MASSACHUSETTS
HEALTH POLICY COMMISSION

CHART PHASE 2: JUNE 2017 REGIONAL MEETINGS
JUNE 28 AND 29, 2017

PURPOSE

The June CHART Phase 2 regional meetings, facilitated by Dr. Amy Boutwell, focused on strengthening and accelerating work related to Phase 2 strategic planning. Attendees discussed the capabilities and skills CHART teams have developed over time as well as the value that CHART programs create for patients and providers. Dr. Boutwell reiterated that the purpose of the CHART program is accountable care readiness: preparing community hospitals and their partners to achieve high-quality and low-cost care within a value-based payment environment. Throughout strategic planning and beyond, CHART teams should strive to articulate the skills, capabilities, and infrastructure they have developed for effectively identifying, engaging, and serving patients with complex needs.

The HPC would like to thank all attendees for contributing to the discussion to make this an interactive and engaging shared learning opportunity, as well as Phase 2 awardees for submitting insightful strategic planning proposals. We look forward to continuing to work with you throughout the strategic planning process.

As a reminder, materials from previous meetings, including the March strategic planning meeting summary and presentation, can be found on the CHART Hospital Resource Page.

KEY TAKEAWAYS

CHART Phase 2 **capabilities** highlighted by attendees include:

- Delivering whole-person care by identifying and addressing social needs in addition to medical needs.
- Building, deploying, and sustaining multi-disciplinary teams to address those needs.
- Casting a wider net: engaging and serving more patients in order to impact population health outcomes.
- Developing the right soft skills for forming trusting relationships with patients and providers.
- Measuring patient and programmatic progress in continuous improvement cycles.

CHART Phase 2 program examples of **added value** tie into the quadruple aim of improved population health, increased patient and provider satisfaction, and reduced per-capita spending, including:

- **Improved protocols for service quality and patient safety**: e.g., identifying and addressing gaps in traditional care models for vulnerable patient populations.
- **Improved communication among providers:** e.g., understanding patient needs, communicating information between outpatient and inpatient services in a continuous and streamlined manner, collaborating with community providers on mutual patients.

- **Improved data utilization for decision-making:** e.g., CHART programs serving as a model for improving and sustaining workflows, protocols, and services within and outside of the hospital setting.

As teams begin to compile and synthesize this information into materials for strategic planning purposes, they may wish to consider sharing the "story" of CHART services to include:

- Select patient stories and experiences that capture a range of patient population needs
- Visual representation of service utilization and/or length of time between admissions, at the program and/or patient levels
- Annotation of timeline with CHART services delivered and/or with significant changes in CHART program

STRATEGIC PLANNING: FACILITATED DISCUSSION

1. What are key questions to ask in the remaining 8 to 20 weeks of the CHART program?

Supporting staff

- *Charline Cauley and Carolyn Meuse, Mercy Medical Center:* How can the program retain its behavioral health RNs? What will staffing and community support look like during the gap between CHART Phase 2 and Medicaid ACO ramp up? How to continue patient outreach?
- *Selena Johnson, Heywood-Athol Joint:* How can the program continue funding CHWs in the ED? Current salaries in the CHART program are higher than the hospital's standard, making the transition to the hospital budget more difficult. What are ways to justify higher paid roles?
- *Emerson Hospital:* How important is it for CHART *teams* to continue after the grant program concludes? Should the focus be instead on advocating for certain roles/FTEs?
- *Winchester Hospital:* What are tactics to keep staff engaged in continuing the work after the grant period ends?

Calculating ROI

- *Sandi Akers, Addison Gilbert and Beverly Hospitals:* How does one calculate the ROI? What timeframe(s) should be considered if the payment benefit is a few years down the road?
- *Marian Girouard-Spino, BID-Milton:* The Milton CHART program does not bill for services; CHART services are instead added into a hospital service fee. How can the program translate the value of the savings that the team provides if the current model only looks at billable fees?

Interpreting data

- *Carol Plotkin, Hallmark Health System:* Are CHART patients receiving duplicate services? If so, what are tactics to make CHART services more efficient?
- *Bob Pacl, Emerson Hospital:* CHART services improve care quality and patient experience. What are ways to demonstrate this to leadership?

2. What capabilities have you developed? What capabilities do you want your organization to understand about CHART Phase 2?

Building multi-disciplinary teams and partnerships

- *Annette Szpila, Baystate Franklin Medical Center:*
    - Developing a new role (CHW) that intersects between the hospital and community. Bringing different roles together to work collaboratively: NP, LICSW, mental health practitioner, peer.
- *La Shanda Anderson-Love, HealthAlliance Hospital:*
    - Having the right soft skills and flexibility to work with patients and providers in order to continually share information.
    - Managing client, staff, and partner performance for optimal outcomes.
- *Erin Daley, Mercy Medical Center:* Mercy's behavioral health community partner, Behavioral Health Network, screened applicants for the CHW role based on lived experience and personality fit. They endeavored to find candidates that are the "face of the community," not seeking only mastered-prepared individuals.
- *Marian Girouard-Spino, BID-Milton:* Partnership is a huge capability. Flexibility in information sharing is key.
- *Dr. Boutwell:*
    - **Collaboration and "soft skills" at the core of these capabilities.** It's natural that CHART programs may have started off as siloed—with a new budget and new staff—yet through **collaboration and relationship building, programs have evolved to become more integrated** into standard hospital operations.
    - **Holding partners accountable** and knowing when to disband partnerships that don't work is also important.
    - **Even within an ACO, there's likely to be a cross-continuum set of actors, including ones who are hospital-based,** which is why this work is designed for ACO readiness.
- *Kathleen Beyerman, Winchester Hospital:* Change is always difficult, and the CHART program involves continual change through rapid improvement cycles. How have teams managed staff expectations, engagement, and motivation given the constant push for change?
    - *Lindsay Marino, Lowell:* During the hiring process, it was made clear that the CHART program is a change initiative with many gray areas and ambiguity. Managers check in with staff regularly to address any ongoing gray areas; staff members feel supported throughout this process.
- *Jean Coney, Lowell General Hospital:* The ability to form a multi-disciplinary team: CHW, psych NP, pharmacist, peer recovery coach. It takes time for a multi-disciplinary team to form and mature.
- *Dr. Mitchell, Lowell General Hospital:* At the beginning of the program, the hiring and training process took some time, and team members were not working at the top of their license. Roles expanded over time (e.g., CHWs learned from social workers about assisting with patient transport).

- *Dr. Boutwell:* **This is a sell point: it took time and effort to create a team that is now operational and works effectively. Disbanding the team and re-assembling it later will require additional time and financial investment to get it back to the same level.** Efficiency is gained as roles develop and mature. The CHART program has not only created multi-disciplinary teams, but it has developed, managed, and sustained them. How can this momentum be maintained?
- *Marian Girouard-Spino, BID-Milton:* The Milton team facilitates cross-agency care planning and addresses legal questions.

Changing the treatment culture

- *Charline Cauley, Mercy Medical Center*: Treating the whole person and casting a wider net to serve a broader population—both are critical for moving from pilot programs to population health management.
- *Carol Plotkin, Hallmark Health System:* Identifying and addressing social factors and drivers of utilization.
- *Carolyn Meuse, Mercy Medical Center:* Transforming the way staff view and treat vulnerable patients.
- *Padma Bheri, Marlborough Hospital:* The Marlborough CHART program is inspiring programs and change throughout the hospital; e.g., revising protocols and services around palliative care and chronic pain management.
- *Annette Szpila, Baystate Franklin Medical Center*: Finding patients "where they are," understanding root causes of utilization and patient needs, helping patients navigate the healthcare system, and gaining their trust.

Using data

- *Bob Pacl, Emerson Hospital:* The Emerson CHART team uses patient stories to illustrate drivers of utilization and hopes to conduct further analysis on, for example, whether accessing mental health resources improves patient outcomes.
    - *Marian Girouard-Spino, BID-Milton:* The Milton CHART team dedicated time to describe the CHART patient population to leadership. The team compiled demographic information (e.g., insurance type, zip code, presence/absence of PCP) and included patient stories to illustrate the range of needs of CHART patients.
    - *Emerson Hospital:* The team shared a graph of a patient's progress over 24 months and how the length of time between admissions increased. This visual representation included programmatic information such as when ED care plans were put into place, etc.
- *Dr. Boutwell:* Teams could start by **compiling a spreadsheet to categorize patient needs and stories.** The goal is to capture the range and multiplicity of patient population needs. **Consider combining these stories with a visual representation of utilization and/or length of time between admissions, and annotating CHART services delivered.**

3. What intervention works for which patients?

Dr. Boutwell: Everyone in this room serves a target population that may feel is bigger than expected. The strategic planning process should involve looking at progress made by target population subgroups.

There are likely subgroups within the target population whose needs teams are able to address particularly well. What are results teams have found when doing this analysis?

Patients with substance use disorder

- *Charline Cauley, Mercy Medical Center:* For patients with substance use disorder (SUD), connecting them with the appropriate referrals to social services and other community benefits has made an impact.
- *Yajaira Ramos, Mercy Medical Center:* Also important is connecting patients with SUD to longer term recovery resources to help them get off the streets.
- *Deborah Nichols, Baystate Wing Hospital:* CHART services bridge mental health and SUD needs for patients with behavioral health co-morbidities.

Patients with existing services and connections

- *Maria Waterhouse, Harrington Memorial Hospital:* Patients who already have long-term services in place are usually more stable than those who are not connected with outpatient providers or community supports.
- *Selena Johnson, Heywood-Athol Joint:* Patients may be connected to services but not actually receive what they need. The program provides the opportunity for face-to-face conversations with other providers in determining how the CHART team can help support the patient to back up their plan and/or a shared plan of care.
- *Sara Taylor, Holyoke Medical Center:* The Holyoke CHART program sees many patients who are highly connected to services and continue to come back. The focus is on navigating services and bridging providers, through a multi-disciplinary approach with patient navigators (CHWs), nurse practitioners, and social workers—there is less of an emphasis on medical doctors.
    - *Dr. Boutwell:* It is easy to assume a patient with high utilization may be unconnected, but **there are some with persistent acute care utilization who are very connected to community supports, and yet continue to come to the ED. What are their needs?**
- *Annette Szpila, Baystate Franklin Medical Center*: For patients who are homeless, team members are trained on federal and state housing options and eligibility criteria, including housing applications and disability accommodations.
- *Dr. Boutwell:* Remember that if a program is designed such that patients can opt into the program, those who do accept may be fundamentally different from patients who refuse services. What distinguishes these patients?

4. What is the value the CHART program creates for your organization? What financial and/or organizational priorities—such as safety, quality, and patient experience—does the program advance?

Improved protocols for service quality and patient safety

- *Selena Johnson, Heywood-Athol Joint:* The program improved process flows within the organization, due to the discussions the team initiated. For example, improving safety protocols for all care transitions is a significant value-add of the CHART program.

- *Deborah Nichols, Baystate Wing Hospital:* The 48-hour follow-up calls promote patient safety, as does medication reconciliation for all CHART patients.
- *La Shanda Anderson-Love, HealthAlliance Hospital:* The HealthAlliance CHART team provides continuity of information between outpatient and inpatient services; team members communicate critical patient information to inpatient case managers.
- *Charline Cauley, Mercy Medical Center:* The Mercy CHART team has identified gaps in traditional care models. The team has also become more proactive in identifying patients earlier on before they become high utilizers of services by using a registry to flag and track patients.

Improved communication among providers

- *Annette Szpila, Baystate Franklin Medical Center*: There is respect for the CHART program and what the team does, both by patients and providers. The program now has buy-in from hospital staff—non-CHART staff proactively reach out to discuss CHART patients.
- *Andrea Nathanson, Baystate Franklin Medical Center:* The Baystate Franklin CHART team is analyzing where it is most effective; for example, the team is working with local PCPs on risk-based contracts connecting with PCP care managers. The team identifies common patients between high-risk patient lists and further discusses the value-add of CHART services.
- *Erin Daley, Mercy Medical Center:* Mercy Medical Center is implementing PreManage ED. It is a functionality being rolled out and paid for by a Massachusetts Health & Hospital Association (MHA) grant. All hospitals using PreManage ED can see when patients access an ED to better understand where patients are seeking services. The information can be pushed to a hospital's EHR. The goal is for as many providers as possible to be a part of this network in order to better understand service utilization and to improve patient outcomes by communicating safety alerts and care plans.
    - *Dr. Boutwell:* This type of functionality that promotes information sharing and transparency is transforming care in Maryland.

Improved data utilization for decision-making

- *Dr. Boutwell:* Regarding financial sustainability, most readmission work does not yet make direct sense financially, especially in a fee-for-service context. **CHART is about the investment in the capabilities needed for the long-term, where there may be bigger readmission penalties in the future and/or more risk-based contracting.** Investing in staff is critical, although turnover in healthcare is also real; **how can the momentum CHART teams have built be maintained?**
- *Mary Krause, Emerson Hospital:* As a readmission reduction program, the Emerson CHART team examines and tracks HCAHPS outcomes.
- *Sandi Akers, Addison Gilbert and Beverly Hospitals:* The Addison Gilbert and Beverly CHART program reviewed CMS 30-day readmission penalties. Is it possible to attribute any decrease in penalties to the CHART program?
    - *Dr. Boutwell:* **Remember that readmission penalties use data that lag three years; CMS is looking at 40 months ago.** The penalty program is also growing over time, with new diagnoses every year, and CMS is planning to transition to all diagnoses. **Consider**

capturing how the CHART program will affect the magnitude of penalties over time; in today's dollars, what does a 5-year readmission penalty forecast look like?
    - *Dr. Boutwell:* **Regarding expenses, do not use the CHART grant budget as representative of program costs.** At peak efficiency, a program costing $200,000 - $500,000 could be sufficient to avoid penalties.
- *Dr. Mitchell, Lowell General Hospital:* As a high utilizer program, the Lowell CHART team uses a pre/post historical analysis for our cost savings calculations. The team calculated the difference between program and historical trends, and multiplied it by the average cost of an inpatient visit at our hospital. While decreased utilization means less hospital revenue in a fee-for-service payment model, it also frees up the Emergency Department (ED). Improving ED throughput is important for quality outcomes as well as for staff and patient satisfaction.
    - *Marian Girouard-Spino, BID-Milton:* Improving ED throughput also results in less community pressure to unnecessarily expand the ED.

5. How are lessons learned from your CHART program informing your (MassHealth) Medicaid ACO plans?

- *Carol Plotkin, Hallmark Health System:* The Hallmark CHART program has been involved in the design of the ACO model. The ACO planning team is thrilled that CHART staff have ideas and experience managing patients with complex needs.
- *Dr. Mitchell, Lowell General Hospital:* Capturing accurate homelessness data is a challenge, and it is an input that could be important to ACO model development.
- *Robin Hynds, Lawrence General Hospital:* Successful components of the CHART program may transition into the Medicaid ACO model, but what about the work done with CHART patients with other payers? How can successful CHART services be sustained for Medicare and commercial patients?
    - *Dr. Boutwell:* This is the reality of the current payer world; one needs to focus on certain patients based on payer. However; if, for example, combining the Medicaid ACO and Medicare patients means that a provider is at 75% of the model, operationally it makes more sense to deliver the same services and care model to all patients.
    - *Carol Plotkin, Hallmark Health System:* "Have we taken a step backward by being payer-specific in a paradigm like this?"

6. What are some unaddressed issues you'd like to resolve?

Supporting staff

- *Lindsay Marino, Lowell General Hospital:* Program staff are increasingly nervous about the future of their employment.
- *Sandi Akers, Addison Gilbert and Beverly Hospitals:* On that note, there's uncertainty among staff about when the program actually ends. What is the potential impact of a no cost extension to the end date? Will the hospital continue the program?

- *Annette Roberts, Milford Regional Medical Center:* Potential burnout among the few CHART staff who are working with many patients.
- *Lisa Brown, Lowell General Hospital:* Encouraging staff to design a role that they want to have and continue in order to avoid burnout and keep the cohesion and momentum of the multi-disciplinary team model.
- *Marian Girouard-Spino, BID-Milton:* Once a self-functioning team is established, losing colleagues that are like-minded individuals is a professional loss.