

Community Health Services Network, LLC

Integrated Delivery Network Project Plan

Region 5



Winnipesaukee and Central New Hampshire

New Hampshire Building Capacity for Transformation

1115 Medicaid Waiver

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Submitted to:

NH Department of Health and Human Services

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1. IDN Vision and Theory of Action

The Community Health Services Network began in 2015, developed by the community in response to the alarming rise in substance misuse and overdose in the region. Working together, area health professionals, law enforcement officials and committed citizens recognized that reducing regional substance misuse and mitigating its consequences would require a multi-faceted approach and ongoing cooperation to create sustainable solutions. In response, a group of committed citizens and professionals convened to form the Community Health Services Network (CHSN) with a goal of building a strong behavioral health infrastructure in the Winnepesaukee and Central New Hampshire regions (regions now contiguous with Integrated Delivery Network Region 5).

The Community Health Services Network envisions that the health and social challenges of the whole person will be improved through a regional integrated network of care accomplished through shared governance utilizing clinical and performance standards. Recognizing the need to create greater efficiencies in the delivery of health and human services while simultaneously improving access to, and the outcomes of, health and human services, the Members of CHSN believe that collaboration and coordination in connection with infrastructure and support services will provide economies of scale, service delivery efficiencies, and a better understanding of best practices. These improvements will result in more integrated and sustainable delivery of services and improved health outcomes and quality of life for area residents.

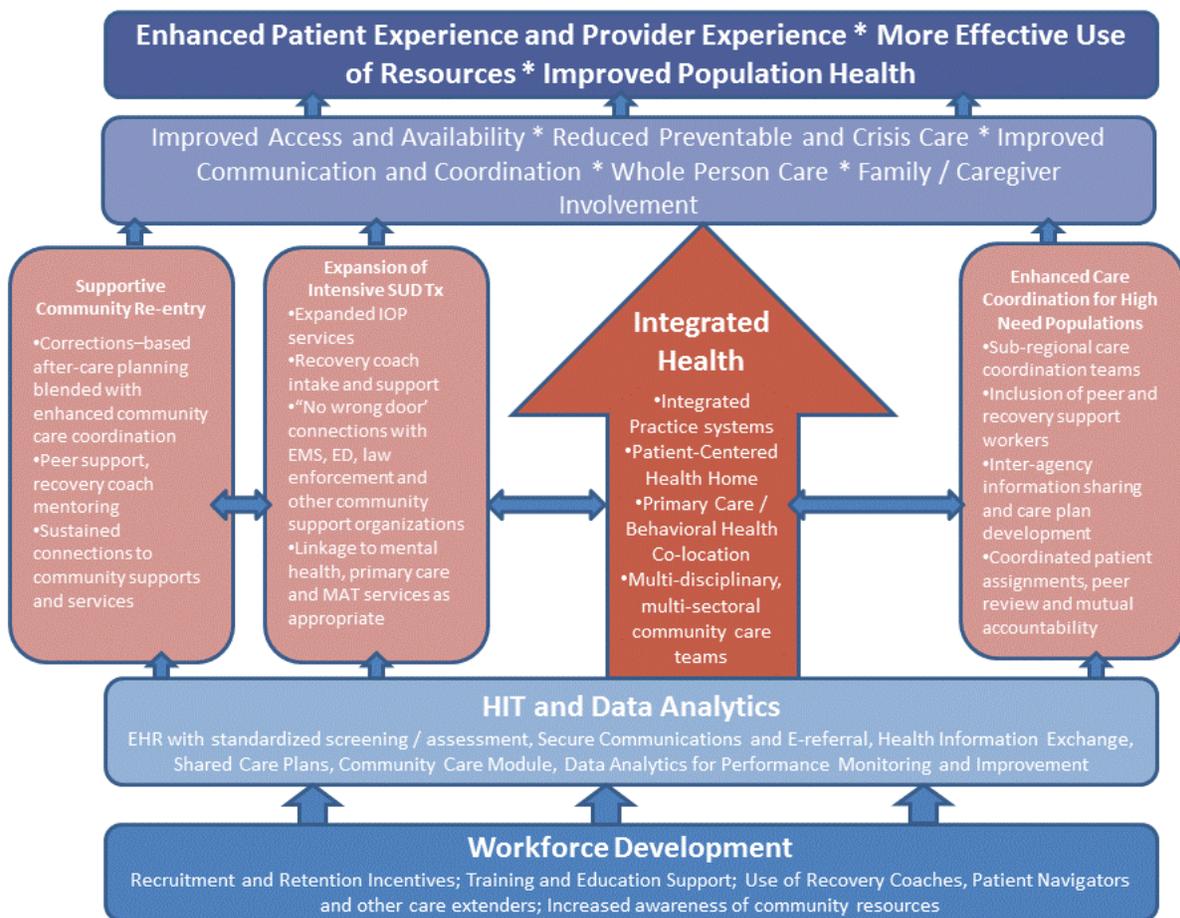
Our theory of action includes the following principles:

- Improving the delivery of health and human services in general, and behavioral health services in particular, requires working collaboratively, removing silos and barriers to strengthen the community as a whole, and achieving efficiencies and improvements in the quality of, and access to, care in our communities.
- We can better serve our patients/clients by aligning and integrating our collective health care and community services across the entire continuum of care, from preventive to acute to end-of-life care and counseling.
- Through collaboration and a clinically integrated network, we will have a sufficient patient base and spectrum of services to: seek and achieve efficiencies in our operations; better manage population health with an emphasis on prevention and quality outcomes; and participate in governmental and commercial alternative payment reforms.
- The service delivery system in our communities can be improved by working together differently in the form of an integrated delivery network. By aligning and integrating our collective health and human services across the broad continuum of care, we can ensure a future service delivery system that is responsive to the needs of the behavioral and physical health and social support needs of our communities.

As will be described in more detail throughout this plan, we have intentionally selected community-driven projects that will be mutually supportive in their activities with the ultimate goal of demonstrating progress on our vision and shared principles of action. Additionally, investments in the areas of workforce development, health information technology improvements, and practice-based and system-wide integration will provide the foundational elements of this future service delivery system for the region. The diagram below illustrates the relationships between the foundational elements of workforce development and HIT, the strategic action pathways of integrated health and community projects, and the intended intermediate and long term outcomes of our work.

STRATEGIC ACTION PATHWAYS AND OUTCOMES

Community Health Services Network (IDN Region 5)



2. IDN Service Area Community Needs Assessment

The Region 5 Integrated Delivery Network serves 33 municipalities located in the Central and Lakes region of New Hampshire with a combined estimated population of 106,067 residents. The region is comprised of two public health networks – Central New Hampshire and Winnepesaukee Public Health Networks – and encompasses all or parts of three New Hampshire Counties. According to information provided by the New Hampshire Department of Health and Human Services, a total of 20,247 residents of the Region 5 Integrated Delivery Network (Region 5 IDN) were eligible for Medicaid as of December 31, 2015; about 19.1% of the total resident population. Section 2.a. below provides information and analysis describing the Medicaid population of the Region 5 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 6,500 residents of Region 5 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

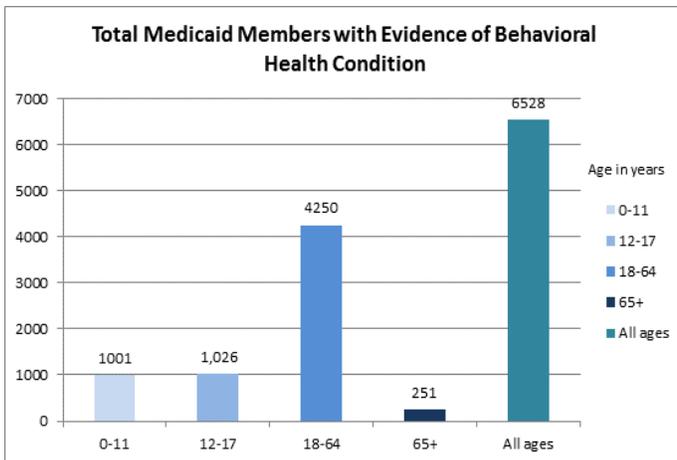
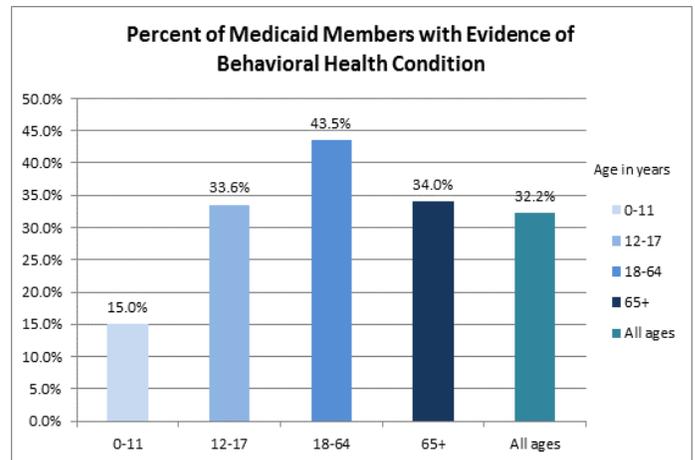


Chart 2.2



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 display information showing that about 91% of Medicaid members with a behavioral health condition also have at least one other physical health condition compared to about 75% of Medicaid members who do not show evidence of a behavioral health condition. Similarly, about 47% of members with a behavioral health condition have 2 or more physical health co-morbidities compared to about 30% 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 wellbeing and associated health and human service and support needs.

Table 2.1: Age and Major Condition Prevalence of the Region 5 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 (Percent of Total Medicaid Members within each age group)			
						CVD	Respiratory	Diabetes	Other Physical Health
	Estimate of Medicaid Members (count) in each category								
Child (0-11)	340		--	--	659	0.3%	5.7%	0.3%	12.9%
Youth (12-17)	313		--	--	698	1.7%	11.1%	0.1%	28.8%
Adult (18-64)		525	493	443	2,873	12.0%	15.8%	4.0%	38.8%
Senior (65+)		10	--	--	72	21.2%	14.3%	11.6%	32.3%

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

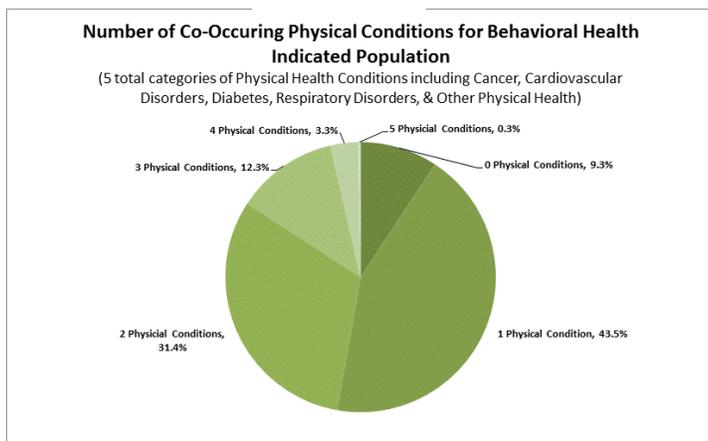


Chart 2.4

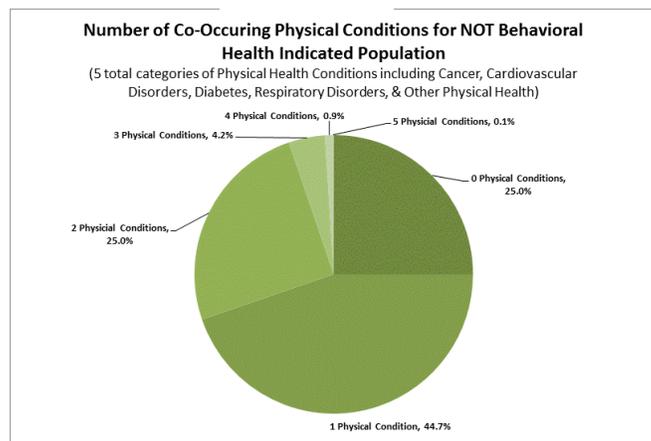


Chart 2.5 on the next page displays information describing pharmacy utilization for the largest age category of 18-64 years. Medicaid members with evidence of a behavioral health condition utilized pharmacy services at a substantially higher rate than those without a behavioral health condition, further 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

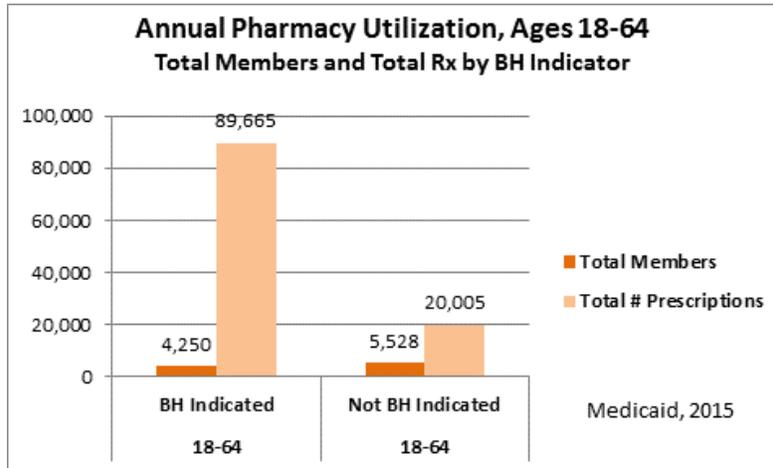


Chart 2.6 displays information suggesting that Medicaid members received preventive health services in 2015 at proportions similar to or slightly higher than those members without a behavioral health condition. However, as displayed by Chart 2.7, members with evidence of a behavioral health condition 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 939 Medicaid members age 19-64 with evidence of a behavioral health condition received care in an Emergency Department (ED) for a condition potentially treatable in primary care, equivalent to about 22% of members in this category. In contrast, 454 Medicaid members without evidence of a behavioral health condition had ED visits of a similar nature, or about 8% of members in this category. 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 (14% and 12% respectively).

Chart 2.6

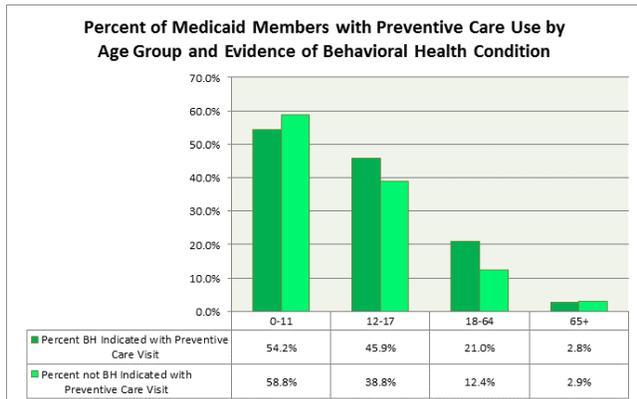
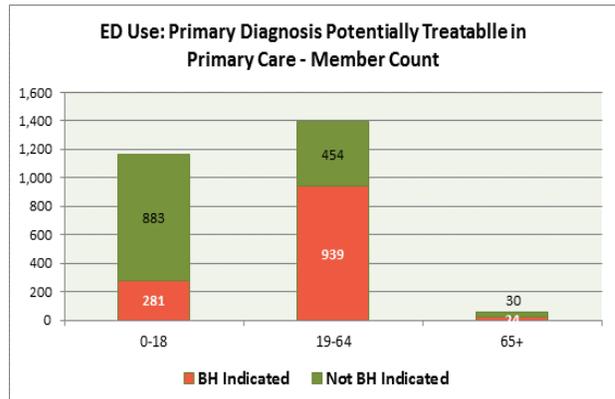


Chart 2.7



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 more than 4 times more likely to have had four or more visits to an ED in 2015 (8.6% of members with evidence of a behavioral health condition compared to 1.9% of members without). Similarly, the 30 day hospital inpatient readmission rate for behavioral health indicated members (13.4%) was more than double the rate for non-behavioral health indicated members (5.9%).

Chart 2.8

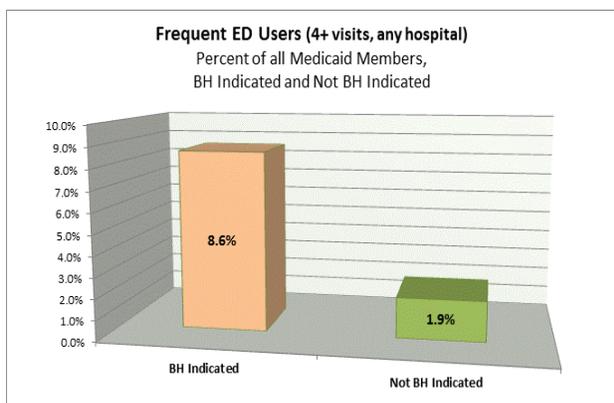
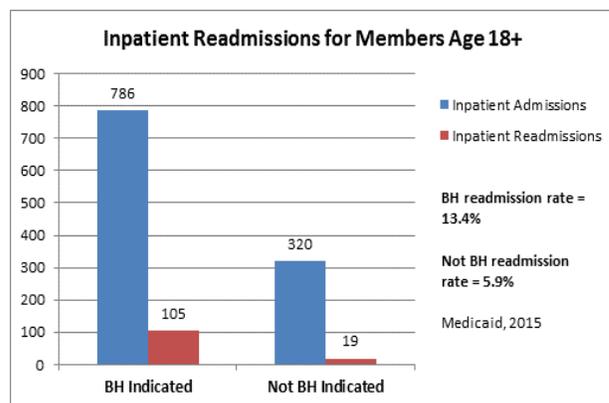


Chart 2.9



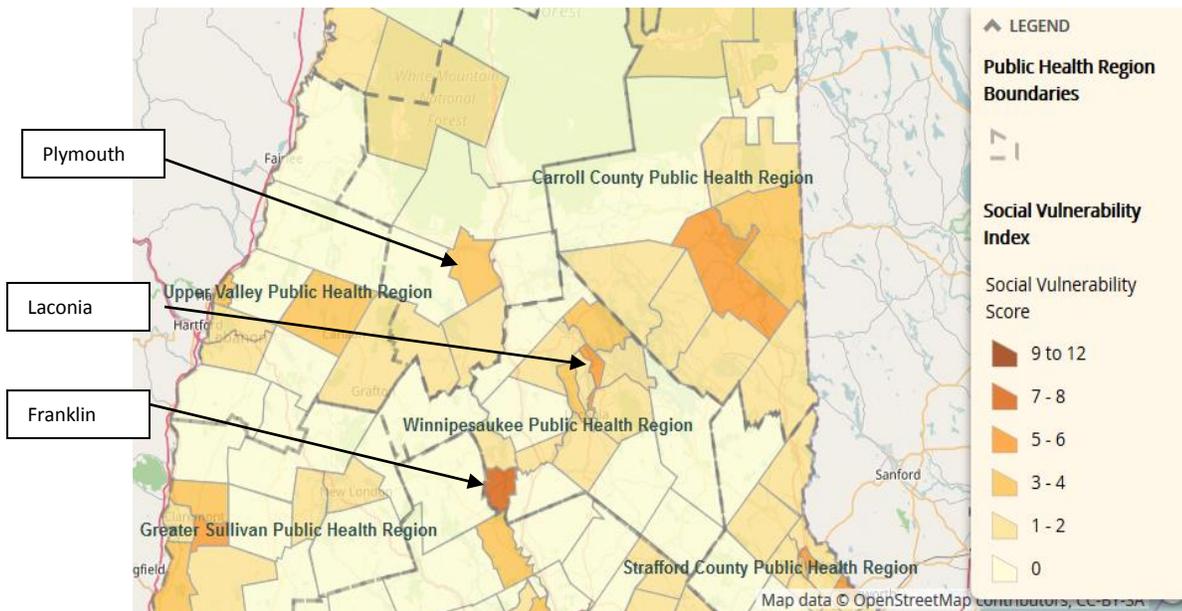
These data suggest important opportunities for enhanced care management with additional, targeted resources focused on the Medicaid population with behavioral health conditions.

2b. Regional demographics

Selected demographic and population health statistics describing the overall population of the Region 5 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 5 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 concentrations in three of the largest population centers in the region – Laconia, Franklin and Plymouth.

Map 2.1 – NH Social Vulnerability Index



Data Source: Screen grab accessed October 2016 from

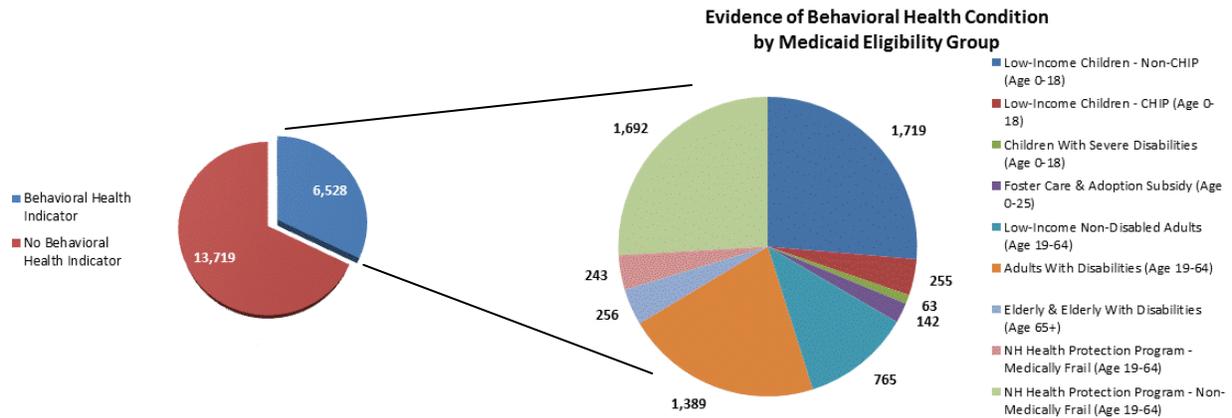
<http://nhvieww.maps.arcgis.com/apps/MapSeries/index.html?appid=148ad00240534964a1559ab823dd80d9>

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 (28.4%) is higher than the estimate for NH overall (22.6%);
- Estimated median household income in the region (\$56,580) 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 (20.2%) is slightly less than the state overall (23.5%);
- About one-third of households in the region with children are single-parent families (34.5%), a higher proportion than for NH overall (28.7%);
- The proportion of the population with a physical disability (13.2%) is similar to NH overall (11.8%);
- The proportions of the population reporting minority race or ethnicity (5.0%) or limited English proficiency (0.4%) are somewhat less than for the state overall (8.3% and 1.0% respectively);

Some demographic information describing the Medicaid population in Region 5 was described at the beginning of this section. Additional demographic information of note includes the following observations.

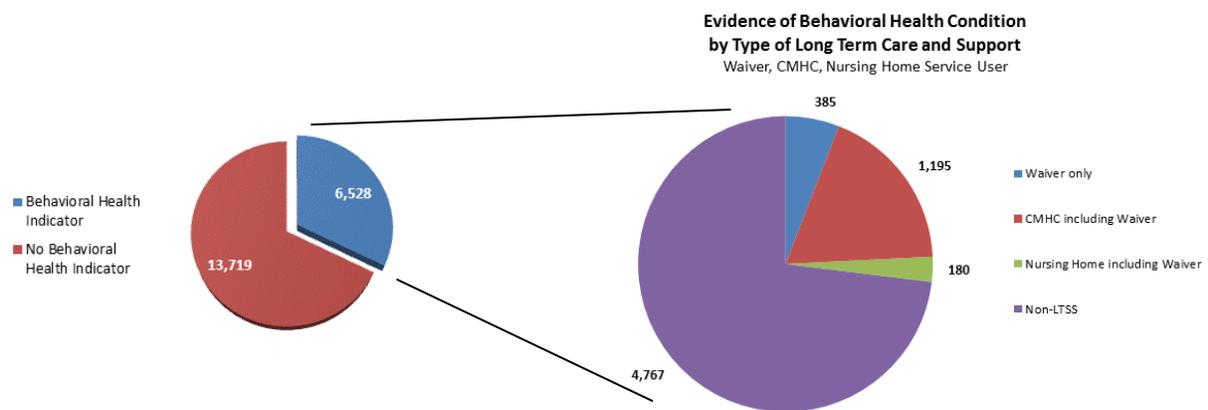
Chart 2.10 – Age and Gender Breakout of NH Medicaid Members with Behavioral Health Indication



Of the 6,528 IDN-5 Medicaid members with a Behavioral Health Indicator:

- 26% are low income children (non-CHIP)
- 26% are NH Health Protection Program - Non-Medically Frail
- 21% 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 6,528 IDN-5 Medicaid members with a Behavioral Health Indicator:

- 73% are not using Long-Term Services & Supports
- 18% 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, rates of smoking, and smoking during pregnancy are higher. (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)	Central NH Pop=30,125	Winnepesaukee Pop=75,944	Region 5 IDN Pop=106,067 *Calculated estimate	NH Pop=1,321,069
Asthma prevalence (adults)	11.3%	8.8%	9.7%*	10.1%
Obesity in adults with asthma	38.8%	43.8%	41.8%*	33.3%
Obesity among adults	24.6%	30.3%	28.8%*	26.4%
Coronary Heart Disease prevalence	4.8%	3.7%	4.1%*	3.8%
Smoking prevalence (adults)	21.1%	22.3%	22.0%*	16.3%
Diabetes prevalence (adults)	8.6%	5.2%	6.6%*	8.1%
Smoking during pregnancy	20.3%	19.1%	19.4%*	13.4%

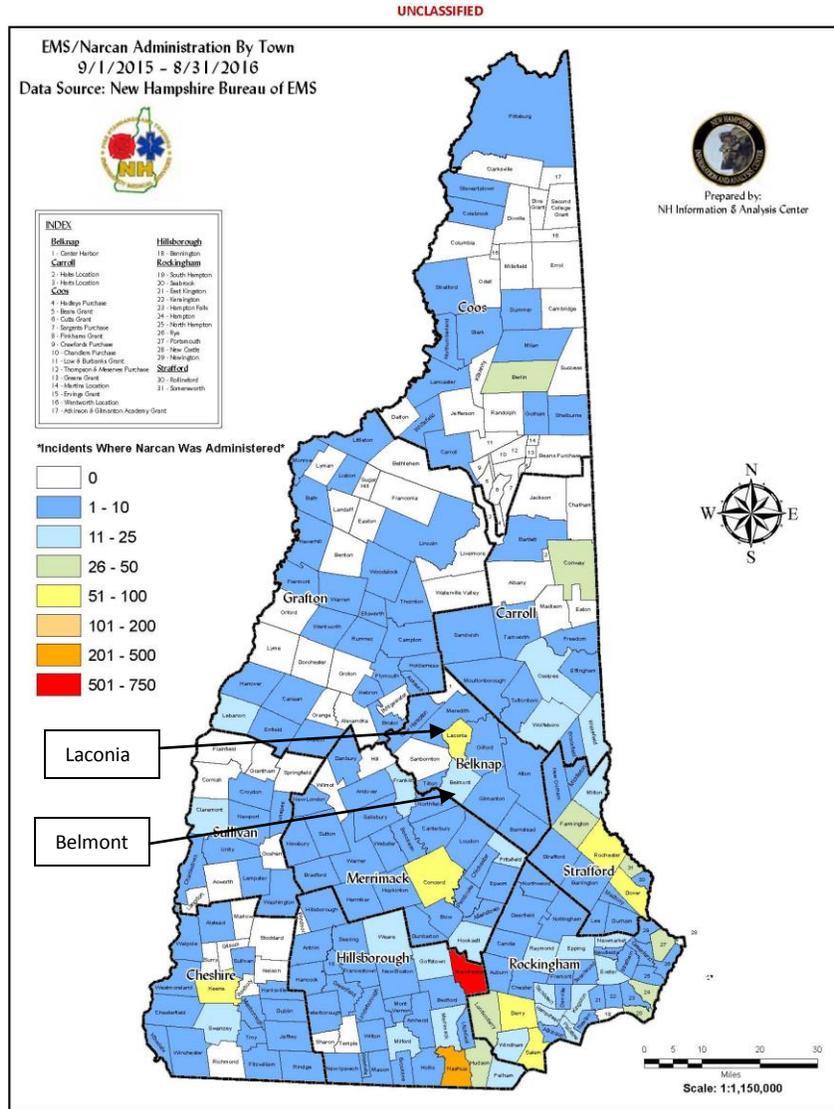
The information shown in Table 2.3 on the next page is abstracted from a web-based survey of young adults in New Hampshire completed in 2015 by the Bureau of Drug and Alcohol Services with assistance from the NH Community Health Institute. The survey was distributed through social media and targeted 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 6% of respondents perceived a need for drug or alcohol treatment in the prior 12 months. Further, nearly one third of these respondents (31%) 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 5 IDN * Number suppressed; n-values unweighted; %s weighted	New Hampshire
Total Respondents	401 (9.3%)	4,334
Past month non-medical marijuana use	104 (29.7%)	1040 (28.6%)
Past month binge alcohol use	109 (31.2%)	1274 (34.5%)
Family members have alcohol problems	107 (35.6%)	1063 (34.0%)
Past year prescription pain reliever misuse	* (7.0%)	250 (6.4%)
Past year heroin/fentanyl use	* (2.9%)	92 (2.7%)
Felt sad/hopeless for two weeks in past year	115 (26.3%)	1060 (25.0%)
Considered suicide in past year	* (12.2%)	488 (12.5%)
Tried to find treatment for alcohol or drugs, past 12 months	*(5.7%)	192 (5.2%)
Of those who needed treatment, treatment could not be found	*(30.8%)	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 Laconia and neighboring Town of Belmont are relative ‘hotspots’ within Region 5 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

Organization/Provider	Location	Populations Served	Services
Central NH Region			
Genesis Behavioral Health	Plymouth	Adults, Adolescents, Children	Screening, Evaluation, Individual Outpatient Counseling, Group Outpatient Counseling, Intensive Outpatient Programs, Psychiatry
Horizons Counseling Center	Plymouth	Adults, Young Adults Specialty, Adolescents/Children, Pregnant and Parenting Women, Homeless, Military and Veterans	Evaluation, Individual Outpatient Counseling, Group Outpatient Counseling, Intensive Outpatient Program
Mid-State Health Center	Plymouth	All ages	Primary Care Services (Community Health Center); MAT, suboxone, Psychology Services
Mid-State Health Center	Bristol	All ages	Evaluation, Individual Outpatient Counseling, MAT, suboxone, Primary Care Services (Community Health Center)
Speare Primary Care/Speare Memorial Hospital	Plymouth	All ages	Primary Care Services (Hospital), Psychiatric Services, Emergency withdrawal treatment, , Emergency Psychiatric Services in conjunction with Genesis
Ammonoosuc Community Health Services	Warren	All ages	Primary Care Services (Community Health Center)
ROAD to a Better Life	Plymouth	Adults, Young Adults	Withdrawal Management, Evaluation, Individual Outpatient Counseling, Group Outpatient Counseling, Recovery Support Services, MAT (buprenorphine, naltrexone, other medication)
Robinson-Wood Applied Psychology, P.L.L.C.	Campton	Adults, Homeless, Pregnant or Parenting Women, Military and Veterans	Evaluation, Individual Outpatient Counseling, Recovery Support Services (Anger Management, Care Coordination)

Organization/Provider	Location	Populations Served	Services
Winnepesaukee Region			
A&D Recovery Counseling	Laconia	Adults	Evaluation, Individual Outpatient Counseling, Group Outpatient Counseling
Bahder Behavioral Services	Gilford	Adults	Medication Assisted Treatment (buprenorphine)
Borderline Counseling Services	Laconia	Adults	Evaluation, Individual Outpatient Counseling, Group Outpatient Counseling
Butterfly House for Women	Laconia	Women	Recovery Support Services (Recovery Mentoring and Relapse Prevention Management, Permanent Supportive Housing, Transitional Living, Sober Housing)
Celebrate Recovery	Laconia	Adults	Group Outpatient Counseling, Recovery Support Services (Childcare, Recovery Mentoring and Relapse Prevention Management)
Chrysalis Recovery Center, LLC	Franklin	Adults, Young Adults, Adolescents/Children, Military and Veterans	Evaluation, Individual Outpatient Counseling, Group Outpatient Counseling, Intensive Outpatient Programs, Recovery Support Services
Cornerstone House for Men	Northfield	Men	Recovery Support Services (Sober Housing)
David Parisi, MLADC, LICSW	Gilford	Adults	Evaluation, Individual Outpatient Counseling
Driven By Circumstances	Franklin	Men	Sober Housing, Recovery Support Services
Families Sharing Without Shame	Laconia	Adults	Recovery Support Services (Parent Support Groups)
Franklin Regional Hospital	Franklin	Adults	Primary Care Services (Hospital), LRGH Recovery Clinic, MAT and LADC services, inpatient psychiatric unit / designated receiving facility

Organization/Provider	Location	Populations Served	Services
Genesis Behavioral Health	Laconia	Adults, Adolescents, Children	Screening, Evaluation, Individual Outpatient Counseling, Group Outpatient Counseling, Intensive Outpatient Programs, Medication Assisted Treatment (buprenorphine), Psychiatry
HealthFirst Family Care Center	Franklin	Adults	Primary Care Services (Community Health Center), Medication Assisted Treatment (buprenorphine), Counseling Services
HealthFirst Family Care Center	Laconia	Adults	Primary Care Services (Community Health Center), MAT, Counseling Services
Horizons Counseling Center	Gilford	Adults, Young Adults, Adolescents/Children, Pregnant and Parenting Women, Homeless, Military and Veterans	Evaluation, Individual Outpatient Counseling, Group Outpatient Counseling, Nathan Brody Intensive Outpatient Programs, Recovery Support Services, Integrated MAT in conjunction with LRGHealthcare Recovery Clinic
Kathleen Russo, LADC / Serendipity Counseling	Tilton	Adults, Military and Veterans	Evaluation, Individual Outpatient Counseling, Group Outpatient Counseling
Lakes Region General Hospital	Laconia	All ages	Primary Care Services (Hospital), Senior Psychiatric Services, Emergency Psychiatric Services in conjunction with Genesis, Emergency withdrawal treatment
Linda M. Brewer, MSW, LICSW, MLADC	Meredith	Adults, Young Adults	Evaluation, Individual Outpatient Counseling, Group Outpatient Counseling
LRGHealthcare	Franklin	Adults	Medication Assisted Treatment (buprenorphine), counseling
LRGHealthcare	Gilford	Adults	Medication Assisted Treatment (buprenorphine)
Patricia Tucker, LADC	Tilton	Adults	Evaluation, Individual Outpatient Counseling, Group Outpatient Counseling, Recovery Support Services (Anger Management)

Organization/Provider	Location	Populations Served	Services
Reach for the Stars Coaching	Danbury	Adults, Homeless, Pregnant or Parenting Women	Evaluation, Individual Outpatient Counseling, Recovery Support Services (Anger Management, Recovery Mentoring and Relapse Prevention Management)
Riverbank House	Laconia	Men	Withdrawal Management, Residential Services, Recovery Support Services
The Launch at Riverbank	Laconia	Men	Withdrawal Management, Residential Services, Recovery Support Services
Farnum North; operated by Easter Seals	Franklin	Adults, Webster Place for Men, Ray House for Women, Military and Veterans	Residential Services, Recovery Support Services (Peer Recovery Coaching, Transitional Living)
Weirs Health Center	Weirs Beach	Adults	Medication Assisted Treatment (buprenorphine)

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
Belknap County	Belknap County	Nursing Home, Court, Corrections
Communities for Alcohol and Drug Free Youth	Lincoln-Woodstock, Newfound, Plymouth school districts	Youth substance use prevention, Court diversion, pro-social alternatives, family support and education programming
Community Action Program Belknap-Merrimack Counties	Belknap and Merrimack Counties	CSFP, Housing, Housing Rehab, Developmental Disability Services, Substance Use prevention-information-referral, transportation, weatherization, WIC, Workforce development

Organization/Agency	Location/Service Area	Services/Supports
Central NH VNA & Hospice	Belknap and Carroll Counties	Home Care, Hospice, Rehabilitation Services, Telehealth, Medication Management, Pediatric Home Visiting, Child Development, Partners in Health
Franklin VNA & Hospice	Franklin, Northern Merrimack	Home Care, Rehabilitation Therapies, Hospice Services, Health Screening, Medical Social Worker, HomeMed Monitoring Program
Lakes Region Visiting Nurse Association	Northern Belknap, Western Carroll counties	Skilled Nursing, LNAs, Re-hab, Pre-hab, Home Safety Evaluation, Senior Companion Volunteers, Multidisciplinary Care Management
Lakes Region Community Services	Belknap, Southern Grafton Counties	Designated Area Agency providing community-based services to individuals with developmental disabilities or acquired brain disorders and their families, Family Resource Center, Parenting programs, Home Assist program for seniors
Newfound Area Nursing Association	Greater Bristol / Newfound area	Home Care, Hospice, Senior Companion Volunteers, Community Wellness and screenings
Pemi-Baker Community Health	Greater Plymouth	Home Care, Hospice, Rehab therapies, Community Wellness and screenings, Aquatics and fitness center
Partnership for Public Health	Belknap County	Healthy Eating, Active Living, substance Misuse, Aging and Disability Resource Center (ServiceLink), Emergency Preparedness, CERT / MRC, Health Insurance Counseling, Immigrant integration
Ascentria Care Alliance	Greater Laconia, New England	Child and Family Services, Refugee assistance, Language bank

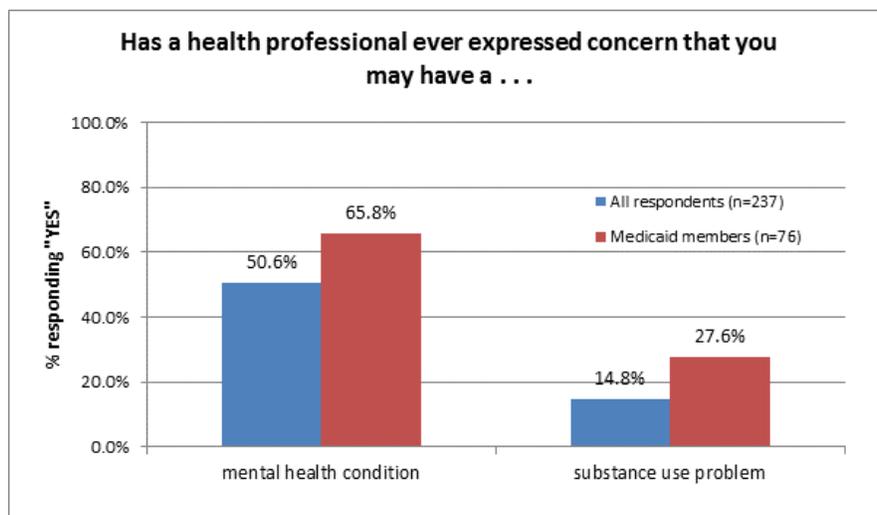
Organization/Agency	Location/Service Area	Services/Supports
Community Bridges	Concord, Central NH	Disability Services, Career Development, Day and Residential Services, Early Childhood Services, Individual and Family Support Services, Shared Living Program
Cornerbridge	Greater Laconia	Peer Support Center, Lakes Region Consumer Advisory Board, Pemi Valley Outreach, Warmline
Grafton County	Grafton County	Nursing Home, Court, Corrections
Granite State Independent Living	Central NH, Statewide	Home Care, Disability Supports, Education/Employment
Hope for NH Recovery	Franklin, Statewide	Recovery support services and drop-in centers. Franklin site opens this fall.
Laconia Area Community Land Trust	Greater Laconia	Affordable housing properties for low to moderate income households, provides transitional shelter and offers resident support services.
Laconia Housing Authority	Laconia	Subsidized housing facilities and administration of Housing Choice Vouchers
Merrimack County	Merrimack County	Nursing Home, Courts, Corrections
National Alliance on Mental Illness-NH	Central NH, Statewide	Community-based networks, support groups, Education and training, family and caregiver support, information and referral
Navigating Recovery of the Lakes Region	Greater Laconia	Recovery community organization, peer-to-peer recovery coaching, wellness workshops, resources for families, 12-step meetings and social events; opening facility in Laconia in conjunction with LRGH
NH Veterans Home	Franklin, Statewide	Long term care services for veterans

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 5 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 clinical service and community support providers broadly defined. A series of five discussion groups and individual interviews with families with youth involved in court diversion were also conducted 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.

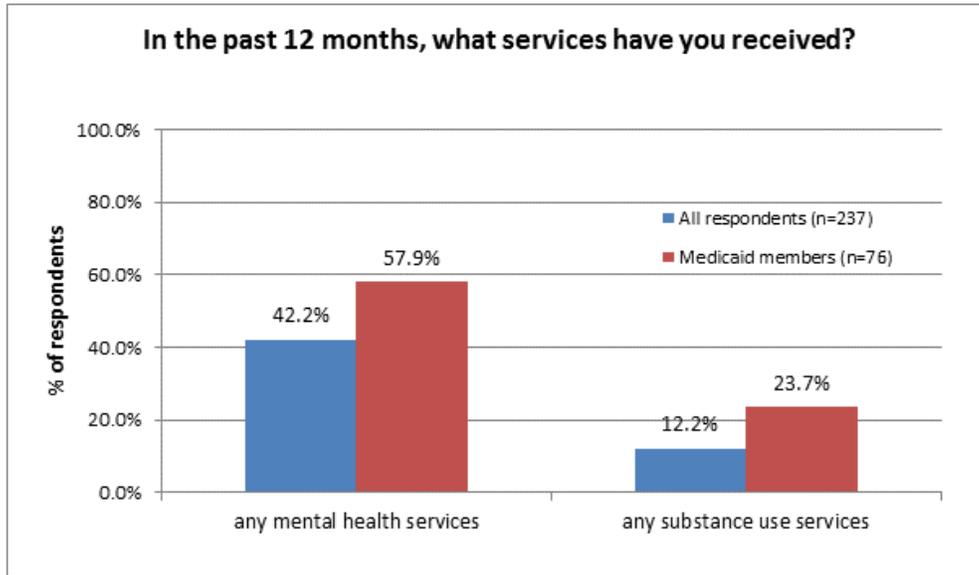
Key Consumer Survey Findings: As displayed by chart 2.12, about 51% of consumer survey respondents indicated that they had ever been told by a health professional that they may have a mental health condition, including about 66% of respondents who also reported having been eligible for Medicaid in the past 12 months. About 15% of respondents indicated having been told they may have substance use problem including about 28% of Medicaid members.

Chart 2.12



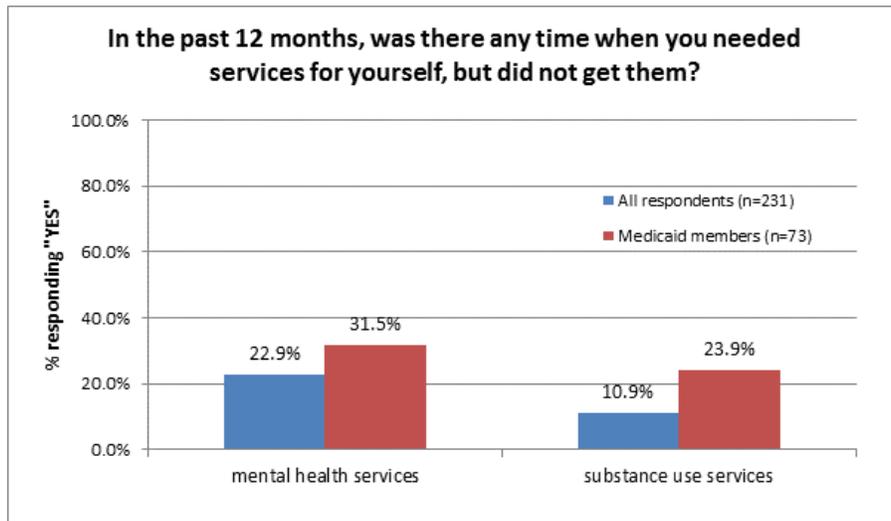
As displayed by Chart 2.13, about 42% of consumer survey respondents indicated that they had received some type of mental health services in the past 12 months including about 58% of respondents who had been eligible for Medicaid in the past 12 months. About 12% of respondents reported receiving services for substance use in the past 12 months including about 24% of Medicaid members.

Chart 2.13



About 23% of consumer survey respondents indicated having difficulty getting the mental health services they needed in the past 12 months (Chart 2.14), including about 43% of Medicaid members; while 11% indicated they had difficulty getting the 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 29% 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

Chart 2.15

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 6% 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).

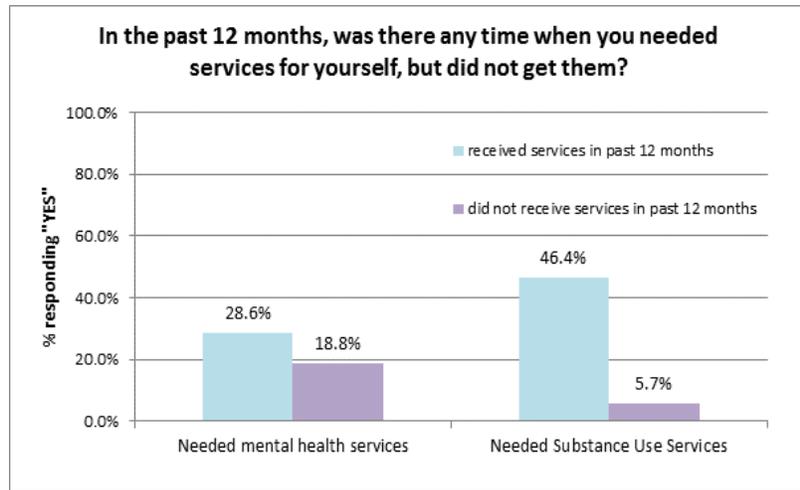


Chart 2.16 displays the top reasons reported for not getting needed mental health services. These are “I thought I could handle the problem without treatment” and “I did not have time (due to job, child care, or other commitments)”, followed by “There were no openings or I could not get an appointment” and “Health insurance did not cover the service or enough of the costs”. The top mental health services that people reported having difficulty accessing (Chart 2.17) are individual therapy or counseling (overwhelmingly) and services for co-occurring mental and substance use conditions. Taken together, these findings help to confirm key stakeholder perceptions of limited workforce capacity with respect to counselors / therapists as well as the need for integration of mental health and SUD services.

Chart 2.16

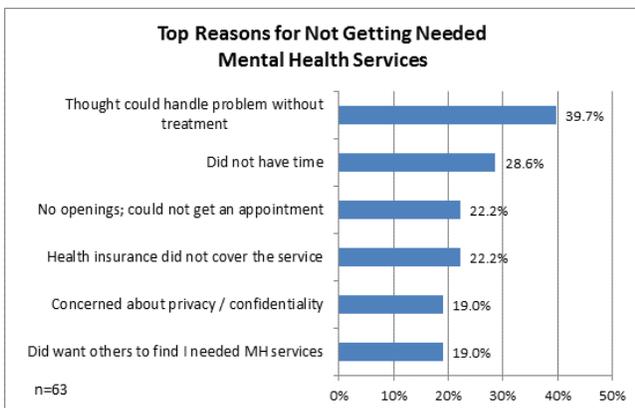
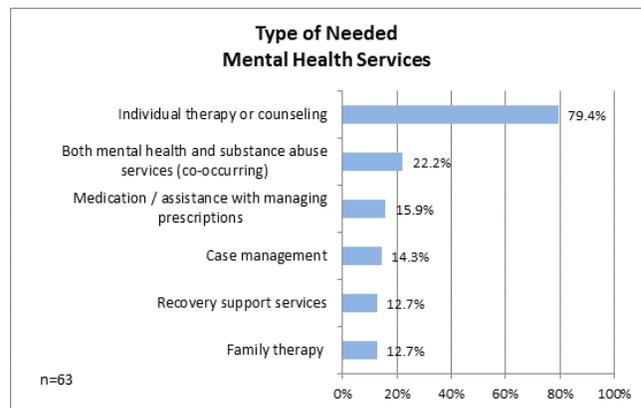


Chart 2.17



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 at 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

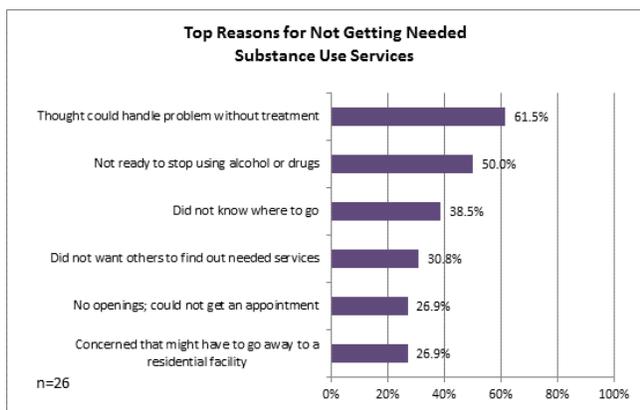
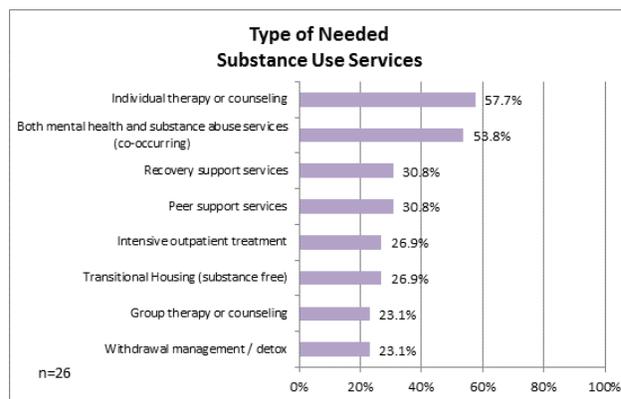
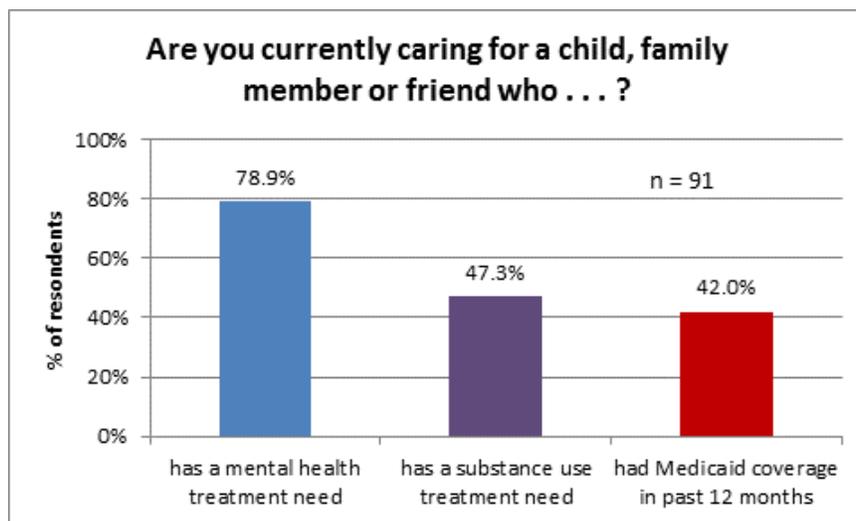


Chart 2.19



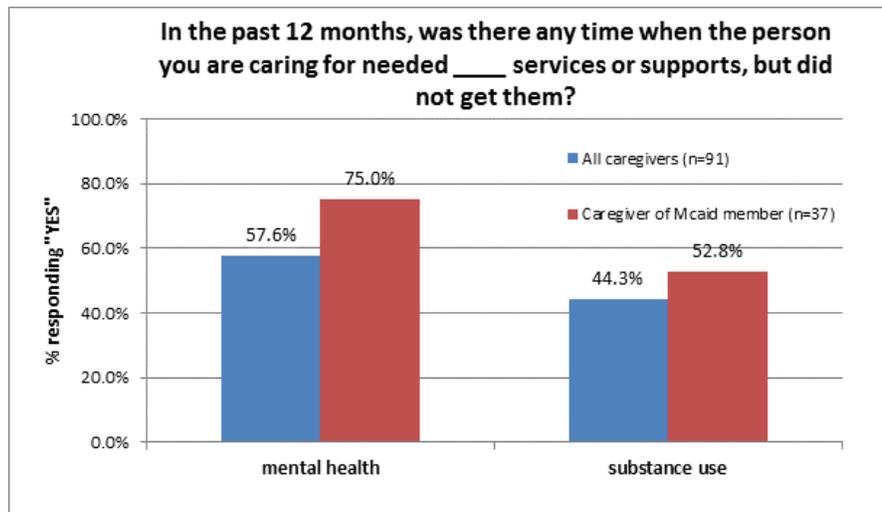
Key Caregiver Survey Findings: A companion survey was conducted of informal caregivers of individuals with mental health and / or substance use service needs. As displayed by Chart 2.20, about 79% of respondents were caring for someone with a mental health need and about 47% were caring for someone with a substance use treatment need.

Chart 2.20



About 58% of caregiver respondents indicated that their family member or friend had difficulty accessing mental health services in the past 12 months, including three of every four respondents caring for someone who was eligible for Medicaid. Nearly half of caregivers (44%) reported difficulty accessing substance use services, including 52% 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 that: a) a larger proportion of respondents in each case indicated access difficulties for mental health services than substance use services and b) caregivers of individuals eligible for Medicaid were more likely to report difficulty accessing needed services.

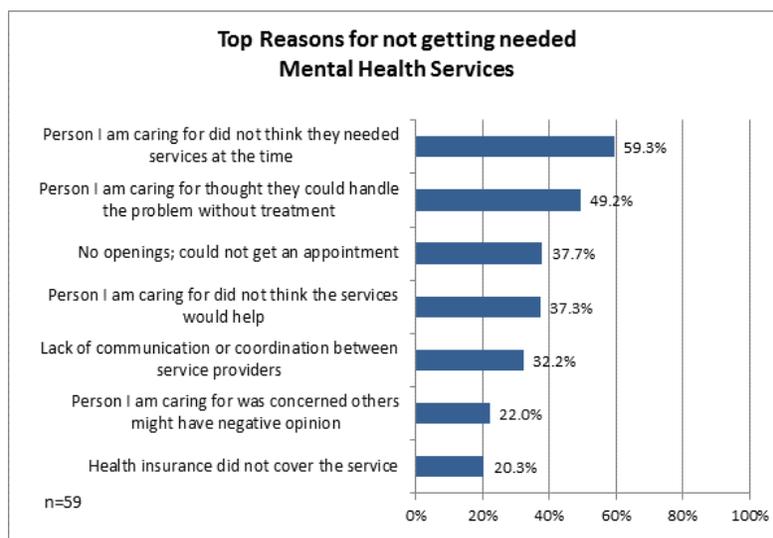
Chart 2.21



As displayed by Chart 2.22, the top reasons cited by caregivers for difficulty accessing mental health services was that the person they were caring for 'did not think they needed services' and 'thought they could handle the problem without treatment'. About a third of caregiver respondents reported difficulty with

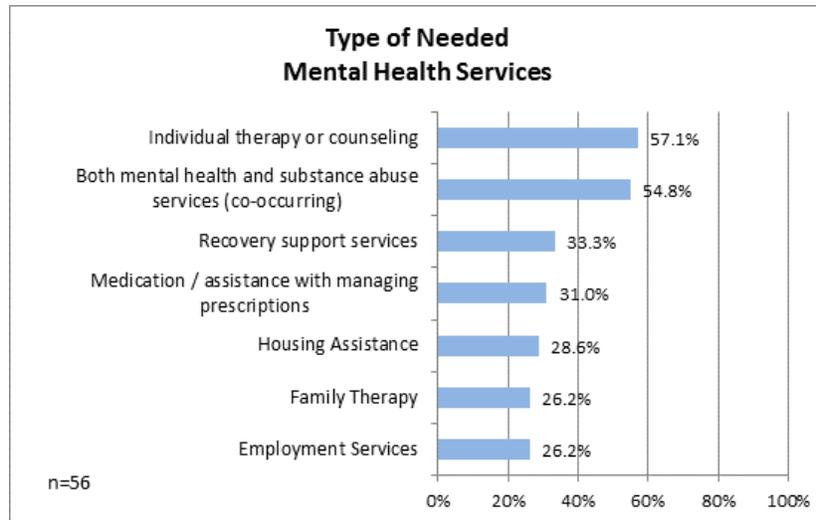
getting an appointment and difficulty resulting from lack of communication or coordination between service providers. These findings perhaps reflect the often important and challenging role of caregivers as the interface between providers and patients.

Chart 2.22



The types of services reported by caregivers as being difficult to access were also similar to the consumer survey results with individual counseling at the top of the list followed by services for co-occurring disorders, recovery support services and medication management. In addition, almost one third of respondents who had difficulty accessing services reported challenges accessing case management services.

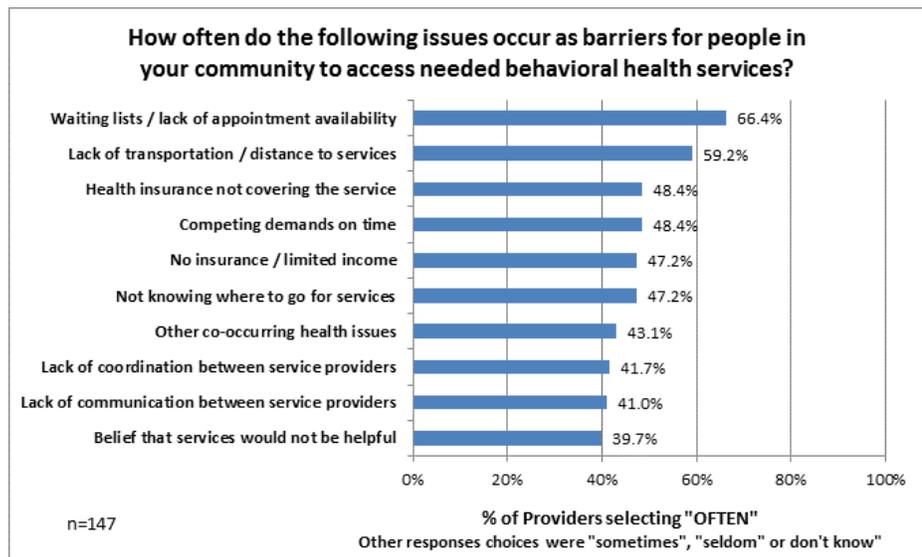
Chart 2.23



Key Provider Survey Findings: Respondents to the Provider Survey (n=147) also reflect the observation that ‘waiting lists / lack of appointment availability’ is a top barrier to accessing behavioral health services in the region, followed by transportation challenges, health insurance coverage limitations and competing demands on time. With respect to the top issue of waiting lists / appointment availability, providers serving the Winnepesaukee region were

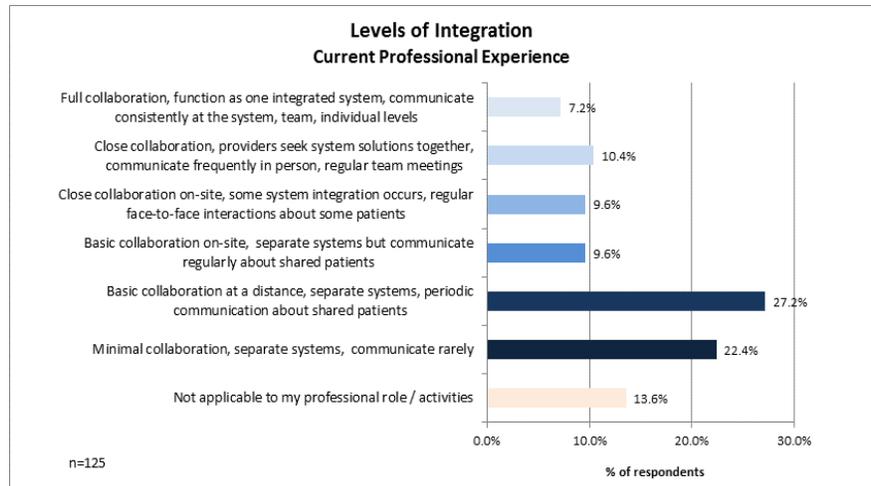
Chart 2.24

more likely to report this as a barrier experienced ‘often’ (75% of respondents) than providers from the Central NH region (61%), although it was the top issue reported by providers in both sub-regions (results not displayed).



Several questions on the provider survey explored the current state of practice integration and integration challenges. About 1 in 4 providers (27%) 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).

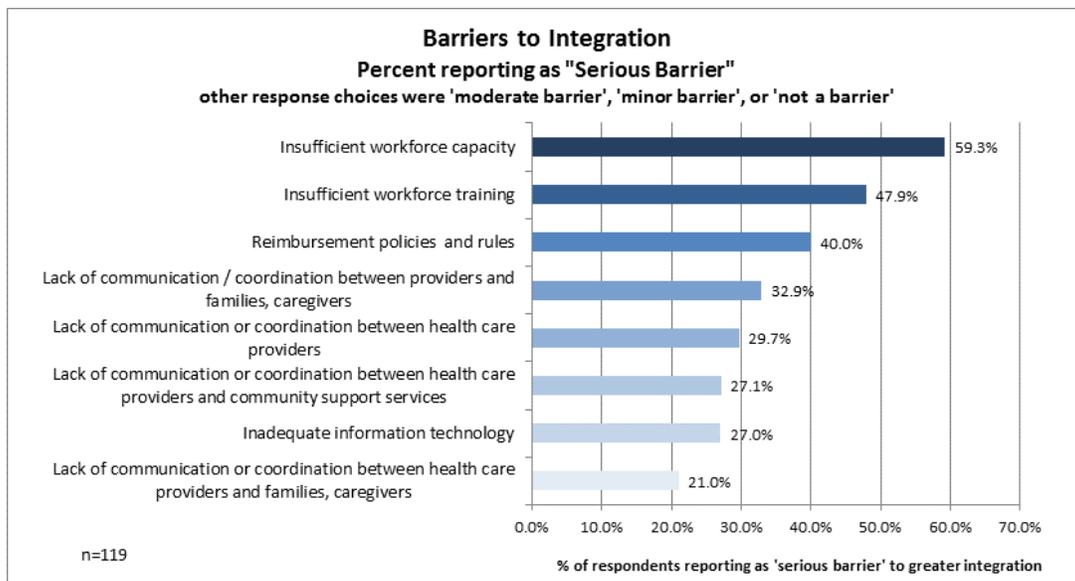
Chart 2.25



The top barriers to integration were both workforce related; insufficient workforce capacity and insufficient workforce training. Reimbursement policies and rules were also commonly cited as a 'serious barrier' to integration.

Provider discussions and survey comments 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/Key Leader 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 Community Input
Increase Workforce, Reduce Turnover (especially counselors, therapists)	C-CG-P- CD-PD-D	C-CG-P- CD-PD-D	C-CG-P- CD-PD-D	C-CG-P- CD-PD-D	CG	C-P	--	"Genesis is understaffed, unless people are in crisis then there are people in the emergency department. There is a 6 week waiting period and a revolving door with staff / counselors, so once you get comfortable with someone they leave." <i>Mental Health Consumer</i>
Expand Services / Resources	C-CG-P- CD-PD-D	C-CG-P- CD-PD-D	C-CG-P- CD-PD-D	CP-CD-PD- D	CG	C-CG-P- CD-PD-D	C-CG-CD- PD	"More local treatment! She has to travel to Concord daily with no reliable transportation." <i>Family Caregiver</i>
Better reimbursement, coverage policies	C-CD-P- PD	C-CD-P-PD	C-CD-P-PD	C-CD-P-PD	--	C-P	--	"We need a reimbursement system that adequately pays for the services provided allowing for increased wages, benefits and as a result a more stable and well trained workforce. Without adequate reimbursement and staffing, integration will not change anything and may even reduce the importance and understanding of the mental health care." <i>Mental Health provider</i>
Improve coordination / integration, including increased capacity for care coordination	C-CG-P- CD-PD	C-CG-P- CD-PD	C-CG-P- CD-PD	C-CG-P- CD-PD-D	CG	C-CG-P- CD-PD	C-CG-P- CD-PD	"Make them work together better. Shouldn't have to go to different places to get services when it's all the same basic problem." <i>MH/SUD Consumer</i>

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 Community Input
Supportive Community Re-entry	CD	CG-CD-PD	CG-CD-PD	PD	--	PD	--	<p>"Some patients get out of jail that night, and they are using in the parking lot even after being clean for 3 years, then they present to the ER that night. Many will use immediately when they get out. You almost need to pick them up there – there can't be too much time. Recovery coach may be needed while in prison – care management needs to be in place before they leave to get them on Medicaid because otherwise they have no meds or ability to pay for meds." <i>Primary Care MD</i></p>
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	C-P-PD	C-CG-P-CD-PD	C-CD-PD	<p>"You don't feel like you have time to handle all of this if you have a SUD. There's a lot of jumping around from place to place and they all ask for the same information over and over." <i>Recovery group participant</i></p>
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	<p>"Communication is the most important thing. Knowing what services are out there. Resources need to be communicated. Communication and training and letting "us" know what is available. If there was a computer at Genesis, we could look up services ourselves. If there was a resource list on line, it would have to be user friendly." <i>Mental Health client</i></p>
Increase Family Involvement and Caregiver Support	C-CG-CD-PD	C-CG-P-CD-PD	C-CG-CD-P-PD	CG-CD	CG-CD	CG-CD	CG-CD-PD	<p>"HIPAA makes it very hard to speak to a medical provider regarding their dispensing of prescriptions. Users are very keen in their persuasive way to "con" their way to refills. You hear of all these new laws regarding reducing the dispensing of medications. I have not seen it happen." <i>Family Caregiver</i></p>
Stigma, trust, respect	C-CG-P-CD-PD	C-CG-P-CD-PD	C-CG-P-CD-PD	CD-PD	CG-CD	C-CG-CD	CG-PD	<p>"They treat you like shit and everyone gives you a different answer. The welfare office makes you feel like a piece of crap for going there, so you refuse to go there. People need to have a heart to work in these places and they don't. They seem to pick and choose who they help." <i>Recovery Group Participant</i></p>

3. Community Engagement and Stakeholder Input

From August 1 through September 30, 2016, extensive efforts were made by the organizational partners of CHSN to engage key community stakeholders across the region as part of a comprehensive Behavioral Health Needs Assessment. The purpose of these community engagement and assessment efforts was to identify community health concerns and solicit input and advice on priorities and opportunities for community behavioral health and behavioral health care delivery system improvements.

3a.i Channels and venues through which input was solicited, key audiences and stakeholder groups

The community engagement efforts were led by the CHSN Community Engagement Work Group. Work group membership included representatives from public health, youth prevention services including restorative justice, home and community health, family support and disability services, primary care for underserved populations, and an 'at large' community member. Methods employed in the community engagement and 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, and a survey of providers including both direct service and community support providers broadly defined.

In addition to the three-pronged survey process, a series of 5 discussion groups were convened (3 consumer groups, 2 provider groups) to explore needs, gaps and improvement opportunities in more depth. In addition to the discussion groups, a series of interviews were held with family members of 10 youth involved in the CADY restorative justice program. The interviews were conducted individually rather than as a group to protect confidentiality. The consumer discussion groups and interviews were intentionally convened with key stakeholders in a manner intended to reach populations expected to have significant experience and critical perspectives on the current array of behavioral health services and supports, including groups associated with peer support, people in recovery, and county corrections. Participants in the consumer discussion groups were provided a \$25 gift card as a token of appreciation for their involvement.

Similarly, enhanced efforts were made to distribute the consumer survey through channels anticipated to reach vulnerable populations or populations with disproportionately high unmet need of behavioral health services such as through community health centers, peer support and recovery groups, community mental health centers and substance use treatment agencies. Paper copies of the survey instrument along with 20 'ballot boxes' for survey return were distributed throughout the region. Additionally, an electronic link to an on-line version of the survey was distributed through listservs and other direct email messaging by provider agencies and consumer support groups in the region.

- A total of 237 useable consumer surveys were completed; 32% of respondents were Medicaid members within the last 12 months, 42% had used mental health services in the past 12 months, 12% had used substance use services in the past 12 months

- A total of 91 useable caregiver surveys were completed; 79% were caring for someone with a mental health need, 47% were caring for someone with a substance use treatment need; 42% were caring for someone with Medicaid coverage
- A total of 142 useable provider surveys were completed representing more than 23 different professional roles from clinical services to a range of community supports including vocational services

Discussion groups and interviews were held with representatives of the following populations (40 total participants):

- Community Mental Health Center clients (focused on SMI population)
- Recovery support group and coaches (combined opioid / alcohol SUD population)
- Restorative Justice participants (parents / guardians, youth)
- County corrections (inmates and staff)
- Primary Care Physicians
- Emergency Medical Services

3a.ii Frequency with which community input was sought

CHSN has consistently invited and incorporated community member input in developing the Project Plan. Community input has been sought from the inception of the planning process. Even preceding the IDN planning work, access to behavioral health services was identified as a priority issue for the regions' Community Health Improvement Plans completed in 2015 by the Public Health Networks. Early meetings involved leaders of the region's two Public Health Advisory Councils, community engagement and gap assessment work of the Continuum of Care Facilitators, input from NAMI-NH volunteers/staff, and input from three emerging substance use Recovery Groups/Centers in the region. The survey and discussion group process described above was ongoing through months of August and September. In addition, representatives of CHSN have made presentations to town and city councils, Belknap County Commissioners, and the county delegation about the DSRIP initiative and associated opportunities and impacts for the region. We have also intentionally included three community members who are long time community advocates in our region in Board meetings, Network meetings and as participants on several workgroups.

3a.iii Mechanisms to ensure the community engagement process was transparent

By focusing our assessment and engagement efforts through organizations and peer networks that serve high concentrations of people with behavioral health needs, we were able to generate a high level of feedback and input into our planning process from those who are directly affected by or caring for those affected by mental illness, substance use disorders, and socio-economic vulnerabilities. All of the

surveys, discussion guides, and community presentations included clear descriptions of the purpose of the initiative and the input process. For example, the community discussion guide included the following description for participants:

*The purpose of our discussion is to get your input on opportunities for improving behavioral health care in your community from your perspective as consumers. This discussion is part of an effort by a number of health and human service organizations involved in planning an improved and more integrated system of care in our region. **You can think of this discussion today as an opportunity to give these organizations some advice.***

3a.iv Examples of three key elements of this Project Plan that were informed by community input

Results of the community engagement and input process have been instrumental in the selection of all three of our community-driven projects, as well as the formation of multi-sectoral, sub-regional access to care and wraparound committees. Specifically, the selection of the Community Re-Entry project is directly informed by input from the corrections, law enforcement and emergency response communities about the need for improved coordination on transitions for justice-involved individuals. Additionally, the selection of expanded SUD treatment with a focus on intensive outpatient programs is directly informed by data and discussion group reports describing wait lists, missed opportunities for engagement in treatment, and the crisis of the opioid epidemic affecting our communities. More generally, our overall plan (as will be described in more detail in later sections) includes a common theme throughout of improved capacity for enhanced care coordination with formal involvement of peer support and recovery support. This theme is in direct response to consistent feedback about not only current limitations in this area, but important opportunities to improve capacity by leveraging developing organizations and longstanding partnerships.

3a.v An explanation of instances in which community input could not be addressed

We are not aware of any specific instances in which community input could not be addressed or taken into account in our project plan. A rate limiting aspect of the process was the narrow time frame for the formal Community Behavioral Health Needs Assessment process from the point of establishing priority populations and methods for outreach to the point of analysis and interpretation. However, as the initiative unfolds over the coming months, we are confident in our ability to further develop and maintain our processes for continuous engagement as described in the next section.

3b.i Channels/ venues through which input will be solicited over the course of the demonstration

CHSN will continue to engage and seek input over the course of the demonstration by creating multiple opportunities for community feedback to foster learning and opportunities for performance improvement. The Consumer Engagement Work Group will continue to guide these efforts to assure ongoing consumer and caregiver representation including further developing methods and venues for ongoing assessment of progress, advice on improvement efforts, and identification of ongoing or emerging gaps. As we transition into the implementation phase, we will develop targeted methods for assessment and feedback from individuals most directly affected by certain project initiatives (e.g.

Community Re-entry participants), while also continuing periodic assessment of perceptions and experience across the overall system of care.

3b.ii Frequency with which community input will be sought

Our region has a long history of collaborative planning and sharing activities involving a broad cross section of community interests and concerns, which will undoubtedly continue throughout the demonstration project period. An example of continuing efforts for community input is the upcoming Second Annual Summit on Substance Misuse, Suicide and Behavioral Health on November 1st sponsored by the Partnership for Public Health. The CHSN and PPH Executive Directors will be presenting on the 1115 waiver and the CHSN plan at the Summit. About 65 people representing multiple community sectors across the region are registered to attend.

Opportunities for community engagement will be generated continuously through regular community forums. Additionally, the Community Engagement Work Group will have responsibility, with oversight from the CHSN Board, for establishing a formal plan for periodic assessment involving similar methods used to inform this plan (surveys, discussion groups, interviews). Periodic community input and assessment will be essential to continuous performance monitoring and evaluation activities and to assure community advice on corrective action plans as indicated.

3b.iii Mechanisms to ensure the community engagement process is transparent

We will continue our practice of regular presentations before town and city councils, many of which are broadcast on local cable access channels, the region's two Public Health Advisory Councils (CHSN updates are provided to the Winnepesaukee Public Health Council on a monthly basis), and holding annual community forums such as the upcoming Summit on November 1. We will also maintain the practice of inviting community members 'at-large' to participate in CHSN network meetings and workgroups that will continue to guide implementation and evaluation of the initiative. The CHSN Board will also have responsibility for developing a project communication plan to assure continuous information flow to key stakeholders and the overall community.

4. Network Composition

4a. Finalized list of network members

Please see tab 4A tab of the IDN Project Plan Supplemental Data Workbook

4b. How the network will be leveraged to address identified care gaps

The Community Health Services Network members and affiliated agencies are inclusive of a full set of provider and social support organizations representing the continuum of care for clinical services and broader social determinants of health. All of our participating network organizations have demonstrated previous success on collaborative efforts to improve the health and wellbeing of our region including developing community-based services for integrating substance use disorder treatment, mental health and primary care services. By building on this history of collaboration with new resources made available through the DSRIP initiative, we are confident in our network's capability to accomplish fundamental systems improvement to address identified needs and gaps in care.

For example, we will leverage our Network to address *insufficient workforce capacity* and related *access and availability of care barriers* by coordinated workforce recruitment and retention efforts for additional counseling capacity, expanding interagency agreements for shared staffing, shared service delivery protocols, cross-training of clinical staff and data sharing. Through the work to develop core competencies for Integrated Health at the practice and at the system level, such as through standardized screening and referral protocols and use of shared care plans, the Network will make progress on *reducing fragmented care and avoidable utilization of higher cost services* for individuals with persistent mental illness and substance use disorders. Enhanced care coordination activities will build on emerging practices in the region *for improving access, communication, and support for individuals and their families* with complex health and psychosocial needs. Similarly, we will draw upon the strength of the network's relationships beyond the health care community to include partners such as county corrections to support *effective transitions of care and community re-entry*.

A fundamental element of all of this work will be creating synergies across the network through development of shared treatment plans including community supports, shared decision-making, mechanisms for peer review, and accountability for results. Another key aspect of this work will be the ongoing training of staff across the network to effectively apply new systems for communication and information sharing, as well as institutionalizing norms across the system that facilitate successful inter-agency cooperation. This work includes support to connect the expertise of our behavioral health care providers for consultation and training on the early identification and response to mental health, substance use and suicide risk to other community providers and first responders such as police and fire departments, VNAs, schools and the criminal justice system. An important aspect of this work is information and training to *reduce stigma both in the community and within the health and human service delivery system*.

Inclusion of peer support and recovery organizations in the network in general and peer support specialists and recovery coaches within the intervention designs in particular will also help to address

issues of stigma, responsiveness to emerging needs, and timely access to services and supports. As described in the previous section (Community Engagement), members of the network also include organizations that incorporate patient and community advocacy as a central value in their mission, which will be essential assuring that the consumer voice is at the IDN table.

CHSN is a natural outgrowth of the strong relationships already forged among its members. Our members have a broad range of expertise in the areas of behavioral and physical health and community based services, as well as a willingness to learn from each other. We believe that these relationships and the depth of experience they represent provide a foundation for the expansion of service coordination, resource sharing and development and inter-agency communication, and position us to be the most effective in the efforts to transform the service delivery system.

5. Relationship with Other Initiatives

As described in the previous section, the participating organizations of the Region 5 Integrated Delivery Network are well positioned to undertake this work with longstanding collaborative relationships within the region and as representatives of the region for a number of statewide initiatives. All of the major activities to be undertaken by the Region 5 IDN through the DSRIP demonstration reflect new initiatives or significantly enhance existing health care initiatives. However, these existing relationships within the region and with statewide initiatives will provide an important foundation for leveraging currently available resources for rapid action and sustainable improvements in the system of care.

Examples of other relationships related to the DSRIP initiative include the following:

- The Partnership for Public Health (PPH) is the backbone/coordinating agency for the Winnepesaukee Public Health Council. PPH is the contracted agent of DHHS for the Council and Continuum of Care work that involves assessment of gaps in the system for substance use prevention, early intervention, treatment and recovery. This work directly informed the IDN plan, although the plan itself takes off from this point to build new capacity for services and supports in the region.
- Mid-State Health Center similarly serves as the fiscal agent for the Public Health Network in the Central NH Region (on behalf of the Central NH Health Partnership) and works closely with CADY and other key stakeholders in the Central NH region to support substance use prevention and Continuum of Care assessment and planning activities.
- Much of the substance misuse prevention work in the region has been aligned with the strategic plan of the Governor's Commission on Alcohol and Drug Abuse Prevention, Intervention and Treatment. Several stakeholders from the region have participated in task groups of the Governor's Commission and Commission members have participated as presenters for community stakeholder summits and forums in our region. Community Mental Health Center

staff has been asked to have input into spending priorities for the Commission including plans for expansion of Medication Assisted Treatment in the state.

- Several stakeholders from the region participated in State Innovation Model (SIM) planning work including Lisa Morris, Exec Director of PPH who was a member of the SIM Governor's Advisory Board and the Community Initiatives Work Group and Maggie Pritchard, Executive Director of Genesis Behavioral Health, who represented the Community Behavioral Health Association on workgroups addressing long term care and managed care.
- Health care provider organizations in the IDN are participating in the NH Health Protection Program and are seeing notable increases in the volume of patients over the past year. Many of these patients were previously uninsured and have multiple health needs due to delayed care. Several agencies including the two community health centers, the two hospital systems and the PPH through the Servicelink program are actively involved in providing navigation services to assist clients with understanding their options and enrollment assistance for Medicaid expansion and other features of the Affordable Care Act.
- Similarly, health care providers in the region are providing services covered through the expansion of SUD Benefits for Traditional Medicaid Population including behavioral health and Medically Assisted Treatment services.
- All of the participating agencies are connected to the work of one or both of the Regional Public Health Networks serving the area as Board Members, Public Health Advisory Council members and / or organizational partners on project activities including participation in public health emergency preparedness planning and response, school based immunization clinics organized by the Public Health Networks, and community health improvement workgroups addressing topics such as access to health care, healthy eating / active living, aging, disability and injury prevention.
- While not related to specific state level delivery system reform initiatives, there are several important collaborative relationships and initiatives in the region that will serve as building blocks for the IDN transformation activities. Spere Memorial Hospital currently has an agreement with Genesis Behavioral Health for Crisis services in the Emergency Department and for services through their Employee Assistance Program. Health First has an interagency agreement with Riverbend to place a Masters level counselor at the community health center's Franklin site who is jointly credentialed and privileged as part of the in-house behavioral health team. Genesis Behavioral Health currently has grant funding from the Substance Abuse and Mental Health Services Administration for the OneHealth project, a model of integrated care in collaboration with Health First and Mid-State to demonstrate a patient-centered behavioral health home for persons with serious mental illness and/or co-occurring substance use disorders.

DSRIP funding will be used to build upon and significantly enhance these existing health care initiatives and will not be duplicative. Throughout our planning for the CHSN and IDN, stakeholders have been careful to not silo funding for different initiatives and to clearly discuss with all the partners how to collaborate and not duplicate efforts. The partner organizations have agreed to leverage services that already exist as feasible and allowable, and to share them across the network in new and more synergistic ways.

6. Description of How This Plan Addresses the Opioid Crisis

As described in Section 2 (Needs Assessment), the ongoing opioid epidemic in New Hampshire, especially fentanyl misuse, is of particular significance to this initiative. In fact, one of the forces of change that propelled development of the Community Health Services Network in 2015 was the need for a coordinated response to the alarming rise in substance misuse and overdose in the region. Concurrently, the regional public health networks have developed strong partnerships with the emergency response community through their public health emergency preparedness work. These efforts have facilitated important collaboration on activities such as community events for training and distribution of Naloxone and promoting awareness of local resources for treatment and recovery support. Just one example of the power of these partnerships is the first known instance in the state of a life being saved by application of Naloxone obtained through a community event held in Laconia.¹ It has become natural for health care, public health, fire and emergency medical services, and law enforcement to work together regularly and effectively in our region on efforts to prevent the consequences of substance misuse. Of particular note is the support by the Laconia Police Department for a Prevention Enforcement Treatment position that has become an award winning model for other communities.²

Our project design includes two strategic pathways intended in part to increase the region's capacity to address the opioid crisis. The selection of expanded intensive outpatient treatment programs that incorporate recovery coaches as part of the team is one example of our plan's response. This community project will also be closely linked with the community re-entry project of justice involved youth and adults with substance use disorders. Each of these channels of work will be further linked through activities to enhance care coordination and recovery supports to assure effective transitions and prevent relapse. Additionally, CHSN members have been working to expand Medication Assisted Treatment in the region, most notably through the two federally qualified health centers and the LRGH Recovery Clinic. These resources are closely connected as referral and support resources to our work on these two community projects – Supportive Community Re-Entry and Expansion of Intensive SUD Treatment - and to the system integration efforts overall.

¹ <http://www.wmur.com/article/narcan-kit-helps-save-overdose-victim-in-laconia/5207748>

² <http://www.wmur.com/article/laconia-officer-armed-with-cellphone-makes-difference-in-heroin-battle/5205558>

A longer term goal connected to our IDN plan is development of a non-medical detoxification facility in the region; recognized as an important component of the SUD treatment service array for those experiencing barriers to treatment, particularly for opioid use dependence. Currently there are no facilities in the region providing this service. Development of this type of resource will require additional resources including capital investment, which will be part of our broader strategic plan for resource development and system transformation.

7. IDN Governance

7a. Overall governance structure

Community Health Services Network (CHSN) has been established as a Limited Liability Company, which provides for a delegated model of governance. The purposes of CHSN are to: (i) bring together health and human service providers in the Service Area delivery system to improve services, (ii) identify gaps in the Service Area delivery system related for unmet needs, (iii) develop strategies and services to fill these gaps, and (iv), with the consent of the Members, such other lawful activities for which the Company may be organized under the laws of New Hampshire. The activities of CHSN will be in furtherance of the charitable missions of the Members, and CHSN is not authorized to take any action which would jeopardize or materially impair the tax-exempt status of any Member.

The following principles have been established to guide the evolution of the Members' relationship and the operation of CHSN so that the spirit of good governance, and the purpose and mutual benefits of the relationship to the Network, can be preserved.

- a) We will utilize a shared governance model under which Members have equal weight in voting.
- b) We will build on the strengths of each other by leveraging competencies of each part of the system.
- c) We will remain focused on clear outcomes and expectations that recognize best practices.
- d) The Members agree to maintain CHSN's focus on the communities' needs with special attention to individuals and population health.
- e) We pursue greater strength by engaging outside agencies and sectors and sharing each other's competencies.
- f) We will operate with open dialogue where the values and opinions of all Members count.
- g) We will utilize active listening to one another's perspectives and priorities for the good of those we serve.
- h) For the long-term success, we agree to be open, honest, and transparent.
- i) We are committed to thinking outside the box and will strive to avoid silos.

- j) The value of compromise for the good of those we serve together will have a high weight and value.
- k) The Members do not intend this collaboration to be exclusive, and are willing to accept new members who will accept and further the goals and purpose of CHSN.

7a.i The IDN's principle governance committee

Each of the members of CHSN are non-profit health and/or human service organizations that provide services in the Central and Lakes Regions of New Hampshire. The members collectively represent the major providers and broad continuum of care in the region. Currently, the CHSN members are:

- | | |
|--|--|
| 1. Communities for Alcohol and Drug Free Youth | 8. Lakes Region Visiting Nurse Association |
| 2. Community Action Program Belknap-Merrimack Counties | 9. Lakes Region Community Services |
| 3. Central NH VNA & Hospice | 10. LRGHealthcare |
| 4. Franklin VNA & Hospice | 11. Mid-State Health Center |
| 5. Genesis Behavioral Health | 12. Newfound Area Nursing Association |
| 6. Health First Family Care Center | 13. Pemi-Baker Community Health |
| 7. Horizons Counseling Center | 14. Partnership for Public Health |
| | 15. Speare Memorial Hospital |

Each member organization designates an individual who serves as a Manager of the company. Meetings of the Managers are held monthly on the first Tuesday of the month, or such other time as agreed by 2/3 of the Managers. At all meetings of the Managers, 51% of the Managers constitutes a quorum for the transaction of business. An important principle of the organization is that each Manager has one vote with respect to all matters requiring the action of the Board regardless of organization size or level of investment. Each appointed Manager holds office until the next annual meeting of the Members at which point the Board of Managers are approved for the following year by the Members.

An annual meeting of the Managers is held during the first week of April each year unless otherwise agreed by two-thirds of the Managers. At the annual meeting, the Managers review the annual operating budgets and plans of the Company. An annual meeting of the Members is also held during the first week of April each year at which time the Members will appoint the Managers, review and approve the Annual Budgets, and review the strategic plans of the Company and such other matters as are typically addressed at an annual meeting.

The authority of the Board of Managers is outlined in detail in the CHSN Operating Agreement and includes the authority to: employ personnel to provide services in connection with the business of CHSN; hire and contract with accountants, attorneys, consultants and other persons necessary or appropriate to carry out the business and operations of CHSN; pay all organizational expenses and general and administrative expenses; develop Quality and Clinical Standards and Guidelines; elect

Officers of the Company; develop company policies; respond to Request for Proposals on behalf of CHSN; develop the staffing structure and composition for the Company; and assign Committee membership.

Two-thirds approval of a quorum of the Managers is required to approve the Annual Budgets to be recommended to the Members; to approve any material deviation from the strategic or business plans of the company to be proposed to the Members for approval; to recommend to the Members of the entry of the company into a risk-sharing arrangement; to adopt, modify or terminate any clinical standards and/or performance criteria or measurements; and to distribute to the Members of surplus revenue of the company, if any.

The Board of Managers appoints annually three to four executive officers of the company to whom it may delegate some or all of its authority and duties under the supervision of the Board of Managers. Each individual is appointed for a one-year term and no individual can serve more than three consecutive years in any one office. Currently, the executive officers of CHSN are Henry Lipman, President (LRGH), Jacqui Abikoff, Vice President (Horizons), Rick Silverberg, Treasurer (Health First), and Maggie Pritchard, Secretary (Genesis).

The Board of Managers may not take certain actions without first obtaining the approval of two-thirds of the Members eligible to vote including approval of the Annual Budgets and any deviation therefrom exceeding \$10,000.00; member cost allocations and discretionary distributions under contractual arrangements with Affiliate Agencies; adding new Members and Affiliate Agencies; appointing Community Representatives; approval of the Strategic Plan and Annual Work Plan/priorities; entering into Contracts on behalf of the company, outside of those delegated to Managers; amending and approving the By-Laws of the Company; approval of new Committees recommended by the Board of Managers; the expansion or other modification of the company's purposes; the entry by the company into an agreement or transaction of any of kind with a Member or any affiliate of a Member; or the expansion or reduction of the Service Area.

7a.ii Other governance committees and their relationship to one another

The Board of Managers may establish one or more committees or advisory groups, the purpose, duties and scope of delegated authority (if any) to be specified by the Managers (see section 7.b for description of committees in each governance domain). Committee members are appointed by the Board of Managers and serve at the discretion of the Board. Committees of the Board may include members who are not Managers. Committee procedures follow the same requirements as described above for the Board of Managers and any proposed action requires the affirmative vote of the majority of the members of the committee or advisory group attending any committee meeting at which a quorum is present.

The CHSN Operating Agreement also includes provisions for affiliate agencies that work in conjunction with NHSC or one of its Members. An Affiliate Agency is not a Member of the Company and has no fiscal responsibility or voting rights, although an Affiliate Agency may enter into separate contractual

arrangements with NHSC and may participate in committees established by CHSN. Currently, Affiliate Agencies include:

1. Ascentria Care Alliance
2. Belknap County
3. Community Bridges
4. Cornerbridge
5. Grafton County
6. Granite State Independent Living
7. Hope for NH Recovery
8. Merrimack County
9. National Alliance on Mental Illness-NH
10. Navigating Recovery of the Lakes Region
11. NH Veterans Home
12. NH Alcohol and Drug Abuse Counselors
13. Northern Human Services
14. Riverbend Community Mental Health
15. Plymouth Area Resource Connection

The Operating Agreement also provides for participation of Community Representatives interested in the work of CHSN. The role and responsibilities of Community Representatives will be determined by the Board of Managers from time to time. Community Representatives are nominated for appointment by the Members and may participate in CHSN committees.

7a.iii A description of any separate legal entities being established as part of the IDN, if applicable

As described above, CHSN has been established as a Limited Liability Company.

7a.iv How this governance structure provides for full participation of IDN partners in decision-making processes

As expressed in the guiding principles stated at the beginning of this section, we have created a governance structure that operates under the premise that there are equal voices and that the true objective must be the care and health outcomes of our Medicaid recipients and our communities at large. Members understand that their relationship with respect to CHSN will not be static, but instead will evolve with changing community and patient/client needs and improvements in health and human services policy and practice. The Members also acknowledge that the myriad circumstances and decisions which CHSN will have to address cannot be anticipated or addressed fully in a written agreement and that the over-riding principle of our governance model requires full participation of partners in decision-making processes.

7a.v How this governance structure ensures accountability among IDN partners

The procedures described in the preceding sections and as specified in the CHSN Operating Agreement include a number of provisions to ensure accountability including specification of Member rights and responsibilities, and Board of Managers authority and responsibilities in core areas of operation including finances, strategic plans, and quality and clinical standards and guidelines. These provisions require by definition a high degree of transparency and accountability among the Network partners.

7a.vi Processes to handle low-performing partners or partners who cease to participate in the IDN

The Operating Agreement specifies conditions under which a Member may withdraw from CHSN. With respect to partner performance under the DSRIP initiative, the Members and the Board of Managers will seek to make informed decisions by consensus that is in the best interests of the overall Network and its purposes whenever possible. In the case of 'low-performing partners', we can project that it will generally be in the best interests of the Network, the partners and the community overall for CHSN and its member organizations to develop and implement a plan for focused technical assistance to assist such organizations with performance improvement.

7a.vii Processes to ensure adequacy of network in serving the behavioral health needs of the Service Region

The Members do not intend this collaboration to be exclusive, and are willing to accept new members who will in turn accept and further the goals and purpose of CHSN. The Operating Agreement states that one or more additional members may be admitted to the Company with 2/3 vote of all of the Members, with the expectation that such new members demonstrate certain characteristics including the following:

- a) *Commitment to Health and Human Service Needs of the Community.* The health and human service needs of citizens in the Service Area are paramount, and the Company will be designed and operated to address best the commitment of the Members to sustain their health care services to such patients through efficient and sustainable delivery methods.
- b) *Commitment to Quality, Effective and Efficient Services through Integration and Collaboration.* Through the creation and operation of the Company, the Members seek to provide the highest quality and most effective health and human services in an efficient manner by integrating their knowledge and skills, resources and administrative capabilities into a single collaborative entity, the Company.
- c) *Furtherance of Members' Charitable Mission.* The Members acknowledge the compatibility of their charitable missions, and those of their affiliates (if any), and no party will be required to take any action which is materially inconsistent with, or in contravention of, its respective charitable mission.
- d) *Promotion of Collaborative Relationships and Patient-Centered Model of Care.* In providing health care services in the Service Area, CHSN members are committed to promoting collaborative relationships under a patient-centered model of care, which includes observance of the following principles:
 - (i) The promotion and maintenance of good health through health education, preventative measures, evidence-based practices, and the pursuit and achievement of high quality clinical outcomes;

- (ii) The advancement of knowledge, training and skills of health care practitioners and the sharing of best practices;
 - (iii) The regular assessment of the health care needs of the Service Area population and the development of delivery methods designed to address any changing needs;
 - (iv) The preservation and/or improvement of access to appropriate health care services for all in need, regardless of ability to pay; and
 - (v) The provision of a true continuum of health care services and the creation of opportunities for joint participation on in a wide variety of health care arrangements.
- e) *Ongoing Evaluation and Adaptation.* The Members commit to ongoing evaluation of the operations of the company and to modifying and adapting them as necessary or appropriate to better serve the purposes of the company.

7b. Four governance domains

As described above, the CHSN Operating Agreement provides for the establishment and operation of committees empowered to undertake certain work activities on behalf of and under the supervision of the Members and Board of Managers.

7b.i Clinical governance

One such committee is the Clinical Integration Committee. This Standing Committee is responsible for all aspects of quality improvement, quality assurance, and clinical management of the clinically integrated network established by CHSN. This responsibility includes:

- Alignment of efforts of the Network members and their respective employed health care providers in areas of quality management, quality improvement, and peer review with the goal of improving patient care in the service area;
- Development of clinical care pathways and treatment protocols among stakeholders;
- Development and implementation of standard credentialing criteria; analysis of clinical data;
- Monitoring clinical activities of participating providers assuring compliance with approved clinical protocols;
- Identifying and developing clinical co-management relationships and disease management protocols to achieve efficiencies and improve overall population health; and,
- Oversight of other clinical activities of the integrated Network.

The Clinical Integration Committee will be chaired by the co-Medical Directors of CHSN (Drs. Racicot and Friend) and will include clinical staff representation including quality assurance/performance improvement managers from each of the participating organizations.

Initially, the Clinical Integration Committee will work closely with the HIT/Data Analytics team to complete a review of existing capabilities of participating organizations to collect and report information describing evidence-based clinical practice and performance measures. Based on this review, procedures will be established and associated technical assistance plans developed to coordinate and improve network-wide capacity to monitor and manage performance at the organizational and system levels. With respect to implementation of the community driven projects, the implementation committees for each of the projects will have responsibility for managing fidelity to evidence-based program standards. However, there is considerable overlap in the objectives, strategies and measures across these projects, as well as the Integrated Health core competency project. Coordinated systems and procedures for monitoring and managing performance across these various process and outcome measures will be the responsibility of the Clinical Integration Committee with assistance from the HIT/Data Analytics team and in collaboration with the project teams.

7b.ii Financial governance and funds allocation

Please refer to Section 8.

7b.iii Data governance

As described in Section 11, CHSN has established an HIT committee that has taken the lead in developing plans in this area. The committee is chaired by Richard Silverberg (Health First) and includes chief information officers / executive technology staff from the two hospital systems, the two health centers, the community mental health centers, and home health agencies. This committee is charged with addressing the substantial technology and data challenges associated with integrated network development including development of capacity for health information exchange, shared care plans and other systems to support collaborative case management, as well as increased capacity across the region for population-based health analytics. In conjunction with work through the statewide HIT committee, the CHSN HIT Committee has responsibility for making recommendations to the Board regarding necessary investments and technical enhancements needed to support development of network-wide HIT capabilities.

CHSN has also recognized the need to establish a sub-committee of the HIT committee focused on Data Analytics. While the HIT committee will work on developing the overall infrastructure capabilities and connections, the Data Analytics team of the HIT committee will inform this work by identifying the necessary functionality, including specification of data sharing standards and processes, to be supported by the infrastructure for collecting and monitoring performance data. This aspect of the HIT/Data Analytics committee will need to be closely connected to the work of the Clinical Integration Committee, as well as the community driven project teams, with ultimate oversight coming from the CHSN Board. An example of these intersections is the work to refine existing or develop new inter-agency data

sharing agreements, which are necessary to support work activities across many different elements of the CHSN plan.

7b.iv Community engagement

As described in Section 3, the Consumer Engagement Work Group will continue as a Committee established by the Board. This Work Group will continue to have responsibility for guiding efforts to assure ongoing consumer and caregiver representation including further developing methods and venues for assessment of progress, gathering advice on improvement efforts, and identification of ongoing or emerging gaps. The Community Engagement Work Group also has responsibility for overseeing a formal plan for periodic assessment. This plan will involve similar methods that were used to inform this plan in order to inform monitoring and evaluation activities and to assure community input to corrective action plans as indicated. The activities of the Consumer Engagement Workgroup will be a standing item on the agenda of regular monthly meetings of the Board of Managers, as well as part of progress presentations to CHSN Membership at the annual meeting. Community Representatives nominated by CHSN members will be encouraged to participate in the Consumer Engagement Work Group to help with providing community voice to our work. The CHSN Board will continue to have overall responsibility for developing a project communication plan to assure continuous information flow to and from key stakeholders and the overall community.

7c. Governance charters

Please refer to the Attachment, “Operating Agreement of Community Health Services Network, LLC”

7d. Key IDN management roles

Please see tab 7D tab of the IDN Project Plan Supplemental Data Workbook.

8. Budget and Funds Allocation

8a. Project Design and Capacity Building Funds: Final Budget Narrative

The Community Health Services Network CHSN anticipates our transformation work to include system changes, core staffing, cross agency training, shared recruitment and retention activities, and IT enhancements that will provide a strong foundation for our shared success. To further develop this foundation, CHSN is projecting use of the Project Design and Capacity Building funds as follows:

- Completion of the Community-Based Behavioral Health Needs Assessment (refer to section 2) and ongoing support of community engagement and assessment activities to inform evaluation and modification of project activities (refer to section 3);
- Development of the IDN Project Plan including establishment of a CHSN DSRIP discretionary fund to provide organizational stipends to a) support significant differential investment of human resources from specific agencies, such as participating behavioral health and community health center organizations, and b) provide initial staff development, training resources or other capacity building work to prepare for implementation of community-driven projects, such as participation in recovery support worker training; CHSN has set aside \$50,000 in this discretionary fund;
- Capacity building activities for direct care workforce including recruitment and hiring of additional case management and recovery support workers, related activities to ensure adequate resources to pay and maintain staff such as coordinated incentive plans, and development of a regional strategy for increasing the number of primary care and behavioral health professionals in the region (aligns with section 10-Workforce Development and identified need for expanded workforce). Use of Capacity Building funding in this area also includes recruitment and hiring of additional direct care staff required for start-up of the Community Re-Entry, SUD Expansion, and Enhanced Care Coordination community-driven projects;
- Capacity building to encourage retention of direct care workers such as licensed social workers, alcohol and drug counselors, care coordinators, peer support specialists, recovery support workers, and psychiatrists through regional coordination on strategies such as educational loan reimbursement, supplemental market or cost of living adjustments, longevity pay, continuing education, IDN leadership activities and other strategies designed to support retention of sufficient and high quality behavioral health care workforce in the region (refer to Section 2 for discussion of workforce turnover as a significant service capacity and quality challenge);
- Workforce training activities with a focus on increasing knowledge and skills for integrated practice including cross training of care coordination / case management staff and quality improvement. Funding in this area includes regional coordination of training activities, in-network contracting for training development and delivery as possible, external contracting as warranted, and support of training reimbursement as indicated. Coordinated application of

resources and incentives in this area will create efficiencies by utilizing existing opportunities and capitalizing on effective training practices across the network;

- Support of the IDN administrative/project management infrastructure including support of an Executive Director (completed), Medical Director (by contract), Project Manager (TBD), Project Coordinator (TBD), Financial Director and general administration (by contract). In addition to these positions, Capacity Building resources will be contracted to support other key functions such as network-wide training coordination, data analytics and reporting, performance improvement, legal assistance for development/refinement of information sharing agreements and patient consent procedures, communication expenses and audit fees.
- Development of Health Information Technology/Health Information Exchange capabilities to support integrated care including further development of electronic health records across the network, applications to support shared care planning and coordination, and technology and standards for assuring information security.

8b. Project Design and Capacity Building Funds: Final Projected Allocation Estimates Suppl. Data Workbook, 8B Tab

See tab 8B tab of the IDN Project Plan Supplemental Data Workbook for final allocation projections in the functional areas describe above, as well as across time periods and organizational types.

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

As described in section 7 (IDN Governance), CHSN has been established as a Limited Liability Company, which provides for a delegated model of governance on matters before the IDN including the distribution of DSRIP funds, and the monitoring of financial impact of payment and system transformation across member organizations.

8c.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

The Operating Agreement for CHSN requires the Board to prepare an Annual Budget prior to the beginning of each fiscal year that identifies the expenses associated with operation of the network. The Board will present the Annual Budget to the Members for approval at least sixty (60) days prior to the beginning of the fiscal year. Annual Budgets require approval of two-thirds of the Board for adoption. The Board of Managers is then authorized to carry on the business and purposes of the Network within the approved budget, except that any deviation from the budget by more than \$10,000 requires another two-thirds vote of the Board.

Annual Budgets will also be aligned with strategic and business plans of the network. Any material deviation from the strategic or business plans of the network must also be approved by two-thirds majority of the membership. The Operating Agreement of CHSN also specifies procedures for distribution of surplus revenue to the Members of the network, if any, remaining after required

expenses, other distributions and allocations. Use of performance criteria and measurements, to the extent possible, will be developed to guide distribution of surplus revenue, if any, as well as to begin the process of informing the network as it moves toward alternative payment models.

In addition to governance rules that provide a structured process for budgeting and fund distribution, it is important to reiterate the governing values and principles of CHSN, which include: a shared governance model under which Members have equal weight in voting, honesty and transparency are essential, reliance on subject matter experts to inform network decisions is a core value, and programmatic and related funding decisions should focus on achieving the best outcomes for population health considering the best evidence and available resources.

The IDN Members are committed to an ongoing evaluation of the operations of the network and to modifying and adapting them as necessary or appropriate to better serve the purposes of the initiative, including rules and procedures for determining the allocation of funds to support the priorities of the network. Whenever possible, the Members and the Board of Managers will seek to make informed decisions by consensus.

8c.ii The process by which the IDN will develop project budgets and a fund allocation plan

In order to prepare the Annual CHSN Budget for approval, the Board as a whole and working through its established program committees will make projections for the specific funding requirements for each of the six strategic channels of activity (HIT, Workforce, Integration and the three community-driven projects). Implicit in this budgeting work will be the need to engage in separate funding agreements with participating members and other key stakeholders to support service delivery improvements that further the progress of the IDN. This ongoing planning and implementation work will by definition shape and inform the overall fund allocation process.

In preparation for submission of this plan, the CHSN formed committees to address each of the six strategic channels of work. Projection of resource requirements was one important aspect of this committee work. We envision this 'from the ground up' process will continue throughout the demonstration project, with information from active committees representing each key area of network activity flowing to the CHSN Finance Committee and Board of Managers. (Note: each of these committees have been comprised of both Board members and other key staff from partner organizations with important subject matter expertise in particular topic areas depending on the focus of the committee.)

The CHSN maintains a Standing Committee for Audit, Finance and Governance. This Standing Committee's purpose includes responsibility for developing and overseeing processes to support the financial success of the Network and for the establishment of financial controls to ensure compliance with DSRIP program requirements. Such responsibilities include:

- Making recommendations to the Board of Managers with respect to allocation and distribution of DSRIP funds;

- Engaging and communicating with network partners on the funds flow model;
- Monitoring the Network budget and its performance relative to budget;
- Developing and overseeing the implementation of the Network’s financial oversight structure;
- Reviewing significant accounting and financial reporting practices including internal financial statements reporting the receipt and distribution of project funds, cash position and cash flow;
- Evaluating the effectiveness of the internal control system with respect to financial reporting and controls over receiving and distributing project funds;
- Making recommendations with respect to value-based purchasing and the management of risk contracts as may be developed over the course of the demonstration.

The Audit, Finance and Governance Committee will thus have an important role in coordinating and communicating with all of the network members and stakeholders with respect to resource needs and expenditures to inform the Board’s overall budgeting and funds distribution decisions.

8c.iii Rationale and justification for this financial governance approach and funds allocation process

Establishment of this delegated model of governance through formation of a member-based Limited Liability Company facilitates a shared decision-making and a consensus-based approach, to the extent possible, for establishing how the funds, risks and obligations of the IDN will be shared and allocated among participants in the network. It is acknowledged by the members that anticipated funding amounts will not be sufficient to support all service and staffing capacity enhancements that are hoped for; and that some difficult choices will need to be made throughout the demonstration project.

Through the governance approach established by CHSN, the network will seek to align as fairly as possible the risks being assumed and the likely savings to be generated by the network participants through the use of performance criteria and measurements, to the extent possible. As specified in the Operating Agreement, an important aspect of this approach is that payments that are made to Members will be considered to be contractual payments and not distribution of reserves or profits. Thus, members of CHSN can give priority to the needs of the network and its patients and will not be obligated to make any payments pro rata to the Members based on their proportional interests in the corporation.

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

The Community Health Services Network will communicate and collaborate with Integrated Delivery Networks serving other regions to assure 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. Currently, there are two possible points of intersection or overlap that we are aware of between the plans and partnerships of the Region 5 IDN and other IDNs as follows:

- Riverbend Community Health is a key agency partner for integration and enhanced care coordination development activities in the Franklin/Northern Merrimack County area of our region. Riverbend maintains headquarters in Concord and is a lead entity serving the Capital Area IDN as well. CHSN will collaborate with Riverbend and the Region 2 IDN to align development activities and expenditures, particularly in the areas of workforce, HIT and related integration and care coordination development work to assure that funding support is not duplicative.
- The Community Re-Entry Program selected by CHSN for the Care Transitions community-driven project will initially be focused on work with the Belknap County Department of Corrections. However, Region 5 also includes parts of Grafton and Merrimack Counties. As the Community Re-Entry project evolves in Belknap County, it will be important for our work to expand to include similar relationships and re-entry activities addressing the correctional populations in Merrimack and Grafton Counties. It is our understanding that the Capital Area IDN in particular has also selected Community Re-entry as a project, so it will be important for our two regions to align activities and expenditures in this area over time. We will similarly coordinate with the North Country IDN to align activities with the Grafton County Department of Corrections, which is physically located in the North Country region, as opportunities and circumstances warrant.

In addition, the CHSN Board, working initially through its Finance Committee, will assure that Capacity Building and Incentive Funds are applied in a manner that is supplemental to and not duplicative of reimbursement of services through fees or other service delivery-based contract vehicles. To this end, fund allocation to members, affiliates and partners will be accomplished through separate contractual agreements that will include provisions for financial monitoring, auditing and compliance to include compliance with the principles of non-duplication or supplanting of funding sources.

9. Alternative Payment Models (APMs)

Several CHSN member organizations have experience with Alternative Payment Models ranging from developmental activities to over a decade of experience. The Table below contains information by organization and organizational type, Alternative Payment Model descriptions, and approximate estimates for the percent of provider payments currently made through these arrangements.

Organization	Alternative Payment Model (APM) Description	Estimated Percent of Payments
HOSPITAL SYSTEMS		
LRGHealthcare (LRGH)	<p>Participates in a shared savings Accountable Care Organization (ACO) with CIGNA through Granite Health</p> <p>Expects to participate in a shared savings ACO with Harvard Pilgrim through Granite Health starting 1/1/17</p> <p>Owns a 12% stake in Granite Health Holding Company that owns a 49% stake in Tufts Health Freedom Plan</p> <p>Participates in a Primary Care Shared Savings Program with Anthem</p>	<p>CIGNA is about 8% of Net Revenue</p> <p>Harvard Pilgrim is about 13% of Net Revenue</p> <p>LRGH takes full risk for the premium amount</p> <p>Anthem is about 21% of Net Revenue</p>
Speare Memorial Hospital (SMH)	<p>Has an agreement with Anthem based on incentive payments if SMH scores enough points on their Hospital Improvement Initiative, which essentially measures systems and processes to ensure high quality care, as well as some outcome measures</p> <p>No risk agreements</p>	Anthem makes up about 20% of payer mix
Federally Qualified Health Centers		
Mid-State Health Center	<p>Has been involved in alternate payment models since 2005</p> <p>The State of NH utilizes a bundled payment APM to reimburse federally qualified health centers for all of Medicaid medical and behavioral health encounters</p>	Medicaid represents about 19% of revenue

	<p>Mid-State also participates with Anthem Blue Cross on upside shared savings</p> <p>Helped form North Country ACO, a first cohort Medicare Advanced Payment / Shared Savings model in 2013</p> <p>Currently part of the NH Accountable Care Partners ACO</p> <p>As an FQHC, eligible each year for quality bonuses based on Uniform Data System (UDS) quality performance outcomes</p>	<p>Amounts to 3% of revenue</p> <p>Federal Bureau of Primary Health Care quality bonuses are about 1% of revenue</p>
<p>Health First Family Care Center</p>	<p>Involved in alternate payment models for many years</p> <p>Bundled payment rate for all of Medicaid work</p> <p>Involved in developing a limited liability corporation with BiState Primary Care Association and the other community health centers in southern NH that has contracts for special shared risk fee-for-service alternative payments structured with incentives based on clinical quality outcomes.</p> <p>Eligible for quality bonuses through federal FQHC program</p> <p>Also eligible for clinical quality outcome incentive payments through Anthem Blue Cross Blue Shield, Harvard Pilgrim, Cigna, and Martin's Point</p>	<p>Medicaid is about 52% of revenue</p> <p>Quality incentive payments in total are about 2% of annual revenue</p>

Community Mental Health Centers (CMHC)		
Genesis Behavioral Health Riverbend Community Health	CMHCs are currently in a fee for service payment environment, but are moving to a capitated MCO rate with quality indicators. Payments are still based on fee for service rates with a revenue cap	
Home Health Care		
Franklin VNA & Hospice	<p>Currently involved with the Medicare Prospective Payment System (PPS), which reimburses services based on clients' severity of need in 3 domains. Scores are based on the responses to a standardized assessment (OASIS).</p> <p>Value Based Purchasing (VBP) is currently being piloted by Medicare for Home Health Agencies in nine states. It is anticipated that all states will be involved in such a payment system by January 2018.</p>	Approximately 65% of clients are paid via PPS
Central New Hampshire VNA & Hospice	Participates in a bundled payment pilot with Wentworth Douglas Hospital for patients with lower extremity joint replacement	It is < 1.5% of total home health revenue; all Medicare Patients; about 38 Medicare patients on this pilot in 2016 to date

10. Project A1: Behavioral Health Workforce Capacity Development

10a. *The IDN Workforce project lead and Statewide Taskforce Participants*

Please see tab 10A of the IDN Project Plan Supplemental Data Workbook

10b. *Critical workforce capacity challenges*

Workforce capacity challenges exist throughout the continuum of care in our region for individuals with behavioral health conditions and their families. Patients and families are impacted by these challenges from resulting delays in treatment, fragmented care, insufficient connection to social supports, and increased burden on family and loved ones.

While substantial behavioral health services exist as evidenced by prior descriptions of CHSN member organizations and other area resources, there is inadequate capacity to meet the demand for services. Of the 33 towns within the IDN 5 region, 21 (64%) are designated primary care shortage areas and 19 (58%) are designated mental health shortage areas.³ These shortages result in significant delays in treatment and are a likely factor in the increased use of hospital emergency departments as noted by the analysis of Medicaid claims data (see Section 2).

The difficulties of recruitment and retention of behavioral health providers and other staff are significant issues across the state, which are acutely experienced in our region. Genesis Behavioral Health reported a 12% vacancy in workforce as of August 2016 including a Nurse Practitioner position that has been vacant for over 6 months.⁴ Horizons Counseling Center reports an even higher vacancy rate of 20% for licensed drug and alcohol counselors. This circumstance is consistent with the general workforce shortage reported across New Hampshire, especially in the area of drug and alcohol counseling.⁵

Provider turnover has significant costs to patients who experience service disruption as well as cost to the agencies that are in a continual cycle of recruiting, hiring and training new staff. Recruitment expenses have a negative effect on the fiscal health of CHSN members. For example, Genesis Behavioral Health must use recruiters to hire its providers with an average cost of \$24,000 for physicians and

“Stability is a big one. It takes us a good month to get used to someone, and then you have back peddled, because you have to rehash everything and have to re-traumatize yourself to catch them up I haven’t had a case manager for months, so you can get lost, get forgotten.” *Mental Health Client*

³ <http://www.hrsa.gov/shortage>

⁴ NH Community Behavioral Health Association, August 2016 Human, Resources Posting Summary, Pero Consulting Group, September 2016.

⁵ Improving Child & Community Health: Addressing Workforce Challenges in Our Community Mental Health Centers. Antal Associates Report for Endowment for Health, May 2016.

\$18,000 for APRNs. Frequently, temporary staffing agencies are used to fill open positions, resulting in additional expenses.

Relatively low pay for professional services in agencies that serve a high proportion of publicly insured and uninsured clients is a direct factor in recruitment and retention challenges. For example, professional salaries are up to \$25,000 less in community mental health than in other areas of mental health and salary increases at community mental health centers have not kept pace with inflation. Cost of living adjustments are rare and staff often chooses to leave for private practice.

A related challenge is the expense of supporting staff who are working towards licensure or certification, such as social workers, alcohol and drug counselors, and recovery support workers. These positions require many hours of supervised clinical time that is not reimbursable. Frequently, agencies will invest time and resources to support young professionals as they work towards their licensure, but then the agencies are unable to retain their services for long due to low pay relative to the private marketplace.

Workforce capacity limitations such as these contribute to lost opportunities to integrate services at the agency and inter-agency levels. The ability of individual providers and provider organizations to effectively collaborate with other health care providers and community-based social support organizations is severely limited by pressure to generate billable services, leaving limited time for collaboration and coordination activities that are not billable. Inversely, community partners across the system of care such as first responders, schools, and human service organizations experience inconsistent communication, disruption of connections, and uncertainties around referrals due to limited availability of service providers.

While assessments of workforce capacity in this area tend to focus on specialty behavioral health settings (e.g. CMHCs and SUD treatment organizations), workforce capacity and competencies in primary care practice settings are similarly important. The majority of individuals with mild to moderate behavioral health conditions can be more readily identified through standardized screening protocols, diagnosed and, in many cases, provided treatment in primary care. Strengthening the workforce in these settings through strategies such as continuing education on topics including team-based care and medication management, supporting consistent specialty referral relationships with consulting psychiatric clinicians, and increasing awareness of community-based resources will be crucial to the success of this initiative.

10c. High level strategies and how the statewide planning process will support the IDN

Strategies that CHSN will pursue to address workforce capacity challenges include providing resources for more incentives to encourage staff recruitment and retention, investing in rising professionals who are pursuing licensure or certification, providing resources and opportunities for continuing education and training, and incorporation of more care ‘extenders’ such as peer support specialists, recovery support and community health workers to support care coordination and integration efforts within and across agencies.

In the area of recruitment and retention, top strategies identified by the current workforce in New Hampshire include regularly scheduled raises, cost of living increases, and loan forgiveness for practice

in underserved areas.⁶ Coordinated recruitment activities through the Network will help to identify opportunities to leverage resources and efforts among partner organizations. CHSN will seek to develop coordinated incentive plans; share space, costs, and resources at job fairs; and work together to create common job descriptions. Offering incentives to encourage staff longevity can be accomplished with funding that allows the flexibility for market adjustments or cost of living raises.

Some member organizations offer incentives now such as tuition reimbursement or other professional development and education opportunities to staff. For example, Genesis Behavioral Health has offered graduate level on-site education for staff interested in pursuing their Master's in Mental Health Counseling. Genesis also works closely with Plymouth State University and Lakes Region Community College to provide on-site clinicians as well as internships for students. These relationships can be leveraged further for the benefit of the entire network.

Support for counselors and recovery support workers who are working toward licensure or certification will be a general strategy applied by the network, but will also be a key strategy related to our community projects for Supportive Community Re-entry and SUD treatment expansion. IDN funding can be used to underwrite the cost of services delivered by staff working toward licensure or certification, fees associated with required training, testing and license application, and supervision hours provided by a Master's level clinician. In return, this workforce can be utilized to expand intensive outpatient program capacity and serve as recovery mentors for justice-involved individuals.

Similarly, we plan to increase the capacity of the workforce engaged in care coordination activities across the network and for specific community-driven projects through additional staff and training of existing personnel across multiple disciplines and sectors. Increased knowledge and skills in the areas of patient and family engagement, health literacy and lifestyle improvement, effective connections to resources for addressing social determinants of health, and efficient, timely sharing of information are essential for more integrated health practice including enhanced care coordination for complex, high need patients and their families.

The training resources of each member agency can be leveraged to maximize efficiency. Early in the next phase of IDN development, the members will identify training needs and design a plan to address them. Each organization will be surveyed to learn what training expectations currently exist, and what is currently offered internally for trainings. An inventory of trainings offered by each member will be created, allowing members to participate in cross-trainings on various topics related to the work of the IDN. This approach will contribute to cost efficiencies and increased awareness of training opportunities that could be replicated or expanded. We will also seek to draw on 'in-network' expertise to develop and implement continuing education activities that further the goals of integrated practice and other related topics. Opportunities for leadership, to serve as 'faculty', and the associated benefits of developing enhanced peer relationships through these types of activities can also be contributing factors to professional satisfaction and staff retention.

⁶ Ibid, Antal Associates

We are hopeful that enhanced provider experiences that result from more integrated practice including more support for care coordination and improved connections to community supports will contribute to greater staff satisfaction and longevity. However, an essential ingredient of this change will be improved systems and supporting workforce capacity to support integrated practice that do not result in more administrative work, onerous documentation requirements, and less time for delivering quality patient care.

Finally, participation in the statewide planning process in the area of Workforce Development will provide CHSN members opportunities for sharing strategies and best practices across the IDN regions. There may also be opportunities for joint participation in workshops and other learning opportunities. Coordinated efforts across the state should also incorporate the participation of academic training programs to align coursework with the goals of integrated health and team-based care within and across organizations. Statewide plans should also include increased support through mechanisms such as loan repayment for health professionals who are serving in underserved communities and health professional shortage areas.

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

11a. *The IDN HIT project lead and Statewide Taskforce Participants*

Please see tab 11A of the IDN Project Plan Supplemental Data Workbook

11b. *Critical HIT gaps, including gaps related to community based organizations*

As described in Section 7 (Governance), CHSN has formed an HIT/Data Analytics (HIT) Work Group to guide development in this area and to serve as the interface between the IDN and the statewide HIT work group. The CHSN HIT Work Group has already begun the process of inventorying existing and planned HIT systems and capabilities among the Network partners including existing inter-agency agreements and technologies to facilitate electronic information exchange.

Health Information Technology, including technology that facilitates Health Information Exchange (HIE), will be fundamental to CHSN's efforts to reduce costs, increase quality, improve access, coordinate care, improve patient safety and stability, provide data to refine or develop evidence-based guidelines and protocols, provide relevant patient information to the care provider when and wherever it is needed, and manage populations of patients with complex behavioral and physical health needs. Through our preliminary assessment work, we have identified challenges and gaps in three broad categories a) organizational capacity challenges, a) technology capacity challenges and c) clinical workflow and related patient care challenges.

Organizational capacity challenges that will need to be addressed by CHSN include limited financial resources, particularly for smaller agencies, to acquire and maintain HIT applications to facilitate improved clinical performance and patient care, as well as a related issue of limited internal HIT staff. Currently, there are several agencies that have very limited or no EHR capacity including Horizons Counseling Center, the major SUD provider in the region.

Technology capacity challenges that will need to be addressed by the IDN include the complexities of establishing interoperability among HIT systems. Electronic health record systems do not always allow for easy sharing of patient information among organizations as various EHRs currently in place do not communicate outside of their own information technology environment. An important development in our region is a collaboration between LRGHealthcare and Speare Memorial Hospital to implement a new health information system in common with a phased rollout beginning by the end of this year.

Other technology capacity challenges include the need to coordinate information flow across diverse health and human service settings including establishment of database standards, the related importance of establishing common privacy and security standards, and the need to align HIT strategy among collaborating organizations in a manner that serves the goals of the Network overall while recognizing the differing business environments and reporting requirements of each participating agency.

An important aspect of NH's DSRIP initiative and our work in Region 5 is the broad, intentional inclusion and recognition of the essential role of community-based human services and supports for affecting social determinants of health outcomes. Implications of this for our HIT efforts are also significant. Accurate data on health status and service utilization across the system of care can be a vital tool for bringing a complex picture into focus. For example, data can make the case for integration of health and supported housing and / or employment assistance efforts by facilitating the monitoring of progress and savings over time. Yet, frequently, individuals receiving public support for housing and employment interact with multiple systems that each track interactions in separate, closed data systems. As a result, it may be possible to get an aggregate view of cost for each system, but difficult to identify duplication of effort, understand the total costs associated with individual patients/clients across systems, or tell a coherent story about how a population is interacting with multiple systems.

A key requirement for HIT development through the IDN is that it must support measurable and attainable improvements to quality of care and the overall effectiveness and efficiency of the Network. By implication, this suggests that modifications of clinical workflow and patient care practices will be key success factors including:

- Ability to access essential data at the point of care;
- Completeness and accuracy of patient data;
- Patient-centered care perspective including a) providing patients access to their clinical records and contextually appropriate educational materials, b) providing a focus on the coordination and transitions of care across different settings, and c) enabling the electronic exchange of health information to improve clinical decision making and quality of care;
- Limiting the burden of health IT on existing workflow;
- Effective clinical decision support tools;
- Patient registries to support effective chronic disease management and coordination of care for patients with co-occurring conditions; and
- High quality data reporting in support of program monitoring and reporting requirements.

Already in our region there are important examples of data sharing efforts to focus on high utilizers of care. High utilizers of multiple systems can serve as the primary focal point for initial efforts to develop an effective data sharing strategy across the Network due to their relatively smaller number within the overall Medicaid population, involvement with multiple agencies and providers, and the potential savings from better coordination and case management.

11c. How the statewide planning process will support the IDN

Participation in the statewide planning process in the area of HIT will provide CHSN members opportunities for sharing strategies and best practices across the IDN regions, as well as coordinated efforts to identify shared standards and statewide solutions to technology and policy issues. Examples of these opportunities may be identification of business requirements and standards associated with

selection of a community care plan application or data warehouse function that could be implemented across the state. A related policy initiative could be to address the need for a unique patient identifier or related solution to facilitate more effective Health Information Exchange within and across regions. We assume that all IDNs will have a shared interest being able to share data within their networks describing eligibility and demographic information, physical health information, behavioral health (including mental health and substance use), and social services (including utilization of public services and community-based social services such as housing and transportation). Capability to share data across sectors could help in providing 'whole person care' by 1) targeting high-need individuals with specific patient-centered interventions; 2) allowing for coordinating services in real time across entities; and 3) supporting payment reforms and evaluation of whole-person care delivery system reforms.

Another joint activity could be education of IDN participants on the confidentiality of private health information protected under both federal and state laws. Given the range of state and federal laws governing health information privacy, real or perceived legal barriers to health information exchange between physical and behavioral health providers can present challenges to achieving the goals of increased coordination and integration of care. Medical care providers are well acquainted with Health Insurance Portability and Accountability Act (HIPAA) regulations and compliance. However, sharing SUD and mental health care information across integrated network systems adds another potential layer of confidentiality due to the Confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR Part 2) requirements, as well as uncertainty or misconceptions.

12. Project B1: Integrated Health (Core Competency)

12a. Current-state Assessment of Network

Please refer to tab 12A of the IDN Project Plan Supplemental Workbook

12b. Participating Organizations and future-state goal

Please refer to tab 12B of the IDN Project Plan Supplemental Workbook

12c. Monitoring Plan

The Integrated Health strategic channel for delivery system transformation will support and incentivize primary care and behavioral health providers to progress along a path from their current state of practice toward a higher level of integrated care as feasible and appropriate to practice context. The overarching framework for assessing progress will be informed by SAMHSA's Standard Framework for Levels of Integrated Healthcare⁷, as well as the Four Quadrant Model developed by the National Council for Community Behavioral Healthcare that describes subsets of the population that behavioral health/primary care integration must address.⁸ The combination of these two conceptual models recognizes that progress toward integration at an organizational practice level also occurs within a wider systemic and environmental context across the Network where the health care needs and preferences of individual patients are at the center.

As such, the attributes of integrated practice may vary to some extent across agencies as influenced by variation in type and intensity of health care and psychosocial needs of patients. Nevertheless, there are fundamental underlying characteristics of integration that are applicable across practices and systems and these characteristics will form the basis for monitoring progress toward greater integration. Ultimately, anticipated outcomes of this work are improvements in all domains of the Quadruple Aim: enhanced patient experience, improved population health, reduced costs, and enhanced provider experiences.⁹ Thus, our monitoring plan will incorporate resources and methods to monitor specific measures of these outcome areas.

The Network will support its primary care practices, community mental health centers, outpatient SUD treatment agency and other network providers in becoming a "Coordinated Care Practice" or an "Integrated Care Practice," depending on what is practical given the practice's current level of integration, patient panel size and risk profile, and available resources. The major focus of the network is the integration of care across primary care, behavioral health (mental health and substance

⁷ Heath B, Wise Romero P, and Reynolds K. A Review and Proposed Standard Framework for Levels of Integrated Healthcare. Washington, D.C.SAMHSA-HRSA Center for Integrated Health Solutions. March 2013

⁸ National Council for Community Behavioral Healthcare. Behavioral Health / Primary Care Integration and the Person-Centered Healthcare Home, April 2009.

⁹ Thomas Bodenheimer, MD and Christine Sinsky, MD, "From Triple to Quadruple Aim: Care of the Patient Requires Care of the Provider". Annals of Family Medicine, Vol. 12, No. 6, November/December 2014

misuse/SUD) and social support services. This includes a focus on creating an overarching system of health care that improves the outcomes, experience, and coordination of care across a continuum of physical and mental health for individuals with behavioral health conditions or at risk for such conditions. The goal of integrating these services is to build a delivery system that effectively and efficiently prevents, treats, and manages acute and chronic behavioral health and physical illnesses across multiple providers and sites of service.

Different practices are currently at different levels of integration and the pace at which different practices can move towards greater integration will vary. Technology to support integration ranges from no EHR (Horizons) to more advanced EHR capabilities (Health First and Mid State FQHCs). There is substantial variation in capability to make electronic referrals, use of patient registries, use of standardized assessments specific to or inclusive of behavioral health, sharing of care plan documents, intra- and inter-organizational case conferencing, capacity for care coordination, and existence of inter-agency information and referral agreements. Practices are also at different levels of integration readiness within their respective workforces including staffing levels available to support integrated practice, staff proficiencies, education levels, and primary care/behavioral health care co-location characteristics.

The implementation process will include development of individualized integration plans for each practice along with staged implementation to take into consideration practice/provider readiness level for change. Practice involvement at the outset will vary where some practices may only participate in basic information sharing and training activities in the beginning, while others may be involved with technology enhancements and workflow modifications from the start. An important timing consideration is that practices associated with LRGH and Speare Memorial are currently undergoing roll out of a new health information system (Cerner). The timing of implementation efforts for the IDN-related integration work will need to fit within and adapt to the significant changes and learning that will be occurring with implementation of this new system across the major hospital systems.

To support the Integrated Health core competency work, four task teams will be supported by CHSN including:

- The Clinical Integration Committee, a standing committee of CHSN as described in Section 7 (Governance), will develop protocols for patient assessment, treatment, management, communication and referral. This Committee will build on the preliminary assessment completed for this plan by reviewing current practices, protocols and procedures used by participating practices in more depth, drawing on standards and guidelines such as those associated medical or health homes. The team will determine protocols based on what practices are doing now, what works, what doesn't work, and incorporating best practices in a collaborative manner. The Clinical Integration Committee will also work to develop common terminology for job titles and descriptions of integrated practice within the overall system context and existing assets of the region.

An important building block for this work is the OneHealth project; a model of integrated care under development through Genesis Behavioral Health, Health First Family Care Center, and Mid-State Health Center. The focus of this work is to demonstrate a model for patient-centered behavioral health home for persons with serious mental illness (SMI) and/or co-occurring substance use disorders. Health First and Mid-State (FQHCs) also are far along the continuum of integration with mental health and SUD counselors physically co-located and part of collaborative teams in the primary care setting. The Network will build on these models by expanding systems and procedures for clinical co-management, disease management protocols and provider communication. The Clinical Integration Committee will have overall responsibility for monitoring the progress of the Integrated Health core competency work and for ongoing communication with participating practices to identify and address project challenges and plan modifications as necessary.

- A CHSN Training Team will be established drawing on personnel among the IDN partners to build individual and organizational level capabilities for integrated practice. The training team will design and develop relevant training sessions based on the results of more in-depth individual practice assessments. Training methods will include “Train the Trainer” sessions to build practice-based leadership, Network-wide educational opportunities, and one on one practice-based consultation focused on workflow and visit design. As an example of work in this area, the Training Team may draw on the local expertise found in the FQHCs on SBIRT implementation to provide consultation to other Network practices in order to facilitate broader and more consistent adoption of this evidence-based practice.
- The Data Analytics team previously described will convene staff from participating practices that can work to identify common terminology, existing reporting capabilities and procedures, and challenges for collecting data across the Network associated with the DSRIP project outcome metrics. As part of this area of work, CHSN will support QI/QA staff from member agencies to consult with Network members lacking sufficient internal QI/QA resources on approaches to collecting and applying information supporting performance improvement.
- The Health Information Technology Team established for the overall IDN (refer to previous Section – HIT Infrastructure) will be essential for assisting participating practices and agencies with the information technology aspect of the project. The work of this team also underpins other strategic channels for system transformation, most notably technology to support shared care plans and the multi-disciplinary case management / care coordination aspects of each of the community-driven projects selected by CHSN.

As part of the work to be accomplished through these task teams, the network will be refining and implementing agreements with collaborating providers and organizations for inter-agency data sharing and patient information release. The network will contract with legal counsel to assist with development of interagency agreements that meet federal requirements for personal protected information.

In addition to measuring specific indicators of process and outcomes (see next page), the network will monitor developments on certain structural elements essential to the Network's progress on integrated care. These elements include, but are not limited to, development and communication of an organization-specific inventory of services such that each is more aware of the available services and resources in the region; monitoring work force capacity, recruitment and retention efforts; development and implementation of standardized and systematic screening and evaluation procedures; and implementation of collaborative systems and procedures for shared care management.

12d. Expected Outcomes

As previously mentioned, fundamental outcomes of this work are expected to be enhanced patient experience; improved population health including improved prevention, early identification, and intervention to reduce the incidence of serious illnesses; more cost effective utilization of health and human service resources; and enhanced provider experience. All of the outcome metrics listed in the CMS approval protocol for the NH DSRIP project are associated with the Integrated Health core competency and will not be repeated here in their entirety. Priority statewide measures on this list include:

- Readmission to Hospital for Any Cause (Excluding Maternity, Cancer, Rehab) at 30 days for the Adult (18+) behavioral health population
- Comprehensive and consistent use of standardized core assessment framework including screening for substance use and depression for age 12+ by IDN providers
- Potentially Preventable ER Visits for BH Population and Total Population
- Initiation of Alcohol and Other Drug Dependence Treatment (1 visit within 14 days)

The Data Analytics team will lead the Network in aligning data collection and reporting capabilities to match the comprehensive set of state specified outcome measures, as well as other Network-defined measures of integration process and system development outcomes. The latter measures are necessary to inform Network participants on progress and to facilitate modification and adaptation of project activities as needed. Custom measures may be added at any time as identified by the Clinical Integration Committee in conjunction with the Data Analytics team. A preliminary set of measures of interest in addition to state-defined measures that describe practice and system-based developmental outcomes include:

- Percent of practices (or agencies) adopting a common protocol for release of patient / client information
- Percent of practices that can communicate through secure email
- Percent of practices that can send and receive electronic referrals
- Percent of practices adopting standardized assessment tools and procedures

- Percent of practices with EHRs; with EHRs that include evidence-based guideline prompts
- Percent of practices adopting use of a common Patient Centered Care Plan
- Percent of practices/providers reporting adequate time and resources for care coordination
- Percent of practices/providers participating in case conferences for complex or high risk patients
- Percent of practices using patient registries to track complex or high risk patients; to track referrals to and from community service and support agencies
- Percent of practices with sufficient access to specialist consultation
- Percent of practices with co-location of primary care, mental health staff and / or substance use treatment (including the various possible permutations of co-location)
- Percent of practices with information strategies and materials to engage patients as participants in integrated care practice

In addition to measuring these types of practice/organization/system attributes, an essential element of monitoring outcomes will be continued patient, provider and community engagement to assess perspectives on what is working and what is not. Procedures for ongoing assessment and engagement were discussed earlier in Section 3. The Network will also support participating organizations that do not currently have resources for periodic assessment of patient, family and provider experiences and satisfaction to implement simple procedures for collecting and analyzing this information.

As mentioned previously, in order to capture these data points a data analytics team will be formed. The data analytics team will make recommendations to the CHSN Members for reporting mechanisms and system requirements by June 2017. The team will report periodic measurement of progress toward integration using more comprehensive criteria along the lines of health homes, the SAMSHA integration framework or other criteria tailored to the region's context. The team will determine the appropriate time frame for periodic assessment (i.e., quarterly, monthly, etc.).

An inherent activity in this area will be to periodically compare progress across the network against the baseline assessment conducted as part of the initial IDN planning process currently underway. Another important aspect of outcome monitoring over time will be the need to understand the impact of integrated work on cost of care and associated value of the work to inform alternative payment models.

12e. Challenges and Proposed Solutions

The CHSN and participating agencies in the IDN are tasked with supporting and incentivizing integration across primary care, behavioral health (mental health and substance misuse/SUD) and social support service providers along a path from their current state of practice towards the highest feasible level of integrated care. The Network recognizes that this work will be complex and multifaceted. The Network

has identified several barriers and challenges that are anticipated to arise during the roll out of this process as follows.

There is substantial literature stressing the importance of active engagement of direct care professionals and office practice staff in any practice transformation work. While this seems obvious and intuitive, it also takes time, effective communication, attention to detail, and entails providing sufficient flexibility to allow clinic teams to design approaches that work best for them.¹⁰ The Clinical Integration Committee will be critical to accomplishing this engagement and must be accomplished through peer relationships and direct care provider champions.

Given the region's status as an underserved area with health professional shortages, it is historically difficult to recruit and retain adequate numbers of skilled mental health and SUD treatment providers to meet population demand. By definition, workforce shortages in these areas make integrated practice more challenging. The Network's approach to responding to this barrier is aligned with underlying foundational activities to occur through the Workforce Development strategic pathway and include regional coordination on strategies such as educational subsidies and loan repayment, supplemental market or cost of living adjustments, longevity pay, financial support for continuing education, IDN leadership activities and other strategies designed to support retention of sufficient and high quality behavioral health care workforce in the region.

Related to the challenge of workforce availability is the availability of staff time to participate in some key aspects of integrated care including case conferencing and multi-disciplinary team meetings, case management and care coordination activities that are often not reimbursable, and competing demands for standardized screening activities within the patient visit. Strategies to address these issues include patient visit re-design, team role definition and workflow re-design, and EHR development. Ultimately, an important factor influencing this area will be the nature and resource sufficiency of alternative payment models that move away from paying for units of face-to-face patient encounters.

Currently, different organizational types have different funder/payer requirements for patient assessment and evaluation. These differences result in a challenge for certain practices to adopt common tools and procedures. The Clinical Integration Committee will work together to propose protocols for comprehensive screening and assessment from the various assessment tools already in use. An important area of work will be to develop a core set of measures from the various assessment tools that can be extracted / reconciled to inform the development of a shared care plan for each individual patient. As a starting point, the IDN partners will work toward increased capabilities for electronic sharing of continuity of care documents from agency EHRs to form the basis of shared care coordination plans. A related challenge is that different agency types have different funder / payer requirements for quality measurement and reporting and outcome measurement and reporting. The data analytics team will work to resolve this challenge to network-wide measurement and progress

¹⁰ Coordinating Care for Adults with Complex Care Needs in the Patient-Centered Medical Home: Challenges and Solutions, Agency for Healthcare Research and Quality, AHRQ Publication No. 12-0010, January 2012.

reporting by identifying common data elements, as well as protocols and mechanisms for data collection.

An important issue described briefly at the beginning of this section is the need to simultaneously consider integration work at the practice and at the system level, with the intention of achieving system transformation that maintains the needs and preferences of the patient/client/family at the center. The integration 'end-state' will not look the same for each agency and there will on all likelihood continue to be differentiation of services responsive to variation in population health needs. The work of the Health Information Technology task team to develop the technology infrastructure to support integration will be the foundational strategic pathway that supports simultaneous integration improvements at the practice level and across the continuum of care. Eventual progress toward implementation of a community care plan module with inter-agency input to individualized care plans will enable seamless integration of services and supports characterized by a 'No Wrong Door' approach across the system.

Inherent to the challenge of integration at the system level is the integration of health care with non-clinical community / social support provider organizations. Health information and exchange systems development will be critical in this area as well to build the multi-disciplinary, multi-resource care plans and real-time communication linkages necessary to support effective care transitions, prevent crises and promote psychosocial stability.

In addition to the barriers identified above, there are other underlying organizational challenges that the network faces. The original members of the Network have invested significant amounts of time in the development of CHSN and the development of this plan. It will be difficult for executive leaders of member organizations to sustain this level of time commitment in the form of multiple and frequent meetings while simultaneously leading their respective organizations. The development of executive staff capacity based in the Community Health Services Network will be essential for continuing to drive this project forward. A companion issue will be the need to develop procedures for regular and effective communication with the IDN partners in order to maintain momentum and clarity of purpose, progress and expectations.

12f. Implementation Approach and Timing

Refer to tab 12f of the IDN Project Plan Supplemental Workbook

C2: Community Re-entry Program for Justice-Involved Adults and Youth with Substance Use Disorders or Significant Behavioral Health Issues

13a. Project selection rationale and expected outcomes

The Network has selected the Supportive Community Re-Entry Program as a means to improve health and social outcomes for adjudicated Medicaid-eligible youth and adults transitioning from correctional facilities to home communities and community-based services. The project approach will blend after-care planning efforts that occur within corrections with enhanced case management, peer support and recovery mentoring to improve access to sustained community supports and services. Through this approach, re-entering individuals will be more likely to access needed supports and services resulting in lower recidivism into the corrections system, reduced use of high cost care such as emergency room care, reduced relapse of SUD and BH conditions, and improved health outcomes and social and economic stability for individuals and their families.

Supportive Re-Entry Care Coordination will involve a team of staff from multiple community organizations and county corrections who will establish and maintain referral mechanisms for all inmates with a SUD and/or other behavioral health problems who have met the criteria for the community corrections program. The Supportive Re-Entry Care Coordination team will assign and monitor re-entry responsibilities for inmates individually and as a whole. For example, the team will establish when SUD and other behavioral health assessments are conducted, how they are shared with team agencies and their staff, and how they are used in developing after-care plans. Supportive Re-Entry Care Coordination will be initiated no later than 6 months prior to re-entry to the community and carry through 12 months after the date of re-entry.

The team will also establish and monitor each organization's role and activity in the Supportive Re-Entry Care Coordination approach. For example, the team may establish that prior to release each eligible inmate will be paired with a recovery coach that aligns with the individual's culture and his/her SUD or other behavioral health history, that each will be paired with a primary care, SUD and other mental health provider, and that each will be paired with and meet their supportive re-entry care coordinator before release who will determine needs and help them meet those needs, including registering for health care, providing appointment reminders, setting up transportation to appointments, and finding stable housing.

A Re-entry Leadership Team will be established with membership to include high level administrative/management representation from county corrections, SUD and MH treatment, recovery organizations, community supports, and, to the extent possible, consumers of re-entry services. This Leadership Team will develop memorandums of understanding and corresponding client privacy and confidentiality releases to be able to collect and share individual client data to facilitate case management and to measure program outcomes. This team will also be responsible for monitoring the project's progress, revising policies and procedures within their organizations to support project and participant goals, and

developing and implementing a long-range sustainability plan to ensure program continuity after investment funding ends.

This project will address significant gaps in services, including but not limited to the following:

- The current lack of capacity in the Belknap County Correctional facility to be able to screen and/or assess all adjudicated individuals for substance use disorder and other behavioral health needs, to provide adequate after-care planning and case management for inmates, and to integrate transition plans with community-based services and supports;
- The current lack of capacity in existing community support and service organizations to serve an increased number of clients who are re-entering the community from correctional facilities; and
- The current lack of infrastructure to implement a robust, integrated continuum of care between correctional systems and community-based supports and services (e.g. case management data sharing, trained workforce, community transportation and housing).

This project builds upon existing knowledge, services and capacity, including the following:

- Merrimack County Corrections' continuing care planning and monitoring program known as SOAR (Successful Offender Adjustment and Re-entry);
- Belknap County Corrections' existing continuing care planning and monitoring;
- Relationships between correctional facilities and probation and parole to encourage compliance with continuing care plans;
- Existing clinical, peer support and community education services offered by Horizons Counseling, Navigating Recovery, Lakes Region Community Services Family Resource Center, Genesis and Riverbend, and other community providers and support groups; and
- Existing ancillary supports in the community, including employers, family education and support programs, court diversion and prevention programs, housing/shelters, job training, Lakes Region Community College, and other community assets.

13b. Participating organizations

The key agencies involved in the Region 5 IDN Supportive Re-Entry Care Coordination program are critical to its success because staff within these organizations have unparalleled knowledge and understanding of the incarcerated population, of high quality primary and behavioral health care and treatment approaches, of the nature and progression of behavioral health disorders and recovery from such disorders, and of the many community assets that can be tapped to help re-entering individuals. Each of the participating agencies are firmly rooted in the community and committed to helping meet the needs of this vulnerable population. They are essential assets to the program because they are most aware and connected to both formal and informal supports in the community that can help individuals

realize their goals of being stable, healthy, and contributing community members. Participating organizations include, but are not limited to those agencies specified beginning on the next page.

A Re-entry Leadership Team has been formed to further develop the Supportive Re-Entry Care Coordination approach, protocols, staffing and budget plans. The Re-Entry Leadership Team will also oversee initial implementation of the project, will monitor additional challenges as they emerge, and guide modifications to the implementation approach as needed. Agencies comprising the Re-Entry Leadership Team at this time include:

- *Belknap County Corrections* provides detention and confinement of pre-trial detainees and post-trial confines in a safe and secure condition.
- *Merrimack County Corrections* serves male and female inmates who are awaiting arraignment, pre-trial and/or sentenced, administrative transfers from other correctional facilities, and federal inmates.
- *Grafton County Corrections* maintains a balanced correctional system of institutional and community programs that provide a range of control and rehabilitative options for criminal offenders and those awaiting trial.
- *Horizons Counseling Center* is a licensed treatment agency and Medicaid provider located in Plymouth and Gilford and serves clients from throughout the region, providing assessment, outpatient (OP) services to adolescents and adults, and intensive outpatient program (IOP) counseling services to adults with SUDs or co-occurring BHDs. Horizons clinical staff operates the Nathan Brody IOP program and provide OP and IOP services to patients in the LRGH Recovery Clinic.
- *Genesis Behavioral Health* and *Riverbend Community Mental* provide services within the county jails under contractual relationships that include evaluations, treatment and screening for Assertive Community Treatment and other evidence based practices.
- *Navigating Recovery of the Lakes Region* is a recovery community organization in downtown Laconia that provides a setting where those in recovery are supported to pursue a productive life without drugs or alcohol, with peer-to-peer recovery coaching, wellness workshops, resources for families, 12-step meetings and social events.
- *LRGHealthcare (LRGH)* is the most prominent health care entity in the region, with two hospitals in Laconia and Franklin as well as primary and specialty care clinics.
- *Lakes Region Community Services/Family Resource Center of Central NH (FRC-CNH)* provides area families with family supports, including playgroups; parent education and support; early childhood; a home visiting program with case management; information and referral services; and childcare resource and referral services. The Center currently meets with inmates at Belknap County Corrections to establish family supports before re-entry.

Other key organizations involved in the Community Re-entry Program as part of the planning and implementation workgroup and/or as a referral resource to support successful re-entry include:

- *Communities for Alcohol- and Drug-free Youth* is a non-profit organization in Plymouth that provides court diversion, pro-social alternatives, and family support and education programming to help prevent alcohol and other drug misuse among youth.
- *Belknap and Merrimack Court Diversion/Restorative Justice* programs provide an alternative to court involvement for juvenile offenders as well as a range of educational and support services.
- *HealthFirst Family Care Center* providing integrated care (primary care, behavioral health and SUD services).
- *Central NH VNA & Hospice, Franklin VNA & Hospice, Lakes Region Visiting Nurse Association, Newfound Area Nurses Association, and Pemi-Baker Community Health* are not-for-profit community-based health care organizations serving patients of all ages and all circumstances across the region.
- *Community Action Program Belknap-Merrimack Counties* provides a variety of social and family support services including housing support, homeless services, transportation, workforce development, WIC, Head Start, Early Head Start, Home Visiting, Mediation
- *Laconia Housing Authority (LHA)* provides subsidized housing opportunities at properties owned/managed by LHA and through partnerships and by the administration of Housing Choice Vouchers (formerly Section 8).
- *Laconia Area Community Land Trust* develops affordable housing properties for low to moderate income households, provides transitional shelter and offers resident support services.
- *Lakes Region Community College* provides Job training and vocational education services
- *Lakes Region Public Partnership for Health (LRPPH)* works with partners in health care, schools, business, safety, and others to improve the health and wellbeing of the region through inter-organizational collaboration and community and public health improvement activities.
- *LRGH Recovery Clinic (suboxone clinic)* is a program established a year ago at Franklin Regional Hospital and in collaboration with Horizons Counseling Center of Gilford. The program offers the important combination of suboxone with counseling and therapy.
- *Plymouth Area Recovery Connection (PARC)* provides recovery mentoring and a drop-in center for those working toward or in recovery from alcohol and other drug dependence. The organization opened to the public this fall.
- *HOPE for NH Recovery* provides recovery support services and drop-in centers in communities across the state. Their Franklin site opens this fall.

13c. Participating Organizations: List of Organizations

See tab 13c of the NH DSRIP Plan Supplemental Workbook

13d. Monitoring Plan

Implementation progress will be measured using the state's Core and Community Driven Project Outcome metrics as well as project specific process measures to demonstrate changes in capacity, infrastructure, and care coordination that will build long-range sustainability.

Data systems that are in place currently to support the monitoring plan include the following:

- WITS client record system for clients receiving SUD treatment services paid for by state block grant and general funds
- Electronic health records used by hospitals and primary care clinics
- Medicaid data system
- The Dashboard system used by family resource centers
- The recidivism calculation model used by the Juvenile Court Diversion Network
- Existing correctional facility data system
- Existing community mental health data system
- Existing data system of the NH Courts
- Other data systems of partner organizations

Implementation progress will be measured through the development and implementation of a monthly partner reporting plan and the anticipated design and utilization of a care coordination data system. Regardless of the data systems eventually deployed for inter-agency care coordination, all partners will collect and report on data associated with training, workforce development, and de-identified client data to track expanded services and monitor project goals. In addition, a client satisfaction tool will be developed to capture self-report measures noted above and to ensure on-going quality assurance and client satisfaction. The key partners in the project will review client feedback quarterly to make adjustments and improvements to policies and protocols to ensure goals are met, standards are maintained, and individuals receiving services are satisfied with their care.

Process monitoring of the Community Re-entry project will entail documenting the presence or occurrence of key features of the model including:

- Assessment, supports, services, after-care planning in correctional facility via team approach with CHSN members
- Recovery coach pairing before release
- Primary care appointments made before release
- Behavioral Health service appointments made before release

- Transportation to primary care and BH set up before release
- After-care plans include appropriate supports and services before release with connections with staff of those supports and services made before release
- After-care plans include incentives for sustained participation in plan, including connections with probation/parole and supportive court involvement as appropriate
- Family/friend engagement and communication as appropriate
- Identification of care coordinator (based on client choice) for check-ins and one-on-one communications (e.g. choice of recovery coach, family support worker, clinical service staff)
- Application to Medicaid/Health Insurance program upon release
- Patient confidentiality and privacy assurances and releases established before release
- Housing and employment supports before release

The number of individuals anticipated to be served through the Supportive Re-Entry Care Coordination project will be finalized over the next few months of additional planning as resource requirements and priorities across each of the strategic pathways for system transformation are further refined. The socio-demographic characteristics of the population served through this community project will be tracked to include housing, economic and employment stability; further criminal justice system involvement; and social and family supports.

Systems to support collaborative case management will be established in conjunction with the CHSN Health Information Technology (HIT) work group and the Enhanced Care Coordination community project (refer to Section 15). Leveraging these and emerging data systems that may be developed to support the IDN’s re-entry work, the following measures will reflect project state and local outcomes (State-defined outcome measures are indicated by an asterisk):

Measure	CHSN Plan
Rate of recidivism	Dept of Corrections (DOC) Data System
Self-report of improved status of employment, housing, arrest, relapse, interpersonal relationships, family interaction, community connectedness and other measures of recovery stability (based on national Transition from Jail to Community instrument)	DOC and Care Coordinators
Retention in SUD/COBHD treatment for recommended duration	CHSN SUD and BH treatment providers
*Readmission to Hospital for Any Cause	Hospital data system
*Follow-Up After ED visit for AOD Dependence - within 30 days	Hospital data system and CHSN partners

Measure	CHSN Plan
*Follow-Up After ED visit for Mental Illness- within 30 days	Hospital data system and CHSN partners
*Follow-Up After Hospitalization for Mental Illness- within 30 days	Hospital data system and CHSN partners
*Follow-Up After Hospitalization for Mental Illness – within 7 days	Hospital data system and CHSN partners
*Percent of patients screened for AOD abuse in the past 12 months using age appropriate standardized AOD use screening tool AND if positive, a follow-up plan is document on the date of the positive screen age 12+	Corrections data system and CHSN partners
*Timely Electronic Transmission of Transition Record (Discharges from an Inpatient Facility in IDN including rehab and SNF to Home/Self Care or Any Other Site of Care)	Corrections and CHSN partners
*Comprehensive and consistent use of standardized core assessment framework including screening for substance use and depression for 12+ by IDN providers	CHSN partners
*Global score for selected general HEDIS physical health measures, adapted for BH population	Medicaid data system and/or CHSN partners
*Global score for selected BH-focused HEDIS measures	Medicaid data system and/or CHSN partners
*Smoking and tobacco cessation counseling visit for tobacco users (CPT codes 99406-99407)	CHSN partners
*Frequent (4+ per year) ER Visits Users for BH population	Hospital data system
*Potentially Preventable ER Visits for BH Population and Total Population	CHSN HIT work group
*Rate per 1,000 of people without cancer receiving a daily dosage of opioids greater than 120 mg morphine equivalent dose (MED) for 90 consecutive days or longer	Medicaid data system
*Engagement of AOD Dependence Treatment (initiation and 2 visits within 44 days)	CSHN partners
*Initiation of AOD Dependence Treatment (1 visit within 14 days)	CHSN partners
*Percent of new patient call or referral from other provider for CMHC intake appointment (90801 HO) within 7 calendar days	CHSN partners
*Percent of new patients where intake to first follow up visit was within 7 days after intake	CHSN partners
*Percent of new patients where intake to first psychiatrist visit was within 30 days after intake	CHSN partners

In addition to the specific work to develop improved data systems to support inter-agency care coordination across this and other related project pathways, the CHSN HIT work group will work in collaboration with the state HIT work group to address and resolve any gaps in data infrastructure to meet the above data measure requirements for project compliance.

13e. Challenges and proposed solutions

The network understands the unique challenges of this population and of developing a seamless system for coordination of care that supports improved physical and behavioral health outcomes, economic and social stability, and the avoidance of renewed justice-system involvement. These challenges include those associated with the disease of addiction and other behavioral health disorders, with the psychological and social effects of criminal behavior and incarceration, with disconnected systems of care and the lack of sufficient human and infrastructure resources to support integrated care, workforce capacity and related reimbursement challenges, and the lack of community supports, such as transportation and housing, to support successful community re-entry.

Solutions to address these challenges include the following:

- *The utilization of recovery coaches with lived experience with addiction and other behavioral health problems, and potentially justice-system involvement:* This component of the approach to supporting successful re-entry will increase the likelihood that clients will feel understood, that those working with clients will be more attuned to their unique needs and barriers, and that clients will be more receptive to the supports and services offered to them resulting in higher retention in treatment and other supports and services.
- *Implementation of shared case management procedures and data systems:* This component of the approach will ensure shared knowledge and real-time client data to inform communications and service/support recommendations. This shared knowledge and real-time data will result in better coordination of care, timely access to care, and coordination of care. This component of the approach will also address patient confidentiality and privacy while allowing for sharing data permitted by the patient and shared decision-making for coordinated care. It will also support effective outcome data and reporting. This work aligns with the work of the Enhanced Care Coordination, Integration and HIT strategic pathways.
- *The establishment and maintenance of a Re-entry Leadership Team will ensure a timely means to respond to policy, service access and other barriers to effective supports, services and case management.* The Team will be a means by which community partners are made aware of and educated in the social and psychological impacts of criminal behavior and incarceration (criminogenic behavior) and its effects on access to and success with available supports and services. The Re-entry Leadership Team will manage the challenges of long-term sustainability by focusing their efforts on policy, procedures, and infrastructure during the course of this program to ensure its continuation after Medicaid waiver funding concludes.

- *Workforce capacity and related reimbursement challenges* include the inability to bill for clinical SUD and BH services provided by staff working toward licensure (requires 5,000 hours of supervised direct service yet their work is not Medicaid reimbursable), certification as a recovery support worker, or inability to bill for multiple SUD and BH assessments while an individual is still in a corrections facility. The CHSN will apply IDN resources to support staff as they work toward licensure or certification and will support staff embedded in correctional facilities licensed for both SUD and co-occurring SUD/BH services who can administer comprehensive assessments using the ASI and DSM structured interview assessments.
- *The expansion of the CHSN to include the ancillary supports needed by clients, including transportation, housing and job training programs in the region.* This expansion will be the responsibility of the Executive Director of the CHSN and will be supported by the Leadership Team and the CHSN members.

Participation in the regional and state-wide IDN project will help the region address broader challenges relative to integrated care, such as integrated data systems and electronic health records, access to health care, and expanded treatment and recovery support capacity.

13f. Implementation Approach and timing

Refer to tab 13f in the NH DSRIP Supplemental Workbook.

D3: Expansion of Intensive SUD Treatment Options

14a. Project selection rationale and expected outcomes

The Community Health Services Network selected Expansion of Intensive SUD Treatment Options for Medicaid-eligible adults experiencing a substance use disorder (SUD) or co-occurring substance use and other behavioral health disorder (COBHD) in response to the unmet demand for Intensive Outpatient Program (IOP) services in the region as described in Section 2 (Needs Assessment). This unmet need and demand is evidenced by a) the current month-long wait list for IOP services at the only state-licensed specialty SUD treatment provider in the area, Horizons Counseling; b) the next closest provider, a 45 minute one-way drive from the Laconia area in Concord, has an even longer wait list for those in need of IOP services; and c) by the complete lack of IOP services for SUD and COBHD in the geographic hubs of greater Franklin and greater Plymouth.

In addition to the service gaps evidenced by these wait lists, providers and stakeholders in the region, including those in recovery, recognize that a significant barrier to IOP services is the lack of a short-term (5-7 day) non-medical detoxification facility in the area. Currently, the closest non-medical detoxification facility is 45 minutes away in one direction and has a 30-40 day wait list. Implementation of this project will include working toward a long-range vision of tapping potential private funding and meeting licensing requirements to meet this gap that is recognized as an important component of the SUD treatment service array for those experiencing barriers to treatment, particularly for opioid use dependence.

An expanded IOP service array with integrated peer support and recovery coaching and other ancillary services will address several specific infrastructure gaps that result in limited service capacity:

- *Effective, comprehensive assessment conducted within and/or in concert with a variety of referral pathways* is necessary to ensure that adults with a SUD or COBHD are placed in a level of care appropriate for their needs and reflective of their long-term recovery goals.
- *Care coordination to support adults with SUDs or COBHDs, supporting the integration of physical, SUD and BH care needs and community assets available to support recovery goals as well as supporting access to health insurance coverage.* Care coordination is a best practice in specialty care that is not currently covered by Medicaid. Information technology to support care coordination among traditional and non-traditional providers (e.g. primary care, SUD treatment and recovery support workers) is also lacking.
- *Workforce development in the form of supervision of clinical treatment providers and peer recovery support workers working toward licensure and certification, respectively.* Supervision hours are not currently covered by Medicaid.
- *Cross-training of clinical service staff, peer support and recovery workers, and care managers.* Training costs are not currently covered by Medicaid, but cross training of the mental health and

SUD workforce could help to expand treatment availability to more populations being served in different settings.

- *Expanded IOP hours in evening hours to reduce barriers to treatment are needed in all three sub-regional geographic hubs (Laconia, Franklin and Plymouth).*
- *Ancillary supports that reduce barriers to SUD and COBHD services, particularly transportation, are needed. Currently, the transportation benefit for Medicaid clients is limited to transportation to Medicaid-covered clinical services. However, transportation for important, non-Medicaid covered services such as 12 step meetings and other recovery supports services in the community is needed.*

These infrastructure and resulting service gaps will be addressed through this project. Key outcomes of this work will include substantial reduction of wait lists for IOP services, increased assessments for SUD and COBHDs in traditional and non-traditional referral pathways, integration of peer support, recovery coaching and other recovery supports into IOP treatment, effective care coordination to improve retention in services, and delivery of IOP treatment to significantly more adults in the region. Additionally, this project will establish a means to operationalize this service expansion in a way that improves the integration and coordination of care among primary and specialty care providers and recovery and community supports. With this effort the CHSN hopes to improve health and recovery outcomes for adults with SUDs and COBHDs in the region, thereby reducing admissions to higher care costs, reducing relapse, and improving the quality of life for individuals and their families.

Work in this strategic pathway of expanding SUD treatment options will be closely coordinated with the Supportive Community Re-entry project to optimize the potential of mutually supporting referral, care coordination, peer and recovery support relationships and activities. The project also builds upon existing resources, expertise, referral relationships, community supports, and workforce in the region, including two SUD treatment providers, Horizons and Farnum North, the LRGH Recovery Centers that provides Medication assisted treatment services combined with counseling to assist SUD treatment, the strong partnership of Navigating Recovery and Lakes Region General Health Care, the two community mental health agencies, the other CHSN members and community support organizations within the CHSN Network . We will work to coordinate our efforts in this area with other new SUD-related funding coming to the region such as developmental support of recovery organizations, primary care-based MAT, and emergency department capacity to link people to treatment services. As mentioned, an important aspect of the long term vision for this strategic pathway for system transformation is development of increased capacity for non-hospital, non-medical withdrawal management services in the region.

14b. Participating organizations

The key agencies involved in the Expansion of Intensive SUD Treatment Options Project are critical to its success because staff within these organizations have unparalleled knowledge and understanding of high quality primary and behavioral health care and treatment approaches, of the nature and progression of behavioral health disorders and recovery from such disorders, and of the efficacy of

comprehensive assessment, recovery coaching, and care coordination. These organizations are firmly rooted in the community, knowledgeable about needs and effective treatment for adults with SUDs and COBHDs, and committed to expanding capacity from the perspective of workforce, coordinated care, information technology, integrated peer recovery coaching and recovery support services, and reduced barriers to care.

An SUD Treatment Options Leadership Team has been formed to further develop the approach, protocols, staffing and budget plans. The SUD Treatment Options Leadership Team will also oversee initial implementation of the project, will monitor additional challenges as they emerge, and guide modifications to the implementation approach as needed.

Agencies comprising the SUD Treatment Options Leadership Team at this time include:

- *Horizons Counseling Center* is a licensed treatment agency and Medicaid provider located in Plymouth and Gilford and serves clients from throughout the region, providing assessment, outpatient (OP) services to adolescents and adults, and IOP counseling services to adults with SUDs or COBHDs. Horizons clinical staff operate the Nathan Brody IOP program and provide outpatient counseling and IOP services to patients in the LRGH Recovery Clinic. As with other IOPs, an important feature of the program is that it provides clients the opportunity to maintain family structure and employment throughout the course of the recovery program.
- *LRGHealthcare (LRGH)* is the most prominent health care entity in the region, with two hospitals in Laconia and Franklin as well as primary and specialty care clinics. LRGH operates the *LRGH Recovery Clinic (suboxone clinic)*, a program established a year ago at Franklin Regional Hospital, in collaboration with Horizons Counseling Center. The program offers an important combination of suboxone with counseling and therapy and is led by Drs. Friend and Racicot, the Co-Medical Directors of the Region 5 IDN.
- *Genesis Behavioral Health* and *Riverbend Community Mental Health* are state-licensed mental health providers offering a wide range of behavioral health services, including emergency services, in the region.
- *Navigating Recovery of the Lakes Region* is a recovery community organization in downtown Laconia that provides a setting where those in recovery are supported to pursue a productive life without drugs or alcohol, with peer-to-peer recovery coaching, wellness workshops, resources for families, 12-step meetings and social events.

Other key organizations involved in the planning and implementation of expanded Intensive SUD Treatment Options include:

- *Farnum North* is a campus in Franklin that is operated by Farnum Center and provides residential and IOP treatment. Easter Seals/Farnum is a state-licensed SUD treatment program providing services to individuals from across the state. *Plymouth Area Recovery Connection (PARC)* downtown Plymouth provides recovery mentoring and a drop-in center for those

working toward or in recovery from alcohol and other drug use and dependence. The organization opened to the public this fall.

- *HOPE for NH Recovery* provides recovery support services and drop-in centers in communities across the state. Their Franklin site opens this fall, providing a place where recovery development occurs and individuals are matched with people offering recovery support services.
- *Lakes Region Public Partnership for Health (LRPPH)* has a decade of experience working with partners in health care, schools, business, safety, and other stakeholder to achieve its mission of improving the health and wellbeing of the region through inter-organizational collaboration and community and public health improvement activities.
- *Central NH VNA & Hospice, Franklin VNA & Hospice, Lakes Region Visiting Nurse Association, Newfound Area Nurses Association, and Pemi-Baker Community Health* are not-for-profit community-based health care organizations serving patients of all ages and all circumstances across the region. These organizations are seeing increasing numbers of referrals for infants with neonatal abstinence syndrome. It is thus anticipated that home care organizations may serve as referral sources for those families in their home visit program who may have family members in need of IOP services.

14c. Participating organizations – list of organizations

See tab 14c of the NH DSRIP Plan Supplemental Workbook

14d. Monitoring Plan

The focus of the project will be on expansion of IOP services to include expansion of services during evening hours for those working or caring for children/families during the day and expansion of populations served including those with co-occurring mental illness. Expansion activities will aim to ensure that there is ‘no wrong door’ to IOP services. Whether a person presents in the emergency room at LRGH, Horizons, Genesis, local police stations, EMS providers or recovery centers, the first response will be a call to a recovery coach who will conduct an initial interview with the person and help him/her schedule an assessment by a licensed clinician to determine the level of SUD or COBHD treatment needed.

Expanded IOP features include client services and activities over two phases of treatment. Phase I will generally entail group counseling sessions three hour per day, three days per week over the course of 4 to 6 weeks. Phase I clients will also be required to attend at least five community based, sober peer support group meetings and to meet individually with a counselor once per week to monitor progress. Phase II clients must have a community sponsor and attend one session per week for twelve consecutive

weeks. Phase II clients are also required to attend at least five community based, sober peer support group meetings.

Other key features of the approach that support the overarching goal of greater service integration include:

- The recovery coach conducting the intake will schedule an assessment through Horizons, or if necessary at the LRGH Recovery Clinic, within 24-48 hours.
- An enhanced Addiction Severity Index assessment and DSM structured interview will be conducted by a Master's level licensed clinician to preauthorize medication assisted treatment if appropriate and to determine IOP or other level of care. The assessment findings will also help determine the best care coordination home for the individual.
- The recovery coach will maintain regular communication with the individual through their entry into treatment services, set up initial transportation needs, and transition the person to long-term recovery supports and care coordinator.
- Depending on the individual's needs and preferences, the care coordinator may be one embedded within the LRGH Recovery clinic, the local recovery center in their area, or in an SUD treatment or community mental health agency.
- Primary care needs will be identified and scheduled as well as other needs that can be met within the community, including the family resource center and other outreach, support and education programs.
- Care coordinators and/or recovery coaches can introduce the individual to the recovery community center and peers in recovery, set up a schedule for 12 step or other support meetings in the community, and work on other individual needs such as housing and employment.
- Care coordinators and recovery coaches will work in tandem to support retention in IOP services and meeting the physical, emotional, social and recovery needs of clients in the IOP program.

Implementation progress will be measured using the state's Core and Community Driven Project Outcome metrics as well as project specific process measures to demonstrate changes in capacity, infrastructure, waiting lists, participant numbers and success rates that will build long-range sustainability.

Data systems that are in place currently to support the monitoring plan include the following:

- WITS client record system for clients receiving SUD treatment services paid for by state block grant and general funds
- Medicaid data system
- Electronic health records used by hospitals and primary care clinics

- Existing community mental health data system
- Other data systems of partner organizations

Implementation progress will be measured through the development of a monthly partner reporting plan and the anticipated design and utilization of IDN-wide partner organization reporting tools. Participating organizations will report data associated with training, workforce development, and de-identified client data to track expanded services and monitor project goals. In addition, a client satisfaction tool will be developed to capture self-reported measures and to ensure on-going quality assurance and client satisfaction. The key partners in the project will review client and provider feedback quarterly to make adjustments and improvements to policies and protocols to ensure goals are met, standards are maintained, and patient and provider satisfaction with expanded services.

Process monitoring of the Expansion of Intensive SUD Treatment Options project will entail documenting the presence or occurrence of key features of the model including:

- Referral pathways, standardized assessments, and care coordination protocols
- Patient confidentiality and information release procedures
- Recovery coach pairing, frequency and duration ranges
- Communication protocols to support successful IOP for each client
- Family/friend engagement and communication as appropriate
- Assigning of care coordinators per individual client needs
- Application to Medicaid/Health Insurance program
- Housing and employment supports

The number of individuals anticipated to be served through the Expansion of Intensive SUD Treatment Options project will be finalized over the next few months of additional planning as resource requirements and priorities across each of the strategic pathways for system transformation are further refined. Systems to support tracking patient characteristics and outcomes will be established in conjunction with the CHSN Health Information Technology (HIT) work group and in synchrony with the data collection and reporting requirements of the other strategic pathways. Leveraging these and emerging data systems that may be developed to support the IDN’s Treatment Expansion work, the following measures will reflect project state and local outcomes (State-defined outcome measures are indicated by an asterisk):

Measure	CHSN Plan
Self-report of employment, arrest, relapse, interpersonal relationships, family interaction, community connectedness and other measures of recovery stability	Care Coordinators
Retention in SUD/COBHD treatment for recommended duration	CHSN SUD and BH treatment providers

Measure	CHSN Plan
*Readmission to Hospital for Any Cause	Hospital data system and CHSN partners
*Follow-Up After ED visit for AOD Dependence - within 30 days	Hospital data system and CHSN partners
*Percent of patients screened for AOD abuse in the past 12 months using age appropriate standardized AOD use screening tool AND if positive, a follow-up plan is document on the date of the positive screen age 12+	CHSN partners
*Timely Electronic Transmission of Transition Record (Discharges from an Inpatient Facility in IDN including rehab and SNF to Home/Self Care or Any Other Site of Care)	CHSN partners
*Smoking and tobacco cessation counseling visit for tobacco users (CPT codes 99406-99407)	CHSN partners
*Frequent (4+ per year) ER Visits Users for BH population	Hospital data system
*Potentially Preventable ER Visits for BH Population and Total Population	CHSN HIT work group
*Rate per 1,000 of people without cancer receiving a daily dosage of opioids greater than 120 mg morphine equivalent dose (MED) for 90 consecutive days or longer	Medicaid data system
*Engagement of AOD Dependence Treatment (initiation and 2 visits within 44 days)	CHSN partners
*Initiation of AOD Dependence Treatment (1 visit within 14 days)	CHSN partners

14e. Challenges and proposed solutions

Challenges to project implementation include those associated with the disease of addiction and other behavioral health disorders that interfere with retention in care; unavailability of non-medical detoxification facilities; lack of peer recovery mentors with lived experience to support access and retention in services; currently disconnected systems of care that compromise effective and continuous treatment; insufficient licensed treatment and certified recovery support workforce to meet demand; lack of reimbursement for essential care coordination activities; lack of affordable transportation to access care in a rural area, and lack of systems to support cross-agency data sharing.

Potential solutions to address these challenges include the following:

- *Cross-training of service providers and care coordinators:* Cross-training care coordinators and other staff embedded in primary care, behavioral health and recovery support will expand understanding

about the disease of addiction and co-occurring behavioral health disorders and the triggers and obstacles that often undermine successful treatment. Funding will be used to develop and deliver cross-training and to cover time lost to direct services to participate in trainings.

- *The utilization of recovery coaches with lived experience with addiction and other behavioral health problems:* This component of the approach to supporting successful IOP treatment will increase the likelihood that clients will feel understood, that recovery coaches will be more attuned to their unique needs and barriers, and that clients will be more receptive to the supports and services offered to them resulting in higher rates of retention in and completion of treatment. Funding will be used to cover the cost of recovery support workers as they work toward certification to allow for Medicaid reimbursement and to cover recovery support services not covered by Medicaid.
- *The development of a treatment and recovery support workforce:* Medicaid does not reimburse for services delivered by SUD treatment, BH or recovery support workers who are working toward licensure that requires between 500 (CRSW) to 5,000 (MLADC) supervised hours to meet different credentialing requirements. Funding will be used to cover the cost of services delivered by staff working toward licensure or certification; fees associated with required training, testing and license application; and supervision hours provided by a Master's level clinician. This expanded workforce will be utilized to expand IOP service capacity including expansion of evening hours to accommodate clients with day time work responsibilities.
- *The institution of care coordination at multiple service sites:* Care coordinators are one of the most effective best practices in health and specialty care. The implementation of care coordinators is associated with retention in and compliance with treatment plans and with patient satisfaction with care. Care coordinators are often tapped to help patients access health insurance and to help schedule and make appointments. As care coordination is not a Medicaid-reimbursable service, IDN investments will be made to support care coordination in the LRGH Recovery Clinic to coordinate care for those IOP clients also receiving medication assistance with their SUD treatment; in three recovery community centers in the region; and in the SUD IOP treatment provider agency in the region.
- *Transportation services and ancillary supports:* A lack of affordable transportation is one of the most significant barriers to consistent participation in IOP treatment, which requires 3 days of 3 hour sessions in addition to attendance at recovery support meetings in the community. Funding will be allocated to provide transportation to ancillary supports and services in the community that are not Medicaid covered services. Consideration will be given to having participants "pay back" these costs through service to the recovery community.
- *Short-term non-medical detoxification facility:* Although this is a barrier to entering IOP services, IDN funding does not allow for facility costs necessary to stand up this service component in the region. However, the project leaders have identified this as a challenge they will continue to work

toward addressing by pursuing private funding to develop facilities that meet state licensing requirements.

14f. Implementation Approach and timing

Refer to tab 14f in the NH DSRIP Supplemental Workbook.

E5: Enhanced Care Coordination for High-Need Populations

15a. Project selection rationale and expected outcomes

The Community Health Services Network has selected Enhanced Care Coordination for High Need Populations as our community driven project in the Integration Category. This selection was made to address key identified health needs and gaps, as well as to build on important efforts to improve care coordination and case management in the region that are currently underway. Through these efforts, we intend to address more comprehensively the current challenges experienced by patients, families and providers resulting from fragmented care through multiple health and human service agencies and programs; challenges that contribute to poorer health outcomes and costly patterns of service utilization for individuals with complex behavioral health care needs.

Current needs and gaps to be addressed through this initiative include:

- Patient and family caregiver difficulties with accessing appropriate and timely care and support, as well as experiences with limited collaboration and information sharing between physical health care, behavioral health care, and community services and supports;
- Related provider experiences of having limited information and communication beyond their own organizations, and in some cases duplication of efforts for complex, high need patients leading to frustration, dissatisfaction and burnout;
- Limited staff capacity and high turnover of case management staff among partner agencies contributing to time constraints on participation in inter-agency care coordination and case management activities outside of each agencies' scope of services;
- Inconsistent linkages between hospital emergency and inpatient care, primary care, behavioral health care, and home and community-based care leading to increased likelihood of insufficient transitions of care, unstable social circumstances, and unintended care patterns such as frequent emergency department utilization and unplanned hospital readmissions.

Current efforts that this work will seek to leverage include:

- An inter-agency, multi-disciplinary wraparound team that has been co-facilitated by LRGHealthcare and PPH over the past year. The team's focus is improving case management and coordination of services for specific patients identified as high utilizers of the Emergency Department. The team's work has not specifically focused on Medicaid patients with behavioral health conditions; although many patients served have those characteristics. This existing wraparound team will serve as an important foundation for expanding care coordination and case management team structure and processes to other parts of the IDN region.
- The Plymouth Area Transitions Team (PATT) serving the Greater Plymouth area is currently being rejuvenated. The PATT was most active several years ago with support from a federal Rural Health Outreach grant with activities focused on preventing unplanned readmissions for patients with chronic diseases such as congestive heart failure, diabetes and cardiovascular disease. The PATT has recently been formed anew and will seek to expand participation beyond

hospital, primary care, and home health care providers to include representatives from emergency medical services, law enforcement and others addressing broader social determinants of health. The PATT will also seek to connect with and build on shared tools and strategies with the Laconia area team.

- A gap that has been identified through this planning process exists in the greater Franklin area. While LRGHealthcare does sponsor similar work centered on Franklin Regional Hospital, a robust team with broad, multi-agency participation does not currently exist in this part of the IDN region. Work through this initiative will seek to build greater capacity for enhanced care coordination in the Franklin / Northern Merrimack County area. A team of this type existed in the Franklin area from 2005 until 2011 until funding cuts led to reductions in outreach and care coordination staff at the key agencies involved in this work.
- An Access to Care Committee has been formed in the Greater Laconia area composed of senior staff from multiple agencies working to examine and address improvement in access at the policy, system and resource level. This committee does not engage in direct care coordination of patient services. However, CHSN sees an important supportive and long term sustainability connection for this group to the Enhanced Care Coordination project. We will seek to expand participation on this committee across the whole IDN region and this group can serve a role in helping to monitor project successes, support needs and challenges.
- Another initiative that can serve as a building block for this work is the state-sponsored No Wrong Door pilot project for assisting people with eligibility and linkage to Long Term Services and Supports. Tools, procedures and cross-training activities around eligibility assistance and information sharing on available community resources developed through No Wrong Door will be integrated into this IDN community project.

The conceptual framework for this work will seek to incorporate elements of Care Management – whole person focused activities intended to ensure that individuals at high risk get the care and services they need – and Care Coordination – system focused activities intended to ensure that care is seamless and consistent across providers and transitions of care. As such, we will seek a balance between assigning care coordinators to work with individual providers and assigning clients to work with case management teams regardless of their primary provider. The anticipated outcomes of this work are improvements in all domains of the Quadruple Aim: enhanced patient experience, improved population health, reduced costs, and enhanced provider experiences.¹¹

Key elements of the implementation approach include, but are not limited to the following with specific details to be worked out over the next few months of additional planning:

- A single project coordinator will be hired to provide logistical support to the sub-regional care coordination teams, including facilitating training activities, building relationships and awareness of community resources, identifying best practices and monitoring implementation progress;

¹¹ Bodenheimer and Sinsky, op cit. note 9

- Additional case management staff will be hired through key organizations including federally qualified health centers and behavioral health provider organizations (links to Workforce Development)
- Community care coordinators will be equipped to move in the spaces between agencies to assure continuity for shared clients;
- Inclusion of peer and recovery support workers as part of the care coordination team to help with patient activation, coaching and advocacy to better connect the different parts of the system;
- Development of common job and team descriptions with cross-training such that care coordinators can support each other's work, thereby helping to address limited capacity of each agency to assure patients can get the same support and hear the same messages wherever and whenever they 'touch' the system;
- Implementation of common tools and procedures for risk identification, standardized screening and assessment, patient and family engagement, development and follow up of care plans, transitional care procedures, promotion of self-management skills, and monitoring patient and provider satisfaction and outcomes.
- Development of new inter-agency policies, agreements and forms for data sharing and patient consent for information release;
- Development of common terminology, formats and capacity for shared care plans, with patient consent and proper safeguards for protected information (links to practice-based Integration efforts);
- Improved data sharing and data analytics to support risk identification, trigger events and performance monitoring (links to HIT Development);
- Coordinated patient assignments, peer review and mutual accountability.

15b. Participating organizations

Participating organizations in this initiative are a broad and inclusive set of organizations from across the region representing a full range of physical health care, behavioral health care, social services, and community support organizations. As described above, we envision three geographically-based care coordination / case management teams that are multi-agency and multi-disciplinary in nature. This set of organizations includes not only those that have intensive contact with high-need patients for clinical services, but also organizations that can help to address broader social determinants of health. The nature of the Enhanced Care Coordination project thus requires participation of a broad collaborative of organizations.

The lead coordinating entities for the enhanced care coordination work initially will be the three hospitals in the region – Lakes Region General Hospital, Franklin Regional Hospital (each part of LRGHealthcare) and Spearre Memorial Hospital - because each is in the best position to identify patients

who are high utilizers of emergency departments or at risk for poor transitions to community based care. Patients meeting these criteria with serious behavioral health conditions will be the first tier priority for enhanced care coordination intervention, although all participating agencies may refer cases with complex needs to the regional care coordination teams.

While the hospitals will be the coordinating entities for team logistics, the care coordination teams will follow a collaborative leadership model. We will also work to assure the linkage of enhanced care coordination to the other strategic pathways of our transformation work, particularly the community re-entry and SUD expansion project areas. Other organizations that will be encouraged to participate in care management activities, as appropriate to each case and with patient consent, include but are not limited to the following:

Organizational Type	Agency
Federally Qualified Health Centers	Health First Family Care Center Mid-State Health Center
Other Primary Care and Specialty Practices	LRGHealthcare Speare Memorial Hospital
Behavioral Health Care Providers	Genesis Behavioral Health Horizons Counseling Center Riverbend Community Mental Health
Home Health Care Providers	Central NH VNA & Hospice Franklin VNA & Hospice Lakes Region Visiting Nurse Association Newfound Area Nursing Association Pemi-Baker Community Health
Social Service Organizations including transportation, housing, nutrition assistance, developmental disability supports, family resources, refugee assistance, eligibility assistance and navigation, and case management	Community Action Program Belknap-Merrimack Counties Lakes Region Community Services, Partnership for Public Health Ascentria Care Alliance Granite State Independent Living Community Bridges
Peer Support / Recovery Support	Navigating Recovery of the Lakes Region National Alliance on Mental Illness-NH Cornerbridge Hope for NH Recovery Plymouth Area Recovery Connection

County-based corrections and long term care	Belknap County Grafton County Merrimack County
EMS providers and Public Safety departments	Multiple municipalities
Other Organizations	To be determined

15c. Participating Organizations: List of Organizations

See tab 15c of the NH DSRIP Plan Supplemental Workbook

15d. Monitoring Plan

Our model for developing Enhanced Care Coordination for high need populations will require development of new inter-organizational strategies and structures, processes and technology to support the work. Consequently, our monitoring plan will encompass assessment of implementation progress in each of these areas. In addition, the monitoring plan will include periodic review of outcome measures for this project as defined in the CMS approval protocols.

The project coordinator will have day to day responsibility for implementation of the monitoring plan with review and feedback accomplished by the care coordination teams, the existing Access to Care Committee, and ultimate oversight resting with CHSN Board.

Specific elements to be included in the monitoring plan include the following:

- 1) Documentation of Strategy and Structure Improvements
 - Progress on staff recruitment, training and development including care coordinators and staff resources for peer support and recovery coaching
 - Progress on development of policies and procedures for care coordination team operations including interagency referral and patient consent procedures for patients with behavioral health care needs
 - Documentation of workflows, referral and communication pathways including connections with providers of non-clinical community services and supports
- 2) Documentation of Process Improvements and Outputs
 - Implementation of new workflows, referral and communication relationships
 - Use of standardized assessment tools and shared care plans
 - Implementation of procedures for peer review and feedback
 - Implementation of procedures for staff performance management and evaluation

- Implementation of procedures for patient and caregiver engagement
- Implementation of procedures for ongoing documentation and reporting of gaps in the system of care; ongoing documentation and reporting of gaps and other system level challenges encountered through this work will be important for informing overall IDN improvement plans and strategies throughout the demonstration project and beyond.
- Outputs of the enhanced care coordination activities that may be monitored include:
 - Number of referrals, enrollments, refusals, and discharges from the enhanced care coordination project
 - Time interval from first referral and care coordination team contact
 - Number of care coordination team contacts
 - Follow-up after an emergency department visit
 - Follow-up after hospitalization

3) Development of Improved Technology and Analytics

- Progress on development of criteria and methods for population health data-based risk identification and referral, with periodic review and refinement for optimal utility
- Progress on identification or development of a shared care plan platform, format and technology for inter-organizational health information exchange
- Development of data-based performance measures and performance reporting procedures
- Development of methods for aggregating network-wide information on patient outcomes and program impact

4) Documentation and Reporting of Project Outcomes

As described at the beginning of this section, intended outcomes of this project area include:

- Improved access to timely and appropriate services and supports for high need Medicaid patients with behavioral health conditions;
- Improved patient engagement, treatment adherence and self-management skills;
- Expanded access for providers to information about patients' / clients' care across the continuum, with proper consent
- Assistance for providers in managing some of their most complex, high need, and high cost patients.

Consequently, our plan for monitoring this project will include methods for ascertaining outcomes in these areas in addition to monitoring the specific outcome metrics specified in the CMS approval

protocols. Methods will include formal tools for assessing patient and provider satisfaction with the enhanced care coordination services, as well as procedures for documenting qualitative information and sharing anecdotal evidence of program successes to inform stakeholders and promote sustainability as warranted.

Methods for periodic (e.g. quarterly) analysis and reporting will be developed for the following Outcome Metrics as defined in the CMS Approval Protocols:

- Readmission to Hospital for Any Cause (Excluding Maternity, Cancer, Rehab) at 30 days for Adult 18+ BH Population
- Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence - within 30 days
- Follow-Up After Emergency Department Visit for Mental Illness - within 30 days
- Follow-up after hospitalization for Mental Illness – within 30 days
- Follow-up after hospitalization for Mental Illness – within 7 days
- Percent of patients screened for alcohol or drug abuse in the past 12 months using an age appropriate standardized alcohol and drug use screening tool AND if positive, a follow-up plan is documented on the date of the positive screen age 12+
- Timely Electronic Transmission of Transition Record (Discharges From an Inpatient Facility in IDN (including rehab and SNF) to Home/Self Care or Any Other Site of Care)
- Comprehensive and consistent use of standardized core assessment framework including screening for substance use and depression for age 12+ by IDN providers
- Global score for selected general HEDIS physical health measures, adapted for BH population
- Global score for selected BH-focused HEDIS measures
- Smoking and tobacco cessation counseling visit for tobacco users (CPT codes 99406-99407)
- Frequent (4+ per year) ER Visits Users for BH Population
- Potentially Preventable ER Visits for BH Population and Total Population
- Rate per 1,000 of people without cancer receiving a daily dosage of opioids greater than 120 mg morphine equivalent dose (MED) for 90 consecutive days or longer.
- Engagement of Alcohol and Other Drug Dependence Treatment (Initiation and 2 visits within 44 days)
- Initiation of Alcohol and Other Drug Dependence Treatment (1 visit within 14 days)
- Percent of new patient call or referral from other provider for CMHC intake appointment (90801 HO) within 7 calendar days
- Percent of new patients where intake to first follow-up visit was within 7 days after intake
- Percent of new patients where intake to first psychiatrist visit was within 30 days after intake

15e. Challenges and Proposed Solutions

The network recognizes that this initiative to modify patterns of practice and utilization for populations with complex needs through enhanced care coordination is itself a long and complex process. We can anticipate a variety of challenges in the areas of technology and data challenges, intra- and inter-organizational development challenges, development and adoption of common tools and procedures, patient and family engagement, and long term sustainability.

Technology and data challenges include development of capacity for shared care plans and health information exchanges, as well as increased capacity across the region for population-based health analytics. Other IDNs will have similar challenges and participation in the state-wide HIT and Integration workgroups will be a key strategy for addressing challenges in this area. In the interim, the Region 5 IDN partners will work toward increased capabilities for electronic sharing of continuity of care documents from agency EHRs to form the basis of shared care coordination plans. The IDN will also work through each hospital to develop common procedures for generating real time information on frequent ED utilizers and other patients with high needs and risks for poor care transitions.

A challenge for development and adoption of common tools and procedures is that different organizational types have different funder / payer requirements for patient assessment (e.g. CANS / ANSA for Community Mental Health Centers, OASIS for home health providers, variable use of SBIRT, ASI or ASAM criteria for determination of appropriate substance use treatment). An important area of work for the care coordination teams will be to develop a core set of measures from the various assessment tools that can be extracted / reconciled to inform the development of a shared care plan for each individual patient.

A related inter-organizational challenge will be development of common role definitions, work procedures and caseload expectations to optimize the work of the care coordination teams. Ongoing training will be an essential strategy for assuring common understanding of the different services, resources and capacities of participating agencies, including cross-training activities such that care coordinators are familiar with the areas of expertise and duties of staff from different settings. This cross-training will facilitate capability for mutual assistance and support offered across the team as part of the process of care coordination. Training activities may focus on such topics as community health needs and resources, team-based work, health advocacy, and motivational interviewing.

A key strategy we will apply to help address patient and caregiver engagement challenges will be the deployment of peer and recovery support workers as part of the enhance care coordination teams. This component of the approach to supporting improved care coordination will increase the likelihood that clients will feel understood, that those working with clients will be more attuned to their unique needs and barriers, and that clients will be more receptive to the supports and services offered to them resulting in higher treatment adherence and productive utilization of other supports and services.

A different, but related challenge in this area is assuring proper consent procedures for inter-agency information sharing. Several partner agencies already have some inter-agency referral agreements, as well as capabilities for electronic viewing or exchange of health records. Early in the project planning and development phase, the IDN will engage legal services for review and refinement of existing

interagency referral agreements and patient consent procedures to assure compliance with state and federal regulations on confidentiality and protected health information. In addition, care coordination teams will work to develop messages and materials for patient engagement that effectively explain the purpose and what patients should expect from participation in enhanced care coordination services.

One particular type of inter-organizational challenge that should be mentioned is the need to develop effective working relationships with Medicaid Managed Care Organizations (MCO). These relationships will be important to this area of work in two primary ways. First, the MCOs can assist the work by providing more real time information on patients exhibiting high needs based on claims history. Second, the MCOs also maintain capacity for some manner of case management services. It will be important to coordinate those services with the IDN efforts to avoid duplication of effort or, more importantly, working at cross purposes by providing clients' mixed messages or contradictory information.

Overcoming sustainability challenges can be addressed through a variety of strategies including:

- Assuring broad-based partnerships and representation, which are essential to the vision of enhanced care coordination across a continuum of health and community services;
- Assuring quality and effectiveness through peer review, transparency and mutual accountability;
- Regular information sharing and communication of project successes;
- Adhering to a collaborative leadership model for care coordination teams to facilitate learning and adaptability.

Many of these challenges intersect with challenges across all of the strategic pathways for IDN development and system transformation. It is thus important to note that efforts to develop improved HIT/HIE capabilities, workforce capacity, and practice-based integration should provide foundational support to the enhanced care coordination work.

15f. Implementation Approach and timing

Please refer to tab 15f in the NH DSRIP Supplemental Workbook.