Integrated Medical, Behavioral Health, and Social Services

Care in the Community

Better Data and Analytics

Value-Based Care

THE CHART PLAYBOOK:

A GUIDE TO BUILDING CAPACITY, ENGAGING PATIENTS, AND TRANSFORMING CARE IN COMMUNITY HOSPITAL SETTINGS

Based on lessons learned from the Community Hospital Acceleration, Revitalization, and Transformation (CHART) Investment Program

SEPTEMBER 2020

MASSACHUSETTS HEALTH POLICY COMMISSION

CONTENTS

INTRODUCTION

"The [emergency department] is the doorman to inpatient care and CHART is the doorman to the community."

OVERVIEW OF THE CHART PROGRAM

The Massachusetts Health Policy Commission's (HPC) Community Hospital Acceleration, Revitalization, and Transformation (CHART) program made phased investments in certain Massachusetts community hospitals to enhance the delivery of efficient, effective care. With technical assistance from the HPC, CHART hospitals designed and implemented new care models for target populations with complex medical, social, and/or behavioral health needs in order to provide the most appropriate care in the right place.

The goal of the CHART program was to promote care delivery transformation by improving community hospitals' capacity to: 1) deliver integrated care to across medical, behavioral health, and social needs, 2) shift care from the hospital to the community, as appropriate, 3) prepare to succeed in value-based care models; and 4) use data and analytics to better serve patients.

From 2014 through 2018, through two phases of grants, the CHART program invested nearly $70 million across 30 Massachusetts community hospitals. In Phase 1 of the CHART program, hospitals undertook business planning, capacity-building, and pilot activities to build a foundation for more comprehensive transformation. CHART Phase 2 investments supported community hospitals in implementing new care models to transform care delivery for their target population patients – generally those with a history of high inpatient or emergency department (ED) use, and/or with a behavioral health diagnosis.

With the support of CHART investments, community hospitals developed and implemented whole-person care models to provide integrated care across medical, behavioral health, and social needs for their target patient populations. These approaches often required forming multidisciplinary care teams, enhancing post-discharge services in collaboration with community providers, and prioritizing patient needs beyond the walls of the hospital. CHART teams also focused on effectively using data–including the CHART hospital's own administrative billing and clinical data, and local utilization and demographic data[1]–to identify target population patients and monitor their patterns. As a result of these investments, the majority of CHART hospitals made significant strides toward their targets for reducing unnecessary acute care utilization. Twenty awardees met or made significant improvement toward their target aims, such as reducing hospital readmissions and/or ED revisits by at least 20%. Many also achieved significant improvements in behavioral health integration within their ED and inpatient settings, while also working to address health-related social needs. At the conclusion of the program, 76% of CHART hospitals reported that CHART facilitated broader hospital culture changes that helped prepare them to participate in the MassHealth Accountable Care Organization (ACO) program.

More information about the CHART program, including target patient populations and care models, can be found at www.mass.gov/service-details/chart.

1 http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/investment-programs/chart/chart-case-study-011615.pdf

OVERVIEW AND PURPOSE OF THE CHART PLAYBOOK

During the CHART Phase 2 implementation period, community hospitals developed new tools and processes to implement innovative care models and move toward systems of more robust wrap-around care for patients with social, behavioral health, and/or medical complexity. As the CHART teams innovated, they learned valuable lessons about the challenges and potential solutions around implementing these types of programs. The HPC collaborated with the CHART teams to develop, refine, and compile the most impactful of these tools, processes, resources, and lessons learned through the implementation of the CHART program to create this Playbook. For more information about how this Playbook was developed, please see the Methods section (page 26).

The HPC intends the Playbook to be a practical resource for providers seeking to develop or expand programs and policies that promote efficient, high-quality care. Playbook lessons and tools may be particularly useful to managers and staff in health care systems developing or implementing complex care or population health management programs to address the needs of patients with complex medical, behavioral health, and social needs. While providers reading this resource may develop care models that fit the unique needs of their hospitals and patient populations, the lessons outlined in the Playbook highlight important considerations to take into account during program development and implementation.

The Playbook is organized into five lessons:

- **LESSON 1** Defining and identifying patients: strategies to define high-risk/high-need patient populations and identify them at the point of presentation to the acute care setting;
- **LESSON 2** Establishing effective patient-provider relationships: consideration of the patient's prior experiences with the health care system and some approaches to improve patient engagement;
- **LESSON 3** Collaborating with patients: approaches to configuring a multi-disciplinary care team to deliver high-value services, from initial patient engagement through ongoing care in the community;
- **LESSON 4** Staffing and managing a team: considerations for management of multi-disciplinary, community-based care teams;
- **LESSON 5** Measuring for improvement: example dashboards to support a data-informed approach to program operations

Each of the five lessons includes the following components:

Lessons Learned: strategies identified by CHART teams that worked to improve patient engagement and care delivery.

Patient Stories and Provider Narratives: patient and provider perspectives offered by CHART teams about their experiences with their CHART care models.

Tools and Resources: tools and templates developed or used successfully by CHART teams, with links to some related online resources.

LESSON 1:

DEFINING & IDENTIFYING TARGET POPULATION PATIENTS

"Today's health care system can be so complex, it is essential to ensure that patients do not 'fall through the cracks' and receive the help that they deserve."

SUMMARY

CHART hospitals worked with the HPC to analyze their discharge data to define broad target populations with frequent acute care utilization and behavioral, medical, and/or social complexity. Based on the target population definition, each CHART hospital developed and implemented a care model that emphasized deploying behavioral health, medical, and social services to address patient needs in the community in order to reduce unnecessary acute care utilization and provide the most appropriate care in the right place.

In order to deliver services to their target population patients, CHART hospitals developed methods to identify patients in real-time as they presented to the emergency department (ED) or were admitted to the hospital. A number of CHART hospitals developed automated patient identification systems by creating "flags" within their electronic health records, so that regardless of where patients sought care, providers could quickly identify them as part of the CHART program.

Lesson 1 covers:

- Defining the target population
- Methods to identify target population patients at the point of presentation
- Data source considerations in patient identification
- Testing and refining patient identification methods

DEFINING THE TARGET POPULATION

With support from the HPC, CHART hospitals analyzed their discharge data to assess which patient populations had the greatest opportunity for improvement (e.g. patients with behavioral health diagnoses and frequent ED-revisits or patients discharged to post-acute care settings experiencing high readmission rates). Nearly all CHART hospitals defined their target populations either by a history of high utilization or by behavioral health diagnosis.

CHART hospitals that developed programs to care for patients at high risk of reutilization using one or more of the following patient identification criteria:

- A history of frequent acute care utilization
- Behavioral health diagnosis
- Social complexity, such as housing instability or dual eligibility for Medicaid and Medicare
- Medical complexity, such as chronic medical conditions or discharge to post-acute care

Table 1. Methods to Identify Eligible Target Population Patients

	METHOD A: Patient identification using clinical diagnoses, factors, or chief complaint	METHOD B: Patient identification using administrative diagnosis data	METHOD C: Patient identification using administrative utilization data
DATA SOURCE	Clinical data from an in-person screen at the point of care or through medical record review	Clinical diagnoses from administrative (e.g. billing) data	Utilization counts of ED visits and/or inpatient admissions for individual patients from administrative data
STRENGTHS	• Provides a high level of confidence that patients have been accurately identified because of the ability to apply target population criteria in real-time • In-person screen allows for initial conversations with eligible patients and can increase engagement • Enables identification of patients based on health-related social needs	• Leverages diagnosis data within existing administrative datasets	• Relatively low administrative burden compared to Methods A and B • Provides for adjustments to target population size by adjusting selection ratio (# of acute events /# months)
LIMITATIONS	• Time intensive • Requires substantial staff training	• Diagnoses may be inconsistently captured in administrative data • Behavioral health conditions historically have been inconsistently diagnosed and coded in administrative data, resulting in inaccurate patient identification. (See following section for approaches to enhancing accuracy) • Most administrative datasets do not capture social determinants of health factors	• Does not capture clinical or health-related social needs

IDENTIFYING TARGET POPULATION PATIENTS: THREE METHODS

In order to provide CHART services in a timely manner, CHART hospitals used several methods to identify target population patients for their interventions at the point of acute presentation. The table above compares the strengths and limitations of three different methods and data sources used by CHART hospitals to identify target population patients.

CONSIDERATIONS FOR IMPROVING BEHAVIORAL HEALTH PATIENT IDENTIFICATION

Because of the inconsistency with which behavioral health diagnoses are identified and coded in administrative data, a number of CHART teams engaged their data analysts and program staff to audit the accuracy of behavioral health coding.

FALSE NEGATIVES: Some CHART teams found that using historical electronic health record (EHR) data was usually effective at identifying patients with prior behavioral health diagnoses, but at times failed to identify patients with new behavioral health presentations, particularly those presenting with a primary medical complaint. For example, a patient presenting with a head wound from a fall due to intoxication may have had the head laceration coded, but not the root cause—intoxication. When the results of the audit process returned a large number of patients missed by administrative diagnosis data, the CHART team implemented a brief clinical screen to replace administrative-based behavioral health patient identification.

FALSE POSITIVES: At the other end of the spectrum, some CHART teams found that using historical records of behavioral health administrative diagnostic codes could result in over-identification of patients because all prior behavioral health conditions were flagged, even if the patient no longer had an active behavioral health need. CHART hospitals employed two remedies for this scenario:

1. Restrict queries to identify patients with recent behavioral health diagnoses (which does not address the possibility of "false negatives" discussed above), or
2. Implement brief clinical screens to verify the behavioral health condition

To audit the accuracy of behavioral health patient identification, some CHART hospitals did the following:

1. Selected a time period (1–4 weeks) during which patient-facing staff implemented an in person clinical screen (Method A) to identify patients
2. Compared the patients identified using the clinical screen to the patients identified using administrative diagnosis data
3. Considered the following questions:
    a. False negative test: Did using administrative diagnosis data fail to identify patients who were identified using the clinical screen?
    b. False positive test: Did using administrative diagnosis data identify patients who were determined inappropriate for the program using a clinical screening?

TESTING AND REFINING PATIENT IDENTIFICATION CRITERIA AND METHODS

As described in the preceding section, by reviewing patients who seemed appropriate for the CHART program but were not flagged by identification criteria, CHART teams were able to investigate why such patients were not identified (e.g., the exclusion of a relevant diagnosis code). Similarly, some CHART teams evaluated why some patients who were identified did not seem appropriate for enrollment in their CHART programs (e.g., the inclusion of an inappropriate diagnosis). By ensuring that CHART program staff had clarity on the definition of target populations, the teams were able to continuously improve patient identification methods.

LESSON 2:

ENGAGING PATIENTS

"I know [the CHART staff] are paying attention and keep track of what I am saying. I don't have to tell my story over and over again. I can tell that [they] really care about how I am doing. [They] check in with me and help me to believe life can be better."

SUMMARY

Programs are more effective when patients are meaningfully engaged in their care and when that care is integrated to address patients' behavioral health, medical, and social needs.[2] CHART teams found that patients with high acute care utilization and unmet behavioral health or social needs, often had been labeled "difficult" or "non-compliant" by providers, resulting in low patient trust. This mistrust sometimes manifested in behavior that gave the appearance of low engagement.[3] CHART teams challenged themselves to find ways to build trusting relationships to address their patients' previous experiences of stigma in the health care system.

Lesson 2 covers:

- Initial patient encounter
- Pathways to patient engagement
- Assessing patient readiness
- Adapting the approach based on setting
- Prioritizing timely follow-up

2 Hibbard, J. H., & Greene, J. (2013). What the evidence shows about patient activation: better health outcomes and care experiences; fewer data on costs. Health affairs, 32(2), 207-214.

3 Fleming, M. D., Shim, J. K., Yen, I. H., Thompson-Lastad, A., Rubin, S., Van Natta, M., & Burke, N. J. (2017). Patient engagement at the margins: Health care providers' assessments of engagement and the structural determinants of health in the safety-net. Social Science & Medicine, 183, 11-18.

INITIAL PATIENT ENCOUNTER

When initially approaching eligible patients, CHART teams learned to prioritize patients' immediate concerns rather than describing the program. For example, some CHART team members would approach patients by asking, "What do you need?" or "How might I help you?" By determining an initial item for action, explaining next steps, and demonstrating follow-through on these commitments, CHART teams were able to successfully engage patients in the program, laying the groundwork for sustained engagement.

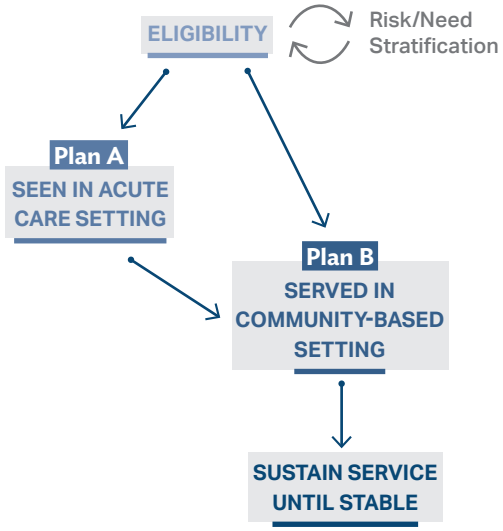
CHART teams developed straightforward approaches to describing the CHART program and communicating its benefits. At some hospitals, CHART team members explained the program in face-to-face conversations. In other cases, the team did not describe CHART as a separate program and instead presented CHART as an extension of the hospital's existing services. In either case, teams generally found that structuring the program to be an opt-out versus opt-in model improved participation. Persistent outreach was important to engaging patients who were initially hesitant to participate. Outreach was often conducted by CHWs or peer coaches, who were able to establish a connection and subsequently gain the trust of the patients over time.

PATHWAYS TO PATIENT ENGAGEMENT

A central component of many CHART programs was meeting patient care needs in community settings in order to

reduce unnecessary hospital utilization and provide the most appropriate care in the right place. CHART teams sought to engage patients in CHART programs until the patient achieved stability in the community. Eligible patients were approached for program engagement while in the acute care setting or post-discharge. The graphic below illustrates these two pathways to patient engagement in the program:

Figure 1.



Below are two examples of how these pathways to engagement played out in CHART:

Plan A Eligible Patient A presents to the ED. Patient A receives medical services in the ED. Prior to discharge, a member of the CHART team meets the patient. Patient A agrees to participate in the program.

Plan B Eligible Patient B presents to the ED. Patient B receives medical services, but is discharged before the CHART team meets the patient. Following discharge, the team conducts a follow-up call and goes to Patient B's home to discuss participation in the program. Patient B declines initially; however, the team continues to contact Patient B after each acute care presentation. After multiple conversations with the CHART team, Patient B agrees to participate.

After the patient agrees to participate in the CHART program, the next step is to establish relationships whereby the CHART team and the patient become collaborators in care.

ASSESSING PATIENT READINESS

During the initial meetings with eligible patients, rather than focusing on CHART program enrollment, CHART teams learned the importance of listening to patient stories, creating a safe space, and building trust in order to understand a patient's challenges and reasons why a readmission or revisit may have occurred. Several CHART teams used the ASPIRE Guide Readmission review tool[4] while others created checklists to identify their patients' immediate needs. Teams that were more focused on enrollment during those initial encounters with patients found that patient relationships suffered, whereas teams that prioritized relationship-building tended to have better rates of enrollment and sustained patient engagement.

LESSON LEARNED: CHART teams found that non-medical providers like social workers and community health workers were often most effective in building initial trust through active listening and identifying simple ways to help patients: providing access to a phone, a meal, or a fresh pair of clothes.

TOOL 2.1: Immediate Needs Checklist

ADAPTING THE APPROACH BASED ON SETTING

CHART teams learned to adjust their approaches to enrollment and relationship-building based on the setting of the encounters. CHART teams found that the majority of eligible target population patients who came to the ED did so because they felt overwhelmed by the challenge of managing their care needs and did not know where else to go. In addition, many patients had untreated or undertreated behavioral health conditions that further complicated their care. When initially approaching patients in the ED, CHART teams kept interactions with patients brief and friendly, laying the groundwork for re-approaching during a less stressful time.

LESSON LEARNED: In ED-focused CHART programs, teams found that placing a team member in the ED enhanced work flow and access to patients and encouraged engagement while the patient was in the hospital setting.

4 Source: Designing and Delivering Whole-Person Transitional Care: The Hospital Guide to Reducing Medicaid Readmissions. (Prepared by Collaborative Healthcare Strategies, Inc., and John Snow, Inc., under Contract No. HHSA290201000034I). Rockville, MD: Agency for Healthcare Research and Quality; September 2016. AHRQ Publication No. 16-0047-EF.

PROVIDER STORY: A CHART nurse reflected, "Our patients arrive in crisis and struggle with fear and uncertainty, often with little awareness of what they are feeling or how to appropriately express it. Yet they often do express it through their behavior. When ED staff are at loss as to how best to respond, it becomes easy to see them as "uncooperative," "difficult" and "noncompliant." Responding to such situations requires flexibility and judgement. This is where staff who are free from the imperative of providing immediate medical care can step in and focus on the underlying emotional needs of the patient: what is the patient saying with their behavior that they can't put into words? A little sensitivity, concern, and reassurance can go a long way in softening disruptive behavior."

In contrast, CHART teams found that approaching eligible patients in the inpatient setting presented better opportunities for engagement. Many CHART teams learned that in the inpatient setting, the team could initiate a personal connection, provide a concise description of their CHART program, and inform patients about the team's availability to help after discharge.

RESOURCE: https://www.hudexchange.info/housing-and-homeless-assistance/

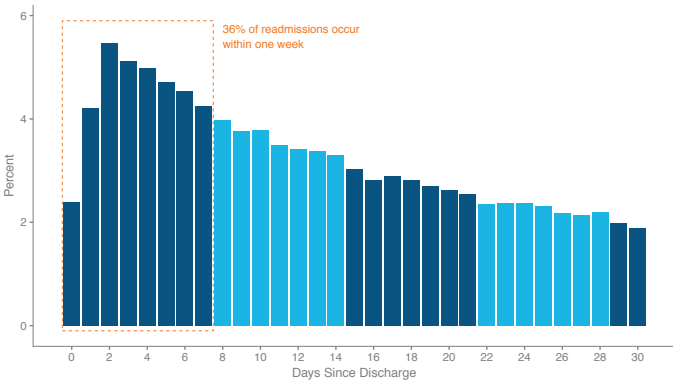
PRIORITIZING TIMELY FOLLOW-UP AFTER AN ACUTE CARE ENCOUNTER

Between July 2014 and June 2015, more than one-third (36%) of inpatient readmissions and 42% of ED revisits at Massachusetts hospitals occurred within the week following discharge, with the number of readmissions and ED revisits peaking within two days (48 hours) after initial discharge.[5]

In consideration of these inpatient readmission and ED revisit findings, the CHART teams were required to attempt follow-up with eligible target population patients within 48 hours of an ED visit or inpatient discharge. Timely follow-up after a hospital stay provided a valuable opportunity for the team to reconnect with patients and identify issues, misunderstandings, or gaps in post-discharge care that could result in a readmission or revisit.

Figure 2.

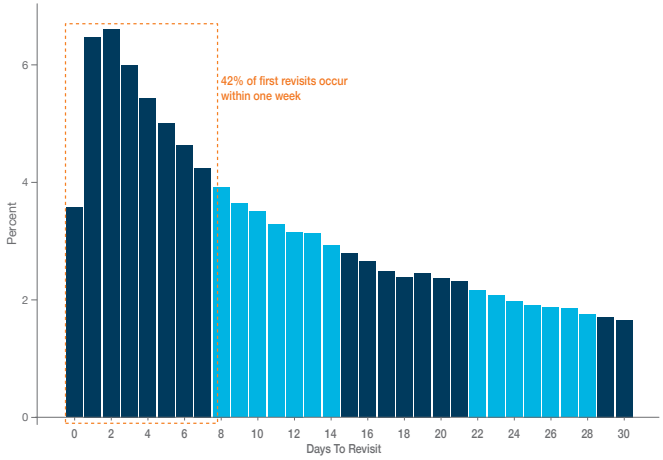
All-Payer Readmissions by Days Since Discharge



Note: Analyses include discharges for adults with any payer, excluding discharges for obstetric or primary psychiatric care.

Data source: Massachusetts Hospital Inpatient Discharge Database, July 2014 to June 2015.

Number of Days to First Revisit



Notes: A revisit is defined as an emergency department visit after an eligible inpatient discharge.

Data source: Massachusetts Acute Hospital Case Mix Database, July 2016 to June 2017.

5 Hospital-wide Adult All-Payer Readmissions in Massachusetts: SFY 2011-2015. Center for Health Information and Analysis. December 2016. Accessible from http://www.chiamass.gov/assets/docs/r/pubs/16/Readmissions-Report-2016-12.pdf

LESSON LEARNED: Another important component of relationship building was obtaining patients' current contact information, enabling teams to check in periodically with patients. CHART staff attempted to obtain all relevant contact details including:

- Cell phone and home phone numbers (if applicable)
- Current or recent address (including shelters)
- A list of places frequented by patients (e.g. library, coffee shop, Salvation Army, soup kitchen, etc.).
- Phone numbers of family, friends, caregivers, healthcare and social service providers associated with patients

CHART teams found value in approaching patient follow-up as a conversation. The goal was not to overwhelm patients with options and information, but to assess and close any gaps in care or communication. CHART teams reported that by approaching the follow-up conversation in a friendly and professional way, they often were able to:

- Identify patients' immediate needs
- Gauge patients' understanding of the discharge plan and next steps
- Schedule a home visit
- Identify other providers already serving the patients to coordinate care

TOOL 2.2: 48-Hour Follow-up Script

By documenting a summary of follow-up attempts, completed contacts, and next steps in a shared location, CHART teams were able to make informed attempts to reengage eligible patients. CHART teams also established information sharing processes with ED providers to ensure that CHART teams were notified when eligible target population patients returned to the hospital, enabling CHART team members to see patients before they left the ED.

LESSON 3:

COLLABORATING WITH PATIENTS

"Typically, when I've been in the hospital, I've felt like no one was listening to me. The [CHART] program changes have made all the difference in the world. I am not struggling to breathe. You even taught to me to take peppermint to help with my nausea so that I can eat more frequent meals without being sick. You keep the information coming and include me with my medical care which is not something I have felt before."

SUMMARY

Following initial engagement, CHART teams continued to build trust with patients while learning about their priorities and care goals. CHART teams were composed of multidisciplinary staff who contributed unique skills and expertise to this collaborative process. Lesson 3 describes the services and strategies that CHART teams deployed to collaborate effectively with patients in their care.

Lesson 3 covers:

- Comprehensive needs assessment
- Care planning
- Assigning a lead contact
- Roles and responsibilities of the CHART care team members
- Patient outreach
- Improving transitions of care
- Evolving care models

COMPREHENSIVE NEEDS ASSESSMENT TO SUPPORT CARE PLANNING

After patients were enrolled in hospitals' CHART programs, members of the CHART teams, typically social workers or, in the case of patients with significant medical needs, nurses conducted comprehensive needs assessments (CNA). CHART teams used CNAs to identify patient needs, care goals, and appropriate next steps as identified by patients. CNAs documented patients' behavioral health, medical, and social needs such as chronic medical conditions, medications, mental illness and substance use, trauma, food insecurity, and housing insecurity. CNAs also identified current health care and social service professionals who may have played a role in patients' ongoing care.

TOOL 3.1: Comprehensive Needs Assessment

LESSON LEARNED: CHART teams emphasized the importance of having an up-to-date resource directory with contact information. Some CHART teams went further to create binders for patients tailored to include the resources most relevant to the patient's needs.

LESSON LEARNED: CHART teams found that CNAs were most effectively conducted on the inpatient floor after a readmission or in the community after a discharge, rather than in the ED.

CARE PLANNING

After conducting a CNA, CHART teams synthesized data about patient needs to develop care plans. CHART teams utilized two types of patient care plans with distinct purposes: longitudinal care plans and acute care plans. Any given patient might have both kinds of care plans on file, as appropriate.

Longitudinal care plans are comprehensive plans shared between care teams and patients. CHART teams found longitudinal care plans to be a useful tool for patients with frequent inpatient admissions or with complex behavioral health and social needs affecting their ability to manage chronic medical conditions. Longitudinal care plans address all aspects of the patients' lives, and are completed in collaboration with patients, with input from other medical providers, social service professionals, and social supports (family and friends), as appropriate. Since longitudinal care plans address all aspects of the patients' health and well-being, subsequent care providers with access to the plans are able to gain a thorough understanding of patients' history, current status, and care goals.

TOOL 3.2: Longitudinal care plan

Acute care plans are concise, provider-facing assessments of the root cause of patients' frequent presentation in the acute care setting, typically used in the ED. CHART teams often used acute care plans to communicate concisely the results of the most recent clinical evaluation to the next provider. In contrast, longitudinal care plans comprehensively catalogue patient needs and care goals. Acute care plans often followed a Situation, Background, Assessment, Recommendation (SBAR) format, guiding providers on how to manage patient expectations of care and connect patients with the appropriate provider or community contact. Acute care plans were helpful to both providers and patients in

6 The CNA was more commonly done in the hospital by CHART teams focused on the inpatient setting, rather than ED-focused teams. ED teams primarily focused on completing the immediate needs checklist (Tool 2.1) during visit and worked to complete the CNA post-discharge, in a patient's home or other community setting.

Table 2. Lessons from CHART

COMPREHENSIVE NEEDS ASSESSMENTS	
User	CHART team social workers, nurses, and community health workers (CHWs) were the primary users of the CNA. With patient consent, CNA data may be shared with the patient's treating providers and with social service and community-based organizations
Purpose	• To allow the patient to verbalize their most pressing needs • To promote development of an open, respectful, effective relationship between the CHART team and patient by providing a tool to guide the conversation between the frontline staff and patient • To document information needed for effective care planning
Setting	• Upon inpatient admission[6] • Post-discharge in the home or other setting specified by the patient in order to observe the patient's living situation and level of social support
Process	The completion of the CNA may take the form of a conversation, with formal documentation of the information taking place after the patient engagement. The assessment is a tool that allows for ongoing engagement with the patient and discovery of the circumstances, conditions, and needs of the patient, and it should be updated accordingly.

Table 3. Creating Longitudinal and Acute Care Plans

	LONGITUDINAL CARE PLAN	ACUTE CARE PLAN
User	Shared: Among patient/family, case manager (CM), and primary care provider (PCP)	Acute care provider (e.g. ED or admitting physician)
Length	Multiple pages	1 page, at most
Purpose	• Comprehensive summary of a patient's behavioral, medical, and social needs • Goals of care to inform care plan development	• Brief summary of the primary driver(s) behind a patient's repeated use of the acute care setting with guidance to the next acute care provider
Typical Listed Contact	PCP	CM, CHW, social worker
How Created	Collaboratively developed by CM, PCP and patient	Impressions from last acute care setting presentation and workup

avoiding duplicative and unnecessary diagnostic tests and medications, while promoting a connection to the hospital's CHART program.

TOOL 3.3: Acute care plan

ASSIGNING A LEAD CONTACT PERSON

As part of the care planning process, CHART teams categorized patient needs as primarily behavioral health, medical, or social, and identified who on the team was best suited to support patients in achieving their goals. A "lead contact" was designated as each patient's primary contact, care navigator, and advocate. Non-clinical members of the team, such as CHWs, often served as lead contacts for patients with social needs. By pairing CHWs with a clinician, CHART teams were able to have clinicians conduct patient assessments while paraprofessionals provided additional information, support, and advocacy to medical and non-medical providers on behalf of the patients. The range of factors that CHART teams considered when assigning lead contacts is illustrated in the table below.

TOOL 3.4: Large Format Business Cards

ROLES AND RESPONSIBILITIES OF CHART CARE TEAM MEMBERS

As discussed above, CHART teams served patients by broadly identifying patient needs, developing care plans and goals to meet those needs, and assigning lead contacts to support patients receiving services through the hospital's CHART program. CHART programs included a wide range of health and social services, as well as care coordination, advocacy, and follow-up by CHART team members to support patient health and stability in the community. CHWs, social workers, and nurses delivered a significant portion of patient-facing services in CHART programs.

This section describes the roles and responsibilities of key CHART team members in the delivery of CHART services: CHWs, social workers, nurses, community-based pharmacists, physician consultation, peer support specialists and recovery coaches, and palliative care specialists.

Community Health Workers[7]

CHWs on CHART teams focused on developing trusting relationships with patients, serving as their advocates, and creating bridges between patients and community providers. Key responsibilities included:

- Establishing trust through face-to-face encounters and active listening
- Maintaining consistent contact via secure text messages, phone calls, and community-based visits
- Validating and prioritizing patients' stated primary needs, and supporting the patient to take steps toward resolution
- Helping patients navigate the health care and social service systems, including accompanying patients to appointments
- Assisting with job or housing applications, transportation coordination, or securing of public benefits

Table 4. Assigning a Lead Contact: Factors to Consider

FACTOR	LEAD CONTACT CONSIDERATIONS
Clinical presentation	• Patients with complex medical conditions often benefited from a medically-trained lead contact (e.g., nurse practitioner, registered nurse, CHW with extensive experience in chronic disease management) • Patients with behavioral health conditions often benefited from a mental health/substance use-trained lead contact (e.g., psychiatric nurse, LICSW, cognitive behavioral therapist) • Patients with primarily social-related health needs often benefited from a social worker or CHW
Pre-existing relationships	• Positive pre-existing relationships between a patient and a lead contact usually facilitated more effective patient engagement
Demographics	• Shared language and/or ethnic background often facilitated better communication, trust, and engagement with patients
Logistics	• Consideration of the location of community providers and any transportation challenges helped minimize travel time to patients

7 Examples include community health advocates, outreach educators, peer leaders, promotores de salud, doulas, and patient navigators.

CHWs met with patients at coffee shops, in their homes, or in other locations comfortable for the patients. CHWs observed that putting the patients' needs first helped create strong bonds that enabled patients to trust CHWs to help them navigate the complicated health and human services systems. As reflected in patient and provider stories throughout the CHART program, CHWs maintained a non-judgmental attitude towards their patients, sharing in their needs and struggles and celebrating with them when they made progress.

LESSON LEARNED: Discretionary funds can be helpful to subsidize the cost of specific, practical solutions to patient needs. Many CHART teams used "patient assistance funds" to provide items such as over-the-counter medications, cab or bus vouchers, toiletries, meals, phones or minutes. Some teams also used the fund to cover copays or other health-related expenses that were unaffordable to patients.

Social Workers

Social workers were key members of CHART teams. Their unique training and experience navigating health and human services systems were instrumental in identifying and bridging gaps in the behavioral health, medical, and social needs of patients by linking them to needed resources. Key responsibilities included:

- Leading or collaborating with CHART team members on the CNA
- Leveraging the CNA to establish patient care goals
- Using the CNA to identify which team member should serve as lead contact to facilitate each patient's care
- Identifying resources patients would need post-discharge
- Linking and facilitating engagement with social workers and clinicians from other settings, including withdrawal management facilities, skilled nursing facilities, and psychiatric facilities
- Providing bridging therapeutic services via short-term counseling and crisis intervention
- Accompanying patients to some appointments and serving as a patient advocate
- Facilitating opportunities for patients to reconnect with family members, while helping patients to maintain healthy boundaries
- Continually assessing behavioral health status and imminent safety risks

PATIENT STORY: A woman with a complex behavioral health history repeatedly presented to the ED for substance use-related diagnoses where she regularly declined detoxification or outpatient treatment referrals. Fitting the program's criteria, she was enrolled in the hospital's CHART program and received support from a CHW. The CHW was able to meet the patient's needs through a broad range of care coordination activities. The CHW:

- Referred to a psychiatric nurse practitioner and sent patient texts about upcoming visits
- Assisted in applying for the Supplemental Security Income program
- Completed state rehabilitation commission paperwork to qualify the patient to receive financial aid and attend classes
- Provided grief support when a family member died from an overdose
- Coordinated rides to the food pantry
- Rescheduled outpatient appointments during hospitalizations
- Connected with the hospital's financial services office for Medicaid coverage
- Supported the patient in re-attending Alcoholics Anonymous meetings after an alcohol use relapse
- Conducted regular check-ins by phone and in-person

PATIENT STORY: A patient suffering from severe alcohol withdrawal and repeated admission to a CHART hospital's intensive care unit (ICU) was enrolled in the CHART program. A recent housing eviction had triggered his alcohol relapse. Based on the needs assessment the team learned that losing his job had caused him to lose his health insurance and made it impossible for him to pay his rent. To best meet his needs, he was assigned a CHW and social worker.

While in the ICU, the social worker helped him apply for Medicaid. Over the next few days the team attempted to meet his immediate needs through substance use counseling and connections with resources to obtain food stamps and pay outstanding bills. Once enrolled in Medicaid, the team helped schedule therapist appointments to enable long-term care for his substance use.

The patient maintained sobriety, obtained Medicaid coverage, could afford to pay rent, and actively searched for a job in his field. The team remained actively involved with him, providing support and encouragement through phone calls and home visits. The patient responded well to the short-term interventions and expressed appreciation for the support he received.

Nurses

In addition to managing clinical responsibilities, nurses often worked alongside social workers to help support the full range of patient needs. Key responsibilities for nursing staff included:

- Leading or collaborating with CHART team members on the CNA
- Leveraging the CNA to establish patient care goals
- Ensuring that patients' medical goals align with their behavioral health and social goals
- Providing patient-centered, culturally appropriate education to assist patients in the management of their health
- Engaging with the patients' social support systems or caregivers to reinforce care plans
- Partnering with social workers and CHWs to visit patients in the home or community settings
- Acting as liaisons with PCPs, visiting nurse associations (VNAs), and pharmacies

Through their understanding of patients' complex medical needs, nursing staff facilitated communication and warm handoffs among clinical providers. Their care coordination responsibilities included linking patients to appropriate specialists, conducting routine phone calls to post-acute care providers, and collaborating with other providers to oversee discharges to home.

Pharmacists

Pharmacists were another important resource in providing post-discharge patient services. While CHW, social worker, and nurse responsibilities can be wide-ranging and sometimes difficult for patients to understand, a pharmacist's role is clear: to dispense and advise on prescribed medication. CHART teams found that this clarity provided an understandable and familiar foundation for patient interactions. Key responsibilities included:

- Reviewing medication lists as patients are discharged from the hospital
- Providing patients with medication counseling
- Conducting medication reconciliation and disposal of expired or outdated medication
- Engaging with patients in the home or community settings
- Discussing strategies for managing chronic disease
- Collaborating with pharmacies and prescribers to identify cost-reduction strategies (e.g., compounding, prescribing generics, identifying rebates)
- Collaborating with prescribers on optimizing medication choices
- Acting as liaisons with PCPs, VNAs, pharmacies

CHART teams found that home visits by a pharmacist proved to be a valuable tactic to increase patients' medication adherence. During these visits, pharmacists conducted medication evaluations and disposals, provided supplemental education, and discussed medication affordability. Their unique responsibilities made them valuable members of the multidisciplinary team.

PATIENT STORY: A patient living alone in elder housing had several visits to the ED in the six months prior to CHART program enrollment. Recognizing a history of psychiatric diagnoses, substance use disorder, and limited self-care, the CHART team deployed a pharmacist, social worker, and CHW to meet the patient's needs.

After six weeks of services, the patient was admitted to a geriatric psychiatry inpatient unit and subsequently to a specialized outpatient program. The CHART team secured the appropriate authorizations to cover the patient's participation in the program and copay costs. The pharmacist completed multiple medication interventions and coordinated changes with the patient's PCP and local pharmacies.

The patient reported significant improvement: "I remember when [the team] first came here, I was a basket case. I didn't know which way to go. Today, now I feel different. [The team] helped me [get] my thoughts together. I can live a life without alcohol and drugs, and [I have] what I need to keep myself going."

Physicians

Physicians engaged with the CHART program provided consultation during case conferencing, particularly for patients with complex medical and behavioral health needs. CHART teams leveraged physician clinical expertise for diagnostic evaluations, treatment planning, protocol development, prescribing, and care plan development for the most medically-complex patients. Physicians also were particularly helpful in linking patients to their PCPs. CHART physician-champions helped garner hospital leadership support for the program and supported improved interface between the CHART program and hospital service lines. Key responsibilities included:

- Diagnosing and providing treatment recommendations for patients with high medical acuity
- Providing medical consults to the CHART team

- Serving as liaison and support to PCPs in the community
- Suggesting innovative and creative treatment/management alternatives for complex patients for whom traditional methods are failing
- Partnering with community programs to provide community-based medical supports, such as VNA services, telehealth home monitoring, and hospital-at-home programs
- Providing staff training on whole-person health and providing guidance on how to prioritize each patient's unique problem list

Peer Support Specialist And Recovery Coaches

CHART teams found great value in the roles of peer support specialists and peer recovery coaches with lived experience with mental illness and substance use disorders, respectively. Similar to the CHW or social worker roles, peer support specialists and peer recovery coaches were effective at engaging patients and providing psycho-social support. Teams found that the unique, lived experience of peers both carried credibility with some patients and demonstrated that stability and recovery were achievable by someone with a relatable history. Key responsibilities included:

- Modeling successful recovery and relating to patients from lived experience
- Educating team members about stigmatizing behaviors and helping to reduce them
- Establishing rapport with patients when other team members were not able to
- Encouraging hope, optimism, and health
- Linking patients to recovery community resources

RESOURCE: AdCare Educational Institute - Supporting the Massachusetts Substance Use and Addictions Workforce, DPH Recovery learning Center, Transcom

Palliative Care Specialists

Palliative care is specialized medical care focused on the relief of stress and symptoms of serious illnesses such as cancer, chronic obstructive pulmonary disease, congestive heart failure, and renal failure. Many CHART teams engaged a palliative care specialist (physician, nurse practitioner, or physician's assistant) to complete an initial palliative care consult. For many patients, follow-up care was then managed by the patient's PCP. Palliative care specialists' key responsibilities included:

- Reviewing prior hospitalizations from the past year
- Conducting a history and performing a physical examination
- Arranging family meetings for education on palliative care services
- Inviting care team members to the conversation as needed (e.g., oncologists for patients with a cancer diagnosis)
- Discussing perceptions and goals, advanced directives, health care proxies, and Medical Orders for Life-Sustaining Treatment forms

LESSON LEARNED: When implementing or expanding a palliative care program, CHART teams prioritized the following: early identification of eligible patients, education for patients, families, and providers about the service, and development of strategic partnerships with community-based palliative care providers.

PATIENT OUTREACH

Home Visits

At the start of their programs, many CHART teams prioritized face-to-face visits with patients in their homes. Doing so enabled team members to gather contextual data about patients' lives and to conduct home safety assessments. In addition to scanning for fall risks (particularly for older adults and people with disabilities), CHART team members were able to identify health-related social needs (e.g., lack of food or heat, hoarding behavior, domestic violence, and other environmental conditions affecting health such as mold, poor air quality, and sanitary issues).

Phone/Text Communication

CHART team members used phone calls and secure text messaging to communicate with patients. Teams observed that young adults were often more comfortable checking in via text message whereas older adults sometimes preferred phone calls. CHART teams required staff to use work phones—not personal phones—and consulted with their organizations' privacy officers to identify appropriate, secure platforms for exchanging text messages with patients and among team members.

Stratifying Outreach

CHART teams observed that certain patients required more frequent touch-points than others. Based on information gathered during the CNA and care planning processes, CHART teams stratified patients into three categories:

OUTREACH CATEGORIES	FREQUENCY OF OUTREACH (VIA PHONE, SECURE TEXT, OR IN PERSON)
High touch	Up to daily
Medium touch	4-6 contacts per month
Low touch	2-3 contacts per month

IMPROVING TRANSITIONS OF CARE

As CHART teams took responsibility for coordinating patient care across settings, they proactively identified points of contact at long-term care facilities, skilled nursing facilities, detoxification centers, and inpatient psychiatric facilities in their communities in order to collaborate on transitions of care. These relationships proved crucial to ensuring that patients received appropriate care post-discharge (e.g., hospital to post-acute care facility (PAC) or PAC to home). Through weekly, face-to-face visits with points of contact in each setting, many CHART teams were able to solidify relationships, conduct regular check-ins, and better coordinate discharge planning at these facilities. Several CHART teams used the ASPIRE Guide's Community Resource Guide and Discharge Process checklist to facilitate these activities.[8]

EVOLVING CARE MODELS

CHART teams learned to adapt their programs through their own experiences, those of other CHART teams, knowledge of existing evidence-based care transition models, evolving perspectives on patient needs, and availability of organizational resources. Examples of different team configurations based on the type of patients served in the care model are on page 17 – page 18.

RESOURCES: Existing care transition models include:

- Transitional Care Model
- Care Transitions Intervention
- Bridge Model
- BOOST Toolkit
- Project RED

The team's physical placement within a care setting is also an important consideration, and should be driven by where the team will be finding and engaging patients. For example, it may be beneficial for some team members to be situated in the ED with access to patient care plans and documentation, in order to meet with patients as they present. In other cases, a field-based team may develop robust protocols with existing ED staff who contact team members as needed.

As described throughout this section, CHART teams prioritized care and service delivery outside the hospital. CHART teams deployed mini-teams to meet with patients in community and home settings. For example, one team paired a social worker with a CHW to collaborate with patients both within and outside the hospital, addressing social support and behavioral health needs. CHART programs with licensed social workers leveraged their clinical expertise in mental health and substance use disorder treatment to provide guidance and supervision to CHWs engaging with patients outside the hospital setting. Both CHWs and social workers possessed knowledge pertaining to available social services and local resources which assisted discharge planning and care transitions.

8 Designing and Delivering Whole-Person Transitional Care: The Hospital Guide to Reducing Medicaid Readmissions. (Prepared by Collaborative Healthcare Strategies, Inc., and John Snow, Inc., under Contract No. HHSA290201000034I). Rockville, MD: Agency for Healthcare Research and Quality; September 2016. AHRQ Publication No. 16-0047-EF.

Sample Emergency Department CHART Staffing Models

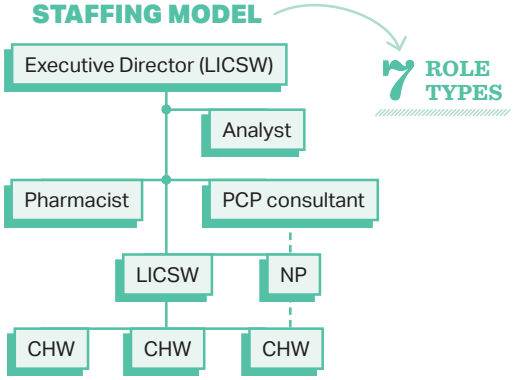
MODEL A

Primary Aim: Reduce ED visits for patients with ≥10 ED visits in the last 12 months

IMPLEMENTATION STRATEGIES

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

STAFFING MODEL



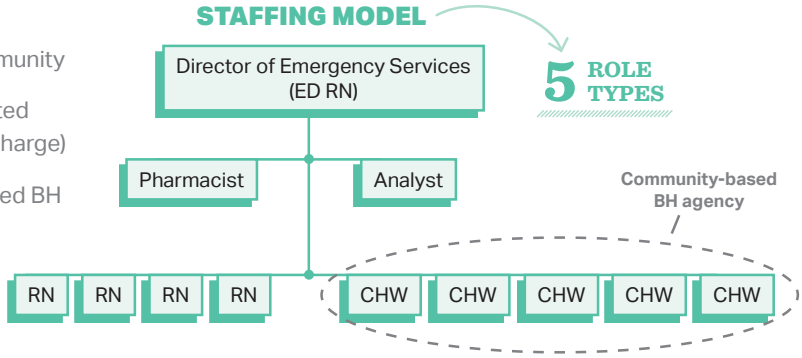
MODEL B

Primary Aim: Reduce 30-day ED revisits for patients with a primary behavioral health diagnosis

IMPLEMENTATION STRATEGIES

- CHWs continuously engage patients in the community
- Coordinated care between ED staff and co-located CHW (pre-medical clearance and/or prior to discharge)
- Dedicated BH RNs provide 24/7 care in designated BH space
- Championship by Director of Emergency Services (RN) and Chief of Medicine (MD)

STAFFING MODEL



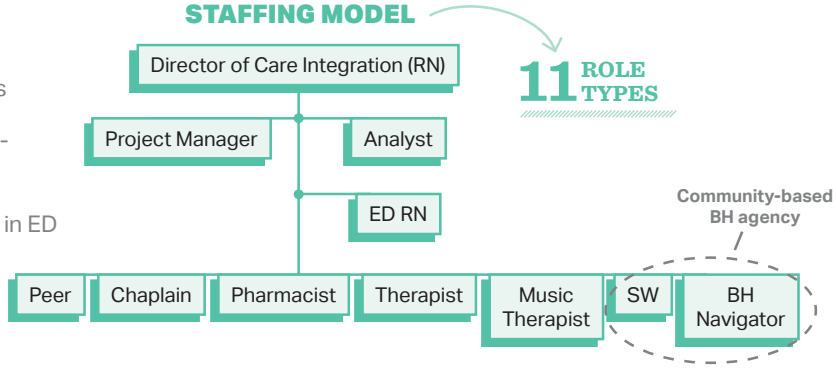
MODEL C

Primary Aim: Reduce excess ED boarding for patients with a length of stay of >8 hours who are referred to BH partner provider for evaluation

IMPLEMENTATION STRATEGIES

- SW assessment completed by community partnership led to improved post-ED care transitions
- Focus on addressing BH patient stigma throughout ED
- Comprehensive patient assessment conducted in ED
- When transitioning patient from ED, community partner assumed responsibility for long-term care management

STAFFING MODEL



Sample Inpatient CHART Staffing Models

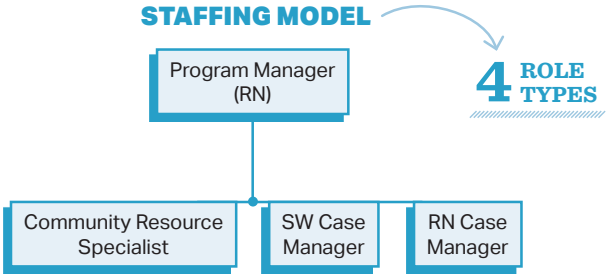
MODEL A

Primary Aim: Reduce returns (IN/OBS) for patients with dual eligibility (Medicare and Medicaid)

IMPLEMENTATION STRATEGIES

- RN/SW co-management of patients based on clinical and psycho-social needs
- Community Resource Specialist played active role in compiling relevant resources and navigating patients to them
- Continuously engage patient while hospitalized to hasten rapport-building

STAFFING MODEL



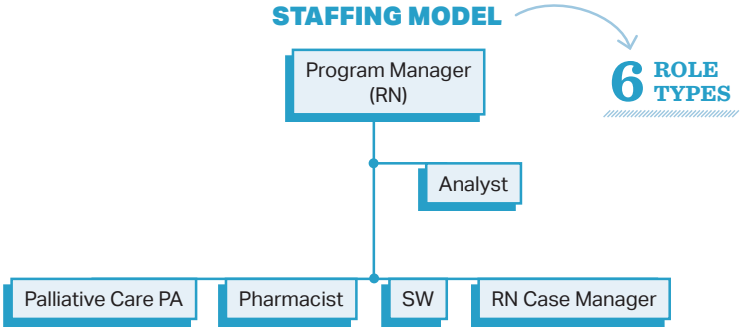
MODEL B

Primary Aim: Reduce 30-day readmissions for patients with ≥3 hospitalizations in the past 12 months

IMPLEMENTATION STRATEGIES

- Multi-disciplinary team spent majority of the day interfacing with patients in the community.
- Pharmacist conducted intensive cost-conscious medication reconciliation and patient education
- Multi-disciplinary case conferencing on all readmitted patients
- Improved referrals for Palliative Care consults

STAFFING MODEL



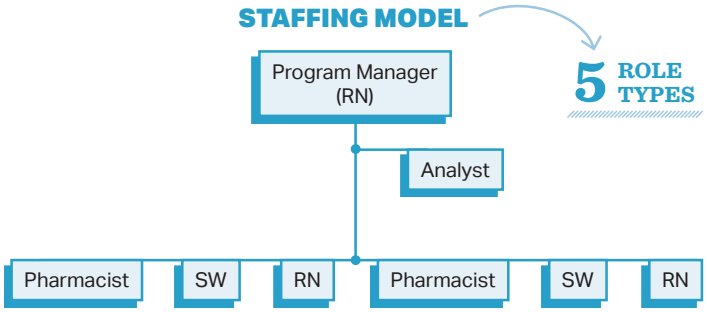
MODEL C

Primary Aim: Reduce 30-day returns for patients with: ≥ 4 hospitalizations per year, or social complexity, or history of 30-day readmissions

IMPLEMENTATION STRATEGIES

- Championship and active use of ED care plans by physicians
- Efficient RN-SW-Pharmacist teamlets provided comprehensive community-based care.
- Trending of patient and program-level data to guide care delivery.
- Collaborated with local police department to deploy crisis intervention training.

STAFFING MODEL



LESSON 4:

STAFFING AND MANAGING A TEAM

"Not only has [the CHART] program helped our patients, but it has also helped the staff here at the medical center. We've learned how to work together as a team for our patients' needs and how to communicate better with each other."

SUMMARY

CHART programs assembled care teams composed of clinical and non-clinical staff to work together to engage and collaborate with patients with complex behavioral health, medical, and/or social needs. Given the broad range of patient needs and the flexibility required to meet those needs, the most successful CHART teams tended to have expertise across disciplines and settings, as outlined in Lesson 3. This section describes important considerations, derived from the experience of CHART teams, for recruiting, orienting, managing, and retaining a primarily community-based multi-disciplinary team working with patients with complex needs.

Lesson 4 covers:

- Supporting roles for CHART teams
- Recruiting, onboarding, and retaining
- Communications to support operations
- Supporting and motivating the team

SPECIALIZED ROLES FOR CHART TEAMS

CHART teams frequently featured three supporting roles that provided valuable information and/or coordination services. These specialized roles are described in detail below:

Data Analyst

The HPC required CHART programs to dedicate data analyst time to support programs. By involving the analyst in program design, implementation, and sustainability planning, teams were able to build programs based on data rather than on anecdote or instinct. With valuable perspective on their organizations' data systems, analysts helped their teams use data to innovate and improve program operations.

Key responsibilities included:

- Ensuring accurate and timely capture and storage of patient information through an electronic system
- Supporting the development of operational measures
- Conducting data quality checks and queries on measures used to evaluate performance and operations
- Interpreting data analyses for clinical colleagues and leveraging those analyses to inform team operations, progress reports, and sustainability planning

"Air Traffic Control" Role

With team members out in the community visiting patients and working with community-based providers, CHART teams noted that it was helpful to have a coordinator to ensure organization and efficiency of day-to-day operations. These "air traffic controllers" also interfaced with patients by scheduling times for team members to visit them and referring them to resources, as appropriate. The role was typically filled by a highly organized administrative assistant who was comfortable working as part of a team and interacting with patients, familiar with community resources and organizations, and able to field questions from community-based CHART team members.

Key responsibilities included:

- Establishing the operational flow of the day and coordinating daily and weekly assignments of team members to patients
- Coordinating communication between community-based team members and relevant hospital staff
- Assigning team members to meet patients in the ED or hospital during acute encounters
- Collaborating with the CHART team managers to assign team members to serve as lead contacts for patients
- Checking-in with community-based team members throughout the day to ensure safety

Partnership Coordinator

Some CHART teams found it was useful to have a specific staff member dedicated to developing and enhancing collaborative efforts within their hospital and in the community. Within the hospitals, these individuals established a presence throughout all departments involved in delivering services to target population patients. Out in the community, partnership coordinators helped to build and maintain relationships with medical providers and non-medical professionals in the community.

CHART teams identified the following qualities as the most important for this role:

- Effective at communicating about the CHART program and potential shared opportunities
- Professional and respectful of multiple areas of expertise in caring for behavioral, medical, and social needs of patients
- Knowledgeable of the local health care and social service landscape

RECRUITING, ONBOARDING, AND RETAINING TEAM MEMBERS

Recruitment Criteria

CHART leadership learned that strategic recruitment involved consideration of candidates with appropriate credentials, personality types, and behavioral attributes well suited to relationship-building with patients and providers. CHART teams prioritized candidates who were familiar with their local communities and their resources, had the skills and experience required for connecting with patients and providers, and embraced a patient-centered approach to care delivery.

CHART teams identified the following desired qualities for candidates:

- Background and experience reflective of the community's demographics
- Familiarity with the needs of patients
- Flexibility, patience, and persistence to address patients' needs both physically and mentally
- Compassion and a non-judgmental attitude
- Ability to communicate clearly and respectfully with patients and providers
- Adaptability to a changing work environment
- Ability to innovate
- Initiative and independence

LESSON LEARNED: Team managers communicated to their teams that roles and responsibilities would need to be flexible as care protocols, provider collaborations, and patient enrollment strategies were developing. CHART teams learned the importance of checking-in with each other to review the scope of their responsibilities and opportunities to clarify, streamline, or coordinate those responsibilities to create processes that were sustainable.

Orientation

In addition to the standard human resources orientation protocols at their hospitals, CHART programs created specific onboarding processes:

- CHART program background, care model, and goals
- Existing processes for identifying, engaging, and collaborating with target population patients
- Content-specific trainings (e.g., trauma-informed care, motivational interviewing, substance use disorder training, and medication for addiction treatment)
- Communication, documentation, and safety protocols
- Meetings with team members, key hospital staff, and community partners with whom the teams collaborate
- Orientations specific to working in the community including:
  - Safety protocols (home/community visits)
  - Culturally-appropriate care training
  - De-escalation training
  - CPR
  - Naloxone administration

Since many CHART programs were onboarding multiple team members at program launch, they organized orientation sessions to promote team building and included a combination of the following activities:

- Developing mission and vision statements for their program
- Reviewing team processes and documentation
- Assessing community resources and touring partner sites
- Role-playing patient example cases
- Identifying individual learning and communication styles
- Shadowing experienced team members on community or home visits

PROVIDER STORY: "It was important for staff to understand not only how our program would function, but also why we are in existence and what we are hoping to accomplish. Dedicating multiple days to role-playing and documentation practice was vital to allowing staff to hit the ground running. Touring and participating in community resource presentation also helped staff become more knowledgeable regarding the resources they could later connect clients with."

COMMUNICATIONS TO SUPPORT OPERATIONS

CHART programs worked to find the right balance of information sharing among team members and facility staff, and across community partner providers. Communication patterns and forums evolved over time. When establishing their modes and methods of communication, CHART teams considered the time commitment (both duration and time of day), attendees, location, and agenda. In the table below are a few examples of meeting types used by CHART teams.

LESSONS LEARNED: Teams benefited from identifying champions who could communicate the benefits of their programs throughout the hospitals. By having care management leads and champions regularly attend rounds, including relevant hospital departments and partners in case conferencing and care plan development, and providing in-service sessions to promote the initiative, CHART teams were able to increase awareness of their programs and benefits to patients. CHART teams found that when hospital leadership was dedicated to the program's long-term vision, it was easier to advocate for necessary resources. (Tool 4.1)

TOOL 4.1: Daily Huddle one-pager

Table 5.

MEETING TYPE	PURPOSE	STRENGTHS	CHALLENGES
Daily Team Huddles (Tool 4.1)	To check in with the full team to review daily schedule, logistics, and responsibilities for the day	Allows the entire team to check in on the day's tasks, and address any barriers or concerns Can assess caseload and reassign as needed	Takes time and patience to develop a structure May take extra travel time to meet at the hospital in the morning
Hospital Rounds	To connect with hospital staff during medical rounds	Develops relationships and trust with hospital staff and program name recognition (at program launch)	Time-consuming
Case Conferences (Internal)	To meet with the full team, clinical and non-clinical staff, to discuss particularly challenging patient cases and develop care plans	Opportunity to consult with physicians and gain buy-in on patient care plans	Does not include external providers Physicians may have limited availability
Case Conferences (External)	To meet with external providers or partners involved in complex patient cases to coordinate care	Convenes all relevant providers in one place to develop collaborative care approach and durable solutions	Difficult to get external and internal providers in same place at same time
Internal Care Team Meeting	To enable the core team to reflect on program operations, successes, and opportunities	Allows team members to discuss quality improvement opportunities, celebrate successes, and lend support	Additional meetings may lead to meeting fatigue

SUPPORTING AND MOTIVATING THE TEAM

As roles evolved, CHART teams found that patience was required to build the right operational teams and approaches. In order to keep team members engaged and inspired, CHART programs employed a number of strategies to support and motivate their teams as seen in the table below.

Table 6.

STRATEGY	DESCRIPTION
Involving team members in decision-making	• Soliciting feedback from team members on challenges or potential solutions to improve the program
Instilling resilience	• Constructively discussing disappointments and failures with the team and using them as learning opportunities
Prioritizing self-care	• CHART teams learned that it was important to provide team members with support, including healthy coping skills, tools to achieve work-life balance, and mechanisms for "letting go" • While providing guidance to their teams, team managers noted that it was important to attend to their own self-care needs, by being aware of their own energy levels, emotional bandwidth, and work capacity
Assessing caseloads regularly	• Rotating members of the team in order to diminish frustration, alleviate tension, and avoid negative confrontation. CHART teams found that sometimes team members needed a break from working with particularly challenging patients • Teams worked to keep caseloads manageable for staff taking into consideration their background, experience, skill set, and style
Establishing protocols for addressing stigma	• Creating opportunities for ongoing education of team members about stigma and its effects • Sharing information about patients with challenging behaviors, including possible underlying drivers of behavior and best practices for interacting with them, was helpful for team members to separate distressing behaviors from the individual
Celebrating successes	• CHART teams realized the importance of "story-telling" as a way to promote and celebrate the work of their programs within their hospitals and in the community. Activities included: ◦ Sharing (de-identified) patient stories ◦ Visualizations of the team's quantitative performance ◦ Newsletters, notices on bulletin boards, and outreach to other departments and leadership to promote the work of the team • Acknowledging and celebrating accomplishments in supervisory meetings, team meetings, and external publications throughout the hospitals and in the communities, while ensuring that all stories were in compliance with hospitals' privacy rules
Providing professional development opportunities	• CHART managers also worked with their team members to develop individual goals and strategies to attain them. They ensured team members had direct supervision in order to feel supported in their work and professional development. Regular meetings allowed everyone to reflect on personal progress, career goals, and future milestones

LESSON 5:

MEASURING FOR IMPROVEMENT

"[A]necdotally, we could say why patients were being readmitted. Through CHART, we now have that data to back it up. We can go to our community partners and say, 'Okay, you seem to have a higher readmission rate,' and work with them to identify why. We really have that data."

SUMMARY

CHART programs harnessed their data, identified best practices and opportunities for continuous quality improvement, and communicating outcomes to key decision-makers. CHART teams learned that careful planning and up-front investment of time and resources were important to creating a streamlined approach for data collection and analysis.

Lesson 5 covers:

- Using data to support a culture of continuous quality improvement
- Creating a dashboard
- Lessons from example dashboard

USING DATA TO SUPPORT A CULTURE OF CONTINUOUS QUALITY IMPROVEMENT

Continuous quality improvement (CQI) in health care is a process of ongoing reflection and refinement of care protocols and models based on relevant data. CHART teams implemented CQI models to review their data, reflect on missed opportunities to engage patients, and consider ways to improve program performance. For example, one CHART team implemented new processes to review data on a weekly basis with team members, including frontline staff. The team drew on findings from these sessions to inform resource allocation and developed a protocol to provide higher intensity services to a subset of patients with the highest hospital utilization. In addition, by examining utilization data, the team identified a coverage gap on Fridays and reconfigured their staffing model to ensure consistent coverage.

When data reports did not reflect what CHART team members observed, it became important to convene the team and analyst to discuss discrepancies. This often led to new analytic methods, revealing signals of success or opportunities to improve the program.

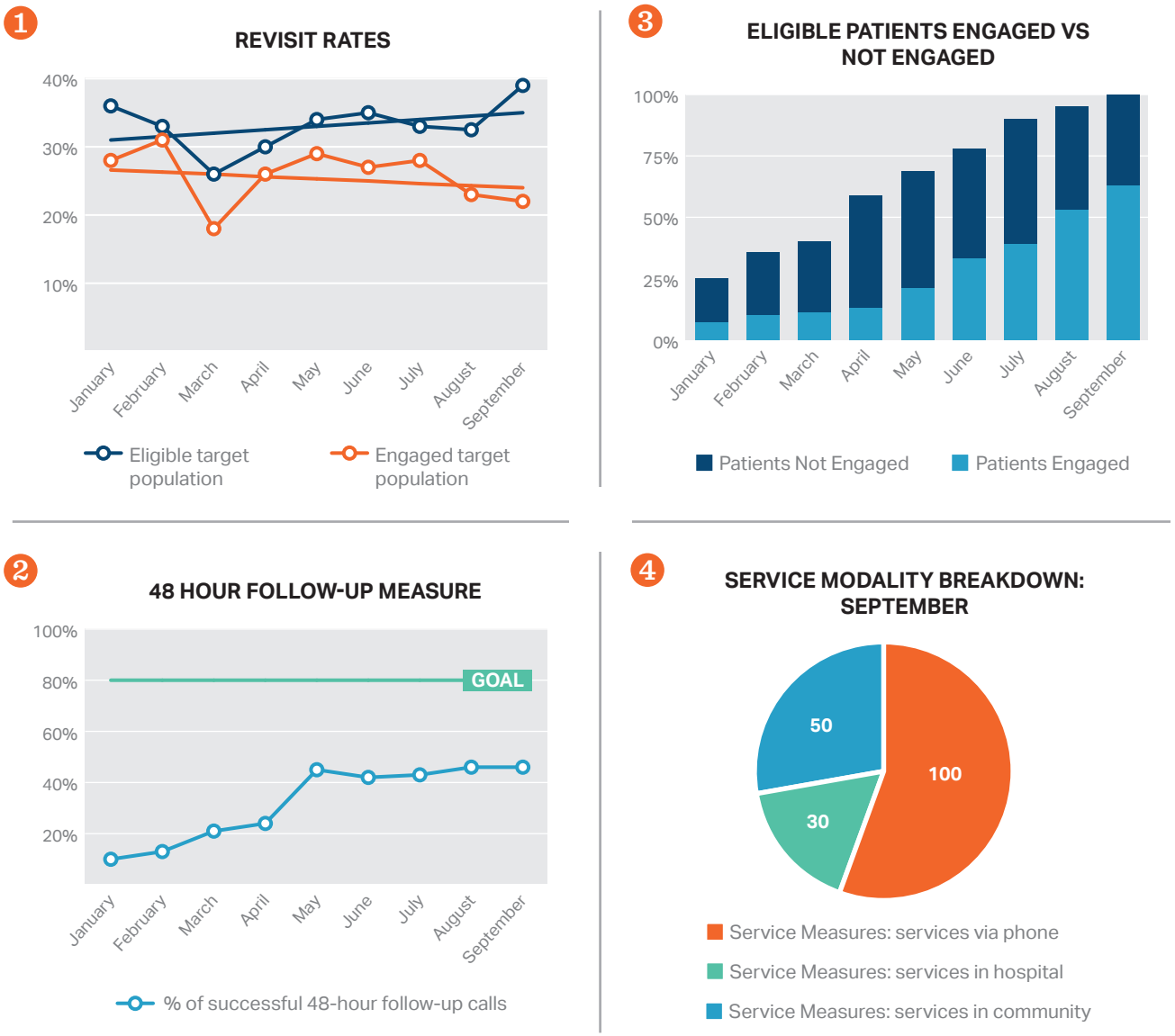
Finally, these same processes of data sharing and review added value to relationships with community partners, similarly highlighting gaps in care or outcomes. For example, one CHART team identified which skilled nursing facilities (SNFs) had the highest and lowest ED revisit and hospital readmission rates and shared those rates with the SNFs. This exercise helped drive discussions around discharge-planning to SNFs and the most appropriate circumstances for transferring patients to acute care.

CREATING A DASHBOARD

By presenting operational measures in a dashboard, many CHART teams were able to quickly identify outliers and trends and, based upon what they saw, set goals. While there was variability in the ability to collect accurate data, teams that were able to build a real-time data dashboard reported numerous benefits to the operation of their care models. Dashboards allowed CHART teams to see where a patient was in the hospital, understand their previous visit history, and access their care plan. Dashboarding was also important for collecting data on programmatic performance and informed data-driven decision making for Plan-Do-Study-Act (PDSA) strategies.

When presenting data to others, CHART teams found it useful to have the data table behind the visualizations to provide more detail and clarification when questions emerged. The following page is an example dashboard created with sample operational measures. This example was created using a standard spreadsheet program such as Microsoft Excel.

Figure 3. Dashboard Examples



LESSONS FROM SAMPLE DASHBOARD

GRAPH 1

In this example, where the program was focused on reducing ED revisits, the eligible patient revisit rate is increasing, but the enrolled patient revisit rate is decreasing. This may indicate that when patients do receive services, their ED revisit rate decreases.

GRAPH 2

This dashboard shows that the care team was initially connecting with 10-24% of acute encounters within 48 hours of discharge. The follow-up rate then began to plateau in the 42-46% range. Next, this team could annotate this graph with program milestones to understand how the team initially improved follow-up rates and how they might do so again.

GRAPH 3

This graph shows that the number of eligible and enrolled patients has steadily increased each month. However, the number of eligible patients who are not receiving services has remained high. This could indicate that resource allocation should to be adjusted to improve outreach and enrollment.

GRAPH 4

Presenting services provided by modality, this graph shows that almost 75% of services are provided in the hospital or over the phone. Several CHART programs began this way and many made significant operational changes to move care delivery into the community.

METHODS

OVERVIEW

To develop the CHART Playbook, HPC staff analyzed qualitative data collected from CHART hospitals during the grant implementation period to empirically identify challenges CHART hospitals faced deploying their programs, and the tools, processes, and resources that teams developed to mitigate these challenges and enhance their programs. During implementation, CHART hospitals regularly provided self-assessment reports to the HPC, reflecting on their processes, opportunities for improvement, and performance. Through inductive qualitative coding and analysis of these reports, key implementation lessons emerged. HPC staff collaborated with CHART hospitals and quality improvement experts to develop, refine, and compile the lessons learned, tools, processes, and resources in this Playbook.

DATA SOURCES

Qualitative Program Reports

CHART hospitals were required to submit monthly and periodic qualitative reports to the HPC throughout the two-year implementation period. Qualitative reports based on the RE-AIM framework were submitted by CHART hospitals quarterly.[9]

Operational Deliverables

CHART hospitals submitted protocols, tools/templates, job descriptions, and program-level policies as they were developed and deployed over the implementation period. These deliverables were collected at intervals of 2 months, 8 months, 12 months, and 16 months from the start of each hospital's CHART program. Additional qualitative information gathered by HPC staff and the HPC's contracted technical advisor complemented CHART hospital reports.

Qualitative Analysis

HPC staff conducted analysis of a sample of qualitative reports to identify the specific implementation challenges experienced by hospitals. These were then organized into themes representing categories of frequently experienced challenges. A code list based on these themes was developed and used to identify strategies, protocols, and/or tools that hospitals described as novel, successful, or valuable in their program reports.

Using this code list, HPC staff identified thematic program design and operations features for each CHART hospital. HPC staff applied the coding schema to 96 reports from 25 hospitals and coded approximately 2,134 observations. The inductive coding process produced a compilation of strategies and practices pertinent to each challenge theme. Specific tools and protocols submitted by hospitals were reviewed to identify operational items relevant to each theme. For each theme, the findings from program reports and the operational items were organized into a "Lesson" which was refined with feedback from CHART hospitals to develop the outline and subsequent narrative for each Implementation Lesson.

Methods For The Selected Tools Compilation

The tools and templates ("tools") that appear in the Selected Tools Compilation were curated from work products developed or used by CHART hospitals during the program. To develop the final list of tools, HPC staff compiled all of the tools of a common type (e.g., all of the care plans) and adapted them for Playbook readers. Revisions to these tools were minimal and solely for the purposes of removing any hospital-specific details (e.g., referral to organization-specific clinical pathways or clinical units); formatting for usability (e.g., adjusting margins or the size of blank text-entry fields to consolidate content onto fewer pages); or updating terminology to be more culturally competent (e.g., adding "Other" under gender identity).

9 Glasgow RE, Vogt TM, Boles SM. Evaluating the public health impact of health promotion interventions: the RE-AIM framework. American journal of public health. 1999 Sep;89(9):1322-7.

ACKNOWLEDGMENTS

HPC staff Gabe Malseptic, Tayler Bungo, and Kevin Comeau conducted analyses and prepared this document with guidance and support from David Seltz, Executive Director, Coleen Elstermeyer, Deputy Executive Director, Kelly Hall, Senior Director of Health Care Transformation and Innovation, Catherine Harrison, Deputy Director of Health Care Transformation and Innovation, and Lois H. Johnson, General Counsel. Many other HPC staff contributed to the preparation, design, and production of the Playbook, including Jasmine Bland, Vivian Haime, Michelle Savuto, and Lisa Snellings. The report was designed by Ashley Johnston.

The HPC gratefully acknowledges its contractor, Collaborative Healthcare Strategies, for the provision of technical assistance throughout the CHART Phase 2 Program.

The HPC recognizes HealthCentric Advisors, Winchester Hospital, Harrington Memorial Hospital, Emerson Hospital, Southcoast Hospitals Group, HealthAlliance Hospital, Hallmark Health System, Beth Israel Deaconess – Plymouth Hospital, and the following individuals for their valuable contributions and assistance: Selena Johnson from Heywood Hospital, Roger Orcutt from Beth Israel Deaconess - Milton Hospital, Carol Plotkin from Hallmark Health System, and Wendy Mitchell from Lowell General Hospital.

The HPC extends its sincere gratitude to all of the participating community hospitals and to their clinical and non-clinical staff whose contributions to the CHART Phase 2 Program helped inform the lessons contained in this CHART Playbook.

SELECTED TOOLS COMPENDIUM

The following section features tools and templates developed or used by CHART hospitals to implement their CHART programs.

LESSON 2

TOOL 2.1 Immediate Needs Checklist

TOOL 2.2 48-Hour Follow-Up Script

LESSON 3

TOOL 3.1 Comprehensive Needs Assessment

TOOL 3.2 Longitudinal Care Plan

TOOL 3.3 Acute Care Plan

TOOL 3.4 Large Format Business Cards

LESSON 4

TOOL 4.1 Daily Huddle Tool

TOOL 2.1:

SAMPLE IMMEDIATE NEEDS CHECKLIST

Adapted from Harrington Memorial Hospital

This checklist is an adaptation of assessment questions developed by Harrington Memorial Hospital. Questions like these were used by several CHART hospitals to identify a patient's most immediate needs.

BASIC NEEDS

- Housing?
- Access to food?
  - Need food stamps?
- Cash assistance?

TRANSPORTATION

- Does the patient have adequate transportation?

MENTAL HEALTH/PSYCHOSOCIAL

- Does the patient have outpatient providers for therapy and psychiatry?
  - Have appointments been scheduled?
- Does the patient regularly attend appointments?
  - If not, why?
- Is the patient interested in seeing providers in a particular location/area?
- Does the patient have social supports they are comfortable contacting?

COMMUNITY SUPPORTS

- Does the patient have a caseworker or similar support?
- Is the patient a client of the state or a local agency?

DAY STRUCTURE/SUPPORT GROUPS

- Has the patient been involved in a day program?
- Has the patient been involved in support groups?

SUBSTANCE USE

- Does the patient have a history of substance use?
  - If so, is the patient interested in:
    - Intensive outpatient program?
    - Recovery coaching?
    - Medication for addiction treatment?
    - Detoxification/rehabilitation facility?
    - Training in how to administer naloxone (Narcan)?

MEDICAL

- Does the patient have a primary care provider?
- Does the patient have any complex medical diagnoses?
  - If so, is the patient seeing any specialists for this diagnosis?
  - Is the patient able to perform activities of daily living independently (bathing, toileting, dressing, etc.)
  - Does the patient take medications regularly?
  - Does the patient feel comfortable and familiar with their medication regimen?

TOOL 2.2:

SAMPLE 48-HOUR FOLLOW-UP SCRIPT

Adapted from Emerson Hospital and Southcoast Hospitals Group Joint Award

This script is an adaptation of scripting developed and used by several CHART hospitals to facilitate a conversation with a patient immediately following an acute encounter. The purpose was to identify the patient's immediate needs, gauge the patient's understanding of the discharge plan and next steps, schedule a community visit, and identify other providers already serving the patient to coordinate care.

"Hello my name is [CALLER'S NAME] calling from [ORGANIZATION] I'm calling to check on how you have been doing since we last saw you at [ORGANIZATION] on [DATE]. Is now a good time to talk?"

Yes - *Proceed with conversation*
No - *Ask when to call back*

1. How have you been feeling lately?

2. What did you eat last night and this morning?

3. Have you been outside since you have been home from the hospital?

4. Have you had any difficulty getting your medications at the pharmacy? Taking your medications? Understanding your medications?

5. Do you have any appointments coming up? *(Check discharge summary to determine if any should have been scheduled)*

    a. What is it for? Who is it with? When is it?

    b. How are you going to get to your appointment?

6. Are you finding you are able to get around your home okay?

7. If something goes wrong, who are you going to call?

8. Do you have the phone number for your doctor? *(If no, give it to them)*

9. Can you tell me about any warning signs or triggers related to your condition that you are monitoring? *(use condition-specific questions)* If you observe these signs or triggers, do you know what steps to take?

10. Is someone else helping you, such as a family member? Does that person have your doctor's *(or other relevant provider's)* phone number? Does that person know what medications you need to take and any warning signs or triggers to look out for?

11. *(If patient was discharged with home-based support visiting nurse service)* Has a nurse been by to check on you and see how you are doing?

TOOL 3.1:

SAMPLE COMPREHENSIVE NEEDS ASSESSMENT

Adapted from HealthAlliance Hospital

This template is an adaptation of a comprehensive needs assessment developed and used by some CHART hospitals to document a patient's comprehensive medical, behavioral health, and social needs. Additionally, this tool may be used to promote the development of the relationship between a care provider and patient and serve as an input to care planning.

Service Date: [Date]	**Provider Name:** [Name]	
PATIENT INFORMATION		
Last Name: [Last Name] **First Name:** [First Name]	**MRN:** [MRN #]	**Community Partner Record #:** [CPR #]
PATIENT GENERAL ASSESSMENT		

Reason for Referral:
Click here to enter text.

History of Hospitalizations/ED Visits:
Click here to enter text.

What occurred to cause the person to seek services now?
Click here to enter text.

Living Situation:
Click here to enter text.

Vocational/Educational History:
Click here to enter text.

Legal Status & Legal Involvement:
Click here to enter text.

Substance Use/Addiction History: (Primary substances, how often, last use)
Click here to enter text.

MEDICAL/BEHAVIORAL HEALTH HISTORY

How well is the person connected to his/her primary care provider?
Click here to enter text.

History of Medical Problems (Include hx of diabetes, asthma, allergies, and other medical conditions)
Click here to enter text.

Current Non-Psychiatric Medications:
Click here to enter text.

Mental Health History:
Click here to enter text.

Current Psychiatric Medications:

Click here to enter text.

DSM-5 Diagnosis:

ICD-10 Diagnosis 1: Click here to enter text.

ICD-10 Diagnosis 2: Click here to enter text.

ICD-10 Diagnosis 3: Click here to enter text.

MH Symptoms reported by client: Click here to enter text.

STRENGTHS, RESOURCES, & SUPPORTS

Person's strengths, skills, and capabilities:

Click here to enter text.

What supportive services does the person want or need?

Click here to enter text.

What resources and supports does the person have and use?

Click here to enter text.

Other relevant information:

Click here to enter text.

SUMMARY AND INITIAL PLAN

Click here to enter text.

Total Time: [00:00]	**Service Codes:** Choose an item.	**Service Codes:** Choose an item.	**Service Codes:** Choose an item.

Completed By: _____

Staff Signature: _____ Date: _____

Supervisor Signature:
(If Required) _____ Date: _____

Service Date: [Date]	**Provider Name:** [Name]	
CLIENT DEMOGRAPHICS		
Last Name: [Last Name] **First Name:** [First Name]	**MRN:** [MRN #]	**CHL Record #:** [CHL #]

SELF-SUFFICIENCY MATRIX

Instructions: Complete this assessment for all High-Intensity Care Coordination and Community Outreach patients upon entry to the CHART program and at program exit.

1. Physical Health

- ☐ No chronic illness and maintaining pro-active preventative medical and dental care practices (10a)
- ☐ Good health insurance with low co-pays (10b)
- ☐ Enrolled in Medicare with Supplemental Insurance (10c)
- ☐ No chronic illness or stable chronic illness and maintaining good preventative medical and dental health care practices (8a)
- ☐ Has some private health insurance (8b)
- ☐ Has health insurance through Medicare (8c)
- ☐ Chronic illness generally well managed and attempting to make and keep routine medical and dental appointments (6a)
- ☐ Has subsidized medical coupons or health insurance (6b)
- ☐ Has subsidized Medicare and/or Medicaid (6c)
- ☐ Chronic medical conditions, potentially life threatening, with inconsistent follow up with care (3)
- ☐ Inconsistent use and/or limited access to health care (2)
- ☐ No health insurance or access to care (1)
- ☐ Is unable to articulate needs (0b)
- ☐ Untreated chronic medical, life threatening conditions with inconsistent to minimal follow up with care (0)

Level Scoring: 0-2 = In Crisis, 3-4 = Vulnerable, 5-6 = Stable, 7-8 = Safe, 9-10 = Thriving

Level: ☐ In Crisis ☐ Vulnerable ☐ Stable ☐ Safe ☐ Thriving

General Notes: Click here to enter text.

2. Mental Health

- ☐ No problems in work, school, social life; superior functioning in activities that are meaningful (10)
- ☐ No or minimal problems in all areas of life; some involvement in activities that are meaningful (8)
- ☐ Mild to occasional problems with work, social, or school settings; usually makes good choices (6)
- ☐ Has great difficulty caring for self or others; significant problems with social, work or school settings (3)
- ☐ Cannot care for self or family (1)
- ☐ At clear risk of harm to self or others (0)

Level Scoring: 0-2 = In Crisis, 3-4 = Vulnerable, 5-6 = Stable, 7-8 = Safe, 9-10 = Thriving

Level: ☐ In Crisis ☐ Vulnerable ☐ Stable ☐ Safe ☐ Thriving

General Notes: Click here to enter text.

3. Support System

- ☐ Is able to give support as well as receive support (10)
- ☐ Always has support (9)
- ☐ Has a healthy support system most of the time (8)
- ☐ Has a healthy support system only in times of crisis (6)
- ☐ Has a healthy support system but is unreliable (4)
- ☐ Has a support system but is unhealthy and limited (3)
- ☐ Does not have a support system (0)

Level Scoring: 0-2 = In Crisis, 3-4 = Vulnerable, 5-6 = Stable, 7-8 = Safe, 9-10 = Thriving

Level: ☐ In Crisis ☐ Vulnerable ☐ Stable ☐ Safe ☐ Thriving

General Notes: Click here to enter text.

SELF-SUFFICIENCY MATRIX

Instructions: Complete this assessment for all High-Intensity Care Coordination and Community Outreach patients upon entry to the CHART program and at program exit.

4. Access to Services

☐ No longer in crisis, no longer needs services or is receiving a full range of services to meet needs (10)

☐ Receiving a full range of services that he/she wants and needs (9a)

☐ No significant barriers limit access to needed services (9b)

☐ Receiving needed services but access barriers may limit choice of providers, geography, times of service or other quality related aspects (8)

☐ Knows what he/she needs, knows how to learn about the services available to meet his/her need; but choices are limited (7)

☐ Knows what he/she needs, knows how to learn about the services available to meet his/her need, but only has one option for service provision (6)

☐ Knows what he/she needs, knows how to learn about the services available to meet his/her need, but has a limited number of barriers that discourage access to services or service alternatives (5)

☐ Knows his/her needs and where to get services, but significant barriers inhibit him/her from accessing services on his/her own. Assistance required (4)

☐ Knows some of his/her needs and where to get services to meets some needs but barriers inhibit him/her from accessing services on his/her own. Assistance required (3)

☐ Service doesn't exist in location the person can access or barriers prevent access (e.g. cost of services, transportation, geography, physical or mental disabilities, language, religion, culture, etc.) (2)

☐ Is unaware of resources or services that he/she may need or needs help to identify his/her needs (1)

☐ Is unaware of resources or services that he/she may need or needs help to identify his/her needs (0a)

☐ Is unable to articulate needs (0b)

Level Scoring: 0-2 = In Crisis, 3-4 = Vulnerable, 5-6 = Stable, 7-8 = Safe, 9-10 = Thriving

Level: ☐ In Crisis ☐ Vulnerable ☐ Stable ☐ Safe ☐ Thriving

General Notes: Click here to enter text.

5. Substance Use

☐ Uses alcohol and prescription drugs in an appropriate manner (minimal to no usage) (10)

☐ Occasional misuse of alcohol and/or prescription drugs, generally uses in an appropriate manner (8)

☐ Occasional abuse of substances. Usage of chemicals has a tendency to lead to an abuse pattern, resulting in negative consequences (6)

☐ Significant abuse of substances, resulting in chronic family/work difficulties (3)

☐ Toxicity due to chemical dependency or alcoholism. Detoxification may be required (0)

Level Scoring: 0-2 = In Crisis, 3-4 = Vulnerable, 5-6 = Stable, 7-8 = Safe, 9-10 = Thriving

Level: ☐ In Crisis ☐ Vulnerable ☐ Stable ☐ Safe ☐ Thriving

General Notes: Click here to enter text.

SELF-SUFFICIENCY MATRIX

Instructions: Complete this assessment for all High-Intensity Care Coordination and Community Outreach patients upon entry to the CHART program and at program exit.

6. Employment Stability

- ☐ Employed in permanent, stable employment for as many hours per week as desired with full benefits including health, vision and dental, as well as retirement and supplemental benefits (10)
- ☐ Employed in permanent, stable employment for as many hours per week as desired with employer offering benefits including health, vision, dental and retirement (9)
- ☐ Employed in permanent, stable employment for as many hours per week as desired, with benefits including health, vision and dental (8)
- ☐ Employed in permanent, stable employment with employer offering health benefits (7)
- Employed in permanent, stable employment for as many hours per week as desired with no benefits (5)
- ☐ Employed in temporary, seasonal, or part-time employment for 75-99% of the desired number of hours with no benefits (4)
- ☐ Employed in temporary, seasonal, or part-time employment for 50-74% of the desired number of hours with no benefits (3)
- ☐ Employed in temporary, seasonal, or part-time employment for less than 50% of the desired number of hours with no benefits (2)
- ☐ Desiring employment but unemployed and receiving unemployment compensation or extension (1)
- ☐ Desiring employment but unemployed with all forms of unemployment compensation exhausted (0)

Level Scoring: 0-2 = In Crisis, 3-4 = Vulnerable, 5-6 = Stable, 7-8 = Safe, 9-10 = Thriving

Level: ☐ In Crisis ☐ Vulnerable ☐ Stable ☐ Safe ☐ Thriving

General Notes: Click here to enter text.

7. Mobility

- ☐ Always has transportation needs met through public transportation, a car, or a regular ride (10)
- ☐ Has most transportation needs met through public transportation, a car, or a regular ride (8)
- ☐ Has some transportation needs met through public transportation, a car, or a regular ride (6)
- ☐ Rarely has transportation needs met through public transportation, a car, or a regular ride (3)
- ☐ Does not have transportation needs met and has no available public transportation, a care, or a regular ride (0)

Level Scoring: 0-2 = In Crisis, 3-4 = Vulnerable, 5-6 = Stable, 7-8 = Safe, 9-10 = Thriving

Level: ☐ In Crisis ☐ Vulnerable ☐ Stable ☐ Safe ☐ Thriving

General Notes: Click here to enter text.

8. Income

- ☐ Income is sufficient and stable, adequate for paying monthly bills and provides for regular savings and some non-essential purchases (10)
- ☐ Income is sufficient and stable, adequate for paying monthly bills but provides for little savings or non-essential purchases (8)
- ☐ Income is adequate for meeting basic needs (income meets standard, adjusted for family size) (6)
- ☐ Income is inadequate for meeting basic needs (income is between 75-99% of standard, adjusted for family size) (4)
- ☐ Income is inadequate for meeting basic needs (income is between 50-74% of standard, adjusted for family size) (3)
- ☐ Income is inadequate for meeting basic needs (income is between 25-49% of standard, adjusted for family size) (2)
- ☐ No income. Basic needs are not met (income is between 0-24% of standard, adjusted for family size) (0)

Level Scoring: 0-2 = In Crisis, 3-4 = Vulnerable, 5-6 = Stable, 7-8 = Safe, 9-10 = Thriving

Level: ☐ In Crisis ☐ Vulnerable ☐ Stable ☐ Safe ☐ Thriving

General Notes: Click here to enter text.

SELF-SUFFICIENCY MATRIX

Instructions: Complete this assessment for all High-Intensity Care Coordination and Community Outreach patients upon entry to the CHART program and at program exit.

9. Housing

- ☐ Homeownership in a neighborhood of choice (10)
- ☐ Secure rental housing in a neighborhood of choice (9)
- ☐ Safe and secure homeownership, choice limited by moderate income (8)
- ☐ Safe and secure, non-subsidized rental housing, choice limited by moderate income (7)
- ☐ Living in affordable private housing (50% or less of household income is spent on housing (6)
- ☐ Living in subsidized housing (5)
- ☐ Living in unaffordable, overcrowded, or transitional housing (4)
- ☐ Living in temporary shelter or unsafe or substandard housing (3)
- ☐ Households with eviction notice or forced displacement (i.e. nursing home discharge without housing, fire, natural disaster) (2)
- ☐ Couch surfing or doubling up with others (1)
- ☐ Homeless (0)

Level Scoring: 0-2 = In Crisis, 3-4 = Vulnerable, 5-6 = Stable, 7-8 = Safe, 9-10 = Thriving

Level: ☐ In Crisis ☐ Vulnerable ☐ Stable ☐ Safe ☐ Thriving

General Notes: Click here to enter text.

10. Legal Issues

- ☐ No legal issues or legal issues fully resolved through litigation, negotiations, dismissal or other legal means (10)
- ☐ Has legal representation and issues are moving towards resolution (8)
- ☐ With legal assistance, has initiated or responded to legal actions, is in court system (6)
- ☐ Has obtained pro se assistance (assistance to individuals representing themselves) or representation sufficient to initiate legal action or respond to actions initiated by others (5)
- ☐ Has legal information/advice; correctly identifies the problem as legal problem; knows what to do but lacks ability to proceed without legal assistance (4)
- ☐ Has received legal information/advice and correctly identifies the problem as a legal problem, may not know what to do (3)
- ☐ Has significant legal problem, recognizes the legal issues but does not know what to do (2)
- ☐ Has significant legal problem but does not understand that the problem involves legal issues and does not know what to do (1)

Level Scoring: 0-2 = In Crisis, 3-4 = Vulnerable, 5-6 = Stable, 7-8 = Safe, 9-10 = Thriving

Level: ☐ In Crisis ☐ Vulnerable ☐ Stable ☐ Safe ☐ Thriving

General Notes: Click here to enter text.

Service Codes: Choose an item.	**Service Codes:** Choose an item.	**Service Codes:** Choose an item.

Completed By: _____

Staff Signature: _____ Date: _____

Supervisor Signature: _____ Date: _____

TOOL 3.2

SAMPLE LONGITUDINAL CARE PLAN

Adapted from Hallmark Health System Joint Award

This template is an adaptation of longitudinal care planning documentation developed and used by some CHART teams to collaboratively capture a patient's comprehensive needs, strengths, and supports in order to develop short- and long-term care goals.

A. DEMOGRAPHICS

Patient Name: _____ Gender Identity: ☐ M ☐ F ☐ Other _____

Medical Record Number: _____ Date of Birth: _____

Address: _____

Phone Number: _____ Emergency Contact: _____

Preferred Method of Contact: _____

Staff:

Name:_____ Credentials:_____ Date and Time:_____

Location:_____ Source of Information:_____

Cohort:_____

IN THE PATIENT'S WORDS

Why are you enrolling in this program?

Please describe the major areas of stress in your life:

Have you had any recent losses of family, friend, job, pet or health? ☐ YES ☐ NO

What would you like to change?

Current Living Arrangements:_____ Who do you live with?_____

Do you live in subsidized housing? ☐ YES ☐ NO

B. WORK AND MONEY

Education: _____

Describe work history strengths and challenges:

Please describe a "typical day":

FINANCIAL

Do you have enough money to provide for your basic needs? ☐ YES ☐ NO

Do you have money worries or struggles? ☐ YES ☐ NO

Do you have health Insurance? ☐ YES ☐ NO

Do you collect benefits? *(Social Security, Disability, Food Stamps, Emergency Cash Assistance)* ☐ YES ☐ NO

MILITARY

Do you have any current legal concerns?

Are you a veteran? ☐ YES ☐ NO

If Yes, please describe your assignment:

C. SOCIAL RELATIONSHIPS

Relationship status: _____

Do you have children? ☐ YES ☐ NO

If yes, list names and ages:

Do you have someone or somewhere to turn to for help and support? ☐ YES ☐ NO

Are you a member of a faith-based or spiritual community? ☐ YES ☐ NO

D. SAFETY

Do you feel safe where you live? ☐ YES ☐ NO

Does anyone hurt or threaten you? ☐ YES ☐ NO

How often do you feel afraid?

Do you every think about hurting yourself or someone else? ☐ YES ☐ NO

Have you ever been abused? ☐ YES ☐ NO

Have you even been a survivor of a crime or natural disaster? ☐ YES ☐ NO

E. HEALTH STATUS

Current health concerns:

☐ Abdominal Pain	☐ Cholecystitis	☐ GI Bleed	☐ Pneumonia
☐ Abscess	☐ Cirrhosis	☐ Heart Failure	☐ Pyelonephritis
☐ AFIB	☐ COPD	☐ Hip/Knee	☐ Rectal Hemorrhage
☐ AMI	☐ CVA	☐ HIV/AIDS	☐ Renal Failure
☐ Asthma	☐ Decubitus Ulcer	☐ Hypertension	☐ Respiratory Failure
☐ Behavioral Health	☐ Dehydration	☐ Meningitis	☐ Septic Shock
☐ CABG	☐ Diabetes	☐ Multiple Sclerosis	☐ Septicemia
☐ Cancer	☐ Diabetic Foot Ulcers	☐ Organ Transplant	☐ SOB
☐ CAD	☐ Fever	☐ Osteomyelitis	☐ Syncope
☐ CHF	☐ Fracture	☐ Other	☐ UTI
☐ Cellulitis	☐ General Weakness	☐ Pancreatitis	☐ Wound Infection

If Other, please explain:

What have you been told about your health and medical problems?

Lifestyle: Do you engage in regular physical activity? ☐ YES ☐ NO

Do you have any special nutritional needs? ☐ YES ☐ NO

How many hours of sleep do you typically get in a 24 hour period?___

Have you fallen in the past year? ☐ YES ☐ NO

Do you have any mobility challenges? ☐ YES ☐ NO

How do you manage stress?

CURRENT MEDICATIONS:

List medications taken for mental health problems:

Name	Dosage	Frequency	Prescribed By	Taken for How Long?	Why was this medication prescribed?	Indication

Do you have any problems getting your medication? ☐ YES ☐ NO

Do you have a pharmacy you use regularly? ☐ YES ☐ NO

HEALTHCARE TEAM

PCP _____

Specialists _____

Psychiatrist _____

Physical Therapy _____

Therapists _____

Visiting Nurse _____

Mental Health _____

MENTAL HEALTH HISTORY AND TREATMENT

Have you had mental health or psychiatric treatment *(Counseling, medication, hospitalization?)* ☐ YES ☐ NO

If yes, list diagnosis and treatment:

OVERUSE DISORDERS

	Last Use	Method of Use	Amount of Use	History
☐ Alcohol				
☐ Drugs				
☐ Food				
☐ Gambling				
☐ Sex				

Have you had treatment for substance use disorders? ☐ YES ☐ NO

WORK STOP

Review record for adherence to appointments, medications and recommendations. Note frequency of adherence issues.

Do you have any difficulties keeping appointments with healthcare providers? ☐ YES ☐ NO

How can we help you? e.g., transportation or reminder calls.

Do you have any difficulties remembering to take your medicine? ☐ YES ☐ NO

How can we help?

Is this relationship helpful to you? ☐ YES ☐ NO

Other community services?

☐ DMH Services	☐ Housing Services
☐ DCF	☐ DTA
☐ Elder Services	☐ Other
☐ Food Programs	*Describe Other:*

We would like to ask several questions to help us, together, keep track of your improvement over time.

Needs List:

☐ Care Coordination		☐ Legal	
☐ Community Involvement		☐ Medication Education	
☐ Employment		☐ Mental Health	
☐ Financial		☐ Mobility	
☐ Food Insecurity		☐ Safety	
☐ Health		☐ Structure of Day	
☐ Health Management		☐ Substance Abuse	
☐ Housing		☐ Other	
☐ Interpersonal Relationships			

Thank you for talking about your life and some of your challenges. Now can you please describe your strengths?

If you could change three things about your life, what would you change?

1.

2.

3.

F. PLAN

Short Term Goals	Measurement	COACHH Staff	Update

Long Term Goals	Measurement	Staff	Responsibility

Intervention	Duration	Modality	Responsibility

Criteria for discharge from the program:

SUMMARY

Patient Name:_____ Signature:_____ Date:_____

Staff	Signature	Credentials	Date

TOOL 3.3

SAMPLE ACUTE CARE PLAN

Adapted from Beth Israel Deaconess – Plymouth Hospital

This template is an adaptation of acute care plan templates developed and used by some CHART teams to develop a brief summary of the primary driver(s) behind a patient's repeated use of the acute care setting (particularly the ED), and provides the opportunity to give guidance for the next acute care provider.

Patient Medical Record #	
DOB / Age / Gender	
Care plan date	Date care plan created: Date(s) modified:
Situation [Reason for care plan]	X # of visits with chief complaint of XXXX. Primary driver of frequent visits appears to be XXXX.
Background [Patterns of acute care utilization and summary of relevant lab/tests/procedures]	
Assessment [Drivers of repeated utilization, resource(s) in place]	
Recommendations [Directed at ED clinical staff to promote safety, quality, consistency and otherwise advance care]	
Whom to contact about care plan [May be PCP, caseworker, care manager]	Name: XXXX; email address XXXX; Phone number: XXXX

TOOL 3.4

LARGE BUSINESS CARDS

Adapted from Winchester Hospital

BACKGROUND

Several CHART Phase 2 programs used large business cards as a tool for engaging and communicating with patients, families, and other providers.

WHY USE LARGE BUSINESS CARDS?

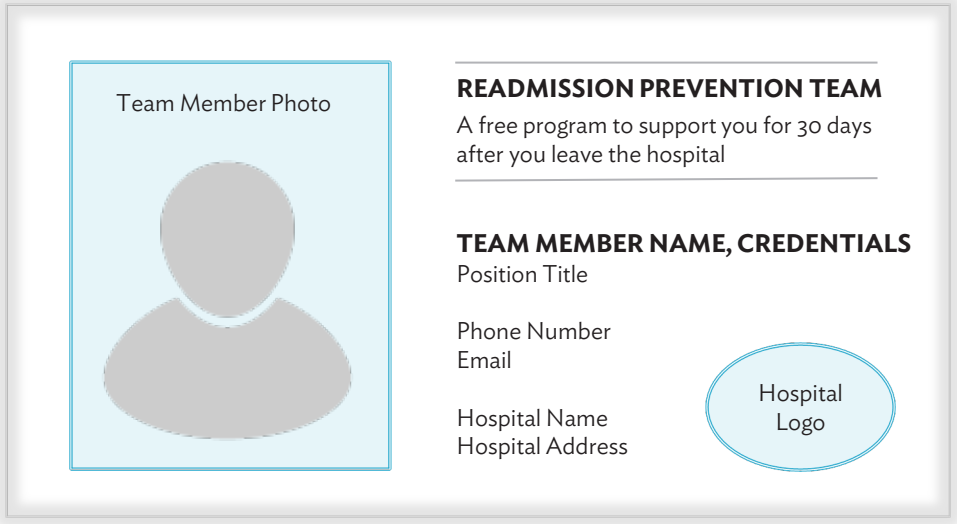
- **To facilitate identification** among CHART team members**,** other providers, and patients and their families, for safety and engagement purposes.
- **To improve communication** with patients, their families, and other providers within the hospital and in the community, for care coordination purposes.
- Advantages of these cards:
  - **Color photos** and large size make them memorable
  - **Large text** makes them easier to read
  - **Large size** makes them harder to lose

HOW ARE BUSINESS CARDS USED?

- Carried by patient-facing CHART team members
- Typically provided to patients (and families) during an initial meeting with CHART team members.
- Patients sometimes provided additional cards to share with caregivers, family, and other providers, such as primary care teams and transportation staff.
- Cards also provided to staff at skilled nursing facilities to help build relationships and communication.
- Additional information (e.g., upcoming appointments, personal notes) can be handwritten on the back of the cards as helpful reminders.

SUCCESS STORIES

- A CHART patient presented at the ED of a non-CHART facility. **The staff found the business card in the patient's belongings and contacted the CHART team** to obtain relevant information for care coordination.
- Long-distance family members note feeling a **sense of comfort and relief** when they are able to view a team member's face during phone conversations.
- Cards included in patient folders at skilled nursing facilities **serve as a reminder for staff to contact the CHART team** with information on discharges.
- A local primary care provider was unaware that his patient was receiving CHART services until he was shown the card. **He contacted the CHART team to learn more about the program's services.**



Actual size

TOOL 4.1

DAILY HUDDLE TOOL

Adapted from Hallmark Health System Joint Award

KEY PRINCIPLES & PRIORITIES

- To ensure safety of all team members
- To promote effective, consistent team communication
- To oversee and prioritize caseloads
- To provide a supportive space for learning & development
- *Primary target population:* Patients with ≥ 10 ED visits in previous 12 months
- *Primary aim:* Reduce ED utilization by 20%
- *Team:* Social Worker (LICSW) who supervises 3 CHWs; NP; Executive Director; (part-time: Pharmacist, Physician consultants, Administrative Assistant)

DESIGN

- Daily (M-F), 30 minutes, 8:30-9am
- Attendance is mandatory for all COACHH staff
- Staff may call in if being on-site conflicts with community-based visits
- LICSW leads the huddle
- Active participation by all is encouraged

PREPARATION

- LICSW reviews report of overnight ED visits
- NP reviews current inpatients
- Coaches (CHWs) prepare questions from previous day and identify goals for today's scheduled patients

AGENDA

Recap from previous day:

1. **ADDRESS ANY SAFETY CONCERNS**
   Staff should feel comfortable to raise any concerns. The team should have a clear understanding of who the patients are and where staff members are going. Initial home visits are typically conducted in pairs (CHW and LICSW or NP).

2. **DISCUSS QUESTIONS AND/OR CONCERNS**
   All questions raised are answered by the team. The clinicians typically provide resource and treatment recommendations, while the Coaches give detailed insight into a patient's situation.

Prep for today:

3. **ADDRESS OVERNIGHT CALLS OR VOICEMAILS**

4. **REVIEW OVERNIGHT ADMISSIONS**

5. **ASSIGN FOLLOW-UP CALLS OR VISITS FOR RECENTLY SEEN PATIENTS**
   When assigning new patients, the team rotates among Coaches to ensure even caseload. LICSW monitors caseload and makes adjustments as needed. All assignments are recorded in Hallmark's care coordination system.

6. **REVIEW GOALS FOR EACH PATIENT VISIT SCHEDULED FOR THE DAY**
   The team limits updates to 2 minutes per patient. LICSW and NP provide a brief summary while Coaches add further detail. The goals are short and driven by the patient's care plan.

7. **WRAP UP WITH ANNOUNCEMENTS OR ITEMS FOR FOLLOW UP**

TIPS

For the most service intensive cases, rotate Coach every few months to prevent staff burnout. Provide your patient with a warm hand-off.

Celebrate all successes! From enrolling a new patient in the program to diverting a patient from the ED – no success is too small. Team meals and positive messages go a long way.

As a team, be patient and perseverant. It takes time and practice to address each agenda item efficiently and effectively within a short timeframe.

MASSACHUSETTS
HEALTH POLICY COMMISSION
50 MILK STREET, 8TH FLOOR
BOSTON, MA 02109
WWW.MASS.GOV/HPC