Advocates for Human Potential, Inc.

wellforce

Key Informant Interview (KII) Report of Findings

Task 2 Deliverable

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Executive Summary

Wellforce Care Plan Accountable Care Organization (ACO) is working with consulting firm Advocates for Human Potential, Inc. (AHP) to help them identify the critical pathways for treatment intersection and design and implement a strategic plan to reduce behavioral health (BH) admissions, re-admissions, and Emergency Department (ED) visits related to mental health concerns and substance use disorders (SUDs).

This engagement involves

1. A review of documents, data, and analyses
2. Site visits and key informant interviews
3. Strategic action planning
4. The development of an action plan to achieve the goals of the project

This report is the result of the second task: ***a brief report of the interview and site visit outcomes.***

Strengths in the Current Wellforce ACO System of Care

- Across sites and informants, AHP observed among primary care leaders a consistent commitment to, and awareness of, BH concerns as drivers of unnecessary utilization and poor patient outcomes. This type of "buy-in" is critical to the success of system change initiatives such as the Massachusetts DSRIP program and it is a clear strength for the strategic planning process. Additionally, all three sites are engaged in efforts to increase access to BH consultations, warm handoffs, and/or short-term treatment in the primary care setting.
- All sites are engaged in some type of analysis of a Milliman high-risk population profile. These data are a powerful resource with additional opportunities for using them.
- Strong relationships with preferred behavioral health community partners (BHCPs) are under development in Lowell, Melrose-Wakefield, and Tufts. These partnerships are critical for care coordination for the ACO's most vulnerable members, including improving access to community based BH services.
- Lowell and Melrose-Wakefield both experienced successful implementation of the Massachusetts Community Hospital Acceleration, Revitalization & Transformation (CHART) Investment Program, which helped them begin to enhance access to BH services and coordination between hospitals and community-based providers and organizations.

How To Read This Report

This report is divided into three sections, one for each region within the Wellforce ACO.

1. Lowell
2. Melrose-Wakefield/Hallmark Health
3. Tufts Medical Center

Within those sections are summaries of what key informants said about the drivers, contributors, and solutions around unnecessary ED visits and inpatient admissions and readmissions.

While each section is unique based on what key informants had to say, they are built around common themes in the findings. These include:

- System-wide challenges to addressing BH and SUD and factors that contribute to preventable utilization.
- How data and reports are being accessed and used to manage these patients.
- How care teams are addressing the needs of these patients and opportunities to further strengthen their approach.
- The contribution of system partners to the issue and to the solutions.

Each section concludes with some proposed opportunities for strategic planning.

Ongoing Challenges

- The care teams across all three sites are still works in progress – each for different reasons. The linkages with primary care, use of high-risk data to identify actionable members, and sharing of relevant clinical information in efficient and effective ways continues to evolve.
- Wellforce sites struggle with many of the same challenges all ACOs are struggling with in the age of health reform: managing high-risk patients with resource constraints and limited access to community based BH providers and other referral sources.
- There are long waits to see community based BH providers both internally and at other organizations.
- Care team staff experience data entry fatigue due to requirements to document in multiple EMRs.
- Finally, many patients are dealing with social determinants of health (SDOH), such as limited transportation or food or housing insecurity that both make the ER the easiest source of care and lead them to reach crisis level before they seek help.

Opportunities for Improvement

One of Wellforce's greatest opportunities is to focus on the management of high-risk, high-need patients within its system of care through partnerships, staff training, and workforce development, especially training in BH and motivational interviewing (MI) for all staff. Helping the most vulnerable patients access high-quality services quickly and easily will be a strong contributor to reducing ED overuse and avoidable psychiatric admissions and re-admissions.

Along with this, Wellforce should prioritize creation of same day access for BH services. SDOH such as unreliable transportation or childcare, unstable housing, or lack of a phone number make attendance at a prescheduled appointment incredibly challenging for some people. The ACO should consider

- Harmonizing the available data in order to more effectively identify gaps and patterns of care to be addressed through the most appropriate targeted approach, including patient level interventions (e.g., care management and care coordination) and system level interventions (e.g., development of workflows).
- Building system partnerships to strengthen BH service delivery and improve access to outpatient BH services.
- Strengthening alignment of provider network management efforts in partnership with Beacon Health Strategies.
- Strengthening BH access within Wellforce.
- Stratifying risk regarding the interface between BH conditions and co-occurring medical conditions.
- Development of workflows to guide the work of and with care teams.
- Installing recovery coaches within the ACO Care Team, affiliated EDs, and/or primary care setting.
- Establishing a platform for ongoing interdepartmental training and coaching in the practical applications of MI skills across all three sites.

More details of these strategic areas are outlined in the report.

Lowell Area Findings

In November and December 2019, AHP conducted interviews with key informants and stakeholders at three primary ACO sites in Lowell. These included:

- Lowell Community Health Center (LCHC)
- Lowell General Hospital (LGH)
- Lowell General Physician Hospital Organization (PHO)

Interviewees included

Name	Location/Affiliation
Scott Wallace	Regional Clinical BH Manager, Team Manager Behavioral Health Engagement/Stabilization Team, Lowell General Hospital
Lisa Brown	Behavioral Health Nurse Practitioner, Lowell General Hospital
Mary Silva	Nurse Practitioner, Bridge Clinic
Duncan Speel	Director of Behavioral Health, LCHC
Lori O'Connor	Program Director, ACO Case Management and Community Partnerships, Lowell General Hospital
Dr. Wendy Mitchell	President of the Medical Staff, Medical Director of Wellforce Care Plan and of Lowell General Physician Hospital Organization, Lowell General Hospital
Dr. Nate MacDonald	Chief of Emergency Medicine, Lowell General Hospital
Dr. Randi Berkowitz	Chief Medical Officer, LCHC
Dr. Padma Suresh	Chief of Psychiatry, LCHC
Dr. Neelam Sihag	Psychiatry Consultant, Lowell PHO
Karen Peugh	Senior Director, Clinical Systems & Support, LCHC
Dr. Shaun Farraher	Family Medicine Physician, LCHC
Becky Williams	Director of Integrated Care and Case Management, LCHC

The AHP team asked informants a series of customized questions regarding challenges to addressing the needs of their unique mental health (MH)/SUD (collectively referred to as behavioral health [BH])

population and their contribution to ED utilization acute admissions and readmissions. These questions explored:

- Access to BH services, especially in the community;
- Coordination across all levels of care, including transitions from ED and inpatient back to primary care provider (PCP) and community BH provider, and coordination with Wellforce;
- The availability and use of data, both individual and aggregate, such as population health data and the Milliman high risk data;
- Partnerships, including those between the ACO and BHCP, the ACO and community stakeholders, and between the ACO and primary care organizations within the Lowell ACO; and
- Utilization of the ED.

The following sections describe the aggregate and overall findings of these interviews.

Challenges to Addressing BH & SUD and Factors That Contribute to Preventable Utilization

Key informants report a number of challenges to managing patients' BH needs that, when left unchecked, are believed to be contributing factors to preventable ED utilization and psychiatric readmission. These include issues with

- Transition planning from the ED to community based BH and primary care services and from inpatient to community services;
- Access the BH services in the community;
- Competing priorities across the system of care;
- Inconsistent efforts to divert from ED and hospital level of care; and
- Uniquely challenging patient profiles.

These are explained in more detail below.

Transition planning

Key Informants report several challenges:

- Insufficient discharge planning occurs at many inpatient psychiatric facilities. This includes a lack of timely information being shared with the PCP and scheduling primary care appointments in lieu of, rather than in addition to, a psychiatric prescriber appointment when one is warranted.
- Presenting at the ED due to inability to refill a prescription, especially for individuals transitioning out of jail.
- A lack of information shared from acute psychiatric facilities and narrow discharge planning that is limited to traditional outpatient services when a step down to transitional support services (TSS), clinical stabilization services (CSS), or a halfway house is indicated.

Area of Strength
in transition planning

Key informants who review admissions at LGH note a high prevalence of co-occurring psychiatric diagnoses. These patients' aftercare plan often includes a transition of care visit with their PCP. LCHC has established a protocol for visits with the PCP following any inpatient admission.

Access to behavioral health services in the community
Key informants report:

- Long waitlists to see outpatient therapists and psychiatric prescribers at LCHC (two to three months) and elsewhere, which forces PCPs or urgent care to bridge the patient's psychotropic medication needs.
- Gaps in access to recovery coaches after hours in the LGH ED and in meeting with patients in detoxes prior to discharge. Lack of access to substance use detoxification programs. There are none in Lowell and limited contacts with the Tewksbury detox.
- Unfamiliarity with the complete psychiatric continuum of care and the process to navigate it leaves some PCPs at LCHC and Lowell General PHO treating patients with serious mental illness (SMI) that they would typically refer on to BH outpatient services. This includes patients on multiple medications and/or with multiple psychiatric diagnoses, and patients whose symptoms are unresponsive to treatment after three months.
- A need for more intensive community-based services such as intensive outpatient program (IOP), partial hospitalization program (PHP), and day treatment.

Area of Strength
in access to BH services

LCHC is expanding BH access in their primary care setting by providing BH consultation via the BH Department and moving toward a more delimitated model where PCPs treat lower level BH concerns and the BH Department targets more complex and severe BH presentations.

Competing priorities
Key informants report competing priorities and workflows that create challenges in reducing or preventing ED overutilization and avoidable hospitalizations:

- The Care Team's process guides them to connect face to face with patients in the ED, while the ED's longstanding process is to discharge patients early in the morning outside the operating hours of the Care Team. This is ongoing despite Care Team efforts to collaborate with the ED around holding patients until the Care Team starts their day.

Diversion from ED and hospital level of care
Key informants report the following contributors to overuse of the ED and hospital level of care:

- PCPs, emergency service providers (ESP), police, respite bed programs, local shelters, and schools have directed patients to the ED rather than attempting a mobile ESP evaluation or sending the patient to the LCHC Walk-In Center when that is a more appropriate option. There are limited protocols for diverting patients or criteria for accessing community-based walk-in centers or community-based ESPs.
- Patients and some system partners (noted above) are unaware of the Walk-In Center.
- ESP providers have limited open access hours.

Note: These findings are the impressions of key informants; not the result of data or patient reports.

Patient profile
Key informants describe the following patient factors that present challenges:

- Alcohol dependence is a key feature of many patients presenting in the ED.

- Social factors contribute to ED overutilization, including a lack of transportation to outpatient appointments, homelessness, barriers to filling prescriptions, and criminal justice involvement including police picking up intoxicated individuals and bringing them to the ED.
- There are sometimes cultural barriers for the Cambodian population in Lowell that can result in a pattern of using the ED over outpatient psychiatric services.
- A number of patients presenting in the ED are pre-contemplative about engaging in longer term treatment and are instead seeking prompt resolution of an unmet medical, psychiatric, or social need. Key informants identified how recovery coaches may help to improve engagement with this population.
- For some patients, the ability to receive food and a bed incentivizes using the ED over using the Walk-In Center.

Note: Again, this information is based on anecdotal reports from key informants, not patient data.

Data and Reports: Accessing, Using, and Managing with Data

Most key informants report ongoing or recent use of Fallon's Risk Stratification (Milliman High Risk) Report and Beacon's BH inpatient Admit, Discharge and Transfer (ADT) census report. The BHCPs and Care Teams have recently begun receiving information from Collective Medical Technology (CMT) and Patient Ping event notification systems, which feature real-time notification of a Wellforce patient in the ED and the capacity to customize member information from BHCPs and care teams.

Other important findings regarding data include:

- The BHCP leadership is motivated to make data-driven decisions. They are interested in determining what the top five diagnoses are and creating preventative clinical pathways to help manage patients in the community, thereby avoiding ED and inpatient utilization. They are also considering the creation of specialty community partner (CP) teams for patients with common medical co-occurring disorders, such as COPD and asthma.
- LCHC office-based addiction treatment (OBAT) and Bridge Clinic nurses are flagging relapses and tracking patients with positive drug screens and positive SUD screens from initial intake.
- The Behavioral Health Engagement Team (BHET) care team completes an initial one-page list of patient goals and a Fallon TruCare treatment plan at 60 days, which is updated during team meetings. They are in the process of developing a discharge/closing note.
- Tiger Connect is a useful way to communicate with preferred CPs in real time. For example, Tiger Connect can be used to text the CP that a patient has presented in the ED and coordinate a warm handoff to them.

Report/Data Source	Who is Using It?	Special Notes
Beacon's BH Admit, Discharge, and Transfer (ADT) census	Care Teams BHCP LCHC	Care teams use it to outreach discharged patients at their homes. LCHC leadership has used this list to look at patients with four or more hospital visits (≈ 50 patients) and discovered that they had come to LCHC typically to address an urgent complaint (such as pain) after not showing for a scheduled appointment.
Fallon's Risk Stratification (Milliman High Risk) Report	Care Teams BHCP	Care teams use to identify patients to outreach, including patients who are predicted to be a future high-risk.
TruCare reports	Care Teams LCHC leadership	LCHC is unable to import into EHR.
Collective Medical and/or Patient Ping Event Notification System (ENS)	BHCP Care Teams LCHC	
Positive social determinant of health (SDOH) screens	BHCP LCHC	
claims data	BHCP LCHC	
eHana Care Management platform	BHCP	
Custom reports created by LCHC Chief Medical Officer (CMO)		
medically acute admissions to LGH	LCHC leadership LCHC Department of Psychiatry LCHC Primary Care	Weekly report The physician head of medication assisted treatment (MAT) reports that there are about 10 admits a week to the LGH medical-surgical units.
LCHC patients who have been seen in ED	LCHC Department of Psychiatry LCHC Primary Care	Daily report

Challenges and Gaps in Data and Reporting

The following gaps were identified during interviews:

- A number of key informants report staff frustration with having to document in multiple EMRs and how this hampers one's ability to quickly and efficiently coordinate, integrate, and plan care in real time with other Wellforce system partners.
- Alignment between the daily reports of ED and inpatient admits and the high-risk profile is not clear. Notification of ED and inpatient admits can be delayed, limiting the opportunity for patient engagement in those settings and for more seamless transitions of care back to the PCP or BH providers. However, the care team and BHCP are just becoming facile with these data and starting to harness the potential of the ENSs to develop more timely and informed interventions.
- The coding in the report obtained at LCHC does not identify SUD related concerns. This affects the capacity to flag ED clients for outreach, follow-up, etc. LGH ED does not code for identification of overdoses. This restriction is likely a result of the interpretation of 42 CFR, Part 2.
- There are challenges sharing information between eClinical Works EHR and Cerna EHR.
- LGH ED and LGH Medical Inpatient Psychiatric Consultation Team do not have access to any BH related utilization data or high-risk data.

Care Team

The Behavioral Health Engagement Team (BHET) is one of three distinct care teams that Wellforce has implemented in Lowell. (The other two teams focus primarily on medical patients.) BHET is a 90-day program designed to address gaps in patient outreach, transition, and treatment engagement that are unmet by the BHCP program. BHET's goal is to decrease ED over utilization and avoidable readmissions and increase rates of successful 7-day follow up after an ED or inpatient discharge for patients with a psychiatric diagnosis. The BHET has many strengths based on its model of care. This section will focus on the challenges and barriers that key informants identified.

Challenges to Identifying Patients

- The ED EMR does not reflect that a patient is under the care of the BHET, making it hard for the local ED to know when to contact a care team. Consequently, the hospital ED staff do not typically notify the BHET about a patient. However, the BHET has worked with the local ESP team to notify them about patients whose disposition is to return to the community.

Challenges in Engaging Patients

- Barriers to engagement include patient distrust, patient fatigue from having numerous provider involvement, staff compassion fatigue, and patient fear of legal ramifications for patients with outstanding/unresolved legal issues. The team has received training in MI and ongoing supervision and coaching in MI skills can be used to help address these barriers.
- The team is currently working together with the LCHC BHCP to determine the circumstances and threshold for discontinuing outreach attempts when a patient is not engaging.

Challenges to Documentation

- The requirement of documenting in multiple separate systems causes inefficiencies. For instance, when LCHC patients are seen LGH, the BHET documents in the hospital record, PCP record, and Collective medical.

System Partners

The following information reflects the current state of other local service providers and resources who also address the mental health and substance use needs of Wellforce patients, according to key informants.

Behavioral Health Care Partners (BHCPs)

Strengths

- BHCPs are reported to work with "tough patients," including those who are highly acute, experiencing substance use and SMI and often having a medical comorbidity. The staffing model includes recovery coaches and peer counselors.
- The LCHC leadership meets with the LCHC BHCP (Greater Lowell Behavioral Health Community Partner) weekly to review high risk and difficult to engage patients, as well as address operational challenges, duplication of efforts, communication pathways, strategizing around engagement efforts and clarifying roles and responsibilities. The LCHC BHCP is working to demonstrate worth by establishing an intensive team to work with Wellforce patients, and the BHET has provided training and coaching to help guide and develop the BHCP staff.

Challenges

- Key informants report gaps in BHCP knowledge, skills, and abilities to address the needs of their patients. Most notable gaps include limited basic knowledge of patient's medical concerns, limited knowledge of system navigation, limited awareness of how to locate and engage difficult to outreach patients, and a general lack of attunement to the utilization goals of the ACO and utilization patterns of patients.
- Key informants identified several factors related to working with CPs, including
  - variation in skills at engaging some patients through persistent and aggressive outreach,
  - timely outreach for transient members when they are identified in the ED or admitted to an inpatient setting,
  - lack of familiarity with some chronic medical conditions,
  - minimal skill in accessing outpatient BH and other community resources for BHCP clients, and
  - lack of alignment with ACO incentives and prioritization of utilization measures.

The table below is a report created from the Milliman High Risk Report that shows overall BHCP attribution by risk strata among Lowell area LCO (LCHC, PHO and MERRIMACK VALLEY IPA NEQCA) ACO members.

Count of CP ENROLLMENT PROGRAM								
Row Labels	1. Very Low	2. Low	3. Moderate	4. Mod. High	5. High	6. Very High	NULL	Grand Total
SOUTHEAST COMMUNITY PARTNERSHIP LLC	1							1
BOSTON COORDINATED CARE HUB				1				1
LTSS CARE PARTNERS, LLC	1	1						2
LTSS CENTRAL COMMUNITY HEALTH PARTNERSHIP	1				1			2
NORTH REGION LTSS PARTNERSHIP				6	5			11
ELIOT COMMUNITY HUMAN SERVICES INC	1	1	1	5	3	1		12
BEHAVIORAL HEALTH PARTNERS OF METROWEST LLC		1	3	11	5	6		26
MASSACHUSETTS CARE COORDINATION NETWORK	2	5	1	19	8	1		36
RIVERSIDE COMMUNITY PARTNERS	5	6	2	24	3	4		44
LAHEY HEALTH BEHAVIORAL SERVICES	4	8	4	36	31	10	1	94
COMMUNITY CARE PARTNERS LLC	4	3	4	62	38	38	1	150
MERRIMACK VALLEY COMMUNITY PARTNER	6	12	8	73	34	25	1	159
GREATER LOWELL BEHAVIORAL HEALTH COMMUNITY PARTNER	16	31	21	253	151	83	5	560
Grand Total	41	68	44	490	279	168	8	1098

Proposed or current strategies to address challenges

- BHET has daily contact with the LCHC BHCP and has provided support, coaching, and training to help grow and develop their staff. For example, the BHET has taught CPs how to navigate the system and brought them to local places that patients frequent.
- Key informants report a great deal of variation among the CPs and their care coordinators, especially in their ability to engage patients. Consequently, they have selected to limit efforts to replicate the Greater Lowell BHCP CP management process with other CPs.
- To address the knowledge gap among CP staff in chronic medical conditions, Wellforce provides nursing consultation for the CP patients with co-occurring medical conditions. The CP is working to flag patients and establish care coordination pathways such as:

- Patients with 3 or more ED visits or admissions in 60 days resulting in a case conference with PCP and chief.
- Patients with two or more ED visits or admissions in 60 resulting in a case conference with the CP Medical Director and LCHC Director of Behavioral Health (when indicated for BH patients).
- Dedicating a CP staff to pull a list of rising risk homeless patients and prioritize visitation to them whenever they present in the ED, Walk-in Center, PCP office, or inpatient unit.

The table below, created with data from the high-risk report, shows how many LCHC patients have four or more ED visits.

Count of ED VISITS	LOWELL COMMUNITY HEALTH CENTER	Grand Total
4	205	205
5	82	82
6	54	54
7	31	31
8	26	26
9	16	16
10	6	6
11	4	4
12	7	7
13	6	6
14	6	6
15	4	4
16	5	5
17	3	3
19	1	1
20	1	1
21	2	2
22	3	3
23	3	3
25	2	2
27	1	1
28	1	1
29	1	1
33	1	1
35	1	1
50	1	1
73	1	1
Grand Total	474	474

Lowell General PHO

Strengths

- The leadership of the PHO was one of the leaders in the establishment and implementation of the CHART and COACH grants and maintains supervisory oversight of the Bridge Clinic.

Challenges

- The PHO has little BH support. Most of the contact comes from the newly established care teams, including the BHET.

The table below, created with data from the high-risk report, shows how many Lowell General PHO patients have four or more ED visits.

Count of ED VISITS	LOWELL GENERA PHO	Grand Total
4	95	95
5	47	47
6	24	24
7	19	19
8	16	16
9	7	7
10	4	4
11	3	3
12	2	2
13	4	4
14	1	1
15	1	1
16	1	1
17	2	2
19	1	1
22	1	1
25	1	1
26	1	1
Grand Total	230	230

Bridge Clinic

Strengths

- The Bridge Clinic is an important point of walk-in access to treatment for patients with SUD, especially those patients who do not typically plan or schedule appointments, are unable to secure reliable transportation to a scheduled appointment or postpone care until it feels urgent.
- Key informants report an increase in ongoing engagement when a patient visits the Bridge Clinic on the day they are discharged from detox, as it allows them to be oriented to ways the Bridge Clinic can assist them and to meet the team of staff invested in helping them as they transition back to the community.

- The LGH/Saints ED and LGH psychiatric nurse consultants makes use of the clinic, referring patients as warranted, especially those in need of opiate treatment.

Challenges

- The clinic is limited by traditional business operating hours.

BH Outpatient Services, both internal (LCHC) and with external partners

Strengths

- Key informants note that that since the start of the ACO there has been greater integration between the PHO, LCHC, and LGH/Saints with both the CMO and BH Director communicating regularly with ACO team. The LCHC BH Department is moving toward an integrative approach with primary care involving BH consultation, warm handoffs, and short-term visits. This is helping primary care increase their capacity to treat some patients' BH needs within the primary care setting so that the BH Department can focus on treating patients with the most complex and severe psychiatric needs.
- Additionally, the LCHC BH Department is developing the capacity to conduct immediate BH consults in the PCP office (based on BH clinician availability). Currently there are about one or two consults daily, typically for patients with suicidal ideation, homicidal ideation, or psychosis. Such collaboration sometimes can result in PCP's increased comfort giving an injectable upon consult from the psychiatric prescriber.

Challenges

- All key informants note a lack of access to outpatient BH therapists and prescribers, with significant wait times (two to three months) both internal and external to the Wellforce system of care. In short, access to community based BH care in the Lowell area is extremely limited.
- Key informants report that most of the LCHC patients who go to the ED are not engaged in BH services at LCHC. The overall cancelation rate for the BH department is approximately 35% to 40% with same day no show/cancellation rate even higher.
- There is a large cohort of patients who are referred to LCHC psychiatry/therapy by their PCPs but never show up or engage in treatment.
- Lack of transportation and childcare are key barriers to appointment follow through.
- Key informants report that BH patients seen at LCHC have to check in or register twice. Once at the main registration, where long lines may delay or deter a patient in getting to their appointment, and then again when they get to the BH Department. The impact of this workflow on appointment follow through for patients experience psychological symptoms (psychosis, anxiety, depression, dissociation, flashbacks) may be worth further exploration.

Proposed or current strategies to address challenges

- Some key informants see CPs as a way to help engage patients in need of more intensive outpatient services such as intensive outpatient programs (IOP), day treatment, and partial hospitalization programs (PHP). The LCHC BHCP works with the LCHC Director of Behavioral Health to try and obtain access to outpatient serves.
- Patients who have a strong outpatient therapy no-show rate are less likely to be able to obtain an appointment as some of them may be considered *persona non grata*. The BHET tries to collaborate with providers to repair and prevent this pattern. Additionally, the LCHC BH Director is notified for no shows and attempts to intervene and cancel a future appointment if patient is hospitalized so as to prevent them from going on the *persona non grata* list.

- Key informants report that strengthening communication between the ED/ESP and LCHC may be warranted given that LCHC is reportedly not typically notified when one of their BH Department patients is in the ED for BH concerns, nor do they receive the ESP assessment when a patient is admitted to higher level of care.
- A BH clinician and community health worker (CHW) are embedded in the LCHC Walk-In Center. Efforts to publicize this new resource are underway and measuring BH utilization of this service is under consideration.
- Key informants report that there is a "back line" phone number for obtaining a transition appointment for existing patients that can help improve access, though it is unclear who is aware of and utilizes this pathway or how widely the phone number has been shared and publicized.

LCHC Primary Care Practice

Strengths

- Case conferences between LCHC BHCP and PCP division chief has reportedly helped develop a greater understanding among PCPs of the services available and increased their knowledge of patients' needs and circumstance.
- LCHC BHPC documents in the same system as PCP providers, which helps them become more familiar with the work of this CP and informs primary care approach.
- The CMO reviews every inpatient admission to LGH and noted the prevalence of co-occurring BH conditions secondary to the medical admission.

Challenges

- Some PCPs reportedly hand off patients to the care team and do not stay as involved as may be warranted, while other PCPs are said to be available to consult to the care teams and, in their absence, the chief can be available.
- Patients with MH and SUD concerns have been observed to underutilize their PCP.

Proposed or current strategies to address challenges

- An exemplary primary care practice has emerged with one provider but is reportedly difficult to scale and sustain unless the PCP has a large number of BH patients on their panel. It includes allowing patients to have a walk in visit when they are located in the community, establishing a care plan with action items to do and avoid, and an alert for how to best manage patient care, as well as the PCP using Tiger Connect to contact the Care Team so they can meet the patient at the PCP office immediately.
- Additionally, primary care is developing workflows or pathways to address prescription refills for patients discharged from higher level of care (HLOC) with insufficient medications to last until their outpatient psychiatry appointment.
- Primary care is reportedly informed by Collective Medical when a patient is in the ED. Division leadership see this as an opportunity to contact the ED and drive care, ensuring that the ED continues care where the patient last left off (i.e., requesting that the ED complete tests the patient had no showed for).
- PCPs or the division chief (if PCP is not engaged) case conferences with the LCHC BHCP on patients with 3 or more ED visits or admissions in 60 days. And the BH division director is considering ways to increase access to BH services for patients with multiple ED visits or admissions.

- Primary care is reportedly beginning to address some of the lower level BH needs, which is freeing up the BH Department to see those with a greater BH need. Additionally, LCHC provides OBOT (suboxone) and it was reported that "most" physicians have been waivered to provide MAT.
- The clinic is planning to install an integrated BH clinician in Internal Medicine to provide a combination of short- and long-term treatment.

The table below is a report created from the Milliman High Risk Report that shows CP attribution by risk strata among LCHC patients. The "Null" field represents individuals unattributed to a CP. There are 106 patients that are not assigned a CP and qualify as "6. very high" risk.

Count of CP ENROLLMENT PROGRAM							
	1. Very Low	2. Low	3. Moderate	4. Mod. High	5. High	6. Very High	Grand Total
Row Labels							
LTSS CARE PARTNERS, LLC		1					1
LTSS CENTRAL COMMUNITY HEALTH PARTNERSHIP	1						1
BOSTON COORDINATED CARE HUB				1			1
SOUTHEAST COMMUNITY PARTNERSHIP LLC	1						1
NORTH REGION LTSS PARTNERSHIP				3	2		5
ELIOT COMMUNITY HUMAN SERVICES INC	1	1		2	1		5
BEHAVIORAL HEALTH PARTNERS OF METROWEST LLC			1	2	4	6	13
MASSACHUSETTS CARE COORDINATION NETWORK	1	4		9	4		18
RIVERSIDE COMMUNITY PARTNERS	3	5	2	11	1	1	23
LAHEY HEALTH BEHAVIORAL SERVICES	2	1	2	8	14	4	31
MERRIMACK VALLEY COMMUNITY PARTNER	4	6	4	36	19	9	78
COMMUNITY CARE PARTNERS LLC	2	2	4	35	15	20	78
GREATER LOWELL BEHAVIORAL HEALTH COMMUNITY PARTNER	14	26	15	190	108	62	415
NULL				2542	345	106	2993
Grand Total	29	46	28	2839	513	208	3663

Emergency Department

Strengths

- Care team management and ACO management are attempting to engage LGH ED leadership in efforts to reduce preventable psychiatric and SU utilization and promote improved treatment coordination.

Challenges

- Care coordination has been hampered by limitations of the Collective Medical alert and a lack of access to medical records (e.g., the ED is unable to access the care team care plans).

Proposed or current strategies to address challenges

- In the future, the LGH ED leadership plans to reach out to the care teams directly to learn more about them.
- Key informants report an increase in efforts between the ED and LCHC to collaborate, but the mechanisms to collaborate (other than meetings) and the effect these efforts have had on addressing ED utilization is unclear.

BH Inpatient Facilities

Strengths

- The BHET leadership is actively collaborating with inpatient psychiatric facilities (such as Haverhill Pavilion, BayRidge Hospital, TaraVista, and Arbour Hospital) to work together on discharge planning in an effort to improve 7-day follow up rates.

Opportunities for Strategic Planning

The following are some opportunities for strategic planning and proposed activities to help address Wellforce's ultimate goal to reduce overall BH admissions, readmissions, ED utilization. and eliminate avoidable admissions and readmissions.

1. **Harmonize the data and articulate the data disconnect.**
    a. Standardize training on how to evaluate and sort the Fallon High Risk tables and how to align those members with the list of high ED users, daily reports from the ED, and Beacon ADT. Care teams may benefit from more a longitudinal look at patient episodes of care to identify gaps in outpatient treatment, especially following inpatient episodes and ED visits. Having data reflecting community-based utilization could help improve the Care Teams' work and provide some evidence of successful patient outcomes.
    b. Build competency in the use of Patient Ping and Collective Medical, which will allow for greater collaboration with the ED to inform them of a patient's involvement with CP, BHET, or other care teams, support more timely intervention and match the patient with the right resource such as a recovery coach.
    c. Tracking the following information on BHET and ED activity:
        i. reason for referral and utilization of ED;
        ii. source of referral (e.g. shelter, PCP, police);
        iii. patients admitted to the ED with SDOH needs; and
        iv. determining the ED patient's awareness of the Bridge Clinic and Walk-In Center.

Documentation across multiple platforms is redundant and a disincentive.

2. **Build system partnerships to strengthen BH service delivery and improve access to outpatient BH services.**
    a. Consider additional partnering with Beacon Health Strategies regarding contractual expectations of their provider network. Fallon may opt to request all Beacon/Massachusetts Behavioral Health Partnership (MBHP) Provider Network Alerts currently in effect for ESP, inpatient, detox, and crisis stabilization units. Sharing specific examples and incidents in which Beacon providers are not performing in line with these expectations could create opportunities for Fallon and Beacon to partner around strengthening performance of the BH provider network on behalf of Wellforce and Beacon members. Additionally, consideration could be given to establishing new network alerts that set expectations such as inpatient facilities' registering with Patient Ping and other goals common to both entities.
    b. Continue to build on the foundational relationship between the ACO and LCHC BHCP (Greater Lowell Behavioral Health Community Partner). Consider further exploration of additional data/reports each has and could share with the other in order to support a shared understanding of the patient population and the development of organizational goals, strategic planning, and operational plans.
3. **Strengthen BH access within Wellforce.**
    a. Workforce development:
        i. Hire or train staff as recovery coaches and peer support staff, especially outside traditional business hours and for use in any setting struggling to engage patients, such as the ED.
        ii. Train or otherwise inform the system of care used by Wellforce members (e.g., PCP, Care Teams, BHCP, ESP, Bridge Clinic, Walk-In Center) in the preferred BH framework/approaches Wellforce encourages for use with their members. Examples include practical applications of MI, anticipatory guidance, trauma-informed care, MAT, OBAT.
        iii. Establish a residency program similar to the one at Tufts and rotate residents through the Walk-In Center, Bridge Clinic, and internal BH consult for Internal Medicine.
        iv. Embed psychiatric nurse practitioners in primary care and in the Walk-In Center.
    b. Address the high rate of no-shows at LCHC via a performance improvement process. Consider open access as a potential solution.
    c. Brand Walk-in Center and BH capacity and track utilization.
    d. Market "back-door" phone number and track volume.
    e. Improve staff competency to work with refugees seeking asylum with undiagnosed BH concerns, especially related to trauma. This population can be difficult to engage and efforts to engage this population be may strengthened by hiring staff, such CHWs, from the identified refugee and immigrant community who can also act as cultural brokers. Focus outreach efforts on stigma reduction and mental health psychoeducation and educate all staff and providers on the on the refugee and immigrant experience, symptoms of trauma, and trauma-informed care.

4. **Strengthen team-based care for complex patients.**
    a. Strengthen relationships between
        i. Care Teams
        ii. Care Teams and CPs
        iii. Care Teams, CPs, and PCPs
    b. Key components of team-based care that should be part of any plan include:
        i. Team member accountability (e.g., accept assignments and follow through).
        ii. Clear goals for interventions.
        iii. Assignment of best staff person to address patient needs (the value of recovery coaches, peers, and CHWs with some members has been demonstrated).
        iv. Delegation by the PCP or other clinical lead to other team members
        v. Ready means of communication (e.g., Tiger Connect) and crisis planning (e.g., Credible Medical, Patient Ping).
        vi. Recovery-oriented and strength-based approach to patients (all members have a foundation in MI).
    c. Workflows and processes to consider developing or strengthening include:
        i. Recovery-oriented and strength-based approach to patients (this requires that all members have a foundation in MI).
        ii. Communication between ED and or ESP provider and PCP, outpatient therapist, and Care Team so that all are informed when a patient presents to the ED.
        iii. ED determination of when to contact Care Team instead of or in addition to ESP provider.
        iv. PCP guidance for determining when to send a patient to the ED verses contacting the BH Department for consult or the Care Team for patient outreach.
        v. Uniform approach to pain management by ED, PCP, Bridge Clinic, and other system partners.
        vi. Uniform protocol for using long-acting injectable at whichever “door” patient enters (e.g., Walk-In Center, PCP, Bridge Clinic, ED).
5. **Stratify risk regarding the interface between BH conditions and co-occurring medical conditions.**

Melrose Wakefield Findings

In November and December 2019, AHP conducted interviews with key informants and stakeholders at Hallmark Health offices in Woburn.

Interviewees included

Name	Location/Affiliation
Dr. Patricia Sereno	Chief, Family Medicine and Women's Health
Carol Plotkin	Executive Director, The COACHH Program, System Director, Behavioral Health Services, Executive Director, Behavioral Health
Caryl A Beison	Executive Director, Hallmark Health PHO & Vice President of Managed Care, MWHC
Lisa Flanagan	Director, Clinical Management Programs at Tufts Medical Center Community Care
Elizabeth Tanner	Care Team Lead

The AHP team asked informants a series of customized questions regarding challenges to addressing the needs of their unique mental health (MH)/SUD (collectively referred to as behavioral health [BH]) population and their contribution to ED utilization and acute admissions and readmissions. These questions explored:

- Access to BH services, especially in the community;
- Coordination across all levels of care, including transitions from ED and inpatient back to PCP and community BH providers, and coordination with Wellforce;
- The availability and use of data, both individual and aggregate, such as population health data;
- Partnerships, including those between the ACO and community partner (CP), the ACO and community stakeholders, and between the ACO and primary care; and
- Utilization of the ED.

The following sections describe the aggregate and overall findings of these interviews.

Challenges to Addressing BH & SUD and Factors That Contribute to Preventable Utilization

Key informants report a number of challenges to managing patients' BH needs that, when left unchecked, are believed to be contributing factors to preventable ED utilization and psychiatric readmission. These include issues with:

- Transition planning;

- Access the BH services in the community; and
- Uniquely challenging patient profiles.

These are explained in more detail below.

Transition planning
Key informants report the following challenges:

- Inpatient facilities are sometimes reluctant to talk with the ACO Care Team when they have already conducted utilization review with Beacon, thus creating barriers to effective transition planning.
- There is a lack of access to and communication with Beacon for authorizations and inpatient status for Melrose-Wakefield ACO members. This has been a barrier to smooth transitions from inpatient to community based BH services.

Access to behavioral health services in the community
Key informants report:

- PCPs' level of knowledge regarding SUD is variable and additional education may help to address stigma that can sometimes be a barrier to treatment.
- With the change in access to visiting nurses association (VNA) services, some patients struggle to access injectables.
- There is a lack of local access to SUD treatment. While the Community Counseling Center is expanding access to mental health services, they do not provide treatment to patients with primary SUD diagnosis. The nearest outpatient SUD provider is in Woburn.
- The preferred BHCP, Eliot Community Health Services, has some capacity to access BH services in the community but it does not address all of the need.

Area of Strength
in access to BH services

Melrose/Wakefield adding an embedded part time LICSW at the Malden Family Center to engage in warm handoffs and provide short-term therapy.

Patient Profile
Key informants describe the following patient factors that present challenges:

- Patients who frequent the ED are often the most challenging patients to engage. Therefore, these individuals require immediate in-person response when they visit the ED or other provider, as well as rapid in-person follow up when they are back in the community.
- SMI is often less of a driving force for ED visits than homelessness, alcohol dependence, social isolation (especially for elders), and economic barriers to resources.
- Approximately 80% to 85% of the patient population in Care Management has a co-occurring BH disorder and the leadership of the team lacks access to psychiatric consultation.
- The target population views the ED as reasonable option for non-acute care, they do not typically make appointments, or are only available int the evenings or weekends. Additionally, these patients are described as being unaware of what can be accomplished though their PCP (such as a 3-day methadone start). Patients who do utilize their PCP over the ED were said to be those that have a relationship with their PCP.

Data and Reports: Accessing, Using, and Managing with Data

- Key informants report having recently begun receiving and using Fallon's Risk Stratification (Milliman High Risk) Report. The ACO Care Team is using the list to flag patients for outreach and consult with the PCP and expressed a desire to also strengthen identification and engagement of "rising risk" patients.
- A number of metrics are reportedly being collected or will soon be collected to help manage care relative to ED utilization, reduction of SU admissions, reduction of per member per month (PMPM) costs, billable coding, PCP satisfaction, and number of referrals to Community Counseling.
- Informants expressed a desire to obtain additional detailed data on the top 10 utilizers that included such information as PCP name, number of visits to the ED, and number of admissions to higher level of care, along with facility name.

Care Teams

Key informants report the following barriers and challenges in regard to the care teams:

Melrose-Wakefield Care Teams

1. Wellforce Care Team – 1 nurse, 3 CHWs, 1 navigator, 2 social workers
2. Transition Nurse Program – following Colman model
3. BH Team – in development

- The ACO Care Team is in the process of developing a stronger understating of rising risk for the BH and SU population. They report that further consideration around processes and workflows for responding to rising risk may be helpful.
- The CHW role on the ACO Care Team is crucial component, often demonstrating the most significant impact, particularly in regard to engaging members.
- There is a history of high staff turnover on the care teams.
- Historically, there has been minimal contact between the care teams and the health center. The geographical isolation of the care team in an office building is also a potential obstacle to better coordination with BH and PCPs.
- Documentation inefficiencies are the result of having to document in three separate systems: Meditech for inpatient, EMR for outpatient, and TruCare for Fallon.

System Partners

The following information reflects the current state of other local service providers and resources who also address the mental health and substance use needs of Wellforce patients, according to key informants.

Behavioral Health Care Partners (BHCPs)

Strengths

- Eliot BHCP is a preferred CP. Multiple key informants described Elliot, which also provides ESP services, as a collaborative system partner, willing to work together on new initiatives including the potential establishment of a subcontract to offer recovery coaching to Wellforce members.

Outpatient Services

Strengths

- Key informants report some recent improvement in the waitlist for psychiatric outpatient services at Community Counseling Services.
- Community Counseling is co-located in the same building as Malden Family Center. PCPs are able to review the CC prescriber note but not the therapy notes.

Challenges

- Community Counseling reportedly does not accept active substance using patients as a matter of policy and in the event that a patient in recovery relapses, they are discharged from care.
- There is currently no process or capacity for PCPs to engage a patient in a psychiatric warm handoff to Community Counseling.

Proposed or current strategies to address challenges

- The Behavioral Health Integration Program (BHIP) provides some capacity to link members to Community Counseling. (See below.)
- Melrose-Wakefield has established a working relationship with Middlesex Recovery in Woburn for training, consultation, and referral for SUD services.

Primary Care Practices

Strengths

- Ryan O'Conner from Middlesex Recovery has consulted with PCP pod meetings (monthly insurance-blind PCP peer clinical case consultation aimed at sharing exemplary practices and resources) to provide an overview of SU. Motivational interviewing training was also recently offered to PCPs and SBIRT training is being considered.
- Malden Family Health Center PCPs are notified when a patient is in the ED via Quick Text or Patient Ping (for non-Hallmark EDs), which provides limited information indicating that the patient is in the ED but does not provide information regarding patient's presentation. Primary care reports having a policy of outreaching Melrose-Wakefield Hospital and indicates the need to develop a workflow for follow up on Patient Ping notifications from non-Hallmark EDs.
- When patients are discharged from the Melrose-Wakefield inpatient unit, the PCP receives a discharge summary, completes a medication reconciliation, and ensures a follow up appointment is scheduled for the patient.

Challenges

- Primary care has reportedly experienced some challenges accessing BH services for their patients, as well as addressing SUD and SDOH.

Proposed or current strategies to address challenges

- With BHIP funds slated to be exhausted in 2020, Malden Family Center is considering ways to establish a model similar to the Cherokee Health Systems model, with a billable part-time licensed clinical social worker embedded in the primary care setting to provide warm handoffs and short-term therapy.
- Establishing at least some members of the ACO Care Team staff in treatment settings where high risk patients frequent improves potential for patient engagement, warm handoffs, and provider collaboration.

- To help address provider confusion regarding the new care team model and who on the Care Team to send referrals to (e.g., for patients in need of SODH or BH services) a "bucket list" was created. This allows PCPs the ease of sending a referral to a queue to be triaged by the ACO Care Team. Some patients with lower level BH needs may be referred on to Fallon case management.
- Key informants report a plan to establish a rounding process where high-risk Wellforce patients can be reviewed by a multidisciplinary team that includes a pharmacist, a social worker, CHW, PCP, and the medical director.
- Some key informants expressed a desire for the ACO Care Team or other BH staff to hold meetings with high ED utilizing patients, their PCPs, and other treaters to develop a plan for preventing over utilization.
- Malden Family Health Center is reportedly developing a suboxone group visit model, staffed with a nurse and three waivered physicians beginning in January 2020. This is an opportunity for approximately 50 patients currently receiving suboxone at Middlesex Recovery (often challenging for patients to travel to) to transfer over to the primary care setting.

Emergency Department

Strengths

- Eliot ESP and the Wellforce Care Team are working together on patients that are not admitted. The process involves the ESP contacting the CHW for a warm handoff prior to the patient being discharged to the community. Additionally, the Care Team transition nurse takes warm handoffs when in the ED.
- Key informants report that the local ED has partnered with Middlesex Recovery to address the outpatient needs of substance using patients who present in the ED.

Proposed or current strategies to address challenges

- There is a potential opportunity for installing a recovery coach in the ED. Eliot and the ED are reportedly in the process of discussing this.

BH Inpatient Facilities

Strengths

- Regular communication from Melrose-Wakefield inpatient facility to system partners was reported.
- PCPs at Malden Family Health Center have access to Lahey Health, Melrose-Wakefield Hospital, and Partners EMR information.

Challenges

- There is a lack of communication from other inpatient facilities (besides those noted above).
- PCPs must request paper medical records from Whidden Hospital and Cambridge Health Alliance.

Opportunities for Strategic Planning

The following are some opportunities for strategic planning and proposed activities to help address Wellforce's ultimate goal to reduce overall BH admissions, readmissions, and ED utilization.

1. **Harmonize the data and articulate the data disconnect.**

a. Standardize how the Fallon High Risk Report and frequent ED users are organized for interventions by the care teams. The leadership had little familiarity with how these reports are used to identify interventions.

b. Consider how to leverage the Patient Ping notification system to bring the care teams, PCPs, and BHCPs together with a timely intervention and follow up to engage the patient. The team members can also insert key notes into Patient Ping, alerting EDs and inpatient providers of their involvement with the patient. More timely notification will assist in transitions of care and help achieve the quality metrics established by MassHealth.

c. Clarify the necessity of data entry into the EMR and TruCare, along with standard protocols and workflows to help streamline the process and potentially reduce existing redundancies. The issue of duplicate data entry was raised by several key informants.

d. Establish baselines of utilization via Fallon High Risk file and the accompanying claims files, which can be re-measured through the course of involvement of the care teams for validation of the interventions, as well as identification of opportunities for improvement.

2. Build system partnerships to strengthen BH service delivery.

a. Align Fallon, Wellforce, and Beacon goals to help establish a foundation from which to strengthen their partnership. A potential shared goal of reducing psychiatric hospital admissions and length of stay, for instance, may help Fallon and Beacon collaborate to support both the ACO Team and inpatient facilities in working together in new and creative ways to achieve this end. One method to align the programs may be through participation of the ACO Care Team on the Beacon inpatient utilization review process.

b. Consider establishing a more formal forum for Lowell, Tufts, and Melrose-Wakefield to share best practices and review data together.

3. Strengthen BH provider access within Wellforce.

a. **Prioritize team-base care involving BH providers.** The prevalence of co-occurring BH conditions among the care team population is estimated to be 80% to 85%.

i. Invest in additional consultation from a clinical subject matter expert, which will benefit the nurses and CHWs on the team in their approaches to the medical conditions of these patients. The presence of a social worker has already benefited members, according to one key informant.

ii. Routinely review the follow up from the “bucket list” requests from PCPs for care management and BH access services of the PCPs’ patients. A feedback loop will keep the PCPs informed.

b. **Prioritize Workforce Development.** Potential opportunities to further develop the workforce based on key informant recommendations and AHP observations include:

i. Provide additional training and coaching around the provision of same day service access and the practical application of MI, a proven way to address barriers to treatment and perceived lack of engagement.

ii. Solicit employee recommendations in the ongoing design and development of the ACO Care Team model, as well as new data entry process and subsequent reports via TruCare.

iii. Consider embedding an ACO Care Team CHW at Malden Family Center.

4. Stratify risk regarding the interface between BH conditions and co-occurring medical conditions.

a. Develop protocols, pathways and or workflows including the following
    i. Care team workflows that standardize how resources are deployed based on highest potential for impact, method of patient engagement based on stratification of patients, and unifying patient approach with other community-based providers and inpatient facilities.
    ii. Protocols for engaging BH consultation for complex and high-risk patients with co-occurring medical and BH conditions.
    iii. Workflows for accessing the recovery coaches to support the Care Teams and PCPs who have patients with SUD.
    iv. Embed MI terminology into all protocols, workflows, and guiding documents to reinforce efforts to reduce stigma and encourage consistent approaches to patients who may be pre-contemplative and/or prone to relapse.
    v. Create pathways and protocols that ensure ACO Care Team is located close to the patients they serve in order to increase opportunities for immediate face to face contact when a patient presents.

C. Tufts Findings

In December 2019, AHP conducted interviews with key informants and stakeholders at Tufts Medical Center and Tufts Floating Hospital for Children.

Interviewees included

Name	Location/Affiliation
Wil Hartigan	Clinical Social Worker, Tufts Medical Center, Primary Care
Dr. Shirley Huang	Chief of General Pediatrics; Pediatrician; Assistant Professor, Tufts University School of Medicine
Dr. Annette Hanson	Vice Chair, Public Sector Psychiatry, Department of Psychiatry, Tufts Medical Center
Dr. John Sargent	Chief, Child and Adolescent Psychiatry
Lindsay Hardgrave Massena	Clinical Social Worker, General Pediatrics & Outpatient Specialty Clinics
Dr. Deborah Blazey-Martin	Chief, Internal Medicine and Primary Care
Liz Barnhart	Nurse Manager, Tufts Medical Center

The AHP team asked informants a series of customized questions regarding challenges to addressing the needs of their unique mental health (MH)/SUD (collectively referred to as behavioral health [BH]) population and their contribution to ED utilization and acute admissions and readmissions. These questions explored:

- Access to BH services, especially in the community;
- Coordination across all levels of care, including transitions from ED and inpatient back to PCP and community BH, and coordination with Wellforce;
- The availability and use of data, both individual and aggregate, such as population health data;
- Partnerships, including those between the ACO and BHCP, the ACO and community stakeholders, and between the ACO and primary care; and
- Utilization of the ED.

The following sections describe the aggregate and overall findings of these interviews.

Challenges to Addressing BH & SUD and Factors That Contribute to Preventable Utilization

Key informants report a number of challenges to managing patients' BH needs that, when left unchecked, are believed to be contributing factors to preventable ED utilization and psychiatric readmission. These include the following identified obstacles:

- Patients' significant basic needs and SMI are beyond the scope of a what can be managed in an under-resourced primary care setting.
- The persistent nature of many SDOH, compounded by a lack of available resources (e.g., a reported 15-year waitlist for subsidized housing, insufficient food resources, unreliable PT-1 transport making patients late for appointments), makes it difficult to remediate SDOH in the short-term.
- A lack of timely access to outpatient (OP) psychiatric services and long waits for Children Behavioral Health Initiative (CBHI) services for Chinese, Mandarin, and Spanish speaking patients.
- Informants noted increased pediatric costs. Although the driver of this is unclear, contributing factors may include referring out for applied behavioral analysis (ABA), and a new requirement to prescribe brand name ADHD medications.

Areas of Strength
in access to BH services

The following staff have been embedded into the primary care setting to assist the practice in addressing patients BH needs:

- Social worker to engage in warm handoffs and provide short-term crisis management interventions.
- SUD-trained psychiatrist to assist with assessment and case consultation.
- Psychiatric nurse practitioner.

Data and Reports: Accessing, Using, and Managing with Data

One key informant reported a thorough review of the top 300 patients identified in the Milliman High Risk list. Others report some use of data and reports to stratify and understand patients. They report a desire to have a better understand of "rising risk" data and how to address this population. They expressed interest in receiving more detailed data to assist in discerning whether an individual's underlining illness may be opiate, alcohol, or other substance-related given the presenting medical diagnosis (i.e., cellulitis, liver failure).

The following are more details of these conversations regarding data.

- Some key informants report that the risk stratification report helped them better understand the following information regarding their top 300 most expensive patients:
  - Most of patients have MH and SUD as an identified need.
  - Upon review by the Care Team, the chief of Internal Medicine, and primary care, of the top 100 patients who visited the Tufts ED, 75% had a BH component in first three diagnoses.
- The ACO Care Team reportedly uses the following data:
  - The risk stratification report to identify patients an targeted interventions (e.g., via a case conference to care plan with the PCP).

  - a daily report of upcoming appointments to scan for ACO patients who have primary care appointment so a team member can check in with them during the visit.
  - a list of Tufts ED and acute utilization, as well as Patient Ping that allow them to work with the hospital to transition patients back to the community.
- The Pediatric ACO Care Team reportedly uses the following data:
  - the ADT census report. However multiple informants reported being limited by the accuracy of this data.
  - Fallon's Risk Stratification (Milliman High Risk) Report. Weekly review in ACO Team meetings is underway and coupled with review of each patient's chart to determine whether patients would benefit from an ACO Team intervention.
  - All acute admissions are reviewed to determine if they were preventable (most of the time they are reportedly not).
  - SDOH - a new initiative is being launched to more successfully capture information on food insecurity through the SDOH screening.

Care Teams

Adult Medicine

- The ACO Care Team is available to assist PCPs (via Patient Ping) with SDOH and when patients are experiencing a BH crisis. The CHW outreaches patients via phone, face-to-face, and in the community to help with food insecurity and other SDOH.
- The Care Team conducts a twice-weekly team huddle with the nurse case manager, CHW, transitions nurse, social worker, and Annette Hanson, vice-chair, Public Sector Psychiatry. Bay Cove BHCP joins every other week. There is also a monthly case conference on high risk patients.

ACO Care Team
adult primary care

- 1 Nurse Case Manager
- 2 Community Health Workers (CWHs)
- 1 Social Worker
- 1 Pharmacist (consultant)
- Coming soon: 1 half-time psych NP

Pediatrics

- The Pediatric ACO Care Team has a collaborative team approach with a "no wrong person" philosophy that encourages parents to share concerns with anyone on the team. The team helps high-risk/high-need families develop self-advocacy skills in order to advocate for their basic needs, increase their understanding of purpose of medical visits and increase confidence and skill in asking doctors questions.
- Pediatric ACO Team activities include:
  - Linkage to community resources to address SDOH (e.g., access to housing and food, transport to appointments, coordination of appointments, applications to Department of Transitional Assistance (DTA), and shelters).
  - Development of comprehensive care plans and emergency plans.
  - Phone triage, home visits, and parent education.

- Maternal mental health support to high-risk infants and children.
- Referral, outreach and coordination with outpatient providers and community supports, schools, Department of Children and Families (DCF).
- Outreach and coordination with inpatient psychiatry.

ACO Care Team *pediatrics*

- 1 social work team lead
- 2 CHWs (1 Cantonese speaking)
- 1 nurse care manager
- 1 social worker

Challenges

- Informants report that Multiple EMR systems create redundancy in documentation for care team staff.

System Partners

The following information reflects the current state of other local service providers and resources who also address the mental health and substance use needs of Wellforce patients, according to key informants.

Behavioral Health Care Partners (BHCPs)

Strengths

- Tufts' preferred BHCP, Bay Cove Human Services, has reportedly demonstrated a willingness to assist the ACO in working with patients experiencing chronic risk. Additionally, they are considering embedding Bay Cove BHCP in the primary care setting.
- The ACO Care Team and Bay Cove BHCP meet biweekly to review patients, coordinate approaches, and establish and refine communication pathways.
- The ACO Care Team is also considering working with Boston Health Care for Homeless to develop them into a preferred BHCP.

Tufts is exploring ways to

- leverage Bay Cove's recovery coach,
- create pathways for warm handoffs to the BHCP, and
- assign one BHCP staff dedicated to all Wellforce members, rather multiple staff, thus streamlining communication and coordination with the ACO Care Team.

Challenges

- A significant lag time between referral engagement and LTSS CPs eventually resulted in discontinuation of using LTSS CPs and a preference for the ACO Care Team to serve these patients instead.

Outpatient Services

Strengths

- The Tufts Department of Psychiatry has strengthened BH access by establishing three separate clinics with psychiatry residents providing consultation to PCPs. The model includes up to three face to face meetings with patients, submission of a written consultation summary to the PCP, and availability for phone consultation with the PCP.

Challenges

- Key informants report limited access to OP psychiatry and psychotherapy both at Tufts (3-month wait) and at South Boston Community Health Center for adults, and Tufts, the Massachusetts Society for the Prevention of Cruelty to Children (MSPCC), and South Boston Behavioral Health Clinic for children. OP psychiatry at Tufts is restricted to appointments with psychiatry residents and interns in psychology and clinical social work.
- Beacon's "look-up" system for network providers for referrals is reportedly difficult to use.
- Many private practitioners in Boston do not accept Wellforce patients, and few community mental health centers, besides South Boston Community Health Center, are accessible to treat this population.
- There is insufficient access to Mandarin speaking therapists and psychiatrists.

Primary Care Practices

Strengths

- Key informants report that the strength of the Primary Care practice lies in their skill of building relationships with patients, utilizing embedded social workers, screening for, and treating low grade anxiety and depression.
- Some recent efforts to increase BH resources in primary care include
  - embedding a SUD-trained psychiatrist in the primary care practice one day a week to help with assessing patients and holding case consultation meeting with practitioners.
  - adding a social worker and a part-time psychiatric nurse practitioner; and
  - having CHW sit in the primary care practice.
- Tufts operates a payer blind chronic SUD program through which a small number of patients receive suboxone via approximately eight waivered providers. Some providers are beginning to treat with vivitrol, and providers have reportedly been trained in MAT protocol. Two embedded pharmacists have helped with the development of information sheets. The hospital is said to have a pain management service, which mostly offers consultation and injections.
- To help address provider confusion regarding referrals, the ACO Care Team developed a process in which PCPs could contact any SW (even those not assigned to the ACO). That SW then triages the referral to the correct person.

Challenges

- PCPs can become overwhelmed by complex patients acute symptomatology when "bridging" them while they await OP psychiatry appointments.
- Key informants report a history of a psychiatric consultant as part of ACO Care Team that was underutilized. Additionally, the Massachusetts Child Psychiatry Access Program (MCPAP) was said to be minimally utilized due to the complex nature of patients who require an ongoing psychiatric prescriber rather than a consult.

Proposed or current strategies to address challenges

- Considerations are underway for embedding a .1 FTE psychiatric prescriber into pediatric primary care to provide consultation and bridge complex and high-risk patients awaiting OP appointments.

Emergency Department

Challenges

- The EMR is said to get "pinged" indicating that a patient is in the ED or admitted to the inpatient unit, but that can go unseen until the end of the day or the next day, rendering a less effective real-time notification to the team. It is unclear whether there is an established protocol for addressing Patient Ping communications or direct communication between the Tufts ED Care Team, BHCPs, and PCPs.
- Reportedly there is a high-risk banner in the EHR, but no flag or trigger to prompt the ED to contact the ACO Care Team when a patient presents in the ED.

BH Inpatient Facilities

Strengths

- Tufts Inpatient Psychiatry Department has reportedly established a regular practice of contacting the ACO Team upon review of the patient record to determine if a patient is a Wellforce member.
- Pediatric inpatient hospitals discharge planning is often limited to a follow up appointment with the PCP. Consequently, the Care Team proactively contacts inpatient facilities to ensure that discharge planning also includes follow up appointment with a psychiatrist.

Opportunities for Strategic Planning

The following are some opportunities for strategic planning and proposed activities to help address Wellforce's ultimate goal to reduce overall BH admissions, readmissions, and ED utilization.

1. **Harmonize the data and articulate the data disconnect.**
    a. Expand the analysis of the high-risk report across the care teams to identify the "rising risk" sub-populations and establish benchmarks for improvement. The BHCPs can be a partner in building a population health approach for the most complex ACO members.
    b. Align the different notification systems within and outside of Tufts to promote timelier follow up and to inform the PCP as needed to support transitions of care.
2. **Build system partnerships to strengthen BH service delivery and improve access to outpatient BH services.**
    a. Solidify Bay Cove and Healthcare for the Homeless as preferred BHCPs.
    b. Align the interventions of BHCPs with the work of the care team to reduce duplication. The bi-weekly meetings with the BHCP is an effective model that can be enhanced with strategic use of the high-risk profile, notification data, and BHCP claims data.
    c. Charge BHCPs with improving access to OP providers through their established networks.
    d. Leverage Beacon to hold network providers accountable for timely access and improved electronic look up with updated information on network providers.
    e. Standardize team-based approaches to complex BH patients that include clear roles and responsibilities for team members, accountability for follow up to all team members, and streamlined information sharing on the patient's progress.
3. **Strengthen BH access within Wellforce.**

a. Commit to the success of the models for increasing support to primary care through the ongoing management of their implementation. Tracking success, conducting ongoing management to address gaps in care, working to improve no-show and engagement rates are key tasks for the ACO Team.

b. Install recovery coaches within the ACO Care Team and/or embed them at Tufts ED and/or primary care setting to provide a needed resource to support SUD consultant and the care teams. This can be another source of strengthened role with the Bay Cove BHCP.

4. Stratify risk regarding the interface between BH conditions and co-occurring medical conditions.

a. Continue to improve competency in understanding the Fallon High Risk Report, which can provide a foundation for developing customized interventions for members with co-occurring medical and BH conditions. Through effective team-based interventions, staff can be deployed more effectively to address the myriad problems that cover the full range of member clinical and social needs. The population health profile can identify gaps in care, the individual assessments can identify SDOH needs, and the clinical team can identify the best way to engage the member with the right mix of clinical and non-clinical (e.g., BHCP care coordinator, CHW, and recovery coach) resources.

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