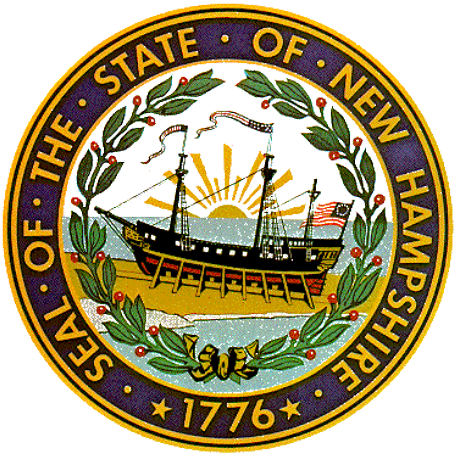

New Hampshire Building Capacity for Transformation 1115 Medicaid Waiver

IDN PROCESS MEASURES SEMI-ANNUAL PROGRESS REPORT

For

Year 4 (CY2019)

2019-12-31

CHSN-IDN5

FINAL DRAFT

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Introduction

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

Per the Standard Terms and Conditions and contractual requirements Integrated Delivery Networks who have met 100% of the required deliverables will be required to submit ongoing Semi-Annual Progress Reports. It is the expectation that all partners will continue to make progress along the SAMHSA Integrated Care Practice Designation Continuum.

Submission of the semi-annual progress 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.). The January- June 2020 semi-annual report is due July 31, 2020 and the July-December 2020 semi-annual report is due January 29, 2021. 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.

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

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Project Plan Implementation (PPI)

Narrative

Provide a detailed narrative to reflect progress made during this reporting period as it relates to the Administration, Network, and Governance.

PPI - Administration

- The CHSN-IDN5 Board and its Administrative Lead, the Partnership for Public Health (PPH) remain in close contact on a regular basis. In particular, the CHSN Board Chair and Executive Director meet with the PPH Executive Director and/or Financial Director to discuss important IDN matters as they arise. A close relationship exists between all parties to ensure operations are running smoothly and that accurate reporting of funding is available and shared in a timely fashion. The CHSN Executive Director's office is in the same building as the Partnership for Public Health allowing for daily interactions with all staff. She also serves on the PPH Management team and is involved with regular business and staff meetings allowing for a very transparent relationship conducive to frequent information sharing; not just with our administrative lead but it dually serves as an effective, close knit relationship and understanding of the activities of our region's public health agency.
- CHSN operates with one full time Executive Director, one full time Data Analyst and a part time Administrative Assistant. In the past, it has also employed one full time Project Manager as well. This position was vacated mid-2019 at which time the position and its functions were re-evaluated by the CHSN Executive Director and leadership who chose not to rehire or fill the position given the late stage of the DSRIP waiver. This position had primary oversight of the three community driven projects and given they are all running smoothly the administrative oversight was shifted to another individual serving on the project. For the C2 and D3 projects, the IDNs project lead has accepted this function and the CHSN Executive Director has taken administrative oversight of the E5 project in conjunction with designating a Community Care Team Leader to serve as liaison between the community care team and CHSN. This resolution has been working very well since July and we do not anticipate hiring another Project Manager.

PPI - Network Development

The Community Health Services Network (CHSN) 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. A few highlights from the past six months are noted below.

- There were no CHSN-IDN5 partners off-boarded or requests for new partners to be on-boarded during the reporting period of July 1 – December 31, 2019. There is a total of 31 partners, 15 of which are members (members have a vote on the Board) and 16 affiliate agencies (affiliates do not have a vote on the Board). Our 31 partners either provide or support primary, behavioral, mental and/or social health care.

- CHSN has been open to adding additional key stakeholders from inception if/when they or their field of expertise was identified as needed within a specific project or the IDNs overall goals. In 2018, a CHSN governance subcommittee reviewed and presented to the board that the existing board composition adequately represented all constituents needed for and related to the work being performed within the DSRIP waiver projects and since that time no additional partners have been added, or have requested to be added to the network.

- To address insufficient workforce capacity for the region and our partners, CHSN-IDN5 has worked hard to develop, offer and make available relevant training and educational opportunities and offerings. CHSN has been engaged in numerous regional and statewide efforts over the years and also has a strong presence on the Statewide BH Workforce Taskforce. The CHSN Executive Director sits on the Statewide Training & Education subcommittee; and the CHSN Board Chair chairs the Statewide Policy subcommittee. Both individuals are involved and engaged in this work and helping connect statewide efforts to address regional needs wherever possible. Both serve as the workforce liaisons with the CHSN Board and partners to share news, policy updates, and more.

- CHSN began its commitment to fund all trainings for CHSN partners and their staff in April 2018. Through a contract with the New Hampshire Alcohol & Drug Abuse Counselors Association (NHADACA) we were able to identify and address our regional training/education needs. The original CHSN and NHADACA training contract ended December 31, 2018 however it has remained "open" with monies left unspent from the original contract throughout 2019. Requests by partners wishing to send their staff to a NHADACA offered training are handled on an as individual basis through a request to the CHSN Executive Director via email or a call and if approved, a code is provided to use as payment when registering online with NHADACA. CHSN-IDN5 also supported the registration fees and associated mileage for interested IDN partners' staff, including ten of the E5 community care coordinators and two CHSN staff members to attend the NH Behavioral Health Summit on December 16-17, 2019.

- Between the CHSN training contract with NHADACA and other trainings IDN5 partners' staff participated in (that were reported to CHSN), 807 individuals have been trained on various integration/SUD/BH topics since mid-2017, and 93 within the July – December 2019 reporting period.

- Above and beyond the NHADACA offerings, partners are routinely reminded and encouraged to reach out to CHSN when there is a training opportunity that they or their staff would benefit from to improve their workforce's overall integration knowledge as funds are likely available to assist them. CHSN-IDN5 also participates in the State's Loan Repayment Program (SLRP) and has $150,000 in funding set aside to assist our partners' staff that meet Tier 2 & Tier 3 guidelines (by discipline/specialty set by SLRP) with a flat match of $7,500. This will assist 20 individuals in the CHSN-IDN5 region by matching other SLRP funds. The CHSN Board continues to support training the workforce as one of its most meaningful and lasting investments into our region.

- New in late 2019 the CHSN board extended an offer to pay for member partners' internal expenditures that related directly to recruitment, retention or training of staff that work within a specific DSRIP project or their agency's growth as it relates to hiring or training integrated behavioral health and primary care staff. Partners' who provided back-up documents along with

an explanation of and purpose for their 2019 expenses could receive up to $15,000 in reimbursement for their agency's recruitment costs, retention-related expenses and in-house training/education expenditures. Six CHSN partners submitted reimbursement requests to assist with their workforce recruitment and training expenses totaling $83,569.39.

- The CHSN Executive Director participated in meetings called by Jim Monahan from the Dupont Group which represents each of the NH County Commissions. These meetings have been held with the seven IDN Leads to discuss a solution for statewide county funding of the DSRIP waiver. The first meeting was held in June 2019 and has been a long and tedious process which has remains unresolved at time of this writing. CHSN-IDN5 is willing to work with the statewide group of County representatives as well as its county commissioners and delegation however it can to assist in the process. To this effect, as of October 2019, one county representative is invited to join the CHSN monthly Board meetings to help improve communication channels and transparency between parties. This request was the result of the three counties being invited to attend the CHSN Strategic Planning meeting held in late May 2019. Representatives from Belknap and Grafton joined (Merrimack declined) and said that their preference was for them to "come to us" rather than have us go to them. We then all agreed to open a guest seat at our Board meetings for one identified county representative to participate. To date, Belknap and Grafton representatives has participated sporadically at CHSN Board meetings either via telephone or in person and we feel it has been an effective method for enhancing communication and understanding of DSRIP project activities.

- In late October, CHSN announced its "Integration Demonstration Projects" funding opportunity to IDN member partners. CHSN received nine proposals from IDN5 member partners who applied for incentive dollars to be used to assist with additional "Integration Demonstration Projects." A subcommittee was formed to develop the proposal criteria and application form. Another subcommittee was formed to review, score and recommend to the CHSN Board those proposals that met all the criteria for funding. The goal was to get out 50% of the funds by year-end so there would be ample time (with just one year remaining in the DSRIP waiver) for partners to implement their integration projects and have time to make an impact in the region. A total of $1,144,512 has been earmarked to support these projects. Half of which was issued in December 2019 and the remaining 50% has been accrued in CHSN's budget and be issued after six months upon receipt of an interim progress report detailing progress. This new funding opportunity offers an exciting opportunity for partners to be creative in adding new or complementing existing services and programs which align with the DSRIP waiver's integration goals and initiatives. Based on the initial success of the nine projects and available incentive funds, the CHSN Board reserves the right to open up a second round of funding in early 2020. More information will be shared in the B1 section of this report.

- The CHSN Executive Director and CHSN Board Chair participated in an initial meeting coordinated by DHHS which included the three NH MCOs to discuss the Local Care Management Entity (LCME) requirement within their new contracts. Additionally, the IDN Leads hosted an "All MCO" meeting on June 21st in Manchester where Amerihealth Caritas, NH Healthy Families and WellSense all presented for 1.5 hours each to the IDN Leads. Since that time, CHSN-IDN5 invited representatives from the three MCOs to speak at its full Network Partner meeting held on November 14th to discuss their experience to date with Alternative Payment Models (APMs). A second meeting was

held between AmeriHealth Caritas representatives and the CHSN Board Chair and Executive Director on November 18th where they discussed the current LLC structure, existing care coordination program design, regional capabilities and how we may move forward to pursue working together as a Local Care Management Network (LCMN) which would allow for some level of sustainability for the IDN.

- On November 14th CHSN held a full Network Partner Meeting at which 30+ partners attended as well as six MCO guests and four E5 Community Care Coordinators. The agenda highlighted our Enhanced Care Coordination project and then a panel of MCO representatives spoke to the group on their philosophies and experiences to date surrounding Alternative Payment Models.

Governance

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

- The CHSN Board of Managers is comprised of fifteen member agencies. The executive officers of the Board shifted slightly this reporting period due to the retirement in November of one officer. The CHSN slate of officers now includes [redacted], Chair (Lakes Region Mental Health Center), [redacted], Vice Chair (Horizons Counseling Center), [redacted], Secretary (Central NH VNA), and [redacted], Treasurer (Lakes Region Community Services).

- An annual meeting of the Members is held on a date agreed upon by the Members. The last annual meeting was held on May 31, 2019 at which time the Members appointed the Managers, Executive Officers, reviewed and approved the annual operating budget, reviewed the strategic plans of the Company and discussed any other matters as are typically addressed at an annual meeting.

- An outcome of the professionally facilitated strategic planning meeting that CHSN held in May was a Strategic Plan which identified five priority areas based on strategic themes that would support CHSN in becoming sustainable beyond the waiver end date in December 2020. Beginning in September 2019, five sub-committees formed and started meeting to begin working on the action items identified that would support CHSN in ideally becoming sustainable once DSRIP funding is no longer available. Subcommittee meetings are ongoing and verbal report outs by each committee lead occurs at the monthly CHSN Board meeting for the following subcommittees:
    i. Communications
    ii. Infrastructure

iii. Collaborations & Partnerships
iv. Services Provided and/or Supported
v. Financial Sustainability

One outcome of the Communications subcommittee was the decision to hire a writing consultant to assist CHSN in promoting itself and educating the public on the DSRIP waiver, what an IDN is, introducing the concept of integrated healthcare and highlighting some of our most impactful client stories. Various articles with a different focus will be written and circulated to print media outlets beginning with a high-level overview piece which was released December 9th. A second article is scheduled for early January and these will continue monthly through July 2020.

- At its last Board meeting there was a decision to invite CHSN's attorney to a future meeting in early 2020 to review our current LLC structure and explore whether there may be benefits to forming a 501(c)3 in order to seize future funding opportunities that may offer sustainable options, i.e. LCMN contract with the MCOs. Additionally, we would like to seek legal guidance to help the Board understand and prepare for how CHSN can accept DSRIP payments that are anticipated to come in from performance measures in mid-to-late 2021 after the waiver has essentially ended.

Budget

The total IDN5 projected budget available to perform the work of all projects is $12,784,874. A budget of $1,496,557 is allocated for Administrative expenses to perform the work, which leaves $11,288,317 in available funds to perform all related project work. Shown below you will see the actual expenditures to date for major activities in all projects to date totaling $5,905,771 with an anticipated projected expense of $10,033,004. CHSN-IDN5 set aside a 10% reserve (of the available funds) to secure for potential DHHS/County matching fund uncertainties and a small reserve for CHSN-IDN5 achievement of performance metrics for a total of $1,255,313. Please note that the CHSN Board addressed the need to **review the CY 2021** projections but **agreed** to put this **exercise** off until such time that we know what financial contribution will be made by the NH Counties as it impacts our future funding situation significantly. This will be revisited by the CHSN Board and Administrative Lead's finance director hopefully by spring once the level of County funding is known and has been confirmed.

CHSN-IDN 5: Total Budget & Actual - Projected July 1, 2016 - June 30, 2022									
	Total Program Cost								
Line Item	CY 2016 Actuals	CY 2017 Actuals	CY 2018 January to June Actuals	CY 2018 July to December Actuals	CY 2019 January to June Actuals	CY 2019 July to December Actuals	CY 2020 Projected	CY 2021 Projected	Total
PPI									-
- Administrative lead	62,303	224,993	103,562	139,617	131,217	108,109	239,326		1,009,128
-Project lead expenses		41,525	42,776	20,650	19,582	10,025	10,000		144,558
-Partner discretionary or other grants	1,200	62,647	6,080	2,500	3,500	5,446	13,627		95,000
-Community input	42,467	34,147							76,614
Total PPI	**105,970**	**363,312**	**152,418**	**162,767**	**154,299**	**123,580**	**262,953**		1,325,300
A1	-	-	13,688	280,769	237,452	331,044	568,496		1,431,448
A2	-	21,956	154,773	82,324	65,634	109,770	160,941		595,398
B1	-	2,500	72,500	-	70,000	6,284	70,000		221,284
- Integration Demonstration Projects	-					1,144,512			1,144,512
C2	-	35,370	84,986	75,871	118,992	160,269	279,261		754,749
D3	-	40,281	96,982	116,801	128,073	126,216	254,289		762,642
E5	-	45,941	264,268	330,775	315,167	310,227	625,394		1,891,772
Total DSRIP Projected Expenditures	**105,970**	**509,360**	**839,615**	**1,049,307**	**1,089,617**	**2,311,902**	**3,169,072**	958,161	10,033,004
10% Reserve for Matching Fund and Performance Metrics Uncertainty	-	-	-	209,219	209,219	209,219	418,438	209,218	1,255,313
	105,970	509,360	839,615	1,258,526	1,298,836	2,521,121	3,587,510	1,167,379	11,288,317

Project A1: Behavioral Health Workforce Capacity Development

Narrative

As previously stated in the PPI-Network section, there were no CHSN-IDN5 partners off-boarded or requests for new partners to be on-boarded during the reporting period of July 1 – December 31, 2019. There remains to be a total of 31 partners, 15 members and 16 affiliates all of which provide or support primary, behavioral, mental and/or social health care.

CHSN-IDN5 continued to make steady progress in the areas of recruitment, retention, hiring and training this reporting period. Many of these highlights were addressed in the PPI section but will be re-emphasized here along with additional information. The importance of workforce education and training remains one of, if not the most important, key funding priorities of the CHSN Board. Knowing that DSRIP funds can leave a mark by increasing the level of competence of partners' staff and grow their understanding and training in integration within our region is critically important and is emphasized and supported financially by CHSN-IDN5 on an ongoing basis. CHSN has supported numerous recruitment efforts by major hospitals and mental health agencies, it has offered incentives for partners to utilize to retain staff and has had an ongoing training offering to pay for related educational opportunities since early 2018.

Notable Recruitment, Retention, Hiring and Training Progress

- The community projects projected a total of 25 FTEs were needed to operationalize the three projects. As of June 2019, all projects reported being fully staffed and remain full at time of this writing. There are 7.5 FTEs hired or assigned to the C2 project of the projected 7.5; 8.1 FTEs hired or assigned to serve on the D3 project of the projected 8.1; and 9.4 FTEs hired out of the 9.4 projected to operationalize the E5 project. Thus 100% of the positions have been filled for our community driven projects. CHSN's current retention rate is 100% with a current vacancy rate of 0%.
- To address insufficient workforce capacity for the region and our partners, CHSN-IDN5 has worked hard to develop, offer and make available relevant training and educational opportunities and offerings. CHSN has been engaged in numerous regional and statewide efforts over the years and also has a strong presence on the Statewide BH Workforce Taskforce. The CHSN Executive Director sits on the Statewide Training & Education subcommittee; and the CHSN Board Chair chairs the Statewide Policy subcommittee. Both individuals are involved and engaged in this work and helping connect statewide efforts to address regional needs wherever possible. Both serve as the workforce liaisons with the CHSN Board and partners to share news, policy updates, and more.
- CHSN began its commitment to fund all trainings for CHSN partners and their staff in April 2018. Through a contract with the New Hampshire Alcohol & Drug Abuse Counselors Association (NHADACA) we were able to identify and address our regional training/education needs. The original CHSN and NHADACA training contract ended December 31, 2018 however it has remained "open" with monies left unspent from the original contract throughout 2019. Requests by partners wishing to send their staff to a NHADACA offered training are handled on an as requested basis through the CHSN Executive Director via email or a call and if approved, a code is provided to use as payment when registering online with NHADACA. CHSN-IDN5 also supported the registration fees and associated mileage for interested IDN partners' staff, including ten of the E5

community care coordinators and 2 CHSN staff members to attend the NH Behavioral Health Summit on December 16-17, 2019.

- Between the CHSN training contract with NHADACA and other trainings IDN5 partners' staff participated in (and that were reported to CHSN), 807 individuals have been trained on various integration/SUD/BH topics since mid-2017 and 93 within this July – December 2019 reporting period.

- Above and beyond the NHADACA offerings, partners are routinely reminded and encouraged to reach out to CHSN when there is a training opportunity that they or their staff would benefit from to improve their workforce's overall integration knowledge as funds are likely available to assist them.

- CHSN-IDN5 is one of the IDNs that collaborated with the NH State Loan Repayment Program to provide a match on behalf of organizations within our IDN whose employees are eligible for the Loan Repayment Program regardless of whether their employers currently offer a match. Offering a match elevates applicants higher on the list. CHSN-IDN5 has set aside $150K to assist 20 individuals with a $7,500 match for the following behavioral health specialties as delineated in the SLRP Tiers listed: Tier 2 = PA, APRN, CP, PNS, MHC, CSW, MFT, LPC, MLADC and Tier 3 = LADC. The CHSN-IDN5 match is in effect from Sept. 1, 2018 through Sept. 30, 2020 (or until such time that funds are depleted) to support matches for those partners who employees are eligible. 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 administers all aspects of the program and is notified when an applicant from our IDN is approved. CHSN-IDN5 then works directly with their employer to disburse the match payment.

- Effective October 2019, the CHSN Board extended a new offer to member partners to assist them with burdensome internal expenditures that related directly to recruitment, retention or training of staff that work within a specific DSRIP project or their agency's growth as it relates to hiring or training integrated behavioral health and primary care staff. Partners who provided back-up documents along with an explanation of and purpose for their 2019 expenses, could capture up to $15,000 in reimbursement for their agency's recruitment costs, retention-related expenses and in-house training/education expenditures. Six CHSN partners requested and received reimbursements totaling $83,569.39.

- CHSN-IDN5 has been offering all partners incentives through its Employee Retention Incentive Plan (ERIP) since January 2018. Network partners have now received three ERIP payments of either $5,000/$10,000/$15,000 depending on their identified "tier" which is based on agency type and level of IDN involvement. The incentive payments were designed to be paid out to partners every six months beginning January 2018 and ending December 2020. Payouts to partners are aligned with the timing of when an IDN learns if it received its DSRIP incentive payment based on semi-annual reporting performance. This enticement was set up to keep partners engaged in our

work by being accountable, producing data when needed, as well as being responsive to CHSN requests and being present at meetings. The objective is to assist partners by putting dollars back in their pockets to utilize for their unique and specific retention and recruitment efforts, loan repayment, merit increases, assistance with tuition, etc. CHSN tracks agencies' performance based on the established criteria and if criteria is met, an ERIP payment is made. The first payment was received in August 2018, the second payment was made in February 2019 and most recently in September 2019. CHSN partners have found that this incentive method allows them the flexibility to meet the ever-changing needs of their specific organization type and their unique hiring or recruitment needs at the time. Additionally, partners have stated that the ERIP funds have assisted their organization with overall employee satisfaction and retention (based on responses from a CHSN partner satisfaction survey performed in the spring 2019).

- The Statewide Billing and Coding committee has been meeting quarterly since early 2019 and in October they formed three subcommittees based on provider type: CMHC, FQHC and Hospital Outpatient. The focus for these groups is for Advocacy and Billing/Policy with a deliverable of identifying barriers to billing codes in Collaborative Care, Behavioral Health and Integrated Care. Leads for each of the groups were established and CHSN assisted them in gaining four representatives; three from the hospital and FQHC sector along with a subcommittee lead who works at our community mental health center.

- The CHSN Executive Director serves on the DSRIP Advisory Panel which meets monthly to help guide learning collaborative topics that Myers & Stauffer coordinates with DHHS. The Advisory Panel was formed to get well-rounded IDN representation to brainstorm ideas and topics that will best meet the needs of the IDNs and their partners by bringing forward educational opportunities surrounding integration topics, best clinical practices, strategic planning, alternative payment models and more.

- As mentioned earlier in this section, the CHSN Executive Director serves on the Statewide Workforce Taskforce Training and Education Workgroup which meets monthly to coordinate trainings being offered across the state, share IDN training resources and take on initiatives as they arise. IDN5s most recent activity includes the financial support, along with other IDNs, of the development and printing of the 5th edition of the New Hampshire Area Health Education Center's "Finding Your Career in Health Care" catalog. CHSN-IDN5 has plans to distribute this comprehensive resource to all of its region's high schools and technical colleges.

- As previously mentioned, the CHSN Board Chair serves also as the Chair of the Statewide Workforce Taskforce Policy subcommittee. This subcommittee is extremely active and on a monthly basis, the CHSN Board is provided updates of statewide and regional activities at its regular monthly board meeting through either a verbal or written report provided by the Chair. Workforce and legislation updates are also shared with network partners on a quarterly basis to keep partners informed of regional and statewide workforce activities and potential legislation, etc. An excerpt of the significant policy legislation being followed by the subcommittee is below.

Bill #	Title	Status
HB 113	**Relative to qualifications for and exceptions from licensure for mental health practice** Allows experience as a master licensed alcohol and drug counselor to qualify as experience for licensure as a clinical social worker or clinical mental health counselor. The bill also clarifies the mental health license exemption for psychotherapy activities and services of psychologists and master licensed alcohol and drug counselors.	Chapter 74 Signed by Governor Effective 08/17/2019
HB 131	**Establishing a commission on mental health education and behavioral health and wellness programs** Establishes a commission to develop and promote mental health programs and behavioral health and wellness programs in kindergarten through grade 12.	Chapter 255 Signed by Governor 7/19/19 Effective 7/19/2019
HB 239	**Relative to requirements for supervision for licensure of certain mental health and drug counselors** Permits supervision to take place at a location mutually convenient to the supervisor and the candidate for licensure.	Chapter 207 Signed by Governor Effective 9/10/2019
SB 5-FN-A	**Making an appropriation relative to Medicaid provider rates for mental health and substance misuse and emergency shelter and stabilization services** $3,000,000 for fiscal year ending 6/30/19 for the purpose of enhancing provider rates for mental health and SUD inpatient and outpatient services consistent with 2018, 342. $450,000 for emergency shelter and stabilization services.	Governor Vetoed. Veto sustained See HB 2, sec. 416 – emergency shelter and stabilization services - $450,000
SB 11-FN-A	Relative to mental health services and making appropriations therefor • Authorizes surplus funds for DRFs and for voluntary inpatient psychiatric admissions • Makes an appropriation to DHHS to renovate certain existing facilities • Provides for rulemaking for involuntary admission hearing requirements • Requires insurers to reimburse certain facilities for emergency room boarding $607,509 – increase DRF rates $500,000 – atypical rate for voluntary inpatient psych $4.4 million – renovate DRFs $2.1 million – supported housing for persons with SMI $3 million – mobile crisis team or BH crisis treatment center	Chapter 41 Signed by Governor Effective 5/21/2019; 7/1/2019
SB 80	**Relative to membership on the board of mental health practice, applications for licensure by mental health practitioners, and insurance credentialing of out-of-state mental health practitioners and psychologists** • Adds 2 members to the board (CMHC, CHC) • Requires MHP board to adopt rules for timely action on license applications by qualified applicants • Clarifies procedure for insurance credentialing of out-of-state mental health practitioners and psychologists applying for state licensure	Chapter 228 Signed by Governor Effective 9/10/2019
SB 176	**Establishing a committee to study mental health and human service business process alignment and information system interoperability** Committee's study to include, but not be limited to, methods to improve access to services, reduce duplicative effort, and integrate primary care mental health and substance use treatment systems.	Chapter 272 Signed by Governor Effective 7/19/19

SB 180	**Relative to privileged communications under the law governing mental health practice** Clarifies when disclosure of privileged communications is authorized under the law governing mental health practice	Chapter 200 Signed by Governor Effective 9/8/19
SB 225	**Adding physician assistants to certain New Hampshire laws** Inserts physician assistants in various statutes concerning mental health services, involuntary emergency admissions to mental health facilities, mental health practice, and insurance coverage	Chapter 278 Signed by Governor Effective 7/19/19
SB 258	**Relative to telemedicine and telehealth services** Adds definitions to and clarifies the statute governing telemedicine and Medicaid coverage for telehealth services.	Chapter 321 Signed by Governor Effective 10/11/19 for Medicaid; 1/1/20 for Insurance statute
SB 292-FN	**Relative to implementation of the new mental health 10-year plan** Requires the commissioner to submit a report containing the procedures for implementation of the 10-year mental health plan within 6 months of finalization of the plan. Amendment removes 2-year implementation	Chapter 248 Signed by Governor Effective 7/12/2019
SB 308-FN-A	**Relative to the health care workforce and making appropriations therefor** • Increases Medicaid provider rates. (in HB 2) • Requires certain health care professionals to complete a survey collecting data on the primary care workforce. (in HB 127) • Requires DHHS to amend the income standard used for eligibility for the "in and out" medical assistance policy. • Permits the department of safety to contract with a private agency to process background check applications, and requires the department to accept and process background check applications online. • Amends the definitions and services covered through telemedicine. • Makes appropriations to DHHS for new positions and programs to develop and enhance healthcare workforce. (in HB 2) • Makes an appropriation to the governor's scholarship program for scholarships to students majoring in a health care field and to postsecondary educational institutions to develop and enhance programs of study offered in health care.	Senate Tabled SB 308 sections included in HB 1 and HB 2 Conference Committee Report, **#2019-2630c** See HB 2: Rate Increases: Sec. 69, 374-375 SLRP: Sec. 399-400 - $3,250,000/yr
HB 127	**Relative to the board of medicine and the medical review subcommittee and relative to health care workforce survey data** ▪ Senate inserted SB 308 provision to require certain health care professionals to complete a survey collecting data on the primary care workforce.	Chapter 254 Signed by Governor Effective 7/1/19
HB 570 Added 9/6/19	Establishing a commission to study career pathways from full-time service year programs to postsecondary education and employment opportunities in support of New Hampshire's future workforce needs	Chapter **135**

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

Use the format below to provide an **updated list of key organizations** and providers participating in the IDN to support workforce development within the reporting period. Include and note workforce related to the IDN HIT Infrastructure, IDN Integrated Healthcare, and the IDN selected community projects.

Key organizations and providers participating in the IDN to support workforce development are displayed in the table below. Please note that the 14 organizations identified as participating in the B1 – Integrated Care project are listed first, all other CHSN-IDN5 partner organizations follow.

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

Organization Name	Organization Type	Associated with IDN Projects (A1, A2, B1, C, D, E)
Cornerbridge	Peer Support Agency	A1, A2, E
Crotched Mountain Foundation	Disability Services and Support	E
Easter Seals/Farnum North	SUD Treatment Agency	A1, A2, D
Grafton County	Corrections	C
Granite State Independent Living	Disability Services and Support	E
Merrimack County	Corrections	C
National Alliance on Mental Illness – NH	Peer Support Agency	C, E
Navigating Recovery of the Lakes Region	Recovery Support Organization	A1, A2, C, D, E
NH Alcohol and Drug Abuse Counselors	Professional Association and Training	A1
NH Veterans Home	Long term care	A1, A2, E
Plymouth Area Recovery Connection	Recovery Support Organization	A1, A2, C, D, E

Staffing All Projects

Provide the IDN's current number of full-time equivalent (FTE) staff needed to address the gaps identified in the IDN's Workforce Capacity Development Implementation Plan. Include workforce related to the IDN HIT Infrastructure, IDN Integrated Healthcare, and the IDN selected community-driven projects. This table should be the sum of all community-driven projects and also include any IDN administrative staff.

CHSN-IDN5 began hiring for key positions to support its three community project needs immediately upon receiving Implementation Plan approval. There were 3.5 FTEs assigned to CHSN administration staff and 25 community project staff projected. All 28.5 positions were successfully filled before or no later than 6/30/19. In brief, the C2-Community Re-Entry project projected the need for 7.5 positions to support the project and all positions have been and remain filled. The D3-Expansion of Intensive SUD Treatment Options project projected the need for 8.1 positions to support the project and all have been filled. The E5-Enhanced Care Coordination project projected the need for 9.4 positions to support the project and all are currently filled. Therefore, 100% of all identified staff have been hired to perform the functions of the community-driven projects. The CHSN administrative staff has been comprised of one full time Executive Director, one full time Data Analyst, one full time Project Manager and a part time Administrative Assistant. The CHSN Project Manager position was vacated mid-2019 and in September 2019, the position and its functions were re-evaluated by the CHSN Executive Director and leadership who chose not to rehire for the position given the late stage of the DSRIP waiver. This position had primary oversight of the three community driven projects and given they are all running smoothly the administrative oversight was shifted to another individual serving on the project. For the C2 and D3 projects, the IDNs C2/D3 Project Lead, [redacted], has accepted this administrative oversight function and the CHSN Executive Director, [redacted], has taken administrative oversight of the E5 project in conjunction with designating a Community Care Team Leader to serve as liaison between the community

care team and CHSN. Therefore, please note in the table below that the Project Manager position has been stricken to reflect this change and our new workforce total will now reflect 27.5 (rather than 28.5).

Provider Type	IDN 5 Workforce (FTEs)				
	Projected Total Need	Baseline Staffing on 12/31/18	Staffing on 6/30/19	Staffing on 12/31/19	Staffing on 6/30/20
CHSN Executive Director	1	1	1	1	
~~CHSN Project Manager~~	~~1~~	~~1~~	~~1~~	~~0~~	
CHSN Data Analyst	1	1	1	1	
CHSN Administrative Assistant	.5	.5	.5	.5	
Chief Information Officers *(agency-based – NOT included in IDN projected totals)*	10	11	11	11	
Re-entry Care Coordinator (Horizons)	1	1	1	1	
Re-entry Care Coordinator (LRMHC)	1	1	1	1	
Peer recovery support workers - future CRSW (Navigating Recovery)	2	2	2	2	
SUD Counselor/LADC (positioned at jail) (Horizons)	1	1	1	1	
SUD/ Co-occurring counselor/MLADC (Horizons)	1.5	0.5	1.5	1.5	
Case Manager or clinician, shared float (Horizons)	0.5	0.5	0.5	0.5	
Case manager or Clinician (Masters level) (LRMHC)	0.5	0.5	0.5	0.5	
MD (Horizons) (increase to 0.2 when expand to Plymouth)	0.1	0.1	0.1	0.1	
SUD Counselors / LADC (Horizons)	2	2	2	2	
SUD/Co-occurring counselor/MLADC (Horizons) Laconia IOP	1	1	1	1	
Admin. Assistant (Horizons)	0.5	0.5	0.5	0.5	
Recovery support worker (Horizons)	1	1	1	1	
Benefit Navigator (LRGHealthcare)	0.1	0.1	0.1	0.1	
Benefit Navigator (HealthFirst)	0.1	0.1	0.1	0.1	

Provider Type	IDN 5 Workforce (FTEs)				
	Projected Total Need	Baseline Staffing on 12/31/18	Staffing on 6/30/19	Staffing on 12/31/19	Staffing on 6/30/20
Case Manager / Care Coordinator (LRMHC)	0.4	0.4	0.4	0.4	
Recovery Support Worker (Navigating Recovery)	1	1	1	1	
Recovery Support Worker (PARC)	2	0	2	2	
Care Coordinator (LRGHealthcare)	1.25	1.25	1.25	1.25	
Care Coordinator (Horizons)	1.0	1.0	1.0	1.0	
Care Coordinator (ServiceLink)	0.5	0.5	0.5	0.5	
Care Coordinator (HealthFirst) *.25 shared with Riverbend*	2.25	2.25	2.25	2.25	
Care Coordinator (LRMHC) *1 – Laconia; .5 – Plymouth*	1.5	1.5	1.5	1.5	
Care Coordinator (Riverbend) *.75 shared with HealthFirst*	.75	.75	.75	.75	
Care Coordinator (Speare Memorial)	1.0	1.0	1.0	1.0	
Care Coordinator (Mid-State)	1.0	1.0	1.0	1.0	
Care Coordinator (Pemi-Baker Community Health)	0.15	0.15	0.15	0.15	

Budget

Provide a narrative and a brief project budget outlining actual expenditures and projected costs to support the workforce capacity development implementation plan which must include financial reporting on actual spending to **recruit, hire, train, and retain the workforce**.

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 this reporting period were utilized to support CHSN-IDN5 participation in statewide trainings, IDN5 specific regional trainings to support integrated practice development, SLRP loan repayment to support provider recruitment or retention, a NHADACA training contract to provide required and ongoing trainings, an Employee Retention Incentive Plan to assist in training, retention and overall employee satisfaction for CHSN member and affiliate organizations and new in 2019, CHSN offered up to $15,000 in reimbursement for partners who had proof of workforce recruitment, retention and training expenditures that directly supported the DSRIP waiver and/or expanded behavioral health programming at their agency.

Please note that the CHSN Board addressed the need to review the CY 2021 projections but agreed to put this exercise off until such time that we know what financial contribution will be made by the NH Counties as it impacts our future funding situation significantly. This will be revisited by the CHSN Board and Administrative Lead's finance director hopefully by spring once the level of County funding is known and has been confirmed.

Specific A1 expenditures for this reporting period total $331,044 which include $5,500 paid to [redacted] for registration fees within the training contract; $90,544 in additional DSRIP training/recruitment/retention related reimbursements to partner agencies; and $205,000 was paid out in September 2019 to CHSN-IDN5 partners for the third issuance of Employee Retention Incentive Plan checks which incentivize partners and reward them with funds to be used towards employee retention and recruitment efforts within their agency. There were four SLRP applications approved for a CHSN-IDN5 match of $7,500 each totaling $30,000 in committed funds. Detailed activities can be found in the table below.

CHSN-IDN 5: Total Budget & Actual - Projected July 1, 2016 - June 30, 2022									
	Total Program Cost								
Line Item	CY 2016 Actuals	CY 2017 Actuals	CY 2018 January to June Actuals	CY 2018 July to December Actuals	CY 2019 January to June Actuals	CY 2019 July to December Actuals	CY 2020 Projected	CY 2021 Projected	Total
PPI									-
- Administrative lead	62,303	224,993	103,562	139,617	131,217	108,109	239,326		1,009,128
-Project lead expenses		41,525	42,776	20,650	19,582	10,025	10,000		144,558
-Partner discretionary or other grants	1,200	62,647	6,080	2,500	3,500	5,446	13,627		95,000
-Community input	42,467	34,147							76,614
Total PPI	**105,970**	**363,312**	**152,418**	**162,767**	**154,299**	**123,580**	**262,953**		1,325,300
A1	-	-	13,688	280,769	237,452	331,044	568,496		1,431,448
A2	-	21,956	154,773	82,324	65,634	109,770	160,941		595,398
B1	-	2,500	72,500	-	70,000	6,284	70,000		221,284
- Integration Demonstration Projects	-					1,144,512			1,144,512
C2	-	35,370	84,986	75,871	118,992	160,269	279,261		754,749
D3	-	40,281	96,982	116,801	128,073	126,216	254,289		762,642
E5	-	45,941	264,268	330,775	315,167	310,227	625,394		1,891,772
Total DSRIP Projected Expenditures	**105,970**	**509,360**	**839,615**	**1,049,307**	**1,089,617**	**2,311,902**	**3,169,072**	958,161	10,033,004
10% Reserve for Matching Fund and Performance Metrics Uncertainty	-	-	-	209,219	209,219	209,219	418,438	209,218	1,255,313
	105,970	509,360	839,615	1,258,526	1,298,836	2,521,121	3,587,510	1,167,379	11,288,317

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

Narrative

CHSN-IDN5 participates in the UNH/CHI Site Self-Assessment survey and the most recent results from fall 2019 were analyzed this quarter. The areas that saw the biggest increases from last year's SSA results were the overall level of integration and screening/follow-up for mental health disorders. The increase in the screening/follow-up score is a big positive for our IDN ahead of the next semi-annual reporting period. Hopefully, the increases in the SSA will correlate with increases in performance for our screening measures. In addition, there has been a steady increase in the data systems/patient records category of the SSA over each iteration. This speaks to our IDNs willingness to work with and engage with partners on increasing data quality and supporting their efforts to upgrade EMR systems and improve HIT infrastructure as well as our partners' willingness to work with the IDN when we ask for more fields in their systems to capture data for DSRIP reporting. Overall, the SSA results were much improved from last year and we look forward to seeing increased improvement toward integration when partners take the final SSA scheduled for fall 2020.

HealthFirst Family Care Center

- HealthFirst has continued to improve their technical workflows surrounding administration of the CCSA. They are using the PRAPARE assessment tool within Centricity to accomplish this. By improving CCSA workflows within Centricity, we anticipate their CCSA screening results increase for our performance measures.

Mid-State Health Center

- On 09/26/2019 Mid-State upgraded to eMDs Solution Series 9.1.
- On 11/13/2019 Mid-State performed a service pack upgrade from 2019.06.04 to 2019.10.07.

Riverbend Community Mental Health

- Riverbend added fields to their EMR to collect additional fields for data reporting which should lead to improved performance results.
- They worked to solved workflow issues related to uploading patient rosters to CMT as well as the release date of their clients in CMT.
- MAeHC uploads have been through multiple data quality checks during the reporting period to refine and update the files being sent to MAeHC so that they are more accurate.
- CMT penetration increased to 62% of clients.
- ED is only receiving fax notifications for clients with a Shared Care Plan entered to increase population of Shared Care Plans in CMT.

Horizons Counseling Center

Horizons has obtained a new main computer with greater hard drive capacity and memory and newer OS. They have also purchased four new laptops so that case managers and CRSWs have access to email communication as well as data centers, CMT, etc. They have also obtained three Chromebooks, with the

support of CHSN, to assist clients in signing up for Medicaid when they come in for screening or intake and are not yet covered by insurance and so that C2 Project clients can do job searches and applications when they are in for treatment. This has been a positive addition to the recovery support services they provide, and they are looking to expand this to IOP clients as well.

In this reporting period, Horizons met with IT companies to explore a new EHR. They have narrowed it down to three possibilities and their office manager will be testing all three in the next 1-2 months. They hope to have a system in place that will more readily communicate with other systems by the spring. The systems being explored all have a billing component to them, which will allow them to consolidate the clinical case recording and the billing in one product thereby streamlining both functions and combining the data collection capabilities of both tasks into one system.

Lakes Region Mental Health Center

- Trained all staff in collaborative documentation.
- IT staff did a ride along / shadowing exercise with community-based care staff to assess connectivity, internet access, ease of forms/documentation, and size/style of laptop.
- Switched to WEB based forms for community support notes, treatment plans and med notes which allows staff to complete paperwork with patients faster without being dependent on internet connectivity.
- Received a grant that allowed them to purchase 9 Microsoft Surface tablets for patients to use with their EMR vendor's patient portal to capture medical screening information in real time and populate record for prescribers prior to visit.
- Purchased 65 new smart phones upgrading community-based staff from flip phones to allow texting with patients that assists in improving cancellation and DNA rates, improving ability to fill down time (increasing accessibility).
- Began the upgrade from Windows 7 to 10 now and should finish for all users in the next 2 months.
- Purchased the first five of 65 new lightweight computers for community staff.
- Engaged an external vendor to help assess and revise their network infrastructure.

LRGHealthcare & Speare Hospital Practices

It has been a busy 2019 for Asquam Community Health Collaborative supporting Speare Memorial Hospital and LRGHealthcare. Both organizations share a single but separated Cerner EHR currently running version 2015.01.27. On top of kicking off a major Cerner system upgrade to a new version (2018.02.XX), they completed several Cerner and ancillary system upgrades. They implemented many Cerner and ancillary system enhancements to optimize operations and they addressed the regulatory and vender requirements for EOL and EOS systems. Below are some of the high-profile system enhancements, upgrades, and integration items they completed in the second half of 2019.

- HealthFirst (LRGH) interface for primary care lab results
- Electronic lab reporting to the state of NH
- Installed and integrated 2 lab (BACTEC) cultural analyzers
- Installed a new DH Telepharmacy interface with Cardinal Health
- Attested for MU 3 out of Cerner Millennium
- Completed the flu preparation services for both organizations
- Redesigned and implanted new orders workflow for ED charge procedures
- Installed a new pathology Seacoast interface for ADT, orders and results

- Implement a new Seacoast Pathology interface for detailed financial transactions
- Completed new CPT code load for 2020
- Upgraded iBus and Fetalink interface systems to address new version moving forward
- Upgrade NCR to replace CAHPS paper surveys with new electronic HL7 ADT interface
- Implemented a Hepatitis A vaccine screening and intervention protocol
- Upgrade infrastructure to support Dartmouth Tele-Services
- Implemented ACR Optimization process and protocol to address state requirements
- Implemented integration with Jefferson Powerscribe and Mammo Gi Rad.
- Embedded UP TO Date UTD links within Cerner
- Completed new data closet buildout to the ED renovation project
- Implemented Paylocity for timekeeping, scheduling and payroll
- Kicked off the Windows7 to Window10 upgrade for all desktops, laptops and peripherals
- Implemented system changes to support free-standing imaging center
- Implemented Medication Assisted Treatment service offering for ED

Pemi-Baker Community Health

Pemi-Baker Community Health (PBCH) submitted a proposal to receive CHSN-IDN5 "Integration Demonstration Funds" to help them acquire a new EMR system (Kantime). The IDN was able to approve the proposal and the new EMR system will be implemented in 2020. Below is a summary of the proposal.

PBCH has had its current EMR (Electronic Medical Record) since early 2005. As they grew and found that their patients needed more acute care in their homes, PBCH recognized the need to move to a new software. They reviewed many different options and found that Kantime would be best for the Agency. In addition to needing an improved EMR, their homecare program will be going through a change with how billing and reimbursement operate due to the government's transition to PDGM (Patient Driven Grouper Model). They anticipate a decrease in productivity and an impact on revenues for at least the first 3 months of 2020. Kantime will assist with the move to PDGM by improved documentation components and compliance. Ultimately, the new EMR will enable them to reduce documentation redundancy, improve quality of patient records, and result in efficiencies. By being cloud based, Kantime will allow for quicker flow of information from the field clinicians to staff at the office, which will increase the ability to communicate more effectively with external medical staff. This increased communication between their agency and referring physicians will increase quality of care, as well as patient outcomes.

Evaluation Project Targets

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

Performance Measure Name	# of Participating Practices	Progress Toward Target		
		As of 12/31/18	As of 6/30/19	As of 12/31/19
Event Notification Services	14	9	14	14
Shared Care Plan	14	9	14	14
Closed Loop Referral	14	14	14	14
Data Reporting	14	13	14	14

Performance Measure Name	# of Participating Practices	Progress Toward Target		
		As of 12/31/18	As of 6/30/19	As of 12/31/19
Data Sharing	14	10	14	14
Care Coordination	14	14	14	14

Budget

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

Expenditures within this reporting period include payments to [redacted], [redacted] for reimbursement of an invoice from CHAN for work performed to assist with MAeHC reporting simulation; [redacted] for annual subscription fees for partners utilizing secure messaging; [redacted] for subscription fees and [redacted] for CHSN's Data Analyst salary, benefits, mileage and cell phone reimbursements for a total of $109,770 in expenditures between July - December 2019. See table below for detail.

Budget Item	Item Description	CY 2017 Actual Cost	Jan – Jun 2018 Actual Cost	Jul – Dec 2018 Actual Cost	Jan-Jun 2019 Actual Cost	July-Dec 2019 Actual Cost	Total Project Cost to Date
[redacted]	[redacted]	0	$35,763	$35,763	$35,763	$36,299.46	$143,588.46
Mileage and cell phone reimbursement	CHSN Data Analyst reimbursements	0	$549.50	$431.50	$563.66	$592.87	$2.137.53
Consultants/ Subcontracts	[redacted] – development of client consent for inter-agency data sharing documents	$5,500	0	0	0	0	$5,500
[redacted]	[redacted]	$12,217.50	$24,435	$24,435	$24,435	$24,435	$109,957.50
[redacted]	[redacted]	0	$92,500	$21,695	0	$46,000	$160,195
Agency-specific support	Costs to bring agencies up	$900	$1,500	0	$2,100	0	$4,800

	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	0	0	0	$2,687	$643	$3,330
Miscellaneous	Reimbursement to consultants for developing privacy/data sharing documents	$2,625	0	0	0	0	$2,625
Data Analyst miscellaneous expenses and office supplies	CHSN cost to purchase laptop for new Data Analyst	$713.53	$25	0	$84.95	0	$823.48
HIT CAPACITY BUILDING TOTAL		$21,956.03	$154,772.50	$82,324.51	$65,633.61	$109,770.33	$434,456.98

Project B1: Integrated Healthcare

Narrative

Include a detailed narrative which lists every participating provider at the practice level and the progress made during the reporting period toward the Integrated Care Practice Designation. This should include the number of participating individuals, major accomplishments, barriers and setbacks.

Integrated Care Practice must include:

- Medication-assisted treatment (MAT)
- Evidence-based treatment of mild-to-moderate depression within the Integrated Practice setting either (e.g., IMPACT or other evidence-supported model)
- Enhanced use of technology

Numerous integration improvements including access to care and/or social service improvements have occurred across the IDN5 region this reporting period. Although not all are specifically tied to one of the six required DSRIP projects, we believe you will agree that these region-wide improvements will only help our Medicaid population with receiving much needed services to improve their overall physical, mental and social health concerns. Some improvements and developments are highlighted below.

CHSN Integration Demonstration Projects

A new "CHSN-IDN5 Integration Demonstration" funding opportunity was released on October 25th to member partners which included proposal guidelines and an application to support projects that align with the DSRIP waiver intentions and goals and additionally supporting regional integration of behavioral health, increased access to services/programming. The application deadline was November 15th and produced nine applications from seven partner agencies proposing a variety of integration projects all of which met the pre-established criteria. A review committee was formed of board members whose partner agencies who had no conflict of interest with the proposals along with the CHSN Executive Director. In early December the review committee recommended to the CHSN Board that nine proposals totaling $1,143,551.63 be approved and that 50% of the requested funds be issued by year-end. The vote passed unanimously. The remaining 50% will be accrued in our budget but will not be issued for 6-months and an interim report on progress is received reflecting that the projects remain in compliance and goals are being met. Some of the integration projects include: supporting a new IOP program in Plymouth, assisting with the purchase of a home health agency EMR, providing funds to continue the OneHealth program for another year, providing support to add an onsite behavioral health counselor at a Plymouth pediatric practice, funding to assist with the ACERT program, funding to add Recovery and SUD Services Program for dually diagnosed patients, and more. All of these projects will assist in making additional BH services available to the IDN5 region while supporting the DSRIP waiver goals and intentions.

Compass House

Horizons Counseling Center, Navigating Recovery and Lakes Region Community Developers partnered to apply 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. Funding was received and the new Compass House, located at 658 Union Avenue in Laconia, will provide a much-

needed resource for sober living for women in the Lakes Region with a grand opening anticipated in February 2020.

Same Day Access

Lakes Region Mental Health Center received a grant which will allow them to implement a new initiative, called Same Day Access. In an era of integrated healthcare reform, access to treatment is even more critical and Same Day Access is an engagement strategy for organizations to offer an assessment on the same day requested by the consumer. By eliminating scheduling delays and waitlists, consumer no-shows should stop and thus improve LRMHCs capacity to serve more individuals who are in need of services. They will do so by offering blocks of time when patients are invited to walk in and have an intake assessment completed by a clinician and at least one goal of the treatment plan based on the patient's presenting problem. The patient would then leave the office with a therapy appointment and a psychiatric evaluation appointment if warranted. The grant funds will be used to support the purchase of technology needed to automate current paper workflows, the investment of information technology resources needed to rewrite code, build Electronic Medical Record integration programs and conduct data mapping for the project as well as conduct all-staff and management training on new data processes, procedures and outcome measurement protocols.

Adverse Childhood Experiences Response Team (ACERT)

In August 2019, Lakes Region Community Services, along with the Laconia Police Department announced the rollout of a program designed to help children who experience some kind of traumatic event. ACERT, offers a new way for local police and other first-responders to ensure that affected children are appropriately cared for and supported in dealing with both the immediate-term fallout from whatever the incident was, as well as the often-underlying and related longer-term issues. With opioid incidents, for example, it offers a way for parents to enable immediate and ongoing outside support for their children. LRCS modeled its program on the nation-leading innovative work of the Manchester, NH Police Department in 2015. When a police officer responds to a call where a child has witnessed or been involved in a traumatic event, they work with the family to get a release signed which allows the police to contact the LRCS Family Resource Center and the school district (if applicable) to address the child's additional support needs to mitigate ACE's (Adverse Childhood Experiences). The most significant element of this program is referring children and families to the appropriate supports they need to address trauma. Within ACERT a child/family will experience a warm hand off to services that include (but are not limited to); behavioral health, physical and/or mental health support, peer support, benefit needs and crisis interventions. Adverse Childhood Experiences are significant enough events for children that it can affect their emotional and physical health as adults. By supporting children, ACERT has proven to lessen the lasting effects of their trauma and is being discussed on a number of levels across the country. Being able to have one of the first programs in the country (second to Manchester) Laconia is on the cutting edge of supporting children. LRCS knew the ACERT program funding was not sustainable and did not allow for any growth, so being an IDN5 partner providing services for individuals with developmental disabilities, they submitted a proposal for "CHSN Integration Demonstration" project funding in November to provide funding for the ACERT program director for one additional year while they work with state legislation and grants to secure sustainable funding to offer and grow this valuable program and resource to the region's children.

Plymouth Area Recovery Connection (PARC)

A new recovery community organization (RCO) in Plymouth NH has formed and an Executive Director was hired in November. PARC is an independent, non-profit organization led and governed by representatives of local community organizations. They will have two recovery support workers available to assist the clients within the greater Plymouth community with much needed peer recovery services and will be play a significant role in the new Plymouth based Intensive Outpatient Program (IOP) slated to open in January 2020 through a collaborative effort between Mid-State Health Center, Speare Hospital and PARC.

Fall 2019 UNH/CHI Site Self-Assessment Survey Results Overview

In October 2019 CHSN-IDN5 B1 partners completed the "Follow-up 3" site self-assessment survey issued by UNH/CHI. Results from this latest report show significant growth in our region's integration efforts at the practice level. Although there are many accomplishments reflected in the SSA Roll-Up Report table below, CHSN-IDN5 is most pleased to highlight a few for purposes of this report. In the left column labeled "*Integrated Services and Patient and Family Centeredness*" IDN5 scored exceptionally high this last round on Question 2, "Screening and assessment for emotional/behavioral health needs." The IDN has shown marked improvement from its initial score of 8.2 to now a 9.3. We believe this increase is primarily affected by the addition of the 7 LRGH and 2 Speare practices who were the last to begin utilizing the CCSA (Sept. 2019). Additionally, on Question 6, "Communication with patients about integrated care" marks considerable improvement in the culture of our B1 practices to speak about integrated care with patients as we went from a 7.1 to a 8.2. Another increased score is with Question 7, "Follow-up of assessments, tests, treatment, referrals and other services" reflects the hard work invested by partners and CHSN to update processes and workflows to "close the loop" for patient referrals and more. This score went from an initial 7.0 to an 8.4 this reporting period. Lastly, in the right-hand columns for "*Practice/Organization*" we saw two exceptional improvements reflective of our IDNs investment and involvement with assisting our partner practices in their data systems. Question 6 "Data Systems/patient records" jumped from an initial 6.2 score to an 8.1. Proudly, Q8, "Physician, team and staff education and training for integrated care," went from a score of 4.7 at baseline to a 7.4 this reporting period. We strongly believe this increased score is due to the commitment, emphasis and value that the CHSN Board has placed on the increasing the regions' workforce through funding training and education offerings. A screenshot of the SSA Roll-Up Report is below for reference.

IDN Region: 5

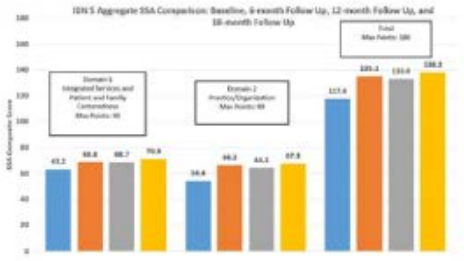
Site Self-Assessment (SSA) Roll-Up Report

Average Scores: Domain One
Integrated Services and Patient and Family Centeredness

	BL	F/U 1	F/U 2	F/U 3
1. Level of integration: primary care and mental/behavioral health care	4.8	4.6	4.6	5.8
2. Screening and assessment for emotional/behavioral health needs (e.g. stress, depression, anxiety, substance abuse)	8.2	7.7	8.5	9.3
3. Treatment plan(s) for primary care and behavioral/mental health care	6.5	7.3	6.5	6.8
4. Patient care that is based on (or informed by) best practice evidence for BH/MH and primary care	6.9	7.2	7.2	7.4
5. Patient/family involvement in care plan	7.8	8.6	8.4	7.8
6. Communication with patients about integrated care	7.1	8.4	8.1	8.2
7. Follow-Up of assessments, tests, treatment, referrals and other services	7.0	8.0	7.6	8.4
8. Social support (for patients to implement recommended treatment)	7.9	8.7	9.0	8.3
9. Linking to community resources	7.1	8.2	8.8	8.9

Average Scores: Domain Two
Practice/Organization

	BL	F/U 1	F/U 2	F/U 3
1. Organizational leadership for integrated care	7.4	8.6	8.5	8.6
2. Patient care team for implementing integrated care	6.6	8.3	7.3	7.8
3. Providers' engagement with integrated care ("buy-in")	7.2	7.5	7.0	7.7
4. Continuity of care between primary care and behavioral/mental health	6.3	7.3	6.8	7.0
5. Coordination of referrals and specialists	6.3	6.9	7.0	7.4
6. Data systems/patient records	6.2	7.2	7.6	8.1
7. Patient/family input to integration management	6.2	7.8	7.5	7.6
8. Physician, team and staff education and training for integrated care	4.7	6.9	6.4	7.4
9. Funding sources/resources	3.5	5.8	6.1	5.7



Note: BL - Baseline Assessment; F/U 1 - First Follow-Up Assessment; F/U 2 - Second Follow-Up Assessment; F/U 3 - Third Follow-Up Assessment

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

Use the format below to identify the total number of practices/providers who have **achieved** designation as a Coordinated Care Practice or Integrated Care Practice. IDNs are expected to make continual progress toward achieving their projected number of designated Coordinated Care Practices and Integrated Care Practices. **Please note that the six integrated care practices are included in our total number of coordinated care practices (14) because by virtue of being "integrated" those eight practices have already attained "coordinated" designation.**

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

Of the fourteen total practices, all eight practices identified to **solely** reach Coordinated Care Practice designation (Speare Primary Care, Plymouth Pediatrics & Adolescent Medicine, Belknap Family – Belmont, Belknap Family – Meredith, Lakes Region Family Practice, Hillside Family Medicine, Laconia Clinic, Caring for Kids), met this designation by the 6/30/19 reporting period and have continued to make progress across the SAMHSA continuum of care. Some of these activities are highlighted below.

Speare Primary Care

- Speare started initiating MAT in their ED when appropriate and then refer patients to Mid-State for continuation of care/services as they offer onsite MAT in both Plymouth and Bristol.

Plymouth Pediatrics & Adolescent Medicine (PPAM)

- PPAM received CHSN Integration Demonstration Project funding in December 2019 to hire an embedded behavioral health clinician within their practice, which will reduce the number of outsourced referrals to various specialists. Having in house behavioral health services will not just meet an unmet need in the region but will also provide continuity of care for pediatric patients and their families.
- The PPAM practice manager provided valuable input on the pediatric version of the CCSA and worked closely with the IDN and ASQUAM staff to develop the workflow for administering the CCSA in a pediatric setting.

Belknap Family Healthcare – Belmont

- CHSN, LRGH, and ASQUAM staff, the IT consultants for LRGHealthcare, worked closely to update Cerner, the hospital's shared EMR with Speare Hospital, with the CCSA social determinants of health questions. This change was effective to all of the B1 LRGH practices as of September 30th. Much of this reporting period was spent finalizing processes and workflows at the practice level for staff administering the CCSA and working through the kinks of handling referrals when a positive screen was identified. Utilization of the new CCSA screening tool has helped LRGH practices identify patients who may need additional social services or connections to resources. Additionally, at Lakes Region General Hospital specifically, a second LADC was hired and added to their Recovery Clinic to meet with patients on an individual and group basis.
- Some additional HIT upgrades related to LRGHealthcare and its practices are listed below.
    - HealthFirst (LRGH) interface for primary care lab results
    - Electronic lab reporting to the state of NH
    - Installed a new DH Telepharmacy interface with Cardinal Health
    - Installed a new pathology Seacoast interface for ADT, orders and results
    - Upgrade NCR to replace CAHPS paper surveys with new electronic HL7 ADT interface
    - Implemented a Hepatitis A vaccine screening and intervention protocol
    - Upgrade infrastructure to support Dartmouth Tele-Services
    - Implemented ACR Optimization process and protocol to address state requirements
    - Implemented Medication Assisted Treatment service offering for ED

Belknap Family Healthcare – Meredith

- CHSN, LRGH, and ASQUAM staff, the IT consultants for LRGHealthcare, worked closely to update Cerner, the hospital's shared EMR with Speare Hospital, with the CCSA social determinants of health questions. This change was effective to all of the B1 LRGH practices as of September 30th.

Much of this reporting period was spent finalizing processes and workflows at the practice level for staff administering the CCSA and working through the kinks of handling referrals when a positive screen was identified. Utilization of the new CCSA screening tool has helped LRGH practices identify patients who may need additional social services or connections to resources. Additionally, at Lakes Region General Hospital specifically, a 2nd LADC was hired and added to their Recovery Clinic to meet with patients on an individual and group basis.

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Lakes Region Family Practice

- CHSN, LRGH, and ASQUAM staff, the IT consultants for LRGHealthcare, worked closely to update Cerner, the hospital's shared EMR with Speare Hospital, with the CCSA social determinants of health questions. This change was effective to all of the B1 LRGH practices as of September 30th. Much of this reporting period was spent finalizing processes and workflows at the practice level for staff administering the CCSA and working through the kinks of handling referrals when a positive screen was identified. Utilization of the new CCSA screening tool has helped LRGH practices identify patients who may need additional social services or connections to resources. Additionally, at Lakes Region General Hospital specifically, a 2nd LADC was hired and added to their Recovery Clinic to meet with patients on an individual and group basis.
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Hillside Family Medicine

- CHSN, LRGH, and ASQUAM staff, the IT consultants for LRGHealthcare, worked closely to update Cerner, the hospital's shared EMR with Speare Hospital, with the CCSA social determinants of health questions. This change was effective to all of the B1 LRGH practices as of September 30th. Much of this reporting period was spent finalizing processes and workflows at the practice level for staff administering the CCSA and working through the kinks of handling referrals when a positive screen was identified. Utilization of the new CCSA screening tool has helped LRGH

practices identify patients who may need additional social services or connections to resources. Additionally, at Lakes Region General Hospital specifically, a 2nd LADC was hired and added to their Recovery Clinic to meet with patients on an individual and group basis.

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    - Upgrade infrastructure to support Dartmouth Tele-Services
    - Implemented ACR Optimization process and protocol to address state requirements
    - Implemented Medication Assisted Treatment service offering for ED

Laconia Clinic (primary care)

- CHSN, LRGH, and ASQUAM staff, the IT consultants for LRGHealthcare, worked closely to update Cerner, the hospital's shared EMR with Speare Hospital, with the CCSA social determinants of health questions. This change was effective to all of the B1 LRGH practices as of September 30th. Much of this reporting period was spent finalizing processes and workflows at the practice level for staff administering the CCSA and working through the kinks of handling referrals when a positive screen was identified. Utilization of the new CCSA screening tool has helped LRGH practices identify patients who may need additional social services or connections to resources. Additionally, at Lakes Region General Hospital specifically, a 2nd LADC was hired and added to their Recovery Clinic to meet with patients on an individual and group basis.
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    - Implemented Medication Assisted Treatment service offering for ED

Caring for Kids

- CHSN, LRGH, and ASQUAM staff, the IT consultants for LRGHealthcare, worked closely to update Cerner, the hospital's shared EMR with Speare Hospital, with the CCSA social determinants of health questions. This change was effective to all of the B1 LRGH practices as of September 30th. Much of this reporting period was spent finalizing processes and workflows at the practice level for staff administering the CCSA and working through the kinks of handling referrals when a positive screen was identified. Utilization of the new CCSA screening tool has helped LRGH practices identify patients who may need additional social services or connections to resources. Additionally, at Lakes Region General Hospital specifically, a 2nd LADC was hired and added to their Recovery Clinic to meet with patients on an individual and group basis.

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    - Implemented a Hepatitis A vaccine screening and intervention protocol
    - Upgrade infrastructure to support Dartmouth Tele-Services
    - Implemented ACR Optimization process and protocol to address state requirements
    - Implemented Medication Assisted Treatment service offering for ED

Of the fourteen total practices, the six practices identified to reach Integrated Care Practice designation (HealthFirst, Mid-State, Riverbend, LRMHC, Horizons, and LRGH-Westside) all reached integrated care practice designation within the 6/30/19 reporting period. These practices have all continued to make progress to further their practice's level of integration. Some of these activities are highlighted below.

HealthFirst Family Care Center

- HealthFirst continues to offer its Medication Assisted Treatment (MAT) Program services in both their Franklin and Laconia sites. There are currently 227 patients receiving MAT services.
- An existing HealthFirst APRN received his certification/education/training as a Psychiatric Nurse Practitioner increasing their behavioral health expertise onsite.
- They hired a new Behavioral Health Manager who has pushed forward the continued need to perform CCSAs for all patient assessments. The tracking of the CCSA information helps their team to better document and pay attention to the patient's Social Determinant of Health (SDoH) needs.
- Another member of the Behavioral Health team was hired in October. This individual is a half time counselor and half-time case manager, also helping to meet patient needs and managing wait times more effectively.
- A wait list was created in October for behavioral health patients, as their team was very busy, and patient needs were not being met in a timely manner. Guidelines and procedures for the waitlist have since been developed and specific intake slots were added to schedules to meet the needs of new patients without there being an extensive wait. Focusing on this one item has already decreased their BH waitlist significantly and has increased workflow and patient satisfaction.
- New behavioral health forms were created by Community Health Access Network (CHAN) that were rolled out at the end of the year for purposes of documentation for the EMR. In an effort to continuously improve the CCSA workflow at HealthFirst, the PRAPARE tool workflow was improved by the staff at CHAN to make the CCSA easier for providers to fill so that results of the CCSA could be more easily tabulated for reporting internally and to DHHS, as well as more easily readable by providers within Centricity.

Mid-State Health Center

- Mid-State continues to offer outpatient Medication Assisted Treatment (MAT) Program for opioid use disorder at both their Bristol and Plymouth locations using medications in combination with counseling and behavioral therapies for the treatment of substance use disorders. The program is for adults 18 years of age or older. Mid-State's Recovery Team is available 5 days a week during regular business hours.

- Four members of the clinical team completed Upskills Medical Assistant training which includes Inter-professional Team-Based Care; Quality Improvement and Making Data Count; Immunizations, and Professionalism and Effective Communication modules. The course focuses on training MAs to understand their important role in the care team in integrated care settings.
- They launched an organizational wide training Addiction 101 - a series of webinars that highlights the ever-changing landscape of substance use disorder to help their organization give the most effective treatment to patients. Topics covered include the disease process; why people use; how to view addiction as a disease; Medicated Assisted Treatment information; professional boundaries; and stigma and harm reduction. 65% +/- of Mid-State's staff were trained during this reporting period.
- Mid-State began offering Same Day appointments in the fall to accommodate for the demands of their patients.
- Mid-State hired 1 FTE MLADC who will lead the development and implementation of the Intensive Outpatient Treatment at Mid-State's new location at Whole Village Family Resource Center.
- Mid-State developed several operational policies focused on recovery programming and operations to ensure evidence-based best practices are followed.
- Mid-State established a relationship with Littleton Regional Hospital (IDN 7) to host visiting specialists in its Plymouth office to improve patient access to specialists in its rural region.

Riverbend Community Mental Health Center

- Riverbend offers MAT services in their Concord location only. They have not expanded these services yet to their site in Franklin (IDN5). To assist with this gap in the region they began offering a 60-minute relapse prevention group on Mondays from 9-10am.
- Riverbend partnered with HealthFirst Franklin to offer psychiatric consultations for prescribers who are not experienced with psychiatric medications. This service offers improved clinical care for clients who are either not eligible for services within the community mental health system or who have long term stability and can "step down" to psychiatric care at a PCP office. This formal consultation with a new psychiatric provider is held at HealthFirst Franklin with one-hour appointments each month. Meetings are conducted on an as needed basis between the HealthFirst medical director and the Riverbend Franklin adult psychiatrist to coordinate patient care.
- As part of their enhanced use of technology, Riverbend solved workflow issues related to uploading patient rosters to CMT as well as the release date of their clients in CMT. This increased CMT penetration to 62% of all clients seen. As part of an effort to increase Shared Care Plans, the ED is only receiving fax notifications for clients with a Shared Care Plan entered.

Lakes Region Mental Health Center

- LRMHC opened a new "Choices Group" for adults with Severe Mental Illness (SMI) and Serious and Persistent Mental Illness (SPMI) at their Plymouth site and created a new position to oversee these services. They are in the process of developing an MOU for this MLADC to provide supervision for CRSW's with the Plymouth Area Recovery Center (PARC) and she is setting up Peer Consultation with the MLADC at Mid-State who is overseeing their IOP. LRMHC has identified approximately 300 adults that are currently in services that have co-occurring disorder. Although they are currently providing individual therapy to a small percentage of these individuals this expansion will allow for an increase to those services. They also working on a sustainability plan

and have held meetings to set up program and billing codes which will allow them to serve a greater array of individuals (those adults that do not meet state criteria for eligibility). The new MLADC will also be reaching out to Navigating Recovery of the Lakes Region regarding collaboration around CRSW's with regards to training and provision of services.

- LRMHC hired a Medical Assistant for their OneHealth program as they continue this project in collaboration with HealthFirst in Laconia and Mid-State in Plymouth. Having an MA provides more flexibility for the provision of services and allows nursing staff to focus on patient face-to-face contact preserving a valuable resource given the workforce shortage in nursing in particular. This position will also provide tighter administrative controls on follow-up and continuity of integrated care.
- The OneHealth program continues to provide integration of behavioral and physical health services and has documented success in achieving increased health outcomes for nearly 400 individuals with SPMI and SMI served by this program. It is expected that these numbers will increase as the program continues. These health goals: reduced BMI, reduced HBP, reduced ACL, address long standing health related issues among those with chronic mental health issues who have been historically less well served by a medical community not integrated with mental health. These goals are also achieved by the close collaboration of their InSHAPE program. InSHAPE is an evidenced-based practice that provides nutritional, health and fitness support to those with mental illness.
- LRMHC continues to hold monthly meetings of all staff involved with IDN5 projects. These meetings have helped them identify and address issues and barriers with partners. As a result, they have established ongoing opportunities for communication; examples would be their weekly meetings with other IDN participants serving Belknap House of Corrections and ad hoc meetings with other community care coordinators/case managers (CCCs) to address continuity of care issues. These meetings have helped them identify internal needs regarding IDN projects, such as expanding staff access to CMT and formalizing communication between LRMHC CCCs and the other CCCs working for other IDN partners in the region. One process/workflow identified as a need from these meetings resulted in their CCC now meeting monthly with Community Support Program CCCs and arranging meetings as needed with CCCs working with other stakeholders when there are issues.
- HIT Integration Updates include:
  - Trained all staff in collaborative documentation.
  - Switched to WEB based forms for community support notes, treatment plans and med notes which allows staff to complete paperwork with patients faster without being dependent on internet connectivity.
  - All LRMHC nurses and Community Support Program Coordinators now have access to CMT.

Horizons Counseling Center

- In this reporting period Horizons obtained (with IDN support) three Chromebook laptops for clients at all levels of care to use to apply for Medicaid if they apply for treatment without having active health insurance and to work with their care coordinator on applying for employment, sober housing or submitting applications for residential treatment when indicated.
- Horizons worked closely with the Belknap County Department of Corrections to begin implementing MAT in the jail as of late November 2019. There are currently 12 inmates on MAT and four have been released from confinement with appointments at a MAT clinic in the

community along with an appointment for either IOP or outpatient treatment services in their local community. Horizons trained DOC nursing staff, case managers and corrections and community corrections staff on the different types of MAT and their indications; evidence approaches to MAT in criminal justice; and the increase in positive outcomes in treatment when medication and counseling are integrated to reduce stigma and address the barriers it produces to the acceptance of MAT in the jail and the equal treatment of MAT clients within the work-release and community corrections systems. Training was also provided to the county's C.O.R.E Program staff to ensure the smooth inclusion of inmates on MAT into the residential treatment program. Horizons staff is currently working with the DOC administration and counseling/care management staff to develop and implement a group and individual counseling and education program for MAT clients who are not involved in the C.O.R.E. Program. The MAT program is available to both sentenced and pre-trial inmates with moderate to severe OUD.

- Horizons worked closely with the Laconia Deputy Officer of the Division of Field Services to improve communication protocols for sharing information regarding C2 Project clients who are on probation/parole and to develop intermediate sanctions for those not following through with post-release treatment recommendations for medical, mental health and SUD recommendations, utilizing incarceration as a last resort.
- One Horizons masters level clinician was trained on an evidence based treatment for trauma with the intent of implementing it in February 2020 for the treatment of criminal justice involved clients in the Recovery Court Program (Drug Treatment Court) and those transitioning from incarceration into community based treatment through the C2 project. The goal is to expand the program to all clients with trauma treatment needs who seek SUD and co-occurring disorder treatment.
- Two Horizons recovery support workers and one counselor were trained to become providers of the Moral Reconation Therapy (MRT) cognitive behavior therapy (CBT) program to address criminal thinking in clients in the C2 re-entry program. We are planning to expand our trained providers to C2 staff to begin this CBT program prior to release from confinement for offenders beginning the re-entry process.
- As reported earlier in this section, Horizons worked with Lakes Region Community Developers and Navigating Recovery of the Lakes Region to obtain funding to develop a supportive transitional housing program. Compass House will assist women completing SUD residential treatment, with priority given to those coming out of treatment in jails and prison. The rules, application criteria and protocols for accessing treatment (counseling, education, medical services and care coordination) were developed in this last reporting period and the selection of residents is targeted for mid-February 2020.
- As part of their enhanced use of technology, Horizons has been meeting with IT companies and exploring a new EHR. They have narrowed it down to three possibilities and their office manager will be testing all three in the next 1-2 months. They hope to have a system in place that will more readily communicate with other systems by the spring. The systems being explored all have a billing component to them, which will allow them to consolidate the clinical case recording and the billing in one product thereby streamlining both functions and combining the data collection capabilities of both tasks into one system.

LRGH - Westside

- CHSN, LRGH, and ASQUAM staff, the IT consultants for LRGHealthcare, worked closely to update Cerner, the hospital's shared EMR with Speare Hospital, with the CCSA social determinants of health questions. This change was effective to all of the B1 LRGH practices as of September 30th. Much of this reporting period was spent finalizing processes and workflows at the practice level for staff administering the CCSA and working through the kinks of handling referrals when a positive screen was identified. Utilization of the new CCSA screening tool has helped LRGH practices identify patients who may need additional social services or connections to resources. Additionally, at Lakes Region General Hospital specifically, a 2nd LADC was hired and added to their Recovery Clinic to meet with patients on an individual and group basis.
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Budget

When CHSN designed its budget, we recognized many expenses will ultimately support Integrated Healthcare and could have been budgeted within the B1 Integrated Healthcare project, however we elected to capture costs in the actual project they are most closely related to, thus our B1 budget appears to have far fewer expenditures. Expenses projected in the Implementation Plan are shown below and actual expenditures within the reporting period can be found in the "July – Dec 2019 Actual Cost" column below. The CHSN Board voted to provide a 3% cost of living increase effective October 1, 2019 for all IDN funded salaries. This period there was [redacted] to perform ongoing site self-assessments of our B1 practices.

Since our last SAR was submitted in July 2019, CHSN staff recognized that the design of the original B1 budget still included very specific line items to support Integrated Healthcare such as a stipend for a clinical director ($15,000), a Practice Transformation Specialist ($100,000) and a stipend for a consulting psychiatrist ($12,000). In mid-2018 the CHSN Board recognized that this far into our projects, the need for these specific positions was becoming less likely and decided against hiring a Practice Transformation Specialist for example. They did wish to keep the funds set aside to utilize to contract or outsource these resources at a later date if necessary, but the budget categorization had not been updated to reflect this change. The $127,000 dollars is now shown below in bold as one line item labeled "Miscellaneous consulting / stipends" and the specific line items originally defined in the B1 budget are shown with a strikethrough.

Another change reflected is the addition of the CHSN "Demonstration Integration Projects" which I spoke to in greater detail earlier in this section. We have taken incentive dollars earned by IDN5 and reissued them back to our partners who applied for funding via a proposal/application process based on criteria defined by the CHSN Board. All projects that were funded will support the work of the DSRIP waiver

initiatives and goals and will further the investment in integration activities, programs and services across the region. Although these are not required projects of the DSRIP waiver, we wanted to reflect the expenditures in the B1 section to reflect our continued investment toward integration. A new line item below reflects the $1,144,512 committed to date. 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 and are not duplicated below.

Budget Item	Item Description	2017 Actual Costs	Jan–Jun 2018 Actual Cost	July–Dec 2018 Actual Cost	Jan–June 2019 Actual Cost	July-Dec 2019 Actual Cost	Total Projected Cost of Program
Miscellaneous Consulting / Stipends	**Stipends for psychiatrist, medical director, practice transformation expertise, etc.**	**0**	**0**	**0**	**0**	**0**	**$127,000**
~~Clinical Director Stipend~~	~~Stipend for Director (MD) of the Clinical Integration Team~~	~~0~~	~~0~~	~~0~~	~~0~~	~~0~~	~~0~~
~~Consulting Psychiatrist~~	~~Psychiatrist stipend for support of B1 multi-disciplinary care team~~	~~0~~	~~0~~	~~0~~	~~0~~	~~0~~	~~$ 12,000~~
~~Practice Transformation Specialist consultative services~~	~~funding to provide consultation to practices to facilitate integrated care development~~	~~0~~	~~0~~	~~0~~	~~0~~	~~0~~	~~$ 100,000~~
Technical Assistance	[redacted] for BH Integration Site Self-Assessment Survey	$2,500	$2,500	0	0	$6,284	$ 15,000
Annual CHSN Board Member Stipend			$70,000	0	$70,000	0	$290,000
CHSN Integration Demonstration Projects	Introduced in Dec. 2019; CHSN partners can apply for incentive funds to stand up integrated					$1,144,512	$1,144,512

	health projects separate from the six DSRIP projects.						
INTEGRATED HEALTHCARE TOTAL SPEND TO DATE		$2,500	$72,500	0	$70,000	$ 1,150,796	$1,295,796

Projects C: Care Transitions-Focused

Narrative

The C2 Project Lead met with the Division of Field Services, mental health provider partners and the courts and received positive response for the efforts made to work on offender engagement and care transitions for a limited number of high-utilizing, high-need individuals who generally are released from confinement before being sentenced and don't have a scheduled release date that would provide notice to C2 project staff that a release was imminent. As a result of this meeting, the C2 Care Coordinator and Project Lead worked with the medical and mental health providers inside the Belknap County DOC to develop a protocol for identifying these individuals when they are admitted to facilitate engagement early in their incarceration (rather than within three months of scheduled release as this information would not be available). This engagement process assesses medical, mental health and SUD treatment needs, and obtains relevant releases of information early in the process so they are ready to work with potential receiving services and can facilitate post release appointments with little to no prior notice. Criteria for identifying these pre-trial inmates include: 1) awaiting evaluation or court hearing regarding competency to stand trial; exhibiting symptoms of severe and persistent mental illness potentially putting them at risk for recurrent contact with law enforcement and/or the Emergency Department; being assessed as needing or being prescribed significant medications to manage disruptive thought or affective disorder. In this reporting period, eight offenders received re-entry services in this manner doubling the number of non-sentenced inmates reached by the C2 project in this reporting period.

A significant area of progress for the supportive re-entry project was marked by the start of the Belknap County Department of Corrections' Medication Assisted Treatment (MAT) program in late November 2019. This event is the culmination of a collaborative effort among the Department of Corrections, the medical providers contracted by the DOC, Horizons Counseling Center and the Belknap County Administration. While the MAT program is not an initiative of the C2 Project, project staff have played an integral role in its development and implementation. The Project Lead worked closely with the DOC's Medical Director to develop policies and protocols for identifying appropriate candidates for MAT and protocols for the monitoring and treatment of program participants. As of December 31st, there were 12 inmates on MAT in the Belknap County facility, four of whom have been released from confinement with appointments at a MAT clinic in the community along with an appointment for either IOP or outpatient treatment services in their local community. The C2 Care Coordinator at Horizons obtained releases of information enabling the receiving programs to benefit from the records of treatment of each program participant while they were in custody and is following their follow-through and progress in the community. Horizons Counseling Center did trainings for DOC nursing staff, case management, corrections officers and community corrections staff on the different types of MAT and their indications, evidence based approaches to MAT in criminal justice, and the increase in positive outcomes in treatment when medication and counseling are integrated for DOC. The goal was to open discussion about the myths about opioid agonists as "legalized using", to reduce the stigma attached to MAT in the minds of many corrections staff members, the barriers this stigma produces to the acceptance of MAT in the jail/house of corrections and to promote the equal treatment of MAT clients within the work-release and community corrections systems. Training was also provided to the staff of the C.O.R.E. Program in the county facility to ensure the smooth inclusion of inmates on MAT into the residential treatment program. Horizons staff is working with the DOC administration and counseling/care management staff to develop and implement a group and individual counseling and education program for MAT clients who are not involved in the

C.O.R.E. Program. The MAT program is available to both sentenced and pre-trial inmates with moderate to severe OUD.

The MAT providers within the Belknap County DOC are also the providers of primary care in that facility. Horizons Counseling Center provides integrated behavioral health assessment and treatment to inmates through the medical services department. This initiative further expands the integration of SUD, mental health and primary care within the correctional facility.

Project Targets

From the Evaluation Project Plan, use the format below to provide a list of the progress toward targets or goals that the program has achieved. Targets required by the STCs, include but should not be limited to:

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

Performance Measure Name	Target	Progress Toward Target		
		12/31/18	6/30/19	12/31/19
Number of individuals served	Approximately 60 per year once fully operational	Milestone Met; The program has served 51 individuals to date.	Milestone met; 71 individuals served	Milestone met; 72 individuals served
Percent of referred clients for whom assessment and continuing care plan development in correctional facility is completed	>90% by end of the waiver.	Milestone Met; 100%	Milestone met; 100%	Milestone met; 99.96% 3 inmates who received services while pre-trial were sentenced to NH State Prison (NHSP).
Percent for whom *case manager* pairing before release is completed	>90% by end of the waiver.	Milestone Met; 100%	Milestone met; 93% 3% are still incarcerated and pairing has not yet been done. 4% had their release status change after assessment and care planning was completed -their timeframe for release is no longer clear.	Milestone met; 97% In addition to the 3 inmates who were sentenced to NHSP, 4 are still incarcerated and had not been paired with a case manager by the end of this reporting period.
Percent for whom recovery coach pairing before release is completed	>90% by end of the waiver.	Milestone Met; 100%	Milestone met; 93% 3% still incarcerated and pairing has not yet been done. 4% had their release status change after assessment and care planning was completed - their timeframe for release is no longer clear.	Milestone met; 97% In addition to the 3 inmates who were sentenced to NHSP, 4 are still incarcerated and had not been paired with a case manager by the end of this reporting period.

Performance Measure Name	Target	Progress Toward Target		
		12/31/18	6/30/19	12/31/19
Percent for whom Primary care appointments are made before release	>80% by end of the waiver.	Milestone Met; 100%	Milestone met; 93% 3% still incarcerated and pairing has not yet been done. 4% had their release status change after assessment and care planning was completed - their timeframe for release is no longer clear.	Milestone met; 97% In addition to the 3 inmates who were sentenced to NHSP, 4 are still incarcerated and had not been paired with a case manager by the end of this reporting period.
Percent for whom appropriate Behavioral Health service appointments are made before release • 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.	>75% by end of the waiver.	Milestone Met; 100%	Milestone met; 100%	Milestone met; 97% In addition to the 3 inmates who were sentenced to NHSP, 4 are still incarcerated and had not been paired with a case manager by the end of this reporting period.
Percent for whom Transportation needs to primary care and BH are identified and advised prior to release	>90% by end of the waiver.	Milestone Met; 56.5%. The remainder are not yet at close enough to their release date to work on transportation needs.	Milestone met; 93% 3% still incarcerated and pairing has not yet been done. 4% had their release status change after assessment and care planning was completed and their timeframe for release is no longer clear.	Milestone met; 97% In addition to the 3 inmates who were sentenced to NHSP, 4 are still incarcerated and had not been paired with a case manager by the end of this reporting period.

Performance Measure Name	Target	Progress Toward Target		
		12/31/18	6/30/19	12/31/19
Percent for whom consents are put in place to include probation/parole in the care planning process in order to create offender incentives and supportive structure for sustained participation in the after-care plan	>90% for CORE graduates by end of the waiver. >75% for offenders not sentenced to the CORE program.	Milestone Met; 100% of offenders released signed consents for probation. One revoked the consent after release.	Milestone met; 100% of offenders in the CORE Program signed consents for probation (Division of Field Services) within 2 weeks of their release on electronic monitoring or within 30 days of their discharge from the facility. This enabled Probation to be involved in the discharge planning process prior to offenders officially coming under the jurisdiction of Field Services. Of the offenders not sentenced to the CORE Program, only a small number had probation included in their sentence and of these, only 66% agreed to sign consents to their probation officer before their release from custody. The remainder signed consents for their PPO soon after reporting. While this does not fully meet the intent of the milestone for obtaining releases of information prior to release from custody, it effectively accomplishes the goal of permitting the cooperation between Field Services and treatment providers in incentivizing offender engagement in post-release treatment and intervention in all areas identified in the assessment and re-entry plan.	Milestone met; 100% of offenders in the CORE Program signed consents for Probation within two weeks of release on electronic monitoring or within 30 days of completion of their sentences. This enabled Probation to be involved in the discharge planning process prior to offenders officially coming under the jurisdiction of Field Services. Of the offenders not in the CORE Program, 3 were sentenced to NHSP and, therefore, not released to Probation. 7 others were to be on probation but only 3 signed an ROI for their PPO prior to release. The other 4 signed ROIs with their PPO once they reported and were given their stipulations of probation.
Percent of offenders without current coverage for whom application to Medicaid/Health Insurance program is made *prior to* release	>80% by end of the waiver.	Milestone Met; 100% of those released. 43.5% still in custody.	Milestone met; 100% of those released on electronic monitoring or discharged.	Milestone met; 100% of those released on electronic monitoring or discharged.

Performance Measure Name	Target	Progress Toward Target		
		12/31/18	6/30/19	12/31/19
Percent for whom patient confidentiality and privacy assurances and releases are established before release	>90% by end of the waiver.	Milestone Met; DOC administration has not yet approved the IDN uniform consents. Individualized consents are being used to cover all involved services and including MAeHC and CMT. 100% of all offenders released signed consents; one revoked it post release.	Milestone met; 100% of inmates referred and who have been released signed consents prior to release. Five revoked those consents post release and are currently either absconded or back in custody as a result of their choice to abscond from supervision.	Milestone met; 100% of inmates referred by the CORE program signed assurances and releases prior to release from custody. CORE referrals made up 87.5% of all referrals in this reporting period. Of the additional 12.5% (9 individuals), 3 went to NHSP, 3 (.4%) refused to sign releases.
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) • Horizons to establish partnership with Lakes Region Community Developers to provide transitional housing for inmates upon release back into the community.	>50 % by end of the waiver. (Target was changed to accommodate the availability of housing for this project's population in the region)	60% (3/5)	100% of all inmates referred by the CORE Program received information about available safe and sober housing in the community and 52% of these received assistance in obtaining scholarships for and space in sober housing. CORE referrals make up 80% of referrals for those inmates who have been released during this reporting period.	100% of all inmates referred by the CORE Program received information about housing resources and safe and sober housing and 35% of these received assistance in obtaining scholarships for sober housing. 87.5% of referred inmates released during this reporting period were referred by the CORE Program.
Percent for whom employment referral is made as appropriate before release. (This measure was updated to split into two measures- one for housing and one for employment. This was done because there is great variability in resource availability)	>75% by end of the waiver. (original target for this measure was far too high considering job availability in the region)	100% of offenders released to the community were already employed as they were initially released on Work Release. An exploration of options for education and additional vocational training was begun by the case manager.	Milestone met. 81% were employed at the time of their release as they were on work release prior to discharge. The 19% not employed were all disabled on SSI or SSDI and were given information about Vocational Rehab.	Milestone Met; 89% were employed at the time of their release as they were on work release prior to discharge. The additional 11% were assisted by their case manager in accessing NH Employment services and NH Works for Recovery.
Criminal Recidivism rate at one-year post release.	Reduce by 25% from baseline of 72%	Milestone Met; 22% (6 out of the 28 served)	Milestone met; 29% returned to custody.	Milestone met; Only 3% returned to custody during this reporting period.

Performance Measure Name	Target	Progress Toward Target		
		12/31/18	6/30/19	12/31/19
*Initiation of SUD Treatment (1 visit within 14 days)	>70% by end of the waiver.	Milestone Met; 84.6% (11 of 13 clients)	Milestone met; 87%	Milestone met; 87%
Retention in SUD/COBHD treatment for recommended duration per ASI/ASAM evaluation	>70% by end of the waiver.	Milestone Met; 92.3%; 2 of 13 are currently involved in treatment. It is too early to determine that they will remain in treatment for the recommended duration.	Milestone met; 73% remained in treatment as recommended by the ASI/ASAM assessment. 27% of those elected to remain in treatment to deal with co-occurring disorders that became evident through the treatment process.	80% remained in treatment as recommended and set up by their case manager. 5.8% required a referral to a higher level of care, which was accomplished through cooperation between the Care Coordinator and the PPO.
*Number / percentage of clients engaged in criminal justice follow-up services (4+ per year) ER Visit Users	<20%	Milestone Met; 8%	Milestone met; 13%	Milestone met; 4.8%
*Number / percentage Potentially Preventable ER Visits	<20%	Milestone Met; 8%	Milestone met; 13%	Milestone met; 4.8%

Budget

Funds were budgeted for the Community Re-Entry project to support salaries and benefits of project staff as outlined in the previous section. Salaries were budgeted and agreed upon by the C2 workgroup based on prevailing wages by position type and fringe benefits were budgeted uniformly across all partner organizations at 31% of salary. A 3% cost of living increase was awarded effective October 1, 2019 for all IDN funded salaries. Expenditures during this reporting period totaled $160,269.88 for project staffing reimbursements. [redacted], [redacted] and [redacted]. Financial reporting on actual expenditures between July – December 2019 are reflected in the table below.

Budget Item	Item Description	2017 Actual Costs	Jan – Jun 2018 Actual Cost	July – Dec 2018 Actual Cost	Jan – Jun 2019 Actual Cost	July-Dec 2019 Actual Cost	Total Project Costs to Date	Total Projected Cost of Project
Project Staff Salaries/ Wages (sub-contracted)	Salaries for counselors, case managers, care coordinators, and recovery	$35,370	$58,640.50	$52,350.84	$82,105.22	$110,586.22	$339,052.78	$1,106,000

	support workers							
Project Staff Benefits	31% of salary / wages		$26,346.72	$23,519.94	$36,887.40	$49,683.66	$137,437.72	$ 342,860
Total Salary		*$35,370*	*$84,986.22*	*$75,870.78*	*$118,992.62*	*$160,269.88*	*$475,489.50*	*$1,448,860*
Supplies	Misc. expenses over waiver period							$2,000
PROJECT TOTAL		$35,369	$84,986	$75,871	$118,992.62	$160,269.88	$475,489.50	$1,450,860

Projects D: Capacity Building Focused

Narrative

Horizons Counseling Center has increased capacity to serve individuals with SUD and co-occurring mental health disorders through workforce development initiatives that have included the hiring and training of individuals working toward LADC, MLADC and Social Work/Clinical Mental Health licensure with the support of the IDN. They currently have two LADCs who completed master's degree programs, with one of these submitting an application for the MLADC next month and the LICSW in three months. They also have two masters prepared clinicians completing their requirements for licensure by both the LADC Board and the Board of Mental Health Practice, two completing requirements for the LADC and two that became certified as CRSWs. This has supported Horizons' ability to increase access to outpatient treatment for the region through increased qualified staffing and expanded interim services.

Horizons worked closely with the Doorway at LRGH, with local MAT providers and with the C2 Project through the Belknap County Department of Corrections to prioritize entry to outpatient services for individuals being referred from those entities, tying timely administration of MAT with smooth and timely inclusion in counseling services and recovery supports.

In this reporting period, Horizons sent one masters level clinician to training in an evidence-based Stephanie Covington trauma treatment program geared toward individuals with SUD. They began incorporating this program into the established IOP practice and anticipate starting an outpatient gender specific group for women utilizing this trauma treatment program in February 2020 and a second group for men in the spring.

Horizons has also welcomed graduates of the Nathan Brody IOP back to Phase II for life without fee so long as they continue to foster a recovery lifestyle. Because of the expansion of the Laconia-based IOP and the numbers of clients who are taking advantage of this benefit, we have designed a recovery support group focused on the maintenance needs and concerns of individuals in recovery and trained two recovery support workers to facilitate this group. We anticipate offering this service to graduates of the Nathan Brody IOP in February and expanding access to ongoing recovery support to clients in the action and maintenance stages of change. Furthermore, in honor of the tradition of having alumni at the program to provide inspiration and encouragement to clients, we will not be closing this option to our alumni.

In this reporting period, Lakes Region Mental Health Center has also taken steps to integrate SUD services into their comprehensive behavioral health services for the eligible population. They have appointed a Director for substance use services and are examining the areas in their existing programming where SUD services will best fit into both their Plymouth and Laconia sites.

Mid-State Health Center will be adding a new service site to their Community Health Center scope in February 2020. As the FQHC serving the Plymouth region they are committed to ensuring access to substance use disorder treatment and recovery services to anyone in need regardless of ability to pay. Mid-State currently offers Medication Assisted Treatment at both of its current service sites as part of its direct response to the opioid misuse crisis facing the communities it serves. Through the addition of this new site in Plymouth, Mid-State will further its commitment by establishing a community-based location for those seeking recovery services with a particular focus on Intensive Outpatient Treatment (IOP) which is a service that has been sorely lacking in the region for years. The new site will be co-located with the region's Recovery Community Organization (RCO), Plymouth Area Recovery Connection. The co-location

of these two safety-net recovery organizations ensures optimal use of available resources and is conveniently located for clients to access and promotes the best hope for success for those in the region seeking recovery services and supports. There will be more to report in June 2020 once this IOP has become established in the community.

Project Targets

Use the format below to provide a list of all of the progress toward targets that the program has achieved. Targets should include

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

Performance Measure Name	Target	Progress Toward Target		
		12/31/18	6/30/19	12/31/19
Number of individuals served • Develop job descriptions for counselors and recovery support workers to be hired • Hire staff for expansion in IOP services, inclusive of CRSWs • 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. • Train new staff in IOP programmatic workflows and protocols	Up to 50 additional IOP clients per year once fully operational in all 3 sub-regions	Milestone Met; 43 clients served	Milestone Met; 60 clients were served during this reporting period; Of the 23 clients served in Phase II of the IOP program, 9 completed both phases of the IOP program, 14 remained in Phase II as alumni and 19 continued in outpatient co-occurring counseling beyond Phase I and Phase II of the IOP.	Milestone Met; 81 clients were served during this reporting period; Of the 26 clients served in Phase II of the IOP program, 13 completed both phases of the IOP, 11 remained in Phase II as alumni and 17 continued in outpatient co-occurring disorders counseling beyond the IOP.
Percent of referred clients placed in interim services pending appropriate level of care per ASAM criteria	>75% by end of waiver.	Milestone Met; 100% of clients on the waiting list received interim services.	Milestone Met; 86% of clients on the waiting list received interim services. 17% of the clients in interim services were waiting for beds in residential treatment and 3 of these were offered IOP as part of their interim services and were successful at that level of care, eliminating the need for residential treatment.	Milestone Met; 84% of clients referred who were on a wait list for treatment, including residential treatment not available at Horizons, received interim services.

Performance Measure Name	Target	Progress Toward Target		
		12/31/18	6/30/19	12/31/19
Waiting list for treatment services, number of clients and wait time (As of Dec. 2017 wait list is 6 weeks for IOP services). • Develop alternative plan to address long wait time for clients • Implement new plan/Interim Services to offer clients case management care and SUD education and recovery support while they await a spot in IOP	Decrease by 50% of current wait time	Milestone Met; There is currently no wait for services for clients seeking treatment in the evening IOP. The wait for daytime IOP services is reduced to about 17 days, though everyone is offered the evening program. Those who choose to wait are incorporated into Interim Services in 2-3 business days unless they refuse this service.	Milestone Met, There is currently no wait for evening services and the wait for day program is currently 3-4 business days. There is no wait for interim services.	Milestone Met; There is currently a 2-week wait for both the day and evening IOP services in Laconia. Interim services were offered to all applicants for IOP and there is no wait for interim services.
Percent for whom recovery coach pairing is completed • Develop protocol of Recovery Coach pairing with Navigating Recovery of the Lakes Region • Outline the CRSW Credentialing pathway	>90% by end of waiver.	Milestone Met; Recovery Coach pairing was completed for 100% of those clients who moved into step-down, though 3 have not followed through.	Milestone Met; 2 Navigating Recovery coaches (1 male and 1 female) are embedded in the evening IOP and 2 Horizons coaches (1 male and 1 female) are embedded in the day IOP. 100% of clients were paired with a coach prior to their transition to Phase II of the IOP.	Milestone met; 100% of clients in the IOP were paired with a recovery coach prior to their transition to Phase II of the IOP.
*Initiation of SUD Treatment (1 visit within 14 days)	>70% by end of the waiver.	Milestone Met; Horizons has been able to initiate SUD services within 14 days for 100% of the clients in the evening IOP, with 2 of them beginning actively engaged in Interim Services.	Milestone Met; Horizons has been able to accommodate 100% of clients applying for SUD services at the OP or IOP level of care with 1 visit within 14 days (usually 7 days) with 6 clients who sought interim services while they awaited a residential treatment beds being incorporated into interim services within 2-3 days.	Milestone Met; Horizons was been able to accommodate 94% of clients applying for SUD services at the OP or IOP level of care with 1 visit within 14 days (usually less) during this reporting period. Six percent were offered appointments within that timeframe but declined interim services or didn't show for their appointment.
Retention in SUD/COBHD treatment for recommended duration per ASI/ASAM evaluation	>70% by end of waiver.	Milestone Met; 77%	Milestone Met; 85%	Milestone Met; 89%

Budget

Funds for the Expansion in IOP project budget were to support salaries and benefits of project staff. 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. A 3% cost of living increase was awarded effective October 1, 2019 for all IDN funded salaries. Expenditures in the reporting period total $126,216.13. They include reimbursements to LRGHealthcare for $2,834.82, LRMHC for $11,432.34, Horizons Counseling Center for $87,296.72, Navigating Recovery for $19,279.92 and HealthFirst for $5,372.33 for project staffing expenditures. Financial reporting for July – Dec 2019 actual expenditures are reflected in the table below.

Budget Item	Item Description	2017 Actual Cost	Jan – Jun 2018 Actual Cost	July – Dec 2018 Actual Cost	Jan – Jun 2019 Actual Cost	July-Dec 2019 Actual Cost	Total Project Costs to Date	Total Projected Cost of Project
Salaries and Wages								
Project Staff Salaries / Wages (subcontracted)	Salaries for clinicians, recovery support workers, case managers, benefit navigators, admin support and driver as outlined in the previous section	$40,281	$66,918	$80,592.72	$87,370.29	$87,089.13	$362,251.14	$ 1,227,289
Project Staff Benefits	31% of salary / wages		$30,064	$36,208.32	$39,702.58	$39,127	$145,101.90	$ 380,459.59
IOP subcontract	Stipend for Treatment slot with Riverbend IOP serving Franklin in 2019 & 2020	0	0	0	0	0	0	$43,120
Total Salary		*$40,281*	*$96,982.09*	*$116,801.04*	*$128,072.87*	*$126,216.13*	*$508,353*	*$ 1,672,428.59*
Other Direct Costs								
Transportation van	Reimbursement for travel @ .535 p/mile (estimated	0	0	0	0	0	0	$ 8,025

	@100 miles p/week x 50 weeks							
Supplies	Miscellaneous expenses over waiver period	0	0	0	0	0	0	$ 2,000
PROJECT TOTAL		$40,281	$96,982.09	$116,801.04	$128,072.87	$126,216.13	$508,353	$ 1,682,453.59

Projects E: Integration Focused

Narrative

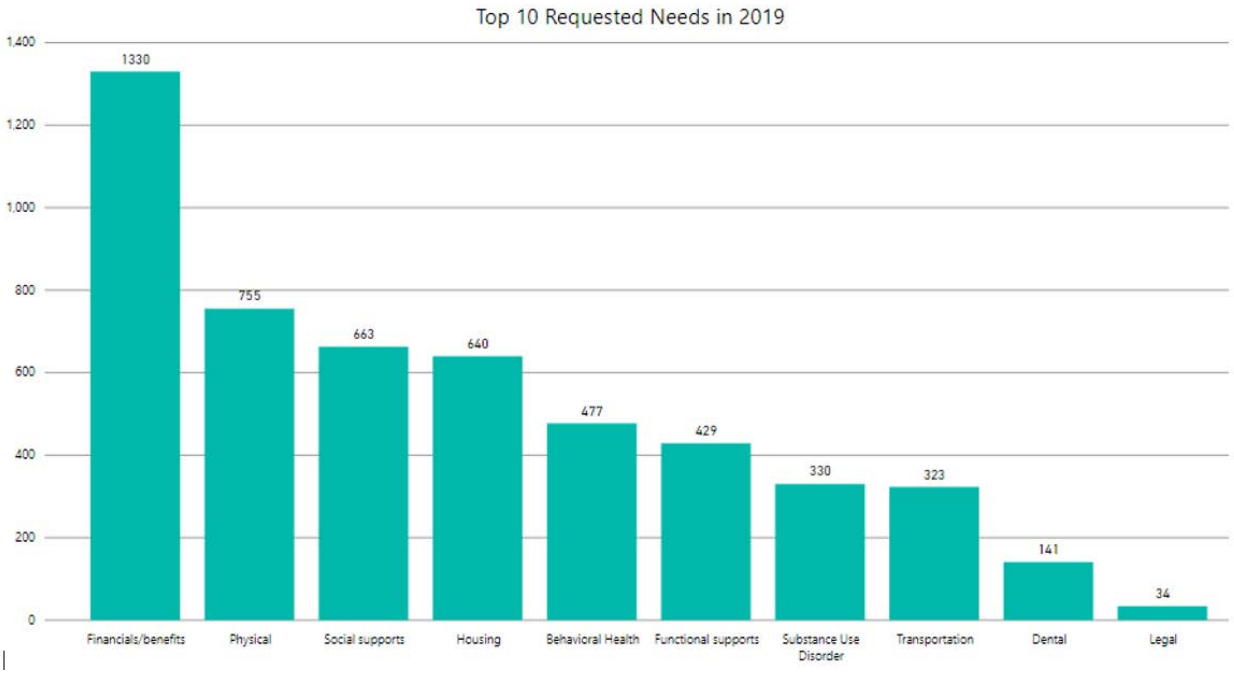
The E5 Enhanced Care Coordination for High-Need Populations project continues to exceed expectations and projected goals. The cohesive team of Community Care Coordinators (CCC's) offer a comprehensive wrap-around approach of service providers and community-based agencies to meet the complex needs of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

The Enhanced Care Coordination team remains fully staffed and is comprised of 9.4 FTE care coordinators who are employed across 15 IDN partner agencies. All 9.4 of the E5 care coordinator positions are funded by CHSN-IDN5 via the DSRIP waiver.

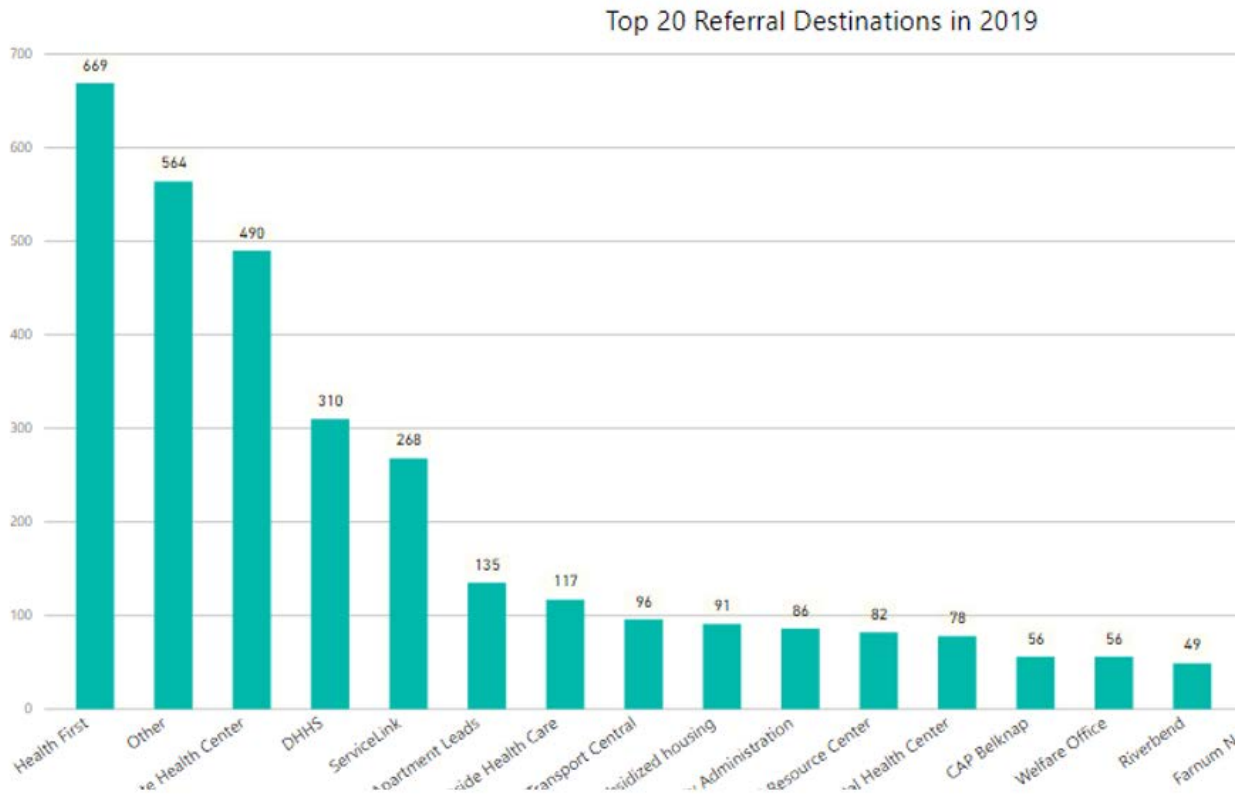
Additional highlights of the E5 Enhanced Care Coordination project

- The E5 Enhanced Care Coordination team remained very active and engaged in the communities served during this reporting period. Their client encounters continue to grow significantly. The E5 program collectively served 1918 clients in 2019 resulting in 4460 encounters. In this reporting period alone, CCCs engaged with 987 new clients resulting in 2396 client encounters. This means our care coordination team is effectively working with 160+ new clients on average consistently each month.
- There are now a total of 9 different organizations that are using CMT with a total of 31 users, 11 of which were active in the month of December. Our active users on average spend 1.4 hours per day logged in to CMT. Our most active users are seated at HealthFirst and spend 3.3 hours on average per day logged into CMT (average of 4 active users!). Our three hospital partners had a total of 3,710 visits in December with 655 notifications sent to partner agencies for these visits. Shared care plan adoption is still slow with just 5 active care plans in the IDN.
- Year-end 2019 data (see table below) shows that the E5 care coordinators referred out 1330 individuals to assist with financial/benefits, 755 for physical, 663 for social supports, 640 for housing, 477 for behavioral health, 429 for functional supports, 330 for SUD, 323 for

transportation, 141 for dental and 34 for legal referrals. Furthermore, the care coordination team agreed upon definitions for each of the referral "buckets" to ensure that all CCCs are identifying referrals similarly to give more validity to the data being captured.



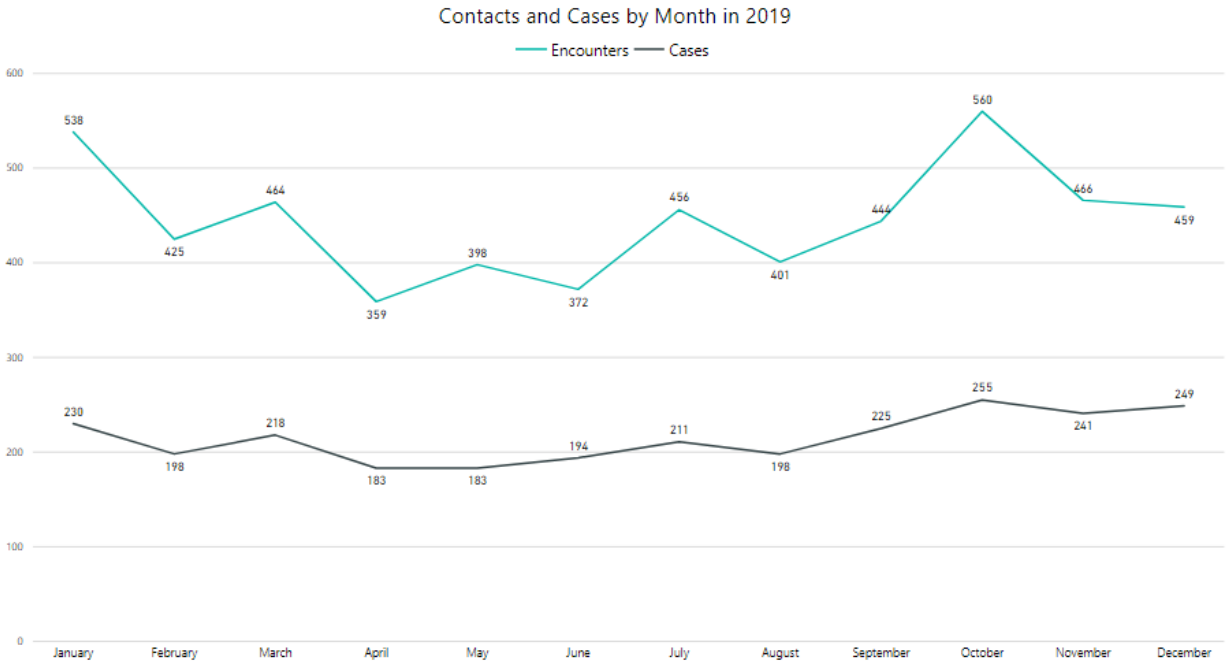
- Of the referrals noted above, the second graph (below) represents where the majority of 2019 referrals were made to by the E5 Care Coordination team.



- Monthly "All Team" meetings occur for care coordinators to address achieving DSRIP outcome measures, workflow development, highlighting successes of integration of care, process related/operational challenges or barriers, technical support (CMT and Smartsheet) and team building.
- Additionally, since June 2019, a monthly Wraparound meeting is held which focuses on sharing high-utilizer client cases in hopes of identifying solutions by wrapping around the care for some of the most complex needs patients within this high risk population and agreeing upon a shared care plan across the team. Care coordinators rotate as presenters and share one of their high-need cases and the team collectively identified solutions to client barriers and collaboratively reducing those barriers to produce better patient care and outcomes. A mutually agreed upon shared care plan for the client is then entered into CMT for all CCCs and other providers to follow regardless of where the patient should present. Depending on which cases are presented, other providers and social service agencies (i.e. housing, transportation, legal assistance, etc.) are invited to attend as needed to discuss high-utilizer patient cases and identify solutions to meet their needs and eliminate barriers. CCC's have been busy building and strengthening relationships this reporting period with numerous area agencies surrounding housing, transportation, legal assistance, and others to help them better connect their patients to much needed support services. To date the following agencies have been invited to the E5 Wraparound meetings: Salvation Army's Carey House, Bureau of Elderly and Adult Services, Partnership for Public Health, Tilton Family Resource Center, The Belknap House, Lakes Region Community Services, Laconia Housing Authority, Harbor Homes SSVF - (supportive services to veteran families), Lakes Region Community Developers, Homeless Outreach Workers – 211/CAP, Gateway Community Services and behavioral health providers at HealthFirst.
- A select group of E5 community care coordinators presented at the CHSN network partners meeting in November where the MCOs were also in attendance. The CCC's shared some impressive client impact stories as well as explained the purpose of their Wraparound meetings to partners.
- The E5 Steering Committee continues to serve in an advisory capacity and meets quarterly. The Steering Committee meets to discuss progress of project related implementation activities, to support operational project efforts and/or issues and help to address project related challenges. CHSN's Executive Director provides updates to this committee on a routine basis to ensure all affiliated partners are informed of project activities and outcomes. This communication is essential to the project's success and will continue moving forward so the more robust project related updates of progress across the region are being shared with all E5 partners. Future conversations surrounding the probability of working with the MCOs in any form of LCMN capacity will be heavily discussed at the Steering Committee level to identify care coordination tasks IDN5 would be best suited to perform.
- The Community Care Coordinators continue to actively attend trainings to grow and enhance their skill base and competency within their roles. They do so through trainings offered via CHSN's training contract with NHADACA as well as other community-based settings. Their attendance at each training has provided a valuable forum for community networking and E5 project visibility. Due to the diversity of skills across the CCC team the topics of interest and frequency of attendance of trainings varies based on individualized CCC training needs. In 2018, the CCC's had participated in 177 trainings and in 2019 they participated in 162 trainings covering a variety of

training opportunities related to integrated health, MH, SUD topics and more (70 during this reporting period.

- CCC's capture their patient data via Smartsheet and has been consistently used to track E5 project data. The CCC Team developed a CCC Smartsheet User Manual which was distributed across all sites with a designated CCC peer mentor available for 1:1 training to ensure competency with Smartsheet for all (including new) users. This standardization led to CHSN having access to credible and consistent monthly reports illustrating regional care coordination activity. Site activity graphs for the entire project and by agency are shared regularly with the CCC Team and the E5 Steering Committee to reflect the progression of activity over a period-of-time. A screen shot of the site activity graphs by project and agency is shown below.



2019 New Enrollments by Location

Location	Enrollments
LRGH	644
Franklin Regional Hospital	287
Mid-State Health Center (Plymouth)	266
Speare Memorial Hospital	184
HealthFirst Family Care Center (Franklin)	164
Service Link (Belknap County)	119
Riverbend Community Mental Health Center	90
LRMHC (Laconia)	70
HealthFirst Family Care Center (Laconia)	52
Pemi-Baker Community Health	33
LRMHC (Plymouth)	9
Total	**1918**

2019 Client Encounters by Location

Location	Encounters
LRGH	694
HealthFirst Family Care Center (Franklin)	650
Mid-State Health Center (Plymouth)	622
LRMHC (Laconia)	567
HealthFirst Family Care Center (Laconia)	514
Franklin Regional Hospital	470
Riverbend Community Mental Health Center	360
Speare Memorial Hospital	286
Service Link (Belknap County)	194
Pemi-Baker Community Health	60
Total	**4460**

Highlights by ALL sub-regions within this reporting period:

Overall reported accomplishments for ServiceLink, HealthFirst, LRMHC, Horizons, LRGH-Westside, Riverbend, Pemi-Baker Community Health and Mid-State include:

- All Community Care Coordinator positions remain filled
- All CCC's report increased communication with their counterparts in the IDN for improved quality care
- All CCC's have benefited from the monthly E5 Wraparound meetings either by presenting a case and seeking input from others as to best plan of care or connecting/learning of a new community resource.
- All's CCC's reported that even though they might come in contact with someone who doesn't meet their original "high utilizer" definition, they work with all individuals to address SDOH needs, which is seen as preventative measures to keep patients/clients out of the ED.
- Having a point of contact at each location has made it easier to follow up and request services and continuity of care is far more streamlined.

Highlights specific to the Franklin regional team:

- Report that their bi-weekly hospital utilization meetings are beneficial for reviewing patients in CMT and checking with doctors about specific patients.
- CCC's report they will walk around to the doctors to let them know they are available to assist patients.
- The CCC's worked to create their own workflow which allows them to get connected with patients sooner so they can get them connected to services (this alternative approach is necessary because Franklin Regional Hospital does not utilize the IDNs universal patient consent form). They are able to discuss any patients that have a signed release release signed or by using non-identifying info to address their SDoH needs.

Highlights specific to the Laconia regional team:

- 3 of the CCCs meet 2-3x per month at the LRGH ED to review cases and all active patients in the ED or inpatients at LRGH. In some cases, CCC's get pulled in to meet with a patient during this meeting time or will see an already established patient.
- Using their internal workflow with other CCC's they can follow up on needs of patients much quicker (i.e. calling CCC at Service Link to follow up on status of a patient who applied for Choices for Independence Medicaid (CFI) application).
- Because the "practice/agency silos" don't exist due to the positions being funded by the IDN, it allows flexibility of CCCs to support their patients wherever and whenever they present in the community. (i.e. The hospital's CCC covered for HealthFirst's CCC and was able to mutually support and accompany the patient to City Welfare appointment).
- Physician staff at both HealthFirst and the LRGH ED have recognized the benefits of onsite CCC's and are more routinely utilizing them to get their patients connected to resources sooner for their various needs.
- LRGH/ FRH social workers have shown increased outreach attempts to HealthFirst for follow up and better wrap around services of mutual patients.
- The LRMHC Annex (where patients get evaluated for psychiatric needs) have been outreaching to CCC's for additional support to ensure the patients are better supported or to check if they are care coordination services offered by the E5 project.

Highlights specific to the Plymouth regional team:

- The 2 primary CCC's have created their own workflow to address patient needs if/when one of their agency's has not adopted the IDNs universal patient consent.
- Through its participation in the monthly E5 Wraparound meetings held in Laconia, our Plymouth CCC's were able to learn of additional housing resources and connections available to patients.
- The team outreach to one another regularly when they need to problem solve concerns regarding a patient's SDoH needs.

Project Targets

Use the format below to provide a list of all of the progress toward targets that the program has achieved. Targets should include

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

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/18	As of 6/30/19	As of 12/31/19
Number of individuals served	400 clients per year once fully operational in all 3 service areas Target for 6/30/18 will be 100 individuals served.	Milestone Met; This reporting period the total number of patient encounters was 1081; the total number of new patients served was 597 For the year 2018, the following activity occurred across sites: Total number of patient encounters was 1688, Total number of new patients served was 849	Milestone Met; This reporting period the total number of patient encounters was 2038; the total number of new patients served was 930	Milestone Met; In the last six months the number of patient encounters was 2396; the total number of new patients served was 987 For the year 2019, the following activity occurred across sites: Total number of patient encounters was 4460. Total number of new patients served was 1918.
Time interval from referral and to first care coordination team contact to be 3 business days	>80% by end of waiver.	Milestone Met; This reporting period per all CCC reports and encounter data, all patient encounters have consistently occurred within 3 business days upon receipt of any referral.	Milestone Met; This reporting period per all CCC reports and encounter data, all patient encounters have consistently occurred within 3 business days upon receipt of any referral.	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 12/31/18	As of 6/30/19	As of 12/31/19
Time interval for follow-up by care coordination team after an emergency department visit or hospitalization by enrolled client 3 business days	>80% by end of waiver.	Milestone Met; This reporting period per all CCC reports and encounter data, all patient encounters have consistently occurred within 3 business days upon receipt of any referral post hospitalization.	Milestone Met; This reporting period per all CCC reports and encounter data, all patient encounters have consistently occurred within 3 business days upon receipt of any referral post hospitalization.	Milestone Met; This reporting period per all CCC reports and encounter data, all patient encounters have consistently occurred within 3 business days upon receipt of any referral post hospitalization.
Percent of assessed client needs that were given a referral	75%	Milestone Met; 85.77%	Milestone Met; 85.77%	Milestone Met; 89.83%
Percent of clients with a housing need that were given a referral for housing	70%		Milestone Met; 74.6%	Milestone Met; 84.67%
Percent of clients presenting with substance/behavioral health needs who received at least one referral	75%	Milestone Met; 83.73%	Milestone Met; 84.21%	Milestone Met; 90.41%

Budget

Funds were budgeted for the Enhanced Care Coordination for High Need Populations project to support salaries and benefits of project staff. 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. A 3% cost of living increase was awarded effective October 1, 2019 for all IDN funded salaries. Expenditures in the reporting period include reimbursements for project staffing totaling $310,226.33. Reimbursement was made to [redacted]. Additional reimbursement of cell phone monthly fees, mileage for CCC's and office supplies are represented below for total expenditures totaling $8,032.30. Financial reporting on actual expenditures between July – December 2019 are reflected below.

Budget Item	Item Description	2017 Actual Cost	Jan – Jun 2018 Actual Cost	July-Dec 2018 Actual Cost	Jan – Jun 2019 Actual Cost	July-Dec 2019 Actual Cost	Total Project Cost to Date	Total Projected Cost of Project
Salaries and Wages								
Project Staff Salaries / Wages (subcontracted)	Salaries for lead care coordinator, agency-based care coordinators and transportation driver	$45,031.24	$177,616	$225,598.26	$212,416.41	$208,513.88	$869,175.79	$ 1,984,500
Project Staff Benefits	31% of salary / wages		$79,799	$101,355.74	$95,433.45	$93,680.15	$370,268.34	$ 615,195
Staff Development		$459.85						
		$45,491.09	*$257,415*	*$326,954*	*$307,849.86*	*302.194.03*	*$1,239,444.10*	*$2,599,695*
Other Direct Costs								
Hardware	Laptop Computers and cell phones for CCCs	$450	0	0	0	0	$450	$ 11,000
Software	Internet, software license fees and cell phone service plans	0	0	0	0	0	0	$ 15,030
Mileage	Reimbursement for care coordinator travel	0	$2,199	$2,530	$5,692.84	$6727.84	$17,149.68	$320,000
Mileage reimbursement for D3 & E5 van driver		0	0	0	0	0	0	$16,050
Cell phone reimburse-ments of CCC's		0	$1,169	$1,290	$1,120.18	$1203.71	$4,782.89	$15,000

Supplies / Marketing	Miscellan-eous expenses	0	$3,485	0	$504.32	100.75	$4,090.07	$6,000
PROJECT TOTAL		$45,941.09	$264,268	$330,774.55	$315,167.20	$310,226.33	$1,266,377.71	$2,982,775

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

As a part of the DSRIP demonstration, the state has committed to value-based health services reimbursements. The DSRIP APM Roadmap articulates the process by which the state will work with the IDNs, Medicaid Managed Care Organizations (MCO), and other Medicaid services stakeholders to develop a statewide APM workgroup for the completion of the DSRIP APM Implementation Plan. The goal of the DSRIP APM Implementation Plan is to achieve 50% Medicaid provider payments in an APM by 12/31/2020.

IDNs will be evaluated on their engagement with the state and managed care plans in support of the APM goals consistent with Special Terms and Conditions (STC) 24, Project Milestones; STC 33 MCO and Medicaid Service Delivery Contracting Plan; and STC Attachment C: DSRIP Planning Protocol IV Project Stages, Milestones, and Metrics.

APM Narrative

Provide a brief narrative which speaks to the following:

- Describe how the IDN is aligning performance metrics to the MCO APMs
- Identify partners who are currently participating in or in the planning process for MCO APMs

- As previously reported, just three CHSN member organizations (LRMHC, Mid-State and Speare Hospital) have involvement or experience with Alternative Payment Models (APM) and those range from developmental activities to many years of experience. There are five organizations who participate in public (MCO) and private (e.g. Anthem, HP, CIGNA) outcome incentive payments for quality measures.
- Being mindful that a transition to Alternative Payment Models (APM) that support and incentivize integrated care delivery shall be in place following the expiration of the waiver, these new approaches must move reimbursements from volume based to value based in order to continue to achieve improved health outcomes. The community projects implemented in this region have demonstrated improved outcomes but may not align themselves with what payers have traditionally supported. The challenge in our region is the lack of infrastructure such as EMR(s) or administrative support in agencies that are small serving rural communities. Fiscal stability is compromised by workforce constraints linked to a lack of regional reimbursement rates that recognize the impact of inadequate transportation, staff travel time and terrain/road travel as well as population penetration. The healthcare system and social service system in a fee for service model supports volume versus outcome, only perpetuating the existing disparities in communities.
- It also remains clear that our challenges rest in the development of infrastructure for members and affiliate agencies who lack capacity, infrastructure and resources to report and actuarial support to move forward. CHSN-IDN5 recognizes that consultants may be necessary to provide technical support to CHSN and its partners in efforts to implement alternative payment models.
- During this reporting period, CHSN has begun discussions and meetings with each of the three MCOs to garner their specific APM experiences to date relative to integrated care. CHSN-IDN5 interactions to date include having a total of 7 representatives from the three MCOs attend its November 2019 full Network Partner meeting where they provided a panel discussion on APMs specifically. In

addition, CHSN's Board Chair and Executive Director met with two representatives from AmeriHealth Caritas to discuss our capabilities in the local care management realm.

- With an established goal of moving at least 50% of Medicaid payments to APMs by 2020, CHSN recognizes the opportunity we have as a voice in that collective IDN experience which should the APMs to be implemented, and the related financial and operational components of each.

DSRIP Outcome Measures for Years 4 and 5

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.