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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Last revised 01/13/2020

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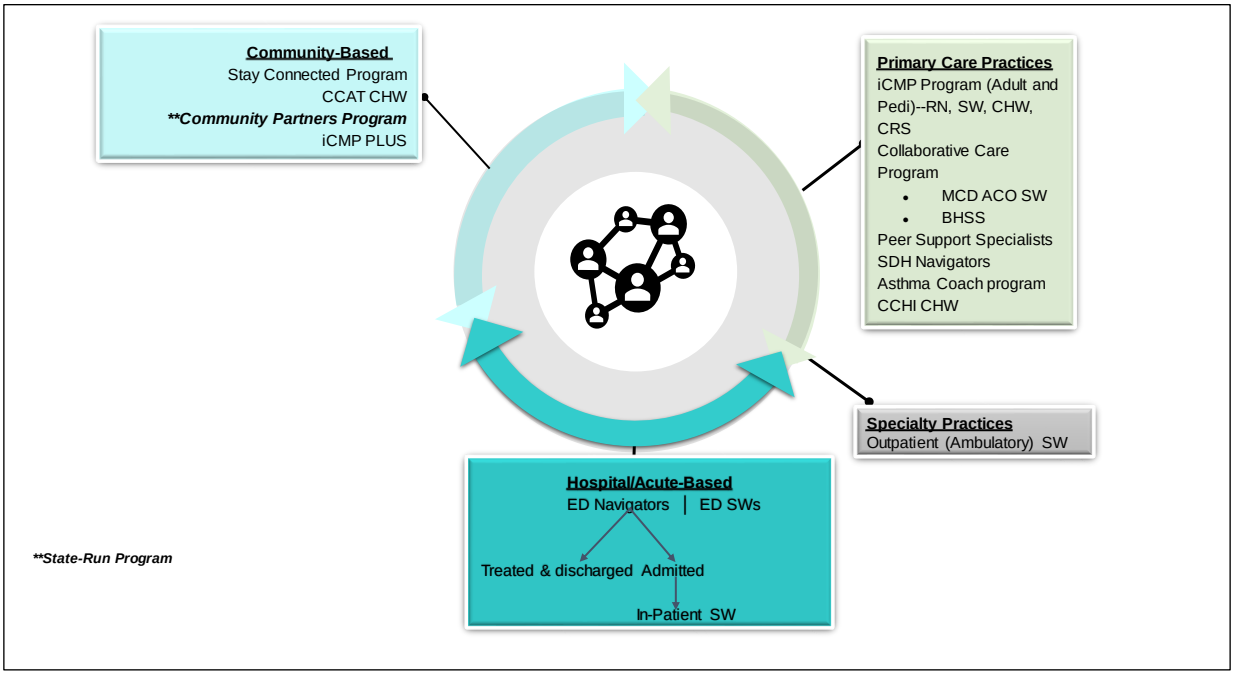
OVERVIEW

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)

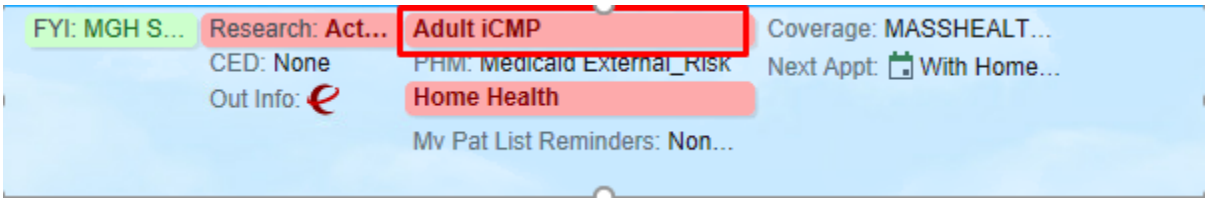
Role Groups: Registered Nurse (RN), Social Worker (SW), Community Health Worker (CHW), and Community Resource Specialist (CRS).

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

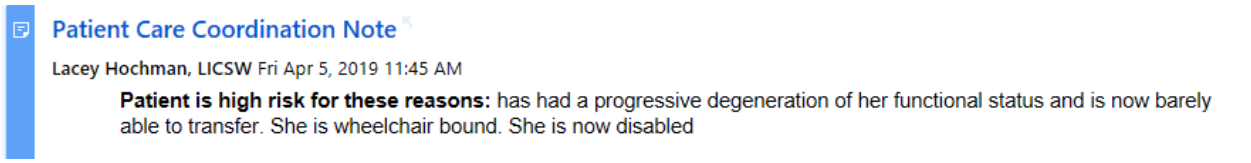
Summary/Overview	iCMP is a primary care practice-based service designed to support patients in achieving improved health and well-being.
Administrative Contact(s)	Debra Birkenstamm, Nursing Director
Payor Eligibility	All Payors
Program Eligibility	• Partners PCP • Meets high risk score
Referral	All referrals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

Epic Banner identifier

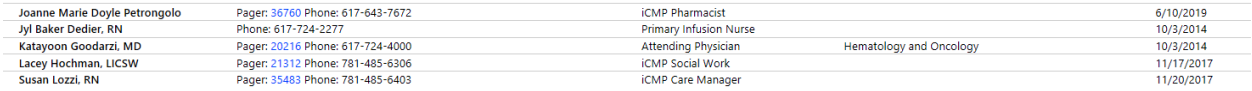


Patient Care Coordinator Note

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

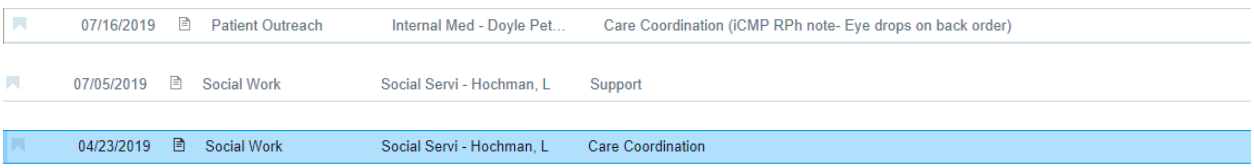


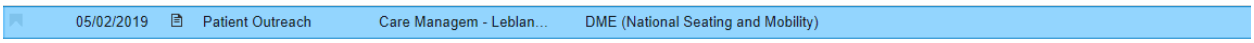
Care Team



Encounter Documentation

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





Pediatric Integrated Care Management Program (iCMP)

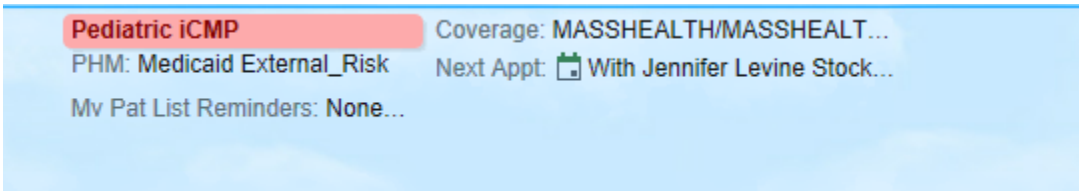
Role Groups: Registered Nurse (RN), Social Worker (SW), Community Health Worker (CHW), and Community Resource Specialist (CRS).

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 Contact(s)	Lynn Doxey, Project Manager 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



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.

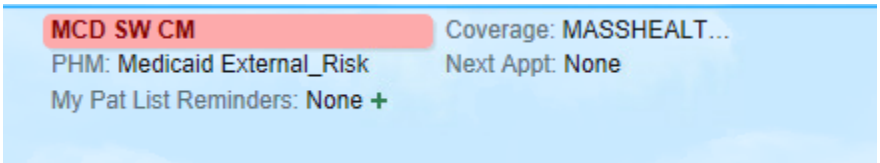
Encounter Documentation

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	• 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. • New Referrals: EPIC In-Basket to BHSS or ACO SW to determine eligibility for program

EPIC Banner Identifier



Care Team

Yes, as ACO Social Worker

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.

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	• Patients with positive screenings on standard psych assessment tools
Referral	• 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. • New Referrals: EPIC In-Basket to BHSS or ACO SW to determine eligibility for program

Epic Banner Identifier

None

Patient Care Coordination Note

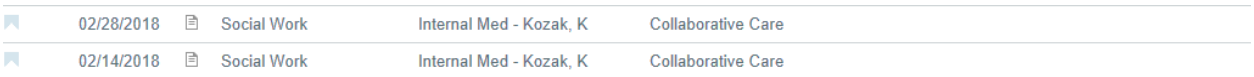
N/A

Care Team

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

Encounter Documentation

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



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 Contact(s)	Elizabeth Powell
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	• Find a list of peer support specialists assigned to each practice site in Appendix I. • Contact patient's health center PCP. See Appendix I.

Epic Banner identifier

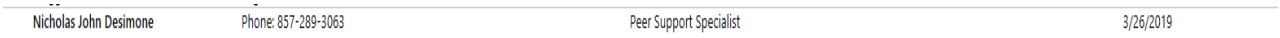
None

Patient Care Coordination Note

None

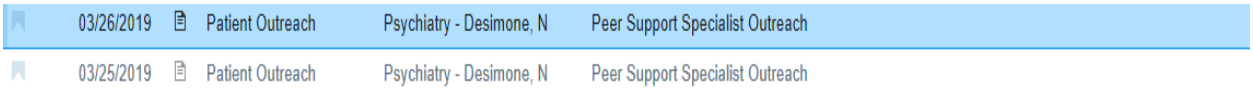
Care Team

Yes



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.



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 Contact(s)	Kristen Risley
Payor Eligibility	All Payor
Program Eligibility	• N/A
Referral	• Positive screens active a referral order smartest to be approved by the PCP where appropriate. • See three things you should know about the SDH Screening process in Appendix IV.

Epic Banner Identifier

None

Patient Care Coordination Note

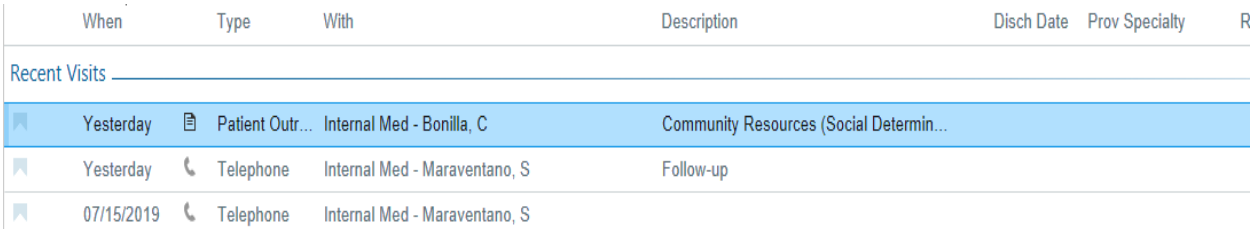
N/A

Care Team

N/A

Encounter Documentation

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



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	• Pediatric patients (0-21 years) • Patients attributed to Charlestown Pediatrics and Revere Pediatrics practices • Chelsea pediatrics—Asthma Coach under CCHI*

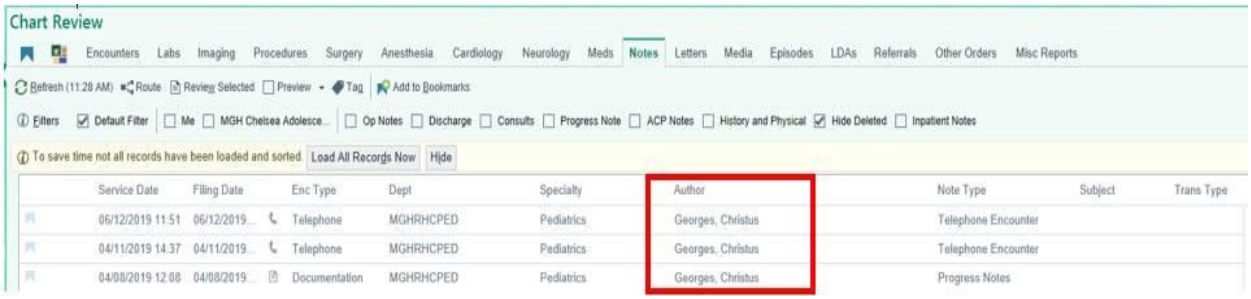
Referral	• Submit referrals via Epic In-Basket to Christus Georges, Pediatric Asthma Coach.

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.



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

Program Snapshot

Summary/Overview	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.
Administrative Contact(s)	Anna Spiro
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)	

Behavioral Outreach Coordinator –MGH Revere

Program Snapshot

Summary/Overview	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 Contact(s)	Saja Alani
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 Contact(s)	Avital Desharone
Payor Eligibility	All Payor
Program Eligibility	• Adult • A principal hospital problem of CHF, COPD, Acute MI, Pneumonia, or Cirrhosis

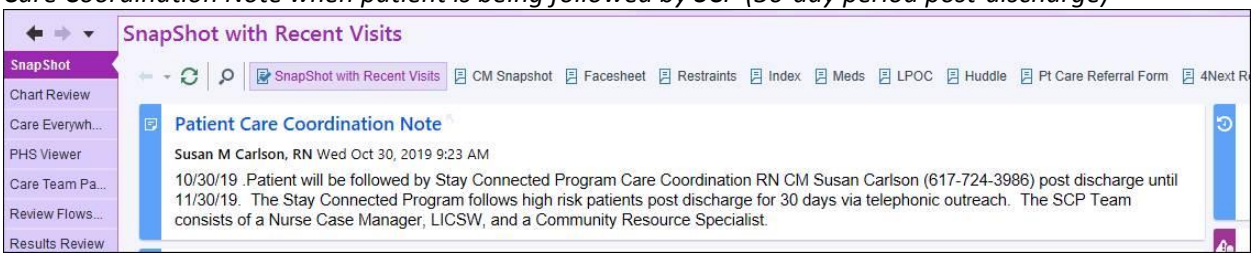
	• Other Services: SCP Patients are also eligible for support with post-discharge appointment scheduling by the Inpatient Administrative Coordinators (IACs), Meds2Beds medication delivery to the bedside prior to discharge, and home visits by a PMOU Nurse Practitioner (for select patients).
Referral	• 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 • See program flyer in Appendix II.
Discharge/Handoff	Patients are followed for 30-days post-discharge.

Epic Banner Identifier

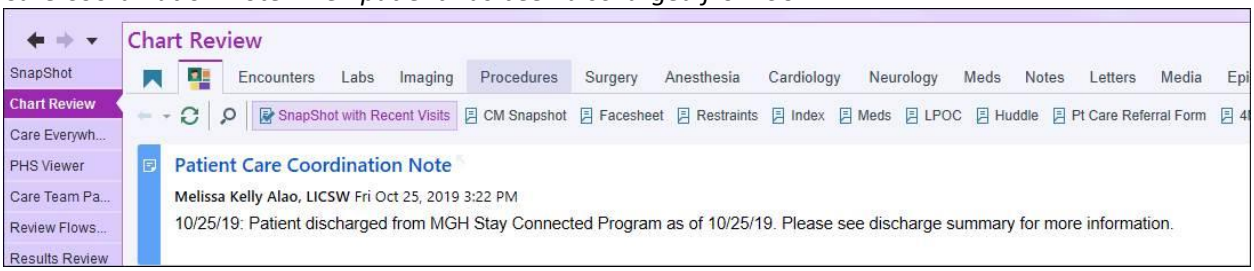
Home Health banner is activated for SCP patients that get an NP visit.

Patient Care Coordination Note

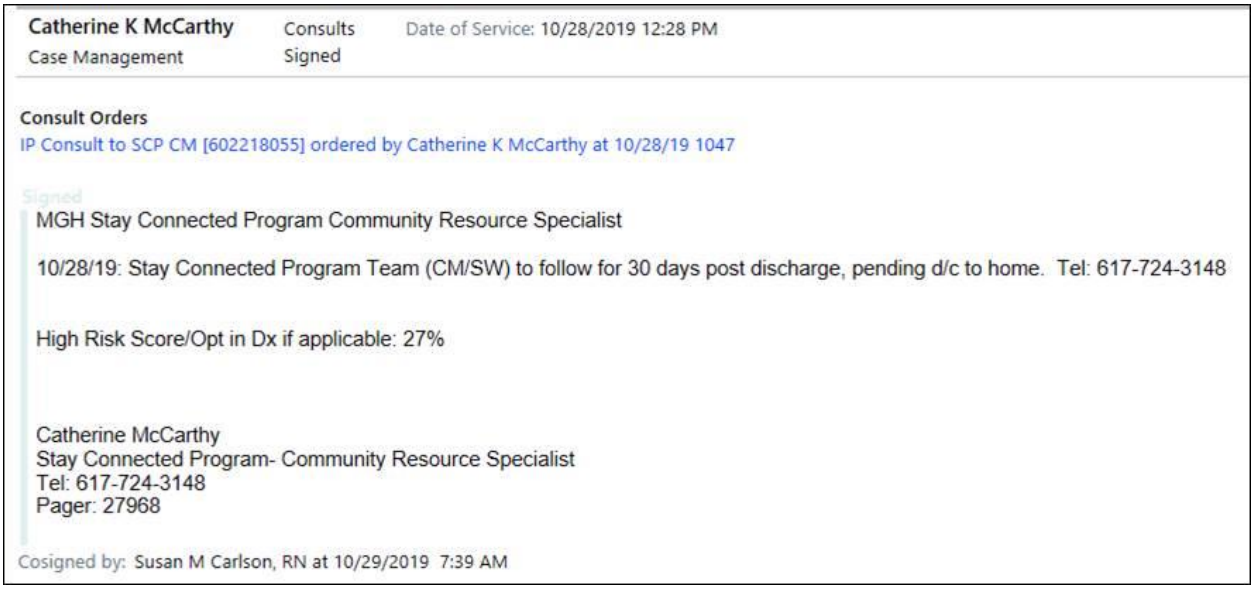
Care Coordination Note when patient is being followed by SCP (30-day period post-discharge)



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 Consults Date of Service: 10/28/2019 12:28 PM
Case Management Signed

Consult Orders
IP Consult to SCP CM [602218055] ordered by Catherine K McCarthy at 10/28/19 1047

Signed
MGH Stay Connected Program Community Resource Specialist

10/28/19: Stay Connected Program Team (CM/SW) to follow for 30 days post discharge, pending d/c to home. Tel: 617-724-3148

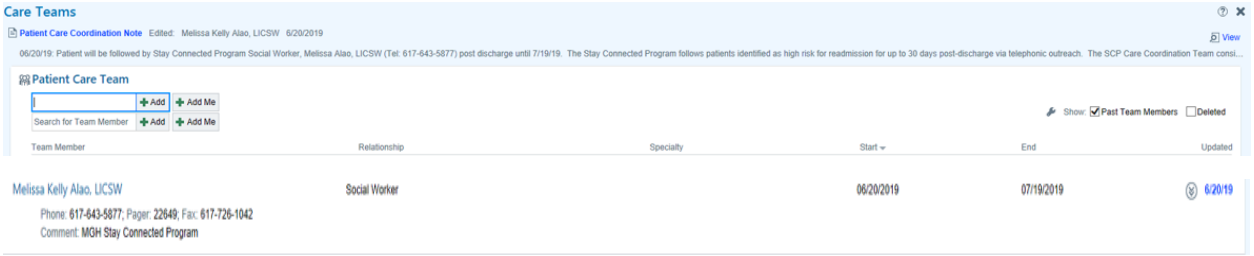
High Risk Score/Opt in Dx if applicable: 27%

Catherine McCarthy
Stay Connected Program- Community Resource Specialist
Tel: 617-724-3148
Pager: 27968

Cosigned by: Susan M Carlson, RN at 10/29/2019 7:39 AM

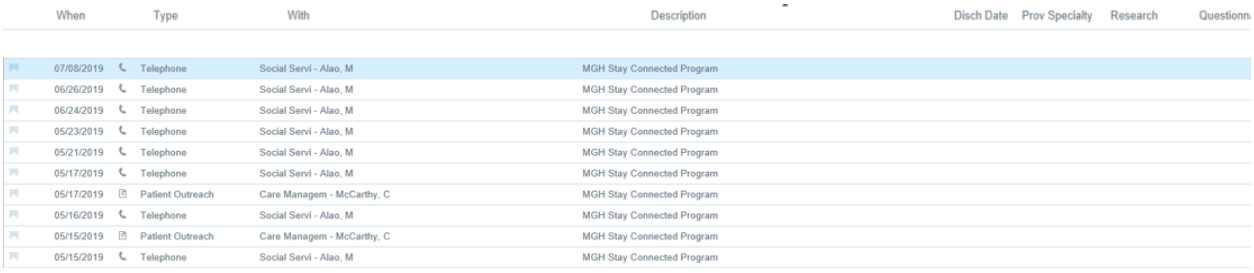
Care Team

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.



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	Type	With	Description	Disch Date	Prov Specialty	Research	Questionn
07/08/2019	Telephone	Social Servi - Alao, M	MGH Stay Connected Program				
06/26/2019	Telephone	Social Servi - Alao, M	MGH Stay Connected Program				
06/24/2019	Telephone	Social Servi - Alao, M	MGH Stay Connected Program				
05/23/2019	Telephone	Social Servi - Alao, M	MGH Stay Connected Program				
05/21/2019	Telephone	Social Servi - Alao, M	MGH Stay Connected Program				
05/17/2019	Telephone	Social Servi - Alao, M	MGH Stay Connected Program				
05/17/2019	Patient Outreach	Care Managem - McCarthy, C	MGH Stay Connected Program				
05/16/2019	Telephone	Social Servi - Alao, M	MGH Stay Connected Program				
05/15/2019	Patient Outreach	Care Managem - McCarthy, C	MGH Stay Connected Program				
05/15/2019	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 Contact(s)	Kristen Risley Selina Osei
Payor Eligibility	Medicaid ACO only
Program Eligibility	• Behavioral Health (BH): 21 -64 years old; with serious mental illness and substance use disorders • Long Term Support Services (LTSS): 3-64 years old; with complex physical and developmental conditions or disabilities
Referral	• MassHealth referral list based on claims and data analysis of service utilization • Opt-in referrals by ACO care team (PCP, care managers, etc.) to PHSCommunitypartners@partners.org • Find referral form in Appendix III.

Epic Banner Identifier

None

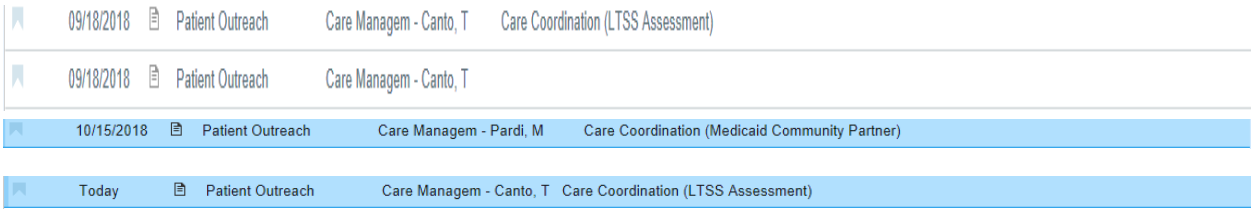
Patient Care Coordination Note

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.)



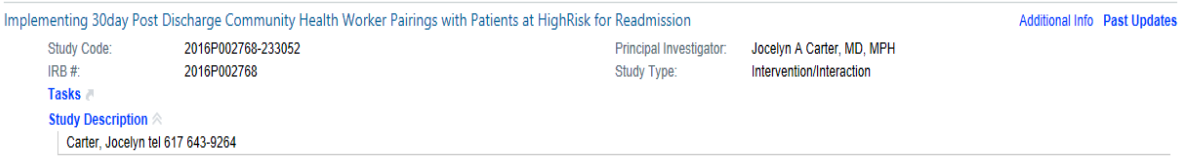
Community Care Transition (CCAT) Program

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	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: • 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 • Lives within 30 miles radius of MGH Main Campus • MGH attributed PCP
Referral	
Discharge/Handoff	Patients are followed for 30 days post-discharge

Epic Banner Identifier

Research: Active Enrollment

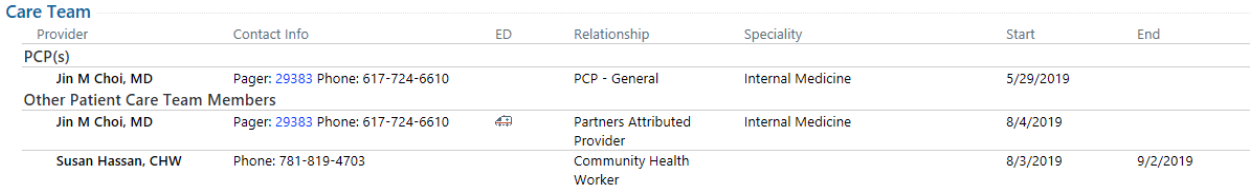


Patient Care Coordination Note

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.

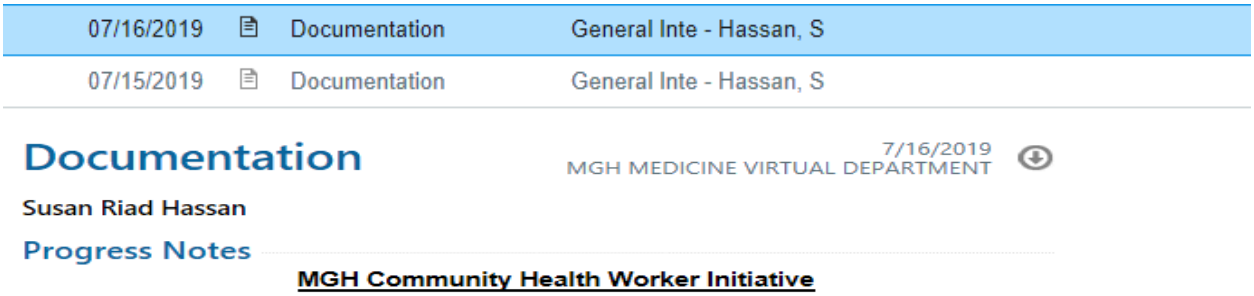


Care Team

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		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***".



07/16/2019	Documentation	General Inte - Hassan, S
07/15/2019	Documentation	General Inte - Hassan, S

Documentation 7/16/2019
MGH MEDICINE VIRTUAL DEPARTMENT

Susan Riad Hassan

Progress Notes

MGH Community Health Worker Initiative

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

Program Snapshot

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 Contact(s)	Dylanne Axelson
Payor Eligibility	Medicaid ACO only
Program Eligibility	• Medicaid ACO Adult (>18yo) • Partners PCP • Home address is within 20 miles of Boston • A combination criterion which may include high (>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".
Referral	**iCMP PLUS Opt-In Referral Process:** • The process for referring an opt-in patient to the program is to email icmpplus@partners.org with the following information: ○ Patient's name and MRN

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

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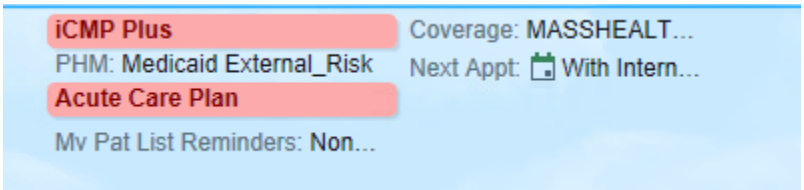
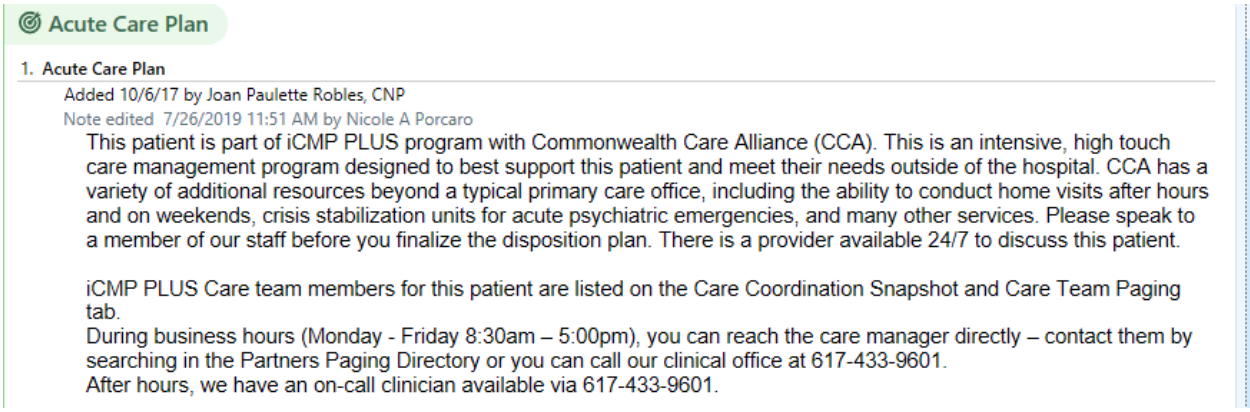
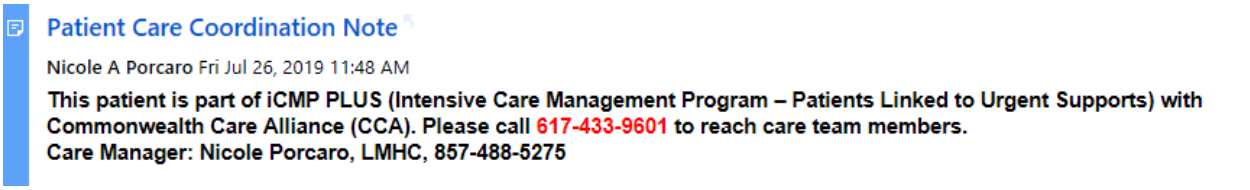
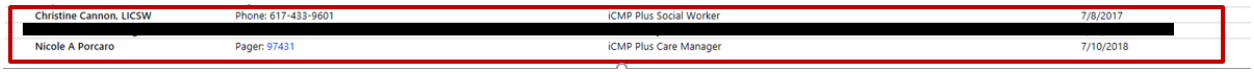




Patient Care Coordination note



Care Team



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	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 Contact(s)	Kristen Risley 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

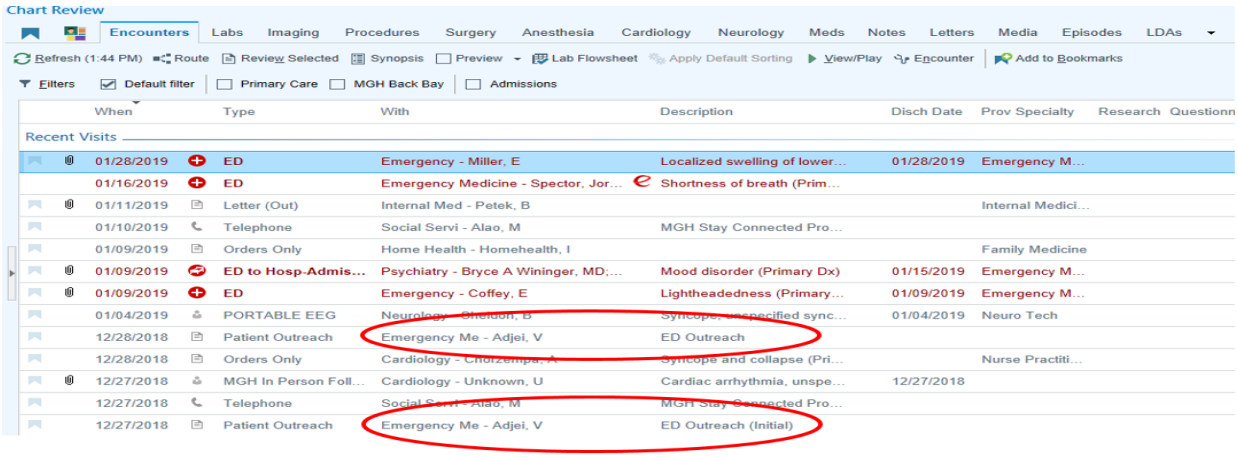
Piloted for pediatric patients.

Care Team

N/A

Encounter Documentation

Engagement with Medicaid ACO ED Navigators is documented as ED Outreach



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 Contact(s)	Marie Elena Gioiella
Payor Eligibility	• All Payor
Program Eligibility	• Patient has continuity of care and/or social issues • 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

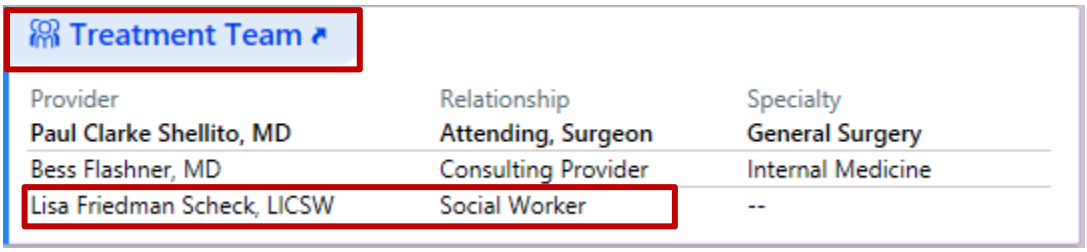
None

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.



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

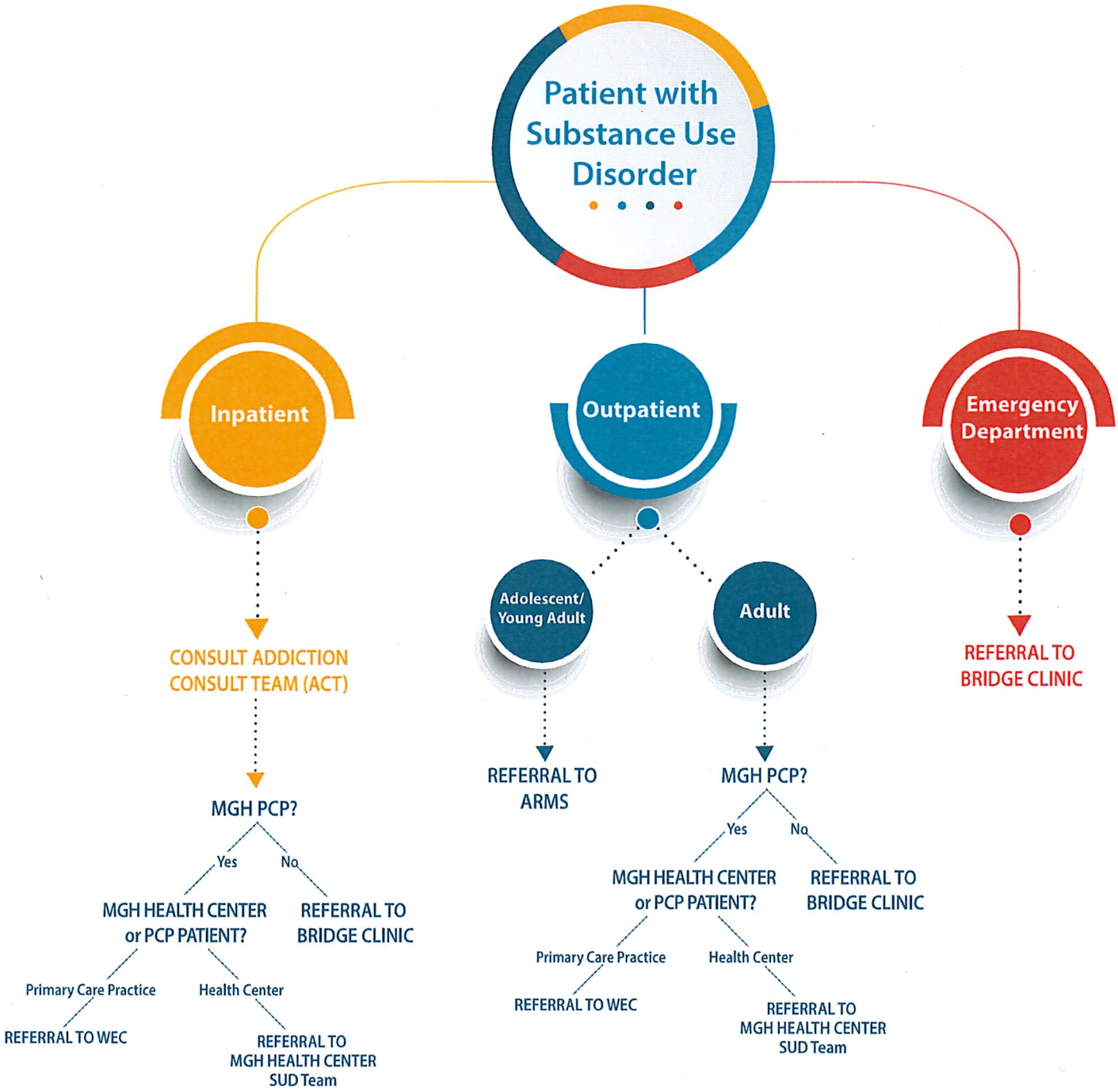
Social Determinants of Health (SDH)—3 things you should know

SUDs Recovery Coaches and Group Meetings

Coach		Contact Information		Group Information		Practice Risk Rounds
Name	Practice	Phone	Email	Location	Day/Time	Time/Location
Stephen Keizer, CARC MGH	ACT/Bridge Clinic Founders 8	857-393-3950	skeizer@partners.org@partners.org	MGH Bridge Clinic Founder's Building Suite 810/811	*Peer Support Group*: Tues 1-2 pm	Tuesdays at 8:30AM in Founders 860
Michael Jellison, CARC MGH	Boston Healthcare for the Homeless Street Team 780 Albany Street	857- 320-1560	mjellison@partners.org	BHCHP Walk In Clinic Wang Basement Room 026	Wed 9-11:30 am *Street Team Patients Only*	N/A
Ryan O'Brien, MGH	MGH Charlestown HealthCare Center	TBD	TBA	MGH Charlestown 73 High Street	Tuesday 12pm Fri 10 am	2nd Friday and 4th Monday at 12PM in the Charlestown Basement Conference Room
Raina McMahan, CARC, Team Lead MGH	MGH Chelsea HealthCare Center	857-205-4201	rmcmahan@partners.org	Chelsea HealthCare Center 151 Everett Ave. 4th Floor Behavioral Health	*Creative Arts Peer Support Mondays 1-2pm at the Bridge, Founders 8, MGH Main campus* *Creative Arts Peer Support* Tues 3-5 pm *Recovery Meeting* Thurs 6:30 pm	4th Friday at 8am Eleanor Clark Conference Room 4th Wednesday at 12pm Winnisimmet conference room

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	Daiello3@mgh.harvard.edu	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, 3rd Floor, Behavioral Health	Peer Recovery Group, Friday, 2pm	3rd Tuesday at 2:30PM in the Revere Sweet Conf Room and 4th 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, 6th floor, Wang building, Pod A conference room	Peer Recovery Group, Fridays 4pm	1st Wednesday at 12:30PM and 3rd Friday at 3PM in Wang 645
Kristen Cahillane, MGH	Bulfinch Medical Group 50 Staniford Street, 9th Floor	857-291-8717	kcahillane@partners.org	Bulfinch Medical Group Wang 5th 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 Barbara McInnis House 780 Albany Street	857-310-7095	mhall@bhchp.org	TBA	TBA
RC Name	**Practice**	**Phone number**	**Email address**	**Group Location / Day & Time**	**Practice Risk Rounds**
Open, MGH	ED & (Bridge, Evenings) Main campus			N/A	TBA
Open. RC BayCove	New Day Residential Methadone Clinic		Currently interviewing		
Eileen Stocker MGH	Revere/Ocean Ave 300 Ocean Ave, Revere		TBA		
Lorraine Fitzgerald, CARC New Health	New Health/Charlestown 17 Tufts Street	617-620-3241	LFITZGERALD14@mgh.harvard.edu		


Patient with Substance Use Disorder
Inpatient
Outpatient
Emergency Department
CONSULT ADDICTION CONSULT TEAM (ACT)
MGH PCP?
Yes
No
MGH HEALTH CENTER or PCP PATIENT?
REFERRAL TO BRIDGE CLINIC
Primary Care Practice
Health Center
REFERRAL TO WEC
REFERRAL TO MGH HEALTH CENTER SUD Team
Adolescent/ Young Adult
Adult
REFERRAL TO ARMS
MGH PCP?
Yes
No
MGH HEALTH CENTER or PCP PATIENT?
REFERRAL TO BRIDGE CLINIC
Primary Care Practice
Health Center
REFERRAL TO WEC
REFERRAL TO MGH HEALTH CENTER SUD Team
REFERRAL TO BRIDGE CLINIC

	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, 1st 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	• Individual Therapy • Parent Coaching • Parent Groups • Medication management • Program Referrals • Peer Support Services	• Day & evening IOPs • Dual Diagnosis Clinic • Medication management • Individual therapy • Groups • Family therapy • After Care Programs • Peer Support Services	• Transitional clinic • Medication management • Peer support services • Groups • After-care planning/ resource support	• Psychopharmacology • Individual therapy (except MGH Everett) • Groups (except MGH Everett) • Peer support (recovery coaches)	• Comprehensive evaluation • Treatment recommendations • Linkage to community resources
Eligibility Requirements	• Ages 14-26 • In-Network insurance • Registered MGH patient with MRN	• 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 10 AM-12 PM Tuesday & Friday	Place order in Epic Contact: (617) 643-8281	Contact patient's health center PCP	Place consult order in EPIC early in admission

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 qualifying 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

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.

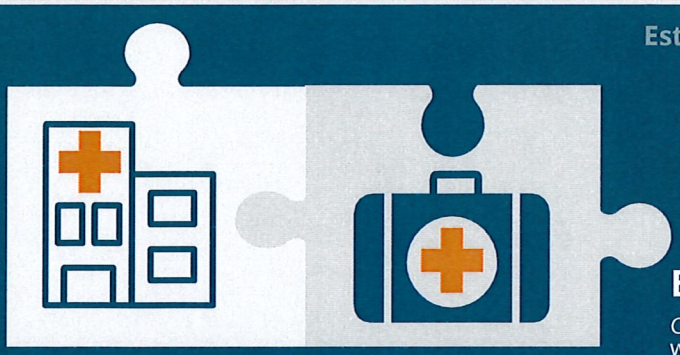
ACTIVATE
Place order for "IP Consult to DOM IAC," then specify GI Liver Follow up.

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

QUESTIONS? Contact
Catherine McCarthy *ckmccarthy@mgh.harvard.edu or*
Margaret Chapman, MD *mmchapman@mgh.harvard.edu*

MASSACHUSETTS GENERAL HOSPITAL

MassHealth Accountable Care Organization - Community Partners Program



Partners' Provider Practices

Vetted Non-Profit Community-Based Organizations

Est. **2018**

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.

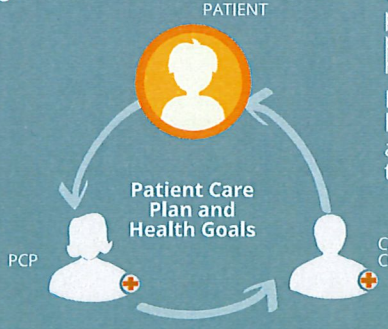
Some of the organizations we work with include:

- 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.

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.

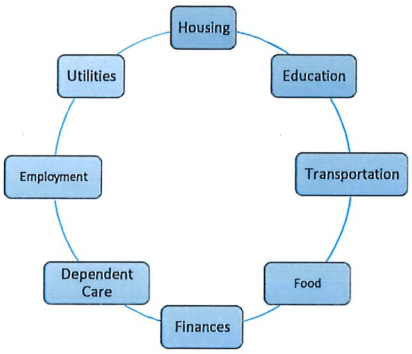
REFERRED MEMBER INFORMATION		
Name *(Last, First, M.I.):* Click here to enter text. ☐ M ☐ F ☐ Non-Binary		**DOB:** Click here to enter a date.
MassHealth Identification Number (if known): Click here to enter text.	**Member's address:** Click here to enter text.	
Member's primary language: Click here 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.	
Member's primary medical/behavioral health/LTSS-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.	

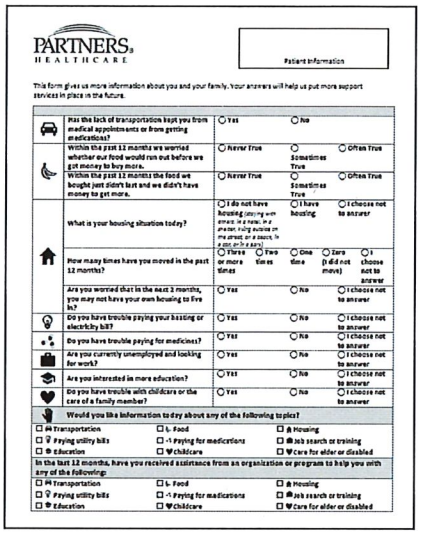
REFERRAL SOURCE INFORMATION
Referral Source's Name: Click here to enter text.
Referral Source's organization/agency: Click here to enter text.
Referral Source's phone number: Click here to enter text.
Signature of Referral Source: Click here to enter text.

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:




PARTNERS HEALTHCARE

Patient Information

This form gives us more information about you and your family. Your answers will help us put more support services in place in the future.

	Has the lack of transportation kept you from medical appointments or from getting medications?	○ Yes	○ No	
	Within the past 12 months we worried whether our food would run out before we got money to buy more.	○ Never True	○ Sometimes True	○ Often True
	Within the past 12 months the food we bought just didn't last and we didn't have money to get more.	○ Never True	○ Sometimes True	○ Often True
	What is your housing situation today?	○ I do not have housing (staying with others, in a hotel, in a shelter, living outside on the street, or in a space not meant for sleeping)	○ I have housing	○ I choose not to answer
	How many times have you moved in the past 12 months?	○ Three or more times ○ Two times	○ One time ○ Zero (I did not move)	○ I choose not to answer
	Are you worried that in the next 2 months, you may not have your own housing to live in?	○ Yes	○ No	○ I choose not to answer
	Do you have trouble paying your heating or electricity bill?	○ Yes	○ No	○ I choose not to answer
	Do you have trouble paying for medicines?	○ Yes	○ No	○ I choose not to answer
	Are you currently unemployed and looking for work?	○ Yes	○ No	○ I choose not to answer
	Are you interested in more education?	○ Yes	○ No	○ I choose not to answer
	Do you have trouble with childcare or the care of a family member?	○ Yes	○ No	○ I choose not to answer

Would you like information today about any of the following topics?

☐ Transportation ☐ Food ☐ Housing
☐ Paying utility bills ☐ Paying for medications ☐ Job search or training
☐ Education ☐ Childcare ☐ Care for older or disabled

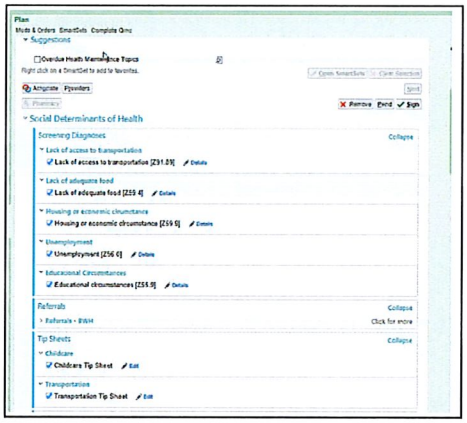
In the last 12 months, have you received assistance from an organization or program to help you with any of the following:

☐ Transportation ☐ Food ☐ Housing
☐ Paying utility bills ☐ Paying for medications ☐ Job search or training
☐ Education ☐ Childcare ☐ Care for older or disabled

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, ✔ Accept the Order.
- Otherwise, you can simply ✖ Cancel the order.
- The order will be followed up by Doreen Anderson and/or Cheryl Kram.