



**New Hampshire Building Capacity for Transformation 1115 Medicaid Waiver  
IDN PROCESS MEASURES SEMI-ANNUAL REPORTING GUIDE**

**For**

**Year 4 (CY2019)**

**2019-6-30 v.28**

**CHSN-IDN5**

**FINAL DRAFT**

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## Introduction

The Centers for Medicare and Medicaid Services (CMS) approved New Hampshire’s application for a five-year Medicaid demonstration project to improve access to and the quality of behavioral health services by establishing regionally based Integrated Delivery Networks (IDN) and developing a sustainable integrated behavioral and physical health care delivery system. To achieve the goals of the demonstration waiver, the IDNs are charged with participating in statewide planning efforts and selecting and implementing community-driven projects. These projects are built around three enabling pathways: mental health and substance use disorder treatment capacity building, integration of physical and behavioral care, and improving transitions of care across settings.

This Reporting Guide is for use by the IDNs to identify required documentation for achieving project requirements according to the Special Terms and Conditions of the DSRIP Waiver. The state will use the information to review and document the IDNs’ progress on project implementation and to award incentive payments. IDNs are required to complete separate implementation plans for each of their statewide projects (i.e., workforce, health information technology and alternative payment models), core competency project, and community-driven projects. Required deliverables must be submitted to the Department of Health and Human Services by July 31, 2017 and within 31 days after each six-month reporting period, as indicated in below. A score of “Met” will be scored for a timely and complete submission. A score of “Not Met” will be scored for late and/or incomplete information.

Submission of the semi-annual report shall be a single pdf document which includes all attachments. In addition, due to printing and size constraints your attachments should also be uploaded separately in the original file version as well (ms project, ms excel, etc.) Attachments should use the naming convention identified in the weekly update dated week ending July 7, 2017. The naming convention shall correlate with the project deliverable for which it is being submitted. See below for illustration of attachment for project B1 deliverable 2A:

Attachment\_B1.2A

For the Reporting Period:	Process Measures Reporting Due to DHHS no later than:
January 1, 2017 – June 30, 2017	July 31, 2017
July 1, 2017 – December 31, 2017	January 31, 2018
January 1, 2018 – June 30, 2018	July 31, 2018
July 1, 2018 – December 31, 2018	January 31, 2019

To be considered timely, supporting documentation must be submitted electronically to the State’s eStudio by the dates indicated above into each IDN’s semiannual reporting folder. For questions, contact:

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## DSRIP IDN Project Plan Implementation (PPI)

### PPI-1: Community Input

The initial IDN plan was informed by extensive efforts by the organizational partners of CHSN-IDN5 to engage key community stakeholders across the region as part of a comprehensive Behavioral Health Needs Assessment. The purpose of these community engagement and assessment efforts was to identify community health concerns and solicit input and advice on priorities and opportunities for community behavioral health and behavioral health care delivery system improvements.

CHSN has continued to engage and seek input from partners, the community and participants over the course of the demonstration waiver by creating multiple opportunities for community feedback to foster learning and opportunities for performance improvement. The CHSN Executive Director will take the lead along with CHSN membership to guide these efforts to assure ongoing consumer and caregiver representation including further developing methods and venues for ongoing assessment of progress, advice on improvement efforts, and identification of ongoing or emerging gaps. Mechanisms of community and consumer input will or have included:

- CHSN Executive Director and the HealthFirst Family Care Center's E5 community care coordinator presented at the April MSLC Statewide learning collaborative in Concord where they spoke as part of a panel on the topic of "The New Normal: Enhanced Care Coordination."
- Client program evaluation tools that were originally developed in the fall 2018 to capture feedback from clients within each of the community-based projects were refined in the spring 2019 to include simplified questions and identify a more streamlined process/workflow for those implementing their use. The evaluations are administered on an ongoing basis to assess client perceptions of effectiveness and inform quality assurance. Horizons Counseling Center (part of the C2 and D3 projects) has been administering the evaluation tool with inmates 30 days after the tracking bracelet is put on (they are released from jail but are in the community), again at 6 months and at one year. The key partners in each of the projects will review client feedback semi-annually to make adjustments and improvements to policies and protocols to ensure goals are met, standards are maintained, and individuals receiving services are satisfied with their care.
- The E5 Care Coordination team held their first Wraparound meeting on June 25<sup>th</sup>. Care coordinators from different agencies presented two or three cases and the team collectively identified solutions for these patients' care. The result was that they agreed upon a shared care plan for the patient that was then entered into CMT for all CCCs and providers to follow regardless of where the patient should present. The plan is for the wraparound meetings to occur monthly and for other providers and social service agencies (i.e. housing, transportation, etc.) to be invited to attend where high-utilizer patient cases are reviewed to discuss needs/barriers/solutions.
- CHSN participates regularly in local and statewide events such as the Annual Summit on Substance Misuse, Suicide and Behavioral Health sponsored by the Partnership for Public Health and the Annual Prevention Summit sponsored by the Central NH Public Health Network. We financially support and attend the NH Behavioral Health Summit and various other statewide offerings on related integration topics (i.e. Value Based Payment symposium offered by UNH/CHI).

- Ongoing collaboration occurs with the Continuum of Care Coordinators in each Public Health Network (PHN) region to ensure current knowledge of projects and continued stakeholder engagement.
- CHSN’s Executive Director is actively involved with the Winnepesaukee Public Health Network. She and CHSN’s Data Analyst serve as the team lead for the WPHC’s Community Health Improvement Plan (CHIP) overseeing Priority Area 2 - *Improve Access to Behavioral Health Services*. To accomplish this, the focus is on two objectives: 1) to increase the ratio of behavioral health care providers per resident population by 10% by 2020 and 2) to decrease the rate of emergency department visits for mental health conditions by 10% by 2020. Periodic presentations and discussions with the Public Health Advisory Councils for this region occur and attendance at monthly meetings is ongoing.
- CHSN’s Data Analyst was a key player working with the Winnepesaukee Public Health Network’s community needs assessment that was conducted in early 2019. It consisted of a survey that was distributed online through local Facebook groups as well as in-person at community health events and CHSN-IDN5 partners’ waiting rooms. The results of the community needs assessment spoke to the visibility of substance use issues and mental health issues within the community as well as a lack of primary care, dental care, and public transportation within the region. The results were similar to previous community needs assessments performed within the region. The results of the community needs assessment will inform the next draft of the Community Health Improvement Plan (CHIP) for the Winnepesaukee public health region.
- Facilitated discussions are held and/or surveys are collected from clients of peer support and recovery service organizations via the Executive Director serving on the Navigating Recovery of the Lakes Region’s Advisory Council.
- CHSN maintains its practice of inviting community members ‘at-large’ to participate in CHSN network meetings and workgroups that will continue to guide implementation and evaluation of the initiative. Most recently, and an outcome of the May strategic planning meeting, the Board voted to invite a representative from each County Commission to attend our board meetings on a regular basis to encourage participation and more regular information sharing. This new practice will begin in August/September 2019.
- CHSN is actively involved with LRGHealthcare as it serves as one of the nine HUBs for the Statewide Opioid Response (SOR) Grant. CHSN is invited to regional SOR meetings to remain in the loop regarding activities, impacts their efforts may have on DSRIP related projects/activities, and opportunities for collaboration.

Implementation Activity/ Milestone: Community Input	Responsible Party/ Organization	Time line	Progress Measure / Notes
Conduct outreach to organizations involved in providing supportive housing	CHSN Executive Director	Ongoing	Milestone Met; Ongoing; CHSN-IDN5 continues to work with supportive housing agencies to collaborate on meeting regional needs for homelessness, transitional and sober housing. Multiple meetings have been held between CHSN, Horizons

Implementation Activity/ Milestone: Community Input	Responsible Party/ Organization	Time line	Progress Measure / Notes
			Counseling Center, LRMHC and the Lakes Region Community Developers regarding sober housing opportunities in the region. We have supported Lakes Region Community Developers as they submit for a grant to bring housing options to Laconia. Other supporting agencies include: Laconia Housing Authority, Laconia Salvation Army's Carey House, Belknap House in Laconia and CAP Belknap-Merrimack Counties. These agencies are invited to CHSN network meetings to maintain an open line of communication and information sharing on projects and progress to date.
Develop client satisfaction/program evaluation tools to capture feedback from clients of each of the community-based projects.	Project Team Leads	Drafted tools were completed in Q2 2018 in preparation for use. Further refinement of forms occurred and implementation began within community projects in Q4 2018.	Milestone Met; program evaluation tool was completed in 2018. The C2, D3 and E5 workgroups all began developing workflows for when/how to introduce the tool to clients. By Q4 2018 very few clients had completed services with any of the projects so there are very few completed but is being initiated upon initial connection and at certain intervals along the way (depending on the project) and again when closing the loop on a client's services.
Participation in and guest speaker at the Annual Summit on Substance Misuse, Suicide and Behavioral Health sponsored by the Partners in Community Wellness (PicWell) team	CHSN Executive Director; Partnership for Public Health; PicWell team	Nov. 8, 2018	Milestone Met
Participation in stakeholder meetings convened by Continuum of Care Coordinators	SUD Expansion Team Lead; CoCs	Ongoing	Milestone Met; Ongoing; CHSN Executive Director and the CoC are co-located and meet every other month to share information as it pertains to each other's work. A new CoC was funded in July 2018 and the ED reached out to this individual to ensure these critical information sharing meetings continued on the same schedule.

Implementation Activity/ Milestone: Community Input	Responsible Party/ Organization	Time line	Progress Measure / Notes
Presentation, discussion and attendance at or with Public Health Advisory Councils	CHSN Executive Director	Ongoing; Participation in Winnepesaukee Public Health Council meetings are routine; attendance at the Central Public Health Council is more intermittent or as requested.	Milestone Met; Ongoing; CHSN's Executive Director is very active with the Winnepesaukee PHC. She provides an IDN update monthly for the Winnepesaukee Public Health Council written report and serves as the team lead for the Community Health Improvement Plan (CHIP) evaluation workgroup as it pertains to Priority Area 2: Improve Access to BH Care Services. Through this involvement, the CHSN ED served on several CHIP related focus groups in Q1 2018; presented on the DSRIP waiver and CHSN-IDN5 to the Partnership for Public Health's Board in April, participated in a day-long strategic planning session for the Partnership for Public Health in June and presenting on mid-point evaluation findings for CHIP priority area 2 on Dec. 5 <sup>th</sup> .
Work with peer support and recovery service organizations to develop plans and methods for periodic group discussions with clients for ongoing assessment of needs, gaps, successes	CHSN Executive Director	Mechanism for assessment developed by Q2 2018	Milestone Met; Ongoing; Navigating Recovery of the Lakes Region has established an Advisory Committee of clients and community members that meet to evaluate and make recommendations to programming. CHSN ED serves on the Advisory Committee which is utilized as a mechanism for assessing CHSN-IDN5 clients' needs, gaps and successes. The Advisory Committee was formed in Q2 2018 and the first meeting was held July 23, 2018. Meetings occur monthly.
Maintain practice of 'at large community member' participation in CHSN governance and workgroups. Seek to increase/add number of community members	CHSN Board	Ongoing	Milestone Met; Ongoing; community member representatives participate in CHSN network meetings, B1 meetings and receive all CHSN communications. The Board has not added any new community board members, but continuously seeks input from those currently serving as CHSN community member

Implementation Activity/ Milestone: Community Input	Responsible Party/ Organization	Time line	Progress Measure / Notes
			representatives and is always seeking and open to community input in general.
Ongoing project communications with key stakeholders	CHSN Board members and CHSN Executive Director	Ongoing	Milestone Met; Ongoing; CHSN is always seeking opportunities to speak and inform key constituents of the DSRIP waiver work and its regional impacts. Attendance occurs by Board members and the CHSN ED at the LRGH Community Access meetings; SOR Hub & Spoke meetings/forums; Public Health Council Meetings; regional forums; local trainings and seminars, DSRIP 101: Lunch & Learns, and other engagements as they arise to ensure information sharing and exposure with key regional stakeholders. As previously addressed, this includes ongoing communication with supportive housing agencies.

**PPI-2: Network Development**

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

- There have been no CHSN-IDN5 partners off-boarded or new partners on-boarded during the reporting period of January 1 – June 30, 2019.
- CHSN’s Administrative Lead, the Partnership for Public Health and CHSN’s Board Chair and Executive Director remain in close contact to discuss important IDN matters as they arise. A close relationship exists between the PPH Financial Director and CHSN Executive Director to ensure accurate reporting of funding is available in a timely fashion. CHSN Executive Director serves on the PPH Management team and is involved with regular business and staff meetings allowing for a very transparent relationship which allows for frequent information sharing.
- To address insufficient workforce capacity and related training/education access and availability, CHSN has been engaged in numerous regional and statewide efforts which are explained in greater detail in the A1 – Workforce Development section. CHSN is fortunate to have a strong presence on the Statewide BH Workforce Taskforce. The CHSN Executive Director sits on the Statewide Training & Education subcommittee; and the CHSN Board Chair chairs the Statewide Policy subcommittee. Both individuals are involved and engaged in this work and helping connect statewide efforts to address regional needs wherever possible.

- CHSN has a continued commitment with the New Hampshire Alcohol & Drug Abuse Counselors Association (NHADACA) to address CHSN’s training/education needs. The original CHSN and NHADACA training contract ended December 31, 2018, however with remaining monies left unspent from the original contract CHSN-IDN5 partners can still request trainings be paid for by the IDN. Requests are not handled on an as requested basis through the CHSN Executive Director. Partners are being encouraged to reach out when there is a training opportunity they or their staff would benefit from to improve their workforce and overall integration knowledge. The CHSN Board has supported training as a meaningful investment into our region. CHSN’s training contract with NHADACA successfully trained 712 individuals since inception in April 2018, and 159 within this reporting period.
- The CHSN Executive Director participated in a meeting called together by [REDACTED] from the Dupont Group with representatives from each of the NH County Commissions and the seven IDN Leads on June 13<sup>th</sup> to discuss how to support and identify the process for statewide county funding of the DSRIP waiver. This was the first meeting of their “County funding sub-committee” and the IDNs. Because each county is different in size and their ProShare dollars vary based on county nursing home revenues, Commissioner Meyers tasked the counties to come up with their own methodology for reaching the necessary combined \$10 million (which when matched becomes \$20M) to fund the DSRIP waiver. Last year, the dollar amount that each County was to contribute was derived by a calculation that DHHS provided to the Counties and it received significant pushback. The Counties have been tasked with determining what they consider to be a “fair” contribution for each County in order to support the waiver.
- The CHSN Executive Director and CHSN Board Chair along with representatives from the six other IDNs have participated in two meetings coordinated by DHHS which included the MCOs to discuss the local care management entity (LCME) requirement within their new contracts. Additionally, the IDN Leads hosted an “All MCO” meeting on June 21<sup>st</sup> in Manchester where Amerihealth Caritas, NH Healthy Families and WellSense all presented for 1.5 hours each to the IDN Leads. The purpose of the meeting was surrounding the LCME requirement and criteria and their vision for how the IDNs may best serve them in this capacity. The IDNs discussed what may need to occur in order for an IDN to operationally provide value by being in the mix. Additional discussions will take place over the summer, in particular with DHHS, as to the design and criteria for an LCME and the role that an IDN may play.
- In compliance with the Standard Terms and Conditions, DHHS was tasked with completing a Midpoint Assessment of the IDNs and their partners via an outside evaluator who reports directly to CMS to summarize the impacts/outcomes/etc. of the waiver to date. The Muskie School was selected as the vendor and an initial evaluation of the HIT projects was performed. CHSN-IDN5’s letter from the evaluators stated we were performing well and have done a good job at engaging our partners and stakeholders and encouraged our IDN to continue learning what APM models are being utilized and are effective. All other HIT efforts to date were on track or have already been attained.
- One of CHSN’s self-imposed evaluation metrics was to perform a “partner satisfaction survey” to determine satisfaction with the operations of the CHSN board and staff and to identify what our partners see as the benefits of partnership with the IDN. This survey was distributed via Survey

Monkey in June 2019 and 23 responses were received out of 31 recipients. Some of the actionable items or suggestions will be passed along to the strategic planning subcommittees that are forming for consideration and possible action. The survey also asked the question surrounding how our partners are utilizing their Employee Retention Incentive Program funds (ERIP) to strengthen their workforce retention and recruitment efforts and needs. The data collected surrounding the use of ERIP funds is addressed more comprehensively in the workforce Section A1. The overall satisfaction responses are summarized in the table below.

<b>CHSN Partner Satisfaction Survey</b>	<b>Extremely Dissatisfied</b>	<b>Somewhat Dissatisfied</b>	<b>Neutral</b>	<b>Somewhat Satisfied</b>	<b>Extremely Satisfied</b>
General Operations of the CHSN Board				13.04%	73.91%
General Operations of the CHSN Staff				13.04%	78.26%
Clear & Effective Communication from the staff				4.35%	82.61%
Responsiveness of the staff				13.04%	86.96%
Professionalism of the staff				8.70%	91.30%
<b>OVERALL satisfaction with the operations of CHSN-IDN5</b>			9.09%	13.64%	<b>77.27%</b>
IDN benefits they have utilized/taken advantage of as a partner of IDN5				<i>Education &amp; Training Opportunities</i>	69.57%
				<i>Financial Support</i>	52.17%
				<i>Data Analytics and support</i>	30.43%
				<i>Other</i>	13.04%
				<i>SLRP match for staff</i>	8.70%
<b>OVERALL satisfaction with being a CHSN-IDN5 partner</b>		4.55%	4.55%	18.18%	<b>72.73%</b>

<b>Implementation Activity/ Milestone: Network Development</b>	<b>Responsible Party/ Organization</b>	<b>Time line</b>	<b>Progress Measure / Notes</b>
Implement workforce development and training Plan (also see A1 - workforce section)	CHSN Executive Director, CHSN Board Chair and CHSN members	CHSN Training Plan complete; Workforce development and hiring for project staff primarily complete; participation of	Milestone Met; a training contract with NHADACA began mid-April and ended Dec. 31, 2018 to address identified DSRIP BH training/education needs. 712 individuals were trained

Implementation Activity/ Milestone: Network Development	Responsible Party/ Organization	Time line	Progress Measure / Notes
		CHSN staff in Statewide WFTF (Education & Training Subcommittee and Policy Subcommittee) is ongoing.	from all training sources year-to-date.
Development of a Network Partner Employee Retention Incentive Plan (ERIP)	CHSN Executive Director	ERIP Plan development complete. Rollout of tiered incentive plan and criteria made to network partners in Sept. 2017. Tracking of criteria began January 1, 2018.	Because CHSN received its full incentive payment for the SAR ending December 2017 the first payout of ERIP funds was issued in August 2018 to partners who met established criteria. A second payout is scheduled for February 2019 for the SAR ending July 2018 and CHSN receiving its full incentive. Funds can be utilized as agencies deem appropriate as long as for purposes of employee recruitment, retention and satisfaction.
Implement plan for HIT improvements to support integration	HIT Leadership Team, all CHSN Members	Contracts are now signed by all partners who are providing data for DSRIP projects.	Milestone met; all CHSN partners who need to be providing data have signed contracts with CMT (for shared care plan and event notification) and with MAeHC.
Implement plan for advancing practices and the overall network along a continuum of integrated health care delivery	Integrated Health Leadership team, all CHSN members	UNH/CHI completed their follow up round 2 SSA survey in November 2018.	Milestone met; Ongoing; CHI follow-up round 2 SSA was completed in November 2019 and results are available to CHSN staff but due to holiday schedules will not be rolled out to partners until the B1-Integrated Health meeting scheduled for Jan. 17, 2019. There was 100% participation in the SSA by CHSN's B1 partners.
Implement plans for community projects that will develop capability for improved communication and coordination of patient care across the network	Community Project Leadership Teams, all CHSN members	Ongoing	In process; Ongoing; County corrections, recovery organizations, family resource centers, transportation agencies and supportive housing, etc. are at the table for our community project workgroups to support

Implementation Activity/ Milestone: Network Development	Responsible Party/ Organization	Time line	Progress Measure / Notes
			effective transitions of care and community re-entry.
Continue to review network composition and adequacy for gaps and opportunities for member development	CHSN Board	Ongoing	A governance subcommittee reviewed and recommended no changes to the CHSN Operating Agreement in April 2018 in regards to affiliate and member status. The board composition was deemed adequately represented by area agencies for the DSRIP projects and no changes were recommended within CHSN governance documents. In September, upon learning of HOPE for NH Recovery's closing (a small recovery support affiliate partner) the CHSN board has discussed onboarding the Greater Tilton Resource Center as a new affiliate to fill this gap in services.

**PPI-3: Addressing the Opioid Crisis**

One of the primary forces that propelled the development of the Community Health Services Network in 2015 was the need for a coordinated response to the alarming rise in substance misuse and overdose in the region. Our project design includes two strategic pathways intended in part to increase the region's capacity to address the opioid crisis and the growing number of individuals whose need for substance use disorder (SUD) treatment was not being met, in a meaningfully timely manner. The D3 project, geared to expand intensive outpatient treatment programs in the greater Laconia region and introduce brand new services in the Plymouth region, has doubled the capacity for IOP level of care in the Laconia region. It has also begun to incorporate recovery coaches as part of the treatment team. This community project is closely linked with the C2 community Re-Entry project of justice involved youth and adults with substance use disorders. Each of these channels serves to further link activities to enhance care coordination and recovery supports to assure effective transitions among services and levels of care, to institute relapse prevention strategies and to re-engage patients in the case a relapse does occur. Additionally, CHSN partners continue to work to expand Medication Assisted Treatment (MAT) in the region, most notably through the two federally qualified health centers and the LRGH Recovery Clinic. Discussions continue between the C2 and D3 project team leader and the Belknap County Corrections medical providers and administration to introduce MAT services in the Department of Corrections.

Horizons Counseling Center has been working with the LRGH Recovery Clinic since the beginning of CHSN project implementation to expedite the admission of individuals in the D3 and C2 projects into integrated MAT medical and SUD treatment services through the LRGH Recovery Clinic and Horizons' outpatient services. Integrated care between these two systems includes joint care management with regular weekly contact about the participation, compliance and progress of each individual receiving services through

both programs to ensure a consistent and coordinated approach to each client. Discussions with Belknap County DOC medical providers and administration to begin offering MAT as part of comprehensive medical and behavioral health services have progressed significantly. The C2 and D3 Project Lead has worked with DOC personnel to develop protocols for evaluation of inmates testing positive for opioids upon admission into the facility or reporting a history of opioid misuse, confirming a diagnosis of opioid use disorder and determining appropriateness for MAT based on ASAM criteria; for educating those inmates to the benefits of MAT for successful use of treatment and recovery services and long-term recovery, and to the types of MAT available to them based on individualized needs and availability within their home communities. While the protocols have not yet been approved by the county administration, the medical providers have agreed to complete the buprenorphine waiver training to be prepared to induct buprenorphine for inmates who choose this option prior to their release from confinement either on electronic monitoring, on probation or without ongoing supervision. A C2 Care Coordinator would ensure that the offender is set up with Medicaid, a MAT prescriber and an appointment for SUD treatment in their local area, whether within IDN 5 or another IDN serving their receiving communities. The C2 Project Lead has also met with the Alkermes Representative to begin to arrange for Vivitrol doses to be provided to the Belknap County DOC at no cost to the County in order to afford the DOC with the ability to start inmates who choose opioid antagonist therapy on Vivitrol before they are released from confinement when Medicaid is not yet a payment resource and giving care coordination staff a window to arrange for medical follow up for on-going Vivitrol administration and management. This will become available once MAT protocols are approved and the program implemented. Expedited access to MAT strategies are under discussion with the LRGH Recovery Clinic and HealthFirst in order to make follow-up realistic for all offenders who need it once they are released back into their communities. It is significant to note that HealthFirst Family Care Center has successfully waived four providers and has begun providing integrated MAT in-house. HealthFirst has also begun to coordinate services with Horizons Counseling Center to open the IOP level of care for their MAT recipients who need more intensive treatment than the FQHC can provide using its own behavioral health staff. In addition, HealthFirst has opened its Suboxone and Vivitrol prescribing resources to Horizons' clients to expand access to those medications without requiring that clients change treatment providers in order to expedite MAT availability. CHSN continues to explore how to encourage new prescribers by offering the support of expanded SUD treatment services as we continue to utilize all resources available to connect incarcerated individuals with the supports and resources needed to keep them stable and focused on recovery activities once they are back in their communities.

Horizons Counseling Center has also developed a cognitive behavioral and psycho-educational treatment group for individuals involved in MAT through the LRGH Recovery clinic and other local prescribers. The group utilizes both clinicians and recovery support workers to capitalize on the impact of both treatment and recovery support approaches to individuals with opioid use disorder. Treatment providers and care management staff at Horizons and at the LRGH Recovery Clinic review each participant weekly and target group activities and educational presentations to the individualized needs of the participants as identified through this joint communication. Finally, Horizons continues to prioritize opioid users, IV drug users and individuals who have been hospitalized or treated by first responders for overdose. IV drug users are seen within two business days of referral and integrated into the identified level of care or maintained with interim services until that level of care becomes available. In addition, Horizons and LRGHealthcare have developed protocols to ensure that, where appropriate, clients can be "fast tracked" to a MAT prescriber even before their full integration into counseling/treatment services. LRGHealthcare has begun to induct patients who present to the ED at LRGH due to an overdose or in withdrawal from opioids with Suboxone in the ED, setting them up with a follow-up appointment with the Recovery Clinic the next business day and then connecting them with a SUD treatment provider of their choice within the next week. Horizons continues to maintain these patients in interim services to support on-going engagement in treatment and "fast tracks" these clients into the ASAM level of care appropriate for their assessed clinical needs.

LRGH has been identified by DHHS as one of the “hubs” established by the State Opioid Response (SOR) grant. LRGH is building on the partnerships and resources of CHSN to support the services of the “Doorway”. It is partnering with Navigating Recovery to utilize CRSWs to be the initial point of contact for individuals and families seeking help and directions from the Doorway and with Horizons to provide assessment and treatment recommendations to those seeking help. In this way, the goals of the SOR are being met through immediate access to assessment and referral without competing with local treatment and recovery support organizations for staff at a time where workforce is already limited. Both Horizons and Navigating Recovery have made a commitment to serving as representatives of the Doorway at Lakes Region General Hospital and honoring client choice in making referrals to ongoing care. This partnership is evidence of the strength of the inter-organizational relationships that have developed among IDN partners in this community over time.

Finally, Horizons Counseling Center, Navigating Recovery and Lakes Region Community Developers have partnered in applying for NH Housing Finance Authority funding to provide transitional housing for women completing residential treatment, with a focus on women completing treatment during incarceration, ensuring that women receiving MAT and women with co-occurring disorders are welcome and accommodated.

<b>Implementation Activity/ Milestone: Addressing the Opioid Crisis</b>	<b>Responsible Party/ Organization</b>	<b>Time line</b>	<b>Progress Measure / Notes</b>
Implement community projects that address the opioid epidemic	SUD Expansion and Community Re-entry Project Leadership Teams, all CHSN members	Ongoing	Milestone Met; Ongoing; C2 and D3 projects address these needs extensively within their plans.
Maintain referral and practice support relationships with MAT providers	CHSN members	Ongoing	Milestone Met; Ongoing; Key MAT providers are part of the CHSN Board and various projects. There are strong working relationships in place and MAT services are growing within the region as described in narrative above. Discussions continue with Belknap County Corrections to pursue offering MAT services in the jail continue.
Partner with emergency response community on awareness and education efforts and naloxone distribution	CHSN and community members	Ongoing	Milestone Met; Ongoing; strong working relationships had been established with regional Continuum of Care and the Partners in Community Wellness (PicWell) team and with regional policy and fire department leadership. Ongoing communication and awareness of projects help ensure awareness of each other’s efforts and activities surrounding substance misuse and the opioid crisis. Naloxone distribution is communicated and coordinated

Implementation Activity/ Milestone: Addressing the Opioid Crisis	Responsible Party/ Organization	Time line	Progress Measure / Notes
			between the public health networks, fire departments and now with the new LRGH “Hub” as well to ensure effective distribution channels exist in the region.
Continue to review network composition and adequacy for gaps and opportunities for member development related to the opioid epidemic	CHSN Board	Ongoing	Milestone met, Ongoing; A CHSN governance subcommittee was formed to establish criteria for the process of identifying gaps in network composition and developing a process for adding new members and/or changing a CHSN partner membership type. It was determined that the CHSN board composition was adequately served by appropriate constituents. Since the departure of a small recovery support affiliate partner, HOPE for NH Recovery, the CHSN board has discussed onboarding the Greater Tilton Resource Center as a new affiliate to fill this gap in services.

**PPI-4: Governance**

Community Health Services Network (CHSN) established as a Limited Liability Company to provide for a delegated model of governance. Each member organization designates an individual who serves as a Manager of the company. Meetings of the Managers are held no less than ten times per year at a date and time agreed upon by 2/3 of the Managers. Each Manager has a named Alternate Manager which is on file with CHSN, who may also attend meetings and vote in the Manager’s absence. An important principle of the organization is that each Manager has one vote with respect to all matters requiring the action of the Board regardless of organization size or level of investment. Each appointed Manager will hold office until his or her successor is duly appointed by the appointing Member and qualified, or until his or her earlier resignation, removal or death.

CHSN welcomes and will consider adding additional key stakeholders if/when they or their field of expertise is identified as needed within a specific project or the IDNs overall goals. In 2018, a CHSN governance subcommittee reviewed and presented to the board that the existing board composition adequately represents all constituents currently needed for and related to the work being performed within the DSRIP waiver projects.

The CHSN Board of Managers remain the same as previously reported with fifteen member agencies. The executive officers of CHSN shifted slightly in this reporting period due to a vote at its annual meeting held May 31, 2019 where the officers holding the Secretary and Treasurer seats switched due to the future retirement of [REDACTED] who has served as Treasurer up until this time and knowing it may be less

difficult recruiting for a Secretary to serve in that role upon his departure. The CHSN Slate of Officers now include [REDACTED], Chair (LRMHC), [REDACTED], Vice Chair (Horizons), [REDACTED], Secretary (HealthFirst), and [REDACTED], Treasurer (Lakes Region Community Services).

An annual meeting of the Members is held annually at a date agreed upon by the Members. The annual meeting was recently held on May 31, 2019 at which time the Members appoint the Managers, Executive Officers, review and approve the annual operating budgets, review the strategic plans of the Company and any other matters as are typically addressed at an annual meeting.

CHSN held its first strategic planning meeting on May 31<sup>st</sup> facilitated by [REDACTED]. The focus was to discuss CHSNs future priorities surrounding sustainability strategies beyond the waiver end date in 2020 and how to work more closely with the counties to ensure continued funding. The meeting was very well attended (13 of the 15 member agencies were present) and two County Commissioners were also in attendance [REDACTED] from Grafton County and [REDACTED] with Belknap County). All three of IDN 5's respective County Commissioners and their Administrators were invited to join us for the morning portion of the meeting to hear how we could best meet their needs and to ensure stronger communication between all. Participation was very productive and the outcome was a draft Strategic Plan which identified five priority areas/strategic themes to assist CHSN in becoming sustainable. Each area will now form a sub-committee to begin working on the action items that were identified in order to help us be successful and ideally sustainable. Requests for participation on subcommittees has been sent out to CHSN board members and committees will likely begin convening later this summer to begin the real work required to strengthen these areas. The strategic intentions were identified as being:

1. We will advance the mission of CHSN;
2. We will refine the structure of CHSN as needed to support its strategic plan;
3. We will strengthen and expand our partnerships;
4. We will improve access to integrated, comprehensive, holistic healthcare to all demographics within our communities;
5. We will be financially sustainable.

<b>Implementation Activity/ Milestone: Governance</b>	<b>Responsible Party/ Organization</b>	<b>Time line</b>	<b>Progress Measure / Notes</b>
Convene monthly board meetings	CHSN Chair and Executive Director	Monthly, Ongoing	Milestone met; Ongoing record of meetings minutes, % attendance is monitored
Establish and support committees as needed to guide implementation of Network plans and activities	CHSN Board	Ongoing, review committee structure as needed	Milestone met; Committees formed in all essential and required areas of IDN operations and subcommittees are formed on an as-needed basis
Review implementation progress and outcomes; take corrective actions as needed	CHSN board and membership	Ongoing	Ongoing; Measures and data collection procedures reviewed by respective committees; meeting minutes are shared and discussed at Board meetings by respective Project Leads

Implementation Activity/ Milestone: Governance	Responsible Party/ Organization	Time line	Progress Measure / Notes
Assess member/partner satisfaction with CHSN operations and benefits of participation	CHSN Executive Director and reviewed by Executive Committee	Annually beginning Q1/Q2 2019	In Process; CHSN combined its member/partner satisfaction survey with its annual follow-up request to partners as to how they are spending their Employee Retention Incentive Program payments. The first ERIP checks were cut in August 2018 and the 2 <sup>nd</sup> checks were issued February 2019. CHSN staff is planning to survey partners simultaneously regarding their satisfaction with CHSN operations and the benefits of participation as well as how their ERIP payments have assisted their agency with workforce recruitment and retention.

**PPI-5: Budget**

The total projected budget available to perform the work of all projects is \$ [REDACTED]. A budget of \$ [REDACTED] is allocated for Administrative expenses to perform the work, which leaves \$ [REDACTED] in available funds to perform all related project work. Shown below you will see the identified expenses as well as actual expenditures to date for major activities in all projects totaling \$ [REDACTED]. CHSN-IDN5 set aside a 10% reserve (of the available funds) to secure for potential DHHS matching fund uncertainties and a small reserve for CHSN-IDN5 achievement of performance metrics for a total of \$ [REDACTED]. In **Attachment\_A1.6A** you will find CHSN-IDN5’s complete budget representing each project and its respective projected expenditures throughout the waiver.

CHSN-IDN 5: Total Budget & Actual - Projected									
July 1, 2016 - June 30, 2022									
Line Item	Total Program Cost								
	CY 2016 Actuals	CY 2017 Actuals	CY 2018 January to June Actuals	CY 2018 July to December Actuals	CY 2019 January to June Actuals	CY 2019 July to December Projected	CY 2020 Projected	CY 2021 Projected	Total
<b>PPI</b>									
- Administrative lead									
-Project lead expenses									
-Partner discretionary or other grants									
-Community input									
<b>Total PPI</b>									
A1									
A2									
B1									
C2									
D3									
E5									
<b>Total DSRIP Projected Expenditures</b>									
10% Reserve for Matching Fund and Performance Metrics Uncertainty									

### DSRIP IDN Process Milestones

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

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

## Project A1: Behavioral Health Workforce Capacity Development

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

CHSN's training contract with NHADACA successfully trained 712 individuals since inception in April 2018, and 159 within this reporting period on important, meaningful, DSRIP related behavioral health topics. Offering these trainings free of charge to partners and their staff has significantly impacted staff satisfaction and a practice's ability to grow an employee and/or assist individuals with the skills needed to be fully competent and educated within their BH roles. CHSN Partners have expressed to the Board that the free and abundant trainings were received and relayed as a true "employee benefit" which saved them thousands of dollars and assisted them in not just retaining their staff but growing their staff which results in overall employee satisfaction and increased competence within our region. CHSN continues to work closely with NHADACA to offer trainings as needed for partners to be successful and knowledgeable in their fields and have continued to financially support trainings on an as requested basis. This is available due to unspent dollars from within the original NHADACA contract and will continue until the funds are completely drawn down. We regularly share with our regional partners any announcements of trainings being offered in the region. CHSN remains open to collaborating with IDNs and organizations to offer trainings and share in expenses for a trainer/speaker, meeting facilities and food expenses as well as covering the cost of providing CEUs. Examples of such collaborations include the Co-Occurring Medical Conditions for Medical and Behavioral Health Providers training, the BDAS Initial Training on Addiction and Recovery and hosting the "IDN Track" at the annual NH Behavioral Health Summit and more. We also provided funding assistance for development and printing of the Northern AHEC Health career catalogs.

To address the STC requirement that all MDCT members shall be trained in hypertension, diabetes and hyperlipidemia **CHSN has** provided links to the various trainings which were pre-recorded by Network 4 Health and Antioch College lunch and learn series. Although many partners stated that they liked having the webinar option available so they could participate at their convenience, finding a mechanism to track their compliance became extremely time consuming and challenging. In an effort to close the gap for complying with this requirement, a training attestation form was developed in which each B1 partner/practice **was asked to** complete stating that their **prescribing providers on their** multi-disciplinary care teams have complied with the requirement to receive training in hypertension, diabetes and hyperlipidemia. An authorized signature from each of the identified agencies ((Mid-State, HealthFirst (Franklin & Laconia sites), LRMHC, Riverbend and Horizons Counseling) **is now on file with CHSN-IDN5 and** serves as proof that their identified MDCT members have met this training requirement. More information on the MDCT training requirement is addressed in B1-8C.

Additional workforce activities include CHSN's involvement with the Statewide Workforce Taskforce (WFTF) and its subcommittees. IDN 5 has representation in the Statewide WFTF by both the CHSN Executive Director and Chair of the CHSN Board. The Executive Director serves on the statewide Training and Education subcommittee and CHSN Chair serves as the Chair of the statewide Policy subcommittee. Each of the subcommittees continue to make great strides and progress during this reporting period. The Training and Education subcommittee meets monthly and utilized the WFTF statewide plan to develop its own strategic plan and to prioritize the work of the subcommittee. This allows for the goals of the Training and Education subcommittee to be compared to other WFTF subcommittees to identify synergies and reduce duplication of efforts. On a monthly basis, the CHSN Board is provided updates of statewide and regional activities at its regular monthly board meeting through a verbal or written report provided by the Chair. A1 workforce updates are part of the Board and B1-Integrated Healthcare agendas, along with sharing any Statewide WFTF minutes, to help keep partners informed of regional and statewide workforce activities and potential legislation, etc. Particular updates surrounding statewide WFTF activities are highlighted in the bullet below.

- Educating and training, including gaps in educational preparation of behavioral health providers' workforce readiness. **Progress made:** To reach students prior to graduation, we have relied on and partnered with the statewide efforts to address this current gap as it not a stand-alone IDN problem. The statewide WFTF approach will assist NH in reaching both high school and college level students prior to graduation. We anticipate efforts would not just assist with and encourage their interest in, but also help best preparing them for a future in the field of behavioral health.
  - Efforts on the statewide level this reporting period surrounded a meeting with WorkReadyNH. WorkReadyNH features 60-hour work readiness classroom curriculum and online tutorials, and is available at all community colleges and the program is free. Employers can also refer people to WorkReadyNH directly. Participants obtain a NH certification and national certification. Opportunities lie for the recovery and peer support community to find appropriate people to use WordReadyNH as well as many peers who have been out of the workforce for a while. There has been interest in creating a curriculum especially for peers, which would serve as a good retention tool. IDNs support getting the word out as many providers don't think of using WorkReadyNH for peers.
  - The Retention and Sustainability Subcommittee has seen movement towards value-based payments by reviewing billing codes that may be switched on for Medicaid that reflect the work IDNs are doing in B1 and local projects. The subcommittee has researched billing codes and identified that some codes may not be worth the effort due to low payments; however, if IDNs don't use them, the codes will never be switched on. A group of 12 has been meeting with the state led by [REDACTED]. They have completed the codes for integration, primary care, BH intervention, and two additional categories. Following this, a plan will be presented to the state with justification to turn on certain codes, including an estimate of the fiscal impact on Medicaid. The subcommittee will look to the workforce taskforce to advocate for additional revenue. This subcommittee is also working on various models of telehealth.
  - The Education and Training Subcommittee has made efforts to build workforce including scholarship and management programs. IDN4 has taken the lead in offering to make introductions for other IDNs. The Health Careers Catalogs that have been financially supported by all seven IDNs was delayed but the plans are to print this summer. IDN

discussions on creating a centralized training calendar have taken place. IDN7 will develop a webpage for this purpose with links to existing sites so that there is one centralized location for all training resources. Conversations are already under way as to whether to have a separate IDN track at the BH Summit in 2019.

- The Recruitment and Hiring Subcommittee has identified licensing opportunities and opportunities for trailing partners. They are planning to perform a survey about recruitment, and what IDNs are doing.
  - The Policy Subcommittee has been very busy this last reporting period in particular their work has been surrounding the Board of Mental Health Practice which is especially challenging for applicants who have licenses from other states. There has been discussion of legislation (SB 80) that would grant an interim license if license was not granted in 60 days. Updated legislation put interim licensing back in, as well as the 60-day timeframe. The subcommittee is also tracking SB 308. SLRP, the Medicaid rate increase and electronic background checks are the top priorities which all paid off – although a 5-7% per year Medicaid rate increase was requested, 3.1% per year for 2 years was received. Student Loan Repayment Program (SLRP) was appropriated \$████ million per year for 2 years. Also, \$████ per year for 2 years shall be expended by clinicians solely to deliver mental health and substance use disorder treatment services in Carroll, Cheshire, and Coos counties. Electronic background checks were also approved and will make the process easier.
- Recruitment of new providers and staff. **Progress Made:** The community projects projected a total of 26.2 FTEs to operationalize the three projects. To date all projects are fully staffed with the exception of 1 FTE for the D3 project MLADC to run the Plymouth IOP. Currently, there are 7.5 FTEs hired or assigned to the C2 project of the projected 7.5; 8.2 FTEs hired or assigned to serve on the D3 project of the projected 9.2; and a total of 9.4 FTEs hired out of 9.4 for the E5 project. To date, 96% of all positions have been filled for our community driven projects. Please see section A1-5 for extensive recruitment efforts surrounding the 1 MLADC position.
  - Retention of existing staff, including the IDN’s targeted retention rates. **Progress Made:** CHSN’s current retention rate is 100% with a current vacancy rate of 2.6%. CHSN-IDN5 has offered all partners incentives through an Employee Retention Incentive Plan (ERIP), which is explained in detail in section PPI-2, since January 2018. Network partners have now received two ERIP payments of either \$████/ \$████/ \$████ depending on their identified “tier” which is based on agency type and level of IDN involvement. The incentive payments are designed to be paid out to partners every six months beginning January 2018 and ending December 2020. Payouts to partners will be alignment with when an IDN learns if it received its DSRIP incentive payment based on semi-annual reporting performance. This enticement was set up to keep partners engaged in our work by being accountable, producing data when needed, as well as being responsive to CHSN requests and being present at meetings. The objective is to assist partners by putting dollars back in their pockets to utilize for their unique specific retention and recruitment efforts, loan repayment, merit increases, assistance with tuition, etc. CHSN tracks agencies’ performance based on the established criteria and if criteria is met, an ERIP payment is made. The first payment was received in August 2018, the second payment was made in February 2019. A CHSN partner satisfaction survey was performed in June 2019 which asked how our partners have utilized their ERIP funds to assist in their recruitment, retention and employee satisfaction and

the responses received were extremely positive and unique based on the agency size and type. The sample responses below were received via the survey and reflect how our partners have been utilizing their ERIP funds to date.

**EMPLOYEE RETENTION INCENTIVE PROGRAM FUND USE BY CHSN-IDN5 PARTNERS**

<ul style="list-style-type: none"> <li>• Underwrite multiple advertising campaigns, including new mediums previously unaffordable such as billboard and movie theater advertising.</li> <li>• Create a recruitment video to be used in ads as well as on social media.</li> <li>• Provided managers with Visa Gift Cards to use for immediate gratification type thank you's when staff picked up extra shifts.</li> <li>• Set aside funds for both education and stress relief programs for front line staff retreat, the first we will have had in almost 10 years!</li> </ul>
<ul style="list-style-type: none"> <li>• Support our ongoing involvement and the numerous unfunded positions within the organization focused on population health, collaboration, and community well-being</li> </ul>
<ul style="list-style-type: none"> <li>• Hosted a Christmas luncheon for staff</li> <li>• Each staff member received a [REDACTED] gift card as a holiday bonus</li> <li>• Provided a raise for data coordinator/admin. assistant</li> </ul>
<ul style="list-style-type: none"> <li>• Staff votes on how they want to use the funds, with at least a portion going towards team building / staff communication.</li> <li>• We use the funds to highlight workplace performance improvements, encourage self-care, and team bonding</li> </ul>
<ul style="list-style-type: none"> <li>• Staff training</li> <li>• loan repayment</li> <li>• paid for certification of one staff member pursuing their LDAC</li> </ul>
<ul style="list-style-type: none"> <li>• Created the HERO Award (Honorable, Exceptional, Reverent and Optimistic) for employee recognition; employees given flowers, candy and a gift to recognize their dedication and exceptional service to the residents and their co-workers</li> </ul>
<ul style="list-style-type: none"> <li>• Traditional recruitment through various media venues for nursing recruitment.</li> <li>• Upgraded computer/laptop performance to improve employee satisfaction.</li> <li>• provide a small employee bonus for retention</li> </ul>
<ul style="list-style-type: none"> <li>• Enhanced our education support for employees</li> <li>• Tuition assistance policy revised to include staff that are pursuing education for a position we need. So far we have paid for the education of a housekeeper to become a phlebotomist; and two receptionists to become Medical Assistants</li> </ul>
<ul style="list-style-type: none"> <li>• Salary increases and hiring of staff</li> </ul>
<ul style="list-style-type: none"> <li>• \$[REDACTED]/hour raise for full time employees</li> <li>• Allowed us to compensate those part time employees and others not acknowledged by receiving a \$[REDACTED]/hour raise</li> </ul>
<ul style="list-style-type: none"> <li>• Friday's 30-minute coffee and snacks around the water cooler to socialize with your peers</li> <li>• Professional chair massages for team members</li> <li>• Professional certification for all team members in their field who want it</li> <li>• Professional Conferences</li> <li>• Incentivize team members to recruit their friends and receive a referral bonus</li> <li>• Our overall team member satisfaction is improving → 4.3-star work-life balance; 3.2-star compensation/benefits; 4.0-star Job security/advancement; 4.1-star management; 4.3 agency culture</li> </ul>
<ul style="list-style-type: none"> <li>• relocation costs</li> <li>• retention bonuses</li> </ul>

<ul style="list-style-type: none"> <li>employee retention efforts i.e. employee appreciation breakfast, season tickets to Bank of NH concerts that were raffled off to staff</li> </ul>
<ul style="list-style-type: none"> <li>CEUs and other workshops</li> <li>license renewals</li> <li>license exam fees</li> </ul>

- Strategies to support training of non-clinical IDN staff in Mental Health First Aid. **Progress Made:** Significant progress was made in previous reporting periods toward the training of non-clinical staff in MH First Aid. CHSN-IDN5 brought a Basic Mental Health First Aid training to the region in November 2018 which was taught by two LRMHC staff who had previously been trained at a “train the trainer” event funded by the IDN and reached 10 new attendees with an overall evaluation score of 4.5 (out of 5). As previously reported, both the Statewide Workforce Taskforce training and education subcommittee and CHSN’s Master Training Matrix address strategies to support the training of non-clinical staff in Mental Health First Aid. CHSN supported the work of Riverbend Community Mental Health Center who offered a Mental Health First Aid train-the-trainer program in April 2018 to increase trainer capacity in the state. That said the current state-of-our region is well equipped as there are currently two trainers on staff at LRMHC that were trained by the MHFA National Council that CHSN financially supported. Riverbend also has 2-3 trainers and NAMI NH has four which are certified in not just Adult, but also in Veterans, Youth and Older Adult. NAMI NH also just completed a grant in which they intend, if funded, to offer MHFA to all first responders (police, fire and EMS) in the state of NH. Laconia School District has five MHFA youth trainers.

**Timeline, Milestones and Evaluation Project Plan**

The table below outlines the key activities, milestones and timelines, responsible party, and progress measures for the Workforce Capacity Development Implementation plan. Following this table is the Master training plan for CHSN-IDN5 to support Workforce Capacity Development. Smartsheet detail and timeline is included as a graphic at the end of this section and included as **Attachment\_A1.3A**

Implementation Activity/ Milestone	Responsible Party/ Organization	Time line	Progress Measure / Notes
Participate with representatives of other IDNs in developing and implementing state level policy improvements and other strategies for strengthening the BH workforce and develop Statewide Workforce Capacity Plan	CHSN Executive Director; Workforce Lead – Executive Director Genesis	By June 30, 2017	Milestone Met; regular participation is ongoing; statewide workforce plan developed and CHSN Chair is also Chair of the Policy subcommittee
Identify and update workforce training needs assessment	CHSN Executive Director, MSLC	By July 31, 2017	Milestone Met; Facilitated meetings were held to assess workforce training needs with 3 segments of the IDN: BH/SUD Providers; Hospitals/Primary Care/FQHC’s/Home Health agencies; and

Implementation Activity/ Milestone	Responsible Party/ Organization	Time line	Progress Measure / Notes
			other Community Service Agencies
Develop a training matrix of CHSN-IDN5 training needs and area resources	CHSN Project Manager	By September 30, 2017 with ongoing updates	Milestone Met
Implement IDN-specific training plan	CHSN Executive Director	Initiate by November 1, 2017 and ongoing	Milestone Met; ongoing. 712 individuals trained to date; 159 of those were trained during this reporting period.
Initiate recruitment of Training Coordinator	CHSN Executive Director	Initiate by October 1, 2017. – <i>CLOSED</i>	Milestone Met; CHSN decided in Nov. 2017 to contract with NHADACA and others to provide this resource rather than hire a training coordinator. Training contract implemented April 2018 and closed December 31, 2018.
Initiate discussions with New Hampshire Alcohol & Drug Abuse Counselors Association and Northern NH AHEC to provide training plan needs	CHSN Executive Director	By November 2017	Milestone Met; CHSN contracted with NHADACA in April 2018 to coordinate and offer trainings identified within the scope of our projects. We also worked with Northern NH AHEC to coordinate the NH Behavioral Summit IDN track and remains open to other opportunities to work collaboratively on trainings as the need or opportunity arises. A total of 712 individuals have been trained to date through a variety of training resources; 159 of those were trained during this reporting period.

Implementation Activity/ Milestone	Responsible Party/ Organization	Time line	Progress Measure / Notes
Develop criteria and obtain board approval for providing employee retention incentive payments to participating agencies	CHSN Executive Director	By November 15, 2017	Milestone Met
Develop and communicate policies and procedures for agencies to achieve employee retention incentive payments	CHSN Executive Director	Initiate by December 15, 2018 and ongoing	Milestone Met
Provide employee retention incentive payments to participating agencies and monitor effect on recruitment and retention	CHSN Executive Committee	Initiate payments upon receipt of IDN incentive payout (mid-August 2018) and ongoing	Milestone Met; Ongoing; ERIP payments to partners made in August 2018 for the Jul-Dec 2017 SAR. Second payment made February 2019 for the IDN's Jan-Jun 2018 SAR success.
Develop criteria and obtain board approval for providing financial support for IDN-related staff pursuing licensure or certification in their fields	CHSN Executive Director	Initiate by April 1, 2018	Milestone Met; Ongoing; basic criteria was identified for those seeking financial support. Because funds are limited to just \$██████, rather than "roll this out" to the entire network, details were shared with the CHSN Board (representing our 15 members). Requests for financial support by our members' staff will be reviewed on a first-come, first-served basis by the Executive Director.
Develop and communicate policies and procedures for agencies to request licensure / certification support on behalf of staff	CHSN Executive Director	Updated to Q3 2018	Milestone Met; Ongoing; CHSN's involvement with the SLRP program was shared with partners in September 2018.
Provide reimbursement to staff pursuing licensure / certification and monitor effect on recruitment and retention	CHSN Executive Committee	Updated to Q3 2018	Ongoing; there have been no applicants to date seeking reimbursement. They will be handled on a first-come, first-served basis for CHSN Member agencies' staff.

Implementation Activity/ Milestone	Responsible Party/ Organization	Time line	Progress Measure / Notes
Research NH's loan repayment program and --- develop IDN specific criteria to model after this.	CHSN Executive Director	Initiate April 1, 2018	Milestone Met; formalization of the program specifics occurred in July 2018 after conversations with [REDACTED] with the State Loan Repayment Program (SLRP). Details of the CHSN match (totaling up to \$ [REDACTED]) were shared in September 2018 to partners explaining the details and who was eligible, and how to apply.
Present criteria and obtain board approval for providing loan repayment for key IDN-related staff	CHSN Executive Director	Initiate by July 2018	Milestone Met; formalization of SLRP program match specifics for CHSN-IDN5 partners was voted on at the July 2018 Board meeting and was rolled out to partners in Sept. 2018.
Develop and communicate policies and procedures for key agencies to request loan repayment support on behalf of staff	CHSN Executive Director	Initiate by June 2018 and ongoing	Milestone Met; loan repayment through SLRP will follow the exact criteria already established. CHSN-IDN5 will serve as a matching fund contributor similar to an employer in the amount of \$ [REDACTED] per applicant for up to 20 people.
Provide loan repayment to key staff and monitor effect on recruitment and retention	CHSN Executive Committee	Updated to Q3 2018 and ongoing	Milestone Met; Ongoing; Loan repayment from CHSN-IDN5 is paid directly to the employing agency who then pays the student/employee. Five SLRP candidates have been approved by CHSN-IDN5 to date a \$ [REDACTED] has been paid out. In one year we will review fund balance

Implementation Activity/ Milestone	Responsible Party/ Organization	Time line	Progress Measure / Notes
			and if appropriate, in order to spend down the dollars, we will design another mechanism to assist key staff with loan repayment more directly.

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

A comprehensive Master Training Matrix was developed for each community-driven project that identified the specific number of trainees by position type and by agency back in 2017. This Master Training Matrix has since been utilized to identify which trainings were the most critical and from there we built our contract specifics with the New Hampshire Alcohol and Drug Abuse Counselors Association (NHADACA). CHSN signed a contract with NHADACA on April 12, 2018 to begin offering in-person regional trainings to our partners and their staff. Additionally, their library of existing webinars was made available to all partners as well. All trainings were offered free of charge via use of a promo code which CHSN-IDN5 was billed. Ongoing training attendance is tracked by CHSN staff and is kept up to date on an ongoing basis upon receipt of monthly registration reports from NHADACA which provides data on all who participated in online or in person trainings. We capture their name, agency, job title at minimum. We recognize not all trainings that occur are brought to staff by NHADACA therefore making it difficult to capture 100% of all related trainings by our network partner staff/employees. On a regular basis, we remind community project workgroups to forward any trainings they have attended (beyond NHADACA trainings) to also capture in our training tracker.

CHSN-IDN5 is one of three IDNs that collaborated with the NH State Loan Repayment Program to provide a match on behalf of organizations within our IDN whose employees are eligible for the Loan Repayment Program regardless of whether their employers currently offer a match. Offering a match elevates applicants higher on the list. CHSN-IDN5 has set aside \$150K to assist 20 individuals with a \$[REDACTED] match for the following behavioral health specialties as delineated in the SLRP Tiers listed: Tier 2 = PA, APRN, CP, PNS, MHC, CSW, MFT, LPC, MLADC and Tier 3 = LADC. The CHSN-IDN5 match is in effect from Sept. 1, 2018 through Sept. 30, 2020 (or until such time that funds are depleted) to support matches for those partners who employees are eligible. According to SLRP administrators, there are eight CHSN member or affiliate partners eligible for loan repayment, which include: LRGHealthcare, Speare Memorial Hospital, Lakes Region Mental Health Center, HealthFirst Family Care Center, Horizons Counseling Center, MidState Health Center, Riverbend and Farnum North. All of the SLRP rules, eligibility guidelines and application for the program must be followed. Applicants are evaluated by SLRP on a first come first served basis across all tiers. The SLRP office will continue to administer all aspects of the program in the same way they normally do and CHSN-IDN5 will reimburse the agency once a match being awarded.

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

Given several community project workgroups have just completed the development of their program evaluation tool, it did not begin being utilized in earnest until Q4 2018. Project workgroups have all been discussing and formalizing their workflows at workgroup meetings which identify to whom, at what intervals in time, where, how and by whom the evaluations will be administered. Because the three community projects just began implementing their respective program evaluation tools during this reporting period; there is still little meaningful participant data available at this point in time.

Below you will find a snapshot of the CHSN-IDN5 Training Tracker, (**Attachment\_A1.4A**) which is the tool utilized by CHSN to capture all trainings and IDN partner attendance to date. This is as comprehensive of **a list available of** all trainings going on with partners. The tracker is divided into separate tabs identifying NHADACA trainings, other trainings, care coordinator training, and a Master page of all trainings. Data is provided to CHSN from various sources **including** a monthly spreadsheet submitted by NHADACA which identifies who attended a training or webinar, their agency and job title. It also provides information on who is signed up for future trainings. All members of the three community projects (**primarily the E5 Care coordinators**) forward any relevant trainings that are being attended so those non-NHADACA sponsored educational opportunities and trainings are also captured. When we have large activities that CHSN is a part of (i.e. DSRIP 101 Lunch and Learns, the NH BH Summit, etc.) we are able to capture partner attendance of such events and include them in our master training tracker as well.

### Attachment\_A1.4A

Attachment_A1.4A	CHSN-IDN 5 Training Tracker		Apr. 2019	Apr. 2019	Apr. 2019	Apr. 2019	Apr. 2019	April 2019	April 2019	May-19	May 2019
Agency	Name	Position	Opioid Treatment & Recovery Workshop	Environmental Strategies in Substance Use Prevention	How to Support Parents in the Recovery Process	Marijuana Forum SUD Providers	Psybersik	Substance Use, MH & Other Providers	Planning & Evaluating for Preventing Substance Use	Trauma-Informed Integrated Care	Ethical Challenges in Behavioral Health
		Community Care Coordinator									
Lakes Region Mental Health Center		Care Coordinator									
		Care Manager									
		Therapist									
		Targeted Care Manager									
		Therapist									
		Case Manager									
		Case Manager Facilitator									
		CSP Director									
		Health Mentor									
		Clinical Mental Health Counselor									
		ARNP									
		Health Mentor									
		Supported Employment									
		Community Case Manager									
Current 12.17.18		Care Coordinator		4.15.19			4.19.19				5.2.19
		Child & Family Therapist									
		Community Case Manager									
		Adult Community Case Manager									
		Therapist						4.25.19			
		Health Mentor									
		Housing Facilitator		4.15.19							
		Facilitator									
		Chief Quality Officer									
		ES Clinician									
		Coordinator									
		Therapist									

Performance Measure Name	Target	Progress Toward Target		
		As of 6/30/18	As of 12/31/18	As of 6/30/19

<p>Trainee satisfaction</p>	<p>At least 85% of training participants rate training programs as either “excellent” or “very good” in an evaluation survey</p>	<p>3 DSRIP 101 programs were held in 2018 at which 32 participants attended and 23 evaluations were received. The presentations received a 100% satisfaction rate based on receiving either a “very good” or “excellent” rating in the evaluation. The one in-person training on Motivational Interviewing offered by NHADACA in this reporting period received an overall score of 4.6 out of 5.</p>	<p>Milestone Met; Trainee satisfaction is shown in parenthesis next to each training topic offered by NHADACA (scale is 0-5). The mean evaluation score for all trainings was 4.7 (94%).  Introduction to Motivational Interviewing (4.9 ES)  Connect Program: Responding to Suicide Risk in those Impacted by Substance Use Disorder (4.8 ES)  Opioid Addiction &amp; Treatment (4.7 ES)  Ethics of Suicide Prevention (4.9 ES)  Intermediate Motivational Interviewing (4.4 ES)  Effective Communication Skills (4.8 ES)  Intervention Strategies &amp; Skills for the Helping Professional (4.6 ES)  Street Drugs: Current Trends (4.8 ES)  Biological Aspects of Substance Use Disorders (4.7 ES)  Cultural Competency: Communicating Across Boundaries (4.6 ES)  Mental Health First Aid (4.5)  Trans-theoretical Theory: Stages of Change (4.5)  Stress &amp; Trauma in the Practice of</p>	<p>Milestone Met; Trainee satisfaction is shown in parenthesis next to each training topic offered by NHADACA (scale is 0-5). The mean evaluation score for all trainings was 4.7 (94%).  Introduction to Motivational Interviewing (4.9 ES)  Connect Program: Responding to Suicide Risk in those Impacted by Substance Use Disorder (4.8 ES)  Opioid Addiction &amp; Treatment (4.7 ES)  Ethics of Suicide Prevention (4.9 ES)  Intermediate Motivational Interviewing (4.4 ES)  Effective Communication Skills (4.8 ES)  Intervention Strategies &amp; Skills for the Helping Professional (4.6 ES)  Street Drugs: Current Trends (4.8 ES)  Biological Aspects of Substance Use Disorders (4.7 ES)  Cultural Competency: Communicating Across Boundaries (4.6 ES)  Mental Health First Aid (4.5)  Trans-theoretical Theory: Stages of Change (4.5)  Stress &amp; Trauma in the Practice of Behavioral Health (4.6)</p>
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Performance Measure Name	Target	Progress Toward Target		
		As of 6/30/18	As of 12/31/18	As of 6/30/19
			Behavioral Health (4.6)	
Trainees will demonstrate knowledge and skill gains as measured by post training assessment	Average survey score of 4 or higher (out of 5) in agreeing with the statement "The training enhanced my knowledge/skills in the topic area"	In Process; Ongoing; NHADACA utilizes an evaluation tool for all trainings offered and provides CHSN-IDN5 with results on monthly basis.	Milestone Met; average was 4.67 based on NHADACA evaluation tool shows demonstrated gains in knowledge via their post training assessments.	Milestone Met; average was 4.67 based on NHADACA evaluation tool shows demonstrated gains in knowledge via their post training assessments.

Performance Measure Name	Target	Progress Toward Target		
		As of 6/30/18	As of 12/31/18	As of 6/30/19
Total number of training participants	Train 280 individuals in total by Dec. 31, 2018. (based on 14 partners x 20 staff each)	A total of 167 individuals have been trained on various BH/Integrated health care topics in this reporting period. 77 of those were through NHADACA offerings.	Milestone met; Through our contract with NHADACA, a total of 553 individuals were trained by year-end on a variety of BH/Integrated health care topics. These included MSLC learning collaborative topics, practice-specific training offerings and other non-NHADACA trainings attended by partners. CHSN-IDN5 used 2018 as it's time to do a major push promoting as many education/training opportunities possible for partners. Additionally, pre-recorded training links on the topics of diabetes, hypertension and hyperlipidemia was shared with all partners for their clinical staff to view by year-end thanks to a collaborative efforts with Network 4 Health's lunch and learn recorded series.	Milestone met; Through our contract with NHADACA, a total of 712 individuals were trained by year-end on a variety of BH/Integrated health care topics. These included MSLC learning collaborative topics, practice-specific training offerings and other non-NHADACA trainings attended by partners. CHSN-IDN5 used 2018 and 2019 as it's time to do a major push promoting as many education/training opportunities possible for partners. Additionally, pre-recorded training links on the topics of diabetes, hypertension and hyperlipidemia was shared with all partners for their clinical staff to view by year-end thanks to a collaborative efforts with Network 4 Health's lunch and learn recorded series. In June 2019 an Attestation of Training Completion form developed in which each B1 partner/practice will complete stating that their MDCT members have complied with the requirement to receive training in hypertension, diabetes and hyperlipidemia. An authorized signature from each agency will serve as proof that the MDCT members have met the training requirement and will provide CHSN-IDN5 with the back-up needed to report to DHHS.

Performance Measure Name	Target	Progress Toward Target		
		As of 6/30/18	As of 12/31/18	As of 6/30/19
Average recruitment time for key BH positions (see comprehensive list of provider types in next section - specific position types included in this measure to be determined)	Less than 90 days	In Process; specific position types to capture average recruitment were identified.	Milestone Met; the average recruitment for key BH positions is 86 days.	Milestone Met; the average recruitment for key BH positions is 86 days
Overall key position current (point in time) vacancy rate	Less than or equal to 10% (current baseline estimated at 12%)	In Process; Ongoing; Based on updated workforce capacity poll performed in June 2018 (see table A1-5) the identified vacancy rate is currently 21.13%.	Milestone Met; Currently the vacancy rate is 9.2%. Our workforce table now corresponds directly to project staffing whereas in earlier reporting the table tried to capture all staffing within the IDN (not just project specific). This adjustment has caused our vacancy rate to decline.	Milestone Met; CHSN's current retention rate is 100% with a current vacancy rate of 2.6%.
Number of IDN-related staff receiving financial support to pursue licensure / certification	Up to 10 recipients	0; under development - will be rolled out to partners in Q3 2018 in conjunction with details regarding the State Loan Repayment Program (below).	Milestone Met; 0; program rolled out Q4 2018 but to date there have been no applicants seeking financial support to pursue their licensure/certification.	Milestone Met; 0; program rolled out Q4 2018 but to date there have been no applicants seeking financial support to pursue their licensure/certification.

Performance Measure Name	Target	Progress Toward Target		
		As of 6/30/18	As of 12/31/18	As of 6/30/19
Number of IDN-related staff receiving loan repayment	Up to 10 recipients	0; under development – phone meetings have occurred with SLRP to formalize a plan for CHSN-IDN5 to assist in funding the loan repayment our network partner’s applicants. This will be rolled out to partners in Q3 2018	Milestone Met; 5 applicants to date have been approved for IDN matching funds at \$ [REDACTED] each. Applications were received in Sept. 2018 though contract dates aren’t official until 1/1/19. The SLRP match criteria was formalized in September 2018 and shared with CHSN-IDN5 partners with hopes of assisting up to 20 applicants for a total of \$ [REDACTED].	Milestone Met; 5 applicants to date have been approved for IDN matching funds at \$ [REDACTED] each. A total of 5 applicants have been approved from partner agencies and \$ [REDACTED] in payments has been made to date. The SLRP match criteria was formalized in September 2018 and shared with CHSN-IDN5 partners with hopes of assisting up to 20 applicants for a total of \$ [REDACTED].

**A1-5. IDN-level Workforce: Staffing Targets**

CHSN-IDN5 identified the staffing targets needed to perform the DSRIP waiver projects. These targets represent all positions identified in the A2, B1, C2, D3 and E5 projects and are reflected in the IDN 5 Workforce table below. The A2 project identified 11 FTEs (CIOs at various agencies and CHSN Data Analyst), the B1 project includes 2.5 FTEs for CHSN staff (Executive Director, Project Manager, PT Administrative Assistant) and all others are project specific: C2 = 7.5 FTEs, D3 = 9.2 FTEs and E5 = 9.4 FTEs for a total of 39.6 FTEs. Of those, 38.6 FTEs have been filled, leaving a remainder of 1 FTE still to be hired **for the D3 project**. Because there are two recovery support workers positioned for the Plymouth IOP project we are considering these positions filled as the individuals are trained, in place and ready to go at Plymouth Area Recovery Connection (PARC) the moment the Plymouth IOP opens. Therefore, there is just one Plymouth IOP MLADC FTE, which remains vacant to fulfill the needs of all projects. **Additional information surrounding our efforts to hire for this position follow below.**

To give some background to the difficulty our IDN has experienced in hiring for the **one MLADC FTE to fulfill opening a Plymouth IOP**, the following summary is being provided. Since 2018, Horizons Counseling Center has been actively recruiting for the Plymouth MLADC 1 FTE and a summary of those activities are listed here. The MLADC position was posted with the NH Providers Association, NHADACA, on Indeed, Craigslist, Zip Recruiter and at the behavioral health graduate education departments at UNH, SNHU, Plymouth State University and Antioch College. In the last six months Horizons received 16 inquiries/resumes; however, only nine of those had masters degrees and only three were licensed (two LCMHCs and MLADC). All nine applicants were contacted by Horizons for interviews and just two of those individuals responded. An interview was offered to one LCMHC who then didn’t show for the interview. Another interview was held with one LCMHC, one bachelors level counselor with multiple years of experience and licensed as an independent LADC and one masters level individual who had not yet

completed his work supervised practice toward licensure. An offer was made to the LADC in April, but the offer was turned down when she was offered a position by an organization in the Manchester area offering a significantly higher salary. Horizons then offered the position to the LCMHC who never responded to the offer. The unlicensed individual was not found to be qualified or prepared to take the lead on an IOP program. In the last year, Horizons has interviewed five individuals working toward their MLADC; two were hired by Horizons to fill other vacancies as they were not interested in the Plymouth IOP position. Over the course of the year it has become clear that the ability for northern, more rural communities to compete with the opportunities and wages offered by southern and urban areas, in particular with the infusion of funding from the Doorways has been even more challenging than in the past. This, along with the inadequate Medicaid reimbursement rate for IOP services (sometimes as much as half that of private insurance) makes northern area programs less competitive and less able to ensure sustainability of new hires once IDN funding is no longer available.

**Due to our lack of success in hiring an MLADC to run the IOP Program in Plymouth, and given the point we are at in the DSRIP demonstration, CHSN-IDN5 performed a rapid cycle evaluation and determined that in order to best meet the needs of the individuals in the region that we had to offer something different. An interim solution was approved by the Board in February 2019 to assist clients in need of SUD services in southern Grafton County. Horizons Counseling Center placed a counselor in its Plymouth office effective March 1, 2019 at the Whole Village Family Resource Center to provide ASAM assessment of clients referred for SUD services, to provide stabilization services for clients requiring a level of care other than the IOP level of care, making appropriate referrals and connecting clients with the appropriate level of care to available resources. This interim solution is being run indefinitely until CHSN-IDN5 is successful in hiring an MLADC to run the Plymouth IOP or another solution becomes available.**

Additional workforce activities this reporting period include funding our partner recruitment and retention activities via the CHSN Employee Retention Incentive Program and offering a match to applicants of the NH State Loan Repayment Program. CHSN-IDN5 has set aside \$██████ to assist up to 20 individuals with a \$██████ SLRP match. CHSN has committed to assisting five individuals already and has paid out with \$██████ to date to assist with their education loan repayment (via the SLRP match program). The CHSN Board has invested over \$██████ to support its network partners' staff trainings on behavioral/integrated healthcare topics and continues to make ongoing investments in partner staffing opportunities wherever possible.

Provider Type	IDN 5 Workforce (FTEs)				
	Projected Total Need	Baseline Staffing on 12/31/18	Staffing on 6/30/19	Staffing on 12/31/19	Staffing on 6/30/20
CHSN Executive Director	1	1	1		
Project Manager	1	1	1		
Data Analyst	1	1	1		

Provider Type	IDN 5 Workforce (FTEs)				
	Projected Total Need	Baseline Staffing on 12/31/18	Staffing on 6/30/19	Staffing on 12/31/19	Staffing on 6/30/20
Administrative Assistant	.5	.5	.5		
Chief Information Officers (agency-based)	10	11	11		
Re-entry Care Coordinator (Horizons)	1	1	1		
Re-entry Care Coordinator (LRMHC)	1	1	1		
Peer recovery support workers - future CRSW (Navigating Recovery)	2	2	2		
SUD Counselor/LADC (positioned at jail) (Horizons)	1	1	1		
SUD/ Co-occurring counselor/MLADC (Horizons)	1.5	0.5	1.5		
Case Manager or clinician, shared float (Horizons)	0.5	0.5	0.5		
Case manager or Clinician (Masters level) (LRMHC)	0.5	0.5	0.5		
MD (Horizons) (increase to 0.2 when expand to Plymouth)	0.1	0.1	0.1		
SUD Counselors / LADC (Horizons)	2	2	2		
SUD/Co-occurring counselor/MLADC (Horizons) Laconia IOP	1	1	1		
<del>SUD/Co-occurring counselor/MLADC (Horizons) Plymouth IOP</del>	<del>1</del>	<del>0</del>	<del>0</del>		
Admin. Assistant (Horizons)	0.5	0.5	0.5		
Recovery support worker (Horizons)	1	1	1		
Benefit Navigator (LRGHealthcare)	0.1	0.1	0.1		
Benefit Navigator (HealthFirst)	0.1	0.1	0.1		
Case Manager / Care Coordinator (LRMHC)	0.4	0.4	0.4		

Provider Type	IDN 5 Workforce (FTEs)				
	Projected Total Need	Baseline Staffing on 12/31/18	Staffing on 6/30/19	Staffing on 12/31/19	Staffing on 6/30/20
Recovery Support Worker (Navigating Recovery)	1	1	1		
Recovery Support Worker (PARC)	2	0	2		
Care Coordinator (LRGHealthcare)	1.25	1.25	1.25		
Care Coordinator (Horizons)	1.0	1.0	1.0		
Care Coordinator (ServiceLink)	0.5	0.5	0.5		
Care Coordinator (HealthFirst) <i>.25 shared with Riverbend</i>	2.25	2.25	2.25		
Care Coordinator (LRMHC) <i>1 – Laconia; .5 - Plymouth</i>	1.5	1.5	1.5		
Care Coordinator (Riverbend) <i>.75 shared with HealthFirst</i>	.75	.75	.75		
Care Coordinator (Speare Memorial)	1.0	1.0	1.0		
Care Coordinator (Mid-State)	1.0	1.0	1.0		
Care Coordinator (Pemi-Baker Community Health)	0.15	0.15	0.15		

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

CHSN-IDN5 began hiring for key positions to support its community project needs immediately upon receiving Implementation Plan approval. All positions but one have been hired thus far. Specifics are reflected within each community-driven section respectively. In brief, the C2-Community Re-Entry project projected the need for 7.5 positions to support the project and all positions are currently filled. The D3-Expansion of Intensive SUD Treatment Options project projected the need for 9.2 positions to support the project and have onboarded 8.2 to date. The E5-Enhanced Care Coordination project projected the need for 9.4 positions to support the project and have hired 9.4. Thus, to date, 96% of all identified staff have been hired to perform the functions of the community-driven projects.

Actual expenditures for recruitment, hiring and training are reflected within each of the project specific budgets as it pertains to staff hired to support projects. Funds were budgeted to support CHSN-IDN5 participation in statewide trainings, IDN 5 specific regional trainings to support integrated practice development, licensure or certification support for recent graduates, loan repayment to support provider recruitment or retention, a training contract to provide required trainings through NHADACA or other

agencies and an Employee Retention Incentive Plan to assist in training, retention and overall employee satisfaction for CHSN member and affiliate organizations.

A1 expenditures for this reporting period total \$ [REDACTED] which include \$ [REDACTED] paid to NHADACA for registration fees within the training contract; \$ [REDACTED] paid to the North County Health Consortium for continuing education credits for the NH Behavioral Health Summit; and \$ [REDACTED] was paid out in February 2019 to CHSN-IDN5 partners for the second issuance of Employee Retention Incentive Plan checks which incentivize partners and reward them with funds to be used towards employee retention and recruitment efforts within their agency. There were five SLRP applications approved for CHSN-IDN5 matching funds and a total of \$ [REDACTED] paid to date. Detailed activities can be found in the table below. Please note the overall CHSN-IDN5 five-year waiver budget can be found in **Attachment\_A1.6A**.

CHSN-IDN 5: Total Budget & Actual - Projected									
July 1, 2016 - June 30, 2022									
Line Item	Total Program Cost								
	CY 2016 Actuals	CY 2017 Actuals	CY 2018 January to June Actuals	CY 2018 July to December Actuals	CY 2019 January to June Actuals	CY 2019 July to December Projected	CY 2020 Projected	CY 2021 Projected	Total
<b>PPI</b>									
- Administrative lead									
-Project lead expenses									
-Partner discretionary or other grants									
-Community input									
<b>Total PPI</b>									
<b>A1</b>									
<b>A2</b>									
<b>B1</b>									
<b>C2</b>									
<b>D3</b>									
<b>E5</b>									
<b>Total DSRIP Projected Expenditures</b>									
10% Reserve for Matching Fund and Performance Metrics Uncertainty									

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

Key organizations and providers participating in the IDN to support workforce development are displayed in the table below. One update reflected is the removal of HOPE for NH Recovery, a recovery support center operating in Franklin, NH which closed its doors in September 2018. Below you will note that the 14 organizations identified as participating in the B1 – Integrated Care project are listed first, all other CHSN-IDN5 partner organizations follow.

Organization Name	Organization Type	Associated with IDN Projects (A1, A2, B1, C, D, E)
LRGH - Westside Healthcare	Hospital practice	A1, A2, B1
LRGH - Caring for Kids	Hospital practice	A1, A2, B1
LRGH – Laconia Clinic	Hospital practice	A1, A2, B1
LRGH – Lakes Region Family Practice	Hospital practice	A1, A2, B1
LRGH - Belknap Family Health - Meredith	Hospital practice	A1, A2, B1
LRGH – Belknap Family Health - Belmont	Hospital practice	A1, A2, B1

Organization Name	Organization Type	Associated with IDN Projects (A1, A2, B1, C, D, E)
LRGH – Hillside Family Medicine	Hospital practice	A1, A2, B1
Speare Primary Care	Hospital practice	A1, A2, B1
Speare Pediatric and Adolescent Medicine	Hospital practice	A1, A2, B1
Mid-State Health Center	FQHC	A1, A2, B1, C, D, E
HealthFirst Family Care Center	FQHC	A1, A2, B1, C, D, E
Lakes Region Mental Health Center	CMHC	A1, A2, B1, C, D, E
Horizons Counseling Center	SUD treatment provider	A1, A2, B1, C, D, E
Riverbend Community Mental Health	CMHC	A1, A2, B1, C, D, E
Lakes Region Community Services	Social Services Organization	A1, A2, C, D, E
Partnership for Public Health	Public Health Agency	A1, A2, C, D, E
Pemi-Baker Community Health	Home Health Agency	A1, A2, E
CAP Belknap-Merrimack Counties	Community Action Program	A1, A2, C, E
Central NH VNA & Hospice	Home Health Agency	A1, A2, E
Communities for Alcohol & Drug-free Youth (CADY)	SUD Prevention Agency	A1, A2, C
Franklin VNA & Hospice	Home Health Agency	A1, A2, E
Newfound Area Nursing Association (NANA)	Home Health Agency	A1, A2, E
Ascentria	Social Services Organization	E
Belknap County	Corrections	C
Bridge House	Homeless Shelter	C, D, E
Community Bridges	Peer Support Agency	A1, A2, E
Cornerbridge	Peer Support Agency	A1, A2, E
Crotched Mountain Foundation	Disability Services and Support	E
Easter Seals/Farnum North	SUD Treatment Agency	A1, A2, D
Grafton County	Corrections	C
Granite State Independent Living	Disability Services and Support	E
Merrimack County	Corrections	C
National Alliance on Mental Illness – NH	Peer Support Agency	C, E
Navigating Recovery of the Lakes Region	Recovery Support Organization	A1, A2, C, D, E
NH Alcohol and Drug Abuse Counselors	Professional Association and Training	A1

Organization Name	Organization Type	Associated with IDN Projects (A1, A2, B1, C, D, E)
NH Veterans Home	Long term care	A1, A2, E
Plymouth Area Recovery Connection	Recovery Support Organization	A1, A2, C, D, E

## Project Scoring: IDN Workforce Process Milestones

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

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

# A1 Statewide BH Workforce (IDN 5)

Attachment\_A1.3A

Task	
1	Phase 1
2	Form Statewide BH Workforce Capacity Taskforce
3	Participation in BH Workforce Capacity Taskforce planning
4	Phase 2
5	Develop inventory of existing workforce data, initiatives, and activities
6	Participate/create gap analysis
7	Phase 3
8	Develop Statewide BH Workforce Capacity Strategic Plan
9	Workgroups defined: Policy, Education, Training, Recruitment/Hiring/Retention
10	Identification of Goals and timelines
11	Phase 4
12	Repeat workforce gap analysis and submit with SAR
13	Develop IDN level Workforce Capacity Development Implementation Plans
14	Identify SAMHSA workforce development initiative
15	Identify recommendations for revisions to CRSW requirements
16	Develop criteria and obtain CHSN Board approval for providing employee retention incentive payments for CHSN partners
17	Develop and communicate policies and procedures to CHSN partners re: employee retention incentive payments
18	Research NH's loan repayment program and develop IDN 5 criteria to model after this if deemed appropriate
19	Present criteria and obtain Board approval for providing loan repayment for key IDN-related staff
20	Develop and communicate policies and procedures for key agencies to request loan repayment support on behalf of staff

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

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

CHSN IDN-5 continues to reevaluate targets set at the beginning of the project as we get a better sense of the reality of the HIT environment within the IDN. Every organization now has its own CCSA that has been implemented (to different degrees, LRGH and Speare Practices will implement the CCSA they already developed for the ED in mid-September 2019). Certain locations are finding greater success in implementing CCSA workflows depending on the type of organization, but we expect improvements in CCSA rates at these locations where they are newly adopted. Implementation of shared-care planning software (CMT) at every B1 practice was completed as of June 30, 2019. Usage patterns and workflows for shared-care planning are at different stages in each location but the technological capability is present. All shared-care planning work is now focused on workflows related to integrated care. All B1 partners are now receiving ED notifications and the three hospitals in our network are sending ED notifications to the other partners. All partners implemented direct secure messaging as of June 30, 2018 through the Kno2 platform. As of this report, there are no new HIT projects that the IDN is implementing. One HIT focus for this reporting period however was evaluating the closed loop referral tools that are being utilized across the state and in other IDN's and monitoring the thoughts of the state and SOR grant recipients around these tools so that CHSN-IDN5 could make an informed decision regarding the acquisition of a closed loop referral tool should it determine one necessary. At this point in time, CHSN-IDN5 is not planning to acquire a closed loop referral tool but will rather focus instead on CMT and increasing the number of shared care plans that are being created and utilized across sites.

#### Direct Secure Messaging

Direct secure messaging has been implemented at all of the CHSN-IDN5 practices since June 30, 2018. We find that organizational use of DSM and DSM workflows vary greatly by individual practice, with some practices taking frequent advantage of this technology while other practices use it very little if at all. The main limiting factor it seems is explaining the advantages of using DSM to our partners as well as the use of other technologies such as secure email encryption to bypass using another software/workflow for DSM like Kno2.

#### CCSA Collection

CHSN-IDN5 does not utilize one specific technology or tool to collect CCSA's for the IDN. Partners have built forms into their existing EHR systems to capture the required CCSA data. There is currently just one location that is using a paper form to capture CCSA data and that practice anticipates switching over to an electronic form once their new EHR is operational (anticipated in August 2019). **All B1 practices within CHSN-IDN5, including LRGH and Speare practices, are now collecting a CCSA's though we are still fine-tuning reporting some of the data reporting aspects and details to ensure we can track CCSA completion dates across all practices.**

## ED Event Notification

ED Event Notification has been live at all the three hospitals (Spere Hospital, Lakes Region General Hospital and Franklin Regional Hospital) since late 2018. All of the practices in our region are now receiving event notifications through CMT. We are actively working to increase the number of users at each practice with access to CMT so that notifications are being received by staff who can then respond to notifications and follow up as appropriate. On average, CMT users within our IDN spend 2.5 hours per day logged into the notification/shared-care planning system.

## Shared Care Planning

All of the B1 practices have now implemented CMT. Adoption of workflows surrounding shared care plans has been slow but educating practices on the benefits continues to occur and the more they are utilized, more will use it. The E5 Community Care Coordination (CCC) team has been trained in utilizing the SCP module within CMT and have recently started holding monthly Wraparound meetings where a shared care plan for a client is agreed upon at the meeting. The “lead” CCC for that client is then responsible for updating the SCP within CMT for all providers to have access to regardless of where the client presents next. To date, there are around 20 shared care plans that have been created. CHSN-IDN5 staff continues to emphasize the importance of this tool and is working with practices and community care coordinators on their workflows surrounding shared care planning to increase the overall number of shared care plans that are being created by partners.

## Closed Loop Referral Software

Recently, there have been discussions statewide regarding the State Opioid Response (SOR) grant and the need for bed management and referral technology. CHSN-IDN5 has been part of these discussions with other IDN’s and have participated in software provider demos for OpenBeds and Unite Us. Currently, CHSN-IDN5 is not actively looking to acquire software for this purpose, but we remain at the table to discuss its operability and potential advantages should other IDNs agree that it has value; then at such time, CHSN-IDN5 may then determine to get on board with other IDNs.

The table below outlines the key activities, milestones and timelines, responsible party, and progress measures for the HIT/HIE Capacity Development Implementation plan. Smartsheet detail and timeline is included as a graphic at the end of this section and included as **Attachment\_A2.3A**

Implementation Activity/ Milestone	Responsible Party/ Organization	Time line	Progress Measure / Notes
HIT-related Policy and Procedures			
Participate with representatives of other IDNs in developing and implementing state level plans and coordinated investments for strengthening the statewide HIT/HIE infrastructure	CHSN Executive Director; HIT Lead – CEO HealthFirst	Ongoing	Milestone Met: regular participation in statewide HIT/Data meetings; statewide HIT plan developed
Maintain standing CHSN HIT Committee with responsibility for making recommendations to the Board on investments and technical enhancements to support development of network-wide HIT capabilities.	HIT Committee Lead	Meets monthly, ongoing	Milestone Met: regular meetings occurring with documentation of minutes; board

Implementation Activity/ Milestone	Responsible Party/ Organization	Time line	Progress Measure / Notes
			approval for CMT investment
Maintain CHSN Data Analytics subcommittee of the HIT committee to establish data sharing standards / processes and procedures for collecting and monitoring performance data	HIT Committee Lead	Meets monthly, ongoing	Milestone met; Ongoing; work occurring at state level with regard to performance metrics and data aggregation. Currently, there is not enough performance data being captured/monitored in order to justify a subcommittee. CHSN's IDN Data Analyst meets individually with each organization to discuss performance data after each reporting cycle.
Develop forms and procedures for informed patient consent to share information	HIT Committee Lead	By December 31, 2017	Milestone met; Universal consent forms developed and shared in June 2018 (previous reporting period). These include an Authorization and Consent to Share PHI with Treating Providers, Authorization and Consent to Share PHI with Non-Treating Providers and Consent to Release Information for Purposes of Billing Services.
Develop inter-agency data sharing agreements addressing requirements for data security, storage, maintenance and exchange	CHSN Executive Director, HIT Committee Lead	By December 31, 2017	Milestone Met; MOU's with BAA's or a QSO/BAA were distributed to all CHSN network partners in December 2017 which address requirements for data security and exchange.

Implementation Activity/ Milestone	Responsible Party/ Organization	Time line	Progress Measure / Notes
			Contract signed with MAeHC data aggregator which addresses the requirement for storage and maintenance.
Train providers in HIPAA, Confidentiality/Privacy-42 CFR Part 2	CHSN-IDN5 Training Committee, HIT Taskforce	Begin Q4 2017	Milestone met; initial training provided at CHSN's full network meeting on February 2018. Ongoing trainings offered to providers and partners occurred throughout the year. The E5 CCC team had a training specific to their role on Ethical Communication and Decision Making in an Integrated Care Environment in May. Regional 42 CFR Part 2 expert [REDACTED] [REDACTED] has provided several practice-specific trainings on Confidentiality/42 CFR Part 2 on an as requested basis.
Continue to assess capabilities of all CHSN members to meet and sustain minimal HIT standards	HIT Committee	By December 31, 2017 and ongoing	Milestone Met; Ongoing
<b>HIT Infrastructure Improvements / Applications to Facilitate Integrated Care</b>			
Support specific CHSN members to achieve minimum HIT standards; install capabilities for data encryption and Direct Secure Messaging (e.g. Kno2); applies to Horizons, NANA, PPH and Navigating Recovery of the Lakes Region	HIT Committee and CHSN Executive Director	By December 31, 2017	Milestone Met; four agencies who were deficient in secure messaging were identified and had Kno2 installed in Dec. 2017. Those agencies included Horizons, NANA, PPH and Navigating Recovery
Execute agreement with Collective Medical Technologies (CMT) on behalf of CHSN-IDN5 partners for installation and support of PreManage application for shared care plan and event notification	CHSN Executive Director, Board	By September 30, 2017	Milestone Met; agreement signed on October 12, 2017

Implementation Activity/ Milestone	Responsible Party/ Organization	Time line	Progress Measure / Notes
<p>Initiate PreManage Primary Implementation with FQHCs and BH provider organizations</p> <ul style="list-style-type: none"> <li>• Send list of prioritized clinics to CMT</li> <li>• CMT contact prioritized agencies / practices</li> <li>• Agency / Practice implementation steps               <ol style="list-style-type: none"> <li>1. View Video Demo of PreManage</li> <li>2. Set up Q&amp;A meeting with CMT</li> <li>3. Set up eligibility file discussion</li> <li>4. Complete On-Boarding packet</li> <li>5. Train Users on PreManage Primary</li> </ol> </li> </ul>	<p>CHSN Executive Director; CMT; HIT Committee</p>	<p>Timeline adjusted: Initiate implementation between October 1, 2017 and March 31, 2018.</p>	<p>Milestone Met; all Wave 1 participants who are not fully 42 CFR Part 2 have been implemented and are participating in shared care planning using PreManage Primary. All of the care coordinators using PreManage Primary were trained by CMT rep, [REDACTED] at a live training in November 2018 at Lakes Region Mental Health Center.</p>
<p>Initiate PreManage ED Implementation with hospitals</p> <ul style="list-style-type: none"> <li>• IT steps:               <ol style="list-style-type: none"> <li>1. Establish VPN Connectivity</li> <li>2. ADT Feed/Messages – receive ADT feed from Hospital</li> <li>3. Historical File – 12-24 Months of patient enrollment and encounter data prior to go live</li> <li>4. Notification Return Type – can support a print or electronic type notification. Coordinate with each hospital as to what will work best for their workflows.</li> </ol> </li> <li>• Clinical steps:               <ol style="list-style-type: none"> <li>1. Clinical Workflow discussion with clinical team</li> <li>2. User Provisioning</li> <li>3. Train Providers</li> <li>4. Train Users</li> </ol> </li> </ul>	<p>CHSN Executive Director; CMT; HIT Committee</p>	<p>Timeline adjusted: Initiate implementation between October 1, 2017 and July 31, 2018.</p>	<p>Milestone Met; VPN connectivity was established for the ADT feed in Phase 1 of this implementation. In Phase 2, PreManage ED was integrated with the existing Cerner implementation at the hospitals. Care coordinators are receiving email notifications for their patients that present at the ER. Training for initial users was completed and future trainings for “power users” and other staff will be scheduled in Q2 2019.</p>
<p>Initiate PreManage Primary Implementation with hospital affiliated primary care practices</p> <ul style="list-style-type: none"> <li>• Send list of prioritized clinics to CMT</li> <li>• CMT contact prioritized agencies / practices</li> <li>• Agency / Practice implementation steps               <ol style="list-style-type: none"> <li>1. View Video Demo of PreManage</li> <li>2. Set up Q&amp;A meeting with CMT</li> <li>3. Set up eligibility file discussion</li> <li>4. Complete On-Boarding packet</li> <li>5. Train Users on PreManage Primary</li> </ol> </li> </ul>	<p>CHSN Executive Director; CMT; HIT Committee</p>	<p>Timeline adjusted: Initiate implementation between July 1, 2018 and December 31, 2018.</p>	<p>Milestone met; hospital partners had PreManage at their sites in fall 2018. Implementation at all practices occurred simultaneously with onboarding of PreManage.</p>

Implementation Activity/ Milestone	Responsible Party/ Organization	Time line	Progress Measure / Notes
Monitor PreManage utilization, troubleshoot; provide ongoing support and training	CMT; HIT Committee	Initiate November 1, 2017; ongoing	Milestone Met; Ongoing; CMT is training organizations as they are being implemented and assisting with any questions that users have.
Initiate development of capacity for intra-network data aggregation for quality, utilization and cost measurement and reporting	Statewide HIT Workgroup; CHSN HIT Committee	Initiate September 1, 2017	Milestone Met
Review and select vendor for data aggregation / intra-network quality reporting	Statewide HIT Workgroup; CHSN HIT Committee	Selection by November 1, 2017	Milestone Met
Facilitate agreements with participating agencies / practices to build interfaces with the data aggregator (DA) application	Data aggregator vendor; HIT Committee; CHSN Board	Initiate by December 1, 2017; ongoing	Milestone Met; Have engaged with all organizations that are submitting data to MAeHC.
Configure data aggregator <ul style="list-style-type: none"> <li>define CCSA tracking requirements / definitions;</li> <li>configure other DSRIP measure tracking requirements / definitions</li> </ul> Verify patient privacy requirements met;	Data aggregator vendor; HIT Committee	Initiate by January 1, 2018	Milestone Met; CCSA protocols have been defined and were shared with partners in 2018. All questions surrounding DSRIP measure tracking are discussed at the regular B1/A2 combined meetings.
Test / initiate clinical quality measures reporting	Data aggregator vendor; HIT Committee; Data Analyst	Initiate by March 1, 2018	Milestone Met; individual reviews with each organization are being conducted by the CHSN Data Analyst.
Provide ongoing support and training on use of data aggregator functions; Provide consultation on use of reports for performance improvement	Data aggregator vendor; HIT Committee; Data Analyst Practice Transformation Specialist	Initiate July 1, 2018; ongoing	Milestone Met; Multiple trainings have been offered on the MAeHC portal for users in the IDN and they have been well attended.
Initiate development of tracking and reporting of utilization and cost to inform development of alternative payment models	Data aggregator vendor; HIT Committee; Data Analyst CHSN Board	Initiate by January 1, 2019; ongoing	Ongoing; Pending statewide development of APMs.

## A2-4. IDN HIT: Evaluation Project Targets

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/18	As of 6/30/19	As of 12/31/20
Number of IDN participants achieving minimum HIT standards as appropriate to provider type (refer to Statewide HIT Implementation for description of minimum standards)	14 of the B1 partners that maintain a health record	7	14	
Number of IDN participants utilizing ONC Certified Technologies	13 of the B1 partners that provide primary care/mental health care	13	13	
Number of IDN participants capable of conducting ePrescribing	13 of the B1 partners that prescribe	13	13	
Number of IDN participants capable of conducting other core functions such as registries, standardized patient assessments, collection of social determinants, treatment and care transition plans	13 of the B1 partners that provide primary care/mental health care	14	13	
Number of IDN participants able to exchange relevant clinical data with each other and with statewide facilities such as New Hampshire Hospital via health information exchange (HIE) standards and protocols.	14 of the B1 partners that maintain a health record	10	14	
Number of IDN participants able to protect electronically-exchanged data in a secure and confidential manner meeting all applicable State and Federal privacy and security laws (e.g., HIPAA, 42 CFR Part 2).	14 of the B1 partners that maintain a health record	14	14	
Number of IDN participants able to use comprehensive, standardized physical and behavioral health assessments.	14 of the B1 partners that maintain a health record	14	14	
Number of IDN participants able to share a community-wide care plan to support care management, care coordination, patient registries, population health management, and quality measurement.	14 of the B1 partners that maintain a health record	9	14	
Number of IDN participants able to directly engage with their patients through bi-directional secure messaging, appointment scheduling, viewing care records, prescription management, and referral management.	9 of the hospital practices and FQHC's	8	9	

## A2-5. IDN HIT: Workforce Staffing

Staff Type	IDN Workforce (positions)				
	Projected Total Need	Staffing on 12/31/17	Staffing on 6/30/18	Staffing on 12/31/18	Staffing on 6/30/19
Data Analyst	1	0	1	1	1
Chief Information Officers (agency-based)	10	11	11	11	11

## A2-6. IDN HIT: Budget

The budget below outlines projected costs to support the IDN HIT project. Financial reporting on actual spending during the January to June 2019 reporting period is reflected in the table below. CHSN started reimbursing agencies for project staffing expenses effective October 1, 2017 and/or upon hire of personnel. Reimbursements are being submitted regularly by partner agencies on a monthly or quarterly basis for those who have brought on staff to serve in the identified roles. Signed Memorandum of Understanding's (MOU) are on file between PPH/CHSN and all partners receiving IDN funds.

Expenditures within this reporting period include payments to CMT for \$██████; \$██████ to HealthFirst for reimbursement of an invoice from CHAN for work performed to assist with MAeHC reporting simulation; \$██████ to Kno2 for annual subscription fees for partners utilizing secure messaging and \$██████ to the Administrative Lead for CHSN's Data Analyst salary, benefits, mileage and cell phone reimbursements for a total of \$██████ in expenditures between July - December 2018. See table below for detail.

Budget Item	Item Description	CY 2017 Actual Cost	Jan – Jun 2018 Actual Cost	Jul – Dec 2018 Actual Cost	Jan-Jun 2019 Actual Cost	Total Project Cost to Date
Salary and benefits, mileage and cell phone	CHSN Data Analyst					
Mileage and cell phone reimbursement	CHSN Data Analyst reimbursements					
Consultants / Subcontracts	UNH– development of client consent for inter-agency data sharing documents					
CMT	CMT PreManage and Event Notification					
MAeHC Data Aggregator	MAeHC					

Agency-specific support	Costs to bring agencies up to HIT "Minimum standards", e.g. installation of capability for data encryption and secure messaging	
Data Consultant fees	To assist partners w/report automation and writing	
Miscellaneous	Reimbursement to consultants for developing privacy/data sharing documents	
Data Analyst miscellaneous expenses and office supplies	CHSN cost to purchase laptop for new Data Analyst	
HIT CAPACITY BUILDING TOTAL		

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

Key organizations and providers participating in the IDN to support workforce development are displayed in the table below. HOPE for NH Recovery is no longer an affiliate partner and has been removed from the organizational table below (reference PPI-2 Network Development for more information).

Organization Name	Organization Type
LRGHealthcare	Hospital System
Franklin Regional Hospital	Hospital System
Speare Memorial Hospital	Hospital System
Mid-State Health Center	FQHC
HealthFirst Family Care Center	FQHC
Lakes Region Mental Health Center	CMHC
Horizons Counseling Center	SUD treatment provider
Lakes Region Community Services	Social Services Organization
Partnership for Public Health	Public Health Agency
Pemi-Baker Community Health	Home Health Agency

Organization Name	Organization Type
CAP Belknap-Merrimack Counties	Community Action Program
Central NH VNA & Hospice	Home Health Agency
Communities for Alcohol & Drug-free Youth (CADY)	SUD Prevention Agency
Franklin VNA & Hospice	Home Health Agency
Newfound Area Nursing Association (NANA)	Home Health Agency
Community Bridges	Peer Support Agency
Cornerbridge	Peer Support Agency
Easter Seals/Farnum North	SUD Treatment Agency
Navigating Recovery of the Lakes Region	Recovery Support Organization
NH Veterans Home	Long term care
Plymouth Area Recovery Connection	Recovery Support Organization
Riverbend Community Mental Health	CMHC

## A2-8. IDN HIT: Data Agreements

Inter-agency data sharing agreements were developed with legal assistance and are addressed within CHSN-IDN5's Memorandum of Understanding's with all partners in late 2017. Within the MOU, either a Business Associate Agreement (BAA) or a Qualified Service Organization / Business Associate Agreement (QSO/BAA) was provided for each network partner. In this reporting period, CHSN-IDN5 collected five additional MOU's for a total of 27 signed MOU's to date that have been returned and are on file out of 32 total member and affiliate agencies that comprise the CHSN network. The five outstanding MOU's are from affiliate members who do not report data. CHSN-IDN5 staff continues to work with these partners to collect outstanding MOU's. Because not having an MOU on file directly correlates to an agency receiving their Employee Retention Incentive Plan payout, we anticipate getting these on file in early 2019. Every agency that will be sharing data with CMT for shared care plans and event notification has a signed BAA directly between their agency and CMT. MAeHC, who is providing data aggregation services, contracted directly with CHSN-IDN5 and an addendum was attached to the MOU which spells out the MAeHC agreement and their responsibilities to support our contract.

Organization Name	Data Sharing Agreement Signed Y/N
LRGHealthcare (includes LRGH & FRH)	Yes
Speare Memorial Hospital	Yes
Mid-State Health Center	Yes
HealthFirst Family Care Center	Yes
Lakes Region Mental Health Center	Yes
Horizons Counseling Center	Yes

Organization Name	Data Sharing Agreement Signed Y/N
Lakes Region Community Services	Yes
Partnership for Public Health	Yes
Pemi-Baker Community Health	Yes
CAP Belknap-Merrimack Counties	Yes
Central NH VNA & Hospice	Yes
Lakes Region VNA	Yes
Communities for Alcohol & Drug-free Youth (CADY)	Yes
Franklin VNA & Hospice	Yes
Newfound Area Nursing Association (NANA)	Yes
Riverbend Community Mental Health	Yes
Crotched Mountain	Yes
Navigating Recovery of the Lakes Region	Yes
NAMI NH	Yes
NH Alcohol & Drug Abuse Counselors Associations (NHADACA)	Yes
NH Veterans Home	Yes
Merrimack County	Yes
Bridge House	Yes
Cornerbridge	Yes
Belknap County	Yes
Plymouth Area Recovery Connection	Yes
Easter Seals/Farnum North	No
Granite State Independent Living	No
Ascentria	No
Grafton County	No
Community Bridges	No

### A2-9. Project Scoring: IDN HIT Process Milestones

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

Process Milestone Number	Process Detail	Submission Format	Results (Met/Not Met)			
			6/30/17	12/31/17	6/30/18	12/31/18
A2-3	IDN HIT/HIE Implementation Plan and Timeline	Narrative & Spreadsheet (Microsoft Project or				

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

Attachment\_A2.3A

## A2 Statewide HIT (IDN 5)

Attachment\_A2.3A

Task	Complete	End
<input type="checkbox"/> Phase 1- Initiation	<input checked="" type="checkbox"/>	04/30/17
<input type="checkbox"/> Participate in Statewide HIT Taskforce	<input checked="" type="checkbox"/>	04/30/17
<input type="checkbox"/> Participate in State assessment of HIT for participating members of IDNs	<input checked="" type="checkbox"/>	04/30/17
Assist in developing standardized current-state assessment tool	<input checked="" type="checkbox"/>	04/30/17
Conduct an IDN-member assessment of existing and scheduled HIT efforts and develop a statewide rep	<input checked="" type="checkbox"/>	04/30/17
Assist taskforce in conducting an updated review of pertinent State and Federal Privacy laws	<input checked="" type="checkbox"/>	04/30/17
Review HIT assessment and create gap analysis for both IDN and State levels	<input checked="" type="checkbox"/>	04/30/17
<input type="checkbox"/> Phase 2 Building Consensus of minimal, desired, and optional HIT requirements for IDN infrastructures	<input checked="" type="checkbox"/>	07/31/17
Maintain standing CHSN HIT committee with responsibility to make recommendations to the board	<input checked="" type="checkbox"/>	07/31/17
<input type="checkbox"/> Alignment of goals designed to help close the gaps in HIT that will support the DSRIP demonstration	<input checked="" type="checkbox"/>	07/31/17
Development of acceptable levels of ONC certified Technology adoption and electronic health record functi	<input checked="" type="checkbox"/>	03/30/17
Identify transaction sets, methods, and mechanisms for health information exchange ((HIE) between IDN pa	<input checked="" type="checkbox"/>	03/30/17
Evaluate requirements for a shared care record across the care continuum	<input checked="" type="checkbox"/>	03/30/17
<input type="checkbox"/> Engage in discussion to enable clinical outcomes and financial performance measurement and reporting fu	<input checked="" type="checkbox"/>	07/31/17
Discuss adoption of electronic Clinical Quality Measures (eCQMs)	<input checked="" type="checkbox"/>	07/31/17
Discuss utilization reporting	<input checked="" type="checkbox"/>	07/31/17
Discuss financial performance reporting	<input checked="" type="checkbox"/>	07/31/17
Discuss managing reporting between IDNs and the State using a Stat-approved standardized format for	<input checked="" type="checkbox"/>	07/31/17
Discuss availability of State-approved standardized data sets to be provided by the State and MCO part	<input checked="" type="checkbox"/>	07/31/17
Consensus Report Published	<input checked="" type="checkbox"/>	07/31/17
<input type="checkbox"/> Phase 3 Develop IDN specific HIT Implementation Plan	<input checked="" type="checkbox"/>	06/30/18
Develop a HIT implementation plan and timeline	<input checked="" type="checkbox"/>	07/31/17
Ensure inclusion of IDN provider(s): hospital, CMHC, community mental health providers, primary care, SUD, ai	<input checked="" type="checkbox"/>	06/29/17
Initiate recruitment of Health Data Analyst	<input checked="" type="checkbox"/>	10/31/17
<input type="checkbox"/> Develop IDN 5 Privacy forms	<input checked="" type="checkbox"/>	12/31/17

## **Project B1: Integrated Healthcare**

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

To date, UNH/CHI has facilitated the baseline, follow-up Round 1 and a follow-up Round 2 site self-assessments with CHSN partners. The latest, follow-up Round 2 wrapped up in November 2018 and results were presented to practices at the CHSN B1-Integrated Healthcare meeting scheduled in January 2019. Results from the assessments illustrate that while participants with historically lower scores are improving, some of our highest performers have lower scores compared to their past performance. In spite of this, the average SSA score has improved about 18% since the baseline was taken in the second half of 2017. We plan to discuss the drop in our highest performers at the next A2/B1 meeting in Q1 of 2019. All of the respondents score above 92 on this SSA which puts them at the level of Co-Located Care IV or above. Two of our respondents who scored high enough to achieve Integrated Care V have dropped down to Co-Located Care IV. We believe this is due to a change in who filled out the SSA at these two sites. Conversely, two of our previously Co-Located Care IV practices that were targeted for Integrated Care increased to Integrated Care V. This is great news because we believe if the other score drops are anomalies, it's probable that all of our targeted Integrated Care partners are close to achieving integrated care if not already achieving. The next site self-assessment will be performed in fall 2019.

There were no changes within the CHSN network composition during this reporting period.

Due to having no success hiring a Practice Transformation Specialist, and recognizing the need for this critical resource in the region, CHSN's previously identified in its July 2018 SAR its threefold approach. First, we decided we would pilot working with a few willing agencies in the to help expedite the process, for example identifying a champion at a few key agencies of which CHSN would reimburse them for their time working with other agencies and possibly others in integrated healthcare. Initial discussions to pilot this concept occurred with one FQHCs and one primary CMHC in our network. To date, both agencies have made themselves and their quality/integrated specialists within their agency available to assist other partners. This resource has not been taken advantage of as heavily as we may have hoped, but the two agencies are available for a consultative call or meeting if requested. This was just one idea to address the need for having someone available to work directly with our targeted Integrated Care practices, and build upon if it is viable. The second part to CHSN's solution has been to have the CHSN Executive Director available to facilitate with partners that these important conversations take place within their practices, not to guide, direct, or advise, but to coordinate that the conversations are occurring and to ensure documentation of their plans are captured. The third option, was to reach back out to UNH/CHI to see if they will reconsider contracting with CHSN-IDN5 to perform this role and unfortunately they have expressed their resources are at full capacity so this is no longer a viable option for us to consider.

Smartsheet detail and timeline is included as a graphic at the end of this section and included as **Attachment\_B1.2A**

To actively support continued protocol and workflow development, CHSN-IDN5 made a concerted effort in the fall 2018 to outreach to other IDN's to enhance our collaborative efforts towards the

standardization of integrated work throughout the state of New Hampshire. The process of integrating protocols statewide will support the mission of this project in implementing best practices across all settings to provide quality of care to all patients. This standardization will create increased efficiency of care to patients and providers resulting in more optimal project outcomes. The IDNs collaborative approach was critical in the development of CHSN-IDN5's protocol guidance that was successfully completed and shared with partners by year-end 2018.

As was reported in January 2019, CHSN-IDN5 developed its own B1 Partner Protocol Guidance Document (**Attachment\_B1.2B**). This document was shared with all partners in December 2018 and provides protocol guidance on the following outstanding topics: Secure Messaging – page 3, Closed Loop Referrals – page 4, Interactions Between Providers and Community Based Organizations – page 6, Shared Care Plan – page 7, Timely Communication – page 9, Privacy – page 10, Case Management Coordination – page 12, Safe Transitions from Institutional Settings Back to Primary Care, Behavioral Health and Social Service Providers – page 13, Intake Procedures – page 15, Adherence to NH Board of Medicine Guidelines on Opioid Use – page 17 and Joint Service and Communication Channels with Community Based Social Service Providers – page 19.

Implementation Activity/ Milestone	Responsible Party/ Organization	Time line	Progress Measure / Notes
<b>Planning phase</b>			
Identify / obtain Commitment from key organizational /provider participants	CHSN Executive Director; CHSN Board	By June 30, 2017	Milestone met
Organizational leaders sign-off	CHSN Executive Director; CHSN Board	By July 31, 2017	Milestone met
Complete Workforce plan to support integrated practice	Workforce Team Lead	By July 31, 2017	Milestone met
Complete Training plan to support integrated practice	CHSN Project Manager	By July 31, 2017	Milestone met
Complete HIT plan to support integrated practice	HIT Team Lead	By July 31, 2017	Milestone met
Complete Site Self-Assessments for updated information on level of integration	CHSN Executive Director; UNH/CHI	By Sept. 15, 2017	Milestone met; Ongoing; baseline SSAs performed in 2017; follow-up #1 SSA was performed in May 2018 with 21 partners; follow-up #2 SSA performed November 2018 with 22 partners and was shared with partners Jan 2019.
<b>Implementation Plan for Coordinated Care Practices</b>			
Complete DSRIP CSA Gap Analysis	CHSN Project Manager	By March 31, 2017	Milestone met
Confirm regional goals and timeline for Coordinated Care Practice development	CHSN Executive Director; B1 - Clinical Integration Committee	By October 31, 2017	Milestone met; Ongoing; participating practices identified; individualized plans and timelines are in place though practices are in varying stages of

Implementation Activity/ Milestone	Responsible Party/ Organization	Time line	Progress Measure / Notes
			progression towards coordination as is reflected in other tables identifying progress. Results from the most recent round 2 follow-up site self-assessments will assist us in gleaning more current information pertaining to progress made at the practice level.
Develop practice specific technical assistance and training plans	B1 - Clinical Integration Committee; Training Coordinator; Practice Transformation Specialist	By December 31, 2017	Milestone met; Ongoing; technical assistance needs are being met via CHSN Data Analyst and the B1 - Clinical Integration Committee which meets bi-monthly to address technical and data needs as they arise. Follow-up round 2 SSA completed in November; results scheduled for roll out to partners January 2019 (due to holidays in December). Trainings occur regularly and are ongoing with partner staff as needed.
Develop Comprehensive Core Standardized Assessment tools and preliminary procedures for inter-agency data collection to ensure capture of required domains	B1 - Clinical Integration Committee; Data Analyst	By December 31, 2017	Milestone met; CHSN Data Analyst has and continues to work with B1 partners to identify required domains and gaps in their existing processes. If gaps exist, plans are put into place to introduce a mechanism to capture missing domains.
Assess practice workflows and create plan for introduction / modification of assessment tools and shared care plan as appropriate to each practice	B1 - Clinical Integration Committee; HIT Team; Practice Transformation Specialist	By December 31, 2017	Milestone met; Ongoing; practice workflows reviewed and/or developed with B1 Tier 1 partners. E5 Enhanced Care coordinators have identified and developed assessment tools and have become more involved with utilization of shared care plans

Implementation Activity/ Milestone	Responsible Party/ Organization	Time line	Progress Measure / Notes
			since CMT is now available for all to use.
Implement Comprehensive Core Standardized Assessment process for aggregating information across multiple assessment domains and from multiple providers	B1 - Clinical Integration Committee; HIT Team; Practice Transformation Specialist; Data Analyst	Initiate by January 31, 2018	Milestone met; Ongoing; CHSN developed and provided CCSA tools and resources to all IDN partners at its full network meeting in February 2018. Additionally, for those who were capturing some but not all domains, the Data Analyst assisted them in determining how to incorporate the missing components within their existing practice. A more formal "CCSA Protocol" from the original guidance provided in February was created in December 2018 and shared with partners again.
Facilitate adoption of evidenced based screening & assessment tools / procedures including SBIRT, PHQ 2 & 9, and developmental / behavioral assessment	B1 - Clinical Integration Committee; Training Coordinator; Practice Transformation Specialist; Data Analyst	Initiate by December 31, 2017	Milestone Met; partners are utilizing these tools; B1 - Clinical Integration Committee has worked with those who were not in compliance to assist them by providing them with best practices and tools. Trainings on SBIRT and PHQ 2 & 9 also occurred.
Develop / identify core team meeting protocols and relevant workflows for communication among core teams and other patient providers, including case conferences	B1 - Clinical Integration Committee; Coordinated Care Team Leader; Practice Transformation Specialist; E5 CCC Team	Initiate by December 31, 2017	In process; Ongoing; Tier 1 B1 partners are all meeting this requirement. All Tier 2 partners are now holding core team/case conferences and have a formal schedule established. All LRGH practices utilize their ECC's to coordinate their core team bi-weekly meetings. Workflows were mapped for the Emergency rooms at LRGH/FRH and Spearc hospitals.

<b>Implementation Activity/ Milestone</b>	<b>Responsible Party/ Organization</b>	<b>Time line</b>	<b>Progress Measure / Notes</b>
Document roles and responsibilities for core team members and other members as needed	B1 - Clinical Integration Committee; Practice Transformation Specialist	Initiate by December 31, 2017	Milestone met; work has been completed by Enhanced Care Coordination Team
Specify / implement training plan for core team members and extended team as needed	B1 - Clinical Integration Committee; Training Coordinator	Initiate by December 31, 2017	Milestone met; E5 care coordinator training plan complete
Develop / identify mechanisms (e.g. patient registries) to track patients and adherence to evidence based care recommendations	B1 - Clinical Integration Committee; HIT Team; Practice Transformation Specialist	Initiate by January 31, 2018	In Process; Ongoing; all sites with CMT have access to the default reports which act as registries for target populations in need of care management.
Install Shared Care Plan to support inter and intra organizational communication and coordination of care	B1 - Clinical Integration Committee; HIT Team; Practice Transformation Specialist	Initiate September 2017	In Process; Ongoing; the larger sites within our IDN have adopted the technology necessary for shared care planning. However, the organizations without on-site IT are still in the planning/implementation phase. All sites are using CMT in collaboration with other organizations who also have it.
Map participating partner workflows, introduce / train on shared care plan use	B1 - Clinical Integration Committee; HIT Team; CMT	Initiate 1 <sup>st</sup> tier (B1) partners October 2017, all others February 2018	Milestone met; Ongoing; work began with help from Data Analyst and CMT staff to train partner agencies on shared care plans. A special training was held with just care coordinators on the CMT shared care plan module on 11/28/2018.
Implement Intake procedures to include consent to share information among providers	B1 - Clinical Integration Committee; HIT Team; CMT	Initiate October 2017; ongoing 2018	Milestone met; Ongoing; all partners have a procedure to collect patient consent to share among providers. Also, significant work has been done to encourage partners to utilize the "universal consent" documents developed by CHSN-IDN5. Their use varies among partners but for those utilizing them, their workflows are in place, training has

Implementation Activity/ Milestone	Responsible Party/ Organization	Time line	Progress Measure / Notes
			occurred with relevant staff and they have been well received by the patients. The added time saver and efficiencies have been noted by all parties involved to date.
Develop / modify referral protocols as needed to/from PCPs, BH providers, community care coordination teams, social service support providers, Hospitals, and EDs	B1 - Clinical Integration Committee; Enhanced Care Coordination Team	Initiate by January 31, 2018	Milestone Met; CHSN-IDN5 developed all required B1 protocols in December 2018 and shared with B1 partners to assist and direct them in their work. Additionally, this "Protocol Guidance" document is on the agenda for review and discussion with B1 partners at the January 17, 2019 B1 meeting to offer any clarification if needed.
Develop / modify protocols as needed to ensure safe, supported care transitions from institutional settings to primary care, behavioral health, social support service providers and family / friend caregivers as appropriate	Enhanced Care Coordination Team; Community Re-entry team	Initiate by January 31, 2018	Milestone Met; CHSN-IDN5 developed all required B1 protocols in December 2018 and shared with B1 partners to assist and direct them in their work. The "Protocol Guidance" document was reviewed with B1 partners at the January 17, 2019 B1 meeting to offer any clarification if needed.
Implement workforce plan to recruit and retain multi-disciplinary care team members	CHSN Executive Director; CHSN member agencies	Initiate by January 31, 2018; ongoing	Milestone met; Ongoing; CHSN's Workforce plan to recruit and retain MDCT has been aided by the implementation of the CHSN Employee Retention Incentive Plan (ERIP). The first payment to partners was in August 2018 and a second was made in February 2019. These funds have assisted partners greatly in recruiting needed staff and retaining critical positions by having additional funding to

Implementation Activity/ Milestone	Responsible Party/ Organization	Time line	Progress Measure / Notes
			work with keeping them satisfied in their roles.
Provide consultation on selection / use of certified EHR and related technology to support integrated care	HIT Team; Practice Transformation Specialist	Initiate by January 31, 2018; ongoing	Milestone Met; Ongoing; Data Analyst works closely with all partners and is aware of activities within the ASquam group (data provider for the 3 hospitals) to ensure updates are occurring within their EHR as it pertains to CCSA domain requirements.
<b>Implementation Plan for Integrated Care Practice</b>			
Confirm regional goals and timeline for Integrated Practice development	CHSN Executive Director; B1 - Clinical Integration Committee	By September 30, 2017	Milestone met; Ongoing; participating practices identified; individualized plans and timelines are in place though practices are in varying stages of progression towards integration as is reflected in other tables identifying progress. Results from the round 2 follow-up site self-assessments have assisted us in gleaning most recent information pertaining to progress made at the practice level.
Assess opportunities and challenges for Integration of Medication-assisted treatment (MAT) in CHSN-IDN5 primary care and BH practice settings	B1 - Clinical Integration Committee	By December 31, 2017	Milestone Met; Ongoing; practices identified and several new opportunities have allowed for added growth in the number of practices regionally who are offering MAT at the primary care or BH practice settings. Spere hospital has begun offering MAT within their ED.
Facilitate training / technical assistance as needed for integration of MAT practice within CHSN-IDN5 practices moving to Integrated Care Practice level	B1 - Clinical Integration Committee; Training Coordinator	Initiate by January 31, 2018	In Process; Ongoing; HealthFirst and MidState offer their own training on integrating MAT within practices. CHSN seeks out and shares information to partners on related trainings as

Implementation Activity/ Milestone	Responsible Party/ Organization	Time line	Progress Measure / Notes
			they arise (i.e. CHI is offering a MAT prescribers in NH-based Project ECHO and is enrolling MAT prescribers and their teams in the upcoming PACT-MAT Project ECHO® which begins spring 2019).
Assess opportunities and challenges for adoption of evidence-based treatment of mild-to-moderate depression within CHSN-IDN5 practices moving to Integrated Care Practice level	B1 - Clinical Integration Committee; Practice Transformation Specialist	Initiate by January 31, 2018	Milestone Met; Ongoing; CHSN has addressed this with partners already and awareness/ education has occurred. NHADACA offered a training on the topic and additional SBIRT trainings are scheduled for March 2019 (there have been numerous opportunities in the region from other sources for SBIRT trainings). All relevant training opportunities are shared with not just Integrated Care practices but all B1 partners.
Facilitate training / technical assistance as needed for adoption of evidence-based treatment of mild-to-moderate depression within CHSN-IDN5 practices moving to Integrated Care Practice level	B1 - Clinical Integration Committee; Training Coordinator	Initiate by January 31, 2018	Ongoing; as stated above, CHSN coordinated a training for partners through its contract with NHADACA.
Provide consultation on enhanced use of HIT to support integrated care including use of the technology for identifying at risk patients, to plan care, to monitor/manage patient progress toward goals and ensure closed loop referrals.	B1 - Clinical Integration Committee; HIT Team; Practice Transformation Specialist	Initiate by January 31, 2018	Milestone met; Ongoing; HIT consultation by CHSN's data analyst has been given and made available to all partners. Multiple partners have upgraded HIT systems to capture social determinants of health and confirm when referrals are closed. All sites with PreManage Primary implemented have access to reports which identify at-risk patients. Data analyst has consulted multiple

Implementation Activity/ Milestone	Responsible Party/ Organization	Time line	Progress Measure / Notes
			times with care coordinators to improve workflows and data collection that will identify the most common needs of our vulnerable population.
Develop or modify as needed workflows, joint service protocols and communication channels with community based social support service providers	B1 - Clinical Integration Committee; Enhanced Care Coordination Team	Initiate by January 31, 2018	Milestone Met; CHSN-IDN5 developed all required B1 protocols in December 2018 and shared with B1 partners to assist and direct them in their work. Additionally, this "Protocol Guidance" document was reviewed and discussed with B1 partners at the January 17, 2019 B1 meeting to offer any clarification if needed.
Periodically assess designated practices for progress along the SAMHSA Integrated Care continuum	CHSN Executive Director; Practice Transformation Specialist	By June 30, 2018 and then semi-annually	Milestone met; Ongoing; CHSN periodically assesses practice designation via the UNH/CHI site self-assessment surveys. To date, a baseline and 2 follow-up surveys have occurred with partners and results have been reviewed with them. Both CHSN Data Analyst and Executive Director will have increased communication and activities with practices who are delinquent in certain areas and thus did not obtain either coordinated or integrated designation by Dec. 31 2018. A plan of action is in place to bring all practices up to Coordinated/Integrated designation by mid-September 2019.
Monitor and report measures of integrated practice outcomes as defined in the DSRIP measures	CHSN Executive Director; Data Analyst	Initiate by January 31, 2018	Ongoing; some sites have increased the rate of reporting to MAeHC. This, in addition to the

Implementation Activity/ Milestone	Responsible Party/ Organization	Time line	Progress Measure / Notes
			monthly statistics processing that MAeHC has begun, has helped the IDN begin to develop protocols and workflows for data validation prior to the end of the reporting period.

**Evaluation Plan**

CHSN-IDN relies heavily on its Data Analyst, [REDACTED] and HIT Project Lead, [REDACTED]. They guide the network in aligning data collection and reporting capabilities to match the comprehensive set of state specified outcome measures, as well as other network-defined measures of integration process and system development outcomes. The latter measures are necessary to inform network partners on progress toward coordinated and integrated practice designations and to facilitate modification and adaptation of project activities as needed. Process evaluation of the B1 - Integrated Healthcare efforts will entail documenting the presence or occurrence of core characteristics of integrated healthcare. Custom measures may be added as identified by the B1 – Clinical Integration Committee in conjunction with the Data Analytics team. Data systems and procedures to support integration-related evaluation measures of this community project will be established in conjunction with the CHSN Health Information Technology (HIT) work group and the E5 Enhanced Care Coordination community project.

The primary evaluation activity in this area will be to periodically compare progress across the network against the baseline, follow-up round 1 and follow-up round 2 site self-assessment surveys. In addition to measuring practice/organization/system attributes related to integration, an essential element of monitoring outcomes will be looking at patient, provider and community engagement to assess perspectives on what is working and what is not. Procedures for ongoing assessment and engagement are included in the state level evaluation process through the Consumer Assessment of Healthcare Providers & Systems survey process. CHSN-IDN5 also began utilizing a program evaluation tool in Q4 2018 within two of the three community-driven projects (C2 and D3). These satisfaction/evaluation tools were developed earlier in 2018 and included in the July 2018 SAR, but workgroups had not identified/clarified workflows surrounding their use until later in the year. Each project is using a similar survey in that a few common questions are included with the addition of a few project specific questions.

A CHSN network partner evaluation was administered in June 2019 via Survey Monkey and was shared with our 31 partner agencies. This was combined with a survey question asking how partners are utilizing their employee retention incentive funds to retain/recruit employees. The annual survey of partners helps CHSN gauge partners’ feelings surrounding CHSN operations and the benefits of participation within the IDN. Ongoing participation in community advisory groups is a mechanism being used to gathering patient and community feedback on an ongoing basis.

CHSN Executive Director serves on Navigating Recovery’s advisory committee that began in July 2018. CHSN-IDN5 continues to support participating organizations that do not currently have resources for periodic assessment of their own patient, family and provider experiences and satisfaction to implement simple procedures for collecting and analyzing this information. In December 2018, the CHSN board passed a motion giving the CHSN Executive Director the authority to negotiate data-related expenses (up to \$5,000) to assist partners’ with data requirements specific to the DSRIP waiver. This provision will only reinforce relations between partners and the IDN. An important aspect of outcome monitoring over time

will be the need to understand the impact of integrated work on cost of care and associated value of the work to inform alternative payment models.

Beginning with the December 31, 2018 reporting period, all results for the table below are being derived from a new survey that uses language directly from the evaluation measure to ascertain a yes/no answer. The survey is designed with freeform responses since the questions have complicated answers in some cases. In addition, the survey target has changed from all partner organizations to organizations with integrated/coordinated practice designations. As a result of this change, some measures have decreased as a result of a lower denominator and/or exclusion of organizations we previously included.

<b>Evaluation Measure</b>	<b>Source</b>	<b>Frequency of Collection / Reporting</b>	<b>Results / Notes</b>
<b>Developmental Measures</b>			
Percent of practices (or agencies) adopting a common protocol for release of patient / client information	Care Coordination Team conference records	Monitor quarterly; report semi-annually	Milestone Met; 100% of coordinated and integrated practices
Percent of practices that can communicate through secure email	Practice assessment	Monitor quarterly; report semi-annually	Milestone Met; 100% of coordinated and integrated practices
Percent of practices that can send and receive electronic referrals	Practice assessment	Monitor quarterly; report semi-annually	In Process; 57% of coordinated and integrated practices.
Percent of practices adopting standardized assessment tools and procedures	Practice assessment	Monitor quarterly; report semi-annually	Milestone Met; 100% of coordinated and integrated practices
Percent of practices with EHRs; with EHRs that include evidence-based guideline prompts	Practice assessment	Monitor quarterly; report semi-annually	Milestone Met; 100% of coordinated and integrated practices
Percent of practices adopting use of a common Shared Care Plan	Practice assessment	Monitor quarterly; report semi-annually	In Process; 71% of coordinated and integrated practices
Percent of practices/providers reporting adequate time and resources for care coordination	Practice assessment	Monitor quarterly; report semi-annually	In Process; 71% of coordinated and integrated practices
Percent of practices/providers with multidisciplinary teams and case conferences for complex or high risk patients	Practice assessment	Monitor quarterly; report semi-annually	Milestone Met; 100% of coordinated and integrated practices
Percent of practices using patient registries to track complex or high risk patients; to track referrals to and from community service and support agencies	Practice assessment	Monitor quarterly; report semi-annually	In Process; 42% of coordinated and integrated practices
Percent of practices with sufficient access to specialist consultation	Practice assessment	Monitor quarterly; report semi-annually	In Process; 86% of coordinated and integrated practices. Some organizations reported sufficient

Evaluation Measure	Source	Frequency of Collection / Reporting	Results / Notes
			access but could benefit from greater access
Percent of practices with co-location of primary care, mental health staff and / or substance use treatment (including the various possible permutations of co-location)	Practice assessment	Monitor quarterly; report semi-annually	In Process; 71% of coordinated and integrated practices. One of our organizations has made co-location available at the county jail but not at their own location.
Percent of practices with information strategies and materials to engage patients as participants in integrated care practice	Practice assessment	Monitor quarterly; report semi-annually	In Process; 86% of coordinated and integrated practices meet this goal with one of our practices currently developing the materials.
<b>Outcome Measures</b>			
*Readmission to Hospital for Any Cause (Excluding Maternity, Cancer, Rehab) at 30 days for the Adult (18+) behavioral health population	Medicaid Claims	Monitor quarterly effective 2018; report semi-annually	Pending; As soon as our CMT portal is complete, we should be able to report this measure in real-time.
*Comprehensive and consistent use of standardized core assessment framework including screening for substance use and depression for age 12+ by IDN providers	EHR aggregate reports	Monitor quarterly effective 2018; report semi-annually	In Process; LRGH is piloting their CCSA in the ED to begin with. Only two other partners are not using the CCSA at present and one of these partners mainly gets referrals from other partners who have already performed the CCSA.
*Potentially Preventable ER Visits for the BH Population and Total Population	Medicaid Claims	Monitor quarterly effective 2018; report semi-annually	Pending; waiting on report out from DHHS on this measure
*Initiation of Alcohol and Other Drug Dependence Treatment (1 visit within 14 days)	EHR aggregate reports	Monitor quarterly effective 2018; report semi-annually	Pending; we are currently able to report this measure for our C project but not across the entire IDN

### B1-3. IDN Integrated Healthcare: Evaluation Project Targets

Below are the established targets that are inclusive of all primary care and behavioral health practices. In order to achieve the greatest impact, we anticipate placing the greatest emphasis for system improvement efforts on those organizations with the greatest number of Medicaid clients.

Performance Measure Name	Target	Progress Toward Target			As of 6/30/19
		As of 12/31/17	As of 6/30/18	As of 12/31/18	
Number of primary care and BH practices with all characteristics of a Coordinated Care Practice	14	10	4	4	14
Number of primary care and BH practices with all characteristics of an Integrated Care Practice	6	3	4	4	6
*Comprehensive and consistent use of standardized core assessment framework including screening for substance use and depression for age 12+ by IDN providers	23	In Process; Tier 1 partners CSA tools were collected and reviewed to identify gaps in their CSA process. Additional work with other partners to occur February 2018.	In Process; several partners are performing upgrades to their EMR systems in order to capture this data.	In Process; LRGH is piloting their CCSA in the ED to begin with. Only two partners (Speare and Horizons) are not using the CCSA at present and one of these is an SUD provider which mainly receives referrals from other partners who have already performed the CCSA.	<b>Milestone Met; As of 9/30/2019 all coordinated and integrated practices are utilizing a CCSA.</b>
Referral rate for care coordination clients presenting with behavioral health needs	75%			Milestone Not Met; 74.36%	Milestone Met; 75.91%
Referral rate for care coordination clients presenting with substance use disorder	75%			Milestone Met; 88%	Milestone Met; 95.1%

## B1-4. IDN Integrated Healthcare: Workforce Staffing

CHSN-IDN5 began hiring for key positions to support its community project needs immediately upon receiving Implementation Plan approval. All positions but one have been hired thus far. Specifics are reflected within each community-driven section respectively. In brief, the C2-Community Re-Entry project projected the need for 7.5 positions to support the project and all positions are currently filled. The D3-Expansion of Intensive SUD Treatment Options project projected the need for 9.2 positions to support the project and have onboarded 8.2 to date. The E5-Enhanced Care Coordination project projected the need for 9.4 positions to support the project and have hired 9.4. Thus, to date, 96% of all identified staff have been hired to perform the functions of the community-driven projects. The one vacancy in the D3 project is due to difficulty hiring an MLADC for the expansion of our IOP program into the Plymouth. Expanded detail on the hiring/recruiting efforts can be found in section A1-5.

To support the integrated healthcare development activities CHSN had to pivot from its original plan of hiring a Practice Transformation Specialist that would have provided consultation to practices for performance improvement in the areas of patient visit design, workflows, efficient screening and assessment procedures, and EHR use for reporting and quality improvement. Unfortunately, the expertise in the state is limited and those who are trained in this work are at full capacity. CHSN-IDN5 has since filled this void through a couple of ways. We identified a couple of champions within our two FQHC's and one or our CMHC's and with their knowledge of integration they have offered to share their expertise with other partners. In addition, both the CHSN Executive Director and CHSN Data Analyst have made themselves available to facilitate practice meetings and capture progress/plans to identify improvement targets towards integration. Though we all would have preferred having regional consultative expertise available to practices, we have not had that luxury and have made due with our minimal resources.

CHSN staff related to integration activities remains the same with a full time Executive Director, full time Project Manager, part time Administrative Assistant and full time Data Analyst. These positions are listed in other areas of the semi-annual report. Staff at the organizational / practice level to support integrated health care are captured in Section A-1, Workforce Development and are also not duplicated here.

Provider Type	IDN Workforce (FTEs)					Staffing on 6/30/19
	Projected Total Need	Baseline Staffing on 6/30/17	Staffing on 12/31/17	Staffing on 6/30/18	Staffing on 12/31/18	
CHSN Executive Director, Project Manager, Administrative Asst.	1	1	1	1	1	1
Project Manager	1	1	1	1	1	1
Data Analyst	1	0	0	1	1	1
Administrative Assistant	.5	.5	.5	.5	.5	.5

## B1-5. IDN Integrated Healthcare: Budget

When CHSN categorized its budget, it recognized many expenses will ultimately support Integrated Healthcare and could have easily been captured and accounted for in the B1 Integrated Healthcare project, however we elected to capture costs in the actual project they are most closely related to, thus

making it appear that there are very few expenditures within the B1 project. Expenses projected in the Implementation Plan are shown below and actual expenditures within the reporting period can be found in the “Jan – June 2019 Actual Cost” column below. This period there was \$ ██████ expended to all CHSN Board member agencies in form of an annual Board stipend of \$ ██████ each which assists with expenses related to both the board member and their staff’s time and resources spent at CHSN meetings and on various CHSN project activities.

Funds were budgeted to support Integrated Healthcare which included a stipend for a clinical director, consulting psychiatrist and the UNH/CHI contract to perform baseline/follow-up site self-assessments of partners’ integration. These are budgeted expenses to support existing individuals or contracts, not to be confused with intended new hires for the projects. Although the CHSN Board decided to remove the need to hire a Practice Transformation Specialist from our plan in 2018, they opted to keep the funds set aside to utilize to contract for/or outsource this resource at a later date if necessary. Since that time, the function/tasks of this position have been absorbed by the CHSN Executive Director and Data Analyst wherever possible. Significant investments in Integrated Healthcare are reflected in other sections of the Implementation Plan including workforce recruitment and retention, training contracts, HIT infrastructure and staffing of community projects. These budgeted expenditures are not duplicated below.

Budget Item	Item Description	2017 Actual Costs	Jan – Jun 2018 Actual Cost	July –Dec 2018 Actual Cost	Jan – June 2019 Actual Cost	Total Projected Cost of Program
Clinical Director Stipend	Stipend for Director (MD) of the Clinical Integration Team					
Consulting Psychiatrist	Psychiatrist stipend for support of B1 multi-disciplinary care team					
Practice Transformation Specialist consultative services	funding to provide consultation to practices to facilitate integrated care development					
Technical Assistance	Contract with UNH for BH Integration Site Self-Assessment Survey					



this initial introduction, there has been significant work done by several partners and CHSN staff to improve, update or introduce questions or mechanisms for collecting comprehensive CCSA's. At each of the B1 Integrated Healthcare meetings, components of the CCSA are reviewed and there is a constant reminder of the requirements for its implementation in practices by December 2018. Several partners have adjusted their intake documents or updated their EMRs with additional fields to accommodate the various social determinants of health if they were not already being addressed or captured elsewhere during the intake process. Although guidance on this topic had already been provided to partners much earlier in 2018, it had not been formalized into a protocol. The Comprehensive Core Standardized Assessment Protocol can be found as **Attachment\_B1.8A**.

**CHSN-IDN5 is pleased to report that the nine outstanding LRGH and Speare practices that had yet to formally utilize a CCSA for their Medicaid patients began doing so in late September. The new CCSA process is now being performed on the Medicaid population ages 12 years and older and may be extended to the general population after a 3-month trial period to determine the realities of time/capacity required of practitioners to perform the CCSA and also to make referrals when needed. A tremendous amount of work was done by CHSN-IDN5 staff to get all relevant players from both hospital's clinical teams, as well as necessary IT staff to make this to happen. The team meetings entailed conversations about workflows and processes for handling referrals upon a positive screen, and the development and agreement of the questions/language to be used in both the adult and pediatric CCSAs. Both hospitals utilize the same EMR and their IT collaborative group ASquam began the build in Cerner during the month of August. The new CCSA form and workflow in Cerner was demoed to all parties on September 3<sup>rd</sup>. After going through a brief change control period, it was finalized and went live for providers to begin utilizing on September 30<sup>th</sup>.**

CCSA Domain	Belknap Family Health - Meredith	Belknap Family Health - Belmont	Lakes Region Family Practice	Hillside Family Medicine	Westside Healthcare	Laconia Clinic
Demographic Information						
Physical Health Review						
Substance Use Review						
Housing Assessment						
Family and Support Services						
Educational Attainment						
Employment or Entitlement						
Access to Legal Services						
Suicide Risk Assessment						
Functional Status Assessment						
Universal Screening for Depression						
Universal Screening for SBIRT						
Developmental Screening for Pediatrics						

	Domain already captured
	Domain not yet captured
	Domain doesn't apply

CCSA Domain	Speare Primary Care	Plymouth Pediatrics	HealthFirst	Mid-State	Lakes Region MHC	Horizons Counseling	Riverbend
Demographic Information							
Physical Health Review							
Substance Use Review							
Housing Assessment							
Family and Support Services							
Educational Attainment							
Employment or Entitlement							
Access to Legal Services							
Suicide Risk Assessment							
Functional Status Assessment							
Universal Screening for Depression							
Universal Screening for SBIRT							
Developmental Screening for Pediatrics							

**B1-8b - Multi-disciplinary core team members:** CHSN-IDN5 has been working closely with its 14 coordinated and/or integrated care designated practices for the past two years and all practices have now identified their multi-disciplinary core team members. Any changes to our B1 practices' MDCT members

were updated and are reflected in the table below for this reporting period. An ongoing workforce struggle in our region significantly affects the psychiatry field in that many of our B1 partners refer out to a consultant psychiatrist and/or are utilizing a psychiatric nurse practitioner. **For the B1 practices who do not have a psychiatrist on staff a protocol in place with two area psychiatrists for consultative purposes as needed to ensure proper patient care.** Although remote, the consulting psychiatrist remains in contact with the referring practice or MDCT and provides his feedback/patient recommendations via phone or electronic messaging. Having recognized the lack of available psychiatrists in our region, CHSN-IDN5 built funding into its B1 budget to encourage that psychiatric consultation be available to our practices' multi-disciplinary core teams and to assist B1 partners for these consultative fees should it be a hardship for them to pay for them. The MDCT teams have been meeting routinely for some time. The process in place is that although a psychiatrist may not be present at a MDCT meeting, that a consultative psychiatrist is contacted to review the notes should the team deem that psychiatric review is necessary. Upon review of the patient notes, the consulting psychiatrist is responsible for responding to the team lead with their assessment/review of the patient to inform patient care to close the loop. In the table below, those who have a psychiatrist on staff are listed. Those who consult out to meet the need for psychiatric evaluation or review primarily utilize LRMHC's [REDACTED] or Riverbend's [REDACTED] (unless otherwise noted). In addition to the consultant psychiatrist being available to teams, CHSN-IDN5 is also exploring tele-psych as a viable option to assist with the region's additional psychiatric consultation needs and workforce shortage of this clinical profession.

<b>Providers identified to make progress toward Coordinated Care Practice designation (Includes Integrated Care Practices also)</b>	<b>Names of individuals and title within each provider practice by core team</b> Include PCPs, BH providers (including a psychiatrist), assigned care managers, care coordinators or community health workers and others  <b>Progress Made through 12/31/17</b>	<b>Progress Made through 6/30/18</b>	<b>Progress Made through 12/31/18</b>	<b>Progress Made through 6/30/19</b>
HealthFirst Family Care Center	<b>Laconia Office</b> [REDACTED] [REDACTED] [REDACTED] [REDACTED] [REDACTED] [REDACTED] [REDACTED] [REDACTED] [REDACTED] [REDACTED]	This practice has had no turnover in staff since last reporting period and information remains the same as 12/31/17.	<b>Laconia site:</b> [REDACTED] [REDACTED] [REDACTED] [REDACTED] [REDACTED] [REDACTED] [REDACTED] [REDACTED] [REDACTED] [REDACTED]	<b>Laconia site:</b> [REDACTED] [REDACTED] [REDACTED] [REDACTED] [REDACTED] [REDACTED] [REDACTED] [REDACTED] [REDACTED] [REDACTED]





	<p>[REDACTED]</p>	<p>[REDACTED]</p>	<p>[REDACTED]</p>	<p>[REDACTED]</p>
<p>Lakes Region Mental Health Center</p>	<p>[REDACTED]</p>	<p>This practice has had no turnover in staff since last reporting period and information remains the same as 12/31/17.</p>	<p>[REDACTED]</p> <p>The practice maintains 5 multidisciplinary teams for adults in long term care (including ACT) :  Membership at a minimum is as follows:</p> <ul style="list-style-type: none"> <li>(1) Psychiatrist or Psychiatric Nurse Practitioner</li> <li>(1) Master’s level Clinical Coordinator</li> <li>(2) RN –representing medical /physical health</li> </ul>	<p>[REDACTED]</p> <p><b>Other prescribing providers serving on the 5 MDCTs (see 12/31/18 column) include:</b></p> <p>[REDACTED]</p>

			<p>(1 ) In-Shape clinician</p> <p>(1) Supported Employment Specialist</p> <p>(1) Peer Support Specialist</p> <p>Case managers, Therapists, Community care clinicians</p> <p>ONE HEALTH, our primary care practice team, meets weekly and includes the specialty care team including the PCP, integrated care manager, integrated care nurse, medical assistant, nurse manager and will engage the MD or APRN as needed as they serve patients across our five teams</p> <p>Adult Outpatient team for short term care: Membership includes;</p> <p>(1) Psychiatric Nurse Practitioner</p> <p>(1) Master’s level Clinical Coordinator</p> <p>Therapists</p> <p>Children’s Service has 2 multidisciplinary teams</p> <p>(1) Child Psychiatrist / Psychiatric Nurse Practitioner</p> <p>(1) Master’s Level Clinical Director</p> <p>(1) Master’s Level Clinical Coordinator</p> <p>Therapists, Case managers, Community care clinicians</p>	
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		<p>addressed the need for coordinated care practices to have a formal case conference schedule with multi-disciplinary teams and will work with Speare to meet this requirement.</p>	<p>██████████ is the Patient Care Coordinator who orchestrates the collaboration between the patient and the provider(s) as well as care coordination beyond the practice's ability.</p> <p>██████████ is the E5 (.5 FTE) Community Care Coordinator for Speare Primary Care who is responsible for the collaboration between the ED and the Patient Care Coordinator.</p>	<p>██████████ ██████████ ██████████</p>
<p>Plymouth Pediatric and Adolescent Medicine</p>	<p>Pending</p>	<p>Similarly, Speare's Plymouth Pediatrics &amp; Adolescent Medicine does not hold formal case conferences on patients with BH or chronic health conditions. Practitioners do so as needed. All significant BH issues are referred to LRMHC.</p> <p>CHSN Executive Director has addressed the need for coordinated care practices to have a formal case conference schedule with multi-disciplinary teams and will work with Speare to meet this requirement.</p>	<p>The Care Team at PPAM includes:</p> <p>██████████ ██████████ ██████████ ██████████ ██████████ ██████████ ██████████ ██████████ ██████████ ██████████ ██████████</p>	<p>██████████ ██████████ ██████████ ██████████ ██████████ ██████████ ██████████ ██████████ ██████████ ██████████ ██████████ ██████████</p>

<p>LRGH / Westside Healthcare</p>	<p>Pending</p>	<p>[REDACTED]</p>	<p><b>Westside Healthcare:</b></p> <p>[REDACTED]</p>	<p>[REDACTED]</p>
<p>Belknap Family Health – Meredith</p>	<p>Pending</p>	<p>[REDACTED]</p>	<p><b>Belknap Family – Meredith:</b></p> <p>[REDACTED]</p>	<p>[REDACTED]</p>

Belknap Family Health – Belmont	Pending		<b>Belmont Family Health</b>	
Hillside Family Medicine	Pending		<b>Hillside Family Medicine</b>	
Lakes Region Family Practice	Pending	Pending	<b>Lakes Region Family Practice</b>	
LRGH / Caring for Kids	Pending	Pending	<b>Caring for Kids</b>	



## ATTESTATION OF TRAINING COMPLETION on hypertension, diabetes and hyperlipidemia

**Mid-State Health Center** attests that the prescribing providers below who serve on our multi-disciplinary core team (MDCT) have received appropriate education and training on **hypertension, diabetes and hyperlipidemia** as required by the NH Medicaid 1115 DSRIP waiver Special Terms & Conditions (STCs).

Please initial or check the respective box below if training has been received. Leave blank if training has not occurred or is unknown. If a name listed below is no longer on the MDCT, please cross through their name and add any new names of MDCT members if not listed below.

Name of MDCT member	hypertension	diabetes	hyperlipidemia
[REDACTED]			
[REDACTED]			
[REDACTED]			

To assist those that are still in need of training in these areas, CHSN-IDN 5 will provide links to recorded trainings for individual's to review at their convenience that will serve as meeting the training requirement for these subject areas. **All trainings must occur and be on file with CHSN-IDN5 no later than August 31, 2019.**

\_\_\_\_\_  
**Authorized Signature / Title**

\_\_\_\_\_  
**Date**

Please email this completed attestation to [REDACTED] If you have any questions, please contact [REDACTED] CHSN Executive Director at [REDACTED].

**B1-8d – Non-direct care staff training:** Also identified within the CHSN-IDN5 Master Training Matrix are trainings for non-direct care staff on topics such as knowledge and beliefs about behavioral health disorders and mental health first aid. CHSN supported the Statewide BH Workforce activities by assisting Riverbend Community Mental Health to coordinate a Mental Health First Aid train-the-trainer course in April 2018 which helped to increase the pool of trainers in the state. CHSN also contracted with NHADACA to host a Mental Health first aid course which was held in November 2018. Numerous topics surrounding BH and SUD were also offered via the CHSN-IDN5 training contract with NHADACA that has been referenced several times within this document already. As previously stated within the A1 Workforce section, the CHSN-IDN5 Training Tracker captures the practice name, individual and their title that attended any training captured to date. (**Attachment\_A1.4A**). There was a huge emphasis on training non-direct care staff during this reporting period. Pulling information directly from the Master Training Tracker which is attached, below is just an excerpt of some of the trainings that non-direct care staff housed at our B1 partner practices attended on topics to enhance their knowledge and understanding about mental health and substance use disorders and increased their competencies surrounding the recognition and management of these conditions.

Cultural Competencies & Boundaries	25
Intervention Strategies and Skills for Helping Professionals	14

Effective Communication Skills	11
Cultural Considerations for Increasing Positive Outcomes	1
Ethical Communications	7
Confidentiality and Ethical Practice	2
How to Talk About SUD	1
Opioid Addiction & Treatment: Understanding the disorder, treatment and protocol	21
Motivational Interviewing Basics	5
Introduction to Motivational Interviewing	25
Motivational Interviewing	12
Intermediate Motivational Interviewing	12
Mental Health First Aid	11
SBIRT	27
Transitions thru Collaboration	1
DSRIP 101	54+

**B1-8e - Core team case conferences:** Tracking for each B1 practices' core team case conferences has been reported previously and nearly all partners successfully reported that their multi-disciplinary core teams meet for inter-agency care coordination and case management on a routine basis. Nearly all practices had met this requirement in December 2018, however we had two practices (Speare Primary Care and Speare Pediatric and Adolescent Medicine) that, although they reported that their practitioners/care teams discuss BH or chronic patients when needed, they had not formalized a schedule at time of last reporting. CHSN-IDN5 staff educated and continued to emphasize the requirement for a coordinated or integrated practice to formalize a core team schedule and the two remaining practices now have a routine case conference schedule which is documented in the table below. The LRGH practices workflow is such that their embedded care coordinators hold a bi-weekly case conference between themselves (ECC's), Ambulatory Pharmacist and Ambulatory social worker (at minimum) every other Tuesday from 11am-12pm. Demonstrated in the table below, you will find an up to date meeting schedule for all CHSN-IDN5 partners.

<p><b>Providers identified to make progress toward Coordinated Care Practice designation (Includes Integrated Care Practices also)</b></p>	<p>List the monthly (or more frequent) core team case conferences <b>schedule</b> on behalf of patients with significant BH or chronic conditions.</p> <p><b>Progress Made through 12/31/17</b></p>	<p><b>Progress Made through 6/30/18</b></p>	<p><b>Progress Made through 12/31/18</b></p>	<p><b>Progress Made through 6/30/19</b></p>
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<p>HealthFirst Family Care Center</p>	<p><b>Laconia Office</b> Second and fourth Monday of the month, 8:00-9:00AM Cross agency care coordinators team meeting with Franklin TBD <b>Franklin Office</b> Second and fourth Monday of the month; 8:00-9:00AM</p>	<p>All information remains the same</p>	<p>Twice Monthly on the 2<sup>nd</sup> and 4<sup>th</sup> Monday, 8:00-9:00 am to review status of current cases, high risk cases, referrals, processes and to discuss care plans Also live in real time, warm handoffs of clients from PCP, TP or Behavioral Health or joint visits with clients</p>	<p>Twice Monthly on the 2<sup>nd</sup> and 4<sup>th</sup> Monday, 8:00-9:00 am to review status of current cases, high risk cases, referrals, processes and to discuss care plans Also live in real time, warm handoffs of clients from PCP, TP or Behavioral Health or joint visits with clients</p>
<p>Mid-State Health Center</p>	<p>Care Transitions Team meetings; Meets weekly via conference call to coordinate care for Mid-State patients transitioning from Speare Memorial Hospital  Recovery Team meetings; Weekly, Tuesdays 4:00-5:00PM  Interdisciplinary hall team meetings; Each hall will meet monthly 11:30-1:30pm. (First meeting will be completed on March 15<sup>th</sup>).</p>	<p>Care Transitions Team meetings have ceased.  Recovery Team meetings continue as reported.  Interdisciplinary hall team meetings are held routinely since March 2018 from 11:30-1:30pm once a month. Process on hold for July/August due to an identified need to revamp the process.</p>	<p><b>Recovery Team Meetings</b> (providing MAT Program Services) meetings weekly on Tuesdays, 4:00 PM to review the status of incoming and current high risk cases as well as discuss program successes and challenges. <b>Care Transitions Team Meetings</b> - Mid-State's Care Coordinator and Speare Memorial Hospital's Care Coordinator meet by phone, each morning, Monday – Friday to discuss Emergency Dept. transitions of care between the ED and Mid-State. <b>Primary Care Team Meetings</b> – Mid-State's primary care teams meet each morning – “huddle” to review the schedule for day – meeting includes PCP, MA, and Hall Resource RN. Patients are funneled to BH providers, patient support specialists, recovery</p>	<p><b>Recovery Team Meetings</b> (providing MAT Program Services) meetings weekly on Tuesdays, 4:00 PM to review the status of incoming and current high risk cases as well as discuss program successes and challenges. <b>Care Transitions Team Meetings</b> - Mid-State's Care Coordinator and Speare Memorial Hospital's Care Coordinator meet by phone, each morning, Monday – Friday to discuss Emergency Dept. transitions of care between the ED and Mid-State. <b>Primary Care Team Meetings</b> – Mid-State's primary care teams meet each morning – “huddle” to review the schedule for day – meeting includes PCP, MA, and Hall Resource RN. Patients are funneled to BH providers, patient support specialists, recovery team members as needs are identified</p>

			team members as needs are identified (all support services are co-located to address patient needs at the time of visit).	(all support services are co-located to address patient needs at the time of visit).
Horizons Counseling Center	<p>IOP team meetings; Weekly, Mondays 1:00 -3:00PM</p> <p>IOP team meeting with MD; Weekly, Tuesdays 10:00-11AM</p> <p>All staff team meetings; Weekly, Mondays 12-1:30PM</p> <p>Care coordination meeting with Recovery Clinic; Bi-monthly, Wednesdays 10:00-11:30AM</p>	All information remains the same	<p>Weekly case conferences including all outpatient clinical staff Mondays 12PM-1PM.</p> <p>Weekly case conferences including all IOP clinical staff, recovery support workers and imbedded recovery coaches from Navigating Recovery Mondays 1PM-3:30PM.</p> <p>Criminal justice re-entry team also including the Programs Director BCDOC, ██████ ██████ MA, the treatment providers (2 SUD counselor, 1 co-occurring counselor), 2 Community Corrections Officers (1 working toward LADC), Captain and Sergeant, Care Coordinator from Horizons and case manager from LRMHC – Fridays 2PM-4PM.</p> <p>Care coordination team IOP including ██████ ██████ ██████ and LADCs, MLADCs / counseling staff as needed for clients being discussed – Tuesdays 10am-11am.</p>	<p>Weekly case conferences including all outpatient clinical staff Mondays 12PM-1PM.</p> <p>Weekly case conferences including all IOP clinical staff, recovery support workers and embedded recovery coaches from Navigating Recovery Mondays 1PM-3:30PM.</p> <p>Criminal justice re-entry team also including the Programs Director BCDOC, ██████ ██████ MA, the treatment providers (2 SUD counselor, 1 co-occurring counselor), 2 Community Corrections Officers (1 working toward LADC), Captain and Sergeant, Care Coordinator from Horizons and case manager from LRMHC – Fridays 2PM-4PM.</p> <p>Care coordination team IOP including ██████ ██████ ██████ and LADCs, MLADCs / counseling staff as needed for clients being discussed – Tuesdays 10am-11am.</p>

Lakes Region Mental Health Center	Twice weekly on Mondays and Fridays, 8:00-9:30AM	All information remains the same	<p>Child and Family clinical team meetings occur twice weekly for 1.5 hours to review status of current cases, high risk cases, referrals, and processes.</p> <p>Assertive Community Treatment team (ACT) meets Monday, Tuesday and Friday from 11:00 -12:00; Wednesday 10:00 - 11:00 to review all patients. This team has the most medically compromised patients so review includes nursing roles, medication needs/prompts, communication with specialists and PCPs and follow through on medical appointments.</p> <p>There is also a weekly Case Consult with the Psychiatrist to review status of current cases, high risk cases and identify/modify treatment plans.</p> <p>The additional 4 adult long term teams meet weekly for 1.0 -1.5 hours to review caseload for medical and psychiatric treatment needs and progress.</p> <p>Adult Outpatient (short term) meets one hour weekly to review individual pts that need consult with the nurse practitioner or peer supervision. This may include identified</p>	<p>Child and Family clinical team meetings occur twice weekly for 1.5 hours to review status of current cases, high risk cases, referrals, and processes.</p> <p>Assertive Community Treatment team (ACT) meets Monday, Tuesday and Friday from 11:00 -12:00; Wednesday 10:00 - 11:00 to review all patients. This team has the most medically compromised patients so review includes nursing roles, medication needs/prompts, communication with specialists and PCPs and follow through on medical appointments.</p> <p>There is also a weekly Case Consult with the Psychiatrist to review status of current cases, high risk cases and identify/modify treatment plans.</p> <p>The additional 4 adult long term teams meet weekly for 1.0 -1.5 hours to review caseload for medical and psychiatric treatment needs and progress.</p> <p>Adult Outpatient (short term) meets one hour weekly to review individual pts that need consult with the nurse practitioner or peer supervision. This may include identified need for</p>
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			need for collaboration with the PCP regarding medications for mental health treatment.	collaboration with the PCP regarding medications for mental health treatment.
Riverbend Community Mental Health	Twice weekly on Wednesdays and Thursdays, 1:00-2:00PM to review status of current cases, high risk cases, referrals, and processes	All information remains the same	<p>Adults: Twice weekly on Wednesdays and Thursdays, 1:00-2:00PM to review status of intakes, case consultations, high risk clients, referrals, and processes.</p> <p>Children: Twice weekly on Tuesdays, 11:00am for clinical consultation, dispo, referrals, and high risk clients, then 1:00-2:00PM to for case consultations and processes.</p>	<p>Adults: Twice weekly on Wednesdays and Thursdays, 1:00-2:00PM to review status of intakes, case consultations, high risk clients, referrals, and processes.</p> <p>Children: Twice weekly on Tuesdays, 11:00am for clinical consultation, dispo, referrals, and high risk clients, then 1:00-2:00PM to for case consultations and processes.</p>
Speare Primary Care	Pending	There is no formal schedule to date for core team case conferences. Currently these occur PRN given all practitioners are in close proximity with one another. Formalization of meeting schedule will be reviewed with CHSN-IDN5 with an anticipated meeting schedule introduced by/before December 2018.	<p>██████████ was the Patient Care Coordinator for Speare Primary Care. Her departure placed a void in the practice for a period. ██████████ has assumed the part-time duties of the Patient Care Coordinator role for Speare Primary Care. Rachael is fully functional in the role of the Patient Care Coordinator, and has developed processes and procedures to manage the patient population. At this time, beginning the integration of ██████████ (DSRIP funded care coordinator) and ██████████ to collaborate patients visiting the ED who are patients of Speare</p>	The Speare Primary Care team meets every Monday at 12pm.

			<p>Primary Care.</p> <p>██████████ have been in discussion about patients who are Speare Primary Care patients; however, regularly scheduled meetings have not been factored into either individual's schedule. Further discussion is underway between the practice and CHSN to identify how they will meet this requirement in 2019.</p>	
Plymouth Pediatric & Adolescent Medicine (Speare)	Pending	<p>There is no formal schedule to date for core team case conferences. Currently these occur PRN given all practitioners are in close proximity with one another. Formalization of meeting schedule will be reviewed with CHSN-IDN5 with an anticipated meeting schedule introduced by/before December 2018.</p>	<p>A formal schedule for core team case conferences has not been established. Currently these occur PRN given all practitioners are in close proximity with one another. Further discussion is underway between the practice and CHSN to identify how they will meet this requirement in 2019.</p>	<p>The Plymouth Pediatric &amp; Adolescent Medicine Provider team meets on the first Thursday of each month at 10am.</p>
LRGH / Westside Healthcare	Pending	<p>Not applicable at this time. CHSN Executive Director to work with LRGH practice managers to introduce a routine core team case conference schedule by/before December 2018.</p> <p>MAT takes place at FRH &amp; LRGH Hillside. Primary care providers manage depression and typically refer</p>	<p>Meeting coordination is the responsibility of the Embedded care coordinators at all LRGH practices. The ECCs meet bi-weekly with their Clinical Manager, Ambulatory Pharmacist and Ambulatory social worker (at minimum) every other Tuesday from 11am-12pm. Other team members are brought in as needed to discuss patients with complicated care</p>	<p>Meeting coordination is the responsibility of the Embedded care coordinators at all LRGH practices. The ECCs meet bi-weekly with their Clinical Manager, Ambulatory Pharmacist and Ambulatory social worker (at minimum) every other Tuesday from 11am-12pm. Other team members are brought in as needed to discuss patients with complicated care</p>

		out for counseling services.	plans, review best practices and provide each other with peer guidance.	plans, review best practices and provide each other with peer guidance.
Belknap Family Health – Meredith	Pending	<p>Not applicable at this time. CHSN Executive Director to work with LRGH practice managers to introduce a routine core team case conference schedule by/before December 2018.</p> <p>MAT takes place at FRH &amp; LRGH Hillside. Primary care providers manage depression and typically refer out for counseling services.</p>	<p>Meeting coordination is the responsibility of the Embedded care coordinators at all LRGH practices. The ECCs meet bi-weekly with their Clinical Manager, Ambulatory Pharmacist and Ambulatory social worker (at minimum) every other Tuesday from 11am-12pm. Other team members are brought in as needed to discuss patients with complicated care plans, review best practices and provide each other with peer guidance.</p>	<p>Meeting coordination is the responsibility of the Embedded care coordinators at all LRGH practices. The ECCs meet bi-weekly with their Clinical Manager, Ambulatory Pharmacist and Ambulatory social worker (at minimum) every other Tuesday from 11am-12pm. Other team members are brought in as needed to discuss patients with complicated care plans, review best practices and provide each other with peer guidance.</p>
Belknap Family Health – Belmont	Pending	<p>Not applicable at this time. CHSN Executive Director to work with LRGH practice managers to introduce a routine core team case conference schedule by/before December 2018.</p> <p>MAT takes place at FRH &amp; LRGH Hillside locations. Primary care providers manage depression and typically refer out for counseling services.</p>	<p>Meeting coordination is the responsibility of the Embedded care coordinators at all LRGH practices. The ECCs meet bi-weekly with their Clinical Manager, Ambulatory Pharmacist and Ambulatory social worker (at minimum) every other Tuesday from 11am-12pm. Other team members are brought in as needed to discuss patients with complicated care plans, review best practices and provide each other with peer guidance.</p>	<p>Meeting coordination is the responsibility of the Embedded care coordinators at all LRGH practices. The ECCs meet bi-weekly with their Clinical Manager, Ambulatory Pharmacist and Ambulatory social worker (at minimum) every other Tuesday from 11am-12pm. Other team members are brought in as needed to discuss patients with complicated care plans, review best practices and provide each other with peer guidance.</p>
Hillside Family Medicine	Pending	<p>Not applicable at this time. CHSN Executive Director to work with LRGH practice managers</p>	<p>Meeting coordination is the responsibility of the Embedded care coordinators at all LRGH practices. The</p>	<p>Meeting coordination is the responsibility of the Embedded care coordinators at all LRGH practices. The</p>

		<p>to introduce a routine core team case conference schedule by/before December 2018.</p> <p>MAT takes place at Hillside.</p>	<p>ECCs meet bi-weekly with their Clinical Manager, Ambulatory Pharmacist and Ambulatory social worker (at minimum) every other Tuesday from 11am-12pm. Other team members are brought in as needed to discuss patients with complicated care plans, review best practices and provide each other with peer guidance.</p>	<p>ECCs meet bi-weekly with their Clinical Manager, Ambulatory Pharmacist and Ambulatory social worker (at minimum) every other Tuesday from 11am-12pm. Other team members are brought in as needed to discuss patients with complicated care plans, review best practices and provide each other with peer guidance.</p>
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**B1-8f - Secure messaging:** All agencies that were without secure messaging were assisted with CHSN resources to install this capability via Kno2 in early 2018. CHSN has agreed to pay for all annual subscription fees until 2020. All partner practices were brought up to this minimum standard as of December 31, 2017. Since late 2018, the IDN’s Administrative Lead (Partnership for Public Health) also has the capability to send encrypted emails using Virtru through Microsoft Outlook and has adding an exclusive secure server for CHSN business only to store any sensitive data related to PHI. Secure Messaging protocol guidance was developed and shared with partners in December 2018 and can be found on page 3 of the CHSN-IDN5 B1 Partner Protocol Guidance document (**Attachment\_B1.2B**).

**B1-8g - Closed loop referrals:** CHSN-IDN5 has worked hard to address the need for and importance of closed loop referrals with its identified B1 practices and partners since the waiver’s inception. Most of our practices had a closed loop referral process in place and some, due to the waiver, have increased its strength by formalizing their processes into protocols within their agencies. Two of our FQHC’s partners are also Patient Centered Medical Homes and have been utilizing a formal, documented closed-loop referral process for quite some time. LRGHealthcare and its seven practices also have strong closed loop referral practices in place via their EMR, Cerner, which they continue to follow. Both Speare Primary Care and Plymouth Pediatrics & Adolescent Medicine also follow the same protocol as they share an EMR (Cerner) with LRGH. This leaves our two mental health centers – LRMHC and Riverbend who both also have strong closed loop referral protocols in place at their practices. The one outlier to this practice is our SUD provider, Horizons Counseling Center, who still performs much of its work via phone, email or fax for following up on referrals. CHSN provided Closed Loop Referral protocol guidance (page 4 of the CHSN-IDN5 B1 Partner Protocol Guidance document Attachment\_B1.2B) to aid any partner, such as Horizons Counseling Center, who did not have a formal closed loop process and/or was seeking language to formalize their internal protocols.

At the time of our last report all but one B1 partner had a closed loop referral practice and protocol in place for following up with the referring agencies as to their patient’s follow through. This confirmation is documented and “closed” within their record or is deemed unclosed and followed-up on until it can be closed. Though not all of our B1 partners execute their referrals in an electronic fashion, most have a sophisticated enough electronic record to accommodate this documentation within it. The one B1 partner

who did not have a closed loop referral protocol in place was Horizons Counseling Center, our primary SUD provider.

CHSN staff continued to work with Horizons’ Counseling Center during this reporting period to implement a more formalized closed loop referral process. We are pleased to report that Horizons Counseling Center has newly implemented an IDN-grown process for tracking closed loop referrals electronically using the CHSN purchased software Smartsheet which allows for an online spreadsheet to be available. Smartsheet is CHSN’s project management software and is also used by all E5 Community Care Coordinators to track patient encounters and referrals. The software was adapted by CHSN’s Data Analyst to assist Horizons in tracking closed loop referrals. Now once the referral loop is closed, it is marked next to the referral column in the online spreadsheet. With this most recent addition, all 14 of our 14 B1 partners are in compliance with having a closed loop referral practice and protocol in place

Additionally, there have been discussions statewide regarding the State Opioid Response (SOR) grant and the need for bed management and referral technology. CHSN-IDN5 has been part of these discussions with other IDN’s and a few software providers like OpenBeds and Unite Us. Currently, CHSN-IDN5 is not actively working to acquire software for this purpose but is staying in the discussion with other players.

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

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

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

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

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

Process Milestone Number	Process Detail	Submission Format	Results (Met/Not Met)			
			6/30/17	12/31/17	6/30/18	12/31/18
		for participating individuals on progress for each training				
B1-8d	Training for staff not providing direct care that at minimum includes knowledge and beliefs about mental disorders that can aid in recognition and management	Training schedule and table listing all staff indicating progress on each process detail				
B1-8e	Monthly (or more frequent) core team case conferences on behalf of patients with significant behavioral health conditions or chronic conditions	Conference schedule and Table				
B1-8f	Secure messaging	Narrative				
B1-8g	Closed loop referrals	Narrative				
B1-8h	<p>Documented work flows and/or protocols that include, at minimum:</p> <ul style="list-style-type: none"> <li>• Interactions between providers and community based organizations</li> <li>• Timely communication</li> <li>• Privacy, including limitations on information for communications with treating provider and community based organizations</li> <li>• Coordination among case managers (internal and external to IDN)</li> <li>• Safe transitions from institutional settings back to</li> </ul>	Work flows and/or Protocols (submit all in use)				

Process Milestone Number	Process Detail	Submission Format	Results (Met/Not Met)			
			6/30/17	12/31/17	6/30/18	12/31/18
	primary care, behavioral health and social support service providers <ul style="list-style-type: none"> <li>• Intake procedures that include systematically soliciting patient consent to confidentially share information among providers</li> <li>• Adherence to NH Board of Medicine guidelines on opioid prescribing</li> </ul>					

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

**B1-9a - Coordinated Care Practice designation:** Section B1-10 lists the 14 CHSN-IDN5 related practices and agencies that were identified within IDN 5 to achieve coordinated care practice designation. Based on both the UNH/CHI follow-up round 1 and 2 site self-assessment results performed in the spring and again in late fall 2018, each of the 14 Coordinated Practices have reached or exceeded Coordinated Care Level 3 or a score of 47 or above on the SAMHSA crosswalk scale of coordination/integration. That said, although the 14 practices have met SAMHSA’s scale for coordinated, not all have met the additional NH Plus requirements, thus keeping the number of true coordinated practices at just four. Practice progress for the reporting period is represented in the table below. The main impediment to achieving coordinated care for these organizations is the slow adoption of the CCSA by the LRGHealthcare system. Reasons for this slow lead out include confusion regarding the necessity of certain CCSA domains and how applicable and relevant some CCSA domains are to capture. In addition, the workflow of the CCSA has been a major question between determining who will administer the CCSA and how appropriate it is for certain providers to administer screenings within the CCSA. As an example, a suicide risk assessment is one of the required domains of a CCSA. LRGH only administers the PHQ-2 and PHQ-9 (following a positive PHQ-2) annually at office visits. Any formal suicide risk assessment would be performed by a mental health provider following a referral and there isn’t a reasonable way for that suicide risk assessment flag to find its way back into the LRGH patient record. In addition, the number of different domains that need to be captured could significantly impact patient visit time which is why LRGH has opted for a 2 question screen in the ED which generates referrals to the care coordinator without extending ER intake. Forms are being planned for the care coordinator to fill out that will satisfy most social determinant of health domains. However, some domains are not appropriate for the care coordinator to screen and these will have to be gathered from office visits which isn’t ideal because the CCSA isn’t being filled out all at once. At time of this writing, the 9 affected LRGH (7) and Speare (2) practices have agreed to begin implementing an electronic CCSA within their practices effective mid-September 2019.

**B1-9b - Additional Integrated Practice designation requirements:** Section B1-10 lists the six CHSN-IDN5 practices and agencies that are identified to achieve integrated care practice designation. Of the six, four are currently meeting that designation based on the UNH/CHI follow-up round 1 and 2 site self-assessment results received. Adoption of evidence-based practices is addressed below. Several practices in the region have been utilizing or have adopted both SBIRT and are Medication-assisted treatment (MAT) providers. Practice progress for the reporting period is represented in the table below.

List of providers identified to make progress toward Integrated Care Practice designation	Target	Progress Made through 12/31/17	Progress Made through 6/30/18	Progress Made through 12/31/18	Progress Made through 6/30/19
HealthFirst Family Care Center	Tier 1 practice – This practice is currently at Integrated Care Level V. CHSN began working with this practice in Q4 2017 to assist in moving them towards integrated practice designation requirements and will be ongoing throughout 2018.	<p><b>Laconia office</b></p> <ul style="list-style-type: none"> <li>• In house MAT services provided</li> <li>• When MAT began it was limited to 29 RX clients and 45 counseling clients. As of May 1, 2018 they anticipate this to expand to 70 RX clients receiving in-house MAT services and up to an additional 100 for counseling</li> <li>• PHQ2 performed for all clients annually</li> <li>• PHQ9 for any that score 2 on PHQ2</li> <li>• Internal referral to BH team for counseling in coordination with PCP and Rx</li> </ul>	Information remains the same. No new information to report.	<p><b>1. Progress on MAT</b> Hired additional LPN with MAT experience to help coordinate and schedule program components - two MDs and two APRNs received certification to prescribe for MAT.</p> <p>Protocols procedure and group schedules set.</p> <p>Received additional federal grant to recruit and train MAT staff.</p> <p>To date, over 45 clients receiving integrated MAT prescription PCP visits and Behavioral Health counseling</p> <p><b>2. Evidence based treatment of mild-</b></p>	<p><b>1. Progress on MAT</b> Hired additional LPN with MAT experience to help coordinate and schedule program components - two MDs and two APRNs received certification to prescribe for MAT.</p> <p>Protocols procedure and group schedules set.</p> <p>Received additional federal grant to recruit and train MAT staff.</p> <p>To date, over 45 clients receiving integrated MAT prescription PCP visits and Behavioral Health counseling</p> <p><b>2. Evidence based treatment of mild-</b></p>

		<ul style="list-style-type: none"> <li>Practice has been utilizing SBIRT on 12 years and older for 1 ½ years on all clients at annual visit. Any who score are referred for SUD counseling</li> <li>Currently collect all CCSA domains in the EMR other than those related to food, shelter and transportation. New questions will be added in paper form in May 2018 to address the 3 gaps identified</li> <li>Trained staff is lined up to perform SBIRT trainings with other practices</li> </ul> <p><b>Franklin office</b></p> <ul style="list-style-type: none"> <li>When MAT began it was limited to 29 RX clients and 45 counseling clients. As of May 1, 2018 they anticipate this to expand to 70 RX clients receiving in-house MAT services and up to an additional 100 for counseling.</li> <li>PHQ2 performed for all clients annually</li> <li>PHQ9 for any that score 2 on PHQ2</li> <li>Internal referral to BH team for</li> </ul>		<p><b>to-moderate depression</b></p> <p>All Clients get a PHQ2 to screen for depression annually. Anyone who scores 2 or more gets a PHQ9. For anyone scoring high on the PHQ9, a referral to our internal behavioral health counseling occurs.</p>	<p><b>to-moderate depression</b></p> <p>All Clients get a PHQ2 to screen for depression annually. Anyone who scores 2 or more gets a PHQ9. For anyone scoring high on the PHQ9, a referral to our internal behavioral health counseling occurs.</p>
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		<p>counseling in coordination with PCP and Rx</p> <ul style="list-style-type: none"> <li>Practice has been utilizing SBIRT on 12 years and older for 1 ½ years on all clients at annual visit. Any who score are referred for SUD counseling</li> <li>Currently collect all CCSA domains in the EMR other than those related to food, shelter and transportation. New questions will be added in paper form in May 2018 to address the 3 gaps identified</li> </ul>			
Mid-State Health Center	<p>Tier 1 practice – This practice is currently at Integrated Care Level V. CHSN began working with this practice in Q4 2017 to assist in moving them towards integrated practice designation requirements and will be ongoing throughout 2018.</p>	<ul style="list-style-type: none"> <li>MAT program has a Recovery Team that is using evidence-based interventions</li> <li>Interdisciplinary team treating substance misuse patients meets weekly</li> <li>All BH patients have an initial PHQ9 and a follow-up screening performed every six months. Re-evaluation of treatment plan made if necessary</li> </ul>	<p>Information remains the same. No new information to report.</p>	<p><b>Medication Assisted Recovery</b> Patients seeking Recovery services complete an initial screening process to appropriateness of the Mid-State Recovery Program for their needs. They are then scheduled with one of the Recovery Program BH Providers who conduct a more in-depth intake and screening process, and offered program orientation prior to beginning treatment. Visits with the Recovery Program</p>	<p><b>Medication Assisted Recovery</b> Patients seeking Recovery services complete an initial screening process to appropriateness of the Mid-State Recovery Program for their needs. They are then scheduled with one of the Recovery Program BH Providers who conduct a more in-depth intake and screening process, and offered program orientation prior to beginning treatment. Visits with the Recovery Program</p>

				<p>prescribing provider and behavioral health provider are then scheduled on an ongoing basis, often on the same day to provide easier access for the patient. Social, behavioral, and other supports are offered as identified by the recovery team and are referred as appropriate to either Mid-State's Patient Support Specialist, or externally to area community safety-net services based on the needs of the patient.</p> <p>If Mid-State's Recovery Program is deemed not the best treatment option by either recovery team staff or the patient at point in the screening or treatment process, recovery team staff work with the patient to refer them to the appropriate type of treatment outside of Mid-State.</p> <p><b>Mild-to-Moderate Depression</b> Patients are screened for depression using PHQ-2 and for substance use disorder using an SBIRT process using age</p>	<p>prescribing provider and behavioral health provider are then scheduled on an ongoing basis, often on the same day to provide easier access for the patient. Social, behavioral, and other supports are offered as identified by the recovery team and are referred as appropriate to either Mid-State's Patient Support Specialist, or externally to area community safety-net services based on the needs of the patient.</p> <p>If Mid-State's Recovery Program is deemed not the best treatment option by either recovery team staff or the patient at point in the screening or treatment process, recovery team staff work with the patient to refer them to the appropriate type of treatment outside of Mid-State.</p> <p><b>Mild-to-Moderate Depression</b> Patients are screened for depression using PHQ-2 and for substance use disorder using an SBIRT process using age</p>
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				<p>appropriate screening tools. (CRAFFT for adolescents and CAGE-Aid for adults) at their comprehensive physical exam and at other visits as indicated by health history, current condition, or chief complaint. Patients with a positive PHQ-2 are then referred to behavioral health for treatment. Patients who screen positive in the SBIRT process have a brief intervention with their PCP and are offered further options for treatment as indicated.</p> <p>Mid-State's delivery sites are designed to accommodate this integration and the electronic health record templates have been designed so that the mental health providers, can document care within the patient's Mid-State electronic record. This has facilitated sharing of chart notes for a population from which it is often difficult to obtain accurate information. Notes from both the medical clinicians and the</p>	<p>appropriate screening tools. (CRAFFT for adolescents and CAGE-Aid for adults) at their comprehensive physical exam and at other visits as indicated by health history, current condition, or chief complaint. Patients with a positive PHQ-2 are then referred to behavioral health for treatment. Patients who screen positive in the SBIRT process have a brief intervention with their PCP and are offered further options for treatment as indicated.</p> <p>Mid-State's delivery sites are designed to accommodate this integration and the electronic health record templates have been designed so that the mental health providers, can document care within the patient's Mid-State electronic record. This has facilitated sharing of chart notes for a population from which it is often difficult to obtain accurate information. Notes from both the medical clinicians and the</p>
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				<p>mental health clinicians are immediately accessible to all providers in the system, further improving the coordination of care.</p> <p>The utilization of the behavioral and recovery services has improved with integration by reducing the stigma commonly attached to the use of mental and behavioral health services. A behavioral/mental health patient appears to the public as any other medical patient, and reduces potential stigma.</p>	<p>mental health clinicians are immediately accessible to all providers in the system, further improving the coordination of care.</p> <p>The utilization of the behavioral and recovery services has improved with integration by reducing the stigma commonly attached to the use of mental and behavioral health services. A behavioral/mental health patient appears to the public as any other medical patient, and reduces potential stigma.</p>
Horizons Counseling Center	<p>Tier 1 practice – This practice is currently at Integrated Care Level V. CHSN began working with this practice in Q4 2017 to assist in moving them towards integrated practice designation requirements and will be ongoing throughout 2018.</p>	<ul style="list-style-type: none"> <li>• Integrated MAT Program (began prior to July 1 2017) has served 54 clients</li> <li>• Use PHQ2, PHQ9 and CBT to address mild to moderate depression in clients with co-occurring disorders</li> <li>• Plans to implement CCSA on paper as EHR does not readily accept this change in a usable manner. SBIRT is not utilized because the SUD program screening and assessments in</li> </ul>	<p>HealthFirst initiated their MAT program early in 2018. They have three Nurse Practitioners and two Physicians waived to prescribe Medication Assisted Therapy (MAT), which consists of Suboxone and Vivitrol. As part of the MAT program, all patients are required to participate</p>	<p>Horizons Counseling Center continues its work with the LRGHealthcare Recovery Clinic ensuring integrated medical and SUD treatment coordination with weekly communication between counseling and Recovery Clinic staff and joint ongoing assessment of client medical and behavioral health needs.</p> <p>Horizons offers a specialized group for individuals receiving medication</p>	<p>Horizons Counseling Center continues its work with the LRGHealthcare Recovery Clinic ensuring integrated medical and SUD treatment coordination with weekly communication between counseling and Recovery Clinic staff and joint ongoing assessment of client medical and behavioral health needs.</p> <p>Horizons offers a specialized group for individuals receiving medication</p>

		<p>place go beyond the scope of SBIRT</p>	<p>in behavioral health counseling which assists patients navigating through their substance use disorder and helps them to obtain and sustain recovery. Within their primary care setting, they have integrated Behavioral Health services with three FT and one PT Masters prepared counselors.</p>	<p>assistance for their treatment with Vivitrol or Suboxone. The group has expanded its psychoeducational material including helping clients understand how mental health symptoms may have been caused or exacerbated by opioid use and assisting clients in reassessing their symptoms to help them make decisions around the need for and use of psychotropic medications in conjunction with MAT.</p> <p>Horizons is also working with the Belknap County DOC to develop protocols for the assessment of all inmates who test positive for opioids on admission to the facility, to establish appropriateness for MAT based on diagnostic and ASAM criteria, and work directly with the inmate to educate them to the benefits of MAT, to the services available to them in the community post release and to assist them in making decisions around what form of MAT would be</p>	<p>assistance for their treatment with Vivitrol or Suboxone. The group has expanded its psychoeducational material including helping clients understand how mental health symptoms may have been caused or exacerbated by opioid use and assisting clients in reassessing their symptoms to help them make decisions around the need for and use of psychotropic medications in conjunction with MAT.</p> <p>Horizons is also working with the Belknap County DOC to develop protocols for the assessment of all inmates who test positive for opioids on admission to the facility, to establish appropriateness for MAT based on diagnostic and ASAM criteria, and work directly with the inmate to educate them to the benefits of MAT, to the services available to them in the community post release and to assist them in making decisions around what form of MAT would be</p>
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				<p>most appropriate for their needs and most compatible with their lifestyle.</p> <p>Horizons has begun discussions with Groups Recovery Together to enable incorporating their clients in need of IOP services into our IOP level of care and to assist them in providing integrated co-occurring disorders interventions for those clients in need of co-occurring interventions in order to be successful in their recovery efforts.</p> <p>Horizons screens all clients for mild to moderate depression using the PHQ9, the ASI and the DSM 5 criteria and co-occurring staff treat depression in an integrated approach with the treatment of the client's SUD using CBT combined with motivational interviewing and TCU interventions.</p>	<p>most appropriate for their needs and most compatible with their lifestyle.</p> <p>Horizons has begun discussions with Groups Recovery Together to enable incorporating their clients in need of IOP services into our IOP level of care and to assist them in providing integrated co-occurring disorders interventions for those clients in need of co-occurring interventions in order to be successful in their recovery efforts.</p> <p>Horizons screens all clients for mild to moderate depression using the PHQ9, the ASI and the DSM 5 criteria and co-occurring staff treat depression in an integrated approach with the treatment of the client's SUD using CBT combined with motivational interviewing and TCU interventions.</p>
Lakes Region Mental Health Center	Tier 1 practice – This practice is currently at Co-Located Care Level IV. CHSN will begin working with this practice	<ul style="list-style-type: none"> <li>PHQ9, CBT, DBT, IMR are currently utilized</li> </ul>	Information remains the same. No new information to report.	<b>MAT services</b> are provided short term to patients in hospital who are followed primarily for after care and on-going treatment by the recovery service at LRGH. They currently employ	<b>MAT services</b> are provided short term to patients in hospital who are followed primarily for after care and on-going treatment by the recovery service at LRGH. They employ four

	<p>to assist in moving them towards integrated practice designation requirements in Q1 2018 and will be ongoing throughout 2018.</p>			<p>four individuals 3 docs and 1 APRN who are certified.</p> <p><b>1. Mild-Moderate Depression:</b> The PHQ-9 is administered at intake and as identified by the score per LRMHC procedure. The PHQ score populates on the prescriber notes, progress notes and treatment plans The prescriber upon seeing the score and questions in the medical staff notes selects an intervention based on scoring. (Additional evaluation, medication, suicide risk assessment, in treatment or other)</p> <p><b>In One Health:</b> The PHQ-2 is administered. If positive for depression, the PHQ-9 is administered The nurse addresses with patient treatment team for moderate to severe depression</p> <p><b>2. Hypertension:</b> Once a year the nurse takes blood pressure for mental health patients and records in the electronic health record</p>	<p>individuals 3 docs and 1 APRN who are certified.</p> <p><b>1. Mild-Moderate Depression:</b> The PHQ-9 is administered at intake and as identified by the score per LRMHC procedure. The PHQ score populates on the prescriber notes, progress notes and treatment plans The prescriber upon seeing the score and questions in the medical staff notes selects an intervention based on scoring. (Additional evaluation, medication, suicide risk assessment, in treatment or other)</p> <p><b>In One Health:</b> The PHQ-2 is administered. If positive for depression, the PHQ-9 is administered The nurse addresses with patient treatment team for moderate to severe depression</p> <p><b>2. Hypertension:</b> Once a year the nurse takes blood pressure for mental health patients and records in the electronic health record</p>
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				<p>The prescriber reviews the blood pressure and identifies an intervention based on NQF 0018 and selects an intervention based on the reading (education, referral to PCP, nutrition education, other such as inShape, Peer Wellness Coach)</p> <p><b>3. BMI:</b> The BMI is taken once yearly by nursing and entered into the electronic health record Nursing informs the prescriber who reviews the BMI and selects an intervention based on NQF 421(education, referral to dietician, nutritionist, OT,PT, referral to PCP, referral to exercise counseling, other)</p> <p><b>4. Tobacco Screening:</b> The patient is asked at intake and yearly if they smoke This information populates to the progress notes and medical staff notes If the patient smokes, the prescriber offers smoking cessation and based on NQF 0028 selects an intervention (tobacco cessation,</p>	<p>The prescriber reviews the blood pressure and identifies an intervention based on NQF 0018 and selects an intervention based on the reading (education, referral to PCP, nutrition education, other such as inShape, Peer Wellness Coach)</p> <p><b>3. BMI:</b> The BMI is taken once yearly by nursing and entered into the electronic health record Nursing informs the prescriber who reviews the BMI and selects an intervention based on NQF 421(education, referral to dietician, nutritionist, OT,PT, referral to PCP, referral to exercise counseling, other)</p> <p><b>4. Tobacco Screening:</b> The patient is asked at intake and yearly if they smoke This information populates to the progress notes and medical staff notes If the patient smokes, the prescriber offers smoking cessation and based on NQF 0028 selects an intervention (tobacco cessation,</p>
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				<p>pharmacological interventions, other such as smoking cessation groups offered by mental health)</p> <p><b>5. PCP Communication:</b> Release and PCP Communication form put in place to assure shared information is faxed to the PCP and/or specialist Prescriber populates the form and transfers to medical record who faxes to the PCP office Communication form also populated at intake to inform PCP of mental health treatment</p> <p><b>Additional areas we have identified or are developing:</b></p> <ul style="list-style-type: none"> <li>▪ Diabetes Screening for People with Schizophrenia or Bipolar Disorder NQF 0003</li> <li>▪ Medication Reconciliation Post Discharge, NQF 0997</li> <li>▪ Metabolic Monitoring for Children and Adolescents NQF 2800</li> <li>▪ Suicide Risk Assessment; NQF 0104 and 1365 just put in place; administered</li> </ul>	<p>pharmacological interventions, other such as smoking cessation groups offered by mental health)</p> <p><b>5. PCP Communication:</b> Release and PCP Communication form put in place to assure shared information is faxed to the PCP and/or specialist Prescriber populates the form and transfers to medical record who faxes to the PCP office Communication form also populated at intake to inform PCP of mental health treatment</p> <p><b>Additional areas identified that have made progress:</b></p> <ul style="list-style-type: none"> <li>▪ Policy and procedure implemented for Diabetes Screening for People with Schizophrenia or Bipolar Disorder NQF 0003</li> <li>▪ Medication Reconciliation Post Discharge, NQF 0997</li> <li>▪ Metabolic Monitoring for Children and Adolescents NQF 2800</li> <li>▪ Policy and procedure for</li> </ul>
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				<p>at intake with flow up per triage; use of the Columbia Suicide Severity Risk Screening</p> <ul style="list-style-type: none"> <li>▪ Identification of a system for “alerts” for nursing staff to refer to all medical specialties and mental health teams as our electronic health record does not have a way for prescribers to “order”</li> <li>▪ For all referrals, development of a “closed loop system”</li> <li>▪ Job descriptions for nurses that specify integrated health responsibilities</li> </ul>	<p>Suicide Risk Assessment; NQF 0104 and 1365 was implemented; it is administered at intake with flow up per triage; use of the Columbia Suicide Severity Risk Screening</p> <ul style="list-style-type: none"> <li>▪ Work continues on a procedure for Identification of a system for “alerts” for nursing staff to refer to all medical specialties and mental health teams as our electronic health record does not have a way for prescribers to “order.”</li> <li>▪ For all referrals, development of an electronic “closed loop system” remains in process as issues with their EMR are being worked through.</li> </ul>
Riverbend Community Mental Health	Tier 1 practice – This practice is currently at Co-located Care Level IV. CHSN will begin working with	<ul style="list-style-type: none"> <li>• MAT offered via continued partnership with Lakes Region Recovery Clinic and Concord Riverbend based, Choices Program</li> </ul>	Information remains the same. No new information to report.	Riverbend offers MAT via partnerships with Lakes Region Recovery Clinic and Concord Riverbend-based Choices Program. The Choices program now has a	Riverbend offers MAT via partnerships with Lakes Region Recovery Clinic and Concord Riverbend-based Choices Program. The Choices program now has a

	<p>this practice to assist in moving them towards integrated practice designation requirements in Q1 2018 and will be ongoing throughout 2018.</p>	<ul style="list-style-type: none"> <li>• Anticipate opening Choices Program in Franklin to provide IOP services by Q4 2018</li> <li>• Evidence-based treatment of mild-to-moderate depression within the Integrated Practice setting either through use of the IMPACT or other evidence supported model</li> <li>• Continued use of these tools and interventions throughout the Adult Treatment Team</li> <li>• Use of PHQ9 at every intake appointment and subsequent Cognitive Behavior Therapy for depressive symptoms</li> <li>• Plan to have MOU with HealthFirst Family Care Center completed and signed by Q2 2018 to ensure that the two practices continue to work in collaboration and to have a Riverbend</li> </ul>		<p>clinician on-site in Franklin one day per week providing assessments and referrals to both Choices MAT program in Concord and other SUD services in Concord. It is anticipated that a Relapse Prevention Group will be starting in Franklin in Q1 2019 and an IOP in Q3 2019.</p> <p>Evidence-based treatment of mild-to-moderate depression within the integrated practice setting is either through use of the IMPACT or other evidence supported mode. Continued use of these tools and interventions through the Adult Treatment Team. Use of the PHQ-9 is provided at every intake appointment and subsequent Cognitive Behavioral Therapy (CBT) is used to treat depressive symptoms. An MOU with HealthFirst Family Care Center was completed and signed. This ensures that the two practices continue to work in collaboration and there is now a Riverbend therapist onsite at the PCP practice at</p>	<p>clinician on-site in Franklin one day per week providing assessments and referrals to both Choices MAT program in Concord and other SUD services in Concord. It is anticipated that a Relapse Prevention Group will be starting in Franklin in Q1 2019 and an IOP in Q3 2019.</p> <p>Evidence-based treatment of mild-to-moderate depression within the integrated practice setting is either through use of the IMPACT or other evidence supported mode. Continued use of these tools and interventions through the Adult Treatment Team. Use of the PHQ-9 is provided at every intake appointment and subsequent Cognitive Behavioral Therapy (CBT) is used to treat depressive symptoms. An MOU with HealthFirst Family Care Center was completed and signed. This ensures that the two practices continue to work in collaboration and there is now a Riverbend therapist onsite at the PCP practice at</p>
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		therapist onsite at the PCP practice.		least one day per week, currently Wednesdays.	least one day per week, currently Wednesdays.
LRGH / Westside Healthcare	Tier 2 practice – This practice is currently at Co-located Care Level IV. CHSN will begin working with this practice to assist in moving them towards integrated practice designation requirements in Q2 2018 and will be ongoing throughout 2018.	Pending	Regarding LRGH practices: MAT takes place at FRH & Gilford locations. Primary care providers manage depression and typically refer out for counseling services.	For all LRGH practices: MAT is currently through our Recovery Clinic at Franklin Regional Hospital and Hillside Medical Center. Primary care providers manage depression and refer out for counseling services.  Meeting coordination is the responsibility of the Embedded care coordinators at all LRGH practices. The ECCs meet bi-weekly with their Clinical Manager, Ambulatory Pharmacist and Ambulatory social worker (at minimum) every other Tuesday from 11am-12pm. Other team members are brought in as needed to discuss patients with complicated care plans, review best practices and provide each other with peer guidance.	For all LRGH practices: MAT is currently through our Recovery Clinic at Franklin Regional Hospital and Hillside Medical Center. Primary care providers manage depression and refer out for counseling services.  Meeting coordination is the responsibility of the Embedded care coordinators at all LRGH practices. The ECCs meet bi-weekly with their Clinical Manager, Ambulatory Pharmacist and Ambulatory social worker (at minimum) every other Tuesday from 11am-12pm. Other team members are brought in as needed to discuss patients with complicated care plans, review best practices and provide each other with peer guidance.

**B1-9c – Enhanced use of technology:**

All of our integrated partners continue to upgrade their EMR’s and make progress using different technologies to identify at-risk patients. All locations have been fully implemented with CMT and are using cohorts and group reports to identify high-utilizers within their population. Some of our partners are looking into population health management tools or are currently utilizing one like i2i Tracks to improve processes and health outcomes at their practices as well as improve performance for both DSRIP

measures as well as MIPS and other incentive programs. In addition, our partners are doing lots of infrastructure upgrades, as well as security testing and improvements to password workflows to better secure their patients' data and privacy. Below is a more specific list of all the ways that our partners are enhancing their use of technology to identify at-risk patients and protect their privacy.

Integrated Care Practice Designation	Progress Made as of 12/31/17	6/30/18	12/31/18	6/30/19
HealthFirst Family Care Center	HealthFirst signed their contract with CMT to begin using shared care plan technology. Shared-care planning is set to begin by 6/30/2018.	HealthFirst began using PreManage Primary in late April 2018.	HealthFirst has been using PreManage Primary and recently has developed a workflow for checking reporting quality before the end of a MAeHC data submission cycle.	HealthFirst underwent a major computer security review with an outside company who did intrusion testing HIPAA compliance and data network integrity tests. Findings were all extremely positive showing a very tight security system. Intrusion testing showed their system to be not penetrated during repeated testing over 48 hour period. The only recommendation that came out of this entire review was that they should consider changing their password structure to be consistent with some new standards that were going to into effect this year. As a result, HealthFirst is implementing a new 12 character password standard for network login and electronic medical record login.

				<p>HealthFirst installed several new security servers and firewall security software and hardware during the first part of this period, bringing them to a much higher level of security.</p> <p>During this time period, HealthFirst expanded the use of a 42 CFR Part 2 and HIPAA compliant patient combined release of information. They have discovered that getting 100% buy in to using the combined form has been challenging in that their general client population (those using primary care services) did not want to “check off” that they were willing to share their BH/MH/SUD information. For example, general medical clients who had not tested positive on any screenings for mental health issues such as depression or anxiety or had no positives on SBIRT screening for alcohol or drug abuse did not want to initially share mental health or</p>
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				<p>substance abuse data believing they didn't have any use right at that point.</p> <p>HealthFirst had a change in care coordinators. The new care coordinators were given new logons for CMT, received basic training in CMT and have started to use it to record suggestions for care management and to track ongoing utilization of the ER and to plan daily schedules of reach out and calls to client showing up at the ER that have high utilization.</p> <p>HealthFirst QA/QI director worked intensely with CHAN (community health access network) to help assure that CHAN was able to create a CCSA for use by the IDNs and staff from HealthFirst and report out to CHSN-IDN5 on its CCSA totals and other electronic transfer of data for measurement term. Payment for these services to CHAN was partially funded with money from CHSN which was well spent as it helped other IDNs and their</p>
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				<p>community health centers to have the access to the same data in the latter part of this second quarter. Other community health centers had similar payments from their IDN to CHAN which helps support finishing this community wide project.</p> <p>During this time frame the electronic medical record utilized by HealthFirst underwent another minor upgrade. All of the upgrade components were completed as planned which allowed for some additional data elements needed by CHSN to report to the state under IDN5 to be integrated and completed. Again the power of the health centers working together across many IDNs facilitated this process.</p> <p>One of HealthFirst's care coordinators was one of the first in the state to figure out how to actually enter a shared care plan into CMT. While this process remains somewhat complicated, we</p>
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				believe that CMT could do much better to revise this process, but it is a start. The same care coordinator has offered training sessions both within our region and to other care coordinators in the state on utilization of CMT to do shared care planning.
Mid-State Health Center	Mid-State has committed to using CMT along with other members of the IDN. Shared-care planning is set to begin by 6/30/2018.	Mid-State has a lack of dedicated IT resources for software integration. Priority has been given to the MAeHC project during this time. Shared-care planning is now targeted for completion by December 2018.	CHSN-IDN5's Data Analyst has been working with Mid-State to help with monthly reporting. An upgrade to SQL server at their location is still pending and must be completed before monthly reporting automation can be finished. Mid-State has provisioned their patients for the PreManage Portal but still has to request users for their portal.	Mid-State has added a storage area network to their IT environment. This improves the speed of their network. In addition, they've hired a full-time QI manager who will be using i2i Tracks to analyze the patient population and improve risk stratification of patients as well as patient outcomes.
LRGH / Westside Healthcare	LRGH received requests from multiple organizations to resume sharing lists of high utilizers with other providers in the IDN. No work has begun but they are committed to resuming this practice. LRGH has been given a technical onboarding call from CMT but we are still waiting for the contract to be reviewed by their legal team and signed. Shared-care planning and event notification	ASquam has signed their contract with CMT on behalf of the hospitals in our region. They began implementation in late June 2018 for PreManage ED. Work on PreManage Primary for Westside Healthcare will follow once the ED's notifications are being sent from the hospitals.	The PreManage implementation for the hospitals has been finished as of November 2018. They are working on identifying providers to train as well as super users. IDN 5's Data Analyst has been working with the reporting team at LRGH to make monthly reporting to MAeHC less cumbersome. In addition, the CCSA has been partially implemented at the	LRGH is extending use of its CCSA to the practices beginning in mid-September 2019. This will allow providers to have a better understanding of the SDOH needs of their patients and will allow LRGH to stratify their patient risk.

	by the hospital is set to begin by 6/30/2018.		ED and further domains will be captured going forward.	
Lakes Region Mental Health Center	Practice is planning to add additional features to their EMR to for purposes of storing screening results for SUD and depression. Genesis has not received a technical onboarding call but they are still set to begin shared-care planning by 6/30/2018.	LRMHC has been devoting their limited IT resources towards MAeHC data reporting. Work with CMT on PreManage Primary will begin following the work for this data reporting period.	LRMHC has completely implemented CMT but hasn't used it for shared care planning yet. Monthly data submissions to MAeHC have been put on hold while their IT has limited time to devote to the DSRIP project.	Identification of a system for "alerts" for nursing staff to refer to all medical specialties and mental health teams as their electronic health record does not have a way for prescribers to "order" <ul style="list-style-type: none"> <li>Development of an electronic closed loop referral system within their EMR has encountered obstacles but should be completed by the end of 2019.</li> </ul>
Horizons Counseling Center	Kno2 secure messaging software was installed Q4 2017; Horizons is working closely with Genesis to provide treatment for patients that are diagnosed for SUD. We are anticipating there will be 42 CFR Part 2 concerns with CMT so we have begun discussing these internally and plan to discuss and resolve with CMT by 3/31/2018.	Horizons signed a QSO/BAA with CMT in May 2018. CMT will be introducing the new 42 CFR Part 2 workflows in PreManage Primary in July 2018. After this introduction, we can begin working with Horizons IT staff	Horizons has begun looking for a new EMR system that will better suit their practice and help them with progressing towards integrated care designation.	Horizons picked an EMR system to implement. This will allow Horizons to begin electronic reporting and will streamline workflows. In addition, they are beginning to use CMT to identify high-utilizers and address their reasons for high utilization.
Riverbend Community Mental Health	Riverbend is working closely with HealthFirst on care coordination and an MOU is drafted. We anticipate that Riverbend will be using CMT for shared	Riverbend began working with CMT in May 2018 and has been using PreManage Primary. They are upgrading their EMR system to add ePrescribing,	Riverbend completed their EMR upgrade in November 2018. This added ePrescribing, an HL7 interface, direct messaging, a patient portal, and many	Riverbend engaged in a PDSA cycle to evaluate the effectiveness of current CCSA processes and determine a need for further action. Previously,

	care planning by 6/1/2018.	an HL7 interface, direct messaging, a patient portal, and many other internal improvements.	other internal improvements.	<p>Riverbend had sought to create a CCSA "form" in the EHR, pulling data points from multiple electronic sources to create a single summary document. It was theorized that this would support the completion of screening across all CCSA domains and thereby, the achievement of associated metrics. Upon review of MAeHC data, it has become clear that Riverbend's existing processes are sufficient, eliminating the need for the creation of a single form.</p> <p>Reached out to NHH to discuss their experience with CareConnect.</p> <p>Report was written by CMT which shows which clients hit high utilizer criteria and whether a SCP was entered to allow for QA.</p>
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**B1-9d - Documented workflows with community based social support service providers:** Workflow development between community based social support service providers has been ongoing, many workflows existed but were being further modified in conjunction with the C2, D3 and E5 projects. As discussed in section B1-8h, CHSN has identified several workflows, communication channels and joint service protocols. The workflows that have been finalized have been submitted throughout our reports within the specific community projects as attachments.

To actively support continued protocol and workflow development, CHSN-IDN5 outreached to other IDN's to enhance collaborative efforts towards standardization of integrated work throughout the state of New Hampshire. The process of integrating B1 protocols statewide supports the mission of this project in

implementing best practices across all settings to provide quality of care to all patients. The result of this, and as reported more comprehensively in section B1-8a, a robust B1 Partner Protocol Guidance document was developed (**Attachment\_B1.8A**) and shared with partners in December 2018 covering all outstanding topics, thanks to the collaborative IDN approach utilized. In particular, to address the need for joint service protocols and communication channels between partners, a Collaborative Care Agreement template (**Attachment\_B1.9D**) was developed and shared with partners for them to utilize if they were in need of one. By providing template language, the IDN could ensure it would cover all pertinent topics required in the DSRIP waiver. CHSN and other IDNs feel that even if a handful of IDNs utilize standardized protocols during this demonstration project, it will create increased efficiency of care to patients and providers resulting in more optimal project outcomes.

### **Project Scoring: IDN Integrated Healthcare Process Milestones, Achievement of Integrated Care Practice Designation Requirements**

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

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

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

**B1-10. IDN Integrated Healthcare Project: Achievement of Coordinated Care Practice and Integrated Care Practice Designation**

Of the eight practices identified to reach Coordinated Care Practice designation (Speare Primary Care, Plymouth Pediatrics & Adolescent Medicine, Belknap Family – Belmont, Belknap Family – Meredith, Lakes Region Family Practice, Hillside Family Medicine, Laconia Clinic, Caring for Kids), all have been able to reach coordinated care practice designation within this reporting period.

**CHSN-IDN5 is pleased to report that the nine outstanding LRGH and Speare practices that had yet to formally utilize a CCSA for their Medicaid patients began doing so in late September. The new CCSA process is now being performed on the Medicaid population ages 12 years and older and may be extended to the general population after a 3 month trial period to determine the realities of time/capacity required of practitioners to perform the CCSA and also to make referrals when needed. A tremendous amount of work was done by CHSN-IDN5 staff to get all relevant players from both hospital’s clinical teams, as well as necessary IT staff to make this to happen. The team meetings entailed conversations about workflows and processes for handling referrals upon a positive screen, and the development and agreement of the questions/language to be used in both the adult and pediatric CCSAs. Both hospitals utilize the same EMR and their IT collaborative group ASquam began the build in Cerner during the month of August. The new CCSA form and workflow in Cerner was demoed to all parties on September 3<sup>rd</sup>. After going through a brief change control period, it was finalized and went live for providers to begin utilizing on September 30<sup>th</sup>. Of the six practices identified to reach Integrated Care Practice designation (HealthFirst, Mid-State, Riverbend, LRMHC, Horizons, and**

Westside) **all have reached** integrated care practice designation within this reporting period. The implementation of CMT at Horizons Counseling and the CCSA implementation at Westside was responsible for the increase from 4 to 6 integrated care facilities this reporting period.

	Total Goal Number Designated	Baseline Designated 6/30/17*	Number Designated 12/31/17	Number Designated 6/30/18	Number Designated 12/31/18	Number Designated 6/30/19
<b>Coordinated Care Practices (= 8)</b>	14	0	7	4	4	<b>14</b>
<b>Integrated Care Practices (= 6)</b>	6	0	3	4	4	<b>6</b>

Use the format below to identify the progress each practice made toward Coordinated Care Practice or Integrated Care Practice designation during this reporting period.

<b>Coordinated Care Practice</b>	<b>List of providers identified to make progress toward <i>Coordinated Care Practice</i> designation</b>	<b>12/31/17</b>	<b>6/30/18</b>	<b>12/31/18</b>	<b>6/30/19</b>
	Speare Primary Care	Co-located Level IV	Speare Primary Care has hired an additional .5 Patient Care Coordinator (to make one FT position) who will interact with their Community Care Coordinator (CCC hired as part of the E5 Project). This individual/position will assist with triaging and patient care coordination. Speare Primary Care providers continue to work closely with [REDACTED]	Speare Primary Care's Patient Care Coordinator has begun categorizing patients who are at high risk. Processes and procedures are underway whereby the Patient Care Coordinator will receive all discharges from the hospitals and she will make an assessment using an algorithm as to the patient's risk level. Providers will have the opportunity to review the assessment and make any necessary changes. Implementing this	<b>Milestone met;</b> Speare has added an MAT program in their Emergency Department which will provide screening, referral and if appropriate, begin initial MAT services for those seeking recovery with referral to Mid-State for ongoing SUD treatment.  Speare is also bringing in peer recovery coaches from PARC to engage with families and patients who seek

			<p>site office psychiatrist.</p>	<p>program in conjunction with building the relationship with the Patient Care Coordinator at the hospital for patients who are classified as E5 candidates will begin the integration of care.</p>	<p>emergency services for SUD.</p> <p><b>Speare Primary Care began formally utilizing a CCSA for their Medicaid patients Sept. 30<sup>th</sup>. The new CCSA process is now being performed on the Medicaid population ages 12 years and older (this may be extended to the general population after a 3 month trial period once capacity is better understood for practitioners to perform the CCSA and make referrals as needed).</b></p>
	<p>Belknap Family Health – Meredith</p>	<p>Information not available</p>	<p>At LRGHealthcare, each practice has an Embedded Care Coordinator (RN). The ECC's follow patients who have had 4 or more ED visits and along with the patient's PCP, they redirect patients to the appropriate level of care.</p> <p>They have an established workflow with Riverbend and HealthFirst to support patients in the greater Franklin area (Westside) to help get them back to integrated status.</p>	<p>At LRGHealthcare, each practice has an Embedded Care Coordinator (RN). The ECC's follow patients who have had 4 or more ED visits and along with the patient's PCP, they redirect patients to the appropriate level of care.</p> <p>They have an established workflow with Riverbend and HealthFirst to support patients in the greater Franklin area (Westside) to help get them back to integrated status. They hired a BSW in the ED to follow patients who have behavioral or mental health needs. She</p>	<p><b>Milestone Met; Belknap Family Health began formally utilizing a CCSA for their Medicaid patients Sept. 30<sup>th</sup>. The new CCSA process is now being performed on the Medicaid population ages 12 years and older (this may be extended to the general population after a 3 month trial period once capacity is better understood for practitioners to perform the CCSA</b></p>

			<p>They hired a BSW in the ED to follow patients who have behavioral or mental health needs. She coordinates care for those patients along with any other social needs. She can also support any of the practices for patients with other social needs.</p> <p>They also have an established workflow with Navigating Recovery, HealthFirst and Lakes Region Mental Health for our patients in the greater Laconia area. This includes coordinated care to address the social and mental health needs of our patients.</p> <p>They also have the Recovery Clinic for medication-assisted treatment, which is part of their integrated network, and have established a plan of care for substance misuse patients who present to the ED.</p> <p>ECC's work with their providers to work collaboratively to</p>	<p>coordinates care for those patients along with any other social needs. She can also support any of the practices for patients with other social needs.</p> <p>They also have an established workflow with Navigating Recovery, HealthFirst and Lakes Region Mental Health for patients in the greater Laconia area. This includes coordinated care to address the social and mental health needs of our patients.</p> <p>They also have the Recovery Clinic for medication-assisted treatment, which is part of their integrated network, and have established a plan of care for substance misuse patients who present to the ED.</p> <p>ECC's work with their providers to work collaboratively to manage complex patients. We have a closed loop referral system from providers to their ECC's, their Ambulatory Social Worker, their Community Educator, and their Ambulatory Pharmacist. (workflow has been shared with CHSN-IDN5).</p> <p>Their providers work with mental health agencies to manage</p>	<p><b>and make referrals as needed).</b></p> <p>At LRGHealthcare each practice has an Embedded Care Coordinator (RN). The ECC's follow patients who have had 4 or more ED visits and along with the patient's PCP, they redirect patients to the appropriate level of care.</p> <p>They have an established workflows with Riverbend and HealthFirst to support patients in the greater Franklin area (Westside) to help get them back to integrated status. They hired a BSW in the ED to follow patients who have behavioral or mental health needs. She coordinates care for those patients along with any other social needs and can also support any of the practices for patients with other social needs.</p> <p>They have an established workflow with Navigating Recovery, HealthFirst and Lakes Region Mental Health for patients in the greater Laconia area. This includes coordinated care</p>
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			<p>manage complex patients. We have a closed loop referral system from providers to their ECC's, their Ambulatory Social Worker, their Community Educator, and their Ambulatory Pharmacist.</p> <p>Their providers work with their mental health agencies to manage mild to moderate depression in the practices.</p> <p>They use technology to identify at risk patients with daily ED and hospital discharges. In addition, they run reports for patients who have chronic conditions. They are then managed by the ECC's.</p> <p>They continue to enhance the components of the CCSA such as the mini-cog and the depression screening. By the end of the year, they anticipate adding a substance use disorder screening in the ED and a social determinant of health survey.</p> <p>Since their last report, they now</p>	<p>mild to moderate depression in the practices.</p> <p>All ECCs are now included in CMT's event notifications and follow the LRGH ED discharge workflow to ensure appropriate follow-up occurs. Reports are run for patients who have chronic conditions and are then managed by the ECC's.</p> <p>They continue to enhance the components of the CCSA such as the mini-cog and the depression screening.</p> <p>Since their last report, the SDoH assessment is being piloted in the ED and plans to expand beyond the ED to additional LRGH practices is anticipated in the first half of 2019. The CMT global consent is in place and though the ECCs are not yet utilizing shared care plans (in this reporting period) they have scheduled a training by HealthFirst to speak with the LRGH ECC's on January 29, 2019 to share how they are utilizing the shared care plan module within CMT and train them appropriately.</p>	<p>to address the social and mental health needs of our patients.</p> <p>They also have the Recovery Clinic for medication-assisted treatment, which is part of their integrated network, and have established a plan of care for substance misuse patients who present to the ED.</p> <p>ECC's work with their providers to work collaboratively to manage complex patients. They have a closed loop referral system from providers to their ECC's, their Ambulatory Social Worker, their Community Educator, and their Ambulatory Pharmacist. (workflow has been shared with CHSN-IDN5).</p> <p>Their providers work with mental health agencies to manage mild to moderate depression in the practices.</p> <p>All ECCs are now included in CMT's event notifications and follow the LRGH ED discharge workflow to ensure appropriate follow-up occurs. Reports are run for patients who have chronic conditions</p>
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			participate in CMT and have a global consent in place as well as a shared care plan.		and are then managed by the ECC's.  They continue to enhance the components of the CCSA such as the mini-cog and the depression screening.  The CMT global consent is in place and the ECCs are now utilizing shared care plans. They had a training by HealthFirst to speak with the LRGH ECC's on January 29, 2019 to share how they are utilizing the shared care plan module within CMT and train them appropriately.
	Belknap Family Health – Belmont	Information not available	At LRGHealthcare, each practice has an Embedded Care Coordinator (RN). The ECC's follow patients who have had 4 or more ED visits and along with the patient's PCP, they redirect patients to the appropriate level of care.  They have an established workflow with Riverbend and HealthFirst to support patients in the greater Franklin area (Westside) to help get them back to integrated status. They hired a BSW	At LRGHealthcare, each practice has an Embedded Care Coordinator (RN). The ECC's follow patients who have had 4 or more ED visits and along with the patient's PCP, they redirect patients to the appropriate level of care.  They have an established workflows with Riverbend and HealthFirst to support patients in the greater Franklin area (Westside) to help get them back to integrated status. They hired a BSW in the ED to follow patients who have behavioral or mental	<b>Milestone Met; Belknap Family Health began formally utilizing a CCSA for their Medicaid patients Sept. 30<sup>th</sup>. The new CCSA process is now being performed on the Medicaid population ages 12 years and older (this may be extended to the general population after a 3 month trial period once capacity is better understood for practitioners to perform the CCSA</b>

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			and have a global consent in place as well as a shared care plan.		and are then managed by the ECC's.  They continue to enhance the components of the CCSA such as the mini-cog and the depression screening.  The CMT global consent is in place and the ECCs are now utilizing shared care plans. They had a training by HealthFirst to speak with the LRGH ECC's on January 29, 2019 to share how they are utilizing the shared care plan module within CMT and train them appropriately.
	Lakes Region Family Practice	Information not available	At LRGHealthcare, each practice has an Embedded Care Coordinator (RN). The ECC's follow patients who have had 4 or more ED visits and along with the patient's PCP, they redirect patients to the appropriate level of care.  They have an established workflow with Riverbend and HealthFirst to support patients in the greater Franklin area (Westside) to help get them back to integrated status. They hired a BSW	At LRGHealthcare, each practice has an Embedded Care Coordinator (RN). The ECC's follow patients who have had 4 or more ED visits and along with the patient's PCP, they redirect patients to the appropriate level of care.  They have an established workflows with Riverbend and HealthFirst to support patients in the greater Franklin area (Westside) to help get them back to integrated status. They hired a BSW in the ED to follow patients who have behavioral or mental	<b>Milestone Met; Lakes Region Family Practice began formally utilizing a CCSA for their Medicaid patients Sept. 30<sup>th</sup>. The new CCSA process is now being performed on the Medicaid population ages 12 years and older (this may be extended to the general population after a 3 month trial period once capacity is better understood for practitioners to perform the CCSA</b>

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	Hillside Family Medicine	Information not available	At LRGHealthcare, each practice has an Embedded Care Coordinator (RN). The ECC's follow patients who have had 4 or more ED visits and along with the patient's PCP, they redirect patients to the appropriate level of care.  They have an established workflow with Riverbend and HealthFirst to support patients in the greater Franklin area (Westside) to help get them back to integrated status. They hired a BSW	At LRGHealthcare, each practice has an Embedded Care Coordinator (RN). The ECC's follow patients who have had 4 or more ED visits and along with the patient's PCP, they redirect patients to the appropriate level of care.  They have an established workflow with Riverbend and HealthFirst to support patients in the greater Franklin area (Westside) to help get them back to integrated status. They hired a BSW in the ED to follow patients who have behavioral or mental health needs. She	<b>Milestone Met; Hillside Family Medicine began formally utilizing a CCSA for their Medicaid patients Sept. 30<sup>th</sup>. The new CCSA process is now being performed on the Medicaid population ages 12 years and older (this may be extended to the general population after a 3 month trial period once capacity is better understood for practitioners to perform the CCSA</b>

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	LRGH / Laconia Clinic (primary care)	Information not available	At LRGHealthcare, each practice has an Embedded Care Coordinator (RN). The ECC's follow patients who have had 4 or more ED visits and along with the patient's PCP, they redirect patients to the appropriate level of care.  They have an established workflow with Riverbend and HealthFirst to support patients in the greater Franklin area (Westside) to help get them back to integrated status. They hired a BSW	At LRGHealthcare, each practice has an Embedded Care Coordinator (RN). The ECC's follow patients who have had 4 or more ED visits and along with the patient's PCP, they redirect patients to the appropriate level of care.  They have an established workflow with Riverbend and HealthFirst to support patients in the greater Franklin area (Westside) to help get them back to integrated status. They hired a BSW in the ED to follow patients who have behavioral or mental health needs. She	<b>Milestone Met; Laconia Clinic began formally utilizing a CCSA for their Medicaid patients Sept. 30<sup>th</sup>. The new CCSA process is now being performed on the Medicaid population ages 12 years and older (this may be extended to the general population after a 3 month trial period once capacity is better understood for practitioners to perform the CCSA and make referrals as needed).</b>

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	LRGH / Caring for Kids	Information not available	<p>At LRGHealthcare, each practice has an Embedded Care Coordinator (RN). The ECC's follow patients who have had 4 or more ED visits and along with the patient's PCP, they redirect patients to the appropriate level of care.</p> <p>They have an established workflow with Riverbend and HealthFirst to support patients in the greater Franklin area (Westside) to help get them back to integrated status. They hired a BSW in the ED to</p>	<p>At LRGHealthcare, each practice has an Embedded Care Coordinator (RN). The ECC's follow patients who have had 4 or more ED visits and along with the patient's PCP, they redirect patients to the appropriate level of care.</p> <p>They have an established workflows with Riverbend and HealthFirst to support patients in the greater Franklin area (Westside) to help get them back to integrated status. They hired a BSW in the ED to follow patients who have behavioral or mental health needs. She</p>	<p><b>Milestone Met; Caring for Kids began formally utilizing a CCSA for their Medicaid patients Sept. 30<sup>th</sup>. The new CCSA process is now being performed on the Medicaid population ages 12 years and older (this may be extended to the general population after a 3 month trial period once capacity is better understood for practitioners to perform the CCSA and make referrals as needed).</b></p>

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	Plymouth Pediatric and Adolescent Medicine (Speare)	Information not available	Speare's Plymouth Pediatric & Adolescent Medicine still does not have a Patient Care Coordinator on staff; however, should a patient arrive in the emergency room who meets the criteria and needs, the social support from the Community Care Coordinator would be inserted into the visit.	At this time, PPAM does not have a Patient Care Coordinator for the practice. The majority of the care coordination is handled through the Practice Manager [REDACTED]; however PPAM is looking to add a PCC in 2019. They are also exploring the addition of a psychologist to the practice. Currently, all psychiatrist / therapist appointments are referred out to a list of regional providers (Attachment_B1.10A )	<b>Milestone Met; Plymouth Pediatric and Adolescent Medicine began formally utilizing a CCSA for their Medicaid patients Sept. 30<sup>th</sup>. The new CCSA process is now being performed on the Medicaid population ages 12 years and older (this may be extended to the general population after a 3 month trial period once capacity is better understood for practitioners to perform the CCSA and make referrals as needed).</b>

					Speare is also bringing in peer recovery coaches from PARC to engage with families and patients who seek emergency services for SUD.
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Integrated Care Practice	List of providers identified to make progress toward <i>Integrated Care Practice</i> designation	12/31/17	6/30/18	12/31/18	6/30/19
	HealthFirst Family Care Center	Integrated Care Level V	<p>HealthFirst has increased its behavioral health staff, increased team meeting time, fully cross-implemented shared clinical records, and instituted a 42 CFR Part 2 compliant informed consent across the entire agency.</p> <p>The primary care and behavioral health care provider function in all aspects as an integrated unit focused on the client's involvement in a joint treatment plan where the team and clients are all partners in seeking the most effective methods that the client can work with that</p>	<p>HealthFirst Family Care Center is a federally qualified health center serving the Twin Rivers and Lakes Region of New Hampshire. We are part of IDN 5. At the beginning of this reporting period, HealthFirst conducted a self-assessment using the SAMHSA rating scale of our degree of integration of behavioral health and primary care. At that point we scored an average of eight overall for the agency. Taking the individual rating sections we identified several key areas that we would concentrate on to do more work to achieve higher levels of integration.</p> <p>These included: 1). Developing a larger number of</p>	<p><b>Milestone Met;</b> In addition to the progress reported last period, HealthFirst expanded the use of a 42 CFR Part 2 and HIPAA compliant patient combined release of information. They have discovered that getting 100% buy-in to using the combined form has been challenging in that their general client population (those using primary care services) did not want to "check off" that they were willing to share their BH/MH/SUD information. For example, general medical clients who had not</p>

			<p>achieves the highest possible measurable health and mental health outcomes. The teams function in an environment where full collaboration is encouraged and institutionalized in policies and procedures that stress the importance of shared integrated care plans and the regular exchange of info in actively working with the clients on all aspects of their care. Team members consult with each other throughout the workday in short impromptu consults that are true exchanges of ideas about patient care. The team meetings are an integrated discussion and sharing of methods and ideas from all disciplines and members of the team.</p>	<p>coordinated care plans for the identified population that were risk stratified based on our E5 project for individuals that had more than four visits to the emergency room each month.</p> <p>2). Being more inclusive of family members in developing coordinated care plans.</p> <p>3). Completing, in conjunction with other agencies in IDN 5, a CFR42 Part 2 HIPPA combined informed consent and release process and forms (“universal consent”) and implementing them across HealthFirst Family Care Center. In November 2018 HealthFirst declared itself a CFR 42 Part 2 agency and is using these forms across the entire agency for all new intakes and conversion of existing release of information on return visits for all other clients. To date, this transition has been received very well with over 80% of the clients agreeing to utilize this new method and agreeing to share information with all past, present and future treatment providers under the CFR 42 Part 2 rules for behavioral health</p>	<p>tested positive on any screenings for mental health issues such as depression or anxiety or had no positives on SBIRT screening for alcohol or drug abuse did not want to initially share mental health or substance abuse data believing they didn't have any use right at that point.</p> <p>HealthFirst had a change in care coordinators. The new care coordinators were given new logons for CMT, received basic training in CMT and have started to use it to record suggestions for care management and to track ongoing utilization of the ER and to plan daily schedules of reach out and calls to client showing up at the ER that have high utilization.</p> <p>HealthFirst QA/QI director worked intensely with CHAN (community health access network) to help assure that CHAN was able to create</p>
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				<p>and treatment of SUD.</p> <p>4). Risk stratification - HealthFirst began and continues working with CHAN (Community Health Access Network) who functions as our computer service Bureau to develop software reports within our electronic medical record that can be used to do risk stratification across our entire patient population. This has been helpful in identifying clients at risk for chronic primary care conditions and SUD.</p> <p>5). HealthFirst utilizes SBIRT (Substance Abuse Brief Intervention and Referral to Treatment) screening with all new clients. As part of our work and to help with integration, we have been doing training sessions for other IDN 5 agencies to teach them how to utilize SBIRT within their practices and in developing their own internal workflows.</p> <p>6). HealthFirst utilizes comprehensive screening methods to identify individuals coming into agency who have depression, utilizing a PHQ2 followed by a PHQ9. Individuals who score high on a PHQ9 are</p>	<p>a CCSA for use by the IDNs and staff from HealthFirst and report out to CHSN-IDN5 on its CCSA totals and other electronic transfer of data for measurement term. Payment for these services to CHAN was partially funded with money from CHSN which was well spent as it helped other IDNs and their community health centers to have the access to the same data in the latter part of this second quarter. Other community health centers had similar payments from their IDN to CHAN which helps support finishing this community wide project.</p> <p>During this time frame the electronic medical record utilized by HealthFirst underwent another minor upgrade. All of the upgrade components were completed as planned which allowed for some additional data elements needed by CHSN to report to the state under</p>
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				<p>automatically referred internally to a behavioral health counselor to develop a coordinated care plan.</p> <p>7). Coordinated care plans are being developed by our IDN's care coordinators and our case manager and other internal care coordinators hired through other sources of funds for individuals with high risk on primary care chronic illnesses, SUD, tobacco and behavioral health issues of a wide variety. The coordinated care plans for these individuals utilize a CCSA as the basis for identifying and developing the care plan components. HealthFirst has developed a mechanism, working with CHAN, to include coordinated care plans within our electronic medical record and together save CCSA data into a cumulative data report for risk stratified group within the electronic medical record using data warehouse software and special reports developed using the Vizolution software.</p> <p>8). HealthFirst utilized funding from several different grants including a</p>	<p>IDN5 to be integrated and completed. Again the power of the health centers working together across many IDNs facilitated this process.</p> <p>One of HealthFirst's care coordinators was one of the first in the state to figure out how to actually enter a shared care plan into CMT. While this process remains somewhat complicated, we believe that CMT could do much better to revise this process, but it is a start. The same care coordinator has offered training sessions both within our region and to other care coordinators in the state on utilization of CMT to do shared care planning.</p>
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				<p>large federal grant for SUD – MAT development to train 2 nurse practitioners and 2 MDs and our behavioral health counselors to utilize MAT. We also utilized money from this federal grant to hire additional staff including a nurse dedicated to coordinating and managing the MAT program. We started up the full service of the program in November 2018. To date, HealthFirst has 61 individuals enrolled for MAT services which is growing rapidly.</p> <p>9). During this reporting period we have also developed output reports using Vizolution software which helps us to further stratify the population and identify others in high risk.</p> <p>10). Care coordinators and case managers from HealthFirst have developed workflows for the integrated care teams which are utilized in regularly occurring meetings every two weeks to discuss individuals and readjust care plans mechanisms. In addition, we use a method known as warm handoff, where behavioral health providers are available at the top</p>	
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				<p>of every hour for the medical providers to access them, introduce them to a primary care client, set up the first visit or connect them to behavioral health services.</p> <p>11). In November 2018, the staff of HealthFirst conducted its 2<sup>nd</sup> follow-up round of the SAMHSA integration scale and it found that we had move the needle to a 9 average across the entire scale. Clearly, we are making progress towards our goal of a fully integrated behavioral health and primary care practice. Working off of the individual sections we will continue to make action plans for the next quarter.</p>	
	Mid-State Health Center	Integrated Care Level V	Mid-State offers an integrated primary care model with embedded behavioral health and outpatient substance use disorder treatment services. The electronic health record templates have been designed so that primary care clinicians can screen for mental health and substance use. The same electronic health record is utilized across the	<p>Mid-State recently received funding from HRSA to expand its Behavioral Health and Substance Use Disorder integration. Through this funding Mid-State will implement the following improvements/expansions to its existing integrated model:</p> <ul style="list-style-type: none"> <li>▪ improve transportation options by providing transportation directly by the health center;</li> <li>▪ contract with an expert</li> </ul>	<p><b>Milestone Met;</b> Due to significant growth within their BH and SUD programs they have added five additional providers to their Recovery Team due to demand</p> <p>██████████  ██████████  ██████████  ██████████  ██████████  ██████████  ██████████  ██████████  ██████████  ██████████</p>

			<p>integrated team. This facilitates sharing of chart notes to ensure care is coordinated across the care team. Notes from both the medical clinicians and the mental health clinicians are immediately accessible to the clinical team responsible for the patient, further improving the coordination of care.</p> <p>Also, they have a diabetic support group that meets once every month and participation is opened to everyone not only Mid-State Health patients. During the support group meeting, they have specialists educate these patients about ways to control their A1C levels. They are on the verge of introducing "Cooking Matters" which is an initiative of helping their diabetic patients prepare or make a healthy meal. They will have a nutritionist educate these patients about how to shop for a healthy meal and each participant will be given an incentive to help them shop for a healthy meal.</p>	<p>consultant to further evolve it's integrated primary care model;</p> <ul style="list-style-type: none"> <li>▪ add 1 FTE Recovery Support Specialist to assist in the care coordination of its Recovery Program participants, including the addition of group recovery meetings; and</li> <li>▪ provide staff training specifically focused on the HIPAA and 42 CFR Part 2 rules for substance use disorder treatment.</li> </ul> <p>Mid-State's QI Manager is also working with an outside consultant to improve the collection and reporting of QI measures, several of which are related to SBIRT screening and depression screening.</p>	<p>Recovery Support Specialist).</p> <p>In addition, Mid-State has had a vacancy for their QI manager position that was recently filled which will help improve delivery of integrated services as well as provide a point of contact for DSRIP measure data refinement at this site.</p>
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	LRGH / Westside Healthcare	Co-located Care Level IV	<p>At LRGHealthcare, each practice operates similarly (<i>as you will read similar progress for each LRGH practice</i>) in that they have an Embedded Care Coordinator (RN). The ECC's follow patients who have had 4 or more ED visits and along with the patient's PCP, they redirect patients to the appropriate level of care.</p> <p>They have an established workflow with Riverbend and HealthFirst to support patients in the greater Franklin area (Westside) to help get them back to integrated status. They hired a BSW in the ED to follow patients who have behavioral or mental health needs. She coordinates care for those patients along with any other social needs. She can also support any of the practices for patients with other social needs.</p> <p>They also have an established workflow with Navigating Recovery, HealthFirst and Lakes Region Mental Health for</p>	<p>At LRGHealthcare, each practice operates similarly (<i>as you have read the same progress for each LRGH practice</i>) and utilizes an Embedded Care Coordinator (RN). The ECC's follow patients who have had 4 or more ED visits and along with the patient's PCP, they redirect patients to the appropriate level of care.</p> <p>They have an established workflows with Riverbend and HealthFirst to support patients in the greater Franklin area (Westside) to help get them back to integrated status. They hired a BSW in the ED to follow patients who have behavioral or mental health needs. She coordinates care for those patients along with any other social needs. She can also support any of the practices for patients with other social needs.</p> <p>They have an established workflow with Navigating Recovery, HealthFirst and Lakes Region Mental Health for patients in the greater Laconia area. This includes coordinated care to address the social and mental health needs of our patients.</p>	<p><b>Milestone Met; Westside Healthcare began formally utilizing a CCSA for their Medicaid patients Sept. 30<sup>th</sup>. The new CCSA process is now being performed on the Medicaid population ages 12 years and older (this may be extended to the general population after a 3 month trial period once capacity is better understood for practitioners to perform the CCSA and make referrals as needed).</b></p> <p>At LRGHealthcare each practice operates similarly and utilizes an Embedded Care Coordinator (RN). The ECC's follow patients who have had 4 or more ED visits and along with the patient's PCP, they redirect patients to the appropriate level of care.</p> <p>They have established workflows with Riverbend and HealthFirst to support patients in the greater Franklin area</p>
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			<p>our patients in the greater Laconia area. This includes coordinated care to address the social and mental health needs of our patients.</p> <p>They also have the Recovery Clinic for medication-assisted treatment, which is part of their integrated network and have established a plan of care for substance misuse patients who present to the ED.</p> <p>ECC's work with their providers to work collaboratively to manage complex patients. We have a closed loop referral system from providers to their ECC's, their Ambulatory Social Worker, their Community Educator, and their Ambulatory Pharmacist.</p> <p>Their providers work with their mental health agencies to manage mild to moderate depression in the practices.</p> <p>They use technology to identify at risk patients with daily ED and hospital discharges. In addition, they run</p>	<p>They also have a Recovery Clinic for medication-assisted treatment, which is part of their integrated network, and have established a plan of care for substance misuse patients who present to the ED.</p> <p>ECC's work with their providers to work collaboratively to manage complex patients. We have a closed loop referral system from providers to their ECC's, their Ambulatory Social Worker, their Community Educator, and their Ambulatory Pharmacist. (workflow has been shared with CHSN-IDN5).</p> <p>Their providers work with mental health agencies to manage mild to moderate depression in the practices.</p> <p>All ECCs are now included in CMT's event notifications and follow the LRGH ED discharge workflow to ensure appropriate follow-up occurs. Reports are run for patients who have chronic conditions and are then managed by the ECC's.</p> <p>They continue to enhance the components of the CCSA such as the</p>	<p>(Westside) to help get them back to integrated status. They hired a BSW in the ED to follow patients who have behavioral or mental health needs. She coordinates care for those patients along with any other social needs and can also support any of the practices for patients with other social needs.</p> <p>They have an established workflow with Navigating Recovery, HealthFirst and Lakes Region Mental Health for patients in the greater Laconia area. This includes coordinated care to address the social and mental health needs of our patients. They also have a Recovery Clinic for medication-assisted treatment, which is part of their integrated network, and have established a plan of care for substance misuse patients who present to the ED.</p> <p>ECC's work with their providers to work collaboratively to</p>
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			<p>reports for patients who have chronic conditions. They are then managed by the ECC's.</p> <p>They continue to enhance the components of the CCSA such as the mini-cog and the depression screening. By the end of the year, they anticipate adding a substance use disorder screening in the ED and a social determinant of health survey.</p> <p>Since their last report, they now participate in CMT and have a global consent in place as well as a shared care plan.</p>	<p>mini-cog and the depression screening.</p> <p>Since their last report, the SDoH assessment is being piloted in the ED and plans to expand beyond the ED to additional LRGH practices is anticipated in the first half of 2019. The CMT global consent is in place and though the ECCs have not begun utilizing the CMT shared care plan module, a training is scheduled with HealthFirst to speak with the LRGH ECC's on January 29, 2019 to share how they are utilizing the shared care plan module within CMT and train them appropriately.</p>	<p>manage complex patients. We have a closed loop referral system from providers to their ECC's, their Ambulatory Social Worker, their Community Educator, and their Ambulatory Pharmacist. (workflow has been shared with CHSN-IDN5).</p> <p>Their providers work with mental health agencies to manage mild to moderate depression in the practices. All ECCs are now included in CMT's event notifications and follow the LRGH ED discharge workflow to ensure appropriate follow-up occurs. Reports are run for patients who have chronic conditions and are then managed by the ECC's. They continue to enhance the components of the CCSA such as the mini-cog and the depression screening.</p> <p>The CMT global consent is in place and the ECCs are now utilizing shared care plans. They had a training by HealthFirst to</p>
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					<p>Speak with the LRGH ECC's on January 29, 2019 to share how they are utilizing the shared care plan module within CMT and train them appropriately.</p>
	<p>Lakes Region Mental Health Center</p>	<p>Co-Located Care Level IV</p>	<p>Lakes Region Mental Health Center Inc. (LRMHC) has coordinated with project partners, HealthFirst Family Care Center and Mid-State Health Center to develop an integrated model of care that has become a person-centered behavioral health home for people with serious mental illness (SMI) and/or co-occurring substance use disorders. The OneHealth program is funded by a Substance Abuse and Mental Health Services Administration (SAMHSA), Primary Behavioral Health Care Integration Grant.</p> <p>The population of focus is individuals with SPMI and/or co-occurring substance use disorders who</p>	<p><b>CCSA</b> A CCSA is done on intake so as to ensure the annual assessment is completed the practice is looking for approval of our current state required quarterly report. This effort ensures we are not increasing administrative burdens or duplicating paperwork and we extend the CCSA to all Medicaid patients vs just the new ones to our practice.</p> <p>Hypertension:</p> <ul style="list-style-type: none"> <li>▪ Once a year the nurse takes blood pressure for mental health patients and records in the electronic health record</li> <li>▪ The prescriber reviews the blood pressure and identifies an intervention based on NQF 0018 and selects an intervention based on the reading (education, referral to PCP, nutrition education, other</li> </ul>	<p><b>Milestone Met;</b> <b>Additional progress that occurred within this reporting period are:</b></p> <ul style="list-style-type: none"> <li>▪ A policy was created and procedures implemented for Diabetes Screening for People with Schizophrenia or Bipolar Disorder NQF 0003.</li> <li>▪ A policy was created and procedures implemented for Metabolic Monitoring for Children and Adolescents NQF 2800.</li> <li>▪ A Suicide Risk Assessment; NQF 0104 and 1365 just completed and put in place; this is administered at intake with flow up per triage; use of the Columbia Suicide Severity Risk Screening.</li> </ul>

		<p>have or are at risk for developing comorbidity primary care conditions and/or chronic diseases. At the start of this program, less than 20% of LRMHC clients were noted in the electronic medical record as having a primary care provider, and those who did were mostly patients of their project partners. This poised the program collaboration to achieve improved outcomes, integration and communication. They also work with community partners to engage eligible minorities, refugees, victims of trauma, veterans, persons with HIV/AIDS, and/or Hepatitis A, B &amp; C in the project.</p> <p>The program includes two primary care providers, a Grant Nurse and an Integrated Care Manager with the goal of alleviating barriers to care for our rural area. All program activities</p>	<p>such as inShape, Peer Wellness Coach)</p> <p>BMI:</p> <ul style="list-style-type: none"> <li>▪ The BMI is taken once yearly by nursing and entered into the electronic health record</li> <li>▪ Nursing informs the prescriber who reviews the BMI and selects an intervention based on NQF 421 (education, referral to dietician, nutritionist, OT, PT, referral to PCP, referral to exercise counseling, other)</li> </ul> <p>Tobacco Screening:</p> <ul style="list-style-type: none"> <li>▪ The patient is asked at intake and yearly if they smoke</li> <li>▪ This information populates to the progress notes and medical staff notes</li> <li>▪ If the patient smokes, the prescriber offers smoking cessation and based on NQF 0028 selects an intervention (tobacco cessation, pharmacological interventions, other such as smoking cessation groups offered by mental health)</li> </ul> <p>PCP Communication:</p>	<p><b>Other areas being worked on at time of reporting:</b></p> <ul style="list-style-type: none"> <li>▪ Medication Reconciliation Post Discharge, NQF 0997 – work continues on the development of this policy and procedure.</li> <li>▪ Identification of a system for “alerts” for nursing staff to refer to all medical specialties and mental health teams as our electronic health record does not have a way for prescribers to “order” – this policy and procedure is in process.</li> <li>▪ For all referrals, development of an electronic “closed loop system” - there have been some EMR issues regarding the referral form and process identified that are still being worked out.</li> </ul>
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			<p>support the Triple Aim, Million Hearts Initiative, and principles of recovery. With their partners, LRMHC has developed a patient-centered behavioral health home that improves health outcomes for persons with SMI by integrating primary and behavioral health care at the patient’s main access point – the community mental health center.</p> <p>Between January and June of 2018 they enrolled 53 new clients into the OneHealth program, bringing the total number of clients they have engaged to 313. During this time, they hired a Peer Wellness Coach, who has either received services or is in recovery, to provide support with a recovery focus to adult clients and their families by maximizing client choice, self-determination and decision-making in the planning,</p>	<ul style="list-style-type: none"> <li>▪ Informed consent and PCP Communication form put in place to assure shared information is faxed to the PCP and/or specialist</li> <li>▪ Prescriber populates the form and transfers to medical record who faxes to the PCP office</li> <li>▪ Communication form also populated at intake to inform PCP of mental health treatment</li> </ul> <p>Global Release:</p> <ul style="list-style-type: none"> <li>▪ LRMHC adopted the global consent forms and will have staff trained and begin using them in February 2019</li> </ul> <p><b>Additional areas identified that are under development:</b></p> <ul style="list-style-type: none"> <li>▪ Diabetes Screening for People with Schizophrenia or Bipolar Disorder NQF 0003</li> <li>▪ Medication Reconciliation Post Discharge, NQF 0997</li> <li>▪ Metabolic Monitoring for Children and Adolescents NQF 2800</li> <li>▪ Suicide Risk Assessment; NQF 0104 and 1365 just put in place;</li> </ul>	
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			<p>delivery and evaluation of treatment, recovery, and support services. They also assist in helping clients keep their appointments within our building and other specialty appointments. In January, Lakes Region Mental Health Center moved to its new 40 Beacon Street East, Laconia NH. The new building includes a defined clinic space including two exam rooms, a provider's office, and nursing station. In March, they also added a half-day of clinic time to their schedule which has increased patient care time tremendously. The CLIA lab, which has been functioning since 2017, expanded beyond their SAMHSA funded labs to become a draw station. This allows their clients to receive lab draws in the same location as their other integrated services.</p>	<p>administered at intake with flow up per triage; use of the Columbia Suicide Severity Risk Screening</p> <ul style="list-style-type: none"> <li>▪ Identification of a system for "alerts" for nursing staff to refer to all medical specialties and mental health teams as our electronic health record does not have a way for prescribers to "order"</li> <li>▪ For all referrals, development of a "closed loop system"</li> <li>▪ Job descriptions for nurses to include increased integrated health responsibilities</li> </ul>	
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			<p>MAT is provided on a limited basis at LRMHC being applied only in the psychiatric inpatient setting at the DRF with support of Dr. Suarez prescribing patients these medications.</p> <p>LRMHC is currently in the process of credentialing one of their APRN's to also provide MAT support to patients at the LRGH ED in the near future.</p>		
	Horizons Counseling Center	Integrated Care Level V	<p>Horizons has focused its integration efforts primarily on the Department of Corrections. They are now fully integrated into the Medical Department of the Belknap County Department of Corrections with all behavioral health (SUD and MH) assessments and interventions being shared with the primary care providers and the nursing staff and regular communication among behavioral health and medical staff around the care of inmates.</p> <p>They have been meeting with primary care providers at the</p>	<p>Horizons Counseling Center has designated two counselors to share the position of Care Coordinator to work with clients who are high utilizers of the emergency department and who recidivate in the criminal justice system. As part of the C2 Re-entry project, care coordinators make contact with incarcerated clients as much as 3 months prior to their release from confinement, participate in the assessment of their ongoing behavioral health, SUD and medical needs and assist the clients in setting up and accessing the post-release services identified. Care Coordinators</p>	<p><b>Milestone Met;</b> Horizons Counseling Center has been utilizing a paper CCSA while they select their new electronic EMR system.</p> <p>Horizons got their CMT implementation up and running and hired a FT care coordinator so they are now capable of shared care planning.</p>

			<p>Department of Correction (DOC) around the development of protocols and procedures for introducing MAT into the Belknap County DOC. Preliminary protocols have been drawn up that are now going to the County for approval. They are planning meetings with correctional authorities around implementation should the protocols be approved by the county.</p>	<p>maintain regular contact with clients leaving incarceration to check in on their follow-through with services set up, to troubleshoot barriers to accessing those services as needed and to encourage, remind and facilitate client follow-through with those resources. The care coordinators work closely with primary care, specialty care providers, mental health, SUD and MAT providers to identify areas where the client may not be engaged, to help identify barriers to engagement and to utilize the development of a relationship with the client to support and encourage engagement.</p> <p>Integration progress has been most measurable in the area of criminal justice re-entry. Horizons SUD/BH staff meets weekly with nursing staff at the Belknap County DOC to discuss inmates with multiple conditions that increase risk for recidivism and that would likely complicate successful re-entry. Communication with the medical provider happens once a month at the facility to address complicated</p>	
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				<p>presentations and need for integrated care approaches with complicated presentations. Communication is available by phone as needed, initiated by the provider, nursing staff or BH staff to ensure that all information regarding a patient's presentation is taken under consideration in the development of a case plan at the time the need is identified, without having to wait for a next scheduled meeting.</p> <p>Horizons has begun to work with a psychiatric APRN in addressing the co-occurring needs of our outpatient and IOP clients when the level of need for treatment of mild to moderate depression does not rise to the level of requiring a referral to LRMHC due to the likelihood that the client would not be found to be an eligible client. Joint assessment of client needs is done with work toward the development of a joint care plan in process.</p> <p>Horizons and LRMHC have made significant progress on developing protocols for sharing clients with high SUD and high MH needs including protocols</p>	
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				for addressing client emergencies and for joint decision making and case planning.	
	Riverbend Community Mental Health	Co-located Care Level IV	<p>Riverbend has worked towards a higher level of integration in this past period through implementing a variety of tools, assessments and facilitating partnerships in the IDN community. To improve their clinical care, they have implemented the use of the PHQ-9 to standardize screening for depression and development of a plan to address the symptoms.</p> <p>They have also adjusted clinical intakes to include the CCSA. The CCSA has been integrated into their clinical record and pulls information from documents that are already in use such as the treatment plan and the Adult Needs and Strength Assessment. They have added question regarding domestic violence and cigarette smoking with immediate plans for appropriate referrals after the assessment. They have instructed the intake clinicians to</p>	<p>Riverbend has worked towards a higher level of integration in this past period through implementing a variety of tools, assessments and facilitating partnerships in the IDN community. To improve our clinical care, we have implemented the use of the PHQ-9 to standardize screening for depression and development of a plan to address the symptoms. Clients who are evaluated as high risk are screened for depression and suicidal ideation at each subsequent contact until they are no longer deemed a high risk client. We have also adjusted our clinical intakes to include the CCSA. The CCSA has been integrated into our clinical record and pulls information from documents that are already in use such as the treatment plan and the Adult Needs and Strength Assessment (ANSA). We have added questions regarding domestic violence and cigarette smoking and immediate appropriate referrals are made at the time</p>	<p>Riverbend engaged in a PDSA cycle to evaluate the effectiveness of current CCSA processes and determine a need for further action. Previously, Riverbend had sought to create a CCSA "form" in the EHR, pulling data points from multiple electronic sources to create a single summary document. It was theorized that this would support the completion of screening across all CCSA domains and thereby, the achievement of associated metrics. Upon review of MAeHC data, it has become clear that Riverbend's existing processes are sufficient, eliminating the need for the creation of a single form.</p>

			<p>review the CCSA with the client to ensure that we are capturing all the necessary information to gain a holistic view of the client's life. They have also encouraged the clinicians to use the CCSA as a way to learn more about their client and to steer treatment with the client's multidisciplinary team. They have a team of licensed clinicians, case manager's, vocational supports, psychiatric nursing and a psychiatrist. All cases are presented at a weekly team meeting and the team is able to share thoughts, concerns, and resources to help support the client's care.</p> <p>With the use of CMT, we are able to get a clinical picture of how the client is also presenting in crisis situations at local EDs. This information is also reviewed at team meetings and is included in the overall care and treatment with the client.</p> <p>Most importantly, Riverbend has</p>	<p>with immediate plans for appropriate referrals after the assessment.</p> <p>Riverbend prescribers are now also measuring and monitoring BMI with clients and having appropriate discussions around nutrition and weight management.</p> <p>We have instructed the intake clinicians to review the CCSA with the client to ensure that we are capturing all the necessary information to gain a holistic view of the client's life.</p> <p>We have also encouraged the clinicians to use the CCSA as a way to learn more about their client and to steer treatment with the client's multidisciplinary team.</p> <p>The recently implemented CMT universal release allows Riverbend case managers to consult with PCPs and other appropriate treatment providers to provide more comprehensive and holistic care to clients.</p> <p>We have a team of licensed clinicians, case manager's, vocational supports,</p>	
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			<p>noted having richer conversations with clients about their wellness as it relates to physical health, mental health, sobriety and their social systems. Riverbend continues to work as part of a greater team to improve client care by partnering with local PCP offices including HealthFirst, MAT programs such as the LRGH Recovery Clinic and local Emergency Departments. They look forward to furthering these connections and also developing an MAT psychotherapy group this fall 2018.</p>	<p>psychiatric nursing and a psychiatrist. All cases are presented in our weekly team meeting and the team is able to share thoughts, concerns, and resources to help support the client's care.</p> <p>With the use of CMT, we are able to get a clinical picture of how the client is also presenting in crisis situations at local ED's. This information is reviewed at team meetings and is included in the overall care and treatment with the client. A process has now been put into place that when a client is identified in a CMT alert, the program manager immediately alerts the assigned case manager and therapist for contact within that day, if possible, to address client concerns and challenges. A shared care plan is now being entered into CMT as soon as a client is identified as a high utilizer and the plan is revised as necessary for clearer communication between behavioral health providers and emergency room clinicians.</p> <p>Most importantly, richer conversations are occurring with clients about their</p>	
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				<p>wellness as it relates to physical health, mental health, sobriety, and their social systems. Riverbend continues to work as part of a greater team to improve client care by partnering with local PCP offices including HealthFirst, MAT programs such as Lakes Region Recovery Clinic, and local Emergency Departments. We look to further these connections and also have planning a relapse prevention psychotherapy group in spring 2019. Clients now also have the option of having an on-site assessment with a LADC from the Choices program at any time in their treatment to address substance misuse issues. Riverbend and Choices use the same EMR and this closed loop referral fosters more an efficient and productive coordination of client care.</p> <p>In January 2019, the Franklin Riverbend program will also become a "spoke" in the NH SOR Grant's Hub and Spoke model of substance misuse treatment.</p>	
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## Attachment\_B1.2A

# B1 Integrated Healthcare (IDN 5)

Attachment\_B1.2A

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

## **Projects C: Care Transitions-Focused**

### **IDN Community Project Implementation and Clinical Services Infrastructure Plan**

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

##### **Project Progress Made**

CHSN's Supportive Community Re-Entry Program continues to reflect consistent progress this reporting period due to the continued support received from all affiliated partners since the beginning stages of project implementation. The project continues to closely align itself with the existing SUD treatment and vocational rehabilitation program in the Belknap County House of Corrections as well as with the medical and behavioral health services offered to all sentenced and pre-trial inmates alike. While the Supportive Re-entry Project targets sentenced inmates who have identifiable release dates and are in custody long enough to be assessed and paired with a care coordinator, during this reporting period we have been successful in capturing referrals of 4 pre-trial inmates with significant behavioral health needs who, because of individualized circumstances, could have predictable discharge dates. All are "frequent flyers" in the jail system, though their offenses are more related to their behavioral health issues and lack of follow-through with prescribed treatment than with criminality. While one of these offenders was eventually sentenced to the prison when his pretrial status was resolved, his sentence was in no way associated with the services provided to him pre-trial.

Particular progress is noted in that the Care Coordinators and Case Managers have worked to build relationships with the DOC nursing staff to ensure that releases of information are included with medical records leaving the facility to receiving medical and behavioral health providers and to assist nursing staff in initiating applications for Medicaid, SUD treatment, MH treatment and PCP appointments prior to an inmate's release from confinement. This collaborative effort has reduced some of the burden on the DOC's limited medical staff and has encouraged growing cooperation between the DOC staff and the project. Another area of particular progress has been in the pre-release engagement and monitoring of inmates on the DOC's electronic monitoring and vocational rehabilitation program. C2 Project Care Coordinators have worked closely with the two Community Corrections Officers and the Counselor/Case Manager of the DOC to initiate some integration of roles in order to ensure that all parties involved in the supervision of inmates as they transition from incarceration to community are on the same page with their understanding of the individual needs and the individualized definition of successful re-entry for each offender. Over the course of this reporting period we have seen Community Corrections and project staff collaborate on decisions around when an inmate is ready to move out on electronic monitoring and what appointments, supports and services should be required of them, and should be accommodated within their home confinement schedule, that would most positively impact their successful re-entry. As part of this team approach, DOC treatment and security staff have begun developing trust in the aspects of offender re-entry that each of them can best contribute to a re-entry plan; Community Corrections staff regularly seeks out treatment and Care Coordinator input into work release and electronic monitoring decisions and Care Coordination staff increasingly relies on the observations, home and work visitation impressions and monitoring of follow-through with recommended interventions in order to recognize a need for care plan revision before it becomes problematic. We have also seen some role sharing between

DOC and C2 project staff assisting each other and covering each other's overlapping responsibilities when necessary. This level of integration allows necessary services to be provided to re-entry clients even when their treatment provider or care coordinator is unavailable. We see this integration and mutual support among staff as in the long run contributing to the sustainability of both the county SUD treatment program and the C2 Supportive Re-entry Project.

Another notable example of progress made in the C2 Project during this reporting period has been the involvement of the Division of Field Services in the re-entry planning and preparation earlier than is traditionally seen. Probation Parole Officers (PPOs) are often familiar with inmates leaving incarceration from prior experience with them on supervision and have insights into their risk factors that care coordinators who are new to the client can't possibly have gained. This early involvement allows care coordinators to obtain the insights gained over time by PPOs and incorporated them in the relapse prevention planning work done with the offender pre-release. This early involvement has also encouraged release plan buy in by the PPOs, which has led to an increased team approach among PPOs, care coordinators and treatment providers in their interactions with clients post release from confinement and in their willingness to prioritize treatment interventions over punitive ones when client follow-through is not realized. In addition, it has resulted in probation officers expecting to receive consents and after care plans for offenders leaving the Belknap County HOC and requesting them for offenders who report post release for whom they have not received a consent. While this does not fully meet the intent of the milestone for obtaining releases of information prior to release from custody, it effectively accomplishes the goal of permitting the cooperation between Field Services and treatment providers in incentivizing offender engagement in post-release treatment and intervention in all areas identified in the assessment and re-entry plan.

One protocol that continues to be in place in the jail is for a HealthFirst Family Care Center (FQHC) or LRGHealthcare benefit navigator to come and meet with inmates every two weeks to complete Medicaid application paperwork. A case manager follows up with each client to facilitate their follow through with all necessary documentation to DHHS to ensure their Medicaid will be active upon release from confinement. One area of progress with respect to this process has been the involvement of care coordinators in expediting Medicaid applications and in initiating it for those inmates who leave the facility in between times when neither a HealthFirst nor LRGH navigator is available.

Progress was made on engaging individuals with substantial mental health needs in C2 Supportive Re-entry services prior to their release in that a Lakes Region Mental Health Center (LRMHC) case manager began participating in the Supportive Re-entry Care Coordination Team and began intervening, identifying post release service needs and setting up those services for clients identified as having primary mental health needs. Approximately 18% of clients preparing to leave the facility were identified as having primary mental health needs for assignment to this new case manager. As a result, 4 pre-trial inmates with significant behavioral health needs, two of whom did not have diagnosable SUD, were assigned to the LRMHC case manager for re-entry planning. Two of those individuals were not yet released from custody at the end of this reporting period and one was ultimately sent to NH State Prison when an assessment of "incompetent to stand trial" was not upheld. While this is not within the initial plan set out in the C2 Project, through implementation of the program we have learned that there are a number of offenders who are held in custody, though they are ultimately found to be incompetent to stand trial. The

timeframe between adjudication and release is often too short to effectively identify and set up vital services to ensure that these offenders do not slip through the cracks while in the application for services process. C2 staff has begun working with the Public Defender’s Office to identify this population early in the pre-trial process and assess them for treatment needs, begin to engage them in relationship building with a case manager, monitor their response to behavioral health interventions within the facility while they are in custody and be prepared for quickly setting up comprehensive services for them once the finding of incompetency is made.

Within this reporting period, Horizons staff has been providing training for correctional staff, CORE program treatment staff, Community Corrections staff, medical staff and administration on suicide prevention in jails and prisons and understanding SUD, mental health disorders, co-occurring disorders and their impact on suicidality and self-harming behavior in custody. This was the first time that this training was offered to treatment, medical and security staff jointly. The result of this change in training strategy has been an improved understanding on the parts of each faction of the challenges, concerns and perspectives of the other factions with respect to communication with inmates, care and custody issues, and therapeutic issues vs. staff and inmate safety issues. This has resulted in improved communication among the different departments within the DOC, increased trust and respect between treatment and security personnel and an increased willingness on the part of security staff to approach treatment staff with questions about how to handle situations where they think an inmate might be at risk.

Horizons has continued to work with the DOC administration and medical department to bring MAT to the facility. During this reporting period Horizons staff has participated in meetings with the DOC administration, supervisory staff, medical providers, nursing and County administrators to examine logistics, legal issues, liability issues and clinical benefits that could positively impact recidivism and costs related to inmate census. In June, a meeting including representatives from 3 other DOCs and representatives of Alkermes met at the Belknap County DOC with both DOC and C2 project staff to map out a plan for bringing MAT with Vivitrol to those facilities. Belknap County has made a formal commitment to this venture and protocols are being drafted currently with a tentative goal of beginning MAT as part of the re-entry process to the facility by October 2019. The CHSN-IDN5 Supportive Re-entry Program will be instrumental in the assessment of inmates for an SUD and for setting up follow up MAT services for those inmates started on Vivitrol just prior to their release either on electronic monitoring or discharge from custody.

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

Implementation Activity/ Milestone	Responsible Party/ Organization	Time line	Progress Measure / Notes
Establish and support Re-Entry Leadership Team	CHSN Executive Director;	Within 30 days of plan approval; meet bi-monthly	Milestone Met: Leadership Team established; regular meetings occurring with documentation of minutes. Leadership Team

Implementation Activity/ Milestone	Responsible Party/ Organization	Time line	Progress Measure / Notes
	Team Lead – Executive Director of Horizons Counseling Center		continues to meet bi-monthly with sub-committees meeting more frequently in between full team meetings to actively address project related tasks.
Initiate recruitment process for identified staffing needs		Initiate by December 31, 2017	Milestone Met; Recruitment initiated; Horizons Counseling Center has identified a Care Coordinator who has been working with the case managers and treatment staff of the CORE Program, with the DOC medical department and the Community Corrections Officers of the DOC. This staff supports identification of pre-release needs of each inmate being released to the community on electronic monitoring and with those getting ready for release from custody to begin the process of connecting these individuals with medical, treatment, educational and vocational supports. The Care Coordinator has been following them in the community to encourage and facilitate follow-through with services for the last 3-4 months. Navigating Recovery has identified 5 recovery coaches/CRSWs (comprising 2 FTEs) who have been providing recovery support services to inmates in the Community Corrections Program, developing relationships with those inmates and then providing them with an appointment with their coach at the Recovery Center within a few days of their release. LRMHC identified a case manager who began working with inmates identified as having primary mental health care needs during the month of December 2018. This case manager has now joined the Supportive Re-Entry Care Coordination Team.
Develop case management approach and protocols including: - Assessment, supports, services, after-care planning in	Re-Entry Leadership Team	Ongoing through December 31, 2018	Ongoing; Protocol identification in process; CMS (NH) allows for inmates to apply for Medicaid within 2 weeks of release, with

Implementation Activity/ Milestone	Responsible Party/ Organization	Time line	Progress Measure / Notes
<p>correctional facility via team approach</p> <ul style="list-style-type: none"> <li>- Recovery coach pairing before release</li> <li>- Primary care appointments made before release</li> <li>- MH/SUD service appointments made before release</li> <li>- Transportation to primary care and BH set up before release</li> <li>- After-care plans include appropriate supports and services before release with connections with staff of those supports and services made before release</li> <li>- After-care plans include incentives for sustained participation in plan, including connections with probation/parole and supportive court involvement as appropriate</li> <li>- Family/friend engagement and communication as appropriate</li> <li>- Identification of case manager (based on assessment) for check-ins and one-on-one communications (e.g. choice of recovery coach, family support worker, clinical service staff)</li> <li>- Application to Medicaid/Health Insurance program upon release</li> <li>- Patient confidentiality and privacy assurances and releases established before release</li> <li>- Housing and employment supports before release</li> <li>- Other components of re-entry supports and services</li> </ul>			<p>Medicaid becoming active once they are released, not prior to this timeframe. There is a protocol in place in the jail for a navigator from HealthFirst or LRGH to come in to meet with inmates every two weeks (thereby capturing those projected for release within the 2 week period) supporting completion of the necessary paperwork to obtain Medicaid eligibility. Protocols continue being standardized for recovery coach pairing.</p> <p>Nursing staff coordinate primary care appointments for all inmates whose release date they are aware of (pre-trial inmates have no predictable release date and are not included in our target population for C2). Nursing informs care coordinator of appointments arranged prior to inmate’s release. All inmates referred, who are released on probation, sign consents for care management and aftercare programs to communicate with Probation when the offender is on probation. If the offender chooses not to sign the release, the PPO will enforce in at the first probation meeting.</p> <p>Protocol for assignment of case manager has been formalized between Horizons and LRMH.</p> <p>For individuals involved in the CORE Program, assessment and aftercare planning is done primarily by the CORE counselors, including case management / care coordination staff as the CORE participants move from intensive treatment into Work Release, ensuring aftercare plans are in place and Medicaid applications as well as resource connections are made prior to their release on electronic monitoring. Care</p>

Implementation Activity/ Milestone	Responsible Party/ Organization	Time line	Progress Measure / Notes
			<p>Coordinators take primary responsibility for assessment and aftercare planning for offenders involved in other aspects of Community Corrections, drawing on the familiarity that in-house treatment staff has with these inmates in developing the re-entry plan. The multidisciplinary nature of the team allows for comprehensive assessment and post-release monitoring and supportive services.</p> <p>All inmates who are released on probation sign releases of information for their Probation Officer to allow for communication and cooperation between care coordination and supervision. The DOC informs the Division of Field Services of the release date of all offenders and a protocol developed with the Division of Field Services ensures that, if they do not receive a release of information for a given inmate on supervision, they will follow up with that individual to obtain that consent.</p> <p>Inmates meet with their case manager/care coordinator within 3 months of release to complete the assessment and re-entry planning process and to develop a trusting relationship with the inmate to strengthen the probability of sustained connection post release.</p> <p>The DOC nurses continue to take primary responsibility for the Medicaid application process, turning application information over to the case managers at the time of release. We are seeing increasing willingness on the part of medical staff to seek out assistance from case managers.</p> <p>Patient confidentiality, limits of confidentiality, privacy assurances</p>

Implementation Activity/ Milestone	Responsible Party/ Organization	Time line	Progress Measure / Notes
			<p>and importance of consents to care coordination are established and explained prior to offender release.</p> <p>Community Corrections Officers work with inmates in the Community Corrections Program, including the CORE Program, to find employment for them prior to release on electronic monitoring. Care Coordinators are already working with inmates in the CORE Program on identifying satisfaction with the work being done and setting goals for further training and education when appropriate.</p> <p>The lack of housing in the Lakes Region has made connecting inmates with housing difficult. However, Care Coordinators are providing inmates with information about the housing supports available to them in the community including facilitating the application process to the limited Sober Living houses available in the area and with scholarship and financial support resources to cover first month's rent.</p>
Develop inter-organizational care coordination protocols, including shared decision-making and crisis management	Re-Entry Leadership Team and CHSN members	Ongoing through December 31, 2018	Milestone met; Interagency Care Coordination Policy was adopted this reporting period. Previously developed protocols included coordination of services between Horizons and LRMHC, Horizons and Navigating Recovery, Navigating Recovery and LRCS and Horizons and LRCS. Protocol between LRMH and Horizons for shared decision making and crisis management was also developed and in the process of revision as needed based on defining of roles between agencies throughout the process. LRMH and Horizons continue to support further staff education related to formal implementation of the protocols.

<b>Implementation Activity/ Milestone</b>	<b>Responsible Party/ Organization</b>	<b>Time line</b>	<b>Progress Measure / Notes</b>
Develop and implement procedures for data collection and sharing	Re-Entry Leadership Team and CHSN Board	Ongoing through December 31, 2018	Milestone met; Database created for referred inmates in the CORE Program to track their progress through the program, including work-release, electronic monitoring and community based aftercare.
Establish data sharing agreements with participating organizations	CHSN ED, Board and participating organizations	By December 31, 2017	Milestone met
Establish and implement all NH DHHS and CHSN data collection and reporting requirements	CHSN ED and CHSN members	Ongoing through December 31, 2018	Milestone met; Data collection and reporting requirement procedures performed with DHHS, MAeHC and CHSN Data Analyst
Initiate recruitment of required staff	CHSN ED and participating organizations	By October 1, 2017	Milestone met; Horizons re-entry care coordinator identified and in place; LRMHC has hired a care coordinator; Navigating Recovery re-entry recovery coaches identified and in place.
Provide cross-training to all staff and organizations involved in the project (see training plan)	Re-Entry Leadership Team	Ongoing through December 31, 2018	Milestone met; Training plans developed and implemented.
Initiate referral mechanisms and Continuing Care Coordination and Transitional Supportive Case Management	All participating organizations	Ongoing through December 31, 2018	Milestone met; Referral mechanisms in place
Identify, develop and implement licensure and certification pathway support for project staff to meet requirements as needed (see workforce development plan)	Re-Entry Leadership Team	By June 30, 2018 and ongoing	Milestone met; Horizons licensed staff continue to provide supervision for C2 project staff seeking LADC, MLADC and licensure by the Board of Mental Health Practice and CRSW Certification under agreement with the Belknap County DOC and Navigating Recovery of the Lakes Region. Included in the agreement with the DOC is the supervision of a Community Corrections Officer working toward her LADC.
Continue to develop relationship with Grafton County Department of Corrections	Re-Entry Leadership Team	By June 30, 2018 and ongoing	Ongoing; slightly new and increased engagement has occurred this period with Grafton County administration than in the past (as they appear to be more immersed in IDN 7 work). Efforts and inclusion activities will be ongoing.
Initiate referral mechanisms and Continuing Care Coordination and Transitional Supportive Case	Re-Entry Leadership Team	By January 1, 2019 and ongoing	Progress pending; see above

Implementation Activity/ Milestone	Responsible Party/ Organization	Time line	Progress Measure / Notes
Management in partnership with Grafton County			

## C-2. IDN Community Project: Evaluation Project Targets

### Evaluation Plan

Process evaluation of the Supportive Community Re-entry project continues to include documenting the presence or occurrence of key features of the model, as well as specific outcome metrics. Data describing process and outcome measures associated with this community project continue to be collected from participating organizations including de-identified client data to track care coordination and case management activities and monitor project goals. The key partners in the project currently informally review client feedback to make adjustments and improvements to policies and protocols to ensure goals are met, standards are maintained, and individuals receiving services are satisfied with their care. The C2 project has begun implementing a program evaluation tool. Due to the complex involvement of care involved in the re-entry process it was essential to confirm the appropriate target questions within this evaluation to accurately illustrate targeting outcomes, define whom will be administering this evaluation to participants and frequency of administration.

The project anticipates serving approximately 60 individuals per year through the Re-Entry Care Coordination project and is currently exceeding this goal. The socio-demographics of the population served through this project will be tracked to include housing, economic and employment stability; further criminal justice system involvement; and social and family supports.

CHSN has reviewed data systems in place to support the evaluation of this community project via the CHSN Health Information Technology (HIT) work group, Enhanced Care Coordination staff and CHSN Data Analyst. Leveraging these data systems along with CMT has helped to support the IDN's re-entry work. The following evaluation and performance measures began being collected in January 2018 and will be used to evaluate project process and outcomes.

Performance Measure Name	Target	Progress Toward Target		
		12/31/18	6/30/19	12/31/19
Number of individuals served	Approximately 60 per year once fully operational	Milestone Met; The program has served 51 individuals to date.	Milestone met; 71 individuals served	
Percent of referred clients for whom assessment and continuing care plan development in correctional facility is completed	>90% by end of the waiver.	Milestone Met; 100%	Milestone met; 100%	

Performance Measure Name	Target	Progress Toward Target		
		12/31/18	6/30/19	12/31/19
Percent for whom <i>case manager</i> pairing before release is completed	>90% by end of the waiver.	Milestone Met; 100%	Milestone met; 93% 3% are still incarcerated and pairing has not yet been done. 4% had their release status change after assessment and care planning was completed -their timeframe for release is no longer clear.	
Percent for whom recovery coach pairing before release is completed	>90% by end of the waiver.	Milestone Met; 100%	Milestone met; 93% 3% still incarcerated and pairing has not yet been done. 4% had their release status change after assessment and care planning was completed - their timeframe for release is no longer clear.	
Percent for whom Primary care appointments are made before release	>80% by end of the waiver.	Milestone Met; 100%	Milestone met; 93% 3% still incarcerated and pairing has not yet been done. 4% had their release status change after assessment and care planning was completed - their timeframe for release is no longer clear.	
Percent for whom appropriate Behavioral Health service appointments are made before release <ul style="list-style-type: none"> <li>Horizons to collaborate with Genesis Behavioral Health for referral of high needs BH and SUD clients prior to release and to determine focus of primary agency/case manager responsible for those clients.</li> </ul>	>75% by end of the waiver.	Milestone Met; 100%	Milestone met; 100%	

Performance Measure Name	Target	Progress Toward Target		
		12/31/18	6/30/19	12/31/19
Percent for whom Transportation needs to primary care and BH are identified and advised prior to release	>90% by end of the waiver.	Milestone Met; 56.5%. The remainder are not yet at close enough to their release date to work on transportation needs.	Milestone met; 93% 3% still incarcerated and pairing has not yet been done. 4% had their release status change after assessment and care planning was completed and their timeframe for release is no longer clear.	

Performance Measure Name	Target	Progress Toward Target		
		12/31/18	6/30/19	12/31/19
(Measure change) Percent for whom consents are put in place to include probation/parole in the care planning process in order to create offender incentives and supportive structure for sustained participation in the after-care plan	>90% for CORE graduates by end of the waiver.  >75% for offenders not sentenced to the CORE program.	Milestone Met; 100% of offenders released signed consents for probation. One revoked the consent after release.	Milestone met; 100% of offenders in the CORE Program signed consents for probation (Division of Field Services) within 2 weeks of their release on electronic monitoring or within 30 days of their discharge from the facility. This enabled Probation to be involved in the discharge planning process prior to offenders officially coming under the jurisdiction of Field Services.  Of the offenders not sentenced to the CORE Program, only a small number had probation included in their sentence and of these, only 66% agreed to sign consents to their probation officer before their release from custody. The remainder signed consents for their PPO soon after reporting. While this does not fully meet the intent of the milestone for obtaining releases of information prior to release from custody, it effectively accomplishes the goal of permitting the cooperation between Field Services and treatment providers in incentivizing offender engagement in post-release treatment and intervention in all areas identified in the assessment and re-entry plan.	
Percent of offenders without current coverage for whom application to Medicaid/Health Insurance program is made <i>prior to</i> release	>80% by end of the waiver.	Milestone Met; 100% of those released. 43.5% still in custody.	Milestone met; 100% of those released on electronic monitoring or discharged.	

Performance Measure Name	Target	Progress Toward Target		
		12/31/18	6/30/19	12/31/19
Percent for whom patient confidentiality and privacy assurances and releases are established before release	>90% by end of the waiver.	Milestone Met; DOC administration has not yet approved the IDN uniform consents. Individualized consents are being used to cover all involved services and including MAHeC and CMT. 100% of all offenders released signed consents; one revoked it post release.	Milestone met; 100% of inmates referred and who have been released signed consents prior to release. Five revoked those consents post release and are currently either absconded or back in custody as a result of their choice to abscond from supervision.	
Percent for whom housing referral is made as appropriate before release (This measure was updated to split into two measures- one for housing and one for employment. This was done because there is great variability in resource availability) <ul style="list-style-type: none"> <li>Horizons to establish partnership with Lakes Region Community Developers to provide transitional housing for inmates upon release back into the community.</li> </ul>	>50 % by end of the waiver. (Target was changed to accommodate the availability of housing for this project's population in the region)	60% (3/5)	100% of all inmates referred by the CORE Program received information about available safe and sober housing in the community and 52% of these received assistance in obtaining scholarships for and space in sober housing. CORE referrals make up 80% of referrals for those inmates who have been released during this reporting period.	
Percent for whom employment referral is made as appropriate before release. (This measure was updated to split into two measures- one for housing and one for employment. This was done because there is great variability in resource availability)	>75% by end of the waiver. (original target for this measure was far too high considering job availability in the region)	100% of offenders released to the community were already employed as they were initially released on Work Release. An exploration of options for education and additional vocational training was begun by the case manager.	Milestone met. 81% were employed at the time of their release as they were on work release prior to discharge. The 19% not employed were all disabled on SSI or SSDI and were given information about Vocational Rehab.	
Criminal Recidivism rate at one-year post release.	Reduce by 25% from baseline of 72%	Milestone Met; 22% (6 out of the 28 served)	Milestone met; 29% returned to custody.	
*Initiation of SUD Treatment (1 visit within 14 days)	>70% by end of the waiver.	Milestone Met; 84.6% (11 of 13 clients)	Milestone met; 87%	

Performance Measure Name	Target	Progress Toward Target		
		12/31/18	6/30/19	12/31/19
Retention in SUD/COBHD treatment for recommended duration per ASI/ASAM evaluation	>70% by end of the waiver.	Milestone Met; 92.3%; 2 of 13 are currently involved in treatment. It is too early to determine that they will remain in treatment for the recommended duration.	Milestone met; 73% remained in treatment as recommended by the ASI/ASAM assessment. 27% of those elected to remain in treatment to deal with co-occurring disorders that became evident through the treatment process.	
*Number / percentage of clients engaged in criminal justice follow-up services (4+ per year) ER Visit Users	<20%	Milestone Met; 8%	Milestone met; 13%	
*Number / percentage Potentially Preventable ER Visits	<20%	Milestone Met; 8%	Milestone met; 13%	

### C-3. IDN Community Project: Workforce Staffing

A total of 7.5 FTEs across three organizations was projected for new workforce staffing for the Community Re-Entry Project. CHSN now has a fully complemented C2 project at this time. The types of staff are shown by organization in the table below as of June 30, 2019. During this reporting period two positions (the Re-Entry care coordinator position at LRMHC and one SUD/Co-occurring counselor MLADC position oot Horizons Counseling Center) were filled thus making the projects fully staffed.

Provider Type	IDN Workforce (FTEs)				
	Projected Total Need	Staffing on 12/31/17	Staffing on 6/30/18	Staffing on 12/31/18	Staffing on 6/30/19
Re-entry Care Coordinator (Horizons)	1	1	1	1	1
Re-entry Care Coordinator (LRMHC)	1	1	0	0	1
Peer recovery support workers -future CRSW (Navigating Recovery)	2	2	2	2	2
SUD Counselor/LADC (non-reimbursable; positioned at jail) (Horizons)	1	0.5	1	1	1
SUD/ Co-occurring counselor/MLADC (Horizons)	1.5	0	0.5	0.5	1.5
Case Manager or clinician, shared float (Horizons)	0.5	0	0.5	0.5	.5
Case manager or Clinician (masters level) (LRMHC)	0.5	0	0.5	0.5	.5

#### C-4. IDN Community Project: Budget

Funds were budgeted for the Community Re-Entry project to support salaries and benefits of project staff as outlined in the previous section. Salaries were budgeted and agreed upon by the C2 workgroup based on prevailing wages by position type and fringe benefits were budgeted uniformly across all partner organizations at 31% of salary. Expenditures during this reporting period totaled \$ [REDACTED] for project staffing reimbursements. Navigating Recovery of the Lakes Region was reimbursed \$ [REDACTED], Horizons Counseling Center was reimbursed \$ [REDACTED] and Lakes Region Mental Health Center was reimbursed \$ [REDACTED]. Financial reporting on actual expenditures between January – June 2019 are reflected in the table below.

Budget Item	Item Description	2017 Actual Costs	Jan – Jun 2018 Actual Cost	July – Dec 2018 Actual Cost	Jan – Jun 2019 Actual Cost	Total Project Cost to Date	Total Projected Cost of Project
Project Staff Salaries / Wages (sub-contracted)	Salaries for counselors, case managers, care coordinators, and recovery support workers	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
Project Staff Benefits	31% of salary / wages	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
<i>Total Salary</i>		[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
Supplies	Miscellaneous expenses over waiver period	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
PROJECT TOTAL		[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]

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

There were no changes within the CHSN network composition during this reporting period.

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

## C-6. IDN Community Project: Standard Assessment Tools

There have been no changes made since the last report on July 31, 2018. The original tools identified are represented in the table below as they relate to the Assessment and Screening tools that will be used in the Community Re-entry Project. The assessment tool (ASI/ORAS) is administered one week before an inmate goes into the CORE program and is repeated when they go from work release to the bracelet to identify how high of a risk they are and if they meet criteria to continue in the program.

Standard Assessment Tool Name	Brief Description
Addiction Severity Index (ASI)	The ASI is a computer-based assessment that address seven potential problem areas in substance-abusing patients: medical status, employment and support, drug use, alcohol use, legal status, family/social status, and psychiatric status. This tool will be administered a week before inmates go into the CORE program and repeated when they go from work release to the bracelet to identify how high of a risk they are and if they meet criteria to continue in the program.
American Society of Addiction Medicine (ASAM) criteria	The ASAM criteria provide guidelines for assessment, service planning, level of care placement, continued stay and transfer/discharge of patients with addiction and co-occurring conditions.
Adult Needs and Strengths Assessment (ANSA)	The ANSA is a multi-purpose tool developed for adult's behavioral health services to support decision making.
Clinical Interview for DSM-5	The Structured Clinical Interview for DSM-5 is a semi-structured interview guide for making DSM-5 diagnoses. It is administered by a clinician or trained mental health professional that is familiar with the DSM-5 classification and diagnostic criteria.
Case Management (CM ) Assessment	The CM Assessment assesses for certain health and behavioral health conditions (chronic illness, mental health, substance use), lifestyle and living conditions (employment, religious affiliation, living situation) to determine risk factors, establishes risk categories and hierarchy, severity, and level of need

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

Several protocols surrounding patient assessment, treatment, management and referral specific to the Supportive Community Re-entry Project have been completed. Since many of the same agencies are involved in both C2 and D3 projects and the defined work is similar, there naturally is overlap in protocols and they will continue to be emphasized in both projects.

Horizons Counseling Center has a long history of working closely with the Belknap County Department of Corrections and has a manual of protocols and procedures that have been adopted and/or modified to support capturing milestones related to this project.

Protocol Name	Brief Description	Use (Current/Under development)	Progress Towards Target
Client Identification and Referral	Protocols and workflows for working with the corrections on timely identification of individuals who are within 3 months of release	Anticipated completion May 2018 unless additional changes necessitated by county funding cuts impacts staff and programming this project was relying on.	Milestone met; Horizons has placed a Case Manager/Care Coordinator in the HOC who has been doing client assessment, service referral, and the following of clients through re-entry and into their first year post release. The DOC CM has continued to provide support to the C2 Project CM/CC while inmates are housed within the DOC. The availability of the C2 CM/CC has made ongoing relationship building and supportive services possible and has provided the project with a liaison between the services identified for each offender and the supervision PPO. The LRMHC CM transitioned to working with high need inmates within the facility in December 2018, also allowing for the onset of expanding CM services beyond the CORE Program as the majority of inmates identified as having primary MH needs are in Community Corrections outside the CORE Program.
Screening, assessment, treatment, and care plan development	Protocols and workflows for application and frequency of screening and assessment tools and treatment planning; care plan development and review	Screening and assessment protocols and workflows completed. Discharge care planning in process to be completed by May 2018 unless additional changes necessitated by county funding cuts on the county level.	Milestone met; C2 workgroup has adopted use of the assessment tools and identified ASI, ORAS, and PHQ 9 for use with the assessment and treatment planning process.  The internal House of Corrections (HOC) workgroup, which includes CORE counselors and Horizons staff approved use of the assessment tools and added an additional tool for criminal thinking.  C2 workgroup continues to review existing protocols and workflows pertaining to screening and treatment planning.  Additional meetings continue to occur with the CORE and DOC staff to review and approve the protocols and workflows.

Protocol Name	Brief Description	Use (Current/Under development)	Progress Towards Target
Team-based care coordination and case management	Protocols and workflows for communication and case conferencing by community re-entry project staff including CRSWs	Anticipated completion Q1 2018	Milestone met; Protocols in place and team meetings including CORE counseling staff, Community Corrections Officers, C2 CM/CC, DOC Counselor/Case Manager, Corrections Officers, DOC Programs Director and Horizons Clinical Supervisor began including CRSWs in September 2018, with LRMCH CM being added in December 2018.
Data collection and evaluation	Protocols and workflows for collection, reporting and analysis of client data for program monitoring and improvement	Anticipated completion Q1 2018	Milestone met; Protocols for collection of data for CORE Program participants in place.

### C-8. IDN Community Project: Member Roles and Responsibilities

Project Team Member	Roles and Responsibilities
██████████	CADY / Offers restorative justice program for youth
██████████	NAMI NH / community supports
██████████	Horizons Counseling Center / Project Lead and SUD provider
████████████████████	Merrimack County / HOC leadership
██████████	Salvation Army / community supports
██████████	CHSN / Executive Director / oversight of project
████████████████████	LRMHC / key player in case management of inmates
██████████	Navigating Recovery of the Lakes Region / key player in recovery support
████████████████████	Belknap County / HOC leadership
████████████████████	LRCS / community supports / offer sober parenting course for inmates
██████████	CAP Belknap-Merrimack / community supports
████████████████████	LRGH / hospital liaison to care coordinators and community supports
██████████	HealthFirst Family Care Center / FQHC offering PC, MAT, counseling, etc.
████████████████████	Dept. of Corrections / key player in HOC and project activities

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

#### Training Plan

Training activities related to the Supportive Community Re-entry program continue to focus on team and partnership building, skill development for recovery coaches, cross-training for corrections officers and education for individuals working in the court system. CHSN contracted with NHADACA to meet the training needs identified for our projects and staff and several of the identified trainings occurred such as

Motivational Interviewing, Suicide Prevention and Ethical Competency. The CHSN-IDN5 Training Tracker (**Attachment A1.4A**) identifies individuals by name, practice and training topic they have participated in to date.

Project-Related Training Activities	Target Trainees	Time line	Progress Measure / Notes
New project staff orientation, team building, partner building	Project Staff (8 FTEs) and supervisors	By December 31, 2017 and ongoing	Milestone met for all existing project staff; Project is fully staffed. Of those hired, all have been trained in the 1115 waiver and the mission of CHSN; they have been oriented to their roles within the program, have received training in ethics and boundaries, confidentiality, ethical communication in an integrated care environment and suicide prevention.
Supervision of recovery coaches for maintenance of certification	CRSWs based at Recovery Support Organizations	By December 31, 2017 and ongoing	Milestone met; Ongoing; Weekly supervision meetings continue to be happening routinely. Two recovery coaches at Navigating Recovery have become certified as CRSWs and two others from Navigating and one from Horizons have submitted paperwork for action by the LADC Board. Recovery coaches continue to receive weekly MLADC supervision through Horizons.
Cross-training for corrections officers – understanding roles, recognizing signs and symptoms of SUD / MH for non-clinicians, suicide prevention for corrections staff	Corrections Officers	Identify staff and initiate training by January 1, 2018 and ongoing	Milestone met; Ongoing; [REDACTED] meets with nursing staff, community corrections staff

Project-Related Training Activities	Target Trainees	Time line	Progress Measure / Notes
			<p>and counseling staff at the DOC on a weekly basis to help staff identify SUD and MH needs of inmates and to provide education on protective approaches to inmates presenting with suicidal ideation and/or self-harming behavior.</p> <p>██████ met with staff at the Division of Field Services on 11/28/2018 to provide training on management of high risk behaviors in probationers and how to make decisions on accessing the appropriate service or assessment for those probationers.</p> <p><b>Trainings offered this reporting period:</b> training of treatment (SUD and MH) staff on safety protocols within a correctional facility that was conducted by a DOC Sargent.</p> <p>Training for COs and other security personnel on suicide prevention that was conducted by ████████ of Horizons.</p>
<p>Education for Justice System on project purpose and goals; understanding relationship of SUD / MH intervention and reducing costs / recidivism; understanding value of longer term monitoring in exchange for shorter incarceration</p>	<p>Judges, other court personnel and attorneys</p>	<p>Identify trainees and initiate training by December 31, 2018</p>	<p>Milestone met; training was provided to judges on MAT, the different types and positive use of MAT and on ASAM criteria of client</p>

Project-Related Training Activities	Target Trainees	Time line	Progress Measure / Notes
			placement. Education also provided to nursing staff at the HOC on ASAM criteria.

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

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

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

Attachment\_C.1B

## C2 Community Re-entry (IDN 5)

Attachment\_C1.B

Tasks	complete	End date	Order
1 <input type="checkbox"/> Planning	<input type="checkbox"/>	06/30/19	
2     Establish Re-Entry Leadership Team	<input checked="" type="checkbox"/>	12/02/16	
3     Identify key organizational/providers participants	<input checked="" type="checkbox"/>	12/09/16	
4     Execute meeting schedule	<input checked="" type="checkbox"/>	01/31/17	
5 <input type="checkbox"/> Develop implementation plans	<input checked="" type="checkbox"/>	06/30/19	
6 <input type="checkbox"/> Develop workforce plan	<input checked="" type="checkbox"/>	06/07/17	
7         Develop staffing plan	<input checked="" type="checkbox"/>	06/07/17	
8         Identify projected annual client engagement	<input checked="" type="checkbox"/>	07/31/17	
9         Develop implementation timeline	<input checked="" type="checkbox"/>	07/31/17	
10        Develop project budget	<input checked="" type="checkbox"/>	07/31/17	
11 <input type="checkbox"/> Design/develop Re-Entry Care Transition Team infrastructure	<input checked="" type="checkbox"/>	09/02/17	
12     Document and submit to CHSN protocol/workflow with corrections facility on identification of individuals who are within 3 m	<input checked="" type="checkbox"/>	09/02/17	
13     Identify roles and responsibilities for team members and submit to CHSN	<input checked="" type="checkbox"/>	08/31/17	
14     Identify training curricula needed by provider type	<input checked="" type="checkbox"/>	07/31/17	
15     Develop a training plan	<input checked="" type="checkbox"/>	07/31/17	
16 <input type="checkbox"/> Identify/develop patient management protocols/workflows	<input checked="" type="checkbox"/>	03/31/18	
17     Develop process to ensure compliance with Privacy/Confidentiality requirements	<input checked="" type="checkbox"/>	12/31/17	
18     Develop protocol for recovery coach pairing pre-release ans submit to CHSN	<input checked="" type="checkbox"/>	11/01/17	
19     Develop process to assist patient in Medicaid/Health insurance enrollment pre-release	<input checked="" type="checkbox"/>	03/31/18	
20     Identify current assessment tool(s) being used	<input checked="" type="checkbox"/>	06/05/17	

## **Projects D: Capacity Building Focused**

### **IDN Community Project Implementation and Clinical Services Infrastructure Plan**

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

##### **Project Update and Overview**

The D3 project's goal of expanding access to IOP treatment in the region has shown significant progress over this reporting period. Horizons Counseling Center has seen a consistent increase in clients receiving services in the expanded evening program as the community becomes aware of the service through community outreach efforts. In this reporting period, these outreach activities have included Horizons' staff making direct contact with potential referral sources such as the medical community, residential SUD treatment programs, the courts, and the local Recovery Community Organizations (RCOs). Horizons has also worked collaboratively with the Doorway at LRGHealthcare to facilitate quick admissions of Doorway referrals to the IOP level of care, interim services, and co-occurring outpatient counseling services when needed as an adjunct to MAT specific services as well as IOP. Horizons has begun to match clients with significant mental health needs who are not eligible clients in the MH system or who chose to remain in Horizons services with co-occurring counselors while they are still in the IOP level of care. While these counselors are generally not involved in the IOP, they have been cross-trained to be familiar with the information being imparted through the IOP program so as to ensure their ability to support the goals of the IOP level of care. This allows for continuity of care and has contributed to the significant numbers of clients who have chosen to remain in outpatient counseling beyond both Phase I and Phase II of the IOP. To date, the IOP expansion has decreased the wait for IOP services from what was three to four weeks to no more than three to four days. Horizons staff participates in a weekly meeting with Navigating Recovery of the Lakes Region and the Doorway staff to review procedural effectiveness, to discuss any difficulties encountered in client transitions among service delivery systems, care coordination and client follow-up to ensure that gaps in services or in service accessibility are addressed with immediacy.

In collaboration with Navigating Recovery of the Lakes Regions, Horizons has embedded Recovery Coaches into its expanded evening IOP and has increased its use of Horizons' Recovery Support Workers in the daytime IOP. This has not only allowed for IOP clients to be paired with Recovery Support Workers who can follow the client through their recovery journey after the need for SUD treatment is passed, but has fostered a recovery perspective throughout the treatment interventions offered through the IOP. Horizons staff also provides supervision for Navigating Recovery coaches to ensure that they can obtain and maintain the certification they need to meet DHHS requirements and to eventually be Medicaid reimbursable. In this reporting period, Horizons and Navigating have worked with the facilitating organization of Harbor Homes to complete the Medicaid applications to allow Navigating to bill Medicaid for coaching services under the supervision of Horizons staff.

Horizons continues to work closely with the LRGHealthcare Recovery Clinic to expedite client admissions to both services. Our collaboration has pointed to the need to expedite access for clients with OUD to access SUD treatment with MAT with minimal disruption, this has led us to allow for clients to initiate our

integrated services through either partner. Clients can now be assessed as appropriate for MAT and started into the services through whichever program they first connect with and with admission into the reciprocal program occurring within 1-2 business days. The Horizons IOP also works closely with Groups, along with HealthFirst and Mid-State, to ensure choices are available in MAT providers to all SUD treatment clients. In the last six months we have also engaged with Groups to facilitate sharing of clients that are struggling to manage their use of non-opioid substances with traditional MAT services, allowing the integration of Groups clients into the IOP level of care without interrupting their established MAT. We are also working with Groups to formalize referral protocols for MAT clients who are assessed as needing trauma-focused treatment or other co-occurring disorders treatment not available through traditional group MAT services. Horizons has also made its OUD treatment group targeted toward recipients of MAT available to clients receiving MAT with buprenorphine, methadone and naltrexone, available to clients of MAT providers beyond the LRGH Recovery Clinic.

CHSN-IDN5's Implementation plan was to also expand the IOP level of care to the Plymouth area and this has been unsuccessful to date, primarily due to workforce issues that have impeded the ability to hire qualified professionals to staff the Plymouth program. In the past six months, Horizons worked to serve our northern area clients requiring the IOP level of care through our Laconia IOP utilizing care coordination services to assist with transportation needs through CTS and ride sharing. Horizons has also worked to outreach potential referral sources among our northern IDN partners and stakeholders along with the E5 Care Coordination team for the Plymouth area in attempt to accurately identify the demand for this level of care in that region. As of March 1<sup>st</sup>, Horizons placed a counselor in its Plymouth office one day a week to offer ASAM assessment to clients referred for SUD treatment to determine appropriate level of care, to facilitate referrals to that level of care and to provide interim services to those unable to travel to the Laconia IOP. In the 4½ months that this limited needs assessment has been in place, only a handful of clients applied for the IOP level of care or were assessed as appropriate for the IOP level of care and all of these could be accommodated through the Laconia program. Horizons and CHSN recognize the limited scope of services available to our North Country residents and continue to pursue options for supporting the attraction of qualified SUD professionals to the Plymouth area and for expanding IOP services to that part of our IDN's territory.

The Belknap County Correctional facility continues to medically manage detox for alcohol and other drug withdrawal for all offenders who are admitted to the facility that meet criteria for either ambulatory or non-ambulatory detox. The Counselor/Case Manager of the DOC continues to work with the facility's medical department to refer individuals identified as needing SUD treatment as a result of their need for medical detox on admission to the jail or house of corrections to set up post-release follow-up treatment, though no aftercare monitoring or care coordination is built in to the system. They also continue to facilitate and coordinate referral and access to the appropriate post release level of care for offenders being released from confinement shortly after detox or prior to this medical intervention being completed. The D3 Project has continued to support the efforts of the DOC to facilitate post-release treatment for offenders identified as needing those services. In the past 6 months, 68% of inmates sentenced to the BCHOC received assessment and supportive case management through the D3 and C2 Projects including assessment, re-entry planning, and care-coordination follow-up. While the projects have targeted offenders incarcerated for 3 months or longer (recognizing that "good time" reduces sentences by 33%), care coordination efforts actually reached about 10% of short-term inmates along with four individuals who were not sentenced but who were confined pre-trial for more than 10 months.

The location of the Laconia outpatient and IOP center in downtown Laconia is in close proximity to LRGH, DHHS, the Division of Field Services and the Circuit and Superior Courts which has resulted in Horizons seeing a marked increase in walk-in traffic of clients seeking services in person versus on the phone. This phenomenon has increased significantly with the opening of the Doorway at LRGH, with clients assessed at the Doorway being sent directly to Horizons when the outpatient or IOP level of care is deemed appropriate, or when interim services are needed. This walk-in application for services allows Horizons staff to engage potential clients early on in the treatment process and we anticipate it will result in increased engagement and follow-through by applicants for services.

Since HealthFirst Family Care Center initiated their MAT program in 2018, they continue to have three Nurse Practitioners and four Physicians waived to prescribe Medication Assisted Therapy (MAT) with Suboxone. As part of the MAT program, all patients are required to participate in behavioral health counseling which supports patients navigating through their substance use disorder and helps them to obtain and sustain recovery. Within their primary care setting, they continue to have integrated Behavioral Health services with three FT and one PT Masters level counselors. One counselor is an MLADC; however, all four Behavioral Health counselors have been trained and are prepared to provide counseling services to MAT patients. Following the team-based Risk Reduction Model, all patients seeking enrollment in the MAT program are assessed by a Behavioral Health counselor and discussed with the MAT Team. Once accepted into the MAT program, patients begin with weekly MAT appointments with both medical and behavioral health providers. Gradually, patients will be extended to bi-weekly meetings, and then finally to monthly meetings as their recovery progresses. As they follow the Risk Reduction Model, they do expect patients to have difficulty maintaining consistent sobriety and are prepared to adjust their treatment to focus on their individualized needs. Sobriety and recovery are life-long commitments that HealthFirst is prepared to participate in helping their patients be successful with for as long as the needs present to support one's recovery journey. HealthFirst has been successfully providing MAT with Vivitrol to clients receiving counseling services at Horizons. Currently there are four clients involved in the Recovery Court program and another three are in counseling at Horizons who are being referred to HealthFirst's PCP for Vivitrol and successfully getting started on MAT without having to leave their outpatient services at Horizons. HealthFirst also continues building on the integrated model being used between Horizons and the LRGHealthcare Recovery Clinic and they continue to utilize the IOP services at Horizons to help stabilize patients with more intensive SUD treatment needs.

The CHSN-IDN5 training contract and extension of funding continues to promote efforts for staff recruitment and offering new counselors additional support with direct supervisory hours when applicable to assist them towards licensure and it helps promote interagency understanding for cross-training and care integration. Horizons Counseling Center continues to provide in-service training and weekly supervision for internal staff and for Navigating Recovery staff. This collaboration has enabled Navigating Recovery staff to meet requirements for obtaining and maintaining CRSW certification and to begin to position themselves for sustainability through billing Medicaid. Horizons has also provided training for the E5 Community Care Coordinators on ASAM Criteria for Client Placement and on Ethical Communication in an Integrated Care Environment. CHSN-IDN5 has also collaborated with IDN 7, providing this important training on communication among disciplines on a repeating basis for our North Country counterpart.

In this reporting period, Horizons sent one counselor/supervisor to the Stephanie Covington Curriculum Conference for training in the Beyond Trauma for Women and Girls curriculum. The goal is to incorporate elements of this curriculum into the IOP as well as to add a module for women for whom their trauma histories poses a barrier to effective assimilation and integration of treatment and recovery strategies and skills.

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

Implementation Activity/ Milestone	Responsible Party/ Organization	Timeline	Progress Measure / Notes
Establish and support SUD Treatment Options Leadership Team	CHSN Executive Director;  Team Lead – Executive Director of Horizons	Within 30 days of plan approval; meet bi-monthly	Milestone met; Leadership Team established regular bi-monthly meetings continue to occur with documentation of minutes; small workgroups of stakeholders continue including Horizons, LRMHC, Navigating Recovery, LRCS meet between Leadership Team meetings to continue discussion related tasks and process challenges.  In recognition of the challenges being faced by Horizons Counseling Center and PARC in expanding IOP services to the Plymouth area, CHSN implemented a sub-committee of the D3 Leadership Team to seek out solutions for the barriers being encountered, primarily in the area of workforce.
Develop Expanded IOP with care coordination and integrated recovery coaching approach and protocols including:  -Referral pathways, assessments, care coordination  -Patient confidentiality agreements	SUD Treatment Options Leadership Team	By June 30, 2018	In Process; Ongoing; D3 meetings continue to be held on a bi-monthly basis, with sub-committees meeting in between full team meetings, to review protocols, referral pathways and assessment protocols developed to date by the workgroup.  Workgroup members began the discussion of meeting transportation needs for non-Medicaid clients and

Implementation Activity/ Milestone	Responsible Party/ Organization	Timeline	Progress Measure / Notes
<ul style="list-style-type: none"> <li>-Recovery coach pairing</li> <li>-Transportation needs for non-Medicaid services</li> <li>-Family/support system engagement and communication as appropriate</li> <li>-Assigning of care coordinators per individual client needs</li> <li>-Application to Medicaid/Health Insurance program</li> <li>-Patient confidentiality and privacy assurances and releases established before release</li> <li>-Housing and employment supports</li> <li>-Other community supports</li> </ul>			<p>how to maximize the benefit of the transportation van designated for the Grafton County constituents in the first half of 2018. This discussion continues as barriers still remain for those who do not have reliable transportation or a Medicaid transportation benefit. The D3 project has set aside funds to utilize a van available through LRMHC to assist clients without personal transportation or a transportation benefit to access the expanded IOP as well as other levels of care within the continuum of care once active implementation is underway.</p> <p>The D3 workgroup developed protocols for assigning care coordinators to individual clients in late 2018.</p> <p>Horizons met with Lakes Region Community Developers to examine the options for expanding safe, sober housing options for high need clients/families and to support the development of sober housing in the IDN. With the support of Navigating Recovery, Horizons and LR Community Developers are in the process of submitting a grant proposal to the NH Housing Finance Authority to rehab and open a Transitional Housing home for women leaving residential community-based treatment or residential treatment in a jail or prison. The house would serve 8 women in early recovery and provide them with access to continuing SUD and co-occurring disorders treatment at Horizons, recovery support services through</p>

Implementation Activity/ Milestone	Responsible Party/ Organization	Timeline	Progress Measure / Notes
			<p>Navigating Recovery of the Lakes Region and support for education, vocational training, workforce and assistance in transitioning to safe, permanent housing. The RFP proposal was submitted by Lakes Region Community Developers in January 2019, if successful, will target late 2020 for opening the Compass House for Women in Laconia.</p> <p>Patient confidentiality consents and agreements were formalized and introduced to the Leadership Team. Navigating Recovery coaching staff began training on how and when to utilize HIPAA and Part 2 compliant consents and how to approach clients to help them understand the benefits they will receive from the care coordination made possible by utilizing these consent forms.</p> <p>Protocols for engaging family in the treatment and recovery process is being formalized with the coordination of effort between Horizons and Navigating Recovery. Horizons is encouraging family members of IOP participants to engage in the family support services being offered by Navigating Recovery. Protocols for referring family members of IOP clients to Navigating Family Support Services have been developed and parallel protocols for the referral of all Horizons clients to Navigating Recovery.</p> <p>Application to Medicaid/Health Insurance, housing, employment and other community supports</p>

Implementation Activity/ Milestone	Responsible Party/ Organization	Timeline	Progress Measure / Notes
			<p>protocols complete and being implemented.</p> <p>Horizons and Navigating Recovery met several times to focus specifically on the workflows between the recovery coaches and counselors and how to engage the client’s family.</p> <p>Workflows between recovery coaches and counseling staff completed.</p> <p>Protocols for recovery coach pairing and care coordinator pairing completed.</p> <p>Protocols for making referrals for other identified community supports on an individualized basis as driven by the treatment/recovery plan in place.</p> <p>Protocols for referrals to housing and employment supports completed, though resources for safe housing are extremely limited within the IDN.</p>
Initiate recruitment of staff for evening IOP in Belknap County	Hiring organization; SUD Treatment Options Leadership Team	By December 31, 2017	In Process; One Masters Level counselor fully trained and prepared to move into the evening IOP transitioned out in May 2018 on FMLA due to a family issue and eventually made the decision not to return. This position was filled in August 2018 with a Masters level counselor who had previously worked in the morning IOP and was experienced in the modality and the program curricula. One LADC who was trained and working in the evening IOP left employment temporarily due to a family

Implementation Activity/ Milestone	Responsible Party/ Organization	Timeline	Progress Measure / Notes
			responsibility. Horizons is actively seeking a replacement.
Develop inter-organizational care coordination protocols, including shared decision-making and crisis management	SUD Treatment Options Leadership Team and CHSN partners	By June 30, 2018	<p>Milestone met; workflows between LRMHC and Horizons have been developed and formalized with the understanding that revisions can and will be made as the effectiveness of the protocols is vetted. These protocols include agreements on crisis management of shared clients and agreements on shared decision making around the treatment of shared clients were developed and currently in place, though still to be revised as practical application is being piloted for efficiency.</p> <p>Horizons and LRMHC have identified a need for further staff training and ongoing training as new staff is hired to continuously support implementation of the protocols and to consistently exemplify a sense of cooperation and collaboration. Training may be valuable across other IDN projects to enhance the concept of integration across all entities for enhancement of outcomes and quality of care for clients.</p>
Develop and implement procedures for data collection and sharing	SUD Treatment Options Leadership Team and CHSN Board	By December 31, 2017	Milestone Met; development of data sharing procedures for SUD (42 CFR Part2) and co-occurring information has been completed through the implementation of CMT for sharing of information across care teams and with the addition of CHSN's "universal consent" documents which have assisted both patients and agencies utilizing them by streamlining the process

Implementation Activity/ Milestone	Responsible Party/ Organization	Timeline	Progress Measure / Notes
			and clearly stating who PHI can be shared with across agencies. For the partners who have not adopted the universal consent documents, their consents have all been upgraded to include approved legal 42 CFR Part 2 language within.
Establish data sharing agreements with participating organizations	CHSN ED, Board and participating organizations	By December 31, 2017	Milestone met; Data sharing agreements distributed to partners.
Establish and implement all NH DHHS and CHSN data collection and reporting requirements	CHSN ED and CHSN partners	By December 31, 2017 and ongoing	Milestone met; Data collection procedures in place with D3 partners
Provide cross-training to all staff and organizations involved in the project (see training plan)	SUD Treatment Options Leadership Team	By January 31, 2018 and ongoing	Milestone met for existing staff; Ongoing for new staff; D3 project staff at Horizons and Navigating have participated in training on 42 CFR Part 2, the use of Part 2 compliant integrated care IDN consents, motivational interviewing, ASAM criteria for level of care and confidentiality and ethical communication in an integrated care environment provided by NHADACA and through in-service training.
Initiate referrals, IOP services and care coordination for evening program in Belknap County	All participating organizations	By January 31, 2018 and ongoing	Milestone met; Ongoing; evening IOP began accepting referrals in September 2018 with services starting in September.  The evening IOP opened in late August at Horizons new site on Beacon Street in Laconia. IDN partners and other medical, mental health, and medical providers, social service agencies and the criminal justice system were informed of the

Implementation Activity/ Milestone	Responsible Party/ Organization	Timeline	Progress Measure / Notes
			<p>referral process for this new program.</p> <p>The new site houses both the AM and PM IOP. The centralized location in downtown Laconia has resulted in increased walk-ins for services, underlying the added convenience for this client base created by the downtown location. As a result, while Horizons continues to offer traditional outpatient services at its established Gilford office, it is now also offering group aftercare for the IOP and traditional outpatient counseling for SUD and co-occurring disorders in the Laconia office as well.</p>
<p><b>MOU signed between CHSN and Riverbend Mental Health to assist in funding the equivalent of 2 Medicaid slots (serving our Merrimack County constituents) as part of their IOP expansion in the Franklin area</b></p>	<p>CHSN Executive Director</p>	<p>By January 31, 2018.</p>	<p>Milestone met; MOU signed on 1/5/2018 but Riverbend has experienced a delay in their plans to open their IOP in Franklin until mid-2019 due to workforce issues. This item will be revisited when Riverbend notifies CHSN that they are opening their IOP in Franklin at which time payment for the two Medicaid slots will begin being issued.</p>
<p>Publicize expanded IOP availability through communication to all PCP practices, local media (radio, newspaper, public access channel), grand opening event</p>	<p>SUD Treatment Options Leadership Team</p>	<p>By January 31, 2018</p>	<p>Milestone met; PCP practices and IDN partners all notified. Media announcement and invitations sent out to stakeholders including the courts, the criminal justice system, DCYF, social service agencies and other healthcare and behavioral health providers to an open house and information session.</p> <p>Open house was held October 1, 2018 with local press coverage including an article about the new</p>

Implementation Activity/ Milestone	Responsible Party/ Organization	Timeline	Progress Measure / Notes
			site and the IOP expansion in the Laconia Daily Sun.
Initiative recruitment of staff for Plymouth area IOP	Hiring organization; SUD Treatment Options Leadership Team	By June 30, 2018	Milestone met; Recruitment for staff has been ongoing since mid-2018. Efforts continue for recruitment of Plymouth IOP staff. CHSN Board established a sub-committee of the D3 Leadership Team to examine and explore solutions and expanded marketing efforts to help resolve this issue.
Initiate referrals, IOP services and care coordination for Plymouth area IOP	All participating organizations	By December 31, 2018 and ongoing	<p>In Process; Pending completion of staff recruitment and development activities as stated above.</p> <p>Staff recruitment efforts actively continue for the Plymouth IOP.</p> <p>Horizons has entered into an agreement with the Whole Village Family Resource Center to house the IOP and Horizons' outpatient services which will also be shared with PARC (recovery support agency). This will put the IOP services in a site that houses multiple social services. It will also facilitate communication and integration of services between Horizons and PARC as PARC recovery coaches are integrated into the IOP once it opens.</p>
Develop criteria and certification pathway support for project staff to meet requirements as needed (see workforce development plan)	SUD Treatment Options Leadership Team	By June 30, 2018 and ongoing	<p>Milestone met; Ongoing; Horizons continues to provide in-service training for its staff and for Navigating Recovery staff to support meeting the education needs of the workforce.</p> <p>Horizons has also developed an agreement with NHADACA for co-sponsorship of in-house in-service</p>

Implementation Activity/ Milestone	Responsible Party/ Organization	Timeline	Progress Measure / Notes
			<p>training to facilitate offering CEU’s for licensed/certified staff and for staff seeking licensing/certification.</p> <p>Horizons provides supervision for Navigating CRSWs and Recovery Coaches to support their path to certification and their maintenance of that certification. It is intended that this same model will be used in the relationship between PARC and Horizons.</p>

**D-2. IDN Community Project: Evaluation Project Targets**

**Evaluation Plan**

The process evaluation of the SUD Treatment Expansion project will continue to entail documenting the occurrence of key features of the model, as well as specific outcome metrics. Once the expanded IOP programs are fully operational, the data collection process and outcome measures associated with this community project will be collected from participating organizations on a quarterly basis including data associated with training and workforce development activities, client data to track IOP participation, case management and referred activities and monitor project goals. In addition, a program evaluation tool was developed and implemented during this reporting period to capture additional client feedback to assess client perceptions of effectiveness and inform on-going quality assurance. Key partners in the project will review client feedback semi-annually to make adjustments and improvements to policies and protocols to ensure goals are met, standards are maintained and individuals receiving services are satisfied with their care.

CHSN identified the goal of serving 50 individuals per year once the expanded IOP services are fully operational through the SUD Treatment Expansion project. To date the program has served 60 individuals. The socio-demographic characteristics of the population served through this community project will be tracked to include housing, economic and employment stability, and social and family supports. The CHSN Executive Director, Project Manager and Data Analyst will continue to have overall responsibility for internal evaluation of this community project. Data systems to support evaluation of this community project will be established in conjunction with the CHSN Health Information Technology (HIT) work group and the Enhanced Care Coordination community project. Leveraging these and other data systems set up to support the IDN’s re-entry work, the following measures and data sources will be used to evaluate project process and outcomes (selected State-defined outcome measures are indicated by an asterisk).

Percent of referred clients for whom assessment occurs within 48 hours <b>Performance Measure Name</b>	Target	Progress Toward Target		
		12/31/18	6/30/19	12/31/19
Number of individuals served <ul style="list-style-type: none"> <li>Develop job descriptions for counselors and recovery support workers to be hired</li> <li>Hire staff for expansion in IOP services, inclusive of CRSWs</li> <li>Formalize program protocols for referrals to the IOP, the assessment and treatment planning process and the responsibilities of each partner in the IOP for these tasks.</li> <li>Train new staff in IOP programmatic workflows and protocols</li> </ul>	Up to 50 additional IOP clients per year once fully operational in all 3 sub-regions	Milestone Met; 43 clients served	Milestone Met; 60 clients were served during this reporting period; Of the 23 clients served in Phase II of the IOP program, 9 completed both phases of the IOP program, 14 remained in Phase II as alumnae and 19 continued in outpatient co-occurring counseling beyond Phase I and Phase II of the IOP.	
Percent of referred clients placed in interim services pending appropriate level of care per ASAM criteria	>75% by end of waiver.	Milestone Met; 100% of clients on the waiting list received interim services.	Milestone Met; 86% of clients on the waiting list received interim services. 17% of the clients in interim services were waiting for beds in residential treatment and 3 of these were offered IOP as part of their interim services and were successful at that level of care, eliminating the need for residential treatment.	
Waiting list for treatment services, number of clients and wait time (As of Dec. 2017 wait list is 6 weeks for IOP services). <ul style="list-style-type: none"> <li>Develop alternative plan to address long wait time for clients</li> <li>Implement new plan/Interim Services to offer clients case management care and SUD education and recovery</li> </ul>	Decrease by 50% of current wait time	Milestone Met; There is currently no wait for services for clients seeking treatment in the evening IOP. The wait for daytime IOP services is reduced to about 17 days, though everyone is offered the evening program. Those who choose to wait are incorporated into	Milestone Met, There is currently no wait for evening services and the wait for day program is currently 3-4 business days. There is no wait for interim services.	

support while they await a spot in IOP		Interim Services in 2-3 business days unless they refuse this service.		
Percent for whom recovery coach pairing is completed <ul style="list-style-type: none"> <li>Develop protocol of Recovery Coach pairing with Navigating Recovery of the Lakes Region</li> <li>Outline the CRSW Credentialing pathway</li> </ul>	>90% by end of waiver.	Milestone Met; Recovery Coach pairing was completed for 100% of those clients who moved into step-down, though 3 have not followed through.	Milestone Met; 2 Navigating Recovery coaches (1 male and 1 female) are embedded in the evening IOP and 2 Horizons coaches (1 male and 1 female) are embedded in the day IOP. 100% of clients were paired with a coach prior to their transition to Phase II of the IOP.	
*Initiation of SUD Treatment (1 visit within 14 days)	>70% by end of the waiver.	Milestone Met; Horizons has been able to initiate SUD services within 14 days for 100% of the clients in the evening IOP, with 2 of them beginning actively engaged in Interim Services.	Milestone Met; Horizons has been able to accommodate 100% of clients applying for SUD services at the OP or IOP level of care with 1 visit within 14 days (usually 7 days) with 6 clients who sought interim services while they awaited a residential treatment beds being incorporated into interim services within 2-3 days.	
Retention in SUD/COBHD treatment for recommended duration per ASI/ASAM evaluation	>70% by end of waiver.	Milestone Met; 77%	Milestone Met; 85%	

**D-3. IDN Community Project: Workforce Staffing**

A total of 9.2 FTEs across four organizations were identified as needed to operationalize the Expansion of Intensive IOP Services Project. A total of 8.2 FTEs have been recruited to date. The one remaining FTE vacancy is for an MLADC to run the Plymouth IOP project which has not been able to open due to a lack of qualified applicants for the position. Please note, a thorough summary of all CHSN-IDN5 recruitment activities surrounding the search for a qualified MLADC to run the Plymouth IOP can be found in section A1-5. Essentially recruitment efforts have been ongoing for over a year with limited applicants for the position and no success to date in finding a qualified candidate from those who did apply. The CHSN board formed a subcommittee in October to work on escalating the recruitment efforts (advertising in various online postings, print media, university connections, Facebook and other social media, etc.) for the Plymouth IOP project’s search for an MLADC still to no avail. Once the MLADC position is filled, CHSN-IDN5 will be positioned to open almost immediately (space is secured, all other staff assigned, phone systems are ready, etc.) and able to offer IOP services, we are simply dealing with this one workforce

hardship. Upon hiring an MLADC, we will begin utilizing/paying for the support of two PARC recovery support workers that are intended to assist the project.

**As was previously stated in Section A1-5, CHSN-IDN5 recognized that due to our lack of success in hiring an MLADC to run the IOP Program in Plymouth, and given the point we are at in the DSRIP demonstration, a rapid cycle evaluation was performed and it was determined that in order to best meet the needs of the individuals in the region that we had to offer something different. An interim solution was approved by the Board in February 2019 to assist clients in need of SUD services in southern Grafton County. Horizons Counseling Center placed a counselor in its Plymouth office effective March 1, 2019 at the Whole Village Family Resource Center to provide ASAM assessment of clients referred for SUD services, to provide stabilization services for clients requiring a level of care other than the IOP level of care, making appropriate referrals and connecting clients with the appropriate level of care to available resources. This offering will be made available indefinitely; until an MLADC is hired to run the Plymouth IOP; or until another solution offering IOP services becomes available.**

The types of staff are shown by organization in the table below along with staff that was on boarded to assist with the IOP project during this reporting period.

Provider Type	IDN Workforce (FTEs)				
	Projected Total Need	Staffing on 12/31/17	Staffing on 6/30/18	Staffing on 12/31/18	Staffing on 6/30/19
MD (Horizons) (increase to 0.2 when expand to Plymouth)	0.1	0	0	0.1	0.1
SUD Counselors / LADC (Horizons)	2	1	1	2	2
SUD/Co-occurring counselor / MLADC (Horizons) <i>Laconia IOP</i>	1	1	1	1	1
<del>SUD/Co-occurring counselor / MLADC (Horizons) <i>Plymouth IOP</i></del>	<del>1</del>	<del>0</del>	<del>0</del>	<del>0</del>	<del>0</del>
Admin. Assistant (Horizons)	0.5	0.5	0.5	0.5	0.5
Recovery support worker (Horizons)	1	1	1	1	1
Benefit Navigator (LRGHealthcare)	0.1	0.1	0.1	0.1	0.1
Benefit Navigator (HealthFirst)	0.1	0.1	0.1	0.1	0.1
Case Manager / Care Coordinator (Genesis)	0.4	0.2	0.4	0.4	0.4
Recovery Support Worker (Navigating Recovery)	1	0.5	1	1	1
Recovery Support Worker (PARC)	2	0	0	0	2

#### D-4. IDN Community Project: Budget

Funds for the Expansion in IOP project budget were to support salaries and benefits of project staff as outlined in the previous section. Salaries were budgeted and agreed upon by the D3 workgroup based on

prevailing wages by position type and fringe benefits were budgeted uniformly across all partner organizations at 31% of salary. Expenditures in the reporting period total \$ [REDACTED]. They include reimbursements to LRGHealthcare for \$ [REDACTED], LRMHC for \$ [REDACTED], Horizons Counseling Center for \$ [REDACTED], Navigating Recovery for \$18,994.98 and HealthFirst for \$ [REDACTED] for project staffing expenditures. Financial reporting for Jan – Jun 2019 actual expenditures are reflected in the table below.

Budget Item	Item Description	2017 Actual Cost	Jan – Jun 2018 Actual Cost	July – Dec 2018 Actual Cost	Jan – Jun 2019 Actual Cost	Total Project Cost to Date	Total Projected Cost of Project
Salaries and Wages							
Project Staff Salaries / Wages (subcontracted)	Salaries for clinicians, recovery support workers, case managers, benefit navigators, admin support and driver as outlined in the previous section						
Project Staff Benefits	31% of salary / wages						
IOP subcontract	Stipend for Treatment slot with Riverbend IOP serving Franklin in 2019 & 2020						
Total Salary							
Other Direct Costs							
Transportation van	Reimbursement for travel @ .535 p/mile (estimated @100 miles p/week x 50 weeks						

Supplies	Miscellaneous expenses over waiver period						
PROJECT TOTAL							

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

There were no changes within the CHSN network composition during this reporting period.

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

### D-6. IDN Community Project: Standard Assessment Tools

The table illustrates the Assessment and Screening tools that continue to be used for the SUD Treatment Expansion Project. The following assessment / screening tools have been identified by our primary SUD provider as valuable assessment tools for this targeted population:

- Addiction Severity Index (ASI)
- DSM IV Psychosocial Interview
- American Society of Addiction Medicine (ASAM) Criteria for Patient Placement Assessment for level of care
- PHQ 9
- Beck Depression Scale
- PTSD Checklist
- GAD 7
- Columbia Suicide Severity Rating Scale (C-SSRS)
- Suicide Assessment Five-step Evaluation and Triage (SAFE-T) Screening Tool

Upon review of the above standard assessment tools, progress has been made determining the most appropriate screening tools to utilize with this high risk population. To effectively assess a client’s level of depression, two possible forms of assessment were discussed as potential options including the PHQ 9 and the Beck Depression Scale. Both are valuable standardized assessment tools in effectively measuring the severity of depressive symptoms relative to overall independent functioning. For the purposes of this project, both screening tools are available for use at the discretion of the provider. This flexibility

enhances the provider’s ability to apply their clinical judgment on which assessment best fits the needs of the client.

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

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

CHSN has completed the development of protocols for patient assessment, treatment, management and referrals. The D3 workgroups formed subcommittees to focus energies on working together to agree on processes and formalizing and documenting protocols. To actively support continued protocol and workflow development, CHSN-IDN5 outreached to other IDNs to enhance collaborative efforts towards standardization of integrated work throughout the state of New Hampshire. The process of integrating protocols statewide (specifically for management and referral) will support the mission of this project in implementing best practices across all settings to provide quality of care to all patients. This standardization will create a forum of increased efficiency of care to patients and providers resulting in more optimal project outcomes.

As previously reported, [REDACTED] with Horizons Counseling Center, shared her expertise in the fields of confidentiality and SUD treatment which led our IDN in the development and implementation of CHSN-IDN5’s universal consent documents: Authorization and Consent To Disclose Protected Health Information for Treating Providers and Authorization and Consent to Disclose Protected Health Information for Non Treating Providers for release of patient information (all shared in June 2018 SAR). Since distribution of the new consent forms in June 2018, they continue to be adopted in various capacities across the region based on each site’s level of implementation and use. Despite the related challenges across sites adopting full use of these forms, all partners have agreed to recognize them as effective means to enhance collaboration and care coordination efforts within the integrated care delivery network.

Protocols developed within this reporting period include Screening and Assessment (**Attachment\_D.7A**), Treatment Planning (**Attachment\_D.7B**), Management & Referral (**Attachment\_D.7C**) and After Care (**Attachment\_D.7D**). These policies and procedures are all included as attachments and further complement the existing integrated care coordination efforts supporting smooth care transitions for this fragile population.

Protocol Name	Brief Description	Use (Current/Under development)
Client Identification and Referral	<p>Protocols and communication procedures timely identification and referral from primary care, emergency departments, and other health and human service providers of individuals who may benefit from SUD-related assessment, evaluation and connection to appropriate treatment</p>	<p>Milestone met; Ongoing; the D3 Leadership Team subcommittee on continues work on formalizing protocols for communication among potential referral sources. Protocols have been completed with Lakes Region MH and Navigating Recovery of the Lakes Region and protocols have been informally developed with Health First, with formalization and acceptance by each organization completed this reporting period.</p> <p>Horizons and LRMH have developed protocols for client referrals between agencies, for sharing of clients and for communication between agencies. To actively support continued protocol and workflow development, CHSN-IDN5 has outreached to other IDN's to enhance collaborative efforts towards standardization of integrated work throughout the state of New Hampshire. The process of integrating protocols statewide will support the mission of this project in implementing best practices across all settings to provide quality of care to all patients. This standardization will create increased efficiency of care to patients and providers resulting in more successful project outcomes.</p> <p>Horizons staff has met with Navigating Recovery of the Lakes Region, behavioral health staff at Health First, Family Resource Center of Greater NH (Lakes Region Community Services), the Whole Village Family Resource Center in</p>

		<p>Plymouth and the NH Public Defender Program in Laconia, the Belknap County Restorative Justice Program, the Belknap County DOC medical department and the DOC Community Corrections Officers and in-house counselor/case manager and with the Circuit and Superior Court judges to provided information on ASAM patient placement criteria, referral process to the IOP (as well as to IOP and MAT services).</p> <p>DCYF staff attended the Horizons open house in October 2018 and participated in gathering information on referral procedures and how they are ASAM criteria-driven. Efforts of the D3 subcommittee to identify primary care practices for outreach is ongoing.</p>
<p>Screening, assessment and care plan development</p> <ul style="list-style-type: none"> <li>• Add B1 section CCSA</li> <li>• PHQ 9 utilized more frequently than the Beck's</li> </ul>	<p>Protocols and workflows for application and frequency of screening and assessment tools; care plan development and review</p>	<p>Milestone met; Existing assessments include: Addiction Severity Index (ASI)</p> <p>DSM V Psychosocial Interview, American Society of Addiction Medicine (ASAM), PHQ 9, Beck Depression Scale, PTSD Checklist, GAD 7, Columbia Suicide Severity Rating Scale (C-SSRS), and</p> <p>Suicide Assessment Five-step Evaluation and Triage (SAFE-T) Screening.</p> <p>Workflows and referral agreements have been established among Horizons and LRMHC, Horizons and Navigating Recovery, Horizons, Navigating Recovery and LRCS Family Resource Center. Workflows and referral protocols between the medical departments at Belknap County DOC are in active progress with referral protocols between the DOC CORE program and SUD services through Horizons and Health First are in draft and require</p>

		acceptance by the organizations, though they are being implemented successfully. Workflows and referral protocols between Horizons and LRGH and the LRGH Recovery Clinic are completed.
IOP procedures	Protocols and workflows for appropriate group placement, core and enhance program content, client progress assessment, discharge and connection to community services and supports	Milestone met; Workflows and protocols as delineated earlier are in place and being operationalized.  Subcommittee work continues to formalize workflows across partner agencies is a fluid process and considered ongoing.
Data collection and evaluation	Protocols and workflows for collection, reporting and analysis of client data for program monitoring and improvement	Milestone met; CMT is now functioning and CHSN data analyst assists with collection and reporting of data for program monitoring.

**D-8. IDN Community Project: Member Roles and Responsibilities**

Project Team Member	Roles and Responsibilities
[REDACTED]	Horizons Counseling Center / Project Lead and SUD provider
[REDACTED]	CHSN / Executive Director / oversight of project
[REDACTED]	Pemi-Baker Community Health / community supports
[REDACTED]	LRMHC / key player in case management, counseling services
[REDACTED]	Cornerbridge / peer support
[REDACTED]	Navigating Recovery of the LR / key player in recovery support
[REDACTED]	Farnum North / recovery center
[REDACTED]	Speare Hospital / ED coordinator
[REDACTED]	LRGHealthcare, recovery clinic within hospital
[REDACTED]	Riverbend / CMHC / Franklin site
[REDACTED]	PARC / recovery support

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

**Training Plan**

Training activities specifically related to the SUD Treatment Expansion project will continue to focus on team and partnership building, skill development for recovery coaches, cross training for project staff and partner organizations.

The CHSN-IDN5 Training Tracker (**Attachment A1.4A**) identifies individuals by name, practice and training topic they have participated in to date.

Project-Related Training Activities	Target Trainees	Time line	Progress Measure / Notes
New project staff orientation, team building, partner building	Project Staff (approximately 15 staff, 10 FTEs) and supervisors	By December 1, 2017 and ongoing	Milestone met for existing staff; Ongoing for new staff; 8.4 project staff have been hired of the 9.4 identified. All hired staff have been trained in the DSRIP 1115 waiver and the mission of CHSN, they have been oriented to their roles within the program, have received training in ethics and boundaries, confidentiality, ethical communication in an integrated care environment and suicide prevention.
HIPAA and CFR 42 Part 2; Ethics and Boundaries	All new staff including recovery coaches	Begin January 2018 and ongoing	Milestone Met for those hired; Ongoing as new staff are on boarded (see above)
Supervision of recovery coaches and SUD counselors/LADCs for maintenance of certification and licensure respectively.	CRSWs based at Recovery Support Organizations and at the IOPs. SUD counselors/LADCs based at the IOPs.	Begin January 2018 and ongoing	Milestone met; weekly supervision meetings continued this reporting period. Two recovery coaches at Navigating Recovery have become certified as CRSWs and two more from Navigating and one from Horizons have submitted their paperwork for action by the LADC Board.  Recovery coaches continue to receive weekly MLADC supervision through Horizons.  Supervision has included training on ASAM client placement criteria, IOP protocols, interventions and curricula, criteria for client transitions to higher or lower levels of care and the role of recovery coaches in the treatment setting.
Cross-training for interagency team – understanding roles, recognizing signs and symptoms of SUD / MH	Counselors, care coordinators, recovery coaches, ED and PCP practice staff, other CHSN partner organizations	Identify staff and initiate training January 2018 and ongoing	Milestone met; Ongoing; Horizons staff provide training to all counselors, care coordinators, recovery coaches, etc.

## Project Scoring: IDN Community Project Process Milestones

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

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

Attachment\_D.1A

# D3 Expansion in IOP (IDN 5)

Attachment\_D.1A

Tasks	Complete
1 <b>Planning Phase</b>	<input type="checkbox"/>
2 Establish and support SUD Treatment Options Leadership Team	<input checked="" type="checkbox"/>
3 Identify key organizational/providers participants	<input checked="" type="checkbox"/>
4 Execute meeting schedule	<input checked="" type="checkbox"/>
5 <b>Develop implementation plans</b>	<input checked="" type="checkbox"/>
6 <b>Develop workforce plan</b>	<input checked="" type="checkbox"/>
7 Develop staffing plan	<input checked="" type="checkbox"/>
8 Develop recruitment and retention strategy	<input checked="" type="checkbox"/>
9 Identify projected annual client engagement	<input checked="" type="checkbox"/>
10 Develop implementation timeline	<input checked="" type="checkbox"/>
11 Develop project budget	<input checked="" type="checkbox"/>
12 <b>Design/develop Expanded IOP services infrastructure</b>	<input type="checkbox"/>
13 Identify roles and responsibilities of team members	<input checked="" type="checkbox"/>
14 Identify training curricula/topics by provider type	<input checked="" type="checkbox"/>
15 Develop training plan	<input checked="" type="checkbox"/>
16 <b>Identify/develop patient management protocols/workflows</b>	<input checked="" type="checkbox"/>
17 Identify intake process	<input checked="" type="checkbox"/>
18 Identify process for assigning clients to care coordinators and submit to CHSN	<input checked="" type="checkbox"/>
19 Identify process to ensure compliance with Privacy/Confidentiality requirements	<input checked="" type="checkbox"/>
20 Identify protocol for Recovery Coach pairing process and submit to CHSN	<input checked="" type="checkbox"/>
21 Identify process to assist patient in Medicaid/Health Insurance enrollment and submit to CHSN	<input checked="" type="checkbox"/>

## Projects E: Integration Focused

### IDN Community Project Implementation and Clinical Services Infrastructure Plan

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

There were no changes within the CHSN network composition during this reporting period.

##### Project update and milestones

The Enhanced Care Coordination for High-Need Populations project continues to offer a creative wrap-around approach among service providers and community-based agencies to meet the complex needs of the high risk, high needs population. This client centered approach continues to provide consistent care from initial interaction with the Community Care Coordinators (CCC's), throughout all the steps in the process of connecting each individual to community based resources which includes assisting them in making their connection to identified resources. This quality of care encourages positive interpersonal skill development with individuals that often lack the presence of any natural supports and/or community connections. The Enhanced Care Coordination approach provided by the CCC's directly minimizes a client's barriers to ensure all needs are met by the delivery of individualized care. This role continues to encourage enhancement of collaborative efforts across various service providers throughout the region. The E5 project care coordination sub-regional teams in Laconia, Franklin and Plymouth continue to establishing positive rapport with service providers to efficiently "meet clients where they are at" related to their emergency department utilization. To reemphasize the dynamic collaborative efforts amongst providers, the CCC teams reflects a diverse group of disciplines inclusive of behavioral health, primary care, hospitals, home health and substance use treatment and recovery supports. The placement of each of the 9.4 Community Care Coordinators offers enhancement of an array of professional skills within each organization. This placement results in consistent care between service providers, ensuring appropriate follow through of individualized needs as well as effectively facilitating the comprehensive wraparound services for this targeted high-risk population.

The E5 Enhanced Care Coordination team remained very active and engaged in the communities served during this reporting period. Their client encounters continue to gain momentum as they have grown significantly over time. In this reporting period alone, the CCCs had 926 new enrollments or cases resulting in 2036 total encounters. There is continued emphasis being placed with all CCCs to utilize the shared care plan module within CMT. They have begun holding wraparound meetings which, when combined with having a mutually agreed upon shared care plan, result in significant and impactful client outcomes.

The Enhanced Care Coordination team remains fully staffed and is comprised of 9.4 FTE care coordinators who are employed across 15 IDN partner agencies. Funding for the CCC's salaries is supported by the DSRIP waiver. The team has become noticeably more consistent with their data entering standardization within Smartsheet, allowing for CHSN staff to have a good handle on the number of enrollments/cases and the flow of support to more accurately report on CCC activities.

Smartsheet detail and timeline is included as a graphic at the end of this section and included as **(Attachment\_E.1A)**.

As previously reported, CHSN provides 1:1 monthly support (or designated frequency based on site) with the designated CCC at each site and their site supervisor. This monthly check-in is designed to provide an opportunity to assess the CCC's level of competency within their role related to workflow development, documentation, referral sources, use of CMT, productivity, offer support with any site specific challenges, to set personal goals for the following month and identify future training opportunities. The CCC Supervision Contact Form (**Attachment\_E.1B**) is distributed to each CCC prior to each meeting with the previous month's notes for review and a monthly activity graph illustrating site activity. This general format has supported each CCC directly with navigating their role, exploring related challenges and encourages them to set and achieve personal goals month to month as defined by them. Currently the CCC Monthly Supervisory Schedule (**Attachment\_E.1C**) is used to ensure consistency of communication each month between all involved, keeping the E5 targeted goals at the forefront of discussion.

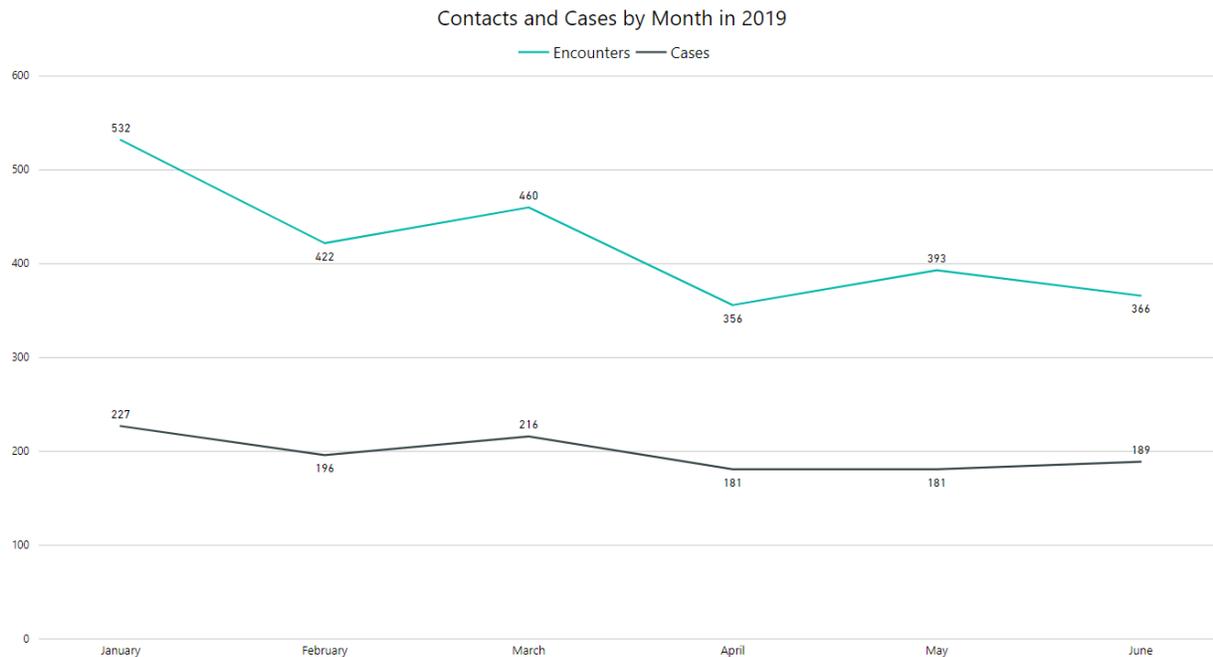
- Updates within this reporting period:
  - There had been three separate CCC teams all of which held their own monthly “small team” meetings. This transitioned this reporting period to no longer having small sub-regional (Laconia, Franklin and Plymouth) meetings but rather one “All Team” meeting that all CCCs attend. Additionally, the E5 team has now begun holding a “Wraparound” team meeting once a month. Each meeting type follows a standardized meeting agenda for consistency. The All Team meeting focus is on achieving outcome measures, workflow development, highlighting successes of integration of care, process related/operational challenges or barriers, technical support (CMT and Smartsheet) and team building. The Wraparound meeting entirely focuses on sharing high-utilizer client cases in hopes of finding solutions and identifying/agreeing upon a shared care plan across the team. This is in response to our IDNs focus to increase the number of shared care plans that have been developed and in CMT. The wraparound meetings just began in June 2019 and are already proving to be effective in identifying solutions by wrapping around the care for some of the most complex needs patients within this high-risk population.
  - As mentioned above, the E5 Care Coordination team held their first Wraparound meeting on June 25<sup>th</sup>. Different care coordinators presented high-need cases and the team collectively identified solutions to client barriers and collaboratively reducing those barriers to produce better patient care and outcomes. One outcome expected as a result of case discussions at the Wraparound meetings is to develop a mutually agreed upon shared care plan for the client which is then entered into CMT for all CCCs and other providers to follow regardless of where the patient should present. The E5 CCC team will be hosting Wraparound meetings on a monthly basis and will be inviting other providers and social service agencies (i.e. housing, transportation, 211, etc.) to attend as needed to identify and discuss high-utilizer patient cases and potential solutions to meeting their needs and eliminating barriers. Growing the network of social service providers that attend these meetings will be ongoing and will further ensure that the best and most appropriate patient care and solutions are agreed upon and understood between all provider and social service agencies working with the clients.
  - The E5 Steering Committee serves in an advisory capacity and meets quarterly. The Steering Committee meets to discuss progress of project related implementation

activities, to support operational project efforts and/or issues and help to address project related challenges. CHSN's ED and/or Project Manager provides updates to this committee on a routine basis to ensure all affiliated partners are informed of project activities and outcomes. This communication is essential to the project's success and will continue moving forward so the more robust project related updates of progress across the region are being shared with all E5 partners.

- Two Enhanced Community Care Coordination rack cards were developed – one for clients and one for providers. These have been widely distributed this reporting period. Due to demand they have already had a reprint as they are placed in PCP and BH offices as well as Emergency Departments. The CCC Team utilizes the rack cards as a “leave behind” when attending regional meetings to help continue in our education efforts of what enhanced care coordination is and who the resources are to call in the region. Having these rack cards will also aid the LRGH and Speare practices who will begin utilizing the CCSA in mid-September and will assist them in referring clients seeking assistance to the appropriate “regionally based” community care coordinator as all are listed on the rack cards along with the services provided.
- Networking and collaboration across the region continues to be a priority of the CCC team. This reporting period there have been connections made directly with the team to build upon this goal of integration of care. Guest speakers at monthly All Team meetings included a training on ASAM criteria and by [REDACTED] who runs the LRGH SOR HUB. These connections to both programs and individuals in the region has led to a stronger working relationship resulting in successful connections being made for patients accessing appropriate care. This 1:1 forum of having presentations at All Team meetings enhances collaborative efforts to meet the needs of potential mutual patients, provide clarification of the E5 project to resource presenter(s) and inform the CCC team of what each resource can provide for support to their high needs patients.
- The Community Care Coordinators continue to actively attend trainings to grow and enhance their skill base and competency within their roles. They do so through trainings offered via CHSN's training contract with NHADACA as well as other community-based settings. Their attendance at each training has provided a valuable forum for community networking and E5 project visibility. Due to the diversity of skills across the CCC team the topics of interest and frequency of attendance of trainings varies based on individualized CCC training needs. In 2018, the CCC's had participated in 177 trainings and in 2019 they participated in 92 trainings covering a variety of training opportunities related to integrated health, MH, SUD topics and more. Please refer to the Training Tracker (**Attachment\_A1.4A**) for more detailed information. To accurately capture all the trainings attended by each CCC, a CCC Monthly Training Log (**Attachment\_E.1D**) form is collected to ensure CCC engagement in essential trainings to enhance their skill base within their role.

## E-2. IDN Community Project: Evaluation Project Targets

Data capturing via Smartsheet has been consistent for the E5 project. The CCC Team developed a CCC Smartsheet User Manual (**Attachment\_E.2A**) which was shared last reporting period. This user manual was, and continues to be, distributed across all sites with a designated CCC peer mentor available for 1:1 training to ensure competency with Smartsheet. This has been particularly helpful for new staff given there is regular turnover of care coordinator staff. This standardization led to CHSN having access to credible and consistent monthly reports illustrating regional care coordination activity. Site activity graphs (screen shots below) for the entire project and by agency are shared regularly with the CCC Team and the E5 Steering Committee to reflect the progression of activity over a period-of-time.



### 2019 Encounters by Location

Location	Encounters
LRGH	366
Mid-State	318
HealthFirst Laconia	292
HealthFirst Franklin	240
LRMHC Laconia	229
Franklin Regional Hospital	170
Service Link	164
Speare Memorial Hospital	129
Riverbend	80
Pemi Baker	34
LRMHC Plymouth	16
<b>Total</b>	<b>2038</b>

### 2019 Enrollments by Location

Location	Enrollments
LRGH	327
Mid-State	129
Franklin Regional Hospital	122
Service Link	89
Speare Memorial Hospital	84
HealthFirst Franklin	65
Riverbend	35
HealthFirst Laconia	33
LRMHC Laconia	24
Pemi Baker	17
LRMHC Plymouth	5
<b>Total</b>	<b>930</b>

In a recent review of our measures, CHSN-IDN5 has determined that a change to the measure related to self-reported satisfaction would be more meaningful if we instead measured the significant housing need and number of referrals to housing that occur in the region. Lack of housing has a large effect on our region and is being experienced by many of the other IDNs across the state of NH. We have decided to track the percentage of housing referrals that we are able to make in order to focus on and hopefully alleviate one of the deepest felt needs that our community is experiencing. During this time period, 71 clients approached an E5 care coordinator with a housing need and 53 of these clients were referred to places that could assist them with their needs (74.6%). You will see the changes reflected in the table below (old satisfaction measure is stricken and new housing measure is in bold).

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/18	As of 6/30/19	As of 12/31/19
Number of individuals served	400 clients per year once fully operational in all 3 service areas Target for 6/30/18 will be 100 individuals served.	Milestone Met; This reporting period the total number of patient encounters was 1081; the total number of new patients served was 597  For the year 2018, the following activity occurred across sites: Total number of patient encounters was 1688, Total number of new patients served was 849	Milestone Met; This reporting period the total number of patient encounters was 2038; the total number of new patients served was 930	
Time interval from referral and to first care coordination team contact to be 3 business days	>80% by end of waiver.	Milestone Met; This reporting period per all CCC reports and encounter data, all patient encounters have consistently occurred within 3 business days upon receipt of any referral.	Milestone Met; This reporting period per all CCC reports and encounter data, all patient encounters have consistently occurred within 3 business days upon receipt of any referral.	
Time interval for follow-up by care coordination team after an emergency department visit or hospitalization by enrolled client 3 business days	>80% by end of waiver.	Milestone Met; This reporting period per all CCC reports and encounter data, all patient encounters have consistently occurred within 3 business days upon receipt of any referral post hospitalization.	Milestone Met; This reporting period per all CCC reports and encounter data, all patient encounters have consistently occurred within 3 business days upon receipt of any referral post hospitalization.	
Percent of assessed client needs that were given a referral	75%	Milestone Met; 85.77%	Milestone Met; 85.77%	
<b>Percent of clients with a housing need that were given a referral for housing</b>	<b>70%</b>		Milestone Met; 74.6%	

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/18	As of 6/30/19	As of 12/31/19
Self-report of improved status of employment, housing, criminal justice involvement, interpersonal relationships, family interaction, community connectedness and other quality of life measures	>80% self-report of improved status by end of waiver.	In Process; The E5 CCC Team completed the development of their program evaluation tool but it did not begin being utilized in earnest until Q4 2018 thus we do not have much information to show improvement in self-reporting of status.  The CCC Team has been discussing and formalizing their workflows at meetings which identify to whom, at what intervals in time, where, how and by whom the evaluations will be administered. Because the E5 project just began implementing their evaluation tool during this reporting period, there is still little meaningful participant data available at this point in time. CCC regional teams continue to enhance connectedness within each community with resources available to refer patients to for support. The CCC team attends monthly networking meetings to increase collaboration and support patient care.	In Process;	
Percent of clients presenting with substance/behavioral health needs who received at least one referral	75%	Milestone Met; 83.73%	Milestone Met; 84.21%	

**E-3. IDN Community Project: Workforce Staffing**

A total of 9.4 FTEs was identified across fifteen organizations as being needed to fully staff the Enhanced Care Coordination project and all positions are currently filled. Although there was turnover of one .15 FTE position at Pemi-Baker Community Health that occurred, it has since been filled. There was also one FTE care coordinator at HealthFirst Family Health Center in Franklin which was vacant for approximately two weeks in April before being filled, thus keeping the E5 project fully staffed this reporting period.

Provider Type	IDN Workforce (FTEs)				
	Projected Total Need	Staffing on 12/31/17	Staffing on 6/30/18	Staffing on 12/31/18	Staffing on 6/31/19
Care Coordinator (LRGHealthcare)	1.25	1.0	1.25	1.25	1.25

Provider Type	IDN Workforce (FTEs)				
Care Coordinator (Horizons)	1.0	0	1.0	1.0	1.0
Care Coordinator (ServiceLink)	0.5	0.5	.5	0.5	0.5
Care Coordinator (HealthFirst) <i>.25 shared with Riverbend</i>	2.25	.25	2.25	2.25	2.25
Care Coordinator (LRMHC) <i>1 – Laconia; .5 – Plymouth</i>	1.5	1.5	1	1.5	1.5
Care Coordinator (Riverbend) <i>.75 shared with HealthFirst</i>	.75	.75	.75	.75	.75
Care Coordinator (Speare Memorial)	1.0	0	1.0	1.0	1.0
Care Coordinator (Mid-State)	1.0	0	1.0	1.0	1.0
Care Coordinator (Pemi-Baker Community Health)	0.15	0	.15	.15	.15

#### E-4. IDN Community Project: Budget

Funds were budgeted for the Enhanced Care Coordination for High Need Populations project to support salaries and benefits of project staff as outlined in the previous section. Salaries were budgeted and agreed upon by the E5 workgroup based on prevailing wages by position type and fringe benefits were budgeted uniformly across all partner organizations at 31% of salary. Expenditures in the reporting period include reimbursements for project staffing totaling \$ [REDACTED]. Reimbursement was made to HealthFirst for \$ [REDACTED], Horizon’s Counseling Center for \$ [REDACTED], LRGHealthcare for \$ [REDACTED], LRMHC for \$ [REDACTED], MidState Health Center for \$ [REDACTED], Pemi-Baker Community Health for \$ [REDACTED], Riverbend Community Mental Health for \$ [REDACTED], Speare Memorial Hospital for \$ [REDACTED] and the Partnership for Public Health for \$ [REDACTED]. Additional reimbursement of cell phone monthly fees, mileage for CCC’s and office supplies are represented below for total expenditures totaling \$ [REDACTED]. Financial reporting on actual expenditures between January – June 2019 are reflected below.

Budget Item	Item Description	2017 Actual Cost	Jan – Jun 2018 Actual Cost	July – Dec 2018 Actual Cost	Jan – Jun 2019 Actual Cost	Total Project Cost to Date	Total Projected Cost of Project
Salaries and Wages							
Project Staff Salaries / Wages (subcontracted)	Salaries for lead care coordinator, agency-based care coordinators and transportation driver						

Project Staff Benefits	31% of salary / wages	
Staff Development		
Other Direct Costs		
Hardware	Laptop Computers and cell phones for CCCs	
Software	Internet, software license fees and cell phone service plans	
Mileage	Reimbursement for care coordinator travel	
Mileage reimbursement for D3 & E5 van driver		
Cell phone reimbursements of CCC's		
Supplies / Marketing	Miscellaneous expenses	
PROJECT TOTAL		

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

As described throughout, there are three geographically-based care coordination teams that are multi-agency and multi-disciplinary in nature. This set of organizations includes not only those that have intensive contact with high-need patients for clinical services, but also organizations that can help to address broader social determinants of health. The table below lists the 'key' organizations that will have lead roles and CHSN funded care coordinator positions. There have been no changes to the Key Organizational participants within the Enhanced Care Coordination Program.

Organization/Provider	Agreement Executed (Y/N)
LRGHealthcare (LRGH, FRH)	Y
Speare Memorial Hospital	Y
HealthFirst	Y
Mid-State Health Center	Y
Lakes Region Mental Health Center	Y
Horizons Counseling Center	Y
PPH / ServiceLink	Y
Riverbend	Y
NANA	Y
Lakes Region VNA	Y
Central NH VNA	Y
Pemi-Baker Home Health	Y

There were no changes within the CHSN-IDN5 network within this reporting period.

**E-6. IDN Community Project: Standard Assessment Tools**

The table describes the Assessment and Screening tools that will be used for the Enhanced Care Coordination Project. These have not changed since our last report.

Standard Assessment Tool Name	Brief Description
<p>Case Management (CM) Assessment. The following processes and/or tools to develop a standard assessment and intake process</p> <ul style="list-style-type: none"> <li>• Scripting for the CCCs for introduction to a new client</li> <li>• Intake form</li> <li>• Case presentation form and client progress tracking form</li> <li>• Adoption of a common protocol for release of client/patient information</li> <li>• Review of communication channels and implementation of secure messaging</li> <li>• Review of referral process</li> </ul>	<p>The process for increasing standardization of CM Assessment tools continued this reporting period. The Intake Form continues to progress into the implementation stages as each partner agency supports embraces use of this tool at each site. The Intake Form has now been integrated as part of supervisory meetings to ensure each CCC is familiar with this assessment tool and comfortable with presentation to patients. Additional activities related to integration of use of this tool will continue across sites towards full implementation.</p> <p>Workflow development is continuous across sites as referral systems are created as CCC's strive to increase site activity. Healthfirst and Riverbend Mental Health Center created a robust working protocol that has resulted in an effective "warm hand off" of patient care between providers. With the new small team meeting format enhancing interagency referrals, the process of formalizing workflows for each CCC will continue throughout next reporting period to increase efficiency of optimal patient care.</p> <p>As follow up to last reporting period, related to practices that can communicate through secure email currently 100% report the ability to electronically protect secure data.</p> <p>Also related, pertaining to practices that can send and receive electronic referrals currently 57% according to the latest HIT survey.</p>

Standard Assessment Tool Name	Brief Description
<p>Comprehensive Core Standardized Assessment (CCSA)</p> <ul style="list-style-type: none"> <li>• After review of CCSA process and domains by B project and the development of sample CCSA tool then E5 leadership to review for alignment with CCC intake process.</li> <li>• Crosswalk all intake forms of core CCC team members for common CSA domains.</li> <li>• Review of CCC role in data collection of CSA domains.</li> </ul>	<p>CCSA guidance was previously shared with B1 partners by CHSN staff at its February 2018 network meeting and significant work has been done by partners throughout the year. To meet one of the DSRIP waiver requirements, a formalized CCSA Protocol was developed later in 2018 and shared again with partners in December 2018. Most partners had already been working to close the gaps for any that were identified in their existing intake processes and all have either corrected intake forms to address all domains by year-end or have a plan in place to do so. LRGH practices are waiting for an EMR upgrade which will adjust their existing EMS to accommodate new SDoH questions. Currently, the comprehensive CSA is just being performed within their ED and spring 2019 is the anticipated upgrade rollout where all practices will also be able to capture SDoH directly within the EMR. Currently 57% of partner practices have a complete CCSA and CCSA workflow within their organization.</p>

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

The protocols for patient assessment, treatment, management and referral specific to the Enhanced Care Coordination Project continued development this reporting period. To actively support continued protocol and workflow development, CHSN-IDN5 successfully outreached other IDN’s to enhance collaborative efforts towards standardization of integrated work throughout the state of New Hampshire. The process of integrating protocols statewide (specifically for Assessment, Treatment, Management and Referral) collectively supports the mission of this project in implementing best practices across all settings to provide quality of care to all patients. This standardization of practices continue to create increased efficiency of care to patients and providers resulting in more optimal project outcomes. The IDNs collaborative approach to protocol development was successful with completion by December 31, 2018 and is referenced considerably within the B1 section of this report.

To continue workflow development progress, the previously submitted workflows CCC’s affiliated with local hospitals including Spere Memorial Hospital, Lakes Region General Hospital/Franklin Hospital and Healthfirst have been successfully sustained and implemented to efficiently streamline the integration of the CCC with actively engaging the project’s targeted population. As this project continues implementation additional workflows will be created to tailor to the CCC’s site specific needs to effectively perform their role. These workflows continue to be a top priority across sites to support effective patient care and collaboration amongst affiliated partners. As previously reported, CHSN-IDN5 developed a “B1 Partner Protocol Guidance” document which was shared with all partners in 2018. The

purpose was to assist those who did not already have an accurate or quality protocol in place for various activities. Though many had existing protocols, the guidance document helped some build upon existing language and/or offered best practice links or language which could be added/include to their own protocols or the option of course to adopt the CHSN protocol provided was recommended. To ensure that all of our B1 partners have existing protocols in place, language was placed at the end of each protocol regarding what they must do to be in compliance with the DSRIP waiver requirement – an example of such language is below.

#### Closed Loop Referral: Protocol Submission

- If you are a CHSN-IDN5 partner organization involved with a B1 Integrated Healthcare project that is actively using the process for closed loop referrals shared in the guidance protocol, there is no further information needed.
- If your organization is using an alternate process for ensuring closed loop referrals and you have not engaged with the IDN previously around your process please follow the steps below;
  - Submit a one paragraph narrative regarding your organization process, tools used, level of information being shared, and frequency of use information to CHSN Executive Director, [REDACTED].

Protocol Name	Brief Description	Progress to date
<p>Client Identification and Referral</p> <ul style="list-style-type: none"> <li>• Work w/partner agencies to develop process of identifying the high needs populations.</li> <li>• Develop/identify referral process to and within the Community Care Coordination team(s.) <ul style="list-style-type: none"> <li>• Identify current communication channels across the Community Care Coordination team partner agencies.</li> <li>• Evaluate communication channels and determine best practices for implementation.</li> <li>• Implement best practice communication channels.</li> </ul> </li> </ul>	<p>Protocols and communication procedures timely identification and referral from primary care, emergency departments, and other health and human service providers of individuals who may benefit from assessment, evaluation and connection to appropriate Enhanced Care Coordination</p>	<p>Targeted criteria for the high utilizer population continued this reporting period with the use of outcome metrics consistent to sustain progress with project implementation related tasks.</p> <p>Consistent communication with partner agencies continues to develop to enhance efficacy of developing consistent referrals. Each CCC is attending at minimum one regional community based meeting and/or training to enhance networking with any/all potential referral sources. The CCC Team is motivated to invite one community based resource to their monthly All Team meeting to also increase collaborative efforts and enhance project visibility.</p> <p>The previously submitted workflows created to support collaboration amongst partner agencies and the CCC teams have remained effective methods for patient care; LRGH-FRH Workflow; SMH Workflow via ED; SMH Workflow ED; CCC HealthFirst-LRGH Workflow. In addition to those mentioned, an effective workflow between Riverbend and HealthFirst was created this reporting period in conjunction with others (protocols/workflows illustrated in narrative section E.7). Active discussion is ongoing to continue enhancing referral collaboration with CCC's during the regional team meetings (Laconia, Franklin, and Plymouth) and monthly all team meetings.</p>

Protocol Name	Brief Description	Progress to date
<p>Screening, assessment and care plan development</p> <ul style="list-style-type: none"> <li>Identify and crosswalk current screening, assessment, and care plan tools used by partner agencies for care coordination.</li> <li>Evaluate screening, assessment, and care plan tools and identify/develop tool for Community Care Coordinator (CCC) use.</li> <li>Pilot CCC use of screening, assessment, and care plan tools.</li> </ul>	<p>Protocols and workflows for application and frequency of screening and assessment tools; care plan development, shared care plan charting and review</p>	<p>The Intake assessment tool continued with implementation as the process for use continued development this reporting period. Each CCC is familiar with this form and the Intake Form has been integrated within monthly supervisory meetings to ensure competency.</p> <p>As phases of implementation of this Intake Form continues, the active Shared Care Plan (SCP) Task Force developed with representatives from IDN-5 and other IDNs to collaboratively strategize standardization of protocols towards utilization continues to meet routinely to support this implementation. Two representatives from IDN-5 continue active participation in this SCP Task Force to discuss regional concerns and actively support steps towards full implementation across regions.</p> <p>The following forms continue application to improve this process of screening, assessment and care plan development: Intake Form, CHSN Universal Consent Forms. In addition to these forms an Assessment Protocol is also used to efficiently capture all interventions related to the assessment process to fully address each patient's needs.</p>

<p>Enhanced Care Coordination procedures</p> <ul style="list-style-type: none"> <li>• Identify current protocols and workflows for care coordination assignments within designated agencies.</li> <li>• Develop process for assigning CCC caseload based on population distribution and level of CCC involvement.</li> <li>• Develop/Identify tools for care planning and client progress.</li> <li>• Pilot use of care planning and client progress tool.</li> <li>• Track client engagement with community supports and positive referral process.</li> <li>• Identify/develop discharge criteria and process for client completion or withdrawal from CCC team engagement.</li> </ul>	<p>Protocols and workflows for appropriate care coordinator assignment, care plan development and presentation, client monitoring and progress assessment, connection to community services and supports, and discharge</p>	<p>There has been continued progress with development of efficient protocols and workflows related to all entities between PCP offices, hospitals, SUD providers and BH agencies. Several protocols have been submitted previously. Continuous development and reevaluation of these processes are expected to strive improve efficacy as needed to capture intended outcomes. To actively support continued protocol and workflow development, CHSN-IDN5 successfully outreached to other IDN's to enhance collaborative efforts towards standardization of integrated work throughout the state of New Hampshire. The process of integrating protocols statewide will support the mission of this project in implementing best practices across all settings to provide quality of care to all patients. This standardization will create increased efficiency of care to patients and providers resulting in more optimal project outcomes.</p> <p>Progress made towards development/identification of protocols pertaining to CCC assignment of cases:</p> <p>The process for tracking CCC caseloads is in active development as site-specific baseline for productivity is now close to being established. This progress is due to increased standardization of monthly reports available via Smartsheet to illustrate all site activity. The current caseloads reflecting activity continue to vary based on the agency having access to CMT vs. sites that do not have this access and obtain encounters forcing them to capture patient encounters via a more complex manner. Through consistent data entry and analysis of trends of this data, a CCC's caseload will continue to be more defined based on total number of</p>
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		<p>encounters, total number of new enrollees, level of acuity of needs, domain related to need i.e. PCP vs. housing. This process is actively being discussed with the Project Manager, Data Analyst and the CCC Team to continue progress towards full standardization to capture all project related targeted goals.</p> <p>Progress made towards developing/identifying care planning tools: the Intake form continues to roll out towards full implementation across sites through training and continued development of process for use. Each CCC is familiar with this tool and competency is now integrated within supervisory meetings. Individual training provided as needed.</p> <p>Future work to continue progress include:  Pilot of the Intake Form to assess efficacy.  Development of integration of the Intake Form with the CCC workflow to enhance efficiency of utilization.</p> <p>Progress made towards tracking client engagement with community supports and positive referral process:  The E5 CCC Team has just completed the development of their program evaluation tool, it did not begin being utilized in earnest until Q4 2018. The CCC Team has been discussing and formalizing their workflows at meetings which identify to whom, at what intervals in time, where, how and by whom the evaluations will be administered. Because the E5 project just began implementing their evaluation tool during this reporting period; there is still little meaningful participant data available at this time.</p>
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Protocol Name	Brief Description	Progress to date
		<p>Development of workflows between partner agencies will continue building support increasing a strong foundation of referrals between sites.</p> <p>Progress continues related to identification of discharge criteria as previously created by the E5 leadership team.</p>

<p>Data collection and evaluation</p> <ul style="list-style-type: none"> <li>• Develop method(s) of data collection of CCC team process measures and performance.</li> <li>• Pilot method/tool for data collection and evaluate against target measures.</li> <li>• Analyze data for ongoing monitoring and process improvement.</li> </ul>	<p>Protocols and workflows for collection, reporting and analysis of client data for program monitoring and improvement</p>	<p>Progress made towards developing method of data collection of CCC team process measures and performance:</p> <p>The CCC tracking form continues to successfully link to a Master tracking sheet to capture CCC caseload development, number of encounters, level of need acuity, domain specific needs, and referral sources. To support data reporting requirements, monthly Smartsheet activity reports are now available (and live) to illustrate levels of activity at each site to continuously support development of robust referral systems across the regions.</p> <p>The tracking forms are actively being used and continuously being assessed for efficacy of capturing project related outcomes. Continued expansion will be necessary with the support of the CHSN Data Analyst as trends are identified to increase efficacy. To assess this tracking tool questions related to this data collection instrument are integrated in the project evaluation tool.</p> <p>This reporting period the CC Smartsheet User Manual, <b>(Attachment_E.2A)</b> was implemented across sites. This reference tool has been an essential training tool for each CCC relative to data collection. The Smartsheet User Manual has been distributed across all sites to ensure consistent competency of each CCC relative to data collection through December 2018. Each region has identified a designated CCC as a peer mentor to provide 1:1 training for others across sites as needed. This training process has created a new tier of standardization of both CCC competency with data collection as well as fully accurate monthly site activity.</p>
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Protocol Name	Brief Description	Progress to date
		The CCC Team finalized a CMT user manual specific to the CC role and it has been essential in assisting each CCC becoming competent with use of this valuable tool.

**E-8. IDN Community Project Member Roles and Responsibilities**

Project Team Member	Roles and Responsibilities
██████████	LRMHC / Project Lead & CEO of CMHC
██████████	CHSN / Executive Director / oversight of project
██████████	CHSN / Project Manager / E5 coordinated care team leader
██████████	HealthFirst / community care coordinator (Laconia)
██████████	HealthFirst / community care coordinator (Franklin)
██████████	LRGH-Franklin Hospital/Westside Healthcare/community care coordinator (Franklin)
██████████████████	Riverbend / community care coordinator (Franklin)
██████████	MidState / community care coordinator (Plymouth)
██████████	ServiceLink / care coordinator (Laconia)
██████████	LRMHC / community care coordinator (Laconia)
██████████	LRGHeathcare / community care coordinator (Laconia)
██████████	Speare Hospital / community care coordinator (Plymouth)
██████████████████	Horizons/community care coordinator (Laconia)
██████████	Pemi Baker Community Health/community care coordinator(s) (Plymouth)

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

Trainings specifically related to the E5 Enhanced Care Coordination project continue to focus on a broad variety of team and partnership building activities. CHSN contract continued with NHADACA to meet the training needs identified for our projects and staff as well as others pertinent to the CC role. Some valuable trainings that occurred included Motivational Interviewing, Ethical Communication and Decision Making in an Integrated Care Environment, Mental Health First Aid, Biological Aspects of SUD, Suicide Prevention, Basics of Medicaid, Ethical Competency and much more. The CHSN-IDN5 Training Tracker (**Attachment A1.4A**) identifies individuals by name, practice and training topic they have participated in through December 31, 2018.

Project-Related Training Activities	Target Trainees	Time line	Progress Measure / Notes
New project staff orientation, team building, partner building, DSRIP 101; understanding Medicaid	Project Staff and supervisors	By December 31, 2017 and ongoing	Milestone met for all CCCs; Ongoing for new staff; 9.4 staff have been hired out of the 10.3 identified. All hired have been trained to date in DSRIP 101, Basics of Medicaid, new staff orientation, and team building routinely occurs at monthly All Team meetings. CCC's have taken advantage of 269 trainings to date in BH/integrated health related topics to support an increased knowledge base. The CCC Team has one community based resource join their monthly team meeting to support partner building relationships which enhance collaborative efforts and referrals for patient care across the region.
HIPAA and CFR 42 Part 2; Ethics and Boundaries; familiarity with patient consent to interagency data sharing form and procedures	All new staff	By January 1, 2018 and ongoing	<p>Milestone Met; CCCs continue to receive HIPAA and CFR 42 Part 2 training routinely through their employer agencies, previously CHSN coordinated an Ethical Communications in an Integrated Environment training specific for CCC's which covered 3+ hours of confidentiality and ethical boundary training.</p> <p>The use of the universal consent forms continues to grow, to date they have successfully bridged more comprehensive and efficient sharing of patient information to enhance care coordination. Adoption of this form is variable across sites at this time yet all partners have agreed to recognize them as credible documents re: disclosure to enhance care coordination. Specific trainings on the forms and workflows surrounding their use between partner agencies will continue to be addressed as implementation continues across affiliated entities.</p>

Cross training for care coordination stakeholders to increase shared knowledge base; e.g. understanding chronic physical health conditions for behavioral health-based care coordinators; understanding mental health conditions for primary care and home health based care coordinators	Project Staff and supervisors	By January 31, 2018 and ongoing	Milestone Met; Ongoing; a number of trainings were offered through the CHSN sustained contract with NHADACA to meet its identified training needs by project. In addition, CCC's have taken advantage of 269 trainings to date (92 in this reporting period alone) in related topics to support an increase shared knowledge base.
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## DHHS Project Scoring: IDN Community Project Process Milestones

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

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

Attachment\_E.1A

E5 Enhanced Care Coordination (IDN 5)



Attachment\_E.1A

Tasks	Complete	End	Q4		
			Oct	Nov	Dec
1 <b>Planning Phase</b>	<input checked="" type="checkbox"/>	09/05/18			
2     Establish and support Enhanced Care Coordination Leadership Team	<input checked="" type="checkbox"/>	12/30/16			
3     Identify key organizational/providers participants	<input checked="" type="checkbox"/>	12/30/16			
4     Execute meeting schedule	<input checked="" type="checkbox"/>	12/30/16			
5     Research care coordination models from other states	<input checked="" type="checkbox"/>	06/30/17			
6 <b>Develop Implementation Plans</b>	<input checked="" type="checkbox"/>	11/01/17			
7 <b>Develop workforce plan for Multi- disciplinary Care Coordination Teams</b>	<input checked="" type="checkbox"/>	11/01/17			
8         Identify workforce gap (refer to A1-7) and baselines assessment	<input checked="" type="checkbox"/>	07/26/17			
9         Develop staffing plan	<input checked="" type="checkbox"/>	05/01/17			
10        Develop "Employee Retention" Incentive Payment Plan	<input checked="" type="checkbox"/>	11/01/17			
11        Identify projected annual client engagement	<input checked="" type="checkbox"/>	07/31/17			
12        Develop implementation timelines	<input checked="" type="checkbox"/>	07/31/17			
13        Develop project budget	<input checked="" type="checkbox"/>	07/31/17			
14 <b>Design/develop Care Coordination and clinical services infrastructure</b>	<input checked="" type="checkbox"/>	09/05/18			
15 <b>Identify/develop roles/ responsibilities of team members</b>	<input checked="" type="checkbox"/>	07/14/17			
16         Develop job description for Care Coordinator	<input checked="" type="checkbox"/>	06/30/17			
17         Develop job description for CCTL activities overseen by Project Manager	<input checked="" type="checkbox"/>	07/14/17			
18         Develop training curricula by provider type	<input checked="" type="checkbox"/>	09/22/17			
19 <b>Identify training plan</b>	<input checked="" type="checkbox"/>	09/29/17			
20         Identify standard set of care coordinator knowledge and skills requirements	<input checked="" type="checkbox"/>	09/29/17			

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

### **APM-1. Project APM Scoring: IDN Participation in Statewide APM Taskforce and Implementation Plan Development and IDN APM Implementation Plan**

- As previously reported, just three CHSN member organizations have experience with Alternative Payment Models (APM) and those range from developmental activities to many years of experience. There are five organizations who participate in public (MCO) and private (e.g. Anthem, HP, CIGNA) outcome incentive payments for quality measures.
- It is clear that a transition to Alternative Payment Models (APM) that support and incentivize integrated care delivery must be in place following the expiration of the waiver. These new approaches must move reimbursements from volume based to value based in order to continue to achieve improved health outcomes. The community projects implemented in this region have demonstrated improved outcomes but may not align themselves with what payers have traditionally supported. The challenge in our region is the lack of infrastructure such as EMR(s) or administrative support in agencies that are small serving rural communities. Fiscal stability is compromised by workforce constraints linked to a lack of regional reimbursement rates that recognize the impact of inadequate transportation, staff travel time and terrain/road travel as well as population penetration. The healthcare system and social service system in a fee for service model supports volume versus outcome, only perpetuating the existing disparities in communities.
- It is also clear that our challenges rest in the development of infrastructure for members and affiliate agencies who lack capacity, infrastructure and resources to report and actuarial support to move forward. CHSN-IDN5 anticipates that consultants may be necessary to provide technical support to CHSN and its partners in efforts to implement alternative payment models. In effort to be proactive, CHSN will be soliciting each of the 3 MCO(s) to presentation to either our board or at a full network meeting on their specific APM experiences relative to integrated care. CHSN's participation in the recent strategic leadership meeting has given us an opportunity to proactively engage providers and payers to help us to formulate a strategy to strengthen our advocacy and policy efforts. With an established goal of moving at least 50% of Medicaid payments to APMs by 2020, CHSN recognizes the opportunity we have as a voice in that collective IDN experience which should the APMs to be implemented, and the related financial and operational components of each.