

Question 1

Please provide a narrative describing the IDN's vision and theory of action as to how it plans to measurably and significantly improve outcomes for the behavioral health (mental health and/or SUD) population within the IDN Service Region. In addition to the role of individual projects, the response should articulate how the IDN's program as a whole, across projects, will holistically address the Service Region's behavioral health gaps. Please see the draft Project and Metrics Specification Guide for additional detail on the specific outcome metrics targeted for improvement as part of this demonstration.

Network4Health's vision is one where all residents—regardless of income, race, ethnicity, language, ability, gender, or identity—have access to affordable, high-quality, person-centered integrated medical and behavioral health (BH) services that promote the highest possible level of wellness, health, and functioning. It is our goal that all Medicaid members in Region 4 are treated with dignity and respect, are active participants in their care, and are able to access the right care at the appropriate time, and in the right setting. Our vision is consistent with the Results-Based Accountability framework, which is currently used by the City of Manchester Department of Health and brings rigor to decision-making to ensure meaningful investments and outcomes.

Medicaid members with behavioral health needs will benefit from a more integrated approach to care that includes primary care, BH care, and services that address the social determinants of health. To fulfill our vision, Network4Health partners include mission-driven medical, behavioral health, and community-based social services providers with expertise serving vulnerable populations. These organizations share a commitment to obtain the best health outcomes for this population, and will work together to help drive systemic change.

Network4Health is prepared to implement the three required community projects to advance broad-based system changes. The projects were selected to address the identified gaps in behavioral health care in Region 4. Our partners will work collaboratively to transform the way we serve our patients and make changes to the delivery of care for members with substance use and co-occurring disorders. Network4Health will measurably improve outcomes for individuals with BH conditions by:

- providing necessary community supports and services to vulnerable populations as they transition from institutions to the community via the Critical Time Intervention (CTI) project;
- expanding services for those with co-occurring disorders, such as partial hospitalization and IOP programs; and,
- establishing evidence-based, person-centered programs aimed at addressing the multifaceted and complex health and social needs of individuals with co-occurring disorders.

The combination of the statewide projects to improve workforce capacity and access to health information technology, the BH integration project, and the three community projects described above, will together transform healthcare in our region. Together these projects will (1) holistically improve how individuals interact with the system by improving access to care by addressing workforce gaps and health information technology, as well as by expanding treatment options, and (2) better support

individuals with BH issues by focusing on the integration of physical and behavioral health for the entire Medicaid population, and by educating providers on the identification and treatment of members with co-occurring disorders. Network4Health has specifically selected projects that are scalable across organizations and sustainable after DSRIP funds expire, assuming a viable APM framework has been implemented.

When these projects are fully implemented, Network4Health anticipates achieving the following outcomes for our Medicaid population:

- reduced inpatient hospitalizations for substance use disorders;
- reduced readmission rates for those discharged from mental health inpatient or residential rehabilitation programs; and,
- lower inappropriate ED utilization among patients with co-occurring disorders.

Question 2a

Please provide a narrative that describes the implications of this disease prevalence (and any other relevant IDN Service Area) data for the IDN and its Project Plan.

A number of data sources were used to respond to this question including multiple community needs assessments (CNA) and health improvement plans for our region, Medicaid data, and other state wide data sources. Findings from our focus groups are reported in our response to question 3. All sources used were consistent in their identification of disease burden and prevalence in the region. The most pressing health problems identified were behavioral health (BH) conditions; including substance misuse and addiction, mental health, suicidal behavior, co-occurring illness, and co-morbidities with physical health.

Behavioral Health

Our region is experiencing an increase in the incidence of behavioral health conditions. The Medicaid utilization data for our region, finds that nearly one-half (46%) of the adult (19–64) Medicaid population has a behavioral health condition with a higher prevalence in females than males (49% and 41%). One-third (33%) of youth aged 11–17 have a behavioral health condition, with a slightly higher rate for males than females (34% and 31%). Behavioral health conditions left untreated often lead to costly emergency department (ED) utilization. Medicaid data indicate that 41% of Medicaid members with a BH condition had at least one ED visit compared to 22% of members without a BH condition. Moreover, 7% of members with a BH condition had at least four ED visits in a year, as compared to 1% of members without a BH condition. In adults, those with a BH condition used the ED for ambulatory care sensitive conditions 23% more than those without a BH condition.

Substance misuse and alcohol

The Greater Manchester region is experiencing exponential growth in the incidence of substance use. As noted in the 2016 Greater Manchester CNA, New Hampshire has the highest per-capita drug rate in New England and the third-highest in the nation. Substance use contributes to both acute and chronic disease and injury, and is associated with destructive social conditions, including family dysfunction, lower prosperity, domestic violence, and crime. It is also deadly. In 2015, 439 people died from a drug overdose in New Hampshire, a 60% increase from 2013. Manchester has the highest rates of overdose deaths and Narcan administration in New Hampshire. From June 2015 through May 2016, EMS/Narcan administration for Manchester was over 500. In addition to drug use, alcohol abuse also is problematic in our Medicaid population. We reviewed utilization data from the State for our region and found within combined substance use- and alcohol use-related ED visits, 42% were substance use-related while 58% were alcohol related.

Reduction of “substance misuse and addiction through prevention, treatment and recovery” was identified as among the five priorities of the Greater Manchester Regional Public Health Network. Moreover, as part of the CNA process, CMC and Elliot reviewed data from their communities and

identified substance misuse/addiction and mental health care as the number one and two problems in the populations they serve.

Co-occurring illness

Regarding co-occurring disorders, according to the Centers for Medicare and Medicaid Services (CMS), “Individuals with mental health conditions experience substance use disorders (SUDs) at a much higher rate than the general population.” They further note that individuals with the most serious mental illnesses have the highest rates of substance use disorders. A 2009 study of Medicaid claims in New Hampshire indicated that “10.8% of all Medicaid members have a mental health condition with secondary substance abuse disorders or co-occurring disorders. Of these, the depression categories such as Major Depression, Bipolar & Other Affective Psychoses and Depression NEC, when combined, comprise the greatest percentage (41%) of Medicaid recipients with secondary substance abuse disorders.”

Suicide

There are strong relationships between behavioral health and suicidal behavior. Despite extensive suicide prevention efforts in the State, the 2016 Greater Manchester, New Hampshire Health Improvement Plan reports that suicide remains the second leading cause of death among New Hampshire youth and young adults up to age 34, and it is the fourth leading cause of death for adults up to age 55. Suicide results in nearly 15 times more deaths in the State than homicide, resulting in a 2014, suicide rate for NH of 18.62 per 100,000 compare to a national rate of 13.41 per 100,000.¹

Co-morbidities

While BH issues top the list of concerns in the region, the prevalence of other physical diseases and conditions complicate the health status and treatment approach for residents of Region 4. In the 2016 Greater Manchester CNA, additional health concerns identified included injuries and violence, obesity, diabetes, high cholesterol rates, asthma, and prostate cancer. According to Medicaid data for our region, the prevalence of a chronic disease and a BH condition among Medicaid members is high at 29%. Among members with a BH diagnosis, 92% also have a physical co-morbidity. Only 3% of the total Medicaid population has a BH-only diagnosis. It is important to note that 69% of adult Medicaid members with disabilities (aged 19–64) in Region 4 have a BH condition, and 60% of children (aged 0–18) with severe disabilities have a BH condition.

There are multiple associations between physical and mental health that impact people’s lives. Mental illnesses can affect a person’s ability to participate in health-promoting behaviors and appropriate utilization of health care services. Similarly, problems with physical health can have a serious impact on mental health and often decrease a person’s ability to participate in treatment and recovery.

¹ CDC, WISQARS, 2014

Recognizing the complex needs of individuals with behavioral health conditions, Network4Health established a network of mission-driven health and community-based social service providers with expertise serving individuals with these needs across the continuum of care. We believe that the core projects aimed at expanding workforce and health information technology capacity, and increased behavioral health integration across the Network4Health system, combined with our selected community projects, will work synergistically to transform the health care system in our region. It is our goal to better serve these individuals by addressing critical gaps in service through better care transitions, expanded treatment options for substance use disorders, and better and more integrated services for individuals with co-occurring disorders.

Question 2b

Please provide a narrative describing the overall demographic profile of the Service Region's Medicaid beneficiaries and larger population, with particular focus on how these demographic factors inform the IDN's approach to addressing behavioral health needs and the social determinants of health within the region. Demographic factors may include race, ethnicity, income, education level, etc. and may also include geography, housing, household composition, transportation, primary language spoken, etc. IDNs are encouraged to consult census data and demographic data provided by the state in presenting this analysis.

According to the State's Data Books, the current population of the Region is 314,766. Most people (34%) live in Manchester. The town with the next highest population is Derry (10%). Ten out of 18 municipalities each have less than 3% of the population. Because of this population distribution, the Region's characteristics are dominated by Manchester and the Greater Manchester Public Health Region which comprises eight municipalities and 57% of the Region's population. Significant demographic variation exists across the region's population characterized by the center city of Manchester, with 25 neighborhoods extending to the suburbs, the outer suburbs, and more rural areas of the region. While 34% of the population lives in Manchester, 60% of the enrolled Medicaid beneficiaries are from the city.

Region 4's population is 49.5% male and 50.5% female, and the median age is 40, slightly younger than the State's median age. As detailed in the 2016 Greater Manchester CNA, the HSA is aging. The 65+ population is projected to grow 22% through 2019, and many towns will experience over 30% growth in the 65+ age group. In contrast, the child/adolescent population (ages 0–17) within the Greater Manchester HSA (excluding Manchester) is projected to decline slightly over the next 5 years. Within Manchester, however, the child/adolescent population is projected to increase by 2%.

There are 45,725 Medicaid members in Region 4, which represent almost 15% of the population. Regarding race and ethnicity, Region 4 is the most diverse in NH with the Medicaid population being more racially diverse than the region overall. The Region 4 Medicaid racial/ethnic composition is as follows, with state figures in parentheses: White, 80.1% (91.1%); Black, 4.6% (2.5%); Hispanic 9.3% (5.0%); Multirace, 7.3% (1.8%); Other, 3.4% (1.6%); Asian, 2.5% (2.8%). American Indian/Alaskan Native and Hawaiian/Pacific Islander each represent less than 0.5% of the population.

The HSA has become more racially, ethnically, and linguistically diverse over the past several years. The majority of racial and ethnic diversity is within Manchester's city limits, as nearly 86% of the minority population lives in Manchester. The city has welcomed more than 1,500 refugees since 2008. The composition of the refugee population has changed over time, but it continues to grow and add to the diversity of culture and language. One indication of the impact of resettlement over the past seven years is that 80 languages are now spoken in the Manchester school system. Over the past five years, an average of 1,800 students in the Manchester school system are considered to have Limited English Proficiency (LEP). Over the next 20 years, the White population is expected to decline by 1%, and those identifying as Non-Hispanic by 0.9%. The percentages of all other groups are projected to increase, most notably the Hispanic population (17.5%), Other Race (12.9%), and Multi-race (11.8%) populations.

The median household income for the Region is \$73,104, with a per capita income of \$35,329. These are higher than the median household and per capita income of the State (\$64,152, \$33,291, respectively). The median household income for Manchester is \$55,306. This is significantly lower than all other towns within the Greater Manchester HSA and is also much lower than the median household income for New Hampshire. Manchester also has a significantly higher percent of individuals and families living below poverty—14.3% and 10.8%, respectively—than other towns in the Region and the state. Moreover, Manchester has higher rates of child poverty particularly on the East and West sides of the city; more than half of the children are eligible for free or reduced price meals in school. Since poverty is highly associated with increased health risk behaviors, low educational attainment, poor health status, unemployment, and a lower self-reported quality of life, this is important to understanding community needs. Another important aspect is the impact of those who are incarcerated or former inmates on the population, bringing toxic stress into neighborhoods.

The demographic factors driving Network4Health's overall approach to our projects are income and poverty, cultural differences and limited English proficiency (LEP). The issue of LEP is particularly salient for the integrating physical-behavioral health care, as language barriers make navigating an already fragmented system even more difficult. Additionally, the link between low income/poverty and BH (including substance use disorder) is strong. Although these factors each contribute independently to this population's vulnerability; they do not operate in isolation. Together the region has a social vulnerability index far higher than the State, making its population more susceptible to economic instability, and poor health.

Question 2c

Please provide a narrative describing the behavioral health resources available across the care continuum, noting whether these resources are a) existing b) being deployed c) anticipated to be deployed. Please note that health information technology resources are addressed in Section II and therefore do not need to be discussed here. The response, at a minimum, should address the following types of resources:

i. Mental health and SUD resources (including intensive treatment and recovery services such as partial hospitalization or intensive outpatient services). Please also discuss the extent to which mental health/SUD resources are available in primary care settings. ii. Community-based social services

organizations and resources that could provide social supports to beneficiaries with behavioral health conditions, including supportive housing, homeless services, legal services, financial assistance, education, nutritional assistance, transportation, translation services, community safety, and job training or other employment services

Region 4 has numerous resources to assist individuals experiencing BH issues, including but not limited to mental health treatment services, SUD treatment and recovery services, community-based social supports, and faith-based resources. Medicaid members may access services from 15 statewide providers that the Department of Health and Human Services (DHHS) contracts with to provide treatment and recovery support services, including services traditionally funded by DHHS (e.g. outpatient, intensive outpatient services [IOP], and low- and high-intensity residential services) and newly funded services, such as partial hospitalization programs (PHP), medication assisted treatment, and ambulatory and residential withdrawal management. These providers also assist with recovery support and continuous recovery monitoring services. DHHS also contracts with seven entities to enhance treatment capacity with infrastructure funding for SUDs. Three of these entities - Families in Transition, Serenity Place and the Farnum Center - are Network4Health partners.

The list below includes a sample of organizations providing services in Region 4. Given space limits, it is not exhaustive and while many organizations offer a range of services, each is listed only once.

Comprehensive Health Care Services (including Behavioral Health)

- *Catholic Medical Center (CMC)*: In addition to inpatient services provided through the acute care hospital, CMC offers primary care and specialty care services in the greater Manchester community. CMC Behavioral Health Services is an adult outpatient program that assists in patient evaluation, symptom management and skill development. Within the ED comprehensive BH and substance use assessments are provided, and linkages are made to community-based services.
- *Dartmouth-Hitchcock (DHC)*: DHC includes six clinic locations offering a broad range of medical services and participates in the SBIRT program.
- *Elliot Health System (EHS)*: EHS includes a 12-bed inpatient psychiatric unit for ages 18–64, and robust outpatient BH care for ages 2–65. Its inpatient gero-psychiatric unit offers multidisciplinary services for older adults. The ED includes an Acute Psychiatric Unit with dedicated psychiatric nursing. EHS also offers co-located and integrated BH services at several EHS primary care locations.
- *Health Care for the Homeless*: Clinic services include integrated primary care, mental health care, addiction counseling, nurse case management, health education, and social services.
- *Manchester Community Health Center (MCHC)*: MCHC provides comprehensive primary care and support services, including integrated physical and BH care and SBIRT screens for patients age 12 and over. MCHC offers substance abuse counseling sessions and a medication assistance treatment program. Children’s Health Services provides services for at-risk youth from low-income families including bio-psychosocial health care, social and nutritional services, and BH care.

- *Parkland Medical Center*: provides a comprehensive array of medical services including in-patient, emergency care, outpatient diagnostic among many others. PMC does operate both an in-patient behavioral health unit as well as a new behavioral health partial hospitalization program.
- *Veterans Affairs Medical Center*: Variety of health services to meet the needs of veterans.

Focus on Behavioral Health

- *Mental Health Center of Greater Manchester (MHCGM)*: MHCGM offers several services at multiple locations including a full range of outpatient counseling and psychiatric treatments for all ages, including services for children and teens experiencing more serious emotional/behavioral issues; and a range of services for people whose mental illness seriously impacts their ability to function in their lives and community. Treatment plans may include SUD services, illness management and recovery, medication management, and trauma recovery. Community support services include ACT, fitness services, supported employment, residential services, and In SHAPE. MHCGM also operates a 24-hour, 16-bed short-term inpatient crisis stabilization program.
- *Center for Life Management (CLM)*: CLM provides comprehensive outpatient BH services to individuals of all ages including individual and group counseling, medical services, emergency services, community support services, targeted case management, functional support services, homeless outreach, and a number of evidence based practices (e.g., illness management and recovery, supported employment, and Integrated Dual Disorder Treatment (IDDT)). CLM also has integrated behavioral and physical health services in partnership with Core Physicians and Dana Farber.
- *Child and Family Services*: Serves adolescents, children, young adults, adults, pregnant or parenting women, and the homeless. Programs include parenting, assessment, care coordination, individual and group outpatient counseling, recovery support services, and transitional living program (18–21). The Teen Center offers counseling for drug/alcohol use and severe depression.
- *Hampstead Hospital*: The first private psychiatric hospital in the State, Hampstead is a 111 bed facility serving individuals with psychiatric and substance use needs.
- *NAMI New Hampshire*: Provides support, education, and advocacy for people affected by mental illness, including programs that support and educate families affected by mental illness, intensive family peer support for parents/caregivers of youth with SED, and mental health and suicide prevention.
- *On The Road To Wellness*: Provides peer-led support and recovery services for individuals with mental illness.
- *Pastoral Counseling Services*: Provides a wide range of services designed to promote emotional, mental, and spiritual support, healing, and guidance with compassion, respect, and openness.

Focus on Prevention Services:

- *Makin' It Happen Coalition*: provides comprehensive prevention and youth development services, suicide prevention and SUD continuum of care work across the lifespan.

- *Manchester Health Department (MHD)*: Oversees city services to improve health through disease prevention, health promotion, and protection from environmental threats. MHD has specific initiatives connected to prevention including the Neighborhood Health Improvement Strategy.
- *Manchester School District*: Offers student assistance services and early identification, intervention and referrals.
- *YWCA NH*: Provides advocacy and support services for domestic violence, sexual assault, and substance use disorders including crisis support, emergency shelter, support groups, and community education.
- There are only five Certified Prevention Specialists residing in Region 4, according to the NH Prevention Certification Board.²

Focus on Intervention

- *Greater Derry Community Health Services*- Provides case management including education, information and support to obtain needed health services.
- *Hillsborough County Department of Corrections*: Provides educational and rehabilitative programs including Operation Impact and Residential Substance Abuse Treatment.
- *Manchester Fire Department*: The Safe Station program enables individuals seeking physical and BH treatment to receive immediate assistance with obtaining emergency/urgent care and/or identifying available resources.
- *Manchester Police Department*: supports individuals with substance use issues, through initiatives such as a “drug take-back” day and a prescription drop box to safely dispose of drugs at any time. The Department also has School Resource Officers across the district.
- *Manchester Office of Youth Services*: Includes an alcohol court referral program, anger management, crisis intervention and referral, fire safe intervention, restitution, substance abuse evaluation, and the Youth Educational Shoplifting program.
- *Rockingham County Department of Corrections*- Provides an Adult Diversion Program.
- Other Network4Health partners: American Medical Response, Service Link Resource Center.

Focus on SUD Treatment

- *Families in Transition and Family Willows IOP*: Services include intensive outpatient program with services for substance abuse; affordable housing; family emergency shelter; permanent supportive and transitional housing.

² While this data looks at where certified prevention specialists live, not work, it is not a complete picture, but it still shows a real shortage considering the size of Region 4.

- *Farnum Center*: Services include medical detoxification; residential; outpatient and intensive outpatient; family services; and a Suboxone clinic.
- *Manchester Comprehensive Treatment Center*: Services include medication assisted treatment and evaluation and group outpatient services.
- *Manchester Metro Treatment Center*: Methadone-assisted treatment.
- *NH Catholic Charities*: Individual, marital, family, and couples' counseling, including depression, stress, family conflicts, relationship problems, anxiety, substance abuse, life adjustment issues, grief, and loss.
- *Serenity Place*: Residential and Outpatient Substance Use Disorder Treatment and Services, Transitional Living Program, and 24/7 Wrap Around Services as a Regional Access Point for the State.

Focus on SUD Recovery

- *Helping Hands Outreach Center*: Alcohol/drug recovery-related transitional housing; sober living environment offered to men aged 18 and up.
- *Hope for NH Recovery Center*: Advocacy and education to improve public perception about those in recovery from substance use disorders. Provides recovery support services and coaching, community-based training, and a recovery community center.
- *Liberty House*: Substance-free housing for veterans transitioning from homelessness. Provides employment and housing assistance, food pantry, and a clothing closet.
- Other Network4Health partners: Derry Friendship Center, Granite Pathways

Focus on Social Supports

- *Harbor Homes Veterans First*: Veterans' transitional and permanent supportive housing, and homeless veterans' reintegration program.
- *Granite United Way*: Community Impact Committee volunteers have targeted investments in literacy, financial stability, mental health, and the prevention of substance misuse.
- *Easter Seals of NH*: Provides a wide variety of community based and social support services across the region, including substance use treatment and services to support seniors and veterans, workforce development and transportation.
- *New Horizons for NH Homeless Shelter*: Provides primary medical care, addiction counseling, mental health care, dental, eye, and specialty care as well as mental health services.
- *Southern NH Services (SNHS)*: Provides assistance to low-income families for child development; workforce development; health, food and nutrition programs; energy programs; and community and multi-cultural programs. Provides housing and homelessness services.
- Other Network4Health partners: Ascentria Care Alliance, Bhutanese Community of NH, Community Crossroads, Crotched Mountain, Goodwill Industries of Northern NE, Granite State Independent Living, Home Health & Hospice, International Institute, Life Coping Inc.,

Question 2d

Please provide a narrative assessment of the gaps in care by age group for the sub-populations listed below (at a minimum). The response shall assess gaps across the entire continuum of care, including detection, diagnosis, treatment, management, and recovery. It also should address gaps from both the patient’s perspective and the provider’s perspective. Gaps may be reflected in terms of access barriers, wait times, workforce shortages, poor outcomes, etc. Please note that gaps in health information technology resources are addressed in Section II and therefore do not need to be included here.

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

Although Region 4 has a significant number of BH providers, as well as organizations providing physical health care, BH care, and social supports to address social determinants of health, there remain significant barriers to accessing care. Specific populations identified as underserved include youth and young adults, households for whom English is a second language, and people living in poverty and significant gaps in care as people transition from institutional to community settings.

As described in response to Question 3, Network4Health conducted focus groups to obtain important information regarding consumers’ perception of gaps. The groups collectively raised a number of themes that are key to understanding the gaps in care for residents of Region 4, including:

- **Long waits for both mental health and substance use care.** One participant noted, “You have to do something dangerous or commit a crime in order to get into the state hospital.” Another participant connected the experience of long waits for care to the high use of the ED. Participants also reported waiting to receive housing, domestic violence shelter placement, and health and social services referrals following incarceration as impacting their overall health and well-being. Each of these waits negatively impacts an individual’s ability to access care timely and reduces the likelihood of positive health outcomes.
- **Inadequate supply of providers.** There are 114 LADC/MLADC providers who are working in the region out of the 456 total across the state.³ While Network4Health’s region has the highest number of providers in the State, the region also has the highest need for services and treatment. Both qualitative data from focus group participants and providers as well as quantitative data on inpatient and ED utilization provide evidence that the region has significant unmet need. This finding

³ Information provided by the New Hampshire Board of Licensing for Alcohol and Other Drug Use Professionals.

is linked to wait times for care, and many focus group participants observed that the problems were most acute with specialty providers, particularly those offering BH care. A 2014 DHHS study of service providers found that many providers did not have the capacity to service people with co-occurring illness including severe and persistent mental illness. In addition, many focus group participants noted that available BH providers did not participate in their health insurance plan.

- **Care transition risks and problems.** Many focus group participants expressed frustration with accessing services upon their discharge from a medical or other institution. These are in part linked to wait times for care, though focus group participants noted a lack of communication and collaboration during a number of transition periods, including discharges from acute-care hospitals, rehabilitation and nursing home stays, mental health inpatient stays, and different levels of substance use treatment (detox, IOP, residential, etc.). This lack of communication resulted in missing or delayed referrals, as well as difficulty accessing necessary medications. Care transitions were also difficult for individuals transitioning from youth treatment to adult treatment providers and for individuals transitioning from homelessness to housing. Individuals with SMI frequently experience difficulty in navigating systems, and negotiating transitions in care. Too often such individuals fall through the cracks because their illness interferes with their ability to make and keep appointments and follow through with a provider's aftercare instructions. The vulnerabilities of the population compound the issues of the system.
- **Stigma.** Many focus group participants believed that there was significant stigma associated with having a BH condition, and they believed they were treated differently upon revealing a BH issue, particularly if they had a history of substance use. This stigma can also impact individuals getting care based on their own particular ethnic/racial group and the effect of cultural stigma.

Focus group participants reported reluctance to disclose their illness to health care providers based on these concerns. Several participants described providers whose perceived demeanor changed upon learning of a psychiatric diagnosis or substance use issue. Some participants reported that once substance use was identified, every report of injury or illness was viewed as "drug seeking." One participant described their ED experience following an overdose: "They had a beautiful opportunity to scoop me up and save me but instead they were angry, discontent, and judgmental." Another noted: "I definitely felt discriminated against by my PCP because of my addiction." However, several individuals described positive experiences with their primary care providers, especially in practices that seem more integrated and with a greater BH presence. The 2016 report of the NH Legislative Commission on Post-Traumatic Stress Disorder (PTSD) and Traumatic Brain Injury (TBI) identified stigma as the number one barrier to treatment for NH veterans and service members. According to the latest statistics from the [National Institute of Mental Health](#) (NIMH), 40 to 50 percent of all people with bipolar disorder or schizophrenia go untreated each year. The number of untreated people suffering from some other disorders, such as anxiety or depression, is even greater. Those most affected by the stigma included young people, men, minorities, people in the military and, perhaps surprisingly, those working in the health field.

While transportation issues were raised less frequently in the focus groups, key informants raised it as an important issue. Many individuals with severe mental illness or substance use disorders are not able to drive or do not own a car. Public transportation is primarily limited to the City of Manchester. This limits access not only to health care appointments, but also to other activities that affect overall health and well-being (e.g. grocery shopping, social activities, green space). To address the lack of transportation, some organizations cobble together transportation for their clients, and in some cases, provide transportation directly. While this helps fill in the gaps, it is not a sustainable solution.

Workforce Challenges

As reported recently and described in our response to Question 10, workforce shortages in the mental health system are problematic across the State and pose significant access issues including increased wait times, reduced continuity and quality of care for our most vulnerable population. These shortages in particular affect substance use disorder treatment programs. Even more challenging is recruiting clinicians licensed in both mental health (LICSW, LCMHC, etc.) and drug and alcohol counseling to treat members with co-occurring disorders. Addressing workforce issues is a critical component of our community-based projects (expanding treatment options for substance use disorders integrated care for co-occurring disorders, and community transitions Critical Time Intervention).

Additionally, integrating behavioral health and primary care will require a workforce with the skills and training to address the population’s continuum of needs, as well as the knowledge and understanding of the various treatment options available to individuals with complex needs. Finally, new practitioners will need training in how to navigate potentially complex administrative and operational processes. We summarized the gaps in services that exist across the region, in the chart below:

	SMI	SUD, incl. opiate addiction	Co-occurring disorders (MH/SUD)	Co-morbid conditions	Co-Occurring DD and MH/SUD	Mild to Mod Mental Illness	Those at-risk for MH/SUD condition
General underservice in outlying towns (outside of Manchester)	X	X	X	X	X	X	X
Lack of access to detox when not medically necessary		X	X		X		
Limited age- and developmentally appropriate treatment and recovery programs/support for youth and young adults	X	X	X		X	X	

	SMI	SUD, incl. opiate addiction	Co-occurring disorders (MH/SUD)	Co-morbid conditions	Co-Occurring DD and MH/SUD	Mild to Mod Mental Illness	Those at-risk for MH/SUD condition
Lack of diversity in the range and types of peer recovery programs	X	X	X		X		
Lack of a SUD treatment program in the Hillsborough County jail		X	X				
Lack of physical space to expand current and treatment programs	X	X	X	X	X	X	
Limited perinatal addiction services for pregnant mothers and infants born addicted		X	X				
Lack of a comprehensive health curriculum in all schools, for students as well as for staff and parents, using a whole community approach	X	X	X	X	X	X	X
Limited inpatient mental health and SUD capacity for youth	X	X	X	X	X		
Limited support for those transitioning from incarceration and their families	X	X	X	X	X	X	X
Limited linkage to treatment when in ED or inpatient at hospital		X	X		X		
Lack of prevention/intervention services in schools						X	X
Lack of recovery housing for women or families		X	X				
Lack of education and protocols for first responders on how to treat someone in recovery who refuses pain medications		X	X		X		

	SMI	SUD, incl. opiate addiction	Co-occurring disorders (MH/SUD)	Co-morbid conditions	Co-Occurring DD and MH/SUD	Mild to Mod Mental Illness	Those at-risk for MH/SUD condition
Need recovery support for families where there is a family member with addiction, as well as support for families who have experienced an addiction-related loss		X	X		X		
Need support for secondary trauma of first responders who experience stress from responding to overdoses		X	X		X		
Need for additional suicide prevention education	X		X	X			X
Need for increased use of trauma-informed interventions and treatment, and other evidence-based practices	X	X	X	X	X		
Need for consistent, thorough and shared data, including the creation of a dashboard of indicators that can track and be shared across Network4Health partners	X	X	X	X	X	X	X
Need for information on where and how to access the treatment system for families and non-BH providers	X	X	X	X	X	X	X

Question 3a

Community Engagement and Stakeholder Input Please provide a narrative describing the 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. Please include: i. Channels and venues through which input was solicited (e.g., public-facing website(s), webinars, participation in IDN workgroups, etc.), as well as key audiences/stakeholder groups ii. Frequency with which community input was sought iii. Mechanisms to ensure the community engagement process was transparent iv. Examples of three key elements of this Project Plan that were informed by community input v. An explanation of any instances in which community input could not be addressed or taken into account

Additional Guidance: Document fully the process by which the IDN collected key stakeholder input. A full description of the engagement process confirms that those who can contribute to achieving the full vision of the projects have discussed the expectations.

Network4Health engaged stakeholders in both the selection of projects and the development of the project plans, leveraging the structure and approach that was developed for the IDN-application process.

Target audiences for project selection and development included individual consumers, community-based organizations not participating in Network4Health, and our partner organizations. We relied primarily on bidirectional communication to obtain input, including meetings (face-to-face, telephonic), workgroups, focus groups, surveys, and key informant interviews.

Network4Health obtained significant input from partner organizations via the IDN Partnership Team, which is composed of representatives from each IDN partner. Although initial project selection was conducted by Network4Health's Steering Committee; feedback from the IDN Partnership Team was sought on issues such as relevance of specific projects to their client base; current resources; and provider/staff capacity and infrastructure. The full Partnership Team convened a total of three times since the IDN application was approved: once to review and approve the project selections, and twice to approve the overall direction of the project plans. The Partnership Team will continue to meet regularly throughout the planning process. Partner organizations received numerous opportunities to assist in the development of this project plan, including participating in project planning meetings, and responding to surveys on workforce capacity, HIT, use of alternative payment models, and levels of physical and behavioral health integration.

Network4Health implemented mechanisms to ensure transparency in the stakeholder engagement process, as follows. Documentation referred to below is available for review by the State upon request.

- *Focus groups:* Recruitment for the focus groups was conducted by stakeholders, including community-based organizations and partner organizations. Typically, groups leveraged existing meetings (such as a hospital patient advisory group) or were held at places where individuals with BH issues would be able to participate (e.g., a residential rehabilitation center). Other focus groups required recruitment that was conducted by a sponsoring partner organization. Notes

were taken at each of the 16 focus groups conducted 16 between July 12, 2016, and September 13, 2016, including one in Spanish. A total of 170 consumers, peer advocates, family members and ethnic community leaders participated. These focus groups were structured to elicit information, feedback, and opinions on access to care, familiarity or direct experience with integrated care, experience in care transitions, and availability of health care services, programs or providers.

- *Key informant interviews:* Interviews were held on an informal basis to supplement information being gathered through the focus groups, existing CNAs and state data.
- *Partnership team engagement:* All communication between Network4Health and its partners (via the Partnership Team) is documented in writing. Meeting agendas are distributed in advance, and detailed minutes—including partner input and feedback—are prepared and distributed. As noted above, partner organizations were asked to participate in project planning workgroups and to complete several written surveys.

Time and resource constraints prohibited Network4Health from convening the Consumer Advisory Council (CAC) and Stakeholder Organization Advisory Council (SOAC), as proposed in our IDN application. However, we believe that our other engagement activities solicited input from a representative set of consumers and organizations that will likely participate on the SOAC. In addition, because Network4Health believed that the complexity of issues required deep—rather than broad—input from stakeholders, we opted not to use social media during the project-planning phase. Network4Health remains committed to launching a public-facing website in 2017.

All elements of the project plan have been informed by community input. Key issues that the community found problematic included:

- *Wait times for care, particularly for BH services,* particularly for non-emergent mental health care, appointments with mental health care prescribers, behavioral health inpatient services, and substance use disorder treatment;
- *Care transition risks and problems,* specifically discharges from acute-care hospitals; residential rehabilitation or nursing homes; or mental health inpatient care; between different levels of substance use treatment (detox, intensive outpatient services, residential, etc.); from youth treatment to adult treatment providers; from homelessness to some form of housing; and from incarceration back to the community; and,
- *Experience with integrated care:* varied across focus groups. Although some described timely response from a primary care provider (PCP); many cited a lack or inadequacy of follow-up by a PCP or a BH provider following the screening.

Network4Health has worked diligently to consider and/or address community input in all project plans and we have reflected the major themes raised by our focus group participants and partner organizations. This input is particularly evident in our selection and planning of our three community projects:

- Selection of Project C1: The risk of relapse and adverse outcomes during transitions is an important gap identified by community stakeholders, both individuals and partner organizations. The choice of Critical Time Intervention (CTI), an evidence-based intervention that has been successfully implemented across numerous populations, was directly informed by the community as it is a realistic approach to improving outcomes for populations with co-morbid conditions including physical health and significant behavioral health needs.
- Selection of Project D3: Numerous provider organizations and community participants expressed concern with the lack of services for individuals with co-occurring conditions; therefore, Network4Health chose to develop expanded services via a focused PHP and plan for implementation of an IOP for individuals with co-occurring conditions.
- Selection of Project E4: Focus group participants also expressed concern and frustration with fragmented care, including difficulty obtaining requisite follow-up services, and stigma associated with their SUD issues. To address these concerns, Network4Health chose to implement a project designed to improve integration of mental health and substance abuse services with a focus on evidence-based practices.

Both the focus group and key informant processes revealed additional valid concerns that are not directly actionable as part of this initiative including low provider reimbursement rates and inadequate transportation outside the Manchester area. The movement towards APMs may partially address the provider rate issue in the future and our partner organizations will continue to be mindful of transportation barriers as we implement these programs.

Question 3b

Please provide a narrative describing the process by which the IDN will solicit community input in implementing its program over the course of the demonstration. The response should address: i. Channels and venues through which input will be solicited, as well as key audiences/stakeholder groups ii. Frequency with which community input will be sought iii. Mechanisms to ensure the community engagement process is transparent

Network4Health intends to fully implement the community engagement strategy proposed in the IDN application. We will work with our partner organizations to leverage existing strategies and capitalize on existing partnerships to achieve engagement goals.

Stakeholder engagement target audiences include:

- General public
- Individual consumers receiving BH services, including but not limited to:
 - Adults with mental illness (MI), substance use disorder (SUD), co-morbidity, or co-occurring disorders;
 - Parents/guardians of children/adolescents with MI or SUD;
 - Adults with significant physical health care needs/disabilities;
 - Adults transitioned from a correctional facility to the community, and

- Seniors transitioned from a nursing facility to the community.
- Partner organizations
- Key area providers that have opted to not join Network4Health and providers outside of the Network4Health region that serve our residents
- Social service/community-based organizations not participating in Network4Health

Network4Health intends to use a multi-pronged approach to engagement, including meetings (face-to-face, telephonic, and via webinar), surveys, web-based methods, traditional media, and social media. We will continue to conduct focus groups and key informant interviews as warranted.

- Stakeholder meetings
 - Audience: Consumer Advisory Council (CAC); Stakeholder Organization Advisory Council (SOAC)

Frequency: Monthly and quarterly, depending on the phase of the project

Network4Health will establish a Consumer Advisory Council (CAC), consisting of individual consumers and/or family members that partner organizations (such as NAMI NH and On the Road to Wellness) identify as knowledgeable and strong self-advocates. We will also establish a Stakeholder Organization Advisory Council (SOAC), consisting of representatives of stakeholder organizations described above that are not part of the Partnership Team—for example, representatives of law enforcement or housing organizations.

These Councils will provide input and feedback on implementation strategies, potential challenges, and risks, as well as provide guidance on engagement strategies. Meeting agendas will be developed by the Network4Health’s Executive Director, and meetings will be facilitated by our Project Managers.

- Partnership Team Meeting

Frequency: As needed, but anticipated to be monthly during project planning and design phases; bi-monthly during implementation and stabilization phases; and quarterly thereafter; ad hoc as needed.

The Partnership Team is composed of representatives of each of our partner organizations. Their input will be solicited on all major topics/issues, via in-person or telephonic meetings as well as via surveys, when necessary.

- Public meetings and speaking engagements
 - Audience: General public; consumers and family members/caregivers; organizations

Frequency: Annually, quarterly, or monthly (as needed)

The IDN will hold public meetings and offer speaking engagements to present information, respond to questions, and maintain strong public relations with the community. Examples of such meetings and engagements include:

- Community forums/health fairs
- Meetings convened by community-based organizations

- Traditional media

- Audience: General public; organizations; consumers and family members/caregivers

Frequency: Varied; no less than quarterly

To reach the general public and consumers, the IDN will leverage radio and print media to promote community engagement. Activities may include:

- Issuing press releases and reports
- Letters-to-the-editor campaigns
- Billboard/print media campaigns

- Web-based activities

- Audience: General public; consumers; family members/caregivers; partners

Frequency: Varied; no less than monthly

Network4Health will establish and maintain open and transparent two-way communication with stakeholders via a dedicated Network4Health website. The site will provide general information about the projects, ongoing status updates, a master events calendar, FAQs, and links to additional resources. A secure password-protected section for partner organizations will be used to keep partners informed of all project activities and to solicit information through, for example, online surveys. This website will also be used to broadcast informational webinars.

- Social media

- Audience: General public; consumers; family members/caregivers

Frequency: To be determined; target three times per week

Network4Health recognizes the impact that social media can have on community engagement. Social media is inherently participatory and facilitates real-time engagement with an audience who may otherwise not be reached. Strategies may include:

- Development of a Facebook page where visual (videos, etc.) and written information is shared

- Use of Twitter to facilitate discussions on regional health care issues/challenges, and the impact of DSRIP projects on the health care delivery system
- Use of a blog to communicate about community engagement activities, events, and health and wellness topics

Mechanisms to ensure transparency in all community engagement activities include but are not limited to:

- Making participation criteria for the CAC and SOAC publicly available, and soliciting participation from a broad pool of candidates to prevent insularity
- Making available to the public via the Network4Health website:
 - names and affiliations of committee participants
 - all meeting agendas and minutes
 - results of surveys, focus groups, and key informant interviews (preserving confidentiality as appropriate)
- Publicly advertising all public events (speaking engagements, health fairs, etc.)

The Partnership Team, in its role as the primary governance committee, is responsible for ensuring that all community engagement activities are fully transparent. Any questions, concerns, or complaints regarding these activities that are brought to the attention of Network4Health will be referred to the Partnership Team for resolution.

Question 4a

Please submit a finalized network list using the 4A tab in the IDN Project Plan Supplemental Data Workbook, including the name of the organization, type of service(s) provided, address, telephone contact, email, and brief description. This information may be used to inform an IDN partner directory.

Tab 4A in the IDN Project Plan Supplemental Workbook includes a final list of Network4Health provider organizations. There have not been any additional providers added since our initial application in May 2016 (including the June 2016 write-backs).

Question 4b

Please describe in detail how this network will be leveraged to address the care gaps identified in the IDN's Service Area Community Needs Assessment (Question 2d)

Network4Health is uniquely positioned to improve clinical outcomes for the BH population, particularly—though not exclusively—those with co-occurring disorders, including addressing social determinants of health. As detailed in our full network list, our provider organizations include all major regional physical and behavioral health providers and key social service agencies, covering a full spectrum of care across the region. In addition, our partner organizations include the Hillsborough and Rockingham County Commissioners and the Manchester Department of Health. Together we have a long history of strategic collaboration on programs that serve our target population.

This foundation will allow Network4Health to build more expansive initiatives to integrate behavioral health and physical health services. The region has in place some infrastructure for collaborating across organizations, such as the Manchester Homelessness Continuum of Care, the South Central NH Public Health Network Advisory Committee, the Greater Manchester Public Health Regional Advisory Committee, the Greater Manchester Association of Social Service Agencies, the Greater Manchester Substance Abuse Collaborative, and the Behavioral Health Integration Project.

The IDN structure provides a mechanism to leverage our regions expertise and experience in a manner and to an extent not realized before. Network4Health will be the catalyst and structure for fostering:

- a collaborative learning environment among partner organizations;
- meaningful collaborations across sectors on the full continuum of care;
- synergistic relationships among partners; and
- a collective thought process for how to serve the target population across the care continuum.

Each partner has in-depth knowledge of the residents of the area and a long history of excellence in the services they provide. This experience and expertise will be leveraged in a variety of ways. First, organizations have begun project planning, and they will continue to participate in project workgroups based on their expertise. Organizations that have experience in a particular area have been assuming significant responsibility and leadership for projects most relevant to them and their clients. Second,

the composition of the Steering Committee ensures that participating organizations are accountable for actively contributing to the planning and implementation phases. Third, all partner organizations participate on the Partnership Team and have a voice in all aspects of the initiative. Finally, partner organizations serve as “outreach arms” to their respective provider and client bases to ensure that each project consistently communicates to the community and obtains community feedback.

Examples of existing or prior collaborative relationships upon which to build include but are not limited to:

Mental Health Center of Greater Manchester (MHCGM) Partnerships for Integrated Care: MHCGM has agreements with 15 organizations—including FQHCs, hospitals, county jails, peer support centers, residential substance use treatment programs and social service agencies—to co-locate mental health providers. This experience allows for important sharing of lessons learned in provision of integrated services and best practices in focusing on members with co-occurring conditions.

Improving care transitions from institutional settings to the community: There are several care transition initiatives underway that focus on a variety of points of transition. Both MHCGM and the Center for Life Management provide mental health liaisons that coordinate discharge planning with New Hampshire Hospital (NHH) to ensure that all discharged patients receive follow-up care within seven days of discharge. Partnering with NAMI NH, NHH also has a dedicated social worker who follows up post-discharge with high-risk suicide youth and young adults and their families to ensure that they receive follow-up care coordination. Additionally, NAMI NH has a dedicated recovery support specialist who provides peer support to individuals transitioning from transitional housing on the NHH campus.

As another example, Hillsborough and Rockingham County are leaders in working with justice-involved individuals with mental illness. Mental health counselors from MHCGM serve as court liaisons, working with the Mental Health Court staff to connect individuals to community-based services. Through its Community Connections program, the Counties work with local organizations to provide mental health treatment in lieu of the traditional criminal justice system.

While these programs have shown success, our focus group participants revealed that transitions in care remain a significant challenge. In implementing the Critical Time Intervention we hope to learn from these experienced practices and share this evidenced-based intervention with these program staff to improve transitions across these and other settings.

As Network4Health developed, our larger partner organizations, including CMC, the MHCGM, and the Elliot Health System, have leveraged their own financial stability to support the development and startup of the IDN to position Network4Health for success in meeting the requirements of the DSRIP program and working as a network to further system change.

Question 5

This demonstration is only one of several ongoing initiatives to support New Hampshire's vision for behavioral health reform and is designed to work in concert with other efforts, including:

- *Governor's Commission on Alcohol and Drug Abuse*
- *State Innovation Model (SIM)*
- *SUD Benefit for Traditional Medicaid Population (July 2016)*
- *New Hampshire Health Protection Program*
- *Establishment of Regional Public Health Networks and Continuum of Care Facilitators*
- *Community Mental Health Agreement*

In accordance with Special Term and Condition 28 of the demonstration, projects implemented by IDNs must reflect new health care initiatives or significantly enhance existing health care initiatives.

To this end, please provide a narrative identifying existing, notable delivery system reform initiatives related to the objectives of this demonstration that involve IDN participants. The response also should explain how the activities proposed in the IDN Project Plan are not duplicative of activities that are already supported with federal funds.

Network4Health partners are actively involved in many ongoing state initiatives focused on supporting New Hampshire's vision for behavioral health reform and improving care through better care integration and coordination. Partner organizations are involved in the following initiatives:

- **Governor's Commission on Alcohol and Other Drug Prevention, Treatment and Recovery:** The Commission's mission- to significantly reduce alcohol and drug problems and their behavioral, health and social consequences – is at the heart of many of Network4Health's activities. Network4Health partner organizations are committed to delivery of effective and coordinated alcohol and drug abuse prevention, treatment and recovery services. Each of the selected community projects are aimed at improving care for individuals with substance use disorders. A number of Network4Health partner organizations participate in the Commission, including Network4Health steering committee members Cheryl Colletti and Stephanie Savard. In addition to serving on the Governor's Commission, Ms. Savard also serves as the Chair for the Treatment Task Force. Members of Network4Health also participate in several of the other Task Forces under the Governor's Commission, including the Healthcare Task Force, the Perinatal Substance Exposure Task Force, the Prevention Task Force, the Recovery Task Force and the newly formed Military Task Force.
- **State Innovation Model (SIM):** Through SIM, New Hampshire has worked to develop the regionally-based integrated health delivery model that begins with the seven IDN regions.

Network4Health partner organizations were represented on the Governor's Advisory Board and actively participated in the five workgroups.

- SUD Benefit for Traditional Medicaid Population: In July 2016, New Hampshire expanded its Medicaid coverage to include substance use treatment services for the traditional Medicaid population. The inclusion of these services within Medicaid provides for enhanced access to comprehensive SUD treatment services in the state. The projects that Network4Health are undertaking will help increase access and positive health outcomes, through increased capacity for individuals with co-occurring conditions and implementation of evidence-based practices, such as Critical Time Intervention.
- New Hampshire Health Protection Program (NHPP): Based on 2014 changes in state law, the NHPP provides free or low-cost health insurance to residents previously ineligible for Medicaid. Many of these individuals have mental health and substance use conditions. Coverage is offered through Qualified Health Plans available through the Federally Facilitated Marketplace. Making coverage available to this population allows NH to reach more individuals with behavioral health needs. We recognize that projects pursued through the 1115 Waiver also impact these individuals.
- Establishment of Regional Public Health Networks and Continuum of Care Facilitators: There are two Regional Public Health Networks which overlap with the Region 4 IDN. Network4Health partner organizations are actively involved in developing educational materials and training continuum of care facilitators on available resources. The work of the Regional Public Health Networks and the IDNs is well-aligned and will reinforce the strategies being put forward through Network4Health's community projects, particularly education on the treatment of co-occurring conditions.

The Substance Use Disorder Continuum of Care (CoC) shares many of the same goals as Network4Health including integration of behavioral and physical health, access to care, workforce development, capacity and care transitions. Network4Health is a valuable opportunity to bring partners together and put dollars behind the planning and implementation needed for real change to occur on a large level. We have leveraged the stronger partnerships that have formed through the CoC blueprint project and the substance misuse collaborative group. The asset and gaps mapping and the recommendations for action planning session held by the collaborative were incorporated into our CNA and helped to inform project selection

- Community Mental Health Agreement: As part of a lawsuit settlement, New Hampshire agreed to expand availability of certain services, including Mobile Crisis Response, Crisis Apartments, Assertive Community Treatment (ACT), Supported Housing, Community residence beds and Supported Employment. The two community mental health centers participating in Network4Health, the Center for Life Management and the MHCGM, have participated with the State on enhancements to ACT, supported housing, community residence beds and supported employment. MHCGM has also worked with the State to increase Mobile Crisis Response and

Crisis Apartments. There have been some workforce challenges in implementing the program, which may be addressed through the statewide workforce project.

In addition to these initiatives, members of Network4Health are involved in other related initiatives, including the Governor's Commission on Health Care and Community Support Workforce. Workforce shortages are a key issue impacting the delivery of behavioral health services, including for example lack of ability to hire psychiatrists and peer specialists across the state and in Region IV. Finding solutions to these issues is a key component of the overall success of NH's multi-pronged efforts to improve the quality of care provided to our citizens while constraining costs over time. The findings of this Commission and any related recommendations likely will have a strong influence on the Statewide Workforce Development Committee which Network4Health is committed to actively participate in as part of this project plan. Dennis Powers of Community Crossroads (a Network4Health partner organization) is a member of the Commission and will actively consult with Network4Health representatives to the Statewide Workforce Development Committee.

Another statewide initiative that aligns with the work of Network4Health is the System of Care (SOC) Initiative. For the past 4 years, many child-serving NH organizations have worked together to develop a comprehensive, multifaceted plan for improving children's behavioral health services with an integrated system that is family driven and youth guided, and culturally and linguistically competent. Network4Health will be able to leverage this work as it moves to further integrate physical and BH care and provide additional support through the community-focused projects.

In selecting the three community projects to be implemented by Network4Health, we carefully considered all of these activities to understand where resources were being devoted and to ensure that we were not duplicating effort. The three projects selected include Critical Time Intervention (CTI), implementation of a Partial Hospitalization Program focused on those with co-occurring conditions, and the integration of services for those with co-occurring conditions, are focused on particular gaps in Region 4 that are not fully addressed by other activities within the state.

Question 6

New Hampshire is facing a major opioid addiction crisis. One of the driving purposes for the transformation initiative is to provide the state with additional resources to combat this epidemic and other substance use disorders in coordination with other efforts across the state.

Please describe how the IDN's Project Plan addresses the opioid crisis and will improve timely access to opioid-related services in its Service Region, based on gaps identified as part of the IDN's Community Needs Assessment. The response should include a description of how the IDN will leverage and build upon other existing initiatives across the state. While it is likely that IDNs will be focused primarily on addressing short-term needs, please also consider the long-term effects of the opioid crisis on the population, the resources that may be needed to address those effects, and steps that can be taken in the years ahead to treat opioid addiction as a chronic condition in appropriate circumstances.

Like the rest of New Hampshire and the nation, the Greater Manchester, Derry and Salem areas are facing a major opioid addiction crisis. Network4Health partners have been working diligently to address this issue head on, and our efforts were recently recognized by the Robert Wood Johnson Foundation (RWJF) recognizing our “data-driven, block-by-block approach to better health.” RWJF noted that “Manchester’s swift and compassionate response to the emerging opioid and heroin epidemic – which has successfully mobilized first responders, non-profits, and health care providers to connect residents with critical treatment services, has set a national example...”⁴

While we have made progress, there is much more to be done to combat this epidemic and other substance use disorders in coordination with targeted efforts across the state. As noted above, in 2015, 439 people died from a drug overdose in New Hampshire, a 60% increase from 2013. The City of Manchester has the highest rates of overdose deaths and Narcan administration in the state of New Hampshire. From June 2015 through May 2016, Narcan was administered by public safety officials over 500 times.

Despite the strides made in recent years to combat the opioid epidemic, treatment capacity has not kept up with demand. According to one analysis, Region 4 has a dearth of capacity for critical behavioral health services. For example, there are currently no partial hospitalization program (PHP) slots by providers who accept Medicaid in Region 4; although one organization in the region is planning to open 12 beds soon.. This lack of PHP beds is a large driver of our focus on adding additional capacity for service as part of our community-driven projects.

Many initiatives in the region are focused on addressing the opioid epidemic, including expansion of SUD services within the Medicaid program and the work of the SUD Continuum of Care. Individual providers are also doing their share. For example, CMC will host its second annual Summit on Treatment of Opiate-Dependent Patients on November 11, 2016. In addition, public safety officials

⁴ See Robert Wood Johnson Foundation Awards Seven Communities the 2016 RWJF Culture of Health Prize; <http://www.rwjf.org/en/library/articles-and-news/2016/09/robert-wood-johnson-foundation-awards-seven-communities-the-2016.html>.

across the region serve as safe stations and have drop boxes to appropriately dispose of prescription drugs.

Network4Health joins the many organizations focused on finding solutions to this challenge. Network4Health's Project Plan addresses the opioid crisis in many ways and through use of available DSRIP funding will provide our region with the opportunity to improve timely access to opioid –related services. Each project Network4Health has selected to pursue will have an important impact on addressing the opioid crisis, including:

- focusing workforce efforts on ensuring access to peer specialists to support individuals in recovery;
- including as part of our integration efforts, a focus on increased screening for individuals at risk of substance use within the primary care setting, including increase use of SBIRT and education to primary care providers on available treatment resources;
- focusing on individuals with co-occurring conditions who often have trouble accessing appropriate services today, both as part of developing a focused partial hospitalization program and plan for implementation of an intensive outpatient program (D3) and expanding integrated treatment programs for co-occurring disorders (E4). In part, this will be accomplished by providing education across the continuum of care on identifying individuals with co-occurring disorders and on appropriate and available treatment options, and
- providing critical time intervention (C1) for individuals with SUD upon discharge to provide necessary support as they transition to the community.

Network4Health selected the projects described above based on our understanding of and involvement in other initiatives occurring in New Hampshire, including substance use disorder expansion grants which are currently being deployed to enhance access to services offered through Families in Transition, Farnum and Serenity Place. In addition, there is a concerted effort across the state to increase access to Medication Assisted Treatment (MAT) to treat SUDs.

While we believe the projects that we are undertaking will help treat those with opioid addiction, much additional work needs to occur outside of Network4Health in order to stem opioid use. Continued focus on prevention is crucial – particularly for teens and young adults. In addition, while improved treatment options are needed, so too are recovery support services that help individuals maintain recovery over time. Continued focus and funding for these services are essential to appropriately serve New Hampshire residents.

Question 7a

a. Overall governance structure

Please provide a narrative that presents the IDN's overall governance and decision-making structure, including descriptions of:

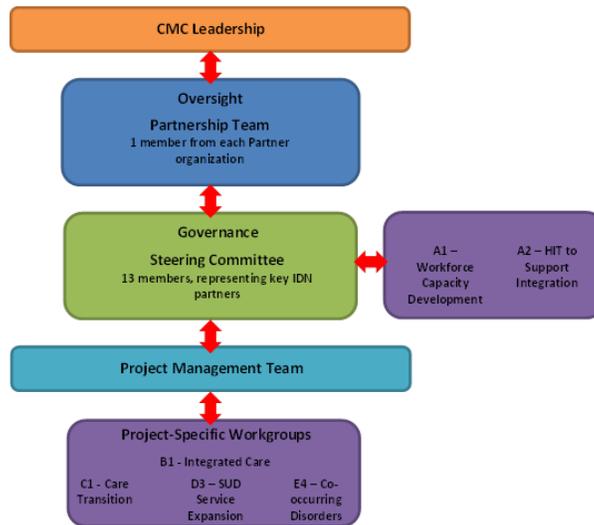
- *The IDN's principle governance committee (e.g., its Board or Executive Committee)*
- *Other governance committees and their relationship to one another and the principle governance committee*
- *A description of any separate legal entities being established as part of the IDN, if applicable*
- *How this governance structure provides for full participation of IDN partners in decision-making processes (e.g. composition, voting rules, etc.)*
- *How this governance structure ensures accountability among IDN partners (including the Administrative Lead), e.g., frequency and content of key performance reports to be reviewed by governance committees*
- *Processes to handle low-performing partners or partners who cease to participate in the IDN*
- *Processes to ensure adequacy of network in serving the behavioral health needs of the Service Region*

The foundational principle of Network4Health's governance strategy and structure is "partnership." This highly collaborative and cooperative approach is critical to Catholic Medical Center's (CMC's) strategy to ensure continued partner engagement. However, just as collaboration and cooperation are built into the governance structure, so is performance accountability. CMC is the lead agency for Network4Health and, as such, retains final authority and responsibility for all decision making. While CMC is the lead agency, all partner organizations participate as full partners, as reflected in the IDN partnership organizational structure. The IDN has not established or pursued a separate legal entity to date.

Network4Health has appointed Peter Janelle as its Executive Director. Peter brings a wealth of experience to this role, most recently serving as the Executive Director of the MHCGM. In his role as Executive Director, Peter is responsible for the overall success of Network4Health and the projects it is implementing. He is the key contact with the state and also works collaboratively with the six other IDNs across the state. Peter's collaborative leadership style and deep knowledge of the behavioral health system in New Hampshire provides Network4Health with a distinct advantage as it embarks on the six projects the IDNs' are responsible for.

Lead Agency

As the lead agency for Network4Health, CMC has responsibility and accountability above and beyond that of the other IDN partner organizations. Alex Walker, CMC's Executive Vice President, chairs both the IDN Partnership Team and the Steering Committee (described below), and senior CMC leaders—including CMC's Chief Medical Officer, Executive Director of Community Mission, and Director of Behavioral Health—serve on both. CMC financial staff will be responsible for managing IDN funds and will ensure that all IDN funds remain separate and segregated from CMC revenue.



Partnership Team

As pictured above, the IDN Partnership Team is the oversight body for the IDN. It is composed of representatives from the CMC Leadership Team, and one representative from each of the 42 partner organizations. While organizations may have only one official member of the Partnership Team, organizations may choose to bring as many additional individuals as they wish to Partnership Team meetings.

The primary role of the Partnership Team is to provide overall project guidance, approval of high-level strategic, IDN-wide, or financial issues/decisions, and resolution of issues not able to be resolved at a lower level.

The Partnership Team also serves as a key component of the IDN’s ongoing communications strategy to ensure the flow of complete, accurate, and timely information to all partners. To foster a sense of partnership and collaboration, meeting locations will rotate among IDN partner organizations that are able to host large meetings.

As noted above, Alex Walker, Executive Vice President of CMC, chairs the Partnership Team. All meetings are organized and staffed by Peter Janelle, Network4Health’s Executive Director, with support by the IDN’s Project Manager, Karen Collinsworth. This includes preparing meeting agendas, providing all necessary materials and background documentation, briefing members on all relevant issues prior to meetings (as necessary), documentation of proceedings (including votes) and, when necessary, escalating issues to the CMC Leadership Team for resolution.

Having all partner organizations represented on the Partnership Team ensures that all partnership voices are reflected in project decision making. Whenever possible, and when in the interest of the overall project and the people we serve, CMC will work to achieve consensus among all partners. When this is not possible, decisions are made by majority vote, when a quorum (50% of partnership organizations) is present. In some instances—where, for example, there is the potential for financial conflicts of interest—decisions may be made by the CMC Leadership Team. In such instances, full documentation of the issue, decision, and rationale will be provided to the Partnership Team.

Steering Committee

Network4Health's Steering Committee, composed of the CMC Leadership Team and leaders of the IDN's selected key partner organizations, is responsible for guiding the day-to-day work for the project and for the project-specific workgroups. This 12-member committee is the primary governing body for the IDN and is directly accountable to the Partnership Team. As described in the Steering Committee Charter, the Steering Committee is limited to twelve members, with no more than one voting member from each IDN partner. Any IDN partner can petition to join the Steering Committee. Membership is determined by majority vote of the Steering Committee members. Initial composition of the Steering Committee was approved by the Network4Health Partnership Team, which includes representation from each Partner organization. The committee includes at least two steering committee members that have no financial interest in the process (impartial representation).

Steering Committee membership approved by the Network4Health Partnership Team is as follows:

- Alexander J. Walker, Esq., Executive Vice President, Operations & Strategic Development, Catholic Medical Center (Chair)
- Vic Topo, President & CEO, Center for Life Management
- Borja Alvarez de Toledo, President, Child and Family Services of NH
- Steven A. Paris, Regional Medical Director, Community Group Practices, Dartmouth Hitchcock, Manchester
- Larry Gammon, Chief Executive Officer, Easter Seals
- Jennifer P. Driscoll, MSHSA, VP, Planning & Business Development, Office of Strategy, Management, Elliot Health System
- Stephanie Savard, Chief Operating Officer, Families in Transition
- Patrick Tufts, President, Granite United Way
- Toni Pappas, County Commissioner, Hillsborough County
- Cheryl Coletti Lawson, Board Chair, HOPE for New Hampshire Recovery
- Kris McCracken, President, Manchester Community Health Center, Child Health Services & West Side Neighborhood Health Center
- Timothy M. Soucy, MPH, REHS, Public Health Director, Manchester Health Department

The Steering Committee is responsible for guiding the work of the individual workgroups, providing initial and ongoing guidance to the workgroups, providing feedback on workgroup recommendations, addressing mid-level issues, and escalating higher-level, strategic issues to the Partnership Team as

warranted. As with the Partnership Team, all meetings are organized and staffed by Network4Health's Executive Director, with project management support. This includes preparing meeting agendas, providing all necessary materials and background documentation, briefing members on all relevant issues prior to meetings (as necessary), documentation of proceedings (including votes) and, when necessary, escalating issues to the Partnership Team for resolution. Peter is also responsible for ensuring communication of Steering Committee decisions to the different IDN partners and projects, as appropriate.

Because of the day-to-day involvement of the Steering Committee (versus the Partnership Team), this body will have primary responsibility for monitoring overall project performance via status reports provided by the Project Management Team, as described below.

Steering Committee decisions are made on the basis of majority vote (in person or remotely, via electronic voting), when a quorum is present. For the Steering Committee, a quorum is 75% of the membership is required, given the small size of the group and the need for a high level of engagement among Steering Committee members. We expect in most cases that decisions will be made by acclamation. In some instances—where, for example, there is the potential for financial conflicts of interest—decisions may be escalated to the Partnership Team or the CMC Leadership Team.

Project Management and Accountability

Project-Specific Workgroups

As described below, each project-specific workgroup includes representatives of CMC, key partners involved in the project, and support partners contributing to the project. For the development of the initial project plans, the Steering Committee has functioned as the workgroup for Projects A1 and A2, Workforce and HIT, respectively. Over time, particularly as the projects move from statewide initiatives to being implemented in the region, separate workgroups will be established for each of these projects.

Each workgroup has specific project milestones and deadlines, which will be documented in individual work plans. All work produced by the workgroups will be presented to the Steering Committee for feedback and direction. It is anticipated that there will be some overlapping workgroup activities. The Steering Committee will provide input as to how these activities can be coordinated across workgroups to limit duplication of effort.

Project Management Team

Reporting to the Executive Director, the Project Management Team oversees the development of the project plan and will supervise additional project management resources responsible for specific functions (e.g., IT project management) and for day-to-day project activities. This Project Management Team will participate in all project workgroups, to ensure a system-wide approach to project implementation.

The Project Management Team is responsible for day-to-day project management activities, including:

- documentation of the overall project plan;
- supporting each of the six project workgroups through:
 - development and documentation of project work plans, including establishing milestones and deadlines
 - documentation of issues and decisions
 - tracking project activities and tasks
 - monitoring compliance with deadlines for tasks and deliverables, and
 - escalating issues to the Steering Committee as necessary
- establishing and documenting the risk management approach for use by project workgroups;
- establishing and documenting the change management approach for use by project workgroups; and,
- project resource allocation and monitoring.

The Project Management Team will also work with project leads to define the scope of key decisions (high-level, by category) that need to be made throughout the planning and implementation phases, and the level of approval required (e.g. CMC Leadership Team, Partnership Team, Steering Committee).

The Project Management Team will prepare monthly status and key performance reports for the Steering Committee. These reports, which will address the status of each project, including at a minimum:

- milestones
- monitoring compliance with deadlines for tasks and deliverables
- project risks
- project change requests (scope, schedule, finance/budget)
- issues for escalation
- status of resource allocation
- community engagement activities
- performance measurement related to the project

The Steering Committee will closely monitor the success of the workgroups in meeting the project plan milestones and deliverables, and will monitor performance on project-specific measures by partner organizations where possible. While reports will be made to the Steering Committee on a monthly basis, we recognize that performance metrics will not be available on such a frequent basis, and will more likely be provided on a quarterly, semi-annually or annual basis as appropriate.

When project leads or other project participants identify a low-performing partner, Network4Health will first work to help that partner improve performance by providing technical assistance or other resources as appropriate. If improvement is not seen, the Network4Health Executive Director will work with the partner to develop a performance improvement and corrective action plan, and will work with the Project Management Team to monitor implementation of the corrective action plan. If a partner

continues to underperform, the issue will be escalated to CMC for a decision of whether the partner should remain part of Network4Health.

As described above, Network4Health contains all major primary care, behavioral health, and social service agencies in the region. Based on the State's Data Books, we have identified additional primary care providers that see a small but strong minority of our region's population, and we will work to engage those providers in Network4Health activities. In addition, Network4Health will continue its efforts to improve access to behavioral health services through improved workforce capacity, increased integration, improved care transitions, and increased services for individuals with co-occurring conditions.

Question 7b

Please provide narratives describing how the IDN's governance structure provides oversight for the following four required governance domains: i. Clinical governance: Please describe how and by whom standard clinical pathways will be developed. Please also describe strategies for monitoring implementation of clinical standards, managing IDN performance, supporting and monitoring individual partner performance, and fidelity to evidence-based standards. ii. Financial governance and funds allocation: IDNs are asked to provide information about financial governance in the Budget and Funds Allocation section of the Plan (Question 8) below. There is no need to describe Financial governance in this section. iii. Data governance: Please describe how the IDN will oversee data sharing standards and processes, including approach to draft and execute data sharing agreements among IDN partners, and what role existing information technology, health informatics, clinical, and administrative leadership within partner organizations will play in the data governance process. iv. Community engagement: Please describe how the IDN will ensure that the community engagement activities described earlier in Question 3 will be continued throughout the demonstration and supported by the IDN's governance committee structure.

Network4Health has selected to utilize its Steering Committee, described above, to provide clinical, financial, and data governance for the IDN, and it will monitor ongoing community engagement activities. We believe that by having one governance committee to focus on all of the issues facing the IDN, including clinical, data, and financial issues in addition to project specific issues and community engagement, that Network4Health will be able to most efficiently and consistently address both challenges and opportunities. Network4Health has appointed strong CMC leads for each of the clinical, data and financial areas. Where particular issues require broader representation than is included on the Steering Committee, the lead in the particular area (clinical, financial, data) will be responsible for including other partner organizations as appropriate. The Steering Committee appreciates the potential to create formal sub-committees to help guide and govern the work for Network4Health and will continually monitor its own ability to perform these duties. If the Steering Committee is not able to fully address all issues before it, then Network4Health may amend its governance structure in the future to have separate committees of the Steering Committee to focus on clinical, data, financial and community engagement considerations of the IDN.

Below we provide an overview of how clinical, data and consumer engagement issues will be addressed by Network4Health, in terms of individual accountability and raising particular issues to the Steering Committee and full Partnership Team, as necessary.

Clinical governance: CMC's Chief Medical Officer, Dr. William Goodman, will serve as the Chief Medical Officer for Network4Health and participate in Steering Committee meetings that will include discussions of clinical approaches and implementation of evidence-based clinical guidelines. Dr. Goodman will work with medical and behavioral health directors of partner organizations to consult on clinical governance issues as needed. We anticipate the following potential clinical activities occurring within Network4Health as part of the implementation of the Behavioral Health Integration Project and the three community projects that Network4Health has selected to implement:

- developing standard clinical pathways and strategies for monitoring and managing patient outcomes;
- developing guidelines for supervision of clinical staff in implementing any new clinical strategies;
- developing strategies for communication with clinicians in implementing new guidelines;
- developing guidance on clinical improvements;
- developing strategies for monitoring the implementation of clinical standards;
- monitoring IDN performance and determining interventions to support the IDN for enhancing outcomes; and,
- developing and approving clinical reporting for the IDN.

To the extent that specific projects require clinical input, shared clinical pathways, or decisions on implementation of evidence-based practices, project leads will solicit input for approaches and will bring those decisions/proposals to the Steering Committee as part of the project's monthly report. If clinical input is needed between Steering Committee meetings, Dr. Goodman will have the authority to pull together a subcommittee to discuss particular issues. As noted above, the Steering Committee will monitor provider performance as part of overall project monitoring. The Partnership Team will be kept informed of these activities and will be asked for input and feedback, where appropriate.

Data governance: As projects move into the implementation phase Network4Health partners will need to share data. Network4Health will address data-sharing standards and processes, including the need for any standardized data-sharing agreements across partner organizations and determine how these arrangements will be monitored. CMC leadership will play a key role in the HIT workgroup, led by Thomas Della Flora, and will work closely with IT leads of other partner organizations, where applicable. One of our first steps will be to identify the current data collection capabilities at each of our partner organizations who will be involved in data collection and sharing activities. We will develop mechanisms for data sharing that provide robust data to ensure coordination for our clients across all programs while also providing confidentiality as required by NH state law. Data-sharing proposals, including the potential to leverage existing tools in use across our partner organizations, will be brought to the Steering Committee for discussion and approval. As with clinical issues, CMC will work with HIT directors and other appropriate staff within partner organizations to consult on data related issues as necessary.

We anticipate the following data sharing issues to be discussed to further the efforts of Network4Health, particularly as needed for implementation of the specific DSRIP project:

- providing processes and standards for data sharing among the partners in the IDN;
- providing guidance on the approach to drafting and executing data sharing agreements;
- developing reporting and reporting processes for the IDN; including both clinical and financial reporting;
- developing monitoring policies and procedures; and,
- determining the roles of information technology, health informatics, clinical, and administrative leadership within partner organizations will play on overall data governance.

Currently, Network4Health does not have any plans to create a patient registry for shared patients within the region. If there appears to be a need for such a patient registry, Network4Health will consider developing and implementing one at a future date.

Community engagement: As described earlier, the Project Management Team’s monthly project status reports submitted to the Steering Committee will address the status of community engagement activities for each project during the month. Topics addressed will include, consistent with our community engagement strategy described above in our response to Question 3:

- a description of all community engagement that has occurred during the month, including any community meetings that Network4Health participate in and traditional or social media provided by Network4Health, and level of response to those communications;
- a discussion of whether Network4Health is effectively obtaining community input and included in the strategic path of the IDN;
- a discussion of the channels and venues through which input is solicited and;
- a discussion of how the communication strategies will continue through the demonstration, including appropriate topics for community input or outreach.

This monthly report will be reviewed by the Steering Committee, and the Steering Committee will make recommendations for further action based on this report. In addition to sharing this information with the Steering Committee, any communications will be shared with the Partnership Team and the Steering Committee will use Partnership Team meetings as a way both to further communicate Network4Health activities and to utilize partner organizations to help brainstorm communication strategies and opportunities. By engaging the Partnership Team in communication, Network4Health will ensure the flow of complete, accurate, and timely information to all partners. Partners will frequently be tasked with participating in efforts to engage the community—for example, by hosting events at their locations, recruiting for and hosting focus groups, surveying their providers, staff, or clients—and performance will be monitored by the Executive Director and the Project Management Team.

Project planning and implementation workgroups will have the authority and will be encouraged to reach out directly to stakeholders to receive feedback on particular project approaches. Project leads will report their plans for this outreach as part of reports to the Steering Committee, allowing for consistent and efficient communication across stakeholders regarding all Network4Health activities.

Question 7c: Governance charters

Network4Health's Steering Committee Charter is included as an attachment to this response.

Question 7d: Key IDN management roles

Key Network 4Health management roles are included in tab 7D of the IDN Project Plan Supplemental Data Workbook:

- Executive Director, or equivalent: Peter Janelle
- Medical Director, or equivalent: Dr. William Goodman, Chief Medical Officer, CMC
- Financial Director, or equivalent: Pamela Martel, CMC

Question 8a

The state will be distributing one-time Project Design and Capacity Building Funds in 2016. These funds allow IDNs to develop the foundational tools and human resources that will enable IDNs to build core competencies and capacity in accordance with community-based priorities.

As part of the IDN Application, each applicant IDN was asked to provide a high-level description of how Project Design and Capacity Building funds would be allocated, with the opportunity to finalize these estimates as part of the IDN Project Plan.

Please provide an updated budget narrative describing the IDN's planned use of Project Design and Capacity Building funds

Network4Health's planned use of Project Design and Capacity Building funds remains consistent with our initial IDN application. We intend to use these funds over the course of the five years, however, anticipate that the funds will be significantly front-loaded to cover initial administrative costs of Network4Health and infrastructure needs of our partners. By allowing some funding to be available in later years, Network4Health will be able to provide ongoing support to our partner organizations for both initial project support and continued implementation and transformation.

Administrative Funds

To date, Network4Health has committed administrative funds for the Executive Director, project management and strategic consulting services to assist in the development of Network4Health's governance structure, development of the IDN Project Plan application, meeting facilitation, and initial project plan development. Administrative funds will be focused on continued project plan development and implementation. Network4Health, through CMC, has posted a position for a seasoned project manager to provide additional support to project plan development and implementation. Administrative funds may also be used to cover the cost of securing meeting locations, although we anticipate that most will be provided at no cost by partner organizations. Funds may also be used to assure that consumers will be able to participate in the development process by receiving a modest stipend to attend meetings and cover transportation costs, where appropriate.

Capacity Building Funds

As noted in our initial application, there is significant need to improve our behavioral health workforce and we anticipate using some capacity building funds to assist in the recruitment, hiring and maintenance of direct care or service provision workforce, particularly to support the recruitment and hiring of LDACs, Licensed Masters in Social Work, Mental Health Counselors, Community Health Workers and care managers experienced in mental health and substance use services. Addressing workforce issues will be an important component of our behavioral health integration project as well as each of the three community projects that Network4Health has selected to pursue.

We anticipate that funds will be used to develop job descriptions, advertise positions, interview candidates and the onboarding of new staff.. Funds also will be used to work with existing staff to

redesign job responsibilities to increase job satisfaction by assuring that they are working “at the top of their license” as much as possible. Funds will also be used to make reasonable compensation adjustment, conduct professional development programs, and cross-train staff, as necessary. In addition, Network4Health anticipates providing technical assistance to staff seeking licensing on completing their application and navigating through the application process.

Because it is so difficult to hire LADCs, particular focus will be given to enhancing existing training programs and to training LICSWs and Mental Health Counselors to obtain core competencies identified by the state for professionals to have comparable MLADC skill set to work with individuals with a substance use disorder. Training funds will also be used for new staff hired to implement initiatives develop under this initiative.

Health Information Technology / Health Information Exchange

There are significant capacity gaps across Network4Health partner organizations related to the availability of and capacity to use health information technology and to exchange health information across partners. Network4Health will focus funds on essential technology to implement the projects being pursued by the IDN, including the behavioral health integration project. As noted in our initial application, if funds are available locally, Network4Health will consider using them to select and implement a community-based care coordination/care management tool that can be used to coordinate all services provided to the targeted population, including behavioral and physical health services and social services. This would be of significant benefit to both our partners and the patients we serve, by allowing for greater system transformation, collaboration and coordination.

Ideally, such a care management/coordination software would connect Network4Health partners’ EMRs so that duplicate entry will be avoided. As envisioned, smaller partners without an EMR would be able to use the care management tool to document care management/coordination activities for sharing with other IDN Partners. Under this sort of model, these smaller agencies could print the case management notes from the online system and place them in the client’s agency record. Funds could be used to purchase software licenses and provide the technical assistance that Network4Health will need to link the tool to the EMR. Funds can also be used to train all partners in use of the tool and to develop a common vocabulary among all partner organizations.

Question 8b

Tab 8b provides final projected budget estimates.

Question 8C

Describe how decisions will be made about the distribution of funds earned by IDNs over the course of the demonstration and how the IDN will develop project budgets and a fund allocation plan.

As described in our governance structure, Network4Health has vested authority to make financial decisions in its Steering Committee. Specifically, as detailed in the draft Steering Committee Charter, the Steering Committee will be responsible for:

- establishing rules for making financial decisions
- defining roles and responsibilities of partnering organizations
- making decisions on the distribution of funding across projects including timing and amounts, being careful not to create potential or perceived conflicts of interest;
- establishing the budget for the IDN and IDN projects
- developing and approving financial reporting for the IDN.

At monthly Steering Committee meetings, Network4Health's Executive Director will make reports on current spending and upcoming decisions regarding fund distribution. On a quarterly basis, the Network4Health's Financial Director will also attend Steering Committee meetings and give a more in-depth financial report.

The Steering Committee has developed initial rules for making financial decisions; however, these will be further developed once the planning year begins. Financial decisions will begin as recommendations from either Network4Health's Executive Director or the project leads of the six projects being undertaken by the IDN. Based on recommendations from the Executive Director, the Steering Committee has begun to make decisions about distribution of funds earned by Network4Health. Specifically, Network4Health has a dedicated Executive Director who is paid from administrative funds. Other administrative funds that have been approved by the Steering Committee to date include funding for project management and other support from CMC, as well as funding for strategic consulting and assistance in development and completion of the behavioral health needs assessment and the project plans. The Steering Committee has also agreed in principle to having project management support for each of the six projects that will be undertaken by the IDN.

As indicated in Tab 8b of the Supplement Work Book, Network4Health has made initial estimates of how funding will be divided across broad initiatives (e.g., project plan development, workforce related issues, health information technology) and how it will be divided across participating partners. These are estimates based on our current understanding, but fund allocation may change as we dive deeper into project planning. It is our intention that the administrative and capacity building funds distributed in Year 1 be available across the five years of the project, with the largest allocation during the first two years, and lower allocations in the last three years when Network4Health will be eligible to earn funds based on our collective performance.

In looking at fund distribution, Network4Health plans to distribute funds by project consistent on the value that the State has assigned to each project, as a starting point. We expect to stay close to those project amounts, particularly for the core competency project, and recognize the need to invest significantly in workforce and health information technology. However, the Steering Committee may consider recommendations from the project plan work groups to increase (or decrease) funding needed to implement a particular project based on the final project approach and level of effort needed to implement a project, including the number of impacted organizations and required investment for

success. Given that the overall funding for the three community-based projects are relatively small, the Steering Committee will consider how best to utilize the funds across each of the three projects to ensure the greatest impact. Steering Committee recommendations on budget will be shared with the Partnership Team for review. Where Network4Health seeks to modify fund allocation from what is included in Tab 8b, we will notify the State of the proposed modification and seek State approval of the change.

Following approval of this overall project plan and approach by the State, Network4Health will ask each of the six project plan work groups to develop a proposed budget for implementation to present to the Steering Committee. The initial budget will be based on project implementation costs and may include costs related to implementing the project including project management, consultant costs, training in new case delivery and case management approaches and implementation of evidence-based practices, hiring costs, retention enhancements, infrastructure and technology needs, and other implementation costs which may be identified by the work groups. Funds to be distributed to partner organization for project implementation efforts will be based on the roles and responsibilities of the partners relative to the particular project and its ultimate success.

Following implementation, funds will be distributed to partner organizations based on overall performance of Network4Health on quality measures and outcomes. While we anticipate that most partners of Network4Health will share in those funds based on a formula that takes into account activity within each of the projects by an organization and overall performance of attributed Medicaid lives across the measures, this formula will be reviewed and refined prior to project implementation.

Network4Health is committed to sharing all funds earned with partner organizations, and limiting to the greatest extent possible, the use of funds for administrative costs. We believe that it is important to ensure that the funds appropriately flow to partner organizations to make a difference in the lives of the patients we collectively serve. Network4Health will work closely with partner organizations to monitor quality performance outcomes to ensure that the IDN is able to collect the maximum amount of funding, and will use funding to best support our providers in delivery system transformation and ultimately to improve health outcomes for our residents.

Question 8D

Please provide assurance that an organization or provider participating in multiple IDNs will not receive duplicative payments for providing the same services to the same beneficiary through a project activity.

With any new, complex endeavor, program integrity is essential. CMC, as the Lead Entity for Network4Health, will ensure that no provider organization that participates in multiple IDN networks will receive duplicative payments for providing the same services to the same beneficiary through a project activity. First, Network4Health does not anticipate making any specific payment tied to a service for a particular member. Funds will be based on performance and calculated using only individuals attributed to Network4Health.

Second, Network4Health is collaborating with the other IDNs in the State regarding a standardized compliance plan to promote consistency within the State on behalf of those we serve and on behalf of entities and vendors that may work across IDNs. As part of the compliance plan, there will be a conflict of interest policy and required conflict of interest disclosure form to be completed by all Network4Health partners on an annual basis. In addition to their primary intended purposes, these disclosure forms will be a useful tool to determine whether Network4Health partners are participating in any other IDNs. In cases where partners do participate in more than one IDN, Network4Health will work with the other IDN(s) to determine whether any organization or provider participating in multiple IDNs will receive funding from more than one IDN and assure through each of the IDNs that the particular partner sign an assurance that they will not request or receive duplicative funding for services provided to the same beneficiaries through a project activity.

Question 9

Please provide a narrative describing at a high-level the current use of APMs among IDN partner organizations across all payer types. These may include, for example, bundled payments, pay-for-performance, PCMH primary care payments with shared savings, population based payments for condition-specific care (e.g., via an ACO or PCMH), and comprehensive population-based payment models. Include any commercial APMs currently in use in the IDN. For additional information on the state's transition to Alternative Payment Models, please see the Introduction.

Network4Health is supportive of the state's efforts to transition 50% of Medicaid provider payments to Alternative Payment Models (APMs). Currently there is limited participation in APMs by Network4Health partners. The larger hospital systems participate in APMs as part of their commercial and/or Medicare revenue, but there is limited use of APMs within the Medicaid market, except sub-capitation payments made to community mental health centers. To the extent that providers participate in contracts with Medicare and/or commercial payers where they manage clinical and financial risk, they typically utilize a FFS payment methodology and calculate a total cost of care, allowing providers to share in savings if the actual cost is less than the expected cost and quality performance standards are met, or to share in risk if actual cost is more than expected cost. A number of partners within Network4Health formerly participated as a Pioneer ACO as part of their Medicare line of business but are no longer participating in the program.

Despite the minimal use of APMs to date for services provided to the Medicaid population, Network4Health's provider organizations understand the importance of moving away from the fee-for-service payment system and increasingly tying payment to a combination of improved quality and greater efficiency. Network4Health believes that fee-for-service medicine does not provide the right incentives for delivery high-quality, integrated care to its members. We believe that many of the services that will be developed and implemented through this DSRIP initiative, such as Critical Time Intervention, will demonstrate a significant return on investment in terms of both improved quality outcomes and reduced costs. It will be important for New Hampshire to consider how APMs will be able to incorporate the services that are provided by IDN partners in Region 4 and across the state to ensure sustainability of these efforts once the DSRIP funds expire.

While partner organizations agree with value-based purchasing and APMs as a long-term strategy, providers are in varying places in terms of their ability to provide care under an APM. To do so, it is essential for the right data systems to be in place to allow for appropriate financial and quality reporting and predictive modeling capabilities. In addition, focusing on practice transformation such as implementation of primary care medical homes and integration of physical and behavioral health care is equally important to the long term success.

Question 10a

Tab 10A tab of the IDN Project Plan Supplemental Data Workbook identifies the project lead and individuals nominated to participate from Region 4.

- i. The IDN Workforce project lead: Peter Janelle (Temporary)
- ii. The individuals from the IDN participating (or nominated to participate) in the Statewide Behavioral Health Workforce Capacity Taskforce: **Lisa Descheneau, Cheryl Colletti**

Question 10b

Drawing on the IDN's Service Area Community Needs Assessment, please provide a narrative describing the critical workforce capacity challenges facing the IDN. The response should include a discussion of challenges associated with recruitment, hiring, training, and retention.

There are numerous workforce challenges that are not unique to Region 4 or to New Hampshire. For example, according to SAMHSA, 55% of U.S. counties do not have any practicing behavioral health workers, and 77% reported unmet behavioral health needs.

In New Hampshire, workforce shortages are particularly acute in mental health and substance use disorder treatment programs. Even more challenging is recruiting clinicians licensed in both mental health and drug and alcohol counseling (LICSW, LCMHC, etc.) to treat members with co-occurring disorders. Additionally, there is a lack of consistent and attainable certification standards across the continuum of care.

According to a presentation of the NH Community Behavioral Health Association to the Governor's Commission on Health Care and Community Support Workforce noted the following:

- In August 2016, there were 173 vacant positions across nine of New Hampshire's community mental health centers, and the month-to-month trend in vacancies is increasing
- The gap between the high end of the wage range across the 9 CMHCs is well below the state mean for APRN and MDs (4% and 12% respectively). Looking at the low end of the range, the gap is 17% and 29%, respectively. For Masters Licensed or Licensable Therapists, the gaps are even greater. The high end of the wage range across the nine centers is 35% lower than the state mean, and the low end of the wage range is 57% lower than the state mean.
- Length of time to fill postings: ranges between 68 days to 157 days among the nine centers.

Among the negative effects of this workforce shortage on patients are: increased wait times for consumers, reduced continuity and quality of care, less individualized care, and less timely access to services.

This presentation cited such factors as restrictive regulation (policy and legislative barriers) as a factor contributing to shortages, including a "lack of licensure reciprocity, which staff are allowed to sign off

on a treatment plan, and the lack effective coordination of services and billing across the service environment supporting individuals with mental illness.”

The issue of licensure reciprocity is significant in regions that border Maine and Massachusetts. Qualified professionals from out-of-state are available but unable to be hired. The State of New Hampshire is so restrictive that experienced clinicians will not go back to the drawing board to comply with NH licensing requirements. The problem is particularly acute in behavioral health resulting in care being denied.

Network4Health key partners have, based on their own experiences, identified the following as key challenges that the IDN faces with respect to recruitment/hiring, training, and retention BH personnel includes:

- Fewer people are choosing a career in BH due to low compensation rates as compared to the training and experience needed. The low compensation is large part due to insufficient reimbursement.
- Low job satisfaction due to insufficient wrap around services to appropriately care of the patient.
- Mental health is not valued by the community.
- Lack of supply in certain areas of BH due to increasing sub-specialization of BH services and the workforce (psychiatrists looking for positions with no call, adult only, child/adolescent only, outpatient only, etc.).
- Training programs not keeping pace with changes in demand.
- Staff safety concerns.
- Limited use of peer supports, recovery specialists and outreach workers who, if made available, may free up time for other professionals in the workforce to practice more efficiently.
- Inability of APRN to provide medication assisted treatment limits overall capacity in the face of increasing need and demand.

As Network4Health—and New Hampshire as a whole—moves toward more and better integration, other challenges will likely become apparent. Integrating behavioral health and primary care will require a health workforce with the skills and training to address the continuum of needs, as well as navigating mental and physical health care needs and potentially complex administrative and operational processes. Moreover, education and training requirements of the behavioral health occupations needed for integration with primary care will likely increase. Finding solutions to these workforce issues is essential to ensure a high quality of services to individuals with mental health and substance use issues in the State who are unable to obtain necessary care due to these shortages.

Question 10c

Please provide a narrative describing at a high level the 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

Network4Health looks forward to participating in the Statewide Behavioral Health Workforce Development Taskforce, as we recognize that many of the challenges we face are common to all of the IDNs and to the behavioral health sector in general. Furthermore, we recognize that some of the necessary strategies to address these issues must be undertaken by the state (e.g., regulatory and rate relief).

In advance of the workgroup, Network4Health has identified some general approaches that we will recommend for evaluation at the statewide level and in our region, including:

- Offer incentives for pursuing behavioral health positions (pay for schooling, job placement, loan forgiveness, etc.). Incentives can be tiered to provide career progression.
- Create an educational collaborative with BS to BSN, RN to APRN, MSW, programs, etc.
- Develop and offer training programs to enhance understanding and skills across the workforce in identifying mental health and substance use needs, and referring to providers with appropriate skills and knowledge; program should be available in person and online.
- Support enhanced capacity to treat individuals with mental health and substance use disorders through skills trainings for current staff.
- Consider licensing reciprocity with neighboring states to increase the potential applicant pool for NH job opportunities.
- Promote opportunities and support for bachelor-level in psychology students to obtain licensed nursing assistants training.
- Educate high school students and/or partner with technical schools.
- Leverage the work of Easter Seals in teaching English to refugees to help provide necessary skills to meet job requirements.
- Help foreign-educated residents move their certifications and address statewide barriers on this front.
- Create an education/training collaborative with the hospitals, State Hospital, and community mental health partners.
- Reduce administrative burden on providers to allow for greater efficiency.
- Allow for APRNs to prescribe MAT.
- Work with insurance carriers to improve reimbursement by linking the benefit of behavioral health services to reduced medical costs overall.
- Conduct ongoing data collection and benchmarking to document workforce issues and trends.

Additionally, Network4Health is considering utilizing telemedicine to leverage highly skilled, low supply personnel. We are considering this not only in rural areas, but also in more urban areas where the workforce is aging, as a critical strategy to ensure 24/7 coverage for people with severe and persistent

mental illness

It is in everyone's best interest to work through a statewide planning process to support the IDN in addressing these challenges at the IDN level as we can collectively identify where needs are by IDN and where resources are needed and work collaboratively to align supply of resources with that demand.

Question 11a

Tab 11a identifies the HIT Lead for Network4Health as **Thomas Della Flora** from Catholic Medical Center.

Question 11b

Please provide a narrative describing the IDN's critical HIT gaps, including gaps related to community based organizations

Providers face several challenges with respect to EHR and HIE. First, the state HIE utilizes three different systems, so each time a record is updated, the information has to be entered three separate times. Second, while EMRs have been widely adopted by the key IDN partners, they are for the most part not interoperable. Third, state SUD providers are required to use the state Web Information Technology System (WITS), an EHR which is considered to be difficult and cumbersome to use. In addition, there is currently no reliable index for safe identification of patients across care settings. Today's process relies heavily on human reconciliation from various data sources. Finally, as discussed below, state health information privacy laws impede providers' ability to share information. New Hampshire state law exceeds HIPAA requirements regarding the use and disclosure of Protected Health Information (PHI). The practical implication of this is that patients – who often do not wish for their information to be shared (particularly with respect to incarceration or behavioral health issues) -- do not provide authorization for the release of information. Anecdotal evidence points to the haphazard nature of information sharing. From the perspective of the behavioral health system, there is currently no way to systematically identify physical health issues. There is also a significant technology gap related to resource disparity across members of the partnership. The resource disparity is associated with technology assets; both human resource assets and material assets. The disparity is particularly acute when one considers the hospital systems within Network4Health in comparison to some of the smaller participating community based social service organizations. Aside from the community mental health centers, most community-based behavioral health and social service providers do not utilize HIT and still rely primarily on paper records or non-standards based electronic data capture tools for care. This is a clear example of the disparity in material technology assets related to currently active software solutions across members of the partnership. The solutions used in the inpatient environment have historically been perceived as too costly for smaller members of the partnership. A number the more industry specific software vendor solution used by specialty providers encourage their vendor centric solutions, which are less efficient and do not provide ready participation for those not currently using their software. Some participating partners lack an electronic solution that manages content appropriate for exchange.

In addition, providers use different care management mechanisms and tools, and to the extent that there is electronic care plans, they are not compatible with other provider systems. This leads to the potential for significant gaps in information, and importantly for this population which may have difficulty explaining conditions on an ongoing basis, requires for patients to have to repeat difficult or traumatic information as they visit each provider.

Where providers do have access to technology, there are several data management considerations which stem from changed expectations based on the historical perspective versus the current perspective and anticipated expectations associated with information exchange. An example of a data management concern would be not putting in place the structures in an application that would provide for data segmentation or failing to adequately train employees to use those structures appropriately. Either of these factors taken independently would result in inadequate data segmentation to appropriately manage concerns like differential protection or transfer management of substance abuse information.

The statewide survey that Myers & Stauffer has distributed to the IDN for completion in mid-November will provide the State and each region with a stronger understanding of the HIT capabilities and gaps by individual provider and provider type. This will go a long way in helping Network4Health to understand where best to target its focus and resources to make foundational improvements first, and to address other challenges or gaps after tackling the essential building blocks.

Question 11c

Please describe how the IDN anticipates it will address these gaps

While Network4Health can take some steps to address gaps in HIT, the issue is far broader than can be expected to be addressed through the IDN. The statewide HIT work group will have many issues to address on a statewide basis, including potential funding for HIT for our behavioral health and social service agencies that currently do not have EHRs, and funding to help connect the EHRs of partner entities, allowing for interoperability across EHRs, HIE and other data sources.

Through Network4Health however, we can together work to develop security standards and standardize reporting of information that allows us to collectively share information across partners and improve knowledge, within HIPAA and New Hampshire privacy requirements. It is the intent of the partnership to develop opportunities for collaboration across human resources partner members with technical expertise. The partnership also intends to participate in the technology groups spanning the regions. These resources will meet to discuss and propose potential solutions addressing data management and technology based HIT gaps.

In addition, if possible, as noted above, Network4Health is interested in selecting and implementing a community-based care coordination/care management tool that can be used to coordinate all services provided to the targeted population, including behavioral and physical health services and social services. As envisioned, the care management/coordination software will connect with IDN partner's EHRs so that duplicate entry will be avoided. In addition, smaller partner organizations without an EHR will be able to use the tool to document care management/coordination activities for sharing with other IDN Partners. They can print off the entries and place in the client's agency record. Funds could be used to purchase software licenses and provide the technical assistance that IDN partners will need to link the tool to the EHR. Funds will also be used to train all partners in use of the Tool and to develop a common vocabulary among all the IDN partners.

Question 12a

Tab 12a of the Supplemental Data Workbook provides details on the current assessment of Network4Health providers specific to core competencies of behavioral health integration.

Question 12b

Tab 12b of the Supplemental Data Workbook lists the Network4Health partners participating in this project.

Question 12c

Please provide a narrative describing what indicators the IDN will use to manage day-to-day performance and understand in real-time whether the IDN is on the path to improving broader outcomes.

Network4Health will develop a comprehensive monitoring and evaluation plan with a two-fold objective: monitoring progress during the early implementation years and providing sufficient information to understand whether the intervention has been effective. First, it is important to collect the necessary data to ensure timely and effective implementation of the integration strategies necessary for partner organizations to meet designation as a Coordinated Care Practice or an Integrated Care Practice. It is equally important to collect and report key information that will enable Network4Health and the State to understand the impact of this integration intervention in our region.

Based on our initial assessment of current integration levels among the primary care, mental health and substance use partner organizations participating in Network4Health, we understand that various partner organizations are at different levels of integration of physical health and behavioral health services. A handful of our partner organizations are poised to be designated as an Integrated Care Practice, while most Network4Health providers will work towards becoming designated as a Coordinated Care Practice. In order to assure that Network4Health can meet the project's expectations of dramatically increasing integrated care across the region, it will be essential to have a strong monitoring plan to allow Network4Health to appropriately monitor progress of our partner organizations in their implementation of transformation strategies. Network4Health will use information gathered from this monitoring to determine where it should focus additional training, technical assistance, and support.

As a planning first step, Network4Health will confirm which of its providers are required to become an Integrated Care Practice based on percent of Medicaid members served. We will also develop clear criteria for being designated as an Integrated Care Practice, giving close consideration to the SAMHSA framework for evidence-based practice for integrated care.

Network4Health will assign a project manager to work closely with the Executive Director and Project Leads to ensure that partner organizations are making progress in moving towards either designation as a Coordinated Care Practice or an Integrated Care Practice. In order to meet state requirements, Network4Health will require that each participating provider organization demonstrate their progress in

becoming a Coordinated Care Practice by December 31, 2017, or an Integrated Care Practice by December 31, 2018. As such, our initial focus will be on how quickly and how well partner organizations are doing in planning and implementing strategies within their practice to transform them to becoming Coordinated Care Practices or Integrated Care Practices.

Each partner organization will complete a self-assessment of their current state and ability to move to either a Coordinated Care Practice or Integrated Care Practice within the specified timeframes allowed under the project. Network4Health will catalog each organization's need for comprehensive technical assistance for implementing the strategies through a combination of learning collaboratives, trainings, and one-on-one technical assistance or coaching within practices. We will develop our implementation plan, which will be built off of the core project components and process milestones detailed by the state, which will include specific tasks, milestones and associated timeframes, budgets, a workforce plan, and will identify critical path items where interdependencies will be clearly delineated.

Network4Health will review partner organization progress using SAMHSA's Framework for Integrated Levels of Care and will periodically determine whether or not they are meeting the process milestones detailed in the project protocol. Partner organizations will be required to report to Network4Health on their progress on a quarterly basis and, as part of that reporting, they also will be asked to request specific training and technical assistance or other support required in order to make progress on implementing various requirements of the SAMHSA Framework. Network4Health will maintain open, two-way communication with all participating organizations so they can feel comfortable sharing any problems they have with implementing their strategies.

During the first implementation year, Network4Health will also begin to work with providers on specific data reporting that is required as part of this process. This is important in order to allow ample time to seek feedback from the partner organizations, and to allow them time to put in place the work flows and processes necessary to report outcome information to Network4Health. We will develop a comprehensive plan for data collection which includes quality control and allows for sufficient time for CMC to aggregate information across the IDN. We will seek input from partner organizations regarding the best approach for collecting data to ensure we balance the burden of data collection with robust information from which to monitor the program's outcomes.

During the first implementation year, we anticipate holding regular meetings with key staff from each partner organization to ensure that the necessary infrastructure, training, support, and guidance are provided by Network4Health. In addition, Network4Health's overall approach to project governance includes regular project meetings to guarantee that progress is being made regarding implementation. Network4Health anticipates scheduling quarterly team meetings to review progress using specific performance measures in anticipation of initiation of formal data reporting, including:

- number of Medicaid beneficiaries receiving Comprehensive Core Standard Assessments
- number of Medicaid beneficiaries with a positive screening tool

- number of Medicaid beneficiaries with a positive screening tool and referral for intervention
- number of new staff positions recruited and trained
- inpatient admission and ED utilization data

Throughout the project, the Steering Committee will receive monthly updates on partner organization progress against the SAMHSA Framework and will discuss ways to mitigate challenges and risks to meeting required project milestones. The Partnership Team will receive quarterly updates and will also be asked for input in resolving any identified barriers to progress. As noted below, primary outcomes for this intervention include reduced avoidable inpatient and ED utilization and improved overall health status for our target population of Medicaid beneficiaries with or at risk for behavioral health conditions. However, we will include input from partner organizations and also from the literature to determine if it makes sense to monitor other outcomes.

Question 12d

Please provide a narrative describing the anticipated outcomes of this project in relation to the care gaps identified as part of the IDN's Service Area Community Needs Assessment.

Network4Health fully supports transforming its delivery system to improve the integration of physical and behavioral health care services so that it “effectively and efficiently prevents, treats and manages acute and chronic behavioral health and physical illnesses across multiple providers and sites of services,” as described in the state’s plan for this project.

The literature documenting the problems of poor integration between behavioral and physical health care service delivery is robust. This research informs us as to which outcomes are important for this population and where we can make significant improvements with this project. It is well known that nearly 30 percent of adults suffer from a behavioral health disorder.⁵ We also know that behavioral health issues are 2-3 times higher in patients with chronic conditions, including diabetes, arthritis, chronic pain, headache, back and neck problems, and heart disease.⁶ It is clear that it is important to integrate service delivery as untreated behavioral health disorders often lead to functional impairment and complications with physical health care issues, resulting in higher health care costs.⁷ More importantly, we know that, on average, individuals with a serious mental illness live 25 years less than

⁵ Kessler, R. C., Chiu, W. T., Demler, O., Merikangas, K. R., & Walters, E. E. (2005). Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry*, 62(6), 617-627.

⁶ Katon, Wayne, Clinical and Health Services Relationships between Major Depression, Depressive Symptoms, and General Medical Illness, *Society of Biological Psychiatry*, 2003;54:216–226; Katon, W. Lin, EH, and Kroenke, K. The association of depression and anxiety with medical symptom burden in patients with chronic medical illness. *Gen. Hosp. Psychiatry*. 2007; 29:147-155.

⁷ Kessler et al., 2005.

individuals without behavioral health issues.⁸ Similarly, individuals with substance use disorders live, on average, 22.5 years less than those without the diagnosis.⁹ The first signs of mental illness often occur in childhood, with half of all lifetime mental illness beginning by age 14 and three quarters by the time an individual is 24.¹⁰ Approximately 20 percent of children and adolescents experience signs and symptoms of a diagnosable mental health disorder during the course of a year. Adolescents who begin drinking before age 15 are four times more likely to develop alcohol dependence some time in their lives compared with those who have their first drink at age 20 or older.¹¹ Review of Medicaid data on all ages for our region shows that people with co-morbid conditions experience higher rates of high cost health care utilization including repeat emergency department visits, lengthy inpatient stays, and readmissions.

Given the prevalence of behavioral health conditions in our Medicaid population, and its impact on physical health conditions, and costly health care utilization, Network4Health believes it is imperative for our IDN to put significant resources towards educating our providers to increase understanding and identification of behavioral health conditions as well as transforming key primary care and behavioral health practices into Coordinated and Integrated Care Practices.

In implementing this project, it is our primary goal to significantly increase the number of providers in our region that are qualified as Coordinated Care Practices and Integrated Care Practices. By improving the integration of behavioral and physical care delivery we hope to significantly improve health care quality and the health status of our population, while simultaneously reducing overall health care costs. We know that this is possible because our current delivery system has significant overutilization of unnecessary, costly emergency department utilization, as well as inpatient hospitalizations and readmissions particularly for populations with co-morbid conditions. The costs of this unnecessary care both in terms of dollars and impact on our populations' health are not inconsequential. In combination with our selected community projects, improving the integration of care delivery in our region, at a minimum, Network4Health aims to see the following health outcomes:

- increased screening of MH/SU in primary care
- improved engagement of individuals with MH/SU
- increased referral to specialty care
- reduced emergency department visits
- reduced avoidable acute inpatient admissions
- reduced readmissions

⁸ Morbidity and Mortality in People with Serious Mental Illness, National Association of State Mental Health Program Directors, October 2006.

⁹ Neumark, Y.D. et al *Subst Use Misuse* 2000;35(3):313-327

¹⁰ National Institute of Mental Health (NIMH) *Mental Illness Exacts Heavy Toll, Beginning in Youth*, June 2005. See also, *Mental Health Surveillance Among Children – United States, 2005-2011*, The Centers for Disease Control and Prevention, *Morbidity and Mortality Weekly Report, Supplement Volume 62, No. 2, May 17, 2013.*

¹¹ Califano, Joseph (Center on Addiction and Substance Abuse (CASA) press release, 2-26-02; NIAA Alcohol Alert #59, April 2003, Grant, B.F. et al *Journal of Substance Abuse* 9:103-110, 1997

- increased follow up visits after ED use
- increased follow up visits after an inpatient stay
- improved HEDIS scores on co-morbid conditions (e.g., diabetes)
- increased smoking cessation counseling
- increased well visits for the behavioral health population
- improved health status
- improved provider satisfaction

In addition, Network4Health believes that the provision of integrated care also has the potential to reduce stigma associated with behavioral health conditions. To that end, Network4Health also expects to see:

- improved patient experience and satisfaction, as well as improved family/caregiver experience and satisfaction
- reduced stigma related to the treatment of patients with behavioral health needs

Question 12e

Please provide a narrative describing the key challenges the IDN faces in implementing this project and the key barriers to successful improvement of outcomes measures. This response should address the IDNs strategy to mitigate these risks and overcome these barriers.

There are significant challenges to the provision of integrated care. Some challenges cannot be addressed by Network4Health alone because they require state intervention including: reimbursement issues, state regulatory frameworks, and privacy concerns. However, other challenges can be addressed through this core competency project, including:

Development of Work Flows and Handoffs: Partner organizations noted the need to develop new work flows and handoffs to transform practices to either a Coordinated Care Practice or an Integrated Care Practice. Transforming a practice requires serious commitment from all levels of the organization and requires a focus on developing and implementing new strategies. Part of this effort will include developing and implementing new screening tools. In addition, all staff within the practices, including physicians, will need to be trained in integration, and particularly on what to do if there is a positive screen, including understanding referral options. Handoffs of individuals with SMI/SPMI into primary care will need to be carefully and specifically addressed. Practices would also benefit from training on how to talk to families coping with a loved one with a MH/SU condition. All of this will take time and resources, both of which are in short supply. Perhaps more important than the process piece of this work is the need to ensure a culture of integration within our provider organizations.

Response: Using DSRIP funds, Network4Health will provide partner organizations with the training, technical assistance and practice coaching needed to develop new work flows and handoffs, and other processes necessary to implement the strategies required of a Coordinated Care Practice or an

Integrated Care Practice. Organization leadership will also receive training in culture change to ensure that integrated care becomes a core value of all Network4Health partners.

Workforce Issues: Long waits for services and lack of available providers are an ongoing workforce challenge in our region and beyond. Partner organizations expressed concerns regarding recruitment of staff, the ability of providers to appropriately supervise staff, and need for additional training and staff supervision. Given existing vacancies in workforce and the difficulty with hiring, this integration project is likely to place an additional strain on the already difficult workforce issues facing the region and the State. In addition to initial hiring, resources are also necessary for retaining staff and re-hiring when there is staff turnover. It will also be particularly important to ensure that staff who are trained in integration speak the languages of the patients to allow for strong communication.

Response: We will explore several strategies to address these workforce issues. Using the DSRIP funding, Network4Health will provide recruitment assistance to partner organizations, including development of job descriptions, screening of job candidates and sharing resumes. Use of peer supports will be encouraged. Network4Health will also offer appropriate trainings and technical assistance to assist partner organizations with implementing the particular requirements to be designated as either a Coordinated Care Practice or an Integrated Care Practice, including training of supervisors.

Network4Health understands the need to consider language when hiring, training, and implementing any intervention with its vulnerable populations. This is especially important given the number of refugees who now reside in Manchester and the number of students in the Manchester school system identified with limited English proficiency (LEP). Fortunately, many partners have already adapted their hiring and training practices to address language needs. We will work with partners to ensure that adequate training and supervision are provided to allow for culturally competent services for the non-English speaking population.

Health Information Technology and Data Collection: Network4Health partners have different levels of current usage of EHRs. Even among those providers that have EHRs, many are limited in their capabilities for using their systems. Moreover, across our network there is a lack of interoperability. In fact, a number of behavioral health providers do not even have EHRs. Another issue is that of maintaining patient confidentiality and privacy while also providing timely identification and access to services and robust monitoring of outcomes.

Response: Network 4Health supports the State's efforts to increase behavioral health integration and is committed to devoting resources to assist all of our provider organizations in obtaining, training, and implementing the evidence-based HIT practices associated with being designated a Coordinated Care Practice or an Integrated Care Practice. Network4Health will assist its partner organizations with implementing HIT, selecting appropriate care management modules, and developing data collection and reporting capabilities.

Sustainability: Given that DSRIP funds are only available for a limited time, there is concern over sustainability of integrated models after the funding disappears. In implementing an integrated

approach to physical and behavioral health care, Network4Health and the other IDNs will be implementing services and systems that have not traditionally been reimbursed.

Response: To the extent possible, Network4Health will focus its use of DSRIP funds for development of infrastructure and for recruiting and training of staff. In addition, Network4Health partners will begin working with Medicaid managed care organizations and other insurers to ensure that these integrated services are appropriately included in provider contracts and rates. Moreover, it is essential to look at the success of the model both in terms of outcomes and costs, and to understand how those costs will be incorporated appropriately into alternative payment models going forward. In addition, Network4Health partners are committed to working together to identify other collaborative grants or federal opportunities to leverage funding to further this work.

Stigma: As noted from our focus group findings, stigma remains a big issue to accessing care for individuals with mental health and substance use issues. For integration to have its desired effect of improving quality and costs, it is essential for stigma to be addressed head on.

Response: The overall focus of the DSIRP funding on improving awareness of behavioral health issues in New Hampshire and improving access to behavioral health services is an important step in reducing stigma. For this particular project, training providers around stigma-reduction will be a critical and ongoing element for success. An example may be introduction of evidence-based models such as peer support which can be tailored to a particular culture.

Question 12f

Network4Health's Implementation Approach and Timing is included as Tab 12f of the Supplemental Data Workbook.

Question 13 -- Care Transitions

Question 13b

Describe the rationale for selecting this project, how it addresses specific gaps in the IDN's Service Area Community Needs Assessment, and the anticipated outcomes of the project.

Network4Health selected Care Transition Teams (C1)—Critical Time Intervention (CTI)-- as a community-driven project. The Steering Committee identified care transitions as an important area of opportunity to improve the overall health of the population and reduce avoidable health care costs. This project satisfies the four criteria set forth by the Steering Committee. First, the risk of relapse and adverse outcomes during transitions is an important gap identified by community stakeholders during the focus groups, as well as a problem supported by quantitative Medicaid and other data for the region signifying high relevance. The CTI is an evidence-based approach that has had significant impact in other communities regarding our key outcomes of interest. In addition, the intervention has been successfully implemented across numerous populations, suggesting that it is a realistic approach to improving outcomes for populations with co-morbid conditions including physical health and significant behavioral health needs. Finally, CTI has been shown to be scalable across organizations and we believe it offers an affordable, sustainable approach to addressing care transitions long after the DSRIP funds expire.

A recent report by the Foundation for Healthy Communities conducted for New Hampshire documents the significant barriers Medicaid members experience when transitioning out of the hospital including: lack of supportive care in the community, inability to access needed outpatient mental health care, difficulty with the Medicaid application process, and lack of decision-making capabilities. The report finds that these barriers ultimately lead to longer lengths of stay, repeat visits, and additional, unnecessary expenditures.

Focus group participants cited the importance of effective programs to support patients transitioning from one care setting to another along the continuum of care. Participants cited their own personal experiences and challenges with transitions. Particularly distressing to them was the lack of access to substance use treatment and recovery services, including detox centers, intensive outpatient programs (IOP), and residential programs. Focus group participants also described significant gaps in care when transitioning from youth to adult behavioral health programming and from experiencing homelessness to some form of housing. They noted that gaps in care often left them helpless and frustrated and forced many of them to return to the institution for additional care and treatment because of limited community-based options.

According to Medicaid data for Region 4 in 2015, 46% of members aged 18-64 have a behavioral health condition and utilization of the ED and inpatient services is higher among Medicaid populations with behavioral health conditions. Nearly half of those individuals had at least one ED visit during the year. By comparison, 22% of members ages 18-64 without a behavioral health need accessed the ED. In addition, those members with behavioral health conditions used the ED when a primary care visit may have been more appropriate. Susceptibility for relapse also increases during these care transitions for this vulnerable population, which leads to repeat ED visits and readmissions to the hospital. For example, 7% of members with a behavioral health condition had four or more visits to the ED while only 1% of members without a behavioral health indicator had such high utilization.

Focus group participants as well as the community organizations which serve these populations also highlighted transitions from youth to adult behavioral health programming as a particularly difficult

transition. Data from Medicaid on the young adult population in Region 4 provide additional evidence of significant behavioral health morbidity and hospital utilization for this population. One-third (33%) of youth aged 11-17 have a behavioral health indicator with a slightly higher rate for males (34%) than females (31%). In addition, despite extensive suicide prevention efforts in the State, the Greater Manchester Health Improvement Plan of 2016 reports that suicide remains the second leading cause of death among New Hampshire youth and young adults up to age 34, providing further evidence supporting the need for addressing care transitions for this population.

Although Network4Health did not select “Community Reentry of Justice Involved Adults and Youth” as one of its community-driven projects, the IDN believes that the justice-involved population also could benefit from CTI, including youth being released from the Sununu Youth Services Center. The justice-involved population has significant physical and behavioral health needs and their reentry from correctional facilities poses great risk for overall offender health and safety. According to data presented on September 13, 2016 to the NH Department of Corrections (NHDOC) Women’s Correctional Facility Citizen’s Advisory Board, between August 2015 and August 2016, approximately 50% of the male and 94% of the female incarcerated population received behavioral health services. Moreover, a comprehensive assessment of recidivism conducted by the NHDOC found that: “In total, new felony sentences or arrests on new Drug & Alcohol (D&A) charges, and/or other D&A related behavior was cited in 61.5% of the all prison returns,” suggesting that behavioral health needs are an important risk factor for recidivism. Likewise, we believe that CTI will also benefit the homeless population as they transition from care.

Network4Health is positioned to implement CTI to successfully fill this gap in care for our Medicaid at-risk population. CTI will help us to achieve our goals of providing assistance to our most vulnerable populations as they transition from institutional to community-based care; lower inappropriate ED utilization among members with co-occurring disorders, and improve social indicators of reduced incarceration, more stable housing, and employment. This intervention will leverage existing resources, and will provide the necessary supports and training to participating community organizations.

The primary outcomes for this project include fewer institutional days, and unnecessary ED visits, particularly for behavioral health and other ambulatory care sensitive conditions; improved client experiences during transitions; reduced recidivism to correctional facilities and better integration with community supports; and a reduction in recurring homelessness.

CTI has been implemented in communities across the country with positive results. CTI is a realistic approach to improving outcomes for populations with co-morbid conditions including physical health and significant behavioral health needs and has been shown to be scalable across organizations. Network4Health believes it is an affordable, sustainable approach to addressing care transitions long after the DSRIP funds expire.

Question 13c

Describe the criteria used by the IDN to identify which organizations are required to participate in this project.

Interested hospitals, primary care providers, behavioral health providers, correctional facilities and other social service agencies in Region 4 were invited by the CTI project team to attend a kick-off meeting on October 4th. Participants learned about the intervention, its history and evidence base, its goals, and expected outcomes. The participants in attendance asked questions and were generally very engaged in the process.

The project team brainstormed possible transitions to include in this effort and then prioritized among the transitions, as participants believed it is better to begin small and achieve success with certain well-defined populations rather than to try to include all transitions. The transitions participants mentioned included transitions from hospitals to home, from nursing facilities to home, from homelessness to housing, from youth to adult behavioral health services, from inpatient behavioral health facilities to outpatient services, and from correctional facilities to the community. Most, but not all of these transitions were from institutional to community settings and most involved people with significant comorbid and/or co-occurring conditions. The group used the following questions to guide decisions about prioritization and ultimately about which transitions to target with the CTI project:

- Which transitions did both focus group participants and social service staff characterize as most difficult?
- According to Medicaid data for Region 4, which populations are most vulnerable to gaps during transitions, and therefore where can CTI have the greatest impact?
- During which transitions has CTI been particularly successful at improving our outcomes of interest?

We prioritized three transitions to target with this intervention:

Transitions from Hospital to the Community: This target population includes Medicaid clients with either an ED visit or Inpatient stay where either a primary or secondary diagnosis or comorbidity includes a behavioral health condition.

Transitions from Corrections to the Community: This target population includes Medicaid-eligible clients released from correctional institutions, including the Sununu Youth Services Center, with an identified behavioral health condition.

Transitions from Youth Behavioral Health programming to Adult Services : This target population includes Medicaid beneficiaries who age-out of their behavioral health programming.

We anticipate that within the first two groups there will be a number of homeless individuals.

There was significant interest in CTI and its ability to improve the lives of Region 4's most vulnerable populations. The community organizations present at the meeting expressed interest in continuing a dialog regarding how CTI could be used more broadly across all organizations serving these vulnerable populations in the region even if not the focus of this DSRIP effort.

Although we narrowed our focus for this intervention to three target populations, as planning continues Network4Health will further specify eligibility criteria for the CTI program for these transitions. For example, due to resource constraints, we may need to target the hospital to community CTI towards patients with behavioral health needs who have experienced more than one visit to the ED over the past year and/or those with lengthy inpatient stays. Likewise, justice-involved individuals with significant

mental illness may be prioritized over others for the corrections to community CTI. As part of the implementation plan, Network4Health will develop specific screening criteria for use by participating partner organizations.

After deciding to target these three transitions, we discussed which community partners and organizations within the IDN are important for this project's success. We articulated two different roles for participating organizations:

- **Primary CTI organization** – these organizations, which are directly involved with the transition of the interested populations from the institution to the community, would need to identify people in need of CTI, and have on staff case worker(s) trained in CTI to deliver the CTI intervention.
- **Secondary CTI organization** – these organizations, which are not directly involved in the transition of these populations, but service the clients in some capacity, will act as referral and service organizations. These organizations would need to be familiar with the intervention and also be provided with training and resources to assist them in the referral and service components of the intervention.

Only organizations identified as primary would be required to participate in the program although given the interest expressed in this intervention we do not believe it will be difficult to engage Secondary CTI organizations. We also discussed that, to the extent possible, we would make the CTI training resources available to all interested parties in Region 4. Given the interest in this intervention within New Hampshire, there may be economies of scale that can be achieved in procuring training resources on a state-wide basis for all interested community-based organizations.

Question 13d

Tab 13d in the Supplemental Data Workbook includes a list of participating organizations.

Question 13e

Please provide a narrative describing which indicators the IDN will use to manage day-to-day performance and understand in real-time whether the IDN is on the path to improve broader outcome measures.

Network4Health will develop a comprehensive evaluation plan with a two-fold objective: allowing us to collect the necessary data to improve the delivery of the programming during implementation; as well as, providing us with key information enabling us to understand the impact of the intervention in our region. The evaluation plan will include a number of process measures, and short-term and longer term outcome measures, to monitor CTI's performance and progress. The primary outcomes for this project include fewer institutional days including inpatient hospitalizations, and unnecessary ED visits, particularly for behavioral health conditions and other ambulatory care sensitive conditions; improved client and family/caregiver experiences during transitions; reduced recidivism to correctional facilities and better integration with community supports; and reduction in recurring homelessness.

Our initial focus will be on assessing how well Network4Health plans and implements the program across the three types of Primary CTI organization sites described above. Network4Health will develop a detailed implementation plan that includes a workforce plan to ensure staffing capacity at the Primary

CTI organizations, comprehensive training programs for Primary and Secondary CTI organizations as well as other interested community organizations in the region, screening tools and a referral system for Primary and Secondary CTI participating organizations, and tools to collect the necessary data to monitor our progress. Our implementation plan will include tasks, milestones and associated timeframes, and critical path items with interdependencies clearly delineated.

During the first implementation year, Network4Health will hold regular meetings with key staff from each of the Primary CTI organizations to ensure that the necessary infrastructure, training, support, and guidance are provided. In addition, Network4Health's overall approach to project governance includes regular project meetings with each of the Community Project Teams to guarantee that progress is being made regarding implementation. Key tasks that will be assessed during this phase include:

- define roles and responsibilities for Primary and Secondary CTI organizations and execute any necessary agreements;
- develop an initial and on-going training plan including supervision, for CTI case workers and plans for training when staff turnover occurs;
- develop staffing plans, including hiring, addressing staff turnover, for the Primary CTI organizations;
- develop screening criteria and referral protocols for Primary and Secondary CTI organizations to use to identify which clients should be referred to the program;
- develop a data tracking mechanism to track and monitor client progress through the three stages of the CTI program; and,
- develop an evaluation plan, including metrics that will be used to measure short-term and longer term outcomes of the intervention including client and staff satisfaction.

During years 2 and 3, monitoring will evolve to evaluate implementation and outcomes of the CTI intervention. We will schedule at least quarterly meetings for this phase. Performance will be assessed using the specific measures defined in the implementation plan such as:

- % of staff vacancies, based on the staffing plan;
- % of case workers who have received CTI training;
- staff confidence and satisfaction with the CTI training and supervision;
- completion and dissemination of CTI protocols and other operating policies and procedures;
- % of Secondary CTI organizations who accurately use the referral and screening protocol;
- % of eligible clients who enroll and complete the CTI treatment; and,
- other measures to be identified during the implementation planning phase.

The project team will assess performance on these measures on a quarterly basis, and will report to the Project Management Team and Steering Committee. Additional process measures to be tracked for each reporting period and cumulative and compared to projected numbers, as defined in New Hampshire Building Capacity for Transformation 1115 Medicaid Waiver Draft Project and Metrics Specification Guide, including:

- number of individuals served;
- number of staff recruited and trained;
- impact measures as defined in the evaluation plan, including annual evaluation of fidelity to evidence-supported program elements; and,

- staff vacancy and turnover rates.

Network4Health will report on the outcome metrics developed by the State for our project and also review the evidence on outcome measures used for CTI in other states with attention to our populations of interest in developing other specific outcomes measures. We will also seek input from our CTI Primary and Secondary Organizations and present to the Steering Committee for approval.

Question 13f

Please provide a narrative describing the key challenges the IDN faces in implementing this project and the key barriers to successful improvement of outcome measures. Please describe the IDN's strategy to mitigate these risks and overcome these barriers.

Network4Health anticipates three primary challenges in the implementation of CTI: workforce, data collection, and sustainability. These challenges are not unique to the CTI project and we will work with project leadership, the Steering Committee, and our community partners to address these challenges.

Workforce Issues: During our meeting with community partners, they expressed concern regarding staff resources needed to implement the CTI. In particular, a few of the correctional facilities do not currently have staff who can absorb these new responsibilities. Moreover, leadership at many of the partner organizations noted that their current case management staff are already overwhelmed with responsibilities and wondered how they can do more with few additional resources. Additional workforce issues identified included the need to plan for staff turnover and training of new CTI caseworkers; the need to ensure that there are CTI caseworkers who speak the languages of the clients; and the need to plan for the reality that care capacity may not always be available when needs are identified.

Response: Network4Health is exploring several strategies to address the need for additional staff resources. Our primary approach for staffing is to expand part-time caseworker staff hours to full time and to cover the onboarding costs of caseworker staff. We also are assessing options for reimbursement of these intense case management services under Medicaid for organizations that do not currently bill Medicaid. Finally, the addition of peer support specialists serve as workforce extenders which may provide additional flexibility for caseworkers to free up time to provide CTI.

We discussed options for on-going training of CTI caseworkers when turnover occurs including the possibility of web-based training and train-the-trainer models. Decisions regarding which approaches are best will be determined in conjunction with our community partners during the planning phase.

As noted in our response to Question 12, Network4Health understands the need to consider language when hiring and training staff to implement this model. Many community partners have already adapted their hiring and training practices to address language needs. Network4Health will work with partner organizations to ensure that adequate training, supervision, and access to CTI for the non-English speaking population is achieved.

According to the model specifications, the average caseload of a CTI worker is 20 clients, and thus, we will need to delineate additional eligibility criteria so that CTI targets those clients most in need. Because, our correctional facilities may not have the part-time staff to facilitate our primary staffing approach, we may need to refer clients to nearby community organizations with trained CTI

caseworkers onsite. Network4Health hopes to learn from other communities that have successfully implemented CTI about staffing strategies to leverage best practices in this regard.

Data Collection: Another issue is that of maintaining patient confidentiality and privacy while also providing timely identification and access to services and robust monitoring of outcomes.

Response: Network4Health will need to establish a robust data collection system at each of the Primary CTI organizations to track clients' progress throughout the three-phase CTI program. In addition, we will need to establish the appropriate infrastructure at the Secondary CTI organizations for referral to Primary CTI organizations and data collection on the number of clients who are referred to CTI services but do not enroll so we can better understand the barriers to enrollment. Network4Health understands the need to balance patient confidentiality laws and policies with effective care management and integration models. We will work across the IDN projects, in particular the HIT project, to develop standardized methods for the collection of data that allow for referrals and reporting of information while adhering to HIPAA and NH privacy requirements.

Sustainability: The issue of sustainability was identified by community partners because of the time-limited DSRIP funding. Concerns were expressed about sustaining reimbursement for the additional staffing hours and onboarding once the DSRIP funding ends.

Response: CTI is an evidence-based intervention with documented successful outcomes across populations. We plan on learning from others about best practices for integrating this intervention into our organization in the most cost efficient manner. In the short term, the additional DSRIP funding provides an opportunity to support our partner organizations in training and securing additional staff hours and to cover onboarding which is extremely beneficial to these organizations. As we move towards alternative payment models, it is expected that the CTI services, because of their proven ability to reduce unnecessary hospitalizations and ED visits, will essentially pay for themselves under a partially or fully capitated model.

Questions 13g

Tab 13g in the Supplemental Workbook provides Network4Health's implementation approach for CTI.

Question 14: Capacity Building - Implementation of a Partial Hospitalization Program (D3)

Question 14b

Describe the rationale for selecting this project, how it addresses specific gaps identified in the IDN's Service Area Community Needs Assessment, and the anticipated outcomes of the project.

Network4Health will be expanding intensive substance use disorder (SUD) treatment options via implementing a partial hospitalization program (PHP) focused on individuals with co-occurring disorders, as well as expanding outpatient counseling for individuals with SUD. In doing so, Network4Health will ensure that Region 4 residents with SUD or co-occurring disorders have access to the level of intensity of care that is appropriate to their unique needs. PHP programs have been shown to produce similar results to residential care and offer a level of treatment not currently available in our region but desperately needed for this population. Along a continuum of care, PHP would be a "step down" from residential care and a "step up" from intensive outpatient treatment (IOP). Access to partial hospitalization would help reduce unnecessary care including avoidable hospitalizations and readmissions.

Network4Health applied the following selection criteria to determine the community-driven projects it would implement:

- **Relevance:** The extent to which the project aligns with (1) region needs, as identified in the CNA, and through the experience and expertise of project partners; and (2) the extent to which it aligns with ongoing efforts in the community.
- **Realistic:** The extent to which it is feasible, given the funding, and the resources and timeline required to implement.
- **Impact:** Overall number of Medicaid recipients that the project can reach and positively impact.
- **Cost:** The estimated cost (high/low), based on possible project parameters.

This project is relevant because Region 4 has a high prevalence both of SUD as well as co-occurring disorders, across all age cohorts. New Hampshire has the highest per-capita drug rate in New England and the 3rd highest in the nation. In 2015, 439 people died from a drug overdose in New Hampshire, a 60% increase from 2013. As noted in the 2016 Greater Manchester Community Needs Assessment (CNA), Manchester is the epicenter of New Hampshire's opioid abuse crisis. Manchester has the highest rates of overdose deaths and Narcan administration in New Hampshire. EMS-administered Narcan for the City of Manchester exceeded 500 cases from June 2015-May 2016. The highest rate of opioid use is in the 20-39 age cohort; however, all age groups are affected by it.

With respect to alcohol, the 2013 Youth Risk Behavior Survey (YRBS) found that 35% of 12-to 20-year-olds from the Greater Manchester HSA reported drinking alcohol in the past 30 days. This is far higher than the national rate of 25% and the northeast rate of 29%. Furthermore, according to the report, "Transforming Children's Behavioral Health Care, The New Hampshire Children's Behavioral Health Collaborative – 2013," of those children receiving mental health services, approximately 43% are diagnosed with a co-occurring alcohol or drug use disorder. Similarly, of adolescents in New Hampshire alcohol or drug treatment programs, 2/3 of males and 4/5 of females have a co-occurring mental health disorder. According to one analysis on recidivism conducted by the New Hampshire Department of Corrections, drug and alcohol (D&A) were cited as factors in 61% of all prison returns. While female

offenders were 20% less likely to return to prison than males, they were 12% more likely than males to return to prison on a new sentence, new charges or technical violations that were D&A related.

Providers report increases in the number of people in the region with co-occurring illnesses who do not meet the level of care required for residential treatment but need more intensive care options than what is currently available. A University of New Hampshire treatment capacity study confirmed critical capacity shortfalls for residential and Withdrawal Management (WM) programs in the region. The UNH study recommended an expansion of WM and PHP programs to begin to address the gap in treatment services. This is consistent with asset and gaps assessment completed by the SUD Continuum of Care Facilitators in Greater Manchester and South Central regions which also identified WM programs as an unmet need, and identified additional treatment options for co-occurring disorders as well as additional education and training opportunities for clinicians regarding co-occurring disorders. Expanded medication assisted treatment (MAT) and more intensive outpatient options also were identified as strategies to address this shortfall.

Network4Health believes that implementing this project is realistic and the costs reasonable, given existing resources, the availability of funds to support it, and the relatively modest timeline required to implement the expansion. To the extent possible, efforts will be focused on expanding existing PHP and IOP capacity, leveraging existing infrastructure and expertise from participating providers and community-based organizations rather than attempting to establish new programs. Further, while there are outstanding questions about the long term sustainability of such expansion, Network4Health believes that for the duration of the waiver period, there will be adequate funds to support the program and that the movement towards alternative payment mechanisms will ensure its sustainability after the DSRIIP funds expire. Further, we can leverage work done for Project E4 (Integrated Treatment for Co-Occurring Disorders) to maximize use of limited resources.

One of the most significant barriers to proper treatment of individuals with co-occurring disorders is that oftentimes a mental health disorder disqualifies a client from SUD treatment programs, and an SUD disqualifies the client from mental health treatment. Given the high incidence of co-occurring disorders among the Medicaid population, and the dearth of treatment options, we believe there is the potential to significantly impact a number of poor health outcomes for Medicaid members with co-occurring illnesses. In particular, we believe that inpatient admission and readmission rates for individuals with SUD will decrease as well as the acuity of individuals in an inpatient setting as they will have these other treatment options. Moreover, we anticipate that arrest rates for a substance-related crime or for individuals with known MH or SUD condition will also decrease.

Question 14c

Describe the criteria used by the IDN to identify which organizations are required to participate in this project.

Network4Health is committed to implementing our community projects with partner organizations who have the requisite experience, patient/client base, resources, and interest necessary to achieve success. To that end, we have defined specific criteria for the selection of project partners for this project.

We held several brainstorming and working sessions and invited interested community and provider organizations to attend to help develop this project plan. In addition to project staff, participants in attendance at these sessions included representatives from two hospitals, non-profit community-based

organizations, a community mental health center, and SUD treatment and/or recovery organizations in Region 4. This working group jointly defined tentative participation criteria, which was proposed to the Steering Committee for approval. Partner organizations need to only meet one of the criteria in order to participate:

- organizations with demonstrated expertise in providing and/or facilitating access to mental health services along the continuum,
- organizations with expertise in providing, and/or facilitating access to SUD treatment services along the continuum,
- organizations with current or previous experience operating a PHP, IOP, MAT, or co-occurring treatment program, or
- organizations with behavioral health and/or SUD resources that can be leveraged for this service expansion.

Network4Health also placed an emphasis on including organizations based on their level of interest in participating in this program and their experience in servicing the population of interest. Based on the criteria described above, Network4Health identified 12 organizations whose participation is highly desirable. Project leadership has begun the process of reaching out to these organizations, describing the project and securing their support and participation. These are all organizations who currently serve the population of interest and through our prior conversations with them, have all identified these gaps in services as important to the work they are doing. We therefore do not anticipate difficulty in obtaining agreement from these organizations. However, in the event that ensuring their participation proves problematic, the issue will be escalated to the Steering Committee and higher, if necessary.

In addition to these 12 organizations that have been prioritized, there may be some organizations who would like to be part of this project although they may not meet all of the selection criteria. The project's leadership will consider participation by these organizations especially in the planning phases of the project. It also may be necessary to include other organizations in our project planning phase to fully assess available resources across the region. In particular, staffing of the PHP requires a master's-level clinician as program director, a psychiatrist (if it is not the program director), and a psychiatric nurse. We would also need substance abuse counselors. We will want to reach out to other Network4Health organizations to assist us in finding the best staff for these positions. These decisions will likely be made during our first year of planning.

Question 14d

Tab 14d of the Supplemental Workbook lists all organizations participating in this project, their type and role in the project.

Question 14e

Please provide a narrative describing which indicators the IDN will use to manage day-to-day performance and understand in real-time whether the IDN is on the path to improve broader outcome measures.

Network4Health intends to utilize a variety of process measures, as well as short-term outcome measures, to manage the day-to-day performance and assess in real time progress toward improving outcomes. The project team recognized that there are already best practices for monitoring these programs and Network4Health will focus on SAMHSA recommendations to make sure to utilize evidenced-based approaches, training and monitoring

Along with several of Network4Health's other projects, this project will focus on outcomes including increased stable remission of substance misuse, reduction in inpatient hospitalizations and readmissions, reduction in arrests, and a decrease in psychiatric symptoms. Network4Health intends to use SAMHSA, as well as the literature and other sources to identify the exact measure specification ensuring that the measures selected are timely and realistic and that they measure the important outcomes over the duration of the waiver and beyond. We will work with participating provider organizations on the identification of these measure specifications.

Detailed advanced planning, and managing to that plan, will be critical to achieving the desired outcomes for this project. Therefore, Network4Health's initial focus of our monitoring efforts will be on compliance with planning activities, including the development of a detailed implementation plan, as well as the design and development of clinical services infrastructure.

To that end, the project team will work closely with the Project Management Team to develop a detailed project implementation plan, as well as a closely integrated Clinical Infrastructure Design and Implementation work plan. Both plans will have interim milestones, assigned tasks and associated deadlines, with critical path items clearly identified.

Consistent with Network4Health's overall approach to project governance, the D3 Project Team will report to the Project Management Team, on a weekly basis, on Project Team's progress during the preceding week, with any deficiencies highlighted. Key metrics that will be assessed during this phase include progress toward:

- identifying a location for the PHP;
- developing the infrastructure needs for the PHP based on the selected location;
- developing a staffing plan for the PHP;
- developing and/or identifying patient assessment, treatment, management, and referral protocols;
- defining roles and responsibilities for participating organizations and team members;
- developing a training plan and training curricula for staff, as necessary;
- executing agreements with collaborating organizations;
- developing an evaluation plan, including metrics that will be used to measure program impact; and,
- developing mechanisms (e.g., registries) to track and monitor individuals served by the program, adherence, impact measures, and fidelity to evidence-supported project elements.

During the operational phase, monitoring will shift to the executing of the implementation and clinical infrastructure design and implementation plans. Performance will be measured against the targets defined in the implementation plans, and assessed on key measures, including but not limited to:

- PHP and expanded outpatient treatment established;
- % of staff vacancies, vis a vis the staffing plan;
- % of providers who have received training;
- completion and dissemination of clinical protocols and other operating policies and procedures;
- % of clinicians who utilize assessment, treatment, management and referral protocols; and,
- performance on other metrics to be identified during the Implementation Planning phase.

The project team will assess performance on these measures on a monthly basis, and will report to the Project Management Team and Steering Committee.

Additional process measures will be tracked on an ongoing basis as defined in New Hampshire Building Capacity for Transformation 1115 Medicaid Waiver Draft Project and Metrics Specification Guide, and will include reporting period measurement, and cumulative measurement compared to projections as follows:

- number of individuals served;
- number of staff recruited and trained;
- impact measures as defined in evaluation plan, including annual evaluation of fidelity to evidence-supported program elements;
- number of individuals served;
- number of staff recruited and trained; and,
- staff vacancy and turnover rate.

Specific outcomes measures will be developed in conjunction with all participating partner organizations, and with the input and approval by the Steering Committee. They will be developed by the project team, utilizing national resources (e.g. SAMHSA), and best practices defined in the literature. They may include such measures as:

- inpatient admission rates for individuals with SUD;
- acuity of individuals in an inpatient setting;
- readmission rates for a BH condition; and,
- arrest rates for a substance-related crime or for individuals with known MH or SUD condition.

Question 14f

Please provide a narrative describing the key challenges the IDN faces in implementing this project and the key barriers to successful improvement of outcome measures. Please describe the IDN's strategy to mitigate these risks and overcome these barriers.

Network4Health has identified four challenges related to implementation of a PHP and expanded outpatient services including workforce, cross organization coordination and collaboration, operational, coordination and sustainability. Each of these challenges and proposed strategies to mitigate these risks are described below.

Workforce: A lack of qualified providers, and difficulties recruiting and retaining workers, are a significant challenge in Region 4. This is especially acute for Licensed Alcohol and Drug Counselors and Master-level Licensed Alcohol and Drug Counselors, specifically those trained in co-occurring disorders.

Salary discrepancies between Massachusetts and New Hampshire organization contributes to issues our organization face in hiring and retaining staff. Moreover, a PHP is expensive to staff requiring at a minimum, a master's-level clinician as program director, a psychiatrist (if it is not the program director), and a psychiatric nurse. We would also need to have substance abuse counselors available. It will be difficult to find staff who can do both MH and SUD, so we will need to more resources to meet these requirements or allow for cross-training of staff.

Response: The project team will explore the potential for reallocating current resources but we must be mindful of overall capacity of existing programs. That is, until and unless we have demonstrated success in transitioning patients to the most appropriate level of care, we cannot reallocate existing resources. This project will be closely coordinated with Project A1: Behavioral Health Workforce Capacity Development, which in turn will be coordinated with the statewide taskforce on Workforce. We also will coordinate closely with Project E4: Integrated Treatment for Co-Occurring Disorders, which will address the cross-training of the staff who will work in the PHP. In the shorter term, the Bi-State Primary Care Association is expanding its Recruitment Center to include behavioral health and substance use disorder (SUD) treatment providers, which may help to partially mitigate this problem. Additionally, participating organizations will assess their own workforce and identify potential opportunities to reallocate existing resources or develop creative alternatives, including the use of peer supports. This may include, for example, evaluating their recruitment strategies to determine whether there are opportunities to improve recruitment and retention.

Cross-organizational coordination and collaboration: While Network4Health has demonstrated success in collaborative initiatives (as described in the IDN Application) we have identified potential challenges with this project, including different treatment philosophies and potential competing interests.

Response: Given the history of collaboration, as well as the stated and demonstrated commitment of partner organizations to the goals and objectives of this project, the risk of such conflicts is relatively low. However, to ensure that the risk does not become an issue, Network4Health will engage in advanced collaborative planning, including: putting in place a process among project participants to establish consensus on project objectives and metrics; incorporating a stakeholder assessment of impact of each project element on participating organizations, and taking steps to proactively address concerns. We will also establish vehicles for frequent communication among the organizations and Network4Health leadership; and ensure transparency regarding decision making, not only among participating organizations, but with the Steering Committee, Partnership Team and CMC Leadership.

Operational coordination: Participating organizations will need to establish referral policies and procedures, establish a common mechanism for documenting and reporting on utilization, and coordinating with non-participating providers regarding care management.

Response: As described above, extensive advanced collaborative planning is critical to mitigating this risk. Additionally, Network4Health will invite non-participating providers to provide input into the planning process. This project will be coordinated with the statewide HIT project to ensure that the needs of this program regarding documentation and reporting are addressed as part of the broader Health Information Technology initiative.

Sustainability: There is significant overhead associated with establishing a PHP relative to Medicaid MCO reimbursement (including the Medicaid cap on this benefit). This will affect every aspect of program

design, including capacity. We do not believe that this program is sustainable beyond the Demonstration period under the current reimbursement model.

Response: Network4Health has confidence in the state's development and implementation of alternative payment methodologies will support the initiatives implemented under DSRIP. Assuming that the demonstration is successful and as a result there is a desire to sustain it beyond 2020, Network4Health will require an APM structure to be in place in order for the program to be financially sustainable. We recommend that this issue be addressed jointly with all IDNs.

Question 15: Integrated Treatment for Co-Occurring Conditions

Question 15b

Describe the rationale for selecting this project, how it addresses specific gaps identified in the IDN's Service Area Community Needs Assessment, and the anticipated outcomes of the project.

Individuals who experience co-occurring disorders- mental illness and substance use disorders- are more likely to experience negative outcomes including psychiatric episodes; use, abuse and relapse to alcohol and other drugs; hospitalization and emergency room visits; relationship issues; violence; suicide; arrest and incarceration; unemployment; homelessness; poverty; infectious diseases and; complications resulting from chronic illness such as diabetes and cancer.¹² Over 50% of those diagnosed with a serious mental illness will also have a diagnosable co-occurring substance use disorder.¹³ Similarly, about 45% of Americans seeking substance use disorder treatment have been diagnosed as having a co-occurring mental and substance use disorder.¹⁴

It is well documented that co-occurring disorders can be difficult to diagnose due to the complexity of symptoms. In many instances, individuals receive treatment for one disorder but not the other. This may be due to inadequate provider training regarding co-occurring conditions or screening for co-occurrence, an overlap of symptoms, or the need to prioritize issues to be addressed. Regardless of the reason, undiagnosed, untreated or under-treated co-occurring disorders can lead to a higher likelihood of homelessness, incarceration, medical illnesses, suicide and early death.¹⁵ During the focus groups we held with individual stakeholders in Region 4, many comments were made relative to the lack of an integrated approach in health care. Also mentioned were long waits for care resulting in increases in relapse and poor health outcomes. Finally, stigma experienced by clients in treatment settings was reported multiple times.

In addition to focus group participants noting gaps in coverage, a 2009 study of Medicaid claims in New Hampshire provided evidence of this growing problem indicating that "10.8% of all Medicaid members have a mental health condition with secondary substance abuse disorders or co-occurring disorders. This is likely higher in our region as Manchester has experienced exponential growth in substance misuse in recent years as well as an increase in members with mental health conditions. These patients often end up in EDs if their co-occurring conditions are not treated in the community, continuing the cycle of uncoordinated care and poor outcomes for these patients.

Moreover, with the expansion of Medicaid in New Hampshire, SUD providers report a significant increase in referrals for treatment and recovery support in recent years. These providers also report that they are witnessing an increase in the incidence and severity of mental illness. Similarly, one of the two community mental health center's in our network reports that more than 60% of the new admissions to its Community Support Program (state funded services for those who experience serious and persistent mental illness) also present with a substance use disorder.

¹² Center for Evidence-Based Practices, Case Western Reserve University.

¹³ Ibid.

¹⁴ 2014 National Survey of Substance Abuse Treatment Services (N-SSATS)

¹⁵ SAMHSA.

To obtain the best outcomes, it is important to provide integrated treatment to individuals with co-occurring disorders.¹⁶ Addressing mental health and substance use disorders must be done at the same time in order to achieve the best outcomes. In selecting project E4, Network4Health will focus on educating our partner organizations on identifying individuals with co-occurring disorders and implementing evidence-based practices for treatment of co-occurring disorders. In doing so, Network4Health aims to ensure that Region 4 residents with co-occurring disorders are appropriately identified and referred for services, and that the services they receive, whether from a provider that primarily serves individuals with mental health issues or individuals with substance use disorders, receive services that treat them as a whole person and address mental health and substance use conditions together.

Selecting this project in addition to D3, which is aimed at developing a partial hospitalization program for those with co-occurring conditions, Network4Health is addressing a specific gap in care that has been identified by all partner organizations within our network – lack of adequate or appropriate services for those with co-occurring disorders. It also will fill gaps mentioned by focus group participants and confirmed by data from Medicaid on the prevalence of members with co-occurring conditions. This also aligns well with the broader core project focused on behavioral health integration.

As described in the rationales for C1 and D3, Network4Health selected projects on the basis of an assessment of 4 key criteria. These include:

- Relevance – the extent to which the project aligns with (1) Region needs, as identified in the CNA, and through the experience and expertise of project Partners; and (2) the extent to which it aligns with ongoing efforts in the community
- Realistic – the extent to which it is feasible, given the funding, and the resources and timeline required to implement
- Impact: Overall number of Medicaid recipients that the project can reach and positively impact, and
- Cost: The estimated cost (high/low), based on possible project parameters.

The project met each of the criteria above. Given the reported high need and difficulty in treating individuals with co-occurring conditions, it is directly relevant to our community needs.

Network4Health believes that implementing this program is realistic, given existing resources, the availability of funds to support it, and the relatively modest timeline we believe will be able to provide education on identifying and referring individuals with co-occurring conditions across the partnership and in implementing evidence-based practices within our mental health and substance use provider agencies. Network4Health believes that for the duration of the waiver period, there will be adequate funds to support the program. Further, we can leverage work done for Project D3 (Expanded Capacity for PHP and IOP, focusing on those with co-occurring conditions) and for the core Behavioral Health Integration project to maximize use of limited resources.

One of the most significant barriers to proper treatment of individuals with co-occurring disorders is that oftentimes a mental health disorder disqualifies a client from SUD treatment programs, and an SUD disqualifies the client from mental health treatment. Given the high incidence of co-occurring disorders

¹⁶ Ibid.

among the Medicaid population, and the dearth of treatment options, we believe there is the potential to impact the health status of individuals in Region 4 in a significant way.

Question 15c

Describe the criteria used by the IDN to identify which organizations are required to participate in this project.

This project will begin with the utilization of the Case Western Reserve University Center for Evidence-Based Practices Dual Diagnosis Capability Index in Addiction Treatment (DDCAT) and the Dual Diagnosis Capability in Mental Health Treatment (DDCMT). These indexes serve as an assessment and planning tool for behavioral health service providers desiring to improve organizational capacity in serving individuals who experience both mental illness and substance misuse. DDCAT was developed by the New Hampshire-Dartmouth Psychiatric Research Center with funding from Robert Wood Johnson Foundation's Substance Abuse Policy Research Program and from SAMHSA's Co-Occurring State Incentive Grants (COSIG). Research on adapting the index for mental health service organizations (DDCMHT) is on-going.

All behavioral health providers in the Network4Health partnership will be offered the opportunity to participate in an organizational review using the DDCAT and DDCMHT indexes. These indexes comprise approximately 35 items that explore an organization's policies, clinical practices and workforce capacities. These items are organized into seven domains- program structure, program milieu, clinical practices/assessment, clinical practice/treatment, continuity of care, staffing and training. An on-site review utilizing these indexes will be facilitated and we anticipate that it will take no longer than one day per organization to complete. The results will lead to the organization being categorized along a continuum of capability ranging from Addiction-only or Mental Health- only services to Dual-Diagnosis Capable to Dual-Diagnosis enhanced Capable.

Each participating organization will be offered a debriefing once the review is scored and completed, and technical assistance will be offered to develop and implement a plan to enhance capabilities for providing services for co-occurring disorders. The organizational plan will include training needs focused on high fidelity implementation of evidence based practices such as Integrated Dual Disorder Treatment (IDDT) among others.

We will further categorize Region 4 organizations as either primary or secondary participating organizations. Primary organizations are those that provide clinical services to individuals who experience co-occurring disorders. Secondary organizations are other Network4Health partners who serve our network's target population but who do not provide services directly related to a member's co-occurring illnesses. Secondary providers can include acute and primary care providers, as well as social support providers, as well as some behavioral health providers who are not able to serve as primary providers. Primary organizations will receive both educational strategies for identification and referral and implementation strategies for providing services to individuals with co-occurring illnesses based on evidence-based practice while secondary organizations will receive training in recognizing co-occurring illness, strategies to engage those individuals, and basic approaches used in the evidence-based practice and referral resources.

For many organizations and providers, their participation in the project will be limited to the educational components around identifying and referring members with co-occurring illness. We anticipate this

education to be provided by technical experts in co-occurring conditions and to be repeated at regular intervals for Network4Health partners. There could be some secondary partner organizations that due to the particular work that they do, also would be offered and provided additional training- for example, Hope 4 NH Recovery is a recovery center not a treatment center but training in stages of change could be helpful to them. Training plans will be developed in conjunction with leadership and staff from the participating organizations.

For primary organizations and providers of mental health and substance use treatment services, this project will also include training in specific evidence-based practices that have been proven successful in treating individuals with co-occurring conditions. All treatment providers will be trained in the IDDT practice and must agree to high fidelity implementation and participation and on-going clinical supervision, case reviews and learning collaborations. Secondary providers agree to participate in training related to the identification and referral of individuals with co-occurring illness.

Based on our initial discussions, primary provider organizations include but are not limited to:

- the Mental Health Center of Greater Manchester
- the Center for Life Management
- the Farnham Center
- Families in Transition (FIT)
- Serenity Place

Other primary partner organizations may include Elliot Health, CMC Behavioral Health, and the Manchester Community Health Center.

Question 15d

Tab 15d of the Supplemental Workbook lists all organizations participating in this project, their type and role in the project.

Question 15e

Please provide a narrative describing which indicators the IDN will use to manage day-to-day performance and understand in real-time whether the IDN is on the path to improve broader outcome measures.

Network4Health will utilize a variety of process measures and short-term outcome measures to manage day-to-day performance and assess progress toward improving outcomes.

This project includes widespread education regarding identification and referral of individuals with co-occurring disorders for treatment, and implementation of evidence-based treatment practices. In 2017, Network4Health will utilize the Four Quadrant Model to assess the network's understanding of co-occurring conditions and treatment, and design targeted training that meets partner organizations where they are. This training will be provided on an ongoing basis for interested staff from partnership organizations. The project team will work with project management to develop a detailed implementation plan and will monitor progress in the development of the training module and

scheduling and conducting of the trainings.

Both CMHCs participating in Network4Health have implemented IDDT, an evidence-based practice that treats both disorders (MI/SU) “at the same time- in the same service organization by the same team”. IDDT emphasizes that individuals achieve big changes including “sobriety, symptom management, and an increase in independent living through a series of small, overlapping, incremental changes that occur over time”. As recommended for high fidelity implementation of IDDT, other foundational training will be provided to primary partners. At a minimum, training available in evidenced-based programs will include: “Stages of Change” model, Motivational Interviewing, Listen Empathize Agree Partner (LEAP), Dialectical Behavioral Therapy for Substance Use and Cognitive Behavioral Therapy for Psychosis.

The project team, will develop a clear implementation timeline for identification of partners as primary vs. secondary, and develop a training and technical assistance plan to assist each provider in implementing and/or expanding their implementation of IDDT and other evidence-based practices in a way that fits best for the organization and the individuals served. The implementation plan will have interim milestones, assigned tasks and associated deadlines, and critical path items clearly identified. Consistent with Network4Health’s overall approach to project governance, the project team will report to the Project Management Team, on a weekly basis.

In measuring progress towards project goals Network4Health will monitor process milestones, and identify measurable, timely, and realistic metrics to assess performance relative to these key measures to ensure success over the duration of the waiver.

Detailed planning is critical to achieving the desired outcomes. Therefore, Network4Health’s initial focus will be on compliance with planning activities, including the development of a detailed implementation plan, as well as the design and development of a clinical services infrastructure.

Key metrics that will be assessed during this planning phase include:

- developing assessment of provider understanding of co-occurring disorders;
- developing training modules based on level of understanding;
- developing training modules for implementation of IDDT and other evidence-based practices;
- identifying and procuring technical assistance support for Primary and Secondary providers with implementation of IDDT and other evidence-based practices;
- developing an evaluation plan, including metrics that will be used to measure program impact; and,
- developing mechanisms (e.g., registries) to track and monitor individuals served by the program, adherence, impact measures, and fidelity to evidence-supported project elements.

During the operational phase, monitoring will shift to providing training and implementing the IDDT and other evidence-based models. Performance will be measured against the targets defined in the implementation plan. The following key measures will be assessed during the reporting period and cumulatively, and measured against projections:

- the number of staff trained in identifying individuals with co-occurring conditions and referring them for treatment;
- the number of individuals receiving SBIRT screening;

- the number of referrals from network providers to primary IDDT providers for treatment;
- the number of staff trained in required evidence-based and best practices;
- the number of patients served in IDDT programs and other evidence-based practices for individuals with co-occurring conditions; and,
- performance on other impact and outcome metrics identified during the implementation planning phase, including:
 - quality of life index
 - period of abstinence measures
 - work outcomes.

The project team will assess performance on a regular basis, and will report to the Project Management Team and Steering Committee. On a quarterly basis, the full Partnership Team will be updated on the project's progress.

Specific outcomes measures will be developed in conjunction with participating partners, and with the input and approval by the Steering Committee and Partnership Team. The project team will utilize national resources (e.g. SAMHSA), and best practices defined in the literature. Measures may include:

- inpatient admission rates for individuals with co-occurring conditions;
- acuity of individuals with co-occurring conditions in an inpatient setting;
- readmission rates for a co-occurring condition; and,
- arrest rates for a substance-related crime or for individuals with known MH or SUD condition.

Question 15f

Please provide a narrative describing the key challenges the IDN faces in implementing this project and the key barriers to successful improvement of outcome measures. Please describe the IDN's strategy to mitigate these risks and overcome these barriers.

Network4Health has identified three key challenges in implementing this project: workforce, training, and resource constraints. These challenges and our proposed risk mitigation strategies are discussed below.

Workforce: Consistent with each of the community projects that we have selected, Network4Health believes that a key challenge is workforce. While there is not necessarily a high need to hire additional staff for this project, it will be necessary to provide significant training to the current workforce across the IDN to ensure a basic understanding of co-occurring conditions. In addition, a higher level of resource commitment for those providers that will be implementing IDDT and other related evidence-based practices is required. In addition to having workforce to provide these services, it will also be important to insure appropriate supervision and case review. Another workforce issue identified by the IDN included ensuring the on-going education and training needs resulting from high turnover of staff in partner organizations

Response: This project will be closely coordinated with Project A1 and D3 which in turn will be coordinated with the statewide taskforce on Workforce. In addition, Network4Health partners will work

closely in the implementation of these evidence-based practices and will provide support to each other based on what they have found to be best practices.

In addition, Network4Health will develop training modules based on providers' current understanding of co-occurring conditions allowing for targeted education across the network. This will allow providers to devote the appropriate level of time and resources to this training. Likewise, providers that will implement IDDT will be provided with training and one-to-one technical assistance to reduce the additional stress on the workforce. Technical assistance will include assistance with developing of work processes that allow for the most efficient and effective implementation of IDDT and other evidence-based practices into the existing work stream. In selecting education and training modules and resources for IDDT and other evidenced-based programs, we will need to consider various modalities to allow for training of new staff. We will work with partner organizations to determine the best approaches to accommodate different learning styles.

Difficulty in Identifying/Understanding Co-Occurring Conditions: Given the complexity of co-occurring conditions and the misunderstanding of this condition by service providers in the health and community-based social service areas, many individuals are not appropriately diagnosed or treated for co-occurring conditions today, impacting their health and overall health care costs. Understanding of complexities are required across the workforce, requiring training to focus across all staff levels. We anticipate continuing challenges in reaching all providers within the IDN with our educational efforts-- in particular providers in acute and emergency facilities.

Response: This project is aimed at educating providers across the health care and social service continuum to understand and identify co-occurring conditions, and appropriately refer individuals to treatment that will meet their needs. However, we understand that providers working in acute or emergency care locations are trained to address presenting, often immediate concerns of the patient. By investing not only in the evidence-based practice of IDDT, but also the general education of Network4Health partners, this project will lead to better integrated care and improved health outcomes thus reducing the need for emergency and acute care treatment. CTI will also address members' needs upon transitioning from acute facilities by connecting them with community-based resources. Network4Health also will serve as a learning collaborative for partners to share best practices across a number of different services.

Training Costs: Given the need to provide education across Network4Health on co-occurring conditions coupled with our commitment to train a significant number of providers in evidence-based and best practices shown to be effective for individuals with co-occurring conditions, training costs may be high – both in terms of direct costs as well as down-service time costs while staff are in training. Moreover, we will meet our partner organizations where they are which requires adaptive training modules as opposed to off-the-shelf resources.

Response: Through this project, Network4Health will support significant training costs across the network in order to provide education to our partners on treatment for co-occurring conditions, and in assisting treatment partners in implementing IDDT and other evidence-based practices. We will monitor training costs, to the extent possible coordinate training efforts with other projects within our IDN and across other IDNs, and consider efficient strategies including train-the-trainer models that allow individuals within organizations the ability to do future trainings as needed within their organization.

Question 15g

Tab 15g provides a description of Network4Health's approach to accomplishing project milestones.