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Chairs Jehlen and Stanley
Joint Committee on Aging & Independence
State House
24 Beacon Street
Boston MA 02133

Dear Chairmen Jehlen and Stanley,

This supplements the testimony provided by MA Aging Access regarding S495, "An Act Codifying the Hospital to Home Partnership Program and H780 "An Act Establishing the Hospital to Home Partnership Program, sponsored by Senator John Velis and Representative Kate Lipper-Garabedian, respectively.

Access Care Partners, formerly WestMass ElderCare, has had the opportunity to partner with Holyoke Medical Center and their Case Management Team on the Hospital to Home Program since July 2023. The goal of the program is to provide a discharge directly to home following a hospital stay, averting possible nursing facility stays and connecting patients and caregivers to public and private resources to promote stability during a transition of care from hospital to home and avoid possible readmissions to the hospital. Through the program, Access Care Partners provided 2 part time bilingual Spanish staff who were embedded and collaborated daily with Holyoke Medical Center's Case Management to achieve the program's goals.

The H2H grant has helped individuals transition smoothly from the hospital to their homes. We achieved key success, including building strong relationships with the hospital team and the hospital overall. These efforts made the transition easier for patients, families, and care teams. The program also helped bring long term care/resource education to the patient and the family, which helped them make an informed decision about the patient's care. These efforts helped with reducing hospital readmissions and provided person centered supports.

The grant program helped improve coordination between hospital professionals, healthcare providers and community services; making sure patients received the appropriate support after leaving the hospital. As the program is "agnostic" to insurance, liaisons had the opportunity to have patients referred regardless of age or payer. The liaisons provided expertise and knowledge of community resources, bridging the transition from hospital to home, educating patients and caregivers and providing options including private pay and referrals to community partners. The program assisted with timely and safe discharges working in collaboration with the Case Management team at Holyoke Medical Center. The in- patient and community-based discharge approach was welcomed by the HMC staff and supported patients during the discharge process.

This is a successful model which should be continued and evaluated further using common metrics to demonstrate its value in support of patient and health care provider needs.

Because of the consistent on-site presence, referrals have been steady ranging from 6 to 29 per week depending on the daily hospital census. Referrals continue to be received via the hospital's Tiger text messaging system and gleaned from daily rounds including referrals from the Emergency Room. A forum for discussing complex referrals was initiated to assist the ACP Liaisons with planning for medically complex consumers to ensure that information pertaining to care needs was communicated with the H2H ASAP RN and CM. For complex cases, the Holyoke VNA and ASAP RN have attended the meeting virtually. It has included the sharing of the discharge planning document from the hospital which has aided in meeting individual care needs at home.

A comparison of the baseline metrics for this reporting period demonstrates a slight reduction in the 90-day admission rate. The initial 90-day admission rate percentage was 15% and more recently the average is 14% (the last two reporting periods*) for an average readmission rate. The data includes individuals discharged to all settings including home with community support. For individuals admitted with the primary diagnosis of UTI, Sepsis, or kidney disease the readmission rate improved from 18% to 16% *and for people with the primary diagnosis of Stroke, CHF, and Cellulitis the readmission rate went from 23% to an average of 17%* for the final reporting period. The readmission rate statistics support that the Hospital to Home activities may have contributed to slightly lower readmission rates for the hospital.

There are approximately 15 Hospital to Home sites across MA. Holyoke Medical Center has been supportive of the collaboration as has the MA Hospital Association. Given the budgetary and clinical needs for hospital stays to be appropriate, the need for safe discharges and constrained nursing facility capacity, the H2H programs demonstrate how working across systems to work with patients quickly and efficiently can improve patient experience and result in better outcomes. The continuation of the H2H program should also include the collection of commonly defined metrics to understand the program's value and positive financial and health related impacts across programs.

Thank you for the opportunity to consider these important Senate and House bills during a time when health systems are challenged as are all publicly supported programs.

Sincerely,

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