Behavioral Health Partners of MetroWest

Executive Summary:

Community Partner Composition

Behavioral Health Partners of MetroWest (BHPMW) Behavioral Health Community Partner (BHCP) five year business plan is founded on longstanding collaborative partners that created a Limited Liability Corporation (LLC) to prepare for health care reform; extensive advanced planning on all aspects of the BHCP model; and knowledge, experience, and investment in health care service delivery reform. BHPMW, LLC is the BHCP Contractor. LLC member agencies Advocates, South Middlesex Opportunity Council (SMOC), Spectrum Health Systems, and Wayside Youth and Family Support Network (Wayside) are Consortium Entities (CE); and Family Continuity (FC) is an Affiliated Partner (AP) in our BHCP program. SMOC, founded in 1965, has the earliest date of incorporation, followed by Spectrum in 1969, Advocates in 1975, Wayside in 1977 and FC in 1985. The missions of the agencies share the overarching purpose of providing person centered services that meet individuals and families where they are at, partnering with them to address the challenges they face, and supporting them in building healthy, sustainable lives. Combined, these agencies served approximately 90,000 people in the past year, including 22,000 in our outpatient mental health and substance use clinics and 2,400 in care coordination and integrated care management programs. With more than 200 years of combined experience, we know we are effective in engaging people in our communities; we know care coordination works; and we know supports improve health and quality of life outcomes. Translating that expertise into effective coordinated care in an integrated healthcare system became a key driver for the development of BHPMW LLC and our BHCP program.

The CEs' and AP's combined expertise enables BHPMW BHCP to provide robust CP supports to many focus populations: Enrollees with SMI, SUD, co-occurring SMI/SUD, co-occurring BH/LTSS, CBFS/ACCS clients, Enrollees who are homeless, Enrollees involved with the criminal justice system, transitional age youth/young adults, and Enrollees with culturally, ethnically and linguistically diverse backgrounds. The CEs and AP are embedded in the proposed Service Areas and will utilize their experience, locations, continuums of care, and community partnerships to provide all CP supports to these diverse populations therein.

Community Partner Population Served	
Region	**Service Areas**
Central	Athol, Framingham, Gardner-Fitchburg, Southbridge, Waltham, Worcester
Northern	Beverly, Gloucester, Haverhill, Lawrence, Lowell, Lynn, Malden, Salem, Woburn

Population Demographics

BHPMW BHCP is prepared to support diverse populations in the Service Areas covered. The BHCP's service area mirrors that of the CEs' and AP's footprint across the Central and Northern regions. According to data gathered from the Massachusetts Department of Public Health, Community Health Assessments (CHA) and Community Health Network Areas (CHNA), many of the cities and towns served by the BHPMW experience significant disparities in health and social outcomes. For example, a large percentage of people served by the five partner agencies are low income individuals and families, most of whom are enrolled in MassHealth and/or Medicare. The behavioral health needs in these communities are well documented.

In the Central Massachusetts region, demographically, the population of Worcester County is 77.7% White, 10.8% Hispanic, and 4.68% Asia; 17.4% of residents speak a language other than English; and 12.5% live below the poverty level. In addition to Worcester County, the greater MetroWest area is included in the BHCP's Central region, in which a major city is Framingham. The population of this community is 66.3% White, 15.5% Hispanic, and 8.07% Asian; 37.1% of residents speak a language other than English, mostly Portuguese and Spanish and 11.5% live below poverty level.

The 2015 Greater Worcester CHA reports that Worcester has a higher rate of mental disorder hospitalizations than the Massachusetts average with a rate of 1,274 per 100,000, 50% higher than the state average (846 per 100,000). Hospitalizations for self-inflicted injuries are also much higher for Worcester than for the state. Additionally, adult treatment admissions rates for substance abuse where heroin is the primary substance are more than statistically twice as high for Worcester (1,703 per 100,000) as for the state average (791 per 100,000). Indicators of mental health issues in Fitchburg, Gardner, Athol, and Leominster are among the highest in the State. The psychiatric hospitalization rate of 1230.4 per 100,000 in the area is much higher than the State rate; prevalence rates for depression and poor mental health are high and the suicide rate is higher than the State rate of 9.0. The 2016 MetroWest CHA cited "Both mental health and substance use were identified as the most pressing health concerns in the region currently." Respondents reported the same barriers as in 2013 including "the lack of mental health providers, challenges with coverage for mental health services, and stigma." Also similar to the 2013 CHA, the report observes that "As a result of these challenges, some focus group participants indicated there are long waits for psychiatric services."

In the Northern Massachusetts region, the CE's and AP's locations include 60 communities in Essex and Middlesex counties. These communities represent a cross-section of rural, urban and suburban populations and a variety of marginalized populations such as LGBT, immigrant, and minority groups. The population of Essex County is 72.1% White, 19.2% Hispanic, and 3.71% Asian; 25.1% of residents speak a language other than English; and 11.5% live below the poverty level. Lynn is a large urban community with 32% of the population Hispanic, 12% African American, 48% of households speaking a language other than English, and 10% with a disability. Salem is next with a 23% Hispanic, 23% of households speaking a language other than English, and 9% disabled. Internal outcome data shows that 41% of clients have an annual income of $9,999 or less and 17% between $10,000 and $19,999. Lawrence has a large Hispanic population with 75% of households speaking a language other than English at home. According to the 2016 Greater Lowell CHA, the city has the largest percent of foreign born at 25.2% in the service area. Lowell is diverse, with 42% non-white with Asian and Latino populations at 20.9% and 18.2% respectively. The majority of professional and provider focus groups and key informants perceived Lowell and Greater Lowell residents to be generally unhealthy.

The 2016 North Shore Community Health Network (CHNA 13/14) Health Assessment and Strategic Planning Project reports that "Many of the cities/towns in CHNA 13/14's service area had higher rates per 100,000 population of alcohol/substance abuse related hospital emergency department (ED) discharges than the Commonwealth. Many… also had higher rates per 100,000 population of opioid-related hospital ED discharges than the Commonwealth. Overall, Essex County experienced a 164% increase in opioid abuse overdose deaths between 2002 and 2013 and a 64% increase between 2013 and 2014, the year that the most recent data is available." Relative to mental health, the report states "Many of the cities/towns in… (the) service area had higher rates per 100,000 population of hospital ED discharges when a mental health condition was the primary reason for the visit."
In summary, the populations in the Central and Northern Massachusetts regions are diverse culturally, linguistically and socioeconomically, with more than 10% of residents living in poverty. Many cities and towns, particularly Framingham, Worcester, Gardner-Athol, Lynn, Lowell and Lawrence have additional disparities based on race, socio economic status and geography. These factors significantly and negatively impact health and health outcomes.

Overview of 5-Year Business Plan

BHPMW BHCP Long Term Goals	
Category	**Goal**
Technology and Information Sharing	• Implement a care management software solution that will facilitate care coordination and information sharing, including a mobile platform that will ensure staff have access to the tools and data they need when they are in the community supporting Enrollees and collaborating and integrating with ACOs, MCOs, PCPs, and other stakeholders.

Workforce Development	• Develop competency across BHCP care coordination staff in domains that are critical to providing effective BHCP supports to Enrollees and supporting the values of person centered service delivery and SAMHSA recovery principles.
Program Administration	• Leverage the expertise and capabilities of the BHCP's community based provider partners, in the areas of mental health, substance use and social determinants of health across the lifespan and with a wide range of diagnostic and cultural linguistic populations, to effectively support Enrollees in meeting their unique needs and goals and demonstrate value to ACOs and MCOs by contributing to positive outcomes and cost efficiencies. • Achieve positive performance on BHCP quality measures by identifying and training care coordination staff on best practices that support those outcomes and utilizing data analytics to implement population health management strategies to target actionable opportunities to improve quality, outcomes, and cost.

Anticipated Challenges	
Category	**Challenges**
Systemic	• Lack of capacity and availability of needed BH and other services • Lack of services that are recovery oriented, culturally appropriate, trauma informed • Lack of communication, coordination and integration among service providers • Fragmentation, misalignment among service structures and service delivery approaches • Reimbursement to support service access, coordination and integration among various service types
Population	• Prevalence of people with BH, SUD and social service needs who do not access needed services, some of which is related to lack of knowledge about where and how to do so • Impact of social needs- housing, financial support, etc.- on people's ability to take care of their health and use services that are available to them • Difficulty locating some Enrollees who have instable housing • Difficulty engaging some Enrollees who may not want or feel they need care coordination and/or information sharing and integration among their various providers.
Implementation	• Workforce adequacy particularly relative to RNs, licensed mental health professionals, and bicultural staff at all levels • Workforce competition among ACOs and CPs, as well as other parts of the service delivery system such as ACCS providers, who will be seeking to hire large numbers of the same types of staff at the same time • Multiplicity of relationships among ACOs, MCOs, and CPs creating very complex and variable workflows and strategies as well as time consuming administrative processes and external relations demands • Funding adequacy and risk needing to be closely monitored to assess financial viability and sustainability of these new models of care in general and BHCP program in particular

Plans for Sustainability

BHPMW BHCP will strive to sustainably fund the proposed infrastructure and capacity building investments and CP supports over the Contract Term and after the initial Contract Term. During the five year Contract Term, BHCP will sustain funding of CP supports through meeting all contract requirements; employing a centralized approach to managing the contract across our CEs and AP; appropriately maximizing care management and infrastructure revenue by engaging Assigned Enrollees as quickly as possible and providing Qualified Activities consistently; managing accurate and efficient billing processes; achieving positive outcomes and a strong DSRIP Accountability Score; and working proactively with ACOs and MCOs on implementing the ACO and BHCP models and developing Alternative Payment Methodologies (APM) and sustainability plans. BHCP will sustain funding of the proposed infrastructure and capacity building investments through these mechanisms, thereby maximizing enrollment and infrastructure investments, and by timely and efficient implementation of all proposed infrastructure and capacity building projects. A major

infrastructure project is the development and implementation of the Care Navigator care management platform that will facilitate our implementation of these strategies.

Ultimately, the intent of MassHealth's waiver is to change the way the health care system does business, resulting in ACOs, CPs and other providers achieving cost efficiencies during the five year demonstration period. Integral to this vision, if implemented as intended, the BHCP will significantly impact where and how high-cost Enrollees receive physical and behavioral health services and other supports, which is also expected to achieve cost savings. BHPMW BHCP's goal is to achieve these cost savings and assist the MCOs and ACOs to realize delivery system efficiencies in an amount greater than ongoing infrastructure costs. BHPMW believes the key to achieving long term sustainability with the ACOs and MCOs is to demonstrate the BHCP's value through the work of the CP teams with their Enrollees, their primary and specialty medical provider networks, and their internal care management programs. Our BHCP's engagement with PCPs, ACOs and MCOs began prior to contract implementation and is integrated throughout BHPMW BHCP's planned delivery of CP supports. Through these efforts and good outcomes data, our goal is to demonstrate enough value to motivate the ACOs and MCOs to develop plans for sustaining CP supports or similar care coordination services after the five year demonstration period. As we negotiate agreements with eleven ACOs and two MCOs, some of them include plans to begin working within the first two years on developing alternative payment methodologies (APMs) and other approaches to sustainability. BHPMW will be flexible in working with ACOs and MCOs to develop alternative funding mechanisms as the demonstration progresses and potential sustainability strategies unfold.

BHPMW BHCP Governing Body Executive Committee and lead operations staff understand that planning for sustainability must begin from the beginning of this initiative. Particular structures for sustainability planning have been integrated into our five year implementation plan. Some key strategies are, beginning in Budget Period 4, including this topic in all Executive Committee meetings, quarterly meetings with EOHHS, and ongoing meetings with ACOs and MCOs and in Budget Period 5, convening a Sustainability and Transition Team that will be charged with writing a Sustainability and Transition Plan by the end of the first quarter for approval by the Executive Committee and discussion with EOHHS, ACOs and MCOs.