Meeting: All-IDN Administrative Lead Learning Collaborative Meeting
Location: NH Department of Health and Human Services, Concord NH
Date: February 2, 2018
Time: 9:00 AM – 10:45AM

Attendees:

<table>
<thead>
<tr>
<th>Name</th>
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<tr>
<td>April Allin, Program Director, IDN7 (phone)</td>
<td>Kelley Capuchino, Senior Policy Analyst, Division of Behavioral Health, NH DHHS</td>
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<tr>
<td>Audrey Goudie, Administrative Lead, IDN5 (phone)</td>
<td>Kevin Erwin, IDN6 (phone)</td>
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<td>Ann Landry, Administrative Lead, IDN1</td>
<td>Leslie Melby, Special Projects Administrator, Medicaid, NH DHHS</td>
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<td>Bobby Courtney, MSLC</td>
<td>Mark Belanger, IDN1</td>
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<td>Brian Earp, DHHS Project management</td>
<td>Michelle Craig, Program Manager, IDN3</td>
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<td>Caroline Trexler, Program Planning and Review Specialist, Medicaid, NH DHHS</td>
<td>Nick Toumpas, Administrative Lead, IDN6</td>
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<td>Catherine Snider, MSLC (phone)</td>
<td>Peter Evers, Administrative Lead, IDN2</td>
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<td>Effie Malley, MSLC (phone)</td>
<td>Tory Jennison, IDN6</td>
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<td>Felicity Bernard, IDN2</td>
<td>Valerie Brown, MSLC</td>
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<td>Jane Emeneau, IDN3</td>
<td>William Gunn, IDN6 (phone)</td>
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<td>Jessica Powell, IDN1(phone)</td>
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Action Items:

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<th>#</th>
<th>Description</th>
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<tr>
<td>1.</td>
<td>An email will be sent out with the electronic sign-up sheet to include other B1 staff in future MSLC Learning Collaborative (LC) Admin Lead Meetings.</td>
<td>MSLC</td>
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<td>2.</td>
<td>MSLC will maintain a list of potential training and/or topics for future consideration at future Learning Collaborative (LC) Admin Lead Meetings, including:</td>
<td>MSLC</td>
<td>In Process</td>
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<td>- Discussion of what to do after a positive CCSA screen. Is there a tool, script, or common set of resources, such as the FQHC “PRAPARE Tool,” that can be leveraged?</td>
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<td>- Discussion of the CCSA as it relates to pediatric patients.</td>
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<td>- Discussion of multi-disciplinary team structures (e.g., IDN6 example of Community Care Teams).</td>
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Discussion:

I. Introduction

B. Courtney welcomed attendees. K. Capuchino took a moment to discuss the format/structure of this meeting moving forward. Specifically, Ms. Capuchino proposed to use this meeting for further discussion of how B1 integration is woven through all projects. She acknowledged that it would be beneficial to invite others from the IDNs involved with B1 and that a bigger space for the meeting was needed. A sign-up sheet circulated the room for attendees to add contact names and information for additional attendees. An electronic copy will also be distributed.

**ACTION ITEM**

II. IDN Admin Lead Presentation (IDN6)

   a. Ms. Jennison presented on behalf of IDN6, with support from N. Toumpas, Kevin Irwin, and William Gunn. Ms. Jennison first noted that IDN6 covers the entirety of the Strafford County Public Health Network and the Seacoast Public Health Network, with the administrative lead being Strafford County. Clinical partners include CMHCs, FQHCs, Hospitals, and SUD provider.

   b. Ms. Jennison noted the value of leveraging existing Community Care Teams from Portsmouth and Rochester to filter information to, and inform, the IDN’s Multi-Disciplinary Core Team. Information is shared among 39 agencies through the Community Care Teams; however, both clients and agencies are required to consent.

   c. Ms. Jennison noted that the IDN had completed a meta-analysis of existing partnerships, reports, and data to establish a baseline assessment of resources and needs. Barriers identified included trust, different perspectives, different priorities, and different allegiances. Trust was highlighted as critical to success as some information can only be obtained through a trusted relationships.

   d. The Collaborative Integrated Design process was described as the method used to assess the planning, implementation and evaluation phases of the project. This included a two hour guided discussion with multiple departments to discuss the partner’s baseline Site Self-Assessment. It was explained that this process is being rolled out in waves starting with a couple of partner agencies. Ms. Jennison also noted that the Rapid Cycle Evaluation tool was used to address the shifting landscape. It was suggested that Rapid Cycle Evaluation be considered as a topic for future discussion during the monthly meeting. **ACTION ITEM**

   e. Comprehensive Core Standardized Assessment (CSA) was described as still under development with conversations being conducted with partners to identify which domains they collect. IDN6 expressed that partners continue to ask the question of what do to with positive CSA result. A tool or a guide was discussed as a possibility of
being developed that would identify resources within the region. MSLC stated they could be helpful with this. **ACTION ITEM.**

**f.** The Community Care Team model was described as the first level of the multi-disciplinary core team for complex patients with an emphasis that the patient is a key member of the team.

**Q:** How does this model fit with what the STCs identify as types of providers that should make up the multi-disciplinary team?

**A:** The STCs definition of a multi-disciplinary core team is valuable for a certain strata of complexity. There are some clients that need care coordination from half the team and some that need some coordination from more than the team. We are really trying to get a handle on what the complexity level is and type of patient that needs the multidisciplinary core team the way it is defined in the STCs.

**Q:** It seems as if the Community Care Teams are being used as a filter. Can you explain this?

**A:** The first filter is if an agency is struggling with a case because they are at capacity. Since the IDN has adopted the Community Care Team process there is now a template used to identify the necessary domains and utilization information. We are leveraging systems that are already in place.

Different structures of multi-disciplinary teams at the IDN level was identified as a future LC item. **ACTION ITEM**

**g.** The culture of an organization as it relates to sharing of information was discussed. Organizations think differently and culture is a barrier that must be worked through.

**Q:** Have you tackled the CSA as it relates to children?

**A:** No, we have not gotten that far yet. The questions on the CSA are different for children.

This will be added for a topic for discussion at a future LC session. **ACTION ITEM**

**h.** PDSA Cycle was explained as the method that IDN6 uses to track, monitor and evaluate planning. The cycle was described as occurring in unequal parts and that more time is spent in planning section. Part of the extended time in the planning phase is related to the community projects because of the interrelationships between them and B1 integration.

**i.** IDN6 worked with the community and stood up a 24/7 warming shelter in Rochester for 15 days that at peak had 80 people. 100% of individuals that came to the center had a behavioral health condition, approximately 70% had a SUD and most were in active use or withdrawal and nobody died.

**j.** Multiple agencies performed an abbreviate version of the CSA called the Coordinated Entry Screen on individuals that entered the warming center. Most were Medicaid eligible but currently not enrolled. Ten different agencies were involved with the warming center. The newly trained CTI team was utilized. Staffing occurred in 6, 4 hour shifts due to the complex population. There were a number of media articles reporting on the Rochester Warming Center that referenced the IDN.
Q: Did the local EMD get involved?
A: This was not a shelter and not funded as such. It was low barrier. This came together because of 18 month of building relationships and when it was time to call these people in they came. We found where the boundaries are and found connections in the community that were not part of any formal network. After action was conducted. As a result there will be additional lessons learned.

Q: Who staffed it?
A: The IDN6 team staffed it with shelter management and incident management represented by leadership from SOS Recovery and Tri-City Coop.

Q: Did the local EMA get involved?
A: The EMA was relatively new but did step up and provide the resources we needed. The city could not use their regular emergency plan because it was temperature related and not storm related.

k. Standing questions generated by IDN 6 which will be brought forward as discussion items in future meetings
   1. How can we change population health without detailed data on the population’s health?
   2. How are your partners aligning IDN process and performance requirements with their own activities?
   3. How do you balance resource investment vs. impact?
   4. How will IDN efforts impact/affect/influence MCO care management efforts?

l. Finding and after actions resulted in the IDN recognizing that the goal for the future is to be able to provide the resources to the organizations and people that are experts at this so that they do not have to do this again.

m. General questions were asked by attendees.

Q: Do you have work teams structures around the big categories you talked about such as CCSA? What do you have for work teams?
A: Our work teams are structured around our projects. We are doing collaborative development of the projects. We did not have an RFP process. We have a clinical advisory team which includes partners so the CCSA discussion has happened at those workgroup projects. The Special Education Director for the school district that has 9 towns in it is also part of the team.

Q: It seems as if IDN6 never really launched a B1 group. It is threaded through everything. B1 is just a foundation for all of the other work you are doing. Is this correct?
A: We have B1 groups in each of the wave practices, each of the agencies.

Q: There is incredible value of Social Service Agencies that are not part of the Medicaid providers. How do we capture the value of this so that any type of APM model is going compensate these organizations?
A: See APM discussion below.
II. **APM Discussion**
   a. K. Capuchino remarked that many people have asked her what the IDN representative’s role is at the APM stakeholder meetings. She suggested that the representative’s role is to share the IDN’s perspective/inform the Department about what they believe needs to be included in an APM, and to be engaging in this discussion representatives of their region.
   b. There was a discussion regarding how critical data is to identifying costs and utilization and how top services that are broken down by behavioral health vs. medical costs show that behavioral health costs are much lower than medical costs, which impacts how integration is perceived.
   c. It was also suggested that this is a critical conversation for WFTF and that the current reimbursement model may complicate a transition to APMs.

III. **Discussion: Future Funding**
   a. Commissioner went to Washington D.C. to meet with CMS.
   b. No update was given at this time from Medicaid Director.
   c. Contingency planning was discussed with reduced future dollars.