### A Reference Document for Population Health Management Programs for Patients in the Medicaid ACO at MGH.

MGH/MGPO Medicaid ACO Team

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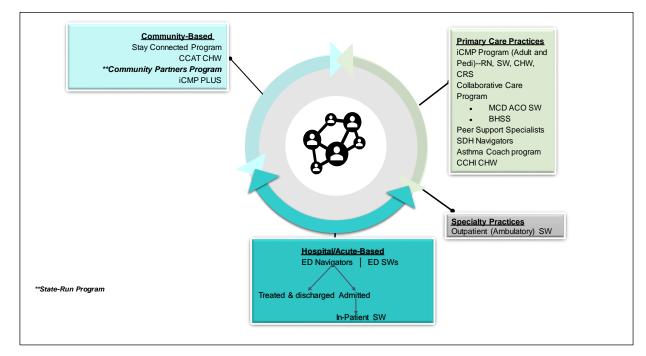
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### **OVERVIEW**

This document serves as a reference guide to EPIC workflows of various care coordination programs to help create synergy across patient care coordination programs that interface with Medicaid ACO patients at MGH.



### PROGRAMS EMBEDDED IN PRIMARY CARE PRACTICES

#### Adult Integrated Care Management Program (iCMP)

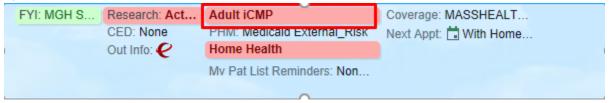
**Role Groups**: Registered Nurse (RN), Social Worker (SW), Community Health Worker (CHW), and Community Resource Specialist (CRS).

**Responsibilities**: Care coordination with patient centered medical and mental health clinical goals (CM and SW), resource navigation (CRS), psychosocial support (CHW and SW), motivational interviewing and behavioral change (CHW).

#### Program Snapshot

Summary/Overview	iCMP is a primary care practice-based service designed to support patients			
	in achieving improved health and well-being.			
Administrative	Debra Birkenstamm, Nursing Director			
Contact(s)				
Payor Eligibility	All Payors			
Program Eligibility	Partners PCP			
	Meets high risk score			
Referral	All referrals are submitted via EPIC by a Partners PCP			

#### Epic Banner identifier



#### Patient Care Coordinator Note

The role group leading the care management, updates the patient care coordinator note.

#### Patient Care Coordination Note

#### Lacey Hochman, LICSW Fri Apr 5, 2019 11:45 AM

Patient is high risk for these reasons: has had a progressive degeneration of her functional status and is now barely able to transfer. She is wheelchair bound. She is now disabled

#### Care Team

Joanne Marie Doyle Petrongolo	Pager: 36760 Phone: 617-643-7672	iCMP Pharmacist	6/10/2019
Jyl Baker Dedier, RN	Phone: 617-724-2277	Primary Infusion Nurse	10/3/2014
Katayoon Goodarzi, MD	Pager: 20216 Phone: 617-724-4000	Attending Physician Hematology and Oncology	10/3/2014
Lacey Hochman, LICSW	Pager: 21312 Phone: 781-485-6306	iCMP Social Work	11/17/2017
Susan Lozzi, RN	Pager: 35483 Phone: 781-485-6403	iCMP Care Manager	11/20/2017

#### **Encounter Documentation**

Varies according to role group but all note types are associated with Care Management-MGH iCMP

07/16/2019	Patient Outreach	Internal Med - Doyle Pet	Care Coordination (iCMP RPh note- Eye drops on back order)	
07/05/2019	Social Work	Social Servi - Hochman, L	Support	
04/23/2019 l	Social Work	Social Servi - Hochman, L	Care Coordination	

#### 05/02/2019 🖻 Patient Outreach Care Managem - Leblan... DME (National Seating and Mobility)

#### Pediatric Integrated Care Management Program (iCMP)

**Role Groups**: Registered Nurse (RN), Social Worker (SW), Community Health Worker (CHW), and Community Resource Specialist (CRS).

**Responsibilities**: Case management with patient centered clinical goals/coordination (CM), resource navigation (CRS), psychosocial support (CHW), motivational interviewing and behavioral change (CHW).

#### Program Snapshot

Summary/Overview	Pedi iCMP is a primary care practice-based service designed to support medically complex patients in achieving improved health and well-being.	
Administrative	Lynn Doxey, Project Manager	
Contact(s)	Erin Swanton, Clinical Manager	
Payor Eligibility	All Payors	
Program Eligibility	MGH Pediatrician	
	Meets high risk criteria	
Referral	All referrals are submitted via EPIC by a Partners PCP	

#### Epic Banner identifier

Pediatric iCMP Coverage: MASSHEALTH/MASSHEALT	
PHM: Medicaid External_Risk	Next Appt: 📩 With Jennifer Levine Stock
Mv Pat List Reminders: None	

#### Patient Care Coordinator Note

Completed by the role group leading the care management (iCMP care manager).

#### Care Team

All role groups except the community resource specialist (CRS) add themselves to the care team.

					Last Refreshed: 7/11/2019 2:15 PM
are Team					
Provider	ED	Relationship	Speciality	Start	End
PCP(s)					
Holly Rothermel, MD		PCP - General	Pediatric Rheumatology, Pediatrics	7/1/2014	
Phone: 617-726-2728, Fax: 617-724-3948, Pager: 36296					
Other Patient Care Team Members					
Donna J Larkin, RN		iCMP Care Manager		11/29/2018	
Phone: 857-210-6387					
Holly Rothermel, MD		Insurance Assigned Provider	Pediatric Rheumatology, Pediatrics	3/4/2017	
Phone: 617-726-2728, Fax: 617-724-3948, Pager: 36296					

#### **Encounter Documentation**

05/21/2019 🗎	Patient Outreach	Care Managem - Canto, T	Care Coordination (REturning Call from CP and Mom)
05/15/2019	Patient Outreach	Care Managem - Canto, T	Care Coordination (Update)

#### Medicaid Social Workers

#### Program Snapshot

Summary/Overview	Part of the collaborative care team program that increases the capacity of primary care practices to manage and coordinate the care for patients. Typically engage with patients for 8-12 weeks to coordinate services but can have patients on their panel for as long as their coordination services are needed.			
Administrative Contact(s)	Sara Macchiano			
Payor Eligibility	Medicaid ACO only			
Program Eligibility	•			
Referral	<ul> <li>If patient is already engaged with a BHSS or ACO SW, reach out to their care team to facilitate an in-person connection with patient.</li> <li>New Referrals: EPIC In-Basket to BHSS or ACO SW to determine eligibility for program</li> </ul>			

#### EPIC Banner Identifier

MCD SW CM	Coverage: MASSHEALT
PHM: Medicaid External_Risk	Next Appt: None
My Pat List Reminders: None +	

#### Care Team

Yes, as ACO Social Worker

Maggie Elizabeth Dobbins, LCSW	Pager: 21624 Phone: 857-331-3431	ACO Social Worker	Behavioral Health	7/10/2019

#### Patient Care Coordinator Note

Have access and can add to the Patient Care Coordination note as needed.

#### Encounter Documentation

Engagement with Medicaid ACO social worker is documented by Social Work or Patient Outreach note types as Care Coordination notes with reason for the note in parentheses.

08/01/2019		Patient Outreach	Internal Med - Dobbins, M	Care Coordination (ACO SW Outreach)
07/12/2019	Ē	Patient Outreach	Internal Med - Dobbins, M	Care Coordination (BH CP Referral)
07/10/2019	Ē	Patient Outreach	Internal Med - Dobbins, M	Care Coordination (Referral Note)
03/13/2019	Ē	Patient Outreach	Internal Med - Dobbins, M	Care Coordination (ACO SW Outreach)
03/12/2019	Ē	Patient Outreach	Internal Med - Dobbins, M	Care Coordination (ACO SW Outreach)
03/06/2019	Ē	Social Work	Internal Med - Dobbins, M	Care Coordination (ACO SW Outreach)

#### Behavioral Health Support Specialists (BHSS)

**Responsibilities**: Assess practice patients with standardized tools and review with resident psychiatrist who then makes plan of care recommendations to patient's PCP.

#### Care modality: Telephonic outreach

#### Program Snapshot

Summary/Overview	Part of the collaborative care team program that increases the capacity of primary care practices to manage and coordinate the behavioral care needs for patients.				
Administrative Contact(s)	Sara Macchiano				
Payor Eligibility	All Payor				
Program Eligibility	<ul> <li>Patients with positive screenings on standard psych assessment tools</li> </ul>				
Referral	<ul> <li>If patient is already engaged with a BHSS or ACO SW, reach out to their care team to facilitate an in-person connection with patient.</li> <li>New Referrals: EPIC In-Basket to BHSS or ACO SW to determine eligibility for program</li> </ul>				

#### Epic Banner Identifier

None

#### Patient Care Coordination Note

N/A

#### Care Team

#### BHSS' add themselves to the care team as part of the Collaborative Care team

Care Team						
Provider	Contact Info	ED	Relationship	Speciality	Start	End
PCP(s)						
Benson Chu, MD, PhD	Pager: 13237 Phone: 781-485- 6300		PCP - General	Internal Medicine	7/1/2014	
Other Patient Care Te	am Members					
Benson Chu, MD, PhD	Pager: 13237 Phone: 781-485- 6300	49	Partners Attributed Provider	Internal Medicine	3/6/2016	
Benson Chu, MD, PhD	Pager: 13237 Phone: 781-485- 6300	40	Insurance Assigned Provider	Internal Medicine	5/7/2016	
Katarzyna Kozak	Pager: 22935 Phone: 617-394- 7586		Collaborative Care BH Support Specialist	4	1/29/2018	

#### **Encounter Documentation**

Engagement with BHSS is documented by Social Work note type and labelled as Collaborative Care Outreach.

02/28/2018	Social Work	Internal Med - Kozak, K	Collaborative Care
02/14/2018	Social Work	Internal Med - Kozak, K	Collaborative Care

#### Peer Support Specialists (Recovery Coaches)

#### Program Snapshot

Summary/Overview	Peer Support Specialists bridge inpatient and outpatient care with a supportive service role that is marked by their one-on-one engagement with patients. The level of engagement between a patient and their recovery coach can be noted in Epic by the frequency of contact. It is best to engage recovery coaches assigned to a patient care team on any care coordination inquiries directly.			
Administrative	Elizabeth Powell			
Contact(s)				
Payor Eligibility	All Payor			
Program Eligibility	Adults and Adolescents			
	SUDs program site specific—for MGH Health Centers, patients only need to have a health center PCP to be eligible for peer support specialist access.			
Referral	<ul> <li>Find a list of peer support specialists assigned to each practice site in Appendix I.</li> <li>Contact patient's health center PCP. See Appendix I.</li> </ul>			

#### Epic Banner identifier

None

#### Patient Care Coordination Note

None

#### Care Team

Yes

Nicholas John Desimone

Phone: 857-289-3063

Peer Support Specialist

3/26/2019

#### Encounter Documentation

Patient outreach by peer support specialists is documented as psychiatry note described as "*Peer Support Specialist Outreach*". Other encounters may be documented as telephonic outreach encounters.

03/26/2019 🗎	Patient Outreach	Psychiatry - Desimone, N	Peer Support Specialist Outreach
03/25/2019 🖹	Patient Outreach	Psychiatry - Desimone, N	Peer Support Specialist Outreach

#### Social Determinants of Health (SDH) Central Pool/SDH Navigators

#### Program Snapshot

Summary/Overview	SDH Navigators are present in most primary care practices and receive
	referrals of patients who screened positive per the SDH screening tools. They

	outreach to patients and provide resources where indicated. Their engagement is more of an episodic touchpoint.			
Administrative	Kristen Risley			
Contact(s)				
Payor Eligibility	All Payor			
Program Eligibility	• N/A			
Referral	<ul> <li>Positive screens active a referral order smartest to be approved by the PCP where appropriate.</li> </ul>			
	<ul> <li>See three things you should know about the SDH Screening process in Appendix IV.</li> </ul>			

#### Epic Banner Identifier

None

Patient Care Coordination Note N/A

Care Team N/A

#### Encounter Documentation

Engagement with SDH Navigators is documented by Patient Outreach note type and described as "Community Resources Outreach".

	When		Туре	With	Description	Disch Date	Prov Specialty	R
Rec	ent Visits							
	Yesterday		Patient Outr	Internal Med - Bonilla, C	Community Resources (Social Determin			
	Yesterday	¢	Telephone	Internal Med - Maraventano, S	Follow-up			
	07/15/2019	¢	Telephone	Internal Med - Maraventano, S				

#### Pediatric Asthma Coach

#### Program Snapshot

Summary/Overview	The Pediatric Asthma Coach engages patients at the clinic to provide education and informational resources as well as visiting patient homes to conduct environmental assessments to better understand the context of social, environmental and economic factors that may influence the patient's health. The coach and families will work together to achieve goals.				
Administrative Contact(s)	Jen Searl-Como				
Payor Eligibility	All payor				
Program Eligibility	<ul> <li>Pediatric patients (0-21 years)</li> <li>Patients attributed to Charlestown Pediatrics and Revere Pediatrics practices</li> <li>Chelsea pediatrics—Asthma Coach under CCHI*</li> </ul>				

Referral	•	Submit referrals via Epic In-Basket to Christus Georges, <u>Pediatric</u>
		Asthma Coach.

Epic Banner Identifier

None

Patient Care Coordination Note

N/A

Care Team

N/A

#### Encounter Documentation

Engagement with the Asthma Coach, Christus Georges is documented by note type (i.e. telephone, progress notes, etc.). Search in notes and filter by author (currently Christus George) to find notes related to Asthma Coach encounters.

hart Re	Encounters Labs	Imaging P	rocedu	ures Surgery	Anesthesia Cardiol	ogy Neurology Meds	Notes Letters Media	Episodes LDAs	Referrals Oth	her Orders	Misc Reports	
Befresh	(11.28 AM) 🕊 🙀 Route 📑 I	Review Selected	🗌 Pre	eview • 🛷 Tag	R Add to Bookmarks							
Eilters	Default Filter	le 🗌 MGH Chi	elsea A	dolesce 🗋 Op	Notes 🔲 Discharge 🗌	Consults 🔲 Progress Note	ACP Notes 📋 History and	d Physical 🖉 Hide D	eleted 🗌 Inpatient	Notes		
To save	time not all records have	been loaded ar	nd sort	ed. Load All Reco	or <u>d</u> s Now Hide							
To save		been loaded a	1000	ed. Load All Reco	ords Now Hide Dept	Specialty	Author	_	Ne	ite Type	Subject	Trans Ty
		Filing Date		Enc Type	nenzann. Linnen	Specialty Pediatrics	Author Georges, Christus	1		ite Type Jephone End		Trans Ty
To save	Service Date	Filing Date 06/12/2019	¢	Enc Type Telephone	Dept	No. of Concession, Name			Te	State and the	counter	Trans Ty

#### Center for Community Health Improvement (CCHI) -Community Health Worker

#### Program Snapshot

Summary/Overview	<ul> <li>Community Health Worker Team facilitate the most high-risk patients including patients with limited language diffusion such as Bosnian, Nepali, Somali, Arabic and Cantonese/Mandarin, to adhere to key components of their healthcare.</li> </ul>	
Administrative	Anna Spiro	
Contact(s)		
Payor Eligibility	All payors	
Program Eligibility	Adult and Pediatric patients especially those from socioeconomically	
	disadvantaged backgrounds and racial/ethnic minority populations.	
Referral	All referrals are submitted via EPIC by a Partners PCP	
Discharge/Handoff	Case discharged within 6-8 months of referral. If long term, referral made to	
	another program.	

#### Epic Banner Identifier

None

#### Patient Care Coordination Note

Although CCHI CHWs have access to and can add to the patient care coordination note, they generally do not.

#### Care Team

#### Yes.

Hertelle Dorine Oniagba

Phone: 617-724-8161

Community Health Worker

7/23/2019

#### Encounter Documentation

Patient encounters with CCHI CHW are documented as patient outreach notes described as "Community Health Worker Outreach".

	07/23/2019 🖹 Patient Outreach	Internal Med - Oniagba, H	Community Health Worker Outreach (mammogram)	
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#### Behavioral Outreach Coordinator – MGH Revere

#### Program Snapshot

Summary/Overview	rview Helps patients and their families navigate some of the complex systems such as accessing special education services through the public schools, mental health, food resources and transitional assistance such as housing. Other responsibilities include advocacy for patients and their families as well as case management	
Administrative	Saja Alani	
Contact(s)		
Payor Eligibility	All Payor	
Program Eligibility	Children and Families	
Referral	Referred through Pediatrician consult	

#### COMMUNITY-BASED PROGRAMS

#### MGH Stay Connected Program (SCP)

#### Program Snapshot

Summary/Overview	The Stay Connected Program is an enhanced transitional support for high-risk Medical and Cardiac patients who discharge "Home" or "Home with Services".
Administrative	Avital Desharone
Contact(s)	
Payor Eligibility	All Payor
Program Eligibility	<ul> <li>Adult</li> <li>A principal hospital problem of CHF, COPD, Acute MI, Pneumonia, or Cirrhosis</li> </ul>

	<ul> <li>Other Services: SCP Patients are also eligible for support with post- discharge appointment scheduling by the Inpatient Administrative Coordinators (IACs), Meds2Beds medication delivery to the bedside prior to discharge, and home visits by a PMOU Nurse Practitioner (for select patients).</li> </ul>
Referral	<ul> <li>The Community Resource Specialist will review eligible patients on floors where Stay Connected Program is active and place an IP Consult to SCP CM for those patients that qualify. Current floors include: Ellison 10-12, 16; White 8-11; Bigelow 9,11,14; PH 20-21</li> <li>See program flyer in Appendix II.</li> </ul>
Discharge/Handoff	Patients are followed for 30-days post-discharge.

#### Epic Banner Identifier

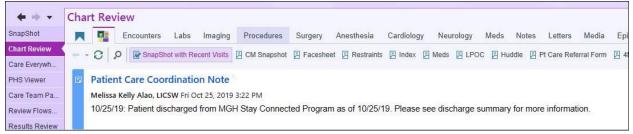
Home Health banner is activated for SCP patients that get an NP visit.

#### Patient Care Coordination Note

Care Coordination Note when patient is being followed by SCP (30-day period post-discharge)

$\bullet \rightarrow \bullet$	SnapShot with Recent Visits					
SnapShot •	🖌 🗸 🗘 😰 SnapShot with Recent Visits 🗄 CM Snapshot 🗒 Facesheet 🗒 Restraints 🗒 Index 🗒 Meds 🗒 LPOC 🗒 Huddle 🗒 Pt Care Referral Form 🖡	🗐 4Next R				
Chart Review						
Care Everywh	Patient Care Coordination Note	ত				
PHS Viewer	Susan M Carlson, RN Wed Oct 30, 2019 9:23 AM					
Care Team Pa	10/30/19 .Patient will be followed by Stay Connected Program Care Coordination RN CM Susan Carlson (617-724-3986) post discharge until 11/30/19. The Stay Connected Program follows high risk patients post discharge for 30 days via telephonic outreach. The SCP Team					
Review Flows	consists of a Nurse Case Manager, LICSW, and a Community Resource Specialist.					
Results Review		- 00				

#### Care Coordination Note when patient has been discharged from SCP



Note by the CRS when patient has been selected to be followed by SCP prior to Hospital Discharge. Visible in inpatient and outpatient notes.

Catherine K McCarthy Case Management	Consults Signed	Date of Service: 10/28/2019 12:28 PM
Consult Orders		
IP Consult to SCP CM [60221	8055] ordered	by Catherine K McCarthy at 10/28/19 1047
MGH Stay Connected P	rogram Comr	nunity Resource Specialist
10/28/19: Stay Connected	ed Program T	eam (CM/SW) to follow for 30 days post discharge, pending d/c to home. Tel: 617-724-3148
High Risk Score/Opt in [	Ox if applicabl	le: 27%
Catherine McCarthy		
Stay Connected Program Tel: 617-724-3148	n- Community	y Resource Specialist
Pager: 27968		
Cosigned by: Susan M Carlso	on, RN at 10/29	9/2019 7:39 AM

#### Care Team

Patients are followed for 30 days post discharge and then care coordinators take themselves off the care team. To find out if SCP coordinator (SW or RN) has engaged with patient in the past, check past care team members.

are Teams					۲
Patient Care Coordination Note Edited: Melissa Kelly Alao, LIC	CSW 6/20/2019				Ø Vie
06/20/19: Patient will be followed by Stay Connected Program Soc	al Worker, Melissa Alao, LICSW (Tel: 617-643-5877) post discharg	e until 7/19/19. The Stay Connected Program follows patients identified as	high risk for readmission for up to 30 days post-	discharge via telephonic outreach. The SCP	Care Coordination Team cons
縃 Patient Care Team					
I         + Add         + Add Me           Search for Team Member         + Add         + Add Me				🖋 Show: 🗹 Past T	eam Members Deleted
Team Member	Relationship	Specialty	Start 🛩	End	Update
Melissa Kelly Alao, LICSW	Social Worker		06/20/2019	07/19/2019	8/20/1
Phone: 617-643-5877; Pager: 22649; Fax: 617-726-1042 Comment: MGH Stay Connected Program					

#### Encounter Documentation

The SCP engages patient primarily via telephone encounters. SCP patients followed by the Clinical Social Worker will require others to "break the glass" to view notes. Social Work and Case Management notes are labeled as "MGH Stay Connected Program (Care Coordination)" and "MGH Stay Connected Program Case Manager", respectively, and should be viewed by collaborating clinicians and other members of the care team.

	When	Туре	With	Description	Disch Date Prov Specialty Research Questionni
PR.	07/08/2019	C Telephone	Social Servi - Alao, M	MGH Stay Connected Program	
R	06/26/2019	C Telephone	Social Servi - Alao, M	MGH Stay Connected Program	
R	06/24/2019	C Telephone	Social Servi - Alao, M	MGH Stay Connected Program	
R	05/23/2019	C Telephone	Social Servi - Alao, M	MGH Stay Connected Program	
R	05/21/2019	C Telephone	Social Servi - Alao, M	MGH Stay Connected Program	
R	05/17/2019	C Telephone	Social Servi - Alao, M	MGH Stay Connected Program	
R	05/17/2019	Patient Outreach	Care Managem - McCarthy, C	MGH Stay Connected Program	
<b>N</b>	05/16/2019	C Telephone	Social Servi - Alao, M	MGH Stay Connected Program	
<b>N</b>	05/15/2019	Patient Outreach	Care Managem - McCarthy, C	MGH Stay Connected Program	
<b>N</b>	05/15/2019	C Telephone	Social Servi - Alao, M	MGH Stay Connected Program	

#### Medicaid ACO Community Partners Program

#### Program Snapshot

Summary/Overview	The Community Partners (CP) program formalizes partnerships between medical care teams and community-based care teams to enhance care coordination to meet the complex behavioral and long-term support service health needs of MassHealth members attributed to the ACO.		
Administrative	Kristen Risley		
Contact(s)	Selina Osei		
Payor Eligibility	Medicaid ACO only		
Program Eligibility	<ul> <li>Behavioral Health (BH): 21 -64 years old; with serious mental illness and substance use disorders</li> <li>Long Term Support Services (LTSS): 3-64 years old; with complex physical and developmental conditions or disabilities</li> </ul>		
Referral	<ul> <li>MassHealth referral list based on claims and data analysis of service utilization</li> <li>Opt-in referrals by ACO care team (PCP, care managers, etc.) to <u>PHSCommunitypartners@partners.org</u></li> <li>Find referral form in Appendix III.</li> </ul>		

#### Epic Banner Identifier

None

#### Patient Care Coordination Note

The patient care coordination note is updated with Community Partner information when a high-risk assessment has been completed for a patient engaged with the Medicaid ACO Community Partners program.



#### **Encounter Documentation**

iCMP Care Team Coordinators outreach and complete LTSS assessment for eligible community partners members. Patient outreach encounters are documented by patient outreach note type and have

varying descriptions (Care coordination—LTSS Assessment; Community Service—outreach; Care management—community partners program, etc.)

	09/18/2018 🗎	Patient Outreach	Care Managem - Canto, T Care Coordination (LTSS Assessment)
	09/18/2018 🗎	Patient Outreach	Care Managem - Canto, T
	10/15/2018	Patient Outreach	Care Managem - Pardi, M Care Coordination (Medicaid Community Partner)
M	Today	Patient Outreach	Care Managem - Canto, T Care Coordination (LTSS Assessment)

#### Community Care Transition (CCAT) Program

#### Program Snapshot

Summary/Overview	The CCAT program is a grant-funded research initiative with a goal of
	minimizing readmission rate for eligible Medicaid ACO patients with a
	dedicated CHW coordination and educational 30-day post discharge
	intervention.
Key Contact(s)	Jocelyn Carter, MD, MPH, Principle Investigator/C-CAT Team Lead
	Anne Walton, RN, CAEd, C-CAT Project Manager
	Susan Hassan, CHW
Payor Eligibility	Medicaid ACO only
Program Eligibility	<ul> <li>Patient registry: Daily list of inpatients located on one of 14 MGH medical/surgical units patients attributed to code "MassHealth Partners Choice ACO". Patients are who meet the following criteria are outreached to for enrollment: <ul> <li>Adult patients who have a high probability of readmission due to comorbidities and at least 1 hospital admission in the prior 3 months or 2 in the prior 12 months</li> <li>Lives within 30 miles radius of MGH Main Campus</li> <li>MGH attributed PCP</li> </ul> </li> </ul>
Referral	
Discharge/Handoff	Patients are followed for 30 days post-discharge

#### Epic Banner Identifier

#### **Research: Active Enrollment**

FYI: MGH	S Research:	Act			
	CED: None	e			
	Out Info:	2			
Implementing 30day Po	st Discharge Community Health Wor	rker Pairings with Patients at H	ighRisk for Readmission		Additional Info Past Update:
Implementing 30day Po Study Code:	st Discharge Community Health Wor 2016P002768-233052	rker Pairings with Patients at H	ighRisk for Readmission Principal Investigator:	Jocelyn A Carter, MD, MPH	Additional Info Past Updates
		rker Pairings with Patients at H	-	Jocelyn A Carter, MD, MPH Intervention/Interaction	Additional Info Past Updates
Study Code:	2016P002768-233052	rker Pairings with Patients at H	Principal Investigator:		Additional Info Past Updates
Study Code: IRB #:	2016P002768-233052 2016P002768	rker Pairings with Patients at H	Principal Investigator:		Additional Info Past Updates

#### Patient Care Coordination Note

N/A

#### Care Team

The CCAT CHW adds his/herself to the care team for the patient for the duration of engagement. View past care team members to determine past engagement if more than 30-days post discharge.

are Team						
Provider	Contact Info	ED	Relationship	Speciality	Start	End
PCP(s)						
Jin M Choi, MD	Pager: 29383 Phone: 617-724-6610		PCP - General	Internal Medicine	5/29/2019	
Other Patient Care Team	Members					
Jin M Choi, MD	Pager: 29383 Phone: 617-724-6610	<b>#</b>	Partners Attributed Provider	Internal Medicine	8/4/2019	
Susan Hassan, CHW	Phone: 781-819-4703		Community Health Worker		8/3/2019	9/2/2019

#### Encounter Documentation

Engagement with CCAT's Community Health Worker, *Susan Riad Hassan* is documented by note type (documentation). Each Progress note is titled "*MGH Community Health Worker Initiative*".

19 NT 🕑
EN

Progress Notes

MGH Community Health Worker Initiative

#### Integrated Care Management Program—Patients Linked to Urgent Services (iCMP PLUS)

#### Program Snapshot

i logi ulli shupshot						
Summary/Overview	The iCMP PLUS program provides home-based, high touch, and intensive care management for high-risk and super utilizer patients who represent the top 0.5-1% of Medicaid expenses. Enrolled patients typically have a combination of social, medical, and behavioral challenges.					
Administrative	Dylanne Axelson					
Contact(s)						
Payor Eligibility	Medicaid ACO only					
Program Eligibility	<ul> <li>Medicaid ACO Adult (&gt;18yo)</li> <li>Partners PCP</li> <li>Home address is within 20 miles of Boston</li> <li>A combination criterion which may include high (&gt;7) ED visits in the past 6 months, inpatient admissions, psychiatric admissions, alcohol or drug abuse, behavioral health needs, limited mobility, and a high number of appointments "no shows".</li> </ul>					
Referral	iCMP PLUS Opt-In Referral Process:					
	<ul> <li>The process for referring an opt-in patient to the program is to email icmpplus@partners.org with the following information:</li> <li>Patient's name and MRN</li> </ul>					

	<ul> <li>Brief explanation of patient's needs or challenges that require intensive, high touch home-based care</li> </ul>
Discharge/Handoff	A patient is enrolled in the AICU or Wrap model of the program.
	<ul> <li>WRAP—Patient keeps their Partners PCP and is provided with additional home-based care management support.</li> <li>Ambulatory Intensive Care Unit (AICU)—Patient transitions to a new iCMP PLUS PCP. The patient would keep any Partners specialists they see.</li> </ul>

#### Epic Banner Identifier

iCMP Plus PHM: Medicaid External_Risk	Coverage: MASSHEALT Next Appt: 🛱 With Intern
Acute Care Plan	
Mv Pat List Reminders: Non	

#### 

#### 1. Acute Care Plan

Added 10/6/17 by Joan Paulette Robles, CNP Note edited 7/26/2019 11:51 AM by Nicole A Porcaro

This patient is part of iCMP PLUS program with Commonwealth Care Alliance (CCA). This is an intensive, high touch care management program designed to best support this patient and meet their needs outside of the hospital. CCA has a variety of additional resources beyond a typical primary care office, including the ability to conduct home visits after hours and on weekends, crisis stabilization units for acute psychiatric emergencies, and many other services. Please speak to a member of our staff before you finalize the disposition plan. There is a provider available 24/7 to discuss this patient.

iCMP PLUS Care team members for this patient are listed on the Care Coordination Snapshot and Care Team Paging tab.

During business hours (Monday - Friday 8:30am – 5:00pm), you can reach the care manager directly – contact them by searching in the Partners Paging Directory or you can call our clinical office at 617-433-9601. After hours, we have an on-call clinician available via 617-433-9601.

#### Patient Care Coordination note

#### Patient Care Coordination Note

#### Nicole A Porcaro Fri Jul 26, 2019 11:48 AM

This patient is part of iCMP PLUS (Intensive Care Management Program – Patients Linked to Urgent Supports) with Commonwealth Care Alliance (CCA). Please call 617-433-9601 to reach care team members. Care Manager: Nicole Porcaro, LMHC, 857-488-5275

#### Care Team

Christine Cannon, LICSW	Phone: 617-433-9601	iCMP Plus Social Worker	7/8/2017
Nicole A Porcaro	Pager: 97431	iCMP Plus Care Manager	7/10/2018
	-		

#### Encounter Documentation

Engagement with the iCMP Plus care team is documented as Social Work notes by the care manager and as telephonic care coordination notes for patient outreach encounters.

07/02/2019	¢	Telephone	Internal Med - Porcaro, N	Care Coordination
06/28/2019	¢	Telephone	Internal Med - Porcaro, N	Care Coordination
06/28/2019	₿	Social Work	Internal Med - Porcaro, N	
06/27/2019	¢	Telephone	Internal Med - Porcaro, N	Care Coordination
06/27/2019	¢	Telephone	Internal Med - Porcaro, N	Care Coordination
06/25/2019	¢	Telephone	Internal Med - Bearnot, B	Internal Medici
06/21/2019	Ē	Social Work	Internal Med - Porcaro, N	
06/21/2019	¢	Telephone	Internal Med - Porcaro, N	Care Coordination

### HOSPITAL/ACUTE BASED PROGRAMS

#### Emergency Department (ED) Medicaid Coordinators/Navigators

#### Program Snapshot

Summary/Overview	The ED Medicaid ACO Navigator program aims to reconnect high ED utilizers					
	with primary care and support services to enable them to better meet their					
	health needs and reduce ED visits.					
Administrative	Kristen Risley					
Contact(s)	Elizabeth Fonseca					
	ED Navigators: Vanessa Adjei, Kendra Liburd					
Payor Eligibility	Medicaid ACO only					
Program Eligibility	Partners PCP					
	Patient has continuity of care and/or social issues					
	Intervention fits plan of care					
Referral	• Patients typically referred by ED Staff (SW and CM) via face to face or					
	page					
	• When Navigator is not in the ED, email for follow up					

#### Epic Banner Identifier N/A

Patient Care Coordinator Note Piloted for pediatric patients.

### Care Team

N/A

#### Encounter Documentation

Engagement with Medicaid ACO ED Navigators is documented as ED Outreach

har	t Revi	ew							
	-	Encounter	rs	Labs Imaging Proc	edures Surgery Anesthesia (	Cardiology Neurology Meds	Notes Letters	Media Episodes	LDAs 👻
CB	efresh	(1:44 PM) ■\$" F	Route	🗈 Review Selected 🟢	Synopsis 🗌 Preview 👻 🖽 Lab Flowshe	et http://www.eet http://www.eet http://www.eet http://www.eet.action.com/action/actio	Play Sr Encounter	Add to Bookmarks	
<b>T</b> 1	Eilters	Default fil	Iter	Primary Care MC	H Back Bay Admissions				
		When		Туре	With	Description	Disch Date	Prov Specialty Resear	rch Questio
Re	cent \	/isits							
	0	01/28/2019	0	ED	Emergency - Miller, E	Localized swelling of lower	01/28/2019	Emergency M	
		01/16/2019	0	ED	Emergency Medicine - Spector, Jor	€ Shortness of breath (Prim			
	Ø	01/11/2019		Letter (Out)	Internal Med - Petek, B			Internal Medici	
		01/10/2019	¢.	Telephone	Social Servi - Alao, M	MGH Stay Connected Pro			
		01/09/2019	=	Orders Only	Home Health - Homehealth, I			Family Medicine	
	Û	01/09/2019	3	ED to Hosp-Admis	Psychiatry - Bryce A Wininger, MD;	Mood disorder (Primary Dx)	01/15/2019	Emergency M	
	Û	01/09/2019	Ο	ED	Emergency - Coffey, E	Lightheadedness (Primary	01/09/2019	Emergency M	
		01/04/2019	ů	PORTABLE EEG	Neurology Sheidon, B	Syncope, unspecified sync	01/04/2019	Neuro Tech	
		12/28/2018		Patient Outreach	Emergency Me - Adjei, V	ED Outreach			
		12/28/2018	=	Orders Only	Cardiology - Chorzempa, A	Syncope and collapse (Pri		Nurse Practiti	
	Û	12/27/2018	ů	MGH In Person Foll	Cardiology - Unknown, U	Cardiac arrhythmia, unspe	12/27/2018		
		12/27/2018	€_	Telephone	Social Servi - Alao, M	MGH Stay Sennected Pro			
		12/27/2018		Patient Outreach	Emergency Me - Adjei, V	ED Outreach (Initial)			

#### **Social Work Services**

Inpatient (ED and Floor-based)

#### Program Snapshot

Summary/Overview	Inpatient Social Workers are consulted to assess patient's adjustment to illness, support system, and any psychosocial stressors. Social Workers provide clinically focused counseling and referrals to community resources to enhance coping and care coordination.
Administrative	Marie Elena Gioiella
Contact(s)	
Payor Eligibility	All Payor
Program Eligibility	<ul> <li>Patient has continuity of care and/or social issues</li> </ul>
	Intervention fits plan of care
Referral	Consult only
	All patients on inpatient Psychiatry, Neonatal ICU, and Burns have a
	Social Worker assigned

#### Epic Banner Identifier

None

Patient Care Coordinator Note N/A

#### Care Team

Yes, inpatient social workers are part of the patient's *treatment team* for the duration of their admission.

🖓 Treatment Team ह		
Provider Paul Clarke Shellito, MD	Relationship Attending, Surgeon	Specialty General Surgery
Bess Flashner, MD	Consulting Provider	Internal Medicine
Lisa Friedman Scheck, LICSW	Social Worker	

#### Encounter Documentation

Notes by inpatient social workers are documented in the admission encounter and labeled as service/specialty –Social Work.

#### **Outpatient/Ambulatory**

Outpatient Social workers cover a variety of ambulatory clinics including but not limited to: *Oncology, Transplant, Pediatrics, Obstetrics, etc.* To inquire about ambulatory Social Work staffing, please contact the Social Service Department at 617-726-2643.

Outpatient Social workers may assign themselves to a patient's care team in EPIC but it is standard practice where patients are followed more long term.

Notes by Outpatient social workers are documented primarily as Social Work and Telephone encounters and are labeled as Specialty-Social Services

#### **APPENDIX I**

Peer Support Specialists Contact List Referral Process Map for Patient with Substance Use Disorders (SUDs) Substance Use Disorder Initiative—Program sites & services information

#### **APPENDIX II**

Stay Connected Program Flyer

#### APPENDIX III

Medicaid ACO Community Partners Program—Infographic Medicaid ACO Community Partners Program—Referral form

#### **APPENDIX IV**

Social Determinants of Health (SDH)—3 things you should know

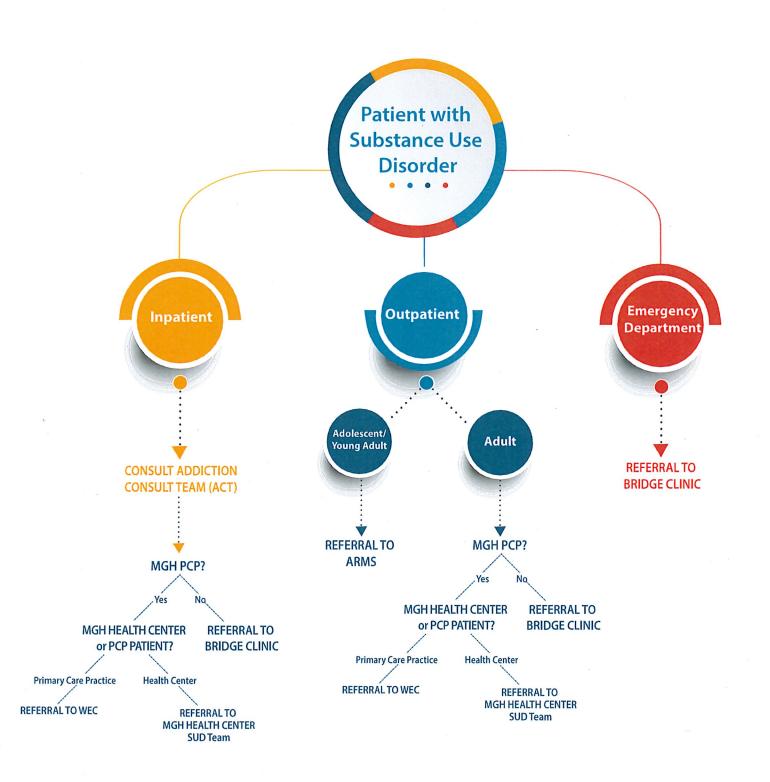
#### **Group Information** Coach **Contact Information Practice Risk** Rounds Name Practice Phone Email Location Day/Time Time/Location ACT/Bridge Clinic 857-393-3950 skeizer@partners.org@partners.org MGH Bridge Peer Support Stephen Tuesdays at 8:30AM Keizer, CARC Founders 8 Clinic Group: Tues in Founders 860 MGH Founder's 1-2 pm Building Suite 810/811 Boston Healthcare 857-320-1560 mjellison@partners.org BHCHP Walk In Wed 9-11:30 N/A Michael for the Homeless Jellison, Clinic am CARC Street Team Wang Basement \*Street Team 780 Albany Street MGH Room 026 Patients Only\* Ryan O'Brien, TBD 2nd Friday and 4th MGH Charlestown TBA MGH Tuesday MGH HealthCare Center 12pm Charlestown Monday at 12PM in the Charlestown 73 High Street Fri 10 am **Basement** Conference Room MGH Chelsea rmcmahan@partners.org 4<sup>th</sup> Friday at 8am Raina 857-205-4201 Chelsea Creative Arts Peer Support McMahan, HealthCare Center HealthCare Eleanor Clark CARC, Center Mondays 1-Conference Room Team Lead 151 Everett Ave. 2pm at the MGH 4<sup>th</sup> Floor Bridge, 4<sup>th</sup> Wednesday at Behavioral Health Founders 8, 12pm MGH Main Winnisimmet campus conference room Creative Arts Peer Support Tues 3-5 pm Recovery Meeting

Thurs 6:30 pm

#### **SUDs Recovery Coaches and Group Meetings**

RC Name	Practice	Phone	Email	Group location	Group Day/Time	Practice Risk Rounds
Dawna Aiello, CARC MGH	MGH Addictions Consult Team (ACT) & West End Clinic (WEC)	617-694-8690	<u>Daiello3@mgh.harvard.edu</u>	TBA	TBA	(ACT) M-F 8:15a-9a & 11:15a-12p in Founders 810 (WEC) every Thursday at 2PM
Katherine (Katie) Raftery MGH	HOPE Clinic/Women's Health	857-324-2998	keraftery@partners.org	Blake 1 Haber room 1-190	Friday 1PM	Women's Health – Tuesdays at 12:15PM as needed
Nick DeSimone, MGH	MGH Revere HealthCare Center 300 Ocean Ave, Revere	857-289-3063	njdesimone@partners.org	MGH Revere/ Ocean Ave 300 Ocean Ave, 3 <sup>rd</sup> Floor, Behavioral Health	Peer Recovery Group, Friday, 2pm	3 <sup>rd</sup> Tuesday at 2:30PM in the Revere Sweet Conf Room and 4 <sup>th</sup> Tuesday at 12:15PM in the Revere Mental health conference room
Allen Ryba, MGH	Internal Medicine Associates (IMA) Wang 6, main campus	617- 879-8968	aryba@partners.org	IMA, 6 <sup>th</sup> floor, Wang building, Pod A conference room	Peer Recovery Group, Fridays 4pm	1 <sup>st</sup> Wednesday at 12:30PM and 3 <sup>rd</sup> Friday at 3PM in Wang 645
Kristen Cahillane, MGH	Bulfinch Medical Group 50 Staniford Street, 9 <sup>th</sup> Floor	857-291-8717	kcahillane@partners.org	Bulfinch Medical Group Wang 5 <sup>th</sup> floor Room 555B	N/A	Tuesdays at 7:30AM, once per month, date depends, Staniford 9, Room 908
Open MGH	Addiction Recovery Management Service (ARMS) Wang 8	857-200-0140	Currently interviewing	N/A	N/A	Tuesday mornings 9am-11:30am, Wang 8 conference room
Daniel Foley, MGH	Nashua Street Jail	857-208-3800	Dfoley9@partners.org	N/A	N/A	N/A

Marcia Hall, BHCHP	Boston Healthcare for the Homeless	857-310-7095	mhall@bhchp.org	TBA	ТВА
	Barbara McInnis				
	House				
	780 Albany Street				
RC Name	Practice	Phone number	Email address	Group Location / Day & Time	Practice Risk Rounds
Open,	ED &			N/A	TBA
MGH	(Bridge, Evenings)				
	Main campus				
Open.	New Day		Currently interviewing		
RC	Residential				
BayCove					
	Methadone Clinic				
Eileen	Revere/Ocean Ave		TBA		
Stocker	300 Ocean Ave,				
MGH	Revere				
Lorraine	New	617-620-3241	LFITZGERALD14@mgh.harvard.edu		
Fitzgerald,	Health/Charlestown				
CARC New Health	17 Tufts Street				



	Addiction Recovery Management Services (ARMS)	West End Clinic (WEC)	Bridge Clinic	MGH Health Centers	Addiction Consult Team (ACT)
Description	Treatment/support for patients ages 14-26 with SUDs/dual diagnosis and their parents	Treatment of adults with SUDs, especially dual diagnosis	Drop-in, transitional addiction clinic for high-risk, unstable patients	Offer pharmacotherapy and behavioral health services for health center PCP patients	Inpatient Consult Team
Hours/Location	Monday-Friday 8:30 AM - Evening Wang 815 & Yawkey 6A	Monday-Friday 8:30 AM - 5:00 PM 16 Blossom Street, 1 <sup>st</sup> Floor Walk-ins welcome 10 AM - 12 PM Tuesday & Friday	Monday-Friday 9:00 AM - 4:00 PM By appointment or drop-in Founders 880 Saturday & Sunday: 55 Fruit Street, Wang Building, Room 150	Varies by location	Seven days per week 8:00 AM - 5:00 PM
Services	<ul> <li>Individual Therapy</li> <li>Parent Coaching</li> <li>Parent Groups</li> <li>Medication management</li> <li>Program Referrals</li> <li>Peer Support Services</li> </ul>	<ul> <li>Day &amp; evening IOPs</li> <li>Dual Diagnosis Clinic</li> <li>Medication management</li> <li>Individual therapy</li> <li>Groups</li> <li>Family therapy</li> <li>After Care Programs</li> <li>Peer Support Services</li> </ul>	<ul> <li>Transitional clinic</li> <li>Medication management</li> <li>Peer support services</li> <li>Groups</li> <li>After-care planning/ resource support</li> </ul>	<ul> <li>Psychopharmacology</li> <li>Individual therapy (except MGH Everett)</li> <li>Groups (except MGH Everett)</li> <li>Peer support (recovery coaches)</li> </ul>	<ul> <li>Comprehensive evaluation</li> <li>Treatment</li> <li>recommendations</li> <li>Linkage to community</li> <li>resources</li> </ul>
Eligibility Requirements	<ul> <li>Ages 14-26</li> <li>In-Network insurance</li> <li>Registered MGH patient with MRN</li> </ul>	MGH PCP     In current active treatment     with MGH specialist	Registered MGH patient with MRN	MGH Health Center PCP	Inpatients identified with SUD
Referral Process	Patient, provider or parent call (617) 643-4699 to request intake appointment	Call Psychiatric Access Line (PAL) at (617) 724-7792 To make an appointment, email Jennifer Blewett & send patient to drop-in	Place order in Epic Contact: (617) 643-8281	Contact patient's health center PCP	Place consult order in EPIC early in admission

10 AM-12 PM Tuesday &

Friday

# MGH STAY CONNECTED PROGRAM (SCP)

Enhanced transitional support for high-risk Medical and Cardiac patients who will discharge "Home" or "Home with Services" and who have:

1) A "Readmission Risk Total Score" of >27% in Epic, and/or

2) A principal hospital problem of CHF, COPD, Acute MI, Pneumonia, or Cirrhosis

### CARE COORDINATION

Nurse Case Manager, Clinical Social Worker, and/ or Resource Specialist provide coordination of care, community services and resource support for up to 30 days after discharge.



#### ACTIVATE

Place order for "IP Consult to SCP CM," select reason(s) for consult

### TIMELY FOLLOW-UP

Primary care appointments within 7-14 days and specialty care appointments as needed.



#### ACTIVATE

Via "IP Consult to DOM IAC" order, contact the Inpatient Administrative Coordinator (IAC)

### PHARMACY SERVICES

Discharge medication reconciliation, counseling, and bedside delivery prior to discharge

ACTIVATE Coordinate with unit-based pharmacists on participating units

### **HOME NURSE PRACTITIONER VISITS**

Nurse Practitioners provide advanced practice visit(s) to patients after discharge (labs, diagnostics, medications) in gualifying zip codes

#### ACTIVATE



Place order for "IP Consult to SCP CM" and specify "Requesting NP visit" in the comments

### Please consider these additional resources



### **HEART FAILURE**

#### **HF** Transitions Clinic

HF Service NP provides follow up care/visit for 30 days for patients with Partners PCP or cardiologist.

ACTIVATE Page 25741

#### HF Telemonitoring (for Population Health Management patients) Call 1-800-307-4898 or email:

telemonitoringnurse@partners.org .....

mgpo.partners.org/ClinicalPriorities/StayConnected.html https://goo.gl/iGeJpj



COPD

**Respiratory** Therapist provides enhanced education for COPD patients (inhaler technique, oxygen use, managing symptoms at home).

#### ACTIVATE

Place order for "IP Consult Respiratory Care," then select "COPD Education"

### CIRRHOSIS

**GI** Liver Clinic provides follow-up as an outpatient visit with a Hepatologist or Liver NP within 5-10 days after discharge.

#### ACTIVATE

Place order for "IP Consult to DOM IAC," then specify GI Liver Follow up.

#### **OUESTIONS?** Contact

Catherine McCarthy ckmccarthy@mgh.harvard.edu or Margaret Chapman, MD mmchapman@mgh.harvard.edu



### MassHealth Accountable Care Organization -Community Partners Program

Est.





Partners' Provider Practices Vetted Non-Profit Community-Based Organizations

### **Breaking Down Silos of Care**

Community Partners (CP) is a MassHealth program where community-based organizations work with Accountable Care Organizations (ACOs), such as Partners HealthCare Choice, to provide care management and coordination to select members based on needs. As an ACO, Partners began to work with MassHealth to implement this program in 2018.

Through a combination of primary care and community-based supports, we can meet patients where they are to provide comprehensive, patient-centered care.

# **Addressing Patient Needs**



Complex patients with high health care utilization rates and co-morbidities are connected with one of two types of Community Partners (CP), based on their needs.



Who identifies patients?

MassHealth and providers who refer high-risk patients appropiate for the program.

#### Behavioral Health Community Partners

For patients who need support in managing their mental health or substance use disorder.

#### OR

#### Long Term Services & Supports Community Partners

For patients with chronic illnesses and disabilities needing services such as hospice and adult day health.

Once matched with a Community Partner organization, an assessment is completed and a patient-centered care plan is developed with a Care Coordinator.

#### How are organizations chosen?



Community Partners are vetted and selected by the state.

Some of the organizations we work with include:

- Eliot Human Services;
- Merrimack Valley Community Partnership and:
- Boston Healthcare for the Homeless.



# **Improving Care Management**

Patients receive support from their ACO and assigned Community Partner in a care team made up of:

- Primary Care Provider (PCP);
- Partners HealthCare ACO Contact;
- Care Coordinator;
- Other Care Team Members as needed.



While receiving care management, patients are still choosing their own path with the creation of a care plan and health goals that makes sense to them.

Providers experience less administrative burden while still providing patient care and collaborating with experts in the community.

ORDINATOR

populationhealth.partners.org



FOR ACO/MCO INTERNAL USE ONLY

Date Received: Click here to enter a date.

Date the Referral was Denied/Approved: Click here to enter a date.

### MASSHEALTH COMMUNITY PARTNERS PROGRAM REFERRAL INTAKE FORM

Please send this intake form to the specified central point of contact for CP program referrals at the member's ACO/MCO. If you are unsure of the member's ACO/MCO, please contact **MassHealth's Customer Service Center** at 800-841-2900 with the member. The member must be present when contacting the Customer Service Center on their behalf.

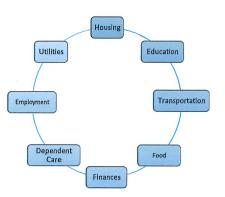
REFERRED MEM	IBER INFORMATION
Name (Last, First, M.I.): Click here to enter text.	□ M □ F □ Non-Binary DOB: Click here to enter a date.
MassHealth Identification Number (if known): Click here to enter text.	Member's address: Click here to enter text.
Member's primary language: Click here to enter text.	Member's legal guardian name and phone number (if applicable): Click here to enter text.
Member's ACO/MCO (if known): Click here to enter text.	Member's phone number: Click here to enter text.
Member's primary care physician: Click here to enter text.	Member's primary care physician's phone number: Click here to enter text.
related diagnosis: Click here to enter text.	
Reason(s) for Referral: Click here to enter text.	Contact information for agencies currently involved in member's care: Click here to enter text.

REFERRAL SOURCE INFORMATION
Referral Source's Name: Click here to enter text.
Referral Source's organization/agency: Click here to enter text.
Referral Source's phone number: Click here to enter text.
Signature of Referral Source: Click here to enter text.

### **Medicaid ACO Social Determinants of Health Survey**

## 1. Administered Annually

Medicaid patients scheduled for a **new patient appointment or annual physical** will complete the survey in Gateway or when they arrive on a tablet. The survey is available in English and Spanish and asks patients about insecurity in the following areas:

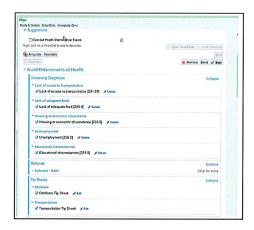


	TNERS.			Patient Infor	mation	
	n gives us more informat In place in the future.	ion about you and your f	endy. Your Institutes	vill help us put n	nore support	
	Has the lack of transp medical appointment medications?	ortation kept you from a or from getting	014	ONS		
	got meney to buy me	ald run out before we re.	O herer true	O Sometime True		
C	Within the past 12 months the food we bought just didn't last and we didn't have money to get more.		O Never True	O Sometime True		
	What is your housing altuation today? Now many times have you moved in the part \$2 months?		OI do not have housing (asymptotic email in a next, in a press, hilly excises me amat or a secon, a car, or in a secon, a car, or in a secon,	5	O I cheose ne te anzwer	
ft			Offires Offices or more times times	time (	idonot choose bidonot choose to act to formate	
	Are you worsed that you may not have you in?		O Yes	0 %9	O I choose no to an curer	
P	Do you have trouble p electricity bill?	shind some propied on	Over	OND	O I choose no	
	Do you have trouble ;	aying for medicines?	Over	ON9	O I cheese ne	
-	Are you currently une for work?	mployed and looking	Over	One	O I checse ne	
-	Are you interested in	more education?	Over	Q No	O I choose no	
۷	Do you have trouble a care of a family ment		Over	C No	O I choose no	
-	Would you like info	mation today about a	ny of the following	topics?		
O Transportation     O Paying utility bits     O B Education		+ Food +	- + Paying for medications		A Housing     A Housing     B tob search or training     Vere for elder or disabled	
	art 12 months, have y	ou received assistance	from an organizati			
	ensportation	C & Food		C & Housing		
□ V Paying utility bills □ -1 Paying □ V Education □ V child		C A Paying for m	adications	a sob seard	to or training	

## 2. See the results in Smart Set

A Smart Set will be activated when you open the Encounter Plan. You will be able to view the patient's responses and, if a patient asks for information, the **tips** sheets they will receive automatically in the After Visit Summary (AVS).

If the patient completes the survey in Spanish, the tips sheets will automatically be sent in the AVS in Spanish.



### 3. Referral, if needed

- If your patient needs more help than a tip sheet can offer, <u>Accept</u> the Order.
- Otherwise, you can simply 🔀 Cancel the order.
- The order will be followed up by Doreen Anderson and/or Cheryl Kram.

