MASSACHUSETTS
HEALTH POLICY COMMISSION

CHART PHASE 2: 2017 STATEWIDE CONVENING
OCTOBER 16, 2017

On October 16, 2017, the Health Policy Commission held its second CHART Phase 2 Statewide Convening to highlight some of the successes, challenges, and lessons learned from the individual and collective work of the two-year, $60 million investment in 25 programs across 27 community hospitals to improve care for high risk and vulnerable populations.

This full-day public event included panel discussions and breakout sessions where attendees heard directly from care team members, program managers, and hospital leadership implementing these initiatives. The HPC would like to thank all panelists and presenters for sharing their work, Dr. Amy Boutwell for facilitating the event, and all attendees—many of whom are key state government partners— for contributing to the discussions and making the event a successful learning opportunity.

This document provides a selection of key takeaways from the presenters participating on each panel and breakout session. In addition, the event booklet, panel session slides, and a summary of lessons learned throughout CHART Phase 2 are available on the HPC website.

KEY LEARNINGS

Panel 1: Reducing Readmissions for High Risk Patients

- **Conduct home visits to address complex medical and social needs:** Clinical and psycho-social assessments by both a nurse and social worker in the home setting provide a more holistic view of patient needs, improving patient engagement and the care planning process.
- **Collaborate with primary care providers (PCPs):** Identify PCPs serving a high volume of patients with complex psycho-social needs and work with them to establish warm hand-off protocols.

Panel 2: Slowing the Cycle of High Utilization for Multi-Visit Patients

- **Build a team that is both flexible and unified:** Leverage team members' individual skills in defining roles, maintain flexibility in meeting patients *where they are*, and work toward common program goals and values.
- **Adopt a whole-person approach:** Use motivational interviewing techniques to better understand a person's situation, motivations, and goals; avoid focusing solely on medical conditions.

Panel 3: Improving Care for Behavioral Health Patients in the Emergency Department (ED)

- **Humanize patients:** Acknowledge and reduce the stigma that exists towards behavioral health patients by hospital staff, other patients, and family members.
- **Adapt team structure to address priorities:** Fundamental social needs such as food, shelter, and safety should be addressed alongside medical needs.

Panel 4: Lessons Learned, Capabilities Developed, and the Future

- **Communicate program goals to staff, leadership, and partners:** Increasing the visibility of the program and its benefits to other providers is critical for cross-team coordination.
- **Leverage both quantitative and qualitative data:** Metrics and storytelling are powerful tools in communicating program impact and offer a comprehensive picture when combined.

Breakout Sessions 1 and 2: Deep Dive into CHART Programs

- **Develop a compassionate team:** It takes patience and persistence to build an effective and driven team that goes beyond the traditional medical model to serve complex and high risk patients.
- **Form authentic and trusting relationships with patients:** Team members who are non-judgmental, reliable, responsive, and flexible to patient needs are best equipped to help patients on their journey for sustained behavior change.
- **Build community connections early on:** Relationship building takes time. From the start, communicate openly about the purpose of partnerships with community resources who may serve common patients—including skilled nursing facilities, visiting nurse associations, group homes, and law enforcement—in order to foster trust and collaboration.
- **Follow up with patients promptly after discharge:** Check in to see if patients have any questions about their discharge instructions and provide additional support, such as direct linkage to community resources, as needed. In many cases, face-to-face contact prior to discharge better enables ongoing patient engagement.
- **Maintain care plans that are relevant and up-to-date:** Care plans should contain succinct, pertinent, and actionable information that is easily accessible to ED and/or hospital staff.
- **Use data to drive performance improvement:** Identify the drivers of high utilization and the trends specific to the facility and community to best prioritize and adapt services.
- **Be nimble and bold when improving the service model:** Refine the model with what works, remove what doesn't work, and embrace change.
- **Learn from teams implementing similar initiatives:** Connect with other teams and learn how to determine a clear aim, engage leadership and community partners, hardwire successful program components, celebrate small successes, and maintain focus on program goals.

At the conclusion of the conference, the audience was asked to share their own key takeaways. Topics shared included the importance of collaboration and communication both within a hospital and across community settings, the role of technology in driving improvement and providing a platform for scalability, and the need to embrace change as we collectively continue to enhance the care and services delivered to vulnerable patients in our communities.