Clinical and Support Options

Executive Summary:

a. CP Composition
CSO's Behavioral Health Community Partner Program will be comprised of fulltime CSO staff. There are no Consortium Entities or Affiliated Partners involved.

b. Community Partners Population Served
   i. Service Areas
   CSO's BH CP covers the Athol, Greenfield, Northampton, Pittsfield, and Adams service areas.

   ii. Demographics
   These geographic areas are comprised of small, generally under-resourced cities and rural towns with a total of 364,903 residents. The population is 93.75% white and 98% speak English as a primary language. About 26% of the residents live below 200% of the federal poverty level. This area of Western Massachusetts is predominantly rural.

   There are many challenges to providing care in this environment, including these three key issues:

   - a shortage of primary care providers--the ratio of residents to PCPs in Franklin County is 51% higher than for the state as a whole;
   - small private primary care practices, unaffiliated with a hospital system or ACO, with the result that BH providers have many more practices with whom they must maintain relationships;
   - public transportation is very limited, leaving low income households isolated and/or facing significant barriers to accessing care and support services.

   Franklin County's population is 70,382. The county covers 725 square miles with a population density of 102.1 people per square mile. The area is 94.2% white; In Greenfield, the only population center, 34% live under 200% of federal poverty, compared to the state rate of 21.7%.[1] Greenfield's rate of admission to SA treatment programs is well over double the state average.[2] Greenfield hospitalizations for mental illness are 2,260.12 per 100,000 population compared to a state rate of 874. In 2010 Franklin County had 972 admissions for SA

[1] U.S. Census ACS 2012, 2016
[2] MassCHIP 2010

treatment, 17% of the Western MA total. Greenfield's rate of violent crime was 34.5 per 1,000 people compared to the state rate of 28.2 per 1,000.[3]

North Quabbin, the most rural part of northwestern Worcester County and eastern Franklin County, includes a total area of 344 square miles. Five towns in the two-county region have a population density of less than 30 people per square mile. The four largest North Quabbin towns have a combined population of 15,354 and are 98% white, 0.8% African American, 0.6% Asian, and 1.7% Hispanic. The per capita income is only $16,299.[4] Chief among the county's problems are high rates of unemployment, teenage pregnancy and alcoholism. The North Quabbin area has a very high rate of domestic violence and the highest rate of sex offenders in the state.[5]

Hampshire County, the most prosperous and populous part of the service area, has 161,816 residents. The per capita income for the county was $31,051 in 2016. The racial makeup of the county was 88.5% White, 3.2% Black or African American and 5.6% Asian; 5.6% of the population were Hispanic of any race. The county is the site of five large colleges totaling 32,550 students. Northampton's rate of mental health hospitalizations per 1,000 people was 23.3 compared to the state rate of 8.1 per 1,000. Northampton's rate of violent crime was 32.4 compared to the state rate of 28.2.[6]

Berkshire County, the largest landmass county in our area and the 2nd largest County in MA, has 126,903 residents. The per capita income for the county was $31,417 in 2016, with a 10.9% poverty rate. The racial makeup of the county was 92.5% White, 3.3% Black or African American and 1.5% Asian; 4.3% of the population were Hispanic of any race. Residents of Berkshire County report a disability rate of 11.2%, and 3.4% of residents were without health insurance according to 2016 Census data.

For the Tri-County region, 2010 enrollment data from MADPH's Bureau of Substance Abuse Services[7] for publicly funded services shows a detailed picture of need and capacity for the rural Western Massachusetts region. Seventy percent of admissions were male and 30% female. Whites accounted for 88.4% of admissions;

[3] Pioneer Valley Community Health Assessment 2013
[4] U.S. Census ACS 2012, 2016
[5] http://www.city-data.com/so/so-Athol-Massachusetts.html
[6] Pioneer Valley Community Health Assessment 2013
[7] MADPH, Bureau of Substance Abuse Services custom generated 6/1/11.

Hispanic 5.9%; and Black 2.9%. Most clients were in the 25-64 age group (73-77%) with the exception of North Quabbin where 30.3% were in the 18-24 age group. In the other parts of the service area, the 18-24 group accounted for an average of 24% of admissions. Alcohol is the reason for admission for 59.1% of admissions, with heroin a distance second at 18.3%. All opiates combined (heroin, other opiates and Oxycodone) total 26.6%. The Baystate Franklin Emergency Department in Greenfield saw 1,524 patients with alcohol or other substance abuse problems between 5/13 and 4/13. Franklin County as a whole is undergoing a major opioid abuse crisis. Forty-two opioid overdoses were reported by emergency services between 12/13 and 4/14. A new heroin and opioid detox center recently opened in Franklin County, which has not had any detox services since 2004. A behavioral health and detox complex is in development in North Quabbin, which has never had a detox facility.

c. Overview of 5-Year Business Plan

Goals*: CSO's service goal* as a CP will be to effect greater collaboration and coordination across the spectrum of healthcare providers--inpatient medical and BH, primary and specialty medical, outpatient and community-based BH, residential, LTSS and emergency care. We share Mass Health's expectation that this effort will achieve the triple aim—improving health status, providing quality care, and reducing the total cost of care—and we are aligned with this purpose. *CSO's operational goal* is to implement this program efficiently, expeditiously, and sustainably. We will approach operations with a clear plan and model set forth for the entire implementation team, with the flexibility and agility to adapt our plans and process in response to changing conditions, consumer feedback, and feedback from ACOs, MCOs and Mass Health.

Number of enrollees to be supported: Based on Mass Health's projections of targeted members, during BP1 we expect to be assigned approximately 1,400 members who live in CSO's contracted service areas. Based on the number of Mass Health members CSO currently serves, we expect that a high percentage of the assigned members will be individuals already familiar to CSO. By the end of year one, we expect to have approximately 850 actively enrolled and we project to reach scale of 2,000 enrolled members per year.

Challenges: These geographic areas are comprised of small, generally under-resourced cities and rural towns. There are many challenges to providing care in this environment, including these three key issues:

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In CSO's 60+ years of working in these communities, we have developed a service culture with high levels of community outreach and home-based services to accommodate isolated clients. We have an intensely relational style of collaborating, working with dozens of independently practicing healthcare providers, as well as more sizeable groups like Baystate Health and Valley Medical Group. We have a long history of working closely with a broad range of community-based organizations—it is the only way to function effectively in this small city/rural culture.

Operational plan:

CSO is in the advantageous position of having a fully operational, optimally flexible EHR in place. Working with the vendor, Credible, our IT and Business Systems team will be working through the rest of 2017 to refine the care management capacity of the system. Every player in the re-designed Mass Health system—ACOs, MCOs, CPs and providers—will be challenged by incompatible record systems and the need to move clinical and utilization from one entity to another in a timely, accurate and secure manner. We are confident that we are in a better-than-most position to both import and export information with Credible.

CSO has an able and experienced executive team to manage the implementation of this program; each member has a focused plan for this important endeavor. The VP overseeing the CP will be Sandi Walters, LICSW, who brings over ten years' experience managing MH and SUD programs, along with demonstrated skills at collaboration. She will be assisted by Deborah Ekstrom, who has nearly 40 years of experience in the field, including eight years of managing integrated primary care and BH service delivery, as well as public sector care management.

Staff recruitment is always a challenge in this market. CSO's plan includes a significant investment of DSRIP infrastructure funds on aggressive recruitment efforts throughout the duration of the project. A recent revision of our recruitment strategy has increased our candidate pool four-fold and resulted in high quality new hires. We will continue (and continually revise) this strategy to sustain the workforce needed for the CP program. As indicated in our DSRIP budget, infrastructure investments will be most substantial in the prep phase (exceeding the resources available) and year one, tapering slightly in year two. By year three, we expect our ongoing infrastructure investment to level out to a maintenance level.