



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

### **Seamless Whole Person Care Through Increased Collaboration Advocates**

COVID-19 has created a significant amount of stress, anxiety, and depression for members of the community. Teenagers and youth have spent months away from their friends and peers. Young children are sitting in front of tablets all day, not experiencing the excitement of early learning. Adults are juggling caregiving and remote school while working from home. And elders are lonely, isolated, and have not been able to hug their grandchildren for more than a year. People are struggling. And the wait list to see a mental health clinician continues to increase. Advocates and Reliant Medical Group (Reliant) have a collaborative relationship, referring clients to each other as needed. But there are many steps and approvals required before a client can be transitioned from one agency to the next, which takes time. Far too long for someone in crisis. With funding, Advocates will hire a part time Care Coordinator who will split their time between Advocates and Reliant. The Care Coordinator will work closely with supervisors from both agencies, completing paperwork and approving requests, to ensure clients' physical and behavioral health needs are being met more efficiently. They will help the two agencies improve collaboration and communication, provide "whole-person" care, and increase access for those in need.

### **Treatment for Methamphetamine Use Disorder Bay Cove Human Services**

Bay Cove Human Services, Inc. seeks to build a comprehensive protocol for people seeing ATS services for methamphetamine use disorder. Anchored by our newly developed medical treatment protocol for methamphetamine detox, Bay Cove will develop a behavioral health treatment protocol to increase our capacity to service the growing number of people with methamphetamine use disorder seeking ATS. Integral to this work will be to establish policies, protocols and guidelines to incorporate methamphetamine use disorder treatment in inpatient acute treatment programs within Bay Cove's Addiction Services Division. The project will focus on a coordinated multidisciplinary team approach that supports screening, treatment and management of patients presenting at Andrew House Programs seeking treatment for methamphetamine use disorder. As part of this project, we will conduct quantitative and qualitative reviews of data collected. Data collected will be analyzed by a multidisciplinary team including the Lead Project and the Consulting Psychiatrist. The same team will provide recommendations for programs to inform best practices in the treatment of methamphetamine use disorder.



**Too Many Cooks: Redesigning Care Teams at Baystate Mason Square Neighborhood Health Center Using a Patient-Centered Definition of Continuity of Care**  
**Baystate Medical Center Health Centers - Baystate Mason Square Neighborhood Health Center**

Baystate Mason Square Neighborhood Health Center seeks to launch a three-part project to improve continuity of care with the goal of increased patient satisfaction and improved chronic disease management in our health center. Critical to this project is redefining continuity of care to be more patient-centered. Part One of our project includes a three-month period of data collection to better understand what continuity means to our patients. Part Two involves redesigning our care teams and redefining their responsibilities so that we can better achieve this continuity. In Part Three, we will pilot these new teams with ongoing data collection. These activities align with Baystate Health overall goals of advancing care and enhancing lives of the individuals we serve.

**Mini-Fellowship to Improve Diabetes Care for Homeless Patients**  
**Boston Health Care for the Homeless Program**

Boston Health Care for the Homeless Program (BHCHP) respectfully requests a mini-fellowship grant of \$40,000 to support the efforts of a lead primary care provider (PA-C) to develop a new leadership position that will serve as a program-wide topic area expert that specializes in caring for patients with diabetes and as a diabetes educator for the organization. Building on the progress of BHCHP's multidisciplinary diabetes team, which operates on a part-time voluntary basis, this project will allow for the professional development of the PA-C to research existing and emerging treatments, create a centralized resource of information and materials, and build BHCHP's expertise in diabetes care for people experiencing poverty and homelessness. Through this mini-fellowship, the PA-C will offer training, support, and consultations for BHCHP clinical staff and their patients to improve diabetes screening and management. Additionally, within the fellowship, the PA-C will conduct quality improvement projects to pilot new strategies to support patients in managing their diabetes and overcoming critical challenges, such as food insecurity. Funds will be used to support the PA-C's dedicated time to undertake this project; the cost of trainings, conferences and guest speakers; and resources and tools for patients and staff to effectively prevent or manage diabetes.

**Supporting Recovery Coaches in Primary Care Behavioral Health Integration**  
**Cambridge Health Alliance**

Cambridge Health Alliance (CHA) is a national leader in integrating behavioral health in primary care with an evidence-based model, adopted and embraced at its twelve primary care patient centered medical homes. We offer addiction screening and treatment with medication at all 12 primary care sites. We have recently expanded our integrated behavioral health team to include a full time Senior Recovery Coach who can draw from his shared lived experience to serve as a guide and support for patients in Primary Care. We propose to apply these funds to formalize an infrastructure for Recovery Coaching in Primary Care as part of the integrated behavioral health program, by 1) exploring evidence-based standards for recovery coaching and supervision; 2) piloting the integration of the Senior Recovery Coach and additional part-time recovery coaches in direct patient care; 3) providing appropriate training to coaches, supervisors,



providers and other staff to support evidence-based addictions care; and 4) covering additional expenses related to recovery coaching, such as transportation and food.

### **A Case for Functional Medicine**

#### **CHC of Cape Cod**

Our quest as primary care providers within a community health environment is to provide access to the highest quality health care and help our patients to meet their health care goals. At times, our priorities are not always the same as the patients in our care. Often in medicine, a diagnosis leads us toward a specific course of action, but does not always identify or address the root cause of the diagnosis and our patients may be more focused on life function. Like most, over 80% of our patient population suffers from one or more chronic illnesses. As we strive to continuously improve outcomes; and, now within a primary care capitation payment structure, it will be more important than ever to offer flexible, individualized health care options which may have the best impact on health measures, financial performance and organizational sustainability. more than ever before, we must use ALL training and tools available to us to "meet our patients where they are" hoping to inspire them to achieve lifelong wellness. This project will allow us to take a detailed look into the concept and impact of a complimentary and functional medicine approach and/or components of our practice. Specifically, we will 1) research and evaluate potential program components and efficacy; 2) ensure at least one primary care provider take a functional medicine certification course; 3) educate the full medical staff broadly in functional medicine; and 4) map a future course of action for implementation for both complimentary and functional programming.

#### **Establishing a Frailty Clinic at DotHouse Health**

##### **DotHouse Health**

Frailty is defined as a syndrome of physiological decline characterized by marked vulnerability to adverse health outcomes. We propose to establish a weekly Frailty and Functional Assessment Clinic encompassing domains of physical strength cognition psychological and social functioning. This will cater to all adult patients over 21 years of age with uncontrolled hypertension, uncontrolled diabetes or Charlson Comorbidity Index (CCI) > 6 We will also focus on our patient population impacted by COVID-19 pandemic who have experienced functional decline as a result of illness, social isolation or economic burden. The goal is early recognition of frail or prefrail conditions and make individualized interventions to improve physical fitness, nutritional status, medication adherence and connect patients with appropriate community care resources and ACO's Complex Care Management program. These interventions for ACO patients may improve our performance on MassHealth's pay for performance healthcare utilization measures. The funding will be used to allow time for the two primary care providers to conduct training and workflow planning.



### **Dementia: Training, Treatment and Care Family Service Association**

The proposed program will assist in the training and certification of a clinician in the FSA Behavioral Health Center (BHC) to work with the aging community regarding Alzheimer's and Dementia issues. Not only will this clinical social worker (Lead Provider) receive training and certification, but she will be equipped to educate staff from our BHC and other agency programs who work with the older adult population to better facilitate the process of becoming a Dementia friendly/informed agency. This initiative will also include collaboration with a number of community partners. Together, we will better serve this population, working alongside older adult-serving agencies, local healthcare and social service providers, Accountable Care Organizations (ACOs) and the Age/Dementia-Friendly Greater Fall River Coalition. Funding will be utilized to train those providing treatment to adults 60 and older, younger patients suffering from early onset Dementia/Alzheimer's and memory issues, and their families. Our Lead Provider will conduct training and consultation to the local ACOs as well as staff in several FSA programs, including the BHC, Adult Day Health programs, Adult Family Care, Home Assistance Program, Guardianship Program and Family Resource Center.

### **Improving Access to Behavioral Health Care Fenway Health**

The proposed special project will allow Monique Willett, LICSW, to engage emerging leaders in Fenway Health's Behavioral Health Department in the development and implementation of a new triage and treatment tracks in order to improve access to behavioral health services at Fenway Health. The new triage and treatment track system will enhance existing models of care and create more satisfaction among clients and clinicians alike. Additionally, this project allows for new leaders in the behavioral health department to gain leadership skills around change management, program development, evaluation and implementation. As Associate Director of Outpatient Behavioral Health Services, Monique is particularly interested in the growth and development of newer leaders in the department and, with that in mind, this project will allow her to focus on developing leadership within the department in a more intentional and structured manner.

### **Psychological & Neuropsychological Testing & Training Harvard Street Neighborhood Health Center**

Psychological & Neuropsychological Testing & Training will address the unmet need for psychological evaluations within our underserved community. By creating and cultivating a new doctoral psychology trainee role within our program - dedicated to psychological and neuropsychological testing - we will be able to fully meet the needs of our patients, many of whom suffer complex histories including trauma, anxiety/depression, poverty, violence, and substance abuse. Harvard Street patients will benefit from the high-quality testing services, they might otherwise be unable to afford. While the specialty doctoral student intern will benefit by learning to develop a specialty testing practice site, a skill that is rarely offered at other training sites. The purchase of updated testing materials, developed in the past several years, will enable Harvard Street to overcome healthcare disparities by providing our patients with the same high-level services that are available to those in more affluent communities.



## **Expanding Access to Psychiatry and MAT Throughout the Continuum High Point Treatment Center**

This project aims to create a telehealth-based, open access same-day platform for urgent psychiatric consultations and MAT access. This will significantly reduce wait times for psychiatry and MAT appointments, thereby decreasing utilization of crisis and emergency services. Target populations include individuals age 18+ currently enrolled in a High Point program or residing in communities served by High Point. This project will benefit the organization by reducing risk of premature discharge from High point programs and offers a pathway for immediate access to psychiatry and MAT appointments for ambulatory patients. Project activities include offering same-day telehealth appointments with a psychiatrist or psychiatric nurse practitioner, managed via a care-navigator, who assists with arranging and tracking follow-up appointments. the funding will be used to support time for the project director to initiate the project, including marketing to programs within the agency and other community partners, streamlining operations, coordinating with care navigator and psychiatric NP, and dedicating supervision time with the psychiatric NP offering psychiatric open access appointments. Additional funding will support time for a care navigator to help support project. patients seen for open access appointment will either continue in an outpatient setting with the psychiatric NP evaluating the patient or another practitioner, or with the assistance of the care navigator, be referred to an appropriate program/level of care or to another agency as appropriate.

## **ASPIRE – Advance Suicide Prevention, Intervention, and Racial Equity Justice Resource Institute**

Our communities are struggling to combat two pandemics – Covid-19 and systemic racism. Many people entered this past year already facing mental health challenges only to be compounded by grief and loss; insecurity of food, housing, and jobs; isolation and loneliness; and racial and health inequities. Youth are experiencing a worsening of the pre-Covid trend of increased youth suicide, with BIPOC and LGBTQ+ youth at an even higher risk. JRI proposes a special project to ASPIRE – Advance Suicide Prevention, Intervention, and Racial Equity. Following our self-assessment phase of a Zero Suicide initiative, it is clear a conversation about justice, equity, diversity, and inclusion must be amplified and infused into our action steps to prevent suicide. By establishing a dedicated Zero Suicide short-term project team focused on BIPOC communities we will identify key, unique factors contributing to health disparities and suicide risk and tailor action plans that are culturally responsive. What we learn will fill the gaps in our current Zero Suicide initiative. We will advance racial equity on multiple levels including professional development of the Project Lead and her team of Justice, Equity, Diversity, & Inclusion Advocates. We will infuse culturally responsive information into existing trainings, develop new trainings, and assess and make available tools and resources taking into account the unique needs of our diverse communities served. We will expand the narrative about suicide beyond white youth and apply a JEDI lens to our Zero Suicide initiative with the goal of yielding better outcomes for our BIPOC youth.



### **Primary Care Behavioral Health Integration Interprofessional Psychiatric Consultations Beth Israel Lahey Health Behavioral Services**

The aim of this project is to support the planning and implementation of an expansion in our primary care behavioral health integration (PCBHI) services, specifically by incorporating interprofessional psychiatric consults. The consults are electronic, asynchronous, and inter-professional with a goal to support primary care providers' (PCP) treatment of behavioral health conditions in primary care settings. The consultation includes an assessment and management service in which a patient's PCP requests the opinion and/or treatment advice of a psychiatric consultant to assist in the diagnosis and/or management of the patient's behavioral health condition without the need for the patient's face-to-face contact with the consultant. The interprofessional consultation enables a comprehensive assessment, enhances patient care, reduces misdiagnosis, and supports the integration of disciplines in the delivery of care. The two primary goals are to improve care quality through timely access to behavioral health treatment within the primary care setting and enhance care by increasing PCP confidence and comfort in managing behavioral health needs. The funding from this Primary Care/Behavioral Health Special Projects Program award will be used to support the level of effort and time of the lead provider in planning the project, implementation and oversight.

### **Closing the Gap: Social Determinants of Health and the Immigrant Population Lynn Community Health Center**

The immigrant population continues to experience increase health disparities and challenges in addressing social determinants of health (SDOH). To improve health equity for immigrant patients in Lynn, MA, the proposed project aims to enhance the capacity and knowledge of health center staff on up-to-date immigration policies and relevant community resources, improve immigration policy and institutional literacy amidst local immigrant serving organizations, and increase overall community awareness of immigrant rights and engagement in immigrant community resources. The proposal entails conducting a training series for essential frontline healthcare workers, health center staff and community social services agencies to build confidence in education and empowering immigrants on their rights and appropriately connect immigrants with support to address SDOH. The initiative will also include creating and promoting culturally appropriate educational materials and resource brokerage support for medical and behavioral health providers and improve access to healthcare for our immigrant patients.

### **Community-Based Psychotherapy Groups Moving Forward Counseling Services**

In accordance with ACO Pediatric Associates of Greater Salem and Beverly (PAGS), Moving Forward Counseling Services (MFCS) proposes to remove barriers to clinical care through the implementation of Community-Based Psychotherapy Groups led by community-based providers. The social isolation, uncertainty, and losses from the COVID-19 pandemic exacerbated pre-existing mental health conditions, while it also created new, acute mental health demands. The proposed project aims to address the critical need of mental health services to the most vulnerable members of the Beverly and Salem communities, particularly serving the patients of the Accountable Care Organization, Pediatrics Associates (PAGS). Both PAGS and MFCS would benefit from this project by meeting the critical demand of patients seeking behavioral



healthcare. Groups will be offered based on client needs and clinical presentation. These Community-Based Psychotherapy Groups will focus on a variety of topics, including Executive Functioning, Social Anxiety, LGBTQIA+ Youth, and a Step Down group for individuals transitioning from inpatient care. These Community-Based Psychotherapy Groups would be offered based on evolving safety protocols and could be easily adapted for both in-person and telehealth offerings. Groups will be based on age-appropriate and evidence-based interventions. Funding will be used to provide group intervention training and development to current staff, along with financing the search and hiring of a full-time, licensed clinician completely devoted to developing and implementing groups. Funding would also be used to develop group curriculum and tools to better serve the needs of the Greater Salem and Beverly areas.

**CSA Family Engagement Night  
The Home for Little Wanderers**

Family Engagement Nights will provide an opportunity for past, new and current families being serviced by our Community Service Agencies to come together both in-person and through virtual opportunities to meet, form and strengthen community bonds. Providing intentional space for families to come together to learn, hear and share their similar experiences of managing children with mental health challenges will support families to create natural bonds with other families facing similar challenges and/or successes. The Family Nights will also create opportunities for community resources to come into the space and share their resources and information with families, while also strengthening the collaboration between the CSAs and community partners. The Family Engagement Nights will invite families that have graduated from our services that can provide experience to newer families while also reconnecting to supports they may need again or wish to connect to. The events will occur monthly and coordinate with theme activities for both clients and their families.