CHART PHASE 2
STATEWIDE CONVENING
OCTOBER 16, 2017

LESSONS FROM 2 YEARS, 25 Awardees, and $60 Million
Welcome

Kathleen Connolly, Director, Strategic Investment
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The CHART Method

Amy Boutwell, MD, MPP
President, Collaborative Healthcare Strategies
Specific aim:

Enhance the delivery of efficient, effective care and develop the capability to succeed under value-based payment.
Broad Capabilities

1. Reduce avoidable acute care utilization
2. Improve care for patients with behavioral health conditions
3. Improve operational efficiency
CHART Universal Design Elements

- Data and root cause analysis
- Real-time identification
- Timely engagement
- Whole-person approach
- Service across settings and over time
- Collaboration across the continuum and across sectors
- Implementation and outcomes measurement
Active redesign over time; we change what we do to drive results
Engagement + Service Delivery = Outcomes

- Actual v. engaged target population
- Timely contact <48 hours
- Type of services delivered
- Location of services delivered
- Intensity of services delivered
- Utilization outcomes
Performance Management

Monthly review of operational performance encouraged change

- Monthly data reports
- Monthly program updates
- Regular communication with Program Officers
- Quarterly review with reflection: successes, challenges, next steps
- Periodic surveys, site visits, celebration events, alignment discussions
Focus of technical assistance evolved over time as each program evolved

Phase 1: Launch
- Identify
- Serve

Phase 2: Signal of Success
- Serve high %
- Timely f/u
- Trend to goal

Phase 3: Optimize + Hardwire
- Effective
- Efficient
- Standard work

Phase 4: Sustain + Spread
- Align with incentives
- Right-sized
- Apply elsewhere

15 shared learning events and >300 on-site coaching sessions over 2 years
CHART Results: Success!

1. The model works; the methods are durable across heterogeneous target populations and operational settings

2. The capabilities developed; every CHART hospital has developed capabilities needed to help them succeed in value-based payment models
Rapid-Fire Panels

- **Panel 1**: Reducing Readmissions for High Risk Patients
- **Panel 2**: Slowing the Cycle of High Utilization for Multi-Visit Patients
- **Panel 3**: Improving Care for Behavioral Health Patients in the Emergency Department
- **Panel 4**: Lessons Learned, Capabilities Developed, and the Future
Key Differentiators You Will See Today

- There are no disease-specific programs here
- These are highest-risk populations, based on their own local data analysis
- There is no predictive modeling used; just epidemiology (who is in a high risk group)
- We don’t exclude patients (leaving AMA, lacking housing, active SUD, etc.)
- Case finding in acute care setting, not in primary care
Key Differentiators You Will See Today

- Impact is reported at the target population level – whether or not they were “served”
- Programs prioritized engagement to drive up service to drive outcomes
- Note the team composition: community health workers, social workers, data analysts
- Impact in a high-risk, high-volume target population can drive hospital-wide results
Ask Yourself

- Do I understand the root causes of utilization of my target population?
- Do I address root causes of utilization with social, behavioral, logistical supports?
- Do I use effective engagement strategies?
- Do I have meaningful collaborative relationships with providers and agencies that share in the care of my target population?
Purpose of Today: Inform, Inspire, Activate

- It is possible to address social drivers of utilization
- It is possible to improve care for patients with behavioral health needs
- It is possible to slow a cycle of high utilization
- It is possible to reduce readmissions…for Medicare, Medicaid, and dually-eligible
- It is possible to reduce avoidable ED utilization
- It is possible to reduce costs by improving care…and changing lives
Thank you for your commitment to improving care

Amy Boutwell, MD, MPP
President, Collaborative Healthcare Strategies
Panel 1: Reducing Readmissions for High Risk Patients
Beverly Hospital
Reducing readmissions for high risk patients

Team

- RN Manager
- Analyst
- 2 RN
- 2 SW
- 2 Pharm
- 8 FTEs
- 5 role types

Average volume

- 400 Discharges/month
- 335 (84%) Discharges served/month
- 260 patients/month

Success factors

- Monthly data to drive improvement
- Weekly clinical review
- Strong impact on Medicaid readmissions
- ED action plans
- Home visits and community partners

*The graph is limited to the second year of program operations due to delays in staffing.
CHART Phase 2 teams developed content for these slides for the purposes of the October 2017 Statewide Convening that reflects their hands-on experience, self-reported data analysis, and key findings.
Emerson Hospital
Reducing returns for high risk patients

Team

- 1 Pharm
- 2 SW
- 1 RN CM
- 1 Navigator
- 6 FTEs
- 5 role types
- Project Manager

Success factors

- Dedicated SW Navigator for BH patients
- CNL oversees high risk patients with team
- Active collaboration with SNF
- Pharmacist med reconciliation and teaching
- Increased palliative care and hospice referrals

Average volume

- 145 Discharges/month
- 135 (93%) Discharges served/month
- 135 patients/month

Emerson Hospital
Target Population Return (IN/OBS) Rate

- 27% reduction to date

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Beth Israel Deaconess Hospital – Plymouth
Reducing returns for high risk patients

Team

- RN Manager
- 1 RN CM
- 1 SW CM
- 1 Resource Specialist
- 4 FTEs
- 4 role types

Average volume

<table>
<thead>
<tr>
<th>Discharges/month</th>
<th>Discharges served/month</th>
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</thead>
<tbody>
<tr>
<td>85</td>
<td>70 (82%)</td>
</tr>
<tr>
<td>125 patients/month</td>
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</tbody>
</table>

Success factors

- Transition from telephone to community outreach
- Co-management of patients
- Leverage Resource Specialist’s skills
- Engage patients while hospitalized

29% reduction to date

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Baystate Wing Hospital
Reducing readmissions for high risk patients

**Team**

- RN Manager
- 3.4 FTEs
- 3 role types
- 1 RN
- 1.4 SW

**Average volume**

- 190
- Discharges/month
- 185 (97%)
- Discharges served/month
- 100 patients/month

**Success factors**

- Team coordination and flexibility
- Broad risk factor criteria for intervention
- High enrollment rate: scripting, inpatient engagement, holistic approach
- Patient-centered home visits

*The team changed its targeting strategy in May 2016, and the graph reflects this approach.
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Panel 2: Slowing the Cycle of High Utilization for Multi-Visit Patients
Winchester Hospital
Reducing inpatient utilization for multi-visit patients

Team

- Clinical Team Manager
- 6 FTEs
- 3 role types
- 5 RN
- 1 NP

Average volume

- 45 Discharges/month
- (44%) 20 Discharges served/month
- 40 patients/month

Success factors

- Relationship building
- Team-driven approach
- Performance improvement focus
- Continuous learning

Winchester Hospital
High Utilizer Readmission Rate

10% reduction to date

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Hallmark Health System
Reducing ED utilization for multi-visit patients

Team

- Executive Director
- Analyst
- 1 NP
- 1 SW
- 3 CHW
- 1 day/wk Pharm
- PCP consultant

7 FTEs
7 role types

Average volume

140
ED visits/month
140 (100%)
ED visits served/month
150 patients/month

Success factors

- Focused, committed leadership
- Structured, efficient daily huddles
- Continuous, responsive learning
- Community-based, person-centric care
- Longitudinal perspective

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Hallmark Health System
Target Population ED Visits

24% reduction to date

ED Visits
Linear (ED Visits)
Baystate Noble Hospital
Reducing ED utilization for multi-visit patients

Team

- RN Manager
- “Air Traffic” and Analyst
- 5 FTEs
- 5 role types
- 1 RN
- 1 SW
- 1 MHC

Average volume

- 100 ED visits/month
- (45%) (45%)
- 35 patients/month
- 45 ED visits/served/month

Success factors

- “Air traffic control” function
- Meet patients while in hospital, every time
- Iterative, patient, persistent
- Home visits

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UMass Marlborough Hospital
Reducing total utilization for multi-visit patients

Team

- Project Manager/Data Analyst
- Clinical Manager

- 4.5 FTEs
- 5 role types

- 1.5 ED RNs
- 0.5 LMHC
- 1.2 SW

Average volume

- 130 Discharges/month
- 120 (92%) Discharges served/month
- 95 patients/month

Success factors

- Operations flexibility
- Retrain care-seeking behaviors and coping strategies
- Frequent patient contact and listening
- ED care plans

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Lahey/Lowell Joint Award: Lowell General Hospital
Reducing ED utilization for multi-visit patients

Team

13 FTEs 5 role types
RN Manager
1 NP 4 SW 6 CHW Admin

Average volume

660 550 (83%) 310 patients/month
ED visits/month ED visits served/month

Success factors

✓ Team approach; clearly defined roles
✓ Collaboration with community partners
✓ Meet patients’ immediate needs to establish rapport
✓ Flexible, persistent, iterative over time

1 Average volume reflects total target population for the Lahey/Lowell Joint program
2 Patients with highest ED utilization = 14+ ED encounters prior to (and inclusive of) qualifying event. Patients measured based on status at time of qualifying event, so this population excludes those qualifying as moderate utilizers (8-13 ED encounters).

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Panel 3: Improving Care for Behavioral Health Patients in the Emergency Department
Harrington Memorial Hospital

Improving care for behavioral health ED patients

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Team

- RN Manager
- Analyst
- SW Supervisor
- LCSW
- 4 Navigators

8 FTEs
4 role types

Average volume

- 275 ED visits/month
- 200 (73%) ED visits served/month
- 120 patients/month

Success factors

- Address patients’ basic needs first
- Creatively leverage community resources
- Effective engagement tactics, frequent contact
- Adapt care model to achieve outcomes
- Drill down on data to understand impact

Harrington Memorial Hospital
Target Population Revisits

34% reduction to date
Heywood and Athol Hospitals
Improving care for behavioral health ED patients

**Team**

- RN Manager
- Analyst
- 3 BH Therapists
- 2 CHW

**Average volume**

- 600 ED visits/month
- 350 (58%) ED visits served/month
- 315 patients/month

**Success factors**

- Co-located in ED
- Clinical case finding, not billing data
- Shift from “medical” to “whole-person”
- Actively link to services, follow through

*The team changed its targeting strategy in May 2016, and the graph reflects this approach. CHART Phase 2 teams developed content for these slides for the purposes of the October 2017 Statewide Convening that reflects their hands-on experience, self-reported data analysis, and key findings.*
Beth Israel Deaconess Hospital – Milton

Improving care for behavioral health ED patients

**Team**

- Director of Care Integration
- Analyst
- SW
- BH Navigator
- Project Manager
- 1 day/wk Peer
- 5.2 FTEs
- 6 role types

**Average volume**

- 45 patients/month
- 45 (100%) ED visits/ month
- 45 ED visits/ month

**Success factors**

- Successful integration of SSMH clinicians into the ED
- Hardwired care processes in ED
- “Humanized” BH population in ED
- Extensive collection of collateral patient information
- Initiate medications and support in ED
- Longitudinal management of care transitions

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*BLong stay ED behavioral health patients are defined as patients with a primary BH diagnosis and a length of stay greater than eight (8) hours. “Excess boarding” describes the portion of the length of stay in excess of four (4) hours.*

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**32% reduction to date**

**BIDH - Milton Excess ED Boarding**

- Length of Stay
- Linear (Length of Stay)
Holyoke Medical Center
Improving care for behavioral health ED patients

Team

BH Manager
BH RN Director
14 FTEs 7 role types

MD consultant
4 APRN/RN
5 SW
4 CMHW

Average volume

870
610 (70%)
140 patients/month

ED visits/month
ED visits served/month

Success factors

- Flexible model to address patient needs
- Active presence in ED
- Persistence and commitment to engagement
- Director-to-Director level advocacy and problem-solving

29% reduction to date

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