



**NH Intensive Treatment Services Workgroup:
Collaboration with Local Stakeholders**

Date: 8/23/17
Time: 3:00 pm – 4:00 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: Jonathan Eriquezzo, Crotched Mountain
Stephanie Parker, Office of Public Guardian
Eric Johnson, Northern Human Services
Todd Ringelstein, DHHS, Bureau of Developmental Services
Jennifer McLaren, BDS Medical Director
Allison O’Neil, Genesis
Celia Gibbs, Genesis
Paula Mattis, Department of Corrections
Alan Greene, Monadnock Developmental Services

It was determined that Jonathan and Barb will present to the Summit follow up group on September 27th, 2017.

A suggestion for the ED protocol was around including a timeline for the Service Coordinator to reach out to the Bureau. There was no timeline established, as this protocol is not a directive, but more of a recommendation to area agencies. The goal is to learn about cases that are at the ED for 24 hours or more.

There was discussion around START services, and how people are in need of services that are more intense than which START can provide. Specifically, there are many people that START will not admit. These are the gaps in service that we are trying to identify and address as a system. An example was shared regarding a situation in which the individual was in the ER, a provider could not take the person home, and therefore START could not work with that individual because the person was then homeless. START services are meant to be transitional, and not meant for extended stays.

START is referenced in the ED protocol, and therefore there may be more referrals to START going forward.

START is not the answer to everything, how do we group and partner with other organizations to support someone in the Emergency Department? A recommendation was brought up about exploring the IDN (integrated delivery networks) that have been established by the DSRIP waiver.

The goal is to integrate services, offer payments for achieving goals, and breaking through silos to better serve those who experience serious mental illness and substance use disorder.

Eric mentioned that his IDN (Region 7) has offered to reimburse providers for small pilots. Communication amongst providers is a focus.

There is a meeting in Claremont on 9/18 from 9-1 pm at the “Common Man” to discuss the goal of the IDN for Region 1.

The group discussed the difficulty of identifying those who are awaiting services in the ED for non-medical purposes. This is difficult because they are not involuntary admissions and therefore not formally tracked. The best way to gather this information is to rely on the area agency.

The START center is offering training to corrections. Region 1 has an on-site START Coordinator who offers trainings to mental health center. START Coordinators are employed by Region 4 and embedded at the area agencies. The challenge is deciding between a system that is embedded or centralized. The group seemed to think that embedded was more effective.

A point was made that the medical component to an individual’s support is important in person centered planning.

A bottom-up approach was recommended to partner with the CMHCs, essentially identifying people before they go into crisis. A thought was to look at the ED visits at Regions 1 and 9, which are the two area agencies that also act as the local CMHC – theoretically these numbers should be low, however it was pointed out that in many cases, even these agencies do not communicate within their own agency regarding the DD and SMI sides of services.

BDS’ approach has been to operate from a case by case basis and partner with the Bureau of Behavioral Health (BBH) regarding people who are dually diagnosed. Years ago, the case management for MH was allowed to be billed alongside of DD case management. This was eliminated; however we have the ability to waive this if needed.

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:
Collaboration with Local Stakeholders**

Date: 7/27/2017
Time: 12:00 pm – 1:00 pm
Location: Conference Call: 1-866-951-1151 #116366164

Facilitator: Sandy Hunt, NH Bureau of Developmental Services

Note Taker: Eric Johnson, Northern Human Services

Attendees: Jonathan Eriquezzo, Crotched Mountain
Stephen Jewell, Office of Public Guardian
Eric Johnson, Northern Human Services
Todd Ringelstein, DHHS, Bureau of Developmental Services
Mary Jo Benosky, Well Sense
Barb Drotos, the Center for START Services
Jennifer McLaren, BDS Medical Director
Jan Skoby, DHHS, Bureau of Developmental Services

-Final version of ED protocol: A recommendation was made to adjust the suggested list of invitees for conference calling about ED admissions. A recommendation was also made to add a statement in the protocol that appropriate release of information consent forms must be obtained before sharing protected patient health information (PHI) with those participating. If Area Agency staff should communicate with Dr. McLaren about a case, they will need to be sure not to include PHI in any e-mail correspondence.

-Timely identification of ED admissions: Currently, the Division of Behavioral Health (DBH) sends out a daily list of all patients in NH EDs who are in need of an involuntary psychiatric admission. The list includes the name of the hospital, and the insurance provider for the patient, if applicable. The majority of these patients are awaiting a bed at New Hampshire Hospital. Sandy will check with DBH staff to see if there is a way to collaborate to generate a similar list to identify Area Agency eligible individuals. A reminder was made that not all of these individuals may need an involuntary admission. The idea is that Area Agencies could possibly receive a similar current list on an ongoing basis in the event there is an admission they are not aware of for some reason.

Operationalizing trainings to include Corrections Dept. and CMHCs by START staff: The group spent considerable time discussing training in terms of the audiences needing to be reached, the venues, and opportunities for incentivizing training with CEUs. Webinars were discussed as a cost effective and efficient means for offering some training. Barb agreed to determine the availability of specific trainings from START. Discussion about diagnosis specific training will be important to include. Other topics included overview of developmental disabilities, autism and traumatic brain injury.

The Mental Health Center of Greater Manchester offers a robust program of continuing education which might be able to play a role in operationalizing some of the training ideas generated today; they are a primary provider of behavioral health training in NH:

<https://www.mhcgm.org/wellness-education/continuing-education/>

Engaging stakeholders in training was discussed as a need for further development. The concept of having training lead to a certification or credential was raised as a way to tailor specialized training and develop needed skill sets in treatment professionals. The Department of Corrections was identified as a potential resource for training for Area Agency staff.

-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. It was noted that the Fletcher diagram should also include sexuality as a domain that needs to be considered in treating the whole person.

-For the next meeting: We will focus on recommendations to move system thinking toward a “whole person approach”. How can the assessment process include all areas of a person’s life to identify needs that should be addressed concurrently and with seamless coordination of providers?

Our premise is that co-occurring disorders should be treated as multiple primary disorders, in which each disorder receives specific and appropriate services. Services should be based on individual needs and not solely on either a MH or DD diagnosis.

-Next Meeting: The next meeting will be scheduled in August via a “doodle” poll.



**NH Intensive Treatment Services Workgroup:
Collaboration with Local Stakeholders**

Date: 6/19/2017
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: Eric Johnson, Northern Human Services

Attendees: Jonathan Eriquezzo, Crotched Mountain
Stephen Jewell, Office of Public Guardian
Eric Johnson, Northern Human Services
Todd Ringelstein, DHHS, Bureau of Developmental Services
Mary Jo Benosky, Well Sense
Barb Drotos, the Center for START Services
Lisa Fortin, Lakes Region General Hospital
Kerri Coy, Beacon
Bernie Campbell, Department of Corrections
Jennifer McLaren, BDS Medical Director

Review of Emergency Department Protocol–feedback: 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.

Currently in NH, patients in the EDs who are in need of an involuntary admission are waiting 10 days or more for a bed at New Hampshire Hospital.

Sandy indicated that she did not want the proposed BDS protocol to be overly directive and the protocol makes recommendations on how the Area Agency may want to proceed.

The group recommended that additional people be added to the list of those who might be engaged to discuss cases. Additional suggestions included Transitional Housing staff, residential staff, DRC, private case managers, CFI case managers, CMHC emergency services staff and the social worker and/or the case manager of the hospital.

It was also noted that ED staff often rely upon people from a patient’s living environment to get a good sense of what is going on...this collateral information is very helpful.

The notion of having the START Coordinators meet with each of the ED staffs for the hospitals in their regions was raised as a way to facilitate better coordination of future cases.

Dr. McLaren offered to assist with challenging cases in terms of contacting the ED physicians should AA staff find that necessary.

It is important that ED staff follow-up with referrals to inpatient settings one or two times per day while the person is in the ED as beds often open without notification. This is also important to assure that the referral information was clear and complete to the inpatient setting to facilitate the potential admission. If the referral is denied, then the patient should be re-referred after receiving clarification on the reason for denial, if appropriate. It was suggested that the AA service coordinator be identified on the proposed protocol as responsible for daily check-ins for ED patients.

Training: 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.

Department of Corrections (DOC): Bernie Campbell from the Department of Corrections presented the levels of screening and testing that occur within her department for individuals who present with dual diagnoses. She indicated that behavioral health bio psych evaluations are conducted to assess for severe mental illness (SMI) or severe and persistent mental illness (SPMI). If identified, then a treatment plan is developed. A case manager or counselor does the Ohio Risk Assessment (ORAS). The Ohio Risk Assessment System is a dynamic risk/needs assessment system used with adult offenders. It offers criminal justice staff the ability to assess individuals at various decision points across the criminal justice system. Bernie also mentioned a prison intake test (PIT) that is utilized to determine what types of programs incarcerated individuals might benefit from; educational needs are also assessed based on an individual's interest. If an individual meets the criteria for special education level services then a special coordinator follows them.

The DOC has M.D.s that collaborate with the CMHCs in NH on discharge planning. The DOC also has in-house clinicians as well as case managers that follow incarcerated individuals during their entire length of stay. These staff interface with CMHC case managers and medical case managers in the community.

Wrap Up: Sandy will finalize the protocol. She will speak with Jan Skoby about training and consider beginning to track who is attending various trainings that are offered.

For the next meeting, it was suggested that we reference page 10 of the Dr. Fletcher PPT presentation so that we can address how to operationalize the ways in which co-occurring disorders should be treated as multiple primary disorders, where each disorder receives specific and appropriate services. The key is to assure that collaboration of appropriate services and supports occurs as needs are identified.

Next Meeting: The next meeting is scheduled for Thursday, July 27th at noon; the same location at BDS.



NH Intensive Treatment Services Workgroup: Collaboration with Local Stakeholders

Date: 5/24/17
Time: 10:00-10:50 am
Location: Conference Call: 1-866-951-1151 #116366164

Facilitator: Sandy Hunt, NH Bureau of Developmental Services

Note Taker: Cathy Sloane in lieu of Mary Jo Benosky, Well Sense

Attendees: Jonathan Eriquezzo, Crotched Mountain
Stephanie Parker in lieu of Stephen Jewell, Office of Public Guardian
Eric Johnson, Northern Human Services
Michelle Harlan, DHHS, Bureau of Behavioral Health
Todd Ringelstein, DHHS, Bureau of Developmental Services
Cathy Sloane in lieu of Mary Jo Benosky, Well Sense
Barb Drotos, the Center for START Services
Tom Vincent, Neurodevelopmental Institute
Jan Skoby, DHHS, Bureau of Developmental Services
Sarah Dupont in lieu of Marge Kerns, Lakes Region General Hospital

Meeting Overview:

This call was 50 minutes in length. The first order of business was to identify a note taker who will take notes of each meeting, publish them to the group and be the one to present the work groups report to the larger group in Sept 2017.

All work group reports will be uploaded to the BDS website. Jon Eriquezzo and Barb Drotos volunteered to conduct the presentation to the larger group in September, Mary Jo was recommended to serve as the note taker. In her absence, Cathy Sloane took today's notes.

DD population overlaps in other areas within the service delivery system /identified other areas local stakeholders in the service delivery system

MH and DD intersect often but the systems are structured very differently/we need to 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

Dr. McLaren was not present but had sent info to Sandy / Dr. McLaren has outreached to all the CMHC Medical Directors/she is now in process of developing CME's for each CMHC for individuals with dual diagnosis – this will be in on the DHC (Dartmouth Hitchcock) 2017-18 cycle.

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 -

START has webinar 60-90 minute trainings and could offer the ones that are line with this/ START has 16 staff-coordinators that can go anywhere in the state to provide training- this can be offered to anyone – prescribers, CMHC's/ looking to educate medical staff too / these trainings are CEU eligible.

Partner with NHH for educational opportunities / Grand Rounds are already free trainings- with new leadership there is opportunity to reopen collaboration/partnership.

List of hospitals that currently have the capacity and experience in serving DD population / where have people been admitted voluntary by guardian / noted Brattleboro - Hampstead up to age 23 - a list does exist and includes : SNH, Cheshire , Concord, Arbor Fuller – list will be provided to workgroup / Inpatient units are treating individuals with acute MI / no other individuals with DD on the units.

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 meeting

Refining the intake/how do individuals with dual diagnosis access the hospital/discharge planning starts on the first day of admission/timelines don't matchup between systems / the reality of the BDS/DD system slower to locate discharge placements then the hospital is used/ challenges with getting CMHC services for dual diagnosed/need training to understand each sides/hospitals focus on stabilizing not treating/who are the points of contact for hospitals at the AA's- when is START involved/clarify roles of the service coordinators /inconsistency AA to AA need to clarify who is in charge who to call/Hampstead has a good protocol for admission and discharge planning.

Also need to look at medical floors and clarify and develop a protocol/specific wrap around model on how to care for dual diagnosed/attend team meetings at hospitals to have direct communication and input into discharge planning.

(At this point Sandy you presented a visual of the population)

Population breakdown- those in crisis at the top of the pyramid/ individuals escalating and de-escalating in the middle/bottom those at baseline –this is where the most services are thru the AA/what services can be provided at baseline to keep people there.

Close of Lakeview- Crotched Mountain set up communication with emergency responders/regular meetings with local hospital ED/ approached Continuous Quality Improvement angle-all hospitals have to have QI in place/it's about establishing relationships and building trust – we are not “dumping” people in the ED but it may take time to bring the additional resources needed/look at formalized relationship AA with local CMHC and hospitals- quarterly meetings/share stories.

LRGH has monthly wrap around team meeting/develop community care plans involve multiple stakeholders (SUD, MH, DD etc) – took the idea from Frisbee- have releases and confidentiality agreements – HIPAA compliant for CR42/can this info and template for care plans be shared /also have hospital based care plans with single stakeholders – outlines medical care, etc./best practices in the state

Collaboration = Commitment to ongoing engaged dialogue

Role clarification/who is taking the lead/who to work with at the AA/who is responsible to get the person out of the hospital –is it the CMHC / the AA?

Development of tools to be used - START has a decision tree that has been shared with all CMHC's who are doing ED assessments – not clear who is using it - Barb will share this tool with the group

START is not best fit for getting people out of the hospital but prevention – crisis plans developed with all the players at the table/ ID services that can be added to prevent hospitalization

Another area of intersection Police/Dept of Corrections/there is some training happening with the police Academy/more pressing need maybe Dept of Corrections/should they join -Jan has a contact

Goals that were identified today include:

Formalized relationships with AA's CMHC and Hospitals – establish quarterly meetings

Identify trainings to dual diagnosis for CMCH's, hospital and medical staff and how to get this incorporated into the systems

Engaging the Dept. of Corrections

Best practice for Wrap Around teams and community care plans

Refining the Intake and Discharge planning process

Sandy reviewed that we touched on all the goal areas expect financial structure

Only 3 meeting left before the large group summit

Next meeting scheduled for Monday June 19th same location at BDS 10:00am

Subsequent meetings will be the 4th Wed of the month at 10am



NH Intensive Treatment Services Workgroup: Collaboration with Local Stakeholders

Date: 4/25/2017
Time: 3:30 pm – 4:00 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: Jonathan Eriquezzo, Crotched Mountain
Stephen Jewell, Office of Public Guardian
Eric Johnson, Northern Human Services
Michelle Harlan, DHHS, Bureau of Behavioral Health
Todd Ringelstein, DHHS, Bureau of Developmental Services
Mary Jo Benosky, Well Sense
Barb Drotos, the Center for START Services
Tom Vincent, Neurodevelopmental Institute
Jennifer McLaren, BDS Medical Director
Jan Skoby, DHHS, Bureau of Developmental 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: It is difficult to get people the services they need, which has been a result of failure to collaborate / Collaboration is essential especially with agencies such as DCYF/BDS and Area Agencies / I have had cases where collaboration was not where we needed it to be / My agency communicates with many different stakeholders and I can be an active part of the solution / 2 Area Agencies are also the Community Mental Health Center – the perspectives of these agencies may lend some important insight / It is a struggle to find appropriate services for people with problematic sexual behavior / Mental health needs affect the people we are supporting, working with local stakeholders would be advantageous / Collaboration will bring a sense of working with the whole person in an integrated manner, such as child, elder wraparound services / This group is good because the managed care organizations collaborate with local stakeholders and can offer some insight / My agency is statewide and originally collaborated with mental health but has recently reached out to local stakeholder such as hospitals and emergency departments / I'm interested in dual diagnosis and hospital diversion by providing rapid crisis response services and wraparound services which offer a holistic view of the person / I have been in DD for 22 years and have seen the pendulum swing: We need to look at the whole person to determine healthier, happier lives – we need to have people come out of NHH safely / we need a list of hospitals that serve the DD population

Goals that were identified include:

- Review the work that had already been done (see 4/19/17 email from Allison Howe, CSNI)
- Identify who the stakeholders are: CMHC, DCYF, School, Police, Assisted Living, etc. Many of these stakeholders have an existing infrastructure that can be built upon.
- Identify the resources that are currently available and articulate how we can maximize these resources (in other words, let's not re-create the wheel).
- Develop a list of hospitals that are "IEA friendly" which would like to hear from this group.
- Identify ways that the members of this group can gain traction in collaboration with local stakeholders – informational / outreach / training / partnerships
- Collaborate with local CMHCs: All Directors are interested in learning about people with DD. People with DD need therapy in addition to psychopharm. Consider the federal guidelines to determine what a CMHC can provide under the current rate.
- Identify or develop education for clinicians about the DD/IDD population
- Reduce ER visits through more support and collaboration
- Look at financial structure of various stakeholders. Many times collaboration falls apart because buckets of money and agencies are bound by their budgets.

A doodle poll will be sent out to schedule the next meeting. Sandy Hunt will submit the 4/28/17 report to CSNI. A group leader will be identified at the May meeting. BDS, A Tech, Community Bridges and Dartmouth offered to host the next meeting. A call-in option will be made available.