Written Testimony in Support of S495/H780, An Act to Codify the Hospital to Home Partnership Program/An Act Establishing the Hospital to Home Program

Presented By:
Lisa Gurgone, Chief Executive Officer
Mystic Valley Elder Services
May 12, 2025

INTRODUCTION

Mystic Valley Elder Services (MVES), founded in 1975, serves as the state-designated Aging Services Access Point (ASAP) and the federally designated Area Agency on Aging (AAA) for the following 11 cities and towns: Chelsea, Everett, Malden**,** Medford, Melrose, North Reading, Reading, Revere, Stoneham, Wakefield, and Winthrop. Working in close collaboration with the Massachusetts Executive Office of Aging & Independence (AGE), our mission is to support the right of older adults and people with disabilities to live independently with dignity in a setting of their own choice by providing information, advice, and access to quality services and resources. We act as the entry point for older adults, people with disabilities, caregivers, and health care professionals to access a wide variety of home- and community-based programs, services, information, and care coordination.

Our agency employs more than 356 staff, coordinates the efforts of over 175 volunteers, and is governed by a 16-member community-based Board of Directors. MVES is one of the largest aging service agencies in the Commonwealth of Massachusetts and serves an ethnically and socio-economically diverse population of older adults, people with disabilities, and their caregivers.

MVES is extremely grateful to Senator John Velis and Representative Kate Lipper-Garabedian for working with our organization and Mass Aging Access (MAA) to file this bill. We are honored to provide the following written remarks to support the verbal testimony provided by members of the MVES leadership team during today's hearing.

OVERVIEW OF LEGISLATION AND HOSPITAL TO HOME PARTNERSHIP PROGRAM (HHPP)

S495/H780 seeks to codify in statute the Hospital to Home Partnership Program (HHPP) currently being piloted through the Executive Office of Health and Human Services (EOHHS) and AGE, with funding from the American Rescue Plan Act (ARPA) to build and strengthen partnerships between hospitals and Aging Services Access Points (ASAPs). The HHPP provides opportunities to create a meaningful impact on reducing rates of readmission to hospitals while

diverting patients from nursing facilities to support them in the community at the crucial point of hospital discharge. This collaboration between hospitals and ASAPs leverages the partnership's collective resources and expertise to work with patients to develop and execute a successful transition back to their communities.

EOHHS created the HHPP to respond to the need documented by the Massachusetts Health & Hospital Association (MHA) that "nearly one out of every seven medical-surgical beds (or 15% of those in MA) are 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 an acute care hospital 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).

The typical HHPP m patient is an older adult with complex medical needs, often either living alone without support or relying on informal caregivers who may themselves need services. Many of these individuals have behavioral health needs, substance abuse issues, dementia, or are unhoused or housing insecure. While most HHPP referrals are adults over 60 years of age, there are no age restrictions for patients referred to HHPP. HHPP is also insurance-agnostic and available to anyone regardless of payor. Over 1,800 patient referrals were made by hospitals to ASAP program liaison staff across the Commonwealth within the first nine months of HHP programs being launched in 2023 (Mass Aging Access Fact Sheet, Hospital to Home Partnership Program, January 2025).

HEART OF THE HHPP MODEL – HOSPITAL TO HOME (H2H) LIAISON

A key component of the HHPP is the Hospital to Home (H2H) Liaison, an ASAP staff member embedded with the hospital care management team. This ASAP employee receives referrals directly from social work and nurse case management staff at the hospital in person, via email, or via encrypted hospital communication systems. The H2H Liaison meets directly with the patient at their hospital bedside to build rapport and assess needs to start service planning. They provide the patient and their family with information and options for additional programs that may benefit them as they transition home from the hospital, reducing the likelihood of readmission.

The H2H Liaison continues to support the patient following their discharge from the hospital. They visit the patient in their community setting to assess their needs and environment and to ensure that the service plan is being received as scheduled. The H2H Liaison ensures that the patient has access to all medications as ordered at discharge and confirms that transportation for follow up primary care appointments has been secured. They serve as a resource to the patient and family until they are successfully transitioned to the appropriate community agency and connected with supports, which for many older adults and people with disabilities will be an on-going ASAP care manager. The H2H Liaison also updates hospital staff on progress and provides information to support patients in subsequent visits and admissions.

Patients enrolled in HHPP are provided with access to care at the time of their return to the

community, which in turn decreases readmissions to hospital and diverts from nursing facility placement. Communication is streamlined and connections are made at the time of a hospital admission, so all parties are aware, and needs are met prior to discharge. A great deal of time and effort is saved by direct connection from the H2H Liaison to the ongoing care management staff at the ASAP. Patients who are ready for discharge are swiftly referred for services, and the home care process is expedited so that needs are met at time of discharge.

DATA FROM HHPP EXPERIENCE AT MVES

MVES was extremely grateful to be awarded funding through three HHPP grants from EOHHS in partnership with other ASAPs during the program pilot. The partnerships established through these grants include:

- MVES led initiative with AgeSpan in partnership with Tufts Medicine - MelroseWakefield Hospital and Lowell General Hospital Main and Saint's Memorial Campuses – Start Date: July 2023
- Somerville Cambridge Elder Services led initiative with MVES in partnership with Cambridge Health Alliance Hospital and Everett Hospital – Start Date: December 2023
- MVES led initiative with Minuteman Elder Services in partnership with Winchester Hospital – Start Date: September 2024

Through the launch of our first HHPP pilot in July 2023 through April 2025, MVES has assisted 659 patients through this program.

- 441 of these individuals are enrolled in HHPP. To date, 218 of these patients were already enrolled in the state home care program or managed care programs offered through MVES and received enhanced coordination services from the H2H Liaison, hospital team, and MVES ongoing care management staff during their in-patient stay and through their transition back home
- 53 of these individuals were discharged from the hospital to a nursing home facility and have enrolled in the MVES Community Transition Liaison Program (CTLP) which will continue to provide navigation services to help their individuals transition back to the community

103 of the patients supported through the MVES HHPP pilot to date have been referred to and enrolled in the State Elder Home Care Program or Frail Elder Waiver post-discharge and are receiving in-home services to better support their needs in the community. To date in the aggregate, these individuals have received:

- 4,470 home delivered meals
- 2,311 hours of homemaking services
- 505 hours of personal care services
- 33 Personal Emergency Response systems (PERS) installed

MVES HHPP CASE STUDY: IMPACT AND RETURN ON INVESTMENT (ROI)

In February 2025, MVES was honored to host EOHHS Undersecretary Dr. Kiame Mahaniah, AGE Secretary Robin Lipson, and key staff members to our organization for a presentation to learn more about the innovative services and supports MVES offers to enable older adults and people with disabilities to age with dignity and independence throughout the community. During this presentation, MVES shared the following case study highlighting the impact and success of the HHPP in supporting patients.

The patient, a 70-year-old woman, began her journey with HHPP in December 2024. She was admitted to Tufts Medicine – MelroseWakefield Hospital with a diagnosis of pneumonia related to lack of heat at her apartment. The MVES H2H Liaison visited her at the bedside and learned that she was unable to complete her recertification for fuel assistance application. This individual agreed to enroll in HHPP. MVES staff worked in close collaboration with the hospital social worker to gather the necessary documentation and information to complete the fuel assistance application. After a nine-day hospital stay, the patient was discharged from the hospital to a nursing facility for a rehabilitation stay of five days.

On the same day that this consumer was discharged from the nursing facility back to her home, the MVES H2H Liaison completed a home visit with a care manager from MVES' Protective Services department. Together they provided the woman with a space heater and helped her complete an application for the MVES Independence Fund, which would pay for oil delivery until her fuel assistance was approved. The MVES team not only addressed the home heating issue but also referred this woman to our State Home Care program. She was enrolled in this program and is now connected to ongoing care management, meals, and laundry service.

Using the most recently available data from the Kaiser Family Foundation and MassHealth, MVES estimates the potential cost savings to the health care system because of this woman's enrollment in the HHPP program:

Estimated Cost Savings from HHPP Program	
Hospital/Rehab Stay	**Post-Rehab MVES Home Care Services**
December 2024: 9 day stay at Tufts MelroseWakefield Hospital	January 2025 to Present: Enrollment in MVES Home Care Services
–Estimated Cost: $3,529/day* for total cost of approximately $31,761	Emergency Oil Delivery: $349
	Laundry Services:
December/January 2025: 5 day stay at Nursing Home/Rehab	–1/week and cost of $139.62/month
–Estimated Cost: $974.96/day** for a total cost of approximately $4,875	Home Delivered Meals:
	–5/week and cost of $194.39/month
	Ongoing Care Management Services:
	–$194.91/month
Estimated cost of 2-week hospital/rehab stay: $36,636 while the estimated monthly cost of MVES home care services post-discharge: $878	
*Kaiser Family Foundation, Hospital Adjusted Expense per Inpatient Day	
** MassHealth: Payments for Chronic Disease and Rehabilitation Hospital Services Effective October 1, 2023	

EFFORTS TO SUPPORT HHPP MOVING FORWARD

Over the last two and half years, the HHPP has been a vital component of the Massachusetts health care landscape in the Mystic Valley area and beyond. With the ending of ARPA funding for this initiative, MVES is engaged in conversations with our ASAP and hospital partners to explore new funding opportunities to keep this successful model in place. The MVES Development department has applied for funding through various philanthropic partners and foundations to continue our programs. Under the leadership of MAA, we also continue to work in collaboration with MHA and state leaders to explore leveraging existing health care dollars to financially support HHPP initiatives moving forward.

The passage of S495/H780, An Act to Codify the Hospital to Home Partnership Program/An Act Establishing the Hospital to Home Program, is a key component of our collective advocacy to mandate continued support of this program by EOHHS. Our direct experience implementing HHPP initiatives at the local level shows that these innovative collaborations help to alleviate the pressure on hospitals, insurance payors, and nursing homes, while also improving patient quality of life by providing essential home- and community-based services that allow people to age in place.

On behalf of our HHPP partners and the communities we serve, MVES respectfully requests that the Joint Committee on Aging and Independence release S495/H780 with a favorable report. The HHPP's success can be attributed to the meaningful health care education, interventions, and care coordination that this program offers. With over 10,000 individuals turning 65 every day, it is vitally important for our Commonwealth to continue to expand and support innovative collaborations like HHPP which help individuals transition from institutions back home with the services and supports they need to live safely in community settings, reduce future hospital visits, and save significant health care/long term care system dollars.