# HEALTH POLICY COMMISSION
# CHART PHASE 2
# OCTOBER 2016 STATEWIDE MEETING – OCTOBER 28, 2016

## Contents

## Purpose

The Health Policy Commission's 2016 CHART Phase 2 statewide convening, facilitated by Dr. Amy Boutwell, gave CHART teams an opportunity to present on their programs, share patient stories, and engage in productive dialogue on operational successes and challenges at the end of Year 1. HPC Executive Director David Seltz and HPC Director of Strategic Investment Kathleen Connolly gave welcoming remarks with a focus on the value of teamwork and partnership as pivotal to the success of the CHART programs.

Below is a summary of key takeaways from each panel with main questions and answers. Please refer to Appendix I for a brief overview of each program. The convening slide deck is available on the CHART Resource Page.

## Panel 1: Readmissions Reduction Programs

*Addison Gilbert and Beverly Hospitals, Berkshire Medical Center, Baystate Wing Hospital, BIDH-Plymouth, Emerson Hospital, Lawrence General Hospital, Signature Healthcare Brockton Hospital, Winchester Hospital*

### Key Takeaways

- Establishing and maintaining a "circle back" process where a team [of nurses] track where patients are discharged to, connect with a single point of contact at each nursing home, and conduct nursing home visits with CHART patient lists helps in keeping up-to-date with patients and in preventing unnecessary readmissions (identified as a next step for Winchester Hospital).

- Increasing team documentation in the hospital's electronic system (Epic) promoted collaboration with other hospital staff by facilitating an understanding of the CHART team's goals and involvement and communicating information on mutual patients (identified as an operational success by Addison Gilbert and Beverly Hospitals).

- Providing patients with a list of community partner appointments that have been scheduled upon hospital discharge can facilitate patient engagement and care coordination (identified as an operational success by Berkshire Medical Center).

- Increasing the number of home visits and overall involvement in the community helps to maintain rapport with patients and prevent unnecessary readmissions (identified as a lesson learned and next step for Lawrence General Hospital).

- Addressing the need for hospice and palliative care consults is important for educating both patients and hospital staff (identified as an operational success by Emerson Hospital).

- Maintaining a shared calendar facilitates communication and awareness of the location of all team members when out in the community (identified as an operational success by BIDH-Plymouth).

- Collaborating with other hospital teams can mean providing them with important information about a patient's background and situation for informed clinical decision making (as reflected in the patient story described by Baystate Wing Hospital).
- Introducing yourself by saying "How can I help you?" and "I have experience in that" can go a long way when initially engaging patients (tip shared by Signature Healthcare Brockton Hospital).

## Q&A

***Question:*** **How have teams accessed housing and detoxification services?**
***Answer:*** Establishing a formal arrangement via a business associate agreement (BAA) can ensure that a local detox facility prioritizes CHART patients (BIDH-Milton).

***Question:*** **What are some successful strategies for initial patient engagement?**
***Answer:*** Large business cards with a profile picture can be a helpful reminder to patients and a way to more easily engage during the 48-hour follow-up call (Winchester Hospital).

***Question:*** **What does the patient consent process entail for other teams?**
***Answer:*** This process differs by hospital. At Berkshire Medical Center, staff consider patients presenting to the hospital as consented to receive CHART services, and have found that completing additional paperwork at the hospital during an acute episode is overwhelming. Upon entering in to the CHART program, staff prepare an information sharing consent form to facilitate collaboration with other relevant providers.

***Question:*** **For 30-day programs, how do teams close transitional follow-up?**
***Answers:***

- Set the expectation that the CHART program is a short-term program. This can help facilitate the hand-off process (BIDH-Plymouth).
- Use a care plan that includes details on patient goals and contact information at program close to document where the patient is at that time. This enables staff to re-open a case with ease, as needed. (Winchester Hospital).
- Partner with a community behavioral health organization where a peer can follow patients indefinitely (BIDH-Milton).
- Engage in minimal follow-up (e.g., a phone call twice a week) if it is difficult to transition patient after 30 days (Milford Regional Medical Center).

***Question:*** **How are teams developing ED care plans?**
***Answers:***

- Action plans are physically stored in a binder in the ED. If ED physicians do not have time to read them, the action plans are read aloud (Addison Gilbert and Beverly Hospitals).
- CHART staff is visible in the ED. ED care plans are written as complex care notes in Meditech. The CHART team prints the plan and shares with the physician when a patient presents (Winchester Hospital).

- The SBAR format (situation, background, assessment, recommendation) is used by CHART staff. Next steps include integrating the plans into the ED EHR so they can be available to ED staff (Milford Regional Medical Center).

***Question:*** **How do teams provide back-up when CHART staff are on leave or extended vacations?**
***Answers:***

- In care coordination system (Loopback), tasks are assigned to other team members (Winchester Hospital).
- Dr. Boutwell reminded us that when running a large program at scale, teams may feel that staff turnover or resource gaps are an issue. However, the data may show that teams are actually achieving their aims in the long run. Bottom line – don't be discouraged!

## Panel 2: ED or Inpatient High Utilizer Programs

*Hallmark Health System, Lahey-Lowell Joint Award, Lowell General Hospital, Milford Regional Medical Center*

### Key Takeaways

- Strategies for contacting patients include calling from the hospital landline, calling from a cell phone, and texting (tips shared by Lowell General Hospital).

- Changing the team workflow so that CHART team members start the day in the community can help ensure that outreach and home visits are prioritized and occurring. Daily huddles are held in the middle of the day (identified as an operational success by Milford Regional Medical Center).

- Setting up an on-call structure during weekend hours—with a schedule that is rotated among pairs of CHWs and clinicians—allows for program and care continuity 24/7. Patients do not necessarily have 9:00am-5:00pm needs and can now call over the weekend. This has also proven helpful in completing timely follow-up calls (identified as an operational success by Hallmark Health System).

- Engaging patients face-to-face in the ED can lead to improved patient engagement and outcomes (identified as a lesson learned by the Lahey-Lowell Joint Award team).

### Q&A

***Question:*** **How are teams addressing the needs of long-term care patients?**
***Answers:***

- Recommendations included: ensuring a health care proxy is in place, completing MOLST forms, identifying the appropriateness of palliative care, engaging family members in treatment plans, and following up within 48 hours with facilities post-transfer.
- Including long-term care facilities in care planning meetings may also improve provider collaboration.

***Question:*** **How are teams collaborating with EDs?**

***Answers:***

- For teams working with inpatients, the ED is "the last great frontier" to respond to patients and connect them back to appropriate support and services in the community (Dr. Boutwell).
- Letting ED providers know that the CHART team can do a home visit first thing in the morning—in case there is a concern of sending someone home by themselves without care—can help reassure providers while providing appropriate support to patients (Addison Gilbert and Beverly Hospitals).
- Creating visual cues in ED trackers to notify ED providers about CHART enrollment and/or prior visits can facilitate coordination between teams (Southcoast Hospitals Group).

## Panel 3: ED and Inpatient High Utilizer Programs

*Anna Jaques Hospital, Baystate Franklin Medical Center, Baystate Noble Hospital, UMass Marlborough Hospital, Southcoast Hospitals Group*

### Key Takeaways

- Collaborating with a community pharmacy liaison who delivers medications to patients at home has prevented ED revisits related to prescription issues (strategy shared by UMass Marlborough Hospital).

- Having an "Air Traffic Controller" is key to team operations as that person alerts the team of presenting patients, prioritizes patients for follow-up, and keeps tasks updated in the Medecision system (identified as an operational success by Baystate Noble Hospital).

- Including patients in care plan development and supporting their desires for their path to recovery can improve engagement and promote successful results (as shared in a patient story by Anna Jaques Hospital).

- Thinking about *person*-centered care instead of *patient*-centered can help identify key drivers and stressors and facilitate trust-building (strategy shared by Baystate Franklin Medical Center).

- Assisting patients with a variety of paperwork—applying for food stamps, identifying housing options, obtaining a driver's license—can make significant big impact in meeting patients "where they are" (tip shared by Southcoast Hospitals Group).

### Q&A

***Question:*** **What are strategies for providing reliable transportation to patients?**

***Answers:***

- Suggestions included: contracting with a local taxi company, using taxi vouchers while awaiting a longer-term arrangement (e.g., initiating a PT-1 request), pre-purchasing bus or train passes if applicable, contracting with a local ambulance company (particularly for transportation to detox facilities), and arranging transport through a contracted partner agency.

## Panel 4: ED Behavioral Health Programs

*Harrington Memorial Hospital, HealthAlliance Hospital, Heywood-Athol Joint Award, Holyoke Medical Center, Mercy Medical Center, BIDH-Milton*

### Key Takeaways

- Introducing yourself in a humanistic manner ("How are you doing? How can I help?") instead of adopting a salesperson-style can go a long way in engaging patients (tip shared by Harrington Memorial Hospital).

- Implementing color-coded icons in the electronic health record to indicate the status of CHART patients (e.g., traffic light system to identify new or screened patients) helps staff prioritize and informs ED staff when to contact the CHART team (strategy shared by HealthAlliance Hospital).

- Reaching out to patients with a friendly follow-up call is critical to meeting patient needs, even if patients may have indicated they are "all set" and can manage on their own (as shared in a patient story by the Heywood-Athol Joint Award).

- Initiating paperwork or processes for long-term goals (e.g., housing applications) as early as possible can ensure that patient needs are met within the program period (strategy shared by Mercy Medical Center).

- Restructuring the CHART program from a medical clinic model to a social support one that serves as an extension to an ED visit has been key to team successes (identified as an operational success by Holyoke Medical Center).

- "The success of this grant is that it has humanized this patient population" (insight shared by BIDH-Milton).

### Q&A

***Question:*** **What are strategies for follow-up with patients who may be difficult to reach?**

***Answers:***

- Strategies included: confirming patient (and family) contact information during the intake process, texting patients, driving around popular public places at lunchtime, and coordinating with other hospital teams as ways to reconnect with patients.

***Question:*** **How do other ED-based programs facilitate warm hand-offs when CHART staff are not present?**

***Answers:***

- Developing a good rapport with existing ED staff improves warm hand-offs (Emerson Hospital)
- Existing ED staff and crisis team are equipped to support overnight CHART patients (Heywood-Athol Joint Award).
- ED nurses complete a transitional discharge form which CHART CHWs use the next morning to follow-up with any "missed" patients (Mercy Medical Center).

## Closing Remarks

Dr. Boutwell commended CHART teams for leading the charge on what collaboration and longitudinal care can look like. Many teams are demonstrating measureable results at Year 1. Executive Director Seltz ended by reflecting on where CHART teams were one year ago, congratulating all on the lives that have been impacted since then, and continuing the momentum for future accomplishments in CHART Phase 2 Year 2 and in the years to come. A special thank you to our panelists for making this convening a success!

Please refer to Appendix II for a list of questions presented and asked by CHART teams to the audience.

# Appendix I[1]

## Panel 1: Readmissions Reduction Programs

| Hospital | Target Population | Primary Aim | Team |
|---|---|---|---|
| **Addison Gilbert & Beverly Hospitals** | Patients identified by one or more of the following:<br>• High utilization (≥ 4 hospitalizations per year)<br>• Social complexity (substance use disorder, Medicaid, homeless, or Medicare <65)<br>• 30-day readmissions to inpatient or observation | Reduce 30-day returns by 20% | **Addison Gilbert Team:** 1 LICSW, 1 NP, 1 Pharmacist, Pharmacy Technician<br><br>**Beverly Team:** 2 LICSW, 2 NP, 2 Pharmacists, 2 Pharmacy Technicians<br><br>**Administrative:** Program Manager, System Analyst, 2 Physician Advisors |
| **Berkshire Medical Center** | All inpatient and observation discharges of Northern Berkshire County residents. | Reduce 30-day returns by 20% | **Hospital-based:** 2 RNs, 1 BH SW<br><br>**Community-based:** 1 CHW, 0.75 Psychiatrist, 0.8 BH NP, 0.5 Medical NP, 0.5 HF NP, 2 SW Care Navigators, 0.4 Diabetes Educator, 0.5 Nutritionist, 0.4 Nicotine Treatment, 1 LICSW, 0.6 SUD Counselor,<br><br>**Administrative:** 1 Office Coordinator, 0.6 Program Manager, 1 Analyst |
| **Baystate Wing Hospital** | Patients with a life-limiting condition and/or a behavioral health diagnosis | Reduce 30-day readmissions by 20% | **Patient-facing:** 1 RN Care Manager<br>0.8 Palliative Care RN, 1 LICSW<br>0.05 Physician Consultant<br>0.05 Psych AP Consultant<br><br>**Administrative:** 0.25 Program Manager |
| **BIDH-Plymouth** | All patients with dual eligibility and/or all ED patients with a primary behavioral health diagnosis | Reduce readmissions by 10% for patients with dual eligibility | **Patient-facing:** 1 RN Case Manager, 1 SW Case Manager, 1 Nurse Practitioner, 1 Resource Specialist,<br><br>**Administrative**: 1 Project Manager, 1 Financial Analyst<br>.20 Clinical Investment Director |
| **Emerson Hospital** | All medical, surgical, and behavioral health patients at a high risk of readmission | Reduce 30-day returns by 20% | **Patient-facing:** 1 Pharmacist, 2 SW, 1 Pt Navigator<br><br>**Administrative:** 1 Program Manager, 1 Admin Coordinator |
| **Lawrence General Hospital** | Patients identified by one or more of the following:<br>• Medium or high biopsychosocial risk<br>• A personal history of 30-day readmissions | Reduce 30-day readmissions by 20% | **Patient-facing:** 1 RN, 2 SW, 1 Resource Specialist, 1.5 Coaches<br><br>**Administrative:** Director Integrated Care, Quality Systems Programmer /Analyst |

[1] Information presented in Appendix I represents non-exhaustive Phase 2 Contract and Phase 2 hospital-reported descriptions of program components.

| Hospital | Target Population | Primary Aim | Team |
|---|---|---|---|
| **Signature Healthcare Brockton Hospital** | All admissions | Reduce 30-day readmissions by 20% | **Patient-facing:** 3 RN Care Managers, 1 CHW, 1 LICSW, 1 Palliative Care RN, 1 NP 2 Pharmacists, 1 Pharmacy Tech<br><br>**Administrative:** Program Coordinator; 4 Team Leaders |
| **Winchester Hospital** | • All patients with high utilization (≥ 4 inpatient hospitalizations in the last 12 months)<br>• All discharges to post-acute care (SNF and home health) | Reduce 30-day readmissions by 20% for patients with high utilization | **Patient-facing:** 0.8 NP, 4.2 RN, 0.8 Social Worker, 0.6 PharmD<br><br>**Administrative:** 0.4 Program Manager, 0.2 Analyst, Quality Associate |

## Panel 2: ED or Inpatient High Utilizer Programs

| Hospital | Target Population | Primary Aim | Team |
|---|---|---|---|
| **Hallmark Health System** | Patients with ≥10 ED visits in the last 12 months | Reduce ED utilization by 20% | **Patient-facing:** 3 Collaborative Care Coaches, 1 NP, 1 Social Work Supervisor, 1 p/t Pharmacist, 2 p/t PCPs<br><br>**Administrative:** 1 Executive Director, 1 part time administrative assistant |
| **Lahey-Lowell Joint Award** | Patients with a personal history of moderate or high utilization of the ED | Reduce 30-day ED revisits by 20% | **Patient-facing:**<br>• Addison Gilbert: 2 CHW, 1 SW<br>• Beverly: 3 CHW, 1 SW<br>• Winchester: 2 CHW, 1 SW<br>• Lowell: 1 NP, 4 SW, 6 CHW, 1 RN<br>• 1 Admin<br><br>**Administrative:** 1.5 Program Manager, .2 FTE Medical Director |
| **Lowell General Hospital** | Patients with a personal history of high utilization of the hospital (≥ 4 inpatient discharges in the last 12 months) | Reduce 30-day readmissions by 20% | **Patient-facing:** 3 SW, 3 CHW, 1.2 Palliative Care, 0.2 Pharmacist<br><br>**Clinical oversight:** 0.2 MD, .75 RN<br><br>**Administrative:** 1 PM/Analyst, 0.5 Admin |
| **Milford Regional Medical Center** | Patients with ≥3 hospitalizations in the last 12 months | Reduce 30-day readmissions by 25% | **Patient-facing:** 1 Palliative Care PA, 1 RNCM, 1 Pharmacist, 1 SW<br><br>**Administrative:** Hospitalist, ED Physician, Intensivist, CNO, CM Coordinator, Informatics, Directors CM/SW and Quality |

## Panel 3: ED and Inpatient High Utilizer Programs

| Hospital | Target Population | Primary Aim | Team |
|---|---|---|---|
| **Anna Jaques Hospital** | Patients with high utilization (≥4 inpatient admissions or ≥6 ED visits in the last 12 months) | Reduce 30-day readmissions by 20% | **Patient-facing:** 1.25 ED Case Managers (RN), 0.4 Pharmacist, 1 ESMV Coach<br><br>**Administrative:** 0.5 Program Manager 0.4 Administrative Assistant, 0.4 IT Analyst<br><br>**In-Kind:** CEO, CMO, CQO, Director of Case Management, Financial Analyst |
| **Baystate Franklin Medical Center** | Patients with a personal history of high utilization (≥ 4 hospital discharges or ≥ 5 behavioral health ED visits in the last 12 months) | Reduce 30-day ED revisits by 25% | **Patient-facing:** 1 NP, 0.5 LICSW, 1 LMHC, 3 CHW, 0.5 Peer Specialist<br><br>**Administrative:** Finance Director, 0.5 Program Manager, Analyst |
| **Baystate Noble Hospital** | Patients with a personal history of high utilization of the ED and hospital | Reduce 30-day readmissions by 25% | **Patient-facing:** 1 RN Manager, 2 RN, 2 SW<br><br>**Administrative:** 1 PM /Analyst |
| **UMass Marlborough Hospital** | Patients with a personal history of high utilization of the hospital or ED (≥ 4 discharges or ≥ 10 ED visits and/or ≥ 5 BH ED visits in the last 12 months) | Reduce 30-day readmissions by 15% | **Patient-facing:** 0.5 ED CM, 0.8 Coach, 0.6 SW, 0.4 MHC, 0.2 Pharmacist<br><br>**Administrative:** 0.4 Program Manager, 0.5 Analyst/PM |
| **Southcoast Hospitals Group** | Patients with a personal history of high utilization of the hospital or ED (≥ 4 inpatient discharges or ≥ 10 ED visits in the last 12 months) | Reduce 30-day readmissions by 20% | 4 teams<br>**Patient-facing:** 1 APRN, 6 RNs, 14 CHWs, 3 SWs, 1 Case Manager, 1-RPh<br><br>**Administrative:** 1 Director, 1 Analyst, 1 Project Manager, Medical Directors |

## Panel 4: ED Behavioral Health Programs

| Hospital | Target Population | Primary Aim | Team |
|---|---|---|---|
| **Harrington Memorial Hospital** | Patients with a primary or secondary behavioral health diagnosis in the ED setting | Reduce 30-day ED revisits by 15% | **Patient-facing:** 1 RN, 3 SW, 5 Navigators<br><br>**Administrative:** 1 Program Director, Analyst |
| **HealthAlliance Hospital** | ED patients with a primary and/or secondary behavioral health diagnosis | Reduce 30-day ED revisits by 15% | **Patient-facing:** 1 Lead Navigator/SW, 3.4 Navigators, 1.75 Care Managers, 1 Intake Coordinator, 4.7 CHWs<br><br>**Administrative:** 2.4 Program Managers, .2 Analyst, 1 Program Specialist |
| **Heywood-Athol Joint Award** | ED patients with a behavioral health diagnosis | Reduce 30-day ED revisits by 10% | **Patient-facing:**<br>• Athol: 1 SW, 1 CHW<br>• Heywood: 2 SW, 1 CHW<br><br>**Administrative:** 2 Program Managers, Analyst |

| Hospital | Target Population | Primary Aim | Team |
|---|---|---|---|
| **Holyoke Medical Center** | Patients with a primary or secondary behavioral health diagnosis in the ED setting | Reduce 30-day ED revisits by 25% | **Patient-facing:** 5 Patient Navigators, 3 RNs, 3 Community Mental Health Workers, .5 MD, .75 APRN, 1 Med Assistant<br><br>**Administrative:** Project Manager, IT, CNO |
| **Mercy Medical Center** | ED patients with a primary BH diagnosis | Reduce 30-day ED revisits by 20% | **Patient-facing:** 5 CHWs, 4.2 BH-trained RNs<br><br>**Administrative:** Project Manager, Complex Care Coordinator, Supervision for CHWs |
| **BIDH-Milton** | All patients in the ED with a primary behavioral health complaint | Reduce excess ED boarding by 40% for long stay behavioral health patients | **Patient-facing:** 1 SW, .5 Navigator, .2 Peer, .2 Music Therapist, 1 Therapist, .2 Pharmacist, .1 Chaplain, 1 Director of Care Integration, Security (24 hours)<br><br>**Administrative:** .2 RN/MD ED Champion, 1 Program Manager, 1 Data/IT Analyst |

# Appendix II

Dr. Boutwell compiled the questions raised by CHART hospital teams into five main themes:

## Engaging & Persisting

- What are successful engagement strategies?
- How are other teams "consenting" patients?
- What to do when a competent patient is making poor life choices and you have exhausted all options?
- How long do we work with persistent high-utilizers without improvement?

## Clinical Care

- How have other teams used a community-based nurse?
- How do other teams leverage NP skills?
- How do other teams close transitional follow up?
- What are effective strategies for the highest utilizers?
- How do you effectively mobilize or intensify supports to reduce ED use?

## Program Operations

- How to teams achieve high rates of 48 hour contact?
    - How do you complete 48 hour contact when unable to reach patient?
- How do teams provide back-up when staff are out for extended periods of time (vacations, leave)?
- Does anyone have CHART weekend, holiday, off-shift coverage? Benefit vs. cost analysis?
- Who are the other very large high volume programs?
    - How do other teams deal with unexpected high volume?

## Working with Partners

- How is your CHART team influencing or impacting the readmission rate for nursing home patients?
- How do other teams work with the ED?
- How should EDs be included in the continuum of care for complex co-morbid patients?
- How to start developing ED care plans?

## Mobilizing Resources

- How have other teams accessed housing?
- How have other teams accessed detox and behavioral health services?
- How are teams addressing transportation needs?
- Are there creative pathways to sustainability?
- How to communicate value of program: decreased visits with increased cost?