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
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)
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

<table>
<thead>
<tr>
<th>CHART or ACO</th>
<th>Trust Fund Source</th>
<th>Applicant Entity</th>
<th>HPC Funding</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACO</td>
<td>PRTF</td>
<td>Community Care Cooperative (C3)</td>
<td>$750,000.00</td>
</tr>
<tr>
<td>ACO</td>
<td>PRTF</td>
<td>Boston Medical Center</td>
<td>$542,883.53</td>
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<tr>
<td>ACO</td>
<td>PRTF</td>
<td>Steward Health Care Network, Inc</td>
<td>$745,350.96</td>
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<tr>
<td>ACO</td>
<td>PRTF</td>
<td>Baystate Health Care Alliance</td>
<td>$750,000.00</td>
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<tr>
<td>Part of ACO</td>
<td>PRTF</td>
<td>Hebrew Senior Life</td>
<td>$500,000.00</td>
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<tr>
<td>Part of ACO</td>
<td>PRTF</td>
<td>Holyoke Health Center</td>
<td>$565,422.00</td>
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<tr>
<td>CHART</td>
<td>DHTF</td>
<td>Lowell General Hospital</td>
<td>$606,609.00</td>
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<tr>
<td>CHART</td>
<td>DHTF</td>
<td>BID Plymouth</td>
<td>$742,407.02</td>
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<tr>
<td>CHART</td>
<td>DHTF</td>
<td>Beverly/Addison Gilbert</td>
<td>$750,000.00</td>
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<tr>
<td>N/A</td>
<td>DHTF</td>
<td>UMass Memorial Medical Center</td>
<td>$750,000.00</td>
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<tr>
<td>CHART</td>
<td>DHTF</td>
<td>Harrington Memorial Hospital</td>
<td>$486,580.00</td>
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<tr>
<td>CHART</td>
<td>DHTF</td>
<td>Mercy Medical Center</td>
<td>$516,048.00</td>
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<tr>
<td>CHART</td>
<td>DHTF</td>
<td>Holyoke Medical Center</td>
<td>$750,000.00</td>
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<td>N/A</td>
<td>DHTF</td>
<td>MGH</td>
<td>$550,000.00</td>
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<tr>
<td>N/A</td>
<td>DHTF</td>
<td>North Shore Medical Center</td>
<td>$750,000.00</td>
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**Note:** All proposed recommendations are contingent on successful contracting between Awardees and HPC.
Geography of SHIFT-Care Recommended Awards

- **CHART Hospital**
- **ACO**
- **Non CHART Hospital or Part of ACO**
Addressing Health-Related Social Needs Recommended Proposals

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
Timely Access to Behavioral Health Recommended Proposals

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
Initiation of Pharmacologic Treatment in the ED Recommended Proposals

<table>
<thead>
<tr>
<th>8 initiatives</th>
<th>Recommended for funding</th>
</tr>
</thead>
<tbody>
<tr>
<td>27 Partner Organizations</td>
<td>In proposed HPC funding</td>
</tr>
</tbody>
</table>

**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

<table>
<thead>
<tr>
<th>12,000+ patients</th>
<th>In proposed target populations</th>
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<tr>
<td>$7.8 million</td>
<td>in initiatives’ total costs</td>
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</table>

**In proposed HPC funding**
- $5.2 million

**Total costs**
- $7.8 million
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.

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

The model consists of the following steps:

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

- **Identify patients**
  - Patient presents with history or symptoms of OUD or overdose

- **Enroll in program**
  - SW/CHW/Nurse recommends patient to program
  - ED physician or other qualified prescriber initiates pharmacological treatment for OUD

- **Initiate pharmacological treatment**
  - SW/CHW/Nurse enrolls patient in program, with patient consent

- **Engage in recovery services**
  - 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

Investment procurement released

Board vote on RFP

Info session webinar

Responses due

Review and Selection Committee Process

Board vote on awards

Contracting

Contract Execution/Preparation Period begins

Implementation Period begins

2018/2019

Jan  Feb  Mar  Apr  May  Jun  Jul  Aug  Sep  Oct  Nov  Dec  Jan
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.
Community Care Cooperative (C3)

**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 (C3)**

**Primary Aim**

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**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.
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**Total Initiative Cost**

- Requested HPC Funding: $750,000
- Applicant Contribution: $327,571
- Grand Total Cost of the Initiative: $1,077,571
Steward Health Care Network, Inc

**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 health-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

**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.

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

**Health-related social needs**
- HPC Certified ACO: Yes
- CHART Hospital: No
Hebrew Senior Life

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
### Holyoke Health Center

*Partners: BHN*

<table>
<thead>
<tr>
<th>Primary Aim</th>
<th>Total Initiative Cost</th>
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</table>
| Reduce readmissions by 30% compared to baseline. | • Requested HPC Funding: $565,422  
  Applicant Contribution: $188,474  
  • Grand Total Cost of the Initiative: $753,896 |

| Target Population | • Behavioral health needs <br> Reimbursement: Yes  
  HPC Certified ACO: Yes  
  CHART Hospital: No |
<table>
<thead>
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<tbody>
<tr>
<td>Approximately 2,800 non-ACO Holyoke Health Center patients with a psychiatric diagnosis.</td>
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<table>
<thead>
<tr>
<th>Care Model</th>
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<tr>
<td>▪ 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.</td>
</tr>
<tr>
<td>▪ 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.</td>
</tr>
<tr>
<td>▪ Funds support an expansion of the NP psychiatric prescribing clinic at Holyoke. Highly complex patients are referred to BHN’s psychiatry clinic, City Clinic.</td>
</tr>
<tr>
<td>▪ 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.</td>
</tr>
<tr>
<td>▪ Evaluation will use baseline and control group comparisons.</td>
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</table>
Lowell General Hospital

**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

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

**Behavioral health needs**
- HPC Certified ACO: Yes
- CHART Hospital: Yes
Beth Israel Deaconess Hospital-Plymouth

*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

**OUD treatment in the ED**
- HPC Certified ACO: Yes
- CHART Hospital: Yes
Beverly/Addison Gilbert Hospitals

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
UMass Memorial Medical Center

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
Harrington Memorial Hospital

**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.

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

**Partners: Harrington Hospital Outpatient Behavioral Health Services, Southbridge Police Department,**
Mercy Medical Center

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 recovery 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

**OUD treatment in the ED**
- HPC Certified ACO: Yes
- CHART Hospital: Yes
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.
Massachusetts General Hospital

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

OUD treatment in the ED
HPC Certified ACO: Yes
CHART Hospital: No
North Shore Medical Center

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 waiving 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

HPC Certified ACO: Yes
CHART Hospital: No