

Collaboration with Local Stakeholders

Steering Committee Link: Sandy Hunt

Participants:

Jon Eriquezzo- Crotched Mountain- presenter, Barb Drotos- START- presenter, Stephan Jewel- OPG, Eric Johnson- R1, Michele Harlan- DHHS, Todd Ringelstein- BDS, Mary Jo Benosky-MCO, Tom Vincent- Consultant, Jen McLaren- BDS Medical Director, Kerri Coy- MCO, and Jan Skoby- BDS

Other participants:

Allison O'Neil-Genesis, Celia Gibbs-Genesis, Paula Mattis-Department of Corrections, Lisa Fortin-Lakes Region General Hospital, Kerri Coy-Beacon, Bernie Campbell-Department of Corrections, Stephanie Parker-Office of Public Guardian, Michelle Harlan-DHHS Bureau of Behavioral Health, Cathy Sloane-Well Sense, Sarah Dupont-Lakes Region General Hospital

Meeting Occurrence:

4/25/17, 5/24/17, 6/19/17, 7/27/17, and 8/23/17

Group Discussion Summary:

We discussed who the stakeholders are: CMHC, DCYF, School, Police, Assisted Living, etc. Many of these stakeholders have an existing infrastructure that can be built upon. We need to define collaboration/partnering – what does it look like/initial connection/sitting down to discuss shared folks/identifying and understanding common goals /who can come to the table and see the benefits of being involved/challenges with getting stakeholders to come to meetings (see list of additional participants listed above).

We sought to identify the resources that are currently available and to articulate how we can maximize these resources (in other words, let's not re-create the wheel). We discussed hospitals that are "IEA friendly" which would like to hear from this group. We talked about ways that the members of this group could gain traction in collaboration with local stakeholders – informational / outreach / training / partnerships and to collaborate with local CMHCs: our understanding is that all Directors are interested in learning about people with DD. People with DD need therapy in addition to psychopharm.

We reviewed the Robert Fletcher PowerPoint presentation – "how to best serve those with co-occurring disorders": Currently in NH services are provided to individuals with multiple needs from a silo-based approach where providers individually focus treatment and support on the diagnosis that their system is funded to serve (i.e. mental health, substance abuse, developmental disabilities, medical, etc.). This approach is not effective for people with multiple needs as there is not an integration of care or coordination between providers. The 1115 waiver demonstration grants that are being implemented across the state may provide opportunities for service providers to pilot integrated models of care. It is

expected that in the future, client outcomes will be measured using evidenced based benchmarks and value based payment systems will evolve.

The group discussed the concepts raised in the Dr. Robert Fletcher power point presentation. We then talked about training for various stakeholders and engagement methods. Barbara recommended that START training be provided to the CMHC system and to the Department Of Corrections. Bernie Campbell mentioned that DOC also offers training and invited the START coordinators to do training with DOC staff. Accessing experts in the field via webinars to train teams was suggested.

The group noted that often individuals who present with aggressive behavior stabilize within a day or two after admission to the emergency department. Then it can become difficult to refer them for an inpatient evaluation or admission. The behaviors are often the individual's means of communicating in situations where they may be nonverbal. Discussion of an effort to reduce ER visits through more support and collaboration.

At times collaboration falls apart because buckets of money and agencies are bound by their budgets so we felt the need to examine the financial structure of various stakeholders. Consider the federal guidelines to determine what a CMHC can provide under the current rate.

We discussed using a bottom-up approach to partnering with community providers, especially the Community Mental Health Centers (CMHCs) and to include the individual's day to day staff in addition to administrative staff.

We need to identify specific training opportunities for treating people with dual diagnosis and a way to compel both the DD and MH system to attend and engage in these trainings / how will the trainings be made accessible – webinar etc / importance of CEU eligible trainings as an added benefit to attendees / look at reimbursement for lost billable time training at CMHC / Hospital staff orientation / is there a way to work these trainings into the CMHC contracts and/or MCO driven. We discussed the need to identify or develop education for clinicians about the DD/IDD population.

Collaboration = Commitment to ongoing engaged dialogue

Group Accomplishments:

The workgroup developed an Emergency Department (ED) Protocol to be provided for Area Agencies and community partners. This is still in draft form, but it's hoped to be implemented for October 1st. The protocol written does not stand alone with every situation and/or with each area agency. It's to act as a guide to move the individual from the ER into appropriate services and long term care.

Barb Drotos will be increasing communication regarding the role of NH START and the START Center to help bridge the service gap in NH for our individuals. The START Leadership team will be going out to all AAs to help re-educate and gain knowledge on what services and trainings are offered.

In order to bridge the gap between MH and IDD services, and to effectively treat individuals with multiple primary disorders, we learned that we can pursue a case management waiver to combine services for both DD and MH.

Next Steps:

Investigate the application of new or existing Integrated Delivery Networks (IDNs) – that addresses the needs of people accessing mental health and substance abuse services and evaluate the use this framework for people to better access IDD/MH services.

Identify or develop education for MH clinicians about the DD/IDD population.

Reach out to CMHC to build bridges and assure people are getting the services they need/ how can people benefit from the existing structure of services. Bumping up against different values and philosophical approaches

Look at the federal guidelines to determine what a CMHC can provide under the current rate structure, and explore how to better allow for funding to be used across the MH/IDD service array.

Distribute the final version of the emergency department protocol.