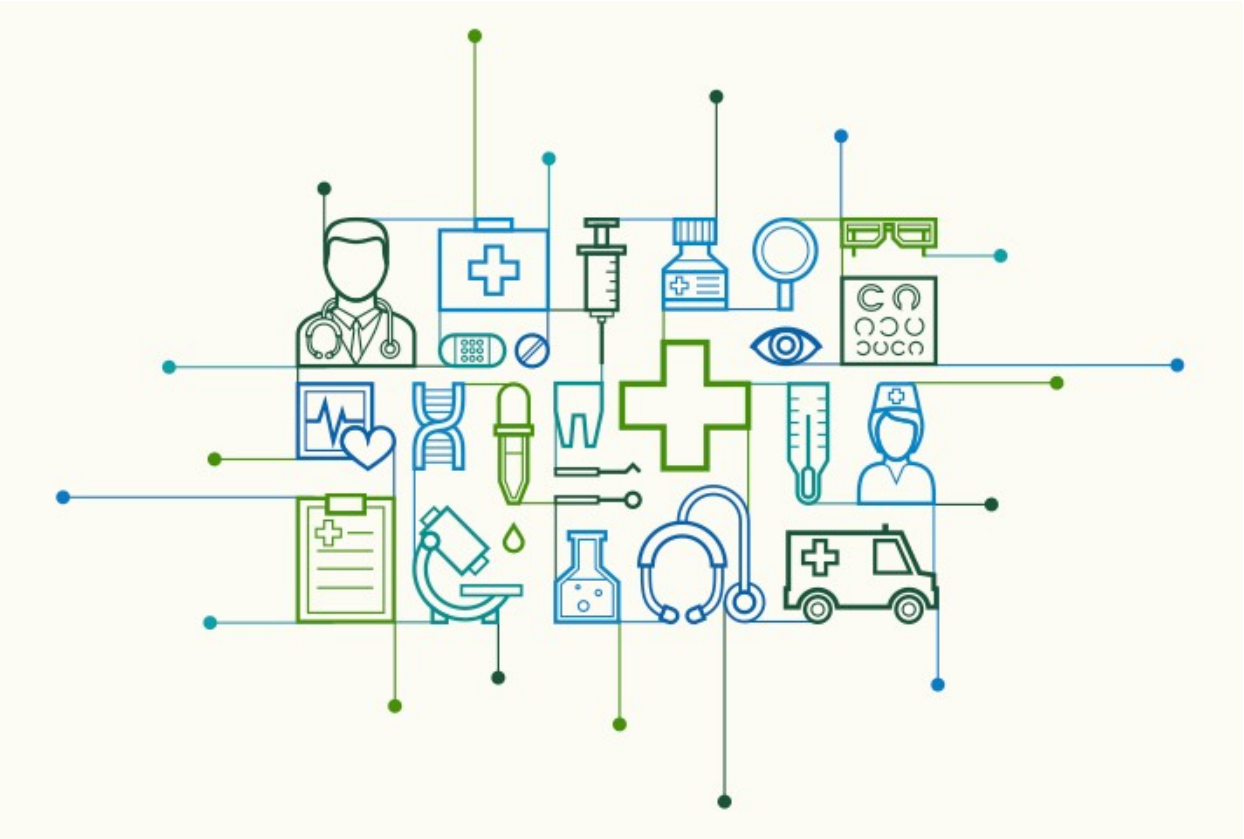
Capital Area Integrated Delivery Network (IDN2)

Concord Hospital, Administrative Lead

Capital Region Health Care (CRHC), Primary lead

Semi-Annual Report July – December 2019



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

Concord Hospital

Concord Regional Visiting Nurse Association

Riverbend Community Mental Health, Inc.

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1. All Member Presentations – Aug. and Nov. 2019

The **Capital Area Integrated Delivery Network (IDN2)** has, at its core, the longstanding relationship between Riverbend Community Mental Health, Inc. (Riverbend), Concord Hospital, and the Concord Regional Visiting Nurse Association (CRVNA). These entities have been committed to integrated health care for years under the umbrella of Capital Region Health Care. Delivery System Reform Incentive Payment (DSRIP) funds have allowed this group to strengthen and expand their existing work, collaborate more effectively with community-based organizations, and reach new populations. In addition to capacity building, training for providers and staff, and the creation of efficient systems and workflows, IDN2 has placed great emphasis on communication (both between organizations and between providers and patients/clients) and transitions (how do patient/clients safely and smoothly move between care sites). Patient/client outcomes, recovery, and success is always at the core of our work. This report illustrates the work IDN2 has done between July and December 2019.

Project Plan Implementation (PPI)

Administration

IDN2 separates the key oversight tasks among its three core entities:

- Riverbend – Day to day operation, mental health and substance use
- Concord Hospital – Finance, medical
- CRVNA – Technology

The Chief Executive Officers (CEO) of these three entities along with two Chief Medical Officers (CMO) from Riverbend and Concord Hospital, a Chief Technology Officer from CRVNA, and a Chief Financial Officer (CFO) from Concord Hospital form the executive committee, which provides oversight of the entire DSRIP project and supervises the consultant Project Director. IDN2 has 4.7 FTE administration staff:

Employed by Concord Hospital:

- Associate Chief Medical Officer (.35)
- Project Director (1.00)
- Accountant (.40)
- Project Manager (.20)

Employed by Riverbend:

- Managing Chief Executive Officer (.30)
- Administrative Assistant (.40)
- Bookkeeper (.50)
- Financial Data Analyst (.45)
- Human Resources (1.00)

Employed by CRVNA:

- Chief Technology Officer (.10)

In addition, there are project oversight staff who are listed under individual projects including the Director of Integration (1.00 hired by Riverbend). Most of the direct care staff are hired by Riverbend.

Supervision is provided through the hiring entities and overall supervision is provided through the IDN2 executive committee.

Network

IDN2's members and their roles are listed on page 12 and 13. Many members work directly on specific projects. Others serve on workgroups and oversight committees. Still others sit on IDN's steering committee. IDN2 holds quarterly "all member" meetings. Presentations from the August 2019 and November 2019 meetings are Attachment 1.

In addition to formal members, IDN2 works with multiple stakeholders in the region and those organizations and activities will be listed under the individual project reports.

IDN2 also provides community presentations about DSRIP and its regional projects. The following took place during this reporting period:

- July 29 - Merrimack County
- September 10 - Capital Region Health Care
- September 20 - Workforce Taskforce Manchester
- October 30 - Presentation to Optum Clinical Advisory Group Waltham
- November 19 - Merrimack County Providers Group
- November 26 - Hillsborough County
- December 10 - Merrimack County

IDN2 works with the NH Department of Health and Human Services (DHHS) and all of the NH IDNs to facilitate statewide and regional solutions to behavioral health needs. IDN2 works collaboratively with this group on the collection of metrics, uses of data and technology to support integration, billing & coding for integration, behavioral health workforce development, and sustainability of the core components of the DSRIP projects once federal funding is no longer available.

IDN2 oversees a SUD Continuum of Care (CoC) facilitator. This position was funded in the past by the Bureau of Drug and Alcohol Services (BDAS) to serve through the Division of Public Health Services (DPHS). Riverbend hired and oversaw this person through to when BDAS funding ended, at which time the position was funded by IDN2. Here are some of the community building activities that person worked on during this reporting period:

- Capital Area Leadership Team - This collaborative meeting brings various community organizations together to share information on program updates and ways to improve access to care for individuals with substance use disorders.
    - Facilitates monthly meeting of approximately 38 leaders, providers, and others to ensure on-going discussion and communications across the SUD continuum and re-affirm priorities to build sustainable networks with stakeholders in the Capital Region.
    - Identifies additional stakeholders who may assist in building a robust Capital Area Leadership Team and continue to shape an Integrated Delivery Model of care and supports for Substance Use Disorders.
    - Conducts 1:1 meeting with SUD stakeholders to gather further information and build stronger relationships across the region.
    - Keeps monthly meeting minutes, agendas, handouts, PowerPoint slides, and other files organized for communication and future documentation purposes.

- Mental Health First Aid Trainings

- The Doorway
    - Collaborates with The Doorway Team to build a current SUD resource database for the Capital Region including all SUD treatment providers, MAT providers, Recovery resources, and extended services within a 60-mile radius.

    - Assists in promotion of The Doorway and introduced manager to established coalitions such as the Bow education group.
    - Identifies and collaborates with new providers to inform them of 211 information crisis line and regional resources.
    - Attends information sessions and workshops on The Doorway when possible to stay informed of initiatives and processes being implemented to share with Capital Area Leadership Team.

- Community Education Group
    - Attend monthly meetings of the CEG and assist in community-wide activities to educate the public on mental health as a disease and will be chairing two events for Mental Health Month in May 2019.
    - Met with national author to discuss attendance at May 2020 MHAM event. Participate in monthly planning committee.

- The Governor's Commission Recovery Task Force
    - Attended monthly Governor's Commission Recovery Task Force meetings on issues pertaining to recovery resources throughout the State.
    - Co-chaired, developed, and facilitated a sub-committee for developing standards and criteria for a "Recovery Friendly Community" per request from Manchester Community Mental Health. Researched evidence-based practices and guidelines for what constitutes an RFC. Guidelines finished in draft form and sent to MCMH for review and suggestions.

In addition to the work described above, the Capital Area CoC Facilitator will now oversee IDN2's Complex Care Coordination project and provide support to IDN2 administrative staff.

IDN2 also has regular meetings with community entities (most are monthly) to conduct outreach and collaborate on a system of care for the region. Some of those include:

- Bow Community Resource Group
    - DCYF/Juvenile Justice
    - Bow School district SW
    - Weare School district SW
    - Waypoint
    - Bow Mills Methodist church
    - Bow Police Department

- Concord Community Resource Group
    - Waypoint
    - Head Start
    - Wellsense
    - NH Healthy Families
    - The Children's place
    - Concord School district
    - Friends Emergency Housing,

- Concord Homeless Resource Provider
    - Concord Homeless Resource Ctr
    - Mckenna House
    - Concord City Welfare
    - Granite United Way
    - Concord Police Department
    - Veterans Services

    - Concord City Council representative
    - Friends Emergency Housing
    - Office of Public Guardian
    - Portsmouth Hospital
    - Riverbend
    - Senior Law Project
- Pembroke/Allenstown Community Providers
    - Pembroke and Allenstown School District
    - Pembroke/Allenstown Police Department
    - Riverbend
    - Juvenile Justice
- Hillsboro area Resource Providers
    - Hillsboro-Deering school district
    - Hillsboro Town welfare
    - Southern NH Services
    - Hillsboro Police Department
    - Genesis project (juvenile Diversion)
    - Home Healthcare and Hospice
    - local churches

Governance

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

The IDN2 Executive Committee consists of six members. The three Chief Executive Officers (CEO) of Capital Region Health Care's (CRHC) organizations: Concord Regional Visiting Nurse Association (CRVNA), Riverbend, and Concord Hospital (CH) head the Executive Committee. Other members of the Executive Committee include the clinical (RB, CH), technology (CRVNA), and financial (CH) leads. The Project Director attends these meetings and is guided in her day to day work by them.

The Finance Committee develops the budget and provides financial reports. It is comprised of the Chief Financial Officers (CFO) of CRVNA, Riverbend, and Concord Hospital as well as IDN2s Managing CEO, Project Director, and Accountant.

The Oversight & Sustainability Committee is the quality control branch of IDN2's governance structure. Its charter is to:

- Review and understand all process and performance metrics required by the DSRIP project
- Receive reports from Project Management Team about process and performance metrics achieved to date and those to be achieved in the future
- Identify and evaluate any potential obstacles to achieving process and performance metrics
- Consider and discuss proposed or other sustainability issues and concerns
- Make recommendations for action

This Committee is comprised of clinical, technology, compliance, and QI/QA decision-makers and leaders from Riverbend, Concord Hospital, Concord Hospital Medical Group, and Dartmouth Hitchcock-Concord.

Budget

Budget Item	Potential 2021	Approved 2020	Actual 2019	Actual 2018	Actual 2017	Actual 2016
Admin Staffing	$325,343	$574,726	$577,535	$536,430	$368,992	$119,653
Travel & Mileage	$0	$15,000	$14,113	$17,809	$3,653	$765
Meeting Supplies / Refreshment	$0	$5,000	$4,928	$4,751	$261	$0
Office Supplies	$0	$5,000	$7,552	$8,113	$7,342	$692
Minor Equipment	$0	$0	$0	$0	$1,376	$1,326
Other Direct Expense	$0	$0	$0	$0	$486	$281
PPI ADMIN TOTAL	**$325,343**	**$599,726**	**$604,128**	**$567,103**	**$382,110**	**$122,716**
BH WF Staffing	$382,030	$425,030	$323,111	$134,890	$90,325	$0
Staff Training	$0	$15,000	$31,530	$25,996	$20,294	$0
Recruitment	$0	$3,000	$2,278	$28,053	$33,481	$0
A1 Behavioral Health Workforce TOTAL	**$382,030**	**$443,030**	**$356,919**	**$188,939**	**$144,100**	**$0**
HIT Staffing	$27,000	$112,000	$86,943	$105,536	$9,833	$0
Technology Equipment	$0	$10,000	$0	$0	$0	$0
Vendors, DM, ST, Interfacing	$57,000	$85,619	$79,959	$154,906	$16,516	$0
A2 HIT TOTAL	**$84,000**	**$207,619**	**$166,902**	**$260,442**	**$26,349**	**$0**
Integration Staffing	$1,552,490	$2,002,713	$1,250,980	831,819	335,950	$0
Incentives	$9,500	$16,000	$0	$0	$0	$0
Malpractice	$0	$10,000	$10,000	$9,999	$5,000	$0
B1 INTEGRATION TOTAL	**$1,561,990**	**$2,028,713**	**$1,260,980**	**$841,818**	**$340,950**	**$0**
Reentry Staffing	$0	$219,326	$196,947	$234,926	$153,291	$0
Testing Supplies	$0	$11,755	$10,445	$143	$4,367	$0
C2 REENTRY TOTAL	**$0**	**$231,081**	**$207,392**	**$235,069**	**$157,658**	**$0**
MAT Staffing	$222,095	$374,826	$335,375	$257,465	$26,957	$0
Provider Incentives	$0	$52,500	$51,440	$37,416	$5,520	$0
Flex Funds	$0	$10,000	$0	$0	$0	$0
D1 MAT TOTAL	**$222,095**	**$437,326**	**$386,815**	**$294,881**	**$32,477**	**$0**
ECC Staffing Sub-Total	$37,500	$81,200	$89,979	$185,085	$74,341	
Flex Funds	$0	$10,000	$15,264	$3,256	$0	$0
E5 ECC TOTAL	**$37,500**	**$91,200**	**$105,243**	**$188,341**	**$74,341**	**$0**
TOTAL	**$2,612,958**	**$4,038,696**	**$3,088,379**	**$2,576,593**	**$1,157,985**	**$122,716**

On the following page is a breakdown of actual and projected income and expenses over the years of the DSRIP project. Of note is that there is a delay in the receipt of earned funds meaning that IDN2's projects will mostly continue through 2021. In addition, county funding is not secure and that has not been taken into account in this chart.

Five Year Cash Flow - Actual and Projections

	2016	2017	2018	2019	2020	2021	TOTAL
Income	**Actual**	**Actual**	**Actual**	**Actual**	**Budgeted**	**Proposed**	
Carry over		**$2,272,314**	**$3,031,715**	**$1,495,749**	**$482,074**	**$1,594,240**	
Received:							
Infrastructure	$2,395,030						
Project Plan		$548,140					
Jan-Jun 2017		$1,369,247					
Jul-Dec 2017			$1,040,627	$328,620			
Jan-Jun 2018				$1,355,819			
Jul-Dec 2018				$390,266			
Expected:							
Jan-June 2018					$13,428		
Jul-Dec 2018					$978,981		
Jan-Jun 2019 SAR					$1,369,247		
Jul-Dec 2019 SAR					$1,369,247		
Jan-Jun 2020 SAR					$1,419,959		
Jul-Dec 2020 SAR						$1,419,959	
Total Income	**$2,395,030**	**$1,917,387**	**$1,040,627**	**$2,074,704**	**$5,150,862**	**$1,419,959**	**$13,998,569**
Income + Carry Over	**$2,395,030**	**$4,189,701**	**$4,072,342**	**$3,570,453**	**$5,632,936**	**$3,014,199**	
Expenses	**Actual**	**Actual**	**Actual**	**Budget**	**Projected**	**Projected**	**Projected**
PPI Administration			$590,597	$604,128	$599,726	$325,343	
A1 BH WF Dev			$120,892	$356,919	$443,030	$382,030	
A2 HIT			$251,923	$166,902	$207,619	$84,000	
B1 Integration			$777,048	$1,260,980	$2,028,713	$1,561,990	
C2 Re-entry			$211,825	$207,392	$231,081	$-	
D1 MAT			$340,369	$386,815	$437,326	$222,095	
E5 ECC			$152,845	$105,243	$91,200	$37,500	
Total Expenses	**$122,716**	**$1,157,985**	**$2,576,593**	**$3,088,379**	**$4,038,696**	**$2,612,958**	**$13,597,328**
Contingencies	**$2,272,314**	**$3,031,715**	**$1,495,749**	**$482,074**	**$1,594,240**	**$401,241**	**$401,241**

PPI Administration Budget Notes

4.70 FTE Staff

0.10 Chief Technology Officer [redacted]
0.30 Managing Chief Executive Officer [redacted]
0.35 Associate Chief Medical Officer [redacted]
0.40 Administrative Assistant [redacted]
0.40 Accountant [redacted]
0.50 Bookkeeper [redacted]
0.45 Financial Data Analyst [redacted]
1.00 Human Resources [redacted]
1.00 Consultant Project Director [redacted]
0.20 Project Manager [redacted]

Travel & Mileage – Local and statewide travel for all IDN2 admin and project staff

Meeting Supplies / Refreshments – For all member and governance meetings

Office Supplies – For all IDN2 staff

Minor Equipment – Was used during start up in 2016

Other Direct Expense – Was used during start up in 2016

Project A1: Behavioral Health Workforce Capacity Development

Studies, including those relied on by the all-IDN statewide behavioral health workforce taskforce, show that the key reasons for a behavioral health workforce shortage in NH are:

- Cumbersome rules around licensing, supervision, and out of state hiring.
- Low wages, most often due to low rates of Medicaid reimbursement for Community Mental Health Center (CMHC) services.
- Stigma surrounding working with those with mental health and substance use disorders.

In the IDN2 region, we have eleven (11) integrated health care sites and they fall into the following categories. Numbers served is in parentheses. This is not just Medicaid, but all served.

Concord Hospital Medical Group (CHMG) sites with an embedded Riverbend employee (each individual site is its own B1 integrated health care entity)

- Concord Family Medicine (8,728)
- Epsom Family Medicine (5,194)
- Family Physicians of Pembroke (5,093)
- Internal Medicine Horseshoe Pond (3,968)
- Penacook Family Physicians (6,597)
- Pleasant Street Family Medicine (6,585)

CHMG sites with their own behavioral health employees (each individual site is its own B1 integrated health care entity)

- Family Health Center – Concord (11,869)
- Family Health Center – Hillsboro (3,408)

Dartmouth Hitchcock Concord (DHC) with its own behavioral health employees (the overall site is a B1 integrated health care entity)

Riverbend as a mental health and substance use disorders (SUD) provider and as a reverse integration site (the overall site is a B1 integrated health care entity, with an emphasis on these programs):

- Children's Intervention Program (ChIP) (1000)
- Community Services Program (CSP) (1200)
- Riverbend Counseling Associates (700)
- Choices Addiction Treatment and Recovery Services (150)
- Riverbend Integrated Center for Health with embedded Family Health Center medical staff (300)

Concord Hospital Substance Use Services (SUS) as a SUD provider (the overall site is a B1 integrated health care entity)

The difference in salary between a hospital employed (DHC or CH) behavioral health staff member and a Riverbend one is approximately $20,000 per year.

The Family Health Center has six (6) behavioral health staff, most of whom have been in their positions for a while. Dartmouth Hitchcock Concord has three (3) behavioral health staff, who have been in their roles for about a year and a half.

For most of this reporting period, the six (6) CHMG sites have had to share anywhere from two-four (2-4) Riverbend employed behavioral health staff. One site has been without a behavioral health staff person for nearly a year. Many of those who have left their jobs did so to work for a managed care organization (MCO), where they could make more money.

These problems are beyond the scope of what IDN2 can do alone. It does most of its advocacy work along with the other IDNs through the statewide behavioral health workforce taskforce. In addition, IDN2 started a billing and coding committee to address Medicaid reimbursement. That committee grew to include all regions and more than 75 participants. It is now managed statewide. Regionally, IDN2 has taken the following steps:

Recruitment / Hiring

- Hiring persons with the right mix of interest, experience, and skills and providing them with additional educational and training opportunities to advance their knowledge.
- Hiring at the top of the credential. For example, hiring APRNs to fill psychiatrist roles.
- Offering sign-on bonuses for IBHCs.
- Building a network of peers who can delivery recovery support services.
    - IDN2 now has 10.75 peers, all of whom are Certified Recovery Support Workers (CRSW) or working toward CRSW
        - 6.25 peers are based at Riverbend's CHOICES site
        - 1 is contracted from NAMI NH to address family-focused needs.
        - 1 is contracted from Youth Move to address youth-focused needs.
        - Another 2 are being hired to be based at partner sites Waypoint and CH Substance Use Services (SUS)
    - A peer navigator oversees and manages peer deployment to IDN2 partner sites including:
        - Emergency room
        - Primary and specialty care practices
        - In the community

Retention

- Providing meetings, by project and/or role, for all IDN2 staff, whereby they can discuss and receive support for challenges and successes.
- Distributing learning opportunities to all IDN2 staff and encouraging participation, including through the availability of scholarships.
- Offering annual incentives for IBHCs who remain in their jobs.

Training

IDN2 places a premium on training and pays for staff to attend trainings and conferences. This is a sample of those attended during this report period.

Training	IDN Project Attendees	Description
July		
MAT Community of Practice meeting	MAT	Polysubstance Use: Utilizing a harm reduction lens
Matrix Training	MAT	Evidence-based treatment program for substance use disorder that addresses resistance, engagement, developing pro-social activities, peer support, self-management, and relapse prevention skills.

Improving Cultural Competency for Behavioral Health Professionals	Integration	- How culture, cultural identity, and intersectionality are related to behavioral health and behavioral health care. - Principles of cultural competency and cultural humility. - How bias, power, and privilege can affect the therapeutic relationship. - Ways to learn more about a client's cultural identity. - How stereotypes and microaggressions can affect the therapeutic relationship. - How culture and stigma can influence help-seeking behaviors. - How communication styles can differ across cultures. - Strategies to reduce bias during assessment and diagnosis. - How to elicit a client's explanatory model.
ASAM Criteria Conference	MAT	
August		
Military Culture	Integration	Examines general military culture, distinguishes between the various branches and components of the military, including the role and mission of the NH National Guard and Reserve Force, as well as understand the differences between types and frequency of deployments. Participants will: increase understanding of the military and veteran population and culture; gain an increased understanding of the strengths, values, and unique qualities that veterans, military families, and service members possess; be able to list at least 2 specific challenges this population encounters while serving, upon returning from deployment; and after discharge; name at least one strategy that may assist providers that are treating this population.
September		
Mental Health and Addiction Treatment Conference	MAT	• Improve the overall quality of services delivered and increase the competencies of clinicians • Apply clinical skills from a broad range of professional core functions including assessment and therapeutic approaches. Cite advances in the field resulting from research and practice innovations. • Bring awareness to key issues such as cultural diversity, gender issues, sexual orientation and age specific differences in relation to clinician/client interaction. Discuss ways to build a collaborative culture within the allied health professions. Provide training necessary to implement innovations toward achieving organizational excellence and improving clinical/financial outcomes and operational efficiencies. • Assist participants in building and sustaining competitive advantages through outcomes, informed treatment and recovery services. Protectively address the challenges, risks and opportunities presented by a changing competitive environment.
Protective Factors	MAT	Comprehensive suite of training materials that support implementation of the Strengthening Families™ Protective Factors Framework in multiple settings. The curriculum content includes materials on partnering with parents and concrete examples of everyday actions that research has shown to be effective in strengthening families.

Pro Health NH Conference	Integration	Explore whole person thinking about physical and behavioral health for improved outcomes. Grasp youth culture today and learn effective interventions. Audience: NH Community Mental Health Centers & Primary Care Clinics Administrators, Case Managers, Peers, and Clinical Staff 3.5 CME/CEUs available Southern NH AHEC is an Approved Provider of continuing nursing education by the Northeast Multistate Division (NE-MSD), an accredited approver of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.
Wraparound Training	MAT	Family and Youth-Driven Wraparound is a facilitated, team-based process to assist children and youth with significant emotional or behavioral challenges and their family to develop a plan that will lead to improvements in the child's and family's life. Wraparound is facilitated by a well-trained and coached individual called a Wraparound Coordinator. Family and youth peer support are integral parts on NH's model.
Annual Mental Health Conference	ECC	Understanding and Addressing the Impacts of Maternal Substance Misuse
Mental Health and Wellness in the Workplace: Strategies to Support Living with Mental Illness	ECC, Integration	Learning Objectives: In this presentation, our speaker will share statistics about mental health in the workplace and explore the underutilization of employee assistance programs due to fear of stigma and discrimination. She will introduce a term called "presenteeism" and its impact on mental health in the workplace and share a personal story of being a high performing, award-winning professional navigating the corporate world, while suffering in silence with alcohol use disorder, major depression, anxiety, and suicidal thoughts. Finally, a "judgement free zone" and its effect on compliance and recovery will be presented.
RENEW Graphic Facilitation	ECC	- The logic and target population for The RENEW model. - How to engage youth using graphic facilitation - How to facilitate The RENEW mapping process
Project ECHO	Integration, MAT	Collaborative learning experience with a case presentation and input for all participants.
October		
Buprenorphine Waiver Training	MAT	Training is available for physicians interested in seeking their waiver to prescribe buprenorphine in the treatment of opioid use disorders. To obtain the waiver to prescribe, providers are required to take eight hours of training. • Following trainings, physicians who have successfully completed the course, may apply to the Substance Abuse and Mental Health Administration (SAMHSA) to obtain the waiver. • 8 AMA PRA Category 1 credits and a Buprenorphine Training Completion Certificate will be awarded to those who complete all 8 hours of the course and receive a minimum cumulative score of 75% on the examination. • Resident physicians may take the course and apply for their waiver when they receive their DEA license. They will need to maintain their certificate of completion following the training. • PAs, NPs, CNMs, CNSs and CRNAs who take this 8-Hour MAT waiver course will receive a certificate of completion and can apply it toward the 24-hour training requirement established by the Comprehensive Addiction and Recovery Act (CARA). PCSS-MAT is also providing the additional 16 hours of online coursework FREE and together they meet the required training to be eligible to apply for the waiver to prescribe buprenorphine.

Mental Health and Wellness in the Workplace: Strategies to Support Living with Mental Illness	ECC, Integration	In this presentation, our speaker will share statistics about mental health in the workplace and explore the underutilization of employee assistance programs due to fear of stigma and discrimination. She will introduce a term called "presenteeism" and its impact on mental health in the workplace and share a personal story of being a high performing, award-winning professional navigating the corporate world, while suffering in silence with alcohol use disorder, major depression, anxiety and suicidal thoughts. Finally, a "judgement free zone" and its effect on compliance and recovery will be presented.
Project ECHO	Integration, MAT	Collaborative learning experience with a case presentation and input for all participants.
November		
NHADACA Annual Meeting	Integration	Brain injuries related to substance use
Sexual and Domestic Violence	MAT	
Pain Management and Opioids: Balancing Risks and Benefits	Integration, MAT	Improve the management of Patients with pain with increased competence related to applying the pathophysiology of pain as it relates to pain management; accurately assessing patients with pain; developing a safe and effective pain treatment plan; recognizing the risks and benefits associated with opioid therapy to initiate safe and judicious treatment; monitoring and reevaluating ongoing opioid treatment; recognizing behaviors that may be associated with opioid use disorder.
NH Opioid CME Competency Requirement Program	MAT	Perioperative Management of Patients with Opioid Use Disorders; Overview of MAT injectable & Experience in NH Correction Facilities; Fast and furious OMT: A Hands-On Workshop (alternative pain treatment)
Managing Psych Issues for the Non-Psych Nurse	MAT, Integration	This program session is designed to provide nurses who practice in non-psychiatric settings with an overview of common psychiatric diagnoses, specific interventions to manage a wide range of behavioral issues and important information related to the medical-psychiatric patient.
December		
SUD Treatment Community of Practice	MAT	The presentation reviewed assessment tools and other considerations when working with clients who have schizophrenia and schizoaffective disorder. Attendees observed and assessed a role play of an initial counseling session.
NH Behavioral Health Conference	Integration, MAT, ECC	Multiple topics and subjects
MAT Community of Practice meeting	MAT	Presented
Project ECHO	Integration, MAT	Collaborative learning experience with a case presentation and input for all participants.

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

No key organizations, providers, or partners have been off-boarded or added.

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

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

Staffing (on IDN2 payroll) - All Projects

Provider Type	Project	FTE Need	12/31/18	6/30/19	12/31/19	Licensed MH, MLADC, Peer, other front-line providers
Managing Chief Executive Officer	A1, A2, B1, C2, D1, E5	.30	.30	.30	.30	.30 Licensed MH Professional
Chief Technology Officer	A1, A2, B1, C2, D1, E5	.10	.10	.10	.10	
Associate Chief Medical Officer – Concord Hospital	A1, A2, B1, C2, D1, E5	.35	.35	.35	.35	
Accountant	A1, A2, B1, C2, D1, E5	.40	.40	.40	.40	

Bookkeeper	A1, A2, B1, C2, D1, E5	.50	.50	.50	.50	
Financial Data Analyst	A1, A2, B1, C2, D1, E5	.45	.45	.45	.45	
Human Resources	A1, A2, B1, C2, D1, E5	1.00	1.00	1.00	1.00	
Consultant Project Director	A1, A2, B1, C2, D1, E5	1.00	1.00	1.00	1.00	
Concord Hospital Project Manager	A1, A2, B1, C2, D1, E5	.20	.20	.20	.20	
Administrative Assistant	A1, A2, B1, C2, D1, E5	.40	.40	.40	.40	
Peers	A1, B1, C2, D1, E5	10.75	5.75	9.25	10.75	9.75 Peer Recovery Coaches; 1 other front-line provider
Tech Support	A2, B1	.70	.70	.70	.70	
Data Analyst	A2, B1	.50	.50	.50	.50	
Integrated Behavioral Health Clinician	B1, D1	7	6	5	5	5 Other front-line providers
Integrated Care Manager	B1	3	2	2	3	3 Other front-line providers
Behavioral Health Clinician	C2	1	1	1	1	1 Other front-line providers
Care Coordinator	D1, E5	3	2	2	3	3 Other front-line providers
Case Manager	B1, C2	3	3	3	3	3 Other front-line providers
Clinical Manager	B1, D1	1.6	1.6	1.6	1.6	.5 Licensed MH Professional
Project Supervisor	B1, C2, D1, E5	1.45	1.45	1.45	1.45	1.45 Licensed MH Professional; .1 MLADC
Psychiatrist / Psychiatric Nurse	B1, C2	1.7	2	1.7	1.7	1.7 Licensed MH Professional; .1 MLADC
Medical Assistant	B1	1	1	1	1	1 Other front-line providers
Substance Use Disorder Counselor	C2, D1	1.5	1	0	1.5	1.5 Licensed MH Professional
Medicated Assisted Treatment Provider at Choices	D1	1	1.4	1.4	1	1 Other front-line providers
Registered Nurse	B1	1	0	0	0	
Nurse Care Coordinator	B1	1	1	1	1	1 Other front-line providers
Practice Care Coordinator	B1	1	0	0	1	1 Other front-line providers
Practice Manager	B1	.10	0	0	.10	
Program Assistant	C2, E5	.30	.30	.30	.30	
TOTALS		**45.30**	**35.40**	**36.60**	**42.30**	

Provider Type	As of Dec. 31, 2019
Master Licensed Alcohol and Drug Counselors	.20
Licensed Mental Health Professionals	5.45
Peer Recovery Coaches	9.75
Other Frontline Providers	20.00

Budget

Budget Item	Potential 2021	Approved 2020	Actual 2019	Actual 2018	Actual 2017	Actual 2016
BH WF Staffing	$382,030	$425,030	$323,111	$134,890	$90,325	$0
Staff Training	$0	$15,000	$31,530	$25,996	$20,294	$0
Recruitment	$0	$3,000	$2,278	$28,053	$33,481	$0
BH Workforce TOTAL	**$382,030**	**$443,030**	**$356,919**	**$188,939**	**$144,100**	**$0**

Budget Notes

A1 Behavioral Health Workforce Development

10.75 FTE Staff

0.75 Peer Support Specialist (PSS) [redacted]
1.00 PSS [redacted]
1.00 PSS [redacted]
1.00 PSS [redacted]
1.00 PSS [redacted]
1.00 PSS [redacted]
1.00 PSS (for CH Substance Use Services) [redacted]
1.00 PSS (for Waypoint) [redacted]
1.00 Peer Engagement Specialist [redacted]
1.00 Family Support Specialist [redacted]
1.00 Youth Peer [redacted]

Staff Training – For all IDN2 Staff

Recruitment – Advertising for open positions

Retention is addressed in the integrated health care budget as incentives paid for Integrated Behavioral Health Clinicians

Project A2: IDN Health Information Technology (HIT)

IDN2 B1 Partners		
Capital Region Health Care		**Dartmouth Hitchcock**
Within Concord Hospital: Concord Family Medicine Epsom Family Medicine Family Health Center Concord Family Health Center Hillsboro Family Physicians of Pembroke Internal Med. Horseshoe Pond Penacook Family Physicians Pleasant Street Family Medicine CH Substance Use Services	**Within Riverbend:** CHOICES Children's Intervention (CHiP) Program Community Support Program (CSP) Riverbend Counseling Associates (RCA)	**Concord Primary Care**

Evaluation Project Targets

Performance Measure Name	# of Participating Practices	Progress Toward Target		
		As of 12/31/18	As of 6/30/19	As of 12/31/19
Event Notification Services	17	7	15	17
Shared Care Plan	4	4	4	5
Closed Loop Referral	16	16	16	16
Data Reporting	15	15	15	15
Data Sharing	17	15	17	17
Care Coordination	17	17	17	17

Collective Medical Technologies (CMT)
Event Notification Services and Shared Care Plan

As of the end of this reporting period, July-December 2019, the following IDN2 B1 and partner sites are receiving **event notifications**:

- 8 Concord Hospital primary care sites
- Concord Hospital Emergency Department
- 4 Riverbend-based programs
- Concord Regional VNA
- IDN2 Complex Care Program
- Dartmouth Hitchcock-Concord (they went live with event notifications November 2019).
- NAMI NH (they went live with event notifications during this reporting period).

Please note that New Hampshire Hospital will be going live in the early part of 2020.

Progress in being able to implement new workflows and collaborate with IDN-based partners on entering **shared care plans** was significantly delayed due to NH-wide CMT technical issues that prevented any shared care plan from being viewed either in the CMT portal or on printed/faxed event notifications. The ability to view shared care plans was resolved in August 2019 and in September 2019, the issue with shared care plans not printing as part of an event notification was resolved.

Below are implementation narratives for the IDN2 sites using CMT for event notification services and/or as a shared care plan:

Concord Hospital Emergency Department (CHED)

Based on feedback from the physicians and staff in the CHED about the numbers of event notifications they were receiving, the HIT project team changed the level of their notifications to viewing those that contain shared care plans as well as event information that occurs at other CMT member hospitals. They already have notification processes in place directly in their electronic health record (EHR), Cerner, for their own patient encounters. This change allows them to more efficiently allocate their time and historical data is still viewable in their portal. Once the CMT-based technical issue with the shared care plan was fixed, the Concord Hospital-based analyst in charge of overseeing the rollout of CMT in CHED confirmed that they were able to see shared care plans, both on faxed event notifications and via the portal. In the next reporting period, IDN2 HIT project team members will work with the CHED team to further expand their use and knowledge of CMT.

Concord Hospital Substance Use Services

They are still reviewing the viability of implementing CMT at their location due to the structure of their services whereby they interact with their clients for a continuous period of time-based on treatment protocol. The consent process was reviewed and confirmed by Concord Hospital's Privacy Department who determined that the consent form in place for the other CHMG sites can be utilized as Concord Hospital Substance Use Services will not be sharing/entering any 42CFR Part 2 data into CMT.

Concord Hospital (CH) Primary Care Provider (PCP) Sites

Epsom is leading the efforts in CMT utilization by focusing their patient care coordination processes based on patients seen in the ED more than 3 times in 3 months. Once the faxed event notification is received, it is shared with the PCP and they reach out to the patient for follow up. On a quarterly basis, the Practice Manager accesses the portal and runs and exports utilization reports and graphs to distribute and review with the staff.

The IDN2 HIT project team has dedicated meeting time with the other primary care practices in discussing CMT overall and learning from Epsom's experience in order to guide them in their efforts to adopt CMT workflows. All sites have attended CMT demonstrations and will receive a refresher.

In addition to data validation taking a higher priority for all PCP sites, some sites expressed not knowing what to do with the information they obtain from the event notification, considering that they most likely are already interacting with the patient in a care management role. At a minimum, having access to the event notification information can be reviewed when meeting with the patient at their next appointment to determine if any additional care coordination is needed.

Now that the CH PCP sites have weekly-based Cerner reports to perform their data validations, they can devote more time to CMT utilization. The IDN2 HIT project team intends to explore specific workflow scenarios with them in future integration meetings and use Epsom's hands-on usage of CMT to guide them further.

Riverbend Community Mental Health, Inc. (Riverbend)

As of Dec. 2019, Riverbend remains steady with CMT penetration at 62% with some variation across their four programs. This exceeds their Strategic Plan milestone of 60%. The CHOICES program regularly relies upon and uses the CMT data they receive in collaborating with Drug Court staff for both engagement (through event notification) and shared care plans. The CMT release tracking process was adjusted to ensure that participants are not automatically removed from the eligibility file until the participant specifically opts-out.

IDN2 Complex Care Coordination Program

Based on the ongoing, monthly Complex Care program meetings and CMT event notification review, criteria have been established for closing cases (two quarters in a row of sustained decrease in number of event notifications). A second meeting with the client will be scheduled when there is a noted increase in event notifications in the next quarter. These workflows are validated by the verification steps that are in place to review and monitor the IDN2 Complex Care CMT portal data.

Concord Regional VNA

The clinical based teams at Concord Regional VNA continue to view receiving CMT event notifications as an important collaboration tool in caring for their patients, averaging 500+ notifications each month, based on Emergency Department, Inpatient, and Outpatient visits at the NH- and MA- based Hospitals using CMT.

Concord Regional VNA's clinical management team attended a CMT refresher and demonstration of the platform in September. In this demonstration, they were able to view shared care plans that had been entered by Riverbend. As a result of this demo, their takeaway was to identify the most useful information that the VNA could provide to another CMT member. Workflow discussions included possibly entering shared care plans for their patients with frequent fall incidents and having their Behavioral Health coordinator gain access to CMT to allow her to view the Riverbend-based shared care plans for common clients. Their next step to expand usage of CMT is to glean from other newly on-boarded VNAs in other IDNs (2 in IDN1) what information would add the most value in sharing with Hospital partners on the CMT platform. This was expressed as a shared goal by Dartmouth Hitchcock's team on a monthly NH wide IDN CMT status call in November and is on the agenda on the January 2020 scheduled team call.

Dartmouth Hitchcock Concord (DHC)

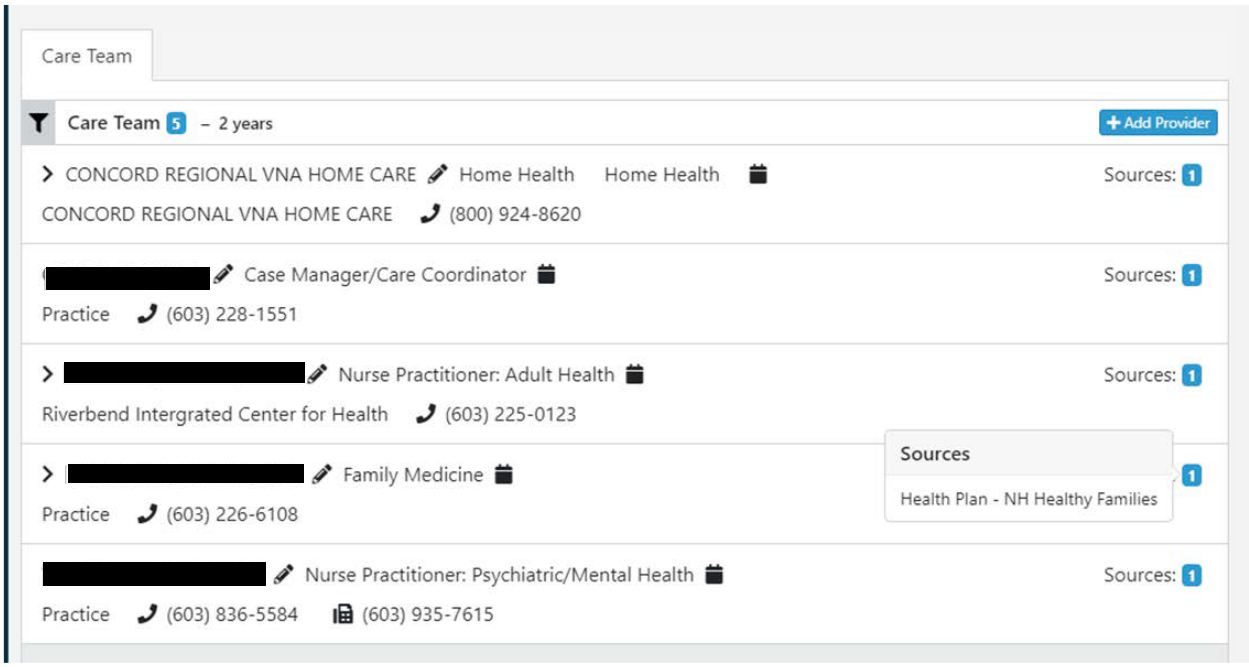
As the Dartmouth-Hitchcock Integration team continues to implement CMT at all of their IDN partner sites, and now that the Concord site is live with event notifications, the next phase of entering shared care plans can be considered and planned for execution in 2020. They currently have one primary care site entering shared care plans in another IDN and are working towards processes that align across all sites.

IDN2 CMT Activity Summary July-December 2019

Facility Name	Total Active SCP's to date	# of SCP's authored July-Dec.	Event Notifications	Total ED Visits
Concord Family Medicine	N/A	N/A	339	N/A
Epsom Family Medicine	N/A	N/A	186	N/A
Family Health Center Concord	N/A	N/A	0	N/A
Family Health Center Hillsboro	N/A	N/A	123	N/A
Family Physicians of Pembroke	N/A	N/A	128	N/A
Internal Medicine Horseshoe Pond	N/A	N/A	218	N/A
Penacook Family Physicians	N/A	N/A	258	N/A
Pleasant Street Family Medicine	N/A	N/A	0	N/A
Concord Hospital	N/A	N/A	433	11793
Concord Regional VNA	N/A	N/A	3507	N/A
Riverbend-ChIP	21	1	65	N/A
Riverbend-CHOICES	45	3	85	N/A

Riverbend-CSP	73	6	151	N/A
Riverbend-RCA	0	0	24	N/A
Complex Care Coordination Project	4	3	4	N/A
Dartmouth Hitchcock-Concord	N/A	N/A	0	N/A
Grand Totals	**143**	**13**	**5521**	**11793**

As a result of having multiple partners now using event notifications, below is an example of how each site is made aware of other patient associated care team members, including the NH MCO's as well.



<u>Sustainability of CMT After the 1115 Waiver ends:</u>

IDN2 needs to discuss and decide as a group the viability of continuing with CMT at all current IDN partner sites and if we decide not to continue, what other options we have. We need to explore our existing systems - particularly Cerner. For example, are there options with custom reporting to have access to the same data in a similar fashion as CMT? The project team can learn from our successes and identify any shortcomings and determine what is most relevant and sustainable long term. Another key component of deciding to continue with CMT is funding: will Concord Hospital still participate by supplying the ADT feed to CMT? Will each partner be responsible for funding their own CMT portal program? While some sites are seeing significant value, others find the information redundant and not beneficial based on existing EHR capabilities in receiving the same information for patients that present at CHED. Two key components of CMT's value are having access to a live snapshot of aggregated data based on all hospitals an individual might visit, especially outside of our immediate region, and seeing which care team members are associated with a given patient/client.

Closed Loop Referral

Existing processes that are in place currently:

Closed Loop Referrals are accomplished at the CH B1 Sites in the following way:

- The primary care physician orders a referral.
- The primary care physician or a designated staff person communicates the referral to the subspecialist.

- The referral is reviewed and authorized.
- An appointment is scheduled.
- The consult appointment occurs.
- The subspecialist communicates the plan to the patient.
- The subspecialist communicates the plan to the primary care physician.
- The primary care physician acknowledges receipt of information from the subspecialist.

In addition, the CH B1 Sites have all achieved Level 3 accreditation with the National Committee for Quality Assurance (NCQA) Patient Centered Medical Home (PCMH). To achieve accreditation, organizations MUST PASS on "Referral tracking and Follow-Up". The practice coordinates including implementing these elements:

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

At the CH B1 Sites, IBHCs are noting referrals to Community Based Organizations (CBO) within Cerner and then adding them to an excel spreadsheet. The IBHCs use the excel spreadsheet to track referrals and ensure that the loop is closed. The IBHC documents the activity within Cerner.

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

At Riverbend, Case Managers at the Community Support Program and the Children's Intervention Program are using a Targeted Case Management note in TIER to document social determinants of health needs and referrals made. These are updated monthly and when a client follows through with a referral, this is documented. Riverbends IDN2 Case Manager uses the same Targeted Case Management note to document referrals and follow through at Choices and RCA.

Unite Us is a potential new closed loop referral system IDN2 could use. IDN2 HIT project team members attended various meetings that discussed in great detail this closed-loop referral platform. It offers a lot of functionality and could be a viable platform to integrate the closed-loop referral processes and workflows across all IDNs. But, considering the late introduction and high costs associated, we have many concerns around short- and long-term sustainability of a new product.

Data Reporting

All B1 measure reporting entities continue to submit all applicable DSRIP measure data to Massachusetts Electronic Health Collaborative (MAeHC) on a regularly scheduled monthly basis. Follow up status calls with MAeHC's project manager are conducted on an as-needed basis. MAeHC's monthly analyzed data is reviewed by IDN2's HIT Team members each month. As a result of ongoing data validation, IDN2 continues to see increased improvement in the data performance percentages each month.

Riverbend

Riverbend has made EHR updates that have resulted in a more streamlined approach to collecting Assess 04 data by adding new evaluation and management reporting fields which represent the notes that are completed by their psychiatric providers to document counseling to quit smoking. This update ensures accurately captured data for reporting purposes. As a result of their ongoing data validation, they identified under-reporting with Assess 01 and Assess 02 and were able to send corrected data files for the current measurement period.

Concord Hospital PCP Sites

All 9 of the reporting B1 sites continue to perform data validation between the MAeHC portal-based data and their EHR, Cerner, which allows them to incorporate and imbed their DSRIP measure-based workflows into their daily clinical processes. IDN2's HIT support person performs MAeHC portal refresher trainings, as requested.

In November, Concord Hospital's data analyst created Cerner-based reports that are structured similarly to the MAeHC portal data with pass/fail viewable data and associated visit encounter information, allowing them to view this data on a weekly basis. Corrections can be made directly in Cerner, as needed, before the DSRIP measure specific data is extracted and reported to MAeHC on the 25th of the month. These reporting tools allow the practices to spend less time performing data validation.

As of 12/15/19, the Riverbend Integrated Center for Health (RICH) program was unbundled from the Family Health Center Concord's reporting and, as a result, their specific encounters will be reported separately to MAeHC, with a newly created facility "CH Primary RICH", along with having a new program created in the MAeHC portal to house their data for viewing and reporting purposes. These changes will take place sometime in January 2020. RICH's CCSA numbers are captured in overall Riverbend reporting.

Starting with 2019 data for the Care 03 DSRIP measure, IDN2 will be submitting data from non-B1 CH PCP sites as confirmed in recent IDN wide data meetings. This is due to these specific patient events being attributed to an IDN2 based on their associated claims data. This is not a heavy lift for the analyst in charge of extracting the data due to their EHR's capabilities.

Dartmouth Hitchcock Concord

Dartmouth Hitchcock put in place a Data Sprint team to review all DSRIP measure data being reported to MAeHC for all of their IDN-based sites and, during this last reporting period, they continued to perform a rigorous review and quality validation of the data to ensure they were meeting their goals of standardized data collection. As a result of this in-depth data analysis, Dartmouth Hitchcock made significant corrections to how data was being captured in their EHR to be more in line with the DSRIP measure criteria. Key Updates:

- Assess 01: Incorporated the 12 months look back criteria into their reporting logic.
- Assess 02: Added components to use billing codes and smart phrases for counseling for positive SUD and Depression screenings as additional interventions.

These corrections were then submitted and accepted by MAeHC as overwrites of the existing previously submitted data, resulting in considerable improvements in measure outcome values as reflected in the portal data.

Dartmouth Hitchcock Concord now has a dedicated Population Health Project Manager who reviews and analyzes the MAeHC portal data on a regular basis along with her Data Sprint team.

Data Sharing

Riverbend

Riverbend continues to explore and discuss their short- and long-term IT related needs and initiatives in determining how they may align with 1115 Waiver priorities.

- Common EHR across all CMHCs
- Laptops for Telehealth
- Embedded EMR direct secure messaging product, CareConnect

Plans are underway to implement two modules from the NetSmart software family to integrate them into Riverbend's existing EHR platform; the first one being their CareConnect product (allows for the bidirectional sharing of continuity of care document across EHR platforms), and the second being TIER's patient portal (allows for clinician and client communication, including client requested appointment scheduling).

Once Riverbend has completed its EHR upgrade to integrate the CareConnect product and New Hampshire Hospital completes its DSM CareConnect implementation, bi-directional data sharing across EHR platforms can commence between these two IDN partners as well as with others who have a DSM address.

The CareConnect project at New Hampshire Hospital has been delayed due to a configuration issue with the continuity of care document set up on their EMR side. The vendor is aware of the issue and is working on a resolution. Until this is resolved, neither IDN2 partners nor anyone else will not be able to electronically share data with New Hampshire Hospital.

Care Coordination

The following chart shows existing care coordination processes.

	DHC	Riverbend	CH Integrated Care Sites
Identify at Risk Patients	Through CCSA, which is built into eDH (EPIC EMR). This is administered on iPads in reception room or via MyDH patient portal.	Intakes, through TIER, is done on all clients, to determine risk level. In addition, Riverbend emergency services staff are embedded at Concord Hospital and document emergency assessments in TIER. This allows for the monitoring of high-risk patients.	Concord Hospital utilizes claims and clinical data to identify high risk patients in a variety of medical conditions including, but not limited to, congestive heart failure, COPD, asthma, diabetes, depression, obesity, chronic kidney disease, and many other conditions. They use analytic tools through Cerner Health-e Intent to identify high risk and high utilizer patients. With the B1 project, at risk patients for MH, SUD, and SDOH are identified through the CCSA.
Plan Care	Patients with "positive" responses will be elevated to Share Care Plan status and uploaded to CMT.	Following intake, a therapist develops a preliminary treatment plan. In addition, identification of high risk medical / non-PCP patients are referred to the RICH program. These are recorded in TIER.	This is done through Cerner's shared care plan, which is used by the B1 team.

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

New Care Coordination Project

During this reporting period, a new care coordination project has been initiated, the Collaborative Care Model (CoCM). CoCM will be piloted at Family Physicians of Pembroke with a projected go live in March of 2020.

As part of this model, IDN2 will be using a robust Excel-based, HIPPA compliant registry designed by the AIMS Center at the University of Washington. It is designed specifically to track the care of behavioral health patients in integrated care settings. It will be used in parallel with the existing EHR as clinical notes are not entered in the registry. Pending approval by Concord Hospital, it will be securely stored on their servers. Authorized users will be given specific rights of access.

Built-in functionality includes:

- Visit dates
- Provides reminders for patient follow-up

- Separate portals for care managers, psychiatric consultants, clinic supervisors, and data analysts to allow them to perform their specific job functions
- Identifies patients not improving to be prioritized for treatment adjustment or psychiatric case review
- Color-coded PHQ-9 and GAD-7 scores based on results of entered scales/assessments (*IDN2 is adding an evidence-based SUD assessment to the registry*)
- Displays progress over time for individual trends
- Calculates real-time statistics like caseload size, length of time in treatment, and frequency of visits.
- Tracks minutes of service delivered each month to facilitate CPT and CoCM Code billing
- Report options to send to other team members based on active caseload list, caseload statistics, monthly time tracker
- Clinical Dashboard view that summarizes all recorded information for a patient in one screen

Budget

Budget Item	Potential 2021	Approved 2020	Actual 2019	Actual 2018	Actual 2017	Actual 2016
HIT Staffing	$27,000	$112,000	$86,943	$105,536	$9,833	$0
Technology Equipment	$0	$10,000	$0	$0	$0	$0
Vendors, DM, ST, Interfacing	$57,000	$85,619	$79,959	$154,906	$16,516	$0
HIT TOTAL	**$84,000**	**$207,619**	**$166,902**	**$260,442**	**$26,349**	**$0**

Budget Notes

A2 Health Information Technology

1.20 FTE Staff

0.70	HIT Manager	Pam Leduc
0.50	HIT & Data Analysis	CH IT Team

Technology Equipment - Computers, Tablets, Phones, etc.

Vendors – MAeHC, CMT

Project B1: Integrated Healthcare

As stated within the A1 Behavioral Health Workforce Development portion of this report, IDN2's eleven (11) integrated healthcare sites are grouped into several types. This update on each's integration progress will address them in that way. Please note that data is limited to four months for CHMG sites due to issues with the data aggregator vendor and five months for all others because the December data is not validated until the end of January.

CHMG sites with an embedded Riverbend employee

Concord Family Medicine (CFM)	
# of Medicaid patients Jul, Aug, Sept, Nov	900
# of CCSAs completed Jul, Aug, Sept, Nov	596
# of referrals for SUD/MH Jul, Aug, Sept, Nov	4
# of smoking cessation counseling Jul, Aug, Sept, Nov	100

CCSA completion scores have improved significantly at CFM. They continue to initiate process improvement ideas and workflows to improve their smoking cessation scores. The IBHC at CFM is included in the morning Pod Huddles, which allows everyone to be proactive in identifying patients that may need IBHC assistance at the time of their PCP/Primary Care Visit (including CCSA identified patients). She maintains a positive rapport with providers and staff, attending important meetings in which behavioral health topics are discussed with the intent to improve patient outcomes. The psychiatrist is at CFM one day per week and is a resource in person and by phone for providers who are prescribing and managing psychiatric medications. The entire team has monthly case management meetings, which include the clinical leader, physician(s), nurse navigator, practice manager, and IBHC. In addition to formal trainings, the IBHC facilitated two behavioral health topics at monthly staff meetings and Riverbend Mobile Crisis and Crisis Treatment Center (CTC) presented to all staff about available services. Prior to the IBHC's departure, CFM dedicated two one-hour meetings to behavioral health topics, community resources, and outreach ideas. The IBHC and resource nurse created resource binders that were placed in each pod (4) and triage (2). There are three MAT providers at CFM who have a panel of MAT patients and can accept others in need from the practice. CFM providers follow the mild-moderate depression protocol that was developed and shared with them.

Epsom Family Medicine (Epsom)	
# of Medicaid patients Jul, Aug, Sept, Nov	638
# of CCSAs completed Jul, Aug, Sept, Nov	315
# of referrals for SUD/MH Jul, Aug, Sept, Nov	39
# of smoking cessation counseling Jul, Aug, Sept, Nov	105

Epsom revised its CCSA workflow after the departure of the IBHC so that they could still provide behavioral health screening and follow up services. When the IBHC was in place, she attended the clinical team huddles each morning. Each team identified patients being seen that day that needed to be introduced to the IBHC and/or required behavioral health services. Providers give warm handoff to the IBHC after completion of the office visit. The IBHC office at Epsom is centrally located to provide easy access for all team members. Clinical staff connected with the IBHC for input and questions and the IBHC attended all staff meetings and provided education. Referrals for psychiatric consultations are processed through the EMR. Resource for providers regarding prescribing and managing psych medicines. The IBHC developed a strong relationship with providers and would connect in real time with any questions, follow up, and collaborate on a care plan. The psychiatrist is at Epsom one morning per week and is a resource in person and by phone for providers who are prescribing and managing psychiatric medications. In addition to formal trainings, the following were held at all staff practice improvement meetings: Guidelines for referral to IBHC during staffing shortage;

Referral guidelines to Choices, CH SUS, and Mobile Crisis; and CCSA workflow. Epsom does not have a PCP MAT provider currently and refers to Choices or CH SUS for those requiring SUD or MAT services. Peers are available to support transitions to care. Epsom providers follow the mild-moderate depression protocol that was developed and shared with them.

Family Physicians of Pembroke (Pembroke)	
# of Medicaid patients Jul, Aug, Sept, Nov	712
# of CCSAs completed Jul, Aug, Sept, Nov	330
# of referrals for SUD/MH Jul, Aug, Sept, Nov	26
# of smoking cessation counseling Jul, Aug, Sept, Nov	162

Pembroke continues to improve and strengthening their workflows and ability to capture vital information. A major accomplishment for this reporting period is that many patients who may have not been connected to services in the past are now getting connected to the services and resources that they need. Pembroke providers frequently loop in the IBHC to visits, allowing patients to meet them before scheduled appointment with IBHC. In addition, they also work to coordinate visits with the psych provider to optimize the patients' time in the office. In addition to formal training, Pembroke has had in-house training in crisis management. Pembroke does not have a PCP MAT provider currently and refers to Choices or CH SUS for those requiring SUD or MAT services. Peers are available to provide support for transitions to care. Pembroke providers follow the mild-moderate depression protocol that was developed and shared with them. IDN2 is piloting the Collaborative Care Model (CoCM) at Pembroke in March 2020. More about the CoCM is under Alternative Payment Models (APM) beginning on page 46.

Penacook Family Physicians (Penacook)	
# of Medicaid patients Jul, Aug, Sept, Nov	915
# of CCSAs completed Jul, Aug, Sept, Nov	443
# of referrals for SUD/MH Jul, Aug, Sept, Nov	54
# of smoking cessation counseling Jul, Aug, Sept, Nov	155

Penacook providers regularly consult with the IBHC and include her in visits and/or make warm handoffs to her. Communication between the IBHC and Penacook providers and staff has greatly improved after some confusion about when and how to refer to her. In addition to formal training, Penacook has had in-house training in crisis management. Penacook does not have a PCP MAT provider currently and refers to Choices or CH SUS for those requiring SUD or MAT services. Peers are available to provide support for transitions to care. Penacook providers follow the mild-moderate depression protocol that was developed and shared with them.

Pleasant Street Family Medicine (PSFM)	
# of Medicaid patients Jul, Aug, Sept, Nov	509
# of CCSAs completed Jul, Aug, Sept, Nov	61
# of referrals for SUD/MH Jul, Aug, Sept, Nov	5
# of smoking cessation counseling Jul, Aug, Sept, Nov	43

PSFM does not currently have an IBHC. Additional education with the staff and providers has been done to manage behavioral health needs. In addition, a modified workflow was adapted to work around not having an IBHC. The psychiatric consultant is at PSFM every Tuesday and she delegates the pre-work needed (such as ensuring prior records have been received) and/or does these tasks herself. She also provides information about available behavioral health resources. There are two MAT providers at PSFM who have a panel of MAT patients and can accept others in need from the practice. PSFM providers follow the mild-moderate depression protocol that was developed and shared with them.

Internal Medicine Horseshoe Pond (IMED HSP)	
# of Medicaid patients Jul, Aug, Sept, Nov	379
# of CCSAs completed Jul, Aug, Sept, Nov	132
# of referrals for SUD/MH Jul, Aug, Sept, Nov	6
# of smoking cessation counseling Jul, Aug, Sept, Nov	64

IMED HSP does not currently have an IBHC and underwent significant staff and leadership turnover in 2019. They are expected to merge with IMED Pillsbury later in 2020, which will increase the size of the practice by 13 providers and 30-40 additional staff. IMED HSP has one MAT provider, who has a very large patient panel and is open to receiving referrals from other CH PCPs and from Choices. IMED HSP providers follow the mild-moderate depression protocol that was developed and shared with them.

IBHC status and activity for above sites

CHMG Sites with RB IBHC	Concord Family Medicine						Penacook Family Physicians						Epsom Family Medicine						Family Physicians of Pembroke						Pleasant Street Family Medicine Internal Medicine HSP					
2019	Jul	Aug	Sep	Oct	Nov	Dec	Jul	Aug	Sep	Oct	Nov	Dec	Jul	Aug	Sep	Oct	Nov	Dec	Jul	Aug	Sep	Oct	Nov	Dec	Jul	Aug	Sep	Oct	Nov	Dec
IBHC Days in Office	**21**	**20**	**24**	**17**	**15**	**0**	**8**	**22**	**24**	**20**	**13**	**20**	**23**	**2**	**0**	**0**	**0**	**0**	**24**	**18**	**22**	**14**	**18**	**19**	**0**	**0**	**0**	**0**	**0**	**0**
Type of Client Interaction																														
Scheduled	53	26	49	38	44	N/A	28	55	63	57	37	40	79	12	N/A	N/A	N/A	N/A	32	14	39	38	45	44	N/A	N/A	N/A	N/A	N/A	N/A
No Show	28%	19%	39%	29%	43%	N/A	64%	29%	19%	16%	16%	38%	18%	9%	N/A	N/A	N/A	N/A	22%	43%	21%	24%	31%	39%	N/A	N/A	N/A	N/A	N/A	N/A
Warm hand-off	8	12	22	10	6	N/A	12	16	29	21	12	11	11	0	N/A	N/A	N/A	N/A	3	5	4	2	7	5	N/A	N/A	N/A	N/A	N/A	N/A
Unscheduled	2	7	15	7	4	N/A	3	3	3	9	2	0	3	0	N/A	N/A	N/A	N/A	5	3	5	7	4	6	N/A	N/A	N/A	N/A	N/A	N/A
VISITS TOTAL	**63**	**45**	**86**	**55**	**54**	N/A	**43**	**74**	**95**	**87**	**51**	**51**	**93**	**12**	N/A	N/A	N/A	N/A	**40**	**22**	**48**	**47**	**56**	**55**	N/A	N/A	N/A	N/A	N/A	N/A
TEAM CONSULTS	**63**	**79**	**133**	**74**	**69**	N/A	**8**	**6**	**40**	**24**	**16**	**43**	**33**	**5**	N/A	N/A	N/A	N/A	**78**	**30**	**44**	**29**	**40**	**58**	N/A	N/A	N/A	N/A	N/A	N/A
PHONE CHECK-INS	**10**	**15**	**25**	**16**	**25**	N/A	**11**	**15**	**25**	**20**	**24**	**31**	**8**	**1**	N/A	N/A	N/A	N/A	**52**	**44**	**61**	**36**	**48**	**63**	N/A	N/A	N/A	N/A	N/A	N/A
RESOURCE CALLS	**6**	**9**	**11**	**14**	**6**	N/A	**3**	**5**	**12**	**11**	**12**	**9**	**0**	**0**	N/A	N/A	N/A	N/A	**116**	**120**	**73**	**69**	**85**	**78**	N/A	N/A	N/A	N/A	N/A	N/A
Staffing	Current coverage Mon and Fri AM (FHC IBHC) and Thurs (Penacook IBHC). New CM begins March 2020						Current coverage Mon, Tues, Wed, Fri while this IBHC also covers CFM on Thursday.						Current coverage on Mon and Wed (Pembroke IBHC). New IBHC begins Jan 2020						Current coverage on Tues, Thurs, Fri while this IBHC also covers Epsom on Mon and Wed.						Position vacant since July 2019. IBHCs being interviewed for hire.					
Bullet Points	Average amount of activity per day, per site, per IBHC: - Patient visits - 3.12 - Team consults - 2.5 - Phone check ins - 1.5 - Resource calls - 1.86																													
Key	**Scheduled Visits:** visits that were pre-planned in any capacity, even if that means that they were scheduled an hour prior **Warm hand-offs:** introductions to the patient by another team member lasting less than 15 minutes. A warm hand-off may turn into an unscheduled visit in which case it will count for both. **Unscheduled Visits:** any visit longer than 15 minutes that was not pre-planned **Team Consults:** in-person or phone consultation about a patient with a member of the team (provider, Nurse Navigator, Psychiatric consultant, IBHC, etc) **Phone Check Ins:** calls made to a patient or natural support wherein clinical conversation takes place (not just to schedule/reschedule) **Resource Calls:** Calls to collaterals or resources, including referrals																														

CHMG sites with their own behavioral health employees

Family Health Centers (FJC) Concord and Hillsboro	
Current status of IBHC	Five IBHCs
# of Medicaid patients Jul, Aug, Sept, Nov	4490
# of CCSAs completed Jul, Aug, Sept, Nov	1184
# of referrals for SUD/MH Jul, Aug, Sept, Nov	303
# of smoking cessation counseling Jul, Aug, Sept, Nov	349

FHC Hillsboro is included in FHC Concord's monthly report. FHC Concord continues to have barriers in providing the CCSA survey to their non-English speaking patients. FHC patients speak thirteen (13) different languages and many are not able to read or write in their native language. The Integrated Care Manager (ICM) is on-site at Hillsboro one day per week but gets referrals through Cerner as well. The ICM and Hillsboro's IBHC work closely on maintaining an accurate list of community resources which is housed electronically on their Basecamp communication tool. Psychiatric consults are primarily in Concord, but a psychiatrist will be going to Hillsboro once per month to meet with patients who might have transportation challenges getting to Concord. There is a quarterly meeting between the IBHC, ICM, and Riverbend CSP to ensure seamless referrals and clear communication as the FHC Concord provides the medical staff to the RICH program, which is housed within CSP. FHC Concord has

two MAT providers who consult with an IBHC/MLADC to determine level of care. A primary RN meets with patients regularly based on phase of MAT. The IBHC/MLADC and RN meet regularly and communicate with the provider. Outside MAT referrals go to either Choices or CH SUS. The IBHC/MLADC meets weekly with CH SUS to collaborate and review cases. FHC follows the mild-moderate depression protocol that was developed and shared with them.

Dartmouth Hitchcock Concord (DHC) with its own behavioral health employees

Dartmouth Hitchcock Concord	
Current status of IBHC	Two IBHCs, Resource Support Specialist (RSS)
# of Medicaid patients Jul, Aug, Sept, Oct, Nov	4181
# of CCSAs completed Jul, Aug, Sept, Oct, Nov	870
# of referrals for SUD/MH Jul, Aug, Sept, Oct, Nov	463
# of smoking cessation counseling Jul, Aug, Sept, Oct, Nov	310

At DHC, the CCSA has been built into the EHR (Epic) and is administered on iPads upon check in at the reception area or via myDH patient portal for the following appt types 1x per 365 days: New Patient, Physical Exam, Office Visit, Follow-up Visit. The two IBHCs and RSS are an integral part of the medical team. One of DHC's MAT providers left the practice and they currently have 2 MAT providers working with IBHCs at their MAT clinic. DHC uses the collaborative care model (CoCM) workflow for the treatment of mild- to moderate-depression.

Riverbend as a mental health and SUD provider

Riverbend	ChIP	CSP	RCA	Choices
# of Medicaid patients Jul, Aug, Sept, Oct, Nov	1372	2006	628	699
# of CCSAs completed Jul, Aug, Sept, Oct, Nov	815	1020	259	434
# of referrals for SUD/MH Jul, Aug, Sept, Oct, Nov	142	440	174	326
# of smoking cessation counseling Jul, Aug, Sept, Oct, Nov	4	226	46	158

All clients in the largest programs, ChIP and CSP, are offered case management as a core service. The domains screened by the CCSA are part of the case management assessment and monitored at least monthly as part of this service. Clients served by RCA and Choices are connected with the Integrated Case Manager (ICM) when needs are identified via the CCSA or at any point in treatment. The ICM tracks her contacts on a spreadsheet and continues to engage the client until the need has been met. She also documents this work in a shared medical record with the rest of the treatment team. All Riverbend clients are screened for substance use at least annually and needs are monitored monthly. If a client is in need of MAT, the case manager supports referral and follow-up to the provider, either internally via Choices or externally if a different medication is needed (e.g. methadone). The case manager continues to coordinate these services as needed. Riverbend, as community mental health center, uses multiple levels of depression protocols. Choices acts as a MAT/SUD HUB, along with CH SUS, for IDN2. Choices is a continuum of care SUD services site and has four MAT providers with the highest panel of patients within IDN2. Choices, along with CH SUS, also manages The Doorway. Choices' information here is as an integral part of the Riverbend B1 Integration site. Please see more under the D2 MAT project report, beginning on page 33.

Riverbend Integrated Center for Health (RICH) with embedded CH FHC medical staff

Riverbend Integrated Center for Health	
# of Medicaid patients Jul, Aug, Sept, Oct, Nov	Included with CSP above
# of CCSAs completed Jul-Nov	
# of referrals for SUD/MH Jul-Nov	
# of smoking cessation assessments / counseling Jul-Nov	

All patients receive case management as a core service. All domains of the CCSA are screened at least annually and monitored at least monthly. Services are documented in a shared record. RICH's approach to depression management and MAT are the same as Riverbend. See above.

Concord Hospital Substance Use Services (CH SUS) as a SUD provider

Concord Hospital Substance Use Services	
# of Medicaid patients Jul, Aug, Sept, Nov	204
# of CCSAs completed Jul, Aug, Sept, Nov	172
# of referrals for SUD/MH Jul, Aug, Sept, Nov	59
# of smoking cessation counseling Jul, Aug, Sept, Nov	70

At CH SUS, the CCSA is completed upon admission; it is part of the admitting documentation. The clinician reviews it and documents the completion and addresses any identified barriers as part of the treatment plan. It is monitored to be repeated every 365 days on patients who have remained in services during that time. CH SUS scores have always been the highest; recent completion of CCSA was 100%, 100% for follow up on SUD, and 89% for smoking cessation. Upon admission to the CH SUS program, patients are asked if they have a PCP; if yes, then when a release is in place, a fax is sent to notify their provider that they are engaging in services with us. If, during this initial visit, any concerns for depression or other behavioral health symptoms, or desire for smoking cessation arise, then we refer to their PCP by completing a care coordination form or send via secure messaging in Cerner. It is important that the PCP is aware of and can support them in these life management areas. In addition, the PCPs have access to the psychiatric consultation, if needed. If they do not have a PCP, then we make that a priority by giving them the physician finder number and assist them in obtaining a PCP prior to discharge. Patients without a PCP are set up to see the Psychiatric Nurse Practioner (NP) for these services while we obtain a PCP. CH SUS's core team of counselors, case manager, and Psychiatric NP meet every Monday and Friday to review new cases and current cases progress. CH SUS is starting to pilot using secure messaging via Cerner with the FHC for referrals. The plan is to move the secured messaging for referrals and communication out to other practices. CH SUS acts as a MAT/SUD HUB, along with Choices, for IDN2. CH SUS is a continuum of care SUD services site and continues to increase the numbers of patients seen for MAT services as well as those who are maintained in MAT and clinical services. CH SUS, along with Choices, also manages The Doorway. This information is for CH SUS as a B1 Integration site. Please see more under the D2 MAT project report, beginning on page 33.

Budget

Budget Item	Potential 2021	Approved 2020	Actual 2019	Actual 2018	Actual 2017	Actual 2016
Integration Staffing	$1,552,490	$2,002,713	$1,250,980	831,819	335,950	$0
Incentives	$9,500	$16,000	$0	$0	$0	$0
Malpractice	$0	$10,000	$10,000	$9,999	$5,000	$0
INTEGRATION TOTAL	**$1,561,990**	**$2,028,713**	**$1,260,980**	**$841,818**	**$340,950**	**$0**

Budget Notes

B1 Integrated Healthcare

21.60 FTE Staff

1.00 Director of Integrated Health Care [redacted]

1.00 Case Manager - Riverbend [redacted]

1.00	Case Manager - CFM	TBH
1.00	ICM - FHC	[redacted]
0.25	BH - IMED HSP	Share with PSFM
1.00	IBHC - Penacook	[redacted]
1.00	IBHC - CFM	TBH
1.00	IBHC - Epsom	[redacted]
1.00	IBHC - Pembroke	[redacted]
0.75	IBHC - PSFM	TBH
0.20	Psychiatrist	[redacted]
1.00	Psychiatrist	[redacted]
2.20	IBHC, Psych, RSS - DHC	[redacted]
1.00	ICM - West St.	[redacted]
1.00	ICM - West St.	[redacted]
1.00	Clinical Manager - West St.	[redacted]
1.00	NCC - West St.	[redacted]
1.00	Peer Wellness Coach - West St.	[redacted]
1.00	APRN - West St.	[redacted]
1.00	RN - West St.	TBH
0.10	Practice Manager - West St.	[redacted]
1.00	PCC - West St.	[redacted]
1.00	MA - West St.	[redacted]
0.10	Clinical Manager - West St.	[redacted]

Incentives – Instituted in 2020 to address severe BH staff shortages

Malpractice – To cover IDN2 BH staff

Achievement of Coordinated Care Practice and Integrated Care Practice Designation

Achieved	Total Goal Number Designated	Baseline Designated 12/31/18	Number Designated 6/30/19	Number Designated 12/31/19	Number Designated 6/30/20
Coordinated Care Practice	11	11	11	11	
Integrated Care Practice	11	11	11	11	

Projects C: Care Transitions-Focused

C2 Community Reentry Program for Justice-Involved Adults and Youth with Substance Use Disorders or Significant Behavioral Health Issues

Over the last six months, the Reentry project has made strides toward improved understanding of the disparate values held by the mental health and corrections systems and improved understanding of roles. The team is able to talk openly, and with shared language, when they identify that their values are being challenged. Trust has also been developed which has helped the Riverbend behavioral health providers to feel as though they have more influence over programmatic and client-level decisions.

Nonetheless, value differences and poor role clarity persist as barriers. The Riverbend team has expressed a desire for more objective, algorithmic processes for responding to participants who violate a rule and more clarity with regard to who is responsible for what. In the absence of this, participants complain of receiving different responses from different staff persons to the same issue and of seeing their peers receive different treatment. This issue has also led to inadvertent redoubling of one another's work, sometimes with approaches that conflict with one another.

In an effort to address this, the team has met to discuss roles and attempt to redefine specific processes, such as the transition of care from Merrimack County Department of Corrections (MCDOC) case manager to Riverbend case manager. The team has also started to be more explicit in talking through these processes in real time. For example, when convening a client-centered meeting, team members might start by identifying their role in the meeting.

A new case manager (CM) began in August 2019. This individual has reentry experience and has improved coordination and communication. In addition, MCDOC hired a new Administrator of Programs & Services in September 2019. These additions have added to improvements.

The clinical staff have also improved their connectivity to Probation which has resulted in quicker response time and a broader-team approach to recommendations for higher levels of care. Psychiatric support has transitioned fully to telemedicine and is in the process of moving towards a consultation model. This allows the psychiatric provider to support a higher volume of individuals with behavioral health needs.

In continuing efforts to identify those most at need, MCDOC has agreed to start sending minutes from their Multi-Disciplinary Team meetings (focused on addressing inmates who are presenting as difficult to manage) to Riverbend Community Support Program (CSP) Program Director. CSP Program Director can then scan the list for CSP clients and connect staff to support behavior plans as indicated. There is also continued connectivity with the Doorway and the Crisis Treatment Center (CTC), as needed.

MCDOC discontinued the practice of immediate taper of Medicated Assisted Treatment (MAT) for new inmates with existing prescriptions. There are no immediate plans to provide inductions, but this may be an option once the jail gains experience with MAT. There are many procedural issues needed before this can build due to the high potential for diversion.

Project Targets

Performance Measure Name	Target	Cumulative served to date	Progress Toward Target		
			12/31/18	6/30/19	12/31/19
Total number of clients served	250 over five years	687 over three years	93	245	237

Reentry Jul-Dec 2019	Jul	Aug	Sep	Oct	Nov	Dec
Clients served pre-release	12	15	12	11	13	13
Of these, how many were new?	2	5	6	4	4	4
Of these, how many were continuing?	10	10	6	7	8	10
Clients served post-release?	27	27	27	25	28	27
Of these, how many were new?	2	2	3	4	3	3
Of these, how many were continuing?	25	25	24	21	25	24
How many received case management?	27	0	27	25	25	24
How many received individual therapy?	0	0	0	0	0	0
How many received group therapy?	25	27	27	25	25	24
Referred to SUD Services	4	1	2	5	2	4
Follow through rate	1	1	1	2	2	100%
Referred to MH Services	2	0	2	1	1	2
Follow through rate	2	0	1	1	1	100%
Referred to Primary Care	1	0	0	3	0	2
Follow through rate	1	0	0	0	0	100%
Clients completing 12 months of service?	1	0	0	1	1	2

Budget

Budget Item	Potential 2021	Approved 2020	Actual 2019	Actual 2018	Actual 2017	Actual 2016
Reentry Staffing	$0	$219,326	$196,947	$234,926	$153,291	$0
Testing Supplies	$0	$11,755	$10,445	$143	$4,367	$0
REENTRY TOTAL	**$0**	**$231,081**	**$207,392**	**$235,069**	**$157,658**	**$0**

Budget Notes

C2 Community Re-entry

2.55 FTE Staff

0.25 Program Assistant [redacted]

1.00 Clinician [redacted]

0.30 Psych APRN [redacted]

1.00 Case Manager [redacted]

Testing Supplies – For SUD urine testing

Projects D: Capacity Building Focused

D1 Medication Assisted Treatment (MAT) of Substance Use Disorders (SUD)

IDN2's MAT project has expanded MAT and SUD services in the region to primary care, behavioral health, hospital in-patient, and emergency room sites and supports fourteen (14) active MAT providers. Services include:

- Crisis stabilization
- Evaluations and assessments
- MAT induction and maintenance care
- Individual and group counseling
- Intensive outpatient programs
- Peer support from those with lived experience
- For pregnant and parenting individuals (including those who are incarcerated): home visits, wraparound services, and parent education classes
- Linkage to community services
- Connection to The Doorway and Mobile Crisis Services

Delivery of MAT in the region is accomplished through a HUB and SPOKE model.

The HUBs are the two (2) SUD continuum of care sites in the region: Choices and Concord Hospital Substance Use Services (CH SUS). Choices, a program of the B1 site Riverbend, has four (4) MAT providers and CH SUS, its own B1 site, has one (1).

These sites provide all of the above services and oversee the MAT project and PCP MAT providers with coordination, support, and ongoing education. The directors of the HUBs also oversee The Doorway making that a seamless connection to IDN2. In addition, the HUBs provide MAT for the three (3) B1 sites who do not have an onsite MAT provider: Epsom Family Medicine, Family Physicians of Pembroke, and Penacook Family Medicine.

The SPOKEs are the nine (9) MAT providers at six (6) B1 sites: Concord Family Medicine, Dartmouth Hitchcock Concord, Family Health Center Concord & Hillsboro, Internal Medicine Horseshoe Pond, and Pleasant Street Family Medicine.

Below are individual site statistics and a brief narrative for each MAT site.

[redacted], Concord Family Medicine		
Month	**#s Treated**	**Brief Narrative**
July	3	[redacted] had four (4) unique patients during this period of time. One long-term patient slowly tapered and stopped MAT and has remained off of opiates. A new patient is being successfully treated for Kratom dependence. The loss of the CFM IBHC has been difficult as she was helpful in engaging patients in substance use and mental health care. Two interim IBHCs are filling in one full and two half days weekly. [redacted] completed training in *Assisting Patients with OUD Treatment: Identification and Treatment.*
Aug	3	
Sep	3	
Oct	4	
Nov	4	
Dec	3	

[redacted], Pleasant Street Family Medicine		
Month	**#s Treated**	**Brief Narrative**
July	4	[redacted] had seven (7) unique patients during this period of time.
Aug	6	

Sep	4	Two patients were referred to higher levels of care. One was lost to follow up and the other had a positive heroin screen and was transitioned to buprenorphine through a methadone clinic. Four patients remain in care. One stabilized patient has begun to taper and is now mentoring others through the early stages of recover. PSFM is currently without an IBHC to support MAT patients. [redacted] attended *Scope of Pain: Safer/Competent Opioid Prescribing* for primary care providers.
Oct	4	
Nov	5	
Dec	4	

[redacted], Pleasant Street Family Medicine		
Month	**#s Treated**	**Brief Narrative**
July	0	[redacted] has had no MAT patients during this period of time. PSFM has one other MAT provider and is currently without an IBHC to support MAT patients. Choices at Riverbend has referred three patients to [redacted]. One has returned to inpatient facility and another went to another MAT prescriber. [redacted] is currently seeing one patient, but that statistic is outside the date of this report.
Aug	0	
Sep	0	
Oct	0	
Nov	0	
Dec	0	

[redacted], Concord Family Medicine		
Month	**#s Treated**	**Brief Narrative**
July	3	[redacted] had four (4) unique patients during this period of time. Three remain in care and one was transferred to Choices. The three in care are stable and help others engage in mental health and/or substance use services. One patient continued in recovery despite a family crisis. Another relapsed when a sibling overdosed but then became re-engaged in MAT and is now stable in recovery. An out of state patient would like to stop suboxone due to being tied down to the monthly travel. One patient's father died at home in hospice and patient helped administer end of life medications including morphine. Patient remained in recovery during this time by following a plan to come to the clinic for weekly appointments, meet with the IBHC and a counselor, and attend NA meetings. The loss of the CFM IBHC has been difficult as she was helpful in engaging patients in substance use and mental health care. Two interim IBHCs are filling in one full and two half days weekly. [redacted] received the following trainings during this period of time: 6/23/19: Cannabis and Opioids in Pain Management Grand Rounds DHMC 6/24/19 Collaborating patient provider relationship in Opioid Clinic Decision Making 6/24/19 Implementing CDC Opioid Prescribing Guidelines in Clinical Practice
Aug	3	
Sep	3	
Oct	3	
Nov	3	
Dec	3	

[redacted], Dartmouth-Hitchcock Concord		
Month	**#s Treated**	**Brief Narrative**
July	18	[redacted] saw forty-three (43) unique patients during this period of time. Twenty-four (24) patients remain in the care of D-HC's MAT providers going forward. [redacted] resigned her position at the end of December. Patients have been transferred to [redacted] and [redacted] who will take over management of these patients in collaboration with the IBHC providers. A Resource Specialist also supports the MAT practice. Several patients raised concerns after hearing [redacted] was leaving. Patient relations worked to address any perceived concerns with the transition plans put in place.
Aug	27	
Sep	25	
Oct	25	
Nov	19	
Dec	16	

[redacted], IMED Horseshoe Pond		
Month	**#s Treated**	**Brief Narrative**
July	42	
Aug	42	
Sep	45	

Oct	45	[redacted] had forty-five (45) unique patients during this period of time. Forty-four patients remain in his care and, of those, only one has tested positive on a drug screen. He has treated numerous patients for Hepatitis C. This practice is open to accepting new MAT clients from other CHMG sites and from Choices at Riverbend. Some of his patients complain of discriminatory treatment at some pharmacies. [redacted] views a lack of telemedicine as a barrier to MAT practice. [redacted] is hoping to sit for the Addiction Medicine Certification Exam this year.
Nov	44	
Dec	44	

[redacted], Concord Family Medicine		
Month	**#s Treated**	**Brief Narrative**
July	1	[redacted] has seen one unique patient during this period of time and that patient remains in her care and is two-years into her recovery, maintaining employment, and raising a child. The loss of the CFM IBHC has been difficult as she was helpful in engaging patients in substance use and mental health care. Two interim IBHCs are filling in one full and two half days weekly. CFM continues to train staff in the process of MAT monitoring and support. This site had previously been using Point of care urine toxicology testing which is around $15 per test compared to the $170-ish for a send out urine tox screen. The "Icup" (point of care test) is out of stock with no estimated time that it will be back in stock. This presents a hardship for [redacted] patient, who pays a large portion of her office visit, testing, and prescription costs out of pocket. Dr. Martel has chosen to screen her less frequently given her long term stability in treatment.
Aug	1	
Sep	1	
Oct	1	
Nov	1	
Dec	1	

[redacted], Family Health Center Concord		
Month	**#s Treated**	**Brief Narrative**
July	2	[redacted] has had two (2) unique patients during this period of time. That patient remains in his care and has been stable and opioid free for over 12 months, which is his longest period of time in recovery. He attributes this to having one location for his primary care and SUD. This patient has also engaged in dental care as well as working on reducing alcohol use with the goal of getting his driver's license back. This patient was presented at the Regional ECHO meeting last year given some of his psychiatric complexities and our team got very positive feedback on the wrap around services we are able to provide, including psychiatric care. While the efficacy of this modality has been established, and the LDAC and RN who coordinate care for MAT patients are a consistent and invaluable presence, there has not been any further progress in FHC capacity to take on additional patients. I can only support two patients at this time. All FHC providers and staff have been trained to deliver MAT, but the demands of this work do not fit into current primary care practice. Time constraints in providing MAT care from an RN standpoint require more staffing. The first step in addressing this will be assessment, recruitment, and retention of staff. Once staffing is stable, scheduling and process flow support for MAT can be established. Until these things occur, we cannot move forward internally to increase our MAT practice. Teaming with CHOICES initially was really helpful but the transition of high acuity patients back to clinic setting rarely resulted in follow through from a patient perspective (n of 2). The interplay between SUD and chronic pain has been a challenge. One patient had some initial benefit for both pain and SUD in the first 3-4 months. At about 6 months, however, she found that function was declining due to chronic pain not being well controlled. Despite trials of many different non opioid pain control regimens and behavioral health the patient's daily function has declined due to pain.
Aug	2	
Sep	2	
Oct	2	
Nov	2	
Dec	2	

[redacted], Family Health Center Concord		
Month	**#s Treated**	**Brief Narrative**
July	7	[redacted] has treated seven (7) unique patients this month. Six remain under his care. One of these patients remained abstinent from opioids even though her son had a health crisis, which created a high degree of anxiety and worry for her. The FHC has had a successful model of integration for over 20 years. As a Family Physician in the FHC, [redacted] feels well supported by the Integrated Behavioral Health Clinicians (IBHC) as well as the Nurses and Medical Assistants on the team to assist with the complex medical and psychosocial issues our patients bring to their medical visits, including those receiving MAT. At FHC's current level of staffing and staff training, however, they cannot increase the number of MAT patients they see. FHC is reviewing what would be needed to increase patient numbers as well as to incorporate addiction services into the residency training. Current staffing shortage of medical assistants and nurses do not allow the FHC to expand at this time. Concord Hospital Leadership is aware of the situation. [redacted] attended *Scope of Pain: Safer/Competent Opioid Prescribing* for primary care providers.
Aug	7	
Sep	6	
Oct	6	
Nov	6	
Dec	6	

[redacted], CH Substance Use Services		
Month	**#s Treated**	**Brief Narrative**
July	16	[redacted] has treated 35 unique patients during this period of time. 16 remain under her care. 12 of these 16 patients are currently opioid-free at the time of this report. There was a total of 207 appointment visits for MAT services b/t 7/1-12/31/19. CH SUS continues to increase its numbers of MAT patients since beginning MAT at that site in 3/4/2019. CH SUS implemented a recovery group specifically for patients that are being maintained with MAT. CH SUS began using Cerner for referrals to MAT at its site. This was piloted with the FHC-Concord. Some of the identified barriers at this site are the additional staff time needed to manage some of the following scenarios: Patients who miss their MAT appointments and then call for a prescription when the provider is not present; patients who continue to have + tox screens for opioids despite being on MAT, patients who continue to use other substances while on MAT, and patients who have co-occurring mental illnesses. These are addressed in a variety of ways: reminding staff and myself about harm reduction, utilizing MI, and exploring if patient would benefit from other services. For co-occurring mental health issues, the Psych ARNP addresses these with a plan to transition to a PCP once the patient is established and stabilized on a medication regime. Staffing remains a challenge. They did hire one of their open counselor positions with a previous CH SUS intern. She will help out with inpatient consultation, ER on call, and case management activities while ultimately developing the skills to become licensed as a counselor. CH SUS had previous success in utilizing one of their clinical positions for the professional development of a counselor. They are excited and proud that we again can help support an individual's professional growth in the SUD field. Staff at CH SUS received the following training: • SUD Treatment Community of Practice - this presentation reviewed assessment tools and other considerations when working with clients who have schizophrenia and schizoaffective disorder. Attendees observed and assessed a role play of an initial counseling session. • MAT Community of Practice • Project ECHO Didactic on recovery support services; case presented with discussion CH SUS is a member of the Capital Area Leadership Team, a collaborative meeting bringing various community organizations together to share information on program updates and ways to improve access to care for individuals with substance use
Aug	17	
Sep	18	
Oct	20	
Nov	19	
Dec	19	

		disorders. This month's meeting reviewed updates and progress for Project First. Also, data was reviewed that showed a decline in the number of drug overdose related deaths. Additional services of providing inpatient consultation; a total of 900 Inpatient consults completed b/t 7/1-12/31/19; 93 of these inpatient consultations were completed in the month of December. Most consults don't result in treatment. Everyone, however, is assessed and offered resources to include The Doorway, if desired, and any future assistance with SUD through CH SUS.

CHOICES at Riverbend (Fusion – MAT Providers)		
Month	**#s Treated**	**Brief Narrative**
July	50	Fusion has treated 139 unique MAT patients at CHOICES during this period of time with fifty-nine remaining in treatment. Some success stories: Client was attending Recovery Skills group (peer lead group) and client really opened up to peer. Has been in recovery for 31 days now. Client was struggling to connect at the program because she was not sure she was ready for the recovery journey. With a lot of time and effort on the part of the peer to help her feel comfortable and trust the peer enough to let her help her, the client stayed in treatment and reported it was because this peer and one other peer that she ultimately decided to keep going. Peer reported that he was outside with other clients on a break when he approached a client sitting on the front steps. His intention was to let him know that smoking was not allowed there but instead he noticed the client was really upset. He ended up striking up a conversation where the client told him he was really having a hard time staying sober and he couldn't deal with the feelings and emotions any longer. The client also reported that all he wanted to do once group was over was go get a drink. The peer decided to share a brief part of his life story and how his life has changed after he surrendered. The peer noticed that the client went back into the group and his attitude was a little bit better. This client then started to attend the Recovery Skills group run by this peer where they started to share more each week. Now this client just celebrated 15 months of sobriety, has completed all 3 phases of IOP, continues to attend recovery skills group, continuing care group and goes to 3-4 AA meetings a week. CHOICES is a continuum of care HUB for the MAT project and relies on a team of recovery support peers to assist in the MAT work. These peers are encouraged and supported to receive their CRSW. CHOICES received a request to extend the hour-long recovery skills support group to 1.5 hours and will do this in 2020. Along with CH SUS, CHOICES oversaw IDN2's perinatal MAT program. The providers for that program have left and CH SUS, CHOICES, and CH OBGYN are working on a solution for those patients who need MAT. CH SUS and CHOICES also oversee the PCP MAT providers and lead a bi-monthly meeting. Because there has been limited participation in these meeting, the content is being changed to include useful information and education for the providers. Staff at CHOICES attended the following trainings: • How to Stay Ahead of Key Compliance Pitfalls for Behavioral Health Providers • Medication Assisted Treatment for Opioid Use Disorder: Delivering Best Practice Care in New Hampshire • Mental Health Challenges Faced by Transgender and LGBTQ Individuals • The Doorway NH: Increasing Access to Care • Ethical Concerns in Working with Individuals at Risk for Suicide: Looking Across the Lifespan
Aug	61	
Sep	64	
Oct	65	
Nov	61	
Dec	64	

IDN2's E5 Enhanced Care Coordination project began with a 0-5-year-old category. Very quickly, that project began to work with the MAT patients who were pregnant or newly parenting. At this point, the project is considered a part of the MAT project. It is delivered through staff at Waypoint. Below is narrative and data for that project:

MAT Wraparound Services for Pregnant and Parenting Individuals

Major accomplishments:

- Of the nineteen women served, eight babies were delivered. Of the eight babies delivered, six remained in the home of their mother.
- The Doorway has helped support the women in successfully accessing recovery services.
- The project has had increased referrals from DCYF and a new referral from Dartmouth Hitchcock.
- The support group for mothers has increased in size.

Challenges and Mitigations:

- Challenge: MAT providers within Concord OBGYN and the social worker from Dartmouth Hitchcock left their positions during this reporting period, resulting in a lack of referrals from Concord OBGYN.

  Mitigation: Steps have been made to create new connections with existing providers at each site and in the community. Continued attempts to engage and collaborate with Concord OBGYN.

- Challenge: The Better Together group that was occurring each week at CH ended in the month of December.

  Mitigation: The Better Together group members began their own group at Waypoint to continue their peer support. The women have taken ownership of the group and have developed their own agenda items and areas of need they would like to focus on.

- Challenge: Lack of referrals from project partners

  Mitigation: Outreach to additional referral sources has increased our referrals from other community sources like DCYF.

- Challenge: Disruption in program design.

  Mitigation: Team continues to work on including new partners and re-defining roles and workflows.

- Challenge: Only one Family/Peer Support Worker per two ECCs.

  Mitigation: Utilizing the Family/Peer Support Worker in the best way for each family to gain assistance and support. A new Family/Peer Support worker will begin working for Waypoint in January of 2020.

- Challenge: Disruption in expectation for clients entering into the Choices for Families program.

  Mitigation: The Riverbend and Waypoint teams are collaboratively working to develop a means to support the expectation while also meeting the needs of the clients.

Client success stories:

- One of the mothers is transitioning out of ECC and into the community with natural supports to help maintain her success. She is currently interning in another family support program within Waypoint to gain experience in the social services field.
- One mother and her boyfriend were able to secure housing for themselves and their child.

MAT Wraparound Services Jul – Dec 2019	Jul	Aug	Sep	Oct	Nov	Dec
Individuals served during this period of time	14	18	22	19	19	19
Intake to determine eligibility	2	4	4	1	0	0
Decided not to participate	1	1	1	1	0	0
Of these, how many new?	2	1	4	1	0	1
Of these, how many continuing?	12	17	18	18	18	19
# of client contacts	23	26	42	55	59	41
# attending parent education	3	6	6	8	8	7
Discontinued service with linkage to other resources	0	0	2	2	0	0
Discontinued service without linkage to other resources	0	0	0	0	0	0
How many delivered	0	4	3	1	0	0
Of those that delivered, # retained custody	0	4	3	0	0	0
Placement outside the home	0	0	0	1	0	1

Project Targets

Performance Measure Name	Target	Cumulative Served to Date	Progress Toward Target		
			12/31/18	6/30/19	12/31/19
Number of individuals receiving MAT	300 over 5 years	534 in 3 years	142	82	162
Number of individuals receiving Wraparound Services	33 over 5 years	79 in 3 years	14	19	11

Budget

Budget Item	Potential 2021	Approved 2020	Actual 2019	Actual 2018	Actual 2017	Actual 2016
MAT Staffing	$222,095	$374,826	$335,375	$257,465	$26,957	$0
Provider Incentives	$0	$52,500	$51,440	$37,416	$5,520	$0
Flex Funds	$0	$10,000	$0	$0	$0	$0
MAT TOTAL	**$222,095**	**$437,326**	**$386,815**	**$294,881**	**$32,477**	**$0**

Budget Notes

D1 Medicated Assisted Treatment

6.4 FTE Staff

	Mobile OB-GYN MAT Provider	not being re-hired
	Mobile OB-GYN MAT Provider	not being re-hired
	Medical Assistant - CH OB GYN	not being re-hired
	CoC	reallocated to E5 ECC and Admin
0.10	Coordinator	[redacted]
1.00	MAT & Mentoring	Fusion
0.10	Coordinator	[redacted]
0.50	Clinical Manager	[redacted]
1.00	SUD Counselor - Choices	[redacted]
0.50	SUD Counselor - PAT	[redacted]
3.20	Supervisor, 2 Coordinators, Peer	Waypoint Staff

Provider Incentives – Semi-annual incentives for PCP MAT providers

Flex Funds – Emergency funding for clients to maintain participation in program and further their recovery (administered through E5 ECC so they do not show up in past financial reports for MAT). Below is the protocol for distributing Flex Funds:

Flex Funds 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.

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

Projects E: Integration Focused

E5 Enhanced Care Coordination for High-Need Populations

IDN2's E5 project has had many changes since implementation in 2017. Initially, the project served three levels of children and youth: 0-5, 6-15, and 16-20. The 0-5 portion of the project gravitated toward serving pregnant and parenting individuals receiving MAT and is now considered a MAT project. The two other portions were conceived to serve youth/young adults coming from Sununu Youth Services and New Hampshire Hospital but, due to staff changes and other barriers communicated to IDN2 from those institutions, that referral route did not take off. When the 6-15-year-old coordinator left, we decided to not continue that portion of the project, which had very low numbers. The 16-20-year-old portion of the program is supervised by Riverbend's Children's Intervention Program (ChIP) and became a natural fit for youth/young adults who were aging out and needed a different level of care as well as bridging to adult services. Last year, we saw an additional need in our region for enhanced care coordination and stood up a Complex Care Coordination project. Descriptions and progress updates for the ECC RENEW and ECC Complex Care Coordination projects are below.

ECC RENEW

IDN2's ECC RENEW project uses a model developed by the University of New Hampshire (UNH) Institute on Disability (IOD) called Rehabilitation for Empowerment, Natural Supports, Education, and Work (RENEW). RENEW is an evidence-informed, youth-driven planning process that focuses on school-to-adult life transition and the development of a network of people who will help the youth to achieve his or her goals. There are (4) phases in the RENEW process. Phase 1 begins with the youth making the decision that RENEW is the support they need. Then the youth works with a RENEW facilitator to develop a personalized plan that reflects who they are and where they want to go in life. In phase 2, the facilitator then supports the youth to recruit help and resources that are necessary to implement their plan. During the third phase, the facilitator mentors the youth to monitor progress toward goals and reflect on their experiences and outcomes. Finally, when the youth has developed strong self-determination skills, the youth then transitions out of RENEW into less intensive supports completing the fourth phase. It is an intensive program that serves fewer clients with a deeper level of services administered over a length of time. IDN2's RENEW project staff have been trained by and receive ongoing coaching from UNH IOD.

The transitional ages of 16-20 are especially challenging for youth/young adults who have multi-system involvement and/or do not have available and well-resourced guardians. The skills needed for successfully transitioning to adulthood; such as job finding, independent living, completing education, budgeting, becoming responsible for completing medical and legal forms, and developing a healthy and supportive network are often lacking. RENEW supports the young adult in establishing their goals, identifying the steps needed to achieve them, building a support system to help them and addresses some of the concrete barriers that can interfere, e.g. getting a copy of a birth certificate, transportation issues, financial support for finding a place to live. With a network of support and assistance with concrete resources, RENEW services helps the youth/young adult successfully bridge into the adult world. RENEW, as a service within Riverbend's Children's Intervention Program (CHiP), is offered in schools where we have contracts with the school to provide this service. What is unique about this program is that the position is not tied to a school, so the coordinator can specifically work with youth who are not in school, in an alternative school, or in a school that does not have a contract for RENEW services.

The ECC RENEW position is at 50% of 1 FTE. It is focused on transition aged youth and working with systems that touch that population to coordinate and remove barriers. ECC's RENEW Coordinator has worked hard on developing regional relationships to benefit youth/young adults in the program. He works closely with PACE Career Academy, NH Training Institute (NHTI), Vocational Rehabilitation, Riverbend's ChIP and CSP programs, and crisis services. Since August, Vocational Rehabilitation has ensured that ECC RENEW youth enrolled in a school program receive pre-employment services from Vocational Rehabilitation and youth over 18 remain connected to Vocational Rehabilitation while on the waiting list.

Below are statistics for ECC RENEW:

ECC RENEW Jul - Dec 2019	July	Aug	Sep Q3	Oct	Nov	Dec Q4	Jul-Dec 2019
Individuals served over during this period of time			12			7	14
New intake			2			1	3
Continuing in program			6			4	2
Left program			4			2	5
Newly placed outside the home			0			0	
Returned to home from placement			0			0	
Number enrolled in academic program			4			2	
Improved or sustained academic performance			2			1	
Number Employed			2			1	
New psychiatric hospitalizations			0			0	
New legal offenses			0			0	
CANS/ANSA # where actionable items increased			3			1	
CANS/ANSA # where actionable items decreased			2			1	
CANS/ANSA # where actionable items stayed the same			1			3	
CANS/ANSA # with initial CANS completed			1			1	
# unable to gather data on for this period			5			2	

ECC Complex Care Coordination

The Complex Care Coordination (CCC) program began in March 2019 to identify, plan for, and structure interventions for high-utilizing behavioral/medical populations in the Capital Area. The CCC program coordinator facilitates regular communication across projects and teams through an administrative workgroup to ensure mutual understanding of goals, avoid duplication of services and/or service silos, and reduce the frequency of unnecessary emergency department use. She also facilitates a regular meeting of providers and responders to address and respond to individuals identified as having complex care needs, improve transitions of care and communication across teams and organizations, and ensure that all clients are served in the least restrictive settings according to their needs.

The CCC program works actively with the Concord Police Department, Emergency Medical Service, and CH ED representatives in receiving and reviewing referrals into the program. Since its inception, the CCC program has worked with the following entities on case management of high utilizers:

- Bicentennial Square Counseling Associates
- Bureau of Adult & Elderly Services
- Disability Rights Center
- Center for START Services
- Community Bridges
- Concord Fire Department.

- Concord Hospital
- Concord Housing Authority
- Concord Human Services
- Concord Police Department
- Concord Regional VNA
- Dartmouth Hitchcock Concord
- Merrimack County Department of Corrections
- Metropolis Property Management Group
- NH Hospital
- Office of Public Guardian
- Portsmouth Hospital
- Riverbend
- Senior Law Project

The CCC coordinator has been persistent in reaching out and meeting with a variety of programs to explain/remind them about the CCC program. The CCC coordinator has been working to understand partners needs and where there are gaps in order to tailor the project to be most beneficial. In addition to direct communication, CCC developed a survey and distributed to better understand these gaps.

The CCC coordinator met with the Riverbend ChIP Director in September to discuss the best ways to improve clarity / interface between the Complex Care Coordination and Riverbend programs. Another meeting took place with ChIP Managers in November to discuss the Complex Care Program. In August, the CCC coordinator met with Riverbend's CSP Managers to discuss the CCC program, the referral process, and to receive feedback on what is and is not working between the CCC and CSP programs. The CCC coordinator also met with the IBHC and Nurse Navigator at Concord Family Medicine to discuss the CCC program, the purpose of the program, CCC role, and the referral process. Also, in August, the CCC coordinator met with Riverbend's Mobile Crisis Team and Emergency Services Clinical Managers to discuss the best ways to improve clarity/interface between the Complex Care Coordination and Riverbend programs. In July, the CCC coordinator met with the Care Team Coordinator at DHC to discuss workflows for their Multidisciplinary Care Team Meetings and introduce the CCC program to DHC.

The CCC program uses CMT for event notification as shared care plans. The CCC program is also working with EMS in developing an automated shared report for data collection to monitor the frequency of utilization of services in order to assess and improve the efficacy of the program.

In September, the CCC administrative workgroup drafted a CCC project charter that includes:

- Vision Statement
- Mission Statement
- Workflows
- IDN2 Release of Information
- Frequently Asked Questions
- IDN2 Member Organizations

The Complex Care Coordination (CCC) coordinator resigned effective 12/3/19 and was replaced 1/20/20 so the program was on hiatus in Dec. 2019.

Complex Care Coordination Statistics					
Client Identifier	**Date Referred**	**Referral Source**	**1st Meeting**	**# providers in attendance**	**Date Switched to Monitoring**
JU	4/22/19	Riverbend	5/10/19	12	10/16/19
CE	4/23/19	Riverbend	5/13/19	11	
CB	5/31/19	Riverbend	7/22/19	11	
RW	6/7/19	Riverbend	7/25/19	12	
TL	6/19/19	Concord Hospital	7/1/19	16	
DB	6/27/19	Concord Fire Dept	8/1/19	15	
ES	7/16/19	Riverbend	8/19/19	15	
CL	7/22/19	Concord Hospital	8/19/19	11	10/8/19
SS	8/28/19	Concord Fire Dept	9/24/19	20	

Project Targets

Performance Measure Name	Target	Cumulative Served to Date	Progress Toward Target		
			12/31/18	6/30/19	12/31/19
Total number served RENEW	33 over five years	21 over three years	7	9	5
Total number served CCC	25 over 18 months	9 over 7 months	N/A	2	7

Budget

Budget Item	Potential 2021	Approved 2020	Actual 2019	Actual 2018	Actual 2017	Actual 2016
ECC Staffing Sub-Total	$37,500	$81,200	$89,979	$185,085	$74,341	$0
Flex Funds	$0	$10,000	$15,264	$3,256	$0	$0
ECC TOTAL	**$37,500**	**$91,200**	**$105,243**	**$188,341**	**$74,341**	**$0**

Budget Notes

E5 Enhanced Care Coordination

1.00 FTE Staff

0.40 Complex Care Coordinator [redacted]

0.50 Enhanced Care Coordinator [redacted]

0.05 Intake [redacted]

0.05 Project Oversight [redacted]

Flex Funds – Emergency funding for clients to maintain participation in program and further their recovery (Past financial amounts include MAT Wraparound / Waypoint). Please see page 40 for Flex Funds protocol.

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

IDN2 has worked with the state and other IDNs to develop APMs to fund the work done through the demonstration project.

There have been statewide and IDN2 specific meetings with MCOs. NH Healthy Families developed a proposal, which IDN2 is reviewing and will discuss with them at a meeting in February. IDN2 is not convinced that acting as a Licensed Care Management Entity (LCME) will substantially help sustain integrated healthcare. It is possible that the LCME might work in a limited way, for example in the RICH program, a reverse integration project at Riverbend that utilizes FHC medical staff. Another items of interest with the MCOs is the collection of Z codes. If the MCOs pay the IDNs to collect those, it could possibly dovetail with the use of the CCSA.

IDN2 started a billing & coding learning group after seeking technical assistance from Meyers & Stauffer (M&S) regarding billing for integrated health care. DHHS also provided technical assistance and attends the meetings. IDN2 invited all IDNs to attend and, when the group grew to more than 75 members, IDN2 asked M&S to take over the facilitation. The group has several sub-groups now. IDN2 is leading the one for billing within primary care and hospital settings.

IDN2 is also working on a regional sustainability plan following this approved plan to plan:

IDN2 Sustainability Planning Worksheet

1. The IDN2 executive and finance committee members will review recommendations made by those with expertise from among the committee members. The IDN2 project director will work with IDN2 staff and partners to develop the work for committee review.
2. Define long-term goal or vision within a state and regional system of care
    a. Review and update vision from IDN2 2016 application for Project Plan
    b. Identify and review needs assessments
    c. Identify and review long-term planning documents for state and region
    d. Identify and review similar state or regional projects
3. Determine which elements of current project outcomes and operations (first, second, third tier in priority), including HIT/Data need to be maintained, eliminated, or adapted to support the long-term goal or vision
    a. Define current project outcomes and operations
        i. Evaluate strengths, weaknesses, and relevance to long-term goal
    b. Establish operations to be sustained ("the project")
        i. Develop outcomes and evaluation measures for the project
4. Define the 2020-2025 costs of sustaining the project
5. Identify resources to support costs
    a. Investments in capacity already paid for by DSRIP funds
    b. Unallocated DSRIP 2021 payments
    c. Continued financial support from NH DHHS/BDAS
    d. Existing partners' operations can absorb aspects of projects
    e. Fee for services
        i. All insurance not just Medicaid
        ii. Research billing & coding for integration
            1. Collaborative Care Model
            2. "Turn on" Medicaid codes that might help
            3. Utilize Medicaid codes that are dormant

4. Advocate for higher reimbursements from Medicaid
5. Advocate for changes in what type of provider/service can bill to Medicaid

f. Fundraising
   i. Application to federal and state agencies under identified RFRs
   ii. Corporate support
   iii. Individual support

The Collaborative Care Model (CoCM)

Collaborative care is a specific type of integrated care developed at the University of Washington that treats common mental health conditions such as depression and anxiety that require systematic follow-up due to their persistent nature. Based on principles of effective chronic illness care, collaborative care focuses on defined patient populations tracked in a registry, measurement-based practice, and treatment to target. Trained primary care providers and embedded behavioral health professionals provide evidence-based medication or psychosocial treatments, supported by regular psychiatric case consultation and treatment adjustment for patients who are not improving as expected.

Collaborative care originated in a research culture and has now been tested in more than 80 randomized controlled trials in the US and abroad. Several recent meta-analyses make it clear that collaborative care consistently improves on care as usual. It leads to better patient outcomes, better patient and provider satisfaction, improved functioning, and reductions in health care costs, achieving the Triple Aim of health care reform.

IDN2 spent a considerable amount of time researching and vetting the CoCM before deciding to implement it within its B1 project. The CoCM implementation project at IDN2 is overseen by the Project Director and the Director of Integrated Healthcare. Workgroups are comprised of experts in their fields working on the financial, clinical, documentation, and technology aspects of migrating to the CoCM model. In addition, IDN2 attends the University of Washington Advancing Integrated Mental Health Solutions (AIMS) Center's monthly CoCM financial and implementation technical assistance calls. These are attended by individuals and organizations from across the country.

IDN2 is planning to implement CoCM as a demonstration pilot at one B1 site, Pembroke, in early March 2020. From that demonstration, IDN2 will collect data and develop a financial model to support further CoCM implementation across the other integrated healthcare sites. Key differences between the integrated health care model that IDN2 is currently using and CoCM are:

- Targeting resources to those who cannot be managed by the primary care physician alone or with moderate behavioral health staff support but who also do not require full-time specialty behavioral health care (serious and persistent mental illness for example).
- Focusing on specific behavioral health diagnoses: depression, anxiety, and SUD.
- Using validated assessment tools to continually track progress with time limited care based on assessment tool results.
- Use of a patient registry to track visits, test results, and progress. It also collects patient data and billing information.
- Weekly care management meetings between the IBHC and the psychiatrist to discuss patient needs with an emphasis on those not progressing well or in need of medication changes or other forms of care including face to face with psychiatrist. The registry is the point of communication at weekly psychiatrist and IBHC meetings.
- Securing reimbursement for integrated care through use of CoCM billing codes in addition to other behavioral health codes.

IDN2

CAPITAL AREA INTEGRATED DELIVERY NETWORK

August 28, 2019

A1 Behavioral Health Workforce Development

Peers

Increased peer staffing to 9.25

- 7.25 at Riverbend HUB including:
  - 1 Peer Navigator
  - .5 to be deployed for CFF
  - .5 to be deployed to HUB CH SUS
  - All have or are working toward CRSW
- 1 NAMI NH
- 1 Youth Move

Statewide Work

IDN2 leads statewide work to address behavioral health workforce shortages.

Jan – Jun 2019 Training

- Project ECHO NNE MAT Sessions for PCP Teams
- Hoarding: Outpatient Perspective
- NH's Connect Suicide Prevention and Intervention
- NH Wraparound Training
- Asthma Training
- COPD Training
- MSLC Learning Collaborative - Population Health
- 8-Hour MAT X-Waiver Course
- 16-Hour MAT X-Waiver Course
- MSLC Learning Collaborative - The New Normal: Enhanced Care Coordination
- CHW/Resource Specialist Festival
- Cognitive Behavioral Therapy: How to Change Thinking to Change Lives
- Facing Our Fears: Treating Suicidal Clients and Their Families
- Behavioral Management Lunch and Learn
- Solutions from the Frontlines: A Behavioral Health Conversation
- Mindfulness in Recovery
- NH NASW Conference
- Cognitive Behavioral Therapy for Substance Use Disorders
- DBT
- Post Intervention Suicide
- Trauma-Informed Care
- Essentials of Project Management
- HIV for Substance Use Professionals
- Recovery Coaching (CRSW)
- Effects of Substance Abuse on Young Children
- New England Summer School of Addiction
- Psychotropic Medications and Older Adults: Update on Safety Considerations
- Mental Health and Wellness in the Workplace: Strategies to Support Patients and Providers Living with Mental Illness

PEER SERVICES

"I first met Josh at the homeless resource center back in 2018. At that time, Josh was 31 years old and identified himself as an alcoholic. Josh and I shared some of our mutual experiences and found out that we both love making pizzas and had been in the pizza business for years. Unfortunately for Josh and others, including myself, we had stopped our passion for pizza making because addiction to alcohol was more powerful.

I continued to work at the Center in the hopes of starting a recovery group, which I was finally able to do with an initial 6 people. Unfortunately, Josh did not want to be part of it and I didn't see him around much.

Then one day, I received an email from the clinical manager saying I have a client that is asking for help, can you meet him? I was very surprised to find out that it was Josh. We met and called The Doorway together. Josh was admitted to the Farnum Center for detox and successfully completed a 28-day program. He relapsed 3 days later.

A few months later, Josh asked me again if I could help him stop drinking so we started meeting up again and looking at resources. This past April, Josh completed orientation and pre-admission at Choices. He is attending a recovery skill group, as well as group and individual therapy. Josh also received MAT.

This morning, Josh shared with his recovery skill group that he has been sober for 3 days and is buying a camper that he will park at his mother's house so he will no longer have to live in a tent on the street. For the first time since I met him, Josh has a big smile on his face and looks genuinely happy."

A2 Health Information Technology

Massachusetts e-Health Collaborative (MAeHC) is the data aggregator for metrics we are required to report to NH DHHS and for which we receive incentive payments.

- Actively working on addressing gaps and ensuring that workflows and data input are accurate.
- NH DHHS is evaluating how metrics are paid out now that IDNs will receive less funding overall due to reduced County contributions.

Collective Medical Technology (CMT) is being used for event notification and a shared care plan.

- Piloting its use with emergency department, Riverbend, CHMG PCP integrated healthcare sites, CVNA, and others.
- Working on privacy concerns.

Equipment, interfacing

- Hardware & software
- Connections between EMRs and other systems
- Infrastructure (development, build outs, etc.)

HEALTH INFORMATION TECHNOLOGY

"Once we implemented Collective Medical Technology (CMT) and started to receive event notifications from the emergency department (ED), we noticed that one of our patients had more than five ED visits in the past 3 months.

We took the opportunity to drill down into the data and presented the information to the provider, who was able to follow up with the patient and make a plan for her to see the IBHC.

This led to a decision to make it a practice plan to follow up on any patient that shows up in CMT with 3+ ED visits and to review one case each month with the provider team for any patient with an excess of ED visits over the past year."

B1 Integrated Healthcare

PC sites w/ integrated RB BH staff

Concord Family Medicine

Epsom Family Medicine

Family Physicians of Pembroke

Penacook Family Physicians

Pleasant Street Family Medicine

PC sites w/ own integrated BH staff

Family Health Center Concord

Family Health Center Hillsboro

Dartmouth Hitchcock Concord

PC sites without BH staff

IMED Horseshoe Pond

BH site w/ integrated CH medical staff

RB Integrated Center for Health (RICH)

BH sites without medical staff

CH Substance Use Services

Riverbend (all programs)

Jan-Jun 2019 - Met all process measures to achieve Integrated Healthcare

- Use of a comprehensive core standardized assessment tool
- On site PCP and BH providers
- Cross disciplinary training
- Core team case conferences for those with significant behavioral health conditions or chronic conditions
- Secure messaging
- Closed loop referrals
- Documented work flows and/or protocols
- Adoption of both of the following:
  - Medication-assisted treatment (MAT)
  - Treatment of mild-to-moderate depression
- Use of technology for at risk patients to:
  - Identify
  - Plan care
  - Monitor/manage patient progress toward goals
- Ensure closed loop referral
- Documented work flows with community based social support service providers including, at minimum:
  - Joint service protocols
  - Communication channels

B1 Integrated Healthcare

PC sites w/ integrated RB BH staff

Concord Family Medicine
Epsom Family Medicine
Family Physicians of Pembroke
Penacook Family Physicians
Pleasant Street Family Medicine

PC sites w/ own integrated BH staff

Family Health Center Concord
Family Health Center Hillsboro
Dartmouth Hitchcock Concord

PC sites without BH staff

IMED Horseshoe Pond

BH site w/ integrated CH medical staff

RB Integrated Center for Health (RICH)

BH sites without medical staff

CH Substance Use Services
Riverbend (all programs)

Sites	CFM			PFM			EFM			FPP			PSFM			2nd Q total
2019	Apr	May	Jun	Apr	May	Jun	Apr	May	Jun	Apr	May	Jun	Apr	May	Jun	
IBHC Days in Office	24	12	17	22	5	0	24	16	20	22	19	17	22	9	14	243
Type of Client Interaction																
Scheduled	69	30	62	42	4	N/A	91	49	56	28	45	36	88	26	30	656
No Show	26%	27%	32%	17%	0%	N/A	21%	24%	21%	18%	18%	36%	33%	15%	33%	24% AVG
Warm hand-off	19	6	9	11	1	N/A	13	7	10	7	16	11	16	2	5	133
Unscheduled	11	4	2	3	7	N/A	4	0	3	16	6	9	4	8	1	78
Totals																
VISITS TOTAL	81	32	73	49	12	N/A	89	44	69	46	59	56	79	32	36	757
TEAM CONSULTS	111	55	75	67	7	N/A	71	24	25	51	43	39	21	9	3	601
PHONE CHECK-INS	20	14	10	218	11	N/A	20	9	11	20	27	32	36	14	16	458
RESOURCE CALLS	14	4	5	19	24	N/A	8	3	1	53	22	99	15	6	13	286
Notes				Low IBHC attendance in May. June covered by Epsom and Pembroke and reflected in those numbers.									Low IBHC attendance in May. Missing one week of data in June.			**2,102** IBHC contacts on behalf of PCP patients with BH needs
Key	**Scheduled Visits:** visits that were pre-planned in any capacity, even if that means that they were scheduled an hour prior **Warm hand-offs:** introductions to the patient by another team member lasting less than 15 minutes. A warm hand-off may turn into an unscheduled visit in which case it will count for both. **Unscheduled Visits:** any visit longer than 15 minutes that was not pre-planned **Team Consults:** in-person or phone consultation about a patient with a member of the team (provider, Nurse Navigator, Psychiatric consultant, IBHC, etc) **Phone Check Ins:** calls made to a patient or natural support wherein clinical conversation takes place (not just to schedule/reschedule) **Resource Calls:** Calls to collaterals or resources, including referrals															

INTEGRATED HEALTHCARE

"Ted showed up for his annual exam appointment with significant and overwhelming anxiety. He was accompanied by his sister as he wasn't able to speak to the doctor on his own.

After the exam, the primary care physician introduced him to the IBHC, who was able to help Ted talk about his anxiety and come up with a plan to address it.

The IBHC made a warm hand-off to Riverbend Behavioral Health Crisis Treatment Center for wraparound services to include case management, individual therapy, and medication support. Ted was also introduced to a peer for ongoing support in managing new situations."

C2 Reentry

Merrimack County DOC & Riverbend

IDN funded staff at MCDOC include:

- Case manager
- Clinician
- Psychiatric nurse practitioner

These staff work specifically with inmates sentenced to the SOAR program.

By providing clinical assessments, medication management, case management and individual therapy for participants while they are incarcerated, staff are able to identify treatment needs, initiate treatment, and activate resources before the individual is released.

Once released, IDN staff continue to support participants for a year post-release through the provision of group therapy and case management.

The same staff provide services both inside of the jail and in the community which helps to reduce the stress and change participants are faced with during this time of transition.

Reentry Data Jan-Jun 2019	
Clients served pre-release?	36
Of these, how many were new?	26
Of these, how many were continuing?	10
Clients served post-release?	39
Of these, how many were new?	28
Of these, how many were continuing?	11
How many received case management?	39
How many received group therapy?	33
Referred to SUD Services	18
Follow through rate	60%
Referred to MH Services	19
Follow through rate	58%
Referred to Primary Care	18
Follow through rate	39%
Clients completing 12 months?	8

REENTRY

"John successfully completed SOAR classes while incarcerated and has transitioned out of supervision of both the department of corrections and probation. He also successfully attended one year of after-care meetings. John now has a full-time job, an apartment, and a healthy relationship. He is active in his child's life and volunteers as a football coach. He remains sober and actively works on his recovery daily."

"While incarcerated, Jane also successfully completed SOAR classes and transitioned her supervision to probation once she was released. She now has a full-time job, an apartment, and is volunteering at an organization that provides service animals to first responders and veterans. She is active in her recovery and in the maintenance of her mental health. She goes to the gym daily and has reestablished a relationship with her children."

D1 MAT HUBs & SPOKES

HUBs (CH SUS & RB Choices)

Provides:

- Oversight & coordination of all MAT & SUD services
- Continuum of care services: MAT, individual & group counseling, peer support, intensive outpatient programs
- Connection to all SUD services including the Doorway, Mobile Crisis, Complex Care Coordination, CH Emergency Department, CH inpatient
- Mentoring and monthly group meetings for MAT providers
- Linkage for patients/clients between SPOKEs and HUBs
- Education and site visits

SPOKEs: Choices for Families

Jan-Jun 2019

- 4 pregnant women received MAT
- 2 delivered earlier and are still receiving MAT onsite
- 35 pregnant or parenting women received wraparound services and supports

SPOKEs: PCP MAT Providers

For the last three reporting periods, the total number of patients receiving MAT has increased from 116 (Jan-Jun 2018) to 142 (Jul-Dec 2018) to 160 (Jan-Jun 2019).

Here is data for the most recent period of time:

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

MEDICATION ASSISTED TREATMENT

"Susan came to us near the beginning of her third pregnancy. She was using Suboxone that she purchased "off the street" as well as marijuana. She was Hepatitis C positive and had advanced dental decay.

At the outset of treatment, she was late frequently, struggled with the paperwork needed to stay enrolled with her insurance, and her urine tests persistently came back positive for marijuana.

Since working with our entire team, she received her driver's license and began showing up to appointments on time. She saw the dental clinicians and was fitted with dentures and an Infectious Diseases doctor began actively treating her Hepatitis.

After several months of maintaining her sobriety, she gave birth to a baby girl and transferred her care to CHOICES, where she meets with a peer and is actively maintaining her recovery. She also continues to work with Waypoint for help coordinating her services and to attend parenting classes.

Recently, she went to court and was awarded custody of her oldest child who is now living with her and the younger children."

CHOICES FOR FAMILIES (CFF)

"When Ellen came to CFF, she had just learned that she was pregnant with her second child. She had only recently reunited with her 5-year old daughter, who had been removed from her care previously due to substance use issues.

Ellen had been working on her sobriety since the birth of her first child and was substance free when we met. She was, however, living in an unsafe and unstable housing situation with a friend. Because of this, Ellen was in danger of losing custody of her daughter again. While she had saved some money, Ellen's work as an unskilled laborer meant she couldn't save enough – soon enough – for an apartment.

With the help of flexible funds from CFF, she was able to expedite the move to her own apartment. Ellen maintained her employment throughout, taking only a brief break when her new baby was born. CFF helped Ellen secure day care for both children.

Ellen is outspoken about her recovery and finds strength in sharing her story with others. She has aspirations to become a Certified Recovery Specialist and CFF is helping her secure training and employment in this field. This fall, she will be participating as a co-trainer in a conference where she will be sharing her journey and her experience in working with CFF."

E5 Enhanced Care Coordination

RENEW Program

Serves ages 15-22, primarily those aging out of Riverbend's Children's Intervention Program.

Provides Empowerment, Natural Supports, Education, and Work (RENEW) services.

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

Complex Care Coordination

Serves those identified as having complex care needs.

Provides:

- **Workgroup meetings** to ensure mutual understanding of goals, avoid duplication of services & service silos, improve transitions of care & communication across teams & organizations, and reduce the frequency of unnecessary ED use.
- **Clinical meetings** to address and respond to individuals identified as having complex care needs

The Complex Care Coordination project began March 2019 and was still in its implementation phase through April 2019.

Jan-Jun 2019 data:

- Two workgroup meetings - April and May 2019
  - Addressing referral workflows, data sharing, privacy concerns
- Two client-centered meetings in May 2019

ENHANCED CARE COORDINATION (ECC): RENEW

"Kevin recently transitioned out of ECC, meeting all three of his identified goals, which were obtaining a HiSET diploma, getting his driver's license, and finding and maintaining employment. Kevin also has an apprenticeship planned for the electrical trade, which he attained through a job shadow set up with support from his employer who was part of his RENEW team."

"Cheryl continues to actively work on passing the HiSET. She has faced some barriers but is not giving up. She was recently able to use resources we gave her to identify transportation to the HiSET test from the town where she lives, a big step for someone who previously became overwhelmed when faced with these kinds of challenges."

"Sam successfully passed his HiSET with a score of 94 out of 100 and got his driver's license. He is now working additional hours to save money for a car. He will "graduate" from ECC soon with the skills to manage his life independently."

COMPLEX CARE COORDINATION (CCC)

"Sharon, a long-term, high utilizer of Emergency Medical Services, was referred to CCC. She was in a dire housing situation and was about to lose her apartment. Her mental health symptoms were severe and she wasn't capable of cleaning, organizing, and otherwise managing her living and health needs. Because of the urgent nature of her needs, the CCC Coordinator was able to schedule a team meeting for the following day.

The CCC project allowed for the sharing of information across agencies, which otherwise might not have had the opportunity to come together to resolve the issues and coordinate their efforts

As a result of the CCC team meeting, an emergency guardianship was established for Ellen. She is being referred to nursing homes and will be receiving a representative payee. In addition, her home was cleaned and organized so that she has a stable environment and a place to live while waiting for a spot in the nursing home." **CCC Team: Concord Fire Department, Concord Hospital, Riverbend, Office of Public Guardian, Community Bridges, Bureau of Adult & Elderly Services, Metropolis Property Management, Concord Human Services, and the Senior Law Project**

Sustainability Planning Process

- Executive and finance committee members convened to review and approve a sustainability planning process.
- Committee members and IDN2 project director will develop work for review.
- Group will meet on a regular basis, combining the preciously separate executive and finance committee meetings.
- Outline of work to be done:
  - Define long-term goal or vision within a state and regional system of care
  - Evaluate and determine which elements of current project outcomes and operations (first, second, third tier in priority), including HIT/Data need to be maintained, eliminated, or adapted to support the long-term goal or vision
  - Define the 2020-2025 costs of sustaining the project
  - Identify resources to support costs
    - Continued NH DHHS support
    - APM
    - Fee for service
    - Value based payment

Sustainability Planning Evaluations:

Some Initial Thoughts

A2 HIT

- Evaluating CMT (event notification, shared care plans) vendor for continued use post-DSRIP project
- Looking at opportunities for technology infrastructure funding

B1 Integration

- Reviewing staffing models/needs
- Mapping potential transition to a collaborative care model
  - Billing – Financial modeling, reviewing codes and licensing requirements to bill
  - Documentation – Patient registry to plan, track
  - Clinical – Continued work as team; some changes in workflow

C2 Reentry

- Reviewing grant funding to support continuation post-DSRIP

D1 MAT

- Evaluating MAT in pregnancy project model; how to collaborate more closely with CH high risk pregnancy and HUBs as well as Waypoint
- MAT PCP providers being folded into integration including greater access to BH providers

E5 Enhanced Care Coordination

- Renew most likely to continue as Riverbend project
- Complex Care Coordination as part of overall integration

IDN2

CAPITAL AREA INTEGRATED DELIVERY NETWORK

August 28, 2019

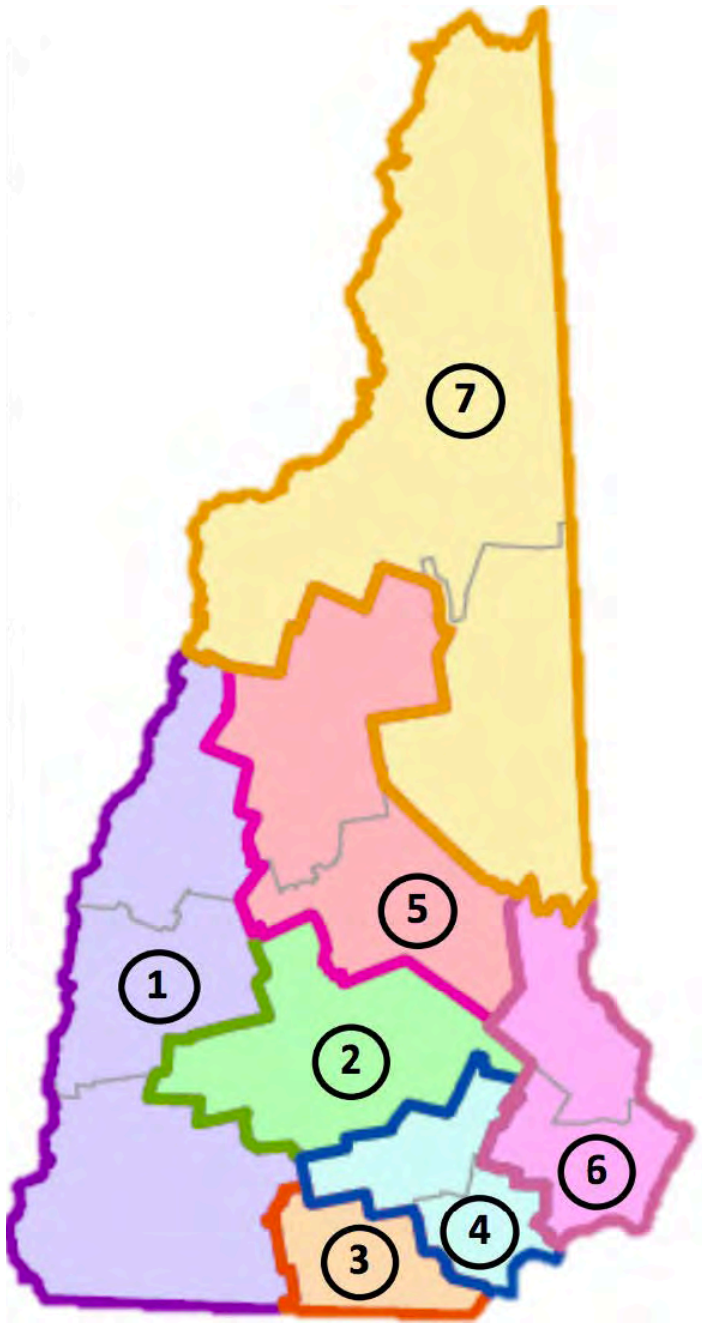
Capital Area Integrated Delivery Network (IDN2)

NH Delivery System Reform Incentive Payment (DSRIP) Five-year Demonstration Project:

Focused on improving outcomes for Medicaid patients with behavioral health risk or diagnosis

IDN2 Footprint

- Allenstown
- Andover
- Boscawen
- Bow
- Bradford
- Canterbury
- Chichester
- Concord
- Deering
- Dunbarton
- Epsom
- Henniker
- Hillsborough
- Hopkinton
- Loudon
- Northwood
- Pembroke
- Pittsfield
- Salisbury
- Warner
- Washington
- Weare
- Webster
- Windsor



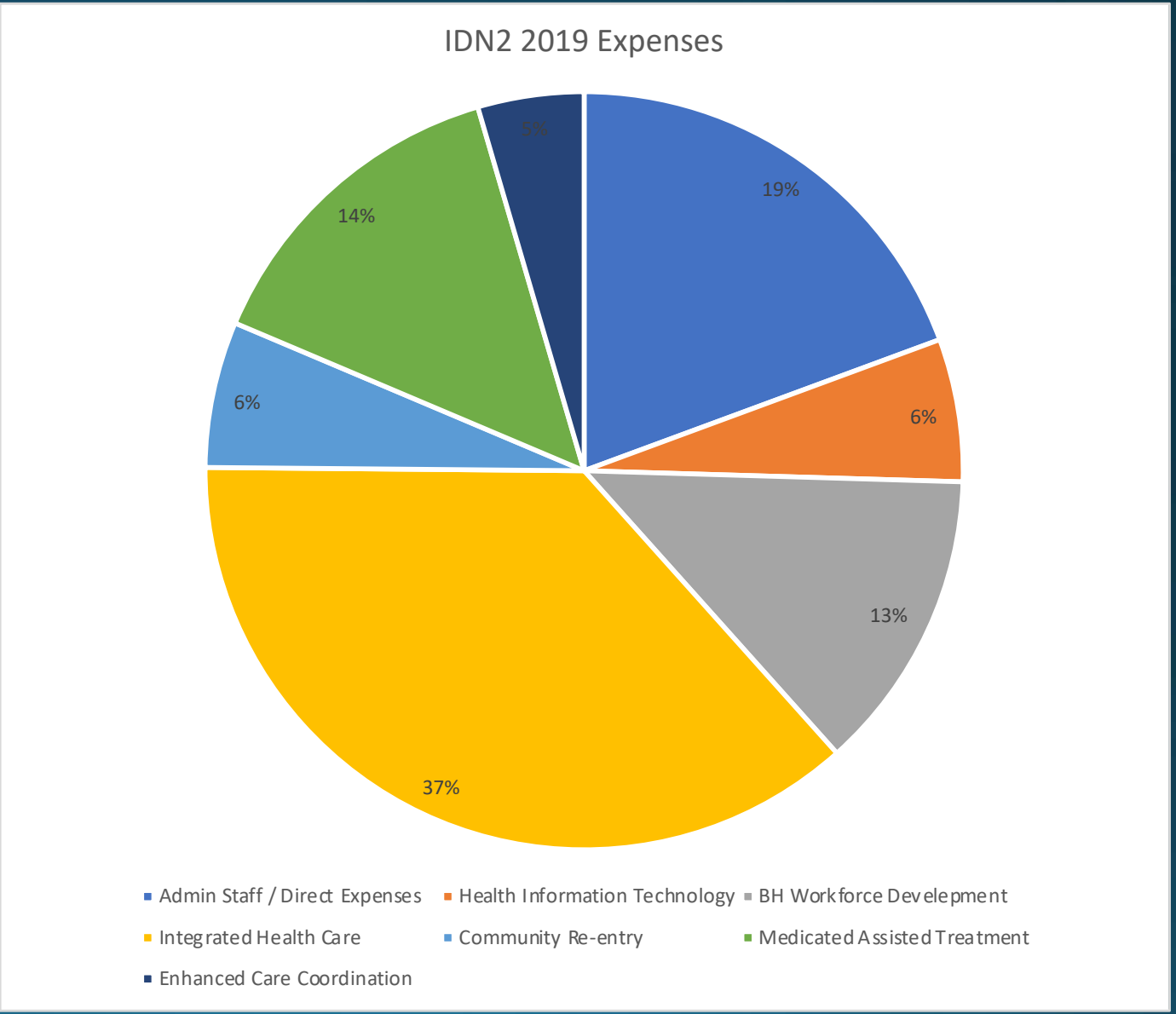
Demonstration timeline

We are here

Evaluating processes & outcomes
Making needed changes
Exploring funding & payment options
Planning for the future

Funding

- Just under $14 million for five years
- 48.65 FTE staff members – all but 7 are direct care staff
- Administration includes oversight, supervision, planning, finance, human resources, reporting, evaluation
- Expenses by year:
  - 2016 - $122,716 (planning phase)
  - 2017 - $1.4 million (planning + initial start up)
  - 2018 - $2.5 million (ramping up)
  - 2019 - $3.3 million (steady state)
  - 2020 - $4 million (steady state)
  - 2021 - $2.3 million (core projects: integration and MAT/SUD)
  - Future = sustainability



Integrated Healthcare

Integrated Behavioral Health Clinicians (IBHC) within primary care sites:

- On site behavioral health care for medical patients presenting with mental health or substance use needs
- Evaluations and assessments
- Brief interventions
- Medical/behavioral health team consults
- Phone check-ins with patients and other providers
- Resource calls on behalf of patients
- Linkage to psychiatric consultation and community based services

Medical and support staff within behavioral health sites:

- Preventative and primary health care for those with behavioral health needs who might not otherwise have access to care
- Wellness support
- Coordination of services

Integrated healthcare is proven to reduce emergency room visits and chronic disease proliferation by providing care to those who need it, when they need it, in an environment that reduces the stigma sometimes associated with behavioral health needs.

3rd Quarter Statistics

Monthly average, per site:

70 visits

50 team consults

24 phone check-ins

30 resource calls

Visits include:

- Scheduled Visits: Pre-planned in any capacity even if scheduled an hour prior
- Warm hand-offs: introductions to the patient by another team member lasting less than 15 minutes.
- Unscheduled Visits: Any visit longer than 15 minutes that was not pre-planned

Team Consults: In-person or phone consultation about a patient with a member of the team

Phone Check Ins: Calls made to a patient or natural support wherein clinical conversation takes place (not just to schedule/reschedule)

Resource Calls: Calls to collaterals or resources, including referrals

Addressing the Opioid Crisis: MAT and SUD Services

Expanding access to Medication Assisted Treatment (MAT) and Substance Use Disorder (SUD) services through primary care, behavioral health, OBGYN, in-patient, and emergency room sites.

- Crisis stabilization
- Evaluations and assessments
- MAT induction and maintenance care
- Individual and group counseling
- Peer support from those with lived experience
- For pregnant and parenting: home visits, wraparound services, and parent education classes
- Linkage to community services
- Connection to The Doorway and Mobile Crisis Services

Recovery is a process of change through which people improve their health and wellness, live self-directed lives, and strive to reach their full potential. Prevention works, treatment is effective, and people recover from substance use disorders

3rd Quarter Statistics

Month	Received MAT	Pregnant / Parenting Wraparound Services
Jul	152	14
Aug	175	18
Sep	175	22

- 99% of pregnant MAT recipients were opioid free at delivery
- 93% of all MAT recipients remain in service and opioid free
- 2% transferred to a higher level of care
- 2% were incarcerated
- 3% discharged and status is unknown

Enhanced Care Coordination for High Need Populations

Meeting the needs of the region's most vulnerable populations

- High utilizers of the ER with complex and under met needs
- Transition aged youth and young adults with multiple areas of need
- Pregnant and parenting women with substance use disorder including those receiving MAT and/or re-entering from incarceration

With highly coordinated, cross-agency collaborations

- Dedicated coordinator to manage the shared care plan and reduce fragmentation and silos
- Medical and behavioral health providers
- First responders
- Corrections staff

Care coordination involves deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care.

3rd Quarter Statistics

34 individuals in Enhanced Care Coordination

Jul-Sep 2019

- Average of 14 individuals representing 6 agencies present at complex care meetings
- 50% of transitional aged youth / young adults in program attending a new academic program
- NO transitional youth / young adults in program placed outside the home or had new legal offenses
- 100% of pregnant / parenting participating in enhanced care retained custody of their children

Community Re-entry Program

For justice-involved adults and youth with substance use disorders or significant behavioral health issues

- Assessment and evaluation
- Participation in the Successful Offender Adjustment and Reentry program (SOAR) while incarcerated
- Behavioral health case management
- Transition planning
- Monitoring
- Assistance with housing, education, work, recovery, and engaging in primary care services
- Individual and group therapy
- Bridge to long-term supports and services

Statistics show high rates of mental illness and substance abuse in prisons and jails. In order to reduce recidivism and increase public safety, jurisdictions need to focus on systems level responses to people with mental illness and substance abuse issues.

3rd Quarter Statistics

Month	Pre-release services	Post-release services
Jul	12	27
Aug	15	27
Sep	12	27

- Most post-release attendees were in continuing service
- 100% received case management and group therapy

IDN2 Survey Results of Providers

at Select Concord Hospital Primary Care Sites

November 2019

31

Questions

9 min 13 sec

Average time to complete

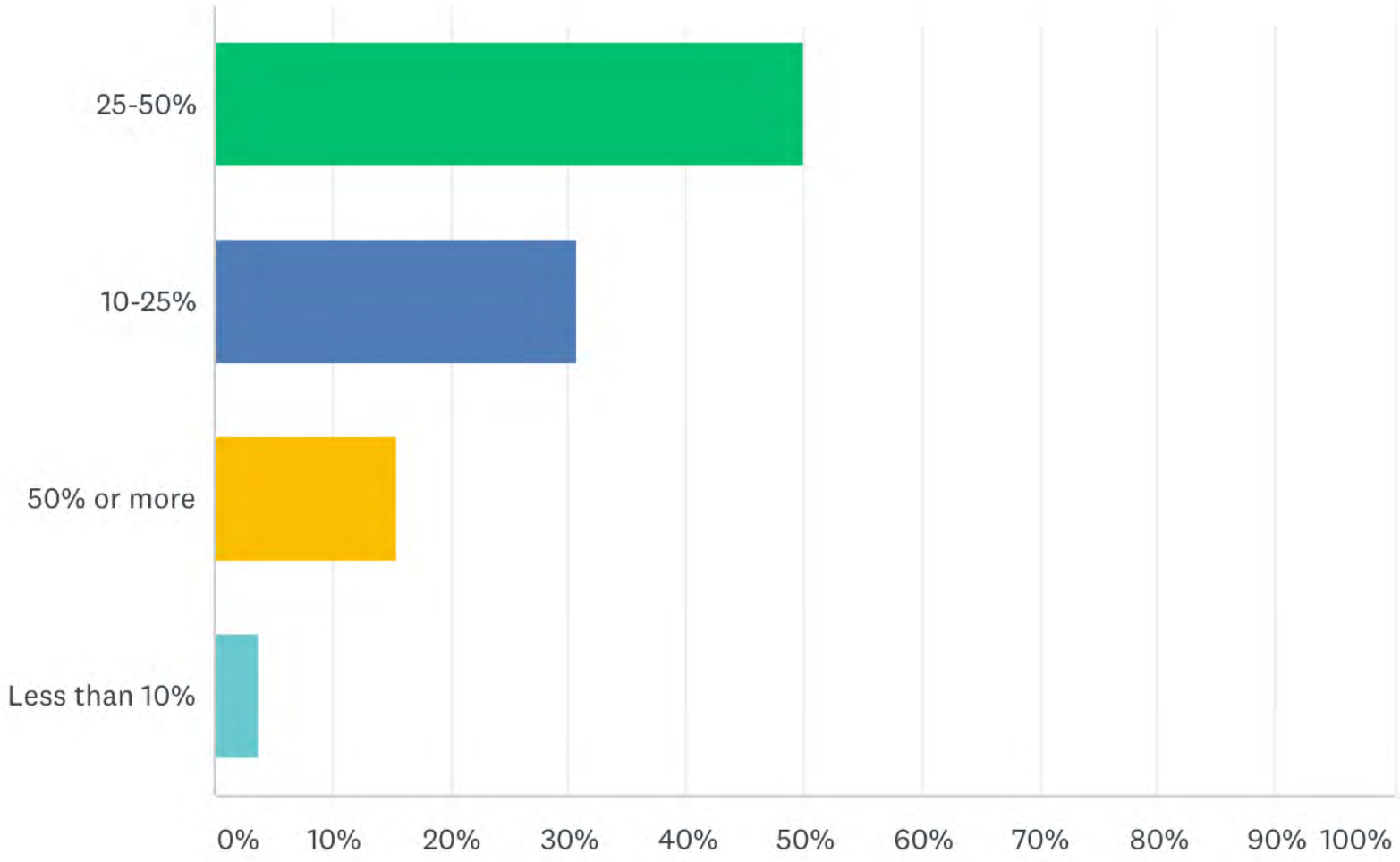
39%

Response rate

Site	Responses	Total Possible	% of Site	% of Overall Survey
Concord Family Medicine	3	13	23%	12%
Epsom Family Medicine	2	7	29%	8%
Family Health Center - Concord	6	17	35%	23%
Family Health Center - Hillsboro	4	4	100%	15%
IMED – Horseshoe Pond	2	5	40%	8%
Pembroke Family Medicine	1	5	20%	4%
Penacook Family Physicians	4	8	50%	15%
Pleasant Street Family Physicians	4	7	57%	15%
	26	**66**	**39%**	**100%**

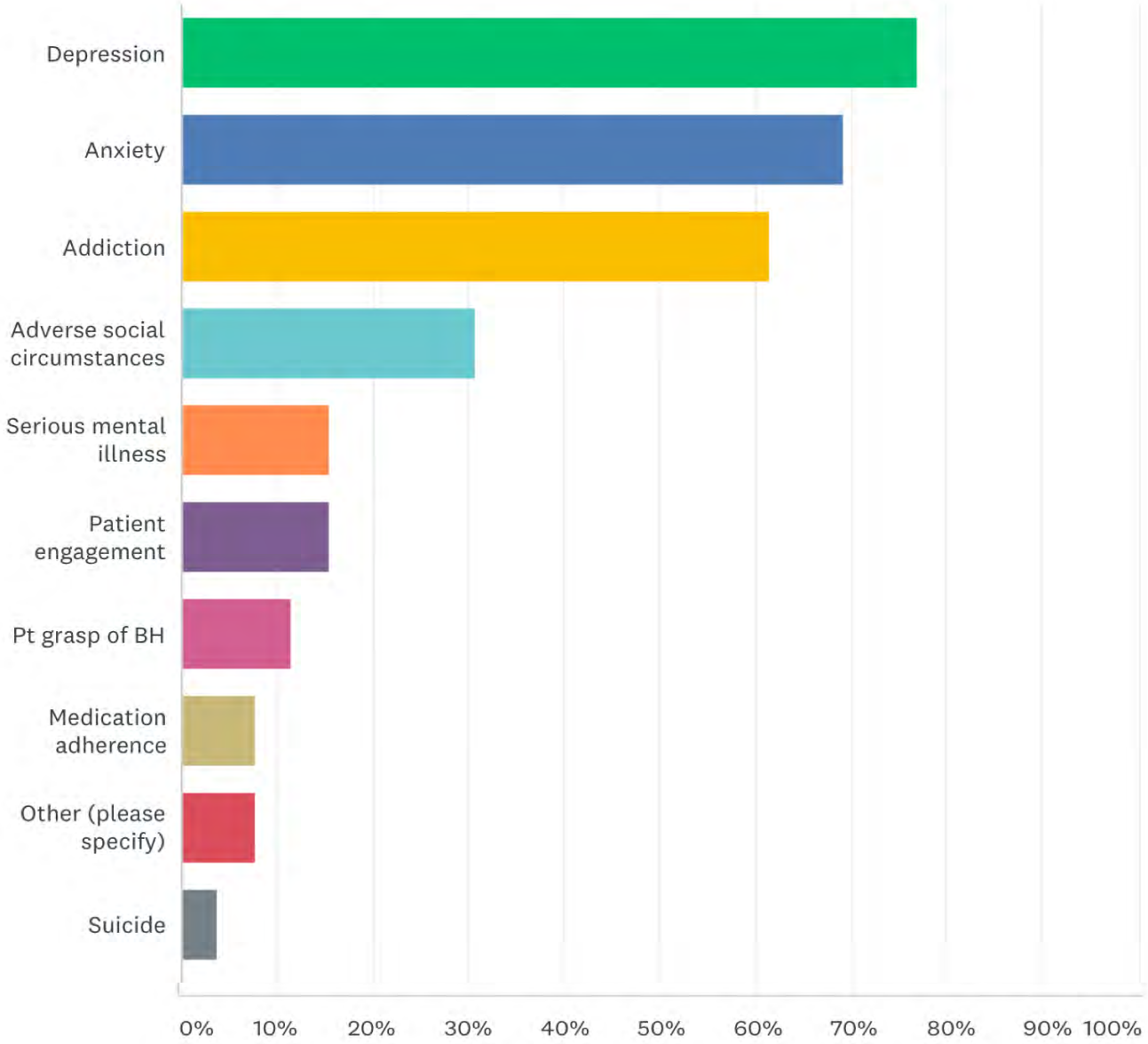
What percentage of your patients present with significant untreated or under-treated behavioral health needs?

Answered: 26 Skipped: 0



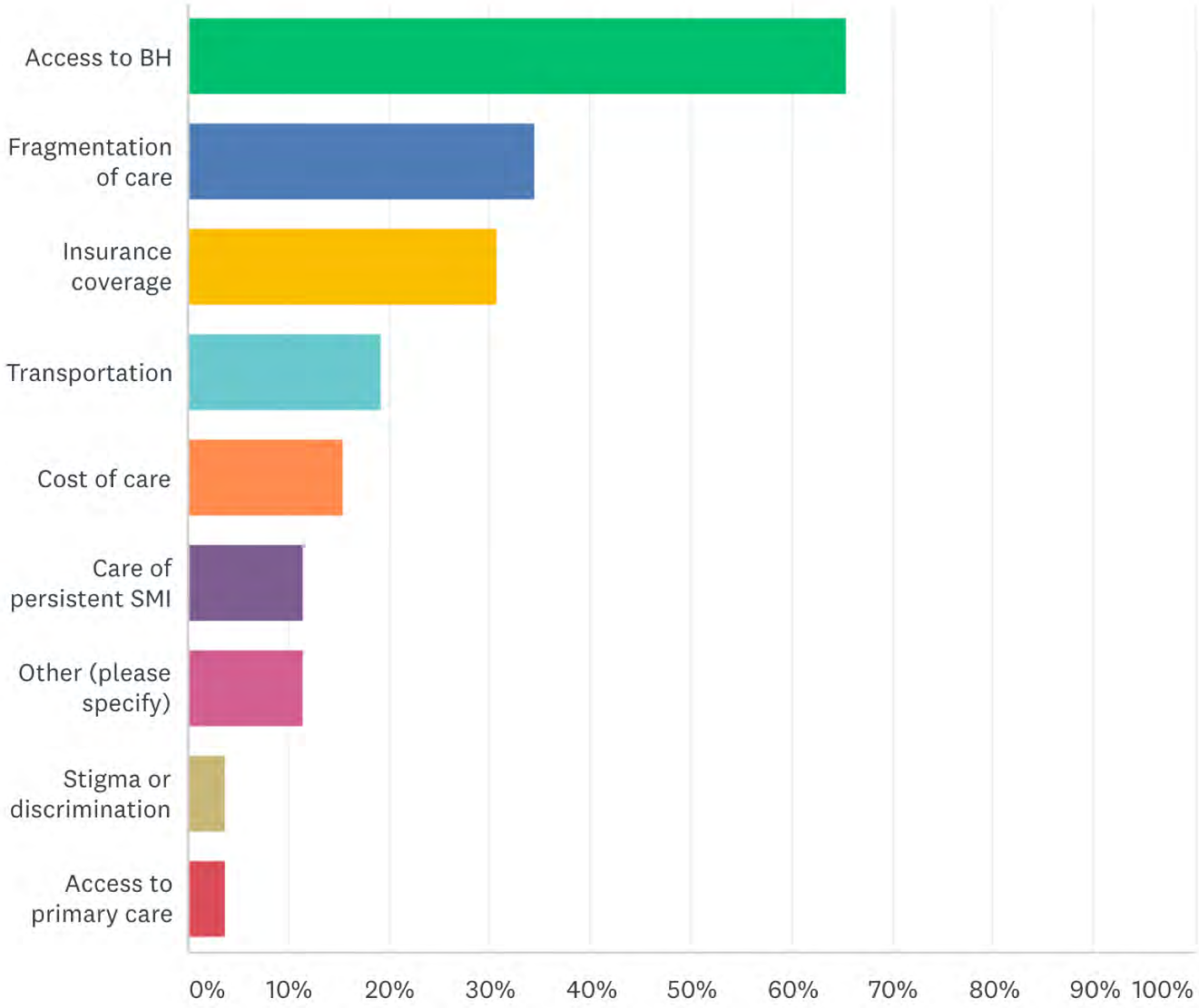
What do you consider the top three most pressing behavioral health issues for your patient population?

Answered: 26 Skipped: 0



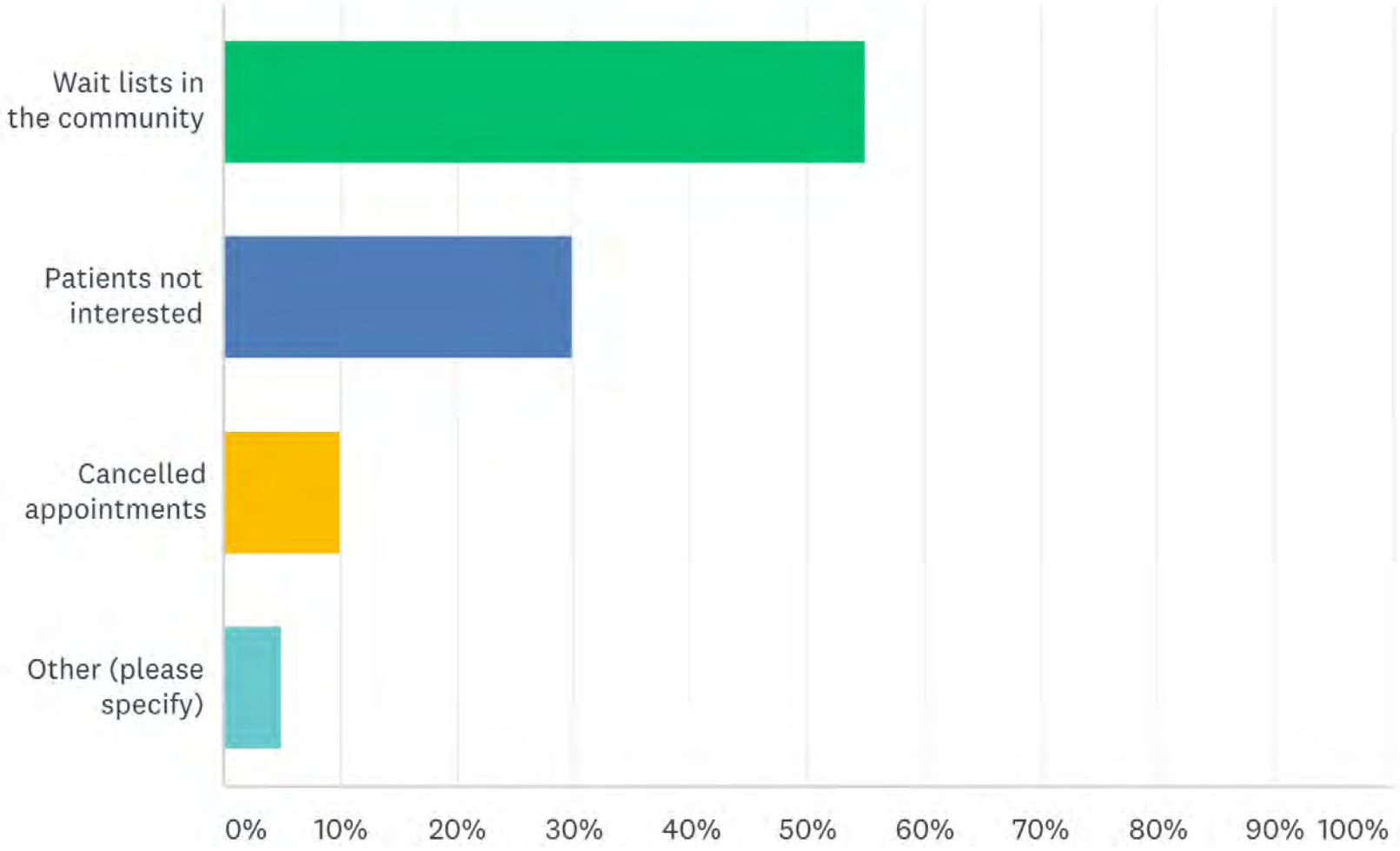
What do you consider the top two most pressing barriers related to delivery of behavioral health in your community?

Answered: 26 Skipped: 0



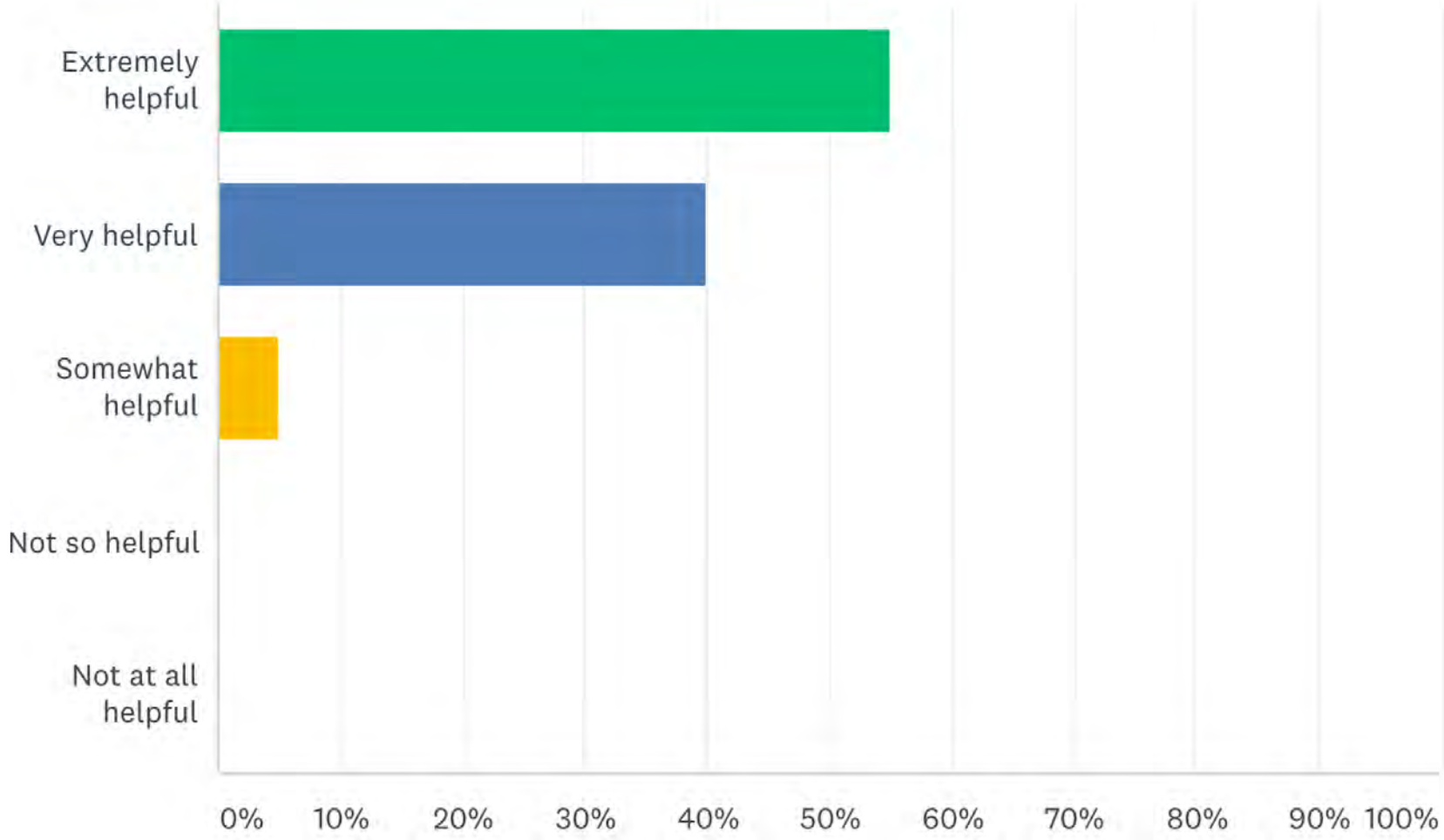
What are the current barriers you experience in attempting to access behavioral health treatment for you patients?

Answered: 20 Skipped: 0



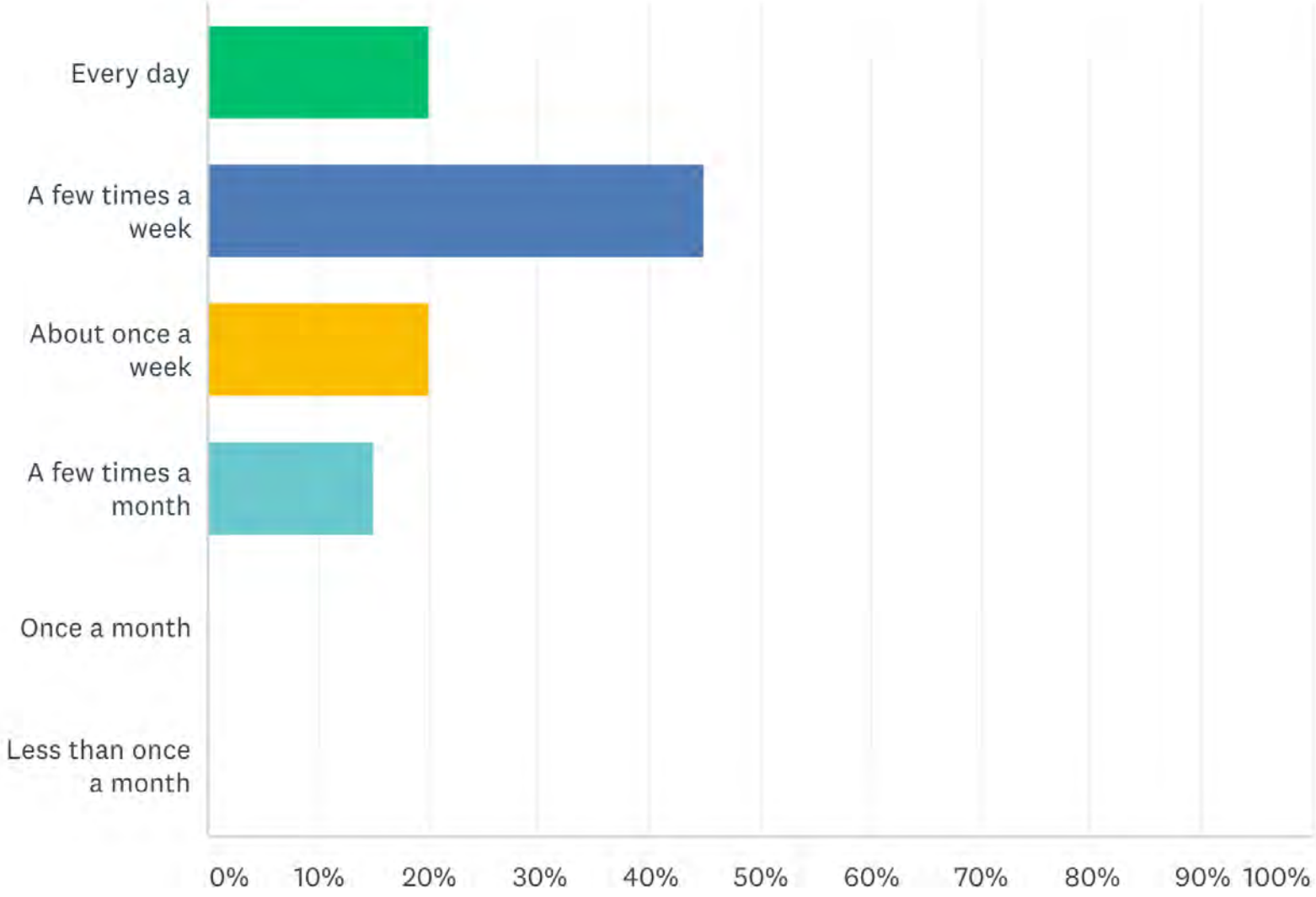
How helpful have the integrated behavioral health providers been for your patients?

Answered: 20 Skipped: 0



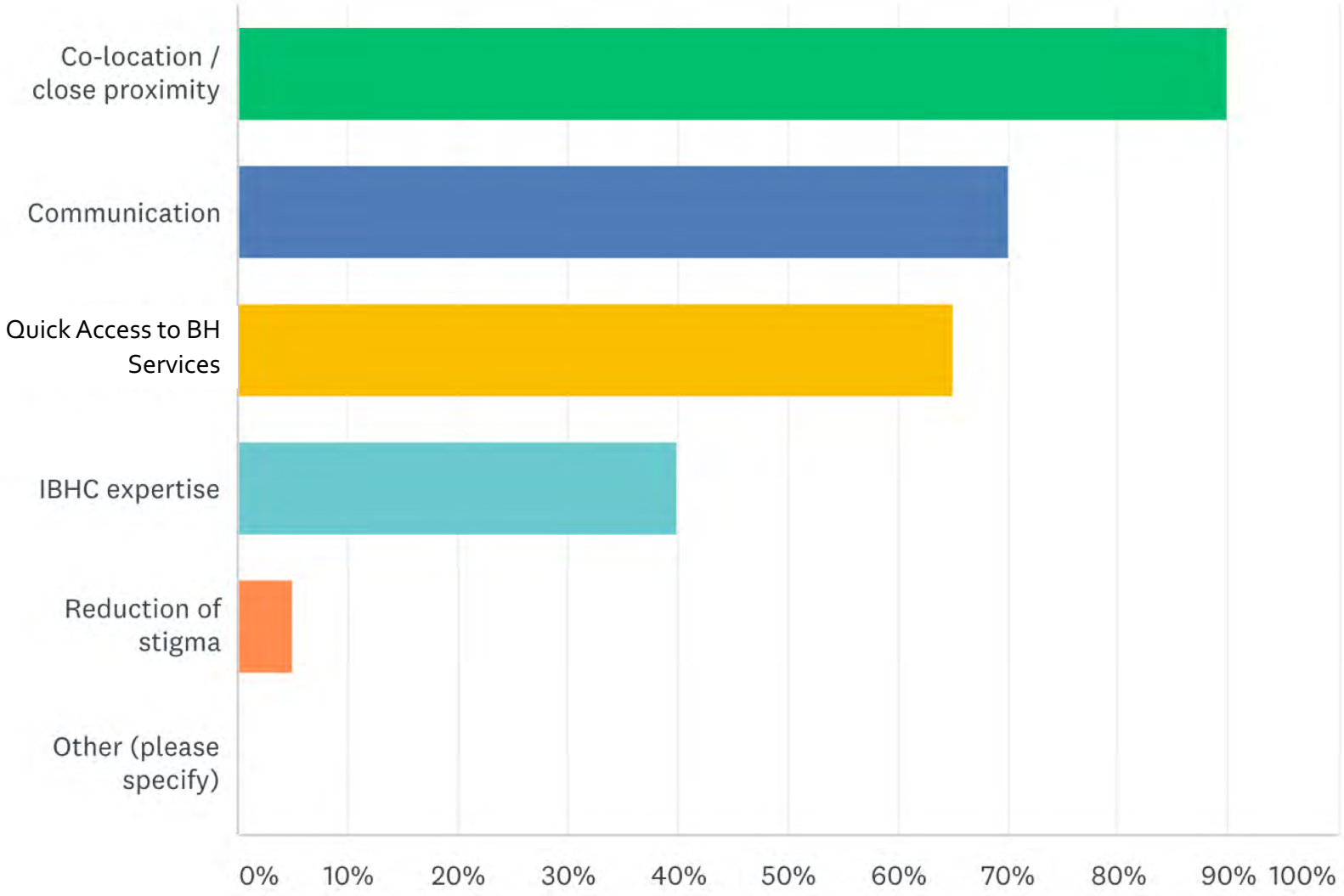
How much do you use the integrated behavioral health providers?

Answered: 20 Skipped: 0



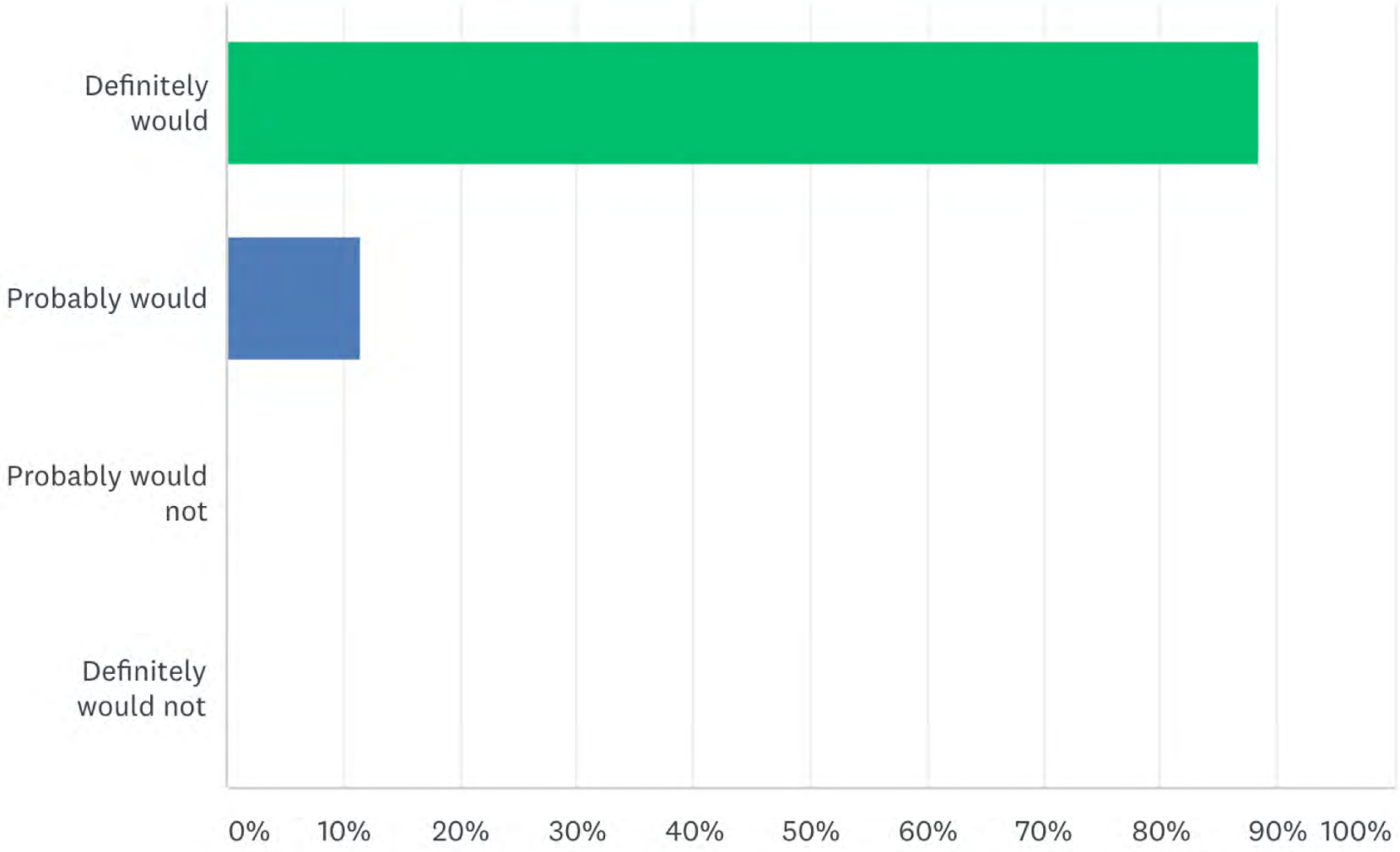
What are the most important aspects of your clinic's integrated behavioral health program?

Answered: 20 Skipped: 0



Would you recommend to your medical colleagues that they integrate behavioral health providers into their clinics?

Answered: 26 Skipped: 0



Questions?