

Table of Contents

1.	IDN Vision and Theory of Action.....	4
2.	IDN Service Area Community Needs Assessment.....	6
2a.	Analysis of IDN Service Area Disease Prevalence	6
2b.	Regional Demographics	9
2c.	Current Resources Available	13
2d.	Assessment of Gaps in Care.....	18
3.	Community Engagement and Stakeholder Input.....	28
3a.	Narrative describing the process by which the IDN has solicited community input in developing this Project Plan	28
3b.	Narrative describing the process by which the IDN will solicit community input in implementing its program over the course of the demonstration	30
4.	Network Composition	32
4a.	Finalized Network List.....	32
4b.	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)	32
5.	Relationship with other initiatives.....	34
6.	Description of how this plan addresses the Opioid Crisis.....	36
7.	IDN Governance	38
7a.	Overall Governance Structure	38
7b.	Four Governance Domains	43
7c.	Governance Charters	47
	Finance	47
	Data/IT	52
	Clinical Governance	57
	Community Engagement	62
7d.	Key IDN Management Roles	66
8.	Budget and Funds Allocation	67
8a.	Project Design and Capacity Building Funds.....	67
8b.	Project Design and Capacity Building Funds: Final Project Estimates	68
8c.	5-year IDN Incentive Funding: Funds Allocation Governance	70
8d.	5-year IDN Incentive Funding: Funds Flow to Shared Partners	72
9.	Alternative Payment Models (APMs).....	74
10.	Project A1: Behavioral Health Workforce Capacity Development	75
10a.	IDN Workforce Project Lead and Participants	75

10b.	Narrative describing the critical workforce capacity challenges facing the IDN	75
10c.	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.....	76
11.	Project A2: Health Information Technology (HIT) Infrastructure to Support Integration	79
11a.	IDN HIT Lead and Participants	79
11b.	Narrative describing the IDN’s critical HIT gaps.....	79
	Establishing high level requirements to guide capabilities and gaps assessment.....	79
	Assessing Capabilities and Gaps	81
11c.	Narrative describing the IDN’s plan to address critical HIT gaps.....	82
	Starting with guiding principles and an understanding of budget and timing constraints	82
	Recommending IT Solutions to address IDN-1 gaps	83
	IT solutions to IDN operations and reporting.....	85
12.	Project B1: Integrated Health (Core Competency)	86
12a.	Current-state assessment of network	86
12b.	Participating Organizations and future-state goal (Coordinated Care level or Integrated Care level).....	86
12c.	Monitoring Plan	86
12d.	Expected Outcomes	88
12e.	Challenges and Proposed Solutions.....	90
12f.	Implementation Approach and Timing.....	92
13.	Project C1: Care Transition Teams.....	93
13a.	Project Selection Rationale and Expected Outcomes.....	93
13b.	Participating Organizations: Selection Criteria	95
13c.	Participating Organizations: List of Organizations.....	96
13d.	Monitoring Plan	97
13e.	Challenges and Proposed Solutions.....	98
13f.	Implementation Approach and Timing.....	99
14.	Project D3: Expansion in Intensive SUD Treatment Options	100
14a.	Project Selection Rationale and Expected Outcomes.....	100
14b.	Participating Organizations: Selection Criteria	102
14c.	Participating Organizations: List of Organizations.....	103
14d.	Monitoring Plan	103
14e.	Challenges and Proposed Solutions.....	105
14f.	Implementation Approach and Timing.....	107
15.	Project E5: Enhanced Care Coordination for High Need Population.....	108

15a. Project Selection Rationale and Expected Outcomes.....	108
15b. Participating Organizations: Selection Criteria	110
15c. Participating Organizations: List of Organizations	111
15d. Monitoring Plan	111
15e. Challenges and Proposed Solutions.....	113
15f. Implementation Approach and Timing.....	115
16. Attachments.....	116
Governance Document.....	116
Team Bios	128

1. IDN Vision and Theory of Action

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.

The Region 1 IDN envisions a system of care that creates better health outcomes and quality of life for our Medicaid population with behavioral health challenges, primarily through improvements in integration, coordination, effectiveness and cost effectiveness of services and supports. An inclusive process for development of a Regional Integrated Delivery Network has already enhanced alignment of purpose among service organizations and other stakeholders. The Region 1 IDN has embraced as its preeminent value the improvement of consumer well being and there is consensus that we must transform, not merely improve, our current operations. This spirit is most apparent in initiatives to improve access to patient-centered care, through integration of BH expertise into settings where the target population is already present, coordination of care across both health and social service settings, and engagement of patients and families/caregivers as part of the care team.

Region 1’s Theory of Action is summarized in the table below. Key assumptions driving this plan include: 1) estimates of unmet need for mental health and substance use services must include patients unable to obtain desired services due to unavailable appointments, inadequate insurance coverage or difficulties navigating complex referral systems and those who fail to seek help due to stigma and cultural barriers (contributing to the case for Integration of care across settings); 2) our workforce challenges are attributable partly to an inadequate *supply* of relevant providers, and equally to the need for *appropriate training and deployment* to support integration and coordination of care (contributing to the case for practice transformation and technical assistance, not just credentialing of more providers); 3) successful management depends on recruiting the partnership of the patient in the improvement and maintenance of their own health (contributing to the case for patient-centered care teams); 4) our Community Driven Projects should “seed” initiatives in strategic locations across the region, concentrating resources to ensure high fidelity implementation that can serve as a model for subsequent scaling and dissemination (contributing to the case for strategic selection of implementation sites).

DSRIP Region 1 Theory of Action ("Logic Model")			
Context / Inputs	Strategies / Activities	Outcomes	Impacts
IDN members; stakeholder advocacy orgs	Broadly inclusive planning and governance	DSRIP initiative genuinely addresses highest priority community needs	Stakeholder investment; sustainability
Capacity throughout the Region: expertise in Population Health, IT and Finance (Dartmouth system, County Govts, CMHCs)	Admin Leads recruit resources and drive processes to support regional priorities	High quality planning and implementation	Better lives, quality of life for consumers with behavioral health needs More responsive and effective population health initiatives More prevention Better access to care, reduced stigma, better case management Reduced use of avoidable high intensity services Greater cost effectiveness of services and supports
	HIT initiatives: facilitate data capture, communication across providers, monitoring population outcomes	Better capacity for data sharing, strategic planning, integrating care across settings, rapid cycle QI	
	Payment Reform	Shift toward value-based care	
DSRIP Infrastructure and Incentive funding	Elevate integration, coordination: interprofessional, patient-centered care teams (patient level); care navigators	Patients receive effective care <i>where they present</i> : enhanced BH screening, referral, info sharing among providers Utilization of "right care, right time"	
Training institutions (Dartmouth, AUNE) Statewide DSRIP Learning Collaborative	BH Workforce development: support for design, training, implementation, Quality Improvement	Enhanced technical skills and protocols for integration Enhanced capacity to implement early, effective, population-focused BH interventions More stable, higher quality workforce	
IDN Members Existing programs/resources/best practices in the region Scholarly Models	Comm Driven Project #1: Care Transition Teams	More staff trained in the intervention	
	Comm Driven Project #2: Expand Intensive SUD Tx	Improved patient preparedness for self-mgmt, connection with community supports	
	Comm Driven Project #3: Care Coordination for High Needs Patients	Reduced patient "adverse events"	
Key Assumptions			
Unmet BH need driven by cost barriers , BH provider capacity barriers, and challenges and stigma of accessing specialty care (supports Integrated Care across settings)			
Recruiting the partnership of the patient is critical to addressing BH needs (supports Patient-Centered Care Teams)			
Workforce challenges require both increased <i>supply</i> of providers and <i>appropriate training and deployment</i> to support integration and coordination, highest use of existing workforce, potential new "connector" roles (supports practice transformation, not just credentialing more providers)			
Comm Driven Projects should seed the spread of innovative "bright spots" across the region (supports strategic selection of implementation sites)			
Supportive Housing remains high priority, to be supported where possible across our Comm Driven Projects (supports strategic selection of implementation sites)			

2. IDN Service Area Community Needs Assessment

The Region 1 Integrated Delivery Network serves 61 municipalities located in the Southwestern and Upper Valley areas of New Hampshire with a combined estimated population of 192,394 residents. The region is comprised of three public health networks - Greater Monadnock, Greater Sullivan and Upper Valley Public Health Networks – and encompasses all or parts of five New Hampshire Counties. According to information provided by the New Hampshire Department of Health and Human Services, a total of 27,980 residents of the Region 1 Integrated Delivery Network (Region 1 IDN) were eligible for Medicaid as of December 31, 2015; about 14.5% of the total resident population. Section 2.a. below provides information and analysis describing the Medicaid population of the Region 1 IDN. Following that section, information is provided describing the region’s demographics overall, available health and human services in the region, and assessment of current gaps in care.

2a. Analysis of IDN Service Area Disease Prevalence

As displayed by Charts 2.1 and 2.2 below, about 9,050 residents of Region 1 who were eligible for Medicaid at the end of 2015 showed evidence of having a behavioral health condition based on claims data ; about one third of the total Medicaid population. The age group with the highest proportion of Medicaid members with evidence of a behavioral health condition was the adult population ages 18 to 64 years (about 44%).

Chart 2.1

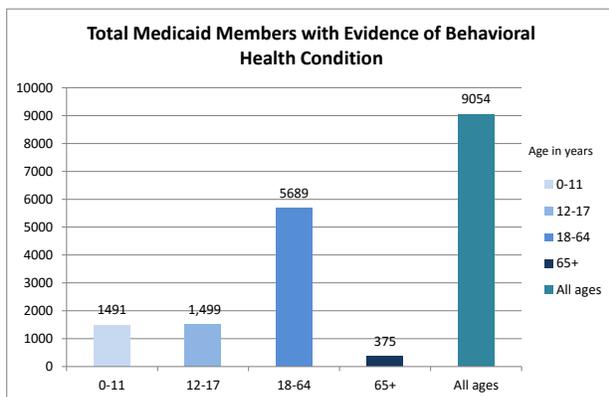
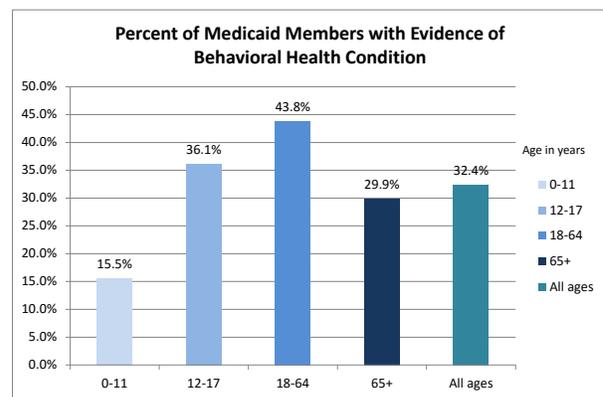


Chart 2.2



Data Source: NHDHHS, Office of Quality Assurance and Improvement, September 2016.

Table 2.1 on the next page displays prevalence information by major condition category for this population. Charts 2.3 and 2.4 on the next page display information showing that about 89% of Medicaid members with a behavioral health condition also have at least one other physical health condition compared to about 74% of Medicaid members who do not show evidence of a behavioral health condition. Similarly, about 44% of members with a behavioral health condition have 2 or more physical health co-morbidities compared to about 28% of those members without a behavioral health condition. As one might expect, these statistics suggest that Medicaid members with behavioral health conditions may also have notably higher rates of other health conditions that impact their health, human service, support needs, and overall wellbeing.

Table 2.1: Age and Major Condition Prevalence of the Region 1 Medicaid Population

Age Group	SED*	SMI*	SUD, including opiate addiction +	Co-occurring mental health and SUD Condition++	Mild-to-moderate mental illness (e.g. anxiety, depression)**	Physical health conditions co-morbid <u>with</u> behavioral health conditions (<u>Percent of Total</u> Medicaid Members within each age group)			
						CVD	Respiratory	Diabetes	Other Physical Health
	Estimate of Medicaid Members (count) in each category								
Child (0-11)	420		--	--	1,068	0.50%	6.27%	0.08%	13.73%
Youth (12-17)	327		--	16	1,139	1.90%	9.79%	0.51%	31.94%
Adult (18-64)		615	674	543	3,968	10.23%	14.31%	3.63%	37.68%
Senior (65+)		14	--	--	350	17.91%	14.33%	7.64%	29.86%

Table Notes: * = Member Count with CMHC Involvement; ** = Member Count with Indication of Behavioral Health Utilization, NO CMHC Involvement and NO Evidence of SUD; + = Evidence of Substance Misuse or SUD, No Evidence of Mental Health Utilization; ++ = Evidence of Substance Misuse or SUD and Mental Health Utilization including CMHC or Other Mental Health Utilization, members in this category may also be included in the SED or SMI counts. -- Categories with less than 5 members are suppressed.

Chart 2.3

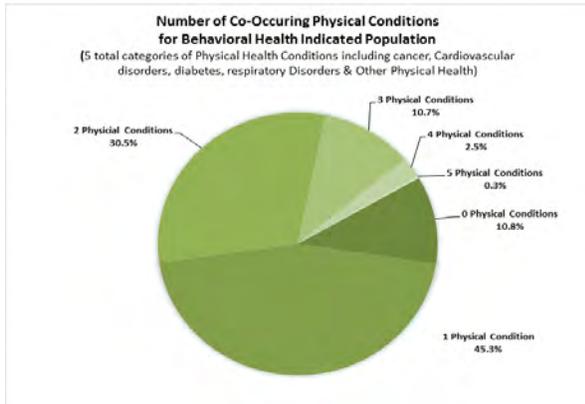


Chart 2.4

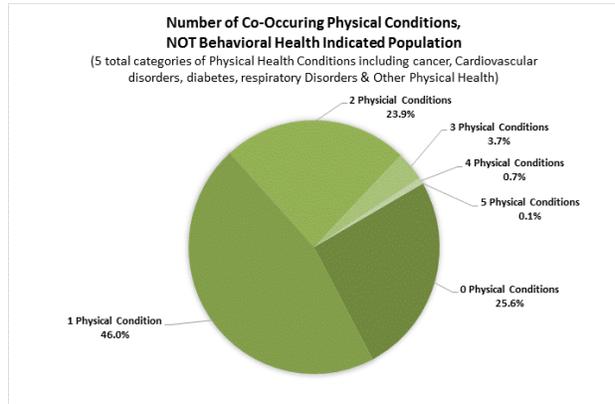


Chart 2.5 on the next pages displays information describing pharmacy utilization for the largest age category of 18-64 years. Medicaid members with evidence of a behavioral health condition utilized pharmacy services at a substantially higher rate than those without a behavioral health condition, further reinforcing the observation that the population with behavioral health conditions has significantly greater health care-related needs. Similar relationships are observed for pharmacy utilization in other age categories.

Chart 2.5

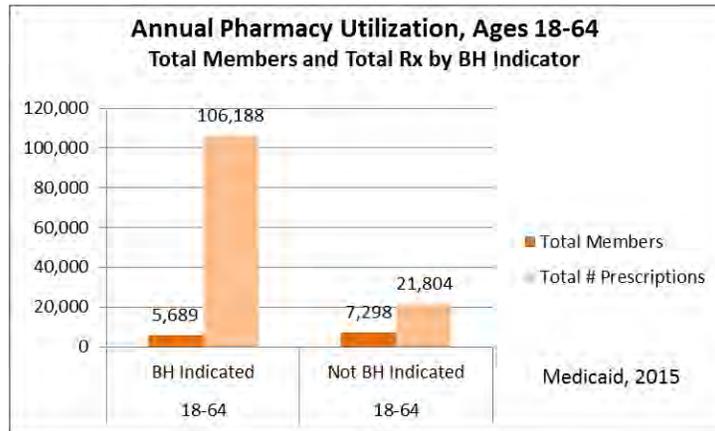


Chart 2.6 displays information suggesting that Medicaid members received preventive health services in 2015 at proportions similar to or slightly higher than those members without a behavioral health condition. However, as displayed by Chart 2.7, members with evidence of a behavioral health condition in the 19-64 age range were substantially more likely to have used an Emergency Department in 2015 for reasons that were potentially treatable in a primary care setting. A total of 931 Medicaid members age 19-64 with evidence of a behavioral health condition received care in an Emergency Department (ED), equivalent to about 16% of members in this category, compared to 442 members without evidence of a behavioral health condition or about 6% of members in this category. In contrast, the proportion of Medicaid members age 18 or less that utilized the ED for conditions potentially treatable in primary care was more similar between the subgroups with or without a behavioral health condition (11% and 10% respectively).

Chart 2.6

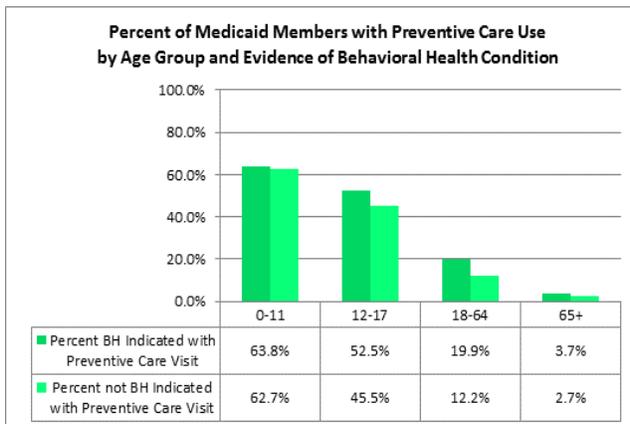
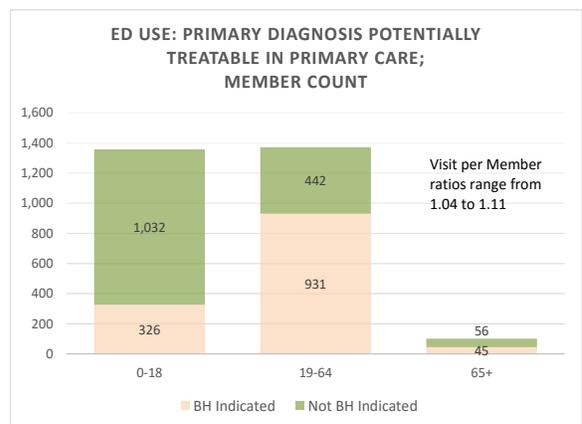


Chart 2.7



The two charts below further illustrate the increased likelihood of using higher cost services by Medicaid members with evidence of behavioral health conditions. Chart 2.8 displays the finding that members with a behavioral health condition were nearly 5 times more likely to have had four or more visits to an ED in 2015 (6.7% of members with evidence of a behavioral health condition compared to 1.4% of members without). Similarly, the 30 day hospital inpatient readmission rate for behavioral health

indicated members (10.6%) was more than double the rate for non-behavioral health indicated members (4.7%).

Chart 2.8

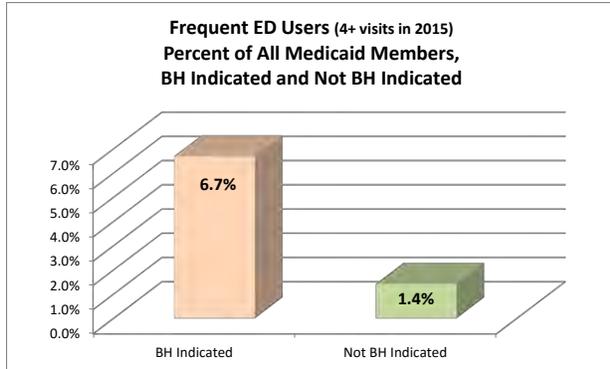
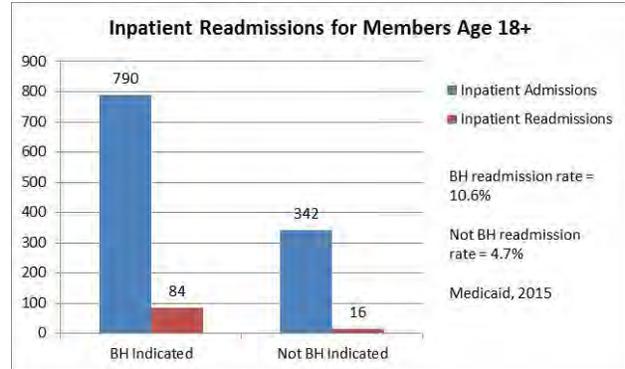


Chart 2.9



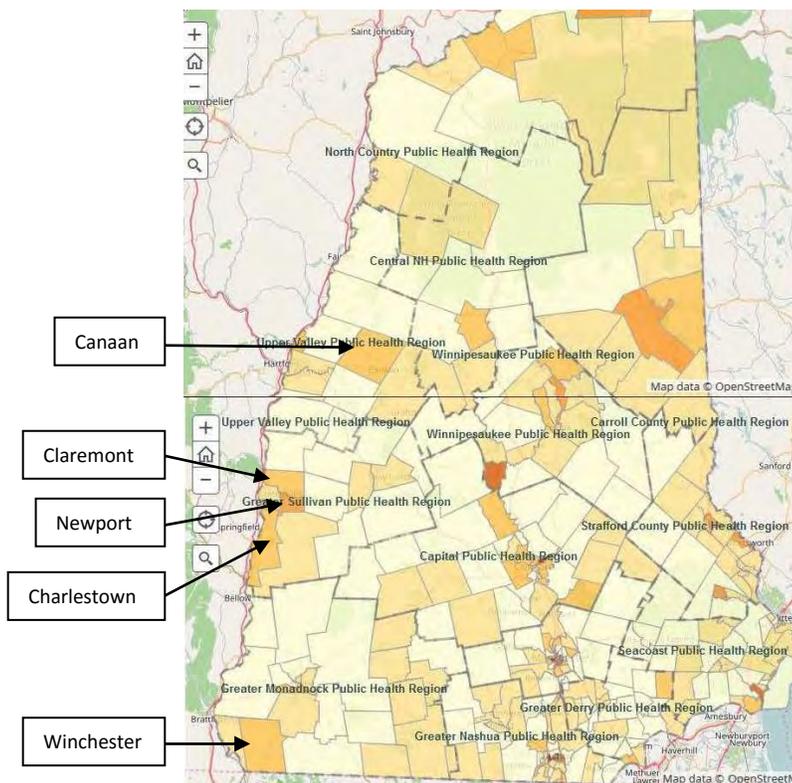
These data suggest important opportunities for enhanced care management with additional, focused resources focused on the Medicaid population in Region 1 with behavioral health conditions.

2b. Regional Demographics

Selected demographic and population health statistics describing the overall population of the Region 1 IDN are included as an additional worksheet in the Supplemental Excel Workbook. Primary data sources include the American Community Survey (U.S. Census Bureau), the New Hampshire Young Adult Survey focused on substance use issues, and NH Health Wisdom, which assembles population health indicators from several sources, most notably the Behavioral Risk Factor Surveillance System, the Youth Risk Behavior Survey and the Uniform Hospital Discharge Data Set.

Review of these data indicate that residents of the Region 1 IDN are mostly similar to the New Hampshire population overall. This observation means that residents of the region are generally more healthy and socioeconomically stable compared to the U.S. population overall, but that there are also important sub-populations within the region who are more vulnerable to adverse health outcomes. The map below displays a composite social vulnerability index by census tract. The index includes 16 factors associated with social vulnerability including measures of socioeconomic status, household composition, disability status, minority and language status, housing and transportation. Darker shaded areas on the map represent census tracts with higher social vulnerability on these measures including a concentration of three relatively large communities in Sullivan County – Claremont, Newport and Charlestown.

Map 2.1 – NH Social Vulnerability Index



Data Source: Screen grabs accessed October 2016 from

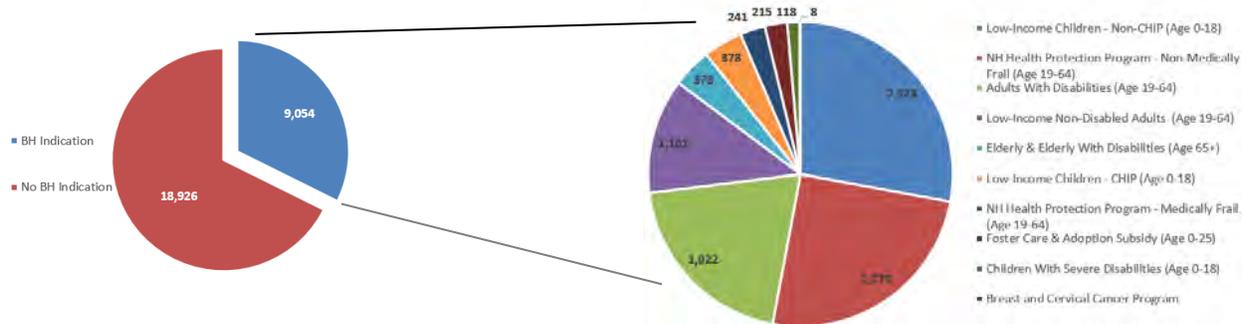
<http://nhvieww.maps.arcgis.com/apps/MapSeries/index.html?appid=148ad00240534964a1559ab823d80d9>

Some key demographic statistics describing the region overall include the following (all data are from the most recently available US Census Bureau information, American Community Survey, 5 year estimates, 2010-2014):

- The proportion of the overall population under 200% of the Federal Poverty Level (24.7%) is slightly higher than the estimate for NH overall (22.6%);
- Estimated median household income in the region (\$60,177) is less than for NH overall (\$65,986);
- The estimated proportion of the population with income less than 138% of the Federal Poverty Level who are also uninsured (22.6%) is similar to the state overall (23.5%);
- About one-third of households in the region with children are single-parent families (32.9%), a higher proportion than for NH overall (28.7%);
- The proportion of the population with a physical disability (12.4%) is similar to NH overall (11.8%);
- The proportions of the population reporting minority race or ethnicity (6.2%) or limited English proficiency (0.2%) are somewhat less than for the state overall (8.3% and 1.0% respectively);

Some demographic information describing the Medicaid population in Region 1 was described at the beginning of this section. Additional demographic information of note includes the following observations.

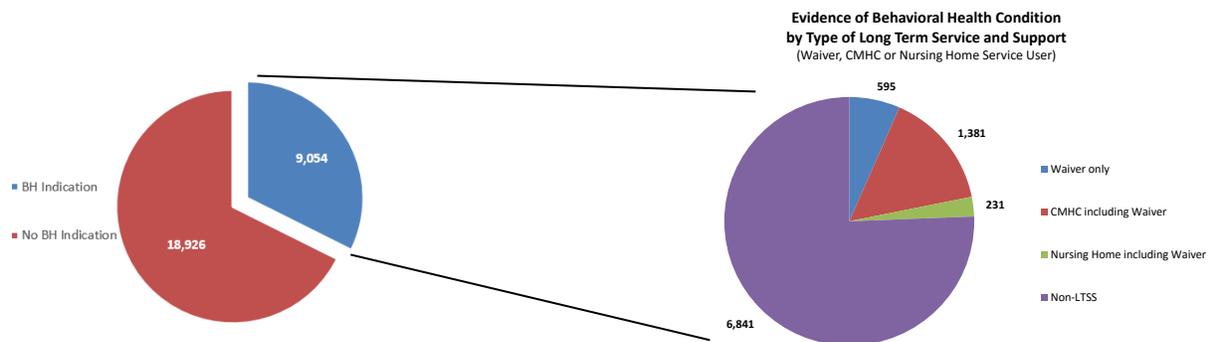
Chart 2.10 – Age and Gender Breakout of NH Medicaid Members with Behavioral Health Indication



Of the 9,054 IDN-1 Medicaid members with Behavioral Health Indicator:

- 28% are low income children (non-CHIP)
- 25% are NH Health Protection Program - Non-Medically Frail
- 20% are Adults With Disabilities (Age 19-64)
- 12% are Low-Income Non-Disabled Adults (Age 19-64)

Chart 2.11 – NH Medicaid Program Eligibility Breakout of Members with Behavioral Health Indication



Of the 9,054 IDN-1 Medicaid members with Behavioral Health Indicator:

- 76% are not using Long-Term Services & Supports
- 15% are using Community Mental Health Centers

Health status indicators presented in the table below suggest that, while the region is similar to NH overall on a number of population health measures, the Greater Sullivan Public Health Network Region has substantially worse health indicators in several key areas including prevalence of diabetes, childhood asthma, smoking, and smoking during pregnancy. (Note: See supplemental worksheet for more complete set of indicators.)

Table 2.2: Selected Population Health Measures

WISDOM (health status indicators various years; accessed September 2016)	Greater Monadnock Pop=101,224	Greater Sullivan Pop=44,858	Upper Valley Pop=46,312	Region 1 IDN Pop=192,394 *Calculated estimate	NH Pop= 1,321,069
Asthma prevalence (children)	7.0%	14.2%	7.1%	9.6%*	7.2%
Obesity in adults with asthma	56.4%	65.8%	38.7%	57.1%*	33.3%
Obesity among adults	27.1%	33.0%	17.2%	27.3%*	26.4%
Coronary Heart Disease prevalence	3.1%	4.6%	2.6%	3.5%*	3.8%
Smoking prevalence (adults)	21.1%	22.4%	9.6%	20.0%*	16.3%
Diabetes prevalence (adults)	5.6%	13.7%	4.6%	9.1%*	8.1%
Smoking during pregnancy	15.0%	25.2%	8.1%	18.0%*	13.4%

The information shown in Table 2.3 on the next page is abstracted from a web-based survey of young adults in New Hampshire completed in 2015 by the Bureau of Drug and Alcohol Services with assistance from the NH Community Health Institute. The survey was distributed through social media and targeted 18-30 year olds living in New Hampshire, an often difficult to reach population through standard survey methodologies. Response frequencies were weighted to reflect the demographics of this age group in New Hampshire overall. One finding of particular note for this initiative is that approximately 5% of respondents perceived a need for drug or alcohol treatment in the prior 12 months. Further, nearly half of these respondents (45.4%) indicated that they could not find the treatment they needed.

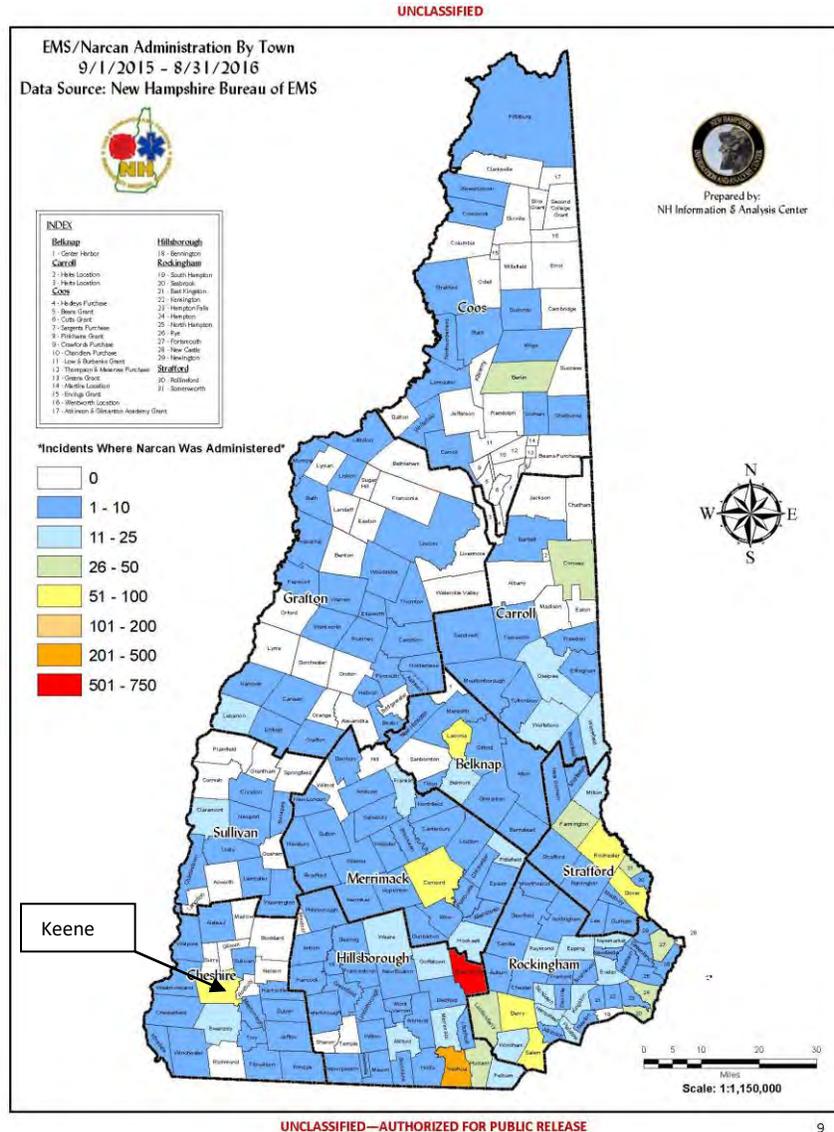
Table 2.3: Selected Young Adult Survey Results

NH Young Adult Survey (ages 18-30); 2015	Region 1 IDN * Number suppressed; n-values unweighted; %s weighted	New Hampshire
Total Respondents	601 (13.9%)	4,334
Past month non-medical marijuana use	132 (28.4%)	1040 (28.6%)
Past month binge alcohol use	169 (35.0%)	1274 (34.5%)
Family members have alcohol problems	147 (34.1%)	1063 (34.0%)
Past year prescription pain reliever misuse	* (7.2%)	250 (6.4%)
Past year heroin/fentanyl use	* (2.6%)	92 (2.7%)
Felt sad/hopeless for two weeks in past year	135 (23.4%)	1060 (25.0%)
Considered suicide in past year	64 (12.0%)	488 (12.5%)
Tried to find treatment for alcohol or drugs, past 12 months	*(4.7%)	192 (5.2%)
Of those who needed treatment, treatment could not be found	*(45.4%)	77 (40.2%)

The ongoing opioid epidemic in New Hampshire, especially fentanyl misuse, is of particular significance to this initiative. One indicator of the prevalence of opioid misuse is the count of Emergency Medical Service calls involving administration of Narcan to counteract opioid overdoses. Map 2.2 on the next

page displays information indicating that the City of Keene in particular is a ‘hotspot’ in Region 1 of EMS calls involving Narcan administration.

Map 2.2 – EMS Narcan Administration by Town



2c. Current Resources Available

The table beginning on the next page displays information on existing resources in Region 1 for mental health and SUD services. The table is organized by sub-region and includes a variety of providers from the major hospital systems to individual practitioners. The types of services provided including mental health/SUD resources in primary care settings are incorporated into the table.

Table 2.4: Behavioral Health Resources

Org/Provider	Location	Populations Served	Services
<i>Greater Monadnock Region</i>			
Cheshire Medical Center	Keene	Adults, Seniors, Children, Families	Primary Care Services (Hospital)
Community Improvement Associates	Keene	Adults, Young Adults Specialty	Evaluation, Withdrawal Management, Individual/Group Outpatient Counseling, IOP, Recovery Support Services,
Dartmouth Hitchcock - Keene	Keene	Adults	Primary Care Services, -MAT
Jaffrey Family Medicine	Jaffrey	Adults, Seniors, Children, Families	Primary Care Services
Keene Metro Treatment Center	Swanzy	Adults, Pregnant or Parenting Women Specialty	Evaluation, Withdrawal Management, Individual/Group Outpatient Counseling, Medication Assisted, Methadone, Recovery Support Services
MAPS Counseling Services	Keene Peterborough	Adults, Adolescents/Children, Seniors, Families, Couples	Evaluation, Individual Outpatient Counseling
Maryanne Strong, LICSW, MLADC	Swanzy	Adults	Evaluation, Individual Outpatient Counseling
Monadnock Community Hospital	Peterborough	Adults, Seniors, Children, Families	Primary Care Services (Hospital)
Monadnock Family Services	Keene Peterborough	Adults, Seniors, Children, Families - CMHC	Screening, Evaluation, Individual/Group Outpatient Counseling
Peter Lolocono, MLADC	Keene	Adults, Adolescents	Evaluation, Individual Outpatient Counseling, Recovery Support Services
Phoenix House - Dublin Center	Dublin	Adults	Residential Services
Phoenix House	Keene	Adults	Evaluation, Withdrawal Management, Group Outpatient Counseling, IOP, Partial Hospitalization, Residential Services, -MAT, Recovery Support Services

Org/Provider	Location	Populations Served	Services
Recover Together	Keene	All Adults	Evaluation, Group Outpatient Counseling, -MAT
Rosemary Moran Weidner, MLADC	Keene	All Adults	Evaluation, Individual/Group Outpatient Counseling
Veteran Homestead Inc.	Fitzwilliam	Homeless Specialty, Military and Veterans Specialty, Men Specialty	Withdrawal Management, Evaluation, Individual/Group Outpatient Counseling, Residential Services, -MAT, Permanent Supportive Housing, Transitional Living
Victoria Keller, MLADC	Keene	Adults, Young Adults Specialty, Women	Individual Outpatient Counseling
<i>Greater Sullivan County Region</i>			
Charlestown Family Medicine	Charlestown	Adults, Seniors, Children, Families	Primary Care Services (Community Health Center)
Hope for NH Recovery	Newport Claremont	Adults, Military and Veterans Specialty	Recovery Support Services (Employment Services, Anger Management, Peer Recovery Coaching)
Lynn C. Hayward, LADC, LCMHC	Claremont	Adults	Evaluation, Individual Outpatient Counseling
New London Hospital/Newport Health Center	Newport	Adults, Seniors, Children, Families	Primary Care Services (Hospital)
Recover Together	Claremont	Adults	Evaluation, Group Outpatient Counseling, -MAT
Sugar River Counseling and Consultation, PLLC	Claremont	Adults	Evaluation, Individual/Group Outpatient Counseling
Valley Regional Hospital	Claremont	Adults, Seniors, Children, Families	Primary Care Services (Hospital)
Walk Away Your Troubles	Alstead	Adults	Evaluation, Group Outpatient Counseling
West Central Behavioral Health	Claremont	Adults, Seniors, Children, Families	Evaluation, Individual Outpatient Counseling
<i>Upper Valley Region</i>			
Alice Peck Day Memorial Hospital	Lebanon	Adults, Seniors, Children, Families	Primary Care Services (Hospital)
DHMC Addiction Treatment Program	Lebanon	Pregnant or Parenting Specialty	Withdrawal Management, Evaluation, Individual/Group Outpatient Counseling, IOP, -MAT

Org/Provider	Location	Populations Served	Services
Dartmouth Medical Center	Lebanon	Adults Adults, Seniors, Children, Families	Withdrawal Management, Screening, Evaluation, Individual Outpatient Counseling, -MAT Primary Care Services (Hospital)
Donlon Wade, LADC	Lebanon	Adults, Adolescents/Children	Evaluation, Individual Outpatient Counseling, Group Outpatient Counseling
Habit Opco	West Lebanon	Adults	Withdrawal Management (Methadone), Evaluation, Group Outpatient Counseling, -MAT (Methadone), Recovery Support Services
HALO Educational Systems	Canaan	Young Adults, Adolescents, Homeless Specialty, Pregnant or Parenting Women, Military and Veterans Specialty	Evaluation, Individual Outpatient Counseling, Recovery Support Services Childcare, Transportation, Employment Services,
Hanover Psychiatry	Hanover	Adults	Evaluation, Individual/Group Outpatient Counseling, -MAT
Headrest	Lebanon	Adults	Evaluation, Individual/Group Outpatient Counseling, IOP, Residential Services (Transitional Living)
Jacqueline Brill, MLADC, LCMHC	Lebanon	Adults	Evaluation, Individual Outpatient Counseling, Recovery Support Services
Recover Together	Lebanon	Adults	Group Outpatient Counseling, -MAT
ROAD to a Better Life	Lebanon	All Adults, Young Adults Specialty	Withdrawal Management, Evaluation, Individual/Group Outpatient Counseling, Recovery Support Services. -MAT
Second Growth	West Lebanon	Young Adults Specialty, Children, Adolescents, Gender-Specific Men Specialty, Women Specialty	Evaluation, Individual/Group Outpatient Counseling, Recovery Support Services

Org/Provider	Location	Populations Served	Services
West Central Behavioral Health	Lebanon	Adults, Seniors, Children, Families – CMHC	Evaluation, Individual Outpatient Counseling

A variety of governmental and non-governmental agencies are available in the region to help address broader social determinants of health through provision of community-based social services and other community supports. Key organizations connected to this initiative are included in the following table.

Table 2.5: Community Services and Supports

Organization/Agency	Location/Service Area	Services/Supports
Cheshire County	Keene, Cheshire County	Nursing Home, Court, Corrections
Child and Family Services	Keene Area and Upper Valley	Adolescent Community Therapeutic Services, Counseling/Therapy, Family Stabilization, Integrated Home Based Services, Parent Aide/Child Health Support Services, Permanency Solutions/ISO
Contoocook Valley Transportation	Jaffrey, Eastern Monadnock region	Coordinates transportation services
Crotched Mountain Rehab	Greenfield, Statewide	Rehabilitation Hospital, Accessible Recreation, Behavior Disorders, Community Care. Outpatient Services, Therapeutic Recreation
Easter Seals	Keene, Lebanon, Statewide	Children and Family Services, Dental Center, Military & Veterans Services, Special Transit Service, Substance Abuse Services, Employment Services
Grafton County	Haverhill, Grafton County	Nursing Home, Court, Corrections
Granite State Independent Living	Keene, Claremont, Statewide	Home Care, Disability Supports, Education/Employment
Home Healthcare Hospice and Community Services	Keene, Southwestern NH	Visiting Nurses, Hospice. Healthy Starts, Nutrition for Seniors, Adult Day Care, Wellness, Transportation
Keene Housing	Keene, Monadnock region	Housing assistance for low income and vulnerable populations, Resident Self-Reliance Program, Youth Program, Community Resources

Organization/Agency	Location/Service Area	Services/Supports
Grafton County Senior Citizens Council, Monadnock Partnership and ServiceLink	Keene, Claremont, Lebanon	Aging and Disability Resources, Navigation, Home-delivered Meals, Transportation, Senior Centers, Community Outreach
Listen Community Services	Lebanon, Upper Valley	Rent, fuel payment assistance, and loans for housing, community dinners, food pantry, teen center
Monadnock Developmental Services	Keene, Southwestern NH	Service coordination, Family support services, Supported living services, Self-Directed Services , Partners in Health, Vocational supports, Consumer benefits coordination, Training/education
NAMI	Community-based networks, support groups	Education and training, family and caregiver support, information/referral
Next Step and Stepping Stone	Lebanon, Claremont	Peer Support, Transportation, Employment Assistance, Financial Counseling
Southwestern Community Services	Cheshire and Sullivan Counties	CSFP, Housing, Housing Rehab, Developmental Disability Services, Substance Use prevention-information-referral, transportation, weatherization, WIC, Workforce development
Sullivan County	Unity, Sullivan County	Nursing Home, Court, Corrections
TLC Family Resource Center	Claremont, Sullivan and Lower Grafton County	Home visiting for pregnant women and new parents, Family Support,, Information/referral, Thrift store
Twin Pines Housing Trust	White River Junction, Upper Valley	Housing assistance for low income and vulnerable populations, Community Resources
Upper Valley Haven	White River Junction, Upper Valley	Supportive housing for adults and families in transition; temporary, seasonal sheltering
Visiting Nurse and Hospice of VT/NH	White River Junction, Upper Valley	Visiting Nurses, Hospice, Pediatric Care, Nutrition for Seniors, Community Wellness

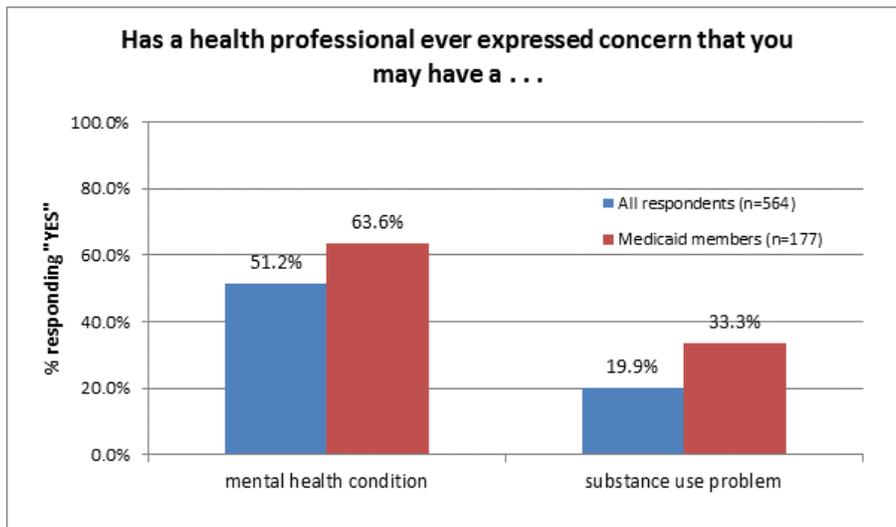
2d. Assessment of Gaps in Care

In addition to review of Medicaid, population health data and existing resources, extensive efforts were made by the organizational partners of IDN Region 1 to engage key community stakeholders across the region as part of a comprehensive Behavioral Health Needs Assessment to assist in plan development. The purpose of these community engagement efforts was to identify community health concerns and solicit input and advice on priorities and opportunities for community behavioral health care delivery

system improvements. Methods employed in the community assessment process included a consumer survey of area residents targeted to high need locations and populations, a survey of caregivers of people with behavioral health service and support needs, a survey of providers including both direct service and community support providers broadly defined and a series of nine discussion groups (6 consumer groups, 3 provider groups) to explore needs, gaps and improvement opportunities in more depth. Key findings of the behavioral health needs assessment are described here. More comprehensive discussion of the methods employed to engage the community and obtain key stakeholder input is presented in the next section.

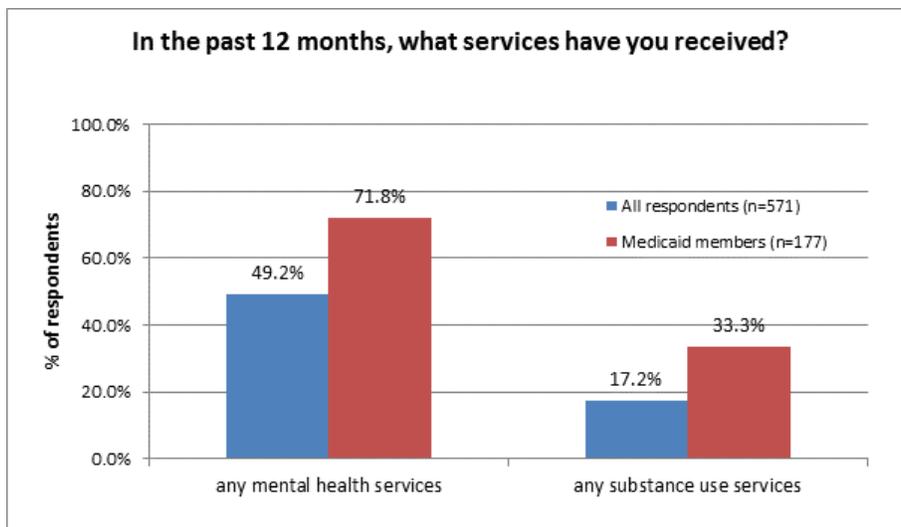
Key Consumer Survey Findings: As displayed by chart 2.12, about 51% of consumer survey respondents indicated that they had ever been told by a health professional that they may have a mental health condition, including about 64% of respondents who also reported having been eligible for Medicaid in the past 12 months. About 20% of respondents indicated having been told they may have substance use problem including about 23% of Medicaid members.

Chart 2.12



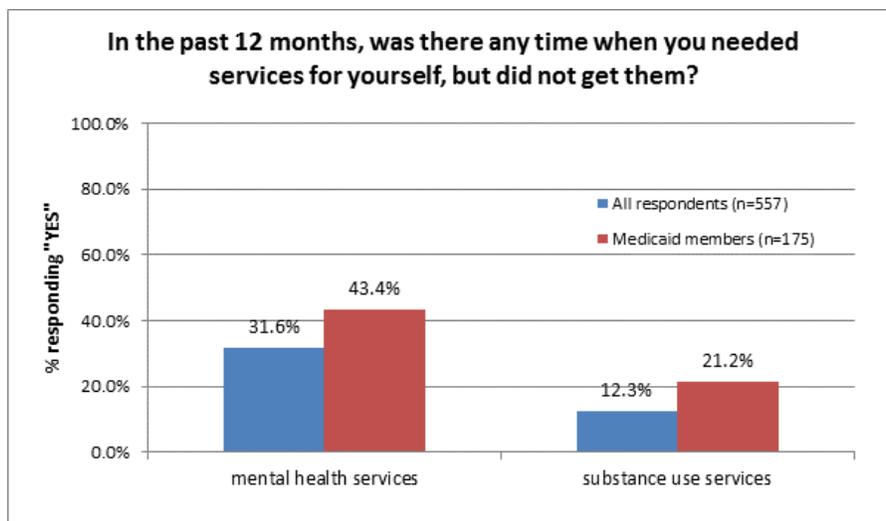
As displayed by Chart 2.13, about 49% of consumer survey respondents indicated that they had received some type of mental health services in the past 12 months including about 72% of respondents who had been eligible for Medicaid in the past 12 months. About 17% of respondents reported receiving services for substance use in the past 12 months including about 33% of Medicaid members.

Chart 2.13



About 32% of consumer survey respondents indicated having difficulty getting the mental health services they needed in the past 12 months, including about 43% of Medicaid members; while 12% indicated they had difficulty getting substance use services they needed including about 21% of Medicaid eligible respondents.

Chart 2.14



Further analysis of these results shows that of those respondents who did receive some type of mental health services in the past 12 months, about 44% also indicated having difficulty getting the mental health services they needed. Among respondents who received no mental health services in the past 12 months, nearly 1 in 5 (about 19%) indicated a need for mental health services that they did not get. These findings may reflect different challenges to receiving services such as waiting lists (e.g. respondents may have had difficulty getting services initially, but eventually did so), gaps in the appropriateness or acceptability of services, financial obstacles to care and respondent readiness to seek services.

Similar findings are observed for respondents indicating difficulty accessing substance use services where nearly half of respondents (46%) who did receive substance use services in the prior 12 months also indicated difficulty in getting services they needed. Among those respondents who did not access substance use services in the prior 12 months, about 5% reported a need for services that they did not get. (Note: This percentage is similar to that reported earlier from findings of the Young Adult Survey).

Chart 2.15

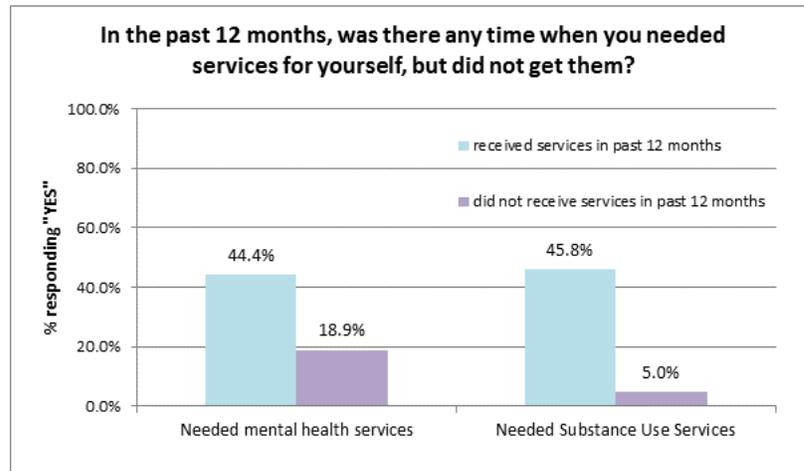


Chart 2.16 displays the finding that the top reasons reported for not getting needed mental health services are “I thought I could handle the problem without treatment” and “There were no openings or I could not get an appointment”. The top mental health services that people reported having difficulty accessing (Chart 2.17) are individual therapy or counseling and assistance with medication management. Taken together, these findings help to confirm key stakeholder perceptions of limited workforce capacity with respect to counselors / therapists as well as primary care or specialty providers available to support medication management.

Chart 2.16

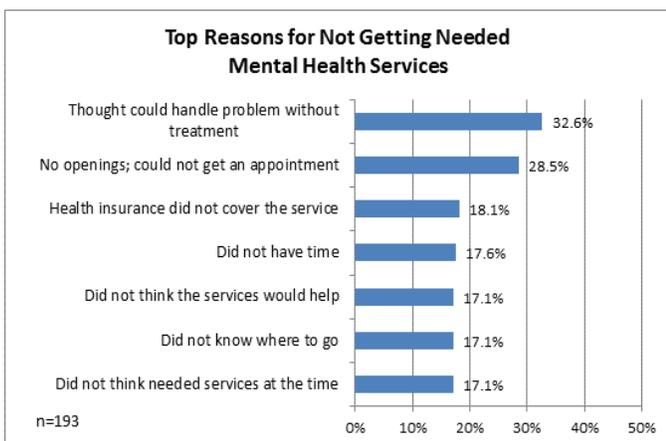
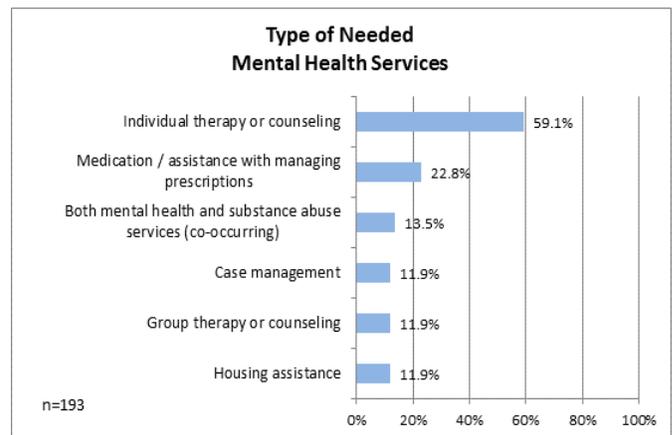


Chart 2.17



Reported reasons for substance use service access difficulties are similar with the top reasons being “I was not ready to stop using alcohol or drugs”, “I thought I could handle the problem without treatment”, and “There were no openings or I could not get an appointment”. However, some differences are observed for the type of services respondents had difficulty getting (Chart 2.19). While ‘individual therapy or counseling’ was again the top service mentioned, it was mentioned by a smaller proportion of respondents and a more diverse array of services were mentioned with some higher frequency including co-occurring mental health and substance use services, peer and recovery support services, intensive outpatient treatment and opioid treatment.

Chart 2.18

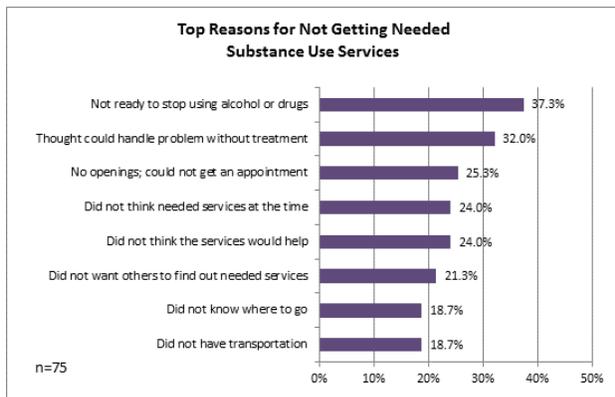
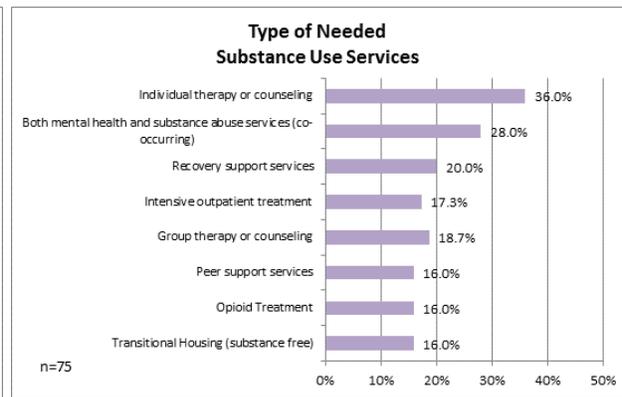
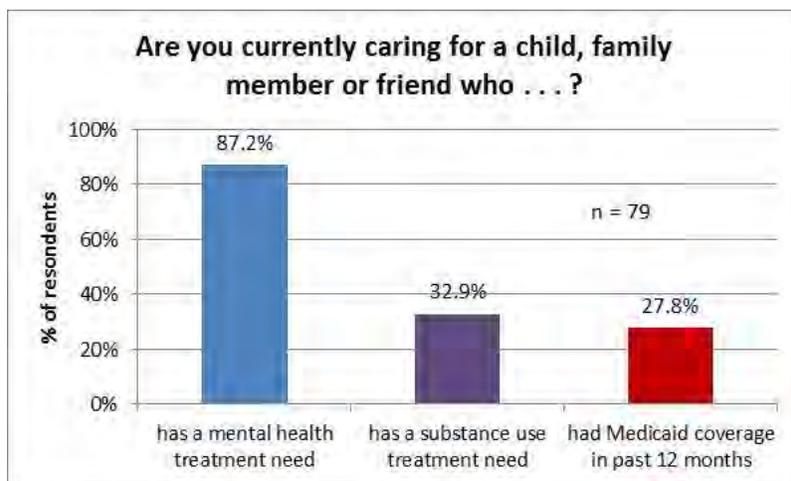


Chart 2.19



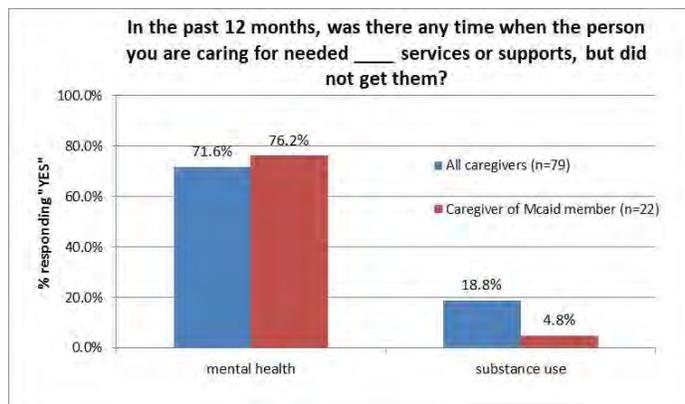
Key Caregiver Survey Findings: A companion survey was conducted of informal caregivers of individuals with mental health and / or substance use service needs. As displayed by Chart 2.20, about 87% of respondents were caring for someone with a mental health need and about 33% were caring for someone with a substance use treatment need.

Chart 2.20



Nearly three-quarters of caregiver respondents indicated that their family member or friend had difficulty accessing mental health services in the past 12 months, including similar proportions of respondents caring for someone who was eligible for Medicaid. In contrast, about 19% of caregivers reported difficulty accessing substance use services with a notably lower proportion of those caring for someone eligible for Medicaid. While the small sample size and non-random distribution channels for this survey should be noted, these results mirror the findings of the consumer survey in the finding that a larger proportion of respondents in each case indicated access difficulties for mental health services than substance use services.

Chart 2.21



An important difference in the responses of caregivers compared to consumers is displayed by Chart 2.22 where the top reason cited for difficulty accessing mental health services was “lack of communication or coordination between service providers”, followed by lack of appointment availability (the top reason cited on the consumer survey). This finding perhaps reflects the often important and challenging role of caregivers as the interface between providers and patients.

The types of services reported by caregivers

as difficult to access were similar with individual counseling at the top of the list followed by medication management. However, almost one third of respondents who had difficulty accessing services reported challenges accessing case management services.

Chart 2.22

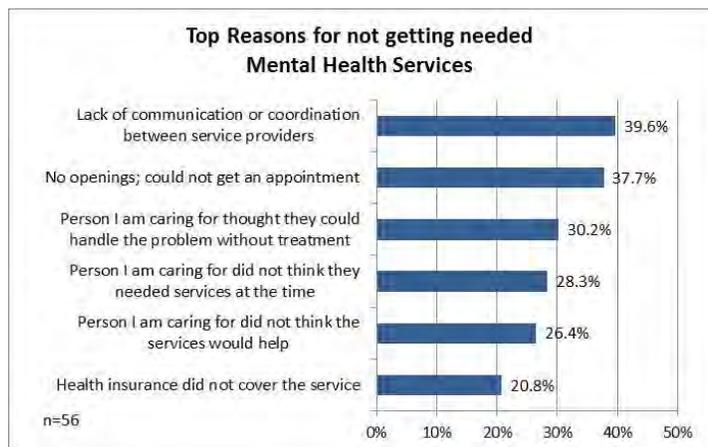
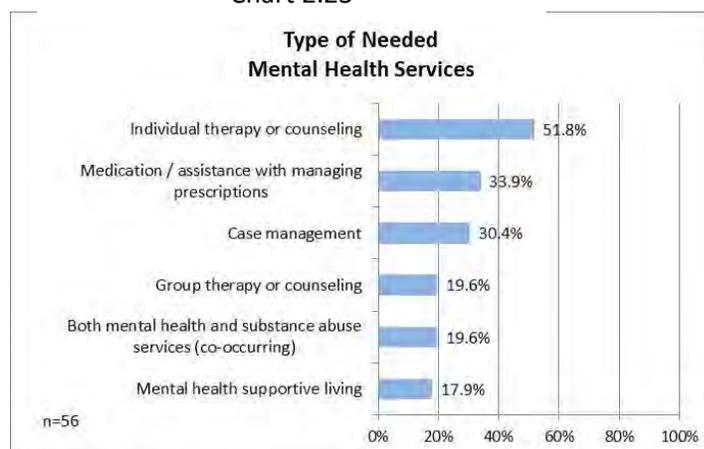
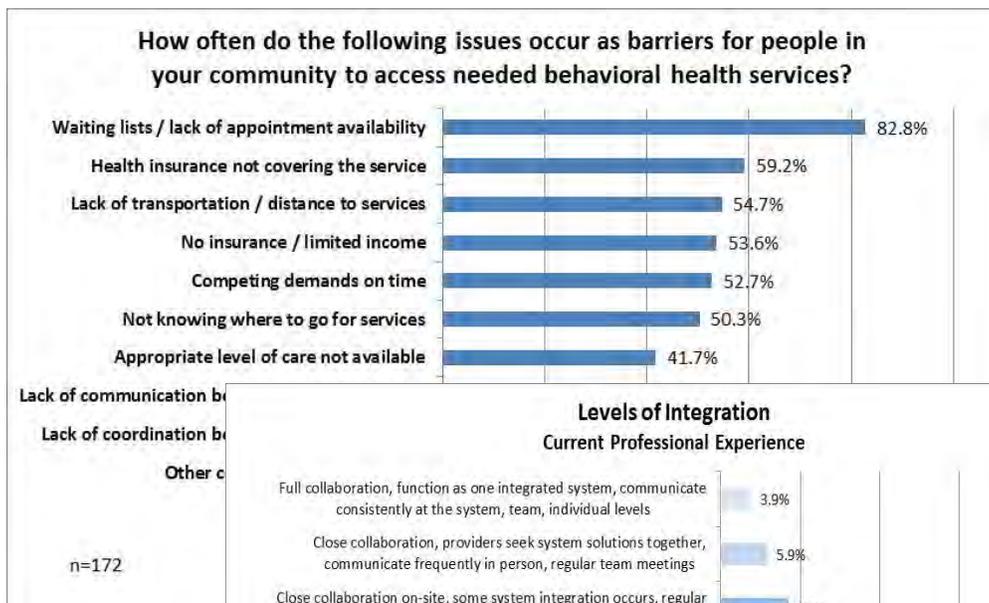


Chart 2.23



Key Provider Survey Findings: Respondents to the Provider Survey (n=172) also reflect the observation that ‘waiting lists / lack of appointment availability’ is the top barrier to accessing behavioral health services in the region, followed by health insurance coverage limitations and transportation challenges. With respect to the top issue of appointment availability, it is useful to note that analysis of this factor by sub-region (public health network regions) showed no substantial differences with over 80% of respondents citing it as a barrier in each region (results not displayed).

Chart 2.24



Several questions on the provider survey explored

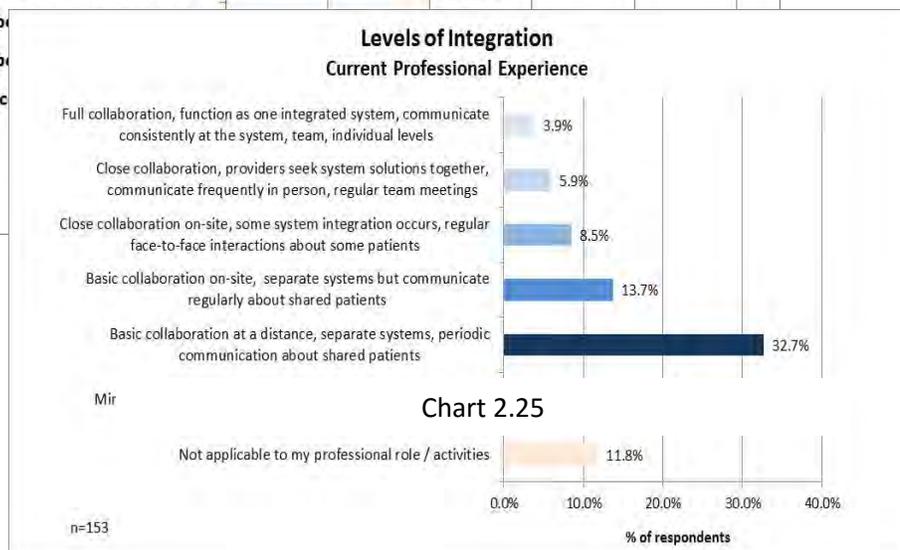
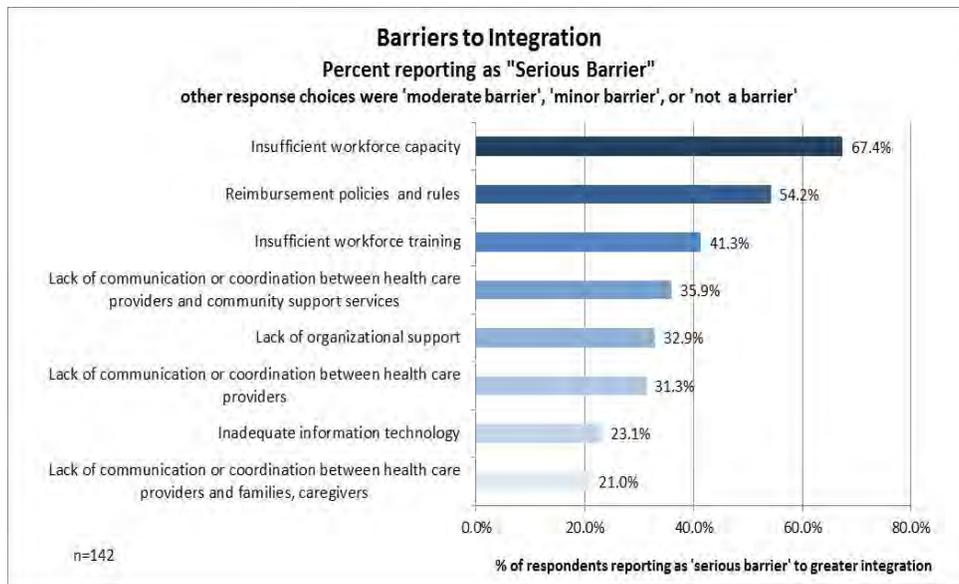


Chart 2.25

the current state of practice integration and integration challenges. Less than 20% of provider respondents indicated that their current professional experience was best described as close or full collaboration. (Note: respondents included a broad cross-section of clinical and non-clinical providers from multiple health and human service sectors).

The top barriers to integration were reported as insufficient workforce capacity, reimbursement policies and rules, and insufficient workforce training. Provider discussion groups shed additional light on these challenges with participants citing the relationships between lack of time, insufficient workforce and reimbursement limitations supporting care coordination activities between face to face visits.

Chart 2.26



The following table summarizes major themes from the assessment of behavioral health needs and gaps for specific sub-populations. The table provides information on the source of supporting evidence according to the following abbreviation Key: Consumer Survey (C), Caregiver Survey (CG), Provider Survey (P), Consumer Discussions (CD), Provider Discussions (PD), Medicaid and Population Data (D)

Table 2.6: Major Behavioral Health Needs Assessment Themes

Major Themes	Serious mental illness	Substance use disorder including opiate addiction	Co-occurring mental health and SUD conditions	Co-morbid medical and behavioral health conditions	Co-occurring developmental disability and mental health/SUD	Mild-to-moderate mental illness	Those at-risk for a mental health and/or SUD condition	Illustrative Quotes from Discussion Groups
Increase Workforce, Reduce Turnover	C-CG-P-CD-PD	C-CG-P-CD-PD-D	C-CG-P-CD-PD	CG-CD-PD-D	CG-CD	C-P-PD	--	"The biggest issue is staff turnover and reliability of care. People start something that is working but then a resource closes, or someone leaves and you have to start all over." Recovery Center participant
Expand Services / Resources	C-CG-P-CD-PD	C-CG-P-CD-PD-D	C-CG-P-CD-PD-D	C-CG-P-CD-PD-D	CG-CD-PD	C-CG-P-CD-PD-D	C-CG-CD-PD	"We need more intensive outpatient treatment program capacity. There is no capacity for that in the whole County" Sullivan County provider
Improve coordination / integration, including increased capacity for case management	C-CG-P-CD-PD	C-CG-P-CD-PD	C-CG-P-CD-PD	C-CG-P-CD-PD-D	CG-CD	C-CG-P-CD-PD	C-CG-P-CD-PD	"The IOP at Dartmouth is a good example of an integrated program, and it's really hard to get patients into it, but patients had their medical problems taken care of, their MAT taken care of, I could see all the notes as a PCP and call up the psychiatrist and get them on the phone and there was better access because it was all in the same system." Upper Valley Provider
Improve quality of care	C-CG-P-CD-PD-D	C-CG-P-CD-PD-D	C-CG-P-CD-PD-D	C-CG-P-CD-PD	CG-CD	C-CG-P-CD	C-CG-CD	"I went to this therapist and she said 'Looks like you're getting it,' and I had no idea what she meant." Recovery group participant
Improve communication / systems to share information	C-CG-P-CD-PD	C-CG-P-CD-PD	C-CG-P-CD-PD	CG-P-CD-PD	CG-CD-PD	C-CG-P-CD-PD	C-CD-PD	"Technology could be the answer to improving our ability to communicate and share information. We need some sort of professional networking service "hub" to share resources." Sullivan County provider
Improve awareness of existing services / resources	C-CG-P-CD-PD	C-CG-P-CD-PD	C-CG-P-CD-PD	CG-P-CD-PD	CG-CD-PD	C-CG-P-CD-PD	C-CG-P-CD-PD	"We all don't know about each other's services...there's no central location for that information, that primary care docs can access and mental health providers can access...who's doing what and how do I get my client to that provider, and keeping that information up to date." Upper Valley Provider

3. Community Engagement and Stakeholder Input

3a. Narrative describing the process by which the IDN has solicited community input in developing this Project Plan

IDN 1 has consistently engaged community members in developing the Project Plan. We solicited input in a way that respected our stakeholders' autonomy, honored their particular perspective and expertise, and viewed them as authorities on local conditions and priorities. We empowered community members to speak their minds, in a place and time that was convenient for them.

i. Channels and venues through which input was solicited (e.g., public-facing websites, webinars, participation in IDN workgroups, etc.), as well as key audience/stakeholder groups

Region 1 has embedded community engagement at governance and grassroots levels of project planning. At the governance level, IDN 1 includes unduplicated community members of the Executive Committee (4 designated seats), Advisory Council, and Community Engagement Work Team. At least one community member was present at every bi-weekly Executive Committee meeting, beginning in May 2016. At the grassroots level, community members were engaged extensively through the needs assessment process. We leveraged the personal and professional networks of community and Region 1 Network members to place multiple opportunities for input in the hands of people with lived experience.

ii. Frequency with which community input was sought

The Region 1 Administrative Leads invited participation of consumer and family member representatives in our decision making teams, establishing community member seats on the IDN 1 Executive Committee and the Community Engagement Work Team (CEWT).

The CEWT provided extensive guidance, facilitation, and support for the Behavioral Health Needs Assessment. CEWT includes consumer and family members, leaders of each of Region 1's Public Health Advisory Councils, Continuum of Care Facilitators, and NAMI-NH. All members of the work team helped shape our consumer, provider, and caregiver survey tools.

For a more granular, chronological description of our community engagement efforts:

- Through a combination of Mary Hitchcock Memorial Hospital and Cheshire Medical Center's standing Community Health teams and our regional Public Health Networks, IDN member organizations were recruited.
- Region 1 members organizations contacted consumers and family members to serve as members of the Executive Committee and Advisory Council.
- CEWT members were recruited from Region 1 membership.
- CEWT reviewed and finalized the tools for the behavioral health needs assessment; developed strategy for geographic distribution of surveys; and provided outreach to organizations who could most effectively recruit participants.
- Through this outreach, community member surveys were disseminated to targeted populations.
- CEWT disseminated separate provider surveys through their health care, public health, and community organization networks.

- CEWT worked personally or with targeted partner organizations to recruit both consumer and professional providers to participate in community discussion groups.

iii. Mechanisms to ensure the community engagement process was transparent

The Administrative Leads and CEWT ensured that the community engagement process was transparent to all. The input of the broadest possible cross-section of community members was solicited, with a clear understanding that their input would be used to inform Region 1’s project plan. In turn, the needs assessment data was represented in both written and verbal form, which shaped the deliberations and decision-making of the IDN 1 Executive Committee.

iv. Examples of three key elements of this Project Plan that were informed by community input

Every element of the Project Plan was informed by community input. Below, we highlight three exemplars:

Region 1 vision and theory of action. Community members, in the form of consumer and family member representatives, as well as leaders in peer support and recovery supports, were integral participants in crafting the Region 1 Vision and Theory of Action.

Region 1 service area community needs assessment. The purpose of the needs assessment was to identify community behavioral health needs and solicit input and advice on priorities and opportunities. The needs assessment was in the field from August 1 through September 15, 2016 and included:

- Consumer survey targeted to high need locations and populations
- Caregiver survey of people caring for others with behavioral health service and support needs
- Provider survey (broadly defined)

The consumer survey was distributed through channels anticipated to reach vulnerable populations (e.g., homeless shelters, peer support and recovery centers, community mental health centers and substance treatment agencies). Surveys were distributed in hardcopy and electronic formats.

In addition to the three-pronged survey process, a series of nine discussion groups were convened (6 consumer groups, 3 provider groups) to explore needs, gaps, and improvement opportunities in more depth.

The aforementioned efforts resulted in the following participation rates:

- 566 consumer surveys were completed: 31% of respondents were Medicaid members within the last 12 month; 51% had used mental health services and 19% substance use services in the past 12 months
- 79 caregiver surveys were completed: 87% were caring for someone with a mental health need, 33% were caring for someone with a substance use treatment need; 28% were caring for someone with Medicaid coverage
- 172 provider surveys were completed, representing more than 30 professional roles, ranging from clinical providers to first responders
- Consumer Discussion groups were held with representatives of the following populations (47 total participants):
 - Family caregivers of adult children with mental illness
 - ServiceLink clients (older adult behavioral health needs)
 - Peer Support Center members (persons with severe mental illness)
 - Recovery Center members (persons with opioid /alcohol use disorders)

- Family Resource Center, Young Mothers group (young adult, limited income)
- Recovery support group (adults recovering from alcohol use disorders)
- Provider discussion groups (55 total participants, multi-disciplinary across direct service and community supports) – 1 group in each of Region 1’s three sub-regions

Community-driven projects. The results from the community needs assessment were driven into our data-informed, stakeholder-infused community-driven project selection process. The degree to which each project met an identified community need was a key criterion in our decision-making process. For instance, the needs assessment pointed to extensive unmet mental health and care coordination needs in our region, which steered us toward Care Transitions Teams and Care Coordination for High Need Patients. At the same time, the needs assessment underscored extensive supportive housing needs in our region. Thus, housing considerations will be infused into our implementation of the aforementioned interventions (Supportive Housing was not selected due to cost, reach, and feasibility concerns).

v. An explanation of any instances in which community input could not be addressed or taken into account

During the 6-week August-September period in which we completed the Needs Assessment, we were not able to complete a planned focus group in a correctional facility, due to a variety of logistical barriers. We anticipate holding this focus group in October/November 2016.

3b. Narrative describing the process by which the IDN will solicit community input in implementing its program over the course of the demonstration

Our community input strategy will co-evolve with the project as it shifts from broad planning (current phase) to operationalization (next phase) and then implementation, monitoring, and improvement (final phases). Whereas we developed a broad understanding of community realities and needs to inform the Project Plan during this phase, during the next phase, we’ll seek more targeted and focused consultation about how best to operationalize the program. As we transition into the implementation phase, the focus will be on creating multiple opportunities for formative community feedback on project performance, to foster learning and quality improvement.

i. Channels and venues through which input will be solicited, as well as key audiences/stakeholder groups

Region 1 will continue to incorporate input at both structural/governance and grassroots levels. Structurally, we will continue to reserve seats on the Executive Committee, Advisory Council, and CEWT for community members/residents. CEWT will continue to meet monthly to oversee/facilitate Region 1’s community engagement strategy/activities.

At the grassroots level, the Executive Director will be charged with holding regular forums to invite input from the community. They will hold a community forum in each of our public health regions) on a bi-annual basis, to provide updates and information to residents about the project, and to solicit input and feedback about implementation plans and performance. We will partner with service organizations, NAMI-NH, and behavioral health peer recovery organizations, to help engage community members with behavioral health-related needs in these events.

The Executive Director will meet quarterly with a Citizen Team consisting of 10-12 residents with lived behavioral health experience that is directly relevant to elements of our Project Plan. We will seek assistance from existing consumer support organizations (NAMI, others) to identify and recruit the

members of the Citizen Team, with additional nominations from service providers and staff from implementation sites as needed. Citizen teams will consult with the Project Director and Coordinator about project implementation, evaluation, and improvement. Citizen Team meetings will be held at a time and place that is most convenient for its members, to reduce logistical and financial barriers to participation. As funding permits, transportation, food, and childcare will be provided to support meeting attendance as well.

In addition, the CEWT workgroup will issue regular newsletters, newspaper articles, and the like, to keep the community informed about project status and updates.

Finally, bi-annual conference calls will be offered to all Region 1 leaders (e.g., County administrators, social service and healthcare leaders) who are not already represented on the Executive Committee or Advisory Council, to keep them up to date on IDN activities and outcomes, and solicit their feedback and input.

ii. Frequency with which community input will be sought

As described above, community members will be involved in all Executive Committee, Advisory Council, and CEWT meetings, ensuring ongoing involvement and engagement. In addition, open community forums will be held in each sub-region every six months. Citizen Team meetings will be held on a quarterly basis. Input from consumers of the Community-driven projects and other IDN 1 interventions will be sought on an ongoing/routine basis.

iii. Mechanisms to ensure the community engagement process is transparent.

CEWT will continue to be the custodian, facilitator, and communicator of community engagement, thereby ensuring transparency. In this role, CEWT will map and identify stakeholder networks, decide who needs to receive/be involved in communication, and suggest communication frameworks/strategies. The Communication Workgroup and Project Staff will implement these suggestions, to ensure transparency. The CEWT chair serves on the Executive Committee and uses those meetings to keep information flowing with project decision makers.

4. Network Composition

4a. Finalized Network List

See Supplemental Data Workbook 4A Tab

4b. 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)

Broad Themes of Gaps/Needs	Gaps/Needs Identified in Regional Behavioral Health Needs Assessment	How will this Network be Leveraged to Address Gaps in Care?
Access to Care	Increase Workforce / Reduce Turnover	A core concept of our IDN is to maximize our existing behavioral health workforce by developing mid-level capacities such as case managers, care coordinators, community health workers, and peer coaches. By developing these capacities, we anticipate reducing no-shows; and allowing clinically trained providers to work to their highest licensure, making the greatest use of our existing resources. Rather than simply hiring more clinicians, we aim to develop a workforce that matches workforce skill to consumer needs.
	Increase Awareness of Services	
	Expand Services/Resources	Similarly, developing integrated care teams should help improve access to prescribing and monitoring care, allowing specialty BH care to be more rationally deployed to serve higher need consumers. Providers working in well designed, efficient care teams have improved satisfaction with their work environment. By restoring joy in the workplace, we hypothesize workforce turnover rates can be reduced. Finally, we anticipate expansion/development of outpatient and intensive outpatient substance (IOP) use disorder services to address the significant SUD service gaps identified. IOP services also will help us provide effective community-based treatment when indicated, which may in turn reduce the demand/reduce waiting lists for scarce residential programs
Quality of Care	Address Stigma, Increase Trust and Respect for Consumers.	At this time our region has limited integration of behavioral health in primary care. Our plan will expand access to behavioral health services to additional primary care practices in the region, defining and using a standard model of care and providing training, IT, and quality improvement resources to help us achieve a high level of quality.
	Quality of Care	

	<p style="text-align: center;">Increase Involvement of Caregivers</p>	<p>Our plan also includes a focus on improved person-centered care plans, care transitions, care coordination, and connections to community resources to improve care during vulnerable transition periods, decrease barriers to care, and to decrease escalation from routine care to emergency, hospitalization, and residential care.</p> <p>Patients and their caregivers will be involved in creating these standard care models. We anticipate that we will include peer coaching resources in our standard care model. Stigma will be directly and indirectly addressed through training, education, and through witnessing the impacts of effective care.</p>
<p style="text-align: center;">Coordination of Care</p>	<p style="text-align: center;">Increase Coordination/Case Management Services</p>	<p>Through the use of a common, shared person-centered care plan, combined with training in common standards regarding patient health information releases and IT solutions that enable better sharing of care plans, we intend to improve communications between patients, caregivers, and clinical providers.</p> <p>Additionally, our plan stresses the development of improved care coordination, case management, and other mid-level staff in our integration strategies.</p> <p>Finally, two of our community-driven projects, Care Transition Teams and Enhanced Care Management, substantially focus on improvements in communications and care transitions within and between clinical and community service organizations to address consumers housing, transportation, and other social determinants needs. This emphasis on increasing coordination of care should enable more seamless care transitions, increase consumer confidence they are receiving coordinated care, and increase our ability to identify emerging needs before they require crisis level care.</p>
	<p style="text-align: center;">Improved Communication Between Providers</p>	

5. Relationship with other initiatives

Organizations across region 1 have a long history of partnership and experience leveraging and integrating multiple initiatives, including several that are federally funded, with the ultimate goal of improving the health of the population we all jointly serve. These initiatives range in scope and size with respect to delivery system reform initiatives.

The New Hampshire Health Protection Program has positively impacted the population we serve by including behavioral health benefits. Through the actions and activities proposed on this plan we will enhance the quality, availability, coordination and integration in the front and back end of the services, so patients and their families have seamless transitions and optimized services delivered to them. The actual clinical service will not be paid with DSRIP funds; their reimbursed goes through the regular contractual mechanisms for service provision. As the DSRIP evolves and new payment methodologies are developed and implemented we will work jointly with the state, regional partners and the IDN across the state on sustainability mechanisms tied to evolving payment reform.

Aside from the NH Health Protection Plan for region 1 the most notable existing delivery system reform initiatives that involve IDN participants are two “System of Care” projects.

In 2016, Governor signed System of Care legislation requiring New Hampshire build a coordinated statewide service system for youth with mental health challenges.

Originally, with the support from the Endowment for Health and New Hampshire Charitable Foundation, key statewide stakeholders met for over five years to develop a comprehensive System of Care for children in the state. The New Hampshire **Children’s Behavioral Health Plan** emerged from these efforts. It is a comprehensive, multi-faceted strategy for improving children’s behavioral health services with a system that is family driven and youth guided, and culturally and linguistically competent.

The New Hampshire **Children’s Behavioral Health Collaborative** is a coalition of over 50 agencies working together to transform how New Hampshire cares for children and youth with the most complex behavioral health challenges and their families and to transform New Hampshire's current children's behavioral health care services and supports into an integrated, comprehensive system of care.

The initial statewide System of Care grant resulted in the FAST Forward Program (Families and Systems Together) which serves youth with severe emotional disturbances (SED) and their families whose needs are not met by traditional service streams and programs statewide. FAST Forward utilizes the New Hampshire Wraparound approach to coordinate care. Services are home and community-based and utilize trained family peer support specialists. Family peer support is provided through a contract with NAMI NH. Youth MOVE NH provides peers support to the youth with SED in the FAST Forward Program.

Within the Region 1 IDN we have two separate System of Care initiatives.

- The Monadnock Region System of Care grant which is overseen by the County of Cheshire is a four year 4-million-dollar project focusing on youth with a severe emotional disturbance in the Greater Monadnock Public Health Region. Work in the region will be directly aligned with state efforts with New Hampshire Wraparound care coordination modeled after the FAST Forward

Program. Efforts will also focus on capacity and infrastructure development, peer support with NAMI NH and Youth MOVE NH, strategic communications, training and evaluation.

- The State of New Hampshire, through the office of Student Wellness at the New Hampshire Department of Education received a 12 million grant from SAMHSA to more deeply imbed System of Care statewide. The Claremont School District was chosen as one of three districts to move this work forward statewide. The focus of the state's efforts will be on school and district wide culture as well as NH Wraparound care coordination.

In addition to these, there are many some other ongoing initiatives supporting the NH vision for a behavioral Health reform. The following is a shortened list of selected community specific initiatives that showcase how, in region ,1 we assessed all opportunities and work in concert with them to prevent duplication:

- West Central Behavioral Health has a Medicaid Innovation Accelerator Program (IAP). IAP PMH (Physical and Mental Health) project planning is designed to help states refine the scope of their IAP PMH projects. Through this initiative they have done the strategic planning required for the design and implementation of plans that will improve the behavioral and physical health outcomes and experience of care of individuals with a mental health condition. Their experience and lessons learned are part of what the whole IDN will look at as our local best practices for scaling-up and disseminating across the region.
- Cheshire and Sullivan County government and DHMC are the fiscal agent for the Regional Public Health Networks grant with DHHS. Through subcontracts they meet contract deliverables. Those included the hiring of personnel charged with substance misuse prevention and continuum of care facilitation. They have been fully integrated as part of IDN administrative leadership, and their activities are part of the base in which we are building the ongoing community and patient engagement as well as the community based projects.
- Some of the IDN partners have staff members that are certified application assister. The counselors are certified by NH-DHHS to provide presumptive eligibility for healthcare and prescription services. We provide one-on-one application assistance to families in completing NH Medicaid Applications for NH Medicaid for Children & Pregnant, NH Health Protection Program, Parent Caretaker Program, and Food Stamps. In addition to NH Medicaid, the Family Resource Counselors are a Certified Application Counselor for the Health Insurance Marketplace. These services will be made available to populations identified as insured and eligible for the services to be provided by the IDN, increasing the positive impact of the NH Health Protection Plan.

These activities together create spaces for discussion and facilitate the environment changes required for delivery system reform. None of them are duplicative of the activities proposed by region 1 IDN, but they are clearly aligned and supplement the regional plan. We have in place the mechanism to exercise the strong oversight that will be required to ensure funding and programmatic integrity.

6. Description of how this plan addresses the Opioid Crisis

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.

Region 1 Opioid-Related Challenges

Available data on opioid overdoses, opioid treatment demand, naloxone administration and non-medical use of opioids in Region I indicate significant and rising levels of opioid-associated harm roughly commensurate with that across New Hampshire. The Region I Community Needs Assessment identified challenges to addressing this harm, including inadequate psychosocial and medication-assisted treatment (MAT) availability, limited awareness of existing resources, readmissions following treatment, and barriers related to insurance, transportation and others. The Community Driven Projects elected by Region I will address these and are expected to continue to reduce opioid-related harm by informing routine chronic condition care of persons with opioid and other substance disorders.

Interventions to improve access to care, care delivery and care coordination will be developed by Project Work Groups informed by Region 1 Clinical Governance, HIT/Data, Community Engagement and Finance Work Groups. Specific interventions will be vetted by the Clinical Governance Work Group, reviewing evidence and best practices (when evidence is weak or non-existent). The sections below describe a series of interventions that will be considered by the Work Groups as they define care models to achieve measurable improvements in harm due to opioid and other substance disorders. Specific interventions and care models for implementation require Region 1 Executive Committee review and endorsement.

Region 1 Community Driven Projects

1. Care coordination for high risk patients

The Region I care coordination model targets use of community-based, patient-centered care coordinators (CBPCCs) who will engage with participants across organizational boundaries in needed contexts to provide support and facilitate self-management. In addition, enhanced care-coordination within specified clinical settings will improve care, especially when interfaced with community-based care coordination.

Opportunities to improve coordination of care to reduce opioid-related harm include:

- *Coordination of OUD treatment services* in different clinical contexts with warm hand-off to CBPCCs for continuing coordination on discharge:
 - Inpatient services for patients hospitalized with opioid-related medical problems with coordination between inpatient MAT prescriber and psychosocial services and referral to outpatient providers at discharge.
 - Emergency room care for patients presenting with opioid-related problems with coordinated engagement in OUD treatment on discharge.
 - Coordination of medication-assisted treatment in outpatient primary care settings

- *Coordination of recovery support and services in the community* including: transportation, transitional housing support, availability of naloxone.
- *Implementation of safer opioid prescribing practices*, as defined by CDC guidelines and NH Board of Medicine rules, involve numerous strategies and require significant clinic-based care-coordination that can be supported in the community by CBPCCs.

2. Care transition teams

Transitions of care present both opportunities to improve care and vulnerabilities to lapses in care. Region I will consider opportunities to secure gaps in opioid-related care at key transitions. Potential interventions include:

- Screening, intervention and indicated referral of persons transitioning into ER, inpatient, or primary care with opioid-associated medical problems such as overdose, abscesses, endocarditis, or HIV or infectious hepatitis. (Leveraging existing models at CMC, Elliot Hospital, DHMC and others).
- Pharmacologic stabilization of patients in opioid withdrawal in ER and inpatient settings with engagement in MAT on discharge. (Leveraging demonstration model piloted at Yale-New Haven).
- Enhancing communication systems between PCP offices and addiction treatment providers in transitioning MAT. (Leveraging models between Frisbee Memorial with Groups and/or Boston University nurse case manager model).
- Enhancing communications systems between PCP offices and pain providers/other specialists for patients transitioning opioid prescribing.
- Initiation of naltrexone or buprenorphine in corrections inmates with OUDs prior to release. (Evolving in NH prison system, leverage model for country jails).
- Improving access to resources to support transitions of care through shared IT systems and unified web resources

3. Expansion of Intensive Substance Use Disorder Treatment Services

Region I will target expansion of intensive treatment services for OUDs that include medication-assisted treatment (MAT), consistent with evidence based practice. Specific interventions that will be considered by Region 1 Work Groups involved in this Community Project include:

- Provider recruitment through educational sessions on OUD and the critical need for MAT as a component of care at hospitals/practices in the region
- MAT-buprenorphine trainings for physicians, advance practice nurse practitioners and physician assistants at minimum three regionally distributed hospitals leveraging PCSS-MAT support.
- Development of clinical support systems for buprenorphine MAT at the selected training sites to include designated psychosocial treatment provider and nurse coordinator, building on DHHS-Foundation for Healthy Communities buprenorphine support project
- Expand and incentivize LADC training in the region I with optimized OUD curricula including role of MAT in treatment.

7. IDN Governance

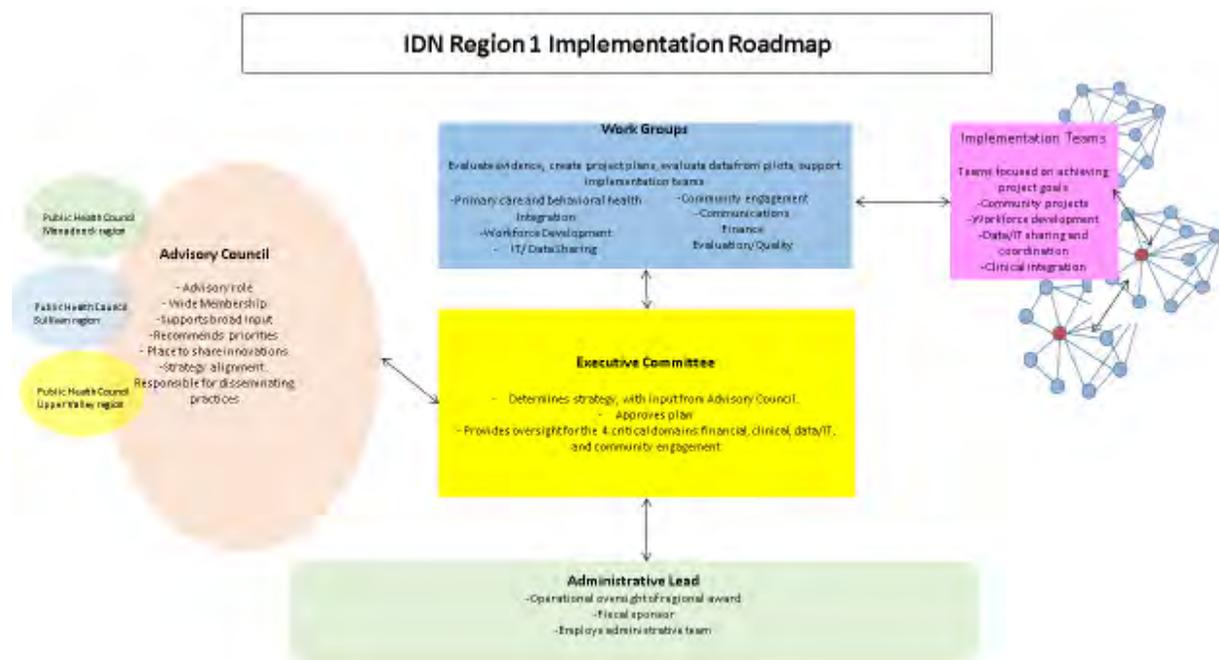
7a. Overall Governance Structure

We understand governance as the establishment of policies and continuous monitoring of their proper implementation, by the members of the governing body of the IDN. It includes the mechanisms required to balance the powers of the members (with the associated accountability), and their primary duty of improving health outcomes for the populations we serve and the best possible cost. All IDN participant organizations agreed that our governance structure should and will provide a framework that supports open communication and sets priorities for the institutional and community collaboration required to successfully develop and implement the IDN for Region 1, and to direct the funding in ways that encourages the best value and health outcomes for the population served.

The governance approach for the Region 1 includes a diverse and complementary set of structures with different levels of authority and differentiated, but complementary, tasks and accountabilities. Full details can be found on the attached standalone Region 1 governance document (Attachment 16. Governance Document).

The core components are:

1. Advisory Council
2. Executive Committee
3. Administrative lead
4. Workgroups
5. Task forces
6. Implementation teams



Advisory Council

The role of this council is advisory in nature. Membership will include all IDN partners and a broad based representation of all other organizations and individuals playing a role on improving outcomes for the Medicaid population with behavioral health needs and who reside in the state defined Region. Such representation should include members of the population using the services and their families.

The advisory council can advise the Executive committee of the need for specific workgroups or taskforces to help advance its function and responsibilities. The advisory council will serve as a bridge with the regional Public Health Advisory Councils and validate the IDN work with the regional priorities of the Community Health Improvement Plans

The Advisory Council will meet on a regularly scheduled basis as set by the Executive Committee. The meetings will provide opportunities for networking, updates, specific organizational or programmatic issues, etc. The council meetings will allow for an informal flow of conversation necessary to generate information, identify challenges and opportunities, and discuss solutions.

Specific responsibilities were agreed upon for the members of the advisory council are as follows:

1. Help identify and encourage action planning to ensure that the health needs of the population are served by the IDN efficiently and valuing both clinical and non-clinical patient needs in its considerations
2. Communicate about IDN activities to the community and bring the voice of the community to IDN stakeholders
3. Support the coordination, needs assessments, and data collection activities that produce actionable and consistent data as it relates to the IDN activities and goals
4. Advise and make recommendations, as appropriate, to the IDN executive committee on funding opportunities that overlap or complement IDN priorities
5. Serve as a place to share innovations; align strategies.
6. Engage partners to implement the IDN strategies and plans
7. Identify community assets and mobilize and leverage their resources in support of the IDN goals
8. Responsible for disseminating best practices.
9. Serve as a bridge with other regional and state related stakeholders

The council membership will include all IDN partners and a broad based representation of the multi-stakeholder sectors in the Region. Though not complete, stakeholder groups include:

- a. Service users from the region
- b. Primary care provider organizations
- c. Mental health care providers
- d. Substance use disorders care providers
- e. Recovery community and organizations
- f. County and city authorities
- g. Public School Districts
- h. Social Service/Non-Profit organizations
- i. Educational Organizations
- j. Correctional and justice systems
- k. Employers

Executive Committee:

The Executive Committee is the primary governing body of the Region 1 Integrated Delivery Network (IDN). The Executive Committee provides strategic direction to the Administrative Lead and in partnership with the IDN Administrative Lead, is accountable for the execution of Region 1 project plans. This group will provide the oversight for the 4 critical domains of the IDN: financial, clinical, data/IT, and community engagement.

The Executive Committee approves planning documents and budget allocations and it is responsible for setting direction, identifying priorities, and making decisions specifically on the 4 critical domains mentioned above. It will receive, review and approve progress reports from the Administrative lead and the committees created to develop and oversee the 4 critical domains and the overall adequacy of the network in servicing the behavioral health needs of our population.

Composition of the Executive Team will represent the diversity of IDN partners and members will make decisions on behalf of IDN partners.

Executive Committee Members Responsibilities (Job description):

- In addition to representing their sector and professional organization, members of the Executive Committee will actively seek input from and represent all IDN partners across the Region.
- Executive committee members will make strategic decisions for the collective benefit of the Medicaid beneficiaries attributed to Region 1 IDN and to help the IDN achieve success
- Understand the strengths/needs of IDN partners in order to fairly represent Region 1
- Have full knowledge of the requirements in the State Project Plan application
- Provide expertise and experience to the development, implementation and evaluation of the Region 1 Project Plan application, drawing from personal knowledge or gathering input from external sources
- Attend meetings regularly
- Complete assigned tasks by agreed upon deadlines
- Communicate with IDN partners. Provide information to IDN partners and communicate partner information back to the Executive Team.
- Agree to serve a two-year term
- Assist in developing structure and procedures to assure efficient executive committee functions and communication
- Lend expertise and experience to the action planning, assessment, and prioritization of health needs for the Medicaid patients with behavioral health diagnosis within region 1
- Engage and recruit new members to the Advisory Council and executive committee as appropriate
- Represent the IDN to the community by sharing information regarding roles, responsibilities, actions, and priorities
- State conflict of interest and abstain from voting where applicable
- Expected to serve as an ambassador on behalf of region for Population Health Improvement

Executive Committee membership

Initial Executive Committee will be comprised of 7 institutional members and 4 community members as shown on Table 7.1 below. As the IDN develops this number can be revised upwards to a maximum of 15. The administrative lead staff will attend the executive committee meetings, with no voting rights.

The institutional positions will strive for geographic representation and diverse expertise as it relates to oversight of the 4 key domains: financial, clinical, data/IT, and community engagement. The term limits and election process are described on the attached standalone governance document, Attachment Governance Document.

**Table 7.1
Region 1 Executive Committee**

# Seats by Sector	Sector	Current members (Bios are found as Attachment 16. Team Bios)
1	Provider of Primary Care Services	Andre Tremblay, MD. Chair of Primary care at CMC/DHK
1	Provider of Mental Health Care Services	Sue Ellen Griffin, President and CEO West Central Behavioral Health
1	Provider of Substance abuse disorders care services	Holly Cekala, VP of programs for Hope for NH Recovery
1	County and/or city government	Chris Coates, Cheshire County Administrator
1	Human services (i.e. wrap around services, service link, housing, transportation etc.)	John Manning, CEO Southwestern Community Services
1	Other sectors on the Social determinants of Health (i.e. PH networks, education, employment, etc.)	Alice Ely, Executive Director for the Public Health Council of the Upper Valley
2	Service user (community member)	Michelle Nuttle (Current Vice-Chair), <open seat>
2	Family member (community member)	Ruth Bleyler; <open seat>
1	At large	Dennis Calcutt, Program Director, Monadnock System of Care (Current Chair)

Officers:

The chair and vice-chair are the elected officers of the executive committee and the advisory committee. The IDN administrator will be an appointed officer. Clear process and guidelines for the election, qualifications, terms of office and duties are detailed on the attached standalone governance document

Decision Making Process:

The Advisory Council and the Executive Committee will strive for consensus following guidance that can be found on the stand alone governance document. Some decisions such as the election of executive committee members, election of officers, approval of IDN plans or funding decisions will require a vote. Votes will be held at regularly scheduled meetings if at all possible and a simple majority will be required to approve or deny the item under vote. Items for vote will be carefully worded and read before the vote takes place. Documentation of the vote will be made by the secretary in the minutes of the meeting. If votes are held electronically, such as the Executive Committee membership election, clear instructions for deadlines need to be included with the item under consideration. Simple majority of voters will make the decision. Policy changes, priority selections or re-prioritization, and election of

officers will only occur at regular meetings. The IDN Executive Director will advise the Executive Committee when a decision may be considered contrary to the ethical and administrative policies and procedures of the administrative lead organization.

Administrative Lead

Administrative Lead will serve as the coordinating entity for the IDN's partner network in planning and implementing projects and as a single point of accountability for the State.

The administrative lead has the authority to hire/fire, and sole responsibility for daily supervision of project staff. Following NH-DHHS directives the administrative lead will appoint an IDN Executive Director, Medical Director, Finance Director, IT Director and other staff as appropriate and necessary. The administrative lead will advise the executive committee of its internal administrative policies as they relate to hiring, contracting and finance management and how they are implemented. At no moment are those policies subject to the approval of the executive committee.

Administrative Lead responsibilities:

- Act as single point of accountability for DHHS
- Submit single application and reports on behalf of IDN
- Hire administrative staff.
- Implement IDN governance structure in accordance with DHHS parameters and agreed-upon approach of IDN partners
- Oversee and approve the distribution of funds to vendors and partners in accordance with the plan approved by the Executive Committee.
- Provide administrative support for governing committees
- Document/define Advisory Council activities and Executive Committee systems, processes
- Utilize existing resources within the community to assist with some of these tasks.
- Assure effective communication and coordination with and between Advisory Council and other committees and coalitions in the region
- Receive funds from DHHS and distribute funds to partners
- Compile, analyze, and submit required data and reporting to DHHS
- Collaborate with partners in IDN leadership and oversight
- Collaborate with IDN partners to manage performance against goals and metrics

IDN Partner Organizations

- To be an IDN partner organization an entity shall provide services with the potential to positively impact the health and social outcomes of the population with behavioral health conditions. Those entities can be direct service providers or be recognized conveners and advocates for improved health outcomes, multi-sector collaboration, community engagement and outreach.
- Each IDN partner organization agrees to comply with the policies and procedures set for and by the IDN.

- Each IDN partner organizations will actively contribute to achieving the collective IDN goals, adhere to the IDN guiding principles and will sign an agreement with Dartmouth Hitchcock, who as the administrative lead is responsible of the contract management and reporting to the state.
- The IDN partner organizations are collectively responsible for the outcomes of the partnership.
- Each IDN partner organization will be directly accountable on the performance measures results related to their organization.
- No IDN partner will require the administrative lead to apply policies or procedures that go against the administrative lead internal business practices.
- If an IDN partner organization does not perform, as measured by their contribution to achieve the mandated goals, the Executive Council can terminate their membership, by following the procedures developed by the administrative lead and approved by the Executive Council.
- Each IDN partner organization will have one vote for the election of the Executive Council members and only partner organizations can vote to elect the Executive

The workgroups and taskforces described on section 7b will develop standards for the continuum of care, implementation maps and will provide regular reports to be submitted for approval by the Executive Committee.

7b. Four Governance Domains

As described above the Executive Committee will charter as many workgroups or task forces as it deems necessary to develop, monitor and evaluate the implementation of action plans that respond to the identified priorities.

A taskforce would be a group of people working on a specific problem with the goal of solving the problem quickly (typically 6 months, but never longer than 12months). Workgroups will address issues that require a term longer than a year of ongoing activity. Authority for adoption of recommendations or reports will not be delegated to any workgroup or taskforce.

Workgroups will initially include: community engagement, Data/IT, Finance and Clinical care. Other workgroups will be chartered as the Advisory Council may find necessary or expedient from time to time.

Region 1 recognizes that there is a clear and distinct overlap between the work necessary to succeed on an integrated health model and the community based projects. To this end all workgroups have to understand and manage their objectives and scope within that framework, as shown on the table below. Since all workgroups report to the Executive Committee, it has the responsibility and ultimate accountability for achieving project goals and ensure the adequacy of the network in serving the behavioral health needs of our population. Because of this overlap we have standardized responsibilities, roles, membership selection and decision making process across all workgroups.

As depicted in the table below, some of the Work Groups address core functions (listed along vertical axis) while other Work Groups are directed to implementing models of care as measured by process and outcome metrics (listed horizontally). As we develop additional care model-focused Work Groups, we will ensure consistency and coordination by using a matrixed relationship across the portfolio of projects. Representatives from the functional, core Work Groups (clinical governance, HIT/Data, finance, community engagement) will populate the care model Work Groups along with other IDN

members selected following Region 1 policies. This organizational structure minimizes the risk of working in “silos.” Our executive team (Executive, Medical, Finance Directors and Project Coordinator) are responsible for coordinating and aligning across work groups.

	Integrated health Care	Care Transitions	Care coordination for High need	Intensive Outpatient treatment
Care (clinical) workgroup	✓	✓	✓	✓
IT/data workgroup	✓	✓	✓	✓
Finance workgroup	✓	✓	✓	✓
Community Engagement workgroup	✓	✓	✓	✓

Responsibilities for the Executive Committee include: approve the Work Group charter and plan; secure resources for the project; confirm the project’s goals and objectives; keep abreast of major project activities; make decisions on escalated issues; and assist in the resolution of roadblocks. The IDN Executive Director is responsible for timely communications between Work Groups and the Executive Committee and ensuring Work Group needs are adequately addressed by the Executive Committee. Project plans will be reviewed and endorsed by the Executive Committee.

The IDN Project Manager will ensure Work Groups receive adequate support for project management, communicating to the Executive Director if additional resources are required.

Work Group membership will be drawn from IDN partner organizations, patients/consumers, and caregivers/families or IDN contracted entities. All Work Groups will have 2 or more positions for individuals representing patients/consumers or caregivers. Work Group composition will strive for balanced geographic representation and include stakeholders who have subject matter expertise and/or will be impacted by Work Group activities. The Executive Committee will work with the Administrative Lead/ IDN staff teams to establish processes for selecting Work Group members. Work Groups will determine meeting frequency but will be no less than monthly in the first year of IDN operations. Every Work Groups is led by a Work Group lead or co-leaders. Work Group Leader and/or Co-Leaders will lead the Work Group through team motivation and maintaining and enhancing relationships with key stakeholders and customers in the planning and development of the project. Responsibilities include: Coordination with the IDN Executive Director on developing the project plan and deliverables that will meet the requirements of the IDN goals, New Hampshire objectives for this DSRIP project and fulfill CMS requirements, scope control, change management, conflict resolution with other projects, approval of risk mitigation strategies; final signoff on resource deployment and utilization; and organizational communication.

The Workgroup Project Manager will lead in the planning and development of the project; manages the project to scope. Responsibilities include: develop the project plan; identify project deliverables; identify risks and develop risk management plan; direct the project resources (team members); scope control and change management; oversee quality assurance of the project management process; maintain all documentation including the project plan; report and forecast project status; resolve conflicts within the project or between cross-functional teams; ensure that the project's product meets the business objectives; and communicate project status to stakeholders. The project manager for Region 1 IDN may identify a designee to serve as workgroup project manager.

Team Members will work toward the deliverables of the project. Responsibilities include: understand the work to be completed; complete research, data gathering, analysis, and documentation as outlined in the project plan; inform the project manager of issues, scope changes, and risk and quality concerns; proactively communicate status; and manage expectations. Attend and actively participate in Work Group meetings.

Term Limits/Maximum length of term for Work Group members: Term will be two-year period with ability to renew for an additional two-year period. Limit of 2 terms. Failure to attend 6 of the 12 monthly meetings in a calendar year may result in termination. The Executive Committee will work with a nominations workforce to determine the processes for selection of new members or the confirmation of current ones. This process should be approved by the Executive Committee and the Advisory Council Decision making in the Work Group will follow the same procedures as outlined in the standalone Region 1 Governance Document: Strive for consensus. If the Work Group reaches an impasse and cannot move forward, the Work Group leader(s) will communicate with the IDN Executive Director who has the authority to escalate to the Executive Committee.

Common components of the scope of work for the workgroups are: All work will be focused on Region 1 DSRP attributed population and the term of the work will coincide with the NH DSRP waiver 1115 project term. Even though limited by geography and attribution, Region 1 is interested in encouraging across regions participation and standardization as appropriate and supported by the state. With this common framework in mind the four core domains workgroups have defined objectives and scope. For a full version of those charters see section 7c.

1. Clinical Workgroup. In Region 1 we use an expanded definition of "clinical" to include some aspects of social determinants of health. That is why refer more to the standards for the continuum of care. This group will establish the processes to develop evidence-based care guidelines for behavioral health disorders and the integration of behavioral health, general health and the social aspects that impact health. Working with the Region 1 Data and IT Work Group, meaningful measures will be developed to inform care teams of their progress implementing evidence-based care. The Clinical Governance Work Group will monitor performance at the Region- and partner-level, working with IDN partners to identify barriers to implementation and secure necessary resources for improvement. Recognizing holistic care includes more than clinical therapeutic interventions, this Work Group will also address the non-clinical interventions and supports that are critical in healing for patients and families suffering from behavioral health disorders. Best practices and evidence-based interventions focused on non-clinical care will be evaluated, vetted, and included as recommendations in care model design and implementation.

The workgroup will:

- develop processes for evaluating evidence and when evidence is lacking to evaluate best practices regionally or nationally;

- establish processes to vet and endorse the evidence based knowledge related to care for behavioral health disorders;
 - establish processes to maintain and curate the knowledge base for behavioral health care;
 - develop clinical decision support tools such as clinical guidelines;
 - work with the Data and IT workforce to identify meaningful measures to inform implementation (process metrics) and to communicate performance (outcome metrics);
 - monitor IDN performance in aggregate and at the organization level, identifying opportunities for continuous improvement, facilitating learning amongst IDN partners, and communicating barriers to improvement to appropriate IDN committees
2. IT/Data Workgroup. The objectives of this workgroup will be to:
- convene Region 1 stakeholders that bring technology subject matter expertise, information policy expertise, and wide-ranging perspective (patient & caregiver, technical, clinical, and operational) to the 1115 waiver program;
 - to consider and recommend IT investments and projects that can support IDN-1 clinical and operational goals and requirements;
 - to develop strategies for information exchange between IDN partners using IT and guided by input from the State IT Task Force;
 - to provide processes and standards for data sharing among the partners in the IDN;
 - to establish IDN policies and procedures related to data collection, data integration, and data reporting;
 - to provide guidance on the approach to drafting and executing data sharing agreements;
 - to support IDN-1 decisions with data and analyses including clinical quality measures for operating the IDN and evaluating impact of IDN activities;
 - to develop reporting and reporting processes for the IDN;
 - to develop monitoring policies and procedures;
 - to determine the roles of information technology, health informatics, clinical, and administrative leadership within partner organizations will play on overall data governance.
3. Finance workgroup objectives include:
- Overseeing of the finances for the region;
 - to ensure that Region 1 meets the financial requirements and provisions of Building Capacity for Transformation Section 1115(a) Waiver;
 - to establish financial control policies and procedures, including accounts payable, purchasing and receiving, treasury, accounting, reporting, and audit;
 - to establish and monitor budgets;
 - to oversee the preparation of financial reports for external stakeholders and the Executive Committee;
 - to advise the Executive Committee on financial issues related to proposed programs for Region 1;
 - to review and approve the financial provisions of contracts entered into by Region 1 in fulfillment of Region 1's Project Plans;
 - to review and advise on the adoption of alternative payment models.

4. Community Engagement Workgroup responsibilities include:
- plan and recommend strategies for engaging patients, families, and organization stakeholders in decisions of the Region 1 IDN;
 - advise Administrative Lead and IDN staff regarding approaches to conducting Behavioral Health Needs Assessments and provide networking assistance with disseminating BHNA surveys and organizing BHNA community discussion groups;
 - recommend to IDN staff strategies to more broadly disseminate information about the work of the IDN and to obtain broad community input into its efforts;
 - determine how community input will be received and included in the strategic path of the IDN;
 - determine the channels and venues through which input is solicited;
 - determine how the communication strategies will continue through the demonstration.

7c. Governance Charters

Finance

A. General Information

Work Group:	Region 1 Finance Committee		
Brief Work Group Description:	This document outlines the charge, function, and structure of the Finance Committee for the Region 1 Building Capacity for Transformation Section 1115(a) Waiver		
Prepared By:	Mark Russoniello		
Date:	10/25/16	Version:	1.0

B. Work Group Objective:

Explain the specific objectives of the Work Group

<ol style="list-style-type: none"> 1. To oversee finances for the Region 1 Waiver 2. To ensure that Region 1 meets the financial requirements and provisions of Building Capacity for Transformation Section 115(a) Waiver. 3. To establish financial control policies and procedures, including accounts payable, purchasing and receiving, treasury, accounting, reporting, and audit. 4. To establish and monitor budgets 5. To oversee the preparation of financial reports for external stakeholders and the Executive Committee 6. To advise the Executive Committee on financial issues related to proposed programs for Region 1 7. To review and approve the financial provisions of contracts entered into by Region 1 in fulfillment of Region 1's Project Plans. 8. To review and advise on the adoption of alternative payment models.

C. Work Group Scope:

Describe the scope of the Work Group. The scope establishes the boundaries of the project. It identifies the limits of the project and defines the deliverables.

The Finance Committee serves primarily as a financial control, monitoring and advisory function on behalf of the Executive Committee.

D. Guiding Principles

The efforts of this Work Group will be guided by Region 1 Guiding Principles including:

1. Patient/Client – Family centeredness
2. Transparency
3. Efficiency
4. Respectfully include patient/clients and families
5. Trust
6. Responsibility for the entire community, not a single IDN partner
7. Strive for consensus

(See Region 1 Governance Document for additional details).

E. Work Group Milestones:

List the major milestones and deliverables of the work group.

Milestones	Deliverables	Date
Write committee charter	Charter	complete
Establish fund distribution protocol	Protocol document	complete
Prepare draft budgets	Versioned budget drafts	ongoing
Draft, send and summarize APM survey	Survey, written summary	complete
Prepare Sec. 8 & 9 of the Imp. Pln.	Tables and narrative	complete
Prepare Monthly financial reports	Reports	In process

F. Roles and Responsibilities:

Describe the roles and responsibilities of Work Group members followed by the names and contact information for those filling the roles. The table below gives some generic descriptions. Modify, overwrite, and add to these examples to accurately describe the roles and responsibilities for this project.

Region 1 IDN Finance Committee The Committee serves primarily as a financial control, monitoring and advisory function on behalf of the Executive Committee.

Name	Role
Mark Russoniello	Finance Director, IDN Region 1
<p>Work Group Leader or Co-Leaders: Because the material financial agreement for Region 1 is between DHHS and Dartmouth Hitchcock, which will be the recipient of DISRIP funds, the chairperson of the Finance Committee and the Finance Director will be appointed by Dartmouth Hitchcock. The finance director leads the Finance Committee in the development of the charter, fund disbursement policies, contract financial policies, and establishes the financial control policies and procedures, including accounts payable, purchasing and receiving, treasury, accounting, reporting, and audit. Leads budget preparation.</p>	
Name	Role
Name	Role
<p>Team Members: Committee members commit to actively and consistently participate in meetings. Committee members may also be assigned to review specific projects or requests associated with other Region 1 teams. While each Committee member is associated with specific organizations within Region 1, Committee members have as their first interest the improvement in the health and well-being of Medicaid beneficiaries and other NH residents with behavioral health conditions. Committee will operate on a consensus basis with regard to preparing recommendations to the Executive Committee</p>	
Name	Representing IDN Partner and/or Patient/Consumer/Care Giver
Eileen Fernandes	Cheshire County Public Health Council
John Manning	Southwestern Community Services
Mark Russoniello	Dartmouth Hitchcock Medical Center
Chris Coates	Cheshire County
Debbie Krider	Granite State Independent living
Cathy Sorenson	Home Health Hospice and Community Services
Maryanne Ferguson	Monadnock Collaborative/Pilot Health
Peter Write	Valley Regional Hospital
Ted Purdy	Sullivan County

G. Work Group Governance

All Work Groups report to the Region 1 Executive Committee; the Executive Committee has ultimate accountability for achieving project goals.

The IDN Finance Director is responsible for timely communications between the Finance Committee and the Executive Committee and ensuring Work Group needs are adequately addressed by the Executive Committee. Project plans will be reviewed and endorsed by the Executive Committee.

Work Group membership will be drawn from IDN partner organizations, patients/consumers, and caregivers/families or IDN contracted entities. All Work Groups will have 2 or more positions for individuals representing patients/consumers or caregivers. Work Group composition will strive for balanced geographic representation and include stakeholders who have subject matter expertise and/or will be impacted by Work Group activities. The Executive Committee will work with the Administrative and Executive leadership teams to establish processes for selecting Work Group members.

Work Groups will determine meeting frequency but will be no less than monthly in the first year of IDN operations.

Term Limits/Maximum length of term for Work Group members:

- Term will be two-year period with ability to renew for an additional two-year period. Limit of 2 terms.
- Failure to attend 6 of the 12 monthly meetings in a calendar year may result in termination.
- The Executive Committee will work with a nominations workforce to determine the processes for selection of new members or the confirmation of current ones. This process should be approved by the Executive Committee and the Advisory Council.

Decision making in the Work Group will follow the same procedures as outlined in the Region 1 Governance Document:

Strive for consensus. Use the following scale for consensus assessment:

Levels of agreement

1. I enthusiastically agree!
2. Yes, I agree.
3. I have minor reservations, and generally agree. I will actively support the decision of the group.
4. I have major reservations and would like more dialogue before moving forward.
5. I will actively work against this idea. I do not think it is in our best interest to move forward.

Discussion rule: Discuss, try to resolve reservations for ≥ 3

Decision rule: if everyone 3 or lower à “good enough” consensus, move forward!

If the Work Group reaches an impasse and cannot move forward, the Work Group leader(s) will escalate to the Executive Committee.

H. Signatures

The signatures of the people below document approval of the formal Project Charter. The project manager is empowered by this charter to proceed with the project as outlined in the charter.

Name/Role	Signature	Date
<i>Chair, Work Group</i>		
<i>Chair, Executive Committee</i>		
<i>Administrative Lead</i>		

A. General Information

Work Group:	Data & IT Work Group, Integrated Delivery Network region 1, New Hampshire 1115 Waiver program		
Brief Work Group Description:	The Data & IT Work Group considers and recommends IT investments and projects that can support IDN-1 clinical and operational goals and requirements. The work Group supports IDN-1 decisions with data and analyses.		
Prepared By:	Sally Kraft, Mark Belanger		
Date:	October 25, 2016	Version:	3.0

B. Work Group Objective:

Explain the specific objectives of the Work Group

<p>The objectives of the Data & IT Work Group are:</p> <ul style="list-style-type: none"> • <i>To convene IDN-1 stakeholders that bring technology subject matter expertise, information policy expertise, and wide-ranging perspective (patient & caregiver, technical, clinical, and operational) to the 1115 waiver program.</i> • <i>To consider and recommend IT investments and projects that can support IDN-1 clinical and operational goals and requirements.</i> • <i>To develop strategies for information exchange between IDN partners using IT and guided by input from the State IT Task Force.</i> • <i>To provide processes and standards for data sharing among the partners in the IDN.</i> • <i>To establish IDN policies and procedures related to data collection, data integration, and data reporting.</i> • <i>To provide guidance on the approach to drafting and executing data sharing agreements.</i> • <i>To support IDN-1 decisions with data and analyses including clinical quality measures for operating the IDN and evaluating impact of IDN activities.</i> • <i>To develop reporting and reporting processes for the IDN.</i> • <i>To develop monitoring policies and procedures.</i> • <i>To determine the roles of information technology, health informatics, clinical, and administrative leadership within partner organizations will play on overall data governance.</i>
--

C. Work Group Scope:

Describe the scope of the Work Group. The scope establishes the boundaries of the project. It identifies the limits of the project and defines the deliverables.

The scope of the Data & IT Work Group is defined by the following dimensions:

- *Subject area: The Work Group focuses on the data and information technology aspects of the 1115 waiver project.*
- *Geography: The Work Group is focused on IDN region 1 (though this may expand should the work groups of multiple regions consolidate).*
- *Time: The Work Group is limited to the NH 1115 waiver time period.*

D. Guiding Principles;

The efforts of this Work Group will be guided by Region 1 Guiding Principles including:

1. *Patient/Client – Family centeredness*
2. *Transparency*
3. *Efficiency*
4. *Respectfully include patient/clients and families*
5. *Trust*
6. *Responsibility for the entire community, not a single IDN partner*
7. *Strive for consensus*

(see Region 1 Governance Document for additional details).

Additional principles guiding the work of this specific Work Group include:

- *Make effective and efficient use of IT resources within the state by working across IDNs on technology.*
- *Leverage existing tools and methodologies when possible.*
- *Utilize common resources when possible (contractors, vendors).*
- *Share project plans and technology plans.*
- *Avoid making this an IT project; make it a care project that has a component of technology support.*
- *Utilize the State HIT Task force as much as possible to coordinate and recommend solutions.*
- *Business requirements (“what are we trying to accomplish and how”) drive the technology and data requirements.*
- *Sometimes, simpler is better.*

E. Work Group Milestones:

List the major milestones and deliverables of the work group.

Milestones	Deliverables	Date
M: Convening of Work Group		8/17/16
M: Prioritization of clinical use cases	D: Clinical use case inventory	8/31/16
M: Completion of policy area inventory	D: Policy area inventory for future planning	9/13/16
M: Completion of options for evaluation	D: IT solution options	9/21/16
M: Completion of Environmental Scan	D: Capabilities analysis	9/26/16
M: Completion of recommendation to EC	D: IT solution recommendation	10/5/16

M: Completion of IT project plan content	D: IT sectional content for IDN-1 project plan	10/24/16
M: Completion of IT budget items	D: IT budget items for IDN-1 budget	10/26/16

F. Roles and Responsibilities:

Describe the roles and responsibilities of Work Group members followed by the names and contact information for those filling the roles. The table below gives some generic descriptions. Modify, overwrite, and add to these examples to accurately describe the roles and responsibilities for this project.

Region 1 IDN Executive Committee: Provides overall direction for all Work Groups. Responsibilities include: approve the Work Group charter and plan; secure resources for the project; confirm the project’s goals and objectives; keep abreast of major project activities; make decisions on escalated issues; and assist in the resolution of roadblocks. The IDN Executive Director serves as the main point of contact between the Work Group and the Executive Committee.	
Name	Role
Ann Naughton Landry (starts 11/21/16)	Executive Director, IDN Region 1
Work Group Leader or Co-Leaders: Leads the Work Group through team motivation and maintaining and enhancing relationships with key stakeholders and customers in the planning and development of the project; Responsibilities include: Coordination with the project manager on developing the project plan and deliverables that will meet the requirements of the IDN goals, New Hampshire objectives for this DSRIP project and fulfill CMS requirements, scope control, change management, conflict resolution with other projects, approval of risk mitigation strategies; final signoff on resource deployment and utilization; and organizational communication.	
Name	Role
Mary Beth Eldredge	Co-Chair
Patricia Witthaus	Co-Chair
Sally Kraft	Administrative Lead
Project Manager: Leads in the planning and development of the project; manages the project to scope. Responsibilities include: develop the project plan; identify project deliverables; identify risks and develop risk management plan; direct the project resources (team members); scope control and change management; oversee quality assurance of the project management process; maintain all documentation including the project plan; report and forecast project status; resolve conflicts within the project or between cross-functional teams; ensure that the project’s product meets the business objectives; and communicate project status to stakeholders. The project manager for Region 1 IDN may identify a designee to serve as workgroup project manager.	
Name	Role
Jessica Powell (starts 11/7/16)	Project Manager, Region 1 IDN
Team Members: Works toward the deliverables of the project. Responsibilities include: understand the work to be completed; complete research, data gathering, analysis, and documentation as outlined in the project plan; inform the project manager of issues, scope changes, and risk and quality concerns; proactively communicate status; and manage expectations. Attend and actively participate in Work Group meetings. Team	
Name	Representing IDN Partner and/or Patient/Consumer/Care Giver
Christine Pillsbury	Monadnock Community Hospital

Dave Foss	New London Hospital
Debbie Krider	Granite State Independent Living
George Tremblay	Antioch University New England
Holly Cekala	Hope for NH Recovery
James Stahl	Dartmouth Hitchcock Medical Center
Jennifer Seher	Monadnock ServiceLink
Jerry Hunter	Crotched Mountain Rehab
Jessica Johnson	Dartmouth Hitchcock Medical Center
Justin Bell	Visiting Nurse and Hospice
Kevin Ma	Dartmouth College
Kristen Kneisel	Alice Peck Day Memorial Hospital
Peter Malloy	Cheshire Medical Center
Peter Mason	Retired, multiple stakeholder perspectives
Scott Farr	Dartmouth Hitchcock Medical Center
Shawn Cornell	West Central Behavioral Health
SueEllen Griffin	West Central Behavioral Health
Valerie Kitter	Granite State Independent Living

G. Work Group Governance

All Work Groups report to the Region 1 Executive Committee; the Executive Committee has ultimate accountability for achieving project goals.

The IDN Executive Director is responsible for timely communications between Work Groups and the Executive Committee and ensuring Work Group needs are adequately addressed by the Executive Committee. Project plans will be reviewed and endorsed by the Executive Committee.

Work Groups are led by a Work Group lead or co-leaders (this could be a member of the Administrative or Executive leadership teams). The IDN Project Manager will ensure Work Groups receive adequate support for project management, communicating to the Executive Director if additional resources are required.

Work Group membership will be drawn from IDN partner organizations, patients/consumers, and caregivers/families or IDN contracted entities. All Work Groups will have 2 or more positions for individuals representing patients/consumers or caregivers. Work Group composition will strive for balanced geographic representation and include stakeholders who have subject matter expertise and/or will be impacted by Work Group activities. The Executive Committee will work with the Administrative and Executive leadership teams to establish processes for selecting Work Group members.

Work Groups will determine meeting frequency but will be no less than monthly in the first year of IDN operations.

Term Limits/Maximum length of term for Work Group members:

- Term will be two-year period with ability to renew for an additional two-year period. Limit of 2 terms.
- Failure to attend 6 of the 12 monthly meetings in a calendar year may result in termination.

- The Executive Committee will work with a nominations workforce to determine the processes for selection of new members or the confirmation of current ones. This process should be approved by the Executive Committee and the Advisory Council.

Decision making in the Work Group will follow the same procedures as outlined in the Region 1 Governance Document:

Strive for consensus. Use the following scale for consensus assessment:

Levels of agreement

1. I enthusiastically agree!
2. Yes, I agree.
3. I have minor reservations, and generally agree. I will actively support the decision of the group.
4. I have major reservations and would like more dialogue before moving forward.
5. I will actively work against this idea. I do not think it is in our best interest to move forward.

Discussion rule: Discuss, try to resolve reservations for ≥ 3

Decision rule: if everyone 3 or lower à “good enough” consensus, move forward!

If the Work Group reaches an impasse and cannot move forward, the Work Group leader(s) will communicate with the IDN Executive Director who has the authority to escalate to the Executive Committee.

H. Signatures

The signatures of the people below document approval of the formal Project Charter. The project manager is empowered by this charter to proceed with the project as outlined in the charter.

Name/Role	Signature	Date
<i>Chair, Work Group</i>		
<i>Chair, Executive Committee</i>		
<i>Administrative Lead</i>		

A. General Information

Work Group:	Clinical Governance		
Brief Work Group Description:	Develop the processes to establish evidence based clinical pathways and IDN partner performance.		
Prepared By:	Sally Kraft		
Date:	10/23/16	Version:	1.0

B. Work Group Objective:

Explain the specific objectives of the Work Group

The Clinical Governance Work Group will establish the processes to develop evidence-based clinical care guidelines for behavioral health disorders and the integration of behavioral health and general health. Working with the Region 1 Data and IT Work Group, meaningful measures will be developed to inform care teams of their progress implementing evidence-based care. The Clinical Governance Work Group will monitor performance at the Region- and partner-level, working with IDN partners to identify barriers to implementation and secure necessary resources for improvement.

Recognizing holistic care includes more than clinical therapeutic interventions, this Work Group will also address the non-clinical interventions and supports that are critical in healing for patients and families suffering from behavioral health disorders. Best practices and evidence-based interventions focused on non-clinical care will be evaluated, vetted, and included as recommendations in care model design and implementation.

C. Work Group Scope:

Describe the scope of the Work Group. The scope establishes the boundaries of the project. It identifies the limits of the project and defines the deliverables.

- This Work Group will focus on Region 1 DSRIP attributed population and participants in Region 1 IDN
- The term of this project will be the NH DSRIP Waiver 1115 project term
- Develop processes for evaluating evidence and when evidence is lacking to evaluate best practices regionally or nationally;

- Establish processes to vet and endorse the evidence based knowledge related to care for behavioral health disorders;
- Establish processes to maintain and curate the knowledge base for behavioral health care;
- Develop clinical decision support tools such as clinical guidelines;
- Work with the Data and IT workforce to identify meaningful measures to inform implementation (process metrics) and to communicate performance (outcome metrics);
- Monitor IDN performance in aggregate and at the organization level, identifying opportunities for continuous improvement, facilitating learning amongst IDN partners, and communicating barriers to improvement to appropriate IDN committees.

D. Guiding Principles:

The efforts of this Work Group will be guided by Region 1 Guiding Principles including:

1. Patient/Client – Family centeredness
2. Transparency
3. Efficiency
4. Respectfully include patient/clients and families
5. Trust
6. Responsibility for the entire community, not a single IDN partner
7. Strive for consensus

(see Region 1 Governance Document for additional details).

E. Work Group Milestones:

List the major milestones and deliverables of the work group.

Milestones	Deliverables	Date
<i>To be completed when Work Group convenes</i>		

F. Roles and Responsibilities:

Describe the roles and responsibilities of Work Group members followed by the names and contact information for those filling the roles. The table below gives some generic descriptions. Modify, overwrite, and add to these examples to accurately describe the roles and responsibilities for this project.

Region 1 IDN Executive Committee: Provides overall direction for all Work Groups. Responsibilities

include: approve the Work Group charter and plan; secure resources for the project; confirm the project’s goals and objectives; keep abreast of major project activities; make decisions on escalated issues; and assist in the resolution of roadblocks. The IDN Executive Director serves as the main point of contact between the Work Group and the Executive Committee.	
Name	Role
Ann Naughton Landry (starts on 11/21/16)	Executive Director, IDN Region 1
Work Group Leader or Co-Leaders: Leads the Work Group through team motivation and maintaining and enhancing relationships with key stakeholders and customers in the planning and development of the project; Responsibilities include: Coordination with the project manager on developing the project plan and deliverables that will meet the requirements of the IDN goals, New Hampshire objectives for this DSRIP project and fulfill CMS requirements, scope control, change management, conflict resolution with other projects, approval of risk mitigation strategies; final signoff on resource deployment and utilization; and organizational communication.	
Name	Role
Peter Mason	Leader IDN Medical Director
Project Manager: Leads in the planning and development of the project; manages the project to scope. Responsibilities include: develop the project plan; identify project deliverables; identify risks and develop risk management plan; direct the project resources (team members); scope control and change management; oversee quality assurance of the project management process; maintain all documentation including the project plan; report and forecast project status; resolve conflicts within the project or between cross-functional teams; ensure that the project’s product meets the business objectives; and communicate project status to stakeholders. The project manager for Region 1 IDN may identify a designee to serve as workgroup project manager.	
Name	Role
Jessica Powell	Project Manager, Region 1 IDN
Team Members: Works toward the deliverables of the project. Responsibilities include: understand the work to be completed; complete research, data gathering, analysis, and documentation as outlined in the project plan; inform the project manager of issues, scope changes, and risk and quality concerns; proactively communicate status; and manage expectations. Attend and actively participate in Work Group meetings. Team	
Name	Representing IDN Partner and/or Patient/Consumer/Care Giver
<i>To be determined</i>	

G. Work Group Governance:

All Work Groups report to the Region 1 Executive Committee; the Executive Committee has ultimate accountability for achieving project goals.

The IDN Executive Director is responsible for timely communications between Work Groups and the Executive Committee and ensuring Work Group needs are adequately addressed by the Executive Committee. Project plans will be reviewed and endorsed by the Executive Committee.

Work Groups are led by a Work Group lead or co-leaders (this could be a member of the Administrative or Executive leadership teams). The IDN Project Manager will ensure Work Groups receive adequate support for project management, communicating to the Executive Director if additional resources are required.

Work Group membership will be drawn from IDN partner organizations, patients/consumers, and caregivers/families or IDN contracted entities. All Work Groups will have 2 or more positions for individuals representing patients/consumers or caregivers. Work Group composition will strive for balanced geographic representation and include stakeholders who have subject matter expertise and/or will be impacted by Work Group activities. The Executive Committee will work with the Administrative and Executive leadership teams to establish processes for selecting Work Group members.

Work Groups will determine meeting frequency but will be no less than monthly in the first year of IDN operations.

Term Limits/Maximum length of term for Work Group members:

- Term will be two-year period with ability to renew for an additional two-year period. Limit of 2 terms.
- Failure to attend 6 of the 12 monthly meetings in a calendar year may result in termination.
- The Executive Committee will work with a nominations workforce to determine the processes for selection of new members or the confirmation of current ones. This process should be approved by the Executive Committee and the Advisory Council.

Decision making in the Work Group will follow the same procedures as outlined in the Region 1 Governance Document:

Strive for consensus. Use the following scale for consensus assessment:

Levels of agreement

1. I enthusiastically agree!
2. Yes, I agree.
3. I have minor reservations, and generally agree. I will actively support the decision of the group.
4. I have major reservations and would like more dialogue before moving forward.
5. I will actively work against this idea. I do not think it is in our best interest to move forward.

Discussion rule: Discuss, try to resolve reservations for ≥ 3

Decision rule: if everyone 3 or lower à “good enough” consensus, move forward!

If the Work Group reaches an impasse and cannot move forward, the Work Group leader(s) will communicate with the IDN Executive Director who has the authority to escalate to the Executive Committee.

H. Signatures

The signatures of the people below document approval of the formal Project Charter. The project manager is empowered by this charter to proceed with the project as outlined in the charter.

Name/Role	Signature	Date
<i>Chair, Work Group</i>		
<i>Chair, Executive Committee</i>		
<i>Administrative Lead</i>		

A. General Information:

Work Group:	Region 1 Community Engagement Work Team		
Brief Work Group Description:	Plan and Support Engagement of Patients, Families, Organizations, and Broader Community in the Region 1 IDN.		
Prepared By:	Greg Norman		
Date:	10/23/16	Version:	2.0

B. Work Group Objective:

Explain the specific objectives of the Work Group

<p>Purpose:</p> <ul style="list-style-type: none"> • The workgroup will plan and recommend strategies for engaging patients, families, and organization stakeholders in decisions of the Region 1 IDN. • The Work Group will advise Admin Lead and IDN staff regarding approaches to conducting Behavioral Health Needs Assessments and provide networking assistance with disseminating BHNA surveys and organizing BHNA community discussion groups. • The work group will recommend to IDN staff strategies to more broadly disseminate information about the work of the IDN and to obtain broad community input into its efforts.

C. Work Group Scope:

Describe the scope of the Work Group. The scope establishes the boundaries of the project. It identifies the limits of the project and defines the deliverables.

<ul style="list-style-type: none"> • This Work Group will focus on Region 1 DSRIP attributed population and participants in Region 1 IDN • The term of this project will be the NH DSRIP Waiver 1115 project term • Determine how community input will be received and included in the strategic path of the IDN; • Determine the channels and venues through which input is solicited; • Determine how the communication strategies will continue through the demonstration.
--

D. Guiding Principles:

The efforts of this Work Group will be guided by Region 1 Guiding Principles including:

1. Patient/Client – Family centeredness
2. Transparency
3. Efficiency
4. Respectfully include patient/clients and families
5. Trust
6. Responsibility for the entire community, not a single IDN partner
7. Strive for consensus

(see Region 1 Governance Document for additional details).

E. Work Group Milestones:

List the major milestones and deliverables of the work group.

1. Milestones: Project Plan Phase 1 (July 1, 2016-October 31, 2016)

Disseminate and collect 400+ BHNA consumer surveys
Disseminate and collect 75+ BHNA provider surveys
Assist with recruitment of providers, consumers, and family members to participate in BHNA discussion groups
Ensure participation of consumers and family members in IDN leadership structures
Draft plan for ongoing Community Engagement for IDN Project Plan

F. Roles and Responsibilities:

Describe the roles and responsibilities of Work Group members followed by the names and contact information for those filling the roles. The table below gives some generic descriptions. Modify, overwrite, and add to these examples to accurately describe the roles and responsibilities for this project.

Region 1 IDN Executive Committee: Provides overall direction for all Work Groups. Responsibilities include: approve the Work Group charter and plan; secure resources for the project; confirm the project’s goals and objectives; keep abreast of major project activities; make decisions on escalated issues; and assist in the resolution of roadblocks. The IDN Executive Director serves as the main point of contact between the Work Group and the Executive Committee.	
Name	Role
Ann Naughton Landry (starts 11/21/16)	Executive Director, IDN Region 1
Work Group Leader or Co-Leaders: Leads the Work Group through team motivation and maintaining and enhancing relationships with key stakeholders and customers in the planning and development of the project; Responsibilities include: Coordination with the project manager on developing the project plan and deliverables that will meet the requirements of the IDN goals, New Hampshire objectives for this DSRIP project and fulfill CMS requirements, scope control, change management, conflict	

resolution with other projects, approval of risk mitigation strategies; final signoff on resource deployment and utilization; and organizational communication.	
Name	Work Group Role IDN affiliation
Alice Ely	Co-Leader Public Health Council of the Upper Valley
Greg Norman	Co-Leader Community Health DHMC
Project Manager: Leads in the planning and development of the project; manages the project to scope. Responsibilities include: develop the project plan; identify project deliverables; identify risks and develop risk management plan; direct the project resources (team members); scope control and change management; oversee quality assurance of the project management process; maintain all documentation including the project plan; report and forecast project status; resolve conflicts within the project or between cross-functional teams; ensure that the project’s product meets the business objectives; and communicate project status to stakeholders. The project manager for Region 1 IDN may identify a designee to serve as workgroup project manager.	
Name	Role
Jessica Powell (starts 11/7/16)	Project Manager, Region 1 IDN
Team Members: Works toward the deliverables of the project. Responsibilities include: understand the work to be completed; complete research, data gathering, analysis, and documentation as outlined in the project plan; inform the project manager of issues, scope changes, and risk and quality concerns; proactively communicate status; and manage expectations. Attend and actively participate in Work Group meetings.	
Jonathan Stewart	JSI/Community Health Institute
Aita Romain	Dartmouth-Hitchcock
Liz Henig	Sullivan County
Natalie Nielsen	Cheshire County
Donna Stamper	NAMI-NH
Kevin Ma	Dartmouth College
Holly Cekala	Hope for NH Recovery
Jennifer Seher	Service Link Cheshire/Sullivan
Michele Nuttle	Family Member
Ruth Bleyler	Family Member

G. Work Group Governance:

All Work Groups report to the Region 1 Executive Committee; the Executive Committee has ultimate accountability for achieving project goals.

The IDN Executive Director is responsible for timely communications between Work Groups and the Executive Committee and ensuring Work Group needs are adequately addressed by the Executive Committee. Project plans will be reviewed and endorsed by the Executive Committee.

Work Groups are led by a Work Group lead or co-leaders (this could be a member of the Administrative or Executive leadership teams). The IDN Project Manager will ensure Work Groups receive adequate support for project management, communicating to the Executive Director if additional resources are required.

Work Group membership will be drawn from IDN partner organizations, patients/consumers, and caregivers/families or IDN contracted entities. All Work Groups will have 2 or more positions for individuals representing patients/consumers or caregivers. Work Group composition will strive for balanced geographic representation and include stakeholders who have subject matter expertise and/or will be impacted by Work Group activities. The Executive Committee will work with the Administrative and Executive leadership teams to establish processes for selecting Work Group members.

Work Groups will determine meeting frequency but will be no less than monthly in the first year of IDN operations.

Term Limits/Maximum length of term for Work Group members:

- Term will be two-year period with ability to renew for an additional two-year period. Limit of 2 terms.
- Failure to attend 6 of the 12 monthly meetings in a calendar year may result in termination.
- The Executive Committee will work with a nominations workforce to determine the processes for selection of new members or the confirmation of current ones. This process should be approved by the Executive Committee and the Advisory Council.

Decision making in the Work Group will follow the same procedures as outlined in the Region 1 Governance Document:

Strive for consensus. Use the following scale for consensus assessment:

Levels of agreement

1. I enthusiastically agree!
2. Yes, I agree.
3. I have minor reservations, and generally agree. I will actively support the decision of the group.
4. I have major reservations and would like more dialogue before moving forward.
5. I will actively work against this idea. I do not think it is in our best interest to move forward.

Discussion rule: Discuss, try to resolve reservations for ≥ 3

Decision rule: if everyone 3 or lower à “good enough” consensus, move forward!

If the Work Group reaches an impasse and cannot move forward, the Work Group leader(s) will communicate with the IDN Executive Director who has the authority to escalate to the Executive Committee.

H. Signatures

The signatures of the people below document approval of the formal Project Charter. The project manager is empowered by this charter to proceed with the project as outlined in the charter.

Name/Role	Signature	Date
<i>Chair, Work Group</i>		
<i>Chair, Executive Committee</i>		
<i>Administrative Lead</i>		

7d. [Key IDN Management Roles](#)
See Supplemental Data Workbook 7D Tab

8. Budget and Funds Allocation

8a. Project Design and Capacity Building Funds

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

Project planning and capacity funds will be invested in building the learning infrastructure that will drive project plan decision making and establish a blueprint for ongoing learning and improvement through the course of the DSRIP program. Our success will depend on knowledge of evidence-based and effective best practices, access to accurate data to drive decision making and manage ongoing operations, efficient information exchange, and workforce expansion to meet population need. Data-driven decision making is critical to successful system redesign. Initial funds will be invested in data collection and analysis to understand root causes of the mismatch between demand and supply for care. Our administrative lead has vast knowledge and experience in data collection, warehousing, analytics and reporting. Project design funds will be invested in establishing the IDN data plan that will inform initial project planning and establish capacity for ongoing data analysis to inform IDN operations over the funding cycle.

Efficient and effective information exchange is a fundamental requirement for system performance. Understanding business requirements of the IDN system will ensure accurate decision making around hardware, software, and training needs. The relatively short time frame of the waiver period and funds available for IT solutions will force us to focus on feasible solutions for our project plan; solutions that will be sustainable by IDN partners after 2020. Our initial investments to understand business requirements and secure IT expertise will create the foundation for future IT decisions and implementation.

Understanding current workforce capacity will allow the IDN to design interventions to meet demand. Expanding access to clinical and support services can be accomplished through a variety of strategies but developing those strategies requires an informed understanding of the current state. Consultants will guide the IDN in decision making based on the IDN workforce survey. Long term sustainability will guide all decision making about workforce expansion including strategies for role optimization, improved referral processes to meet needs across network of providers, and innovative service delivery. The current planned use of Project Design and Capacity Building funds is to use these funds for implementation plan development, build out of administrative infrastructure, technology assessment, and initial seed funding for statewide and community projects. Funds not used in year 1, (July 2016 – December 2016) will be spread into future years to fund direct and indirect administrative expenses, with any remaining funds placed into reserve/contingency status with the intent to use these for direct program expenses. At this time, Region 1 does not have enough information to specify the allocation of

funds across the different organization categories, but in the future we will be able to show this as specific contracts are awarded and executed.

Thus, use of Project Design and Capacity Building Funds will be in seven areas:

1. A Behavioral Health Needs Assessment
2. Preparation of the Project Plan
3. Funding to reimburse community participants for their time and participation
4. To develop an Information Technology Assessment
5. Initial seed funding for statewide and community projects
6. To fund five years of compensation for the IDN Administrative Infrastructure, including:
 - 6.1. Full Time Executive Director
 - 6.2. Full Time Program Manager
 - 6.3. Practice Implementation Coaches (2)
 - 6.4. Part Time Finance Director
 - 6.5. Part Time Medical Director
 - 6.6. Indirect expense
7. Amounts not spent in year one will fund \$1.2M in Unallocated Project Design and Capacity Building Expense. Over the following five years of the DSRIP project it is expected that these funds will be used for program expense.

8b. Project Design and Capacity Building Funds: Final Project Estimates

As part of the IDN Application, each applicant IDN was asked to provide preliminary estimates for 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 use the 8B tab of the IDN Project Plan Supplemental Data Workbook to provide final projected estimates for the allocation of Project Design and Capacity Building Funds (please refer to Appendix A for an outline of these tables). IDNs will be required to report expenditures on a quarterly basis, and variances in actual expenditures vs. these estimates will require written explanations.

Period	Q3-Q4 2016	Q1-Q2 2017	Q3-Q4 2017	2018	2019	2020	Total
IDN Project Design and Capacity Funds spent, or allocated to be spent	18%10%	12%	12%10%	25%20%	24%21%	9% 23%	100%100%
	\$66110%	\$453K	\$45310%	\$92310%	\$91811%	\$35713%	\$3,76610%

Allowable Funds Use Category	Projected (or Actual) \$ Allocation, if applicable	
Development of a Behavioral Health Needs Assessment (Actual)	\$62K	2%
Development of IDN Project Plan (Actual)	\$59K	2%
Capacity building for direct care or service provision workforce: <i>Recruitment and Hiring</i>	\$10K	0%
Capacity building for direct care or service provision workforce:	\$10K	0%

<i>Retention</i>		
Capacity building for direct care or service provision workforce:	\$10K	0%
<i>Training</i>		
Core Competency	\$10K	0%
Community Projects	\$15K	0%
Establishment of IDN administrative/management infrastructure	\$2,020K	54%
Health Information Technology/Exchange	\$ 216K	6%
Unallocated Project Design & Building Capacity Funds	<u>\$ 1,353K</u>	<u>36%</u>
Total	<u>\$ \$3,766K</u>	<u>100%</u>

Organization Category	Dollars Allocated, if applicable
IDN Administration	\$ 218K
Primary Care Practices (including hospital-based, independent, etc.)	\$
Substance Use Disorder (SUD) Providers	\$
Community Mental Health Centers	\$
Non-CMHC Mental Health Providers	\$
Hospital facilities	\$
Federally Qualified Health Centers	\$
Community Health Centers	\$
Rural Health Clinics	\$
Community-based organizations providing social and support services	\$
Home and Community-based Care Providers	\$
County corrections facilities	\$
County nursing facilities	\$
Other county organizations	\$
Non-county nursing facilities	\$
Public Health	\$
Other organizations (please describe)*	<u>\$ 443K</u>
Total	<u>\$ 661K</u>

*Region 1 has not yet determined the Organization Category for a portion of the Year One funds. See Region 1's Year One Planned Fund Use, below, for the Region's plans to date.

Building Capacity for Transformation Section 115(a) Waiver		
Region 1		
Year One Planned Funds Use		
<i>in thousands</i>		Year 1
	Development of a Behavioral Health Needs Assessment	\$ 62
	Development of IDN Project Plan	59
	Unallocated Project Design and Capacity Building Funds	50
	<i>Statewide project</i> : Capacity building for direct care	30
	<i>Statewide project</i> : Health Information Technology Exchange	216
	Core competency:	10
	Community projects (proposed for Region 1)	15
		443
	IDN Admin/Mgmt infrastructure/Indirects	218
	Year One Planned Funds Use	\$ 661

8c. 5-year IDN Incentive Funding: Funds Allocation Governance

Please describe:

i. The process and governance rules by which decisions will be made about the distribution of funds earned by IDNs over the course of the demonstration

Region 1 IDN partners have committed to the following principles to guide our distribution of funds earned by the IDN over the course of the demonstration:

1. Optimizing the value of care for our patients/clients (including prevention of illness) is our first and most important goal.
 - Value = $\frac{[(\text{Patient/client experience} \times \text{Quality of care})]}{\text{Cost}}$
 - Our work will be guided by evidence (when evidence exists)
2. Transparency amongst IDN partners
3. Efficient planning process
 - Use existing data and resources whenever possible
 - Leverage existing networks and relationships whenever possible
4. Include patients/clients/families as members of our planning team
5. IDN partners work together in trusting relationships
6. Strive for consensus

Adhering to these principles, allocation of IDN funds will be based on data collected during the project planning and demonstration period. We anticipate revisions to our preliminary budget as project planning progresses.

Region 1’s process, strategic priorities, programs, and broad fund allocations are established and approved by the Executive Committee within the guidelines developed by DHHS. The execution of the strategies and programs is the responsibility of the administrative staff, who plan, execute, and monitor the strategy. Sub-contracts will be awarded to carry out the specific services required to achieve goals. As part of the broader governance process, Region 1 has established a Finance Committee and a financial control plan. Included in our submission are two key financial documents: 1) the charter for the established Finance Committee, and 2) the Region 1 Financial Control Protocol.

The charter of the Finance Committee summarizes its core responsibilities:

- Policy making and fund allocation are the responsibility of the Executive Committee, within the guidelines of the larger DISRIP project. The specific roles of the Finance Committee is:
 - i. To oversee finances for the Region 1
 - ii. To ensure that Region 1 meets the financial requirements and provisions of the Building Capacity for Transformation Section 115(a) Waiver.
 - iii. To establish financial control policies and procedures, including accounts payable, purchasing and receiving, treasury, accounting, reporting, and audit.
 - iv. To establish and monitor budgets
 - v. To oversee the preparation of financial reports for both external stakeholders and the Executive Committee
 - vi. To advise the Executive Committee on financial issues related to proposed programs for Region 1.
 - vii. To review and approve the financial provisions of contracts entered into by Region 1 in fulfillment of Region 1's Project Plan.
 - viii. To review and advise on the adoption of alternative payment models.

Because the material financial agreement for Region 1 is between DHHS and Dartmouth Hitchcock, which is the recipient of DISRIP funds, the chairperson of the Finance Committee and the Finance Director will be appointed by Dartmouth Hitchcock. Dartmouth Hitchcock staff will administer the funds.

ii. The process by which the IDN will develop project budgets and a fund allocation plan

Annually, or as needed, the Finance Committee, under the program approvals and funding guidelines established by the Executive Committee, and in partnership with the Executive Director, will submit an annual budget and multi-year fund projection to the Executive Committee for approval. The process for preparing the budgets will be:

- To reassess current spending levels and fund allocations compared to budget against key goals and targets established by the Executive Committee
- To size new or evaluate current year progress and prepare year end and monthly Forecasts for each program.
- To account for current NH Medicaid population within Region 1
- To assess the impacts of performance and demonstration metrics on funding
- To prepare budget packages for each initiative, detailing project expense life to date, current year spend, and projected remaining funding
- To distribute budget package details to initiative workgroups and obtain next year budget requests
- To consolidate next year's budget requests across all Region 1 initiatives and forecast budget shortfall or overage
- To recommend and communicate adjustments, obtain direction from the Executive Director and the Executive Committee
- To present balanced budget to Committee

iii. The IDN's rationale and justification for this financial governance approach and funds allocation process. In articulating this rationale, please describe how the chosen approach supports in the IDN in successful implementation of its projects and achievement of its performance metrics.

Region 1's approach to financial governance supports the IDN in successful implementation of its projects and goals through a number of important processes. Consistent with accepted practice, policy making and executive functions stand separately from the management and disbursement of funds. The Executive Committee sets policy and chooses programs. The role of the finance function is to assure that financial planning is realistic and fact-based, tied to performance metrics, to ensure that funds are appropriately secured and that the disbursement of funds is based on the Implementation Plan, budgets and contractual agreements approved by the Executive Committee and as executed by the Executive Director. The Finance Committee also monitors ongoing financial performance and risk against project performance metrics. The Finance Committee will also address compliance issues related to fund disbursements. Any issues over use of funds will be brought to the attention of the Executive Director, the Executive Committee, and external parties if appropriate. Contracts executed in support of the various programmatic strategies will contain the necessary compliance, audit and oversight language to ensure that, if necessary, use of funds within any one of the IDN organizations can be audited and pulled back if necessary. Contracts will also contain performance requirements consistent with overall DSRIP performance measurement as well as contract- or program- specific performance criteria. Contracts will have provisions where failure to meet performance requirements will initiate the development of performance improvement plans and, if there is lack of improvement, the ability to terminate of the contract. Additionally, contracts will have provisions that require payback of funds should contractors prematurely terminate agreements.

8d. 5-year IDN Incentive Funding: Funds Flow to Shared Partners

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.

The primary control for this requirement at the beneficiary level will be through specific language in subcontract award agreements that will require the awardee to develop protocols to guard against duplicate payments to the same beneficiary for the same service on the same date. These activities will be auditable by representatives of the Finance Committee, with take-back provisions included in the contract. This contract language will need to be coordinated with the terms of agreements executed for other DSRIP regions to prevent cross-regional duplicative payments.

At the institutional and contract level, the Finance Committee has established a Financial Control Protocol to provide oversight over the funds disbursement process. This protocol defines the process for awarding subcontracts, approving payment requests, and the types of expenses that may be reimbursed. The Finance Committee will receive monthly reporting of expenditure details for their review, prior to presenting financial information to the Executive Committee.

In addition, as the Region 1 administrator, all disbursements flow through the accounting system and process controls established and maintained by Dartmouth-Hitchcock for all of their grants, both federal and state. These controls include, but are not limited to:

- Review of Funds Availability prior to Disbursement
- Duplicate invoice edit
- Manual Comparison and Review of Invoice to check

- Use of Project Number for each Award that includes a geographic site designation.

Because the Region 1 covers the 61 specific cities and towns within Monadnock, Sullivan counties and the Upper Valley, the three selected Community Projects services are expected to be confined to these same 61 cities and towns. Disbursements for services outside the Region will receive additional scrutiny. Statewide project disbursements will generally be expected to be coordinated and controlled by the applicable state workgroup.

9. Alternative Payment Models (APMs)

Please provide a narrative describing at a high-level the current use of APMs among IDN partner organization, delineated by payer type (Medicaid, Medicare, Commercial, Other). 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. Please include estimates for the % of provider payments currently made through APMs to provider organizations within the IDN by payer type

Region 1 conducted a survey of its members about their participation in Alternative Payment Methods (APM'S) using a tool that was designed by the Finance Director with input from the Finance work group and the Executive Committee. The survey tool was given to all Region One partners with request to complete based on their experiences with APM if they have a traditional insurance-like arrangement or for our partners who do not bill insurances, provide some basic information on the number of clients served and description of payment arrangements.

As a general matter, APMs are very challenging to classify into uniform categories, particularly across providers types with very different missions. Every arrangement has unique characteristics, and a brief survey cannot capture the range of APM nuances. With this understanding, the survey had several key findings. First, the survey showed large variances in the scale of services offered. Dartmouth Hitchcock and Cheshire Medical Center have by far the greatest volume of patients. Other providers have patients in the few thousands or hundreds. Dartmouth Hitchcock has the largest volume under APMs. Its APM arrangements are primarily in the commercial market. These models use underlying FFS as the basis to calculate total cost of care, including MH/SUD care, with the opportunity to share in savings generated, or to accept liability for sharing in deficits if the actual claims costs exceed the expected cost of care in any given performance year. Each of these risk models includes both a cost and quality component, meaning that eligibility to share in any cost savings generated is dependent upon performance against established patient safety and process/outcomes measures. About 15% of patients fall under this type of APM. Dartmouth Hitchcock also has small pay for performance arrangements under managed care Medicare and Medicaid. Region One's two community mental health centers, West Central Behavioral Health, and Monadnock Family Services, have experience with population-based capitation payments under Medicaid managed care. Up to 75% of Medicaid patients are reported to have been under such an arrangement. The only other arrangement reported was a per diem rate for housing services. All other Region 1 IDN participants reported FFS payment arrangements with a sprinkling of grant funding, county or town funding, and free services.

10. Project A1: Behavioral Health Workforce Capacity Development

10a. IDN Workforce Project Lead and Participants

See Supplemental Data Workbook 10A Tab

10b. Narrative describing the critical workforce capacity challenges facing the IDN

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.

The Kaiser Family Foundation designates NH overall as having a sufficient number of Mental Health providers, while simultaneously identifying *twenty* Mental Health Professional Shortage Areas within our boundaries (<http://kaiserf.am/2d4pQDD>). This reflects the discrepancy in workforce adequacy between rural and urban areas, with rural, low income patients dramatically underserved.

In assessing the BH workforce, it is helpful to distinguish between specialty BH settings (such as CMHCs and Substance Abuse service organizations), and BH services delivered within primary care settings. Most BH workforce needs assessments have focused on specialty settings, whereas approximately 75% of people with diagnosable mental health or substance abuse disorders present only in primary care (Blount, 1998), where they are often more open to addressing their mental health and substance abuse problems. Placing BH clinicians directly in primary care has been implemented mostly in settings serving patients with the most acute BH needs, including safety net health clinics such as FQHCs and Rural Health Clinics. While the primary care BH workforce has not been studied with the same precision as the specialty BH workforce, we do know that retention is improved in integrated practices (citation). At the same time, integrated primary care demands targeted training to help all involved staff design and deliver effective, interprofessional, patient-centered care (Hall et al., 2015).

The NH Community Behavioral Health Association has been compiling statewide data that can inform our understanding of recruitment, hiring, training and retention challenges in specialty BH settings serving the Medicaid population. According to the NH CBHA's most recent data, CMHCs in New Hampshire are truly struggling. Recruitment is particularly challenging, with 173 open positions in August of this year, and an average of 158 unfilled positions open over the last six months. Vacancies are spread proportionally across the various roles in the BH workforce: prescribers (MDs and APRNs), therapists (masters and doctoral clinicians), case managers and others. The average time required to fill an open position is 113 days. This means that other staff members are habitually overworked covering the caseloads that should be assigned to the unfilled positions. Hiring is challenging because CMHC salaries are dramatically below market levels: Masters-level staff at CMHCs, for instance, earn 35-57% below similarly credentialed workers in other settings, so CMHCs are not competing well for the most qualified and skilled professionals. Low pay and understaffing, in turn, contribute to an annual turnover rate of about 19% of the CMHC workforce.

Turning to safety net health settings, a recent survey commissioned by the NH Endowment for Health and completed by Antioch University's Center for Behavioral Health Innovation, assessed the various behavioral health roles in primary care and estimated demand trajectories for these roles. Survey responses suggested 4 broad roles that contribute to behavioral health treatment in primary care: primary care clinicians (physicians, PC APRNs and PAs), behavioral health clinicians (masters and doctoral level licensed mental health and substance abuse clinicians), "care enhancers" (a wide array of

roles such as care manager, care coordinator, navigator, patient educator, health coach, filled by nurses of varying degrees, social workers with bachelors and masters degrees, medical assistants and workers with other bachelors degrees), and consulting psychiatric clinicians (psychiatrists and APRNs). There is data suggesting that these same roles are implicated across the system of care, such that enhancing the capacity for these functions could support integration across institutions, with sufficient systemic care protocols.

Survey respondents reported their most urgent workforce need is for BH clinicians who can offer mental health and substance abuse services. Extrapolating from the 65 existing positions reported by the 71% of safety net clinics who responded to the survey, we estimate that there are currently approximately 92 BH clinicians working in NH's safety net clinics. The clinics report an immediate desire for 60% more clinicians than they have, and estimate needing approximately twice the current supply in 5 years. Given that these clinics serve just under ½ of NH's Medicaid patients, a minimal estimate of the current need for BH clinicians to serve the full Medicaid population would be about 200, and a 5 yr projected need approaching 400. Region 1's share of that growth, extrapolating from our portion of the Medicaid population (just under 15%), would translate to an additional 30 or so BH clinicians over the next 5 years.

10c. 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

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.

The most important functions that Region 1 seeks to support with additional workforce capacity are care coordination and integration across the care system. Coordination involves sharing a standardized health plan with clear delegation of activities so everyone is operating at top of licensure and skill set; working as a team on behalf of a patient, even though medical, behavioral health and social professionals may be working in different organizations. The minimum level of coordination that would be worthy of the name, would involve behavioral health and medical settings sharing diagnoses/problem lists and medication lists, and sharing critical information with social services agencies such as housing or others as appropriate. This sharing should impose minimal burdens and delay to obtain releases; an MOU or release to permit sharing should be routine. The organization that was the object of a referral for the patient would automatically inform the referring organization at the first visit. Finally, there would be a structured way for clinicians and representatives of social services agencies to meet, in the few complex cases for which routine exchange of information is not sufficient for coordination of care.

Integration of care involves minimizing the burden on patients of navigating across multiple professions, agencies, and appointments, to receive the care they need. Integration can be addressed through multiple strategies. The highest levels of integration are achieved with interprofessional care teams working together in a primary care setting to seamlessly address BH and medical needs, referring out to specialty care in both domains as needed. Other models of integration involve varying degrees of collaboration across social service, medical and specialty BH settings, perhaps with the addition of "patient navigator" roles, either to provide direct assistance to patients (patient-level navigator), and/or

to monitor and adjust systemic processes to facilitate ready access and transfer among nodes of care (systems-level navigator).

Whatever configuration of coordination and integration strategies are adopted, training of care providers of all types, and technical assistance to help the care system develop, adapt, and improve innovative approaches to integration are likely to be critical to our success. Our workforce aspirations include empowering patients and their families with education and self-management skills to manage these chronic diseases. We will need to look for varied ways to deliver training to diverse audiences across different institutional and community settings. We will need to tie the curriculum to the development of practice improvement, monitoring methods and financial models to support it, including the training of the back office personnel on the clinical models approach and needs as well as of the clinical teams on the implications and needs of different care payment models. Region 1 is fortunate to have multiple resources for training and developing the BH workforce, including two academic centers with relevant expertise (Geisel School of Medicine at Dartmouth College for medical providers and staff; and Antioch University New England for training of clinical psychologists, marriage and family therapists, mental health counselors, and a new certificate program in substance abuse treatment); plus a network of sites that could supply experiential training. Trainees drawn to the region for the academic programs, are much more likely to remain if they become connected to potential employment opportunities during their training. The expense of providing experiential training is often underestimated, because although trainees receive low pay or no pay for the work that they do, the costs for the host organization to provide supervision can be substantial, and reimbursement for services delivered by trainees is often constrained. In order for training placements to be stable (and therefore attractive to students), revenue other than billing needs to be provided to the community sites or primary care practices. Where training is stable, participating as faculty in a training program has a significant positive impact on staff retention.

Beyond regionally located training opportunities, other existing resources in on-line training programs should be made available in Region 1 and beyond through a Technical Assistance Center/Program. This is a prime opportunity for resource sharing across all of the IDN regions in the State, perhaps supported by the DSRIP Learning Collaborative anticipated in the State's 1115 Waiver application. We see the enhancing of both the specialty and primary care BH workforce as requiring training and technical assistance in best practices for clinical programming and for administrative support of the clinical work. Clinical best practices developed by or identified by a technical assistance center can be the backbone for creating flexibility and improved care in our system (Kilbourne et al., 2007; Kraft et al., 2014).

References

Blount, A. (1998). *Integrated Primary Care: The Future of Medical and Mental Health Collaboration*. New York: W. W. Norton. pp 1-43.

Hall J., Cohen D.J., Davis, M, Gunn, R., Blount, A., Pollack, D.A., Miller, W.L., Smith, C., Valentine, N., Miller, B.F. (2015). Preparing the workforce for behavioral health and primary care integration. *Journal Of The American Board Of Family Medicine*, 28, S1, S41-51.

Kilbourne, A., Neumann, M., Pincus, H., Bauer, M., and Stall, R. (2007). Implementing evidence-based interventions in health care: Application of the replicating effective programs framework. *Implementation Science*, 2. doi:10.1186/1748-5908-2-42

Kraft, S., Carayon, P., Weiss, J., and Pandhi, N. (2014). A simple framework for complex system

improvement. *American Journal of Medical Quality*, retrieved Aug 10, 2016 from:
<http://ajm.sagepub.com/content/early/2014/04/09/1062860614530184>. DOI:
10.1177/1062860614530184.

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

11a. IDN HIT Lead and Participants

See Supplemental Data Workbook 11A Tab

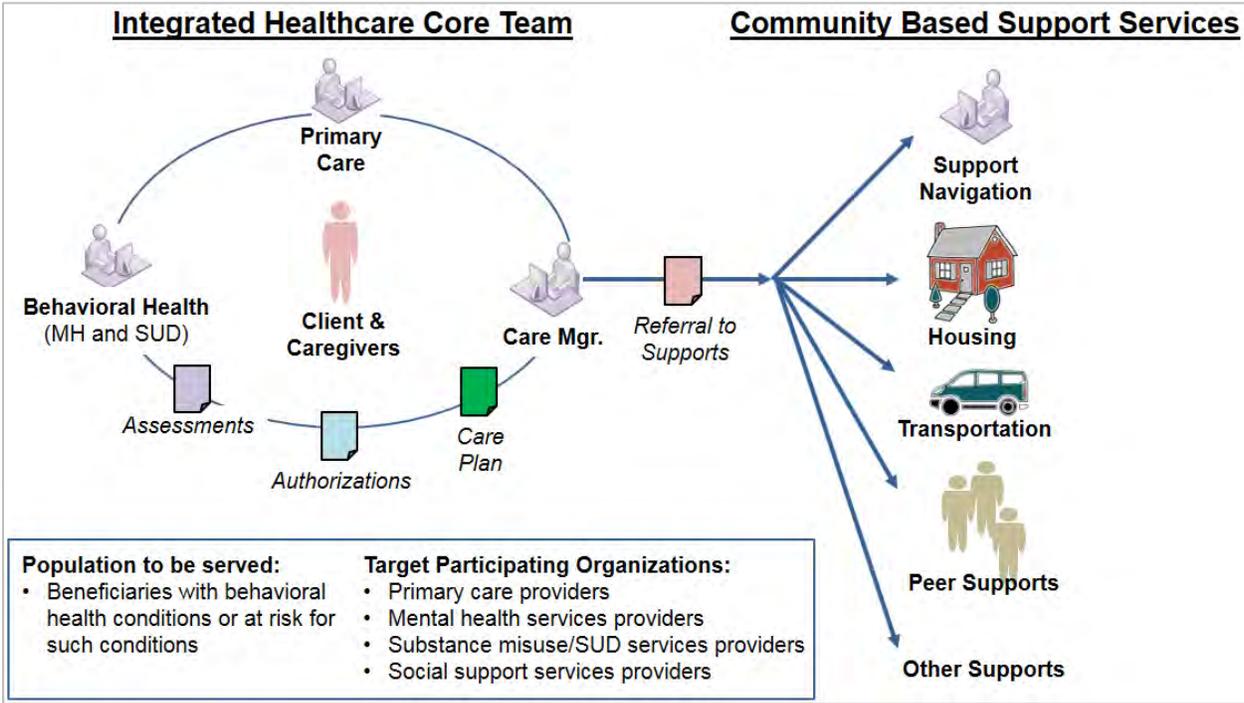
11b. Narrative describing the IDN’s critical HIT gaps

Throughout August and September 2016 IDN-1 conducted parallel planning efforts to select community projects and to determine HIT capabilities and gaps. The methodology was to assess capabilities and gaps relative to information requirements of the IDN’s selected projects. The following analyses was led by the IDN-1 Data & IT Workgroup and accepted by the IDN-1 Executive Committee.

Establishing high level requirements to guide capabilities and gaps assessment

The following exhibits illustrate the selected IDN-1 projects and their high level information requirements:

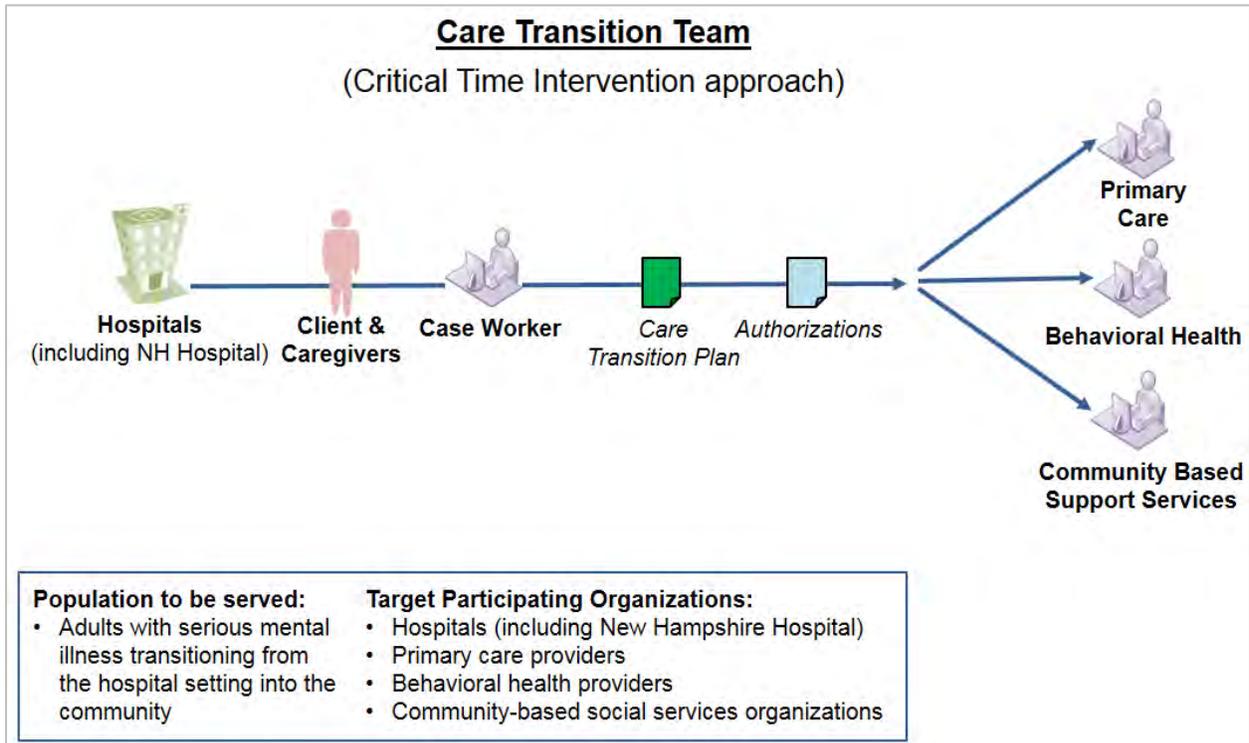
Figure 1: Projects B1 and E5 - Integrated Healthcare and E5 - Enhanced Care Coordination for High-Need Populations



The high level information requirements for Projects B1 and E5 are as follows:

1. Document and share *standardized assessment results* among core team
2. Document and share *care plan* among core team
3. Document and manage *patient privacy preferences and authorizations* among core team
4. Locate and send *referral to Community Based Support Services* with support services provider(s)

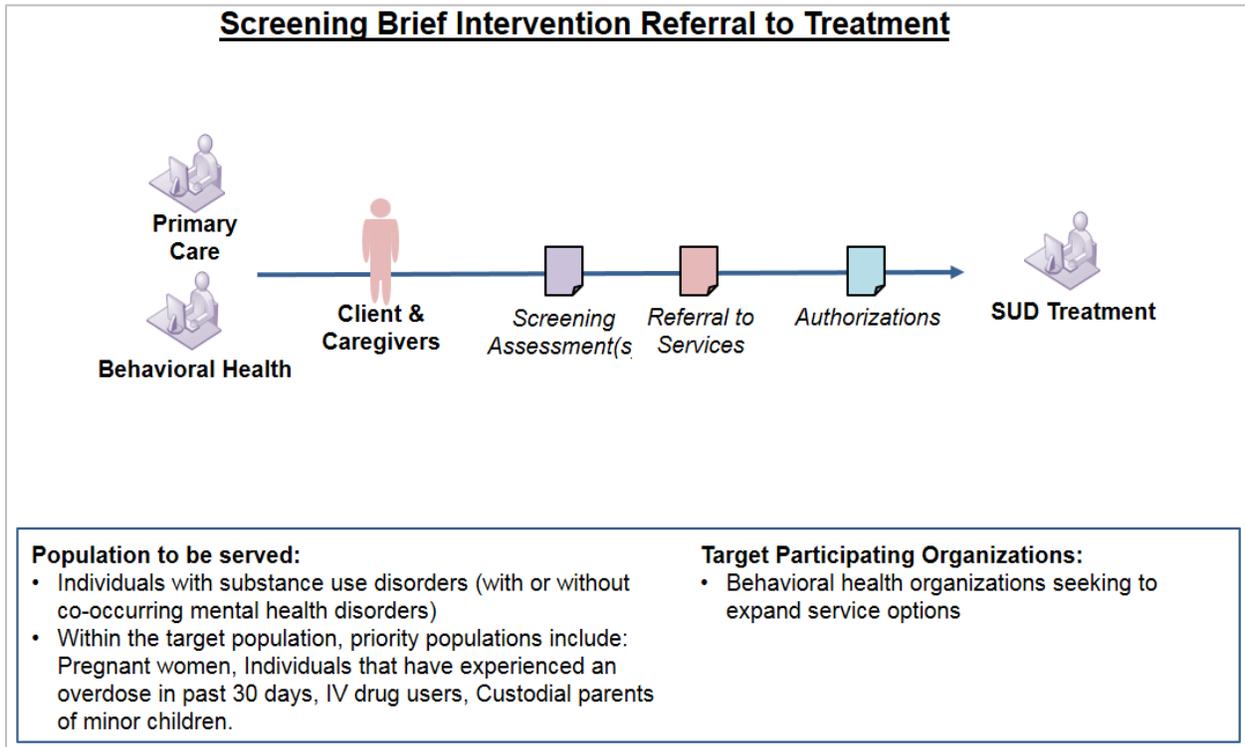
Figure 2: Project C1 - Care Transition Teams



The high level information requirements for Project C1 are as follows:

1. Locate and engage care transition team with patient and caregivers (note: Deeper integration than traditional referral to services)
2. Document and share *Standardized Care Transition Plan* among care transition team
3. Document and manage *patient privacy preferences and authorizations* among care transition team

Figure 3: Project D3 - Expansion in intensive SUD Treatment Options



The high level information requirements for Project D3 are as follows:

1. Support *Screening Brief Intervention Referral to Treatment (SBIRT)* process
2. Document and share *standardized assessment* results
3. Document and manage *patient privacy preferences and authorizations* among care team

Assessing Capabilities and Gaps

Throughout September 2016 IDN-1 conducted a capabilities and gap analysis of the partner organizations that are patient/client facing. 26 organizations were assessed through survey and interviews. The following exhibit is a high level dashboard of current capabilities and gaps across the IDN followed by assessment details:

Figure 4: IDN-1 Dashboard of HIT Capabilities and Gaps

Capability	ANT	APD	CMC	CMSH	CVTC	DHMH	GSIL	HR	HHH	H4NH	KH	MCS	MCVP	MBTC	MCH	MFS	NAMI	NLH	SER	SLNK	SCS	SULL	TLC	VRH	VNH	WCBH
Hardware	G	G	G	G	G	G	G	G	G	G	G	G	G	G	G	G	G	G	R	G	G	G	G	G	G	G
Internet Connectivity	G	G	G	G	G	G	G	G	G	G	G	G	G	G	G	G	G	G	?	G	G	G	G	G	G	G
Work Management Applications	Y	G	G	G	G	G	Y	Y	G	R	Y	R	R	Y	G	Y	Y	G	R	Y	Y	Y	Y	G	G	G
Interorganizational Hand-offs and Records Management	R	Y	G	Y	R	G	Y	R	G	Y	R	Y	R	Y	G	Y	R	G	R	Y	R	Y	R	G	Y	Y
Consumer/Patient Record Disclosure	G	G	G	G	G	G	G	G	G	G	?	G	G	G	G	G	G	G	?	?	G	G	G	G	G	G
Experience with Electronic Systems	Y	Y	G	G	G	G	Y	Y	G	Y	G	Y	R	Y	G	G	Y	G	R	G	G	Y	Y	G	G	G

Capabilities in place:

1. Basic hardware (e.g., Desktops, laptops, mobile devices) are in place across most respondents
2. Internet connectivity is in place across most respondents both in office and remote locations

3. Disclosure processes and authorization forms are largely in place with the IDN organizations that handle Personal health information (PHI) (Note: The projects bring new levels of integration and disclosure complexity that will be solved for in the next phase)
4. Experience with electronic information systems is relatively deep across respondents

Gaps to address:

1. Inter-organizational handoffs and records management is the primary capability gap across respondents
 - a. 10 organizations have electronic channels in place for information exchange (via Direct secure messaging, view only access to hospital EMRs, and inter-vendor channels)
 - b. Active use of electronic channels for information exchange is in its infancy
 - c. The majority of information exchange occurs through fax, phone, mail or via the patient/client themselves
2. The functional capabilities of the work management applications (e.g., Electronic Health Records, Customer management systems) varies widely across respondents.
 - a. 27 different applications are in use among the IDN-1 organizations
 - b. 15 of the applications in use are certified electronic health record technologies (CEHRTs) while 6 are not CEHRTs
 - c. Several non-medical applications are in place for managing customers and workflow for organizations addressing social determinants of health including applications for managing housing, independent living, and transportation.

11c. Narrative describing the IDN's plan to address critical HIT gaps

Throughout September and October 2016 the Data & IT Workgroup developed a HIT strategy to support the information requirements of IDN-1. The following strategy was accepted by the IDN-1 Executive Committee.

Starting with guiding principles and an understanding of budget and timing constraints

IDN-1's Data & IT Work Group began with agreement to a set of guiding principles suggested by Dr. Peter Solberg, CMIO, Dartmouth Hitchcock:

- Make effective and efficient use of IT resources within the state by working across IDNs on technology.
- Leverage existing tools and methodologies when possible.
- Utilize common resources when possible (contractors, vendors).
- Share project plans and technology plans.
- Avoid making this an IT project; make it a care project that has a component of technology support.
- Utilize the State HIT Task force as much as possible to coordinate and recommend solutions.
- Business requirements ("what are we trying to accomplish and how") drive the technology and data requirements.
- Sometimes, simpler is better.

The group was also advised on the limited budget available to the state for the 1115 waiver and the project timeframes. This information made it clear to all that the strategy needs to be highly practical and quick to implement.

Recommending IT Solutions to address IDN-1 gaps

The following are the 5 IT solutions identified to address IDN-1 HIT gaps:

Figure 5: IT Solutions to Support NH 1115 Waiver

Solutions (non-exclusive)	Description
1 Shore up EHRs and work applications	Set and meet capability thresholds for EHRs and work applications.
2 Interconnect orgs. through multiple pathways	Promote connection and active use of Direct Messaging, DH-Connect, and EHR vendor inter-vendor connectivity solutions.
3 Role out Shared Care Plan (with alerts)	Implement <i>Pre-Manage Community</i> solution which includes a shared care plan and event notification service.
4 Actively use existing service locators	Promote active use of the data assets currently in place for location of services organizations.
5 Implement capacity management tools	Implement simple system(s) to support IDN-wide capacity transparency and management.

Solution 1: Shore up work applications

Set capability thresholds (minimum, desired, optional) for IDN-1 organizations. Divide into two types of services organizations:

1. Primary Care, Behavioral Health, and Care Management Organizations that are central to IDN-1 projects
 - a. Project B1 and E5 “Integrated Core Teams”
 - b. Project C1 Hospitals and “Care Transition Case Workers”
 - c. Project D3 Behavioral Health organizations expanding intensive SUD treatment
2. Organizations that provide Community Based Support Services for IDN-1 projects

Provide technical support services to help organizations meet capability thresholds

Provide capital to offset investments in HIT infrastructure (budget dependent).

Solution 2: Interconnect organizations through multiple pathways

Promote connection and active use of interoperability solutions. Choose from the most viable available solutions based upon use case requirements, EHR vendor constraints, and trading partners. Remain flexible and evolve with the capabilities of the vendors.

Inter-organizational solutions:

- Direct Messaging services supported through a range of solutions vendors:
 - New Hampshire Health Information Organization (NHHIO)
 - Native EHR connection

- DSM Connect Device - interface engine connection
- Secure, Encrypted Webmail
- EHR based Health Information Services Providers (HISPs)
- DH-Connect services for authorized view of patient record within Dartmouth Hitchcock Epic system
- EHR vendor inter-vendor connectivity solutions (e.g., Commonwell, Carequality)*
- Secure texting service(s)

Solution 3: Role out Shared Care Plan (with alerts)

Implement Pre-Manage Community solution. This product includes a shared care plan and event notification service.

- Solution may be used for inter-organizational shared documentation/communication
 - Project B1: Shared Care Plan
 - Project C1: Care Transition Plan
- Solution provides event notifications including patient disposition and chief complaint.
- Solution provides statewide enterprise master patient index and patient matching.
- Solution is designed to solve common Emergency Department issues:
 - Provide critical information at ED to help ED staff redirect patients to a more appropriate care setting
 - Provide critical information to aid ED staff in appropriate treatment for individuals with history of substance abuse
- The service has been vetted at the state level through NHHIO.

Solution 4: Actively use existing service locators

Promote active use of the data assets currently in place for location of services organizations.

- NH Alcohol and Drug Treatment Locator (<http://nhtreatment.org/>)
- Refer Web - Servicelink Community Resource Directory (<http://www.referweb.net/nhsl/>)
- NH Easy – Gateway to Services (<https://nheasy.nh.gov/#/>)
- NH Peer Support by region: (<http://www.dhhs.nh.gov/dcbcs/bbh/peer.htm>)
- 2-1-1 New Hampshire and <http://www.homehelpnh.org/> for housing assistance
- Monadnock Regional Council for Community Transportation (<http://monadnockrcc.weebly.com/need-a-ride.html>) (other regions <https://www.nh.gov/dot/programs/scc/rcc.htm>)
- Coordinated access points

Solution 5: Implement capacity management tools

Implement simple system(s) to support IDN-wide capacity transparency and management.

Specifically implement tools to track:

- Current capacity (e.g., Available beds for intensive SUD treatment)
- Wait times
- Patients waiting in ED for placement

IT solutions to IDN operations and reporting

Additional solutions will be required to operate the IDN and to periodically report progress. These IDN “back office” functions will be supported by extending the current IT systems of the IDN participants where possible and through new solutions where current solutions are insufficient. Back office functions to be supported include:

- Partnership arrangements and contracting
- Financial management, revenue distribution, and cost accounting
- Clinical quality measurement and reporting
- Governance management
- Business communications

12. Project B1: Integrated Health (Core Competency)

12a. Current-state assessment of network

See Supplemental Data Workbook 12A Tab

12b. Participating Organizations and future-state goal (Coordinated Care level or Integrated Care level)

See Supplemental Data Workbook 12B Tab

12c. Monitoring Plan

Describe what indicators the IDN will use to manage day-to-day performance and understand in real time whether it is on the path to improving broader outcomes.

The Integrated Care work will begin in earnest with a standardized approach to care model design and improvement, informed by input from the IDN Clinical Governance, HIT/Data, Finance and Community Engagement Work Groups. Process and outcomes measures for assessing IDN performance have already been selected by DHHS.

Additional measures will need to be developed to provide rapid feedback on performance that will allow IDN partners to rapidly respond with iterative cycles of improvement. The HIT/Data Work Group will be tasked with creating guiding principles for developing performance measures and working with IDN partners to create collection and reporting processes that are efficient. These metrics can only be created as the Clinical Governance and Integrated Model Work Groups are formed.

Developing a parsimonious set of performance measures to monitor IDN activity in ‘real time,’ will require thoughtful input from all Work Groups and the implementation teams. We anticipate measures that capture the following domains of care will be critical for managing performance:

- Access to services, including timeliness and availability to the appropriate level of service;
- Quality of communication amongst providers and between providers and patients/clients;
- Patient/client experience and confidence managing their health conditions;
- Completeness of care plans (see below)

Measures for these domains need to be developed and collection and reporting processes created.

Given our full commitment to person-centered care, our IDN proposes using a set of performance metrics related to a person-centered care plan that measures the quality of care integration.

We strive to develop and implement models that guide care delivery and improve health outcomes. Successful care integration needs to address social determinants of health such as housing, education attainment or work. Those providing care must be competent in aligning services, activities, resources and supports around a single plan of care, and the integrated delivery system should be designed to support that approach. Payment of services should be designed to facilitate the easy flow of information and services that create high value, holistic care.

A central tool for addressing gaps in care and recruiting patients’ active engagement in their own health is the Person Centered Care Plan (PCCP). Key principles of this approach include communication across

an integrated care team, and placing the person at the center of that team (“Nothing about me, without me”). The PCCP is negotiated with the person, written in language that is understandable and acceptable to the person, and signed by the person.

The design of the PCCP will be one of the first elements in the implementation of the program and will be done with primary care providers, BH providers, care managers, social services liaisons, and patient/client representatives at the table. It will be informed by the literature on PCCPs (e.g., Council, Geffken, Valeras et al., 2012; Chunchu, Mauksch, & Pauwels, 2012). The plan template will incorporate permission to communicate, as designated by the person, between those person(s) who provide service to the patient/client. It will incorporate a current problem list, including relevant social determinants, diagnoses, and a current medication list. It will specify steps to be taken in the event of a deterioration or crisis in the person’s life, with defined triggers for reviewing the plan. It will have a set of goals for improved health and functioning set by the person (in consultation with the team), and a set of goals for health and management of illness set by the team (and communicated to the patient/client). This would allow for definitions of improved health from an individual’s and provider’s point of view

The PCCP needs to be simple and easily understood. Parsimony in descriptions and goals will be crucial. It should be available to all clinical and social service providers, as well as to the patient/client and their designees. The plan should be reviewed and updated as needed at primary care, behavioral health or social agency visits.

The care manager for each person must be designated, but care management is a function, not necessarily a position description. Any member of the team - PCP, psychiatrist, behavioral health clinician, social agency personnel, someone with a job title of care manager, or a properly trained family/community member - can take that role. The care manager will ensure that the person is a partner in discussion of all domains listed in the standardized assessment, and that the PCCP records as brief a summary as can express the elements the person would like to share with the team.

Metrics describing the utilization of the Person-centered Care Plan (PCCP) will provide performance information to care teams and IDN management systems. The feasibility of collecting and reporting PCCP-related metrics is as yet untested, however these measures reflect person-centered care. Importantly, provider assessment of the value of this tool will provide important information for ongoing improvement.

Indicator	Source	Administration	Reporting
Process Measures			
Number and % of persons with PCCPs completed	IDN Project records	Ongoing	Quarterly
% of PCCPs that patients/clients were involved in creating and signed			
% of self-identified goals that were accomplished by the patient/client			
% care team rating the PCCP as an important tool in serving/providing care			

12d. Expected Outcomes

Expected Outcomes. Please describe the anticipated outcomes of this project in relation to the care gaps identified as part of the IDN's Service Area Community Needs Assessment.

The integration needed to meet the care gaps identified in our Community Assessment can be conceptualized at three nodes: the *integration of systems* of organizations; the *integration of teams* of care; and the *integration of patients* into leadership roles in their own health and healthcare. Each element of the design of the integrated system will have potential impacts at all three nodes. Table 12.1 depicts indicators of integration success across these three nodes, for multiple system functions.

Table 12.1 Gaps in Care and Expected Outcomes: Integration at Person, Team, and System levels.

INTEGRATION ELEMENTS NOT CURRENTLY IN PLACE THROUGH OUR NETWORK	EXPECTED OUTCOMES		
	SYSTEM	TEAM	PERSON
<i>System Level Gaps</i>			
Universal Release	Accepted by all partner organizations	Simple script about working together for better care lets all know how to describe it	6th grade reading level, quick to execute
Secure email	All info can be shared by email	Communicating with patients is part of work time	Person portal with email access to providers
Referral forms	Can be emailed, includes med and problem lists	Clear to referral destination what change would count as success	Signed by person wherever feasible, lists person's strengths or resources
Standard Assessment	Once done, not repeated in new settings within next year.	Balance between breadth and relevance, can be done in 15 minutes	Up to 3 meetings before completed, to promote engagement of patient
Person Centered Care Plan	Easily accessible across settings, comes up on EMR, or paper record	Substantial training in how to use w/o adding time, some latitude in decision to use, PCP/team assessment and recommendations	Expresses person preferences to system: Who can share info, choices about treatment, info about pt that s/he wants team to know

Ongoing work on Coordination	Regular mtg among administrative group to address network coordination issues	Reducing clinician administrative work is a stated goal and test of suggested changes	Patients with positive experience of integrated care on admin group
Ongoing meetings across agencies about complex patients	Relevant Medical, social and BH expertise at each meeting	Release from direct care for the subject's PCP, BHC and CE for meeting time	Commitment by professionals to learning to involve the patients in these meetings
Each agency can fund time for BH or medical consultation and has arranged the relationships	Agencies taught how to bill for consultation time and use 1115 funds to make up the difference	Both the consulting professional and the consultant can count consultation as care time.	Person can be part of conversation with consultant; assessment and consultation one process where possible
<i>Team Level Gaps</i>			
Administrators support integration as core part of the mission	Integration of BH is articulated as crucial element of core mission	Whole team is helped with how to discuss BH topics in a way that is engaging to patients	Patients experience regular conversation and materials addressing "stress" as part of health. Behavioral issues clarified as core to PCMH
Definition of roles within the organization is clear but flexible.	Roles are not discipline dependent.	Functions do not adhere only to roles: everyone does some care management in their role and care manager helps them (prepares lists of resources)	How each role can help is clearly spelled out
Training for Integrated Care expected and available to all roles	Health and social services systems recognize that integrated care requires training for all roles	Training includes practice in developing new workflows to fit integrated team and protocols	Patients/clients recruited as community health workers have easy access to training in the role.
Designated time for discussion of complex cases	BH, PCP, and social services personnel in meetings about complex cases ensures best expertise supports all care	Staff are spared the frustration of "more of the same" ineffective approaches, feel supported by best expertise.	Patients who are engaging poorly or are at risk from ineffective usage patterns get the expertise of system to re-think system's approach to them

Workforce support and development a core value.	Systems use their sites to develop the workforce for the future; offers clearly articulated paths for career development	Team experiences each other as growing over time and potentially future leaders. Learning is basic to the mission.	Adequate workforce to provide the array of services patients need.
---	--	--	--

Person Level Gaps

Education about integrated care	Brochure part of IDN communication to all patients	Language describing care across settings useful to all team members as scripts for offering services	6 th grade reading level. Explains what persons can ask for or decline
Person signs PCCPplan	% of signed treatment plans is a measure of person centeredness	Team trained in language for treatment plan that person can understand. Tx plan can be used by team even if person doesn't sign.	Expresses person preferences to system: Who can share info, choices about treatment, info about pt that s/he wants team to know.
Team trained in activation language	Training for writing tx plans, speaking in front of patient, conducting trauma informed care	Team training in transparent language, solution focused approach, MI, and attributions for activation	Activation language enfranchises and activates pts to healthy behavior & participation
Awareness of services across sites	Participating sites keep updated list on shared info site. Easy search for care manager in any other site.	Team members can help persons find services quickly and easily.	Persons experience support in successful referrals because they have help locating services
Patients seen as resources to the practice for their experiences of coping and resilience	System develops a process for training "peer" health workers, first as volunteers and then as paid staff	Team members look for patient expertise to help with other persons in structured group setting.	Regularly highlighting the value of patient experience contributes to person engagement.

12e. Challenges and Proposed Solutions

Challenges and proposed solutions. 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. The response should address the IDN's strategy to mitigate these risks and overcome these barriers.

The benefits of integrated models of care have been well described; few health systems have been able to implement. Barriers to implementation have been well described and we anticipate our teams will experience some (or all) of the barriers listed in the table below.

Table 12.2. Anticipated challenges and tactics to address them.

Challenges, risks, and barriers	Opportunities and mitigation strategies
Clinical cultures and practices that are not aligned with integrated health models	Formation of Region 1 IDN, ongoing collaboration, provision of training and other resources to support practice transformation, availability of alternative payment models – all of these will help to create critical mass and shift culture.
Simple inertia: this will mean a lot of work	Align with other regional and institutional initiatives to recruit/support the investment of our clinical and other partners
Deficits in skills and roles needed to effectively implement integrated health models	Develop curriculum and other training resources through statewide DSRIP workforce initiative
Limited infrastructure and technology to support information sharing across integrated care system	Address statewide, regional infrastructure and technology needs through DSRIP project: development of centralized information directories and portals.
Lack of financial mechanisms to reimburse for integrated models of care	Develop alternative, value-based payment models

Of all barriers described, transforming care models begins with the commitment of those who will experience change. Region 1 IDN has evolved over the past 6 months from a collection of skeptical (but hopeful) clinical care and service providers to a group of providers energized by the possibilities this DSRIP offers. Never underestimating the difficulty of the task ahead, partners at our IDN meetings participate with commitment and optimism.

Critical to a culture that supports large-scale, disruptive change, partners must work in trusting relationships. Our decision making process (described in detail in Governance) requires open dialogue and respectful discussion to reach consensus. Our Advisory Council meeting on October 20, 2016 was testimony to the culture of trust and respect that has developed over the past months. The majority of this meeting was spent reflecting on our work to-date, identifying opportunities for improvement and facilitators of change. The discussion was frank, honest, and constructive. Members concluded that Region 1 IDN has successfully engaged partners in open and transparent communications that have promoted a culture of trust and respect.

Work Groups will develop the structures and processes to address anticipated barriers. Our project structure brings members from all Work Groups together with IDN partners to design and implement integrated care models. Patients/clients and family members will contribute to all phases of this work, ensuring barriers to care are based on person- and family-centered principles.

We believe the implementation challenges ahead (as outlined in Table 12.2), can be tackled when partners work together in trusting relationships. The aphorism, “culture eats strategy for breakfast,” has played out in many of our organizations. We are committed to creating a culture of trust and respect that will allow us to achieve the ambitious goals to integrate behavioral and general health services.

References

Council, L. S., Geffken, D., Valeras, A., Orzano, A.J., Rechisky, M. S., & Anderson, S. (2012). A medical home: Changing the way patients and teams relate through patient-centered care plans. *Families, Systems, & Health, 30*: 190-198.

Chunchu, K., Mauksh, L., Charles, C., Ross, V., & Pauwels, J. (2012). A patient centered care plan in the EHR: Improving collaboration and engagement. *Families, Systems, & Health, 30*: 199-209.

Kazdin, A. (2015). Evidence-Based Psychotherapies: Novel Models of Delivering Treatment. In Kaplan R, Spittel M, David D (Eds). Population Health: Behavioral and Social Science Insights. AHRQ Publication No. 15-0002. Rockville, MD: Agency for Healthcare Research and Quality and Office of Behavioral and Social Sciences Research, National Institutes of Health

12f. [Implementation Approach and Timing](#)

See Supplemental Data Workbook 12F Tab

13. Project C1: Care Transition Teams

IDNs are asked to select a total of three Community Driven projects, one from each of the following categories: (1) Care Transition Projects designed to support beneficiaries with transitions from institutional settings into the community; (2) Capacity Building Projects designed to strengthen and expand workforce and program options; and (3) Integration Projects designed to integrate care for individuals with behavioral health conditions among primary care, behavioral health care and social service providers. At least one of these projects must be focused on the SUD population.

The IDN Community Driven menu of projects gives IDNs the flexibility to undertake work reflective of community-specific priorities identified through its IDN Service Area Community Needs Assessment and community engagement.

For each of the three Community-driven projects selected by the IDN, please provide the following Project Plan information

13a. Project Selection Rationale and Expected Outcomes

The selection of Community Driven Projects in Region 1 was data-informed and stakeholder-driven. The selection process was informed by the following information, which was fed into the Executive Committee’s consensus decision-making process (see Governance section).

- 1) Estimates of the *Importance* and *Feasibility* of each Project option based on stakeholder surveys of Executive Committee, Administrative Lead Team, and Advisory Council members;
- 2) An estimate of the *fit* between each Project option and community need, based on the results from the needs assessment conducted by CHI and the Medicaid data supplied by the State;
- 3) Estimates of the *population health characteristics* of the two Project options in each category with the highest fit, importance, and feasibility estimates, based on the scholarly literature.

We describe this information in greater detail below, as it relates to Region 1’s selection of Care Transition Teams.

1. Stakeholder Perceptions of Importance and Feasibility. The Region 1 IDN Executive Committee, Administrative Lead Team, and Advisory Council (chosen for those roles in part for their representation across sectors and sub-regions) members completed an electronic survey about the extent to which each project option targeted high priority populations and outcomes, and aligned with existing regional efforts (Importance); and our regional readiness and capacity to implement each project option (Feasibility). For importance, respondents rated the degree to which each Community-Driven Project option: 1) targets a high priority population, 2) addresses a key service need/gap, 3) produces valued outcomes; 4) has the potential to elicit key system change, and 5) complements existing efforts. For feasibility, respondents rated each Community-Driven Project in terms of the: 1) acceptability of the intervention to potential consumers and intervention agents, 2) history of success with similar interventions in the region, 3) organizational readiness/capacity to implement the intervention, 4) IT/infrastructure capacity to support the intervention, and 5) likelihood/presence of sufficient leadership and community support. All ratings were made on a four-point scale.

The two top stakeholder-rated Care Transitions Projects, in terms of Importance and Feasibility, were: 1) Care Transition Teams and 2) Supportive Housing.

2. Fit with Community Needs. The Antioch team provided initial estimates – again, on a four-point scale – of the degree to which each top-rated Community-driven project option would address our region’s most important needs, based on the Medicaid and Needs Assessment results. These estimates, along with the underlying data on which they were based, were reviewed in a meeting with the Administrative Lead Team and Jonathan Stewart of the Community Health Institute, and revised/adjusted accordingly, at which point they were discussed with the Executive Committee.

Supportive Housing and Care Transition Teams again emerged as the strongest Care Transition options, in terms of fit with community needs.

3. Population-Health Characteristics. Based on the DSRIP materials and narrative or meta-analytic reviews of research (e.g., Cochrane reviews) and cost benefit analyses (e.g., <http://www.wsipp.wa.gov/BenefitCost?topicId=7>), the Antioch consultants estimated the following public health characteristics (inspired by Glasgow’s “REAIM” model; Glasgow, Vogt, & Boles, 1999) of Supportive Housing and Care Transition Teams:

- **Reach:** How much of the Region 1 BH-indicated Medicaid population we could potentially reach with the intervention, given level of funding/existing community resources
- **Effectiveness:** The potential effectiveness of the intervention, as demonstrated in rigorous, controlled trial research
- **Implementability:** Ease of implementing the intervention (i.e., degree of difficulty/complexity to implement the intervention with integrity/fidelity)
- **Affordability:** Degree to which the region could afford the intervention, given DSRIP funding and existing community resources
- **Evidence:** The level/quality of scholarly evidence on the intervention

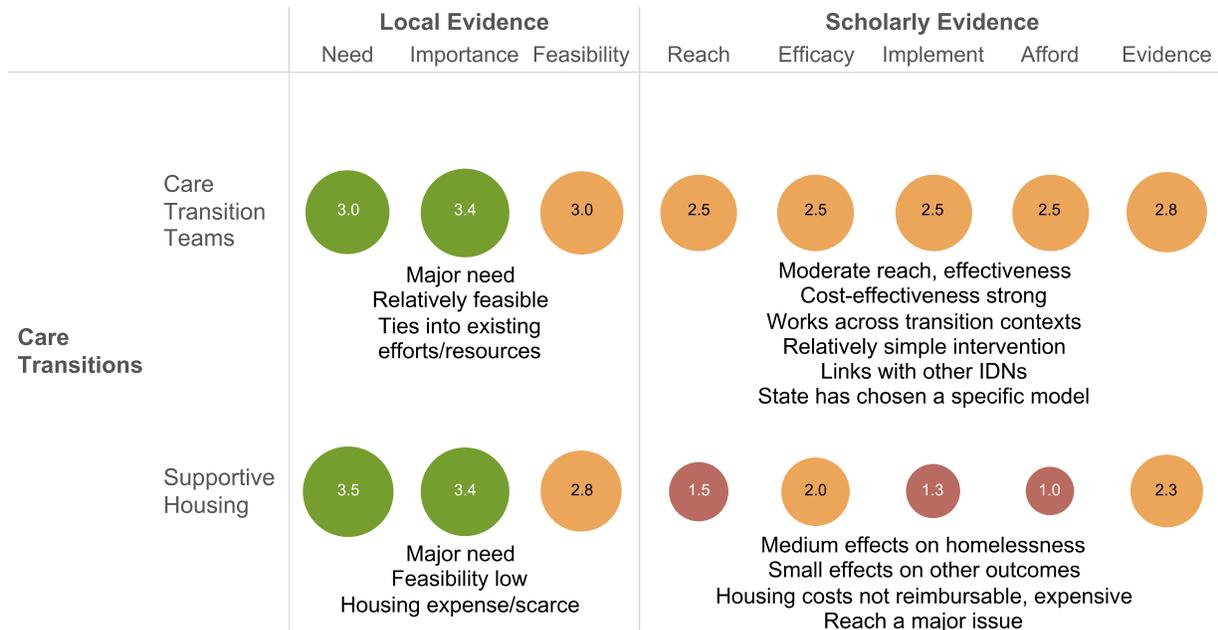
As with the other indicators, these estimates were placed on a four-point scale. Here, Care Transition Teams distinguished itself from Supportive Housing (see Figure 13.1, below).

Figure 13.1. Comparison of 2 highest stakeholder-rated Care Transition projects

Comparison of 2 highest stakeholder-rated Care Transitions projects

Size scaled to rating

High (3-4) | Moderate (2-3) | Low (1-2)



The figure above presents the population health estimates for Care Transition Teams and Supportive Housing. The size of each circle is scaled to the estimate for each indicator (the actual value can be found inside each circle). The color of the circle reflects whether that estimate was categorized as low, moderate, or high.

Supportive Housing emerged as slightly stronger in terms of fit with community needs/importance, but Care Transition Teams fared better in terms of feasibility-related factors, across the board. Ultimately, the following factors proved decisive in the Executive Committee’s consensus to move forward with Care Transition Teams: 1) the fact that the cost of housing could not be reimbursed with DSRIP funds; 2) the stronger feasibility, reach, and flexibility of Care Transition Teams, especially if applied across transition contexts; 3) the potential to address at least the *support* side, of the supportive housing need, through the use of Care Transition Teams.

13b. Participating Organizations: Selection Criteria

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

We intend to disseminate Community Projects region-wide, ensuring access to these projects in each of our three Public Health Regions. When disseminating funding for projects, we will utilize a Request for Qualifications process to qualify partner organization to receive IDN funds. We then will issue project specific Requests for Proposals, with a preference for organizations to submit collaborative proposals that either serve our entire region or a specific Public Health Region.

In our Request for Qualifications process, organizations will be asked to demonstrate:

- Readiness to implement, including support of organization leadership, commitment of in-kind leadership time, and the ability to access existing or new staff and resources for project implementation.
- The ability to manage sub-contracted funds and to complete projects on budget.
- The ability to successfully manage implementation projects
- A commitment to using person/patient-centered care and evidence-based practices.
- Readiness and commitment to work in collaboration with other partners.
- An intention, to align with our goals of maximizing and making highest use of our region's existing clinical work force by integrating non-clinical staff, services, and capacities to improve care and address non-clinical factors that impact health outcomes.
- Readiness to participate in regional or statewide work teams focused on the specific community project implementation.
- A commitment to incorporate expertise and learnings from other regional and statewide partners.
- Commitment to using common program models, protocol, and data systems approved by the region.
- Commitment to participate in the Region 1 alternative payment model and to return IDN funds if the organization withdraws from the IDN prior to funds being spent.

In addition to assessing the organizational qualifications above, the Region One Executive Committee will evaluate the following factors to determine the schedule/sequence of Community Project pilots and dissemination:

- Current readiness of interested organizations and their partners to engage in pilots within specified time-frames.
- Value to Cost of each pilot, with priority given to organizations that can demonstrate high value (such as higher numbers of Medicaid Beneficiaries served; service to highest priority populations; or impact on critical patient outcomes compared to cost of pilot)
- Staging and sequencing of Community Projects in relation to other IDN projects to make best use of resources.

The Region 1 IDN Executive Committee will encourage IDN partners to collaborate on Community Project implementation proposals when feasible, preferring to leverage integration of efforts within our three Public Health Regions and across these sub-regions when possible. If we are unable to leverage collaborative proposals from qualified organizations, the Executive Committee will exercise authority to choose IDN partner organizations for IDN funding support for these projects based on the basis of anticipated value to cost of proposals and level of integration of proposal to other IDN initiatives.

13c. Participating Organizations: List of Organizations

See Supplemental Data Workbook 13C Tab

13d. Monitoring Plan

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.

Region 1's performance monitoring plan is designed to create a learning system, through which project stakeholders can understand and improve the performance of Care Transition Teams over time. Thus, the plan is heavy on proximal indicators that provide rapid/real-time feedback for the caseworkers, their supervising behavioral health professionals, and other project stakeholders. See Table 13.1, Performance Indicators (DSRIP-required indicators in bold).

Participant indicators:

- The number of participants served vs. projected, captured on an ongoing basis through project/administrative records, and shared monthly with project stakeholders.
- The characteristics of participants enrolled in the intervention vs those expected/projected, to monitor use of inclusion/exclusion criteria and to detect disparities by age, sex, minority status, geography, etc. This indicator will come from project/administrative records, be entered in an ongoing way (as Participants enroll), and reported to stakeholders monthly.
- Participant preparedness for life in the community without the intervention, in terms of their self-management skills, connectedness with professional and natural supports, and sense of hope and meaningful goals for the future. This indicator will be collected by the caseworker every time s/he meets with a Participant using a brief participant preparedness tool. These data will be available to the caseworker (and supervisor) in real time, to help guide/target the intervention. Aggregate preparedness data will be reported to other project stakeholders quarterly.
- Participant experience of Care Transition Teams will be collected by the caseworker at every participant encounter using a simple one to three item participant self-report tool. These data will be available to the caseworker (and supervisor) in real time, to help guide/target the intervention. Aggregate preparedness data will be reported to other project stakeholders on quarterly.
- The number and types of adverse events experienced by the participant will be collected by the caseworker based on participant self-report, information from collateral sources, and Medicaid and other healthcare data. The data will be collected on an ongoing basis, available to the caseworker and supervisor in as close to real time as possible, and presented in aggregate to other stakeholders quarterly.
- The number and percentage of participants successfully completing/graduating from the intervention within 9 months will be recorded by the caseworker whenever a participant leaves the program (and the reason for leaving, for those participants that attrit). This information will be reported quarterly.

Practice/workforce indicators:

- The number and qualifications of staff recruited and trained in Critical Time Intervention versus projected will be recorded on an ongoing basis, and reported quarterly.
- Staff vacancies and turnover rate versus projected will be recorded on an ongoing basis, and reported quarterly.
- The fidelity with which the model is implemented/delivered (e.g., quality/type of interactions with participants, natural, professional supports; presence/quality of care plan; etc.) will be monitored

with a Critical Time Intervention fidelity tool, and fed back to caseworkers and supervisors in real time, and reported to other project stakeholders quarterly.

Table 13.1. Care Transition Teams: Performance Indicators (DSRIP-required indicators in **bold**)

Indicator	Source	Administration	Reporting
# served vs. projected	Project records	Ongoing	Monthly
Participant characteristics vs targeted	Project records	Ongoing	Quarterly
Participant preparedness for community life	Preparedness tool	At every participant meeting	Immediate to caseworker; quarterly to other stakeholders
Participant experience of intervention	Intervention rating tool		
# & types adverse events	Participant & collateral report; Medicaid records	Ongoing	
% completing/graduating	Project records		
# staff recruited/trained vs. projected	Project records		
Staff vacancy and turnover rate vs. projected	Project Records	Ongoing	Quarterly
Critical time incident fidelity (frequency/quality of contact with participant, natural, professional supports; presence/quality of care plan; communication with team, etc.)	Fidelity Tool(s)		Immediate to caseworker; quarterly to other stakeholders

13e. Challenges and Proposed Solutions

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.

The Antioch team solicited input from the Advisory Council, Admin Lead Team, and Executive Committee members about the challenges, risks, and barriers, as well as opportunities and mitigation strategies, associated with Care Transition Teams. These stakeholders identified a number of potential risks and mitigation strategies (see Table 13.2).

Lack of Supportive Housing in the region was identified as a risk that could threaten or otherwise undermine the success of Care Transition Teams. To mitigate this risk, stakeholders recommended pursuing housing grants to increase the supply of housing in the region and leveraging the Care Transition Teams to address the support/coordination side of the supportive housing equation.

Strong, technology-facilitated communication across the health care and social service system is a hallmark of high functioning Care Transition Teams. Stakeholders worried that the limited IT and

communication infrastructure in our region (and state) would undermine this critical ingredient. They pointed to the IT/infrastructure elements of this project as a critical means for addressing this barrier.

Lack of access to high quality services and supports could undermine the success of Care Transition Teams. The primary means for addressing this risk is through the workforce/training initiative, and developing a regional directory of high quality services and supports. Peer and natural supports – not just professional services – should be a focus of workforce development.

Finally, sustaining the intervention beyond the DSRIP funding period is a major concern of Region 1 stakeholders. The key mitigation strategies are to use the funded period to demonstrate improved outcomes, cost savings, and the power of alternative payment models, as well as leveraging existing resources to enhance the impact/power of Care Transition Teams insofar as possible.

Table13.2. Care Transition Teams: Challenges and risks, opportunities and mitigation strategies

Challenges, risks, and barriers	Opportunities and mitigation strategies
Lack of supportive housing	Leverage housing grants to increase supply of housing; address support side of equation through Care Transition (and Care Coordination) interventions
Limited infrastructure and technology	Address statewide, regional infrastructure and technology needs through DSRIP project
Quality of services and support, workforce, training, implementation support	Address statewide, regional workforce needs through DSRIP workforce initiative, other efforts and funding opportunities; develop regional directory of services
Sustainability beyond 2020	Demonstrate outcomes including cost-savings and benefits of alternative payment models; leverage existing resources wherever possible

References

Glasgow, R. E., Vogt, T. M., & Boles, S. M. (1999). Evaluating the public health impact of health promotion interventions: the RE-AIM framework. *American Journal of Public Health, 89*(9), 1322–1327. <https://doi.org/10.2105/AJPH.89.9.1322>

13f. Implementation Approach and Timing

See Supplemental Data Workbook 13F Tab

14. Project D3: Expansion in Intensive SUD Treatment Options

IDNs are asked to select a total of three Community Driven projects, one from each of the following categories: (1) Care Transition Projects designed to support beneficiaries with transitions from institutional settings into the community; (2) Capacity Building Projects designed to strengthen and expand workforce and program options; and (3) Integration Projects designed to integrate care for individuals with behavioral health conditions among primary care, behavioral health care and social service providers. At least one of these projects must be focused on the SUD population.

The IDN Community Driven menu of projects gives IDNs the flexibility to undertake work reflective of community-specific priorities identified through its IDN Service Area Community Needs Assessment and community engagement.

For each of the three Community-driven projects selected by the IDN, please provide the following Project Plan information

14a. Project Selection Rationale and Expected Outcomes

The selection of Community Driven Projects in Region 1 was data-informed and stakeholder-driven. The selection process was informed by the following information, which was fed into the Executive Committee's consensus decision-making process (see Governance section).

- 1) Estimates of the *Importance* and *Feasibility* of each Project option based on stakeholder surveys of Executive Committee, Administrative Lead Team, and Advisory Council members;
- 2) An estimate of the *fit* between each Project option and community need, based on the results from the needs assessment conducted by CHI and the Medicaid data supplied by the State;
- 3) Estimates of the *population health characteristics* of the two Project options in each category with the highest fit, importance, and feasibility estimates, based on the scholarly literature.

We describe this information in greater detail below, as it relates to Region 1's selection of Expansion of Intensive SUD Treatment.

1. Stakeholder Perceptions of Importance and Feasibility. The Region 1 IDN Executive Committee, Administrative Lead Team, and Advisory Council (chosen for those roles in part for their representation across sectors and sub-regions) members completed an electronic survey about the extent to which each project option targeted high priority populations and outcomes, and aligned with existing regional efforts (Importance); and our regional readiness and capacity to implement each project option (Feasibility). For importance, respondents rated the degree to which each Community-Driven Project option: 1) targets a high priority population, 2) addresses a key service need/gap, 3) produces valued outcomes; 4) has the potential to elicit key system change, and 5) complements existing efforts. For feasibility, respondents rated each Community-Driven Project in terms of the: 1) acceptability of the intervention to potential consumers and intervention agents, 2) history of success with similar interventions in the region, 3) organizational readiness/capacity to implement the intervention, 4) IT/infrastructure capacity to support the intervention, and 5) likelihood/presence of sufficient leadership and community support. All ratings were made on a four-point scale.

The two top stakeholder-rated Capacity Building Projects in terms of Importance and Feasibility were: 1) Expansion of Intensive SUD Treatment and 2) Medication-Assisted Treatment.

2. Fit with Community Needs. The Antioch team provided initial estimates – again, on a four-point scale – of the degree to which each top-rated Community-driven project option would address our region’s most important needs, based on the Medicaid and Needs Assessment results. These estimates, along with the underlying data on which they were based, were reviewed in a meeting with the Admin Lead Team and Jonathan Stewart of the Community Health Institute, and revised/adjusted accordingly, at which point they were shared and discussed with the Executive Committee.

Expansion of Intensive SUD Treatment and Medication-Assisted Treatment again emerged as the strongest Capacity Building options, in terms of fit with community needs.

3. Population-Health Characteristics. Based on the DSRIP materials and narrative or meta-analytic reviews of research (e.g., Cochrane reviews) and cost benefit analyses (e.g., <http://www.wsipp.wa.gov/BenefitCost?topicId=7>), the Antioch consultants estimated the following public health characteristics (inspired by Glasgow’s “REAIM” model; Glasgow, Vogt, & Boles, 1999) of Expansion of Intensive SUD Treatment and Medication-Assisted Treatment:

- **Reach:** How much of the Region 1 BH-indicated Medicaid population we could potentially reach with the intervention, given level of funding/existing community resources
- **Effectiveness:** The potential effectiveness of the intervention, as demonstrated in rigorous, controlled trial research
- **Implementability:** Ease of implementing the intervention (i.e., degree of difficulty/complexity to implement the intervention with integrity/fidelity)
- **Affordability:** Degree to which the region could afford the intervention, given DSRIP funding and existing community resources
- **Evidence:** The level/quality of scholarly evidence on the intervention

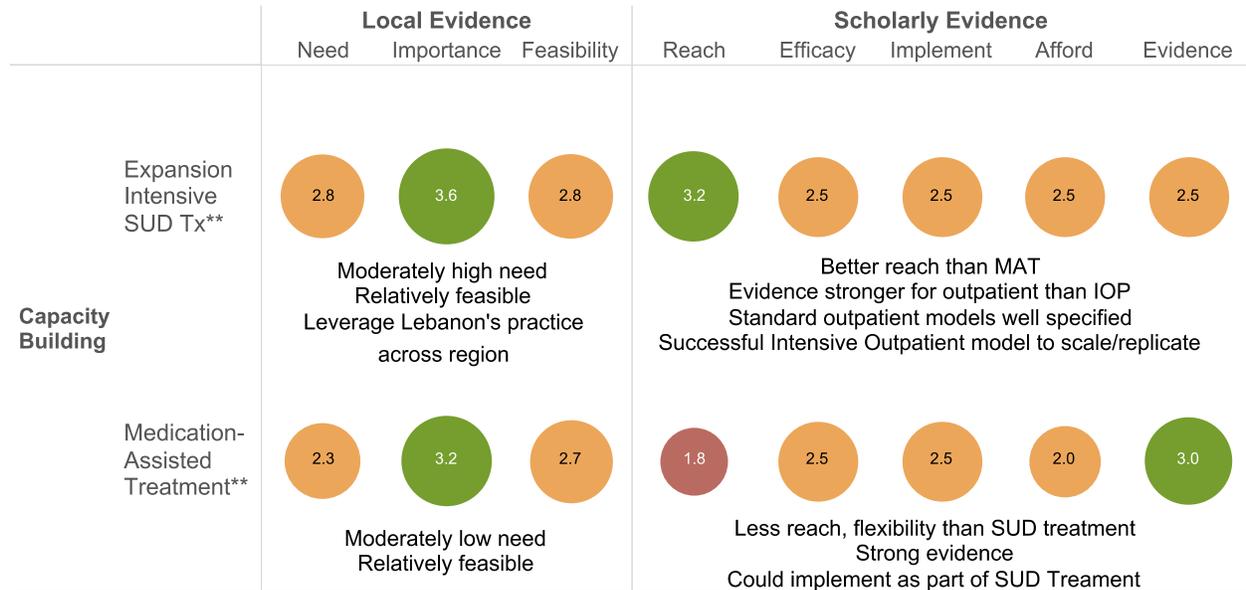
As with the other indicators, these estimates were placed on a four-point scale. Expansion of Intensive SUD treatment received stronger ratings in terms of reach and affordability, whereas the evidence associated with MAT was perceived as a bit stronger (see Figure 14.1, below).

Figure 14.1. Comparison of 2 highest stakeholder-rated Capacity Building projects

Comparison of 2 highest stakeholder-rated Capacity Building projects

Size scaled to rating

High (3-4) | Moderate (2-3) | Low (1-2)



The figure above presents the aforementioned estimates for Expansion of Intensive SUD Treatment and Medication-Assisted Treatment. The size of each circle is scaled to the estimate for each indicator (the actual value can be found inside each circle). The color of the circle reflects whether that estimate was categorized as low, moderate, or high.

Ultimately, the greater reach and flexibility of Expansion of Intensive SUD Treatment won out over the slightly stronger evidence associated with Medication Assisted Treatment. Also favoring Expansion of Intensive SUD Treatment were the potential to 1) extend an existing Intensive Outpatient Treatment “bright spot” throughout the rest of the region, and 2) offer Medication Assisted Treatment as part of the expansion of SUD treatment if warranted/desired.

14b. Participating Organizations: Selection Criteria

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

We intend to disseminate Community Projects region-wide, ensuring access to these projects in each of our three Public Health Regions. When disseminating funding for projects, we will utilize a Request for Qualifications process to qualify partner organization to receive IDN funds. We then will issue project specific Requests for Proposals, with a preference for organizations to submit collaborative proposals that either serve our entire region or a specific Public Health Region.

In our Request for Qualifications process, organizations will be asked to demonstrate:

- Readiness to implement, including support of organization leadership, commitment of in-kind leadership time, and the ability to access existing or new staff and resources for project implementation.
- The ability to manage sub-contracted funds and to complete projects on budget.
- The ability to successfully manage implementation projects
- A commitment to using person/patient-centered care and evidence-based practices.
- Readiness and commitment to work in collaboration with other partners.
- An intention, to align with our goals of maximizing and making highest use of our region’s existing clinical work force by integrating non-clinical staff, services, and capacities to improve care and address non-clinical factors that impact health outcomes.
- Readiness to participate in regional or statewide work teams focused on the specific community project implementation.
- A commitment to incorporate expertise and learnings from other regional and statewide partners.
- Commitment to using common program models, protocol, and data systems approved by the region.
- Commitment to participate in the Region 1 alternative payment model and to return IDN funds if the organization withdraws from the IDN prior to funds being spent.

In addition to assessing the organizational qualifications above, the Region One Executive Committee will evaluate the following factors to determine the schedule/sequence of Community Project pilots and dissemination:

- Current readiness of interested organizations and their partners to engage in pilots within specified time-frames.
- Value to Cost of each pilot, with priority given to organizations that can demonstrate high value (such as higher numbers of Medicaid Beneficiaries served; service to highest priority populations; or impact on critical patient outcomes compared to cost of pilot)
- Staging and sequencing of Community Projects in relation to other IDN projects to make best use of resources.

The Region 1 IDN Executive Committee will encourage IDN partners to collaborate on Community Project implementation proposals when feasible, preferring to leverage integration of efforts within our three Public Health Regions and across these sub-regions when possible. If we are unable to leverage collaborative proposals from qualified organizations, the Executive Committee will exercise authority to choose IDN partner organizations for IDN funding support for these projects based on the basis of anticipated value to cost of proposals and level of integration of proposal to other IDN initiatives.

14c. Participating Organizations: List of Organizations

See Supplemental Data Workbook 14C Tab

14d. Monitoring Plan

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.

Region 1’s performance monitoring plan is designed to create a learning system, through which we will understand and improve performance of the Expansion of Intensive SUD Treatment over time. Thus, the plan is heavy on proximal/leading indicators that provide rapid/real-time feedback for practice stakeholders. See Table 14.1, below; DSRIP-required indicators in bold.

Participant indicators:

- The number of participants served vs. projected, captured on an ongoing basis through project/administrative records, and shared monthly with project stakeholders.
- The characteristics of participants enrolled vs. projected, to monitor application of inclusion/exclusion criteria, as well as disparities by age, sex, minority status, geography, etc. This indicator will come from project/administrative records, be entered as participants enroll, and be reported to stakeholders monthly.
- The number and proportion of sessions/contacts delivered at the appropriate level of care and the percentage of patients that receive an adequate dose of the appropriate level of care. This will ensure optimal allocation of care. This measure will be collected on an ongoing basis through project/administrative records, and reported quarterly to stakeholders.
- Ongoing/regular collection and feedback of participant alliance and treatment progress. From this information, we can derive the percentage of participants achieving an adequate therapeutic alliance and reliable/clinically significant change. More importantly, feedback of this kind of information to providers (and their supervisors) significantly improves psychotherapy/counseling effectiveness and efficiency (Lambert & Shimokawa, 2011; Owen & Imel, 2009). The Session Rating Scale (SRS) and Outcome Rating Scale (ORS) would be a good fit for this purpose, since they are very brief, effective, flexible (in terms of treatment type, modality, etc.), and well-established tools for this purpose (Miller, Duncan, Sorrell, & Brown, 2005). SRS/ORS data would be collected by providers at each session (but no more than weekly), and fed back to them (and supervisor, as applicable) in real-time to aid in treatment planning/delivery. These data would also be fed back in aggregate to other project stakeholders quarterly.

Practice/workforce indicators:

- The number and qualifications of staff recruited and trained versus projected will be recorded on an ongoing basis and reported quarterly.
- Staff vacancies and turnover rate versus projected will be recorded on an ongoing basis and reported quarterly.
- The fidelity with which the intensive and standard outpatient programs/models is implemented/delivered, as well as the fidelity with which specific evidence-based practices are delivered within those programs, will be monitored and fed back to practitioners/supervisors in as close to real-time as possible, and to other project stakeholders annually.

Table 14.1. Expansion Intensive SUD Treatment: Performance Indicators (DSRIP-required indicators in bold)

Indicator	Source	Administration	Reporting
# served vs. projected	Project records	Ongoing	Monthly
Participant characteristics vs.	Project records	Ongoing	Quarterly

Indicator	Source	Administration	Reporting
targeted			
# of sessions/contacts of appropriate form(s) of care; % receiving “adequate” dose of appropriate care	Project records	Ongoing	Quarterly
Participant-rated alliance & outcome: % adequate alliance; % clinically significant change	Session and Outcome Rating Scales	Every session (max once weekly)	Immediate to provider/supervisor/coach; quarterly to other stakeholders
# staff recruited/trained vs. projected	Project records	Ongoing	Quarterly
Staff vacancy and turnover rate vs. projected	Project Records		
Fidelity (integrity with which program elements and specific EBPs are implemented)	Fidelity Tool(s)	Program level: annual EBP level: as per tool(s)	Immediate to provider/supervisor/coach; quarterly to other stakeholders

14e. Challenges and Proposed Solutions

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.

We solicited input from Advisory Council, Admin Lead Team, and Executive Committee members about the challenges, risks, and barriers, as well as opportunities and mitigation strategies, associated with Expansion of Intensive SUD Treatment. These stakeholders identified a number of potential risks and mitigation strategies. In the text below, we highlight a few of the most thorny/worrisome for this intervention; Table 14.2 provides a more comprehensive list.

Stakeholders expect that difficulties finding/hiring/retaining qualified staff, especially for intensive interventions that might require specialized training and certifications/licenses (e.g., LADAC) will be the most significant risk to the Expansion of Intensive SUD Treatment. Developing new staffing/workforce through DSRIP and other funding opportunities, as well as advocating for changes to licensing regulations/requirements could mitigate this risk.

Lack of readiness/stigma – both of which emerged from the Needs Assessment – could inhibit utilization of SUD treatment. Mitigation strategies include developing a social marketing strategy to decrease stigma and promote awareness/utilization of services and support; leveraging situations (e.g., ED visits, DUI arrests, etc.) that tend to enhance readiness to change among substance-misusing populations to initiate/engage them in treatment; and using individualized, alliance- and motivation-enhancing therapeutic strategies to enhance engagement and retention in treatment.

Table 14.2. Expansion of SUD Treatment: Challenges & risks, opportunities & mitigation

Challenges, risks, and barriers	Opportunities and mitigation strategies
Staffing/workforce/licensing barriers	Develop new staffing/workforce through DSRIP; Advocate for changes to licensing requirements
Under utilization and/or limited engagement in services, due to stigma, low readiness	Identify and leverage nodes in the community where substance-abuse related risks and motivation-enhancing contexts collide; use individualized, motivational enhancing strategies; promote awareness of services and stigma reduction
Intensive outpatient, MAT, other intensive substance abuse treatment interventions are difficult to pull off; Fidelity, integrity, quality of services a concern	Replicate successful/gold standard regional models/practices; strong performance monitoring and other implementation drivers
Transportation barriers	Replicate successful programs in all three regions; enhance transportation options; bring interventions to substance using populations;
High risk population for suicide	Provide training and technical assistance with suicide prevention (e.g., NAMI NH’s “CONNECT” program, Mental Health First Aid)
Privacy/confidentiality regulations, limited IT/communication infrastructure threaten integration/coordination/communication between substance treatment and other services	Learn from other states/areas that have resolved privacy/confidentiality barriers
Lack of supportive housing undermines readiness/capacity to change, treatment engagement and retention	Leverage housing grants to increase supply of housing; address support side of equation through Care Transition (and Care Coordination) interventions
Sustainability beyond 2020 (e.g., HMOs, not those bearing the costs of the intervention, benefit financially)	Demonstrate outcomes including cost-savings and benefits of alternative payment models; leverage existing resources wherever possible; care coordination can relieve burden of providers, boosting productivity/morale/retention

References

- Glasgow, R. E., Vogt, T. M., & Boles, S. M. (1999). Evaluating the public health impact of health promotion interventions: the RE-AIM framework. *American Journal of Public Health, 89*(9), 1322–1327. <https://doi.org/10.2105/AJPH.89.9.1322>
- Lambert, M. J., & Shimokawa, K. (2011). Collecting client feedback. *Psychotherapy, 48*(1), 72–79. <https://doi.org/10.1037/a0022238>
- Miller, S. D., Duncan, B. L., Sorrell, R., & Brown, G. S. (2005). The partners for change outcome management system. *Journal of Clinical Psychology, 61*, 199–208. <https://doi.org/10.1002/jclp.20111>
- Owen, J., & Imel, Z. (2009). Rating Scales in Psychotherapy Practice. In L. Baer & M. A. Blais (Eds.), *Handbook of Clinical Rating Scales and Assessment in Psychiatry and Mental Health* (pp. 257–270). Humana Press. https://doi.org/10.1007/978-1-59745-387-5_12

14f. Implementation Approach and Timing

See Supplemental Data Workbook 14F Tab

15. Project E5: Enhanced Care Coordination for High Need Population

IDNs are asked to select a total of three Community Driven projects, one from each of the following categories: (1) Care Transition Projects designed to support beneficiaries with transitions from institutional settings into the community; (2) Capacity Building Projects designed to strengthen and expand workforce and program options; and (3) Integration Projects designed to integrate care for individuals with behavioral health conditions among primary care, behavioral health care and social service providers. At least one of these projects must be focused on the SUD population.

The IDN Community Driven menu of projects gives IDNs the flexibility to undertake work reflective of community-specific priorities identified through its IDN Service Area Community Needs Assessment and community engagement.

For each of the three Community-driven projects selected by the IDN, please provide the following Project Plan information

15a. Project Selection Rationale and Expected Outcomes

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.

The selection of Community Driven Projects in Region 1 was data-informed and stakeholder-driven. The selection process was informed by the following information, which was fed into the Executive Committee’s consensus decision-making process (see Governance section).

- 1) Estimates of the *Importance* and *Feasibility* of each Project option based on stakeholder surveys of Executive Committee, Administrative Lead Team, and Advisory Council members;
- 2) An estimate of the *fit* between each Project option and community need, based on the results from the needs assessment conducted by CHI, and the Medicaid data supplied by the State;
- 3) Estimates of the *population health characteristics* of the two Project options in each category with the highest fit, importance, and feasibility estimates, based on the scholarly literature.

We describe this information in greater detail below, as it relates to Region 1’s selection of Care Coordination for High Needs Populations.

1. Stakeholder Perceptions of Importance and Feasibility. The Region 1 IDN Executive Committee, Administrative Lead Team, and Advisory Council (chosen for those roles in part for their representation across sectors and sub-regions) members completed an electronic survey about the extent to which each project option targeted high priority populations and outcomes, and aligned with existing regional efforts (Importance); and our regional readiness and capacity to implement each project option (Feasibility). For importance, respondents rated the degree to which each Community-Driven Project option: 1) targets a high priority population, 2) addresses a key service need/gap, 3) produces valued outcomes; 4) has the potential to elicit key system change, and 5) complements existing efforts. For feasibility, respondents rated each Community-Driven Project in terms of the: 1) acceptability of the intervention to potential consumers and intervention agents, 2) history of success with similar

interventions in the region, 3) organizational readiness/capacity to implement the intervention, 4) IT/infrastructure capacity to support the intervention, and 5) likelihood/presence of sufficient leadership and community support. All ratings were made on a four-point scale.

The two top-rated Integration Projects in terms of Feasibility and Importance were: 1) Care Coordination for High needs populations and 2) Treatment of Co-occurring Conditions. See Figure_ below.

2. Fit with Community Needs. The Antioch team provided initial estimates – again, on a four-point scale – of the degree to which each top-rated Community-driven project option would address our region’s most important needs, based on the Medicaid and Needs Assessment results. These estimates, along with the underlying data on which they were based, were reviewed in a meeting with the Admin Lead Team and Jonathan Stewart of the Community Health Institute, and revised/adjusted accordingly, at which point they were shared and discussed with the Executive Committee.

Care Coordination for High Needs Populations and Treatment of Co-occurring Conditions again emerged as the strongest Integration options, in terms of fit with community needs.

3. Population-Health Characteristics. Based on the DSRIP materials and narrative or meta-analytic reviews of research (e.g., Cochrane reviews) and cost benefit analyses (e.g., <http://www.wsipp.wa.gov/BenefitCost?topicId=7>), the Antioch consultants estimated the following public health characteristics (inspired by Glasgow’s “REAIM” model; Glasgow, Vogt, & Boles, 1999) of Supportive Housing and Care Transition Teams:

- **Reach:** How much of the Region 1 BH-indicated Medicaid population we could potentially reach with the intervention, given level of funding/existing community resources
- **Effectiveness:** The potential effectiveness of the intervention, as demonstrated in rigorous, controlled trial research
- **Implementability:** Ease of implementing the intervention (i.e., degree of difficulty/complexity to implement the intervention with integrity/fidelity)
- **Affordability:** Degree to which the region could afford the intervention, given DSRIP funding and existing community resources
- **Evidence:** The level/quality of scholarly evidence on the intervention

As with the other indicators, these estimates were placed on a four-point scale. Here, Care Coordination for High Needs Populations distinguished itself from Treatment of Co-occurring Conditions (see Figure 15.1, below).

The figure below presents the aforementioned estimates for Care Coordination of High Needs Populations and Treatment of Co-occurring Conditions. The size of each circle is scaled to the estimate for each indicator (the actual value can be found inside each circle). The color of the circle reflects whether that estimate was categorized as low, moderate, or high.

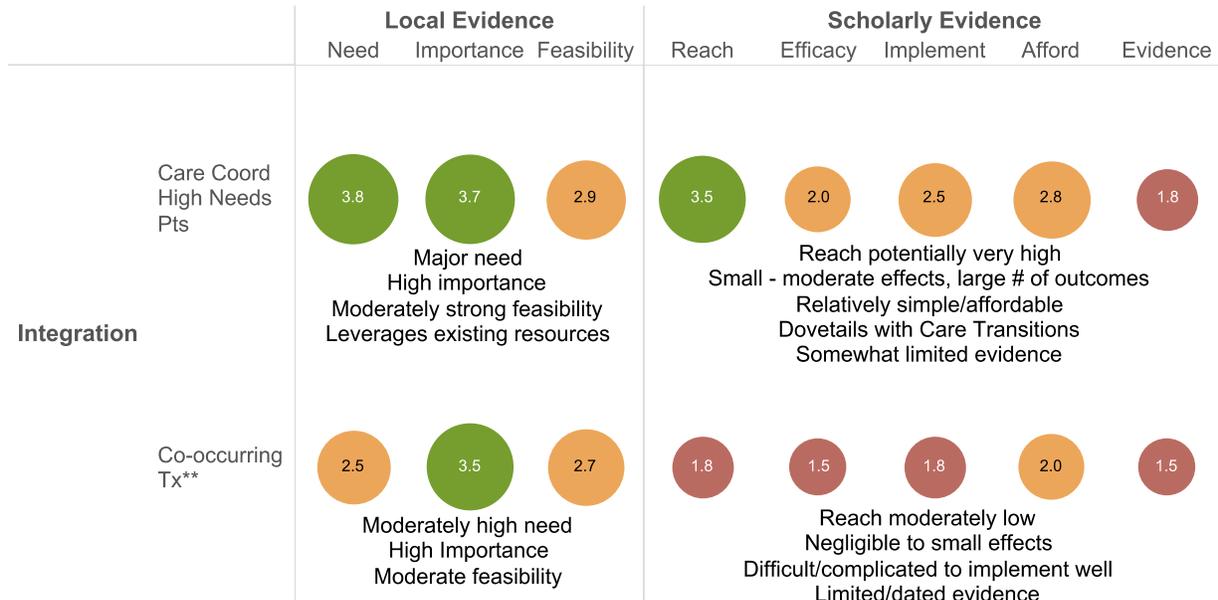
We can see from this chart that Care Coordination of High Needs Populations received higher estimates across the board. It was viewed as an intervention that better fit with the needs of the community, would be more feasible to implement, and would reach a higher proportion of the target population with a more potent intervention, partially through leveraging existing resources. As such, the Executive Committee easily reached consensus that Care Coordination would be Region 1’s Integration project.

Figure 15.1. Comparison of 2 highest stakeholder-rated Integration projects

Comparison of 2 highest stakeholder-rated Integration projects

Size scaled to rating

High (3-4) | Moderate (2-3) | Low (1-2)



15b. Participating Organizations: Selection Criteria

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

We intend to disseminate Community Projects region-wide, ensuring access to these projects in each of our three Public Health Regions. When disseminating funding for projects, we will utilize a Request for Qualifications process to qualify partner organization to receive IDN funds. We then will issue project specific Requests for Proposals, with a preference for organizations to submit collaborative proposals that either serve our entire region or a specific Public Health Region.

In our Request for Qualifications process, organizations will be asked to demonstrate:

- Readiness to implement, including support of organization leadership, commitment of in-kind leadership time, and the ability to access existing or new staff and resources for project implementation.
- The ability to manage sub-contracted funds and to complete projects on budget.
- The ability to successfully manage implementation projects
- A commitment to using person/patient-centered care and evidence-based practices.
- Readiness and commitment to work in collaboration with other partners.
- An intention, to align with our goals of maximizing and making highest use of our region’s existing clinical work force by integrating non-clinical staff, services, and capacities to improve care and address non-clinical factors that impact health outcomes.

- Readiness to participate in regional or statewide work teams focused on the specific community project implementation.
- A commitment to incorporate expertise and learnings from other regional and statewide partners..
- Commitment to using common program models, protocol, and data systems approved by the region.
- Commitment to participate in the Region 1 alternative payment model and to return IDN funds if the organization withdraws from the IDN prior to funds being spent.

In addition to assessing the organizational qualifications above, the Region One Executive Committee will evaluate the following factors to determine the schedule/sequence of Community Project pilots and dissemination:

- Current readiness of interested organizations and their partners to engage in pilots within specified time-frames.
- Value to Cost of each pilot, with priority given to organizations that can demonstrate high value (such as higher numbers of Medicaid Beneficiaries served; service to highest priority populations; or impact on critical patient outcomes compared to cost of pilot)
- Staging and sequencing of Community Projects in relation to other IDN projects to make best use of resources.

The Region 1 IDN Executive Committee will encourage IDN partners to collaborate on Community Project implementation proposals when feasible, preferring to leverage integration of efforts within our three Public Health Regions and across these sub-regions when possible. If we are unable to leverage collaborative proposals from qualified organizations, the Executive Committee will exercise authority to choose IDN partner organizations for IDN funding support for these projects based on the basis of anticipated value to cost of proposals and level of integration of proposal to other IDN initiatives.

15c. Participating Organizations: List of Organizations

See Supplemental Data Workbook 15C Tab

15d. Monitoring Plan

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.

Region 1's performance monitoring plan is designed to create a learning system, through which project stakeholders can understand and improve Care Coordination for High Needs Populations performance over time. Thus, the plan is heavy on proximal/leading indicators that provide rapid/real-time feedback for care coordinators, the rest of each person-centered care team, and other project stakeholders. See Table 15.1, below; DSRIP-required indicators in bold.

Participant indicators:

- The number of participants served vs. projected, captured on an ongoing basis through

project/administrative records, and shared monthly with project stakeholders.

- The characteristics of participants enrolled in the intervention vs. projected, to monitor application of the inclusion/exclusion criteria, as well as disparities by age, sex, minority status, geography, etc. This indicator will come from project/administrative records, be entered as participants enroll, and reported to stakeholders monthly.
- Participant preparedness for life in the community without the intervention, in terms of their self-management skills, connectedness with professional and natural supports, and sense of hope and meaningful goals for the future. This indicator will be collected by the care coordinator every time s/he meets with a participant, using a three-item Preparedness Tool. These data will be available to the coordinator and rest of the person’s care team in real time, to help guide/target the intervention. Aggregate preparedness data will be reported to other project stakeholders quarterly.
- Participant experience will be monitored at every participant-care coordinator encounter, using a simple one to three item participant self-report tool. These data will be available to the coordinator in real time, to help guide/target the intervention. Aggregate preparedness data will be reported to other project stakeholders quarterly.
- The number and types of adverse events experienced by the participant will be collected by the coordinator at every encounter based on participant self-report, information from collateral sources, and Medicaid and other healthcare data. The data will be collected on an ongoing basis, available to coordinators in real time, and presented in aggregate to other stakeholders quarterly.
- The duration, the number and percentage of participants successfully completing/graduating, and reason for termination will be recorded by the coordinator whenever a participant leaves the program. This information will be reported on a quarterly basis.

Practice/workforce indicators:

- The number and qualifications of staff recruited and trained in Critical Time Intervention versus projected will be recorded on an ongoing basis, and reported quarterly.
- Staff vacancies and turnover rate versus projected will be recorded on an ongoing basis, and reported quarterly.
- The fidelity with which the care coordination model is implemented/delivered (e.g., quality/type of interactions with participants, natural, professional supports; presence/quality of care plan; etc.) will be monitored with one or more fidelity tool, fed back to coordinators and supervisors in real time, and reported to other project stakeholders quarterly. This tool should capture timeliness/quality of coordinator contact with participants and their professional and natural supports, presence/quality of an up-to-date care plan, frequency/quality of communication with other team members, etc.

Table 15.1. Care Coordination High Needs: Performance Indicators (DSRIP-required indicators in bold)

Indicator	Source	Administration	Reporting
# served vs. projected	Project records	Ongoing	Monthly
Participant characteristics vs targeted	Project records	Ongoing	Quarterly
Participant preparedness for community life	Preparedness tool	At every Participant meeting	Immediate to coordinator; quarterly to other stakeholders
Participant experience of intervention	Intervention rating tool		
# & types adverse events	Participant & collateral report; Medicaid records	Ongoing	

Indicator	Source	Administration	Reporting
# served vs. projected	Project records	Ongoing	Monthly
Participant characteristics vs targeted	Project records	Ongoing	Quarterly
% completing/graduating	Project records		
# staff recruited/trained vs. projected	Project records		Quarterly
Staff vacancy and turnover rate vs. projected	Project Records		
Fidelity (frequency/quality of contact with Participant, natural, professional supports; presence/quality of care plan; communication with team, etc.)	Fidelity Tool(s)		Immediate to coordinator; quarterly to other stakeholders

15e. Challenges and Proposed Solutions

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.

We solicited input from Advisory Council, Admin Lead Team, and Executive Committee members about the challenges, risks, and barriers, as well as opportunities and mitigation strategies, associated with the Care Coordination for High Needs Populations. These stakeholders identified a number of potential risks and mitigation strategies (see Table 15.2).

Lack of access to qualified/trained care coordinators and peer/family support specialists was cited as a potential barrier. This could be mitigated by developing the care coordination workforce of tomorrow, such as trained, indigenous community health workers, through the DSRIP project, braiding and pooling of existing care coordination resources, and other funding opportunities.

Failing to address/anticipate suicide risk was perceived as another threat, according to stakeholders. Incorporating suicide prevention training, such as NAMI NH's "CONNECT" model, could help mitigate this threat.

Traditional organizational boundaries/silos could limit the flexibility/breadth of the intervention and/or lead to wasteful and counterproductive duplication of care coordination/management services across the system. To mitigate this risk, stakeholders recommended conceiving of care coordination as a person- and community-centered (rather than organization-centered), resource. Untethered from traditional organizational boundaries, care coordinators would be free to pursue participant needs, wherever that might take them, while avoiding duplication of costly efforts across systems.

Stakeholders worried that this project might decrease costs without improving participant quality of life. Ensuring the participant needs, plans, and self-management skills are at the center of gravity of the intervention can mitigate this risk, as can assuring access to high quality professional services as well as peer and natural supports.

Privacy and confidentiality-related barriers, as well as the State and Region’s limited IT/electronic communication infrastructure, could undermine communication – a critical ingredient of successful care coordination. To address these risks, we should look to other states/communities that have successfully addressed privacy and confidentiality related regulatory barriers. Building out the State and Region’s IT/communication environment should be a major focus of the overall project.

The lack of Supportive Housing in the region was identified as another risk. To mitigate this risk, stakeholders recommended pursuing housing grants to increase the supply of housing in the region and leveraging the Care Transition Teams and Care Coordination projects to deal with the support and coordination side of the supportive housing equation.

Finally, sustaining the intervention beyond the DSRIP funding period is a major concern of Region 1 stakeholders. The key mitigation strategies are to use the funded period to demonstrate improved outcomes, cost savings, and the power of alternative payment models, as well as to leverage existing resources to enhance the impact/power of the intervention insofar as possible.

Table 15.2. Care Coordination: Challenges and risks, opportunities and mitigation strategies

Challenges, risks, and barriers	Opportunities and mitigation strategies
Staffing/workforce problems: hiring/training strongly qualified coordinators, enhancing availability of family/peer specialists, etc.	Develop new workforce through DSRIP (e.g., shared Community Health Worker workforce)
Failing to address/implement suicide prevention best practices	Provide training and technical assistance with suicide prevention (e.g., NAMI NH’s “CONNECT” program, Mental Health First Aid)
Traditional organizational boundaries get in the way, by limiting portability/flexibility and/or duplication of services	Care coordinators are a <i>person-centered resources</i> that are <i>shared across the community</i> , traditional organizational boundaries
Achieve cost/system outcomes without improving participant quality of life	Participant-centeredness; focus on self-management and what would make for a better life
Privacy/confidentiality regulations, limited IT/communication infrastructure threaten seamless communication between systems/providers	Learn from other states/areas that have resolved privacy/confidentiality barriers; address statewide, regional infrastructure and technology needs
Excluding developmental disabilities staff/expertise	Include developmental disabilities staff/expertise in planning and implementing
Lack of supportive housing	Leverage housing grants to increase supply of housing; address support side of equation through Care Transition (and Care Coordination) interventions
Quality of services and support, workforce, training, implementation support	Address statewide, regional infrastructure and technology needs through DSRIP workforce initiative, other efforts and funding opportunities; develop regional directory of services
Sustainability beyond 2020 (e.g., HMOs, not those bearing the costs of the intervention, benefit	Demonstrate outcomes including cost-savings and benefits of alternative payment models; leverage

Challenges, risks, and barriers	Opportunities and mitigation strategies
financially)	existing resources wherever possible; care coordination can relieve burden of providers, boosting productivity/morale/retention

References

Glasgow, R. E., Vogt, T. M., & Boles, S. M. (1999). Evaluating the public health impact of health promotion interventions: the RE-AIM framework. *American Journal of Public Health, 89*(9), 1322–1327. <https://doi.org/10.2105/AJPH.89.9.1322>

15f. [Implementation Approach and Timing](#)

See Supplemental Data Workbook 15F Tab

Governance structure for the Region 1 Integrated Delivery Network for the Medicaid population with behavioral health related diagnosis.

Background

We understand governance as the establishment of policies and continuous monitoring of their proper implementation, by the members of the governing body of the IDN. It includes the mechanisms required to balance the powers of the members (with the associated accountability), and their primary duty of improving health outcomes for the populations we serve and the best possible cost.

We adopt the principles of good governance as enunciated by The United Nations Development Program (UNDP). As stated by the Institute on Governance by grouping them under five broad themes, we recognize that these principles often overlap or are conflicting at some point, that they play out in practice according to the actual social context, that applying such principles is complex and that they are all about not only the results of power and authority but how well it is exercised.

Legitimacy and Voice	<p>Participation – all men and women should have a voice in decision-making, either directly or through legitimate intermediate institutions that represent their intention. Such broad participation is built on freedom of association and speech, as well as capacities to participate constructively.</p> <p>Consensus orientation – good governance mediates differing interests to reach a broad consensus on what is in the best interest of the group and, where possible, on policies and procedures.</p>
Direction	<p>Strategic vision – leaders and the public have a broad and long-term perspective on good governance and human development, along with a sense of what is needed for such development. There is also an understanding of the historical, cultural and social complexities in which that perspective is grounded.</p>
Performance	<p>Responsiveness – institutions and processes try to serve all stakeholders.</p> <p>Effectiveness and efficiency – processes and institutions produce results that meet needs while making the best use of resources.</p>
Accountability	<p>Accountability – decision-makers in government, the private sector and civil society organizations are accountable to the public, as well as to institutional stakeholders. This accountability differs depending on the organizations and whether the decision is internal or external.</p> <p>Transparency – transparency is built on the free flow of information. Processes, institutions and information are directly accessible to those concerned with them, and enough information is provided to understand and monitor them.</p>

Purpose:

To provide a framework that supports open communication and sets priorities for the institutional and community collaboration required to successfully develop and implement the Integrated Delivery

Network (IDN) for region 1 and to direct the funding in ways that encourages the best value and health outcomes for the population served.

Guiding principles

Guiding principles for the governance of the IDN Region 1 partners include:

1. Patient/Client- Family-Centered Care: Optimizing the value of care for patients/clients is the first and most important goal.
 - Value = $\frac{[(\text{Patient/client experience X Quality of care})]}{\text{Cost}}$
 - Care plans and interventions will be guided by evidence (when evidence exists)
 - Prevention of illness is included in this definition of care
2. Transparency amongst IDN partners
3. Efficient planning process
 - Use existing data and resources whenever possible
 - Leverage existing networks and relationships whenever possible
4. Include patients/clients/families as members of our planning team
5. IDN partners work together in trusting relationships
6. To serve and make decisions with a responsibility to the whole population/community we serve, not simply to the organization we work for.
7. Strive for consensus. Use the following scale for consensus assessment

Levels of agreement

6. I enthusiastically agree!
7. Yes, I agree.
8. I have minor reservations, and generally agree. I will actively support the decision of the group.
9. I have major reservations and would like more dialogue before moving forward.
10. I will actively work against this idea. I do not think it is in our best interest to move forward.

Discussion rule: Discuss, try to resolve reservations for ≥ 3

Decision rule: if everyone 3 or lower à “good enough” consensus, move forward!

Structure

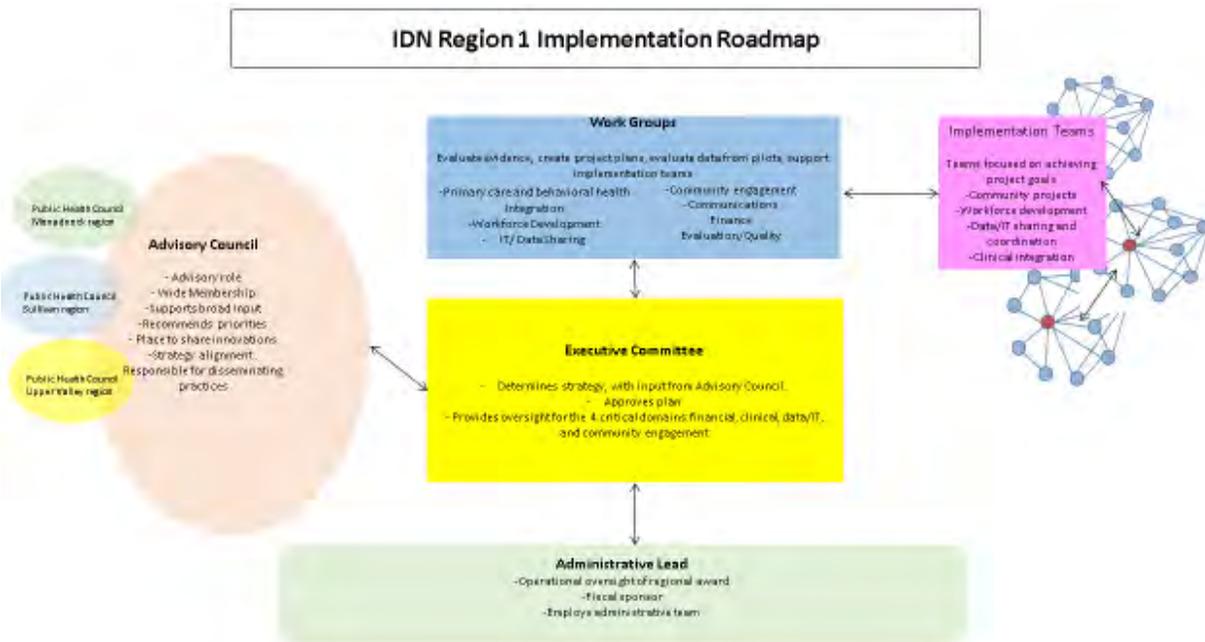
The governance approach for the region 1 IDN will include a diverse and complementary set of structures with different levels of authority and differentiated, but complementary, tasks and accountabilities.

The core components include, but are not limited to:

1. Advisory Council
2. Executive Committee
3. Administrative lead
4. Workgroups
5. Task forces
6. Implementation teams

Assumptions for the Governance Transition Process

- The membership of the Advisory Council and the Elected Executive Committee agreed that the governing structure put in place as the initial application for the IDN Region 1 was submitted to the state on June 2016 was temporary.
- It is expected that the governing documents and the elected bodies composition are revisited as the IDN administrative lead submits the application to the state by its due date (Now October 31, 2016)
- This governance structure document, approved on Sept XX, 2016 should be reviewed at least annually to determine if still fulfill the needs of the IDN partners, new structural, financial or organizational developments and above all the needs the of the population the IDN serves.



IDN Partner Organizations

To be an IDN partner organization an entity shall provide services with the potential to positively impact the health and social outcomes of the population with behavioral health conditions. Those entities can be direct service providers or be recognized conveners and advocates for improved health outcomes, multi-sector collaboration, community engagement and outreach.

Each IDN partner organization agrees to comply with the policies and procedures set forth and by the IDN.

Each IDN partner organizations will actively contribute to achieving the collective IDN goals,

Each IDN partner organizations will adhere to the IDN guiding principles

Each IDN partner organizations will sign an agreement with Dartmouth Hitchcock, who is the administrative lead and as such responsible of the contract management and reporting to the state.

The IDN partner organizations are collectively responsible for the outcomes of the partnership.

Each IDN partner organization will be directly accountable on the performance measures results related to their organization

No IDN partner will require the administrative lead to apply polices or procedures that go against the administrative lead internal business practices.

If an IDN partner organization does not perform, as measured by their contribution to achieve the mandated goals, the executive council can terminate their membership, by following procedures developed by the administrative lead and approved by the Executive Council.

All IDN partner organizations are members of the IDN advisory council

Each IDN partner organization will have one vote for the election of the executive council members and only partner organizations can vote to elect the Executive

Advisory Council

The role of the council is advisory in nature. Membership will include all IDN partner organizations and a broad based representation of all other organizations and individuals playing a role on improving outcomes for the Medicaid population with behavioral health needs and who reside in the state defined Region 1 for the Delivery System Reform Incentive Program (DSRIP). Such representation should include members of the population using the services and their families. There is no limit on the number of members and no term limit for participation in the advisory council.

The advisory council can advise the Executive committee of the need for specific workgroups or taskforces to help advance its function and responsibilities. As an example it may identify the need for a patient/family workgroup, with broad regional representation. The advisory council will serve as well as a bridge with the regional Public Health Advisory Councils and validate the IDN work with the regional priorities of the Community Health Improvement Plans

The Advisory Council will meet on a regularly scheduled basis as set by the Executive Committee. It is anticipated to occur at least six times per year. The meetings will provide opportunities for networking, updates, specific organizational or programmatic issues, etc. The council meetings will allow for an informal flow of conversation necessary to generate information, identify challenges and opportunities, and discuss solutions. Meeting agendas will be developed by the executive committee, and any member of the Advisory Council may suggest items to be reviewed at one of the council meetings.

Advisory Council Responsibilities:

5. Help identify and encourage action planning to ensure that the health needs of the population served by the IDN efficiently and valuing both clinical and non-clinical patient needs in its considerations
6. Communicate about IDN activities to the community and bring the voice of the community to IDN stakeholders
7. Support the coordination, needs assessments, and data collection activities that produce actionable and consistent data as it relates to the IDN activities and goals
8. Advise and make recommendations, as appropriate, to the IDN executive committee on funding opportunities that overlap or complement IDN priorities
10. Serve as a place to share innovations; align strategies.
11. Engage partners to implement the IDN strategies and plans
12. Identify community assets and mobilize and leverage their resources in support of the IDN goals
13. Responsible for disseminating best practices.
14. Serve as a bridge with other regional and state related stakeholders

Advisory Council Membership: The council will include a broad based representation of the multi-stakeholder sectors in the Region. It is important to demonstrate that the advisory council composition

is representative of the stakeholder groups listed below as well as geographic representation. Though not complete, stakeholder groups include:

- l. Service users from the region
- m. Primary care provider organizations
- n. Mental health care providers
- o. Substance use disorders care providers
- p. Recovery community and organizations
- q. County and city authorities
- r. Public School Districts
- s. Social Service/Non-Profit organizations
- t. Educational Organizations
- u. Correctional and justice systems
- v. Employers

Members are expected to:

- Attend a minimum of 50% of the full Council meetings in a calendar year
- Serve on standing committee or workgroup and attend at least 50% of the meetings in a calendar year

Executive Committee:

The Executive Committee is the primary governing body of the Region 1 Integrated Delivery Network (IDN). The Executive Committee provides strategic direction to the administrative lead and in partnership with the IDN Administrative Lead, is accountable for the execution of Region 1 project plans. As requested by the state of NH this group will provide the oversight for the 4 critical domains of the IDN: financial, clinical, data/IT, and community engagement.

The Executive Committee approves planning documents and budget allocations and it is responsible for setting direction, identifying priorities, and making decisions specifically on the 4 critical domains mentioned above. It will receive, review and approve progress reports from the Administrative lead and the committees created to develop an oversee the 4 critical domains and the overall adequacy of the network in servicing the behavioral health needs of our population.

Composition of the Executive Team will represent the diversity of IDN partners and members will make decisions on behalf of IDN partners.

Executive Committee Members Responsibilities (Job description):

- In addition to representing their sector and professional organization, members of the Executive committee will actively seek input from and represent all IDN partners across the Region.
- Executive committee members will make strategic decisions for the collective benefit of the Medicaid beneficiaries attributed to Region 1 IDN and to help the IDN achieve success
- Understand the strengths/needs of IDN partners in order to fairly represent Region 1
- Have full knowledge of the requirements in the State Project Plan application
- Provide expertise and experience to the development, implementation and evaluation of the Region 1 Project Plan application, drawing from personal knowledge or gathering input from external sources
- Attend meetings regularly

- Complete assigned tasks by agreed upon deadlines
- Communicate with IDN partners. Provide information to IDN partners and communicate partner information back to the Executive Team.
- Agree to serve a two-year term
- Assist in developing structure and procedures to assure efficient executive committee functions and communication
- Lend expertise and experience to the action planning, assessment, and prioritization of health needs for the Medicaid patients with behavioral health diagnosis within region 1
- Engage and recruit new members to the Advisory Council and executive committee as appropriate
- Represent the IDN to the community by sharing information regarding roles, responsibilities, actions, and priorities
- State conflict of interest and abstain from voting where applicable
- Expected to serve as an ambassador on behalf of region for Population Health Improvement

Executive Committee membership

Initial Executive Committee will be comprised of 7 institutional members and 4 community members. The administrative lead staff will attend the executive committee meetings, with no voting rights. The institutional positions will strive for geographic representation and diverse expertise as it relates to oversight of the 4 key domains: financial, clinical, data/IT, and community engagement

# Seats by Sector	Sector
1	Provider of Primary Care Services
1	Provider of Mental Health Care Services
1	Provider of Substance abuse disorders care services
1	County and/or city government
1	Human services (i.e. wrap around services, service link, housing, transportation etc.)
1	Other sectors on the Social determinants of Health (i.e. PH networks, education, employment, etc.)
2	Service user (community member)
2	Family member (community member)
1	At large

- Term Limits/Maximum length of term:
 - Term will be two-year period with ability to renew for an additional two-year period. Limit of 2 terms.
 - Failure to attend 4 of the 12 monthly executive committee meetings in a calendar year may result in termination from the executive committee
 - A nominations workforce will set a process for the selection of new members or the confirmation of current ones. This process should be approved by the Executive Committee and the Advisory Council.
 - Any vacancy on the EC should always be reported to the Advisory Council
 - Vacant positions on the executive committee will require election based on sector representation and recommendation from the nominations workgroup.
 - The Executive Committee will jointly with the administrative lead develop an operational manual and decision making process

Officers:

- A. Elected and Appointed Officers: The chair and vice-chair shall be the elected officers of the executive committee and the advisory committee. The IDN administrator will be an appointed officer.
- B. Nomination and Election of Officers: At the first constituting meeting after an election the IDN administrative lead will solicit interest and nomination for the elected roles. At that meeting the elected roles will be voted in by simple majority.
- C. Qualifications for Elected Officers: Only members currently serving on the Executive Committee are eligible for election as officers.
- D. Terms of Office: The chair and vice-chair shall be elected to a one-year term of office.
- F. Duties of the Officers:
 1. *Chair*: It shall be the duty of the Chair:
 - a. Support the role of the Administrative lead representing the IDN in its contacts with governmental, and other public and private agencies for the purpose of advancing the objectives and policies of the IDN.
 - b. To be chair and preside at the meetings of the Advisory Council and the executive committee.
 2. *Vice-chair*: It shall be the duty of the vice-chair:
 - a. To assist the chair as requested.
 - b. To preside at meetings in the absence of the chair.
 - d. To succeed the Chair if a vacancy is realized.
 3. IDN Director. It shall be the duty of the IDN Director:
 - a. To serve as the operating officer of the IDN
 - b. To direct and manage all activities of the IDN under the strategic and policy guidance of the Executive Committee, while staying within the legal and operating policies of the Admin Lead org
 - c. To serve as an ex-officio member of the Executive Committee and the advisory council without vote.
 - d. To perform as the secretary of the Executive committee and the advisory council.
 - To preside at meetings in the absence of the chair and co-chair.
 - To provide for the recording and timely distribution of the minutes of all meetings of the CHC and the executive committee
 - To see that all notices for meetings are duly given

Decision Making Process:

As described above, the Advisory Council and the Executive Committee will strive for consensus. Some decisions such as the election of executive committee members, election of officers, approval of IDN plans or funding decisions will require a vote. Votes will be held at regularly scheduled meetings if at all possible and a simple majority will be required to approve or deny the item under vote. Items for vote will be carefully worded and read before the vote takes place. Documentation of the vote will be made by the secretary in the minutes of the meeting. If votes are held electronically, such as the Executive Committee membership election, clear instructions for deadlines need to be included with the item under consideration. Simple majority of voters will make the decision. Policy changes, priority selections or re-prioritization, and election of officers will only occur at regular meetings. The IDN director will

advise the Executive Committee when a decision may be considered contrary to the ethical and administrative policies and procedures of the administrative lead organization.

Administrative Lead

Administrative Lead will serve as the coordinating entity for the IDN's partner network in planning and implementing projects and as a single point of accountability for the State.

The administrative lead has the authority to hire/fire, and sole responsibility for daily supervision of project staff. Following NH-DHHS directives the administrative lead will appoint an IDN Director, Medical director, finance director, IT director and other staff as appropriate and necessary.

The administrative lead will advise the executive committee of its internal administrative policies as they relate to hiring, contracting and finance management and how they are implemented. At no moment those practices are subject to the approval of the executive committee.

Administrative Lead responsibilities:

- Act as single point of accountability for DHHS
- Submit single application and reports on behalf of IDN
- To hire administrative staff.
- Implement IDN governance structure in accordance with DHHS parameters and agreed-upon approach of IDN partners
- Oversee and approve the distribution of funds to vendors and partners in accordance with the plan approved by the Executive Committee.
- Provide administrative support for governing committees
- Document/define Advisory Council activities and Executive Committee systems, processes
- Utilize existing resources within the community to assist with some of these tasks.
- Assure effective communication and coordination with and between Advisory Council and other committees and coalitions in the region
- Receive funds from DHHS and distribute funds to partners
- Compile, analyze, and submit required data and reporting to DHHS
- Collaborate with partners in IDN leadership and oversight
- Collaborate with IDN partners to manage performance against goals and metrics

Workgroups and Task forces:

Executive Committee will charter as many workgroups or task forces as it deems necessary to develop, monitor and evaluate the implementation of action plans that respond to the identified priorities.

A taskforce would be a group of people working on a specific problem with the goal of solving the problem quickly (typically 6 months, but never longer than 12months). Workgroups will address issues that require a term longer than a year of ongoing activity. Authority for adoption of recommendations or reports will not be delegated to any workgroup or taskforce. Workgroups and task forces will present periodic reports to the Executive Committee and will be invited to present progress reports to the advisory council as appropriate. The Executive Committee will determine, in a charter, the composition

of each such workgroup or task force and the manner of selection, removal and replacement of its members. Not all members of these groups are expected or required to be members of the advisory council or executive committee.

Such workgroups shall include at least a community engagement, Data/IT, Finance, workforce capacity, Clinical care, nominations and Communications workgroups, and such other workgroups as the Advisory Council may find necessary or expedient from time to time.

Workgroups will initially include: community engagement, Data/IT, Finance and Clinical care. Other workgroups will be chartered as the Advisory Council may find necessary or expedient from time to time.

Region 1 recognizes that there is a clear and distinct overlap between the work necessary to succeed on an integrated health model and the community based projects. To this end all workgroups have to understand and manage their objectives and scope within that framework, as shown on the table #? Since all workgroups report to the executive committee this has the responsibility and ultimate accountability for achieving project goals and ensure the adequacy of the network in serving the behavioral health needs of our population. Because of this overlap we have standardized responsibilities, roles, membership selection and decision making process across all workgroups.

As depicted in the table below, some of the Work Groups address core functions (listed along vertical axis) while other Work Groups are directed to implementing models of care as measured by process and outcome metrics (listed horizontally). As we develop additional care model-focused Work Groups, we will ensure consistency and coordination by using a matrixed relationship across the portfolio of projects. Representatives from the functional, core Work Groups (clinical governance, HIT/Data, finance, community engagement) will populate the care model Work Groups along with other IDN members selected following Region 1 policies. This organizational structure minimizes the risk of working in “silos.” Our executive team (Executive, Medical, Finance Directors and Project Coordinator) are responsible for coordinating and aligning across work groups.

	Integrated health Care	Care Transitions	Care coordination for High need	Intensive Outpatient treatment
Care (clinical) workgroup	✓	✓	✓	✓
IT/data workgroup	✓	✓	✓	✓
Finance workgroup	✓	✓	✓	✓
Community Engagement workgroup	✓	✓	✓	✓

Responsibilities for the executive committee include: approve the Work Group charter and plan; secure resources for the project; confirm the project’s goals and objectives; keep abreast of major project

activities; make decisions on escalated issues; and assist in the resolution of roadblocks. The IDN Executive Director is responsible for timely communications between Work Groups and the Executive Committee and ensuring Work Group needs are adequately addressed by the Executive Committee. Project plans will be reviewed and endorsed by the Executive Committee.

The IDN Project Manager will ensure Work Groups receive adequate support for project management, communicating to the Executive Director if additional resources are required.

Work Group membership will be drawn from IDN partner organizations, patients/consumers, and caregivers/families or IDN contracted entities. All Work Groups will have 2 or more positions for individuals representing patients/consumers or caregivers. Work Group composition will strive for balanced geographic representation and include stakeholders who have subject matter expertise and/or will be impacted by Work Group activities. The Executive Committee will work with the Administrative and Executive leadership teams to establish processes for selecting Work Group members. Work Groups will determine meeting frequency but will be no less than monthly in the first year of IDN operations.

Every Work Group is led by a Work Group lead or co-leaders (this could be a member of the Administrative or Executive leadership teams). Work Group Leader and/or Co-Leaders will lead the Work Group through team motivation and maintaining and enhancing relationships with key stakeholders and customers in the planning and development of the project; Responsibilities include: Coordination with the project manager on developing the project plan and deliverables that will meet the requirements of the IDN goals, New Hampshire objectives for this DSRIP project and fulfill CMS requirements, scope control, change management, conflict resolution with other projects, approval of risk mitigation strategies; final signoff on resource deployment and utilization; and organizational communication.

The Work Group Project Manager will lead in the planning and development of the project; manages the project to scope. Responsibilities include: develop the project plan; identify project deliverables; identify risks and develop risk management plan; direct the project resources (team members); scope control and change management; oversee quality assurance of the project management process; maintain all documentation including the project plan; report and forecast project status; resolve conflicts within the project or between cross-functional teams; ensure that the project's product meets the business objectives; and communicate project status to stakeholders. The project manager for Region 1 IDN may identify a designee to serve as workgroup project manager.

Team Members will work toward the deliverables of the project. Responsibilities include: understand the work to be completed; complete research, data gathering, analysis, and documentation as outlined in the project plan; inform the project manager of issues, scope changes, and risk and quality concerns; proactively communicate status; and manage expectations. Attend and actively participate in Work Group meetings.

Term Limits/Maximum length of term for Work Group members: Term will be two-year period with ability to renew for an additional two-year period. Limit of 2 terms. Failure to attend 6 of the 12 monthly meetings in a calendar year may result in termination. The Executive Committee will work with a nominations workforce to determine the processes for selection of new members or the confirmation of current ones. This process should be approved by the Executive Committee and the Advisory Council Decision making in the Work Group will follow the same procedures as outlined in the standalone Region 1 Governance Document: Strive for consensus. If the Work Group reaches an impasse and

cannot move forward, the Work Group leader(s) will communicate with the IDN Executive Director who has the authority to escalate to the Executive Committee.

Common components of the scope of work for the workgroups are: All work will be focused on region 1 DSRP attributed population and the term of the work will coincide with the NH DSRP waiver 1115 project term. Even though limited by geography and attribution, region 1 is interested in encouraging across regions participation and standardization as appropriate and supported by the state. With this common framework in mind the four core domains workgroups have defined objectives and scope. For a full version of those charters see section 7c.

1. Clinical workgroup. In region 1 we use an expanded definition of “clinical” to include some aspects of social determinants of health. That is why refer more to the standards for the continuum of care. This group will establish the processes to develop evidence-based care guidelines for behavioral health disorders and the integration of behavioral health, general health and the social aspects that impact health. Working with the Region 1 Data and IT Work Group, meaningful measures will be developed to inform care teams of their progress implementing evidence-based care. The Clinical Governance Work Group will monitor performance at the Region- and partner-level, working with IDN partners to identify barriers to implementation and secure necessary resources for improvement. Recognizing holistic care includes more than clinical therapeutic interventions, this Work Group will also address the non-clinical interventions and supports that are critical in healing for patients and families suffering from behavioral health disorders. Best practices and evidence-based interventions focused on non-clinical care will be evaluated, vetted, and included as recommendations in care model design and implementation.

The workgroup will develop processes for evaluating evidence and when evidence is lacking to evaluate best practices regionally or nationally; Establish processes to vet and endorse the evidence based knowledge related to care for behavioral health disorders; Establish processes to maintain and curate the knowledge base for behavioral health care; Develop clinical decision support tools such as clinical guidelines; Work with the Data and IT workforce to identify meaningful measures to inform implementation (process metrics) and to communicate performance (outcome metrics); Monitor IDN performance in aggregate and at the organization level, identifying opportunities for continuous improvement, facilitating learning amongst IDN partners, and communicating barriers to improvement to appropriate IDN committees

2. IT/Data Workgroup. The objectives of this workgroup will be to convene IDN-1 stakeholders that bring technology subject matter expertise, information policy expertise, and wide-ranging perspective (patient & caregiver, technical, clinical, and operational) to the 1115 waiver program. To consider and recommend IT investments and projects that can support IDN-1 clinical and operational goals and requirements. To develop strategies for information exchange between IDN partners using IT and guided by input from the State IT Task Force. To provide processes and standards for data sharing among the partners in the IDN. To establish IDN policies and procedures related to data collection, data integration, and data reporting. To provide guidance on the approach to drafting and executing data sharing agreements. To support IDN-1 decisions with data and analyses including clinical quality measures for operating the IDN and evaluating impact of IDN activities. To develop reporting and reporting processes for the IDN. To develop monitoring policies and procedures. To determine the roles of information technology, health informatics, clinical, and administrative leadership within partner organizations will play on overall data governance.

3. Finance workgroup the objectives of this workgroup include the overseeing of the finances for the region. To ensure that Region 1 meets the financial requirements and provisions of Building Capacity for Transformation Section 1115(a) Waiver. To establish financial control policies and procedures, including accounts payable, purchasing and receiving, treasury, accounting, reporting, and audit. To establish and monitor budgets. To oversee the preparation of financial reports for external stakeholders and the Executive Committee. To advise the Executive Committee on financial issues related to proposed programs for Region 1. To review and approve the financial provisions of contracts entered into by Region 1 in fulfillment of Region 1's Project Plans. To review and advise on the adoption of alternative payment models.
4. Community engagement Workgroup. This workgroup will plan and recommend strategies for engaging patients, families, and organization stakeholders in decisions of the Region 1 IDN. The Work Group will advise Admin Lead and IDN staff regarding approaches to conducting Behavioral Health Needs Assessments and provide networking assistance with disseminating BHNA surveys and organizing BHNA community discussion groups. The work group will recommend to IDN staff strategies to more broadly disseminate information about the work of the IDN and to obtain broad community input into its efforts. Scope: This Work Group will focus on Region 1 DSRIP attributed population and participants in Region 1 IDN. The term of this project will be the NH DSRIP Waiver 1115 project term. Determine how community input will be received and included in the strategic path of the IDN; Determine the channels and venues through which input is solicited; Determine how the communication strategies will continue through the demonstration.
5. Nominations Workgroup: Its purpose is to identify suitable candidates for the executive committee and crafting the slate of members on an annual basis. This workgroup consists of five active members of the Advisory Council/Executive committee. A member of the Advisory Council will serve as co-Chair of this committee.
6. Communication Workgroup: The aim of the work group is to recommend policies, strategies and activities that facilitate communication between internal and external audiences. The internal audience includes all IDN partners as well as the people and families they serve. The external audience includes the general public, the media, and other non-partner organizations and government agencies. This committee consists of at least five active members of the Advisory council/Executive committee and one of the Executive Committee members will serve as co-Chair.
7. Task Forces: as needed to address short term needs of IDN

Team Bios

Executive Committee



Region 1 Bio: Ruth Bleyler retired from the US Environmental Protection Agency and for many years has been an advocate for disability issues as a family member, including mental health. She has served in the NH Legislature, the WCBH board of directors, NAMI and continues to serve in several volunteer roles. Contact Information: ruth.bleyler@gmail.com. Phone: (603) 790-8338



Dennis Calcutt, MPA, is the project manager of the Monadnock Region System of Care planning grant, a grant held by the Cheshire County government and funded by the Substance Abuse and Mental Health Services Administration, serving the Monadnock Public Health Region. He has 25 plus years of experience working with children, focusing on children's mental health, with a particular interest in building community. Dennis is a New Hampshire Listens Fellow in the Carsey School of Public Policy at the University of New Hampshire. He lives in Frankestown with his wife and three girls. Contact information: email: dcalcutt@co.cheshire.nh.us, phone 603-357-1738.



Holly Cekala is currently the Vice President of Programs for HOPE for NH Recovery. She opened the first recovery community center in New Hampshire in July of 2015. She holds near and dear the mission to advocate for those in recovery and their families. This position was a natural transition after serving as the Executive Director of Rhode Island Communities for Addiction Recovery Efforts (RICARES), Manager of the Anchor Recovery Community Centers in Rhode Island, as well as designing and implementing the first recovery support program in hospitals in the country. Contact information: holly@recoverynh.org. Office phone: (603) 935-7524

Region 1 - Christopher Coates is the County Administrator for the County of Cheshire, one of ten counties in NH and one of four (Grafton, Sullivan, Hillsboro, and Cheshire), represented in Region 1. Cheshire County is an innovated and progressive leader and is an example of the best in local government, as we drive to meet the unique and unmet needs of the county residents. Chris lives in Keene with his wife. Contact Information: ccoates@co.cheshire.nh.us. Cell: (603) 313-9002.



Alice R. Ely, MPH, CPS, is Executive Director of the Public Health Council of the Upper Valley, which as one of the State of New Hampshire's 13 regional health networks has quickly become the largest and broadest coalition of advocates on public and population health issues in the greater Upper Valley region. Contact information: alice.ely@mvhi.org. Office phone: (603) 523-7100.



Suellen Griffin, MSN, MHCDS, FACHE is President and CEO of West Central Behavioral Health. WCBH is one of 10 Community Mental Health Centers in New Hampshire providing a full range of mental health services to all ages. Suellen is also President of the New Hampshire Community Behavioral Health Association. Contact information: sgriffin@wcbh.org. Office phone: (603) 448-0126 X 2127.



John A. Manning, CPA is the Chief Executive Officer of Southwestern Community Services, Inc., the community action agency serving Sullivan and Cheshire Counties. He previously served as their CFO for 25 years. He and his wife live in Marlborough, where he serves as the town's Fire Chief. His contact information is as follows: jmanning@scshelps.org. Office phone: (603) 719-4211.



Michele Nuttle is a family representative on the Executive Committee. Her lived experience includes an 11-year-old son with mental and behavioral health issues. She is also in long-term recovery. Contact information: nuttlemichele@gmail.com. Phone: (603) 562-0986



Andrew Tremblay, MD is the Chair of Primary Care at Dartmouth Hitchcock-Keene – a multispecialty group practice located in Keene, NH. He received his medical education at Boston University School of Medicine from which he graduated in 1997. He went on to complete his residency in family medicine at the Toledo Hospital Family Practice Residency Program in Toledo, OH. He practiced briefly in Swanton, OH before joining the Dartmouth Hitchcock-Keene Family Medicine Department in 2001.

Dr. Tremblay and the entire Department of Primary Care at CMC/DHK are committed to bringing high-quality; compassionate and innovative care to their community to help fulfill the organizational vision of Health Monadnock 2020....building the healthiest community by 2020.

Administrative Lead Support Team



Eileen Fernandes, MS is the Director of Operations for the Center of Population Health at Cheshire Medical Center/Dartmouth Hitchcock-Keene where she ensures continuous coordination, communication, and integration across the Center and the CMC/DH system. Eileen actively works with state and local partners to assess community health needs and develop action plans based on local and regional needs; develops strategies and plans for the scaling up and dissemination of products and initiatives developed and/or used at the center. Contact information: EFernandes@cheshire-med.com. Office Phone: (603) 354-5454 X 2130



Alexander (AJ) Horvath is a participating member of the IDN Administrative Leadership Team. AJ is currently serving as the project manager for Dartmouth Hitchcock's Substance Use and Mental Health Initiative, which has targeted improvement projects throughout the delivery system. Contact information: alexander.j.horvath@hitchcock.org. Phone: (603) 443-0054



Dr. Sally Kraft, MD, MPH is VP of Community Health at Dartmouth Hitchcock where she leads a multi-disciplinary team dedicated to improving the health of communities across the region served by Dartmouth Hitchcock faculty and affiliates. Contact information: sally.a.kraft@hitchcock.org. Office phone: (603) 653-6856



Dr. Jose Thier Montero, MD, MHCDS is the VP of Population Health and health Systems Integration at Cheshire medical center/ Dartmouth Hitchcock Keene. He leads a multi-disciplinary team dedicated to the development and implementation of community based approaches that improve population health across the Monadnock region. Contact information: jmontero@cheshire-med.com. Office Phone: (603) 354-5454 X 2000



Greg Norman serves as Director of Community Health at Dartmouth-Hitchcock in Lebanon. In his work he supervises community health staff building care connections between health providers and community organizations, as well as supporting staff working in multi-sector community health partnerships. He provides oversight for Dartmouth-Hitchcock's Community Health Needs Assessment Process and leads the development of Dartmouth-Hitchcock's Community Health Improvement Plan resulting from identified community needs. . Contact information: Gregory.A.Norman@hitchcock.org. Office Phone: (603) 653-6849.

Region 1 Directors

Peter Mason, MD is a family physician who has been in community practice at Alice Peck Day Memorial Hospital since 1981. He has done extensive work with underserved populations at Good Neighbor Health Clinic, The Haven, Headrest and the Claremont Soup Kitchen. His recent practice has focused on substance use disorders in both Lebanon and Claremont. He is also involved in teaching students in several capacities at the Geisel School of Medicine at Dartmouth.

Mark D. Russoniello, Vice President – Finance, Dartmouth-Hitchcock Population Health. Mark.D.Russoniello@hitchcock.org