



**\$2.8M**

TOTAL PROJECT COST

**\$2.5M**

HPC AWARD

## Target Population & Aims

### TARGET POPULATION 1

Patients with  $\geq 10$  ED visits in the last 12 months

**2,359**

ED visits for 147 unique patients

### TARGET POPULATION 2

ED patients requiring a Narcan reversal or obstetric (OB) patients with substance use disorder (SUD)

**339**

Patients requiring Narcan reversal

**46**

OB patients with SUD

### PRIMARY AIM

Reduce ED utilization by

**20%**

### SECONDARY AIM 1

Increase post-ED contact with patients or families of patients who were seen in the Hallmark Health ED following an opioid overdose with Narcan reversal within 1 week of the index event by

**25%**

### SECONDARY AIM 2

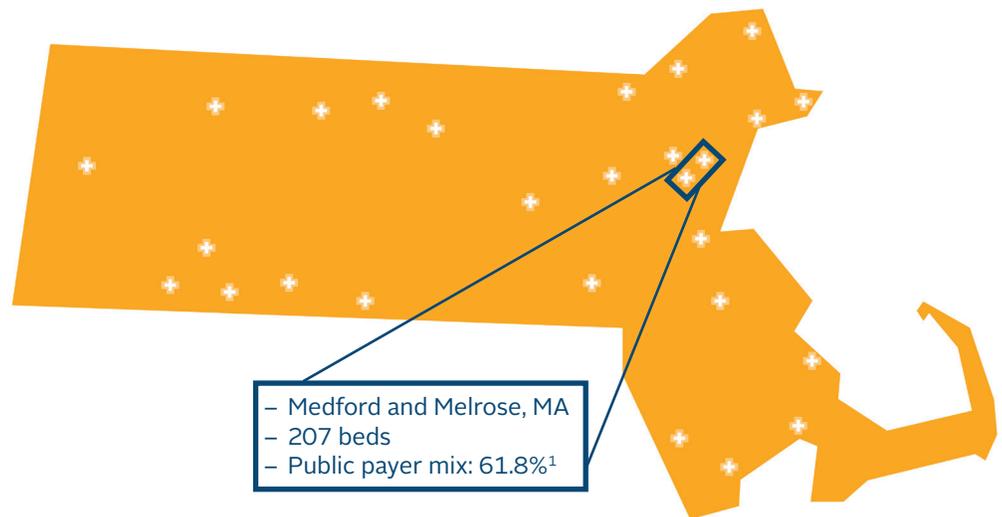
Provide at least 1 COACHH team contact per week for the duration of their pregnancy, for 80% of Hallmark Health OB patients with SUD as referred to the COACHH program

## Summary of Award

The Hallmark Health System joint hospital program aims to reduce Emergency Department (ED) utilization by 20%. Hallmark Health developed the Collaborative Outreach and Adaptable Care at Hallmark Health (COACHH) program to improve care for three patient subpopulations: patients with high utilization of ED services, obstetric patients with active substance use disorder, and patients with a history of near-lethal opioid overdose requiring a Narcan reversal. Eligible patients are seen by a team of community health workers supported by a social worker to coordinate post-discharge follow-up care. Should patients elect to engage with the COACHH program, they are cared for by a multidisciplinary, integrated care team that follows up with patients in the community over time to ensure access to services and stability within the community setting. Comprehensive care planning is a key component of Hallmark's program.

## Collaborative Outreach and Adaptable Care at Hallmark Health

An elderly woman living alone had over 150 ED visits over the course of 15 months. Following a home visit with Hallmark staff, she enrolled in the COACHH program. The COACHH team made over ten home visits and many follow-up calls with the patient, collateral providers, her primary care provider, and family. The level of engagement with the patient, including assistance with simple logistical issues, has averted a pattern of anxiety and panic that historically resulted in an ED visit. Whereas prior to the COACHH team's intervention she may have had over 30 ED visits since enrollment, she has had only one ED visit lasting for just one hour.



## CHART Background

The Community Hospital Acceleration, Revitalization, and Transformation Investment Program (CHART) makes phased investments for certain Massachusetts community hospitals to enhance their delivery of efficient, effective care. The goal of the program is to promote care coordination, integration, and delivery transformations; advance electronic health records adoption and information exchange among providers; increase alternative payment methods and accountable care organizations; and enhance patient safety, access to behavioral health services, and coordination between hospitals and community-based providers and organizations.

1. Source: Center for Health Information and Analysis, 2015.