I. Introduction

Geographic description of region
The Sullivan County Region is predominately rural with Sullivan County containing 537 square miles of land area and a population density of approximately 81 persons per square mile. The Public Health region include one City (Claremont). The public health region of the Greater Sullivan County Regional Public Health Network includes the 16 rural New Hampshire towns within both Sullivan and Merrimack Counties: Acworth, Charlestown, Claremont, Cornish, Croydon, Goshen, Langdon, Lempster, New London, Newbury, Newport, Springfield, Sunapee, Sutton, Unity, and Wilmot. The Greater Sullivan County Regional Public Health Network serves the approximately 42,000 people living in these communities.

The Greater Sullivan County Public Health Network is housed by the Sullivan County government and is financed under an agreement with the New Hampshire Department of Health & Human Services - Division of Public Health Services with funds provided by the Centers for Disease Control and Prevention.

The Greater Sullivan County Public Health Network is bordered by the Greater Monadnock Public Health Network to the south, the Upper Valley Public Health Network to the north, and the Franklin/Bristol Public Health Network and Greater Concord Public Health Network to the east.

Demographics of region
Sullivan County at over 43,000 residents (Comprising 90% of the Public Health Region) shows an average per capita income of $29,073 for individuals, and a median household income of $56,851 per annum with 9.1% of individuals falling below the poverty rate. Over half of those employed work in the County with over 45% commuting to some other area for work). Comprising over 31,000 adults 25 and over, 90.2% have a high school or higher degree (27.4% have a bachelor’s degree or higher). The Sullivan County region has an aging population with a median age of 44.8 years as of 2014. The largest two employers in the region are manufacturing related with 1,455 and 800 employees respectively. Education follows at over 500 employees, then Health Care at almost 500, retail at 209, and mortgage services at 200. There are 162 individuals employed in the human services industry.

Overall Goals for Continuum of Care Development:

- To assess the current capacity of substance misuse services, where they are delivered, and their accessibility
- To use that information to work toward the establishment of a robust, comprehensive, and accessible substance misuse continuum of care

Connection Continuum of Care Development has to Regional Public Health Network and Regional Public Health Advisory Council:

The Greater Sullivan County Public Health Network is a collaborative of county, municipal, health and human service agencies, schools and community groups that are working together to improve the region’s capacity and capability to manage all health emergencies, including the deadly opioid epidemic in Sullivan County.

The Continuum of Care development effort aligns with the mission of the Greater Sullivan County Public Health Network which is to work closely with regional partners to create consistent public health messages and programs, and to ensure that the region is prepared for health emergencies. The GSCPHN is committed to helping people live healthier lives - in accordance with the Sullivan County mission “All Day, Every Day, We Make Life Better”. By identifying gaps, assets, capacity, and opportunities for a full continuum of substance use disorder and mental health supports the CoC effort is integral in message and program development.

The Public Health Advisory Council has established an aspirational goal that is the guiding principle for the region’s CoC work. This aspirational goal to “Foster a community that supports healthy lives, health equity, and wellbeing for people of all ages.” was developed through the work of the PHAC following several sessions that included reviewing regional assessments, engaging in technical assistance training from County Health Rankings, and team a team development process to finalize the aspirational goal.

Comprised of community leaders and representatives from a diverse group of community sectors. This group’s primary work is to set regional health priorities, provide guidance to regional public health activities, and ensure coordination of health improvement efforts.

CoC is also working in partnership with Substance Misuse Prevention effort to utilize an asset-based public health approach. CoC is aligning with Substance misuse prevention efforts to provide infrastructure, leadership, and coordination. The goal of this focus is to increase the number and reach of evidence-based substance misuse prevention programs, policies, and practices implemented in the region. By engaging members of the regional Substance Misuse Prevention Committee called the RACC, and other key partners, CoC and SMP are collaborating to develop involvement of business, education, health, safety, government, and community and family supports sectors in the implementation of the region’s strategic plan and to achieve Continuum of Care goals.
Overview of partners engaged in the CoC development process through group or individual input (PHAC, groups, subject matter experts, and other stakeholders):

Continuum of Care development has primarily involved health care, treatment providers, recovery community, and groups and organizations that support recovery.

Treatment providers are involved in discussions to develop capacity for treatment of adults and approaches toward adolescent treatment. Payment barriers are discussed and collaboratively worked on to help identify funding inconsistencies or where parity is not being utilized.

Health providers, many who are developing approaches to wellness and implementing SBIRT, are reaching out along with the CoC coordinator to identify partners and improve processes that integrate care across the spectrum from identification to intervention and recovery.

A committed group of a newly trained CCAR (Connecticut Community for Addiction and Recovery) recovery coaches has been instrumental in communicating needs and gaps of those involved with substance use disorders and addiction. Collaboratively working as a member of the Greater Sullivan County Public Health Network team, Hope for Recovery of NH, New Futures of New Hampshire, and other state agencies, the CoC effort has been developing supports and support systems for individuals, family members and peers who may know someone suffering from a substance abuse (misuse) disorder. Sullivan County is in need of intensive substance abuse (misuse) treatment, but there is a shortage of providers throughout the state and these new recovery coaches are stepping up to help fill the gaps by providing peer support and connecting individuals with treatment services.

Brief description of the ACPIE model, and how it will be used to frame the plan

The ACPIE (Assessment, Capacity, Planning, Implementation, and 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. As an example as healthcare providers develop screening and referral capacity the CoC coordinator continues to develop opportunities for referral and care coordination with community partners to meet further identified needs.

Brief description of engagement and planning processes to date (meetings, partnerships, etc.)

Beginning with meetings centered on parity that included providers, corrections, and probation, the continuum of care work identified funding potential and gaps as described by these partners. Following meetings identified treatment resources and gaps with a series of discussions with related providers. These discussions involved several meetings with the same agenda so that all of the related partners could provide input from the region. By connecting LADCs with health care providers and referral
sources LADCS have begun to integrate services in health care practices and coordinate care. By introducing the invested recovery community coaches to potential resources and discussing the need, resources such as HOPE for NH, and retired LADCs have become active in the region. With the advent of two HOPE centers now in the Sullivan County Region and partnerships with Southwestern Community Services connections to recovery and interventions are being discussed in individual and group meetings that include providers, police, and emergency response. Developing efforts both in the Cheshire and Dartmouth regions are being shared and expanded through development work that includes maternal treatment, intervention, and housing for SUD involved pregnant women. Suicide prevention and postvention are trainings that have been ongoing and offered in the region to increase interventions for mental health and co-occurring issues.

II. Assessment

This section provides an overview of the needs and challenges that exist in the state and the region relative to building comprehensive and coordinated substance misuse continua of care in each region of the state. The determination of need 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.

Information in this section of the plan should include:

- **State-level determination of need:**
  - The NH Department of Health and Human Services/Bureaus of Drug and Alcohol Services (DHHS/BDAS has determined that the best way to prevent and/or decrease the damage that substance misuse causes to individuals, families, and communities is to develop a robust, effective and well-coordinated continuum of care in each region of 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, healthy families, and access to care, and healthy eating and living as four of the five priority health issues in its Community Health Improvement Plan (CHIP). These are all relevant and interrelated to continuum of care development. The region’s vision statement for continuum of care development is to work with community partners and individuals to identify gaps in identification, intervention, treatment, and recovery for SUD and mental health conditions and to connect and develop resources toward reduction of prevalence.

- **A description of how the region’s statement for continuum of care development was formulated including:**
  Stakeholders across the community spectrum were educated through regular community meetings, participation in PHAC education and development, radio and community legislative forums, and individual meetings. Stakeholders identified were
involved in some aspect of the gaps and through organic connections with those involved in the SUD and mental health continuum (referral and collaborative partnership development).

Stakeholders identified were invited to relevant additional meetings, and engaged in individual conversations with the CoC coordinator and also other members of the Public Health team as appropriate.

- The Continuum of care facilitator presented gaps and raised questions for potential development in a multi approach strategic development that included both formal meetings and individual conversations. By identifying the related partners and potential resources and connections the CoC coordinator fostered community systems development.
- Primary barriers in the process involved fragmented information for what was occurring both locally and at the State level, and also stressed systems such hospitals that perceived risk in engaging in potential alternative approaches. Organizational stresses significantly limit any organization or entity from engaging in Continuum development as well.

III. Capacity

The region will complete assets and gaps scan to identify resources, gaps and barriers to 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.

**Information in this section of the plan should include:**

- A description of the assets and gaps scan process including:
  - The assets and gaps assessments process, and methodologies used included initially the Sullivan County Commission on Wellness that brought community members together over two years ago to comprehensively identify the wellness gaps in the region, contributing factors, and specific areas related to substance use disorders and mental health. That foundation was the starting point for the Continuum of Care coordination effort which included involvement of community stakeholders through SUD and Mental Health focused resource, gap, and needs meetings and individual development.
  - Stakeholders were identified and engaged in the process based on a relationship to the SUD and Mental Health systems. If they had an area of involvement or were significantly impacted by these conditions, they were involved.
  - As the Continuum of Care Facilitator I supported identification of these partners through assessment and referral by other partners.
  - Barriers to the process identified were partners that were identified as being a significant potential support to the issues may not have been interested, motivated, or able due to limited organizational capacity in being involved.
• *A brief description of processes to be used to enhance the capacity scan process (examples: additional stakeholders to engage, additional information and data to be integrated, etc.),* (Not sure how to answer this)

• **The results of the asset scan including:** (Please see submitted Report and Power Point for this section)
  
  o *What substance misuse services are available in your region by component (prevention, early identification and intervention, treatment and recovery support services, primary health care, behavioral healthcare and other providers):*
    
    ▪ Service provider,
    ▪ Areas served,
    ▪ Service setting,
    ▪ Services offered,
    ▪ CoC component,

  o *Generally, give your region’s impression of how well the current system of providers appears to be connecting and coordinating their work.* There are significant challenges in stepping outside the typical focus of service for providers due to funding constraints or incentives and in some cases organizational safety.

• **The results of the gaps scan including:**
  
  o *What concerns were identified:* (These gaps and perspectives are explained well in the narrated power point presentation that was submitted)
    
    ▪ **Gaps – services that are needed but not available:** Coordinated care with a primary care provider at the center is lacking. Licensed treatment providers. Void of adolescent services except diversion.
    
    ▪ **Barriers – practices, policies, or procedures, or lack thereof, that hinder continuum development or access to the services in the continuum:** Overdose and SUD data is not collected or shared so there is no way to accurately gauge prevalence or progress. Primary care providers do not understand addiction prevention or treatment and therefore leave any of those supports to fragmented isolated care. Savings for patient centered SUD or MH care is realized by entities that do not bear the burden of getting the needed supports to those individuals. The only MAT in the region does not bill for Medicaid for the group sessions that are required as part of MAT. Those with the addiction issue have no choice but to somehow find the $65 dollars a week even though they do not typically have jobs and if they do are in or near the poverty level. They are resorting to illegal or immoral means to provide the partial agonist. There is little difference from doing what they need to do in order to get the addictive drug on the street. Further the individuals are kept on high doses rather than individually tapered to get them away from the addictive substance. Primary care doctors are not involved in this aspect of a patient’s care because they are not familiar with MAT, do not understand the need in some cases for health and recovery, and do not feel empowered to be involved in that management in any way.
- Communication – hindrances to meaningful dialog or information sharing between components and/or increasing awareness of or access to component services. Lacking shared records, fear of privacy violation, lack of understanding for the real meaning and restrictions for privacy information, lack of understanding for need, value, or process to share information related to patient care are all barriers.

- Collaboration – hindrances to continuum components working together to develop a continuum of care that is robust, comprehensive, and accessible, See Communication above and also funding.

- Others – any other difficulties, attitudinal (example – stigma) or physical (example – transportation) that hinders the development of or access to a comprehensive continuum of care Flexible payment systems are needed so that doctors can include social emotional/environmental supports in care. Prevalence of SUD customers are homeless but hospitals in NH are unlikely to seek that information due to requirement to keep individuals in facility if they are homeless. Motivation is not to explore the patient situation, but rather just to release them following SUD/MH, or overdose. Studies show and community recovery community shows that there is lacking needed attention to get SUD or MH burdened individuals connected with health care due to lack of understanding and resulting lack of empathy from medical community for those involved in addiction. When someone in recovery indicates that they cannot have opioids they report that they are then typically treated poorly with little engagement of the individual in next steps for their care.

- Which of the areas identified above are your region’s high level priorities for continuum of care development and access to continuum of care services? Coordinated Care, Patient Centered Care, Shared Risk.

- What, if any, priorities were identified for each component of the continuum?
  - Prevention, Early Childhood Interventions and Participation in Delay of Onset by all parts of the community.
  - Early Identification and Intervention, SBIRT in all sectors or support by all sectors for those that are engaged.
  - Treatment, LADC workforce, IOP, MAT that is part of coordinated care.
  - Recovery Supports Housing

- What, if any, underserved communities/areas were identified as needing increased access to continuum of care services? Children and Families who have experienced trauma and those with mental illness.

IV. Planning

The region will use 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, to work toward
achieving the region’s continuum of care statement identified in the Assessment section. The planning process will be ongoing based on the identification, engagement and input of additional stakeholders, and the integration of new information/data as it becomes available.

**Information in this section should include:**

- **Using the region’s statement for continuum of care from the Assessment section, describe the region’s goals for developing the following components:**
  - **Prevention services,**
    - Utilization of Medicaid and other insurances for transportation in support of SUD / MH prevention
    - Suicide prevention and postvention training promotion and delivery including mental health first aid training in schools, community organizations, workplaces.
  - **Early Identification and Intervention services,**
    - Depression screening promotion in community and health care as part of standard health care with response and referral processes in place.
    - Processes in place to follow effect of suicide prevention and postvention training promotion and delivery including mental health first aid training in schools, community organizations, workplaces.
    - *Increased adoption and enhanced use of SBIRT in community increasing identification and connection with resources to include:*
      - **Youth and young adults involving**
        - Second Growth of VT
        - West Central Behavioral Health
        - Hope for NH
        - Diversion services and DCYF
  - **Treatment services,**
    - Connect HOPE centers, Southwestern Community Services, Police, EMTs, Emergency Departments and other community resources when treatment intervention needed.
    - IOP (Intensive Outpatient Treatment) and increased LADC and other specialized counseling
    - Coordinated Vivitrol, Nalone, and MAT with primary/patient centered care.
  - **Recovery supports,**
    - Recovery Housing development through partnerships and grants
    - Peer Recovery Support utilization and connection with community when PRS beneficial
  - **Coordination with primary and behavioral health care**
    - Education of primary care for resources, understanding addiction, effective approaches, prescribing and MAT related training
- Development of increased patient centered care including changed practices, integration with resources, utilization of IDN funds and other insurance funding, increased communication with other providers about patient health,
- Adoption of SBIRT or utilization of SBIRT with fidelity that is coordinated with community care.

- **A description of the planning process including:**
  - **An overview of the planning process,**
  - The planning process for each of the components were somewhat varied. For prevention working with the public health team in particular the SMP coordinator and the communications coordinator in addition to collaborative work with providers, primary objectives were developed. These primary objectives reflected the regional PHAC assessments and input from PHAC membership for general direction and aspirations. Early identification was developed through input from school community and workplace entities and through discussions with related providers about need and potential. Treatment was developed with the cooperation of treatment providers and those who have a vested interest in access to treatment for their area of work. Recovery supports needed have been identified in close partnership with peer recovery support centers, recovery community meetings, and working development with the Sullivan County Corrections TRAILS program. Finally, as a key member of the PHAC and as SBIRT development we are in continued discussions with primary care providers related to areas of related need, resources, and developing education and awareness about SUD and MH systems development options.

V. **Implementation**

Using information from the Planning section, the region will implement proposed actions in the Planning sections through shared responsibility with regional stakeholders. Whenever possible, plan implementation should be enhanced by the inclusion of new stakeholders and adapted based on new information and data as it becomes available.

**Information in this section of the plan should include:**
- **The timeline for implementing actions,** Actions that will be implemented fall into the following categories:
  - Patient Centered Care
  - SBIRT
  - Utilization of funding for transportation and recovery housing
  - Gaps in data
  - Provide Information
- **Identification of responsible partners/parties for implementing action,** Mechanisms and procedures to track progress toward anticipated outcomes, A brief description of proposed
processes to enhance the Implementation process (examples; engagement of additional stakeholders by matching them to proposed actions, meetings to discuss progress toward and barriers to implementing proposed actions, etc.), Describe the way your region will organize actions to be implemented (examples – by component, by category of action).

- **Patient Centered Care** (ongoing)
  - Develop through education of primary care providers around funding, resource availability and utilization, impact of social/emotional supports on health outcomes, use and application of Vivitrol, Naloxone, and MAT (Medicated Assisted Treatment).

- **SBIRT** (ongoing)
  - Increase adoptions in school settings and diversion
  - Increase utilization within systems through intake in health care settings, social worker position responsibilities, Certified Health Worker position responsibilities. Also increase through connections between community resources.

- **Gaps in Data** (ongoing)
  - Improve collection of SUD overdose prevalence and occurrence through hospitals, EMTs, and EDs
  - Continue to identify needs to support reduction of SUD /MH through community collaboration
  - Continue to reduce gaps in treatment, identify what is occurring, what resources are being utilized or not, and what resources are not available.
  - Identify where there are opportunities to address depression and mental health, what are the responses, and what are the potential adaptations.

- **Youth and Young adult SUD/MH Support Systems Developed** including below (ongoing):
  - Identification
  - Intervention
  - Services
  - Integration

- **Utilization of funding and resources to develop recovery housing and development of Transportation affecting SUD /MH** (ongoing) including:
  - Rides for supportive care
  - Volunteer Driver Program
  - Transportation options with HOPE center

- **Provide Information and education** (ongoing)
  - About prevention specific to relapse prevention and at risk families, treatment supports, and recovery information at:
    - Food shelters
    - Press releases and other media
    - EMTs/Police with resource cards
VI. Evaluation (and Monitoring)

Using information from the Planning and Implementation sections, the region will describe the process for monitoring and evaluation processes that compares anticipated outcomes from proposed actions with actual outcomes, and to recommend adaptations to the plan. These processes will be an ongoing process based on the inclusion of additional stakeholder, and new information/data as it become available.

Information in this section should include:

- A description of proposed outcome measures for actions in the plan which may include, but are not limited to:
  - Results of actions to assure communication and collaboration among providers,
    - Increased touch points for individuals with SUD and MH (including depression screenings)
    - Patient-centered care evidence through standing processes and procedures
    - Increased time that primary care participates in related training
  - Results of actions to increase awareness of and access to services,
    - Increased utilization of Medicaid and insurance payments for transportation, SUD treatment, MH treatment, peer recovery support, IOP, MAT, recovery housing
    - Increased venues with information available and provided to clients and community.
  - Results of actions to increase services in the region,
    - Increased patient satisfaction for those with SUD and MH conditions
    - Increased integration and utilization of SBIRT (number of facilities, number of individuals, number of referrals)
  - Results of actions to involve additional stakeholders in CoC development work
    - Process changes that reflect increased utilization of resources and collaboration.
    - Improvements in capturing and utilization of data (collaborated systems, increased accuracy and reliability)

- A description of the proposed methods to compare anticipated outcomes from proposed action with actual results, including:
  - An overview of the process,
  - Identification of stakeholders to be included in the process and their roles,
  - Role of the Continuum of Care Facilitator in the process,
o **Anticipated barriers to the process and how they could be addressed,**
o **Anticipated technical assistance support needs,**
   - Outcomes will be identified as part of ongoing collaborative development with the support of the CoC facilitator. As collaboration occurs, changes in these measures will be reported and specifically sought by point in time reports as required by the CoC effort and also will be captured as part of the PHAC assessment processes as those point in time reporting events occur.
   - Development of ownership of this evaluation process by PHAC committees, members, and other partners is both an opportunity and a challenge that will be an area of focus by the Public Health Network.

VII. Conclusion

*Points that you may want to include in a brief conclusion to the document:*

- **Brief summary of the state and regional determination of need.**
  - Stressed organizations including schools, hospitals, police, and non-profit providers are challenged to engage in “additional” efforts even if in the long run those efforts will reduce the stresses on their organizations. Where there is additional cost or economies of scale challenges to make system changes or utilize Medicaid and other payment systems, the region and state are in need of support. This is particularly true in rural areas where organizations do not have the organizational depth or ability to leverage assets toward improved systems. Approaches such as the theory behind the statewide IDN effort may be helpful. Also, any federal or state support for regions to continually identify insurance or payment barriers and intervene to help entities make use of that funding is also needed.

- **Brief summary of the major points identified in the asset and gaps assessment.**
  - This region primarily faces lacking incentive or ability to identify SUD and/or mental health issues, lacking connectivity due to payment and system supports, lacking incentive or ability to develop patient-centered approaches, lacking flexibility of payment systems to provide for primary socio-economic barriers such as transportation, lacking workforce and licensing barriers, lacking treatment and recovery housing.

- **Major goals outlined in the Implementation and Planning Sections.**
  - Planning involves efforts around the following categories:
    - Develop Patient Centered Care
    - Enhance SBIRT
    - Utilization of funding for transportation and recovery housing
    - Improve Gaps in data
    - Provide Information
  - Targeted implementation in the areas of prevention, early identification, treatment, recovery, and coordination with primary care include:
• *Prevention services including utilization of* Medicaid and other insurances for transportation in support of SUD / MH prevention. Also increasing awareness of identification of both SUD and MH through education and awareness including suicide prevention training. Venues include schools, workplaces, and community organizations.

• *Early Identification and Intervention services including depression screening and support promotion and suicide prevention awareness and increased use of* SBIRT *including services for youth and young adults.*

• *Treatment services connectivity and sharing of successes with neighboring regions in developing improvements and broad reaching sharing of resources such as integration with emergency departments, emergency responders, and services. Additionally incorporation of all treatment options including* Vivitrol, Naloxone, and MAT with primary/patient centered care.

• *Recovery supports including recovery housing development and increasing peer recovery support utilization.*

• Coordination with primary and behavioral health care including education, development of patient centered care and adoption and development of SBIRT.

This is a “Living” Document and will be subject to ongoing revision.