# Continuum of Care Development Plan

## Capital Area Public Health Network

01/19/2018


NH DEPT. OF HEALTH AND HUMAN SERVICES
NHBDAS
BUREAU OF DRUG AND ALCOHOL SERVICES
*Promoting Prevention and Recovery*

CENTER FOR EXCELLENCE | Addressing Alcohol & Drug Misuse in NH

# Capital Area Public Health Network Development Plan

## I. Introduction

***Overview***

In May 2015, a group of Substance Use Disorder (SUD) treatment providers in Concord, including those from Concord Hospital and Riverbend Community Mental Health, Inc., came together to develop a collective approach to addressing the SUD needs of the Capital Area's population. This group has been meeting monthly since then to share best practices and create collaborative processes. It has expanded to include SUD providers along the continuum of prevention, intervention, treatment, and recovery and is currently serving as the "workgroup" for the Capital Area region of the State's Continuum of Care (CoC) project. It also provides input and support to Region 2 (Capital Area) of the State's Section 1115 Waiver Demonstration Project (1115 Project) ensuring that there is cohesion between the two projects. In addition to this workgroup, information for this report relied on other existing Capital Area plans including:

- *Capital Area Community Health Improvement Plan 2015-2020*, Capital Area Public Health Network.
- *Capital Area Misuse of Alcohol and Drugs Prevention Plan 2016-2019*, Capital Area Public Health Network.
- *Capital Region Community Health Needs Assessment: A Collaborative Partnership to Identify Community Health Needs*, Facilitated by Concord Hospital, 2015.

This group embraces the Capital Area Public Health Network's (CAPHN) vision of a continuum of care to address substance use disorders that is comprehensive, integrated, and well-coordinated to meet the full spectrum of needs of individuals, families, and communities in the Capital Area. The continuum of care will incorporate a strengths-based, whole-person, whole-community approach focused on increasing resiliency through environmental strategies, prevention, intervention, treatment, and recovery supports and services. We will work together to increase the understanding that substance use disorders are chronic conditions that can be successfully prevented, treated, and managed through a recovery-oriented system of care.

***Geographic description of region***

The Capital Area region of New Hampshire is home to 130,067 residents and spans 880.99 square miles. The area is comprised primarily of Merrimack County municipalities (1 city, 17 towns), but also includes four towns from Hillsborough County, and one town each from Rockingham County and Sullivan County. Merrimack County's seat is Concord, the state capital. In total, the area consists of the following twenty-four municipalities: Allenstown, Andover, Boscawen, Bow, Bradford, Canterbury, Chichester, Concord, Deering, Dunbarton, Epsom, Henniker, Hillsboro, Hopkinton, Loudon, Northwood, Pembroke, Pittsfield, Salisbury, Warner, Washington, Webster, Weare, and Windsor.

***Demographics of region***

*Selected Demographics in Merrimack County and NH. Source: US Census Bureau, NH DHHS.*

| | Merrimack County | NH |
|---|---|---|
| ***Race & Ethnicity (2014)*** | | |
| White alone (a) | 95.0% | 94.0% |
| Black or African American alone (a) | 1.4% | 1.5% |
| American Indian and Alaskan Native alone (a) | 0.3% | 0.3% |
| Asian alone (a) | 1.9% | 2.5% |
| Native Hawaiian and Other Pacific Islander alone (a) | Z | Z |
| Two or More Races | 1.4% | 1.6% |
| Hispanic or Latino (b) | 1.9% | 3.3% |
| White alone, not Hispanic or Latino | 93.4% | 91.3% |
| ***Foreign Born & Language (2009-2013)*** | | |
| Foreign born persons | 3.9% | 5.4% |
| Language other than English spoken at home, age 5+ | 5.2% | 8.0% |
| ***Refugee Resettlement (2008-2014)*** | | |
| Number of refugees resettled | 1,348 (Capital Area) | 3,317 |

According to the CAPHN's *Capital Area Community Health Improvement Plan 2015-2020*, the median age in the area is 43 and the population over age 65 (13.14%) is similar to the state (14.18%). From 2000-2010, the Capital Area also saw a 7.5% increase in the percent of population over the age of 85 to a current rate of 1.52%. During the same timeframe, the Capital Area saw a -5.8% decrease in the school age population.

While much of the data collected for CAPHN's plan pointed to overall positive health outcomes in the area, especially when compared to state and national figures, there are several communities within the region that face significant socioeconomic barriers to good health. Many residents face unequal access or limited access to high-quality jobs, education and safe environments based on the community or neighborhood in which they live. These health inequities can lead to higher rates of injury, disease, and mortality.

This range of inequity can be seen in the following statistics: The median household income for the Capital Area ($69,398) is slightly higher than NH ($66,283) and ranges from a low of $52,592 in Concord to a high of $97,028 in Bow. The percent of individuals at or below the poverty level ranges from 1.7% in Weare to 18.3% in Pittsfield.

The Capital Area Public Health Network plans to address the following goals through the Continuum of Care development process, taking into consideration the particular needs and challenges of the region, as identified within this report and through ongoing assessments.

***Overall goals for continuum of care development***

- To assess the current capacity of substance misuse services, where they are delivered, and their accessibility.
- To develop awareness among individuals, families, and communities as to:
    a) What services are currently available in their community;
    b) Where they are located; and

c) How to access these services; or
d) If the community does not provide a service, where go to learn about programs and services outside their community.

- To use that information to work toward the establishment of a robust, comprehensive, and accessible substance misuse continuum of care.

# II. Assessment

***State-level determination of need***

The NH Department of Health and Human Services/Bureau of Drug and Alcohol Services (DHHS/BDAS) has determined that the best way to prevent and/or decrease the damage that substance misuse causes to individuals, families, and communities is to develop a robust, effective, and well-coordinated continuum of care in each region of that state, and to address barriers to awareness and access to services. The regional continuum of care will include health promotion, prevention, early identification and intervention, treatment, recovery supports and coordination with primary health and behavioral health care.

***Regional level determination of need***

The region has identified substance misuse as a priority health issue in its Community Health Improvement Plan (CHIP). The region's vision statement for continuum of care development is as follows:

> *The Capital Area Public Health Network envisions a continuum of care to address substance use disorders that is comprehensive, integrated, and well-coordinated to meet the full spectrum of needs of individuals, families, and communities in the Capital Area. The continuum of care will incorporate a strengths-based, whole-person, whole-community approach focused on increasing resiliency through environmental strategies, prevention, intervention, treatment, and recovery supports and services. We will work together to increase the understanding that substance use disorders are chronic conditions that can be successfully prevented, treated, and managed through a recovery-oriented system of care.*

The region's statement for CoC development was developed and approved early on by the Public Health Advisory Council (PHAC) in February of 2015 as the result of several initial meetings held by CAPHN that included a roundtable and PHAC education sessions on the CoC project. There were a series of sessions for PHAC members to increase understanding of the CoC, including a webinar, power point presentation, and a forum. During the roundtable, input was received from about 40-50 attendees to approve the key components of a robust continuum of care system.

There are three major activities that will contribute to the successful completion of contract deliverables for regional CoC development, which will also support the work towards building a Resiliency and Recovery Oriented System of Care (RROSC).


# III. Capacity

***Assets and gaps scan process***

The region completed a recent updated "assets and gaps scan" in November of 2017 to identify resources, gaps, and barriers that continue to exist or have been newly identified that can help or hinder the achievement of the region's statement for continuum of care development presented in the Assessment section of this plan. The assets and gaps scan will be an ongoing process based on the identification, engagement and input of additional stakeholders and the integration of new information/ data as it becomes available, and formally submitted to the DHHS Bureau of Drug and Alcohol Services (BDAS) annually for review.

The CoC Facilitator oversaw and facilitated the assets and gaps scan process and identified additional stakeholders and services through recommendations of the existing SUD CoC Workgroup, community partners and CAPHN. Methodologies used included 1:1 interviews, information garnered through stakeholder meetings, such as Choices Addiction Program, Bow HR Interagency Group, Pittsfield Interagency Coalition and the Allenstown/Pembroke wrap-around meetings. Barriers and gaps to SUD services were defined by the aforementioned groups and included outreach to nearly all of the area municipalities.

Additionally, the development of a regional Integrated Development Network (IDN) for the 1115 project has expanded capacity and members of the IDN are working in alignment with the CoC project. The Region 2 Integrated Delivery Network (IDN) upholds and supports the goal of the Capital Area Public Health Network to "improve access to a comprehensive, coordinated continuum of behavioral health care services in the Capital Area by 2020." Further, the vision includes improving outcomes and increasing access to care for adult and youth populations (including those reentering from incarceration, pregnant women, and youth with developmental disabilities) across the Capital Area in a service-integrated continuum of care that addresses mental health, substance use disorders, and chronic/primary health care needs.

Region 2's IDN has developed the integration and community projects in an interlocking way to maximize resources and eliminate as many gaps in care and transition between care as possible. The projects will work together to identify and address the needs of the Medicaid population with behavioral health disorders or those at risk for behavioral health disorders at the following community locations: ten primary care sites; the Community Mental Health Center and substance use disorder

(SUD) service provider (Riverbend); Concord Hospital emergency room and SUD programs; three correctional facilities; and an array of community-based organizations who provide case management, benefits, housing, recovery and other behavioral health supports.

***Capital Area Assets & Gaps Scan 2017-2018***

The following tables include the results of the most recent assets and gaps scan, updated in November 2017.

### Capital Area - CoC Component Assets 2017-2018

| PROVIDER | AREAS SERVED | SERVICE SETTING | SERVICES OFFERED | COC COMPONENT |
|---|---|---|---|---|
| **PREVENTION** | | | | |
| Capital Area Public Health Network - Substance Misuse Prevention Network (committee) | Capital Area | Community Based Organization | Recruitment of key community stakeholders and sectors, technical assistance to area schools and emerging community coalitions, resource development and advocacy | Prevention |
| Granite Pathways - Regional Access Point Services (RAPS) | Statewide (except Manchester area and Monadnock Region), including Capital Area | Community Based Organization | Activities: Referral, Screenings, Insurance enrollment, access to Primary Care Providers, LDAC/MLDAC Federal/State | Prevention |
| Youth Councils (Leadership/Empowerment) * The councils were not fully funded this year but some of them still regularly meet. | Bow, Pembroke, Kearsarge, Concord, Pittsfield | Regional High Schools | Key activities included: Participation in Trainings (New Futures Advocacy Training, NH Teen Institute Summer Leadership Program, Media Power Youth Training, Dover Youth to Youth Training), Sticker Shock Campaigns, Social Media Posts, Outreach Events (open houses, advisories, pep rally), Spartan Safety Box, Peer Mentoring, Red Ribbon Week, School Climate Activities | Prevention |
| Permanent Prescription Take Back Boxes | Allenstown, Bow, Concord, Henniker, Hillsboro, Northwood, Pembroke, Pittsfield Epsom | Police Departments | No cost and anonymous disposal of unused/unwanted prescription drugs | Prevention |

| PROVIDER | AREAS SERVED | SERVICE SETTING | SERVICES OFFERED | COC COMPONENT |
|---|---|---|---|---|
| Life of an Athlete | Concord, Pittsfield, Pembroke, Bishop Brady, Bow, Hopkinton | Regional High Schools | The program is centered on ensuring strong Athletic Codes of Conduct, while Student Leadership, Engaging Coaches, Stakeholder Unity and Pre-Season Meeting support the enforcement of athletic codes | Prevention |
| Local Prevention Coalitions<br>* Bow has slowed down its participation. | Pittsfield, Bow, Pembroke | Community Based Organization | Various local substance misuse prevention activities focused on promoting protective factors and reducing community risk factors | Prevention |
| Concord Hospital Family Health Center | Concord Hospital Service Area | Hospital | Scope of Pain - Opioid Prescriber Education/Training | Prevention |
| Riverbend Community Mental Health Center | Capital Area and Statewide | Community Mental Health Center | Substance Use Disorder Provider, Mental Health provider, Mental Health First Aid curriculum development | Prevention |
| City of Concord Police Department | Concord Region | Police Department | Community Resource Unit/Officer: The Community Resource Unit organizes, establishes, maintains, expands, and promotes coordinated crime prevention and community related programs within the City of Concord. This includes an on-going outreach to groups, neighborhoods, businesses, schools, and other members of the public and private sectors. Their efforts result in pro-active crime awareness and crime prevention programs while developing and strengthening a healthy rapport with the community | Prevention |
| Concord Schools | Concord Region | High School/ Middle School/ community day | Safe Schools/ Healthy Students Program | Prevention |

| PROVIDER | AREAS SERVED | SERVICE SETTING | SERVICES OFFERED | COC COMPONENT |
|---|---|---|---|---|
| | | cares | | |
| Second Start | Hopkinton Middle/High School, Pittsfield Middle/High School, Concord High School, Rundlett Middle School, Merrimack Valley Middle School, Merrimack Valley High School. | Schools | Student Assistance Program - Prevention Education Series, Universal Prevention Strategies | Prevention |
| Tri-Town EMS | Allenstown /Pembroke | Community Based Provider | Overdose Service Calls/Fire Safety | Prevention, Early Identification & Referral |
| New Futures | Capital Region and Statewide | State Government | Assists with developing trained community advocates, creates action alerts on bills that are potentially hazard to public health, created the advocacy hub | Prevention |
| Pittsfield Interagency Community Coalition PICC | Pittsfield | Community Providers | Provides wrap services for high-risk students. | Prevention, Intervention |
| The Governor's Commission Prevention Task Force | Statewide | Early childhood, schools, and community based | The mission of the Prevention Task Force is to utilize data to identify trends related to substance misuse; increase knowledge to better understand the impact of emerging trends; identify and take action to address the gaps in the current prevention system; recommend strategic initiatives for the Governor's Commission | Prevention |
| Bow Human Resources | Bow | Community based | Provides wrap services for area families around delinquency, poverty, | Prevention |

| PROVIDER | AREAS SERVED | SERVICE SETTING | SERVICES OFFERED | COC COMPONENT |
|---|---|---|---|---|
| New Hampshire Alcohol and Drug Counselor Association | New Hampshire | Community support | Provides certified trainings for Prevention specialist, LADC's, peer recovery coaches. Supports professionals by promoting programs and policies related to addiction. | Prevention, Treatment, Recovery |
| **EARLY INTERVENTION** | | | | |
| Merrimack County Drug Court | Merrimack County | Merrimack County Courts | Individuals 18 years or older with Felony charges of 5 years or more pending, 18-24 month program of intensive IOP and clinical/community supports, case management services, clinical and legal team. MAT management. | Prevention, Intervention |
| DCYF | Capital Region and Laconia Area | DCYF District Offices | Available 24/7 Central line now available for calls nights, weekends and Holidays. A Supervisor is on call. | Prevention, Intervention |
| Concord Hospital Family Health Center | Capital Region and Statewide | Hospital | Screening Brief Intervention and Referral to Treatment with one clinical team--will be expanding to the whole clinic soon | Early Intervention |
| Second Start | Hopkinton Middle/High School, Pittsfield Middle/High School, Concord High School, Rundlett Middle School, Merrimack Valley Middle School, Merrimack Valley High School. | Middle and High Schools | Student Assistance Program - Brief Individual and crisis counseling, group counseling | Early Intervention |
| Circuit Court District Division – Concord | Capital Area | Court | Drug Court | Early Intervention |
| Merrimack County Diversion Center | Merrimack County | Court | Court Diversion | Early Intervention |

| PROVIDER | AREAS SERVED | SERVICE SETTING | SERVICES OFFERED | COC COMPONENT |
|---|---|---|---|---|
| Circuit Court District Division – Concord | Capital Region | Mental Health Court | Medium to high-risk adult defendants diagnosed with a Bipolar Disorder, Schizophrenia, Major Depression or other mental illness, intellectual disability along with substance abuse. | Early Intervention |
| Capital Area Public Health Network | Capital Area | Community-Based Organization | Naloxone distribution community events and provider trainings | Early Intervention |
| **TREATMENT** | | | | |
| A Better Pathway Mary Joy Yost- (Part- time practice) 387- 2556 | Concord | Treatment Facility | Evaluation, Individual Outpatient Counseling, Group Outpatient Counseling | Treatment |
| Bicentennial Square Counseling Services | Concord | Treatment Facility | Evaluation, Individual Outpatient Counseling, Group Outpatient Counseling, Mental Health | Treatment |
| Changing Point Counseling, LLC Sarah Zeigler, MLADC | Concord | Treatment Facility | Evaluation, Individual Outpatient Counseling, Group Outpatient Counseling | Treatment |
| Child and Family Services – (Mental Health and Child Care issues) | Concord | Treatment Facility | Evaluation, Individual Outpatient Counseling, Group Outpatient Counseling, Intensive Outpatient Programs | Treatment |
| Chrysalis Recovery Center, LLC DWI/OUI 856-7745 | Concord, Northwood | Treatment Facility | Evaluation, Individual Outpatient Counseling, Group Outpatient Counseling, Intensive Outpatient Programs Recovery Mentors, DWI After Counseling, Military Re-integration and Counseling | Treatment |
| Governor's Commission Treatment Task Force | Capital Area, State | Capital Area, State | SUD Treatment and Co-Occurring Disorders | Treatment |
| Concord Hospital Program for Addictive Disorders | Capital Area and State | Treatment Facility | Evaluation for level of care, Medication Assisted Treatment for Alcohol Disorders and Opioid Disorders (Naltrexone and | Treatment |

| PROVIDER | AREAS SERVED | SERVICE SETTING | SERVICES OFFERED | COC COMPONENT |
|---|---|---|---|---|
| | | | Buprenorphine) | |
| New Season Concord Metro Treatment Center | Concord and Statewide | Treatment Facility | Withdrawal Management, Medication Assisted Treatment (Buprenorphine, Methadone) | Treatment |
| Kim Thurlow-MLADC | Concord | Treatment Facility | IOP, SUD Counseling | Treatment |
| Kat Guyet - MLADC | Concord Area | Treatment Facility | IOP, SUD counseling | Treatment |
| Elsa Johnson, LCMHC, MLADC | Concord | Treatment Facility | Evaluation, Individual Outpatient Counseling, Group Outpatient Counseling | Treatment |
| Reach For the Stars Counseling Doris Faughnan, MLADC | Concord Area | Treatment Facility | Evaluation, Individual Outpatient Counseling, Recovery Support Services (Anger Management, Recovery Mentoring and Relapse Prevention Management). | Treatment |
| LADC & SAP Services, LLC | Concord | Treatment Facility | Evaluation, Individual Outpatient Counseling | Treatment |
| Riverbend Community Mental Health Center | Concord | Treatment Facility | Evaluation, Individual Outpatient Counseling, Group Outpatient Counseling, Intensive Outpatient Programs | Treatment |
| ROAD to a Better Life | Concord, Somersworth, Plymouth, Wolfeboro, Lebanon, Newington and Merrimack | Treatment Facility | Withdrawal Management (Buprenorphine, Vivitrol), Evaluation, Individual Outpatient Counseling, Group Outpatient Counseling, Intensive Outpatient Programs | Treatment |
| RTT Associates, LLC | Concord | Treatment Facility | Evaluation, Individual Outpatient Counseling, Group Outpatient Counseling, Peer Recovery Coach | Treatment |
| Self-empowerment-NH LLC | Concord | Treatment Facility | Evaluation, Individual Outpatient Counseling, Group Outpatient Counseling | Treatment |

| PROVIDER | AREAS SERVED | SERVICE SETTING | SERVICES OFFERED | COC COMPONENT |
|---|---|---|---|---|
| SKY Counseling Services, LLC | Concord | Treatment Facility | Evaluation, Individual Outpatient Counseling, Group Outpatient Counseling, Intensive Outpatient Programs | Treatment |
| Warren Street Family Counseling Associates, Inc. | Concord | Treatment Facility | Evaluation, Individual Outpatient Counseling | Treatment |
| Eberhart Counseling, LLC | Contoocook | Treatment Facility | Evaluation, Individual Outpatient Counseling, Group Outpatient Counseling | Treatment |
| EqWise Counseling Services | Hopkinton | Treatment Facility | Evaluation, Individual Outpatient Counseling | Treatment |
| Chrysalis Recovery Center, LLC | Northwood | Treatment Facility | Evaluation, Individual Outpatient Counseling, Group Outpatient Counseling, Intensive Outpatient Programs | Treatment |
| Growing Harmony Services, LLC | Pittsfield | Treatment Facility | Evaluation, Group Outpatient Counseling | Treatment |
| New England Recovery and Wellness (RAW) | Capital Region | Treatment Facility | PHP: Partial Hospitalization, Individual Outpatient Counseling, | Treatment |
| Granite Recovery Centers<br>The Granite House for Women | Statewide | Residential Treatment Facility | Evaluation, IOP, Group Therapy, Teaches Vital Life skills, education opportunities, career opportunities, goal setting | Treatment |
| Granite Recovery Centers<br>New Freedom Academy | Statewide | Treatment Facility | Medical Detoxification, Co-Occurring Disorders, Residential | Treatment |
| Riverbend “Choices "For Adults (SUD) | Statewide | Treatment Facility | Intensive Outpatient Program, Family Counseling, Individual & Group Counseling, Medication Assisted Treatment | Treatment |
| Riverbend “Choices” for Adolescents (SUD) | Statewide | Treatment Facility | Intensive Outpatient Program, Family Counseling, Individual Counseling, Medication Assisted Treatment | Treatment |
| **RECOVERY** | | | | |
| New Futures | Statewide - Capital Area | Community Based Organization | Certified Recovery Coach Training (CCAR) | Recovery |
| HOPE for NH Recovery | Statewide and Concord - Capital | Community Based Organization | Recovery Community Center | Recovery |

| PROVIDER | AREAS SERVED | SERVICE SETTING | SERVICES OFFERED | COC COMPONENT |
|---|---|---|---|---|
| | Area | | | |
| Granite Pathways | Statewide/Concord Area | Community Based Organization | Trainings | Recovery |
| A Better Pathway | Concord | Treatment Facility | Recovery Support Services (Recovery Mentoring/Relapse Prevention Management) | Recovery |
| Chrysalis Recovery Center, LLC | Concord | Treatment Facility | Recovery Support Services (Anger Management, Recovery Mentoring and Relapse Prevention Management, Peer Recovery Coaching, Care Coordination, Other Recovery Support Services) | Recovery |
| Concord Hospital, Substance Use Services | Concord | Treatment Facility | Recovery Support Services (Recovery Mentoring and Relapse Prevention Management) | Recovery |
| Elsa Johnson, LCMHC, MLADC | Concord | Treatment Facility | Recovery Support Services (Anger Management) | Recovery |
| SKY Counseling Services, LLC | Concord | Treatment Facility | Recovery Support Services (Recovery Mentoring/Relapse Prevention Management, Peer Recovery Coaching) | Recovery |
| Chrysalis Recovery Center, LLC | Northwood | Treatment Facility | Recovery Support Services (Anger Management, Recovery Mentoring and Relapse Prevention Management, Peer Recovery Coaching, Care Coordination, Other Recovery Support Services) | Recovery |
| RTT Associates, LLC | Concord | Treatment Facility | Recovery Support Services (Peer Recovery Coaching) | Recovery |
| Families Sharing Without Shame | Concord | Community Based Organization | Recovery Support Services (Parent Support Groups) | Recovery |
| Child and Family Services | Concord | Community Based Organization | Recovery Support Services (Parent Support Groups) | Recovery |

| PROVIDER | AREAS SERVED | SERVICE SETTING | SERVICES OFFERED | COC COMPONENT |
|---|---|---|---|---|
| Homestead Inn Sober House | Concord-Boscawen | Recovery Facility | 12-step based sober living facility for men, Peer supports, CRSW staffing, Vivitrol, Community AA Meetings | Recovery |
| New England Recovery and Wellness- RAW | Capital Area | PHP: Partial hospitalization/IOP Sober Living Housing (Live Free) | 12- step recovery platform, Alpha, SMART Program | Recovery |
| Governor's Commission Recovery Task Force | Capital Area | Recovery Group | Recovery Supports | Recovery |
| McKenna House | Capital Area | Shelter | Recovery Housing and supports | Recovery |
| Donna Marston - CRSW | Capital Area and Statewide | Group Support Services | Group Sessions with Family members of children w/SUD (Thursday eves/Sundays at Farnum Center) | Recovery |
| Families Sharing Without Shame | Concord and Statewide | Support group for parents | Thursday evenings: 7 - 8:30 p.m. Concord 3rd floor, Richard Pitman Family Conference Room | Recovery |

*Updated 11/30/17*

### Capital Area - CoC Component Gaps and Barriers 2017-2018

| GAP OR BARRIER | COMPONENT | DESCRIBE GAP(s) OR BARRIER(s) |
|---|---|---|
| **CATEGORY** | **SYSTEM** | **DESCRIPTION: Summarize concern and/or information.** |
| Barrier | Enforcement | The Concord PD would like to replicate their domestic violence program model to address Substance Use Disorders (SUD) but does not have the necessary resources. |
| Barrier | Enforcement, Prevention | The Concord PD is operating at 76% capacity in officer workforce due to staff on medical leave, trainings, military leave, and injury. In 2015, they were at 80% capacity. |
| Barrier | Family Support | **It has been difficult to get Families Sharing Without Shame groups going in locations other than Concord.** A Family Support Coordinator for New Hampshire has recently been hired. Her role is to support families who have loved ones suffering with SUD. She works with all the Family Support groups in the State. |
| Barrier | Recovery | **Additional funding is needed for the STARS (recovery support) Program.** $6,000.00 was raised this year (2017) after expenses. This will help 40 people with a $150.00 scholarship- most recovery homes are $200.00 or more per week |

| GAP OR BARRIER | COMPONENT | DESCRIBE GAP(s) OR BARRIER(s) |
|---|---|---|
| **CATEGORY** | **SYSTEM** | **DESCRIPTION: Summarize concern and/or information.** |
| Barrier | Treatment, Ancillary Recovery Support Services | **Clients need better access to transportation and childcare services to access and maintain treatment.** Medicaid transportation services only cover "treatment" appointments and do not allow for transportation to recovery groups or other appointments. These services have been improved, but need much more improvement. |
| Barrier | Primary Care/SUD Treatment Integration | **Workflow can be challenging in settings where SUD treatment and primary care are integrated. There is some role confusion due to the infancy of Concord Hospital/Family Care center/Riverbend program**. The Program for Addictive disorders at Concord Hospital is currently underway and is addressing some of these challenges in terms of roles of various clinicians. |
| Barrier | Primary Care/SUD Treatment Integration, Treatment, Recovery | A value-based system is needed rather than one that focuses on cost-savings. |
| Barrier | Primary Care/SUD Treatment Integration, Treatment, Recovery | **42 CFR -Confidentiality laws are a barrier to practicing integrated care.** Concord Hospital has engaged UNH Law to advise and design forms in Cerner and create a release of information that covers informed consent for clients. |
| Barrier | Treatment | **Prescriptions for Medication Assisted Treatment (MAT) are not always covered by insurance.** |
| Barrier | Treatment | **Parity laws are not enforced.** For an Individual with Medicaid, the wait for a residential treatment center ranges from 2-5 weeks. If Individual has private insurance, they are often admitted the same day. |
| Barrier | Recovery | **It is difficult for previously incarcerated individuals in recovery to access recovery support services (housing, employment, etc.) upon leaving jail/prison due to policies related to eligibility for those services**. The IDN Re-Entry Program is addressing these needs and developing a model of care that will provide incarcerated individuals options for care, including housing, and ancillary supports. |
| Barrier | Recovery | **There is no statewide database of individuals trained as Recovery Coaches**. Currently, no statewide database is in place. |
| Barrier | Treatment | **Insurance carrier approval is a barrier.** The NH Parity law is currently being better supported by a full-time employee at the NH Department of Insurance. More work needs to be done to enforce this law. |
| Barrier | Enforcement | Individuals with a substance use disorder can be in need of emergent care frequently, which may contribute to compassion fatigue among first responders. |
| Barrier, Communication | Enforcement | **EMS and Hospitals can't share medical information with police, which can lead to communication difficulties**. |
| Collaboration | Recovery | HOPE for NH Recovery wants to collaborate more with DCYF families. |

| GAP OR BARRIER | COMPONENT | DESCRIBE GAP(s) OR BARRIER(s) |
|---|---|---|
| **CATEGORY** | **SYSTEM** | **DESCRIPTION: Summarize concern and/or information.** |
| Collaboration | Prevention, Treatment and Recovery | **The CoC services are currently not well-coordinated across the continuum.** Currently, the integration of SUD services is improving greatly by an increased capacity of trained professionals across the continuum. Training, support, enhanced services are being accomplished throughout the region. More work is needed, and the CoC Leadership Team is strategically setting priorities to attain these goals. |
| Collaboration | Full CoC | **The Concord PD works in silos. The officers on the ground are not connected to other work that's happening to address SUD.** The immediate Concord area has enhanced communication with first responders and the Capital Area Public Health Network as evidenced by participation in the CoC Leadership Team. Less engaged communities participate in low-level collaboration currently. Priorities to address the Gap is presently being addressed. |
| Collaboration | Prevention | **A lack of funding for prevention makes it difficult to sustain a prevention coalition**. More money is needed to develop evidence-based prevention efforts with youth starting in grade school and older. |
| Collaboration | Enforcement, Recovery | **The PD would like to have a system to connect individuals to Certified Recovery Coaches to assist with navigating treatment options**. There are currently 5 in the Capital Region, which is an improvement from 2016. |
| Collaboration | Prevention, Early Intervention | There is an opportunity to better integrate and coordinate prevention and family support education. If parents of ES and MS children knew more about the progression of addiction, they may be able to better identify problems earlier. |
| Communication | Full CoC | There is a misconception that all treatment needs to be inpatient. In the provider community, this is not the case. However, in the public community there is this misconception. |
| Communication | Primary Care/SUD Treatment Integration, Treatment, Recovery | Patients and families do not understand the system in which integrated services are provided. |
| Communication | Treatment, Primary Care/SUD Treatment Integration | There needs to be a common language among all staff assisting someone with an SUD including those who are by default involved in the care. |
| Communication | Primary Care/SUD Treatment Integration, Treatment, Recovery | **Having a shared Electronic Medical Record (EMR) is positive, but there is a need to figure out how to share info without breaking confidentiality laws**. There must be strong firewalls in any EMR which can be a barrier to integrated care. However, in an environment that still endures stigma this is essential. |

| GAP OR BARRIER | COMPONENT | DESCRIBE GAP(s) OR BARRIER(s) |
|---|---|---|
| **CATEGORY** | **SYSTEM** | **DESCRIPTION: Summarize concern and/or information.** |
| Communication | Primary Care/SUD Treatment Integration | **We need to create a "culture of engagement" where primary care providers are willing to engage in integrated SUD services.** Deliberate Integration with Primary Care providers seems to be the best model currently. PCP's need to be able to see that this model works first, then others will sign on. |
| GAP | Recovery | There are a limited number of trained Recovery Coaches in the Capital Area. Currently there are 5 Certified Peer Recovery Coaches in the Capital Area. |
| Gap | Recovery | **There is a lack of sober living facilities.** This gap has been identified by many stakeholders across the continuum as a major gap in the SUD service delivery system. |
| Gap | Treatment | **More resources are needed to stabilize individuals prior to receiving treatment.** The IDN has posted for 4 Peer Support Specialists and they will be trained in IPS and CPRW to support all local projects, including re-entry and Enhanced Care Coordination and MAT. |
| Gap | Treatment | **There is a lack of specialty treatment services (especially services for adolescents).** This has improved slightly as Choices Adolescent Program opened in January of 2017. But gaps still exist with regard to adolescent treatment ages 12 - 17 years old. |
| Gap | Treatment | **There is a gap in the array of services available in the region including inpatient, residential, partial hospitalization, housing, detox, refugee services and services for individuals with co-occurring disorders**. There is only one place in NH that currently takes an individual with a co-occurring disorder who is in distress which is Portsmouth Regional Hospital. Transportation is an issue with this option. |
| GAP | Treatment, Behavioral Healthcare | **There is very limited to no access to treatment in the community of Pittsfield.** Pittsfield area has improved it's supports around youth in the middle and high schools. The Pittsfield Interagency Coalition meets monthly to discuss high-risk students. "Stand Up Pittsfield" has been established to enhance collaboration and awareness of SUD services throughout the community. |
| Gap | Prevention | **There is a lack of prevention initiatives focused on high school population.** Currently 6 schools that participate in "Life of an Athlete" Program and 5 schools that have Youth Councils (although the councils were unfunded this year, some of them continue to meet). Pittsfield has both programs currently. |
| Gap | Treatment | There is a lack of adolescent treatment services. Already addressed above. |
| Gap | Primary Care/SUD Treatment Integration, Treatment, Recovery | Treatment providers need the benefit of Recovery Coaches at no cost to system. **(Medicaid expansion has assisted in providing funding for Recovery Coaches).** |
| Gap | Enforcement, Treatment | Police officers don't know how to assist individuals who are seeking treatment. The PD does not have a protocol for assisting individuals seeking treatment. There is a need for a road map/protocol. |

| GAP OR BARRIER | COMPONENT | DESCRIBE GAP(s) OR BARRIER(s) |
|---|---|---|
| **CATEGORY** | **SYSTEM** | **DESCRIPTION: Summarize concern and/or information.** |
| GAP | Recovery | **There is no formalized system to mobilize trained Recovery Coaches to be available to individuals after an overdose in coordination with the ER or post-assessment and pre-treatment/during waiting period**. Basic protocols have been established in the Capital Area. Regional Access Point Services will call HOPE for NH Recovery. A better integrated system is currently being evaluated and developed through IDN system of care. |
| Gap | Primary Care/SUD Treatment Integration, Treatment, Recovery | Training for primary care providers should include SBIRT, addiction, SCOPE training. |
| Gap | Recovery | Populations that are underserved include those previously incarcerated; younger people who don't have parental support; people at the poverty level who don't know what resources are available and how to access them. |
| Gap, Communication Collaboration | Primary Care/SUD Treatment Integration | More cross-training is needed for staff treating someone with SUD in settings where SUD treatment and primary care are integrated. |

*Updated 11/30/17*

***Summary***

Engaging community sectors, including key stakeholders from businesses, government, education, health, and safety, is a major responsibility of the Continuum of Care Facilitator. The Facilitator works to assure awareness and connectivity, develop capacity, and connect with the places where individuals and families go in their communities to seek help. The SUD landscape is ever-changing at multiple levels and new emerging initiatives continually arise. These factors can often pose challenges and have the ability to significantly impact CoC work.

# IV. Planning

The region has used information from the Capacity section to propose strategies and actions, or report on actions already taken, to maximize assets, address identified gaps, barriers, or concerns and to work toward achieving the region's continuum of care statement identified in the Assessment section. The planning process is ongoing and based on the identification, engagement and input of diverse community stakeholders and the integration of new information/data as it becomes available.


***Planning Process & Model***

The ACPIE (Assessment, Capacity, Planning, Implementation, Evaluation) is a planning model that encourages data-driven decision making to identify concerns, determine capacity to address those concerns, develop a plan to enhance the ability to address concerns, implement the plan, and evaluate results. The planning model is circular and will be used to inform adaptations based on results from implementing each component, and from the inclusion of new data, information, and input from new stakeholders.

### Capital Area CoC High Priorities and Actions 2017-2018

| Component | Priority Action |
|---|---|
| Prevention 1. | Increase community levels of collaboration and trust to build the capacity within the region for prevention activities. |
| Prevention 2. | Increase community stakeholder knowledge and skills regarding the extent of substance misuse in the community and effective prevention strategies. |
| Prevention 3. | Increase coordination of prevention activities in outlying or less engaged communities. |
| | |
| Identification / Intervention 1. | Promote the use of evidence-based screening tools to identify risk factors with primary care providers, 1st responders, and home care providers to increase early identification of Substance Use Disorders. |
| Identification/ Intervention 2. | Promote the use of standardized assessment tools to ensure coordination among providers. |
| Identification /Intervention 3. | Increase early identification of behavioral health concerns through promotion of Know the 5 Signs Campaign. |
| | |
| Treatment 1. | To ensure proper coordination of all available resources to providers so they can collaborate to manage care and transitions across the SUD Continuum. |
| Treatment 2. | To promote training opportunities to providers to increase capacity of the workforce. |
| Treatment 3. | Support IDN- MAT work group in efforts to increase capacity of MAT providers in the Capital Area. |
| | |
| Recovery Support Services 1. | Work with Recovery organizations to increase access and coordination of ancillary services. |
| Recovery Support Services 2. | Increase availability and capacity of recovery coaches in the Capital Area. |

| Component | Priority Action |
|---|---|
| Recovery Support Services 3. | Promote access to and awareness of recovery supports and services throughout the Capital Area. |
| *Edited 10/13/2017* | |

***Description of the planning and stakeholder engagement process***

A Continuum of Care Facilitator (CoC) for the Capital Area Public Health Network (CAPHN) was hired in October of 2016 and has actively worked with the Substance Misuse Prevention Coordinator (SMP) and community partners to engage and increase capacity of the CoC Work Group from its original size of roughly 14 stakeholders in 2015 to approximately 42 stakeholders in 2017 (200% increase in capacity). These regional stakeholders are leaders from various sectors such as healthcare, social services, safety, education, business, behavioral health providers and consumers. They represent a broad spectrum across the Substance Use Disorder (SUD) Continuum. Extensive outreach efforts took place over 8 months to engage the appropriate stakeholders through educational meetings, 1:1 individual meetings, business/community meetings, the Public Health Advisory Committee (PHAC) and various networking opportunities.

The engagement of regional stakeholders was collectively initiated through meetings with community partners and referrals from key stakeholders in the region from various sectors. Some important themes that helped shape the decision-making process to invite a partner to the CoC Leadership Team were the following:

1. The services they provided along the SUD continuum of care as they relate to areas of improvement identified in the 2016 Continuum of Care Assets and Gaps Assessment;
2. The ability of the stakeholder or community partner to address a particular area of need or gap;
3. The resources they could provide that were currently not utilized or underutilized across the SUD continuum that could help enhance and streamline the delivery of services.

***Role of CoC Facilitator***

The CoC Facilitator's focus has been on promoting awareness and connectivity across the continuum. While significant progress has been made in the region, additional outreach must take place with less-engaged and high-risk communities, as identified in the assets and gaps scan, the Community Health Improvement Plan, and other regional assessments. Working with the Substance Misuse Prevention (SMP) Coordinator and various prevention committees has afforded the CoC Facilitator the opportunity to increase community levels of collaboration and trust and help build capacity for prevention activities throughout the region *(CoC Priority 1 for Regional Prevention Strategy)*.

In addition, through presentations, panel discussions and staff meetings with educators, providers and the public, the CoC Facilitator has helped to inform people about substance misuse throughout region, which helped to engage more stakeholders in building effective prevention strategies. Partners have commented that they feel more informed about the effects of substance use disorders on individuals and communities as a whole. In addition, there seems to be a general increase in awareness concerning resources available in the region, according to ongoing observations by the CoC Facilitator. Training opportunities such as "Addiction and the Brain" and "Mental Health First Aid" have been identified as a need for first responders, due to compassion fatigue, that will be held in Spring/Fall 2018 *(CoC Priority 2*

*for Regional Prevention Strategy)*. To assist the SMP in the coordination of prevention activities in less engaged communities, the CoC is meeting with individual providers in these regions to establish connection and engagement in the initiatives of the Capital Area Public Health Network.

Throughout the past year, additional activities were implemented to provide education, outreach and engagement to the CoC Leadership Team, the Bureau of Alcohol and Drug Services (BDAS), providers, educators and the public to ensure the existence of informed community leaders. Examples include:

1. A presentation to the CoC Leadership Team by the Nashua Public Health and Community Services Director, Bobbie Bagley, who shared their experience with building a strategic plan for SUD delivery of services;
2. The CoC Showcase, where CoC's statewide presented regional developments to NH Charitable Foundation, BDAS Directors, and members of the Governor's Commission on Alcohol and Drug Abuse Prevention, Treatment, and Recovery;
3. Presentations to area coalitions by Subject Matter Experts such as: Audrey Clairmont, Lead Clinician of "Choices Adolescent Addiction Program" to Pittsfield Interagency Community Coalition (PICC); Shanna Large, Director, "Choices Addiction Program" (Adult) to Bow HR group; and Olivia Dupell, Granite Pathways representative, to Concord Metro Clinic.

Efforts have been made to engage prevention, intervention, treatment, and recovery service providers to identify geographic SUD services in the outlying areas and levels of SUD services available in the region. These outreach efforts were the beginning steps of utilizing the ACPIE model and furthering the development of *The 2016* Continuum of Care *Assets and Gaps Assessment.* Connecting subject matter experts with community partners to promote evidence-based programs, collaboration and support for SUD initiatives across the Capital region has provided continuity and better access to care across the SUD Continuum, although significant barriers and gaps remain evident.

In SUD Intervention, the CoC Leadership Team has worked to identify priorities for primary care providers, first responders and homecare providers that help pinpoint risk factors to increase early identification of substance use disorders; Promote the use of standardized assessment tools to ensure coordination among providers and; Increase early identification of behavioral health concerns through promotion of "Know the 5 Signs Campaign."

Additionally, the Treatment priorities for the CoC Leadership Team will address not only foundational aspects of the SUD Continuum such as; Ensuring coordination of resources among providers to support a more seamless transition across the continuum of care; Promoting training opportunities to providers, consumers and community partners to build capacity and increase knowledge of the workforce; And increasing understanding of Medication Assisted Treatment (MAT) as a treatment modality among community stakeholders, but will be providing information and resources to improve systems of care and integration of behavioral and medical healthcare. Developing action steps and plans to implement change to the degree possible in these areas will be paramount over the course of 2018.

***The following partners have contributed to the CAPHN Continuum of Care Development process:***

Shannon Bresaw, Granite United Way, Capital Area Public Health Network
Monica Edgar, Program for Addictive Disorders, Concord Hospital
Peter Evers, CEO, Riverbend Community Mental Health Center
Christopher Gamache, Tri-Town EMS
Jed Fiato, VolunteerNH!
Kristine Paquette, Homestead Inn Sober Living Community
Molly Rossignol, MAT Provider, Concord Hospital
Annika Stanley-Smith, Granite United Way, Capital Area Public Health Network
Terry Sturke, Riverbend
Donna Marston, Families Sharing Without Shame
Christopher Mulcahy, Program Director, New Season Clinic
Devin Oot, Executive Director, Partnership for a Drug Free NH
Bradley Osgood, Chief, Concord Police Department
Adam Brickner, Concord Probation and Parole
Aly McKnight, New Futures
Ron Sayres, MLADC
Dave Roarick, Chief, Hillsboro Police Department
Marilyn Sullivan, Bi-State Primary Care
Tamara Tessier, DCYF
Mary Reed, Granite United Way, Capital Area Public Health Network
Keliane Totten, Concord Regional VNA
Jim Doremus, Concord Family YMCA
Jeff Hatch, Granite Recovery Centers
Dominic DiNatale, VolunteerNH!
Jay Batchelder, Pembroke Academy
Kara Wyman, Merrimack County DOC
Karen Emis-Williams, Concord Human Services
Michele Merritt, New Futures
Kim Haley, Second Start
Doreen Shockley, Granite Pathways
Brian Mooney, HOPE for NH Recovery
Shanna Large, Director, Choices Addiction Recovery
Kathy Labonte, Northeast Delta Dental
Michelle Chadwick, Concord Regional VNA
Karen Morton-Clark, Granite Pathways
Kim Contant, Concord Hospital Behavioral Health

# V. Implementation

Using information garnered during the planning process, the region plans to implement the following proposed actions through shared responsibility with regional stakeholders. The work forthcoming will embrace CAPHN's vision of a continuum of care that addresses substance use disorders in a way that is comprehensive, integrated, robust and well-coordinated to meet the full spectrum of needs of individuals, families, and communities in the Capital Area. The Capital Area Continuum of Care (CoC) Development Work Plan below outlines more specifically the steps that will guide the work of the Continuum of Care Facilitator and the CoC Leadership Team for the current year.

## Capital Area - CoC Development Work Plan 2017-2018

| 1. **The CoC Facilitator will work with Subject Matter Experts (SMEs) and other regional partners to provide BDAS with an annual update of the regional assets and gaps assessment.** | | |
|---|---|---|
| *1A. Describe processes you will use to complete the update.* | | |
| **Activities:** | **By Whom:** | **Timeline/Progress Measure(s):** |
| 1. Update the Assets and Gaps Document based on new program developments in the region and information gathered from community stakeholders and SUD partners. | CoC Facilitator / SMP/ CAPHN members | Sept 2017 – June 2018<br>Evaluation Measures**:** Assets and Gaps Document |
| 2. Develop and disseminate a survey to a diverse group of stakeholders across the continuum and region to facilitate assessment process and Assets and gaps review. | CoC Facilitator/COC Work Group Chairs/ CAPHN | September 2017<br>Evaluation Measures: a) # of Updates b) Assets and Gaps Document |
| 3. Identify results of the survey and analyze top priorities. | CoC Facilitator /CoC Work Group Chairs/SMP | Sept. 2017 – October 2017<br>Evaluation Measures: Assets and Gaps Document |
| 4. Conduct ten 1:1 meetings with SUD stakeholders, community educators, the business sector, emergency personnel, and law enforcement to gather further information and build stronger relationships across the region. | CoC Facilitator | September 2017- June 2018<br>Evaluation Measures: a) # of Meetings held b) Meeting outcomes |
| *1B.* List SMEs and other stakeholders to be engaged.<br>• Governor's Commission Task Force<br>• Granite United Way<br>• Concord Hospital<br>• Riverbend<br>• Tri-Town EMS<br>• Region 2 IDN Project Manager<br>• New Futures<br>• Homestead Inn (Sober Living Housing for men)<br>• NH Provider's Association | • Hope for NH Recovery<br>• RAPS<br>• New Seasons Treatment Center (Concord Metro)<br>• Partnership for a Drug Free NH<br>• Concord PD<br>• Concord Probation and Parole<br>• New England RAW<br>• Second Start | • Hillsboro PD<br>• Bi-State Primary Care<br>• DCYF<br>• Concord YMCA<br>• Granite Recovery Centers<br>• VolunteerNH!<br>• Pembroke Academy<br>• Merrimack County DOC |

| **2. The CoC Facilitator will work with Subject Matter Experts (SMEs) and other regional partners to provide BDAS with an annual update of the regional CoC development plan.** | | |
|---|---|---|
| *2A. Describe processes you will use to complete the update.* | | |
| **Activities:** | **By Whom:** | **Timeline/Progress Measure(s):** |
| 1. Convene and facilitate a monthly CoC Work Group meeting to ensure on-going update of Assets and Gaps document. | CoC Facilitator/ CoC Work Group Chairs | <u>Monthly</u><br>Evaluation Measures: a) # of meetings held b) Meeting agenda c) Meeting minutes |
| 2. Reaffirm the high priority areas are current and have been researched By CoC SME's. | CoC Facilitator/ CoC Work Group Chairs | <u>Quarterly</u><br>Evaluation Measures: a) On CoC Meeting Agenda Quarterly for review b) Meeting minutes |
| 3. Conduct an annual strategic planning session with SME's, CoC Work Group, and others to identify barriers and gaps to SUD services and reaffirm priorities and sustainable solutions. | CoC Facilitator/ CoC Work Group Chairs/SME's | <u>Annually</u><br>Evaluation Measures: a) CoC Annual Report |
| 4. Provide BDAS with a quarterly update to of priority areas and progress within the SUD continuum and/or barriers that have been revealed through SPF process. | CoC Facilitator/CoC Work Group/ Regional SME's | <u>Quarterly</u><br>Evaluation Measures: a) Assets and Gaps Document b) Quarterly reports to BDAS |
| *2B. List SMEs and other stakeholders to be engaged.* | | |
| Stakeholders:<br>• CAPHN<br>• CoC Work Group (Listed in #1)<br>• SME's<br>• CoC F<br>• Regional Providers<br>• SMP | | |

| **3. Describe processes you will use to initially identify and then update as necessary at least three (3) high priorities/actions for each continuum of care component (Prevention, Early Identification and Intervention, Treatment, Recovery Support Services).** | | |
|---|---|---|
| *3A. Describe processes you will use to identify CoC component priorities/actions.* | | |
| **Process/Activities**<br>1. Schedule a meeting with the SMP to discuss Prevention strategies For youth in the Capital Area. | CoC Facilitator/SMP | Sept. 2017- October 2017<br>Evaluation Measures**:** Identification of focus areas for Prevention strategies. |
| 2. Develop and disseminate a survey to SME's across the continuum to gather information about challenges, successes, and priorities over the next year to evaluate with CoC Work Group for common themes. | CoC Facilitator/SME's | Sept. 2017 –December 2017<br>Evaluation Measures: a) Survey b)Survey Results c) Evaluation |
| 3. Conduct a review and prioritization of assets in the Capital Area through CoC Work Group. | CoC Facilitator /SME's/ | Sept 2017 – December 2017<br>Evaluation Measures: a) Assets and Gaps Document |
| 4. Meet with PHAC Coordinator to identify priorities as identified in the CHIP. | CoC Facilitator / PHAC Coordinator | Sept. 2017 - Dec 2017<br>Evaluation Measures: Meeting and Identified CHIP priorities. b) Alignment with CoC Work Group Plan |

| **4. Plan to facilitate and/or be significantly involved in processes that result in at least two (2) new programs being initiated and/or in the developmental process each contract year.** | | |
|---|---|---|
| *4A. Describe effort underway or to be taken that will result in development of two (2) new programs* | | |
| **Activities:** | **By Whom:** | **Timeline/Process Measure(s):** |
| **1.** Participate in appropriate IDN Work Groups and liaison information with CoC Work Group to ensure consistent communication. | CoC Facilitator/CoC Work Group/ IDN Work Groups | September 2017 – June 2018<br>Evaluation Measures: a) CoC Work Group meeting minutes b) Involvement in New Programs produced |
| **2.** Align services and initiatives with behavioral health to CoC Work Group. | CoC Facilitator/ CoC Work Group/Community stakeholders | September 2017- June 2018<br>Evaluation Measures: a) # of presentations b) Agenda c) Meeting minutes |
| **3.** Participate in relevant regional work groups to address needs across the continuum. | CoC Facilitator/ Community stakeholders/public | Sept. 2017 – June 2018<br>Evaluation Measures: a) # of attendees b) # Materials distributed to promote the event c) Evaluation and feedback |

*4B. List SMEs or other stakeholders engaged or to be engaged.*

**Stakeholders:**

- Regional SME's
- CoC Work Group
- CAPHN
- Community Partners
- CoC Facilitator
- IDN Work Groups

**5. Develop a plan to distribute and track number of information materials that help increase awareness and access to services.**

*5A. Describe activities that will support the distribution of materials to points in the community where people may go seeking information or help.*

| **Activities:** | **By Whom:** | **Timeline/Progress Measure(s):** |
|---|---|---|
| 1. Provide resources to wellness coalitions, schools and providers on Statewide Crisis Hotline, RAPS, Treatment Programs, and Recovery Programs. | CoC Facilitator/ CoC Work group/ CAPHN | <u>September 2017 – June 2018</u><br>Evaluation Measures: a) # of resources distributed b) # of meetings attended c) What resources distributed |
| 2. Develop with SME's a SUD "Resource Packet" that can be delivered to Town Halls throughout the region, libraries, community centers, churches, and civic organizations to bring provide support for local communities. | CoC Facilitator/SME's | <u>October 2017-June 2018</u><br>Evaluation Measures: a) # of packets made b) # of packets distributed |
| 3. Develop and implement a tracking program tool to log resources distributed, to what stakeholders and how many. | CoC Facilitator | <u>October 2017 – November 2017</u><br>Evaluation Measure: Approved tracking document |

*5B. List stakeholders to be engaged in distribution.*

**Stakeholders:**

- CoC Facilitator
- CoC Work Group
- Wellness Coalitions
- Youth Coalitions
- Businesses
- Health Departments
- Providers
- Schools
- Volunteers

| **6. Other Activities of Importance (Optional: Use to provide information on other important CoC development work that may not be adequately captured in the areas above.** | | |
|---|---|---|
| *6A. Describe other important activities.* | | |
| **Activities:**<br><br>*1.* Promote collaboration efforts and drive awareness of CoC initiatives throughout the Capital Region Public Health Network by collaborating with community stakeholders to produce a 3- minute PSA to air on the Public Access Channel. The PSA is aimed at informing the public of work being done to improve awareness, access, and a more streamlined SUD service delivery system. | **By Whom:**<br><br>CoC Facilitator/ BDAS/ Community Stakeholders | **Timeline/Progress Measure(s):**<br><br><u>Sept. 2017- December 2018</u><br>Evaluation Measures: Completed PSA product |
| *6B. List stakeholders engaged or to be engaged in these activities.* | | |
| Stakeholders:<br>• CoC Facilitator<br>• BDAS<br>• Community Stakeholders<br>• CAPHN | | |

***Work plan progress***

The CoC Leadership Team has met six times over the course of the past year (bi-monthly), with two additional workgroup sessions held in October 2017 and November 2017. The bi-monthly meeting times, typically one-hour meetings from 4-5 pm on the last Monday of the month, were moved to a different location to promote easier access for the Team and reflect a better environment with additional technical equipment. In addition, the CoC Facilitator increased the meeting times by 30 minutes starting in May 2017, to give extra time for discussion, training, and work. Each component of the continuum was well represented. In March of 2017, the CoC Leadership Team participated in a visual exercise where each member identified the component of the SUD Continuum that is a focus of their work. Through this exercise, we learned that each component (Prevention, Intervention, Treatment, and Recovery) was represented, with 12 members on average. This data showed great representation across the board, which indicates great depth and expertise across all areas of the continuum.

During this process, it is important to note that the CoC Facilitator sought guidance from area experts such as: Peter Evers, CEO, Riverbend Community Mental Health; Shanna Large, Director of "Choices" Addiction Program; Shannon Bresaw, VP of Public Health for Granite United Way; Mary Reed, Senior Director of Public Health, Granite United Way; and Annika Stanley-Smith, SMP for CAPHN, as well as others. It was identified the Leadership Team would benefit from some trainings as a group to better understand Capital Area issues and initiatives around: integration of behavioral and physical health; access to care; workforce development capacity; care transitions and the Integrated Delivery Network (IDN), as they are valuable pieces of an integrated services delivery plan. The Capital Area Public Health Network, the Providers Association, Concord Hospital, and Riverbend are valuable stakeholders and these collaborations offer a great opportunity for the resource development, planning and implementation needed for real change to occur on a large level.

In July, training by the Greater Nashua Public Health Division was held to promote strategic planning methods and offered the Leadership Team tools and models to think about as we began the process of developing a strategic plan for the Capital Area. The training outlined preliminary steps they used in the Collective Action/Collective Impact model such as forming a common agenda, reporting on common progress measures, developing mutually reinforcing activities and communications, and having a backbone organization to propel the initiative. Other models, such as the Strategic Prevention Framework were also discussed. These existing and ongoing partnerships across organizations and across the state have strengthened the work of the CoC Leadership Team and will help as we build upon data and evidenced-based models to provide a roadmap and recommendations for future actions.

The last few meetings in the Fall 2017 were a push to get priorities in place for each component and reach consensus. The goal was to identify and develop three priorities for each area of Prevention, Intervention, Treatment, and Recovery. In October, Leadership Team members met to decide on Prevention and Intervention. In November, Treatment and Recovery priorities were set.

The strategic planning process is time consuming and demands a comprehensive and deeper look towards the issues at hand and potential long-term solutions. While we know this process is important

and can have great impact on a larger scale of the population, we also recognize that we are in the midst of a public health crisis. A new report by the U.S. Centers for Disease Control shows New Hampshire had an overdose death rate of 39 per 100,000 in 2016, third-highest nationally behind West Virginia and Ohio[1]. For this reason, there is heightened community and even national political awareness around addiction and the impact on communities and our nation. Thus, during the planning process, programs are being implemented simultaneously and some of these actions directly impact planning and need to be taken into consideration.

For example, In January of 2017, Riverbend Community Mental Health opened the Adolescent "Choices" Addiction Program for adolescents and teenagers ages 12 and older. This was the first Intensive Outpatient Program of its kind in the state to address substance and opioid use among youth. Similarly, in October 2017, with collaboration between Riverbend and Merrimack County, the Merrimack County Drug Court was initiated to provide high risk, high need individuals who carry multiple felonies the opportunity to participate in an 18-month intensive rehabilitation program. In addition, the Campaign to Change Direction "Know the Five Signs" has increased awareness regarding recovery and mental health in the region. Former NH Supreme Court Justice John Broderick is promoting this national campaign statewide to address the stigma attached to mental health and substance use issues, which creates a significant barrier to people accessing the proper medical attention they need.

While positive steps are being taken to address substance misuse and mental health concerns in NH, other efforts continue to pose a threat for our communities working to address these issues. This past year the NH legislature passed a law loosening the penalties on marijuana possession. Essentially a decriminalization law, residents found with three-fourths of an ounce of marijuana will now face a $100 fine rather than jail time. While efforts to view substance use disorder as a chronic disease rather than a criminal behavior are valid steps to address stigma and the need for treatment, there are concerns about the impact of these laws on youth access and social norms. Additional ongoing efforts regarding legalization provide a clear indication that our communities must be aware and engaged in advocacy and political discourse concerning these issues.

The CoC Leadership Team is prepared to enter 2018 with a full agenda to work on addressing the assets and gaps of service delivery in the Capital Area. Below is the outline of proposed priorities and actions to be taken with indicated timelines. These priorities are the result of the planning efforts implemented by the CoC Leadership Team as described previously. The following tables are organized by CoC component and include identified priorities, baseline data (where available) that was used to determine the priority, and specific activities that must be implemented to address each priority. In addition, a brief description of proposed processes to enhance the implementation process and procedures to track progress toward anticipated outcomes are included.

## PREVENTION

[1] Hedegaard, H., Warner, M., and Miniño, A.M. (2017). NCHS Data Brief. Drug Overdose Deaths in the United States, 1999-2016. Retrieved from https://www.cdc.gov/nchs/data/databriefs/db294.pdf on January 17, 2018.

**Prevention Priority 1**: Increase community levels of collaboration to build the capacity & readiness within the region.

**Baseline (What we know right now):**

- 61 % of CAPHN Stakeholders reported an increased involvement with the prevention activities over the past year. (2017 CAPHN Stakeholder Survey)
- SMP Leadership Team has 9 members who represent the community supports, education, health & medical, safety/law enforcement, business sectors. Currently, there are no representatives for the government sector. As a network the lowest engagement is in the business, safety/law enforcement and government sectors.
- 84.6% of CAPHN stakeholders reported that as a region we were making moderate to great progress in building capacity. (2017 CAPHN Stakeholder Survey)

**Other Examples (What do you see from the community perspective):**

- Lack of workforce in law enforcement.
- Lack of communication/engagement/outreach.
- The limits of the SMP coordinator, only 1 person.
- Pace is too slow for how quickly issues arise and fall to the way side. Specifically, around EMS/Safety Law Enforcement, they need solutions now.

The Table outlines the CoC Priorities and actions across the continuum and identifies the people and groups that may be integral to strategically laying out the activities and processes involved to accomplish the goal. Each component of the continuum with be identified and the activities will evolve with actions taken.

**Take Action (What can we do as a group to reach this priority):**

| Suggested Activity: | Responsible Party: | Current CoC Workplan Activities: |
|---|---|---|
| Build relationships by identifying existing relationships in the CoC/SMP Leadership Team. | CoC Facilitator<br><br>SMP Coordinator<br><br>SMP Leadership Team<br><br>Coc Workgroup | • Increase sector representatives on the SMP Leadership Team, prioritizing under represented communities (Business, Government, Safety/Law Enforcement). (SMP 2018 Workplan, pg. 4)<br>• Partner with New Futures to identify 2 local government officials to possibly recruit for the SMP Leadership Team. (SMP 2018 Workplan, pg.4)<br>• Partner with F.A.S.T.E.R. and Hope for NH Recovery to identify 2 parents to possibly recruit for the SMP Leadership Team. (SMP 2018 Workplan, pg.5) |
| Improve communications from the region by; identifying the best communication format for each sector and providing content based on | CoC Facilitator<br><br>SMP Coordinator | • Research and promote reliable Prevention, Treatment & Recovery resource lists. (SMP 2018 Workplan, pg. 24) |

| | | |
|---|---|---|
| what the audience's role in prevention is. | | |
| Build relationships with Employee Assistance Programs to: identify SUD problems/barriers, increase awareness of SUD issues, and identify partners who can help. | CoC Facilitator<br>SMP Coordinator<br>Hope for NH Recovery | • Increase sector representatives on the SMP Leadership Team, prioritizing under represented communities (Business, Government, Safety/Law Enforcement). (SMP 2018 Workplan, pg. 4) |

**Prevention Priority 2:** Increase community stakeholder knowledge and skills regarding the extent of substance misuse in the community and effective prevention strategies.

**Baseline:**

- When people become engaged with CPAHN 88.4% report an "increased knowledge about causes, consequences and impacts of substance misuse". (CAPHN 2017 Stakeholder Survey)
- 73.1 % of respondents "learned new information about the extent of substance misuse in the community". (CAPHN 2017 Stakeholder Survey)
- 46.2% "learned new information about what they can do to reduce substance misuse." (CAPHN 2017 Stakeholder Survey)

**Other Examples:**

- Lack of understanding around "effective" prevention.
- Community members don't know what SUDs are and what causes them. "Alcohol is not a drug".
- Education Sector can struggle with finding the balance of providing necessary prevention programs vs. upsetting the parents.

**Take Action:**

| Suggested Activity: | Responsible Party: | Current CoC Workplan Activities: |
|---|---|---|
| Increase the knowledge of community members by: sharing what substance use disorders are, what prevention is, what causes substance use disorders, what is prevention doing to stop substance use disorders. | CoC Facilitator<br><br>CoC workgroup<br><br>SMP Coordinator<br><br>SMP Leadership Team | • Partner with New Futures, Partnership for a Drug Free NH, and other organizations to develop a presentation on how substance use disorders personally affect each sector. (SMP 2018 Workplan, pg. 8)<br>• Promote the Leadership Team by bringing members to professional development and community events at least 4 times. (SMP 2018 Workplan, pg. 6)<br>• Share Frameworks Institute's recommendations on prevention messaging to community coalitions, the Substance Misuse Prevention Leadership Team, and other community stakeholders to reflect effective prevention communication frames. (SMP 2018 Workplan, pg. 13) |

| Suggested Activity: | Responsible Party: | Current CoC Workplan Activities: |
|---|---|---|
| Increase the trust and value in prevention in community stakeholders by showing how prevention is making a difference. | SMP Coordinator | • Promote the 2017 Youth Risk Behavior Survey results through community presentations and reports to increase understanding of substance use trends. (SMP 2018 Workplan, pg.8)<br>• Develop a community presence by attending events such as recovery rallies, prevention trainings and other events at least monthly. (SMP Workplan, pg.5)<br>• Attend Continuum of Care workgroup meetings to increase collaboration across the continuum. (SMP 2018 Workplan, pg. 6)<br>• Arrange at least one presentation at a regional police department and/or a Sheriff's office to present on substance use disorders and the public health approach to prevention. (SMP 2018 Workplan, pg. 9) |

**Prevention Priority 3:** Increase the coordination of prevention activities in outlying or less engaged communities.

**Baseline:**

- 8 towns in our region (24 towns) have 0 prevention activities.
- 9 towns in our region only have 1 prevention activity.
- 7 towns have 2 or more prevention activities.

**Other Examples:**

- Public Health officers not involved.

**Take Action:**

| Suggested Activity: | Responsible Party: | Current CoC Workplan Activities: |
|---|---|---|
| Encourage involvement from the public health officers by attending at least 1 selectmen's meeting in each of the outlying towns. | CoC Facilitator<br>SMP Coordinator<br>CoC Workgroup<br>SMP Leadership Team | • Increase sector representatives on the Substance Misuse Leadership Team, prioritizing underserved communities. (SMP 2018 Workplan, pg. 4) |
| Conduct 1on 1 interviews with stakeholders to keep up to date on emerging threats and to increase engagement. | CoC Facilitator<br>SMP Coordinator | • Partner with the Continuum of Care Facilitator to collect 2-1-1 & Regional Access Point Services data to determine the number of calls requesting information around SUD services and compare that to available resources to determine gaps in the Capital Area. (SMP 2018 Workplan, pg. 21)<br>• Increase the collection of information around overdose deaths through sources like the Medical Examiners office, local police departments, fire departments, Emergency Departments, etc. (SMP 2018 Workplan, pg.27)<br>• Review overdose death and Narcan administration data |

| Suggested Activity: | Responsible Party: | Current CoC Workplan Activities: |
|---|---|---|
| | | quarterly with the SMP Leadership Team. (SMP 2018 Workplan, pg. 27)<br>• Identify content experts to provide information or present on emerging threats. (SMP 2018 Workplan, pg. 28)<br>• Keep up to date with emerging promising practices; evidence based practices, and evidence informed programs through prevention network meetings and the Governor's Commission Prevention task force meetings. (SMP 2018 Workplan, pg. 28)<br>• Promote the Partnership for a Drug Free NH's "Threat Alert" for emerging threats. (SMP 2018 Workplan, pg. 29)<br>• Educate on the use of the Drug Monitoring Initiative and other avenues of communication around emerging threats. (SMP 2018 Workplan, pg. 29)<br>• Develop a way to quickly educate schools and students on emerging threats. (SMP 2018 Workplan, pg. 29) |
| Keep stakeholders informed on prevention activities in the region. | CoC Facilitator<br>SMP Coordinator | • Develop a list of locations that are disseminating information about prescription drop boxes, and other means of reducing access, to ensure the public is receiving consistent and reliable information. (SMP 2018 Workplan, pg. 18) |
| Promote prevention activities that address stigma like Partnership for a Drug Free NH's Speak Up NH campaign. | CoC Facilitator<br>SMP Coordinator | • Distribute Partnership for a Drug Free NH's media campaigns through social media and community events. (SMP 2018 Workplan, pg. 13)<br>• Promote Partnership for a Drug Free NH's Speak Up NH Campaign. (SMP 2018 Workplan, pg. 22) |

## INTERVENTION/IDENTIFICATION

**Intervention Priority 1:** Promote the use of evidence-based screening tools to identify risk factors with primary care providers, first responders and home care providers to increase early identification of Substance Use Disorders.

**Baseline:**

- Current screens include:
  - Alcohol Use Disorder Screening Tool(AUDIT),
  - Drug Abuse Screening Tool(DAST),
  - Screening, Brief Intervention and Referral to Treatment (SBIRT)
  - Recovery Capital Index(RCI)

**Other Examples:**

- Adverse Childhood Experiences Tool (ACES)

| Suggested Activity: | Whose Responsible: | Current CoC Workplan Activities: |
|---|---|---|
| Identify the access points in the Capital Region so we can begin to identify risk factors of substance use disorders (SUD). | CoC Facilitator,<br><br>CoC Leadership Team,<br><br>Providers,<br><br>Home Care Providers,<br><br>Firefighters,<br><br>First Responders | • Increase sector representatives on the CoC Leadership Team, prioritizing non-represented partners on the Leadership team.<br>• Identify all access points in the Capital Area and where individuals access SUD services.<br>• Identify current screening tools and promote consolidation of tools to better standardize SUD process. |
| Partner with the Providers Association to promote SBIRT screening tool as the standard screening tool | CoC Leadership Team<br><br>Providers Association<br><br>CoC Facilitator | • In collaboration with the Providers Association, host an informational event that promotes SBIRT and inform providers of current CoC/SUD initiatives.<br>• Generate with CoC Leadership team a web-based resource guide that can be distributed among providers. |

**Intervention Priority 2:** Promote the use of standardized assessment tools to ensure coordination among providers.

**Baseline:**

**Current assessment tools:**

- EMS lacks standardized assessment tool for SUD
- IDNR2 -Core standardized assessment is required in all integrated practices including medical, behavioral, depression, substance use disorders, health questions and social determinants of health.
- Riverbend, Concord Hospital Medical Group and Primary Care Practices (DMHC – Concord)

**Take Action:**

| Suggested Activity: | Responsible Party: | Current CoC Workplan Activities: |
|---|---|---|
| Review laws and government policies for first responder liabilities to ensure maximum first responder abilities to address overdose emergencies to the fullest extent possible. | CoC Facilitator,<br><br>CoC Leadership Team,<br><br>New Futures | • Partner with New Futures to ensure current policies, laws and protocols maximize first responder abilities to respond appropriately to overdose events. |

| | | |
|---|---|---|
| Generate discussion around the "Next Step" of action towards a stabilization unit for the Capital Area (The group felt without a place to bring people who overdose to a stabilization facility, the repeated trips to Concord Hospital ED will continue) | CoC Facilitator<br><br>CoC Leadership Team<br><br>First Responders<br><br>Fire fighters<br><br>EMS personnel | • Set up meeting with providers, first responders, recovery professionals, and city officials and insurance providers to discuss steps to develop a detox /stabilization unit for the region. |

**<u>Intervention Priority 3:</u> Increase early identification of behavioral health concerns through the promotion of the Campaign to Change Direction "Know the Five Signs" Campaign.**

**Baseline: Current Promotion of Campaign**

- IDNR2 – Facebook Post
- PSA Campaign with Justice Broderick
- Pledge campaign
- Speaking engagements by Justice Broderick

**Take Action:**

| **Suggested Activity:** | **Responsible Party:** | **Current CoC Workplan Activities:** |
|---|---|---|
| Engage Justice Broderick in presenting "Know the Five Signs" for the CoC Leadership Team | CoC Facilitator<br><br>Justice Broderick<br><br>SMP or representative | • Set up a presentation with SMP to have Justice Broderick present his "Know the Five Signs" speech. |
| Work with SMP to promote the "Know the Five Signs" campaign to partners, under engaged communities at schools, town hall meetings and civic organizations | CoC Facilitator<br><br>CoC Leadership Team<br><br>Justice Broderick<br><br>SMP or representative | • Collaborate with Justice Broderick and partners to call schools who have not yet participated in "Know the Five Signs" Campaign and set up assemblies.<br><br>• Call local civic organizations and set up presentations in for their membership groups to promote the "Know the Five Signs" Campaign.<br><br>• Partner with area libraries to set up at least one presentation of the "Know the Five Signs Campaign" for the public. |

## TREATMENT

**<u>Treatment Priority 1</u>: Ensure coordination of resources among providers to support seamless transitions across the continuum of care.**

**Baseline:**

- SBIRT is not universally used.

**Other Examples:**

- There's no immediate place to send someone when they ask for help; for treatment or detox.
- There are limited detox beds that accept non-insured people or Medicaid insured people.
- We need a better triage system because not everyone needs detox.
- Post-acute withdrawal, as well needs coordination of care after recovery/treatment.
- Patient medical care lacks coordination from discharge and connection to a PCP.

**Take Action:**

| Suggested Activity: | Responsible Party: | Current CoC Work Plan Activities: |
|---|---|---|
| Encourage the use of SBIRT to providers not currently using it. | Treatment Work Group/ Stakeholders | • Identify current SBIRT providers in Capital Area and promote SBIRT trainings to engage other providers to use.<br>• Collaborate with The Providers Association to hold information session on SBIRT and utilize current providers to promote utilization. |
| Develop recommendations for providers, as part of a treatment plan or a discharge plan with a patient, to identify resources like PCPs and recovery supports. | Treatment Work Group/Partners/Providers | • Identify what information providers currently use and assist in developing a comprehensive list of SUD PCP's and Recovery supports from Assets and Gaps Assessment. |
| Promote training opportunities that focus on Harm Reduction. | Treatment Work Group/ Prevention professionals/ | • Initiate training opportunities that focus on harm reduction tools that can be utilized throughout primary care practices in a simple flyer or brochure or webinar. |
| Identify regional points of entry in the SUD continuum and develop a flow chart of transitions. | Treatment Work Group/CoC Leadership Team/ Area stakeholders | • Develop a Continuum of Care model for the Capital Area as it looks currently and develop a flow chart of SUD transitions across the continuum that identifies Gaps/Barriers in services. |

**<u>Treatment Priority 2</u>: Promote training opportunities to Providers to increase capacity of the workforce.**

**Other Examples:**

- Physician schedules are prohibitive to increasing services like MAT.
- There is a concern around sustainability of resources in the region.
- Challenges exist around ensuring reimbursement for increased physician services.

**Take Action:**

| Suggested Activity: | Responsible Party: | Current CoC Work Plan Activities: |
|---|---|---|
| Create a flow chart with all the access points along the continuum that shows the transitions and gaps through the care program. | CoC Leadership Team/ Treatment Team Work Group/Partners | • Identify Points of entry into the current SUD system of care and work and begin to identify barriers/Gaps with Access Points throughout the Capital Area and look to current services to possibly leverage to meet needs. |
| Promote an inventory of the continuum of care treatment providers. | Treatment Team Work Group/Providers Association/Community Partners | • Collaborate with RAPS. 211, NH Crisis Addiction Line to identify current providers and services and develop a process to identify provider by services offered. |
| Promote trusted community resources, i.e. RAPS, 2-1-1, NH Treatment Locator. | Treatment Team Work Group/ BDAS/ Community Partners/ | • Build a survey to stakeholders in outlying communities and Concord Area that will identify what they are looking for in terms of materials to assist them in being more informed in the Region. |
| Host a presentation from the IDN to compare activities, ensure collaboration and breakdown any duplication. | Regional IDN Partners/CoC Treatment Team Work Group/ Stakeholders | • Work with IDNR2 Coordinator to hold a presentation/update on activities and identify possible areas of collaboration and support for SUD services. |

**<u>Treatment Priority 3</u>: Increase understanding of Medication Assisted Treatment as a treatment modality among community stakeholders.**

**Other Examples:**

- There is a lack of understanding and bias around MAT.
- People from abstinence based communities need a better understanding of how MAT treats SUD and the long-term goals of the treatment modality.
- Increased awareness around and understanding of MAT

**Take Action:**

| Suggested Activity: | Responsible Party: | Current CoC Work Plan Activities: |
|---|---|---|
| Host a training or webinar on the Harm Reduction Model of MAT. Include stories of the successes of MAT and the many pathways to recovery including the abstinence based model. | Treatment Work Group/Stakeholders/MAT Providers | • Collaborate with current MAT providers to hold a training on the Harm Reduction Model of MAT. Work with stakeholders, MAT SME's to develop simplified presentation to the public and others on the validity of MAT and other pathways to recovery including abstinence –based model. |
| Present a training on what the goals are in MAT treatment. | MAT SME's /Treatment Work Group/ stakeholders | • Collaborate with Recovery providers on hosting a presentation on Addiction and the Brain including information on MAT and goals in this treatment |

| | | |
|---|---|---|
| | | modality. |
| Identify trainings for the workforce like Harm Reduction, X – waiver, MAT, and ways to incentivize attendance for providers. | MAT Work Group/ providers/ stakeholders | • Promote MAT as a treatment modality in the region with a presentation by SME's in outlying communities and in Capital Area. |

## Recovery

**<u>Recovery Priority 1</u>: Work with recovery organizations to increase access to and coordination of ancillary services.**

**Baseline:**

- Recovery support organizations effectively provide information to their clients.

**Other Examples:**

- Organizations across the continuum would benefit from information sharing regarding ancillary services.

**Take Action:**

| Suggested Activity: | Responsible Party: | Current CoC Work Plan Activities: |
|---|---|---|
| Identify ancillary services that exist in the Capital Area and different providers to share this information with them. | Coc Recovery Work Group/Community Partners/ CoC Leadership Team | • Develop a current database of Ancillary Services in the Capital Area. Identify Insurance coverage benefits that coincide with service providers. Include Peer to Peer recovery supports. |
| Part I: Identify what "Recovery Organization" means in this context as there are different perceptions out there. | CoC Recovery Work Group/ Recovery Providers/ Stakeholders | • Identify and define the term "Recovery Coach" as it is used in SUD services. |
| Identify transportation services presently and look at ways to increase access to these services. | CoC Recovery Work Group/Transportation providers/community Stakeholders | • Evaluate current transportation services; what they provide; what services are covered by insurances; gaps in services. |

**<u>Recovery Priority 2:</u> Increase the capacity of recovery coaches in the Capital Area.**

**Baseline:**

- Need a cost benefit analysis of recovery supports and reducing barriers to sustainable recovery.

- What would the perfect system look like? We need to build a model to better explain what NH is doing.

**Take Action:**

| Suggested Activity: | Responsible Party: | Current CoC Work Plan Activities: |
|---|---|---|
| Part II. Educate on the different qualifications of the recovery field and different language that's used in recovery supports. | CoC Recovery Work Group | • Once Part I is completed, develop a listing of qualifications inherent with each term and its use in the recovery field. * Look to identify potential resources for Peer Recovery Coaches and ways to increase capacity. |
| Research a cost-benefit analysis that would show the difference that recovery supports make in reducing barriers to sustained recovery. | CoC Recovery Work Group | • Identify data that supports evidence-based information about cost-benefit analysis of recovery supports in reducing barriers to resources and sustained recovery. |
| Build a model to explain the current system in NH and the Capital Area. | CoC Recovery Work Group/Recovery stakeholders | • Begin to develop and current system visual model of the Peer Recovery Support model and identify service area gaps in system. |

**<u>Recovery Priority 3</u>: Promote Access to and awareness of recovery supports and services throughout the Capital Area.**

**Baseline:**

- The community doesn't know what already exists.
- Who should be the focus of outreach? The 10% of people with a SUD or the whole population?

**Take Action:**

| | | |
|---|---|---|
| Develop outreach plan to the community on what recovery resources already exist. | CoC Recovery Work Group/Community based resources/Recovery partners | • In collaboration with other SUD promotional efforts, coordinate outreach efforts on recovery resources that are currently available to people with SUD. |
| Develop a presentation on all the different recovery models to promote those opportunities. | CoC Recovery Work Group/Recovery Partners/Stakeholders/First Responders/Hospital Partners/Providers | • As part of public outreach efforts, incorporate and promote recovery models to engage all different types of recovery pathways. |
| Identify recovery supports, not just recovery centers but faith based, NA, AA, SMART, self-help, refuge recovery, 3 principles, etc. | CoC Recovery Work Group/Recovery partners/ Faith based Communities/ Service Organizations/Support Groups | • Explore alternative recovery supports and possible services that are offered in the Capital Area. Promote these services as part of a comprehensive resource to stakeholders and community partners in the region. |
| Identify a main access point for | CoC Recovery Work | • Identify and explore one main access |

| | | |
|---|---|---|
| this information; whether its RAPS, etc. | Group/Referral Networks | point for information regarding recovery information – one that we can all promote. |
| Promote resources based on the Public Health calendar; i.e. September is Recovery month. | CoC Recovery Work Group/ Chamber of Commerce Business Network/Public Health Community Partners. | • Leverage existing Recovery resources by developing recovery-oriented activities around current Public Health Calendar Events in the Capital Area. |

# VI. Evaluation (and Monitoring)

The CoC development work is guided and supported by BDAS and a designated program manager to ensure consistent, thorough, and strategic processes and plans are followed that align with regional goals, the NH State Health Improvement Plan, and the Capital Area 2016 Needs Assessment so that continuity exists at the various levels of engagement. The Capital Area Public Health Network is poised with dedicated, passionate stakeholders and community partners to initiate change that will reflect in a robust, collaborative, and integrated service delivery system that answers the needs of individuals, families and communities concerning substance use disorders. The CoC Facilitator, Capital Area Public Health Network staff, Granite United Way contract administrator, and community stakeholders will evaluate and monitor the Continuum of Care Development Plan on an ongoing basis. Goals and objectives that have been determined will be readily measurable on a quarterly and annual basis as described within the workplan. Specific, attainable benchmarks will be documented by assigned work groups using evidence-based strategic approaches to identify and achieve outcomes. By applying the principles of the ACPIE model and utilizing subject matter experts to guide the process, key community stakeholders, the Public Health Advisory Committee (PHAC), providers and mental health professionals will be informed to assist in helping to solve and mitigate barriers to excellent service delivery and solve complex public health priorities.

# VII. Conclusion

The Capital Area Continuum of Care Development Plan, along with the Capital Area Community Health Improvement Plan 2015-2020, the Capital Area Substance Misuse Prevention Strategic Plan 2016-2019, the 2016 Capital Region Health Needs Assessment, and the Region 2 IDN project set the stage for the Capital Area to move forward on a very complex issue in a deliberate, strategic way that minimizes risk and maximizes opportunities to achieve positive outcomes over the next 12 months. Funding opportunities will present additional resources to leverage assets and build on existing programs to achieve positive health outcomes, increase awareness of SUD as a disease, and demonstrate the effectiveness of prevention, intervention, treatment, and recovery strategies. Our goal over the next year will be to build strong, healthy community environments and adequate resources to decrease the impact of substance misuse and improve the overall health and well-being of Capital Area community members

*For more information on the Capital Area Public Health Network and the Continuum of Care scope of work, please contact Pam Littlefield, Continuum of Care Facilitator by email at plittlefield@riverbendcmhc.org, by phone at 226-7505 x4733 or visit www.capitalareaphn.org.*