SHIFT-CARE CHALLENGE

Boston Medical Center

ADDRESSING HEALTH-RELATED SOCIAL NEEDS

MASSACHUSETTS HEALTH POLICY COMMISSION

CARE MODEL

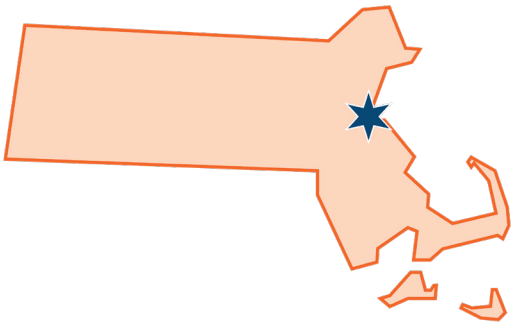
Boston Medical Center (BMC) developed THRIVE+, a program to systematically screen for and address health-related social needs (HRSN) among patients at risk of high acute care utilization enrolled in an existing pharmacy program focused on medication adherence. THRIVE+ is a partnership with Action for Boston Community Development (ABCD), a community-based human services organization that provides housing services, adult education, job training, early childhood education, and other services. A pharmacy liaison dually trained as a patient navigator and pharmacy technician screens for and addresses HRSN while promoting medication adherence and ambulatory care engagement. Liaisons help patients overcome identified barriers to care through motivational interviewing, patient education, assistance with making and attending appointments, and connection to social support, transportation, interpreter, and childcare services. The liaisons work directly with ABCD and other community-based organizations to coordinate patients' receipt of resources.

IMPACT

HPC AWARD	**$542.9K**
TOTAL PROJECT COST	**$724K**
TARGET POPULATION	**Top 3-10% of health care utilizers in BMC's attributed ACO population**
PRIMARY AIM	**10%** **Reduction in inpatient hospitalizations and emergency department visits**

PARTNERS

– Action for Boston Community Development



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SHIFT-CARE CHALLENGE

Community Care Cooperative

ADDRESSING HEALTH-RELATED SOCIAL NEEDS

MASSACHUSETTS HEALTH POLICY COMMISSION

CARE MODEL

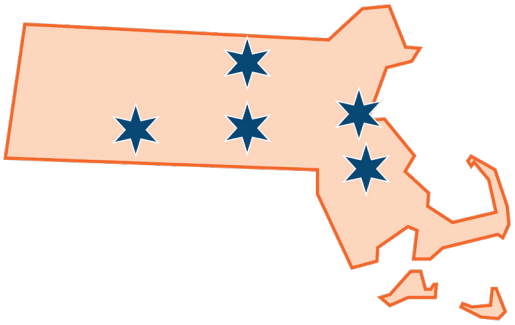
Community Care Cooperative (C3), a community health center-led MassHealth accountable care organization (ACO), developed *Healthy Connections*, a community-based, integrated care management program for patients with complex needs. The program is intended for patients who have not experienced positive results with C3's other clinical care management strategies. It includes intensive patient engagement with community health workers and care managers to identify and work towards patients' health-related goals, including addressing their medical, behavioral health, and social needs. Care managers meet enrolled patients in their homes or other community settings to conduct in-depth health-related social needs (HRSN) screenings and to discuss the goals patients identified as the most important to them. The care manager regularly engages patients via in-person meetings, phone calls, and text messages. *Healthy Connections* was designed and is operated in close collaboration with the Brookline Center for Community Mental Health and Health Law Advocates (HLA). In addition to receiving support for clinical needs and HRSN, youth patients have access to HLA lawyers who provide navigation and representation with social services and education agencies.

IMPACT

HPC AWARD	**$750K**
TOTAL PROJECT COST	**$1.0M**
TARGET POPULATION	**Adult and pediatric ACO patients with complex care needs and significant HRSN**
PRIMARY AIM	**18%** **Reduction in inpatient and emergency department utilization**

PARTNERS

- Brookline Center for Community Mental Health
- Health Law Advocates
- Dartmouth College Master of Health Care Delivery Science



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SHIFT-CARE CHALLENGE

Steward Health Care Network, Inc.

ADDRESSING HEALTH-RELATED SOCIAL NEEDS

MASSACHUSETTS HEALTH POLICY COMMISSION

CARE MODEL

Steward Health Care Network ("Steward") developed a program to more effectively coordinate the medical, behavioral health, and health-related social needs (HRSN) of accountable care organization (ACO) patients with substance use disorders (SUD). The program includes collaboration among behavioral health and primary care providers, community health workers, recovery coaches, and emergency medical services (EMS) providers. Steward social workers identify and enroll eligible patients with SUD diagnoses and documented HRSN. Once the SHIFT team has worked with a patient to develop a care plan, they coordinate appropriate next steps, including social services referrals and transportation to medical appointments. Community partners such as recovery coaches and EMS providers offer supports such as wellness education, recovery outreach, and post-discharge check-ups. One of Steward's partners in the program, MLPB, provides customized HRSN screening tools and participates in patient case conferences to help address housing and legal needs.

IMPACT

HPC AWARD **$745K**

TOTAL PROJECT COST **$1.3M**

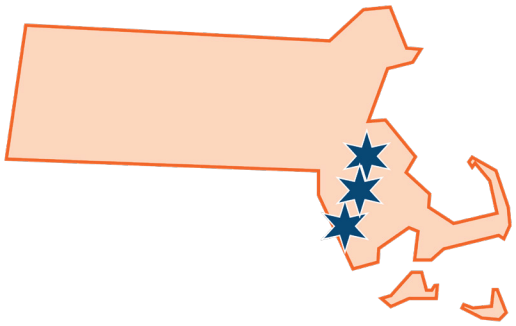
TARGET POPULATION **Steward ACO patients who are eligible for services to treat SUD and identified HRSN**

PRIMARY AIMS

- ▼ **6%** **Reduction of emergency department utilization**
- ▼ **6%** **Reduction of future inpatient hospitalizations**
- ▼ **6%** **Reduction of total cost of care**

PARTNERS

- Community Counseling of Bristol County
- High Point Treatment Center
- Steppingstone
- MLPB
- Circulation
- Brewster Ambulance
- Fall River Fire Department
- Steward Good Samaritan Medical Center
- Steward Saint Ann's Hospital
- Steward Morton Hospital



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SHIFT-CARE CHALLENGE

Baystate Health Care Alliance

ADDRESSING HEALTH-RELATED SOCIAL NEEDS

MASSACHUSETTS HEALTH POLICY COMMISSION

CARE MODEL

Baystate Health Care Alliance developed the *Springfield Healthy Homes Project* to address health-related social needs of patients with asthma and their families in partnership with the Public Health Institute of Western Massachusetts and several other community-based organizations in the Springfield area. Following discharge from an asthma-related inpatient hospitalization or emergency department (ED) visit, the *Springfield Healthy Homes Project* provides patients with home visits from a community health worker (CHW) who then collaborates with the patients' primary care providers or pulmonologists to assess and support patients and families in their homes. Patients and their families are assigned to one of three tiers of follow-up depending on their needs: education, asthma-related home repairs, or referral to other housing services. CHWs and other program staff then coordinate the provision of services based on the assigned tier.

IMPACT

HPC AWARD **$750K**

TOTAL PROJECT COST **$1.1M**

TARGET POPULATION **Adult and pediatric ACO patients with at least one asthma-related inpatient stay or two or more asthma-related ED visits in the previous year**

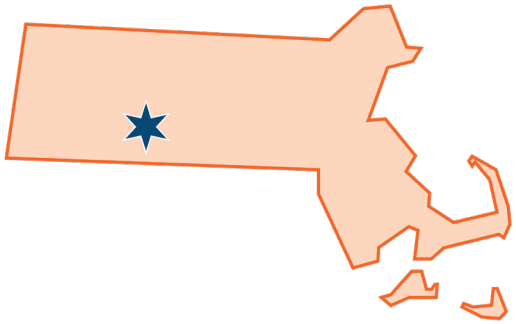
PRIMARY AIMS

▼ **15%** **Reduction of inpatient hospitalizations**

▼ **20%** **Reduction of ED utilization**

PARTNERS

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



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SHIFT-CARE CHALLENGE

Hebrew SeniorLife

ADDRESSING HEALTH-RELATED SOCIAL NEEDS

MASSACHUSETTS HEALTH POLICY COMMISSION

CARE MODEL

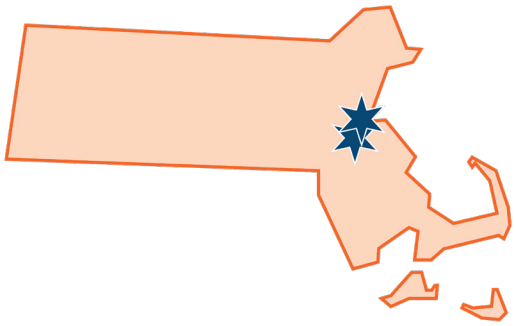
Hebrew SeniorLife (HSL) expanded its *Right Care, Right Place, Right Time* (R3) initiative—an integrated housing and care model originally developed through an HPC Targeted Cost Challenge Investment award—to focus on specific risk categories and a sustainable model. R3 embeds teams of wellness coaches and nurses in seven affordable senior housing sites (HSL and partner-owned). These wellness teams help seniors manage their health care needs, access supports, and address their health-related social needs. Once residents opt into the program, the team conducts detailed whole-person assessments of the residents' goals and needs. The teams then work to meet those needs by providing preventative services or connecting residents with community supports for nutrition, memory support, mental health, and emergency department (ED)/hospital avoidance. For example, R3 program staff collaborate with HSL's Center for Memory Health to assess and care for residents with cognitive decline, and with Brookline Community Mental Health Center and Aspire Mental Health to improve access to on-site mental health services for residents.

IMPACT

HPC AWARD	**$500K**
TOTAL PROJECT COST	**$1.2M**
TARGET POPULATION	**Low-income seniors (age 62+) living in any of seven HSL affordable housing sites**
PRIMARY AIM	**20%** **Reduction of ED visits and inpatient hospitalizations**

PARTNERS

- Milton Residences for the Elderly
- WinnCompanies
- Tufts Health Plan
- Beth Israel Deaconess Medical Center
- Boston Medical Center
- Brookline Police Dept
- Fallon Ambulance
- Randolph Fire Dept
- Springwell
- HSL Center for Memory Health
- HSL Home Care
- UMass Boston



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SHIFT-CARE CHALLENGE

Holyoke Health Center

IMPROVING BEHAVIORAL HEALTH

MASSACHUSETTS HEALTH POLICY COMMISSION

CARE MODEL

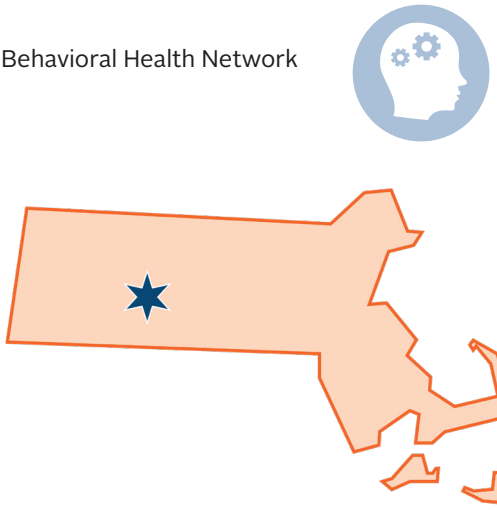
Holyoke Health Center (HHC), in collaboration with Behavioral Health Network (BHN), developed a program to integrate treatment for mild to moderate mental health issues into primary care settings. Primary care teams use the Patient Health Questionnaire-9 screening tool to identify patients who would benefit from behavioral health support. Embedded behavioral health providers conduct an additional patient assessment during primary care visits. The SHIFT-Care team also reviews BHN and HHC's psychiatric clinic patient panels to identify eligible patients who would benefit from additional behavioral health support. During an initial encounter, a community health worker (CHW) administers the Arizona Self-Sufficiency Matrix to inform care plan development. CHWs may also provide counseling to support adherence to treatment, address health-related social needs, and resolve barriers to care.

IMPACT

HPC AWARD	**$565K**
TOTAL PROJECT COST	**$887K**
TARGET POPULATION	**Non-ACO HHC patients with a psychiatric diagnosis**
PRIMARY AIM	**30%** **Reduction of readmissions**

PARTNERS

– Behavioral Health Network



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SHIFT-CARE CHALLENGE

Lowell General Hospital

IMPROVING OPIOID USE DISORDER CARE

MASSACHUSETTS HEALTH POLICY COMMISSION

CARE MODEL

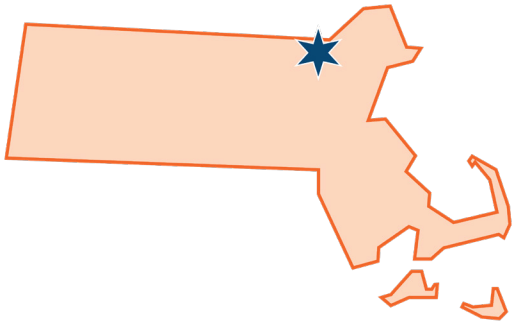
Lowell General Hospital developed a program that expands access to opioid use disorder (OUD) treatment through medication bridging services, community-based treatment, and recovery support for patients. The program team engages patients through the emergency department (ED) or by referral from the Lowell Community Opiate Outreach Program. When patients with OUD come to the ED, members of a multi-disciplinary team composed of a psychiatric nurse practitioner, social worker, registered nurse, community health worker, and recovery coach assess patients for social, medical, and behavioral health needs to develop care plans and determine eligibility for medication for addiction treatment (MAT). Patients who are eligible for MAT are connected to the bridge clinic where clinicians can initiate medication. After patients are engaged in treatment, the program team refers them to outpatient addiction recovery providers to facilitate further SUD treatment post-discharge.

IMPACT

HPC AWARD	**$607K**
TOTAL PROJECT COST	**$825K**
TARGET POPULATION	**Adult patients who present to the hospital's ED with evidence of opioid overdose or OUD**
PRIMARY AIM	**15%** **Reduction in 30-day opioid-related ED revisits**

PARTNERS

- Middlesex Recovery
- Lowell Community Opiate Outreach Program



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SHIFT-CARE CHALLENGE

Beth Israel Deaconess Hospital – Plymouth

IMPROVING OPIOID USE DISORDER CARE

MASSACHUSETTS HEALTH POLICY COMMISSION

CARE MODEL

Beth Israel Deaconess Hospital-Plymouth (BID-Plymouth) offers a program to expand access to opioid use disorder (OUD) treatment through medication bridging services, community-based treatment, and recovery support for patients. Once a patient has undergone evaluations for substance use disorders or opioid withdrawal in BID-Plymouth's emergency department (ED), an ED physician can initiate medication for addiction treatment (MAT) for clinically appropriate patients. Patients who start MAT receive continuing assistance from a hospital-based behavioral health clinician (i.e., psychiatric nurse practitioner or social worker) and a recovery navigator. This care team helps patients connect with contracted partner organizations for continued outpatient treatment, at which point patients can start on the most appropriate form of medication for their needs. Patients who are members of BID-Plymouth's partner accountable care organization, Beth Israel Deaconess Care Organization, are linked back to their primary care providers for care coordination and ongoing support. If a patient flagged for OUD services leaves the ED against medical advice, Plymouth County Outreach will attempt to re-engage the patient through an outreach visit with a recovery navigator and plain clothed police officer within 24-28 hours of the ED visit.

IMPACT

HPC AWARD **$742K**

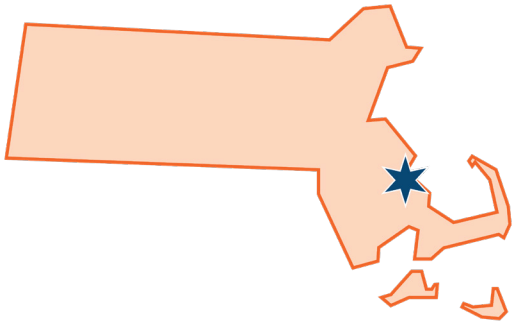
TOTAL PROJECT COST **$990K**

TARGET POPULATION **Adult patients who present to the ED after overdose and naloxone reversal, have other clinical indicators of OUD, or seek withdrawal management**

PRIMARY AIM **8%** **Reduction in ED revisits**

PARTNERS

- Harbor Health Services
- CleanSlate Centers
- Crossroads Treatment Centers
- Gosnold
- Spectrum Health Systems



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SHIFT-CARE CHALLENGE

Beverly Hospital and Addison Gilbert Hospital

IMPROVING OPIOID USE DISORDER CARE

MASSACHUSETTS HEALTH POLICY COMMISSION

CARE MODEL

Beverly Hospital and Addison Gilbert Hospital's program expands access to opioid use disorder (OUD) treatment by connecting eligible patients in the emergency department (ED) with recovery coaches and clinical staff who assess their willingness and eligibility to begin medication for addiction treatment (MAT). The hospitals have expanded their capacity to provide MAT by training ED clinicians who are currently waivered to prescribe buprenorphine. Patients seeking treatment may be discharged from the ED with a 3-day kit of buprenorphine with patient instructions for home induction. The hospitals and their behavioral health partner, Lahey Health Behavioral Services (LHBS), facilitate access to MAT post-discharge through the LHBS's Lahey Enhanced Assessment Program (LEAP) to Recovery Clinic. All patients desiring MAT or who have been provided a kit are provided a follow-up appointment at the LEAP to Recovery Clinic. LEAP recovery coaches maintain contact with each patient to ensure follow-up and assist with accessing care through support services such as transportation to appointments.

IMPACT

HPC AWARD **$750K**

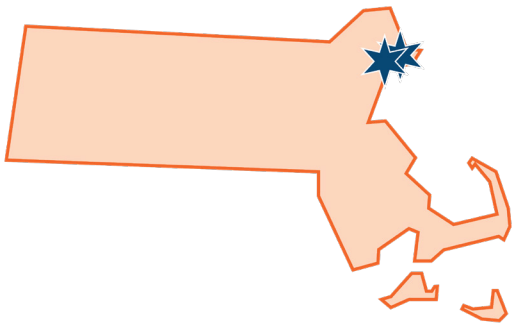
TOTAL PROJECT COST **$1.1M**

TARGET POPULATION **Adult patients who present to the ED with an OUD**

PRIMARY AIM **25%** **Reduction in 30-day ED revisits**

PARTNERS

– Lahey Health Behavioral Services



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SHIFT-CARE CHALLENGE

UMass Memorial Medical Center

IMPROVING OPIOID USE DISORDER CARE

MASSACHUSETTS HEALTH POLICY COMMISSION

CARE MODEL

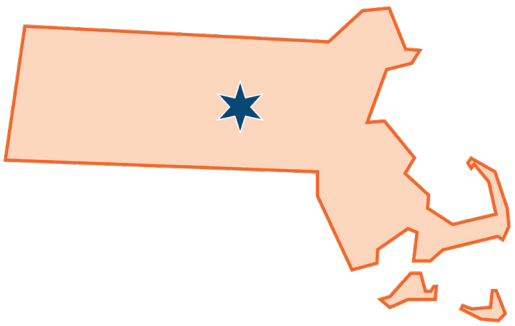
The UMass Memorial Medical Center (UMMMC) program expands access to opioid use disorder (OUD) treatment by introducing a bridge clinic to the hospital and providing services for patients, specifically those who present to the emergency department (ED) with OUD. ED physicians and staff identify eligible patients and connect them with social workers, recovery coaches, psychiatric consultants, and prescribers of medication for addiction treatment (MAT) who support them in accessing hospital and community-based services while continuing MAT. Eligible patients have access to MAT through the ED or the bridge clinic and are subsequently referred to local outpatient provider partners to increase the likelihood that they will stay in recovery. The UMMMC program continues to explore opportunities for process improvement in caring for patients with OUD through collaborations with community-based providers, city and state programs with similar objectives, departments and programs of UMMHC, and the academic endeavors of UMMS.

IMPACT

HPC AWARD	**$750K**
TOTAL PROJECT COST	**$1.1M**
TARGET POPULATION	**Adult patients who present to the ED with OUD**
PRIMARY AIM	**25%** **Reduction in ED revisits**

PARTNERS

- Community Healthlink
- AdCare Hospital
- UMass Medical School
- UMass Memorial Medicare ACO
- Department of Health and Human Services: City of Worcester



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SHIFT-CARE CHALLENGE

Harrington Memorial Hospital

IMPROVING OPIOID USE DISORDER CARE

MASSACHUSETTS HEALTH POLICY COMMISSION

CARE MODEL

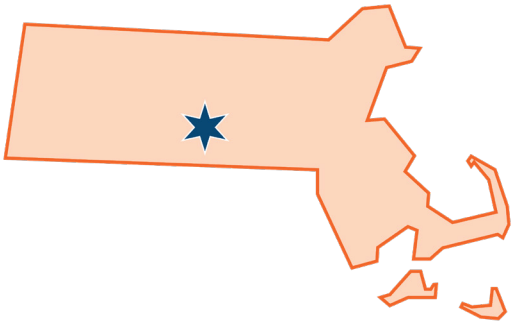
Harrington Memorial Hospital (Harrington) expands access to opioid use disorder (OUD) treatment by implementing a workflow for emergency department (ED) clinicians and staff to screen and assess patients who present to the ED with opioid withdrawal, overdose, or OUD. Typically, a recovery specialist, social worker, or nurse identifies eligible patients through a live update from the electronic medical record, though ED clinicians can also identify patients and contact the SHIFT-Care team for intake. Harrington clinicians conduct medical, social, and behavioral health evaluations, and eligible patients can either be administered buprenorphine in the ED or prescribed a take-home dose. After discharge, a substance use disorder therapist and a patient navigator follow-up with patients to ensure that they have access to appropriate social and medical services by providing care coordination, individualized engagement and support, and assistance resolving barriers to treatment (e.g., unstable housing, transportation, childcare). Harrington also has dedicated psychiatrists available to provide immediate follow-up after a patient is discharged from the ED and continue the patient on buprenorphine. Harrington is also expanding its capacity to provide MAT by training and supporting ED clinicians pursuing waivers to prescribe buprenorphine with financial support and incentives. The Harrington program builds upon an existing, successful relationship with the Southbridge Police Department that links patients who experience overdose but decline transport to the ED with a Harrington recovery specialist.

IMPACT

HPC AWARD	**$487K**
TOTAL PROJECT COST	**$654K**
TARGET POPULATION	**Adult patients who present to the ED with opioid withdrawal, overdose, or OUD**
PRIMARY AIM	**20%** **Reduction in ED visits**

PARTNERS

- Harrington Hospital Outpatient Behavioral Health Services
- Southbridge Police Department



SHIFT-CARE CHALLENGE SUMMARY

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SHIFT-CARE CHALLENGE

Mercy Medical Center

IMPROVING OPIOID USE DISORDER CARE

MASSACHUSETTS HEALTH POLICY COMMISSION

CARE MODEL

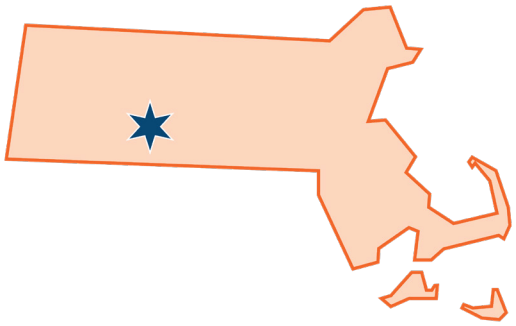
Mercy Medical Center's program, *Emergency Room Starting Treatment Assisting Recovery (ER-STAR)*, expands access to opioid use disorder (OUD) treatment by focusing on initiating patients in medication for addiction treatment (MAT) and engaging them in ongoing recovery services provided by their partner organization, Behavioral Health Network (BHN). ER-STAR social workers screen patients presenting to the emergency department (ED) with evidence of OUD to identify those eligible for buprenorphine initiation. ED clinicians use the clinical opiate withdrawal scale and administer or prescribe buprenorphine to patients as appropriate. BHN peer recovery coaches provide support to patients as they transition from the ED to outpatient care. ER-STAR social workers provide long-term support with MAT as well as health-related social needs and assist patients with securing follow-up outpatient services as they continue in recovery.

IMPACT

HPC AWARD	**$516K**
TOTAL PROJECT COST	**$688K**
TARGET POPULATION	**Adult patients who present to the Mercy ED with OUD**
PRIMARY AIM	**20%** **Reduction in 30-day readmissions**

PARTNERS

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



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SHIFT-CARE CHALLENGE

Holyoke Medical Center

IMPROVING OPIOID USE DISORDER CARE

MASSACHUSETTS HEALTH POLICY COMMISSION

CARE MODEL

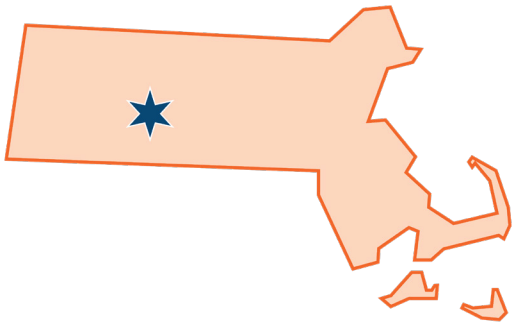
Holyoke Medical Center (HMC)'s program expands access to opioid use disorder (OUD) treatment by engaging patients with OUD who come to the emergency department (ED), inpatient or outpatient settings, or are identified through referrals from local courts and jails. Social workers trained to evaluate substance use disorders provide brief interventions and assess patients' eligibility for the program. A psychiatric advanced care practice nurse with a waiver to prescribe buprenorphine evaluates eligible patients and, if appropriate, prescribes medication for addiction treatment or refers patients to next-day follow-up at HMC's Comprehensive Care Center (CCC). The CCC offers open walk-in hours and does not require a referral for treatment, both of which ease access for patients. Patients can also seek mental health services at River Valley Counseling Center, co-located in the CCC office. The Gándara Center, a peer recovery support center, staffs evening hours in the ED with peer recovery coaches with lived experience with substance use disorders who help patients navigate medical, behavioral health, and social services. Patients in the program are assigned a nurse navigator who can coordinate appointments with primary care providers, help patients enroll in withdrawal management services, and refer to methadone clinics and counseling.

IMPACT

HPC AWARD	**$750K**
TOTAL PROJECT COST	**$1.2M**
TARGET POPULATION	**Adult patients who present to the Holyoke ED with primary or secondary diagnoses of OUD and/or a positive OUD screen**
PRIMARY AIM	**20%** **Reduction in ED visits**

PARTNERS

- Gándara Center
- HMC Comprehensive Care Center
- River Valley Counseling Center
- Providence Behavioral Health Hospital
- Hampden County Sheriff's Department



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SHIFT-CARE CHALLENGE

Massachusetts General Hospital

IMPROVING OPIOID USE DISORDER CARE

MASSACHUSETTS HEALTH POLICY COMMISSION

CARE MODEL

Massachusetts General Hospital's (MGH) program expands access to opioid use disorder (OUD) treatment through its Bridge Clinic, which provides outpatient addiction services to patients discharged from inpatient care or the emergency department (ED) but are not yet connected to outpatient care. Other patients can make use of the Bridge Clinic on a drop-in basis. Through the program, the MGH Bridge Clinic is expanding its prescribing capacity, hours of operation, and recovery coach resources. The MGH ED is also expanding its capacity to provide access to medication for addiction treatment (MAT) by offering training resources to its clinicians. This program facilitates referral of Boston Health Care for the Homeless Program (BHCHP) patients to the MGH Bridge Clinic and provides ongoing support to those patients through a BHCHP recovery coach and recovery coach supervisor. In addition to serving patients in the Bridge Clinic, recovery coaches serve patients in the ED and patients discharged to Barbara McInnis House, a respite program within BHCHP.

IMPACT

HPC AWARD **$550K**

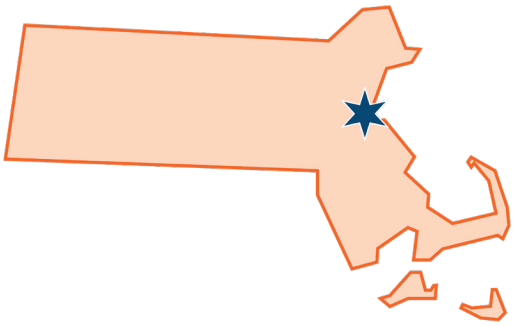
TOTAL PROJECT COST **$1.1M**

TARGET POPULATION **Adult patients who present to the ED or Bridge Clinic with OUD**

PRIMARY AIM **50%** **Reduction in ED revisits**

PARTNERS

– Boston Healthcare for the Homeless Program Barbara McInnis House



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SHIFT-CARE CHALLENGE

North Shore Medical Center

IMPROVING OPIOID USE DISORDER CARE

MASSACHUSETTS HEALTH POLICY COMMISSION

CARE MODEL

North Shore Medical Center (NSMC)'s program expands access to opioid use disorder (OUD) treatment by offering medication for addiction treatment (MAT) initiation for patients who have experienced opioid overdose or who screen positively for opioid use disorder (OUD) in the emergency department (ED) and on inpatient floors. A care team, including a recovery coach, meets with eligible patients to discuss available care options and support services. Patients who initiate MAT then receive a referral to their primary care providers (PCP) or one of NSMC's outpatient behavioral health partners. NSMC is focused on building staff capacity to prescribe buprenorphine, and on implementing anti-stigma efforts throughout the hospital. Through the program, Lynn Community Health Center, an outpatient partner with robust OUD services, is expanding access at its urgent care clinic to include Sundays. North Shore Physicians Group is also expanding its capacity to provide MAT by training and supporting PCPs who are pursuing waivers to prescribe buprenorphine.

IMPACT

HPC AWARD **$750K**

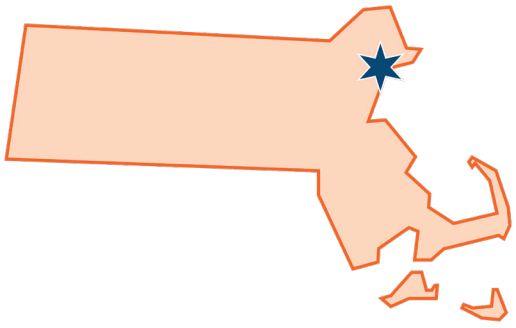
TOTAL PROJECT COST **$1.0M**

TARGET POPULATION **Adult patients who present to the ED following opioid overdose, or who have a positive OUD screening result**

PRIMARY AIM **50%** **Reduction in ED revisits**

PARTNERS

- Lynn Community Health Center
- North Shore Physicians Group
- North Shore Community Health
- Bridgewell



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