BOSTON HEALTH CARE *for the* HOMELESS PROGRAM

5Ps to Building Accountable Collaborations: Partnerships, Person-centeredness, Pitch, Performance, and Payment

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National Health Care for the Homeless Conference

Washington, D.C.

June 23, 2017

Q. What is an Accountable Care Organization?

A. An Accountable Care Organization is a group of health care providers, potentially including doctors, hospitals, health plans and other health care constituents, who voluntarily come together to provide coordinated high-quality care, cost efficient care to populations of patients.

Accountability for High Costs, High Needs Homeless Populations

I. BHCHP patients are complex:

- 68% mental illness
- 60% substance use disorders (SUD)
- 48% co-occurring mental illness & SUD
- High prevalence of medical illnesses, e.g. HCV (23%) & HIV (6%)
- High prevalence of chronic illnesses, e.g. 37% hypertension, 26% COPD or asthma, &18% diabetes mellitus
- Disease burden = DxCG score of 3.8

II. BHCHP patients are costly:

- $2036 PMPM vs. $568 for all MassHealth members
- > 1/3 had 6 or more ED visits/yr; 1/5 had 3 or more hospitalizations
- 10% population accounted ~50% total expenditures

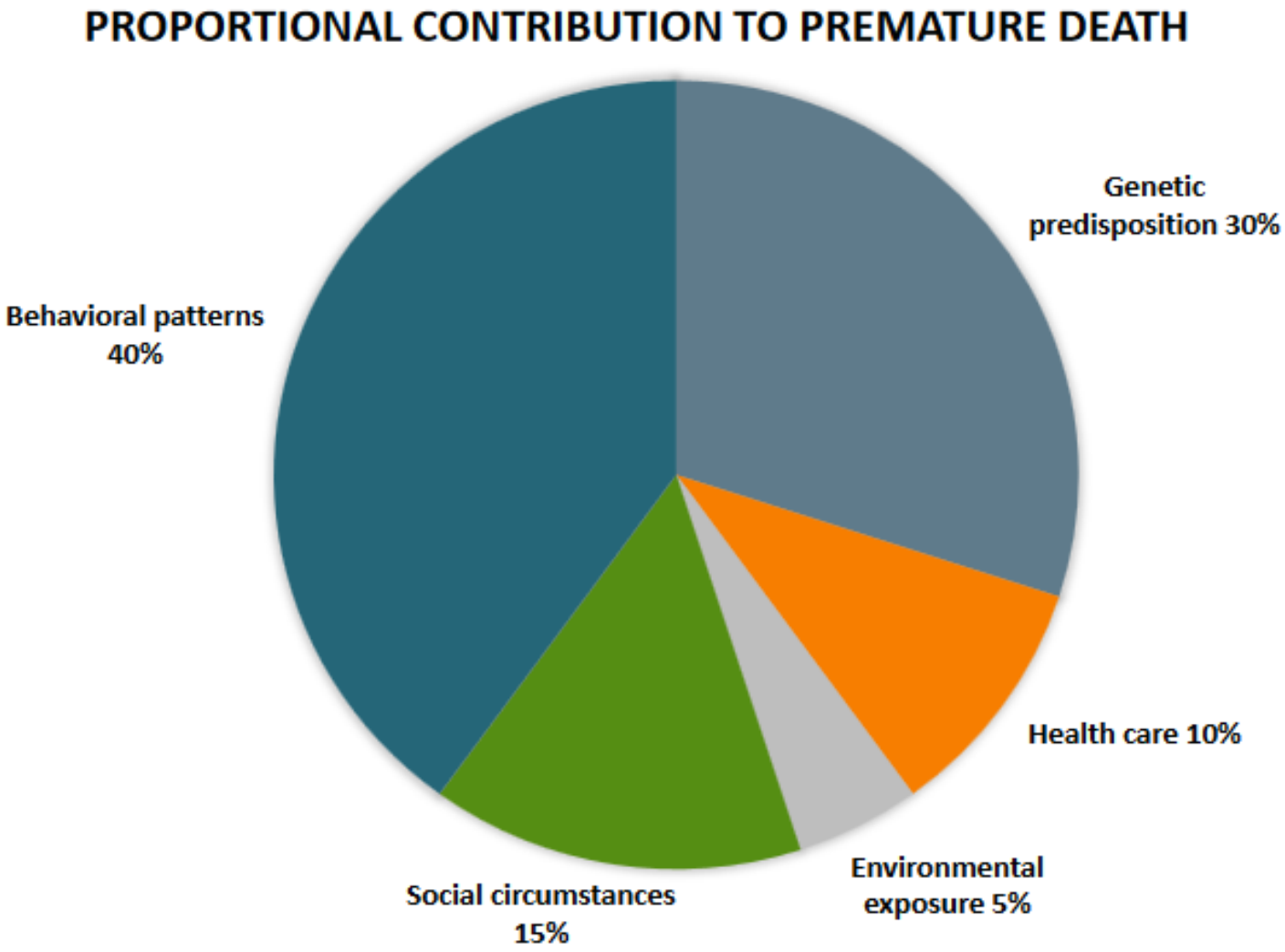
Bharel, M., et al., Health care utilization patterns of homeless individuals in Boston: preparing for Medicaid expansion under the Affordable Care Act. Am J Public Health, 2013. ***103 Suppl 2****: p. S311-7*

Massachusetts Snapshot

- Chapter 58 of the Acts of 2006: “Near“ universal health insurance coverage: #1 in USA
- Chapter 224 of the Acts of 2012: Improving the Quality of Health Care and Reducing Cost Growth: 2013-2015 Benchmark for cost growth set at 3.6%
  - 2014 - 2015: 4.1%
  - 2013 - 2014: 4.2%
- Medicaid almost 40% ($15B+) of the state’s budget
- Current Medicaid Delivery System Reform Investment Program (DSRIP) waiver ends 6/2017. Opportunity to leverage $1.5B federal and reform delivery system
- Massachusetts Medicaid pioneering SDH risk adjustment for ACO and MCO capitation rates (http://www.mass.gov/eohhs/docs/eohhs/healthcare-reform/masshealth-innovations/1610-umass-modeling-sdh-summary-report.pdf)

1. Partnerships

Role of Primary Care in Health Outcomes



McGinnis et al. The case for more active policy attention to health promotion. Health Affairs. 2002;21(2):78-93.

Graphic from:
http://www.orpca.org/APCM/SDH%20Webinar%20Slides%20for%20Redistribution%20Final_1.pdf

SDH Consortium

- Boston Health Care for the Homeless Program
- Bay Cove Human Services
- Boston Public Health Commission
- Boston Rescue Mission
- Casa Esperanza
- Massachusetts Housing and Shelter Alliance
- New England Center and Home for Veterans
- Pine Street Inn
- St. Francis House
- Victory Programs

Formalizing Partnerships

- Organized Health Care Arrangement (OHCA)
  - Legal agreement that binds our organizations and enables sharing PHI across health care, mental health, substance use, housing, shelter & social service providers
  - Links to City of Boston's Continuum of Care
  - Establishes formal governance procedures
  - Legal co$t$. Grant funding helped.
  - Positioned us to leverage partnerships to bid on proposals

Targeted Cost Challenge Investment Awardee Highlight:
Boston Health Care for the Homeless Program

BOSTON HEALTH CARE *for the* HOMELESS PROGRAM

Challenge Area	Proposed Award
Social Determinants of Health	$750,000

Partners

- Bay Cove Human Services
- Boston Public Health Commission
- Boston Rescue Mission
- Casa Esperanza
- Massachusetts Housing and Shelter Alliance
- The New England Center and Home for Veterans
- Pine Street Inn
- St. Francis House
- Victory Programs

Primary Aim

Reduce ED visits and admissions by 20% for high cost and high need homeless patients

Innovative Model

Coordinated care hub for primary care, behavioral health care, housing agencies and shelters, and social services providers

BHCHP will serve as a hub for a team of primary, acute, and specialty medical providers along with shelters, and advocacy organizations to identify patients, track utilization, and provide intensive case coordination for patients whose needs and day-to-day paths span many types of services and providers.

Evidence Base

- Yamhill Community Care Organization's Community Hub, Oregon; 2015
- Veteran's Health Administration's Homeless Patient Aligned Care Team Program, USA; 2016

Total Initiative Cost	Estimated Savings
$919,085	$1,496,000

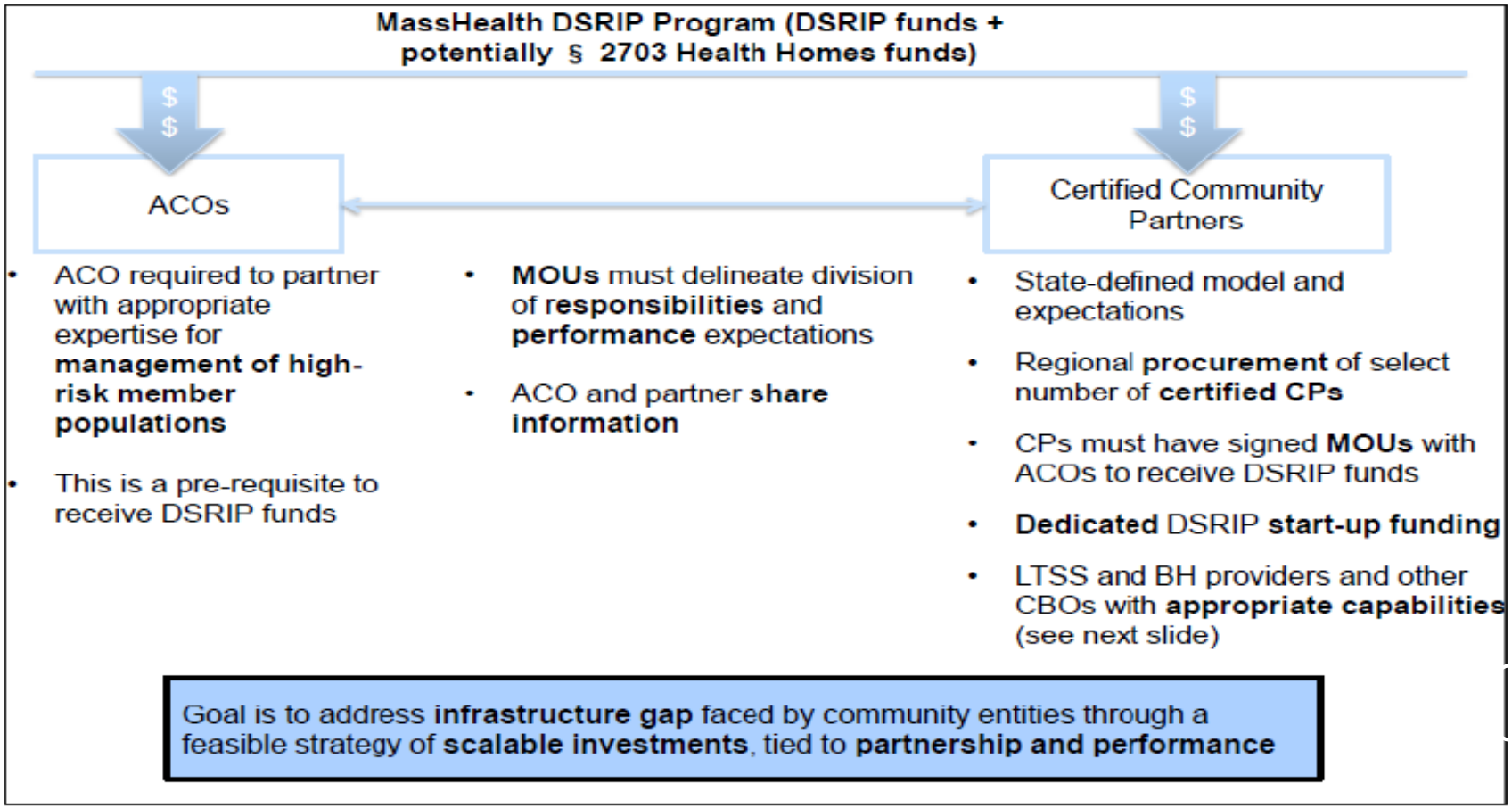
HPC

59

Source: Health Policy Commission Board Meeting, July 27, 2016

MassHealth Community Partners aka Health Homes

Community Partners are a Required Network Partner for ACOs



SOURCE: MH Payment and Care Delivery Transformation: Strategic Design Workgroup , 1/28/16

2. Person-centeredness

Person-centered design principles

- Focus on meeting SDH needs as strategy to reduce hospital/ED utilization
- Input from Consumer Advisory Board with representation from partner organizations
- Opt in: Would you like us to help you stay out of the hospital?
- Decentralized case management:
  - Assignments based on existing relationships
  - Coordinated case management: reduce redundancy
- Patient reported outcomes: Arizona Self Sufficiency Matrix
- Integrated care teams
- Integrated care plan with patient self function goal improvement
  - Case conferences to develop plan with patient ideally

'SDH Coordinated Care Hub for Homeless Adults' Service Delivery Model

Planning
January - April 2017

May - July 2017

Implementation
June 2017 - December 2018

Identify Target Pts

Jan.-Feb. 2017
Review claims & encounter data to ID target pts

BHCHP will produce list of pts:
- Attributed to BHCHP
- Top 10% Medicaid costs
- 6 or > ED visits last 6 mos.
- 2 or > hospital adm last 6 mos

Feb.-March 2017
Determine CM sites with existing relationships

SDH org reviews pt list & using chart review identifies:
- How is patient using system?
- Are there existing robust relationships?

March 2017
Assign CM Organization

Consortium meets to assign pts to CM site

March-April 2017
Projects staff needs

SDH org plans staffing needs
- Assigns CMs
- Develops contingency plan for CM turnover, weekends/eves

May 2017
Train staff

BHCHP develops & hosts training for SDH CMs& PCMHs

Find & Enroll Pts

Pt in hospital.....
BHCHP RN navigator reviews census, EHR, communicates with BHCHP hospital-based RNS, hospitals, & health plans to determine if pt in hospital
- RN obtains consent
- Notifies SDH CM same day
- Makes PCMH appt within 7 days post d/c , optimally accompanied by SDH CM
- uploads PHI, consent, pt appt, other info in ETO

Pt in BHCHP clinics.....
BHCHP RN navigator determines if pt has PCMH appt via EHR
- RN or PCMH obtains consent
- Notifies SDH CM same day
- uploads PHI, consent,… in ETO

Pt on street.....
BHCHP RN navigator works with BHCHP Street Team
- RN or Street Team obtains consent
- Notifies SDH CM same day
- uploads PHI, consent,… in ETO

Pt is housed.....
BHCHP RN navigator works with PCMH to set up home visit
- RN or PCMH obtains consent
- Notifies SDH CM same day
- uploads PHI, consent,… in ETO

Pt in shelter.....
BHCHP RN uses ETO data to track pt
- RN, PCMH, or SDH org obtains consent
- Notifies SDH CM same day
- uploads PHI, consent,… in ETO

Pt accessing SDH org services.....
SDH org reviews own data to find pt
- SDH CM obtains consent, uploads consent in ETO, & notifies BHCHP RN Navigator same day
- BHCHP RN uploads PHI, other data in ETO

Engage Pts

Within 3 days of consent.....
SDH CM meets with pt
- Meets basic needs (e.g. socks)
- Identify key members of pt's circle (trusted family, friends)
- Perform intake assessment including pt self-function
- Determine pt's short range goals
- Documents care, upload assessments in ETO

Every week.....
SDH CM meets with pt face to face (optimal), connects by phone, text
- DOCUMENTS ALL ENCOUNTERS
- Refers/connects to SDH services, City housing queue
- Attends weekly calls with BHCHP RN Navigator & PCMH
- Reviews portal info

Within first month.....
SDH CM
- Schedules & executes with BHCHP RN Navigator case conference with PCMH team & pt
- With pt & PCMH team, creates pt centered care plan, upload in ETO
- Conducts home visit if housed

Every 6 months.....
SDH CM
- Updates care plan, self-fxn assessment; uploads in ETO

Ongoing.....
BHCHP RN Navigator monitors transitions of care:

Pt in hospitalization, BMH, Detox, Psych facility.....
- Notifies SDH CM same day
- Assists facility with discharge (d/c) planning
- Notifies PCMH. Makes PCMH appt within 7 days post d/c , optimally accompanied by SDH CM

Pt becomes housed.....
- RN & SDH CM makes joint home visit, assess pt needs within one week

Ongoing.....
SDH CM:
- Accompanies pt on appts: medical, BH, housing, etc.
- Works with pt toward reaching care plan goals

Pt in hospitalization, BMH, Detox, Psych facility.....
- Visits pt in facility (optimal); or within 3 days after d/c

Pt becomes housed.....
- RN & SDH CM makes joint home visit, assess pt needs within one week

Track & Share Data

By May 2017.....
BHCHP Staff:
- Develop with City & Green River data sharing platform
- Develop data dashboard for pop health monitoring

Ongoing.....
- **BHCHP RN Navigator** monitors ETO portal, connects with BHCHP Sr. team. PCMHs, CMs
- **BHCHP Sr. team** reviews dashboard, address issues

Ongoing.....
SDH CM:
- SDH org oversees own CM performance & capacity

Ongoing.....
Consortium: meet monthly to review data dashboard, assess progress, brainstorm problems

1/2017

Arizona Self Sufficiency Matrix

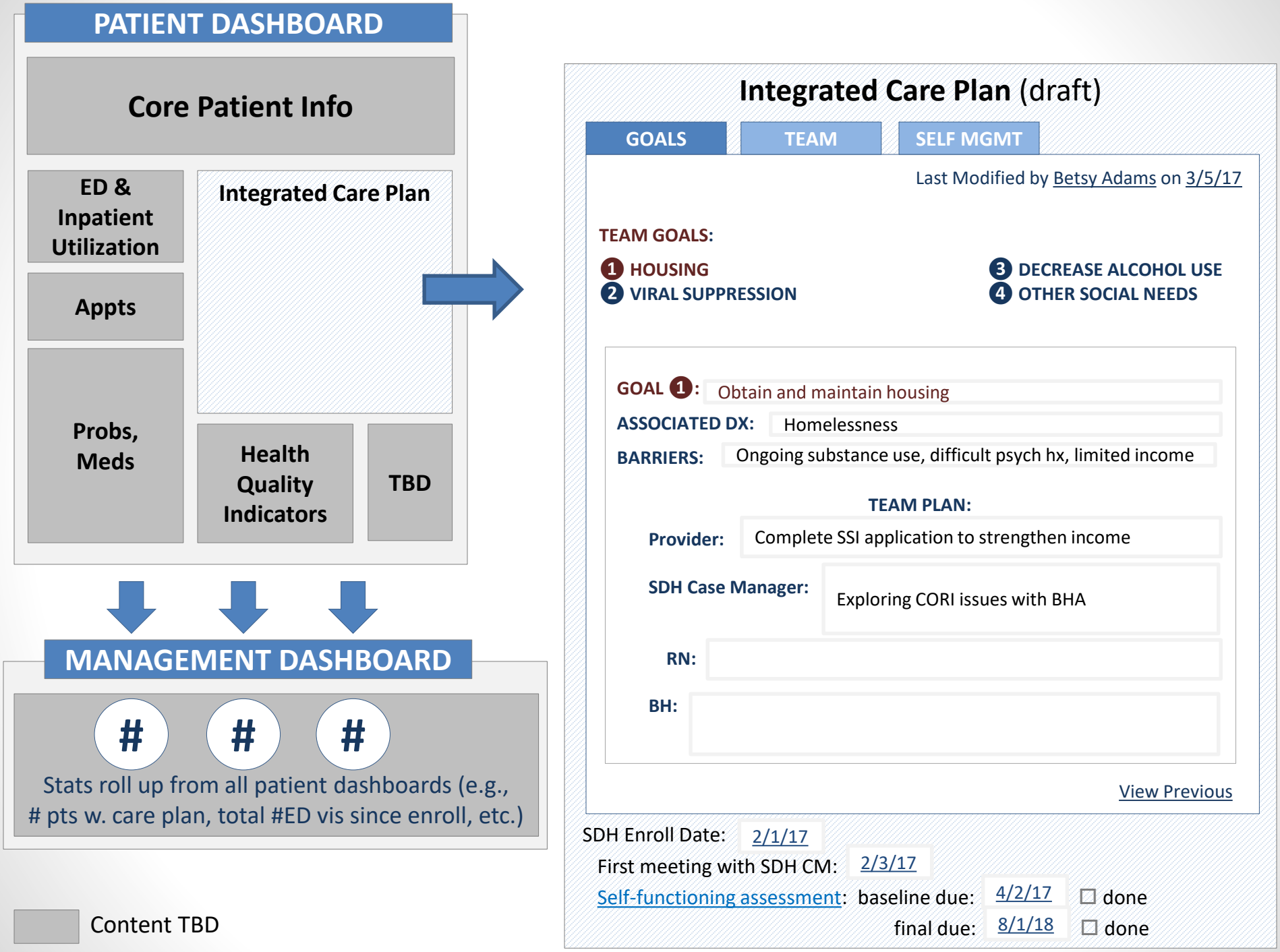
Self-Sufficiency Matrix Participant Name _____ DOB __/__/____ Assessment Date __/__/____ Initial Interim Exit

(If using ServicePoint) Program Name _____ HMIS ID _____

Domain	1	2	3	4	5	Score	Participant goal? (✓)
Housing	Homeless or threatened with eviction.	In transitional, temporary or substandard housing; and/or current rent/mortgage payment is unaffordable (over 30% of income).	In stable housing that is safe but only marginally adequate.	Household is in safe, adequate subsidized housing.	Household is safe, adequate, unsubsidized housing.		
Employment	No job.	Temporary, part-time or seasonal; inadequate pay, no benefits.	Employed full time; inadequate pay; few or no benefits.	Employed full time with adequate pay and benefits.	Maintains permanent employment with adequate income and benefits.		
Income	No income.	Inadequate income and/or spontaneous or inappropriate spending.	Can meet basic needs with subsidy; appropriate spending.	Can meet basic needs and manage debt without assistance.	Income is sufficient, well managed; has discretionary income and is able to save.		
Food	No food or means to prepare it. Relies to a significant degree on other sources of free or low-cost food.	Household is on food stamps.	Can meet basic food needs, but requires occasional assistance.	Can meet basic food needs without assistance.	Can choose to purchase any food household desires.		
Child Care	Needs childcare, but none is available/accessible and/or child is not eligible.	Childcare is unreliable or unaffordable, inadequate supervision is a problem for childcare that is available.	Affordable subsidized childcare is available, but limited.	Reliable, affordable childcare is available, no need for subsidies.	Able to select quality childcare of choice.		
Children's Education	One or more school-aged children not enrolled in school.	One or more school-aged children enrolled in school, but not attending classes.	Enrolled in school, but one or more children only occasionally attending classes.	Enrolled in school and attending classes most of the time.	All school-aged children enrolled and attending on a regular basis.		
Adult Education	Literacy problems and/or no high school diploma/GED are serious barriers to employment.	Enrolled in literacy and/or GED program and/or has sufficient command of English to where language is not a barrier to employment.	Has high school diploma/GED.	Needs additional education/training to improve employment situation and/or to resolve literacy problems to where they are able to function effectively in society.	Has completed education/training needed to become employable. No literacy problems.		
Health Care Coverage	No medical coverage with immediate need.	No medical coverage and great difficulty accessing medical care when needed. Some household members may be in poor health.	Some members (e.g. Children) have medical coverage.	All members can get medical care when needed, but may strain budget.	All members are covered by affordable, adequate health insurance.		
Life Skills	Unable to meet basic needs such as hygiene, food, activities of daily living.	Can meet a few but not all needs of daily living without assistance.	Can meet most but not all daily living needs without assistance.	Able to meet all basic needs of daily living without assistance.	Able to provide beyond basic needs of daily living for self and family.		
Family /Social Relations	Lack of necessary support form family or friends; abuse (DV, child) is present or there is child neglect.	Family/friends may be supportive, but lack ability or resources to help; family members do not relate well with one another; potential for abuse or neglect.	Some support from family/friends; family members acknowledge and seek to change negative behaviors; are learning to communicate and support.	Strong support from family or friends. Household members support each other's efforts.	Has healthy/expanding support network; household is stable and communication is consistently open.		

Domain	1	2	3	4	5	Score	Participant goal? (✓)
Mobility	No access to transportation, public or private; may have car that is inoperable.	Transportation is available, but unreliable, unpredictable, unaffordable; may have car but no insurance, license, etc.	Transportation is available and reliable, but limited and/or inconvenient; drivers are licensed and minimally insured.	Transportation is generally accessible to meet basic travel needs.	Transportation is readily available and affordable; car is adequately insured.		
Community Involvement	Not applicable due to crisis situation; in "survival" mode.	Socially isolated and/or no social skills and/or lacks motivation to become involved.	Lacks knowledge of ways to become involved.	Some community involvement (advisory group, support group), but has barriers such as transportation, childcare issues.	Actively involved in community.		
Parenting Skills	There are safety concerns regarding parenting skills.	Parenting skills are minimal.	Parenting skills are apparent but not adequate.	Parenting skills are adequate.	Parenting skills are well developed.		
Legal	Current outstanding tickets or warrants.	Current charges/trial pending, noncompliance with probation/parole.	Fully compliant with probation/parole terms.	Has successfully completed probation/parole within past 12 months, no new charges filed.	No active criminal justice involvement in more that 12 months and/or no felony criminal history.		
Mental Health	Danger to self or others; recurring suicidal ideation; experiencing severe difficulty in day-to-day life due to psychological problems.	Recurrent mental health symptoms that may affect behavior, but not a danger to self/others; persistent problems with functioning due to mental health symptoms.	Mild symptoms may be present but are transient; only moderate difficulty in functioning due to mental health problems.	Minimal symptoms that are expectable responses to life stressors; only slight impairment in functioning.	Symptoms are absent or rare; good or superior functioning in wide range of activities; no more than every day problems or concerns.		
Substance Abuse	Meets criteria for severe abuse/dependence; resulting problems so severe that institutional living or hospitalization may be necessary.	Meets criteria for dependence; preoccupation with use and/or obtaining drugs/alcohol; withdrawal or withdrawal avoidance behaviors evident; use results in avoidance or neglect of essential life activities.	Use within last 6 months; evidence of persistent or recurrent social, occupational, emotional or physical problems related to use (such as disruptive behavior or housing problems); problems have persisted for at least one month.	Client has used during last 6 months, but no evidence of persistent or recurrent social, occupational, emotional, or physical problems related to use; no evidence of recurrent dangerous use.	No drug use/alcohol abuse in last 6 months.		
Safety	Home or residence is not safe; immediate level of lethality is extremely high; possible CPS involvement.	Safety is threatened/temporary protection is available; level of lethality is high.	Current level of safety is minimally adequate; ongoing safety planning is essential.	Environment is safe, however, future of such is uncertain; safety planning is important.	Environment is apparently safe and stable.		
Disabilities	In crisis – acute or chronic symptoms affecting housing, employment, social interactions, etc.	Vulnerable – sometimes or periodically has acute or chronic symptoms affecting housing, employment, social interactions, etc.	Safe – rarely has acute or chronic symptoms affecting housing, employment, social interactions, etc.	Building Capacity – asymptomatic – condition controlled by services or medication	Thriving – no identified disability.		
Other (Optional)	In Crisis	Vulnerable	Safe	Building Capacity	Empowered		

https://aspe.hhs.gov/report/toward-understanding-homelessness-2007-national-symposium-homelessness-research-accountability-cost-effectiveness-and-program-performance-progress-1998/case-study-arizona-evaluation-project


PATIENT DASHBOARD
Core Patient Info
ED & Inpatient Utilization
Appts
Probs, Meds
Integrated Care Plan
Health Quality Indicators
TBD
MANAGEMENT DASHBOARD
# # #
Stats roll up from all patient dashboards (e.g., # pts w. care plan, total #ED vis since enroll, etc.)
Content TBD
Integrated Care Plan (draft)
GOALS
TEAM
SELF MGMT
Last Modified by Betsy Adams on 3/5/17
TEAM GOALS:
1 HOUSING
2 VIRAL SUPPRESSION
3 DECREASE ALCOHOL USE
4 OTHER SOCIAL NEEDS
GOAL 1: Obtain and maintain housing
ASSOCIATED DX: Homelessness
BARRIERS: Ongoing substance use, difficult psych hx, limited income
TEAM PLAN:
Provider: Complete SSI application to strengthen income
SDH Case Manager: Exploring CORI issues with BHA
RN:
BH:
View Previous
SDH Enroll Date: 2/1/17
First meeting with SDH CM: 2/3/17
Self-functioning assessment: baseline due: 4/2/17 done
final due: 8/1/18 done

Integrated Care Plan (draft)

GOALS | TEAM | SELF MGMT

Last Modified by Betsy Adams on 3/5/17

TEAM GOALS:

1. **HOUSING**
2. **VIRAL SUPPRESSION**
3. **MAINTAIN SOBRIETY**
4. **OTHER SOCIAL NEEDS**

GOAL 4: Other social needs

OTHER SOCIAL NEEDS: GOALS

Food Insecurity Obtain SNAP	**Utility Needs** Obtain cell phone	**Financial Resources** Seek childcare assistance	**Transit & Mobility** Improve access to appt transit
Exposure to Violence Discuss with psych	**Education** Improve health literacy	**Employment** Review any job training interests	**Social Support** Supports at day program

Social Needs Goals last reviewed by SDH Case Manager: 2/5/17

View Previous

GOALS:
Not task-level detail here… Tasks can go in the case manager's normal documentation

Integrated Care Plan (draft)

GOALS | TEAM | SELF MGMT

Last Modified by Betsy Adams on 3/5/17

TEAM MEMBERS

PROVIDER (MD/NP/PA)

Jessie Gaeta, MD
BHCHP
Last vis: 2/21/17

SDH CASE MANAGER

Janet Chu
St. Francis House
Last vis: 3/4/17

NURSE CARE MANAGER

Jane Staunton, RN
BHCHP-SFH
Last vis: 3/1/17

BEHAVIORAL HEALTH

Derri Schtashel, MD
BHCHP
Last vis: 1/17/17

Emily Cunha, LICSW
St. Francis House
Last vis: 2/15/17

OTHER IMPORTANT CONTACTS

FAMILY/FRIENDS:

SPECIALISTS:

OTHER:

PREVIOUS CASE MANAGER:

View Previous

Team Case Conferences for this Patient:

Last: 2/21/17 Next: 3/15/17

Integrated Care Plan (draft)

GOALS | TEAM | SELF MGMT

Last Discussed between patient and Betsy Adams on 3/5/17

PATIENT SELF-MANAGEMENT GOAL:

1 TAKE MEDICATIONS EVERY DAY

GOAL: Take medications every day

ASSOCIATED DX: HIV/AIDS

BARRIERS: Ongoing substance use, transit issues, lack of housing

Goal Details: Set up a reminder alarm on my phone to see if that helps, and come to clinic each Monday morning to set up my pill box.

Confidence: On a scale of 1 to 10, how confident are you that you can meet your goal?

1 2 3 4 5 **6** 7 8 9 10

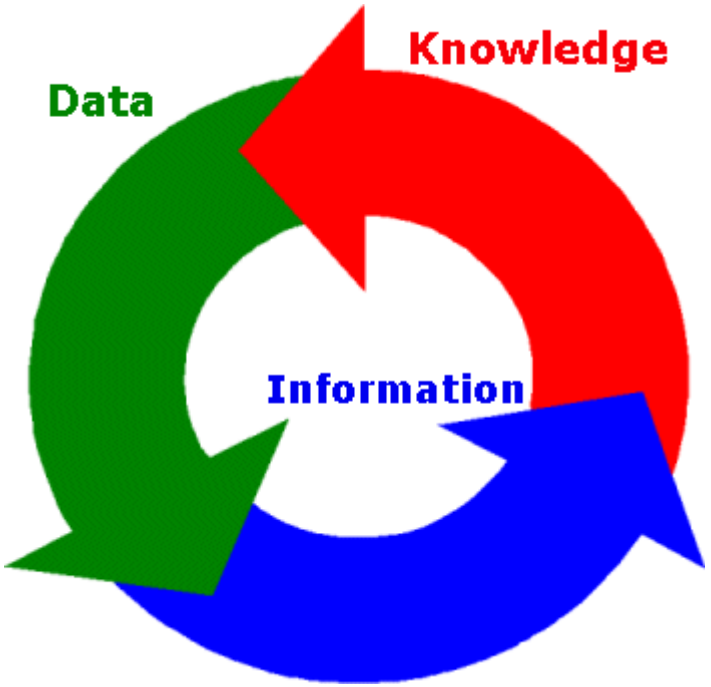
View Previous

3. Pitch

Marketing our approach

- Reduce unnecessary ED and hospital utilization by 20% each: $919k investment, $1.5 million estimated health system savings
  - Transitions of care: Acute care, psychiatric facilities, medical respite
  - Medication reconciliation/adherence
- FFS and Managed Care patients
- Find and engage patients
  - High functioning collaborations e.g. meningitis outbreak
  - HMIS Data
  - Face to face connections; small caseloads
- Integrated case teams
  - PCMH teams + SDH Organizations
  - Reduce case management redundancy
  - Shared physical, behavioral, social services info via data platform
- Scalable foundation to transition to larger population focus

4. Performance



Key Performance Indicators: SDH Coordinated Care Hub

Health Care Utilization Metrics

- % change in total # ED visits
- % change in total # hospital admissions
- % change in hospital all-cause readmissions
- % change in average time to readmission

Health Care Quality Metrics

- High blood pressure control
- Comprehensive diabetes care: A1c control
- Comprehensive diabetes care: blood pressure control
- Screening for clinical depression & follow-up
- Members with current opioid addiction who were counseled regarding psychosocial AND pharmacologic treatment options
- Screening for breast cancer, cervical cancer, and colorectoral cancer (for relevant patient groups)

Social Determinants of Health Metrics

- Improvement in housing status
- SDH service access measure
- Initiation of alcohol/other drug treatment
- Engagement in alcohol/other drug treatment
- Improvement in patient self-functioning

Process Metrics

- # case conferences completed
- % target population enrolled in initiative
- % patients that meet within 72 hours of enrollment with case manager
- % patients that have PCMH appointment within 1 week post hospital discharge
- # of weekly engagement touches
- Patient retention rate
- % of enrolled patients who have a care plan uploaded to portal within 60 days of enrollment

For further detail with data specifications, see HPC grant contract.

Data, data, data and more data

- Shared data platform with Integrated Care Plan, dashboard—patient-, case manager-, site-, pop health-level
- Shared limited amount of PHI (med list, problem list, upcoming appts, etc.) with partner organizations—giving SDH case managers info to enhance care
- Shared care management software (Efforts to Outcomes (ETO))—reducing case management redundancy
- Notifications to Integrated Care Teams: real time communication
- HMIS to locate where patients are sleeping, establish service baseline
- Tracking systems: ASSM, engagement touches, HMIS, etc.
- Hospital-based RNs to review daily census data to facilitate transitions, notify teams
- Epic EHR in widespread use
- Documentation standards

5. Payment

Funding streams

$750K/2 years Massachusetts Health Policy Commission grant

- $325 PMPM/18 months BHCHP pass through to partner organizations based on 15:1 caseloads
- $10,000/2 years to partner organizations for administrative support
- $213,000/2 years BHCHP administrative support including director, RN navigator, data analyst, training support, data platform, etc.

It takes a village and more but the potential to improve care delivery for our patients is exciting

- Complex, high costs chronically ill homeless men and women require integrated systems
- Relationships matter esp. funders
- Rethink the ways we work both within and outside our walls
- Leverage what's out there
- Measure what we do to justify the need for existing and new resources and services
- 60 to 1000 in a year building on the lessons learned in this pilot.
- Advancing our relevance in complex, dynamic health systems

For more information:

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Barry Bock bbock@bhchp.org

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