Community Partners Overview

June 2023

WellSense HEALTH PLAN

Agenda

What is a Community Partner (CP)?

CPs are community-based organizations that were selected by MassHealth to contract with ACOs to provide care management and coordination to MassHealth members with complex needs.

There are two types of CPs:

- Behavioral Health (BH)
- Long-Term Services and Supports (LTSS)

What is a Community Partner (CP)?

- There are two types of CPs:
  - Behavioral Health (BH)
  - Long-Term Services and Supports (LTSS)

Organization	BH CP	LTSS CP
Behavioral Health Network (BHN)	★	★
Behavioral Health Partners of Metro West (BHPMW)	★	
Boston Allied Partners (BAP)		★
Boston Coordinated Care Hub (BCCH)	★	
Brien Center	★	
Central Community Health Partnership (CCHP)	★	★
Clinical and Support Options (CSO)	★	
Community Care Partners (CCP)	★	★
Community Counseling of Bristol County (CCBC)	★	
Eliot Community Human Services	★	
Family Service Association (FSA)		★
Innovative Care Partners (ICP)	★	★
MA Coordinated Care Network (MCCN)		★
North Regional LTSS		★
Riverside Community Partners	★	
SSTAR	★	

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What populations are supported by CPs?

Demographics	BH CP	LTSS CP
Age	18-64	3-64

Enrollment criteria	Predominant behavioral health need(s), such as:
	• Serious and persistent mental illness (SMI)
	• Serious emotional disturbance (SED)
	• Substance use disorder (SUD)
	• Co-occurring SMI/SUD
		Predominant LTSS needs, such as:
		• Significant functional impairments
		• A history of high and sustained LTSS utilization or LTSS-related diagnoses, including but not limited to:
		  • Members with physical disabilities
		  • Members with acquired or traumatic brain injury or other cognitive impairments
		  • Members with intellectual or developmental disabilities (ID/DD), including members with Autism.

Excluded populations	• Program of Assertive Community Treatment (PACT) • Program of All-Inclusive Care for the Elderly (PACE) • Senior Care Options (SCO) program • One Care	• Program of Assertive Community Treatment (PACT) • Program of All-Inclusive Care for the Elderly (PACE) • Children's Behavioral Health Initiative (CBHI) • Intensive Care Coordination (ICC) services • MassHealth CARES for Kids • Senior Care Options (SCO) program • One Care

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How can CPs help patients and ACOs?

Community Partners Provide:

Outreach to Patients
Encourages members to participate in the program; minimum of three attempts, including at least one face to face, expected

Assessment & Care Planning
Comprehensive assessment; must be person-centered with goals identified and approved by the member

Care Team Coordination
Facilitate communication among members; act as subject matter experts for BH/LTSS community services

Care Management
Coordinate between members, state agencies, and specialty providers; connect programs appropriate for members

Transitions of Care
Assist with discharge planning, appointment access/follow-ups and a face-to-face interaction within three days post-discharge

Connection to Social Services
Assist enrolled members with SDOH needs including referral to Flexible Services

How to Partner with CPs

Recommendations for ACO Groups

- Generate referrals
- Warm handoffs
- PCP engagement with CP/patient
- Provide EMR access to CPs
- Site CM or CCM leverage community expertise of CP
- Provider a clinic Point of Contact (POC) for CPs/Wellsense

A **point of contact (POC)** acts as a liaison between each site's PCP and CP and who has a relationship with the site's PCP and access to member demographic data.

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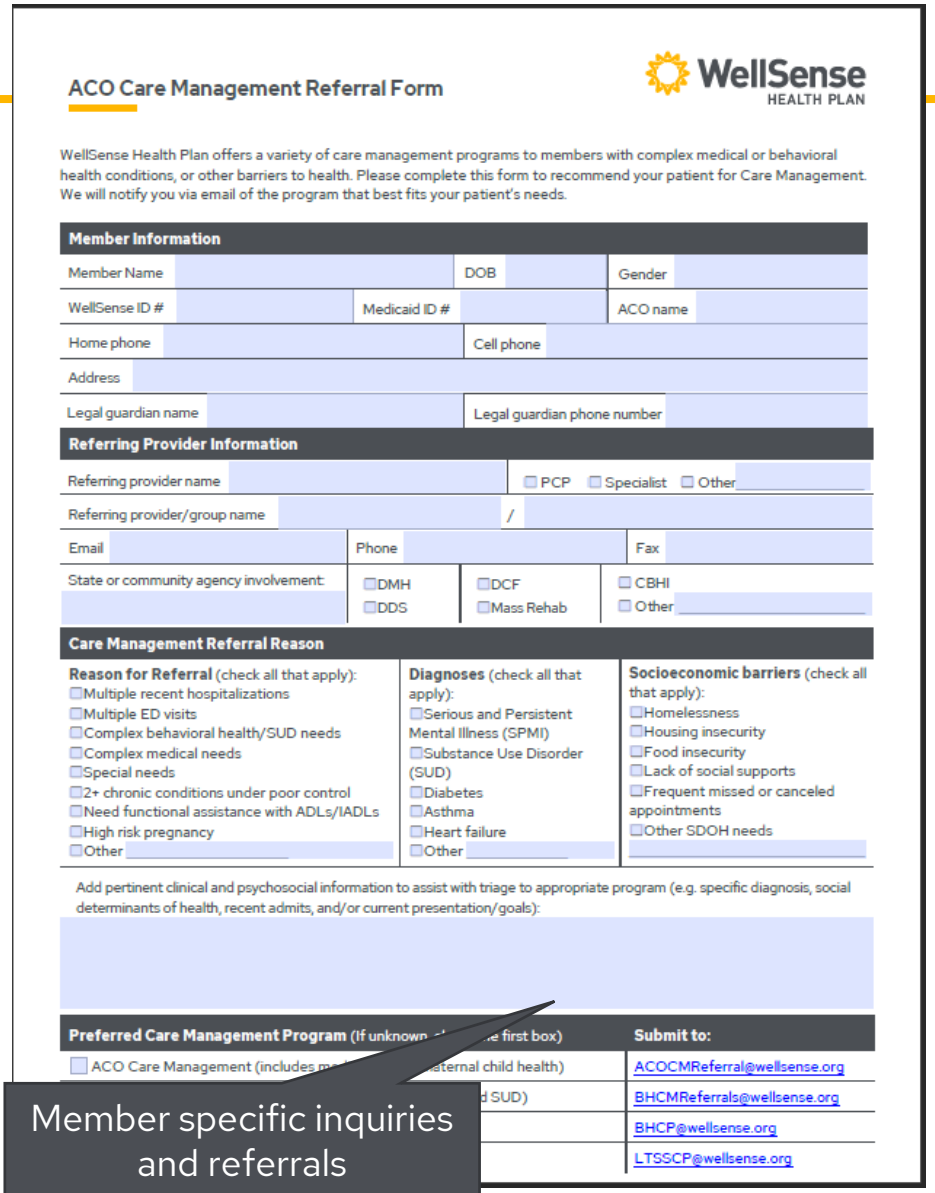
How do I make a referral?

- **Referral Process:** Email the ACO Care Management Referral Form to either: BHCP@wellsense.org or LTSSCP@wellsense.org
- Unsure-email to ACOCMReferral@wellsense.org
- For members who are inpatient and require immediate community support, it is helpful to have the social work and hospital contact information and the reasoning for and urgent referral to expedite the request.
- Referral forms can be found under MA Provider Resources>Documents and Forms>Member Support
- All CP referrals confirmed by BHCP/LTSS team and will show on MassHealth's Electronic Verification System (EVS).
- **Reporting on enrollment:** All ACO groups receive a monthly roster of enrolled members and a status and outreach report

For BH and LTSS CP Questions and escalations: Aimee.garman@wellsense.org



ACO Care Management Referral Form

WellSense HEALTH PLAN

WellSense Health Plan offers a variety of care management programs to members with complex medical or behavioral health conditions, or other barriers to health. Please complete this form to recommend your patient for Care Management. We will notify you via email of the program that best fits your patient's needs.

Member Information

Member Name		DOB		Gender	
WellSense ID #		Medicaid ID #		ACO name	
Home phone		Cell phone			
Address					
Legal guardian name		Legal guardian phone number			

Referring Provider Information

Referring provider name		☐ PCP ☐ Specialist ☐ Other	
Referring provider/group name		/	
Email	Phone		Fax
State or community agency involvement:	☐DMH ☐DDS	☐DCF ☐Mass Rehab	☐CBHI ☐Other

Care Management Referral Reason

Reason for Referral (check all that apply):	**Diagnoses** (check all that apply):	**Socioeconomic barriers** (check all that apply):
☐Multiple recent hospitalizations	☐Serious and Persistent Mental Illness (SPMI)	☐Homelessness
☐Multiple ED visits	☐Substance Use Disorder (SUD)	☐Housing insecurity
☐Complex behavioral health/SUD needs	☐Diabetes	☐Food insecurity
☐Complex medical needs	☐Asthma	☐Lack of social supports
☐Special needs	☐Heart failure	☐Frequent missed or canceled appointments
☐2+ chronic conditions under poor control	☐Other	☐Other SDOH needs
☐Need functional assistance with ADLs/IADLs		
☐High risk pregnancy		
☐Other		

Add pertinent clinical and psychosocial information to assist with triage to appropriate program (e.g. specific diagnosis, social determinants of health, recent admits, and/or current presentation/goals):

Preferred Care Management Program (If unknown … first box)	**Submit to:**
☐ ACO Care Management (includes … aternal child health)	ACOCMReferral@wellsense.org
… d SUD)	BHCMReferrals@wellsense.org
	BHCP@wellsense.org
	LTSSCP@wellsense.org

Member specific inquiries and referrals BHCP@wellsense.org or LTSSCP@wellsense.org

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LTSS CP Providers by Region

LTSS CP Name	ACO Relationship									Geographic Location					
	BACO	Mercy	Signature	Southcoast	BCH	BILHPN	Tufts	East Boston	MCO	Boston	SS	Southeast	North	Central	Western
Behavioral Health Network (BHN) (d.b.a. Care alliance of Western Mass)	X	X			X				X						X
Boston Allied Partners (BAP)	X				X	X	X	X	X	X					
Open Sky (d.b.a. Central Community Health Partnership)	X				X	X			X					X	
Community Care Partners	X		X	X	X	X	X	X	X	X	X		X		
Family Service Association (FSA)	X		X	X	X	X	X		X		X	X			
Center for human development (d.b.a. Innovative Care Partners LLC (ICP))	X	X			X				X						X
Seven Hills (d.b.a. Massachusetts Care Coordination Network (MCCN))	X		X	X	X	X	X	X	X	X	X	X	X	X	
Greater Lynn Senior Services (d.b.a. North Region LTSS Partnership)	X				X	X	X	X	X				X		

CBHC Organizations

BH CP Providers by Region: Varies By Service Area

BH CP Name	ACO Relationship									Geographic Location					
	BACO	Mercy	Signature	Southcoast	BCH	BILHPN	Tufts	East Boston	MCO	Boston	SS	Southeast	North	Central	Western
Behavioral Health Network (BHN)	x	x							x						x
Behavioral Health Partners of Metro west LLC	x					x	x		x				x	x	
Boston Coordinated Care Hub (BHCHP)	x					x	x	x	x	x					
Brien Center Community Partnership									x						
Central Community Health Partnership	x					x			x					x	
Clinical and Support Options, Inc. (CSO)	x	x							x						x
Community Care Partners, LLC (CCP)	x		x	x		x	x	x	x	x	x	x	x		
Community Counseling of Bristol County, Inc. (CCBC)	x		x	x		x	x		x		x	x			
Eliot Community Human Services Inc.	x					x	x	x	x	x	x		x		
Innovative Care Partners LLC (ICP) Center for human dev	x	x							x						x
Riverside Community Partners	x		x			x	x	x	x	x	x		x	x	
SSTAR Care Community Partners	x		x	x		x	x		x			x			

BH CP Quality Measures

Measure	Description
F/U with BH CP after acute or post-acute stay (7 days)	Percentage of discharges from acute or post-acute stays for enrollees 18 to 64 years of age that were succeeded by a follow-up with a BH CP within x business days of discharge
Follow-up with BH CP after ED visit (7 days)	Percentage of ED visits for enrollees 18 to 64 years of age that had a follow-up visit within x days of the ED visit
Annual Primary Care Visit	Percentage of enrollees 18 to 64 years of age who had at least one comprehensive well-care visit during the measurement year
Initiation/Engagement of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment	Percentage of members 18 to 64 years of age who are diagnosed with a new episode of alcohol, opioid, or other drug abuse or dependency who initiate treatment within 14 days of diagnosis and who receive at ≥2 additional services within 34 days of the initiation visit
Follow-Up After Hospitalization for Mental Illness (7 days)	Percentage of discharges for enrollees 18 to 64 years of age, hospitalized for treatment of mental illness, where the member received follow-up with a mental health practitioner within 7 days of discharge

BH CP Quality Measures (cont.)

Measure	Description
Diabetes Screening for Individuals With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication	Percentage of enrollees with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication, and had diabetes screening test during the measurement year
Antidepressant Medication Management	Percentage of members (18-64) treated with antidepressant and had diagnosis of major depression who remained on antidepressant medication treatment
Treatment Plan Completion	TBD
Member Experience	TBD

LTSS CP Quality Measures

Measure	Description
Follow-up with LTSS CP after acute or post-acute stay (7 days)	Percentage of discharges from acute or post-acute stays for enrollees 3 to 64 years of age that were succeeded by a follow-up with a LTSS CP within x business days of discharge
Annual Primary Care Visit	Percentage of enrollees 3 to 64 years of age who had at least one comprehensive well-care visit during the measurement year
Care Plan Completion	TBD
Oral Health Evaluation	Percentage of enrollees 3 to 20 years of age who received a comprehensive or periodic oral evaluation within the measurement year
Member Experience	TBD