



## Region 6 IDN Project Plan

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to address workforce capacity

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## Region 6 IDN Project Plan

### Section I: IDN Level Plan

**Q1. Vision Statement** The Region 6 IDN envisions a system of care in the Strafford County and Seacoast areas that enables people to achieve their greatest potential and quality of life, and adopt meaningful community roles. To realize this vision, we must reconcile the gaps and remove the barriers in our region's behavioral, physical and social health services to improve outcomes by creating an integrated healthcare delivery system that considers the whole person and supports self-determination. Our long-term objective is to develop models of service delivery that reward improved outcomes and valued by consumers and providers alike. To achieve our aim of systems transformation we will adopt a framework that supports data informed decision-making and considers the social determinants of individual, community and population health. Increased efficiency in our transformed care delivery system will allow us to redirect/reinvest resources into the clinical and non-clinical services and partnerships that have the most impact.

Our efforts will include the following actions:

- Continuously assess the gaps, barriers and opportunities in behavioral, physical and social health systems based upon provider and consumer input
- Establish a sustainable integrated delivery system that moves from volume based to value based care with appropriate payment system adaptation
- Create an evidence informed integrated system that is accessible and acceptable to consumers/patients
- Develop transparent data collection and reporting mechanisms that ensure valid and reliable information is available to inform collaboration and shared responsibility
- Advocate for the adequacy and alignment of resources, programs and policy including those social services not traditionally included in health system design such as transportation and safe, affordable housing

We are guided by these principles:

- We recognize that to transform the system we must all be willing to change
- All Region 6 IDN residents, regardless of community, socioeconomic, family or health status should have the opportunity to achieve their full potential
- We approach our colleagues and the people we serve with dignity, compassion, integrity, and cultural sensitivity
- We work to provide the highest quality care that is comprehensive, person-centered and responsive to the changing needs and priorities of the person.
- We collaborate with community members to promote and advocate for policies, values and norms that are supportive of behavioral health and wellness
- We are responsible to our members, our partners and the public to improve care delivery, partner effectively and use resources wisely
- We encourage new ideas and creativity at every level of the organization
- We partner openly and honestly with other providers to eliminate administrative, financial and clinical barriers to integrated care

- We are transparent in sharing information with stakeholders and the general community
- We cooperate to foster a culture that will bring trust and change that will benefit the individuals we serve
- We hold all providers accountable to remove barriers and improve services and systems that result in improving individual's total wellness outcomes
- We see the consumer as a whole person deserving of the highest quality consumer driven care in the least restrictive environment

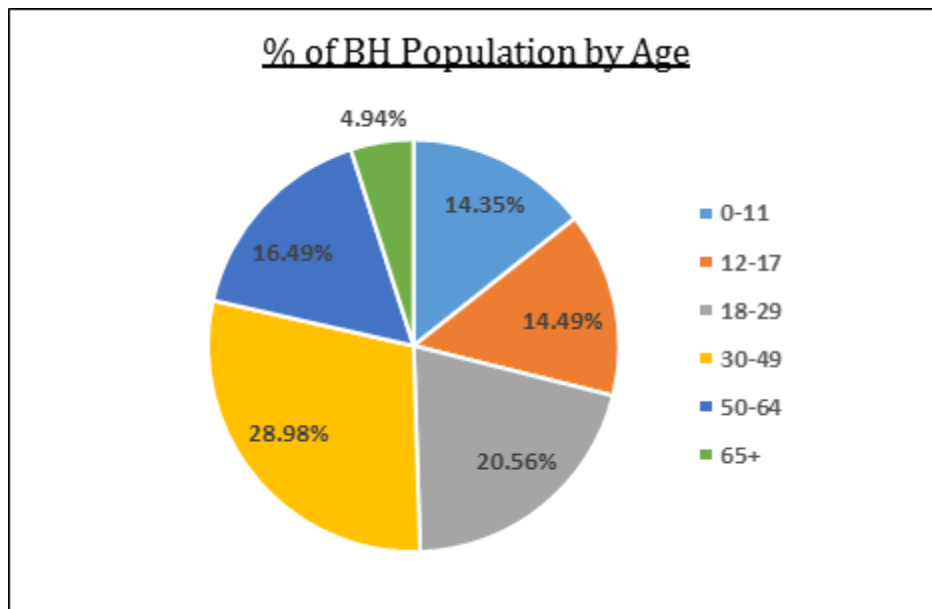
## Q2. IDN Service Area Community Needs Assessment

### 2a. Analysis of IDN Service Region Prevalence Rates

IDN Region 6 is home to 33,311 residents who received Medicaid benefits in 2015. Over one-third of those, or 11,414 people, were reported to have at least one behavioral health related claim for services submitted to the state of NH for reimbursement under their Medicaid benefit in 2015. The state did not receive any behavioral health related claims for the remaining beneficiaries.

Of those 11,414 members who received behavioral health care in 2015, more than 1 out of every 4 was between 30 and 49 years old, an important age range for prime employment. See Figure 1 for the complete distribution of members with behavioral health conditions by age.

Figure 1.



- 2,829 members sought services from a Community Mental Health Center in 2015. 94.7% of those, or 2,678, received care from CMHCs within the Region 6 IDN. On average, members received 33.4 visits per member from the CMHCs within the Region 6 IDN and 32.5 visits per member from those CMHCs outside of Region 6.
- 11,720 members sought preventative care in 2015. Unfortunately, that accounts for only 35% of the region's attributed members. Almost 2/3 of beneficiaries in Region 6 failed to receive any preventative care in 2015.
- 6,173 members attributed to Region 6 sought primary care services from a federally qualified health center, rural health center or hospital based rural health center in 2015. 95% of those members were seen at one of the three Federally Qualified Health Centers

located in Region 6. Claims data from the state of NH suggests that 37% of those members experienced at least one preventative care related visit, slightly higher than the preventative care seeking among the entire IDN population in Region 6. Of note, almost half of those seeking primary care from a federally qualified health center (46%) were identified as having a behavioral health condition, a concentration well above that in the general population where only 36% of beneficiaries with behavioral health conditions (34%) in Region 6.

- 452 Region 6 IDN members received Substance Use Disorder treatment from 24 providers in 2015. Members received a range of 1 to 70 SUD treatment visits, with the average number of visits per member being 10.7. Given the initiatives rolled out since December 2015 including reauthorization of Medicaid expansion, establishment of an SUD benefit for traditional Medicaid beneficiaries, and a number of additional grants and awards to develop SUD treatment and recovery supports, additional clarity regarding SUD service utilization is expected when NH DHHS provides updated data books with 2016 claims data.
- 500 members received Methadone treatment for a substance use disorder from 6 different providers in 3 different agencies in 2015. Participating providers claimed a range of visits per member from 51 to 222 with an average of 212 methadone treatment visits per member across all regional providers. Taken daily, this suggests the average member received 7 months of Methadone treatment.
- 821 members received prescriptions for Medication Assisted Treatment from 128 providers in 2015. On average, members received 7.9 scripts. In all, members received between 1 and 18.75 scripts per member.

This utilization data is consistent with trends and observations identified by a Region 6 Community Assessment working group during a meta-analysis of 24 documents, plans and reports that addressed behavioral health asset and gap assessments, socioeconomic, social determinant, health behavior, risk behavior, and workforce capacity issues at the local, regional, and state level over the last 5 years. See the Supplemental Workbook, Tab CA Meta-Analysis for a list of the documents reviewed. From three hospital Community Benefit Assessments to two Continuum of Care regional planning efforts to four municipal Community Development Block Grant reports, three consistent trends were identified that informed the project planning process for Region 6.

The most frequently identified observation in this meta-analysis was related to strain on the current system and especially on the behavioral health system, across the entire region. While the overall patient-to-Mental Health provider ratio in NH is 387:1, the Strafford and Seacoast regions report similar patient-to-provider ratios of 481:1 and 479:1, respectively, an almost 25% increase above the state norm. Of note, the regions report a large difference between them with respect to patient to primary care provider ratios. The Seacoast region reports a ratio of 1197:1, well below the Strafford ratio of 1400:1. Both are above the state average of 1064:1 but the Seacoast ratio is only 7% higher while the Strafford ratio is almost 35% higher, suggesting a potential disparity in availability of primary care providers that will need to be further explored.

Since only 34% of the Region 6 IDN eligible Medicaid beneficiaries received a preventative care visit in 2015, this disparity could increasingly impact access to care. This is of critical concern in Region 6 IDN because beneficiaries with a behavioral health condition are even less likely to receive preventative care than those without a behavioral health condition. Of the 11,414 Region 6 IDN beneficiaries with a behavioral health condition, 40% of youth under age 12, 49% of adolescents between 12 and 17, and 78% of adults aged 18-64 did not receive any preventative care in 2015.

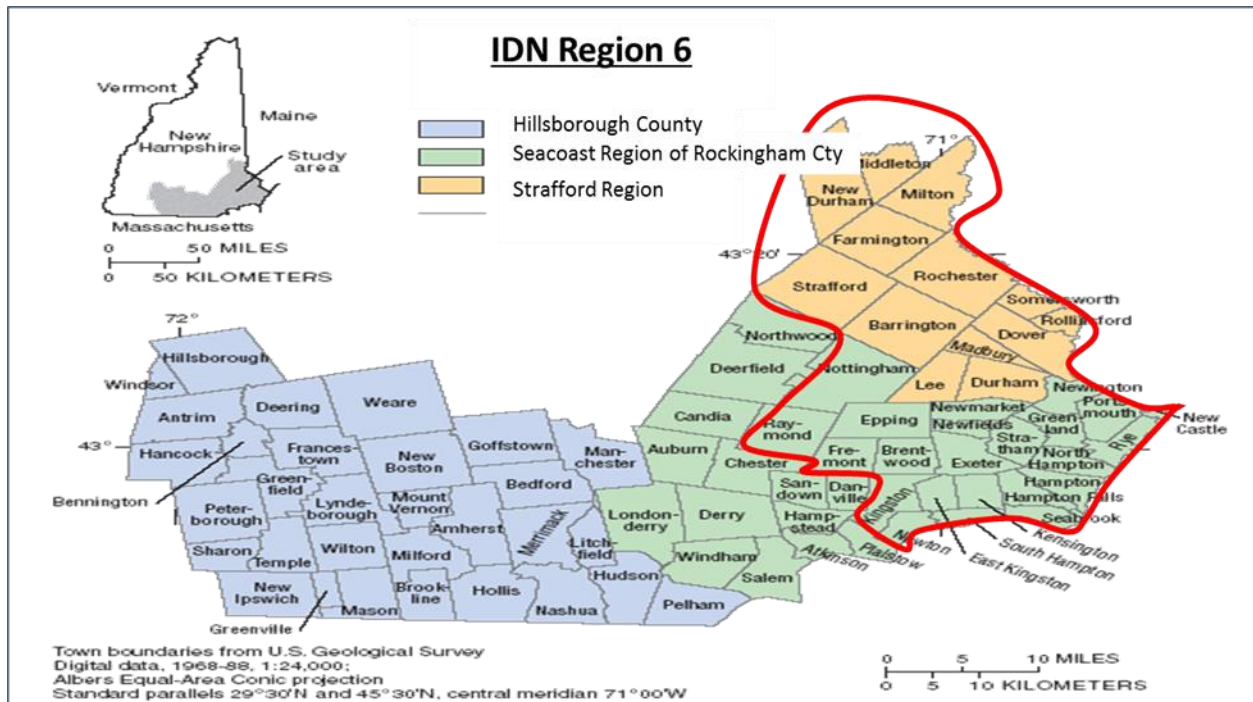
A second trend, challenges inherent in serving complex populations, was frequently and significantly referenced across multiple documents. Whether the complexity was related to social determinant vulnerability, socio-economic status, disease comorbidity, or combinations thereof, the intricacies of communicating and collaboration around care for complex populations were identified as a critical barrier to improved outcomes. The entirety of Region 6's attributed 33,311 population could be considered complex because their very Medicaid eligibility suggests that they are more likely to be economically vulnerable compared to the general population. Almost 1 out of every 3 Medicaid beneficiaries (32%) in Region 6 are even more complex, however, because they received care for both a behavioral health condition and a physical condition. In an environment where both the behavioral health and primary care systems are experiencing strain, that complexity carries additional risk to continuity of care and higher costs.

A third trend assessed to have direct impact on Region 6 IDN project planning was repeated mention of the difficulty people have figuring out how to access the appropriate level of care for behavioral health issues for themselves or a loved one. While most of the population knows a primary care provider is a good resource to assess physical or medical complaints, many have much less knowledge or confidence about where to seek help for a general or specific mental health or substance use concern. While Region 6 Medicaid beneficiaries with a behavioral health condition used the Emergency Department about as often as beneficiaries without a behavioral health condition, they were more than twice as likely to use the Emergency Department for care related to a condition that was potentially treatable in primary care, an expensive and inefficient.

## 2b. Regional Demographics

Home to 268,800 people, (21% of the entire State) the Region 6 IDN is a compact geographic area anchoring the state's southeastern coastline that demonstrates a dual identity with respect to wellness. The northern tier of Region 6 includes the 3 towns and 10 cities of Strafford County, also the Strafford Public Health Region. In the southern tier, the Seacoast Public Health Region serves 1 city and 22 towns in eastern Rockingham County and is home to 50% of Rockingham County residents. Although the Seacoast Public Health region only represents about 50% of the Rockingham County population, the populations are very comparable so a vast majority of population health data for Rockingham County can serve as an accurate proxy for the Seacoast Public Health region, which has limited discrete population health data. Region 6 is bordered to the east by Maine and to the south by Massachusetts, as Figure 1 below illustrates.

Figure 1.



Although most of Region 6 is within a two-hour drive to the NH White Mountains, the central Lakes Region and Boston, Massachusetts, the condensed geography belies two very diverse subsections of the region. A recent report on regional health status found that Rockingham County ranked first among the 10 NH counties in health outcomes, or how long people live and how healthy people feel while alive, and in health factors, including health behaviors, clinical care, social and economic variables, and physical environment factors. Strafford County ranked 8th out of 10. ([RWJF County Health Rankings 2016](#)). Bordered by Maine and the Atlantic Ocean to the east and Massachusetts to the south, there are many challenges that both sub-regions share despite their many differences. Those differences can be observed in Figure 2.



Figure 2. Region 6 IDN General Demographics by Sub-Region

	<b>Strafford PHN</b>	<b>Seacoast PHN</b>	
Population	124,000	142,000	
Median Household Income	\$58,577	\$66,469	
Per Capita Income	\$29,757	\$39,605	5 yr avg 2010-2015
Children eligible for free lunch	26%	12%	
Children in poverty	14%	8%	NH = 13%
Individuals below poverty	11.2%	5.7%	
Unemployment rate	4.0%	4.7%	* 2014 (NH = 4.3)
Median Age m/f	35.9/38.2	42.2/44	
Medicaid enrollment	19031	14280	
% rural population	32.4	24.9	NH = 39.7
HS Graduation Rate	86%	91%	88%
% of single parent households	29%	21%	NH = 28%
Severe Housing Problems	18%	16%	NH = 16%
Uninsured Adults	16%	13%	NH = 16%
Uninsured Children	4%	4%	NH = 4%
Frequent Mental Distress	10%	9%	NH = 11%
Frequent Physical Distress	10%	9%	NH = 9%
Mentally Unhealthy Days	3.6	3.4	NH = 3.6
Social Associations	8.4	8.9	NH = 10.3
Adult Obesity	30%	26%	NH = 27%
Food Environment Index	8.1	8.6	NH = 8.4
Excessive Drinking	22%	20%	NH = 19%
Patient/Primary Care provider ratio	1400:1	1197:1	NH = 1064:1
Patient/Mental Health provider ratio	481:1	479:1	387:1
Preventable Hospitalization Rate	56	52	46
Avg Annual Health Care Costs	\$8,060	\$8,805	\$8,284

Figure 2 illustrates several key variances between the Strafford and Seacoast sub-regions in Region 6. Strafford has a smaller geography, smaller population, is less well-off, and has fewer mental health and primary care providers per resident. Fifteen percent of the Strafford population are Medicaid beneficiaries while Seacoast has 10%. In the Seacoast region, the general population is more financially well-off, fewer children are in poverty, fewer people went hungry or lived far away from a grocery store (Food Environment Index), and the obesity rate is lower than the state average.

Findings from a 2014 assessment of NH's substance use disorder service system identified 74 licensed mental health professionals in the Seacoast region and 45 in the Strafford region. Despite the convenience sampling model for this survey based assessment, sub-regional capacity differences are reflective of extensive anecdotal experience and support the limited quantitative data presented in Figure 2. ([Substance Use Disorder Treatment and Other Service Capacity in New Hampshire \(2014\), NH Center for Excellence](#))

These sub-regional variances reinforce the importance of a strong community and provider engagement strategy to ensure that IDN programming is responsive to the pervasive macro and micro nuances within Region 6 as the Project Plans are detailed. In addition to the population level differences between regions, there are also notable variations in service provider capacity both within the sub regions and between them. While MAT providers in the Strafford region have been scarce, the development of peer SUD recovery services has outpaced that in the Seacoast, where more MAT providing organizations exist.

Finally, the powerful negative impact of insecure housing status on behavioral health was an indisputable trend identified across the majority of the reviewed documents

## 2c. Current Resources available

Behavioral health resources do exist across the continuum of care in Region 6. As a blended region with partners serving residents across two counties within two public health regions, Region 6 is fortunate to have two Community Mental Health Centers, three Federally Qualified Community Health Centers, four hospitals, 2 County based Drug Court programs, 2 of the state's 10 District Mental Health Courts, and 20 school administrative units within our borders. These partners provide, alone or in partnership, a number of behavioral health programs and resources. In general, trends in behavioral health resources in Region 6 reflect the previously discussed sub-regional diversity. While the Strafford region has developed a more mature network of substance use recovery supports and very successful drug court and community corrections diversion programming, the Seacoast region has a more robust network of school-based substance misuse prevention programming and more capacity for partial outpatient hospitalization for mental health care. We recognize that these differences are valuable opportunities to develop sub-regional strengths across the entire region in creative ways that will move our transformation efforts forward.

2c.i In addition to those mentioned above mental health and SUD oriented resources in Region 6 include

- Safe Harbor Peer Recovery Center (Portsmouth)
- SOS Recovery Community Centers (Durham and Rochester)
- Seacoast Mental Health Center Military Liaison Initiative
- MAT programs at 2 FQHCs
  - Families First Health and Support Center
  - Goodwin Community Health Center
- Behavioral Health programs integrated with Primary Care at FQHCs
  - Families First Health and Support Center
  - Goodwin Community Health Center
  - Lamprey Health Care (2 sites)
- Portsmouth Hospital Intensive Outpatient Program
- Community Based care teams
- Community Partners & Seacoast Mental Health Center (CMHCs)
  - Crisis Intervention/Response/Support
  - School Based services
  - In Home/Early Intervention supports for mental health & developmental services
  - Military Liaison
- Seacoast Pathways Club House for peer mental health support
- Private mental health & SUD care providers
  - Addiction Recovery Services
  - Merrimack River Services
  - Pinewood Healthcare Inc./Pain Care/ ROAD to Recovery
  - Great Bay Mental Health Associates
- Strafford & Seacoast Public Health Networks – provide resources, training,

regional coordination and network development support for substance misuse prevention and the SUD continuum of care, public health emergency preparedness, and community health improvement priorities.

- PHN coordinated Community Based Narcan distribution (including associated community forums, conversations, and educational events)

Cross-regional or statewide direct service and policy related resources identified as important partners in Region 6 include

- 211 Info-Link community resource phone line
- NH Addiction Crisis Line
- NAMI – NH
- Granite Independent Living
- United Way for the Greater Seacoast

Several policy changes in the last 18 months have created new resources for Region 6 that did not previously exist. These include legislative re-authorization of NH's Medicaid expansion program, allowing continued provision of health care coverage including an SUD benefit to over 50,000 people including almost 9,000 Region 6 beneficiaries. This reauthorization encouraged many behavioral health (both mental health and SUD) providers to consider expanding their capacity to deliver services because there was now more stability in the reimbursement arena. Unfortunately, workforce related challenges across the entire state have further slowed the impact this delayed confidence has had on actual increases in service delivery capacity. In addition, provisions for an SUD benefit for the traditional (non-expanded) Medicaid population were made by legislative authority to begin in July of 2016, providing reimbursement for SUD related care for slightly more than 8,000 additional very low-income adults in Region 6 for the first time.

A variety of resources that are currently in deployment were recognized through the Region 6 IDN Community Assessment process. Resources identified as in deployment include both initiatives that expand capacity, scope, or reach of existing resources across the region and those that create a novel resource that did not previously exist. These include

- The addition of MAT providers to current MAT programs in FQHCs and private agencies.
- Safe Stations – expansion of first responder/law enforcement partnership with recovery service providers to provide a community location for immediate/crisis referral SUD support can be found
- Hope on Haven Hill – development of new prenatal & parenting treatment and recovery program
- Granite Pathways – new Regional Access Points (RAPs) for assessment of treatment needs and referral to appropriate resources
- Peer Based Recovery supports - Recovery Coaching, Peer-to-Peer Support services, Job search assistance, Telephone Recovery support, Community led groups/activities which focus on Education, Employment, Health and Wellness, Life

Skills, Coping/Symptom Management, and “Sober” Social activities, 24/7  
Community Access to Recovery Program

- Rochester Community Recovery Center
- SOS Recovery Community Organization & Center

The region has seen expansion in the number and variety of planned resources in development since Medicaid expansion was reauthorized and traditional Medicaid beneficiaries received an SUD benefit. These include

- Sober Living facilities
- Expanded prescribing for Nurse Practitioners and Physician Assistants

The Community Assessment process in Region 6 has identified many potential resources that IDN staff and partners will engage to inform further planning and execution of the Project Plans. These potential partners either don't currently deliver services to a significant portion of beneficiaries, don't self-identify as behavioral health or primary care providers, or have not historically been closely tied to primary or behavioral health care transitions in Region 6. These resources include 11 (5 hospital affiliated and 6 private) Urgent Care/Walk-In centers across the region, the NH Department of Health and Human Services Division of Children, Youth and Families, New Hampshire Hospital, regional school districts with student assistance services, pharmacies and district court programs. As the project plans develop Region 6 will continue to survey the resources to bring new and relevant partners into the network.

2c.ii The Region 6 IDN recognizes the importance of developing a system of care that is considerate of and responsive to the social determinants of mental health as identified by the World Health Organization (1:2 1. [Compton, M.T. & Shim, R.S., \(2015\). The Social Determinants of Mental Health. \*Psychiatry & Society: Global Mental Health\*. 13\(4\). pp.419-425.](#) 2: [World Health Organization and Calouste Gulbenkian Foundation](#)) Social determinants of mental health. Geneva, World Health Organization, 2014) Community based social service agencies are critically important partners in efforts to improve early and equitable access to behavioral health care in the Region 6 IDN. Both the Strafford County and Rockingham County Community Action Partnerships have been engaged in the community assessment and project planning process. They provide many of the nutrition, childcare, literacy, energy, personal finance, housing and crisis supports and services our most vulnerable residents need to improve their social, physical and economic environments.

Although the community based social service partners above provide critical services and supports for many of the social determinants, the Region 6 community assessment confirmed that engagement with one specific sector, housing, was essential to the successful development of all 6 project plans. All four of the housing authorities in Region 6 have been represented in both community engagement events and All-Partner meetings. Crossroads House, the largest regional homeless shelter in the Region 6 IDN area, has been a strong and vocal advocate for inclusion of housing support in IDN planning. Planners and advocates from the regional Greater Seacoast Coalition to End Homelessness have been invited to project planning efforts as subject matter experts.

The community assessment process reinforced the importance of including resources from a few specific additional community sectors in IDN planning. These include transportation, public safety, and government.

The transportation sector is engaged with the IDN's work through the Alliance for Community Transportation, a collaborative strategic planning consortium of public and private transportation vendors that serve the entire IDN region including the COAST bus company and Strafford and Rockingham County Planning Commissions. Public safety partners are important allies in efforts to reduce the stigmas around behavioral health needs.

First responders and law enforcement across Region 6 have demonstrated a commitment to learning more about behavioral health issues and to developing new partnerships with behavioral health providers. The IDN will continue to encourage this sector to be engaged with the entire DSRIP initiative through municipal partnerships and in collaboration with both the Strafford and Seacoast Public Health Network public health emergency preparedness and substance use prevention efforts.

Municipal and state government partners are important allies in the development of smart regulatory, eligibility, and reimbursement policies that improve social determinants and improve behavioral health. Many of the 36 Region 6 municipalities have been represented to date in IDN planning efforts. Social service and welfare partners, city and town officials, and citizen state legislators have provided valuable feedback and support for this initiative in focused small group meetings, key informant interviews, community forums and All-Partner meetings. The Strafford County government, led by the Board of Commissioners and overseen by the Strafford County delegation of legislators, is an ideal Administrative Lead entity for Region 6 because they have strong existing relationships with a variety of local, regional and state government representatives and an expertise in administering population based services. Representatives from both Strafford and Rockingham County government have contributed invaluable expertise around the behavioral health needs of people served in long-term care and corrections.

## 2d. Assessment of gaps in care

Gaps across the continuum are informed by meta analysis of 24 documents including Asset & Gap analyses done by both the Seacoast and Strafford Public Health Networks in 2016, data received from the state of NH in a series of utilization and claim based data books, and information derived through a variety of community engagement strategies discussed in Question 3 including community forums, sector specific focus groups, on-line surveys, and key informant interviews.

A gaps scan during the IDN community assessment process revealed gaps and barriers in two broad categories, geographic and functional. The geographic gap assessed to have the most significant impact on care in Region 6 is the service desert along the entire western border of the region, demonstrates significantly fewer resources across the continuum of care. The three participating hospitals in Region 6 are oriented along the eastern border of the region. The two Community Mental Health Centers are also aligned toward the central or east of their respective regions. While the Community Mental Health center sites are distributed a bit more evenly across the entire region, the FQHC with two sites in the western area of the region does not yet provide MAT care.

Two distinct functional gaps were identified in the system of care in Region 6. The first functional gap, defined as 'access', refers to the myriad of reasons, identified by multiple stakeholders in multiple ways, that beneficiaries have difficulty accessing the right services at the right time across the entire behavioral health continuum of care. Access gaps that affect most everyone include things like coordination challenges between multiple vendors when a wide variety of levels of care are necessary to support transitions from hospital to home, reimbursement that doesn't clearly compensate for care coordination, even if a lead agency was identified. One consistent and reliable current indicator of this access gap is the high percentage of Medicaid beneficiaries who don't access preventative care. According to NH claims data, 66% of all Region 6 members did not receive any preventative care in 2015. Only 1 out of every three beneficiaries was evaluated during a preventative care eligible encounter. Of more concern, however, is that members with a behavioral health condition were even less likely to receive preventative care. Just 31% of members with a behavioral health condition experienced preventative care compared to 35% of members with no behavioral health condition. That so many members are not engaged with preventative care is a significant priority for the Region 6 IDN to better understand and respond to. No amount of transformation in the behavioral health care system will result in an integrated model of care without increased participation in preventative care.

The second functional gap, defined as 'supports', includes those resources that allow members to sustain health seeking behavior. While specific support deficits are identified for certain sub-populations below, some are observed across the entire population of Medicaid beneficiaries including difficulty obtaining transportation to care when it's scheduled (or scheduling care when

the transportation is available) and difficulty maintaining continuity of care when housing is unstable.

Specific populations do face additional gaps and barriers unique to the system of care that has developed to support their more defined needs. More exclusive barricades to integrated care are presented across the continuum of care for the populations below.

#### 2d.i Serious Mental Illness

Detection:

- Inconsistent triage standards based on bed availability, not member symptoms, decreases trust in system.

Diagnosis:

- Lack of capacity for emergency assessment & stabilization

Treatment:

- Waiting lists @ Community Mental Health Centers is extended due to workforce capacity
- Emergency Departments do not have environmental or provider capacity to perform thorough assessments and/or stabilize severe mental illness
- Persistent severe mental illness is a challenging chronic illness. Limited access to Center of Excellence/advanced specialty providers within the region, especially pediatric SMI.

Management:

- Lack of housing - Only 1 group home for people with SMI in Region

Recovery:

- Lack of housing (supportive as above and traditional)
- Limited employment supports to encourage re-entry to/maintenance of employment

#### 2d.ii SUD including addictions

Detection:

- Reimbursement barriers
- Inconsistent screening, especially among youth

Diagnosis:

- Primary care provider knowledge deficits
- Extremely limited availability for walk-in/just-in-time skilled assessment

Treatment:

- Provider knowledge deficit



- Inconsistent withdrawal medical management
- Long waits for residential beds/beds available for Medicaid beneficiaries
- Limited intensive outpatient slots

Management:

- Inadequate (capacity in and coordination of) support services for pregnant women, youth, and members in urgent need of detoxification or receiving inpatient care.
- Inadequate HIT resources limit prospective and real time oversight of provider prescribing habits to identify trends deviating from CDC/practice guidelines

Recovery:

- Emerging network of Recovery support workers (certified and peer) leads to confusion about scopes of practice, inconsistent user experiences, and uncertainty about reimbursement models that limits service expansion

2d.iii. Co-occurring MH and SUD conditions

Detection:

- IV drug users not assessed or treated for physical health and vice versa

Diagnosis:

- Limited cross-specialty expertise among providers can delay root cause diagnosis

Treatment:

- Inadequate treatment options – hard to find providers comfortable addressing whatever condition needs primary attention (i.e. mental health provider is more comfortable treating mental health condition – may defer/delay care for SUD condition despite the SUD condition being the priority for member)

Management:

- Limited provider capacity & reimbursement for integrated assessment & treatment
- Competing policies and practices between partners (conflict between law enforcement engagement policies and behavioral health crisis best practices can impact care plan coordination)

Recovery:

- Limited availability of family supports

2d.iv Co-morbid medical and behavioral health conditions

Detection:

- Limited preventative care utilization in the region limits screening and access to health maintenance services

Diagnosis:

- Complexity of co-morbidity increases likelihood that presentation of symptoms of a behavioral health condition manifest as physical symptoms (e.g. 'Pain' vs. 'Depression')

Treatment:

- Limited co-located or integrated care practices where evaluation and response to individual needs can be flexible enough to be immediately responsive (e.g. A primary care provider who can't access a behavioral health provider will struggle to convert a visit for 'back pain follow-up' to a behavioral health assessment if depression screening indicates need.)

Management:

- Poor care coordination around service and resource prioritization

Recovery:

- Limited availability of family supports
- Limited access to and deficient coordination of transportation resources for high utilizer clients to visits and extended supports

d.v Co-occurring developmental disability and mental health

Detection:

- Knowledge deficits among family and/or unskilled professional caregivers prevents or delays assessment of acute mental health needs. Impact increases as degree of developmental disability increases.

Diagnosis:

- Workforce shortages limit capacity of organizations to release providers for adequate professional development time to attend continuing education about complex populations.

Treatment:

- Lack of expertise and integration between developmental disability providers and mental health providers for youth, especially in schools, for youth with 504 and/or IDEA plans.

Management:

- Limited care coordination due to DD and MH services provided by separate agencies.
- Options can be confusing/complex/poorly integrated

Recovery:

- Lack of access to training and respite for parents, families, and home care providers.
- Support groups for clients/families outside of cities is very limited

2d.vi Mild to moderate mental illness

Detection:

- Less than 1/3 of Region 6 beneficiaries received preventative care in 2015 where screening and education could be offered
- Stigma prevents members from discussing risk with friends and family

Diagnosis:

- Hospital phone triage staff have limited awareness of resources to provide

Treatment:

- Lack of transportation and child care supports impact ability of clients to adhere to regular appointment schedule for medication management, counseling, or psychotherapy.
- High number of prior authorizations required for treatment adjustments strain workforce capacity.

Management:

- Transportation

Recovery:

- Stigma

2d.vii Those at risk for a MH or SUD

- Lack of Universal Screening (SBIRT)
- Low utilization of Preventative Care decreases likelihood MH or SUD condition will be detected or diagnosed at early stages when management is likely to be both less clinically complex and less expensive.
- Students with SUD are often suspended/expelled from school, not offered supports normally available for medical IEPs because possession of or being under the influence of substances (symptoms of SUD) are violations of school policy.

### **Q3. Community Engagement and Stakeholder Input**

#### **3a. Narrative description of IDN solicitation of community input in developing Project Plan**

##### **Deliverables and Timeline-Phase I**

Our first step to ensure robust community participation in the creation of our Project Plan was to create a multi-stakeholder Workgroup of committed volunteers to guide and help implement our work. The following types of agencies/sectors were represented in our Workgroup, mostly at the Director-level:

- Public Health Network (2 co-leads)
- City Welfare Department
- Area Health Education Center
- Largest Area Homeless Shelter
- National Alliance on Mental Illness
- Greater Seacoast Coalition to End Homelessness
- Recovery Community Organization
- Community Action Partnership
- Home-Based Care Services
- City Community Development Coordinator
- Strafford County Managed Care
- CMHCs
- FQHCs
- Hospitals

Our objectives for Phase One were to design and document inclusive and transparent processes to:

- Deliver and document Public Education about DSRIP/IDN
  - Aims and objectives, structure, processes
  - Opportunities to get involved
  - Strategies to stay informed
- Solicit and document meaningful input on Needs Assessment Workgroup findings. Describe Assets, Gaps, and Opportunities for integrated care from multiple perspectives.

We employed a combination of strategies to share information and solicit input, including:

- 1) All Partner Meetings (over 85 stakeholders invited for public updates and feedback every two weeks throughout planning process)
- 2) Open-invitation Community Conversations
- 3) Outreach to existing multi-stakeholder groups
- 4) Focus Groups with Consumers
- 5) Community Project Plan Survey, formatted to allow the priority ranking of projects in each of three categories, as well as comments on the rationale for ranking and open feedback.

### **Community Conversations:**

We conducted two Open Community Conversations, one in each county comprising our IDN. Announced in advance, these forums included a basic 30-minute overview of the entire DSRIP and orientation to the IDN development process for Region 6, including an overview of the Community Project Menu options.

- In total, there were 87 discrete attendees from across a wide array of services and consumer sectors.
- Following our overview, attendees were divided into breakout groups (9 total) to participate in conversations about data, service and capacity gaps, barriers, and assets. Conversations were facilitated using common guidelines and detailed notes recorded by members of our Community Engagement Workgroup.
- Following each Breakout Group session we distributed a paper version of the Community Project Plan Survey.

### **Existing multi-stakeholder groups**

We visited several existing groups comprised of multiple stakeholders that are focused on efforts related to the objectives and activities of the IDN. Each was provided a 20-30 minute overview of the DSRIP followed by a period for questions and answers. Following these sessions we electronically distributed the Community Project Survey. The groups we visited and the number of attendees totaled an additional 109 service providers reached:

- Prevention, Treatment and Recovery Roundtable (n=25)
- Elder Wrap (n=15)
- Group of regional Welfare Directors (n=6)
- Coordinated Entry for Homeless to Shelter/Housing (n=15)
- FQHC Managers and Directors (n=10)
- Community Care Teams in both Counties (n= 18; n=20)

### **Focus Groups with Consumer Groups**

The Workgroup placed a high premium on engagement with consumers and the community of people who support them. Focus groups were conducted with a cross-section of stakeholders to better understand experiences related to awareness, availability, accessibility and acceptability of identified, desired or referred services. Conversations were focused not solely on barriers and gaps, but assets, positive experiences, and recommendations for improving access to, and integration of appropriate and desired services where, how and when to maximize quality and impact. The focus groups we conducted totaled an additional 40 consumers and their family/supporters reached:

- Parents of people with SPMI (n=6)
- Current patients in IOP (n=13)
- Current residents of homeless shelter (n=9)
- People in recovery (n=6)
- Parents of people living with SUD (n=6)

All community meetings were open to the public, and notification circulated through multiple large listservs throughout the region.

### **Three examples of how the Project Plan was influenced by the Community input**

1. The prominence of the feedback that we received from across our community of stakeholders led us to add seats on the Executive Committee that are intended to represent oral health and

housing sectors to ensure attention to opportunities for their meaningful integration into every aspect of the IDN.

2. Due to the value of our community outreach, engagement, stakeholder mobilization and input efforts during the formative stages of our project planning, a Director of Operations with community engagement expertise was hired in recognition of ongoing transparent and broadly inclusive community input as critical element of project integrity and sustainable success.

3. The selection of the three Community Projects was significantly informed by the described systematic input of nearly 250 consumer and service provider stakeholders. Project options were triangulated with our composite needs assessment and Medicaid claims data.

### **Explanation of community inputs that could not be addressed in the plan**

There was consistent and overwhelming feedback related to unaddressed gaps and barriers that constrain consumers' ability and capacity to achieve their wellness goals: adequate oral health access; adequate transportation; and safe, affordable and stable housing.

While we cannot currently directly address oral health needs of our population in the plan, we are committed to identifying and leveraging opportunities to do so in our IDN development process. Thus, we created a seat on our Executive Committee that is represented by a FQHC Executive Director with a long history of expertise in this service area. Likewise, as transportation capacity and supports are not immediately available for inclusion into our planning, we are currently crafting an outreach and engagement plan to establish an ongoing effort to meaningfully integrate transportation services and resources into our plans as they unfold.

We had much discussion about the Supportive Housing Community Project option, as the lack of affordable, safe and stable housing was perhaps the most prominent non-clinical need that was repeated throughout every phase of community outreach and engagement process. Based on recent efforts, we collectively did not feel that the requirement to "develop" housing options was tenable. Rather, we concluded that we will be best positioned to integrate and demonstrate the value of housing support services in and across the community projects we have selected.

### **3b. Narrative description of IDN solicitation of community input during demonstration PHASE II**

In Region 6 we believe that transparency and continuous community input are keys to ensuring the appropriateness, efficiency, acceptability, and ultimately the strength and value of the IDN and our ability to meet our collective objectives to deliver well-coordinated appropriate and holistic care when it is needed and where it is sought. Ensuring continuous stakeholder input is not easy to accomplish; rather, it is the right thing to do.

We have benefitted greatly from the wide range of efforts and experiences of Phase One Community Engagement and Outreach. Certainly among the most powerful insights gained is the value of bringing multiple perspectives to bear on every aspect of the IDN objectives, aims, needs, barriers and potential solutions.

As a complex, multi-stakeholder and multi-project undertaking, we know that it is not possible to create, nor do we aim to create, one static plan to which all stakeholders adhere. Rather, the entirety of implementation will require continuous quantitative and qualitative data inputs and a commitment to knowledge transfer to support well-informed quality improvement and adaptability in structure and process. As such, our outreach, engagement and community input strategy must be equally nimble and responsive to ever-shifting needs, priorities and opportunities.

There are a number of possible ways to configure ongoing community engagement efforts. To design a fully structured plan that identifies specific target groups, venues and frequencies would assume that we have clearly delineated plans and needs. This approach may also inadvertently constrain input from critical stakeholders. Rather, the process must be iterative and responsive to needs and opportunities as they emerge in the project planning process. We also value the importance of informed feedback. That is, there is a strong positive correlation between the relevance of the feedback we elicit from stakeholders and the degree to which stakeholders are well informed about the aims, objectives and potential assets of the IDN as a precursor to our conversation.

In the previous section we reviewed the considerable community outreach and engagement completed to date. From July through October we have conducted All Partner IDN Meetings every two weeks. The All Partner IDN meetings are open to the public, as our e-mail list for notifications continues to grow. We will continue regular All Partner Meetings to update stakeholders on IDN progress on a monthly basis.

We are in the process of establishing Workgroups for the Workforce, HIT-HIE, Core Competency and three Community Projects in Region Six. In keeping with our aims to maximize inclusion and transparency, we have solicited, and will continue to solicit broad stakeholder feedback on the composition and agenda for each of the Workgroups. The Workgroups are, of course, one form of deeply community engaged input. Our Workgroups will not only be instrumental in the design, work planning, budgeting and implementation of our projects, but in the design of the next phase of our community input strategy as well. In addition to project specific workgroups, we may convene expert advisory groups to address the integration of identified resource gaps that cut across projects such as housing and housing support services and transportation.

We have begun the initial process of identifying and recruiting broad stakeholder representation into our Workgroups, starting with our All Partner meetings as well as outreach to our

Community Care Teams, which includes 39 agencies and organizations authorized on one unified Release of Information.

We have a dedicated website under development for the Region Six IDN, having met twice with our IT support specialist at Strafford County (<http://region6idn.org>). The website is organized to facilitate easy public access to information and materials related to the Building Capacity for Transformation1115 Waiver; the aims, objectives, mission statement and values of our IDN; the Executive Committee and Operations Team; IDN partners; IDN Workgroups; the six IDN projects; all supporting documents related to IDN development; a calendar of network events scheduling, and much more. A section of the Region Six IDN website will be password protected for access to non-public materials that are restricted to contracted partners. The website functions will also facilitate communications to the entire range of stakeholders including anonymous feedback solicited from consumers.

Again, the Region 6 IDN is committed to public notification, web-based availability and accessibility of process and program documentation, through the continued building of our comprehensive stakeholder listserv, website and public meetings.



#### **Q4. Network Composition- Supplemental Worksheet**

##### **4b. Description of how IDN network will be leveraged to address care gaps**

The Region 6 IDN understands that constructing a system of care that enables people to achieve their greatest potential and quality of life is an enormous undertaking. To realize this ambitious vision, we must reconcile the gaps and remove the barriers that stymie integration of our region's behavioral, physical, and social health systems. The Region 6 IDN has identified and engaged over 70 unique partners in early planning efforts toward these goals because system transformation relies on transforming the way everyone works together.

To achieve our vision of system transformation, Region 6 will improve population health by improving partner network performance. Partner network performance will be improved by improving data and information integration and increasing workforce capacity to reduce the barriers and gaps that impede delivery of care with good value to IDN members.

The IDN will leverage the network to address regional gaps and barriers to integrated care by first establishing a baseline of network capacity and performance via network mapping. Network mapping allows for assessment of connectivity between network partners, an antecedent to knowledge exchange.

To deliver good value, the IDN network must incent connectivity to develop network capital, the currency of trust. The Region 6 IDN network considers both data informed decision-making and consideration of the social determinants of individual, community and population health to be essential to the development of IDN network capital. The IDN has already begun building that capital by convening partners in Community Engagement, Community Assessment, Strategic Vision, and Governance workgroups and through a variety of community engagement strategies to inform the development of the Region 6 Project Plan document. By facilitating these opportunities for resource and information exchange, the IDN has begun to build connectivity, laying the foundation for a resilient network. A resilient network is robust, displays evidence of strong relationships, can respond to change rapidly, demonstrates redundancy in key domains, and, most importantly, is reliable.

Region 6 IDN partners recognize that HIT can be a very powerful tool to improve the connectivity required to address both the geographic and functional gaps identified in the Region 6 IDN service area community needs assessment and presented in Question 2d. For example, a geographic gap in SUD service providers along the western border of the region is expected to be addressed through initiation of MAT services by Lamprey Health Care, an FQHC that services both the southern and northern parts of the currently MAT barren western area of the region. The IDN would facilitate discussion around smart practices and lessons learned between Lamprey Health Care and the two other FQHCs that currently provide MAT services in the region to ensure a robust and reliable expansion into the Region's geographic service desert. Geographic gaps may also be addressed by leveraging relationships current Region 6 IDN network members have with potential IDN members. An example of this strategy would be expansion of efforts to include both private and hospital-system affiliated Urgent Care/Walk-In centers in partner engagement efforts to better understand the ways less traditional care providers are filling gaps in the traditional systems of acute and primary behavioral and physical care.

The IDN will leverage the network to help itself in a number of ways. Data and analysis produced by the Population Health Affiliate (Director of Population Health and the Population Health workgroup) in support of the Region 6 IDN goals will be made available to IDN network partners to support regional collaboration efforts. The IDN will support efforts and initiatives that

do not create singular new lanes of care delivery, but demonstrate increased connection and collaboration. The IDN Operations Team will also leverage the network to address gaps and barriers by providing technical assistance to IDN partners and coordinating the exchange of resources and information among Partners through standing and project workgroups. Finally, the Executive Committee Charter identifies a number of ways the Executive Committee can be leveraged to address gaps, including collaborative brainstorming around Performance Adjustment improvement plans and development of increased connectivity that will ultimately build network capital.

Historically, conversation about integrated care has been primarily constrained to the table reserved for agencies who deliver Medicaid reimbursable services. The Region 6 IDN will expand network connectivity to non-traditional community and social service partners who currently provide few or no reimbursable services. Indeed, the impetus for NH's Building Capacity for Transformation 1115 waiver application is the philosophy that a truly transformed system of behavioral health care offers high value connectivity to Partners working to achieve the successful health outcomes Medicaid was designed to procure.

**Q5. Relationship with Other Initiatives: Description of existing initiatives**

It is imperative for transformation of care to continually scan the regional, statewide and federal environment for ongoing and new initiatives being made to address the gaps and needs of the issues raised in this demonstration project. Region 6 will continue to do outreach to potential partners who are developing programs such as Exeter Hospital’s initiative on suicide prevention.

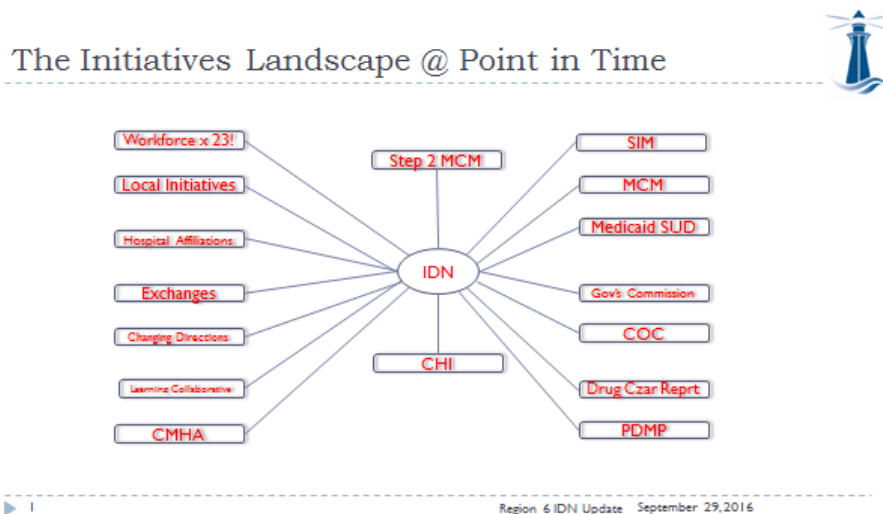
One area requiring examination is the 46 current workforce initiatives being rolled out across the state. A few of these include the Workforce Innovation and Opportunity Act (WIOA); New Hampshire Sector Partnerships Initiative with NH Works; Gateway to Work; and the Primary Care Workforce report with Citizens Health Initiative.

Programs that continue to support the growing needs of our vulnerable populations include the Changing Directions movement regarding suicide prevention and mental health; the Governor’s Commission on Alcohol and Drug Abuse Prevention, Treatment, and Recovery; the Drug Czar’s recent report entitled The Opiate/Opioid Public Health Crisis; continued collaboration with Public Health Networks and the Continuum of Care & Substance Misuse Prevention.

Innovative programs including NH Prescription Drug Monitoring Program, Community Health Institute, Community Mental Health agreement, Strafford County Drug Courts and Mental Health Courts and the IDN Learning Collaborative will further inform our efforts to expand opportunities as a region. Another area that bears watching is the Accountable Health Communities (AHC) Model- a different 1115 waiver demonstration project looking at the effects of social determinants of health an awareness of resources on health costs.

A few other initiatives that can be utilized and incorporated are the Ask the Question program for veteran status; the Public Health Networks; the Continuum of Care Development and Substance Misuse Prevention Strategic plans; the 2 Drug Free Community Grantees in Rochester and Somersworth; the Youth to Youth Development programs in nine regional schools; and the 21<sup>st</sup> Century Learning Collaborative in two communities.

These are opportunities from a point in time scan of our local and greater communities. The Operations Team will continue to review ongoing and new initiatives to keep the Executive Committee and Partner agencies informed.



**Q6. Impact on Opioid Crisis: Description of how this Plan addresses the opioid crisis**

Region 6 has numerous existing initiatives upon which IDN stakeholders will build, expand and integrate services and resources that address the needs of people who are experiencing the negative consequences of opioid misuse. We acknowledge that while there are a number of opioid focused policy and practice efforts underway, we are collectively striving towards systems transformation that centers the health of the whole person. If anything, the upsurge in opioid misuse and its negative consequences have served to expose the broad and deep inadequacies of any coordinated system of prevention, treatment, care and support that is required to address all classes of substance use disorders and their co-occurring conditions.

Both of the Public Health Networks in Region 6 recently completed cross-sector Assets and Gaps analysis for their respective Continuums of Care We combined the data with our systematic needs assessment data and community conversations with services providers and consumer focus groups. In the following table each shaded cell depicts specific identified gaps, all of which include but may not be exclusively opioid specific. Each gap is followed by references to local and/or state level initiatives and resources that the IDN will seek to include or leverage and strengthen through integration into a larger coordinated system.

<p><b>Screening: Providers consistently describe inadequate frequency and standardization of SUD screening and assessment practices.</b></p>
<ul style="list-style-type: none"> <li>· Expand existing local initiatives using SBIRT</li> <li>· Regional Access Points (RAPs)</li> </ul>
<p><b>Treatment Access: Low threshold and same day points of treatment access are rare</b></p>
<ul style="list-style-type: none"> <li>· Statewide Addiction Crisis line and NH Alcohol and Drug Treatment Locator</li> <li>· RAPs</li> <li>· Crisis Response and treatment advocacy by Recovery Community Organizations (RCOs)</li> <li>· Development of ED-based programs for screening, brief intervention and treatment initiation</li> </ul>
<p><b>Treatment Capacity: Demand for comprehensive and integrated evidence-based treatment is far greater than capacity. Concluded by:</b></p> <ul style="list-style-type: none"> <li>• <b>Emergency response and ED visits by opioid crises far more than available treatment slots of opioid-specific therapy models</b></li> <li>• <b>Those agencies that are providing opioid-specific treatment (Suboxone®, methadone, Vivitrol®) report far greater demand than available slots.</b></li> </ul>
<ul style="list-style-type: none"> <li>· Service Rate Increases authorized by BDAS Southeastern – partial hospitalization, transitional, withdrawal management</li> <li>· Workforce Development Plan and Recruitment</li> <li>· Coverage for buprenorphine by State Medicaid without copays, or limitations on duration or dose</li> </ul>
<p><b>Providers and consumers consistently report inadequate options for ongoing supports (i.e. recovery, employment, housing, etc.) for people transitioning out of institutional settings (i.e. jails, inpatient, hospitals).</b></p>
<ul style="list-style-type: none"> <li>· Lessons learned from our CCTs – integration of opioid-related services and application to</li> </ul>

<p>other settings</p> <ul style="list-style-type: none"> <li>· Payment for Peer Recovery Support Services (PRSS) via two RCOs in Region Six (SOS; Safe Harbor)</li> </ul>
<p><b>Integrated Care: Providers and consumers consistently report inadequate options for planning and operationalizing the integration of substance use, mental health, primary and specialty care services for people with co-occurring needs.</b></p>
<ul style="list-style-type: none"> <li>· Examples/lessons of well-coordinated care in FQHCs</li> </ul>
<p><b>Overdose Mortality: Our region continues to suffer from overdose mortality rates that are among the highest in the state.</b></p>
<ul style="list-style-type: none"> <li>· Good Samaritan Law</li> <li>· Strafford County home to state's first peer-based distribution program</li> <li>· Emergency responders, including law enforcement officials</li> </ul>
<p><b>Care Coordination: with supports like child care, transportation, etc.</b></p>
<ul style="list-style-type: none"> <li>· Lessons learned from our CCTs</li> <li>· Goodwin FQHC received funding for MAT-IOP (██████) reimburses these supports.</li> </ul> <p>Lessons learned and expand.</p> <ul style="list-style-type: none"> <li>· Continue to explore and leverage opportunities through multi-stakeholder groups</li> <li>· Expansion of PRSS will be critical</li> </ul>
<p><b>Demand for prenatal, neonatal and postnatal services</b></p>
<ul style="list-style-type: none"> <li>· Hope on Haven Hill (sole source award (██████) opening in November 2016 (8 residential beds for opioid dependent pregnant mothers and their children)</li> <li>· Innovative methods of treating neonatal withdrawal underway at WDH</li> </ul>
<p><b>Injection-related consequences: skyrocketing soft tissue and HCV infections associated with injection</b></p>
<ul style="list-style-type: none"> <li>· Support opening of syringe services programs subsequent to recommendations and legislation produced by HB1681 Commission on Hypodermic Needles and Syringes</li> </ul>
<p><b>Stigma: Focus groups (compassion fatigue among Emergency Response), poor understanding of SUD and interpersonal treatment by untrained personnel</b></p>
<ul style="list-style-type: none"> <li>· Must be addressed to have meaningful and lasting impact. RCOs will play critical roles</li> </ul>
<p><b>Prior-authorization delays</b> <b>High opioid prescribing rates in our Region</b></p>
<ul style="list-style-type: none"> <li>· IDN will integrate efforts to raise awareness and education in clinical settings</li> <li>· HB 1423 rules to provide uniform, statewide standards for prescribing opioids.</li> <li>· Establishment of a prescription monitoring program (CPMRS) and regulations to promote its use</li> </ul>

It is impossible to predict the long-term effects of the opioid crisis on the population. A fully realized IDN will be integral to building a comprehensive data-driven and evidence-based system of prevention, screening, and linkage to a broad spectrum of treatment options and recovery supports that are responsive and appropriate for treating the misuse of all classes of substances and co-occurring conditions, thus reducing the morbidity and mortality associated with opioid misuse.

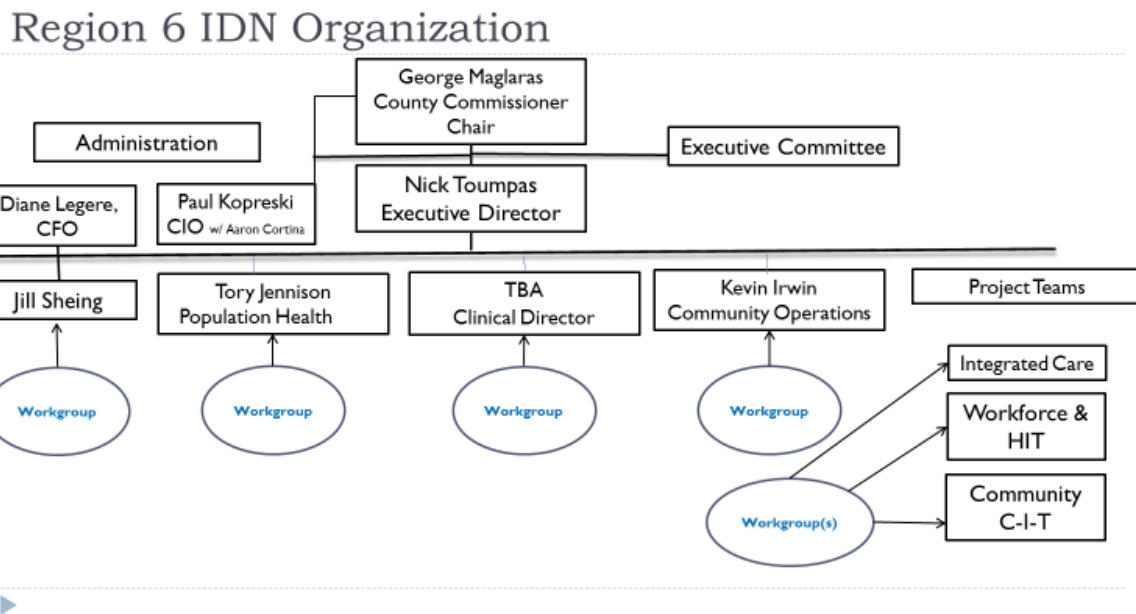
## Q7. IDN Governance

### 7a. Overall governance structure

7a.i. The Region 6 IDN is grounded in a governance perspective that is transparent and inclusive. This perspective is in keeping with the representative governance structure of the Administrative Lead agency and preserves the spirit of many of the partnerships already in place across the region. Those existing partnerships form a foundation for the governance structure under development in Region 6, where a representative Executive Committee of no more than 15 members oversees the work of a dedicated Operations Team charged with executing the project plans developed with the engagement and support of multiple partners.

The Operations Team is led by the Executive Director and supported by the Director of Operations, Director of Population Health, Finance Director and Clinical Director. The Operations Team and Executive Committee are supported by an IT team comprised of key staff from the Administrative Lead agency. The full organizational structure of the Region 6 IDN is presented in Figure 3.

Figure 3.



The Executive Director serves as the liaison between the Executive Committee, the IT team, and the Operations Team. On the Operations team, the Executive Director serves as the lead Administrator of the IDN initiative. The Director of Operations (DO) is primarily responsible for community engagement and project implementation oversight and leading the Community Engagement Workgroup. The Director of Population Health (DPH) is primarily responsible for the development of all things related to data and its use, including data creation, availability, collection, security, storage, management, and quality. The Director of Population Health leads the Data workgroup. Both the DO & DPH provide support to the Clinical, Workforce, HIT, and project specific workgroups.

Inaugural Executive Committee members were identified through an open and inclusive process that sought nominations to the Executive Committee from anyone who self-identified as an IDN stakeholder. Stakeholders were invited to nominate individuals with expert knowledge of care coordination among diverse populations and/or regional influence in their sector. Nominees were interviewed to confirm their interest and availability to participate by the Region 6 Executive Director and the Chair of the Executive Committee, who, as the Chair of the Strafford County Board of Commissioners, also serves as the Administrative Lead’s executive representative. Repeated communications to all partners emphasized that Executive Committee members would be expected to represent all partners in their associated sector, not specifically their own agency.

A final slate of Executive Committee members was identified through these interviews and presented to the full partner population by email for feedback and ultimately, a unanimous vote at an ALL-Partner informational meeting. The Executive Committee is currently comprised of 13 members from sectors deemed essential to the development of a strong integrated system of care for IDN 6 members including Oral Health and Housing, two sectors identified as critical to the success of system transformation. The Executive Committee Charter provides insight into the specific responsibilities of Executive Committee members, who participated in crafting and ultimately approving the document, which can be reviewed in section 7d. See Figure 4 for a list of Executive Committee members, their home agencies, and the sectors they represent on the Region 6 IDN Executive Committee.

Figure 4. Region 6 IDN Executive Committee Membership Roster

Domain	Name	Organization
<b>Administrative Lead</b>	<b>Chair - George Maglaras</b>	<b>Strafford County Board of Commissioners</b>
Hospital	John Skevington	Portsmouth Regional Hospital
Community Mental Health	Jay Couture	Seacoast Mental Health Center
FQHC	Greg White	Lamprey Health Care
Public Health	Janet Laatsch	Goodwin Community Health Center
Substance Use Provider	Sharon Drake	Southeastern NH Services
Social Services	Kathy Crompton	Community Action Partnership of Strafford County
Peer/Recovery Service	John Burns	Safe Harbor Recovery Center
Community Based Care	Chris Kozak	Community Partners Behavioral Health and Developmental Services of Strafford County
County Nursing Home	Steve Woods	Rockingham County Nursing Home
County Corrections	Carrie Conway	Strafford County Community Corrections
Family/Consumer	Bernie Seifert	National Alliance for the Mentally Ill, New Hampshire
Housing	Allan Krans, Jr.	Dover Housing Authority
Oral Health	Helen Taft	Families First Seacoast



7a.ii. The Executive Committee is the primary governance entity in the Region 6 IDN. The Region 6 IDN Executive Committee will establish a Membership sub-committee to further develop policies and practices Executive Committee membership like term limits, nominations, and appropriate sector representation. The Executive Committee has the authority to establish or recommend other ad hoc and/or standing Executive Committee subcommittees based on identified need. The Executive Committee is responsible for approving the charge, scope of work, and deliverables for any future such entity.

Other workgroups within the Region 6 IDN structure will advise the Operations Team and the Executive Committee on an ongoing basis. These are considered working groups and as such, are not deemed governance entities at this time. They are, however, reflected in the Region 6 IDN Organizational Structure in Figure 3. Current workgroups include:

- Finance
- Population Health (Data)
- Clinical
- Community Engagement
- Workforce Development
- Health Information Technology
- Integration Core Competency
- Community Project 1 (Care Transitions): Care Transition Teams
- Community Project 2 (Capacity Building): Expansion in Intensive SUD Treatment Options Including Partial-Hospital & Residential Care
- Community Project 3 (Integration): Enhanced Care Coordination for High Need Populations

7a.iii. There are no separate legal entities currently being established as part of the Region 6 IDN.

7a.iv. The Region 6 IDN governance structure reflects a representative governance model that encourages full participation of IDN partners including the Administrative Lead by establishing multiple mechanisms for partners to provide both feedback and influence. As a function of the Administrative Lead's civic duty, all IDN Executive Committee and ALL-Partner meetings are open to the public, noticed at least 3 days in advance, and subject to all applicable state Right-To-Know laws. In addition, Executive Committee members are nominated as representatives of a specific sector in which they are recognized for expert knowledge and regional influence, ensuring every stakeholder can identify and relate to one or more Executive Committee members most connected with their work. Regular All-Partner meetings have been held every two weeks since August 2016 to invite Partner feedback on Project Plan design. These forums will continue at a frequency to be determined by the Community Engagement Workgroup to best achieve the Region 6 IDN goal of inclusive transparency.

The Region 6 IDN governance structure is informed by the Collaborative Contracting model philosophy, in which partners remain autonomous but each partner has a contract with the IDN, through the administrative lead agency, that stipulates roles and responsibilities. In Region 6, the administrative lead has delegated significant decision making authority to the Executive Committee to empower the Committee to exercise care and diligence in coordination and oversight responsibilities for the entire initiative. Region 6 is focused on outcomes, not transactions; specifying what needs to be done and supporting variations in how it gets done. Region 6 has built an infrastructure with exceptional transparency and the capacity to provide extensive expert oversight to assist Partners with the execution of the

transformational change they designed. This strategically laid foundation is critical to maximize committed Partner participation and fundamentally change the way care is provided to our most vulnerable beneficiaries.

7a.v. This governance structure ensures accountability among IDN partners including the Administrative Lead Executive Committee through both contracting tools and open, transparent network engagement with strong data informed monitoring.

A key monitoring tool in this process will be a monthly Dashboard of vital indicators that include process and performance data across the primary domains of:

Community Operations (community engagement)

Population Health (Data/IT/Quality)

Finance

Clinical

This Dashboard will be developed by the Operations Team in consultation with the slate of workgroups, which are comprised of and open to partner members to ensure community needs are represented. The Dashboard will provide both trend and point-in-time metrics for relevant process and performance indicators for all six of the regional Projects. Workgroups will help develop, monitor, and make recommendations on Dashboard measures to the Operations team and the Executive Committee. The Workgroups will meet regularly to review the Partners' progress against the Plans and budget; provide updates to the Executive Committee on the Workgroups' progress; and suggest changes to the Project Plans and budgets as necessary.

7a.vi. It is the goal of the Region 6 IDN to work collaboratively with Partner agencies to identify any risk of underperformance at the earliest evidence of potential difficulty to avoid the need to put a Performance Adjustment (PA) plan in place. The Region 6 IDN Operations Team will review Partner performance at least monthly and will mobilize technical assistance whenever possible to support a Partner agency that is at risk of failing to meet DSRIP process or performance goals. When necessary, the Clinical workgroup, under the Clinical Director's direction, will provide the first line of status review to draft a PA plan, with Partner agency input, to avoid further performance decline. This evaluation and resulting response plan may include, but is not limited to, a systems survey, a root cause analysis, an in-depth data query, on-site observation, and/or staff and client interviews. The Executive Director and Executive Committee will be briefed regarding any initiation (with subsequent updates) of discourse or efforts with Partner agencies that are considered corrective.

In the event of continued underperformance by a Partner that is not responsive to Operations Team intervention, the Operations Team will, upon submission of a summary of issues and efforts to date, request that the Executive Committee issue a written warning describing the underperformance to the Partner. This warning includes the request that the Partner develop and submit, with support from the IDN Operations Team and Clinical team as appropriate and requested, a formal Performance Adjustment plan for review and approval of the Executive Committee. The Performance Adjustment plan will set forth steps for remediating the underperformance, and will include milestones for determining successful implementation of the Plan and dates by which milestones must be completed. The Partner will be required to submit periodic reports to the Executive Committee describing the status of compliance with the plan, including attestations that the Partner has completed each milestone by the milestone completion date.

In the event of continued non-performance, the Executive Committee will convene a closed session meeting with the Partner to review and discuss performance relative to the collaborative contract and Performance Adjustment plan. The Partner will be asked to prepare a formal response, and will be given the opportunity to present evidence to the contrary.

Failure to meet the terms of the PA plan may lead to suspension of DSRIP funds to the participant, temporary suspension of the Partner's participation, or, as a last resort, removal of the participant from the Region 6 IDN network in accordance with DSRIP requirements.

At any point in the Performance Adjustment process, the Partner will be permitted to appeal the findings and recommendations to the next-highest level of Region 6's governance. The Region 6 Executive Committee will approve procedures for appeal, based on the existing appeals procedures at Strafford County and other Partners.

7a.vii. Region 6 recognizes the IDN governance and organizational structure will need to change as the DSRIP program objectives and goals evolve toward sustainability and value-based contracting. The Region 6 governance structure has been designed to allow evolution of the governance tools and processes necessary for that phase change. Governance phase 1 is to fulfill the requirements of developing an operational IDN. The initial operational structure is in place and provides for centralized, transparent and inclusive governance with significant local participation

The second governance phase will guide greater levels of operational coordination among providers who influence physical health, behavioral health, and the social determinants of health. Finally, the third phase of IDN governance demands consideration of the IDN as a risk bearing entity across a continuum of integrated care providers. Region 6 will continuously evaluate its governance and organizational structure to ensure it is responsive to the needs and objectives of Partners as well as larger organizational goals. This phased approach considers and compliments the DHHS proposed timeline for Medicaid Managed Care in July 2018 and beyond.

Currently, all Region 6 IDN Workgroups are considered open to any Partners who have declared participation in the IDN as evidenced by submission of a Certificate of Authorization. Partners will be asked to submit a Response To Invitation (RTI) created by the Operations Team and Workgroup Leads, where identified, in support of their desire to participate. The RTI will ask responders to name the designee they wish to participate, to certify their understanding of the Workgroup charge, deliverables, and time commitment (to be determined by individual workgroups), and to provide any additional information they would like considered in support of their nomination. The Operations Team may solicit representation from essential stakeholders. The Executive Committee will approve Workgroup rosters and will be the entity responsible for hearing any challenges to those rolls.

## **7b. Four governance domains**

### **7b.i Clinical Governance**

Clinical governance in Region 6 will be effected by the Executive Committee per the Executive Committee Charter adherence to Principles of transparency, open communication and inclusion of all perspectives. Clinical oversight will be provided by the Clinical Director and the Clinical Workgroup currently under formation. The Clinical Workgroup will be comprised of senior clinical and social experts and community providers drawn from a wide range of disciplines and Partners. Representation will be solicited from Clinicians with experience and expertise in primary care, acute medical and mental health care, outpatient medical and behavioral health care, SUD care, corrections health services, long term care, and other specialties as identified.

The Clinical Director, Clinical Workgroup, the Director of Population Health and Director of Operations will comprise a Clinical Team that is responsible for clinical program design, establishment of common evidence-based protocols for DSRIP projects, creation and management of Dashboard monitoring, and overall assessment of Region 6 Partner performance against established outcome and quality metrics. The Clinical Team will be responsible for the creation of standardized care management pathways that will be recommended for Executive Committee approval. The Clinical Team will then be responsible for monitoring Partner implementation of those approved pathways, including associated data reporting required to demonstrate accountability to clinical process and performance metrics. The Clinical Team will review project performance metrics regularly to ensure any Partners at risk for underperforming are offered appropriate support. When necessary, the Clinical Team will assume responsibility for initiating, developing, proposing, supporting and monitoring Performance Adjustment plans for underperforming individual Partners. The Clinical Team will also monitor region wide performance to ensure the IDN is addressing population health outcomes as efficiently and effectively as possible.

The Clinical Director, Clinical Workgroup, the Director of Population Health and Director of Operations will comprise a Clinical Team that is responsible for clinical program design, establishment of common evidence-based protocols for DSRIP projects, creation and management of Dashboard monitoring, and overall assessment of Region 6 Partner performance against established outcome and quality metrics.

### **7b.ii. Financial Domain-See Section 8c**

### **7b.iii. Data Governance**

Region 6 understands that the development and use of clinical and IT capabilities and requirements is essential to creating the integrated, patient centered care delivery system DSRIP aims to achieve. Region 6 is well positioned to establish the clinical, quality and IT capabilities necessary to succeed in DSRIP. By establishing the IDN, Strafford County and partners created the framework to enable providers from multiple institutions to coordinate care, breaking down barriers that impede care delivery to extremely vulnerable patient populations.

Data governance in Region 6 will be effected by the Executive Committee per the Executive Committee Charter adherence to principles of transparency, open communication and inclusion of all perspectives. Data governance will be informed by the Director of Population Health in affiliation with the Population Health Workgroup. This affiliate will be responsible for reports and updates to the Executive Committee regarding oversight on IDN policies, procedures, and

performance related to data informed knowledge and resource exchange among IDN Partners. This oversight includes responsibility for development and monitoring of data sharing agreements, standards and processes; and assessment and analysis of existing information technology and health informatics resources. The Population Health affiliate will provide both data and quality assessments directly to the Clinical Team to inform Dashboard development and ongoing monitoring and, when appropriate, to guide Performance Adjustment planning.

The Region 6 Director of Population Health will serve as the Liaison between the Population Health Workgroup and the HIT Workgroup to ensure that the Region 6 Operations Team has the data and tools to monitor the following functions that are critical to DSRIP performance improvement success:

- Variance and cost reduction — to improve operational efficiencies
- Clinical efficiency — Reducing avoidable, unproductive and duplicative services
- Care redesign — Ensuring treatment in the most optimal setting and by the right provider
- System optimization — Shifting focus to preventive care and population health
- Patient experience — Objective and meaningful comparisons between providers of care

This monitoring will also inform budgeting for both capacity building and all 6 project plans and add value to Partner operational and strategic planning wherever possible. Administrative leadership within Partner organizations will have ample opportunity to participate in Region 6 data governance by maintaining situational awareness of the key functions monitored in the Dashboard, through organizational representation in the Population Health or HIT Workgroups, by membership on the Executive Committee, or by participating in one of the six Region 6 Project Plans. Region 6 is committed to the development of robust data analytics as a tool to drive system transformation through population health based project success and value based payment reform.

#### **7b.iv. Community Engagement**

Community Engagement governance in Region 6 will be effected by the Executive Committee per the Executive Committee Charter adherence to Principles of transparency, open communication and inclusion of all perspectives. Our overall governance structure is intentionally designed to ensure that our commitment to transparent and inclusive community engagement and input is met at every stage of IDN development, as memorialized in our Vision and Principles. Accountability for the plans described in Question Three rests with the Director of Operations (DO). The DO has two primary responsibilities, a) to facilitate program implementation and program management plans and tools, and b) to ensure transparent, representative and meaningful community input in every aspect of IDN development. The DO is accountable to our multi-sector Executive Committee, Operations Team colleagues, Workgroup members, and our community partners.

Working closely with fellow members of the Operations Team, the DO plays a leadership role in the Integration/Core Competency Workgroup, participates in the Clinical, Workforce, and HIT Workgroups, and leads the creation and facilitation of Community Project Workgroups. At a high level, the DO will continually scan the federal, state, regional and

local health services environment for relevant changes in the policy, regulatory, funding and program environment in which the IDN stakeholders operate. The DO will also establish a process for continuous assessment of the integration between the Core Competency, Workforce, HIT and three community projects.

On the ground the DO works closely with community stakeholders to facilitate and support agency and inter-agency onboarding, implementation, management, monitoring and continuous improvement of IDN projects, ensuring requisite communication among stakeholders and that technical assistance is available when needed. The DO will work closely with stakeholders to design and adopt a framework for ongoing self-assessment and response to factors that enable or constrain culture change in their respective practice environments.

**7c. Governance Charter-** See Executive Charter

**7d. Key IDN Management Roles-** workbook

## **Q8. Budget and Funds Allocation**

### **8a. Final budget narrative**

#### **Development of a Behavioral Health Needs Assessment - Budgeted Amount: \$20,000**

Estimated costs for GIS Mapping capabilities to assist with the development of the needs assessment. Funds will cover estimated costs for procurement of network analysis software and technical support. IDN Region 6 has hired a Director of Population Health and a Director of Operations where both possess the skill set to develop this behavioral needs assessment as well as the duties related to Data/Quality and Community Engagement oversight. The salaries and benefits for these positions are included in the section Establishment of IDN Administrative/Management Infrastructure. This IDN plans to revise this budget amount in Q1-Q2 of 2017 as additional needs for this purpose develop.

#### **Development of IDN Project Plan - Budgeted Amount: \$100,000**

Estimated costs associated with the development of IDN Region 6 Project Plans to include meetings with partner organizations, contracts with industry experts such as project management firms and legal counsel. This IDN plans to revise this budget amount in Q1-Q2 of 2017 when more information will be available for the development of the Project Plan.

#### **Capacity Building for Direct Care or Service Provision Workforce: Recruitment and Hiring - Budgeted Amount: \$275,000**

Estimated costs to provide funding to IDN Region 6 partners to develop job descriptions, advertisements for new positions, organization of job fairs for hiring staff involved in the direct delivery of health care, mental health care, substance use disorder care and social services. This budget will also be used to fund sign-on bonuses for newly hired individuals when appropriate. This IDN plans to revise this budget amount in Q1-Q2 of 2017 when more information has been gathered regarding the specific gaps and needs of IDN Region 6 partner organizations.

#### **Capacity Building for Direct Care or Service Provision Workforce: Retention - Budgeted Amount: \$525,000**

Estimated costs to provide funding to IDN Region 6 partners such as compensation adjustments, benefit adjustments, and new career ladder programs for positions which involve direct delivery of health care, mental health care, substance use disorder care and social services. This IDN plans to revise this budget amount in Q1-Q2 of 2017 when more information has been gathered regarding the specific gaps and needs of IDN Region 6 partner organizations.

#### **Capacity Building for Direct Care or Service Provision Workforce: Training - Budgeted Amount: \$305,000**

Estimated costs to provide funding to IDN Region 6 partners to provide training to new and existing staff as well as create new training programs for positions which involve direct delivery of health care, mental health care, substance use disorder care and social services. This IDN plans to revise this budget amount in Q1-Q2 of 2017 when more information has been gathered regarding the specific gaps and needs of IDN Region 6 partner organizations.

**Establishment of IDN Administrative/Management Infrastructure - Budgeted Amount  
\$2,350,640**

Estimated costs to fund and establish the administrative and management infrastructure for IDN Region 6. This budget includes funds for salaries and benefits for the hiring of an Executive Director, Director of Operations, Director of Population Health at 1 full time equivalent each for 4.5 years and Clinical Director at .50 full time equivalent for 4.5 years. Strafford County serving as Administrative Lead for IDN Region 6 will provide existing financial and IT infrastructure and this budget will provide funds for salary and benefits for the existing Finance Director, Finance Clerk, IT Director and IT Staff at .25 full time equivalent for four and one half years to compensate these individuals for the additional duties they will assume as a result of the operations of the IDN Region 6.

This budget also includes funding for the operation of the physical office for IDN Region 6 to include office supplies, postage, telephone, photocopy expense, travel and mileage, computers, printers, and office furniture.

Contracted professional services are also reflected within this budget to include such services as audit, legal counsel, website development tools, grant writing, training, and rental of meeting and conference room space required for the four and one half year period.

This IDN plans to revise this budget in Q1-Q2 of 2017 as the infrastructure develops and additional needs are determined.

**Health Information Technology/Exchange - Budgeted Amount: \$633,749**

Estimated costs associated with the investment of Health Information Technology/Exchange infrastructure to include electronic health record systems, and the enabling of common treatment plans and care transition plans to be shared between providers across sites of service and health information exchange. This IDN plans to revise this budget in Q1-2 of 2017 as the Statewide HIT project plan is developed.

**8b. Final projected budget estimates- workbook**

**8c. Funds allocation governance**

Strafford County of New Hampshire serves as the Administrative Lead for IDN Region 6 and will provide the financial infrastructure for this region. The financial structure of the County is designed where the County's budget, debt and tax levies are authorized by a County Convention or "Delegation" consisting of all members of the State of NH House of Representatives elected from the cities and towns within the County. The County is administered by a three-member Board of Commissioners elected for two years by the voters. Once the County Convention adopts the gross appropriations within the annual County budget, the County Commissioners may not spend above the gross appropriations during the budget year regardless of offsetting revenues. Line item transfers with the budget may be made by vote of the Board of Commissioners. Department Heads have the authority to spend the appropriations within their designated department's budget.



On a quarterly basis, the County Commissioners are required to report to the Executive Committee of the Delegation highlighting the status of the annual County budget to date. A detailed report of each budget line item is provided to the Committee for their review along with explanations from County Department Heads regarding any irregularities in their respective budget.

Strafford County's elected Treasurer serves for a two year term as the custodian of all County funds and is responsible along with the County Commissioners to authorize payments and investments.

The Strafford County Finance Director oversees the County's Finance Department which includes payroll, accounts payable, billing, accounting, internal controls, banking, investments, and asset management, and will serve as the IDN Region 6 Finance Director on an annual basis, Strafford County will undergo an annual independent financial audit of its operations as well as the operations of IDN Region 6 DSRIP program, in the same capacity.

The budgetary and financial transactions for IDN Region 6 will be approved by the IDN Region 6 Executive Committee and then upon approval will be executed by the IDN Executive Director and Finance Director and flow through the Strafford County financial infrastructure as indicated.

The Executive Committee of IDN Region 6 has approved the Final Projected Budget Estimates submitted within the enclosed workbook per the requirements set forth in the Committee's Governance Charter. As indicated in Section 8.a. Project Design and Capacity Building Funds: Budget Narrative, the approved budget estimates will be revised over the course of the five year project as projects plans are developed, and cost, gaps, and needs are determined.

8c.i. The distribution of funds earned by IDN Region 6 over the course of the demonstration period will be determined by the Operations Team which includes the Executive Director, Director of Operations, Director of Population Health, Clinical Director, and Finance Director. The Operations Team will develop a budget and fund allocation plan to determine the purpose, dollar amount, and the recipients or partner organizations selected for the receipt of the funds. The budget and plan will then be presented by the Operations Team to the IDN Region 6 Executive Committee where the committee will vote to approve the recommendations for the distribution of funds. The Governance Charter for IDN Region 6 requires that a vote must be passed by a 2/3 majority of members present. Please refer to the Region IDN 6 IDN Governance Charter to review the complete process for approval by the Executive Committee.

As indicated in Q7. IDN Governance, IDN Region 6 has selected and will develop a Collaborative Contracting Model which will include a solid understanding of roles, responsibilities and expectations of performance and that these standards will be developed through a collaborative and inclusive structure to include input from the participating organizations, recommendations from the Operations Team and final approval by the Executive Committee.

The Operations Team will be charged with overseeing the compliance program for IDN Region 6 and will also be responsible for preparing and presenting reports directly to Region 6's Executive Committee. This structure will ensure compliance can be monitored and enforced quickly, that the team will have direct access to and support from the data

and monitoring capabilities and rapid cycle evaluation activities of the IDN will have direct access to the highest level of Region 6 decision-making. Region 6 will leverage the IDN's compliance experience for the compliance program, customizing existing practices as needed. The compliance plan goals will be to deter non-compliance, detect violations and ensure that responses to a violation are appropriate. Region 6's plan will be administered by the IDN Region 6 Administrative Lead and will conform with NH state laws and include, at a minimum:

- Written standards of conduct, policies, and procedures promoting compliance (e.g., including compliance as an element in evaluating Partners) and addressing areas of potential fraud.
- Training for Participants and IDN Region 6 staff, written standards of conduct, policies and procedures.
- A process to receive complaints anonymously, and protect whistleblowers.
- Develop and implement a system to respond to improper/illegal activities and enforce disciplinary action against individuals violating compliance policies, applicable laws/regulations, and program requirements.
- Perform regular audits to monitor compliance and reduce identified problem areas.
- Investigation/remediation of identified systemic problems, and development of policies on non-employment or retention of sanctioned individuals.
- Procedures for ongoing monitoring.

Region 6 will implement regular effective education, training and re-training programs for Region 6 Partners, coalition partners and IDN Region 6 staff. Existing compliance training programs, such as HIPAA, will be customized for DSRIP and Region 6 if available, and implemented as soon as available. Where provider-specific compliance programs have not been developed, Region 6 will work with relevant Partners, the Operations Team, and/or outside counsel as necessary to develop such program(s). Region 6 anticipates implementing a comprehensive training program during the first quarter of DSRIP Year 1 and completing initial training of all participant, coalition partners and IDN Region 6 employees within six months of implementation.

Region 6 will establish, publicize, distribute (using beneficiary materials) and maintain a process, such as a hotline, to receive compliance complaints from attributed members, including Medicaid beneficiaries and other attributed community members. Region 6's website will also note that, at any time, if an individual or organization feels their (or its) rights have been violated, or the IDN is acting in conflict with its obligations under DSRIP, the individual or organization may contact the IDN Region 6 Operations Team, in writing or via email. The appropriate contact information will be included on the website, along with contact information for relevant state oversight entities. Region 6 will also implement and publicize a non-retaliation policy with regard to complainants. Region 6 will also adopt policies and procedures to protect anonymity of complainants and to protect whistleblowers from retaliation.

8c.ii. The Operations Team will develop project budgets and a fund allocation plan for the IDN Region 6. Though the work conducted by a needs assessment and community engagement initiatives, the team will determine the needs, gaps, and barriers relative to the project plans approved by the IDN Region 6 Executive Committee. From this analysis, the team will develop the detailed initiatives within the project plans, develop the project budgets, and determine the partner organizations who will be required to fulfill these initiatives. A fund allocation plan will then be created.

8c.iii. The IDN Region 6 rationale and justification for this financial governance approach and funds allocation process will support successful implementation of its projects and achievement of its performance metrics. The established infrastructure of Strafford County, who serves as the Administrative Lead for IDN Region 6, the composition of the Executive Committee which is represented by leaders in all partner network sectors, the expertise of the IDN's Operations Team, and the commitment of transparency to all partner organizations are the key components for this successful implementation. The implementation of the Collaborative Contracting Model will be designed to maximize participating organization buy-in, provide support, oversight, of program milestones, enforcing participant obligations, evaluating and tracking participant performance relative to established metrics. IDN Region 6 will continuously evaluate its governance and organizational structure to ensure it is evolving to meet the needs, objectives and milestones of the Project Plans.

#### **8d. Funds flow to shared partners**

IDN Region 6 will assure that a partner organization participating in multiple IDNs will not receive duplicative payments for providing the same services to the same beneficiary through a project activity. This IDN plans to use a proactive approach as well as a formal review process to provide this assurance. The proactive approach will be used at the contracting phase (Collaborative Contracting Model) of the process where education as well as specific language in the contract between the Administrative Lead and the partner organizations will not only itemize the specific scope of services to be performed by the partner organization, but will also include a statement that the partner organization will not receive duplicative payments for providing the same services in multiple IDNs. The partner organizations will be counseled about this statement and its requirements upon execution of the contract.

The formal review process will involve the development of a list of partner organizations participating in multiple IDN's where these organizations will be required to meet with the Executive Director of IDN Region 6 on a quarterly basis to review that this requirement is being followed. At this time the partner organization will be required to sign off on a self-attestation form certifying that it is in compliance with this provision in the contract.

### **Q9. Alternate Payment Models: Current use of alternate payment models**

Our largest partners report a small number of programs that employ Alternative Payment Models.

The Community Mental Health Centers (CMHC) are contracted with the Medicaid Care Management vendors using an alternative payment model with allows the CMHC to better control service delivery without undue administrative burden. The base model is one of capitation. However, to ensure that the per-member per-month (PMPM) dollars paid to the CMHC are being used for services there is a minimum maintenance of effort threshold in place. In addition, there is the potential to earn additional dollars if specified quality metrics are achieved.

Frisbie Memorial Hospital is engaged in one risk-related program in an arrangement with Harvard Pilgrim in conjunction with the Benevera Program. Benevera is a Population Health Management system to which Frisbie is one of four hospital investors (others being Dartmouth Hitchcock Medical Center, Elliott Hospital, and St. Joseph's Hospital). The program has an up and downside risk corridor, for both the primary and non-primary members. Frisbie is not participating as yet in any bundled payment plans as of this date.

Wentworth Douglass Hospital (WDH) is engaged in four Alternative Payment Models that serve a significant portion of their patient population.

#### **1. Medicare ACO**

- Through "New Hampshire Accountable Care Partners" relationship
- Upside only model with Fee for Service payments as a base and bonuses tied to meeting quality and financial metrics

#### **2. Anthem Shared Savings**

- Similar to the above involving the Hospital, Wentworth Health Partners (hospital owned medical staff), and independent medical staff
- Through PHO contract – Health Partners of New Hampshire, Inc.

#### **3. Cigna Shared Savings**

- Very similar to Anthem except it is through Granite Health contract with PHO – Health Partners of New Hampshire, Inc.

#### **4. Medicare Bundled Payment**

- WDH only arrangement covering Stroke and total joint replacement patients admitted to the hospital and 90 days post discharge
- A paid FFS with quality and financial budget targets

## Section II: Project-level Plans

### Q10. Project A1: Behavioral Health Workforce Capacity Development

#### 10a. IDN workforce project leads and participants: workbook

#### 10b. Narrative describing IDN's workforce capacity challenges

As mentioned in our scan of the landscape of initiatives there are at least 46 different workforce initiatives in the works across the state and local communities. This issue is throughout the state and throughout all industries. When an economy is doing well with a low unemployment rate there will be many areas where there will be shortages of people to fill the positions.

This is quite true of the behavioral health (BH) industry as well. There are several reasons that it is especially hard to find staff to meet the needs of these agencies and the people they serve. Many of these are to blame for the lack of recruitment and retention of these employees.

Agencies and mental health centers have limited resources to spend in recruiting the staff they need. Human resource departments are often short on funding and staffing needed to pursue candidates. There is a great deal of time and cost associated with attending job fairs, advertising job postings, and the interviewing process. Having these positions remain open for extended periods of time eats away at the time HR has to further develop their staff and keep up with the demands of the hiring process such as back ground checks for staff they have not even hired yet.

Agencies often find they are competing with other larger entities that may be able to spend more money and time to attract the new employees and perhaps more funds to pay them a higher wage. Large insurance companies are a frequent poacher of staff in this field as they are often offering case management services to their clients as part of their health cost savings' measures. These companies can often pay a much higher wage for a less stressful position than a BH agency or center may be able to provide.

The rules and regulations regarding licensure, accreditation and reciprocity across the state borders are time consuming and restrictive. Since our region borders Maine and Massachusetts it would greatly improve our ability to hire staff if there were fewer regulations that are state specific rather than federal.

After the staff person is finally found, vetted, and brought on board there are still many issues that will threaten the retention of this staff. Agencies find they have less funding that can be set aside for professional development and ongoing trainings. The lack of capacity to meet the demands of the community will wear away at the newly hired and veteran employee as well. The constant turnover strains the remaining staff as well as disrupts the care provided for the children and adult clients with mental illness or substance use disorders.

This lack of continuity of staff can lead to a lack of knowledge of other roles in the continuum of care and other silos of care. Staff often does not know where to refer their clients to get the proper care and assessments they may need. Maintaining the culture of working with integrated teams is difficult when the staff is always realigning themselves with new hires. It is difficult to implement policies and procedures agency wide when the agency does not have the continuity it needs to know where they are coming from and where they are headed.

Staff site being overloaded with paperwork, record keeping and low pay as being primary reasons they do not stay in the BH industry especially if they are not in a private practice setting.

Staff often find that they are not able to sustain a lifestyle or family with the wages they earn and lack of affordable housing in this area adds to that financial burden. All of these factors lead to burnout for these employees.

### **10c. Narrative describing expected IDN efforts to address workforce capacity challenges**

Region 6 IDN proposes to establish Workgroups to address the issues of each of the Project areas. These Workgroups will grow out of the Partner organizations and will cross the various sectors including FQHCs, hospitals, CMHCs, social services, primary care, SUD, and county agencies. As stated earlier workforce issues exist across the local and state levels.

Region 6 will participate in various Workforce initiatives where appropriate. As new initiatives are being created it will be important to assess these continually and participate collaboratively with the State, DHHS and the other IDNs. It is imperative that the State, departments and IDNs understand and build linkages to multiple statewide initiatives which now number at 46 separate plans. While we work to reduce silos in primary and behavioral health care it is essential that we do not create more silos in other areas.

The Workgroup will work to expand and enhance the New Hampshire State Loan Repayment Program (SLRP) which provides funds to health care professionals working in areas of the State designated as being medically underserved and who are willing to commit and contract with the State for a minimum of three years (or two if part-time).

It has become evident that our workforce issues are going to continue to be an issue for the foreseeable future. In the meanwhile with the advances in technology we can learn to work smarter not harder. The use of telehealth or telemedicine can be a tool we can use to reach greater numbers of patients and clients in need of health care. These advances will need to work hand in hand with changes and breaking barriers in the reimbursement rules and regulations in order to have these services reimbursed.

Progressive ideas regarding salary enhancements and signing bonuses, investing in the retraining of our existing workforce and new training programs will need to be explored and acted upon. Formalized on the job training programs and apprenticeships will enable the industry to grow our own pool of well trained and talented employees. Employees will also need to see a path for their growth and professional development through organized career ladders within and across the newly integrated healthcare industry.

Innovative ideas regarding recruitment need to be developed as the “old fashioned” ones no longer net the results we need to meet the demand. An effort to outreach to minorities and new Americans will need to be made as well as crossing borders with Massachusetts and Maine. This will have to go hand in hand with efforts to improve the rules regarding reciprocity. Partnerships with private companies, community and four year colleges and education centers such as Area Health Education Center will enable partner agencies to expand their reach in recruitment and expand the success of their employees and therefore retention of this workforce.

## **Q11. Project A2: Health Information Technology (HIT) Infrastructure to Support Integration**

### **11a. IDN HIT project leads and participants: workbook**

#### **11b. Narrative describing IDN's HIT gaps**

Gaps are identified by assessing capacity to reach a standard. HIT standards have not yet been provided to the IDN regions for this project. As a result, critical HIT gaps are difficult to assess. Region 6 IDN partners recognize that HIT can be a very powerful tool to integrate care. In order to realize sustainably integrated system transformation, HIT must be seamlessly integrated and, whenever possible, invisible to both providers and patients.

Some gaps can be anticipated based on Community Assessment and Community Engagement efforts to date in Region 6. The Region 6 IDN expects to thoroughly assess HIT capacity to collect, exchange, evaluate and analyze data related to care management, process evaluation, and performance management against provided standards. Unfortunately, it is impossible to prioritize these gaps or have confidence in HIT related budget assumptions until standards are defined. Gaps are anticipated in the following infrastructure/software and culture domains:

#### Infrastructure/Software:

- Differing levels of HIT utilization among mental health, primary care and hospital system providers
- Limited HIT utilization among SUD and SS providers
- Very limited/no HIT utilization among community and social service providers
- Variability in integration of in-house systems within Partner agencies
- Variability in integration of systems between Partner agencies
- Inconsistent use of client management tools by Partner agencies
- HIT product incompatibility results in decreased interoperability between current HIT Partner agencies
- Differing Inter- and Intra-agency reporting and regulatory requirements result in complicated agency IT networks and confound organizational capacity to contribute data to inform population level health.

#### Culture

- Knowledge gaps around HIPPA and confidentiality constraints
- Limited IDN partner participation in NH HIO
- Variable levels of Partner comfort and experience with information sharing
- Variability in how Providers value and use data at the individual, panel, and practice level
- Lack of clarity at the organizational and regional levels about how to assess data quality and how to collect, manage and report data to meet population health level goals leads to uncertainty about what types of HIT are necessary to do so.



### **11c. Narrative describing expected IDN efforts to address HIT gaps**

Since the statewide planning process is in a very early developmental stage and no standards have yet been identified, it is difficult to conceptualize how this planning process will support gap management in any IDN region. Region 6 assumes that the state-wide HIT Task Force is the primary vehicle through which the state-wide planning process will support the IDNs to address HIT gaps at the regional level. This response is crafted based on that assumption.

One priority expectation of the state-wide HIT Task Force is generation of a consensus driven slate of standards to assess regional gaps against so that HIT planning can be operationalized to support the project plans. These standards should address not only what information collection and communication goals are expected, but why.

A second expectation of the state-wide HIT Task Force is consensus driven strategic refinement of the HIT Assessment Tool based on review of the tool's ability to assess gaps against those newly defined standards. This refinement will allow Region 6 to query Partners efficiently to better understand the breadth and depth of the gaps specific to our particular project dynamics.

The Region 6 IDN expects that participation in the statewide planning process will provide an opportunity to share and learn from smart practices generated across all seven IDN regions. In addition, Region 6 hopes the statewide planning process will integrate technical and industry experts as appropriate to inform the process, including MCO entities and other relevant state-wide partners with a stake in HIT development at all levels.

A fourth and final expectation of the statewide planning process is that there will be some findings and recommendations generated by the group at-large that will inform the state's own HIT planning and investment to improve alignment with regional efforts. This improved alignment will allow regions to streamline their own efforts and leverage state efficiencies at the individual organizational and regional level to improve provider experience.

## **Q12. Project B1. Integrated Health (Core Competency)**

**12a. Current-state assessment of network specific to Core Competencies: workbook**

**12b. Participating organizations: workbook**

### **12c. Monitoring Plan**

The development of the Region 6 Monitoring Plan will be guided by the Operations Team in alignment with three general Phases of: 1) Design, 2) Implementation and 3) Continuous Outcomes Assessment. The indicators to be used will require continued development and refinement as we move through each phase, from process-oriented to outcomes-oriented measures. The definitions and operationalization of indicators, reporting mechanisms and targets or thresholds will be designed through a process to be facilitated by our Operations Team that integrates DHHS requirements with assessment, data and stakeholder workgroup inputs.

We are currently identifying and recruiting members to comprise our Core Competencies Workgroup, which we have named our Integration Workgroup. As with all of our workgroups, the Integration Workgroup will be comprised of multiple stakeholders from every relevant sector in the IDN, including consumers and their support networks. In keeping with our core principles, our recruitment strategy is designed to be transparent and inclusive. To uphold these principles in our outreach efforts, we are crafting a description that includes the objectives, timelines, draft meeting schedules and deliverables of each Workgroup, as well as the responsibilities and expectations that come with participation.

As part of the Response to Invitation we will recruit through outreach via our All Partners meetings and communications, our website, multiple listservs, as well as existing multi-stakeholder groups we engaged in our Community Outreach efforts, such as Community Care Teams and the Prevention, Treatment and Recovery Roundtable, etc. Once assembled the Workgroup can further determine which partners and who within them will be committed, and what experience and skills may remain unrepresented and still needed in the workgroup, whereupon we will conduct further recruitment accordingly.

Our monitoring efforts must also be agile to accommodate a very diverse range of stakeholder agency sizes, existing capacities and cultures. Part of our monitoring efforts will entail the provision of training and capacity building to agencies that may have data collection and reporting systems that are under-developed, misaligned, or non-existent.

The Operations Team and our Integration Workgroup will work closely together to support the Region Six IDN to reach Q1/Q2 2017 Milestones, including but not limited to efforts to:

- Develop a detailed Implementation Plan, including timeline, budget, workforce assessment and capacity building, HIT assessment and capacity building, agency and staff recruitment and onboarding, workflows, roles and responsibilities, leadership and communications plan, etc.

- Develop Timeline and Milestones for the creation of assessment and screening tools (i.e. Comprehensive Core Standardized Assessment, Depression Screen and SBIRT, developmental/behavioral screen for pediatric providers, etc.), protocols for assessment, shared care plans, referrals, etc.
- Establish a systematic process for monitoring and reporting aggregate/Regional progress towards CCP and/or ICP designation (SAMHSA)
  - Assessment of current practices across providers
  - Identification of gaps
  - Define needed feasible resources to achieve designation
- Advise Operations Team and Executive Committee on the development of Universal Standards for participating Organizations, including performance monitoring
- Develop training plans tailored to participating agency sectors to meet identified needs, requirements, competencies (including specialties, cross-training)
- Develop model for continuous input on challenges and proposed solutions to address evaluation plan
  - From Coordinated Care to Integrated Care Designation
  - Key Metrics to be used as indicators for targeted population identification and outcomes
  - Develop Continuous Improvement Process Tools
- Identify Resources and Budgeting Needs and make Recommendations to the Executive Committee
- Establish a systematic process for monitoring and reporting degree of coordination among/between six projects, ensuring mutuality and eliminating overlap
- Support the development of MOUs (for information/data sharing, referrals, etc.)

The Operations Team and our Core Competencies Workgroup will continue to work closely together to support the Region Six IDN to reach Q3/Q4 2017 Milestones, including but not limited to efforts to:

- Implementation and Deployment: workforce and training
- Operational: assessment, shared care plan, core teams
- Facilitate the use of shared data from EHR or other documented data flows
- Initiation of reporting

## 12d. Expected outcomes

We identified a large range of gaps in care in our Needs Assessment across a number of clinical and non-clinical sectors. It is premature to operationalize the specific outcomes we hope to affect as a result of our collective efforts, however we can provide a narrative of the types or categories of impacts we hope to produce, subject to further specification in our development activities during Q1 and Q2 of 2017.

There are a number of impacts we may anticipate target directly, measuring and tracking for improvements, such as provider knowledge, rates and universality of screening and assessment, appropriate referrals and follow-ups, etc.

We anticipate tracking a number of outcomes related to our workforce capacity efforts, such as: core competencies, levels of cross training, scope of services, satisfaction, retention, etc. Indeed, some of these objectives will be shaped by the state project on Workforce Capacity. Likewise, outcomes related to expanding HIT/HIE capacity are yet to be determined, as those will be based on assessments that have yet to be completed.

Additionally among service providers, of course, we will continue to refine the development of reliable inputs to assess the movement of partners from coordinated care to integrated care. We will also be interested to track, at a basic level, the increased availability of types of services, like detoxification, partial hospitalization, inpatient SUD treatment, etc. Specific provider sectors may employ program level indicators like waitlist sizes, days on waitlist, etc.

Of course, service utilization metrics will be a primary and common cross-regional source of outcome indicators, such as:

- Emergency Department utilization
- Other Emergency Services utilization
- Preventable Hospitalization
- Re-hospitalization
- Readmissions to acute care
- Inappropriate use of the ED
- Preventive Care
- Associated experiences, like recurring homelessness, arrest, incarceration, etc.

Among consumers in the community we will be interested to assess and track indicators that demonstrate improvements in:

- General awareness and comprehension of available services and resources
- Ability to access those services and resources
- The acceptability and continued utilization (when appropriate) of services and resources.

Others will be more challenging to track but important to seek opportunities, such as community members' experiences of stigma and discrimination, or self-efficacy, etc.

We anticipate the need for, and efforts to affect policy or regulatory changes that are pertinent to meeting the objectives of the IDN. For example, the range of reimbursement barriers, reciprocity of licensing, and other opportunities to expand capacity that may have an expected impact on outcome measures. And we anticipate, but cannot reliably predict that some opportunities to

further serve and affect positive outcomes for our population will emerge during the course of the demonstration. For example, the authorization of syringe services programs could open numerous pathways to serving one of the vulnerable and most marginalized members of our communities.

We will also be attentive to assessing the relative impact or contributions that integration of social services has on population health outcomes. For example, the impact of integrating housing supports, transportation or child care services into coordinated and integrated models of care. The ability to operationalize and reliably demonstrate the value of these services will be critical to potentially directing the reimbursement of earned revenue in our care models, and establishing the rationale for reimbursement of such services in value-based payment packages.

## 12e. Challenges and proposed solutions

We have identified a number of potential challenges and/or barriers to IDN implementation in our early stages. More importantly, we will be better equipped to identify more specific, tangible barriers and opportunities to overcome those barriers when we are walking through detailed project design in Q1 and Q2 of 2017 with all of the stakeholders engaged in the process.

At a higher, more abstract level, we have already identified the following:

- Stakeholder Participation challenges
  - General capacity
  - Agency fiscal solvency
  - Competing or overlapping initiatives
  - Lack of an internal champion
  - Ability to recruit and retain new staff to execute against the model
  - Staff turnover
  - Internal Change Management
- Wide range of capacity or mechanisms for sharing data amongst partners
- Shifting Policy environment
- Parallel referral pathways (e.g. Granite Pathways Regional Access Points)
- Unknown costs associated with HIT/HIE and Workforce taskforce
- Ability to address regulatory or policy barriers
- Competing service models and associated cultures within participating organizations (i.e. individual versus team)
- Discontinuity in program development timelines, for example: building the system and reporting standards based on metrics in advance of knowing identified performance metrics
- Balancing administrative burden vs. client and practice benefits
- Sustained commitment by leadership in IDN, provider and sectors

We can speculate a great deal more about upcoming challenges and potential barriers. However, we are currently more focused on the development of a Workgroup infrastructure that is well equipped to reliably anticipate and identify challenges and potential barriers specific to our project plans as they are being created. Likewise, this Workgroup infrastructure will be instrumental in advising response strategies and monitoring of those efforts. Among those types of resources we will plan to have available to IDN partners, include:

- **Resources**
  - Project Management Office
    - Tools, methodology, and training
  - Facilitation Assistance
  - Outreach, education and/or team-building of providers and community
  - Operations support for staging and managing transitions and change
  - Targeted Technical Assistance identified and/or requested by agencies and stakeholder groups

## 12f. Implementation Approach and Timing: workbook

## **Q13. Community-Driven Project #1 C1: Care Management Teams**

### **13a. Project Selection Rationale and Expected Outcomes**

As with many jurisdictions around the country, service utilization data for the Region Six attributed Medicaid population demonstrates an over-representation of members with behavioral health conditions in categories of inappropriate and high volume ED utilization, as well as re-admissions. Among our attributed population:

- 88% of 230 readmissions had BH condition
- 10,000 members using the ED had BH condition
- 4,045 of those members used the ED for conditions potentially treatable by Primary Care
- Members with a BH condition were two times more likely to use the ED for conditions potentially treatable by Primary Care (18.4% vs. 8.9%)
- 1344 members used the ED more than four times in the previous year, and 72% of those members had a BH condition
- 666 members used the ED for care that was primarily related to a BH condition

The selection of the Care Transition Teams option was very strongly supported, in particular because of the lessons learned through the experiences of the Community Care Teams (CCTs) we have described previously. With two CCTs in full operation (one in each county in Region Six), the successful implementation of these unfunded multi-stakeholder initiatives clearly supports the feasibility and potential for a more formalized Critical Time Intervention model. CCTs experiences to date have demonstrated that the majority of the highest frequency visitors present with BH conditions that are complicated by unstable housing or homelessness.

Our Workgroup will further develop specific outcomes to be targeted through this project, however among those we anticipate include:

- Reduction in re-hospitalizations
- Reduction in overall ED utilization
- Reduction in ED utilization for conditions potentially treatable by Primary Care
- Reduction in ED utilization for care that was primarily related to a BH condition
- More efficient alignment among and between existing care plans
- Improved integration with non-clinical supports, like housing, transportation, childcare, food security, etc.

### **13b. Participating organizations-selection criteria**

This process will be guided through the actions of our Care Transitions Workgroup. As with all of our workgroups, the Care Transitions Workgroup will be comprised of multiple stakeholders from every relevant sector in the IDN, including consumers and their support networks. In keeping with our core principles, our recruitment strategy is designed to be transparent and inclusive. To uphold these principles in our outreach efforts, we are crafting a description that includes the objectives, timelines, draft meeting schedules and deliverables of each Workgroup, as well as the responsibilities and expectations that come with participation.

As part of the Response to Invitation we will recruit through outreach via will recruit through outreach and open solicitation to our All Partners meetings and communications, our website, multiple listservs, as well as existing multi-stakeholder groups we engaged in our Community Outreach efforts, such as Community Care Teams and the Prevention, Treatment and Recovery Roundtable, etc. Once assembled the Workgroup can further determine which partners and who within them will be committed, and what experience and skills may remain unrepresented and still needed in the workgroup, whereupon we will conduct further recruitment accordingly.

As a hospital based initiative a key to the eventual agency identification and inclusion will be influenced by which hospital(s) agree to participate. There are four hospitals in our region. Two of those, Portsmouth Regional and Frisbie Memorial, already serve as homes to the two Community Care Teams that are operating in our region. A third, Exeter Hospital, has recently joined one of the CCTs, but is not yet a committed partner in our IDN. A fourth, Wentworth Douglass Hospital, is still working through the internal compliance process to join the CCT in Strafford County.

While no agency or organization can be required or compelled to participate, once we have commitment from one or more hospitals to participate in this project, we are confident that a broad range of IDN stakeholder organizations will be prepared to join. The CCT model is experience very broad-based participation from multiple clinical and non-clinical sectors. In total, forty-four (44) agencies and organizations are listed on the combined Release of Information form that members sign to authorize the coordination of their care and support. Eventual participation will also be shaped by the geographic correspondence of agency service areas to participating hospitals.

### **13c. Participating organizations-list of organizations: workbook**



### 13d. Monitoring plan

As with other IDN projects, it is premature to fully describe a monitoring process for a project that is not yet fully developed. Likewise, our monitoring efforts will need to be agile to accommodate a very diverse range of stakeholder agency sizes, existing capacities and cultures. Part of our monitoring efforts will entail the provision of training and capacity building to agencies that may have data collection and reporting systems that are under-developed, misaligned, or non-existent.

We will benefit greatly from the anchoring of this project in the well-established evidence-based Critical Time Intervention model. There is a considerable knowledge base from which to draw in the design, implementation, support, monitoring and evaluation of CTI. At the project level we will be interested to track such indicators as patient acuity, caseloads, fidelity to phases, etc. We will use these indicators in conjunction with patient outcomes to conduct continuous quality improvement. Patient outcomes will include, among others to be identified:

- ED utilization
- ED utilization for conditions potentially treatable by Primary Care
- ED utilization for care that was primarily related to a BH condition
- Indicators of patient stability (i.e. medication adherence, etc.)

This project will especially be interested to facilitate and track improved integration with non-clinical supports, like housing, transportation, childcare, food security, etc.

In consultation with the Integration, Workforce and HIT Workgroups, the Operations Team and our Care Transitions Workgroup will work closely together to support the Region Six IDN to reach Q1/Q2 2017 Milestones, including but not limited to efforts to:

- Develop a detailed Implementation Plan, including timeline, budget, workforce assessment and capacity building, project specific HIT assessment and capacity building, agency and staff recruitment and onboarding, workflows, roles and responsibilities, leadership and communications plan, etc.
- Develop Timeline and Milestones for the creation of assessment and screening tools protocols for assessment, shared care plans, referrals, etc.
- Advise Operations Team and Executive Committee on the development of Universal Standards for participating Organizations, including performance monitoring
- Develop training plans tailored to participating agency sectors to meet identified needs, requirements, competencies (including specialties, cross-training)
- Develop model for continuous input on challenges and proposed solutions to address evaluation plan
  - Key Metrics to be used as indicators for targeted population identification and outcomes
  - Develop Continuous Improvement Process Tools
- Identify Resources and Budgeting Needs and make Recommendations to the Executive Committee

Support the development of MOUs (for information/data sharing, referrals, etc.)

### **13e. Challenges and proposed solutions**

We have identified a number of potential challenges and/or barriers to full Care Transitions implementation in our early stages. More importantly, we will be better equipped to identify more specific, tangible barriers and opportunities to overcome those barriers when we are walking through detailed project design in Q1 and Q2 of 2017 with all of the stakeholders engaged in the process.

We are especially well positioned to predict and address potential barriers and challenges in this project due to the accumulated lessons we have learned from CCTs. Again, we must first identify and enlist hospital(s) participation. If the hospital is already hosting a CCT, we must work through the process of onboarding this model. Since CCTs are unfunded, there is no risk of supplanting, but it may be the case the CCTs will be willing to transition into adopting this model. Several of the challenges identified previously are relevant to this project as well, for example:

- Lack of an internal champion (at the hospital level is very important)
- Wide range of capacity or mechanisms for sharing data amongst partners
- Ability to address regulatory or policy barriers
- Competing service models and associated cultures within participating organizations (i.e. individual versus team)
- Discontinuity in program development timelines, for example: building the system and reporting standards based on metrics in advance of knowing identified performance metrics
- Balancing administrative burden vs. client and practice benefits
- Sustained commitment by leadership in IDN, provider and sectors

We are currently focused on the development of a Workgroup infrastructure that is well equipped to reliably anticipate and identify challenges and potential barriers specific to our project plans as they are being created. Likewise, this Workgroup infrastructure will be instrumental in advising response strategies and monitoring of those efforts.

### **13f. Implementation approach and timing: workbook**

## **Q14. Community-Driven Project #2 D3: Expansion in Intensive SUD Treatment Options, Including partial-hospital and residential care**

### **14a. Project selection rationale and expected outcomes**

Substance use services utilization data were difficult to employ as a basis of decision-making since the landscape of treatment delivery and reimbursement has changed significantly since the December 31, 2015 cutoff date. We did, however consider those data in conjunction with the comprehensive Needs Assessment and considerable community stakeholder input we solicited and received.

- We found consistent reporting of inadequate capacity for every modality of treatment, including Intensive Outpatient, MAT in Primary Care and other settings, partial hospitalization, short term and long term residential care, and treatment tailored for specific populations, such as women, pregnant and new mothers, youth of all ages, elderly, those with co-occurring mental health conditions
  - Availability of, and integration with recovery supports
  - Participation and retention undermined by lack of child care and/or transportation
  - Lack of co-location, or poor coordination with mental health, primary care, specialty care and/or social and supportive services
  - Lack of cross-training of clinicians and support staff to address multiple domains relevant to comprehensive SUD treatment
  - Families and informal caregivers report barriers to ability to offer support based on privacy regulations
  
- Analysis of our systematic feedback on Community Project Menu options indicated the highest support for the Expansion of Intensive SUD Treatment option among all SUD options. In total, 50% of respondents ranked this option #1 and 38% ranked it #2 in this category.

Among the efforts to be implemented and guided by the Workgroup include a comprehensive, up-to-date scan of SUD treatment capacity in Region Six. The scan will include not only current SUD services and capacity among stakeholders, but also assessments of readiness and capacity to expand services. This assessment, in conjunction with updated population data that we anticipate receiving, and our existing gaps and assets assessments will then lead us to selecting Intensive Outpatient, and/or partial hospitalization, and/or residential treatment services to be included in our projects.

Only after our systematic and thorough project selection process will we be in a position to identify the specific outcomes that we hope to target and achieve through this/these projects. At a very high level we are likely to be interested to measure indicators related to:

- Increased availability of intensive SUD treatment options in Region 6
- Increased access intensive SUD treatment options in Region 6
- Reduction in hospitalization associated with SUD
- Reduction in arrests and/or incarceration associated with SUD
- Decrease in psychiatric symptoms for individuals with co-occurring mental health conditions.
- Decrease in a range of other negative consequences of substance misuse

#### **14b. Participating organizations-selection criteria**

This process will be guided through the actions of our Intensive SUD Treatment Capacity Workgroup (SUD Workgroup). As with all of our workgroups, the SUD Workgroup will be comprised of multiple stakeholders from every relevant sector in the IDN, including consumers and their support networks. In keeping with our core principles, our recruitment strategy is designed to be transparent and inclusive. To uphold these principles in our outreach efforts, we are crafting a description that includes the objectives, timelines, draft meeting schedules and deliverables of each Workgroup, as well as the responsibilities and expectations that come with participation.

As part of the Response to Invitation we will recruit through outreach via will recruit through outreach and open solicitation to our All Partners meetings and communications, our website, multiple listservs, as well as existing multi-stakeholder groups we engaged in our Community Outreach efforts, such as Community Care Teams and the Prevention, Treatment and Recovery Roundtable, etc. Once assembled the Workgroup can further determine which partners and who within them will be committed, and what experience and skills may remain unrepresented and still needed in the workgroup, whereupon we will conduct further recruitment accordingly.

Again, the identification of eventual projects to be selected, and the organizations that will be included in those efforts will be determined through a systematic process. The process will begin with an up-to-date scan of SUD treatment capacity in Region Six. The scan will include not only current SUD services and capacity among stakeholders, but also assessments of readiness and capacity to expand services. This assessment, in conjunction with updated population data that we anticipate receiving, and our existing gaps and assets assessments will then lead us to selecting Intensive Outpatient, and/or partial hospitalization, and/or residential treatment services to be included in our projects.

While no agency or organization can be required or compelled to participate, the existence and enthusiastic participation of numerous cross-sector groups and efforts focused on SUD in our region make us confident that a broad range of IDN stakeholder organizations will be prepared to join. The CCT model is experience very broad-based participation from multiple clinical and non-clinical sectors. And again, eventual participation will also be shaped by the geographic correspondence of agency service areas to participating hospitals.

#### **14c. Participating organizations-list of organizations: workbook**

## 14d. Monitoring plan

As with other IDN projects, it is premature to fully describe a monitoring process for a project that is not yet fully developed. Likewise, our monitoring efforts will need to be agile to accommodate a very diverse range of stakeholder agency sizes, existing capacities and cultures. Part of our monitoring efforts will entail the provision of training and capacity building to agencies that may have data collection and reporting systems that are under-developed, misaligned, or non-existent.

At the project level we will be interested to track such indicators as patient acuity, caseloads, fidelity to evidence-based practice, etc. We will use these indicators in conjunction with patient outcomes to conduct continuous quality improvement. There would be both similarities and differences among targeted outcomes for the three models of intensive SUD treatment supported by the IDN.

- Increased stable remission of substance misuse among members enrolled in intensive SUD services.
- Reduction in hospitalization associated with SUD
- Reduction in arrests and/or incarceration associated with SUD
- Decrease in psychiatric symptoms for individuals with co-occurring mental health conditions.
- Decrease in a range of other negative consequences of substance misuse

This project will especially be interested to facilitate and track improved integration with non-clinical supports, like housing, transportation, childcare, food security, etc.

In consultation with the Integration, Workforce and HIT Workgroups, the Operations Team and our Care Transitions Workgroup will work closely together to support the Region Six IDN to reach Q1/Q2 2017 Milestones, including but not limited to efforts to:

- Develop a detailed Implementation Plan, including timeline, budget, workforce assessment and capacity building, project specific HIT assessment and capacity building, agency and staff recruitment and onboarding, workflows, roles and responsibilities, leadership and communications plan, etc.
- Develop Timeline and Milestones for the creation of assessment and screening tools protocols for assessment, shared care plans, referrals, etc.
- Advise Operations Team and Executive Committee on the development of Universal Standards for participating Organizations, including performance monitoring
- Develop training plans tailored to participating agency sectors to meet identified needs, requirements, competencies (including specialties, cross-training)
- Develop model for continuous input on challenges and proposed solutions to address evaluation plan
  - Key Metrics to be used as indicators for targeted population identification and outcomes
  - Develop Continuous Improvement Process Tools
- Identify Resources and Budgeting Needs and make Recommendations to the Executive Committee
- Support the development of MOUs (for information/data sharing, referrals, etc.)

## **14e. Challenges and Proposed Solutions**

We have identified a number of potential challenges and/or barriers to the expansion of intensive SUD treatment options in the early stages of our development. More importantly, we will be better equipped to identify more specific, tangible barriers and opportunities to overcome those barriers when we are walking through detailed project design in Q1 and Q2 of 2017 with all of the stakeholders engaged in the process.

We are especially well positioned to predict and address potential barriers and challenges in this project due to the high degree of participation in IDN activities among practically all of the potential major stakeholders that would likely be integral to this project(s). Several of the challenges identified previously are relevant to this project as well, for example:

- Wide range of capacity or mechanisms for sharing data amongst partners
- Ability to address regulatory or policy barriers
- Competing service models and associated cultures within participating organizations (i.e. individual versus team)
- Discontinuity in program development timelines, for example: building the system and reporting standards based on metrics in advance of knowing identified performance metrics
- Balancing administrative burden vs. client and practice benefits
- Some potential participating agencies already at capacity (however may benefit from expanded complementary services)
- Sustained commitment by leadership in IDN, provider and sectors

We are currently focused on the development of a Workgroup infrastructure that is well equipped to reliably anticipate and identify challenges and potential barriers specific to our project plans as they are being created. Likewise, this Workgroup infrastructure will be instrumental in advising response strategies and monitoring of those efforts.

## **14f. Implementation approach and timing: workbook**

## **Q15. Community-Driven Project #3 E5: Enhanced Care Coordination for High-Need Populations**

### **15a. Project selection rationale and expected outcomes**

This project aims to develop comprehensive care coordination/management services for high need adult and child populations with multiple physical health and behavioral health chronic conditions.

- Of the 11,414 members identified in our attributable population, 92% (10,512) also reported a physical health condition

Our scan of existing needs assessments and the available Medicaid data, triangulated with community feedback, strongly supported the rationale for this project. We have also begun to receive requested agency level Medicaid claims data that provisionally indicate that the data books we have received may considerably underestimate the proportion of our Medicaid population with multiple behavioral health and physical health conditions and needs. We will continue to collect agency/organization level data, and we look forward to more recent and granular detailed data books to understand our current population characteristics in order for our Care Coordination Workgroup to deliberate and make informed recommendations.

There is considerable affinity between this community based project and our Integrated Care (Core Competency) efforts. It is premature to identify specific outcome measures, but at a high level we will task the Care Coordination Workgroup with defining our approach to demonstrating that these coordinated services will:

- Improve consumer awareness of, connection to, and engagement with the constellation of clinical and non-clinical services in their region/network.
- Maintain or improve an individual's functional status
- Increase that individual's capacity to self-manage their condition
- Improve efficiency and eliminate unnecessary or duplicative services, like clinical testing
- Meaningfully and measurably address the non-clinical social factors that constrain or create barriers to health improvement, and reduce the need for acute care services

## **15b. Participating organizations-selection criteria**

This process will be guided through the actions of our Care Coordination Workgroup. As with all of our workgroups, the Care Coordination Workgroup will be comprised of multiple stakeholders from every relevant sector in the IDN, including consumers and their support networks. In keeping with our core principles, our recruitment strategy is designed to be transparent and inclusive. To uphold these principles in our outreach efforts, we are crafting a description that includes the objectives, timelines, draft meeting schedules and deliverables of each Workgroup, as well as the responsibilities and expectations that come with participation.

As part of the Response to Invitation we will recruit through outreach via will recruit through outreach and open solicitation to our All Partners meetings and communications, our website, multiple listservs, as well as existing multi-stakeholder groups we engaged in our Community Outreach efforts, such as Community Care Teams and the Prevention, Treatment and Recovery Roundtable, etc. Once assembled the Workgroup can further determine which partners and who within them will be committed, and what experience and skills may remain unrepresented and still needed in the workgroup, whereupon we will conduct further recruitment accordingly.

Again, the identification of eventual projects to be selected, and the organizations that will be included in those efforts will be determined through a systematic process. The process will begin with an up-to-date scan of existing care coordination initiatives in Region Six. The scan will include not only current initiatives and capacity among stakeholders, but also assessments of readiness and capacity to expand services. This assessment, in conjunction with updated population data that we anticipate receiving, and our existing gaps and assets assessments will then lead us to selecting Intensive Outpatient, and/or partial hospitalization, and/or residential treatment services to be included in our projects.

While no agency or organization can be required or compelled to participate, the existence and enthusiastic participation of numerous cross-sector groups and efforts in our region make us confident that a broad range of IDN stakeholder organizations will be prepared to join. The CCT model is experience very broad-based participation from multiple clinical and non-clinical sectors. And again, eventual participation will also be shaped by the geographic correspondence of key identified agencies and their respective service areas.

## **15c. Participating organizations-list of organizations: workbook**



## 15d. Monitoring plan

As with other IDN projects, it is premature to fully describe a monitoring process for a project that is not yet fully developed. Likewise, our monitoring efforts will need to be agile to accommodate a very diverse range of stakeholder agency sizes, existing capacities and cultures. Part of our monitoring efforts will entail the provision of training and capacity building to agencies that may have data collection and reporting systems that are under-developed, misaligned, or non-existent.

In consultation with the Integration, Workforce and HIT Workgroups, the Operations Team and our Care Transitions Workgroup will work closely together to support the Region Six IDN to reach Q1/Q2 2017 Milestones, including but not limited to efforts to:

- Develop a detailed Implementation Plan, including timeline, budget, workforce assessment and capacity building, project specific HIT assessment and capacity building, agency and staff recruitment and onboarding, workflows, roles and responsibilities, leadership and communications plan, etc.
- Develop Timeline and Milestones for the creation of assessment and screening tools protocols for assessment, shared care plans, referrals, etc.
- Advise Operations Team and Executive Committee on the development of Universal Standards for participating Organizations, including performance monitoring
- Develop training plans tailored to participating agency sectors to meet identified needs, requirements, competencies (including specialties, cross-training)
- Develop model for continuous input on challenges and proposed solutions to address evaluation plan
  - Key Metrics to be used as indicators for targeted population identification and outcomes
  - Develop Continuous Improvement Process Tools
- Identify Resources and Budgeting Needs and make Recommendations to the Executive Committee
- Support the development of MOUs (for information/data sharing, referrals, etc.)

This project will aim to operationalize and monitor the facilitation and tracking of improved coordination among clinical and non-clinical supports, like housing, transportation, childcare, food security, etc. We will review and employ established care coordination indicators and seek opportunities to enhance or customize our monitoring efforts in conjunction with patient outcomes to conduct continuous quality improvement. Some sample fields of indicators for care coordination include:

- Conducting standardized assessments
- Establishing person-centered plans of care
- Tracking timely transitions
- Medication reconciliation
- Adoption of HIT and transfers
- Tracking of clinical goals measures/indicators (condition/disease specific or non-specific)
- Tracking of non-clinical goals measures/indicators
- Monitoring follow-up and response

## **15e. Challenges and proposed solutions**

Our stakeholders have identified a number of potential challenges and/or barriers to care coordination for high needs populations in the early stages of our development. Moore importantly, we will be better equipped to identify more specific, tangible barriers and opportunities to overcome those barriers when we are walking through detailed project design in Q1 and Q2 of 2017 with all of the stakeholders engaged in the process.

We are especially well positioned to predict and address potential barriers and challenges in this project due to the high degree of participation in IDN activities among practically all of the potential major stakeholders that would likely be integral to this project(s). Several of the challenges identified previously are relevant to this project as well, for example:

- Wide range of capacity or mechanisms for sharing data amongst partners
- Ability to address regulatory or policy barriers
- Competing service models and associated cultures within participating organizations (i.e. individual versus team)
- Discontinuity in program development timelines, for example: building the system and reporting standards based on metrics in advance of knowing identified performance metrics
- Balancing administrative burden vs. client and practice benefits
- Some potential participating agencies already at capacity (however may benefit from expanded complementary services)
- Sustained commitment by leadership in IDN, provider and sectors

We are currently focused on the development of a Workgroup infrastructure that is well equipped to reliably anticipate and identify challenges and potential barriers specific to our project plans as they are being created. Likewise, this Workgroup infrastructure will be instrumental in advising response strategies and monitoring of those efforts.

## **15f. Implementation approach and timing: workbook**