NH BUILDING CAPACITY FOR TRANSFORMATION SECTION 1115 WAIVER DEMONSTRATION

SECTION 1115 QUARTERLY REPORT

Demonstration/Quarterly Reporting Period: April 1- June 30, 2020

I. Present information describing the goal of the demonstration, what it does, and the status of key dates of approval/operation.

The goals of this DSRIP demonstration are: to build behavioral healthcare capacity; promote integration of physical and behavioral health care and substance use disorders across New Hampshire. The demonstration seeks to achieve these goals by providing funding to Medicaid providers for organizing themselves into regional networks that can address the full spectrum of needs for individuals with behavioral healthcare needs as well as those who may be at risk.

STATUS

During this reporting period the National Public Health Emergency was extended, and the global pandemic continued to impact healthcare systems and service access across the nation and in New Hampshire as well. DHHS continued to score metrics and process performance payments in accordance with the Terms and Conditions. Reporting was relaxed in this quarter although Semi annual reports and quarterly reports for this period were due as of July 31, 2020.

II. Integrated Delivery Network (IDN) Attribution and Delivery System Reform Information

1: Trends and any issues related to care, quality of care, care integration and health outcomes.

IDN 1

Since early March, 2020 there has been profound impact across IDN1 partners given their pandemic response to COVID-19. With this emergency response the priorities of all teams/organizations have refocused internally to address unique population challenges and undertake measures targeted at decreasing community spread. As a result, the vast majority of project meetings were suspended through late June and the IDN administration has messaged support for the necessary steps taken by organizations to support their staff and enable COVID-19 response planning.

The administrative team objectives have also pivoted in response to the pandemic. While we are maintaining relationships with our teams, there are new challenges across our network that we are trying to support. One example of this is the continued need for modification and adaptation of B1 project team protocols and practices. MDCTs have resumed but are being completed over tele-meeting technology such as Zoom or WebEx. For several of our partners telehealth access and reliability for remote providers is an ongoing issue as internet connection is often subpar in our rural regional areas. Additionally, outfitting all staff with telehealth enabled laptops with working cameras etc. has been an undertaking with significant cost for many of our partner organizations. The IDN admin team has been convening with our statewide counterparts to share information on available funding sources and supporting our partners to connect with potential relief funds.

Another area of ongoing concern is around the economic impact to our partner organizations and the expected longer term budget deficits through FY2021.

As the state of COVID-19s presence in NH evolves as do numerous areas of the IDN work and partner practice.

IDN 2

In addition to a focus on open up activities post-COVID shut down, IDN2 is focused on sustainability and detailed planning for now until the end of 2021, the expected length of funding, and beyond.

IDN 3

Use of telehealth to support patient care (treatment and case management/care coordination)

The majority of IDN Member Entity provider partners continued to utilize telehealth as part of providing treatment and other services, with most using both telephone and video. Even as some providers started to slowly increase in person visits in June, telehealth continues to be a major way to deliver their services. The regional community mental center began using phone and video for their intakes when they were forced to close their walk-in services in April. Those partners reporting continued use of audio and video platforms in Q2 2020 to serve and support their patients/clients include:

- Ascentria Care Alliance
- Dartmouth Hitchcock
- Foundation Medical Partners
- Gateways Community Services
- Granite State Independent Living
- Greater Nashua Mental Health
- HEARTS Peer Support and Respite Care
- Home Health and Hospice Care
- Lamprey Health
- Life Coping
- NAMI NH
- Revive Recovery Center
- St. Joseph Hospital and Physician Services

IDN 3 met with regional care coordinators in the region to discuss the effects COVID-19 has on the ability to support SUD and SMI/SPMI individuals during this critical time. Meetings were held via skype twice a week beginning in April to May and reduced to one day a week in June. Since April, twenty-five partner organizations and 14 care coordinators per call, on average, from hospitals, providers and MCOs participated in the calls, sharing successes and challenges in a supportive environment. The goal was to learn from each other and to identify gaps, needs, and potential solutions for the continued support of this target population.

Telehealth was a main theme in all the discussions. Some themes around telehealth include: access to telehealth, types of platforms, positive outcomes, other challenges, the future of telehealth beyond Covid-19, and MCO support. Generally, Care Coordinators were in favor of telehealth continuing.

Discussion Examples:

Theme: Access

- Challenges exist for patients with underlying mental health or homeless people because they don't have phones
- No-shows are high for the immigrant/refugee community's usage of telehealth because many don't have working numbers.
- No computer, no internet or no Wi-Fi
- Patient's discomfort with technology
- Patient's technical limitations
- Video not available for some patients
- Technology platform expense
- Delay in getting SafeLink phone, especially if they lost one in the past

Theme: Platform Type

- Various audio and video platforms were used including: Zoom, Doxy.me, Skype, Doximity, SnapMD, What's App, Facetime, Microsoft Teams

Theme: Positive Outcomes

- Phone calls with patients are more successful than in-person visits because there are more opportunities to check in and strategize
- Some providers had more frequent check-ins
- Video helps feeling more "in-person" than phone call only
- Zoom meetings cut down on travel time
- Helpful for homebound patients

Theme: Other Challenges

- It is challenging to talk a regular 45-50-minute visit
- Concern from patients that they will lose medical or behavioral health services since they aren't going into the office
- After initial eagerness to answer calls over time some patients appeared less responsive
- There was some difficulty expressed over engaging individuals for LADC visits
- Face-to-face, particularly in teens, is important to build trust and relationships
- It is difficult for BH adults who have children underfoot to speak on the phone – no private time for calls
- Concern about HIPAA secure texting platforms
- Need additional resources for phones
- Provider burn-out

Theme: Future of Telehealth

- Some billing codes were changed and hope that telehealth continues
- Telehealth can be used as in-between appointments to avoid coming into the office every week
- Telehealth helps the stable patients who travel for work and helps the struggling patients who don't want to face-time and just want meds delivered
- Telehealth can alleviate the pressure patients feel who have trouble making appointments and risk losing meds
- Most Care Coordinators expressed hope that it will continue at least in some capacity

MCO Support and Other Solutions:

- MCOs will help to get patients a SafeLink phone
- MCOs can potentially add minutes to SafeLink phone.
- MCOs provide support services to their members with any connection to technology or telehealth services including audio and video.
- More frequent shorter calls for partner and provider

Suggested Resources:

- To deal with the less responsive patients to tele-visits, suggestions were made to mask the phones calls or call from different numbers.
- Send "unable to reach" letters by mail
- For people who need private time, Open Access is open for calls as well as most practitioners during nap times or times when patient is available
- For teens, look into connecting youth with other youth by virtual group
- For a solution to the concern of losing benefits or telehealth discontinuing members of the group talked about a bill being sent to the Governor's office on June 30

Completion and use of universal screening tools (including CCSA) to provide follow-up support/care

Due to COVID, the trend has been a lower number of CCSAs being completed during Q2 of 2020 even though other types of universal screenings continued based on priorities. Partners report that their focus shifted to more complex care and high priority issues such as diabetes and heart disease as well other challenges

- Saw a drop off in gathering of "rooming" stats as well as CCSA completions rates as some CCSA workflows are more geared towards in-office visits and have not yet fully integrated with telehealth
- InteGreat reporting that due to furloughed staff, no CCSA's were completed during May.
- Mitigation: CCSA's will resume as staff comes back – expected June/July
- Dartmouth Hitchcock did report twenty-nine completed CCSA's for this quarter with the Resource Specialist receiving 2 referrals through the CCSA. This is a significant decrease from previous quarters.

Multi-disciplinary care team (MDCT) and other care coordination/case management efforts to support patients with complex health care needs

Few candidates for MDCT have been identified. The most common barrier shared by our partners is that the organization does not have clients over the age of 18 or over the age of 18 with the need (NAMI, The Youth Council)

- The Emmaus Institute has submitted one patient into the MDCT program

- Ascentria has identified a potential candidate, but client will not provide consent. Ascentria has noted that the initial criteria were too restrictive.

Staffing furloughs and shifts in roles/responsibilities impact on DSRIP goals

Loss of IDN Team members:

The IDN Team had two team member departures, our Integration Project Manager and Administrative Assistant, during this quarter. This had an immediate impact on the team's ability to continue with the 1-1 partner liaison meetings/interactions and required more reliance on monthly and quarterly reports provided by our partners as well as email interactions.

Partner Impacts

GNMHC CTI

- A .5 FTE CTI Specialist has been vacant since program start due to limited referrals outside of SNHH.

GNMHC IDDT

- 1 FTE Mental Health/SUD Therapist is vacant due to prior therapist moving out of state during the month.
- The loss of therapist resulted in others on team taking on his clients on top of their caseloads.

IDN 4

As part of the Network4Health (N4H) Executive Director's involvement with the Manchester Emergency Operations Center's leadership team that includes the Mayor, it became apparent that a cohesive city-wide approach was needed to address the growing issues related to Manchester's homeless encampments during the pandemic. In addition to the in-kind advisory and neutral convening expertise provided by N4H's Executive Director, he offered additional in- kind support in the form of coordination and project management by N4H's Integrated Care Program Manager. The N4H Program Manager's time and efforts focus on addressing both the cross-organization collaboration regarding homeless outreach to connect Manchester's unsheltered homeless with support and resources at the height of Covid-19's first wave in New Hampshire, as well as the more strategic, long-term issues related to housing and homelessness. Key stakeholders include Families in Transition-New Horizons (FIT-NH), the Mental Health Center of Greater Manchester (MHCGM), Catholic Medical Center's Healthcare for the Homeless (HCH), and Manchester's Health, City Welfare, Fire, and Police Departments.

As part of this initiative N4H supports weekly cross-organization operations meetings, weekly outreach staff huddles and a community steering committee that will begin in July. A census of unsheltered homeless individuals residing in Manchester encampments is maintained and enhanced on a daily basis, with monthly statistics and outcomes shared with participating organizations. Future plans for this initiative include discussions around a Manchester landlord engagement initiative and sustainable data collection and reporting. An initial meeting was held in early July and the group is exploring funding opportunities to for this work.

IDN 5

CHSN-IDN5 experienced numerous COVID 19 related changes during this quarter. There were furloughs of our primary hospital system of over 400 employees. Nearly half of our B1 practices closed entirely while others functioned in different ways to accommodate the pandemic. Telehealth rose to the forefront as the most feasible delivery of care for primary and behavioral health services. The ability to "see" patients was beneficial for some and for others it was not enough. Our E5 care coordinators continued to work with and follow-up on their clients in different ways – with social distancing from 6 feet, meeting in driveways, dropping off food at doorsteps, and coordinating other services that were needed. By early June, the LRGH hospital practices began phasing back in by specialty and practice. At the end of June all but two specialty services were open for limited services again. The state of NH stood up homeless COVID shelter surge sites across the state and one was in the city of Laconia. The CHSN-IDN5 Executive Director stepped into this role for 90 days (after getting CHSN Board approval to reduce her time spent with IDN activities to 25% during this time) and assisted with mobilizing the homeless shelter project. The IDN network in general seemed to be "quiet" from the outside looking in, but really most

agencies and practices were diligently working to alter their workflows and adjust the way they provide care during these changing times in order to keep everyone safe. Very few of our partner agencies (other than the LRGH practices mentioned above) physically closed, although many worked from home or had rotating schedules to go into the office to ensure safe distancing could occur.

IDN 6

IDN-6 was able to award over $340,000 in COVID Emergency Funds to thirty (30) agencies and organizations in our region. Funds are being used for a wide range of purposes. Lessons learned will be consolidated through progress reports that are due in August 2020, and opportunities for strengthening internal and cross-agency capacity in support of our shared mission will be identified and addressed.

Three key areas that have been elevated as a result of COVID-19 are the continued development of Telehealth, opportunities to strengthen the coordination and impact of entities addressing food insecurity throughout the region, and renewed efforts to strengthen Consumer Engagement as a vital component of informing existing, new and emerging shifts in programming, service delivery and coordination.

Director of Population Health continued working at the state Emergency Operations Center to provide support / planning for the COVID-19 Quarantine / Isolation planning for vulnerable populations.

IDN 7

During the reporting period, Region 7 IDN partners have continued their efforts to hardwire the delivery of integrated care by maintaining and improving upon initiatives that have started throughout the demonstration. One notable change related to integration is the decision Ammonoosuc Community Health Services (ACHS) made this quarter to dissolve their Behavioral Health (BH Case Manager position and instead partner more closely with the Wellness and Recovery Model (WARM) team at North Country Health Consortium (NCHC). Some duties of the BH Case Manager have been absorbed by ACHS Behavioral Health staff, but they are also positioned and empowered to refer patients with SUD to the WARM program for additional case management and assistance connecting patients with more resources and wrap around services during their recovery.

Cottage Hospital/Rowe Health Center reported that their integrated healthcare processes, including Inter-Disciplinary Team (IDT) meetings and Behavioral Health meetings, were conducted as usual despite the pandemic. This speaks highly to their success in hardwiring integrated healthcare workflows and processes during the demonstration. In contrast, several other partners have struggled to maintain care coordination processes in their agencies due to increased turn over and lack of available staff to run the departments effectively throughout the pandemic.

The development of the Regional Care Coordinator Network (RCCN) late last year provided care advocates across the region with a peer cohort that serves as an asset for collegial communication, support, and access to resources to further enhance care coordination within the region. When the COVID-19 public health emergency was declared future meetings were canceled due to limited availability of members to attend these sessions. The regional care coordinators are essential healthcare workers who were utilized to cover many roles required for pandemic management within their home organizations. By their own report, they lacked the bandwidth necessary for collaboration, education or professional development related to care coordination through May.

The group met again in June via Zoom with limited attendance. Those present provided an update on what they were experiencing in their departments/organizations and what the IDN can do to help move the regional team forward. The care coordinators feel that it is too overwhelming right now to consider professional development and there is not enough care coordination actually happening to "network" about. Care coordinators reported during this time that they believe their leadership teams are philosophically supportive of building large ambulatory case management and care coordination teams but are fiscally challenged to realize that goal. The emergence of the COVID pandemic has further complicated the issue, as staff members have been retasked to COVID activities and healthcare organizations have experienced financial downturns.

There is a general consensus that care coordination staff have limited bandwidth for focusing on enhanced care coordination activities because they are typically tasked in the primary care setting with activities that have an attached

revenue stream. Medicare reimbursed Annual Wellness Visits, Transitional Care Management, Chronic Care Management, and chronic disease education services are several key activities for which there are sustainable reimbursement models that adequately offset labor expenses. These activities are prioritized over others that have less clear or dependable sustainability models.

In addition, the following notable points regarding changes made in the context of the COVID-19 pandemic have been shared by Region 7 IDN partners:

• Huggins Hospital, White Mountain Community Health Center, Littleton Regional Healthcare and Ammonoosuc Community Health Services have worked diligently to reopen for in-person visits but note that visit counts are still lower than they were during the same time last year. The agencies continue to offer telehealth services for certain appointments and will be looking to implement sustainable telehealth offerings based on permanent policy changes at the state level moving forward.

• Northern Human Services (NHS) has continued to provide telehealth services for almost all clients but has started opening in person visits for the clients who have not done well with telehealth. Some staff were furloughed, which resulted in other staff picking up a larger caseload. NHS notes that the introduction of telehealth has necessitated a shift to reducing appointment length down to 15-30 minutes but having them more frequently, rather than maintaining their traditional model of less frequent 90-120 minute appointments as clients have struggled to engage remotely for such long periods of time. NHS has also struggled with reimbursement rates and securing COVID relief funds due to the structure of the organization. The partner spent $100,000 on technology to stand up effective telehealth services and is working to recoup this investment. NHS continues to work hard to provide exceptional care to clients throughout the region and collaborate with partners to coordinate services for clients in need despite significant fiscal challenges introduced by the pandemic.

• Rowe Health Center responded to the pandemic by implementing process changes which allowed them to continue offering in-person visits. Considerable redesign of spaces and traffic patterns were necessary to accommodate this approach. This partner has also limited the number of appointments per day to allow for the safe delivery of services and adequate cleaning time between appointments.

• White Mountain Community Health Center had success with transitioning to telehealth services and is preparing to explore the opportunity to continue past the state of emergency orders. Telehealth has been an asset to the agency, helping clients have increased access to care without having to worry about transportation or childcare, two issues that have been a huge barrier in the past for WMCHC patients. With the introduction of telehealth in early April, WMCHC reports that their no-show and cancellation rates have been lower during the pandemic than they were at the same time last year.

2: Any changes, issues or anticipated changes in population attributed to the IDNs, including changes to attribution methodologies.

No changes in these area's.

3: Information about each regional IDN, including the number and type of service providers, leader provider and cost-savings realized through IDN development and maturation.

IDN 1

There has been one change in the IDN1 network in the quarter- the removal of Mindful Balance Therapy, LLC from the IDN partner group. This change came after years of significantly limited engagement due to a lack of Medicaid billing.

IDN 2

No changes to our provider network.

IDN 3

Partners delaying participation

Continued outreach to gap partners:

The IDN3 Admin Lead Team met with the following partners in June to discuss opportunities for them to participate in the IDN and their ability to provide the required reporting of outcome measures.

For outcome measure reporting, the IDN team reached out to SNHMC (PHP/IOP), PSL (Harbor Homes/Keystone Hall) and SJH Physician Practices. Although these partners expressed the potential ability to manually provided limited data set for the CY2018/CY2019 reporting periods, they could not commit to full reporting for all of their Medicaid attributed population as is required by DHHS to full the IDN's gap reporting requirements before the August deadlines.

For Event notification hospital transmission, the IDN facilitated multiple meetings in June between St. Joseph's Hospital (SJH) and Collective Medical (CM) to discuss the technical details and feasibility for SJH's to have the ability to transmit admissions, discharges and transfer (ADT's) notification to the CM network. The next steps are for the SJH team to work through significant challenges regarding their current IT backlog and barriers in scheduling the required changes which will require a new build

IDN 4
At the time of this report, there have been no additions or deletions of partners in our IDN. In support of our partners during the public health emergency, extensions were granted in due dates of status reports on the progress on B1 Project Integration Enhancement Plans and E4 Integrated Treatment of Co-Occurring Disorders Quality Improvement Plans. Status reporting is up to date. Thus far, partners have indicated a continued willingness to pursue efforts that were begun as part of the waiver. We have provided outreach to partners to assess each situation and to provide support to find solutions.

IDN 5
As stated above, the LRGHealthcare system not only closed 7+ practices due to COVID 19, but they are also experiencing ongoing financial difficulties which forced them to furlough over 400 employees. The IDN felt this in that our primary contacts in IT, Quality, and Care Coordination, were no longer available to outreach to, essentially many of our "go-to" individuals were either furloughed or working from home making normal communications infrequent or not at all. The IDN network partners remained in close communication during this time via email and switched all meetings to a Zoom video meeting platform. There were no changes in numbers or types of services providers in the last quarter to report.

IDN 6
Our network has actually expanded through the quarter. The COVID Emergency Fund resulted in the establishment of 20 new formal IDN partnerships, all agencies serving the most vulnerable populations in our region, creating new opportunities for cross-sector collaboration and coordination.

The acquisition of Frisbie Memorial Hospital by HCA was completed in the previous quarter. This is good news for the stability of the organization that serves the relative highest ratio of Medicaid members in our region. But as with all major institutional acquisitions, the bandwidth and capacity for engaging in new collaborative efforts, along with considerable workforce disruptions and constraints, have limited participation in existing or new DSRIP efforts.

In all, partner engagement and participation has remained robust. For example our virtual All Partner Meeting on May 6 of this quarter attracted 85 participants.

Our **Clinical Advisory Team (CAT)** continued to meet monthly to provide expert input on operational considerations and problem-solving related to the care integration objectives across IDN projects (with emphasis on B.1). The CAT meetings in the second half of this reporting period were especially valuable in their focus on managing the clinical challenges introduced by COVID-19, including implementing telehealth services that are reliable, effective, user-friendly for patients and providers, and that maintain quality and confidentiality standards.

IDN 7
In March 2020, Hope for NH Recovery in Berlin was closed due to COVID-19 and leadership decided to dissolve the center entirely due to lack of capacity to provide services. Hope remains operational at their central office in Manchester but does not feel that it is feasible to reopen a center in Berlin at this time. At the time of this report, Hope for NH Recovery is contemplating withdrawal from the Region 7 IDN for the remainder of the demonstration because they are no longer able to be active in the region.

4: Information about the state's Health IT ecosystem, including improvements to governance, financing, policy/legal issues, business operations and bi-directional data sharing with IDNs.

IDN 1

We are now in year 5 of the waiver and all core IT implementations are complete in Region 1 IDN. Pre-COVID-19, our IT focus was on supporting the maintenance of IT implementations and continued scaling to more providers throughout our Partner organizations. We also were working with Partners to 'harvest' the data assets we have worked so hard to deploy in support of population health and quality improvement efforts. As the department is well aware, we had planned to stretch our IT implementation efforts and deploy the UniteUs platform in a "Sullivan County Community Hub pilot" which we hoped would inform a statewide initiative connecting healthcare and community supports providers.

Region 1 IDN and our Partners have shifted attention and resources to COVID-19 response. This shift has impacted our IT implementation components in the following ways:

Minimum Requirement – Internet Connectivity (Status - Completed): Region 1 IDN Partners were all connected very early in the program and met the threshold for data connectivity. With the shift of healthcare providers to telemedicine and the shift of schools and community supports organizations to online services and virtual classrooms, we have recognized that access to services is gated by internet accessibility. Our community coalition work is looking specifically at technology/internet connectivity among NH residents to determine if there is action or investment that the IDN can consider. This is exploratory at this point through the Greater Sullivan Strong community project.

Minimum Requirement – Secure Data Storage (Status - Completed): Region 1 IDN Coordinated and Integrated Care Partners were all able to secure data storage early in the program and met the threshold for Secure Data Storage. COVID-19 has not impacted this component.

Minimum Requirement – Electronic Data Capture (Status – Completed): Region 1 Coordinated and Integrated Care Partners were all able to use electronic health record (EHR) systems early in the program and met the threshold for Secure Data Storage. COVID-19 response has required our Partner organizations to shore up their remote access to EHR systems so providers may chart telehealth visits while working remotely. Partners have been capable of making this shift with minimal help from the IDN.

Minimum Requirement – Direct Secure Messaging (Status – Completed): Region 1 Coordinated and Integrated Care Partners were all capable of sending and receiving patient care summaries via Direct Secure Messaging (DSM) early in the program and met the threshold for DSM. We had planned to expand connectivity to Community Supports Organizations using the UniteUs platform with our Sullivan County Community Project this year but this expansion has been cancelled. Given the 14 months of planning and barrier clearing for the UniteUs investment, this was a very hard decision to make. Ultimately, we polled the Partners that would be implementing the program and platform and recognized that there is no additional capacity for new work beyond COVID-19 response right now. Conversations are ongoing within IDN1 network partners as well as statewide to assess the feasibility of re-engaging with UniteUs at this time.

Minimum Requirement – Shared Care Plan & Event Notification (Status – Completed): Region 1 Coordinated and Integrated Care Partners were all connected to and using Shared Care Plans and Event Notification as of the end of 2019 (using Collective Medical Technologies (CMT) platform). The attention shift to COVID-19 has resulted in cancelling of many Multi-Disciplinary Core Team (MDCT) meetings across Region 1 in April, May. Since Shared Care Plans work in tandem with the MDCT meetings, this work is expected to pick up as pandemic response abates and as MDCT meetings resume in both virtual and in-person formats. Despite the interruption of MDCT meetings, Region 1 Partners continued to expand their use of Shared Care Plans. The (duplicated) count of new Region 1 IDN Shared Care Plans in CMT for May 2020 was 56. (duplicated means that a PCP and a CMHC may both have a SCP for the same patient – CMT does not de-duplicate its reports). The increase is largely attributable to the Dartmouth Hitchcock Medical Center Emergency Department staff who have begun entering information for high complexity patients in the ED.

Several Partners have continued to expand their patient enrollment with CMT through 2020. This means that Emergency Department (ED) and Hospital utilization data assets are growing in size and value. Region 1 Partners are currently enrolled to receive notifications for over 29,000 patients. The CMT event notification service continues to inform Region 1 Partners of their patients' ED and Hospital admissions, transfers, and discharges, helping to orchestrate care coordination and follow up efforts among primary care and visiting nursing providers. In May 1,040 notifications were sent for 5,345 emergency department visits.

(Note: Our vendor CMT is attempting to innovate to support its customers with COVID-19 response. We expect this to take the vendor a few months but may have additional CMT features this year that can aid with COVID-19 patient identification and tracking and with statewide dashboarding to detect surges in flu-like symptoms in real time.)

Minimum Requirement – Data Extraction for Quality Reporting (Status – Complete): Region 1 Coordinated and Integrated Care Partners are all connected to and using the Massachusetts eHealth Collaborative Quality Data Service (MAeHC QRS). Region 1 IDN prepared a detailed analysis of the impact of COVID-19 and its response on the NH 1115 Medicaid Waiver performance program. The major findings in the analysis were that Partner capabilities for data submission would be diminished and that overall impact of COVID-19 would be significant decline in the majority of measures. (DHHS received the recommendations and those may be reviewed separately)

Despite the resource shift to COVID-19, Region 1 Partners were able to complete chart reviews for the Diabetes and Hypertension measures. Partners that report quality data on a monthly cycle were all able to continue these data submissions.

The departure of MAeHC has unfortunately corresponded with COVID-19 and has put great strain on the performance program. Together with DHHS, Region 1 IDN was also able to navigate the privacy challenges of moving MAeHC historical data to DHHS and created a Business Associate Agreement and Qualified Services Organization Agreement (BAA/QSOA) to enable this data disclosure. Replacement of the MAeHC QRS is not viable during the COVID-19 response.

IDN1 Partners are well poised to fulfill their data submission for CY2019 measures as of July 15, 2020.

Minimum Requirement – Data Sharing Consents (Status – Complete): Region 1 Coordinated and Integrated Care Partners have all been able to lawfully share patient information for care coordination and quality reporting purposes for many years. Region 1 IDN distributed the Governor's emergency orders and Federal guidance regarding Telehealth and patient privacy. We were able to quickly get ahead of privacy concerns and questions which cleared a major barrier to telehealth.

Website: Region 1 IDN has updated our website to keep our Partners informed of COVID-19 related announcements, information, and resources. Since mid-March we have had a COVID-19 specific page with updates every few days. Please see the website at http://www.region1idn.org/COVID-19.html

IDN 2

As we continue to utilize telehealth platforms to service and meet the needs of both our patients and with our community partners, knowing that technology can truly help bridge the communication needs across various infrastructures just further confirms that with adequate training, education, and support, new technology solutions prove to be successful both short and long-term.

Even though many users are most comfortable performing their job roles "as they always have" using old school methods in some areas, when presented with situations that require us to adapt and change gears, especially during an ongoing health crisis, relying on different technology solutions really is obtainable and our IDN partners across the state have demonstrated this in various ways and continue to.

We need to be more cognizant of how technology is constantly evolving and changing so that we all are fully informed of our options as technology can truly help streamline workflows and processes.

The use of Telehealth plays such a vital role now and will continue to as it has proven to be a tool that most everyone at various levels of expertise are aware of and are comfortable using in their day to day operations-both at the professional level and personal level.

Partner Engagement:

- 6/24/20-HIT support person attended monthly IDN2 Operations/Implementation Meeting
- 6/23-HIT Support person attended monthly IDN2 call with DHHS
- 6/9-HIT Support person attended IDN2 meeting with CMT representatives to discuss sustainability options and to hear about new CMS rule and how that will affect Concord Hospital and community partners.

Implementation Activity:

- Week of June 8th-NH Hospital has scheduled kick off call with CMT. Go Live should be within 30 days.

Challenges:

- As we continue to explore long term sustainability plans post waiver, we have received feedback from some of our IDN partners who are not sure about continuing with CMT due to limited value being seen on their CMT notifications since they are already being notified from their current EMR processes.

Mitigation:

- IDN project managers and Project Director are dedicating time and resources to re-convene with certain parties and connect them directly with CMT's team to explore all options both from a funding standpoint and to re-visit CMT's workflows to show value across entire platform not just by partner.

IDN 3

DSRIP clinical outcomes measure reporting to support IDN 3 outcome measure targets

During the quarter, the IDN Team continued to support our already reporting partners in their reporting to MAeHC and their quality review process by:

- Partner Monthly Performance Update – this report provides all our MAeHC reporting and expected to report partners details on their reporting status and allows them to see stats in relation to target goals as well as in relation to each other and at an IDN3 level.
- Outcome Measure partner review meetings – the IDN Lead team set up one-on-one meetings with all of our reporting partners to review their current reported stats to identify any need to be re-evaluated or updated prior to the 07/15/20 reporting deadline.

As most of our already reporting partners continued to report to MAeHC on a monthly basis for the current reporting period that ends on 07/15/20, in mid-June the IDNs were notified that CMS approved the modification to DSRIP Funding and Mechanics Protocol due to COVID-19. The modification mainly addresses the funding protocol, which allows the DSRIP program to use year 4 performance results to score year 5. Even though DHHS has confirmed in late June that they do not plan to use any 2020 outcome measure data for funding purposes, MAeHC is still planning to provide DHHS all partner reported data including Jan-Jun 2020 6 month measures as part of their final report to DHHS. Thus, the message to IDN3 partners has been to continue to report as they have been.

The changes reflected in the modifications puts a greater emphasis on filling any gap reporting for 2018 and 2019 measurement periods in order to achieve any "mets" for 2020. IDN3 has struggled with meeting the no-gap reporting funding requirements with partners who have been unable to report for CY2018/CY2019 data for both CY and 6 month measures. The IDN has continued to engage the following partners to discuss opportunities for them to report these gap outcome measures but the IDN is also working with DHHS and Admin Lead to determine feasibility of achieving 100% reporting during this PHE environment for the following partners:

- SNHMC (PHP/IOP)
- PSL (Harbor Homes/Keystone Hall)

- SJH Physician Practices
- Merrimack River Medical Services

Providers have also expressed several other challenges/barriers influencing the IDN's ability to achieve its measure targets for these reporting periods. In May, the IDN's Integrated Health Outcomes (IHOS) work team focused their May meeting on identifying the barrier/challenge trends and potential mitigation plans to the region achieving its outcome measure targets during the PHE:

Incorporation of Telehealth
On 04/02/20, Telehealth was formally added to the DSRIP Narrative Guide V1.10 as a valid method for Office, Community Based, and Outpatient definitions to temporarily respond to the PHE where telehealth was not previously allowable. Most of our partners have been able to move to Telehealth with favorable trends expressed by both providers and clients. Below are also some challenges/barriers:

- Dartmouth Hitchcock was unable to incorporate Telehealth activities into their Jan-Jun 2020 reporting due to staffing redirection. **Mitigation:** DH abandoned making this change in light of CMS approval of the relieve waiver resulting in DHHS confirming that they do not plan to use any 2020 reported measures.
- Moving to telehealth had its own technical challenges although the feedback was that many patients preferred telehealth and that there was a reduction in "missed appointments":
    - not all patients have access to telehealth technology, so phone calls were utilized
    - patients are providing their own measurements (blood pressure, glucose values) to the providers which they are recording in their EMRs.

Changes in service delivery/operations and Lack of staffing capacity

- Due to a small fire, InteGreat closed their co-located practice in early March. Because InteGreat uses point of service NPI to differentiate between Lamprey and InteGreat patients, data was reported against Lamprey Health for March/April 6 month measures as InteGreat consolidated their services with Lamprey Health. **Mitigation**: This issue was addressed by a change made for May/June data submission.

- With the limitations in place for in-office services, including well-care visits, and reduction in staff (furloughed), providers have had to react to a rapidly changing environment with new workflows where the "rooming" supports were not always in place. The majority of the IDN treatment providers have expressed that they expect to see reduction in measure outcomes as their efforts have been focused on supporting those patients/clients with complex healthcare needs such as diabetes and heart disease during the PHE. These check-ins have not allowed for completing universal screening tools/questions in the same ways they would have for in-person visits, impacting the ability to document these interventions in ways that their data analysts can pull from their EMRs during this time.

Other barriers/challenges

- Foundation Medical Partners has been unable to report on a monthly basis during 2020 due to IT staff being reassigned to support the organization's EPIC EMR migration, which is scheduled to go live in November 2020. **Mitigation**: FMP completed CY2019 reporting on 06/15/20 but in light of CMS approval of the relieve waiver FMP prioritized focus on CY2019 measure reporting and quality review activities.

Attestation for Implementation and Operationalization of all HIT Standards Platforms (minimum, desired, optional)
Data/IT Governance Committee met on 04/23/20 for their quarterly meeting where the team reviewed requirements and definitions for all of the minimum/desired/optional HTI Standards listed in the IDN's A2 Project Plan with the goal of identifying the best way to determine partner status on implementation and operationalization of these platforms; the IDN continued to work with the Data/IT Co-Chairs to finalize the document and best approach to gather the feedback from all of our IDN partners.

Bi-directional data sharing through use of HIT platforms
Kno2 and integrated DSM platforms:

Due to COVID, significant progress towards expanding usage of the Direct Secure Messaging (DSM) protocol (as a method of sending/receiving referrals and transferring of other patient information) beyond those who had already operationalized its use has been delayed due to staffing redirection/furloughs. However, the IDN continues to educate and encourage movement towards the usage of a secure electronic method for sharing and collaboration of patient information. The following partners continue their operationalization of the IDN funded Kno2 platform:

- CTI and GNMHC are receiving referrals and sending information requests through their published Kno2 address when referring facility has the DSM capability.
- Emmaus Institute continues to use Kno2 and have reached out to encourage other partners to advocate usage of this secure messaging protocol.

Use of ADT information in Collective Medical

During this quarter, the IDN has been actively focused on working with our partners on how to operationalize the use of the hospital admission, discharge and transfer event notifications (ENS) they now have access to through the Collective Medical PreManage Platform via several different venues:

- At the 04/23 Full IDN meeting, the IDN in conjunction with CM offered ENS Operationalization discussion/demo where partners were educated on standardized Medicaid specific cohorts and reports available to all of our CM participating partners who have identified their Medicaid panel in their patient file. The IDN reviewed and made available the ENS Information Guidelines Sheet which was approved by the Clinical Committee in March.
- Throughout the quarter, the IDN continues to meet with partners via 1-1 partner check ins to review how they can utilize the CM platform and their Medicaid panel monthly report in reducing hospitalizations and improving patient care and outcomes. In addition, the IDN continues to support any lingering partners to complete their CM implementation process:
    - Revive was able complete their CM process and came on-line with CM on 04/22/20
    - Nashua Department of Health completed their sub-contracting with CM. The IDN is supporting the DPH in completing their kickoff call and user training towards receiving real time event notifications for their Medicaid patient panel.
- The CM Medicaid Census report is run monthly on the 1st of each month. This allows partners to review hospital usage activities and trends for their Medicaid patient panel and to identify high utilizers and potentially high risk patients within this population. As part of the partner monthly report template, partners are sharing with the IDN their patient activities, partner responses and opportunities to educate and support their clients.
    - For example, GSIL is now able to report that out of 58 notifications for their May reporting, (11) were repeat visits within the same month, (7) went into the hospital twice on the same day representing activity for 47 unique Medicaid beneficiaries. GSIL has developed protocols to increase collaboration with the consumer to attempt to mitigate reoccurrence of hospitalization especially during COVID.
    - Life Coping is also utilizing the CM Medicaid Cohorts and Monthly reports and sharing with their Nurse Clinical Director for input on how to limit ER visits for those who may be going more than once each month.
    - CTI reports that ENS is working well for those hospitals in the CM network

Operationalization of Shared Care Plans (SCP):

During this quarter, the IDN also focused on operationalization of the electronic Shared Care Plan also using the Collective Medical PreManage Platform. In May, the IDN 3 Clinical Governance Committee members reviewed the newly developed one-page IDN 3 Shared Care Plan Information Sheet and participated in a live demo provided by Collective Medical (CM). The recommendation from the committee was to pilot implementation of the SCP with a couple of partners, with the goal of sharing the experiences and lessons learned back with all IDN 3 partners. Subsequently, the IDN3 IT Lead reached out to several of our partners to participate in the pilot covering a range of provider types: PCP, MH, SUD, Support Services. On 06/24/20, the IDN invited the partners to a kickoff meeting where Collective Medical demo'd their SCP capabilities, reviewed the IDN3 SCP Information Sheet and the timeline for the next steps:

- Identification of patient(s) target date: 06/30/20
- Acquire patient consent & develop care plan target date: 07/07/20
- Update patient consent in patient file & upload to CM target date: 07/14/20
- Enter patient care plan into CM target date: 07/21/20
- Regroup for feedback and next steps target date: 08/05/20

Transmittal of Admissions/Discharges/Transfer (ADTs) for ENS:

During this quarter, IDN3 Admin Lead Team continues to actively engage the other IDN3 hospital, St. Joseph's Hospital, to join the Collective Medical network to transmit ADTs. Our partners have expressed that while they value receiving these notifications, not having both of our local hospitals on the network limits visibility for their entire patient panel activities. Couple of meetings were held in June with SJH leadership and CM to discuss potential next steps to moving forward with their sub-contracting with CM. Although SJH has articulated their desire to complete this implementation, they continue to express significant concerns regarding their current IT backlog and barriers in scheduling the required changes which will require a new build. The IDN will continue to follow up and support SJH in making progress.

***P**ausing on implementing pilot electronic closed loop referrals platform (Unite Us):*
The Unite Us effort continues to be on pause due to uncertainty in funding availability and statewide impact on providers due to the PHE. IDN 3 continues to revisit this effort at the monthly DSRIP data meetings in collaboration with other IDNs around the state as well as Granite United Way/2-1-1 to pilot the use of an electronic closed loop referral platform through Unite Us.

IDN 4

This quarter Health IT (HIT) initiatives have focused mainly on the implementation and improvement of telehealth services across our region.

We continue to see evidence of the success of N4H HIT initiatives in the wake of this crisis. Our work to provide our partners adequate IT infrastructure allowed our partners to quickly transition to at-home working, support telemedicine services and allow for remote communication. At the current time we have supported the implementation of telemedicine services to more than 200 providers through the doxy.me (https://doxy.me/) software platform including setting up full telehealth services at our local homeless shelters. In addition, N4H stood up a telehealth support line to assist with questions, technical issues and additional implementations.

We worked with our partners to support workflows using Collective Medical for monitoring patients during the pandemic. These workflows included support for identification and monitoring of the homeless population and patients with chronic illness.

We will continue to support equipment and technical needs of our partners to ensure the ability to care for patients in new and innovative ways.

IDN 5

Each of the IDN5 B1 partners was able to submit data for the full year 2019 submission in June. The reporting was not as complete as we would have liked but unfortunately there were fewer reporting resources to complete this data submission due to COVID response. Several of our partner agencies noted that they were busy creating new reports related to COVID and did not have the bandwidth to complete the submission.

Each IDN received sample files from DHHS for a few measures that we will look into completing gaps for although again our concern is it may not be possible due to the focus on COVID within our partner agencies and their resources being very strapped to anything extra.

IDN 6

- Due to the primary and all-consuming focus of partners on the COVID-19 response, further development of UniteUs as a statewide resource was halted with the intention of picking it back up later in 2020. Recent news that Granite State United Way has continued to negotiate with UniteUS is promising.
- Due to COVID-19, all clinical and several SUD partners are engaged in providing services via telephone or video calling, many for the first time. Most had new telehealth systems set up within a week of the SOE being declared. Telehealth implementation and sustainability were discussed in June at a Clinical Advisory Team meeting, to which local partners' IT people were also invited. Out of that came a smaller meeting convened by the IDN at which partners shared information on the more technical aspects of the electronic systems and devices each organization is using to inform those looking to possibly move away from systems that were available immediately but are not necessarily sustainable.

- To support telehealth efforts, the IDN engaged a clinical consultant (Elizabeth A. Tracy PsyD, MSW, LICSW, LCSW, dba Resilience and Hope) to provide customized trainings to staff who are doing telehealth currently. Issues of licensure, informed consent, and setting up the environment were covered. This two-part webinar series received very positive reviews. To supplement the trainings delivered, the consultant created a 104-page Telemedicine Resource Guide specifically for Region 6 partners.
- IDN-6 also has been responding to partners' requests for legal information on telehealth-related privacy statutes and regulations.
- Discussions with an ENS vendor to replace MAeHC were put on hold during the immediate COVID-19 response, but have since restarted with the vendor that already has a presence in our region and a contract with one hospital. Presentations by the vendor for regional partners that will be ADT data subscribers are currently scheduled to scope the interest, after which a timeline for implementation will be finalized.
- Despite diverted organizational IT resources, all data reporting partners continue to submit data on the DSRIP metrics, several achieving 100% performance on multiple metrics for a second or third reporting period.

IDN 7

The COVID-19 pandemic has caused a disruption to HIT initiatives, much as it has for other areas of the project. The Region 7 IDN team remains focused on the core goals of region-wide outcome reporting and region-wide event notification/shared care plan utilization. As highlighted in previous reports, these goals were already threatened by staffing, data management and organizational buy-in at several partner organizations. Unfortunately, the distorting effect of the pandemic has only exacerbated these issues, causing delays and pauses in projects that, at the end of 2019, were moving forward.

At three partner organizations (White Horse Recovery, Littleton Regional Healthcare and Friendship House), the COVID-19 pandemic has created delays in planned PreManage implementation or exploration. In a comparable way, several partners have reported an inability to report fully on statewide outcome measures. These delays are not only related to immediate shifting of existing IT resources to pandemic response initiatives such as telehealth but also to the reduction of said resources due to staffing cutbacks during this time.

Region 7 IDN remains committed to continuing to advance the goals of DSRIP but is also attempting to balance this with sensitivity to partner capacity during these chaotic times. As more organizations adapt to the new climate, we have begun to see movement again on key areas, including the sending of Admission, Discharge, and Transfer (ADT) data to Collective Medical by Cottage Hospital or the re-engagement of Indian Stream on outcome reporting. These areas of movement prove that Region 7 IDN partners truly share the vision of improved health information technology infrastructure despite being hampered by the challenges highlighted above. With patience and consistency, the Region 7 IDN team believes that partners will accomplish the goals of the Delivery System Reform Incentive Payment (DSRIP) program.

5: Information about integration and coordination between service providers, including bi-directional integrated delivery of physical, behavioral health services, SUD services, transitional care and alignment of care.

IDN 1

During the quarter, the IDN1 team saw a reopening of many of the primary care and service oriented partner agencies across the region. These partners are working through ongoing challenges related to COVID-19. The IDN continues to support the following:

- Bi-weekly Greater Sullivan Strong meetings
- Bi-weekly IDN1 Direct Care meetings
- Ad-hoc meeting with partners on COVID-19 related needs
- Support for project teams and partners to adjust the terms of their scopes of work to better suit the new clinical realities of operating with COVID-19

- State and Regional meetings, trainings and forums addressing all facets of work post COVID-19. The leadership team has been invested in tracking down all available resources for partners and participating in conversations on how best to resume work, manage, adapt, and support partners doing direct care work.

IDN 2

IDN2 continues to work on collaborative care model (CoCM), which was supposed to launch as a pilot at one site (Pembroke) in March 2020 and was delayed due to COVID-19. IDN2 has decided instead to launch CoCM in August at all of the CHMG practices that have an embedded Riverbend Integrated Behavioral Health Clinician (IBHC). The CoCM will focus on anxiety, depression, and substance use disorders (SUD). The only remaining task before implementation is to create evaluation metrics.

IDN 3

Interactions/coordination efforts

Dartmouth Hitchcock

- Resource Specialist has continued to make successful referrals to Greater Nashua Mental Health Center. Two individuals have begun to receive behavioral health services there and have been able to provide collaborative care to many others. This includes checking in regularly with GNMH counselors and case managers for mutual patients.
- Three Medicaid beneficiaries have begun to utilize Salvation Army food pantry, either receiving deliveries through United Way volunteers or accessing the pantry during open hours.
- Resource Specialist has joined the Greater Nashua Food Council to provide better services to DH patients that are experiencing food insecurity, as well as providing the council with insight about needs of individuals in the community.
- Resource Specialist has worked closely with BEAS to ensure safety and healthcare needs are met for a number of patients that are Medicaid beneficiaries.
- With many individuals experiencing job loss, Resource Specialist has collaborated much more closely with NH Employment Security, helping many patients successfully connect to Unemployment income, and work programs.
- MSW referred multiple patients to Salvation Army current food program.
- Work with Home Health and Hospice Liaison on an on-going basis with questions about patients' home services.
- Ongoing contact with St. Joseph Community Services Meals on Wheels re: one specific vulnerable patient. Another patient was connected to the Meals on Wheels program for meal delivery.
- St Joseph Hospital-In communication with their specialty practices to assist a Spanish-speaking patient with scheduling care.
- United Way-Provided gloves for a patient, had a volunteer deliver food to another patient who could not go to a food pantry. MSW has reached out to United Way for guidance on COVID resources.
- Brides DV Agency- In contact with them for advice on a domestic violence case,
- Greater Nashua Mental Health-Connected a patent to the REAP program. Assisted another pt to connect to counseling.
- Southern NH Services-assisted one patient with connecting to them for electric assistance. Assisted 2 patients with connecting to their Commodity Foods program.
- Life Coping-MSW reached out to them for advice on a patient situation. MSW has been collaborating with a Life Coping CFI case manager.

Ascentria

- Ascentria interacted/coordinated efforts with the following IDN3 member partners during this quarter: Lamprey (10 times), SNHMC (5 times), SNHS (1 time), and St. Joseph Hospital (1 time). Additionally, Ascentria interacted with NH DHHS, area landlords, and Ascentria Services for New American's employment program.

SNHMC

- SNHMC was able to successfully coordinate efforts w/ GNMHC to track ED and BHU discharges and follow up appt compliance.
- Sent referrals to SNHMC IOP, Keystone, Safe Station, GNMHC.

The Emmaus Institute

- Has several patients that are seen at GNMHC as well as at Emmaus. Information sharing is ongoing between both parties.

Case reviews for individuals with complex healthcare needs

- Lack of cases submitted to IDN 3 Regional MDCT

- IDN 3 continues to have difficulty in identifying candidates for MDCT; however, two partners have engaged in the process. Emmaus has submitted one patient to the monthly regional MDCT and Ascentria has identified a patient but is unable to get patient consent.

IDN 3 COVID-response activities

Weekly care coordination calls

As stated above in the Telehealth section, skype calls occurred twice a week from April to May and reduced to one per week in June. The goal was to learn from each other and to identify gaps, needs, and potential solutions for the continued support of this target population during the pandemic crisis. Twenty-five partner organizations and from 7 to 21 Care Coordinators (14 per call on average) participated in the one-hour skype calls. The following organizations participated in at least one call: AmeriHealth Caritas, Ascentria, Crotched Mountain, Dartmouth, DHHS, Foundation Medical Partners, Foundation Medical, Partners MAT, Gateways, GNMH CTI, GNMH IDDT, Granite State Independent Living (GSIL), IDN 4/Network for Health, InteGreat, Life Coping, NAMI NH, Nashua Soup Kitchen and Shelter, NH Healthy Families, Revive, SJH, SNHMC BHU, SNHMC ED/IP, SNHMC IOP/PHP, Southern NH Services, The Emmaus Institute, WellSense.

This word cloud generated from notes taken during the calls from April to June illustrates some of the various topics discussed. Topics include telehealth, services-related operations like appointment lengths or clinic consolidations, support

of SUD patients, homelessness, effects of social determinant of health on patients like housing issues, transportation, food access, and general topics based on Care Coordinators front line experiences.

The discussions can be grouped into six main themes which are broken down further into additional sub-themes. The six themes are telehealth, health-related services, social determinants of health (housing, transportation, economic, food, social needs), SUD, Covid Testing, and Staff Support. Most of these themes contain a sub-theme around MCO Support, Requests, and Suggested Resources as a result of information sharing in each meeting. A detailed report can be provided upon request.

Weekly information sharing updates (shifts in partner services/operations, timely state updates, additional resources available, etc.)

In addition to the weekly Coordinator Care Calls, the IDN solicits updates on changes in the service delivery and/or operations of its partners and shares it weekly via email. This allows every partner to have up-to-date information for each other in a timely and efficient way. The email typically includes:

- Pdf of Partner services which include the service category, website link, services provided, current service modality, and description of changes
- Contact sheet for MCOS (Amerihealth, NH Healthy Families, WellSense)
- A list of additional resources related to COVID-19 of SDOH services often obtained from the Regional Care Coordinator Calls
- Other timely attachments like the MDCT information sheet or the Family Well-being Guide from DHHS, Division for Children, Youth & Families
- The IDN also participates in weekly calls with other IDNs, DHHS and other State Agencies, as well as the Medicaid MCOs. The goal of these calls is for the IDNs to share information from our region's partners as well as gather information from these statewide organizations that we then share back with our partners. Areas of information sharing have included housing, transportation, federal/state funding sources, and gaps in care.

IDN 4

A number of our partners tell us that a silver lining of this pandemic has been the increased level of truly impactful cross-agency collaboration. Sustaining this is something they want, and tell us that N4H has been instrumental in pulling the right people together. Examples of our IDN's bi-directional integrated care delivery across sectors, and transitions of care for this quarter are highlighted below:

- Cross-organization collaboration to connect Manchester's unsheltered homeless with support and resources during this public health crisis: Coordinated services, information and joint workflows were developed between FIT-NH, MHCGM, HCH, and Manchester's Health, City Welfare, Fire, and Police Departments.
- The quick adoption of telehealth during this pandemic: N4H supported our partners with various training, technology, and operational resources; and participated in meetings with IDN 6 and various stakeholders across NH and the northeast region to explore how the IDNs can support the sustainability of telemedicine post-pandemic.
- N4H held collaborative meetings with the Managed Care Organizations (MCO) and our partners to ensure their input and buy-in as we developed job aids for primary care and (MCO) Care Management (CM) teams.
- Easterseals NH/Farnum Center, MHCGM and FIT-NH met this reporting period to improve cross-agency collaboration, particularly to refine the intake referral, medication management, and discharge planning inter-organizational workflows.
- Addressing gaps in care between mental health providers, and brain injury and developmental disability service agencies. Planning by N4H's B1 team to bring various stakeholders together to discuss the issues, with a goal within the coming months to formalize referral workflows and joint service protocols with several of these agencies, and develop other potential solutions. A meeting was scheduled for July 1, 2020.

IDN 5

The E5 Community Wraparound meetings continued to be held via Zoom which was beneficial for all community partners to remain connected and to understand the regional impacts of COVID and how some of their work and needs have changed during these times. By having so many of these relationships already established it has enhanced the community's ability to collaborate easily and in a timely fashion to meet the immediate needs that COVID has brought with it. Staff are shifting and assisting where needed and it remains a fluid time with our workforce.

Another great example of the bi-directional integrated delivery of care occurred within our C2 and D3 projects. Due to the jails immediate need to release as many inmates as possible due to COVID 19, it resulted in a different way of working within the C2-Supportive Community Re-Entry project and services were significantly decreased. Horizons Counseling staff and Navigating Recovery peer support staff was no longer allowed in the jail to work with inmates and most were released early to the community with electronic monitoring. In effect however, this increased the need for services provided within our D3–Intensive Outpatient Treatment program. Although the IOP shifted to being offered via telehealth/video, it did allow for a larger ratio of clients to providers so the program could serve more individuals. That however was still not enough to serve the increased population needing services (the released inmates) so a third Laconia IOP was immediately opened to meet the growing need for services.

IDN 6

In response to the challenges of the COVID-19 pandemic, IDN 6 instituted additional **CCT meetings** in which partners throughout the region are able to identify any critical areas of need not being met for their clients, to describe how their access and delivery of direct services have changed, and to update details on new or changed services or resources partners have learned about - at their agency or others. These meetings are held in addition to the regularly scheduled CCT meetings in the region that are focused on case-based care coordination. Initially convened three times per week (M-W-F) during the Crisis Response period, the collective chose to maintain meetings twice per week (W-F), referencing the continued value of the forum to inform their respective efforts moving through subsequent phases of COVID-19 recovery. In addition to timely and practical information sharing, these CCT meetings have stimulated many instances of

collaboration and coordination among partners serving vulnerable populations throughout Region 6. Average attendance remains stable and meeting agendas and discussion robust.

The **Regional Case Manager Networking and Support Group** quarterly meeting has served to bring clinical case management and Social Determinants of Health case management conversations into better alignment and identify professional / workforce development opportunities in integrated / collaborative settings. This "boots-on the-ground" group has been instrumental in providing timely insights and supportive resources and strategies for managing the challenges of delivering high quality case management services in the context of physical and social distancing. It also aims to create a cohort for those who may be the only case manager at their agency in order to provide a supportive community to encourage continued work in this field.

Food Security Assessment: The Connections for Health Team has observed that while there are a tremendous number of efforts underway throughout the region to address food insecurity, there is currently no entity coordinating across all these initiatives. The absence of coordination is naturally resulting in gaps and unmet needs, as well as duplication or redundancy of effort. This is complicated by the fact that these efforts/resources vary greatly in terms of size, compositions, process, coverage and shifting accessibility. To address this at the network level, the CfH Team initiated a project to validate and update current sources of information (i.e. the robust spreadsheet created by Strafford CAP, and the Food Access Map created by UNH) to create a user-friendly tool. Through a systematic outreach effort, publicly available information was confirmed, updated, and centralized in a new Food Resource Guide that is usable in hardcopy or online. Through this effort, interviews with over 30 key partners engaged in addressing food security in the region also explored the structure, functions, reach, priorities, needs, strengths and opportunities for agency and network enhancement.

UNH Surge Site: All four regional hospitals worked collaboratively to staff a potential COVID-19 hospital discharge surge site with both Nursing and Case Management staff. The IDN was asked to partner with the Case Management Directors to build a compliment of community case managers to support the site. A group of seven community care managers have volunteered, registered with NHResponds, and remain ready to assist, if needed.

Dover Quarantine: Isolation site for vulnerable populations: As support to the statewide effort and our local partners, the IDN has provided staff training and operational support to open the site in April. Sandi Denoncour has been actively participating in the efforts which are being coordinated by Tory Jennison from her role at the State Emergency Operations Center. Ongoing support includes Case Management support, additional staff training, and collaboration with regional partners utilizing the Community Care Team approach to identifying appropriate service providers and community supports for successful quarantine and transition back to the community. Hoping that it will prove to be a successful model for addressing clinical, BH, SUD, and SDoH needs in a unique public health model.

IDN 7

During the reporting period, referral patterns have continued to function as they did in prior quarters, but partners report that there have been fewer office visits as patients have adhered to Safer at Home guidelines. Several Region 7 IDN partners are anxious for beds to become available at Friendship House (FH), which closed in March under concerns about facility design and staffing constraints that challenged the facility's ability to adhere to COVID-19 practice guidelines issued at the state and federal levels. During this reporting period the staff at FH continued their Intensive Outpatient Program (IOP) and Outpatient services using telehealth modes, and leaders worked diligently to develop and implement a plan to reopen residential treatment services. At the end of June after almost three months of staff furloughs and layoffs, FH was able to return to a staffing model that allowed them to gradually begin accepting admissions to the 3.1 low intensity residential program. FH plans to gradually increase the census and program offerings using a series of PDSA cycles that evaluate the efficacy of the plan and adapt it along the way. While this approach set the facility up for a careful and successful reopening, it meant starting with a census far below the break-even point on overhead expenses, forcing the partner to operate at a loss as it gradually increases the number of admissions in a safe way.

Region 7 IDN partners continue to collaborate with and rely upon each other for providing essential services and resources to the community. Collaboration has increased during the pandemic as partners made extra efforts to ensure that their patients and clients who have been deeply impacted by the change in service delivery were connected to resources. At the IDN level, North Country Health Consortium leveraged the IDN to stand up "COVID Touch Base" calls during

the pandemic to allow partners and community members to come together for support and collaboration as they all navigated the new normal COVID-19 had imposed. These weekly calls were implemented beginning on April 23 and have a loosely facilitated town hall format where participants are asked to share updates from their organizations, give voice to barriers that they're experiencing and request help from the network. Attendance at the meetings vary from one week to the next and housing coordinators from all three NH Managed Care Organizations have been invited. New Hampshire Healthy Families regularly participates in the calls, as does AmeriHealth Caritas. In the earliest weeks, participants primarily reported on the struggles they were experiencing, but as the pandemic has progressed and partners have begun reopening to in-person services, these meetings are now primarily used as a mechanism to share updates on services available.

NCHC has also continued work this quarter on the development and implementation of a central resource hub for members of the community seeking information and resources related to substance use disorders. The AskPETRA initiative was developed to strengthen and expand Substance Use Disorder/Opioid Use Disorder (SUD/OUD) prevention, education, treatment, and recovery programming, offering a helpline and a website for SUD/OUD and recovery resources in Northern NH. The free, non-clinical resource aims to connect residents of the North County to appropriate resources. This has required the help of partners as a large database of local resources and access processes was created to inform the website and the staff members taking calls on the hotline. AskPETRA covers the Continuum of Care: Prevention, Education, Treatment, Recovery, Assistance (PETRA) and is for everyone including providers, residents, families and more. The website (www.AskPETRA.org) provides 24/7 connection to professional trainings; treatment and recovery information; an expansive directory for local and statewide resources; prevention programming; and information for communities and schools.

The AskPETRA and WARM program also continued efforts during this reporting period to strengthen relationships between the region's recovery community organizations and clinical partners who were forced to refocus their day-to-day efforts on COVID-19 response.

During this quarter, Mount Washington Valley Supports Recovery (MWVSR) implemented two collaborating partner agreements with Saco River Medical Group and White Mountain Community Health Center for syringe service program referrals, allowing individuals with syringe related injuries or needing testing and/or prophylaxis medication for HIV to be referred by MWVSR to those local agencies. The center also worked with Tri-County Community Action Program (TCCAP) to help house homeless individuals seeking recovery services and resources. Affordable housing remains a huge issue in Carroll County, although an agreement with a local hotel was made for temporary housing during the pandemic.

As noted above, the Regional Care Coordination Network (RCCN) continued to play a role in connecting care coordination departments across the region, however multiple meetings were canceled due to limited availability of partner attendance during the pandemic. The Regional Care Advocate Supervisor continues to check in with the care coordinators around the region periodically to offer support and query for needs. The group is scheduled to meet next in August, when it is hoped that their practices will be better settled into the "normal" operations during the COVID-19 pandemic and can begin resuming some of their professional support and development activities.

6: Information about specific SUD-related health outcomes including opioid and other SUD-dependency rates, opioid and other SUD-related overdoses and death – and trend rates related to Hepatitis C and HIV acquisition.

IDN 1

Prior to the Covid19 pandemic there was slow, but steady increase in the numbers of clinicians waivered to prescribe MAT in the Region, with the most significant expansion in practices affiliated with Cheshire Medical Center and Dartmouth-Hitchcock in Lebanon. At Monadnock Community Hospital efforts were underway to integrate SUD care in primary care practices with behavioral health services based at the main facility in Peterborough. At the Multispecialty Clinic at Alice Peck Day Memorial Hospital in Lebanon all of the primary care clinicians became waivered and were prescribing MAT,

and a robust counseling program was developed on the APDMH campus in partnership with Headrest. Individuals from all of these practices, and others in the Region, were also participating in the MAT Community of Practice meetings, sponsored by BDAS and coordinated by JSI, and our Medical Director has served on the planning committee for these sessions.

As a result of the pandemic, and the accompanying lockdown, all SUD treatment in the Region transitioned to telehealth mode. In addition to the above-named providers, the two major buprenorphine providers, Groups, Inc. and Better Life Partners, also transitioned to telehealth for their prescribing and group sessions; they have continued to accept referrals from community agencies, medical practices, and individuals. HabitOpco, the methadone treatment provider, began providing some take-home prescriptions to stable long-term clients, but continues to see unstable and new clients on a daily basis in their office in West Lebanon. The Doorway in Lebanon continues to be active, mostly referring patients to the Addiction Treatment Center at the Rivermill Complex in Lebanon. At the same facility, the Moms in Recovery Program (including its IOP) has transitioned to limited hours and telehealth counseling with MAT prescriptions. Headrest, in Lebanon, now has an arrangement with the emergency departments at DHMC Lebanon and Alice Peck Day Memorial Hospital to accept 24/7 counseling referrals for individuals with SUD crises.

Since the last Quarterly Report the number of participants in MAT programs in the Region has remained essentially stable. Some individuals have dropped out for financial reasons, but they have been replaced by new ones who are challenged by increasing difficulty obtaining drugs of choice on the street. There are subjective reports of significant increases in overdoses, but hard data is scarce and of questionable value: due to the wide distribution of naloxone it is suspected that many overdoses are successfully treated without contacting police or emergency personnel (traditionally the best source of data). Telehealth has become even more robust since the last report, and it is expected that post-pandemic much SUD care will still be provided through this modality. Studies are now ongoing to determine the accessibility and retention effects of virtual MAT enrollment versus mandatory in-person initiation visits. Preliminary data seems to indicate there is no difference.

The Safe Syringe Program (SSP) which was operating out of Valley Regional Hospital has transitioned to a mobile model, greatly increasing the numbers of individuals reached who use intravenous drugs. These individuals are provided with information about MAT, counseling and other services at the time they access the SSP. There are no data on whether these services are accessed. Because of the nature of the SSP, no identifying information is collected.

IDN 2

Drug Overdose Deaths
Trends:

- As of 19 May there were 411 total confirmed drug overdose deaths for 2019. The 2019 numbers are finalized.
- In 2019, Strafford County had the highest suspected drug use resulting in overdose deaths per capita, at 4.38 deaths per 10,000 population.
- The age group with the largest number of drug overdose deaths is 30-39 years, which represents 32% of all overdose deaths for 2019.
- As of 19 May there are 79 confirmed drug overdose deaths and 78 cases pending toxicology for 2020. Merrimack
- County has 3.1 deaths per 10,000 population

Treatment Admissions
Trends:

- Opioid/opiate, Methamphetamine, & Cocaine/Crack treatment admissions decreased 2.5% from March to April.
- In April, residents from Hillsborough County were admitted at the highest per capita rate for opioid/opiate treatment, with 1.55 admissions per 10,000 population. Merrimack County was admitted at 0.8 admissions per 10,000
- More males than females were admitted to treatment programs in April for Opioid/Opiate, Methamphetamine, & Cocaine/Crack use

- Methamphetamine treatment admissions decreased 7% from March to April
- Cocaine/Crack treatment admissions decreased 35% from March to April
- Heroin/Fentanyl treatment admissions increased by 2% from March to April

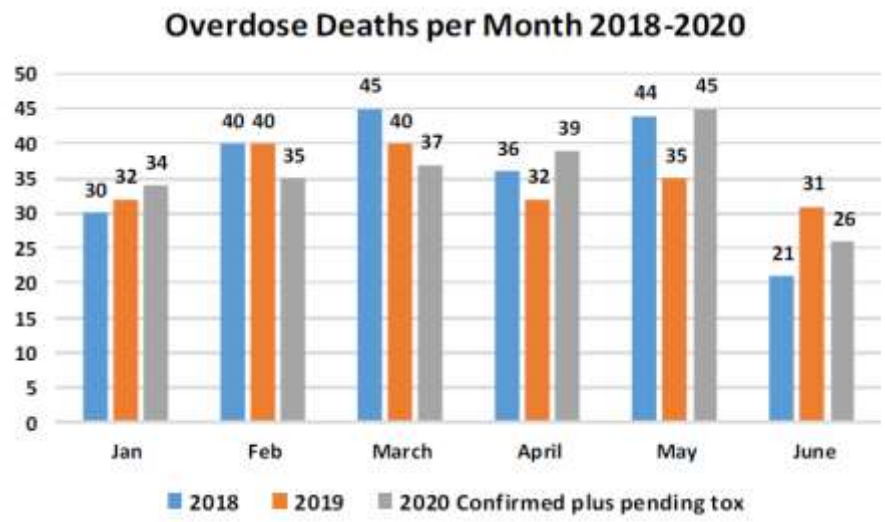
*** IMPORTANT DATA NOTES***
• County represents where the patient resides.
• These data represent treatment admissions to state funded facilities.
• These data have decreased due to numerous factors. The Affordable Care Act has been fully implemented, resulting in increased access to affordable health insurance and coverage for substance use disorder treatment in NH. New Hampshire expanded its Medicaid program, which also provided increased opportunities for substance use disorder treatment in the state. Substance use disorder treatment in the state has increased sharply in response to these policies which has shifted clients served by State of New Hampshire contracted treatment providers to other payment models and facilities.

Opioid Related ED Visits
Important Note the data being reported for 2020 has different collection criteria than previous months. Due to the new collection criteria, new data is no longer comparable to previous data.
Trends:
• Opioid related ED visits decreased by 40% from March to April.
• In April, residents from Strafford County had the most opioid related ED visits per capita with 1.41 visits per 10,000 population. Merrimack County was 0.7 visits per 10,000 population.
• In April, Sullivan County residents had the second highest number of opioid related ED visits per capita with 1.36 visits per 10,000 population.
• In April, the age group with the largest number of opioid related ED visits was 20-29-year-olds at 28%

*** IMPORTANT DATA NOTES***
- County represents where the opioid use patient resides
- These data represent any encounter with the term "heroin, opioid, opiate, or fentanyl" listed as chief complaint text
- These data also represent any encounter with an ICD-10 code that was designated for heroin and opioids • Currently all but one (1) of the hospitals are sending ICD-10 data
- These data include other opioid-related encounters such as poisonings, withdrawals, and detox.
- These data are now collected using criteria the CDC established for their Overdose Data to Action (OD2A) grant "making this report more transparent."

IDN 3
Some data compiled by the NH Drug Monitoring Initiative (DMI) managed by the NH Information & Analysis Center has not been updated since April 2020 due to COVID-19 response priorities. When possible IDN 3 reached out to various members of the community or state who compile SUD and HIV data. The following agencies were contacted directly for Q2 2020 data updates: Medical Examiner's Office, NH Information and Analysis Center (NH State Police), AMR, Doorways, , State Opiate Treatment Authority Designee Bureau of Drug and Alcohol Services Division for Behavioral Health, Bureau of Infectious Disease Control (DHHS Dept. of Public Health), Trauma and Emergency Medical Services Information System (TEMSIS)

Drug Deaths
NH, Office of the Medical Examiner
Overdose deaths in New Hampshire have increased since February when the pandemic was in the beginning stages with the most notable spike in April. The chart below from the Office of the Medical Examiner shows that overdose deaths in May of this year increased by 29% from the same month last year (includes cases pending toxicology). Drug deaths in June, including those pending have declined by 42% from the prior month and 16% from the same month last year. There have been 138 confirmed drug deaths from January 1 through July 17 2020 in NH with the highest rates coming from Manchester and Nashua. Most of the deaths have been from fentanyl.



Source: Office of the Medical Examiner as of 7/17/2020
Note: The number of confirmed drug deaths plus those that are pending toxicology in 2020.

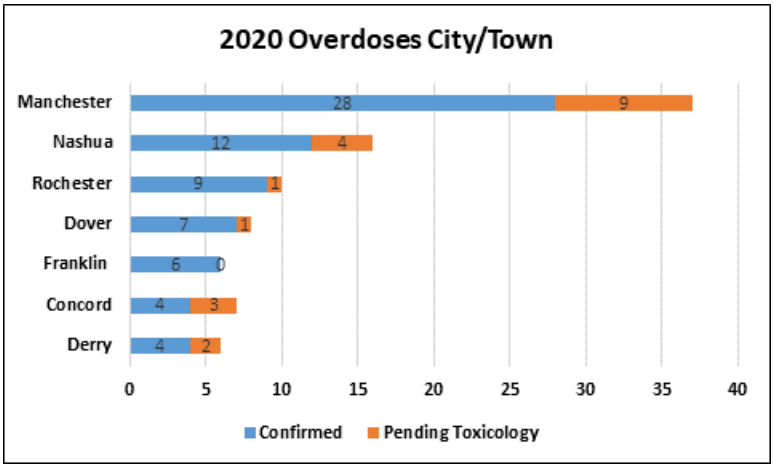
2020 Drug Death Data

1/1/2020—7/17/2020

Fentanyl (no other drugs)	55
Fentanyl and Other Drugs (excluding heroin)	63
Heroin (no other drugs)	0
Heroin and Other Drugs (excluding fentanyl)	0
Heroin and Fentanyl	3
Other Opiates/Opioids	16
Unknown Opioids	1
Total	**138**
Other drugs	23
Unknown drugs	0
Total Confirmed Drug Deaths	**161**
Pending Toxicology	**73**

Included in the data above are 21 cocaine related deaths and 20 methamphetamine related deaths. Sixteen (16) of the 21 cocaine related deaths and 15 of the 20 methamphetamine related deaths also included fentanyl.

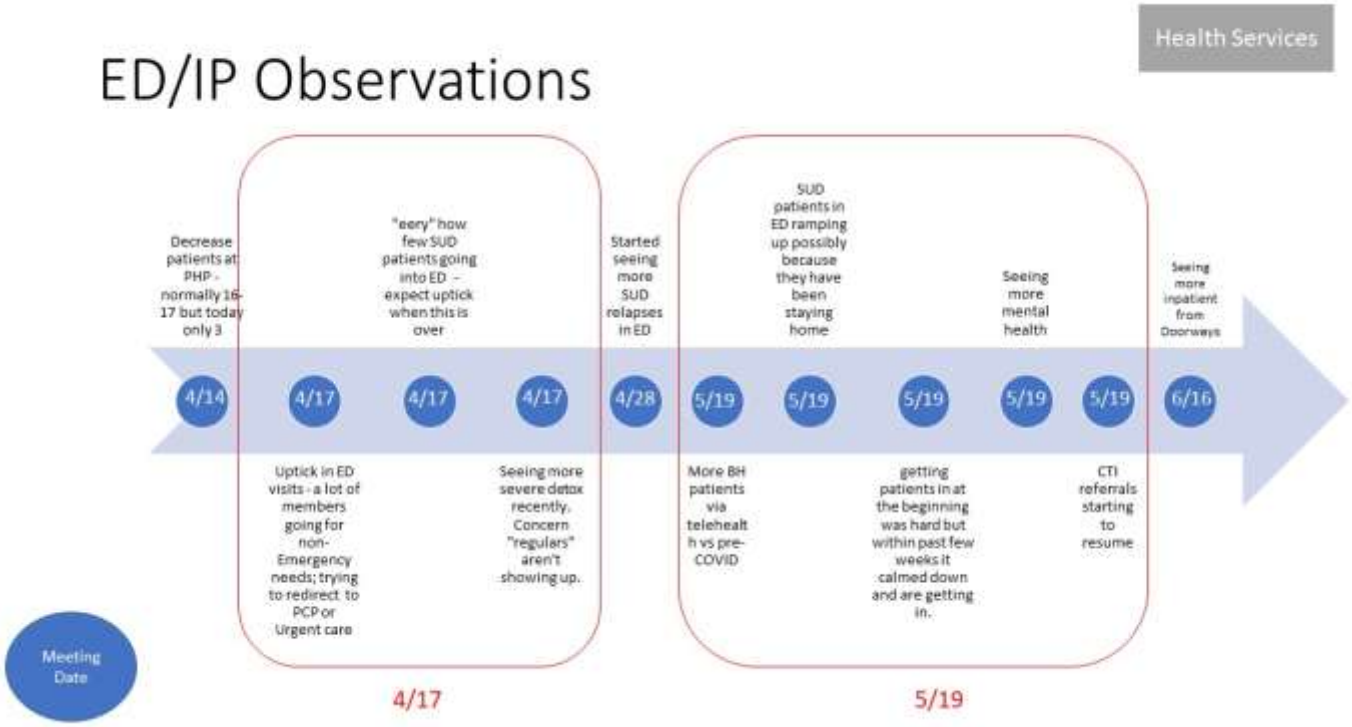
'Pending toxicology' means that the death may be due to drug intoxication based on circumstances, scene investigation and/or autopsy findings but the final determination also depends on the results of toxicology testing. It can take up to 2 to 3 months to finalize the death certificate following a suspected drug intoxication death. This delay reflects the time required for specimen processing, toxicology testing and reporting and interpretation of the report by the pathologist.



Source: Office of the Medical Examiner as of 7/17/2020

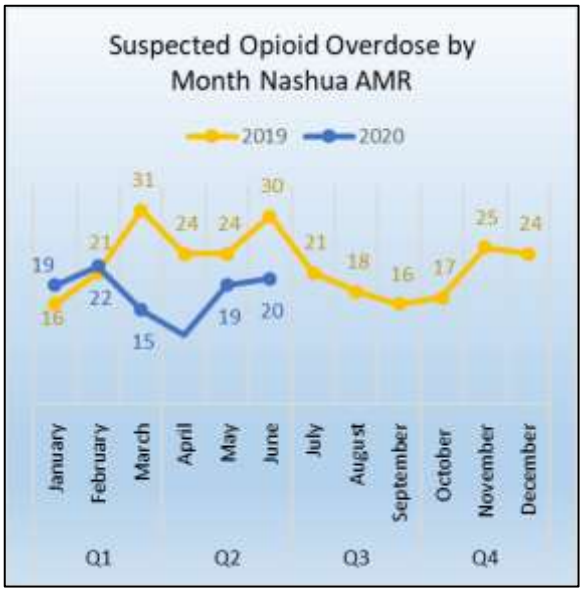
It has been suggested that the spike in April was expected due to people avoiding Emergency rooms early in the pandemic (Concord Monitor, "Overdose deaths up compared to 2019", https://www.concordmonitor.com/Overdose-Rates-Increase-

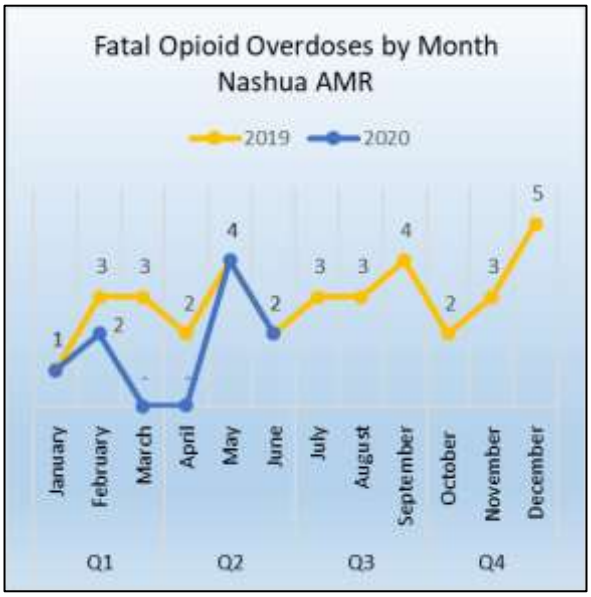
COVID-19-35202409). According to the NH Bureau of Drug & Alcohol, ED visits per 10,000 population in April declined in Hillsborough County from prior months. Additionally, the Regional Care Coordinator Calls that IDN 3 held twice a week in Q1 and Q2 2020 confirms the avoidance of ED rooms in the Greater Nashua area. Concern was expressed by multiple care coordinators in the IDN 3 region that SUD patients were not going into the ED. The figure below attempts to convert notes taken from the meeting into a timeline of observations related to health services issues during the pandemic, particularly ED observations and remarks made.



AMR Nashua

- AMR reported a decline in suspected opioid overdoses in Q2 over the same period last year; however, in May overdose fatalities were on the rise in Nashua
- May was the worst month in 2020 with an increase in suspected overdoses from prior month and 4 opioid overdose fatalities
- 103 overdoses in Nashua as of June 26 with 7 fatalities and 2 pending toxicology
- Public use of Narcan prior to EMS arrival is on the rise in Nashua with May being particularly active in public Narcan use





Source: American Medical Response (AMR), AMR Nashua Suspected Opioid Overdose and SS Report 07022020.pdf
Note: 2020 results as of July 2, 2020

	2015	2016	2017	2018	2019	2020	All Years
Total Overdoses	256	361	302	314	266	106	1605
Fatalities	26	44	45	35	35	9	194
Pending	0	0	0	0	3	2	5
Fatality (%)	10	12	15	11	14	10	12

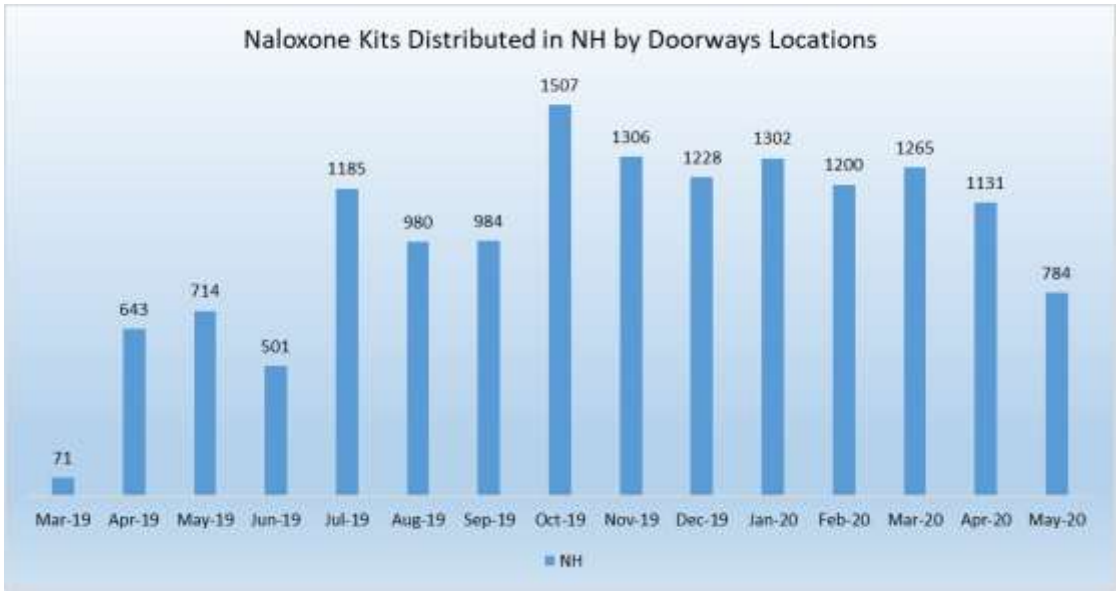
Source: American Medical Response (AMR), as of 7/2

Narcan administration

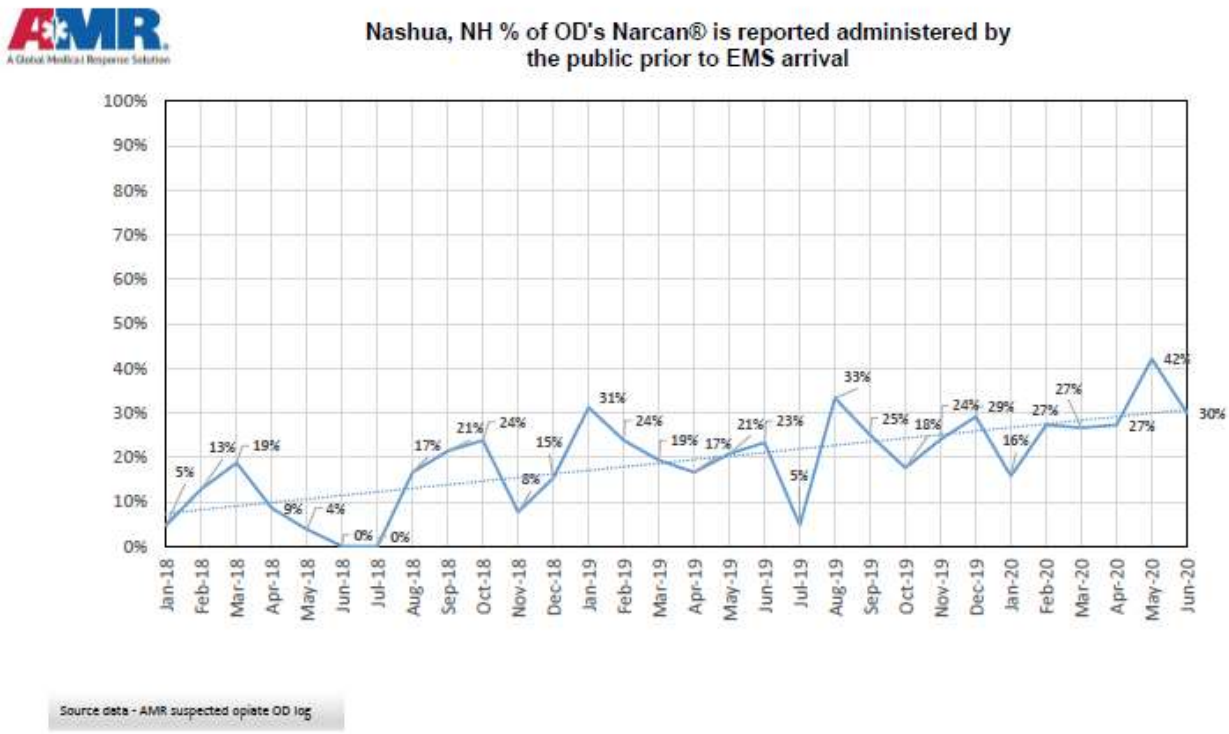
- As of July 2, 329 mg of Narcan have been administered by Nashua AMR, which is currently running lower per month on average than the prior year (54.8 mg per month vs 72.3 mg per month in 2019). Evidence suggests that public Narcan use is on the rise (see AMR line chart below).
- New Hampshire Doorways locations show a decrease in Narcan kits distributed to their served population in the first two months of Q2 vs Q1 (Doorways of Greater Nashua opened in May under new management)
- Public use of Narcan prior to EMS arrival is on the rise with a spike in the percent of overdoses in May 2020.

	2015	2016	2017	2018	2019	2020	All Years
Narcan (mg)	720	997	766	841	868	329	4521
***Narcan (mg) per Month**	60.0	83.1	63.8	70.1	72.3	54.8	

Source: NH Bureau of Emergency Medical Services (EMS) as of July 2 2020
* Narcan (mg) per Month = Narcan (mg) 2015 through 2019 divided by 12 months; 2020 divided by 6 months



Source: DHHS, State Opioid Response Grant, https://www.dhhs.nh.gov/dcbcs/bdas/sor.htm as of 5/31/2020

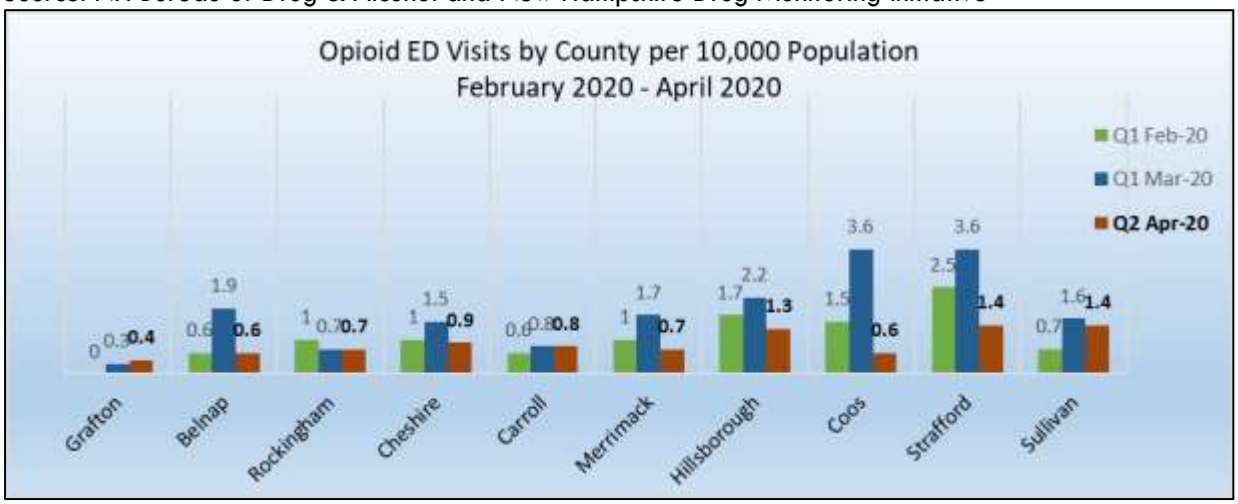


Opioid-related ED visits and treatment admissions

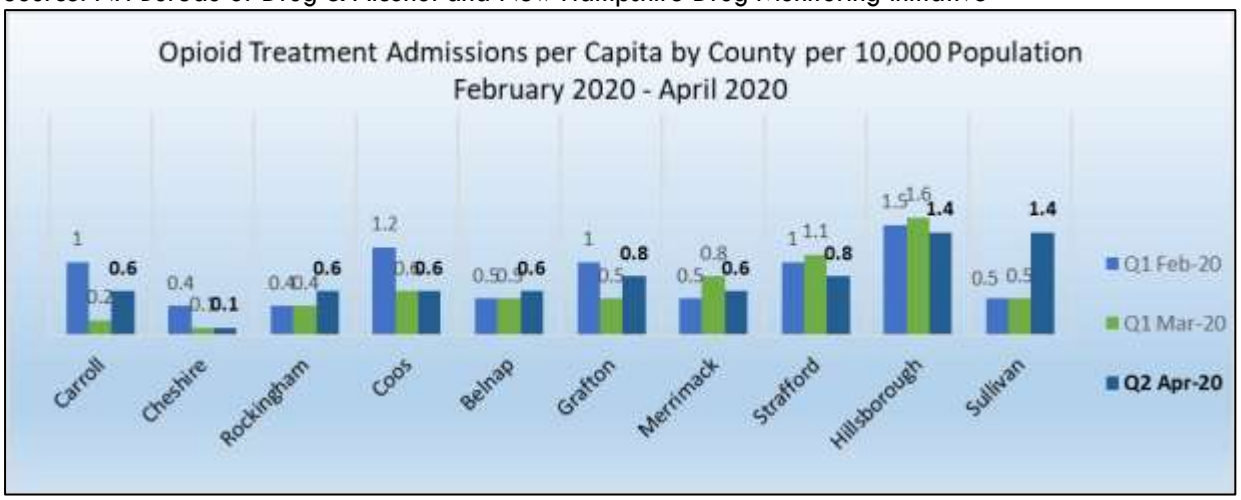
Based on the latest available data from the NH Bureau of Drug and Alcohol Services, *opioid-related ED visits* in Hillsborough County continue the decline in 2020 with 1.3 ED visits per 10,000 population in the first month of Q2 2020, down from 2.2 in the prior month.

In the first month of Q2 2020, opioid treatment admissions declined slightly in Hillsborough county from 1.6 to 1.4 per 10,000 population. Hillsborough county tied with Sullivan county in April with the most treatment admissions per capita.

Source: NH Bureau of Drug & Alcohol and New Hampshire Drug Monitoring Initiative



Source: NH Bureau of Drug & Alcohol and New Hampshire Drug Monitoring Initiative



Source: NH Bureau of Drug & Alcohol and New Hampshire Drug Monitoring Initiative

Safe Stations

As of June 30 2020, Safe Stations will no longer be operating in the Greater Nashua area. During operational hours people seeking help from the Fire Stations will be directed to Doorways of Greater Nashua and to call 2-1-1 during off hours. Anyone needing immediate medical care will continue to be treated and transported to a hospital.

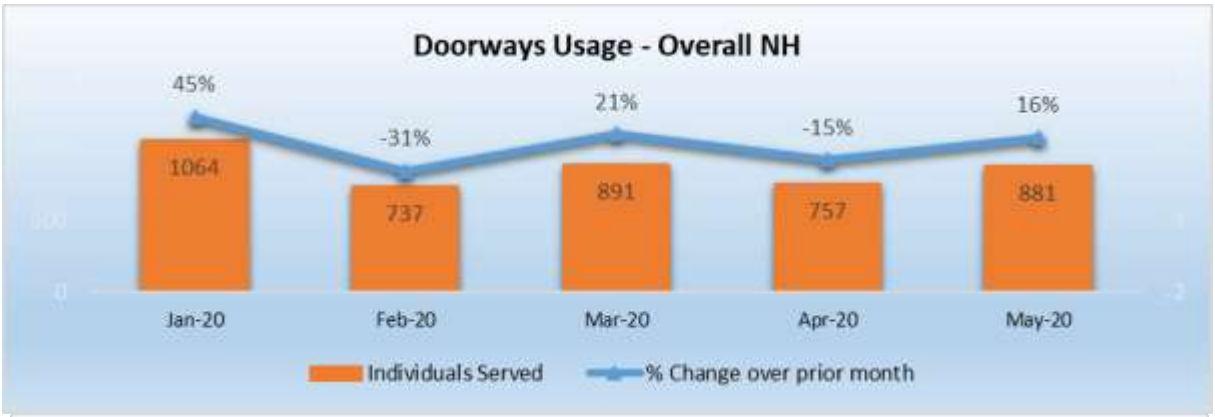
Nashua Safe Stations

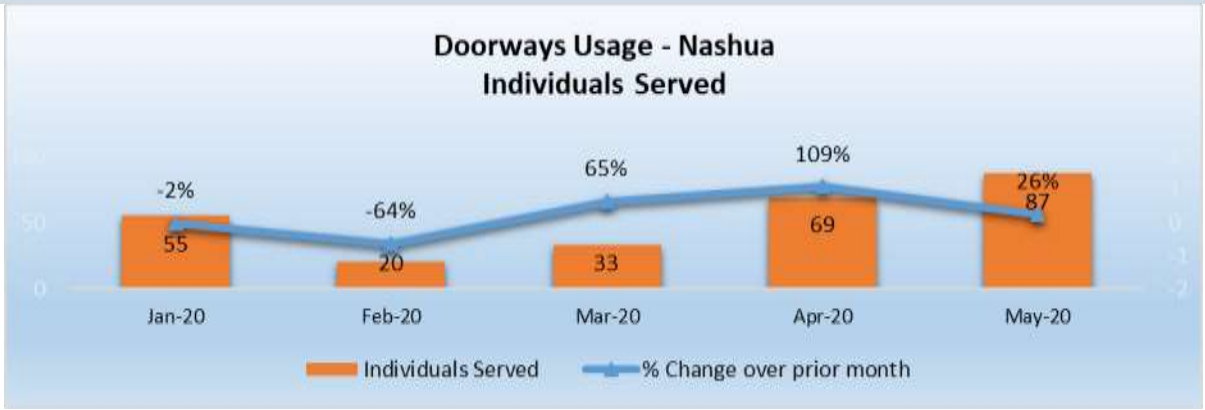
	2016	2017	2018	2019	Q1 2020	Q2 2020	Total since Nov 2016
Number of walk-in requests for Nashua Safe Station	51	1301	1209	788	192	165	3706
Average Safe Station contacts per day	1.21	3.56	3.31	2.2	2.1	1.8	2.8
Number of participants taken to Substance Misuse Treatment Facilities	45	1153	1065	608	154	148	3173
Number of participants transported to hospital Emergency Department	5	130	138	175	37	17	502

SJH	0	65	60	93	16	6	240
SNHMC	5	65	78	82	21	11	262
Percentage of participants transported to hospital ED	10%	10%	11%	22%	19%	10%	14%
Average number of minutes AMR/fire companies "Not Available"	14.3	11.1	9.1	9.1	9.3	8.1	10.6
Number of UNIQUE participants	45	814	754	617	146	119	1989
Number of REPEAT participants	15	673	709	481	122	44	2043
Gender Breakdown:							
Male	31	905	868	602	153	135	2694
Female	20	396	340	186	39	30	1011

Source: American Medical Response (AMR) Q2 2020 results as of 7/2/2020

Doorways of Greater Nashua opened on May 11 under SNHMC management. According to the published Doorways data online, there were 87 individuals served in May which is an increase of 26% from the prior month. According to the June monthly report provided by Doorways of Greater Nashua there were 76 client calls and 57 clients seen during the month of June.





Source: https://www.dhhs.nh.gov/dcbcs/bdas/sor.htm

Doorways June Report

Count of **ALL** new CLIENT referral calls during the month. Includes client direct calls, and 211 calls. A client is an individual who is eligible to receive or is receiving services from the program.	Total
A. Opioid related	48
B. Alcohol related	18
C. Other Substance related	2
D. Other Social service related	8
E. Total amount of time spent on the phone with clients during the month. Add each calls time together and report as total **minutes** for all calls.	37696.2
Count of new FRIEND/FAMILY or OTHER party referral calls received during the month, by age group breakout. If age is not provided count them as Age 18 and over. (**Other party includes Primary Care Physicians.**)	Total
A. Opioid related	5
B. Alcohol related	7
C. Other Substance related	0
D. Other Social service related	2
E. Total amount of time spent on the phone with a friend or family member during the month. Add each call's time together and report as total **minutes** for all calls.	350
Count of new clients seen during the month by access type: A client is an individual who is eligible to receive or is receiving services from the program.	Total
A. Who scheduled their appointment by phone? **(Includes client direct calls, and 211 calls.)**	15
B. Who were walk-ins to the Hub?	5
D. Referred by Safe Station	0
E. Referred by First Responder (Exclude NH Project FIRST, count them in I. below)	0
F. Referred by Medical Professional (other than first responder, i.e. primary care)	3
G. Referred by social service agency or clergy: GNMHC, DCYF, Mobile Crisis, Other Doorway	6
H. Referred, other specify: Respite, Sober Housing, Treatment Programs, Revive	28
I. Referred by NH Project First	0
Total	57
J. Total amount of time spent **in minutes,** with clients during the month. Add each time together and report as total **of minutes** for all visits.	0
Count of new clients seen during the month by **primary** reason type: (The total number of clients seen in question 4 should match the total number of clients seen by access type, question 3.) A client is an individual who is eligible to receive or is receiving services from the program.	Total
A. Opioid Related	42
B. Alcohol Related	13
C. Marijuana Related	0
D. Methamphetamine Related	1
E. Cocaine Related	1
F. Other Substance related	0
G. Other Social service related	0
Total	57
Count of all clinical evaluations **(ASAM evaluation)** completed by method:	Total
A. In person	49
B. Video	0
C. Phone	8
D. Other	0
Total	57

Count of new clients served by **primary** diagnosis type, diagnosis based on the results of the clinical evaluation. (The total number of clients served by diagnosis type, should equal the total number of clinical evaluations completed in question 5 above.): A client is an individual who is eligible to receive or is receiving services from the program.		Total
A.	Opioid Use Disorder	42
B.	Alcohol Use Disorder	13
C.	Marijuana	0
D.	Methamphetamine	1
E.	Cocaine	1
F.	Other Substance related	0
For clients waiting for a treatment slot during the reporting period, provide the **TOTAL number of days** all clients have been waiting. A client is an individual who is eligible to receive or is receiving services from the program. Calculate the TOTAL number of days by totaling the total number of days all clients have been waiting. For example, if you have 3 clients, one waiting 2 days, one waiting 7 days and one waiting 3 days the total number of days waiting would be 12.		Total
A.	Outpatient-ASAM Level 1.0: Outpatient	0
B.	Outpatient-ASAM Level 2.1: Intensive Outpatient	21
C.	Outpatient-ASAM Level 2.5: Partial Hospitalization	0
D.	Outpatient-Withdrawal Management	0
E.	Residential-ASAM Level 3.1: Low Intensity	16
F.	Residential-ASAM Level 3.5: High Intensity (Adult)	47
G.	Residential-ASAM Level 3.5: Medium Intensity (Adolescent)	0
H.	Residential-Withdrawal Management	125
I.	Peer Recovery Support	0
J.	Medication Assisted Treatment	37

Source: Doorways of Greater Nashua, Excerpts from Monthly Report_June.xslx

HIV and HCV trends

HIV and HCV data has not been updated. The Community Health Department's activities were primarily focused on COVID-19 response as routine operations were suspended since mid-March.

IDN 3 partner monthly demographics and diagnosis info for Medicaid beneficiaries served

While determining the factors needed to reduce SUD deaths is a challenge, IDN 3 partners began providing monthly reports outlining demographics and diagnoses for Medicaid beneficiaries served by their organization. As the outcome measure targets increase every reporting period, compiling and sharing this level of information back with our partners may assist in increasing awareness and knowledge about the populations being served and allow for dialogue to occur to identify strategies that may support achievement of those outcome measure targets, including:

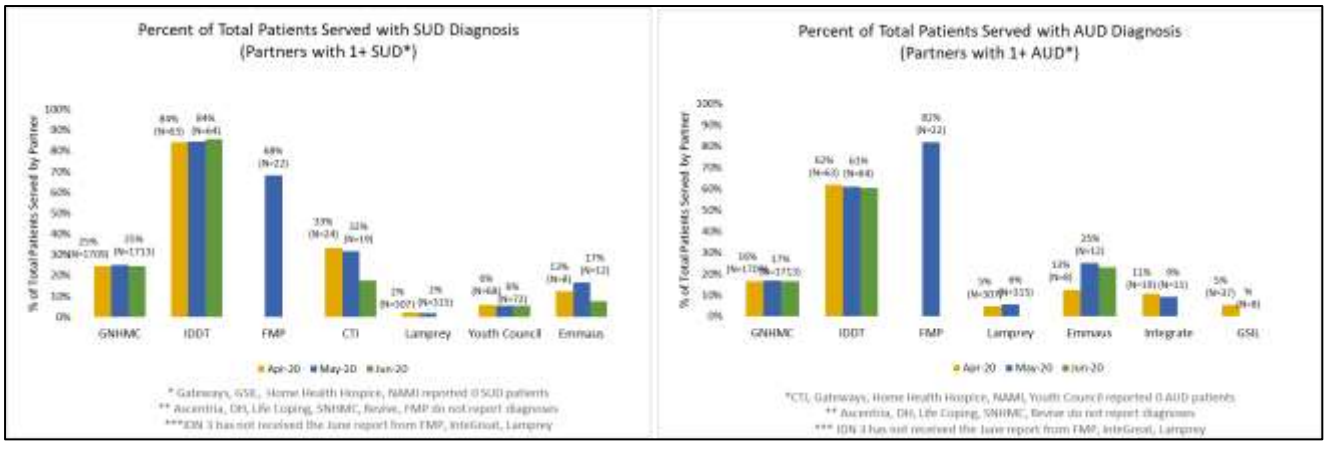
- **Assess.Screen.02:** appropriate follow-up plan in place for positive screenings of substance use disorder by IDN primary care and BH providers, ages 12+;
- **Care.04:** initiation of alcohol and other drug dependence treatment, ages 13+; new episode; treatment within 14 days of initial treatment visit;
- **Care.05:** engagement of alcohol and other drug (AOD) dependence treatment, ages 13+; two or more additional treatment services with 34 days of initial treatment visit;

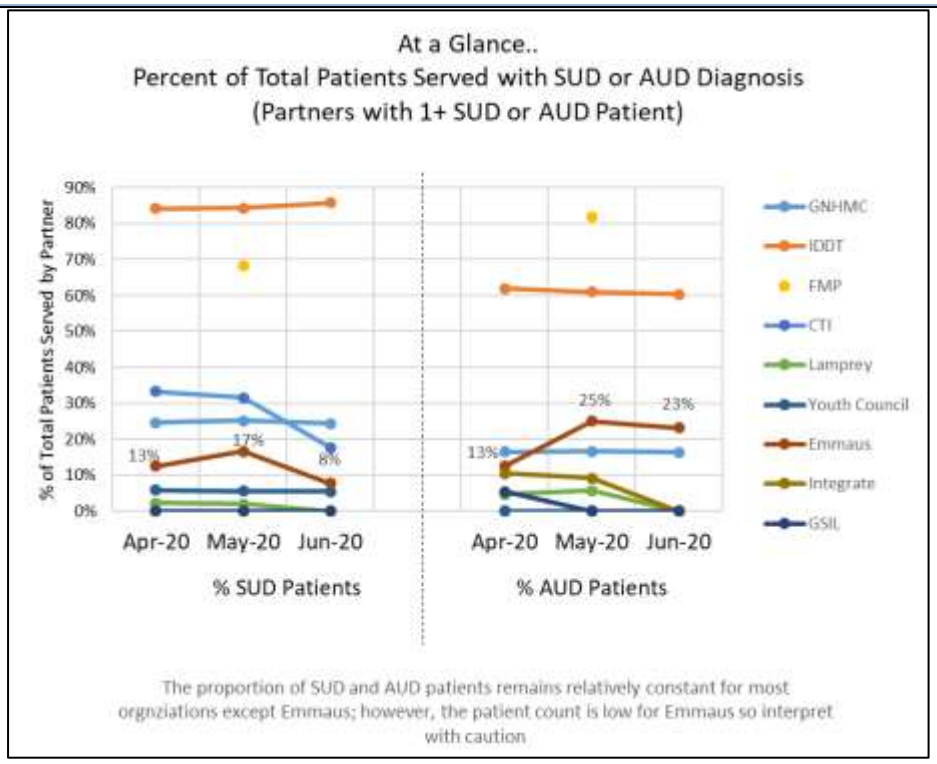
- **Hosp_ED.04:** follow-up after ED visit for alcohol and other drug dependence within 30 days, ages 13+; and
- **OpioidRx.02:** risk of continued opioid use with at least 15 days of prescription opioids in a 30-day period.

The following charts provide an overview of what IDN partners who submitted diagnosis information for Medicaid beneficiaries they served in Q2 2020 focusing specifically on substance use disorder (SUD) and Alcohol Use Disorder (AUD). For the months of April, May, June, Greater Nashua Mental Health (GNMHC) reported serving the highest number of patients with SUD and AUD. GNMH provided separate monthly reports for unduplicated patients receiving services through their organization, which includes IDDT and CTI for which GNMHC is the umbrella organization implementing these programs

	# SUD Patients			# AUD Patients		
	Apr-20	May-20	Jun-20	Apr-20	May-20	Jun-20
GNHMC	420	430	431	281	285	290
IDDT	53	54	54	39	39	38
Revive	0	48	0	0	0	0
FMP	0	15	0	0	18	0
CTI	8	6	3	0	0	0
Lamprey	7	6	0	14	18	0
Youth Council	4	4	4	0	0	0
Emmaus	1	2	1	1	3	3
Home Health Hospice	0	0	0	0	0	0
Integrate	0	0	0	2	1	0
GSIL	0	0	0	2	0	0

Note: Foundation Medical Partners, InteGreat, Lamprey did not submit monthly reports in June. Dartmouth-Hitchcock, Revive, SNHMC, Life Coping, Ascentria have not provided monthly diagnoses data.





IDN 4

The N4H Community Outreach Coordinator, in conjunction with work by N4H partner Makin' It Happen (MIH), has pivoted to increase community outreach and surveillance of emerging issues specific to changes in the community related to the pandemic. Available data sets through DHHS and American Medical Response (AMR) have been used to survey conditions around SUD, children and families, and overdose death rates. The Community Outreach Coordinator has joined outreach teams in the Manchester encampments weekly, specifically to support our involvement with Veteran Homelessness.

Observations driving the work:

Decreased: Calls to Division for Children, Youth & Families (DCYS)

Decreased: New mental health patients

Decreased: Safe Station visits

Decreased: Doorway Visits

Increased: Overdose and Overdose Death calls (Change from last report)

Increased: Help line calls including suicide prevention hotlines (Change from last report)

Increased: Domestic Violence (DV) calls (Change from last report)

Increased: Alcohol sales, gun sales, ammunition sales

Increased: Homelessness

Increased: Death Care unrelated to covid-19, related to social distancing

Increased: Reoccurrence of SUD

Increased: Unemployment

Increased: Disease advancement and acuity increase in the elderly

There is considerable concern over the sharp increase in guns and alcohol being brought into homes, children home from school, and parents often times still leaving the home for work. The decrease in calls to DCYS, primarily from schools and healthcare providers, may indicate that people needing help don't have a safe place to reach out. Calls to NH DCYS have decreased 50% since March 15th, 2020. There were social marketing efforts around the availability of services in the region. Following these efforts, we experienced a return to near normal rate of calls. Following school vacation week and now with no school during the summer, calls have returned to lower than pre-pandemic levels. Having text options for Hotlines increases engagement in Hotline use; many hotlines do not have texting options or live chat, including the State 2-1-1 number.

Increased homelessness has been met with a second and potentially a third low barrier homeless shelter being opened in Manchester. Although opiate overdoses are lower in shelters, they are still happening. There has been a sharp increase in alcohol intoxication at the shelters. Encampments in the Manchester area have increased significantly. Support of onsite hand washing, porta-potties and meal distribution for these encampments was discontinued on 6/26/2020.

In the early stages of the pandemic response we were experiencing record low level numbers of overdose and overdose deaths from opioids in the region. This was based on the safe station data from AMR that counts ambulance responses. We attributed these low numbers to Narcan distribution, interruptions in illicit drug supply, and reduced use due to preservation of supply and alternate substances to opioids being used.

The State Medical Examiner's Office released its "NH Drug Death" report on 6/22/2020. This report showed that drug deaths in NH (when annualized) are running higher than 2019, and in Manchester, drug deaths are over 60% higher than was indicated in the AMR data. Further discussion with the medical examiner's office shed light on the differences in methodology between their statistics and the AMR statistics around methodology. It will be important that in the future these two data sets are reconciled, and entities using this data understand these differences.

Further work by N4H and MIH with community partners indicated changes in the support system for those seeking treatment and respite for SUD. The Farnum Center reported a waitlist of over 50 people at the end of June. A dramatic shift in their payor mix to primarily Medicaid beneficiaries from commercially insured patients has caused financial strain for the organization. In addition, staffing has become increasingly difficult due to both the nature of the work, staff concerns over the pandemic, and their safety in the workplace. N4H is connecting Farnum Leadership to its workforce development resources.

During the pandemic, the Manchester Doorway was in a state of transition from Granite Pathways to CMC. CMC reported unusually low volumes during this period. Another change was the elimination of the Narcan outreach and training position, with a change in Narcan distribution to a mail order pharmacy system. The Doorway is still working out the details of this new distribution system. The state Doorway data has shown a decreased amount of Narcan being distributed during this period, and the state Doorway Director indicated in the Governor's Commission Meeting on 6/26/2020 that the decrease was attributable to the change in vendor.

IDN 5

There are no statewide statistics from the New Hampshire Bureau of Alcohol and Drug Services (BDAS) Drug Monitoring Initiative since April 2020, but those are reported here. Belknap County saw 1.62 EMS Narcan Administration per 10,000 population for the month of April which is the 2nd highest in the state right behind Strafford County. This marks a steady increase since February 2020 where the rate was almost half the current rate (.97). Emergency Department Opioid Use Visits per 10,000 has fluctuated between .65 and 1.94 this year in Belknap County. This is interesting because most counties in NH experienced a spike during March 2020. Opioid/Opiate Treatment Admissions per 10,000 pop has held steady for Belknap this county around .5 for February-April of this year.

IDN 6

No update available.

IDN 7

Datasets are now available through April for the New Hampshire Drug Monitoring Initiative, allowing Region 7 IDN to analyze the data points in conjunction with what our partners have been communicating. Rather than display the data in quarters, which would camouflage the effect of COVID-19 on population health, we have decided to focus on the first two months of 2020 (designated Pre-COVID-19) vs March and April 2020 (designated COVID-19).

While Narcan administrations per 10,000 population are down slightly (.67 in COVID-19 vs .75 Pre-COVID-19) and Emergency Department (ED) visits related to opioids actually experienced an increase (1.11 in COVID-19 vs only .86 in Pre-COVID-19), treatment admissions per 10,000 have decreased moderately (.55 in COVID-19 vs .87 Pre-COVID-19). Taken together, the 29% increase in ED utilization and the 36% decrease in treatment admissions may show the start of a new treatment environment in which it has become more difficult to achieve admission to a treatment program, resulting in patients needing critical care at emergency departments. Some caution should be taken before taking too much from these data points. The fact that treatment admission numbers have been nearly as low as this on a two-month basis as recently as August and September of last year (.59 per 10,000) may indicate that this fluctuation is not as dramatic as it appears More concerning are the ED numbers, especially when taken in the context of the healthcare industry as a whole. While the numbers for this period are well below our regional high (2.91 per 10,000 in April of 2019), the fact that our region actually experienced an increase in opioid emergency department visits in a time frame in which our hospital partners reported to us a decrease in the utilization of emergency room services, is cause for concern. It could well be that people suffering from opioid addiction are needing care but choosing not to seek it as a result of caution related to the pandemic., as has been reported for the general population throughout the healthcare system.

Overall, the first four months of DMI data for 2020 present only a very brief glimpse into the distorting effect of the pandemic on care. It will be instructive to view further months to see if these points represent a permanent shift or merely a time-limited aberration to the way care for substance use disorder is sought and delivered within the region.

III. Attribution Counts for Quarter and Year to Date

DSRIP CY 2020 Q2 - Quarterly Enrollment Changes

Source: MMIS enrollment data as of 7/29/2020

IDN	IDN Attributed Population[1]	Newly Enrolled in Current Quarter[2]	Disenrolled in Current Quarter	Current Enrollees: Year to Date[3]
1	28,207	1,553	410	29,350
2	17,863	1,117	219	18,761
3	25,303	1,501	398	26,406
4	47,122	2,931	773	49,280
5	16,680	1,096	204	17,572
6	32,887	1,932	469	34,350
7	18,136	1,019	201	18,954
Total	**186,198**	**11,149**	**2,674**	**194,673**

Notes:
1. Attributed population includes 171,908 members from the 12/31/2019 Outcome Attribution
who were attributed through claims and geography and were Medicaid Eligible
on 4/1/2020, and 14,290 members newly enrolled on 4/1/2020 who were attributed through geography only.

2. Newly Enrolled population includes members who were attributed on 12/31/2019, but were not eligible as of 4/1/2020, and became eligible later in the quarter.
3. Current population are members who were Medicaid Eligible on 6/30/2020.
4. Decreased disenrollment and increased current enrollment due to FFCRA protections during COVID-19.

IV. Outreach/Innovation Activities to Assure Access

Summarize marketing, outreach, or advocacy activities to potential eligible and/or promising practices for the current quarter to assure access for demonstration participants or potential eligibles.

IDN 1

The IDN1 administrative team is leading and supporting numerous efforts underway to engage with not only partner organizations but the greater community support landscape that has evolved and developed in response to COVID-19. The IDN1 administrative team in the Apr-Jun term attended numerous regional and statewide meetings convened around issues such as community support, homelessness, access to testing, contact tracing etc. as pertaining to COVID19 response in the IDN1 communities. Many of these series continue and the IDN1 administrative team maintains involvement and disseminates information on the IDN1 website and to the broader network list-serve.

IDN 2

Riverbend launched an initiative on social media and as an electronic newsletter that focused on the following: "Be Kind to Your Mind," "You Are Not Alone – We Are Here to Help," and "Need to Talk?" This was to let current and potential clients know that online and telehealth services were still available despite the shut-down of in-person services as well as to provide strategies for individuals with (increased) anxiety and depression as a result of the pandemic.

IDN 3

Community Engagement Governance Committee community outreach/education

The Community Engagement Committee continued their monthly meeting cadence with the Committee Chair back from extended personal leave. During Q2 the committee focused on a better understand the community needs due to the challenges of COVID-19. The committee worked on a survey targeting getting feedback around social isolation especially for the elderly, identifying the unmet needs in the community and finally outreach to individuals with cards, notes, letters to provide support.

The committee also suggested translating the current information flyer into Spanish with content to inform of available services. The committee chair will provide a draft for committee review at next meeting.

Full IDN monthly meetings

The April full IDN meeting was held via webinar with the focus on Event Notification implementation and operationalization overview including review of the IDN3 1 page information guidelines, cohorts and monthly reporting available via Collective Medical and providing *GSIL* the opportunity to spotlight their use and operationalization of the ENS platform. The meeting also provided the IDN Admin team the forum to share the updates on funding, NH DSRIP relief waiver application for COVID-19 as well as reminders for training opportunities, 2020 annual compliance documents and MDCT opportunities.

Due to the holiday and along with other competing priorities, the May Full IDN meeting was cancelled.

The June Full IDN meeting was also held via webinar and *NAMI NH* presented NAMI NH presented their Family Peer Support Program to the audience. Additionally, the IDN Admin team reviewed the Outcome Measure results received by DHHS to date: review of measure details, Met/Not Met Results & associated funding with an additional goal to review provider and patient behaviors encouraged by the DSRIP Performance Outcome Measures.

IDN 4

• Community Outreach Meetings	• Usual Frequency	• Met During Reporting Period	• N4H Staff Attended
• Association of State and Territorial Health Officials (ASTHO) Community Health Worker Learning Community	• Monthly	• Yes	• Yes
• Culturally Effective Organizations (CEOrgs) Work Group	• Monthly	• Yes	• Yes
• Dartmouth Hitchcock Substance Use and Mental Health Initiative (SUMHI) Opioid Substance Use Disorder Action	• As Needed	• Yes	• Yes
• Derry Mental Health Alliance	• Monthly	• Yes	• Yes
• Governor's Commission on Alcohol and Other Drugs	• Bi Monthly	• Yes	• Yes
• Governor's Healthcare Task Force	• Monthly	• Yes	• Yes
• Greater Manchester Youth SUD Task Force	• Monthly	• Yes	• Yes
• Hillsborough County Coalition on Mental Health and Justice	• Quarterly	• Yes	• Yes
• Hillsborough County Delegation	• As Needed	• Yes	• Yes
• Hillsborough County Delegation Executive Committee	• As Needed	• Yes	• Yes
• Manchester ACERT (Adverse Childhood Experiences Response Team	• As Needed	• Yes	• Yes
• Manchester Community Care Team	• Monthly	• Yes	• Yes
• Manchester Emergency Operations Center for SUD and Homelessness	• Monthly	• Yes	• Yes
• Manchester Perinatal Substance Use Disorder Alliance	• Monthly	• Yes	• Yes
• Manchester Police Department Community Advisory Board	• Monthly	• Yes	• Yes
• Manchester Safe Station Committee	• Monthly	• Yes	• Yes
• Manchester Weed & Seed Committee	• Monthly	• Yes	• Yes
• Manchester Veterans Homelessness Task Force	• Monthly	• Yes	• Yes

• Manchester Youth Collaborative	• Monthly	• Yes	• Yes
• NH Children's Behavioral Health Network	• Every Other Month	• Yes	• Yes
• NH Commission on Environmental Risks	• Quarterly	• Yes	• Yes
• NH DHHS Diabetes/Coronary Heart Disease Grant Meeting	• Monthly	• Yes	• Yes
• NH Higher Education RoundTable	• Quarterly	• Yes	• Yes
• NH Legislative Commission on Primary Care Workforce	• Monthly	• Yes	• Yes
• NH Providers Association Board of Directors	• Monthly	• Yes	• Yes
• NH Recovery Task Force of Governor's Commission on Drugs and Alcohol	• Monthly	• Yes	• Yes
• N4H COVID Supportive Services Huddle	• Weekly	• Yes	• Yes
• Prevention Community of Practice	• Monthly	• Yes	• Yes
• Revive Recovery Meetings	• As Needed	• Yes	• Yes
• Rockingham County Commissioners	• As Needed	• Yes	• Yes
• Rockingham County Corrections WRAP	• Every Other Month	• No	• No
• South Central Leadership Team	• Monthly	• Yes	• Yes
• Southern NH Planning Commission Story Mapping Project	• As Needed	• Yes	• Yes
• Southern Rockingham Coalition for Healthy Youth	• Monthly	• Yes	• Yes
• Stand Up Salem	• Monthly	• Yes	• Yes
• Statewide Substance Use Disorder Brain Injury Task Force	• Monthly	• Yes	• Yes
• Statewide Substance Use Disorder Community of Practice	• Monthly	• Yes	• Yes
• Statewide Medication Assisted Treatment Community of Practice	• Monthly	• Yes	• Yes
• Substance Use Disorder Continuum of Care	• Monthly	• Yes	• Yes

IDN 5

Marketing activities were minimal at best. Outreach however continued to occur with all network partners to ensure their needs were being met during COVID. The DHHS team held weekly meetings with IDNs to ensure they could assist us should needs arise with our partners. IDNs 1, 5 and 7 worked together to develop an updated Q1 2020 Grafton County Impact Report which was shared with Grafton County Administrator and Commissioners for a meeting they had in June. The result was a favorable vote to continue to fund the DSRIP waiver.

A promising practice of course that has been noticed by nearly all partners and patients/clients during this quarter has been the introduction of telehealth to provide care. This practice has made great strides at the state and national level as well and we anticipate potential legislation being passed to allow for billing of telehealth appointments to be the same as an in-person appointment as early as this summer.

The Plymouth IOP which opened in February had plans to release its new marketing/branding campaign for their IOP – the program is called "RISE" and this too was slowed due to COVID response at partner agencies and the doors to the newly opened IOP actually closed and switched to remote peer counseling services. The program anticipates a slow re-opening by late summer based on NH guidelines for COVID.

IDN 6

As previously noted, the COVID Emergency Fund resulted in the establishment of 20 new formal IDN partnerships, all agencies serving the most vulnerable populations in our region, creating new opportunities for cross-sector collaboration and coordination.

We are working closely with Exeter Hospital and the other three hospitals in our region on preparations for the potential opening of an Alternative Care Site at UNH/Durham. The Hospitals requested IDN assistance in recruiting, training and support of Community Case Management volunteers/staff in the event that the Site goes live.

We participate in and contribute to weekly calls among Rockingham County agencies that is hosted by Exeter Hospital.

IDN 7

This quarter, the Region 7 IDN team made sure to continue leveraging Basecamp to share training opportunities and COVID-related resources with partners and prepared to rejuvenate the use of Facebook. Once the pandemic reached northern NH and healthcare priorities pivoted to respond, the Region 7 IDN team also pivoted in focus from usual partner and community engagement to COVID-related supports. As noted earlier in this report, this included the initiation of weekly Region 7 IDN COVID Touch Base calls to provide space for early needs to be identified and addressed by the network and/or be communicated to resources at the state level. The IDN7 team also conducted direct one-on-one partner calls in April to identify what support was needed during the pandemic and The NCHC Community Health Workers conducted outreach to providers, community-based organizations, and community members sharing fliers and information regarding the AskPETRA website and helpline. They reached out individually to each organization to drop off copies for partners to distribute, coordinated the inclusion of fliers in meals-on-wheels packets and bags distributed through the food pantry, and otherwise used a grass roots level approach to get information about both SUD resources and general resources in the context of COVID out to people in need across the region.

The Carroll County Coalition for Public Health has worked throughout the pandemic to facilitate a similar sharing of resources throughout Carroll County, including distribution of paper resource guides through school lunch bus routes and assisting Building Resilience Mount Washington Valley in several Facebook Live events aimed at addressing real-time concerns of Carroll County residents.

Additionally, the NCHC Public Health Emergency Preparedness Coordinator connected staff from the Tri-County Community Action Program (TCCAP) to statewide stakeholder meetings related to the COVID testing of homeless individuals.

V. Operational/Policy/Systems/Fiscal Developments/Issues

A status update that identifies all other significant program developments/issues/problems that have occurred in the current quarter or are anticipated to occur in the near future that affect health care delivery, including but not limited to program development, quality of care, approval and contracting with new plans, health plan contract compliance and financial performance relevant to the demonstration, fiscal issues, systems issues, and pertinent legislative or litigation activity.

IDN 1

*No significant change in the Apr-Jun Term

During the current quarter the IDN has continued to see a continuation and increase in challenges we've addressed previously but the most significant as referenced in all sections above is due to organization level impact from COVID-19 across all IDN partners. Significant staffing, operational and fiscal issues are present for all IDN partners at this time.

IDN 2

MAeHC's departure and the change in metric reporting has had an impact on IDN2 as has the uncertainty of 2020 county contributions and the timing of additional DHHS funding.

IDN 3

Lack of engagement from several treatment providers (Merrimack River Medical Services, Partnership for Successful Living, and St. Joseph Hospital and Physician Practices) continue to be a challenge, as these providers serve some of the region's Medicaid beneficiaries with the most complex medical and behavioral health conditions. In addition, this has impacted our ability to meet the "no gap" outcome measure requirements reducing the IDN's ability to maximize 100% performance-based funding targets. The IDN continues to engage with each of them to strategize on some of their organizational leadership and capacity barriers/challenges.

IDN 4

Governance

N4H is guided by a Steering Committee created at the inception of the IDN's. During the quarter, there have been no changes to membership on the committee. The Steering Committee continuously monitors the activities of the IDN including performance outcomes and financial status of N4H as well as the statewide NH 1115 Waiver implementation. The ongoing public health emergency continues to present operational interruption and reorientation of priorities for our network partners. The Steering Committee has fully supported the use of N4H human and financial resources in supporting our partners during this difficult time.

At its monthly meeting, a report is made to the N4H Steering Committee relative to our financial position, most importantly the cash on hand, as well as the length of time these funds allow continued operation of all projects at current levels. N4H expresses it appreciation to NH DHHS leadership for supporting the resolution of NH county participation in IDN funding and providing additional funding in the beginning of this reporting period. We were able to extend all Integration Enhancement Plans (as part of the B1 Integration Project) and Quality Improvement Plans (as part of the E4 Integrated Treatment of Occurring Projects) through December 31, 2020.

IDN 5

Of most significance this quarter was the reality of CHSN-IDN5 Board that we must be facing the reality of the situation should no additional county funding become available in 2020. In late May a Board meeting was held to review a proposed FY 21 budget that had some significant cuts made to it in order to keep the three community projects and their IDN funded staff in place through the end of December 2020. To do this, significant cuts had to be made to the A1 Workforce budget which will impact network partners who utilized some of these funds and counted on them for workforce recruitment, retention, and job satisfaction activities. Any other reserve funding was also cut, so the budget is extremely tight with little wiggle room should there be no additional funding received. Although IDN5's three Counties (Belknap,

Grafton and Merrimack) have all stated they are in favor of supporting DSRIP activities, unfortunately the fate of the IDN's future lies in the hands of two or three outstanding counties who have yet to vote. Because of the COVID pandemic it has caused additional strains on county resources causing them to reconsider their options and potentially utilizing the ProShare funds they receive for different purposes given the current pandemic.

IDN 6
No Updates.

IDN 7
During the COVID-19 pandemic, Region 7 IDN partners using telehealth have expressed pleasure with expanded telehealth policy changes under the Governor's executive orders. They have been carefully watching the movement of legislation to preserve expanded telehealth capacity permanently. Several partners have offered testimony and letters of support to the legislature, while at the same time signaling the rural infrastructure challenges (i.e. inadequate access to broadband and cellular service) that makes it difficult for patients and clients to connect to telehealth services.

While several federal and state policies offered support and financial relief for healthcare providers experiencing significant financial distress during the pandemic, the rapidity with which these relief programs were developed and deployed also resulted in gaps that failed to address several key issues prevalent in rural healthcare settings like the North Country and Carroll County. Namely:

- As the state's only Community Mental Health center in the North Country, Northern Human Services (NHS) requires more than 500 employees to staff the six (6) office locations placed around their region, which accounts for almost half of the state's geography and includes all of Coös, Carroll and the northern half of Grafton Counties. NHS' workforce was, therefore, large enough to make this CMHC ineligible for relief under the Payroll Protection Program, creating significant financial stress for the agency.

- It appears that several of the federal relief programs were written without the necessary detail to provide relief to agencies other than hospitals, Federally Qualified Healthcare Centers and Rural Health Clinics. For example, Region 7 partner White Mountain Community Health Center has experienced challenges in accessing federal relief and loan programs because it holds FQHC Look-alike status, a category not covered in the CARES act, effectively eliminating their access to the relief offered to FQHCs that also have the benefit of having access to a number of grants and HRSA funding opportunities.

- While the expansion of telehealth services allowed for services and support to be continued during the pandemic, the nature of this service delivery mode has not secured reimbursement equal to that previously experienced when the agency offered primarily in-person visits. As mentioned earlier in this report, NHS reports that their providers are billing for shorter visits with clients seeking services for serious mental illness (SMI) because it is harder to get SMI clients to stay on the line and actively engaged in a telephone or video-based appointment. Providers have pivoted to booking more frequent appointments of shorter duration in order to ensure that care continues to be clinically appropriate, but the cumulative payments for these visits is less than the cumulative payments for longer and less frequent in-person visits.

- NHS also reports that the reimbursement model for services provided to individuals with developmental disabilities (DD) does not work in the context of the COVID pandemic. Many of the DD staff members are Functional Support workers whose time is only reimbursed when they accompany and provide support to their clients in community. Because many of the DD clients also have physical conditions that place them in the COVID high-risk population, these clients have been advised to stay at home as much as possible. DD staff have continued to provide support to their clients by picking up groceries, prescriptions and running other errands – tasks that they would normally assist their clients in completing. Because their clients are not with them during these activities their work time is no longer billable and reimbursable. This has created an ethical quandary for these functional support workers, who feel strongly that their efforts are ensuring the health and wellness of their clients but also worry that their efforts create a financial burden on the CMHC because there is no revenue stream to offset their labor expense.

- After a careful consideration of the remaining unmet Health Information Technology infrastructure targets and the limited bandwidth on the part of partners to accomplish the work necessary to meet those targets, Region 7 IDN lead agency North Country Health Consortium (NCHC) made the decision to eliminate the position of IDN Integration Coach

from the lead team in mid-May, following a temporary layoff of the position In late March as the agency shifted in response to financial uncertainties created by the COVID-19 pandemic. Additionally, after an extended leave, the Region 7 IDN Program Coordinator made the decision to decrease to a part time position at the beginning of June. As a result of these staffing changes, the Region 7 IDN lead team has experienced a net decrease of 1.5 FTE during the reporting period. Currently there is no plan to replace these staffing hours through the end of the demonstration. Budget projections included in the Region 7 IDN semi-annual report for the January – June 2020 reporting period will reflect a decrease in the infrastructure costs for the rest of the demonstration.

VI. Financial/Budget Neutrality Development/Issues

Identify all significant development/issues/problems with financial accounting, budget neutrality, and CMS 64 and budget neutrality reporting for the current quarter. Identify the state's actions to address these issues.

New Hampshire is awaiting formal communication with CMS re budget neutrality reconciliation.

VII. Consumer Issues

A summary of the types of complaints or problems consumers identified about the program or grievances in the current quarter. Include any trends discovered, the resolution of complaints or grievances, and any actions taken or to be taken to prevent other occurrences.

IDN 1
The Apr-Jun quarter continued the dramatic impact across all IDN network partners due to COVID-19. Some of the significant challenges during the quarter are:

- Limited technology needed for effective telehealth both for providers and patients/clients
- Lack of availability of BH services for Sullivan, Grafton Counties.
    - Persistent understaffing at West Central Behavioral Health has exacerbated the challenge of new BH referrals in the region.
- Providers have reported a challenge in balancing telehealth, in person visits and many organizations are juggling returning to normal volumes with new procedures and safety practices
- Reported concerns through the Greater Sullivan Strong meetings about significant concern across the region for patients/clients fearful about reduction in increased unemployment and the timeout of the eviction protection in place.

IDN 2
None to report.

IDN 3
None reported to date.

IDN 4
Network4Health has received no consumer complaints or grievances during the quarter. This is especially relevant during a period of uncertainty and disruption resulting from the COVID-19 pandemic.

IDN 5
There were no complaints or problems consumers identified about the program in this quarter.

IDN 6
There were no complaints, grievances or other problems identified to the IDN by consumers during this period.

IDN 7
IDN 7 has not received any complaints from consumers to date.

VIII. Quality Assurance/Monitoring Activity

Identify any quality assurance/monitoring activity or any other quality of care findings and issues in current quarter.

IDN 1
Across IDN1 projects that have been operational since summer, 2017. Project outcome measurement and fidelity to model review is consistently reviewed for all projects for evidence based practice standards;

- B1 @ Dartmouth Hitchcock Medical Center Adult Primary Care
- B1 @ Dartmouth Hitchcock Medical Center General Internal Medicine
- B1 @ Dartmouth Hitchcock Medical Center Pediatric Primary Care
- B1 @ Valley Regional Hospital Primary Care
- B1 @ Newport Health Center
- B1 @ Cheshire Medical Center
- B1 @ Alice Peck Day
- B1 @ Monadnock Community Hospital
- C1/E5 @ Monadnock Family Services, Monadnock Collaborative
- D3 @ Perinatal Addiction Treatment Program-Intensive Out Patient
- E5 Sullivan County Complex Care Team and Community Hub Pilot

All active IDN1 projects are monitored quarterly through an evaluation framework which includes project process milestones specifically selected for each awarded project. These measures in alignment with the State determined project measures will serve as tollgates for project development quarterly. Payments are made to awarded projects based on attainment each quarter of baseline milestones.

All B1 projects are evaluated are now evaluated on the same four milestones as they have already achieved their respected designation and implementation of project components. The below grid showcases the quarterly milestones for the projects. Leniency was provided on meeting the needs in this quarter. Support was provided to those teams who still had the resources and ability to continue project work. However we understand that several of our team's resources were redirected, overused or furloughed during this time. All project teams still submitted budgets, attestation of time and participation in relevant IDN activities. Similarly, the community projects had reoccurring milestones focused on improvement, sustainability and adherence efforts. Teams worked to on these as time and resources allowed over the quarter, however due to COVID-19 response taking priority deliverables were not required.

B1 Quarterly Evaluation Grid

	Project Milestones:	Deliverable:	Met or Unmet	Use of Funds: Met or Unmet (See Supportive Budgets, Expense Reports)	Accountability of Time: Met or Unmet	Participation in IDN Activities: Baseline participation Met or Unmet
April 1, 2020 - June 30, 2020						
	Milestone 1 : Utilization of SCP for all indicated high acuity patients	SCP Quarterly Data				
	Milestone 2 : Adherence to CCSA response protocol	CCSA Quarterly Data				
	Milestone 3 : MDCT meetings held monthly (at minimum)	Meeting Calendar				
	Milestone 4 :Utilize Data and SSA to Improve Integration Efforts	Meeting Notes				

C1/E5 Quarterly Evaluation Grid

Project Name, Lead Organization	Project Milestones:	Deliverable:	Met or Unmet	Use of Funds: Met or Unmet (See Supportive Budgets, Expense Reports)	Accountability of Time: Met or Unmet	Participation in IDN Activities: Baseline participation Met or Unmet
Q4 Y3: April 1, 2020 - June 30, 2020						
Co-Pilot	*Milestone 1* : Adherence to CTI Phases	CTI Phase Data by Quarter	*Covid Impact*	Met	Met	Met
	Milestone 2 : Adherence to ECC referral pathways and eligibility criteria	ECC Case Management Data	*Covid Impact*			
	Milestone 3 : Continuous demonstration of QI work, implementation	Documents supporting work	*Covid Impact*			
	Milestone 4 : Ongoing Funding Sustainability Efforts Undertaken	Demonstration of ongoing efforts to pursue sustainable project funding	*Covid Impact*			

D3 Quarterly Evaluation Grid

Project Name, Lead Organization	Project Milestones:	Deliverable:	Met or Unmet	Use of Funds: Met or Unmet (See Supportive Budgets, Expense Reports)	Accountability of Time: Met or Unmet	Participation in IDN Activities: Baseline participation Met or Unmet
Q2 Y3: April 1, 2020 - June 30, 2020						
Moms in Recovery Dartmouth Hitchcock	*Milestone 1* : Documented efforts of securing sustainable funding	**Ongoing**	*Covid Impact*	Met	Met	Met
	Milestone 2 : Collect and Interpret Outcome Data	**Quarterly Submission**	*Covid Impact*			
	Milestone 3 : Share Continued Efforts for Program Improvement	**Share Meeting Notes and developed/ updated materials**	*Covid Impact*			

E5 Quarterly Evaluation Grid

Project Name, Lead Organiz	Project Milestones:	Deliverable:	Met or Unmet	Use of Funds: Met or Unmet (See Supportive Budgets, Expense Reports)	Accountability of Time: Met or Unmet	Participation in IDN Activities: Baseline participation Met or Unmet
April 1, 2020 - June 30, 2020						
E5: Sullivan County Complex Care Team (SCCCT) and Community Hub Expansion	SCCT reviews cases monthly	Case forms	Met	Met	Met	Met
	Community Hub Steering Committee meeting bi-weekly	Meeting Schedule	Team evolved to Greater Sullivan Strong			
	Steering Committee review model policies	Completed Policies				
	Steering Committee Draft	Draft Process				

IDN 2

None to report.

IDN 3

COVID-19 Relief and MAeHC contract phase-out Impact

In mid June, CMS approved the modification to DSRIP Funding and Mechanics Protocol due to COVID-19. This results in the DSRIP program using year 4 performance results to score year 5. Between the MAeHC contract phaseout and this relief waiver, the IDN's visibility into the any outcome measure stats for either the 2020 six month measures or the CY2020 measures is extremely limited. This inhibits visibility into current stats and the ability to identify potential areas which need improvements/attention, as the Admin Lead currently does not have direct access to partner reported data. To mitigate this barrier/challenge, the Admin Lead has modified the Partner Monthly Report Template which has been approved by the Clinical Committee Chair. The IDN is also working on updating their Partner Quarterly Report Template to mitigate the lack of visibility for 2020 stats. The new Partner Monthly Report Template will be rolled out for use starting the July reporting period and the Partner Quarterly Report Template will start for the Q3 reporting period.

IDN 4

During the quarter, monitoring of homelessness data related to the impact of the public health emergency has increased dramatically with leadership provided by N4H. In addition, our B1 Integrated Care Project continues to utilize the Maine Site Self-Assessment Evaluation Tool from the Maine Health Access Foundation Integration Initiative to evaluate levels of integration achieved by organizations. To complement the Site Self-Assessment process that each of our partners completes, N4H contracted with the NH Citizens Health Initiative (NH CHI) to provide annual facilitation for our partners using NH CHI's tool, Blueprint for Integration. This includes in-person facilitation with a practice or organization to review progress and recommendations, and facilitated organizational discussion around integrated care continuum work, Strength-Weaknesses-Opportunities-Threats (SWOT) analysis and feasible focus areas for continued integrated care practice improvement.

The E4 Integrated Treatment of Co-Occurring Disorders project has utilized the Case Western Reserve University Center for Evidence Based Practice Dual Diagnosis Capability tools to establish baseline data. Areas identified for improvement are reassessed utilizing elements of the tools.

IDN 5

We are continuing to closely monitor our E5 program during COVID. Numbers for encounters and enrollments have not fallen as far as we previously predicted. This is probably a result of the re-opening of our partners to in-person services with masks required and the creativity of our care coordinators to meet individuals where they are at in creative ways (driveways, food pantries, etc.). The LRGH hospital FT Emergency Department embedded care coordinator position was eliminated in June (even though it was funded by IDN5) which truly served as the hub of most Laconia referrals. We expect that enrollments might dip slightly for the year overall but other care coordinators are finding work arounds to ensure services are provided for everyone needing them. On a positive note, the overall COVID infection rates within the Central and Winnipesaukee region remain low compared to other areas of the state.

IDN 6

While access to services commenced to being constrained towards the end of this quarter, there were no specific quality of care issues reported as related to COVID.

IDN 7

This quarter, the Region 7 IDN team has continued to participate in conversations at the state level regarding the dissolution of data aggregator services provided by the Massachusetts e Health Collaborative (MAeHC). Additionally, the process of engaging partners with reporting gaps has begun at the request of NH DHHS as CMS approved the state's request for an amendment to the DSRIP waiver.

The Region 7 IDN team has also begun the planning of the region's final Site Self-Assessment and will be engaging NH Citizen's Health Initiative later this summer to schedule that process.

IX. Demonstration Evaluation

Discuss progress of evaluation plan and planning, evaluation activities, and interim findings.

EVALUATION IMPLEMENTATION ACTIVITIES

Due to the COVID-19 pandemic, the Interim Evaluation Report deadline of 3/30/2020 was granted extensions by CMS twice: to 5/31/2020 and finally 6/30/2020. The Draft Interim Evaluation Report was submitted by the Department to CMS on 6/26/2020. We are currently waiting feedback from CMS.

Overall, the quarter ending 6/30/2020 has placed the Department on track to meet the CMS deadline of the Final Evaluation Report now due 6/30/2022. The independent evaluator (Muskie) will remain in place throughout the evaluation life cycle.

Claims and Administrative Data

The Muskie data team completed all DSRIP measure coding for 2019 claims data (2020 Specifications, all 23 measures completed). In addition, they processed and reviewed monthly data feeds into the DSRIP data warehouse, and analyzed claims to troubleshoot missing costs from Well Sense.

Surveys

The second wave of the Beneficiary Experience of Care Survey closed on April 29, 2020. Data was analyzed in May and early June, and the results were sent to the Department. The Beneficiary Experience of Care Survey response rate improved by 2 points over last year's initial survey. The response rate for Wave 2 was 40.5%. (Wave 1 n = 3,456; Wave 2 n = 3,644).

Analysis and Report Development

Muskie continued the Draft Interim Evaluation Report review process with Department throughout Quarter 2 and incorporated applicable Department comments and made further refinements as requested/ agreed upon in April and June.

Muskie began work on the Draft Final Evaluation Report by conducting preliminary analyses of a subpopulation of beneficiaries who have a diagnosis of diabetes, asthma, COPD, or cardiovascular disease and initiated data visualization for this sub-analysis. Several activities began for both IDN comparative analysis and the chronic condition sub-analysis for this report:

- Literature review of chronic condition prevalence in the state of New Hampshire and/or among Medicaid Beneficiaries;
- Preliminary comparative analysis and visualization of project incentive goals met by IDN (weighted and unweighted);
- Preliminary comparative analysis, visualization, and narrative of IDN features using federally standardized descriptors of rurality and provider availability;
- Initial review of variable standardization across IDN semi-annual reports.

EVALUATION INTERIM FINDINGS

Please refer to the Draft Interim Evaluation Report submitted to CMS on 6/26/2020 for a summary of findings from evaluation work completed in the four quarters of Demonstration Year 4 (1/1/2019-12/31/2019) and the first quarter of Demonstration Year 5 (1/1/2020-3/31/2020).

There is one current new finding which will be include in the Draft Final Evaluation Report due to CME on 6/30/22:

> Findings at this time are from analysis of the annual Beneficiary Experience of Care Survey and preliminary comparative analysis between Waves 1 and 2. Analysis of Wave 2 of the annual **survey of patient experience indicate a high level of satisfaction with care coordination (3.49;** Wave 1 was 3.45), getting care quickly (3.49; Wave 1 was 3.37), and getting needed care (3.29/ Wave 1 3.28) (Averages based on 4 point composite scale). In addition, across all IDNs, the average overall rating of the health plan was 8.13 out of 10 (Wave 1 = 8.06). There were no statistically significant differences between Waves 1 and 2 for these composite scores.

X. Enclosures/Attachments

NH Medicaid DSRIP IDN Qtrly Enrollment Changes, CY20 Q2

NH Medicaid DSRIP MM by Qtr, 16Q1-20Q2

CMS 64 DSHP and DSRIP (expenditure report)

Statewide DSRIP Performance Metric Achievement log

XI. State Contacts

Identify the individual(s) by name, title, phone, fax, and address that CMS may contact should any questions arise.

PLEASE NOTE:

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