CHART COMMUNITY HOSPITAL ACCELERATION, REVITALIZATION, AND TRANSFORMATION INVESTMENT PROGRAM

CHART PHASE 2 STATEWIDE CONVENING

Lessons from 2 years,
25 awardees,
and $60 million

MASSACHUSETTS
HEALTH POLICY COMMISSION

About the Health Policy Commission

Established through the Commonwealth of Massachusetts' landmark cost containment law, Chapter 224 of the Acts of 2012, the Health Policy Commission (HPC) is an independent state agency governed by an 11-member board with diverse experience in health care. The HPC is leading efforts to advance Chapter 224's ambitious goal of health care cost containment. The HPC's mission is to advance a more transparent, accountable, and innovative health care system through independent policy leadership and programs. Our goal is better health and better care at a lower cost across the Commonwealth.

About the CHART Investment Program

The Community Hospital Acceleration, Revitalization, and Transformation (CHART) Investment Program makes phased investments for certain Massachusetts community hospitals to enhance their delivery of efficient, effective care. CHART hospitals share the common characteristics of being non-profit, non-teaching, and having low relative price. 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. In CHART Phase 1, a total of $10 million was distributed to 28 community hospitals to support short term, high-need expenditures. The HPC awarded a total of $60 million in CHART Phase 2 funding across 25 hospital programs.

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MASSACHUSETTS
HEALTH POLICY COMMISSION

October 16, 2017

We are honored to share this day with you as Phase 2 of the Community Hospital, Acceleration, Revitalization, and Transformation (CHART) Investment Program awardees present lessons learned and important insights from their care delivery redesign initiatives. Five years ago, the Health Policy Commission (HPC) began planning the first phase of CHART, designed to build organizational capacity within eligible Massachusetts community hospitals for care delivery transformation. Many CHART Phase 1 pilots informed the framework for Phase 2 care delivery models.

September of 2015 marked the rolling launch of CHART Phase 2 clinical transformation programs to reduce unnecessary hospital utilization, enhance care for patients with complex social, behavioral, and medical needs, and improve post-acute care in the community. Over the last two years, 27 community hospitals participating in 25 CHART programs employed over 250 full time equivalents to serve thousands of patients across Massachusetts. Now reaching the end of the program, we are in awe of the accomplishments of CHART Phase 2 programs and their tremendous effort and capability to deliver high-quality, low-cost care to the Commonwealth's most vulnerable individuals.

To the CHART Phase 2 hospital teams and their community partners – thank you for your impressive hard work, commitment, and dedication as you reach, serve, and positively impact thousands of patients and their families.

To our colleagues in the field – thank you for joining us in today's discussions and for your contribution to this work.

Today and beyond, we look forward to continuing to learn from each other for better health and better care, at a lower cost, in Massachusetts.

Warm regards,

David Seltz
Executive Director

AGENDA

8:00AM	Registration and Breakfast
8:30AM	Welcome
8:45AM	CHART Model and Accomplishments
9:15AM	**Rapid Fire Results Panel 1** Reducing Readmissions for High Risk Patients
9:50AM	**Rapid Fire Results Panel 2** Slowing the Cycle of High Utilization for Multi-Visit Patients
10:20AM	Morning Break
10:45AM	**Rapid Fire Results Panel 3** Improving Care for Behavioral Health Patients in the Emergency Department
11:20AM	**Panel 4** Lessons Learned, Capabilities Developed, and the Future
12:15PM	Lunch
1:00PM	Breakout Session 1
1:50PM	Afternoon Break
2:00PM	Breakout Session 2
3:00PM	Summative Remarks and Lessons Learned
3:30PM	Adjourn
4:00PM	Celebration for CHART Phase 2 Teams

DAVID SELTZ, *Executive Director*

Massachusetts Health Policy Commission

David Seltz is the first Executive Director of the Massachusetts Health Policy Commission (HPC). Prior to this role, Mr. Seltz was the chief health care advisor for then-Senate President Therese Murray and served as the Special Advisor on health care for former Governor Deval Patrick (MA). Through these positions, Mr. Seltz advised the passage of Chapter 58 of the Acts of 2006 and Chapter 224 of the Acts of 2012. Mr. Seltz is a 2003 graduate of Boston College and originally from Minnesota. He was a recipient of Modern HealthCare's 2015 Up and Comer Award, which recognizes young executives that have made significant contributions in the areas of healthcare administration, management or policy.

THE STRATEGIC INVESTMENT TEAM

Massachusetts Health Policy Commission

The HPC's Strategic Investment Team is responsible for developing and implementing the agency's investment strategy, including administering two innovative grant programs, totaling nearly $160 million. The Community Hospital Acceleration, Revitalization, and Transformation (CHART) Investment Program and the Health Care Innovation Investment (HCII) Program collectively represent a key component of the Commission's broad mandate to increase health care quality and access while reducing cost growth in the Commonwealth. The team is further responsible for developing and implementing innovative care delivery pilot programs focused on enhancing and integrating behavioral health care. Led by Director Kathleen Connolly, MSW, LICSW, the team is comprised of 15 staff that manage relationships with investment awardees, administration and operations of the programs, evaluation, and learning and dissemination.

AMY BOUTWELL, MD, MPP, *President*

Collaborative Healthcare Strategies

Amy Boutwell is the Strategic and Technical Advisor for the HPC's CHART Investment Program since the program's inception. Dr. Boutwell is a nationally recognized thought leader in the field of reducing readmissions and improving care for patients with high utilization, advising large-scale initiatives to reduce readmissions and improve care for high utilizers nationally. In collaboration with the Health Policy Commission, Dr. Boutwell designed the model methodology that unifies all 25 programs, and provided over 325 in-person, site specific implementation coaching sessions and over a dozen regional and statewide learning sessions over the two year implementation period. Dr. Boutwell is the co-developer of the Institute for Healthcare Improvement's strategy to reduce avoidable hospital use at the state level (STAAR) and the co-developer of the *AHRQ Hospital Guide to Designing and Delivering Whole-Person Transitional Care* (ASPIRE Guide). Dr. Boutwell is a graduate of Stanford University, Brown University School of Medicine, and the Harvard Kennedy School of Government where she received the Robert F. Kennedy Award for Excellence in Public Service. She trained in primary care internal medicine at Massachusetts General Hospital and practices hospital medicine.

PANEL 1

Panel 1: Reducing Readmissions for High Risk Patients

SANDI AKERS, RN, MSN, *Clinical Administrator, CHART Grants*

Addison Gilbert and Beverly Hospitals

As the Clinical Administrator for the Addison Gilbert and Beverly Hospital CHART Grants, Sandi provides clinical leadership and oversight for the multidisciplinary team of registered nurses, a nurse practitioner, social workers, community health workers, pharmacists, and a data analyst. The target population served by this program includes patients with high utilization, patients with readmissions within 30 days, and patients with social complexity. Sandi supports the team through weekly clinical case review, ED action planning meetings, and advocacy for the team's mission throughout the Lahey Health system and greater community. Prior to joining Lahey in this role, Sandi worked for the Department of Public health in various roles including Bureau Director for Public Health Hospitals and CEO of Tewksbury Hospital.

MARGARET FOLEY, RN, MSN, *Director, Care Management*

Emerson Hospital

As the Director for Care Management at Emerson Hospital, Margaret is responsible for overseeing CHART program development, job development, and interdepartmental collaboration within the hospital as well as ensuring partnerships with the local community agencies and post-acute care facilities. Margaret also leads the Care Transitions Collaborative, which is comprised of Emerson Health System and community leadership to improve transitions of care for patients in to the community. She has experience in providing leadership in clinical practice, strategic planning, and operational aspects of case management.

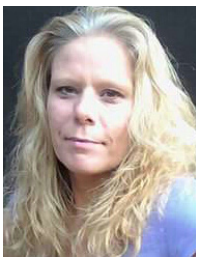
ELIZABETH BINARI, RN, MHA, *Program Manager, Community Case Management*

Beth Israel Deaconess Hospital - Plymouth

As Manager for the BID – Plymouth Community Case Management Complex Patient Program, Elizabeth oversees a multidisciplinary care team that consists of a curse case manager, social work case manager, and resource specialist. The CHART team provides targeted outreach and engagement to Beth Israel Deaconess Care Organization dual eligible (Medicare and MassHealth) aged and/or disabled patients, with complex medical and/or behavioral health needs, who are at high risk for hospital readmission, repeat ED visits, and who may incur high health care costs with poor health outcomes. Elizabeth provides daily operational oversight, drives workflow design and implementation, compiles and reports CHART data, and collaborates with internal and external partners to promote the Complex Patient Program Case Management model and its successes.

DEBI NICHOLS, RN-CM, LNC, *Case Manager*

Baystate Wing Hospital



As the RN Case Manager of Baystate Wing Hospital's CHART team, Debi coordinates the daily activities of the CHART team, comprised of an RN and two social workers. Debi's role consists of managing and organizing each team member's daily assignments, including home visits, telephone support, 48-hour discharge calls, patient engagement on the unit, daily huddles, and weekly team meetings. Debi has been instrumental in facilitating discussions about the most effective and efficient way to provide services to those in Baystate Wing's catchment area. Debi brings knowledge of the community and its needs with 25 years of direct care experience with a diverse population of patients, 10 years of managerial experience, and 8 years of home care with Baystate Wing VNA and Hospice. She holds a Legal Nurse Consultant certification and certificates in Statistics, Global Healing Systems, Mindfulness and Happiness, Violence Prevention and Awareness, and Stress Management.

Panel 2: Slowing the Cycle of Utilization for Multi-Visit Patients

MARY BETH STRAUSS, DNP, RN, NE-BC,
Director of Quality/Patient Safety and Magnet Program Director
Winchester Hospital

As the Project Manager of the Winchester Hospital CHART team, Mary Beth is responsible for the management and operation of this successful, multi-faceted program. With her background as Director of Quality and Patient Safety, she inspires and encourages innovative quality improvement initiatives to deliver the most effective care to patients with high utilization and patients who are discharged to post-acute care. She ensures the team is well supported with the resources they need to make the greatest impact. Mary Beth is the liaison to senior management and serves as champion for this dynamic team, communicating its successes and promising innovative practices to hospital leadership.

CAROL PLOTKIN, LICSW, *Executive Director, COACHH*
Hallmark Health System

As the Executive Director of COACHH—Collaborative Outreach and Adaptable Care at Hallmark Health—Carol has the privilege of leading an outstanding team that includes a nurse practitioner, social work supervisor, pharmacist, physician, and three collaborative care coaches. Carol supports the "COACHH Culture" of flexibility, creativity, safety, and clinical excellence through consistent communication, continuous learning and shared problem solving. Prior to Carol's role with COACHH, she was the System Director of Behavioral Health at Hallmark Health and looks forward to the challenges ahead in the development of integrated care delivery systems.

TRACY CLAPP, BSN, RN, *CHART Program Manager*
Baystate Noble Hospital

As Program Manager of the Baystate Noble Hospital CHART team, Tracy oversees a highly skilled multidisciplinary team composed of nurses, social workers, and mental health clinicians. Tracy holds daily safety huddles to discuss high risk patients and encourages innovative thinking for care plans and complex discharges to ensure a safe transition home. She has fostered strong relationships with community providers and hospital staff to promote high quality care and improved outcomes. Prior to this role, she was a Clinical Liaison for Baystate Home Infusion and Respiratory and has accepted a position as the Educator and Manager of Case Management which will allow her to continue integrating the most effective components of CHART.

PADMA BHERI, MBA, *CHART Project Manager*
UMass Marlborough Hospital

As Project Manager of Marlborough Hospital's CHART team, Padma monitors the program's metrics and the performance of the integrated care team which consists of case managers, social workers, and a mental health counselor. Padma assists to make evidence-based decisions, frequently evaluates for any missing opportunities, and improves efficiency for a successful program. She collaborates with the clinical program manager and hospital leadership to promote the CHART team's activities. Prior to this role, Padma worked in various population health-focused programs and research studies.

LISA BROWN, PMHNP, *Psychiatric NP, Circle Care Behavioral Health*
Lahey/Lowell Joint Award

As a Psychiatric Nurse Practitioner for the Lowell General Hospital team within the Lahey/Lowell Joint Award, Lisa provides oversight and guidance to a team of social workers and community health workers. Lisa has a diverse background in oncology, HIV nursing, and addiction. She leveraged her experience and extensive training to provide expert clinical care to a high risk patient population with critical behavioral health needs. She is a confident and capable leader who inspires a determined clinical team, "making the patient's world smaller" by coordinating care across the continuum to address patients' most pressing social and mental health needs.

PANEL 3

Panel 3: Improving Care for Behavioral Health Patients in the Emergency Department

MARIA WATERHOUSE, RN, BSN, *CHART Program Coordinator*

Harrington Memorial Hospital

As Program Coordinator of Harrington Memorial Hospital's CHART team, Maria oversees a multidisciplinary care team of patient navigators and social workers. The Harrington CHART team endeavors to serve behavioral health patients with high utilization of the ED. Maria ensures that the team is supported by promoting a team-based approach to serving complex patients to prevent burnout, performing caseload reviews with the social worker on a biweekly basis, and liaises with hospital leadership to promote further integration of the CHART team into hospital operations. Prior to this role, Maria was a Registered Nurse in a nearby city hospital providing direct nursing care to patients with a multitude of comorbidities, including behavioral health and substance use disorders.

SELENA JOHNSON, *CHART Project Manager*

Heywood and Athol Hospitals

As Project Manager of Heywood Healthcare's CHART Team, Selena oversees a multidisciplinary care team of navigators and community health workers across two campuses: Heywood Hospital and Athol Hospital. The Heywood/Athol CHART team focuses on 30-day ED revisit reduction for behavioral health patients through a whole-person, team approach to patient engagement, care coordination, and enhanced patient support emphasizing access to appropriate services post-ED. Heywood's CHART team is located in the heart of the ED, identifies patients in real time, and has become blended within the overall ED structure. A key initiative moving forward will be to continue to advocate for, and work towards, behavioral health integration across the health system.

MARIAN GIROUARD-SPINO, RN, MSN, CCM, *Director of Care Integration*

Beth Israel Deaconess Hospital - Milton

As Director of Care Integration, Marian oversees a multidisciplinary Care Integration Team from BID-Milton and South Shore Mental Health who provide care in the BID-Milton ED. The Care Integration Team includes two social workers, a part-time music therapist and chaplain, an ED physician and RN champion, a part time pharmacist, a security officer and administrative and analytical support. Care Integration patients receive a bundle of services to reduce their risk of symptom escalation, including more timely crisis evaluation, insurance verification, care transition management, therapeutic interventions (i.e., cognitive behavioral therapy), medication management, music therapy, faith counseling, peer services, and familial counseling. All services are focused on the goal of improved patient care and reducing long stay boarding time in the ED.

MELISSA PERRY, BS/BA, RN, *CHART Project Manager*

Holyoke Medical Center

As Program Manager of Holyoke Medical Center's CHART team, Melissa oversees a multidisciplinary care team of patient navigators (social workers, LMHCs and RNs), psychiatrists, community mental health workers, recovery coaches, and a physician. Holyoke's CHART team serves behavioral health patients in the ED to intervene, provide navigation, and follow-up to prevent avoidable 30-day ED revisits. The team collaborates with community providers and agencies including the Department of Mental Health (DMH) and Community Based Flexible Supports (CBFS) as well as hospital medical case management and medical high utilizer teams. Every other month, she and the team meet with community providers to establish appropriate supports to stabilize patients in the community. Additionally, Melissa is the Director of Behavioral Health at Holyoke Medical Center and sits on the board of River Valley Counseling Center and on the Western Massachusetts DMH Citizen's Advisory Board.

Panel 4: Lessons Learned, Capabilities Developed, and the Future

PAUL MACKINNON, PhD, RN, *Corporate Executive Vice President and COO, UMass Memorial HealthAlliance-Clinton Hospital*

HealthAlliance Hospital

As the Investment Director for the CHART Program, Paul brings a wealth of knowledge to the program with over 40 years of health care experience. His career began in public mental health where he worked as a crisis intervention specialist. His career progressed as Registered Nurse in the ED setting where he expanded his skills in caring for patients with medical illness, addiction, and psychiatric issues. Paul received his Ph.D. in research focusing on violence in the ED as it correlates to staff and the community. Paul is an active clinician as a Family Nurse Practitioner. In his role as the hospital's Chief Operating Officer, he understands the program from the patients' view and the impact to the organization and community.

MARY ANN DOERR, *Director of System Development and ACO Operations*

Beth Israel Deaconess Hospital - Plymouth

As Director of System Development and ACO Operations at BID – Plymouth, Mary Ann serves as the Program Manager for the CHART Program. In this capacity, she provides administrative oversight for the three initiatives within the program: 1) The Integrated Care Initiative, 2) The Complex Patient Program, and 3) The ED Behavioral Health Program. She is instrumental in identifying synergies and promoting collaboration across each program. She has extensive involvement with internal and community partners and promotes strategic planning and relationship building. Mary Ann has final oversight for the monthly CHART metrics and is the identified liaison with the Health Policy Commission. She is a strong advocate for all program awardees and is a true champion of their exceptional work.

NICOLE GARABEDIAN, RN, MSN, *Director of Integrated Care*

Lawrence General Hospital

As Director of Integrated Care at Lawrence General Hospital, Nicole oversees a multidisciplinary department consisting of Inpatient and Outpatient Care Management, Social Work, Inpatient Rehab, Interpreter Services, Spiritual Care, and Infusion Services. In this role, Nicole provides oversight and program management for the Lawrence General Hospital CHART Program consisting of two social workers, a nurse care manager, and a resource specialist. The CHART team works closely with medically and socially complex patients, both in the hospital and in the community, for 90 days post discharge.

NICOLE HEIM, *Executive Vice President and COO*

Milford Regional Medical Center

As Operational Investment Director of the CHART team, Nicole is the executive sponsor to the team and is the liaison to the senior management team as well as the physician leadership. The Milford Regional Medical Center (MRMC) CHART team aims to reduce readmissions for patients with three or more admissions over the past year. Every other month, Nicole shares the readmission data with the PCAC and Board of Trustees. She includes a patient story to display the significant impact the team is having on patients. Recently, MRMC engaged a consultant to review and offer recommendations to sustain the program. Nicole was an active member of the strategic planning process and she worked with the senior management team to ensure that MRMC could support the program moving forward.

Panel 4 continued →

PANEL 4

Panel 4: Lessons Learned, Capabilities Developed, and the Future

PATRICK GANNON RPh, MS, FABC, *Executive Director and Chief Quality Officer*

Southcoast Hospitals Group

Since 2002, Patrick has served as the Chief Quality Officer at Southcoast Health, a not-for-profit, community-based, four-hospital, integrated health network throughout southeastern Massachusetts and Rhode Island. As the Operational Investment Director for Southcoast's CHART Phase 2 program, Patrick works closely and collaboratively with the CHART Clinical Operations Director as a liaison to other organization-wide resources to help address program needs. Patrick also serves as the principal contact between Southcoast and the Health Policy Commission for CHART reporting requirements, budgetary needs and networking requests to identify best practices from other CHART Phase 2 organizations.

WENDY MITCHELL, MD, *Medical Director, Circle Care Program*

Lowell General Hospital

As Medical Director of Lowell General Hospital's Circle Care Program, Dr. Mitchell oversees both an individual CHART grant targeting inpatient high utilizing patients, and a joint CHART grant (with 3 Lahey community hospitals—Winchester, Addison Gilbert, and Beverly) which targets ED high utilizing patients, with a particular focus on substance abuse and behavioral health. Dr. Mitchell oversees both multidisciplinary care teams of RN case managers, social workers, community health workers, a pharmacist, and psychiatric NP. Dr. Mitchell also works to reduce ambulatory sensitive admissions in the Medicare population by leading a chronic disease program for Medicare patients. Dr. Mitchell is also current President-Elect of the Lowell General Hospital Medical Staff, and in this leadership role, is integrely involved in numerous hospital committees dedicated to improving quality, safety, and efficiency at the hospital, as well as to reducing inappropriate utilization of hospital services. Prior to her work as a medical director in the Lowell General PHO, Dr. Mitchell was a hospitalist for the last decade, and prior to becoming a hospitalist, she was a primary care physician. She is board certified in Internal Medicine.

ERIN DALEY, BSN, RN, MBA, *Director, Emergency Services*

Mercy Medical Center

As the Director of Emergency Services at Mercy Medical Center, Erin serves as the Clinical Investment Director for the CHART Phase 2 award. Adhering to her commitment to "whole person care," Erin was instrumental in successfully partnering with Behavioral Health Network (BHN) and co-locating BHN's staff and services in the ED to facilitate patient engagement and community outreach to BH patients as they discharge from the ED. Erin established the Complex Care Program for frequent visitors to the ED, and this program charts a course for all providers involved with the patient through the creation of a Complex Care Map. Erin is to be the recipient of the BusinessWest inaugural Healthcare Heroes Emerging Leader Award in recognition of all her transformative work at the "front door" of Mercy Medical Center.

CYNTHIA CAFASSO DONALDSON,
Vice President, Addison Gilbert Hospital and Lahey Outpatient Center, Danvers

Addison Gilbert and Beverly Hospitals

Cynthia Cafasso Donaldson is the Vice President for Addison Gilbert Hospital and Lahey Outpatient Center, Danvers. She is also the Investment Director for the Addison Gilbert and Beverly Hospital CHART High Risk Intervention Teams. Ms. Cafasso Donaldson is a Registered Pharmacist with an MBA and a certificate in Healthcare Management. She has worked within the Addison Gilbert/Beverly Hospital system for 30 years and has had the opportunity to gain experience in multiple settings, including inpatient, ambulatory, pharmacy, and long term care.

CHART AWARDEE PROFILES

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

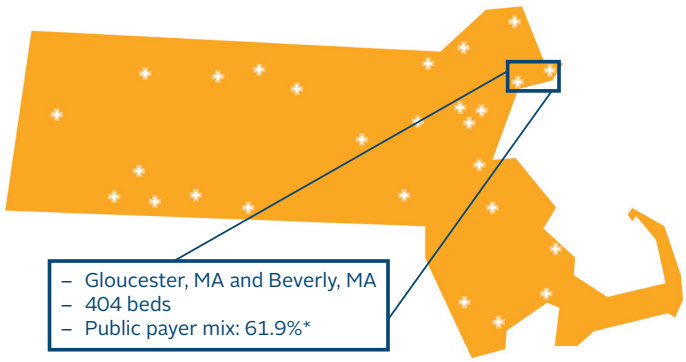
TARGET POPULATION
Patients identified by:
- High utilization (≥ 4 hospitalizations per year); or
- Social complexity; or
- A personal history of 30-day readmissions

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 coordination. 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.



Anna Jaques Hospital

ESSEX COUNTY

$1.4M
TOTAL PROJECT COST

$1.2M
HPC AWARD

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

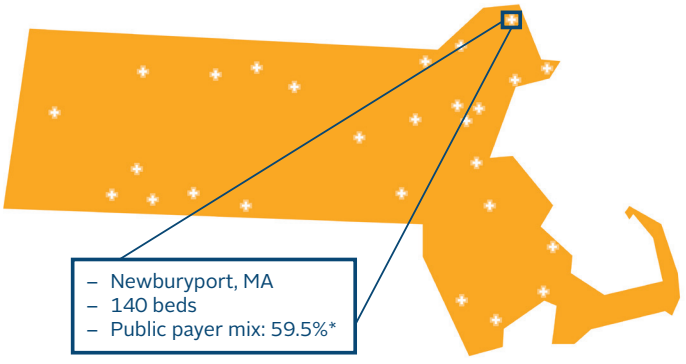
TARGET POPULATION 2
Patients at risk of high utilization

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.



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.

Baystate Franklin Medical Center

FRANKLIN COUNTY

$2.08M
TOTAL PROJECT COST

$1.6M
HPC AWARD

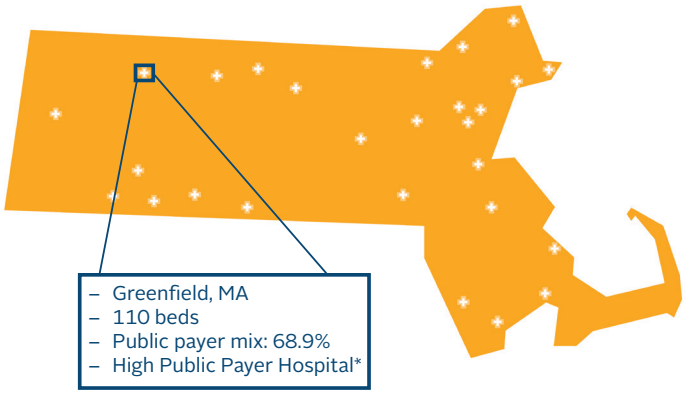
TARGET POPULATION
Patients with a personal history of high utilization, identified by one or more of the following:
- ≥ 4 hospital discharges in the last 12 months
- ≥ 5 behavioral health ED visits (primary or secondary diagnoses) in the last 12 months

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.



Baystate Noble Hospital

HAMPDEN COUNTY

$1.5M
TOTAL PROJECT COST

$1.04M
HPC AWARD

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

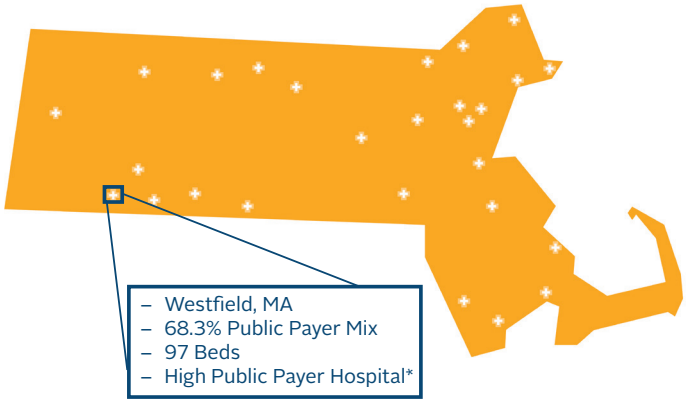
TARGET POPULATION 2
All patients with high utilization of the ED and hospital

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.



Baystate Wing Hospital

HAMPDEN COUNTY

$1.25M
TOTAL PROJECT COST

$1M
HPC AWARD

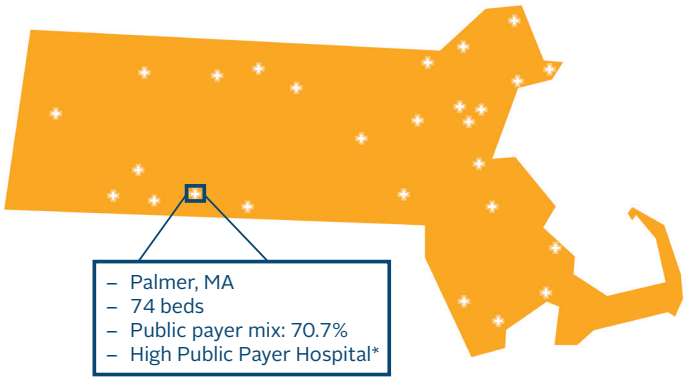
TARGET POPULATION
Patients with a life-limiting condition and/or a behavioral health diagnosis

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.



Berkshire Medical Center

BERKSHIRE COUNTY

$4.04M
TOTAL PROJECT COST

$3M
HPC AWARD

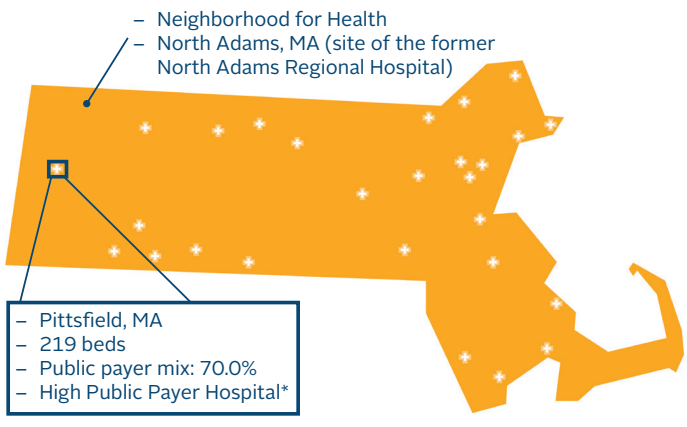
TARGET POPULATION
All inpatient and observation discharges of Northern Berkshire County residents.

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.



Beth Israel Deaconess Hospital – Milton

NORFOLK COUNTY

$2.28M
TOTAL PROJECT COST

$2M
HPC AWARD

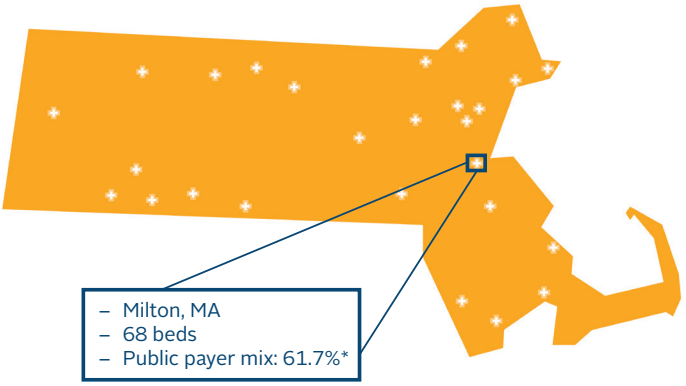
TARGET POPULATION
Patients in the ED with a length of stay > 8 hours who are referred to SSMH for a behavioral health crisis evaluation

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.



Beth Israel Deaconess Hospital – Plymouth

PLYMOUTH COUNTY

$5.2M
TOTAL PROJECT COST

$3.7M
HPC AWARD

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

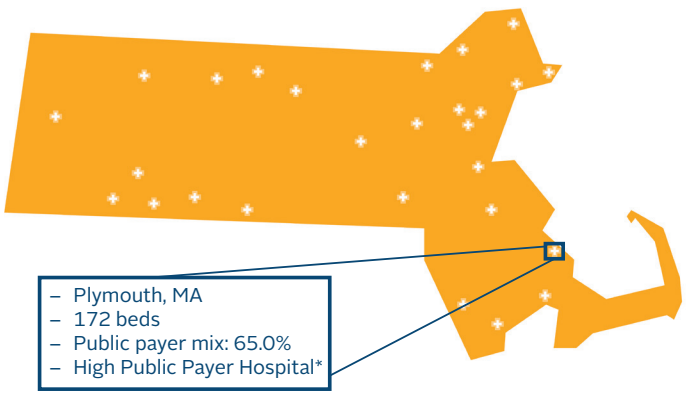
PRIMARY AIM 1
Reduce readmissions for patients with dual eligibility by
10%

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.



Emerson Hospital

MIDDLESEX COUNTY

$1.92M
TOTAL PROJECT COST

$1.2M
HPC AWARD

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

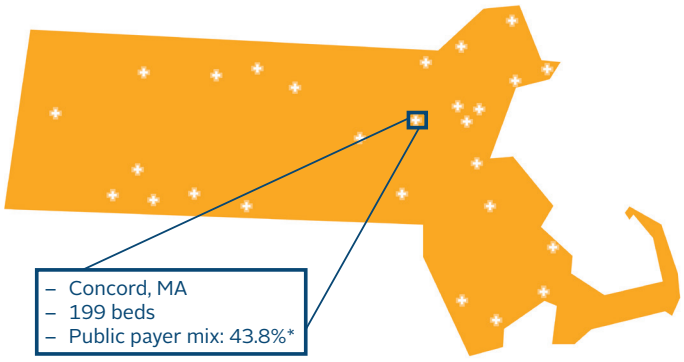
PRIMARY AIM
Reduce 30-day returns by
20%

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 readmission. 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.



Harrington Memorial Hospital

WORCESTER COUNTY

$2.3M
TOTAL PROJECT COST

$2.1M
HPC AWARD

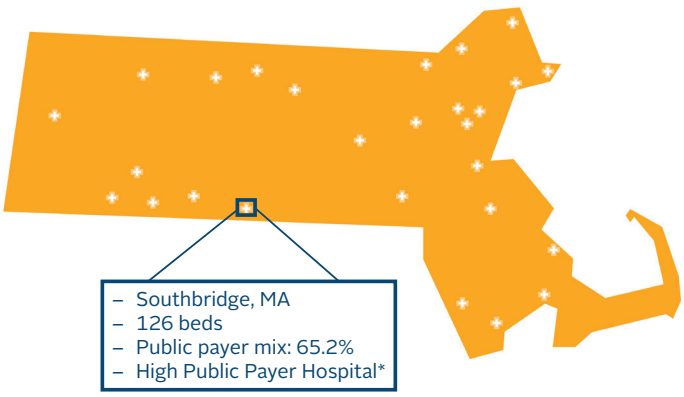
TARGET POPULATION
Patients with a primary or secondary behavioral health diagnosis in the ED setting

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.



HealthAlliance Hospital

WORCESTER COUNTY

$10M
TOTAL PROJECT COST

$3.8M
HPC AWARD

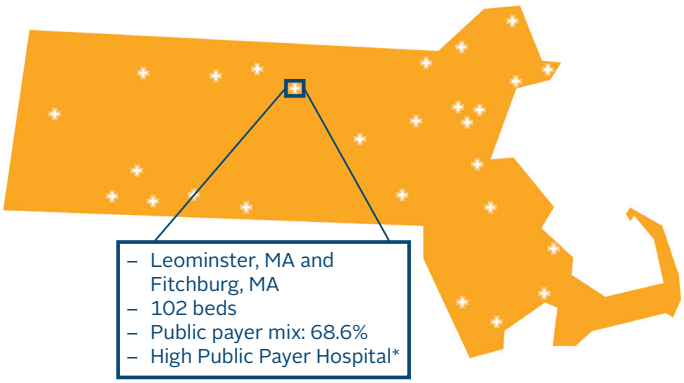
TARGET POPULATION
Adult primary and/or secondary ED behavioral health patients who are identified as high risk of an ED revisit

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.



Holyoke Medical Center

HAMPDEN COUNTY

$3.6M
TOTAL PROJECT COST

$1.9M
HPC AWARD

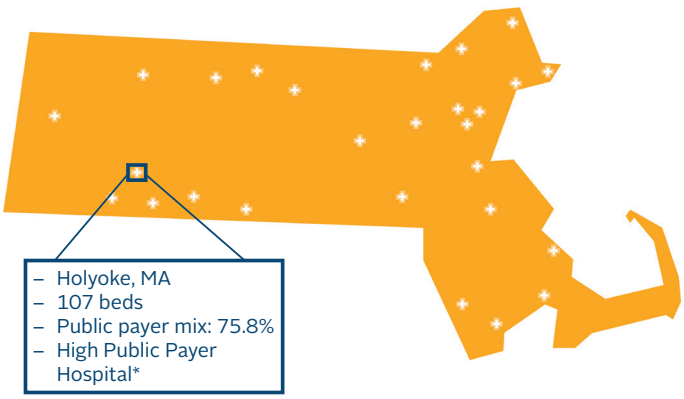
TARGET POPULATION
Patients with a primary or secondary behavioral health diagnosis in the ED setting

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.



1. A separate contract awarding Holyoke Medical Center $2 million supports this component of the project.

Lawrence General Hospital

ESSEX COUNTY

$1.9M
TOTAL PROJECT COST

$1.48M
HPC AWARD

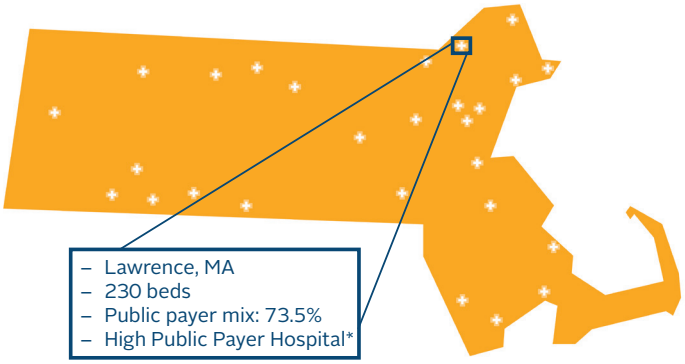
TARGET POPULATION
Patients identified by one or more of the following:
- Medium or high biopsychosocial risk
- A personal history of 30-day readmissions

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.



Lowell General Hospital

MIDDLESEX COUNTY

$2.02M
TOTAL PROJECT COST

$1M
HPC AWARD

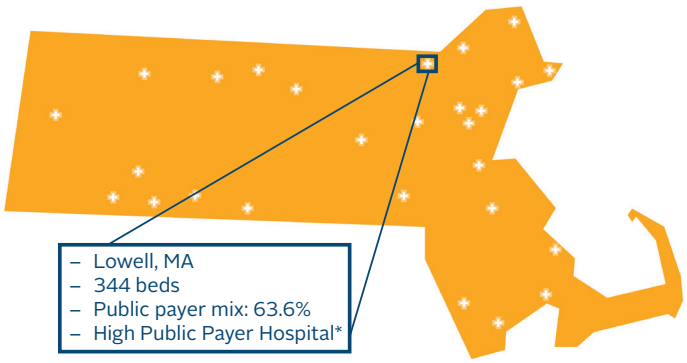
TARGET POPULATION
Patients with a personal history of high utilization of the hospital

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.



Mercy Medical Center

HAMPDEN COUNTY

$1.66M
TOTAL PROJECT COST

$1.3M
HPC AWARD

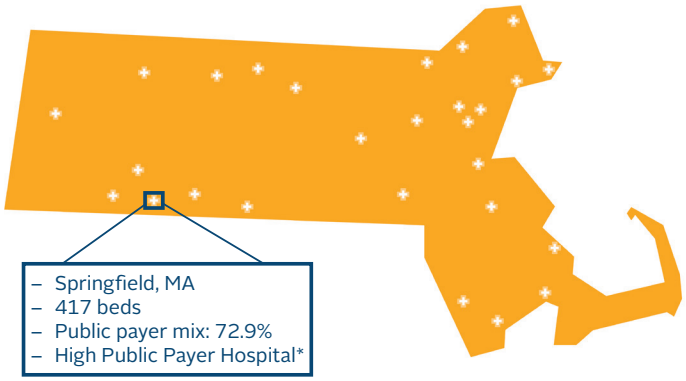
TARGET POPULATION
ED patients with a primary behavioral health diagnosis

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.



Milford Regional Medical Center

WORCESTER COUNTY

$2.24M
TOTAL PROJECT COST

$1.3M
HPC AWARD

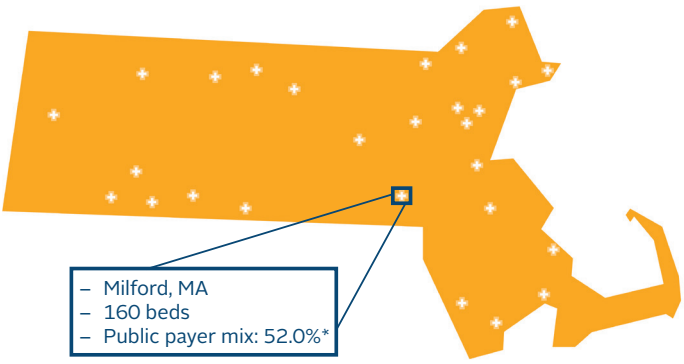
TARGET POPULATION
Patients with ≥ 3 hospitalizations in the past 12 months

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.



Signature Healthcare Brockton Hospital

PLYMOUTH COUNTY

$3.76M
TOTAL PROJECT COST

3.5M
HPC AWARD

TARGET POPULATION 1
All admissions

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

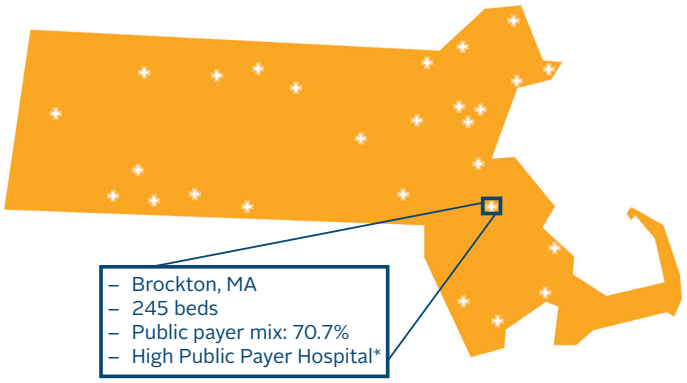
PRIMARY AIM 1
Reduce 30-day readmissions by
20%

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.



UMass Marlborough Hospital

MIDDLESEX COUNTY

$1.47M
TOTAL PROJECT COST

$1.2M
HPC AWARD

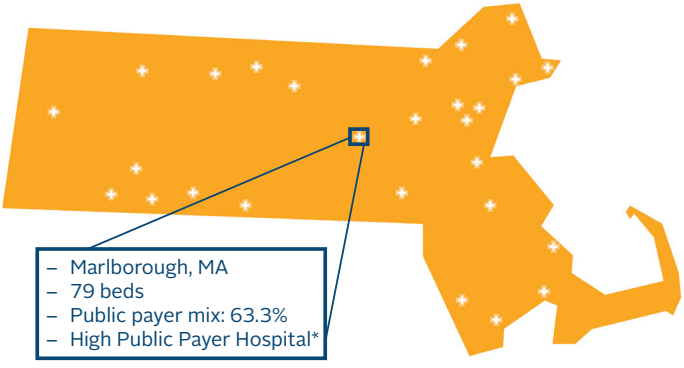
TARGET POPULATION
Patients with a personal history of high utilization of the hospital or ED

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 multi-disciplinary 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.



Winchester Hospital

MIDDLESEX COUNTY

$3.09M
TOTAL PROJECT COST

$1M
HPC AWARD

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

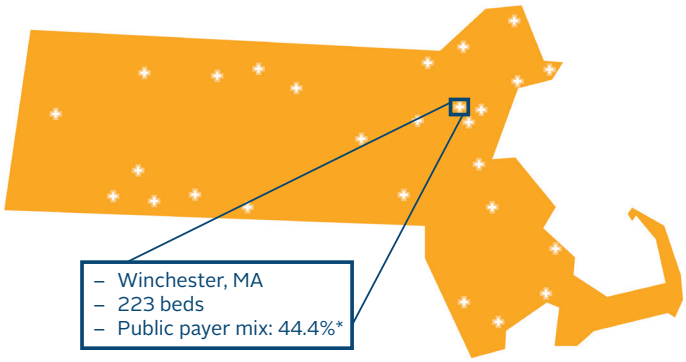
PRIMARY AIM 1
Reduce 30-day readmissions for patients with high utilization by
20%

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.



Addison Gilbert, Beverly, Winchester, and Lowell General Hospitals

ESSEX AND MIDDLESEX COUNTIES

$6.3M
TOTAL PROJECT COST

$4.8M
HPC AWARD

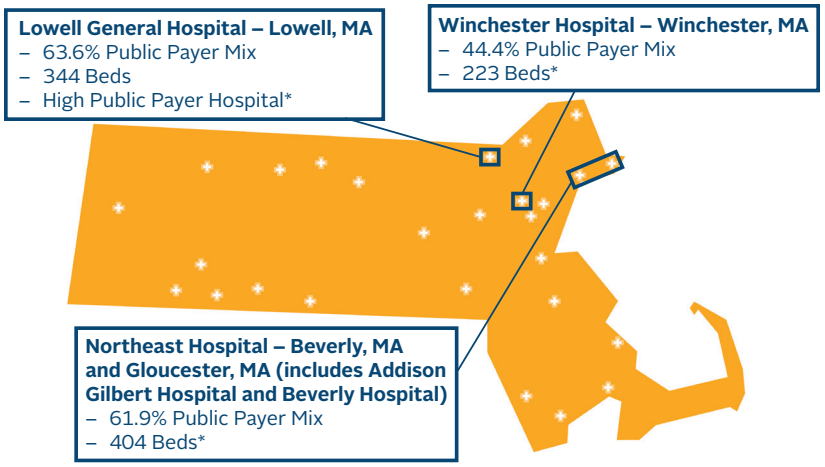
TARGET POPULATION
Patients with a personal history of moderate or high utilization of the ED

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.



Baystate Franklin Medical Center, Baystate Noble & Baystate Wing Hospitals

FRANKLIN AND HAMPDEN COUNTIES

$1.04M
TOTAL PROJECT COST

$900K
HPC AWARD

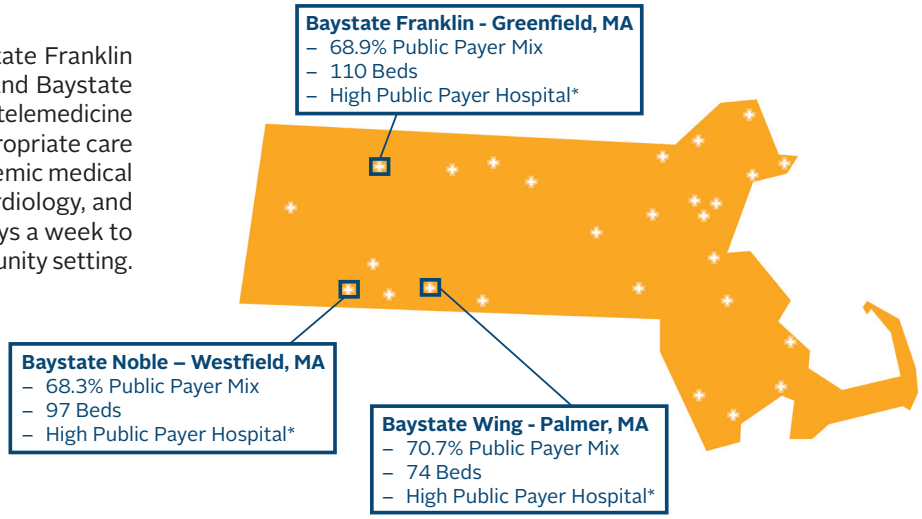
TARGET POPULATION
Lower acuity medically-focused Neurosciences, Adult Medicine (includes Pulmonary, Infectious Disease, Geriatrics/ Palliative Care Services, Critical Care), and Cardiology patients

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.



Hallmark Health System

MIDDLESEX COUNTY

$2.8M
TOTAL PROJECT COST

$2.5M
HPC AWARD

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

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

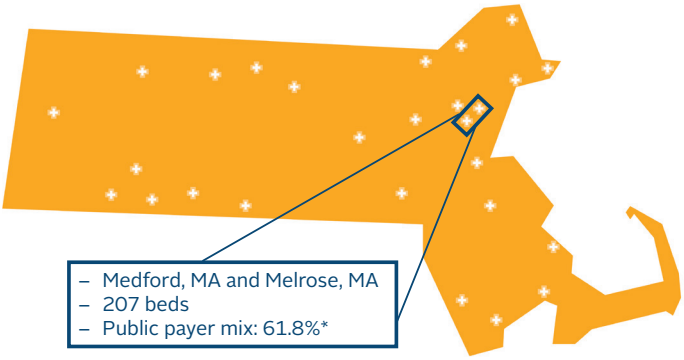
PRIMARY AIM
Reduce ED utilization by
20%

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.



Heywood and Athol Memorial Hospitals

WORCESTER COUNTY

$3.3M
TOTAL PROJECT COST

$2.9M
HPC AWARD

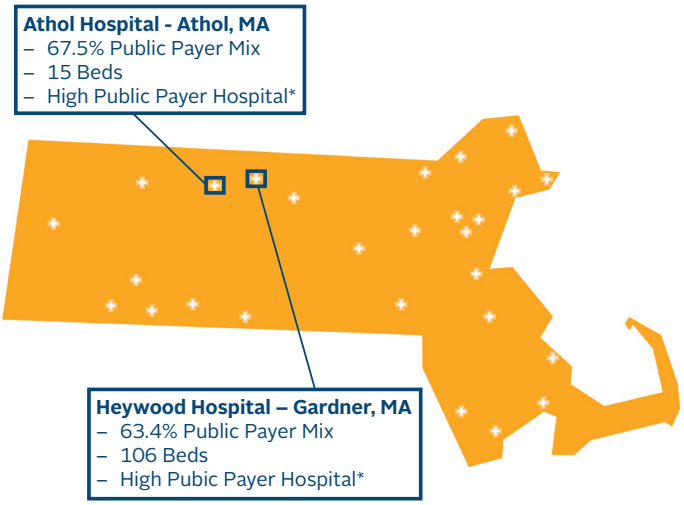
TARGET POPULATION
Patients identified by one or more of the following:
- ED patients with a behavioral health diagnosis
- Youth and families of the Gardner and Athol/ Royalston school systems with behavioral health needs

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.



Southcoast Hospitals Group

BRISTOL AND PLYMOUTH COUNTIES

$9.16M
TOTAL PROJECT COST

$7.5M
HPC AWARD

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

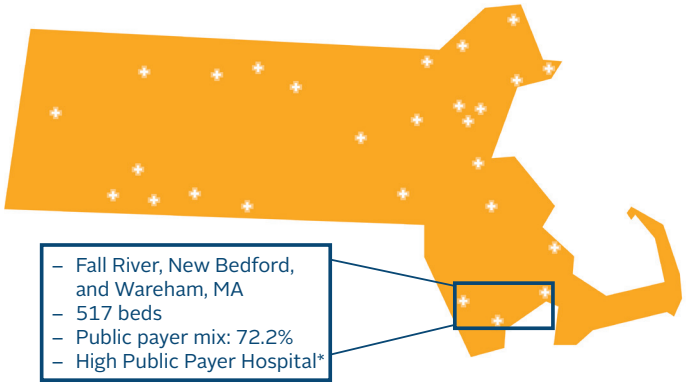
PRIMARY AIM 1
Reduce 30-day readmissions by
20%
for patients with high utilization of the hospital

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.



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

LESSONS LEARNED

CHART Phase 2: A Snapshot of Opportunities and Solutions Identified by Programs

Through rapid-cycle improvement strategies and data-driven technical assistance, CHART programs have continuously iterated upon their operational models. These care delivery models aim to provide patient-centered care within and beyond the hospital for patients at high risk of avoidable acute care utilization, such as patients with complex medical, behavioral, and/or social needs.

CHART programs submit narrative reports to describe implementation barriers, opportunities, and solutions. Below is a snapshot of lessons learned over the past two years from these reports.

PROGRAM COMPONENTS	IDENTIFYING OPPORTUNITIES	SOLUTIONS
IDENTIFYING PATIENTS **Capturing when patients present to the acute care setting**	How can technology be used to identify and notify teams when patients present to the acute care setting?	• Create flags or markers in electronic health record (EHR) to identify target population patients in real-time • Generate patient lists from EHR for a concise overview of recent and current visits, based upon target population criteria • Incorporate screening questions for underlying behavioral health needs and social determinants of health (e.g., housing instability, food insecurity, trauma history) into assessment for earlier identification of patient needs
ENGAGING PATIENTS **Communicating and establishing relationships with patients**	What are effective strategies for initial patient engagement?	• Prioritize relationship-building when engaging patients: meet patients where they are, physically and emotionally • Promote program services as an extension of hospital services; avoid rigid scripting with unfamiliar names and jargon • Implement on-call coverage by care coordination staff during off-hours (e.g., evenings and weekends) for service continuity • Use multimedia: communicate services and contact information to patients, families, and providers via pamphlets and large-sized business cards that are culturally and linguistically appropriate
SERVING PATIENTS **Delivering the right services and supports to patients at the right place and time**	What are effective strategies for post-acute follow-up? What are integral components to patient-centered care coordination?	• Conduct follow-up communication within two days post-discharge • Meet patients in familiar community or home settings; prioritizing home visits helps to understand a patient's world and to better ensure service quality and safety • Collaborate with patients and post-acute care providers when developing goals during care and discharge planning • Capture services and social determinants of health information in a care plan or progress note accessible to other hospital staff and providers • Integrate pharmacy workflows, such as medication reconciliation, optimization, and education • Understand and leverage community-based resources; go beyond referrals and conduct warm handoffs that link patients to the support they need

LESSONS LEARNED

PROGRAM COMPONENTS	IDENTIFYING OPPORTUNITIES	SOLUTIONS
STAFFING **Cultivating an effective and efficient team**	What are the appropriate skills and roles for improving care transitions? How can the team best be integrated into both the medical and community settings?	• Deploy non-medical providers to care for patients with complex needs, such as community health workers and social workers, who can address the non-medical root causes of utilization and readily connect to community resources • Prioritize non-medical providers who demonstrate motivation and compassion versus emphasizing credentials • Engage team in hiring process and decisions • Train staff on motivational interviewing skills to improve patient engagement and outcomes • Showcase the importance and benefit of non-medical roles for better integration into medical settings and workflows • Institute quick daily huddles for efficient information sharing and team building • Celebrate all successes!
MEASURING **Collecting and analyzing data to inform decision making**	What are feasible strategies for data collection and analysis for quality improvement (QI) initiatives?	• Determine and report on a slate of process and outcome measures that concisely capture program goals • Institute a systematic feedback loop process whereby results from frequent data analysis inform operational improvements • Collaborate with hospital IT staff and software vendors to maximize interoperability between platforms; consider manual workarounds to ensure team members get the information they need when they need it • Complement the quantitative with the qualitative; patient and provider stories are critical to understanding the full impact of QI initiatives
PARTNERING **Developing critical and sustainable relationships within the hospital and in the community**	What are strategies for communicating the purpose and benefits of the program? How can strong partnerships be developed with minimal financial incentives?	• Obtain leadership support early on to facilitate communication and collaboration with other hospital staff • Establish regular interdisciplinary meetings with hospital staff and community-based providers regarding shared patients • Host community meetings with local providers and social service agencies to raise awareness of available resources and common goals • Proactively work with community resources, such as law enforcement, the court system, shelters, schools, food banks, and faith-based organizations to establish unified support for common causes and patients

CHART Phase 2: By the Numbers

$60 MILLION

250 FTES

180,000 PATIENT ENCOUNTERS SINCE PROGRAM LAUNCH*

27 HOSPITALS IMPLEMENTING

25 PROJECTS

24 MONTHS

*Based on reports received from CHART Phase 2 awardees as of September 2017.

NOTES

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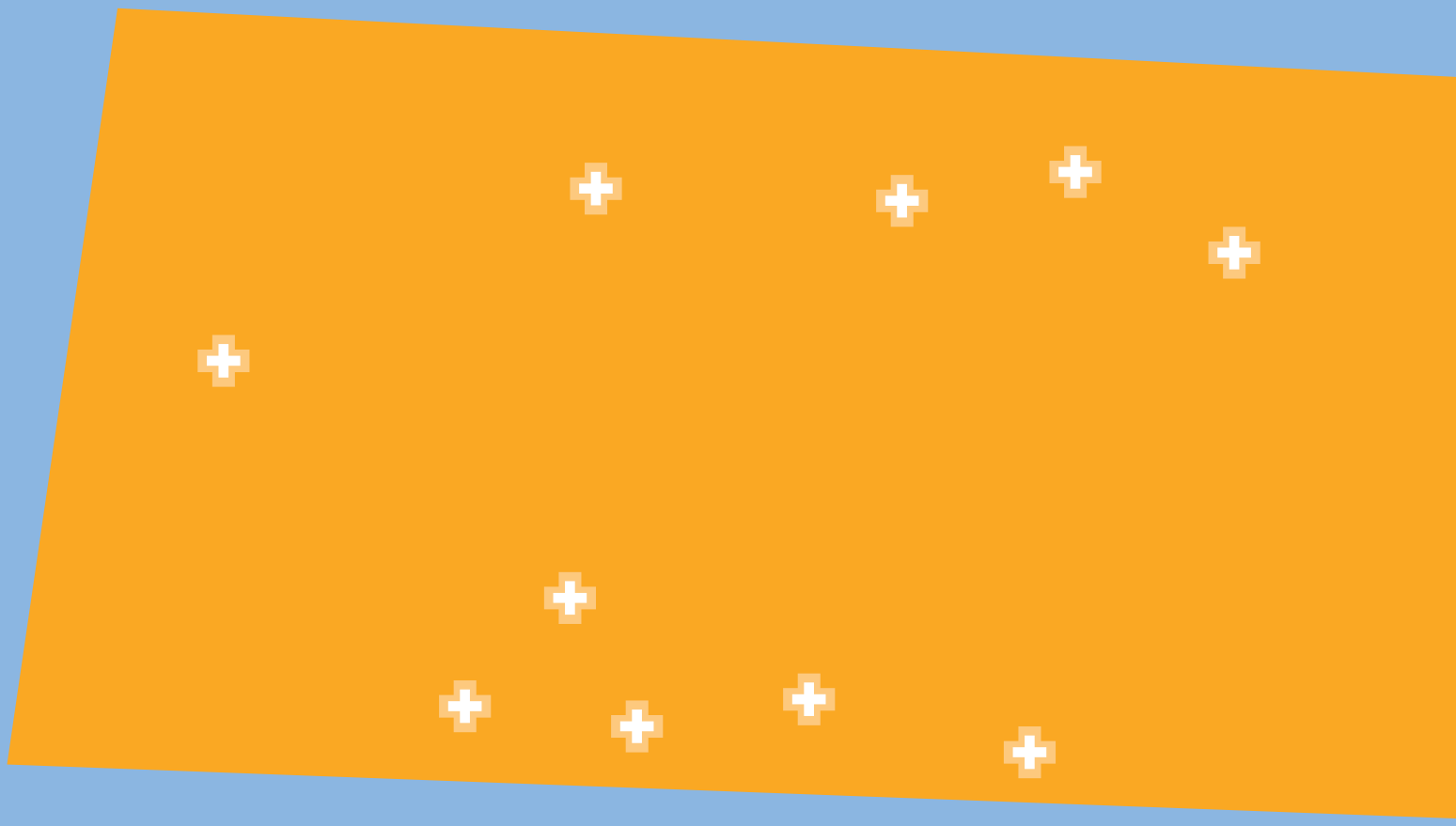

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