



NH Intensive Treatment Services Workgroup: Capacity Development

Filling the Gaps in the Continuum of Care

Date: 8/25/2017

Time: 1:00 pm – 2:00 pm

Location: Conference Call: 1-866-951-1151 #116366164

Facilitator: Sandy Hunt, NH Bureau of Developmental Services

Note Taker: Sandy Hunt, NH Bureau of Developmental Services

Attendees: Lisa O'Connor, New Hampshire Healthy Families
Karen Kimball, New Hampshire Healthy Families
Bob Scholz, the Center for START Services

Meeting Overview: Sandy acknowledges that the date / time of this meeting had been changed a number of times and it was a challenge to identify a time that everyone could attend within the month of August. Sandy will be the presenter of this workgroup's efforts at the Summit in September.

The "ITS Metrics" which has recently been renamed to "Performance Measures for Intensive Services" were briefly discussed; however representatives from New Hampshire Health Families had not received them. Sandy will send them these measures after the call.

Karen mentioned that there was a tool that had been previously developed by Cynthia Mahar and associates which was used to help identify those who should be considered "high risk" or "in need of ITS". Sandy indicated that there is a definition that the Community of Practice (CoP) uses to identify those in need of ITS which has been helpful in collecting survey data across the state.

BDS is hoping to work with HRST to identify a way to include identifiers within the Health Risk Screening Tool (HRST) which will be a single point of data entry, less subjective and applicable to those receiving waiver services. It was pointed out that the HRST is only used for those receiving residential services, and therefore those under 21 and others may be left out of this data collection process. This is an important fact to consider when having discussions with HRST folks. The goal is to anticipate the need for ITS capacity in NH, and therefore it is essential to see those who are under 21, coming into the system.

There was discussion regarding the Projected Services Needs List (PSNL) and that area agencies should be working with people as young as 16 in transitional services so that their needs can be placed on the waiting list. This is currently happening, and it is a matter of being able to call out those who may be in need of ITS and include them in a capacity report.

NHHF representatives indicated that they rely on area agencies to report those members who are dually diagnosed (DD/SMI) and are considered "boarding" in emergency departments awaiting admission. This is the best way to collect the data, because the claims data is limited to those who have received treatment, and not those who are considered boarding. NHHF was clear that this is the process for NHHF and they are unable to speak to what Well Sense has in place for this population.

Sandy mentioned that there is a draft of a protocol to address those who are awaiting services in an ED for non-medical purposes for 24 hours or more. This protocol prompts area agencies to notify the MCO, which should help in their data collection.

Karen pointed out that on the mental health side, there have been several closures over the past years of designated receiving facilities (DRFs) due to lack of funding. Additionally, there used to be more resources at New Hampshire Hospital.

There have been a number of providers who have expressed interest in developing programs for ITS however there is a lack of funding to develop these programs. The group agreed that there is not a single solution, and that capacity will improve as various solutions are proposed and developed. We may be able to approach providers in Mass to inquire if they are interested in expanding to NH. A roadblock for this type of development has been NH regulations around residential homes being limited to 3 or less beds. If treatment facilities were developed, there would need to be additional beds to make this cost effective. This is a point that Becket has brought to BDS' attention.

NH is in need of providers, and it is essential to ensure that creative options are developed. Looking to provider outside of NH may be a fruitful endeavor.

Thank you to everyone who has participated in the workgroup. Your time and expertise has been invaluable. We are looking forward to the Summit follow up on September 27th from 9 – 12 in the Tom Fox Chapel, Concord NH.



NH Intensive Treatment Services Workgroup: Capacity Development

Filling the Gaps in the Continuum of Care

Date: 7/18/2017

Time: 10:30 am – 11:30 am

Location: Conference Call: 1-866-951-1151 #116366164

Facilitator: Sandy Hunt, NH Bureau of Developmental Services

Note Taker: Sandy Hunt, NH Bureau of Developmental Services

Attendees: Lisa O'Connor, New Hampshire Healthy Families
Amanda Nelson, NeuroInternational
Noah Riner NeuroInternational
Missy Hill, Northern Human Services

Meeting Overview:

The group briefly reviewed the ITS survey data. BDS is working on ways to look further into this data and make it less subjective. It is a good start and gives us an idea of the demand for ITS in the state of NH.

The group reviewed the ITS Metrics. The Metrics are measurements that will be used to track progress within ITS program. The Metrics will be applied to those programs that have received enhanced rates (Becket, Easter Seals, Neurointernational) and will be fine-tuned as we move forward.

Missy brought up the “Good Lives” model, which helps people identify what they want when they move out of the more restrictive model of support. This model is used at the Columbia House which is operated by Northern Human Services (Region 1). Missy mentioned that this model focuses on building self-regulation skills. It is based on human needs and identifies 10 different segments within an individual’s life. The person is asked to identify what is important to him, and the steps to get to where he wants to be in the future.

Neurointernational uses other measures and a rating scale called the RIC-FAS. This is a measurement tool that was developed in Chicago which measures how someone is doing. This tool is applied during treatment and upon discharge. Noah asked, “How can we measure durability?” and wondered if this could be added to the metrics.

These metrics are important because they assist providers in providing the right support at the right time based on where the person is at in his/her life. These measures will assist us as a system in moving people across the continuum of care, and hopefully towards the least restrictive environment possible for that individual.

With regard to building capacity in the community, it was brought up again that there are 81 provider agencies in NH and fewer than 10 agencies that provide ITS. The groups brainstormed on how providers might be incentivized to offer ITS. It is difficult for providers to offer ITS because of various factors such as staffing challenges, housing, lack of financial resources, liability and lack of treatment (clinical) providers. One suggestion was to get providers together to discuss what is needed in NH.

Most programs develop core competency over time: perhaps there should be a gradual increase in complexity of supports that are provided over time, so that providers can sharpen their skills. Over time, providers will become more confident in serving people with complex needs. Some suggestions on how we might get providers more comfortable with serving individuals who have complex needs:

- Develop a “START house” (or something similar to the START house) for people with complex needs.
- Collaboration with the Bureau of Developmental Services and the Bureau of Behavioral Services in training: Gain “buy in” to the system structure
- Identifying clinicians to work with this population
- Create a “next step” (up or down) for the individual if needed
- Train providers in working with this population, strengthen clinical support
- Respite
- Financial Support

Neurointernational has transitioned mental health (behavioral health) services in house because of the limited exposure to that individual in treatment. In many cases, an external provider is involved; however for the most complex cases it makes sense to use an internal provider.

New Hampshire Healthy Families has developed an intensive case management model which offers access to a number of resources that work collaboratively as a team to work with the person. Everyone from all backgrounds should be at the table.

There must be a culture shift in the state in that developmental and mental health service resources give the provider the support to work with that person.

The group did not have enough time to discuss the four person setting recommendation put forth by Becket in last month’s meeting.

The next meeting is scheduled for August 15th, 10:30 – 11:30 am. This will be the final workgroup meeting prior to the Summit on September 27th from 9 am – 12:00 noon. Sandy Hunt will submit the 7/18/17 report to CSNI.



NH Intensive Treatment Services Workgroup: Capacity Development

Filling the Gaps in the Continuum of Care

Date: 6/20/2017
Time: 10:30 am – 11:30 am
Location: Conference Call: 1-866-951-1151 #116366164

Facilitator: Sandy Hunt, NH Bureau of Developmental Services

Note Taker: Sandy Hunt, NH Bureau of Developmental Services

Attendees: Lisa O'Connor, New Hampshire Healthy Families
Lisa D'Innocenzo, Becket
Bob Scholz, the Center for START Services

Meeting Overview: Only four people participated in today's call but we had a lively discussion regarding supply and demand of ITS services in NH.

The group reviewed the survey data that was collected from state risk management committee members from their respective Area Agencies. This data broke down by Area Agency the number of people that are served at the area agency who qualify as follows:

- High Risk Behavior over 21
- ITS program in NH
- NHH / Incarcerated / Secure Psychiatric Unit
- Out of State Placement (over 21 / under 21)
- High Risk Behavior ages 16-20
- CoP Profile completed
- CoP Referral or profile in the future (ages 16-20)
- Risk Management Plan in the future (ages 16-20)
- Substance Abuse (all ages) Former Axis 1 Diagnosis / Mental Health (over 21 / under 21)
- Autism Diagnosis (over 21 / under 21)

The group discussed potentially putting this data on the BDS website. Sandy Hunt will look into this, as it might be a breach of confidentiality and wondered if we could make the report statewide so that it is more generic.

The group also discussed potentially adding a feature to NH Leads so that this data can easily be captured. It would require that the Area Agency update the data regularly. Special thanks to Allison Howe from CSNI for gathering this data.

This survey data was very helpful in that it confirmed our beliefs that there is a large need for ITS programs and very little capacity in NH. We discussed the "demand" and how this affects the "supply"

The group also reviewed the official list of provider agencies in the State of NH. There are 81 provider agencies on this list. It was discussed that perhaps these vendors should be included in all ITS RFPs so that people are given the opportunity to receive services in a non-traditional ITS environment, and providers are given the opportunity to expand their services.

In order to expand capacity in this way, we would have to find a way to lower liability for providers, and utilize an assessment process to determine which individuals would be the best candidates for this approach.

The group discussed that the approach to funding an ITS program is mainly around the staffing of that individual, when there are many other factors that we should be taking into account. The bulk of the cost of an ITS program is with staffing the program and maintaining safety. Is this individual centered, or agency centered? How can we move closer to individual centered approaches, while maintaining the safety of the person that is being served, and the staff?

It was mentioned that there should be a predictable, fun, strengths based milieu available to the individuals receiving services.

The group discussed the requirements of START staff (bachelor level required, experience preferred) and applying this requirement to the vendors who may be interested in working with the ITS population. The education and training of staff would contribute to building capacity, and would have to be funded through ITS individual budgets.

Another recommendation was to think about four person settings. Becket would like to look into this and get back to us on how this may be achieved. This would build capacity without drastically driving up the cost. Licensing would have to be on board and make recommendations.

The group discussed the idea around expanding the vendor list: It is important to make sure that they have the resources and relief that they needs. A back door to intensive services and a built in support network will build capacity. A mobile crisis unit for the State of NH could satisfy the need to support vendor agencies. Another recommendation was to partner with other vendors for outpatient care, such as counseling.

Sandy Hunt will submit the 6/20/17 report to CSNI. A group leader has not been identified for this group. Meetings take place on the third Tuesday at 10:30 am.



NH Intensive Treatment Services Workgroup: Capacity Development

Filling the Gaps in the Continuum of Care

Date: 5/18/2017

Time: 2:00 pm – 3:00 pm

Location: Conference Call: 1-866-951-1151 #116366164

Facilitator: Sandy Hunt, NH Bureau of Developmental Services

Note Taker: Le'Ann Milinder, The Institute of Professional Practice Inc.

Attendees: Karen Kimball (in lieu of Lisa O'Connor), New Hampshire Healthy Families
Sue Silsby, Easter Seals
Le'Ann Milinder, The Institute of Professional Practice Inc
Lisa D'Innocenzo, Becket
Bob Scholz, the Center for START Services
Missy Hill, Northern Human Services

Meeting Overview: The meeting was held at BDS, with some individuals on the phone. We addressed the agenda items laid out in the initial call. Possible dates for regular meetings were discussed. No one date was good for all. The third Thursday at 10:30 was best, Sandy will follow up. No group leader was selected. This will be done later in the process. Le'Ann Milinder took notes.

- Review the work that had already been done (see 4/19/17 email from Allison Howe, CSNI)

There are 215 people characterized as ITS folks in NH. This is from the data received from Alison Howe.

We discussed how to develop the framework of the overall capacity of the state. We want a global perspective but each of us is involved regionally. Are we looking just at designated ITS beds or something else? ITS beds are tracked at Community of Practice. Staff residences have a much lower number of beds than 215. Alison Howe has information of the distribution and where folks are: staffed, EFC, who has day programs, or 525/521, his is done on behalf of CSNI and compiled the info for the area agencies. We want demographic information on them. This would define the demand in NH. Sandy sees pockets of activity in terms of tracking, such as COP. But maybe this has been captured if they are part of an area agency. In developing a list, it should include waitlist. Also include the out of state folks placed through area agencies. There are a bunch of people out of state who don't qualify for ITS.

- Piece together a framework of available capacity in the State (see docs from Allison Howe)

What is the supply of ITS services in the state? Look at current providers, what they are providing: program type and treatment being rendered. Not all beds are equal. Different vendors get rfp's, read the plans, and determine if they can support them. There are both ITS vendors and other vendors who could be part of the continuum of care.

In Maine, the vendors had to provide a list of programs and their parameters so that appropriate referrals could be made.

We may need to broaden who has submitted capacity documents. There are some who have submitted, but there are likely more.

NH is going through a corrective action plan for the waiver. One action is to separate case management from service provision. One question is how we divest the area agency of services, then how do we ensure that there are sufficient available services. One activity that will happen is a mapping of the state and who does what. We may want to piggy back on the info that is being collected there, rather than having a separate process. That would help us get a sense of what is out there for step down services in each region.

Names of vendors can be obtained from each area agency. Also vendors vary on what they do in each region, so need to know what they do locally. It may be better to use a standard electronic form that vendors can use to report their capacity – that would enable easy compiling of the data. This process was done previously a while ago – if this document could be used to define what we’re looking for, we can update it. Sandy will contact John Capuco about getting this. The new form should actually ask for what clinical staff and services they have for ITS clients. Some vendors may say they will serve individuals but don’t really have the clinical capacity. Some vendors will do it without the right supports. Also we should also ask what people want to develop in the future and in what areas.

- Develop a roadmap to move from where we are (capacity) to where we want to be

Need to start with the information discovered above. We need to know where we are in more detail first.

- Increase movement from high intensity to lower intensity models so people are not stuck

BDS is brainstorming different models. What’s the group’s opinion about funding someone at a high level, who then they becomes stable after 6 months-- how do we reduce their funding and make those funds available to someone else? What if there’s a base budget and a 6-month enhancement budget, which is then reduced. Or you could have a program that is funded at a consistent high level, but is strictly crisis and short term.

The problem with the crisis program is that people can get stuck there if there’s no lesser place for them to go. Should we be attaching a dollar figure to each model, consistent across the state, for each level of intensity? Some think funding should stay with the program. Discharge criteria need to be established-- can’t be an arbitrary timeline. Many will need a couple of years of high intensity. Length of treatment in the program should be discussed as soon as they arrive – what is the plan and criteria for stepdown. Does this model already exist? START resource and Easter Seals Weare program does discharge planning. The model at FINR had various settings from locked down intensive treatment through a continuum with criteria to move. We would need this either within a program or across programs in NH, with clear understanding of how to move. We do need to have a true emergency placement for people acutely in distress. When these acute folks are present in a non-acute setting, the treatment milieu for high intensity falls apart. More providers would be willing to do the step down care if there was true emergency care – right now folks get staffed in hotel rooms and ERs in settings where we can’t get paid. The true crisis situation is very short-term.

You can’t have one set budget across the state – the costs and resources vary by region both in terms of travel and availability and local rates.

All programs need to be seen as treatment centers, not an individualized budget— these are not people’s homes. We need to locate them in places where we can actually support them. There has to be a whole conversation about how to fund these different levels and be consistent with the guidance – future need to figure out to find the funds for the stepdown—would need to be an opening in a stepdown program if there wasn’t an individualized budget.

Also, need to look at the levels of funding – how much variability among ITS is there – would 3 high, med, low be enough levels?

- Identify more specialized clinicians who are able to work with this population

Region 1 pays more to get clinicians from out of region.

No time to discuss this today. Discuss next time.



NH Intensive Treatment Services Workgroup: Capacity Development

Filling the Gaps in the Continuum of Care

Date: 4/20/2017

Time: 9:00 am – 9:30 am

Location: Conference Call: 1-866-951-1151 #116366164

Facilitator: Sandy Hunt, NH Bureau of Developmental Services

Note Taker: Sandy Hunt, NH Bureau of Developmental Services

Attendees: Lisa O'Connor, New Hampshire Healthy Families
Kim Shottes, the Plus Company
Sue Silsby, Easter Seals
Le'Ann Milinder, Institute of Professional Practice Incorporated
Lisa D'Innocenzo, Becket
Bob Scholz, the Center for START Services
Amanda Nelson, NeuroInternational
Noah Riner NeuroInternational
Neil Flannery, NeuroInternational
Missy Hill, Northern Human Services

Meeting Overview: This call was a 30 minute introductory call in which members were given the opportunity to introduce themselves, discuss why they chose to participate in this workgroup, goals of the workgroup and offer times available in May for the group to meet in person.

When asked about why they chose to participate in this workgroup, members shared the following information: This is the population that I work with in my agency / there are limited options for people with ITS needs and a lack of step down options / my agency is interested in expanding / my agency has been working with people who have risk management plans and present with challenging behaviors and we would like to support them in the best way possible / my agency has proposed new and innovative approaches to ITS services and step down approaches but there are no funding options / START would like to offer its current curricula which has some elements that could be helpful in working with the ITS population / my agency is expanding into NH and we would like to contribute to the bigger picture / we would like to offer one slice of a bigger solution / we would like to have a voice / my agency struggles with capacity due to geography (North Country).

There is no lack of enthusiasm or commitment from the agencies that participated in this call. Goals that were identified include:

- Review the work that had already been done (see 4/19/17 email from Allison Howe, CSNI)
- Piece together a framework of available capacity in the State (see docs from Allison Howe)
- Develop a roadmap to move from where we are (capacity) to where we want to be
- Increase movement from high intensity to lower intensity models so people are not stuck
- Identify more specialized clinicians who are able to work with this population

The group suggested the following dates which will be sent out in a doodle poll: May 5th, 8th, 11th, 16th, 19th, and 18th. Sandy Hunt will submit the 4/28/17 report to CSNI. A group leader will be identified at the May meeting. BDS, Northern Human Services, New Hampshire Healthy Families and Easter Seals offered to host the next meeting. A call-in option will be available for out of state agencies.