Stanley Street Treatment and Resources

Executive Summary:

A. Executive Summary

a. CP Composition
   i. Description of Consortium Entities/Affiliated Partners

SSTAR CP includes: HealthFirst Family Care Center, Greater New Bedford Community Health Center, Fellowship Health Resources (FHR), Counseling Services of Martha's Vineyard and Stanley Street Treatment and Resources. As community health centers, substance use treatment and behavioral health providers, our combined organizations will provide outreach, care management, and coordination. We will also offer primary care and support services that will be very beneficial to enrollees assigned to our community partnership. SSTAR is the lead agency, with a governing board of leadership from all affiliated partners. In addition to the governing board the combined care agencies provide direction and support to a quality committee and workgroups on EHR development and implementation. SSTAR, HealthFirst and Greater New Bedford CHC are all part of Boston Medical Center ACO-BACO collectively providing primary care to over 30,000 patients. In addition to pediatrics, women's health and infectious disease, dental services and on-site pharmacy are also available at HealthFirst and Greater New Bedford CHC. All three health centers are federally qualified CHC's.

Fellowship Health Resources (FHR) provides services in Fall River, New Bedford and Cape Cod. FHR operates a number of club houses, residential programs and Community Based Flexible supports and serves medical ill/mentally ill clients. FHR also operates a therapeutic arts program, Studio 34. They are a private, nonsectarian, not-for-profit behavioral healthcare organization. FHR was incorporated in 1975to support individuals in their recovery from mental illness and co-occurring disorders (i.e., substance use, developmental disability, related chronic health conditions). They are a front-runner in behavioral health care, working with communities to accept and support residential programs, substance abuse programs, and fully-integrative programs, such as Assertive Community Treatment. The cornerstone of such work is the organization's deep and longstanding commitment to the principles of recovery and the inclusion of peers in the recovery process.

Martha's Vineyard Community Services/Island Counseling Center serves over 6,000 people each year. A community-based organization, Community Services employs nearly 100 staff and scores of volunteers who provide services through six core programs: CONNECT to End Violence, Early Childhood Programs, Disability Services, Island Counseling Center, Island Wide Youth Collaborative and a thrift shop. Located across from the Martha's Vineyard Regional High School in Oak Bluffs, the agency also delivers many of the program services at other locations including the Martha's Vineyard Hospital Emergency Room, Dukes County House of Correction, the Martha's Vineyard Regional High School and other schools, senior centers, employer sites, to name a few. The Family Center, Thrift Shop and the Daybreak Clubhouse are located in Vineyard Haven. Island Counseling Center provides community-based mental health programs including individual, family, couple, group, psychiatric evaluations, medication management, substance use, outreach, and crisis and consultation services.

SSTAR, in addition to primary care services, offers a full range of substance abuse treatment including inpatient detox, dual diagnosis, CSS, IOP and outpatient behavioral health services. The agency offers MAT at two locations in Fall River. SSTAR operates one of the three

Opioid Treatment Centers in Massachusetts serving walk-in clients seven days a week. Staffing includes medical and behavioral health professionals, as well as peer recovery coaches. Clients seeking services can often be seen same day or within a few days depending on client need and level of care. The SSTAR OTC works closely with area emergency departments and emergency services to ensure all people who walk in get to the care they need.

b. CP Population Served

i. Service areas covered by CP: SSTAR CP serves six service areas in the southern region of Massachusetts including: Fall River, Attleboro, New Bedford, Oak Bluffs, Taunton, Barnstable, Falmouth, Orleans, and Wareham.

ii. Demographics of the population CP supports

The collective agencies primarily serve some of the regions hardest hit by the opioid crisis. Rates of overdose and use tend to be some of the highest in the state. The increasing availability of strong and cheap heroin and other opiates has contributed to even greater abuse, and a trend toward younger and younger users. While Massachusetts has the dubious distinction of having the most heroin traffic and use in the country, the southeast region of Massachusetts has consistently had three to four times the heroin admissions into drug treatment than anywhere else in the state. The majority of the population identifies as White, and the most dominant languages other than English are Spanish and Portuguese. The racial breakdown for the region is roughly 8% African-American, 40% Portuguese, and 15% Latino/a.

c. The goals for our Community Partners program are 1) to establish a network of strategic partners to address factors that contribute to high utilization of health services and 2) to improve health and social outcomes for enrollees through an integrated patient-centered care model. SSTAR will partner with a diverse group of organizations such as hospitals, health centers, community-based organizations, housing programs, homeless shelters, private practitioners, and local government entities to achieve these goals. The roles of these strategic partners are varied; they range from affiliated partnerships, which will deliver CP services, to referral organizations that will address social needs such as transportation, housing, food etc. SSTAR plans to implement a variety of evidence-based approaches to improve health and social outcomes for enrollees, including care coordination and management, integration of care, and addressing unmet social needs.

The challenges we currently face in the delivery of care to SMI/SUD patients are unmet social needs (i.e., transportation and housing), coordinating care among multiple providers, lack of insurance due to churn, and stabilization/self-management. Studies have found that addressing a patient's basic resource needs such housing, transportation, and food can significantly improve health outcomes. A recent study by Harvard Medical School researchers at Massachusetts General Hospital found that addressing the social needs of hypertensive patients significantly reduced their blood pressure compared to patients whose needs were not addressed. A pilot project by Kaiser Permanente found that among its high utilizers, unmet social needs was quite prevalent. Based on these and other similar findings, SSTAR and its project partners will place emphasis on addressing unmet social needs to improve health outcomes among enrollees.

A major contributor to poor health outcomes is when patients have multiple providers that are not aware of one another and/or communicate with one another. Our care coordinators will work with enrollees to identify all health and social providers involved in their care. We will work extensively with internal departments and external partners to facilitate communication and collaboration around service delivery so as to reduce duplication of services. Our Behavioral Health Community Partners program will strengthen collaborations with local hospitals so that we can receive daily reports on enrollees who use the ER for non-emergency visits. We also want the hospitals to include us in discharge planning to ensure continuity of care for our enrollees after they have been discharged from the hospital. These types of collaborations will help us to decrease unnecessary health care costs and improve health outcomes for enrollees.

Among residents surveyed for our 2016 Community Health Needs Assessment, 30% reported being uninsured. The most common reason identified for lack of insurance among these individuals is "churn" meaning that they were disenrolled from MassHealth for failing to renew the annual application. Many patients forget that they have to renew their MassHealth insurance annually. When they fail to complete the renewal application, they often lose coverage and have to start the process over again. Through the BH CP program, we will have care coordinators work with the outreach and enrollment navigators to reduce churn and increase stable insurance coverage. We will make it possible for outreach staff to enroll/re-enroll individuals during community outreach. We will provide laptops and cell phones with hot spots for all outreach and enrollment navigators that will allow them to access the Health Connector during community outreach.

Self-management and stabilization is an important component of care management. One of our outcomes for this project is to have enrollees take charge of their health. We will do this by working collaboratively with enrollees to develop a treatment plan, identify unmet social needs, and provide health and wellness events.