New Hampshire
10-Year Mental Health Plan

January 2019

Message from the Commissioner

The Department of Health and Human Services (DHHS), pursuant to 2017 Laws Chapter 112 (House Bill 400), is pleased to submit to Governor Christopher T. Sununu, President of the Senate Donna M. Soucy, and Speaker of the House Steven Shurtleff, the Department's 10-Year Mental Health Plan (Plan).

This Plan was developed from a statewide stakeholder process that included input from hundreds of interested parties who took a critical look at the current system. Input came from focus groups, workgroups, and public sessions held in recent weeks. The Plan addresses the needs of individuals and families across the continuum of care, and provides innovative models to meet the evolving environment and increasing complexity of the mental health system. DHHS has taken the work that came forward from this public process in shaping its final recommendations.

Not all the statements in the Plan are findings of DHHS, but rather reflect stakeholder and public input. It is a product, in part, of that robust public process. In putting it forward, we fully anticipate that the Plan will help inform the Governor and the legislature in further strengthening the state's mental health system in the coming legislative session.

It is important to note that, unlike the 10 Year Plan issued in 2008, this Plan takes a comprehensive approach to essential services and supports across the life span. The 2008 Plan and the Community Mental Health Agreement (CHMA), signed in 2014, only took into account the needs of adults, leaving out children. The Plan includes child-focused strategies and recommendations.

Over the past six years, funding for mental health services in New Hampshire has significantly increased. In State Fiscal Year 2013 (which is the year prior to the implementation of the Community Mental Health Agreement), some $97 million in total funds were allocated to mental health services. Most of those funds paid for mental health services through the state's Medicaid Fee for Service Program. By State Fiscal Year 2019, these expenditures grew to nearly $164 million, of which $108 million was paid through the Medicaid Care Management Program. Thus, over this time period, state funding for mental health services apart from the Medicaid program, and excluding New Hampshire Hospital (NHH), grew from $7.3 million to nearly $50 million. That was accomplished in a bi-partisan manner under Governor Hassan and Governor Sununu and the legislature by funding services critical to the Community Mental Health Agreement (CMHA) and more. The detail of state spending for mental health services over this 7-year period appears as Appendix A to this report. All told, total spending for mental health services in this six-year period exceeds $949 million dollars.

While meaningful investments have been made to address the mental health system, more significant challenges remain. The Plan identifies these challenges and presents recommendations to the Governor and the legislature to address them beginning in the next biennial budget.

We hope that all stakeholders recognize the efforts that have been taken in the past year to enhance the system. These steps include funding 40 new transitional housing beds, crisis services, a new children's mental health benefit, a new targeted payment to the Community Mental Health Centers (CMHC) of $5 million that will be distributed in early 2019 and, significantly, an increase in the mental health fee schedule of $6 million dollars.

The Department looks forward to presenting the Plan to the legislature early in the forthcoming session. We welcome the continued input from all stakeholders as we work collaboratively to fund an effective and sustainable Plan in the next biennium and beyond.

DHHS would like to express its sincere appreciation to the Center for Behavioral Health Innovation at Antioch University New England for its support and hard work in coordinating the public stakeholder process. The work of Megan Edwards, Jim Fauth, and George Tremblay was instrumental in this process. I also wish to thank the many mental health advocates, providers, and other stakeholders who participated in the process facilitated by Antioch, as well as the many persons with lived experience and their family members who attended our public sessions and told their stories, powerfully and heartfelt. And I wish to also thank all of the DHHS staff who brought their expertise, commitment and hard work to this process.

Jeffrey A. Meyers
Commissioner

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A New Vision for New Hampshire's Mental Health System

The Department's 10-Year Mental Health Plan envisions a mental health system that provides access to a full continuum of care for all populations – community education, prevention and early intervention, outpatient supports, step-up and step-down options, and crisis and inpatient services – across the state. Assistance with barriers to access and the social determinants of mental health, attention to the needs of special populations, enhanced school-based mental health, multiple alternatives to the ED and psychiatric hospitalization, more integrated primary care, supported transitions between "steps" in the continuum of care, and infusion of peer supports throughout the system are among the elements called for in the Plan.

Access to mental health services for different populations across the continuum of care can vary greatly throughout the state. Long wait times for psychiatric hospitalization is one visible symptom of a stressed mental health system. Limited access to care, the difficulties inherent in navigating a complex and fragmented system, shortages and turnover in the mental health workforce, limited alternatives to the Emergency Department (ED), lack of inpatient bed capacity, and the need to comprehensively address the social determinants of mental health are also common concerns raised about New Hampshire's (NH) mental health system. Underlying it all, in the minds of many from whom we heard in this process, is the need to increase funding for mental health.

This Plan and recommendations for implementation that follow propose action steps and funding benchmarks to continue to transform NH's mental health system. Additional infrastructure and systems improvements, including enhanced use of technology, a more fully integrated data and quality assurance system, and a less burdensome regulatory system, will also be needed to continue the transformation of NH's mental health system. Shared leadership – the Governor and Legislature, DHHS, advocacy and philanthropy organizations, providers, and grassroots support – will be key to continue the transformation of our mental health system. These additional resources, together with increased recognition of the importance of mental health, will help expand the necessary qualified workforce.

Any 10-year plan requires the support and active collaboration of all interested parties, including government, providers, stakeholders, and the public. What follows are a number of action steps that would continue to improve the capacity and strength of the state's mental health system in the years to come. Review and adaptation of the Plan to changing conditions in concert with biennial budget cycles is critical to successful implementation. The Plan is not and cannot be static over the 10-year period. It must be continuously reviewed every budget cycle to ensure that it is responding to evolving needs. At the system level, all of us wish to achieve improved access, coordination, quality, equity, and cost efficiency. At the population level, all of us anticipate better lives for the residents of NH, in the form of fewer suicides, opioid overdoses, and other causes of early/preventable mortality; lower rates of abuse, delinquency, and incarceration; better care experience and satisfaction; enhanced social networks and relationships; and enhanced quality of life. We begin with presentation of the recommendations, which highlight and reflect both the stakeholder input we received and the Department's proposed implementation.

10 Year Plan Policy & Funding Recommendations for SFY 2020 & SFY 2021 (funding amounts are in state general funds)

Recommendation 1: Medicaid Rates for Mental Health Services

For Fiscal 2019, DHHS temporarily raised the Medicaid fee schedule for mental health services by $6M in total funds. At a minimum, this increase should be sustained in the forthcoming FY 2020-2021 Biennial Budget. In order to raise the New Hampshire fee schedule rates to the national average, an additional appropriation of general funds would be required that would be matched by federal funds. The DHHS should work with the Governor and legislators to develop a proposed timeline to reach the national average.

- SFY 2020: $3M
- SFY 2021: $3M
- Budget Action

Recommendation 2: Action Steps to Address Emergency Department Waits

The elimination of emergency room boarding in hospitals will require a number of actions by the state, the state's hospitals and the managed care organizations. A combination of additional mobile crisis services, community designated receiving facility and voluntary bed capacity, re-allocation of current NHH capacity, and enhanced involuntary emergency admission (IEA) screening care coordination and management of emergency room patients by providers and payers will be needed to materially impact the current boarding crisis.

I. Short Term Measures

- Mobile crisis services have proved to be extremely effective in diverting patients away from treatment in hospital emergency departments. These services are now operational in three areas of the state – Concord, Manchester and Nashua under a model required by the terms in the CMHA.. DHHS is also going forward with a new stationary behavioral crisis treatment center that is also expected to be equally as effective in diverting emergency department use. DHHS recommends that it issue an RFP for expanded mobile crisis services in areas that are now underserved that takes into account regional differences, as well as for additional stationary centers in areas of the state for which mobile teams may not be practicable.

  This recommendation includes the expansion of mobile crisis services to serve children to address their acute needs at the community level rather than in higher levels of care, incuding emergency departments.

- The rates for community-based Designated Receiving Facilities (DRF) bed capacity should be raised to a level that incentivizes new community bed capacity. Similarly, there should be funding for an atypical rate for the establishment of new community based voluntary services. The state should also make available funds to provide to hospitals to cover the capital costs of renovation for the establishment of new DRF capacity in exchange for a commitment of the hospitals to operate those DRF beds for a minimum of 7 years.

- Training and education efforts by NHH clinical staff and DHHS with the hospitals should be enhanced with funding to ensure that only those persons who need treatment though an involuntary inpatient admission are certified for that treatment.
- The regulatory authority of the Departments of Insurance and Health and Human Services should be used to the fullest extent to require that public and commercial payers are providing care coordinators in the state's hospitals to direct their insureds to the appropriate level of care and that all federal mental health rate requirements are demonstrated to be met.
- DHHS should file a new Section 1115 waiver request with the Centers for Medicare and Medicaid Services (CMS). One waiver is to access Medicaid reimbursement for mental health services provided to those adult patients diagnosed with Serious Mental Illness and children diagnosed with Serious Emotional Disturbance for inpatient stays of up to 30 days as provided under the new policy announced by CMS on November 13, 2018 by HHS Secretary Alex Azar.
- The Legislature should amend the statute authorizing the licensing of hospitals to allow DHHS to condition all current and future hospital licenses upon the implementation of hearings for IEA patients within the 72-hour limit now prescribed in RSA 135-C:31, I. DHHS should be required to promulgate rules implementing that new requirement.

II. Reallocation of Capacity at New Hampshire Hospital

The reallocation of existing capacity at NHH is critical to ensuring adequate inpatient bed capacity for the state. There are two options that should be fully explored in the coming legislative session.

- Option 1: Establish a Psychiatric Residential Treatment Facility at the Sununu Youth Services Center for the treatment of children now being served at NHH, which would both establish a more appropriate, non-hospital based treatment model for children and would allow the existing Philbrook Wing of NHH to be renovated for the addition of up to 48 new adult beds. This option would involve renovations to an existing 36-bed unit at SYSC in order to attain Joint Commission accreditation that is required, as well as staffing and operational costs regardless of whether the PRTF is operated by the state or a third party. This option would also entail renovation, staffing and operational costs of converting and repurposing the Philbrook Wing at NHH.
- Option 2: Relocate the approximately 30 forensic/justice involved patients out of NHH to a new forensic hospital, which would allow the use of those 30 beds for adult patients. This option would involve the cost of securing new forensic hospital services operated either by the state or a contacted vendor in a new or renovated facility. Under this option, the state would enter into a service contract with an owner/operator of a facility for services. The state could obtain an option to purchase the facility after a period of time.

The costs of Options 1 and 2 are now being estimated by both DHHS and Public Works and will be made available as early in the budget process as possible.

- SFY 2020: $3M crisis services (mobile and stationary)
- SFY 2020: $500,00 children's mobile crisis
- SFY 2020: $750,000 for existing DRF rate increases (doubles existing rate)

- SFY 2020: $1.2M for each additional 10-bed DRF
- SFY 2020: $500,000 for voluntary bed rate increases
- SFY 2020: $2M for renovations for 2 new DRFs
- SFY 2020: $250K for training and education of hospital staff
- SFY 2021: $3M crisis services (mobile and stationary)
- SFY 2021: $500,000 children's mobile crisis
- SFY 2021: $750,000 for existing DRF rate increases (doubles existing rate)
- SFY 2021: $1.2M for each additional 10-bed DRF
- SFY 2021: $500,000 for voluntary bed rate increases
- Budget, Law Change and Federal Waiver Application Action

Recommendation 3: Renewed and Intensified Efforts to Address Suicide Prevention

The increase in suicide rates over the past 20 years is alarming and the state should redouble its suicide prevention and education efforts. Funding for suicide prevention activities should be increased from the present low levels for greater education and outreach in schools and communities. Evidenced-based suicide prevention models should be deployed. DHHS should coordinate these efforts with the New Hampshire Suicide Prevention Council, the Department of Education (DOE), community mental health and substance use disorder service providers and advocacy organizations and be in line with the strategies outlined in the NH Suicide Prevention State Plan. The state also needs to ensure that the toll free prevention crisis line is sustained and enhanced.

- SFY 2020: $750,000
- SFY 2021: $750,000

Recommendation 4: Enhanced Regional Delivery of Mental Health Services

Using federal grant funds, the State recently established hubs in nine regions to ensure individuals with opioid use disorders and opioid misuse have immediate access to assessments and evaluations no less than an hour away. It also has established 7 Integrated Delivery Networks (INDs) across the state and funds 10 CMHCs. Any one of these delivery systems could be enhanced to integrate 24/7 access to mental health assessments and referrals to streamline and coordinate behavioral health services' access as well as to offer training and education services. The hubs, IDNs, or CMHCs could also oversee a bed availability tracking system. Working with stakeholders, DHHS should be required to develop a phased in approach to integrate centralized access to services no later than July 1, 2019.

- SFY 2020: $1.5M
- SFY 2021: $1.5M
- Budget Action

Recommendation 5: Community Services and Housing Supports

The State has invested in community-based housing supports, funding up to 40 beds in the current biennium as well as provided funding to sustain and expand the housing bridge subsidy program. The efforts need to continue to provide stability to individuals, who not only need mental health services, but basic supports. This recommendation adds bed capacity for expanded populations, including supervised housing for transition-age youth, peer respite beds, additional adult housing and additional slots for the subsidy program. The recommendation also includes scaling up the Families and Systems Together (FAST Forward) wraparound program to support children and families.

- SFY 2020: $2.1M
- SFY 2021: $2.1M
- Budget Action

Recommendation 6: Step-up/Step-down Options

Through several efforts, including that of the IDNs, communities are building the capacity to serve individuals with mental health illness and substance misuse and disorders as they transition to and from different levels of care. This has highlighted gaps in services for those who do not need institutional care but are not ready for independent living with supports. The recommendation is to establish new and/or expand programs for those leaving inpatient facilities and those at risk of admissions, filling the current system's gap in the continuum of care as adults and children transition to and from higher levels of care. The sub-acute, short term stay services include therapeutic day programs and partial hospital programs.

- SFY 2020: $1M
- SFY 2021: $1M
- Budget Action

Recommendation 7: Integration of Peers and Natural Supports

This recommendation is to use peer navigators in emergency rooms as well as to expand the availability of peers in practice settings and support the development of youth ambassadors. Training and education will be required to integrate peers into these settings. This effort should be developed through a public-private partnership.

- SFY 2020: $350K
- SFY 2021: $350K
- Budget Action

Recommendation 8: Establish a Commission to Address Justice Involved Individuals

This recommendation is to establish a commission by executive order or legislation to bring together the Department of Corrections (DOC), County Corrections, the Judicial Branch, DRFs, NHH and community service providers to address issues that arise when individuals with mental illness end up in the correctional system. The commission should examine and make recommendations on steps that can be taken to reduce incarceration, improve mental health services and transitions, including transportation, to and from the county and state institutions. The commission also should revisit the issue of using restraints during transports to and from facilities.

- Executive Order or New Law Action

Recommendation 9: Community Education

This recommendation is to conduct a multi-media statewide campaign on what individuals can do to access services, recognize the signs of mental distress and intervene. A coalition of community partners should be formed to oversee the campaign to ensure the messaging is on target for given populations, especially at risk youth and older adults as well as to leverage additional private funding.

- SFY 2020: $200K
- SFY 2021: $200K
- Budget and New Law Action

Recommendation 10: Prevention & Early Intervention

This recommendation is to provide Early Serious Mental Illness intervention services statewide. It also includes the implementation of the Infant Mental Health Plan.

- SFY 2020: $500K
- SFY 2021: $500K
- Budget Action

Recommendation 11: Workforce Coordination

This recommendation is to create an oversight commission to bring together all of the efforts taking place to address healthcare workforce shortages. The commission should leverage the work that has been done and is currently underway to develop a statewide, comprehensive and integrated approach to growing the workforce all healthcare professions, including those needed to serve individuals with mental illness.

Recommendation 12 Quality Improvement & Monitoring/DHHS Capacity

This recommendation is to ensure DHHS has the capacity to oversee and monitor implementation of the 10-Year Plan and embed subject matter experts in its work, including hiring 3 to 5 additional staff in the areas of quality improvement, housing, justice involvement, early childhood mental health, education and access.

- SFY 2020: $350K
- SFY 2021: $350K
- Budget Action

Recommendation 13: Streamlining Administrative Requirements

The state places myriad requirements on providers to ensure that individuals are receiving high quality care and are conforming to state and federal regulations. These requirements appear in many forms, including state law, administrative rule, contracts with Medicaid managed care organizations and contracts with DHHS. This recommendation is to require DHHS to conduct a LEAN or similar process to determine where there is redundancy in quality reviews, designations, CMHA-related reporting and other requirements. This review must include the procurement and contracting process to ensure that when funds are allocated to programs there is an efficient manner in which to disseminate the funds without unnecessary delay. This should include educating potential bidders about any significant, new-to-the-state services being established prior to issuance of the request for proposals. The DHHS should report on its findings to the Governor and Legislature no later than July 1, 2019.

Recommendation 14: Reporting on Implementation

The DHHS should report on the implementation of the Plan on a quarterly basis beginning October 1, 2019. The report should include progress on each recommendation and any related activities in the area of system improvements. It also should include process and outcome data to assist policymakers in determining the effectiveness of the strategies contained in the Plan. The report should be issued to the Governor, Senate President and House Speaker and made available to stakeholders and the public.

Proposed Funding — 10-Year Mental Health Plan Recommendations

- SFY 2020: $11,950,000
- SFY 2021: $9,700,000

A Brighter Tomorrow for NH's Mental Health System

The World Health Organization defines mental health as "a state of wellbeing in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community." Not only individuals, but communities too, function best when all of their members reach their mental health potential, and when the agencies charged with supporting mental health have the infrastructure and tools they need to fulfill their missions.

The wellbeing of our population expressed in some current statistics are well known. Opioid overdose deaths in NH over the past three years placed the state in the national news. In 2016, such overdose deaths were approximately 437 according to the federal government. In 2017, that number grew. While it now appears that the overdose death rate will decrease in 2018, NH continues to experience some of the highest numbers of opioid deaths in the nation. Suicide is another deep concern. According to the Centers for Disease Control and Prevention (CDC), suicides have risen by more than 30 percent in NH in the last 5 years.[1] Homelessness remains a persistent challenge,[2] and several recent, well publicized critiques of NH's Division for Children, Youth and Families remind us of the challenges faced by our child protective system.

To be sure, we are not alone – the dramatic escalation of substance misuse and suicide across our nation has contributed to the reversal of what had been a long-term upward trend in life expectancy. In a 2017 report entitled, "Pain in the Nation," the Trust for America's Health called these losses "deaths of despair," arising fundamentally from pain, disconnection, and lack of opportunity.[3] These burdens can fall disproportionately on segments of our population already bearing debilitating illness or other disadvantages.

One of the fundamental responsibilities of society is to support the wellbeing of all its people, including the less fortunate among us. We confront this moral imperative in virtually every facet of public life (education, distribution of natural resources and perils, public safety and criminal justice), but particularly in the design and delivery of healthcare. And yet, society has proven highly susceptible to averting its gaze from this imperative – time and again – when it comes to mental health.

Psychiatric Care Wait Times: A Sign of System Stress and How the State is Responding

The past few decades have seen a dramatic decline in NH's psychiatric inpatient capacity, reducing beds in the state's psychiatric hospital (NHH) even as community hospitals have simultaneously reduced or eliminated mental health units.[4] At the same time, the limited array of community supports in some areas means that too much of our current inpatient capacity is occupied by patients who might be able to be effectively treated in less restrictive and more economical environments.[5] The number of NH residents waiting in hospital EDs for admission to inpatient psychiatric treatment fluctuates significantly, but has increased steadily over the past several years. It has varied from between 20 and 70 adults across the state on a given day this past year. Over the past year, it has averaged 38 adults per day. In many cases, adults and children remain in hospital examination cubicles in hectic ED environments for a week or more before they are transferred to specialty psychiatric treatment or are discharged. EDs are not intended to serve as long-term waiting spaces. More importantly, these waits delay comprehensive therapeutic treatment.

It is important to note that during that time, neither Medicare, private insurers, nor Medicaid is providing any reimbursement for the days someone is waiting, despite the costs in stabilization, care and security for

those waiting. While the Department itself cannot address those insured by Medicare and private insurers, it is taking steps to ensure that its Medicaid managed care organizations (MCO) fairly reimburse hospitals for the cost of care for their beneficiaries who are waiting. The Department's forthcoming new Medicaid care management contracts will also place new requirements on the MCOs to provide additional services to the waiting population beyond the services of the community mental health centers.

The Need for Expanded Funding for NH's Mental Health System

Most stakeholders believe that the fundamental cause of NH's inadequate mental health service array is insufficient and unreliable funding over a period of years. A steady stream of highly regarded policy recommendations, dating back to at least the *2008 10-Year Mental Health Plan*, historically stalled against a deep national recession.

One major source of fuel for the mental health system is the fee structure that determines what providers will be paid for the services they deliver. Recent analyses indicate that NH Medicaid, which funds most services provided through our community mental health system, reimburses mental health providers at about 58 percent of the rates paid for the same service by commercial (or private) insurance. Both Medicaid and commercial insurers pay less for mental health services in NH than they pay for the same services in surrounding states.

Moreover, it appears that commercial insurers in NH pay a smaller fraction of the actual cost of delivering services for mental health than they do for other health specialties. The New Hampshire Department of Insurance is now conducting an examination of "mental health parity" in payment as required under federal law and hopefully will issue its findings soon.

This year, DHHS increased the mental health fee schedule by $6 million in total funds. That rate increase is temporary and should be extended and enhanced in the next biennial budget.

Low reimbursement rates translate into lower salaries, limited benefit and ultimately, into migration of the needed workforce out of the state. The lowest salaries are found in agencies with the highest proportion of Medicaid patients. That means NH's community mental health centers are forced to compete with salary and benefit packages in the private sector, which, in turn, struggles to compete with the workforce marketplace in surrounding states. In April of 2018, the NH Community Behavioral Health Association reported that more than 10 percent of clinical positions across NH's public mental health system were unfilled, for a total of 244 vacancies.[6] The inability to recruit psychiatrists, in particular, is a constant concern, cited among the reasons why community hospitals have eliminated inpatient psychiatric beds and why agencies have not come forward to serve as designated receiving facilities for people with urgent psychiatric needs.

Stakeholders with whom we met were assertively skeptical of the power of any Plan to address our mental health priorities without a commitment to securing the resources needed to realize that vision. This Plan proposes benchmarks for additional funding. Enacting these fiscal changes will require determination, sound thinking and policy, and strategic allocation of resources.

Mental Health "Bright Spots" In NH

Despite the gaps in our current mental health system, bright spots also abound. Anyone who travels NH's mental health landscape comes away humbled by the wisdom, passion, and commitment of administrators, clinicians, and staff alike to the individuals, families, and communities they serve — despite low salaries and otherwise stressful work conditions. This attests to a spirit of service that is part of NH's rural can-do, communitarian tradition – any discussion of NH's mental health bright spots needs to begin here. The commitment and ingenuity of our many committed, dedicated mental health professionals will surely play a pivotal role in driving the next iteration of NH's mental health system, just as it underlies the other bright spots outlined below.

The State and NH's mental health and substance misuse professionals, advocates, and funders have demonstrated the vision and skills to undertake innovative projects that will serve as guides for mental healthcare expansion under the new Plan. Three mobile crisis response teams provide community-based emergency services, including stabilization beds. The Housing Bridge Subsidy Program, for example, has provided safe, stable, and affordable housing for more than 800 individuals with severe mental illness statewide who are awaiting Section 8 Housing Vouchers. Assertive Community Treatment (ACT) teams that offer intensive, interdisciplinary support to help adults with serious mental illness avoid inpatient placement where feasible, and function more independently at work, home, and in community. ACT teams and Supported Employment are now in place across NH's CMHCs. Similarly, team-based and intensive, the FAST Forward program, launched in 2015, serves youth with serious emotional disturbances and their families throughout the state with complex needs that traditionally result in frequent – but often avoidable – out of home placements.

Offering wraparound services to support youth and family guided goals, FAST Forward helps families navigate across mental health, education, juvenile justice and other systems to develop a coherent plan for success. The FAST Forward model is currently being expanded in the Monadnock region and in school districts throughout the state. School districts, too, are beginning to address the social emotional learning and behavioral health needs of students, with trauma-informed, family-engaged implementation of the Multi-Tiered Systems of Support for Behavior and Wellness (MTSS-B). These child- focused efforts were accelerated when, in the Summer of 2016, NH's legislature passed Senate Bill 534, directing DHHS and DOE to collaboratively develop systems of care to better meet the behavioral health needs of NH's children and youth. The statewide Delivery System Reform Incentive Program (DSRIP) project is two years into a five-year demonstration project in rethinking the design, delivery, payment, and monitoring of services to address the behavioral health needs of NH's entire Medicaid membership. As this report is being compiled, DHHS and regional partners throughout the state are envisioning a statewide hub and spoke network to improve access to treatment for Substance Use Disorders (SUD). Building off the DSRIP and SUD networks is a central feature of this Plan.

Several common themes that cross these bright spots are worthy of note because they have direct relevance to the Plan to follow. The first is a spirit of innovation; a willingness to invest in new ideas and cast aside the inertia of habit. The second is a drive toward integration of expertise and care pathways into a model organized around the needs and experience of the target population; a recognition that systems designed around professional specialties and institutional boundaries too often present barriers to care. The third is the ambition to pursue federal and foundation funding to launch demonstration projects, which then generate success stories that recruit more sustainable public investments. At the center of these efforts is

DHHS' leadership and collaboration with mental health stakeholders across the state. Many of the initiatives mentioned above began with grant funded partnerships between public and private partners. NH excels at these partnerships because we have a small enough population that the players either already are, or can easily become, known to each other.

From Bright Spots to Transformation

This Plan emerged from extensive engagement with stakeholders in focus and work groups across the state, conducted throughout the Spring and Summer of 2018. The Plan also profited from the accumulated wisdom articulated in many NH proposals, white papers and reports over the past decade, including the *2008 NH Mental Health Plan*[7] and the 2018 capacity assessment conducted by the Health Services Research Institute.[8] Stakeholders who met in focus groups and cross-sector workgroups, both of which included participants with lived mental health experience, strongly reinforced the continued value of these existing analyses and proposals.

One emphasis in this Plan that has not been as visible in previous reports is a focus on high-level systems change. Facilitators of this planning process were encouraged at every step – by key advisors in prominent leadership roles, practitioners, and those with lived experience – to bring ambitious, systems-level change to NH's mental health system. The result is a recommendation to reorganize the mental health system into a hub-and-spoke model with enhanced central accountability and oversight, supporting regional hubs in the delivery of a robust spectrum of evidence-based and promising practices in the communities where people live and work. If we make strategic investments, NH can reduce stigma, eliminate inequities in access to care, and offer all of its citizens a coordinated continuum of high quality services. Fewer people will need to seek mental healthcare at hospital EDs, and none of them will wait there for extended periods until specialty care becomes available. The problem of ED wait times is a recent phenomenon in NH and attention is now focused on it. The right care at the right time will reduce more severe manifestations of distress, manage them more effectively when they do arise, and nudge more of our population toward a state of personal wellbeing.

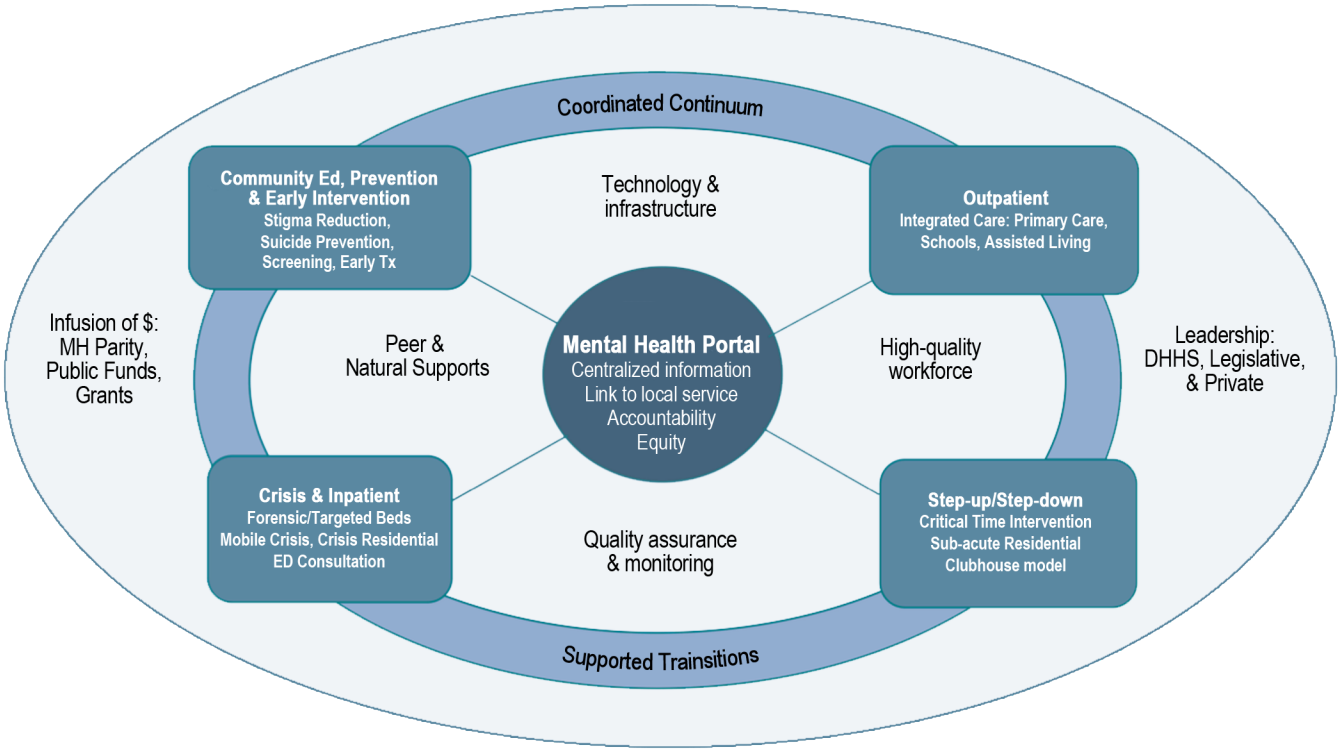
A Vision for NH's Mental Health System

Vision Statement: New Hampshire's mental health system will be robust and cohesive; will respect the dignity and centrality of the whole person; empower people, family, and community; and will reduce stigma while facilitating rapid access to a coordinated, high quality array of localized services and supports for all, through a centralized portal.

Imagine you are a parent with an adolescent in psychiatric crisis late at night, with no prior connections to a mental health provider. Who do you call? Do you dial 911, try calling the local community mental health center, or go straight to the hospital? Is there a mobile crisis service in your area? If so, how do you access it? Is there a way to get your child the targeted help he or she needs without calling an ambulance, law enforcement, or waiting in an ED? NH's mental health system can be hard to access and difficult to navigate.

Blueprint for a New, Coherent System

The graphic below depicts the array of system supports, continuum of coordinated services, and linkages embodied in the envisioned system of care. At the heart of the system, a centralized mental health portal will direct consumers to information and appropriate localized services and serve as a locus of system accountability. Regional links across the continuum of care will support transitions to minimize service gaps and wait times. Strong leadership across public and private spheres will support resource infusion, advocacy, and sustainability for the mental health system. Infusion and alignment of financial, infrastructure, and human resources will ensure efficient and effective functioning. Cross-cutting technology, a high-quality workforce, ongoing quality assurance and monitoring, and infusion of peer and natural supports will further support this envisioned system of mental healthcare.



Improved Access, Services, and Follow-Up

In this new system, the foregoing family in crisis will pick up the phone and dial a short, memorable phone number to access the mental health system. They will be immediately connected via phone to a live person located within their regional hub, who works with them to assess their child's immediate needs and risk level, and the appropriate level of care and service. Once the options are discussed and the appropriate supports agreed upon, the services will be dispatched, and/or appointments made with local providers – with follow-up from the regional hub staff to track the family's engagement in and the outcome of services and make adjustments according to their plan of care.

Values and Principles Supporting the Mental Health Vision

Person-centered	The person (and his or her family) is the driving force in his or her healthcare decisions and an equal partner in planning and delivery of care. The unique values, preferences, and circumstances of the individual are honored, resulting in better engagement and treatment ownership/adherence, while protecting the dignity of the individual.
Whole-person focus	Whole-person care considers the complex intersections between physical, emotional, spiritual, and behavioral health. The focus is not just on behavior, the current mental health crisis, or diagnosis. Attention to social determinants of health is key.
Empowered people, families & communities	People are educated and aware of the resources available, able to navigate the system toward individualized supports and services, increasingly able to rely on natural supports in their home communities, and feel comfortable and heard in voicing preferences in their healthcare decisions. The centrality and power of families and natural supports in the healing process is recognized and supported.
Localized services	Community-based care is prioritized to ensure that, to the highest extent possible, individuals receive care in the areas closest to their homes, natural supports, and social networks, resulting in increased access to and satisfaction with care, and better community integration for individuals with mental health conditions.
Pooled resources, infrastructure & accountability	Organizations and providers share resources (e.g., common data platforms, shared training and professional development) to leverage financial and human resource capacity to provide the most efficient care. There is shared accountability for service delivery and outcomes.
Equity	The system works toward and holds itself accountable for eliminating disparities in social determinants of health, ensuring equal access to supports and services, and eliminating disparities in mental health outcomes for excluded or marginalized groups.

Mental Health Portal and Regional Hub and Spoke System

The Mental Health Portal (Portal) will serve as a single source of phone-based and online information and guidance. The Portal will be accessed by calling one memorable phone number from anywhere in the state, 24 hours a day, 365 days a year. Any individual, family member, teacher, health provider, friend, etc., will be able access the Portal to gain information about his or her condition and corresponding supports and services.

This is consistent with the trend toward replacing traditional "inward" facing hub and spoke models that push patients from community-based services inward toward a central hub for more intensive and specialized care (i.e., the hospital) with "outward" models, in which centralized one-door access (portal) connects people to community-based care that meets their individualized needs (regional hub and spokes). Outward models allow individuals to be served where they live, increase accessibility of care, and minimize demand on hospitals through prevention and follow-up care at the local level.[9]

Once connected to the Portal, callers will receive a "warm hand-off" to a hub in their geographic region. Staff in each regional hub should assess and triage all callers to support a referral matched to each person's level of need. The regional hub will maintain connection to a network of "spokes," consisting of local outpatient mental health services, mobile crisis, peer support, and other localized services. Regional hub staff should have access to current residential bed availability through a centralized database, and the ability to facilitate referrals and support transitions into and out of more intensive care in other regions as necessary. Eventually, the hubs should offer brick-and-mortar walk-in triage, assessment, and facilitated referral services, along with 24-hour short-term crisis stabilization beds.

The Mental Health/SUD Portal should be administered and supported through DHHS – or another contracted system administrator – to provide underlying infrastructure supports for the regional hubs and the continuum of localized care. In addition to providing a central mental health access point for the public, the Portal should also serve the following functions:

Accountability	Transactional and population level accountability for the entire continuum of care
Shared measures	A shared measures platform to monitor performance and improve quality across the regional hubs
Education	A public awareness and stigma reduction campaign to be coordinated throughout the state
Training	A central training and professional development center distributed to providers regionally
Consultation	A central phone line through which primary care providers can receive expert consultation from a psychiatrist (financial and human resources can be pooled to staff the service)
Resource tracking	A data platform for monitoring available resources in real time (tracking beds, wait times in EDs, mobile crisis units and other services, etc.) to facilitate movement through the system, minimize backups, and prevent unnecessary wait times in EDs

Integrated with the Substance Use Disorder System

The state, with federal funding from the State Opioid Respone (SOR) program, has established a hub and spoke model, called The Doorway-NH, for the SUD prevention and treatment system for indivudals and families of all ages. Its model features a state-supported single phone/online access point, through which all NH residents will obtain information about available SUD services and supports. When calling in, individuals will receive a "warm hand-off" to one of nine regional sites distributed geographically throughout the state. Each regional site – consisting of a physical location as well as phone support – will offer screening, evaluation, and a facilitated referral to local SUD services.

Although NH has traditionally operated separate mental health and substance abuse treatment systems, the conditions are undeniably intertwined. Even effective treatment in both areas, if delivered in isolation, will not be enough to end the opioid epidemic or mental health system challenges. That is why it is believed that the mental health Portal's central phone line and regional hubs should be combined with the SUD system, to promote integration of SUD and mental health prevention and treatment and create efficiencies and economies of scale. The priorities of the proposed mental health and substance abuse treatment systems are well aligned, as represented in the figure below.

Built on the DSRIP/IDN Structure

The Mental Health/SUD hub and spoke system should also leverage, extend, and sustain the infrastructure, networks, and successes of NH's DSRIP. Funded by a grant from the CMS, the DSRIP project is designed to serve the behavioral health needs of NH's Medicaid population. DSRIP is administered centrally, with a statewide focus on integrated care, workforce development, and information technology. DSRIP is implemented regionally through seven IDNs across the state, each serving approximately equal numbers of Medicaid recipients. Each IDN is implementing three community-driven projects. At least one community driven project in each region must focus on treatment of SUDs and most emphasize care coordination. The IDNs represent increasingly collaborative networks of mental health and substance use disorder treatment organizations and a growing infrastructure of supports (i.e., integrated care, workforce development, enhanced technology) that align with the goals and strategies of this Plan. Integrating the Mental Health/SUD Portal and its regional hub and spokes within the IDN structure, while simultaneously extending the reach of the IDNs beyond the Medicaid population, makes sense as the IDNs seek sustainability beyond the current period of grant funding.

Journey Through the New Mental Health System

The following is a composite to illustrate the number of challenges faced in the mental health system identified by stakeholders in the Plan development.

A 14 year-old middle school student – Daniela – has erupted into a rage in a North Country classroom. She is coming down from a hypomanic episode, experiencing an agitated mix of anxiety and depression that she tries hard – but not always successfully – to contain. After a chaotic childhood with substance-involved parents, Daniela lives with her financially-strapped and health-challenged but supportive grandmother, Gabriela. Daniela is one of the only Latina youth in her school and community, which, together with her mental health condition, leaves her alienated, scared, and alone.

Situations like this have repeatedly landed Daniela in handcuffs in the local hospital emergency department and – sometimes after days in a small emergency department room with limited treatment – NHH. With the school at wit's end, out of district placement is on the table. With specialty psychiatric care at NHH, Daniela usually stabilizes quickly and is discharged within a few days with a revised medication list and a referral to the local community mental health center. Neither Gabriela nor Daniela have felt particularly comfortable at the local community mental health center, where the ever-changing counselors, though clearly dedicated, makes it hard to stay connected. Lacking access to a child psychiatrist, Gabriela takes Daniela to her family doctor, who tries valiantly to manage a complicated mental health condition for which she received little preparation in medical school. Eventually, Daniela stops going to the doctor, sleeping enough, and/or taking her medication, and the cycle repeats. Her school staff, primary care physician, CMHC staff, Gabriela and Daniela feel increasingly helpless, frustrated, and resigned to perpetual failure.

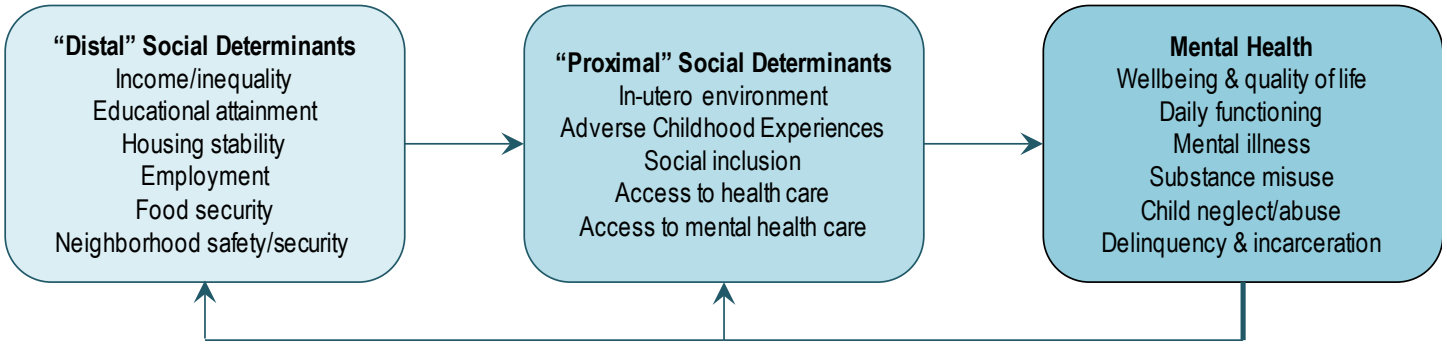
But things are different now. This time, the new school social worker – Jackie – is called into the classroom. Jackie has been connecting with Daniela and her grandmother as part of the school's implementation of Multi-Tiered Systems of Support for Behavioral Health and Wellness. She de-escalates the situation to the point that Daniela, though still agitated, can walk to Jackie's private office. Together, they call her grandmother. When Gabriela arrives, Jackie helps them contact their regional mental health hub. After a phone-based assessment, the regional hub triage specialist suggests that they come in for short-term crisis stabilization and offers safe transport for both of them. After 24 hours, Daniela can safely return home and to school. Before leaving the hub, Gabriela and Daniela are connected to Wraparound services – family-driven and youth-guided care coordination. Wraparound helps them develop a plan of care, expand their network of natural supports, and connect with in-home and other services that Daniela – and her grandmother – need. Through Wraparound, Daniela receives trauma-informed treatment and gets connected to a youth peer support specialist, who helps her feel understood and hopeful. Gabriela meets another grandmother/guardian who can offer support and guidance through the trials and tribulations of caring for a troubled grandchild. Daniela's physician gains access to specialty psychiatric teleconsultation, and results in improvement of Daniela's medication management and self-care.

Daniela continues to struggle with her mental health condition, but with a network of professional services and social supports wrapped around her, her engagement and behavior at school improves. She experiences increments of success in academic progress and peer relationships, two significant indicators of future success. Long, lonely rides to NHH become much less likely in that future.

Mental Health Equity

Where, to whom, and when you were born … what you look like … where you live and work … these conditions of daily life play bigger roles in determining our mental health fortunes than many of us would like to acknowledge, and some subpopulations are particularly vulnerable to these social determinants of health. Throughout the planning process, stakeholders implored us to take the social determinants and the needs of specific subpopulations into account. In this section, we describe how social determinants and the needs of specific populations relate to mental health and how we might address them in this Plan and beyond.

Social Determinants of Mental Health



The environments where we grow, work, and play set the stage for our mental health and wellness; social and economic inequities in our living conditions are root causes of mental illness. These factors are sometimes referred to as "social determinants" of mental health. Some social determinants are "proximal" – they impact our mental health directly. These include adverse childhood experiences, social inclusion, and access to services. Other social determinants are "distal" – they exert their influence indirectly, through the pressure they apply on the more proximal determinants. Examples of these distal social determinants include employment, food security, educational attainment, income/income equality, and housing stability.[10]

To improve the mental health of NH citizens, we as a state need to address these social determinants, starting before birth and extending throughout the lifespan. We can start at the individual level by better recognizing and addressing the basic needs of mental health consumers, such as employment, housing, food, etc. At the multi-system level, we can improve the service array so that all NH citizens can access the services and supports they need, regardless of where they live, how much money they make, or their mental health condition.

In the pages ahead, you will see a number of social determinant-informed recommendations for improving the continuum of care. Addressing adverse childhood experiences – such as abuse and family dysfunction – by infusing the mental health system, schools, medical settings, elder care, and other institutions with trauma sensitivity is just one example. Enhancements to the service array (e.g., mobile crisis) for underserved populations are also critical, including increased access to housing for adults with severe mental illness. Other access barriers, including mental health discrimination, transportation, childcare, and cultural and linguistic

competence, are also system-level change targets.

The largest population-level impact, however, will come from prevention efforts and policy changes that address larger socioeconomic forces and that make the healthy choice the easy choice when making decisions about our lives. Addressing the social determinants at the population level will require social and economic policy changes beyond the scope of the mental health system. NH citizens should band together to advocate for changes in economic, housing, public health, and other policies to address the social determinants of mental health for all NH residents.[11]

- Children (ages 0-18 years)
- Young adults (ages 18-24)
- Elders (ages 65+)
- Individuals with co-occurring substance use disorders and intellectual disabilities
- Legally-involved individuals
- Racial and ethnic minorities
- Immigrant and refugee populations
- Rural populations

Priority Populations

A robust healthcare system addresses the needs and wellbeing of all members of society in order to maximize every person's potential and ensure that our communities are served by the contributions of all. Some subpopulations are especially vulnerable to the social determinants; further, they often require services to be tailored and adapted to fully meet their mental health needs. During development of the Plan, members of focus groups, workgroups, and the Key Advisor team consistently identified the following priority populations as particularly vulnerable and in need of more focused attention.

Mental health services can support wellbeing **throughout the life cycle**. Early identification and intervention at the earliest ages (e.g., infant mental health programs) and high-quality early childhood care and education that supports healthy social-emotional development are essential to later childhood success. Young adulthood, as a stage of life in which mental health concerns often first begin to manifest (e.g., first episode psychosis), also requires particular strategies. At the other end of the spectrum, building systems to eradicate the social isolation commonly experienced by older adults and finding ways to keep older people engaged in their communities should be within the reach of a comprehensive, high-functioning mental health system.

Individuals with mental health concerns who are experiencing **co-occurring disorders**, such as substance use disorders, and/or dual-diagnosis of an intellectual disability, need particular attention to support wellbeing. Because co-occurring disorders can be complex and challenging to properly diagnose and treat, specialized expertise in the interplay of multiple dimensions of symptomatology are needed. When co-occurring disorders are un- or under-diagnosed and treated, elevated rates of homelessness, incarceration, medical problems, suicide, and early mortality can be the result. Many individuals receive treatment for only one disorder, making integrated treatment vital for a whole-person approach to healing and management of multiple, often intersecting symptoms.[12]

Individuals are more likely to encounter law enforcement when experiencing a mental health crisis, resulting in disproportionate bookings into jails. Almost 15 percent of incarcerated men and 30 percent of incarcerated women have a mental health disorder, the majority of which have not (yet) been convicted of a serious or violent crime. **Legally-involved populations** with mental illness – whether currently incarcerated, transitioning from correctional settings back to the community, or managing other legal issues – experience a

complex set of stressors. While incarcerated, individuals may not receive appropriate mental health treatment – and as a result, symptoms can become exacerbated, behavior more problematic, and jail and prison stays longer than necessary. When released to the community without sufficient transition plans and supports, many individuals with mental illness experience trouble at work, housing, and mental health treatment, leading to homelessness, increased ED visits, and re-arrest and recidivism. This cycle might be broken with enhanced transition supports leading to increased functioning, healthy contributions to the community, decreased law enforcement costs, and ultimately, increased public safety.[13]

Nationwide and regionally, **racial and ethnic minorities** experience a variety of mental healthcare access barriers. To fully meet the needs of an increasingly diverse population, the stakeholders believe that NH needs equal access, and culturally and linguistically competent services for all.[14] Access issues can include transportation barriers, challenges with child care and time off work, language barriers, and inadequate healthcare benefits. More fundamentally, stigma, racism, and discrimination can pose significant challenges to equity in mental health access and outcomes.[15]

NH has welcomed over 7,500 **refugees** since the early 1980s, many of whom have settled in Concord, Manchester, Nashua, and Laconia. Their contributions have strengthened the NH economy and enriched our cultural diversity, representing over 30 nations and a wide array of ethnic minority groups.[16] Refugee populations often leave their host countries under traumatic stress and experience harrowing and dangerous journeys en route to the U.S. Stressful resettlement experiences, resulting in frequent trauma, depression, anxiety, and adjustment disorders, especially in refugee children, are all-too-common occurrences. Stakeholders believe screening and use of culturally appropriate, evidence-based treatments for refugee populations (e.g., trauma systems therapy for refugees), tailored to individual needs, are vital parts of community wellbeing.[17]

Sparse populations, stigma, long distances between communities and services, and limited transportation can make it difficult for rural residents to get the help they need. For example, mobile crisis services are unavailable outside of Manchester, Nashua, and Concord. Fewer patients mean fewer services provided and therefore fewer reimbursements from insurance companies and Medicaid, leading to less revenue overall and less money to provide a full array of services. It is harder and less lucrative to practice in rural than in more urban environments. The consequences of untreated mental illness in rural areas can ripple out from the individual and their family, through the social and economic fabric of rural areas, and the NH mental health system in the form of avoidable trips to the ED and/or a psychiatric hospital. The State needs to decrease stigma and expand access in rural areas for NH to thrive.

In the following pages, the strategies to create a robust, coordinated mental health system are described. The vulnerabilities and needs of each priority population cannot be addressed for every step and strategy in the Plan, although the Plan does highlight those populations that were prioritized by workgroup members. Robust implementation of the Plan will require careful planning to tailor services and supports to meet the needs of these priority populations, to ensure strong communities and a stable foundation for all members of NH society

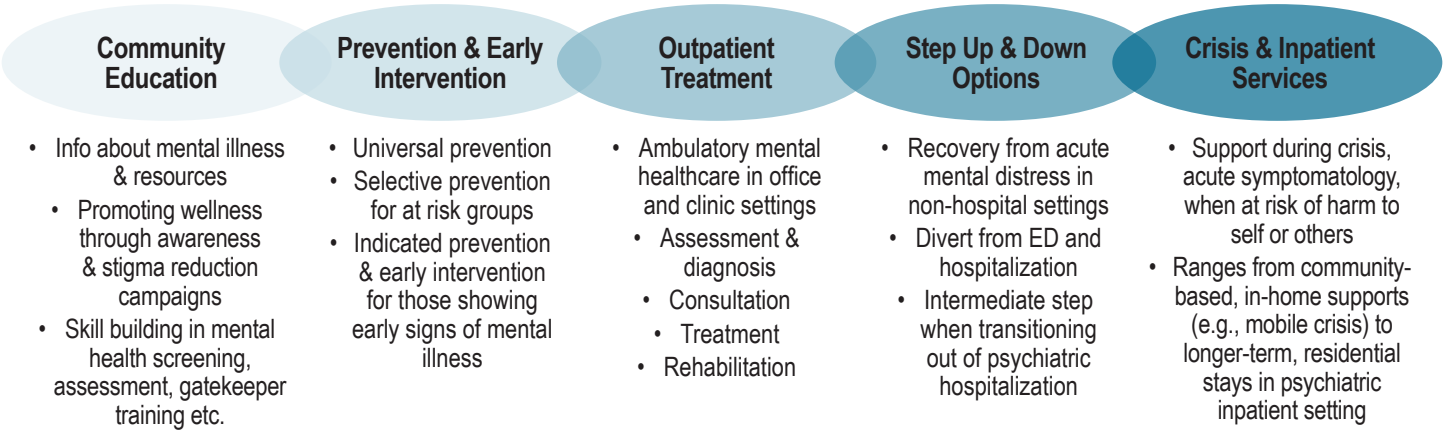
Coordinated Continuum of Care

Goal	Expand a comprehensive, robust, and coordinated continuum of care with supported transitions between steps in the care pathway to meet the mental health needs of all NH citizens.

Coordinating services is largely up to each individual and his or her family in NH, which can be an overwhelming experience for someone in distress because NH's mental health system is fragmented and difficult to navigate. Communication and coordination is left to individual organizations, providers, and their patients (and families), rather than systematically supported and incentivized by the system.

Toward a Coherent, Coordinated System

This Plan will move NH toward a more intentional, coherent mental health system that encompasses a full array of services that support promotion, prevention, treatment, and recovery along the care continuum, with linkages that support effective transitions between steps in the pathway. Integration of health, mental health, social service, and other relevant organizations and providers/supports; mapping of intentional care pathways; ongoing communication between providers offering "adjacent" services; and consistent use of facilitated referrals and follow up are hallmarks of coordinated care. This system must be integrated with other DHHS and other state agency efforts designed to address the whole health needs of children, adutls and families. This includes child welfare systems transformation, the state health improvement plan, the governor's commission on alcohol and other drugs strategic plan, the system of care for children's mental health (RSA 135-F), the Governor's school safety preparedness taskforce and other major initiatives designed to support families and communities.



Each of the following steps in the continuum of care is discussed in detail in subsequent chapters. For each step, we offer a set of strategies to close service gaps based on the collective knowledge and experience of a wide range of NH mental health stakeholders.

Actions	Fill gaps in service array	Create care pathways for common & complex conditions	Integrate substance, healthcare, social service, & long-term support sectors

Community Education

Goal	Reduce mental health stigma and improve recognition and response to signs of mental distress in NH communities.

Stakeholders believe that, despite many knowledgeable and caring citizens, many NH communities remain ill-informed or indifferent about mental health, making them unwelcoming for people with mental illness. Community education is the best way to combat this problem, by increasing public understanding, awareness, and support for persons with mental illness. It builds grassroots support for mental health services and systems and improves community climate for those suffering from mental health conditions.

Eradicate Mental Health Stigma

To make our communities safe and caring places for those with mental illness, we need to eradicate the stereotypes, prejudice, and discrimination that are the hallmarks of mental health stigma. Mental health stigma undermines help seeking, contributes to the homelessness and un- or under-employment of individuals with mental illness, and leads to biased and ineffective public policy.[18] Stigma reduction campaigns involve education to replace myths about mental illness with accurate knowledge, contact with people with lived experience or personal stories to promote connection and undermine prejudice, and protest or advocacy to engage the audience in meaningful action. Large scale stigma reduction campaigns in the U.S. and elsewhere improve knowledge, reduce prejudice, and increase social acceptance of persons with mental illness.[19] We recommend development of a universal mental health and substance misuse education and stigma reduction campaign, delivered in partnership with community-based organizations such as schools, CMHCs, and regional public health networks. Programs that could serve as models include the Change Direction NH program; the National Alliance on Mental Illness's (NAMI) "In Our Own Voice" campaign; and England's "Time to Change" program.

Prepare Gatekeepers to Recognize and Respond to Mental Health Concerns

Community education can also elevate the understanding and skills of "gatekeepers" - non-mental health professionals whose roles (e.g., law enforcement and educators) regularly bring them into contact with individuals experiencing emotional distress. Training and technical assistance can strengthen the ability of gatekeepers to recognize signs of distress, respond in a supportive and soothing manner, and connect the sufferer to appropriate supports. NH should expand and provide more gatekeeper training to non-mental health providers. Model skills training programs include MH First Aid (for adults and youth), Crisis Intervention Team Training for Law Enforcement, and NAMI's Connect Suicide Prevention program. Training for non- clinical workforce is also a critical component of the Zero Suicide model.

Actions	Universal communication & stigma/discrimination reduction campaign	Deliver mental health training to MH gatekeepers throughout NH

Prevention and Early Intervention

Goal Intervene "upstream" to prevent the emergence of and halt the progression of mental illness.

Prevention and early intervention are crucial and cost-effective methods for addressing diseases, yet they are underfunded and underutilized. Prevention ranges from universal strategies appropriate for the entire population to early intervention to reduce current and future impairment and suffering among individuals with emergent mental health conditions.

Prevention Starts With the Social Determinants of Health

The social determinants of health are one such prevention target. As noted earlier, social determinants include socioeconomic status, education, exposure to environmental toxins, neighborhood and physical environment, stability of housing and employment, adverse childhood experiences, social support networks, and access to healthcare. These factors drive dramatic and persistent inequities in health across our population,[20] and inevitably emerge (particularly housing and transportation) in any discussion of barriers to wellbeing in NH. Stakeholders believe there needs to be a statewide health plan that addresses social determinants of health. Social determinants can be addressed from within the healthcare system, with multi-payer federal and state initiatives that specifically target social needs (e.g., supported housing options or housing subsidies), and by shaping non-health policies and practices that promote health equity. The CDC offers extensive guidance for addressing social determinants of health.[21]

Expand Early Childhood Supports

The social and emotional capacities that children develop between birth and six years of age serve as the foundation for experiencing and managing emotions, creating stable relationships with peers and adults, exploring and learning in their environments, and acquiring developmentally appropriate competencies.[22] We recommend expanding early childhood/family strengthening programs, including access to home visiting services, to include screening and additional assessment of infants and caregivers in accordance with best practices. NH's Family Resource Centers, distributed throughout the state and providing a broad array of family support services, are well positioned to expand access to such services with appropriate investment (for example, making these services eligible for reimbursement).

Intervene at the Earliest Signs of Mental Illness

The majority of individuals who develop serious and persistent mental illness show early signs in late adolescence or early adulthood. Early intervention can often mitigate progression of symptoms, improve functioning, and avert other negative impacts of mental illness. The National Institute of Mental Health concluded that findings from the Recovery After an Initial Schizophrenia Episode (RAISE) research initiative "are so compelling that the question to ask is not whether early intervention works for first episode psychosis (FEP), but how specialty care programs can be implemented in community settings throughout the United States."[23] NH should expand coordinated specialty care for FEP and early serious mental illnesses.

Actions	Advocate for statewide attention to social determinants	Enhance early childhood & family strengthening programs	Expand early intervention for mental illnesses

Outpatient Services

Goal

Support people with mental health conditions safely and effectively in their home communities.

High quality, community-based outpatient services are the key step in the care continuum for most individuals experiencing mental distress. Easy access to high quality outpatient services helps to keep individuals in their communities, prevents unnecessary hospitalization and residential care, and helps them recover from mental illness. Our conceptualization of outpatient care extends beyond traditional services offered in CMHCs and private practice settings to integrated mental health services in primary and elder care settings, school-based services, and supported housing.

Integrate Mental Health Services Into Primary Care Settings

The primary gateway to mental health and substance misuse care for most adults is primary care, which is often ill-equipped to recognize and treat mental health and substance misuse disorders. Integrated primary care – the provision of behavioral health services and expertise in primary care and vice versa – can improve mental health access and outcomes and, in the long-term, can produce cost-offsets in the form of reduced ED and inpatient visits.[24] Many strategies are available to support these outcomes, including expert psychiatric consultation for pediatricians and primary care physicians as well as increasing telepsychiatry services in outpatient mental health settings. All of this could reinforce and extend the DSRIP's emphasis on infusion of behavioral health expertise and supports throughout the healthcare and social service system. Federally Qualified Health Centers (FQHCs), which receive funding to expand behavioral health services, are a particularly ripe context for integrated primary care for underserved patients. For persons with severe mental illness, CMHCs tend to be the most appropriate healthcare home, and therefore, the site for integration.[25] For older individuals, integration in elder care settings is helpful. Key integration strategies across settings, especially in rural areas, are tele-medicine and tele-consultation.[26]

Implement Multi-Tiered System of Supports in All NH Schools

Between 14 and 20 percent of children and adolescents experience a mental, emotional, or behavioral disorder; only about half of these children receive treatment; and most of those who do are served in a school setting.[27] NH's Multi-Tiered System of Supports for Behavioral Health and Wellness (MTSS-B) model was designed to promote the behavioral health of NH public school students. MTSS-B blends research-based school mental health practices and social-emotional learning with Positive Behavioral Interventions and Supports (PBIS; see http://www. pbis.org). PBIS teaches school-wide behavior expectations at the universal level (Tier 1), offers targeted group support for at-risk students (Tier 2), and provides intensive, individual services for the highest-need students (Tier 3). MTSS-B increases access to both school- and community-based behavioral health supports and services for students, including intensive school-based services such as wraparound care coordination. It improves school climate, reduces problem behaviors and truancy, increases instructional time, and improves the mental health of high-risk students. MTSS-B is currently implemented in nine school districts; stakeholders recommend large-scale adoption of MTSS-B.

Integrate Treatment for Co-Occurring Disorders

Many people with serious mental illnesses have a co-occurring substance use disorder within their lifetime. Integrated treatment for co-occurring mental health and substance abuse disorders simultaneously addresses both conditions so that individuals do not get lost, excluded, or confused, going back and forth between different mental health and substance abuse treatment programs. The goal of this evidence-based practice (EBP) is not simply abstaining from substance use, controlling symptoms, or complying with mental health treatment but to pursue a personally meaningful life. Integrated treatment specialists understand how mental illness and substance misuse interact, and are trained in skills that have been found to be effective in treating consumers with co-occurring disorders. Integrated treatment specialists support and empower consumers to define and achieve their individual goals.[28] We need more integrated treatment programs throughout NH.

Housing Assistance for Those with Mental Illness

Permanent supportive housing (PSH) is an evidence-based intervention that combines non-time-limited affordable housing assistance with supportive services for people with mental health conditions who are experiencing homelessness. In the PSH model, housing is linked to voluntary and flexible supports and services designed to meet individual needs and preferences.[29] Lack of supportive housing emerged time and again in our discussions with stakeholders that informed the drafting of this Plan – stakeholders believe that NH needs to increase the supply of supported housing options. A particularly promising practice combines the Housing First and Assertive Community Treatment (ACT) models.[30] Collaboration between EDs/ hospitals and Public Housing Authorities around coordinated entry mechanisms and exploration of Medicaid options for housing supports are additional considerations. A centralized/coordinated housing registry and coordinator would also be useful.

Scale Up Evidence-Based Practices

Irrespective of setting, it is critical that individuals have access to high-quality services tailored to their mental health conditions and other needs. Wide-scale adoption of EBPs, when implemented with fidelity, helps ensure access to high quality outpatient services. While support for and implementation of ACT, Supported Employment, and, much more recently, the Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems (MATCH) are promising, other EBPs have not been as systematically supported. NH should expand the high-fidelity implementation of EBPs in outpatient settings including new technologies that support and extend traditional outpatient services. Training and technical assistance as well as funding would be needed to support the implementation, expansion, and sustainability of targeted EBPs, such as Dialectical Behavioral Therapy, Motivational Interviewing, Child Parent Psychotherapy, Cognitive Behavioral Therapy, Integrated Treatment for Co-occurring Disorders, MATCH, Evidence Based Supported Employment, and ACT.

Actions	Integrate behavioral health into primary care, elder settings	Implement multi- tiered systems of supports in schools throughout NH	Develop integrated MH/ SUD treatment programs across NH	Increase access to Permanent Supportive Housing	Expand access to high-fidelity EBPs

Step-Up/Step-Down Services

Goal	Support people at risk of hospitalization safely and therapeutically in their communities while reducing avoidable psychiatric hospitalization and readmission.

You have just been discharged from NHH. Still in the throes of major mental illness and not far removed from being in immediate danger of self-harm, you are thrust back into the community with a new prescription to fill and a referral to your local CMHC, but little else in the way of professional and natural supports – let alone a permanent and safe place to stay. It takes little to imagine the myriad scenarios that could lead you right back to the hospital in such a situation.

Step-up and step-down services help transition people discharged from inpatient settings back into the community, reducing readmissions to the hospital. They also help people experiencing acute distress recover in non-hospital, community-based settings, thereby diverting them from unnecessary ED or inpatient stays. Step-up and step-down services can include short-term, sub-acute residential settings; respite beds; clubhouse peer support programs; and evidence-based interventions that support transitions from more restrictive settings into the community. NH has few step-up and step-down service options.

Supported Transitions Reduce Readmissions to Inpatient Care

Currently, about one-third of discharged patients are readmitted to NHH within six months, a statistic that highlights the need to do a better job supporting transitions back into the community. Supported transitions are a relatively low cost, high impact way of preventing avoidable readmissions to inpatient psychiatric settings. They involve linking a person who is at greatest risk for psychiatric hospital readmission with a transition coordinator who engages with the person and his or her family prior to discharge, helps develop and support implementation of the discharge plan, and facilitates linkages/hand-offs to key community-based professional services and natural supports.[31] Critical Time Intervention is an evidence-based supported transition model[32] that is already being implemented in several regions through NH's DSRIP Program, and which could be expanded throughout the state. In addition, NHH has a discharge coordinator who works with youth at risk of suicide and readmission; this program could also be expanded to serve additional at-risk youth and adults.

Clubhouse Models Offer Daily Structure and Support

Clubhouses are strengths-based, member-run, therapeutic working communities for adults with serious mental illness. They offer members access to vocational and educational resources and support a work-ordered day during which each member's talents and abilities are recognized and utilized. Clubhouses do not offer on-site clinical services, although linkages to community providers are encouraged. Clubhouses are considered a promising practice for promoting employment, reducing psychiatric hospitalization, and improving quality of life.[33] NH currently has only two Clubhouses, located in Portsmouth and Manchester. Expansion of this model throughout the state would offer a useful adjunct to outpatient services and an empowering alternative to psychiatric hospitalization for individuals with serious mental illness.

Peer Respite Offers a Familiar, Safe Space

Peer respites are voluntary, short-term, overnight programs that provide community-based, non-clinical crisis support to people in acute distress. They operate 24 hours per day in homelike environments. Peer respites are staffed and operated by people with lived experience of mental illness.[34] NH currently has three peer respites that are significantly underutilized; we recommend expanding knowledge of, access to, and utilization of peer respite across the state.

Sub-Acute Residential Programs are an Alternative to Inpatient Stays

Sub-acute residential programs provide beds for individuals experiencing acute psychiatric distress in an open, home-like environment with 24-hour staffing, including clinical support. Sub-acute programs accept individuals who are preparing for discharge from psychiatric hospitalization as a transitional service to prepare them for living in the community (step down). They also accept individuals for whom a short stay in a residential rehabilitation program would help prevent psychiatric hospitalization (step up). Sub-acute residential program outcomes are similar to those seen with psychiatric hospitalization –at lower cost and with higher patient satisfaction.[35] Models to support these transitions include partial hospitalization and therapeutic day programs. Stakeholders recommend collaborating with housing authorities to develop sub-acute programs around the state for youth and adults.

Actions	Support transitions from residential to community settings	Expand access to Clubhouses	Increase access to and utilization of Peer respite	Develop community-based sub-acute residential programs

Crisis and Inpatient Services

Goal

Stabilize and support individuals experiencing mental health crises and acute psychiatric episodes while reducing avoidable inpatient stays.

The most immediate way to reduce wait times in EDs is to enhance services that divert avoidable hospitalizations, support transitions to the community, reduce readmissions, and facilitate outflow from inpatient settings. Crisis services stabilize and reduce the distress of individuals experiencing psychiatric emergencies and transition them to appropriate follow-up care. Such services can prevent avoidable psychiatric hospitalizations and facilitate engagement in the least restrictive treatment setting. Psychiatric hospitalization is the treatment setting of last resort for individuals whose mental illness is so acute or severe that they are in danger of harming themselves or others. Psychiatric hospitalization is also an important part of the continuum of care and its goal is to quickly stabilize individuals for a safe return to their communities.

Psychiatric Consultation and Peer Navigation Enhance Mental Healthcare in EDs

Enhanced consultation and support in EDs, through the use of psychiatric consultation and peer support specialist navigators, can help stabilize and expedite safe discharge of mental health-related ED admissions. Psychiatric consultation helps elevate care for mental health crises in EDs. Given the psychiatrist shortage nationwide and in NH, videoconference technology is the most feasible way of bringing this expertise into EDs. The stakeholders recommend establishing 24/7 videoconference access to psychiatric consultation for complex mental health-related cases in EDs. One gold standard telemedicine program out of the University of Mississippi, for example, has installed videoconferencing screens in every ED patient room, with both "regular" and "stat" consultation options. In another location, two psychiatrists staff a room equipped with monitors that allow them to view each ED, facilitating telepsychiatry consultation on a 24-hour basis to multiple EDs.[36]

Experiencing a mental health crisis or concern in the ED – especially if it is accompanied by long wait times – is a harrowing process. Being supported by a peer with both lived mental health experience and knowledge of the system can mitigate these stressors, as peers often establish credibility and form relationships with patients quickly, addressing barriers to care and disparities in access.[37] Peer navigators can provide mental health education and coaching, advocacy, and linkages to community services. They can conduct triage, assessments, and contact a patient's case manager and treatment team. Use of navigators in EDs can help to reduce gaps in care and serve as a basis for supported transitions to appropriate community services, diverting transfer to more restrictive levels of care and ultimately, contributing to a reduction in individuals waiting in EDs.[38] Stakeholders believe that embedding peer support specialists as health navigators in EDs, who can administer psychological first aid, assess mental health status, support patients beyond the ED, and promote use of Peer Support Agency services.

Provide Access to Mobile Crisis for All Ages, Throughout NH

Mobile crisis teams provide 24-hour, rapid response mental health crisis stabilization and assessment to people in their homes or other non-clinical locations. While many mobile crisis teams serve as a liaison between

people in crisis and the ED, they can also effectively divert ED admissions when community linkages are both available and prioritized as alternatives to the ED. Mobile crisis is effective at diverting individuals from inpatient psychiatric admissions, connecting individuals experiencing suicidal ideation with appropriate supports following ED discharge, and engaging those experiencing mental distress in outpatient services.[39] Currently, NH operates three mobile crisis teams for adults in Concord, Nashua, and Manchester, as per the NH Mental Health Settlement Agreement. We recommend expanding the three extant mobile teams with sufficient training, expertise, and resources, to serve children and youth and expanding mobile crisis services into the more rural areas of the state.

Short-Term Crisis Programs and Residential Settings Divert People in Crisis from Jails and Emergency Departments

Short-term crisis residential services deescalate the need for hospitalization through safe and contained 24-hour observation and supervision – helping a person stabilize, resolve problems, and connect with sources of ongoing support. Programs such as 24-hour psychiatric urgent care centers can serve as alternatives to jail and EDs and as places where police could bring people in crisis. Crisis residential services offer longer-term stays and can include psychiatric assessment, daily living skills training, social activities, counseling, treatment planning, and connecting to services. Crisis residential care is as effective, lower-cost, and results in higher patient satisfaction than inpatient care.[40] Short-term crisis residential programs and beds should be considered to be added throughout NH as an alternative to inpatient care, perhaps through the regional hubs.

Targeted Increases in Inpatient Beds Helps Eliminate Wait Times in EDs

To eliminate wait times, we recommend a targeted increase in inpatient psychiatric bed capacity centered in new or expanded community-based designated receiving facilities for patients requiring long-term stays. Dedicated, long-term beds for the forensic population, many of whom require 18-21 month stays, is a promising way of improving NHH outflow. The stakeholders support NH's current Request for Information regarding the development of a new self-contained forensic unit. Relatedly, free-standing, high-security residential treatment sites would also greatly improve bed availability for the general population. These settings are costly and have the potential to stoke "Not in My Back Yard" reactivity; at the same time, they effectively support rehabilitation, re-entry to community settings, and reduce risk to public safety.

In addition, increasing the availability of voluntary psychiatric beds across the state would provide greater access to this necessary level of care for individuals in their communities and decrease the wait times in EDs.

Actions	Psychiatric consults in EDs	Place peer navigators in EDs	Extend mobile crisis geographically and to children and youth	Create crisis residential programs and beds	Add targeted inpatient beds to improve outflow from NHH

Integration of Peer and Natural Supports

Goal

Integrate peer and natural supports throughout the continuum of care to empower consumers, reduce reliance on professional supports, and reduce avoidable ED and inpatient visits.

Fear and isolation are common feelings for people leaving inpatient settings. Connecting with someone who has coped with mental illness, successfully navigated the mental health system, and recovered a meaningful, purpose driven life can be enormously comforting and empowering to individuals living with mental illness. What is more healing than the soothing presence of someone who has been there, done that? That is why we think Peer and natural supports should be integrated at every step along the care continuum.

Consider, for instance, the following experience of one NH resident:
When I left the hospital, I felt scared and alone. I eventually discovered peer support and knew I had found my community. I met people who understood what I was going through and they helped me rediscover hope and optimism; I felt connected to a supportive community and learned new skills, all of which has helped me stay healthy and out of the hospital. Peer support has been transformative for my recovery.

Peer Supports Draw on Personal Experience to Promote Healing in Others

Peer supports draw on their personal experience to help others cope, problem-solve, and manage mental health and/or substance misuse conditions. Peers promote hope and resilience, foster skills and insights, facilitate the development and use of recovery-based goals and care plans, encourage treatment engagement, and facilitate connections with natural supports. Peers can be trained to deliver conventional interventions (e.g., case management, even psychotherapy) or interventions uniquely suited to the peer role (e.g., intentional peer support). Peer support services are generally as effective as professional services, and more effective in engaging difficult to reach patients, reducing psychiatric hospitalization, and decreasing substance use among individuals with co-occurring disorders.[41]

Availability of Peer Support Services Currently Limited in NH

Some peer support services are already available in NH: NAMI Connection, NAMI Family Peer Supports, NH Chapter of Youth Move, Depression and Bipolar Support Alliance (DBSA), Clubhouses, CHMCs, and Peer Support Agencies (PSAs). NAMI's Connection program offers peer-led, recovery-oriented support groups around the state. The DBSA provides support groups to people with depression and bipolar disorder as well as other mental health conditions. NH has two Clubhouses in Manchester and Portsmouth that offer strengths-based, member-run, therapeutic working communities for adults with serious mental illness. PSAs are not-for-profit consumer-run organizations located around NH. They practice Intentional Peer Support to help mental health consumers feel more empowered and less dependent on the mental health system and move toward fulfilling lives. PSAs are currently contracted through DHHS and funded through a combination of the Community Mental Health block grant and general fund dollars.[42] These programs are only a starting point for future enhancement.

Infuse Peer Supports Throughout the Mental Health System

Peer supports should be fully integrated throughout the care continuum, where they can serve as powerful advocates and public educators, provide recovery-oriented outpatient care, and support individuals as they transition into and out of EDs and psychiatric hospitals. Peer support services should also extend to older children, adolescents, and the elderly through Youth Move NH and other groups. This would require additional funding as well as adding peer support to the list of reimbursable services in the NH Medicaid Plan. Successful peer support requires clear role/job descriptions along with training, education, and coaching for peer and professional staff alike. The mental health system would also benefit from creating more opportunities for people with lived experience to occupy leadership roles.

Actions	Integrate peer & natural supports throughout continuum	Expand peer supports for youth and the elderly	Increase funding & add peer support to Medicaid Plan	Develop clear roles & provide technical assistance to peer supports	Create leadership opportunities for people with lived experience

Infusion of Resources

Goal Infuse the resources needed to support a robust mental health system.

An infusion of resources will be needed to expand a more efficient, effective mental health system in NH. This section addresses direct sources of funding leverage in the form of third party payer reimbursements and investments to strengthen our mental health infrastructure, opportunities for public-private partnerships and grant funding, "cost offsets" from mental health interventions, and data to guide expectations for mental health funding.

Low Reimbursement Rates are Constricting NH's Mental Health Service System

While general fund money and the DSRIP Waiver have provided additional funding, most treatment for serious mental illness is delivered through NH's public mental health system and paid for through the Medicaid program. One window into the resource pipeline for NH's mental health system is to examine our Medicaid reimbursement rate structure. Expert consultants engaged in claims analysis were able to compile some instructive data.

	2018 Medicare rate		2015 Medicaid rate (AAP Survey)					
Sampling of MH service codes	NH	US	NH	CT	MA	VT	Low	High
90791 Psych DX evaluation	$137.74	$136.44	$87.82	$147.50	$117.42	$104.13	$66.26 (SC)	$182.31 (AR)
90792 Psych DX evaluation with medical services	$154.27	$152.64	$65.00	$147.50	$95.06	$115.63	$65.00 (NH)	$239.69 (NE)
90832 Psychotherapy 30 min	$66.80	$66.24	$32.50	$61.51	$48.53	$51.55	$29.48 (IL)	$77.22 (AR)
90837 Consult w/family	$-	$-	$72.00	$135.19	$90.29	$100.96	$43.21 (NJ)	$166.31 (OR)

Source: American Academy of Pediatrics 2015 Medicaid Reimbursement Survey, https://www.aap.org/en-us/professional resources/Research/ Medicaid%20Reimbursement%20 Reports/medicaid_reports_national_all.pdf

Beyond inadequate Medicaid funding, NH's mental health system low levels of reimbursement from commercial insurance providers. As illustrated in the table on the next page, commercial insurance typically reimburses at rates substantially higher than the cost of providing services, which helps to offset below-cost Medicaid rates, supporting the solvency of the healthcare system as a whole (left column). Commercial payers in NH follow this pattern for most health specialties (center column) yet reimburse only at cost for mental health services (right column). Beyond inadequate Medicaid funding, NH's mental health system on average is not benefitting from higher levels of payment from commercial insurance providers. As illustrated in the table below, in the U.S. health system commercial insurance typically reimburses at rates substantially higher than the cost of providing services, which helps to offset below-cost Medicaid rates, supporting the solvency of the healthcare system as a whole (left column). Commercial payers in NH follow this pattern for most health specialties (center column) yet reimburse at approximate cost for mental health services (right column).

	Typical US Provider	NH Other Specialties	NH MH
	Payment as percentage of estimated provider cost		
Medicare	~100%	~100%	~100%
Medicaid	72%	58%	58%
Commercial	140%	160%	~100%
Self-pay	Negligible	Negligible	?
Overall	Positive margin	Positive margin	Large negative margin

This combination of lower Medicaid and commercial insurance reimbursement rates is the most fundamental funding challenge for NH's mental health system, constricting access to care by first limiting the services that our public agencies can afford to deliver and driving the mental health workforce out of NH in search of higher wages. According to analyses by health economists with BerryDunn, raising NH Medicaid mental health reimbursement rates to meet the modest goal of the national Medicaid average would infuse $22 million per year to into NH's mental health system, only half of which would need to be covered by NH's general fund, with the remaining 50 percent borne by Federal matching Medicaid funds. Pursuing higher commercial insurance fees for mental health at a level consistent with other health specialties, as well as at levels consistent with other states' fees, would contribute an estimated additional $65 million per year, with the cost distributed across insurers, employers, and employees who pay insurance premiums. Together, these two strategies would boost NH's mental health funding by 38 percent, enhancing the capacity of agencies to elevate the quantity and quality of our mental health workforce, restoring the productivity we are currently losing to high staff turnover, all inevitably converging on greater access to mental health services.

Beyond Reimbursement Rates: Additional Investments to Reshape NH's Mental Health Infrastructure

The costs of community education, technology, and other infrastructure would not be directly covered through enhanced reimbursement rates. Some services not currently covered under existing billing codes, such as Peer Support, should be added to the State Medicaid Plan. Other activities, such as interprofessional communication and certain forms of care coordination, are recoverable through new alternative payment models, to the extent that they enhance population level performance metrics. The state should also cultivate public-private partnerships to invest in initiatives that align with the missions of non-government agencies. Community education efforts, for example, align well with the goals and existing commitments of private coalitions and community hospitals. Coordinated training functions could be supported by a centralized coalition, supported by membership dues from agencies that already invest in the professional development of their staff. Employers could invest in mental health initiatives that touch their workforce, reaping measurable returns in employee wellbeing and productivity.[43]

Still, the primary responsibility for launching infrastructure improvements will fall, at least initially, to the State. Such ambitious initiatives are going to require infusion of human resources, both internal and contracted, into the current, thinly staffed environment of DHHS. When programming is added or expanded, such as through Plan implementation, additional staff will be needed to provide ongoing oversight and monitoring to ensure efficient use of public tax dollars. In order to address the complex needs of priority populations, governance and coordination between DHHS, DOC, and DOE should also be strengthened.

One way to achieve this is to establish liaison positions. Liaisons will leverage opportunities to achieve more effective funding, policy, and programmatic alignment that will, in turn, decrease the burden to all systems and improve individual health outcomes. As recounted in the "Bright Spots" section of the introduction to this Plan, DHHS and other state entities have demonstrated the skill and initiative to undertake major innovations and secure substantial federal funding, but they also have passed up promising opportunities for lack of staff capacity.

Estimating Adequacy of Mental Health Funding

How much more funding should decision makers aim to infuse into NH's mental health system? We have already identified one benchmark in the form of reimbursement rate comparisons with other states (for Medicaid) and health services (for commercial insurance). Beyond reimbursement rates, we can also "zoom out" to examine total Medicaid spending levels for NH and other states, using the population adjusted metric of expenditures per member per month (PMPM). According to claims analyses provided by BerryDunn, NH's Medicaid spending in 2017 was just over $24 PMPM, whereas states with lower median incomes but more generous mental health benefits were spending up to twice that amount ($47 PMPM). NH may wish to compare NH's Medicaid benefit plan to those of other states, with a provider supply and performance profile to which they aspire.

What this Plan aims to achieve is better health impact per dollar invested.[44] In addition to the immediate benefits of any particular intervention, research demonstrates that investments in mental health services can yield reductions in downstream healthcare costs[45],[46] and welfare spending,[47] as well as increases in workplace productivity.[48] Reductions in downstream expenditures effectively offset the net cost of providing mental health services. Reliable and readily accessible evidence exists to guide NH planners toward services that can be expected to yield the greatest cost offsets. In general, these services involve preventing the progression of chronic and severe conditions into intensive treatment settings through early recognition, evidence-based interventions, and coordination across a care continuum and with other social services. Cost-offsets support the case for - and can be reinvested in - alternative payment models that shift the aims and incentives in the system toward population-level outcomes.

Actions	Raise Medicaid reimbursement rates	Pursue higher commercial insurance fees	Apply for mission-aligned external funding	Public-private partnerships	Implement value-based, alternative payment models

Leadership

Goal	Compelling vision, strong state leadership, strategic advocacy, and grassroots support creates commitment among law and policy makers to expand resources and support for NH's mental health system.

Strong, boundary-spanning leadership will be needed to generate the momentum, buy in, and resources needed to enact the envisioned mental health system and priorities outlined in the Plan. Leadership will need to come from a number of quarters, including DHHS, across state government, private foundations, advocacy organizations, and citizens and communities across the state. Alignment across DHHS and other state-related efforts, such as between DCYF's adequacy plan, the Children's Behavioral Health Collaborative strategic plan, and DOE's System of Care efforts for kids is another critical leadership function.

Leadership from the Governor's Office and DHHS Mobilizes Support and Resources

The stakeholders recommend that DHHS and the Governor's Office embrace and prioritize implementation of this Plan, while communicating it in a compelling and consistent fashion. DHHS leaders and staff will be pivotal to spanning internal and external stakeholders, advocating for and mobilizing resources, monitoring progress and making mid-course corrections each biennium, and removing barriers to implementing the Plan.

Cultivating Legislative Champions Improves Policy, Funding Environment

DHHS, along with advocacy groups like New Futures, NAMI NH, Children's Trust and others will need to leverage existing and cultivate additional legislative champions to commit to, appropriate sufficient funding for, and pass enabling legislation in support of the Plan. One possibility to create and sustain ongoing commitment to and advocacy for the Plan is to establish a multi-partisan Mental Health Caucus in the NH Legislature.

Support from NH Foundations Strengthens Plan Implementation

NH is fortunate to be rich in private foundations, such as the Endowment for Health, New Hampshire Charitable Foundation, and HNH Foundation, that recognize and prioritize mental health and substance misuse through their philanthropic work. They can play a key role by convening stakeholders and aligning their funding and capacity building priorities with those embodied in this Plan.

Grassroots Support is Key

And finally, the State needs a groundswell from the grassroots – citizens, businesses, non-profit organizations, and communities everywhere standing up to demand and support a more robust, just, and effective mental health system. A social marketing campaign to educate and stimulate the public, improving community awareness and support for mental health throughout NH, would be useful in that regard. The Frameworks Institute has useful guidance for messaging social issues in a way that resonates and connects with the public.

Actions	Disseminate & prioritize the Plan	Cultivate law and policy maker champions	Create a legislative mental health caucus	Develop social marketing campaign

High-Quality Workforce

Goal	Improve the recruitment, retention, and quality of the mental health workforce.

NH is fortunate to be home to providers and peer supports who dedicate themselves to promoting mental health and helping others heal and recover from mental illness. It is time to take better care of the hard-working mental health service and support providers we have, reducing the burdens and increasing the benefits associated with doing their jobs, while significantly adding to their ranks.

Improving NH's Mental Health Workforce

NH faces shortages of psychiatrists and other mental health professionals, along with high turnover rates. Approximately 10 percent of clinical positions in NH's public mental health system were unfilled in April of 2018. Psychiatrists are particularly rare in NH, yet six times as common (per capita) just across our border in VT. The distributions of clinical psychologists, social workers, and mental health counselors, too, are all uniquely sparse in NH compared with neighboring states.[49] Lower pay, large caseloads, demanding productivity expectations, excessive documentation, and limited opportunities for professional development and advancement are but a few of the factors driving the workforce shortage.

Coordinate Existing Workforce Initiatives

Several statewide workforce initiatives are underway. One supports the development of the overall behavioral health workforce through NH's DSRIP. Another, led by Antioch University New England, addresses behavioral health workforce needs in primary care settings. A third, headed by the Institute on Disability at the University of New Hampshire, is focused on building the children's behavioral health workforce.[50] The stakeholders recommend development of an oversight body to foster collaboration and learning across existing initiatives and to develop a comprehensive statewide workforce action plan.

Enhance Recruitment and Retainment By Improving Compensation, Reducing Barriers, Minimizing Burden

A number of strategies can boost recruitment and retention of the mental health workforce. The first is improving salaries through higher reimbursement rates and (eventually) alternative payment models. Health and other employment benefits might also be improved by having CMHCs and other mental health service providers band together to purchase more affordable, better, and more equitable benefits. Other strategies, such as student loan repayment programs, housing vouchers, licensure reciprocity, manageable caseloads that minimize clinician burnout, and career ladders that allow for upward mobility, could create incentives to enter and remain in the NH mental health workforce.

Support Quality Through Professional Development and Technical Assistance

Workforce quality and competence (and retention) could be enhanced through more robust, high quality training and professional development in EBPs and specialized populations (e.g., dually diagnosed), supervision and coaching, and other professional development. Creating a centralized training and technical assistance center, administered through the Mental Health Portal (see below) and delivered regionally, would be helpful in this regard. The reach of the training hub should extend beyond mental health professionals to mental health gatekeepers such as law enforcement and other first responders, school nurses and teachers, correctional staff, ED nurses, and others.

Actions	Create workforce oversight body	Improve compensation & reduce burden	Enhance professional development	Create technical assistance hub	Apply other recruitment, retainment incentives

Technology and Infrastructure

Goal	Improve the human resource, technology, and infrastructure capacity of the mental health system.

The DHHS Division for Behavioral Health (DBH) has been understaffed and its pursuit of funding, contract administration, and a host of other leadership responsibilities are affected as a result. The many open positions at DHHS/DBH need to be filled. Stakeholders recommend adding two positions to oversee 1) operationalization, implementation, monitoring, and biennial updating of the Plan and 2) development of the central and regional hubs.

Update DHHS Data-Related Capabilities

DHHS' data-related infrastructure also needs updating. Current platforms are fragmented and siloed, in need of a common streamlined system or reliable connectors between existing systems. DHHS could make more meaningful and impactful use of data on service delivery, utilization, and cost, if such data could be maintained in one place and disparities between populations of interest (e.g., by socioeconomic status, race/ethnicity, etc.) could be examined.

Streamline, Enhance the Mental Health Policy and Rule Environment

The mental health system is rife with redundancies and inefficiencies that result from clunky administrative rules, policies, and procedures that need to be updated, streamlined, and reduced. Prominent among these are relieving administrative burdens on the CMHCs by lengthening the duration and streamlining development of state contracts to reduce costs and delays associated with the contracting process. Other strategies for relieving administrative burden include use of a universal application and release of information, single entry claim/encounters, and reduced duplication across state-wide reviews. Similarly, NH stakeholders described mandatory trainings for providers as fragmented, burdensome, and duplicative. Another administrative barrier, for example, is the current CMS restrictions on provisions of care in certain settings, which potentially could be addressed through an expanded scope of practice across the mental health workforce, with billing codes to match.

Actions	Enhance DHHS staff capacity	Review & revise DHHS rules, policies, and procedures	Improve DHHS data platforms

Quality Assurance and Monitoring

Goal	Expand meaningful quality assurance and monitoring systems and procedures that provide real-time feedback and promote ongoing learning and continuous quality improvement.

NH stakeholders consistently report that the burdens associated with accountability are high, but the meaning and utility of the information for improving their work is low because it lacks the right kind of measures and feedback loops. We need to review the meaning to burden ratio of NH's global quality assurance system.

A Centralized, Streamlined Accountability System

DHHS or a contracted system administrator would provide centralized accountability and guidance for the mental health system through the Portal. While regional hubs maintain oversight of what occurs in their local systems, DHHS has oversight of an accessible, coordinated continuum of care throughout NH. Documentation requirements could be streamlined and synchronized as much as possible between DHHS, Medicaid, Medicare, and private insurers.

Collect and Use a Small But Meaningful Set of Shared Performance Measures

We recommend developing a set of shared performance measures at system and population levels. The focus should be on high leverage measures of engagement in and experience of care, quality (fidelity to evidence-based models, for instance), and outcomes (such as quality of life and wellbeing). See the Outcomes section for potential performance measures. Regional hubs will be responsible for tracking and entering data relevant to these performance measures, which become the basis upon which the central administrator provides ongoing data-based feedback, recommendations, guidance, and support to regional sites as they engage in quality improvement efforts.

Common Data Platform Improves Data Integrity, Promotes Use

A common data platform would allow for consistent collection, management, and reporting of the aforementioned performance measures. The data platform should also be able to monitor available resources in real time (inpatient and crisis beds, availability of mobile crisis units, etc.) and track people waiting in EDs to ensure movement through the system and minimize wait times.

Actions	Collect & use meaningful data	Accountability through DHHS or another system administrator	Shared performance measures	Build a common data platform

Strategic Framework

The figure on the next page depicts the logical chain of events that will equip the mental health system with the tools it needs to help all NH residents reach their mental health potential. In the figure, system-level strategies and associated outcomes are depicted in green boxes, practice-level strategies and associated outcomes are displayed in gray boxes, and core assumptions are provided in the box at the bottom.

Develop Strong Systems and Infrastructure

Shared leadership – the Governor, Legislature, DHHS, advocacy and philanthropy organizations, professional organizations, and grassroots support – will be key to recruiting and aligning the resources needed to continue to transform NH's mental health system. An infusion of resources will facilitate the creation of a mental health portal – a centralized source of information, triage, and referral to localized services, as well as accountability – and an enhanced mental health workforce. This hub will, in turn, nurture, support, and sustain better mental health systems and practices. Systems improvements will include enhanced infrastructure and use of technology; more meaningful and less burdensome quality assurance and monitoring; a more intentional and coherent set of coordinated services; and the infusion of peer, volunteer, and other natural supports throughout the system.

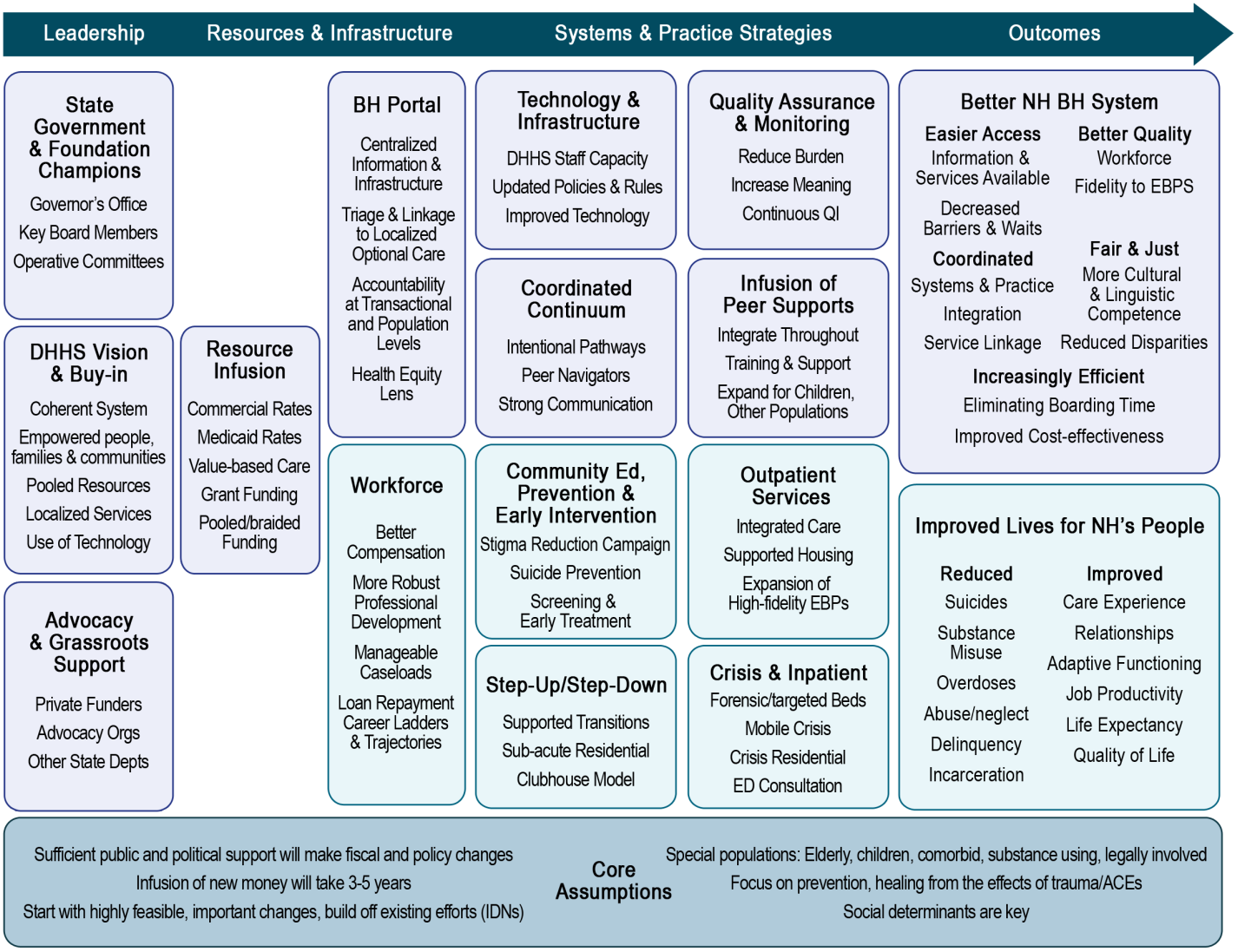
Fill Service Gaps and Increase Reach to Achieve Better Outcomes

These systems structures, combined with a more robust and qualified workforce, will help to fill practice gaps and enhance the reach and quality of existing services and supports. Together, these strategies will enhance outcomes at the system and population level. At the system level, improved access, coordination, quality, equity, and cost-efficiency is anticipated. At the population level, these changes will lead to fewer suicides, opioid overdoses, and other causes of early/preventable mortality; lower rates of abuse, delinquency, and incarceration; better care experience and satisfaction; enhanced social networks and relationships; and better lives at home, at work, and in school.

Strategic, Incremental Implementation Leads to Success

The stakeholders believe that all of this is predicated on the notion that sufficient support can be marshalled, and that the planned infusion of resources will take about five years to fully come to fruition. As such, we will have to start off by addressing the "low hanging fruit" while expanding the foundation for a more robust mental health system. In addition, we are aware that the system needs to attend and adapt to urgent needs of particular populations including children, the elderly, dual diagnosed and co-occuring populations, and those with legal involvements. And finally, we understand that social determinants are implicated in most mental health (and substance misuse) problems and as such, must be attended to and addressed.

NH 10-Year Plan Strategic Framework



Implementation Timeline and Milestones

Stakeholders urged that the Plan be divided into three time periods (state fiscal years 2020-2021, 2022- 2026, and 2027-2028). The Department believes that this concept is useful but that the Plan should be evaluated and updated in every biennium in the 10-year period, in concert with state funding cycles, to adapt to emerging evidence and changing conditions.

2020-2021: Address Wait Times in EDs, Mental Health Rates, Crisis Services, Inpatient Bed Capacity and Regulatory Reform

The first two years, in the Department's view, should focus on actions and strategies that will immediately mitigate wait times in EDs, such as addressing DRF and voluntary inpatient community psychiatric bed rates, capital funds for establishment of new DRFs, reallocation of existing bed capacity at New Hampshire Hospital, and a number of other measures that will improve the capacity and effectiveness of the mental health system.

By the end of this period, wait times in EDs should be reduced significantly. Determining the implementation and operation of the Mental Health Portal in concert with the SUD hub and spoke, Community Mental Health Center, or IDN systems should be another priority. Cultivating buy-in and commitment from a variety of stakeholders (especially law and policy makers), allocating existing resources to the most easily implemented system and practice strategies, and setting higher fee levers in motion to infuse the system with resources in subsequent years will set the foundation for future success. Building DHHS capacity to target high leverage grant funding opportunities and review rules and administrative burdens will also be key activities during the initial implementation phase.

2022-2026: Full Infusion of Resources; Regional Hubs Fully Operational; Continuum of Care Accessible to All

An infusion of additional resources should be made during the middle years (2022-2026), allowing for robust implementation of the Plan. Leadership will remain crucial, as will internal DHHS prioritization of the Plan, regular public updates regarding the Plan's progress, and review and adaptation of the Plan in alignment with the biennial funding cycle. During this phase, a regional delivery system should be capable of providing 24-hour walk-in and crisis stabilization services in locations around the state. With higher reimbursement rates and pooled benefits, compensation should increase, improving recruitment, training, and retention of a high-quality mental health workforce. Practice gaps should be filled and a full, coordinated continuum of care should be well established by the end of this time period.

2027-2028: Reflect on Progress, Celebrate Successes, Identify Deficiencies, Look Forward to Next 10 Years

The final two years of Plan implementation must reflect on what works, discontinuing systems and practices that are ineffective or inefficient, and adapting to changing conditions and emergent and promising EBPs. The Mental Health Portal and its integration with an existing regional delivery system will be mature, setting the stage for further integration with other systems (e.g., social services). Data collection practices and platforms should be robust enough at this time to demonstrate outcomes, generate lessons learned, and foster continuous quality improvement at both system and practice levels. All of this should expand NH's mental health system and set the stage for subsequent 10-Year plans.

NH MH Plan Milestones	Build foundation 2020–2021	Establish the system 2022–2026	Reflect, look forward 2027–2028
Leadership	Build internal knowledge and buy-in Disseminate to public Create implementation plan Develop social marketing plan Foster legislative champions	Continue to prioritize plan internally Review and adapt plan biennially Update the public regularly on progress Implement social marketing plan Continue to educate and foster legislative champions	Review and disseminate results Celebrate, maintain successes Identify problems & gaps Foster legislative champions
Resources & Infrastructure	Resources to low cost strategies, grant funding for demo projects, set rate levers in motion MH Portal: Basic information, services, integrated with SUD Workforce oversight, pooled benefits, loan repayment	Impact of high fee levels felt, allocate resources to highest impact strategies, phase in alternative payment model MH Portal fully deployed: walk-in, crisis stabilization Better compensation, professional development for workforce	Reallocate cost offsets, refine alternative payment model Integrate MH Portal with other systems Workforce: manageable caseloads, career ladders and trajectories
System Strategies	Review rules & administration Review DHHS data systems Fill DHHS positions Envision coordinated continuum Add peer support to Medicaid Plan	Streamline rules & administrative procedures Enhance DHHS data systems Maintain/reinforce DHHS staff capacity Create intentional service/support pathways Integrate peer supports at every point in continuum	Maintain, reinforce DHHS staff capacity Use enhanced data systems to promote continuous quality improvement Refine service/support pathways Demonstrate peer support outcomes
Practice Strategies	Plan stigma reduction campaign, enhance suicide prevention, expand early intervention for psychosis Primary care integration, school-based mental health, solidify current EBPs Expand supported transitions, Clubhouses Extend mobile crisis to children	Fully deploy stigma reduction, state suicide plan, extend early intervention to other conditions Supported housing, integration for pediatrics & elderly, expansion of EBPs Open sub-acute residential settings Consultation & navigators in EDs, crisis residential, additional forensic/targeted inpatient beds	Continue to refine, expand successful practices Re-examine gaps in service array, need for additional beds Incorporate new knowledge, emergent promising and evidence-based practices

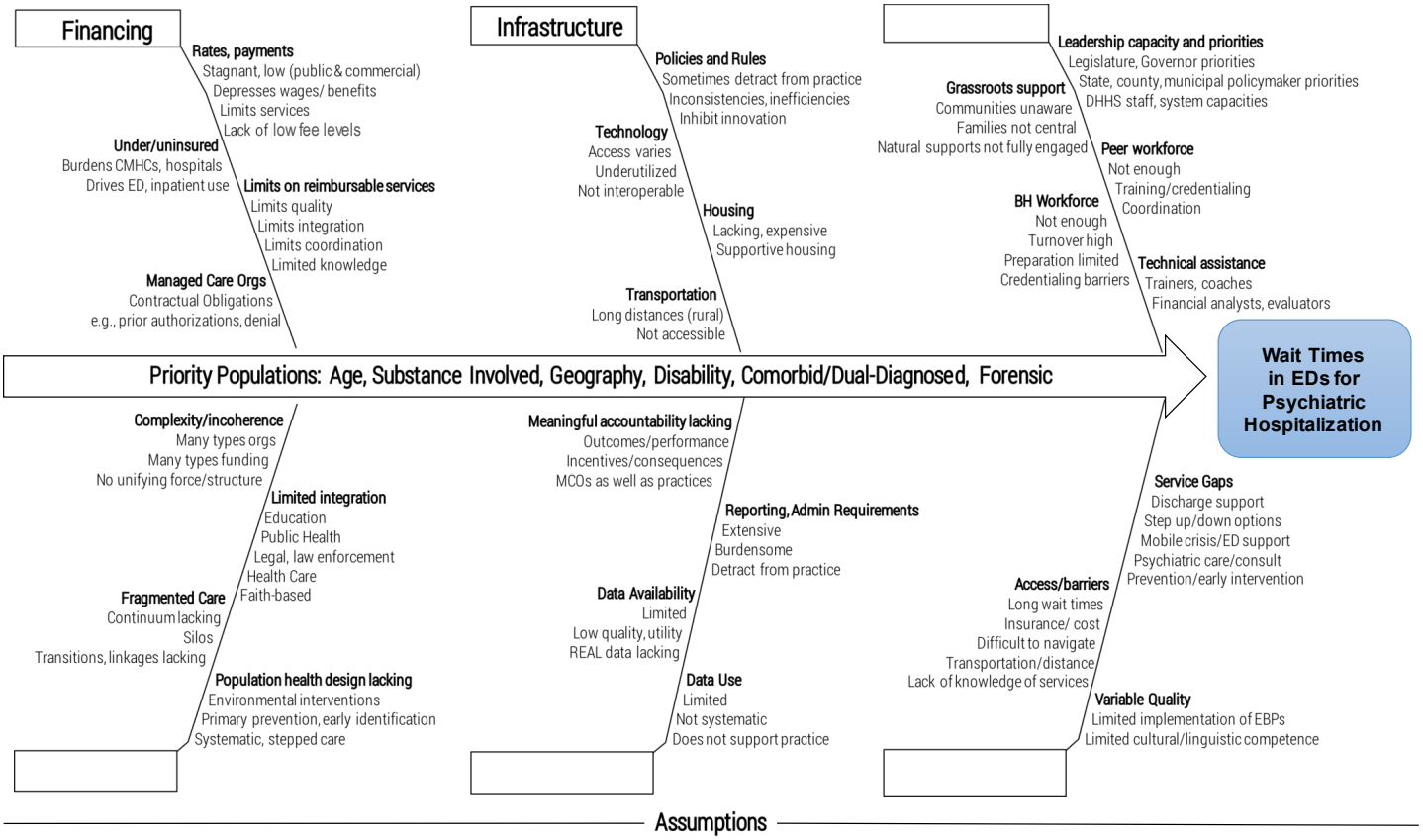
Appendix A: Mental Health Spending SFY13 through SFY19

	SFY13	SFY14	SFY15	SFY16	SFY17	SFY18	SFY19	Total
CMHC Core Contracts	3,290,149	3,485,734	3,239,652	3,239,985	3,423,812	3,433,125	3,285,525	23,397,982
ACT Teams - Adult	679,587	1,268,587	2,475,000	3,150,000	3,405,000	3,405,000	3,405,000	17,788,174
Housing Bridge Program	705,323	1,553,560	2,740,660	3,612,660	4,212,160	4,212,160	4,212,160	21,248,683
Glencliff Transitions	-	-	100,000	450,000	800,000	900,000	900,000	3,150,000
Mobile Crisis Teams/ Crisis Apts	-	-	520,650	1,545,372	2,875,869	4,057,178	4,057,178	13,056,247
Supported Employment	-	-	2,250,000	-	-	-		2,250,000
Peer Support Agencies	2,175,362	2,298,831	2,759,481	2,754,479	2,759,479	2,759,479	2,759,479	18,266,590
Family Mutual Support	447,732	465,820	475,137	475,137	475,137	475,137	475,137	3,289,237
HB400/HB517								
DRF Beds	-	-	-	-	-	484,696	721,440	1,206,136
Transitional & Community Residential Beds	-	-	-	-	-	1,500,000	3,000,000	4,500,000
Mobile Crisis Teams/ Apartments	-	-	-	-	-	866,667	1,300,000	2,166,667
Children's Wrap Services	-	-	-	-	-	2,673,494	5,346,886	8,020,380
MCO Contracts - Mental Health	-	38,939,427	98,401,509	83,160,720	90,078,730	96,276,674	90,848,485	497,705,544
Medicaid FFS for FC BHCMH*	90,300,683	61,200,015	31,223,198	24,928,528	18,692,113	17,927,122	17,797,551	262,069,210
CMHC Temporary Fee Schedule Increase							5,606,000	5,606,000
DSRIP Waiver Spending**	-	-	-	-	24,904,352	20,477,658	20,022,342	65,404,352
Total	97,598,836	109,211,974	144,185,287	123,316,881	151,626,652	159,448,390	163,737,183	949,125,202
Source of Funds:								
General Funds	51,084,029	57,820,536	76,580,221	67,672,146	83,258,943	89,005,978	92,046,040	517,467,892
Federal Funds	46,514,808	51,391,438	67,605,067	55,644,735	68,367,708	70,442,412	71,691,143	431,657,310
Total Funds	97,598,836	109,211,974	144,185,287	123,316,881	151,626,652	159,448,390	163,737,183	949,125,202

*FC BHCMH is for Community MH Providers - CMHCs, HH & NFI

** DSRIP Waiver spending supports both mental health and SUD programs

Appendix B: Contributing Factors



Wait time is a visible symptom of a system under stress, but outcomes like wellbeing and life expectancy are at least as/more critically important. Contributing factors on the left are more encompassing, contributing factors on the right are more focal and proximal to the wait-time problem. Social Determinants of Health underlie and intersect with most of the contributing factors.

Acronyms

ACT . . . . . Assertive Community Treatment
BDAS . . . . . Bureau of Drug and Alcohol Services
CDC . . . . . Centers for Disease Control and Prevention
CMHA . . . . . Community Mental Health Agreement
CMHC. . . . . Community Mental Health Centers
CMC. . . . . Centers for Medicare and Medicaid Services
DBSA . . . . . Depression and Bipolar Support Alliance
DBH . . . . . Division for Behavioral Health
DHHS . . . . . Department of Health and Human Services
DOC . . . . . Department of Corrections
DOE . . . . . Department of Education
DRF . . . . . Designated Receiving Facilities
DSRIP . . . . . Delivery System Reform Incentive Program
EBP . . . . . Evidence-Based Practice
ED . . . . . Emergency Department
FAST Forward . Families and Systems Together
FEP . . . . . First Episode Psychosis
FQHC . . . . . Federally Qualified Health Centers
IDN . . . . . Integrated Delivery Networks
IEA. . . . . Involuntary Emergency Admission
MATCH . . . . Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems
MCO. . . . . Managed Care Organizations
MTSS-B . . . . . Multi-Tiered Systems of Support for Behavior and Wellness
NAMI . . . . . National Alliance on Mental Illness
NHH. . . . . New Hampshire Hospital
PBIS . . . . . Positive Behavioral Interventions and Supports
PMPM. . . . . Per Member Per Month
Portal . . . . . Mental Health Portal
PSA . . . . . Peer Support Agencies
PSH . . . . . Permanent Supportive Housing
RAISE . . . . . Recovery After an Initial Schizophrenia Episode
RFP . . . . . Request for Proposals
SUD . . . . . Substance Use Disorders

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