Cheshire Medical Center

Getting it Right Inside – On Substance Misuse

FINAL REPORT

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Center for Health and Learning

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Introduction

The Center for Population Health, Strategy and Practice at Cheshire Medical Center/Dartmouth Hitchcock (CMC) contracted with the Center for Health and Learning (CHL) in May, 2017 to assist in completing a project called "Getting it Right Inside – On Substance Misuse" (CMC-GIRI).

CHL was contracted to assist CMC to:
- Understand the burden of substance misuse on the organization;
- Inventory substance misuse programs, activities and services;
- Identify gaps in services using a best-practice framework;
  Measure the organization's readiness to expand services across the continuum of care (prevention, intervention, treatment, and recovery support).

This report summarizes the outcomes of this work and provides recommendations for CMC to consider moving forward.

Definitions

Substance Misuse is defined as the use of a drug for a purpose not consistent with legal or medical guidelines.[1]

Substance Use Disorders **(SUD)** refers to the recurrent use of alcohol and/or drugs causing clinically and functionally significant impairment.[2]

Burden of Substance Misuse

Process and Overview

CMC was interested in understanding the burden of substance misuse on services and developed a list of current and potential data sources related to this issue. CHL conducted an online search related to identifying measures of substance misuse in local and regional settings in order to inform this work. CHL also checked with Vermont and national epidemiologists to determine if a review of data related to substance misuse burden was available from other settings. In addition, CHL read resources related to societal and state/county heroin and alcohol use. These activities did not yield new measures of burden, however, it is important to note that the problems associated with alcohol use exceed those of illicit drug use.

Gaps in Data

CHL reviewed the data sources identified by CMC and identified the following gaps in data:

1. Employee Assistance Program – data that tracks employee screening, intervention and referral;
2. Related diagnosis data – data for related diagnoses and services could include chronic pain, injuries from falls and accidents, Driving Under the Influence, etc.
3. Emergency Department – data related to the percent of total patients admitted to the E.D. that are screened, assessed, diagnosed, and related referrals, etc.

Need for Sustainable Approaches to Data Collection

Measuring the burden of substance misuse is a large and emerging field that points to the need for sustained investment in healthcare and non-healthcare related strategies that reduce the likelihood of abuse and provide care and support for users to overcome the disorder. There is some emerging attention to this at the state or county level. For example, John S. Searles, Ph.D., Substance Abuse Research and Policy Analyst, and Chair, with State Epidemiological Outcomes Workgroup at Alcohol and Drug Abuse Programs with Vermont Department of Health, is working to gather evidence and measures of the burden of substance use at the state level. Vermont

Department of Health plans to follow procedures developed by the Pacific Institute for Research and Evaluation (PIR) (primarily Ted Miller), the WHO Global Burden of Disease Group, and the Institute for Health Metrics (http://www.healthdata.org/gbd). This review did not yield new individual measures or a scheme of measures to inform a hospital's systems work. See **Appendix 1:** *Summary of Important Citations Related to Burden of Use.* [3,4]

Recommendations for Measuring Burden of Substance Misuse

1. Focus on data related to early intervention. With systems planning, screening in the Primary Care (PC) setting should lead to effective pathways of care, which include intervention, treatment, and recovery supports. It is critical that the pathway to care is identified, and it should be a priority to track the number of patients referred to treatment and other services within the pathway. It is well understood that PC providers are hesitant to screen and assess if they are unclear about a pathway to care.

2. Engage CMC Primary Care and Behavioral Health through an integrated model to establish screening and assessment, which is tracked within the Electronic Health Record.

3. Work closely with the Employee Assistance Program to establish data collection on the CMC employee population.

4. Work with the CMC Emergency Department to integrate the tracking of substance use disorder (SUD)-related admissions, screening and assessment.

5. Consider data on related measures of burden which may include:
   - impaired driving
   - violence
   - incarceration and crime
   - treatment, chronic infectious disease, e.g., HIV, Hepatitis B and C, and Tuberculosis, and their treatments, treatment of neonatal abstinence syndrome
   - lost productivity
   - death by heroin overdose
   - child abuse

6. Consider collecting data related to times when providers are diverted from caregiving in order to provide testimony, or meet other demands required by substance misuse.

Inventory of Substance Use Disorder Services

Process and Overview

CMC desired to collect information from leadership and providers at CMC about services for substance misuse or substance use disorders (SUDs). The purpose of the survey was to determine current services and the barriers to offering more services. CHL made recommendations to the CMC-GIRI team on the adaptation of a tool previously used to assess gaps in services. The result was a *Substance Use Disorder Services Survey*. CHL suggested that the organization of the tool reflect key components of national best practice models for integrated services, and that services be listed under categories representing a continuum of care (Prevention, Intervention, Treatment, and Recovery).

The Survey asked about services provided in the department in which the staff work, the extent to which they see presenting signs of substance misuse in their practices, and barriers related to the offering of substance misuse or substance use disorder services. The Survey was further revised by the CMC-GIRI Team and piloted in June 2017.

The *Substance Use Disorder Services Survey* was developed by the CMC-GIRI team, vetted by CHL and implemented by online survey to a total of 340 people, with 89 respondents representing a 25.9% response rate. Forty percent (n=34) of respondents reported seeing one or more adult patients and 10% (n=9) reported seeing

one or more children (under age 18) each week who self-reported signs/symptoms of substance misuse. With regard to services, less than 9% (n=10) provided individual or group counseling and/or intensive outpatient services, and 15% (n=13) provided medication-assisted treatment to patients. Serious barriers to providing substance misuse or SUD services included insufficient workforce and capacity at CMC and in the community, lack of appropriate levels of care, and patient insurance issues. Other barriers included lack of will, support, direction and/or comprehensive approach to address the problem, and insufficient time. Priority services for CMC in the future were identified as all forms of treatment, detoxification, M.A.T., and care management. A limitation of the survey implementation is that those who responded may be most highly motivated to address this issue because it is part of their job to do so, rendering a skewed response rate for services offered. See **Appendix 2**: Substance Use Disorder Services Survey: Inventory of Services and Perceived Barriers: Questions & Data for detailed questions and responses**.** For more information, contact Linda Rubin, lrubin@cheshire-med.com

Summary of Findings

1. Of respondents, 40 is the median number of providers and staff who indicated providing SUD education and resources, screening and assessment, referrals to community-based treatment and recovery support services, and referrals to primary care.
2. Less than 10 respondents indicated providing individual or group counseling, and intensive outpatient and residential treatment.
3. Thirteen respondents indicated providing medication-assisted treatment to patients.
4. Of 69 respondents, 34 reported seeing one or more adult patients each week who show signs/symptoms of substance misuse.
5. Of 69 respondents, 5 reported seeing more than ten adult patients each week who show signs/symptoms of substance misuse.
6. Of 68 respondents, 34 reported seeing one or more adult patients each week who self-report having a problem with substances.
7. Of 72 respondents, 9 reported seeing one or more children (under age 18) each week who show signs/symptoms of substance misuse. Two respondents reported seeing more than 10 children each week who show signs/symptoms of substance misuse.
8. Of 72 respondents, 6 reported seeing one or more children (under age 18) each week who self-report having a problem with substances. One respondent reported seeing between six and ten children each week who self-report having a problem.
9. The five most "serious" barriers to providing (38.5% - 66.7% rated these as serious) substance misuse or SUD services in their departments were identified as:
    a) Insufficient workforce in the community (66.7%)
    b) Appropriate level of care is not available (65.2%)
    c) Insufficient workforce capacity at CMC-DH (56.1%)
    d) Patient does not have insurance or can't afford out of pocket costs (46.2%)
    e) Low reimbursement rates from insurance providers for SUD services (38.5%)
    Additional barriers identified that which were not part of the list of choices include:
    a) Lack of will to tackle this problem
    b) Lack of a comprehensive approach to addressing the problem with patient
    c) An absence of support and/or direction within the organization
    d) There is insufficient time to address SUD issues the current way in which care is provided

10. Services that should be added at CMC-DH include: treatment (all forms); detoxification; MAT; and care management.

Community Readiness

Process and Overview

CHL created a *Community Readiness Tool* adapted from Tri-Ethnic Center for Prevention Research[5] at Colorado State University, and conducted ten interviews. The purpose was to assess the readiness of staff across disciplines to take action to address substance misuse through delivery of services at CMC. The CMC-GIRI Team identified ten interviewees representing high levels of leadership at CMC, and a range of perspective. Interviews averaged 45 minutes, with one 20-minute interview. Participation was voluntary. Respondents showed consistent willingness to be involved and were engaged in the interview process. Interviews were recorded with written documentation noted. See **Appendix 3**: Community Readiness Interviewee Roles.

Analysis

Two CHL staff reviewed and scored each interview using the Tri-Ethnic Center rating scale for each Dimension of Readiness. An average score was calculated. Table 1 provides average Readiness Scores and Intervention Goals. Readiness Dimensions, average Readiness scores per Dimension, corresponding Readiness stages (listed below), strategies to improve Readiness scores, major qualitative themes from interviews, and associated Best Practice Framework components are presented in Table 2. Best Practice Framework components were pulled from the *Best Practice Models for Substance Misuse Delivery* document prepared for CMC-GIRI to illustrate under which areas of the Best Practice Model strategies to improve Community Readiness fall.

The nine Readiness Stages and their associated scores are as follows: No Awareness (1.0-1.99); Denial/Resistance (2.0-2.99); Vague Awareness (3.0-3.99); Preplanning (4.0-4.99); Preparation (5.0-5.99); Initiation (6.0-6.99); Stabilization (7.0-7.99); Expansion/Confirmation (8.0-8.99); Community Ownership (9.0-9.99). To further understand the Stages of Community Readiness, see **Appendix 4:** *Descriptions of Readiness Stages and Dimensions – Tri-Ethnic Center, Community Readiness Handbook.*

Table 1: Average Readiness Scores and Levels with Intervention Goal (n=10)

Readiness Dimension	Average Score	Readiness Stage	Stage-specific Intervention Goal
Leadership	**6.18**	Initiation	Explicit commitment to next efforts
Community Climate	**5.98**	Preparation	Capacity-building and planning
Community Knowledge of Efforts	**5.90**	Preparation	Capacity-building and planning
Community Knowledge of the Issue	**5.60**	Preparation	Capacity-building and planning
Resources	**4.45**	Pre-planning	Identify organizational resources, revenue sources, and cost savings

Table 2: Detailed Readiness Dimensions, Scores, Stages, Strategies, Major Themes, and Best Practice Framework Components (n=10)

Readiness Dimension	Avg. Score Per Dimension	Corresponding Readiness Stage	Strategies to Improve Readiness Score (*Adapted from Tri-Ethnic Center Recommendations*)	Major Themes	Associated Best Practice Framework Components
Leadership – *What is leadership's attitude toward addressing the issue?*	6.18	**Initiation** *At least some leadership **plays a key role** in planning, developing, and/or implementing new, modified, or increased efforts. Leadership is **actively involved in ensuring or improving the long-term viability** of efforts to address this issue.*	**Schedule group meetings** with leaders to update them on progress of expanding efforts to maintain buy-in and ensure communication across teams. **Begin to prepare evaluation** methods for intermediate- and long-term tracking & communication of effort impact to key leaders.	**Leadership is significantly concerned about substance misuse.** This is due to awareness about its significance as a central issue to the community and to the hospital as it impacts CMC staff and finances. Both leadership and the general staff population at CMC are **committed to the health of the community they serve.** This is a guiding principle to the work and **why addressing substance misuse feels like a priority to most people.**	**Leadership Support** **Care Coordination** **Workforce Development** **Information Technology** **Financial Incentives & Modeling**
Community Climate – *What is the community's attitude toward addressing the issue?*	5.98	**Preparation** *The attitude in the community is of **concern**, **"we want to do something about it"**, and for many, **"this is our responsibility"**. Some community members are involved in addressing the issue.*	**Hold one-on-one or small group meetings** to recruit a team dedicated to educating CMC community about substance misuse efforts. **Offer opportunities for community members to get involved** or take on leadership roles. Include incentives for this work.	**Most of the CMC community recognizes substance misuse as a central problem** and wants to support efforts to address it. Substance misuse is a significant concern **because it is a high-profile issue in the community and has an impact on the hospital system.** CMC sees a significant amount of people coming into the hospital with SUDs and **how it impacts the patient, family, and the community.**	**Leadership Support** **Workforce Development**
Community Knowledge of Efforts – *How much*	5.90	**Preparation** *Most community members **have at least heard of and**	**Hold one-on-one or small group meetings** to recruit a team dedicated to educating CMC community about	Participants have a variety of **awareness levels about efforts to address substance misuse** across the	**Leadership Support** **Workforce**

Table 2: Detailed Readiness Dimensions, Scores, Stages, Strategies, Major Themes, and Best Practice Framework Components (n=10)

Readiness Dimension	Avg. Score Per Dimension	Corresponding Readiness Stage	Strategies to Improve Readiness Score (*Adapted from Tri-Ethnic Center Recommendations*)	Major Themes	Associated Best Practice Framework Components
does the community know about current programs and activities?		*have basic knowledge* about *the efforts.*	substance misuse efforts. **Key stakeholders or team develops a** communication plan to educate and update the CMC community about efforts and goals to address substance misuse, and a training plan for those employees who require it. Think about accessibility: email communication, presentations, bulletin boards, information vocalized by leaders during team meetings, for example. *For those with lower awareness of services, consider using story-driven communication in addition to the facts about efforts.* **TO CONSIDER:** **Workforce recruitment, development and retention are issues** – recruiting adequate behavioral health providers to engage in programs addressing substance misuse. This may need to be a focus as you develop your action plan moving forward. Attention needs to be focused on cultural considerations and behavioral strategies for **staff at CMC who work directly with patients with SUDs. Participants mention staff feeling frustrated, a concern about personal harm, and developing misconceptions** about *who are* people with SUDs (grouping them together because some exhibit difficult behaviors). New efforts should include a focus on	continuum. Most efforts lie in the prevention, intervention, and treatment spheres, while recovery support has fewer efforts or lower awareness. Almost all respondents identify the *Mothers In Recovery* Program, and note that while there are other efforts, they may not be "formal" programs. **There are misconceptions around the number and extent of services offered** – both underestimating and overestimating services and their financial realities. Not all participants believe that CMC community members have misconceptions around current efforts. However, those who do have misconceptions tend to **because of a lack of communication or lack of knowledge** (whether about efforts or substance misuse in general).	**Development** **Information Technology**

Table 2: Detailed Readiness Dimensions, Scores, Stages, Strategies, Major Themes, and Best Practice Framework Components (n=10)

Readiness Dimension	Avg. Score Per Dimension	Corresponding Readiness Stage	Strategies to Improve Readiness Score (*Adapted from Tri-Ethnic Center Recommendations*)	Major Themes	Associated Best Practice Framework Components
			mitigating these issues.		
Community Knowledge of the Issue – *How much does the community know about the issue?*	5.60	**Preparation** *Community members generally have **basic knowledge** about the issue and are **aware that it occurs locally**.*	**Hold one-on-one or small group meetings** to recruit a team dedicated to educating CMC community about substance misuse and its impacts. **Increase the number of articles and lunch-and-learn sessions** about substance misuse; for example, screening an education documentary during lunch hour. The purpose of this is to further educate CMC community and address existing misconceptions about the issues that impact substance misuse.	Knowledge within the CMC community about the issue and its impact, as well as current CMC efforts to address the issue, **seems to depend on whether the issue or efforts are communicated across staff, and how intimately substance misuse issues are a part of a staff member's role**. Based on these factors, participants share a range of perspectives; for example, housekeeping and maintenance staff whose roles are not clinical.	**Leadership Support** **Workforce Development**
Resources – *What resources are being used or could be used to address the issue?*	4.45	**Pre-planning** *There are **limited resources** that could be used for further efforts to address the issue. Some new **resources have been identified**, and some community members may be actively working to secure these resources. (Themes arose around the limitations of resources and competing priorities - something to keep in mind when developing an action plan.)*	**Hold one-on-one and small-group meetings** with key leaders and stakeholders to determine opportunities for funding expansion of services or re-allocating financial resources. **Focus messaging on prevention & continuum of care**. Emphasize the importance of preventative & early intervention screening and coordination of primary care. **Create team dedicated to developing strategies to increase funding streams**. Focus on private funding (grants & foundations).	**Most of the CMC community recognizes substance misuse as a central issue** and wants to support efforts to address it. The **main barrier to doing so is lack of financial resources**. Although addressing substance misuse is identified as a priority, **it competes with other existing priorities**. Discussion about resources for the efforts to address substance misuse **focus on financial and human resources**. These areas of concern are mentioned without specificity about what financial incentives or approaches to human resources may be used to address the problems or	**Leadership Support** **Workforce Development** **Financial Incentives & Modeling**

Readiness Dimension	Avg. Score Per Dimension	Corresponding Readiness Stage	Strategies to Improve Readiness Score (*Adapted from Tri-Ethnic Center Recommendations*)	Major Themes	Associated Best Practice Framework Components
			<u>TO CONSIDER</u>: **There is a need to identify and sustain a variety of funding streams** given the increase in patients identified with substance misuse or SUDs. Participants note grant funding, philanthropy, state and federal funding/Medicaid, Dartmouth, donors (for prevention awareness) and other external supports (while noting that state and federal support is not increasing). A few mention re-allocating resources internally, although others mention competing priorities.	build a service delivery system. Participants mention how **CMC supports efforts to address substance misuse through partnership with other service providers in the community.** There are several references to CMC/DH's role as a community partner, rather than as an institution that "provides it all". There is high awareness among interviewees that **financial allocation for substance misuse comes from the general operating budget**. Awareness about additional, specific funding opportunities is low among interviewees. Participants feel there needs to be a **focus on grants and philanthropy** for future funding sources.	

Key Concerns About Community Readiness

These issues, questions, and themes emerged during interviews and warrant further treatment:

There is a perception of a lack of formal prevention programs specifically to address the substance misuse issue, which is perceived as being on the rise. There is awareness of efforts looped into existing wellness programs and ambulatory practices, but not formal programs.

Mothers In Recovery **as an example for future efforts and is referred to often as the formal program for intervention.** People know about it because there were significant marketing and communication efforts put behind it. Ambulatory practices are also often mentioned.

There is a need to focus on communication about efforts to address substance misuse in the organizatoin to staff across the organization. There are misconceptions stemming from a lack of knowledge and information, and/or because addressing substance misuse is not formally identified in the staff member's role at CMC.

There is agreement that addressing substance misuse requires that CMC explore new and strengthen existing partnerships. With competing priorities and limited resources, respondents recognize the value of partnering with service providers in the community. CMC is not trying to "own" the entire continuum of care regarding substance misuse. The Board should be engaged in this work. The Monadnock area is in need of a provider structured like Brattleboro Retreat.

There is a need to identify and sustain a variety of funding streams given the increase in patients dealing with substance misuse or SUDs. Participants note there may be opportunities for grant funding, philanthropy, state and federal funding/Medicaid, donors (for prevention awareness) and other external supports (while noting that state and federal support is not increasing). A few mention re-allocating resources internally, although others mention competing priorities.

Attention needs to be focused in staff development on cultural considerations and behavioral strategies for staff at CMC who work directly with patients with substance misuse. Respondents mentioned that staff feel frustrated with the behavior of people who have SUDs, are concerned about personal harm, and that there are misconceptions about *who* people with SUDs are, e.g., grouping them together because some exhibit difficult behaviors.

CMC does not have and is in need of behavioral health counseling resources for substance misuse treatment.

Workforce recruitment, development and retention is an issue and there is a need for mental health providers to work in programs addressing substance misuse.

The Electronic Medical Record needs to be improved to facilitate communication across providers and EMRs. Information needs to be easily and confidentially communicated to facilitate a coordinated care process.

For a list of quotes from interviews to further illustrate the above recommendations, please see **Appendix 5**: *Community Readiness Interview Quotes Aligned to Recommendations.*

Tri-Ethnic Center Recommendations for Action Planning

Tri-Ethnic Center[6] recommends steps for using the Community Readiness data for organizational action planning. The steps are outlined below.

1. **Develop 2-3 goals around your issue.** Tri-Ethnic Center recommends you focus on raising your lowest Community Readiness Dimensions. For example, for CMC these would revolve around the bottom 3: Community Climate, Community Knowledge, and Resources. (*p.32 of CR Handbook*)

2. **Conduct a SWOT (Strengths, Weaknesses, Opportunities, Threats) analysis** to help identify the internal and external realities that impact CMC in order to help you move forward on your action plan. (*p.33-36 of CR Handbook*)

3. **Refine your earlier goals** based on the results of your SWOT analysis.

4. **Create tangible, concrete, and measurable objectives and actions based on finalized goals**, including:
   - targeting the right audience
   - the type of message
   - connections and relationships
   - communicating the message (who, what, how)
   - example actions for raising Community Readiness Levels
   (p. 37-42 of CR Handbook)

Best Practice Models for Substance Misuse Delivery

Overview and Process

CMC is considering how to further address the burden of substance misuse in the community. The CMC-GIRI team conducted an evaluation of practical models being discussed nationally from organizations with reputability and research rigor, including the American Hospital Association (AHA)7, Institute of Medicine (now National Academy of Medicine), and US Surgeon General. A common theme is that high functioning hospital systems work toward improvements that integrate and coordinate with primary care, mental health/substance abuse providers, and other providers to offer comprehensive Substance Misuse/Use Disorders (SUD) services across a continuum of care which includes health promotion, prevention, intervention, treatment and recovery. A review of key concepts from predominant papers upon which these models are drawn are outlined in *Best Practice Models for Organizational Care Delivery - Key Concepts Review* prepared by Center for Health and Learning (CHL), June 15, 2017. See Appendix 6.

We took into consideration current concepts in the field generated by the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Institute for Healthcare Improvement (IHI) regarding behavioral health integration and continuum of care (SAMHSA) and the triple/quadruple aim (IHI) when formulating this framework. We also considered that clinical-community integration has been an organizational strategy at CMC since 2010.

Themes from Best Practices Research

A review of key concepts from the best practice research yielded the following key points, which we recommend applying to the best practice framework adopted by CMC. There was considerable overlap between the best practice recommendations that were reviewed.

- There are many driving factors for integrating behavioral health into the general work of primary care and hospital health care systems. These include: increasing health coverage that incorporates behavioral health, decreasing the total cost of care, and managing a population's health.
- The "Quadruple Aim" serves as the predominant framework for identifying desired outcomes related to the organization and delivery of substance misuse services:
    - Improved outcomes for population health
    - Care cost reduction- reduce per capita cost
    - Patient care quality and experience- improve patient experience of care
    - Staff satisfaction- engagement and retention of care givers
- The Surgeon General's Report[10] identifies four elements for Best Practices: Care Coordination, Workforce Development, Financial, and Technology.
- Hospitals and care systems continue to move out of the walls and into the community to improve population health and manage the cost of care. Strong linkages between health care and community health and social services are necessary, requiring communication and collaboration that are embedded into the work of health care systems.
- Principles of care coordination and service delivery that are being used for preventing and treating chronic health conditions such as heart disease, asthma, and diabetes, apply to the prevention, intervention and treatment of substance misuse and disorders. Attention must be paid to critical elements of a comprehensive and coordinated continuum of care. These include screening as part of routine primary care, rapid

assessment when needed for acute or crisis situations, follow-up and caring contacts, which are necessary for behavior change and adherence to recommended protocols.

Developing a Best Practice Model at CMC

A best practice model represents an overall approach that uses all available knowledge and technology to ensure successful outcomes. In this case, CMC is articulating a comprehensive approach to developing a continuum of services that best meets the needs of the community to address substance misuse and treat substance use disorders. The adopted outcomes for the CMC model are those identified in the literature as the "Quadruple Aim," discussed further below.

The *CMC Best Practice Framework for Substance Misuse Service Delivery* is depicted in Table 3 and described below. It is designed based on the research on national best practices. As part of this model, CMC continues on the current trajectory to make clinical integration an organizational priority, and to determine where best to commit limited organizational resources for local population health improvement activities. Focusing on effective integration aligns with the national Accountable Health Communities Model, designed to address gaps between clinical care and community services in the current health care delivery system.

The goal is to ensure that all elements of the model are working in concert to achieve the *Quadruple Aim* of population health improvement, quality care, patient and staff experience, and reduction of health costs. The *Core Components* are the elements of system infrastructure necessary for achievement of the Quadruple Aim and include: Leadership Support; Workforce Development, Care Coordination, Information Technology and Financial Incentives and Modeling.

Key Approaches, cultivate and build alliances between the hospital and other organizations and entities, and will be the drivers for systems improvements that address substance misuse.   Education, Outreach, Advocacy, and Community Collaboration are key approaches for partner and community engagement, and for the implementation of an effective continuum of services. Data-driven approaches are integral to informing the development of strategic and integrated systems for addressing substance misuse services. These include assessing and documenting population health needs related to mental health, evaluation of resources, and outcomes of policies and programs.
See Table 3: *CMC Best Practice Framework for Substance Misuse Service Delivery*

Table 3:

CMC Best Practice Framework for Substance Misuse Service Delivery

Description

The *CMC Best Practice Framework for Substance Misuse Service Delivery* is aligned to evidence-informed recommendations for expanding and improving services to produce a higher functioning health system that meets the current needs of the population and patients it serves. [1,2,7,8] The objective of the model is to create a system of integrated primary care, with direct linkages to other services and supports in the continuum of care necessary to ensure effective substance misuse service delivery. The anticipated outcomes are defined as a "Quadruple Aim" which includes Patient Care Quality and Experience, Staff Satisfaction, Population Health Improvement, and Cost Reduction for Reinvestment. The core components are elements of system infrastructure necessary for achievement of the Quadruple Aim, and include: Leadership, Data-Driven Approaches, Education, Outreach and Advocacy. The key approaches required to achieve an effective continuum of care are: Data-Drive approaches, Collaboration within and between systems and providers, and Education, Outreach and Advocacy.

Quadruple Aim "Outcomes"

The Quadruple Aim establishes critical outcomes of systems change, and includes:

1. **Patient Care Quality and Experience**

    Patient Experiences is a central facet of Patient Care Quality and encompasses the range of interactions a patient experiences with their health care delivery: care they receive from personnel such as doctors, nurses, and other

medical staff; via healthcare plans; and practices within facilities in pursuit of more patient-centered care. (This is different than patient satisfaction, as it focuses on the type and quality of the experience rather than a patient's expectations of the experience.)

2. **Staff Satisfaction**
There is recognition that the healthcare workforce reports widespread burnout and dissatisfaction, which are associated with lower patient satisfaction, reduced health outcomes, which may increase costs. This potentially jeopardizes the Triple Aim, previously established as a compass to optimize health system performance. This goal aims to improve the work life of health care providers thereby leading to improved outcomes overall. 11

3. **Population Health Improvement**
According to the Population Health Alliance, Population Health Improvement includes the following central principles: Improving health status and holistic person well-being; Reducing avoidable healthcare costs; and Driving healthcare innovations that produce measurable economic value.

4. **Cost Reduction for Reinvestment**
Reducing per Capita Cost of Health Care involves removing waste at all levels, requiring leaders of operating budgets to think across the departmental silos of health care structures.

Core Components
The Core Components are the elements of system infrastructure necessary for achievement of the Quadruple Aim, and include:

1. **Leadership Support**
Health care and hospital leadership are fully engaged in the development of the model. They support addressing substance misuse within the Primary Care setting using a care model that works across health and social services systems through coordination, co-location, or other means.

2. **Care Coordination Across a Continuum**
Care Coordination that is a part of Primary Care is critical to high quality patient services. Substance misuse is considered a high priority, as are other drivers of disease, disability and mortality. Prevention, Screening, Early Intervention, Treatment, Care Coordination that includes timely follow-up, and Recovery Support Services are considered a general and routine part of Primary Care through integrated approaches with behavioral health, and as part of overall approach to wellness.
   - Patient Care Plans that include behavioral and substance misuse treatments are part of a comprehensive and coordinated care plan for patients.
   - Screening at the Primary Care level leads to effective pathways to treatment. Medication Assisted Treatment is a universal part of patient services.
   - Recovery Systems of Support that prioritize peer support are fully developed services within the model.
   - Follow-up and Coordination are hardwired into the system to ensure continuity of care.

3. **Workforce Development**
Key service delivery includes multiple providers who have expertise in the knowledge, concepts and skills for effective substance use services.
   - Medical Providers are trained in Screening and Brief Intervention.
   - Training is provided to prescribers for Medically Assisted Treatments as part of patient services.
   - Behavioral health specialists are available to assist providers within the primary care setting.

4. **Information Technology**
A data driven approach informs service delivery and a measurement system is used to determine effectiveness of substance misuse services. Information technology enables timely communication of patient information between service providers along the continuum of care with a focus on coordination of care. Use of technology is utilized to support screening, assessment and clinical decision making for SUDs.

Health technology is used for communication about clinical activities and care coordination within CMC and with community partners providing services across the continuum of care. The Electronic Health Record serves as a driver for clinical activities.

5. **Financial Incentives and Modeling**
   There are two realms of activity necessary for the financial build-out of this model: Payment Reform and Model Development and Piloting.

   1) *Payment Reform-* CMC leadership advocates (at all levels) for funding mechanisms that address the cost of intervention and treatment. The cost of intervention and treatment predominates the need for prevention and early intervention. The most cost effective approaches emphasize the upstream end of the care continuum: promotion, prevention and early intervention. Health care representatives must advocate for data-driven behavioral health services and work with health payers to ensure funding. Financing models from health care insurance providers are necessary to compensate clinical activities and it is not cost effective to bill clinical settings in two settings the way they currently are. This drives the need for a coordinated and comprehensive systems approach. There is a need to adjust fee for service to other payment methods to move toward integration – CMC needs to secure private and public funding to support pilot models. Primary Care providers need to be able to access the behavioral health specialists without concern about billing reimbursements.

   2) *Model Development and Piloting-* Sources CMC seek additional funding from multiple revenues including private sources (foundations and grants) to support piloting a comprehensive model or components of a model.

Key Approaches
The following strategies and processes are key approaches necessary to design a continuum of care that results in the Quadruple Aim:

1. **Data-driven-** adopting a rigorous method of interpreting data to identify policies, protocols and programs;

2. **Collaboration-** working effectively between units of service delivery, both inside CMC and with the community;

3. **Education, Outreach, and Advocacy-** activities that engage stakeholders in understanding the elements and importance of the model.

Summary of Results

Burden of Substance Misuse
CHL researched existing national data related to the issue of the burden of substance misuse on services in a hospital setting and data provided by CMC. CHL utilized these data sources, identified gaps in the data, and provided recommendations related to measuring the burden of substance misuse at CMC. CMC can further measure the burden of substance misuse by: using early intervention data; tracking data in Primary Care and Behavioral health within the Electronic Health Record; improving data collection and tracking in the Employee Assistance Program and Emergency Department, collecting data on related measures of burden such as co-occurring diagnosis and/or injury, and collecting data that measures the time that providers expend or are diverted from caregiving to attend to substance misuse issues.

Inventory of Substance Use Disorder Services
CHL made recommendations to the CMC-GIRI team on the adaptation of a tool previously used to assess gaps in services, which CMC-GIRI then developed into the Substance Use Disorder Services Survey. The online Survey was

distributed to 340 people at CMC, with a 25.9% response rate (89 respondents). The purpose of the Survey was to identify the extent to which staff members see signs of substance misuse in their practices and the barriers impacting the offering of substance misuse or SUD services. Five "serious" barriers to service were identified by respondents and four additional barriers were noted. Recommended services to be added to CMC care include: treatment (all forms); detoxification; medically-assisted treatment; and care management.

Community Readiness

CHL adapted the Tri-Ethnic Center for Prevention Research Community Readiness tool to interview ten key leaders identified by the CMC-GIRI team to better understand the feasibility of expanding services to address substance misuse and SUDs at CMC. Interviews were conducted with the goal of assessing the readiness levels of five dimensions: Leadership; Community climate; Community knowledge of efforts; Community knowledge of the issue; and Resources. Interviews were conducted and reviewed by CHL staff members; results were aggregated, scored, and shared with the CMC-GIRI team.

- Leadership had the highest readiness score of 6.18 (Initiation). If this effort is to move forward, it will be important for the Leadership to make an explicit commitment to next steps in this effort through organizational strategic planning and communication with hospital board, staff and community.
- Community climate, Community knowledge of efforts, and Community knowledge of the issue had scores between 5 and 6 (Preparation). This indicates the need to focus on capacity-building and planning to improve the scores for each dimension, in order to bring the community along in planning and implementation.
- Resources resulted in the lowest score of 4.45 (Pre-planning). This informs the establishment of a goal to identify organizational resources, revenue sources, and cost savings, to improve upon the availability of resources to expand services.

Best Practice Models for Substance Misuse Delivery

National authorities recommend that high-functioning health systems address substance use disorders using the concepts and strategies outlined above. The CMC Best Practice Framework for Substance Misuse Service Delivery is aligned to evidence-informed recommendations for expanding and improving services to produce a higher functioning health system that meets the current needs of the population and patients it serves. [1,2,7,8] The objective of the model is to create a system of integrated primary care, with direct linkages to other services and supports in the continuum of care necessary to ensure effective substance misuse service delivery. The model prioritizes services along a continuum of care and focuses on the Quadruple Aim which includes Patient Care Quality and Experience, Staff Satisfaction, Population Health Improvement, and Cost Reduction for Reinvestment. The Core Components are elements of system infrastructure necessary for achievement of the Quadruple Aim, and include: Leadership, Data-Driven Approaches, Education, Outreach and Advocacy. The Key Approaches required to achieve an effective continuum of care are: Data-Drive approaches, Collaboration within and between systems and providers, and Education, Outreach and Advocacy.

Conclusion and Next Steps

National authorities recommend that high-functioning health systems organize services to address the burden of substance misuse in communities. The data points to the need for sustained investment in healthcare and non-healthcare related strategies that reduce the likelihood of substance misuse, and provide care and support for users to overcome substance use disorders. The *Cheshire Medical Center - Getting It Right Inside* (CMC-GIRI) team has conducted rigorous work to establish the need based on data, assess the readiness of the organization to respond to the need, inventory organizational resources, and formulate a best practice model to guide the offering of services to meet the current needs of the population and patients it serves.

The burden of substance misuse in the community and on the services offered by CMC substantiates the need to address the issue in comprehensive ways. The Substance Misuse Services Inventory and Community Readiness Survey indicate the need for, and readiness of, health care and hospital leadership at CMC/DH to initiate development of an integrated framework for addressing substance misuse that is in alignment with the evidence-informed recommendations below.

CHL recommends CMC/DH implement the *CMC Best Practice Framework for Substance Misuse Service Delivery* simultaneous to gaining a commitment from other community providers to work collaboratively to structure a continuum of services that meets the needs created by the burden of substance misuse. Substance use is a chronic condition, and requires ongoing monitoring, management and support by staff and systems at CMC and in the community that are prepared to respond to the needs of a chronic condition. This will require a long-term commitment and multi-year effort to define services and payment models, attain and allocate resources, and plan and implement workforce development, in order to produce a sustainable approach to service delivery.

General Recommendations

1. Healthcare and hospital leadership adopt a framework for and make an explicit commitment to integrated approaches to addressing substance misuse inclusive of the Primary Care setting, which emphasizes care coordination, similar to addressing other drivers of disease, disability and mortality, and as a part of the overall approach to promoting wellness.

2. Dedicate operational resources to support the emergence of this work, including identifying who will manage and coordinate the implementation of the model in the early stages.

3. Identify corresponding payment models for substance misuse services along a continuum of care, i.e., prevention, screening, early intervention, treatment, and recovery, and prioritize community collaboration for the offering of services, and inter- agency agreements as needed.

4. Organizational culture focuses on safety of staff as well as clients, opportunities for dialogue and improvement, staff recruitment, engagement, and workforce development to build capacity for effective substance misuse services.

5. Develop a data-driven approach integrated with information technology and the Emergency Medical Record to drive service delivery and contribute to a measurement system used to determine effectiveness of substance misuse services.

Data

Measuring the burden of substance misuse is a large and emerging field.
- Continue to monitor, analyze and report on current data useful for community and staff engagement, and for program and policy decision-making.

➤ Further measure the burden of substance misuse by: using early intervention data; tracking data in Primary Care and Behavioral health within the Electronic Health Record; improving data collection and tracking in the Employee Assistance Program and Emergency Department, collecting data on related measures of burden such as co-occurring diagnosis and/or injury, and collecting data that measures the time that providers expend or are diverted from caregiving to attend to substance misuse issues.

Inventory of Substance Use Disorder Services

Leadership and providers at CMC/DH who participated in the Inventory identified critical barriers that need to be addressed in planning a response to substance misuse in the community. The barriers were:

- Appropriate level of care is not available
- Insufficient workforce capacity at CMC-DH
- Insufficient workforce in the community

Collaborative strategic planning aimed at building a continuum of services must address these issues in ways that address the sustainability of the services over time. It may be possible to partner with local Institutions of Higher Education and the business community/Chamber of Commerce, to ensure programs, marketing and incentives for attracting, training, and maintaining providers in the community.

Community Readiness

Leadership across disciplines at CMC indicate readiness to initiate strategic action to address substance misuse through delivery of services that work on a continuum of care in concert with other community services. However, there is still preparation to do through capacity-building and planning activities, including education, outreach and advocacy, to increase the knowledge in the community at large about the needs for substance misuses services, and the best strategies and services to address the needs. Identification of resources to support this effort is at a pre-planning level, and is critical to the overall success of the effort. The work of pre-planning and the implementation of action steps to ensure readiness, needs to occur in parallel process with a collaborative community planning process which identifies services across the entire continuum of care, thereby creating a pathway to care that is capable of successfully bringing people through a process from identification and assessment to treatment and recovery.

The goals below flow from the data on and need to be built out with corresponding objectives and work plans as part of CMC's organizational strategic plan:

1. Leadership make an explicit commitment to next steps in this effort through organizational strategic planning and communication with hospital board, staff and community.
2. Build staff and community knowledge about the need to address the burden of substance misuse, and the best practices for addressing the need in order to establish a climate suitable for engaging the community in planning and implementation. Include a focus on cultural considerations and behavioral strategies for working with patients with substance misuse.
3. Develop a shared measurement system in order to measure the collective impact of collaborating service providers, with agreement on the ways short and long-term success will be measured and reported, to ensure that all efforts remain aligned and to learn from successes and failures.
4. Identify organizational resources, revenue sources and expenses, in order to gain clarity on the resources needed to expand services.
5. Collaboratively plan with community service providers to offer services along the continuum of care, including behavioral health counseling that has treatment efficacy for substance misuse, along with peer recovery supports.

6. Ensure the Electronic Medical Record is adapted to facilitate communication across providers within and between service systems.

CMC Best Practice Framework

Implement the proposed *CMC Best Practice Framework for Substance Misuse Service Delivery* aligned to evidence-informed recommendations for expanding and improving services to address substance misuse. The objective of the model is to create a system of integrated primary care, with direct linkages to other services and supports in the continuum of care necessary to ensure effective substance misuse service delivery. The anticipated outcomes are defined as a "Quadruple Aim" which includes Patient Care Quality and Experience, Staff Satisfaction, Population Health Improvement, and Cost Reduction for Reinvestment. The core components are elements of system infrastructure necessary for achievement of the Quadruple Aim, and include: Leadership, Data-Driven Approaches, Education, Outreach and Advocacy. The key approaches required to achieve an effective continuum of care are: Data-Drive approaches, Collaboration within and between systems and providers, and Education, Outreach and Advocacy.

CMC/DH has identified data, inventoried services and resources, determined readiness factors, and developed a best practice framework for building a pathway to care to meet the needs created by substance misuse in the community. The next steps require broad and open engagement within CMC and between community organizations, the development of infrastructure including identification of community partners and finance models, integration with web-based technology, staff training, and ongoing data collection to inform the effort.

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Making the case that heroin use in the United States has reached epidemic proportions the authors created an analytic model that included incarceration and crime, treatment, chronic infectious disease, e.g., HIV, Hepatitis B and C, and Tuberculosis, and their treatments, treatment of neonatal abstinence syndrome, lost productivity, and death by heroin overdose. The paper estimated the annual societal cost of heroin use disorder in the United States in 2015 US dollars. Using literature-based estimates to populate the model, the cost of heroin use disorder was estimated to be $51.2 billion in 2015 US dollars ($50,799 per heroin user). One-way sensitivity analyses showed that overall cost estimates were sensitive to the number of heroin users, cost of HCV treatment, and cost of incarcerating heroin users in the region.

2. Miller, Ted, Nygaard, Peter (2017) Heterogeneous costs of alcohol and drug problems across cities and counties in California. Alcoholism: Clinical and Experimental Research.

Estimates of economic and social costs related to alcohol and other drug (AOD) use and abuse are usually made at state and national levels. Ecological analyses demonstrate, that substantial variations exist in the incidence and prevalence of AOD use and problems including impaired driving, violence, and chronic disease between smaller geopolitical units like counties and cities. This study examines the ranges of these costs across counties and cities in California using estimates of the incidence and prevalence of AOD use, abuse, and related problems to calculate costs in 2010 dollars for all 58 counties and an ecological sample of 50 cities with populations between 50,000 and 500,000 persons in California. The estimates were built from archival and public-use survey data collected at state, county, and city levels over the years from 2009 to 2010. The authors concluded that costs related to alcohol use and related problems exceeded those related to illegal drugs across all counties and most cities in the study. Substantial heterogeneities in costs were observed between cities within counties. The findings provide a strong argument for the distribution of treatment and prevention resources proportional to need.

INVENTORY OF SERVICES and PERCEIVED BARRIERS: QUESTIONS & DATA

Q1 Please indicate whether or not you are personally providing Substance Misuse or Substance Use Disorder (SUD) services in your department /service line.

Education & resources for patients	44
Screening for substance misuse	39
Assessing for substance use disorder	38
Referral to community-based treatment services	38
Referral to community-based recovery support services	37
Referral to primary care for coordinated care management	36
Initiate controlled substance use agreements	32
Screening, brief intervention, and referral to treatment (SBIRT)	27
Education & resources for staff	26
Treatment of co-occurring SUD & mental health disorders	19
Provide or refer to internal recovery support services	17
Coordination of SUD care between CMC-DH & specialty SUD care in the community	16
Acute medical care for intoxication and overdose	15
Medically assisted detoxification/ withdrawal management	15
Medication assisted treatment	13
Long-term monitoring or support of patients with SUD	12
Individual therapy or counseling	9
Inpatient SUD treatment (in hospital)	4
Intensive outpatient treatment	2
Group therapy or counseling	1

Q2 In a typical week, how many adults (ages 18 and older) do you see who present with signs & symptoms of substance misuse?

NONE	30	At least 1 or more = 39
1-2	17	
3-5	8	
6-10	9	
More than 10	5	

Q3 In a typical week, how many adults (ages 18 and older) do you see who self-report having a problem with substances?

NONE	34	At least 1 or more = 34
1-2	19	
3-5	7	
6-10	6	
More than 10	2	

Q4 In a typical week, how many children (under the age of 18) do you see who present with any of the signs and symptoms of substance misuse?

NONE	63	At least 1 or more = 9
1-2	6	
3-5	1	
6-10	0	
More than 10	2	

Q5 In a typical week, how many children (under the age of 18) do you see who self-report having a problem with substances?

NONE	66	At least 1 or more = 6
1-2	5	
3-5	0	
6-10	1	
More than 10	0	

Q6 Please identify which of the following are barriers to CMC-DH providing Substance Misuse or Substance Use Disorder (SUD) services in your department/service line:

Insufficient workforce capacity in community   66.7% serious
Appropriate level of care is not available (e.g. inpatient, medically assisted treatment)
        65.2% serious
Insufficient workforce capacity at CMC-DH   56.1% serious
Patient does not have insurance or has high deductible insurance & cannot afford out-of-pocket costs for appropriate level of care   46.2% serious
Low reimbursement rates from insurance providers for SUD services   38.5% serious
Lack of provider knowledge about services & where to get them   28.4% serious
Patient not ready to accept services. treatment, or other care)   26.2% serious
Lack of coordination between providers   25.8% serious
Limited interest/ training among providers to offer SUD services   23.9% serious
Lack of provider training in advocating for needs of patient
(e.g. to educate patient about SUD, importance & availability of
medication, services, family engagement, transportation to service,
&/or how to communicate with employers   23.9% serious
Electronic Medical Record not set up to track information related to SUD 19.7% serious
Lack of screening tools/training   17.9% serious
Provider has greater concerns about other co-occurring health issues   14.9% serious
Lack of leadership support   12.7% serious
Limited interest/ knowledge amongst providers to refer to services   11.9% serious
Provider concerns about HIPAA & confidentiality/
privacy impacting the flow of information between providers   1.5% serious

Q7 Feel free to write down any other barriers to CMC-DH providing services for Substance Misuse or Substance Use Disorder (SUD) in your department/service line:

- Don't even know where to start....Keene full of heroin.....the metro clinic robbing the most compromised population of money, daily transportation keeps them from meaningful employment, no jobs, no counseling, no HEP C tx.... No clean needle exchange....ALL PROVIDERS totally overworked and don't know where to start....epidemic and Keene CMC/DHMC love to look good on paper but in reality are part of the problem. We need to stop checking boxes, get someone from Concord to tell us how to vote, & get some resources that address these issues from the bottom up starting with prevention.
- Rx management alone is not the answer. We need a SUD program to successfully manage these patients.
- Don't seem to give sufficient attention to Prevention
- Absence of support/direction
- Current system for seeing patients in clinic setting does not support sufficient time for providers to engage in conversation with patients on this issue.

Q8 Name one substance misuse or substance use disorder service you would add if you could:

- Inpatient Detox unit concomitant treatment services (especially to include alcohol) (6)
- A care management specialist for SUD who would be aware of all community resources and help patients get into treatment (3)
- LADAC counselor in house (3)
- Medication assisted treatment integrated into primary care (3)
- SBIRT screening with every provider (3)
- psychiatrist (2)
- I think the SUD/providers need to be updated regarding current DSM-5 coding
- More outpatient services for Pediatric patients and more community education so parents are more aware of the use in our community and it implications
- Anything around prevention, we need to continue to go further and further up-stream
- Non-medical residential detox place for both alcohol and other substances
- Addiction specialist. Tighter community resources for follow through. Availability of Mental health care
- More behavioral health advocates
- Peer recovery support program
- Over the counter pain meds
- Much, much more stringent refill guidelines for controlled substances in outpatient clinics. Currently extremely porous
- Inpatient mental health

- President

- Chief Operating Officer

- Director of Pharmacy

- Incoming Board President

- Chief Medical Officer, Acute (20-minute interview)

- Chief Medical Officer, Ambulatory

- Chief Nursing Officer

- Chief Financial Officer

- Vice President, Philanthropy and Community Relations

- Vice President, Facilities and Support Services

TRI-ETHNIC CENTER, COMMUNITY READINESS HANDBOOK

Stages of Community Readiness
- The Community Readiness Model defines **9** stages of readiness.
- Readiness levels for an issue can increase **and** decrease.
- The amount of time to move to a higher readiness level can vary by the issue, by the intensity and appropriateness of community efforts, and by external events (such as an incident which creates focus on the issue).
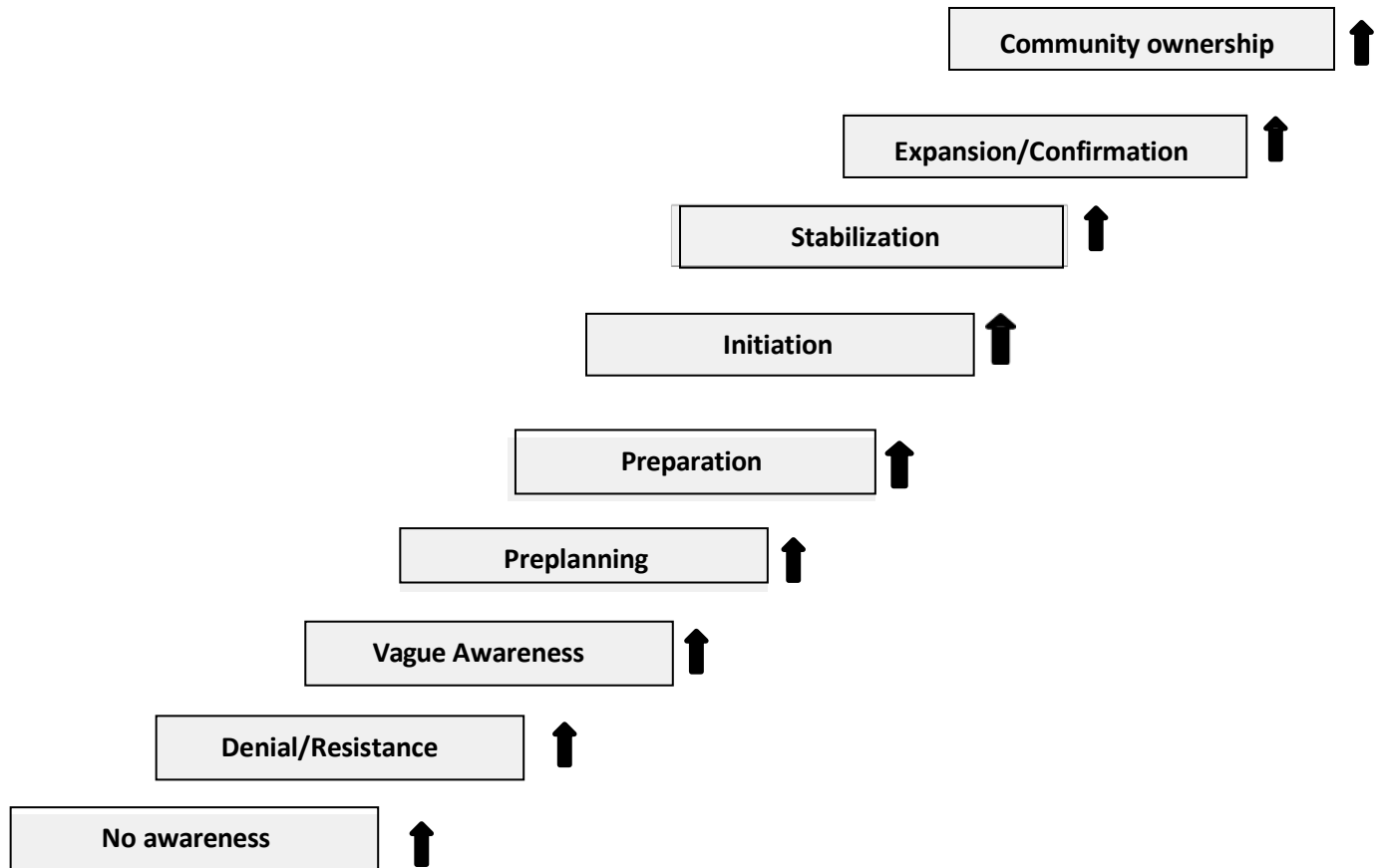
Readiness Level Stages

Stage 1: No Awareness
- Community has **no knowledge** about local efforts addressing the issue.
- Leadership believes that the issue **is not really much of** a concern.
- The community believes that the **issue is not a concern**.
- Community members have **no knowledge** about the issue.
- There are **no resources** available for dealing with the issue.
  "Kids drink and get drunk."

Stage 2: Denial/Resistance

- Leadership and community members believe that this issue **is not** a concern in their community or they think it **can't or shouldn't be addressed**.
- Community members have misconceptions or **incorrect knowledge** about current efforts.
- **Only a few** community members have **knowledge** about the issue, and there may be many misconceptions among community members about the issue.
- Community members and/or leaders **do not support using available resources** to address this issue.

"We can't (or shouldn't) do anything about it!"

Stage 3: Vague Awareness

- **A few** community members have at least heard about local efforts, but **know little about them**.
- Leadership and community members **believe that this issue may be a concern in the community**. They show no immediate motivation to act.
- Community members have only **vague knowledge** about the issue (e.g. they have some awareness that the issue can be problem and why it may occur).
- There are **limited resources** (such as a community room) identified that could be used for further efforts to address the issue.

"Something should probably be done, but what? Maybe someone else will work on this."

Stage 4: Preplanning

- **Some** community members have at least heard about local efforts, but **know little about them**.
- Leadership and community members **acknowledge that this issue is a concern** in the community and that something has to be done to address it.
- Community members have **limited knowledge** about the issue.
- There are **limited resources** that could be used for further efforts to address the issue.

"This is important. What can we do?"

Stage 5: Preparation

- **Most** community members have at least heard about local efforts.
- Leadership is **actively supportive of continuing or improving current efforts** or in developing new efforts
- The attitude in the community is —**We are concerned** about this and **we want to do** something about it.
- Community members have **basic knowledge** about causes, consequences, signs and symptoms.
- There are **some resources** identified that could be used for further efforts to address the issue; community members or leaders are actively working to secure these resources

"I will meet with our funder tomorrow."

Stage 6: Initiation

- **Most** community members have at least **basic** knowledge of local efforts.
- Leadership **plays a key role** in planning, developing and/or implementing new, modified,   or increased efforts.
- The attitude in the community is —**This is our responsibility**, and some community members are involved in addressing the issue.
- Community members have **basic knowledge** about the issue and are **aware that the issue occurs locally.**

- **Resources have been obtained** and/or allocated to support further efforts to address this issue.

"This is our responsibility; we are now beginning to do something to address this issue."

Stage 7: Stabilization

- **Most** community members have **more than basic knowledge** of local efforts, including names and purposes of specific efforts, target audiences, and other specific information.
- Leadership is **actively involved in ensuring or improving the long-term viability** of the efforts to address this issue.
- The attitude in the community is —We **have taken** responsibility. There is **ongoing** community involvement in addressing the issue.
- Community members have **more than basic knowledge** about the issue.
- A considerable part of allocated resources for efforts are from sources that are expected to provide **continuous support**.

"We have taken responsibility"

Stage 8: Confirmation/Expansion

- **Most** community members have **considerable** knowledge of local efforts, including the level of program effectiveness.
- Leadership **plays a key role in expanding and improving efforts**.
- The majority of the community **strongly** supports efforts or the need for efforts. Participation level is high.
- Community members have **more than basic** knowledge about the issue and have **significant** knowledge about **local prevalence** and local consequences.
- A considerable part of allocated resources are expected to provide **continuous** support. Community members are looking into **additional** support to implement new efforts.

"How well are our current programs working and how can we make them better?"

Stage 9: High Level of Community Ownership

- **Most** community members have **considerable and detailed** knowledge of local efforts,
- Leadership is **continually reviewing evaluation** results of the efforts and is modifying financial support accordingly.
- **Most** major segments of the community are highly supportive and actively involved.
- Community members have **detailed** knowledge about the issue and have **significant** knowledge about **local prevalence** and local consequences.
- Diversified resources and funds are secured, and efforts are expected to be ongoing.

"These efforts are an important part of the fabric of our community."

Dimensions of Community Readiness

Note in the statements describing the stages above that there are several important dimensions of community readiness addressed, e.g. leadership and attitude in the community. **Community readiness is composed of five dimensions** or aspects that can help guide the community in moving their readiness levels forward. These dimensions are:

Community Knowledge of Efforts
How much does the community know about the current programs and activities?

Leadership
What is leadership's attitude toward addressing the issue?

Community Climate
What is the community's attitude toward addressing the issue?

Community Knowledge of the Issue
How much does the community know about the issue?

Resources
What are the resources that are being used or could be used to address the issue?

Each dimension will receive a community readiness score. Thus, each dimension can be at a different readiness level. For example, the scores for a community might look like:

Dimension	Readiness Level	Readiness Stage
Knowledge of Efforts	3	Vague Awareness
Leadership	2	Denial/Resistance
Community Climate	2	Denial/Resistance
Knowledge of the Issue	3	Vague Awareness
Resources	4	Preplanning

What do these scores mean?
In the assessment section, we will introduce scales that we use to measure each dimension's readiness level. The statements shown below come directly from these scales.

Community Knowledge of Efforts   3   Vague Awareness
A few community members have heard about local efforts, but **know little about them**.

Leadership   2   Denial/Resistance
Leadership believes that this issue **is** a concern, in general, but believes that it **is not** a concern in this community or that it can't or shouldn't be addressed.

Community Climate   2   Denial/Resistance
Community believes that this issue **is** a concern, in general, but believes that it **is not** a concern in this community or that it can't or shouldn't be addressed.

Community Knowledge of Issue   3   Vague Awareness
Community members have only **vague knowledge** about the issue (e.g. they have some awareness that the issue can be problem and why it may occur).

Resources   4   Preplanning
Current efforts may be funded, but the funding may not be stable or continuing. There are **limited** resources identified that could be used for further efforts to address the issue.

Community Knowledge of Efforts

"It's so apparent in what we do everyday; we are a safety net organization. We are the only provider of healthcare in our county in the ambulatory and acute environment. We pretty much touch every member of our community at some point in their lives, and so people are really aware of what's going on in the community [through] what goes on day-to-day here."

"[Community knowledge of efforts are lower because] it hasn't been our primary focus [to build out programs] and although there are initiatives beginning, I think some are in their infancy and for the limited things that we're doing right now there is really a small silo of individuals who are involved in it."

"We certainly hear regularly from anyone who's involved in the Emergency Department or the EMS system in the town in general about the sorts of things that are a problem and what's being done to try and help them. There's been a tremendous amount in our local paper, as well, looking at both what we can understand about the nature of the problem and the burden this has put on EMS, on treatment – the toll this is taking on the community and the measures that are trying to be implemented to help."

"There is an overreaction by staff, providers, and sometimes even leadership in terms of who has a problem with substance, and that everyone who has pain is assumed to have a substance issue. And that is an obvious misconception."

Leadership

"There's quite a bit of representation from the leadership on the medical side and trying to be proactive and caring for the community…They're passionate about doing the right thing."

"Leaders know that we're spending an inordinate amount of time that isn't really direct care trying to resolve these issues, and that the only way to really manage this is to focus on substance misuse across the spectrum. A lot of times the substance issue is driving some behavioral issues that become really apparent to the staff."

"When we all hear about it, what's going on, and we talk about it we say, 'Yes, something needs to be done. It's impacting us here on this campus'. So we would all agree it's a priority; however, we have so many priorities right now: financial concerns overall for the campus, growth – making sure that we have sustainable growth...so there's a lot of competing priorities. It's definitely a priority; I wouldn't say it's on the top of the list of priorities."

Community Climate

[Most community members would support expanding efforts at CMC to address substance misuse by] *"being involved in committees, decision-making, and resource allocations."*

"We are the driving force for health outcomes in our community based on all the work we've done over the many years. This tells us that unless we focus on something of this magnitude, there probably aren't enough resources or individuals or organizations capable of leading the endeavor to make a difference. So our efforts are really focused on those things…but we don't have the dollars and the funding to do that. So all we can do is to help others who go out and get the funding and apply our expertise. There's limitations to what we're capable of."
"[Substance misuse is a very great concern to CMC because] have at least as many overdoses and fatalities per unit of population as any place in the state, so we can't view ourselves as in any way being spared from this problem. The amount of time, attention and resources that overdoses are taking is quite substantial in terms of the burden this places on our EMS systems and the resources that they have of finance, personnel, time, and equipment."

Community Knowledge of the Issue

"People that are not medically involved in patient care other than what they hear in the news; they're not actively involved in the organization process of dealing with the crisis."

"Most members in the organization aren't aware of what interventions work best for which individuals. [There is an idea] that one-size fits all – [that] everyone should go to Phoenix House, for example."

"[Members have] the belief that we have a stronger array of services than we actually have. I suspect that employees in general believe that the primary care providers are more comfortable with management of substance use disorders than they actually are…Unless they have personally encountered issues with their family or friends, there is a general belief that there are more services in the community available than there actually are – there are not many."

Resources

"Right now [resources are] predominantly funded through our operating margin for our operations. I think we're going to have to seek more federal or state funding to do this because our healthcare system, as well as any healthcare system, can't afford to bear the cost of all this."

"Future funding resources could be from a system-wide approach from Dartmouth to help tackle substance abuse specifically. We could also be reaching out more for grants – your federal, state grants – to help with this. Contributions could be earmarked from donors to target prevention, awareness and treatment for substance abuse."

"I think we're going to have to understand what can be provided from within other community organizations or associations throughout not only the state of New Hampshire but the state of Vermont. Because again, we can't be an island unto ourselves."

"[Substance programs are] all supported by other operational mechanisms right now. Obviously that limits your ability as part of your mission…Especially in state of NH it's really, really difficult because there is so little dollars in terms of those prevention programs or ongoing counseling programs once people actually reach out for those interventions."

"Our society needs to commit to caring for people with substance misuse in the same way they would care for people with hypertension and diabetes. If we believe that this is an illness, we should be willing to pay for that. Whether that's an Anthem, Harvard Pilgrim, or a state of New Hampshire Medicaid or Medicare, it needs to be funded in the exact same way. As long as people who have these kinds of problems are treated differently, we're going to have to find alternative funding which will never really give us the right resources to care for these individuals."

**Best Practice Models for Organizational Care Delivery
Cheshire Medical Center (CMC) Getting it Right Inside (GIRI)**

KEY CONCEPTS REVIEW

Background:
CMC is engaged in a process of evaluating practical models that serve as a framework for informing the structure and delivery of services at CMC related to substance misuse. Assessment of current structure will be carried out through a Community Readiness Survey, an inventory of current services in order to understand gaps, and to think about and plan for the future. The purpose is to find a model that best resonates with hospital systems. American Hospital Association (AHA), US Surgeon General, and Institute of Medicine (now National Academy of Medicine) believe high functioning hospital systems should be doing more to address Substance Misuse/Use Disorders (SUD). A review of key concepts from predominant papers are outlined here. We will use these as a basis of developing a comprehensive and integrated framework for structuring an institutional approach to behavioral health (BH) and substance misuse. Note: For EMR refers to Electronic Medical (or Health) Record

Title: *Behavioral Health Challenges in the General Hospital,* American Hospital Association, 2007		
Description: BH issues are common, unavoidable and costly. The paper lays out recommendations for successful practices in the hospital.	**Key Points:** Reviews health care realities and challenges in 2007 including increased need for BH care. Recommendations include: Assess needs, Evaluate resources, Collaborate with community. Recommends working with health payers and becoming advocates for BH.	**Notes for CMC:** Assess needs Evaluate resources Community collaboration Work with health payers Advocate for BH

Title: *Integrating Behavioral Health Across the Continuum of Care,* American Hospital Association, 2014		
Description: Hospitals and care systems continue to move out of the walls and into the community to improve population health and manage cost of care. No one framework is appropriate for every provider or hospital. There should be an effort to have robust measurement systems to determine effectiveness of the integration efforts for improved outcomes and cost of care reduction.	**Key Points:** *Triple aim* (p. 12) 1. Improved outcomes for population health 2. Care cost reduction- reduce per capita cost 3. Patient satisfaction- improve patient experience of care *Stages of Behavioral Health* (p. 7 Figure 1) Integration: Coordinated, Co-located, Integrated. *Functions for Integrating BH* (p. 8 Table 1) Patient-centered Care Team, Shared Population and Mission, Systematic Clinical Approach Functions for Integrating Behavioral Health *Driving Factors for Integrating Behavioral Health (p.10 Table2):* Increasing Health Coverage including BH Decreasing the Total Cost of Care Managing a Population's Health *Applying an Integration Framework for BH* (p.13)	**Notes for CMC:** Integration Framework Provides models and measurement constructs. Questions on pages 16-17 apply and relate to Readiness Surveys

	Core Measures (Figure 2): Integration Framework and Core Measures for Assessing BH Delivery: Care Team Expertise	

Title: *Health Care Systems and Substance Use Disorders*, Chapter 6 - Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health, 2016

Description:	Key Points:	Notes for CMC:

Lists key components of health systems and highlights the best institutions as those that are "learning health care systems." Desirable future services facilitate wrap around care vs. past approaches.
 	
Substance misuse is seen as part of Primary Care through integrated approaches with behavioral health and as part of overall approach to wellness, including: Prevention, screening, early intervention, treatment, care coordination, RSS, monitoring and follow-up.
 	
Health care leadership supports addressing substance misuse within the PC setting within a coordinated care model (coordination, co-location or other means) and by establishing tight linkages with other health and social services systems
	Purports four major foci:
	    1. Workforce development
	    2. Financial
	    3. Technology
	    4. Care Coordination
	
	Figure 6.2 provides a useful framework for deliberating a design for integrated care in any setting
	
	Medication Assisted Treatment (M.A.T.) is seen as an important part of patient services within the PC framework.
	
	Follow-up and Coordination are critical dimensions of an integrated health care continuum
	
	Screening is seen as part of routine primary care
	
	Primary care's role is the same as would be in a chronic disease treatment plan
	
	Medical providers are trained in screening and brief intervention
	
	Use of Health IT and technology integration to support communication about screening, assessment, Tx and other clinical activities
	
	Health care insurance providers and other structural and financing models compensate clinical activities
		Consistent with the AHA report
		
		Leadership engagement in strategy
		
		Four foci serve as a good organizational construct for CMC Best Practice model
		
		Screening should be happening at the Primary Care Level- need effective pathways to treatment
		
		M.A.T. universal part of patient services
		
		WFD provides training for screening, brief intervention and M.A.T.
		
		Follow-up and Coordination built into system
		
		EMR critical to drive pathway to care
		
		Financing are necessary to compensate clinical activities

Title: *The Advancement and Sustainability of Integration at Cheshire Medical Center/Dartmouth-Hitchcock Keene,* CMC/DHK, 2013

| Description: Proposed model of care to "get it right inside" and integrate CMC services with community services. | Key Points:
Proposed:
    • *Community Health Clinical Integration Logic Model*
    • *Characterization and Prioritization Tool for Integration*
    • *12 Step Framework for CMC/DHK Population Health Improvement Activities* | |