3.2.1 PART I: EXECUTIVE SUMMARY

a. CP Composition

Community Care Partners (CCP) is a limited liability company formed by Bay Cove Human Services (Bay Cove) and Vinfen Corporation (Vinfen) in May 2017 to provide Behavioral Health Community Partner (BH CP) Services in the Greater Boston, South and North regions. As such, Bay Cove and Vinfen are the Founding Members and the two Member Organizations of CCP delivering BH CP services in the field. The MassHealth Delivery Reform initiatives and Community Partner (CP) Programs are progressing the landscape of care delivery and support for people with Serious Mental Illness (SMI) and/or Substance Use Disorder (SUD) in a manner that both Member Organizations fully support.

CCP is committed to the integration of behavioral health (BH), medical and long-term support services (LTSS) to better serve people with SMI/SUD. Both Member Organizations have over four decades of experience serving the diverse healthcare and social support needs of this complex population. Further demonstrating its industry experience, CCP's Member Organizations have annual operating budgets adding up to nearly $325 million, employ over 5,000 staff, and serve over 30,000 people in Eastern Massachusetts. Together, the organizations provide a comprehensive set of community-based mental health, behavioral health and substance use treatment services, including:

- Three outpatient mental health clinics
- Crisis stabilization units (a less costly alternative to inpatient psychiatric hospitalizations) and staffing of several emergency services programs
- Detoxification programs, transitional support services, recovery homes and medication assisted treatment for people with SUD
- Specialized outreach, shelter and day programs for people with SMI/SUD who are homeless

Also of note, Vinfen and Bay Cove provide outreach and care coordination services for 3,000 people with serious mental illness through the Department of Mental Health's (DMH) Adult Community Clinical Services (ACCS) program. Both providers also operate One Care Health Home Teams as funded by Commonwealth Care Alliance, reaching over 800 people in this integrated care management program that impacts the BH, medical and LTSS needs of those served.

Both organizations are leaders in its respective local communities and in its fields of service. Bay Cove is one of the state's premier SUD providers with a full continuum of care for people with addictions. With blended expertise in SMI and SUD, Bay Cove has a reputable track record of meeting the most challenging needs of people with dual diagnoses in the Commonwealth. Vinfen is the largest DMH contractor and ACCS provider in Massachusetts and is known for its adherence to recovery and rehabilitation-based services, adoption of evidence-based practices, and technology innovation.

CCP's Member Organizations have a presence in most communities in Eastern Massachusetts including relationships with social service providers, hospital systems, local government, police and BH providers. This local presence is the foundation for developing locally based Care Teams that perform the functions of the BH CP program. CCP is committed to the integration of BH, medical and LTSS to better serve people with SMI/SUD and recognizes that to be effective, the core BH CP services must be provided in close partnerships with ACO/MCOs. As a result, CCP is invested in developing ACO collaborations that promote coordinated care, reduce duplication of services, and target limited resources to the right Enrollees at the right time. CCP looks forward to

further building on the initial collaborations so far developed with its ACO/MCO partners over the coming years.

b. Community Partners Population Served

Through its Member Organizations, CCP provides services, supports and community connections in the following Service Areas:

- **Greater Boston:** Boston, Revere, Somerville and Quincy
- **North:** Haverhill, Lawrence, Lowell, Lynn, Malden and Salem
- **South:** Attleboro, Barnstable, Brockton, Fall River, Falmouth, Nantucket, New Bedford, Oak Bluffs, Orleans, Plymouth, Taunton and Wareham

Both of CCP's Member Organizations have over four decades of experience serving people with SMI and SUD and extensive histories developing and providing innovative and effective services for these target populations. Leveraging this expertise and experience, CCP supports adults between the ages of 21 and 64 of diverse cultural, linguistic, racial, ethnic and religious backgrounds, many of whom are homeless. Care Teams serve people with a range of complex mental health, medical, developmental, neurological, and substance use disorders, along with persistent behavioral and risk issues such as problematic sexual behaviors, sexual offending, violence and aggression, antisocial behaviors, fire-setting, severe suicidality, victimization, and/or harm to self or others. In fact, 40% of our population is also served by DMH, a percentage that is 25% higher than the statewide average across other BH CPs that serve DMH clients. In that many of these medical and behavioral complexities create functional limitations for people that require LTSS, our care model supports people with LTSS needs as well.

c. Overview of Five-Year Business Plan

CCP's five-year business plan enables it to build the infrastructure and systems needed to serve nearly 4,000 people when at full capacity. Ongoing development of capacities and infrastructure serve to sustain the program throughout the five-year contract term and thereafter. Long-term goals include:

- **Maintenance and ongoing enhancements of Care Coordination Information Technology System to support Care Coordinators and Clinical Care Managers**. CCP is one of over 20 CPs statewide using the eHana CCIT system for documentation and coordination of activities. This group of CP's has formed a Steering Committee to partner with eHana and identify and prioritize enhancements to the system. To support Care Teams, CCP continues to subscribe to PreManageED to provide Admissions / Discharge / Transfer (ADT) data in real time which allows Care Teams to either locate hard to find enrollees and to identify and support Enrollees in times of care transitions.
- **Maintenance of system to support secure data exchange**: CCP maintains SFTP sites, Dropbox accounts, and secure efax and email for sharing Enrollee data between ACO/MCO partners and MassHealth as well as with Member Organizations. As any particular issue arises, CCP's Systems Admin works with the ACO/MCO to resolve.
- **Recruitment of staff for regional BH CP Care Teams**: CCP's Member Organizations have implemented recruitment programs that seek to sustain a competent and caring workforce of both Care Coordinators and Clinical Care Managers that has both the heart and skills to serve people with SMI and/or SUD. A range of recruiting strategies are deployed to attract high-quality candidates, including financial incentives.
- **Retention/Ongoing training and learning**: CCP has implemented a robust training program leveraging subject matter experts across both Member Organizations and making use of MassHealth training material when available. In addition, CCP has established a Learning Collaborative for Care Team staff and Supervisors to promote ongoing learning and process improvements, as well as a venue to share best practices.

- **Care Teams that collaborate with ACO provider practices**: CCP recognizes that to be effective the core BH CP services must be provided in close partnership with ACO/MCOs, the entities at risk for Total Cost of Care in the new MassHealth delivery system. Toward that end, CCP has invested considerable staff resources to the development of ACO collaborations that facilitate coordinated care, reduce duplication of services, and target resources to the right Enrollees at the right time.
- **Development of highly effective strategies for engaging Enrollees**: Many people with SMI/SUD have never been enrolled in outreach or care coordination programs before and often hesitant to participate. Without engagement, the rest of the BH CP support services cannot be of benefit. To that end, best practices for Enrollee engagement have been gleaned over the past 3 years and have been incorporated into ongoing training and job aides offered across Care Teams and within CCP's Learning Collaboratives. Likewise, CCP has enhanced its Interpreter Services in an ongoing effort to promote the most effective care for Enrollees for whom English is a second language or for those who are non English speaking. And in response to the public health crisis in 2020, CCP has effectively adapted to supporting enrollees via telehealth, and to supporting enrollees in gaining access to primary care during the pandemic via telehealth as well.
- **Establishment of a management team to oversee administrative processes, IT systems, data, quality management, financial services and analysis**: CCP has established a central management company to oversee all administrative and operational processes of the BH CP program and provide oversight to Care Teams in the field. In BP3, CCP introduced a Quality Manager to further promote Risk Management initiatives, Contract Monitoring and Quality Improvement. CCP also re-introduced the role of Project Manager in BP3, to support the Director of Program Services in enhancing communications and workflows with our ACO/MCO partners. And in BP4, CCP is re-introducing the role of Director of Analytics and Reporting to oversee the management, development, and integration of data analytics and business intelligence necessary to further support the mission and goals of the program, and further inform strategy. CCP is also introducing two Quality Specialist in BP4 who will work closely with each Member Organization to further promote Quality.

CCP fully supports the system changes that MassHealth is making through its delivery reform initiatives and the CP program. CCP believes that the breadth and scale of reforms is necessary to achieve better care and improved outcomes for people with SMI/SUD. People with SMI/SUD face significant barriers to accessing healthcare services and partnering with their healthcare providers. The BH CP program model promises to impact these barriers and promote more integrated care inclusive of the member's voice.

At the same time, change at this scale and amongst as many stakeholders as are collaborating in this initiative can pose significant challenges This new paradigm of healthcare delivery involves the implementation of new processes, communication methods, data exchange systems and collaboration that have been more challenging to implement, particularly at the practice level. Despite the many advantages of technology, there are occasional SFTP glitches with ACO/MCO partners, and MMIS glitches with MassHealth. Fortunately, there is a very strong commitment to this initiative across all stakeholders and to date, technology glitches are resolved in a more timely way.

This new paradigm within the healthcare system also requires a level of trust and buy in amongst all stakeholders. Some PCP's still require that they see an Enrollee in person prior to reviewing and signing off on an Enrollee's Care Plan, even when the goal of the plan is for the CP to address the barriers the Enrollee faces that impedes a primary care visit. A PCP's unwillingness in this circumstance presents an additional barrier. Overtime, valuable relationships are being forged and PCP's are coming to better understand the goal of the program. Both serve to promote trust and maximize on the potential impact of the CP program.

Sustainability

CCP has maximized on DSRIP funding available to develop critical capacities and infrastructure necessary to further enhance the operations and effectiveness of the BH CP program. CCP is committed to ongoing attention to building and strengthening its capacities and infrastructure at every opportunity as we aim to promote sustainability of the program throughout the five-year Contract Term and thereafter.

Ongoing investments include maintenance of and enhancements to a CCIT platform to support care coordination, and the ongoing maintenance of MedInsight to access historical claims data and quality metrics. Additional investments are being made to enhance both our organization's website, and our intranet system in BP4. Capacity investments include a workforce that is trained in care coordination and workflows for providing services across systems of care. Sustainability of the BH CP program beyond the contract term will ultimately depend on our relationship with ACOs/MCOs and whether the services that CPs provide lead to better health outcomes at reduced costs. CCP is consistently pursuing integration opportunities with its ACO/MCO partners, including access to ACO/MCO EHRs, regular case reviews of shared members, and regular Administrative meetings that serve to improve communications and workflow, and pave the way for additional points of integration. CCP hopes that overtime these evolving relationships and the impact the collaborative efforts are having on the health and wellness of shared Enrollees will confirm for its ACO/MCO partners the value of the BH CP program.