

Community Healthlink

Executive Summary:

Community Healthlink's (CHL) goal in being a Community Partner (CP) provider is to support and coordinate services across the continuum of care for adults on MassHealth in the Worcester and Fitchburg-Gardner service areas of the Central Massachusetts region who suffer from serious mental illness and/or substance use disorders.

As a behavioral health and primary care providers, CHL is closely connected to the rural towns and to the cities of these communities. CHL has over 50 years of experience providing a continuum of primary care and behavioral health services including care coordination throughout the region. We know that both the BH and medical systems of care are complex, that our BH clients die on average 10-20 years earlier than the general population and that conditions of homelessness, victimization, poverty and social isolation negatively impact their ability to navigate and benefit from traditional care. Our CP Enrollees will come from the city of Worcester and in contrast, from the rural, isolated areas of North Central MA. Worcester, Leominster and Fitchburg, the three largest cities have increasing populations of individuals with behavioral health needs who speak a language other than English (Spanish, Portuguese, Vietnamese are the top three). Over 67% of the population we expect to serve are suffering from both Mental Health and Substance Use Disorders and of that population 25% or more have at risk housing or are homeless. Through our work with hospitals to decrease ED usage, we have learned that this Medicaid population frequently uses Emergency Rooms for medical care and many are not well connected to a PCC.

Therefore, our CP staff, following best practices, will support individuals to navigate systems and will coordinate services so that our clients receive holistic, quality and preventative care. We believe our outcomes will show that clients report better health and an improved quality of life. We believe our model will help to break down silos of practice and will address social determinants of health. Our program is based on a philosophy of Community First, SAMHSA recovery principals and cultural competence. Staff offer Enrollees choices through providing clear information in their language of choice. Enrollees are informed of their rights as a participant in our CP program and as a CHL consumer. Our hope is that through collaboration with ACOs, MCOs, Primary Care Practices and BH providers that we will create a system of truly integrated care and reduce or slow down the increase of health care cost.

Our CP model is multidisciplinary and our teams are led by a licensed BH clinician supervisor. Each team is staffed with one full time RN and 5- 6 Care Coordinators. The program is supported by a Program Manager (.2) and Director (.9), Nursing Supervisor (who in BP 1 will participate on a team), Administrative Assistant, Intake Coordinator and .05 Medical Director. We expect five Care Coordinators on each team to have caseloads of approximately 50. Each team will also have outreach specialist- Community Health Worker (CHW) - to carry a smaller caseload of more difficult-to- engage individuals. The RNs and Licensed Clinician may carry a small caseload.

Teams are designed to provide care coordination for approximately 250-270 individuals. We will begin in July 2018 with three teams. Two teams will cover Worcester and one team, North Central. When possible, we will link Care Coordinators to particular PCC practices. We believe that being embedded in the practices; the Care Coordinators will have an increased ability to engage the Enrollees. They will have access to staff to obtain information

for the Comprehensive Assessment or the Person-Centered Plan. They can share updates and outcomes of referrals and linkages and join in staff meetings when appropriate.

We expect to successfully contract with the seven ACOs/MCOs in our catchment area by the end of March and will maintain those contracts with our partners. We are in a process of setting up initial Documented Processes with each entity. We expect those documents to evolve especially through Budget Period 1 as our work together begins.

Overall, CHL's CP program has a 2021 goal to support approximately 2000 individuals in the Worcester and North Central Massachusetts areas with complex Behavioral Health needs to successfully navigate the complicated system of BH and LTSS services; to improve the health and general wellbeing of these Enrollees; and to do this in partnership with the ACOs and MCOs in the Central MA region. To achieve this, we have goals in the following areas:

Technology and Information Sharing:

- To develop a sustainable infrastructure including an Electronic Health Record that allows us to communicate efficiently within CHL, with ACOs and MCOs and with other community providers and which records data and tracks outcomes so that CHL's CP can continuously improve our service.

Workforce Development

- To provide CP support through a well trained, multidisciplinary, diverse, stable work force using evidence based interventions and services that are community based, person centered and holistic.

Program Administration

- To develop strong collaborations with our partner ACOs and MCOs as well as other community based services in order to deliver the best integrated case to our clients.
- To collect data on the impact of our service on the health of the Enrollees. To continually improve our service through regular reviews of data.

Our overall 5 year DSRIP budget plan supports these goals through the following initiatives:

Technology and Information Sharing

- *The implementation of an EHR:* DSRIP funds will be used toward costs related to the development our new EHR, Qualifacts: The EHR will allow Care Coordinators to communicate with all CHL programs through a single record. (Currently CHL uses three EHRs and has paper records). Qualifacts has significant reporting capacity, as well as tasking and messaging functions, alerts, and dashboard configurations. We anticipate developing capacity within Qualifacts for reporting to the ACOs, MCOs and MassHealth. DSRIP funds will help toward the development of this care coordination record within Qualifacts.
- *The purchase of laptops/tablets and smart phones:* This technology is necessary for staff to provide the Care Coordination service effectively in the field.
- *IT support:* Funding will support on-site IT consultation, training and support for both software and hardware.

Workforce Development

- *Well trained workforce:* We are using funding to support CHW training provided by The Center for Health Impact.
- *Successful recruitment:* Time of a Recruiter in the Prep time and Year 1 to support the work force recruitment.

Program Administration

- *The ramp-up costs in the Preparation Budget through Budget Period 3:* We will use DSRIP funds to help support the start-up of new staff as they are trained and pick-up a caseload over three months.
- *Purchase of equipment and furniture for staff (PBB and BP1)*
- *Data analysis:* DSRIP funding will be used for a data analyst who will work with the team on our population health data and develop Quality Management initiatives geared to improve the wellbeing of our Enrollees.
- *Data Entry Specialist:* In 2018 CHL will not be able to electronically upload referral files sent to us by EOHHS. The files will need to be data entered until we are able to develop this capacity within Carelogic. Therefore, we will hire a data entry staff person to enter this data from EOHHS and from ACOs and MCOs.

The greatest challenge CHL has identified in our CP planning is work force development. We compete with hospitals, insurance companies and the State for trained, Licensed, experienced human service and nursing staff. Already our HR team is utilizing our Quality Improvement tools of “Lean Thinking” to address recruitment challenges.

Secondly, we acknowledge that there are still many unknowns. We look forward to participating in the “learning community” as CP providers, BH and PC providers along with the ACOs, MCOs, and EOHHS come together to provide coordinated integrated care for this vulnerable population.

Finally, there are many assumptions in setting up budgets, goals and timelines for 5 years. We will count on many forms of data, from ACOs and our EHR and from EOHHS to continually assess our plan and progress.

Specifically for Budget Period 1 we are proposing to use DSRIP funds as follows:

- To continue to support ramp up staff costs
- To support the continued development of the EHR
- Support for IT staff onsite for both software and hardware assistance and data entry.
- To hire a data analyst to help with report development, writing and support quality projects
- To support the a portion of the salary of a recruitment specialist
- To cover the costs of continued training of CP staff by the Center for Health Impact.

We expect all these activities to be sustainable overtime assuming we have a sufficient volume of referrals. The EHR will be developed and refined to meet the needs of the ACOs, MCOs, MassHealth, and community and state agency partners. IT consultation will be able to be provided through administrative overhead support. Training programs will be developed and ready for on-boarding staff and for providing in-service training opportunities. There should not be a need for significant simultaneous hiring of staff and therefore staff recruitment will be able to be managed within the HR department without additional funding. The data analyst will be absorbed into the on-going program budget.