HEALTH POLICY COMMISSION

CHART PHASE 2

NORTHEAST/SOUTHEAST REGIONAL MEETING – FEBRUARY 23, 2016

Purpose: The CHART Northeast/Southeast Regional Meeting was held at the Massachusetts Hospital Association Conference Center in Burlington, MA, on 2/23/2016. The meeting provided a chance for CHART teams and hospital staff to meet, network, and discuss their programs with other teams. Below is a brief summary of challenges, successes, and patient stories shared at the meeting.

Hospital Attendees:

- Addison Gilbert Hospital
- Anna Jaques Hospital
- Beth Israel Deaconess Hospital – Milton
- Beth Israel Deaconess Hospital – Plymouth
- Beverly Hospital
- Emerson Hospital
- Hallmark Health
- Lahey / Lowell Joint Award
- Lawrence General Hospital
- Lowell General Hospital
- Milford Regional Medical Center
- Signature Healthcare Brockton Hospital
- Southcoast Hospitals Group
- Winchester Hospital

Addison Gilbert and Beverly Hospitals

Challenges/ Successes	Challenges arose from both the large scope of the joint grant and the level of medical complexity of the target population. The team addressed this by pooling resources to best engage with patients across care settings and floors.

Anna Jaques Hospital

Challenges/ Successes	Anna Jaques Hospital's CHART team identified several new best practices they plan to implement, including the "5 Whys" framework to better understand challenges in reaching their target population within 48 hours.

Beth Israel Deaconess Hospital – Milton

Challenges/ Successes	Properly preparing staff to work with behavioral health patients was initially difficult. This was solved by embedding a clinician from South Shore Mental Health (SSMH) in the ED, and engaging the staff in education and safety training.
Patient Story	A ~40 year old male presented to the ED seeking treatment for hallucinations. Integrated records with SSMH allowed staff to see that the patient was prescribed an intravenous medication, which was usually administered by a nurse at SSMH. He had missed a dose. The medication was not on formulary at BIDH – Milton, so the CHART team retrieved the medication at SSMH, brought it to BIDH – Milton, quality checked it with a pharmacist, and administered it to the patient. This was achieved without a hospital admission, and the patient has yet to return to the ED.

Beth Israel Deaconess Hospital – Plymouth

Challenges/ Successes	Safety during home visits is a concern, but the team has also discovered the benefits of providing care in the community, as opposed to only in a hospital setting.

Emerson Hospital

Challenges/ Successes	The Emerson team's challenges emerged from difficulty educating patients. They addressed this by hiring a nutritionist, a pharmacist, and an on-site hospice/palliative care liaison to help patients better understand their care.
Patient Story	A ~60 year-old diabetic, wheelchair bound male was frequently admitted to the hospital for difficulty managing his diabetes. Interventions by the CHART team focused on education, which enabled him to medically manage his diabetes on his own. However, they found that his nutrition was inappropriate for his condition. The team brought this to his attention and connected him with a meal delivery service that he is still using two months later.

Hallmark Health Joint Award

Challenges/ Successes	Hallmark initially found it challenging to recruit a team that is almost entirely community based and comfortable working with complex patients. The team has been successful in engaging patients in the community setting, conducting home visits and changing the model of care to "pushing" services, rather than "pulling" patients in.
Patient Story	A ~80 year-old patient visited the ED, on average, every three days. The Hallmark team began engaging the patient in home visits to alleviate anxiety, helping her with tasks including purchasing toilet paper and fixing curtains that had fallen. In the time since CHART program launch, the patient would have visited the ED approximately 30 times, based on the previous rate. Because of the CHART team's engagement, she has only visited once.

Lawrence General Hospital

Challenges/ Successes	Identifying patients in real time via risk assessments presented a challenge as it resulted in capturing patients not appropriate for inclusion in the target population. The team solved this by establishing a threshold for inclusion: patients scoring ≥2 on the risk assessment are considered to be within the target population.
Patient Story	A ~45 year-year old obese male with COPD and CHF presented to the ED on a weekly basis and was frequently admitted to the hospital. His standard discharge plan was to be transferred to pulmonary rehab, which he found to be too strenuous. CHART staff enabled the care team to treat the patient in a more holistic manner and send him to cardiac rehab rather than pulmonary rehab. He lives at home with his mother, who is elderly and frail, and his father, who must care for both his son and his wife. With his new care plan, he is able to take charge of his care rather than relying on others.

Lowell General Hospital

Challenges/ Successes	Lowell General's team struggled to properly identify patients using an ADT feed, and discovered that patient volume was underestimated, making it difficult for staff to manage the increased volume. They were successful in hiring a diverse team for their CHART program, and establishing relationships with community partners by meeting with all levels of the team.
Patient Story	A patient presented to the ED intoxicated. The CHART team engaged with the patient and asked that he return the next day. When he returned, he presented intoxicated again. He spoke to the team for over an hour, and rather than cutting him off, the team listened to him. At the close of the visit, the patient thanked them for "not shutting him up." Following the visit, he engaged with AA, found a job, and moved in with his brother (he was formerly homeless and unemployed). The team found that time, attention, and active listening encouraged the patient to engage in care.

Milford Regional Medical Center

Patient Story	A ~80 year-old male averaged 10 visits to the hospital per year, including four visits in the last three months. Throughout his hospitalizations, he, his spouse, and the medical team were in disagreement over his care. His spouse did not recognize that he was in pain. Over the course of four hospitalizations, the palliative care PA worked with the family and medical team to ensure the patient's quality of life at home improved and developed a care plan the spouse agreed to. The PA realized that the patient did not have medications at home, and without proper pain management, would immediately return to the ED. The PA wrote a prescription for pain medication, and the high risk mobile team pharmacist delivered medications to the patient's home prior to discharge.

Signature Healthcare Brockton Hospital

Challenges/ Successes	The team experienced trouble reaching their Target Population, 40% of who are homeless. This presents a safety issue when conducting home visits. To solve this, the team is collaborating with community partners including homeless shelters, providing a safe place to connect with patients.
Patient Story	A male homeless patient with SUD and COPD frequently visited the ED. Shortly after being discharged with a COPD primary diagnosis, he was found in a hotel room having overdosed. Responders administered Narcan and transported the patient to the ED. The CHART team worked with the ED physician to discharge him with a Narcan prescription. The patient stubbornly accepted the prescription, expressing that he did not feel he had a problem. Upon a subsequent admission, it was discovered that he had filled the Narcan prescription and was carrying it on his person, which the team found to be a breakthrough in getting the patient to engage in his care.

Southcoast Hospitals Group Joint Award

Challenges/ Successes	Communicating the scope of the CHART program to community partners was challenging, as some requested that the CHART program see patients outside of the Target Population. This was transformed from a problem to a success by clarifying with partners who the most appropriate and qualified team is for each patient, creating individually tailored care.

Winchester Hospital

Challenges/ Successes	Winchester Hospital encountered some trouble integrating the CHART team's work with existing hospital processes. They found that engaging clinicians in practices such as root cause analyses is challenging, but incredibly valuable. They additionally found success with internal processes for their CHART team, such as the creation of a real-time dashboard and biweekly team meetings to discuss complicated readmissions.