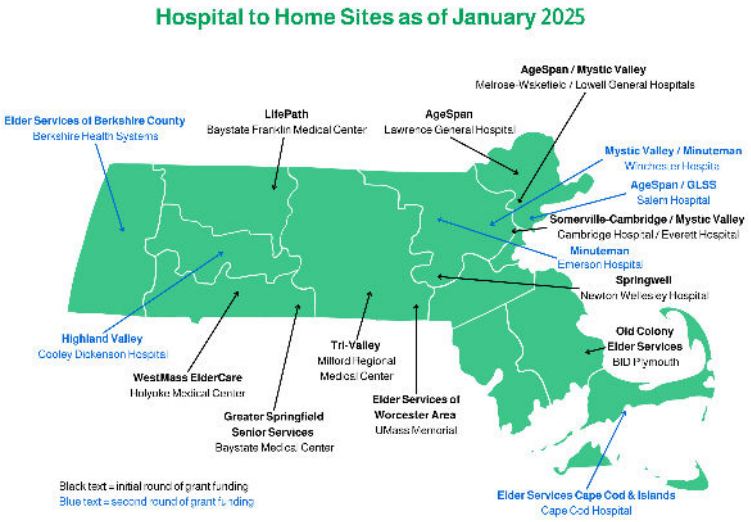
MAA Fact Sheet
Hospital to Home Partnership Program

An Act to codify the Hospital to Home Partnership Program (SD.1616)
Sponsored by Senator John Velis
An Act establishing the Hospital to Home Partnership Program (HD.2876)
Sponsored by Representative Kate Lipper-Garabedian

What is the Hospital to Home Partnership Program?

The Hospital to Home (H2H) Partnership Program was launched by EOHHS in 2023 as a grant-funded program designed to build and strengthen partnerships between hospitals and Aging Services Access Points (ASAPs). The program facilitates successful hospital discharges directly to patients' homes with the support of home and community-based services (HCBS), thereby reducing reliance on nursing home placements and reducing the length of unnecessary hospital stays. ASAP staff embedded at partner sites work with case management, nursing, and other hospital staff on identifying appropriate referrals and facilitating safe and timely discharges. The initial grant funded ten partnerships, with another six partnerships added in the second round of funding. Grant funding for this program ends in March of 2025. Our proposed legislation seeks to codify this program and eventually expand H2H to additional sites in future years.



Who does the H2H program help?

Consumers: The typical H2H referral is a consumer with complex medical needs, often either living alone without supports or relying on informal caregivers who may themselves need additional support. Many have behavioral health needs, substance abuse issues, dementia, or are homeless or housing-insecure. The majority of referrals are for older adults age 60+, however there are no age restrictions for patients referred to this program. The H2H program is also insurance-agnostic and is available to anyone regardless of payor.

Hospitals: The Massachusetts Health & Hospital Association (MHA) found that " nearly one out of every seven medical-surgical beds (or 15% of those in the state) is... occupied by patients who no longer need to be in an acute care hospital." (A CLOGGED SYSTEM: Keeping Patients Moving Through their Care Journey, June 2023). In December 2024, MHA President and CEO Steve Walsh stated, "About 2,000-plus patients are stuck in acute care hospitals unable to transition to the next level of care they need. Hospitals are spending more than $400 million each year to provide extra, unpaid care to patients as they await discharge to a post-acute setting. (SUD Bill Passes; A Financial Primer; Happy Holidays! 12/23/24). Massachusetts has seen the closure of 18 nursing homes since July of 2021 with two more scheduled to close in February of 2025 (Mass.gov), making discharges for patients needing support that much more challenging for hospital staff, and the need for this program is evident: in just the first nine months of the program, more than 1,800 referrals were made.

Summary

The Hospital to Home Partnership Program is a vital component of the Massachusetts health care landscape. The Hospital to Home Partnership Program can alleviate the pressure on hospitals, insurance payors, and nursing facilities, while also improving patient quality of life by providing HCBS in the individual's home and avoiding institutional placement.

Case Studies

Holyoke Medical Center and WestMass ElderCare

Mary R., a 72-year-old married woman residing at home with her spouse presented at Holyoke Medical Center in February 2024 with significant behavioral health issues that her spouse could not manage. Mary has diagnosis of Alzheimer's disease, anxiety, hypertension, major depressive disorder, and schizophrenia. She had numerous hospital admissions, a total of seven between February 2023 and February 2024 primarily due to her behavioral health issues. It had been recommended that she transition to long-term care, however each time the hospital discharge planners secured placement, Mr. R and Mary would decide that she would return home instead. Following the last two hospital re-admissions in February 2024, the H2H Liaison met with the hospital team as well as Mary and her spouse to discuss home care services and options. During the meeting, the hospital psychiatrist noted that the consumer's medication adherence is extremely important to her well-being. Following this statement, Mr. R. acknowledged that Mary requires more assistance than he can provide and verbally agreed to consider a discharge plan that included services at home using a visiting nurse along with home care services coordinated through WestMass ElderCare. Mary was discharged home at the end of March with support from homemaker services, a personal emergency response system, a medication dispensing unit, and home-delivered meals. She continues to have follow-up outpatient care with her Psychiatrist. **Mary remains at home with the support of the WestMass ElderCare services and has not returned to the hospital.**

Beth-Israel Deaconess Plymouth and Old Colony Elder Services

A 95-year-old woman who lives alone was admitted to BID Plymouth on 4/7/24 and discharged on 4/11/24. This consumer came to the hospital with some confusion as she thought two men were breaking into her home. During her admission, a new diagnosis of Alzheimer's dementia with psychotic disturbance was identified and added to her existing diagnoses of hypertension, hyperlipidemia, GERD, hypothyroidism, and chronic kidney disease. With the help of the H2H liaison, homemaker services including cleaning and meal preparation were implemented. Meal preparation was very important as the consumer would not eat unless the food was presented to her and she was encouraged to eat. This consumer was becoming increasingly frail, which was a significant concern for her family. Over the course of the next couple of months, home care services increased to include a home health aide, a personal emergency response system, and home-delivered meals, and the consumer was enrolled into the Enhanced Community Options Program ("ECOP"), which is designed to serve frail older adults living in the community who are at risk of nursing home placement due to functional or cognitive impairment. **Because of the services coordinated by the H2H liaison at Old Colony Elder Services, combined with informal supports, this consumer has now been able to remain safely independent in her home without further hospital re-admissions.**

Melrose-Wakefield Hospital and Mystic Valley Elder Services

A 61-year-old divorced male was referred to the H2H program in March 2024. He was homeless and living in the Revere/Malden areas in his truck, and was admitted to Melrose-Wakefield Hospital with a diagnosis of hypertension and ketoacidosis due to the inability to manage diabetes as he could not afford his insulin. He had been working in construction but had recently been laid off and was unable to afford his rent and subsequently was evicted. He had only been living in his car for a few weeks, but was unable to manage his health and his legs were edematous from the pressure of sitting upright and not being able to rest in a lying position in his car. His goals were to contact the unemployment office as he had not received any funding since the time of his layoff, and to look for housing opportunities in the area. He has limited support from a sister who lives out of state and would not be able to stay long-term with her. The H2H liaison intervened by scheduling an in-person visit to Mystic Valley Elder Services. The H2H liaison was then able to help the consumer access the unemployment website, and locate his insurance information so that the insurance info could be provided to CVS to expedite medications. The consumer had no money for gas or medication co-pays, so the H2H liaison applied for funding to get a gas card and co-payments for medications. Food and toiletries were gathered from the agency's emergency pantry. In the following weeks, the liaison worked to creatively meet this homeless consumer's needs for bathing/dressing. The liaison applied for funding to cover a YMCA membership for three months in Malden to provide a place for showering, in addition to exercise and companionship. Referrals were made to the Malden Warming Center and the consumer was provided with a list of resources for rooming houses. After 30 days, this consumer was transferred from H2H into the agency's ANCHOR program for additional intensive care management and support. **At this time, he has started to receive unemployment and has found a job. He is managing his diabetes and is attending medical appointments for follow up.** He is still sleeping in his car but he a goal to find permanent housing and he continues to research and interview at local rooming houses.