



## Primary Care/Behavioral Health Special Projects Program: Year Three Award Recipients

### **SUD Continuum of Care and Telehealth**

#### **Bay Cove Human Services**

Bay Cove Human Services, Inc. proposes to enhance substance use disorder services through the incorporation of telehealth services across Bay Cove's substance use disorder continuum of care. Telehealth will be implemented to increase access to service and treatment for individuals in various stages of addiction and recovery. The proposed project will focus on building infrastructure to fully implement telehealth; including assessment of equipment needed at each site, development and implementation of policies, protocols, and guidelines as well as ongoing training for staff. We have a continuum of care that delivers outpatient opioid treatment, inpatient acute treatment, inpatient clinical stabilization services, short term and long-term residential treatment for individuals with substance use disorders. Changes in service delivery as a result of COVID-19 have positioned us to incorporate new and innovative strategies to continue to engage individuals and deliver patient-centered care while adhering to physical distancing, universal precautions and mitigating risk related to COVID-19. We will build upon existing best practices to enhance care delivery and provide broader options for persons served.

### **Diabetes Initiative Pilot Project**

#### **Boston Health Care for the Homeless Program**

The proposed program will expand on a diabetes initiative pilot at Boston Health Care for the Homeless Program (BHCHP). The program is focused on a coordinated multidisciplinary team approach that supports screening, treatment and management of patients with diabetes with special focus for those experiencing homelessness. The funds will be used to pay for the initial Certified Diabetes Educator® certifications for the diabetes champions, clinical coverage for lead provider, and tools/resources for our patients to effectively manage their diabetes.

### **Intake Improvement Project**

#### **Brookline Center for Community Mental Health**

The Intake Improvement Project will improve access to behavioral health services for children, adults, and families from the Brookline and Boston communities who are seeking help at the Brookline Center for Community Mental Health through systematic improvements to the Center's intake and case assignment process. The specific goals of the project include increasing responsiveness, reducing wait times between call and first appointments, and integrating tools for collecting and tracking outcome measure data and delivering psychoeducation materials into the intake process. By reducing barriers to accessing care, the project will lead to improved patients' care experience, better clinical outcomes, and more efficient use of Center resources. This improvement in efficiency and effectiveness will position the Center as an effective partner for ACO seeking value-based behavioral health services.



### **Enhancing Self-Management Support Resources for Patients with Chronic Illness Charles River Community Health**

Charles River Community Health will establish a Stanford University Model Chronic Disease Self-Management Support Program in collaboration with ETHOS to improve clinical outcomes for 24 patients with diabetes, hypertension, or chronic pain whose clinical measures of A1c, blood pressure, and narcotic use who are not currently meeting evidence-based benchmarks. Patients will participate in ETHOS group meetings and Charles River Health medical visits that provide patients tools, such as education, self-monitoring, activity pacing strategies, and relaxation training, to better self-manage their chronic illness. The program integrates medical and behavioral health care, promotes non-pharmacological interventions, and enhances patient-centered care creating improved clinical outcomes for patients and greater efficiencies for the community health center, unencumbering resources for community care. Funding will support the personnel expenses for a health center team including the lead provider, a nurse practitioner, as well as a medical assistant, behavioral health professional, community health workers, and population health specialist. Additional project expenses include CDSMP books for patients, training for CDSMP facilitators in English and Spanish, and food and gift cards for patients.

### **Improvement in Management of Chronic, Persistent Depression CHC of Cape Cod**

Depression, including major depressive disorder, continues to be one of the top four diagnoses for patients seen at Community Health Center of Cape Cod (CHC of CC). And currently, as many as one in three patients with a diagnosis of major depressive disorder fail to respond to any of the available psychiatric medications. This often results in higher emergency room utilization, hospitalizations, and other unexpected, perhaps unnecessary health outcomes. Spravado (esketamine) was recently approved by the FDA and our psychiatry staff believes it can have positive results for this high risk population. At the same time, there are potential risks and costs associated with offering a Spravado medication treatment in an outpatient clinic setting. There is currently no one offering the program on Cape Cod. Under Dr. Terkelsen's leadership, this project will closely examine all aspects of implementation of a Major Depressive Disorder clinic, including the supervised use of Spravado.

### **Establishing a Primary Care Cognitive Assessment Clinic at DotHouse Health DotHouse Health**

We propose to establish a geriatrician run, weekly cognitive assessment clinic for patients 55 years of age and older, that will encompass domains of cognitive, psychological, and social functioning with a special focus on our immigrant population and those with language or other social barriers. The goal is early recognition of neurocognitive disorders. Individualized interventions can then be made for patients with dementia to improve adherence with medication and healthy lifestyle care plans, boost health literacy, simplify medication regimens and connect patients with appropriate care resources and our ACO's Complex Care Management program. These interventions for ACO patients may improve our performance on Mass Health's pay for performance healthcare quality and utilization measures. The funding will be used to allow time for two geriatric providers to conduct training and workflow planning for 3 months and to implement a weekly clinic for 8 months.



### **Diabetes Support Initiative**

#### **Family Health Center of Worcester**

Family Health Center of Worcester and Amber Sarkar, MD propose to support and enhance diabetes care by developing integrated, team-based, group telehealth visits in English and Spanish for adults with diabetes. Recruitment into these groups will focus on those individuals with a diagnosis of type 1 or type 2 diabetes with poorly controlled diabetes (A1C>9) or those with co-existing mental health conditions. The goal of the Diabetes Support Initiative is to improve the level of engagement of our patients with diabetes with our behavioral health staff. Integrated Behavioral Health providers and medical providers will co-facilitate the telehealth groups building upon the success of FHCW's medical provider led, in-person groups.

### **Post-Partum Support, Treatment and Consultation Specialty**

#### **Family Service Association**

In response to the need that we observe in our community, we request funding to assist in the development of a Postpartum Treatment and Consultation Specialty (PTCS) in our Behavioral Health Center. The goal is to collaborate with local ACOs and other community agencies to create a more informed agency and community regarding the needs of women suffering from Perinatal Depression. We are requesting a Mini-Fellowship to have an LMHC clinician trained to obtain Perinatal Mental Health Certification. Such certification will allow her to provide training and consultation to Family Service Association (FSA) behavioral health clinicians, local ACOs, and to the community. Our hope is to raise community awareness of this very common but often unrecognized and misunderstood diagnosis and to help de-stigmatize it for women and their families. The focus of the proposed program will be to train a therapist to receive the Perinatal Mental Health Certification through Postpartum Support International (PSI). The lead provider will reach out to the ACOs to network and collaborate with medical staff and to implement a specific plan and some wraparound services for the identified patient.

### **Establishing an Integrative Medicine Department**

#### **Greater Lawrence Family Health Center**

The goal of this project is to establish a Department of Integrative Health that works with all areas of the health center to improve care for our patients. The focus will be to address chronic pain, mental health conditions, and chronic stress, as well as other areas of need identified through a patient and staff needs assessment. The first phase of the project is to build the overall capacity and training of the health center clinicians interested in learning how to provide integrative health services to our patients. In addition to training of staff, the Project Lead will establish three specific integrative health points of access for patients and community members. These include an integrative health consult clinic and group visits. There will also be collaboration with our Mobile Health Unit that provides integrative services to those facing homelessness and addiction. These funds will cover the Project Lead's time to establish the department and identify and train staff to provide services to our patients.



### **HCHC Behavioral Health Provider Mini-Fellowship Project Hilltown Community Health Center**

The Hilltown Community Health Center Behavioral Health Department would like to sponsor three mini fellowships for BH clinicians within the department. These fellowships will include two fellowships in earning EMDR certification and one fellowship in earning a certificate in clinical supervision. EMDR is EYE Movement Desensitization and Reprocessing therapy treatment which is a short term evidence based trauma treatment therapy. These fellowships will enhance our clinician's ability to provide evidence based short term trauma treatment and will expand our ability to provide necessary clinical supervision for future MSW intern placement. The funds will be applied towards tuition for the trainings as well as to release time to allow the clinicians to attend the trainings.

### **Let's Move Holyoke 5210 (LMH)**

#### **Holyoke Health Center**

Dr. Vinny Biggs, MD, a pediatrician on the staff of Holyoke Health Center, Director of Let's Move Holyoke 5210 (LMH), in collaboration with the partnership, plans to use the funding to standardize, expand and sustain their clinical and community based effort from Holyoke to all of Hampden County. LMH is a multi-sector coalition of partners which are focused on addressing weight-based disparities and co-morbidities using evidence-based methods and culturally relevant messaging and programming in order to promote healthy weight. This proposal's overall goals are 1) to improve the health of Holyoke youth and families, especially as related to weight, nutrition and physical activity; and 2) to contribute to decreased health care costs utilizing the proposed evidence-based model, Let's Move Hampden County 5210 (LMHC). The funding, will be used to support the development of standardized materials to be available for expansion to other communities in the county as Let's Move Hampden County 5210. It will allow for recruitment of other partner sites, community and provider champions and the development of a partner agreement that will include screening and referral for social determinants of health. This funding will also support time for Dr. Biggs to lead this effort and develop a sustainability plan to ensure LMHC will continue long into the future.

### **Primary Care Behavioral Health Access Point Justice Resource Institute**

Through the JRI Primary Care/Behavioral Health Access Project, Justice Resource Institute, Inc. (JRI) will embed a master's level clinician in a local pediatric practice in Gloucester to provide evidence based treatment and referral support to children and families at the access point most comfortable to them and at the time at which they need it. The clinician will work with both children and their parents, together and separately, depending upon the need. When issues arise that are similar across families, groups may be considered and offered. All services will be at the primary care office. The clinician's work will be informed by evidence based practices including cognitive behavioral therapy, as well as Triple P – the Positive Parenting Program. Our aim will be to do the actual treatment when possible, and to offer assistance to families who may need more intensive support in navigating the system and with supported referrals. Funding will be devoted entirely to the clinician's salary, training, and supplies to support the delivery of short-term trauma-informed child and family behavioral health services that would otherwise not yet rise to the level of billable service, including consultation and short-term treatment. We believe this practice will ready us for continued evolution of ambulatory services and discussions regarding urgent outpatient walk-in mental health care.



## **Implementing a collaborative care model at North Shore Community Health North Shore Community Health**

With this project we hope to develop a system to overcome the shortage of psychiatric care delivered to patients. At this time, most of the management of anxiety and depression fall upon primary cares. For this reason, we will focus mainly on improving depression and anxiety. We hope to improve communication between the behavioral health service and the primary care by integrating both services. We will introduce a new position in the organization which is the care manager (also called care partner) who will be the link between the primary care team and the psychiatric service. They will be in charge of engaging patients and maintaining a registry to track patient progress. The primary cares will be asked to perform a screening for depression (PHQ-9) and anxiety (GAD-7) at each yearly visit. The psychiatrist's role is to communicate with the primary care team and the care partner and give recommendations. Throughout the course of this plan, many team meetings and case conferences will ensure that everyone involved in the care of patients is kept in the loop.

The budget will be used as follows:

- 80% will be allocated to support the lead provider in activities related to leading, planning and training
- 10% will be allocated to IT support to design and implement the patient registry
- 10% will be allocated for staff training led by Dr. Nehme and her team

## **Joining a Community Care Network (JCCN) East Boston Neighborhood Health Center**

Joining a Community Care Network (JCCN) is a wraparound care program that streamlines client access to behavioral health services and programs that address social determinants of health, through a network of local providers, caseworkers, and community-based organizations and institutions. JCCN's partners include: East Boston Neighborhood Health Center, Project Place, Boston Graduate School of Psychoanalysis, and the Suffolk County House of Correction. By emphasizing the strengths of each organization, JCCN provides transformational and comprehensive support to clients stuck in cycles of addiction, poverty, homelessness, and/or incarceration. JCCN is a true accountable care network, abiding by the principle that it is only through working together that organizations can meet the varied needs of community members. What distinguishes JCCN is its ability to integrate these services into one user-friendly, non-stigmatizing platform that uniquely emphasizes personal counseling interactions, social and medical service referrals, considerations of social determinants of health (SDOH), and psychoanalysis to disrupt entrenched negative habit patterns. Funding will support JCCN's Project Leader as she works with non-clinically trained staff at Project Place to better deliver... SDOH outcomes that impact clients' lives. This is achieved by "meeting clients where they are" through multiple access points in familiar and trusted environments. Providers will travel to partner sites to deliver treatment, case management, and other services to foster trust while encouraging clients to continue with the program. This approach allows JCCN to leverage the positive relationships clients have cultivated with one partner in the network or support deeper engagement with services offered through other partners.



## **Listening to, Comprehending and Acting on "I Can't Breathe" through Liberation Medicine in Tele-Health Exam Room**

### **Southern Jamaica Plain Health Center**

The project looks at how health professionals can better listen to, comprehend and act on the trauma experienced by patients from systematic racism and exposure to COVID-19. The project will use the techniques of Liberation Medicine, specifically racial and culture self-identification of what brings joy, and then exploring potential experiences and observations or racism as part of the patient encounter, as a way to connect and build bridges with the patient and ultimately heal together. The project will explore various patient interactions, working with a volunteer cohort of physicians and other care providers. The goal is improvement of the patient experience as measured in patient satisfaction, baseline metrics of health promotion, and exploration of these social determinants of health.

### **CSA Telehealth**

#### **The Home for Little Wanderers**

The Home for Little Wanderers is proposing a plan that will evaluate and expand on the implementation of telehealth to serve families during the COVID-19 pandemic and social distancing protocols and beyond. HFLW will evaluate clients and their families being currently served through the HFLW Community Service Agencies (CSAs) and identify those families who: have not been able to access telehealth and supporting platforms; discontinued services due to lack of resources; expressed discomfort with using technology; requires additional support. This proposed project could provide a tremendous benefit to our organization and operations. With the ability to see clients with greater flexibility, telehealth could be utilized in every client's care plan with a balance of on-site and remote services. Clients who have significant travel and transportation barriers, could now meet with their Intensive Care Coordinator, Family Partner, or clinician via ZOOM and receive services they need and are often required to complete. Telehealth could also allow our organization to serve more clients with less travel and greater access to their clients. The funding will support the project lead and our two CSA Program Directors to train and support clients and their families being currently served and identify those families who need additional support to utilize telehealth.

### **Adopting the CLAS (Culturally and Linguistically Appropriate Services) Framework**

#### **The Home for Little Wanderers**

The Home for Little Wanderers is proposing a plan that is centered around adopting the CLAS (Culturally and Linguistically Appropriate Services) framework to support recruitment and retention of a diverse workforce to be able to effectively serve clients that are diverse in cultural, religious, racial, and linguistic backgrounds, disability status, socioeconomic status, gender, and sexual orientation and provide access to high quality services by consistent and seasoned providers. Activities include targeted recruitment to hire a new Director, conduct CLAS assessment, assess and provide results to senior leadership and program directors to support implementation of the CLAS framework and present framework to staff and set up trainings, share strategies, and monitor benchmarks for success. Long term goals include improving client health and satisfaction, increasing staff competence and confidence, and expand our cultural awareness and capacity to serve marginalized and underrepresented communities in the Boston area, which will benefit our organization. Funding will support the staff time on hiring the new Director, the Director's time on the CLAS assessment and staff support to implement the framework.



## **Integrated Behavioral Health Services in the Telemedicine Era**

### **Upham's Corner Health Center**

With the help of the Massachusetts League of Community Health Centers, Farah Malar, PA, who has been working as a physician assistant at Upham's Corner Health Center since September of 2019, proposes to spend a year working on improving access to integrated Behavioral Health services, increasing follow up to positive depression/anxiety screening. We will implement tracking methodology to ensure follow ups are set up and take place. We will have a team that will be able to reach out to patients who have not returned for care. Having these measures in place will greatly enhance our quality measures regarding behavioral health as we move to more patient-centered care and the ACO model. The funding will allow Farah, as the lead clinician, to have the protected time to work with staff to implement, supervise, and coordinate the changes needed to implement seamless process of integrated care. In addition, the funding will go toward technology needed to design a space in the clinic for patients to have access to Behavioral Health services via telemedicine. Funding will also go to support the Director of Behavioral Health's time to provide project oversight from the Behavioral Health perspective, along with the Behavioral Health Navigator's time to the project and cost associated with medical interpretation certification as part of her role in the project to provide enhanced linguistic support to integrated services.

## **SBIRT in the Community**

### **Whittier Street Health Center**

Whittier Street Health Center is requesting funding to support a Special Projects Program to expand the capacity of its Mobile Health Van to screen for unhealthy alcohol and other drug use in the community at large. Whittier began its Mobile Health Van services in 2018, with the goal to eliminate barriers to healthcare. In 2020, the Mobile Health Van plans to expand services from its primary function to performing HIV/STD testing to include medical screenings, dental care, eye exams, and screening for depressions (using the PHQ-9). Whittier anticipates over 2,000 new patients will have access and linkage to care as a result of the expanded mobile can services. Whittier's proposed Special Projects Program "SBIRT in the Community", will further expand the capacity and function of the Mobile Van to screen for risky or hazardous substance use that may lead to abuse or dependence. By training all Mobile Health Van staff in SBIRT, we will be able to identify individuals with mild to severe substance use disorders (SUDs) and work to connect them to the appropriate level of substance use treatment options available in Whittier's Behavioral Health Department. Standardizing SBIRT into the existing workflow of the Mobile Health Van staff will allow for early intervention, timely referral to treatment and can effectively reduce the severity of the substance use disorders to improve overall health outcomes for patients, given that unhealthy substance use complicates existing chronic conditions like diabetes, hypertension, cardiovascular diseases or mental health disorders and interact with prescribed medications.