Boston Coordinated Care Hub BP1 Annual Report

Summary

The Boston Coordinated Care Hub (BCCH) comprises eight long-standing community-based providers[1] with expertise working with vulnerable, highly marginalized populations, primarily people experiencing homelessness, including those with serious mental illness, substance use disorders, chronic illnesses, and health related social needs, in the Boston-Prime Service Area. In summary, our BP1 main activities included:

Hire and train a strong workforce. We have devoted significant time and resources to supporting the development of a skilled BH CP workforce of nearly 40 staff to provide timely, patient-centered care to Boston's most vulnerable and hard to reach enrollees.

Enroll and engage 1000 BH CP enrollees leveraging multiple data streams. At the end of BP1, we had 858 assigned enrollees; of these, 67% were consented and 39% were engaged (signed PCTP). BCCH's approach in outreaching and engaging the assigned enrollees was successful due to a number of factors, most notably leveraging multiple data streams including our data platform (the SDH Hub), PreManage ADT notifications, BHCHP's Epic medical record (including Care Everywhere), ACO contacts, as well as relationships with community providers. Although, we were successful in outreaching and engaging enrollees, many front line staff reported not being able to focus time on working with enrollees work toward stated goals because of the intense focus on enrollment and securing PCTP signatures. These efforts involved an unexpected and disproportionate amount of front-line and administrative staff time since so many enrollees were not connected to primary care or had inaccurate information about the right primary care provider or had to wait to get in to see PCPs many months out.

Launch a Consumer Advisory Board (CAB). BCCH launched our CAB in December holding our first meeting with members on December 10, 2018. We discussed the BH CP program and areas that we would like to improve and a general sense of a meeting schedule.

Develop programming to engage hard to engage populations. We were not able to use DSRIP Health and Wellness funds to develop and implement new activities to engage enrollees. Instead, we used these to hire administrative staff to comply with MassHealth and ACO/MCO reporting. Although we did use a modest amount of this funding to provide cell phones to patients that had consented to participate in the BH CP to better engage and communicate with BCCH staff as well as their physical and behavioral health providers.

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[1] Boston Health Care for the Homeless Program (BHCHP) is the lead entity for BCCH with 7 affiliated partners that are: Boston Public Health Commission, Boston Rescue Mission, Casa Esperanza, New England Center and Home for Veterans, Pine Street Inn, St. Francis House, and Victory Programs