TARGETED COST CHALLENGE INVESTMENT

# Behavioral Health Network

SOCIAL DETERMINANTS OF HEALTH

MASSACHUSETTS HEALTH POLICY COMMISSION HCII PROGRAM

## CARE MODEL

Behavioral Health Network (BHN) developed Project FIT (Families In Transition), a care coordination initiative for families affected by homelessness and substance use disorder. BHN and their partners work together to ensure that families in Hampden County are provided whole-person and whole-family supportive services, with the ultimate goal of ensuring a stable and successful housing placement. Project FIT's multidisciplinary team includes community health workers and peer recovery coaches who represent the communities and languages of the families they serve. The program works with housing, shelter, school, primary care, and specialty care partners to find, enroll, and care for eligible families. Once the family is enrolled, the Project FIT team assesses the needs of each family member to create a personalized and adaptive care plan incorporating behavioral health care, primary care, housing supports, social services, and vocational services within the community. The Project FIT team collaborates with their multi-sector partners to address each family's medical, behavioral, and health-related social needs, and to provide vital services and continuity of care.

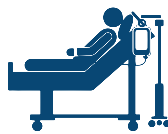
## IMPACT

**$750K**
HPC AWARD

**$786K**
TOTAL PROJECT COST

TARGET POPULATION
**Homeless or housing insecure families impacted by a behavioral health condition**

PRIMARY AND SECONDARY AIMS:



↓ **20%**
ED visits and inpatient admissions

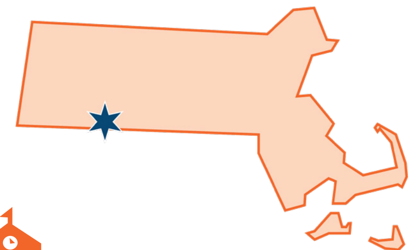
↑ **20%**
improvement on the Protective Factors Survey scores

↑ **20%**
improvement on childrens' attendance at school

Maintain families in stable housing

## PARTNERS

- Baystate Health System
- Home City Housing
- Holyoke Health Center
- Springfield Office of Housing
- Springfield Housing Authority
- Way Finders
- Western MA Coalition to End Homelessness
- West Springfield Public Schools



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18-MONTH IMPLEMENTATION LAUNCHED JULY 2017

TARGETED COST CHALLENGE INVESTMENT

# Berkshire Medical Center

BEHAVIORAL HEALTH INTEGRATION

## CARE MODEL

In order to improve access to behavioral health care in Berkshire County, Berkshire Medical Center formed a telemedicine-based care coordination program. The initiative supports primary care providers in managing high-risk patients with diagnoses including mental illness, substance use disorder, or a co-occurring disorder by providing access to behavioral health providers through telemedicine. The program also employs care coordinators based at the Medical Center to support the integration of primary and behavioral health care and ensure timely, effective care is provided locally.

## IMPACT

**$741.9K**
HPC AWARD

**$822K**
TOTAL PROJECT COST

TARGET POPULATION
**Primary Care Patients with Unmet Behavioral Health Care Needs**

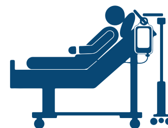
PRIMARY AND SECONDARY AIMS:

↓ **66%** ED visits

↓ **25%** detox or residential treatment admissions

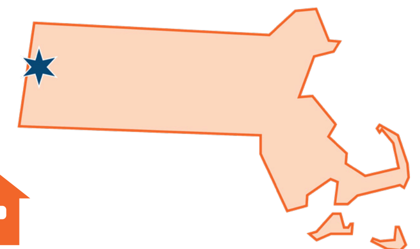
↑ **40%** improvement in health outcomes

↑ **50%** better pain self advocacy



## PARTNERS

- Hillcrest Family Health Center
- Community Health Programs
- Suburban Internal Medicine
- Eastern Mountain Medical Associates



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18-MONTH IMPLEMENTATION LAUNCHED JUNE 2017

TARGETED COST CHALLENGE INVESTMENT

# Boston Health Care for the Homeless Program

MASSACHUSETTS HEALTH POLICY COMMISSION HCII PROGRAM

SOCIAL DETERMINANTS OF HEALTH

## CARE MODEL

Boston Health Care for the Homeless Program (BHCHP) developed a Social Determinants of Health Consortium (Consortium) to serve as a hub to address patients' health-related social needs in a coordinated way. The Consortium, comprised of health care agencies, shelters, and housing services, expands the ability of community-based partner organizations to coordinate care and share information back with BHCHP's medical care team. When patients with a history of high utilization access a Consortium member's services, they are flagged for eligibility to receive enhanced care coordination services provided through the Consortium. The initiative provides intensive care coordination among primary care, recovery, housing, and advocacy organizations to address patients' medical, behavioral, and social needs across various settings and providers. The Consortium leverages a multi-disciplinary care team, including street outreach teams, shelter-based case coordinators, community-based social workers, and primary care providers across many settings. BHCHP leverages technology for real-time notification of local hospital admissions, discharges and transfers, and to document and share patient records and longitudinal care plans among all Consortium member organizations. The Consortium's embedded case coordinators, data integration, and regular leadership-level collaboration allow for greater knowledge sharing and coordination to support the unique needs of each patient, and increase the efficiency and effectiveness of care.

## IMPACT

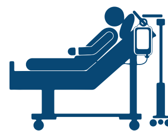
**$750K**
HPC AWARD

**$925K**
TOTAL PROJECT COST

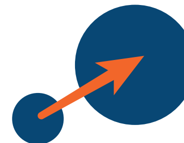
TARGET POPULATION
**High cost Medicaid patients with frequent ED and/or hospital utilization**

PRIMARY AND SECONDARY AIMS:

**↓20%** ED visits and inpatient admissions



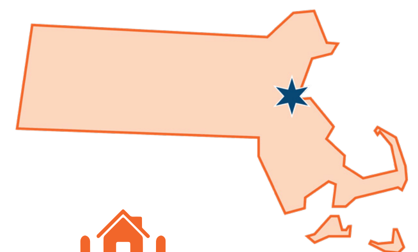
**↑20%** access to services that address social determinants of health



**↑20%** improvement in patient reported health measures

## PARTNERS

- Bay Cove Human Services
- Boston Public Health Commission
- Boston Rescue Mission
- Casa Esperanza
- Massachusetts Housing and Shelter Alliance
- The New England Center and Home for Veterans
- Pine Street Inn
- St. Francis House
- Victory Programs



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TARGETED COST CHALLENGE INVESTMENT

# Boston Medical Center

SOCIAL DETERMINANTS OF HEALTH

MASSACHUSETTS HEALTH POLICY COMMISSION HCII PROGRAM

## CARE MODEL

Boston Medical Center (BMC) developed the High Touch, High Trust (HT2) initiative to provide care coordination and patient navigation services in BMC's large safety-net hospital emergency department (ED). Patients are identified through their utilization history and enrolled by research assistants when they present in the ED. The HT2 initiative deploys community health advocates trained by civil legal aides from the Medical Legal Partnership of Boston (MLPB). The community health advocates assess and partner with patients inside and outside of the hospital to identify, prioritize, and resolve their health-related social needs, including legal-related needs such as utility shut-offs, evictions, domestic violence, benefits assistance, and immigration concerns. The HT2 team assists patients in coordinating and accessing primary care and social services to address their needs and care goals, and collaborates with BMC's Elders Living at Home Program, an initiative focused on supporting unstably housed adults, to coordinate complementary services for patients as needed.

## IMPACT

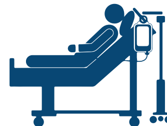
**$747K**
HPC AWARD

**$747K**
TOTAL PROJECT COST

TARGET POPULATION
**Patients with 4 or more ED visits in the previous year**

PRIMARY AND SECONDARY AIMS:

**↓20%**
ED visits and inpatient admissions



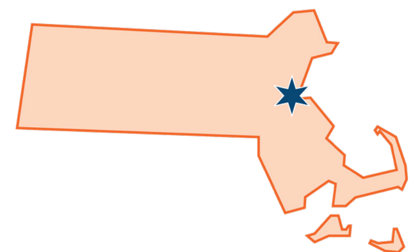
**↑20%**
improvement in patient experience

*Quality improvement*

## PARTNERS

- Medical Legal Partnership of Boston

- Elders Living at Home Program



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TARGETED COST CHALLENGE INVESTMENT

# Brookline Community Mental Health Center

MASSACHUSETTS HEALTH POLICY COMMISSION HCII PROGRAM

BEHAVIORAL HEALTH INTEGRATION

## CARE MODEL

Brookline Community Mental Health Center (BCMHC) implemented a multidisciplinary care management team to integrate behavioral health, primary care, and community services for vulnerable patients for whom Beth Israel Deaconess Care Organization (BIDCO), an HPC-certified ACO, is at risk.

BCMHC's Healthy Lives initiative deploys a nurse care manager, a social worker, and community health workers to identify the complex social, behavioral, and medical needs of their patients, and works collaboratively to deliver services to achieve patients' goals and avoid unnecessary care such as an ED visit or hospital admission. In order to engage patients, the Healthy Lives team operates wherever their patients are, at home and in the community, helping them navigate health care and community resources.

The initiative draws upon BCMHC's deep knowledge of their communities' resources and established working relationships with Springwell Aging Services Access Point (ASAP), which provides community services to elders, and BIDCO, whose close collaboration enables timely identification and coordination of care for their patients.

## IMPACT

**$418.6K**
HPC AWARD

**$598K**
TOTAL PROJECT COST

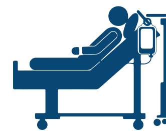
TARGET POPULATION
**High Cost BIDCO Patients with a Behavioral Health Condition and ≥ 1 Comorbidity**

PRIMARY AND SECONDARY AIMS:

**↓15%** total health care expenditures

**↓15%** inpatient admissions

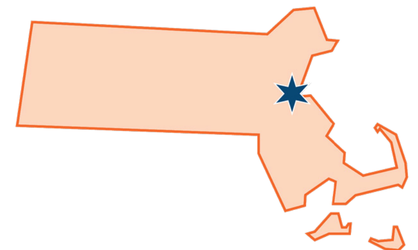
**↓15%** 30-Day inpatient readmissions



**↓15%** ED visits

## PARTNERS

- Beth Israel Deaconess Care Organization (BIDCO)
- Springwell ASAP



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TARGETED COST CHALLENGE INVESTMENT

# Care Dimensions

MASSACHUSETTS HEALTH POLICY COMMISSION HCII PROGRAM

## SERIOUS ADVANCING ILLNESS AND CARE AT THE END OF LIFE

## CARE MODEL

Care Dimensions' Palliative Care+ (PC+) program bridges service gaps among curative care, palliative care, and hospice services for patients with serious illness by integrating palliative care staff into North Shore Physicians Group's (NSPG) primary care sites. The PC+ team consists of palliative care nurse practitioners, a social worker offering psychosocial support and counseling, and a palliative care nurse coach who provides support to patients through telephonic check-ins. Patients are referred to the PC+ team by their primary care providers (PCP), who in turn work with the PC+ staff to improve identification of patients and the timeliness of referrals. A palliative care nurse case manager embedded in the PCP offices serves as the liaison between NSPG sites and the Care Dimensions team, participating in rounds, consulting on specific cases, and supporting providers in engaging patients in conversations about palliative and end-of-life care. The PC+ program supports better, earlier identification of patients likely to benefit from palliative care services, and closes feedback loops to PCPs about the care and health of their PC+ patients, including vital signs reported through Bluetooth-enabled home telemonitoring devices.

## IMPACT

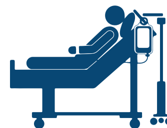
**$750K**
HPC AWARD

**$763K**
TOTAL PROJECT COST

TARGET POPULATION
**NSPG Medicare accountable care organization patients with severe, life-limiting illness**

PRIMARY AND SECONDARY AIMS:

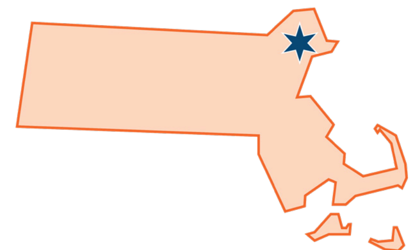
**↓30%**
all-cause readmissions and ED visits



**↑5%**
hospice length of stay

## PARTNERS

- North Shore Physicians Group



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# Commonwealth Care Alliance

SITE AND SCOPE OF CARE

MASSACHUSETTS HEALTH POLICY COMMISSION HCII PROGRAM

## CARE MODEL

Commonwealth Care Alliance (CCA), an integrated payer and care management organization, created a disability-focused ambulatory intensive care unit (A-ICU) to provide integrated primary care, behavioral health care, dental care, palliative care, and chronic disease management to their patients. The A-ICU augments CCA's collaborative care team model with partners such as community paramedics, dentists, housing support specialists, behavioral health specialists, and palliative care trained primary care providers (PCPs) to meet the unique needs of CCA's most vulnerable patients. Patients from CCA's Commonwealth Community Care Clinic are identified by PCPs and partners based on their needs and historic utilization, and are referred to the program for comprehensive care coordination. Care navigators from CCA coordinate the services that would otherwise be inaccessible because of A-ICU patients' disability status or preference to receive care in their home, shelter, community, or other adaptive setting. CCA's A-ICU program leverages innovative partnerships with Harvard School of Dental Medicine and EasCare, an ambulance company providing community paramedicine services, to deliver timely, effective, and competent care to patients through close coordination and data sharing.

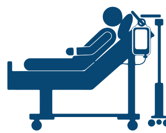
## IMPACT

**$598.9K**
HPC AWARD

**$1.0M**
TOTAL PROJECT COST

TARGET POPULATION
**Patients enrolled in CCA's Senior Care Options or One Care programs**

PRIMARY AND SECONDARY AIMS:



↓ **15%** inpatient hospitalization and ED visits

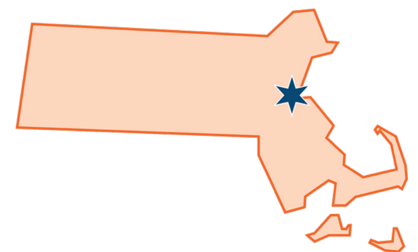
↑ **50%** rate of visits completed 7 days after discharge for patients treated in an inpatient setting for a behavioral health diagnosis

↑ **20%** suitable housing placements

↑ **>90%** patient satisfaction with community paramedicine

## PARTNERS

- EasCare, LLC
- Boston Medical Center
- BU Department of Family Medicine
- Harvard School of Dental Medicine



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TARGETED COST CHALLENGE INVESTMENT

# Hebrew SeniorLife

SOCIAL DETERMINANTS OF HEALTH

MASSACHUSETTS
HEALTH POLICY COMMISSION
HCII PROGRAM

## CARE MODEL

Hebrew SeniorLife (HSL) developed the Right Care, Right Place, Right Time (R3) program to coordinate care for residents in supportive housing. R3 embeds wellness teams comprised of a wellness coach and wellness nurse into affordable housing sites for seniors. These teams help low-income seniors manage their health care needs and address their health-related social needs. Residents opting into the program are assessed by their wellness team through detailed, whole-person assessments of goals and needs. The R3 wellness team then helps coordinate health, social, nutrition, transportation, and housing services according to each participant's goals and needs. R3 participants attend wellness classes and receive monthly newsletters and calls or in-person check-ins with their R3 coach, who helps advocate for participants as they navigate their appointments, providers, medications, home maintenance, and family and social connections. Through R3, HSL partners with other housing, emergency medical services (EMS), and long-term services and supports providers to share data, coordinate services, and rapidly identify care needs or unnecessary services to avoid harm and to support participants living safely in the place of their choice.

## IMPACT

**$421.7K**
HPC AWARD

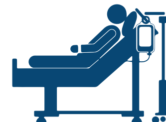
**$826K**
TOTAL PROJECT COST

TARGET POPULATION
**Residents over age 62 of Hebrew SeniorLife supportive housing partners**

PRIMARY AND SECONDARY AIMS:

**↓20%** transfers to hospitals, ED, and long term care

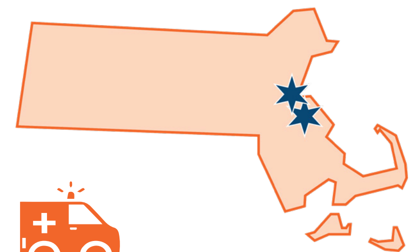
**↓20%** rehospitalizations



**↑8%** improvement in quality of life and ability to live independently

## PARTNERS

- WinnCompanies
- Tufts Health Plan
- Springwell ASAP
- Blue Cross Blue Shield of Massachusetts
- Milton Residences for the Elderly
- Local EMS providers



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# Lynn Community Health Center

SITE AND SCOPE OF CARE

MASSACHUSETTS HEALTH POLICY COMMISSION HCII PROGRAM

## CARE MODEL

Lynn Community Health Center's (LCHC) program coordinates complex care services for patients with serious mental illness in the surrounding community. LCHC patients diagnosed with serious mental illness such as schizophrenia, bipolar disorder, or major depression are identified by their primary care provider (PCP) and referred to the program. Community health workers (CHWs) on the team meet patients in the community and identify patient goals, challenges, and health priorities and develop a person-centered treatment plan. LCHC CHWs work closely with patients and their providers to help navigate care across complex medication regimens, and other medical, behavioral, and social needs, including housing and justice system involvement. The CHWs supporting the LCHC program become a link between patients, PCPs, and initiative partners to support patients in adhering to treatment plans and accessing vital care and services.

## IMPACT

**$690K**
HPC AWARD

**$872K**
TOTAL PROJECT COST

TARGET POPULATION
**Patients enrolled in the MassHealth Primary Care Clinician Plan with a serious mental illness**

PRIMARY AND SECONDARY AIMS:

⬇ **40%** home health utilization

⬇ **10%** acute outpatient utilization

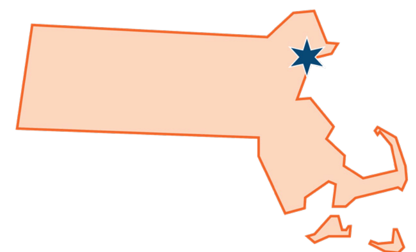
⬇ **15%** unnecessary health care utilization

⬇ **10%** acute inpatient utilization

⬇ **5%** pharmacy expenses

## PARTNERS

- Massachusetts Behavioral Health Partnership



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# Spaulding Hospital Cambridge

POST-ACUTE CARE

MASSACHUSETTS HEALTH POLICY COMMISSION HCII PROGRAM

## CARE MODEL

Spaulding Hospital Cambridge's post-acute care transition (PACT) program provides cross-setting case management and palliative care supports and coordination for chronically, critically ill patients in long-term acute care (LTAC). The PACT team includes a social worker and care transition nurses who identify patients admitted to Spaulding who meet clinical eligibility criteria for the program. The team focuses on coordinating the many administrative and medically complex decisions and services preceding a patient's discharge from the LTAC to facilitate safe and effective transfer to a new site of care such as a nursing home, rehabilitation facility, or home. Patients and families receive support from PACT care transition nurses throughout their transitions until they have been safely discharged home for up to 30 days. The PACT team supports patients' ability to safely remain in lower-intervention facilities by helping them develop and adhere to post-discharge plans that encompass patients' medical, behavioral, and health-related social needs. The PACT team assembles a large network of partners available to support PACT patients, and to improve the efficiency and safety of discharges to lower acuity settings through improved communication and planning about patient needs.

## IMPACT

**$746.5K**
HPC AWARD

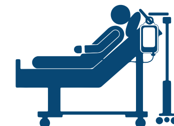
**$937K**
TOTAL PROJECT COST

TARGET POPULATION
**Chronically, critically ill patients with persistent respiratory failure**

PRIMARY AND SECONDARY AIMS:

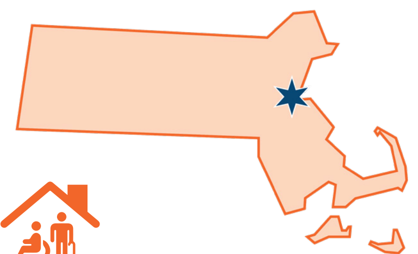
**↓10 days**
average length of stay at long-term acute care (LTAC)

**↓10%**
30-day readmissions after discharge from LTAC



## PARTNERS

- Partners Healthcare at Home
- Care Dimensions
- Fresenius Medical Care
- New England Home Therapies
- More than 10 Skilled Nursing Facility partners



## HCII PATHWAY SUMMARY & HPC BACKGROUND

In 2016, the Massachusetts Health Policy Commission (HPC) launched its $6.6 million Targeted Cost Challenge Investment (TCCI) pathway of the Health Care Innovation Investment (HCII) Program. The TCCI pathway aims to foster innovation in health care payment and service delivery by supporting promising innovations that address the Commonwealth's most complex health care cost challenges. The ten TCCI initiatives are partnering with more than 60 community organizations to demonstrate rapid cost savings within 18 months by addressing one of the following challenge areas: social determinants of health, behavioral health integration, post-acute care, serious advancing illness and care at the end of life, and site and scope of care.

The Massachusetts Health Policy Commission (HPC), established in 2012, is an independent state agency charged with monitoring health care spending growth in Massachusetts and providing data-driven policy recommendations regarding health care delivery and payment system reform. The HPC's mission is to advance a more transparent, accountable, and innovative health care system through independent policy leadership and investment programs. Visit us at Mass.gov/HPC. Tweet us @Mass_HPC.

18-MONTH IMPLEMENTATION LAUNCHED JULY 2017