HEALTH POLICY COMMISSION
CHART PHASE 2
APRIL 2016 REGIONAL MEETINGS – APRIL 25 AND 29, 2016

Purpose

April's regional meetings, facilitated by Dr. Amy Boutwell, placed an emphasis on identifying and addressing social needs through the involvement of community health workers, social workers, and navigators in patient care. The HPC would like to thank Jaclyn Arnold, Nicole Betty, Joellen Falk, Beth Lucey, Deborah Jean Parsons, Denise Quartulli, and Colleen Tata from the Northeast/Southeast Regional Meeting and Mike Ellis, Nicole Guertin, Richard Nevalsky, Brenda O'Connor, and Tamara Perini from the Central/Western Regional Meeting for sharing their perspectives and experiences. Panelists discussed a typical "day in the life," challenges, and successes and shared inspiring patient stories. 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 Dr. Boutwell's presentation and the panelist discussions. A PowerPoint document with Dr. Boutwell and Deborah Jean Parsons' presentations ("Story of success: Signature Healthcare Brockton Hospital") is attached to the same email as this document.

Agenda

1. Observations 25% of the way through CHART Phase 2
2. What "this work" is: Identifying and addressing social needs
3. Story of success: Signature Healthcare Brockton Hospital

Objectives

1. Consider where teams are in the evolution of CHART Phase 2
2. Describe what community health workers, social workers, and navigators do that helps reduce avoidable hospital utilization
3. Understand how to be more person-centered and to avoid over-medicalization of repeated hospital utilization

1. Observations 25% of the way through CHART Phase 2

- Dr. Boutwell noted that within the first six months of Phase 2, many hospital programs are seeing promising indications that when CHART staff connect with patients, patient engagement in the program and treatment often follows.
- CHART teams began with the early work of **engaging**, and **serving** target population patients; they are now moving on to **understanding** how to more effectively serve patients, **using data** to improve operations, and **prioritizing** those efforts that best achieve results.
- Fundamentally, CHART teams can improve performance in three ways, of which the first two are usually higher leverage:
    - Increasing the proportion of target population patients who are served;
    - Improving the services (quality, intensity, targeting, speed, etc.) to served patients to drive down reutilization even further among these patients, beyond the stated aim; and
    - Improving usual care for all patients, including those unserved.
- Hospital teams can and should use their data dashboards to derive insight on the success of a given program, drive advancement, and "turn the dial" on any element of the program (e.g., services provided, role types) for continuous improvement.
- High performance relies on front-line staff to drive results; therefore, data and dashboards should be shared with all relevant role types to further identify areas for improvement and improve program transparency.
- Stacked bar charts or pie charts displaying volume and/or proportion of service modality, type, and provider can shed light on the tradeoffs in a given workflow (e.g., hiring more professional-level staff could mean deploying fewer CHWs to the community).

2. What "this work" is: Identifying and addressing social needs (panelist discussion)

Northeast / Southeast Regional Meeting

Beverly Hospital – Jaclyn Arnold and Joellen Falk

Team dynamics and workflow

- The Beverly Hospital CHART team engages in daily huddles to discuss patient cases, especially those with the highest need, to prioritize and balance contact with patients.
- The team prioritized fostering relationships with services in the community (e.g., behavioral health services, homeless shelters, detoxification facilities, nursing homes) to engage patients within 48 hours to the greatest extent possible.
- Meeting patients where they are, both literally and figuratively, is the most effective way to engage. Beverly Hospital social workers and community health workers often meet with patients in the community (e.g., Dunkin Donuts) rather than requiring them to make an office visit. Additionally, instead of attempting to immediately address medical issues, the team asks patients what they feel they need. Meeting these basic needs opens the door to addressing clinical issues.

Success stories

- A female patient with a complex medical history including substance use disorder and borderline personality disorder frequented the ED up to four times per month. Upon an initial visit with the patient, the team realized that she did not need the acute level of care and services that were initially anticipated; rather, she required assistance with paperwork and regular home check-ins. Since engagement with the program, she has visited the ED just once.
- A female patient with long-term alcohol abuse consistently declined services offered to her and therefore required a tremendous amount of support from her family. The CHART team attempted to visit her in her home numerous times, and with perseverance, was ultimately allowed in. Her living situation was assessed for the first time, revealing, among many issues, that her medication was not managed appropriately. The team relayed this information to her PCP, provided transportation to enable her to reconnect with primary care, and accompanied her to each PCP visit. She is now connected with a neurologist and an adult day program; as a result, her home and family situation has improved.

Hallmark Health System – Beth Lucey

Team dynamics and workflow

- The Hallmark Health System Collaborative Outreach and Adaptable Care at Hallmark Health (COACHH) team engages in daily huddles with three community health workers to discuss cases, care goals, and to plan patient visits in the community.
- Most of the team's work is performed in the community (e.g., home visits, nursing homes, Dunkin Donuts, park benches). Recognizing that goals of the patient may differ from goals of the care team, the team attempts to meet basic needs, enabling them to proceed in addressing clinical/medical issues.
- The team is very persistent with outreach to target population patients. If patients decline services, staff continue to follow-up with phone calls, text messages, and letters. The team has found success in persistence, noting that patients often engage after follow-up is performed.

Success story

- The team encountered a female patient with bipolar disorder and high utilization of the ED. Upon meeting with her and understanding her social situation, the team learned that she was facing eviction by the local housing authority because of her behavior. Ms. Lucey attended housing authority meetings to advocate for this patient to remain in her current housing. She additionally connected the patient with DMH services. Since being engaged with the Hallmark team, the patient is adhering to her treatment plan and has not visited the ED in several months.

Lowell General Hospital – Nicole Betty and Colleen Tata

Team dynamics and workflow

- Three social workers are teamed with several community health workers within Lowell's Complex Care Team. A social worker rounds at both Lowell General campuses daily and, along with the team, runs a list of newly eligible patients and performs patient visits. Upon every readmission, the Complex Care Team re-introduces themselves, providing constant familiar faces and resources to patients within the target population.
- In both inpatient and outpatient settings, active listening is key to make each patient feel like they are the first priority of any staff that interacts with them.
- "Out of the box" thinking and acting has proved to be very important to engaging target population patients.

Success stories

- A paraplegic male patient called 911 every time that he required repositioning and consistently accepted transport to the ED. Following an ED discharge, the team performed an unannounced home visit. Upon entry in to the patient's home, the team engaged him by saying, "we want to make things easier for you" and "what would work for you to improve this situation?" The team learned that he frequented the ED as a means of socialization and to feel comforted. Realizing this, the team was able to provide him with the connection and social engagement he required by linking him with a personal care assistant and providing him with a lifeline to use rather than calling 911. Prior to entering the program, he had over 20 ED visits per month. Since engaging, he has not visited the ED.
- A male with frequent ED utilization required socialization, nutrition assistance, and diabetes treatment. The Lowell General team connected him with a day program and a food bank that provides delivery services. He also engaged with the VNA, a day program, a personal care assistant, SNAP benefits, and housing services. Since engaging with the CHART team, he elects to visit the CHART office rather than the ED, dramatically reducing his ED visits from approximately 20 per month to fewer than 5 monthly.

Milford Regional Medical Center – Denise Quartulli

Team dynamics and workflow

- The Milford Regional Medical Center CHART team found that engaging and collaborating with community resources is critical to success. This engagement can lead to a wealth of previously untapped resources (e.g., veterans' services).
- Understanding patients' basic social needs is key to improving medical health.

Success story

- A young female with diabetic ketoacidosis (DKA) and borderline personality disorder presented frequently to ED and hospital as a result of her DKA. After discussing her social and medical situation, the team realized that the patient did not understand the severity of her condition and therefore continued to poorly maintain her health. In an effort to improve her natural supports, the team acquired an authorization to involve her family in her care. She ultimately allowed a social worker, palliative care PA, and an RN to perform home visits and connect her with behavioral health services and a PCP. Since engaging with Milford's CHART team, this patient has not visited the ED in several months and both she and her family continue to use the services provided to them.

Central / Western Regional Meeting

Harrington Memorial Hospital – Brenda O'Connor

Team dynamics and workflow

- Harrington Memorial Hospital's PCP navigator program aims to connect patients with needed services and fill extant gaps that traditional clinicians are unable to meet because of time and/or training constraints.
- The Harrington CHART team initially engages with patients by developing relationships built on trust and understanding. Once trust is established, the team can address clinical and non-clinical needs.

Success story

- The Harrington team connected with a female patient with a personal history of alcohol abuse. The patient had lost her home, car, and license, and as a result was living with one of her children. Upon engaging with the patient, Ms. O'Connor simply asked, "Are you ready to stop drinking?" Once she agreed, the team connected her with recovery services, social security, a dentist, and a PCP. The team provides transportation to recovery services to ensure adherence to treatment. The patient is still in recovery today.

HealthAlliance Hospital – Richard Nevalsky and Tamara Perini

Team dynamics and workflow

- HealthAlliance's Health Integrated Collaborative Case Coordination (HIc3) team connects with patients using "non-textbook," open-form conversations to identify basic needs, meet those needs, and move to addressing clinical needs from there. The team makes an effort to always treat patients like humans and interact with them in a non-judgmental manner. The team has found success in this method, noting that building trust with patients is critical to engaging them in care.
- The HIc3 team attempts to initially engage patients in the ED. If they accept services, patients are assigned to a social worker and/or intensive community support. Should they require community support, a thorough intake is performed to identify social and clinical issues and needs. Upon discharge, the team performs follow-up to ensure engagement in treatment.

Success story

- A homeless male patient presented frequently to the ED with alcohol abuse. The HIc3 team found that he had recently ended his marriage, his family, and career. The team worked with the patient for several months; ultimately, he reconnected with his family and has remained sober since engaging with the program.

Heywood/Athol Joint Award – Nicole Guertin

Team dynamics and workflow

- Ms. Guertin's office space is closely located to the ED entrance to ensure target population patient identification in real time upon arrival. This location enables her to both see patients as they arrive to the ED and to hear ambulance call-ins to anticipate target population arrivals. Rather than awaiting a notification or medical clearance from an ED clinician to connect with a patient, she is able to immediately greet patients and remain with them throughout their time in the ED as part of her workflow. She acts as an advocate and familiar face during situations that can often be tense and vulnerable.
- The Heywood/Athol CHART team coordinated with ED staff to assist them in identifying patients with chief medical complaints and underlying behavioral health issues that may have previously gone unnoticed.

Success story

- A female patient visited the ED 3 to 4 times per week, presenting after calling 911 with minor medical complaints that did not consistently warrant emergency care. She learned that the patient

previously resided in a group home, left after being the victim of an assault, and lived independently without services. The patient had uncontrolled diabetes and exhibited symptoms of post-traumatic stress disorder. The team connected with a family member to glean more insight into the patient's history, including her traumatic experience in the group home. Following this, the team re-opened an existing case with DMH, connected her with case management services, visiting nurses for diabetes management, and behavioral health services. Since engaging in care, the patient's ED use declined substantially and she is comforted through her connection with the CHART team.

Regional Behavioral Health Collaborative – Mike Ellis

Team dynamics and workflow

- Mr. Ellis noted that great care is not enough in some communities; patients must be connected to that care for it to be successful. The Regional Behavioral Health Collaborative (RBHC) aims to identify, integrate, and build support systems where necessary, and create linkages across agencies, organizations, and health providers using a collective impact model and an online resource directory (available to both providers and consumers).
- The RBHC team uses facilitated discussion in its internal meetings versus a strict agenda model and includes training components in its regular meetings.
- Prior to RBHC's presence, group homes routinely called 911 for issues that did not consistently warrant emergency care. RBHC now assists in handling patient care within group homes, where appropriate.

3. Story of success: Signature Healthcare Brockton Hospital

Deborah Jean Parsons' presentation ("Story of success: Signature Healthcare Brockton Hospital") is attached to the same email as this document. Signature Healthcare Brockton Hospital aims to reduce 30-day readmissions by 20% for all admitted patients (excluding patients served by DSTI) by the end of the 24 month Measurement Period. Signature is making great strides to reach this goal: slide 8 of Ms. Parson's presentation indicates that to date, Signature has reduced its readmission rates by 19% for its high risk population and by 24% for its active population. We thank Ms. Parsons again for sharing her experiences and insights thus far in CHART Phase 2.