Monadnock Region System of Care Network Analysis, 2015 & 2016

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Executive Summary

We conducted assessments of the Monadnock Region System of Care (MRSoC) and the Children’s Behavioral Health Collaborative (CBHC)

• The purpose was to assess network relationships, contributions, and outcomes.

• We used the PARTNER, an online survey and integrated analysis tool and administered it in February 2015 and June 2016.

• 7 (100%) of the key respondents from the MRSoC member organizations completed the survey in 2015 and 10 (91%) in 2016.

Results

• MRSoC is fairly trusting, has moderate density, and is relatively centralized

• MRSoC network grows and weekly contact intensifies

• CBHC contact grows over time; Monadnock gains in centrality

Recommendations

• Set direction and goals for governance and structure of the MRSoC network

• Engage new and peripheral members, especially service and support provider organizations and youth and family members

• Build trust
Why We Assessed the Monadnock Region System of Care (MRSoC) Network and the NH Children’s Behavioral Health Collaborative (CBHC)

Planning to improve care for youth with significant emotional and behavioral health needs in the Monadnock Region

In 2014 Cheshire County was awarded a grant by the Substance Abuse and Mental Health Services Administration (SAMHSA) to develop a plan for an integrated, comprehensive system of care for children and youth with significant emotional and behavioral health needs and their families throughout the Monadnock Region of New Hampshire.

An essential component of planning for the Monadnock Region System of Care (MRSoC) involves developing connections among Monadnock organizations as well as cultivating ties to the NH statewide system of care, FAST Forward (FF), and to the broader network of NH organizations making up the Children’s Behavioral Health Collaborative (CBHC). These enhanced regional and state connections help to build the capacity necessary to support a regional system of care and to ensure coherence across the region and state. The success of the MRSoC planning rests, in part, on the degree to which diverse stakeholders in the region and state are able to collaborate effectively.

Collaborating across region and state

Collaboration around children’s behavioral health in NH connects the MRSoC planning initiative directly to the developing network of organizations comprising the NH’s CBHC, which formed at the initiative of the Endowment for Health and the New Hampshire Charitable Foundation in 2010. At that time, the CBHC began a 3-year strategic planning process to develop a system of care for NH’s children and youth with significant emotional and behavioral health needs. Drawing on input from diverse stakeholders, the CBHC developed the Children’s Behavioral Health Plan, released in March 2013. Since its inception, the CBHC has secured substantial investments toward sustainable best practices, workforce development, service delivery, advocacy and policy. Notably, in 2012, SAMHSA awarded the NH Department of Health and Human Services (NHDHHS) a System of Care Implementation Grant to develop FF. Nurturing collaboration among FF stakeholders, the broader CBHC network, and the organizations making up the MRSoC are an essential component of planning and now implementing a regional system of care.

Evaluators Assessed MRSoC and CBHC Network Functioning

To measure the strengths and weaknesses of partnerships among MRSoC, FF and CBHC organizations, evaluators from Antioch University New England’s (AUNE) Center for Behavioral Health Innovations (BHI) conducted a baseline network assessment in early 2015 and then again about 18 months later in 2016. Network assessments benefit collaboratives by gauging levels and types of partner engagement and offering strategizes to build capacity. Network analysis is also useful in assessing changes in collaboration over time, to help measure how a network is progressing.
How We Assessed the MRSoC and CBHC Networks

MRSoC, FF and CBHC Networks Assessed Using Social Network Analysis

Collaborative networks face the challenges of how to understand the nature of their network, to measure their effectiveness, and strategize ways to enhance their functioning. Social Network Analysis (SNA) offers a methodology for understanding the nature of these kinds of networks. SNA involves the measuring, mapping, analyzing, and interpreting of social network structures. BHI evaluators chose the PARTNER tool, a publically available, integrated online survey and SNA tool, to assess these networks. PARTNER assesses the amount and nature of relationships, capacities and contributions, and outcomes within networks over time. The tool includes a customizable online survey to collect data and an integrated Excel-based social network data analysis program.

PARTNER Survey Modified

We modified the PARTNER survey to meet the learning needs of NH networks through multiple rounds of input from CBHC stakeholders and the PARTNER tool developer (Danielle Varda, University of Colorado Denver). The final version of the survey contained 22 items designed to assess 1) basic demographic information (e.g., length of service, involvement in CBHC working groups, grants and partner projects), 2) NH network relationships (i.e., perceived trust, value, and amount of collaboration between members), 3) CBHC Contributions (i.e., the amount and types of contributions by various members to the functioning of the CBHC), and 4) CBHC outcomes (i.e., the success of the CBHC in achieving its preferred outcomes, as perceived by its members). See Appendix A for survey.

PARTNER survey measured network development over time

To be considered a CBHC member, an organization had to meet one of two criteria: 1) active participation in a CBHC work group, steering committee, and/or grant-funded project and/or 2) mission alignment with the CBHC (i.e., Community Mental Health Centers and Regional Public Health Networks.) The FF network was comprised of the stakeholders directly involved in the FF grant. The MRSoC network was comprised of all CBHC member organizations based in the Monadnock region. For both administrations, a CBHC official provided advanced notice and encouraged participation through an email sent to the key respondents of all member organizations. All other communication about the survey was generated and sent via the PARTNER tool. Appendix B includes a list of organizations.

The first administration took place in February 2015. Eighty-four member organizations met the criteria, and a key respondent was selected from each to respond to the survey. CBHC member organizations (N=84) were invited to participate in February 2015, with an initial PARTNER-generated email and three follow-up email prompts. At the end of the response period, 54 CBHC key respondents had completed at least 40% of the survey, for a response rate of 64%. All 7 MRSoC key respondents responded for a 100% response rate. The second administration took place in June 2016. Ninety-seven organizations met the criteria for CBHC member organization. At the end of the response period, 61 key respondents had completed at least 33% of the survey, for a response rate of 63%. 10 of the 11 MRSoC key respondents completed the survey for a 91% response rate.

Descriptive analyses conducted with PARTNER tool

All analyses were descriptive in nature, with findings displayed in tables, charts, and figures. All findings were generated through PARTNER’s data analysis and visualization tools.
Network Scores Explained

The PARTNER tool describes key attributes of whole networks by calculating scores for density and degree centralization, dimensions that describe the overall structure of the network, as well as overall network trust. The network trust score is an index derived from scores of all network organizations about other network organizations in the areas of “reliability,” “support of mission,” and “openness to discussion.”

Density scores describe the number of ties that exist among organizations in the network. In a very dense network, every organization is connected to every other organization; a diffuse network has few connections among organizations. (See Figure 1.) Density scores are reported as the percentage of ties present in the network in relation to the total number of possible ties. PARTNER developers consider density scores descriptive; there is no ideal density score, each network must consider its own goals and structure.

Degree centrality scores describe the degree to which the network organizations are alike in terms of their number of connections to each other. In a very decentralized network, organizations have similar numbers of connections to each other, while in a very centralized network one or two organizations might have many more connections within the network than other organizations. (Something about how reported---will we reverse score?) Like density, degree centrality is considered a descriptive dimension.
MRSoC is Fairly Trusting, has Moderate Density, and is Relatively Centralized

Figure 3: MRSoC Network Scores, 2015 & 2016

<table>
<thead>
<tr>
<th>Network Attribute</th>
<th>Administration 1 (Feb 2015)</th>
<th>Administration 2 (June 2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Density</td>
<td>57.10%</td>
<td>52.7%</td>
</tr>
<tr>
<td>Degree Centralization</td>
<td>36.70%</td>
<td>33.3%</td>
</tr>
<tr>
<td>Trust</td>
<td>70.80%</td>
<td>76%</td>
</tr>
</tbody>
</table>

MRSoC Reaches “Fair” Levels of Trust

Trust—a resource that increases rather than decreases through use, and becomes depleted if not used—is a key characteristic of properly functioning networks. To achieve a 100% trust score, each member of the network would have to fully trust every other member with whom they interact. At 76%, the MRSoC has fair levels of trust, reflecting members’ commitment to a joint, focused, and important mission. The fair level of trust within the MRSoC network represents a network resource as well as an opportunity for growth. (breakdown of trust to see where need improvement?)

Decreasing Density in MRSoC

Network density is an indicator of overall cohesiveness of a network. Neither dense nor diffuse, the MRSoC network organizations engage in about half of all possible connections in the network, with a trend toward fewer ties. With several new organizations in the network for the 2016 administration, this decreasing density is likely a reflection of new organizations joining the network with fewer network ties in the planning phase. As a point of comparison, the overall density score for the CBHC network is x, reflecting the far more diffuse nature of the larger, statewide network.

MRSoC Relatively Centralized

Lower centralization scores indicate that activity is centralized around a few members who hold highly central positions; in these cases, positions of brokerage and information sharing are held by small number of members. Higher centralization scores indicate a less centralized collaborative in which connections (and thus influence and control) are more evenly distributed, which in turn may increase member willingness to support a collaborative’s goals. The MRSoC score for degree centralization is in the low-mid range at 33.3%, suggesting a network where information, power and control are relatively centralized, distributed across a handful of key organizations.
MRSoC Network Grows and Weekly Contact Intensifies

Figure 4 shows network maps of weekly contact in the MRSoC in 2015 and in 2016. In the network maps, each colored circle represents an organization in the MRSoC network and lines connecting the circles display weekly contact between organizations. (The organization colors displayed in the two maps are not consistent across maps.) The positions of the circles in relation to each other reflect the organizations’ relative centrality.

The maps show growth and maturation of the network, from a small group of organizations with fewer ties to a larger group with distributed contact among them. The MRSoC network grew from seven organizations in February 2015 to eleven in 2016. The 2016 map displays seven core MRSoC organizations holding central positions with even distribution of connections among them, a secondary ring of organizations with many fewer connections, and one isolated organization on the periphery (same organization is also on the edge of the map in 2015).

*Figure 4: MRSoC Network, Weekly Contact, 2015 & 2016*
CBHC Contact Grows Over Time; Monadnock Gains in Centrality

Figures 6 and 7 display networks maps of the entire CBHC network with lines between organizations representing weekly contact. In these maps the colors of the organizations are coded to represent the MRSoC, FF, and Other, meaning all the other member organizations in the CBHC. The maps display a distinct change in the magnitude of weekly contact throughout the CBHC over time. Significantly, peripheral organizations in the 2015 map show more connections and greater centrality in the 2016 map.

Taken as a group, MRSoC organizations gain centrality in the overall network and cohesiveness as a subnetwork, with some notable exceptions. (See top left and right of 2016 map.) As the centrality of MRSoC develops, its proximity to FF organizations draws closer.

**Figure 6: MRSoC and FF Within CBHC Network, Weekly Contact, 2015**

**Figure 5: MRSoC and FF Within CBHC Network, Weekly Contact, 2016**
Recommendations

As MRSoC moves from planning to implementation, considering ways to develop and strengthen the network are valuable investments of MRSoC resources. The following recommendations emerge from this network analysis.

**Set direction and goals for governance and structure of the MRSoC network**
What governance will lead to the most effective functioning of the MRSoC network? Will there be a backbone organization to shepherd this work? What sectors need to be involved and in what way? How will communication flow among MRSoC organizations? What structures need to be in place to support effective communication and collaboration? What network density and degree centrality best supports MRSoC goals?

**Engage new and peripheral members**
Developing strategies to bring in new member organizations will be a crucial next step in implementation. The timing also offers an opportunity to engage peripheral member organizations. The CBHC has faced challenges engaging particular sectors of stakeholders in children’s behavioral health, in particular service and support providers and youth and family members. As a regional network, MRSoC may be well positioned to bring new attention and ideas to engaging youth and family members, in particular.

**Build trust**
Key to enhancing a regional network will be to develop strong trust among the stakeholder organizations. Especially within a regional network, where organizations are working with the same stakeholders, from service and support providers, to youth and families, trust plays a crucial role in network effectiveness.
Appendix A: CBHC PARTNER Survey Questions

1) Please select your organization/entity from the list: (See Appendix B for list of CBHC member organizations.)

2) What is your role in this organization/entity?

3) How long have you been in this role? (Estimate to nearest year.)

4) The mission of the CHBC is to improve the behavioral health of NH's children, youth, and families. Please indicate what your organization/entity contributes to the CBHC. (Choose as many as apply.)
   a) Advocacy for system of care values and other CBHC priorities with funders and policymakers
   b) Public awareness, communication, education, and marketing
   c) Leadership and strategic planning
   d) Planning and facilitating events and meetings
   e) Paid staff
   f) In kind resources (donated and volunteer effort, meeting space, etc.)
   g) Social capital and connections
   h) Mobilization of funding and fiscal management
   i) Shared measurement and data resources (data collection, analysis, reporting)
   j) Behavioral health expertise and tools
   k) Public/population health, systems change expertise and tools
   l) Local, community-based expertise (e.g., norms, customs, values within specific areas of NH)
   m) Implementation of new/better policies, programs, services, and/or supports

5) What is your organization/entity's most important contribution to the CBHC? (Choose one.)
   a) Advocacy for system of care values and other CBHC priorities with funders and policymakers
   b) Public awareness, communication, education, and marketing
   c) Leadership and strategic planning
   d) Planning and facilitating events and meetings
   e) Paid staff
   f) In kind resources (donated and volunteer effort, meeting space, etc.)
   g) Social capital and connections
   h) Mobilization of funding and fiscal management
   i) Shared measurement and data resources (data collection, analysis, reporting)
   j) Behavioral health expertise and tools
   k) Public/population health, systems change expertise and tools
   l) Local, community-based expertise (e.g., norms, customs, values within specific areas of NH)
   m) Implementation of new/better policies, programs, services, and/or supports
6) Which of the following outcomes should the CBHC try to achieve and sustain? (Choose all that apply.)
   a) Improved collaboration among key stakeholders
   b) Increased funding/more efficient use of resources
   c) More well-trained, competent behavioral health workers
   d) Better access to high quality tools and expert help
   e) Enhanced data collection, monitoring, and evaluation
   f) Better early detection and prevention
   g) More access to high quality, community-based supports and services
   h) A more youth/family guided, culturally and linguistically competent system
   i) Better coordinated and integrated services and supports
   j) Better informed and more supportive communities and environments

7) Which outcome is most important to try to achieve and sustain? (Choose one.)
   a) Improved collaboration among key stakeholders
   b) Increased funding/more efficient use of resources
   c) More well-trained, competent behavioral health workers
   d) Better access to high quality tools and expert help
   e) Enhanced data collection, monitoring, and evaluation
   f) Better early detection and prevention
   g) More access to high quality, community-based supports and services
   h) A more youth/family guided, culturally and linguistically competent system
   i) Better coordinated and integrated services and supports
   j) Better informed and more supportive communities and environments

8) How successful has the CBHC been at achieving system change?
   a) Not Successful
   b) Somewhat Successful
   c) Successful
   d) Very Successful
   e) Completely Successful

9) Which of the following contributes most to the CBHC's success to date? (Choose all that apply.)
   a) Bringing together diverse stakeholders
   b) Meeting regularly
   c) Exchanging info/knowledge
   d) Publicizing events
   e) Sharing resources
   f) Strategic planning
   g) Informal relationships created
   h) Making collective decisions
   i) Having a shared mission/goals
   j) Identifying and applying to funding opportunities
   k) Not applicable --- CBHC has not achieved any success
10) Next, please select from the list each organization/entity you are actively working with to advance the CBHC mission. You will then answer a series of questions about each of these organizations/entities. We want to make this as useful for the CBHC and as easy for you as possible. So, report only on relationships with other organizations/entities that a) have been inspired or otherwise facilitated by the CBHC and b) involve intentional efforts to improve the behavioral health of children/youth within the next year. (See Appendix B.)

11) How frequently do you or others in your organization work with this organization/entity to improve the behavioral health of NH’s children?
   a) Never/We only interact on non-CBHC issues.
   b) Once a year or less
   c) About once a quarter
   d) About once a month
   e) Every Week
   f) Every Day

12) What types of CBHC-inspired efforts to improve the behavioral health of NH’s children/youth are you currently planning or implementing with this organization/entity? (Choose all that apply.)
   a) Awareness, education, and/or anti-stigma campaigns
   b) Data gathering, research, and/or evaluation activities
   c) Healthier environments/environmental interventions
   d) Natural support systems
   e) Policy development and/or advocacy
   f) Professional service and support systems

13) How valuable is this organization/entity’s power and influence to achieving the overall mission of the CBHC?
*Power/Influence: The organization/entity holds a prominent position in the community or field by being powerful, having influence, success as a change agent, and showing leadership.
   a) Not at all
   b) A small amount
   c) A fair amount
   d) A great deal

14) How valuable is this organization/entity’s level of involvement to achieving the overall mission of the CBHC?
*Level of Involvement: The organization/entity is strongly committed and active in the partnership and gets things done.
   a) Not at all
   b) A small amount
   c) A fair amount
   d) A great deal
15) How valuable is this organization/entity's resource contribution to achieving the overall mission of the CBHC?
*Contributing Resources: The organization/entity brings resources to the partnership like funding, information, or other resources.
   a) Not at all
   b) A small amount
   c) A fair amount
   d) A great deal

16) How reliable is this organization/entity?
*Reliable: this organization/entity is reliable in terms of following through on commitments to the CBHC.
   a) Not at all
   b) A small amount
   c) A fair amount
   d) A great deal

17) To what extent does this organization/entity share a mission with the CBHC's mission and goals?
*Mission Congruence: this organization/entity shares the vision of the CBHC.
   a) Not at all
   b) A small amount
   c) A fair amount
   d) A great deal

18) How open to discussion is the organization/entity? *Open to Discussion: this organization/entity is willing to engage in frank, open and civil discussion (especially when disagreement exists). The organization/entity is willing to consider a variety of viewpoints and talk together (rather than at each other). You are able to communicate with this organization/entity in an open, trusting manner.
   a) Not at all
   b) A small amount
   c) A fair amount
   d) A great deal

19) This partnership has contributed or led to: (Choose all that apply.)
   a) Expanded and improved infrastructure (e.g. networking, collaboration, data collection and evaluation, training, resources, tools.)
   b) Enhanced services and supports (e.g. early detection/prevention, higher quality, integrated, community-based services and supports, a more youth/family guided, linguistically and culturally competent system.)
   c) Better-informed and more supportive communities/environments.
   d) Has not yet contributed or resulted in systems change.

20) Please indicate to which of the following CBHC structures/workgroups your organization/entity contributes. (Check all that apply.)
   a) CBHC Steering Committee
b) Behavior Health Equity
c) Communications and Social Marketing
d) Evaluation
e) Policy
f) School Behavioral Health
g) Workforce Network

21) Please indicate on which of the following funded projects your organization/entity has a formal/contracted role. (Check all that apply.)
   a) FAST Forward
   b) Project LAUNCH
   c) Rehabilitation for Empowerment, Natural Supports, Education, and Work (RENEW)
   d) Safe Schools, Healthy Students
   e) Spark NH Early Childhood Advisory Council
   f) NAMI-NEXUS Statewide Suicide Prevention
   g) Partners for Change at Dartmouth
   h) Cheshire County System of Care
   i) Project AWARE

22) Do you have any additional comments or feedback about the CBHC?
Appendix B: CBHC Member Organizations

Antal Consulting, LLC
Antioch University New England
Berlin Schools District; Project Aware
Carroll County Coalition for Public Health
Carroll County Prevention Network
Center for Life Management
Center for Program Design and Evaluation, Dartmouth
Child and Family Services
Child Health Services
Children's Behavioral Health Collaborative
Children's Hospital at Dartmouth-Hitchcock, Concord
Children's Hospital at Dartmouth-Hitchcock, Pediatric Residency
Communities for Alcohol and Drug-Free Youth
Communities United Regional Network of Sullivan County
Community Bridges
Community Partners
Concord School District; Safe Schools/Healthy Students
Conval School District
County of Cheshire
Dartmouth Trauma Interventions Research Center
DHHS: Mental Health Services
DHHS: Bureau of Children's Behavioral Health
DHHS: Bureau of Drug & Alcohol Services
DHHS: Division for Children, Youth, and Families
DHHS: Division of Behavioral Health
DHHS: Office of Minority Health and Refugee Affairs
Disability Rights Center - NH
Dover Coalition for Youth
Early Learning NH
Elliot Health Systems: Neonatology Services
Endowment for Health
Families in Transition - Family Willows
FASTER (Families Advocating Substance Treatment, Education and Recovery) Support Group
Foundation for Healthy Communities
Genesis Behavioral Health
Goodwin Community Health
Granite State Federation of Families for Children's Mental Health/YouthMove
Granite United Way
Greater Derry Public Health Network
Cheshire Medical Center/Greater Monadnock Regional Public Health Network
Greater Nashua Mental Health Center
Hampton School District
Headrest, Inc.
Indian Stream Health Center
International Institute of NH
Ken Jue, Independent Consultant
Laconia School District; Safe Schools/Healthy Students
Lakes Region Partnership for Public Health
Makin It Happen Coalition for Resilient Youth
Manchester Community Health Center
Manchester Health Department
MAPS Counseling
Mary Hitchcock Memorial Hospital/Upper Valley Public Health Network
Mental Health Center of Greater Manchester
Mid-State Health Center
MJC Health Solutions, LLC
Monadnock Family Services
Monadnock United Way
Monadnock Voices for Prevention
NAMI NH
Nashua Division of Public Health and Community Services
New Futures, Inc.
New Hampshire Center for Effective Behavioral Interventions and Supports
New Hampshire Center for Excellence
New Hampshire Charitable Foundation
New Hampshire Hospital, Child & Adolescent Psychiatry
New Hampshire Hospital, Social Work Department
New Hampshire Kids Count
New Hampshire Pediatric Society
NH Department of Education
NH Medical Society
North American Family Institute
North Country Health Consortium
Northern Human Services
Office of Youth Services-Manchester
Parent Information Center of NH
Partners in Prevention Coalition
Plymouth State University; School Psychology
Raymond Coalition for Youth
Riverbend Community Mental Health
Rochester School District; Safe Schools/Healthy Students
SAU 18; Project Aware
SAU 7; Project Aware
Seacoast Mental Health Center
Seacoast Public Health Network
Seacoast Youth Services
Southwest Region Planning Committee
Southern New Hampshire University; Community Mental Health and Mental Health Counseling
Spark NH Early Childhood Advisory Council
Strafford Learning Center
Sullivan County Regional Public Health Network
Traci Fowler Consulting
University of New Hampshire; Institute on Disability
Upper Valley Substance Misuse Prevention Partnership
Wediko Children's Services
West Central Behavioral Health
Youth Council-Nashua