Reinventing care for the most vulnerable, at-risk patients

A report based on expert perspectives from:

ABH Association for Behavioral Healthcare

CHA Cambridge Health Alliance

Community Care Cooperative

Massachusetts General Hospital

Partners HealthCare

Tufts Health Plan

Executive Summary

Our most vulnerable, at-risk patients—those with severe mental health challenges, trauma, co-occurring illnesses, substance use disorder, economic and social hurdles, and potential disconnection from the system—need our most innovative support. The question is, are they getting it? Experts know that more targeted resources, fully integrated teams, care plans that encourage patient buy-in, and attention to outcomes are the building blocks of success. Yet to best serve these patients, experts in the broader health care community also need to know and to act on this knowledge in their practices.

Recent investment in behavioral health in Massachusetts, including a redesigned MassHealth program with Accountable Care Organizations (ACOs), Managed Care Organizations (MCOs), and Behavioral Health Community Partners (BH CPs), has created a tremendous opportunity to improve services and quality of life for patients with complex needs. As Dan Tsai, then Assistant Secretary and Director of the MassHealth program; currently EOHHS Deputy Secretary noted at the time of the redesign rollout in June 2017, "We know the current fee-for-service system leads to gaps in care and inefficiencies....The ACOs we selected demonstrate a strong commitment to improving care for the members they serve and will be held to high standards for quality and access of care."

Based on decades of work supporting adults, youth, children, and families with evidence-based, trauma-informed care, Eliot Community Human Services wanted to gather the latest input from practitioners across Massachusetts about the current state of integrated behavioral health

5,400 words. Estimated reading time: 27 minutes.

Insights and best practices from 14 experts on meeting key challenges in integrated mental health care in 2020 and beyond

- Alexy Arauz-Boudreau, MD
- Emily Bailey, LICSW
- Salina Bakshi, MD
- Lydia Conley, JD
- Amy Corveleyn, MSW
- Scott Daniels, RN
- Lauren Falls, MSW
- Liz Fiorello-DiPietro, LMHC
- Erich Goetzel, MD, MA, LAc
- Kelly Irwin, MD, MPH
- Leah Kean, LICSW
- Melisa Lai-Becker, MD
- Pamela Moss, BSN, RN
- Christina Severin, MPH

care and how the new MassHealth design is enabling it.

We organized this report into three areas of insight we uncovered.

In *Making Connections and Creating Solutions*, we discuss how today's best care teams are using an integrated care lens as they: Build relationships and practice dynamic collaboration, Deploy integration with innovation, and Use technology, IT, and information exchange.

In *Addressing Communities that Need Care Now*, we explore frontline fixes that mental health experts are using to meet ongoing challenges, such as Prioritizing prevention with the right interventions and Integrating systems of care.

Finally, in *Matters of Value and Accountability*, we address the need to use a value-based care model in achieving successful person-centered mental health care, exploring Forging cost/care connections, Rewarding success, and System redesign.

We close on the unified sense of *Urgency and Optimism* in serving individuals with complex care needs that is alive and well—even if not yet comprehensively practiced—in our state. As in many areas of care, Massachusetts is listening and leading in integrated mental health care.

Each section of this paper concludes with a key takeaway we distilled from our interviews. Together, they form a draft set of best practices toward reinventing care for vulnerable, at-risk patients, especially those with behavioral health issues.

Who this paper is for: Eliot conceived, researched, and wrote this paper to inform and inspire patients, families, caregivers at ACOs, referring PCPs, and community leaders who serve those with complexity and mental health conditions. Eliot's goal is to share new and proven approaches for

COMMON ACRONYMS

ABH
Association for Behavioral Health

ACO
Accountable Care Organization

BH CP
Behavioral Health Community Partner

DMH
(Massachusetts) Department of Mental Health

DSRIP
Delivery System Reform Incentive Payment Program

EOHHS
(Massachusetts) Executive Office of Health and Human Services

FQHC
Federally Qualified Health Centers

LTSS
Long-Term Services and Supports

MCO
Managed Care Organization

MGH
Massachusetts General Hospital

MGHfc
MassGeneral Hospital for Children

MGPO
Massachusetts General Physicians Organization

PCP
Primary Care Physician

SDOH
Social Determinants of Health

WHO
World Health Organization

Making Connections and Creating Solutions

"Our embedded social worker is like a partner in my practice. That's how closely I work with her."

Dr. Salina Bakshi, MD
A Partners PCP, at MGH

transformative patient engagement, treatment, and retention.

Care teams are evolving to meet the needs of complex patients, but the pace of change must increase to reach all those who require care before their conditions worsen or they are beset with more co-morbidities. Our interviews suggest that engaging a range of specialties and, where possible, dissolving dichotomies between medical and behavioral health, can result in life-changing care.

Experts say it's imperative—and more possible today—to promote the agency of each patient. Innovation is born from listening, collaboration, professional detective work, and meeting people where they are, rather than dictating their care to them.

Build relationships and practice dynamic collaboration

"The medical world is rapidly changing in thinking about team-based care, and a lot of physicians are on a learning curve," says Partners PCP Dr. Alexy Arauz-Boudreau. As both MGHfC Medical Director for Primary Care & Population Health Management and Medical Director of MGH/Massachusetts General Physicians Organization Medicaid ACO, Arauz-Boudreau knows a lot about bringing people together. "There are certainly some elements of hierarchy around 'clinical expertise.' But once clinicians understand how the MassHealth Community Partners program works, they say, 'Oh, yes, I need to speak to this person.'"

"Clinicians may feel helpless when patients have complex mental health needs, and they lack adequate training across disciplines," says Dr. Kelly Irwin, Director of the Collaborative Care and Community Engagement Program at MGH. "Staff on the front lines—group home managers or community mental health practitioners—didn't necessarily feel that their voices were heard when they advocated for their patients. At specialty care appointments, they may have felt more like a babysitter with specialists and clinicians not recognizing their expertise in understanding and supporting this person."

What's the solution? "It's about knowing patients' needs and identifying the right resources," says Dr. Salina Bakshi, a Partners PCP in practice at MGH with a leadership role in Partners HealthCare's ACO. Those resources are found in integrated teams with solid care plans aimed at keeping patients healthy, on vital medications, and out of the hospital.

Having embedded behavioral health staff is optimal. "Our embedded social worker is like a partner in my practice. That's how closely I work with her," says Bakshi, who sees firsthand how mental health and medicine must come together.

Looking holistically at complex-care needs helps patients and caregivers find the best, most creative solutions. "I can quickly connect with the

"You can't do this work in a vacuum. We make sure we've got colleagues we can rely on and bounce things off of."

Lauren Falls, MSW
Former Senior Director of Behavioral Health at C3

social worker I know and trust between patients," says MGH's Dr. Arauz-Boudreau. "Or I can tell her, 'You're going to get a message from me about the situation with Patient So-and-So.' Those are the cases where I feel almost a sigh of relief."

MGH has taken a leadership role in collaborative care, orchestrating flexible care teams and using patient navigators who oversee effective communication. "With oncology, for instance, the team includes psychiatry, social work, and navigation. The specialty team understands what is medically urgent and the front line staff understands the person's limitations and strengths," says Irwin. "We don't ask an individual affected by a physical disability to walk up three flights of stairs, so why do we expect those with mental illness—who may be disorganized, scared, and isolated—to show up at eight-thirty a.m. on a Tuesday? With cancer, the stakes are high. So what if, instead, the care team goes to them through a community-based model? We did home visits and were able to engage patients who had previously declined care. It worked. It was very rewarding to see care delivery change with the patient at the center."

The result of a more collaborative approach? "PCPs see positive outcomes and become more receptive to behavioral health professionals' involvement in the member's care. Something clicks," says Liz Fiorello-DiPietro, a Clinical Leader at Eliot Community Human Services. "They see that the care plan can be holistic. It can include 'attending scheduled appointments and following provider recommendations' as a goal, as well as 'getting proper heating in the member's apartment.'"

Also crucial is what Emily Bailey, Behavioral Health VP at Tufts Health Plan, calls "robust engagement." One no-show can signal trouble. BH CPs and PCPs must engage and stay up-to-date on patients with high-utilization histories, says Bailey, or "the patient resurfaces in a crisis. And you can never really complete their goals, because you never have them long enough."

Pamela Moss, Program Manager of the Community Partners Program for Tufts Health Plan, says Behavioral Health Community Partner nurse managers are often the best ambassadors for engagement and integration: "CP nurse managers who educate practices about the CP program and build direct relationships with PCP practice staff are very successful in getting timely reviews and approvals of care plans."

Integrated mental health care also must be built on dynamic collaboration to succeed, according to our interviewees. "You can't do this work in a vacuum," says Lauren Falls, independent behavioral health consultant and former senior director at C3. "We make sure we've got colleagues we can rely on and bounce things off of."

Christina Severin, President and CEO of Community Care Cooperative (C3), an ACO designed to leverage innovative Federally Qualified Health Centers (FQHCs), agrees, and points to community centers as a linchpin. "Health center PCPs are fiercely dedicated to patients. They want to go above and beyond for individuals and families. As long as they feel like what they're doing adds value to the core objectives, they will absolutely

KEY TAKEAWAY

Initiatives to integrate behavioral health and medical care allow holistic approaches to patients with complex care needs, including mental health services. This model supports collaboration, as well as attention to Social Determinants of Health (SDOH) that have been determined to impact physical and emotional health. Together, care teams with shared expertise can respond to patient needs and identify creative, innovative responses in the moment and on an ongoing basis

"As a team, we come up with ideas to motivate patients and help them to understand the long term benefits of staying engaged in treatment. Because once a patient is motivated, that's a win."

Erich Goetzel, MD, MA, LAc
Psychiatrist and Medical Director at Eliot Community Human Services

do it," she says.

"An overwhelming majority of our ER patients with behavioral health issues struggle with a substance abuse disorder. It's a self-medication component," says Dr. Melisa Lai-Becker, Emergency Medicine and Medical Toxicology Specialist at Cambridge Health Alliance community health care system. "Patients present having abused alcohol to marijuana to cocaine to opioids to a combination of recreational illicit drugs and prescription ADHD meds that aren't theirs." Lai-Becker endorses an integrated patient-centered approach based on an individual's personal experience. "There's a reason they're using; it makes them feel better. Mix that with lacking social supports to develop better coping mechanisms. It is rare to have a patient with an active behavioral health issue who does not also need a cigarette. It's important to tend to these patients' needs in a way that doesn't leave them in complete limbo."

In her ED, Lai-Becker relies daily on case managers, recovery coaches, and cross-disciplinary thinking to find innovative approaches. "First and foremost, Eliot's expertise and manpower has been key to handling the volume," she says. "Yesterday was a typical example: during my 8-hour clinical shift, we had 12 active behavioral health patients in my 32-bed ED. About half met with a crisis team screener."

NOTE: SDOH are defined by the WHO as "the conditions in which people are born, grow, live, work, and age. These circumstances are shaped by the distribution of money, power, and resources at global, national and local levels."

Deploy integration with innovation

Patients with severe mental health challenges, trauma, co-occurring illnesses, substance use disorder, economic and social hurdles, and potential disconnection to the system—or all of the above—may not fully or optimally benefit from traditional, stovepiped care delivery. According to our interviewees, today's care delivery innovation begins by building trust—with the patient and among the care team—to inspire creativity and optimize health outcomes for patients.

"As a team, we come up with ideas to motivate patients and help them to understand the long term benefits of staying engaged in treatment. Because once a patient is motivated, that's a win," says Dr. Erich Goetzel, a psychiatrist and Medical Director at Eliot.

Innovative approaches also increase patient involvement when life-threatening conditions like cancer are involved. Dr. Irwin says true integrated care helps support and serve cancer patients with accompanying mental health complexity who may be overlooked or considered uncooperative. "Individuals with serious mental illness experience one of the largest mortality gaps in medicine, in part because of inequities in care," she says. "But we can increase access to timely, high-quality, collaborative care for people with complex needs by meeting them where

KEY TAKEAWAY

An integrative mindset that rises above stovepiped care delivery begins by involving the patient and helping them understand the long-term benefits of staying engaged in treatment

"When life is really complicated and you can't keep your appointments, you get labeled with my least-favorite terms: 'noncompliant' or 'nonadherent.' I think that telehealth has the ability to bust down those impediments by making needed services available to patients on-demand."

Christina Severin, MPH
President and CEO of Community Care Cooperative

KEY TAKEAWAY

Mobile technologies, telehealth, leveraging data, and cross-disciplinary ideation can break down barriers to holistic mental health treatment.

they are." In a recent trial of 30 patients with serious mental illness and a new cancer diagnosis, Irwin says excellent cancer treatment was possible. "No one said they felt coerced. They had felt ignored before…so I'm really proud of the work we're doing."

"It's about the continuum of care and how we keep it fluid," says Lauren Falls. "[We need to] keep people thinking creatively about what a person needs at a point in time."

Use technology, IT, and information exchange

Amy Corveleyn, a psychiatric oncology social worker at MGH, says she and her colleagues are eager to learn new ways to inspire patient confidence. The research of Karen Fortuna of Dartmouth College and Rob Walker of the DMH has piqued her interest. "They are looking at a smart phone app that can link people to a certified peer specialist for additional support with their mental health care. I imagine that integrating technology is going to be the future."

"Something that's been very exciting to us is the advent of event notification systems, particularly on the Behavioral Health Community Partner side," says Lydia Conley, President of Association for Behavioral Healthcare (ABH). "You get a ping when one of your clients is in the ED. You can go intervene early. That has a lot of potential, in terms of diverting people from hospitalization and reconnecting to the community very quickly."

Christina Severin also sees the potential of tech-enabled, real-time solutions. "When life is really complicated and you can't keep your appointments, you get labeled with my least-favorite terms: 'noncompliant' or 'nonadherent,'" says Severin. "I think that telehealth has the ability to bust down those impediments by making needed services available to patients on-demand."

Further calls are for more robust technology and information exchange between primary and mental health care. "If you're going to be doing a care coordination function, you need to have a coordination platform—the IT and ability to exchange information with other providers," says Conley. ABH is active in promoting health information technology among its 80+ member organizations.

Dr. Bakshi at MGH, as the Inaugural Fellow in Population Health at Partners HealthCare, has great interest in leveraging data and analytics. And population health—a mindset that combines concepts of SDOH with professional collaboration, big data, and policy making—is also on the ABH's radar to address the targeted needs of communities.

"For our members to move into a space where it's a population-health-focused approach, they need resources—the internal technical, analytical, and other data capabilities to get there. The BH CP funding has helped, but we need to seriously think this through together as a community over the next couple of years," says Conley.

Addressing Communities that Need Care Now

"I think of the case of a woman who had experienced past domestic violence: her concern was moving to a higher-level apartment to feel safer. So that became the number-one issue the BH CP addressed."

Alexy Arauz-Boudreau, MD
(MGHfC) Medical Director for Primary Care & Population Health Management and Medical Director of MGH/MGPO Medicaid ACO

Challenges faced by people with severe mental illness have gone largely unaddressed in the standard primary care model. With dialogue increasing around incentives, risk-reduction, and evidence-based approaches, more professionals are joining the discussion and pointing out opportunities for reinvention.

Prioritizing prevention with the right interventions

For patients with mental health complexity, sometimes food, transportation, or other essentials may be more needed than an office visit. Support focused on Social Determinants of Health (SDOH) needs has proven to build self-agency and quality of life.

"Catastrophes are prevented" with smart, lower-touch care, says Eliot's Erich Goetzel. "Maybe they need someone there—not judging them; addressing nutrition, stress situations, smoking cessation." He also firmly believes in the Zero Suicide Initiative, a comprehensive approach to suicide care that aims to reduce the risk of suicide for all individuals seen in health care systems.

"Clients may need somebody looking out for them, helping them with stressful situations and addressing basics needs, like nutrition and housing," adds Goetzel. "It's all about supporting patients beyond that 15-minute doctor visit or 45-minute therapy appointment. Sometimes it's absolutely necessary."

Interventions may be as individual as the patients themselves. Scott Daniels, a Clinical Leader at Eliot who is a registered nurse, says he was especially gratified to help a medically compromised man who needed multiple specialists to compare medical options available to him. The client noted that he felt a major burden was lifted.

"I think of the case of a woman who had experienced past domestic violence: her concern was moving to a higher-level apartment to feel safer," says Dr. Arauz-Boudreau. "So that became the number-one issue the BH CP addressed. If someone has a history of trauma, is that feeling paranoia? Yet without having a basic sense of security, it's almost impossible to begin a clinical treatment plan."

As our interviewees have found, getting at underlying causes can prevent the need for future [high-cost] interventions. "We try to think of things outside the box to support people who are in crisis—to connect them and help steer them toward resources," says Daniels. "A clinician may get a snapshot of someone coming into the hospital—and then a care manager can really dive down and figure out the underlying causes are of why they're showing up at the ED."

"We're using motivational interviewing and saying, 'Okay, what are some ways we can help you out with safe housing, food insecurity, social

KEY TAKEAWAY

Proactive approaches to care that support prevention or interrupt declines in health, social and emotional wellness require a holistic focus.

connections?'" says Leah Kean, BH CP Director at Eliot. "Because if it's 95 degrees in their apartment and they can't really think of anything else, that's where we're going to center our work at the moment."

Dr. Arauz-Boudreau adds that patients also gain confidence by seeing how connections are made. "It helps them navigate not only the medical system, but also social services, community safety-net resources, the education system—to help families and patients learn to advocate for their own social needs."

Professional compassion is huge, says C3's Severin. "Health centers understand the experiences of their community and deliver care in an exam room in a way that is trauma-informed and appropriate from a clinical, linguistic, and community perspective. I think when somebody feels understood—the opposite of alienated: really seen, heard, and valued—they are engaged in driving the care plan. That's very empowering."

Integrating systems of care

What's holding us back in achieving the vision of integrated mental health care?

Those on the ground know: it's just plain hard to integrate care for patients with complexity. The specialty-focused health care system simply isn't built for them. But as our healthcare experts explained, calling out and agreeing upon roadblocks that stand in the way is half the battle to eliminating them.

ROADBLOCKS THAT EXACERBATE MENTAL HEALTH ISSUES INCLUDE:

- unfulfilled goals for mental health equity and addiction parity*
- the opioid epidemic
- other substance abuse
- biology and genetic endowment
- economic stability
- limited access to educational opportunities
- stigma
- physical environments
- employment and working conditions

** as pursued by The Kennedy Forum, among others.*

To meet this challenge, experts are raising the call for "reverse integrated care" or "reverse integration," a new treatment model where primary care is provided for patients with mental health conditions, but this care is delivered in the behavioral health setting versus the PCP's office. Since these patients are more likely to experience preventable conditions such as high blood pressure, diabetes and cardiovascular disease, the goal of reverse integration is to meet them with primary care in the same setting where they receive care for mental health conditions, thereby improving overall patient outcomes.

"We can't put everything on primary or on psychiatry," Eliot's Goetzel says. "But with a PCP in our mental health clinic, we would have better care."

"Anybody who's worked in behavioral health understands the significant value of having someone in the community that can meet people where they are—who can understand their needs, help translate service delivery and clinical language, and break down barriers."

Emily Bailey, LICSW
Behavioral Health VP at Tufts Health Plan

Tufts Health Plan's Bailey agrees. "We are focused on ongoing integration innovation at the practice level. Physical health care in more traditionally psychiatric settings is a real priority for us."

To further drive integration, one of the primary components of the MassHealth ACO redesign is geographic accountability. All designated BH CPs must contract with all the ACOs in their geographic area. The ultimate hope is that ACOs can be more fluid, even helping launch services to meet their members' needs there, without duplicating or rebuilding existing community services. After more than a year, the commitment of the EOHHS and the Baker administration to encourage ACOs to partner with the community is proving a big win for patients—though much remains to be done.

"We felt it was very important that community organizations have access to Delivery System Reform Incentive Program dollars, and that's exactly what happened in Massachusetts," says Conley. "And the Commonwealth went even further: they made infrastructure dollars available to providers, as well.

"SDOH are among the reasons why MassHealth chose to procure Behavioral Health Community Partners," Conley continues, "because our 82 member organizations are embedded in communities and are familiar with local resources—utility assistance, fuel assistance, food pantries, et cetera. That's core to the work they do with MassHealth members."

"Anybody who's worked in behavioral health understands the significant value of having someone in the community that can meet people where they are—who can understand their needs, help translate service delivery and clinical language, and break down barriers," says Bailey. "We want to work with our network to see additional or innovative services in the way membership would like to see them provided."

Empowering community organizations has put a new focus on helping homeless and itinerant patients stay in the system by remaining "findable," or being able to be located (and served) as homeless, as is pulling in patients who haven't taken advantage of their benefits.

"We recently had a member who told their care manager, 'I haven't gone to primary care in seven years,'" says Fiorello-DiPietro. "And through motivational interviewing, when he was challenged to think about why, it came down to remembering appointments, the location of the PCP, and lack of transportation. The member didn't know that he could change his PCP to somebody closer, so that became part of the goal. He felt really proud and relieved when he attended his first appointment and could have that thorough medical exam. Nobody had asked him before why he wasn't attending appointments. It was just, 'He's not coming.'"

KEY TAKEAWAY

Integrating once separated "systems of care" through the MassHealth ACO redesign aspires to support better health outcomes and reduce cost for high-quality care.

Matters of Value and Accountability

KEY TAKEAWAY

The ACO journey to rethink and reallocate mental health resources and delivery requires planning, analytics, and collaboration.

Many across the country ask: what is value-based, patient-centered care? Critics are unsure whether the latest incentive-based revelations are just another flavor of capitation, gaining us marginal savings and a mere blip in patient satisfaction. In a mental health care system in desperate need of sweeping and sustainable change, the experts agree that it's time for real transformation, not a patch.

Forging cost-care connections

The MassHealth redesign brought together behavioral and physical health to put a spotlight on the holy grail of integration, and in so doing posed a simple question: can it save money? ACO administrators are on the frontlines of this service-meets-cost question. And after just over a year, the numbers, when they finally appear, will be telling.

To generate the value that literally creates ACO solvency, our interviewees agree that smart planning, analytics, and collaboration are key. "Joint partnerships between the MCOs and ACOs offer tremendous opportunity to use our resources innovatively to meet joint goals and needs," says Bailey. "We have more flexibility in evaluating problems and thinking about how to use those dollars together. From that perspective, it's a really exciting landscape looking into the future. I'm incredibly energized by the opportunities to partner as providers and payers."

"We know the community partners are doing great work. How do you quantify making a difference?"

Pamela Moss, BSN, RN
Tufts Health Plan

"Health care is a real feed-the-beast industry, and if you're part of the system that's not controlling a lot of the money, it means that you are not controlling a lot of the conversation," says C3's Severin. "And when you don't control the conversation, you don't control the power and the way decisions are made. And ultimately, again, where the money is spent."

Rewarding success

But how to ***quantify*** success—and, thereby, the path of the money—in this redesigned context?

"We all struggle with this question with our community partners. We know the community partners are doing great work. How do you quantify making a difference?" says Tufts Health Plan's Moss.

Every day BH CPs' case management may prevent what used to be costly regular ER visits. Imagine that this cuts the monthly spend to less than half for a large group of patients. A surplus is created.

Severin has crunched the numbers, and so firmly believes in the ACO model that she and her colleagues created their own "upstart" entity, as reported in Commonwealth Magazine.

"[Regarding] budget setting and experience methodology…over the five years, the program starts blending out historic experience and blending

KEY TAKEAWAY

Quantifying ACO value will be proven by lower utilization of costly care resources as well as investments that drive innovation, but cannot overlook "softer" measures to keep morale high and care team turnover low by making caregivers feel valued and appreciated.

in performance against an average market price. Toward the end of the program, if the ACO can deliver total cost of care at, or better than, the average amongst all ACOs, the ACO will be financially rewarded....The ACO can then use those surpluses to do whatever they think is best for program sustainability," says Severin.

Of course, any system where caregivers feel unappreciated and not valued cannot succeed over the long term, regardless of the financial surplus it generates. That's why valuing staff is another critical way to reward success and put patients first—keeping professionals in the community by providing support and promoting job satisfaction. Turnover isn't just inconvenient; it can rattle care plans.

Dr. Goetzel believes that so-called "physician burnout" isn't due to clients, but the demands of the current system. "It's all the documentation, prior approvals, finding solutions to the most complex client situations in less and less time. Providers need to be happy to make patients happier. However, I do believe that more doctors feel more comfortable and empowered today in Massachusetts. We're working as treatment teams and bouncing ideas off each other."

Ultimately, the system is still too new to know what makes for long-term sustainability. Reinvesting at the implementation level? Rewarding staff through bonuses? Sharing resources with hospitals doing excellent discharge planning? The palette of opportunity is wide.

System redesign

MassHealth officials felt it was time to "bend the cost curve," as Assistant Secretary Dan Tsai told lawmakers at a state budget hearing in 2016. The redesign of the MassHealth program into ACOs, MCOs, and BH CPs was its highly anticipated answer.

"The ACOs we selected demonstrate a strong commitment to improving care for the members they serve and will be held to high standards for quality and access of care," Tsai said in the official EOHHS announcement in June 2017. He added at the MIT Sloan Health Systems Initiative conference in November of that year: "Paying a budget for total cost of care, risk-adjusted for the population, is a prerequisite for all the things we think should happen within health care delivery." He pointed out that the $1.8 billion in new federal funding over five years will "follow lives," not fee-for-service. "ACOs coming together were essentially—it was like watching speed-dating: they were all courting the different health centers and primary care practices, because the funding for new infrastructure was following primary-care-based lives," he told the audience.

"MassHealth is explicitly measuring things that are both clinically effective and cost-effective. If you reduce unnecessary hospitalizations, that reduces trauma to people; if you keep them in the community, that's potentially more cost-effective than repeated, unnecessary ED or hospitalization visits. So that's the vision," explains ABH's Conley. "And the hope is that

"MassHealth is explicitly measuring things that are both clinically effective and cost-effective. If you reduce unnecessary hospitalizations, that reduces trauma to people."

Lydia Conley
President of the Association for Behavioral Healthcare (ABH)

KEY TAKEAWAY

Filling gaps to better treatment for patients with mental health conditions, especially for complex cases, begins with behavioral health community partners and community partner integration with primary care, medical specialty and other medical care providers.

BH CPs with their specialized understanding of the resources available in the community can help a subset of the larger MassHealth population start to move away from hospitals and EDs."

"We're having really interesting conversations with our ACO partners around the gaps in the behavioral health system," says Tufts Health Plan's Bailey. "How can we think about centers and pockets of excellence in service provision to have the highest impact for the members' conditions?"

Urgency and Optimism

All those we spoke with about behavioral health and the new ACO landscape addressed urgency: within this five-year period of investment from MassHealth, there's no time to waste or room for financial missteps. Yet all indicators point to great gains.

Dr. Goetzel is particularly encouraged. He feels collaboration and integration for patients with complex mental health care needs is overdue.

"These programs make a big difference with providers," he says. "When I go out and consult—when I meet with all the different teams—I feel like people are really eager to support change. People on the ground are very motivated."

In a system where those doing the work are substantially more collaborative and supported—and those funding it are more engaged in the on-the-ground essentials—mental health care seems sure to benefit by becoming more integrated. Who will remain standing in the accountable care provider market is yet to be seen. Yet as Massachusetts intends to show, without risk there is no advancement.

Eliot Community Human Services is committed to serving the most vulnerable of populations—those at-risk with limited or no resources for help. Along with our partners on this research piece, Tufts Health Plan and Partners HealthCare, we aimed to share expert insights and bring people together around integration in mental health care today.

Want to continue the conversation?

Please email us at **nmelanson@eliotchs.org**. Eliot's clinical leaders can provide more details on the diverse needs of patients with mental health complexity and how it is addressing them.