Boston Health Care for the Homeless

Executive Summary:

The organizations that form the SDH BH CP Consortium have more than 250 collective years of caring for Boston's most vulnerable populations that include a significant breadth of homeless individuals. Having a BH CP with the experience, trust, resources, and mission to address the extraordinary needs of extremely complex populations that often have co-occurring mental illness and substance use disorders in addition to high unmet social determinant of health needs will be a powerful asset for ACOs or MCOs to advance MassHealth goals to provide high quality, cost efficient care.

Our SDH BH CP Consortium pools together the best expertise for delivering primary care, substance use treatment, mental health, social services, housing, and shelter services across 9 long-standing, community-based organizations in Boston; innovative data infrastructure (with legal agreements in place enabling sharing physical, behavioral, social service data as well as housing data from the City of Boston) for integrated care coordination and performance feedback at the enrollee, care coordinator, site, and system level; and the biggest footprint to find, enroll, and engage vulnerable enrollees face-to-face. BH CP Care coordinators will be based in the community where vulnerable Medicaid enrollees--especially those experiencing homeless-- go: the street, day shelters, night shelters, temporary and permanent housing, primary care clinics, mental health centers, substance use treatment facilities, etc.

a. BH CP Composition. The SDH BH Consortium that includes the 9 organizations named on below (plus the Massachusetts Housing and Shelter Alliance (MHSA) who is part of our Organized Health Care Agreement (OHCA) agreement) have been actively convening since 2013. With funding from the Massachusetts Health Policy Commission, we launched the SDH Coordinated Care Hub for Homeless Adults pilot. Through this pilot, we have built the foundation for cross-sector care coordination and communication that spans the continuum of care across our Affiliated Partners and major hospital partners to engage high costs, high needs homeless Medicaid enrollees and advance work that will serve as a foundation as a BH CP.

The nine community-based organizations that comprise our SDH BH CP Consortium are:

(Lead Entity): Boston Health Care for the Homeless Program (BHCHP) is a Federally Qualified Health Center that delivers direct medical, dental and behavioral health services to 11,000 homeless men, women, and children in more than 40 locations in shelters and on the streets.

(Affiliated Partner): Bay Cove Human Services is one of the largest mental health and substance use providers in Massachusetts offering services through five major Service Areas: Mental Health, Developmental Disabilities, Child & Family, Addiction, and Kit Clark Senior Services.

(Affiliated Partner): Boston Public Health Commission is an independent public agency providing a wide range of health services and programs, including operation of over 600 emergency shelter beds as well as outpatient substance use disorder and transitional support services.

(Affiliated Partner): Boston Rescue Mission offers numerous services to the homeless population of Boston including food and shelter through their programs; 24 hour care through residential programming; vocational training, substance use treatment, mental health treatment, counseling, and case management services.

(Affiliated Partner): Casa Esperanza, a bilingual, bicultural behavioral health program that specializes in serving the Latino community with substance use treatment, providing affordable sober housing; parent-child education and reunification; job training, placement and advancement; trauma counseling; and health and wellness services.

(Affiliated Partner): The New England Center and Home for Veterans has been in operation for 26 years as one of the nation's largest private providers of transitional shelter, permanent housing, and behavioral health services to homeless veterans.

(Affiliated Partner): Pine Street Inn is New England's largest emergency shelter and a longtime leader in providing permanent supportive housing, job training and substance use services to homeless men and women.

(Affiliated Partner): St. Francis House is New England's largest day shelter providing basic employment and job training, English as a Second Language, mental health and housing services and permanent supportive housing to homeless adults.

(Affiliated Partner): Victory Programs, a Boston-based nonprofit that provides health, housing, and substance use services to support individuals and families who are homeless and may have HIV, substance use disorders, and chronic health issues.

b. Community Partners Population Served. Our SDH BH CP Consortium will serve Boston Primary area.

Our BH CP comprises established community-based providers who have expertise working with vulnerable, highly marginalized populations including those with serious mental illness, substance use disorders, chronic illnesses, and health related social needs. Among these individuals includes a critical mass of homeless individuals in the Boston-Prime Service Area that are likely to qualify for BH CP service underscoring the need for a BH CP that has the experience to respond to their complex needs.

c. Overview of 5-year Business Plan.

Pre-launch (December 2017-June 2018):

- *Goal: Leverage the infrastructure and framework created by the Health Policy Commission HCII pilot to meet BH CP expectations*. Administrative and IT staff at BHCHP including the CEO, CMO, CFO, BH CP Director, Medical Director, and IT/Data Analyst are leveraging the pilot infrastructure to support the BH CP including: amending existing legal agreements, scaling and improving the data platform by integrating some of our Affiliated Partners EHRs, modifying existing assessments and integrated care plan and exploring the use of tablets and laptops to enable real time data entry in the field. *Challenge*: We are working to meet evolving EOHHS documentation and assessment requirements that may delay our ability to automate front line staff workflows and reduce staff administrative burden. We may have to use paper-based processes until we are able to develop IT solutions.
- *Goal: Develop standardized processes with ACOs and MCOs for contracting and ongoing work to improve administrative efficiency*. Senior BHCHP staff will engage with ACOs and, MCOs to develop Documented Processes and contracts. Our goal is to develop standardized processes with the ACOs and MCOs that will facilitate data flow and reduce administrative burden for each entity. *Challenge*: With 8 ACOs and 2 MCOs to work with, we anticipate a significant amount of negotiating to reach mutual goals and the likely inevitably of having multiple reporting Documented Processes.
- *Goal: Develop opportunities to imbed LICSW at various inpatient facilities with psychiatric beds to improve transitions of care*. We are meeting with psychiatric inpatient providers including Arbour Hospital, Carney Hospital, and MGH with the plan to develop MOUs, BAAs, or other needed agreements to enable a BH CP LICSW to round at the facilities to work with BH CP enrollees with psychiatric diagnoses on discharge transitions. *Challenge:* We anticipate challenges with psychiatric facilities notifying us when our BH CP enrollees are inpatients. There also may be resistance to having the LICSW visit with BH CP enrollees while they are inpatient without obtaining additional consent. We hope that the mutual goals of improved transitions will help overcome these challenges.

- *Goal: Recruit and train a skilled workforce to provide high quality, BH CP services*. We have commenced hiring for qualified BH CP staff and will provide training that will begin in the pre-launch period and continue throughout the next several years to ensure that staff meet EOHHS training requirements and are ready to enroll and engage 1000 enrollees by December 2018. *Challenge*: Hiring skilled heath care staff with modest PMPM funds is a very significant challenge in the competitive, costly Boston labor market. Our BH CP has started hiring for some positions as early as December 2017 anticipating this challenge and we have allocated a modest amount of new funding for our Affiliated Partners to bring on staff as early as May 1 if it helps with their recruitment.

Year 1 (June 2018-December 2018):

- *Goal: Launch a Consumer Advisory Board (CAB) to ensure BH CP program maintains focus on patient-centeredness.* BHCHP and many of our Affiliated Partners have strong CABs. We plan to launch our BH CP CAB with cross-partner representation in the summer. The BH CP Program Manager will work with the CAB on their first assignment: developing a needs assessment to inform 'health promotion' programs & other community activities for our BH CP. *Challenge*: Consumers are busy people and getting consistent attendance at bimonthly meetings can be challenging. We will offer assistance with travel to and from the meetings and food and beverage refreshments to make their attendance more convenient. We will endeavor to ensure that they will find their contribution meaningful in making a difference in our BH CP program.
- *Goal: Enroll and engage 1000 BH CP enrollees.* The BH CP Program Manager will work with Team Coordinators to orchestrate outreach and enrollment in the BH CP. BH CP Care Coordination Team will meet face-to-face with enrollees for ongoing engagement and connection to needed services, case conferencing, care transitions, etc. Our staff will be trained to use a person-centered approach understanding that meeting basic survival needs such as shelter, safety, clothing, and food is a bridge to engagement in needed behavioral health and medical care services. Staff will use harm reduction strategies to engage enrollees on substance use treatment. BH CP team will document all encounters, monitor data, and conduct performance improvement. *Challenges*: There are many challenges during this period but two that stand out as new to us include 1) Having sufficient numbers of enrollees from MassHealth and the ACOs to find and enroll. In order to reach 1000—we will likely need 2-3 times our target number. We will leverage our data platform and PreManage software to locate assigned members and communicate between team members to find and enroll these members, but we need an ongoing influx of assigned members from the ACOs and MassHealth to get us to 1000. 2) Evolving EOHHS requirements regarding what constitutes PCP approval to signify that the Person-Centered Treatment Plan has been reviewed may create administrative burdens for both the BH CP and the PCP and presents a significant impediment to the BH CP for getting paid for providing services. We will work closely with ACOs to help us overcome this barrier and test IT solutions as well in BP1.
- *Goal: Develop programming to engage hard to engage populations.* Using data from the needs assessment developed by our CAB and Affiliated Partners, the Program Manager and Team Coordinators will work with Affiliated Partners & NCMs to develop and implement activities to engage enrollees using Health and Wellness funding. *Challenge:* Although we are excited to have funding to develop Health and Wellness programming, we are concerned that this six months budget period will be very focused on enrollment and may limit our ability to fully leverage this funding. Although we are committed to make every effort to launch this important programming, we may need to roll-over some unspent funds in BP1 to BP2 to continue our efforts.

Years 2-4: (January 2019-December 2021) BH CP activities and goals as above and:

- *Goal: Scale BH CP beyond 1000 to accommodate more enrollees.* As we add more enrollees we will add BH CP team staff and provide training and support. *Challenge:* As noted above,

the Boston labor force is extremely competitive. In addition, we will need to ensure that we are working collaboratively to retain existing workforce—we will work to leverage SWI funding as available. The BH CP will work to conduct bimonthly trainings to keep staff engaged and offer opportunities to receive programmatic input on ways we can improve the workforce environment.

- *Goal: Engage BH CP hard to reach enrollees through strategies that include Health and Wellness Programming. Challenge:* There are many vulnerable groups of patients that will require innovative programming to engage in care. We will use data to identify these groups of individuals and update our community needs assessment annually to help identify strategies to engage target populations.
- *Goal: Improve Accountability Scores*. Our IT staff will refine our data dashboard to ensure staff have access to timely, informative, actionable data. BHCHP medical leadership will work with the BH CP Program Manager and Team Coordinators to use this data to conduct PDSA cycles to drive performance. *Challenge:* The population our BH CP is likely to serve will have higher than average costs —$2036 per member per month on average compared with $568 per month for all MassHealth members according to one study (Bharel, 2013) Although, we will work to beat our own Accountability Score each year, the likelihood of meeting state defined targets is daunting. We will work with MassHealth to develop fairer ways of risk adjusting Accountability Scores.
- *Goal (BP3 & 4): Identify staff whose roles may be consolidated to adapt to declining DSRIP revenue.* We will conduct a thorough assessment of administrative staff and expenses that might be reduced and make the adjustments as needed. *Challenge:* Although we have a budget plan for phased out funding primarily in the IT support lines, it's difficult to anticipate whether or not we will need to use IT funds to invest in better IT systems or offer continued Health and Wellness programming among other line items.

Year 5 (January 2022-December 2022) BH CP activities and goals as above and:

Goal: Negotiate and contract with ACOs and MCOs to improve and grow our SDH BH CP Consortium. We hope that the data regarding our success engaging and caring for our BH CP enrollees will lead to productive conversations about future collaborations with ACOs and MCOs.