

FULFILLING THE PROMISE:

*Transforming New Hampshire's
Mental Health System*

**Volume II
January, 2008**



State of New Hampshire

GENERAL COURT

CONCORD

A Message from Rep. James R. MacKay, Ph.D., Chairman Commission to Develop a Comprehensive State Mental Health Plan

January, 2008

This second volume of a series of reports by the Commission to Develop a Comprehensive State Mental Health Plan (HB 691, Chapter 175:15, Laws of 2005) contains the entire reports of the five work teams. The first volume of *FULFILLING THE PROMISE: Transforming New Hampshire's Mental Health System* includes the consolidation of the work of the teams into a blueprint for action. This volume is a supplement to Volume I and is designed to provide a more detailed and complete report of each of the five work teams: Consumer Driven Practice, Quality Care, Integrated Services, Eliminating Disparities, and Information Technology.

This report contains the work of over a hundred volunteers working more than two years to provide a comprehensive mental health plan. An additional report on Corrections and Mental Health Care will be released soon.

The Commission will now progress to its second stage of work: implementing this plan for transforming New Hampshire's system of mental health care.

Sincerely,

A handwritten signature in cursive script, appearing to read "James R. MacKay".

Rep. James R. MacKay, Ph.D.
Chairman

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Work Team One

Consumer and Family Driven Services

Members:

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MISSION STATEMENT

To use the insights of all persons with mental health issues, their families and communities, to design a sustainable mental health system that is fully responsive to people's needs and combats stigma.

GOAL

Effective and high quality mental health services across all age groups will be accessible in all communities through effective service delivery – integrated, community-based; culturally, ethnically and linguistically sensitive.

*2005-06 Co-chairs

**COMMISSION TO DEVELOP A COMPREHENSIVE
STATE MENTAL HEALTH PLAN
(HB 691-FN-L, Chapter 175:15, Laws of 2005)**

TEAM ONE: CONSUMER AND FAMILY DRIVEN SERVICES

INTRODUCTION

A person centered system of care is one that places high importance on the involvement of consumers and families in the design of the system. Over the last several years, there have been efforts to increase the involvement of consumers in decision making, both on an individual and system basis. However, there continues to be a great deal of room for further involvement of consumers in a wide range of areas. These include but are not limited to resource availability, service plan decision making, and other system improvements. One of the challenges facing all systems includes the degree to which providers and funders are receptive to the voices of consumers when addressing unmet community needs.

With the realistic expectation that there will be some degree of unmet needs, one of the most promising developments over the last few years is the use of peer support by consumers and their families. Peer support can be defined as consisting of supportive interactions based upon shared experience among people and are intended to assist people in understanding their potential to achieve their personal goals (Bureau of Behavioral Health). In some states, Peer Specialists are being utilized as a complement to the existing service system. The use of peer specialists would be consistent with New Hampshire's increasing use of recovery-oriented practices.

A person centered system of care should also place high value on prevention in contrast to treatment. A landmark report published by the Institute of Medicine in 1994 extended the concept of prevention to mental disorders. While it is true that prevention has a different meaning for different people, our view is that it become more included in strategies toward improved mental health and then overall health. Because mental health is so directly tied to other aspects of health, it is imperative for there to be education, early assessment and intervention to prevent further decline in health status or unnecessary risks to individuals and communities.

Moving to a Person Centered system would need to eliminate, where possible, the stigma and discrimination that continues to be a reality for people of all ages who are in recovery. More emphasis should be placed on the many positive and inspirational stories

told by people who have experienced mental illness. Education continues to be a useful tool for changing minds and hearts of everyday people who are often misinformed about mental illness.

RECOMMENDATIONS

#1 Include consumers and families in all aspects of service, policy planning and evaluation.

Action Step: Peer specialists will be recognized as essential members of treatment teams through specialized training and certification as peer specialists. Their services will be reimbursed by the state through private insurance, general funds or Medicaid.

Action Step: A speakers' bureau will be developed and consumers will serve as educators.

Action Step: - Host listening sessions in all 10 counties (e.g., mental health centers and others: NAMI-NH, legislators, Office of Consumer Affairs, and the Disabilities Rights Center with the specific goal of gathering region-specific concerns/needs that are not currently being addressed.

Action Step: Make Peer Support an integral part of the state mental health system.

#2 Effective and the highest quality of services across all age groups will be accessible in all communities.

Action Step: Review restrictive practices and procedures such as Conditional Discharges, Involuntary Emergency Admission and the transport of consumers to New Hampshire Hospital.

Action Step: Reduce financial barriers to treatment (e.g., parity legislation).

Action Step: Provide accessible transportation to CMHC's.

Action Step: Improve accountability measures. Accountability measures should include evidence-based practice fidelity assessments in CMHCs and reporting of outcome measures of adults, children, family members, and significant others who receive services from CMHCs. This should include outcomes that are meaningful to the people receiving services. This data should be made available to a wide audience (e.g., posting fidelity scores on the NH Department of Health and Human Service web site). This sharing of important data is similar to what hospitals have recently started doing by sharing outcomes of cardiac care.

Action Step: Improve collaboration between Bureau of Behavioral Health and CMHCs.

#3 Develop Prevention, Assessment and Early Intervention as strategies for promoting mental health in individuals, families and communities.

Action Step: Educational curriculum in schools of higher learning for mental health majors will emphasize principles of recovery and value of evidence-based practices (EBP).

Action Step: Continue to build the science of evidence-based interventions and strategies to reduce risk factors and increase protective factors, and promote recovery and resiliency.

Action Step: Deliver state-of-the-art treatments by shortening the time between what is known from research to what is accepted practice.

Action Step: Expand training in early identification, screening and early treatment of mental illness for professionals providing primary health care.

Action Step: Include units on the principles of recovery in the annual requirements of continuing education units (CEUs) for licensed professionals.

Action Step: Include Mental Health education in public schools' health curriculum.

Action Step: Increase and make more effective portals to treatment by educating across multiple systems (e.g., health, behavioral health, education, criminal justice, churches, cultural groups, the workplace) to encompass the full range of potential access points within a community and train people to act as liaisons to the mental health community.

Action Step: Stigma will be addressed through statewide community education and public awareness efforts highlighting the efficacy of mental health treatments.

Action Step: Conduct early screening for co-occurring mental health and substance abuse issues.

#4 Increase involvement of consumers and families, from inception to adoption, in critical policy and practice decisions that affect their everyday lives.

Action Step: Improve the effectiveness of the Office of Consumer Affairs to provide, education, support, and necessary information for consumers and families. Include the direct contact information for the Office of Consumer Affairs on Bureau of Behavioral Health's web site face page.

Action Step: Involve consumers and families in ongoing evaluation, quality assessment and improvement activities addressing the delivery of mental health services.

Action Step: Review representative consumer policies including the regulatory requirements placed on families, organizations.

Action Step: Establish a mechanism for certified peer specialists to be directly notified of policy changes and to participate in the review process.

Action Step: Ensure delivery of state-of-the-art treatment by shortening the time between what is known from research to what is accepted practice.

#5 Recognize the importance of Housing

Action Step: Increase collaboration between Bureau of Behavioral Health and the NH Housing Finance Authority.

Action Step: Collaborate with the UNH Institute on Disability to implement supported housing for people with severe mental illness.

#6 Recognize the importance of Employment

Action Step: Implement Supported Employment in all CMHCs, which would enhance the recovery process by further integrating consumers in the community and increasing their independence and control over their own lives.

Work Team Two

Quality Care

Members:

Peter Janelle, Co-chair	Manchester
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MISSION STATEMENT

To recommend a basic, objective quality framework for the mental health system that can help to continuously improve our system in a measured and quantifiable way.

Commission to Develop a Comprehensive State Mental Health Plan (HB 691-FN-L, Chapter 175:15, Laws of 2005)

Quality Care Team 2

Stigma and Quality

“Stigma must be overcome. Research that will continue to yield increasingly effective treatments for mental disorders promises to be an effective antidote. When people understand that mental disorders are not the result of moral failings or limited willpower, but are legitimate illnesses that are responsive to specific treatments, much of the negative stereotyping may dissipate.”

(Mental Health: A Report of the Surgeon General. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999.)

The Cost of Quality in New Hampshire’s Mental Health System

Sometimes states are concerned with the financial costs of the resources, such as investing in the technology to effectively gather accurate data and the services needed to assure that the quality of mental health services is regularly measured and constantly improved. These costs, however, should not be evaluated in a vacuum. The financial costs of high quality services must be compared with both the financial and human costs of low quality mental health services. Low quality mental health systems may raise financial costs in other services, such as hospitals, emergency care facilities, corrections, schools and law enforcement, and low quality mental health services costs also include the human costs of people being homeless, incarcerated, unemployed, having multiple health problems and earlier deaths.

Investing in the necessary infrastructures, supports and system leadership enhances resiliency, improves overall health, and promotes recovery. The development of a quality mental health system assures that ever more limited public and private funding for mental health services is used in the most effective and accountable ways.

Mental Health System Quality Framework and Principles

A quality mental health system can be defined and measured in a variety of different ways. While a systematic emphasis on quality and associated quality improvement has been present for decades in our health care system, the recognition and understanding of how to apply and utilize quality measurements and improvement is not as established in mental health.

Quality and Scientific Outcomes

Three concepts are fundamental to understanding quality for New Hampshire's mental health system. First, some aspects of quality can be scientifically measured such as individual outcomes from services. For example, a mental health agency may be described as having high quality supported employment services if it demonstrates that it helps a high percentage of people with mental illness who want to be competitively employed to find and keep employment.

The use of outcome measures such as independent living, income, overall health, reduced arrests, or reduced involuntary psychiatric hospitalizations represents one of the underlying aspects of quality improvement. Outcomes can be used at the level of the work between an individual provider of services and a person with a mental illness. For example, a person may decide that an important outcome of their treatment would be to have meaningful social relationships with others. The person and the provider may work together to define this goal and then establish a way to track progress towards the goal such as meeting new people, going out to dinner with someone, or joining a civic organization. Outcomes can also be gathered as they relate to a specific group of people, for example, people with co-occurring mental illness and substance use disorders. One of the key strategies for gathering outcomes is to determine which outcomes are most meaningful, to establish clear definitions of outcomes and to develop ways, especially through technology, to gather and report outcomes in the most effective ways possible.

Other aspects of quality measurement include gathering data from people and their families who receive mental health services from an agency. Gathering information about the ways that employees of an agency work with the persons receiving services there may be useful. For example, the staff of an agency that respects the right of people receiving services there to make as many choices as possible about their own goals and preferences in treatment may be considered to have high quality services in that domain.

Quality and Fidelity for Evidence-Based Practices

A relatively new, but highly important quality measure is the use of fidelity assessments. When mental health services, such as the currently federally identified "evidence-based practices," are being used, quality can be measured by evaluating these services through a fidelity assessment. Fidelity refers to the extent of which an agency is providing services

based upon the key principles of that service that have been identified through repeated scientific research projects. For example, Assertive Community Treatment (ACT) has a fidelity assessment scale that measures critical components of the service such as the amount of time the team members spend in the community working with clients and the ratio of staff on the team to clients. Both of these areas have proven to be helpful in helping people with mental illness more effectively.

The second basic concept regarding quality is that while quality may be measured at a single point in time, it is part of an ongoing and evolving process. While measuring the quality of services provided at an agency is useful to the administration of the agency and to the organization that is paying the agency to provide services, quality measures are most important when they are used in a quality improvement process. This process actively works on improving the quality of services provided for the agency to be more effective in helping the people they serve to achieve their desired goals, build resiliency and achieve recovery.

Quality Measurements at Different Levels of the State System

The third fundamental concept of quality is that it can be measured and assessed at different levels in our mental health system. For example, one could look at the quality of the relationship between a case manager and the person that she or he is working with. Or one could look at all of the relationships between a psychiatrist and all of the people the psychiatrist treats. One could gather information about the relationships between all of the staff of an agency and all of the people receiving mental health services and their families that the agency provides services for. The view of quality could be focused on how well an agency helps all of the people it serves who have some common problems, such as how well an agency provides services to people with co-occurring mental illness and substance abuse problems.

Additionally, quality measurements are made across multiple organizations in a mental health system. For example, the Bureau of Behavioral Health may gather information on how well agencies help the people they serve to avoid involuntary psychiatric hospitalizations. This information may be used to establish quality (or performance) benchmarks for other organizations. The information may also be used to develop a learning collaboration for all the agencies to learn effective strategies to help the people they serve reduce their rate of involuntary hospitalizations.

Likewise, in many states, the mental health bureaus use results from fidelity assessments on evidence-based practices to monitor and improve the use of services that have demonstrated effectiveness. For example, the State of Kansas publishes a list of agencies in their state that provide high fidelity Supported Employment services. The State of Kansas also provides ongoing technical assistance and consultation to agencies to help them improve their fidelity to the evidence based practice.

The quality of a state mental health system can be measured, monitored and improved as well. For example, the State of New Hampshire may establish a benchmark for quality

based on aggregate individual outcomes such as providing evidence-based trauma treatment to 50 % of all people receiving services who have been identified as having trauma, or reducing the annual suicide rate of adolescents and young adults by 25 %.

Given this framework for quality and quality improvement, there are nationally recognized areas and components of quality for mental health systems. The following list of quality principles are based upon the nationally recognized "*Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series*" Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders. Each of the principles has been adapted to fit our vision for the mental health system in the State of New Hampshire.

Mental health services are based on resiliency building and recovery-oriented relationships

Providers work with each person in an individualized way that is hopeful and respectful while promoting self-determination and independence. Providers of services honor and respect the voices and choices of people and family members, (as defined by each individual). Information from people receiving services is used to monitor and improve the effectiveness and quality of services. People with mental illness and family members are integrally involved in all aspects of the quality improvement process.

The mental health system provides services based on the needs of the people, families and communities of the State of New Hampshire

The system is designed (or redesigned) to meet the most common types of needs for people affected by mental illness. Peers, family members and communities are full partners in determining and monitoring the mental health needs for the State and how responsive the system is in meeting those needs. The system addresses larger needs while individual services are provided in culturally responsive ways for each person, family and community.

People with mental illness and family members (as defined by each individual in services) drive services

People and family members drive the nature and type of services that are provided. People and their family members are provided the necessary information to make informed choices regarding services that are respected and honored. Providers of services accommodate differences in individual preferences and practice shared decision-making in treatment planning and providing services.

Providers of mental health services at all levels assure effective communication and flow of information with people in services

Providers empower people in services to understand and access important information regarding their overall health care and wellness and to fully participate in an informed way in treatment decisions. People in services have unfettered access to their health information. People in services receive information about the potential risks and benefits of services based upon their individual lifestyles and preferences.

Prioritizing Evidence-Based Practices

Information about and the implementation of evidence-based practices is a priority for the system of care. The mental health system works actively to lead the implementation of evidence-based practices in a timely way to assure high quality services. Where evidence-based practices are identified, they are prioritized and provided with high fidelity. The mental health system uses technology to constantly monitor individual outcomes to support and identify practice effectiveness. The use of technology and other teaching strategies are used to accelerate the workforce learning. The mental health system establishes working partnerships with community colleges, colleges and universities to produce a workforce with evidence-based competencies and skills.

The safety, overall health and well being of people is a priority

Specific measures are developed to assure maximum effectiveness and minimum unsafe and undesired outcomes for people in all services. Standards for safe and effective practices are established and monitored to safeguard people from errors and undesirable treatment outcomes. The mental health system work force is trained to provide effective practices and actively empower people with mental illness and their families to be informed of potentially undesired outcomes. Electronic medical records and electronic medical decision technology is used to prevent and monitor unsafe and undesirable outcomes.

People with mental illness and family members (as defined by individuals) have information that allows them to make informed choices

Providers of services empower people by providing information that allows them to make informed decisions about mental health services, treatments or alternative treatments. This information includes the evidence of effectiveness for the practice, potential undesirable outcomes and the types of services. The system makes information available to the public about the quality of services, including outcomes, fidelity of evidence-based practices and satisfaction for mental health provider agencies.

Demographic data and population growth trends, including cultural diversity and sentinel events in the state are used to forecast mental health needs

This information is used in a timely and planned way to assure that the system provides mental health services in the most timely and effective way possible. Wellness, prevention, and early intervention are priorities in forecasting and responding to emerging and future needs.

Maximizing the Efficient Use of Resources

Quality measurements that are based on the mental health needs of the State are developed, defined and used to measure quality at all levels (system, agency, and provider) of the mental health system. This data is used to assure that services are based on the combination of the most current scientific knowledge of effectiveness and provided in a resiliency enhancing, recovery-oriented way. The mental health system uses this data as part of a collaborative quality improvement process that includes agencies, providers, and people with mental illness and family members.

Health Care Communication and Collaboration

The overall health of people with mental illness is of primary importance. The mental health system actively assures that all providers of mental health services actively share information about each person's health and health care. Wherever possible, providers of mental health services and other health care services coordinate their services through the timely sharing of information. Technology is used to make the sharing of information as accessible and safe as is possible.

Work Team Three

Integrated Mental Health, Primary Health and Substance Use Care

Members:

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Dave Juvet	Concord
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Gail Brown	Concord
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Pam Brown	Bedford
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Lee Ustinich	Tilton
Joseph Harding	Concord
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MISSION STATEMENT

NH develops and promotes a statewide comprehensive, integrated health care system that incorporates medical, including oral health, mental health, and substance use treatment services to effectively address the diverse spectrum of problems that clients bring to their health care provider. We will do this through dissemination of best practices information, developing and supporting enabling legislation towards integrated care, and advocacy within our own individual spheres of influence.

Commission to Develop a Comprehensive State Mental Health Plan for NH
Team III
Integrated Healthcare: Definition, Principles, Mission, Vision, Goals and
Recommended Implementation Steps

Introduction

“Our minds and bodies are always together in our lives, except when we enter the health care system. There they are often separated, and totally distinct specialties take over.” Cynthia Watson, MD

Nearly every major policy statement on mental health in the last decade, ranging from the Surgeon General’s Report on Mental Health (1999) to the Presidents’ New Freedom Commission on Mental Health (2003), has begun with the tenet that mental health is central to overall health and more recent reports have added a corollary – physical health is central to overall health.

Improving the treatment of mental and substance use disorders in primary care settings and improving the medical and dental care of people with serious mental health and substance use disorders served in behavioral health settings has been a growing area of focus over the last decade. The goal of achieving quality of services and outcomes on both sides of the primary care/mental health/substance use interface is gaining long overdue attention and emphasis.

There are two sides to the primary care/mental health interface – the first is the presence of people in primary care that need MH/SU services. By 2003, 54% of people with mental health issues were served in the general medical only sector rather than within or in combination with the specialty mental health sector. Mood disorders (i.e. depression, bipolar disorder, etc.) are the seventh most costly health conditions in the United States, but rank second in the most disabling health conditions, reflecting both a high burden and potential under-funding of those conditions in the United States. Many initiatives have focused on treating depression because of the broad scope of the problem, the degree to which it has been under-recognized and under-treated in primary care settings, and the growing understanding of the impact of depression on other chronic health conditions. In addition, the application of behavioral health treatments to address lifestyle conditions has shown great promise in increasing the overall health of primary care patients and decreasing the cost to the system overall.

The other side of the interface is the issue of primary healthcare for people served in specialty mental health or substance abuse settings. Recent reports demonstrate that people with serious mental illness die, on average, 25 years earlier than their age cohorts in the general population; this is a serious public health problem for the people with these illnesses served by the public and private mental health systems.

We know the successful models of care for addressing MH/SU issues in primary care and have promising models for addressing the healthcare needs of people with serious mental illness. We know that providing stepped care according to specific program models will result in improved outcomes for those served. We know that both public and private policy and financing mechanisms function as barriers to implementing what is known clinically.

Improving care at the primary care/behavioral health interface will require that the MH/SU and medical systems begin to more fully embody the principles to follow and create a health system that is person/family-centered. Moving from today's fragmented, disease-focused system to a more person-centered system will require work by multiple stakeholders in these systems and, as with any collaborative endeavor, some degree of sacrifice and loss of control. However, moving toward a more integrated system of care will ultimately yield gains to consumers, communities, providers, and society that far outweigh these sacrifices.

I. Definitions

As articulated recently by the Institute of Medicine report, "Healthcare for general, mental, and substance use problems and illnesses must be delivered with an understanding of the inherent interactions between the mind/brain and the rest of the body." In the field, the terms integrated care and collaborative care are often used interchangeably, sometimes with differing meanings. **Communication** exists when each clinician caring for the patient shares needed clinical information about the patient to other clinicians also treating the patient. **Collaboration** is multidimensional, requiring a shared understanding of goals and roles, effective communication, and shared decision making. **Care coordination** is the outcome of effective collaboration and corresponds to clinical interaction.

Clinically integrated healthcare strongly endorses the reunification in practice of mind and body, leading toward positive health outcomes. Integrated healthcare combines medical, mental health, and substance use treatment services to effectively address the wide spectrum of problems that clients bring to their health care providers. It provides access to comprehensive services at any entry point of the healthcare system.

Adapted from: Blount, A. (1998); The Future of Medical and Mental Health Collaboration, Norton

II. Principles of Integrated Healthcare

Adapted from Quality Chasm Guidelines, Reference: Improving the Quality of Health Care for Mental and Substance Use Conditions: Quality Chasm Series, 2006

1. A shared paradigm of health and healing provides the foundation for effective healthcare integration. This paradigm pairs recognition of the fundamental unity of the mind and body with sincere respect for the integrity of the whole person. This perspective provides a common set of values and language that fosters

relationships, communication and mutual respect throughout the healthcare system.

2. Care is based on relationships that continually promote health. Relationships are carefully formed, sustained, and demonstrate trust and mutual respect among all involved in care. Clients receive care whenever they need it and in diverse forms, not limited to face-to-face visits. The healthcare system is responsive at all times (24 hours a day, every day) and access to care is provided in multiple ways.
3. Clients and providers participate in a mutual shared decision making process. The clients/families have access to the necessary information that affects them, the opportunity to exercise the degree of control they choose over health care decisions, and knowledge of the process of decision making itself. The health system accommodates to diversity in client preferences.
4. The “exact right amount at the exact right time” of collaboration occurs among clinical health care providers. These providers actively collaborate and communicate to ensure an appropriate exchange of information and coordination of care. In addition, they promote a full spectrum of services including prevention services, assessment, treatment and care management over time
5. The operational and financial systems are aligned with the clinical needs within an integrated healthcare system. Electronic and personal communication systems are built to bridge medical, mental health and substance use treatment services. Quality clinical outcomes and fiscal responsibility are considered equally in integrated care.

III. Mission: NH develops and promotes a statewide comprehensive, integrated healthcare system that incorporates medical, including oral health, mental health, and substance use treatment services to effectively address the diverse spectrum of problems that clients bring to their health care provider. We will do this through dissemination of best practices information, developing and supporting enabling legislation towards integrated care, and advocacy within our own individual spheres of influence.

IV. Vision: NH recognizes that both biological and environmental factors affect physical health, mental health and substance use and that there are interactions between each. All people in NH have access to quality integrated mental health, medical, including oral health, and substance use treatment and prevention services. These services are characterized by therapeutic relationships that share common goals, promote health, demonstrate mutual shared decision making, and are aligned and integrated across clinical, operational, and financial systems.

V. Goals Based on Principles 1, 2, and 4 – (Principles 3 and 5 are addressed by other work teams of the Commission, therefore Team 3 focused its attention 1, 2, and 4.)

Goal 1: A model of change for enacting our shared vision of an effective, integrated healthcare system has been achieved.

Goal 2: The model is translated and implemented throughout the integrated health care system (for all aspects including prevention, assessment, early intervention and treatment) including shared language, communication and technology, program evaluation, quality improvement and financing.

Goal 3: Training and skill building is available and accessible to care providers to strengthen and maintain relationships that are ongoing.

Goal 4: High quality relationships among care providers, and providers and clients are demonstrated among New Hampshire health, including oral health, mental health, and substance abuse clinicians and their clients.

Goal 5: The leadership and structure of medical, mental health, substance use provider organizations have policies and procedures and personnel in place that promote integrated care.

Goal 6: Communication among and between care providers is open, frequent, and effective with primary focus on client and family.

Goal 7: Individuals entering the system will have a team of care providers.

Goal 8: Collaborative teams will demonstrate improved health outcome.

VI. Recommended Initiatives

- 1. Make changes/modifications in the current financial models (i.e. billing for comprehensive services to a client) to support integrated care:**
 - Action step 1:** Establish a working group made up of representatives from DHHS, Medicaid Division; private insurers; the Insurance Department; and private providers and clients of service to solve financial barriers to integrated health.
 - Action step 2:** Integrate funding streams from medical and behavioral health in both public and private sectors.
 - Action step 3:** Investigate and request Medicaid waivers for public sector.
 - Action step 4:** Provide funding for coordination of care services in the public and in the private sectors.
 - Action step 5:** Develop funding mechanisms that support desired behaviors by providers: interdisciplinary communication, cooperation, and patient-centered care.
 - Action step 6:** Change Medicaid plan to adequately cover treatment for substance use disorder and oral health (prevention and treatment).

2. **A team comprised of DHHS and other key stakeholders from the public and private sectors should take the lead in facilitating integrated operational/administrative models of care involving public health services, private primary care practices as well as mental health and substance use services so that all citizens of New Hampshire participate in a seamless system of care.**

Action step 1: Appoint senior level positions for primary care (state Medical Director), mental health/substance abuse, and integrated care.

Action step 2: Build systems and processes such as a medical home, where integration can happen and records are accessible to all providers and clients through web based and/or other mechanisms.

Action step 3: Establish system of outcome measures and data collection tools to measure health outcomes: use results to inform and change practice, provide incentives for highly integrated public and private practices that demonstrate positive outcomes to assure sustainability.

Action step 4: Develop electronic health record systems across care systems and enable systems to have access to records, and aid in treatment decision making, while protecting confidentiality.

Action step 5: Convene regional meetings of medical and mental health/substance use advisory groups with viable consumer/family representation to identify and advocate for operational models that support integrated care principles.

3. **Develop local integrated care communities/program models as pilot sites such as: mental health staff/substance use in community health centers, mental health/substance use workers embedded in primary care practices, or primary care providers in CMHC's.**

Action step 1: Provide incentives and reward sites which demonstrate effective working relationships that cross previous administrative and financial barriers.

Action step 2: All sites use standardized tools to measure health processes and outcomes for mental health and substance abuse conditions.

Action step 3: Develop unified comprehensive plans of care for mental health and substance use conditions that are easily accessible to all providers.

Action step 4: Develop standardized protocols to screen for medical, mental health, dental and substance use conditions in all sites.

Action step 5: Provide education for providers that emphasize the components of recovery and resiliency in a wellness-oriented framework of health care.

Action step 6: Develop quality improvement protocols to address the minimization, among practice staff in the provider setting, of the stigma associated with chronic mental illness and substance use disorder.

(The Team recognized that within NH there are a number of service programs being implemented to integrate care and we commend those other planning initiatives to integrate services. Four examples were reviewed.

They include; Ammonoosuc Community Health Center, Littleton, Norrine Williams, Director, Capitol Region Family Health Center, Riverbend Community Mental Health Center Partnership, Concord, Bill Gunn PhD, Louis Josephson, PhD Mid-State Health Center, Plymouth, Fred Kelsey MD, Vince Scalse, PhD Concord Family Medicine, Concord NH, Gary Sobelson, MD, Carol Sobelson, MSW)

- 4. Establish a Center of Excellence in New Hampshire with representation from all key constituencies to conduct research, deliver trainings based on scientifically supported standards of care and measure outcomes and cost effectiveness of integrated programs**

Action step 1: Engage key stakeholders from business, insurance, provider, client/family and legislative communities to serve as steering committees for the center.

Action step 2: Seek and obtain a grant to develop the infrastructure for integrated care.

Action step 3. Ensure that all levels of post-secondary education and continuing educational programs in medicine, mental health, and substance abuse provide course work and practica working in integrated healthcare settings.

Action step 4: Institute a public education campaign to improve public awareness of the benefits, principles, and standards of integrated health care.

Action step 5: Make information available to the public on standards of care and research results.

Action step 6: Develop a cadre of champions/leaders across disciplines and across regions to deliver messages of the benefits of an integrated system of care.

Action step 7: Provide education for providers that engage them in creating partnerships with patients and families so all are actively involved in prevention, treatment and relapse prevention.

Action step 8: Encourage private foundations to support programs that implement and deliver integrated care.

Selected Sources: Team 3 Integrated Care

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Work Team Four

Eliminating Disparities

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MISSION STATEMENT

To develop recommendations for a continuum of early identification, intervention, and recovery-based treatment services which will improve and sustain the mental health of all NH citizens across their life span by identifying and addressing cultural, ethnic, physical, economic, institutional, regional and financial barriers to the access of effective and equitable mental health services.

**Commission to Develop a Comprehensive State Mental Health Plan
(HB 691-FN-L, Chapter 175:15, Laws of 2005)
Final Report**

ELIMINATING DISPARITIES
(Work Team Four)

“In a transformed mental health system, all Americans will share equally in the best available services and outcomes, regardless of race, gender, ethnicity, or geographic location.”¹

GOAL

To ensure that New Hampshire affords all of its citizens high quality mental health care that is accessible, proactive, responsive and effective by identifying and eliminating cultural, ethnic, physical, economic, regional and financial barriers to seeking and accessing care.

To achieve the goal and ultimately eliminate disparities in mental health care, New Hampshire must actively reach out to and provide mental health care to persons who are easily overlooked and historically underserved. These persons include those who are homeless, those who do not readily seek treatment due to mistrust, fear or stigma, those who are geographically or socially isolated, and persons who do not have transportation. Particular attention must be paid to older adults and children. New Hampshire must also focus on providing care in a manner that is informed, respectful of and responsive to cultural differences. Thus, it is essential that all mental health providers are trained in and embrace the concepts of recovery, resiliency and person-directed care. Finally, to ensure that it is providing high quality mental health care to all of its citizens, New Hampshire must measure and report on treatment outcomes across each of these population subgroups.

STATEMENT OF THE PROBLEM

Immigrants and Refugees

As the profile of the United States population becomes more diverse, so does New Hampshire. New Hampshire’s immigrant and refugee population is growing. As of 2005, 5.7% of New Hampshire’s population was “foreign born.” Over 25% of those persons have come to New Hampshire since 2000.² Approximately 9% of New Hampshire’s

¹ The President’s New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America*, p. 10 (2003).

² U.S. Census, American Community Survey, 2005.

population speaks a “language other than English.” Of this group, approximately one-third report that they speak English “less than very well.”³

Beyond the language issue, culture influences the concerns a person brings to the clinical setting. Coping styles differ by culture. Culture determines whether a person will seek help for a problem or how a person will seek help (through family, a minister, community elders, etc). Some cultures harbor mistrust of public agencies and place a great stigma on mental health treatment in particular.

The Homeless

On any given day in the United States, 800,000 are homeless.⁴ In New Hampshire, a point-in-time count conducted in 2006 identified 3,081 individuals as homeless. At that same point in time, the New Hampshire Department of Education identified 978 school-aged children as homeless.⁵

The cost to the community of homelessness is significant. A 2004 survey of 119 towns in New Hampshire revealed that nearly \$7 million was spent by those communities to provide welfare assistance to homeless individuals.⁶ Importantly, this figure does not include expenditures by the remaining 113 communities that did not participate in the survey. Moreover, the \$7 million figure does not include costs borne by institutions such as hospitals, food pantries, and police departments relating to homelessness.⁷

Although important, addressing homelessness is not merely a matter of providing affordable housing. Between 20 and 25 percent of homeless individuals have a serious mental illness.⁸ Between 50 and 75 percent of homeless individuals have a substance use disorder.⁹ In 2006, New Hampshire state-funded homeless shelters served 6,435 individuals.¹⁰ Of those individuals, 1,847 had a diagnosed mental illness, 2,457 had a substance use or alcohol disorder and 864 were dually diagnosed with mental illness and substance use disorder.¹¹ Persons in these groups need a full range of treatment, housing and support services to successfully exit homelessness. Studies show that providing these services reduces crisis costs. A New York study, for instance, showed a savings of 30% (\$12,145 per individual served).¹²

³ Id.

⁴ Governor’s Interagency Council on Homelessness, *A Home for Everyone: New Hampshire’s Ten-Year Plan to End Homelessness*, p. 11 (Dec. 21, 2006 (citing Burt, 2001)).

⁵ Id. at 11. The point-in-time count was taken from noon on Jan. 25, 2006 and noon on Jan. 26, 2006.

⁶ Id. at 13.

⁷ Id.

⁸ Id. at 13-14.

⁹ Id.

¹⁰ N.H. Dept. of Health and Human Services, Office of Homeless, Housing and Transportation Services, *Emergency Shelter and Homeless Coordination Commission, Annual Report for State Fiscal Year 2006*, p.17 (Feb. 2, 2007).

¹¹ Id.

¹² Id. at 14.

Older Adults

Approximately 12% of New Hampshire's population is aged 65 or older.¹³ Although older adults account for only about 12% of the population, they have the highest suicide rate of any age group and account for 18% of all suicide deaths in the United States.¹⁴

Depression is commonly an underlying condition of older adult suicide. However, it frequently remains undiagnosed and untreated. Symptoms often coexist with another serious illness or are viewed as part of the natural aging process.¹⁵ NAMI reported on a study that 70% of older adults who committed suicide visited their primary care physician within a month of their death, 40% within a week and 20% on the very day of suicide.¹⁶

Beyond the fact that depression is largely underrecognized by professionals, older adults might be hesitant to raise the issue or seek treatment on their own due to stigma. Finally, older adults are more likely to have difficulty finding transportation to enable them to access mental health services. Indeed, according to the New Hampshire Mental Health and Aging Consumer Advisory Council, transportation is the top concern of older adult consumers and family members.

Children and Adolescents

The Surgeon General reports that approximately 6 million to 9 million children and adolescents in the United States have a serious emotional disturbance.¹⁷ Disturbingly, however, the report's foremost finding was that "most children in need of mental health services do not get them."¹⁸

A recent report from Craig Donnelly, MD, of the Dartmouth-Hitchcock Medical Center, made similar findings, noting that approximately 20% of youth in the United States need mental health treatment.¹⁹ However, only one in five receive mental health care and only one in five of those who receive mental health care receive "expert care."²⁰ Thus, about 75 to 80 percent of youth with a serious emotional disturbance do not receive specialty or expert services, and most do not receive any services at all, as reported by their families.²¹

¹³ U.S. Census, American Community Survey, 2005.

¹⁴ U.S. Census Bureau, *65+ in the United States: 2005*, p.48 (Dec. 2005); see also NAMI NH, *A New Hampshire Guide to Mental Health and Healthy Aging for Older Adults and Caregivers*, p. 22 (Apr. 2006).

¹⁵ U.S. Census Bureau, *65+ in the United States: 2005*, p. 48; see also NAMI NH, *A New Hampshire Guide to Mental Health and Healthy Aging for Older Adults and Caregivers*.

¹⁶ NAMI NH U.S. Census Bureau, *65+ in the United States: 2005*, p. 23.

¹⁷ U.S. Dept. of Health and Human Services, *Mental Health: A Report of the Surgeon General*, Ch. 3, p.179 (1999) (citing Friedman et al., 1996; Lavigne, et al., 1996),

¹⁸ Id. at 180 (declaring the finding that most children who need mental health services do not get them as its "foremost finding").

¹⁹ Donnelly, Craig L., MD, *Integrating Behavioral Health & Primary Care for Children & Adolescents*, presentation dated June 2007.

²⁰ Id.; see also *Mental Health: A Report of the Surgeon General*, Ch. 3, p.180 (1999).

²¹ *Mental Health: A Report of the Surgeon General*, Ch. 3, p.180 (1999)

In NH, approximately 63,000 youth are in need of mental health services.²² Unfortunately, Dr. Donnelly's report indicates that there is a shortage of child psychiatrists in NH and that the shortage is exacerbated by the fact that child psychiatrists are clustered in a few counties, leaving rural areas largely uncovered.²³

²² Id.

²³ Id. (reporting that there are only about 7 child psychiatrists per 100,000 in New Hampshire).

RECOMMENDATIONS

1. Implement Assertive Community Treatment to improve access to quality care among the homeless, rural and elder populations.

“Assertive community treatment (ACT) is a way of delivering comprehensive and effective services to individuals who are diagnosed with severe mental illness and who have needs that have not been well met by traditional approaches to delivering services.”²⁴

ACT is one of six evidence-based practices for providing services to persons with severe mental illness. It is a means of providing individualized services by a multidisciplinary team that goes to the person to deliver services. These persons have a severe mental illness and tend to be the most functionally impaired in caring for their basic needs and keeping themselves safe.²⁵ According to SAMSHA’s performance indicators, accessibility to ACT services is one of the three best-practice measures of the quality of a state’s mental health system.²⁶

Researchers have found that as compared to traditional treatment approaches, ACT results in lower use of inpatient services, more independent living, a better quality of life and greater consumer and family satisfaction. When a substance abuse component is included in the treatment, ACT also leads to better substance abuse recovery outcomes. When combined with a supported employment component, consumers achieve higher rates of competitive employment.²⁷ Finally, ACT is Medicaid reimbursable and is endorsed as an essential treatment by the Surgeon General’s Report on Mental Health. Therefore, New Hampshire should immediately begin implementing ACT across the state to reach homeless persons, persons who live in rural regions and older adults who cannot readily access services.

Regarding the homeless issue in particular, implementing a Supportive Housing plan along with ACT could make a significant impact the health and well-being of New Hampshire’s homeless population. Supportive Housing has been shown to reduce hospitalizations, incarcerations and shelter costs, thereby offsetting the cost of providing housing. Moreover, Supportive Housing has been shown to have a positive impact on

²⁴ SAMHSA, *Assertive Community Treatment Implementation Resource Kit: Information for Public Mental Health Authorities*, p. 2 (2003) <

<http://download.ncadi.samhsa.gov/ken/pdf/toolkits/community/10.ACTinfoPMHA.pdf>>.

²⁵ SAMHSA, *Assertive Community Treatment Implementation Resource Kit: Information for Mental Health Program Leaders*, p.2 (2003)

<http://download.ncadi.samhsa.gov/ken/pdf/toolkits/community/09.ACT_Info_Prog_Leaders.pdf>.

²⁶ SAMHSA, *Assertive Community Treatment Implementation Resource Kit: Information for Public Mental Health Authorities*, p.1.

²⁷ *Id.* at 4.

homeless persons with mental illness. Studies have shown that after a year in supportive housing, approximately 80% remained housed.²⁸

²⁸ Corp. for Supportive Housing, *Supportive Housing works to End Homelessness*, <<http://www.csh.org>>; see also Corp. for Supportive Housing, *Supportive Housing Research FAQs: How Long do People Stay in Supportive Housing and What Happens When They Leave?*, <<http://www.csh.org>>, Sept. 2006.

2. **Improve access to quality care that is culturally competent to reduce the gap in access to care and in quality of care for persons of diverse cultures, backgrounds and languages.**

“For decades, many mental health programs neglected the growing diversity around them. Often, people from non-majority cultures found programs off-putting and hard to access. They avoided getting care, stopped looking for care, or, if they managed to find care, they dropped out. The result was troubling disparities: many minority groups faced lower access to care, lower use of care, and poorer quality of care. Altogether, those disparities translated into millions of people suffering needless disability from mental illness.”²⁹

Culturally competent means that mental health care services are provided in a manner that is “responsive to the cultural concerns of racial and ethnic minority groups, including their language, histories, traditions, beliefs, and values.”³⁰ Actually, cultural concerns and the need for responsive and respectful services extend beyond racial and ethnic minorities to persons who live in different geographical areas, persons of advanced age, persons who are deaf or hard of hearing, persons who are blind or visually impaired, persons with HIV/AIDS, and the GBLT population.

The New Hampshire legislature should mandate that cross-cultural curricula be a standard part of all medical, psychology, education and social work education programs in New Hampshire. The programming should include a section on health care disparities and causes, why and how to use an interpreter, and understanding differences across cultures and communities. Training in these areas should be included as a requirement for licensing in each of the above disciplines. To ensure continued sensitivity and responsiveness to cultural differences, a cross-cultural curriculum should also be a standard and required component of continuing education.

To ensure that all components of the state mental health system participate in improving cultural competency, a statewide mental health cultural competency advisory committee should be established by statute to monitor compliance and outcomes. On the committee should be representatives of the racial, ethnic and cultural groups being served and should include a person at the state level to be responsible and accountable for implementing a cross-cultural training program and for improving, monitoring and reporting on cultural competency in mental health.

3. **Implement a targeted public education campaign to promote acceptance of seeking mental health care and to prevent suicide.**

²⁹ SAMHSA, *Assertive Community Treatment Statement on Cultural Competency*, p.2-3 (2003) <<http://mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/community/culturalcompetence/default.asp#2>>.

³⁰ New Freedom Commission, p. 52.

The World Health Organization identified mental illness as the leading cause of disability worldwide; mental illness accounts for approximately 25% of all disability across major industrialized countries.³¹ Yet, many persons do not seek mental health care.

Many persons do not seek care because of the stigma surrounding mental illness. “Stigma is a pervasive barrier to understanding the gravity of mental illnesses and the importance of mental health.”³² Stigma is a particularly imposing barrier for older adults, certain ethnic and racial groups, and rural populations.³³ Many others do not recognize their symptoms or are unaware that mental illnesses can be treated and that recovery is possible.

By not seeking care, these persons do not enjoy a very achievable quality of life and many end up in acute care facilities or even homeless or in jail. Others turn to suicide. Suicide is a serious public health challenge and is the leading cause of violent deaths worldwide, outnumbering homicide and war-related deaths.³⁴

New Hampshire should strengthen its multimedia campaign to teach the public that mental health conditions can be reliably diagnosed and effectively treated and to help prevent suicide. The media campaign should target persons across the lifespan. Such campaigns have shown to be effective, such as the U.S. Air Force Initiative to Prevent Suicide. To address the alarming fact that one in four deaths was due to suicide among active duty personnel, the Air Force initiated a program that included messages encouraging personnel to seek help. The program also provided education and training and employed an integrated delivery system of care. The program reduced suicides by 50%. Interestingly, the biggest challenge noted was “sustaining the enthusiasm of service providers.”³⁵

New Hampshire should also create a health resource website to promote the benefits of seeking care, to help ensure that there is “no wrong door” for those who need mental health care and to enable persons to manage their own care. The website should be a source of information about services available, including community resources and supports. It should include a library and links to resources with pertinent mental health information, including information about diagnoses, insurance and advocacy. It could include information about how to initiate a conversation with one’s primary care physician regarding questions or concerns. All information on the website should be available in other languages including American Sign Language. San Diego has developed such a website called Network of Care for Mental Health.³⁶ New Hampshire should explore partnering with San Diego on the project. Such a website would be cost efficient in terms of updating or changing information. However, it would likely be necessary to dedicate a person or a unit to gather and organize the information and then to make it easily accessible to readers.

³¹ New Freedom Commission, p. 19.

³² New Freedom Commission, p. 20.

³³ New Freedom Commission, p. 20.

³⁴ New Freedom Commission, p. 20.

³⁵ New Freedom Commission, p. 25.

³⁶ New Freedom Commission, p. 84; see also Network of Care website, <<http://www.networkofcare.org>>.

4. **Expand the wraparound process currently used by DHHS for assisting older adults to include all adults with issues relating to mental health care.**

The purpose of the wraparound process is to provide person-directed care to adults with multiple agency involvement who are at risk of falling through the cracks, such as the homeless or socially isolated. Through the wraparound process, a community can maximize existing resources to increase public and private relationships to improve access to mental health care and to address related needs such as transportation, nutrition, medication management, financial management and housing.

Currently in New Hampshire, 13 communities have a wraparound process for older adults. Each month there is a meeting with all community agencies and resources, such as housing, transportation, clergy, police, medical rescue, fire, lawyers, cultural leaders, funeral directors, nurses, hospital discharge personnel, homemaking services, community mental health centers, protective services and ServiceLink. The wraparound is a forum through which different groups and agencies come together to learn what each other does and to learn about particular topics. During the meeting, the wraparound also address particular cases, such as a person who is close to eviction or who is falling through the cracks in trying to get assistance. By coming together, the various agencies can collectively problem-solve and coordinate action. Therefore, to enable a person to access mental health services, the wraparound might first help the person get financial assistance to catch up on rent or talk to the person's landlord to ensure that the person has a stable home and can then concentrate on health issues.

As the wraparound model already exists in the older adult arena, the state should roll out the wrap process into more communities and increase its focus to include adults with mental health issues. Besides those community members already at the table, it would be prudent to also include representatives from schools, shelters, HIV/AIDS programs and domestic violence and trauma resources.

5. **Coordinate and implement a volunteer driver program to ensure that all persons have a means of accessing mental health services.**

Transportation is an issue and barrier common to rural communities, urban communities, older adults, immigrants and refugees. Access to transportation impacts not only a person's ability to access mental health services but also impacts the person's ability to get to a job and to maintain a household.

Not everyone drives. Yet, public transportation in New Hampshire is a limited option at best. In rural areas, public transportation might not exist. Older adults who no longer drive and do not have ready access to transportation have limited access to mental health services and are more likely to be socially isolated. Immigrants and refugees who are new arrivals might not drive or even have the language base necessary to pass the drivers license exam. Moreover, even where public transportation is available, new arrivals

likely face bus schedules written in English and might not yet know how to navigate a bus system.

New Hampshire should study the transportation needs of persons who receive services through community mental health centers (“CMHCs”) to determine what transportation gaps exist region by region. The CMHCs should gather information on a person’s transportation needs during the intake process. Based on the results of that study, New Hampshire should explore and develop a system of employing volunteer drivers as a means of filling identified transportation gaps to ensure that all persons have access to health services. The program should be at no cost to persons of limited income. Rather, the state should reimburse the driver for mileage. Meanwhile, the CMHCs should provide transportation to persons who would otherwise not be able to access mental health services.

6. **Establish a process for expanding the level of staffing and improving retention, diversity and competencies at all levels of the workforce to ensure that the State can provide quality, evidence-based mental health services to all persons.**

“The mental health field needs a comprehensive strategic plan to improve workforce recruitment, retention, diversity, and skills training.”³⁷

To truly increase the level of quality of New Hampshire’s mental health system and implement the many recommendations of this Commission, the state must commit to increasing the level and quality of staffing in all areas. The workforce shortage is widely recognized, as well as the critical shortages in rural areas and for professionals who specialize in working with children, adolescents and older adults. Beyond a general shortage, however, the providers who are available are frequently not well trained in evidence-based and emerging practices.³⁸

New Hampshire should develop and implement a strategic plan to actively recruit mental health professionals to ensure that it can adequately serve all persons at all life stages and in all geographical regions in the state. As part of its plan, New Hampshire should both recruit and train professionals to work with persons who are deaf or hard of hearing or blind or visually impaired. It should ensure that a sufficient number of interpreters are trained in medical interpretation and are available to meet the various communication needs of its citizens. New Hampshire should further ensure that all professionals and mental health staff are trained in communications technologies such as tele-interpreters, teleconferencing and tele-health. Given the influx of the various immigrant and refugee populations, specific attention should be given to children who are attending school perhaps for the first time in an environment that is strange and perhaps hostile, and who, without special interpreters to intervene at all levels including schools, might not be able to communicate their needs and, thus, not receive much needed services. Finally, New

³⁷ New Freedom Commission, p. 75.

³⁸ New Freedom Commission, p. 70.

Hampshire should seek to recruit and retain mental health professionals who are ethnically and culturally representative of the persons they serve.

Work Team Five

Integrated Electronic Technology

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MISSION STATEMENT

To investigate and implement the use of information technology and the exchange of information to transform the NH mental health system while adhering to the principles of confidentiality and privacy of the system stakeholders.

**COMMISSION TO DEVELOP A COMPREHENSIVE STATE MENTAL
HEALTH PLAN
(HB 691-FN-L, Chapter 175:15, Laws of 2005)**

**Team Five – Integrated Electronic Technology
Final Report**

Project Goal Statement: To develop and begin implementation of a comprehensive state mental health plan for New Hampshire children, families, adults and seniors to transform the current system to eliminate barriers to access, to quality services and to good treatment outcomes

Work Team 5 Summary Statement: We recommend using information technology to transform and improve the state's mental health system. Technology is costly and diverts scarce resources; we should therefore focus on using it to improve clients' health and outcomes, as well as system efficiency. Our technology subcommittee recommends using information technology to reduce the stigma of mental illness, increase public education and awareness, promote collaboration and integration of care among all the relevant service systems, and improve access. We envision a future in which technology will connect the many and varied sectors of our communities, such that all in New Hampshire share in creating an atmosphere in which clients can achieve full recovery.

Work Team 5: Integrated Electronic Technology

Introduction and definition

Telehealth is the use of electronic information and telecommunications technologies to support long-distance clinical health care, patient and professional health-related education, public health and health administration. Technologies used in telehealth typically are: videoconferencing, the Internet, store-and-forward imaging, streaming media, and terrestrial and wireless communications. While new applications are increasingly found for using these technologies, significant barriers remain to making these technologies an integral part of daily health care practice.

Telehealth has been used successfully in a variety of settings, including primary care, home care, emergency departments and correctional facilities, though on a small scale. Larger-scale demonstration projects are underway, including some funded by the Centers for Medicare and Medicaid Services (CMS) and the Veterans Health Administration (VHA). Many experts, who have been using these technologies for years expect this next generation of studies to demonstrate significant clinical benefits, as well as reduced costs of care.³⁹ Hilty et al. (2002) described several controlled studies showing providers reliably assessed and diagnosed behavioral health concerns including, for example, major depression, bipolar disorder, panic disorder, and alcohol dependence. A number of controlled studies have demonstrated improved functioning following

³⁹ <http://www.fcg.com/research/serve-research.aspx?rid=335>, accessed 8/28/07

behavioral intervention via telehealth, including, for example, fewer hospitalizations for adults from rural Appalachia with significant behavioral health concerns, and no difference in functioning at outcome for depressed patients seen via telehealth versus in person. Finally, the authors reported that studies of patient response to behavioral telemedicine have shown fewer missed appointments, possibly due to decreased travel time. Satisfaction surveys show patients rate behavioral telehealth services positively, and indicate they would use the service again. The finding that patients were satisfied with telehealth services was true for adult, child, and geriatric samples.⁴⁰

Technologies offer the hope of expanding access to behavioral health care while reducing the cost. These technologies include online self-assessment tools, decision support tools such as drug interaction guides, social networking sites for support groups, online cognitive behavior therapy, virtual reality therapy, relaxation training and meditation instruction, stress management, and other Internet-based interventions. Online personal health records and patient portals include a growing number of behavioral assessments and tools for behavior change. Portable devices for behavioral monitoring and behavior change are proliferating.⁴¹

Guiding Principles

The problems created by the current system, characterized by fragmented clinical information, include:⁴²

1. Fragmented care and lack of coordination of care between providers and patients
Medicare beneficiaries see 1.3-13.8 unique providers annually—on average 6.4 different providers per year
2. Overuse, under use, misuse
1 in 5 lab tests and x-rays are ordered because the originals cannot be found (VA)
3. Unwarranted variation in clinical practice
1 in 7 hospital admissions occurs because care providers do not have access to previous medical records (VA)
4. Perverse incentives to provide unnecessary or unwanted care
5. Quality and safety issues
1 in 4 prescriptions taken by a patient is not known to the treating physician (Middleton, 2005)
6. Inability to perform to accreditation standards (for example, JCAHO's requirement that hospitals reconcile patient medications on admission, transfer, and discharge)
7. Value not commensurate with cost

We contrast the above with the following guiding principles for health care transformation drawn from the Institute of Medicine's "Improving the Quality of Health

⁴⁰ Hilty, DM et. al. Effects of Telepsychiatry on the Doctor-Patient Relationship. *Primary Psychiatry*. 9(9):29-34. 2002.

⁴¹ www.tcbi.org, accessed 8/28/07

⁴² All 7 items from a presentation by the Rhode Island HIE, IHI Conference in December 2006

Care for Mental and Substance-Use Conditions: Quality Chasm Series:⁴³

1. Individual patient preferences, needs, and values prevail in the face of residual stigma, discrimination, and coercion into treatment.
2. The necessary infrastructure exists to produce scientific evidence more quickly and promote its application in patient care.
3. Multiple providers' care of the same patient is coordinated.
4. Emerging information technology related to health care benefits people with mental or substance-use problems and illnesses.
5. The health care workforce has the education, training, and capacity to deliver high-quality care for mental and substance-use conditions.
6. Government programs, employers, and other group purchasers of health care for mental and substance-use conditions use their dollars in ways that support the delivery of high-quality care.

Recommendations

We recommend starting with the following document, which provides guidelines for assessing need for and implementing statewide information technology specifically detailed in the Health Information Exchange Workbook available to states online at http://www.staterhio.org/documents/HHSP23320064105EC_Workbook_090106.pdf.

The workbook outlines in detail current health information initiatives in 9 states: California, Colorado, Florida, Indiana, Massachusetts, Maine, Rhode Island, Tennessee, and Utah. In addition, the Appendix to the workbook contains worksheets with guiding information, as illustrated in Figure 1 below. The workbook suggests the following activities be performed at the state level:

1. Assess Market Characteristics

⁴³ Improving the Quality of Health Care for Mental and Substance Use Conditions: Quality Chasm Series, Institute of Medicine, 2006

Worksheet 1-1. Market Characteristics

(in no particular order)

MARKET CHARACTERISTIC	FINDINGS IN MY STATE	POTENTIAL EFFECT ON STATE-LEVEL HIE	COMMENT
Number or prevalence of local HIE organizations or pre-existing HIE activity locally			
History of collaboration among healthcare entities within the state versus a very competitive market with low collaborative spirit			
Whether there are local markets or regions that significantly vary in their needs (e.g., one has a higher Medicaid population, whereas another has a higher Medicare population with chronic disease)			
Distribution of urban versus rural			
Size of the state and population distribution			
Health of the state economy (e.g., Medicaid crisis or budget surplus)			
Whether the state's local markets are contiguous with other states, which may require coordination with neighboring states			
Number or prevalence of managed care organizations (e.g., could influence who bears the risk and who benefits from the financial incentives)			
Whether one or a small number of payers are dominant (e.g., market share of payers), which could affect how difficult it will be to implement certain services (includes large employers, health plans, etc.)			
Whether one or a small number of health systems or hospitals are dominant (e.g., market share of hospital systems)			
The proportion of large physician practices to small physician practices			
Availability of broadband Internet access			
Prevalence of use of EHR systems in the physician office			
Prevalence of the use of EHR systems in hospitals			
Number of medical research organizations			
Patient population demographics			
Population health status (e.g., prevalence of certain disease or conditions)			
Attitude toward privacy (if known)			
State government initiatives through the governor's office, state agencies, or state legislation			
Other			

2. Identify Champions and Key Stakeholders—the worksheet provides an extensive list of possible stakeholders, as well as the following possible drivers for change:

Worksheet 2-2. Drivers to Action/Triggering Events

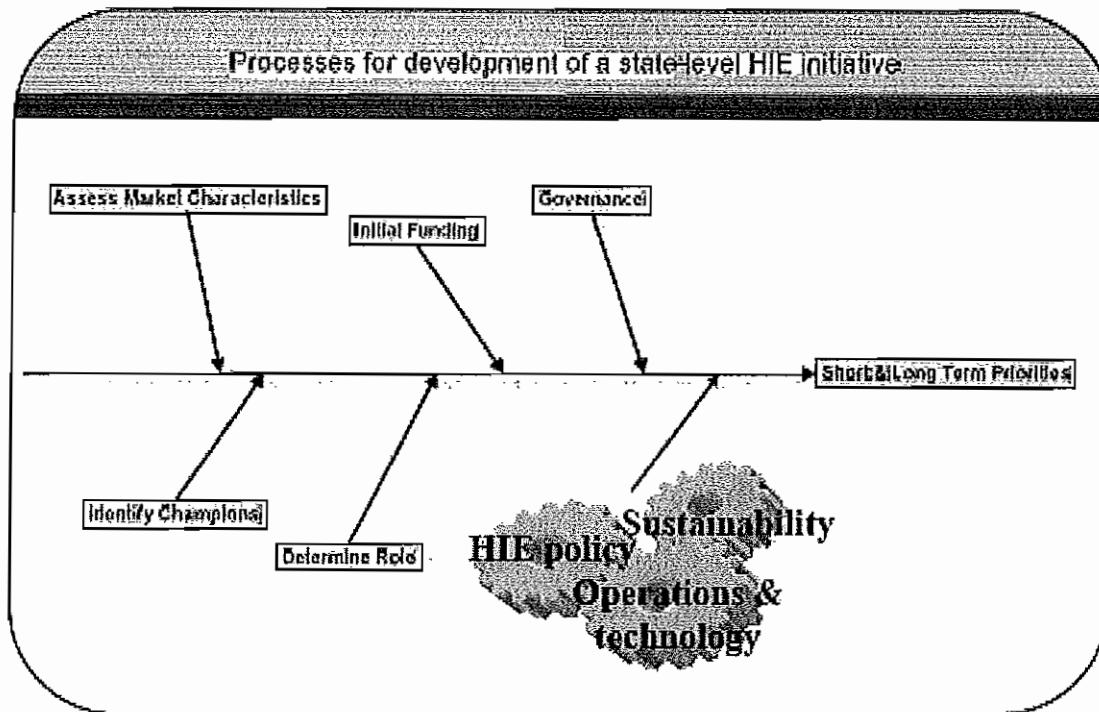
(in no particular order)

DRIVER OR CATALYST	RISK	REWARD	TIME FRAME
Governor's Executive Order			
Legislative mandate			
Grant or other money available for statewide HIE			
Summit or ongoing meetings of healthcare leaders			
Medicaid crisis			
Local leadership impetus			
Self-interest of the organizations seeking value and Return on investment			
Entrepreneurs			
Pressure from major employers			

3. Determine the Role of the State-Level HIE Initiative
4. Establish Governance Structure
5. Obtain Initial Funding
6. Concurrently Develop Financial Model for Sustainability, Formulate HIE
7. Policies, and Set Up Operations and (if applicable) Technology

8. Identify Short and Long Term Priorities
9. Reassess Original Assumptions and Plans Often, Expect Change, and Adjust Accordingly—there are detailed worksheets suggesting multiple barriers to implementation and offering other states' experiences in overcoming them

Figure 1.



This is demonstrated in the above figure, from the HIE Workbook.

Depending on where a state begins and what the historical relationships of the stakeholders are, the process of convening and achieving consensus could be relatively short or very long. Key points to keep in mind include:

- Start by securing a circle of key supporters and develop a vision.
- Consensus of all stakeholders is not necessary before beginning; only a critical mass is required to implement HIE.
- It is better to target smaller scale projects for early wins and to demonstrate the value of the state level HIE initiative, which will also allow the parties to adjust to the (possibly) new concept of collaborating and begin to build trust in the state level HIE initiative as a neutral convener.
- Open communication among stakeholders is important to ensure everyone understands the implications of the HIE model and is comfortable with participating.

Recommendations

Our recommendations to the Commission are grounded in the Institute of Medicine's "Six Aims of High Quality Health Care" from its Quality Chasm series, augmented by "The Quality Chasm's Ten Rules to Guide the Redesign of Health Care." The IOM's Six Aims of High-Quality Health Care provide the underpinning for the argument that adoption of improved information technology statewide will transform mental health services into more safe, effective, patient-centered, timely, efficient and equitable care. Patient and provider access to password-protected medication lists, allergies, past medication trials, diagnoses, primary care provider location, and recent services obtained would clearly improve patient safety in a timely, patient-centered manner. Access to password-protected population-based information would allow the state to improve equity of services, as well as monitor trends in health needs of patients, and anticipate possible outbreaks of infectious diseases before they become unwieldy to manage. Such information would also be helpful in creating more evidence for effective mental health treatments and help eliminate treatments that are costing money but not helping patients recover.

We recommend using information technology to transform and improve the state's mental health system. Technology is costly and diverts scarce resources; we should therefore focus on using it to improve clients' health and outcomes, as well as system efficiency. Our technology subcommittee recommends using information technology to reduce the stigma of mental illness, increase public education and awareness, promote collaboration and integration of care among all the relevant service systems, and improve access. We envision a future in which technology will connect the many and varied sectors of our communities, such that all in New Hampshire share in creating an atmosphere in which clients can achieve full recovery.

In order to close the gulf between what we know is quality mental health care and what the norm in practice is, we recommend the following:

1. Safe—avoiding injuries to patients from care that is intended to help them

We address two issues in this section, privacy of health information and mortality and morbidity due to preventable errors.

Privacy of health care information, particularly mental health information, is paramount, and should be protected in accordance with current federal and state laws. We are concerned about the potential for misuse of protected information made available via technology. Patients have a right to privacy and confidentiality of communication, and many states recognize a higher confidentiality standard for psychiatric records. Evaluation or treatment must be performed in an environment where there is a reasonable expectation of absence from intrusion by individuals not involved in the patient's direct care. However, strict privacy may be difficult to maintain in all circumstances. Hospital or clinic staff involved in the patient's care, family members and telemedical technical staff may at times be present in interviews. Patients should be informed about others present in the room at a distant site if such persons are off camera. On occasion telepsychiatric interviews will be audio-or video-taped, although this practice is often

avoided to prevent lapses of confidentiality. Informed consent involving these issues should be obtained either verbally or in writing from the patient, next of kin or guardian. If a consent form is used, it should adequately reflect that it may not always be possible to assure privacy.

Patients should be safe from injury caused by the care system. Reducing risk and ensuring safety require greater attention to systems that help prevent and mitigate errors. One study by Classen et al indicates that for in-hospital adverse drug events alone, the mortality risk was increased two-fold.⁴⁴ Another study of computerized physician order entry systems showed a 17% decrease in preventable adverse drug events.⁴⁵ These are compelling reasons to consider implementing initiatives such as E-Prescribing, which has already been recommended for New Hampshire by the Citizens' Health Initiative.

As with any procedure, the patient must be made aware of the potential risks and consequences as well as the likely benefits of telemedical consultation, and must be given the option of not participating. Patients should be informed that care will not be withheld if the telepsychiatric encounter is refused, although such care could depend on availability of alternative resources.

Action steps:

- Secure a circle of key supporters and develop a vision
- Conduct a detailed marketing assessment of need for information technology in the state of New Hampshire
- Develop statewide disaster plans in anticipation of potential security breaches
- Conduct annual security audits.
- Educate public about the extent and limitations of electronic privacy protection

2. Effective—providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit

Patients should receive care based on the best available scientific knowledge. Care should not vary illogically from clinician to clinician or from place to place. One of the benefits of information technology is the ability to develop an epidemiologic data-base. This would enable the state to anticipate changes in need for services; an example of this would be a change in the state's demographic profile, leading to an increased need for geriatric specialists. Further, having a data-base of interventions and outcomes would form a feed-back mechanism, allowing for better assessment of current therapies as well as guiding allocation of resources for future interventions.

Action steps:

- Develop an evidence-base tracking outcomes of various interventions to guide future care and where to put resources.
- Review and integrate the relevant findings and recommendations of the Citizens Health Initiative to inform the future application of technology for the improvement of the state's health system and its components, including

⁴⁴ Classen et al. *JAMA*. 1997;277:301-306

⁴⁵ Bates et al. *JAMA*. 1998;280:1311-1316

the public mental health sector, and for the support of health information exchange to improve individual care.

- Implement pilot demonstration efforts as effective strategies to advance the use of technology to improve and integrate healthcare in the state.

3. Person-centered—being respectful of and responsive to individual patient preferences, needs, and values and ensuring that a person’s values guide clinical decisions

Consumers know themselves best, and as such are experts engaged in collaboration with providers to combine their values and preferences with the most up-to-date information to engage in informed decision making.

The health care system should make information available to patients and their families that allows them to make informed decisions when selecting a health plan, hospital, or clinical practice, or choosing among evidence-based treatments. This should include information describing the system’s performance on safety, evidence-based practice, and patient satisfaction.

The system of care should be designed to meet the most common types of needs but have the capability to respond to individual patient choices and preferences.

Patients should be given the necessary information and the opportunity to exercise the degree of control they choose over health care decisions that affect them. The health system should be able to accommodate differences in patient preferences and encourage shared decision making.

Patient should have unfettered access to their own medical information and to clinical knowledge. Clinicians and patients should communicate effectively and share information. Telemedicine can further reinforce patient self-management by integrating self-monitoring into daily activities. Many programs incorporate educational materials and feedback that help teach patients how to care for themselves. Researchers have found that this approach to education and encouragement works for a wide variety of patient populations, including many elderly people with no prior experience with telemedicine devices.

Action steps:

- Include consumers of mental health services as central participants in the decision-making for the application of technology, such that technology will be focused upon and employed to facilitate their health improvement and personal recovery process.
- Ensure open communication among stakeholders, as it is important to ensure everyone understands the implications of the HIE model and is comfortable with participating.

4. Timely and accessible—reducing wait time and sometimes harmful delays for those who receive and give care

People should receive care whenever they need it and in many forms, not just face-to-face visits. This implies that the health care system should be responsive at all times (24 hours a day, every day) and that access to care should be provided over the

Internet, by telephone, and by other means in addition to face-to-face visits. This is care based on continuous healing relationships. Telemedicine can help to establish a continual feedback loop between patients and clinicians.

5. Efficient—avoiding waste of equipment, supplies, ideas, and energy

We know that much inefficiency exists in the current health care system, leading to a waste of valuable human and material resources. Eliminating waste would save time and money that could be used elsewhere. Clinicians, institutions, and patients should actively collaborate and communicate to ensure an appropriate exchange of information and coordination of care. The health system should anticipate patient needs, rather than reacting to events. Once basic connectivity and program management processes are established, almost any type of patient can benefit. Patients with diabetes can transmit glucose readings, patients with hypertension can transmit blood pressure readings, and patients with congestive heart failure (CHF) can transmit their daily weight measurements. By staying abreast of patient status in this way, providers can move away from an event-based approach in which they react to exacerbations of illness and toward active prevention. The time and resources that telemedicine saves can free practitioners to see more patients in a given time period. Second, improved communication can enable providers to make more timely adjustments to care plans, which ultimately reduces the number of hospitalizations and subsequent office visits, thereby creating new capacity. The belief that patients who manage their own health information and make their own choices will take a more active role in managing their own care. Patient empowerment is a critical component of these programs. Numerous studies have shown that patients who are "in the loop" of managing their health tend to make better choices regarding the care and services they consume, and are more attentive to the health management recommendations of their physician.

Action steps:

- Establish an integrated electronic health record within 5 years that connects all elements of the health and mental health sectors in order to create an integrated view of an individual's health status.
- The State of NH should stay informed of the development of national standards that allow for the inter-operability of different software and technology systems and apply such standards to guide the state's own efforts.

6. Equitable—providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status

There are more than 45 million people without insurance in the US. The US remains the only industrialized country that does not guarantee all of its citizens health care. In addition, there is strong evidence that depression and its sequelae is second among the top ten causes of world morbidity. According to the World Health Organization, with the aging of the world population and the conquest of infectious diseases, psychiatric and neurological conditions could increase their share of the total global disease burden by almost half, from 10.5 percent of the total burden to almost 15

percent in 2020.⁴⁶ Treatment of such illness would save lives and increase economic productivity.

Access to quality mental health care in NH is limited by geographic barriers and low numbers of specialty providers such as child psychiatrists. In addition, NH has a number of areas designated as federally underserved for primary and mental health care. Thirty-seven percent of the population of New Hampshire, including a large proportion of the elderly, live in a rural area. The proportion of New Hampshire's population classified as elderly is expected to triple over the next 20 years. Home health monitoring in all areas of the state reduces hospitalizations, allowing elderly patients to remain in their homes. Fortunately, according to the White Paper "Planning and Implementing a Statewide Telehealth Program in New Hampshire," the state has several resource-rich areas with tertiary medical centers that could provide specialty care through telemedicine.⁴⁷

Action Steps:

- Identify champions and key stakeholders
- Create a multi-disciplinary, multi-agency, private, public, consumer board that directs the above.
- Select additional specific technologies that represent significant benefit for the improvement of the health status of individual NH's citizens. These technologies include, but are not limited to, telehealth, consumer information and education software for enhanced consumer self-health management and individual in-home health monitoring devices.

Potential Obstacles to Implementation:

The HIE Workbook outlines multiple obstacles and describes methods by which other states have overcome them. Two of the major obstacles likely to be an issue in New Hampshire are privacy and confidentiality of records, particularly because of the sensitive nature of psychiatric records, and reimbursement for telehealth services. These issues are addressed in greater detail on the following Websites:

<http://tie.telemed.org/legal>

http://www.amdtelemedicine.com/private_payer/searchform.cfm not reimburse for Medicaid

<http://tie.telemed.org/legal/state>

New Hampshire Initiatives Already Underway:

Work Team 5 would like to acknowledge the many initiatives already underway, aiming to bring technology to health care for New Hampshire citizens. The following is not intended to be a comprehensive list, but a guide for those who seek more information:

⁴⁶ <http://www.nimh.nih.gov/publicat/burden.cfm>, accessed 8/28/07

⁴⁷ White Paper: Planning and Implementing a Statewide Telehealth Program in New Hampshire. Kazal and Conner, 2005. Endowment for Health.

<http://www.ehealthinitiative.org/initiatives/programs/aboutstatesummit.msp>
http://www.endowmentforhealth.org/resources_publications.asp
<http://nhtelehealth.org/>

Commission Resource Persons

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Glossary of Terms

Person Centered System

A person centered system respects and responds to individual needs, goals and values. Individuals and providers work in full partnership to guarantee that each person's values, experiences and knowledge drive the creation of an individualized care plan as well as the delivery of services.

Children and Family Centered Services

A family driven/youth guided system respects and responds to individual and family preferences, needs, goals and values. Individuals, family members and providers work in full partnership to guarantee that each person's and family's values, experiences and knowledge drive the creation of an individualized care plan as well as the delivery of services.

Recovery

Recovery involves a process of restoring or developing a meaningful sense of belonging and a positive sense of identity apart from one's disability while rebuilding a life in the broader community.

Resiliency

Resiliency describes the personal qualities and social supports that enable us to rebound from adversity, trauma, tragedy or other stresses – and to go on with life with a sense of mastery, competence and hope.

Peer specialist

A peer specialist is a person recovering from a mental illness who has been trained and certified to help his/her peers gain hope and move towards their own recovery. A peer specialist promotes self-determination, personal responsibility and empowerment inherent in self-directed recovery. A peer specialist provides consumer education, advocacy, peer support services in a variety of community settings such as emergency rooms, outpatient or inpatient settings.

Peer support

Peer support is a practice provided by trained persons in recovery. These peers promote and model self-determination and personal responsibility in healthy, reciprocal relationships. Peers support peers in becoming less dependent on the mental health

system; empowerment and recovery then come from feeling more competent and valued. Rather than working as an adjunct to treatment provided within mental health services, peer support occurs within the community in community-like settings where mutual relationships are built. It enables individuals to see themselves as whole people rather than focusing on illness and problems, A peer support center thus acts as the 'practice ground' to develop the skills needed to facilitate community and vocational integration.