MASSACHUSETTS
HEALTH POLICY COMMISSION
CHART INVESTMENTS

CHART **Phase 2** Awards

Community Hospital Acceleration, Revitalization,
and Transformation (CHART) Program

CHART Phase 2 Awards

Individual Awards

Addison Gilbert and Beverly Hospitals

Anna Jaques Hospital

Baystate Franklin Medical Center

Baystate Noble Hospital

Baystate Wing Hospital

Berkshire Medical Center

Beth Israel Deaconess Hospital – Milton

Beth Israel Deaconess Hospital – Plymouth

Emerson Hospital

Harrington Memorial Hospital

HealthAlliance Hospital

Holyoke Medical Center

Lawrence General Hospital

Lowell General Hospital

Mercy Medical Center

Milford Regional Medical Center

Signature Healthcare Brockton Hospital

UMass Marlborough Hospital

Winchester Hospital

Joint Awards

Addison Gilbert, Beverly, Winchester, and Lowell General Hospitals

Baystate Franklin Medical Center, Baystate Noble & Baystate Wing Hospitals

Hallmark Health System

Heywood and Athol Memorial Hospitals

Southcoast Hospitals Group

Addison Gilbert and Beverly Hospitals[1]

ESSEX COUNTY

$4.5M
TOTAL PROJECT COST

$3.77M
HPC AWARD

Target Population & Aims

TARGET POPULATION

Patients identified by:

- High utilization (≥ 4 hospitalizations per year); or
- Social complexity; or
- A personal history of 30-day readmissions

4,000
Discharges per year inclusive of

1,500
discharges per year for 300 unique patients with high utilization

PRIMARY AIM
Reduce 30-day returns by
20%

SECONDARY AIM
Reduce 30-day ED returns by
10%

Summary of Award

Addison Gilbert and Beverly Hospitals aim to reduce 30-day returns by 20% for patients with high utilization of the hospital, social complexity, or a history of 30-day readmissions. Building on its Phase 1 programs, Addison Gilbert and Beverly Hospitals are deploying a High Risk Intervention Team (HRIT) in the hospital and Emergency Department (ED) to identify eligible patients to develop care plans and to provide integrated services, including care co-ordination. These interventions are customized to the patient and the team includes a care manager, social worker, and pharmacist. The HRIT engages target population patients to ensure appropriate follow-up, and to ensure these high risk of readmission patients receive the appropriate care after discharge. The HRIT also collaborates with local VNA and SNF services to improve continuity of care across the care continuum, from the hospital to the community. The HRIT will follow target population patients for 30 days post-discharge to provide them with these enhanced services.

High Risk Intervention Team

- Builds relationships with patients and families based on trust
- Connects patients with primary care
- Arranges insurance coverage
- Coordinates care and advocates for patients across care settings, within and outside of the hospital

"No one has ever helped guide us before. We've been alone...with little hope of getting out. But now I have hope."
- CHART family member

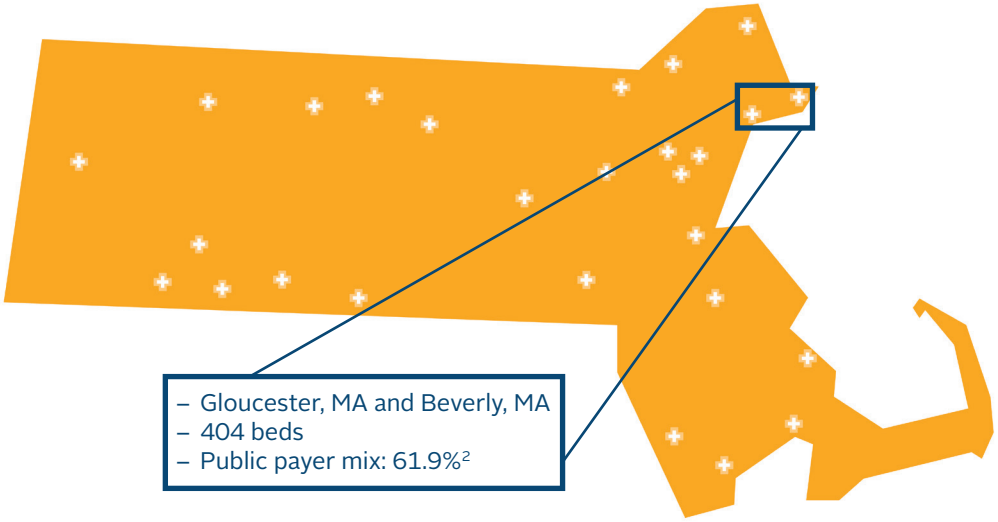

CHART & HPC Background

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1. Addison Gilbert and Beverly Hospitals ("Northeast Hospital") received two separate awards in CHART Phase 2. They are coordinating efforts in a unified approach to program implementation.
2. Source: Center for Health Information and Analysis, 2017.

MASSACHUSETTS
HEALTH POLICY COMMISSION
CHART INVESTMENTS

Anna Jaques Hospital

ESSEX COUNTY

$1.4M
TOTAL PROJECT COST

$1.2M
HPC AWARD

Target Population & Aims

TARGET POPULATION 1
Patients with high utilization, as identified by one or more of the following:

- ≥4 inpatient admissions in the last 12 months
- ≥6 ED visits in the last 12 months

TARGET POPULATION 2
Patients at risk of high utilization

876
discharges per year

2,340
ED visits per year

PRIMARY AIM
Reduce 30-day readmissions by
20%

SECONDARY AIM
Reduce 30-day ED revisits by
25%

Summary of Award

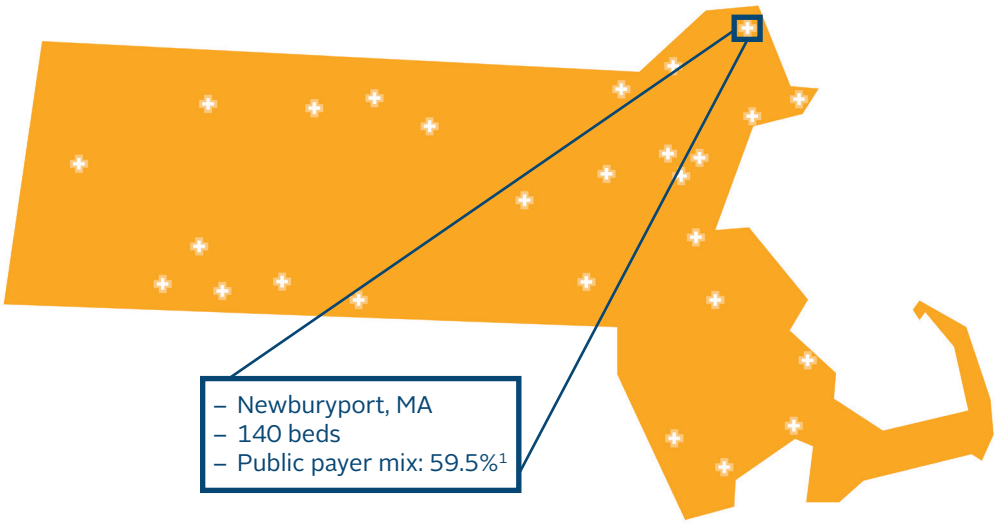
Anna Jaques Hospital aims to reduce 30-day readmissions by 20% for patients with high utilization of the hospital or Emergency Department (ED). An ED case manager identifies patients in the target population that would be better served in alternative care settings, including home services or skilled nursing facilities. In the inpatient setting, a clinical pharmacist provides medication education and performs medication optimization, a key component of the discharge process. Additionally, multidisciplinary rounding ensures that appropriate plans and services are in place prior to discharge. Elder Services of the Merrimack Valley provides transitional coaching and follows patients in the community for up to 180 days.

CHART Pharmacist

- Available to any CHART eligible patient for in-person medication reconciliation
- Identifies barriers to medication adherence that may contribute to repeat hospital visits

"The CHART Program allows us to manage high-risk patients with a coordinated team approach and makes help available at home for patients free of charge"

- ED Case Manager



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1. Source: Center for Health Information and Analysis, 2017.

MASSACHUSETTS
HEALTH POLICY COMMISSION
CHART INVESTMENTS

Baystate Franklin Medical Center

FRANKLIN COUNTY

$2.08M
TOTAL PROJECT COST

$1.6M
HPC AWARD

Target Population & Aims

TARGET POPULATION
Patients with a personal history of high utilization, identified by one or more of the following:

- ≥ 4 hospital discharges in the last 12 months
- ≥ 5 behavioral health ED visits (primary or secondary diagnoses) in the last 12 months

466
Discharges per year for 97 unique patients

1,213
ED visits per year for 95 unique patients

PRIMARY AIM 1
Reduce 30-day ED revisits by
25%

PRIMARY AIM 2
Reduce 30-day readmissions by
25%

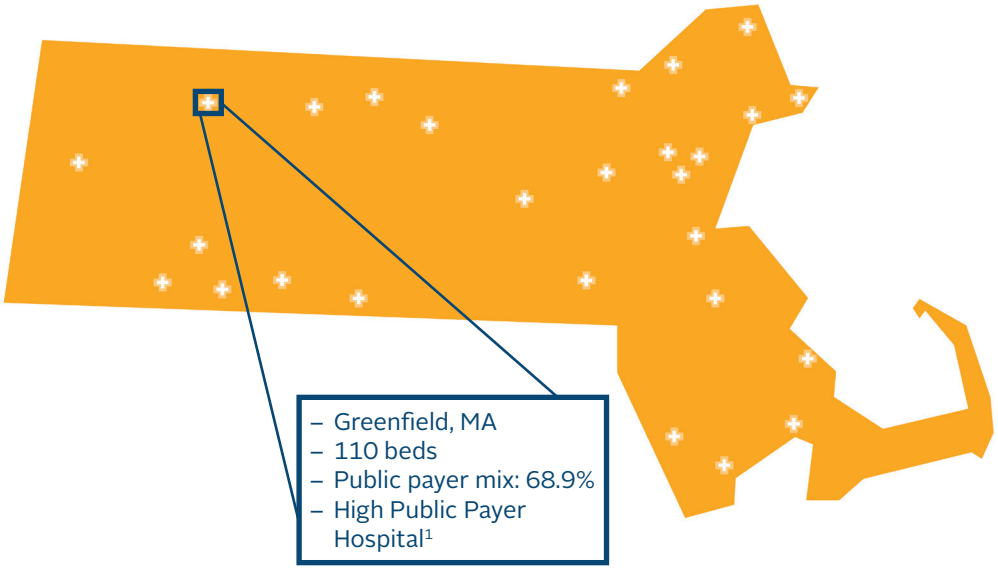
Summary of Award

Baystate Franklin Medical Center aims to reduce reutilization of the Emergency Department (ED) and hospital by enhancing patient assessment and services in the ED and in inpatient settings. Patients are identified either prior to presentation to the ED in a newly created high utilization registry, upon presentation in the ED, or while admitted to the hospital. Staff engage with target population patients across care settings – within the ED, on inpatient floors, and in the outpatient and/or home settings. In the ED, patients are screened for behavioral health issues, including substance use disorder, and provided with a brief intervention and referral to treatment (SBIRT). In the hospital, the Complex Care Team (CCT) participates in multidisciplinary rounds, develops individual care plans, and engages with hospital staff to assess patients' clinical and social needs. For up to 30 days post-discharge, the CCT provides follow-up services as needed, including rapid access to partial hospitalization, behavioral health services, and primary care.

Community Health Workers

- 3.5 full time equivalent Community Health Workers (CHW)
- Integrated with Baystate Franklin's Complex Care Team, CHWs provide community-based care to ensure post-discharge care engagement

"I get to be an advocate."
- CHART CHW



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1. Source: Center for Health Information and Analysis, 2017.

MASSACHUSETTS
HEALTH POLICY COMMISSION
CHART INVESTMENTS

Baystate Noble Hospital

HAMPDEN COUNTY

$1.5M
TOTAL PROJECT COST

$1.04M
HPC AWARD

Target Population & Aims

TARGET POPULATION 1
All discharges to skilled nursing facilities (SNF)

TARGET POPULATION 2
All patients with high utilization of the ED and hospital

432
Discharges to SNF per year

1,380
ED visits for 264 unique patients

PRIMARY AIM
Reduce 30-day readmissions by
25%

SECONDARY AIM
Reduce 30-day ED revisits by
15%

Summary of Award

Baystate Noble Hospital aims to reduce 30-day readmissions by 25% by providing ongoing services to target population patients – in the Emergency Department (ED), during an admission, and following discharge. In the ED, and in collaboration with ED staff (including LCSW, nurses, and physicians), the Complex Care Team (CCT) assesses eligible patients, develops individualized care plans (ICP), coordinates medication optimization, and makes referrals to community and behavioral health services, as needed. In the inpatient setting, the CCT participates in multidisciplinary complex care rounds, develops or modifies the ICP, coordinates services, including palliative care, and facilitates warm handoffs to in-hospital services. Following discharge, the CCT provides an in-home follow up within 48 hours, provides a medication review and reconciliation, and engages in care navigation to ensure that all needs are met.

Complex Care Team

Provides care in the ED, in the hospital, and at home. The CCT may accompany patients to primary care visits, AA meetings, and shelters.

"We realized that most of the work that needs to be done comes when the patient returns home"
- Baystate Noble CHART team member

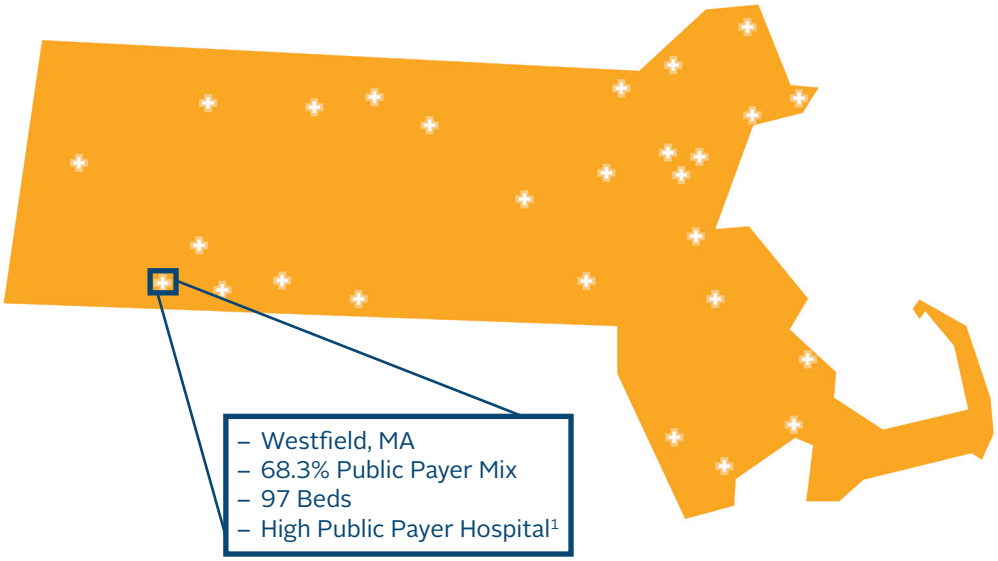

CHART & HPC Background

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1. Source: Center for Health Information and Analysis, 2017.

MASSACHUSETTS
HEALTH POLICY COMMISSION
CHART INVESTMENTS

Baystate Wing Hospital

HAMPDEN COUNTY

$1.25M
TOTAL PROJECT COST

$1M
HPC AWARD

Target Population & Aims

TARGET POPULATION
Patients with a life-limiting condition and/or a behavioral health diagnosis

1,047
Admissions per year

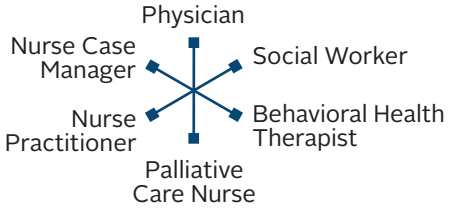
PRIMARY AIM
Reduce 30-day readmissions by
20%

SECONDARY AIM
Reduce 30-day ED returns by
10%

Summary of Award

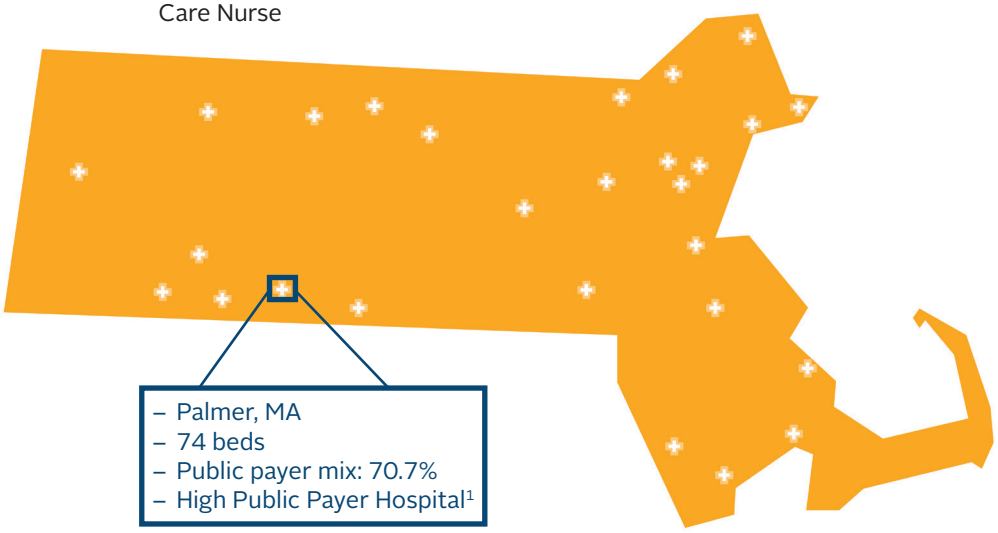
With the primary goal of reducing 30-day readmissions, Baystate Wing Hospital implemented a High Risk Care Team (HRCT) to provide enhanced services to patients with a life-limiting condition and/or a behavioral health diagnosis within the Emergency Department (ED), in the inpatient setting, and following discharge. All target population patients will have an individual care plan, either developed in the ED or in the hospital, which drives services across the continuum of care. In the ED, the HRCT partners with pharmacy staff to conduct medication reconciliation and optimization. Additionally, the HRCT provides warm handoffs to the next care setting – whether inpatient, primary care, VNA, or other services. During an inpatient stay, the HRCT participates in multidisciplinary care rounds and coordinates with hospital staff to improve care planning while in the hospital and post-discharge. Following discharge, the HRCT conducts in-home follow-up within 72 hours and engages with patients for 30 days, or longer, as necessary.

High Risk Care Team



"This service is breaking the cycle of ED visits and readmissions"

- Baystate Wing Hospital CHART team member



- Palmer, MA
- 74 beds
- Public payer mix: 70.7%
- High Public Payer Hospital[1]

CHART & HPC Background

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1. Source: Center for Health Information and Analysis, 2017.

MASSACHUSETTS
HEALTH POLICY COMMISSION
CHART INVESTMENTS

Berkshire Medical Center

BERKSHIRE COUNTY

$4.04M
TOTAL PROJECT COST

$3M
HPC AWARD

Target Population & Aims

TARGET POPULATION
All inpatient and observation discharges of Northern Berkshire County residents.

2,298
discharges per year

PRIMARY AIM
Reduce 30-day returns by
20%

SECONDARY AIM
Reduce 30-day Emergency Department returns by
10%

Summary of Award

Berkshire Medical Center aims to reduce 30-day returns by 20% for patients from Northern Berkshire County. To achieve this goal, Berkshire is working to address social issues that lead to recurrent acute care utilization, provide enhanced care for patients with chronic conditions, and increase access to behavioral health services. The majority of services are based in the Neighborhood for Health (NFH) in North Adams, an outpatient medical care center providing comprehensive behavioral health, chronic disease management, and social services. In partnership with the co-located Brien Center for Mental Health and Substance Abuse Services, NFH provides enhanced behavioral health services to patients in the community.

Suboxone Bridge Program

The Suboxone Bridge Program facilitates engagement with Suboxone treatment upon discharge from a detoxification hospital admission. While admitted, patients are screened by a case coordinator for medication-assisted treatment eligibility, and eligible patients are connected with the NFH's Suboxone program within one day following discharge. There, they meet with a Suboxone-waived psychiatrist several times per week for up to three weeks and participate in the Brien Center Day Treatment Program while awaiting transition to the Brien Center's Suboxone program. These programs narrow the gap between inpatient detoxification to outpatient treatment through high-touch patient engagement, treatment, and care coordination.

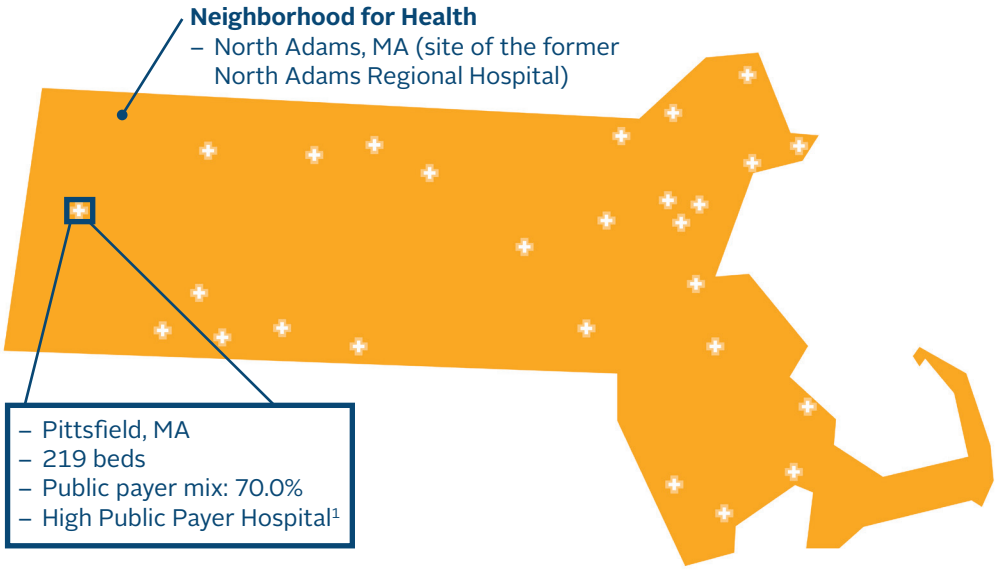

CHART & HPC Background

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1. Source: Center for Health Information and Analysis, 2017.

MASSACHUSETTS
HEALTH POLICY COMMISSION
CHART INVESTMENTS

Beth Israel Deaconess Hospital – Milton

NORFOLK COUNTY

$2.28M
TOTAL PROJECT COST

$2M
HPC AWARD

Target Population & Aims

TARGET POPULATION
Patients in the ED with a length of stay > 8 hours who are referred to SSMH for a behavioral health crisis evaluation

1,338
ED visits per year

PRIMARY AIM
Reduce excess ED boarding for long stay behavioral health patients by
40%

SECONDARY AIM
Reduce 30-day ED revisit rate for ED patients with a primary behavioral health diagnosis by
20%

Summary of Award

With extensive community collaboration with key partner South Shore Mental Health (SSMH), BIDH – Milton implemented an integrated behavioral health initiative with the goal of reducing excess Emergency Department (ED) boarding by 40%. The initiative includes rapid triage and timely crisis evaluation and supportive care, intensive stabilization and care management, expedient linkages to community partners and providers, community care management, peer support, and behavioral health navigation. A multidisciplinary team provides comprehensive clinical and supportive services. SSMH provides behavioral health clinical and navigation services in the BIDH – Milton ED and in the community. Multiple acute, community provider, municipal, and social service stakeholders participate in an integrated learning consortium.

"We have improved our ability to triage and intake patients in behavioral health crisis and ensure they are settled in a safe environment...The overall care and attention paid to behavioral health patients has improved with team planning and a changed focus of the care needs of this subpopulation."

- BIDH – Milton CHART team member

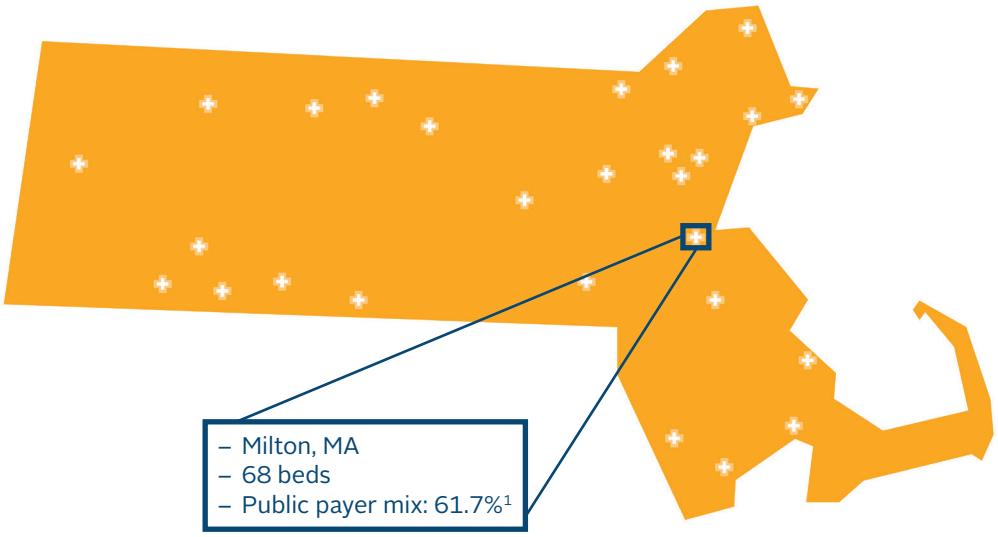

CHART & HPC Background

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1. Source: Center for Health Information and Analysis, 2017.

MASSACHUSETTS
HEALTH POLICY COMMISSION
CHART INVESTMENTS

Beth Israel Deaconess Hospital – Plymouth

PLYMOUTH COUNTY

$5.2M
TOTAL PROJECT COST

$3.7M
HPC AWARD

Target Population & Aims

TARGET POPULATION
All patients with dual eligibility and/or all ED patients with a primary behavioral health (BH) diagnosis

DUAL POPULATION:
849
discharges per year

2,481
ED visits per year

BH POPULATION:
1,322
discharges per year

2,963
ED visits per year

PRIMARY AIM 1
Reduce readmissions for patients with dual eligibility by
10%

PRIMARY AIM 2
Reduce ED revisits for patients with a primary BH diagnosis by
20%

SECONDARY AIM
Reduce ED length of stay for ED BH patients by
10%

Summary of Award

In BIDH – Plymouth's Complex Patient Program, patients with dual eligibility are screened and assessed by a nurse care manager for healthcare services and social support needs. A member of the multidisciplinary care team provides home visits and patient needs are managed across the continuum of care, including collaboration with skilled nursing facilities, primary care, hospice, and palliative care service providers. Care plans are developed, implemented, and reassessed on an ongoing basis. The Integrated Care Initiative (ICI) uses a community-wide approach to care for behavioral health patients: behavioral health services are co-located in primary care practices, with social workers providing care during PCP visits. In the ED, the behavioral health team works with ED staff and community providers to help stabilize patients, assess needs and access necessary supports, and ensure continuity of care in the community.

Beyond the ED

The ICI collaborates with the Plymouth Police Department to send clinicians to patients' homes following an overdose reversal with the goal of enrolling patients in detoxification services, and/or transporting patients directly to detoxification services if desired.[1] ICI clinicians additionally provide referrals to the Plymouth Drug and Mental Health Court for patients with open charges that appear to be related to addiction.

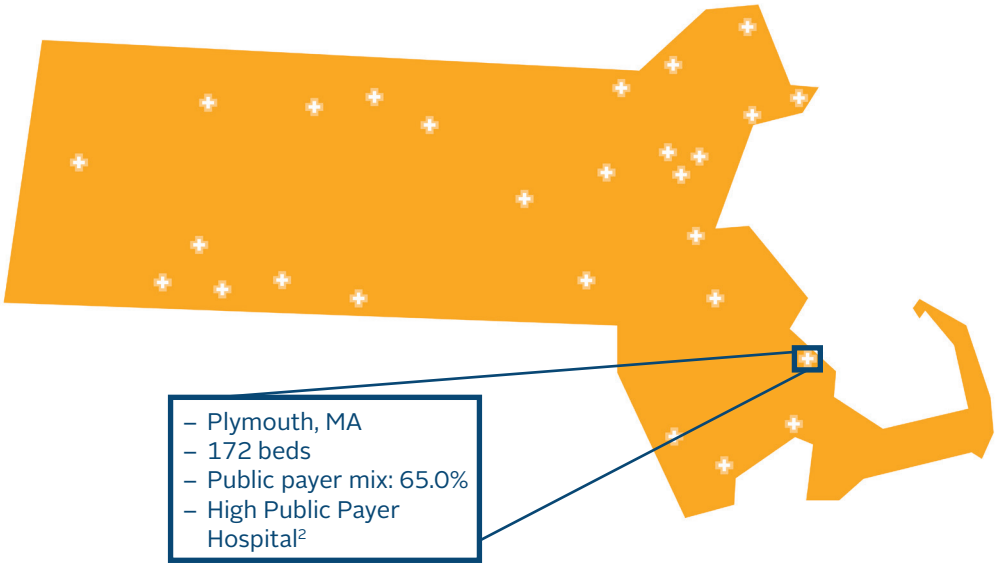

CHART Background

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1. Detoxification services secured by High Point Treatment Center or Gosnold on Cape Cod.
2. Source: Center for Health Information and Analysis, 2017.

Emerson Hospital

MIDDLESEX COUNTY

$1.92M
TOTAL PROJECT COST

$1.2M
HPC AWARD

Target Population & Aims

TARGET POPULATION
All medical, surgical, and behavioral health patients at a high risk of readmission

3,080
discharges per year

PRIMARY AIM
Reduce 30-day returns by
20%

SECONDARY AIM 1
Reduce 30-day returns among patients with a high risk of readmission discharged to a skilled nursing facility by
10%

SECONDARY AIM 2
Reduce 30-day Emergency Department returns for all medical/surgical/behavioral health patients with a high risk of readmission by
10%

Summary of Award

Emerson Hospital aims to reduce 30-day returns by 20% for patients at a high risk of re-admission. The Emerson Hospital CHART program provides interdisciplinary cross-setting transitional care and enhanced hospital-based processes, including multidisciplinary rounding. The CHART team collaborates with post-acute care providers and leverages technologies to improve care and coordination for its patients. Individual care plans are developed and referenced throughout the program. Care Dimensions, a home care and assisted living service provider and nursing facility, provides an on-site RN palliative care and hospice liaison that assists with identifying patients who may be appropriate for palliative care or hospice. She provides education to patients and families about these services, and identifies the need for further consultation, whether during an admission or upon discharge.

Patient Story

A wheelchair bound male with diabetes was frequently admitted to the hospital with difficulty managing his illness. Interventions by the CHART team focused on education, which enabled him to medically manage his diabetes on his own. However, despite this success, the team found that his nutrition was inappropriate for his condition. The team brought this to his attention and connected him with a meal delivery service, improving his nutrition and ability to manage his diabetes.

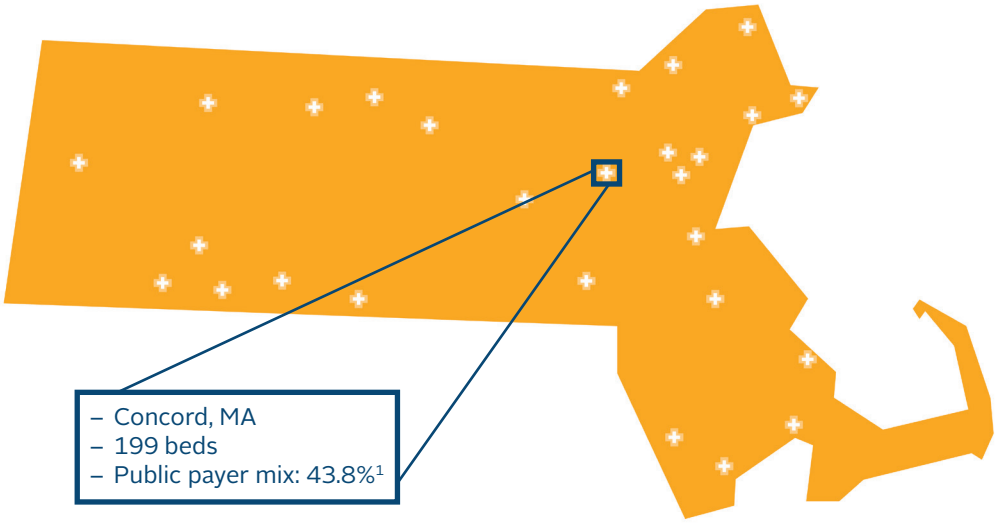

CHART & HPC Background

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1. Source: Center for Health Information and Analysis, 2017.

Harrington Memorial Hospital

WORCESTER COUNTY

$2.3M
TOTAL PROJECT COST

$2.1M
HPC AWARD

Target Population & Aims

TARGET POPULATION
Patients with a primary or secondary behavioral health diagnosis in the ED setting

1,800
ED visits per year

PRIMARY AIM
Reduce 30-day ED revisits by
15%

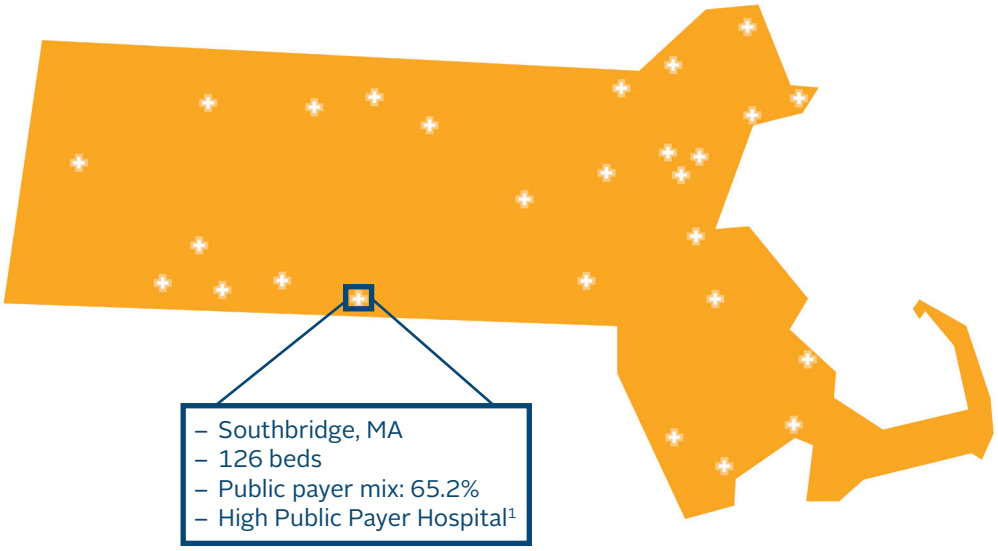
SECONDARY AIM
Reduce ED length of stay by
10%

Summary of Award

Harrington Memorial Hospital aims to reduce recurrent Emergency Department (ED) utilization by increasing access to cross continuum care for patients with a behavioral health diagnosis. Behavioral health screening and assessment occurs throughout the hospital and ED and patients are engaged by a multi-disciplinary community outreach team of nurse navigators, social workers, and community health workers. Services include inpatient treatment for patients with co-occurring mental health and substance use disorders, a substance use intensive outpatient program, a partial hospitalization program, intensive follow-up within the community, and transportation to improve access.

Focus on Substance Use Treatment

Recognizing the disparity in care for patients with substance use disorder, Harrington Memorial Hospital implemented an integrated care model in the ED to screen patients for opioid use disorder, coordinate care with ED clinicians, and help patients engage with substance use and behavioral treatment providers in the community. This model enables caregivers to tailor care to the needs of the patient rather than requiring patients to navigate distinct services, often in a state of vulnerability, without assistance. Patients are identified by an ED clinician, or during an admission connected with a social worker or navigator, and linked to services in the community through warm handoffs and frequent check-ins.



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1. Source: Center for Health Information and Analysis, 2017.

HealthAlliance Hospital

WORCESTER COUNTY

$10M
TOTAL PROJECT COST

$3.8M
HPC AWARD

Target Population & Aims

TARGET POPULATION
Adult primary and/or secondary ED behavioral health patients who are identified as high risk of an ED revisit

7,000
ED visits per year

PRIMARY AIM
Reduce 30-day ED revisits by
15%

SECONDARY AIM
Reduce ED length of stay by
31%

Summary of Award

HealthAlliance Hospital aims to reduce 30-day Emergency Department (ED) revisits by 15% by reengineering ED workflows and deploying a comprehensive set of services to patients presenting to the ED with any behavioral health diagnoses. Patients are identified in the ED, brought to a behavioral health-specific area near the ED, and triaged by a team of specialists. A behavioral health evaluation and brief screening are performed, where patients are educated about the Health Integrated Collaborative Case Coordination (HIc3) Team. Upon engaging in the program, the HIc3 Team initiates services immediately following discharge from the ED or hospital. Once discharged, patients are transitioned to a Community-Based Services model with service intensity stratified by patient need and care pathways are defined accordingly. Community-Based Services include scheduling follow-up appointments, discharge planning, primary care and behavioral health referrals, and long-term care follow-up.

"A patient recently presented to the CHART offices to ask for our assistance. This is a patient we had never spoken with – he had been discharged prior to screening and our attempts at outreach went unanswered...We opted him out and hoped that we could engage him the next time he presented to the ED. But, we didn't have to wait. He heard our messages on his voicemail and decided that he truly did need help. He is now enrolled in the program and we look forward to connecting him with the providers and services he needs."

- Behavioral Health Navigator

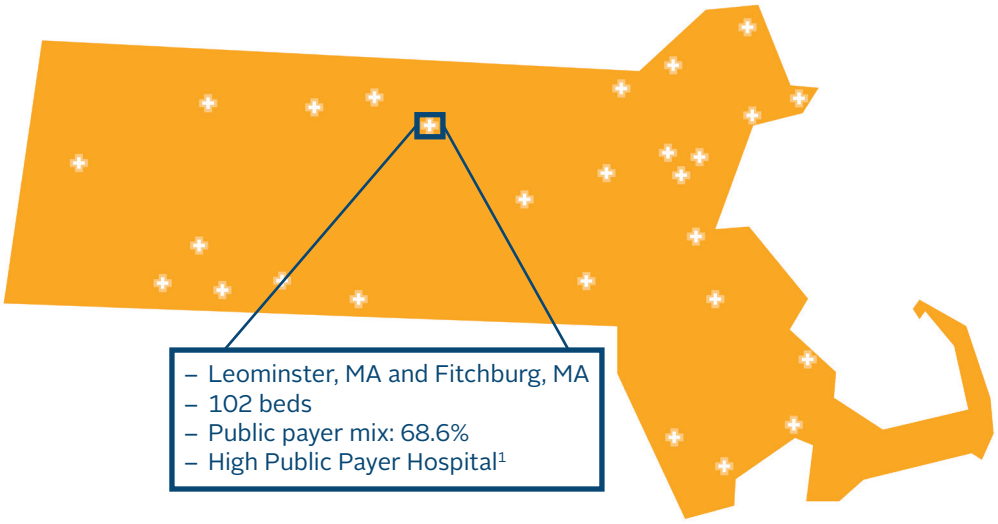

CHART & HPC Background

The Community Hospital Acceleration, Revitalization, and Transformation Investment Program (CHART) makes phased investments for certain Massachusetts community hospitals to enhance their delivery of efficient, effective care. The goal of the program is to promote care coordination, integration, and delivery transformations; advance electronic health records adoption and information exchange among providers; increase alternative payment methods and accountable care organizations; and enhance patient safety, access to behavioral health services, and coordination between hospitals and community-based providers and organizations.

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1. Source: Center for Health Information and Analysis, 2017.

MASSACHUSETTS
HEALTH POLICY COMMISSION
CHART INVESTMENTS

Holyoke Medical Center

HAMPDEN COUNTY

$3.6M
TOTAL PROJECT COST

$1.9M
HPC AWARD

Target Population & Aims

TARGET POPULATION
Patients with a primary or secondary behavioral health diagnosis in the ED setting

7,800
ED behavioral health visits per year

PRIMARY AIM
Reduce 30-day ED revisits by
25%

SECONDARY AIM
Reduce ED length of stay by
10%

Summary of Award

With the goal of reducing 30-day Emergency Department (ED) revisits by 25% for patients with a primary or secondary behavioral health diagnosis, Holyoke Medical Center deployed a behavioral health social work and assessment team in its ED to enhance care coordination, introduce targeted interventions to address complex social issues, and increase information sharing across care providers. Patients with a history of frequent ED utilization are referred to the multidisciplinary community-facing CHART team, comprised of community health workers, patient navigators trained in social work, a psychiatric nurse, a medical assistant, and a physician waived to prescribe Suboxone. The program provides comprehensive care planning, therapeutic behavioral health services, and community-based follow-up and referrals to support services. Additionally, a separate CHART capital award supported the construction of a dedicated behavioral health pod within the new ED.[1] Holyoke Medical Center's CHART initiative was developed to complement its Delivery System Transformation Initiative (DSTI) project, which focuses specifically on behavioral health integration in the primary care setting.

"The experience so far has been a very positive one; bringing behavioral health social workers to the ED has been a huge win for everyone. The patients are so appreciative and the staff and patients' families, providers, and supports have all given positive feedback."

- ED Social Work Navigator

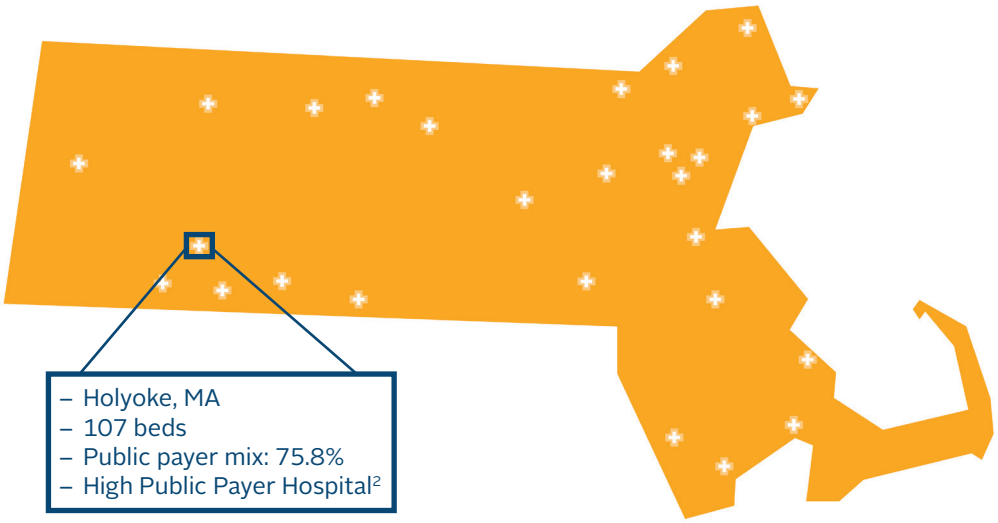

CHART & HPC Background

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1. A separate contract awarding Holyoke Medical Center $2 million supports this component of the project.
2. Source: Center for Health Information and Analysis, 2017.

MASSACHUSETTS
HEALTH POLICY COMMISSION
CHART INVESTMENTS

Lawrence General Hospital

ESSEX COUNTY

$1.9M
TOTAL PROJECT COST

$1.48M
HPC AWARD

Target Population & Aims

TARGET POPULATION
Patients identified by one or more of the following:

- Medium or high biopsychosocial risk
- A personal history of 30-day readmissions

~2424
patients (October 2015 data of 202 unique patients)

PRIMARY AIM
Reduce 30-day readmissions by
20%

SECONDARY AIM
Reduce 30-day ED returns by
20%

Summary of Award

Lawrence General Hospital aims to reduce 30-day readmissions by 20% for target population patients by providing transitional services for the highest need patients. CHART services vary in intensity based on patient risk segments and include longitudinal and interdisciplinary medical and social care. Follow-up phone assessments are designed to evaluate symptoms and compliance with the discharge plan. Culturally relevant patient education and teaching to empower patients to better manage their care is also a part of these enhanced services. Additionally, coordination of a variety of community-based social support services including prescription assistance, transportation, and mental health counseling, are available to the target population. Care plans are developed and shared with all of the patient's providers across the care continuum. Additionally, transition coaches from Elder Services of the Merrimack Valley (ESMV) provide follow-up services for 30 to 90 days post-discharge.

Care Transition Coaches

~$170,000 CHART funding

- 1.5 Elder Services of Merrimack Valley (ESMV) provided full time equivalent care transition coaches

"The partnership between Lawrence General Hospital and Elder Services of the Merrimack Valley (ESMV) has been the most successful partnership of the program. The success is a result of mutual respect and engagement. The [Care Transition Coaches] at ESMV are considered a part of the core CHART team, attend operations meetings, interdisciplinary care meetings, and are constantly communicating with the social workers and registered nurse. ESMV, while a contracted service, is not viewed as an outside entity which has led to successful collaboration and implementation of the partnership."

- Lawrence General Hospital CHART team member

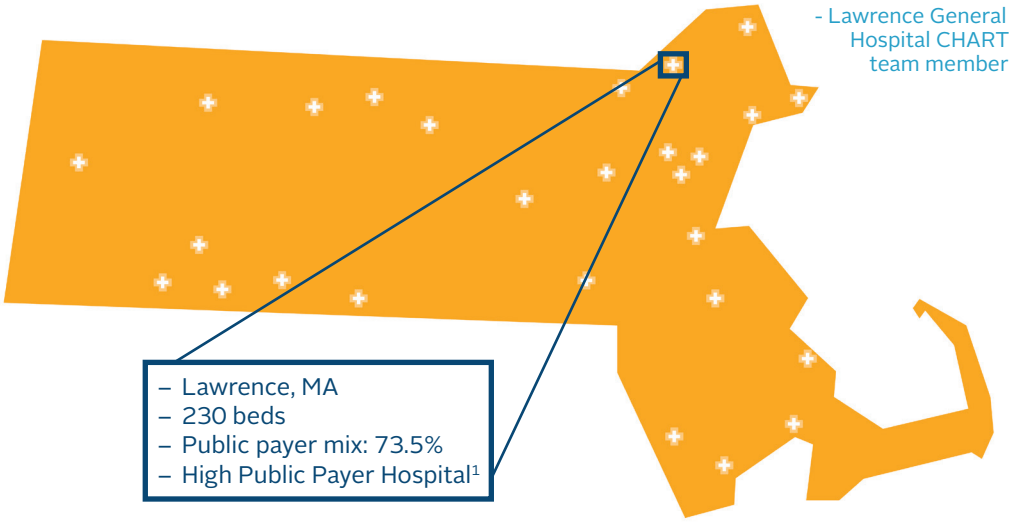

CHART & HPC Background

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1. Source: Center for Health Information and Analysis, 2017.

MASSACHUSETTS
HEALTH POLICY COMMISSION
CHART INVESTMENTS

Lowell General Hospital

MIDDLESEX COUNTY

$2.02M
TOTAL PROJECT COST

$1M
HPC AWARD

Target Population & Aims

TARGET POPULATION
Patients with a personal history of high utilization of the hospital

2,200
visits for 800 unique patients per year

PRIMARY AIM
Reduce 30-day readmissions by
20%

SECONDARY AIM
Reduce 30-day Emergency Department (ED) revisits by
10%

Summary of Award

Lowell General Hospital aims to reduce 30-day readmissions by 20% for patients with a history of high utilization of the hospital and Emergency Department (ED) by leveraging partnerships in the community to improve care coordination, care management, and palliative care services. Through the development of a care transitions program, the Lowell General CHART team provides care transition coaching, care navigation, follow-up engagement services, logistical coordination, medication adherence services, and ongoing clinical follow-up. Patients are followed for 90 days or more with services tailored to individual needs.

The program offers "reassurance that there will be follow-up on patients after discharge, which we never really had before."

- Director, Continuity of Care, Lowell General Hospital

"On a scale of 1 to 10, my social worker is a 20...She keeps tabs on me to make sure I am keeping out of the hospital, and even when I go into the hospital, she finds out and always checks in on me. If I have any paperwork to complete, she helps me. This program helps me a lot."

- CHART patient

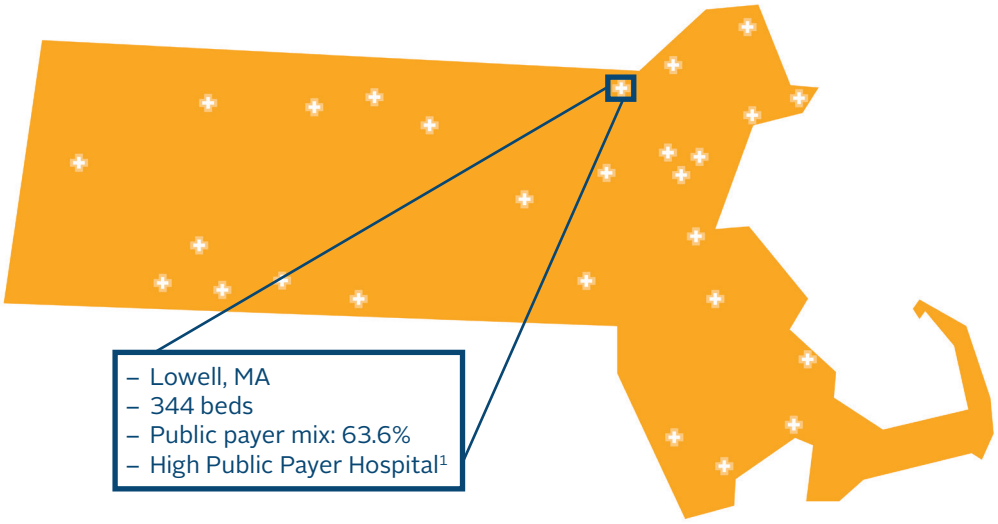

CHART & HPC Background

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MASSACHUSETTS
HEALTH POLICY COMMISSION
CHART INVESTMENTS

Mercy Medical Center

HAMPDEN COUNTY

$1.66M
TOTAL PROJECT COST

$1.3M
HPC AWARD

Target Population & Aims

TARGET POPULATION
ED patients with a primary behavioral health diagnosis

4,200
ED visits per year

PRIMARY AIM
Reduce 30-day ED revisits by
20%

SECONDARY AIM
Reduce ED length of stay by
20%

Summary of Award

Mercy Medical Center, in close partnership with a community-based behavioral health provider (Behavioral Health Network), aims to reduce 30-day Emergency Department (ED) revisits by 20% by improving ED-based behavioral health (BH) services. BH-trained nurses are available 24 hours a day, seven days a week to provide BH clinical care, including medication reconciliation, de-escalation intervention, and care planning in the ED. A community health worker (CHW) is additionally embedded in the ED to support patient transition back to the community. Upon discharge from the ED, Mercy Medical Center coordinates with BHN CHWs to ensure warm handoffs to services and high-touch follow-up, either telephonically or face-to-face. Service intensity is titrated based on patient need.

Community Health Workers

5 Behavioral Health Network (BHN) full time equivalent Community Health Workers (CHWs)

A young male presented to the ED at least 5 times per month, frequently presenting for side effects from heroin use. The CHART team intervened in the ED, connecting him with primary care, outpatient services, and housing. In the past, this patient may have been labeled "difficult;" now, with CHW involvement in his care, he is supported and his caregivers understand his story.

"You don't have to do this alone anymore, we are here for you."
- BHN CHW

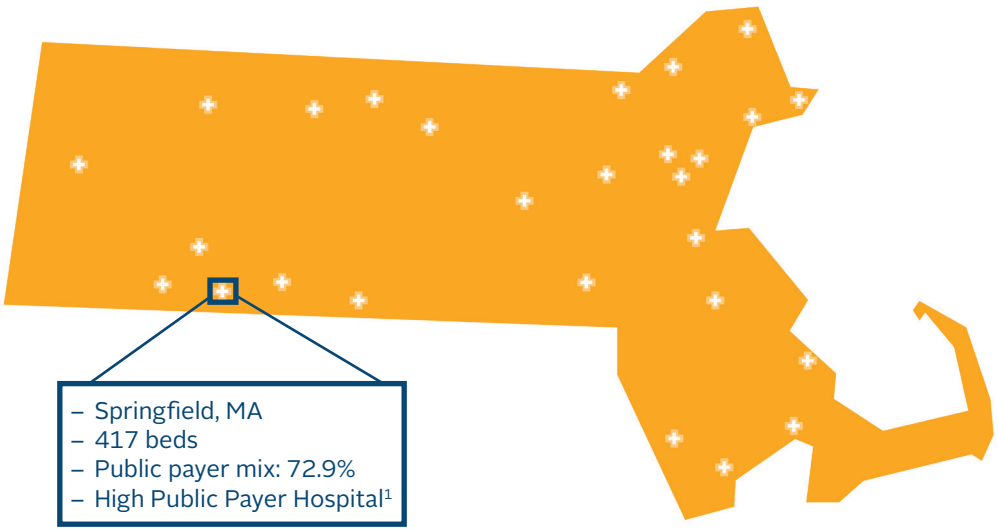

CHART & HPC Background

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MASSACHUSETTS
HEALTH POLICY COMMISSION
CHART INVESTMENTS

Milford Regional Medical Center

WORCESTER COUNTY

$2.24M
TOTAL PROJECT COST

$1.3M
HPC AWARD

Target Population & Aims

TARGET POPULATION
Patients with ≥3 hospitalizations in the past 12 months

1,248
discharges per year for 352 unique patients

PRIMARY AIM
Reduce 30-day readmissions by
25%

SECONDARY AIM
Reduce 30-day ED revisits by
10%

Summary of Award

Milford Regional Medical Center (MRMC) aims to reduce 30-day readmissions by 25% for patients with a personal history of frequent hospitalization by deploying a High Risk Mobile Team (HRMT) comprised of a pharmacist, social worker, registered nurse, and a hospital-based palliative care physician assistant (PA). The HRMT supports Emergency Department (ED) assessments, facilitates alternatives to inpatient admissions, develops individualized care plans, and when appropriate, refers patients for a palliative care consultation. MRMC developed an automated trigger in its electronic health record to notify the PA of a need for a palliative care consultation. Once completed, the PA contacts the patient's attending and/or primary care provider to alert them to the consult. The HRMT continues to engage with the patient through phone calls and home visits (including visits to skilled nursing facilities) to ensure connection to social supports, adherence to treatment plans, and stability within the community.

High Risk Mobile Team

The HRMT is a collaborative team that works to ensure that patients receive the most appropriate and effective medical interventions through hospital and community services.

An elderly patient with frequent recurrent utilization of the hospital met with the HRMT during an admission. The team discovered that the patient had not visited her PCP in several years. The HRMT scheduled an appointment for the same day, preventing a readmission. Since this encounter the patient's hospital utilization has decreased dramatically.

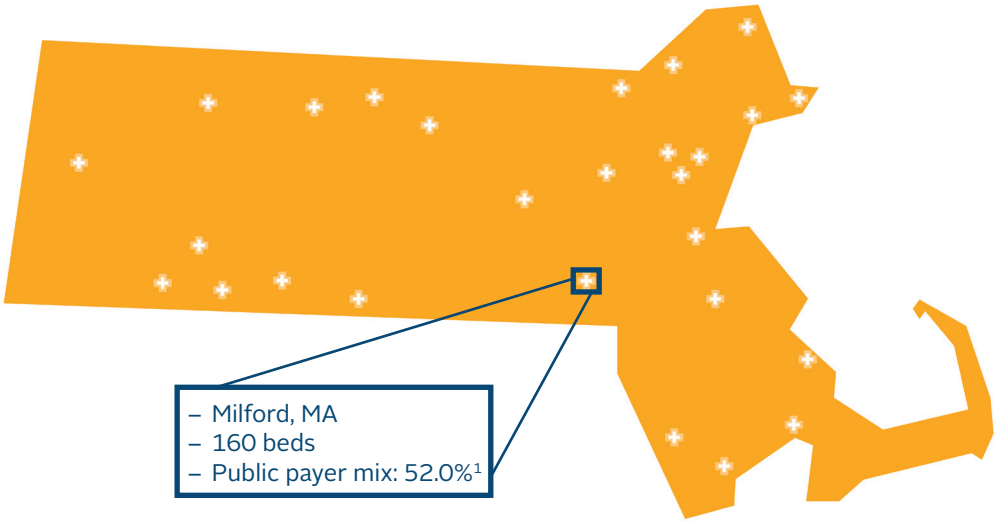

CHART & HPC Background

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MASSACHUSETTS
HEALTH POLICY COMMISSION
CHART INVESTMENTS

Signature Healthcare Brockton Hospital

PLYMOUTH COUNTY

$3.76M
TOTAL PROJECT COST

3.5M
HPC AWARD

Target Population & Aims

TARGET POPULATION 1
All admissions

TARGET POPULATION 2
Lower-acuity ED visits between 3:00-11:00pm

7,582
discharges per year

13,751
ED visits per year

PRIMARY AIM 1
Reduce 30-day readmissions by
20%

PRIMARY AIM 2
Reduce the length of stay in the ED's 3:00-11:00pm Express Care shift by
15%

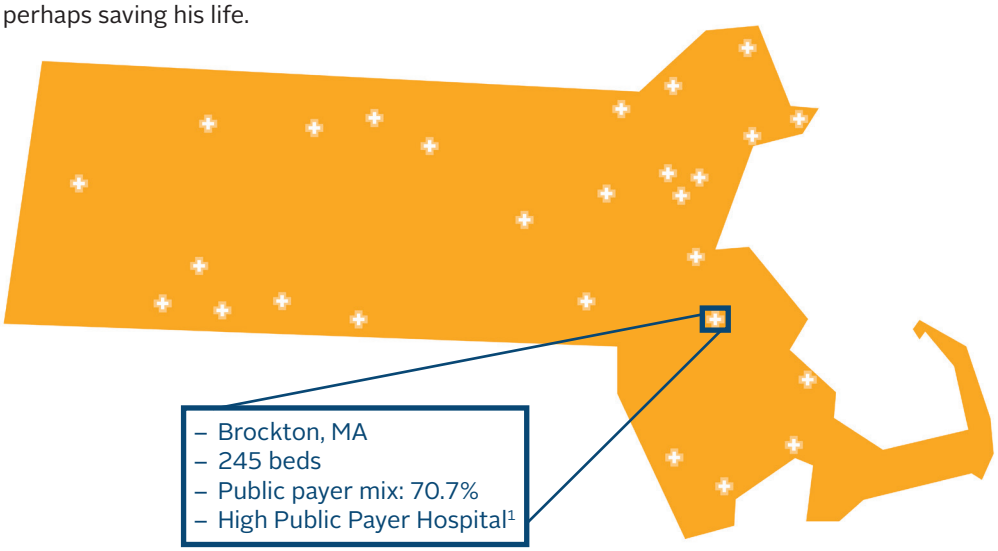
SECONDARY AIM
Reduce patient harm for all admissions and ED visits by
15%

Summary of Award

With primary goals of reducing 30-day readmissions by 20% and Emergency Department (ED) length of stay between 3:00-11:00pm by 15%, Signature Healthcare Brockton Hospital identifies patients at high-risk for readmission, prospectively and in real-time, to receive services from the Complex Care Team (CCT). The multi-disciplinary CCT provides cross-setting care (across the ED, hospital, skilled nursing facilities, and at home) that includes care planning, case management, rescue planning, palliative care, and medication reconciliation. An interdisciplinary team maps patient flow and identifies variation to reduce waste (e.g., staff time, resources). As part of this process, the team expects to redesign triage protocols, develop lab and radiology treatment protocols, and implement bedside registration, among other changes. Signature is additionally increasing early rescue and rapid response activation and engaging in activities aiming to improve the culture of safety, including leadership and frontline staff education.

Patient Story

A homeless patient with substance use disorder and medical comorbidity frequently visited the ED. Shortly after he left, the patient was found having overdosed in a nearby hotel. He was administered Narcan by first responders and stabilized in the ED. The CHART team worked with ED staff to discharge him with a prescription for Narcan. Although the patient initially resisted, he ultimately accepted the prescription. Upon a subsequent ED visit, he was found carrying Narcan, demonstrating that the CHART team successfully coached him to carry the drug in case of overdose - a successful step in the direction of changing his behavior and perhaps saving his life.



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MASSACHUSETTS
HEALTH POLICY COMMISSION
CHART INVESTMENTS

UMass Marlborough Hospital

MIDDLESEX COUNTY

$1.47M
TOTAL PROJECT COST

$1.2M
HPC AWARD

Target Population & Aims

TARGET POPULATION
Patients with a personal history of high utilization of the hospital or ED

INPATIENT:
454
discharges per year for 91 unique patients

ED:
1,607
ED visits per year for 143 unique patients

PRIMARY AIM
Reduce 30-day readmissions by
15%

SECONDARY AIM
Reduce 30-day ED revisits by
20%

Summary of Award

Aiming to reduce 30-day readmissions by 15%, UMass Marlborough Hospital created the Complex Care Team (CCT), a multidisciplinary team responsible for developing and implementing individual care plans and coordinating linkages to care in the community for patients with high utilization of the hospital and Emergency Department (ED). The CCT assists in transition planning, care coordination, and provides in-home, skilled nursing facility, and rehab follow-up services, ensuring warm handoffs and appropriate follow up for at least 30 days. Pharmacists perform medication reconciliation upon admission and at discharge and educate high risk patients on medication adherence during follow-up visits.

Complex Care Team

A patient with serious mental illness frequently presented to the Marlborough ED, sometimes multiple times per day. The CCT worked with the patient to increase medication compliance and develop coping skills, and participated in all discharge planning meetings. The CCT performed home visits and encouraged the patient to engage in calming activities when anxious like journaling, walking, and listening to music, rather than seeking hospital care as appropriate. Since engaging with the CCT, the patient's ED and hospital utilization has dramatically decreased.

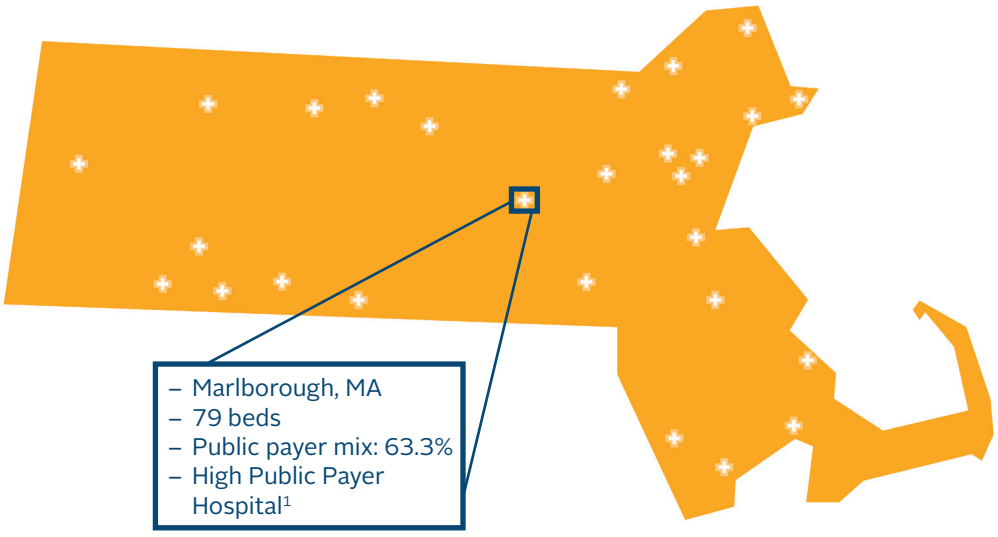

CHART & HPC Background

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MASSACHUSETTS
HEALTH POLICY COMMISSION
CHART INVESTMENTS

Winchester Hospital

MIDDLESEX COUNTY

$3.09M
TOTAL PROJECT COST

$1M
HPC AWARD

Target Population & Aims

TARGET POPULATION

- All patients with high utilization
- All discharges to post-acute care

3,832
Discharges per year

PRIMARY AIM 1
Reduce 30-day readmissions for patients with high utilization by
20%

PRIMARY AIM 2
Reduce 30-day readmissions for patients discharged to post-acute care by
20%

SECONDARY AIM
Reduce 30-day ED returns by
10%

Summary of Award

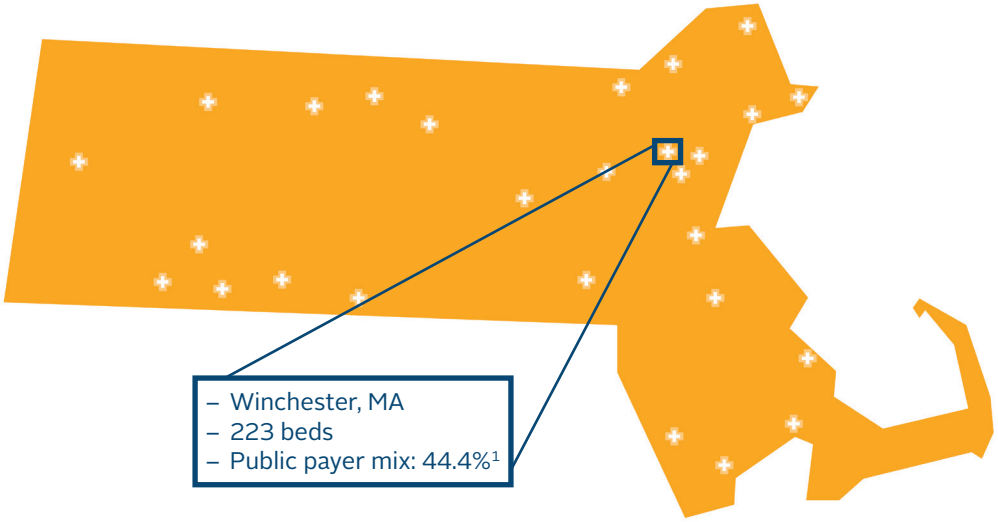
Winchester Hospital aims to reduce 30-day readmissions by deploying a cross-setting complex care team (CCT) to respond in real-time to target population patients in the Emergency Department (ED) and in the inpatient setting. The two different target populations of patients, those with high utilization and those discharged to post-acute care, receive similar services when they are admitted to the hospital. The CCT engages with patients and key supports (e.g., family) to develop individual care plans, provide warm handoffs to care in the community and post-acute care, and follow-up services within 48 hours of discharge. As warranted based on patient need, the Winchester Hospital CHART team may also visit the patient within three to five days post-discharge. Additionally, Winchester Hospital collaborates with Care Dimensions, a home care and assisted living service provider and nursing facility, to facilitate referrals to palliative and hospice services.

5 Whys

With its CHART program, Winchester Hospital implemented root cause analyses in to its regular case discussions. Including all relevant clinical and non-clinical role types in these meetings, staff aim to understand the challenges their patients face by using the 5 Whys framework, allowing for discussion about both clinical and social factors that may act as barriers to achieving stability and health.

"Engaging clinicians in root cause analyses is tremendously challenging and incredibly valuable."

- Winchester Hospital employee



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MASSACHUSETTS
HEALTH POLICY COMMISSION
CHART INVESTMENTS

Addison Gilbert, Beverly, Winchester, and Lowell General Hospitals

ESSEX AND MIDDLESEX COUNTIES

$6.3M
TOTAL PROJECT COST

$4.8M
HPC AWARD

Target Population & Aims

TARGET POPULATION
Patients with a personal history of moderate or high utilization of the ED

6,746
ED visits per year for 706 unique patients with moderate utilization

4,420
ED visits per year for for 248 unique patients with high utilization

PRIMARY AIM
Reduce 30-day ED revisits by
20%

SECONDARY AIM
Reduce total acute care utilization by
15%

Summary of Award

Addison Gilbert Hospital, Beverly Hospital, Winchester Hospital (the Lahey Health community hospitals) and Lowell General Hospital aim to reduce 30-day Emergency Department (ED) revisits for patients with a personal history of recurrent ED utilization. The population is segmented into patients with moderate utilization (8-13 visits) and patients with high utilization (14+ visits) based each patient's 12 month history. This joint program will identify and initiate treatment in the ED, providing either multidisciplinary care coordination or new behavioral health services, as patient needs dictate, staffed in part by Lahey Health Behavioral Services.

Community Health Workers

Shortly after launching its program, the Lahey Lowell Joint Award CHART team encountered a middle-aged homeless male who had over 30 ED visits over the span of two years. He frequented the ED due to intoxication, often with suicidal ideation. He has a documented traumatic brain injury and a diagnosis of substance induced mood disorder, but continued to refuse medications or care from a psychiatrist. He enrolled in the CHART program upon a qualifying ED visit. The CHART team's CHWs have since made thirteen subsequent contacts with this patient in various settings, providing education on insurance benefits, linkage to primary care, access to temporary housing, and a connection to a community support system. He now has a volunteer position at a local organization and regularly attends AA meetings.

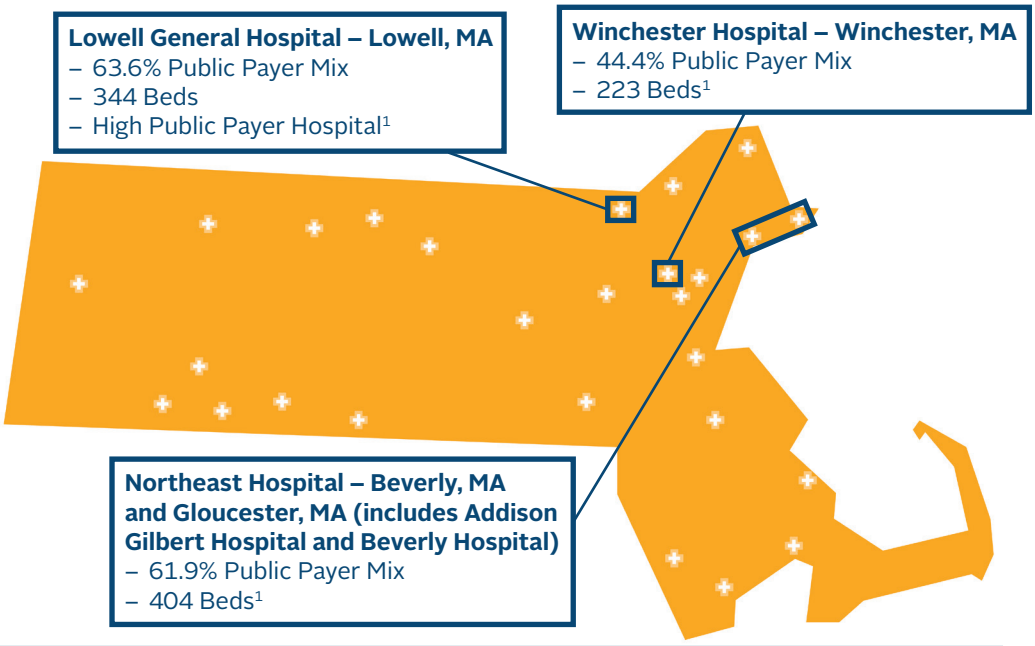

CHART & HPC Background

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MASSACHUSETTS
HEALTH POLICY COMMISSION
CHART INVESTMENTS

Baystate Franklin Medical Center, Baystate Noble & Baystate Wing Hospitals

FRANKLIN AND HAMPDEN COUNTIES

$1.04M
TOTAL PROJECT COST

$900K
HPC AWARD

Target Population & Aims

TARGET POPULATION
Lower acuity medically-focused Neurosciences, Adult Medicine (includes Pulmonary, Infectious Disease, Geriatrics/Palliative Care Services, Critical Care), and Cardiology patients

5,661
Admissions and
270
transferred admissions per year

PRIMARY AIM
Reduce lower acuity adult tertiary transfers by
20%

SECONDARY AIM
Reduce higher acuity adult tertiary transfers by
10%

Summary of Award

As a continuation of a Phase 1 pilot, Baystate Franklin Medical Center, Baystate Noble Hospital, and Baystate Wing Hospital will offer convenient specialty telemedicine consults in several service lines to keep appropriate care local and reduce inpatient transfers to academic medical centers. Teleneurology/telespeech, telecardiology, and telemedicine services will be available 7 days a week to maximize retention of patients in the community setting.

Telemedicine

The CHART grant provides an opportunity for Baystate Health's community hospitals to deliver specialty consults in a novel manner through the use of telemedicine. Residents of these communities are afforded **timely access to high quality specialty consultations for which they may have otherwise required transfer to a higher cost provider,** while staying comfortably and safely at their local hospitals.

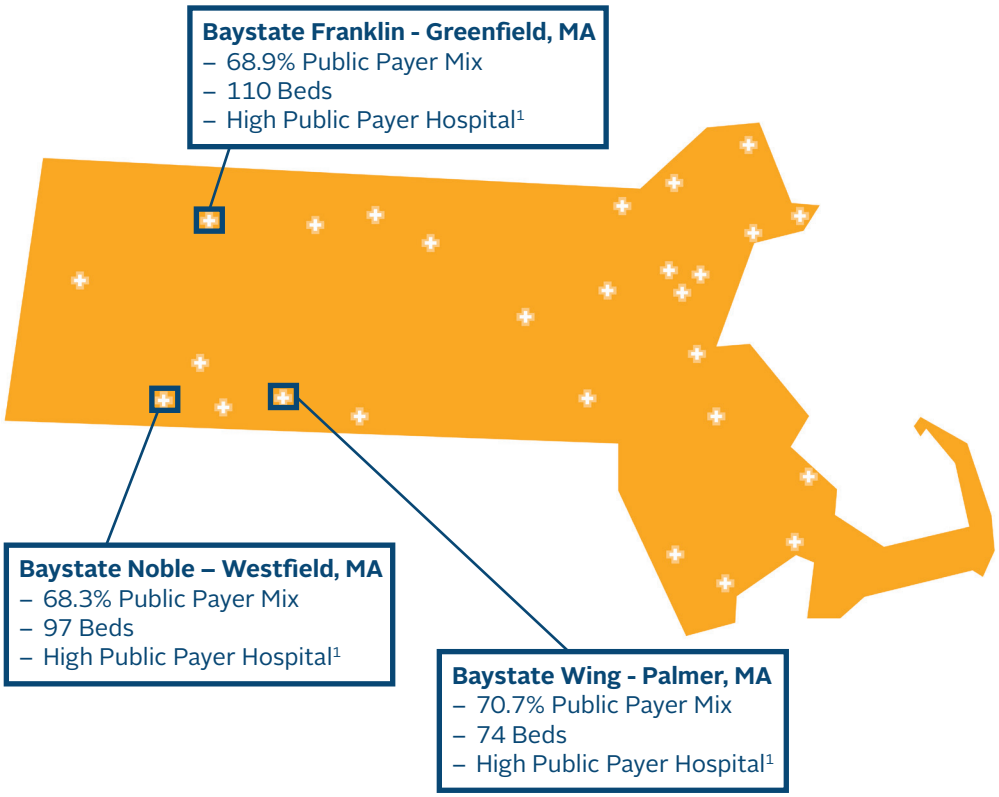

CHART & HPC Background

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1. Source: Center for Health Information and Analysis, 2017.

MASSACHUSETTS
HEALTH POLICY COMMISSION
CHART INVESTMENTS

Hallmark Health System

MIDDLESEX COUNTY

$2.8M
TOTAL PROJECT COST

$2.5M
HPC AWARD

Target Population & Aims

TARGET POPULATION 1
Patients with ≥10 ED visits in the last 12 months

2,359
ED visits for 147 unique patients

TARGET POPULATION 2
ED patients requiring a Narcan reversal or obstetric (OB) patients with substance use disorder (SUD)

339
Patients requiring Narcan reversal

46
OB patients with SUD

PRIMARY AIM
Reduce ED utilization by
20%

SECONDARY AIM 1
Increase post-ED contact with patients or families of patients who were seen in the Hallmark Health ED following an opioid overdose with Narcan reversal within 1 week of the index event by
25%

SECONDARY AIM 2
Provide at least 1 COACHH team contact per week for the duration of their pregnancy, for 80% of Hallmark Health OB patients with SUD as referred to the COACHH program

Summary of Award

The Hallmark Health joint hospital program aims to reduce Emergency Department (ED) utilization. Hallmark Health developed the Collaborative Outreach and Adaptable Care at Hallmark Health (COACHH) program to improve care for three patient populations: patients with high utilization of ED services, obstetric patients with active substance use disorder, and patients who experience an opioid overdose. Patients are engaged by a multidisciplinary team of community health workers, supported by social workers, a pharmacist, nurse practitioner, administrator, and primary care physicians to coordinate post-discharge follow-up care. The COACHH team aims to build relationships with patients to understand the root causes of patients' frequent use of the ED, and works closely with them to establish care plans, access to services, and stability within the community.

Patient Story

An elderly woman living alone had over 150 ED visits over the course of 15 months. Following a home visit with Hallmark staff, she enrolled in the COACHH program. The COACHH team made over ten home visits and many follow-up calls with the patient, collateral providers, her primary care provider, and family. The level of engagement with the patient, including assistance with simple logistical issues, has averted a pattern of anxiety and panic that historically resulted in an ED visit. Whereas prior to the COACHH team's intervention she may have had over 30 ED visits since enrollment, she has had only one ED visit lasting for just one hour.

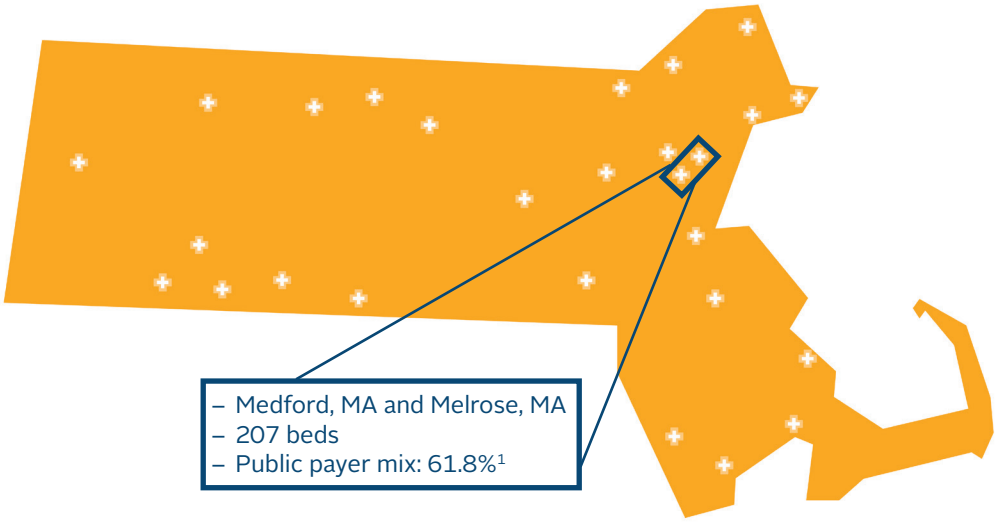

CHART Background

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1. Source: Center for Health Information and Analysis, 2017.

Heywood and Athol Memorial Hospitals

WORCESTER COUNTY

$3.3M
TOTAL PROJECT COST

$2.9M
HPC AWARD

Target Population & Aims

TARGET POPULATION
Patients identified by one or more of the following:

- ED patients with a behavioral health diagnosis
- Youth and families of the Gardner and Athol/Royalston school systems with behavioral health needs

5,500
ED visits per year

933
children and families

PRIMARY AIM
Reduce 30-day ED revisits by
10%

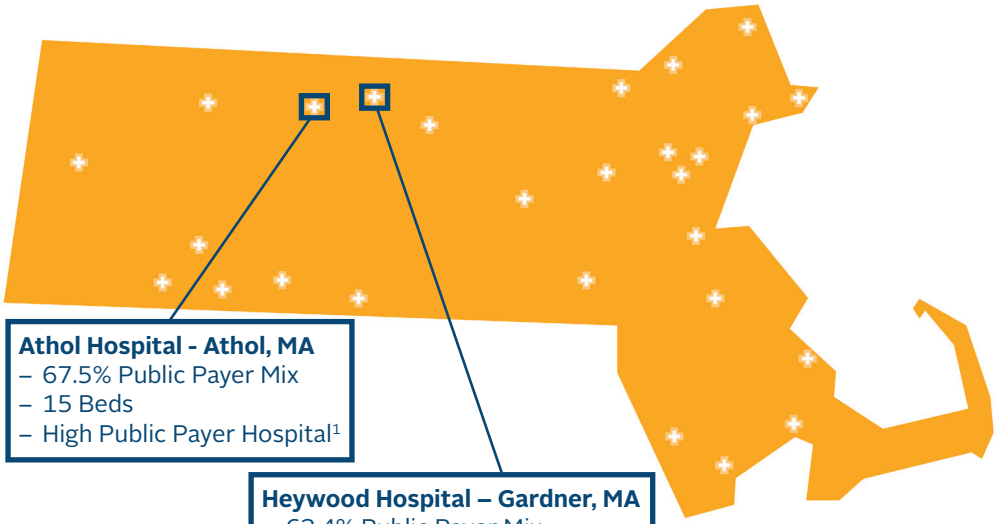
SECONDARY AIM
Increase referrals to behavioral health school-based services by
20%

Summary of Award

With the primary goal of reducing 30-day Emergency Department (ED) revisits by 10%, Heywood and Athol Memorial Hospitals launched a set of initiatives designed to expand behavioral health navigation services in North Central Massachusetts. The model includes an ED-based complex care team that provides intensive case management, behavioral health navigation, peer mentorship, and engagement with community health workers. Beyond the ED, the CHART initiative increased tele-psychiatry access, behavioral health integration in the primary care setting, a comprehensive community education campaign, enhanced addiction treatment services, and school-based case management and therapy services. To ensure patients receive comprehensive coordinated care, Heywood and Athol Memorial Hospitals offer continued community collaboration through the Regional Behavioral Health Collaborative in partnership with HealthAlliance Hospital.

CHART "adds a new focus to mental health that otherwise might not be addressed in the ED. There is a large population that...[without this program] wouldn't receive mental health services at all during an ED visit. We're capturing a population and providing assistance that may be overlooked by strict medical protocol."

- CHART Patient Navigator



Athol Hospital - Athol, MA
– 67.5% Public Payer Mix
– 15 Beds
– High Public Payer Hospital[1]

Heywood Hospital – Gardner, MA
– 63.4% Public Payer Mix
– 106 Beds
– High Pubic Payer Hospital[1]

CHART & HPC Background

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MASSACHUSETTS
HEALTH POLICY COMMISSION
CHART INVESTMENTS

Southcoast Hospitals Group

BRISTOL AND PLYMOUTH COUNTIES

$9.16M
TOTAL PROJECT COST

$7.5M
HPC AWARD

Target Population & Aims

TARGET POPULATION
Patients with a personal history of high utilization of the hospital or ED

14,288
ED visits for 945 unique patients

6,537
hospitalizations for 1,241 patients

PRIMARY AIM 1
Reduce 30-day readmissions by
20%
for patients with high utilization of the hospital

PRIMARY AIM 2
Reduce 30-day ED revisits by
20%
for patients with high utilization of the ED

SECONDARY AIM
Reduce ED length of stay by
20%

Summary of Award

Southcoast Hospitals Group aims to reduce 30-day readmissions by 20% for patients with a personal history of recurrent inpatient utilization and reduce 30-day Emergency Department (ED) revisits by 20% for patients with a personal history of recurrent ED utilization. At St. Luke's Hospital and Charlton Memorial Hospital, Southcoast Hospitals Group is deploying multidisciplinary care teams (including a physician, mid-level prescriber, RN, social worker, nurse case manager, community health workers, a clinical pharmacist, a community resource specialist, and a diabetes educator) to care for patients. Teams provide intensive medical and behavioral health services, linkages to outpatient treatment providers, palliative care, diabetes education, and assistance accessing social services support.

Patient Story

A patient with frequent utilization of the ED averaged approximately 5 ED visits per month. In an effort to intervene and increase appropriate service utilization, a community health worker held a series of phone calls and in-person meetings with the patient. She successfully connected the patient with services in the community to better serve her needs. Following these interventions, the patient's ED utilization decreased dramatically.

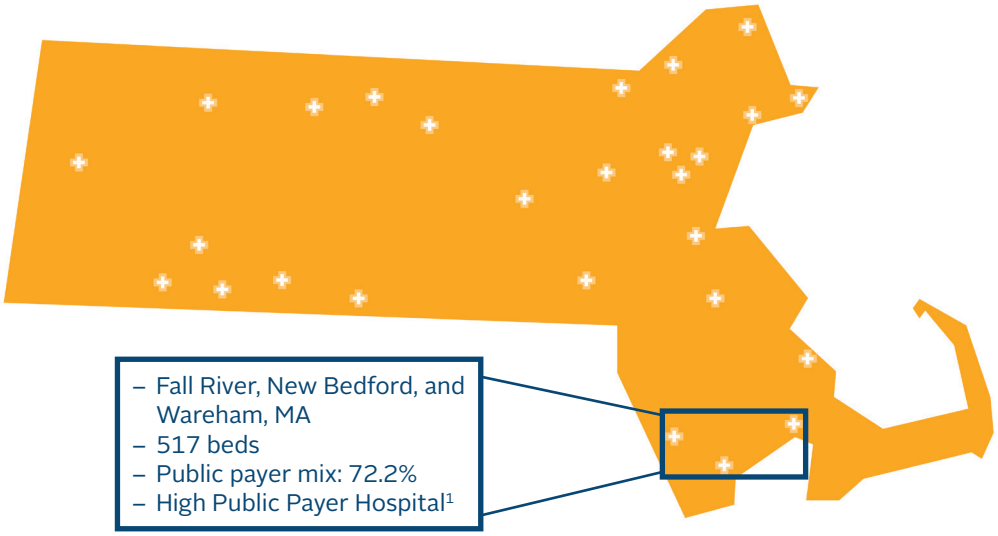

CHART & HPC Background

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