

Section I: Region 2 IDN Plan

1. IDN Vision and Theory of Action

The Region 2 Integrated Delivery Network (IDN) upholds and supports the goal of the Capital Area Public Health Network to “improve access to a comprehensive, coordinated continuum of behavioral health care services in the Capital Area by 2020.” Further, our vision includes improving outcomes and increasing access to care for adult and youth populations (including those reentering from incarceration, pregnant women, and youth with developmental disabilities) across the capital area in a service-integrated continuum of care that addresses mental health, substance use disorders, and chronic/primary health care needs.

Region 2’s IDN has developed the integration and community projects in an interlocking way to maximize resources and eliminate as many gaps in care and transition between care as possible. The projects will work together to identify and address the needs of the Medicaid population with behavioral health disorders or at risk for behavioral health disorders at ten primary care sites, the Community Mental Health Center and substance use disorder (SUD) service provider (Riverbend), Concord Hospital emergency room and SUD program, three correctional facilities, and an array of community based organization who provide case management, benefits, housing, recovery and other behavioral health supports.

The five-year goal for these projects are to meet the Transformation Initiative Outcome Metrics as established by the NH Department of Health and Human Services (DHHS) including follow-up after emergency department visit or hospitalization; integration and core practice competencies in screening and communication between providers; patient reported experience of care; physical health/primary care clinical quality including use of standardized core assessments, screening for SUD and depression, recommended well care and other visits, smoking cessation and tobacco consultation; and HEDIS measures; behavioral health care HEDIS measures; population level utilization of emergency room and numbers/dosages of those receiving opioids; and workforce capacity as measured by timeliness of engagement with clients and initiation of services and follow-up visits. Along with the rest of the IDNs, these collective projects will also demonstrate the cost-effective ways that a better quality of care can be provided for the Medicaid population with behavioral health disorders. The Region 2 IDN will also work with other IDNs and the State to identify and develop alternative payment models (APM).

IDN Service Area Community Needs Assessment

Age	TTL	SED	SMI	SUD	COD	MI	Co-morbid conditions			
							CV	Resp.	Diabetes	Other
0-11	990	327 (M+)				661 (M+)	33 (M+)	422 (M+)	5 (M+)	875 (M+)
12-17	1046	297 (F+)				737 (M+)	67 (F+)	361 (F+)	6 (M+)	893
18-29	1475	19	128	200 (F+)	147 (F+)	992 (F+)	196 (F+)	462 (F+)	24 (F+)	1274 (F+)
30-49	1946		148 (F+)	278 (M+)	265 (F+)	1474 (F+)	429	694 (F+)	139 (F+)	1696 (F+)
50-64	1047		50 (F+)	65 (M+)	74	804 (F+)	439 (F+)	467 (F+)	231	971 (F+)
65+	301		13 (F)			275 (F+)	184 (F+)	151 (F+)	81 (F+)	301 (F+)

a. Analysis of IDN Service Area Disease Prevalence

Using the data sets provided by DHHS in October 2016, the table above indicates the behavioral health diagnoses and co-morbid conditions present in the Medicaid population of the Capital area who are seeking treatment. We have F and M tags to indicate when a diagnoses or disease was more present in one gender or another: F+ or M+. Where no tag exists, the prevalence was nearly equal. In one instance, there are only females in the category: 65+ with SMI.

We extrapolate the following from the data:

More males than females 0-11 are diagnosed with Serious Emotional Disorders (SED) and Mental Illness (MI); This changes with MI 12-17 when males are more often diagnosed with Attention Deficit Disorder (ADD) and Attention Deficit Hyperactivity Disorder (ADHD). Gender conditioning may contribute toward females not displaying as many outward symptoms throughout these years. It indicates a need to educate adults about the less outward symptoms of behavioral health disorders, especially in the female population.

In the years between 18-29, more females are diagnosed with Substance Use Disorders (SUD), Co-occurring Disorders (COD), and MI. Again, gender conditioning may lead males not to seek help; also males may be more likely to be incarcerated during this period of life. It indicates a need to ensure, through education and public awareness, that males are comfortable seeking help during this age range. In addition, if the lack of males in this age group is due to incarceration, it supports a need for focus on re-entry populations with behavioral health conditions.

There is a drop off across all genders for behavioral health diagnoses in the years 50+. This could be due to early deaths, particularly among males. Males also have greater instances of SUD beginning at age 30. This could also be due to gender conditioning away from seeking help from others. This indicates a need to address the health needs of men earlier before they become life-threatening; to make it easier for males to seek medical help; and to encourage more males into recovery.

When addressing the co-morbid diseases across this population, it is important to note that, according to one of the DHHS datasets furnished to this IDN, 51% of the Medicaid behavioral health population has had no preventative care visits. 38% of them (2,587) made 2,732 visits to the emergency department, primarily at Concord Hospital, for primary diagnoses that would have been treatable in primary care. Among these are high utilizers: 467 who made 3,206 visits to the emergency department, again primarily at Concord Hospital. Inpatient admission among the Medicaid population with behavioral health conditions is four times higher than the general Medicaid population and the readmission rate is 19% compared to 9.3%. There is clearly a high need to provide integrated care within primary care and behavioral health settings and to manage transitions from institutions to community in a more cohesive way.

According to the 2011 NH State Health Profile from the NH DHHS and DPHS (2011), heart disease is twice as prevalent among males (5 percent) as females (2 percent) and the risk increases with age (11 percent among those 65 years of age and older). These data sets, however, show the incidence of males with cardiovascular disease as being inordinately low compared to women. This could underscore the need to make it easier for men to seek medical care earlier in their lives and to address their SUDs. Even with this low incidence among men, the rate of cardiovascular disease in the Medicaid behavioral health population is 18% and begins showing up in considerable numbers very young in life (18-29).

According to the Centers for Disease Control and Prevention's online Chronic Disease Indicators, NH adults aged 18+ have a 10.4% rate of asthma and a 5.9% rate of chronic obstructive respiratory disease

(COPD). In the behavioral health population, 26% suffer from respiratory diseases, beginning very early in life (0-11). This is extraordinarily high and is likely due to the rate of smoking among those with behavioral health diseases (75% of people diagnosed with schizophrenia smoke) as well as the rate of smoking among those living in poverty.

The one statistic that did not rise with the DHHS provided data sets, is diabetes. While, according to the CDC, 7.9% of the general NH population presents with diabetes, only 6% of this Medicaid behavioral health population presented with diabetes. This anomaly could be due to the drop off in males seeking medical care. In addition, 27.8% of people with diabetes are undiagnosed and those with mental illness are more likely to see a primary care physician.

b. Regional demographics

Race & Ethnicity	Merrimack County	Region 2 Medicaid BH
Black/African American	1.4%	3.6%
Asian	1.9%	1.8%
American Indian/Alaskan Native	0.3%	0.3%
More than one race	1.4%	1.19%
Other		1.54%
Unknown		5.52%
White	95%	86%
Latino/a (inclusive of above)	1.9%	1.2%

The above data is from the DHHS provided data sets of IDN Region 2’s Medicaid population and the 2014 American Community Survey of the United States Census. Of note is that the Medicaid Behavioral Health population is more likely to be non-White than is the general population. That number could likely be higher by the more than 7% who did not report, or were not asked, for their race and ethnicity.

The following additional demographics are from a recent, successful SAMHSA grant proposal to implement a Primary Behavioral Health Care Integration program among the Capital Region Health Care and many of the Region 2 IDN partners:

Living in poverty or in a low-income household is another leading factor associated with vulnerability. Those in these income brackets face economic barriers to care and tend to have stress in their individual or family lives that limit access to care. Riverbend’s population of focus is 45% low-income reflecting the level of dependence on disability supports in the SMI population. Among Medicaid recipients, 100% of the population is low-income.

Homeless or unstably housed: Persons who are homeless utilize the EDs for shelter, food, showers and clean clothes – particularly as the temperatures drop. In the urban areas, persons experiencing homelessness are often those discharged from in-patient hospital and behavioral health care facilities without transitional plans. At its extreme those without housing, either living on the street or in some transient housing situation, have dramatically higher rates of illness and shorter life expectancy.¹ 3% of the total population Riverbend serves is unstably or poorly housed or homeless. As winter sets in, this becomes life threatening. There continues to be uncertainty about whether or not there will be a cold weather sheathed this year in the Capital Region.

Recently incarcerated: The NH Department of Corrections operates the NH State Prison for Men in Concord, which houses 1,488 men in a prison with a stated capacity of 928. The prison accepts maximum, medium, and minimum-security prisoners. Although NH’s crime rate has been low and stable

¹ <http://www.nationalhomeless.org/factsheets/health.html>

for the past ten years, the prison population has increased 31% and spending on corrections has nearly doubled over the same time period. Factors found to contribute to the rising rate are recidivism is a lack of community resources to address trauma and other needs, including SUD.² This 2010 study went on to state, “traditional care models are not effective with this population [with SUD] and integrative approaches are required.”

New Americans and Refugees: Since the early 1980s, 7,500 individuals who were forced to flee their home countries because of persecution have made NH their home. Just since 2008, 3,317 refugees have been resettled in NH, 1,339 in Concord. Many have since become new Americans. The countries of origin for this population are varied, but the main country of origin is Bhutan. After forced migration, many refugees suffer mental health issues such as depression, post-traumatic stress, and other psychiatric disorders. Studies have shown that refugees have an elevated risk during the resettlement stage. Post-migration stressors such as unemployment, weak social supports, and social integration have been found to increase the likelihood of mental health issues.³ Other common sources include a high rate of unemployment and poverty, a lack of social support in the host country, separation from family and friends, insufficient language skills, or unfriendly reception and racism in their new community.⁴

Language: There are a number of resettled refugees in Concord requiring language assistance and NH’s proximity to Canada and early settlement patterns by the French make that language a common primary or secondary language of the population. Ten of Riverbend’s current clients use interpreter services: 6 Napali, 2 French, and 2 Kinyarwanda.

The Region 2 IDN is focused on expanding/developing Enhanced Care Coordination for High Need Populations, Re-entry, and Medicated Assisted Treatment through an integrated model that places behaviorists and MAT trained physicians at all primary care locations within the region and uses care navigators/peers and other aspects of SAMHSA HRSA’s integrated care model to successfully manage transitions for the region’s Medicaid behavioral health populations.

c. Current resources available

MH/SUD and CB support organizations	Existing Resources
Capital Area Public Health Network - Substance Misuse Prevention Network	SUD Prevention - Recruitment of key community stakeholders and sectors, technical assistance to area schools and emerging community coalitions, resource development and advocacy SUD Early Intervention - Naloxone distribution community events and provider trainings
Middle and High Schools	SUD Prevention - Youth Councils, Life of an Athlete, Safe Schools Program, Second Start SUD Early Intervention - Second Start
Police Departments	SUD Prevention - Permanent Prescription Take Back Boxes, Community Resource Unit/Officer

² Justice Reinvestment in New Hampshire, Analyses & Policy Options to Reduce Spending on Corrections & Increase Public Safety, Justice Center, The Council of State Governments, 2010.

³ Teodorescu, D.-S., Heir, T., Hauff, E. Wentzel-Larsen, T., Lien, L., “Mental Health Problems and Post Migration Stress Among Multi-Traumatized Refugees Attending Outpatient Clinics Upon Resettlement to Norway.” Scandinavian Journal of Psychology, 53: 316–332.

⁴ Murray, K. E., Davidson, G. R. and Schweitzer, R. D., “Review of Refugee Mental Health Interventions Following Resettlement: Best Practices and Recommendations.” American Journal of Orthopsychiatry, 80: 576–585.

Family Health Center, Concord	SUD Prevention - Scope of Pain - Opioid Prescriber Education/Training SUD Early Intervention – SBIRT
Riverbend Community Mental Health	BH Treatment - Evaluation, Individual Outpatient Counseling, Group Outpatient Counseling, Intensive Outpatient Programs, Partial Hospitalization, MAT, Integrated Care for Health, Supported Employment, Benefits Assistance, Wellness Programs, Supportive Housing
Concord Hospital	BH Treatment - Emergency Services, Inpatient Psychiatric Unit, ECT, Consultation Services
Circuit Court District Division - Concord	SUD Early Intervention - Youth Drug Court MH - Mental Health Court
Merrimack County Diversion Center	SUD Early Intervention - Adult Court Diversion
A Better Pathway	BH Treatment - Evaluation, Individual Outpatient Counseling, Group Outpatient Counseling
Bicentennial Square Counseling Services	BH Treatment - Evaluation, Individual Outpatient Counseling, Group Outpatient Counseling
Changing Point Counseling, LLC	BH Treatment - Evaluation, Individual Outpatient Counseling, Group Outpatient Counseling
Child and Family Services	BH Treatment - Evaluation, Individual Outpatient Counseling, Group Outpatient Counseling, Intensive Outpatient Programs
Chrysalis Recovery Center, LLC	BH Treatment - Evaluation, Individual Outpatient Counseling, Group Outpatient Counseling, Intensive Outpatient Programs BH Recovery - Recovery Support Services (Anger Management, Recovery Mentoring and Relapse Prevention Management, Peer Recovery Coaching, Care Coordination, Other Recovery Support Services)
Concord Hospital, Substance Use Services	BH Treatment - Evaluation, Individual Outpatient Counseling, Group Outpatient Counseling, Intensive Outpatient Programs BH Recovery - Recovery Support Services (Recovery Mentoring and Relapse Prevention Management)
Concord Metro Treatment Center	BH Treatment - Withdrawal Management, Medication Assisted Treatment (Buprenorphine, Methadone)
Elsa Johnson, LCMHC, MLADC	BH Treatment - Evaluation, Individual Outpatient Counseling, Group Outpatient Counseling BH Recovery - Recovery Support Services (Anger Management)
LADC & SAP Services, LLC	BH Treatment- Evaluation, Individual Outpatient Counseling

ROAD to a Better Life	BH Treatment- Withdrawal Management (Buprenorphine), Evaluation, Individual Outpatient Counseling, Group Outpatient Counseling, Intensive Outpatient Programs
RTT Associates, LLC	BH Treatment- Evaluation, Individual Outpatient Counseling, Group Outpatient Counseling BH Recovery - Peer Recovery Coaching
Self-empowerment-NH LLC	BH Treatment- Evaluation, Individual Outpatient Counseling, Group Outpatient Counseling
SKY Counseling Services, LLC	BH Treatment- Evaluation, Individual Outpatient Counseling, Group Outpatient Counseling, Intensive Outpatient Programs BH Recovery - Recovery Support Services (Recovery Mentoring/Relapse Prevention Management, Peer Recovery Coaching)
Warren Street Family Counseling Associates, Inc.	BH Treatment- Evaluation, Individual Outpatient Counseling
Eberhart Counseling, LLC	BH Treatment- Evaluation, Individual Outpatient Counseling, Group Outpatient Counseling
EqWise Counseling Services	BH Treatment- Evaluation, Individual Outpatient Counseling
Concord Peer Support	BH Recovery - Non-profit, self-governing peer support organization run by & for consumers.
Growing Harmony Services, LLC	BH Treatment - Evaluation, Group Outpatient Counseling
New Futures	BH Recovery - Certified Recovery Coach Training (CCAR)
HOPE for NH Recovery	BH Recovery - Recovery Community Centers, Peer Training
Fedcap	BH Recovery - Trainings
A Better Pathway	BH Recovery - Recovery Support Services (Recovery Mentoring/Relapse Prevention Management)
Families Sharing Without Shame	BH Recovery - Parent Support Groups
Homestead Inn Sober House	BH Recovery - 12-step based sober living facility for men.
Ascentria Care Alliance	Community based support services: Children and Family Services, In-Home Care, Language Bank, Mental Health and Disability Services, Services for New Americans, Services for Older Adults
Bhutanese Community of NH	Community based support services for New Americans.
Boys & Girls Club of Greater Concord	Community based support services for all young people to reach their full potential as productive, caring, responsible citizens, by offering a safe place to belong, caring adult mentors and programs covering everything from academics

	and leadership development to physical fitness and healthy habits.
CATCH Neighborhood Housing	Community based support services - affordable housing solutions
Community Action Program	Community based support services - Work with low-income families, the elderly and individuals with disabilities to assist them in their efforts to become or remain financially and socially independent.
Concord Coalition to End Homelessness	Community based support services works to eliminate the causes of homelessness for the citizens and residents of Concord, New Hampshire through a coordinated, committed and active effort of our many stakeholders.
Concord Family YMCA	Community based support services Works to strengthen the foundation of community through a focus on youth development, social responsibility, and healthy living. We are the leader in our community in providing value-based health and wellness programs for children, teens and adults.
Concord Regional VNA	Works to improve the health of the people and communities it serves by managing illness and promoting wellness through all stages of life. Offers people of all ages a wide range of personalized services and programs
Crotched Mountain / ATECH Services	Serving individuals with disabilities and their families, embracing personal choice and development, and building communities of mutual support.
Families in Transition	Provides innovative and effective interventions designed to help homeless individuals and families reach beyond the cycle of homelessness to lead healthy, successful lives.
Fellowship Housing Opportunities, Inc.	Provides decent, safe, affordable housing with support to members of our community who live with mental illness.
Granite State Independent Living	Promote life with independence for people with disabilities and seniors through advocacy, information, education, support and transition services.
Life Coping	Assists elderly and adult disabled individuals and their families in identifying needs and seeing that those needs are met with the ultimate goal of keeping individuals in their homes.
Merrimack County Service Link	Helps individuals access and make connections to long term services and supports, access family

	caregiver information and supports, explore options and understand and access Medicare and Medicaid.
NAMI New Hampshire	Grassroots organization working to improve the quality of life for all by providing support, education and advocacy for people affected by mental illness.
New Futures	Nonpartisan, nonprofit organization that advocates, educates and collaborates to prevent and reduce alcohol and other drug problems in New Hampshire
NH Alcohol/Drug Abuse Counselors Assoc.	Non-profit organization dedicated to advancing addiction professions in NH. Through education and advocacy, work to enhance the knowledge and skills of addiction professionals, increase awareness of addiction issues in NH, and promote programs and policies that ensure access to high quality services for NH citizens struggling with addiction.

In collaboration with Riverbend Mental Health, Family Health Center in Concord provides on-site mental health and substance use services. The CEO of Riverbend is the Vice President of Behavioral Health for Concord Hospital. Concord Hospital provides a primary care provider at Riverbend Mental Health through its Integrated Center for Health program.

With this demonstration, CRHC plans to embed behaviorists in nine other primary care settings including Dartmouth-Hitchcock Concord and 8 Concord Hospital-affiliated primary care centers throughout the region. These behaviorists would be overseen by a psychiatrist(s). In addition, the goal is to have two MAT trained physicians at these same sites overseen by an MAT mentor from Family Health Center, Concord.

d. Assessment of gaps in care

The below chart indicates the gaps in care for the following population:

- Serious mental illness
- Substance use disorder (SUD), including opiate addiction
- Co-occurring mental health and SUD conditions
- Co-morbid medical and behavioral health condition
- Co-occurring developmental disability and mental health/SUD
- Mild-to-moderate mental illness (e.g. anxiety, depression)
- Those at-risk for a mental health and/or SUD condition

Age	Gaps
0-18	Wait times to receive treatment from childhood BH specialists; lack of parent support groups; lack of specialty treatment services for this age group; need SBIRT for early identification by law enforcement, primary care providers, and high schools; more youth peer coaches; more support groups for adolescents; transportation to get to healthcare services; number of providers who accept Medicaid; wait time for psychiatric hospital bed; suicide prevention education; smoking prevention programs; substance misuse prevention programs; stigma; lack of evidenced based practice such as Motivational Interviewing; historical lack of Medicaid coverage for SUD.
18-64	Wait times to receive treatment from psychiatrists; role confusion in recently integrated primary care/BH settings; 42 CFR confidentiality laws impede integrated care; resources to stabilize pre-treatment; providers need to know about all resources available and work together to manage care including transitions; coordinated use of instruments for initial assessments for level of care; recovery coaches – database of availability, more expansive training, more coaches; support for reentry and refugees; transportation to get to healthcare services; number of providers who accept Medicaid; wait time for psychiatric hospital bed; suicide prevention education; smoking cessation programs; stigma; wellness programs; need to expand mental health first aid and develop SUD first aid.
65+	All of the above and more intense food, transportation, and socialization needs; services to allow seniors to maintain independence; respite care for family members; behavioral health services in nursing homes

Data above retrieved from:

- NH BDAS Capital Area SUD Continuum of Care Assets and Gaps Report, 2016
- Concord Hospital/Riverbed SUD Treatment Group interviews, 2016
- Region 2 IDN Surveys distributed September, 2016

In addition, the region has two recent existing assessments to draw upon: Capital Region Community Health Needs Assessment, Concord Hospital, 2012, and the Capital Area Community Health Improvement Plan, 2015-2020.

The Concord Hospital Assessment identified the following key needs from 20+ data sets from Community Commons; 11 community organization interviews; 196 focus group participants; 40 community listening session participants; and 987 online, 407 telephone, and 107 written surveys:

- Access to behavioral health intervention and treatment
- Reduction in cardiovascular risk factors
- Most vulnerable populations include low-income, refugees, homeless, reentry
- Insurance education
- Transportation to care
- Affordable dental and medical care
- Affordable prescriptions

The Capital Area Community Health Improvement Plan, 2015-2020, used the following data resources and reports: American Community Survey 5-Year Estimates, 2010-2014; Behavioral Risk Factor

Surveillance System (BRFSS), 2012; Capital Area Region Community Data Profile, 2011; Capital Area Regional Network Strategic Plan for Prevention, 2012; Capital Region Community Health Needs Assessment, 2012; County Health Rankings, 2014; National Survey on Drug Use and Health, 2012-2013; NH Health Wisdom; NH HealthWRQS; Snapshot of NH's Public Health Regions, 2011; State Health Improvement Plan (SHIP), 2013; US Census Bureau, 2010-2014; and Youth Risk Behavior Surveys (YRBS), 2007-2013. Out of the eight priority area it identified two to be addressed by the DSRIP demonstration: Misuse of Drugs and Alcohol and Access to Comprehensive Behavioral Health Services.

2. Community Engagement and Stakeholder Input

a. Process by which the IDN has solicited community input in developing this Project Plan, noting where this process differed from the original plan presented in the IDN Application.

Region 2 IDN's community engagement plan in developing the Project Plan was essentially as described in the Administrative Lead application. All elements of the Project Plan were informed by community input including the six projects and the overall budget.

Face-to-face meetings, conference calls, online surveys, emails, and telephone calls were all used as forms of communication. Materials distributed included resource documents, power point presentations, information compiled by DHHS and/or Meyers & Stauffer, and drafts of the five-year budget and Project Plan.

The first presentation was in mid-June with the entire IDN Membership. At that time, we laid out the work ahead of us, as we knew it, and "brainstormed" a basic governance structure so we could proceed with decision-making. The IDN Membership also met in August to discuss community project selections and existing surveys of behavioral health needs in the region. They were provided with the Capital Region Community Health Needs Assessment; the Substance Use Disorder Continuum of Care Resources, Assets, and Gaps; and the 2015-2020 Capital Area Community Health Improvement Plan. The IDN Membership will meet again in November and quarterly thereafter.

Also beginning in June, the Managing CEO and Project Manager met to discuss and sketch out ideas for each requirement of the Project Plan. Some of those meetings included IDN members with experience and knowledge about whatever was being discussed: state plans, integration, community plans, finances, technology, governance, and etc. These meeting occurred at least weekly and sometimes multiple times per week. We also met with the administrative leads from other IDNS on a weekly basis and later on in the process, with DHHS and Meyers & Stauffer.

Input was solicited from the full IDN Membership throughout this process using surveys or email requests. Surveys included HIT resources and gaps, Behavioral Health needs, Community Project selection, and roles desired regarding workgroups and sub-committees to be developed. Other times, email was used to solicit specific input into an idea.

The ideas generated were brought by the Project Manager to the Executive Committee (CEOs, CFO, CTO, CMO) for further development. The Executive Committee met every two weeks throughout the planning process, beginning in July. While they originally met in person, they went to a conference call format in October. The plan is for them to meet monthly beginning in 2017 and to review financial and other reports in advance of IDN Committee meetings. The Executive Committee and IDN Staff (Project Manager, Project Assistant, Accountant) use DropBox to share documents. The Project Manager provides a monthly report to the Executive Committee.

The Project Manger consolidated all of the generated ideas and input and developed presentations for the IDN Committee, noting which areas were ready for a vote and which required further discussion. The agenda, presentation, handouts, and meeting minutes for the IDN Committee also went to the full

IDN Membership. Votes made by the IDN Committee went to the Capital Region Health Care board of directors. The IDN Committee met monthly and will continue with that meeting schedule.

This cycle of meetings, input solicitation, and material generation continued throughout July, August, and September. During that period of time, presentations about the DSRIP demonstration and Region 2's participation in it were made to various community groups, stakeholders, and other governing bodies. The Project Manager created and distributed a power point presentation to all IDN members to share with their boards of directors and staff.

When these processes led to an almost fully developed five-year budget and plans for implementing the integration and three community projects, we convened four groups to discuss each one individually as well as where it fit within the entire plan. We invited all IDN members to attend any or all of the meetings. We also asked IDN members to invite other community members who they thought might want to provide input. These meetings were well attended and led us back to the drawing board in some instances.

We also convened these individual project meetings to solicit a chair and members for project workgroups. We made it a requirement of IDN membership that each organizational member must serve on at least one workgroup or subcommittee. Following the meetings, we received a lot of interest in serving and were able to staff our initial workgroups. These project workgroups are convening in November or early December 2016 to get to know each other and to carve out a meeting schedule for 2017. It is expected that they will meet at least monthly.

From all of this input, our final project plans were presented to the IDN Committee and approved conceptually in draft form. The IDN Committee voted to allow the Executive Committee to sign off on the final Project Plan presented to DHHS.

There was never an instance in which community input could not be addressed or taken into account. We did have to follow up with about five or six organizations that were not regularly attending meetings or providing input. The result of those follow-ups were that all but two reengaged and are now fully participating. One dropped out citing a lack of staffing as they are in three other IDNs. The other has not responded. We continue to reach out.

b. Process by which the IDN will solicit community input in implementing its program over the course of the demonstration.

The Region 2 IDN will continue to solicit input from the groups mentioned above (IDN Members, IDN Committee, IDN sub-committees, IDN workgroups, IDN staff) according to the meeting schedules listed. We will continue to use face-to-face meetings, conference calls, online surveys, emails, and telephone calls as forms of communication and to distribute materials accordingly. We will also continue to use file sharing software and group calendars. In addition, we are going to distribute an e-newsletter to all IDN members, community members who sit on workgroups, and anyone else who would like to subscribe. We envision the e-newsletter as containing updates on the progress of plans and including links to resources applicable to implementation of the projects.

It is expected that the workgroup chairs will bring ideas and draft plans to the IDN committee for discussion and vote. These workgroups are staffed by IDN and community members. The HIT and Behavioral Health Workforce workgroups will provide the foundation for the Integration workgroup. The Integration workgroup will ensure that the community project workgroups are developing their projects with as high a degree of integration as is possible. The IDN sub-committees (finance, data, and clinical) will assist the workgroups with budgeting, uniform data collections, and the selection and implementation of clinical processes.

On the staff level, the Project Manager and Assistant will assist each of these groups with communication to their members and other IDN groups. We have developed uniform agenda and minutes templates and these will be distributed widely so that IDN members can attend any workgroup or subcommittee they choose even if they aren't a formal member of that group.

We also expect to continue giving presentations to boards of directors, other business groups, and community stakeholders about the DSRIP demonstrations, its current status and plans for the future.

3. Network Composition

a. A **finalized network list**, including the name of the organization, type of service(s) provided, address, telephone contact, email, and brief description is included in the 4A tab in the IDN Project Plan Supplemental Data Workbook.

b. Leveraging the IDN network to address the care gaps identified in the IDN's Service Area Community Needs Assessment (Question 2d)

The Region 2 IDN will be addressing behavioral health care needs across the age continuum. We distributed existing assessments to IDN members and conducted a survey of members to determine additional needs. Every meeting used these assessments for guidance in developing initial project plans. Through the core competency integration project and the three community projects (Reentry, MAT, and Enhance Care Coordination), we will embed behaviorists from Riverbend at nine primary care practices within the IDN and train, incentivize, and mentor (through another IDN member) two physicians at each practice to provide MAT. We will provide peers through additional IDN members to provide recovery support and assist with transitions for adults and youth. Our HIT Workgroup (with five IDN members) will create solutions to share information about treatment and transitions and assist with an integrated approach. We also plan to provide 24/7 Peer Recovery Support Coaches through an IDN member to Concord Hospital's ED, primarily for opioid overdose but to respond to other addiction issues in the ED. Region 2 is also working with the Merrimack County Department of Corrections (IDN member), Sununu Youth Services Center, and the State Prison to address the behavioral health needs of youth and adults leaving their facilities and reentering the Region 2 community. The Reentry workgroup includes representatives from the IDN who provide behavioral health treatment as well as those who will support the housing, benefits, recovery, wellness, and community integration needs of the population. The IDN sketched out a plan to address the enhanced care coordination of high needs populations during a very well-attended IDN and community meeting. The foundation of the plan is to provide a care coordinator(s) to identify high utilizers and assemble providers to develop a plan for integrated wrap around services. Attendees at the meeting discussed the very complex needs of youth and adults who present with multiple needs including developmental disabilities, SED, SMI, and co-occurring SUD and chronic health issues. We discussed the need to provide a deeper and broader level of support to fewer recipients in order to have a lasting impact. We discussed this with DHHS and Meyers & Stauffer in terms of meeting our milestones and, rather than building this community project out to the extent we did others, we are convening the workgroup in December to begin the deeper planning process. That workgroup is comprised of IDN members from behavioral health and primary care treatment providers, peer and advocacy groups, schools, case management and home visiting providers who focus on seniors and those with developmental disabilities, refugee and language assistance organizations, and community organizations who provide support for housing, benefits, and wellness. The Region 2 IDN members all have a long history of working together to address our community's needs. We know where the gaps are in an organic fashion from years of seeing where people slip through the cracks and/or return again and again to treatment. The data we received isn't surprising and supports that knowledge.

Relationship with Other Initiatives

The Capital Area Regional Public Health Network sub-contracts the Continuum of Care Facilitator role to Riverbend. Prior to the initiation of the Continuum of Care program, Concord Hospital and Riverbend had assembled a group of SUD treatment providers to develop a collective approach to addressing the SUD needs of the Capital Area's population. Since May 2015, this group has been meeting monthly to share best practices and create collaborative processes to addressing the SUD needs of the population. The group has since expanded to include providers along the continuum of prevention, intervention, and recovery and is currently serving as the "workgroup" for the Continuum of Care project. This group provided input for the Assets and Gaps document and is working collectively on the Development Plan. When CRHC was contracted as the Administrative Lead for the Region 2 DSRIP demonstration, this group also provided input to the selection of the SUD focused project. Members of this group are now serving as chair and workgroup members for the chosen MAT community project.

Riverbend received SAMHSA PBHCI funds in 2015 to integrate primary health care services and wellness activities within its community-based behavioral health center in Concord, NH and to create a culturally competent and person-centered health home. Riverbend relocated its Community Support Program's (CSP) Interdisciplinary Treatment Team (ITT) for those with SMI to a new facility, which also includes two fully equipped exam rooms and a wellness center. The goal is to improve the physical health status of 500 adults with serious mental illness (SMI) and those with co-occurring substance use disorders in Merrimack County who have or are at risk for co-morbid primary care conditions and chronic diseases. In addition to CSP's ITT, the Integrated Center for Health at Riverbend also includes a Nurse Care Coordinator (RN), Integrated Care Manager, Peer Wellness Coach, PBHCI Project Director, Primary Care person (APRN), Substance Use Disorder Counselor (Masters, Licensed Alcohol & Drug Counselor), Pharmacist, and Administrative Assistant who provide integrated case management, medical and behavioral health care, wellness activities, and appropriate referrals for specialty care or community support. Key collaborators include: Concord Hospital, Concord Hospital Medical Group, Concord Peer Support, Ascentria, Concord YMCA, and the Bhutanese Community of NH. Most of the IDN partners named in this application also provide ancillary services and support to participants in the program. DSRIP funds will not be used for this project. One of the goals of this project is to achieve a fully integrated primary care within a behavioral health care site status by the end of the grant period: 2020. It was assessed as having achieved a level 3 of 6 on SAMHSA-HRSA Center for Integrated Health Solutions' (CIHS) Standard Framework for Levels of Integrated Healthcare. Oversight for this program is provided by a SAMHSA-defined "Coordination Team." It includes the CEO, CFO, and CMO of Riverbend as well as the Integrated Center for Health's Program Director and PCP. The group has two consumers and five community members as well. Its charge is to meet quarterly; provide leadership and guidance in accomplishing the goals of the PBHCI program; serve as a link between the program and the community; ensure compliance with state and federal laws; develop and implement PBHCI sustainability efforts; and review data on program effectiveness with associated development of continuous quality improvement efforts. Every member of this team is involved with the Region 2 DSRIP demonstration. Several are members of the executive committee or serve as chairs of workgroups. We anticipate that the lessons learned from the year we've been working on the Integrated Center for Health and the transformation that it has created within the agency will assist us with core competency project of the DSRIP demonstration.

4. Description of How This Plan Addresses the Opioid Crisis

The Region 2 IDN will leverage DSRIP funding to build on steps it is already taking to address the opioid crisis.

Riverbend has been actively expanding its SUD/COD services. Its CHOICES: Addiction Recovery Services program began medically assisted therapy (MAT) and an outpatient detox program in January 2016. Ten Riverbend clinicians are being supervised to become Master's level licensed drug and alcohol counselors (MLDAC); four of these will be qualified to serve adolescents. With DHHS funding received earlier this year, Riverbend is:

- Expanding the numbers of adults 18+ that it serves through its current Intensive Outpatient Services (IOP) from 100-200.
- Adding a CLIA, State, and OSHA compliant laboratory.
- Expanding the number of adults 18+ that it serves through its current Medication Assisted Therapy (MAT) program from 30-200
- Expanding IOP and MAT services to adolescents 12+ years of age: 100 IOP, 30 MAT.
- Adding a partial hospitalization program for 50 adults and 50 youth 12+ years of age

Concord Hospital's Substance Use Services is an adult outpatient department with services provided by Licensed Alcohol and Drug Counselors for individuals seeking help for substance use and related disorders. Offering an intensive outpatient program (Fresh Start), Gender Based Continuing Care Support Groups, Individual Counseling, Inpatient Hospital Consultations, Court Evaluations, DWI Evaluations and DWI Aftercare groups.

The SUD Continuum of Care workgroup continues to develop plans to address the gaps in care it has identified across the region.

HOPE for NH Recovery and others are expanding Recovery Community Centers across the state and training Peer Support Coaches to help sustain people in long-term recovery. We can't hope for long-term change in the lives of those with SUD without stable recovery and community supports. When Region 2 IDN discovered it could not select Peers as an SUD focused community projects, it decided to include Peers extensively throughout all of its other projects.

The IDN is convening a meeting in November with Peer representatives from the IDN and the community including HOPE for NH Recovery, NH Children's Behavioral Collaborative Youth M.O.V.E. NH, Granite State Pathways, New Futures, NAMI, and organizations that already successfully work with Peers at their sites. This group will review the overall projects and make recommendations for Peer usage throughout them. We expect to be contracting with at least HOPE for NH Recovery and Youth M.O.V.E. NH for peer oversight, training, and support.

The IDN is contracting with HOPE for NH Recovery to provide HOPE ED, an initiative to connect opiate overdose and high risk for opiate overdose patients, as well as those that present with addiction issues in Emergency Departments and hospitals with Peer to Peer Recovery Support Coaches. The Coaches will be on call every day 24/7. Coaches will interact with family members with the patient's permission. Coaches can help to redirect an upset family member's anger from the individual to their disease. Coaches will work with the patient and family after discharge to connect them with valuable resources to process the sentinel event and/or to help them return to previous treatment modalities.

The IDN is contracting with Youth M.O.V.E. NH to implement their (Families and Systems Together) F.A.S.T. Forward program within our community projects that serve youth. The FAST Forward program is

designed to serve youth with serious emotional disturbances and their families, whose needs aren't met by traditional service streams and programs.

CRHC chose MAT as its SUD project and has decided to train, incentivize, and mentor two primary care physicians at each of nine locations in the region. These same primary care locations will receive an embedded FTE behaviorist from Riverbend. The Family Health Center in Concord already has an MAT physician as well as a Behaviorist on site. This model is working and there is a high demand for services. The MAT physician at the Family Health Center in Concord will chair the MAT workgroup and provide ongoing mentoring for newly trained physicians.

In addition, CRHC is going to use DSRIP funding to implement a Neonatal Abstinence Syndrome (NAS) prevention program. The Northern New England Perinatal Quality Improvement Network's (NNEPQIN) surveyed its membership about NAS in the winter of 2015-2016. Respondents from 19 birthing hospitals in NH reported that they believe the problem to be effecting 10-20% of their population. Concord Hospital reported that they cared for a total of 43 babies in 2015 who tested positive for any opioid (methadone, buprenorphine, other). At Dartmouth Hitchcock Medical Center in Lebanon, the number of women whose charts were coded for either buprenorphine or methadone at the time of delivery has risen over the past three years from 4.5% in 2013 and 5.5% in 2014 to 6.5% in 2015 = 6.5%. Because women in treatment probably underrepresent the total number of effected women, and because Dartmouth Hitchcock, as a tertiary care center, may not reflect the experience of all hospitals in the state, we estimate that 5 to 10% of all pregnancies are impacted by substance misuse. The NAS prevention program will include a traveling MAT physician, peer support, and warm linkages to parenting and other support programs.

5. IDN Governance

a. Overall governance and decision-making structure

a. The **principle governance committee** of the region 2 IDN is the IDN Committee. It is comprised of no more than 15 members who are representative of the following organization types: primary care practices and facilities; behavioral health providers; community mental health centers; peer-based support; hospitals; county facilities; and community-based organizations that provide social and support services needed by people with behavioral health issues. Each organization represented on the IDN Committee must designate one representative and one alternate representative. The IDN Committee has two sub-committees:

- i. Financial Sub-Committee: Lead budget development, develop and manage financial processes and procedures, provide monthly financial report to IDN Committee, and make financial recommendations to the IDN Committee.
- ii. Clinical Sub-Committee: Ensure the development of evidence-based and standard clinical pathways, work with the HIT/Data workgroup to monitor patient outcomes, and recommend strategies to improve patient outcomes.

b. Other governance committees include:

- iii. IDN Membership comprised of all IDN member organizations and their staff. Their role is to designate organizational representative(s) for meetings/surveys; respond to requests for information including surveys and questionnaires; attend and participate in quarterly IDN membership meetings; join, attend, and participate in at least one monthly sub-committee or workgroup; identify subject matter experts to join sub-committees and workgroups; and organize consortium partners in geographic region. As workgroup and subcommittee members, they make recommendations to the IDN Committee.

- iv. The Administrative Lead is Capital Region Health Care (CRHC) comprised of Concord Hospital, Riverbend Community Mental Health (Riverbend), and Concord Regional (CR) VNA. The CEOs of these entities are acting collectively as the CEOs for the IDN. They have each taken on a special role in the IDN. Concord Hospital is overseeing the financial management and providing its CFO to act as the CFO for the IDN. Concord Hospital also hired an accountant for the IDN. Concord Regional VNA is overseeing the HIT and data collection aspects of the IDN and providing its CIO to act as the CTO for the IDN. CRVNA is also providing staff for technology and data collection support. Riverbend is overseeing the clinical aspects of the IDN and providing its CEO as the Managing CEO of the IDN and its CMO as the CMO of the IDN. Riverbend has also hired a Project Assistant. The collective CRHC has hired a Project Manager. The Administrative Lead act as a single point of accountability for DHHS and enters into contracts on the IDN's behalf; submit single applications on behalf of the IDN; implements the IDN governance structure in accordance with DHHS parameters; receives funds from DHHS and distributes funds to partners; compiles required reporting; collaborates with IDN partners in leadership and oversight; and collaborates with IDN partners to manage performance against goals and metrics
- v. The Executive Committee is comprised of the Administrative Lead CEOs, CTO, CFO, and CMO and oversees and manages the work of the IDN.

c. No separate legal entities are being established as part of the IDN.

- d. This governance structure provides for **full participation of IDN partners in decision-making processes** because the workgroups and sub-committees are staffed with IDN members who are developing and implementing the plans.
- e. This governance structure **ensures accountability among IDN partners** (including the Administrative Lead) because all meeting agendas and minutes are distributed to the full IDN and all meetings are open to anyone.
- f. The following process have been developed to handle **low-performing partners or partners who cease to participate in the IDN**: the organization's performance is brought forward to the IDN Committee and an appropriate person from that Committee is designated to follow-up personally to determine the cause if any. That person will report back to the IDN Committee who will recommend any action that might be needed. IDN members who receive funds will be required to report to their workgroup. The member and the entire workgroup will then present to the IDN Committee who will recommend a course of action.
- g. Region 2 has ensured **adequacy of the network in serving the behavioral health needs** of the capital region by creating an IDN that crosses a broad spectrum of provider types and engaging them all in workgroups and sub-committees. We have anticipated the needs of the IDN partners and will provide education, support, and mentoring, as needed, to make sure that the whole is working together to meet the needs of the region.

b. Four governance domains

i. Clinical governance:

As described above, the IDN Committee has established a Clinical Sub-Committee chaired by the CMO of Riverbend. All project plans will be subject to review by this committee, which has responsibility for ensuring the development of evidence-based and standard clinical pathways,

working with the HIT/Data workgroup to monitor patient outcomes, and recommending strategies to improve patient outcomes.

ii. Financial governance and funds allocation:

See Question 8.

iii. Data governance:

The IDN Committee has established a Data Sub-Committee, which will work closely with the HIT workgroup. Both entities will be led by the IDN's CTO. The Data-Subcommittee is charged with overseeing data sharing among partners, overseeing data reporting and monitoring processes, and providing a monthly data report to the IDN Committee. The IDN CTO is taking the lead with the state in developing HIT parameters for the DSRIP demonstration. The CTO and Region 2 HIT Workgroup will assess the region's level of integration using Region 2's survey results as well as those of the survey developed by Meyers & Stauffer on behalf of the State. The CTO will lead the development and implementation of the regional HIT plan. The IDN partners have been educated about the need for uniform data collection and have reviewed the data that will be required by the State. They have assented to the process and have provided staff from their IT departments to assist the Data Sub-Committee and the HIT Workgroup.

iv. Community engagement:

The Managing CEO and Project Manager are taking the lead on behalf of the IDN with community engagement activities. Those described in Question 3 will be continued throughout the demonstration and supported by regular reporting to the IDN executive committee and IDN committee. Other community engagement activities will be initiated such as a monthly e-newsletter and the development of materials and presentations that IDN partners can share with their stakeholders.

c. Governance charters

Region 2's IDN Charter is attached. It encompasses all decision-making bodies.

d. Key IDN management roles

Individuals serving in the following roles are identified on the 7D tab of the IDN Project Plan Supplemental Data Workbook: Executive Director, or equivalent; Medical Director, or equivalent; Financial Director, or equivalent

6. Budget and Funds Allocation

a. Project Design and Capacity Building Funds: Final Budget Narrative

2016 Q3 and 4

IDN Managing Chief Executive Officer (CEO) 20% for six months - [REDACTED]

- Responsible for overseeing the development and implementation of the IDN's projects and day to day operations of the IDN; Directly supervises the Project Manager, and represents the IDN at meetings.

IDN Chief Technology Officer (CTO) 10% for six months and Data Support from Concord Regional VNA - [REDACTED]

- Responsible for overseeing all data-related and HIT needs of the IDN and its projects and leading the HIT/Data Workgroup.

IDN Project Manager 75% for six months plus travel - [REDACTED]

- Responsible for managing the process, tasks, and timelines in fulfillment of 1) the development and submission of the project plan proposal and 2) the planning, design, and implementation of the three statewide and three regional project plans; overseeing all workgroup meetings; monitoring process outcomes; writing narrative portions of required reports.

IDN Accountant 40% for three months - [REDACTED]

- Responsible for all accounts receivable and payable; providing account support to Chief Financial Officer

IDN Project Assistant 60% for two months - [REDACTED]

- Responsible for providing administrative support to Project Manager, committees, and workgroups

Office equipment and supplies - [REDACTED]

- Desks, chairs, filing cabinets, computers, phones, supplies for two-person project office.

IDN Committee meeting supplies - [REDACTED]

- Food and beverages for meetings; binders for committee members

Note: For the remaining four years, IDN Region 2 created a budget from the expected incentive funding for administrative oversight, strategic expansion of the overall behavioral workforce, and to support the core integration and three community projects. This required us to create plans before the actual planning period of Jan-June 2017. We had those plans vetted through community meetings with IDN members and concerned or interested community members. We learned enough to know that, while we were certainly on the right track, there was much more to be gained from the months we have ahead of us to finalize those plans. For that reason, we took our remaining project design and capacity building funds and allocated them to modest salary increases in approved budgeted staff (for years 3-5) and to allow the integration and community projects to have an additional pool of funding to expand on the basic premise we developed for those projects. Here are the amounts allocated:

2017

Administrative workforce [REDACTED]
Direct care workforce for Integration [REDACTED]
Direct care workforce for community projects [REDACTED]

2018

5% increase across all staffing established in 2016 and 2017
Administrative workforce [REDACTED]
Direct care workforce for Integration [REDACTED]
Direct care workforce for community projects [REDACTED]

2019

5% increase across all staffing established in 2016 and 2017
Administrative workforce [REDACTED]
Direct care workforce for Integration [REDACTED]
Direct care workforce for community projects [REDACTED]

2020

5% increase across all staffing established in 2016 and 2017

Administrative workforce [REDACTED]

Direct care workforce for Integration [REDACTED]

Direct care workforce for community projects [REDACTED]

b. Project Design and Capacity Building Funds: Final Projected Allocation Estimates

Final projected estimates for the allocation of Project Design and Capacity Building Funds are listed on the 8B tab of the IDN Project Plan Supplemental Data Workbook.

c. 5- year IDN Incentive Funding: Funds Allocation Governance

The Region 2 IDN has approved a budget for all five years and requests for changes beyond 10% of any line item must be placed on the IDN Committee agenda, substantiated through a written report, and approved (or not) by vote of the IDN Committee.

The Project Workgroups will develop project budgets within the parameters established by the five-year budget and further explained in Question 8. These budgets will be reviewed by the Project Manager and CFO. Once approved by them, budgets will be brought to the IDN Committee for approval.

The Region 2 IDN financial infrastructure includes a CFO (Scott Sloane, CFO, Concord Hospital) and accountant (Linda Hoffman) as well as a Finance Sub-Committee of the IDN Committee.

The Finance Committee will monthly, or at agreed upon intervals, and include the CFO from Riverbend and Controller from CRVNA to review detailed financial reports before they are presented to the IDN Committee. These monthly reports will include a balance sheet and income and expenses to date.

Concord Hospital will oversee the financial process of the grant and is well suited for that role. The organization has generated consistent profitability, for more than twenty years and currently holds the highest Hospital bond ratings in the State of NH, according to the rating agencies that review the Hospital (Moody's and Fitch). Concord Hospital is also very well equipped to handle a grant of this nature because it has managed numerous Federal and State grants over the years. Because of these grants the Hospital has been subject to the rigors of A133 audit requirements and has always performed extremely well.

It is the policy of Concord Hospital to maintain a system of internal controls that include both administrative controls and accounting controls. The objective of Concord Hospital's internal control system is to assure management that resources are being used and accounted for appropriately. Administrative controls include the plan of organization, and procedures and records concerned with the decision process leading to management's authorization of transactions. These controls work to assure management the following:

- Resource use is consistent with laws, regulations, and policies
- Resources are safeguarded against waste, loss, and misuse
- Reliable data is obtained, maintained, and fairly disclosed in reports

Accounting controls include the plan of organization, and procedures and records that relate to the safeguarding of assets and the reliability of financial records. Concord Hospital's policy is to establish and maintain controls that provide reasonable assurance of the following:

- Transactions are executed in accordance with management's general or specific authorization
- Transactions are recorded to permit preparation of financial statements to conform with GAAP, or other criteria such as instructions for IRS Form 990 and to maintain accountability for hospital assets

- Access to assets is permitted only in accordance with management authorization
- Recorded accountability for assets is compared with existing assets at reasonable intervals, and appropriate action is taken to reconcile any differences

Any employee who deliberately circumvents an internal control is reported to the hospital Risk Management Department for appropriate action. Legal action will be brought against any employee who violates any state or federal laws while in the employment of Concord Hospital. Additionally, the hospital may pursue legal actions against an employee who violates established laws and /or circumvents internal controls for his/her own gain.

The Region 2 IDN will leverage these financial systems and control processes in place at Concord Hospital but keep the IDN account separate in order to maintain total transparency. Concord Hospital will reconcile this bank account with a different individual than who has access to it through the IDN.

Funds will be paid by the Concord Hospital accounting department from the IDN bank account through an approved invoice process:

- Invoice template will include date sent, Project Manager's signature, pay to / return to information, expense date, expense description, GL account #, and payment amount.
- Invoice to be submitted to Project Assistant by IDN organization occurring expense.
- Project Manager will approve invoices and Project Assistant will submit invoice template to IDN accountant for payment.
- Original invoices will be held by the Project Manager.

Any IDN member receiving funds for programs/services will report on outcomes/measures on a semi-annual basis through the workgroup for that state, core competency, or community project according to the milestones established by the State and/or the Region 2 workforce committee. These reports will go to the Project Manager. Any IDN member receiving funds for programs/services that is not meeting outcomes/measures will present to the IDN Executive Committee, along with their designated workgroup, the potential reasons for not meeting outcomes/measures and a plan for improvement. The IDN Committee will vote to approve any changes in course of action needed.

d. Avoiding Duplicative Payments

We have surveyed the IDN and noted which partners are participating in multiple IDNs. Because payment to these IDNs will be for services rendered in the Capital area, we don't anticipate any duplication of payment. However, the accountant and CFO have been made aware of the potential and have flagged these IDN members to provide additional information about funds received from other IDNs when requesting funds from IDN Region 2.

7. Alternative Payment Models (APMs)

In Region 2, Concord Hospital, Concord Hospital Medical Group, and Dartmouth-Hitchcock (D-H) Concord participate in various alternative payment arrangements with both commercial and governmental players.

Concord Hospital, Concord Hospital Medical Group, Riverbend, and CRVNA all participate in the Accountable Care Organization (ACO) known as NH Accountable Care Partners. NH Accountable Care Partners ACO is a joint venture between five hospitals and ACO professionals. It's a not-for-profit organization based in Concord, NH and founded in 2012.

The ACO consists of more than 1400+ healthcare providers employed by Catholic Medical Center, Concord Hospital, Mid-State Health Center, Riverbend Community Mental Health, Concord Regional Visiting Nursing Association, Elliot Health System, Southern New Hampshire Health System and

Wentworth-Douglass Health System who coordinate the health care of more than 55,000+ Medicare Fee-for-Service beneficiaries in their combined service areas. They are dedicated to promoting improved care coordination, improving patient outcomes and creating a collaborative environment with community partners. This approach ensures patients receive high quality, appropriate care from the right provider at the right time by identifying and addressing problems early.

Working with Medicare, NH Accountable Care Partners ACO provides its beneficiaries with high quality care while reducing growth in Medicare expenditures. This ACO has performed extremely well from a quality perspective and has been cost neutral in terms of savings for Concord Hospital and its affiliates.

In addition to the Medicare shared savings ACO, the organizations participate in shared savings programs with all three major payers in NH. Participation with some dates back for several years. The overall payments made to Concord Hospital and its affiliates by one type of alternative payment method (APM) or another is approximately 52% of total revenue.

D-H participates as an ACO under a variety of APMs. About 28% of D-H's commercial-related unique patients are managed under such programs, or approximately 15% of underlying FFS-based NPSR. Additionally, D-H is a co-founder of One Care Vermont ACO, LLC, along with the University of Vermont Medical Center. D-H also is a co-founder of Benevera Health, LLC, a population health management company that is an insurance/provider partnership with Harvard Pilgrim Health Plan, Elliot Health System, St. Joseph Hospital, and Frisbie Memorial Hospital. D-H was one of the original thirty-two Medicare Pioneer ACOs and participated in this shared risk arrangement for the period 2012-2015. A core long term strategy of D-H is to provide value-based care under comprehensive population based payment arrangements.

D-H has had an electronic data repository in place for over 27 years and continue to build out its reporting and predictive modeling capabilities as the need manage big data becomes ever more critical under alternative payment models. D-H has also focused on a number key efforts to position it for success under APMs: reengineering primary care with an emphasis on team-based medical home processes, including care management and imbedded behavioral health services; the establishment of a separate ACO infrastructure to conduct related activities; creation of the D-H Analytics Institute, which is capable of integrating global claims data and EHR data. D-H has a comprehensive quality outcome reporting system and has strong utilization, cost and \$PMPM reporting tools. Additionally, D-H has significant programs in telemedicine, E-consults (an electronic specialty consult program), and in KnowledgeMap (an electronic care process tool developed by D-H clinicians). D-H's Imagine Care program provides 24/7 nurse-staffed remote monitoring of a comprehensive set of clinical indicators for high risk patients. D-H does not have the capacity to adjudicate and pay insurance claims. Overall, D-H has strong capacity accept APMs, and doing so is consistent with its strategic focus.

Section II: Project-Specific Plans

10. Project A1: Behavioral Health Workforce Capacity Development

- a.** The IDN Workforce project lead and individuals from the IDN participating (or nominated to participate) in the Statewide Behavioral Health Workforce Capacity Taskforce are included on the 10A tab of the IDN Project Plan Supplemental Data Workbook.
- b. Critical workforce capacity challenges facing the IDN.**

The NH Community Behavioral Health Association Workforce Commission gave a presentation September 27, 2016 and share the following statistics:

- Among the nine Community Mental Health Centers, there were 173 Vacant Postings in August 2016, representing \$6.8-7.6M in wages not entering the economy
- On average, the combined CMHCs have 4.1 psychiatric nurse (APRN) vacancies and 4.4 psychiatrist (MD) vacancies per month.
- The wage gap between the CMHCs and the State for APRNs is 4-17% and for MDs 12-29%.
- Across all CMHCs, the average vacancies per month for Bachelors level clinicians is 62.7 and for Masters 67.7
- The wage gap between the CMHCs and the State for Masters Licensed Therapists is 35-57%.
- The average turnover rate for CMHCs is 18.94% (Riverbend is 13.16%)
- The length of time to fill postings is on average 113 days.

The impact on the CMHCs:

- Lower staff morale
- Increased turnover
- Increased locums and overtime
- Increased overall cost of recruitment activities
- Increased training costs
- Decreased Center reputation
- Decreased FFS revenues
- Risk of losing capitation due to not meeting Maintenance of Effort
- Jeopardizes ability to meet CMHA requirements

The risk to patients:

- Lack of individualized care
- Decreased timely access
- Increased wait list
- Reduced continuity of care and EBPs
- Decreased quality of care

Behavioral health workforce issues are driven by a number of factors, chiefly the fact that Medicaid rates have not risen since 2006 and have taken two cuts since then. This makes it hard to retain staff who are lured away by other providers who can pay higher salaries. Some of those providers are hospitals, school systems, insurance companies who manage mental healthcare delivery, and private practice for licensed clinicians who see patients with commercial insurance. They are also not burdened by the enormous paperwork requirements that are required for States contracting with Community Mental Health Centers. In addition, New Hampshire has very arcane license reciprocity agreements with other States. This is a real disincentive to anyone relocating to the State.

c. Strategies the IDN anticipates it will deploy to address these challenges and how the statewide planning process will support the IDN in addressing these challenges at the IDN level.

The IDN is participating in the Statewide Behavioral Health Workforce Capacity Development Taskforce and has encouraged DHHS to advocate on behalf of all of the IDNs to the State to relax reciprocity requirements with other states and to expand loan forgiveness throughout the state as a way of maintaining clinicians in the workforce. It is hoped that the proposed framework to be established by the Statewide Behavioral Health Workforce Capacity Taskforce will assist this IDN with developing and implementing a strategy for addressing its workforce issues. At present, we

have an inventory of workforce data, initiatives and activities that the State has compiled on our behalf.

The following proposed solutions were offered by the NH Community Behavioral Health Association Workforce Commission September 27, 2016 presentation:

Financial policies:

- Increase Medicaid rates beyond 2006 levels
- Expansion of student loan forgiveness programs
- Provide incentives for graduate education
- Provide funding for Fair Labor Standards Act (FLSA) regulation

State policies:

- Remove impediments to licensing of out-of-state providers such as allowing reciprocity
- Reduce administrative burden (e.g., mandated Center paperwork vs. private practice) for patient intake and other reporting functions
- Eliminate silos within NH DHHS (e.g., SUD clinician paperwork)

Federal policies:

- Ask Centers for Medicare and Medicaid Services(CMS) to allow licensed professionals to sign treatment plans for services within credential scope; State would then update its rules
- Modify telehealth payment rules to reflect physician shortages in all geographies, not just rural
- Eliminate "incident to" Medicare billing requirements for physician on-site

Shared CMHC practices:

- Assertive Community Treatment (ACT) learning collaborative
- Online training programming
- Work with the State to develop a plan for ensuring state competitiveness
- Ongoing data collection and benchmarking

11. Project A2: Health Information Technology (HIT) Infrastructure to Support Integration

- a. The IDN HIT Lead and participants are listed on the 11A tab of the IDN Project Plan Supplemental Data Workbook.
- b. **IDN 2's critical HIT gaps, including gaps related to community based organizations**

IDN region 2 participants have a wide gap of information technology capabilities and needs. A short survey was conducted amongst participants. Sixty-five percent use an electronic medical record (EMR). There are seven different vendors in use across the IDN of those who responded. Those that use an EMR are the hospitals, community mental health center, physician practices, and home health. The participants that do not use an EMR appear to be community service providers.

Out of all responding participants, only one agency has implemented a secure texting application for their staff. Secure texting allows for secure quick communication from provider to provider but also allows for secure text messages to be sent to patients.

None of the respondents have an electronic notification system in place to be alerted if their patient is admitted or discharged from the hospital, emergency department, or from other providers.

Only fifty-five percent of respondents are able to receive referral information electronically. When meaningful use was put into place, there were no provisions required for post-acute or community

providers to be able to receive documents electronically. This is an issue for those hospitals and physician practices who are trying to send electronically.

Eighty percent of respondents have staff who are mobile. Out of the eighty percent, seventy-eight percent have laptops. Twenty-two percent have mobile staff without access to data. Out of the seventy-eight percent that have laptops, eighty-eight percent can connect and receive data while out in the field.

Pagers have decreased in use over the years with forty-five percent of the respondents still using pagers. Out of the forty-five percent using a pager, thirty percent are using a mobile app to receive pages.

Respondents were asked to provide what they perceived as the gaps in health information technology for themselves and the region. Their responses:

- Secure electronic transfer of documents
- Integration of lab and test results-ability for EMR to consume data
- E-prescribing
- Alert notifications for ADT
- Interoperability with insurance payers
- Ability to see data from all settings in one patient record
- Lack of appropriate EMR for SUD charting
- Secure communication amongst providers
- Care coordination gaps
- Transitions of care -- currently there is a great deal of faxing, inefficient handoffs
- Lack of knowledge of where the patient is within the system
- Inability of providers to communicate securely with each other

c. IDN 2 anticipates that participation in the statewide planning process will support the IDN in addressing these gaps at the IDN level

There are several ways that identified HIT gaps can be lessened. Some require consensus amongst many and others can be implemented independent of each other.

Direct Messaging

Forty-five percent responding to our survey did not have a secure means to receive or send patient information. This technology can be implemented independently. Because there are standard protocols, each organization can select their own vendor. The vendor can have a standalone direct messaging product or it can be one integrated with the EMR. The IDN HIT workgroup can assist in educating providers on the products that exist. The IDN can promote the need for connection and evaluate if financial or technical assistance is needed to implemented. Once all members have implemented direct messaging, the use must be promoted and work flows evaluated and developed.

Secure Text Messaging

Many IDN members (68%) expressed the need for secure texting. Many patients are asking to be receive text messages instead of phone calls. Text messaging is also helpful between peers managing a specific patient case. Text messaging doesn't require a consensus to select a product. But those wishing to cross over to texting staff in other organizations would need to select the same product. The IDN workgroup can assist in educating its members on the features and use of secure texting and evaluate if technical or financial support is needed to implement the product.

Admission, Discharge, Transfer alerts

This type of product is only reliable if all providers are using the same product. This is one area where the HIT workgroup can assist in evaluating and obtaining consensus amongst members to select and implement a product. A statewide master patient index is also needed. Seventy-five percent of the responding IDN members identified this as a need. Understanding where the patient is, and being able to provide appropriate medical documentation can help improve outcomes and decrease cost of care.

Care Coordination

Another common theme is the need for care coordination across providers and the Emergency Department (ED). Implementing a product that would assist in improving the ED's knowledge of the patient would also improve outcomes and decrease costs. Many times, the ED is treating a patient without their medical record. As well, once discharged, the community providers do not receive enough information to provide continuity of care. Care Coordination would also require some type of state repository to support a query and retrieval of patient information. Currently that is not possible through the state designated HIE unless legislative changes are made.

Community Referrals

There is a need to establish an electronic referral system to community resources. Often referrals are lost in the system or providers rely on the patient to initiate the community resource. A statewide community resource directory with electronic referral ability could improve patient care. This could be a statewide HIT task item.

Patient Portal

Patient portals are becoming more common but a patient may have too many to log on to, and therefore stops using them. Developing a statewide patient portal could assist in providing education and care coordination to the patient.

Education

Not all providers have equal levels of knowledge regarding interoperability, direct messaging, secure texting, and other various HIT technologies. The IDN workgroup will need to provide education to its members and encourage the use of technology to stream line processes. The IDN may need to provide resources in order to assist smaller organizations with implementation.

12. Project B1: Integrated Health (Core Competency)

- a. Current-state Assessment of Network:** A preliminary, high-level assessment of current integration levels among all primary care, mental health, and substance use disorder providers in the IDN, using the factors indicated, are included on the 12A tab of the IDN Project Plan Supplemental Workbook.
- b. Participating Organizations and future-state goal (Coordinated Care level or Integrated Care level):** All primary care, mental health, and substance use disorder providers in the IDN are listed and designated as working toward a Coordinated or an Integrated Care Practice on 12B tab of the IDN Project Plan Supplemental Workbook.
- c. Monitoring Plan**

The Region 2 IDN has an Integration Workgroup who has been charged with monitoring the *progress of integration* using the SAMHSA-HRSA Center for Integrated Health Solutions' (CIHS) Standard Framework for Levels of Integrated Healthcare. Our integration plan includes Concord Hospital Medical Group (9 practices) and Substance Use Services, Dartmouth-Hitchcock Concord, and

Riverbend. We have ensured that decision-makers from these organizations are on the workgroup. We are also in communication with the practice managers from each facility. As described elsewhere, Riverbend and Concord Hospital Family Health Center and Substance Use Services have been working on a PBHCI integration project for one year. We will build upon the ongoing lessons learned from that project and apply them to the new partners. We anticipate that education will be a key element of the integration project as it is for the PBHCI project. We have already developed a trove of resources that we can share with the IDN members. The IDN Project Manager will also provide monthly newsletters for the IDN that include links and other to assist them with the implementation of the project. Leaders from each organization will be given the tools to champion the project at their facilities.

Because we are still in the plan to plan aspect of this project, we don't have all of the specific day to day monitoring worked out completely but envision that it will involve frequent behavioral health and primary care team meetings to:

- Discuss cases, monitor participation with individualized treatment plans, and ensure that plans include client-centered objectives that are inclusive of both physical and behavioral health goals.
- Ensure that plans establish coordination of care procedures with community providers.
- Conduct gap-in-care analysis to ensure that strategies to address behavioral health, primary care, and health/wellness elements are implemented.
- Establish effective practices for medication management and medication adherence.
- Identify barriers to achieving integrated health goals.

In addition, we anticipate the use of daily huddles to:

- Check for clients on the schedule that may require more time/assistance due to age, disability, personal demeanor, etc. and determine who best can help.
- Determine if any clients need a behavioral health person present.
- Check for back-to-back lengthy appointments, such as physicals, and provide suggestions for preventing backlog.
- Determine if there are openings that can be filled or chronic no-shows scheduled.
- Check provider and staff schedules and determine if anyone needs to leave early or break for a phone call or meeting.
- Ensure that lab results, test results, and notes from other physicians are ready and in the client's chart.

It is our hope and expectation that shared HIT practices will also contribute to better outcomes.

We will implement a standard evaluation tool (to be developed) based on the expected DHHS outcome metrics. Report results will be shared with the IDN Committee. The Clinical Sub-Committee (comprised of medical directors from the hospitals and Riverbend) is responsible for making recommendation for changes in course to improve patient outcomes, after consulting with workgroups and practices.

d. Expected Outcomes

Using data provided by NH BDAS Capital Area SUD Continuum of Care Assets and Gaps Report, 2016; Concord Hospital/Riverbed SUD Treatment Group interviews, 2016; Region 2 IDN Surveys distributed September, 2016; and the Capital Region Community Health Needs Assessment, Concord Hospital, 2012, we believe that our projects will result in the following outcomes:

- Onsite behavioral health specialists leading to reduced wait time.

- Suicide prevention education and depression screening through primary care providers in the region leading to early treatment and intervention.
- Substance misuse prevention programs through CRPHN and SUD Continuum of Care leading to fewer adolescents with SUD.
- Increase in psychiatrists leading to reduced wait time and earlier intervention and treatment of mental health needs through support to Primary Care Providers.
- Enhanced patient engagement in the integrated plan of care and improved utilization of treatment resources.
- More sustained recovery through increase and availability of adult and youth behavioral health peer coaches.
- Behaviorists embedded in primary care addressing stigma and encouraging increased use of primary care services leading to prevention, treatment, and reduction of symptoms related to cardiovascular disease, diabetes, and respiratory disease.
- Smoking cessation programs leading to prevention, treatment, and reduction of symptoms related to cardiovascular and respiratory disease.
- Behaviorists embedded in primary care addressing stigma and encouraging increased use of primary care services leading to decreased use of emergency room for non-urgent needs.
- Availability of MAT services onsite at primary care leading to earlier treatment of SUD.
- Availability of Behaviorists onsite at primary care leading to earlier treatment of MH, SED, and SMI.
- Partnership with refugee and language assistance organizations leading to greater accessibility to services for new Americans and those for whom English is not their first language.
- Decrease in numbers of adult and youth high-utilizers because of integrated primary and behavioral health care, well-managed care transitions, and coordinated community based care options.
- Less provider confusion about available resources with integrated and coordinated care.
- Behavioral health education for physicians leading to less stigma and earlier identification and treatment of behavioral health needs.

From the Capital Area Community Health Improvement Plan, 2015-2020, the Region 2 IDN is aligned with the following goals and objectives:

Goal: PREVENT AND REDUCE SUBSTANCE MISUSE (INCLUDING ALCOHOL, MARIJUANA, PRESCRIPTION DRUGS) AMONG YOUTH AND YOUNG ADULTS (12-34) IN THE CAPITAL AREA BY 2020.

Objectives

- Decrease access to alcohol (among underage population), marijuana and prescription drugs (without a doctor's prescription) among youth and young adults
- Increase the percentage of youth and young adults (12-20) who report talking with at least one of their parents or guardians about the dangers of tobacco, alcohol, or other drug use.
- Increase the percentage of youth and young adults (12-20) who report that their parents or other adults in their family have clear rules and standards for their behavior.
- Increase the percentage of youth and young adults (12-34) who think people are at great risk of harming themselves (physically or in other ways) if they....
 - have five or more drinks of alcohol (beer, wine, or liquor) once or twice a week;
 - use marijuana once or twice a week;
 - take a prescription drug without a doctor's prescription.
- Decrease the percentage of youth and young adults (12-34) who misuse substances for the purposes of "self-medicating."

- Increase health equity by creating social and physical environments that promote good health for all across the Capital Area.
- Decrease the discrepancy that exists between perceptions of peer use and actual use of substances among youth and young adults (12-24).
- Increase the perception of peer, parental, and community disapproval for substance misuse among youth and young adults (12-34).
- Increase community knowledge of and access to resources available to address substance misuse across the continuum of care (prevention, intervention, treatment, recovery) among all populations.

Goal: DECREASE THE NUMBER OF DRUG-RELATED OVERDOSE DEATHS IN THE CAPITAL AREA AMONG ALL AGE GROUPS BY 2019.

Objectives:

- Increase community knowledge of and access to resources available to address substance misuse across the continuum of care (prevention, intervention, treatment, recovery) among all populations
- Increase access to and education regarding the use of Naloxone by healthcare providers and community members.
- Increase knowledge among community members regarding Good Samaritan law.

Goal: PROMPTLY RESPOND TO AND PREVENT HARMS ASSOCIATED WITH EMERGING DRUG THREATS IN THE CAPITAL AREA.

Objectives:

- Increase data collection and monitoring efforts among key stakeholders and sectors to identify and track emerging issues of concern related to substance misuse.
- Increase the capacity of key stakeholders and sectors to identify, proactively address, and respond to emerging issues of concern related to substance misuse.
- As emerging issues arise, follow the Strategic Prevention Framework to develop and implement appropriate, research-based strategies to address concerns.

Goal: IMPROVE ACCESS TO A COMPREHENSIVE, COORDINATED CONTINUUM OF BEHAVIORAL HEALTH CARE SERVICES IN THE CAPITAL AREA BY 2020.

Objectives:

- Increase access to affordable insurance coverage.
- Increase access to behavioral health supports in primary care settings.
- Decrease rates of emergency room visits or hospitalizations that could have been prevented.
- Increase awareness of available services across the continuum of care.
- Increase the number of services across the continuum of care to address unmet needs.

e. Challenges and Proposed Solutions

SAMHSA-HRSA's Center for Integrated Health Solutions' Standard Framework for Levels of Integrated Healthcare indicates the following weaknesses of an Integrated Health Care Model at each state of its development. Riverbend Concord Hospital have found these to be true while implementing the PBHCI project.

Level 1 - Minimal collaboration

- Services may overlap, be duplicated or even work against each other
- Important aspects of care may not be addressed or take a long time to be diagnosed

Level 2 - Basic collaboration at a distance

- Sharing of information may not be systematic enough to effect overall patient care
- No guarantee that information will change plan or strategy of each provider
- Referrals may fail due to barriers, leading to patient and provider frustration

Level 3 - Basic collaboration onsite

- Proximity may not lead to greater collaboration, limiting value
- Effort is required to develop relationships
- Limited flexibility, if traditional roles are maintained

Level 4 - Close Collaboration onsite with some system integration

- System issues may limit collaboration
- Potential for tension and conflicting agendas among providers as practice boundaries loosen

Level 5 - Close collaboration approaching an integrated practice

- Practice changes may create lack of fit for some established providers
- Time is needed to collaborate at this high level and may affect practice productivity or cadence of care

Level 6 - Integrated practice

- Sustainability issues may stress the practice
- Few models at this level with enough experience to support value (this is changing with the implementation of PBHCI practices)

One of the primary ways to address these challenges is communication, communication, communication. Region 2 will have frequent meetings and educational opportunities for participant providers during the planning phase. It will be stressed that this is a transformational process and not simply a new project and that sites need to educate everyone in their practice. We will work with the site managers to develop and present educational opportunities for all staff. During implementation, education will continue through site visits. Onsite staff will be expected to meet regularly including during daily huddles. The exact timing and process for these meetings will be developed during the planning process.

f. Implementation Approach and Timing

A short description of the IDN's planned approach to accomplishing these project requirements is included on **12E tab of the IDN Project Plan Supplemental Workbook**.

13. Community-driven Projects

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

a. Project Selection Rationale and Expected Outcomes

The Merrimack County Department of Corrections (MCDOC) and Riverbend applied for a Second Chance Act grant from the Department of Justice, Bureau of Justice Assistance for a Reentry Program for Adults with Co-Occurring Substance Abuse and Mental Disorders. Funding results have not been posted yet. In light of the community needs assessment indicating a high need for a continuum of behavioral health needs in the reentry community, the IDN decided to focus on reentry and either expand (if funded) or initiate the Reentry Program at the County House of Corrections. This program will provide both pre-

and post-release services. Pre-release: MCDOC will assess for risk/needs and determine dosage and intensity of aftercare plans using the Ohio Risk Assessment System (ORAS). Within 30 days of release, Riverbend will provide a comprehensive diagnostic and psychosocial assessment and develop a fully individualized, integrated reentry treatment plan that includes each client's reentry requirements, referrals to services, and personal goals. Post-release: Participants will receive an individualized combination of the following: 1) Intensive case management, 2) SUD services to include, as needed, MAT, IOP, counseling, groups, and linkage to AA/NA or other community recovery support services, 3) MH services to include, as needed, psychiatric services, medication management, counseling, Intensive Family Support Services (IFSS), therapeutic behavioral supports, groups, and linkage to community recovery and support services, 4) Identification of health issues and linkage to primary health care, 5) IPS Supported Employment services, 6) Wellness Activities including InSHAPE, 7) Benefits assistance including SOAR, 8) The continuation of evidence-based curriculums begun pre-release, Thinking For a Change and A New Direction, and 9) Community Supervision. The purpose of the program is to ensure that the transition that medium- to high-risk individuals with CODs make from the MCDOC facility to the community is successful and promotes both long-term recovery and public safety.

When the community and IDN members met to discuss this project, it was decided to include those coming from the State Prison to resettle in Concord as well as youth exiting from Sununu Youth Services Center. The IDN feels that while the numbers of these will be low, the needs will be intense. Most of those released from State Prison have maxed out their sentences and spent a significant amount of their incarceration in solitary confinement. Youth from Sununu Youth Services Center are likely to have multiple, complex needs.

Overall, we expect the reentry program to improve behavioral health and social outcomes for youth and adults transitioning from correctional facilities to the community. Specific and detailed plans, as well as outcomes, for the reentry program will be developed during the planning period January - June 2017.

Please see 12 D for overall outcomes expected from the combination of integration and community projects selected.

b. Participating Organizations: Selection Criteria

Because of the focus on behavioral health needs and the breadth of experience, programs, services, and linkages Riverbend has in the Concord area, the IDN has agreed that the majority of the staff required for the integration and community projects will be hired and supervised by Riverbend. Funds for services and supports will also go to IDN members participating as provider sites in the projects. Final details regarding key organizational/provider participants will be developed during the planning period January - June 2017.

As was mentioned in response to 4b, the Reentry workgroup includes representatives from the IDN who provide behavioral health treatment as well as those who will support the housing, benefits, recovery, wellness, and community integration needs of the population. The chair of this workgroup is the Assistant Superintendent of the House of Corrections. She has great facilitation skills and relationships with staff at the State Prison and the Sununu Youth Services Center. Reentry workgroup members were self-selected as wanting to participate in planning and implementing the program and/or providing the array of services required for the Reentry Project.

c. Participating Organizations: List of Organizations

Organizations participating in each of the community projects, their type and role in the project, is included on **13, 14, and 15D tabs of the IDN Project Plan Supplemental Workbook**

d. Monitoring Plan

As indicated in the materials from DHHS, an evaluation plan, including metrics that will be used to measure program impact, and mechanisms (e.g., registries) to track and monitor individuals served by the program, adherence, impact measures, and fidelity to evidence-supported project elements will be developed during the design and development of clinical services infrastructure scheduled for January - June 2017. Region 2 IDN has agreed to work with a consultant with national expertise in developing, monitoring, and evaluating performance outcome measures for reentry programs.

At a minimum, we will track the following indicators:

- Number of individuals served (during reporting period and cumulative), vs. projected
- Number of staff recruited and trained (during reporting period and cumulative), vs. projected
- Staff vacancy and turnover rate for period and cumulative vs projected
- Impact measures as defined in evaluation plan, including annual evaluation of fidelity to evidence-supported program elements
- Impact measures as defined in evaluation plan

e. Challenges and Proposed Solutions

The challenges in implementing the Reentry project are similar to those in implementing all of the projects: time, technology, and the availability of workforce.

The first challenge is that it takes time to realize results in projects and the time allotted for the demonstration might not be enough.

In anticipation of the time involved in developing and implementing the plans for the community projects, the IDN has approved stipends as incentive for workgroup chairs. People assigned or self-selected to participate on workgroups have been given a realistic estimate of the time and work involved. In addition, the IDN is providing project management support to each workgroup through a Project Manager and Project Assistant.

Ensuring that all of the participating organizations have the necessary technology and skills to maintain client records and record and track outcomes is a challenge we hope will be addressed through the statewide HIT taskforce and the regional HIT planning and implementation.

Workforce challenges may stall the implementation of programs. There is already a lack of qualified behavioral workforce in the State and with the DSRIP demonstration, we will be competing with the entire State to hire the staff needed to implement the projects. It is hoped that the Behavioral Health Workforce Development task force will address these issues and make recommendations for how to approach this on a regional level.

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

a. Project Selection Rationale and Expected Outcomes

This community project was chosen to increase access to MAT programs through primary care offices and clinics and our region. With the integration plan providing a behaviorist at nine primary care locations, the IDN felt it supported that integration while also meeting the identified needs of the community to train, incentive, and mentor two physicians at each of those same practices to implement MAT. The MAT program will also use SUD peer recovery coaches. This integration of mental health and SUD treatment within the primary care setting will allow for greater patient access to treatments, reduce stigma, and educate physicians about the best ways to assist their patients with behavioral health disorders. Region 2 IDN will also provide an MAT physician to travel throughout the region and

provide MAT and warm linkages to community recovery and support services for pregnant women in a Neonatal Abstinence Syndrome prevention program.

Please see 12 D for overall outcomes expected from the combination of integration and community projects selected.

b. Participating Organizations: Selection Criteria

The behaviorists for this program will be hired and supervised by Riverbend. Physicians to be trained, incentivized, and mentored are already hired. Mentoring will be provided by the Addiction Specialist Physician at Family Health Center in Concord. Community-based organizations offering recovery and other services and supports will also be included. Final details regarding key organizational/provider participants will be developed during the planning period January - June 2017.

As was mentioned in response to 4b, the MAT workgroup includes members of the SUD Continuum of Care workgroup, representatives from the primary care sites, CAPHN, and community based recovery and support services organizations. The addiction specialist physician at the Family Health Center in Concord is chairing the workgroup.

d. Monitoring Plan

As indicated in the materials from DHHS, an evaluation plan, including metrics that will be used to measure program impact, and mechanisms (e.g., registries) to track and monitor individuals served by the program, adherence, impact measures, and fidelity to evidence-supported project elements will be developed during the design and development of clinical services infrastructure scheduled for January - June 2017. Region 2 IDN has agreed to work with a consultant with national expertise in developing, monitoring, and evaluating performance outcome measures for reentry programs.

At a minimum, we will track the following indicators:

- Number of individuals served through MAT program (during reporting period and cumulative), vs. projected
- Number of MAT program staff recruited and trained (during reporting period and cumulative), vs. projected
- Impact measures as defined in evaluation plan, including annual evaluation of fidelity to evidence-supported program elements
- MAT program staff vacancy and turnover rate for period and cumulative vs projected
- Impact measures as defined in evaluation plan
- Proportion of MAT patients with urines positive for illicit opioids in first month, 3rd month, 6th month and 12th month of their treatment
- Proportion of MAT patients with urines positive for prescribed non-MAT opioids in first month, 3rd month, 6th month and 12th month of their treatment
- Past 6-month number of opioid-related deaths in IDN region

e. Challenges and Proposed Solutions

The challenges in implementing the MAT project are similar to those in implementing all of the projects: time, technology, and the availability of workforce.

The first challenge is that it takes time to realize results in projects and the time allotted for the demonstration might not be enough.

In anticipation of the time involved in developing and implementing the plans for the community projects, the IDN has approved stipends as incentive for workgroup chairs. People assigned or self-

selected to participate on workgroups have been given a realistic estimate of the time and work involved. In addition, the IDN is providing project management support to each workgroup through a Project Manager and Project Assistant.

Ensuring that all of the participating organizations have the necessary technology and skills to maintain client records and record and track outcomes is a challenge we hope will be addressed through the statewide HIT taskforce and the regional HIT planning and implementation.

Workforce challenges may stall the implementation of programs. There is already a lack of qualified behavioral workforce in the State and with the DSRIP demonstration, we will be competing with the entire State to hire the staff needed to implement the projects. It is hoped that the Behavioral Health Workforce Development task force will address these issues and make recommendations for how to approach this on a regional level.

In addition, specific to this project, it might be difficult to convince primary care providers to this work given the high productivity demands on them and the stigma attached to providing care to this population.

E5: Enhanced Care Coordination for High-Need Populations

a. Project Selection Rationale and Expected Outcomes

This community project was chosen to develop comprehensive care coordination and management services for high need adult and child populations with multiple physical health and behavioral health chronic conditions. These services are intended to maintain or improve functional status, increase capacity to self-manage, eliminate unnecessary clinical testing, address the social determinants creating barriers to health improvement, and reduce the need for acute care services.

As described in 4b, the IDN developed a plan to address the enhanced care coordination of high needs populations during a very well-attended IDN and community meeting. Attendees at the meeting discussed and decided to focus on the very complex needs of youth and adults who present with multiple needs including developmental disabilities, SED, SMI, and co-occurring SUD and chronic health issues.

The foundation of the plan is to provide intensive care coordinator to identify high utilizers and convene key providers, meaning anyone involved in the child's psychiatric, educational, or primary care needs. At this meetings, the providers and intensive care coordinator as well as family members (if adult client approves) to discuss:

- Recent comprehensive core assessment results and any emergent medical or primary health needs
- Typical presentation while in psychiatric crisis: For example, what behaviors will s/he typically present with when decompensated? Are there "red flags," that the client is in need of acute psychiatric intervention? What is the baseline in comparison to his/her behaviors and mental status during a crisis?
- Strategies for intervention: Includes sharing information regarding what approaches have been helpful in the past. Are there specific clinical areas we should be sure to address or avoid? How might we increase our chances of successfully addressing the behavioral, developmental, and medical health needs of the client and his/her family?
- Desired providers: Who has worked successfully with the client in the past? Who is connected with one or all of the his/her current providers? It will also be helpful to obtain information regarding unsuccessful treatment experiences with past providers.

From this, a care plan will be developed for each enrolled patient and the intensive care coordinator will provide services that facilitate linkages and access to needed primary and specialty health care, prevention and health promotion services, mental health and substance use disorder treatment, and long-term care services, as well as linkages to other community supports and resources. Peers will assist with transitions and provide support. The care plan will be revisited as needed and the intensive care coordinator will reconvene the provider team meeting on a regular, to be determined, basis and as needed, if to be developed outcomes aren't met.

Please see 12 D for overall outcomes expected from the combination of integration and community projects selected.

b. Participating Organizations: Selection Criteria

The Intensive Care Coordinators for this program will be hired and supervised by Riverbend. Community-based organizations offering recovery and other services and supports will also be included. Final details regarding key organizational/provider participants will be developed during the planning period January - June 2017.

As was mentioned in response to 4b, the ECC workgroup is comprised of IDN members from behavioral health and primary care treatment providers, peer and advocacy groups, schools, case management and home visiting providers who focus on seniors and those with developmental disabilities, refugee and language assistance organizations, and community organizations who provide support for housing, benefits, and wellness.

d. Monitoring Plan

As indicated in the materials from DHHS, an evaluation plan, including metrics that will be used to measure program impact, and mechanisms (e.g., registries) to track and monitor individuals served by the program, adherence, impact measures, and fidelity to evidence-supported project elements will be developed during the design and development of clinical services infrastructure scheduled for January - June 2017. Region 2 IDN has agreed to work with a consultant with national expertise in developing, monitoring, and evaluating performance outcome measures for reentry programs.

At a minimum, we will track the following indicators:

- Number of individuals served (during reporting period and cumulative), vs. projected
- Number of staff recruited and trained (during reporting period and cumulative), vs. projected
- Staff vacancy and turnover rate for period and cumulative vs projected
- Impact measures as defined in evaluation plan, including annual evaluation of fidelity to evidence-supported program elements

e. Challenges and Proposed Solutions

The challenges in implementing the ECC project are similar to those in implementing all of the projects: time, technology, and the availability of workforce.

In anticipation of the time involved in developing and implementing the plans for the community projects, the IDN has approved stipends as incentive for workgroup chairs. People assigned or self-selected to participate on workgroups have been given a realistic estimate of the time and work involved. In addition, the IDN is providing project management support to each workgroup through a Project Manager and Project Assistant.

Ensuring that all of the participating organizations have the necessary technology and skills to maintain client records and record and track outcomes is a challenge we hope will be addressed through the statewide HIT taskforce and the regional HIT planning and implementation.

Workforce challenges may stall the implementation of programs. There is already a lack of qualified behavioral workforce in the State and with the DSRIP demonstration, we will be competing with the entire State to hire the staff needed to implement the projects. It is hoped that the Behavioral Health Workforce Development task force will address these issues and make recommendations for how to approach this on a regional level.

f. Implementation Approach and Timing

A short description of the IDN's planned approach to accomplishing each set of required project milestones for each of its three selected Community Driven Projects is included on **13, 14, 15 G tabs of the IDN Project Plan Supplemental Workbook**.