HEALTH POLICY COMMISSION
CHART PHASE 2
AUGUST 2016 REGIONAL MEETINGS – AUGUST 22 AND 23, 2016

Contents

Purpose

This month's regional meetings, facilitated by Dr. Amy Boutwell, highlighted the work of CHART front line staff with the goal of facilitating conversations among teams to voice common barriers and to share successful tips, strategies, and lessons learned that can address those challenges. The meetings provided a chance for CHART teams to meet, network, and discuss their programs with others. Below is a summary of Dr. Boutwell's observations and the questions and answers shared during the facilitated discussions, organized by role types and logistical/operational questions (note that this summary is comprised of notes from both Northeast/Southeast and Central/Western regional meetings).

Observations 42% of the way through CHART Phase 2

Previous Regional Meetings: Recap

In February, we discussed operational successes and challenges in the early months of implementation. In April, Ms. Parsons of Signature Healthcare Brockton Hospital presented on the CHART team's work in obtaining measureable results for their program's target population. We began discussing operational milestones: serving a high percentage of target population patients, providing timely follow up, and structuring team roles and services to deliver effective care. Meeting these milestones can lead to signals of success among patients served. In June, we heard from CHART hospitals on how their teams work to achieve operational milestones and successes in months nine through ten of implementation. Following these sessions, many CHART Phase 2 teams expressed a desire to hear more from the Phase 2 hospital cohort.

August 2016 Regional Meetings: Interactive Discussions

Dr. Boutwell facilitated interactive discussions to understand how teams do their work, how different members of the team contribute, how individual skills are leveraged, and how teams engage with each other in teamwork. Dr. Boutwell noted that many people in the room are new to the specific type of work in CHART Phase 2 and that all teams are united in working to identify and address issues.

Participants included executive sponsors, program managers, data analysts, nurses and nurse case managers, nurse practitioners, physician assistants, pharmacists, pharmacy technicians, social workers, community health workers (CHWs), program assistants, and resource specialists. To kick off the discussion, participants were asked to write down questions to ask of other teams present. (See Appendix for a complete list of questions asked at both Northeast/Southeast and Central/Western meetings.)

Discussion

CHART Phase 2 Role Types

Pharmacists and Pharmacy Technicians

Question: **What are the roles of pharmacists and pharmacy technicians?**

Answer: A cornerstone of Signature Healthcare Brockton Hospital's CHART program is medication management.

- Two pharmacists, Ms. Sabre and Ms. Murrell, and one pharmacy technician, Ms. Burns, engage with patients to provide medication management and optimization. One pharmacist works with

COPD/CHF patients and one focuses on patients over 65 and with 10 or more medications. The pharmacy technician reviews a database of eligible patients and compiles a complete medication list for each patient. Using this list, the pharmacy team meets to prioritize patients for the day.

- Upon admission, a comprehensive medication review is performed and medication lists are updated for physicians. The team meets with patients, provides education, and makes recommendations as needed. At discharge, the pharmacists engage in medication reconciliation with physicians on the floor.
- To increase adherence following discharge, the pharmacy technician contacts patients' pharmacies, as appropriate, to ensure that new or updated prescriptions were received and picked up. If not, she attempts to resolve any issues. Patients are contacted within 48 hours of discharge to confirm that medications are taken appropriately and identify any questions or concerns.

Question: **How is the pharmacy workflow integrated with the rest of Signature's CHART program?**
Answer:

- The CHART pharmacy team works closely with the Signature School of Nursing's Homeward Bound initiative, providing virtual medication reconciliation as students perform home visits.
- They also engage with the Community Integration Team by joining home visits for patients with complex medical needs.

Question: **What is the Signature team's experience in collaborating with hospital staff during inpatient discharge planning?**
Answer: Some staff appreciate it more than others. The team makes it clear that proper medication reconciliation and engagement with the discharge planning process can help, rather than burden, staff on the floor.

Community Health Workers (CHWs)

Question: **How do you untangle the various labels for those in same or similar role types as CHWs (e.g., navigators, care coordinators, peer specialists)? How important is the title versus the responsibilities?**
Answer:

- CHWs assess patients, identify needs, and help address those needs.
- CHWs work to connect patients to appropriate resources, may accompany patients to appointments, and often meet patients in their environment (e.g., community setting, Dunkin donuts, campsite).
- The Berkshire Medical Center team noted that CHWs specialize in addressing social determinants of health.
- At Mercy Medical Center, CHWs act as care coordinators, gathering resources for patients, making referrals, and providing transportation when needed. A lead CHW, Ms. Ramos, is embedded within the ED. She is often the first representative from the CHART team that patients engage with; once enrolled in the program, she collaborates with CHWs on the team to coordinate resources and interventions.
- Some participants noted that the roles of CHWs, navigators, and care coordinators can be very similar. Ms. O'Connor, a navigator from the Harrington Memorial Hospital CHART team, reasoned that although the roles are similar, the connotation of the title "CHW" could be one

more related to medical health, while "navigator" could be interpreted as a linking term between medical and non-medical health. In some programs, navigators are clinically based while CHWs are community based.

- For many patients, the ED is seen as a place that fixes problems. However, often issues that CHART patients present for cannot be resolved in acute care settings. CHWs and similar role types provide care coordination, using their skills and resources, to increase care continuity and improve longer-term outcomes.

Question: **What types of backgrounds do CHWs have?**
Answer:

- Some CHWs have four year college degrees, perhaps with coursework in public health, community engagement, psychology, and sociology; many have experience in social services; others have lived experience in the communities they serve.
- Teams noted that one of the most important factors when hiring a CHW is determining how well they can relate to and interact with patients.
- Given that CHWs are front line workers who build rapport and trust with patients, personality fit and flexibility are critical.
- CHWs from the Hallmark Health team emphasized that they strive to see beyond medical conditions, learn, and become experts on existing community resources.
- The Boston Public Health Commission offers several training courses for CHWs. Topics include behavioral health, community outreach, safety, cultural sensitivity and elective coursework (e.g., substance abuse and domestic violence).
- Some teams, including the Lahey/Lowell joint CHART team, provide ongoing monthly trainings for CHWs, with topics such as motivational interviewing and patient engagement strategies.

Question: **How do CHWs document their work?**
Answer:

- Some teams use external case management software for their CHART work. Others enter notes directly in the hospital's EHR system.
- One CHW described using her own form to track contacts with patients. This form gives her flexibility when she's out in the field and may not have access to an electronic system; at a later time, she documents notes in the hospital's electronic system.

Question: **What do CHW caseloads look like?**
Answer:

- For many teams, caseload varies by day of the week, with higher volume on Mondays and less towards the end of the week. The Lowell General Hospital team has a caseload of approximately 200 patients with high utilization, assigned across three "teamlets," each staffed with one CHW and one social worker. The teamlets meet with the medical director on a weekly basis to review the cases.
- The Lahey/Lowell Joint team noted that each CHW has approximately 15 active patients on a weekly basis, plus a handful of patients who are less engaged or require a lower intensity of services.

- One CHW from the Southcoast team estimated 18 to 20 patients daily, with another approximately 40 patients that he tracks and triages if they present to the ED. He noted that patients change from being active to inactive, and that flexibility is key. For example, a patient with a behavioral health diagnosis may be making progress and then experience hardship, at which point the CHW may have to increase intensity of services delivered.

Question: **When and how are patients "graduated" from CHART programs?**
Answer:

- It may be difficult to engage patients immediately, so 30 day programs can be challenging (Winchester Hospital).
- Attempt a warm hand off with providers (Milford Regional Medical Center).
- Some programs leave the engagement timeframe open ended (Lahey/Lowell Joint, Hallmark Health).

Social Workers

Question: **What is the role of the social worker?**
Answer: Ms. Oliphant, a social worker at Baystate Wing Hospital, noted that she was trained to provide a short-term therapeutic role and to connect patients to longer-termed care. She views her role as bridging the gap between acute care and the often long waiting time to treatment, highlighting the importance of a sustained relationship with patients, families, and caregivers.

Question: **How do social workers and those in CHW role types work together? What does their internal communication and supervision look like?**
Answer:

- The Hallmark Health team's social work supervisor, Ms. Lucey, meets with CHWs on a regular basis. Ms. Lucey facilitates daily morning huddles, where she and the CHWs discuss goals for the patients scheduled for a home visit for that day.
- The BIDH – Milton team has a similar structure where the social worker schedules weekly supervisor meetings with the peer specialist.
- The Southcoast team noted that starting off the day with a meeting enhances overall team communication.
- The Winchester team meets every morning to discuss patients and prioritize tasks for the day.
- The CHW role, in part, focuses on building rapport and having frequent contact points with patients. In this regard, CHWs are similar to peer specialists, who are similar to navigator role types. The common factor is connecting with the patients, perhaps even saying: "I've been in your shoes." Joint problem solving with social workers helps ensure care appropriateness and continuity.

Physician Assistants (PAs)

Question: **What is the role of the palliative care PA? What is the impact of palliative care?**
Answer:

- The Milford Regional Medical Center team has a hospital-based palliative care PA, Ms. Morse, who works with inpatients with a personal history of high utilization. She collaborates closely with the mobile care team, comprised of a nurse case manager, a pharmacist, and a social worker.

- Each morning, Ms. Morse reviews the high utilizer list and focuses on those with advanced chronic illnesses (e.g., cancer, COPD, CHF, renal failure) who would likely benefit from palliative care services. Each palliative care consult can take several hours – looking into prior hospitalizations from the past year, performing an H&P, and arranging family meetings. Oncologists are invited to join these meetings for patients with a cancer diagnosis. With the patient, she discusses advanced directives, health care proxies, and MOLST forms.

Question: **To what extent is the PA engaging in case finding versus waiting for consultation requests?**
Answer: Ms. Morse sees a blend of patients through case finding and referrals. Because requests can be numerous, she identifies patients that would most benefit from her services. Screening all patients with high utilization for appropriateness of palliative care services has helped the Milford team reduce barriers to consultation.

Nurse Practitioners

Question: **What is the role of the nurse practitioner?**
Answer:

- Ms. Ferguson, an NP on the Winchester Hospital CHART team, shared her experiences, noting that her role is constantly evolving. Her current focus is on post-acute care transfers and patients with high utilization. She stressed that getting the patient's perspective, and asking them what brought them to the ED, is key to understanding the drivers of utilization.
- The Hallmark team described the NP role (Ms. Pierre) as working closely with the team of CHWs and the social work supervisor. For patients with medical complexity, Ms. Pierre joins home visits to conduct home assessments, provides health promotion and health literacy support, and advises on proper medication usage and utilization of healthcare services. After an initial home visit, the NP makes recommendations to the patient's PCP. The team is often in communication with PCPs, providing information on the patient's drivers for utilization.

CHART Phase 2 Logistics and Operations

Communication and Collaboration

Question: **How do others communicate their CHART programs internally? How do you raise awareness about the initiatives?**
Answer:

- Ms. Perry, Director of Behavioral Health Nursing at Holyoke Medical Center, holds daily huddles with CHART staff, inpatient social work and nursing staff, and ED social workers. Additionally, she holds a provider meeting every other month that includes community-based providers.
- Ms. Clapp, CHART Team Manager at Baystate Noble Hospital, noted that the CHART team is involved in daily rounds with medical staff, but has found difficulty in collaborating with some departments within the hospital.
    - The Holyoke Medical Center team suggested that the Noble team frame their desire to collaborate with other hospital units as helping hospital staff, asking, "what can we do for you?" and "What can we offer you?"

Question: **Which is more effective: joining daily rounds or quickly touching base with hospital staff? Joining rounds can be time-consuming – how does this help the team?**
Answer:

- Many teams indicated that building trust with hospital staff is a key factor of success. Finding the right balance between gaining trust and support and being effective and efficient in information sharing and care coordination is also important.
- Some teams noted that joining rounds in the immediate period post program launch was helpful to develop relationships and create a name for their programs; others continue to regularly join rounds.
- Ms. Bakaian, a patient navigator at Harrington Memorial Hospital, continues to work closely with the inpatient team. She has found it helpful to adopt strict guidelines for what she can and cannot provide, and ensures that the medical team takes over when appropriate. Protecting her time and clearly defining her role has gained her respect amongst colleagues within the inpatient unit.

Question: **Are teams asked to serve patients outside of their target population definition? If so, how are these requests handled?**
Answer: Many CHART teams are receiving requests from internal hospital providers to engage with patients outside of their defined target populations. While this speaks volumes about the work being done, maintaining program focus is critical. Rather than simply declining to offer help to patients outside of the target population, CHART teams are finding ways to redirect non-target population patients to appropriate resources and services.

Timely Follow Up

Question: **How are teams engaging patients within 48 hours of discharge?**
Answer: Several teams have found that engaging with patients within 48 hours of discharge is an ideal time to check in. One team noted that after two days, "the wheels can fall off the bus;" checking in within this time frame to address any issues that arise may help to avoid inappropriate use of higher-acuity care. There need not be a purpose for a phone call other than to check in upon returning to a home setting.

- Teams are using texting models with their patients; closed loop texting (i.e., receive response from patient) qualifies for the HPC's 48 hour follow-up measure.

Appendix: Questions from CHART teams

Dr. Boutwell asked participants to write down questions they had for other CHART teams in order to focus an interactive discussion. Below are the questions that were shared, by regional meeting, categorized by topic.

Northeast/Southeast Regions

Roles and Responsibilities

1. What is the role of the pharmacist?
2. What is the role of the data analyst? How many FTEs?
3. What is the role of the physician advisor?
4. What are the differences between navigators, resource specialists, and CHWs?
5. What is the role of the resource specialist and/or air traffic controller?
6. What is the role of the NP in a home setting versus a hospital setting?
7. What is the role of the PCP in care planning development?
8. What is the role of the executive sponsor?

Data Utilization

9. Which way of breaking down the data has been most effective in creating actionable items?
10. What type of analyses are teams doing to improve program operations? Are there ad hoc reports outside of monthly reporting?
11. What are other signals of success outside of reaching grant-specific aims?
12. How do we measure and evaluate the impact of our work when there are so many factors involved, particularly in the ED (i.e., how do we contextualize appropriate ED utilization within our program)?

Program Operations

13. What process do teams use for reviewing preliminary outcomes in the monthly dashboard with program staff? Who attends these meetings? What is covered? Is there a standard agenda?
14. Insights in to multiple teams across multiple sites? How to bring continuity and consistency?
15. Have teams without a data analyst found a way to minimize the burden of data collection? How can we make clinical documentation for front line staff more efficient and accurate?
16. How many home visits are teams doing? Do more home visits mean better results?
17. What are the hours of coverage?
18. What are the strategies in place to ensure the safety of community based workers?
19. How are teams providing ongoing professional development (e.g., CHW learning collaborative)?
20. How are team meetings structured?
21. How much time is spent on hospital floors?

Services

22. What are strategies to have more impact with services provided? More telephonic interaction, less face to face? Focusing on certain types of patients?
23. What strategies are most effective for CHWs to engage patients?
24. How is the nursing home population being handled?
25. Are other teams using telehealth?

26. What services are teams most frequently connecting patients with?
27. What are other teams doing to address poor medication adherence for patients with behavioral health diagnoses?
    What is the impact of palliative care?

Partnerships

28. How are other teams partnering with community resources to ensure patients are receiving the services they need?
29. How do multidisciplinary care teams work with physicians, medical directors, and PCPs?
30. How are teams promoting CHART programs internally?

Central/Western Regions

Roles and Responsibilities

1. What is the role of the peer specialist and how is that role optimized?
2. What is the role of the CHW?
3. What is the role of the nurse navigator?

Program Operations

4. Have other teams employed overnight staff?
5. How do teams effectively conduct the 48-hour phone call, especially if patients are hesitant to engage?
6. How are other teams providing follow up to homeless populations?
7. With high patient volume, how teams people able to do timely follow-up and also deliver care?
8. How are teams working to engage patients that decline services?
9. How do other teams manage missed opportunities in engaging with target population patients?
10. How are teams managing requests to care for patients not in target population?
11. What are strategies to manage the high volume of patients in areas with provider shortages, particularly in behavioral health?
12. What is contributing to unexpected high volume?

Services

13. What are some unique patient needs that teams have encountered? Have teams been surprised by any specific needs? What are creative solutions to address these needs?
14. Are teams using tele-psychiatric services? If not, what creative solutions have you found for patients on a waiting list? What services are provided in the interim to prevent revisits?
15. How do teams best engage family and caregivers in treatment plan development?
16. Have others experienced difficulty with insurance companies? What strategies do teams use when payers deny coverage?
17. How do teams encourage seniors with alcohol abuse and depression to consider change? How do teams encourage and motivate their caregivers?
18. What are creative strategies or longer-term solutions to breaking the cycle of substance use?
19. Are teams texting with patients? Are teams seeing success with this way of communicating?

Community Partnerships

20. How are hospital-based CHART teams working with long-term care facilities to reduce readmissions?
21. Many community agencies are also experiencing burnout. How do we support them and engage them for effective collaboration?
22. How do teams coordinate and collaborate with other hospital staff?
23. What are teams' experiences with community partnerships?