

New Hampshire Building Capacity for Transformation 1115 Medicaid Waiver IDN Project Plan North Country IDN, Region 7

Section 1: IDN-level Plan

1: Vision Statement: *IDN Vision and Theory of Action*

According to SAMHSA-HRSA Center for Integrated Health Solutions people with mental illness die earlier than the general population and have more co-occurring health conditions. The Center also states that 68% of adults with a mental illness have one or more chronic physical condition, and more than 1 in 5 adults with mental illness have a co-occurring substance use disorder.¹ Region 7 Integrated Delivery Network (IDN) data shows that a significant part of our population suffers from mental illness and/or substance use disorders. In addition data shows many of those with mental illness also have co-occurring chronic health conditions such as cardiovascular disease and diabetes. Both the North Country and Carroll County Public Health Regions have identified mental health (MH) and substance use disorders (SUD) as priority areas in Community Health Improvement Plans – a clear indication that both areas of Region 7 understand how crucial the issues are that need to be addressed to improve outcomes. Improving these outcomes is challenging in Region 7 due to our large geographic area and significant gaps related to behavioral health workforce shortages and a need for treatment and recovery sites in the region. In addition, lack of supportive housing for individuals experiencing mental health issues and transportation challenges both add to the complexity of treating mental illness and substance use disorders in our rural region.

Region 7 IDN partners realize the importance of enhanced care coordination and integration of MH/SUD services within primary care practices to improve health outcomes and control cost. In fact, many of the health centers within our IDN have worked to achieve National Committee for Quality Assurance Patient Centered Medical Home (PCMH) Recognition which is the most widely adopted model for transforming primary care practices into medical homes. Our partners have already been collaborating to improve the health of individuals with MH/SUD and co-occurring medical conditions. 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.

Region 7 IDN will be addressing Core Competency, Care Transition Teams, Expansion in Intensive Substance Use Disorders (SUD) Treatment Options, and Enhanced Care Coordination in High-Needs Population. These projects fit within the PCMH model and will improve health outcomes for the Medicaid population in the region. Region 7 will measure:

- Readmissions to Hospital for Any Cause (Excluding Maternity, Cancer, Rehab) at 30 days for Adult 18+ BH population

¹ http://www.integration.samhsa.gov/Integration_Infographic_8_5x30_final.pdf

- Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence within 30 days
- Engagement of Alcohol and Other Drug Dependence Treatment (Initiation and 2 visits within 44 days)
- Initiation of Alcohol and Other Drug Treatment (1 visit within 14 days)

2: IDN Service Area Community Needs Assessment

2a: Analysis of IDN Service Region Prevalence Rates

Enhanced Care Coordination for High Needs Populations:

Overall incidence of certain BH diagnoses and co-morbid physical health conditions across age groups in Region 7

Age	Serious Emotional Disturbance (SED)	Serious Mental Illness (SMI)	Substance use disorder (SUD),	Co-occurring mental health and SUD	Evidence of Mental Illness without CHMC Involvement	Physical health conditions co-morbid with behavioral health conditions			
						Cardio-vascular	Respiratory	Diabetes	Other
Child (0-11)	243	0	0	0	800	36	438	7	970
Youth (12-17)	211	0	0	0	830	68	397	5	980
Adult (18-64)	17	416	581	343	3061	1034	1622	432	4183
Senior (65+)	0	15	0	0	194	127	113	57	216
IDN 7 Total	471	431	581	343	4885	1265	2570	501	6349
IDN 7 Percentage of Total Members	2.30%	2.10%	2.84%	1.67%	23.84%	6.17%	12.54%	2.45%	30.99%

2b: Regional Demographics

The North Country IDN, referred to as Region 7, is comprised of Coos, Northern Grafton, and Carroll Counties. The Region 7 IDN service area is vastly rural and is the northern most area of the State. The large geographical area has inherent barriers for those residing in the region, including long travel

distances between towns and community hubs, mountainous terrain, and the high probability of inclement weather during colder months that impedes travel, access to care, and acquiring gainful employment for some residents. Public transportation between communities in the area is extremely limited. The travel time required to obtain medical care can vary from 20 to 60 minutes in good weather to two hours or more in winter conditions.

The Coos and Northern Grafton County population is approximately 50,000 people. It is often difficult to obtain sub-county data for Northern Grafton County, because most socio-economic and health data are aggregated by county. For this reason Coos County data will be used because Northern Grafton County is more closely aligned demographically with Coos County than with the rest of Grafton County. The population density in the area is just over 18 persons per square mile and includes many small towns and unincorporated areas. In some portions of the service area especially within the White Mountains the density is 0 to 15 persons per square mile. The population is fairly homogenous with over 97% indicating their race as Caucasian as compared to the state of New Hampshire, which reflects a population that is 94% Caucasian². The economy is dependent upon tourism that supports employment in service providing industries such as hotels, restaurants, and other recreational activity locations.

Carroll County population is approximately 47,000 people, living in 17 towns across a geographic area of 934 square miles. Carroll County is rural, with significant distances between towns, and includes a large portion of the White Mountain National Forest within its borders. The local economy is heavily dependent on four-season tourism which encompasses the hospitality, retail, food, and beverage industries. The county has been growing as a retirement and pre-retirement destination for people throughout New England.

Socio-cultural determinants of health include conditions people are born, grow, live and work and age that can contribute to or detract from the health of individuals and communities. When delving into the social determinants of health for Region 7, there are clear disparities in regard to income, educational attainment, and housing costs than the state of New Hampshire as a whole. The following data regarding depicts the disparate nature of the service area population as compared to the state:

- **Poverty**³. The Region 7 median household income is \$47,400 as compared with the state median income of \$65,986⁴- 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 (FPL), as compared with the state rate of 8.5%
- **Education**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 higher⁶.

² US Census web site, American Community Survey, 2013-2014.

³ Economic and Labor Market Information Bureau, NH Community Profiles, NH Employment Security Web site. 2016 <http://www.nhes.nh.gov/elmi/products/cp/> .

⁴ US Census QuickFacts, New Hampshire <http://www.census.gov/quickfacts/table/PST045215/33>

⁵ Economic and Labor Market Information Bureau, NH Community Profiles, NH Employment Security Web site. 2016 <http://www.nhes.nh.gov/elmi/products/cp/> .

⁶ US Census QuickFacts, New Hampshire <http://www.census.gov/quickfacts/table/PST045215/33>

- **Housing**⁷. The housing costs within the IDN service area vary. For instance, in Coos County, the median sale price of residential real estate in 2015 was \$89,900 and the median two bedroom monthly rental rate was \$790. In Carroll County, the median residential real estate cost was \$205,000 with the median two bedroom monthly rental rate was \$1,010, as compared to the state median residential real estate cost of \$237,400 and a two bedroom monthly rental was \$1,001.

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.

2c: Current resources available

Region 7 IDN has many prevention efforts underway. The North Country Regional Prevention Network serves as part of the North Country Public Health Network and works to reduce consequences of alcoholism and drug addiction by preventing youth substance misuse. It works to accomplish this mission by using a three-pronged approach:

- Positive youth development strength-based approach through Youth Leadership Through Adventure Programs to prevent substance use among high school students, and improve school climate
- Working with groups in the North Country to address youth substance misuse and school climate issues
- Working with schools to provide credentialed professionals to provide evidence-based programs known to be effective at reducing substance misuse and improving school climate

The Carroll County Substance Misuse Prevention Network is an evolving group of organizations and individuals who live and/or work in Carroll County, working together to reduce alcohol and other drug use among Carroll County young people. The Carroll County Prevention Network is committed to promoting environmental and other practices to prevent substance misuse, advocating for behavioral health resources for Carroll County citizens, and supporting the Carroll County recovering community.

NH’s Continuum of Care program is another great resource for the regions in the IDN. The Continuum of Care (CoC) facilitators have been working in each county to complete an assets and gaps assessment of substance use disorder (SUD) services to look at the number and type of SUD services, perceived gaps in SUD services, barriers to coordination, and other areas of concern that need to be addressed. Below is a condensed version of the initial assessments. All of the assets are currently in place, unless otherwise noted in the chart.

NORTH COUNTRY ASSETS			
PROVIDER	SERVICE SETTING	SERVICES OFFERED/Activities	CoC COMPONENT
Coös Coalition for Young Children and Families	Community-based organization	Provides support families and young children	Prevention
Haverhill Area	Community	Community Coalition	Prevention

⁷ Economic and Labor Market Information Bureau, NH Community Profiles, NH Employment Security Web site. 2016 <http://www.nhes.nh.gov/elmi/products/cp/>.

Substance Misuse and Prevention Coalition	coalition	addressing substance misuse issues	
Stand up Androscoggin Valley Coalition	Community coalition	Community Coalition addressing substance misuse issues	Prevention
North Country Health Consortium/North Country Substance Misuse Network	Schools, other locations, provider organizations	Student Assistance Program: Project SUCCESS, prevention education, individual and group intervention, awareness and outreach activities, parent programs, coordination of regional network, Naloxone trainings and distribution, Youth Leadership Through Adventure	Prevention, Intervention
ADAPT	School	Student Assistance Program: Project SUCCESS, prevention education, individual and group intervention, awareness and outreach activities and parent programs	Prevention, Intervention
Northern Human Services	Community Mental Health Center	Mental health and substance abuse screening, evaluation, individual and group outpatient counseling, treatment, Student Assistance Program: Project SUCCESS, prevention education, individual and group intervention, awareness and outreach activities and parent programs	Prevention, Intervention, Treatment
Project AWARE	Schools	Mental Health First Aid Training, Positive Behavioral Intervention and Supports (PBIS),	Prevention, Intervention

		Strengthening Families (Colebrook), School Resource Officer (Berlin)	
Families Advocating Substance Treatment, Education, Recovery (F.A.S.T.E.R.)	Chamber of Commerce	Meetings, support, guidance	Prevention, intervention
Littleton Area Family Resource Center at Child and Family Services	Community-based organization	Community support and education, family assessment	Prevention, Intervention
Child and Family Services	Community-based organization	Adolescent therapeutic services, family assessment, support for homeless youth	Prevention, Intervention
Family Resource Center	Community-based organization	Family assessment, after school youth programs, connect to healthcare providers and other resources	Prevention, Intervention
Grafton Country Drug Court	Drug court	Addresses drug offenses for individuals located in Grafton County	Intervention
Ammonoosuc Community Health Services	Community Health Center	Primary care services, behavioral health	Intervention
Cottage Hospital	Hospital	Primary care services, emergency	Intervention
Androscoggin Valley Hospital	Hospital	Primary care services, emergency	Intervention
Littleton Regional Healthcare	Hospital	Primary care services, emergency, outpatient services	Intervention
Service Link of Grafton County and Coös County	Community-based organization	Foster connections to resources and assists with access	Intervention
North American Family Institute (NFI) – North	Community-based organization, residential facilities	Education, behavioral health services, transitional housing	Intervention
Coös Country Family Health Services	Community Health Center	Primary care services	Intervention
Catholic Charities	Community-based organization	Outreach, counseling services	Intervention, Treatment

Connecticut River Services	Community-based organization	Evaluation, individual outpatient counseling	Intervention, Treatment
Northern Human Services/ White Mountains Mental Health Services	Community-based organization	Mental health and substance abuse screening, evaluation, individual and group outpatient counseling	Intervention, Treatment
Center for New Beginnings	Community-based organization	Evaluation, individual outpatient counseling	Intervention, Treatment
Connecticut River Counseling Services	Community-based organization	Evaluation, individual outpatient counseling	Intervention, Treatment
Indian Stream Health Center	Community Health Center	Primary care services, behavioral health	Intervention, Treatment
Upper Connecticut Valley Hospital	Hospital	Primary care services, emergency	Intervention, Treatment
R.O.A.D. To A Better Life	Community-based organization	Evaluation, treatment	Intervention, Treatment
Tri Community Action Program (CAP)	Community-based organization	Screening, assessment/diagnosis, referral to level of care, court substance use disorder evaluation, individual and family counseling, group therapy intensive outpatient program, NH approved impaired driver care management program, transportation with community van	Intervention, Treatment, Recovery
Weeks Medical Center	Hospital, community-based organization	Individual outpatient counseling, recovery support services, primary care services, emergency	Intervention, Treatment, Recovery
Tri Country CAP Friendship House	Home – 18 licensed beds, 13 high intensity, 5 transitional	Short-term residential, transitional living, peer recovery support services	Treatment, Recovery
Prisons	Prison	Treatment programs for which non-violent offenders get time off of sentence for participation	Treatment, Recovery
North Country	Community-	Peer support	Recovery

Serenity Center	based organization		
The Haven Peer Support Center	Community-based organization	Peer support	Recovery
HOPE for NH Recovery	Community-based organization	Peer recovery	Recovery

CARROLL COUNTY ASSETS			
PROVIDER	SERVICE SETTING	SERVICES OFFERED	COC COMPONENT
Memorial Hospital	Community Hospital/Primary Care/birthing center	Suboxone-out patient, Treatment for pregnant mothers-wrap around support	Treatment, intervention
White Mountain Community Health Center	Community Health Center	Teen/Adult; SBIRT; mental health Counseling, food/financial assistance, referral, insurance navigator	Early identification and intervention
Huggins Hospital	Hospital	Emergency care, referral	emergency intervention, referral
Saco River Medical Group (Conway/Glen) 447-3500	Medical Group	Primary Care, Medically Assisted Treatment in process, Walk-in 7 days week, On-Site Lab/X-Ray, Pediatrics, Spine Center, Acupuncture, Orthopedics	Treatment, intervention
Ossipee Family Planning & Teen Clinic, 539-7552	Community Health Center	physicals, gyn., birth control, counseling	Prevention referral
Carroll County Health and Home Care Services, 323-9394	traveling nurses/care	home based care for seniors/disabled	prevention, referral, medical care
Tamworth Community Nurse Assoc. 323-8511	traveling nurses/care	Free health care, skills nursing, prenatal/new born care, education, health screening	prevention, referral, medical care

Wolfeboro visiting Nurses 569-2729	clinic and in-home	new baby bases, physicals, PT, parent education, dental for children	prevention, referral, medical care
Visiting Nurse Homecare and Hospice	In the home	evaluate; monitor seniors in their home	early identification intervention
Central VNA	In the home	evaluate; monitor seniors in their home	early identification intervention
Whitehorse Addiction 651-1441	Addiction Center	Drug/Alcohol; Evaluation/ Counseling (working towards intensive outpatient and residential care/men) Resources; Education; transportation	Prevention; Intervention, recovery
Green Mountain Treatment Center 877-824-5992	Treatment Center in Effingham, other centers in the state	18+; Men/Women; 12-step treatment; dual-diagnosis, extended care; Recovery Oriented System of Care (ROSC)	Intervention, treatment, recovery - NOTE: Recently opened/Limited staffing communication
Road to a Better Life	Treatment Center	Alcohol, heroin/Opioids; Intensive Out Patient; medication (Suboxone, Vivitrol); Group therapy	Intervention; treatment; recovery NOTE: Limited Communication staffing challenges
Sinfonia, Melissa Fernald MLADAC/MHT - 515-0150	agency, home, other sites	Growing practice: Teens/Adults. Prevention; Education; treatment/Brief-Intervention Program; Outpatient/Intensive Outpatient; groups. Alcohol/Drugs	prevention, early identification intervention, treatment, recovery
Northern Human Services, Community Health Center	Treatment Center, Mental Health, Developmental Delay	Substance Abuse Treatment; Drug/Alcohol; Emergency services; Psychiatric Services; Co-occurring diagnosis; evaluation	Early identification and intervention; treatment; recovery
The Child & Family Center for Wellness	Counseling Center/acupuncture	Therapy; Art therapy; Acupuncture/	treatment; recovery

Mt Washington Valley Psychological Services	Counseling Center	24 hr crisis counseling for clients, therapy, referral, Adults, children and Adolescents	early identification intervention
Diane Johnson	Individual practice	Counseling	early identification intervention
Jenn Bella	Individual practice	Counseling	early identification intervention
Maura Sullivan	Individual practice	Counseling, adolescent	early identification intervention
Wolfeboro Counseling Association	Counseling Center	Counseling	early identification intervention
Tri-County Cap	Multiple sites	Substance Abuse treatment; Screening; Assessment/Diagnosis ; Individual-Group Counseling; Intensive Outpatient Program; Short-term Residential; Transitional Living; Peer Recovery Support Services; Assistance Programs, Homeless	Prevention/Treatment/Recovery
Lance Zack 603-986-0961	Court/agency	identify; referral; peer recovery support services, juvenile diversion	early identification referral
Sinfonia, Melissa Fernald MLADAC/MHT - 515-0150	agency, home, other sites	Teens/Adults. Prevention; Education; treatment/Brief-Intervention Program; Outpatient/Intensive Outpatient; groups. Alcohol/Drugs	prevention, early identification intervention, treatment, recovery
MWV Supports Recovery	Beginning Initiative	FASTER Parent Support	Parent Support
Wayne K. Cunningham, MLADC, LMHC	Individual Practice	Counseling, assessment, participates in MAT	treatment, recovery
Joni O'Brien MFT, MLADC	Indiv Practice	Counseling, evaluation	Prevention, intervention
Wallastook Counseling 569-5099	Indiv Practice	Counseling, evaluation	Prevention, intervention

Peter Stone MLADC	Indiv Practice	Counseling, evaluation, MAT	Prevention, intervention
Kieran Cunningham, MLADC, LCMHC	Indiv Practice	Counseling, evaluation, MAT	Prevention, treatment, intervention
Children's Unlimited	Childcare Center	Child care for mothers in recovery	recovery support
Carroll County Health Line, 877- 499-4171		Medical information	referral/recovery
Ossipee Concerned Citizens - 539- 6851	Volunteer Support	Various outreach/support	referral/recovery
Kids in Distressed Situations 800- 266-3314	Volunteer Support	New Clothing for kids	referral/recovery
Carroll County Adult Education/Carroll Academy 323- 5100	Education	Adult learners/HiSet/HS Diploma	prevention/referral/recov ery
Transportation:			
Caregivers, 569- 6780	Volunteer Transportation	Transportation to medical appts, friendly visits, other assistance	access to treatment/recovery (potential to be explored)
Shepards, 539- 4312	volunteer Transportation	Transportation to medical appts	access to treatment/recovery (potential to be explored)
Blue Loon		transportation	access to treatment/recovery
Gibson Center		Transportation for Srs/Dev. Disab.	access to treatment/recovery (potential to be explored)

2d: Assessment of gaps in care

A provider’s perspective on the gaps in behavioral health care is pretty consistent across the continuum of care for Region 7 IDN. One provider within the Region 7 IDN summarized the issue: “the real issues for us are the bureaucratic demands that increase work load. There is not enough money to compensate staff well so they leave to go to higher paying jobs. Rates for treatment have not increased for us in years, but demands have increased exponentially. Many decisions about services are made without consulting people who deliver service.” A lack of funding and low reimbursement rates have both been contributing factors to workforce recruitment and retention challenges, which in turn have resulted in a negative impact on healthcare delivery and patient outcomes in Region 7 IDN. Providers feel evidence based practices are available but not adequately funded. Providers feel it is often difficult to refer patients for

additional services to the community mental health center due to wait times, and it is difficult to refer patients for voluntary or involuntary inpatient admissions due to lack of beds.

Parents and guardians of children with severe mental illness face many obstacles in schools and child care organizations to get the needed services and supports. There needs to be more education for parents, guardians, and employees at schools and children-focused organizations. This education should focus on serious emotional disorders, including early signs, treatment options, reducing stigma, and who to contact for help or more information. A shortage of child focused psychiatric providers and high turnover of community mental health clinicians leads to long wait lists for children to be seen. There are limited services for autism in the Region 7 IDN service area, and no community support groups for this condition.

Adults living with severe mental illness in Region 7 IDN also have significant challenges. There is a need for integrated health services and screenings to help detect mental health issues by the primary care physician. Clinical interventions and treatment rely on a good relationship between patient and provider, and often a primary care provider is the first point of contact for a patient suffering from severe mental illness, because of a relationship which has already been developed. The behavioral health workforce shortage, especially around recruitment and retention of psychiatrists, means after an adult is referred to a psychiatrist, it may take a month or two to actually be seen. In cases of severe mental illness this is unacceptable. Since it is hard to find a provider to get treatment, the patient often seeks help in emergency rooms. There are disagreements between agencies on who is to provide behavioral health emergency services to certain clients in the emergency room during weekdays leaving hospitals caught in the middle, and patients often not receiving optimum care. Due to the rural nature of Region 7 IDN, emergency services for suicide assessment are often provided by telemetry in the emergency room. While this is better than nothing, it is still not ideal, and often both the patient and emergency room staff feel the process is inadequate.

On top of all the treatment issues, adults living with severe mental illness lack necessary supports to help them with day to day living, especially transitional supports during critical recovery times, and transitional housing. If a person needs ongoing supervision, there are very few group home beds in the State, and there is no funding to address individualized adult foster care settings. There is a shortage of both employment opportunities and employment services and supports within Region 7 IDN. There are not enough peer support specialists to help those with severe mental illness. The area also needs to involve criminal justice systems more, which includes offering more supports to those transitioning from incarceration.

Seniors with severe mental illness also suffer from stigma, and a lack of education, awareness, and understanding of the disease. The region needs to address this issue through education targeted for this age group. There are “old school” ideas about mental health issues, and these ideas need to be dispelled. Often, families and seniors do not understand that depression and other mental health issues are not a normal part of aging. As a group, white males age 85 and older have the highest suicide rate in NH (66.82 per 100,000) and individuals age 65 and up represent just 12 percent of the NH population, however, they account for more than 15.75 percent of the suicide deaths.⁸ There is a need for education on suicide prevention and the older adult workforce needs education regarding early identification of

⁸ <http://theconnectprogram.org/statistics-and-facts-about-suicide-new-hampshire>

mental illness. Home care providers in the region report a huge gap in the treatment, management, and support of seniors with severe mental illness, and their care givers.

Substance use disorder (SUD), including opiate addiction is a big issue within the Region 7 IDN, specifically in the adult population. This problem is hard to address due to a lack of treatment and recovery sites. Very few out-patient services exist to address this issue, and there is a long waiting list, often taking many weeks to receive in-patient treatment. An extraordinary amount of time is needed to refer patients to an inpatient facility because so much time is spent calling around just looking for an empty bed. There is a lack of resources at every level: prevention, residential treatment, and outpatient treatment. A lack of funding has led to low salaries for both mental health and substance abuse professionals, which has caused many workers to leave the field. In addition; there are not enough people entering these professions to meet keep up with the demands of the region. When Medication Assisted Treatment (MAT) is offered it often occurs without behavioral health therapy or case management supports, which are both beneficial in the recovery process.

The prevalence of co-occurring mental health and SUD conditions is pretty high in Region 7 IDN. Dual training for substance use disorders and mental health needs to become part of the basic curriculum for therapists because these two conditions often go hand in hand, and the area does not have enough skilled co-occurring practitioners. Mental health and SUD treatments often exist in silos, so additional work on the integration of behavioral health and primary care will lead to better patient care and improved health outcomes. There is a lack of treatment options and programs to address this population. There are very few in-patient facilities capable of treating this population. Specifically, Region 7 IDN needs to work on early identification of co-occurring mental health and SUD conditions. Families often lack education and an understanding of the high percentage of SUD due to underlying and undiagnosed mental illness. The area also needs transitional services that support individuals and families from the acute care phase of addiction through to long term recovery. One IDN partner organization within Region 7 reported a “behavioral health/SUD referral made to Dartmouth this spring was refused citing the patient was too complex for them & offered the client no options so they returned to our practice & we did our best.” The patient in this instance also reached out to NCHC to share her perspective. She had been struggling with addiction for years, and The Division for Children, Youth and Families felt she was unable to care for her child, so her child was removed from her home. She realized she wanted to “get clean” and reached out for help. Her hometown health center got her into a program at Dartmouth, and she started going there on a daily basis, four days a week, traveling 2 & 1/2 hours each way to get there. Three weeks into the program she had to share her story in a group session. A few days later she received word through a message on her answering machine that her case was too complex and risky, and Dartmouth was going to remove her from this program. It was at this moment that she felt the most helpless. She thought, if one of the best healthcare facilities in the State of NH was unable to help her, who would help her? She returned to her local community federally qualified health center. The staff worked over two months to try to find another program for her, while supporting her in her efforts to the best of their ability. The health center ultimately found another program for the patient, which included medication assisted treatment, and intensive behavioral health sessions. Ten months into this process, and this patient is now “clean”, leading a peer support group, has completed her behavioral health sessions, and has her child back. She said the process has been difficult, the experience with Dartmouth was awful, and she is so thankful that she had the staff at the local health center to get her through this entire ordeal. This patient’s story shows the need for more local treatment options that can be delivered through true

integrated care in a setting that fosters positive patient/provider relations and leads to improved health outcomes.

Co-morbid medical and behavioral health conditions are another big problem in Region 7 IDN, especially within the adult and over 65+ population as some of our previous data has reflected. Many patients in this region suffer from a variety of medical conditions including cardiovascular disease and diabetes. These people often see their primary care physician for treatment of these physical conditions, therefore it is important to work on the integration of primary and behavioral health so their mental health conditions are being addressed appropriately, and the patient is not receiving fragmented care. For this integration to occur, medical practices and mental health centers need to share resources in a way that works for both systems and doesn't duplicate services.

In regards to patients with co-occurring developmental disability and mental health/SUD conditions in Region 7 IDN there is lack of professionals who specialize in this area and understand how to help this population. The region needs funding to train clinical people in both specialties and locate them within the developmental services system. The developmental disability system does not have the internal capacity to manage mental illness/substance abuse within their system, and community mental health centers and substance abuse facilities do not have the resources or expertise to treat persons with significant cognitive impairments. The region needs to streamline ways these patients access services so families do not have to deal with multiple systems. In addition, there is a shortage of residential care options.

Mild-to-moderate mental illness is seen in many youth, adults and older adults in Region 7 IDN, and there is no state or federal funding dedicated to this group. Both of these illnesses can be debilitating if left untreated, and there is a need for early detection and intervention for all ages. There are gaps in early detection since routine screenings are only reimbursed for adult depression. Primary care providers sometimes miss these symptoms and treat for physical illness. Many patients lack an understanding that these disorders are treatable, and they need to be educated about early warning signs. Stigma often causes many people to deny or minimize symptoms and not get treatment. To address this education, there should be a basic course in mental wellness as part of the school curriculum starting in grade 1 and going through high school.

Those at-risk for a mental health and/or SUD condition encompass the entire Region 7 IDN. Anyone can be at risk for one of these conditions in their lifetime. The best way to address this is to increase funding that will be used to embed primary prevention activities within the school systems utilizing student assistant program models. In addition, there needs to be a community clearinghouse of sorts that directs people where to go to get the appropriate care they need.

3. Community Engagement and Stakeholder Input

3a: Narrative description of IDN solicitation of community input in developing Project Plan

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

The primary purpose of community engagement for the IDN is to build relationships with community members who will work together as ongoing partners, in all ways, to build support for the IDN mission, with the ultimate goal of providing integrated health care to improve the lives of

the residents of the North Country. The primary channel of soliciting input from IDN partners throughout the development of this Project Plan was in-person meetings. Additionally, feedback was gathered from IDN member organizations via SurveyMonkey surveys, and questionnaires sent by e-mail. Some of the Work Group meetings were held in-person and some with video conferencing utilizing Zoom technology. IDN community input included more in-person meetings and on-going conversations than presented in the IDN application.

Three full IDN in-person planning meetings were held over the past three months. Meetings were held in venues centrally located in the large geographic region in order to increase access for IDN members. The first two meetings were each two hours. The first meeting had twenty-five attendees representing public health, primary care, substance abuse treatment and recovery, mental health, hospitals, legal services, long term care, and social services. The second meeting had twenty-one attendees representing the same stakeholder groups plus a county administrator, and home health care. The third meeting was an all-day planning retreat that allowed IDN members to provide input and feedback directly related to the development of the Project Plan. Each of the Work Groups met to identify priorities and strategies to carry out their responsibilities. Work Groups include stakeholders from each of the “sub-areas” of the large area included in Region 7. The Steering Committee met to discuss key issues including such things as IDN member accountability, decision-making processes, and evaluation of network adequacy to serve the behavioral health needs of the region. IDN members also worked in small groups to provide input for each of the six required projects. This meeting was attended by 46 people, including stakeholders from groups noted above. Two of the three full IDN meetings were led by outside facilitators who were able to focus on the process of the meetings so participants could focus on meeting content.

SurveyMonkey was used to provide IDN members with information about the choices for community-driven projects and to and elicit their feedback. Survey results were distributed via e-mail and discussed at the full group meetings.

ii. Frequency with which community input was sought

As noted above, full IDN meetings were held monthly throughout the Project Plan development period. The governance Work Groups and Steering Committee each met at least once following the all-day retreat. Each group selected a chair, reviewed and approved their committee charters, and discussed flow of communication. Throughout the development of the Project Plan, IDN members were frequently contacted by e-mail and phone to gather feedback and information to inform the direction of the Plan.

iii. Mechanisms to ensure the community engagement process was transparent

In order to ensure the community engagement process is transparent, all meeting notes have been distributed to the full IDN in a timely manner, regardless of their attendance at meetings. All of the decisions made using SurveyMonkey were distributed to the full group for discussion and feedback. All data was discussed at meetings, and, in fact, community input also influenced a survey “do-over” to decide the community-driven projects.

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

1. Community-Driven Projects

In order to decide which community-driven projects Region 7 would work on, NCHC presented data from community health needs assessments, community health improvement plans, the youth risk behavior survey, and other available resources to the group for discussion and review. IDN partners requested that a SurveyMonkey survey be distributed with an explanation of each of the choices for the project areas. Results from the survey initially identified three projects: 1) Care Transitions Teams; 2) Expansion in Intensive SUD Treatment Options Including Partial-Hospital and Residential Care; and 3) Substance Use Treatment and Recovery Program for Adolescents and Young Adults. Survey results were presented and discussed at the second full IDN meeting. The discussion focused on the capacity and feasibility of successfully implementing each of the projects. Many concerns were expressed about the projects and there was consensus from the group to have a second vote to determine the community projects. Another SurveyMonkey survey was sent to the full group, which resulted in the final choices for the community-driven projects: 1) Care Transitions Teams; 2) Expansion in Intensive SUD Treatment Options Including Partial-Hospital and Residential Care; and 3) Enhanced Care Coordination for High-Needs Populations.

2. Governance Structure

The Governance Structure for Region 7 is based not only on the required domains but also on input from community stakeholders. IDN participants are spread out in a large geographic region and there was concern that the full area would not be well-represented within the Work Groups and Steering Committee. The IDN has 7 “sub-areas” within the region – Northern Carroll County, Southern Carroll County, Colebrook, Berlin/Gorham, Lancaster/Whitefield, Woodsville, Haverhill, and Littleton. Based on consensus of the group, each of these areas are represented on each of the Work Groups and Steering Committee.

3. Process for Funds Allocation

The method that will be used to allocate funds to IDN organizations for each of the projects was suggested and finalized by community stakeholders. A process will be put in place that will require organizations to request funds by following a protocol that has been reviewed and approved by the Financial Work Group and the Steering Committee. Funds will only be allocated when proposals are approved through a comprehensive review process.

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

At this point in the process, there has not been any community input that could not be addressed.

3b: Narrative description of IDN solicitation of community input during demonstration

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

The Region 7 IDN will maintain the same channels and venues to solicit community input that have been taking place, including full IDN meetings, and Work Group and Steering Committee meetings. The Work Groups and Steering Committee will meet monthly via phone or Zoom, and quarterly in person. Additional meetings will take place as necessary, particularly when funding proposals are being reviewed. Full IDN meetings will take place quarterly to review the projects and progress toward specified metrics. All notes from these meetings will be distributed to the full group in a timely manner.

In addition to this, the North Country Health Consortium will utilize their website to create a section for the IDN. There will be different sections on the site, including one for the community, one for IDN members, and one for the Work Groups and Steering Committee. The intent is for the site to be simple and easy to navigate. The website will include secured sections available for IDN members only which may include opportunities for discussion boards. The secured section will also provide an on-line option to submit proposals for funding. All relevant IDN documents will be posted on the website. As the website grows, it may also include a resource section that would be available for both providers and patients. The link to the State of NH DSRIP website would be included. The website will help ensure transparency of IDN program planning and implementation.

Information about the IDN projects will also be presented at Public Health Advisory Council meetings in both the North Country and Carroll County Public Health Regions. NCHC’s participation in local and regional provider meetings will provide opportunities to present information about the IDN and solicit feedback and input.

ii. Frequency with which community input will be sought

In order to maintain effective communication with IDN network partners and other community members, NCHC will develop a communication plan. An example of the type of template that may be used for the communication plan is below:

Communicate What	Purpose	Frequency/duration	Communicate to		Communication Method
			IDN Leaders	Stakeholders	

iii. Mechanisms to ensure the community engagement process is transparent

NCHC will maintain transparency as the IDN infrastructure planning and capacity building moves forward. An important aspect of transparency will be to help IDN stakeholders understand the financial impact of decisions that are made and the impact on program outcomes. Mechanisms, like periodic press releases and articles for partner organizations to incorporate into their publications, will be provided by the Lead Agency and placed on the website to communicate information in a timely manner to the community. Transparency will be maintained by providing venues and opportunities that will enable sharing and collaboration among IDN members.

4. Network Composition

4a: Finalized network list

See the “Supplemental Data Workbook.”

4b: Description of how IDN network will be leveraged to address care gaps

The North Country Health Consortium (NCHC) is the Lead Agency for the Region 7 IDN. NCHC’s mission statement, “leads *innovative collaboration to improve the health status of the region*” reflects why the organization applied to be the Lead Agency. NCHC is a mature, vertical, rural health network which has been dedicated to improving access to health care to residents of Northern New Hampshire for nearly 20 years. During those years, NCHC has focused on the creation and sustainability of a cohesive regional health care delivery network, which includes offering training and development in order to attract and retain qualified health professionals. As a result of all of this experience, NCHC is well positioned to provide strong leadership for the Region 7 IDN. The organization has structured financial processes in place, and will work with IDN partner agencies to offer technical assistance and guidance as necessary to ensure project metrics are being met so the maximum amount of funding is received in the service area.

The rural nature of the Region 7 IDN service area contributes to the behavioral health workforce shortages, the need for treatment and recovery sites, and the lack of supportive housing for individuals experiencing mental health issue. The average travel distances from most towns to available sources of health care available for low income families is 25 miles or more. This, combined with a lack of public transportation, has meant that many of our patients do not receive the services they need. In addition, Northern New Hampshire, like most rural areas, suffers from severe shortages of trained personnel in every facet of health care delivery resulting in another barrier to care -- the capacity barrier -- that is erected when the health professions workforce is not sufficient to meet the needs of area residents.

Region 7 IDN is well-positioned to significantly improve clinical outcomes for the target population because the partners already recognize the challenges and behavioral health gaps within the region, and already have a long history of working together to address these regional healthcare needs, and will lead to sustainability of the Region 7 IDN. Region 7 IDN partners have worked together on transformation initiatives, including an Accountable Care Organization and a Community Care Organization. The Carroll County Public Health Advisory Council has well-established workgroups in the areas of Early Childhood and Parenting Support, Mentally Healthy Families and Addiction Free Families, Aging, and Emergency Preparedness. The proposed IDN has representation from all of the key sectors from both the North Country and Carroll County Public Health Regions that will work together to improve clinical outcomes for the behavioral health population. It is important to note that several organizations that are part of the IDN cover the entire Region 7 area. Most notable are Northern Human Services (NHS) and Tri-County Community Action Program (TCCAP).

NHS provides professional support and services to people affected by mental illness, developmental disabilities, substance abuse, acquired brain injury or related disorders. NHS has been a primary provider of mental health services for over 45 years and offers a comprehensive array of recovery and resiliency oriented community based mental health service for children, adults and older adults. Clinic staff provide

evidenced-based practice interventions and employs dually licensed clinicians who provide comprehensive treatment services to dually diagnosed individuals (mental health/substance abuse), consistent with scientifically proven best practices. NHS staff hold leadership positions in several IDN partner organizations.

TCCAP services range from Head Start child development programs to programs for seniors, including senior center/meal sites and meal on wheels. The Tri-County CAP, Division of Alcohol and Other Drug service program facilitates a continuum of care model offering a comprehensive array of services which include Recovery Support Services, Outpatient and Intensive Outpatient services offered in Coos, Carroll, and Grafton Counties, as well as, both High and Low Intensity Residential Treatment in Bethlehem, NH. TCCAP provides a large array of services including an outpatient department that serves individuals whose alcohol and drug use affects their daily living. TCCAP has a short-term residential substance abuse treatment program, a transitional living program, a residential substance abuse treatment program, and peer recovery support services. With additional funding from this opportunity, both NHS and TCCAP will be able to expand their services, particularly in terms of workforce development, transportation and homeless outreach. Both organizations have strong relationships with IDN partners and understand the unique and varied cultures of the North Country.

Additional organizations that serve the entire region include ServiceLink and Granite State Independent Living.

5. Relationship with Other Initiatives: *Description of existing Initiatives*

As an organization that encompasses a variety of programs, NCHC has developed initiatives that focus on the creation and sustainability of a cohesive regional health care delivery network. NCHC has built an inclusive regional system that provides a vehicle for collaboration; plans, implements and evaluates community-based health activities; improves access, assessment, referral and coordination of client care; and offers training and development in order to attract and retain qualified health professionals.

NCHC is currently involved in several existing delivery reform initiatives that will be enhanced through the IDN as follows:

- 1. Northern New England Transformation Network**-The Northern New England Practice Transformation Network, led by Maine Quality Counts in collaboration with the New Hampshire Citizens Health Initiative at the University of New Hampshire Institute for Health Policy and Practice, and Vermont Program for Quality in Healthcare, Inc., is funded through the Centers for Medicare and Medicaid Services' Transforming Clinical Practice Initiative to provide technical assistance to health care practices in the transition to value-based payment. NH Citizen's Health Initiative has partnered with North Country Health Consortium to provide practice facilitation to health care organizations in NH.

As part of this four year health care reform initiative, the North Country Health Consortium is providing practice facilitation and technical assistance to over 500 healthcare providers. Our practices include the following Region 7 IDN members:

- Northern Human Services-Berlin
- Northern Human Services-Colebrook
- Northern Human Services-Conway
- Northern Human Services-Littleton
- Northern Human Services- Wolfeboro
- White Mountain Health Center
- Huggins Hospital Outpatient Practices

While some providers are primary care and others are behavioral health and specialty care practices, all are providing healthcare to the community members of IDN Region 7. Together we are working on improving quality of care and all of these practices have specific goals of improving care coordination including the integration of behavioral health and primary care.

2. **Continuum of Care-** The NH Department of Health and Human Services/Bureaus of Drug and Alcohol Services (DHHS/BDAS) has determined that the best way to prevent and/or decrease the damage that substance misuse causes to individuals, families, and communities is to develop a robust, effective and well-coordinated continuum of care in each region of the state, and to address barriers to awareness and access to services. As such, funding has been provided to regional public health networks for the facilitation of a regional continuum of care that will include health promotion, prevention, early identification and intervention, treatment, recovery supports and coordination with primary health and behavioral health care. These Facilitators are communicating with and bringing partners together to develop Regional Continuum of Care Plans that use information from the completed regional assets and gaps assessments.

North Country Health Consortium coordinates the Public Health Region for Northern NH and, thus, serves in the role of Continuum of Care Coordinator for our region. NCHC has always recognized the damaging impact that substance misuse and addiction have had on the individuals, families and communities of Northern New Hampshire. Carroll County Public Health region serves the role in Carroll County.

The North Country and Carroll County Prevention Network operates through a series of connected organizations that share a common goal of reducing substance misuse in the North Country. The network includes organizations from all six identified sectors: Education, Health and Medical, Safety and Enforcement, Community and Family Supports, Government and Business. Through the efforts of these partner organizations and coordination provided by both NCHC and the Carroll County Public Health Network, a strong network of prevention services is maintained.

Through the development of a Continuum of Care Facilitator position, these connections have been further strengthened and expanded in the region. Upgrading the prevention system has been a priority, through participation in forums, events and provider groups throughout the region. Reaching out to providers of prevention, intervention, treatment and recovery services has helped to coordinate the systems and smooth the relationships between entities and the transition

between services. The North Country region will work towards implementing proposed actions through shared responsibility with regional stakeholders.

- 3. Behavioral Health Learning Collaborative**-The NH Citizen's Health Initiative, a program of the Institute for Health policy and Practice at UNH, is entering its second year of leading the Behavioral Health Integration Learning Collaborative, an initiative aimed at integrating behavioral health into primary care. This initiative brings together many of our Region 7 IDN members and key regional stakeholders to collaborate on efforts to improve overall health in line with the Triple Aim of "better health, better care, and lower costs." Year two of the project will again bring together health care providers, payers, and other stakeholders to explore ways to integrate behavioral health and primary care; to develop sustainable payment models for integrated behavioral health; and to provide evidenced-based education and support to organizations in the process of integrating primary care and behavioral health. NCHC has been involved in the Behavioral Health Learning Collaborative since its inception. In addition, NCHC has been instrumental in participating in the NH Health Plan in the region. We have had both Navigators and Consumer Assisters on staff and continue to facilitate the regional coordination of Assisters. Many IDN partners have embedded Assisters into their own organizational functions.

Members of the Region 7 IDN are key stakeholders in one, two, and in some cases all, of the initiatives described above. All of the initiatives are all well intentioned and very important to improving the health of our community members. However, one of the frustrations that we hear most often from health care and behavioral health providers is that they are too busy, asked to do more than they can handle, and don't understand what the differences between the initiatives are. Effective leadership of the IDN will help integrate these initiatives by reinforcing common goals and idea sharing, linking potential resources, and building relationships that encourage collaboration. Having an understanding of overlapping initiatives and bringing the same key stakeholders together on initiatives with common themes will further energize and provide the momentum for true health care delivery reform.

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

The Region 7 IDN recognizes the impending opioid crisis that is affecting physical and mental health, safety, and overall quality of life for North Country and New Hampshire residents⁹. In line with state and national efforts, the Region 7 IDN is prioritizing the expansion of Intensive SUD Treatment options. This capacity-building integration will include expansion of capacity and supports to achieve system-wide enhancement that takes a "whole-person" approach to managing and treating individuals with substance use disorders to achieve long-term and stable remission of substance misuse, reduction in hospitalizations, reduction in arrests, and decrease psychiatric symptoms for individuals with co-occurring mental health conditions.

⁹ "The Opiate/Opioid Public Health Crisis: Update on the State of New Hampshire's Comprehensive Response" <http://governor.nh.gov/media/news/2016/documents/pr-2016-08-24-heroin-opioid.pdf>

The North Country IDN Service Region, through community needs assessment processes and key stakeholder input, has identified a multitude of barriers and gaps in the region that affect all aspects of the continuum of care:

- **Prevention-** a cost-effective measure that can represent a return on investment of \$16 for every dollar invested¹⁰ - is not consistent in K-12 schools in the region, including the use of evidence-based programs as well as insufficient supports for student assistance programs. Also cited was lack of training and education for social service and healthcare providers for early detection and intervention. Community-level efforts, including coalitions, teen supports, structured teen centers, and community supports beyond AA, were also indicated as gaps.
- **Intervention-** intervention barriers included lack of communication across sectors, lack of drug courts and youth diversion programs, and insufficient police officers trained in Police Assistance in Addiction and Recovery Initiative create barriers for intervention. Other intervention barriers indicated the limited availability of Naloxone and inconsistent integration of primary care with behavioral/substance abuse services. Limited cell phone and internet connectivity also hinder residents when seeking help.
- **Treatment-** treatment barriers were cited as the most abundant gaps for the provision and expansion of services. The array of barriers include: workforce capacity and lack of specialists and providers who are able to treat individuals with co-occurring MH/SUD; lack of parity for provider and workforce compensation, leading to high turnover, difficulty with recruitment, and retention of qualified staff; lack of transportation with great distances between facilities, transitional supports, transitional housing, and crisis apartments; emergency services, including telemetry in emergency departments; lack of culturally competent treatment options, i.e. veterans and refugees; insurance reimbursement disparities and misaligned/inadequate reimbursement; long wait-lists for current in-patient treatment options; lack of resources for residential and out-patient treatment; lack of Medication Assisted Treatment (MAT) with required behavioral health therapy and case management; and the perception that treatment and care operate in silos.
- **Recovery-** general resources were cited as recovery barriers, including: lack of transitional support for individuals and families; education for families; community supports; and lack of ongoing support. Other needs indicated that all insurers should cover ancillary services to support recovery.

In line with the New Hampshire Governor's comprehensive response and recommendations to combat the opioid crisis, the IDN project goal of expanding SUD treatment will include: integration of care for early detection and intervention, workforce development and recruitment of qualified substance use and mental health professionals, as well as an increase in intensive treatment facilities. Building on the innate collaborative nature of the region for efficiency and resource allocation, IDN partners will focus on systems and processes that allow for timely referrals and appropriate access to treatment, as defined by the American Society for Addiction Medicine (ASAM) and aligned with the project metrics for the DSRIP. Tri-County Community Action Program (TCCAP), the sole residential treatment program in the

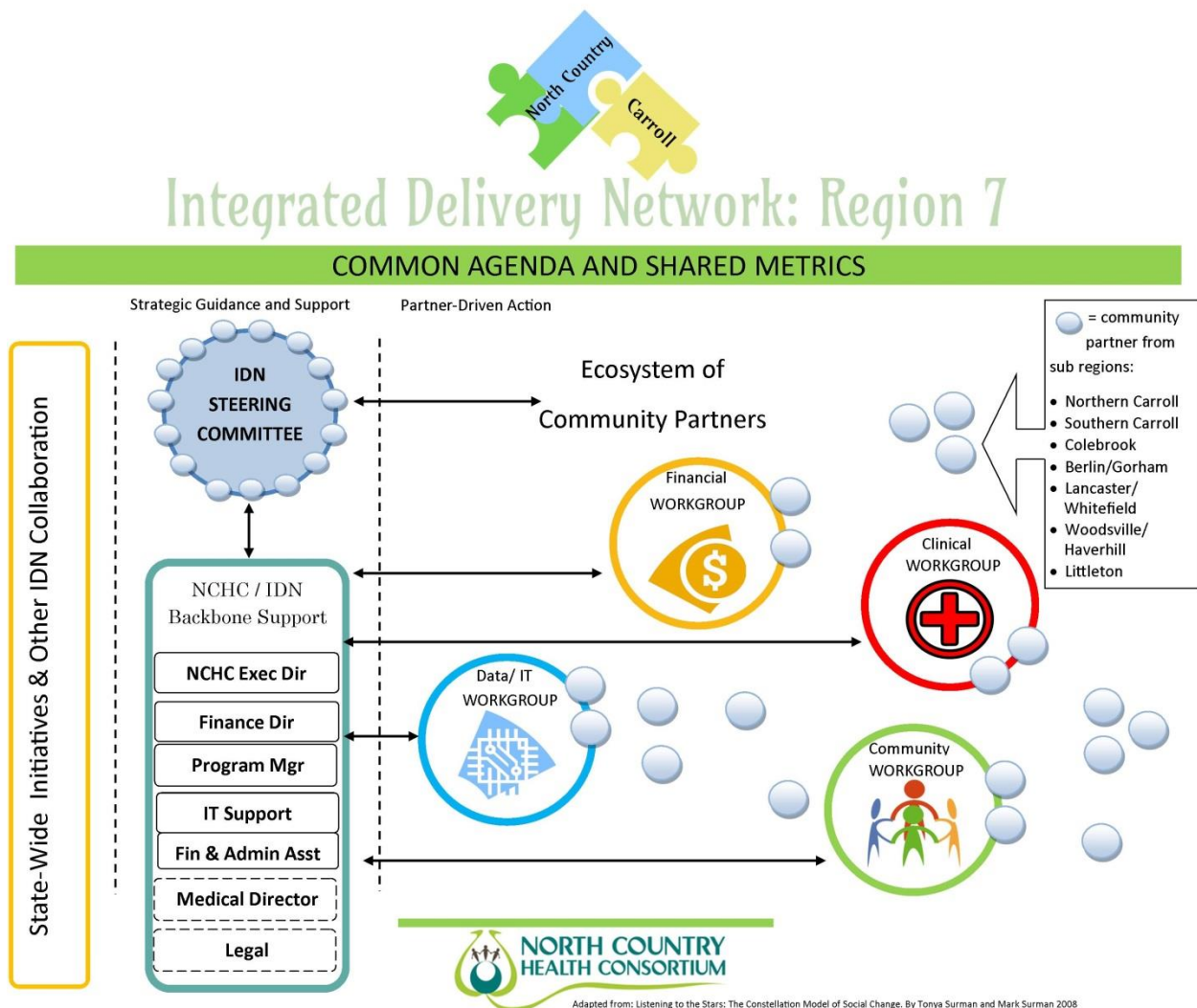
¹⁰ "The Opiate/Opioid Public Health Crisis: Update on the State of New Hampshire's Comprehensive Response" <http://governor.nh.gov/media/news/2016/documents/pr-2016-08-24-heroin-opioid.pdf>

region, and Northern Human Services, the primary mental health provider agency in the region, will be instrumental to support this system development.

Short and long-term effects of this enhancement will lead to resource development, streamlined referrals, adequate and qualified local capacity for treating MH/SUD, and expanded access to treatment for individuals with adequate transitional supports to achieve ongoing recovery. Creating a sustainable infrastructure for timely and appropriate patient referral, treatment, and recovery support will lessen the current burden of the opioid crisis; will expand access to services and awareness of insurance benefits for SUD treatment; will reduce the adverse experiences on families and in communities; and will lead to meaningful transition back into North Country communities. Further, health and human service organization will be better aligned to support patients with MH and SUD, reducing intergenerational and residual effects of addiction within the larger community.

7. IDN Governance

7a: Overall 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 above. The premise of collective impact is that no single organization can create large-scale, lasting social change. Successful collective impact initiatives assume five conditions associated with relative success:

- **Common Agenda:** All participants share a vision for change that includes a common understanding of the program and a joint approach to solving the problem through agreed-upon actions.
- **Shared Measurement:** All participating organizations agree on the ways success will be measured and reported, with a short list of common indicators identified and used for learning and improvement.
- **Mutually Reinforcing Activities:** A diverse set of stakeholders, typically across sectors, coordinate a set of differentiated activities through a mutually reinforcing plan of action.
- **Continuous Communication:** All players engage in frequent and structured open communication to build trust, assure mutual objectives, and create common motivation.
- **Backbone Support:** An independent, funded staff dedicated to the initiatives provides ongoing support by guiding the initiative's vision and strategy, supporting aligned activities, establishing shared measurement practices, building public will, advancing policy, and mobilizing resources.

The five conditions fit with the goals of the IDN and the framework of collective impact will help to keep participants focused as they work to to implement and monitor the project plan. The Region 7 IDN will have a Steering Committee, the “Backbone Support” is the North Country Health Consortium (Administrative Lead) and there will be several sub-committee/work groups with community partners from various sectors. The common agenda and shared metrics will guide the challenging work of the IDN.

A participatory planning process was used when creating the Region 7 IDN Governance structure because this method usually increases the chances of success of a given project. Using this participatory approach everyone who had a stake in the project were invited to three different meetings to voice their opinion on the structure. Everyone's participation was welcomed and respected, and the entire IDN had a role in the decision-making process, and reached a consensus before the IDN Governance Structure was finalized.¹¹ Region 7 IDN members approved the Governance Structure model depicted above as the best way to govern the region's IDN.

The large geographic spread of the IDN's service area leads to seven sub-regions often “naturally” occurring within the area: Northern Carroll County, Southern Carroll County, Colebrook, Berlin/Gorham, Lancaster/Whitefield/Groveton, Littleton, and Woodsville. These sub-regions have been accustomed to working on projects specific to the needs of the sub-regions, so the IDN Lead Agency worked with the group to come up with a structure that would keep this in mind, yet ensure the IDN was taking a full regional approach. This structure shows the seven sub-regions, but the drivers of the IDN program are the four governance domains mandated by the State: clinical, financial, data, and community engagement. A workgroup will be formed for each of these areas with equitable representation from the sub-regions and various member type agencies represented on each workgroup. The IDN membership felt this structure would give a fair voice to partners and allow the Region 7 IDN to focus on improving

¹¹ <http://ctb.ku.edu/en/table-of-contents/analyze/where-to-start/participatory-approaches/main>

patient outcomes and achieve true transformation. It also shows connectivity to the other IDNs and State work (e.g., IT working group, learning collaborative).

i. IDN's Principle Governance Committee

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. These charters will each have a clause that they will be reviewed on an annual basis to ensure IDN participants remember this project requires a flexible process that needs to be monitored and assessed for effectiveness throughout the demonstration period to ensure the outcomes are being met while still meeting the needs of the IDN members. These charters will also address accountability within the IDN. A memorandum of agreement will be drawn up between the IDN lead agency and individual IDN Committee members. This agreement will outline the expectations of the IDN lead agency and the expectations of the IDN Committee members. In addition, when funds are distributed to IDN member organizations, a memorandum of agreement will be executed which will clearly outline expectations of both the recipient and IDN Lead Agency.

The principle governance committee for Region 7 IDN will be referred to as the IDN Steering Committee. The IDN Steering Committee will have no more than 15 members, and have representation from the following stakeholder members, ensuring equitable representation from participating counties and sub-regions of the Region 7 IDN:

- Primary care practices and facilities;
- Substance use disorder (SUD) providers, including recovery providers;
- Regional Public Health Network host agencies;
- Regional Community Health Mental Health Centers;
- Peer-based support and/or community health workers;
- Hospitals;
- Federally Qualified Health Centers, Community Health Centers or Rural Health Clinics where available within a defined region;
- Community-based organizations that provide social and support services needed by people with behavioral health issues, such as transportation, housing, employment services, financial assistance, childcare, veterans services, community supports, legal assistance, etc.;
- County facilities, such as nursing facilities and correctional institutions

The primary role of the IDN Steering Committee is to take responsibility for the strategic vision, fund allocation, and the achievement of project metrics of the Integrated Delivery Network. It is intended that the Steering Committee leverage the experiences, expertise, and insight of key individuals at organizations committed to transforming the delivery of behavioral healthcare. Steering Committee members are not directly responsible for managing project activities, but provide support and guidance for those who do. The IDN Steering Committee will monitor and review the project status, as well as provide oversight of the project deliverables.

Steering Committee members have been identified by the IDN members, and as a result, the IDN membership entrusts the Steering Committee to have decision making authority on the behalf of the

Region 7 IDN. The members of the Steering Committee will strive to reach agreement by consensus at a level that indicates that all partners are willing to “live with” the proposed action. A quorum of any meeting of the Steering Committee shall consist of a majority of its voting members. Decisions will be based on majority of voting members present at the meeting. Partners will strive to work expeditiously and try to avoid revisiting decisions once made. If not at a meeting, member relinquishes control and those present may reach consensus decision. If those present need more input, a decision to wait can be made. The Steering Committee will provide strategic guidance and support for both the IDN Lead Agency and the four Workgroups.

As the Administrative Lead, NCHC has an IDN Executive Director that will provide oversight for all aspects of the project. Additional staff to support project management will include a project manager, a finance director, IT support, and an administrative assistant. Project management tools will be researched and an appropriate tool will be utilized. The management tool will be used to monitor things such as scheduling, budget management, resource allocation, collaboration, communication, quality management, and administrative monitoring.

ii. **Other governance committees and their relationship to one another and the principle governance committee**

The four IDN Workgroups will act as advisory committees for the IDN Steering Committee. The committees will have representation from a variety of IDN key stakeholders from the various geographic and business sectors served by the IDN. Each committee will have a Chairperson who will work with the IDN Lead Agency to ensure consensus-based recommendations on key issues identified by the respective workgroup will be shared with the Steering Committee. All recommendations made by the various workgroups must reflect consideration of various community goals, issues, and concerns, and find the appropriate balance among competing interests. The main roles of each of the four workgroups are as follows:

- **Financial Workgroup** will advise the IDN Steering committee regarding decisions about the distribution of funds earned by the IDN over the course of the demonstration.
- **Clinical Workgroup** will advise the IDN Steering committee regarding clinical pathway standards, and how to monitor fidelity, performance, and patient outcomes of the Region 7 IDN.
- **Community Engagement Workgroup** will advise the IDN Steering committee on ways to engage the entire Region 7 IDN community to gather input and feedback on improving patient outcomes in the region.
- **Data Workgroup** will advise the IDN Steering committee regarding data sharing processes, utilizing existing technology, and identifying what is needed to implement standardized reporting and monitoring for the Region 7 IDN.

iii. **Description of any separate legal entity being established as part of the IDN, if applicable**

At this point in time there is no plan to have any separate legal entity established for the Region 7 IDN. NCHC will be mindful of the provisions within the American’s with Disabilities Act (ADA) and strive to ensure the needs of people with disabilities are met. NCHC will voice

concerns at the statewide level in regards to having all website and electronic communication be accessible and comply with Section 508 of the Rehabilitation Act of 1973 as amended. In addition, NCHC will ensure there are conflict of interest policies and compliance policies in place.

iv. **How this governance structure proved for full participation of IDN partners in decision-making processes (e.g. composition, voting rules, etc.)**

The IDN members have agreed to have the IDN Steering Committee represent them, and have final decision making authority. IDN members are encouraged to participate in Steering Committee meetings and their input will be taken into consideration, although they will not have a final vote. The voting process is described above.

v. **How this governance structure ensures accountability among IDN partners (including the Administrative Lead), e.g. frequency and content of key performance reports to be reviewed by governance committees**

To ensure the partners of the Region 7 IDN are engaged and active in the transformation process, the committee charters have language regarding meeting attendance. The members have agreed to attend 85% of IDN meetings to remain an active member of the IDN and to have a voice in the transformation process.

vi. **Processes to handle low performing partners or partners who cease to participate in the IDN**

A member's position on a committee may be declared vacant if the member either resigns or fails to attend more than two meetings. In this case the appropriate workgroup may appoint an alternative representative from the same interest group to fill the vacant position.

These committees will all meet on a regular basis as the demonstration period moves forward. This will provide committee members an opportunity to review content of key performance reports and use this information to evaluate program metrics and determine if any changes need to be made.

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

The Region 7 IDN governance structure is designed so the behavioral health needs of the region are being met. The Steering Committee has members from Northern Human Services, our only Regional Community Health Center that covers our entire service area. The Committee also has a member from Tri-County Community Action Program who offers Recovery Support Services, Outpatient and Intensive Outpatient services offered in Coos, Carroll, and Grafton Counties. In addition, representation from CEOs of various hospitals and health centers will ensure we get a full picture of the behavioral health needs of the region.

7b: Four governance domains

i. Clinical governance

Standard clinical pathways for Region 7 IDN will be developed by the Clinical Governance Workgroup with input from participating healthcare organizations. The Clinical Governance Workgroup, chaired by the IDN Medical Director, will be the lead in the development of these standardized clinical pathways, and will help communicate the process with participating organizations. The Clinical Workgroup will gather data to evaluate levels of integration, and then analyze the data to identify a care system that needs to be improved. The group will then work to define the ideal outcome and determine the gap between the current and ideal process. They will create a pathway and then test the pathway using rapid cycle testing models. If the result of the new pathway leads to efficiencies and improved patient outcomes then the Clinical Workgroup will share these pathways throughout the Region 7 IDN, and develop a monitoring plan to ensure these pathways are being followed.

These pathways will improve patient care, maximize efficient use of resources, identify and clarify clinical processes, and support both clinical audits and risk management needs. These clinical pathways will embed guidelines, protocols, and evidence-based, patient-centered best practices into everyday use. Clinical pathways differ from practice guidelines and protocols because they are utilized by a multidisciplinary team and have a focus on the quality and coordination of care. Clinical pathways will provide a great opportunity to engage the patient in their own care. The Clinical Workgroup will make sure there is a way to circumvent the pathway if a situation arises based on individual patient needs. The Clinical Pathways will be based on address local and national standards, as well as evidence-based, best practices. Once pathways are developed and tested, the Clinical Workgroup will work on creating information leaflets and satisfaction questionnaires, as well as coming up with a system for measuring clinical effectiveness and patient outcomes.

To manage day-to-day performance the Clinical Workgroup will gather data from the practice sites and provide a Dashboard of the quarterly results back to each site. This information will be used to show the multi-disciplinary team how they are doing. An incentive process will be established to help encourage staff to reach pre-defined benchmarks. The Clinical Workgroup will work with the participating site to ensure a training plan is in place for the multi-disciplinary team and the pathways are distributed to all team members and posted in important areas.

To monitor compliance the Clinical Care Workgroup will develop a monitoring plan that will require the participating sites to report the number of clinical pathway interventions as well as the number of times a deviation was taken in the pathway, including the reason for deviation. If multiple deviations are happening, the Clinical Workgroup will review the pathway to see if it needs to be changed. Practice sites will be asked to provide feedback on how the pathway is working. Each practice site will be required to report on specific performance measures on a quarterly basis, and these results will be compared to baseline data to see how things are working. The Clinical Care Workgroup, and NCHC, will work with senior leadership at participating organizations to get their buy-in, and try to encourage the sites to embed these pathways within

their electronic medical records. The Clinical Workgroup will also look at patient satisfaction surveys as well to see how the patient feels about the process.

To monitor the compliance of the Region 7 IDN the Clinical Workgroup will use information from the HIT Statewide Taskforce to try to find ways to share electronic information among various partner agencies when needed and appropriated. The Clinical Workgroup will encourage the use of a shared data hub that the IDN Lead Agency will be able to access to get aggregated data. In regards to integrated care, data measures around hospital readmission, successful care transitions, and use of community-based services will be analyzed to assess if the sites are moving forward in the integration of care process. In addition, NCHC and the Clinical Workgroup will analyze claims data for Region 7, if available, to determine if there are overall improvements in patient outcomes. On a yearly basis, the Clinical Workgroup will coordinate an on-site visit with each participating provider to observe workflows, and review supporting documentation to assure the implemented clinical pathways are being followed. If a practice is found not to be performing up to standards, the Clinical Workgroup will work with the site until they are meeting the standards. On occasion, desk top audits may be used as well.

Once evidence-based programs are selected for the IDN, The Clinical Workgroup will research the programs to see if there are existing fidelity checklists in place already. If these checklists do not exist, the workgroup will create a checklist using the Stanford Chronic Disease Self-Management Program as a model to follow for fidelity standards.

ii. Financial Governance and funds allocation

Per the IDN Project plan, this will be addressed in Question 8c

iii. Data Governance

The IDN Data Workgroup will make recommendations on how to efficiently construct data sharing agreements, facilitate individual practice site legal reviews, and be accountable for obtaining signatures from those who have signatory responsibility at each site. The Data Workgroup will be responsible for reporting and monitoring data sharing processes among partners. Region 7 Data Workgroup members realize the importance of having senior leaders, providers, and legal counsel involved in creating the process for data sharing. The first task of the Data Workgroup will be conducting a data sharing assessment via Survey Monkey to determine what is already in place and what needs to be developed if this information is not available from the Statewide HIT Taskforce. The Data Workgroup will have members working with the HIT State Taskforce to find a way to expand the work already started by the NH Health Information Exchange regarding data sharing systems and standards. The Data Workgroup will work with partner agencies, and consumers, to determine data sharing processes depending on the nature of the data being collected. The group will distinguish identifying and non-identifying data, programmatic data, patient data, and financial data. They will agree on the definitions and data to be captured, and understand why the data is needed. The Data Workgroup will also work with partner agencies to ensure there is an informed consent process in place that explains to patients that this a broad data sharing initiative.

The Data Workgroup will work to ensure meaningful data is captured. The group will work with partner agencies to determine which indicators will help determine success. The Workgroup will work with partner agencies to determine if the region would find value in creating a shared patient registry, and assess what data needs to be collected for the registry, and how to integrate this shared registry into existing technology including electronic medical records. The data sharing process of Region 7 IDN will be transparent to consumers. The public should be able to access this data via the patient portal because this could be a means of empowering people to care for themselves. Need uniformity of data to allow for comparisons. The Data Workgroup will ensure the measures being collected are not just satisfying performance measure requirements; but are also being used to guide the utility of working with patients and families. When possible, the Workgroup will encourage collecting existing measures when and where available, versus introducing an entirely new set of measures. The Data Workgroup will work on creating a data warehouse that is accessible for both patients and providers, and will make sure data sharing agreements protects electronic patient health information (ePHI).

The Data Workgroup will develop a monitoring plan. This plan will address how to deal with breaches of data, what are the obligations of each organization in the event of a breach, and the processes for dealing with the breach. The monitoring plan will follow a model in which the participating agency agrees to certain things, attest to it, and then random checking by an independent consultant from outside the region will look for vulnerabilities and weaknesses to ensure compliance and privacy for consumers. Staff at the participating agencies will need to sign off that they are aware of the monitoring plan, and will comply with all aspects of the plan.

Region 7 IDN will ensure community engagement activities will be continued throughout the demonstration and be supported by the IDN's governance committee structure. The Community Engagement Workgroup has representation from all sub-regions within the Region 7 IDN service area, as well as representation from a variety of partner organizations. These members will work together to form a cohesive group that will make recommendations to the IDN Steering Committee.

iv. Community Engagement

The community engagement workgroup will meet at least on a quarterly basis to share community activities with key partners. This Workgroup will determine how to engage the public at large and keep them informed of the IDN progress. The group will help to generate information for the IDN website, and use their own expansive group of contacts to share relevant information. The Community Engagement Workgroup will also be part of the planning committee for when the entire IDN gets convened. Funding opportunities will incentivize partner agencies to continue participating in the IDN project. The Community Engagement Workgroup will work on standardizing a couple of questions that can be incorporated into patient satisfaction surveys used at participating agencies. In addition, a few patient satisfaction questions will be added to future community health needs assessments. The Community Engagement Workgroup will work on messaging campaigns and get the information out using newspapers, radio, and, websites, and social media outlets, and well as share information at community events.

7c: Governance charters

See the “IDN Charters”

7d: Key IDN management roles

See the “Supplemental Data Workbook.”

8. Budget and Funds:

8a: Final budget narrative

Region 7 IDN members came together to discuss how the IDN budget would be allocated and the participants reached a consensus to allocate \$2,127,171 of the initial \$2,412,615 to the North Country Health Consortium, as the Administrative Lead for Region 7. The \$2,127,171 will be used to cover the core infrastructure of the IDN over the five year demonstration period. The majority of these funds will be used to cover salaries of IDN project staff. Currently, NCHC has the following for IDN Project Staff, and anticipates hiring additional staff as the project moves forward:

- IDN Executive Director: 0.2 FTE
- IDN Program Manager: 1 FTE
- IDN IT Manager: 1 FTE
- IDN Finance Director: 0.2 FTE
- IDN Medical Director: Stipend
- IDN Financial Assistant: 0.5 FTE
- IDN Program Assistant: 0.5 FTE
- NNH AHEC Program Staff: 0.1 FTE

A portion of the infrastructure funds for the Lead Agency will also go to a proportion of the agencies overhead costs which include things like auditing expenses, communication costs, legal fees, and indirect rate. The remaining portion of the infrastructure funds will be used for things such as travel, IT needs for the Lead Agency, marketing, consultant fees, legal fees, and supplies. The remaining \$955,686 available for Year One (the remainder of the \$2,412,615 plus the second payment of \$670,242) will be distributed through the proposed sub-recipient proposal process through the review method previously discussed in this proposal. The remaining funds will be available for regional partners who will be encouraged to apply for these funds to help them start building their own infrastructure and capacity to succeed in the DSRIP program. Specifically, the funds may be used for recruitment and hiring, retention, and training opportunities, which may include things like development of assessment tools, curriculum, protocols, evaluation plans, tracking systems, IT needs, and creating proposed Memorandum of Agreements with collaborating organizations.

The North Country Health Consortium is home to the Northern New Hampshire Area Health Education Center (NNH AHEC). A portion of the Project Design and Capacity Building funds will be used by NNH AHEC to assess, plan and implement educational and training programs for mental health and substance use disorder providers. NNH AHEC is already approved to award continuing education credits for several

health care professions, and will investigate what is required to include additional professionals if necessary. When appropriate NNH AHEC will partner with Southern New Hampshire AHEC to conduct statewide programs; however, most trainings will be tailored to the needs of North Country providers. NCHC hosts an on-line learning platform that will also be explored as an option to deliver programs. It is anticipated that local educational opportunities and support may help alleviate burnout and high rates of turnover of mental health professionals.

8b: Final projected budget estimates

See the “Supplemental Data Workbook.”

8c: Funds allocation governance

The Region 7 IDN Governance Structure was selected due to our large geographic region, and the wide variety of community partners participating in the IDN. The structure allows for geographic representation from the three involved counties, plus the 7 sub-regions of the service area. In addition, when the Financial workgroup was created, the IDN tried to get equitable geographic and provider type representation. The Financial Workgroup serves as an advisory group to the Steering Committee. This structure works well because it encourages collaboration which is a big component for getting integration to be successful.

Region 7 IDN has decided to use a sub-recipient proposal model to distribute funds earned by the IDN over the course of the demonstration. The purpose of the Region 7 IDN Sub-Recipient Program is to support and enhance the integration of primary care and behavioral health. All qualified applications will be considered in the funding process. There will be two types of funding available, Type 1 will be for agencies applying for up to \$5000, and Type 2 will be for agencies applying for over \$5000.

IDN sub-recipient funds will be issued on a quarterly basis. The application deadlines will be the first Tuesday in December for the January-March quarter, first Tuesday in March for April-June quarter, first Tuesday in June for the July-September quarter, and the first Tuesday in September for the October-December quarter. Sub-recipient proposals will not be reviewed outside of this timeline. The IDN 7 Steering Committee will approve the amount of available funds for these grants during the annual budget process. Funds will be sent to the awardees within 2 weeks of approved proposals.

Sub-recipient funding applications must be received by 4:00 p.m. on the day they are due, and late applications will not be accepted. Applications must be submitted to the IDN Region 7 Lead Agency either electronically or via mail, although electronic submission is the preferred method. Incomplete applications will not be considered. Applicants may be contacted during the review period for follow-up and clarification.

Proposals will be evaluated according to the following criteria:

- Will the funds be used to meet established IDN objectives?
- How does the proposed project benefit the entire IDN?
- Does the proposed project address social determinants of health?
- Does the proposed project have data to back up the need?
- Will this funding have potential to make a lasting impact?

- Does the proposal outline a clear budget (only if asking for more than \$500)
- Innovative projects will have priority over established events that have received funds in the past.
- Collaborative projects will receive priority funding.
- Established criteria within IDN project metrics and specification guide for selected project

All applicants must be members of the Region 7 IDN, and have completed a Certificate of Authorization. Applications can come from both health and human service organizations (multiple organizations may apply under one application, with 1 organization identified as the primary organization who will be maintain fiduciary and reporting responsibilities) and community-based organizations providing social and support services.

The funding proposal process will be used to distribute funds for the Community-Driven Projects, the Statewide Workforce funds, the Statewide Health Information Technology funds, and the Core Competency project. Region 7 IDN will use the funding allocation grids provided by the State of NH to determine what percentage of funds need to go into each category. Then the funds will get distributed based on what is available within each category. Incentive funding earned by the IDN will be split, so half of the money will be available for new projects, and the other half will be used to continue or expand existing projects. In order to be eligible for funding, a proposal must first meet all of the established criteria developed by the IDN Financial Workgroup in conjunction with the IDN Lead Agency.

The selection committee for the sub-recipient process starts with the IDN Financial Workgroup. This body will evaluate and prioritize applications according to the State established project criteria and use a funding matrix to evaluate the proposals. If an organization applies for over \$5000, impact, need, and thoughtfulness of the proposal will also be assessed. When necessary, the Financial Workgroup will solicit additional information to ensure the viability of the proposed project or an expense. The proposals will then be forwarded to the IDN Sub-Recipient Review Panel. This panel will be comprised of one member of the Clinical Workgroup, one member of the Community Engagement Workgroup, one member of the Data Workgroup, one member of the Financial Workgroup, and one member from the IDN Lead Agency. The Sub-Recipient Review Panel will look at the proposals to see how the scope of the project will impact the region and the feasibility of implementation to improve outcomes. The scores from the Financial Workgroup and Sub-Recipient Review Panel will be combined and sent to the IDN Steering Committee along with the proposals. The IDN Steering Committee will review the proposals and make the final decision taking into account recommendations made from the Financial Workgroup and Sub-Recipient Review Panel. To avoid conflicts of interest, the selection committee members must not be sub-recipient applicants or a principal participant of an application for funding.

Once the funding decisions are made, NCHC will prepare letters to each applicant letting them know the decision, and create a summary report of grant awards. This report will be shared with the entire Region 7 IDN and posted on the IDN website. NCHC will also prepare a Memorandum of Understanding between the IDN Lead Agency and the primary sub-recipient outlining all responsibilities and accountability. Sub-Recipient awardees will be required to comply with allowable expenditures as outlined in 2 CFR 200 Uniform Grant Guidance and the Region 7 IDN contract. Sub-Recipients will be required to submit a budget proposal and sign an agreement with the Region 7 IDN Lead Agency to use funds as appropriated and commit to completing a progress report template, expenditure report, including receipts if purchases are made, and explain what difference the funding made. These reports will be due

30 days after the end of the quarter. Funds must be used within the project year that they are approved, or an extension request needs to be filed by the last day of the month prior to the end of the funding year. The appropriate IDN Workgroup will monitor the progress of the proposal. If an agency is requesting over \$5000 they will also be required to explain how goals and objects were met, and explain what difference the grant made. Since the IDN Lead Agency cannot promise more money than the State budgets in a given year, multi-year funding will not be available at this time. If this changes with upcoming budget years, this process will be modified as well. In the meantime, organizations must reapply for funds to continue with established projects. This decision was made in part as a quality assurance provision. It will allow the IDN Clinical Workgroup to review the outcomes from a particular program, and make sure appropriate benchmarks are being achieved. If all performance metrics are in alignment, the organization's new funding proposal will be put in a priority track, based on allocated incentive funding for existing programs.

The budget management and funding allocation process will involve multiple steps. When it is time to work on creating new budgets, Region 7 Lead Agency will bring the Steering Committee and the Financial Workgroup together for a preliminary budget planning meeting. The group will discuss available funds, how to categorize funds, and project priorities. NCHC will then use their project management expertise to draft a budget and project allocation plan based on the discussion from the group. This proposed budget will be brought to the entire IDN at a yearly meeting and the IDN members will have an opportunity for feedback. NCHC will then revise the budget if necessary based on feedback from the IDN members. Lastly, the proposed budget will go to the IDN Steering Committee for final approval.

Region 7 IDN decided to use the sub-recipient proposal model for funding distribution because it allows for accountability and fair distribution. NCHC is required to have an annual A-133 audit, and the auditors require multiple steps when sub-recipient awards are made. A Memorandum of Understanding outlines roles and responsibilities of the Lead Agency and the Recipient, timelines, reporting requirements, and expenditure reports. This document establishes accountability for funds. In addition, the funding proposal model allows equal opportunity for all partner organizations to apply for funds. The multi-level review panel ensures fair decision making. This approach will encourage collaboration and creativity, and will serve as a mechanism to get the funds into the communities to implement projects. Since the proposals need to meet established criteria before they are funded, it is a way of ensuring the money awarded will go towards the IDN achieving its performance metrics.

8d: Funds flow to shared partners

Region 7 IDN will be using a sub-recipient award process to distribute funds to partner agencies. The sub-award application will have a section asking the applicant if they serve other IDN regions. If the applicant answers yes, they will need to sign off on an attestation form that they will not provide the same services to the same beneficiary through a project activity.

9. Alternative Payment Models (APM): *Current use of alternative payment models*

CMMI's Health Care Payment Learning and Action Network notes that all alternative payment models (APM) and payment reforms that seek to deliver better care at lower cost share a common pathway for success: providers, payers, and others in the health care system must make fundamental changes in their day-to-day operations that improve quality and reduce the cost of health care. Making operational changes will be viable and attractive only if new alternative payment models and payment reforms are broadly adopted by a critical mass of payers.

Alternative payment models are a form of payment reform that incorporate quality and total cost of care into reimbursement rather than a traditional fee-for-service structure. Many Region 7 IDN partners are involved with delivery reform initiatives moving toward alternative payment models.

The Medicare Shared Savings Program

The Medicare Shared Savings Program, established by the Affordable Care Act, facilitates coordination and cooperation among healthcare providers to improve the quality of care for Medicare fee-for-service beneficiaries. Eligible providers and suppliers may participate in the Shared Savings Program by creating or participating in an Accountable Care Organization (ACO.) The Shared Savings Program rewards ACOs that lower their rate of growth in health care costs while meeting quality performance standards. The Shared Savings Program aims to improve Medicare beneficiary outcomes and increase value of care by providing: better care for individuals; better health for populations; and lowering growth in expenditures. The Accountable Care Organization Investment Model (AIM ACO) is an initiative developed by the Center for Medical and Medicaid Innovation designed for organizations participating as ACOs in the Shared Savings Program. AIM is a model of pre-paid shared savings in both upfront and ongoing per beneficiary per month payments to encourage new ACOs to form in rural and underserved areas and to transition to arrangements with greater financial risk.

The following Region 7 members are participants in the New Hampshire Rural AIM ACO:

- Cottage Hospital
- Littleton Regional Healthcare
- Upper Connecticut Valley Hospital
- Androscoggin Valley Hospital
- Weeks Medical Center
- Coos County Family Health Services
- Indian Stream Health Center
- Ammonoosuc Community Health Services

Patient Centered Medical Home

The primary care medical home, also referred to as the Patient Centered Medical Home (PCMH), advanced primary care, and the healthcare home, is a promising model for transforming organizations and delivery of primary care. The Patient-Centered Medical Home is a model of care emphasizing care coordination and communication to transform primary care into “what patients want it to be.” The National Committee for Quality Assurance designates the level of care delivered by participating PCMH practices. The highest level designation (III) of PCMH is awarded to programs that are recognized for using evidence-based, patient-centered processes that focus on highly coordinated care and long-term participative relationships. The PCMH designation identifies practices that promote partnerships between

individual patients and their personal clinicians, instead of treating patient care as the sum of several episodic office visits.

The following Federally Qualified Health Centers in Region 7 have received the highest level recognition from the Patient-Centered Medical Home program:

- Ammonoosuc Community Health Services
- Indian Stream Health Center
- Coos County Family Health Services

Transforming Clinical Practice Initiative (TCPI)

The Transforming Clinical Practice Initiative is designed to help clinicians achieve large-scale health transformation. The initiative is designed to support more than 140,000 clinician practices over the next four years in sharing, adapting and further developing their comprehensive quality improvement strategies. The initiative is one part of a strategy advanced by the Affordable Care Act to strengthen the quality of patient care and spend health care dollars more wisely. Through Practice Transformation Networks, TCPI has provided investments to support clinician practices through nationwide, collaborative, and peer-based learning networks that facilitate large-scale practice transformation. Practice Transformation Networks provide practice facilitation and are designed to coach, mentor and assist clinicians in developing core competencies specific to practice transformation. Practice facilitation has been identified as one of the most promising strategies to support the transition to new models of care and to assist with the road map for alternative payment models. As noted in an earlier section, the North Country Health Consortium is a partner with the New Hampshire Citizen's Health Initiative in the Northern New England Practice Transformation Network (NNE PTN), and employs Practice Facilitators that provide technical assistance to providers. The following Region 7 IDN members currently participate in the NNE PTN:

- Northern Human Services
- White Mountain Health Center
- Huggins Hospital Outpatient Practices

Section II: Project-level Plans

10. Project A1: Behavioral Health Workforce Capacity Development

10a: IDN workforce project leads and participants

See the "Supplemental Data Workbook."

10b: Narrative describing IDN's workforce capacity challenges

The North Country IDN Service Region has been designated by the US Department of Health and Human Service, Health Resources and Services Administration (HRSA) as primary care and mental health professional shortage areas. Health Professional Shortage Areas (HPSAs) are designated by HRSA as having shortages of primary medical care, dental or mental health providers and may be geographic (a

county or service area), demographic (low income population) or institutional (comprehensive health center, federally qualified health center or other public facility).

Additionally, with the expansion of health insurance coverage through the Patient Protection and Affordable Care Act (ACA) and the increased emphasis on primary preventative care, the demand for primary and other healthcare workforce capacity has grown significantly. According to the 2016 County Health Rankings¹², access to care data reflects that the ratio of the population to primary care physicians is 860:1 in Coos County, and 1,109:1 in Carroll County. However, the more critical shortage is reflected in the ratio of the population to mental health providers, including psychiatrists, psychologists, licensed clinical social workers, counselors, marriage and family therapists, and advanced practice nurses, which for Coos County is 750:1 and 430:1 for Carroll County, as compared to the NH ratio of 390:1.

Region 7, through community needs assessment processes and IDN partner input, has identified many workforce capacity challenges in the region that affect the provision of MH and SUD services. Workforce challenges range from retention to competency related to professional capacity to treat individuals with co-occurring MH and SUD treatment needs. As echoed by SAMHSA, the behavioral health workforce shortage is being observed nationally, recalling “the need for an educated and seasoned workforce stems not only from demand, but high turnover rates, a shortage of professionals, aging workers, and low compensation.”¹³ Acquired needs assessment data reveal the challenges in regard to recruitment, hiring, training, and retention of qualified professionals to meet behavioral health demands for the population.

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. Families often express the lack of extracurricular activities and other structured opportunities for their children and the lack of gainful employment for spouses who would be relocating to the area. Professionals who look favorably at the region for employment may also be reluctant to seek a position due to the salary discrepancy as compared to more urban areas, especially as student debt continues to rise nationally. The other recruitment challenge is the 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. Recruitment and hiring is also being affected by the aging of current professionals, and the lessened pipeline of new workers to the field.

Training needs have become more complex with the notion of integrated primary care and behavioral health. The emphasis on multi-disciplinary teams creates the need for cross-pollination where behavioral health staff are expected to have competencies associated with working in a primary care setting and primary care staff are expected to have competencies in behavioral health. Increasingly important is the need for primary care professionals to be knowledgeable and proactive about conducting age-appropriate screenings for early detection, intervention, and referral for MH and SUD as is expected to occur.

Training staff is expensive and requires provider time that would otherwise be spent with patients. Given

¹² <http://www.countyhealthrankings.org/app/new-hampshire/2016/overview>

¹³

http://www.samhsa.gov/samhsaNewsLetter/Volume_22_Number_4/building_the_behavioral_health_workforce

the high turnover rates, it becomes costly to train staff members in crucial competency areas when they may ultimately vacate the role after a short time.

Retaining qualified staff once they've been recruited, trained, and oriented to the organization, patients, and community is ultimately difficult for multiple reasons. The small pool of qualified workforce members creates an environment in which organizations must market themselves to attract the candidate, versus traditional recruitment and hiring processes. Fixed reimbursement rates, increased patient loads, and inadequate compensation create challenges that drive competition for high-wage positions located outside of the region. Loan repayment can also impact retention of qualified staff as individuals may acquire experience in more entry-level positions within the region, and then seek employment elsewhere once they've developed more professionally.

10c: Narrative describing expected IDN efforts to address workforce capacity challenges

The Region 7 IDN envisions a centralized approach to addressing and meeting behavioral health workforce needs. The North Country IDN partners will leverage existing resources, capacity, and best-practices for approaching recruitment, hiring, training, and retention of a qualified workforce to meet the demand in the service area. The region identifies with the state stance on workforce needs: “the shortage of trained, licensed, and available workforce is one of the greatest barriers to increasing access to substance misuse prevention, treatment, and recovery support services in New Hampshire and throughout the country.”¹⁴ The IDN recognizes the need for workforce expansion along the continuum of care.

North Country Health Consortium (NCHC), the administrative lead for the Region 7 IDN, has been a reputable resource for workforce development efforts spanning the last 17 years through NCHC's Northern New Hampshire Area Health Education Center (NNH AHEC) program. The NNH AHEC aims to ensure rural challenges and solutions are included in workforce development policy both in New Hampshire and nationally; to ensure an adequately trained workforce exists in rural New Hampshire by providing continuing medical education and other training programs for all levels of North Country healthcare providers; and to expand opportunities for North Country young people to learn about pursue careers in the health professions.

NNH AHEC's pipeline initiatives include engaging health profession students as well as middle and high school students. 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 student 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. In addition to working with health profession students, 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.

¹⁴ “The Opiate/Opioid Public Health Crisis: Update on the State of New Hampshire's Comprehensive Response” <http://governor.nh.gov/media/news/2016/documents/pr-2016-08-24-heroin-opioid.pdf>

Under this DSRIP initiative, the role of the NNH AHEC will be expanded to include a centralized effort to increase the behavioral health workforce by providing regional recruitment support, ongoing development by conducting regional training needs assessments to meet identified gaps in core competencies, and providing technical assistance for navigating the complexities of licensure for professionals from outside of the state. To support the integration of primary care and behavioral health, interdisciplinary training on core competencies and evidence-based practices around MH and SUD will need to be provided for all healthcare professionals, including serving individuals with co-occurring disorders and working in complex multi-disciplinary teams¹⁵.

In accordance with the Governor's recent workforce initiatives¹⁶, 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. A streamlined and centralized approach to recruitment will create efficiencies and result in administrative cost-savings for IDN partner organizations. Broad outreach will be conducted, including state and national-level recruitment. Formalized recruitment strategies will allow for the necessary vetting of candidates to ensure qualified professionals are embraced by regional partners. Recruitment will also focus on expanding the diversity of the workforce, including persons in recovery, paraprofessionals, and practitioner extenders¹⁷.

The IDN will actively participate in the Statewide Task Force and will assist with the statewide planning process to inform workforce recruitment and development efforts. Given the critical nature of workforce shortages affecting the MH and SUD field nationally, in the state, and in the North Country service area, Region 7 is hopeful that strategic and coordinated efforts will occur within the state to ensure parity and baseline competencies for a well-rounded and qualified workforce to combat the current gaps in service provision.

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

11a: IDN HIT project leads and participants

See the "Supplemental Data Workbook."

11b: Narrative describing IDN's HIT gaps

Health Information technology (HIT) is considered a critical component for improving the quality of care, reducing care disparities, improving health outcomes, and impacting health care expenditures. The capacity of HIT to improve communication and information sharing makes it a significant tool for addressing the needs of individuals, families, and populations. Through statewide HIT assessment, we anticipate to learn much more about our partners.

¹⁵ US DHHS, SAMHSA (2013) "Report to Congress on Nation's Substance Abuse and Mental Health Workforce Issues"

¹⁶ "The Opiate/Opioid Public Health Crisis: Update on the State of New Hampshire's Comprehensive Response" <http://governor.nh.gov/media/news/2016/documents/pr-2016-08-24-heroin-opioid.pdf>

¹⁷ US DHHS, SAMHSA (2013) "Report to Congress on Nation's Substance Abuse and Mental Health Workforce Issues"

Among Region 7 health care provider organizations (11 that have responded to date), there are at least six different Electronic Medical Record (EMRs) platforms. These include Meditech, Centricity, eMDs, MedHost, Athena, Paragon, Eclinical Works, Essentia/LWSI, and Greenway Success EHS; and one organization does not have any EMR. Each organization uses them differently and some report not using the full capacity of their systems. Referrals are made through EMRs on a limited or consistent basis by only four of the organizations.

Region 7 members have identified numerous gaps in making the HIT infrastructure adequate for delivery of services within the integrated delivery network.

Lack of interoperability between disparate Electronic Health Record platforms

The myriad of Electronic Health Record (EHR) platforms noted above provide a significant challenge when trying to design a system that provides care coordination and management across the regional system. Both hospitals and health centers with EHRs often have technical variations that make it difficult to establish a common flow of information. Some IDN partners recognize the resistance from some EHR vendors to adapt to needs related to interoperability. Limitations in IT expertise and current capacity also are identified as barriers to development of communication between EHR systems. 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.

Electronic data systems that do not adequately serve patient and/or provider needs

Some electronic data systems are not able to document and track developmental screenings of all types which should be incorporated into the standard medical record and can provide significant information to other providers. Additionally, there is not a single point of entry for patients receiving care and services from multiple organizations. Electronic data systems available for patients and consumers (eg. patient portals) are often difficult to navigate and do not always offer enough functionality to ensure use.

Lack of a common care management platform

There is not a common care management platform that has been identified to facilitate communication across health and social service systems serving the same individuals within the IDN. Data and quality metrics are often not aligned between populations and payers which increases the challenge of a common tool.

Privacy and security concerns

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. This could prove to be a significant issue and will require some workflow redesign when considering the balance of organizational operational needs to transition patients. HIPAA, though very well intentioned, has been identified as a barrier to the flow of critical information from provider to provider. A challenge within the HIT infrastructure is determining a method to improve the flow of critical information about substance misuse or other behavioral health treatment plans from one provider to another without compromising patient privacy.

Community Based Organizations that do not have Electronic Health Records

Health records maintained by community based organizations and schools that do not have EHRs often do not contain comprehensive information from practitioners which can have a negative impact on

patients/clients. Many community based organizations do not have secure systems to receive and/or send personal health information which means there is not an ability to exchange information or to use the information that has been exchanged. An additional gap to effective health information exchange systems may be the lack of understanding about the importance and necessity of an effective method to share information among providers and community based organizations. Organizations that historically have not billed Medicaid or any other insurance carrier may not have the capacity to take on data collection, monitoring, and reporting.

Although there are gaps in the HIT infrastructure in Region 7, there is a firm commitment among members to build a system that is effective, efficient, and that meets the needs of the population served. We look forward to the statewide assessment, and the subsequent standards and infrastructure development and recommendations that will inform the Region 7 HIT system.

11c: Narrative describing expected IDN efforts to address HIT gaps

Region 7's vision for Health Information Technology (HIT) systems is the same as that outlined by the Institute of Medicine: "a safe, efficient and cost-effective healthcare system supported by information technology." Representatives from the Region 7 Lead Agency as well as members of the Data/IT Workgroup will participate on the Statewide HIT Taskforce. It is anticipated that the Taskforce will complete the statewide HIT needs assessment, and that Region 7 will build its HIT infrastructure in a way that will align with the standards and recommendations set out for the state. Development of the HIT infrastructure, regardless of how it is designed, is going to require a strong educational component for providers, patients, stakeholders, and communities. The IDN representatives on the Statewide Taskforce will be responsible for informing the Data/IT Workgroup about the activities of the Taskforce. They will report to the Workgroup, and elicit feedback and suggestions that will be taken back to the Taskforce on behalf of Region 7. The representatives from the IDN intend to bring the unique voice of the North Country to the Statewide Taskforce, and to provide a rural perspective as part of the discussion. Unlike some other parts of the state, the Region 7 members are spread out over a large geographic area, and some parts of the region do not have reliable internet and cell service (although this is getting better, it still poses some technology barriers).

An increasingly important element in the IT infrastructure is the ability to have some standardization while at the same time working with a system that allows for some customization for organizations. Organizations within the region are at different levels of readiness for health information exchange. The infrastructure that is developed must strategically explore opportunities for new electronic health information systems to be put in place as well as enhancement or expansion of systems currently being used. The system must also provide a positive use experience at both the patient and provider level. The framework the State Taskforce provides for regional guidance must allow for data collection in various settings, including primary care, behavioral health/substance use disorder treatment, and other social service agencies – and allow for data to be used to inform and improve clinical care decisions, encourage patient education and self-management, design public health strategies, and promote integration of primary care and behavioral health.

Region 7 will work with the Statewide Taskforce to address HIT infrastructure gaps, with particular interest in increasing:

- The level of IDN participants utilizing Office of the National Coordinator for Health IT's (ONC) Certified Technologies
- 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.
- 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
- 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)
- The level of IDN participants in their level to share a community-wide care plan to support care management, care coordination, patient registries, population health management, and quality measurement

Region 7 anticipates engaging the New Hampshire Health Information Organization (NHHIO) to receive support and technical assistance from for development and implementation of the regional IDN HIT plan. This will help ensure the region is in-line with the rest of the state as well as utilizing the Taskforce's assessment and recommendations, the IDN's current HIT capacity, and the IDN-specific community needs assessment. The NHHIO will assist with bridging the statewide framework and the regional design. The NHHIO is currently working with several of Region 7's partners on the North Country Communities of Practice and Peer Learning Network projects to help providers meet the growing need for innovative technology and challenges with the secure exchange of health information for treatment purposes. This work will be particularly beneficial for the community projects in the region that focus on transitions of care and care coordination. By partnering with the NHHIO, we will reduce the likelihood of duplication of efforts, align HIT initiatives in the region and the state, and support IDN members in their efforts to build interoperable systems and integrate relevant information.

12. Project B1: Integrated Health

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

See the "Supplemental Data Workbook."

12b: Participating organizations

See the "Supplemental Data Workbook."

12c: Monitoring plan

All participating organizations within Region 7 IDN must participate in the core competency project. 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. Sub-recipients that receive funds will be required to indicate: an implementation timeline, a project budget, a work force plan, projected annual client engagement, and key provider participants.

Specific monitoring activities will include: 1) tracking activities to monitor implementation and participation in activities; 2) 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; 3) review of available outcomes data related to the region to understand progress in population health. A detailed project tracking sheet will be developed to identify and track each monitoring activity, including receipt of data.

The measurement plan for Region 7 provides information about collection data for each primary objective. For ongoing outcomes data, there will be an assessment of the usability and feasibility of a dashboard.

Region 7 IDN will develop a standardized evaluation plan that will contain metrics indicating the impact the IDN is making, and whether or not the IDN is on the path to improve broader outcome measures that drive payment reform.

	What	Where	How	When	Who
Program Objective	Measure and Target	Source of Data	How is the Data Collected	Frequency of Data Collection	Who is Responsible for Gathering the Data
Region 7 IDN partner organizations will use Comprehensive Care Standardized Assessment and Shared Care Plan	# of partner organizations using Comprehensive Standardized Assessments and screening tools	Core competency Assessment Template	Participating organizations complete tracking tool	Quarterly	Program Manager
	# of partner organizations using shared care plans for treatment and follow-up	Core competency Assessment Template	Participating organizations complete tracking tool	Quarterly	Program Manager
Region 7 IDN partner organizations use multi-disciplinary core teams	# of partner organizations that have training plans in place for core team members and extended team if needed	Core competency Assessment Template	Participating organizations complete tracking tool	Quarterly	Program Manager

	# of partner organizations that have training curricula in place for each member of the core team and extended team if needed	Core competency Assessment Template	Participating organizations complete tracking tool	Quarterly	Program Manager
	# of partner organizations having written roles and responsibilities for core team members and other members as needed	Core competency Assessment Template	Participating organizations complete tracking tool	Quarterly	Program Manager
Region 7 IDN partner organizations use standardized workflows and protocols	# of partner organizations using protocols for patient assessment, treatment, and management # of partner organizations using referral protocols	Core competency Assessment Template	Participating organizations complete tracking tool	Quarterly	Program Manager
	# of partner organizations that have formal agreements in place around referral protocols, services to be provided by community-based organizations, coverage schedules, and consultant report turn arounds	Core competency Assessment Template	Participating organizations complete tracking tool	Quarterly	Program Manager

	# of registries utilized by partner organizations to track and monitor patients served by the IDN	Core competency Assessment Template	Participating organizations complete tracking tool	Quarterly	Program Manager
Region 7 IDN partner organizations use information sharing for care plans, and treatment plans	# of partner organizations having communication plans regarding documentation workflows between core team members and extended team if needed	Core competency Assessment Template	Participating organizations complete tracking tool	Quarterly	Program Manager
Region 7 IDN partner organizations identify evidence-based programs to implement	# of evidence based programs implemented	Core competency Assessment Template	Participating organizations complete tracking tool	Quarterly	Program Manager

What a potential dashboard may look like:

Objective	Measures	Target	Frequency	Findings	Trending
Goal 1: Increase the number of fully integrated practices sites in Region 7 IDN					
	Coordinated care designation	100% by 12/31/07	Quarterly		
	Integrated care designation	100% of identified practices by 12/31/2008	Quarterly		
Goal 2: Increase behavioral health workforce capacity within Region 7 IDN					
	# of psychologists at each site # of psychiatrists at each site # of LADCS at each site #MSW at each site #LCMHC at each site # other at each site (psychiatric nurse practitioners, etc)	20% increase in behavioral health workforce by 12/31/2020	Quarterly	# new staff positions recruited and trained # Staff vacancy and turnover rate Wait times to be seen	

Goal 3: Reduce gaps in care across care settings					
	# readmissions to hospital # emergency room visits for patients with BH indicators # staff trained in CTI models	20% decrease in readmissions by 12/31/2020 20% decrease in emergency room visits for patients with BH indicators	Quarterly	# primary care/specialty visits # trained care management staff	
Goal 4: Demonstrate cost-savings for selected programs					
	# of IDN partners who enter an Advanced Payment Model Baseline cost of treatment from claims data (as available) Cost of treatment from claims data (as available)	10% of IDN partner organizations will participate in new APM model by 12/31/2020	Quarterly Annual Annual	#partners sharing in savings	

12d: Expected outcomes

Region 7 IDN has identified the following behavioral health care gaps in its service area: shortages in the behavioral health workforce, a lack of treatment and recovery sites in the region, cuts in funding and reimbursement, and the need for mental health education focused on symptoms, treatment options, stigma reduction and who to contact for additional information.

Region 7 IDN will focus on bi-directional integration of care to improve quality in care, achieve better patient outcomes, and reduce treatment costs. Irrelevant on where care originates, and who is coordinating that care, to be effective the care model needs to be patient-centered, population-based, data-driven, and evidence-based. Patients need to share in the decision making of their care and learn self-management support strategies. The Health and Recovery Peer (HARP) program, an adaptation of the Chronic Disease Self-Management Program (CDSMP) for mental health patients, follows a CDSMP curriculum, but adds content on mental health, and adjusts diet and exercise recommendations based on the socioeconomic status of the population.¹⁸ Two other self-management programs worth mentioning are

¹⁸ Druss B. G., et al., (2010). The Health and Recovery Peer (HARP) Program: A peer-led intervention to improve medical self-management for persons with serious mental illness. *Schizophrenia Research*, 118(1-3):264-70.

the Wellness and Recovery Action Plan (WRAP) which is a peer-led intervention that helps people with mental illness monitor their feelings and behaviors, and develop strategies to address these.¹⁹ Through the Self-Management and Recovery Training (SMART) program, participants get motivated to address substance use disorders, and learn how to cope with urges and drug use behaviors.²⁰ Region 7 IDN will research and implement some of these self-management support programs.

Mental health care should be population-based to be effective. This means care should focus on delivery system redesign, along with the use of embedded clinical guidelines and patient registries. Region 7 IDN will ensure participating agencies are utilizing multidisciplinary care teams that are following a shared care plan so no patient falls through the cracks. In addition, NCHC will work with practice sites to ensure they are following evidence-based guidelines and utilizing decision making tools and patient registries to effectively manage patient care.

Data is essential in the integration of behavioral health and primary care. Once evidence-based programs are initiated, data will show the impact of these programs, and allow for opportunities to make programmatic changes as necessary. Region 7 IDN will first gather baseline data, and then use this information to set a reasonable target for improvement over a specified period. Then the region will collect and analyze specific performance measure data, and use aggregated claims data information to identify where systems are falling short, to make corrective adjustments, and to track outcomes. Improvement will be tracked by periodic comparison of pre- and post-data. Collecting data and reporting on standardized clinician performance measures can help improve efficiency and ensure that patients are receiving high quality of care. This reporting can be used to evaluate if a practice is adhering to evidence-based care guidelines.

Many studies have shown that integration of care across treatment settings has been shown to reduce readmission rates for patients and reduce health care costs over time. Region 7 IDN will be measuring both of these areas as they seek to achieve full integration at many practice sites within the region.

Region 7 IDN will work on the core competency module and their three community-driven projects to achieve the following four outcomes:

1. 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
 - # claims/encounters and non-claim discharges from NHH for age 21-64 (HEDIS PCR 2017)
 - Number of Medicaid beneficiaries receiving Comprehensive Core Standardized Assessment vs projected
 - Number of Medicaid beneficiaries scoring positive on screening tools
2. Increase Follow-Up After Emergency Department Visit by 25% for Alcohol and Other Drug Dependence within 30 days by December 31, 2020
 - # claims/encounters –(Proposed 2017 HEDIS FUA)

¹⁹ Cook, J.A., et al., (2009). Results of a randomized controlled trial of mental illness self-management using Wellness Recovery Action Planning, *Schizophrenia Bulletin*, 2011 Mar 14.

²⁰ SMART Recovery. (n.d.) www.smartrecovery.org

- # of Medicaid beneficiaries scoring positive on screening tools and referred for additional intervention
3. Increase Engagement of Alcohol and Other Drug Dependence Treatment (Initiation and 2 visits within 44 days) by 25% by December 31, 2020
 - # claims/encounters (HEDIS IET 2017)
 4. Increase Initiation of Alcohol and Other Drug Treatment (1 visit within 14 days) by 25% by December 31, 2020
 - # claims/encounters (HEDIS IET 2017)
 - # of new staff positions recruited and trained vs projected
 - Vacancy and turnover rate for new staff positions

Region 7 IDN will use the Plan-Do-Study-Act (PDSA) model to see if a new or improved process meets performance expectations.²¹ The PDSA model proposes these four steps:

1. **Plan:** Plan a change. Formulate specific aim statements, develop a detailed data collection plan, and establish project timelines.
2. **Do:** Test the change. Carry out your data analysis plan, document any unexpected problems or challenges, track progress against timeline benchmarks.
3. **Study:** Review the tests. Analyze collected data, compare results to project aims, summarize and present data.
4. **Act:** Take action based on what you have learned. If the change did not work, go through the cycle again with a different change. If the change was successful, use what you learned to begin planning new improvements.

Organizations will be monitoring performance measures and processes on a continual basis, looking for ways to improve systems utilizing the PDSA model.

NCHC, the Region 7 Lead Agency, will create Dashboard Reports for reporting on measures. This method will provide a quick overview of the current state of the data in order to make it easier to identify key trends. These Dashboard Reports will be shared with the entire IDN on a semi-annual basis, and will be placed on the IDN website that will be created.

12e: Challenges and proposed solutions

The key challenges and barriers Region 7 IDN faces in achieving an integrated health system can be broken down into three categories: policies, systems, and environment. First, there are many policy issues that affect levels of integration. 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; absence of reimbursement for services provided by non-physicians; and issues around submission of certain procedural codes are policy challenges healthcare facilities face in regards to integration of behavioral health and primary care. In addition, licensing issues,

²¹ https://www.healthit.gov/sites/default/files/tools/nlc_continuousqualityimprovementprimer.pdf

lack of reciprocity and increased demand for services all lead to shortages in the behavioral health workforce.

In regards to challenges in systems, communication is the main obstacle. Health Insurance Portability and Accountability Act (HIPAA) has made it very difficult to share protected patient information amongst providers. There are even tighter standards in place to protect patient information about mental health and substance abuse. In some ways this increases the stigma associated with mental health conditions. If we treat mental health differently, due to these tighter regulations, we are in effect adding to the culture of stigmatizing mental health. There is a lack of protocols for sharing data and resources effectively. Many organizations use electronic medical records, and often these systems are incompatible with one another. It is difficult to have standardized care plans, and other clinical decision tools, especially when trying to integrate care that is happening at two different physical locations. Challenges in communication are also seen in the day-to-day workflow of staff.

Environmental challenges can be further broken down into the medical perspective and the patient perspective. From the medical side, providers may engage in “turf” wars. What once was their decision to make now needs to be made in collaboration with others. Often times there are significant staff shortages, and these shortages can be on the behavioral health side or the medical side. These shortages lead to increased patient caseloads, and sometimes less than ideal working conditions. Agencies are so used to having their own agendas, that it is often difficult for them to come together under one agenda. Funding is always a concern, especially in regards to sustainability. Another important issue impacting integration of care comes from the resistance of certain providers to offer medication assisted treatment.

The rural nature of the Region 7 IDN is a challenge from the patient perspective. Even with integrated services, patients often have to travel great distances to receive treatment. This distance can be even longer when patients are looking to find a facility that offers substance use disorder treatment. Social determinants of health impact a patient’s perspective on integration. Stigma attached to mental health problems discourage some patients from seeking help and some providers and other caregivers from getting involved.

To overcome barriers to integration, Region 7 IDN must address policies and practices to ensure systems integration, work on collaboration among regional partners to strengthen relationships, and develop information-sharing strategies, while keeping in mind that this integration is a learning process. The ways to overcome these barriers have also been divided into three categories: policies, systems, and environment. 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. In addition, if possible the Region 7 IDN will partner with policy makers to remove state and federal barriers affecting these areas.

In regards to system changes to encourage integration, Region 7 IDN will work to strengthen the IT infrastructure to enhance the ability of our partner agencies to access and share information. Some of this work will be conducted through the State Wide Health Information Technology Workforce Group. The improvements in IT infrastructure will allow for better communication, including the use of shared protocols and care plans, which will lead to better care coordination and health outcomes. 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.

Region 7 IDN will again break down the environment into providers and patients when addressing how barriers to integration will be overcome. NCHC will work with provider organizations to make sure integration is as smooth as possible. There will be extensive conversations in regards to an organization's capabilities, services offered, and rules and regulations it must adhere to. Region 7 IDN will be taking a patient centered medical community approach to integration. This method will be used to ensure community based social support agencies are heavily involved in the integration process, and the entire community can wrap themselves around the needs of the patients being served by the Region 7 IDN.

Stigma associated with mental health conditions often discourages some patients from seeking help and other caregivers from getting involved. Region 7 IDN will work on messaging campaigns, and offer education opportunities for patients and the community around mental illness signs and stigma. 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, or appears depressed or suicidal.²² In addition, NCHC will collaborate with National Alliance on Mental Illness, NAMI NH, a partner of the Region 7 IDN, to utilize their expertise on messaging campaigns around mental illness. NCHC will bridge IDN partner agencies with provider organizations to make sure the social determinants of health are getting properly addressed. Education programs will be developed that will focus on addressing some of the social determinants of health, and teach people starting at birth how to be well and live well. Financial Literacy programs are an example of a program designed to address social determinants of health.

12f: Implementation Approach and Timing

See the "Supplemental Data Workbook."

13. Community-Driven Project #1: Care Transitions

13a: CI: Care Transition Teams

13b: Project selection rationale and expected outcomes

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. Thirty-two percent of Region 7's Medicaid population has a behavioral health indicator, while the same population makes up over 65% of total inpatient admissions. Nationally, between 40 and 50 percent of patients with a history of repeated hospitalizations are readmitted within 12 months.²³ Readmissions are costly, disrupt individuals and families, and often leave providers and patients feeling frustrated. Although severity of

²² <https://www.mentalhealthfirstaid.org/cs/>

²³ <http://www.effectivehealthcare.ahrq.gov/>

mental illness may result in readmissions, in some cases readmissions may be more related to access to community resources and support. An important factor in decreasing the likelihood of readmissions is an effective discharge plan and delivery of sufficient support to transition mental health services from an inpatient to an outpatient setting. Additionally, preventing readmissions includes providing alternatives to support patients, including access to community treatment services and supported housing if necessary.

Emergency department visits are generally not designed to focus on care transitions and coordinated care, or to promote prevention and compliance with care plans. Hospitals face increasing capacity and resource constraints related to the use of emergency departments, and it is an expensive model for care. Care transition teams will assist with reduction of the burden on hospitals that experience high rates of emergency department use by individuals with behavioral health indicators. Despite accounting for only 32% of the total IDN beneficiary population, members with a behavioral health indicator accounted for 52% of the emergency department visits in 2015. Forty-five of the Region 7 IDN members with a behavioral health condition had at least one emergency department visit in 2015, compared with 27% of members who did not have evidence of a behavioral health condition. Frequent emergency department utilizers (those who visited the emergency department 4 or more times in any given year), made up only 4% of the total population, yet accounted for thirty-five percent of all emergency department visits in 2015. Among frequent emergency department utilizers, 67% of Region 7 IDN members had evidence of a behavioral health condition. Among the total IDN member population, only 32% have a behavioral health indicator. Overall, frequent emergency department utilizers with a behavioral health condition accounted for 24.32 % of the total emergency department visits by IDN members, despite making up only 2.4 % of the total IDN member population. Patients with evidence of a behavioral health condition accounted for 45% of all potentially avoidable emergency department visits²⁴, despite accounting for only 32% of the total member population.

Region 7 IDN partners selected Care Transition Teams as a community-driven project after consideration of the feasibility of implementing the Critical Time Intervention model. IDN participants agreed that the model will increase capacity and enhance care transition planning currently in place. Participants identified several areas that will be addressed through this project, including such things as:

- Recidivism that occurs and significantly burdens local capacity;
- Education for patients and families about the unique needs of transitioning back into the community;
- Effective discharge planning that includes effective feedback and follow-up

Additionally, patients with serious mental illness, particularly those with other chronic illnesses, may be vulnerable to unplanned hospital readmissions. A significant population in Region 7 have both a physical health condition and a behavioral health indicator. For example, 32% of adults between the ages of 50 and 64 have a cardiovascular condition as well as a behavioral health indicator; 15% of adults 50-64 have

²⁴ State definition: The list of selected potentially treatable diagnoses were identified as common diagnoses having a higher likelihood of being non-urgent or treatable in the primary care setting rather than the hospital emergency department. The list is not exhaustive and is not intended to represent all potentially avoidable diagnoses nor are all visits avoidable. The group of diagnoses together are used by the Department as an indicator of potential overutilization of the emergency department.

both diabetes and a behavioral health indicator; and nearly 34% of adults 50-64 have both a respiratory condition and a behavioral health indicator.

Critical Time Intervention (CTI) is a time-limited evidence-based practice that mobilizes support for society's most vulnerable individuals during periods of transition.²⁵ CTI is a time-limited phased approach that is highly focused during the transition period. Region 7 will implement CTI or a similar intervention to ensure effective care transitions. Within three years, the region will reduce by 20% the number of preventable hospital readmissions that occur within thirty days of discharge. Region 7 IDN partners prioritized three long-term outcomes for this project focusing on the individual, the community, and the systems:

1. **Individual:** Individuals will reach or sustain recovery for the long term
2. **Community:** Communities will establish capacity for connecting individuals with consistent and available care and resources to empower patients
3. **Systems:** Implementation of efficient, effective, integrated, and cost-effective systems that achieve patient recovery

Short-term outcomes in each priority area have also been identified:

Individual

- a. Individuals will be successfully identified and assisted through the CTI model in at least six IDN partner organizations by December 2017
- b. Clients are integrated into the community through development of independent living skills and building support networks, beginning June – December 2017

Community

- c. Effective resources support networks in place for clients by December 2017
- d. Community services and supports will be mobilized and coordinated by June 2017
- e. CTI model is successfully implemented in six IDN partner organizations by December 2017

Systems

- f. Regional sustained CTI training program will be in place for organizations inexperienced in a three-phased model of care transitions by June 2017
- g. Secure messaging systems between participating organizations will be in place by June 2017

13c: Participating organizations – selection criteria

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 for effective implementation of the project. Organizations will either propose as individual entities or in conjunction with community partners to carry-out the Critical Time Intervention model (or something similar), and demonstrate capacity to implement and report progress toward improved outcomes. Participating organizations will include hospitals, primary care providers, behavioral health providers, and community based social service organizations. Organizations that participate in the Care Transitions Community-Driven Project will be providers who are advocates for patients and who are trained to empower patients and their families to actively participate in the care transition process. Organizations will be asked to exhibit thoughtful collaboration among hospitals, community-based organizations, long-term and post-acute care providers, patient caregivers, and patients and their families.

²⁵ www.criticaltime.org

They will be required to have demonstrated experience and ability to work with individuals with behavioral health needs. Organizations that participate in Care Transition Teams will have effective outreach and engagement by staff working in the community rather than just the office. Organizations will be asked to demonstrate how staff will be engaged and trained in the Critical Time Intervention model as well as methods that will be used to achieve improvement in the effectiveness of the transitions of patients between care organizations. Participating organizations will be patient/client centered.

Organizations participating in this project will demonstrate capacity to design, and/or enhance a clinical services infrastructure that will support:

- 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

Participating organizations will have care teams that are encouraged to be informed about collaboration across the continuum of care. Teams will be expected to be knowledgeable about available services and resources, such as mental health and/or chemical health support groups, social services, financial assistance for medication, transportation assistance, nutritional support, and emergency housing assistance.

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

13d: Participating organizations – list of organizations

See the “Supplemental Data Workbook.”

13e: Monitoring plan

Organizations implementing Critical Time Intervention (CTI) to facilitate smooth transitions of care for adults with serious mental illness from the hospital setting into the community will be required to monitor and report to the IDN Lead agency on a regular basis. All organizations will be required to have staff complete the CTI training, and identify a mental health professional that will provide supervision. Organizations participating in this project will determine their capacity and have a work plan that reflects their ability to implement the project. All sub-recipients that receive funds will be required to indicate: an implementation timeline, a project budget, a work force plan, projected annual client engagement, and key provider participants.

Specific monitoring activities will include: 1) tracking activities to monitor implementation and participation in activities; 2) 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; 3) review of available outcomes data related to the region to understand progress in population health. A detailed project tracking sheet will be developed to identify and track each monitoring activity, including receipt of data.

The measurement plan for Region 7 provides information about collection data for each primary objective. For ongoing outcomes data, there will be an assessment of the usability and feasibility of a dashboard.

Measurement Plan for Region 7

Program Objective	What Measure and Target	Where Source of Data	How How is the Data Collected	When Frequency of Data Collection	Who Who is Responsible for Gathering the Data
Provide adults with serious mental illness with effective transitions of care	50% of identified patients complete CTI	Patient Care Plan Template	Participating organizations complete tracking tool	Quarterly	Program Manager
	50% of identified patients integrated into community services	Patient Care Plan Template	Participating organizations complete tracking tool	Quarterly	Program Manager
	75% of participating individuals and families provide feedback, eg. satisfaction	Program Survey	On-line survey program	Annually	Program Manager
Program Objective	What Measure and Target	Where Source of Data	How How is the Data Collected	When Frequency of Data Collection	Who Who is Responsible for Gathering the Data
Provide IDN partner organizations with design and development of infrastructure to implement CTI model	Agreements in place between collaborating organizations	Program Documents	Signed agreements	Quarterly	Program Manager
	75% of staff in identified organizations trained in CTI	Program Documents	Completed training of care managers Supervisors	Quarterly	Program Manager Northern New Hampshire AHEC

			identified		
	Secured messaging in place for participating organizations	Patient care plan template	Participating organizations provide feedback and revisions for efficient template	Quarterly	Program Manager IT Manager
	CTI model is implemented with fidelity Participating	Program Documents	IDN Tracking Tool	Quarterly	Program Manager

Potential dashboard measures of this project are illustrated below:

Objective	Measures	Target	Frequency	Findings	Trending
Goal 1: Individuals will reach or sustain recovery for the long term					
	Targeted individuals assisted through CTI model	50%	Monthly	# patients/clients	
	Clients integrated into community	50%	Quarterly	#services provided #IDN partner connections	
Goal 2: Communities will establish capacity for connecting individuals with consistent and available care and resources to empower patients					
	CTI model implemented in partner organizations	20	Monthly	#staff recruited	
	Resource networks in place	75%	Quarterly	#agreements with collaborative agencies	
Goal 3: Implementation of efficient, effective, integrated, and cost-effective systems that achieve patient recovery					
	Sustained CTI training program	100%	Quarterly	#staff trained	

13f: Challenges and proposed solutions

Challenges to implementing this project and key barriers to successful implementation of outcome measures were identified by IDN stakeholders.

1. Communication

Communication was identified as the number one challenge to effective implementation of care transitions. Integration of services will only be achieved if effective communication between service providers, community members, clients, and families is improved. Effective communication is part of the core skills required by all health and social service practitioners to ensure that they are effective at meeting the needs of the people who use the services.

Practitioners need to be aware of and implement the use of effective communication tools. When it works well, communication helps establish trusting relationships, ensures information is passed and understood, and enriches the lives of people being served. If communication is not effective, it can lead to misunderstandings, resentments, and frustrations for the patients/clients, families, and health care staff.

2. Accessibility

Accessing services may be challenging even when there is a care transitions model in place. The primary challenges include: transportation, workforce, and resources.

Transportation is often challenging for individuals in our rural communities. The low population density and geographical distance in the region can be isolating for many rural residents and impact their ability to access mental health services. Region 7 residents have to travel by private vehicles, which often poses problems for both elderly and low-income populations. The geographic distance often required to access services can be significant. At times secondary roads in the region are closed for days because of extreme weather conditions in northern New Hampshire. Public transportation and taxi service are unavailable in the region.

Workforce capacity was identified by IDN stakeholders as a significant barrier to effective implementation of care transition teams. Although this barrier will be addressed through other project initiatives, in order for there to be a successful program in place it is important to acknowledge this challenge. Increasing workforce capacity in the region will enhance the ability to have trained staff to implement the CTI initiative.

Accessing resources such as housing and social supports is challenging for many individuals trying to navigate a complex system of services. For some, affordable supportive housing is just not available. The region suffers from a lack of hospital beds, transitional housing, crisis apartments, and supported employment. Social supports may not be in place, which, as noted earlier, is imperative for effective care. It may be challenging for CTI providers to refer patients to services due to personal situations that do not fit into “prescribed” systems. While taking local and regional resources into account, providers must be patient-centered, or individualized in their referrals as transitions are put in place.

Strategies for improved access to transition services may include:

- In addition to the CTI clinical staff that is trained, hiring outreach workers (for example, Community Health Workers), who are from the specific communities they serve, may be an effective addition to the care transition team. An effective way to connect with patients is to recruit community residents to be outreach workers who may be Community Health Workers (CHWs). CHWs may also be an on-going connection to the community for patients once CTI is terminated. CHWs can play a role in helping to mobilize and coordinate housing, services and supports in the community.
- Development of a universal patient care plan template that would be used by all outpatient providers and patients. If a common care plan is used throughout the system communication will be increased and patients will not have to be faced with “re-telling” their story each time they access new services and resources.

- Utilization of a patient health record that is maintained by the patient. This would be an effective way to empower patients to self-manage their health care. It would also be a tool that would keep family or social support members informed.
- A well-maintained web site managed by the IDN Lead Agency with information for patients/clients, health care and social service providers, and community members.
- Development of processes and protocols throughout referral systems that are consistent and easy to navigate.

13g: Implementation approach and timing

See the “Supplemental Data Workbook.”

14. Community-Driven Project #2

14a: CI: Care Transition Teams

14b: Project selection rationale and expected outcomes

Region 7 identified this project based on the need to expand access to substance use disorder services in the region. Data indicate that a significant percentage of individuals in need access services outside of the region. In 2015, only 48% of Substance Use Disorder (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. The New Hampshire Bureau of Drug and Alcohol Services noted that the number of admissions into treatment for prescription opiates or heroin increased from February to June 2016, and the number of admissions for opiates decreased from June to July. When combining the number of heroin and prescription opiate treatment admissions, the overall number of admissions decreased by 31% from June to July. Although the numbers are small, Coos and Carroll Counties both experienced a greater decrease, 75% and 100% respectively, in the number of residents admitted to treatment programs from June to July.²⁶

In addition to the challenge of accessing treatment services, the 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 2016.²⁷ Both the North Country and Carroll County Public Health Networks have implemented trainings for community stakeholders to administer Naloxone (Narcan), a prescription medicine used for the treatment of an opioid emergency such as an overdose or a possible overdose. The New Hampshire Bureau of Emergency Medical Services (EMS) reported an increase in both Carroll County (25%) and Coos County (20%) in incidents involving EMS Narcan administration from June to July 2016.²⁸ Both counties had significant increases compared to the overall state increase of 7%. Both of these significant increases in emergency department visits and administration of Narcan helped inform the IDN’s selection of this project.

²⁶The Opiate/Opioid Public Health Crisis. Update on the State of New Hampshire’s Comprehensive Response.

²⁷ ibid

²⁸ ibid

The majority of services (67.7%) in the region were provided by Tri County CAP (TCCAP). TCCAP services range from Head Start child development programs to programs for seniors, including senior center/meal sites and meals on wheels. The Tri-County CAP, Division of Alcohol and Other Drug service program facilitates a continuum of care model offering a comprehensive array of services which include Recovery Support Services, Outpatient and Intensive Outpatient services offered in Coos, Carroll and Grafton counties, as well as both High and Low Intensity Residential Treatment. TCCAP provides a large array of services including an outpatient department that serves individuals whose alcohol and drug use affects their daily living. TCCAP has a short-term residential substance abuse treatment program, and peer recovery support services

A small percentage (1.6%) of SUD services in the region were provided by Northern Human Services (NHS) in 2015. These data do not capture the full extent of SUD services provided by NHS which are likely captured as mental health services without a distinction between SUD and mental health. NHS provides professional support and services to people affected by mental illness, developmental disabilities, substance abuse, acquired brain injury or related disorders. NHS has been a primary provider of mental health services for over forty five years and offers a comprehensive array of recovery and resiliency oriented community based mental health services for children, adults and older adults. Clinic staff provide evidence-based practice interventions and NHS employs dually licensed clinicians who provide comprehensive treatment services to dually diagnosed individuals (mental health/substance abuse), consistent with scientifically proven best practices.

This project was selected so NHS, TCCAP, and other IDN partners can expand their services and capacity for delivery of partial intensive outpatient, partial hospital, or residential treatment options for SUD, in conjunction with expansion of lower acuity outpatient counseling. Community stakeholders from Region 7 identified this project as an opportunity to impact the following by the end of the demonstration project period:

- address the rapid rate of increase in substance use disorders in the region
- increase access to limited SUD and mental health services
- impact the number of individuals and their families affected by substance use disorders

The gaps in services section of this project plan clearly indicate the need for expanded substance use disorder treatment options in Region 7. Among other things, funds dedicated to this project will increase treatment and recovery resources, reduce long waiting lists for outpatient services by increasing critical workforce, and increase supportive behavioral health therapy in conjunction with Medication Assisted Treatment.

Anticipated outcomes for this project include:

- Expanded capacity to deliver Intensive Outpatient (IOP) services
- Expanded outpatient counseling for substance use disorders provided by qualified practitioners for individuals across the spectrum of health and social service programs within the IDN
- Increased support for Medication Assisted Treatment
- Increased evidence-based screening and identification of high-risk patients in primary care settings

This project will also include an educational component that will provide patients, families, and the community with information about mental health and substance use disorders. IDN partners have raised concerns about the lack of education and understanding of the high percentage of substance use disorders due to underlying and undiagnosed mental illness. Increased awareness and insight into the issues related to SUD and mental health will help reduce the stigma and “old school” ideas about mental health that providers still observe in the region.

14c: Participating organizations – selection criteria

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 for effective implementation of the project. Targeted participating organizations for this project will include behavioral health organizations seeking to expand service options. The primary organizations in the region providing interest to seek funds to expand service options include Northern Human Services, Tri County CAP and other primary care provider practices as they enhance integration with behavioral health services. Organizations seeking funds to participate in this project must have some behavioral health services in place that they would like to enhance. Northern Human Services, as noted above, is the primary provider of community mental health services in the region. NHS has noted that “individuals with emergency needs who are eligible for services can be served immediately. People with less emergent needs are scheduled for assessment and follow-up, based on the level of their need for service. There are waiting lists for some services which are dependent upon NHS obtaining necessary funding in order to begin serving new individuals.”²⁹ Tri-County CAP has prioritized expansion of alcohol and drug clinical services in their 2017-2021 strategic plan. Strategic priorities include: 1) develop and execute intensive out-patient program; 2) extend service offerings to include on-site medical services; 3) increase capacity to serve clients and reduce wait time for services, and 4) increase number of people who complete evidence-based treatment services.

Primary care practices that provide some behavioral health services and intend to expand SUD treatment options may participate in this project. While all IDN participants are required to participate in the Core Competency program which will move them along the continuum of primary care/behavioral health integration, some practices have indicated that they would like to expand SUD treatment options as well. Practices that have indicated this include: White Mountain Health, Huggins Hospital, Indian Stream Health Center, and Coos County Family Health Services. Other statewide IDN participants intending to work on this project include NAMI New Hampshire, Hope for NH Recovery, and White Horse Addiction Center. Understanding this is not an exhaustive list of potential participants in the project, it is an indication that there is consideration throughout the region.

Organization’s proposals will be reviewed to ensure they meet the criteria below for effective implementation of the project. Organizations will either propose as individual entities or in conjunction with community partners, and demonstrate capacity to implement and report progress toward improved outcomes.

Organizations participating in this project will demonstrate capacity to expand capacity for delivery of partial intensive outpatient, partial hospital, or residential treatment options for SUD. Organizations will

²⁹ <http://www.northernhs.org/FAQ.html>

be required to serve individuals with substance use disorders, with or without co-occurring mental health disorders. They will be asked to identify the target population for intervention, with particular emphasis on pregnant women, individuals that have experienced an overdose in past 30 days, IV drug users, and /or custodial parents of minor children. Organizations must be able to have capabilities to enhance services, collaborate with other partners, and to demonstrate:

- 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

14d: Participating organizations – list of organizations

See the “Supplemental Data Workbook.”

14e: Monitoring plan

Organizations implementing projects related to expansion in intensive SUD treatment options, including partial-hospital and residential care, will be required to monitor and report to the IDN Lead agency on a regular basis. Each project will be reviewed quarterly by the appropriate Work Group to ensure progress of the project is in line with overall improvement of outcome measures. If sufficient progress is not being made toward identified outcomes, Work Group members will designate an appropriate member to work with the organization and the Administrative Lead to assess the project and propose alternative activities. The types of evaluation questions that may be addressed include³⁰:

³⁰ http://evaluationtoolbox.net.au/index.php?option=com_content&view=article&id=20&Itemid=159

Focus of Evaluation	Evaluation Question
Process	How well was the project designed and how is implementation going?
Outcome	Is the project meeting overall needs? Was there/is there any significant change and to what extent was it attributable to the project? How valuable are the outcomes to the organization, stakeholders, IDN region?
Learnings	What worked and what did not? What were unintended consequences?
Investment	Was the project cost effective? Was there another alternative that may have represented a better investment?
What's On-Going; What's Next?	Can the project be scaled up? Can the project be replicated elsewhere? Is the change self-sustaining or does it require continued intervention?

All organizations will be required to have adequate workforce to carry out activities related to this project. Organizations participating in this project will determine their capacity and have a work plan that reflects their ability to implement all project activities. All sub-recipients that receive funds will be required to indicate: an implementation timeline, a project budget, a work force plan, projected annual client engagement, and key provider participants.

Specific monitoring activities will include: 1) tracking activities to monitor implementation and participation in activities; 2) 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; and 3) review of available outcomes data related to the region to understand progress in population health. A detailed project tracking sheet will be developed to identify and track each monitoring activity, including receipt of data. Organizations will be responsible for reporting progress on project activities on a quarterly basis.

The draft measurement plan below for this project provides information about collection of data for each primary objective. For ongoing outcomes data, there will be an assessment of the usability and feasibility of a dashboard, similar to the format outlined in the previous community-project plan.

Measurement plan for Region 7

	What	Where	How	When	Who
Program Objective	Measure and Target	Source of Data	How is the Data Collected	Frequency of Data Collection	Who is Responsible for Gathering the Data
Expand capacity to delivery intensive	# new health clinicians	Reporting template	Participating organizations	Quarterly	Program Manager

outpatient (IOP) services			complete tracking tool		
	Procedures and protocols in place for effective delivery	Reporting template	Participating organizations complete tracking tool	Quarterly	Program Manager
	75% of participating individuals and families provide feedback, eg..satisfaction	Program Survey	On-line survey program	Annually	Program Manager
	What	Where	How	When	Who
Program Objective	Measure and Target	Source of Data	How is the Data Collected	Frequency of Data Collection	Who is Responsible for Gathering the Data
Expand outpatient counseling for SUD across the spectrum of health and human service programs, including MAT	# new clinicians	Reporting template	Tracking tool	Quarterly	Program Manager
	# clinicians trained/licensed	Reporting template	Tracking tool	Quarterly	Program Manager
	# sites implementing expanded services, eg. MAT	Reporting template	Participating organizations provide feedback and report barriers to process of expansion	Quarterly	Program Manager
	What	Where	How	When	Who
Program Objective	Measure and Target	Source of Data	How is the Data Collected	Frequency of Data Collection	Who is Responsible for Gathering the Data
Increase evidence-based screening and identification of high-risk patients in primary care settings	# sites with increased capacity to implement SBIRT	Reporting template	Tracking tool	Quarterly	Program Manager
	# patients assessed to determine level of readiness for intervention	Reporting template EHR	Tracking tool	Quarterly	Program Manager

14f: Challenges and proposed solutions

Challenges to implement this project that were identified by the IDN stakeholders include: adequate workforce, relationships and coordination among patients and providers, and effective outcome measures.

Adequate Workforce

The lack of resources and funding in the region leads to high turnover and lack of trained staff. The Community Mental Health Center is unable to retain skilled staff because of low salaries (which includes Medicaid reimbursement, lack of state funding, and no managed care contract). Lack of funding for SUD has led to low salaries for both mental health and substance abuse professionals, which has meant that good people have left the field and few are currently in the pipeline. Trained staff who are not compensated satisfactorily leave the organizations and the area to seek employment elsewhere. Throughout the region workforce is a significant barrier, particularly for patients who suffer from severe mental illness. Adult referrals to a psychiatrist can take a month or two, and there is not a child psychiatrist in the area. There is a lack of trained professionals who specialize in co-occurring developmental disability and mental health/substance use disorders who understand how to help this population.

Relationships and coordination among patients and providers

Clinical interventions and treatment rely on a good relationship between the patient and provider in order for there to be successful outcomes. This is a significant barrier when patients and families do not understand what providers are telling them or if they are not given full information. Patients and families often do not receive education to increase their understanding, awareness, and warning signs associated with substance use disorders, including resources and treatment options.

Effective Outcome Measures

Organizations that provide mental health and substance use disorder services recognize having effective outcome measures as a barrier to successful delivery and evaluation of services. It is often difficult to assess the following types of questions: how effective are treatment services; how can the effectiveness be assessed; have clients' quality of life improved following treatment; how to attribute clients' improvement to participation in a particular treatment program.

Strategies for improved expansion in intensive SUD Treatment Options services may include:

- Participating in the Statewide Workforce Taskforce will inform decisions that will be made to increase an effective workforce for this project in the region;
- Community-based funding for this project will focus on workforce recruitment and retention. It is anticipated that increased funding will enhance both recruitment and retention.
- Development of professional pathways will be explored and funds may be used to increase local training opportunities and programs (i.e. collaboration with the Northern New Hampshire Area Health Education Center)
- Region 7 participants will encourage the Statewide Workforce Taskforce to prioritize work with state credentialing and licensing entities to address policy change/legislation that will impact mental health and substance use disorder personnel
- Improved documentation of outcome measures will result if there are statewide efforts to identify and agree on effective measures. There should be standardized collection and interpretation of

data. There should be an effort to maximize synergy of data that is required to be collected among multiple funders and projects.

- Efforts to improve relationships among patients and providers will focus on gathering information from community members who access services. Case management of integration of resources will increase communication and build trust.

14g: Implementation approach and timing

See the “Supplemental Data Workbook.”

15. Community-Driven Project #3: Community-based Integration

15a: E5: Enhanced Care Coordination for High-Needs Populations

15b: Project selection rationale and expected outcomes

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. By enhancing the focus on care coordination, and allocating resources to all of the potential partners, relationships will be strengthened and patient outcomes impacted in positive ways. Care coordination is the logical strategy to compliment the core competency project, work of the transitions in care project as well as the HIT and workforce initiatives. Care coordination will be most effective if there is adequate workforce at various levels of provider teams, adequate health information technology that facilitates exchange of relevant information, and sufficient support for patients and families. Care coordination for high need adult and child populations with multiple physical health and behavioral health chronic conditions is essential to improve outcomes and improve overall health. Region 7 suffers from significant levels of Medicaid beneficiaries who have physical health conditions as well as behavioral health indicators. The table below indicates the percentage of the Region 7 populations with selected physical health conditions who also have behavioral health indicators:

Region 7 populations by age group with physical health conditions and behavioral health indicators				
	Age	Diabetes condition	Respiratory condition	Cardiovascular condition
Behavioral Health indicator	0-11	.67%	41.79%	3.44%
	12-17	.47%	37.24%	6.38%
	18-29	2.83%	33.49%	12.00%
	30-49	9.6%	36.78%	22.76%
	50-64	20.09%	47.93%	42.38%
	65+	26.39%	52.31%	58.80%

Region 7 stakeholders believe that enhanced care coordination will help reduce duplication of services and will assist patients/clients with successful navigation of a very fragmented system. Enhanced care coordination will increase patient’s engagement in their own care and encourage greater awareness of available resources and services. Better coordination will ultimately result in reduced cost and help

eliminate waste in the system. Regional partners feel strongly that enhanced care coordination will not only benefit patients, but will also improve communication and collaboration among health care providers and agencies.

Community based care coordination integrates primary care, behavioral health, and local health and community resources to provide person-centered, coordinated services. According to the Rural Policy Research Institute, care coordination provides an opportunity to supplement the diagnosis and treatment priorities of medicine with clinical and non-clinical prevention and management in a system that also supports the social aspects of patients' lives that contribute to health.³¹

- In order to effectively implement this project, organizations will use a common process to:
 - Identify the target population (within the required target populations):
 - Adults (18 and older) with behavioral health disorders with or without poorly managed or uncontrolled co-morbid chronic physical and/or social factors that are barriers to community living and well-being
 - Children (<18 years) diagnosed with chronic serious emotional disturbance
- Developmentally disabled population/ aged blind and disabled population with co-occurring behavioral health disorders
- Utilize a tool or survey that will be used by the care coordinator to assess a person's level of need for services and coordination
- Develop a person-centered care plan that is developed with the person/family/caregiver to clearly identify the person's needs
- Develop an interdisciplinary care team of providers identified with the person/family and/or caregiver that represents the clinical, behavioral health, social services, long-term care and community resources needed to help meet the goals and outcomes of the person

Some of the Region 7 partner organizations already engage in care coordination at various levels. Enhanced care coordination will build on successful models already happening around the region, and best practices will be shared. An assessment will be made so effective tools are used throughout the region. Electronic Health Records (EHRs), electronic registries, personal health records, and health information exchange systems will be important to incorporate into organizational and regional systems. Common scheduling tools and referral/tracking follow-up tools will be evaluated and recommended for use.

This project will focus on the following outcomes:

- Improved Provider Relationships
Care coordination will increase communication between primary care providers and other caregivers, including behavioral health and substance use disorder treatment providers. Communication between and among inpatient and outpatient services will also be improved and/or developed.

³¹ Rural Policy Research Institute (RUPRI) – Care Coordination in Rural Communities: Supporting the High Performance Rural Health System, June 2015, p. 2

- Increased Quality of Patient Care

Effective care coordination will increase the ability of patients/clients to maintain or improve their functional status. It will also improve patient/client engagement in their own care and health outcomes. Care coordination will also reduce the need for repeat acute care and services for patients/clients. An important benefit of enhanced care coordination will also be savings that may be distributed to address the social determinants of health. Building a network of providers to collaborate among services and resources will improve access to care which will ultimately result in improved quality of care.

- Reduced Cost of Care

Comprehensive care coordination is a key strategy that will improve patient/client health and reduce excess cost in the health care system. Effective care coordination is designed to reduce unnecessary services, provide more comprehensive care, and improve health. Coordinated care will potentially have an impact on reducing medication errors, unnecessary or repetitive diagnostic tests, and preventable emergency room visits. All of these costs, in addition to hospital readmissions contribute to excess spending which is sometimes considered “wasteful spending.”

Enhanced care coordination will ensure that a Care Coordinator is in place who is an advocate for patients/clients and their families, and who communicates with all of the entities involved individual-centered care.

15c: Participating organizations – selection criteria

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 for effective implementation of the project. 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), and 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. Organizations seeking funds to participate in this project must 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, as well as linkages to other community supports and resources. Organizations choosing to participate in this project must ensure a collaborative model that will include coordination with other programs or resources that serve similar patients in order to have only one care coordinator who is playing a lead role in the management of a patient’s care plan. Organizations will be required to include agencies that are new partners, and must have a collaborative spirit. Organizations must commit to defining a specific care coordination model that will be used and the exact target population they will serve.

Participants in this project will be asked to complete a “Care Coordination Template”³² shown on the following page below:

³² Adapted from the National Rural Health Resource Center. Duluth, MN

Care Coordination Template			
1. Target Population: improving the care, health, and reducing costs for a specific group of people		2. Assessment Tool(s) to be used by the care coordinator to assess a person's level of need: <ul style="list-style-type: none"> Social, environmental, mental health, physical and psychosocial functional needs Risk or severity level of a diagnosis and/or disease 	
1a. Is it specific enough? Clearly define the goal or outcome of the identified problem Be specific It must be measurable	1b. How will the target population be identified?	2a. Is one needed? Commonly the target population is generally defined and an assessment can help determine the level of coordination needed or what types of services are needed	2b. What is the type or how will it be used? The type will be determined by the target population and desired outcomes
1c. How will you communicate and engage the person? By phone, in-person or a combination. Where will it take place and how often		2c. How will the results be communicated? Where will it be stored? Do the results need to be shared with the care team? Do they help identify members of the care team? Can the results be used for evaluation and measurement?	
1d. How will technology be used to perform these functions? Technology can be of great assistance to 'mine' data. Communication: secure messaging, portals?		2d. How will technology be used to perform these functions? The assessment tool can be electronic, web based and saved to EHRs. Can be communicated via secure messaging, portals.	
3. Care Plan: An individualized plan of care that is developed with the person/caregiver and providers to identify the person's needs		4. Care Team: Providers identified with the person and/or caregiver that represents the clinical, behavioral health, social services, long-term care and community resources needed to meet the person's goals and outcomes.	
3a. What approach to developing the care plan is being taken, so that it is: Developed with the person Based on assessed needs Accounts for medical, behavioral health, wellness and human service's needs (social determinants) Incorporates existing care and treatment plan information	3b. What is included? Goal or outcome Clinical and social needs Instructions and interventions Interdisciplinary Care Team Members, including contact information Person demographics	4a. Who is the coordinator? Dependent on the needs of the population, what the focused outcomes are, but can be: community health worker, social worker, nurse, physician assistant, medical assistant, etc.	4b. How will you build collaboration with the provider and partners of the care team? Team meetings to effectively build out the work flow. Communicating so each member of the team knows their role, expectations, and hand offs.
3c. How will the care plan be communicated to engage the person, and include the care team? How will updates be shared and the care		4c. How will the care team communicate with the person, coordinator, and amongst themselves? This is the workflow.	

plan updated	
3d. How will technology be used to perform these functions? EHRs, secure messaging, portals	4d. How will technology be used to perform these functions? EHR, secure messaging, portals, phone, video conferencing
5. Leadership next steps? Community coaches Develop advocates Community education and information meetings Focused conversations	6. What is your Organizational Model? Community mental health Primary care integration Provider based Social support based

15d: Participating organizations – list of organizations

See the “Supplemental Data Workbook.”

15e: Monitoring plan

Organizations implementing projects related to enhanced care coordination will be required to monitor and report to the IDN Lead agency on a regular basis. Each project will be reviewed quarterly by the appropriate Work Group to ensure progress of the project is in line with overall improvement of outcome measures. If sufficient progress is not being made toward identified outcomes, Work Group members will designate an appropriate member to work with the organization and the Administrative Lead to assess the project and propose alternative activities.

The types of process measures that will be used to monitor care coordination programs will include:

- Number of direct/indirect encounter or visits
- Number of duplication/unduplicated encounters
- Number of care coordinators trained to serve patients using an evidence-based curricula
- Number of healthcare providers offering care coordination services
- Number and level of participation of organizations involved in the program
- Number of referrals to other providers
- Number of people receiving services from a care coordinator
- Number of participants who have a self-management plan
- Changes in patient’s healthy behaviors
- Changes in patient costs (e.g. streamlining visits with specialty care)

Monitoring criteria that will be implemented for enhanced care coordination projects will be adapted from the Care Coordination measurement framework from the Agency for Healthcare Research and Quality (AHRQ).³³ AHRQ identifies certain domains required to achieve care coordination. Broad approaches to measure care coordination include:

- Teamwork focused on coordination
- Health care home
- Care management
- Medication management
- Health IT-enabled coordination

All organizations will be required to have adequate workforce to carry out activities related to this project. Organizations participating in this project will determine their capacity and have a work plan that reflects their ability to implement all project activities. All sub-recipients that receive funds will be required to indicate: an implementation timeline, a project budget, a work force plan, projected annual client engagement, and key provider participants.

Specific monitoring sources will include: 1) referral tracking forms; 2) encounter forms and/or outreach logs; 3) targeted qualitative methods (eg. semi-structured interviews or surveys) to understand how the

³³ <http://www.ahrq.gov/professionals/prevention-chronic-care/improve/coordination/atlas2014/chapter3.html>

project is unfolding and to account for overall contextual factors that may affect implementation and sustainability of program efforts either positively or negatively; and 4) EHR data and/or hospital data when available. A detailed project tracking sheet will be developed to identify and track each monitoring activity, including receipt of data. Organizations will be responsible for reporting progress on project activities on a quarterly basis.

The draft measurement plan below for this project provides information about collection of data for each primary outcomes. For ongoing outcomes data, there will be an assessment of the usability and feasibility of a dashboard, similar to the format outlined in the previous community-project plan.

Measurement plan for Region 7

	What	Where	How	When	Who
Program Objective	Measure and Target	Source of Data	How is the Data Collected	Frequency of Data Collection	Who is Responsible for Gathering the Data
Improved provider relationships	# new provider/organization collaborations	Care Plan/Reporting template	Participating organizations complete tracking tool	Quarterly	Program Manager
	Clearly articulate responsibilities of participants in patient care	Care Plan/Reporting template	Participating organizations complete tracking tool	Quarterly	Program Manager
	Facilitate transitions	Referral/tracking form EHR	On-line survey program	Quarterly	Program Manager
	What	Where	How	When	Who
Program Objective	Measure and Target	Source of Data	How is the Data Collected	Frequency of Data Collection	Who is Responsible for Gathering the Data
Increased quality of patient care	Resources aligned with patient	Care Plan/Reporting template	Tracking tool	Quarterly	Program Manager
	Medication management	Care Plan/Reporting template	Tracking tool	Quarterly	Program Manager
	Proactive care plans created and communicated	Care Plan/Reporting template	Tracking tool	Quarterly	Program Manager
	Monitor, follow up and respond to change necessary for patient progress toward care and	Care Plan assessment EHR	Tracking tool	Quarterly	Program Manager

	coordination goals				
	Support self-management goals	Care plan	Tracking tool	Quarterly	Program Manager
	What	Where	How	When	Who
Program Objective	Measure and Target	Source of Data	How is the Data Collected	Frequency of Data Collection	Who is Responsible for Gathering the Data
Reduced cost of care	Decreased visits to specialty care	Care Plan/Reporting template EHR	Tracking tool	Quarterly	Program Manager
	Reduced hospital readmissions and ED visits	Reporting template EHR	Tracking tool	Quarterly	Program Manager

15f: Challenges and proposed solutions

Key challenges the IDN faces in implementing this project include:

- Addressing the needs of a very sick population and the lack of motivation they have to accept change. 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. Both patients and providers have to understand that they are all part of a team that is committed to the success of the patient. In order for this population to be successful it will be important to identify services and to offer choices to them, rather than to just direct what providers believe will be most helpful.
- Provider and agencies may be resistant to change if an enhanced care coordination model is something new to their practice. It will be important to engage providers and agency staff in problem solving and to create “buy-in” for any new program implementation. Effective models of care coordination may take time to initiate because trusting relationships among providers that have not worked together in the past will have to be established. Providers will need to explore options that may blend services within organizations to create efficiencies in the system.
- Financial challenges related to both resources and staff. Financial challenges will be need to be addressed through new alternative payment models that include care management as part of bundled payments. Effective assessments of resources will have to be completed that reduce redundancy and identify opportunities for efficient service delivery.
- Health information technology (HIT) is not used effectively for care coordination measurement. It will be important to address underutilization of HIT system capabilities and clinical workflow barriers. It is hoped that this challenge will be addressed with support from the statewide IT work group. Once organizations have HIT capacity, it will be important to address the lack of data standardization and limited HIT system interoperability; to create protocols for staff to enter selected information into structured fields; and to deal with the technical hurdles required to access the data that is in the system.

15g: Implementation approach and timing

See the “Supplemental Data Workbook.”