

North Suffolk Mental Health Association

Executive Summary:

North Suffolk Mental Association (NSMHA) is pleased to submit a Full Participation Plan to EOHHS to strengthen our Community Service Agency (CSA) and support EOHHS's integration efforts through DSRIP funding and ACO implementation. As a long standing community provider of child and family community-based services, North Suffolk is positioned to engage children and their families in a strength-based, child and family-centered, culturally appropriate and trauma-informed approach to the management and integration of behavioral health and primary care.

Founded by private citizens of East Boston, Chelsea, Winthrop and Revere, Massachusetts in 1959, NSMHA began with a mission of providing mental health services to individuals, and especially children, in these relatively under-served communities. It operated first as a Child Guidance Center in 1963, then expanded into a Community Mental Health Center from the 1960's through the 1970's as Federal and State policies provided more support for community-based services. NSMHA continued to grow in the number and types of services through the 1980s and 1990s to become one of the largest providers in the state. Today, NSMHA touches the lives of more than 10,000 people a year. Our staff of 900 assists families, children and individuals in 4 clinics, 38 residences and 74 programs. NSMHA helps achieve independence by providing a wide variety of treatment, recovery and rehabilitation services, by intervening as early as possible, by promoting prevention and education, and by participating in training and research.

Our five-year business plan concentrates first on building our technology infrastructure to support the integration efforts with ACOs and primary care providers. This endeavor begins during the Prep Budget Period (PBP) where much of the funding will be used to purchase mobile devices for Care Coordinators that will have compatible software to assist with integration of care and tools such as Mass HIway that will facilitate a safe avenue to exchange information as well as video capabilities to increase the opportunities for a Primary Care Provider (PCP) or PCP liaisons to be present at care planning meetings. The secondary push during the PBP is to reinforce the concept of integration by building milestones that support the need for further trainings on how to involve a primary care provider during the care planning process.

Finalization of PBP will ensure we set building blocks for the following budget periods. This includes creating milestones that support retention bonuses to reward Intensive Care Coordinators (ICC) who met outcome measures framed at improving their wraparound care towards consumers and also building operational infrastructure whose sole purpose will be framed to internally evaluate project outcomes as well support external data reporting to necessary entities. Our goal is to improve and expand our capacity for quality reporting and data analytics and our expertise in using data to drive decision-making and quality improvement initiatives. NSMHA will work closely with our EHR vendor, eHana, to implement data tracking, dashboarding and reporting necessary to support Quality Measure capture, management and submission in a manner consistent with EOHHS requirements. This work may include business analysis, EHR modifications, reporting enhancements and data export integrations for reporting quality measures in a structured format. We will also implement interoperability of the CANS assessment.

Woven throughout the PBP and heading into BP1, particular attention will be placed on increasing our workforce to meet the demands of services and thus reduce waitlist numbers and improve timely access of services to our consumers. NSMHA's current Development Plan outlines goals that emphasize increasing timely access to Intensive Care Coordination (ICC) services. To achieve this

goal, we must hire new staff in an increasingly competitive employment market. Our Human Resource Department staff partner with managers in the application, vetting, hiring and training processes for new employees and will engage in additional targeted recruitment efforts. In addition, the CSA Program Manager will accompany the Human Resource Recruitment Officer to college/university job fairs to promote the ICC position. In recent months, the CSA has developed new marketing tools targeted specifically for college/university job fairs. Coupled with these efforts PB1 will focus on utilizing funds to implement one external marketing tool that will run the full 2019 fiscal year framed at increasing Care Coordinator and Family Partner hires.

BP1 will also support ongoing trainings to increase the ICCs knowledge base on how to deliver excellent Wraparound care. With the use of internal trainings, coupled with the expected Mass Health's Fundamentals of High-fidelity Wraparound (HFW) and Fundamentals of Integrated Behavioral Health training modules, these building blocks will be used to develop and support the overall growth of the Care Coordinator. We will utilize preexisting measurement tools such as the Wraparound Provider Practice Analysis (WPPA) that encompasses the Wraparound Fidelity Index Short Form (WFI EZ) and the Team Observation Measure Version 2.0 (TOM 2.0) to monitor our performance. The WPPA, developed by MBHP in collaboration with the Wraparound Evaluation and Research Team in the Department of Psychiatry at the University of Washington "was developed as a tool for providers to gauge the degree to which their CSAs exhibit wraparound fidelity and to identify strengths and areas for improvement." We will use this analysis, which is completed on a yearly basis, to provide a clear indication as to what areas require further improvement in our implementation of care coordination and collaboration. As problematic areas are highlighted within the WPPA, specific internal trainings will be developed to strengthen that capacity. Internal trainings on how best to utilize the new technology introduced in PBP will also highlighted BP1. Care Coordinators will be provide the knowledge on how to effectively use the invested technology to further support the Wraparound experience and successfully provide the highest level of care coordination.

The beginning of BP2 will usher our endeavor to isolate ongoing integration with the ACOs serving our consumers. We will develop bridges with our ACOs by requesting quarterly meetings where the focal point will be to collaborate on consumer care, review Care Coordinator effectiveness and establish any necessary changes in consumer service delivery, if needed, to ensure ACO members are receiving the highest level of Wraparounds service. Quarterly ACO meetings will also be used to discuss any barriers of care and problem solve to barriers to ensure continuity of care for all ICC-Enrolled Youth and their families.

Data tracking and/or dash boarding results collected throughout BP1 and BP2 will be reviewed and analyzed to assist the CSA in making effective long-term changes that will move the CSA into the third year. The push for BP3 and beyond will be sustainability. The data tracking and/or dash boarding results will serve a twofold purpose to not only capture, manage and submit Quality Measures constant with EOHHS requirements but also to assist in steering the CSA to a higher level of care coordination. The analysis will be used to determine what changes need to be made to ensure the overall vision of integration is sustained beyond the funding. Consideration will be made to explore financial capabilities on how to support ongoing projects past year five. North Suffolk understands that the DSRIP funding for the CSA is designed to decrease over the course of the five year contract. We intend to work actively and diligently with our ACO partners to ensure a transition that sustains and supports the infrastructure, the model of integrated care coordination and care planning, and the positive health outcomes we expect to achieve.