COACHH

Collaborative Outreach and Adaptable Care at Hallmark Health

QIPP

June 22, 2016

Hallmark Health System

Outline

1. Hallmark Health and CHART
2. Service Delivery Paradigm
3. Case Vignettes
4. Preliminary Findings
5. Challenges and Innovations
6. Questions and Discussion

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HALLMARK HEALTH AND CHART

CHART 1

- Award for the development of a pilot program to reduce opioid prescriptions in the Emergency Department for patients with back pain
- Focused on prescriber protocols and training
- Reduced opioid prescriptions for back pain patients by 11%-13% in 3 month pilot in 2014

CHART 2 HPC Award

Funding to provide services that are *currently* beyond the reimbursement realities of the healthcare system

CHART 2

- Align healthcare resources, reduce ED overutilization, and coordinate services for defined cohorts of complex patients
- Reduce ED utilization by 20% for high utilizing patients over the 24 month period of performance
- Track data and performance with enabling technology

COACHH: It Takes a Village..

- Senior HHS Leadership: Steven Sbardella, MD, Chief Medical Officer, Ryan Fuller, VP of Strategic Planning, William Doherty, MD, Chief Operating Officer

- Internal Partners: Emergency Department, Quality, Finance, Community Services, Information Technology, Nursing, Behavioral Health, Maternal Child Health

- Community Partners: HPC, CCTP, Mystic Valley Elder Services, Eliot Community Human Services, Local Police Departments, Middlesex District Attorney's Office

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SERVICE DELIVERY PARADIGM

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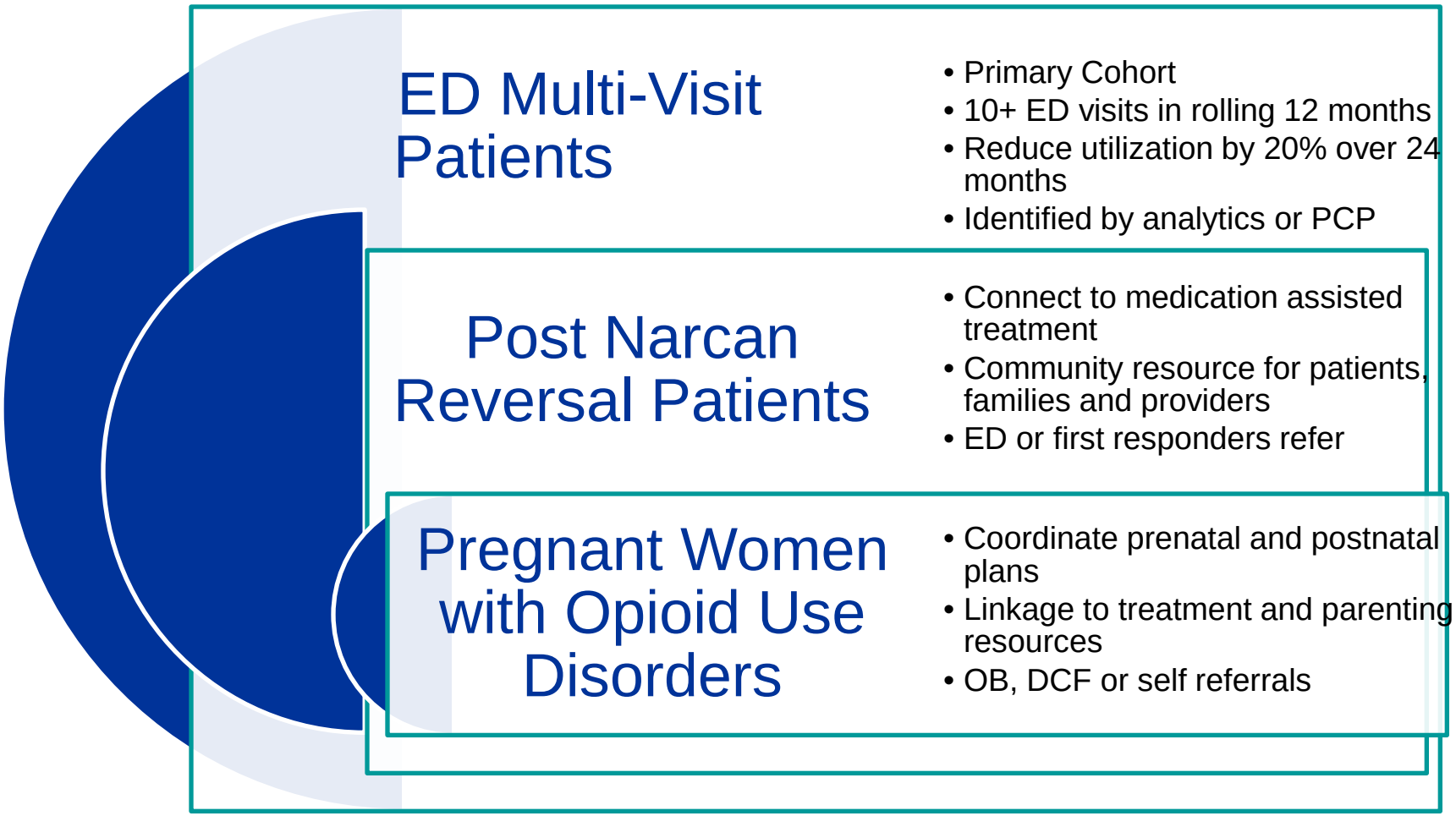
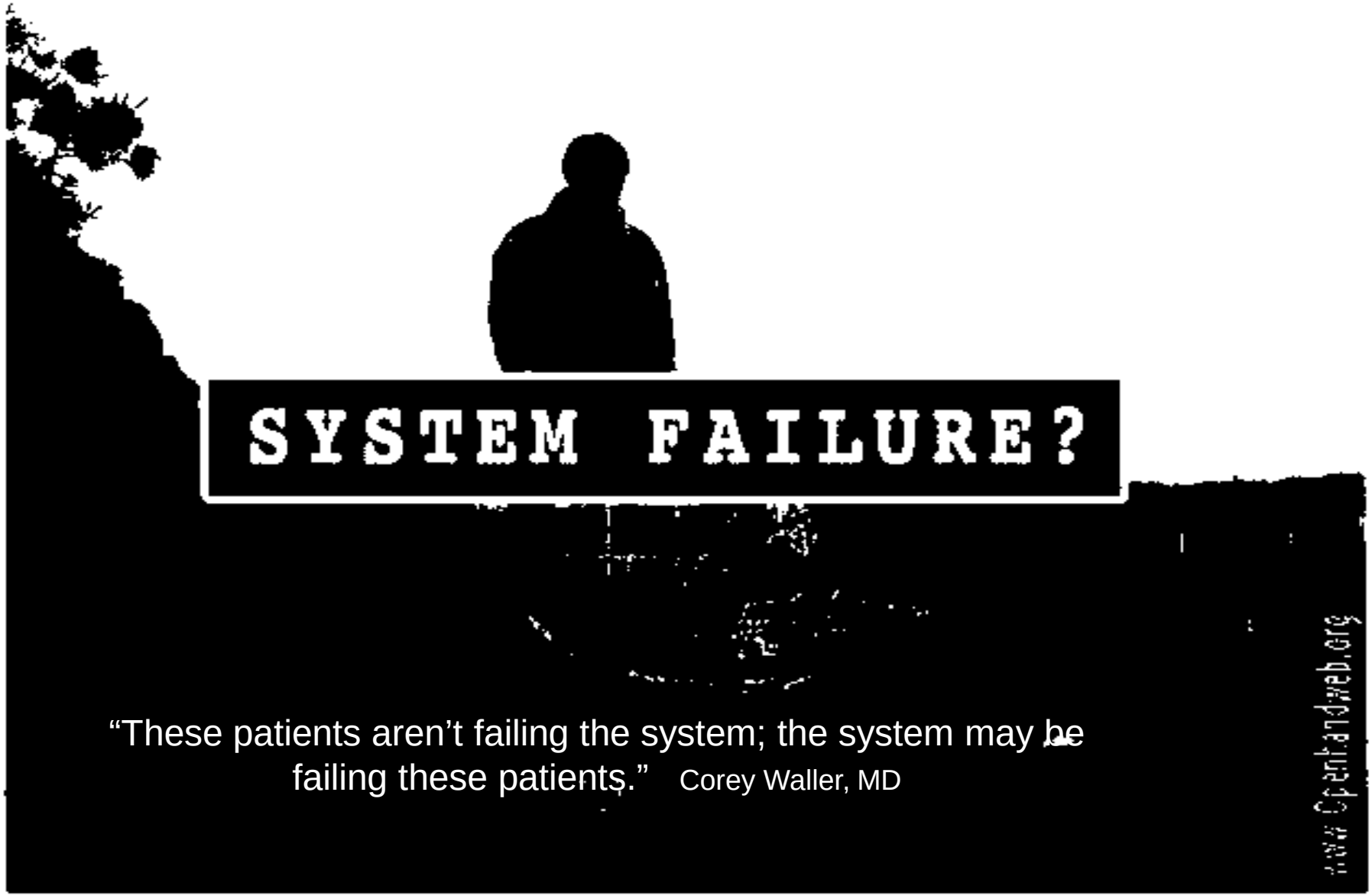
Enhance Not Replace

COACHH: Three Cohorts



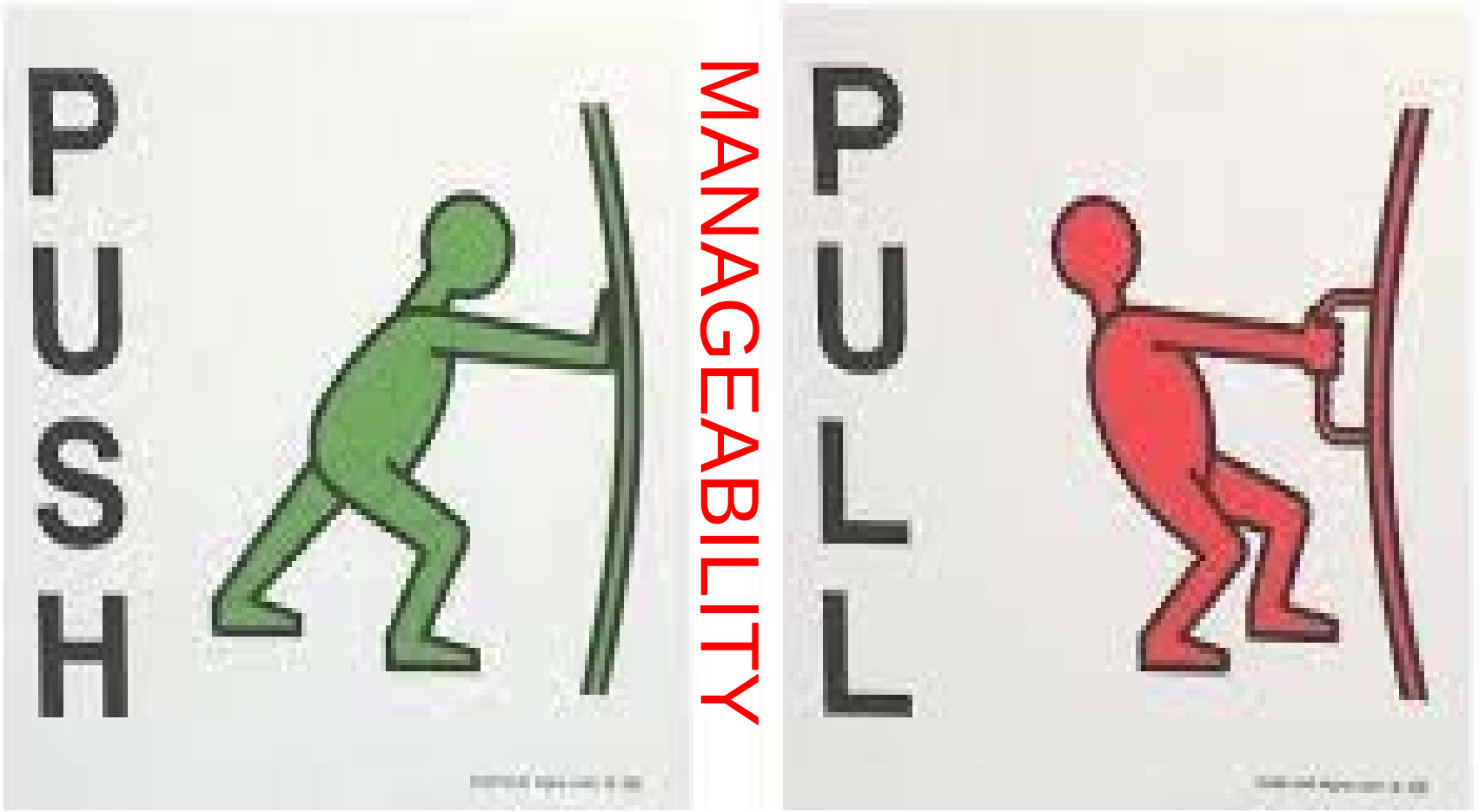


"These patients aren't failing the system; the system may be failing these patients." Corey Waller, MD

COACHH: Guiding Principles

- Focus on collaboration, empowerment, prioritization of needs, and harm reduction
- De-medicalization of the target populations
- Patient Driven/Provider Informed
- Innovative longitudinal vs. episodic interventions
- Elimination of the ED as the default crisis plan for community providers

COACHH: Access to Care



Hallmark Health

The COACHH Team

- Beth Lucey, LICSW: Social Work Supervisor
- Ann Marie Zeimetz, Collaborative Care Coach
- Amy Lemieux, PharmD: Pharmacist
- Gerdine Marsan, Collaborative Care Coach
- Jacqueline Walthall, Collaborative Care Coach
- Lina Feldman, MD, Physician Consultant
- Xiaohui Wang, PhD, MD, Physician Consultant
- Maggie Pierre, RN, NP, Nurse Practitioner
- Carol Plotkin, LICSW, Executive Director
- Suzanne Mitchell, MD Jacob Howe, MD, Training Consultants

COACHH: Launch Activities

- Daily Team Huddles: Focus on safety, communication, education, and collaboration
- Patient Identification via Data Analysis
- Patient Engagement and Enrollment
- Provider and Community Buy In

COACHH: Service Model

48 Hour Follow Up

- All patients contacted within 48 hours of discharge

Consistent Contact

- Weekly phone calls, home visits
- 24 hour on call coverage
- To date: 10 contacts per patient served

Array of Services

- NP, Social Work, Pharmacy, Care Coordination, Health Coaching, Care Plans

COACHH: Visit Locations

Patient Homes

Community: e.g. Coffee Shop/Library/T stations

Emergency Departments

Inpatient Psychiatric and Medical Units

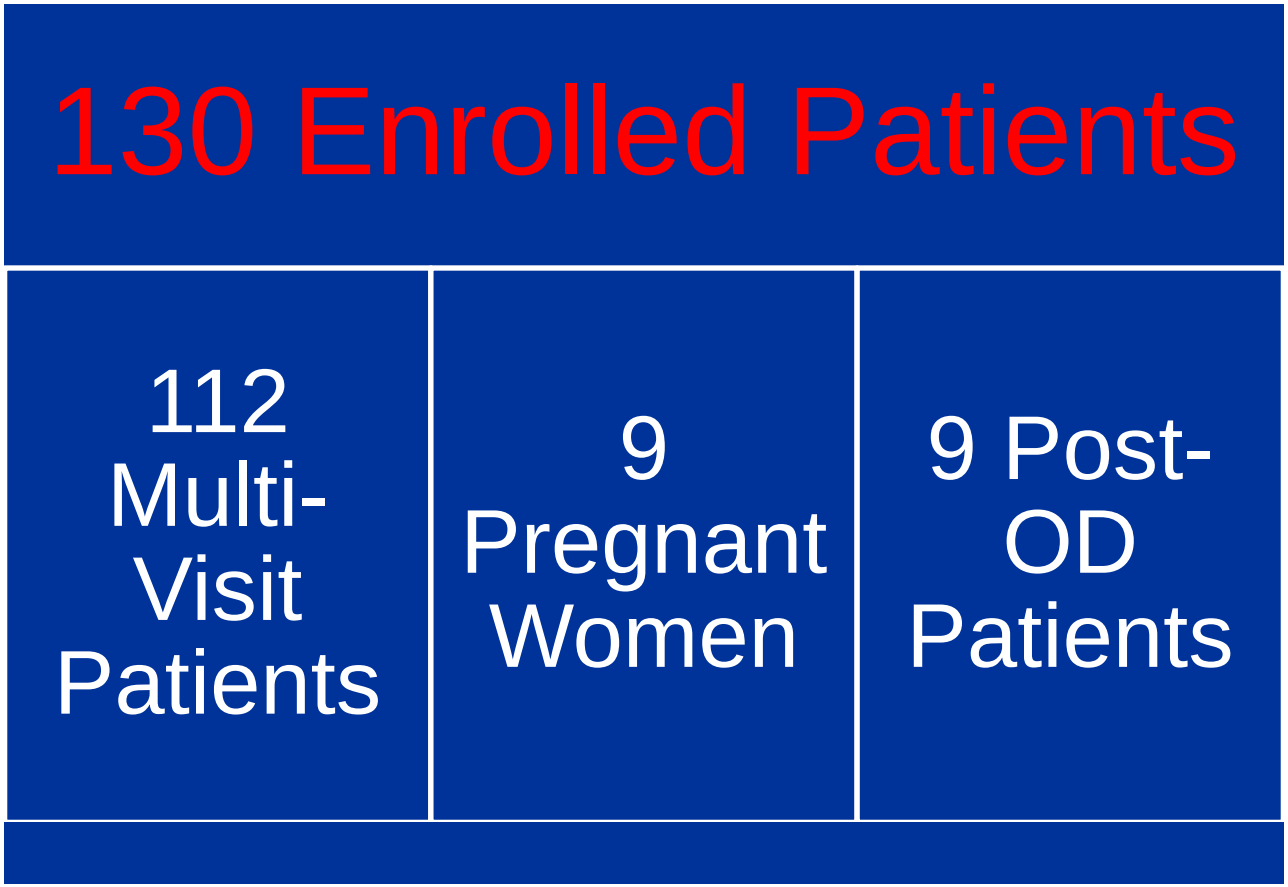
Medication Assisted Treatment Programs

Nursing Homes/Group Homes/Rehab

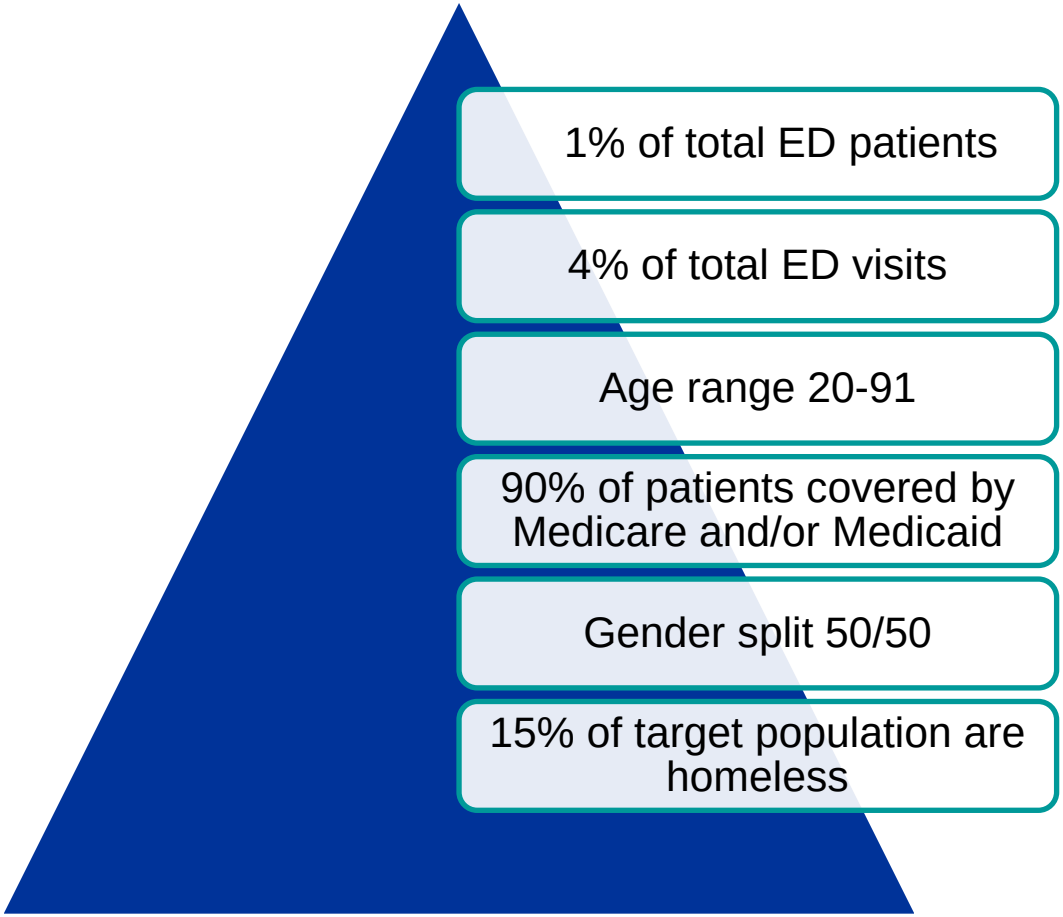
PCP/Specialist Offices

COACHH Office

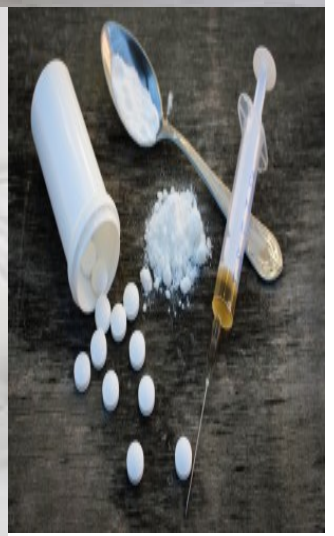
COACHH: Six Month Enrollments



MVP Target Population Factoids



Patient Vignettes



COACHH: MVP

- Senior Citizen with > 150 ED visits in one year for migraines and abdominal pain
- Lives alone; limited financial and social resources; history of anxiety
- Well known to many local care providers and agencies

Basic, Very Basic, Interventions

Hallmark Health

Saving Money and Aligning Resources

Two ED visits at HHS since enrollment in COACHH. Weekly home visits and daily calls made by the COACHH team and crisis plan developed with ED team.

At the run rate of 3 ED visits per week, an estimated **70** ED visits *may* have been averted in the past six months.

The Opioid Epidemic

A young member of the community was referred to COACHH by the Chief of Police following one of multiple heroin overdoses with Narcan reversals in one year. The COACHH social worker met with the patient in the ED; the patient initially declined participation. The social worker persisted with outreach efforts and subsequently enrolled the patient in COACHH. Referrals to detox and methadone maintenance were facilitated. The patient is making significant progress with recovery and return to work. One of the Collaborative Care Coaches meets with the patient weekly.

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PRELIMINARY FINDINGS

COACHH: Initial Results

COACHH	# of Patients	% Change
ED Visits 30 Days PrePost Enrollment	**106**	**-19%**
ED Visits 90 Days PrePost Enrollment	**72**	**-12%**
ED Visits 180 Days PrePost Enrollment	**10**	**-50%**

Clinical Drivers of Utilization

- Substance Use Disorders
- Serious and Persistent Mental Illness
- Chronic Pain

Socioeconomic Drivers of Utilization

Social Isolation

- Elders at home/Elders at risk
- Young adults aging out of “the system”

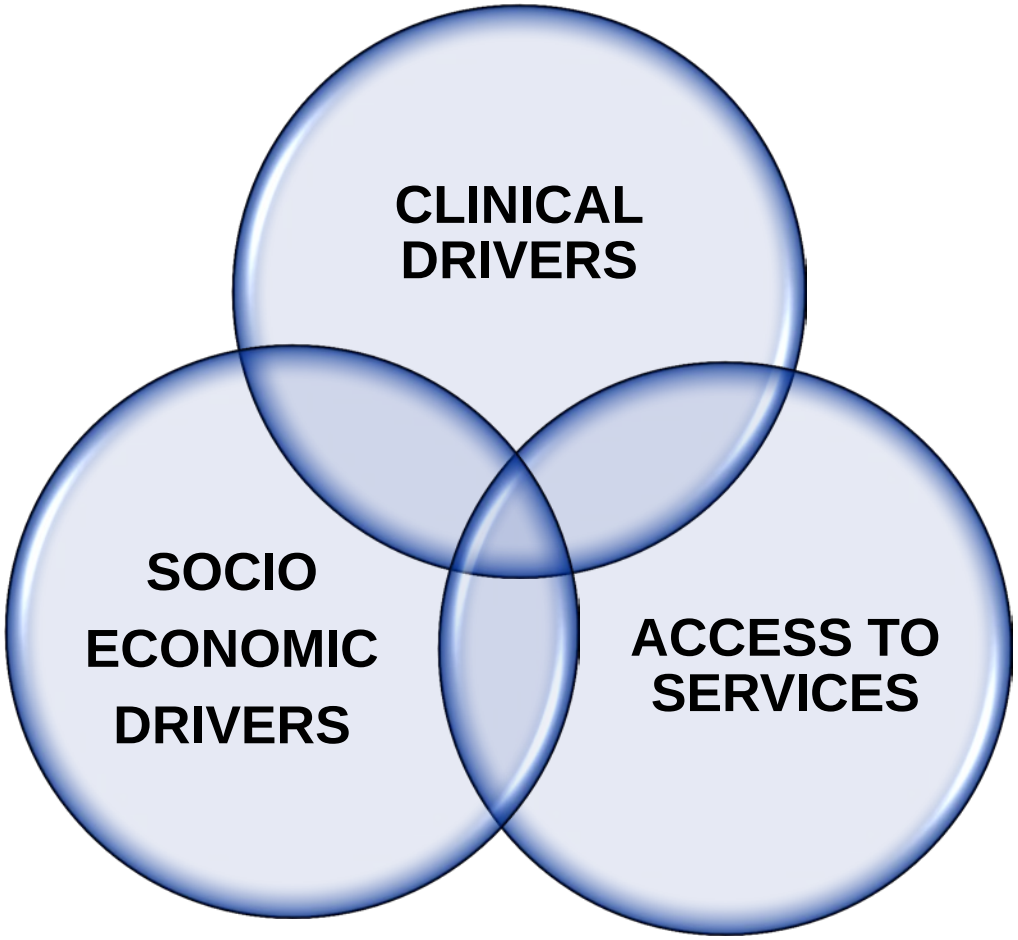
Poverty

- Homelessness
- Food Insecurity

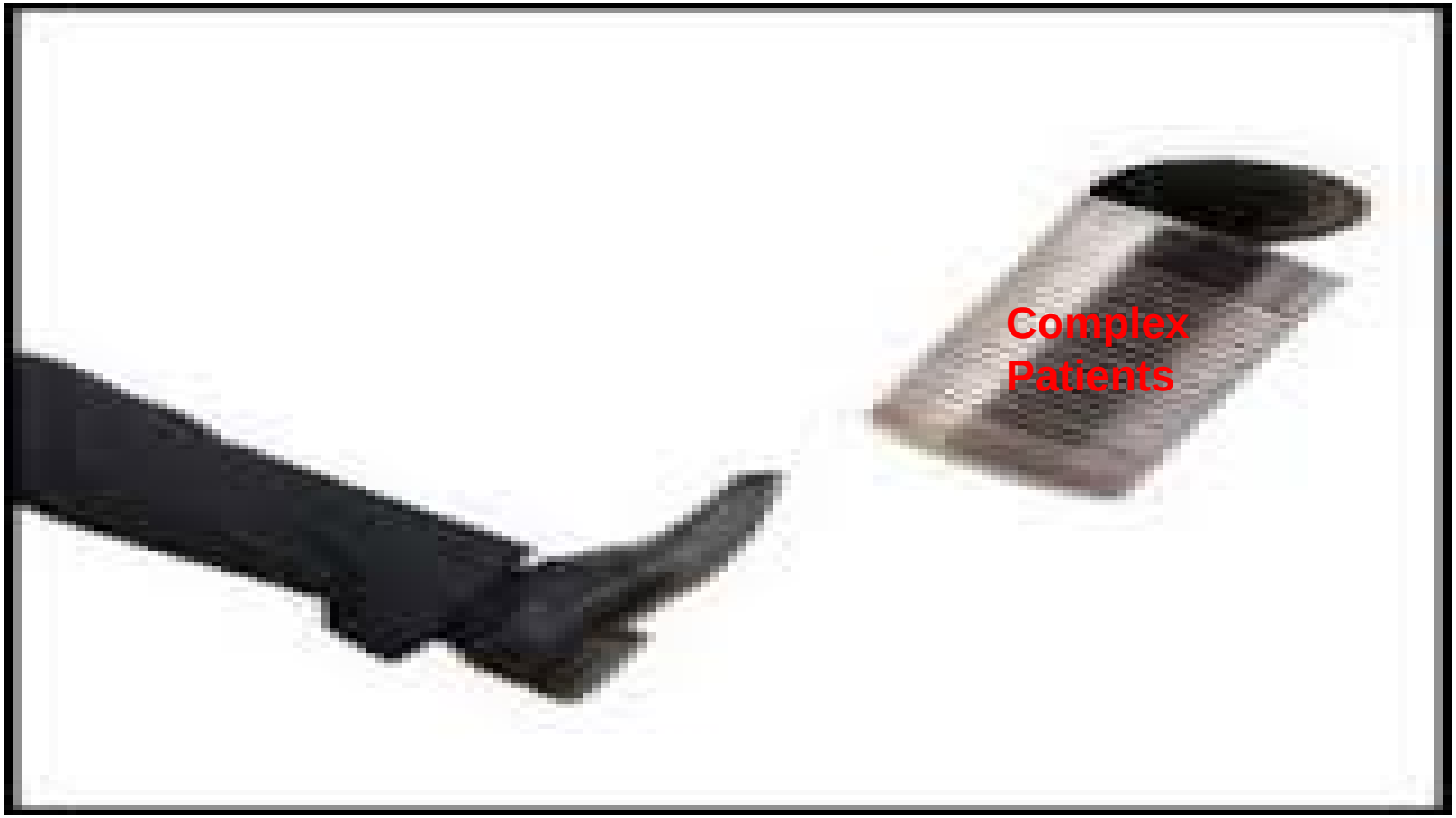
Dis-Integrated Care

- Matching individual needs to available care
- Resource fatigue

COMPLEX PATIENTS



Treatment Ownership



COACHH: Observations

- The majority of high utilizing patients do not visit the ED solely for medical treatment
- Thawing treatment freeze sparks creativity
- A highly engaged team may influence patterns of utilization
- A synergistic relationship exists between provider/patient behavior

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CHALLENGES AND INNOVATIONS

COACHH: Challenges

- Resources for patients with chronic pain, substance use disorders, homelessness, elders at home
- Stigma that freezes care: “Frequent Fliers”, “Addicts”, “Non-Compliant”
- Episodic vs Longitudinal Care
- SUSTAINABILITY

Selected Community Activities and Innovations

- Middlesex District Attorney's Pilot on Identifying Patients at High Risk for Fatal Overdose
- Group for Pregnant Women at Middlesex Recovery
- Collaboration with Local Police and Fire Departments
- Collaboration with DMH, DDS, DCF, Crisis Teams, Group Homes
- Community Presentations on Opioid use, Mental Health and COACHH

COACHH: Next Steps

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On behalf of Hallmark Health and the COACHH team, thank you for your interest and support.