Boston University Initiative on Cities

BOSTON UNIVERSITY

Providing Guidance on How to Implement a Patient-Centered Medical Home in New Bedford, MA

METROBRIDGE

About this Report

This report is a product of student work in Boston University's Health Care Delivery Systems course taught by Prof. Sarah Gordon in Fall 2019.

Acknowledgments

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About BU MetroBridge

MetroBridge empowers students across Boston University to tackle urban issues, and at the same time, helps city leaders confront key challenges. MetroBridge connects with local governments to understand their priorities, and then collaborates with Boston University faculty to translate each city's unique needs into course projects. Students in undergraduate and graduate classes engage in city projects as class assignments while working directly with local government leaders during the semester. The goal of MetroBridge is to mutually benefit both the Boston University community and local governments by expanding access to experiential learning and by providing tailored support to under-resourced cities. MetroBridge is funded by the College of Arts and Sciences and housed at Boston University's Initiative on Cities.

Table of Contents

Introduction

The goal of the Development Initiative to Advance and Manage Outreach to those in Need in Downtown (DIAMOND) is to create an effective yet sustainable system that addresses the health and social needs of homeless and other high-need populations. There are many variables that come into play when understanding what accounts for homelessness; however, this brief focuses on delivery system recommendations to meet the varied health needs of New Bedford's downtown residents.

As a collective of students at the Boston University School of Public Health, we utilized information given to us about the health needs of the citizens of New Bedford along with outside research to recommend models of integrated care delivery, services to be offered, and financing options. The foundation of our project employs a two phase implementation plan. The initial phase recommends the use of a mobile care van to create connections and meet basic needs. The second phase involves the establishment of a full scale patient-centered medical home (PCMH) with services targeted specifically for the New Bedford population.

Recommended services include primary care, group and individual counseling services, and care coordination with treatment services in the area.

Patient-Centered Medical Home: A Promising Model for New Bedford

A Patient-Centered Medical Home (PCMH) is a model of care that is based on coordination, accessibility, quality, and safety with an emphasis on being patient-centered. PCMHs provide the key aspects of primary care including a sustainable relationship between providers and patients, comprehensiveness, and coordination amongst various providers. While primary care is the basis of PCMHs, there is a new way of organizing these practices by enhancing the responsiveness to local patient population needs.[1] Examples of these enhancements can include same-day visits, telehealth visits, group visits, and team-based care, amongst others. A PCMH system allows for the integration, prioritization, and personalization of healthcare to improve the lives of individuals and their communities.[1]

The at-risk and vulnerable homeless population in New Bedford is a group of patients that can significantly benefit from the patient-centered medical home model. These patients have diverse care needs such as physical, mental, and dental health, along with additional support needs including housing and employment. New Bedford has expressed interest in co-locating these services as a "one-stop-shop," which is a primary feature of PCMHs that goes beyond the constraints of traditional primary care.[1] A PCMH will decrease the fragmentation of health and social services for these vulnerable patients, reducing the risks that they fall through the cracks of the health care system. By establishing a PCMH, the City of New Bedford will be better positioned to proactively respond to the priority needs of the population, providing appropriate services to vulnerable patients when and where they need them.

Evidence on Effective PCMHs in Vulnerable Populations

In a study published in 2018, eighty-three PCMH staff members were interviewed to identify the PCMH components necessary to serve a medically complex, homeless population. Important factors identified included:

- Walk-in and same day availability, flexible and extended hours, and a mobile component to provide services in hard to reach areas
- Core services including substance use disorder counseling, mental health, medical, and housing services to teach life and coping skills for moving into stable housing

One successful example of a PCMH that focuses on the homeless population is the nonprofit organization called Care for the Homeless:

- Comprised of 14 sites across New York City with the shared goal to increase care coordination and improve access to healthcare for homeless individuals
- Each site provides primary care, substance abuse treatment, mental health services, dental care, and care management
- Offers comprehensive, holistic care in one location; fixes the issue of fragmented care for homeless patients

Implementing a PCMH in New Bedford: A Two-Phase Approach

Phase I. During the initial phase of the New Bedford Diamond Project, a mobile medical van should be utilized. This van will be a preliminary building block to the other services the medical home will eventually offer and provide a link between the clinical settings and the community. The van will provide services to address both clinical needs and social determinants of health and should provide basic medical services to community members such as first aid, physical exams, basic medications and vaccines. It should also carry supplies like toothbrushes, socks, and other basic needs of the community members. Additionally, the van should stock educational materials to handout to the community. It is crucial that the van has an appropriate interpreter or interpreter services available, as well as having the educational materials in different languages due to the diversity of languages spoken in the population.

Value provided by utilization of a mobile van:

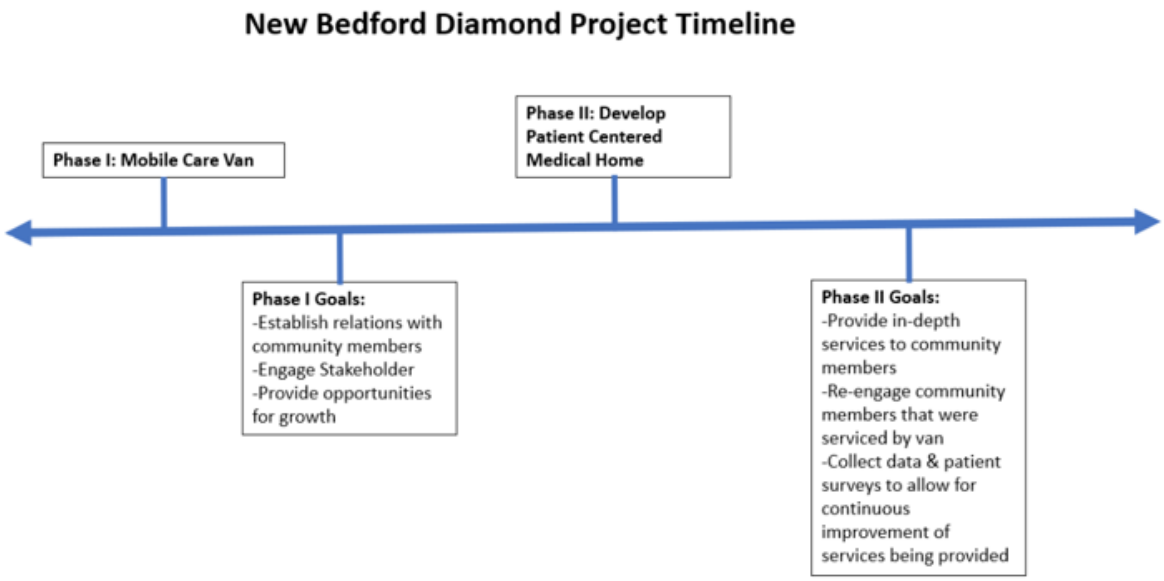
- Mobile vans have been successful in providing vulnerable populations quality care, as demonstrated by the mobile health clinics Kaiser Permanente implemented. [2]
- A mobile van can be implemented more quickly than a full facility and thus can create a more immediate impact.
- Using the van to provide services to the community can build trust so that, once the patient centered medical home opens, community members are already comfortable with the New Bedford Diamond Project and the services they provide.

Phase II. The second phase of the New Bedford Diamond Project will include a variety of clinical and social services at a permanent location modeled after the Patient Centered Medical Home. This location will house:

- General primary care services
- Dental services
- Needle exchange program
- Counseling services
- Educational materials
- Care coordination services

Primary care services will be administered by nurses, physician assistants, social workers, and students from clinical programs. These healthcare professionals will provide clinical care to patients or refer patients to an external provider. The Diamond Project should also include basic dental services such as cleanings, as nearly 25% of New Bedford Residents reported losing 5 or more teeth due to decay or disease. The New Bedford Diamond healthcare facility could benefit the residents by providing both individual and group counseling services. Statistics from the Southcoast Health Community Needs Assessment show that 12.8% of adults report having poor mental health days, which seems to be on the rise with each passing day. [3]

Similarly, the New Bedford area has seen substance abuse admissions increasing since 2013, causing substance abuse to be considered one of the biggest concerns in this area. [3] Because substance use is a growing concern, a needle exchange program could also contribute to overall community health. Existing needle exchange programs have experienced success by encouraging the safe disposal of needles and providing new needles to prevent the spread of infections. Such programs can also reduce needle litter, lower the incidence of diseases associated with sharing needles, and lower the risk of accidental needle sticks among public works employees. New Bedford has the highest rate of illiteracy in Massachusetts, with nearly 20% of the population being foreign-born[3] and as such, educational materials highlighting ways individuals can take care of their personal hygiene at home should be printed in multi-language brochures/pamphlets. To consolidate all these services, care coordination should be implemented so that all facets of the services are in communication regarding the patients.



A Financially Sustainable Model for Supporting the New Bedford PCMH

Due to the diverse health needs of New Bedford residents, diverse funding mechanisms are essential to adequately fund the many programs and services residents require. Below we outline several potential sources of revenue and partnerships to establish short-term and long-term funding streams.

Partnering with Community Stakeholders

1. ***Hospitals*** - Provide workforce, medical expertise. Develop patient-provider relationships to build trust among community which historically may be distrustful of the medical community. Leverage institutional resources with marketing of mobile van outreach and use of electronic medical record. Brand recognition with community health leader may increase utilization of services.
2. ***Individual Donors*** - Spreading the word of your mission can be effective in soliciting one-time monetary or in-kind donations from individuals who support your cause.
3. ***Community Organization*** - Have an established presence in the homeless community, helps build trust among the population you are aiming to serve, allows you to leverage their expertise and resources. May include local food pantries, community health workers, volunteer organizations and religious organizations.
4. ***Colleges and Universities*** – Provides a significant extension of the work able to be completed, provides a potential revenue stream. Students from various disciplines including social work, medicine, pharmacy, nursing, physician assistant and nurse practitioner programs are required to do clinical work. Colleges and universities must pay for the affiliation to send their students on clinical rotations. Can provide clinical faculty to oversee their students on rotation, salary for faculty members provided by the university.

Insurance Reimbursement

We can anticipate a large portion of those utilizing mobile health services are uninsured. Providing an opportunity for insurance eligibility assessment at the point of delivery will increase the reimbursable patient population. Patients may not have coverage established during the first encounter, but establishing a connection with MassHealth will increase their likelihood of coverage and reimbursement on future visits, both to the mobile van and during acute care hospital visits. Once patients have established coverage, patients can be coded for homelessness, which increases the complexity of their visit, resulting in a higher reimbursement rate for these visits. By maximizing opportunity for insurance coverage, you will ensure a long-term funding stream.

Grants

Federal or state grants can provide funding for specific initiatives. Examples of entities that disperse grants include:

1. Bill & Melinda Gates Foundation
2. Americorps VISTA
3. Massachusetts Department of Public Health

Short-Term Funding Opportunities

Funding Source	Benefits	Challenges
Donor Funding	Shows community support from local donors. Less restrictive than grants. Frequency of donations is not dependable.	No guarantee for renewed funding once project is stable. Donor may restrict how funding is used.
Grant Funding	Organizations with similar goals & mission. Does not need to be repaid. Potentially large source of funding. Greatly improve project outcomes.	Definitive timeline and restrictions based on grant. Application and reporting is time consuming and labor intensive. May require the personnel who works exclusively on maintaining / applying for grants. Restrictive on use and often narrow in scope.

Sustainable Funding Opportunities

Funding Source	Benefits	Challenges
Hospital Partnership	Provides workforce and medical expertise. Can be used as reputable backing to support program.	A poor hospital reputation may lead to distrust for services rendered.
Community Partnership	Ability to leverage established relationships between local organizations and the homeless population to establish trust. Not restricted to local organizations.	Expectation of brand marketing.
College and University Partnership	Provides service extension. Allows students to gain experience and earn hours toward their degree while providing labor at a reduced cost.	High turnover in staff can affect patient trust. Training new staff will incur higher cost.
Insurance Reimbursement	Sustainable stream of revenue.	Requires expertise and additional staff.

Conclusion

Adopting the PCMH model can prove to be an effective treatment method for the homeless population, as it will decrease the fragmentation of health and social services for these vulnerable patients. The successful implementation of the New Bedford PCMH will depend on the utilization of the mobile van to provide services in phase I prior to the establishment of the permeant location in phase II. The New Bedford PCMH should aim to provide a range of services with the most important being general primary care. Diverse funding sources should be pursued to ensure the long-term financial sustainability of the New Bedford PCMH. Engaging community stakeholders, ensuring patients accessing services are enrolled in insurance, and applying for grants are all promising means to secure funding. Our analysis suggests that the DIAMOND initiative has an opportunity to make a positive impact on the New Bedford community through the use of a PCMH model to meet the needs of the local homeless and high-need populations.

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Further Reading

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