MASSACHUSETTS
HEALTH POLICY COMMISSION

# SUPPORTING INDIVIDUALS WITH UNMET HEALTH-RELATED SOCIAL NEEDS AND BEHAVIORAL HEALTH NEEDS

## THE SHIFT-CARE CHALLENGE INVESTMENT PROGRAM: HEALTH-RELATED SOCIAL NEEDS AND BEHAVIORAL HEALTH COHORT

**DECEMBER 2023**

> "The Health-related Social Needs and Behavioral Health awardees under the SHIFT-Care Challenge Investment Program truly demonstrated that it is possible to influence the **quality, cost, and patient experience** for those with truly **complex care needs**. And all of this was **accomplished** during a global pandemic!"
>
> – MARTIN COHEN, HPC BOARD VICE-CHAIR AND PRESIDENT AND CEO OF THE METROWEST HEALTH FOUNDATION

In 2018, the Massachusetts Health Policy Commission (HPC) launched the Sustainable Healthcare Innovations Fostering Transformation (SHIFT-Care) Challenge Investment Program. This $10 million initiative supported promising innovations that addressed health-related social needs (HRSN) and increased access to timely behavioral health services for residents of Massachusetts with the goal of decreasing the use of costly and avoidable hospital care. The HPC awarded funding to six organizations and partner organizations to implement programs addressing HRSN or increasing access to behavioral health care.[1]

These programs reached participants who had experienced persistent challenges with social and behavioral health needs and who often had high hospital utilization as a result. During the Covid-19 pandemic, programs made several adaptations to their core program models and continued to provide critical support during that uniquely challenging time. While most awardees saw improvements in measures of HRSN and downward trends in hospital utilization, multiple factors, including the confounding effect of widespread declines in utilization related to the pandemic, make it difficult to draw firm conclusions about the impact of SHIFT-Care programs on utilization. Nevertheless, SHIFT-Care Challenge programs generated fruitful community partnerships, which many awardees intend to continue in some form, along with components of the original programs.

### AREAS OF FOCUS

**ADDRESS** PARTICIPANT HRSN AND BEHAVIORAL HEALTH NEEDS

**ALIGN** STAFF AND SERVICES TO PARTICIPANT NEEDS

**PARTNER** WITH COMMUNITY-BASED ORGANIZATIONS

**IMPROVE** THE CARE EXPERIENCE FOR PARTICIPANTS

1 The SHIFT-Care Challenge included a second track which provided funding to nine hospitals to implement programs that would expand access to opioid use disorder (OUD) treatment by initiating medication for addiction treatment (MAT) in the emergency department and connecting patients to community-based behavioral health services. Findings from these initiatives can be found here: https://www.mass.gov/doc/the-shift-care-challenge-investment-program-opioid-use-disorder-cohort/download

BAYSTATE HEALTH CARE ALLIANCE · BOSTON MEDICAL CENTER · COMMUNITY CARE COOPERATIVE

**$10 MILLION** AWARDED • • • **6** AWARDEES • • • **1,238** PATIENTS SERVED

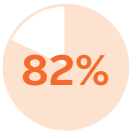
HEBREW SENIORLIFE · HOLYOKE HEALTH CENTER · STEWARD HEALTH CARE NETWORK

# SHIFT-CARE CHALLENGE HRSN-BH INITIATIVES AND IMPACT

The SHIFT-Care Challenge was designed to promote efforts to implement sustainable, transformative care models that would reduce avoidable acute care utilization by addressing health-related social needs and increasing access to timely behavioral health services. All SHIFT-Care awardees designed programs to achieve those goals.

## BAYSTATE HEALTH CARE ALLIANCE ("BAYSTATE")

in partnership with local community-based organizations, developed the *Springfield Healthy Homes Asthma Program* to address social and home remediation needs of participants with asthma and their families to reduce emergency department (ED) utilization.




OF CHILDREN WITH UNCONTROLLED ASTHMA HAD CONTROLLED ASTHMA BY THE FINAL VISIT

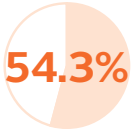
## BOSTON MEDICAL CENTER (BMC)

developed *THRIVE+*, a program that enhanced pharmacy staff training and services to systematically screen for and address HRSN among patients at risk of high acute care utilization.


REDUCTION IN THE NUMBER OF PATIENTS WITH AT LEAST ONE INSTANCE OF ACUTE CARE UTILIZATION (I.E., INPATIENT HOSPITAL ADMISSION OR ED VISIT)

## 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 ACO members with complex social and medical needs.




INCREASE IN FOOD SECURITY AMONG GRADUATES OF THE PROGRAM

## HEBREW SENIORLIFE (HSL)

expanded its integrated housing and care model—Right Care, Right Place, Right Time (R3)—to focus on additional social and health risk categories in a new iteration of the program they called *R3²*.


REDUCTION IN 30-DAY HOSPITAL READMISSION RATES COMPARED TO A 54% INCREASE AT COMPARISON SITES

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# SHIFT-CARE CHALLENGE HRSN-BH INITIATIVES AND IMPACT (CONT.)

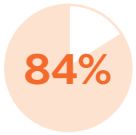
### HOLYOKE HEALTH CENTER (HHC)

in collaboration with Behavioral Health Network (BHN), developed a program to integrate treatment for mild to moderate mental health issues into primary care settings.


OF PATIENTS HAD A KEPT PSYCHIATRIC MEDICATION MANAGEMENT APPOINTMENT WITHIN 90 DAYS OF ENROLLMENT

### STEWARD HEALTH CARE NETWORK ("STEWARD")

developed *Care to Community*, a program to coordinate more effectively the medical, behavioral health, and HRSNs of ACO-attributed patients with substance use disorders.




OF PARTICIPANTS HAD A FAVORABLE RESPONSE TO THE AMOUNT OF ASSISTANCE RECEIVED; 80% OF PARTICIPANTS REPORTED THEY WOULD COME BACK TO THE PROGRAM IF IN NEED OF ASSISTANCE IN THE FUTURE

## HEALTH-RELATED SOCIAL NEEDS AND HEALTH INEQUITIES

Programs focused on addressing HRSN, like the SHIFT-Care Challenge, often face systemic factors that limit their ability to address participant needs fully and sustainably. These systemic factors disproportionately impact people of color and other historically marginalized populations. Systems of oppression create inequitable conditions such as housing segregation, economic disadvantages, and lack of access to protective factors such as healthy food or good job opportunities for certain communities. These conditions have been shown to result in higher levels of individual social needs and poorer health and well-being.[2] Efforts at the level of policy or social change are warranted in order to improve the conditions of populations impacted by these inequities and to more fully address the root causes of their HRSN.[3]

> "There are systematic barriers we are up against over which we have **no control**. This includes the types of available services, funding for those services, and very specific eligibility requirements. It often feels as if we are brainstorming work-arounds or temporary fixes rather than **connecting our patients to upstream services** that will truly mitigate health-related social needs."
>
> – BMC STAFF MEMBER

2 National Academies of Sciences, Engineering, and Medicine; Health and Medicine Division; Board on Population Health and Public Health Practice; Committee on Community-Based Solutions to Promote Health Equity in the United States; Baciu A, Negussie Y, Geller A, et al., editors. Communities in Action: Pathways to Health Equity. Washington (DC): National Academies Press (US); 2017 Jan 11. 3, The Root Causes of Health Inequity. Available from: https://www.ncbi.nlm.nih.gov/books/NBK425845/

3 Williams DR, Costa MV, Odunlami AO, Mohammed SA. Moving upstream: how interventions that address the social determinants of health can improve health and reduce disparities. Journal of public health management and practice. 2008 Nov 1;14(6):S8-17.

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# COMMUNITY HEALTH WORKERS AND NON-CLINICAL STAFF

Many awardees employed community health workers (CHWs) or other types of non-clinical staff in roles related to patient navigation or care coordination. CHWs typically worked personally with participants to identify their HRSNs and connect them to resources to address those needs. With both past experience in and familiarity with the communities they served, CHWs, in particular, played a central role in the care model by offering complex patients supports that were beyond the skills and capacity of clinicians.

"CHWs play an important role in **building trust and relationships.** These trusting relationships can transition to increased engagement with primary care, helping people get medical needs met before they become acute"

**– C3 STAFF MEMBER**

"Every step of the way our CHWs were **advocating for getting supplies and food and services** to our families – while calling them regularly to check on their needs, **provide support and education**."

**– BAYSTATE STAFF MEMBER**

"Our CHW and Community RN staff are truly **bringing care to the members in the communities they live in.** The majority of their workday is spent in the community, meeting with patients and meeting unique needs... Our community-based staff also meet patients when they are admitted to higher levels of care along with attending medical and BH community-based appointments which speaks to our goal and model of integrated care."

**– STEWARD STAFF MEMBER**

"CHWs provide crucial support to HHC patients...and **help to navigate the barriers which prevent them from following their prescribed treatment plans.**"

**– HHC STAFF MEMBER**

## PATIENT STORY

"Our team was working with a member who ... had been homeless for a while. The team made sure she was on all appropriate housing lists and followed up frequently. After a brief wait, the member was able to secure housing but had no furniture. Our CHW tried to call multiple furniture banks and no one was answering the phone. The CHW went out of her way to go to one of the furniture banks and knock on the door until someone came to talk with her. The member had furniture donated and moved in within [two] days. Although the member still had a lot of goals to meet, she reported that, 'now that I have a roof over my head, I can focus on everything else I have been neglecting.'"

**– STEWARD STAFF MEMBER**

# ADDRESSING A RANGE OF PATIENT NEEDS

SHIFT-Care Challenge program awardees, with the goal of addressing HRSN, conducted screenings based on their knowledge of their target populations and the structure of their programs. The social needs that appeared most consistently across programs were food insecurity, housing insecurity, and transportation access. Awardees took different approaches in addressing participants' most pressing needs and reducing avoidable acute care utilization.[4,5]

## FOOD INSECURITY

**WHAT THE RESEARCH SAYS:**
Food insecurity has been associated with significantly higher rates of ED visits, hospitalizations, and longer hospital stays.[6]

**HSL** developed relationships with Community Servings and Eat Well Meal Kits, both of which provide medically-tailored meal options for individuals. Additionally, the R3[2] program introduced participants to the Commodity Supplemental Food Program, a monthly distribution of groceries to residents facing food insecurity.

## HOUSING QUALITY AND SECURITY

**WHAT THE RESEARCH SAYS:**
In Massachusetts' Home and Healthy for Good program, providing supportive housing reduced average health costs of participants from $33,190 to $8,603 per year.[7]

**BAYSTATE,** in partnership with Revitalize CDC, provided home repair and remediation services to reduce asthma triggers, such as vent cleaning, carpet removal, and/or ventilation fan repairs or installations. Oftentimes, participants rented their homes and were reluctant to engage their landlords in the home repairs, so Baystate and its partners provided legal support to help obtain landlord or property manager authorization to make modifications. Other awardees, such as Steward, C3, and BMC, supported their participants in applying for resources such as Residential Assistance for Families in Transition.

## TRANSPORTATION ACCESS

**WHAT THE RESEARCH SAYS:**
Missed medical appointments have been estimated to cost the health care system $150 million per year, with one study finding that on average, one missed appointment resulted in a loss of $292.70 in billing charges and $92.24 of reimbursement revenue.[8] Transportation barriers are a major factor in patients missing appointments.

**STEWARD** partnered with Circulation, which provided on-demand non-emergency transportation to medical visits for patients who lacked reliable transportation access. Providers could schedule transportation for patients through Circulation's digital platform.


4 Bensken WP, Alberti PM, Stange KC, Sajatovic M, Koroukian SM. ICD-10 Z-Code Health-Related Social Needs and Increased Healthcare Utilization. Am J Prev Med. 2022 Apr;62(4):e232-e241. doi: 10.1016/j.amepre.2021.10.004. Epub 2021 Dec 2. PMID: 34865935.

5 Niedzwiecki MJ, Sharma PJ, Kanzaria HK, McConville S, Hsia RY. Factors Associated With Emergency Department Use by Patients With and Without Mental Health Diagnoses. JAMA Netw Open. 2018;1(6):e183528. doi:10.1001/jamanetworkopen.2018.352

6 Berkowitz SA, Seligman HK, Meigs JB, Basu S. Food insecurity, healthcare utilization, and high cost: a longitudinal cohort study. Am J Manag Care. 2018 Sep;24(9):399-404. PMID: 30222918; PMCID: PMC6426124.

7 Massachusetts Housing and Shelter Alliance, 2014. Home and Healthy for Good June 2014 Progress Report. Available at: https://archives.lib.state.ma.us/bitstream/handle/2452/213501/ocn887735103-2014.pdf?sequence=1&isAllowed=y

8 Triemstra JD, Lowery L. Prevalence, Predictors, and the Financial Impact of Missed Appointments in an Academic Adolescent Clinic. Cureus. 2018 Nov 19;10(11):e3613. doi: 10.7759/cureus.3613. PMID: 30680269; PMCID: PMC6340409.


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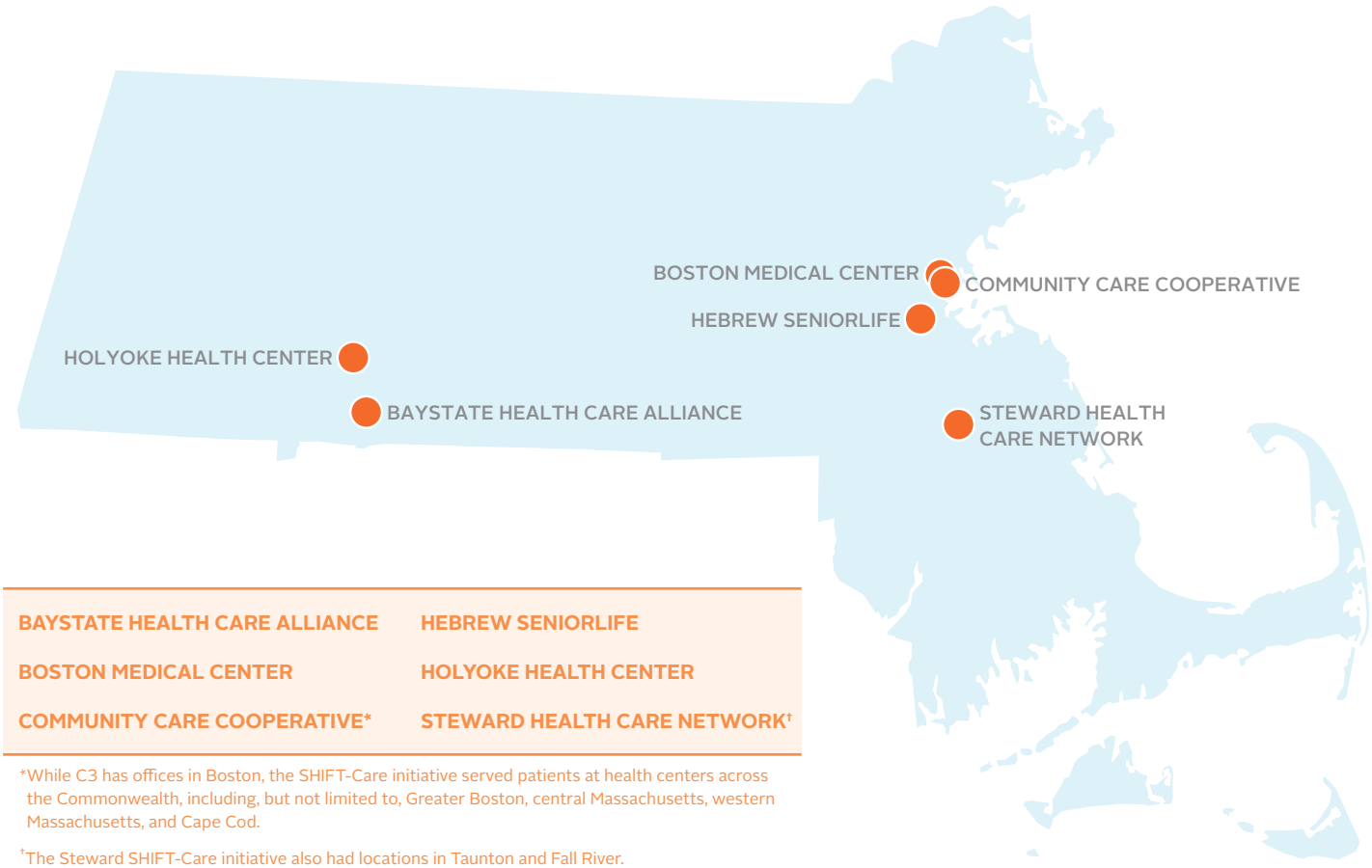
# PARTNERSHIPS WITH COMMUNITY ORGANIZATIONS

A required component of all SHIFT-Care Challenge programs was a partnership with a community organization. Each awardee built a working relationship with at least one partner in service of the program's goals of addressing HRSN and reducing hospital utilization. The community partners brought additional knowledge and expertise, and their perspectives influenced the strategies awardees employed to address the needs of participants. The specific expertise and capabilities of the partners were core to the foundation of supports awardees provided during the Covid-19 pandemic. Most awardees described the immense value in their partnerships and expressed a desire to continue them after the program had ended.


## CASE STUDY: COMMUNITY CARE COOPERATIVE (C3)

C3's Healthy Connections program was a community based, integrated care management program that utilized CHWs to support patients with complex needs who had not seen improvement from other care management programs provided by C3. The Healthy Connections program was operated in close collaboration with the Brookline Center for Mental Health and based on the design of the Brookline Center's Healthy Lives program. The Healthy Connections team worked closely with the Brookline Center staff to develop appropriate training materials for C3 staff. C3 complemented their core program by partnering with Health Law Advocates, who provided representation in legal and navigational services for youth participants in the Healthy Connections program. The teams maintained overall coordination and communication within these formal partnerships via bi-weekly meetings and clinical supervision coverage managed by the Brookline Center and colocation of Health Law Advocates and C3 staff. In addition to these formal partnerships, C3 worked with a patient and family council to share community resources with the Healthy Connections program.

# SHIFT-CARE CHALLENGE PROGRAMS MAP

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|---|---|
| BAYSTATE HEALTH CARE ALLIANCE | HEBREW SENIORLIFE |
| BOSTON MEDICAL CENTER | HOLYOKE HEALTH CENTER |
| COMMUNITY CARE COOPERATIVE* | STEWARD HEALTH CARE NETWORK† |

*While C3 has offices in Boston, the SHIFT-Care initiative served patients at health centers across the Commonwealth, including, but not limited to, Greater Boston, central Massachusetts, western Massachusetts, and Cape Cod.

†The Steward SHIFT-Care initiative also had locations in Taunton and Fall River.

## ABOUT THE MASSACHUSETTS HEALTH POLICY COMMISSION

The Massachusetts Health Policy Commission (HPC) is an independent state agency charged with monitoring health care spending growth in Massachusetts and providing data-driven policy recommendations regarding health care delivery and payment system reform. The HPC's mission is to advance a more transparent, accountable, and equitable health care system through its independent 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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