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# **NH 1115 WAIVER – BUILDING CAPACITY FOR TRANSFORMATION**

**INDEPENDENT REVIEW PANEL – DECEMBER 13,  
2016**

**DEDICATED TO GOVERNMENT HEALTH PROGRAMS**





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# **IDN 4 PROJECT PLAN**

Network4Health

Derry & Manchester

### IDN 4 – Derry and Manchester

- Administrative Lead
  - Catholic Medical Center– Alexander Walker
- Attributable Lives
  - 45,725
- Overall Score of the Project Plan
  - Total                      500/500                      100%      **PASS**

# IDN 4 Project Plan Review

## Section 1: IDN-Level Plan

### **Vision Statement**

- Network4Health’s vision is one where all residents—regardless of income, race, ethnicity, language, ability, gender, or identity—have access to affordable, high-quality, person-centered integrated medical and behavioral health services that promote the highest possible level of wellness, health, and functioning.

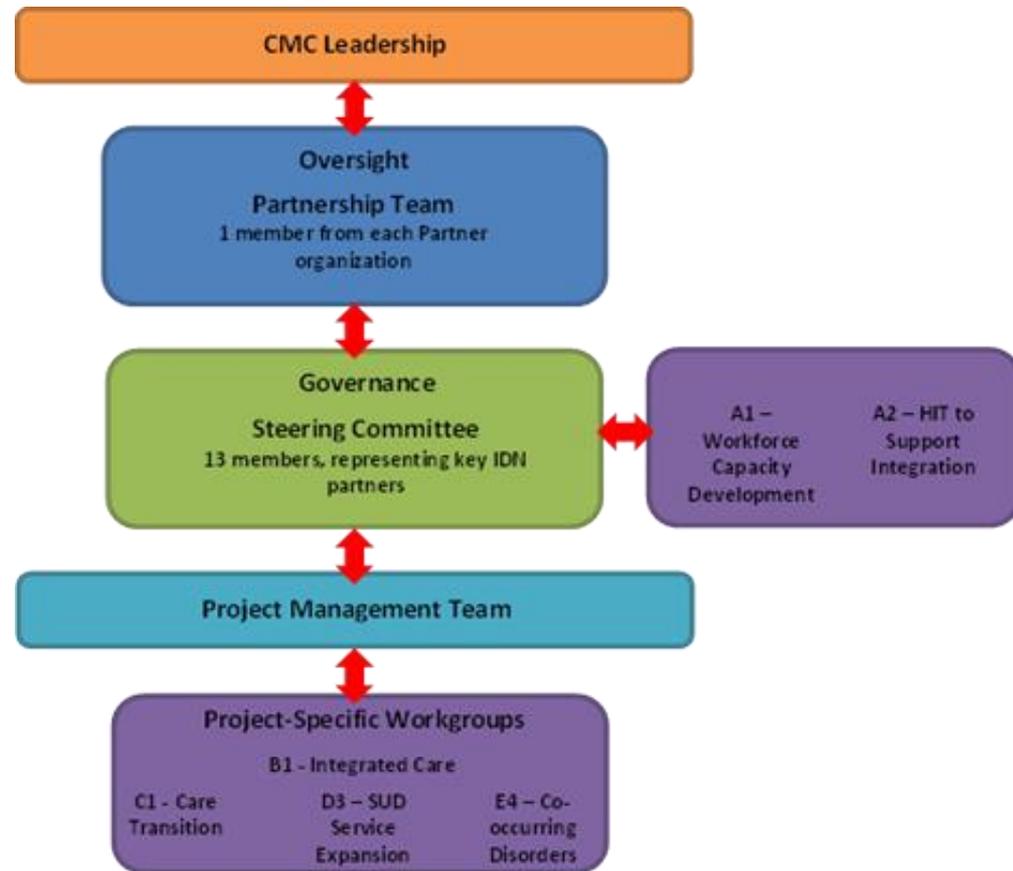
### **Summary of Community Needs Assessment**

- Regarding race and ethnicity, Region 4 is the most diverse in NH with the Medicaid population being more racially diverse than the region.
- The most pressing health problems identified were behavioral health (BH) conditions including: substance misuse and addiction, mental health, suicidal behavior, co-occurring illness, and co-morbidities with physical health.
- Populations identified as underserved: youth and young adults, households for whom English is a second language, people living in poverty and significant gaps in care as people transition from institutional to community settings.
- The demographic factors driving Network4Health’s overall approach to their projects are income and poverty, cultural differences and limited English proficiency.

## Integrated Delivery Network (IDN)

### Governance Structure

- The foundational principle of Network4Health’s governance strategy and structure is “partnership.”
  - Executive Director: Peter Janelle
- The Steering Committee- is the primary governing body that provides clinical, financial and data governance as well as monitoring ongoing community engagement activities.
  - *Clinical Governance*: Dr. William Goodman (CMO)
  - *Data Governance*: Thomas Della Flora (CIO)
  - *Financial Governance*: Pamela Martel (CFO)





# IDN 4 Project Plan Review

## Section 2: Project Level Plans

### Project A1: Behavioral Health Workforce Capacity Development

**Project Lead:** Lisa Descheneau (CMHC)

**Project Co- Lead:** Cheryl Colletti-Lawson (SUD Provider)

IDN Workforce Challenges	Expected Efforts to Address Challenges
<p>Lack of supply due to: <u>low compensation rates</u> compared to the training and experience needed, <u>increasing sub-specialization</u> of BH services and the workforce and <u>low job satisfaction</u> due to insufficient wrap around services for appropriate patient care.</p>	<p>Offer incentives for pursuing behavioral health positions (pay for schooling, job placement, loan forgiveness, etc.) or incentives can be tiered to provide career progression.</p>
<p>Training programs not keeping pace with changes in demand.</p>	<p>Create an educational collaborative with BS to BSN, RN to APRN, MSW, programs, etc. Support enhanced capacity to treat individuals with mental health and SUD through skills trainings for current staff. Promote opportunities and support for bachelor-level psychology students to obtain licensed nursing assistants training.</p>
<p>Limited use of peer supports, recovery specialists and outreach workers.</p>	<p>Educate high school students and/or partners with technical schools. Help foreign-educated residents move their certifications and address statewide barriers on this front. Leverage the work of Easter Seals in teaching English to refugees to help provide necessary skills to meet job requirements.</p>



# IDN 4 Project Plan Review

## Section 2: Project- Level Plans

### Project A2: HIT Infrastructure to Support Integration

**HIT Project Lead:** Thomas Della Flora

Critical HIT gaps	Efforts to Address HIT gaps
Utilization: the state HIE utilizes 3 different systems, which means records need to be updated in 3 different locations. State SUD providers are required to use the state Web Information Technology System (WITS), an EHR which is considered to be difficult and cumbersome to use.	Potential statewide funding for HIT for behavioral health and social service agencies that do not have EHRs.
Interoperability: For the most part EMRs are not interoperable. Providers use different care management mechanisms and tools, which are not compatible with other provider systems.	Select and implement a community-based care coordination/care management tool that can be used to coordinate all services provided to the target population. Potential statewide funding to help connect the EHRs of partner entities, allowing for interoperability across EHRs, HIE and other data sources.
From the perspective of the behavioral health system, there is currently no systematic way to identify physical health issues. No reliable index for safe identification of patients across care settings.	Participate in the technology groups spanning the regions that will meet to discuss and propose potential solutions addressing data management and technology based HIT gaps.
State health information privacy laws impede providers' ability to share information.	Develop security standards and standardize reporting of information to collectively share information across partners and improve knowledge within HIPAA and NH privacy requirements.



# IDN 4 Project Plan Review

## Section 2: Project- Level Plans

### Project B1: Integrated Health

#### Goal Statement

Region 4’s primary goal is to significantly increase the number of providers qualified as Coordinated Care Practices and Integrated Care Practices.

Significantly improve health care quality and the health status of the population, while simultaneously reducing overall health care costs.

Primary outcomes for this intervention include reduced avoidable inpatient and ED utilization and improved overall health status for Medicaid beneficiaries with or at risk for behavioral health conditions.

#### Monitoring Plan Summary

A comprehensive monitoring and evaluation plan with a two-fold objective:

- 1) Monitoring progress during the early implementation years.
- 2) Providing sufficient information to understand if the intervention has been effective.

#### Expected Outcomes:

Increased screening of MH/SU in primary care

Improved engagement of individuals with MH/SU

Increased referral to specialty care

Increased smoking cessation counseling

Improved HEDIS scores on co-morbid conditions

Reduced avoidable acute inpatient admissions

Reduced readmissions

Improved patient, family and caregiver experience and satisfaction

Increased well visits for the behavioral health population

Increased follow up visits after an inpatient stay

Reduced emergency department visits

Reduced stigma related to the treatment of patients with behavioral health needs

# IDN 4 Project Plan Review

## Section 2: Project- Level Plans

### Project B1: Integrated Health

Key Challenges	Proposed Solutions
<b>Work Flows and Handoffs</b>	<ul style="list-style-type: none"> <li>➤ Provide partner organizations with the training, technical assistance and practice coaching needed to develop new work flows and handoffs.</li> <li>➤ Organization leadership will receive training in culture change to ensure integrated care becomes a core value of all Network4Health partners.</li> </ul>
<b>Workforce Issues</b>	<ul style="list-style-type: none"> <li>➤ Provide recruitment assistance including job description development, candidate screening and sharing resumes.</li> <li>➤ Encourage peer support utilization.</li> <li>➤ Ensure adequate training and supervision for culturally competent services for non-English speaking population.</li> </ul>
<b>Health Information Technology and Data Collection</b>	<ul style="list-style-type: none"> <li>➤ Devote resources to assist with obtaining, training, and implementing the evidence-based HIT practices associated with being Coordinated Care Practice/Integrated Care Practice.</li> <li>➤ Assist with implementing HIT, selecting appropriate care management modules, and developing data collection capabilities.</li> </ul>
<b>Sustainability</b>	<ul style="list-style-type: none"> <li>➤ Focus funds for development of infrastructure</li> <li>➤ Work with Medicaid MCOs</li> <li>➤ Identify grants/federal opportunities to leverage funding.</li> </ul>
<b>Stigma</b>	<ul style="list-style-type: none"> <li>➤ Train providers around stigma-reduction.</li> </ul>

# IDN 4 Project Plan Review

## Section 2: Project- Level Plans

### Project C1- Care Transition Teams

#### Goal Statement

Providing assistance to the most vulnerable populations as they transition from institutional to community-based care

Lower inappropriate ED utilization among members with co-occurring disorders

Improve social indicators of reduced incarceration, more stable housing and employment

#### Project Selection Rationale

<b>Relevance</b>	The risk of relapse and adverse outcomes during transitions is an important gap identified by community stakeholders during the focus groups and supported by data.
<b>Realistic</b>	Critical Time Intervention (CTI) has been successfully implemented across numerous populations.
<b>Impact</b>	The CTI is an evidence-based approach that has had significant impact in other communities regarding the key outcomes of interest.
<b>Cost</b>	CTI has been shown to be scalable across organizations and Network4Health believe it offers an affordable, sustainable approach to addressing care transitions after the DSRIP funds expire.

#### Challenges/ Proposed Solutions:

- Primary Challenges: Workforce, data collection and sustainability.
- Proposed Solutions: Expand part-time caseworker staff hours to full time, add peer support specialists, delineate additional eligibility criteria so CTI targets clients most in need, refer clients to nearby community organizations with trained CTI caseworkers onsite, establish a data collection system at each of the Primary CTI organizations, and it's expected CTI services will pay for themselves under a partial or full APM model.

# IDN 4 Project Plan Review

## Section 2: Project- Level Plans

### Project C1- Care Transition Teams

#### Participating Organizations/ Implementation Framework

<b>Primary CTI Organization</b>	Directly involved with the transition of the interested populations from the institution to the community, would need to identify people in need of CTI, and have on staff case worker(s) trained in CTI to deliver the CTI intervention.
<b>Secondary CTI Organization</b>	Not directly involved in the transition of these populations, but service the clients in some capacity, will act as referral and service organizations.

#### Network4Health will focus on three transitions with this intervention:

<b>Hospital to the Community</b>	Medicaid clients with either an ED visit or Inpatient stay where either a primary or secondary diagnosis or comorbidity includes a behavioral health condition.
<b>Corrections to the Community</b>	Medicaid-eligible clients released from correctional institutions, including the Sununu Youth Services Center, with an identified behavioral health condition.
<b>Youth Behavioral Health programming to Adult Services</b>	Medicaid beneficiaries who age-out of their behavioral health programming.

#### Expected Outcomes:

- Fewer institutional days and unnecessary ED visits, particularly for BH/ambulatory care sensitive conditions.
- Reduced recidivism to correctional facilities and better integration with community supports
- Reduction in recurring homelessness

# IDN 4 Project Plan

## Section 2: Project- Level Plans

### Project D3- Expansion in Intensive SUD Treatment Options

#### Goal Statement

Expand intensive SUD treatment options via implementing a partial hospitalization program focused on individuals with co-occurring disorders, as well as expanding outpatient counseling for individuals with SUD.

#### Project Selection Rationale

<b>Relevance</b>	Region 4 has a high prevalence both of SUD and co-occurring disorders, across all age cohorts. Providers report increases in the number of people with co-occurring illnesses who do not meet the level of care required for residential treatment but need more intensive care options than what is available.
<b>Realistic</b>	Network4Health believes that implementing this project is realistic given existing resources. They can leverage work done for Project E4 to maximize use of limited resources.
<b>Impact</b>	PHP programs have been shown to produce similar results to residential care and offer a level of treatment not currently available in the region but desperately needed for this population.
<b>Cost</b>	Network4Health believes there will be adequate funds to support the program during the demonstration and that the movement towards an APM will ensure its sustainability after the DSRIP funds expire.

#### Challenges/ Proposed Solutions:

- Primary Challenges: Workforce, cross organization coordination and collaboration, operational coordination and sustainability.
- Proposed Solutions: Explore reallocating current resources, the Bi-State Primary Care Association is expanding to include BH/SUD providers, engage in advanced collaborative planning, establish vehicles for frequent communication, ensure transparency regarding decision making, invite non-participating providers for input into the planning process, and an APM structure must be in place for to be financially sustainable.

# IDN 4 Project Plan

## Section 2: Project- Level Plans

### Project D3- Expansion in Intensive SUD Treatment Options

## Participating Organizations/ Implementation Framework

### Must meet one criteria listed below

Demonstrated expertise in providing and/or facilitating access to mental health services along the continuum.

Expertise in providing, and/or facilitating access to SUD treatment services along the continuum.

Current or previous experience operating a PHP, IOP, MAT, or co-occurring treatment program.

Behavioral health and/or SUD resources that can be leveraged for this service expansion.

### Expected Outcomes:

- Decrease the inpatient admission and readmission rate for individuals with SUD.
- Decrease the acuity of individuals in an inpatient setting.
- Decrease the arrest rates for substance-related crime or for individuals with known MH or SUD conditions.
- Increase stable remission of substance misuse.

# IDN 4 Project Plan Review

## Section 2: Project- Level Plans

### Project E4- Integrated Treatment for Co-Occurring Disorders

#### Goal Statement

Ensure that residents with co-occurring disorders are appropriately identified and referred for services, and that the services they receive, whether from a provider that primarily serves individuals with MH issues or individuals with SUDs, receive services that treat them as a whole person and address MH and substance use conditions together.

#### Project Selection Rationale

<b>Relevance</b>	Addresses the lack of adequate or appropriate services for those with co-occurring disorders. Aligns with the broader core project focused on behavioral health integration.
<b>Realistic</b>	Network4Health believes that implementing this project is realistic given existing resources. They can leverage work done for Project D3 and for the core Behavioral Health Integration project to maximize use of limited resources.
<b>Impact</b>	Given the high incidence of co-occurring disorders among the Medicaid population, and the dearth of treatment options, there is the potential to impact the health status of individuals in a significant way.
<b>Cost</b>	Network4Health believes there will be adequate funds to support the program during the demonstration.

#### Challenges/Proposed Solutions:

- Primary Challenges: Workforce, training and resource constraints.
- Proposed Solutions: recruitment assistance, use of peer supports, adequate training and supervision for culturally competent services

# IDN 4 Project Plan Review

## Section 2: Project- Level Plans

### Project E4- Integrated Treatment for Co-Occurring Disorders

#### **Participating Organizations/ Implementation Framework**

Utilization of the Case Western Reserve University Center for Evidence-Based Practices Dual Diagnosis Capability Index in Addiction Treatment (DDCAT) and the Dual Diagnosis Capability in Mental Health Treatment (DDCMT).

All behavioral health providers will be offered the opportunity to participate in an organizational review using the DDCAT/DDCMHT indexes. An on-site review utilizing these indexes will be facilitated and will take no longer than one day per organization to complete.

\*\*At a minimum, training available in evidenced-based programs will include: “Stages of Change” model, Motivational Interviewing, Listen Empathize Agree Partner (LEAP), Dialectical Behavioral Therapy for Substance Use and Cognitive Behavioral Therapy for Psychosis. \*\*\* Both CMHCs participating in Network4Health have implemented IDDT.

#### **Expected Outcomes:**

- Decrease inpatient admission rates for individuals with co-occurring conditions.
- Decrease acuity of individuals with co-occurring conditions in an inpatient setting.
- Decrease readmission rates for a co-occurring condition.
- Decrease arrest rates for a substance-related crime or for individuals with known MH or SUD conditions.



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# **IDN 5 PROJECT PLAN**

Community Health Services Network, LLC

Central and Lakes Regions

### IDN 5 – Central and Lakes Regions

- Administrative Lead
  - Community Health Services Network, LLC– Susan Laverack
- Attributable Lives
  - 20,247
- Overall Score of the Project Plan
  - Total                                      500/500                      100%                      **PASS**

# IDN 5 Project Plan Review

## Section 1: IDN-Level Plan

### **Vision Statement**

- The Community Health Services Network envisions that the health and social challenges of the whole person will be improved through a regional integrated network of care accomplished through shared governance utilizing clinical and performance standards.

### **Community Needs Assessment**

- Medicaid represents about 19% of the population in Region 5.
- The age group with the highest proportion of Medicaid members with evidence of a behavioral health condition was the adult population ages 18 to 64 years (about 44%).
- The most pressing health problems identified were behavioral health (BH) conditions including: substance misuse and addiction, mental health, suicidal behavior, co-occurring illness, and co-morbidities with physical health.
- City of Laconia and neighboring Town of Belmont are relative 'hotspots' within Region 5 of EMS calls involving Narcan administration.

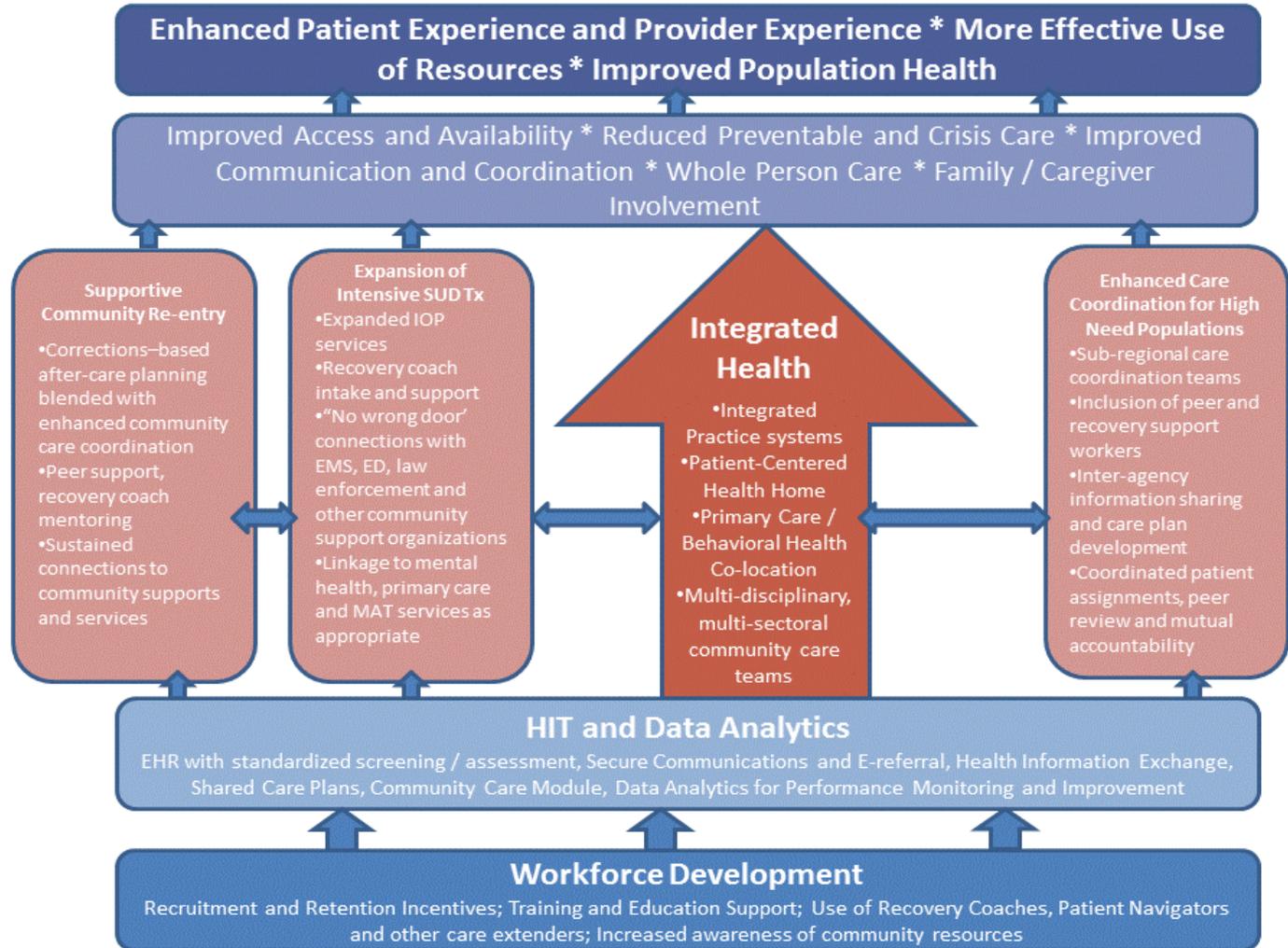


# Integrated Delivery Network (IDN)

## Governance Structure

CHSN has been established as a Limited Liability Company, which provides for a delegated model of governance.

- **Executive Director:** Audrey Goudie
- **CMO:** Paul Friend, MD and Paul Racicot, MD
- **CFO:** Marie Tule, CPA
- **Board Chair:** Henry Lipman



# IDN 5 Project Plan Review

## Section 2: Project Level Plans

### Project A1: Behavioral Health Workforce Capacity Development

**Project Lead:** Maggie Pritchard, Genesis Behavioral Health

IDN Workforce Challenges	Expected Efforts to Address Challenges
Recruitment and Retention	Provide resources for more incentives to encourage staff recruitment and retention. Examples: regularly scheduled raises, cost of living increases, loan forgiveness, coordinated recruitment through the network, and common job description.
Provider Turnover	Incorporate care extenders such as peer support specialists and community health workers to support care coordination and integration. Examples: Inventory trainings offered by Members and participation in academic training programs.
Low Pay for Professional Services	Provide resources and opportunities for continuing education and training. Examples: tuition reimbursement and professional development.
Cost of Licensure or Certification	Invest in staff pursuing licensure or certification. Examples: Underwrite cost of services delivered by staff working toward licensure or certification, training and testing fees, and supervision hours.



# IDN 5 Project Plan Review

## Section 2: Project- Level Plans

### Project A2: HIT Infrastructure to Support Integration

**Project Lead:** Rick Silverberg, Health First Family Care Center

Critical HIT gaps	Efforts to Address HIT gaps
Limited Financial Resources	Support community based organizations so that social determinant data may be shared with health providers.
Limited internal HIP staff	Joint activity in education for IDN Members on confidentiality of private health information protected under state and federal law.
Complexities of establishing interoperability	Participation in the statewide planning process allows best practice sharing.
Minimal data sharing standards	Participating in the statewide planning process allows for identifying shared standards and developing statewide solutions to technology and policy issues.



# IDN 5 Project Plan Review

## Section 2: Project- Level Plans

### Project B1: Integrated Health

#### Goal Statement

The major focus of the network is the integration of care across primary care, behavioral health and social support services.

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

#### Monitoring Plan Summary

The implementation process will include development of individualized integration plans for each practice along with staged implementation to take into consideration practice/provider readiness level for change. Plans will include continued patient, provider and community engagement to assess perspectives.

#### Expected Outcomes:

Enhanced patient experience	Improved population health prevention, early identification and intervention o reduce the incidence of serious illness	4 Statewide Measure data reporting
Enhanced provider experience.	More cost effective utilization of health and human services resources	12 Practice and system-based developmental outcomes

# IDN 5 Project Plan Review

## Section 2: Project- Level Plans

### Project B1: Integrated Health

Key Challenges	Proposed Solutions
Complex and Multifaceted Project	Effective communication, attention to detail and providing sufficient flexibility to allow clinic teams to design approaches that work best for them.
Underserved area with health professional shortages	Underlying foundational activities to occur through the Workforce Development strategic pathway and include regional coordination on strategies such as educational subsidies and loan repayment, supplemental market or cost of living adjustments, longevity pay, financial support for continuing education.
Staff time to participate in integrated care aspects are not reimbursable; Competing demands for standardized screening activities within patient visit	Patient visit re-design, team role definition and workflow re-design, and EHR development.
Different funder/payer requirements for patient assessment and evaluation resulting in inconsistent tools and procedures	The Clinical Integration Committee will work together to identify the various assessment tools already in use. They will develop a core set of measures from the various assessment tools that can be extracted/reconciled to inform the development of a shared care plan for each individual patient.

**IDN 5 Project Plan Review**  
**Section 2: Project-Level Plan**  
**Project C2- Community Re-entry Program for Justice-Involved Adults  
and Youth with Substance Use Disorders or Significant Behavioral  
Health Issues**

## **Goal Statement**

The Network has selected the Supportive Community Re-Entry Program as a means to improve health and social outcomes for adjudicated Medicaid-eligible youth and adults transitioning from correctional facilities to home communities and community-based services.

## **Project Selection Rationale**

The project approach will blend after-care planning efforts that occur within corrections with enhanced case management, peer support and recovery mentoring to improve access to sustained community supports and services. Through this approach, re-entering individuals will be more likely to access needed supports and services resulting in lower recidivism into the corrections system, reduced use of high cost care such as emergency room care, reduced relapse of SUD and BH conditions, and improved health outcomes and social and economic stability for individuals and their families.

## **Challenges/ Proposed Solutions:**

Primary Challenges: psychological and social effects of criminal behavior and incarceration, disconnected systems of care, lack of sufficient human and infrastructure resources to support integrated care, workforce capacity and related reimbursement issues, lack of community supports.

Proposed Solutions: utilization of recovery coaches with lived experience, implementation of shared case management procedures and data systems, establishment and maintenance of a Re-entry Leadership Team, expansion of the CHSN to include the ancillary supports needed by clients including transportation, housing and job training programs in the region.

**IDN 5 Project Plan Review**  
**Section 2: Project-Level Plan**  
**Project C2- Community Re-entry Program for Justice-Involved Adults and Youth with Substance Use Disorders or Significant Behavioral Health Issues**

**Participating Organizations/ Implementation Framework**

Horizons	Local shelters
County Corrections facilities	Home visiting programs
Navigating Recovery	Lakes Region Community College
Lakes Region Community Services Family Resource Center	University of New Hampshire Cooperative Extension
Diversion/Restorative Justice Programs	Lakes Region Partnership for Public Health
Community Mental Health Clinics	Community Health Services Network
Primary Care Services	Housing Services

**Expected Outcomes:**

- The **utilization of recovery coaches with lived experience** with addiction and other behavioral health problems, and potentially justice-system involvement will increase the likelihood that clients will feel understood and receptive to obtaining support services.
- Implementation of **shared case management procedures and data systems** will ensure shared knowledge and real-time client information resulting in better care coordination.
- The **establishment and maintenance of a Re-entry Leadership Team** will ensure a timely means to respond to policy, service access and other barriers to effective supports, services and case management.
- The **expansion of the CHSN to include the ancillary supports needed by clients**, including transportation, housing and job training programs in the region will be integral milestones for the project.



# IDN 5 Project Plan Review

## Section 2: Project-Level Plan

### Project D3: Expansion of Intensive SUD Treatment Options

#### Goal Statement

To expand Intensive SUD Treatment Options for Medicaid-eligible adults experiencing a substance use disorder (SUD) or co-occurring substance use and other behavioral health disorder (COBHD) in response to the unmet demand for Intensive Outpatient Program (IOP) services in the region.

#### Project Selection Rationale

This unmet need and demand is evidenced by

- a) the current month-long wait list for IOP services at the only state-licensed specialty SUD treatment provider in the area, Horizons Counseling;
- b) the next closest provider, a 45 minute one-way drive from the Laconia area in Concord, has an even longer wait list for those in need of IOP services;
- c) the complete lack of IOP services for SUD and COBHD in the geographic hubs of greater Franklin and greater Plymouth.

#### Challenges/ Proposed Solutions:

Primary Challenges: Those associated with addiction and other BH disorders that interfere with retention in care; unavailability of non-medical detoxification facilities; lack of peer recovery mentors with lived experience to support access and retention in services; currently disconnected systems of care that compromise effective and continuous treatment.

Proposed Solutions: Cross-training of service providers and care coordinators, utilization of recovery coaches with lived experience with addiction and other behavioral health problems, development of a treatment and recovery support workforce, institution of care coordination at multiple service sites, short-term non-medical detoxification facility.

# IDN 5 Project Plan Review

## Section 2: Project-Level Plan

### Project D3: Expansion of Intensive SUD Treatment Options

#### Participation Organizations/ Implementation Framework

Horizons

Lakes Region General Health Care

LRGH Recovery Center

Navigating Recovery

Genesis Behavioral Health

Farnum North/Easter Seals

Hope for NH Recovery

Housing Services

Home Visiting Programs

Lakes Region Partnership for Public Health

Community Health Services Network

Farnum North/Easter Seals

Plymouth Area Recovery Connection

#### Expected Outcomes:

- Cross-training of service providers and care coordinators will expand understanding about the disease of addiction and co-occurring behavioral health disorders.
- The utilization of recovery coaches with lived experience with addiction and other behavioral health problems will increase the likelihood that clients feel understood and may be more receptive to utilizing support services.
- The development of a treatment and recovery support workforce will be utilized to expand IOP service capacity.
- The institution of care coordination at multiple service sites will increase retention and compliance.
- Transportation services and ancillary supports will increase attendance at recovery meetings.
- Short-term non-medical detoxification facility developed through private funding that meets state licensing requirements.

# IDN 5 Project Plan Review

## Section 2: Project-Level Plan

### Project E5: Enhanced Care Coordination for High-Need Populations

#### Goal Statement

CHSN intends to address more comprehensively the current challenges experienced by patients, families and providers resulting from fragmented care through multiple health and human service agencies and programs; challenges that contribute to poorer health outcomes and costly patterns of service utilization for individuals with complex behavioral health care needs.

#### Project Selection Rationale

This project addresses key identified health needs and gaps and builds on important efforts to improve care coordination and case management in the region that are currently underway. The following community needs assessment gaps would be addressed:

- Patient and family caregiver difficulties with accessing appropriate and timely care and support
- Experiences with limited collaboration and information sharing between physical health care, behavioral health care, and community services and supports.

#### Challenges/ Proposed Solutions:

Primary challenges: Technology and data challenges, different organizational types have different funder/payer requirements for patient assessments

Proposed solutions: The care coordination team will develop a core set of measures from the various assessment tools that can be extracted/reconciled to inform the development of a shared care plan for each individual patient.

**IDN 5 Project Plan Review  
Section 2: Project-Level Plan  
Project E5: Enhanced Care Coordination for High-Need  
Populations**

**Participating Organizations/ Implementation Framework**

Horizons

Lakes Region General Health Care

LRGH Recovery Center

Navigating Recovery

Genesis Behavioral Health

Farnum North/Easter Seals

Hope for NH Recovery

Housing services

Home visiting program

Lakes Region Partnership for Public Health

Community Health Services Network

Plymouth Area Recovery Connection

**Expected Outcomes:**

- Seek a balance between assigning care coordinators to work with individual providers and assigning clients to work with case management teams regardless of their primary provider.
- Improvements in all domains of the Quadruple Aim: enhanced patient experience, improved population health, reduced costs, and enhanced provider experiences



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# **IDN 6 PROJECT PLAN**

Region 6

Seacoast and Stafford County

### IDN 6 – Seacoast & Stafford County

- Administrative Lead
  - Nick Toumpas
- Attributable Lives
  - 33,311
- Overall Total Score of the Project Plan
  - Total                      389.75/500              78.0%                      **PASS**

## **IDN 6 Project Plan Review Section 1: IDN-Level Plan**

### **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.

### **Community Needs Assessment**

- IDN Region 6 is home to 33,311 residents who received Medicaid benefits in 2015. Over one-third of those were reported to have at least one behavioral health related claim.
- Of the Medicaid 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.
- Home to 21% of the entire State, Region 6 IDN is a compact geographic area anchoring the state's southeastern coastline that demonstrates a dual identity with respect to wellness.
- 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
- 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. 10% of the population are Medicaid beneficiaries.

# IDN 6 Project Plan Review

## Section 1: IDN-Level Plan

### Governance Model

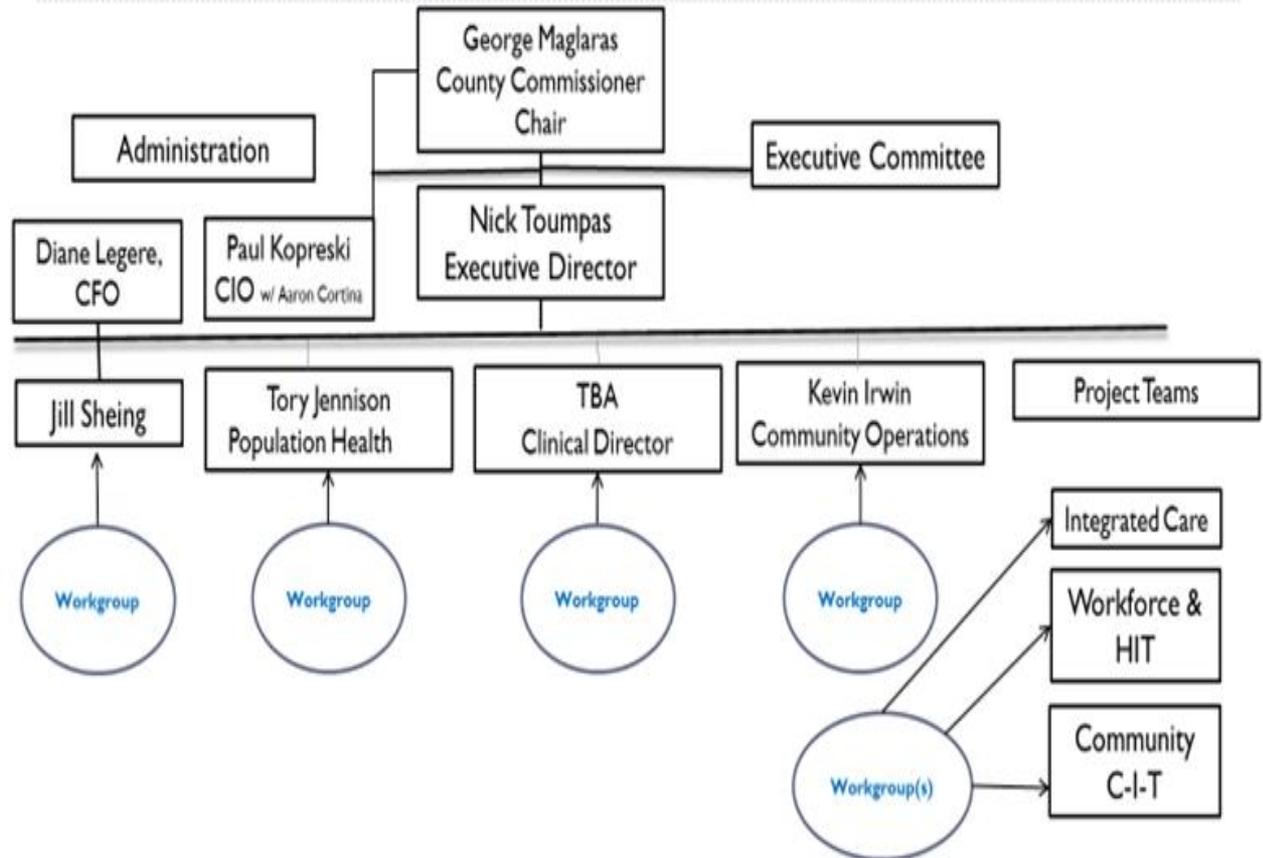
The Region 6 IDN is grounded in a governance perspective that is transparent and inclusive.

- Executive Director: Nick Toumpas

The Executive Committee is the primary governing body that oversees the work of the Operations Team, led by the Executive Director and supported by the Director of Operations, Director of Population Health, Finance Director and Clinical Director.

- *Clinical Director*: Pending
- *Finance Director*: Diane Legere

### Region 6 IDN Organization





# IDN 6 Project Plan Review

## Section 2: Project Level Plans

### Project A1: Behavioral Health Workforce Capacity Development

**Project Lead:** Melissa Milione

IDN Workforce Challenges	Expected Efforts to Address Challenges
<p>Recruitment: Limited funding and staffing needed to pursue candidates</p>	<p>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.</p>
<p>Licensure, accreditation and reciprocity</p>	<p>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.</p> <p>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).</p>
<p>Funding for professional development and ongoing trainings</p>	<p>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.</p> <p>Formalized on the job training programs and apprenticeships will enable the industry to grow our own pool of well trained and talented employees.</p>

# IDN 6 Project Plan Review

## Section 2: Project- Level Plans

### Project A2: HIT Infrastructure to Support Integration

**HIT Project Co-Leads:** Kirsten Platte and Chris Drew

Critical HIT gaps	Efforts to Address HIT gaps
Utilization	<p>Generation of standards to assess regional gaps against so that HIT planning can be operationalized to support the project plans</p> <p>Strategic refinement of the HIT Assessment Tool based on review of the tool’s ability to assess gaps against the newly defined standards.</p>
Data Management	<p>Participation in the statewide planning process will provide an opportunity to share and learn from smart practices generated across all seven IDN regions.</p>
Knowledge gaps regarding HIPAA, confidentiality and information sharing	<p>Participation in the statewide planning process will provide for 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.</p>

# IDN 6 Project Plan Review

## Section 2: Project- Level Plans

### Project B1: Integrated Health

#### Goal Statement

Region 6 will establish a systematic process for monitoring and reporting aggregate/Regional progress towards a CCP and/or ICP designation (SAMHSA).

#### Monitoring Plan Summary

- Development of the Plan is guided by the Operations Team through Design, Implementation, and Continuous Outcomes Assessment.
- The IDN is recruiting for its Integration Workgroup who will be responsible for a Monitoring Plan that integrates DHHS requirements with assessment, data and stakeholder workgroup input.

#### Expected Outcomes:

- Significantly improve health care quality and the health status of the population, while simultaneously reducing overall health care costs.

Workforce Capacity Efforts	Service Utilization Metrics	Consumer Metrics
➤ Core Competencies	➤ Readmissions to acute care	➤ General awareness of available services and resources
➤ Level of Cross Training	➤ Preventative Care	➤ Ability to access those services and resources
➤ Scope of Services	➤ Inappropriate use of ED	➤ Acceptability and continued utilization (when appropriate) of services and resources
➤ Workforce retention and satisfaction	➤ Associated experiences – homelessness, arrest, incarceration	

# IDN 6 Project Plan Review

## Section 2: Project- Level Plans

### Project B1: Integrated Health

#### Key Challenges

#### Key Strengths

Stakeholder Participation challenges - general capacity, agency fiscal solvency, competing or overlapping initiatives, lack of an internal champion, staff turnover

Region 6’s Phase I Workgroups exhibited a high level of engagement, collaboration, critical thinking, problem solving and productivity. As they create project-specific Workgroups for Phase II planning and implementation, it is anticipated that the Workgroups themselves will continue to serve as a critical resource and connection to the skills and capacity to overcome barriers and reduce risks.

Wide range of capacity or mechanisms for sharing data amongst partners

Region 6 has many existing major multiservice providers who provide a density and diversity of expertise, skills and resources that will be key to overcoming barriers and reducing risks including four hospitals, three FQHCs, two CMHCs and 2 CAPs.

Unknown costs associated with HIT/HIE and Workforce taskforce

Region 6 is home to a number of existing multi-stakeholder collaborative efforts that serve vulnerable populations:

- Two Community Care Teams
- Seacoast Community Collaborative
- Portsmouth Care Transitions Committee
- Families First Mobile Health Program

# IDN 6 Project Plan Review

## Section 2: Project- Level Plans

### Project C1- Care Transition Teams

#### **Goal Statement**

Providing assistance to the most vulnerable populations as they transition from institutional to community-based care.

Lower inappropriate ED utilization among members with co-occurring disorders.

Improve social indicators of reduced incarceration, more stable housing and employment.

#### **Project Selection Rationale**

Region 6 has proven success with two fully operational Community Care Teams. The successful implementation of these unfunded multi-stakeholder initiatives clearly supports the feasibility and potential for a more formalized Critical Time Intervention model.

#### **Challenges/ Proposed Solutions:**

- Primary Challenges: Lack of Internal Champion, ability to recruit and retain new staff, addressing regulatory barriers, overlap or lack of congruency with existing protocols, sharing of data amongst partners, tactical responses driven by CTW, reliable data.
- Proposed Solution: A structured work plan will be implemented as designed by CTW in close consultation with Workforce Development Group.

# IDN 6 Project Plan Review

## Section 2: Project- Level Plans

### Project C1- Care Transition Teams

#### Participating Organizations/ Implementation Framework

Participating Organization Roles	
<b>Primary CTI Organization</b>	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 the region.
<b>Secondary CTI Organization</b>	Once the hospitals have committed to the project, secondary organizations will be identified.

#### Expected Outcomes:

- 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.

# IDN 6 Project Plan Review

## Section 2: Project- Level Plans

### Project D3- Expansion in Intensive SUD Treatment Options

#### Project Selection Rationale

- Region 6 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.
- Analysis of the Region's 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

#### Challenges/ Proposed Solutions:

- Primary Challenges: Workforce, cross organization coordination and collaboration, operational coordination and sustainability.
- Proposed Solutions: Explore reallocating current resources, the Bi-State Primary Care Association is expanding to include BH/SUD providers, engage in advanced collaborative planning, establish vehicles for frequent communication, ensure transparency regarding decision making, invite non-participating providers to provide input into the planning process, and an APM structure must be in place for this program to be financially sustainable.

# IDN 6 Project Plan Review

## Section 2: Project- Level Plans

### Project D3- Expansion in Intensive SUD Treatment Options

## Participating Organizations/ Implementation Framework

### Participating Organization Criteria

Demonstrated expertise in providing and/or facilitating access to mental health services along the continuum.

Expertise in providing, and/or facilitating access to SUD treatment services along the continuum.

Current or previous experience operating a PHP, IOP, MAT, or co-occurring treatment program.

Behavioral health and/or SUD resources that can be leveraged for this service expansion.

### Expected Outcomes:

- 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.

# IDN 6 Project Plan Review

## Section 2: Project- Level Plans

### Project E3- Enhanced Care Coordination for High Need Populations

#### **Goal Statement**

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

#### **Project Selection Rationale**

The Region's scan of existing needs assessments and available Medicaid data, triangulated with community feedback, strongly supported the rationale for this project.

#### **Expected Outcomes:**

- 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.

## **Participating Organizations/ Implementation Framework**

Region 6 has many existing major multiservice providers who provide a density and diversity of expertise, skills and resources that will be key to overcoming barriers and reducing risks including:

- 4 hospitals
- 3 FQHCs
- 2 CMHCs
- 2 CAPs

Region 6 is home to a number of existing multi-stakeholder collaborative efforts that serve vulnerable populations:

- 2 Community Care Teams
- Seacoast Community Collaborative
- Portsmouth Care Transitions Committee
- Families First Mobile Health Program

## **Challenges/ Proposed Solutions:**

- Primary Challenges: Lack of Internal Champion, ability to recruit and retain new staff, addressing regulatory barriers, overlap or lack of congruency with existing protocols, sharing of data amongst partners, tactical responses driven by CTW, reliable data.
- Proposed Solution: A structured work plan will be implemented as designed by Care Coordination Workgroup in close consultation with Workforce Development Group and Executive Committee.

## **IDN 7 PROJECT PLAN**

North Country Health  
Consortium

North Country and Carroll

# IDN 7 Overview Information

## IDN 7 – North Country Health Consortium Region

- Administrative Lead
  - North Country Health Consortium – Nancy Frank
- Attributable Lives
  - 19,782
- Overall Score of the Project Plan
  - Totals 465/500 93.0% **PASS**

# IDN 7 Project Plan Review

## Section 1: IDN-Level Plan

### **Vision Statement**

Region 7 IDN will leverage the PCMH model as a foundation, and use the *Building Capacity for Transformation, a Delivery System Reform Incentive Payment (DSRIP) Program* to build a regional system that will achieve its vision: to establish a high quality behavioral health care continuum that is patient-centered. Our Region plans to use the demonstration project to transition from a patient centered medical home model to a patient centered medical community that supports patients through the full continuum of care through integration of all essential services.

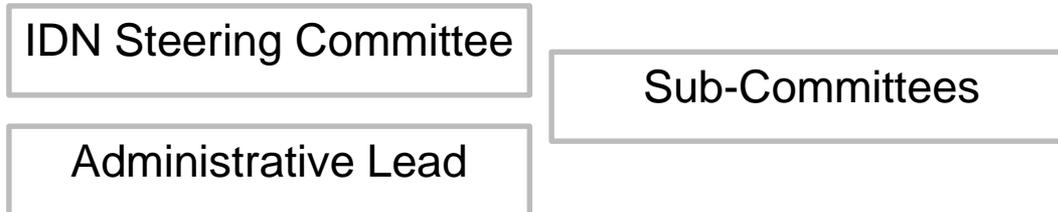
### **Community Needs Assessment**

- The Region 7 median household income is \$47,400 as compared with the state median income of \$65,986- a figure that represents a 28% higher income than the North Country IDN service area. Over 11% of families have incomes at or below 100 percent of the Federal Poverty Level as compared with the state rate of 8.5%.
- Educational attainment, which is a key indicator of many health and wellness factors, in the Region 7 IDN indicates that 89.6% of the population has graduated from high school and 24.7% have a bachelor's degree or higher. Contrastingly, the state high school graduation rate is 92%, and 34.4% of residents have earned a bachelor's degree or higher.
- Demographic factors, including social determinants of health, have informed and influenced the development of all IDN projects. The rurality of the region, particularly geographic distances and poverty, impact access to all key services.

# Integrated Delivery Network (IDN)

## Governance Structure

- Region 7 IDN members used the collective framework model, which is the commitment of a group of individuals/organizations from different sectors to a common agenda for solving a complex problem, to come up with the IDN governance structure depicted to the right.
  - Executive Director: Nancy Frank
  - Clinical Governance: Lisa Bujno
  - Financial Governance: Colleen Gingue
- The governance structure for the IDN will be a Steering Committee and four workgroup committees: Financial Workgroup, Data Workgroup, Community Engagement Workgroup, and Clinical Workgroup. Each of these Committees will have their own charter outlining roles, responsibilities, and meeting structure.
- The IDN has not chosen Chairpersons and members to the Committees as of the date of the Project Plan.



# IDN 7 Project Plan Review

## Section 2: Project- Level Plan

### Project A1: Behavioral Health Workforce Capacity Development

**Project Lead:** Nancy Frank

IDN Workforce Challenges	Efforts to Address Challenges
<ul style="list-style-type: none"> <li>Recruitment of qualified behavioral health professionals poses unique challenges for the Region 7 IDN. The rurality and perception of isolation given the remoteness of the region can be a deterrent for potential professionals to seek employment in the service area.</li> </ul>	<ul style="list-style-type: none"> <li>NNH AHEC focuses on providing rural clinical rotation experiences for health profession students through the "Live, Learn, and Play in Northern NH" program. This program has potential to be expanded to include behavioral health rotation opportunities to attract students into the North Country and to further immerse them into the communities in the service area- a strategy that is known to increase retention upon completion of academic programming.</li> </ul>
<ul style="list-style-type: none"> <li>Complexity of obtaining licensure in the state of New Hampshire for professionals licensed in other states, creating missed opportunities for hiring qualified and experienced professionals.</li> </ul>	<ul style="list-style-type: none"> <li>NNH AHEC will assist with recruitment strategies to attract qualified behavioral health professionals by emphasizing the DHHS State Loan Repayment Program (SLRP) and the recent legislation (SB 424) to simplify and reduce reciprocity barriers in regard to out-of-state licensure.</li> </ul>
<ul style="list-style-type: none"> <li>Recruitment and hiring is affected by the aging of current professionals, and the lessened pipeline of new workers to the field.</li> </ul>	<ul style="list-style-type: none"> <li>NNH AHEC also embraces the rural concept of "growing your own." Given that individuals who are from a rural area are more likely to reside in a rural area, NNH AHEC provides opportunities and information to middle and high school students to expose them to health careers, engaging them into the "pipeline" early on in their academic career.</li> </ul>

# IDN 7 Project Plan Review

## Section 2: Project- Level Plan

### Project A2: HIT Infrastructure to Support Integration

**Project Lead:** Drew Brown

Critical HIT gaps	Efforts to Address HIT gaps
<ul style="list-style-type: none"> <li>▪ When organizations cannot communicate electronically they are using paper, fax, phone calls, and at times secure e-mail- all that lead to inefficiencies and potentially incomplete patient records.</li> <li>▪ Data sharing agreements will be implemented among IDN partners, although there is a potential gap in security assurances with organizations that do not have EHRs or secure systems in place.</li> <li>▪ There are at least six different Electronic Medical Record (EMRs) platforms. These include Meditech, Centricity, eMDs, MedHost, Athena, Paragon, Eclinical Works, Essentia/L WSI, and Greenway Success EHS; and one organization does not have any EMR . Active use of electronic channels for information exchange is in its infancy.</li> </ul>	<ul style="list-style-type: none"> <li>▪ The level of IDN participants capable of conducting ePrescribing and other core EHR functions such as registries, standardized patient assessments, collection of social data, treatment and care transition plans, etc.</li> <li>▪ The ability for IDN participants to exchange relevant clinical data with each other and with statewide facilities such as New Hampshire Hospital via health information exchange (HIE) standards and protocols.</li> <li>▪ The ability for IDN participants to protect electronically-exchanged data in a secure and confidential manner meeting all applicable state and federal policy and security laws (eg. HIPAA, 42 CFR Part 2).</li> <li>▪ <b>Region 7 anticipates engaging the New Hampshire Health Information Organization (NHHIO):</b> receive support and technical assistance from for development and implementation of the regional IDN HIT plan.</li> </ul>

# IDN 7 Project Plan Review

## Section 2: Project- Level Plans

### Project B1: Integrated Health

#### Goal Statement

Throughout the demonstration period, NCHC will work with participating organizations to help the sites progress from their current state of practice toward the highest feasible level of integrated care based on SAMHSA's Standard Frameworks for Levels of Integrated Healthcare. All key organizations will be required to monitor their progress, complete standardized tracking forms, and report to NCHC on a regular basis.

#### Monitoring Plan Summary

Region 7 lists the following specific monitoring activities:

- tracking activities to monitor implementation and participation in activities;
- targeted qualitative methods (eg. semi-structured interviews) to understand how the project is unfolding and to account for overall contextual factors that may affect implementation and sustainability of program efforts either positively or negatively;
- review of available outcomes data related to the region to understand progress in population health.

#### Expected Outcomes:

- Decrease readmissions by 25% to hospital for any cause (excluding maternity, cancer, rehab) at 30 days for Adult 18+ BH population by December 31, 2020
- Increase Follow-Up After Emergency Department Visit by 25% for Alcohol and Other Drug Dependence within 30 days by December 31, 2020
- Increase Engagement of Alcohol and Other Drug Dependence Treatment (Initiation and 2 visits within 44 days) by 25% by December 31, 2020
- Increase Initiation of Alcohol and Other Drug Treatment (1 visit within 14 days) by 25% by December 31, 2020

# IDN 7 Project Plan Review

## Section 2: Project- Level Plans

### Project B1: Integrated Health

#### Key Challenges

- State Medicaid limitations on payments for same-day billing for a physical health and a mental health service/visit;
- Lack of reimbursement for collaborative care and case management related to mental health services;
- Health Insurance Portability and Accountability Act (HIPAA) has made it very difficult to share protected patient information amongst providers.
- Tighter standards in place to protect patient information about mental health and substance abuse.
- Providers may engage in "turf" wars.
- Resistance of certain providers to offer medication assisted treatment.
- Patients often have to travel great distances to receive treatment.

#### Proposed Solutions

- To change policies that affect integration, specifically around reimbursement issues, and workforce shortages, the Region 7 IDN will be involved with many statewide initiatives to ensure the needs of the North Country are being addressed.
- NCHC will work with the leadership at our partner organizations to get their buy-in for integration, and utilize the Northern NH Area Health Education Center (NNHAHEC) to offer health care staff continuing education around integration.
- Mental Health First Aid, a national training program, will be offered to train providers, schools, clergy, first responders, and laypeople how to respond when someone has a panic attack/psychotic episode/appears depressed or suicidal.

# IDN 7 Project Plan Review

## Section 2: Project- Level Plan

### C1- Care Transition Teams

#### Project Selection Rationale

Region 7 selected Care Transition Teams as a community-driven project in order to increase needed support that is critical when individuals with serious mental illness transition from the hospital setting back into the community.

- Over ten percent of inpatient readmissions in Region 7 are individuals with behavioral health factors, as compared to four percent with no behavioral health indicator.
- Data indicate a significant percentage of individuals in need of access services outside of the region. In 2015, only 48% of SUD treatment visits by IDN 7 patients occurred in the region. Additionally, Region 7 is much lower in terms of utilization per member rate. The utilization rate was .6% which is the lowest in the state when compared to the next lowest region which was 1.13% and the highest region which was more than four times Region 7 utilization.

#### Challenges/ Proposed Solutions:

- Primary Challenges: Communication, Accessibility and Lack of Supportive Housing
- Proposed Solutions: Hiring outreach workers (i.e. Community Health Workers); Development of a universal patient care plan template; Utilization of a patient health record that is maintained by the patient; Well-maintained website managed by the IDN Administrative Lead with information; Development of processes and protocols throughout the referral process; Engaging Tri-County Community Action Program and Affordable Housing, Education and Development to outreach members to find affordable housing.

# IDN 7 Project Plan Review

## Section 2: Project- Level Plan

### C1- Care Transition Teams

#### **Participating Organizations/ Implementation Framework**

Organizations choosing to participate in this project will submit a proposal in response to the sub-recipient request for funds previously discussed. Organization's proposals will be reviewed to ensure they meet the criteria below:

- Standardized protocols for Care Transition Team models;
- CTI team members;
- Participation in training planning and curricula;
- Agreements with collaborating organizations;
- Evaluation, including metrics used to measure program impact;
- Mechanisms to track and monitor individuals served by the program, adherence, impact measures, and fidelity to evidence-supported project elements.

Effective Care Transition Teams will be expected to include:

- Patient/family engagement and activation in their care;
- Early identification of patients/clients at risk;
- Medication management;
- Comprehensive transition planning;
- Care transition support;
- Multi-disciplinary collaboration;
- Effective transfer of information to collaborating partners.

# IDN 7 Project Plan Review

## Section 2: Project- Level Plan

### D3- Expansion in Intensive SUD Treatment Options

#### Project Selection Rationale

- In 2015, only 48% of SUD treatment visits by IDN 7 patients occurred in the region.
- Utilization rate was .6% which is the lowest in the state when compared to the next lowest region of 1.13%; highest region was more than four times IDN 7 utilization.
- New Hampshire Division of Public Health Services reported that Coos County had the largest percentage increase (200%) of opioid related emergency department visits in the state between May and July 2016.

#### Challenges/ Proposed Solutions:

- Primary Challenges: Adequate workforce; Relationships and coordination among patients and providers; Effective outcome measures; Lack of supportive housing.
- Proposed Solutions: Participating in Statewide Workforce Taskforce will inform decisions; Development of professional pathways; Case management of integration of resources will increase communication and build trust; Improve documentation of outcome measures including standardized collection and interpretation of the data; Engaging Tri-County Community Action Program and Affordable Housing, Education and Development to outreach members to find affordable housing.

# IDN 7 Project Plan Review

## Section 2: Project- Level Plan

### D3- Expansion in Intensive SUD Treatment Options

#### **Participating Organizations/ Implementation Framework**

Organizations choosing to participate in this project will submit a proposal in response to the sub-recipient request for funds previously discussed. Organization's proposals will be reviewed to ensure they meet the criteria below:

- Capacity to delivery intensive outpatient (IOP); partial hospitalization (PH); or non-hospital based residential treatment services;
- Workforce needs for this project, including desired expansion of behavioral health workforce capacity;
- How services will be delivered in tandem with ambulatory and non-hospital inpatient medically monitored residential, as well as hospital inpatient medically managed withdrawal management services, and treatment services for mental health, substance use and co-occurring disorders;
- Sufficient level of practitioners who can serve individuals with lower levels of acuity;
- Organizations participating in this project will demonstrate capacity to design, and/or enhance SUD services that will support;
- Standard assessment tools;
- Patient assessment, treatment, management, and referral protocols;
- Participation in training planning and curricula;
- Agreements with collaborating organizations;
- Evaluation, including metrics used to measure program impact;
- Mechanisms to track and monitor individuals served by the program, adherence, impact measures, and fidelity to evidence-supported project elements.

# IDN 7 Project Plan Review

## Section 2: Project- Level Plan

### E5- Enhanced Care Coordination for High Need Population

#### **Project Selection Rationale**

Region 7 chose this project as a means to enhance primary care and behavioral health integration by increasing care coordination for high needs populations.

Enhanced care coordination in the region will create a partnership among health care professionals, health centers and hospitals, specialists, pharmacists, mental health professionals, substance use disorder professionals, and community services and resources working together to provide patient-centered, coordinated care.

#### **Challenges/ Proposed Solutions:**

Primary Challenges: Patient engagement, provider buy-in, financial challenges related to both resources and staff, Health information technology (HIT) is not used effectively for care coordination measurement, Lack of supportive housing.

Primary Solutions: Care coordination with this population will be successful if patients are encouraged to begin with small changes that grow over time. Outreach, marketing, and education to both patients and providers will be essential for the success of this project. Effective assessments of resources will have to be completed that reduce redundancy and identify opportunities for efficient service delivery.

#### **Expected Outcomes:**

- Improved Provider Relationships, Increased Quality of Patient Care, Reduced Cost of Care

# IDN 7 Project Plan Review

## Section 2: Project- Level Plan

### E5- Enhanced Care Coordination for High Need Population

#### **Participating Organizations/ Implementation Framework**

Organizations choosing to participate in this project will submit a proposal in response to the sub-recipient request for funds previously discussed. Targeted participating organizations for this project will include:

- primary care providers
- behavioral health providers (including those that provide mental health and substance use disorder services)
- community-based social support service organizations

Almost all of the Region 7 participating organizations have identified enhanced care coordination as a project in which they would like to participate.



- Closing Questions/  
Discussions