Healthy Lives Program

The Challenge

The Healthy Lives Program is an intensive, community-based care coordination intervention that targets patients with a high level of emergency department and in-patient utilization driven by serious mental illness in combination with chronic medical conditions. These 'super-utilizer' patients have lifespans that are 25 years shorter than the average American. This population is typically disorganized and isolated, hindering traditional efforts of care. These patients need an extra level of care coordination and active outreach in order to help them engage with primary care providers.

Aim/Goal

Healthy Lives seeks to decrease avoidable emergency department visits and hospitalization and to increase adherence with disease management strategies, care integration, and access to outpatient primary care resources. Through this process, patients move from passive recipients to active participants in their care.

The Team

Healthy Lives is a collaboration between BIDMC, the Brookline Community Mental Health Center, and the Aligning Forces for Quality (AF4Q) Program of the MHQP.

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The Interventions

- Whole person centered evaluation of medical, behavioral, social, and environmental problems and barriers faced in receiving care
- Home visiting by an NP, RN and/or case manager
- Accompaniment of patients to medical appointments and procedures
- Coordination of medical, behavioral, and in-home healthcare providers
- Medication reconciliation, education, and coordination
- Identifying and gaining access to available resources
- Providing health education and coaching in individual and group settings
- Engaging patients in preventative care and group exercise

Photo: David Binder

Results/Progress to Date

The team has compiled utilization reports to identify the 'super-utilizer' population. 150 patients were identified as super-utilizers. 64 met the clinical and geographical criteria for enrollment in the Healthy Lives Program.
11 patients have been engaged. There has been a decrease in ED utilization compared to baseline. Patients report an improvement to their overall health, and better access to and communication with primary care providers.

Lessons Learned

- 'Super-utilizer' patients are difficult to engage – they require a specialized approach, including assertive outreach
- Given that patients have complex, mutli-morbidities, staff require both medical and behavioral health skills as well as a strong knowledge of local resources
- Most patients are socially isolated and benefit greatly from peer support groups

Next Steps/What Should Happen Next

The program will be working with additional BIDMC programs and sites, including the Post-Acute Care Team (PACT) and the Bowdoin Street Health Center, to serve a greater number of 'super-utilizer' patients. Requests have been made for increased access to patient information to better coordinate care and streamline provider communication. Through continued experience, the team is working to design a model of care to better suit the needs of these complex patients.

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