



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

**For  
Year 3 (CY2018)  
2018-12-31 v.27**

**FINAL**

**CHSN – IDN 5**

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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-IDN 5 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:

- A client satisfaction/program evaluation tool was developed in the fall 2018 to begin capturing feedback from clients of each of the community-based projects. The evaluation tool will be administered on an ongoing basis to assess client perceptions of effectiveness and inform quality assurance. 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.
- 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. In December 2018, CHSN along with the six other IDNs co-sponsored an IDN Track at the NH Behavioral Health Summit.
- Ongoing collaboration occurs with the Continuum of Care Coordinators in each Public Health Network (PHN) region for stakeholder engagement.
- CHSN's Executive Director is actively involved with the Winnepesaukee Public Health Network. She serves 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.
- Facilitated discussions with clients of peer support and recovery service organizations via the Executive Director serving on the Navigating Recovery of the Lakes Region's Advisory Council.
- Maintaining our 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.
- Educating county level officials (i.e. commissioners and delegates in Belknap, Grafton and Merrimack counties) via presentations informing them of the statewide and regional projects that are assisting their county constituents.
- CHSN participated in the State's Plan on Aging listening session/forum.
- Ongoing project communications to assure continuous information flow to key stakeholders and the overall community through written materials, presentations to agencies and municipal

leaders and creative use of local resources such as radio talk shows and local cable access broadcast.

- 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-IDN 5 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 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	CHSN Executive Director; Partnership	Nov. 8, 2018	Milestone Met

Implementation Activity/ Milestone: Community Input	Responsible Party/ Organization	Time line	Progress Measure / Notes
Misuse, Suicide and Behavioral Health sponsored by the Partners in Community Wellness (PicWell) team	for Public Health; PicWell team		
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.
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-IDN 5 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-IDN 5 clients' needs, gaps and successes. The Advisory Committee was formed

Implementation Activity/ Milestone: Community Input	Responsible Party/ Organization	Time line	Progress Measure / Notes
			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 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.

- One change occurred within the CHSN network composition during this reporting period. On September 27, 2018 we received notification from HOPE for NH Recovery, an affiliate partner providing recovery support services, that they had closed their Franklin satellite location. A Withdrawal Authorization Form was signed and notarized by [REDACTED], Executive Administrator and submitted to CHSN-IDN 5 on that date. Their withdrawal could have caused a small impact to our Merrimack County clients seeking recovery support services however, the

CHSN Board has engaged with the Greater Tilton Resource Center to pick up these services. Plans to bring on the GTRC as a new affiliate to fill this void are in place so services will ultimately be uninterrupted and cause no direct affect to the work or outcomes of our projects.

- To address insufficient workforce capacity and related training/education access and availability, CHSN has been engaged in numerous regional and statewide efforts. It has worked collaboratively with IDNs 1 and 7 in particular to co-host northern trainings and participates in statewide training opportunities such as the NH Behavioral Health Summit. CHSN-IDN 5 developed a robust training plan that was rolled out April 2018 and ran through December 2018 via a contract with NHADACA, which identified and offered required trainings to the region that support the work of our projects for the staff involved. Additionally, CHSN has a significant presence on the Statewide BH Workforce Taskforce. The CHSN Executive Director sits on the Statewide Training & Education subcommittee; and the CHSN Board Chair, also chairs the Statewide Policy subcommittee. Both individuals are deeply involved and engaged in this work and connecting statewide efforts to address regional needs wherever possible.
- On April 12, 2018, CHSN signed a contract with the [REDACTED] to address how to best meet CHSN's training/education needs identified in its training plan stated above. The [REDACTED] training plan was rolled out to CHSN-IDN 5 partners on April 16<sup>th</sup>. Effective immediately, individuals could access the [REDACTED] library of existing webinars and in June we began offering local (Winnepesaukee and Central region) in-person trainings based on the identified topic areas. A total of 15 in-person trainings were planned for though just 13 were hosted between June and November (see list below). Two SBIRT trainings were moved to be held in 2019 due to low enrollment during the holidays. [REDACTED] asks that each attendee complete an evaluation survey of the training. Those scores are shared with CHSN-IDN 5 along with all individual comments of participants. Shown below you will see the cumulative evaluation score listed next to the name of each topic. The contract enabled all CHSN-IDN 5 partners and their staff to participate in and take advantage of these trainings free of charge by using a promo code upon registration which was billed to CHSN-IDN 5. All partners were encouraged to share with staff and to take advantage of this significant workforce improvement opportunity that the CHSN Board supported as a meaningful investment into our region. CHSN-IDN 5 was successful in training 553 individuals in our region on various BH topics by year-end primarily through the [REDACTED] contract trainings or other regional/state trainings.

In-Person Training Topics Offered (and cumulative evaluation scores in parenthesis)

- 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 & 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 & 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 & Trauma in the Practice of Behavioral Health (4.6)

## Webinars Topics Recorded

- Cultural Competency: Communicating Across Boundaries
  - Live: <http://nhadaca.adobeconnect.com/pzp9gi5idyop/>
- Increasing Hepatitis C Knowledge Among Behavioral Health Providers
  - Was recorded but still needs to be edited:  
<http://nhadaca.adobeconnect.com/pzr7re3se5f1/>
- 24/7 Connectedness to Technology: Its Impact on Human Development and Its Role in Anxiety and Depression
  - Recorded – scheduled to re-record early January for quality purposes

## Topics Planned But Not Offered in 2018 due to low enrollment (rescheduled to March 18 & 19, 2019)

- Two (2) Screening Brief Intervention Referral to Treatment (SBIRT) trainings which were cancelled due to low enrollment in November 2018
- We continued to seek opportunities to expand collaboration and interagency agreements to share staffing during this reporting period. You will note within the Opioid Crisis section update below and within the community project section updates that we have seen significant collaboration between agencies who are sharing staff or have interagency agreements in place to most efficiently perform the work of the waiver. Previous examples have been shared in our reports which highlight examples of how HealthFirst Family Care Center (FQHC) and Riverbend Community Mental Health Center share an E5 care coordinator. HealthFirst Family Care Center also shares one care coordinator with Franklin Regional Hospital. By sharing a position, it affords the benefit of an employee to be deemed full time by one agency with benefits, the agencies realizing cost savings, and the patients receiving more coordinated care between their primary care and behavioral health providers. Agencies such as Navigating Recovery of the Lakes Region (peer recovery support) and Horizons Counseling Center (BH counselor) continue to find opportunities for sharing service delivery protocols and workflows as well as cross-training staff for C2 and D3 project activities.
- In our efforts to advance practices and the overall network along the continuum of coordinated and integrated health care delivery at the practice and at the system level, our activities to date include:
  - UNH/CHI performed a second follow-up site self-assessment survey with CHSN network partners which concluded in November 2018. The overall round 2 roll up report for CHSN-IDN 5 can be found as **Attachment\_PPI.1**. This SSA served as the round 2 follow-up for most and a round 1 follow-up for partners who did not participate in the original baseline surveys performed in September 2017. There was 100% participation among our B1 partners and a few others, for a total of 22 participants. Due to the busyness of December, the results of the SSA are scheduled to be reviewed at a B1-Integrated Healthcare meeting on January 17, 2019. Individual rollout reports will be distributed at the meeting and electronically in an email to each partner for their sites to review. CHSN-IDN 5 shares with its partners the “practice identifier key” eliminating any anonymity and enabling practices to reach out to the “high achievers” and potentially learn from their practice(s) and integration successes. CHSN has extended its contract with UNH/CHI to perform two additional follow-ups; the schedule will be reduced from twice annually to just once each year in the fall of 2019 and in 2020 to continue to monitor practice progress towards integration.
  - The CHSN Executive Director and Data Analyst have worked with B1 partners to review their SSA results and assist them with developing or agreeing upon a plan of action to

move them along the SAMHSA continuum of Integrated Care. CHSN-IDN 5 had originally anticipated hiring a consultant to work closely with agencies and coach them on integration activities and to formalize agency-specific plans for each to attain either Coordinated or Integrated Care practice designation as defined in our Implementation Plan. Finding this unique skill set in practice integration proved to be rather difficult so we decided to do the best with what we had and shared our CHSN staff with the practices to assist them as needed.

- Universal consent forms were formalized in the previous reporting period, but this period was where they were put to the test. Some of the B1 partners are now utilizing the Authorization and Consent to Disclose Protected Health Information for Treating Providers and for Non-Treating Providers, often referred to within IDN 5 as our “universal consents” forms. Those who have utilized the new forms for patient consent have noticed a streamlined workflow and a more efficient way to best share a patient’s health information amongst care teams. Experiences to date vary, but overall the Authorization and Consent form for Treating Providers is working very well in a practice and have found patients are willing to sign the consent. The disclosure for Non-Treating Providers has presented challenges related to staff turnover given that the non-treating provider’s name has to specifically be documented on the form (specifically with the C2 and D3 projects) and just the general complexity of maintaining resources across the community (workforce is constantly changing, etc.) has posed some challenges with this document in particular.
- Unique to CHSN-IDN 5 is a workforce capacity and employee recruitment/retention strategy that was put in place to assist partners not just monetarily, but also assisting CHSN as a network partner engagement tool for the DSRIP waiver. To encourage ongoing partner engagement, CHSN-IDN 5 will, in return, provide them with funding to assist in maintaining or growing their workforce via our Employee Retention Incentive Plan (ERIP) that was put into effect on January 1, 2018. The ERIP provides the potential for six payouts to partners over the course of the remaining waiver period (following timeline of the IDNs semi-annual reporting to DHHS for incentive payments). If partners meet established criteria they will receive an incentive payment upon the IDN receiving funding from DHHS for meetings its outcomes upon SAR reporting. Partner criteria includes items such as attendance at a certain number of board or network meetings; responsiveness to emails or requests by CHSN staff that has an associated deadline; meeting their staff training expectations as identified in our master training matrix and providing agency-specific data at given reporting periods. Criteria is tracked by CHSN staff and the first incentive payment checks were distributed in August 2018 to partners. Network partners can utilize funds however the agency sees fit as long as it is for purposes of employee recruitment, retention, merit increases, loan repayment, staff celebrations and general employee satisfaction. Partners receiving funds must report on their use annually and to date we have heard an overwhelming response to our first payment and its outcomes including improved staff morale.
- Through our community projects, we continue to develop the network’s relationships beyond the health care community to also include partners such as county corrections, recovery support organizations, family resource centers, transportation agencies, supportive housing, etc. to support effective transitions of care and community re-entry.
- CHSN continued to make strides during this reporting period in regards to its HIT infrastructure improvements with our partners to support integrated health care. CHSN previously reported that all of the CHSN Tier 1 partners (8 agencies including hospitals, FQHCs, BH and SUD providers) within our B1 – Integrated Healthcare project had signed their contract with CMT. In this reporting

period, contracts were secured with any additional partners who are providing data for DSRIP projects. CHSN also signed its contract with Massachusetts eHealth Collaborative (MAeHC) in December 2017 and has been utilizing them for data aggregation services. Their method of contracting was handled differently so the process of onboarding partners was much easier. CHSN has MOU's in place 27 of its 32 partners. The remaining five partners with outstanding MOU's are non-data reporting agencies. We are excited to have begun to experience how the utilization of CMT within partner agencies and by care coordinators has increased the capacity for improved communication and coordination of patient care through shared care plans and for coordinating care in real time.

- CHSN Data Analyst continues to offer his time to assist partners with data related questions, concerns and/or reporting requirements/needs related to CMT, MAeHC reporting requirements and data collection deadlines required by various DHHS requests.

Implementation Activity/ Milestone: Network Development	Responsible Party/ Organization	Time line	Progress Measure / Notes
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 CHSN staff in Statewide WFTF (Education & Training Subcommittee and Policy Subcommittee) is ongoing.	Milestone Met; a training contract with ██████ began mid-April and ended Dec. 31, 2018 to address identified DSRIP BH training/education needs. 553 Individuals were trained from all training sources through year-end.
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	Milestone met; all CHSN partners who need to be providing data have signed contracts with CMT (for

Implementation Activity/ Milestone: Network Development	Responsible Party/ Organization	Time line	Progress Measure / Notes
		providing data for DSRIP projects.	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 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.

Implementation Activity/ Milestone: Addressing the Opioid Crisis	Responsible Party/ Organization	Time line	Progress Measure / Notes
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.

Implementation Activity/ Milestone: <b>Addressing the Opioid Crisis</b>	Responsible Party/ Organization	Time line	Progress Measure / Notes
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 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 now 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 death, resignation or removal.

An annual meeting of the Members is held annually at a date agreed upon by the Members. At the annual meeting, the Members will appoint the Managers, review and approve the annual operating budgets, and review the strategic plans of the Company, and such other matters as are typically addressed at an annual meeting.

As stated previously in PP1-2, one change occurred within the CHSN network composition during this reporting period. On September 27, 2018 we received notification from HOPE for NH Recovery, an affiliate partner providing recovery support services, that they had closed their Franklin satellite location. Their withdrawal will cause little impact to our Merrimack County clients seeking recovery support services because the CHSN Board has engaged with the Greater Tilton Resource Center to pick up these services. Plans to bring on the GTRC as a new affiliate to fill this void are in process so recovery support services will be uninterrupted and cause no direct affect to the work or outcomes of our projects.

CHSN remains open to 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. A CHSN governance subcommittee reviewed and presented to the board in April 2018 that the existing board composition adequately represents all constituents 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. Due to retirement, two managers have shifted on the CHSN Board. Both ██████████, Executive Director at Franklin VNA & Hospice and ██████████, CEO of Mid-State Health Center retired in Q4 2018. Their replacements and new CHSN managers are ██████████ and ██████████ respectively. The executive officers of CHSN continue to be ██████████, Chair (LRMHC), ██████████, Vice Chair (Horizons), ██████████, Treasurer (HealthFirst), and ██████████, Secretary (Lakes Region Community Services). An additional retirement is anticipated in January 2019 by the Newfound Area Nursing Association’s Executive Director, ██████████ but her replacement, ██████████ is already involved with IDN related activities and meetings.

Implementation Activity/ Milestone: Governance	Responsible Party/ Organization	Time line	Progress Measure / Notes
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

Implementation Activity/ Milestone: Governance	Responsible Party/ Organization	Time line	Progress Measure / Notes
			minutes are shared and discussed at Board meetings by respective Project Leads
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 has opted to combine this 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 will be issued in 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. This electronic survey will be issued between March and June 2019 to provide enough time for their ERIP payments to have made an impact.

**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-IDN 5 set aside a 10% reserve (of the available funds) to secure for potential DHHS matching fund uncertainties and a small reserve for CHSN-IDN 5 achievement of performance metrics for a total of \$ [REDACTED]. In **Attachment\_A1.6A** you will find CHSN-IDN 5’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 Projected	CY 2020 Projected	CY 2021 Projected	Total
<b>PPI</b>								-
- Administrative lead								
- Stipends/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

One change occurred within the CHSN network composition during this reporting period. On September 27, 2018, CHSN received notification from HOPE for NH Recovery, an affiliate partner providing recovery support services, that they had closed their Franklin satellite location. Please reference PPI-2 Network Development for further information.

CHSN made significant progress on its identified behavioral health workforce capacity activities. In our previous semi-annual report, CHSN-IDN 5 had just signed a training contract with the New Hampshire Alcohol and Drug Counselors Association (NHADACA) to offer CHSN partner trainings through webinars and coordinated in-person trainings. The contract allows for all CHSN partner agencies and all of their staff to register at no charge for any behavioral health, integrated health, or DSRIP project related educational trainings that may assist them in their work. We identified 15 of the most relevant hot topics from the Master Training Matrix that were presented regionally as in-person trainings in addition to giving them access to NHADACA's existing training library on various topics. All of this has provided education and training for those working within the A1, A2, B1 and community C, D, and E projects. The original work that went into developing the Master Training Matrix identified the training topic, provider types recommended to have it, agency names and potential numbers of providers requiring training. The Matrix was then used with NHADACA to develop the most comprehensive plan to meet our identified needs and formalize training topics. The contract ran from April 12, 2018 – December 31, 2018 where NHADACA conducted 13 (of the 15) in-person trainings between June – November 2018. Trainings were held in venues located in Plymouth, Laconia and Tilton. There were 241 registrations processed and 179 members who attended in-person trainings. There were 28 "No Show" registrants and the remainder were cancellations. The No Show rate was much lower than anticipated among partner organizations considering these were no cost trainings. The mean evaluation score for the trainings was 4.7 (94%). In addition to the NHADACA contract, CHSN-IDN 5 has captured that 553 individuals in total were served either by NHADACA or other training venues on a variety of DSRIP related topics. Further below in this section you will find a snapshot of the CHSN-IDN 5 training tracker, (also included as **Attachment\_A1.4**) which is the tool utilized by CHSN to capture all trainings and IDN partner attendance to date.

The NHADACA training topics sponsored by CHSN included:

### In-Person Training Topics Offered (and cumulative evaluation scores in parenthesis)

- 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 & 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 & 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 & Trauma in the Practice of Behavioral Health (4.6)

#### Webinars Topics Recorded

- Cultural Competency: Communicating Across Boundaries
  - Live: <http://nhadaca.adobeconnect.com/pzp9gi5idyop/>
- Increasing Hepatitis C Knowledge Among Behavioral Health Providers
  - Was recorded but still needs to be edited:  
<http://nhadaca.adobeconnect.com/pzr7re3se5f1/>
- 24/7 Connectedness to Technology: Its Impact on Human Development and its Role in Anxiety and Depression
  - Recorded – scheduled to re-record early January for quality purposes

#### Topics Planned but Not Offered in 2018 due to low enrollment (will be rescheduled in 2019)

- Two (2) Screening Brief Intervention Referral to Treatment (SBIRT) trainings which were cancelled due to low enrollment in November 2018

In addition to our ██████████ contract success, CHSN worked closely with regional partners to share announcements of trainings being offered elsewhere such as at Lakes Region Mental Health Center. When they had a training with space available, they notified us that others may join and we spread the word to our partners. CHSN collaborated with Region 7 to co-sponsor a Co-Occurring Medical Conditions for Medical and Behavioral Health Providers two-part training in September 2018 in the North Country. Additionally, CHSN co-hosted with Regions 1 and 7 to bring an additional BDAS Initial Training on Addiction and Recovery to Plymouth State University in September as well. Through these collaborative efforts, our dollars can be stretched further to make for a better experience. Collaborating with other IDNs allowed for cost savings by sharing the cost of bringing in an expert speaker, cost to host the event in an appealing meeting location, provide lunch/snacks, coordinate CEUs for providers, and fill the room based on more IDN partners being invited. Lastly, we joined the six other IDNs in hosting and sharing the cost of bringing an “IDN Track” to the December 10-11, 2018 NH Behavioral Health Summit in Manchester, NH where the focus was on DSRIP related behavioral health/integrated health topics conveniently offered in one place with CEUs made available for clinical staff.

CHSN-IDN 5 struggled to find a regional resource to offer trainings to meet the STC requirement of hypertension, diabetes and hyperlipidemia. We then collaborated with Network for Health (IDN 4) to utilize their tools and recorded online trainings they had developed via a lunch and learn structure to meet this need within their IDN. This sort of collaborative nature between IDNs is significant in bringing forward expertise to NH when it may not exist in all regions. The online, recorded trainings are available via Network for Health’s website and were shared with our B1 partners. Many partners have noted how they liked the simplicity of having a webinar to view either as part of one of their staff meetings, or on their own time to meet this training objective. Network 4 Health will be offering additional lunch and learn topics winter/spring 2019 which will also be opened up to IDN 5 partners who may be interested. *(Please note, at time of this writing, the hypertension link shown below is broken. Network4Health has been informed and will be working to correct this).*

Recorded  
10/25/2018

Chronic Disease Lunch n Learn Series:  
Hypertension

1 hour

Presented by Network4Health and Rivier University

[Click here to view the training.](#)

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Recorded 11/1/2018

Chronic Disease Lunch n Learn Series: Diabetes

40 minutes

Presented by Network4Health and Rivier University

[Click here to view the training.](#)

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Recorded  
11/8/2018

Chronic Disease Lunch n Learn Series:  
Hyperlipidemia

30 minutes

Presented by Network4Health and Rivier University

[Click here to view the training.](#)

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 continued 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. It also 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 updated of statewide and regional activities at its regular monthly board meeting through a verbal or written report provided by the Chair. When there is important news to share, A1 workforce updates are built into the B1-Integrated Healthcare agenda to help keep partners informed of regional and statewide workforce activities and potential legislation, etc.

- Educating and training, including gaps in educational preparation of behavioral health providers' workforce readiness upon graduation. **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.
- Recruitment of new providers and staff. **Progress Made:** The community projects projected a total of 26.2 FTEs to operationalize the three projects. Through December 31, 2018 there were 5.5 FTEs hired or assigned to the C2 project of the projected 7.5; there were 6.2 FTEs hired or assigned to serve on the D3 project out of the projected 9.2; and a total of 9.4 FTEs hired out of 9.4 for the E5 project. To date, 81% of all positions have been filled for our community driven projects.
- Retention of existing staff, including the IDN's targeted retention rates. **Progress Made:** CHSN-IDN 5 saw that 2018 as the critical timeframe for providing as many education and training opportunities to behavioral health providers employed within the region. Through our extensive training contract with NHADACA, CHSN-IDN 5 trained 553 individuals between April and December 2018 on important,

meaningful, DSRIP related behavioral health topics. Offering so many 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. Additionally, The CHSN Employee Retention Incentive plan (explained in detail in section PPI-2) began on January 2, 2018. Network partners have an ongoing opportunity to receive incentive payments of either \$█████/ \$█████/ \$█████ depending on their identified "tier" which is based on agency type and level of IDN involvement. The incentive payments are paid out every six months from January 2018 – December 2020 in the August and February timeframe which keeps in line with when an IDN learns of whether it has received its DSRIP incentive payment based on meeting goals in each of the semi-annual reporting period. 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 of course is to assist partners by putting dollars back in their pockets to utilize for their specific retention and recruitment efforts, loan repayment, merit increases, assistance with tuition; however they see fit as long as it goes towards their employees. CHSN began tracking agencies' performance in January based on the established criteria and cut the first ERIP payments in August 2018 and the second payment is scheduled for February 2019. Upon polling our network partners to update their workforce capacity numbers, (see table A1-5 below) we received new information concerning our regional workforce. Given these new numbers, the current retention rate is 100% with a current vacancy rate of 9.2%.

- Strategies to support training of non-clinical IDN staff in Mental Health First Aid. **Progress Made:** Significant progress has been made in the training of non-clinical staff in MH First Aid. CHSN-IDN 5 brought a Basic Mental Health First Aid training to the region in November 2018 (excerpt of training flyer below). The training 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.



## THE NH TRAINING INSTITUTE ON ADDICTIVE DISORDERS

Presents:

### MENTAL HEALTH FIRST AID



with [REDACTED] & [REDACTED]

AN 8 HOUR TRAINING EVENT ON NOVEMBER 9, 2018

8:00 a.m. – 5:00 p.m. (registration begins at 7:30 a.m.)

Lakes Region Mental Health, 40 Beacon St. East, Laconia, NH 03247

**PRESENTATION:** Mental Health First Aid introduces participants to risk factors and warning signs of mental health and/or substance use problems, builds understanding of their impact, teaches individuals how to help a person in crisis or experiencing a mental health and/or substance use challenge and overviews appropriate supports. The program teaches common risk factors and warning signs of specific illnesses like anxiety, depression, substance use, bipolar disorder, eating disorders and schizophrenia.

Mental Health First Aid teaches about recovery and resiliency – the belief that individuals experiencing mental health/substance use challenges can and do get better, and use their strengths to stay well. Participants will learn how to apply the Mental Health First Aid action plan in a variety of situations, including when someone is experiencing: panic attacks, suicidal thoughts or behaviors, non-suicidal self-injury, acute psychosis, overdose or withdrawal from alcohol or drug use, and/or reaction to a traumatic event. The opportunity to practice — through role plays, scenarios, and activities — makes it easier to apply these skills in a real-life situation. Participants do not learn to diagnose, nor how to provide any therapy or counseling – rather, participants learn to support a person developing signs and symptoms of a mental illness, substance use disorder or in an emotional crisis by applying a core five-step action plan. Mental Health First Aid is included on the Substance Abuse and Mental Health Services Administration's National Registry of Evidence-based Programs and Practices (NREPP).

As a result of attending this training, participants will: Gain an overview of the prevalence and impact of mental health problems in the United States; Learn the Mental Health First Aid Action Plan and how it fits within the array of interventions available to address mental health problems; and gain an understanding of the signs, symptoms and possible risk factors and warnings signs of: depression and anxiety, psychosis, and substance use disorders including: suicidal thoughts and behavior, symptoms of depression, non-suicidal self-injury, panic attacks, traumatic events, symptoms of anxiety, psychosis, disruptive or aggressive behavior, overdose, and withdrawal.

- **Additional strategies identified in the Statewide Workforce Capacity Strategic Plan. *Progress Made:*** The amended Statewide Workforce Strategic Plan was reviewed by committee members in December 2018 and a formal vote was made to approve the suggested amendments on January 7, 2019. Given DHHS is a key player working with IDNs to develop the SW WF strategic plan, it is therefore not attached.

Some of the highlights of the *Policy* subcommittee work that occurred July – Dec 2018 statewide and regionally include:

- Turnover in the subcommittee membership and the end of the legislative session impacted Policy subcommittee activities with a reduction in meeting time from the scheduled 6 to just 4 meetings.
- The committee met for two educational sessions:
  - OPLC leadership was helpful in our understanding of boards business and the support afforded them by the staff at OPLC
  - Education from the OT and MSW programs at UNH was also helpful as we look to understand the potential need for support promote integration

- The committee welcomed [REDACTED] as member and a member from Region 4/ Manchester to ensure we had all regions covered and had some additional state support and perspective.
- The committee is seeking legal interpretation of existing rules relative to the Mental Health Practice Board.
- The committee looked at introducing legislation that could be added on to the priorities outlined in the original strategic plan, in preparation for the fall.
- The strategic plan was reviewed in detail and priorities/goals were adjusted to be more realistic and attainable, given the time remaining in the DSRIP waiver.
- Data was solicited from all IDNs relative to their experiences related to licensing issues, conflicts and barriers within the existing rules and laws.
- Membership and term limits were reviewed with the Mental Health Practice Board and we are looking to support new members that will align with Medicaid providers.

The Training and Education subcommittee meetings this reporting period primarily focused on activities surrounding the development of the IDN track for the New Hampshire Behavioral Health Summit scheduled in December. The IDN track was a huge success and extremely well attended. Sessions were recorded and will be made available to all participants and beyond upon finalization. Below is a listing of just a few of the highlights of activities that have taken place.

- BDAS Addiction 101: Initial Training on Addiction & Recovery: this program is offered in Concord on a quarterly basis but offered to bring three trainings to the IDN regions. Regions 1, 5, and 7 co-hosted and funded a training in Plymouth on September 20, 2018.
- Mental Health First Aid: Riverbend CMHC hosted a successful Mental Health First Aid train-the-trainer program in April 2018 and trained 30 individuals. CHSN-IDN 5 hosted a Basic Mental Health First Aid training in November 2018 and trained 10 individuals from the region.
- Health Career Catalogs: Area Health Education Centers are still working to revise health career catalogs to incorporate more behavioral health careers. Each IDN contributed \$[REDACTED] in Q4 2018 to support the revisions and will receive catalogs for distribution in their networks to promote behavioral health careers.
- NH Higher Education Behavioral Health Workforce Roundtable: Southern NH Area Health Education Center has convened a group of higher education academic institutions offering behavioral health programs to gain an understanding of what programs, degrees and certificates are currently being offered through higher education. This roundtable offers a way to work together to identify potential gaps in workforce development and identify strategies for addressing these gaps. The group meets quarterly and has begun looking at an inventory of existing behavioral health academic programs in NH and has brought employers together from hospital systems, FQHCs, Mental Health Centers, and social service organizations together to look at workforce needs and discuss labor statistics. Future conversations will focus on accreditation, clinical rotations, and curriculum development.
- Centralized Training Calendar: The Training & Education Subcommittee has recommended that the Myers & Stauffer CPAS website serve as the centralized training calendar for the IDNs. It was suggested that each IDN send Myers & Stauffer their training calendar, and include which trainings are open to other regions. This item remains open.
- Speaker's Bureau/Training Capacity: All IDNs have sent their list of trainers/presenters within their region to IDN 7 to gather, so all of the information can be collated together and shared.
- Integrated care team roles, job descriptions, and functions: The training and education subcommittee has suggested to use SAMHSA as a resource to define these

- Any special considerations for workforce development related to the IDN’s Community-Driven Projects (C2, D3 and E5), including unique training curricula and plans. **Progress Made:** Within the CHSN Master Training Matrix it identified opportunities for team building, utilizing and understanding Smartsheet as a tracking mechanism, CMT training for care coordinators, ethical communications and confidentiality, cross-training of job functions, training on the use of CHSN-IDN 5’s universal consent forms and more. As previously reported, all project staff working at an eligible agency, can participate in/apply for a SLRP match of \$██████ (if eligibility criteria are met) offered by CHSN-IDN 5. Five partner employees have formally applied for assistance to date. Additional training plans are addressed within each project section and an attachment with each project-specific training plan can be found there.

### 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-IDN 5 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 other Community Service Agencies
Develop a training matrix of CHSN-IDN 5 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. 553 individuals trained to date; 386 of those were trained during this reporting period.
Initiate recruitment of Training Coordinator	CHSN Executive Director	Initiate by October 1, 2017. – CLOSED	Milestone Met; CHSN decided in Nov. 2017 to contract with

Implementation Activity/ Milestone	Responsible Party/ Organization	Time line	Progress Measure / Notes
			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 553 individuals have been trained to date through a variety of training resources; 386 of those were trained during this reporting period.
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; the initial ERIP payments to partners made in August 2018 for the Jul-Dec 2017 SAR. Second payment scheduled for Feb 2019 for the IDN's

Implementation Activity/ Milestone	Responsible Party/ Organization	Time line	Progress Measure / Notes
			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 \$ [REDACTED], 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.
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.

Implementation Activity/ Milestone	Responsible Party/ Organization	Time line	Progress Measure / Notes
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-IDN 5 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-IDN 5 will serve as a matching fund contributor similar to an employer in the amount of \$██████ 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-IDN 5 will not be directly paid to staff but rather through the employer to follow existing SLRP guidelines. SLRP has received 3 “new” applications (1 from Mid-State Health Center; 2 from LRMHC) and 2 “renewal” applications (1 from Mid-State and 1 from LRMHC). Though applications were received in Sept. 2018, the contracts have effective dates of 1/1/19 so IDN matching funds won’t be expended until April 2019. In one year we will review fund balance and if appropriate, in order to spend down

Implementation Activity/ Milestone	Responsible Party/ Organization	Time line	Progress Measure / Notes
			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 [REDACTED]. CHSN signed a contract with [REDACTED] 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-IDN 5 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 [REDACTED] 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 [REDACTED] 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 [REDACTED] trainings) to also capture in our training tracker.

CHSN-IDN 5 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-IDN 5 has set aside \$[REDACTED] 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-IDN 5 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-IDN 5 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-IDN 5 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 [redacted] 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 [redacted] 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-[redacted] 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	Aug-18	Aug-18	Aug-18	Aug-18	Aug-18	Aug-18	Aug-18	Aug-18	Aug-18	Aug-18	Sep-18	Sep-18	Sep-18	Sep-18	Sep-18	Sep-18
Agency	Name	Position	The Intersection of Opioid Abuse (SAMHSA)	High Fidelity Wraparound	Wraparound Training	Wrap-around Model & Enhanced Care Coordination	Farnum Center Tour	NH Healthcost.org	Wraparound Model approach Re: Fast Forward Program	Manual Data Reporting NH DSRIP QRS IDN 5	Myers & Stauffer IDN Learning Collaborative Training	NH Citizens Health Initiative Annual Symposium	Ethical Concerns in working with individuals at risk for suicide	CRSW Administrative Rules Overview	BDAS Addiction 101 Training	Intermedial Motivation Interviewing: Enhancing Skills	2018 Housing Stability Conference
Salvation Army	[redacted]	Commanding															
Spauld Hospital	[redacted]	Population Health Care Manager of Practice Operational Medical Social Worker Director, Care															
Lakes Region Mental Health	[redacted]	Community Care Coordinator							8/29/2018				9/18/2018		*****	9/24/2018	
	[redacted]	Care Coordinator															
	[redacted]	Care Manager															
	[redacted]	Targeted Care Manager															
	[redacted]	Therapist															9/24/2018
	[redacted]	Case Manager															
	[redacted]	CSP Director													3/19/2018		
	[redacted]	Case Manager															
	[redacted]	TSS															
	[redacted]	Clinical Mental Health Co ARNP												3/18/2018			
	[redacted]	Health Mentor															
	[redacted]	Community Case Manager												3/18/2018			
Current 12.17.18	[redacted]	Care Coordinator															
	[redacted]	Child & Family															
	[redacted]	Community Case Manager												3/18/2018			9/24/2018
	[redacted]	Health Mentor															
	[redacted]	Housing Facilitator															

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
Trainee satisfaction	At least 85% of training participants rate training programs as either “excellent” or “very good” in an evaluation survey	Of the 3 DSRIP 101 programs held totaling 35 participants (31 evaluations received), there was a 97% satisfaction rate received on evaluation survey	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 ██████ in this reporting period received an overall score of 4.6 out of 5.	<b>Milestone Met;</b> Trainee satisfaction is shown in parenthesis next to each training topic offered by ██████ (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 & 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 & 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 & Trauma in the Practice of Behavioral Health (4.6)

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
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"	Under development; will vary based on training type	In Process; Ongoing; ██████ utilizes an evaluation tool for all trainings offered and provides CHSN-IDN 5 with results on monthly basis.	Milestone Met; average was 4.67 based on ██████ evaluation tool shows demonstrated gains in knowledge via their post training assessments.
Total number of training participants	Train 280 individuals in total by Dec. 31, 2018. (based on 14 partners x 20 staff each)	DSRIP 101 = 24 Attendees; 2-day Suicide Prevention academy = 4 attendees; PSU Suicide prevention & Awareness = 1 attendee	A total of 167 individuals have been trained on various BH/Integrated health care topics in this reporting period. 77 of those were through ██████ offerings.	Milestone met; Through our contract with ██████, 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-██████ trainings attended by partners. CHSN-IDN 5 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.
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	Pending; CHSN has not identified a mechanism to work with partners when they are recruiting new staff to capture this data.	In Process; specific position types to capture average recruitment were identified.	Milestone Met; the average recruitment for key BH positions is 86 days.

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
Overall key position current (point in time) vacancy rate	Less than or equal to 10% (current baseline estimated at 12%)	In Process; based on an updated workforce capacity poll performed in December (see table A1-5) the identified vacancy rate is currently 19.63%. Of note - given the increased need for workforce due to IDN-specific projects it also increased the number of vacant positions which increased the vacancy rate since the last report which did not change our numbers favorably.	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.
Number of IDN-related staff receiving financial support to pursue licensure / certification	Up to 10 recipients	0	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.
Number of IDN-related staff receiving loan repayment	Up to 10 recipients	0	0; under development – phone meetings have occurred with SLRP to formalize a plan for CHSN-IDN 5 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-IDN 5 partners with hopes of assisting up to 20 applicants for a total of \$ [REDACTED].

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

CHSN-IDN 5 identified the staffing targets needed to perform the DSRIP waiver projects. These updated targets represent all positions identified in the A2, B1, C2, D3 and E5 projects and are reflected in the IDN 5 Workforce table below.

Some staffing targets have been adjusted to reflect our current situation. The CHSN Board agreed to remove the .50 FTE for a transportation driver shared between the D3 and E5 project as the need has been deemed no longer necessary. HOPE for NH Recovery closed its doors in the Franklin region, thus removing that FTE and there are four home health/VNAs that were removed from the E5 project as the need was for either .15 or .20 of an FTE. We recognized this should not have been listed as an FTE but rather will be handled in such a way that when the agency performs the function required of the project by existing staff they will bill the IDN for reimbursement. Below you will see that the A2 project has identified 11 FTEs (CIOs at various agencies and CHSN Data Analyst), the B1 project includes the 2.5 FTEs which are 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 new combined total of 39.6 projected total need. Of those, 34.6 FTEs have been filled, leaving a remainder of 5 FTEs yet to be hired. Worth noting is that two of the five FTEs are recovery support workers for the Plymouth IOP project which has not yet opened, however the RSWs are trained, in place and ready to go. Additionally, at year-end 2018, LRMHC was in the hiring process for its Re-Entry Care Coordinator but she was not on-boarded by year-end though she is in place now. Therefore, we see that there is a vacancy of just 2 FTEs to fulfill the needs of the projects.

In 2018 there were significant recruitment activities seeking the Plymouth MLADC 1 FTE with no viable applicants found to date. Additional workforce activities 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-IDN 5 funding will assist up to 20 individuals at \$██████ each towards their education loan repayment. Five individuals have applied to date. The CHSN Board also invested in over \$██████ to support its network partners' staff trainings on behavioral/integrated healthcare topics.

Provider Type	IDN 5 Workforce (FTEs)				
	Projected Total Need	Baseline Staffing on 6/30/17	Staffing on 12/31/17	Staffing on 6/30/18	Staffing on 12/31/18
CHSN Executive Director	1	1	1	1	1
Project Manager	1	1	1	1	1
Data Analyst	1	0	0	1	1
Administrative Assistant	.5	.5	.5	.5	.5
Chief Information Officers (agency-based)	10	12	11	11	11
Re-entry Care Coordinator ( <i>Horizons</i> )	1	0	1	1	1

Provider Type	IDN 5 Workforce (FTEs)				
	Projected Total Need	Baseline Staffing on 6/30/17	Staffing on 12/31/17	Staffing on 6/30/18	Staffing on 12/31/18
Re-entry Care Coordinator (LRMHC)	1	0	1	0	1
Peer recovery support workers - future CRSW (Navigating Recovery)	2	0	2	2	2
SUD Counselor/LADC (positioned at jail) (Horizons)	1	0	0.5	1	1
SUD/ Co-occurring counselor/MLADC (Horizons)	1.5	0	0	0.5	0.5
Case Manager or clinician, shared float (Horizons)	0.5	0	0	0.5	0.5
Case manager or Clinician (Masters level) (LRMHC)	0.5	0	0	0.5	0.5
MD (Horizons) (increase to 0.2 when expand to Plymouth)	0.1	0	0	0	0.1
SUD Counselors / LADC (Horizons)	2	0	1	1	2
SUD/Co-occurring counselors/MLADC (Horizons)	2	0	1	1	1
Admin. Assistant (Horizons)	0.5	0	0.5	0.5	0.5
Recovery support worker (Horizons)	1	0	1	1	1
Benefit Navigator (LRGHealthcare)	0.1	0	0.1	0.1	0.1
Benefit Navigator (HealthFirst)	0.1	0	0.1	0.1	0.1
Case Manager / Care Coordinator (Genesis)	0.4	0	0.2	0.4	0.4
Recovery Support Worker (Navigating Recovery)	1	0	0.5	1	1
Recovery Support Worker (PARC)	2	0	0	0	0
Care Coordinator (LRGHealthcare)	1.25	0	1.0	1.25	1.25
Care Coordinator (Horizons)	1.0	0	0	1.0	1.0
Care Coordinator (ServiceLink)	0.5	0	0.5	0.5	0.5

Provider Type	IDN 5 Workforce (FTEs)				
	Projected Total Need	Baseline Staffing on 6/30/17	Staffing on 12/31/17	Staffing on 6/30/18	Staffing on 12/31/18
Care Coordinator (HealthFirst) <i>.25 shared with Riverbend</i>	2.25	0	.25	2.25	2.25
Care Coordinator (LRMHC) <i>1 – Laconia; .5 - Plymouth</i>	1.5	0	1.5	1.0	1.5
Care Coordinator (Riverbend) <i>.75 shared with HealthFirst</i>	.75	0	.75	.75	.75
Care Coordinator (Speare Memorial)	1.0	0	0	1.0	1.0
Care Coordinator (Mid-State)	1.0	0	0	1.0	1.0
Care Coordinator (Pemi-Baker Community Health)	0.15	0	0	0.15	0.15
Care Coordinator (NANA)	0.15	0	0	0	0
Care Coordinator (Lakes Region VNA)	0.15	0	0	0	0
Care Coordinator (Central NH VNA)	0.2	0	0	0	0
Care Coordinator (Franklin VNA & Hospice)	0.15	0	0	0	0
Transportation Driver (D3 & E5 projects)	0.5	0	0	0	0

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

CHSN-IDN 5 began hiring for key positions to support its project needs immediately upon receiving Implementation Plan approval. Please note that positions hired during this reporting period 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 have hired 5.5 to date. This project had a reduction of .5 FTEs due to the closing of HOPE for NH Recovery who had a .5 recovery support worker assigned and is no longer active. The D3-Expansion of Intensive SUD Treatment Options project projected the need for 9.2 positions to support the project and have hired 6.2 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, 81% of all identified staff have been hired to perform the functions of the community-driven projects.

CHSN-IDN 5 developed a comprehensive training plan in 2017 to support the workforce capacity development. This plan identifies all trainings needed and by whom by position type and/or community-project. This plan was used by [REDACTED] to determine how to best meet our needs in the training contract

that was entered into in April 2018 to begin providing trainings to CHSN-IDN 5 partners. Primary emphasis prior to this date was on recruiting and hiring the workforce required to implement our projects, and since April it has been on provided much needed trainings as close to our partners (regionally offered) with no cost other than their staff time to attend. 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-IDN 5 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 ██████████ or other agencies and an Employee Retention Incentive Plan to assist in training, retention and overall employee satisfaction for CHSN member and affiliate organizations. Expenditures for this reporting period total \$██████████ which include \$██████████ paid to ██████████ for the training contract, \$██████████ to various partners for training reimbursements; \$██████████ paid to ██████████ for the revision of a health career catalog and \$██████████ to the ██████████ to co-sponsor the IDN track at the NH Behavioral Health Summit; and \$██████████ was paid out in August 2018 to CHSN-IDN 5 partners for the first Employee Retention Incentive Plan that incentivizes partners and rewards them with funds to be used towards employee retention and recruitment efforts within their agency. And though there were 5 SLRP applications approved in September 2018 for CHSN-IDN 5 matching funds their contract dates do not become effective until 1/1/19 and payment from IDN 5 will not be issued until April 2019. Detail of all activities can be found in the table below. Please note the overall CHSN-IDN 5 five-year waiver budget will be found as **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 Projected	CY 2020 Projected	CY 2021 Projected	Total
<b>PPI</b>								-
- Administrative lead								
-Stipends/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-IDN 5 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
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

Organization Name	Organization Type	Associated with IDN Projects (A1, A2, B1, C, D, 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
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

Major activities and milestones identified for IDN development to support integration at the practice and community level are intended to:

- Assist selected organizations to achieve the desired and / or optional HIT standards with particular emphasis on providers with a significant proportion of Medicaid clients, such as FQHCs, and key behavioral health care providers.
  - **Progress Made:** Funds and other resources such as reporting work by CHSN-IDN 5's Data analyst have been made offered and accepted by partners (i.e. Mid-State, Speare and LRGH) in order to mitigate the burden/costs of additional reporting that the DSRIP project is placing on our partners. In addition, IDN 5 was able to cover some of the costs of outsourcing report work for HealthFirst to CHAN (an organization that writes reports for practices using the Centricity EHR system).
- Install, train and support a shared application for event notification, patient risk identification and inter-agency shared care planning (CMT PreManage).
  - **Progress Made:** All of our Wave 1 participants are actively engaged in shared-care planning via CMT to different degrees. A large project that we completed this reporting cycle was the two-stage implementation of Pre-Manage ED at Lakes Region General Hospital, Franklin Regional Hospital and Speare Memorial Hospital. The first implementation was designed to bring all of the hospital ED notifications online as quickly as possible. We experienced some early problems with staff being overwhelmed by the amount of event notification emails they were receiving. However, this was quickly resolved by the staff at CMT when the hospitals decided who should receive notifications. The second implementation was a direct interface with the hospitals' EHR solution (Cerner) which improved internal workflows at the hospital further. The IDN is still working with the Wave 2 participants to identify and prioritize which participants need to participate in shared care planning using CMT and which participants have the technological resources to implement and maintain their CMT implementation.
- Select, install, train and support a data aggregation application to facilitate clinical and financial analytics across the network.
  - **Progress Made:** CHSN-IDN 5 took on the challenge of gathering HbA1c and blood pressure readings from 2015 in order to establish a baseline for the CARE 03 measures. With the help and cooperation of our partners, IDN 5 was able to report for approximately 60% of the patients for our HbA1c sample and 95% of the patients for our hypertension sample. During this reporting period, we have also identified issues related to measure accuracy and have begun reviewing new workflows with our partners to identify potential measure inaccuracies and errors before submission deadlines to MAeHC for data. CHSN-IDN 5 has also been assisting some of its partners with data reporting work which has alleviated some of the burden of our partners' reporting staff. This will continue in the next reporting cycle as well with a focus on full automation of the reporting process.
- Universal Consent document(s) development
  - **Progress Made:** In the previous reporting period, CHSN-IDN 5 formalized and submitted its universal consent forms. These included an Authorization and Consent to Disclose

Protected Health Information for Treating Providers; Authorization and Consent to Disclose Protected Health Information for Non-Treating Providers; and a Consent to Release Information for the Purpose of Billing for Services. Utilizing one form for patient consent by IDN partners has already proven that it allows for a streamlined, efficient way to best share a patient’s health information amongst care teams when utilized by practices/agencies/care coordinators, etc. Not all agencies have adopted the use of these new forms, but the more integrated partners who are (i.e. HealthFirst) have shared great success stories in both their success and lack of resistance from patients when asked to sign the new forms and from the agencies identified on the releases that a patient has allowed sharing with. Several agencies who have not adopted the use of an entire new form, have incorporated aspects of the new releases and are also seeing improvement in communication, sharing and streamlining of gathering patient consent.

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 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

Implementation Activity/ Milestone	Responsible Party/ Organization	Time line	Progress Measure / Notes
			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. 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-IDN 5 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

Implementation Activity/ Milestone	Responsible Party/ Organization	Time line	Progress Measure / Notes
			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-IDN 5 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
Initiate PreManage Primary Implementation with FQHCs and BH provider organizations <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>	CHSN Executive Director; CMT; HIT Committee	Timeline adjusted: Initiate implementation between October 1, 2017 and March 31, 2018.	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] [REDACTED] at a live training in November 2018 at Lakes Region Mental Health Center.
Initiate PreManage ED Implementation with hospitals <ul style="list-style-type: none"> <li>• IT steps: <ol style="list-style-type: none"> <li>1. Establish VPN Connectivity</li> </ol> </li> </ul>	CHSN Executive Director; CMT; HIT Committee	Timeline adjusted: Initiate implementation	Milestone Met; VPN connectivity was established for the ADT feed in Phase 1

Implementation Activity/ Milestone	Responsible Party/ Organization	Time line	Progress Measure / Notes
<ol style="list-style-type: none"> <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> <ul style="list-style-type: none"> <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>		between October 1, 2017 and July 31, 2018.	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>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>	CHSN Executive Director; CMT; HIT Committee	Timeline adjusted: Initiate implementation between July 1, 2018 and December 31, 2018.	Milestone met; hospital partners had PreManage at their sites in fall 2018. Implementation at all practices occurred simultaneously with onboarding of PreManage.
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> </ul>	Data aggregator vendor; HIT Committee	Initiate by January 1, 2018	Milestone Met; CCSA protocols have been defined and were

Implementation Activity/ Milestone	Responsible Party/ Organization	Time line	Progress Measure / Notes
<ul style="list-style-type: none"> <li>configure other DSRIP measure tracking requirements / definitions</li> <li>Verify patient privacy requirements met;</li> </ul>			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

CHSN used the data provided by the Round 2 follow-up site self-assessment performed by UNH/CHI in November 2018 as well as an HIT survey filled out by the IT staff at partner agencies to identify progress toward targets below. Please note and give consideration when reviewing our progress toward targets, that Horizons Counseling Center is an SUD provider and is counted as one of our 14, B1 partners. That said, due to federal, state and privacy constraints, they do not fit the “normal” requirements of a coordinated/integrated care practice (i.e. CCSAs are performed by referring agencies and not in-house as routine – if Horizons identifies that a CCSA has not been performed, then a paper CCSA will be provided but it is not their normal practice). Given this situation with this one B1 partner, CHSN-IDN 5 will consistently show a deficiency in fully meeting our targets.

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
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	0	5	7
Number of IDN participants utilizing ONC Certified Technologies	14 of the B1 partners that maintain a health record	3	5	13

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
Number of IDN participants capable of conducting ePrescribing	13 of the B1 partners that prescribe	3	5	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	14 of the B1 partners that maintain a health record	8	10	14
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	6	6	10
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	8	10	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	8	10	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	4	4	9
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.	14 of the B1 partners that maintain a health record	2	3	8

**A2-5. IDN HIT: Workforce Staffing**

Staff Type	IDN Workforce (positions)				
	Projected Total Need	Baseline Staffing on 6/30/17	Staffing on 12/31/17	Staffing on 6/30/18	Staffing on 12/31/18
Data Analyst	1	0	0	1	1
Chief Information Officers (agency-based)	10	12	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 July through December 2018 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 in this reporting period include payments to CMT for \$ [REDACTED]; \$ [REDACTED] to MAeHC; and salary and benefits for a Data Analyst and associated mileage and cell phone reimbursements for a total of \$ [REDACTED] in expenditures between July - December 2018. See table below for detail.

Budget Item	Item Description	Jul – Dec 2017 Actual Cost	2018, 2019, 2020 Projected (Costs Equally Distributed over 3 years)	Jan – Jun 2018 Actual Cost	Jul – Dec 2018 Actual Cost	Total Project Cost
Salary and benefits, mileage and cell phone	CHSN Data Analyst					
Mileage and cell phone reimbursement	CHSN Data Analyst reimbursements					
Consultants / Subcontracts	[REDACTED] – development of client consent for inter-agency data sharing documents					
[REDACTED]	[REDACTED] PreManage and Event Notification					
[REDACTED]	[REDACTED]					
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
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

Organization Name	Organization Type
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-IDN 5'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-IDN 5 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-IDN 5 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-IDN 5 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
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

Organization Name	Data Sharing Agreement Signed Y/N
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 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	Table				

Process Milestone Number	Process Detail	Submission Format	Results (Met/Not Met)			
			6/30/17	12/31/17	6/30/18	12/31/18
	and Provider Participants					
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 partn	<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, a	<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 are scheduled to be presented to practices at the next 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.

One change occurred within the CHSN network composition during this reporting period. On September 27, 2018 we received notification from HOPE for NH Recovery, an affiliate partner providing recovery support services, that they had closed their Franklin satellite location. Please reference PPI-2 Network Development for further information.

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-IDN 5 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-IDN 5 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-IDN 5's protocol guidance that was successfully completed and shared with partners by year-end 2018.

CHSN and its partners were very pleased with the final product which was the development of our own CHSN-IDN 5, 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; ██████████	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 will be 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 progression towards coordination as is reflected in other tables identifying progress. Results from the most

Implementation Activity/ Milestone	Responsible Party/ Organization	Time line	Progress Measure / Notes
			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	<b>Milestone met;</b> 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). Training 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 since CMT is now available for all to use.
Implement Comprehensive Core Standardized Assessment process for aggregating information across multiple	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

Implementation Activity/ Milestone	Responsible Party/ Organization	Time line	Progress Measure / Notes
assessment domains and from multiple providers			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 within this reporting period.
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 holding core team/case conferences with the exception of the two Speare practices which do not 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 Speare hospitals.
Document roles and responsibilities for core team	B1 - Clinical Integration Committee; Practice Transformation Specialist	Initiate by December 31, 2017	Milestone met; work has been completed by

Implementation Activity/ Milestone	Responsible Party/ Organization	Time line	Progress Measure / Notes
members and other members as needed			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. Not all sites using CMT have been using it 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	<b>Milestone met;</b> 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	<b>Milestone met;</b> 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-IDN 5. Their use varies among partners but for those utilizing them, their workflows are in place, training has occurred with relevant

Implementation Activity/ Milestone	Responsible Party/ Organization	Time line	Progress Measure / Notes
			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-IDN 5 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-IDN 5 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.
Implement workforce plan to recruit and retain multi-disciplinary care team members	CHSN Executive Director; CHSN member agencies	Initiate by January 31, 2018; ongoing	<b>Milestone met;</b> Ongoing; CHSN's Workforce plan <b>to recruit and retain MDCT has been aided by the</b> implementation of the CHSN Employee Retention Incentive Plan (ERIP). The first payment to partners was in August 2018 and a second is scheduled in February 2019. The word from partners is these funds have assisted them greatly in recruiting

Implementation Activity/ Milestone	Responsible Party/ Organization	Time line	Progress Measure / Notes
			needed staff and retaining critical positions by having additional funding to 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 is very close with all partners and is aware of activities within the ██████ 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 most recent round 2 follow-up site self-assessments will assist 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-IDN 5 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.
Facilitate training / technical assistance as needed for integration of MAT practice within CHSN-IDN 5 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

Implementation Activity/ Milestone	Responsible Party/ Organization	Time line	Progress Measure / Notes
			on related trainings as 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-IDN 5 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-IDN 5 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 [REDACTED].
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

Implementation Activity/ Milestone	Responsible Party/ Organization	Time line	Progress Measure / Notes
			patients. Data analyst has consulted multiple 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-IDN 5 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.
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.
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 monthly statistics processing that MAeHC

Implementation Activity/ Milestone	Responsible Party/ Organization	Time line	Progress Measure / Notes
			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 will rely heavily on the CHSN Data Analyst, [REDACTED] and HIT Project Lead, [REDACTED]. They will 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-IDN 5 also began utilizing a program evaluation tool in Q4 2018 within each of the community-driven projects. 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 will be administered in the spring 2019 most likely via Survey Monkey or Google Forms. This will occur in conjunction with an annual survey of how partners are utilizing their employee retention incentive funds to retain/recruit employees. The annual survey of partners is intended to 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-IDN 5 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 \$ [REDACTED]) to assist partners’ with data requirements specific to the DSRIP waiver. Although it is too soon to state any results, we feel 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 this 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 access but could

Evaluation Measure	Source	Frequency of Collection / Reporting	Results / Notes
			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 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
Number of primary care and BH practices with all characteristics of an Integrated Care Practice	6	3	4	4
*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.
Referral rate for care coordination clients presenting with behavioral health needs	75%			Milestone Not Met; 74.36%
Referral rate for care coordination clients presenting with substance use disorder	75%			Milestone Met; 88%

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

To date, CHSN-IDN 5 has supported 81% of the identified FTEs required to implement and perform the functions within our community projects C2, D3, and E5. The community projects projected a total of 26.1 FTEs to operationalize the three projects. There are now 5.5 FTEs hired or assigned to the C2 Supportive Re-Entry project of the projected 7.5; there are 6.2 FTEs hired or assigned to serve on the D3 Expansion in IOP project out of the projected 9.2; and a total of 9.4 FTEs care coordinators have been hired out of

the 9.4 identified for the E5 Enhanced Care Coordination project. The majority of vacancies are related to the D3 project which has not expanded into the Plymouth region yet and therefore hires have not occurred. The E5 project has also had some difficulty in retaining care coordinators once on-boarded and trained causing high turnover. CHSN-IDN 5 feels that new E5 Project Manager has helped facilitate needed cohesiveness between the CCC Team and between the care coordinator and their supervisor thus improving the efficacy of their role and our ability to retain care coordinators within the project.

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-IDN 5 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)				
	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
Project Manager	1	1	1	1	1
Data Analyst	1	0	0	1	1
Administrative Assistant	.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 tracked 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 "July - December 2018 Actual Cost" column below. This period there were no expenditures reflected. One reclassification of \$ [REDACTED] (correction noted in table below) of a FY18 board stipend paid out in June 2018 did occur as it was incorrectly coded as "other" in our July 2018 SAR and therefore was not reflected as a B1 expenditure.

Funds were originally budgeted to support Integrated Healthcare which includes 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. Worth noting, due to two failed attempts with recruitment efforts in 2018 to hire a Practice Transformation Specialist (one interview candidate and one rejected inquiry with CHI to perform the work on a consulting basis), the CHSN Board decided to remove the hired position from our plan and rather keep the funds set aside to utilize to contract for/or outsource this resource at a later date. The function/tasks of this position will be absorbed by the CHSN ED and PM as much as possible. Please note, 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 Projected Cost	Jul – Dec 2017 Actual Cost	2018, 2019, 2020 Projected Cost	Jan – Jun 2018 Actual Cost	July – Dec 2018 Actual Cost	Total Project Cost
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 <b>consultative services</b>	<del>0.5 FTE for 2 years</del> ; funding to provide consultation to practices to facilitate integrated care development						
Technical Assistance	Contract with [REDACTED] for BH Integration Site Self-Assessment Survey						
Annual CHSN Board Member Stipend							
<b>INTEGRATED HEALTHCARE TOTAL*</b>							

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

The following list includes the community health centers, hospital-affiliated primary practices and behavioral health provider organizations in the CHSN-IDN 5 region participating in the Integrated Healthcare initiative.

Organization/Provider	Agreement Executed (Y/N)
HealthFirst Family Care Center	Yes
Mid-State Health Center	Yes
Speare Primary Care	Yes
Speare Pediatric and Adolescent Medicine	Yes
Westside Healthcare (FRH)	Yes
Laconia Clinic (LRGH)	Yes
Belknap Family Health – Meredith (LRGH)	Yes
Lakes Region Family Practice (LRGH)	Yes
Belknap Family Health – Belmont (LRGH)	Yes
Hillside Family Medicine (LRGH)	Yes
Caring for Kids (LRGH)	Yes
Lakes Region Mental Health Center	Yes
Horizons Counseling Center	Yes
Riverbend Community Mental Health	Yes

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

CHSN-IDN 5 received and reported that all IDN Governance sign-offs in the July 2017 SAR submission, therefore no resubmission is required.

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

**B1-8a - Comprehensive Core Standardized Assessment (CCSA):**

CHSN-IDN 5 formed a B1 Integrated Care subcommittee in December 2017 for the sole purpose of reviewing existing tools and resources available regionally, statewide and nationally to develop a CCSA guidance template. This was created and shared with partners at the February 2018 CHSN network meeting. At that meeting and since then, CHSN has given significant attention to the waiver requirements of performing a CCSA and providing education and resources pertaining to of each of the domains. Since this initial introduction in February 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**.

LRGHealthcare updated their EMR to capture CCSA domains. For now, they are only utilizing their CCSA evaluation in both of their emergency departments and making a referral to their embedded care coordinator for any positive screenings. CHSN continues to work with LRGH to expand the CCSA utilization across all LRGH practices in 2019. The rest of our organizations are all covering their domains using a variety of tools. Horizons being an SUD provider does not fall into the “normal” category for a practice who will utilize a CCSA but they do have a paper CCSA that they use should a client present who had not had a CCSA performed at their referring agency. All of Horizons patients are being referred from other organizations that already administer a CCSA and have a CCSA process in place. The rest of our organizations are using modules within their EMR to capture CCSA domains. Both LRMHC and Riverbend are using a combination of the ANSA and CANS evaluations along with additional questions/workflows to cover all CCSA domains. HealthFirst is using the PRAPARE module within Centricity to address these domains. Mid-State is using a form within Meditech to address their domains as well. Successfully, pulling data regarding CCSA’s once they are complete from the different EMR’s within the IDN has continued to be a challenge. Currently, the numbers given to the data aggregator are not accurate because CCSA completion is not stored uniformly as a flag. Rather, each section is stored separately and reporting on whether all of these separate pieces have been complete lends a less accurate picture of the work that partners are doing in screening their clients for social determinants of health.

CCSA Domain	Belnap Family Health - Meredith	Belnap Family Health - Belmont	Lakes Region Family Practice	Hillside Family Medicine	Westside Healthcare	Lakes Region MHC
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						

CCSA Domain	Laconia Clinic	Speare Primary Care	Plymouth Pediatrics	HealthFirst	Mid-State	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							

	Domain already captured
	Domain only captured in ER
	Domain not yet captured
	Domain doesn't apply

**B1-8b - Multi-disciplinary core team members:** CHSN-IDN 5 has been working diligently with its 14 coordinated and/or integrated care designated practices through a phased approach based on Tier level.

The table below identifies which Tier a practice was originally categorized in and the targeted approach and timeline for bringing practices up to the requirement of having multi-disciplinary core team members identified within their practices. At this point in time, the work has been done with Tier 1, 2 and 3 practices and all have now identified multi-disciplinary core team members which is reflected in the table below. An ongoing workforce struggle continues within the psychiatry field in that many of our B1 partners refer out and/or are utilizing a psychiatric nurse practitioner. Unfortunately, the DSRIP waiver does not consider a psychiatric nurse practitioner as meeting the requirement of a psychiatrist which we feel is very unfortunate given that the patient needs are being met and it takes into consideration NH's shortage in psychiatrists to meet this need. Several of our practices have a referral protocol in place with a referring psychiatrist – many utilize Lakes Region Mental Health Center's psychiatrist [REDACTED] [REDACTED] to meet this need. [REDACTED], although remote, remains in contact with the referring practice or MDCT and provides his feedback/patient recommendations via phone or electronic messaging.

During this reporting period, we worked diligently with our LRGHealthcare practices. Stronger working relationships now exists between the CHSN Executive Director and the two LRGH practice managers, [REDACTED] and [REDACTED] allowing new inroads to future opportunities and meetings with their practices and physicians. LRGH has had significant staff turnover from the time they signed on to being partners in the waiver and we have struggled with their lack of engagement until now so we are playing a bit of catch up currently we are confident we will have their practices fully engaged over the course of 2019.

<b>Providers identified to make progress toward Coordinated Care Practice designation (Includes Integrated Care Practices also)</b>	<b>Target</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>
HealthFirst Family Care Center	Tier 1 – Work within this practice is underway and will be ongoing throughout 2018.	<b>Laconia Office</b> [REDACTED] - Care coordinator [REDACTED], LICSW, MLADC - Behavioral health counselor [REDACTED], APRN; [REDACTED] ARNP, [REDACTED], MD - PCP [REDACTED], Community patient navigator	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], MSWLI, CSWMLADC - Behavioral Health [REDACTED] MFTC - Behavioral Health [REDACTED], APRN PCP [REDACTED], MD PCP [REDACTED], APRN PCP [REDACTED], RD, LD – Registered Dietician

		<p>██████████, MD – not currently used but plan is to contract for consultive Psychiatrist through Genesis Behavioral Health</p> <p><b>Franklin Office</b></p> <p>██████████, ██████████ ██████████ - Care coordinators</p> <p>██████████, ██████████ ██████████ - Behavioral health counselors</p> <p>██████████, APRN; ██████████ ██████████ ARNP; ██████████ ██████████, MD - PCP</p> <p>██████████, Community patient navigator</p> <p>██████████ MD – not currently used but plan is to contract for consultive Psychiatrist through Genesis Behavioral Health</p>		<p>██████████, MD – MMHC – Community Care Coordinator</p> <p>██████████ MSW - Case manager</p> <p>██████████ MD – Consulting Psychiatrist (LRMHC)</p> <p><b>Franklin site:</b></p> <p>██████████, MHHC - Behavioral Health</p> <p>██████████, MHHC - Behavioral Health</p> <p>██████████, MD PCP - Medical Director</p> <p>██████████, APRN PCP</p> <p>██████████, APRN PCP</p> <p>██████████, APRN PCP</p> <p>██████████, MHHC - Community Care Coordinator</p> <p>██████████, MSW - Case manager</p> <p>██████████, RD, LD - Registered Dietician</p> <p>██████████, MD - Consulting Psychiatrist (Riverbend)</p>
Mid-State Health Center	Tier 1 – Work within this practice is underway and will be ongoing throughout 2018.	<p><b>Care Transitions Team</b></p> <p>██████████ - Community Care Coordinator</p> <p>██████████, ██████████ ██████████, ██████████ - Triage Nurses</p> <p>██████████ - Ignite Care Manager-RN</p> <p>██████████ - Ignite Assistant - LNA</p> <p>██████████ - Patient Support Specialist</p> <p>██████████, ██████████, ██████████ - Resource Nurses</p> <p>██████████ - Bristol Triage Nurse</p> <p>██████████ - RN Care Manager, Speare Mem. Hospital</p> <p>██████████ - Director, Patient Care</p>	<p>All information remains the same as 12/31/17 report other than items/updates reflected below:</p> <p><b>Care Transitions Team meetings</b> with Speare Hospital no longer occur.</p> <p><b>Hall Team Meetings:</b> 3 groups in Plymouth and 1 in Bristol locations who meet monthly since March 2018. Bristol groups met 2x, Plymouth groups 3x for a total of 7 meetings in this reporting period. Individuals involved include: medical providers who work in</p>	<p><b>Care Transitions Team</b></p> <p>██████████ – Mid-State/CHSN Community Care Coordinator</p> <p>██████████, Speare Memorial Hospital, Community Care Coordinator</p> <p><b>Primary Care Team –</b> Primary Care Provider and assigned Medical Assistant</p> <p><b>Recovery Team</b></p> <p>██████████ - MAT Provider &amp; Team Lead</p> <p>██████████, LICSW Recovery Team BH Provider</p> <p>██████████, LICSW Recovery Team BH Provider</p> <p>██████████ - Recovery Team Support/Intake</p> <p>██████████, Mid-State/CHSN Care Coordinator</p>

		<p>Management, Spere Mem. Hospital</p> <p><b>Recovery Team</b></p> <p>██████████ - MAT Provider</p> <p>██████████ - Chief Medical Officer</p> <p>██████████ - Licensed Clinical Social Worker</p> <p>██████████ - Licensed Clinical Mental Health Counselor and Medical Assistant</p> <p>██████████ - Integrated Health Assistant</p> <p><b>Hall Team Meetings –</b> Mid-State plans to hold Interdisciplinary hall team meetings beginning March 2018 will include the following representatives: Behavioral Health Provider, Primary Care Provider , Resource Nurse, Medical Assistant, Community Care Coordinator, IGNITE Member and Patient Support Specialists</p>	<p>a particular hall or office, BH providers, resource nurse, medical assistants, IGNITE team member, Patient Support Specialist, pharmacy team representative and Community Care Coordinator.</p> <p>██████████ credentials were reported incorrectly and should read Licensed Clinical Social Worker.</p>	<p>Psychiatry is provided through referral to Lakes Region Community Mental Health</p>
Horizons Counseling Center	Tier 1 – Work within this practice is underway and will be ongoing throughout 2018.	<p>██████████ LCMHC, MLADC -Clinical supervisor/acting as care coordinator</p> <p>██████████, LADC - Clinical supervisor/Counselor</p> <p>██████████, LADC - Criminal Justice programs coordinator/case manager</p> <p>Interviewing for this position - Criminal Justice case manager/care coordinator</p> <p>██████████ - CORE program case manager (a DOC employee serving in this position for now).</p> <p>██████████ - Medical Director IOP services (by contract)</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>██████████ is still acting as the care coordinator until position is filled.</p>	<p>██████████, LICSW,MLADC Executive Director, Behavioral Health Provider</p> <p>██████████, LADC Director of Intensive Outpatient Treatment Services</p> <p>██████████, LADC Criminal Justice Programs</p> <p>██████████ Internal/Emergency Medicine – Medical Director Nathan Brody Program</p> <p>██████████, LCMHC, MLADC – Assistant Director, Behavioral Health</p> <p><i>**Horizons Counseling is an SUD provider which makes it an exception to performing the normal functions of an Integrated Care Practice**</i></p>

<p>Lakes Region Mental Health Center</p>	<p>Tier 1 – Work within this practice is underway and will be ongoing throughout 2018.</p>	<p>██████████ - Medical Director and Psychiatrist  ██████████ - Project Support and Development Liaison  ██████████ APRN - Primary Care Provider  ██████████, RN - Nurse  ██████████, RN - Integrated Care Manager</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>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> <li>(1 ) In-Shape clinician</li> <li>(1) Supported Employment Specialist</li> <li>(1) Peer Support Specialist</li> </ul> <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> <ul style="list-style-type: none"> <li>(1) Psychiatric Nurse Practitioner</li> <li>(1) Master’s level Clinical Coordinator</li> </ul> <p>Therapists</p> <p>Children’s Service has 2 multidisciplinary teams</p> <ul style="list-style-type: none"> <li>(1) Child Psychiatrist / Psychiatric Nurse Practitioner</li> <li>(1) Master’s Level Clinical Director</li> <li>(1) Master’s Level Clinical Coordinator</li> </ul>
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				Therapists, Case managers, Community care clinicians
Riverbend Community Mental Health	Tier 1 – Work within this practice is underway and will be ongoing throughout 2018.	<p>██████████ - Team Pyschiatrist</p> <p>██████████ - ARNP</p> <p>██████████ LCMHC, MLADC - Program Director</p> <p>██████████ - RN</p> <p>██████████ - Team Leader</p> <p>██████████</p> <p>██████████</p> <p>██████████ - Case Managers and vocational support</p> <p>██████████</p> <p>██████████</p> <p>██████████ – Clinicians</p>	This practice has had no turnover in staff since last reporting period and information remains the same as 12/31/17.	<p>██████████, MD, Psychiatrist</p> <p>██████████, RN, psychiatric nurse practitioner</p> <p>██████████, LCMHC, MLADC, Program Director</p> <p>██████████, Community Care Coordinator</p> <p>██████████, Team Leader</p> <p>██████████</p> <p>██████████ - case managers and vocational support.</p> <p>██████████</p> <p>██████████ - clinicians</p> <p>Due to continued growth, the adult team added an additional clinician in Q3 2018.</p>
Speare Primary Care	Tier 2 –We will begin working with this practice in Q2 2018.	Pending	<p>Speare Primary Care reported they do not have a formal meeting schedule for patients with BH or chronic health conditions. The practitioners all work in close proximity so when a patient needs to be discussed it occurs PRN or on the fly. 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>Speare Primary Care has a Medical Director, ██████████, DO, and a Psychiatrist, ██████████, MD who collaborate with the providers in the practices with patients who present with behavioral health issues. The providers in the practice include:</p> <p>██████████</p> <p>██████████</p> <p>██████████</p> <p>██████████</p> <p>██████████</p> <p>██████████ (periodically)</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>Plymouth Pediatric and Adolescent Medicine</p>	<p>Tier 2 – We will begin working with this practice in Q2 2018.</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>██████████ (per diem)</p> <p>██████████</p> <p>██████████</p> <p>██████████</p> <p>██████████</p> <p>██████████ (per diem)</p> <p>██████████ (per diem)</p>
<p>LRGH / Westside Healthcare</p>	<p>Tier 2 – We will begin working with this practice in Q2 2018.</p>	<p>Pending</p>	<p>██████████</p> <p>██████████</p> <p>██████████</p> <p>██████████</p> <p>██████████</p> <p>██████████</p> <p>██████████ (Pedi), ██████████ (Pedi), ECC Position (OPEN)</p>	<p><b>Westside Healthcare:</b></p> <p>██████████, MD - Primary Care Provider</p> <p>██████████ MD -Primary Care Provider and Medical Director</p> <p>██████████, MD -Primary Care Provider</p> <p>██████████, MD - Primary Care Provider and Infection Control</p> <p>██████████, MD – Primary Care Pediatrician</p> <p>██████████, MD – Primary Care Pediatrician</p> <p>██████████, APRN- Primary Care Provider</p> <p>██████████, APRN -Primary Care Provider</p> <p>██████████, APRN – Primary Care Provider</p>

				██████████, RN – Embedded Care Coordinator
Belknap Family Health – Meredith	Tier 2 – There is no SSA baseline for this practice. They will participate in the April 2018 SSA and we will begin working with this practice in Q2 2018.	Pending	██████████ ██████████ ██████████ ██████████ ██████████ (ECC)	<b>Belknap Family –Meredith:</b> ██████████ – Primary Care Provider ██████████ – Primary Care Provider ██████████, APRN – Primary Care Provider ██████████, RN – Embedded Care Coordinator
Belknap Family Health – Belmont	Tier 2 – There is no SSA baseline for this practice. They will participate in the April 2018 SSA and we will begin working with this practice in Q2 2018.	Pending	██████████ ██████████ (ECC)	<b>Belmont Family Health</b> ██████████, MD – Primary Care Provider ██████████, APRN – Primary Care Provider ██████████, APRN – Same Day Provider ██████████, RN – Embedded Care Coordinator
Hillside Family Medicine	Tier 2 – There is no SSA baseline for this practice. They will participate in the April 2018 SSA and we will begin working with this practice no later than Q3 2018.	Pending	██████████ ██████████ ██████████ (ECC)	<b>Hillside Family Medicine</b> ██████████, MD – Primary Care Provider ██████████, PA-C- Primary Care Provider ██████████, APRN – Primary Care Provider ██████████, APRN – Primary Care Provider ██████████, RN – Embedded Care Coordinator

Lakes Region Family Practice	Tier 3 – There is no SSA baseline for this practice. They will participate in the April 2018 SSA and we will begin working with this practice no later than Q3 2018.	Pending	Pending	<b>Lakes Region Family Practice</b> ██████████, DO – Primary Care Provider ██████████, APRN – Primary Care Provider ██████████, RN – Embedded Care Coordinator
LRGH / Caring for Kids	Tier 3 – There is no SSA baseline for this practice. They will participate in the April 2018 SSA and we will begin working with this practice no later than Q3 2018.	Pending	Pending	<b>Caring for Kids</b> ██████████, MD – Primary Care Pediatrician ██████████, MD – Medical Director and Primary Care Pediatrician ██████████, MD – Primary Care Pediatrician ██████████, PNP – Primary Care Provider
LRGH / Laconia Clinic (primary care)	Tier 3 – There is no SSA baseline for this practice. They will participate in the April 2018 SSA and we will begin working with this practice no later than Q3 2018.	Pending	Pending	<b>Laconia Clinic Internal Medicine</b> ██████████, MD – Primary Care Provider ██████████, RN – Embedded Care Coordinator  <b>Laconia Clinic Family Practice</b> ██████████, MD – Primary Care Provider

**B1-8c - Multi-disciplinary core team training** for service providers will include topics such as diabetes hyperglycemia, dyslipidemia, hypertension, mental health, and SUD. IDN-specific coordination for some of these trainings turned out to be difficult. CHSN’s contract with ██████ did not cover the clinical topics, as it is not their expertise, but it does address a plan to provide the mental health and SUD topics. Presenters to cover the clinical topics were explored but we did not find an easy solution for bringing trainings to our providers. One solution available was to collaborate with Network 4 Health and they graciously allowed us to share their pre-recorded lunch and learn series on trainings covering the topics of Diabetes, Dyslipidemia and Hypertension. Links to these three trainings can be accessed via the Network 4 Health website under Training Resources and are pre-recorded, convenient, and concise trainings. CHSN shared the training resource with our B1 partner practices in late November asking that they be shared with providers and care teams by December 31, 2018. Providers have expressed their appreciation for the ease of watching trainings at their convenience and many have watched the videos as part of their staff meeting agenda. CHSN staff reached out to the practices to collect information and identify which trainings had occurred, separate from those offered by CHSN-IDN 5s training contract, and although the attempt was made, it was late in the year and adequate information to provide actual numbers and names of individuals who were trained was unavailable in time for reporting. This will be followed up on in 2019 and CHSN plans to report its findings more accurately within the next reporting period.

**B1-8d – Non-direct care staff training:** Also identified within the CHSN-IDN 5 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 ██████ 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-IDN 5 training contract with ██████ that has been referenced several times within this document already. As previously stated within the A1 Workforce section, the CHSN-IDN 5 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:** Specific information on core team case conferences by each B1 partner practice differs based on their development and level of coordination/integration. Most partners report that members of their multi-disciplinary core teams meet for inter-agency care coordination and case management on a routine basis. As demonstrated in the table below, the CHSN-IDN 5 partners identified as a “Tier 1” practices are already meeting on a regular basis as they are working towards integrated care designation. Most “Tier 2” practices working towards coordinated care designation are also meeting regularly, with two outliers who stated that their practitioners/care team work in close proximity to one another and discuss BH or chronic patients when needed but do not have a formalized schedule. Some are held on an “as needed” basis within each practice. 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. Work with Tier 2 practices continued during this reporting period emphasizing the expectation that each practice will implement a formalized schedule for such case conferences.

<b>Providers identified to make progress toward Coordinated Care Practice designation (Includes Integrated Care Practices also)</b>	<b>Target</b>	<b>List the monthly (or more frequent) core team case conferences schedule on behalf of patients with significant BH or chronic conditions.</b>	<b>Progress Made through 6/30/18</b>	<b>Progress Made through 12/31/18</b>
HealthFirst Family Care Center	Tier 1- Completed / in process	<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</p> <p><b>Franklin Office</b></p>	All information remains the same	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

		Second and fourth Monday of the month; 8:00-9:00AM		Behavioral Health or joint visits with clients
Mid-State Health Center	Tier 1 – Completed / in process	<p>Care Transitions Team meetings; Meets weekly via conference call to coordinate care for Mid-State patients transitioning from Speare Memorial Hospital</p> <p>Recovery Team meetings; Weekly, Tuesdays 4:00-5:00PM</p> <p>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.</p> <p>Recovery Team meetings continue as reported.</p> <p>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.</p> <p><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.</p> <p><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 (all support services are co-located to address patient needs at the time of visit).</p>
Horizons Counseling Center	Tier 1 – Completed / in process	<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>	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>

		Care coordination meeting with Recovery Clinic; Bi-monthly, Wednesdays 10:00-11:30AM		<p>Criminal justice re-entry team also including the Programs Director BCDOC, [REDACTED], 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 [REDACTED], LADC, IOP Director, [REDACTED] and LADCs, MLADCs / counseling staff as needed for clients being discussed – Tuesdays 10am-11am.</p>
Lakes Region Mental Health Center	Tier 1 – Completed / in process	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,</p>

				<p>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 collaboration with the PCP regarding medications for mental health treatment.</p>
Riverbend Community Mental Health	Tier 1 – Completed / in process	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>
Speare Primary Care	Tier 2 – CHSN-IDN 5 will begin working with this practice in Q2 2018 to train on the requirement of and assist with the implementation of a monthly core team case conference	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-IDN 5 with an	<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. ██████████ is fully functional in the role of the Patient Care Coordinator, and</p>

	schedule for patients with significant BH or chronic conditions.		anticipated meeting schedule introduced by/before December 2018.	has developed processes and procedures to manage the patient population. At this time, beginning the integration of [REDACTED], (DSRIP funded care coordinator) and [REDACTED] to collaborate patients visiting the ED who are patients of Speare Primary Care. [REDACTED] and [REDACTED] 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 <b>between the practice and CHSN to identify how they will meet this requirement in 2019.</b>
Speare Pediatric & Adolescent Medicine	Tier 2 – CHSN-IDN 5 will begin working with this practice in Q2 2018 to train on the requirement of and assist with the implementation of a monthly core team case conference schedule for patients with significant BH or chronic conditions.	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-IDN 5 with an anticipated meeting schedule introduced by/before December 2018.	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.
LRGH / Westside Healthcare	Tier 2 - CHSN-IDN 5 will begin working with this practice in Q2 2018 to train on the requirement of and assist with the implementation	Pending	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.	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)

	of a monthly core team case conference schedule for patients with significant BH or chronic conditions.		MAT takes place at FRH & LRGH Hillside. Primary care providers manage depression and typically refer out for counseling services.	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.
Belknap Family Health – Meredith	Tier 2 – CHSN-IDN 5 will begin working with this practice in Q2 2018 to train on the requirement of and assist with the implementation of a monthly core team case conference schedule for patients with significant BH or chronic conditions.	Pending	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.  MAT takes place at FRH & LRGH Hillside. Primary care providers manage depression and typically 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.
Belknap Family Health – Belmont	Tier 2 – CHSN-IDN 5 will begin working with this practice in Q2 2018 to train on the requirement of and assist with the implementation of a monthly core team case conference schedule for patients with significant BH or chronic conditions.	Pending	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.  MAT takes place at FRH & LRGH Hillside locations. Primary care providers manage depression and typically 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.
Hillside Family Medicine	Tier 2 – CHSN-IDN 5 will begin working with this practice in Q2 2018 to train on the	Pending	Not applicable at this time. CHSN Executive Director to work with LRGH practice managers to introduce a routine	Meeting coordination is the responsibility of the Embedded care coordinators at all LRGH practices. The ECCs meet bi-weekly with their

	requirement of and assist with the implementation of a monthly core team case conference schedule for patients with significant BH or chronic conditions.		core team case conference schedule by/before December 2018.  MAT takes place at Hillside.	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.
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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. In addition, the IDN’s Administrative Lead (Partnership for Public Health) now has the capability to send encrypted emails using Virtru through Microsoft Outlook and is working on adding a secure server for CHSN purposes only to store any sensitive data related to PHI. Secure Messaging protocol guidance was developed and shared with partners in December 2018. It can be found on page 3 of the CHSN-IDN 5 B1 Partner Protocol Guidance document (**Attachment\_B1.2B**).

**B1-8g - Closed loop referrals:** CHSN-IDN 5 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-IDN 5 B1 Partner Protocol Guidance document Attachment\_B1.2B) to aid any partner, such as Horizons Counseling Center, who did not already have a formal closed loop process and/or was seeking language to formalize their internal protocols. At our last check-in with partners, thirteen of the 14 B1 partners have 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. CHSN will continue to work with Horizons’ Counseling Center to implement a more formalized closed loop referral process in 2019.

**B1-8h - Documented work flows and/or protocols:** Workflows and protocols were a primary focus during this reporting period. CHSN-IDN 5 developed a CHSN-IDN 5 B1 Partner Protocol Guidance document which covered eleven B1 related topics per DSRIP waiver requirements. The B1 Partner Protocol Guidance

document was developed and presented in one packet of protocols to provide the highest quality, evidence based, streamlined and well vetted information possible for partners so as to not overwhelm them when it was received. The B1 Partner Protocol Guidance document (**Attachment\_B1.2B**) covers the following protocols:

- Secure Messaging – **p. 3**,
- Closed Loop Referrals – **p. 4**,
- Interactions Between Providers and Community Based Organizations – **p. 6**,
- Shared Care Plan – **p. 7**,
- Timely Communication – **p. 9**,
- Privacy – **p. 10**,
- Case Management Coordination – **p. 12**,
- Safe Transitions from Institutional Settings Back to PC, BH and Social Service Providers – **p. 13**,
- Intake Procedures – **p. 15**,
- Adherence to NH Board of Medicine Guidelines on Opioid Use – **p. 17**, and
- Joint Service and Communication Channels with Community Based Social Service Providers – **p. 19**

In addition, a separate protocol from those noted above titled Comprehensive Core Standardized Assessment Protocol (**Attachment\_B1.8A**) was formalized and shared with partners at the same time. Though CHSN-IDN 5 had provided guidance on this topic to partners much earlier in the year (Feb 2018) it had not been formalized into a protocol. Several workflows were previously identified and submitted as attachments in the community driven projects in both the December 2017 and July 2018 SARs, so those included in the B1 Partner Protocol Guidance covered all outstanding needs that had not been met within our IDN.

### **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				

Process Milestone Number	Process Detail	Submission Format	Results (Met/Not Met)			
			6/30/17	12/31/17	6/30/18	12/31/18
B1-5	IDN Healthcare Integration: Budget	Narrative and Spreadsheet				
B1-6	IDN Integrated Healthcare: Key Organizational and Provider Participants	Table				
B1-7	IDN Integrated Healthcare: Organizational leadership sign-off	Table				
B1-8a	<p>All of the following domains must be included in the CCSA:</p> <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>	<p>CCSAs (Submit all that are in use)</p> <p>Table listing all providers by domain indicating Y/N on progress for each process detail</p>				
	<p>For pediatric providers, the CCSA must also include:</p> <ul style="list-style-type: none"> <li>• Validated developmental screening for all children, such as the ASQ:3 and/or</li> </ul>	<p>Table listing all providers by domain indicating Y/N on progress for each process detail</p>				

Process Milestone Number	Process Detail	Submission Format	Results (Met/Not Met)			
			6/30/17	12/31/17	6/30/18	12/31/18
	<p>ASQ SE at 9, 18 and 24/30 month pediatric visits;</p> <ul style="list-style-type: none"> <li>Developmental Screening using Bright Futures or other American Academy of Pediatrics recognized developmental</li> </ul>					
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</p>				

Process Milestone Number	Process Detail	Submission Format	Results (Met/Not Met)			
			6/30/17	12/31/17	6/30/18	12/31/18
		be trained in each provider practice. Ongoing reporting would indicate Y/N for participating individuals on progress for each training				
B1-8d	Training for staff not providing direct care that at minimum includes knowledge and beliefs about mental disorders that can aid in recognition and management	Training schedule and table listing all staff indicating progress on each process detail				
B1-8e	Monthly (or more frequent) core team case conferences on behalf of patients with significant behavioral health conditions or chronic conditions	Conference schedule and Table				
B1-8f	Secure messaging	Narrative				
B1-8g	Closed loop referrals	Narrative				
B1-8h	Documented work flows and/or protocols that include, at minimum: <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</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
	managers (internal and external to IDN) <ul style="list-style-type: none"> <li>• Safe transitions from institutional settings back to primary care, behavioral health and social support service providers</li> <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-IDN 5 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 LRG Healthcare 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.

**B1-9b - Additional Integrated Practice designation requirements:** Section B1-10 lists the six CHSN-IDN 5 related 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
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> <li>• Practice has been utilizing SBIRT on 12 years and older for 1 ½ years on all clients at annual visit.</li> </ul>	Information remains the same. No new information to report.	<p><b>1. Progress on MAT</b></p> <p>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-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>Any who score are referred for SUD counseling</p> <ul style="list-style-type: none"> <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 counseling in coordination with PCP and Rx</li> <li>• Practice has been utilizing SBIRT on 12 years and older</li> </ul>		
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		<p>for 1 ½ years on all clients at annual visit. Any who score are referred for SUD counseling</p> <ul style="list-style-type: none"> <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 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</p>

				<p>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 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>
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				<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 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	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	<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-</li> </ul>	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	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

	<p>practice designation requirements and will be ongoing throughout 2018.</p>	<p>occurring disorders</p> <ul style="list-style-type: none"> <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 place go beyond the scope of SBIRT</li> </ul>	<p>the MAT program, all patients are required to participate 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>staff and joint ongoing assessment of client medical and behavioral health needs.</p> <p>Horizons offers a specialized group for individuals receiving medication 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 most appropriate for their needs and most</p>
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				<p>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 to assist in moving them towards integrated practice designation requirements in Q1 2018 and will be ongoing throughout 2018.	<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.	<p><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. We currently employ four individuals 3 docs and 1 APRN who are certified.</p> <p><b>1. Mild-Moderate Depression:</b> ThePHQ-9 is administered at intake and as identified by the score per LRMHC procedure.</p>

			<p>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 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</p>
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			<p>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, 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> </ul>
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				<ul style="list-style-type: none"> <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 at intake with flow up per triage; use of the Columbia Suicide Severity Risk Screening</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”</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>Riverbend Community Mental Health</p>	<p>Tier 1 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</p>	<ul style="list-style-type: none"> <li>• MAT offered via continued partnership with Lakes Region Recovery Clinic and Concord Riverbend based, Choices Program</li> <li>• Anticipate opening Choices Program in</li> </ul>	<p>Information remains the same. No new information to report.</p>	<p>Riverbend offers MAT via partnerships with Lakes Region Recovery Clinic and Concord Riverbend-based Choices Program. The Choices program now has a clinician on-site in Franklin one day per week providing assessments and referrals to both Choices MAT program in Concord and other</p>

	<p>in Q1 2018 and will be ongoing throughout 2018.</p>	<p>Franklin to provide IOP services by Q4 2018</p> <ul style="list-style-type: none"> <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 therapist onsite at the PCP practice.</li> </ul>		<p>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.</p> <p>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.</p> <p>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 least one day per week, currently Wednesdays.</p>
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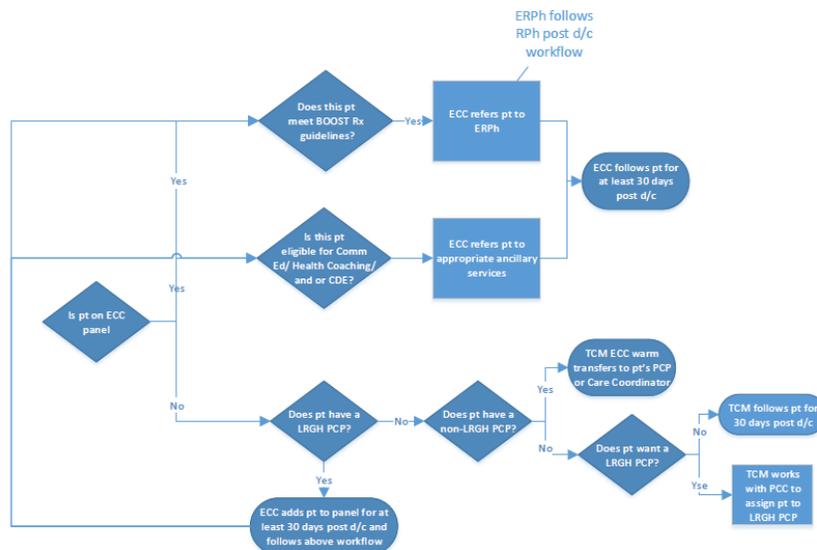
LRGH / Westside Healthcare	Tier 2 practice – This practice is currently at Co-Located Care Level IV. CHSN will begin working with this practice to assist in moving them towards integrated practice designation requirements in Q2 2018 and will be ongoing throughout 2018.	Pending	Regarding LRGH practices: 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.
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**B1-9c – Enhanced use of technology:**

HealthFirst, Riverbend and LRGH all completed upgrades of their EMR systems in Q3 and Q4 of 2018. All of the upgrades allowed the organizations to capture additional CCSA domains that weren’t previously captured. Riverbend Community Mental Health upgraded their EMR system to add functionality including ePrescribing, an HL7 interface, direct messaging, a patient portal, and other internal improvements.

HealthFirst completed their CCSA form in Centricity using the PRAPARE module in late Q2 of 2018. In the second half of this year, they have worked with CHAN, an organization that prepares reports for clinics using the Centricity EMR, to improve data accuracy in their DSRIP reporting and develop workflows that will allow for data review far in advance of reporting deadlines. Adoption of new technologies such as CMT and KNO2 has been slow. CMT has been implemented at most of the integrated care sites but use of CMT in every organization hasn’t been standardized or documented in workflows yet. HealthFirst and Riverbend care coordinators are actively checking their ED notifications and are entering limited shared care plans though there does seem to be some hesitation to dive into extensive shared care planning. Software like Open Beds for closed-loop referrals has been explored but there is hesitation in adding additional portals/workflows to the care coordinators that are outside of their EMR’s with no integration options. With CMT also potentially building out bed management in their portal, it’s the current view of the IDN that it is better for the IDN’s IT resources to focus on data reporting and shared-care planning.

LRGH upgraded their Cerner implementation while also implementing PreManage EDIE to send ER notifications to all of our sites using PreManage Primary. Part of the Cerner upgrade was the addition of a CCSA form that is being piloted in the emergency department at LRGH and Franklin Regional Hospital to identify resources that at-risk patients can be linked with after they are discharged. LRGH’s Embedded Care Coordinators are also included in the CMT event notifications and follow their ED discharge workflow (screen shot of LRGH ED workflow below). CHSN-IDN 5’s Data Analyst has been working with the reporting department in LRGH to streamline the reporting process to MAeHC. He anticipates additional work at this site will be required to finish this project as well as the 2019 reporting measures for MAeHC.



Horizons has begun the process of searching for a new EMR system. They were previously using WITS which had limited reporting capability and wasn’t a true EMR. During their search, they will take into consideration the EMR system’s ability to capture CCSA domains and report data to the data aggregator.

After evaluating Mid-State’s SQL server implementation, CHSN-IDN 5’s Data Analyst requested a small upgrade to the installation which will allow automation of the data files that Mid-State is sending to MAeHC. Once this installation is finished, work at this site will recommence in Q2 of 2019 to finish the automation process. Additionally, all of the new reporting measures for 2019 will require a fair amount of extra reporting time at this site to develop.

Integrated Care Practice Designation	Progress Made as of 12/31/17	6/30/18	12/31/18
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.
Mid-State Health Center	Mid-State has committed to using CMT along with other	Mid-State has a lack of dedicated IT resources	CHSN-IDN 5’s Data Analyst has been

	members of the IDN. Shared-care planning is set to begin by 6/30/2018.	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.	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.
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 by the hospital is set to begin by 6/30/2018.	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 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.
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	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.

	and resolve with CMT by 3/31/2018.		
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 care planning by 6/1/2018.	Riverbend began working with CMT in May 2018 and has been using PreManage Primary. They are upgrading their EMR system to add ePrescribing, an HL7 interface, direct messaging, a patient portal, and many other internal improvements.	Riverbend completed their EMR upgrade in November 2018. This added ePrescribing, an HL7 interface, direct messaging, a patient portal, and many other internal improvements.

**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-IDN 5 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	Progress towards Coordinated				

Process Milestone Number	Section	Process Detail	Submission Format	Results (Met/Not Met)			
				6/30/17	12/31/17	6/30/18	12/31/18
		Coordinated Care Practice	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 identify, at minimum:</li> <li>• At risk patients</li> <li>• Plan care</li> <li>• Monitor/manage patient progress toward goals</li> <li>• Ensure closed loop referral</li> </ul>	<ul style="list-style-type: none"> <li>• Table listing all providers indicating progress on each process detail</li> </ul>				
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**

Overall, SSA scores in our IDN have been increasing linearly over the past three SSA cycles. The average score now sits at 136 which is Integrated Care Level V. This in part is due to the extension of our SSA to all individual LRGH clinics who have scored very highly in both rounds that they participated. Regardless, some of the lowest scoring practices have moved up significantly in that time which has decreased the range of SSA scores and more tightly clustered the scores for each practice type. Fourteen practices are identified for moving towards coordinated care practices and six were identified as moving towards integrated practices. This is a combination of the eight practices identified as coordinated and the six practices identified as integrated for a total of 14. The UNH/CHI follow-up round 1 and round 2 site self-assessment results always assist in shedding some light on progress made since the baseline assessments were first performed in the fall of 2017 within the CHSN-IDN 5 practices identified for Coordinated or Integrated Care Practice designation. The follow-up 2 results identified that each of the 14 Coordinated Practices identified have reached or exceeded Coordinated Care Level 3 or a score of 47 or above based on the SAMHSA crosswalk scale of coordination/integration. However, of these 14 identified practices, just 4 (LRMHC, Riverbend, HealthFirst, and Mid-State) are meeting the additional requirements defined in the STC's of the B1 Project because they are utilizing a CCSA with the SAMHSA domains and additional NH Plus requirements, as well as a shared care plan.

LRGH completed the upgrade of their EMR in order to capture the remaining CCSA domains in fall 2018. They are rolling out the CCSA form in the emergency room to target the most vulnerable population in our region. The IDN has discussed and plans to work with LRGH to include the adoption of this form within all of the clinical practices of LRGH (B1 partners) in 2019. Currently, Westside and all of the other LRGH practices are not utilizing PreManage Primary for shared care planning. However, it is being used by the care coordinators at both LRGH and Franklin Regional Hospital. Furthermore, provider training for CMT is planned for Q1 of 2019 for LRGH providers.

Horizons Counseling Center is identifying a new EMR system to use which will let them store results of their CCSA. Currently, with the amount of referred clients that they are receiving, all of their patients are getting screened by other CHSN-IDN 5 agencies. This is why focusing on their CCSA adoption has been a lower priority for our IDN at this time.

Of the six identified to reach Integrated Care Practice designation, four have reached Integrated Care Level V or a score of 127 or higher on the SAMHSA crosswalk scale of coordination/integration. Unfortunately, two of the practices that were previously scoring as Integrated Care Level V (Riverbend and Mid-State) have slipped out of this category according to the 2018 round 2 SSA results. However, we believe this is a result of different employees at these two practices completing the SSA instead of the people who filled out the baseline survey in 2017 and round 1 SSA earlier in 2018. Because both of these sites are leaders and models of integrated care in the region and because they both fulfill the additional NH Plus requirements for integrated care laid out in the STC's of the B1 Project, they are still being counted as integrated sites in this report.

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

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

Coordinated Care Practice	List of providers identified to make progress toward <i>Coordinated Care Practice</i> designation	12/31/17	6/30/18	12/31/18
	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] their on-site office psychiatrist.	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 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.
	Belknap Family Health – Meredith	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	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

			<p>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 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</p>	<p>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 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-IDN 5).</p> <p>Their providers work with mental health agencies to</p>
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			<p>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 participate in CMT and have a global consent in place as well as a shared care plan.</p>	<p>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 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>
	Belknap Family Health – Belmont	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 follow patients who have behavioral or mental health</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</p>

			<p>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 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</p>	<p>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-IDN 5).</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</p>
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			<p>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>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>
	Lakes Region Family Practice	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 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</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. 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</p>

			<p>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 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</p>	<p>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-IDN 5).</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 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</p>
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			place as well as a shared care plan.	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.
	Hillside Family Medicine	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 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</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. 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>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</p>

			<p>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 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>from providers to their ECC's, their Ambulatory Social Worker, their Community Educator, and their Ambulatory Pharmacist. (workflow has been shared with CHSN-IDN 5).</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 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>
	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.	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.

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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 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>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. She can also support any of the practices for patients with other social needs.</p>

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			<p>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>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>
	Plymouth Pediatric and Adolescent Medicine	Information not available	<p>Speare's Plymouth Pediatric &amp; 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.</p>	<p>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], RN; 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 <b>(Attachment_B1.10A)</b></p>

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
	HealthFirst Family Care Center	Integrated Care Level V	<p>HealthFirst has increased it 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</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</p>

			<p>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 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>identified several key areas that we would concentrate on to do more work to achieve higher levels of integration.</p> <p>These included:</p> <ol style="list-style-type: none"> <li>1). Developing a larger number of 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.</li> <li>2). Being more inclusive of family members in developing coordinated care plans.</li> <li>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 and treatment of SUD.</li> <li>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</li> </ol>
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				<p>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 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</p>
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				<p>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 Visalution software.</p> <p>8). HealthFirst utilized funding from several different grants including a 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 Visalution 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 of every hour for the medical providers to access them, introduce them to a primary care client, set up</p>
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				<p>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 an 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	<p>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 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</p>	<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 consultant to further evolve it's integrated primary care model;</li> <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</p>

			<p>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>are related to SBIRT screening and depression screening.</p>
	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 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</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>They also have a Recovery Clinic for medication-assisted treatment, which is part of</p>

			<p>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 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>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-IDN 5).</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.</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 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>
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	Lakes Region Mental Health Center	Co-Located Care Level IV	<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 have or are at risk for developing co-morbidity 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><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><b>Hypertension:</b></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 such as inShape, Peer Wellness Coach)</li> </ul> <p><b>BMI:</b></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><b>Tobacco Screening:</b></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> </ul>
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			<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 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, 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</p>	<ul style="list-style-type: none"> <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> <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; administered at intake with flow up per triage; use of the Columbia Suicide Severity Risk Screening</li> </ul>
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			<p>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>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. 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>	<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>
	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>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</p>

			<p>They have been meeting with primary care providers at the 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>and accessing the post-release services identified. Care Coordinators 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 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>
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				<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 for addressing client emergencies and for joint decision making and case planning.</p>
	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</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.</p> <p>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</p>

			<p>cigarette smoking with immediate plans for appropriate referrals after the assessment. They 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. 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 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</p>	<p>Needs and Strength Assessment (ANSA). We have added questions regarding domestic violence and cigarette smoking and immediate appropriate referrals are made at the time 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, 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</p>
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			<p>connections and also developing an MAT psychotherapy group this fall 2018.</p>	<p>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 wellness as it relates to physical health, mental health, sobriety, and their social systems.</p> <p>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.</p> <p>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</p>
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				<p>more a 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 checked="" type="checkbox"/> <b>Planning phase</b>
Research DSRIP waivers in other states to ascertain "lessons learned"
<input checked="" type="checkbox"/> <b>Develop Implementation Plan for Coordinated and Integrated Care Practice</b>
<input checked="" type="checkbox"/> <b>Identify and Commit Key Organizational/Provider participants</b>
Organizational leaders sign-off
<input checked="" type="checkbox"/> <b>Complete Project Budget</b>
Salary assessment by profession
Reconcile budget with FTE need and salary designation
<input checked="" type="checkbox"/> <b>Complete Workforce plan</b>
<input checked="" type="checkbox"/> <b>Staffing plan</b>
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 checked="" type="checkbox"/> <b>Initiate process of Designated IDN participating providers progress along SAMHSA framework for Integrated Levels of Care</b>
<input checked="" type="checkbox"/> <b>Perform Gap Analysis of CSA</b>
Develop report on DSRIP CSA Gap Analysis results
<input checked="" type="checkbox"/> <b>Complete Site Self- Assessment for level of Integration for IDN participating providers</b>

## 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

One change occurred within the CHSN network composition during this reporting period. On September 27, 2018 we received notification from HOPE for NH Recovery, an affiliate partner providing recovery support services, that they had closed their Franklin satellite location. Please reference PPI-2 Network Development for further information.

##### Project Progress Made

CHSN's Supportive Community Re-Entry Program continues to reflect consistent progress this reporting period. Part of this sustainment of progress is due to the consistent support received from all affiliated partners since the beginning stages of project implementation. The successful wrap around approach has proven to be essential to the individuals transitioning from correctional facilities back into their communities. The enhanced care management provides a fully comprehensive assessment of addressing the needs of this challenging population. To support this process, it has been imperative to have integration of care across multiple providers involved in each individual's care to provide complete client centered quality care. Some of the key partners include staff from the corrections facility, peer supports, as well as any other internal and/or external providers involved in the patient's care. With implementation of positive integration of providers and the application of the unique intense care management wrap around approach, the positive outcomes from this process are noteworthy. Some of these milestones may include an overall enhancement of quality of life, sustainment of sobriety via recovery support services, group and individual counseling addressing co-occurring disorders and criminal and addictive thinking, consistent use of primary care, MAT and other supports, support with mental health symptom management, access to housing, employment and numerous other community-based resources to meet each individual's complex needs. By consistently exercising this client centered approach, enhancement of interpersonal skills can also be recognized as a foundation of trust and positive relationships are formulated with all members of the integrated team to successfully make the connections necessary with community-based resources needed upon their release from confinement.

Through the application of motivational interviewing techniques and other clinically based interventions, the process of empowerment can occur leading to advancement of a stronger foundation of interpersonal skills across all environments, leading an individual towards enhanced independence with navigating resources, self-advocacy and overall life skill development. As these valuable skills are encouraged and exercised, they become positive bridges towards supporting engagement of services needed to address substance use disorder treatment and/or behavioral health treatment. By the client actively engaging in support services (i.e. SUD and/or BH), additional positive outcomes may follow. These outcomes may result in lower recidivism in the criminal justice system, reduction in use of emergency departments, overall establishment of support system for each client to sustain a higher level of functioning and stability across all environments. Ultimately, with the supports provided through the C2 project, quality of life for each client will be enhanced, providing a sense of empowerment leading to them independently accessing community based resources needed to sustain independent community living and, as a result, become active contributors to their families and communities.

The Supportive Re-Entry Care Coordination Team initially identifies the primary needs of inmates, connects each inmate with a care coordinator from the organization that best matches the individuals primary needs and works collaboratively to ensure that each care coordinator has the support of the resources of the entire team in connecting inmates with community based services to appropriately guide them through the re-entry process. This coordination is initiated within 3 months of re-entry to the community and carries through the probation period or approximately 12 months after release from confinement. Data obtained prior to writing our Implementation Plan shows that 87% of sentenced inmates had a substance use disorder and 82% of those with a substance use disorder had a co-occurring mental health disorder. This staggering statistic is just one that has led to discussions between Horizons Counseling Center leadership and the County Corrections Administration to consider supporting Medication Assisted Treatment (MAT) in the jail. The ultimate goal would be to get inmates started on Naltrexone or Suboxone two weeks prior to release and have them leave with three doses and a 30-day prescription, which would maintain them long enough to get their Medicaid number issued, get their prescription filled and get them started in treatment with an MAT provider. Also under discussion is offering inmates MAT with Vivitrol by starting them on oral Naltrexone 2 weeks prior to release and then a shot of Vivitrol upon release. While Vivitrol, or long acting Naltrexone which lasts for 30 days, would provide offenders with opioid use disorders (OUD) support for their treatment and other recovery services for a month while they get health insurance in place and get established with an MAT provider, it is extremely costly and would not be covered by Medicaid if administered in the jail before their release.

During this reporting period Horizons Counseling Center has been in contact with Alkermes, the pharmaceutical company that produces Vivitrol, to begin working on facilitating the Belknap County Department of Corrections becoming part of an Alkermes initiative to provide one free dose of Vivitrol for any inmate with a diagnosed OUD upon release from confinement. The Supportive Community Re-Entry team is in support of the expansion of MAT in the jail and believe it could be supported through case managers and treatment providers. Continuous application of protocols and workflows has occurred this reporting period. The previously submitted workflow for Community Re-Entry Care Coordination between LRMHC and Horizons are routinely being practiced across affiliated entities. In addition, the previously submitted Family Resource Center roles and responsibilities as well as the Step Ahead referral processes continue to be exercised successfully throughout the C2 Project to support positive outcomes. Individuals from key agencies serving on the C2 Project workgroup continue to meet routinely to continue formalization of protocols between agencies, highlight successes and address workflow related challenges. This reporting period, a new Interagency Care Coordination Policy (**Attachment\_C.1A**) was adopted to support standardization of project related workflow. As stated in previous reporting, the majority of the key partners in the C2 and D3 projects are the same and much of the work around developing interagency policies and workflows naturally overlap.

One protocol that continues to be in place in the jail is for a HealthFirst or LRGH 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.

Inter-organizational care coordination protocols developed between Horizons and Lakes Region Mental Health Center (LRMHC); Horizons and Navigating Recovery of the Lakes Region; Navigating Recovery and Lakes Region Community Services (LRCS); and Horizons and LRCS continue to be practiced and routinely evaluated for efficacy of client care and positive interagency collaboration. Protocols between LRMHC and Horizons for shared decision-making and crisis management are in place and were submitted in Fall 2018, though still likely need revision as practical application is being exercised yet the defined roles and responsibilities of those agencies involved requires additional workgroup discussion. LRMHC and Horizons

will continue to provide further staff education to support implementation of the protocols as they become defined and standardized.

Procedures continue to be in place to track progress for the Corrections Opportunity for Recovery and Education (CORE) Program inmates through the C2 project. Several other protocols identified in previous reporting periods also continue to illustrate project progress which included: Horizons Clinical Supervision and Peer Collaboration; Horizons Confidentiality Policy; Horizons Staff Credentialing Policy; Navigating Recovery's Credentialing Pathway; Navigating Recovery's Recovery Coach Pairing Process and Navigating Recovery's Recovery Wellness Plan and Coaching Procedures. In addition, the Interagency Care Coordination Policy noted above was adopted during this reporting period which will continue to assist in smooth care transitions and enhanced collaboration between the care team:

In an ongoing effort to support families while a parent is incarcerated, inmates are referred to the LRCS Family Resource Center (FRC) Step Ahead program, which offers support through their 14-week Sober Parenting Journey class. When the pre-release needs assessment is initiated in the jail indicating a need for family support from FRC, a referral form is completed and sent to FRC via fax or via email. Once the referral is received, contact continues to be made to the families within a two-week period. CHSN-IDN 5 assisted LRCS in January 2018 by funding two staff members to attend a week-long facilitator training to become trained in a new parent education curriculum which has proven to be a valuable element towards establishing a stronger program foundation.

Early statistics for this class have shown a 100% retention rate, which speaks volumes for the dedication shown by these parents as well as the safe and supportive environment that has been created. The class does not just offer parents an opportunity to reflect on their own upbringing and personal parenting style but it also strengthens their commitment to their personal recovery and heightens awareness of relapse prevention strategies and supports.

### **Challenges and Implementation Alternatives**

CHSN's Supportive Community Re-Entry program is designed to bridge the existing programming and resources utilized within the CORE program. The CORE program is critical to successfully support the transition of inmates back into their communities. To highlight the efficacy of this program, when the CORE program that was initially piloted in October 2015 running 3 days a week instead of 5, the program was shorter and co-ed experiencing continuous growth over the years.

In the Belknap County jail, it led to a 14% recidivism rate in the inmates that participated, compared to a recidivism rate of nearly 70% in the jail without the program.

Due to a consistently unstable county corrections political environment, CHSN elected to make alternative staffing plans for a counselor and a case manager that would be housed outside of the Department of Corrections rather than in-house to ensure more control over the successes specific to the C2 project and its outcomes.

Additional challenges continue to surround CHSN's ability to engage Grafton County Department of Corrections. The workaround to this is for CHSN, shortly after the Belknap County aspect of this project area continues to become well established, is to work with Grafton County through their Plymouth area Field Services office to support identification of individuals who could benefit from this unique intense care coordination and transitional care management services.

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; Team Lead – Executive Director of Horizons Counseling Center	Within 30 days of plan approval; meet bi-monthly	Milestone Met: Leadership Team established; regular meetings occurring with documentation of minutes. Leadership Team 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

Implementation Activity/ Milestone	Responsible Party/ Organization	Time line	Progress Measure / Notes
			Supportive Re-Entry Care Coordination Team.
<p>Develop case management approach and protocols including:</p> <ul style="list-style-type: none"> <li>- Assessment, supports, services, after-care planning in correctional facility via team approach</li> <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>	Re-Entry Leadership Team	Ongoing through December 31, 2018	<p>Ongoing; Protocol identification in process; CMS (NH) allows for inmates to apply for Medicaid within 2 weeks of release, with 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</p>

Implementation Activity/ Milestone	Responsible Party/ Organization	Time line	Progress Measure / Notes
			<p>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 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</p>

Implementation Activity/ Milestone	Responsible Party/ Organization	Time line	Progress Measure / Notes
			<p>increasing willingness on the part of medical staff to seek out assistance from case managers.</p> <p>Patient confidentiality, limits of confidentiality, privacy assurances 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

Implementation Activity/ Milestone	Responsible Party/ Organization	Time line	Progress Measure / Notes
			agencies throughout the process. LRMH and Horizons continue to support further staff education related to formal implementation of the protocols.
Develop and implement procedures for data collection and sharing	Re-Entry Leadership Team and CHSN Board	Ongoing through December 31, 2018	In Process; 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. Procedures under development for referred inmates not in the CORE program.
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	<b>Milestone met</b> ; Training plans developed <b>and implemented</b>
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	In process; Ongoing; Minimal engagement from Grafton County as they appear to be more immersed in IDN 7 work.

Implementation Activity/ Milestone	Responsible Party/ Organization	Time line	Progress Measure / Notes
Initiate referral mechanisms and Continuing Care Coordination and Transitional Supportive Case Management in partnership with Grafton County	Re-Entry Leadership Team	By January 1, 2019 and ongoing	Progress pending; see above

## 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 is currently in the process of implementing a program evaluation tool. Due to the complex involvement of care involved in the re-entry process it is 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. All of these tasks are in active discussion working towards full implementation within the C2 workgroups at this time. Given the C2 project workgroups 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 community project 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.

The project anticipates serving approximately 60 individuals per year through the Re-Entry Care Coordination project. 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 begun reviewing 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, will help 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.

Evaluation Measure	Source	Frequency of Collection / Reporting	Results / Notes
Process Measures			
Percent of referred clients for whom assessment and continuing care plan development in	DOC (number of referred clients) and Horizons	Effective January 2018 Monitor quarterly / report semi-annually	Milestone Met; 100%

Evaluation Measure	Source	Frequency of Collection / Reporting	Results / Notes
correctional facility is completed	(assessment / care plan)		
Percent for whom care Coordinator pairing before release is completed	DOC / Horizons	Effective January 2018 Monitor quarterly / report semi-annually	Milestone Met; 100%
Percent for whom recovery coach pairing before release is completed	DOC / Horizons	Effective January 2018 Monitor quarterly / report semi-annually	Milestone Met; 100%
Percent for whom Primary care appointments are made before release	DOC / Horizons	Effective January 2018 Monitor quarterly / report semi-annually	Milestone Met; 100%
Percent for whom appropriate Behavioral Health service appointments are made before release	DOC / Horizons	Effective January 2018 Monitor quarterly / report semi-annually	Milestone Met; 100%
Percent for whom Transportation <i>needs</i> to primary care and BH are <i>identified and advised prior to release</i>	DOC / Horizons	Effective January 2018 Monitor quarterly / report semi-annually	Milestone Met; 100%
Percent for whom after-care plans include incentives for sustained participation in plan, including connections with probation/parole and supportive court involvement as appropriate	DOC / Horizons	Effective January 2018 Monitor quarterly / report semi-annually	Milestone Met; 100%
Percent for whom application to Medicaid/Health Insurance program is made upon release	DOC / Horizons	Effective January 2018 Monitor quarterly / report semi-annually	Milestone met; 100% this reporting period. All of the participants discharged were assisted with initiating the Medicaid/Insurance application process.
Percent for whom patient confidentiality and privacy assurances and releases are established before release	DOC / Horizons	Effective January 2018 Monitor quarterly / report semi-annually	Milestone met; 100%; All those on probation post release signed consents for communication between Horizons aftercare, LRMHC (when referred there) and Navigating Recovery.  Releases for all services involved are signed with CM prior to release and include CMT and MAeHC.

Evaluation Measure	Source	Frequency of Collection / Reporting	Results / Notes
Percent for whom housing and employment supports are arranged before release	DOC / Horizons	Effective January 2018 Monitor quarterly / report semi-annually	Milestone met; 61%; Housing needs were identified for 5 of the 13 individuals discussed prior to release from confinement. 3 were assisted in getting into sober living and finding financial resources for their first few weeks of transition before they could begin to pay rent.
<b>Outcome Measures</b>			
Recidivism rate; currently defined as re-booking within 1 year of program completion. Working with County Corrections to further define measure definitions and feasibility of data collection).	DOC	Effective January 2018 Monitor quarterly / report semi-annually	Milestone met; 22%
*Initiation of SUD Treatment (1 visit within 14 days)	SUD treatment agency records	Effective January 2018 Monitor quarterly / report semi-annually	Milestone met; This reporting period included 11 of 13 clients. (84.6%)
Retention in SUD/COBHD treatment for recommended duration per ASI/ASAM evaluation	SUD treatment agency records	Effective January 2018 Monitor quarterly / report semi-annually	Milestone met; 12 of 13 are currently involved in treatment. It is too early to determine that they will remain in treatment for the recommended duration. (92.3%)
*Number / percentage of frequent (4+ per year) ER Visit Users	Hospital ED data	Effective January 2018 Monitor quarterly / report semi-annually	Milestone met; 0%; just 1 client of the 13 was seen once in the ED for a suspected OD.
*Number / percentage of Potentially Preventable ER Visits	Hospital ED data	Effective January 2018 Monitor quarterly / report semi-annually	Milestone met; 1 client of the 13 was seen once in the ED for a suspected OD. There were no other reported potentially preventable ED visits.

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
Number of individuals served	Approximately 60 per year once fully operational	The CORE program began operating in the Belknap County DOC with its full curriculum in Oct. 2017. As of December 2017 it served 8 males and 5 females in gender specific groups addressing substance use and co-occurring disorders. Curricula implemented at that point included SUD education, CBT criminal and addictive thinking, relapse prevention and co-occurring disorders (EBT A New Direction). Seeking Safety is scheduled to be added January 2018.	The program has served 28 individuals to date.	Milestone Met; The program has served 51 individuals to date.
Percent of referred clients for whom assessment and continuing care plan development in correctional facility is completed	>90% by end of the waiver.	None of the offenders have yet been referred for re-entry services as the program is 9 months – 1 year in length. Numbers are small at this point because the CORE program was not yet fully funded.	100%	Milestone Met; 100%

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
Percent for whom <i>case manager</i> pairing before release is completed	>90% by end of the waiver.	Pending, due to decreased funding, the internal case manager was never hired and none of the clients have reached the point of being 3 months from release and transitioning from DOC providers to IDN funded case managers.	46.4%	Milestone Met; 100%
Percent for whom recovery coach pairing before release is completed	>90% by end of the waiver.	Navigating Recovery began providing recovery support services in December 2017. Thirteen clients have begun working twice a week with and building relationships with same gender Recovery Coaches. Pairing scheduled to begin within 2-3 months of release date.	46.4%	Milestone Met; 100%
Percent for whom Primary care appointments are made before release	>80% by end of the waiver.	Pending, because none of the referred clients were at the point of pre-release planning.	46.4%	Milestone Met; 100%

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
<p>Percent for whom appropriate Behavioral Health service appointments are made before release</p> <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.	Horizons has protocols in place with Genesis Behavioral Health for referral of high needs BH and SUD clients. Other inter-agency workflows and protocols in process for connecting high need individuals with co-occurring disorders with care coordination and for determining primary responsibility for care coordination.	46.4%	Milestone Met; 100%
Percent for whom Transportation needs to primary care and BH are identified and advised prior to release	>90% by end of the waiver.	Pending, because none of the referred clients were at the point of pre-release planning.	100%;	Milestone Met; 56.5%. The remainder are not yet at close enough to their release date to work on transportation needs.
(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	<p>&gt;90% for CORE graduates by end of the waiver.</p> <p>&gt;75% for offenders not sentenced to the CORE program.</p>	Pending, because none of the referred clients were at the point of pre-release planning.	<p>89.2%;</p> <p>16 of the 28 referred also sentenced to a period of probation post release.</p> <p>9 signed ROIs to PCP, PPO prior to release (one is being released early July). The other 8 are still serving their sentence</p>	Milestone Met; 100% of offenders released signed consents for probation. One revoked the consent after release.
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.	Pending, because none of the referred clients were at the point of pre-release planning.	<p>46.4%;</p> <p>13 of 28 (25 still in custody)</p>	Milestone Met; 100% of those released. 43.5% still in custody.

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
Percent for whom patient confidentiality and privacy assurances and releases are established before release	>90% by end of the waiver.	Pending, because none of the referred clients were at the point of pre-release planning. MAeHC and CMT contracts still under review.	Pending; IDN uniform consent/releases were finalized for use and disseminated to partners in June 2018.	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. <b>100%</b> of all offenders released signed consents; one revoked it post release.
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>	> <b>50</b> % by end of the waiver. (Target was changed to accommodate the availability of housing for this project's population in the region)	Pending, because none of the referred clients were at the point of pre-release planning. Horizons is working with Lakes Region Community Developers to provide transitional housing for inmates upon release back into the community; this plan is a long-term venture.	Horizons held one planning meeting with Lakes Region Community Developers and funding is being explored to provide transitional housing for inmates upon release back into the community.	60% (3/5)
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)	> <b>75%</b> by end of the waiver. <b>(original target for this measure was far too high considering the</b>	Pending, because none of the referred clients were at the point of pre-release planning. However, 4 of the CORE participants were getting close to moving into Phase 2 or the program, which is Work Release and would be beginning job searches in early 2018.	69.2%	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.

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
Criminal Recidivism rate at one-year post release.	Reduce by 25% from baseline of 72%	Pending, because none of the referred clients were at the point of pre-release planning.	15.4%; 2 of 13 re-booked	Milestone Met; 22% (6 out of the 28 served)
*Initiation of SUD Treatment (1 visit within 14 days)	>70% by end of the waiver.	Pending, because none of the referred clients were at the point of pre-release planning. According to our project plans the addition of an intensive outpatient treatment program will increase area based resources and some agencies are adding MAT providers to accommodate demand for these services	54%; Of the 13 released: 2 were given appointments within 1 week – they didn't show up. Rearrested on probation violation (one also on new charges) and incarcerated. 2 entered transitional living directly from the HOC, 4 given appointments within 1 week of release and currently in Horizons SUD programing, 3 connected with services in their county of residence (outside the IDN) but no info on when appointments were given or whether they were kept. 1 refused services. 1 moved out of the region upon release to live with family.	Milestone Met; 84.6% (11 of 13 clients)

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
Retention in SUD/COBHD treatment for recommended duration per ASI/ASAM evaluation	>70% by end of the waiver.	Pending, because none of the referred clients were at the point of pre-release planning. However, all 13 CORE participants referred by the courts and/or the DOC received initial screening and assessment with the ASI, ASAM criteria and a risk assessment with the ORAS within 1 week of becoming eligible for programs under DOC regulations.	54%; 28 received ASI, ASAM assessment within 1 week of referral to the CORE program. 13 released were reassessed and d/c plan developed within 2 weeks prior to release.	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.
*Number / percentage of clients engaged in criminal justice follow-up services (4+ per year) ER Visit Users	<20%	Pending, because none of the referred clients were at the point of pre-release planning.	CMT data not yet available. Contract has been signed and implementation will finish by September 2018.	Milestone Met; 8%
*Number / percentage Potentially Preventable ER Visits	<20%	Pending; increased cooperation between agencies across community driven projects on sharing lists of high-utilizers and avoidable diagnosis codes to be determined.	CMT data not yet available. Contract has been signed and implementation will finish by September 2018.	Milestone Met; 8%

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

An updated total of 7.5 FTEs across three organizations has been projected for new workforce staffing for the Community Re-Entry Project. The types of staff are shown by organization in the table below. The table below reflects all staffing changes with the Community Re-Entry project as of December 31, 2018. This reporting period reflects current staffing is at 5.5 FTE's. The two vacancies remaining are for one

LRMHC Re-Entry care coordinator position that has been in active recruitment since fall 2018. A candidate had been interviewed at time of reporting and was since hired in early 2019 to fulfill this 1 FTE opening. The remaining vacancy for 1 SUD/Co-occurring counselor MLADC position at Horizons Counseling Center continues to be recruited for.

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

\*One change occurred within the CHSN network composition during this reporting period. On September 27, 2018 we received notification from HOPE for NH Recovery, an affiliate partner providing recovery support services, that they had closed their Franklin satellite location. Due to this, a reduction in staffing totals occurred as HOPE had a .5 FTE assigned to their organization which will no longer be filled. Please reference PPI-2 Network Development for further information.

#### 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 █% of salary. Expenditures during this reporting period totaled \$█ for project staffing reimbursements. █ was reimbursed \$█, █ was reimbursed \$█ and █ was reimbursed \$█. Financial reporting on actual expenditures between July – December 31, 2018 are reflected in the table below.

Budget Item	Item Description	2017 Cost	Jul – Dec 2017 Actual Cost	2018, 2019, 2020 Projected (Costs Equally Distributed over 3 years)	Jan – Jun 2018 Actual Cost	July – Dec 2018 Actual Cost	Total Project Cost
Project Staff Salaries / Wages (subcontracted)	Salaries for counselors, case managers, care coordinators, and recovery support workers						
Project Staff Benefits	31% of salary / wages						
Supplies	Miscellaneous expenses over waiver period						
PROJECT TOTAL							

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

One change occurred within the CHSN network composition during this reporting period. On September 27, 2018 we received notification from HOPE for NH Recovery, an affiliate partner providing recovery support services, that they had closed their Franklin satellite location. Please reference PPI-2 Network Development for further information.

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.	<b>Milestone met;</b> 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.	<b>Milestone met;</b> 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-IDN 5 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; Ongoing for new staff; 5.5 project staff have been hired. 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	Milestone met; Ongoing; ██████ meets with nursing staff,

Project-Related Training Activities	Target Trainees	Time line	Progress Measure / Notes
		January 1, 2018 and ongoing	<p>community corrections staff 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>Future trainings include training of treatment (SUD and MH) staff on safety protocols within a correctional facility is being planned for Q1 2019 to be conducted by a DOC Sargent.</p> <p>Training for COs and other security personnel on suicide prevention is planned for Q1 2019 to be conducted by ██████ ██████ of Horizons.</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	Judges, other court personnel and attorneys	Identify trainees and initiate training	Milestone met; training was provided to judges on MAT, the

Project-Related Training Activities	Target Trainees	Time line	Progress Measure / Notes
monitoring in exchange for shorter incarceration		by December 31, 2018	different types and positive use of MAT and on ASAM criteria of client 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	Training schedule and table				

Process Milestone Number	Process Detail	Submission Format	Results (Met/ Not Met)			
			6/30/17	12/31/17	6/30/18	12/31/18
	Driven Project as required in A-1.3					

Attachment\_C.1B

## C2 Community Re-entry (IDN 5)

smartsheet

Attachment\_C1.B

Tasks	complete	End date	Occ
1 <b>Planning</b>	<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 <b>Develop implementation plans</b>	<input checked="" type="checkbox"/>	06/30/19	
6 <b>Develop workforce plan</b>	<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 <b>Design/develop Re-Entry Care Transition Team infrastructure</b>	<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 <b>Identify/develop patient management protocols/workflows</b>	<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**

One change occurred within the CHSN network composition during this reporting period. On September 27, 2018 we received notification from HOPE for NH Recovery, an affiliate partner providing recovery support services, that they had closed their Franklin satellite location. Please reference PPI-2 Network Development for further information.

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

One consistent goal of the expanded IOP services connected to Medication Assisted Treatment (MAT) is to reduce the necessity for costly inpatient detox. Expanded IOP services provide the social supports and structure as well as early access to treatment that can make outpatient medically managed detox more realistic for many individuals who would otherwise require more expensive hospital based medical management. In addition, IOP with MAT for detox and maintenance therapy that is community based will reduce the emergent need for inpatient detox for many individuals with opioid use disorders, facilitate earlier entry into intensive SUD treatment, improve their chances for retention in treatment, and support those individuals in creating stability in their families and employment to the fullest extent possible.

In the past 6 months, despite the consistent challenges associated with the IOP expansion, the D3 Project initiative has effectively worked with the LRGHealthcare Recovery Clinic to facilitate patient transition into coordinated services through Horizons' SUD services or through the Recovery Clinic, with expedited and efficient follow-up by the reciprocal service. Horizons also continues to work with other MAT providers including Groups, Road to a Better Life and the two FQHCs (HealthFirst and Mid-State) to ensure client choice is exercised through every service connection. In this way, patients can begin to stabilize on the medication deemed most appropriate in the quickest manner possible.

The 1/3 expansion in capacity to date has enabled a quicker entrance into IOP services by delivery of coordinated patient centered care and a quicker transition from interim services into the IOP level of care where interim services are deemed a necessity. It is also a goal of the IDN to continue to build on the expansion of IOP services in the fourth year of this service delivery transformation project by building upon the foundation of the IOP by adding a partial hospital component to further cut down on the necessity for more expensive inpatient treatment.

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 who meet criteria for either ambulatory or non-ambulatory detox. The Supportive Community Re-entry project allows the counselor / case manager (this is one DOC employee who is a counselor/case manager; not 2 separated positions) to begin initial critical interventions and post detox level of care assessments with those inmates receiving this medical service without the benefit of aftercare planning. 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.

Sixty-five percent of the inmates sentenced to the BCHOC this reporting period have received supported case management through the D3 Project within one month of their release date. All received assessment, a re-entry plan and care coordination follow-up, with 27% of those still housed within the secure perimeter and not yet ready to follow through with their re-entry plans. Of the remaining 35%, 66.6%

were incarcerated for a period too short to be adequately assessed and followed by the program and 33.3% are currently on Work Release and not yet ready for release.

There are over 200 clients currently enrolled in the MAT program operating collaboratively between LRGH and Horizons, it is clear the region is in need of expansion options. These two organizations continue to work together to integrate care of MAT recipients with Horizons providing initial assessment and level of care recommendations to the LRGH Recovery Clinic, providing the treatment and recovery supports for MAT patients receiving medication and medical supervision through the Recovery Clinic. There are approximately 68 patients receiving integrated services with Horizons. The Recovery Clinic has no wait for services and has been adding MAT providers as needed to meet the demand. Horizons has created group treatment for Recovery Clinic integrated care clients to prevent delays for counseling services for clients in MAT services who are not assessed as needing the IOP level of care and provides individualized counseling for clients with co-occurring disorders that impedes their ability to effectively utilize group therapy.

The new IOP site in Laconia was advertised through the media (local press and radio). Horizons held an open house on October 1, 2018 which received local press coverage to raise community awareness of the new location and the expanded times for this valuable service. Notices were also sent out to PCP offices, behavioral health, other social services and all IDN partners notifying them of the opening of the expanded IOP evening services as well as the new location in Laconia. In addition, Horizons and CHSN sent out promotional flyers announcing the official opening of the evening IOP. Another broadcast flyer was sent out to all IDN partners and other local social service, criminal justice and medical stake holders inviting them to the open house and informational presentation on October 1<sup>st</sup>.

This expanded space now available for SUD programming housed in a centralized location in downtown Laconia will be a valuable asset to the community. This location brings significant benefits to this unique population as it exists in close proximity to other supportive social service agency offices. The expanded office space for the expanded IOP was completed in September 2018 at which time the expanded day program moved to evening. The Expansion of Intensive Outpatient Program (IOP) services has been an exciting and challenging process for CHSN-IDN 5. The expansion of the IOP offers flexibility for those requiring that level of care to attend 3 evenings per week, after the end of the traditional first shift work day, to most efficiently meet their life schedule needs. The barriers that may exist for those to attend the morning IOP may include employment (work scheduling conflict), job searching or caregiving for their families during the daytime hours. The IOP provides integrated MH and SUD treatment often creating an overlap in supporting shared patients with Lakes Region Mental Health Center. To ensure that those with chronic and severe mental illness with high treatment needs have increased access to the recommended intensive level of SUD treatment required by this population, this essential bridge of support services provides an additional benefit of an individual's treatment foundation towards optimal recovery.

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 continues to actively discuss providing MAT with Suboxone or Vivitrol to clients receiving counseling services at Horizons, building on the integrated model being used between Horizons and the LRGHealthcare Recovery Clinic. To date, they continue to utilize the IOP services at Horizons to help stabilize patients with more intensive SUD treatment needs.

This unique approach will continue to enhance collaboration between providers and patients as well as effectively integrate improved efficiency of integration of care. To date, the majority of referrals for the IOP services continue to express a preference for daytime programming. This trend continues to be addressed as to how to best capture interest in the evening IOP program. Active discussions continue in exploring child care support which may reduce this potential barrier to attending IOP services. Discussions are taking place now between Horizons and Lakes Region Community Services Family Resource Center to make child care available to clients in the evening IOP as this program expansion process continues through various phases of implementation.

Since all training for the staff hired by Horizons Counseling Center designated for the evening IOP is now complete, staff are now independent and successful in providing treatment to clients in the evening IOP. The IOP staff from both programs continue to meet weekly to discuss client challenges, review new client referrals and to support each other in the delivery of services through consistent supervision and peer collaboration. Outreach efforts will continue to encourage referrals and active collaboration amongst IDN affiliates. Horizons continues to offer Interim Services to clients who cannot be immediately accommodated in the morning IOP and who are unable to participate in the evening IOP due to work or family responsibilities.

Horizons Counseling Center has worked with the Whole Village Family Resource Center in Plymouth to locate an appropriate space for the expansion of IOP in the Plymouth region, potentially expanding on the space Horizons currently uses in that center. This was achieved in November 2018, with Horizons and Plymouth Area Recovery Connection (PARC) agreeing to share a space that is currently undergoing renovation by the Whole Village facility. The Whole Village houses multiple community services and resources and having the IOP at this site will positively facilitate access to other services by the clients with SUD and co-occurring MH disorders whom often have difficulty navigating the social service system and following through with contacting resources that would support their efforts at recovery.

The CHSN-IDN 5 training and education plan continues to promote efforts for staff recruitment and offering new counselors additional support with direct supervisory hours when applicable to assist them towards licensure. This training plan has proven to be effective in encouraging collaborative efforts across agencies to enhance clinician cross training in working with this high risk, high needs population. Horizons Counseling Center continues to provide in-service training for internal staff and for Navigating Recovery. This collaborative effort ensures that education be provided to staff across both entities tailored to working with SUD individuals. As you have previously read, a successful collaboration this reporting period was with [REDACTED] who served as CHSN's training contractor. [REDACTED] utilized CHSN's Master Training Matrix to determine most pertinent trainings needed by CHSN partners' staff and offered CEU's for licensed/certified staff and staff seeking licensure or certification. To further highlight the benefit of these cross training opportunities and collaboration of care, IDN partners continue to work to provide timely interventions related to SUD outpatient services. One strong alliance that continues building is between Horizons and Lakes Region Mental Health Center, specifically related to expanding supervision and support to existing MH counselors.

## **Current Challenges and Implementation Alternatives**

The opening of an IOP in Plymouth proven to be more difficult than anticipated. It has been delayed due to recruitment issues that have been problematic over time. In particular, we have struggled with receiving interested applicants for the MLADC position in Plymouth. One area of progress has been in the development, foundational structure and cohesiveness of the Plymouth Area Recovery Connection (PARC). PARC has been supported by expertise provided by CHSN and by their relationship with the Harbor Homes Facilitating Organization. CHSN plans to utilize CRSWs as an integral part of the IOP team in the same way in which they are being used in the expanded IOP in Laconia.

Unfortunately, the target of expanding IOP services to the Plymouth area by late 2018 has not been implemented due to the staff recruitment issues cited earlier. Horizons Counseling Center has been diligently attempting to recruit counselors for the Plymouth region for over a year and a half. CHSN convened a subcommittee of the D3 Leadership Team in September 2018 to formulate solution focused plans for addressing the barriers being encountered, primarily in the area of workforce. Several ideas have been implemented including the expansion of advertising of the clinical and CRSW positions being sought, outreach to local colleges and universities in conjunction with the use of IDN resources for recruitment incentives through its Employee Retention Incentive Plan to aid in this recruitment efforts. Overall, recruitment of qualified staff has remained a primary challenge to the opening of the program.

CHSN's Implementation Plan addressed the intent to fund Riverbend Community Mental Health via a stipend which would support two Medicaid slots in their Franklin IOP slated to open in 2018. Due to Riverbend struggling to fully staff their Concord IOP, they have reportedly put their plans for expansion in Franklin on hold until mid-2019. CHSN will remain in close contact with Riverbend regarding this issue as they remain an active participant and member of our D3 and E5 workgroups. To address this need while the IOP is on hold, Riverbend is providing SUD support through the Choices program offering intakes on Mondays and will be starting a relapse prevention group, in February 2019.

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**

<b>Implementation Activity/ Milestone</b>	<b>Responsible Party/ Organization</b>	<b>Timeline</b>	<b>Progress Measure / Notes</b>
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

Implementation Activity/ Milestone	Responsible Party/ Organization	Timeline	Progress Measure / Notes
			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.
<p>Develop Expanded IOP with care coordination and integrated recovery coaching approach and protocols including:</p> <ul style="list-style-type: none"> <li>-Referral pathways, assessments, care coordination</li> <li>-Patient confidentiality agreements</li> <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>	SUD Treatment Options Leadership Team	By June 30, 2018	<p>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.</p> <p>Workgroup members began the discussion of meeting transportation needs for non-Medicaid clients and 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 the first half of this year.</p> <p>Horizons met with Lakes Region Community Developers to examine the options for expanding safe,</p>

Implementation Activity/ Milestone	Responsible Party/ Organization	Timeline	Progress Measure / Notes
			<p>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 Navigating Recovery of the Lakes Region and support for education, vocational training, workforce and assistance in transitioning to safe, permanent housing. The RFP proposal will be submitted by Lakes Region Community Developers early 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>

Implementation Activity/ Milestone	Responsible Party/ Organization	Timeline	Progress Measure / Notes
			<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 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>

Implementation Activity/ Milestone	Responsible Party/ Organization	Timeline	Progress Measure / Notes
			<p>Protocols for referrals to housing and employment supports completed, though resources for safe housing are extremely limited within the IDN.</p>
<p>Initiate recruitment of staff for evening IOP in Belknap County</p>	<p>Hiring organization; SUD Treatment Options Leadership Team</p>	<p>By December 31, 2017</p>	<p>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 responsibility. Horizons is actively seeking a replacement.</p>
<p>Develop inter-organizational care coordination protocols, including shared decision-making and crisis management</p>	<p>SUD Treatment Options Leadership Team and CHSN partners</p>	<p>By June 30, 2018</p>	<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</p>

Implementation Activity/ Milestone	Responsible Party/ Organization	Timeline	Progress Measure / Notes
			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.
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 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

Implementation Activity/ Milestone	Responsible Party/ Organization	Timeline	Progress Measure / Notes
			consents, motivational interviewing, ASAM criteria for level of care and confidentiality and ethical communication in an integrated care environment provided by [REDACTED] 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	<p>Milestone met; Ongoing; evening IOP began accepting referrals in September 2018 with services starting in September.</p> <p>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 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>
MOU signed between CHSN and Riverbend Mental Health to assist in funding the equivalent of 2 Medicaid slots (serving our Merrimack	CHSN Executive Director	By January 31, 2018.	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

Implementation Activity/ Milestone	Responsible Party/ Organization	Timeline	Progress Measure / Notes
County constituents) as part of their IOP expansion in the Franklin area			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.
Publicize expanded IOP availability through communication to all PCP practices, local media (radio, newspaper, public access channel), grand opening event	SUD Treatment Options Leadership Team	By January 31, 2018	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.  Open house was held October 1, 2018 with local press coverage including an article about the new 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	In Process; Pending completion of staff recruitment and development activities as stated above.  Staff recruitment efforts actively continue for the Plymouth IOP.  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

Implementation Activity/ Milestone	Responsible Party/ Organization	Timeline	Progress Measure / Notes
			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.
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 [REDACTED] for co-sponsorship of in-house in-service 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 are being 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 is in development 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 continues to anticipate serving 50 individuals per year once the expanded IOP services are fully operational through the SUD Treatment Expansion project. 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		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
<p>Number of individuals served</p> <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>	<p>Up to 50 additional IOP clients per year once fully operational in all 3 sub-regions</p>	<p>Job descriptions developed in conjunction with Navigating Recovery, positions posted and interviews of potential staff were conducted. Offers were made and two new staff began in Q4 2017 and are in training. Horizons and Navigating Recovery to interview/hire for CRSWs in Q1 2018.</p> <p>Horizons also created a job description for an IOP Director, interviewed candidates and hired a Director to oversee program planning and implementation as the program grows and expands (This position is not paid for with IDN funds, but is seen by the D3 workgroup as necessary for program accountability). Program protocols for referrals to the</p>	<p>Horizons has hired and trained 2 counselors for the IOP expansion. Unfortunately, one experienced counselor took FMLA due to family health concerns and the search for a temporary replacement has been unsuccessful. Horizons has decided to do job sharing with outpatient staff to ensure adequate staffing for the expanded IOP. Horizons began expanding the number of clients served in the IOP level of care in Q1 of 2018, providing an additional cohort in the morning as the majority of applications for services assessed as appropriate for the IOP level of care have been for AM programming. This has also allowed for smooth position sharing between programs and for the training of the new evening program providers. Horizons served 34 clients in the IOP level of care in the first quarter of 2018 and 35 clients</p>	<p>Milestone Met; 43 clients served</p>

		<p>IOP, the assessment and determination of appropriate level of care and the development of treatment plans for each client was completed. The plan for Q1 2018 is to work with Navigating Recovery and Genesis Behavioral Health to expand those protocols to include each partners' responsibility within those protocols and how responsibilities will be coordinated and tracked.</p> <p>Policies for how to deal with clients found inappropriate for IOP are pending coordination with Genesis, HealthFirst and Farnum Center to finalize - projected for Q1 2018.</p> <p>This is still pending as it is not yet fully operational in all 3 sub-regions. In Q1 2018 the initiation of 2 additional staff members will be on-boarded to expand capacity</p>	<p>in the 2<sup>nd</sup> quarter of 2018 for a total of 32 unduplicated clients. 11 of these were served in the expanded IOP service that was begun in the first quarter of 2018.</p> <p>CHSN and Horizons have reached out to primary care, behavioral health and other social services providers to make them aware that an evening program would open June 2018. CHSN sent out an announcement and flyer to all IDN partners on June 5, 2018 announcing the availability of evening programming. To date, applications seeking evening program have been slow and Horizons has continued to offer expanded AM IOP services to avoid renewed waitlist growth. Horizons and IDN partner LRCS have begun to explore strategies for targeting parents requiring SUD treatment by offering childcare through LRCS resources to support parents in accessing IOP services during hours when their children are not in school.</p> <p>Protocols were developed for</p>	
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		<p>of the daytime IOP services and then move towards evening expansion.</p> <p>Navigating Recovery will identify Recovery Coaches to be embedded in the IOP.</p> <p>All new staff will receive training in the goals of the DSRIP, the programmatic workflows and their roles in them, and in the issues of ethics, boundaries and confidentiality of client protected health, including SUD information (Part 2) in Q1 2018.</p> <p>Protocols for MAT with LRGH Recovery Clinic completed. Pending are protocols with HealthFirst as they implement MAT in May 2018.</p>	<p>referring clients not meeting ASAM criteria for the IOP level of care with Farnum Center within the IDN and also with Phoenix House and Southeastern NH Services outside the IDN for those requiring a higher level of care.</p> <p>Protocols with LRMHC have been developed for referral for psychiatric services when this is determined to be the appropriate service or when psychiatric stabilization is necessary to assist a patient in being appropriate for and successful in the IOP. Agreements on joint decision-making regarding shared clients are still in negotiation.</p> <p>Protocols include interim services to be provided by the agency identified as the most appropriate to meet the interim needs of a patient until the appropriate level of care is available.</p>	
Percent of referred clients placed in interim services pending appropriate level of care per ASAM criteria	>75% by end of waiver.	When a client is placed on the waitlist, they are offered Interim Services (IS) within 2-3 business days.	Wait list for services has decreased to 3 weeks. Interim services were offered to 100% of clients placed on the wait list (12 in Jan-June 2018) with 5	Milestone Met; 100% of clients on the waiting list received interim services

			accepting interim services through Horizons and 2 receiving recovery support services at Navigating.	
<p>Waiting list for treatment services, number of clients and wait time (As of Dec. 2017 wait list is 6 weeks for IOP services).</p> <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 support while they await a spot in IOP</li> </ul>	Decrease by 50% of current wait time	<p>Due to the high needs for services a new program called “Interim Services” has been developed and implemented. When a client is placed on the waitlist, they are offered Interim Services (IS) within 2-3 business days. Horizons recovery coaches staff the IS program and focus on addressing social and recovery support needs of clients connecting them to resources, including community based peer recovery support programs. They also provide SUD education, education about different peer support programs in the community and an opportunity to discuss and learn from their experiences with program they</p>	<p>Waitlist reduced to 3 weeks for IOP services with IOP expansion.</p> <p>Interim Services (IS) now partnering with recovery support services at Navigating Recovery to expand options for support and intervention opportunities for individuals awaiting IOP level of care.</p>	<p>Milestone Met; There is currently no wait for services for clients seeking treatment in the evening IOP.</p> <p>The wait for daytime IOP services is reduced to about 17 days, though everyone is offered the evening program.</p> <p>Those who choose to wait are incorporated into Interim Services in 2-3 business days unless they refuse this service.</p>

		<p>have tried.</p> <p>Clients remain at this level of care until an IOP spot opens up. It has been noted that sometimes clients do not end up needing IOP once engaged in IS because they have stabilized and are now appropriate for traditional OP services.</p>		
<p>Percent for whom recovery coach pairing is completed</p> <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.	<p>Navigating Recovery developed and submitted to CHSN protocol for Recovery Coach pairing and their CRSW credentialing pathway.</p> <p>Navigating Recovery has completed a contract with Horizons to provide the supervision necessary for CRSW credentialing and billing to Medicaid. This supervision has begun.</p>	<p>Protocol for recovery coach pairing of clients in the IOP is complete. Navigating Recovery has identified two (one male and 1 female) coaches who will be embedded in the expanded IOP beginning July 2018.</p> <p>Horizons recovery coaches are serving the purpose of providing recovery supports within the prior existing IOP. Navigating Recovery and Horizons are now developing a protocol for transitioning clients receiving recovery support services at Horizons to Navigating Recovery coaches for on-going recovery support and recovery monitoring at the point where they are working</p>	<p>Milestone Met; Recovery Coach pairing was completed for 100% of those clients who moved into step-down, though 3 have not followed through.</p>

			toward leaving care at Horizons.	
*Initiation of SUD Treatment (1 visit within 14 days)	>70% by end of the waiver.	Pending, because program is not operational yet. According to our project plans the addition of an intensive outpatient treatment program will increase area based resources and some agencies are adding MAT providers to accommodate demand for these services	Horizons has been successful in initiating SUD services for within 14 days or contact for 37.5% (12) of clients seeking IOP services utilizing interim services.	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.
Retention in SUD/COBHD treatment for recommended duration per ASI/ASAM evaluation	>70% by end of waiver.	Pending, because program is not operational yet.	Of the 32 individuals served in the IOP level of care, 6 did not remain in treatment for the recommended duration based on ASAM criteria. The remainder have completed the recommended course of treatment or are still involved in recommended treatment.	Milestone Met; 77%

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

An updated total of 9.2 FTEs across four organizations were identified as needed to operationalize the Expansion of Intensive IOP Services Project. A total of 6.2 FTEs have been recruited to date with 1 new FTE SUD counselor hired at Horizons this reporting period. CHSN has determined there is no longer a need for the .25 transportation driver (shared between the D3 and E5 projects) and removed it from our original totals (9.45 previously). The three remaining FTE vacancies are all for our Plymouth IOP which has not been able to open due to a lack of qualified MLADC applicants for the position. Recruitment efforts have been ongoing for nearly one year with limited applicants for the position and absolutely no success in finding a qualified candidate from those who did apply. The CHSN board formed a subcommittee in

October to work specifically on escalating the recruitment efforts for the Plymouth IOP project searching for an MLADC. This includes expanded advertising in various online postings and print media, Plymouth State University and UNH connections, Facebook and other social media, word of mouth and CHSN partner sharing. Once the MLADC position is filled, we will be ready to open almost immediately (space is secured, all other staff assigned, phone systems ready to go, 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. The two recovery support workers are trained and ready to go but PARC has not officially “hired” them to date given some of their contracting/funding issues with the state. This should all be resolved in Q1 2019 as PARC works out its final formation documents with the state and their 501(c)3 status. 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	Baseline Staffing on 6/30/17	Staffing on 12/31/17	Staffing on 6/30/18	Staffing on 12/31/18
MD (Horizons) (increase to 0.2 when expand to Plymouth)	0.1	0	0	0	0.1
SUD Counselors / LADC (Horizons)	2	0	1	1	2
SUD/Co-occurring counselors / MLADC (Horizons)	2	0	1	1	1
Admin. Assistant (Horizons)	0.5	0	0.5	0.5	0.5
Recovery support worker (Horizons)	1	0	1	1	1
Benefit Navigator (LRGHealthcare)	0.1	0	0.1	0.1	0.1
Benefit Navigator (HealthFirst)	0.1	0	0.1	0.1	0.1
Case Manager / Care Coordinator (Genesis)	0.4	0	0.2	0.4	0.4
Transportation Driver (LRMHC)	0.25	0	0	0	0
Recovery Support Worker (Navigating Recovery)	1	0	0.5	1	1
Recovery Support Worker (PARC)	2	0	0	0	0

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

Funds were budgeted for the Expansion in IOP project 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 [REDACTED] for \$ [REDACTED], [REDACTED] for \$ [REDACTED], [REDACTED] for \$ [REDACTED], [REDACTED] for \$ [REDACTED] and [REDACTED] for \$ [REDACTED] for project staffing

expenditures. Financial reporting on actual expenditures between July and December 31, 2018 are reflected in the table below.

Budget Item	Item Description	2017 Cost	Jul – Dec 2017 Actual Cost	2018, 2019, 2020 (Costs Equally Distributed over 3 years)	Jan – Jun 2018 Actual Cost	July – Dec 2018 Actual Cost	Total Project Cost (3.5 years)
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 ██████████ IOP serving Franklin in 2019 & 2020						
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							
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### D-5. IDN Community Project: Key Organizational and Provider Participants

One change occurred within the CHSN network composition during this reporting period. On September 27, 2018 we received notification from HOPE for NH Recovery, an affiliate partner providing recovery support services, that they had closed their Franklin satellite location. Please reference PPI-2 Network Development for further information.

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-IDN 5 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-IDN 5’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-IDN 5 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><b>Milestone met;</b> 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	In Process; item remains pending due to data collection issues making reporting difficult. CMT is also not functional yet. Continued work with CHSN data analyst to occur in regards to 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

\*One change occurred within the CHSN network composition during this reporting period. On September 27, 2018 we received notification from HOPE for NH Recovery, an affiliate partner providing recovery support services, that they had closed their Franklin satellite location. Their agency was removed from the table above to reflect this network change. Please reference PPI-2 Network Development for further information.

## 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-IDN 5 training contract was in full force this reporting period with [REDACTED] to extend meeting the training needs previously identified for our projects. Numerous staff attended previously identified trainings between April and December 2018 which have aided in supporting and growing the foundation of a skilled workforce working with this high risk, challenging population. The CHSN-IDN 5 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; 6.2 project staff have been hired. All 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)

Project-Related Training Activities	Target Trainees	Time line	Progress Measure / Notes
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	<p>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.</p> <p>Recovery coaches continue to receive weekly MLADC supervision through Horizons.</p> <p>In the last 3 months, 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.</p>
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				

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

One change occurred within the CHSN network composition during this reporting period. On September 27, 2018 we received notification from HOPE for NH Recovery, an affiliate partner providing recovery support services, that they had closed their Franklin satellite location. Please reference PPI-2 Network Development for further information.

##### **Project update and milestones**

The Enhanced Care Coordination for High-Need Populations project continues to establish a creative wrap-around approach among service providers and community-based agencies to meet the complex needs of a high risk, high needs population. This valuable client centered approach continues to be unique in providing consistency of 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 CCC often facilitates the initial contact to building the foundation of a support network; in addition, they may assist them with enhancement of self-advocacy skills towards independent functioning. Another continued benefit of contact throughout this enhanced care coordination process is to support psychoeducation related to recognizing symptoms appropriate to seek care from the emergency department versus those conditions necessitating support with their primary care provider. This enhanced form of individualized support can lead to a reduction in emergency department use with implementation of this guidance. Although the role of "case management" continues to exist across other organizations the quality of "individualized care" can be limited resulting in an increased risk of relapsing with substance use, increased non-compliance with prescribed medications, and increased exacerbation of mental health symptoms or other life stressors that may all influence frequency of use of local emergency departments.

As this project progresses, the unique enhanced care coordination approach provided by the CCC's continues to directly minimize the barriers to ensure all needs are met by the delivery of individualized care upon connection. This role continues to encourage enhancement of collaborative efforts across various service providers throughout the region. The E5 project care coordination sub-regional teams, (Laconia, Franklin, Plymouth) continue establishing positive rapport with service providers to efficiently "meet clients where they are at" related to their emergency department utilization. To reemphasize the dynamic potential collaborative efforts amongst providers, the teams continue to reflect 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 Community Care Coordinators offers enhancement of an array of professional skills within each organization. This placement results in consistency of care between service providers ensuring appropriate follow through of individualized needs as well as effectively facilitating the comprehensive wraparound of services for this targeted high-risk population.

The E5 Enhanced Care Coordination project identified the necessity for 10.3 Community Care Coordinators (CCCs) across various agencies to establish common responsibilities and standardized team descriptions inclusive of cross-training such that care coordinators can support each other's work both on

a sub-region level and also regionally. At this time, we are fortunate that 9.4 of those identified have been hired and/or are assigned at the various agencies within CHSN-IDN 5.

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

Upon the Project Manager’s transition and previous feedback received from a staff survey distributed to the CCC team, positive changes have occurred this reporting period. These include the formation of a strong cohesive collaborative CCC team, increased rapport building between each CCC team member and affiliated partners as well as creative activities supporting continued standardization of responsibilities for each staff member performing the CCC role across the Lakes Region.

With the exciting growth and stability of the CCC team this reporting period, a tier of additional support was initiated by the Project Manager to provide 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, site specific challenges, personal goals for the following month and level of involvement in 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.

Continuing the past several months, the Community Care Coordinators remained motivated to attend trainings on a regular basis to grow and enhance their skill base and competency within their roles. They have continued to be active in seeking out 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 have participated in 177 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.

The recruitment of Community Care Coordinators has consistently been a challenge for us as the turnover is relatively high and the re-training/onboarding process is time consuming. Though we were fortunate to achieve a strong dedicated foundation staff across the region, the three sub-regional teams have been sustained this reporting period by continuously increasing the visibility of the E5 project and working to grow the consistency of referrals via networking at each site as well as throughout the community. The E5 Community Care Coordination Teams specific to each region are reflected in the table below.

### E5 Community Care Coordination Teams

Laconia		
LRGH	██████████	Embedded Community Care Coordinator
ServiceLink	██████████	Care Transition Specialist, Belknap County
Health First	██████████	Community Care Coordinator

Lakes Region Mental Health Center	██████████	Community Care Coordinator
Horizons Counseling	██████████	Assistant Director

<b>Franklin</b>		
LRGH/Franklin Hospital	██████████	Embedded Community Care Coordinator
Health First	██████████ ██████████	Community Care Coordinator
Riverbend Community Mental Health	██████████	Community Care Coordinator

<b>Plymouth</b>		
Spear Memorial Hospital	██████████	Embedded Community Care Coordinator
Mid-State Health Center	██████████	Community Care Coordinator
Lakes Region Mental Health Center	██████████	Community Care Coordinator
Pemi-Baker Community Health	██████████ ██████████	Hospice and Palliative Program Supervisor  Hospice & Palliative Care Medical Social Worker

- Logistical aspects addressed in this reporting period:
  - CCC teams have transitioned to bi-weekly meetings based on their regional designated sites (Laconia, Franklin, Plymouth) to increase collaborative efforts of implementation, process challenges, identify systems barriers and highlight successes experienced across sites. Each team is following a standardized meeting agenda for these meetings. This CCC Bi-weekly Small Team Meeting Agenda (**Attachment E.1E**) has proven to be valuable in forcing cohesive collaboration between CCC's towards effective wraparound care for each patient to capture the complex needs of this high risk population. These small CCC teams continue to come together as one large team once a month in their "All Team Meeting" to collectively discuss effective strategies to achieve optimal outcome measures, enhance workflow development, highlight successes of integration of care and process related challenges with the facilitation of the CHSN Project Manager.
  - The E5 Steering Committee serves in an advisory capacity and has shifted to a quarterly meeting frequency since the project has been operational now for a solid year. 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. The Project Manager continues to provide pertinent 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.

- CHSN has continued to reimburse network partner agencies who have hired CCC's and are consistently reimbursed for salary/benefits, mileage, cell phone expenses, etc. Reimbursement occurs on a monthly or quarterly basis depending on the agency.
- Community engagement - the CCC's consistently strive to make community based connections with potential referral sources to enhance project visibility across the region.
  - The Plymouth CCC team now has solid working relationships with area resources as they actively participate in the Plymouth Area Transitions Team (PATT) meeting. This meeting has continued to be a perfect networking forum for increasing awareness of the CCC role within the community and for the CCC's to explore community based resources available to refer clients. The embedded CCC at Speare Memorial Hospital was featured in the Speare Memorial Hospital annual report (see below) highlighting the valuable E5 project.

## HELPING PATIENTS WITH BEHAVIORAL HEALTH & SUBSTANCE USE DISORDERS

Speare's care management team was enhanced this year with the addition of [REDACTED] M.Ed., community care coordinator. [REDACTED] position is funded through New Hampshire's Medicaid Integrated Delivery Network (IDN) waiver program to combat the state's opioid crisis. She is responsible for improving coordination between a patient's healthcare providers and connecting patients to community support across Franklin, Laconia, and Plymouth (IDN 5). Her goals are to:



[REDACTED]  
Community Care Coordinator  
for IDN 5 — the Franklin, Laconia,  
and Plymouth communities.

- ✓ Promote timely access to appropriate care.
- ✓ Increase access to and use of preventative care.
- ✓ Reduce emergency room visits and hospital readmissions.
- ✓ Increase a patient's ability for self-management and shared decision-making.
- ✓ Facilitate medication management.

As a resource for Medicaid patients with behavioral health or substance use disorders, [REDACTED] dedicates her days to working on enhancing a patient's health and well-being, increasing patient satisfaction, and reducing healthcare costs.

- The Laconia CCC team continues making connections throughout the Lakes Region by routinely attending a local community based networking meeting hosted each month at the local Salvation Army. They continue to establish face-to-face rapport with community-based referral sources as well as provide education to others about the value of their role as Community Care Coordinators and unique wrap around care provided in the E5 project.
- The Franklin CCC team continues to attend monthly meetings at the McKenna House in Concord, NH. Attendance at this and other meetings will consistently reiterate the value in client centered care and encourage collaboration amongst other community based service providers across the sub-region. Outreach to the Tilton Family Resource Center continues as another potential community connection to work closely with to capture this high risk, high needs population.
- Connecting and collaboration across the region continues to be a priority of the CCC team. This reporting period there have been exciting connections made directly with the team to build upon this goal of integration of care. A representative from the Farnum Center attended the CCC All Team meeting in October to discuss effective strategies for collaboration. This connection has led to a stronger working relationship with successful connections being made for patients accessing appropriate care. Other presentations occurring this reporting period for the CCC team included psychoeducation related to

ServiceLink and substance use resources available throughout the region. To continue this community based collaboration, the E5 CCC Team hopes to invite one community based resource to attend their CCC All Team meeting each month as a guest speaker throughout 2019. This 1:1 forum will enhance 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.

### **Current Challenges and Implementation Alternatives**

While the E5 project consistently experienced its fair share of challenges this period, there has also been significant growth in increasing overall project visibility across the Lakes Region. Stronger foundations of trust are being developed with all affiliated partners which has led to increased collaboration between entities resulting in optimal patient needs being met. To support overall enhancement of communication across sites the bi-weekly meetings continue for each of the regional teams (Laconia, Franklin, Plymouth) to strategize workflow development, creative planning related to optimal enhanced care coordination efforts for clients, and open discussion related to current challenges, successes, sharing of resources, and training updates. The consistency of these meetings has effectively formed cohesive working relationships between all CCC team members leading to positive mutual patient collaboration efforts across sites.

One of the consistent barriers related to this project has been the slow implementation of CMT. This slow implementation has created a consistent care coordination barrier as it relates to sharing information with service providers for this complex targeted population. Until CMT is fully operational across all sites, each Community Care Coordinator consistently has to physically obtain consent from clients either via the CHSN-IDN 5 universal consents developed, or if their employing agency has not adopted the universal consents, they use the privacy/consent forms from the organization they are affiliated with. Having to capture consent is a critical component of this work to ensure compliance with HIPAA and 42 CFR Part 2 confidentiality standards; however it is time consuming and can slow down coordination that is intended to help individuals. To support CMT implementation across sites, the Project Manager and Data Analyst are working collaboratively to ensure tasks towards implementation continue to progress across the region. The screen shot below illustrates at which phase of implementation each agency is at with CMT.

CHSN IDN 5

E5 Project

CMT Implementation

Site	Status of implementation	Contact person(s)
<u>Healthfirst</u> (Laconia, Franklin)	Actively using	
Lakes Region Mental Health Center	Attribution file complete-staff need log ins created	
LRGH-Laconia	Actively using	
Horizons	<i>Not implemented</i> -needs subscriber level only	
<u>ServiceLink</u>	<i>Not implemented</i>	
Mid-State	Actively using	
<u>Spere Memorial Hospital</u>	Actively using	
<u>Pemi Baker Home Health</u>	<i>Not implemented (question of whether they will use due to IT resources)</i>	
<u>Riverbend</u>	Actively using	
LRGH-Franklin	Actively using	

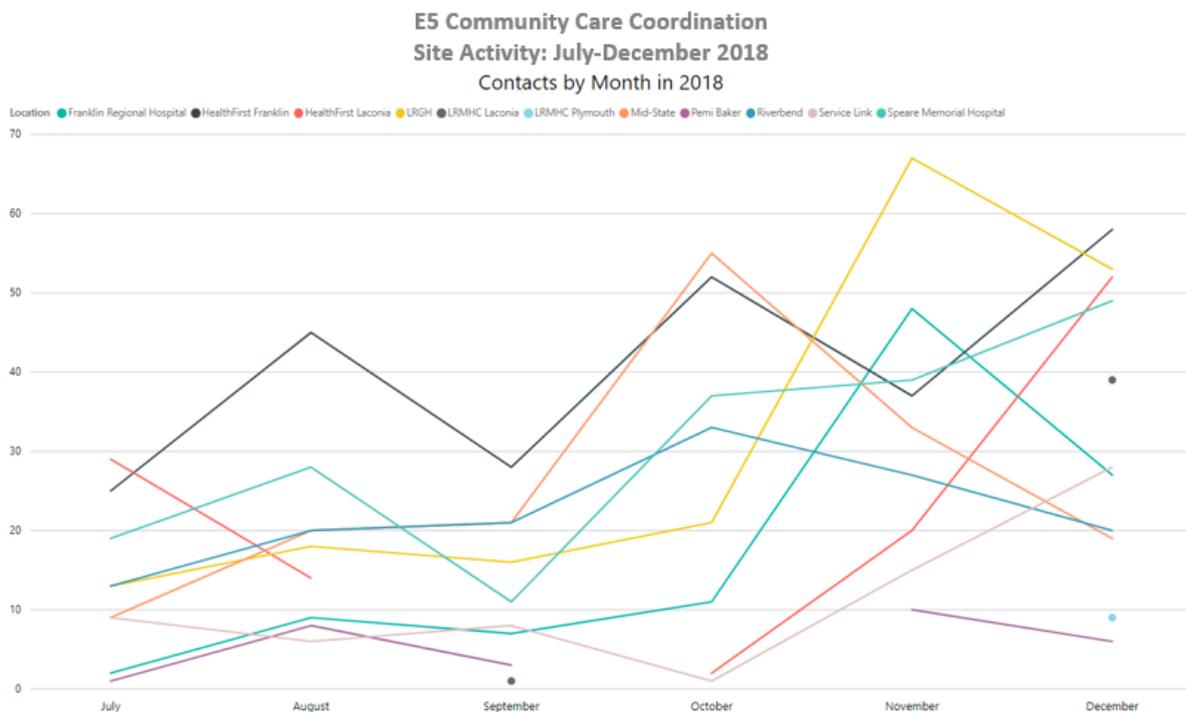
To further support CMT efforts of implementation, the Project Manager collaborated with [REDACTED], Client Success Specialist of CMT to do a training presentation for the E5 CCC Team specific to the care coordination role. This training took place 11/28/18 at LRMHC with the attendance expanding to affiliated partners with staff performing the care coordination role in some capacity. This training was well attended (approximately 25) inclusive of staff, supervisors and leadership representatives from a variety of agencies. As follow up a training link was provided to all in attendance and affiliated partners to support CMT implementation across sites <https://collectivemedicaltech-1.wistia.com/medias/go38b2ln17>. To assist the E5 CCC Team in increasing their skill base with use of CMT collectively, a workgroup is being formed to create a CMT User Manual. This training tool will be designed specifically for the CCC position as another standardization project across sites working towards full implementation to best perform their role and enhance collaboration of patient care with partners through use of the Shared Care Plan. Currently we have two IDN 5 representatives on the IDN Shared Care Plan Task Force actively participating in routine meetings. This continued collaboration will provide a supportive forum to share regional tips for all of the CCC Team as use of the Shared Care Plan continues to be a mutual goal of the E5 project.

An ongoing challenge experienced within the E5 project is the lack of access to a regional high utilizer Medicaid member list. By not having this data provided to IDNs by DHHS or the MCO's as was originally anticipated, it has continued to limit our ability to effectively outreach to all who are in this high risk population. The Community Care Coordinators that are housed within the hospital setting and/or primary care provider office are more effectively able to engage with these high risk individuals, whereas those housed in other provider settings have sustained difficulty obtaining a patient list to support a consistent referral system. There has been marked progress this reporting period with some progress with CMT implementation, enhancement of collaboration between CCC's during small team meetings and changes across sites to creatively capture encounters. With the support of the Project Manager, LRMHC now has "IDN specific" reports available on the LRMHC CCC's desktop to highlight patients that may be potentially eligible for enhanced care coordination. Examples of these lists includes those patients recently hospitalized or those who were no call/no shows for scheduled intake appointments. This integration of lists has significantly increase that site's activity to this high needs population over the past few months.

As the roll out of CMT continues across sites, the CCC team members continue to enhance competence in application of this tool; they are visibly strengthening existing referral sources and creatively forming strong referral systems to support productivity across sites. The CCC Team is confident that their creative outreach to this high risk, high needs population will only increase as their commitment within their role continues across the Lakes Region.

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

To support standardization of capturing accurate data via Smartsheet for the E5 project the Project Manager supported the CCC Team in the development and implementation of a CCC Smartsheet User Manual (**Attachment E.2A**). This user manual was distributed across all sites with a designated CCC peer mentor available for 1:1 training to ensure competency with Smartsheet. This standardization has proven to be of value to each CCC accurately capturing each encounter leading to fully credible and consistent monthly reports illustrating site activity. This monthly report is titled CCC Site Activity/Contacts by Month and can be found as **Attachment E.2B**. These reports are shared with all members of the CCC team and their supervisors to support assessment of strength of a referral base and creative strategies to increase site productivity. In addition to the attached monthly report, to further highlight progress over the past six months across the Lakes Region, site activity graphs (screen shot below) were shared with the CCC Team including the E5 Steering Committee to reflect the progression of activity during this period.



As mentioned previously, the E5 care coordinators have continued using this tracking mechanism for measuring patient adherence, impact measures, and fidelity to evidenced-supported project elements via Smartsheet. This reporting period progress has continued to increase standardization of needs domains as well as brief trainings from the CHSN Data Analyst to provide guidance regarding best practices related to data entry using Smartsheet. The E5 CCC Patient Encounter Tracking Form (screen shot below is a current representation of a template utilized by one CCC working at HealthFirst).

Date Referral made to CCC	Case #	Prio... level	Type of CCC contact	Encou... date	Mode of communication	Needs Domain	Referral made to	Closed loop date
	72		Follow-up	11/13/18	Left message on phone			
11/13/18	73	—	New Enrollment	11/13/18	On site	Housing	Subsidized hc	
11/13/18	74	↓	New Enrollment	11/13/18	Phone	Physical	Health First	
11/14/18	75	↓	New Enrollment	11/14/18	Phone	Legal	Family Court	
11/13/18	76	↓	New Enrollment	11/15/18	Phone	Physical	Health First	
	76		Follow-up	01/03/19				
11/19/18	77	—	New Enrollment	11/20/18	Left message on phone	Financials/benefits		
	77		Follow-up	12/17/18	Left message on phone	Financials/benefits	CAP Belknap	
11/21/18	78	—	New Enrollment	11/21/18	Phone	Housing		
	78		Follow-up	11/26/18	Phone			
	78		Follow-up	11/26/18	On site	Housing	Subsidized hc	
11/27/18	79	↓	New Enrollment	11/27/18	On site	Physical	Health First	11/29/18
11/26/18	80	↓	New Enrollment	11/27/18	Left message on phone	Physical		
11/26/18	81	↓	New Enrollment	11/28/18	Left message on phone	Physical		

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
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.	Due to the delay in operationalizing the E5 CCC teams there is no data point for this target in the reporting period, however, E5 leadership has determined the initial target for 6/30/18 will be 100 individuals served.	For this reporting period there were 274 individuals served across the region. With the now 8 CCCs in place, this number will steadily increase as they develop creative strategies to capture high utilizers and obtain referrals.	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
Time interval from referral and to first care coordination team contact to be 3 business days	>80% by end of waiver.	Progress made during this reporting period include review of performance measures by E5 leadership team and determination of targets.	Progress made includes consistent report from all CCC's that encounters are occurring within 3 business days. In Q3 2018 CCC's will capture this measure via expansion of an additional field in the Patient Encounter Tracking Form.	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.

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
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.	Progress made during this reporting period include review of performance measures by E5 leadership team and determination of targets 0	Same as above to address this measure.	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%
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.	The CCSA process continues to be reviewed with key partner agencies to determine the method of collecting data points and process of training and engaging key providers.	This reporting period the CCC's continue to expand their knowledge of community based resources to establish appropriate data points. The development of a Pre and Post Client Satisfaction Survey (Reference Attachment_B1.2B) was created to highlight capturing these domains as an effective tool to tracking project related trends.	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.

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
Percent of clients presenting with substance/behavioral health needs who received at least one referral	75%			Milestone Met; 83.73%

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

An updated total of 9.4 FTEs was identified (from the previous total of 10.3) across fifteen organizations as being needed to fully staff the Enhanced Care Coordination project. CHSN removed the transportation driver as it was no longer deemed necessary due to additional transportation options available in the Plymouth area (a shared .50 FTE between the D3 and E5 project at .25 each) and is reflected in the table below as a strike through. The remaining .65 FTEs come from the four home health/VNA agencies that were originally identified in our Implementation Plan identified as very small FTEs (i.e. either .15 or .20). We have shifted from the original intent of hiring new individuals to fill these roles to allowing these agencies to bill CHSN for their services if that resource performed by their agency and is accessed by the E5 project team as needed. The Community Care Coordinators are listed below by organization and FTEs in the table below. In this reporting period, a total of .5 FTEs were hired or assigned for a total of 9.4 positions filled to date, making this project fully staffed at this time.

Provider Type	IDN Workforce (FTEs)				
	Projected Total Need	Baseline Staffing on 6/30/17	Staffing on 12/31/17	Staffing on 6/30/18	Staffing on 12/31/18
Care Coordinator (LRGHealthcare)	1.25	0	1.0	1.25	1.25
Care Coordinator (Horizons)	1.0	0	0	1.0	1.0
Care Coordinator (ServiceLink)	0.5	0	0.5	.5	0.5
Care Coordinator (HealthFirst) <i>.25 shared with Riverbend</i>	2.25	0	.25	2.25	2.25
Care Coordinator (LRMHC) <i>1 – Laconia; .5 - Plymouth</i>	1.5		1.5	1	1.5
<del>Transportation Driver (Genesis)</del>	<del>0.25</del>	0	0	0	0
Care Coordinator (Riverbend) <i>.75 shared with HealthFirst</i>	.75	0	.75	.75	.75
Care Coordinator (Speare Memorial)	1.0	0	0	1.0	1.0
Care Coordinator (Mid-State)	1.0	0	0	1.0	1.0
Care Coordinator (Pemi-Baker Community Health)	0.15	0	0	.15	.15
<del>Care Coordinator (NANA)</del>	<del>0.15</del>	0	0	0	0

Provider Type	IDN Workforce (FTEs)				
Care Coordinator (Lakes Region VNA)	0.15	0	0	0	0
Care Coordinator (Central NH VNA)	0.2	0	0	0	0
Care Coordinator (Franklin VNA & Hospice)	0.15	0	0	0	0

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

Provide a narrative and a brief project budget outlining actual expenditures and projected costs to support the community project which must include financial reporting.

Funds were budgeted for the Enhanced Care Coordination of 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 [REDACTED] for \$ [REDACTED], [REDACTED] for \$ [REDACTED] and the [REDACTED] [REDACTED] 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 July and December 2018 are reflected in table below.

Budget Item	Item Description	2017 Cost	Jul – Dec 2017 Actual Cost	2018, 2019, 2020 Projected (Costs Equally Distributed over 3 years)	Jan – Jun 2018 Actual Cost	July – Dec 2018 Actual Cost	Total Project Cost
		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						
Transportation van	Reimbursement for travel						
Mileage	Reimbursement for care coordinator travel						
Cell phone reimbursements of CCC's							
Supplies	Miscellaneous expenses over waiver period						
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

Organization/Provider	Agreement Executed (Y/N)
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

One change occurred within the CHSN network composition during this reporting period. On September 27, 2018 we received notification from HOPE for NH Recovery, an affiliate partner providing recovery support services, that they had closed their Franklin satellite location. Please reference PPI-2 Network Development for further information.

**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.

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-IDN 5 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.

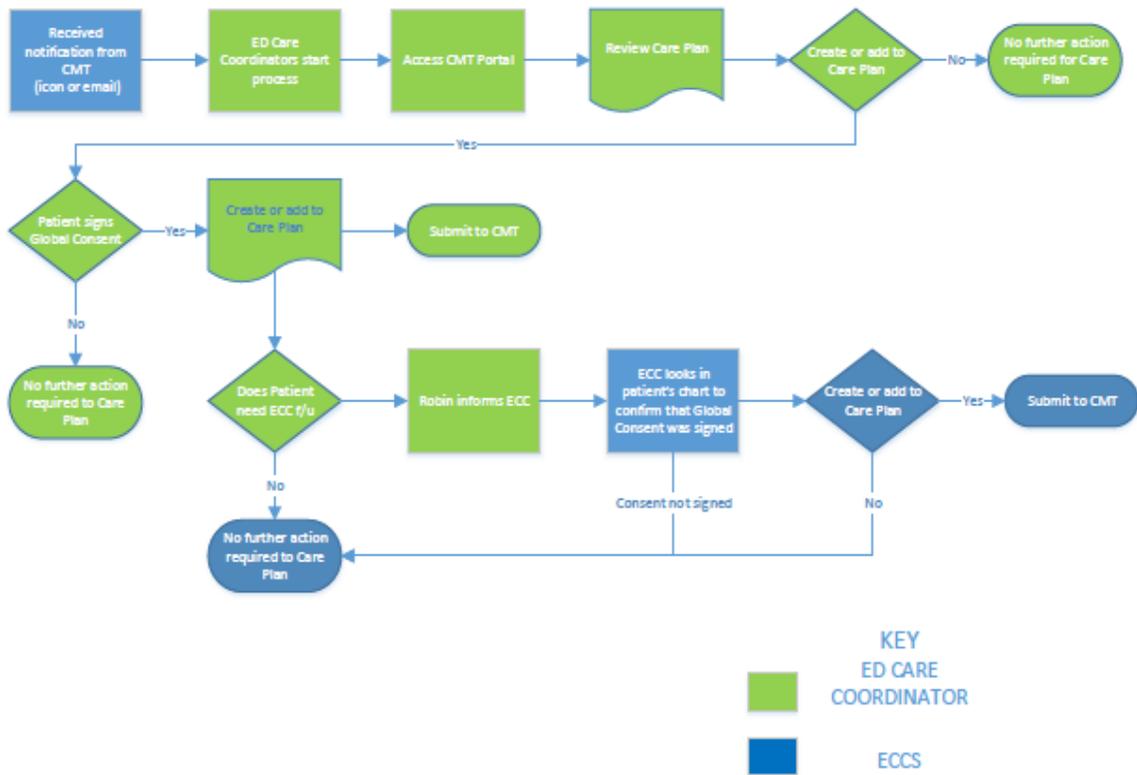
#### Closed Loop Referral: Protocol Submission

- If you are a CHSN-IDN 5 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].

The following protocols and/or workflows were developed this reporting period:

- Riverbend - Healthfirst CCC Patient Care Protocol, **Attachment\_E.7A**
- Assessment Protocol, **Attachment\_E.7B**
- Referral Protocol, **Attachment\_E.7C**
- LRGH CMT Workflow (see screen shot below)

### CMT CARE PLAN WORKFLOW



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>Progress during this reporting period includes the following:</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, 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 (<b>Attachment_E.7B</b>) was created this reporting period 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>This reporting period there been continued progress with development of efficient protocols and workflows related to all entities between PCP offices, hospitals, SUD providers and BH agencies. In addition to those previously submitted, a robust workflow has been created between Riverbend and HealthFirst this reporting period, Riverbend Healthfirst CCC Patient Care Protocol (<b>Attachment_E.7A</b>) This workflow has become a strong template for other CCC's to formulate site specific workflows to best capture optimal patient care and transitions of care between providers.</p> <p>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-IDN 5 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</p>
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		<p>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 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</p>
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Protocol Name	Brief Description	Progress to date
		<p>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> <p>Development of workflows between partner agencies created this reporting period will continue building support increasing a strong foundation of referrals between sites.</p> <p>Since last report, 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
		One future project the CCC Team will be working on is to collectively create a CMT manual specific to the CC role. As each site becomes closer to full implementation it will be essential each CCC be competent with use of this valuable tool. The CCC Team is currently in the process of forming a workgroup to begin developing this CCC CMT User Manual.

**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)
██████████	LRGHealthcare / 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 ██████████ 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-IDN 5 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	<p><b>Milestone met for all CCCs;</b> 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 177 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.</p>
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 be in the process of implementation, 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 between April and December 2018 through the CHSN sustained contract with ██████████ to meet its identified training needs by project. In addition, CCC's have taken advantage of 177 trainings to date 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

CHSN-IDN 5 continues to support APM for all partners. That said, there has been no increase in network partners themselves moving to APM. CHSN's network looks to the State to drive an APM structure with Medicaid payers be they MCO(s) or NH Medicaid direct. Our collective experience does not translate a clear path from which we can train and drive organizations toward APM. The financial infrastructure needed to transform our partners and affiliates is unclear and is anticipated to be costly given the sophistication of, or lack thereof, for relatively small organizations and large organizations with less dependence on Medicaid.

Statewide APM Taskforce activities did not occur in this quarter other than the learning collaborative hosted by MSLC on IDN Sustainability. CHSN-IDN 5 remains committed to participating in the APM Stakeholder Group. It is our intent to model our IDN specific plan to that which the state outlines to ensure we do not create additional administrative burdens and costs to the providers. Our discussions with those currently in APM have helped us better understand the implications this change will have on, in particular our staff, and the increase in costs for technological solutions for tracking data.

Our efforts to move from a draft working plan have been stalled as priorities shifted the latter half of 2018 to more advocacy activities given the uncertainty of county funding availability. It is important to note that the nature of our region and limited workforce has a small number of people wearing many hats which has a direct impact on our ability to juggle the priorities that are unanticipated. Utilizing the current outcome measures and APM(s) of which our members currently participate, is not directly applicable to others and now brings us to establishing a work group designed to cross walk, remove the identified barriers and understand the costs. We believe that there are opportunities that will present themselves as a result of our community projects which will also help.

The current financial administration of CHSN was intentionally established within the local public health entity because of its history and strength in monitoring vendor contracts. It is clear that the APM payment structure will add a complexity to the distribution of funds that will require further infrastructure than that which exists for this demonstration project.

As noted in our last report, the infrastructure for our members and affiliate agencies is that they lack capacity and resources that will actuarial support to the region to ensure costing models are fair and equitable in negotiating with payers. Actuarial services is not a cost we have accounted for in the demonstration project but that we are now clear will be key to our success. We hope to have a better understanding of this through our continued learning and discussions with the State and other IDNs in 2019.

Statewide APM Taskforce and Implementation Plan Activity	Progress		
	As of 12/31/17	As of 6/30/18	As of 12/31/18
Participate in development of statewide APM roadmap through workgroups and stakeholder meetings	Yes	Yes	Yes
Develop an IDN-specific plan for implementing the roadmap which will contain IDN-specific outcome measures		Yes	Yes
Develop the financial, clinical and legal infrastructure required to support APMs		No	No
Meet IDN-specific measures identified in the roadmap that measure progress toward meeting APM goals, including financial, legal and clinical preparedness and engagement with MCOs		No	No

## DSRIP Outcome Measures for Years 2 and 3

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

For Years 4 and 5, CY 2019 and 2020, 100% of the performance funding will be based on the DSRIP Outcomes Measures. See the DSRIP Outcomes Measures, available on the DSRIP website, for more information.

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

# Site Self-Assessment (SSA) Roll-Up Report

## Average Scores: Domain One

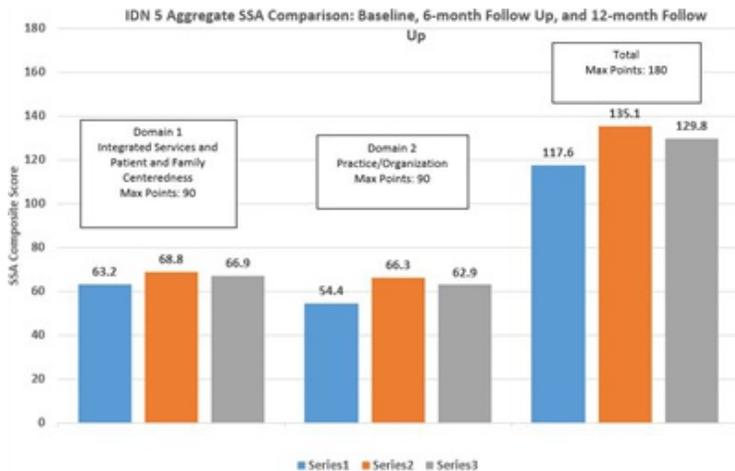
### Integrated Services and Patient and Family Centeredness

	BL	F/U 1	F/U 2
1. Level of integration: primary care and mental/behavioral health care	4.8	4.6	4.8
2. Screening and assessment for emotional/behavioral health needs (e.g. stress, depression, anxiety, substance abuse)	8.2	7.7	8.1
3. Treatment plan(s) for primary care and behavioral/mental health care	6.5	7.3	6.5
4. Patient care that is based on (or informed by) best practice evidence for BH/MH and primary care	6.9	7.2	6.8
5. Patient/family involvement in care plan	7.8	8.6	8.1
6. Communication with patients about integrated care	7.1	8.4	7.9
7. Follow-Up of assessments, tests, treatment, referrals and other services	7.0	8.0	7.9
8. Social support (for patients to implement recommended treatment)	7.9	8.7	8.6
9. Linking to community resources	7.1	8.2	8.4

## Average Scores: Domain Two

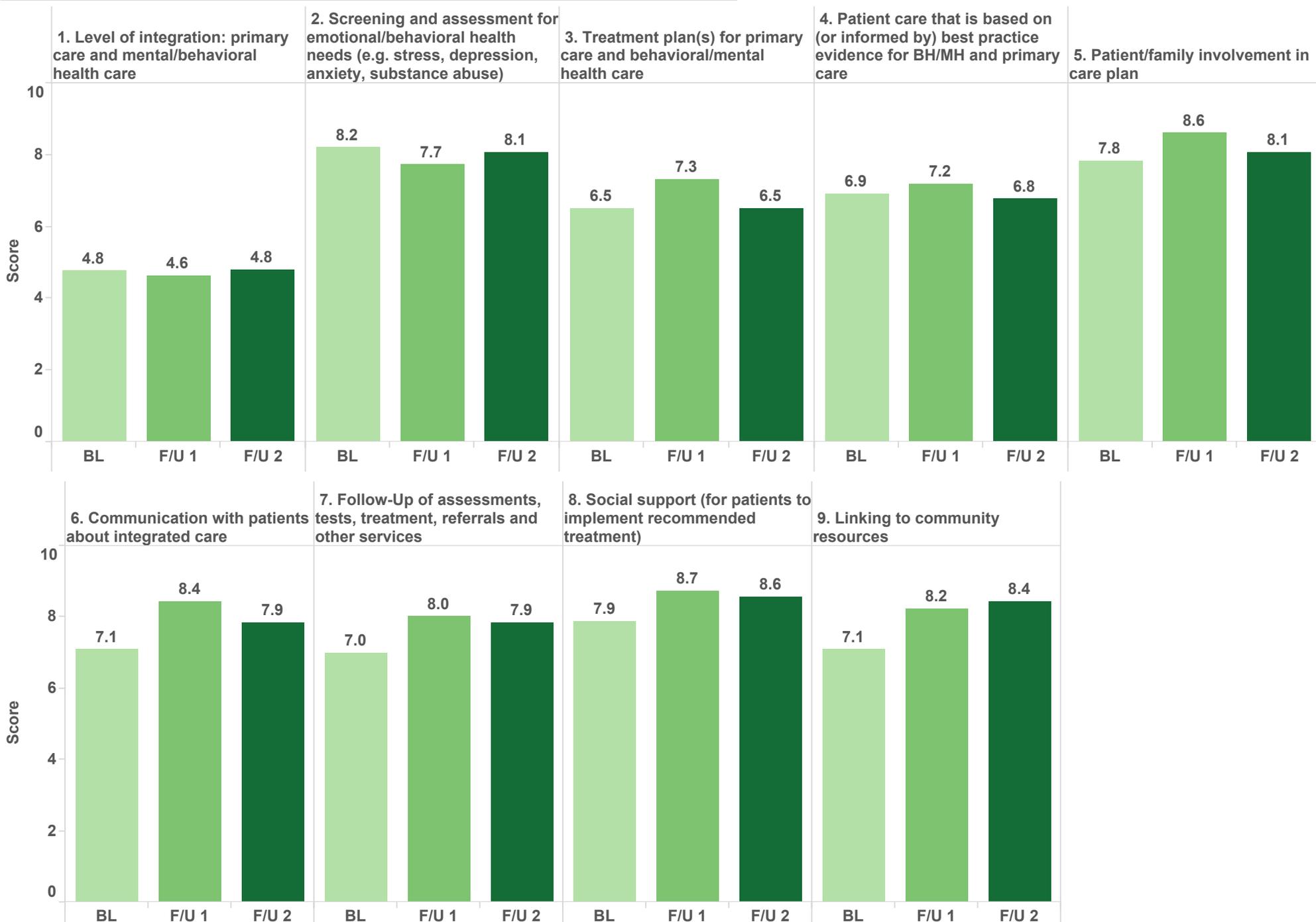
### Practice/Organization

	BL	F/U 1	F/U 2
1. Organizational leadership for integrated care	7.4	8.6	8.0
2. Patient care team for implementing integrated care	6.6	8.3	7.1
3. Providers' engagement with integrated care ("buy-in")	7.2	7.5	7.2
4. Continuity of care between primary care and behavioral/mental health	6.3	7.3	6.9
5. Coordination of referrals and specialists	6.3	6.9	6.9
6. Data systems/patient records	6.2	7.2	7.3
7. Patient/family input to integration management	6.2	7.8	7.1
8. Physician, team and staff education and training for integrated care	4.7	6.9	6.3
9. Funding sources/resources	3.5	5.8	6.1

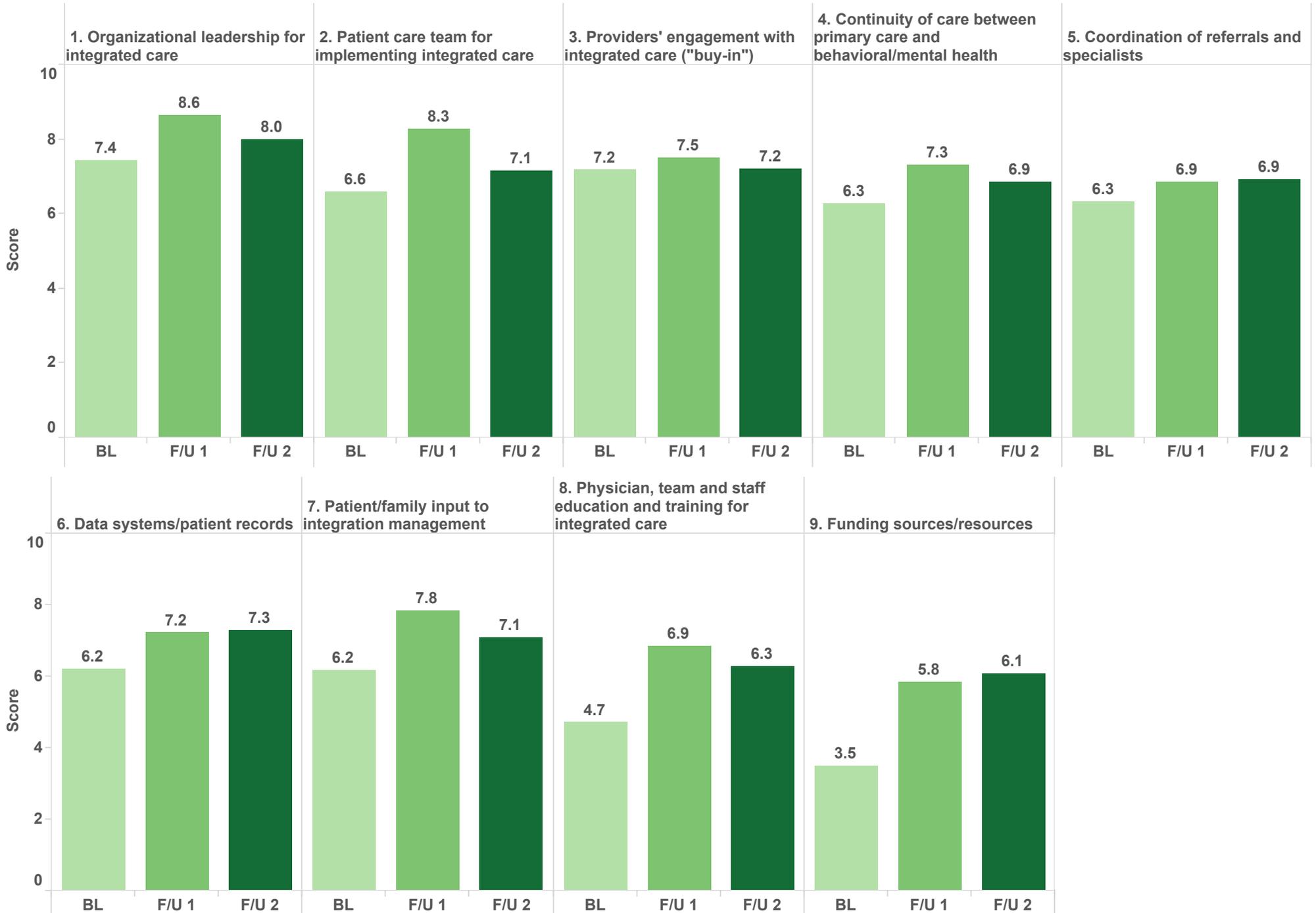


Note: BL - Baseline Assessment; F/U 1 - First Follow-Up Assessment; F/U 2 - Second Follow-Up Assessment

## Graphics: Domain One, Integrated Services and Patient and Family Centeredness



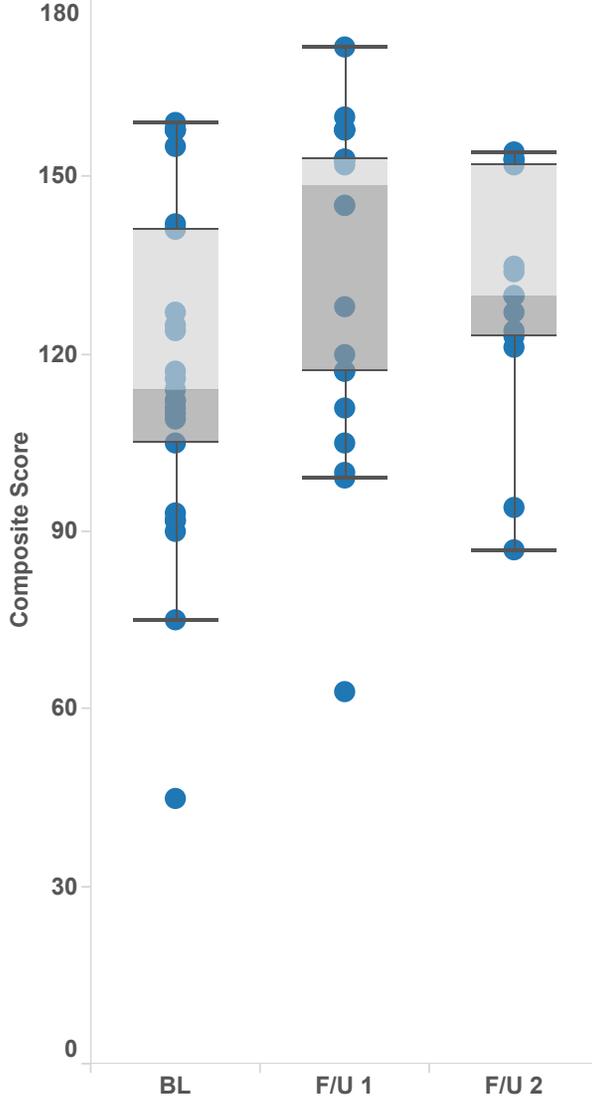
**Graphics: Domain Two, Practice/Organization**



# Site Self-Assessment (SSA) Trend Report

*For IDN Leadership Use Only*

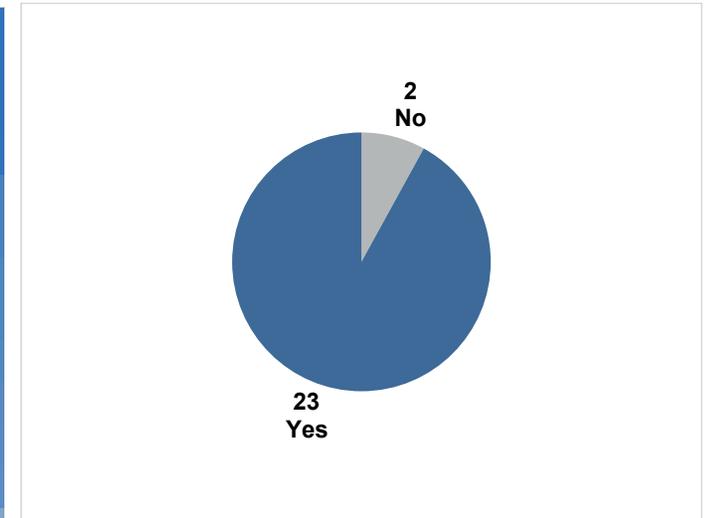
## Composite Score Distribution



## Composite Scores by Practice

Practice	SSA No.		
	BL	F/U 1	F/U 2
5-111	155	158	154
5-113	109	158	153
5-115	111	158	153
5-100	159	172	152
5-103	114	99	135
5-105	127	117	134
5-101	75	105	130
5-118	105	128	130
5-106	116	111	127
5-109	124	145	124
5-110	142	152	123
5-119	112	117	121
5-107	125	120	94
5-108	45	63	87
5-102	112	145	
5-104	90	100	
5-112	110		
5-114	117		
5-116	141		
5-121	158	153	
5-122	158	153	
5-123	158	153	
5-124	93	153	
5-126	92	160	
5-127	92	153	

## "Did you discuss these ratings with other members of your team?" (Most Recent SSA Taken by Practices)



### Baseline:

Upper Whisker: 159  
Upper Hinge: 141  
Median: 114  
Lower Hinge: 105  
Lower Whisker: 75

### Follow-Up 1:

Upper Whisker: 172  
Upper Hinge: 153  
Median: 148.5  
Lower Hinge: 117  
Lower Whisker: 99

### Follow-Up 2:

Upper Whisker: 154  
Upper Hinge: 152  
Median: 130  
Lower Hinge: 123  
Lower Whisker: 87

**Domain One Improvement Opportunities (Average Scores by Question Shown in Ascending Order)**

SSA No.	1. Level of integration: primary care and mental/behavioral health care	3. Treatment plan(s) for primary care and behavioral/mental health care	4. Patient care that is based on (or informed by) best practice evidence for BH/MH and primary care	7. Follow-Up of assessments, tests, treatment, referrals and other services	6. Communication with patients..	2. Screening and assessment for emotional/behavioral health needs (e.g. stress, depression, anxiety, substance ab..	5. Patient/family involvement in care plan	9. Linking to community resources	8. Social support (for patients to implement recommended treatment)
F/U 2	4.8	6.5	6.8	7.9	7.9	8.1	8.1	8.4	8.6
F/U 1	4.6	7.3	7.2	8.0	8.4	7.7	8.6	8.2	8.7
BL	4.8	6.5	6.9	7.0	7.1	8.2	7.8	7.1	7.9

**Domain Two Improvement Opportunities (Average Scores by Question Shown in Ascending Order)**

SSA No.	9. Funding sources/resources	8. Physician, team and staff education and training for integrated ca..	4. Continuity of care between primary care and behavior..	5. Coordination of referrals and specialists	7. Patient/family input to integration management	2. Patient care team for implementing integrated care	3. Providers' engagement with integrated care ("buy-in")	6. Data systems/patient records	1. Organizational leadership for integrated care
F/U 2	6.1	6.3	6.9	6.9	7.1	7.1	7.2	7.3	8.0
F/U 1	5.8	6.9	7.3	6.9	7.8	8.3	7.5	7.2	8.6
BL	3.5	4.7	6.3	6.3	6.2	6.6	7.2	6.2	7.4

# A1 Statewide BH Workforce (IDN 5)

Attachment\_A1.3A

Task	
1	<input type="checkbox"/> Phase 1
2	Form Statewide BH Workforce Capacity Taskforce
3	Participation in BH Workforce Capacity Taskforce planning
4	<input type="checkbox"/> Phase 2
5	Develop inventory of existing workforce data, initiatives, and activities
6	Participate/create gap analysis
7	<input type="checkbox"/> Phase 3
8	<input type="checkbox"/> Develop Statewide BH Workforce Capacity Strategic Plan
9	Workgroups defined: Policy, Education, Training, Recruitment/Hiring/Retention
10	Identification of Goals and timelines
11	<input type="checkbox"/> Phase 4
12	Repeat workforce gap analysis and submit with SAR
13	<input type="checkbox"/> Develop IDN level Workforce Capacity Development Implementation Plans
14	<input type="checkbox"/> 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
21	Develop criteria and receive CHSN Board approval for providing financial support to IDN related- staff pursuing licensure or certifications in their fields
22	Develop and communicate policies and procedures for agencies to request licensure/certification support on behalf of staff
23	Update workforce training needs assessment
24	Develop a training matrix of IDN 5 training needs and area resources with ongoing updates (see C2, D3, E5 projects)
25	Investigate scholarships for national and regional training events
26	Investigate training opportunities with NH Training Institute on Addictive Disorders, Communities of practice, Technical Assistance





## Task

- 27  Phase 5
- 28  Implement IDN Workforce Capacity Development Plans
  - 29 Provide reimbursement for staff pursuing licensure/certification and monitor effects on recruitment and retention
  - 30 Provide loan repayment for key staff and monitor effect on recruitment and retention
  - 31 Initiate dispensing employee incentive payments to participating agencies and monitor effects on recruitment and retention
  - 32 Deploy IDN 5 training plan
  - 33 Report against targets identified in plan
  - 34 Review progress to date and revise plans accordingly

	Q3			Q4			Q1			Q2			Q3			Q4			Q1				
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	



Attachment_A1.4A	CHSN-IDN 5 Training Tracker			November	November	January
Agency	Name	Position	DSRIP 101	2 day Suicide Prevention academy	PSU Suicide Awareness & Prevention	Basics of Medicaid
HealthFirst						
		Clinical Mental Health Counselor				
		LPN, Patient Care Coordinator	4/18/2018			
		Community Health Coordinator	3/7/2017			
Franklin - Current 12.17.18		Community Health Coordinator	4/18/2018			
Laconia - Current 12.17.18		Care Coordinator				
		LCMHC				
		CEO				
		Practice Manager	11/15/2017			
Salvation Army						
		Commanding Officer/Pastor	10/18/17			
Speare Hospital						
		Population Health Care	10/18/17			
		Manager of Practice Operational Performance	10/18/17			
		Medical Social Worker	10/18/17	11/29/17		
		Director, Care Management	10/18/17			
		Community Care Coordinator	4/18/2018			
Lakes Region Mental Health Center						

		Care Coordinator				
		Care Manager				
		Targeted Care Manager				
		Therapist				
		Case Manager				
		CSP Director				
		Case Manager Facilitator				
		TSS				
		Clinical Mental Health Counselor				
		ARNP				
		Health Mentor				
		Community Case Manager				
Current 12.17.18		Care Coordinator				
		Child & Family Therapist				
		Community Case Manager				
		Health Mentor				
		Housing Facilitator				
			4/18/18			
		Chief Quality Officer				
		ES Clinician				
		Coordinator				
		RN, BSN				
		Therapist				
		Hospital Liaison, Adult Services	4/18/18			
		Executive Director				
		Program Facilitator	10/18/17			
		BS				
		CPS Program Manager				
		APRN				
		ES Clinician				

		Neuro Facilitator			
		CCM			
		Counselor			
		Coordinator			
<b>Lakes Region VNA</b>					
		Finance Director	10/18/17		
<b>NANA</b>					
		Executive Director	3/07/18		
		Finance Director	10/18/17		
<b>Farnum North</b>					
		Marketing Manager	10/18/17		
<b>Riverbend</b>					
		Vocational Support			1/23/2018
		Program Director	4/18/2018		
		Community Care Coordinator	4/18/18		1/23/2018
<b>LRCS</b>					
		Social Worker			
		Family Support Specialist			
		Director			
		Resource Coordinator			
		V.P. of Operations	10/18/17		
		Resource Coordinator			
		Resource Coordinator			
		Quality improvement specialist	11/15/17		
		Risk Manger			
		FCESS Educator			
		Resource Coordinator			
		Resource Coordinator	3/7/2018		
		Manager of ESS			
		CFO	11/15/17		
		Family Support Specialist			
		Family Support Specialist			
		Parent Education Manager	10/18/17		

		Director	10/18/17		
LRGHealthcare					
		Embedded Care Coordinator	11/15/17		
		Ambulatory Care Coordinator	4/18/18		
		Community Health Improvement Specialist	1/17/18		
		Clinical Program Director	3/7/2018		
	kins	Embedded Care Coordinator	11/15/17		
		RN-ECC Moultonboro Family Health, Meredith	11/15/17		1/23/18
		Director of Care Management	1/17/18		
		Care Manager	1/17/18		
		Clinical Manager ECC/TCC	11/15/17	11/14/17	1/23/18
		ECC Hillside, LRF, Belmont	11/15/17		1/23/18
		Community Health Improvement Specialist	1/17/18		
		Long Term Care Coordinator	4/18/2018		1/23/18
		ECC Westside, Newfound Family	11/15/17		1/23/18
		Social Worker	1/17/18		
PPH					
CHSN		Executive Director			
CHSN		Project Manager			

CHSN		Data Analyst	1/17/18			
		Emergency Preparedness Coordinator	1/17/18			
		Community Care Coordinator				
		Assistant Director, PPH		11/29/17		
		Community Health Educator				
		Coordinated Care Team Leader	4/18/18			
		Interim Director of ServiceLink	11/15/17			
		Executive Director				
		Options Counselor	4/18/18			
Broadleaf						
		Care Coordinator	11/15/17			
Franklin VNA						
		Nurse Liaison	1/17/18			
			11/15/17			
Horizons Counseling Ctr						
		Director				
		Program Director				
		MSW				
		Counselor				
		Assistant Director	4/18/2018			
		Case Manger				
		Counselor				
		Counselor				
		Counselor				
		Case Manger				
Mid-State						
		Community Care Coordinator	4/18/2018			

		Quality improvement specialist				
		Director of Advancement/Commun.	3/7/2018			
<b>Navigating Recovery</b>						
		Recovery Coach				
		Executive Director				
		Volunteer				
		Recovery Coach				
		Recovery Coach				
		CRSW				
		Recovery Coach				
		Volunteer				
		Recovery Coach				
		Recovery Coach				
		Recovery Coach				
		Recovery Coach				
<b>CADY, INC.</b>						
		Restorative Justice Coordinator				
<b>Pemi-Baker Community Health</b>						
		Care Coordinator				
		Medical Social Worker				
		Care Coordinator	4/18/2018			
		Clinical Director of Hospice & Palliativ				
<b>NAMI-NH</b>						
		Affiliate Liaison				
		Peer Support Recovery Specialist				
		Family Peer Support Coordinator				
<b>CAP</b>						
		Program Assistant				
		Program Director				
		CEO	3/7/2018			
		Homeless Outreach Specialist				

		Program Assistant				
<b>NHADACA</b>						
		NHTIAD Director				
<b>NH Veterans Home</b>						
		Recreation Assistant				
		RN/MDS Coordinator				
		Recreation Therapist 1				
		Recreation Therapist				
		Recreation Therapist Supervisor III				
		Recreation Assistant				
<b>Central NH VNA &amp; Hospice</b>						
		MSW				
		MSW Social Worker Manager				
<b>Total Attendees</b>			<b>52</b>	<b>2</b>	<b>1</b>	<b>7</b>









2/21/18							
	2/7/2018						
	2/7/2018						
			6/15/2018			8/24/2018	
						8/24/2018	
						8/24/2018	
4/17/2018			6/15/2018	4/18/2018	4/19/2018	8/24/2018	



























































































10/5/2018		10/17/2018						
		10/17/2018						
								11/2/2018
10/5/2018								11/2/2018
10/5/2018								11/2/2018
		10/17/2018						
			10/18/2018					11/2/2018
		10/17/2018						
		10/17/2018						

























Nov-18						Nov-18
<b>Screening, Brief Intervention Referral to Treatment: A Public Health Intervention</b>	<b>Best Practices in the Community</b>	<b>SSI for Older Adults: Post Eligibility Tips (W)</b>	<b>Using Harm Reduction Strategies to Move Clients Toward Abstinence (W)</b>	<b>CMT Training @ LRMHC</b>	<b>Non-Violent Crisis Intervention</b>	<b>Stress &amp; Trauma in Practice of Behavioral HealthCare</b>
11/30/2018						11/30/2018
				11/28/2018		11/30/2018
						11/30/2018
				11/28/2018		











11/30/2018						11/30/2018
11/30/2018						11/30/2018
11/30/2018						11/30/2018
11/30/2018						11/30/2018
11/30/2018						11/30/2018
11/26/2018						
11/26/2018						
<b>17</b>	<b>1</b>	<b>1</b>	<b>1</b>	<b>17</b>		<b>17</b>















Attachment\_A1.6A

CHSN/IDN 5	2016 - 100% Process			2017 - 90% Process / 10% Outcome Perf			2018 - 75% Process / 25% Outcome Perf	
	(Design/capacity bldg funds)	(Project Plan approval) Year 1/pymt 2	Total	YTD Expenditures (thru 6/30/17)	Year 2/pymt 1 (Jan-Jun 2017)	Year 2/pymt 2 (Jul-Dec 2017)	Year 3/pymt 1 (Jan-Jun 2018)	Year 3/pymt 2 (Jul-Dec 2018)
Project Design and Capacity Building								
Capacity Building Funds avail as of 6/30/17	\$				\$			
ADMINISTRATIVE EXPENSES and OPERATING BUDGET for IDN 5				\$				
<b>STATEWIDE PROJECTS</b>								
<b>A1 - Workforce Development</b>	STATEWIDE Trainings (Shared with other IDNs)							
	REGIONAL Trainings for IDN agencies and staff related to Integration							
	Licensure / Certification support for project staff (C2, D3, E5)							
	Loan repayment plan (TBD)							
	Training Contract with providing free Integrated Healthcare trainings to all partners and staff							
	Employee Retention Incentive Plan Tier 1 partners							
	Employee Retention Incentive Plan Tier 2 partners							
	Employee Retention Incentive Plan Tier 3 partners							
<b>A2 - H.I.T. &amp; Data Analytics</b>	CMT Shared Care Plan & Event Notification Annual subscription							
	MAeHC Data Aggregator Implementation cost and annual fees							
	Data Analyst salary and benefits							
	Data Analyst mileage and cell phone							
	Technology upgrades to bring partners up to HIT minimum standards							
	Data consultant fees for partner assistance w/report automation and writing							
	Legal fees for work on data sharing/confidentiality documents							
<b>CORE COMPETENCY PROJECT</b>								
<b>B1 - Integrated Healthcare</b>	Medical director stipend for Clinical Integration Team							
	Psychiatrist stipend for B1 multi-disciplinary care team							
	CHSN Board Members annual stipend for meetings, time and mileage							
	Contract for BH Integration Site Self Assessment Survey							
	Practice Transformation Specialist .5 FTE or consultant							

COMMUNITY PROJECTS					
<b>C2 - Supportive Community Re-Entry for Justice Involved Youth and Adults with BH</b>	Staffing costs associated with identified plan of 8 FTEs		█	█	█
<b>D3 - Expansion in Intensive Outpatient Program (IOP) SUD Treatment Options</b>	Staffing costs associated with identified plan of 9.5 FTEs		█	█	█
	█ County clients attending IOP in Franklin (2019-2020)				
<b>E5 - Enhanced Care Coordination for High-Need Populations</b>	Staffing costs associated with identified plan of 11.3 FTE		█	█	█
	Initial purchase of laptops and cell phones for care coordinators x11		█	█	█
<b>All Community projects D3/E5</b>	Mileage reimbursement for D3 & E5 van driver			█	█
<b>E5 Care Coordinator Mileage</b>	Mileage reimbursement for care coordinators in E5 project		█	█	█
<b>All community projects</b>	Miscellaneous supplies for all projects		█	█	█
OTHER EXPENSES					
<b>Discretionary Grant Fund</b>			█	█	█
<b>Consulting Fees</b>			█	█	
<b>Legal Fees (MOUs, privacy/consent form review)</b>			█		
<b>Reimbursements to 3 IDN Project Leads</b>			█	█	█
<b>Unknown staffing, consulting, project and technology needs:</b>			█	█	█

Revised 12.31.18

















# B1 Integrated Healthcare (IDN 5)

Attachment\_B1.2A

Task Name
<b>[-] Planning phase</b>
<b>Research DSRIP waivers in other states to ascertain "lessons learned"</b>
<b>[-] Develop Implementation Plan for Coordinated and Integrated Care Practice</b>
<b>[-] Identify and Commit Key Organizational/Provider participants</b>
Organizational leaders sign-off
<b>[-] Complete Project Budget</b>
Salary assessment by profession
Reconcile budget with FTE need and salary designation
<b>[-] Complete Workforce plan</b>
<b>[-] Staffing plan</b>
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
<b>[-] Initiate process of Designated IDN participating providers progress along SAMHSA framework for Integrated Levels of Care</b>
<b>[-] Perform Gap Analysis of CSA</b>
Develop report on DSRIP CSA Gap Analysis results
<b>[-] Complete Site Self- Assessment for level of Integration for IDN participating providers</b>
Assess current progress along SAMHSA framework of key Primary Care and BH providers and future targets
Identify partner goals and timelines related to Coordinated Care Practice and/or Integrated Care Practice
Develop/Identify Agreements with participating providers and organizations
<b>[-] Develop/Identify Comprehensive Core Standardized Assessment process and screening tools</b>
Obtain examples of CSA questionnaire from other IDNs



Task Name
B1–Clinical Integration Committee convened
Review sample CSA questionnaires
Select Assessment/Screening tools applicable to adults, adolescents, and children
Create a plan for implementation of assessment tools to be integrated into selected partners workflow
– Develop/Identify Protocols for patient assessment, treatment, management
Participating partners selected
Participating partners workflows mapped for use of CSA process
Assess practice workflows and create plan for introduction/modification as appropriate
– Develop/Identify Core team meeting/communication plan and relevant workflows for communication among core care team and other pa
Develop/Identify Collaboration Modalities between B1 and E5
Oversee Community Care Coordination team meeting process for E5
Identify Core team meeting/communication Process as defined in E5 project plan
Process Measurement created– See E5
Develop/Identify mechanisms (e.g. registries) to track and monitor individuals served by the program, adherence, impact measures, an
Develop Shared Care Plan for treatment and follow-up of both BH and physical health to appropriate medical, behavioral health, commun
– Develop/Identify Referral protocols including to those to/from PCPs, BH providers, social service support providers, Hospitals, and EDs
Participating partners referral workflows mapped and protocols identified
Development and sharing of closed loop referral protocols with B1 partners
– Training plan developed
Experts in the State identified and Statewide initiatives tapped into as appropriate
Ongoing Training scheduled and opportunities reviewed from other project– A1, A2, E5
– Evaluation plan
CCSA measurement collection process implemented and evaluated
Identify Medication–assisted treatment (MAT) in IDN 5 primary care and BH practice settings and challenges
– Implementation phase
– Implementation of workforce plan
Initiate recruitment of multi-disciplinary care team members previously identified see E5
Roll out Employee Retention Incentive plan for network partners
– Implement CCSA process and methods for aggregating information from multiple providers
Initiate usage of MAeHC for data aggregator



Task Name
Facilitate use of Comprehensive Core Standardized Assessment tool or process
Facilitate adoption of evidenced based screening & assessment tools
Facilitate adoption of SBIRT by designated primary care providers
Facilitate adoption of PHQ 2 & 9 by designated BH providers
Facilitate adoption of developmental screenings by designated pediatric providers
<b>■ Implement use of shared care plan and coordinated care model</b>
Implement intake procedures to include consent to share information among providers
Operationalization of Core Team meeting/communication plan (including case conferences)
Review and modify protocols and workflows as needed
Develop process for designated Primary Care and Behavioral Health practices to show progress towards Integrated Care Practice designation
Provide consultation on selection/use of certified EHR and related technology to support integrated care
Identify trainings for adoption of evidenced based treatment of mild-to-moderate depression within IDN 5 practices moving to Integrated Care
Facilitate training/technical assistance as needed for adoption of evidenced based treatment of mild-to-moderate depression for practices
<b>■ Initiation of Data Reporting</b>
Participate in Pilot reporting of 2 outcome measures with DHHS
Number of Medicaid beneficiaries receiving annual Comprehensive Core Standardized assessment for period & cumulative vs. projected (Dec date seems too early!)
Number of Medicaid beneficiaries scoring positive on screening tools
Number of Medicaid beneficiaries positive on screening tools and referred for additional intervention
Impact indicator measures as defined in evaluation plan, including annual evaluation of fidelity to evidence-supported program elements
<b>■ Reporting period Jan-Jun 2018</b>
<b>Implement use of PreManage Tier 2</b>
Implement intake procedures to include consent to share information among providers
<b>■ Collect data from designated agencies for progress along SAMHSA Integrated Care Continuum</b>
Number of Medicaid beneficiaries receiving annual Comprehensive Core Standardized assessment for period & cumulative vs. projected
Number of Medicaid beneficiaries scoring positive on screening tools
Number of Medicaid beneficiaries positive on screening tools and referred for additional intervention
Impact indicator measures as defined in evaluation plan
<b>■ Reporting period Jul-Dec 2018</b>
<b>■ Collect data from designated agencies for progress along SAMHSA Integrated Care Continuum</b>
Number of Medicaid beneficiaries receiving annual Comprehensive Core Standardized assessment for period & cumulative vs. projected



**Task Name**

Number of Medicaid beneficiaries scoring positive on screening tools

Number of Medicaid beneficiaries positive on screening tools and referred for additional intervention

Impact indicator measures as defined in evaluation plan, including annual evaluation of fidelity to evidence-supported program elements

**Periodically assess designated practices for progress along the SAMSHA Integrated Care continuum**

	2017				2018				2019			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
									✓			
									✓			
									✓			
									✓			

COMMUNITY HEALTH SERVICES NETWORK  
INTEGRATED DELIVERY NETWORK 5  
“CHSN-IDN 5”

B1 Partner Protocol Guidance

December 2018.V1

*Please note that the requirement of implementing a Comprehensive Core Standardized Assessment (CCSA) is addressed under a stand-alone protocol titled, Community Health Services Network (IDN 5) Comprehensive Core Standardized Assessment Protocol V1.2018*

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CHSN-IDN 5 DRAFT

## Secure Messaging: Guidance Protocol

CHSN-IDN 5 has identified Direct Secure Messaging (DSM) as a channel for secure communication among Partner organizations. We are encouraging partners to use Direct Messaging capabilities that are native to their electronic health record systems. We have provided (at no cost to Partners) Direct Messaging webmail applications in cases where EHR systems are not capable of supporting Direct Messaging. Secure webmail applications are being provided by the vendor Kno2 and all contracting, subscriptions, training, and support is paid for by CHSN-IDN 5 for partners who do/did not already have DSM capabilities.

CHSN-IDN 5 remains flexible with regards to Direct Messaging. Our overarching goal is to support inter-organizational communication for purposes of improved care coordination. We will continue to push Direct Messaging as our preferred technology.

- Use of legacy communication channels (e.g., Fax, Mail) are not encouraged yet may be used as a last resort, acceptable to the IDN with the understanding communication occurs between entities, and thus, positively impacting coordination of quality patient care and ensures protection of each individual's protected health information (PHI) throughout this process.

## Secure Messaging: Protocol Submission

- If you are an IDN partner organization that is actively using Kno2 **there is no further information needed.**
- If you are an IDN partner organization that is using another webmail application and are working directly with CHSN staff **there is no further information needed.**
- If your organization is using an different method or vendor for secure communication with partner organizations, 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, Data Analyst (IDN 5), [REDACTED].

## Closed Loop Referrals: Guidance Protocol

To assist in the reduction of breakdowns in the referral process which can lead to delays in receiving appropriate treatment, CHSN-IDN 5 B1 partners will interface with Community Based Support Services organizations through a formal closed-loop referral process. This is one in which pertinent patient data that requires action is communicated to the right individuals at the right time through the right mode of communication to allow for review, action, acknowledgement and documentation. The Community Care Coordinator or designated Behavioral Health (BH) or Community Health Worker (CHW) support staff will be the accountable member of the Integrated Care Team in all communications with the Community Based Support Services. Upon identification of a need for community support services by the Integrated Care Team, the Care Coordinator will begin the referral to supports process.

Where the provider of supports is not known by the team, the Community Care Team will work with a variety of regional and statewide resources to identify appropriate and available community supports. Significant work has been done to compile an IDN 5 resource guide for Community Based Support Services which may also be referenced. Resources may take the form of a care navigation organizations such as ServiceLink of Belknap or Grafton county and other regional resources which include:

- NH Alcohol and Drug Treatment Locator (<http://nhtreatment.org/>)
- ServiceLink Community Resource Directory (<http://www.referweb.net/nhsl/>)
- NH Easy – Gateway to Services (<https://nheasy.nh.gov/#/>)
- NH Peer Support by region: (<http://www.dhhs.nh.gov/dcbcs/bbh/peer.htm>)
- 2-1-1 New Hampshire and <http://www.homehelpnh.org/> for housing assistance
- Transportation Resources - Central NH Transportation 603-412-2122; Community Action Program 603-225-1989 or [www.bm-cap.org](http://www.bm-cap.org); Grafton County Senior Citizens Council 603-536-1204; NH Medicaid Ride Coordinator 1-800-852-3345 ext. 3770 or other regional transportation services (<https://www.nh.gov/dot/programs/scc/rcc.htm>).

The Care Coordinator will initiate a referral to the Community Based Support Service and securely transfer all pertinent information. This will be facilitated via secure Direct Secure Message. Where EHRs are capable of initiating a referral over Direct, the EHR will be used. Where EHRs are incapable of initiating a referral, a Webmail will be used to send the referral to support this process. Community Support Services organizations will receive the referral to supports via a portal inbox. As the process is being first implemented, the Care Coordinator will also follow up via phone to ensure that the Community Support Services organization is aware of the referral and is following up appropriately.

To complete the “closed loop” referral, the Community Based Support Service organization will acknowledge receipt of the referral, will inform the Care Team Coordinator of patient engagement with the services, and will provide updates periodically. The Care Team Coordinator will actively query Community Support Services Providers to follow up on “open” referrals.

## Closed Loop Referral: Protocol Submission

- If you are a CHSN-IDN 5 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]

CHSN-IDN 5 DRAFT

## Interactions between Providers and Community Based Organizations: Guidance Protocol

The Integrated Healthcare Core Team will use a formal closed-loop referral process (see Closed Loop Referral Guidance Protocol) to connect Medicaid members with Community Based Organizations. The following protocol defines the population to be served by level of acuity.

### Population to be served:

NH Medicaid Beneficiaries with behavioral health conditions or at risk for such conditions. Population is to be divided into three groups:

**High Acuity Members:** Members that are high utilizers of area Emergency Departments and/or who have (or at risk of having) complex medical, behavioral health, and social determinants needs.

- CHSN-IDN 5 is allowing project teams to add additional high acuity criteria based on their immediate team needs to determine MDCT patient selection

**Medium Needs Members:** Members that have Behavioral Health Conditions and who have (or at risk of having) moderately complex medical, behavioral health, and/or social determinants needs.

**Low Needs Members:** Members that have Behavioral Health Conditions and who have low complexity medical, behavioral health, and/or social determinants needs.

Note: These categorizations are an aid in prioritization – Members will likely move upward or downward based on assessment and identification of needs over time.

The population tier may be used by B1 project teams to help determine Multi-Disciplinary Team patients need for review and for whom to use a Shared Care Plan within CMT.

*Also see Joint Service and Communication Channels with Community Based Social Service Providers Guidance Protocol*

*There is no submission format for this guidance protocol*

## Shared Care Plan: Guidance Protocol

CHSN-IDN 5 B1 Integrated Care Team and practices along with the E5 Enhanced Care Coordination Team will utilize a Shared Care Plan (SCP) in conjunction with each organization's electronic health record (EHR), when available, to capture, share, and periodically update the following information:

- Care Team members
- Person-Centered Goals (e.g., Patient's identified goals)
- Health Concerns (e.g., Diagnoses, Problems, Social Determinants of Health needs)
- Shared Plan of Care informed by Primary Care and Behavioral Health
- Other relevant history from the Medicaid member's Medical Record

CHSN-IDN 5 supports Shared Care Plan use through the use of the Collective Medical Technology (CMT) platform

- For organizations not yet ready to use a web-based platform for shared care planning the CHSN-IDN 5 Enhanced Care Coordination team will provide a paper version of the SCP fields.
- Additionally, the CHSN-IDN 5 team will work with your organization and partners to implement Pre-Manage Primary.
- CHSN-IDN 5 encourages, yet does not require, use of the CMT technology platform on top of the sharing that occurs in the Partner's EHR.

### Pre-SCP Use:

1. All necessary privacy protections are in place including updates to patient protected health information (PHI) and forms, scripts for explaining SCP to patients, and consent forms where required by law.
2. SCP Development Workflow – The CHSN-IDN 5 Executive Director or designee will support your team in developing a workflow and timeframe for SCP development.

### SCP Use:

The minimum standard for CHSN-IDN 5 guidance states:

- i. SCP development originates with PC EHR Chart Review, BHC EHR Chart Review (If external)
- ii. PCP or BHC addresses patient goals at patient visit and review SCP content
- iii. All community care coordinators see the SCP prior to the CHSN-IDN 5 Enhanced Care Coordination team regularly scheduled meetings
- iv. All participating providers see the SCP at least 24 hours before the multi-disciplinary care team (MDCT) meeting

In addition, SCP should be made available to patients and updated regularly with patient input upon request or at discretion of Care Team.

## Shared Care Plan: Protocol Submission

- If you are a CHSN-IDN 5 partner organization involved with a B1 Integrated Healthcare project that is actively using the CMT Shared Care Plan and your process has been reviewed with your project team **there is no further information needed.**
- If your organization is enabled with CMT but the SCP is not yet in use and you are actively meeting with the CHSN-IDN 5 project team **there is no further information needed.**
- If your organization is using an alternate process for SCP, not using the CMT technology, and you have previously reviewed this with the CHSN-IDN 5 team **there is no further information needed.**
- If your organization is using an alternative process for shared care planning 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].

CHSN-IDN 5 DRAFT

## Timely Communication: Guidance Protocol

ACTION	TIMING
Capture (or update) EHR and Shared Care plan application (CMT) with Care Plan	Within 1-business days of integrated core team or community care team shared care plan meeting.
Initiate Referral to Supports (Community Care Coordinator)	Within 2 business days of integrated core team shared care meeting.
Close the loop by acknowledging Referral of Supports (Community Support Services Organization)	Within 4 hours of message receipt
For “open referrals” close the loop by contacting the Community Support Services Organization to confirm referral receipt (e.g., by phone, or SMS)	Within 1 business day of message sent
For all referrals - close the loop by Community Support Services Organization to confirm that Medicaid member utilized services	Within 10 business days of message sent
No Shows – if patient does not show up as per scheduled appointment, the provider sends the visit note to the referring provider with the clinical issue.	Urgent Referral - within 5 business days of the missed appointment Priority Referral – within 14 days of the missed appointment Routine Referral – within 28 days of the missed appointment

Also see Closed Loop Referral: Guidance Protocol

- Referral Type - Based on urgency of care required, the referral can be marked as:
  - Urgent Referral – immediate referral per phone
  - Priority Referral – Referrals that require the patient to be seen within 3-14 days (from referral sent to patient seen)
  - Routine Referral – Referrals that require the patient/client to be seen within 28 days (from referral sent to patient seen)

## Timely Communication: Protocol Submission

- If you are a CHSN-IDN 5 partner organization involved with a B1 Integrated Healthcare project that has either achieved Coordinated Care Designation (CCD) or has yet to complete the CCD milestones **there is no further information needed.**
- If your organization is using an alternate communication framework for your related CHSN-IDN 5 project work 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]

## Privacy: Guidance Protocol

Patient privacy protection is required for all workflows implemented under NH's 1115 DSRIP waiver. Much of the provision of care under the integrated model may be conducted with standard HIPAA policies, processes, and forms. A higher level of privacy protection is required for Medicaid members engaging in Substance Use Disorder Treatment as dictated by Federal 42 CFR Part 2 and for Medicaid members seeking care from Community Mental Health Centers.

CHSN-IDN 5 has developed "universal consent" documents unique to its region for all partners, to support and implement privacy protections for purposes of inter-organizational shared care planning and for evaluation/quality reporting:

- Guidance, language and/or universal forms (see below) were developed and shared with CHSN-IDN 5 practices in February 2018. The intent is for these to be used as a supplement to, in conjunction with and/or as a complete replacement of old forms. The new forms are inclusive of providing consent for purposes of shared care planning via Collective Medical Technologies. The developed forms shared with partners include:
  - Patient Notice of Privacy
  - Authorization and Consent to Disclose Protected Health Information for Non-Treating Providers
  - Authorization and Consent to Disclose Protected Health Information for Treating Providers
  - Prohibition on Re-Disclosure
  - Business Associate Agreement
  - Qualified Service Organization / Business Associate Agreement
  - Authorization to Discuss Health Matters with Family Members
- Data sharing agreements were incorporated as an addendum within the Memorandum of Understanding (MOU) between CHSN-IDN 5 and all partners
- Training on the use of newly developed forms were provided. Privacy webinars and individual meetings were offered.
- Training within each agency is encouraged for all staff responsible for capturing patient consents. It involves an understanding and education to patients that integrated care involves sharing of information. We reinforce that the clinician has a responsibility to initiate dialogue with the patient explaining why it is important to have a shared care plan, to listen to the patient's concerns and ideally, resolve them and ultimately obtain patient signature/consent on appropriate documents. Patient is informed of their right to revoke permissions to any/all members or agencies that are part of their care team at any time.

*For support and or questions regarding any of the above-mentioned forms and their use, please contact the CHSN-IDN 5 Executive Director, [REDACTED]*

In accordance with the 1115 waiver special terms and conditions, and the SAMHSA finalized proposed changes to the Confidentiality of Substance Use Disorder Patient Records regulation, 42 CFR Part 2 the privacy recommended protocols should include the following:

- Ability 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).
- Ability for additional disclosures of patient identifying information, with patient consent, to facilitate payment and healthcare operations such as claims management, quality assessment, and patient safety activities.
- Ability for additional disclosures of patient identifying information to certain contractors, subcontractors, and legal representatives for the purpose of conducting a Medicare, Medicaid, or CHIP audit or evaluation.
- Ability for permitting use of an abbreviated notice of prohibition on re-disclosure more easily accommodated in EHR text fields for users of electronic health records (EHRs).

*There is no submission format for this guidance protocol. CHSN-IDN 5 is working with all network partners for adherence to privacy regulation and guidance.*

CHSN-IDN 5 Dkt.

## Case Management Coordination: Guidance Protocol

There are likely multiple care coordinators, or similarly named care managers, case managers, etc. who may be involved in a Medicaid member's health management. These may include Payer/MCO care coordinators/case managers, CHSN-IDN 5 care coordinators and healthcare organization care coordinators/case managers fulfilling this role within an entity.

The CHSN-IDN 5 B1 Integrated Care practice designee(s) along with the E5 Enhanced Care Coordination Team will be accountable for the oversight of care coordination. She/he will determine the care coordination resources that are to be part of the integrated core team and the care coordinators who are to be kept informed of and updating information within the patient's shared care plan. Care coordinators are free to collaborate with their fellow care coordinators with consistent inter-professional confidentiality to address patients' needs related to social determinants of health and difficult cases may be discussed during monthly care coordinator team meetings.

## Case Management Coordination: Protocol Submission

- If your organization is using an alternate case management/care coordination communication framework for your related CHSN-IDN 5 project work and you have not engaged with the Enhanced Care Coordination Team around your process please follow the steps below:
  - Submit a one paragraph narrative regarding your organization's case management coordination framework to CHSN Project Manager, [REDACTED]

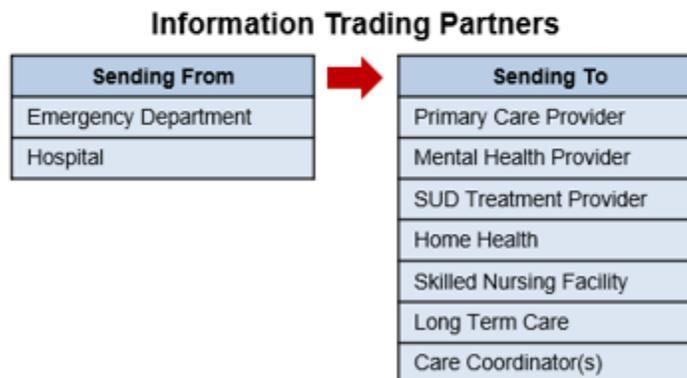
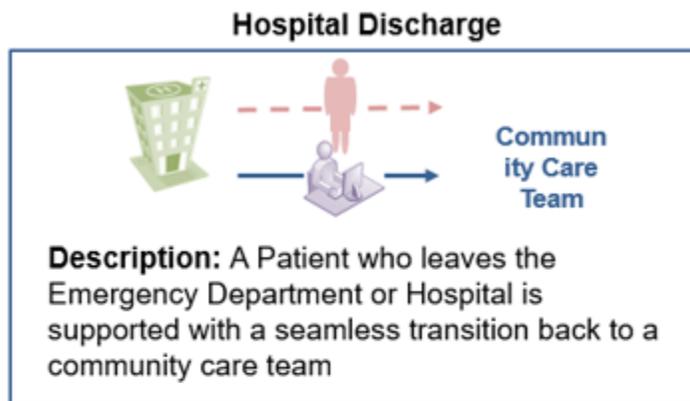
## Safe transitions (from institutional settings back to primary care, behavioral health and social support service providers): Guidance Protocol

CHSN-IDN 5 has worked with network partners to facilitate workflows for safe transitions from institutional settings back to primary care, behavioral health, and social support service providers. Many workflows existed and/or were developed within the respective community-driven project settings (i.e. C2 – Community Re-Entry, D3 – Expansion in Intensive Outpatient Program and E5 – Enhanced Care Coordination for High Need Populations). For specific workflows between agencies, please contact the CHSN-IDN 5 Admin Team.

Priority Information to Support Transitions:

- Current medication list – to enable medication reconciliation among all post-acute care providers and to prevent medication based adverse events.
- Recent history of what happened during the hospitalization, any new problems discovered, any procedures undergone, and any new history discovered.
- Instructions for who is to do what in a post-discharge hand-off between healthcare teams.

See Graphic below for guidance on Hospital Discharge Workflow:

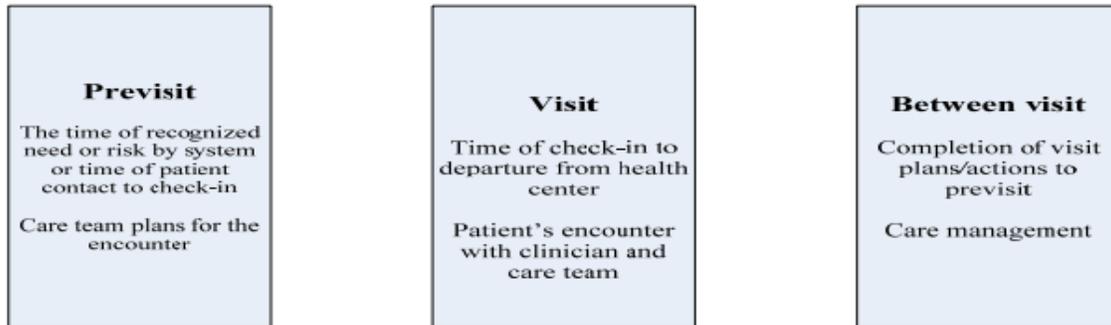


## Safe transitions (from institutional settings back to primary care, behavioral health and social support service providers): Protocol Submission

- If you are a CHSN-IDN 5 partner organization involved with a B1 Integrated Healthcare project that has achieved Coordinated Care Designation (CCD) or have yet to complete the CCD milestones **there is no further information needed**
- If your organization is using an alternate case management/care coordination communication framework for your related CHSN-IDN 5 project work and you have not engaged with the Enhanced Care Coordination Team around your process please follow the steps below:
  - Submit a one paragraph narrative regarding your organization process, tools used, level of information being shared, frequency of use information to CHSN Project Manager, 

CHSN-IDN 5 DRAFT

## Intake Procedures: Guidance Protocol



Work Domain (Pre-Visit, Visit, Between Visit)	Activity/Task	Multi-disciplinary Team Member
Pre-Visit	Assist patient to prepare for visit: <ul style="list-style-type: none"> <li>bring medications to visit</li> <li>prepare questions to ask provider</li> <li>come in for pre-visit lab tests</li> <li>invite family member/caregiver to visit if patient prefers</li> <li>confirm need for interpreter</li> </ul>	E.g., MA, receptionist
Visit-Before Pt/client arrives	Prepare intake packet in advance for each patient and place at the reception desk. <ul style="list-style-type: none"> <li>Pre-visit forms to identify patient goals for the visit</li> <li>Medication lists</li> <li>Patient-specific screens, E.g., CCSA</li> </ul> Huddle	E.g., MA, receptionist  E.g., Provider, MA, Nurse, BHC, Receptionist
Visit	Give intake form(s) to the patient: meds, allergies, family history, past medical history Assess patient's educational needs  Give med reconciliation list to patient and verify pharmacy  Help patients identify their goals for the visit and for their health Share care plan with Pt/client Provide appropriate educational/self-management tools for patient	E.g., MA, receptionist  E.g., MA, nurse or provider  E.g., Nurse or provider  E.g., MA, nurse or provider

	<p>Give after visit summary to patient and review with the patient</p> <p>Schedule patient for primary care follow-up, specialty appointments</p>	<p>E.g., receptionist</p>
Between Visits	<p>Follow-up on test results</p> <p>Monitor Health Maintenance and use Planned Care outreach process to help patients address gaps.</p> <p>Track all important appointments to completion</p> <p>Follow-up on missed appointments and/or referrals</p> <p>Schedule additional primary care and specialty appointments</p> <p>Routine care management/care coordination</p>	<p>E.g., nurse or provider</p> <p>E.g., MA, receptionist, patient navigator/community health worker</p> <p>E.g., referral coordinator</p> <p>E.g., referral coordinator</p> <p>E.g., care coordinator, nurse, social worker</p>

## Intake Procedures: Protocol Submission

- If you are a CHSN-IDN 5 partner organization involved with a B1 Integrated Healthcare project that has achieved Coordinated Care Designation (CCD) or have yet to complete the CCD milestones **there is no further information needed**
- If your organization is using an alternate framework for intake activities for your related CHSN-IDN 5 project work and you have not engaged with the IDN previously around your process please follow the steps below:
  - Submit a one paragraph narrative regarding your intake process, staff involved, timeline matrix and screenings used to CHSN Executive Director, [REDACTED]

## Adherence to NH Board of Medicine Guidelines on Opioid Use: Guidance Protocol

CHSN-IDN 5 Integrated Healthcare Partners are expected to be in adherence with the NH Board of Medicine's Opioid protocols. For further information on prescribing opioids for pain management, please refer to: <https://www.oplc.nh.gov/medicine/opioid-prescribing.htm>.

### The rules include the following:

- (a) use of written treatment agreements;
- (b) provision of information to patients on topics such as risk of addiction and overdose, and safe storage and disposal;
- (c) use and documentation of opioid risk assessments;
- (d) prescription of the lowest effective dose;
- (e) use of informed consent forms;
- (f) periodic review of treatment plans;
- (g) required clinical coverage; and
- (h) use of random and periodic urine drug testing for patients using opioids long term.

CHSN-IDN 5 will continuously help inform prescribers of their responsibilities under NH Law and Opioid rules. This includes connecting providers with resources offered by the State Government, the NH Medical Society, and multiple supporting organizations.

Specifically, CHSN-IDN 5 will promote use of the following resources with partners that are updating their processes for opioid prescribing:

- NH Board of Medicine Resources: <https://www.oplc.nh.gov/medicine/opioid-prescribing.htm>
- Final Rule: PART Med 502 Opioid Prescribing:  
<https://www.oplc.nh.gov/medicine/documents/med502-adopted.pdf>  
[https://www.nhms.org/sites/default/files/Pdfs/NH\\_BOM\\_opioid\\_rules\\_11-2-16.pdf](https://www.nhms.org/sites/default/files/Pdfs/NH_BOM_opioid_rules_11-2-16.pdf)
- Board-Approved Risk Assessment Tools: <https://www.oplc.nh.gov/medicine/opioid-prescribing.htm>
- Training and Continuing Medical Education opportunities:  
<https://www.oplc.nh.gov/medicine/opioid-prescribing.htm> <http://www.nhms.org/opioidcme>
- Checklist for the Prescribing of Opioids for the Management or Treatment of Pain.  
[https://www.nhms.org/sites/default/files/Pdfs/1-4-17\\_Opioid\\_Patient\\_Checklist\\_Med\\_502\\_Opioid\\_Prescribing\\_Rules.pdf](https://www.nhms.org/sites/default/files/Pdfs/1-4-17_Opioid_Patient_Checklist_Med_502_Opioid_Prescribing_Rules.pdf)
- New Hampshire Opioid Prescribing Resources from the NH Medical Society:  
<https://www.nhms.org/resources/opioid>
- Opioid Dose Calculator from the Agency Medical Directors' Group:  
<http://www.agencymeddirectors.wa.gov/Calculator/DoseCalculator.htm>

## Adherence to NH Board of Medicine Guidelines on Opioid Use: Protocol Submission

- If you are a CHSN-IDN 5 partner organization involved with a B1 Integrated Healthcare project that has achieved Coordinated Care Designation (CCD) or you have yet to complete the CCD milestones **there is no further information needed**
- If your organization is providing primary care services, MAT services, or involved in the treatment of SUD services and you have not engaged with the IDN previously around your adherence to the NH Board of Medicine Guidelines on Opioid Use please follow the steps below;
  - Submit a one paragraph narrative regarding your organization Guidelines on Opioid Use adherence process to CHSN Executive Director, [REDACTED]

CHSN-IDN 5 DRAFT

## Joint Service and Communication Channels with Community Based Social Service Providers: Guidance Protocol

CHSN-IDN 5 has worked with its Integrated Healthcare Partners to encourage formalization of joint service and communication channel practices between primary care, behavioral health, and community based social support service providers. CHSN-IDN 5 has emphasized that when interoperability and delivery system transformation are embraced, the goal of improving population health across care settings and provider organizations is more likely to occur. Given many workflows and protocols already existed, some were refined or are embedded within larger overarching protocols or work plans. For those practices who do not have existing joint service and communication channel protocols in place, CHSN-IDN 5 can provide a Collaborative Care Agreement template that can be easily adapted and edited to fit all B1 Integrated Healthcare partner and community based social service provider needs.

Additionally, with CHSN-IDN 5 B1 Integrated Healthcare partners implementing the use of CMT software, it widely and naturally supports communication channels through its capabilities for shared care planning, care coordination, hospital ED event notification, being a collection site for social determinants of health data among the partners in our region and across the state. The use of CMT not only increases collaboration and interoperability between clinical and social service partners in communities, but is already proving successful in better addressing patients' social determinants of health and reducing avoidable hospital use.

## Joint Service and Communication Channels with Community Based Social Service Providers: Protocol Submission

- If you are a CHSN-IDN 5 partner organization involved with a B1 Integrated Healthcare project and your practice has a joint service and communication channels protocol in place for community social service providers **there is no further action required**
- If your organization does not have a formalized joint service and communication channel with community based social service providers protocol(s) in place, please follow the steps below:
  - Contact CHSN Executive Director, [REDACTED] to obtain the CHSN-IDN 5 *Collaborative Care Agreement* template to adapt for your individual practice needs.

COMMUNITY HEALTH SERVICES NETWORK  
INTEGRATED DELIVERY NETWORK 5  
“CHSN-IDN 5”

Comprehensive Core Standardized Assessment (CCSA)  
Protocol

V1.0 December 2018

## What is a CCSA?

A comprehensive core standardized assessment (CCSA) is a patient evaluation administered in an office setting to ascertain additional patient needs that relate to the patient's medical care. Examples of these needs include housing, transportation, social, legal, and behavioral (to name a few). These domains of the CCSA can have a large effect on the care and treatment that a provider is able to give to their patient and also has an effect on the patient's access and ability to be treated.

As part of the 1115 DSRIP waiver, CHSN-IDN 5 B1 project coordinated and integrated care sites are required to administer a CCSA to all members (ages 12+) with a Medicaid payer. The purpose of the CCSA is to identify social determinants of health that may affect a member's care and to address issues related to these social determinants of health to improve the member's care and overall well-being. Though the implementation of the CCSA is directly related to the 1115 DSRIP Medicaid waiver, it is suggested policy that the CCSA be performed on all patients who enter an office setting within the IDN. Additionally, the CCSA should be given at least once per year to any Medicaid members/patients but may be given additionally as circumstances change for the patients.

## Domains of a CCSA

### **Domain 1 – Demographics**

For this domain, we expect our organizations to collect the following fields at a minimum for purposes of reporting CCSA completion to DHHS: first name, last name, address, city, state, zip code, gender, and date of birth, and Medicaid ID. Additional fields that could also be collected and would prove helpful to CHSN-IDN 5 data collection would be phone number, race, ethnicity, and social security number.

### **Domain 2 – Physical Health Review**

Most organizations with primary care conduct a physical health review with their patients that will satisfy the requirements of this domain. For organizations that are not typically accustomed to performing a full physical review of the patient (such as mental health clinics or SUD treatment centers), the following question(s) will suffice to satisfy this domain.

- Are there any new health concerns or developments since your last visit with us?
  - o If the answer is yes and the patient doesn't have an identified primary care physician, offer the patient a referral to applicable sources for treatment.
- Please rate your health in the past 30 days – (Excellent, Very Good, Good, Fair, Poor)
  - o An answer of "Fair" or "Poor" should trigger additional questions specifically concerning the reason for the patient's answer.

### **Domain 3 – Activities of Daily Living and Cognitive Function Assessment**

The purpose of this domain is to assess the ability of the assessed individual to take care of their self and perform daily activities of living. For the ADL/cognitive function assessment, we recommend the following

## Attachment\_B1.8A

tools below though many there are many other forms of these screenings that may be more appropriate based on an organization's EHR tool.

Activities of Daily Living Screening

(<https://www.alz.org/careplanning/downloads/lawton-iadl.pdf>) (Attachment 1)

Cognitive Assessment

([https://www.alz.org/documents\\_custom/141209-CognitiveAssessmentToo-kit-final.pdf](https://www.alz.org/documents_custom/141209-CognitiveAssessmentToo-kit-final.pdf)) (Attachment 2)

### Domain 4 – Substance Use

It is a requirement of the waiver and the CCSA that SBIRT is a part of the CCSA. There are resources within the IDN to train any partners who are not experienced in administering SBIRT. Below is an in-depth guide to SBIRT, which includes the AUDIT tool, the recommended tool of CHSN-IDN 5.

Reference Guide to SBIRT

<http://www.masbirt.org/sites/www.masbirt.org/files/documents/toolkit.pdf> (Attachment 3)

### Domain 5 – Housing

The following question(s) will suffice to satisfy this domain.

- “Are you worried that in the next two months, you may not have stable housing?”
  - o An answer of “yes” to this question will refer the respondent to a care coordinator who will work with the client to find housing resources.

### Domain 6 – Family and Support Services

Social isolation and family support can be especially important to vulnerable individuals dealing with SUD and/or mental health issues. Included in this domain is a question related to lack of transportation which is one of the most common issues that our vulnerable population are facing in this region. The following question(s) will suffice to satisfy this domain.

1. “Do you have someone that you can call if you need help?”
2. “Do problems getting child care make it difficult for you to work or study?”
3. “In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?”
4. “In the last 12 months, are you or have you been threatened or abused physically, emotionally, or sexually by a partner, spouse, or family member?”

### Domain 7 – Education

Education relates both to level of schooling as well as literacy in reading English and/or understanding health forms, pamphlets, and other reading materials. The following question(s) will suffice to satisfy this domain.

1. “What is the highest level of school you have completed?”

## Attachment\_B1.8A

- a. Did not complete High School
  - b. High School or GED
  - c. Trade School
  - d. Associates
  - e. Bachelor's
  - f. Master's
  - g. PHD
2. "Do you need any help reading health-related materials?"

## Domain 8 – Employment

If the patient indicates they are unemployed, there should be a follow-up question to see whether they are actively seeking employment and would like to be speak with a care coordinator for employment assistance.

1. "What was your main activity during most of the last 12 months?"
  - a. Worked for pay
  - b. Attended school
  - c. Household duties
  - d. Unemployed
  - e. Permanently unable to work
  - f. Other

## Domain 9 – Access to Legal Services

The following question(s) will suffice to satisfy this domain.

1. Do you have any legal issues that are getting in the way of your health or healthcare?"

## Domain 10 – Suicide Risk

PHQ-2 (score of 2 or higher) followed by PHQ-9 (score of 10 or higher) followed by Suicide Risk Assessment (*Example, refer to SAFE-T Protocol w/C-SSRS - Attachment 4*)

## Domain 11 – Developmental Screening

**Children under 12** must get ASQ:3 and/or ASQ SE at 9, 18, and 24/30 month pediatric visits; and use Bright Futures or other American Academy of Pediatrics developmental screening. Below are examples of the tools that we recommend for these patients.

ASQ:3 <http://agesandstages.com/wp-content/uploads/2015/02/asq-3-48-month-sample.pdf>

Bright Futures: <https://brightfutures.aap.org/materials-and-tools/tool-and-resource-kit/Pages/default.aspx>

## Collaborative Care Agreement Template

The primary care practice of (*Primary Care Practice Name*) and (*Specialty Practice Name*) has developed a Collaborative Care Agreement. This agreement is based on the following agreed upon collaborative care guidelines.

### Collaborative Guidelines

#### I. Purpose

- To provide optimal health care for our patients
- To provide a framework for better communication and safe transitions of care between primary care and behavioral health care providers

#### II. Principles

- Safe, effective, and timely patient care is our central goal.
- Effective communication between primary care and behavioral health care is essential to providing optimal patient care and to eliminate the waste and excess costs of health care.
- Mutual respect is essential to building and sustaining a professional relationship and working collaboration.
- A high functioning medical system of care provides patients with access “to the right care, at the right time, in the right place”.

#### III. Definitions

- Primary Care Physician (PCP) – a generalist whose broad medical knowledge provides first contact and comprehensive continuous medical care to patients.
- Specialist (Psychiatrist) – a physician with advanced/focused knowledge and skills who provides care for patients with complex problems in a specific organ system, class of disease, or type of patient.
- Prepared Patient – an informed and activated patient who has an adequate understanding of their present health condition in order to participate in medical decision-making and self-management.
- Care Manager – An individual who uses evidence-based guidelines and assessment tools to identify high risk patients in the primary care practice. The CM then facilitates patient care through the complex health system according to PCMH principals including but not limited to:
  - i. Whole person orientation
  - ii. Coordinated and/or integrated care
  - iii. Quality and safety
  - iv. Enhanced access
- Behavioral Health Navigator – a social worker who works as a team member with a Nurse Navigator and the patient’s primary care provider to assist the patient in negotiating the complex health care system

## Attachment\_B1.9D

- Nurse Navigator – an RN who works as a team member with the Behavioral Health Navigator and the patient’s primary care provider to assist the patient in negotiating the complex health care system
- Patient-Centered Medical Home – a community-based and culturally sensitive model of primary care that ensures every patient has a personal physician who guides a team of health professionals to provide the patient with accessible, coordinated, comprehensive, and continuous health care across all stages of life.
- Patient Goals – health goals determined by the patient after thorough discussion of the diagnosis, prognosis, treatment, and expectations taking into consideration the patient’s psychosocial and personal needs.
- Medical Neighborhood – a system of care that integrates the PCMH with the medical community through enhanced, bi-directional communication and collaboration on behalf of the patient.

### iv. Types of Transitions of Care

- Pre-consultation exchange – communication between the PCP and Health Options Social Worker to
  - i Answer a clinical question and/or determine the necessity of a formal consultation.
  - ii Facilitate timely access and determine the urgency of referral to specialty care.
  - iii Facilitate the diagnostic evaluation of the patient prior to a specialty assessment.
- Formal Consultation (Advice) – a request for an opinion and/or advice on a discrete question regarding a patient’s diagnosis, diagnostic results, procedure, treatment or prognosis with the intention that the care of the patient will be transferred back to the PCP after one or a few visits. The specialty practice would provide a detailed report on the diagnosis and care recommendations but not manage the condition. This report may include an opinion on the appropriateness of co-management.
- Complete transfer of care to specialist for entirety of care (Specialty Medical Home Network) – due to the complex nature of the disorder or consuming illness that affects multiple aspects of the patient’s health and social function, the specialist assumes the total care of the patient and provides first contact, ready access, continuous care, comprehensive and coordinated medical services with links to community resources.
- Co-management – where both primary care and specialty care providers actively contribute to the patient care for a medical condition and define their responsibilities including first contact for the patient, drug therapy, referral management, diagnostic testing, patient education, care teams, patient follow-up, monitoring, as well as, management of other medical disorders.
  - i Co-management with shared management for the disease – the specialist shares long-term management with the primary care physician for a patient’s referred condition and provides expert advice, guidance, and periodic follow-up for one specific condition. Both the primary care and specialty practice are responsible to define and agree on mutual responsibilities regarding the care of the patient. In general, the specialist will provide expert advice, but will not manage the condition on a day to day basis.

**Attachment\_B1.9D**

- ii. Co-management with Principal Care for the Disease (Referral) – the specialist assumes responsibility for the long-term, comprehensive management of a patient’s referred medical/surgical condition. The primary care practice continues to receive consultation reports and provides input on secondary referrals and quality of life/treatment decision issues. The PCP continues to care for all other aspects of patient care and new or other unrelated health problems and remains the first contact for the patient.
- iii. Co-management with Principal Care for the Patient (Consuming illness) – this is a subset of referral when for a limited time due to the nature and impact of the disease, the specialist practice becomes first contact for care until the crisis or treatment has stabilized or completed. The primary care practice remains active in bi-directional information, providing input on secondary referrals, and other defined areas of care.
- iv. Emergency Care – medical or surgical care obtain on an urgent or emergent basis.

**v. Mutual Agreement for Care Management**

- Review tables and determine which services you can provide.
- The *Mutual Agreement* section of the tables reflects the core element of the PCMH and Medical Neighborhood and outline expectations from both primary care and specialty care providers.
- The *Expectations* section of the tables provides flexibility to choose what services can be provided depending on the nature of your practice and working arrangement with PCP or Behavioral Health.
- The *Additional Agreements/Edits* section provides an area to add, delete or modify expectations. After appropriate discussion, the representative provider checks each box that applies to the commitment of their practice.
- When patients self-refer to Behavioral Health, processes should be in place to determine the patient’s overall needs and reintegrate further care with the primary care practice, as appropriate.
- The agreement is waived during emergency care or other circumstances that preclude following these elements in order to provide timely and necessary medical care to the patient. Each provider should agree to open dialogue to discuss and correct real or perceived breaches
- Each provider should agree to open dialogue to discuss and correct real or perceived breaches of this agreement, as well as, on the format and venue of this discussion.
- Optimally, this agreement should be reviewed every 2 years.

Transition of Care
<i>Mutual Agreement</i>
<ul style="list-style-type: none"><li>• Maintain accurate and up-to-date clinical record.</li><li>• When available and clinically practical, agree to standardized demographic and clinical information format such as the Continuity of Care Record (CCR) or Continuity of Care Document (CCD).</li></ul>

**Attachment\_B1.9D**

<ul style="list-style-type: none"> <li>• Ensure safe and timely transfer of care of a prepared patient.</li> </ul>	
<i>Expectations</i>	
Primary Care	Behavioral Health
<p>PCP maintains complete &amp; up-to-date record including demographics Transfers information as outlined in Patient Transition Record</p> <p>Orders appropriate studies that would facilitate the Behavioral Health visit</p> <p>Provides patient with Behavioral Health contact information &amp; expected timeframe for appointment</p> <p>PCP Care Manager facilitates the Transition of Care by communicating directly with the Behavioral Health Social Worker to plan a strategy for the transition.</p> <p>Patient/family are in agreement with the referral, type of referral &amp; selections of specialist</p>	<p>Determines &amp;/or confirms insurance eligibility</p> <p>Identifies a specific referral contact person to communicate with in the PCP office</p> <p>Assist PCP prior to the appointment regarding appropriate pre-referral work-up</p> <p>Informs patient of need, purpose, expectations &amp; goals of transfer</p>

Access	
<i>Mutual Agreement</i>	
<ul style="list-style-type: none"> <li>• Be readily available for urgent help to both the physician and patient</li> <li>• Provide adequate visit availability</li> <li>• Be prepared to respond to urgencies</li> <li>• Offer reasonably convenient office facilities and hours of operation</li> <li>• Provide alternate back-up when unavailable for urgent matters</li> <li>• When available and clinically practical, provide a secure email option for communication with established patients and/or providers</li> </ul>	
<i>Expectations</i>	
Primary Care	Behavioral Health
<p>Communicate with patients who miss appointments to Behavioral Health</p> <p>Determines reasonable time frame for specialist appointment</p>	<p>Notifies PCP of missed appointments or other actions that place patient jeopardy</p> <p>Schedule patient's first appointment with requested provider</p> <p>Provide PCP with a list of practice physicians who agree to agreement principles</p>

<b>Patient Communication</b>	
<b><i>Mutual Agreement</i></b>	
<ul style="list-style-type: none"> <li>• Consider patient/family choices in care management, diagnostic testing &amp; treatment plan</li> <li>• Provide information to &amp; obtain consent from patient according to community standards</li> <li>• Explore patient issues on quality of life in regards to their specific medical condition &amp; shares this information with the care team</li> </ul>	
<b><i>Expectations</i></b>	
Primary Care	Behavioral Health
<p>Explains, clarifies, &amp; secures mutual agreement with patient on recommended care plan</p> <p>Assists patient in identifying their treatment goals</p> <p>Engages patient in the PCMH concept and identifies whom the patient wishes to be included in their care team</p>	<p>Informs patient of diagnosis, prognosis &amp; follow-up recommendations</p> <p>Provides educational material &amp; resources to patient when appropriate</p> <p>Recommends appropriate follow-up with PCP</p> <p>Be available to the patient to discuss questions or concerns regarding the consultation of their care management</p> <p>Participates with patient care team</p>

<b>Collaborative Care Management</b>	
<b><i>Mutual Agreement</i></b>	
<ul style="list-style-type: none"> <li>• Define responsibilities between PCP, Behavioral Health, and patient</li> <li>• Clarify who is responsible for specific elements of care (drug therapy, referral management, diagnostic testing, care teams, patient calls, patient education, monitoring, and follow-up</li> <li>• Maintain competency and skills within scope of work &amp; standard of care</li> <li>• Give &amp; accept respectful feedback when expectations, guidelines or standards of care are not met</li> <li>• Agree on type of care that best fits the patient's needs</li> </ul>	
<b><i>Expectations</i></b>	
Primary Care	Behavioral Health

**Attachment\_B1.9D**

<p>Follows principles of PCMH</p> <p>Manages Behavioral Health problem to the extent of the PCP’s scope of practice, abilities &amp; skills</p> <p>Follows standard practice guidelines related to evidence-based guidelines</p> <p>Resumes care of the patient as outlined by Behavioral Health &amp; incorporates care plan recommendations into overall care of the patient</p> <p>Shares data with Behavioral Health in a timely manner including data from other providers</p>	<p>Review information sent by PCP; address provider &amp; patient concerns</p> <p>Confer with PCP &amp; establish protocol before ordering additional services outside of practice guidelines</p> <p>Confers with PCP before referring to other specialists; uses preferred provider list</p> <p>Sends timely reports to PCP; shares data with care team</p> <p>Notifies PCP of major interventions, emergency care, &amp; hospitalizations</p>
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**Additional Agreement Addendums/Edits, please insert in space below**

CHSN-IDN 5 DRAFT

**PLYMOUTH PEDIATRIC & ADOLESCENT MEDICINE  
LIST FOR PSYCHOLOGIST / THERAPIST REFERRALS**

<b>NAME</b>	<b>COMMENTS</b>	<b>LOCATION</b>	<b>PHONE/CONTACT</b>
<b>Alexander DeNesnera, MD</b>	Interim Chief Medical Officer for New Hampshire Hospital	Concord	271.5300
<b>Ashland Play Therapy DeeDee Nold MA,MSW, LICSW, LCSW, RPT-S</b>	Age 18mo-14YR Deedeenold.com	Ashland	Cell: 239.370.1127 536.1933
<b>Bahder Behavioral Services</b>	Psychologist	Gilford	293.0026
<b>CADY</b>	Communities for Alcohol and Drug Free Youth	Plymouth	536.9793
<b>Celia Woolverton LICSW, LCSW, MSW</b>	Ages 8 and up Macleish & Woolverton Psychotherapist/Mediation and Conflict Resolution	Waterville Valley	236.6687
<b>Center for Eating Disorders</b>	Outpatient Treatment	Bedford	472.2846
<b>Concord Psychiatric Associates</b>	Concord Hospital	Concord	228.7100
<b>Dorothy Derapelian, M.ed, LCMHC</b>	Core Attachment Therapy, Play Therapy, and Counseling	Meredith	279.8169
<b>Edward Kahn, MD</b>	Psychiatrist "Mindful Ways"	North Conway	356.3100
<b>Elizabeth Lachapelle Ph.D.</b>	Clinical Psychologist (Quieter)	Plymouth	536.5223
<b>Erinn Fellner</b>	Adult but will consider 16/17 yr olds. At Speare Primary Care 2 days/week and has private practice. Autism and ADHD evals.	Plymouth	
<b>Gail Mears</b>	Whole Village	Plymouth	536.3720 x3
<b>Genesis</b>	Area Agency- Children, Adult, and Emergency Services	Plymouth	536.1118
<b>Holly Cerdarstrom, LCMHC</b>	Older Adolescents and Adults	Meredith	279.8209
<b>Horizons</b>	Counseling/ Drug and Alcohol Help	Gilford/ Plymouth (Whole Village)	G: 524.8005 P: 536.2010

**PLYMOUTH PEDIATRIC & ADOLESCENT MEDICINE  
LIST FOR PSYCHOLOGIST / THERAPIST REFERRALS**

<b>Jan Quintal Ph.D.</b>	School Age/Learning Issues	Plymouth	536.4787
<b>Jeanette Nogales, LCMHC</b>		Plymouth	568.8839
<b>Ken Little</b>			236.6893
<b>Lorraine Jones, LCMHC</b>	Works with Stacey	Plymouth	254.6301
<b>Margaret Buff, ARNP</b>	Over age 18	Plymouth	244.3646
<b>Matthew Beyer, LCMHC</b>	“Unlimited Potential” Families, Children, and Adolescents (Ages 6-19)	Plymouth	238.3270 Cell 254.6640 Free Consult: 287.4184
<b>Mid-State Health</b>	For their patients only	Plymouth	536.4000
<b>Nancy Strapko, Ph.D.</b>	Psychotherapist	Plymouth	536.1306
<b>Phoenix House</b>	Comprehensive Substance Abuse- Outpatient, residential, partial hospitalization	Dublin/ Keene	1.888.286.5027 NH: 1 844-416-3172 <a href="mailto:anherrick@phoenixhouse.org">anherrick @phoenixhouse.org</a>
<b>Regina (Gina) Kelley, Psychiatric Nurse Practitioner</b>	Adults Only- works at PSU and in private practice. Combines Eastern/Western philosophies.	Plymouth	536.1020
<b>Rob Uhlman, LRMHC</b>	“Horizons” Adjunct Faculty at PSU- many services: Drug and Alcohol counseling, Autism, Brain Injuries, etc.	Plymouth	536.2010
<b>Stacey Redman, M.ed</b>	High School Age- Family and Marriage counseling	New Hampton	726.1109
<b>Stephanie Gould, M.ed LCMHC</b>	Accepts HKG or a \$50 fee	Conway	726.6695
<b>Stephen Catalano, MD</b>	Psychologist	Gilford	528.3116
<b>Warren Street Family Counseling</b>	Many services to many ages	Concord	226.1999

**PLYMOUTH PEDIATRIC & ADOLESCENT MEDICINE  
LIST FOR PSYCHOLOGIST / THERAPIST REFERRALS**

<b>White Mountain Mental Health</b>	Adult and Children mental health and developmental disability	Conway	444.5358
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<http://findtreatment.samhsa.gov/>

**IDN 5 – C2 Corrections Re-entry Project**

**INTERAGENCY CARE COORDINATION POLICY**

**Title:** Interagency Care Coordination Policy

**Effective date:** 12/01/2018

**Purpose:** To establish guidelines for the coordination of care for those clients to be served jointly by Horizons Counseling Center, Lakes Region Mental Health Center, Navigating Recovery of the Lakes Region and the Plymouth Area Recovery Community.

**Offenders may be referred to the C2 Release and Reintegration Program by the Court, the Division of Field Services in Laconia, Concord or Plymouth, the Belknap County Department of Corrections Medical Department, Community Corrections Case Manager, the Programs Director or the Corrections Opportunity for Recovery and Education Program (CORE).**

**Procedures: CORE Referrals**

The CORE program is a 4 Phase program consisting of 3-4 months of assessment and intensive group and individual counseling for substance use and co-occurring mental health disorders (Phase I), followed by a period of Work Release (Phase 2), a period of release on electronic monitoring (Phase 3) and then 1 year of continuing treatment and supervision on probation in the community.

- A. Participants in the CORE program receive an assessment at intake and establish short-term treatment goals with their primary counselor.
  - a. Phase I is comprised of group and individual counseling, recovery support services, life skills education, mindfulness, job skills, educational activities and community based peer support
  - b. While in Phase 2, participants are involved in recovery support services, counseling, educational activities and community based peer support when not at work.
  - c. In Phase 3, participants begin to transition their services into the community settings.
    - i. Before leaving the Community Corrections Center on electronic monitoring, participants meet with the Community Corrections Officer to establish rules of release and with the CORE program case manager to assess their behavioral health, medical, educational, housing, health insurance, childcare, transportation, etc. needs and to set up services in the community to address those needs.
- B. The CORE Case Manager and the CORE Team will identify whether a participant's primary needs fall into the area of substance use and co-occurring disorders or in the area of mental health.
  - a. Clients with primary substance use needs will be paired with a Horizons Care Coordinator
  - b. Clients with primary mental health needs will be paired with a Lakes Region Mental Health Center Care Coordinator.
  - c. The CORE case manager will transition responsibility for the care management and coordination of the CORE participants to the appropriate IDN C2 Care Coordinator.
    - i. The CORE participant will be asked to sign a consent to permit communication between the Belknap County DOC, including the CORE Case Manager and the Community Correction Officer and Horizons, Lakes Region Mental Health Center, Navigating Recovery, Health First (or other PCP as identified by the client), Lakes Region Community Services Family Resource Center (when indicated), DCYF (when indicated) and all other treating providers as identified in the exit interview.
    - ii. The CORE participant will be asked to sign a consent to permit communication between the Care Coordination team, all treating providers and the Division of Field Services to

Date Originated 12/01/2018

- allow for ongoing coordination of services with probation supervision.
- iii. The CORE participant will be asked to sign consent for his/her information to be released to into the Massachusetts eHealth Collaborative for the purpose of data collection and storage and with CMT and to Collective Medical Technologies, Inc. (CMT) for the purpose of case management and care coordination.
- d. The Care Coordinator will meet with each CORE participant at least 30 days prior to their release from the jurisdiction of the House of Corrections to review, update and revise the care plan developed with the CORE Case Manager prior to the client's release on electronic monitoring.
  - i. The Care Coordinator will contact each treating provider and other service provider involved with the client to introduce him/herself, explain his/her role as Care Coordinator and how s/he can assist with client engagement in necessary services.
- e. The care coordinator will meet with each client at regular established interviews based on the individual needs of the client and level of risk for recidivism to review the care plan for need for revision, to identify the effectiveness of services being provided and to identify new services, if any that may be indicated.
- f. The Care Coordinator will assist the client with setting up and following through with medical and behavioral health appointments, with transportation, housing, education, employment and other social and economic assistance needs that may arise.
- g. The care coordinator will receive reports of issues regarding lack of follow-through by a client in order to identify and address barriers to follow-through and facilitate re-engagement.

#### **Procedures: Non-Core Referrals**

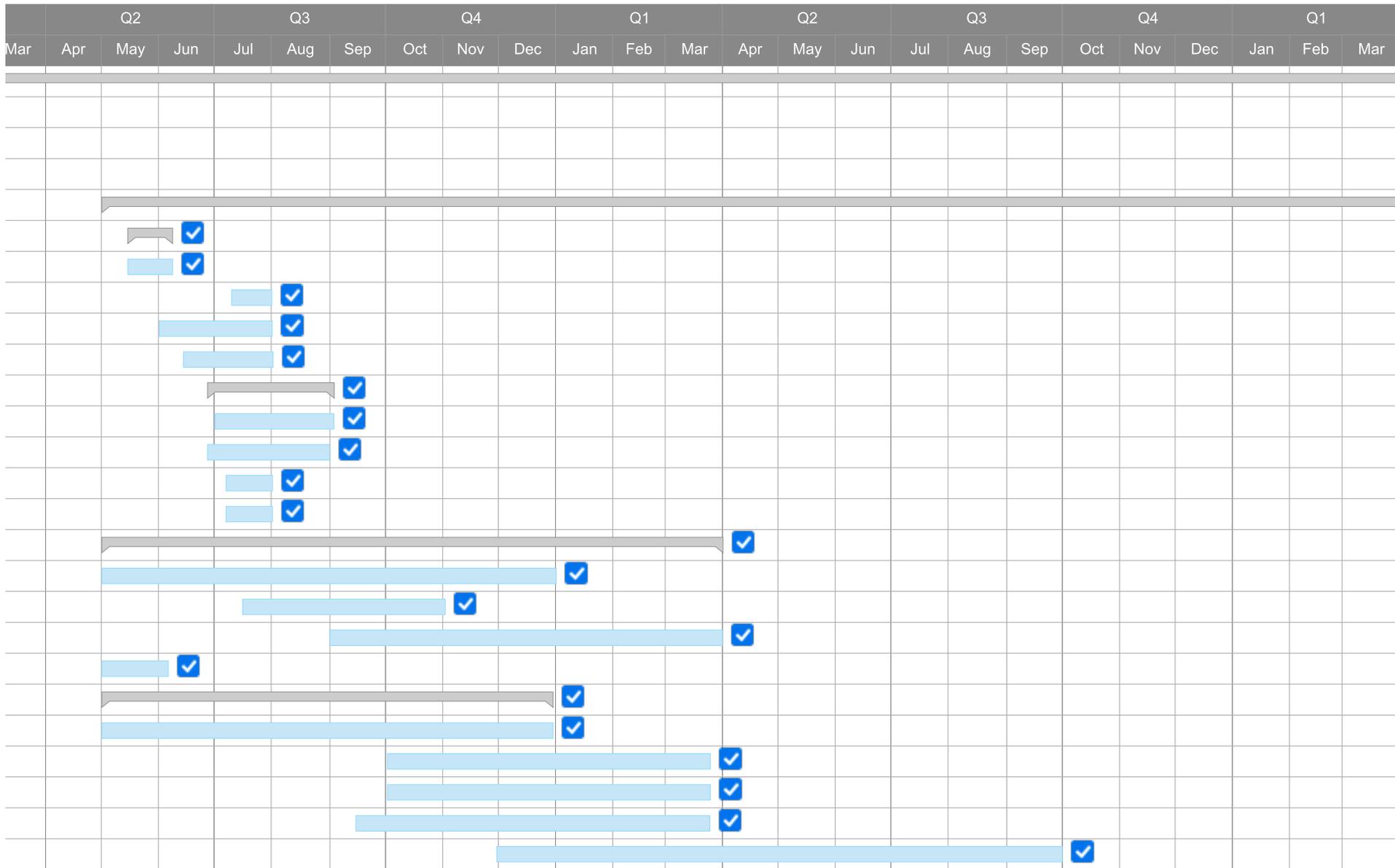
- A. Offenders may be referred to the C2 Re-entry and Reintegration Program by:
  - a. The Programs Director of the Belknap County DOC
  - b. Nursing staff at the Belknap County DOC
  - c. The Community Corrections Officers at the Belknap County DOC
  - d. Behavioral Health Provider at the Belknap County DOC
  - e. The Division of Field Services Probation Parole Officers within the catchment area of IDN 5
- B. The Behavioral Health Provider at the Belknap County DOC will review the release date log of all sentenced inmates to identify those inmates being released from confinement within 3 months and provide a list of those inmates on a weekly basis to the C2 Team.
  - a. The C2 Team will be comprised of:
    - i. The Horizons Counseling center and the Lakes Region Mental Health Center Care Coordinators
    - ii. A male and a female Recovery Coach/CRSW from Navigating Recovery of the Lakes Region
    - iii. The CORE Program counselors, Case Manager and Counselor/Case Manager
    - iv. The Belknap County DOC Programs Director
    - v. A DOC nurse
    - vi. A Community Corrections Officer
    - vii. A Sargent of the Community Corrections Center
  - b. The Behavioral Health Provider, with input from the Team, will preliminarily determine whether an inmate is more appropriate for a Care Coordinator from Horizons or from Lakes Region Mental Health Center.
  - c. The designated Care Coordinator will meet with the inmate no later than 30 days prior to the projected release date and assess the offender's medical, behavioral health (including mental health and substance use disorder) treatment and recovery needs and develop a re-entry plan with the offender.



# C2 Community Re-entry (IDN 5)

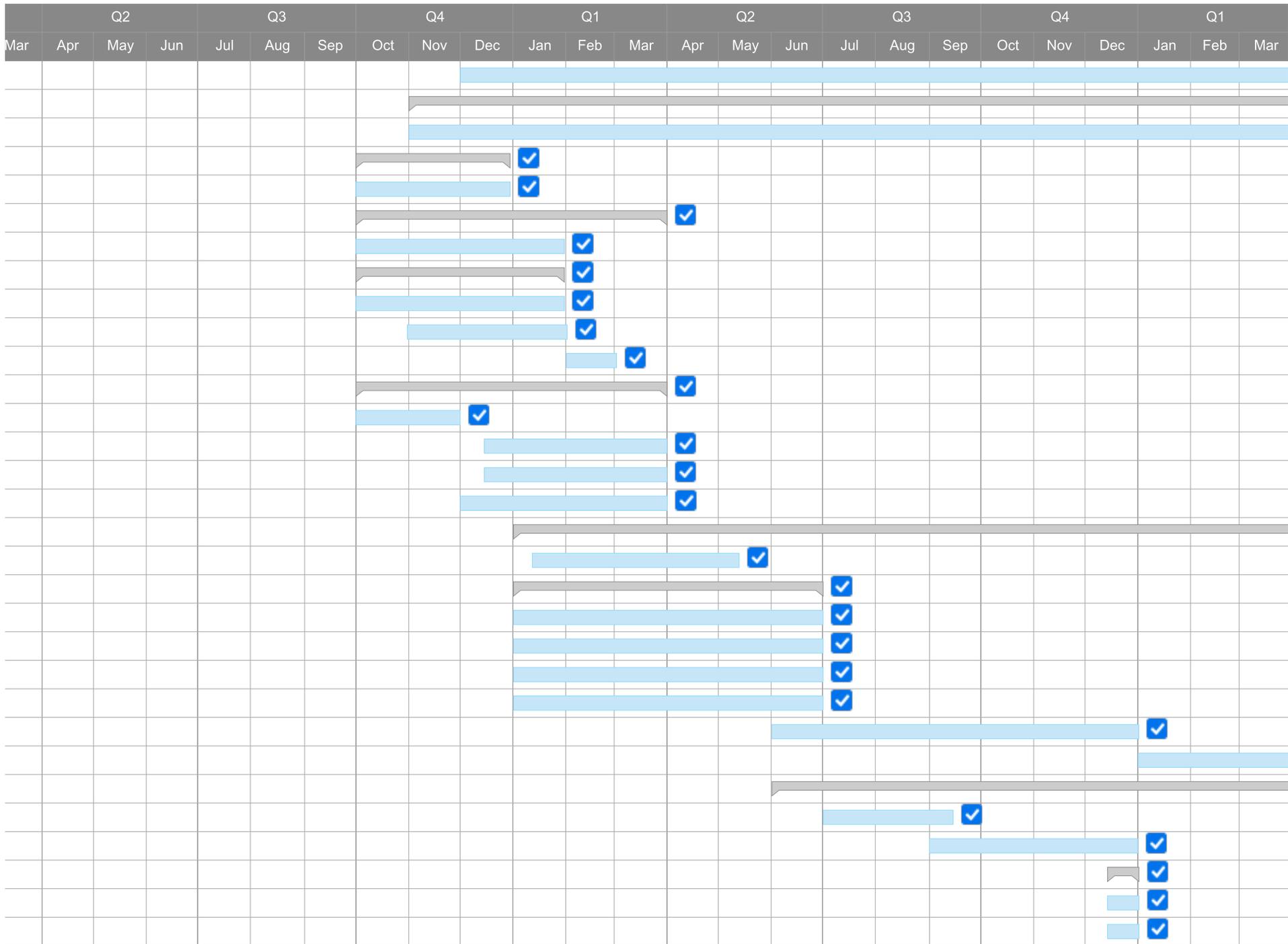
Attachment\_C1.B

Tasks		Q4			Q1	
		Oct	Nov	Dec	Jan	Feb
1	<input type="checkbox"/> Planning					
2	Establish Re-Entry 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	<input type="checkbox"/> Develop implementation plans					
6	<input type="checkbox"/> Develop workforce plan					
7	Develop staffing plan					
8	Identify projected annual client engagement					
9	Develop implementation timeline					
10	Develop project budget					
11	<input type="checkbox"/> Design/develop Re-Entry Care Transition Team infrastructure					
12	Document and submit to CHSN protocol/workflow with corrections facility on identification of individuals who are within 3 m					
13	Identify roles and responsibilities for team members and submit to CHSN					
14	Identify training curricula needed by provider type					
15	Develop a training plan					
16	<input type="checkbox"/> Identify/develop patient management protocols/workflows					
17	Develop process to ensure compliance with Privacy/Confidentiality requirements					
18	Develop protocol for recovery coach pairing pre-release ans submit to CHSN					
19	Develop process to assist patient in Medicaid/Health insurance enrollment pre-release					
20	Identify current assessment tool(s) being used					
21	<input type="checkbox"/> Identify/develop patient assessment and treatment protocols and submit to CHSN					
22	Develop and submit Recovery Wellness Plan process					
23	Identify family/support system engagement and communication process and submit to CHSN					
24	Develop and submit to CHSN pre-release needs assessment for external supports					
25	Identify/develop transition plan and referral process and submit to CHSN					
26	Develop inter-organizational care coordination protocols and submit to CHSN					





Tasks		Q4			Q1	
		Oct	Nov	Dec	Jan	Feb
27	Develop procedure for data collection and sharing and inform CHSN					
28	<input type="checkbox"/> Develop evaluation plan including key metrics					
29	Develop tracking mechanism and submit to CHSN					
30	<input type="checkbox"/> Identify/develop and submit to CHSN licensure and certification pathway for recovery supports					
31	Submit plan to CHSN of how Horizons is supporting licensure of key staff					
32	<input type="checkbox"/> Operational Phase 1					
33	Initiate recruitment process for identified staffing needs					
34	<input type="checkbox"/> Deployment of training plan					
35	Train key personnel in privacy/confidentiality requirements					
36	Implement use of assessment, treatment, management, referral protocols					
37	Implementation of any required updates to clinical protocols or other operating policies/procedures					
38	<input type="checkbox"/> Implement procedures for data collection and sharing					
39	Establish data sharing agreements with participating organizations					
40	Collect number of individuals served vs. projected (for reporting period & cumulative)					
41	Collect number of staff recruited and trained vs. projected (for reporting period & cumulative)					
42	Collect data per DHHS data collection					
43	<input type="checkbox"/> Reporting period Jan-Jun 2018					
44	Implementation of any required updates to clinical protocols or other operating policies/procedures					
45	<input type="checkbox"/> Ongoing data reporting					
46	Collect number of individuals served vs. projected (for reporting period & cumulative)					
47	Collect number of staff recruited and trained vs. projected (for reporting period & cumulative)					
48	Collect staff vacancy and turnover rate for period & cumulative vs. projected					
49	Collect data on impact measures as defined in evaluation plan					
50	Continue to develop relationship with Grafton County Department of Corrections					
51	Initiate referral mechanism and continuing care coordination and transitional supportive case management in partnership with Gr					
52	<input type="checkbox"/> Reporting period Jul-Dec 2018					
53	Identify trainees for Justice System and build into Master Training plan A1					
54	Initiate training/educational opportunities to Justice System per Master Training plan					
55	<input type="checkbox"/> Ongoing data reporting					
56	Collect number of individuals served vs. projected (for reporting period & cumulative)					
57	Collect number of staff recruited and trained vs. projected (for reporting period & cumulative)					





Tasks		Q4			Q1	
		Oct	Nov	Dec	Jan	Feb
58	Collect staff vacancy and turnover rate for period and cumulative vs. projected					
59	Collect data on impact measures as defined in evaluation plan, including annual evaluation of fidelity to evidence-supported p					
60	Pending relationship with Grafton County pursue training needs as appropriate					
61	<input type="checkbox"/> Sustainability Plan					
62	Review progress to date and revise plans accordingly					
63	Initiate the development of the plan for long range sustainability					

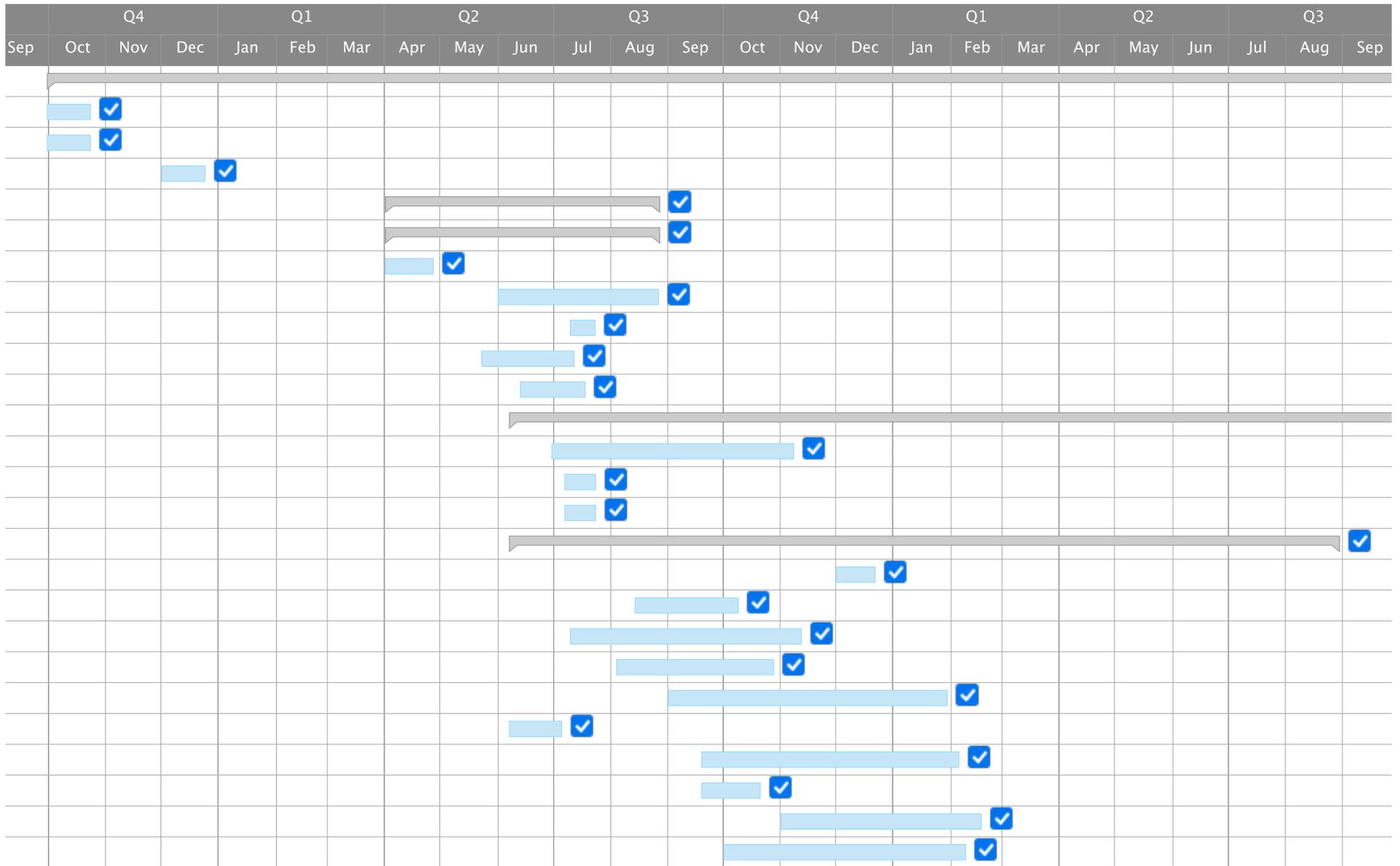
	Q2			Q3			Q4			Q1			Q2			Q3			Q4			Q1			
Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
																						<input type="checkbox"/>	<input checked="" type="checkbox"/>		
																						<input type="checkbox"/>	<input checked="" type="checkbox"/>		

Q2			Q3			Q4			Q1			Q2			Q3		
Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
			<input type="checkbox"/>														
						<input type="checkbox"/>											
									<input type="checkbox"/>								
						<input type="checkbox"/>											

# D3 Expansion in IOP (IDN 5)

Attachment\_D.1A

Tasks		Q3	
		Jul	Aug
1	<b>[-] Planning Phase</b>		
2	Establish and support SUD Treatment Options Leadership Team		
3	Identify key organizational/providers participants		
4	Execute meeting schedule		
5	<b>[-] Develop implementation plans</b>		
6	[-] Develop workforce plan		
7	Develop staffing plan		
8	Develop recruitment and retention strategy		
9	Identify projected annual client engagement		
10	Develop implementation timeline		
11	Develop project budget		
12	<b>[-] Design/develop Expanded IOP services infrastructure</b>		
13	Identify roles and responsibilities of team members		
14	Identify training curricula/topics by provider type		
15	Develop training plan		
16	<b>[-] Identify/develop patient management protocols/workflows</b>		
17	Identify Intake process		
18	Identify process for assigning clients to care coordinators and submit to CHSN		
19	Identify process to ensure compliance with Privacy/Confidentiality requirements		
20	Identify protocol for Recovery Coach pairing process and submit to CHSN		
21	Identify process to assist patient in Medicaid/Health Insurance enrollment and submit to CHSN		
22	Identify standard assessment tool(s) being used and submit to CHSN		
23	Identify client treatment protocols and submit to CHSN		
24	Identify and submit to CHSN Recovery Wellness Plan process		
25	Identify family/support system engagement and communication process and submit to CHSN		
26	Develop/identify plan to address transportation needs for non-Medicaid services and submit to CHSN		



Tasks		Q3	
		Jul	Aug
27	Develop/identify referral process and processes to link clients to supportive services and submit to CHSN		
28	<b>- Develop inter-organizational core care team protocols and submit to CHSN</b>		
29	Protocol for shared decision making		
30	Protocol for crisis management		
31	Identify process for core care team meetings for the care coordinators		
32	<b>Develop procedures for NH DHHS and CHSN data collection reporting requirements</b>		
33	<b>Identify evaluation plan including key metrics</b>		
34	<b>Develop mechanism for tracking-patient adherence, impact measures, and fidelity to evidence-supported project elements</b>		
35	<b>- Operational Phase</b>		
36	<b>Publicize expanded IOP availability through communication to all PCP practices, local media (radio, newspaper, public access channel), grand ope</b>		
37	<b>- Workforce development</b>		
38	Initiate recruitment process of staff for evening IOP in Belknap County		
39	Initiate recruitment process of staff for Plymouth area IOP		
40	Initiate the recruitment process for a part-time driver to operate van for IOP program		
41	Deployment of training plan		
42	Develop criteria for licensure/certification support for project staff to meet requirements as needed		
43	<b>- Initiation of Expanded IOP Model</b>		
44	Execute agreement with Riverbend Mental Health		
45	Initiate referrals, IOP services and care coordination for evening program in Belknap County		
46	Initiate referrals, IOP services and care coordination for morning program in Plymouth		
47	Use of assessment, treatment, management, referral protocols		
48	<b>- Initiate evaluation process</b>		
49	<b>- Implement procedure for data collection and sharing</b>		
50	Implement NH DHHS and CHSN data collection and reporting requirements		
51	Collect number of individuals served vs. projected (for reporting period & cumulative)		
52	Collect number of staff recruited and trained vs. projected (for reporting period & cumulative)		
53	Collect data on impact measures as defined in evaluation plan-including annual evaluation of fidelity to evidenced-supported program ele		
54	<b>- Reporting period Jan-Jun 2018</b>		
55	Implementation of any required updates to clinical protocols or other operating policies/procedures		
56	<b>- Ongoing data reporting</b>		
57	Collect number of individuals served vs. projected (for reporting period & cumulative)		





Tasks		Q3	
		Jul	Aug
58	Collect number of staff recruited and trained vs. projected (for reporting period & cumulative)		
59	Collect staff vacancy and turnover rate for period & cumulative vs. projected		
60	Collect data on impact measures as defined in evaluation plan		
61	<b>- Reporting period Jul-Dec 2018</b>		
62	<b>- Ongoing data reporting</b>		
63	Collect number of individuals served vs. projected (for reporting period & cumulative)		
64	Collect number of staff recruited and trained vs. projected (for reporting period & cumulative)		
65	Develop an agreement with Riverbend Mental Health		
66	<b>- Sustainability plan</b>		
67	Initiate the development of the plan for long range Sustainability		
68			
69			





Screening & Assessment Protocol

**STANDARD OF PRACTICE**

**HORIZONS COUNSELING CENTER /NATHAN BRODY PROGRAM at HORIZONS**

**Title:** Screening and Assessment Process

**Effective date:** 08/01/2012

**Purpose:** To describe the method of client evaluation for appropriate level of services.

**Standard of Practice:** A counselor shall evaluate any client seeking assistance in sobriety maintenance; appropriate recommendations will be made using the ASAM Patient Placement Criteria.

Clients may be referred to the Nathan Brody Intensive Outpatient Program by:

1. Self, family member, friend
2. An IDN Care Coordinator, Case Manager or other care coordinator
3. A primary care provider, other healthcare provider, mental health provider, DCYF, the courts, Criminal Justice System, social service agency, Recovery Community Organization, etc.

**Procedure:**

**A. A brief telephone screening (may be done in person if client walks in) is completed prior to scheduling a face to face interview. This provides the interviewer the opportunity to refer to an alternate level of care if indicated. The phone screen will examine:**

1. Substances used
2. Frequency and intensity of substance use in the last 30 days
3. Presence of and history of withdrawal
4. Co-occurring medical conditions
5. Co-occurring mental health disorders
6. Medications
7. Availability of safe support systems
8. Pregnancy
9. Suicidality

**B. The client will schedule an appointment for a face-to-face assessment triaging by urgency of need and prioritizing:**

1. Pregnancy
2. IV drug use
3. History of overdose
4. History of suicidal ideation or suicide attempts
5. Homelessness
6. Discharge from a hospital or residential treatment program
7. Release from prison or jail

**The client is evaluated based on the six ASAM assessment dimensions using the Addiction Severity Index:**

1. Acute intoxication and/or withdrawal potential
2. Biomedical conditions and complications
3. Emotional/behavioral conditions and complications
4. Treatment acceptance/resistance

Date originated 08/01/2012

Reviewed: 8/16/2016, 9/1/2018

Screening & Assessment Protocol

5. Relapse/continued use potential
6. Recovery/living environment

**Page 2 of 3**  
**Screening and Assessment**

- C. Areas to assess during the first visit, in order to determine if the client will need physiological stabilization include, include at a minimum the following:**
1. Determining if alcohol or other drug use is hazardous use by using existing evidence based screening tools;
  2. Determining if the presence of tolerance exists as outlined by the DSM V;
  3. Determining if the presence of withdrawal exists as outlined in the DSM V;
  4. Determining the potential for an alcohol withdrawal syndrome using the Clinical Institute Withdrawal Assessment for Alcohol, Revised (CIWA-AR) when appropriate;
  5. Evaluating for possible barbiturate, benzodiazepine or opioid tolerance or withdrawal;
  6. Considering and documenting a need for addiction related pharmacology;
  7. Evaluating signs and symptoms of mental health disorders and determining the presence of co-occurring mental health disorders;
  8. Screening for other possible medical conditions;
  9. Evaluating the possibility of danger to self or others including at a minimum child and adult abuse or neglect and Suicidality;
  10. Referral when indicated to a medically monitored or managed detoxification services, as outlined in the ASAM Placement Criteria.
- D. A face to face diagnostic interview with each client to obtain, review, evaluate and document the following:**
1. A history of the client's involvement with alcohol and other drugs including:
    - The type of substance used.
    - The route of admission.
    - Amount, frequency, and duration of use.
    - Patterns of use.
    - Positive and negative consequences of using and not using.
  2. A history of alcohol or other drug treatment or education;
  3. The client's self-assessment of use of alcohol and other drugs;
  4. A relapse prevention and recovery history;
  5. If any, the status of the client's:
    - Current and active mental disorder; and
    - Past or in-remission mental disorder; and
  6. The client's need, if any, of specialized treatment services using ASAM Criteria.
- E. If the client is in need of alcohol or other drug treatment, additional information is necessary:**
1. Motivation for recovery;
  2. Stage of readiness for change;
  3. Current risk behaviors;
  4. Ability to attain and maintain abstinence;
  5. Risk of relapse;

Screening & Assessment Protocol

6. Strengths, weaknesses, needs and goals;
7. Level of service need using PPC Criteria; and
8. Need of treatment for mental disorder, if any;
9. Leisure and activity skills;
10. Social skills

**Page 3 of 3**

**Screening and Assessment**

**F. If the client is found to be in need of alcohol or other drug use TREATMENT, an ASSESSMENT of other factors affecting treatment, including:**

1. Current and historical psychological and social data relevant to the treatment;
2. The possibility of participation in treatment by family or a significant other;
3. The need for referrals to other providers for services not provided by the program
4. The client's health history, including:
  - a. Physical Status
  - b. Mental status
  - c. Medication use and history including over-the-counter medications; and
  - d. Availability and use of medical and other healthcare;
  - e. Nutritional Assessment
5. For women, the likelihood of current pregnancy;
6. Minor children's custody or living arrangements during treatment; and
7. Legal history; including:
  - a. Past charges related to alcohol or other drug use
  - b. Current charges and courts of jurisdiction; and
  - Probation and parole requirements; and
  - d. Conditional discharges

**G. Documentation of the information collected, as follows:**

1. Client-identified problems;
2. Summary of data gathered
3. A diagnostic assessment interpretive summary including signs, symptoms and progression of the client's involvement with alcohol and other drugs;
4. A statement regarding provision of an HIV/AIDS screening, and referrals made;
5. Documentation of the type and length of treatment recommended, in accord with the Patient Placement Criteria.

**H. If the client is determined to be eligible for the IOP level of care, s/he will be enrolled in the program and, when appropriate, the referral source will be notified of the enrollment, with written consent by the client.**

1. Contact will be maintained with the referral source during the course of treatment when appropriate, with client consent, to facilitate continuity of care.

**H. If the client is found inappropriate for the IOP level of care based on ASAM Criteria, the appropriate level of care will be discussed with the client and a referral made to that level of care.**

1. If the appropriate level of care is unavailable at the time of the referral, Horizons Counseling

Date originated 08/01/2012

Reviewed: 8/16/2016, 9/1/2018

Attachment\_D.7A

Screening & Assessment Protocol

Center will provide interim services to the client to support him/her until the appropriate level of care becomes available.

2. Horizons staff will refer the client to Navigating Recovery of the Lakes Region, Plymouth Area Recovery Community (PARC) or other Recovery Community Organization for ongoing recovery support services.
3. If a need for psychiatric services and mental health case management is identified, the client will be referred to Lakes Region Mental Health Center according to the interagency referral and shared client protocols.

**HORIZONS COUNSELING CENTER  
NATHAN BRODY AT HORIZONS INTENSIVE OUTPATIENT PROGRAM  
CLINICAL POLICIES AND PROCEDURES**

**Title: Treatment Planning Policy**

**Effective Date: 9/1/2012**

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**Purpose:** To provide guidelines for the development of treatment plans for clients enrolled in the Intensive Outpatient Treatment Program.

**Standard of Practice:** Each client participating in the Nathan Brody Intensive Outpatient Program will have a comprehensive and individualized treatment plan with based on the needs identified in the assessment and client input.

**Guidelines:**

- A. The treatment plan shall be developed within the first week following admission to the program.
- B. The treatment plan shall acknowledge the client's cultural sensitivities and needs, education level, reading ability, language comprehension and cognitive ability.
- C. **The treatment plan shall contain the following elements:**
  - a. Goals shall be *Specific, Measurable, Attainable, Relevant and Time-based* (SMART);
  - b. Goals shall target problems to be addressed during treatment, including possible barriers to treatment;
  - c. Immediate or short-term goals that can be accomplished during the course of treatment;
  - d. Measurable long-term goals that can be accomplished over months or years that relate to problems identified in the assessment, building on skills learned in the course of treatment;
  - e. Goals will include:
    - i. Timeframes for anticipated achievement or completion of each goal or for reviewing progress toward each goal;
    - ii. Specification or description of the indicators used to assess the individual's progress;

Updated: 4/2017

Updated and revised: 9/1/2018

Attachment\_D.7B  
Treatment Planning Policy

- iii. Measurable recovery plan goals
- iv. The treatment procedures and modalities proposed to assist the client in achieving these goals, including:
  - 1. Type and frequency of services or assigned activities;
  - 2. Referrals for needed services that are not provided directly by the program
  - 3. The incorporation of or referral for recovery support services
- v. Documentation of the client's participation in the treatment planning process;
- f. Counselor shall sign the treatment plan once developed.
- g. The client shall sign the treatment plan once developed.

**D. The treatment plan shall:**

- a. Document the degree to which the client is meeting treatment, personal and recovery goals;
  - b. Be reviewed and updated or revised at least weekly in Phase I and every 30 days in Phase II;
  - c. Modify existing goals or establish new ones as necessary.
  - d. The counselor shall date and sign the updated plan at the time of review.
  - e. The counselor shall ask the client to sign the updated plan.
- E.** At the time of discharge, the counselor, care manager and recovery coach will meet with the client to assess ongoing recovery, behavioral health, housing, educational and healthcare needs and develop an ongoing recovery plan.
- a. The care manager will work with the client to set up continuing care services as identified in the continuing care plan.

**STANDARD OF PRACTICE**

**HORIZONS COUNSELING CENTER /NATHAN BRODY PROGRAM at HORIZONS**

**Title:** Referrals to Services

**Effective date:** 6/01/2018

**Purpose:** To describe the methods by which clients may be referred for substance use and co-occurring disorders services.

**Standard of Practice:** Clients may be referred to the Nathan Brody Intensive Outpatient Program by:

1. Self, family member, friend
2. An IDN Care Coordinator, Case Manager or other care coordinator
3. A primary care provider, other healthcare provider, mental health provider, DCYF, the courts, Criminal Justice System, social service agency, Recovery Community Organization, etc.

**Procedure:**

- A. Clients needing substance use disorder and co-occurring disorders treatment may be identified by any of the above named entities.**
  1. The referral source may contact Horizons Counseling Center by phone or in writing to make a referral and/or discuss referral appropriateness.
  2. If the referral source is a provider, s/he should obtain a release of information from the client and then provide documentation of reason for referral, any concerns regarding substance use, mental health issues, medical complications and social concerns.
  3. If the referral source is a provider, s/he should forward to Horizons Counseling Center any assessments done that would support the referral and the level of care recommendations.
- B. The referral source should instruct the client to contact Horizons Counseling Center to complete the phone screen or may facilitate this contact by initiating it with the client.**
- C. The client will complete the phone screen with a Horizons Counseling Center screener and will then be offered an appointment for full evaluation**
  1. The referral source or other identified collateral supports may accompany the client to the assessment with the client's consent.

**HORIZONS COUNSELING CENTER  
CLINICAL POLICIES AND PROCEDURES  
NATHAN BRODY AT HORIZONS INTENSIVE OUTPATIENT PROGRAM**

**Title: Aftercare Policy**

**Effective Date: 9/1/2012**

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**Purpose:** To describe continuum of care as it is provided by the Nathan Brody Intensive Outpatient Program at Horizons

**Standard of Practice:**

A crucial part of each patient's treatment plan is the continuum of care that takes place after the completion of an inpatient or outpatient program. Participation in weekly maintenance meetings provides the client with an ongoing support system facilitated by a counselor.

**Phase II of the Nathan Brody Program is designed to provide step-down treatment in the form of a maintenance group for those individuals who have completed the intensive Phase I of the Intensive Out-patient Program.**

**Eligibility:**

1. Clients who have completed Phase I of the Intensive Outpatient Program are expected to complete Phase II (12 consecutive weekly meetings) prior to discharge from treatment.

Two consecutive unexcused absences requires an individual meeting with a counselor to determine appropriate level of care needed. Based on the assessment, this may require brief participation in IOP and/or repeating 12 consecutive sessions of Phase II or referral to a more appropriate treatment setting.

2. Clients who have recently (within one month) completed a structured inpatient or outpatient program at another facility are eligible to participate in the Phase II maintenance group. A Consent to Participate will be signed and expectation will be the same as Phase I clients of Nathan Brody at Horizons Program.
3. Alumnae who completed Phase I and II of the NBCDP and are maintaining sobriety are welcome to attend the Maintenance Group indefinitely, at no charge to the client or any third party source.
4. All clients who have completed individual, group, family, couples or intensive outpatient treatment at Horizons Counseling Center will be eligible to receive aftercare and follow-up

Updated: 4/2017

Updated and revised: 9/1/2018

Attachment\_D.7D  
Aftercare Policy

through the Mentor's in Recovery Program.

- a. Mentors will be available to provide phone support and brief face-to-face support for individuals transitioning into community based peer support activities.
  - b. Mentors will introduce clients completing treatment to persons in community based peer support programs who have long-term recovery and are available to serve in the role of sponsor and mentor on an informal basis.
  - c. Mentors will contact clients completing outpatient treatment at Horizons Counseling Center 6 months and 1 year after they have left treatment to ascertain whether they are following their continuing care plan and whether or not they need to be re-connected with treatment services.
5. One male and one female Recovery Coach or Certified Recovery Support Worker from Navigating Recovery of the Lakes Region or Plymouth Area Recovery Community (PARC) will be embedded in the Nathan Brody Program to provide recovery supports, education and perspective to the clients in the program.
- a. Male clients completing Phase I of the IOP will be given an appointment with the male Recovery Coach/CRSW from the RCO.
  - b. Once the client has kept his/her appointment with the Coach/CRSW at the Recovery Center, a decision will be made between the Coach/CRSW and the client whether the client will remain in recovery support services with that Coach/CRSW or whether he/she will be paired with a different Coach/CRSW for ongoing services based on identified client needs and staff availability.

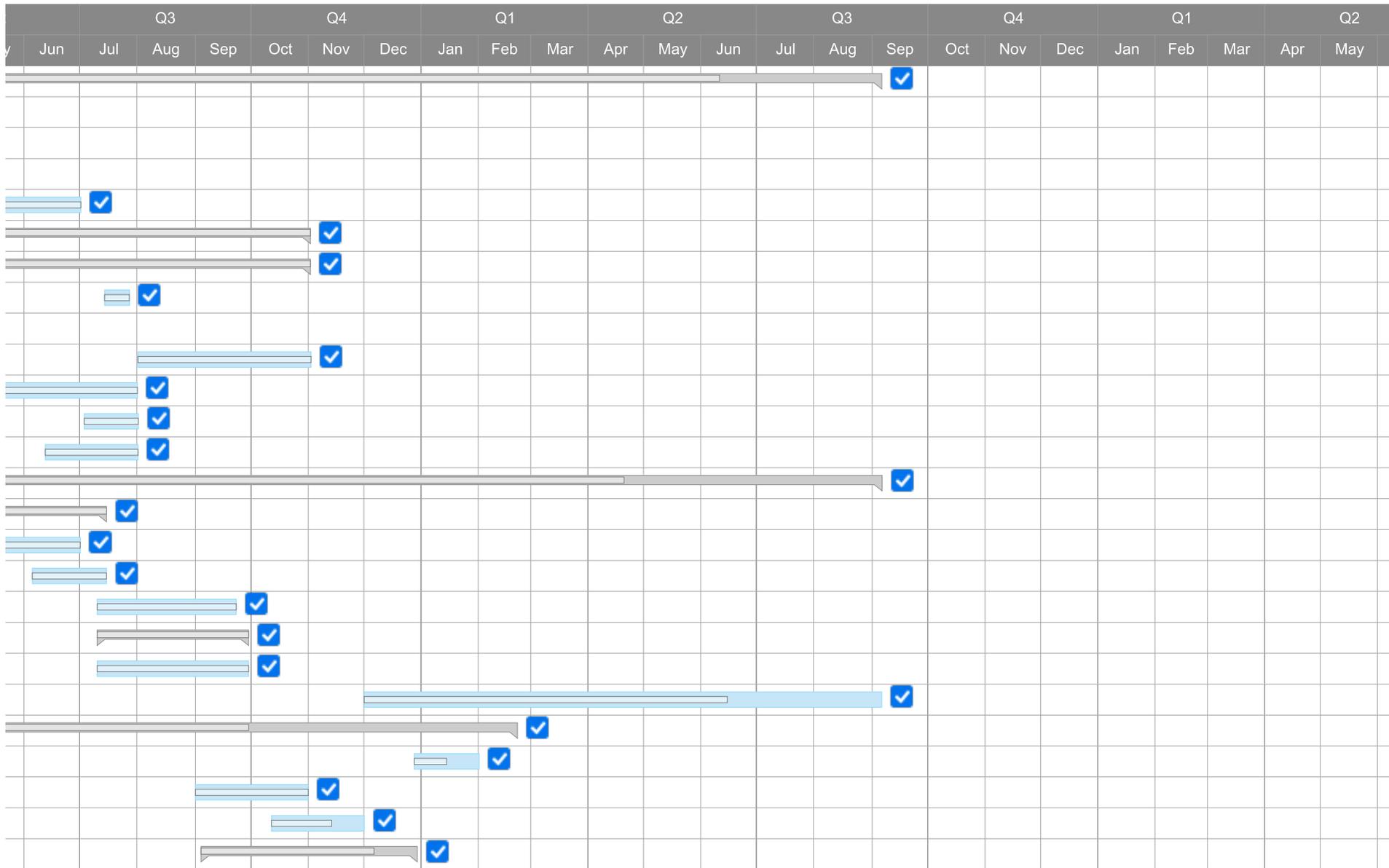
Updated: 4/2017

Updated and revised: 9/1/2018

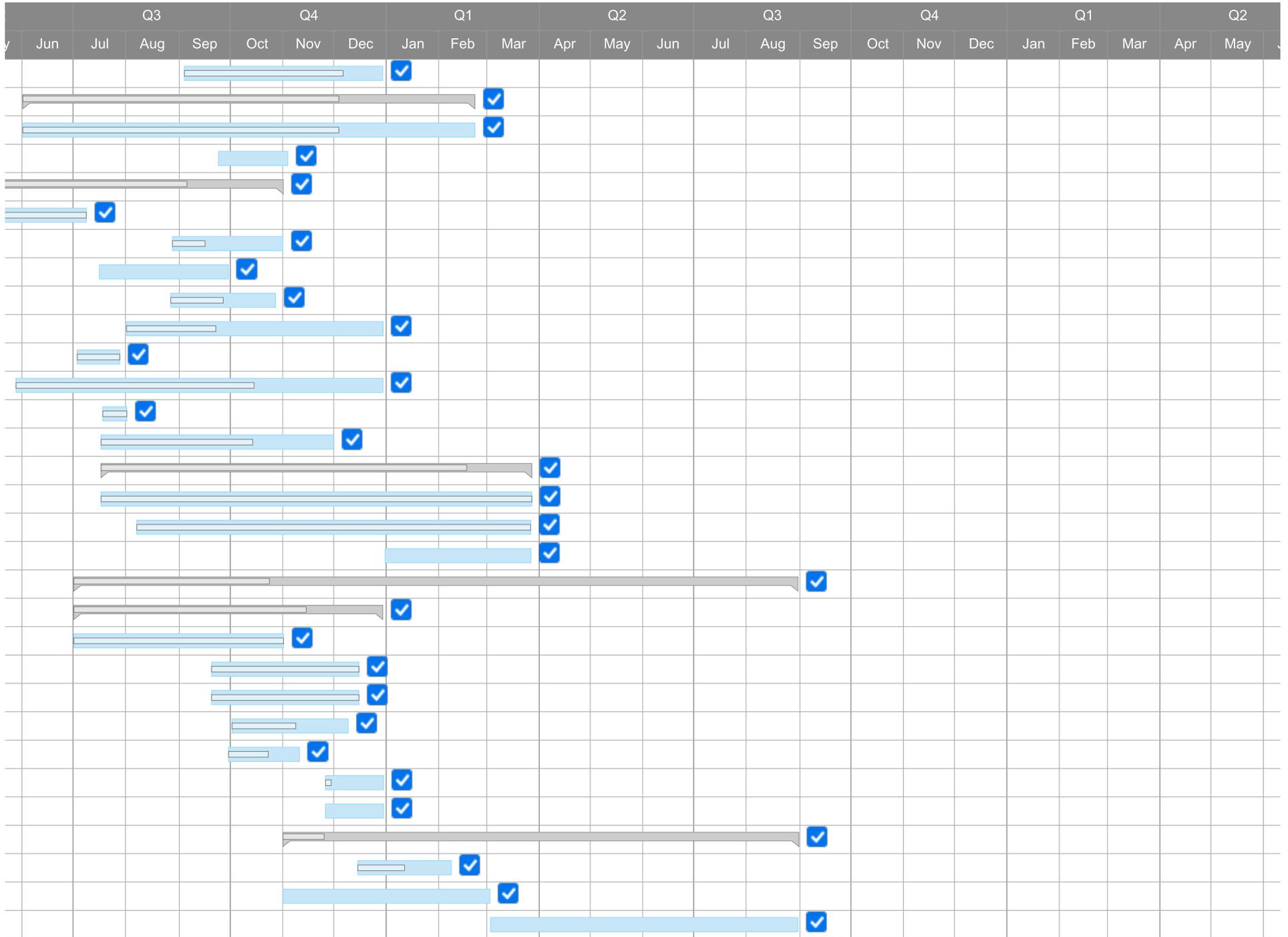
# E5 Enhanced Care Coordination (IDN 5)

Attachment\_E.1A

Tasks	Q4			Q1			Q2	
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
1 <input type="checkbox"/> Planning Phase								
2     Establish and support Enhanced Care Coordination Leadership Team				✓				
3     Identify key organizational/providers participants				✓				
4     Execute meeting schedule				✓				
5     Research care coordination models from other states								
6 <input type="checkbox"/> Develop Implementation Plans								
7 <input type="checkbox"/> Develop workforce plan for Multi- disciplinary Care Coordination Teams								
8         Identify workforce gap (refer to A1-7) and baselines assessment								
9         Develop staffing plan								✓
10        Develop "Employee Retention" Incentive Payment Plan								
11        Identify projected annual client engagement								
12        Develop implementation timelines								
13        Develop project budget								
14 <input type="checkbox"/> Design/develop Care Coordination and clinical services infrastructure								
15 <input type="checkbox"/> Identify/develop roles/ responsibilities of team members								
16         Develop job description for Care Coordinator								
17         Develop job description for CCTL activities overseen by Project Manager								
18         Develop training curricula by provider type								
19 <input type="checkbox"/> Identify training plan								
20         Identify standard set of care coordinator knowledge and skills requirements								
21         Develop eligibility criteria for enrollment in Care Coordination team, including rationale for intervention with								
22 <input type="checkbox"/> Identify/develop care coordination team model/workflows								
23         Convene process mapping workgroup								
24         Develop Intake form to be used by Community Care Coordinators								
25         Develop Resource Guide for Community Care Coordinators								
26 <input type="checkbox"/> Develop process for assigning care coordinators to individual client								



Tasks	Q4			Q1			Q2	
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
27								
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Tasks	Q4			Q1			Q2	
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
58 <input type="checkbox"/> Initiate evaluation process for Laconia								
59 <input type="checkbox"/> Implement procedures for data collection and sharing								
60 Collect number of individuals served vs. projected (for reporting period & cumulative)								
61 Collect number of staff recruited and trained vs. projected (for reporting period & cumulative)								
62 Collect data on impact measures as defined in evaluation plan-including annual evaluation of fidelity to e								
63 Implement NH DHHS and CHSN data collection and reporting requirements								
64 <input type="checkbox"/> Reporting Period Jan-Jun 2018								
65 <input type="checkbox"/> Initiation of care coordination model in Plymouth and Franklin								
66 Use of assessment, treatment, management, referral protocols								
67 Implementation of any required updates to clinical protocols or other operating policies/procedures								
68 <input type="checkbox"/> Initiate evaluation process for Plymouth and Franklin								
69 <input type="checkbox"/> Implement procedures for data collection and sharing								
70 Collect number of individuals served vs. projected (for reporting period & cumulative)								
71 Collect number of staff recruited and trained vs. projected (for reporting period & cumulative)								
72 Collect data on impact measures as defined in evaluation plan-including annual evaluation of fidelity to e								
73 Implement NH DHHS and CHSN data collection and reporting requirements								
74 <input type="checkbox"/> Ongoing data reporting								
75 Collect number of individuals served vs. projected (for reporting period & cumulative)								
76 Collect number of staff recruited and trained vs. projected (for reporting period & cumulative)								
77 Collect staff vacancy and turnover rate for period & cumulative vs. projected								
78 Collect data on impact measures as defined in evaluation plan								
79 <input type="checkbox"/> Reporting Period Jul-Dec 2018								
80 <input type="checkbox"/> Ongoing data reporting								
81 Collect number of individuals served vs. projected (for reporting period & cumulative)								
82 Collect number of staff recruited and trained vs. projected (for reporting period & cumulative)								
83 Collect staff vacancy and turnover rate for period and cumulative vs. projected								
84 Collect data on impact measures as defined in evaluation plan, including annual evaluation of fidelity to evid								
85 <input type="checkbox"/> Sustainability Plan								
86 Initiate the development of the long range sustainability Plan								
87								



**IDN 5  
Enhanced Community Care Coordinator  
Monthly Supervision Contact Form**

CCC Name: \_\_\_\_\_  
 Name of Site: \_\_\_\_\_  
 CCC Site Supervisor (Name): \_\_\_\_\_  
 Date: \_\_\_\_\_

**Communication method:**

- In person meeting
- Conference call
- Other: \_\_\_\_\_

<b>Essential Duties and Responsibilities</b>	<b>Yes</b>	<b>No</b>	<b>Support needed</b>
Consistently assesses patients' unmet health and social needs ( <b>Intake Form</b> )			
Engages in the process of <b>Workflow Development</b> by actively outreaching referral contacts to capture targeted population			

<b>Data Collection: Smartsheet</b>	<b>Yes</b>	<b>No</b>	<b>Support needed</b>
CCC is comfortable with the data entry process and designated tool (Smartsheet)			
CCC enters all necessary data in each column to capture all domains by the end of each month			
<b>Month:</b> _____ <b>Year:</b> _____  <b>Total # unique referrals=</b> _____ <b>Total # of encounters for month=</b> _____  <b>Target # for next month=</b> _____			

<b>Training</b>	<b>Yes</b>	<b>No</b>	<b>Support needed</b>
CCC is motivated to attend training opportunities to enhance his/her skills related to their role			
CCC provided monthly <b>Training Log</b> to Project Manager?			
CCC is registered for at least 1 upcoming training opportunity?			

Comments / Other Identified Needs: \_\_\_\_\_

CCC personal goal (for next month): \_\_\_\_\_

*Attachment\_E.1C*  
**E5 CCC Monthly Supervisory Contact Schedule**  
**As of 12/31/2018**

Site	CCC designee(s)	Supervisor(s)	Recurring Appointment	Method of communication	Other Comments
Pemi-Baker	[REDACTED]	[REDACTED]	TBD		
Healthfirst-Laconia	[REDACTED]	[REDACTED]	2 <sup>nd</sup> Tuesday each month 10a @ HF-Laconia	In person	
LRMHC	[REDACTED]	[REDACTED]	1st Monday of each month @ 10:30a, MOB, Spring St.	In person	
Horizons	[REDACTED]	[REDACTED]	TBD		
LRGH	[REDACTED]	[REDACTED]	2 <sup>nd</sup> Thursday of each month @LRGH Mary's office 9a	In person	
Servicelink/LRPPH	[REDACTED]	[REDACTED]	1st Tuesday of each month at 3p-Carissa's office	In person	
Healthfirst-Franklin	[REDACTED]	[REDACTED]	4th Thurs of each month HF Franklin @ 11a	In person	
Riverbend	[REDACTED]	[REDACTED]	2 <sup>nd</sup> Wednesday of each month @ RBMHC	In person	
FRH/Westside	[REDACTED]	[REDACTED]	Every 3 <sup>rd</sup> Wednesday of each month @ 10a-FRH	In person	
Mid-State	[REDACTED]	[REDACTED]	3 <sup>rd</sup> Monday of every month @ 10a	Conference call	

*Attachment\_E.1C*  
**E5 CCC Monthly Supervisory Contact Schedule**  
**As of 12/31/2018**

Speare Memorial Hospital			Quarterly-TBD	In person	
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## ***E5 CCC Biweekly Small Team Meeting Agenda***

### Administrative Discussion (First 15-20 minutes):

- Project related updates
- Monthly activity report review
- Training updates
- Confirm next meeting date(s)
- Other

### Case Collaboration Discussion (Second ½ meeting 45+min):

To prepare for this portion of each meeting:

*Prior to discussion of any patients all consent forms must be signed to ensure consistent privacy protection of each individual's PHI. No names or identifying information shall be used without obtaining consent from the patient.*

- Bring your laptop (if feasible) to access CMT list or other patient lists you are currently working from
- Each CCC should have a minimum of 1 high utilizer case to present for discussion to strategize how to best meet their needs as a CCC team
- Think about any patients on your lists that may be appropriate to refer to another CCC within your team to address specific complex needs
- Use this time to:

- ~Provide and/Accept new referrals
- ~Follow up on previous referrals-develop action plan for next meeting
- ~Collaborate referral sources-points of contacts with resources, any new networking opportunities (FTF meetings to enhance project visibility)

## E5 Community Care Coordinator

### Smartsheet User Manual

	1	2	3	4	5	6	7	8	9	10	11	12
	Comments	Date Referral made to CCC	Case #	Priority Level	Type of CCC contact	Encounter date	Mode of communication	Needs Domain	Referral made to	Closed loop date	Transportation as an access barrier	Supports engagement established if appropriate
84		06/26/18	20	Low	New Enrollment	06/26/18	On site	Financials/benefits	DHHS		<input type="checkbox"/>	<input type="checkbox"/>
85					Follow-up	07/02/18	On site	Financials/benefits	Welfare Office		<input type="checkbox"/>	<input type="checkbox"/>
86					Follow-up	07/06/18	Left message on phone				<input type="checkbox"/>	<input type="checkbox"/>
87					Follow-up	07/10/18	Phone	Financials/benefits			<input type="checkbox"/>	<input type="checkbox"/>
88					Follow-up	08/07/18	Phone	Behavioral Health	Riverbend	08/07/18	<input type="checkbox"/>	<input type="checkbox"/>
89		05/15/18	21	High	New Enrollment	05/17/18	Phone	Transportation			<input checked="" type="checkbox"/>	<input type="checkbox"/>
90					Follow-up	05/22/18	On site	Transportation	Medicaid tran	05/22/18	<input checked="" type="checkbox"/>	<input type="checkbox"/>
91					Follow-up	06/12/18	Left message on phone				<input type="checkbox"/>	<input type="checkbox"/>
92					Follow-up	06/14/18	On site	Housing	Subsidized hc		<input type="checkbox"/>	<input type="checkbox"/>
93					Follow-up	06/28/18	Phone	Housing	Subsidized hc		<input type="checkbox"/>	<input type="checkbox"/>
94					Follow-up	07/05/18	Left message on phone	Housing			<input type="checkbox"/>	<input type="checkbox"/>
95					Follow-up	07/12/18	Left message on phone	Housing			<input type="checkbox"/>	<input type="checkbox"/>
96					Follow-up	08/02/18	Phone	Housing	Subsidized hc	08/02/18	<input type="checkbox"/>	<input type="checkbox"/>
97		04/26/18	22	Low	New Enrollment	04/27/18	Left message on phone	Financials/benefits			<input type="checkbox"/>	<input type="checkbox"/>

#### **Column 1 – Comments**

After initial contact with a referred patient, type what occurred in this contact. For example: “Met with patient in need of Medicaid health insurance. Completed application online and will follow-up to ensure application is approved”.

#### **Column 2 – Date Referral Made to CCC**

Type in the date that the patient was referred to you, whether it be internally or from an outside organization. **(Is there anywhere that we capture WHO the referral came from? Just curious as I think this would be helpful to know)**

#### **Column 3 – Case #**

**No names or other PHI (protected health information) is recorded on the Smartsheet.** To effectively track the patients, create a separate excel spreadsheet assigning each patient to a “Case #.” Only the CCC will know which # corresponds to which patient by using this tracking system.

#### **Column 4 – Priority Level**

There are 3 options to choose from when clicking this box, “High”, “Medium”, or “Low”. High=frequent contact, whereas, Low=may only require a monthly check-in or may be soon to be discharged from care coordination.

### **Column 5 – Type of CCC Contact**

4 options to choose from:

*New Enrollment*= Initial contact with a patient is a new enrollment

*Follow-up*= Subsequent contacts are recorded as follow-up

*Refusal*= If the patient refuses to engage with CCC or does not respond after multiple outreach attempts

*Discharge*=Choose this option if the patient is no longer meeting with CCC (goals achieved/needs met, moved out of area, etc.)

### **Column 6 – Encounter Date**

Enter the date that the contact occurred. Every subsequent contact for that patient will be entered on a separate line underneath the previous one.

To do this, right click the shaded box all the way to the left of the last row for that patient and click “Insert Below”. This will create a new row under that same patient (you should see a small symbol next to the patient # which will allow you to expand or minimize the rows entered for the patient as to not make the Smartsheet extremely long and difficult to read).

### **Column 7 – Mode of Communication**

This is a drop-down menu where you choose how the patient was contacted, whether it be by phone conversation, a voicemail, on-site meeting, etc. Please select the mode of communication that is most appropriate based on choices provided.

### **Column 8 – Needs Domain**

This is a drop-down menu where you choose the specific area in which the patient needs your help, i.e.: If a patient lost their Medicaid and needs your assistance to reapply, you would select “Financials/Benefits”.

### **Column 9 – Referral Made To**

This is a drop-down menu where you choose the organization that you are referring the patient to. Using the previous example of working with a patient who lost their Medicaid and needs your assistance to reapply, you would select “DHHS” as where the referral was made to once you assist them with the application.

### **Column 10 – Closed Loop Date**

This would be the date that the referral to whichever organization was successful, i.e.: the patient was officially approved for Medicaid, the patient obtained housing – has moved in and is stable, they successfully have starting using a transportation resource that they were referred to, etc. ***Loops are not closed until the need is officially met and/or the issue is resolved.***

**Column 11 – Transportation as an Access Barrier**

Check this box if the patient identified transportation as a barrier to meeting their needs.

**Column 12 – Supports Engagement Established if Appropriate**

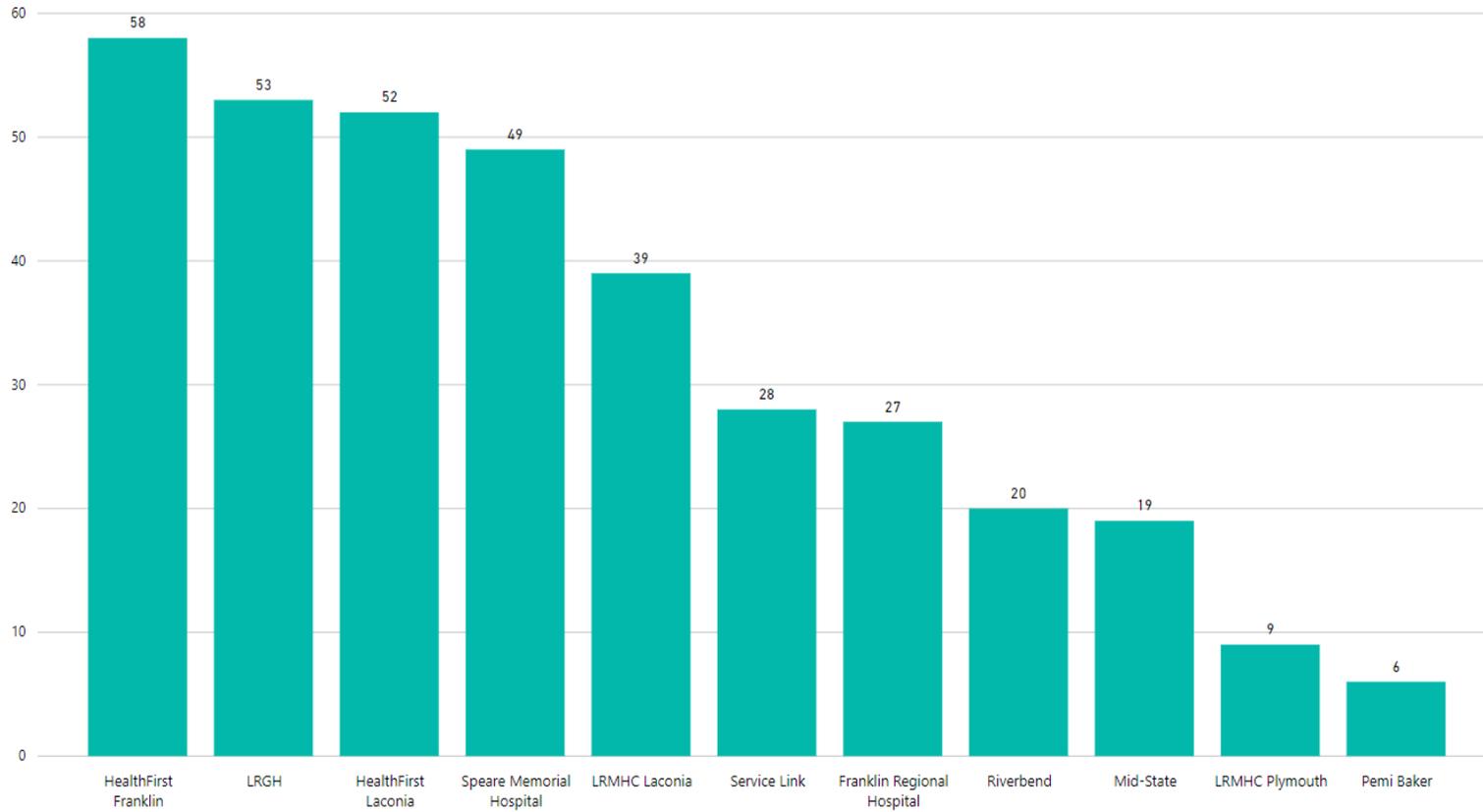
Check this box if the patient has supports in their life that you are actively engaging with to assist in coordinating their care/needs. Supports encompasses a wide variety of types of supports in a patient’s life: in home supports, care providers, church or clergy supports, neighbors, peer support, etc.

***If additional support is needed with use of the Smartsheet tool there is a regional CCC training mentor available to you:***

Laconia: [REDACTED]  
Franklin: [REDACTED]  
Plymouth: [REDACTED]

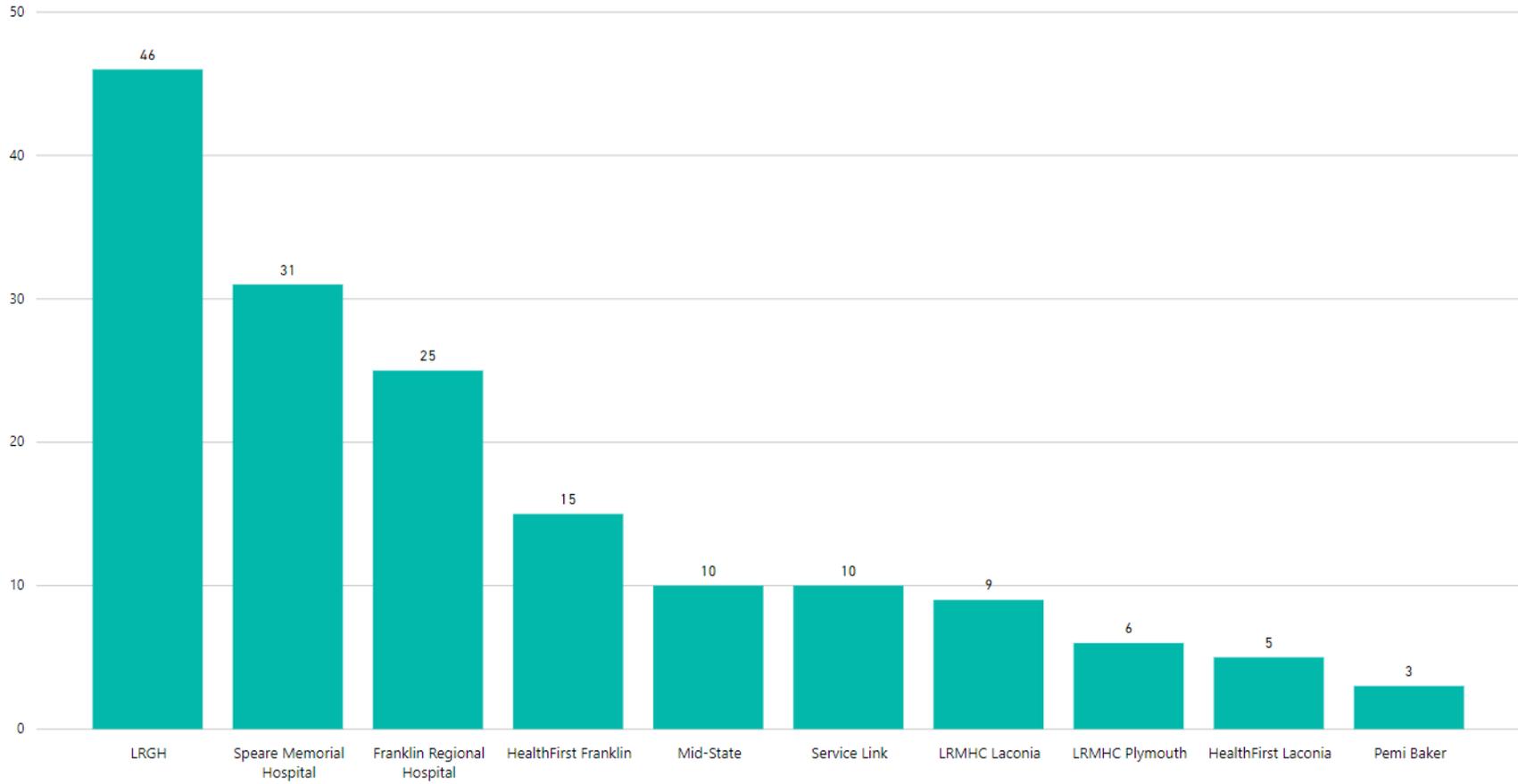
### E5 CCC December 2018 Site Activity

Contacts by Month in 2018



### E5 CCC December 2018 Site Activity

Enrollments December 2018



*Riverbend Community Mental Health Center (Franklin) and Healthfirst-Franklin  
CCC Patient Care Protocol*

**Methods to capture referrals via Riverbend:**

1. Administrative support will do initial screening to determine intake eligibility for patients. If patient does not meet criteria for Riverbend and needs a PCP, referral will be made to CCC Healthfirst-Franklin via phone call or secure email only. If CCC Healthfirst-Franklin is unavailable referral to be made to CCC Riverbend who will complete facilitation of this patient referral.
2. CCC Riverbend will obtain referrals from Riverbend patient waitlist for those patients needing to apply for Medicaid. Follow up referral to CCC at Healthfirst-Franklin when patient needs support with getting established with PCP care. Referrals to be made via phone, secure email or hand delivery of applications to CCC Healthfirst-Franklin.
3. The Riverbend clinicians (therapists) will do their initial intake with patients to determine eligibility and appropriateness for referral to CCC Riverbend. With initial consent obtained by patient, CCC Riverbend will meet with the patient face to face immediately following their scheduled appointment with the therapist to establish rapport and assess needs.

The CCC points of contact related to referrals from the Riverbend therapists will be as follows:

**██████████-CCC RCMHC**  
Mondays 9:00-5:00p  
Wednesdays 9:00-8:00p  
Fridays 9:00-5:00p

**██████████-CCC Healthfirst Franklin**  
Tuesdays 7:00-4:00p  
Thursdays 7:00-4:00p

- ✓ When face to face meetings are possible with patients being referred to the E5 project, the CCC working with the patient will utilize the designated “drop in office” at Riverbend for this initial meeting to do a warm hand off of patient care. CCC-Healthfirst-Franklin to make initial appointments with Healthfirst-Franklin at these meetings to smoothly transition patient care to PCP office.

- ✓ When face to face meetings are not feasible at the time of intake with the patient, the assigned therapist will submit referral documentation to CCC-Riverbend. The CCC-Franklin will outreach patient to begin engagement process and refer to CCC-Healthfirst when appropriate.
4. CCC-Riverbend will log in to CMT at minimum once per day to review current patient lists and screen for appropriate patients to outreach appropriate for the E5 project. CCC-Riverbend to outreach patients and support referral to CCC-Healthfirst-Franklin if additional support is needed with PCP services.

***Additional workflow recommendations:***

- ✓ CCC RCMHC will attend agency meetings routinely to reiterate E5 project and referral process as outlined above. At these meetings handouts will be provided i.e. rack cards and/or business cards to further enhance project visibility and encourage referrals.
- ✓ Always obtain consent from patients with all transfer of care to ensure protection of privacy and maintenance of HIPAA.
- ✓ Maintain consistent communication with CCC between sites and referral sources to ensure quality patient care.

**E5 Project: Assessment Protocol**

**CHSN IDN-5**

***Assessment, Intake and Patient/client Visit Recommended Protocols and Best Practices***

The work of care teams to deliver proactive, population-based, patient-centered care is divided into 3 domains of work: pre-visit, visit, and between visit work. Source: [https://www.samhsa.gov/sites/default/files/programs\\_campaigns/samhsa\\_hrsa/team-based-care-implementation.pdf](https://www.samhsa.gov/sites/default/files/programs_campaigns/samhsa_hrsa/team-based-care-implementation.pdf)



***Comprehensive Assessment of Needs, Intake and Patient/client Visit Protocol***

Consideration for an effective intake and patient/client visit begins during the Pre-Visit phase to better prepare the patient/client and promote self-management abilities, and is reinforced during the visit and between visits. ***Each phase/work domain incorporates Assessment and consistent Reassessment of a patient's needs throughout all activities/tasks for all levels of care provided.***

Work Domain (Pre-Visit, Visit, Between Visit)	Activity/Task	Multi-disciplinary Team Member
Pre-Visit Assessment	<ul style="list-style-type: none"> <li>➤ Assist patient to prepare for visit: bring medications to visit</li> <li>➤ prepare questions to ask provider</li> <li>➤ come in for pre-visit lab tests</li> <li>➤ invite family member/caregiver to visit if patient prefers</li> </ul>	E.g., MA, receptionist



Attachment\_E.7B

	<ul style="list-style-type: none"><li>➤ Schedule additional primary care and specialty appointments</li><li>➤ Routine care management/care coordination</li></ul>	E.g., referral coordinator  E.g., care coordinator, nurse, social worker
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## **E5 Project: Referral Protocol**

### **CHSN IDN-5**

#### ***Closed Loop Referrals***

To assist in the reduction of breakdowns in the referral process which can lead to delays in diagnosis and treatment, CHSN-IDN 5 E5 partners will interface with Community Based Support Services organizations through a formal closed-loop referral process. This is one in which pertinent patient data that requires action is communicated to the right individuals at the right time through the right mode of communication to allow for review, action, acknowledgement and documentation. The Community Care Coordinator or designated BH or CHW support staff will be the accountable member of the Integrated Care Team in all communications with the Community Based Support Services. Upon identification of a need for community support services by the Integrated Care Team, the Care Coordinator will begin the referral to supports process.

Where the provider of supports is not known by the team, the Community Care Team will work with a variety of regional and statewide resources to identify appropriate and available community supports. Significant work has been done to compile an IDN 5 resource guide for Community Based Support Services which may also be referenced. Resources may take the form of a care navigation organizations such as ServiceLink of Belknap or Grafton county and other regional resources which include:

- NH Alcohol and Drug Treatment Locator (<http://nhtreatment.org/>)
- ServiceLink Community Resource Directory (<http://www.referweb.net/nhsl/>)
- NH Easy – Gateway to Services (<https://nheasy.nh.gov/#/>)
- NH Peer Support by region: (<http://www.dhhs.nh.gov/dcbcs/bbh/peer.htm>)
- 2-1-1 New Hampshire and <http://www.homehelpnh.org/> for housing assistance
- Transportation Resources - Central NH Transportation 603-412-2122; Community Action Program 603-225-1989 or [www.bm-cap.org](http://www.bm-cap.org); Grafton County Senior Citizens Council 603-536-1204; NH Medicaid Ride Coordinator 1-800-852-3345 ext. 3770 or other regional transportation services (<https://www.nh.gov/dot/programs/scc/rcc.htm>).

The Care Coordinator will initiate a referral to the Community Based Support Service and transfer all pertinent information. This will be facilitated via secure Direct Secure Message. Where EHRs are capable of initiating a referral over Direct, the EHR will be used. Where EHRs are incapable of initiating a referral, a Webmail will be used to send the referral to support. Community Support Services organizations will receive the referral to supports via a portal inbox.

As the process is being first implemented, the Care Coordinator will also follow up via phone to ensure that the Community Support Services organization is aware of the referral and is following up appropriately.

To complete the “closed loop” referral, the Community Based Support Service organization will acknowledge receipt of the referral, will inform the Care Team Coordinator of patient engagement with the services, and will provide updates periodically. The Care Team Coordinator will actively query Community Support Services Providers to follow up on “open” referrals.

### ***Enhanced Care Coordination***

There are likely multiple care coordinators, or similarly named care managers, case managers, etc. who may be involved in a Medicaid member’s health management. These may include Payer/MCO care coordinators/case managers, CHSN-IDN 5 care coordinators and healthcare organization care coordinators/case managers.

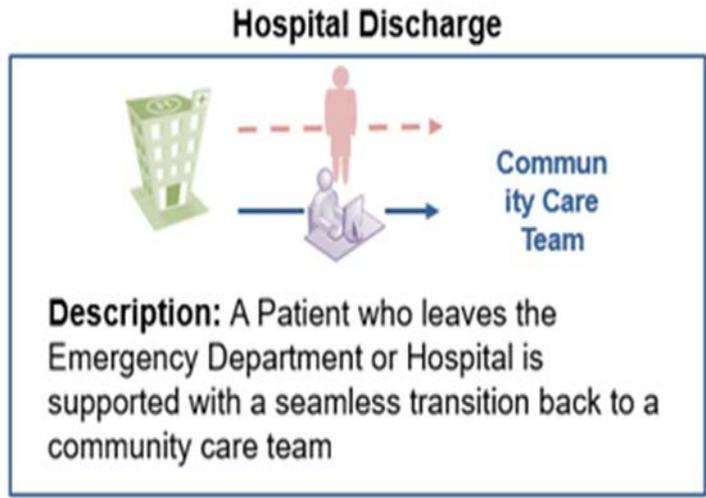
The CHSN-IDN 5 B1 Integrated Care practice designee(s) along with the E5 Enhanced Care Coordination Team will be accountable for the oversight of care coordination. She/he will determine the care coordination resources that are to be part of the integrated care team and the care coordinators who are to be kept informed of and updating information within the patient’s shared care plan. Care coordinators are free to collaborate with their fellow care coordinators to address patients’ needs related to social determinants of health and difficult cases may be discussed during monthly care coordinator team meetings.

CHSN-IDN 5 has worked with network partners to facilitate workflows for safe transitions from institutional settings back to primary care, behavioral health, and social support service providers. Many workflows existed and/or were developed within the respective community-driven project settings (i.e. C2 – Community Re-Entry, D3 – Expansion in Intensive Outpatient Program and E5 – Enhanced Care Coordination for High Need Populations). For specific workflows between agencies, please contact the CHSN-IDN 5 Admin Team.

### ***Priority Information to Support Patient Transitions:***

- Current medication list – to enable medication reconciliation among all post-acute care providers and to prevent medication based adverse events.
- Recent history of what happened during the hospitalization, any new problems discovered, any procedures undergone, and any new history discovered.
- Instructions for who is to do what in a post-discharge hand-off between healthcare teams.

See Graphic below for guidance on Hospital Discharge Workflow:



### Information Trading Partners

Sending From	➔	Sending To
Emergency Department		Primary Care Provider
Hospital		Mental Health Provider
		SUD Treatment Provider
		Home Health
		Skilled Nursing Facility
		Long Term Care
		Care Coordinator(s)