MASSACHUSETTS
HEALTH POLICY COMMISSION

SUPPORTING INNOVATIVE DELIVERY MODELS FOR COMPLEX PATIENT NEEDS

THE HEALTH CARE INNOVATION INVESTMENT PROGRAM: TARGETED COST CHALLENGE INVESTMENTS

APRIL 2021

> "The HPC's TCCI Program enabled **innovation in care** for some of the Commonwealth's most vulnerable patients. By partnering with a diverse group of providers, the HPC has generated **valuable insights** into promising practices on the path to **improving quality and lowering costs** for a population of patients that **need our support** more than ever before."
>
> – BARBARA BLAKENEY, MS, RN, FNAP, HPC COMMISSIONER, CARE DELIVERY TRANSFORMATION COMMITTEE CHAIR

The Massachusetts Health Policy Commission (HPC) launched the **Targeted Cost Challenge Investments (TCCI)** Program in 2016 to support promising innovations to improve outcomes for the Commonwealth's most complex and vulnerable populations. While serving patients with complex needs—including serious medical conditions, multiple comorbidities, behavioral health conditions, high economic and social needs, and trauma histories—the TCCI Program aimed to reduce health care cost growth while maintaining or improving quality, access, and provider and patient experience. Over 18 months, the HPC disbursed $6.6 million in funding to ten awardees to support innovative interventions that leveraged partnerships with more than 60 diverse community-based organizations.[1]

1 For a more detailed summary of each of the TCCI awards, please refer to the HPC's website.

CHALLENGE AREAS

- Address Health-Related Social Needs
- Enable Behavioral Health Integration
- Improve Care Transitions and Reduce Post-Acute Care Utilization
- Support Patients with Serious Advancing Illness
- Optimize Site and Scope of Care

$6.6 MILLION • **10** INITIATIVES • **60+** COMMUNITY ORGANIZATION PARTNERS • **3,836** PATIENTS SERVED

TCCI INITIATIVES AND IMPACT

> "I'm **proud** that we have been really successful in **reaching a lot of patients** [who] have been deemed unreachable by many providers and many systems. It feels really good that we're able to **have an impact** on a population that was otherwise in a way kind of written off. That feels **really significant.**"
>
> – BROOKLINE COMMUNITY MENTAL HEALTH CENTER INVESTMENT DIRECTOR

BEHAVIORAL HEALTH NETWORK

Addressed medical, behavioral, and health-related social needs for families impacted by housing insecurity

43% DECREASE IN THE PERCENTAGE OF HOMELESS OR UNSTABLY HOUSED FAMILIES, FROM 75% TO 43%

BERKSHIRE MEDICAL CENTER

Co-located behavioral health teams at primary care practices and provided telepsychiatry services

1,318 PATIENTS RECEIVED **2,900** PSYCHOTHERAPY SESSIONS, **338** TELEHEALTH BEHAVIORAL HEALTH SESSIONS, AND **984** PSYCHIATRIC EVALUATIONS

BOSTON HEALTH CARE FOR THE HOMELESS PROGRAM

Formed a collaborative of medical providers, shelters, and advocacy organizations to integrate care, share data, and allow case managers to address patients' health-related social needs

40% INCREASE IN THE PERCENTAGE OF PARTICIPANTS WITH HOUSING, FROM 25% TO 35%

BOSTON MEDICAL CENTER

Deployed community health advocates who worked with civil legal aid attorneys and staff to help address patients' health-related social needs

29% OF IDENTIFIED SOCIAL NEEDS MITIGATED

70% OF IDENTIFIED LEGAL NEEDS MET, THROUGH PARTNERSHIP WITH THE MEDICAL-LEGAL PARTNERSHIP|BOSTON

BROOKLINE COMMUNITY MENTAL HEALTH CENTER

Implemented a multidisciplinary care management team to integrate behavioral health, primary care, and community services

61% DECREASE IN PARTICIPANTS' INPATIENT ADMISSIONS

53% DECREASE IN PARTICIPANTS' EMERGENCY DEPARTMENT VISITS

16% REDUCTION IN PARTICIPANTS' TOTAL HEALTH CARE EXPENDITURES

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TCCI INITIATIVES AND IMPACT (CONT.)

> "I have the sense that almost any physical or medical problem, I've got **somebody to talk to**. And the fact of being checked in with regularly does **feel good.**"
>
> – HEBREW SENIORLIFE RESIDENT

CARE DIMENSIONS

Integrated palliative care staff into primary care sites to facilitate referrals to palliative care and hospice

24% DECREASE IN EMERGENCY DEPARTMENT VISITS AND **21%** DECREASE IN INPATIENT READMISSIONS, COMPARED TO BASELINE

COMMONWEALTH CARE ALLIANCE

Created high-acuity ambulatory care programs to provide integrated primary, behavioral health, dental, and palliative care, as well as chronic disease management and housing assistance

218 PATIENTS RECEIVED SUPPORT FOR HOUSING NEEDS

HEBREW SENIORLIFE

Coordinated care for residents by embedding wellness teams in affordable senior housing sites

18% DECREASE IN AMBULANCE TRANSPORTS TO THE EMERGENCY DEPARTMENT FROM PARTICIPATING SITES

LYNN COMMUNITY HEALTH CENTER

Deployed community health workers to coordinate complex care services for patients with serious mental illness

81% OF ENROLLED PATIENTS RECEIVED CARE PLANS

SPAULDING HOSPITAL CAMBRIDGE

Provided cross-setting case management for chronically critically ill patients

66% OF ENROLLED PATIENT DISCHARGES WERE FROM SPAULDING TO THE HOME WITHIN 30 DAYS, COMPARED TO 56% AT BASELINE

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SPOTLIGHT ON COLLABORATIVE CARE MODELS

Building collaborative partnerships was a requirement of TCCI initiatives, and awardees worked with more than 60 organizations, including housing and shelter providers, legal services providers, emergency medical services, schools, and primary care providers. Four awardees specifically focused on improving care coordination: Behavioral Health Network, Boston Health Care for the Homeless Program, Brookline Community Mental Health Center, and Care Dimensions. Through improved communication, data sharing, and/or embedded staff, these awardees and their partners reduced fragmentation in care coordination, improved patient care, and collaborated on addressing patients' complex and evolving needs.

PATIENTS WITH COMPLEX NEEDS REQUIRE SUPPORT FROM MANY DIFFERENT HEALTH CARE AND SOCIAL SERVICES PROVIDERS, AND ROBUST COMMUNICATION BETWEEN THEM IS IMPERATIVE FOR EFFECTIVE CARE COORDINATION.

"I have five doctors and two, maybe three [case managers] and **they all talk to each other.**"

– BOSTON HEALTH CARE FOR THE HOMELESS PROGRAM PATIENT

"We take all the **little pieces** from different providers and help patients put their finger on what's really in line with **their goals of care.**"

– CARE DIMENSIONS TEAM MEMBER

BUILDING TRUST WITH PATIENTS IS A PREREQUISITE FOR SUCCESS, PARTICULARLY FOR POPULATIONS WHO HAVE EXPERIENCED TRAUMA OR HAVE A HISTORY OF NEGATIVE EXPERIENCES WITH THE HEALTH CARE SYSTEM.

"[Many] families need a lot of time **before they build trust** and want to engage in formal services...[T]hat's the role of the [Community Health Worker], to **show up on these people's front porch** over and over and over and over until people **feel heard and understood and held**. Then they're willing to engage."

– BEHAVIORAL HEALTH NETWORK INVESTMENT DIRECTOR

ADDRESSING PATIENTS' HEALTH-RELATED SOCIAL NEEDS IS ESSENTIAL TO IMPROVING THEIR HEALTH OUTCOMES AND REDUCING COSTS.

"[A] lot of times, [patients'] **priorities aren't taking their medications** or getting to medical appointments. [Their priorities are] more **urgent needs** like finding stable **housing** or access to **food** or t**ransportation** or stabilizing a **relationship** within the family."

– BROOKLINE COMMUNITY MENTAL HEALTH CENTER INVESTMENT DIRECTOR

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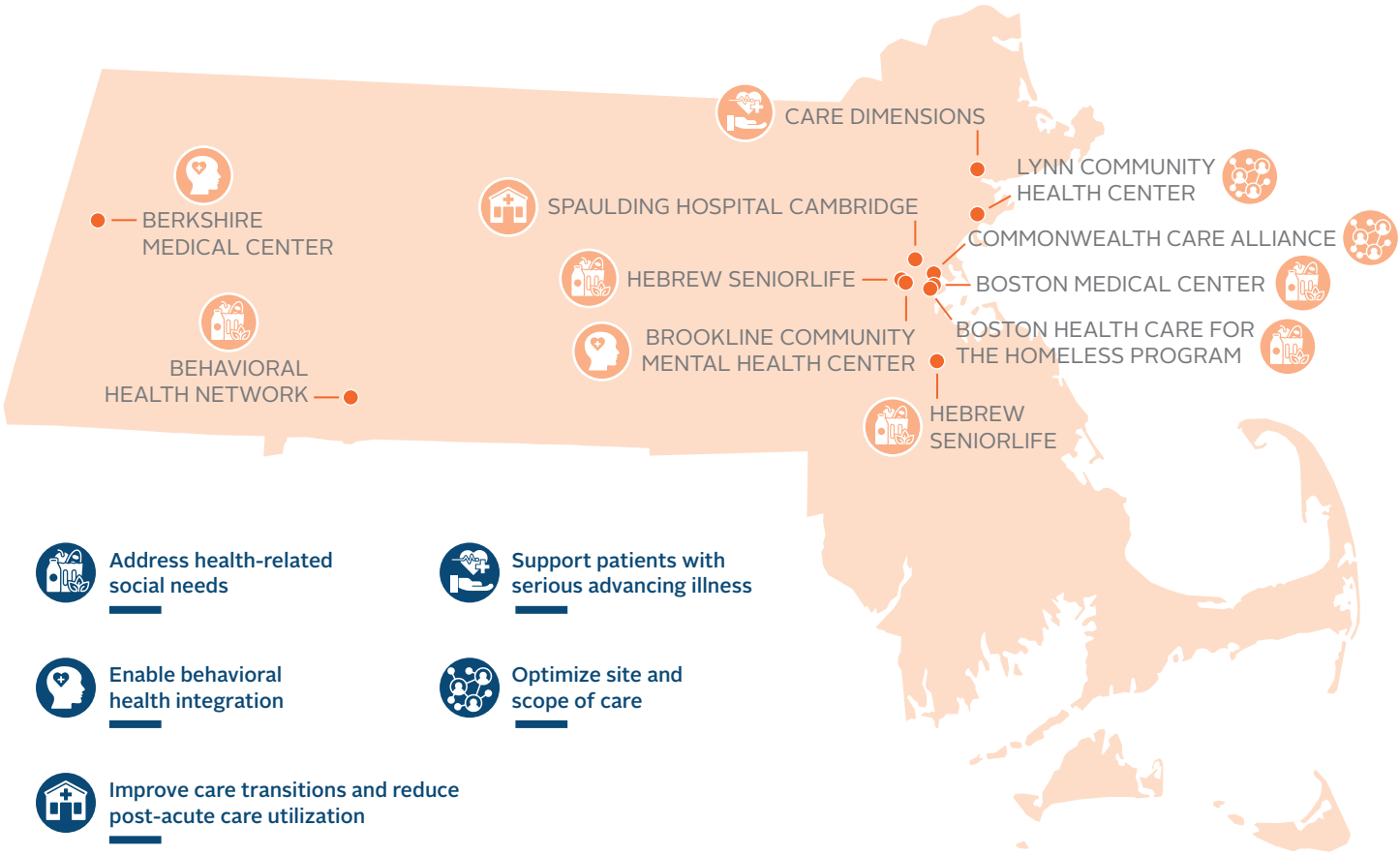
TARGETED COST CHALLENGE INVESTMENTS SITES



Address health-related social needs

Support patients with serious advancing illness

Enable behavioral health integration

Optimize site and scope of care

Improve care transitions and reduce post-acute care utilization

About the Massachusetts Health Policy Commission

The Massachusetts Health Policy Commission (HPC) is an independent state agency that advances a more transparent, accountable, and equitable health care system through its policy leadership and innovative investment programs. The HPC's goal is better health and better care – at a lower cost – for all residents across the Commonwealth.

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