator to support the Wraparound Services for women in the PAT project
 - Begin a parent education program

Timeline with updates:

MAT/PAT Timeline
2017

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

D-2. IDN Community Project: Evaluation Project Targets

- Number of individuals served (during reporting period and cumulative)
- All performance measures identified in the evaluation project plan.

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18

Numbers served over life of project	300	31		
Negative urines for opioids (other than those prescribed for OUD) at 3 months	180	13		
Negative urines for opioids (other than those prescribed for OUD) at 6 months	210	1/1		
Negative urines for opioids (other than those prescribed for OUD) at 12 months	240	n/a		
Treatment retention at 3 months	240	11		
Treatment retention at 6 months	210	1/1		
Treatment retention at 12 months	180	n/a		
Referral to treatment no-shows	<75	1		
PAT: numbers served over life of project	60	20		
PAT: did not return after first visit	<10	3		
PAT: delivered - outside of IDN2 region	40	2		
PAT: delivered - within IDN2 region	20	1		
PAT: attend all scheduled OB-GYN appointments	38	17		
PAT: attend all scheduled MAT appointments	45	17		
PAT: remain engaged through pregnancy & delivery	35	1		
PAT: transferred care to PCP/MAT after delivery	45	1		

D-3. IDN Community Project: Workforce Staffing

Provider Type	IDN Workforce (FTEs)				
	Projected Total Need	Baseline Staffing on 6/30/17	Staffing on 12/31/17	Staffing on 6/30/18	Staffing on 12/31/18
D1 - MAT Co-Coordinator (.2)	2	2	2		
D1 - BH TBD	2	N/A	0		
D1 - PAT Providers (.4)	2	2	2		
D1 - PAT Social Worker (.4)	1	1	1		
D1 - PAT MA (.4)	1	N/A	0		
D1 - Peer Recovery Coach	1	1	0		

D-4. IDN Community Project: Budget

Medicated Assisted Treatment			
Purchase Services / Professional (RB)	230,809	26,957	42,872
Purchase Services / Professional (CH)	82,760	5,520	5,520
Outside Training (PAT Parent Education)	25,000	0	0
Incentives - Processed thru HR	55,000	0	35,000
Total	393,569	32,477	83,392

Purchase Services / Professional (RB)

This line item is for 2 Perinatal Addiction Treatment MAT providers, 1 social worker, and 2 project coordinators based at the HUBs

Purchase Services / Professional (CH)

This line item is for 1 Medical Assistant and 1 Addiction Nurse

Outside Training (PAT Parent Education)

This line item is for a parent education program for PAT + ECC

Incentives - Processed thru HR

Incentives for PCPs to become MAT providers and participate as SPOKES in the IDN2 MAT project.

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

From Project A1: Workforce Capacity Development Implementation Plan, document the Key Organizational and Provider Participants specifically related to this project in this reporting period using the format below.

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

D-6. IDN Community Project: Standard Assessment Tools

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

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

Protocol Name	Brief Description	Use (Current/Under Development)
---------------	-------------------	---------------------------------

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

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

The following trainings occurred during this time frame and reached more than 50 medical providers and IDN2 IBHCs:

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

naloxone in the setting of an opioid overdose.

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

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

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

The ECC was originally conceived to address the following populations through three distinct ECC Coordinators trained to deliver NH Wraparound and RENEW (described under C2 Reentry). Under each age group, **in bold**, are obstacles addressed that resulted in shifts in the projects.

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

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

This is a very high need population and we have successfully bridged this portion of the ECC project to the D1 MAT project (Perinatal Addiction Treatment sub-population). There are 13 women in the project as of the writing of this report. Because of the need, we are taking part of the 6-18 ECC Coordinator's time to provide service to this population.

NH Wraparound does not have a history of serving the 0-5 population. In addition, with so many of the referrals for this age group coming from the PAT project, the "youth" served are pre-born. For implementation of this project, IDN2 is referencing The Strong Start Program, reviewed through JFK Partners of the University of Colorado. The Strong Start Program was one of four Research and Demonstration projects funded through the Quality Improvement Center on Early Childhood to implement a collaborative intervention to prevent maltreatment of young children informed by the Strengthening Families framework. In partnership with the Colorado Office of Behavioral Health, Women's Substance Use Disorders Treatment, and the Colorado Office of Early Childhood, Early Intervention Colorado, the Study was conducted in the Denver metropolitan area from March 2010 through September 2013. NH Wraparound trainers are assisting in the adaptation of NH Wraparound, using this report for guidance.

We are adding a parent education component to this project and are currently conducting research as to the best model and delivery system.

A NAMI NH family peer support person works closely with this project.

Children/Adolescents 6-14 with a diagnosable serious emotional disturbance (SED) and who meet two of the following criteria:

- identified co-occurring substance use disorder (COD)

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

Despite multiple meetings with referral partners, this age group has not had any qualified applicants to the project. For now, we are moving some of the ECC Coordinator’s time to the joint PAT + ECC project due to high need. It was expected that most of the clients for this age group would come from NH Hospital and meetings continue with NH Hospital to line up referrals. The ECC Supervisor will also promote the project’s availability at the next regional interagency meeting.

A NAMI NH family peer support person works closely with this project.

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

This age group has a primary referral source of the Sununu Youth Services Center (SYSC) for the younger population and NH Hospital for the older population. There have been no changes to the project and it has been successfully bridged with the C2 Reentry Project. A YouthMove peer coordinator was added to this project and Granite United Way will be training the ECC Coordinator to provide “Your Money, Your Goals” to participants. A NAMI NH family peer support person works closely with this project.

Timeline with updates

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

E-2. IDN Community Project: Evaluation Project Targets

Changes have been made to the performance measures to align with items that are reportable and based on the input of the NH Wraparound trainer at UNH Institute on Disability.

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
Individuals served over the life of the project	99	14		
Intake to determine eligibility		14		
Not eligible, referred to other services		1		
In process of engagement		9		
Decided not to participate		4		

Performance Measure Name	Target	Progress Toward Target		
Participant satisfaction (Youth Progress Scale and Team Meeting Rating Scale)	High	N/A Yet		
Placement outside the home	Improvement	N/A Yet		
Academic performance	Improvement	N/A Yet		
School attendance	Improvement	N/A Yet		
# psychiatric hospitalizations	Improvement	N/A Yet		
# of juvenile offenses	Improvement	N/A Yet		
Improved behavioral health indicators (CANS for children and youth) or improved performance on developmental screening/assessment for 0-5 (Ages & Stages).	Improvement	N/A Yet		

E-3. IDN Community Project: Workforce Staffing

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

E-4. IDN Community Project: Budget

Enhanced Care Coordination			
Purchase Services / Professional (non-CH staff)	188,826	74,341	130,642
Training & Coaching	16,500	3,396	17,500
Travel	15,000	388	0
Other Direct Expense (Flex Funds)	30,000	0	0
Total	250,326	78,126	148,142

Purchase Services / Professional (non-CH staff)

This line item is for staffing for the project.

Training & Coaching

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

Travel

This project includes home visiting.

Other Direct Expense (Flex Funds)

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

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

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

Organization/Provider	Agreement Executed (Y/N)
Dartmouth Hitchcock Concord	Y
Sununu Youth Services Center	Y
Child and Family Services	Y
UNH Institute on Disability	Y
NAMI NH	Y
Ascentria - NEW - Providing CLAS and Refugee Training	Y
Granite United Way - NEW - Providing 2-1-1 NH and Your Money, Your Goals	Y
Youth Move - NEW - Providing Youth Peers	Y
New Hampshire Hospital	Y

E-6. IDN Community Project: Standard Assessment Tools

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

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

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

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

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

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

Understanding and Addressing Anxiety, presenter Clark Goldstein - 1 Supervisor - September 2017

Introduction to Parent Child Interaction Therapy, presenter Clark Goldstein - 1 Supervisor - September 2017

Understanding and treating Anxiety in the Family, presenter Richardson - 1 Supervisor - September 2017

“Healing Hearts, Opening Minds: Informing the journey from addiction through recovery” - 1 EC Coordinator - October 2017

“Supporting Families affected by Opioid and Other Substance Abuse Disorders” presented by SAMSHA - 1 EC Coordinator and 1 Supervisor - October 2017

Transitions Training - 1 EC Coordinator - November 2017

PTSD and Suicide presented by Veterans Healthy Administration - 1 Supervisor - December 2017

CALM (Counseling on Access to Lethal Means) presented by Suicide Prevention - 1 Supervisor, December 2017

Code of Ethics provided by Social Worker Continuing Education.com - 1 Supervisor - December 2017

Future Training Planned: Culturally and Linguistically Appropriate Service, Traumas Systems Therapy for Refugees, Suicide Prevention, Motivational Interviewing

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

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

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

IDN2 has a designated person participating in the APM meetings but we have not had the opportunity to update the APM information from our previously submitted project plans as there was some confusion about the collection of that. Updates for Riverbend:

IDN2’s Community Mental Health Center has been participating with the State of New Hampshire in an Alternative Payment Model which has been in operation for the past 2 years. New Hampshire has two Managed Care Organizations (MCO's) and they are responsible for oversight of all medical services for eligible Medicaid recipients.

Riverbend has a contractual relationship which assures network adequacy for services for people who are eligible for services in the following categories:

- Seriously and Persistent Mentally Ill
- Seriously Mentally Ill
- Low Utilizers
- and Severe Emotional Disturbance (the children's category)

Once eligibility is established clients are listed in these categories and services are rendered to them according to medical necessity. The MCO's then pay a monthly rate regardless of fluctuation of need in the category and the Community Mental Health Center uses those predetermined funds to provide the medically necessary service.

At the end of the month Riverbend submits a list of encounters that are used to demonstrate a Maintenance of Effort relative to the rate and if that effort is short of the advanced payments then a refund is paid back to the MCO on a quarterly review. If Riverbend spend more that the rates agreed upon then they have to endure that cost without further reconciliation, Hence Riverbend exists in an 'at risk' model.

Statewide APM Taskforce and Implementation Plan Activity	Progress		
	As of 12/31/17	As of 6/30/18	As of 12/31/18
Participate in development of statewide APM roadmap through workgroups and stakeholder meetings	x		
Develop an IDN-specific plan for implementing the roadmap which will contain IDN-specific outcome measures			
Develop the financial, clinical and legal infrastructure required to support APMs			
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			

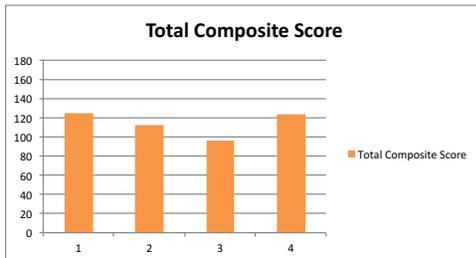
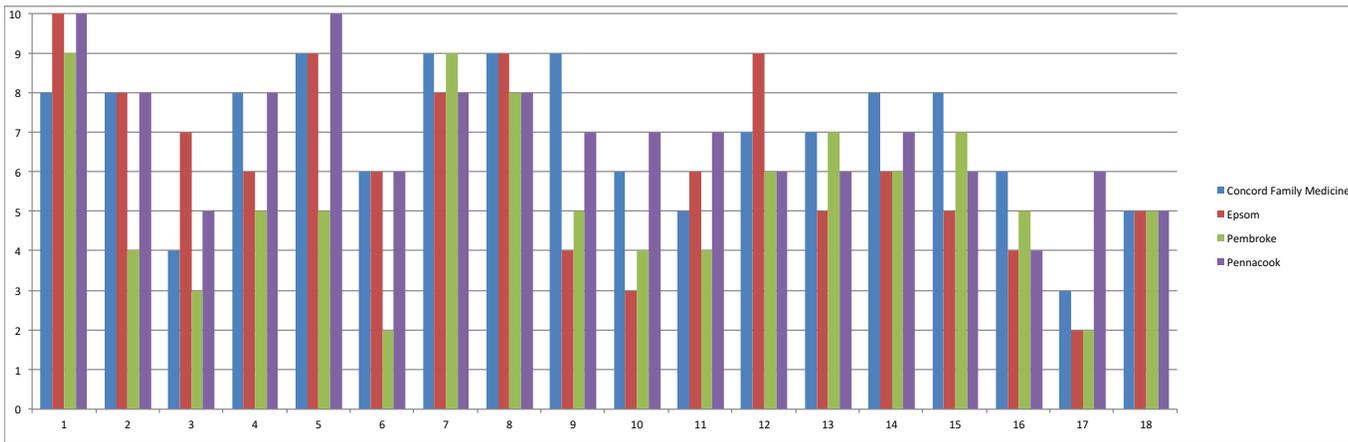
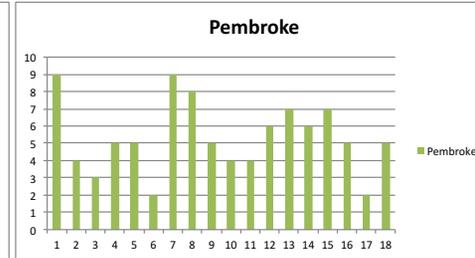
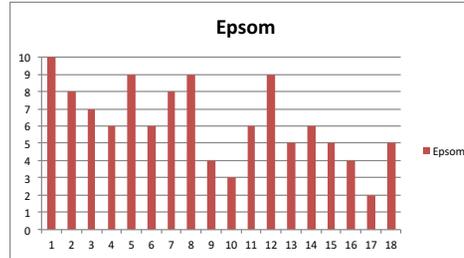
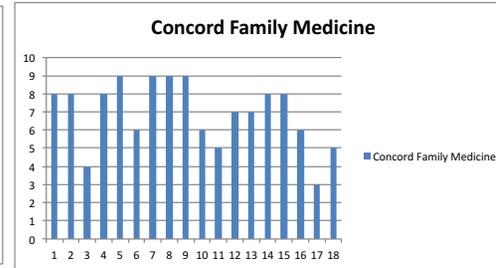
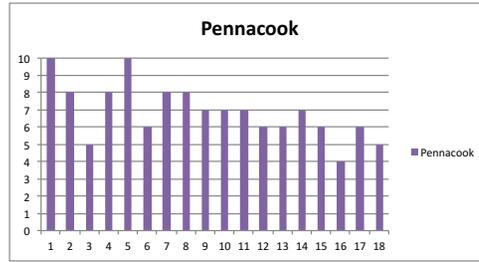
DSRIP Outcome Measures for Years 2 and 3

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

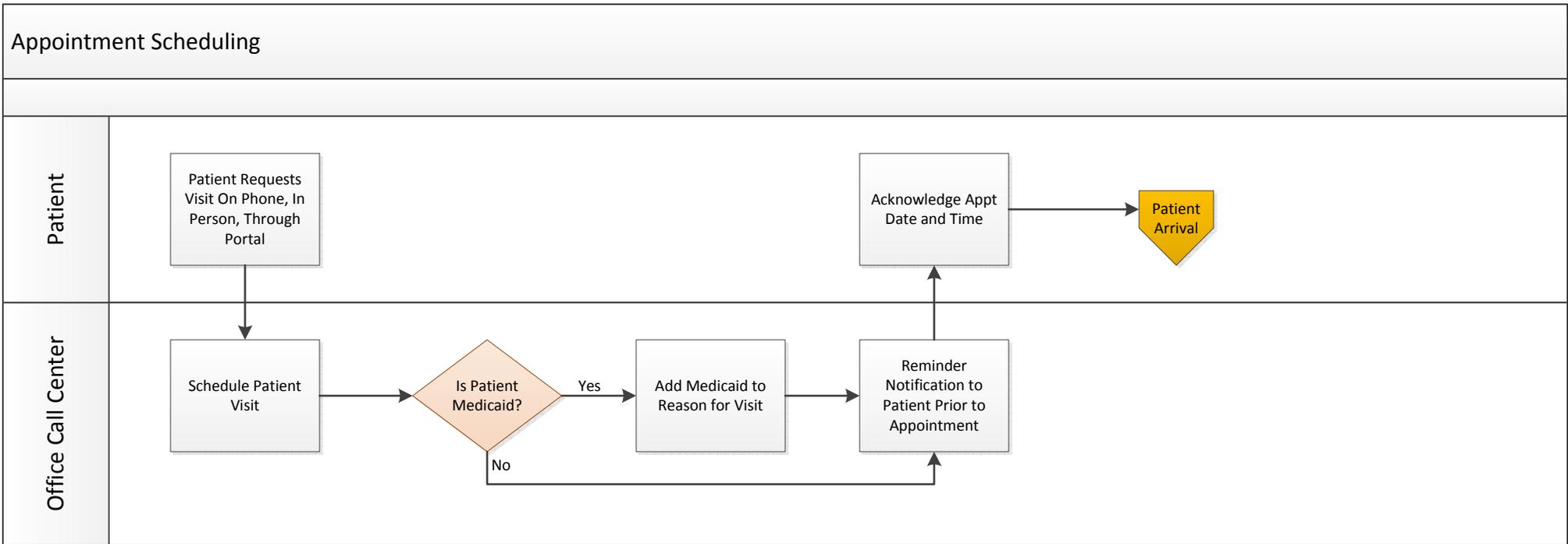
DSRIP Outcome Measures		
Year 2 (CY 2017) Incentive Payment for Reporting Measures	Year 3 (CY 2018)	
	Incentive Payment for Reporting Measures	Incentive Payment for Performance Improvement Measures
Use of Comprehensive Core Standardized Assessment by Medicaid Billing IDN Providers	Recommended U.S. Preventive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

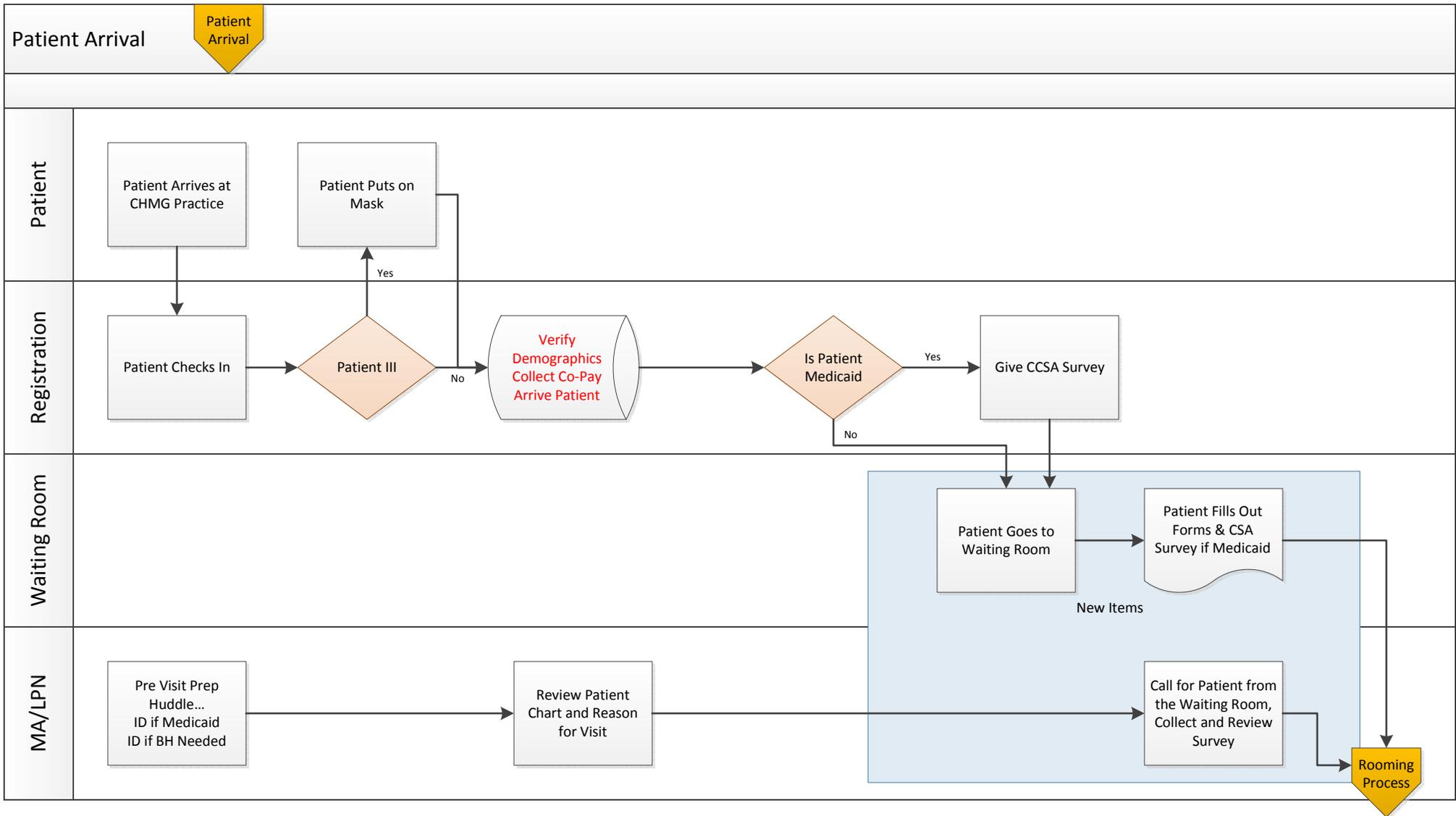
ATTACHMENT A

	Concord Family Medicine	Epsom	Pembroke	Pennacook
1	8	10	9	10
2	8	8	4	8
3	4	7	3	5
4	8	6	5	8
5	9	9	5	10
6	6	6	2	6
7	9	8	9	8
8	9	9	8	8
9	9	4	5	7
1	6	3	4	7
2	5	6	4	7
3	7	9	6	6
4	7	5	7	6
5	8	6	6	7
6	8	5	7	6
7	6	4	5	4
8	3	2	2	6
9	5	5	5	5
Total Comp	125	112	96	124

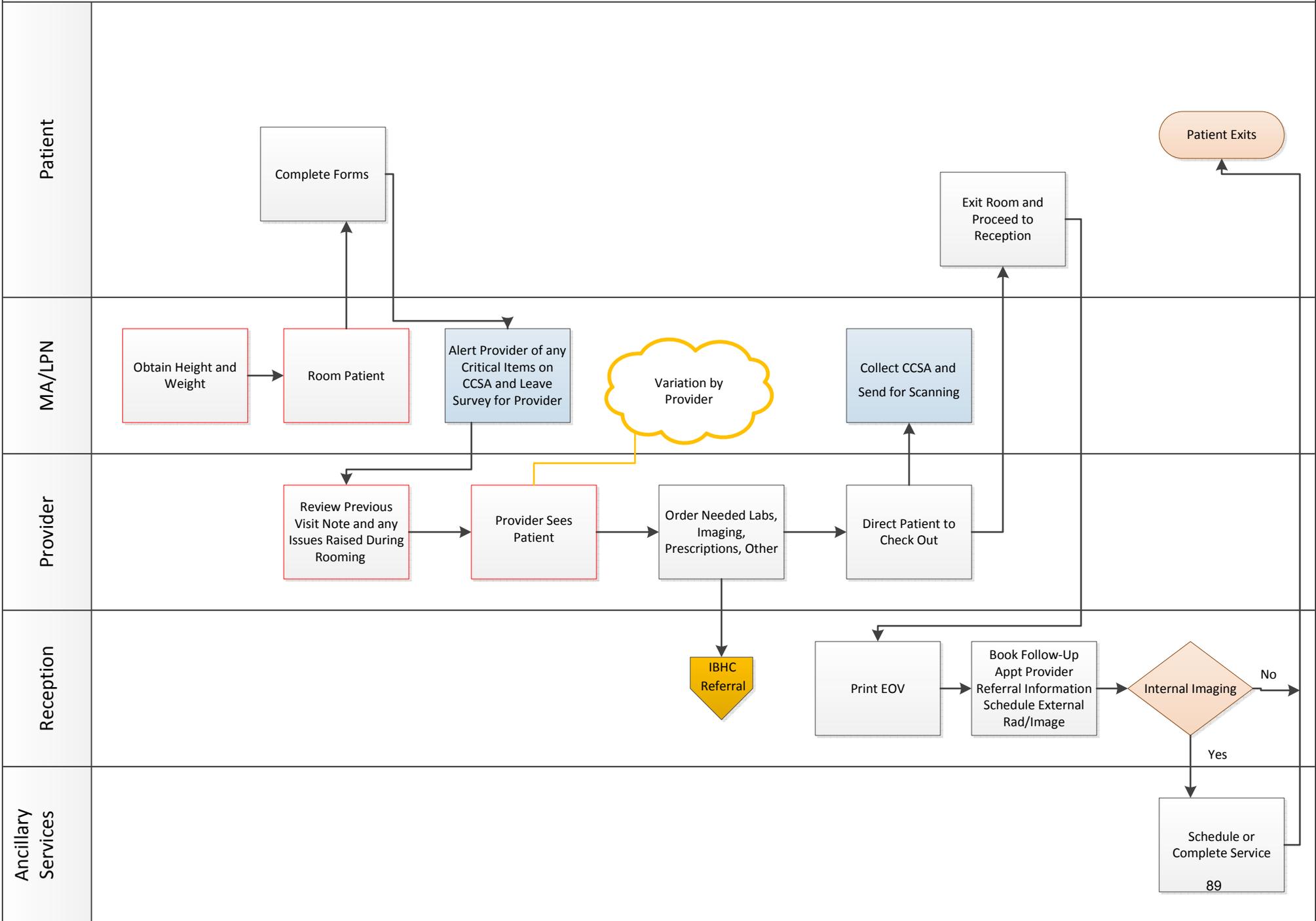


ATTACHMENT B

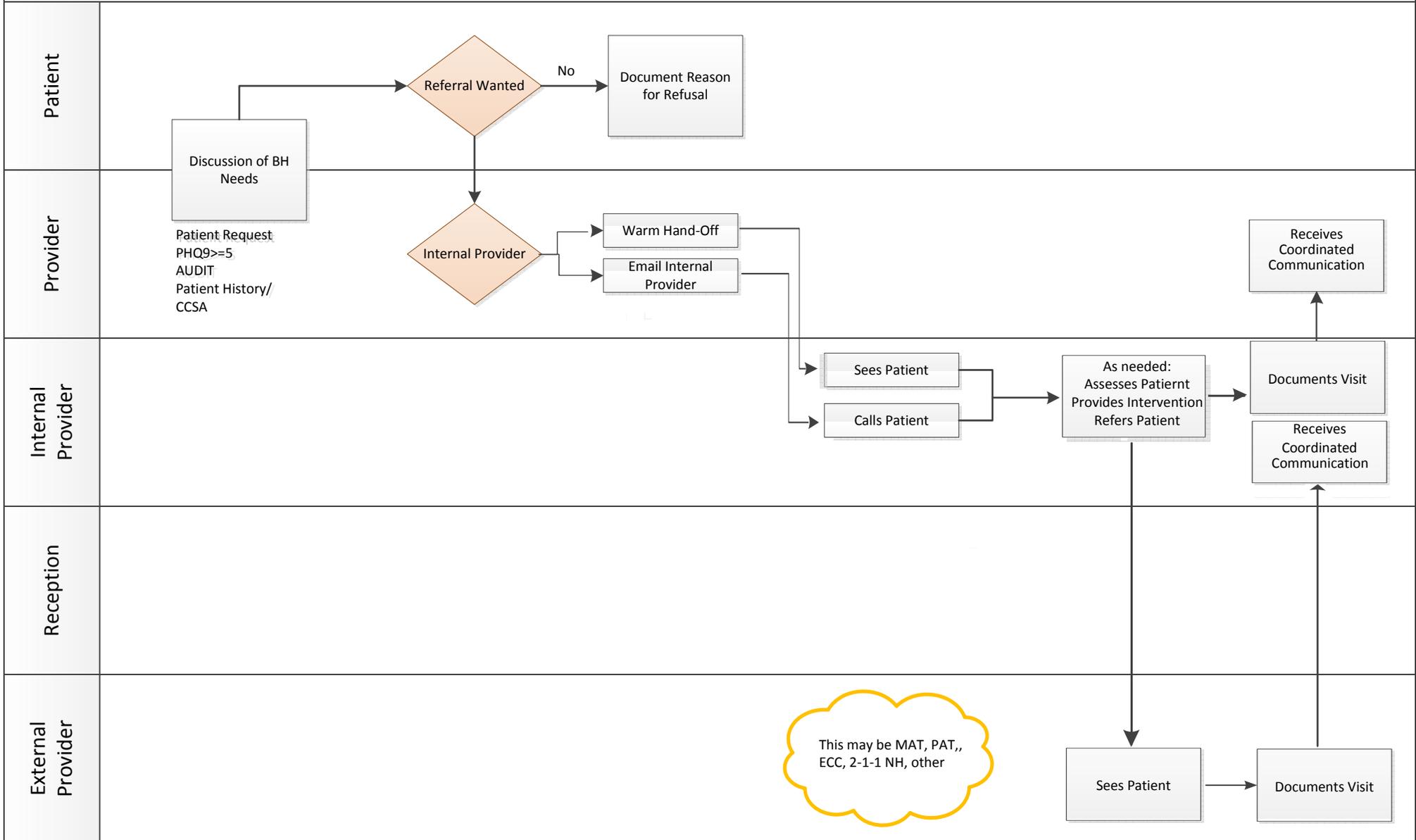




Rooming Process



BH Referral Internal (IBHC)



IDN2 Enhanced Care Coordination Project Flex Fund Protocol

Community, state, and federal resources should be identified and utilized to build upon family strengths and address needs. 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:
 - family support and sustenance which would enable the guardian/family to participate in treatment or improve the support for the youth
 - educational and vocational services not otherwise available or mandated by the local school system
 - medical services not otherwise covered (for example: eating disorder evaluation)
 - independent living services/supports
 - interpersonal and recreational skill development
 - additional reinforcers determined by the ECC Coordinator

Flex Funds requests are to be submitted to the IDN Project Director through the IDN Project Specialist after approval by the IDN ECC Project Supervisor:

- Submit the Flex Fund Request Form by email to: cnnylen@riverbendcmhc.org

The request will be reviewed and notification of approval or a request for more information will be sent to the ECC contact within 3 business days.

- Flex Funds will be obtained through the IDN Project Specialist and provided directly to the ECC Coordinator within 3-5 business days of the request.
 - Flex Funds of less than \$500 can be obtained within 3 business days at the IDN Project Specialist's office at 278 Pleasant Street, Concord, NH.
 - Flex Funds greater than \$500 will be distributed by a check given to the IDN Project Specialist by the IDN Accountant and may require an additional 2 business days. These will also be obtained at the IDN Project Specialist's office.
- Receipts are required for tangible purchases to verify proper expenditure of Flex Funds—in this case an approved amount will be agreed on based on the request and prior to purchase, and reimbursed to the provider agency upon proof of receipts.
- A summary of Flex funds expenditures will be maintained by the IDN Project Specialist and monitored by the IDN2 Finance Committee.

IDN2 Enhanced Care Coordination FLEX FUNDS REQUEST FORM

COORDINATOR: _____ DATE: _____

AGENCY REQUESTING FUNDS: _____

AMOUNT REQUESTED: _____ CHECK ONE: CASH ESTIMATE FOR REIMBURSEMENT

SUPERVISOR
NAME / SIGNATURE: _____

Client:

NAME (F, M., L): _____ DOB: _____

ADDRESS: _____ CITY/ZIP: _____

FAMILY MEMBERS / AGES: _____

Describe the specific request (what will the funds purchase?):

Describe the specific need(s) of the family (i.e. what specifically happened, for example, loss of job, illness, unexpected expenses, etc., which brings the family to need the flex funding?) and how it relates to the parent/child's mental health or substance use needs:

Answer all:			
Have other funding sources been explored and ruled out?	Y	N	
Will the family be able to meet this need next month, or future months? <i>(For example, if flex funds pays for utilities, how will the family be able to pay next month and beyond?)</i>	Y	N	
Does the family receive other benefits?	Y	N	

FOR IDN2 ADMINISTRATIVE USE ONLY

Project Specialist Receipt Date and Initials: _____

Project Director Approval () Date: _____