MASSACHUSETTS
HEALTH POLICY COMMISSION

SHIFT-Care Investment Opportunity Recommendations

July 18, 2018

Dedicate approximately $10 million from the HPC Trust Funds for the next round of investment

Health Care Payment Reform Trust Fund

- Primary Purposes:
  - Grants to providers and their partners to foster innovation in health care payment and service delivery through a competitive grant program (“Health Care Innovation Investment Program”)
  - Technical assistance and provider supports related to the PCMH/ACO certification programs

Distressed Hospital Trust Fund

- Primary Purpose:
  - Grants to low-priced community hospitals and their partners to reduce unnecessary hospital utilization and enhance behavioral health through the Community Hospital Acceleration, Revitalization, and Transformation Investment Program (CHART)

All investment programs are rigorously designed to further the Commonwealth’s goal of better health and better care at a lower cost

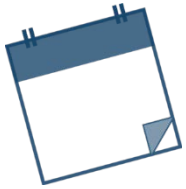
HPC

SHIFT-Care Challenge: Focus on innovative ways to reduce avoidable acute care use

Reducing avoidable acute care utilization by investing in innovative care delivery models that are community-based, collaborative, and sustainable

- **Care model design and impact**
- **Organizational leadership, strategy, and demonstrated need**
- **Evaluation**
- **Sustainability and scalability**
- **Preference provided to CHART-eligible hospitals and HPC-certified ACOs and ACO participants**

Up to $750,000 per award. Applicants are responsible for at least 25% in-kind financial contribution



21 months (3 months of preparation and 18 months of implementation)

HPC

Two funding tracks to reduce avoidable acute care use

FUNDING TRACK 1: Addressing health-related social needs

- Support for innovative models that **address health-related social needs** of complex patients in order to prevent a future acute care hospital visit or stay

FUNDING TRACK 2: Addressing behavioral health needs

- Support for innovative models that **address the behavioral health care needs** of complex patients in order to prevent a future acute care hospital visit or stay

OUD FOCUS: Enhancing opioid use disorder (OUD) treatment

- Support for innovative models that expand access to opioid use disorder treatment by **initiating pharmacologic treatment in the ED** and connecting patients to community-based BH services

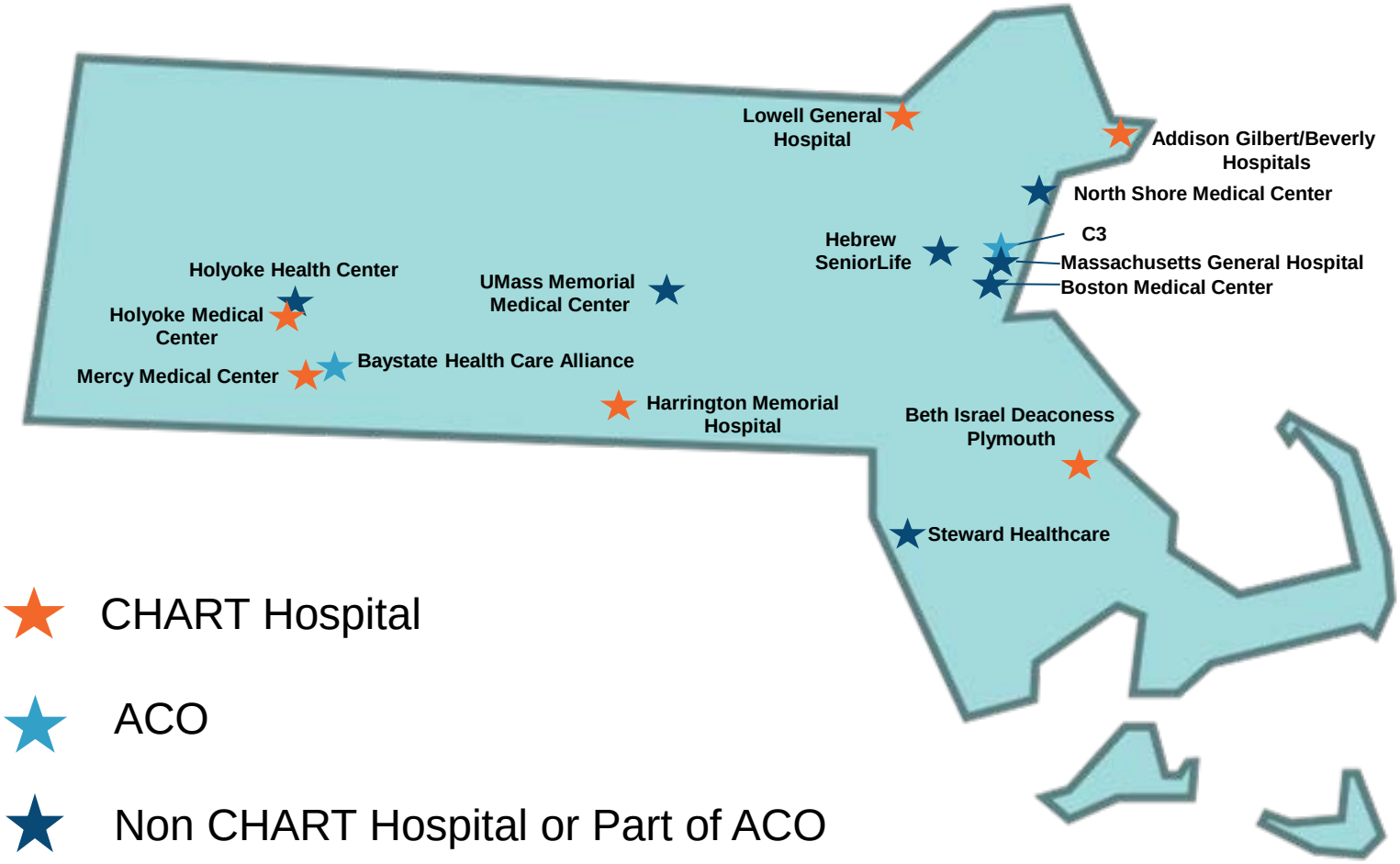
SHIFT-Care Proposed Recommendations

	CHART or ACO	Trust Fund Source	Applicant Entity	HPC Funding
Health-related social needs	ACO	PRTF	Community Care Cooperative (C3)	$750,000.00
	ACO	PRTF	Boston Medical Center	$542,883.53
	ACO	PRTF	Steward Health Care Network, Inc	$745,350.96
	ACO	PRTF	Baystate Health Care Alliance	$750,000.00
	Part of ACO	PRTF	Hebrew Senior Life	$500,000.00
Behavioral health needs	Part of ACO	PRTF	Holyoke Health Center	$565,422.00
	CHART	DHTF	Lowell General Hospital	$606,609.00
OUD treatment in the ED focus	CHART	DHTF	BID Plymouth	$742,407.02
	CHART	DHTF	Beverly/Addison Gilbert	$750,000.00
	N/A	DHTF	UMass Memorial Medical Center	$750,000.00
	CHART	DHTF	Harrington Memorial Hospital	$486,580.00
	CHART	DHTF	Mercy Medical Center	$516,048.00
	CHART	DHTF	Holyoke Medical Center	$750,000.00
	N/A	DHTF	MGH	$550,000.00
	N/A	DHTF	North Shore Medical Center	$750,000.00
				$9,755,300.51

HPC

Note: All proposed recommendations are contingent on successful contracting between Awardees and HPC.

Geography of SHIFT-Care Recommended Awards



Addressing Health-Related Social Needs Recommended Proposals

COMMUNITY CARE COOPERATIVE

BOSTON MEDICAL CENTER

Baystate Health

Steward

Hebrew SeniorLife

5 initiatives
Recommended for funding

$3.4 million
In proposed HPC funding

34 Partner Organizations

Intermediate Measures include:

- Referrals for health related social needs
- Access to food/nutrition support
- Housing stability
- Transportation access
- Reduction in missed school/work days

5,200+ patients
In proposed target populations

$5.8 million
in initiatives' total costs

HPC

Timely Access to Behavioral Health Recommended Proposals

Building healthy communities
HOLYOKE HEALTH

Lowell General Hospital

2 initiatives
Recommended for funding

$1.2 million
In proposed HPC funding

4 Partner Organizations

Intermediate Measures include:

- Reduced use of illicit opioids
- Rates of follow up care
- Utilization of CHW support services

5,700+ patients
In proposed target populations

$1.6 million
in initiatives' total costs

HPC

Initiation of Pharmacologic Treatment in the ED Recommended Proposals

Mercy Medical Center
North Shore Medical Center
Beverly Hospital
Addison Gilbert Hospital
Members of Lahey Health
Beth Israel Deaconess Hospital Plymouth
Harrington Hospital
Holyoke Medical Center
Massachusetts General Hospital
UMassMemorial Medical Center

8 initiatives
Recommended for funding

$5.2 million
In proposed HPC funding

27 Partner Organizations

Measures include:

- Initiation in alcohol and other drug abuse or dependence treatment (HEDIS)
- Engagement in alcohol and other drug abuse or dependence treatment (HEDIS)
- Number of reported overdoses

12,000+ patients
In proposed target populations

$7.8 million
in initiatives' total costs

HPC

Care Model for Initiating Pharmacologic Treatment in the ED (Track 2b)

The legislature appropriated funding to the HPC to implement a pilot grant program to further test a model of ED-initiated pharmacological treatment of opioid use disorder (OUD) for patients who present in the emergency setting with symptoms of overdose or after being administered naloxone.

In addition to initiating pharmacological treatment, Awardees shall provide patients with referrals to outpatient follow-up treatment with the goal of increasing rates of engagement and retention in evidence-based care for their OUD.

What:

Identify patients → **Enroll in program** → **Initiate pharmacological treatment** → **Engage in recovery services**

- **Patient presents with history or symptoms of OUD or overdose**
- **SW/CHW/Nurse recommends patient to program**
  - **Enrolls patient in program, with patient consent**
- **ED physician or other qualified prescriber initiates pharmacological treatment for OUD**
- **Patient leaves ED with medication and a follow-up appointment scheduled within 48 hours of discharge**

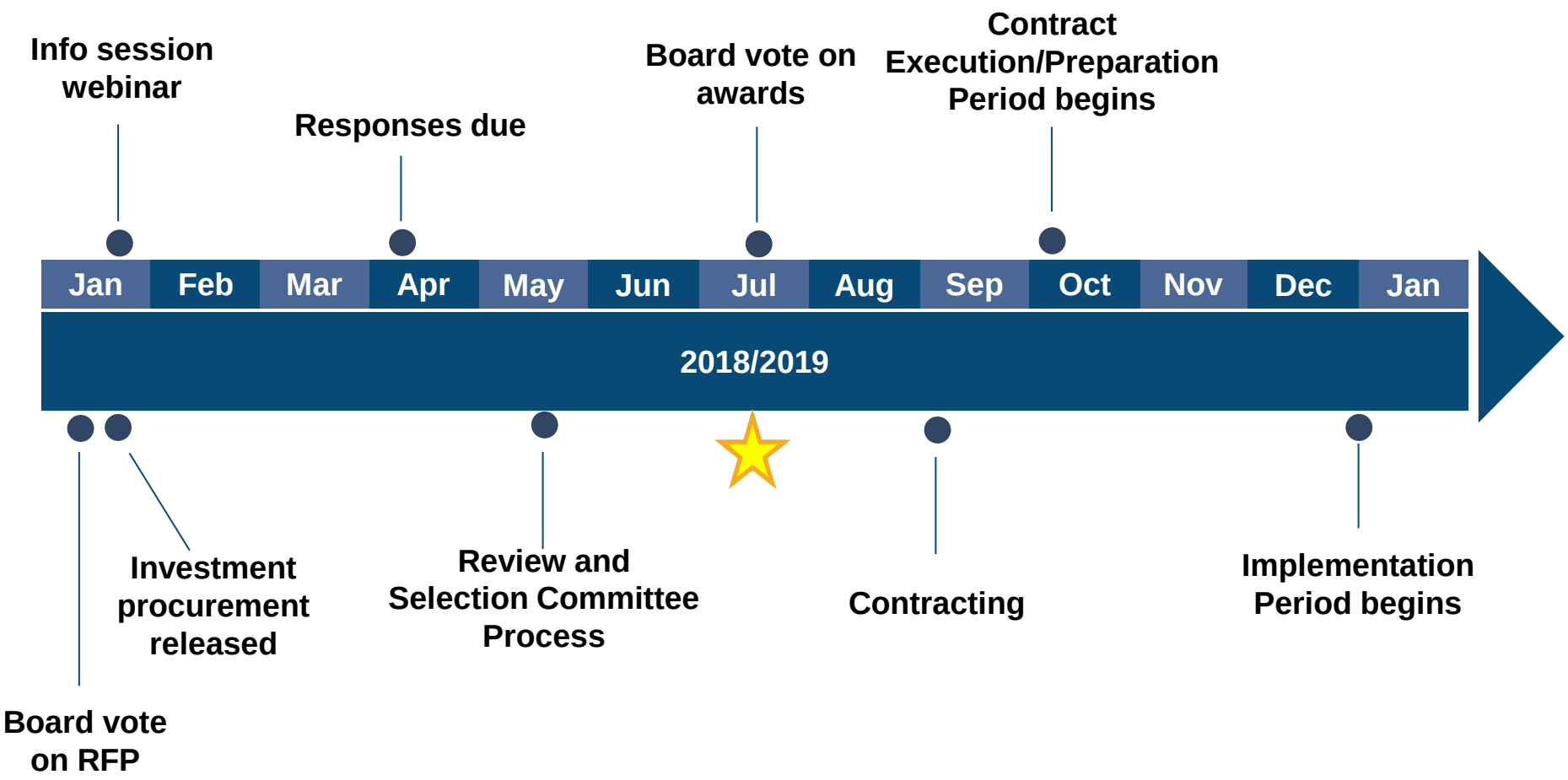
Where:

ED, practice sites, or in the community

Emergency Department

Outpatient Setting

Next steps


Info session webinar
Responses due
Board vote on awards
Contract Execution/Preparation Period begins
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
2018/2019
Board vote on RFP
Investment procurement released
Review and Selection Committee Process
Contracting
Implementation Period begins

Boston Medical Center

Health-related social needs

HPC Certified ACO: Yes
CHART Hospital: No

Partner: Action for Boston Community Development (ABCD)

Primary Aim

Reduce inpatient hospitalizations and ED visits by 10% compared to comparison group.

Target Population

Top 3-5% risk of BMC's ACO (BACO) patients who receive care at Boston Medical Center.

Care Model

- Project tests an expansion of BMC's screening, referral and follow-up model for primary care patients to address health-related social needs in partnership with ABCD (a community-based human services organization that addresses poverty-related needs such as housing services, adult education and job training and early childhood education).
- Grant supports an ABCD program manager to coordinate referrals and Community Wellness Advocates (CWAs) responsible for screening and ensuring follow-up with services by helping patients overcome any financial, logistical or other barriers to accessing services – as well as doing patient education and motivation.
- Strong evaluation design will compare model of using CWAs in the community to the model of services at BMC, which is more referral based.

Total Initiative Cost

- Requested HPC Funding: $542,883
- Applicant Contribution: $180,961
- Grand Total Cost of the Initiative: **$723,844**

Community Care Cooperative (C3)

Health-related social needs

HPC Certified ACO: Yes
CHART Hospital: No

Partners: Brookline Community Mental Health Center, Health Law Advocates, Dartmouth College Master of Health Care Delivery Science

Primary Aim

Build a cost effective health-related social need (HRSN) intervention model that reduces inpatient and ED utilization by 18% compared to baseline.

Target Population

300 adult/youth MassHealth risk patients (900 eligible) with complex care needs and significant HRSN.

Care Model

- Safety-net program for complex members unable to succeed with C3's other clinical CM strategies as a result of significant health-related social needs.
- Frequent community-based/home visits inclusive of attendance at medical appointments, social service agency meetings, school visits, and meetings with family and social supports.
- Represents a core approach difference from C3's other CM programs where teams rely on meeting the member at the health center or support them via telephonic outreach.

Total Initiative Cost

• Requested HPC Funding:	$750,000
• Applicant Contribution:	$327,571
• Grand Total Cost of the Initiative:	**$1,077,571**

COMMUNITY CARE COOPERATIVE

the brookline center for COMMUNITY MENTAL HEALTH

HLA

Dartmouth

HPC

Health-related social needs

HPC Certified ACO: Yes
CHART Hospital: No

Steward Health Care Network, Inc

Partners: Community Counseling of Bristol County, High Point Treatment Center, Steppingstone, Inc., MLPB, Circulation, Brewster Ambulance, Fall River FD, Steward Good Samaritan Medical Center, Steward Saint Ann's Hospital, Steward Morton Hospital

Primary Aim

Reduce ED utilization by 6%, reduce future hospitalizations by 6%, and reduce total cost of care by 6% compared to both baseline and a comparison group.

Target Population

480 (out of 2,661 eligible) all-payer Steward ACO patients in Southeastern Massachusetts who are eligible for service to treat SUD and other identified health-related social needs.

Care Model

- This award tests a multi-sector collaboration across a team of behavioral health providers, primary care, community health workers, peers, first responders, health-related social needs experts (e.g. legal experts) and ambulance providers meet behavioral and social needs of high-risk SUD patients.
- A new digital health company, Circulation, will provide non-medical transportation – and the ambulance will provide medical transportation and do paramedicine, pending regulations.
- MLPB will support customized heath-related social needs screening tools and participate in case conferences of patients to help address housing and other legal needs.

Total Initiative Cost

- Requested HPC Funding: $745,350
- Applicant Contribution: $1,028,289
- Grand Total Cost of the Initiative: $1,773,640

Baystate Health Care Alliance

Health-related social needs

HPC Certified ACO: Yes
CHART Hospital: No

Partners: Baystate Pulmonary Rehabilitation/Baystate Medical Center/Baystate Health, Public Health Institute of Western MA, Mercy Health ACO/Mercy Medical Center/Trinity Health, Revitalize Community Development Corporation, Springfield Partners for Community Action, Springfield Office of Housing, Pioneer Valley Asthma Coalition, Green and Healthy Homes Initiative

Primary Aim

Reduce hospitalizations by an absolute difference of 15% or greater and ED utilization by an absolute difference of 20% or greater compared to a comparison group.

Target Population

150 MassHealth ACO adults and children (out of 600 eligible) from Baystate and Mercy who live in Greater Springfield with at least one asthma related inpatient stay or two or more asthma related ED visits in the previous year.

Care Model

- Strong public health-anchored partnership to support addressing health-related social needs of patients and families with asthma between two regional ACOs, the public health organization, and social/community services agencies including housing.
- Following discharge, patients receive a home visit with a community health worker to assess what the patient needs to improve health in the home. The follow-up visit takes place with the PCP or pulmonologist as appropriate with the community health worker.
- The patient/family is places in one of three tiers of follow up: education, asthma related home repairs, or referral to other housing services.

Total Initiative Cost

- Requested HPC Funding: $750,000
- Applicant Contribution: $420, 854
- Grand Total Cost of the Initiative: **$1,170,854**

Baystate Health

Revitalize CDC
Rebuilding our Community Since 1992

PUBLIC HEALTH INSTITUTE OF WESTERN MASSACHUSETTS
PARTNERS FOR HEALTH EQUITY

Green & Healthy Homes Initiative®

Hebrew Senior Life

Health-related social needs

HPC Certified ACO: Yes
CHART Hospital: No

Partners: Milton Residences for the Elderly, WinnCompanies, Tufts Health Plan, BIDMC, Boston Medical Center, Brookline PD, Fallon Ambulance, Randolph FD, Springwell, HSL Center for Memory Care, HSL Home Care, UMass Boston

Primary Aim

Reduce ED visits and hospitalizations by 20% compared to baseline.

Target Population

All low income seniors (age 62+) living in any of seven affordable housing sites (400 residents served, all payer, out of 1,100 eligible).

Care Model

- Project continues and expands HSL's HCII award, which embeds wellness teams (a nurse and a community health worker) in affordable senior housing to coordinate care for vulnerable older adults.
- Strong focus on monitoring and improving Activities of Daily Living (ADL) and Intellectual Activities of Daily Living (IADL) – as well as coordination of mental health services with Brookline and South Shore mental health for program participants in order to prevent a hospital stay or ED visit
- Expansion of the HCII award here includes a focus on partnerships with ACOs/hospitals and introduces risk arrangement modeling with payers to ensure sustainability.

Total Initiative Cost

- Requested HPC Funding: $500,000
- Applicant Contribution: $489,872
- Grand Total Cost of the Initiative: **$989,872**

Hebrew SeniorLife

TUFTS Health Plan

Beth Israel Deaconess Medical Center

HPC

Holyoke Health Center

Behavioral health needs

HPC Certified ACO: Yes
CHART Hospital: No

Partners: BHN

Primary Aim

Reduce readmissions by 30% compared to baseline.

Target Population

Approximately 2,800 non-ACO Holyoke Health Center patients with a psychiatric diagnosis.

Care Model

- Bolsters behavioral health services and supports in primary care sites for a very high need population (half of the health center's non-ACO patients have a behavioral health diagnosis) in an underserved community.
- Based on the collaborative care model, primary care clinicians are supported by consulting behavioral health clinicians to manage mild to moderate need patients within primary care.
- Funds support an expansion of the NP psychiatric prescribing clinic at Holyoke. Highly complex patients are referred to BHN's psychiatry clinic, City Clinic.
- Community Health Workers will follow up with patients to ensure medication adherence and to address any social needs or barriers to care, as well as to track ED use.
- Evaluation will use baseline and control group comparisons.

Total Initiative Cost

- Requested HPC Funding: $565,422
  Applicant Contribution: $188.474
- Grand Total Cost of the Initiative: **$753,896**

Building healthy communities
HOLYOKE HEALTH

bhn BEHAVIORAL HEALTH NETWORK, INC.

HPC

Lowell General Hospital

Behavioral health needs

HPC Certified ACO: Yes
CHART Hospital: Yes

Partners: Middlesex Recovery, P.C., Lowell Community Opiate Outreach Program, Department of Public Health, Zuckerberg College of Health Sciences University of Massachusetts, Lowell

Primary Aim

Reduce 30-day opioid-related ED revisits by 15%

Target Population

Adult patients who present to the hospital systems two EDs with evidence of opiate overdose or OUD.

Care Model

- Expands access to OUD treatment by engaging patients through either of the system's EDs or by referral from the Lowell Community Opiate Outreach Program (CO-OP)
- Pharmacotherapy is initiated at the Bridge Clinic, when appropriate, and patients are assessed for social, medical, and behavioral health needs, which are addressed by a multi-disciplinary team consisting of Psych NP, Social Worker, RN, CHW, and Recovery Coach.
- Funding supports "bridge" treatment, community based engagement and support for patients.
- Established community partnerships with Lowell CO-OP and Middlesex Recovery will be expanded and enhanced to increase the engagement of patients in OUD treatment.

Total Initiative Cost

• Requested HPC Funding:	$606,609
• Applicant Contribution:	$202,203
• Grand Total Cost of the Initiative:	**$808,812**

Lowell General Hospital

MIDDLESEX RECOVERY

UMASS LOWELL

HPC

Beth Israel Deaconess Hospital-Plymouth

OUD treatment in the ED

HPC Certified ACO: Yes
CHART Hospital: Yes

Partners: Harbor Health Services, CleanSlate Centers, Crossroads Treatment Centers, Gosnold, Spectrum Health Systems, Inc.

Primary Aim

Reduce ED revisits by 8% for the target OUD population compared to baseline.

Target Population

360 all payer ED patients with: 1) Naloxone reversal; 2) Evidence of opioid use; 3) Other clinical indicators of OUD; and 4) Detoxification needs.

Care Model

- Patients with OUD are engaged in this model in both ED and inpatient settings.
- Pharmacotherapy is initiated when appropriate and recovery navigator/NP/LICSW will discuss and schedule follow up services with patient.
- Funds support recovery coaches at Gosnold to support engagement in treatment by helping to address any health-related social needs and barriers to accessing treatment.
- For ACO patients, linked back to BIDCO and his/her primary care team for care coordination and support.
- Partner outpatient sites are responsible for long-term follow up/engagement in treatment.

Total Initiative Cost

- Requested HPC Funding: $742,407
- Applicant Contribution: $247,469
- Grand Total Cost of the Initiative: **$989,876**

Beth Israel Deaconess Hospital Plymouth

CleanSlate

HARBOR HEALTH

CROSSROADS TREATMENT CENTER

Gosnold ON CAPE COD

Spectrum HEALTH SYSTEMS, INC.

HPC

Beverly/Addison Gilbert Hospitals

OUD treatment in the ED

HPC Certified ACO: Yes
CHART Hospital: Yes

Partner: Lahey Health Behavioral Services

Primary Aim

Reduce 30-day ED revisits by 25% for patients meeting target population criteria and engaged in MAT defined services, compared to those patients meeting target population criteria and refusing all services during the period of performance.

Target Population

225 (out of 450 eligible) all payer adult patients who present with an OUD and live within Applicants' community benefits service area.

Care model

- Patients with OUD are engaged in this model in both ED and inpatient settings.
- The model seeks to promulgate ED based prescribing of pharmacotherapy through training, protocols, and waiver licensing
- Recovery Coaches and medical staff meet with patients to assess their readiness and willingness to initiate pharmacotherapy and recovery
- Funding equally supports the hospitals and their long-term behavioral health partner, Lahey Behavioral Health Service (LBHS), to ensure continuity of pharmacotherapy post-discharge and ongoing treatment through LBHS Leap to Recovery Clinic.

Total Initiative Cost

• Requested HPC Funding:	$750,000
• Applicant Contribution:	$375,146
• Grand Total Cost of the Initiative:	**$1,125,146**

Beverly Hospital
Addison Gilbert Hospital
Members of Lahey Health

Lahey Health
Behavioral Services

HPC

UMass Memorial Medical Center

OUD treatment in the ED

HPC Certified ACO: No
CHART Hospital: No

Partners: Community Health Link, AdCare Hospital, UMass Medical School, UMass Memorial Medicare ACO, Department of Health and Human Services, City of Worcester

Primary Aim

Reduce ED revisits by 25% compared to a historical comparison group and establish 50% community-based treatment initiation rates post intervention.

Target Population

2,000 all payer patients presenting in the ED with OUD.

Care Model

- Patients with OUD are engaged in this model in the ED setting.
- Through this model, patients, families, and community are in engaged through direct treatment, referral, and education about community based services for SUD treatment and resources.
- Funding will support Recovery Coaches to engage with patients with OUD through in person or videoconference and initiation of pharmacotherapy will be available for eligible patients, with support services provided by the bridge clinic and Recovery Coaches.
- Through the strengthening of existing partnerships, patients will be referred and followed in the community to increase engagement and retention in outpatient recovery.

Total Initiative Cost

• Requested HPC Funding:	$750,000
• Applicant Contribution:	$383,673
• Grand Total Cost of the Initiative:	**$1,133,673**

UMassMemorial Medical Center

ADCARE We Care

WORCESTER A TOWN JUNE 14, 1722 A CITY FEBY. 29, 1848

HPC

Harrington Memorial Hospital

OUD treatment in the ED

HPC Certified ACO: No CHART Hospital: Yes

Partners: Harrington Hospital Outpatient Behavioral Health Services, Southbridge Police Department,

Primary Aim

Reduce ED visits by 20% compared to baseline.

Target Population

Estimated 3,000-4,500 all payer patients identified through ED, inpatient, and police/EMS with opiate withdrawal, dependence, or overdose.

Care Model

- Patients with OUD are engaged in this model in the ED and inpatient settings, as well as through encounters with first responders/EMS.
- Funding will support the medical, social, and behavioral health evaluation of all patients with OUD and, regardless of recovery status or initiation of pharmacologic treatment initiation, will provide support and follow-up by the SUD therapist and Navigators.
- The model builds on and expands the successful relationship with the Southbridge Police Department by funding a Recovery Specialist to work with the police department to engage and coordinate treatment for target population.

Total Initiative Cost

• Requested HPC Funding:	$486,580
• Applicant Contribution:	$208,190
• Grand Total Cost of the Initiative:	**$694,770**

Harrington HOSPITAL

Southbridge Police Department

HPC

Mercy Medical Center

OUD treatment in the ED

HPC Certified ACO: Yes
CHART Hospital: Yes

Partners: Behavioral Health Network, Mercy Specialist Physicians, Providence Behavioral Health Hospital, Outpatient Services, Healthy Living Program

Primary Aim

Reduce Mercy's 30-day readmission rate by 20% compared to the 2017 baseline of 28% (for all ED OUD patients).

Target Population

1,268 all-payer Mercy ED OUD patients (out of a likely eligible 4,225)

Care Model

- Patients with OUD are engaged in this model in the ED and outpatient settings.
- Through this model, patients are provided services from recover coaches and social workers. Peer Recovery Support Coaches assist patients as they engage in decision-making regarding the initiation of and engagement in buprenorphine treatment and provide support in the transition from the ED to the outpatient providers. Social Workers engage with patients to address social determinants of health during treatment and recovery.
- Funding will support Mercy and their partner, Behavioral Health Network, in providing an evidence-based, social service intervention to enhance patient outcomes in initiating treatment and staying engaged in the treatment and recovery process, along with their addition treatment partners, Mercy Recovery Services, the Healthy Living Program, and Providence Behavioral Outpatient Services ,

Total Initiative Cost

- Requested HPC Funding: $516,048
- Applicant Contribution: $172,015
- Grand Total Cost of the Initiative: **$688,063**

Mercy MEDICAL CENTER

bhn BEHAVIORAL HEALTH NETWORK, INC.

HPC

Holyoke Medical Center

OUD treatment in the ED

HPC Certified ACO: Yes
CHART Hospital: Yes

Partners: Gandara, Western Mass Physician Associates (WMPA) Suboxone Clinic, River Valley Counseling Center, Providence Behavioral Health Hospital, Hampden County Sheriff's Department,

Primary Aim

Bridge 20% of ED patients to MAT or addiction services

Target Population

1,581 (based on 2017 numbers) Holyoke Medical Center ED patients with primary or secondary diagnosis of OUD and/or positive OUD screen.

Total Initiative Cost

- Requested HPC Funding: $750,000
- Applicant Contribution: $437,353
- Grand Total Cost of the Initiative: **$1,187,353**

Care Model

- Patients with OUD are engaged in this model in the ED, inpatient, or outpatient settings, as well as through referral from local courts and jails.
- Funding will support the medical, social, and behavioral health evaluation of all patients with OUD and, regardless of recovery status or initiation of pharmacologic treatment initiation, will provide support and follow-up by the Social Worker and either RN Care Navigator or CHW. Key partners, such as the Gandara Center, will support ongoing treatment.
- The funding of the HMC Suboxone Clinic will support bridge prescribing and ongoing pharmacologic treatment as needed.

Holyoke Medical Center

Gándara Center
Culturally Sensitive Care

SHERIFF'S DEPT • COMM. OF MASSACHUSETTS • HAMPDEN CO.

HPC

Massachusetts General Hospital

OUD treatment in the ED

HPC Certified ACO: Yes
CHART Hospital: No

Partner: Boston Healthcare for the Homeless Program (BHCHP)

Primary Aim

Reduce ED revisits by up to 50% for the target population compared to baseline.

Target Population

3,285 all-payer patients who present to the MGH ED or Bridge Clinic who have an opioid use disorder; and BHCHP adult patients for whom the Bridge Clinic is a more effective site of ongoing care.

Care Model

- Patients with OUD are engaged in this model in the MGH ED and in the outpatient setting by MGH and BHCHP physicians/ providers.
- Funding will support the expansion of existing pharmacologic induction services in the ED and Bridge Clinic to BHCP's patients, as well as an expansion of Recovery Coaches, beyond the Bridge Clinic, to include the ED and McInnis House
- As part of the funded initiative, MGH will establish a Learning Collaborative to offer technical assistance, guidance, and shared learning to organizations interested in developing models that are similar to their initiative and the Bridge Clinic.

Total Initiative Cost

- Requested HPC Funding: $550,000
- Applicant Contribution: $549,414
- Grand Total Cost of the Initiative: **$1,099,414**

MGH 1811 MASSACHUSETTS GENERAL HOSPITAL

BOSTON HEALTH CARE *for the* HOMELESS PROGRAM

HPC

North Shore Medical Center

OUD treatment in the ED

HPC Certified ACO: Yes
CHART Hospital: No

Partners: Lynn Community Health Center, North Shore Physicians Group, North Shore Community Health, Bridgewell,

Primary Aim

Reduce ED revisits by 50% for the target population compared to baseline.

Target Population

500 (out of 10,000 eligible) all payer North Shore Medical Center ED opioid overdose patients and patients with a positive OUD screen.

Care Model

- Patients with OUD are engaged in this model in ED.
- Through this model, initiation of pharmacologic treatment will begin in the ED followed by referral back to primary care or one of North Shore's outpatient behavioral health partners, depending on PCP affiliation/severity of need.
- Funding will support the training and waivering of primary care physicians to allow them to engage in prescribing, thereby expanding access to pharmacologic treatment for OUD in this geographic area of need.

Total Initiative Cost

- Requested HPC Funding: $750,000
- Applicant Contribution: $250,000
- Grand Total Cost of the Initiative: **$1,000,000**

NSMC NORTH SHORE MEDICAL CENTER

Lynn COMMUNITY health CENTER

Bridgewell

HPC