



**MYERS AND
STAUFFER** LC
CERTIFIED PUBLIC ACCOUNTANTS

NH 1115 WAIVER – *BUILDING CAPACITY FOR TRANSFORMATION*

INDEPENDENT REVIEW PANEL – DECEMBER 12, 2016

DEDICATED TO GOVERNMENT HEALTH PROGRAMS



Meeting Agenda

- Introduction
 - Building Capacity for Transformation Overview
 - Independent Assessor Team and Responsibilities
 - IRP Purpose and Responsibilities
- Review IA Processes
- Review Summary of IDN Preparedness:
 - Region 1
 - Region 2
 - Region 3

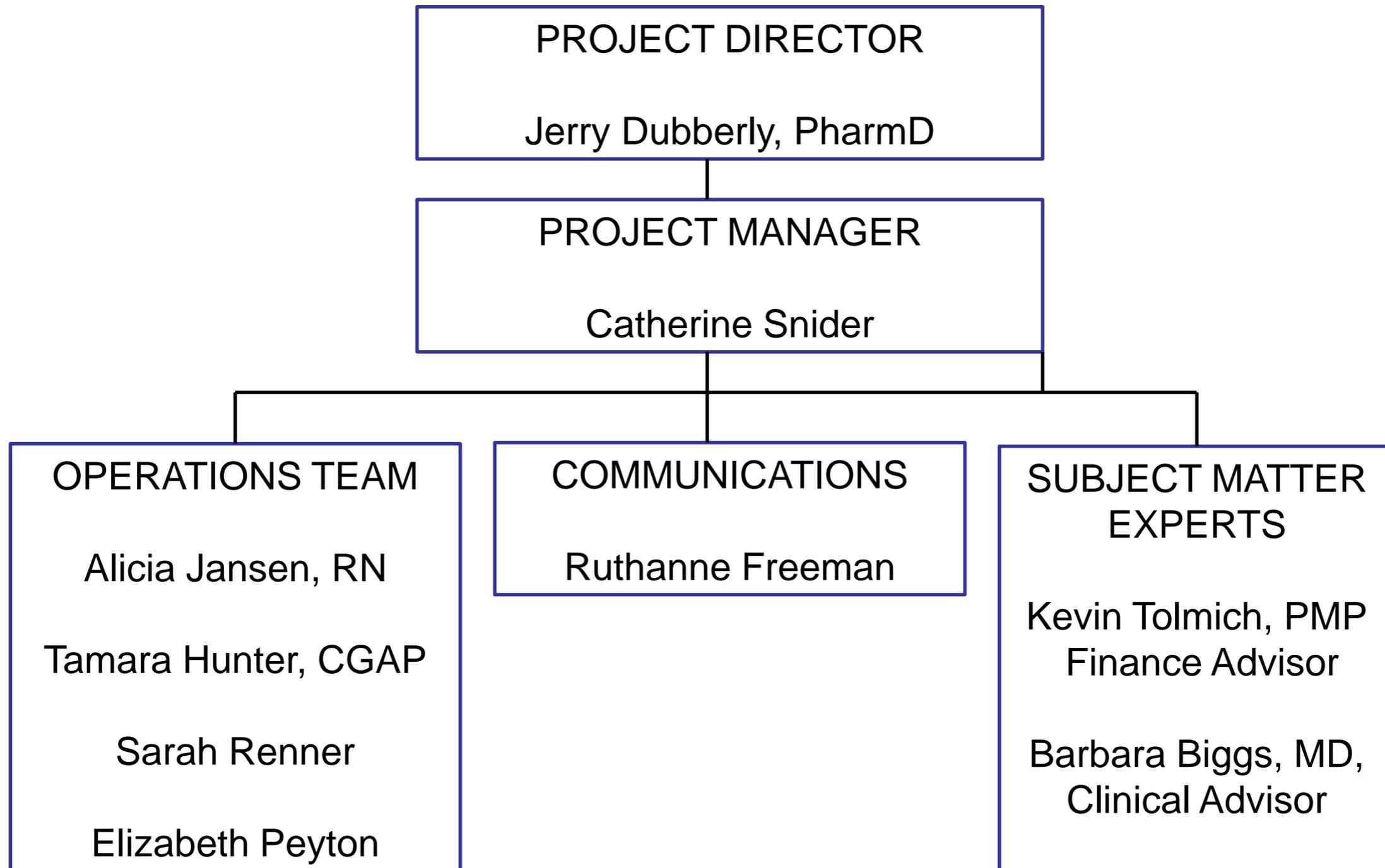
Building Capacity for Transformation

Under the DSRIP demonstration, the state will make performance-based funding available to regionally-based Integrated Delivery Networks (IDNs) that serve Medicaid beneficiaries with the goal to:

- ✓ Strengthen community-based mental health services.
- ✓ Combat the opioid crisis.
- ✓ Drive health care delivery system reform.



Consulting Team





12 Standard Terms and Condition (STC) Waiver Requirements

1. IDN Behavioral Health (Mental Health and Substance Use Disorder) Community Needs Assessment
2. IDN Community Engagement
3. IDN Composition
4. IDN Governance
5. Financial governance and funds allocation
6. Clinical governance
7. Data/Information Technology
8. Workforce capacity
9. IDN Project Selection
10. Implementation Timeline and Project Milestones
11. Project Outcomes
12. IDN Assets and Barriers to Goal Achievement



Key IRP Questions

Process

- Was an independent review performed?
- Were opportunities for correction available?
- Was the scoring methodology clearly defined?

IDN Preparedness

- Do all IDNs Project Plans meet the 12 Project Plan STC requirements?
- Are all IDNs ready to participate in statewide projects to support DSRIP goals?
- Are all IDNs ready to participate in the core competency project to integrate behavioral health and physical health goals?
- Are all IDNs ready to design community projects to support DSRIP goals?

Independent Assessor Responsibilities

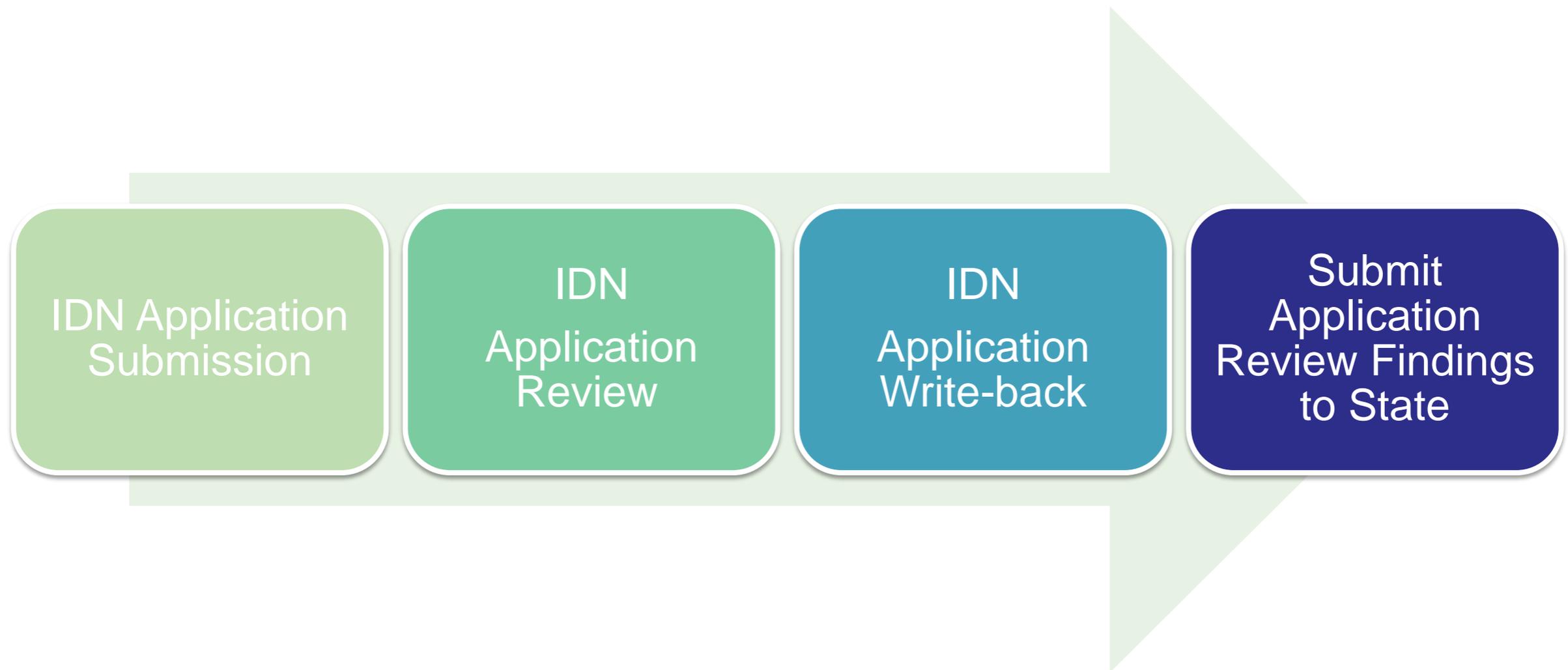
- ***Conduct an impartial review of all proposed Integrated Delivery Network (IDN) applications.***
- ***Submit IDN application approval recommendations to the State including identifying weaknesses and gaps in applications.***
- Provide technical assistance to the IDNs in the development of their Project Plans.
- Conduct a review of all proposed IDN project plans.
- Assemble an Independent Review Panel (IRP) to evaluate the project plan submission and review proceedings.
- Submit IDN Project Plan approval recommendations and IRP findings to the State.

Application Review

Each application was reviewed for completeness and scored on the following:

- Qualifications and capabilities of the Administrative Lead.
- Composition and breadth of the proposed network.
- Comprehensive community and stakeholder engagement plan / process.
- Plan's understanding of regional behavioral health needs faced by Medicaid beneficiaries.
- Evaluation of the project plan development process.

Application Review Process



Application Review Look-back

- June 1, 2016 – Independent Assessor (IA) contract signed and kick-off meeting held with state.
- June 2, 2016 – Application submissions were transmitted to Myers and Stauffer.
- June 6, 2016 – Independent Assessor introduction webinar held to review the IA responsibilities and application review processes.
- June 9, 2016 – State approved final application review methodology based on the Manatt, Phelps & Phillips, LLP application tool.
- June 20, 2016 – Each of the 7 Administrative Lead applicants received a first request for additional information – “write-back.”
 - Applicants were given three business days to respond and offered the opportunity to speak with a member of the MSLC Application Review team.
- June 24, 2016 – 2 applicants received a second write-back and conference calls were held.
- June 30, 2016 – All review materials submitted to DHHS. Final application report and recommendations submitted to DHHS.

Key Application Review Findings

- Based on final application scores, MSLC recommended all Administrative Lead applicants PASS.
- Overall, the applications received an average score of 81.8, with a range between 77.5 and 85.
- Statewide, singular IDN coverage.

Independent Assessor Responsibilities

- Conduct an impartial review of all proposed Integrated Delivery Network (IDN) applications.
- Submit IDN application approval recommendations to the State including identifying weaknesses and gaps in applications.
- ***Provide technical assistance to the IDNs in the development of their Project Plans.***
- ***Conduct a review of all proposed IDN project plans.***
- Assemble an Independent Review Panel (IRP) to evaluate the project plan submission and review proceedings.
- Submit IDN Project Plan approval recommendations and IRP findings to the State.

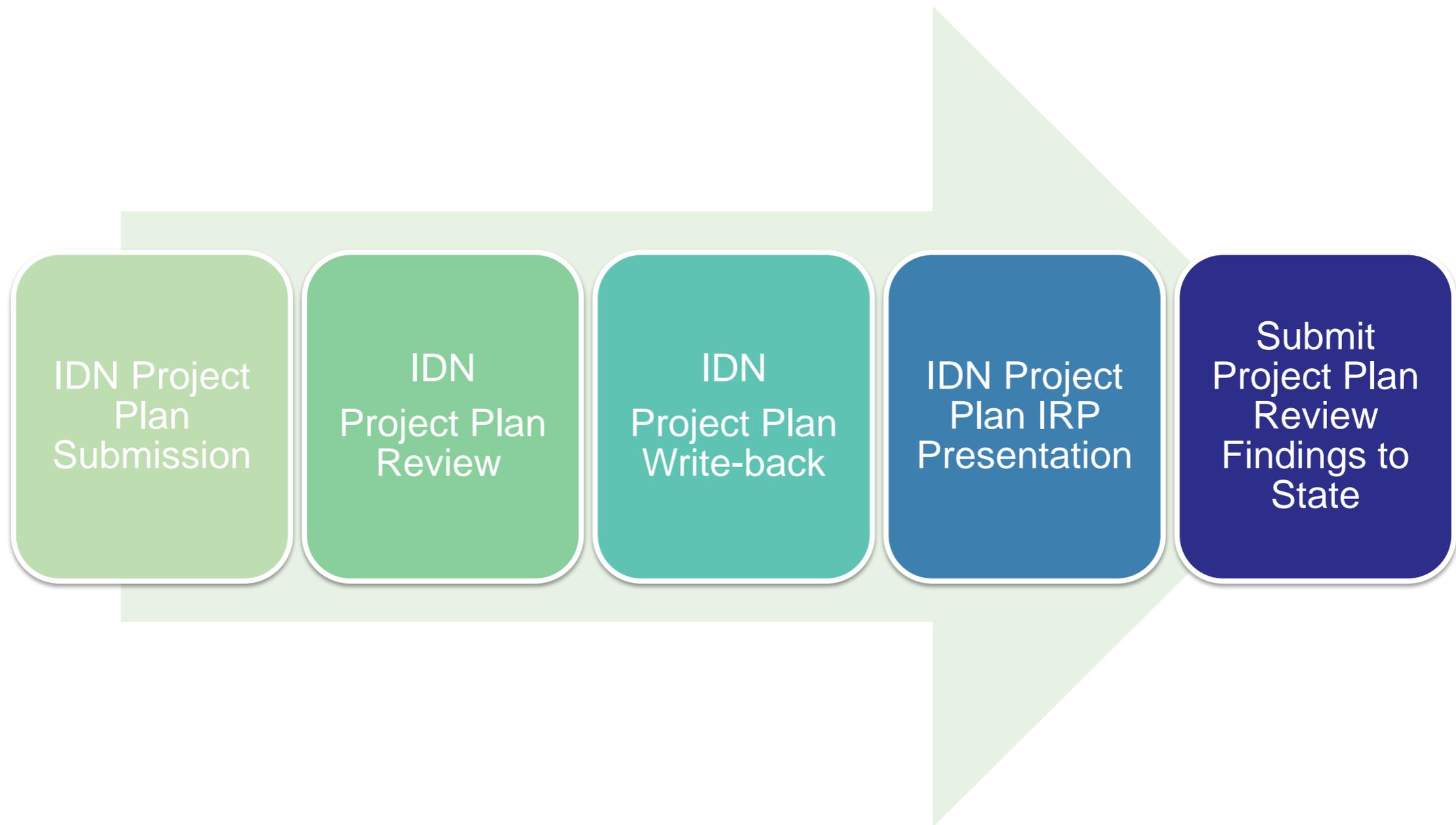
Project Plan Review

Each project plan was reviewed for completeness and scored on the following:

- Submission of a blueprint of the work that an IDN will undertake through the implementation of six projects.
- Work responds to community-specific needs and furthers the objectives of the demonstration.
- Provides details on the IDN's composition and governance structure.
- Supports the IDN in complying with other terms and conditions of participation in the demonstration.
- Incorporates community stakeholders engagement.



Project Plan Review Process



Project Plan Review Scoring

- Manatt, Phelps & Phillips, LLP developed with DHHS a project plan review template to be completed and submitted for IA review.
- IDN Project Plan Scoring Framework
 - The Project Plan is scored out of a possible 500 points
 - Section 1: IDN- level plan is out of 200 points
 - Section 2: Project-level plans is out of 300 points

Project Plan Review Scoring

- Section 1: IDN- level plan is out of 200 points

Question	Total Available Points
Vision Statement	10
IDN Service Area Community Needs Assessment	30
Community Engagement and Stakeholder Input	20
Network Composition	10
Relationship with Other Initiatives	10
Impact on Opioid Crisis	15
IDN Governance	50
Budget and Funds	50
Alternative Payment Models	5
Total	200

Project Plan Review Scoring

- Section 2: Project-level plans is out of 300 points

Question	Total Available Points
Project A1: Behavioral Health Workforce Capacity Development	25
Project A2: Health Information Technology (HIT) Infrastructure to Support Integration	25
Project B1: Integrated Health (Core Competency)	100
Community Drive Project #1	50
Community Drive Project #2	50
Community Drive Project #3	50
Total	300



Project Plan Review Scoring

- High/ Medium/ Low/ Incomplete Score
 - H/M/L Score rubric was developed based on the relevance to the question to ensure objective scoring between reviewers.
 - Training on relevant materials and scoring rubric was completed.
- Level 1 Reviewer
 - Reviewed all materials.
 - Evaluated and completed all scores.
 - Drafted initial write-backs.
- Level 2 Reviewer
 - Reviewed all deficiencies noted by Level 1 reviewer.
 - Reviewed all relevant materials.
 - Reviewed all scores with incomplete, or score lower than high.
 - Any deviation between reviewer scores was discussed and resolved or escalated.
 - Evaluated/ edited write-back draft.

Project Plan Review Look-back

- July 22, 2016 – DHHS approved the Project Plan Point Value recommendations.
- August 9, 2016 – DHHS approved the Project Plan Review Tool.
- August 31, 2016 – Independent Assessor holds project plan review webinar with IDN Administrative Leads to review each of the project plan requirements and offer tips for ensuring that all elements are addressed.
- September 21-29, 2016 – Myers and Stauffer conducted one-on-one calls with the IDNs to discuss the Project Plans and to answer any questions the IDNs had about the process or their plans.
- October 4-5, 2016 – Myers and Stauffer conducted one-one-one in-person meetings with the IDNs to continue to answer any questions the IDNs had about the development of their plans.
- October 31, 2016 – Project plan submissions were transmitted to Myers and Stauffer.
- November 14, 2016 – Each IDN received a write-back and conference calls were held.
 - IDNs were given approximately five business days to respond. All IDNs had a call to walk through every write-back question to affirm their understanding of the question. Extensions were approved for two IDNs. One IDN had a second write-back.
- December 5, 2016 – All write-back responses received and final scores completed.

Key Project Plan Review Findings

- Based on final application scores, MSLC recommended all Project Plan Reviews PASS.
- Overall, the applications received an average score of 86.2%, with a range between 70.3% and 100%.

Key Project Plan Review Findings

Number of Organizations Participating:

Approximately 250 Unique Providers

Provider Type Categories	Provider Counts
Community Mental Health Center	16
Community Based Organization Providers - Social & Support Services	65
County Corrections Facilities	9
County Nursing Facilities	11
FQHC	35
Home and Community Based Care	30
Hospitals	55
Non-CMHC Mental Health Providers	12
Other Organization Types*	68
Primary Care Practice	74
Public Health Organizations	13
Substance Use Disorder	18
Total Partner Locations	406

*Other organizational types includes 18 other designations of organizations.

Key Project Plan Review Findings

Summary of Selected Community Needs Projects

Project #	Project Title	Counts
C1	Care Transition Teams	5
C2	Community Re-entry Program for Justice-Involved Adults and Youth	2
D1	Medication Assisted Treatment of Substance Use Disorders	1
D3	Expansion in Intensive SUD Treatment Options	6
E4	Integrated Treatment for Co-Occurring Disorders	2
E5	Enhanced Care Coordination for High Need Population	5



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IDN 1 PROJECT PLAN

Mary Hitchcock Memorial Hospital

Monadnock, Sullivan and Upper Valley

IDN 1 – Monadnock, Sullivan, and Upper Valley

- Administrative Lead
 - Mary Hitchcock Memorial Hospital – Dr. Sally Kraft
- Attributable Lives
 - 27,980
- Overall Score of the Project Plan
 - Totals 351/500 70.3% **PASS**

IDN 1 Project Plan Review

Section 1: IDN- Level Plan

Vision Statement

- The Region 1 IDN envisions a system of care that creates better health outcomes and quality of life for our Medicaid population with behavioral health challenges, primarily through improvements in integration, coordination, effectiveness and cost effectiveness of services and supports.

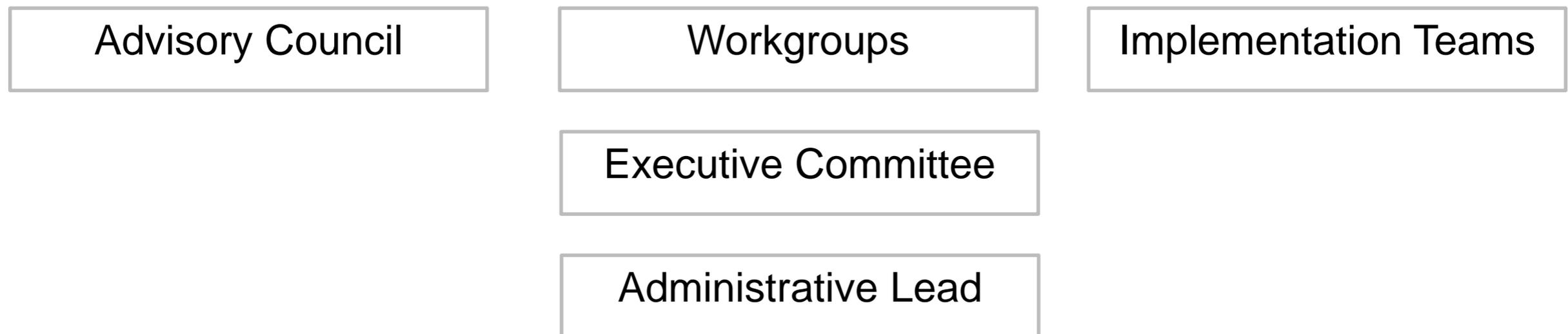
Community Needs Assessment

- Medicaid represents about 14.5% of the population in Region 1.
- About 1/3rd of the Medicaid population in this region showed evidence of having a behavioral health condition.
- Residents are mostly similar to the NH population overall, meaning they are generally more healthy and socioeconomically stable compared to the U.S. population overall.
- The Greater Sullivan Public Health Network Region has substantially worse health indicators in several key areas including prevalence of diabetes, childhood asthma, smoking, and smoking during pregnancy.
- The City of Keene in particular is a 'hotspot' in Region 1 of EMS calls involving Narcan administration.

Integrated Delivery Network (IDN)

Governance Structure

- The governance approach for the Region 1 includes a diverse and complementary set of structures with different levels of authority and differentiated, but complementary, tasks and accountabilities.
- Executive Director: Ann Naughton Landry - The Executive Committee is the primary governing body that provides clinical, financial, data and community engagement oversight.
 - *Clinical Governance*: Peter Mason
 - *Financial Governance*: Mark Russoniello
 - *Community Engagement*: Alice Ely/Greg Norman
 - *Data Governance*: Mary Beth Eldredge/Patricia Witthaus



IDN 1 Project Plan Review

Section 2: Project- Level Plan

Project A1: Behavioral Health Workforce Capacity Development

Project Lead: Peter Mason

IDN Workforce Challenges	Efforts to Address Challenges
<p>Discrepancy in workforce adequacy between rural and urban areas, with rural, low income patients underserved.</p>	<p>Utilizing a shared standardized health plan with clear delegation of activities so everyone is operating at top of licensure and skill set and working as a team on behalf of a patient.</p>
<p>High annual turnover rate of about 19% of the CMHC workforce due to low pay and understaffing.</p>	<p>Collaboration across social service, medical and specialty BH settings, perhaps with the addition of “patient navigator” roles, to provide direct assistance and/or to monitor systemic processes.</p>
<p>Lack of BH clinicians who can offer mental health and substance abuse services. Clinics desire 60% more clinicians than they have, and estimate 2x more needed in 5 years. This means Region 1 would need an additional 30 BH clinicians over the next 5 years.</p>	<p>Enhance both the specialty and primary care BH workforce as requiring training and technical assistance in best practices for clinical programming and for administrative support of the clinical work. Clinical best practices can be the backbone for creating flexibility and improved care.</p>

**Region 1’s workforce aspirations include empowering patients and their families with education and self-management skills to manage these chronic diseases.

IDN 1 Project Plan Review

Section 2: Project- Level Plan

Project A2: HIT Infrastructure to Support Integration

Project Co-Lead: Mary Beth Eldredge

Project Co-Lead: Patricia Witthaus

The methodology was to assess capabilities and gaps relative to information requirements of the IDN’s selected projects. 26 organizations were assessed through survey and interviews.

Critical HIT gaps	Efforts to Address HIT gaps
<p>Inter-organizational handoffs and records management.</p> <p>Functional capabilities of the work management applications vary widely across respondents:</p> <ul style="list-style-type: none"> ▪ 27 different applications are used among organizations. ▪ 15 of the applications in use are certified electronic health record technologies, while 6 are not. ▪ Several non-medical applications are in place for managing customers and workflow for organizations addressing social determinants of health including managing housing, independent living, and transportation. 	<ul style="list-style-type: none"> ▪ Shore up EHRs and work applications: Set and meet capability thresholds for EHRs and work applications. ▪ Interconnect orgs. Through multiple pathways: Promote connection and active use of Direct Messaging, DH-Connect, and EHR vendor inter-vendor connectivity solutions. ▪ Role out Shared Care Plan (with alerts): Implement Pre-Manage Community solution which includes a shared care plan and event notification service.



IDN 1 Project Plan Review

Section 2: Project- Level Plans

Project B1: Integrated Health

Goal Statement

Region 1 strives to develop and implement models that guide care delivery and improve health outcomes.

A central tool for addressing gaps in care and recruiting patients' active engagement in their own health is the **Person Centered Care Plan (PCCP)**. Key principles include communication across an integrated care team and placing the person at the center of that team.

The design of the PCCP will be one of the first elements in the implementation of the program and will be done with PCPs, BH providers, care managers, social services liaisons, and patient representatives at the table.

Monitoring Plan Summary

Region 1 anticipates measures that capture the following domains of care will be critical for managing performance:

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

Summary of Expected Outcomes:

- Number and % of persons with PCCPs completed
- % of self-identified goals that were accomplished by the patient
- % of PCCPs that patients were involved in creating and signed
- % care team rating the PCCP as an important tool in serving/providing care

IDN 1 Project Plan Review

Section 2: Project- Level Plans

Project B1: Integrated Health

Key Challenges

Proposed Solutions

Clinical cultures and practices that are not aligned with integrated health models.

Formation of Region 1 IDN, ongoing collaboration, provision of training and other resources to support practice transformation, availability of alternative payment models- all will help to create critical mass and culture shift.

Deficits in skills and roles needed to implement integrated health models.

Develop curriculum and other training resources through statewide DSRIP workforce initiative.

Lack of financial mechanisms to reimburse for integrated models of care.

Develop alternative, value-based payment models.

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

IDN 1 Project Plan Review

Section 2: Project- Level Plan

C1- Care Transition Teams

Project Selection Rationale

The following factors proved decisive in the Executive Committee's consensus to move forward with Care Transition Teams:

- 1) the fact that the cost of housing could not be reimbursed with DSRIP funds;
- 2) the stronger feasibility, reach, and flexibility of Care Transition Teams, especially if applied across transition contexts;
- 3) the potential to address at least the support side, of the supportive housing need, through the use of Care Transition Teams.

Challenges/ Proposed Solutions:

- Primary Challenges: Lack of Supportive Housing, lack of access to high quality services and support, sustainability beyond 2020.
- Proposed Solutions: Pursue housing grants to increase the supply of housing and leverage the Care Transition Teams, developing a regional directory of high quality services and supports, and demonstrate APM benefits.

IDN 1 Project Plan Review

Section 2: Project- Level Plan

C1- Care Transition Teams

Participating Organizations/ Implementation Framework

When disseminating funding for projects, Region 1 will utilize a **Request for Qualifications, followed by a Requests for Proposals** process to qualify partner organizations to receive IDN funds.

Region 1 will issue project specific requests with a preference for organizations to submit collaborative proposals that either serve the entire region or a specific Public Health Region. The Executive Committee will exercise authority to choose organizations for funding to support these projects based on the anticipated value to cost and level of integration to other initiatives.

➤ Organizations will be asked to demonstrate:

- Readiness to implement
- Commitment to using common program models, protocol, and data systems
- Ability to manage implementation projects
- Commitment to participate in Region 1 APM and to return funds if the organization withdraws from IDN prior to funds being spent.
- Readiness and commitment to work collaboratively
- Readiness to participate in regional/statewide work teams
- Commitment to incorporate expertise from regional/statewide partners
- Ability to manage sub-contracted funds
- An intention to align with Region 1's goals of maximizing and making highest use of existing clinical workforce to improve care and address non-clinical factors.
- A commitment to using patient-centered care and evidence-based practices

IDN 1 Project Plan Review

Section 2: Project- Level Plans

D3- Expansion in Intensive SUD Treatment Options

Project Selection Rationale

- The reach and flexibility for Expansion of Intensive SUD Treatment.
- Also, favoring Expansion of Intensive SUD Treatment were the potential to:
 - 1) Extend an existing Intensive Outpatient Treatment “bright spot” throughout the rest of the region.
 - 2) Offer MAT as part of the expansion of SUD treatment if warranted/desired.

Challenges/ Proposed Solutions:

- Primary Challenges: Licensing barriers, under utilization of services due to stigma/ low readiness, transportation barriers, population at high risk for suicide, lack of supportive housing, and sustainability beyond 2020.
- Proposed Solutions: Advocate for changes to licensing requirements, utilize motivational enhancing strategies, promote awareness of services and stigma reduction, replicate successful programs in all three regions and enhance transportation options, bring interventions to substance using populations, provide training and technical assistance with suicide prevention, leverage housing grants, and demonstrate APM benefits.

IDN 1 Project Plan Review

Section 2: Project- Level Plan

D3- Expansion in Intensive SUD Treatment Options

Participating Organizations/ Implementation Framework

When disseminating funding for projects, Region 1 will utilize a **Request for Qualifications, followed by a Requests for Proposals** process to qualify partner organizations to receive IDN funds.

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- A commitment to using patient-centered care and evidence-based practices

Project Selection Rationale

Care Coordination of High Needs Populations received higher estimates across the board.

- 1) It was viewed as an intervention that better fit with the needs of the community.
- 2) It would be more feasible to implement.
- 3) It would reach a higher proportion of the target population with a more potent intervention, partially through leveraging existing resources.

Challenges/ Proposed Solutions:

- Primary Challenges: Failing to address/implement suicide prevention best practices, traditional organizational boundaries, achieving cost/system outcomes without improving patient quality of life, excluding developmental disabilities expertise, lack of supportive housing, lack of access to high quality services, and long-term sustainability.
- Proposed Solutions: Provide training/technical assistance with suicide prevention, share care coordinators across the community, participant-centeredness, focus on self-management for patient, include developmental disabilities expertise in planning and implementing, leverage housing grants, and demonstrate APM benefits.

IDN 1 Project Plan Review

Section 2: Project- Level Plan

E5- Enhanced Care Coordination for High Need Population

Participating Organizations/ Implementation Framework

When disseminating funding for projects, Region 1 will utilize a **Request for Qualifications, followed by a Requests for Proposals** process to qualify partner organizations to receive IDN funds.

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- An intention to align with Region 1's goals of maximizing and making highest use of existing clinical workforce to improve care and address non-clinical factors.
- A commitment to using patient-centered care and evidence-based practices



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IDN 2 PROJECT PLAN

Capital Region Health Care (CRHC)

Capital

IDN 2 – Capital

- Administrative Lead
 - Riverbend Community Mental Health, Inc.- Peter Evers
- Attributable Lives
 - 20,239
- Overall Score of the Project Plan
 - Total: 391.5/500 78.3% **PASS**

Section 1: IDN-Level Plan

Vision Statement

- Their vision includes improving outcomes and increasing access to care for adult and youth populations (including those reentering from incarceration, pregnant women, and youth with developmental disabilities) across the capital area in a service-integrated continuum of care that addresses mental health, substance use disorders, and chronic/primary health care needs.

Summary of Community Needs Assessment

- Living in poverty or in a low-income household is another leading factor associated with vulnerability. Riverbend's population of focus is 45% low-income reflecting the level of dependence on disability supports in the SMI populations.
- Recently incarcerated: The NH Department of Corrections operates the NH State Prison for Men in Concord, which houses 1,488 men in a prison with a stated capacity of 928. The prison accepts maximum, medium, and minimum-security prisoners. Although NH's crime rate has been low and stable for the past ten years, the prison population has increased 31% and spending on corrections has nearly doubled over the same period.

Section 1: IDN-Level Plan

Governance Structure

The principle governance committee is the IDN Committee.

- CEO of Concord Hospital- Robert Steigmeyer
- CEO of Concord Regional VNA- Beth Sleplan
- CEO of Riverbend CMHC, Inc- Peter Evers

The Administrative Lead is Capital Region Health Care (CRHC) comprised of Concord Hospital, Riverbend Community Mental Health (Riverbend), and Concord Regional (CR) VNA.

Concord Hospital is overseeing financial management

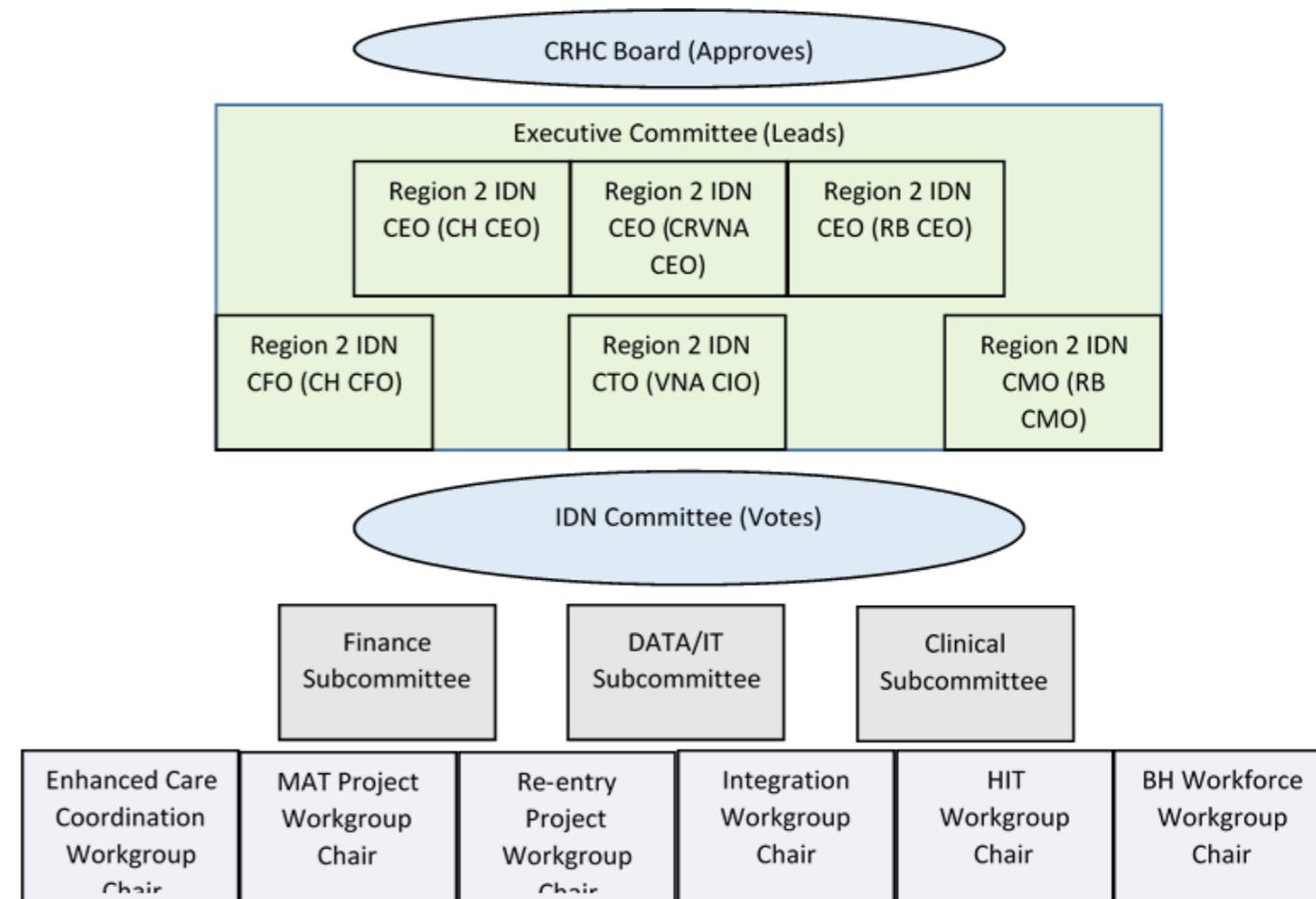
- CFO- Scott Sloane

Concord Regional VNA is overseeing the HIT

- CTO- Deb Mullen

Riverbend CMHC, Inc is overseeing the clinical aspects

- CMO- Osvaldo Evangelista



Section 2: Project Level Plans

Project A1: Behavioral Health Workforce Capacity Development

Project Lead: Peter Evers

IDN Workforce Challenges	Expected Efforts to Address Challenges
<p>Low staff morale Increased turnover Increased locums and overtime Increased overall cost of recruitment activities Increased training costs Decreased FFS revenues</p>	<p>Relax reciprocity requirements with other states Expand loan forgiveness Increase Medicaid rates beyond 2006 levels Provide incentives for graduate education Remove impediments to licensing of out-of-state providers Reduce administrative burden for patient intake other reporting functions Eliminate silos within NH DHHS Ask CMS to allow licensed professional to sign treatment plans for services within credentials cope Modify telehealth payment rules to reflect physician shortages in all geographies Eliminate “incident to” Medicare billing requirements for physician on-site</p>

Section 2: Project- Level Plans

Project A2: HIT Infrastructure to Support Integration

HIT Project Lead: Deb Mullen

Critical HIT gaps	Efforts to Address HIT gaps
Only 65% of IDN participants use an electronic medical record. Those not utilizing an EMR appear to be community service providers.	Direct Messaging
There are 7 different vendors in use across the IDN.	Secure Text Messaging
No participants have an electronic notification system in place to be alerted if their patient is admitted or discharged from the hospital, emergency department, or from other providers.	Admission, Discharge, Transfer Alerts
Only 55% of respondents are able to receive referral information electronically.	Community Referrals
E- prescribing.	Education
Interoperability with insurance payers.	Patient Portal
Lack of appropriate EMR for SUD charting.	Care Coordination across providers and the Emergency Department
Secure communication amongst providers.	

*Region 2 conducted a short survey amongst IDN participants

Section 2: Project- Level Plans

Project B1: Integrated Health

Goal Statement

Region 2 is aligned with the following goals from the Capital Area Community Health Improvement Plan, 2015-2020:

- Prevent and reduce substance misuse in the capital area by 2020
- Decrease the number of drug-related overdose deaths in the capital area among all age groups by 2019
- Promptly respond to and prevent harms associated with emerging drug threats in the capital area
- Improve access to a comprehensive, coordinated continuum of behavioral health care services in the capital area by 2020

Monitoring Plan Summary

A standard evaluation tool will be developed and implemented based on the expected DHHS outcome metrics. Education will be a key element of the integration project. Leaders from each organization will be given the tools to champion the project at their facilities.

Summary of Expected Outcomes:

- Increase in psychiatrists leading to reduced wait time and earlier intervention/treatment of MH needs through support to PCP.
- Behavioral health education for physicians leading to less stigma and earlier identification and treatment of BH needs.
- Suicide prevention education and depression screening through primary care providers leading to early treatment and intervention.
- Enhanced patient engagement in the integrated plan of care and improved utilization of treatment resources.
- Substance misuse prevention programs through CRPHN and SUD Continuum of Care leading to fewer adolescents with SUD.
- More sustained recovery through increase and availability of adult/youth behavioral health peer coaches.

Section 2: Project- Level Plans Project B1: Integrated Health

Key Challenges

- Services may overlap, be duplicated or work against each other
- Important aspects of care may not be addressed
- Sharing of information may not be systematic enough to effect overall patient care
- No guarantee information will change plan or strategy of each provider
- Referrals may fail due to barriers, leading to frustration
- System issues may limited collaboration
- Potential for tension and conflicting agendas among providers as practice boundaries loosen
- Sustainability may stress the practice

Proposed Solutions

- Communication
- Develop and present educational opportunities for all staff
- Education will continue through site visits during implementation



Section 2: Project- Level Plans

Community Driven Project #1

Project C2- Community Re-entry Program for Justice-Involved Adults and Youth

Goal Statement

Improve behavioral health and social outcomes for youth and adults transitioning from correctional facilities to the community.

Project Selection Rationale

The IDN decided to focus on reentry and either expand (if funded) or initiate the Reentry Program at the County House of Corrections. This program will provide both pre- and post-release services.

The Merrimack County Department of Corrections (MCDOC) and Riverbend applied for a Second Chance Act grant from the Department of Justice, Bureau of Justice Assistance for a Reentry Program for Adults with Co-Occurring Substance Abuse and Mental Disorders. Funding results have not been posted yet.

It was decided to include those coming from the State Prison to resettle in Concord as well as youth exiting from Sununu Youth Services Center. The IDN feels that while the numbers will be low, the needs will be intense. Most of those released from State Prison have maxed out their sentences and spent significant time in solitary confinement. Youth from Sununu Youth Services Center are likely to have multiple, complex needs.

Challenges/ Proposed Solutions:

- Primary Challenges: time, technology, and the availability of workforce
- Proposed Solutions: approved stipends as incentive for workgroup chairs, people assigned to participate on workgroups have been given a realistic estimate of the time and work involved, project management support to each workgroup through a Project Manager and Project Assistant.



Section 2: Project- Level Plans

Community Driven Project #1

Project C2- Community Re-entry Program for Justice-Involved Adults and Youth

Participating Organizations/ Implementation Framework

- Hope for New Hampshire Recovery
- Merrimack County House of Corrections
- Riverbend CMHC, Inc.
- NH Alcohol & Drug Abuse Counselors Association
- Boys & Girls Clubs of Greater Concord
- Concord Coalition to End Homelessness
- Merrimack County Service Link
- NAMI New Hampshire
- Concord Human Services
- Alternative Solutions Associations, Inc.
- Capital Regional Healthcare

Section 2: Project- Level Plans

Community Driven Project #2

Project D1- Medication Assisted Treatment of Substance Use Disorders

Goal Statement

Increase access to MAT programs through primary care offices and clinics throughout Region 2.

Project Selection Rationale

With the integration plan providing a behaviorist at nine primary care locations, the IDN felt the selected community project supported that integration while also meeting the identified needs of the community to train, and mentor two physicians at each of those same practices to implement MAT.

Region 2 IDN will also provide an MAT physician to travel throughout the region and provide MAT and warm linkages to community recovery and support services for pregnant women in a Neonatal Abstinence Syndrome prevention program.

Challenges/ Proposed Solutions:

- Primary Challenges: time, technology, and the availability of workforce. Difficulty convincing primary care providers to this work given the high productivity demands on them and the stigma attached to providing care to this population.
- Proposed Solutions: approved stipends as incentive for workgroup chairs, people assigned to participate on workgroups have been given a realistic estimate of the time and work involved, project management support to each workgroup through a Project Manager and Project Assistant.

Section 2: Project- Level Plans Community Driven Project #2

Project D1- Medication Assisted Treatment of Substance Use Disorders

Participating Organizations/ Implementation Framework

- Capital Area Public Health Network
- Concord Hospital
- Dartmouth Hitchcock Primary Care
- Fresh Start Substance Use Provider
- Hope for New Hampshire Recovery – CBO Peers
- Riverbend CMHC, Inc.
- Capital Region Healthcare

Expected Outcomes:

- The integration of mental health and SUD treatment within the primary care setting will allow for greater patient access to treatments, reduce stigma, and educate physicians about the best ways to assist their patients with behavioral health disorders.



Section 2: Project- Level Plans

Community Driven Project #3

Project E5- Enhanced Care Coordination for High-Need Populations

Goal Statement:

To develop comprehensive care coordination and management services for high need adult and child populations with multiple physical health and behavioral health chronic conditions.

These services are intended to maintain or improve functional status, increase capacity to self-manage, eliminate unnecessary clinical testing, address the social determinants creating barriers to health improvement, and reduce the need for acute care services.

Project Selection and Rationale

To focus on the very complex needs of youth and adults who present with multiple needs including developmental disabilities, SED, SMI, and co-occurring SUD and chronic health issues.

Expected Outcomes:

- Maintain or improve functional status, increase capacity to self-manage, eliminate unnecessary clinical testing, address the social determinants creating barriers to health improvement, and reduce the need for acute care services.

Section 2: Project- Level Plans

Community Driven Project #3

Project E5- Enhanced Care Coordination for High-Need Populations

Participating Organizations/ Implementation Framework

The foundation of the plan is to provide **intensive care coordinator** to identify high utilizers and convene key providers, meaning anyone involved in the child's psychiatric, educational, or primary care needs.

A care plan will be developed for each enrolled patient and the intensive care coordinator will **provide services that facilitate linkages** and access to needed primary and specialty health care, prevention and health promotion services, mental health and substance use disorder treatment, and long-term care services, as well as linkages to other community supports and resources.

Challenges/ Proposed Summary:

- Primary Challenges: time, technology, and the availability of workforce.
- Proposed Solutions: approved stipends as incentive for workgroup chairs, people assigned to participate on workgroups have been given a realistic estimate of the time and work involved, project management support to each workgroup through a Project Manager and Project Assistant.



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IDN 3 PROJECT PLAN

Southern New Hampshire Health

Nashua Region

IDN 3 Project Plan Review

Section 1: IDN-Level Plan

Vision Statement

- Working collaboratively, members of the Nashua IDN will achieve demonstrable results in greater behavioral health capacity, improved integration of physical and behavioral health, improved care transitions, and improved outcomes on behalf of the communities we serve.

Community Needs Assessment

- Mental health and SUD are among the top 3 health concerns of the community.
- More than 30% of this Adolescent population is identified as facing the challenge of a behavioral health disorder.
- Residents in the IDN are largely car dependent. It is problematic that The City of Nashua is the only community in the IDN with a fixed route transit service; an additional eight towns have a very limited on-demand response van service.
- Every age group in the IDN is significantly affected by respiratory conditions. A leading cause of these issues are caused by smoking. The rates of smoking for NH residents with mental illness and SUD are 2-3 times higher than that of the general population.
- Service availability for primary care is strong in the IDN.

Governance Structure

- As stewards of the Nashua IDN, the Administrative Lead management team will focus efforts on working collaboratively with the diverse member entities to achieve the vision and mission of the Project Plan, leading efforts to ensure integrity, clarity of purpose, accountability, and effectiveness of the Plan.
 - *Executive Director:* Lisa Madden, MSW
 - *Finance Director:* Paul Trainor
 - *Medical Director:* Marilou Patalingjug-Tyner, MD
 - *Sr. Administrative Sponsor:* Stephanie Wolf-Rosenblum, MD, MMM, FACP, FCCP
- The work of the Executive Committee will be informed by four subcommittees:
 - *Clinical Governance:* Dr. Cynthia Whitaker, GNMHC
 - *Financial Governance:* Greg White, CEO Lamprey
 - *Community Engagement:* Mike Apfelberg, United Way
 - *Data Governance:* Dr. Andrew Watt, CIO/CMIO, SNHH

Executive Committee

Administrative Lead

Sub-Committees

IDN 3 Project Plan Review

Section 2: Project- Level Plan

Project A1: Behavioral Health Workforce Capacity Development

Project Lead: Lisa Madden

IDN Workforce Challenges	Efforts to Address Challenges
<p>Attraction and Recruitment</p> <ul style="list-style-type: none"> • Lack of recognition of public health as a desirable career choice • Lack of marketing among high school and college students • Lack of electives or practicum at local colleges 	<ul style="list-style-type: none"> • Increase marketing among high school and college students by offering entry-level training programs leading to licensing/certifications and entry-level employment opportunities. • Increase recruitment efforts to already employed, skilled professional health care staff already working in other health care fields to replace the current, aging mental health/SUD workforce • Develop opportunities for peer support specialists, family peer support specialists, recovery specialists, and youth peer support specialists.
<p>Training and Career Development</p> <ul style="list-style-type: none"> • Lack of training for non-clinicians • Lack of workforce readiness • Lack of training in electronic record-keeping tools 	<ul style="list-style-type: none"> • Increase access to online training in Mental Health First Aid for non-clinicians. • Expand electives/practicum at local colleges in mental health care/SUD fields. • Expand online courses for flexibility to enhance skills and knowledge and leverage open-sourced materials as appropriate.
<p>Retention</p> <ul style="list-style-type: none"> • High workloads per staff member • Lack of more formal succession planning • High rates of burnout 	<ul style="list-style-type: none"> • Coordinate trainings among Nashua IDN members to maximize opportunity and better monitor the meeting of skill sets needed. • Establish shared database of potential employees. • Shared supervisory, consulting, and/or training resources.

IDN 3 Project Plan Review

Section 2: Project- Level Plan

Project A2: HIT Infrastructure to Support Integration

Project Lead: Andrew Watt

To keep ahead of where the IDN needs to be with implementing a fully integrated, high standard of care health care system, Nashua IDN members are working toward a more comprehensive means to exchange information. Therefore, the IDNs HIT group will concentrate on and work with the State HIT Taskforce around data transition to support the overall IDN goal of improved care transitions. .

Critical HIT gaps	Efforts to Address HIT gaps
<p>Substantial fragmentation in present electronic documentation:</p> <ul style="list-style-type: none"> ➤ IDN members use multiple HIT platforms; ➤ Likelihood of needing to utilize “human” interfaces and manual data entry in some cases. 	<ul style="list-style-type: none"> ➤ Establish a sustainable organizational, governance, and technical foundation for achievement of long term statewide health information goals; ➤ Level-set individual providers’ abilities to meet Stage 2 Meaningful Use criteria by facilitating ePrescribing, lab results delivery, and patient care summary exchange across the state; ➤ Expand availability of HIE services to providers that do not currently have access to robust capabilities for health information exchange; and ➤ Collaborate with Legislators to define the future policy governing HIE purpose and participants.

IDN 3 Project Plan Review

Section 2: Project- Level Plans

Project B1: Integrated Health

Goal Statement

The Nashua IDN joins fellow IDN regions in the state of New Hampshire to implement the Core Competency Project of Integrated Health, which will involve primary care providers, mental health and SUD providers, and social services organizations partnering to:

- Prevent, diagnose, treat and follow-up on both behavioral health and physical conditions
- Refer patients to community and social support services
- Address health behaviors and healthcare utilization

Monitoring Plan Summary

Monitoring is key to ensuring the fidelity of implementation and outcomes to maintain and sustain the effectiveness of a patient-centered, integrated delivery of care. To guide the building of dedicated resources in support of the move to a more integrated delivery of care, Southern New Hampshire Health, the Nashua IDN Administrative Lead, recently established two new leadership positions:

- Associate Vice President of Behavioral Health
- Vice President of Development and External Affairs

Summary of Expected Outcomes:

- Strengthening mental health and SUD workforce
- Developing and implementing health information technology infrastructure to support integration and help coordinate care of patients.
- Increase in skilled workforce; Access to care for vulnerable patients
- Effective electronic health record system allowing information exchange; Efficient transition process to facilitate care coordination.

IDN 3 Project Plan Review

Section 2: Project- Level Plans

Project B1: Integrated Health

Key Challenges	Proposed Solutions
<ul style="list-style-type: none"> • Shortage of skilled workforce. • Lack of access to care for vulnerable patients (who are homeless, living in poverty, incarcerated, elderly, or otherwise limited in mobility to access care) 	<ul style="list-style-type: none"> • Training nurses/care managers within PH settings on a brief screening for BH. If the screening is positive, a warm handoff to the behavioral health provider for a full evaluation of eligibility would take place. • Allow the behavioral health provider be reimbursed for that assessment within any PH location.
<ul style="list-style-type: none"> • Lack of an effective electronic health record system that hinders information exchange. • Inefficient transition process to facilitate proper care coordination. 	<ul style="list-style-type: none"> • Adding Community Health Workers (CHW). • Training and supporting providers on issues related to burnout and compassion fatigue. • Expanding efforts to recruit and retain professionals with the skill sets to treat behavioral health disorders in the primary care setting.
<ul style="list-style-type: none"> • Inefficient transition process to facilitate proper care coordination. 	<ul style="list-style-type: none"> • Expanding access to all levels of care including substance use disorders, medication assisted treatment, prevention services for youth and adults and peer support.

IDN 3 Project Plan Review

Section 2: Project- Level Plan

C1- Care Transition Teams

Project Selection Rationale

- Citing data indicative of the number of patients who visit the ED of multiple local hospitals, repeatedly seeking treatment, the Committee named the establishment of care teams as a priority.
- The IDN wants to have a care transition team that includes multiple organizations. The multidisciplinary team members will have a different skill set. This includes the inclusion of:
 - Community Health Workers;
 - Certified Recovery Support Workers;
 - Home Health Care

Challenges/ Proposed Solutions:

- Primary Challenges: The importance of collaboration and information sharing is imperative to the success of a Critical Time Intervention (CTI) team. Because CTI Specialists are focused on continuity of care, they must have up to date information about available local supports, including informal supports, housing supports, crisis supports, and treatment providers along the entire continuum of care.
- Proposed Solutions: CTI Specialists must have access and cooperation from all members of the IDN. One solution is to embed collaboration into the design of the team by having it be multidisciplinary with shared employment and supervision among IDN members.

IDN 3 Project Plan Review

Section 2: Project- Level Plan

C1- Care Transition Teams

Participating Organizations/ Implementation Framework

- Partnership for Successful Living (The Partnership) and its affiliates - The Partnership for Successful Living is a collaboration of six non-profit organizations providing access to housing, health care, education, employment, and supportive services to help individuals and families achieve sustainable independence.
- Greater Nashua Mental Health Center (GNMHC), the region's certified Community Mental Health Center (CMHC)
- Other organizations with extensive experience providing a variety of services will also participate. They will range from doctorate level experts in spiritual guidance and counseling, providers from certified FQHC's, prevention experts who have been working in school districts and in the community; and physicians and allied health professionals from three highly respected health care systems in the Nashua region.

IDN 3 Project Plan Review

Section 2: Project- Level Plans

D3- Expansion in Intensive SUD Treatment Options

Project Selection Rationale

- The Nashua region is in need of additional treatment options to alleviate the sudden and dramatic rise in the number of residents suffering from SUD.
- IDN members expect added resources will alleviate gaps in service for adolescents, particularly those who fall outside of the typical SUD treatment realm and trauma-informed groups for children/youth with SUDs, and adults with severe SUD or SUD co-occurring with other diseases.

Challenges/ Proposed Solutions:

- Primary Challenges: As the Nashua IDN builds capacity to integrate care, it is imperative that the safety net be broadened to address the myriad of needs our young people face including those self-medicating with alcohol and other drugs to address mental health needs.
- Proposed Solutions: There are a number of Adolescent focused programs recommended by IDN partners.

IDN 3 Project Plan Review

Section 2: Project- Level Plan

D3- Expansion in Intensive SUD Treatment Options

Participating Organizations/ Implementation Framework

- Partnership for Successful Living (The Partnership) and its affiliates - The Partnership for Successful Living is a collaboration of six non-profit organizations providing access to housing, health care, education, employment, and supportive services to help individuals and families achieve sustainable independence.
- Greater Nashua Mental Health Center (GNMHC), the region's certified Community Mental Health Center (CMHC).
- All IDN partners recognize there is a shortage of clinically and financially solid substance use disorders treatment facilities. This region is invested in the development and expansion of quality SUD services for our community. We will build off of successful programs and look to expand such services where appropriate.

Project Selection Rationale

- The Nashua Prevention Coalition administered a behavioral survey with results that pointed to the need for increased awareness, education, and prevention strategies for high-risk behaviors among youth.
- Prevalence of serious emotional disturbance, serious mental health, and co-occurring mental health and SUD among beneficiary adults and youth, and the prevalence of physical health conditions co-morbid with behavioral health conditions among beneficiary adults and seniors, influenced the selection of this community-driven project.
- Feedback from the IDN Community Needs Assessment noted specifically the lack of a continuum of care for those with severe mental illness. Too often patients seeking treatment visit a succession of hospital emergency rooms because of a lack of knowledge about intervention and alternative treatment options.

Challenges/ Proposed Solutions

- Primary Challenges: barriers to establishing an effective integrated treatment for beneficiaries suffering from complex, co-occurring disorders: Lack of upfront start-up costs; lack of skilled workforce, lack of resources to access those who have mobility issues; lack of Medicaid reimbursement for indirect time for consultation and collaboration with other agencies.
- Proposed Solutions: The Nashua IDN is committed to deploying resources to negate these barriers.

Participating Organizations/ Implementation Framework

- Partnership for Successful Living (The Partnership) and its affiliates - The Partnership for Successful Living is a collaboration of six non-profit organizations providing access to housing, health care, education, employment, and supportive services to help individuals and families achieve sustainable independence.
- Greater Nashua Mental Health Center (GNMHC), the region's certified Community Mental Health Center (CMHC). This Center is the only mental health center serving the area, and provides individuals of all ages and families with evidence-based care that focuses on recovery.
- Both the Partnership for Successful Living and the Greater Nashua Mental Health Center have endorsed two proven, well-developed treatment approaches: Motivational Interviewing and Cognitive Behavioral Therapy.
- Both approaches are well documented as evidence-based practices and the integration of these two have been demonstrated as effective with individuals with co-occurring disorders.



- Closing Questions/
Discussion