CHART PHASE 2 STATEWIDE CONVENING

OCTOBER 16, 2017

LESSONS FROM
2 YEARS,
25 AWARDEES,
AND **$60** MILLION

MASSACHUSETTS
HEALTH POLICY COMMISSION

Welcome

Kathleen Connolly, Director, Strategic Investment
David Seltz, Executive Director

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The CHART Method

Amy Boutwell, MD, MPP
President, Collaborative Healthcare Strategies

Purpose of CHART

Specific aim:

Enhance the delivery of efficient, effective care and **develop the capability to succeed under value-based payment**

__C__ommunity __H__ospital __A__cceleration, __R__evitalization, and __T__ransformation (CHART) Investment Program: CHART hospital eligibility, as determined by Chapter 224 of the Acts of 2012, excludes acute care hospitals or health systems with for-profit status, excludes major acute care teaching hospitals, and excludes hospitals whose relative prices are determined to be above the statewide median relative price.

Broad Capabilities

1. Reduce avoidable acute care utilization
2. Improve care for patients with behavioral health conditions
3. Improve operational efficiency

CHART Universal Design Elements

- Data and root cause analysis
- Real-time identification
- Timely engagement
- Whole-person approach
- Service across settings and over time
- Collaboration across the continuum and across sectors
- Implementation and outcomes measurement

CHART Operational Model

Active redesign over time; we change what we do to drive results

CHART Operational Dashboard

Engagement + Service Delivery = Outcomes

- Actual v. engaged target population
- Timely contact <48 hours
- Type of services delivered
- Location of services delivered
- Intensity of services delivered
- Utilization outcomes

Performance Management

Monthly review of operational performance encouraged change

- Monthly data reports
- Monthly program updates
- Regular communication with Program Officers
- Quarterly review with reflection: successes, challenges, next steps
- Periodic surveys, site visits, celebration events, alignment discussions

Intensive Implementation Support

Focus of technical assistance evolved over time as each program evolved

- Identify
- Serve

- Serve high %
- Timely f/u
- Trend to goal

- Effective
- Efficient
- Standard work

- Align with incentives
- Right-sized
- Apply elsewhere

15 shared learning events and **>300** on-site coaching sessions over 2 years

CHART Results: Success!

1. The model works; the methods are durable across heterogeneous target populations and operational settings

2. The capabilities developed; every CHART hospital has developed capabilities needed to help them succeed in value-based payment models

Rapid-Fire Panels

- **Panel 1:** Reducing Readmissions for High Risk Patients
- **Panel 2:** Slowing the Cycle of High Utilization for Multi-Visit Patients
- **Panel 3:** Improving Care for Behavioral Health Patients in the Emergency Department
- **Panel 4:** Lessons Learned, Capabilities Developed, and the Future

Key Differentiators You Will See Today

- There are no disease-specific programs here
- These are highest-risk populations, based on their own local data analysis
- There is no predictive modeling used; just epidemiology (who is in a high risk group)
- We don’t exclude patients (leaving AMA, lacking housing, active SUD, etc.)
- Case finding in acute care setting, not in primary care

Key Differentiators You Will See Today

- Impact is reported at the target population level – whether or not they were “served”
- Programs prioritized engagement to drive up service to drive outcomes
- Note the team composition: community health workers, social workers, data analysts
- Impact in a high-risk, high-volume target population can drive hospital-wide results

Ask Yourself

- Do I understand the root causes of utilization of my target population?
- Do I address root causes of utilization with social, behavioral, logistical supports?
- Do I use effective engagement strategies?
- Do I have meaningful collaborative relationships with providers and agencies that share in the care of my target population?

Purpose of Today: Inform, Inspire, Activate

- It is possible to address social drivers of utilization
- It is possible to improve care for patients with behavioral health needs
- It is possible to slow a cycle of high utilization
- It is possible to reduce readmissions…for Medicare, Medicaid, and dually-eligible
- It is possible to reduce avoidable ED utilization
- It is possible to reduce costs by improving care…and changing lives

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Thank you for your commitment to improving care

Amy Boutwell, MD, MPP
President, Collaborative Healthcare Strategies

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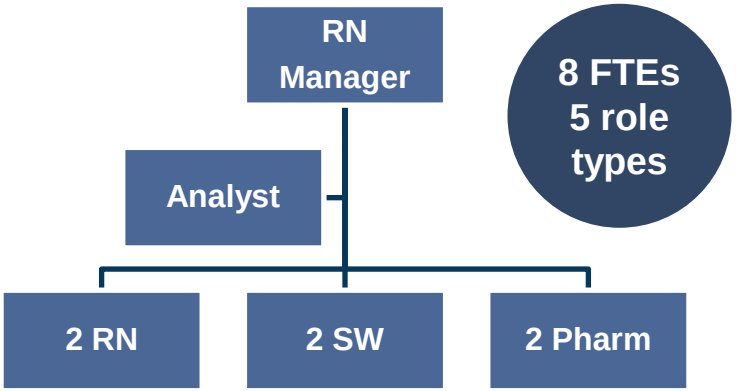
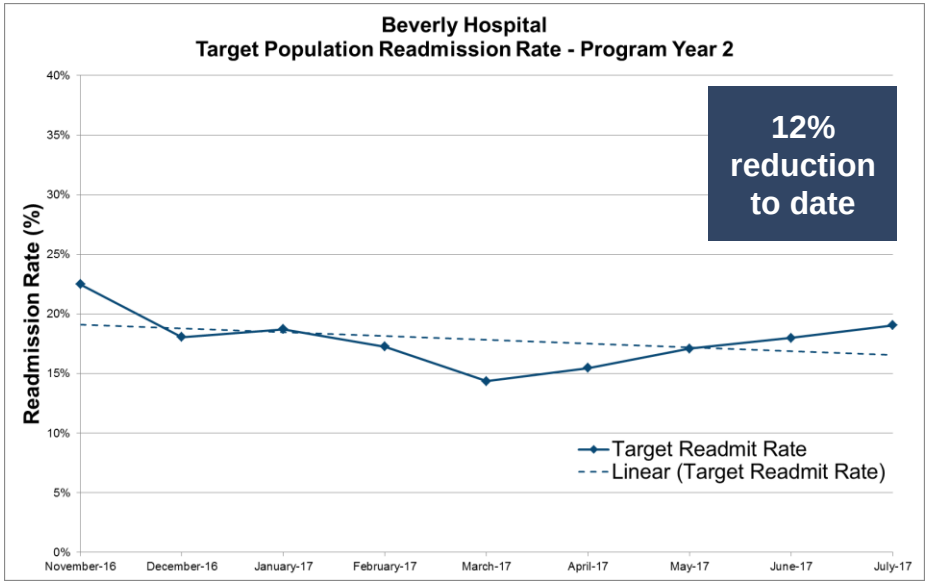
Panel 1: Reducing Readmissions for High Risk Patients

Beverly Hospital
Reducing readmissions for high risk patients

Beverly Hospital
A member of Lahey Health

Team





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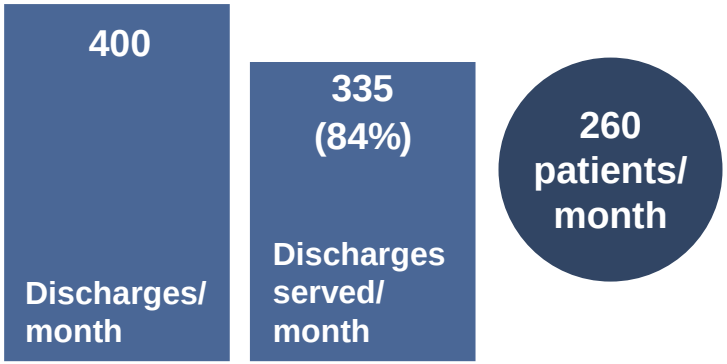

Success factors

- ✓ **Monthly data to drive improvement**
- ✓ **Weekly clinical review**
- ✓ **Strong impact on Medicaid readmissions**
- ✓ **ED action plans**
- ✓ **Home visits and community partners**

*The graph is limited to the second year of program operations due to delays in staffing.

CHART Phase 2 teams developed content for these slides for the purposes of the October 2017 Statewide Convening that reflects their hands-on experience, self-reported data analysis, and key findings.

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Emerson Hospital
Reducing returns for high risk patients

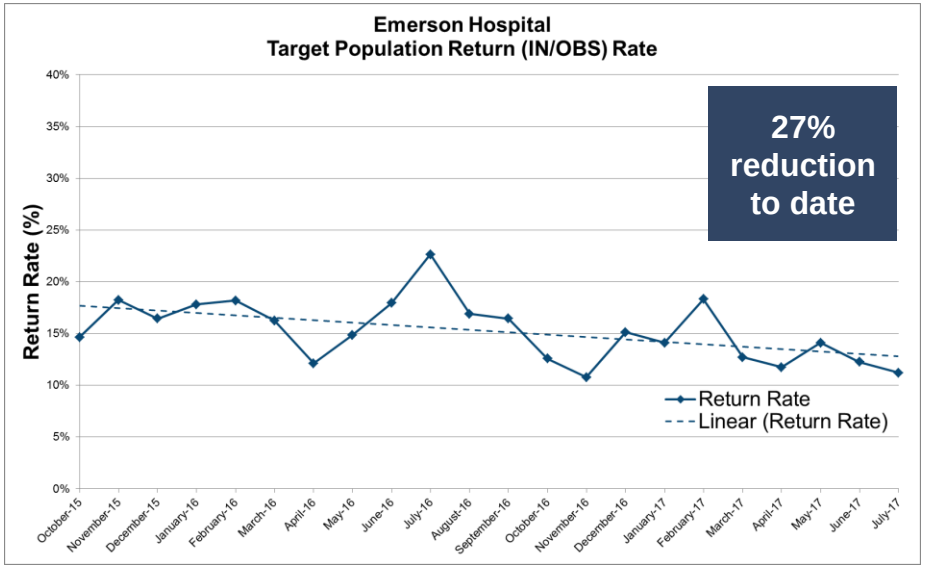
Emerson Hospital

Team

6 FTEs
5 role types

Project Manager

- 1 Pharm
- 2 SW
- 1 RN CM
- 1 Navigator



Average volume

145
Discharges/ month

135 (93%)
Discharges served/ month

135 patients/ month

Success factors

- ✓ Dedicated SW Navigator for BH patients
- ✓ CNL oversees high risk patients with team
- ✓ Active collaboration with SNF
- ✓ Pharmacist med reconciliation and teaching
- ✓ Increased palliative care and hospice referrals

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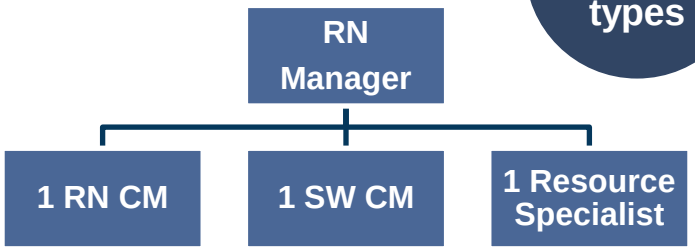
Beth Israel Deaconess Hospital – Plymouth

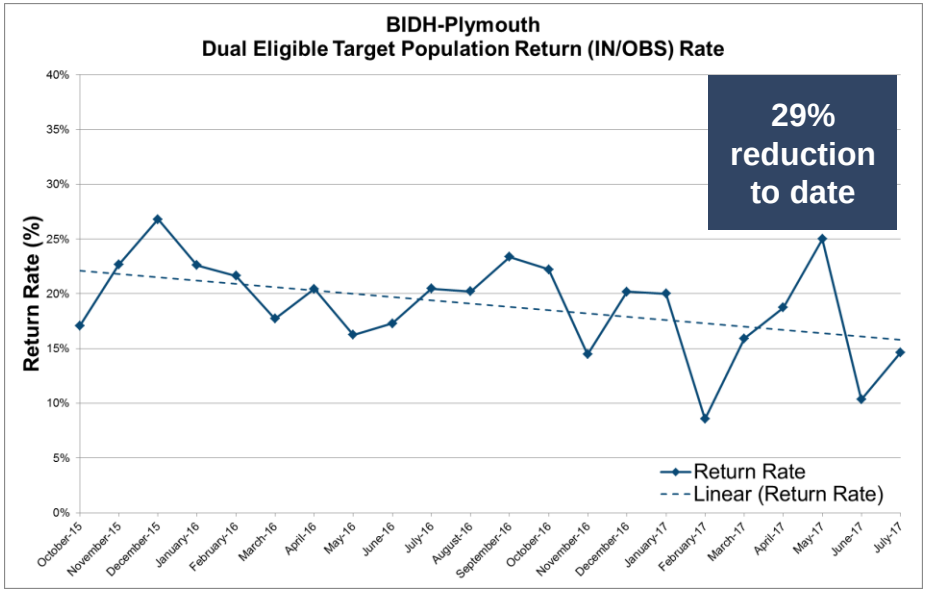
Reducing returns for high risk patients

Beth Israel Deaconess Hospital *Plymouth*

Team

4 FTEs
4 role types





Average volume

85
Discharges/ month

70 (82%)
Discharges served/ month

125 patients/ month

Success factors

- ✓ Transition from telephone to community outreach
- ✓ Co-management of patients
- ✓ Leverage Resource Specialist's skills
- ✓ Engage patients while hospitalized

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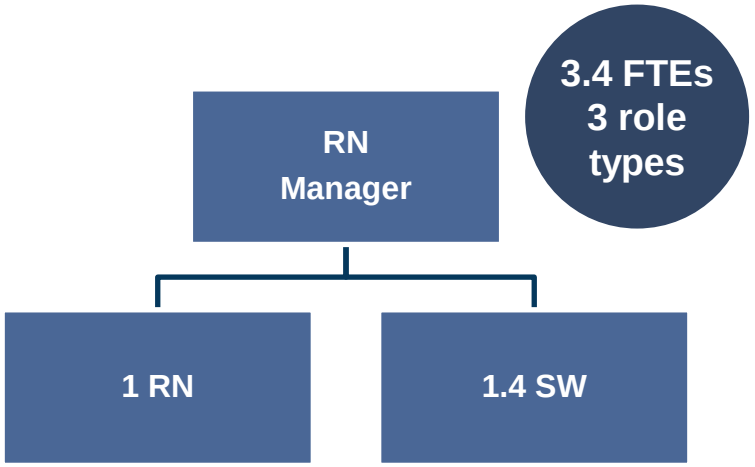
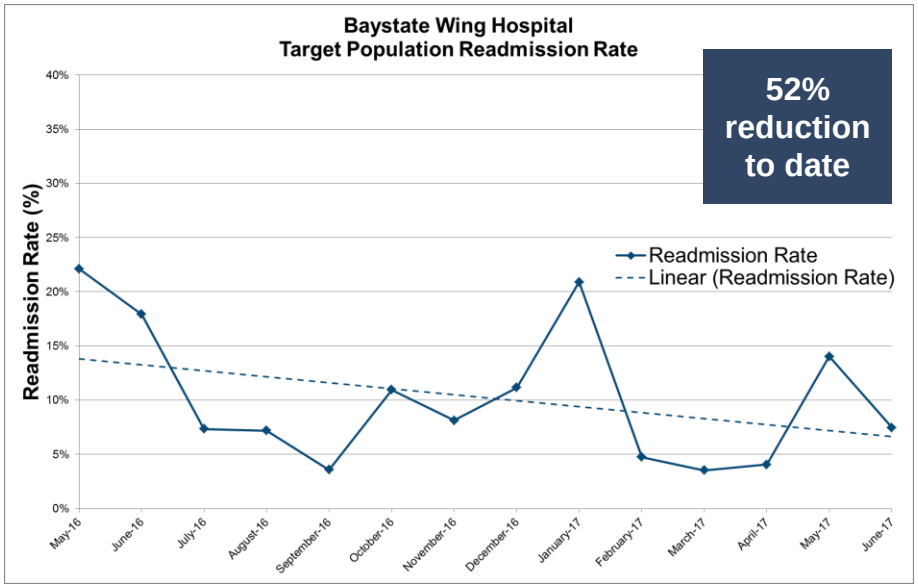
Baystate Wing Hospital
Reducing readmissions for high risk patients

Baystate Wing Hospital

Team





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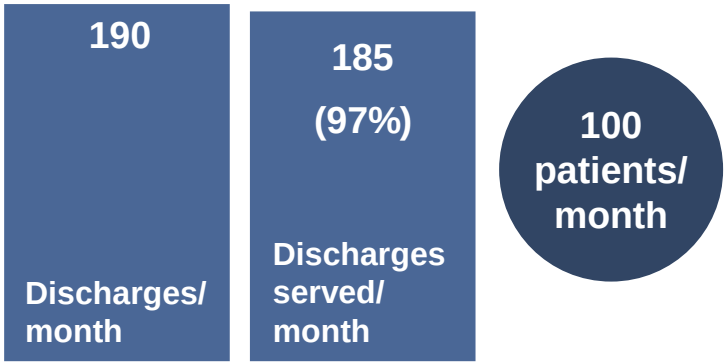

Success factors

- ✓ **Team coordination and flexibility**
- ✓ **Broad risk factor criteria for intervention**
- ✓ **High enrollment rate: scripting, inpatient engagement, holistic approach**
- ✓ **Patient-centered home visits**

*The team changed its targeting strategy in May 2016, and the graph reflects this approach.

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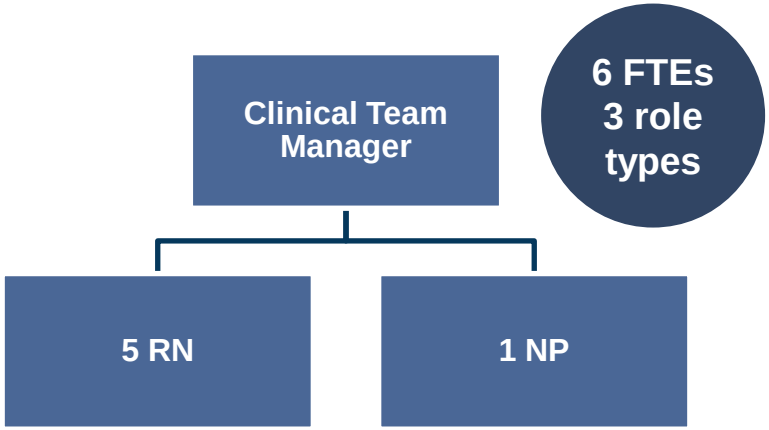
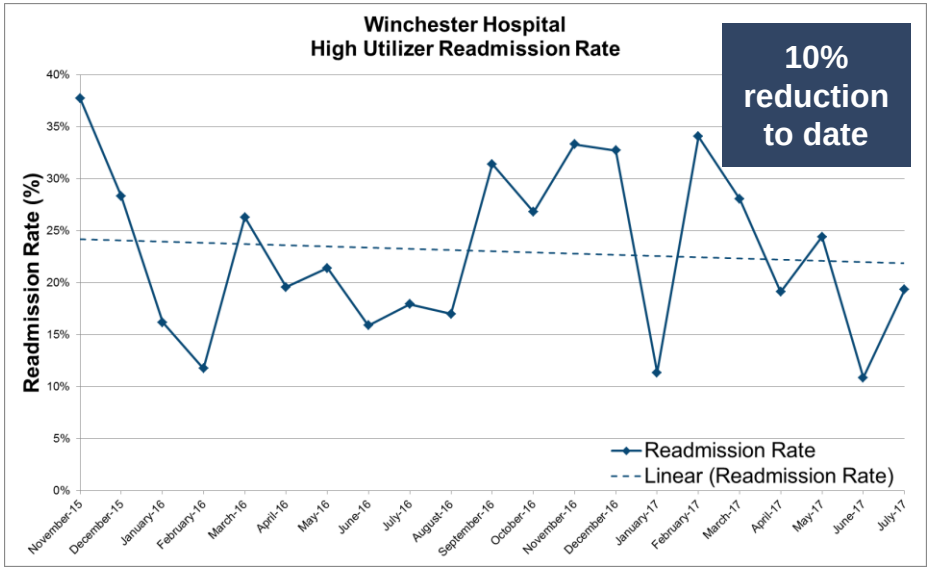
Panel 2: Slowing the Cycle of High Utilization for Multi-Visit Patients

Winchester Hospital
Reducing inpatient utilization for multi-visit patients

Winchester Hospital
A member of Lahey Health

Team





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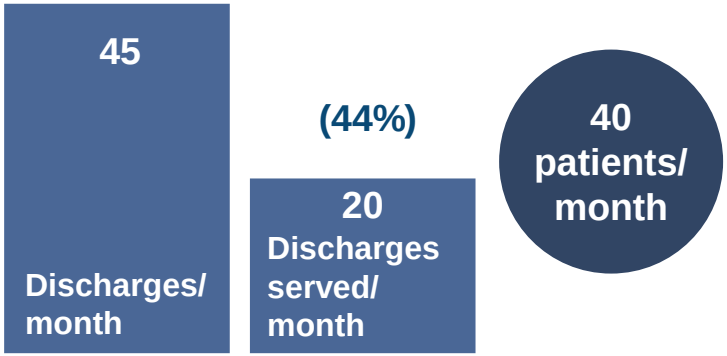

Success factors

- ✓ **Relationship building**
- ✓ **Team-driven approach**
- ✓ **Performance improvement focus**
- ✓ **Continuous learning**

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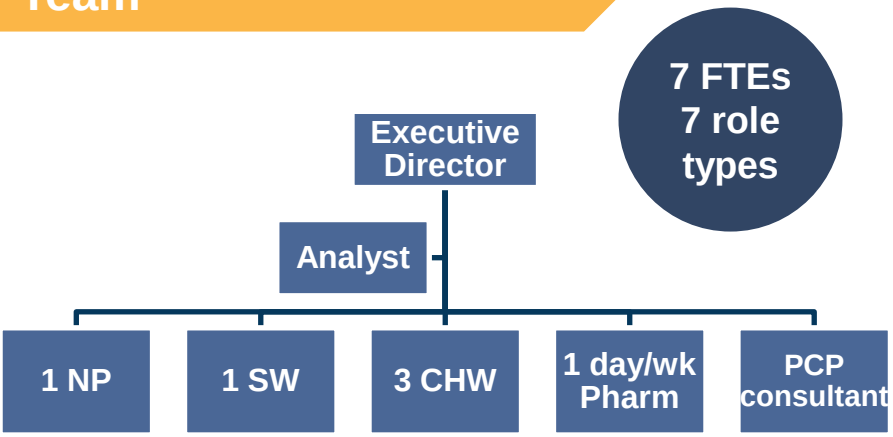
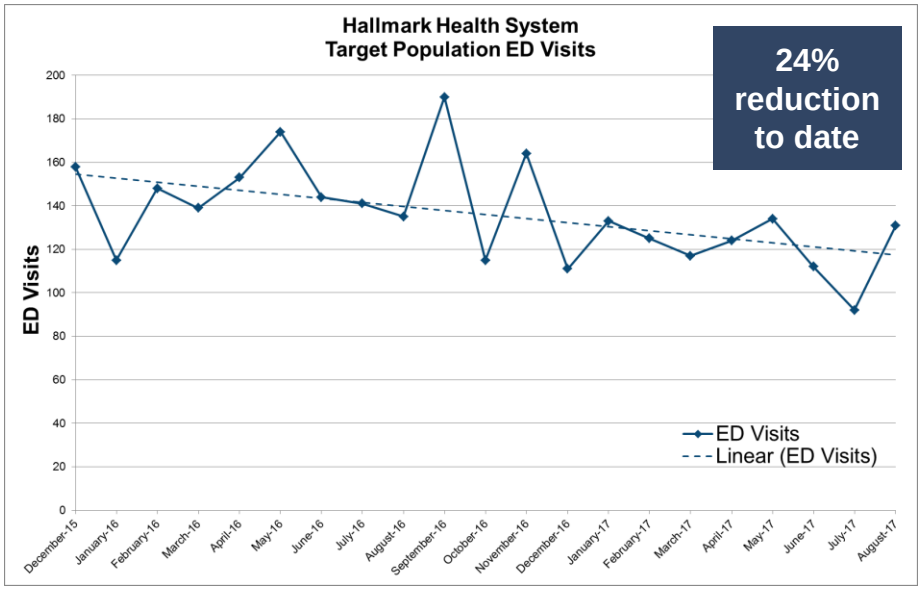
Hallmark Health System
Reducing ED utilization for multi-visit patients

Hallmark Health

Team

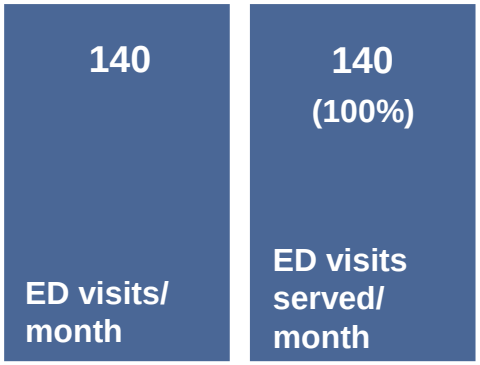


7 FTEs 7 role types



24% reduction to date

Average volume



150 patients/ month

Success factors

- ✓ **Focused, committed leadership**
- ✓ **Structured, efficient daily huddles**
- ✓ **Continuous, responsive learning**
- ✓ **Community-based, person-centric care**
- ✓ **Longitudinal perspective**

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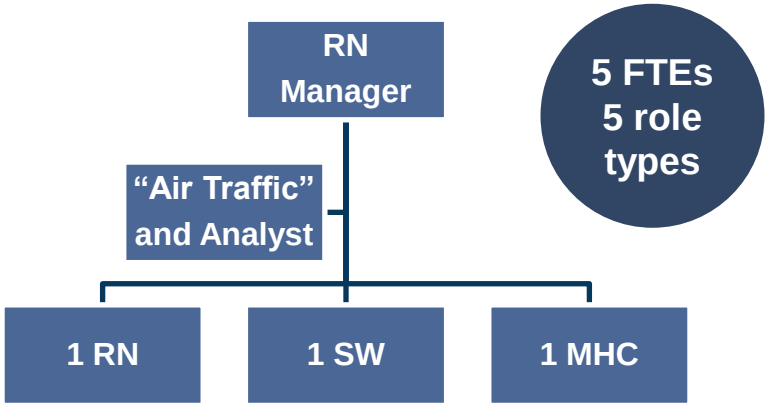
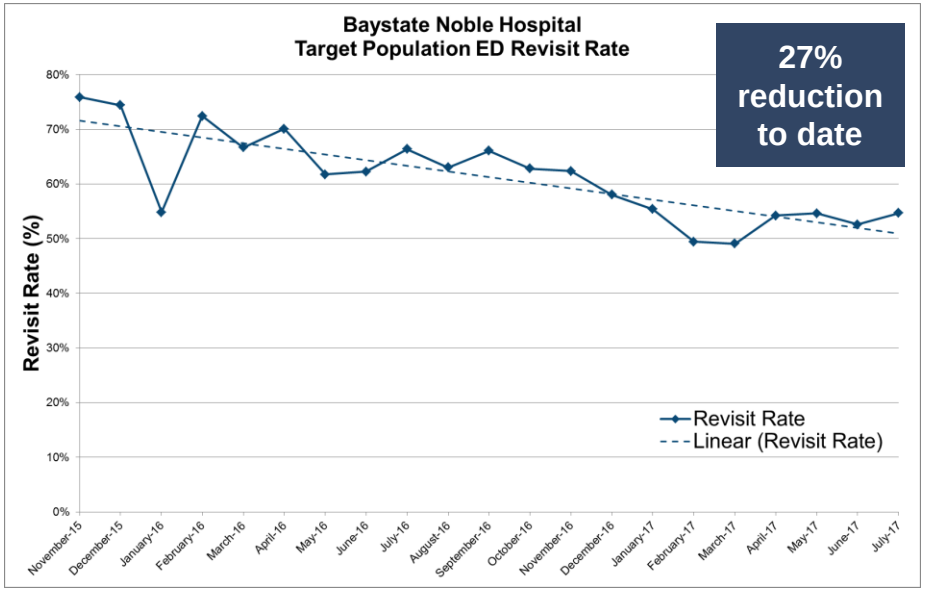
Baystate Noble Hospital
Reducing ED utilization for multi-visit patients

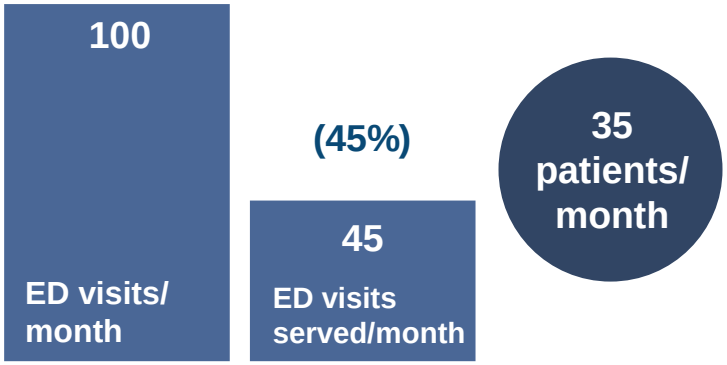
Baystate Noble Hospital

Team





Average volume



Success factors

- ✓ **"Air traffic control" function**
- ✓ **Meet patients while in hospital, every time**
- ✓ **Iterative, patient, persistent**
- ✓ **Home visits**

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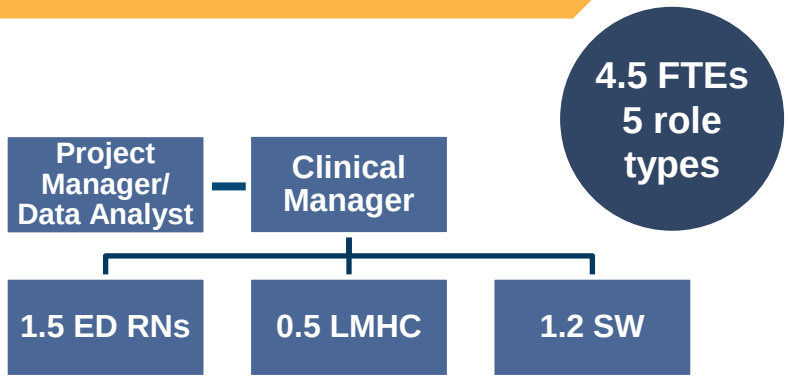
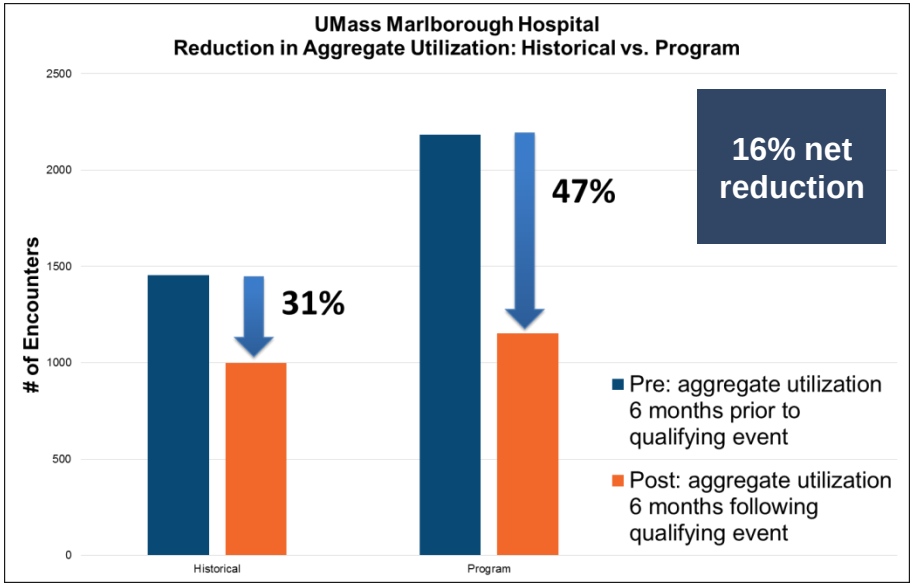
UMass Marlborough Hospital
Reducing total utilization for multi-visit patients

Marlborough Hospital
A Member of UMass Memorial Health Care

Team



4.5 FTEs 5 role types



Average volume

130
Discharges/ month

120 (92%)
Discharges served/ month

95 patients/ month

Success factors

- ✓ **Operations flexibility**
- ✓ **Retrain care-seeking behaviors and coping strategies**
- ✓ **Frequent patient contact and listening**
- ✓ **ED care plans**

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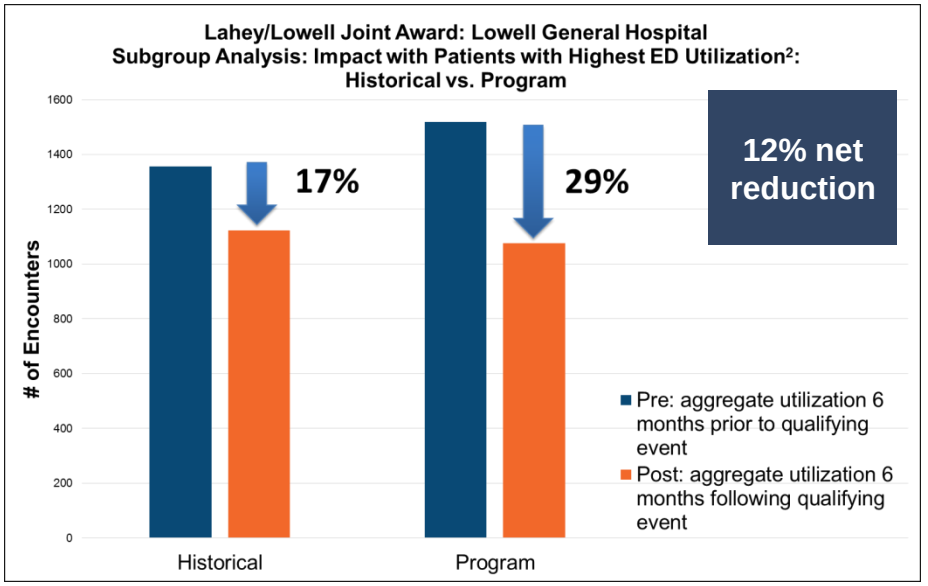
Lahey/Lowell Joint Award: Lowell General Hospital
Reducing ED utilization for multi-visit patients

Lowell General Hospital

Team

13 FTEs
5 role types

- RN Manager
  - 1 NP
  - 4 SW
  - 6 CHW
  - Admin



Average volume[1]

660
ED visits/ month

550 (83%)
ED visits served/ month

310 patients/ month

Success factors

- ✓ Team approach; clearly defined roles
- ✓ Collaboration with community partners
- ✓ Meet patients' immediate needs to establish rapport
- ✓ Flexible, persistent, iterative over time

[1] Average volume reflects total target population for the Lahey/Lowell Joint program

[2] Patients with highest ED utilization = 14+ ED encounters prior to (and inclusive of) qualifying event. Patients measured based on status at time of qualifying event, so this population excludes those qualifying as moderate utiilzers (8-13 ED encounters).

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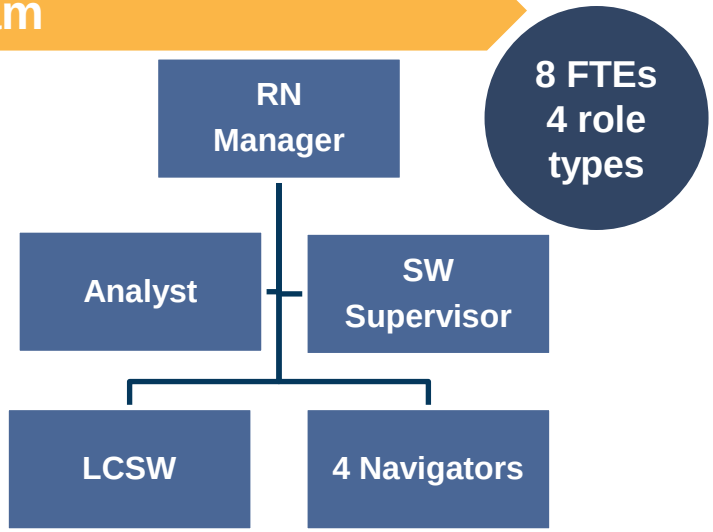
Panel 3: Improving Care for Behavioral Health Patients in the Emergency Department

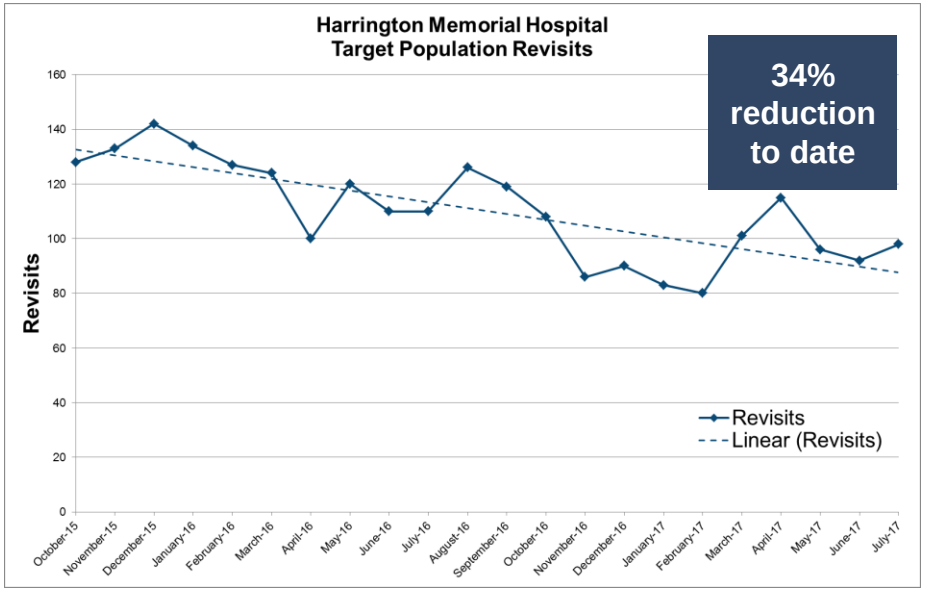
Harrington Memorial Hospital
Improving care for behavioral health ED patients

Harrington HEALTHCARE SYSTEM

Team



8 FTEs 4 role types



34% reduction to date

Average volume

275
ED visits/ month

200 (73%)
ED visits served/ month

120 patients/ month

Success factors

- ✓ **Address patients' basic needs first**
- ✓ **Creatively leverage community resources**
- ✓ **Effective engagement tactics, frequent contact**
- ✓ **Adapt care model to achieve outcomes**
- ✓ **Drill down on data to understand impact**

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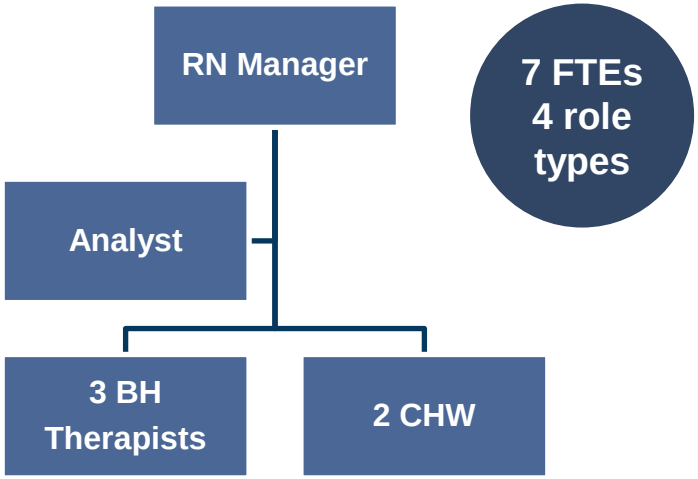
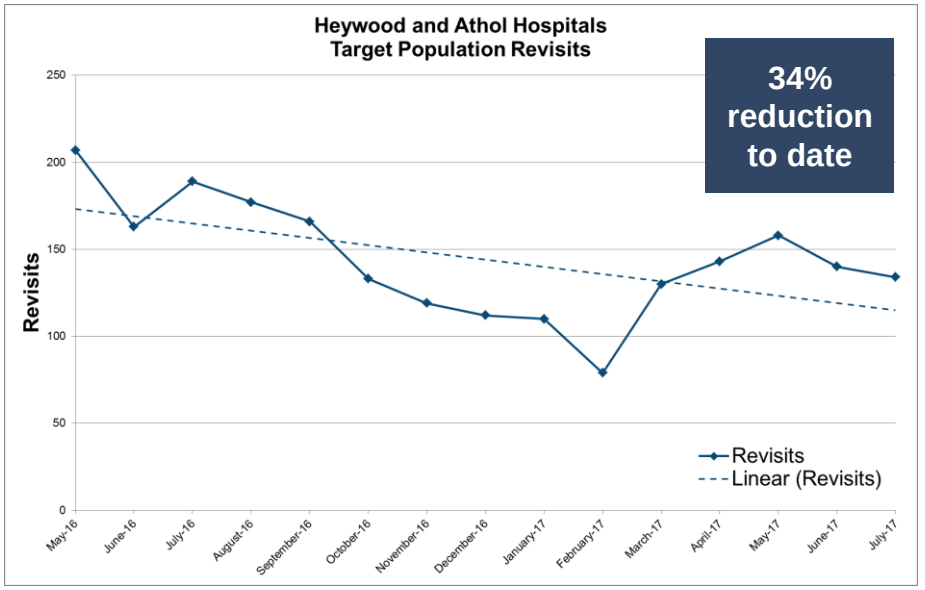
Heywood and Athol Hospitals
Improving care for behavioral health ED patients

Heywood Healthcare
Athol Hospital | Heywood Hospital

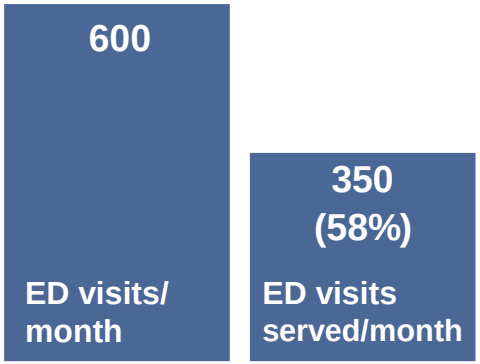
Team



7 FTEs 4 role types



Average volume



315 patients/ month

Success factors

- ✓ **Co-located in ED**
- ✓ **Clinical case finding, not billing data**
- ✓ **Shift from "medical" to "whole-person"**
- ✓ **Actively link to services, follow through**

*The team changed its targeting strategy in May 2016, and the graph reflects this approach.

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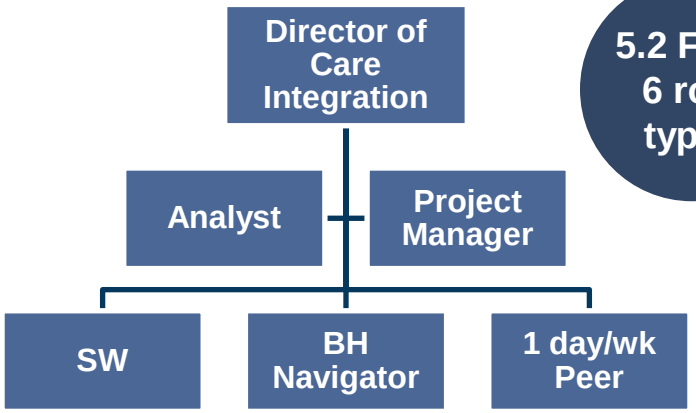
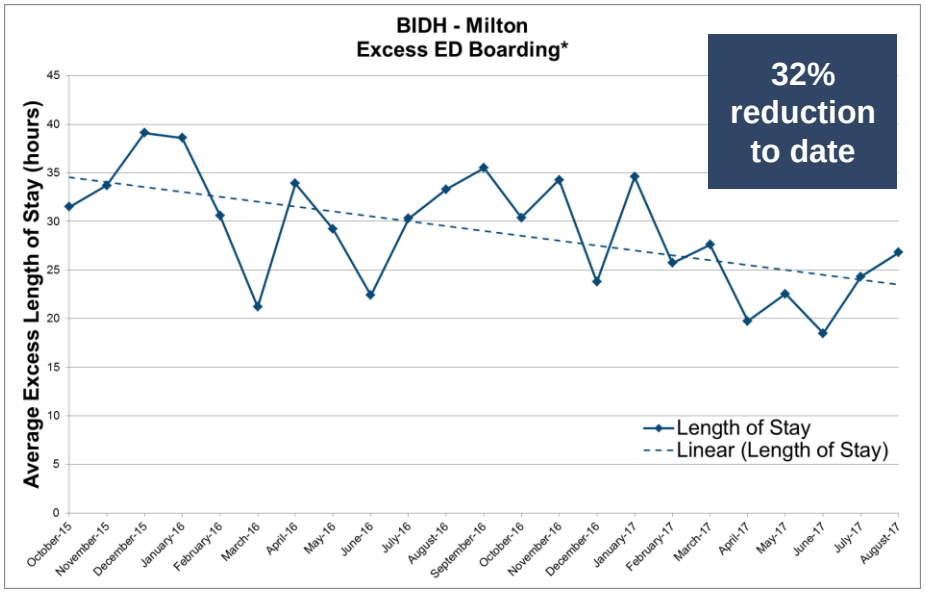
Beth Israel Deaconess Hospital – Milton
Improving care for behavioral health ED patients

Beth Israel Deaconess Hospital Milton

Team



5.2 FTEs 6 role types



Average volume

45	45 (100%)
ED visits/ month	ED visits served/ month

45 patients/ month

Success factors

- ✓ **Successful integration of SSMH clinicians into the ED**
- ✓ **Hardwired care processes in ED**
- ✓ **"Humanized" BH population in ED**
- ✓ **Extensive collection of collateral patient information**
- ✓ **Initiate medications and support in ED**
- ✓ **Longitudinal management of care transitions**

*Long stay ED behavioral health patients are defined as patients with a primary BH diagnosis and a length of stay greater than eight (8) hours. "Excess boarding" describes the portion of the length of stay in excess of four (4) hours.

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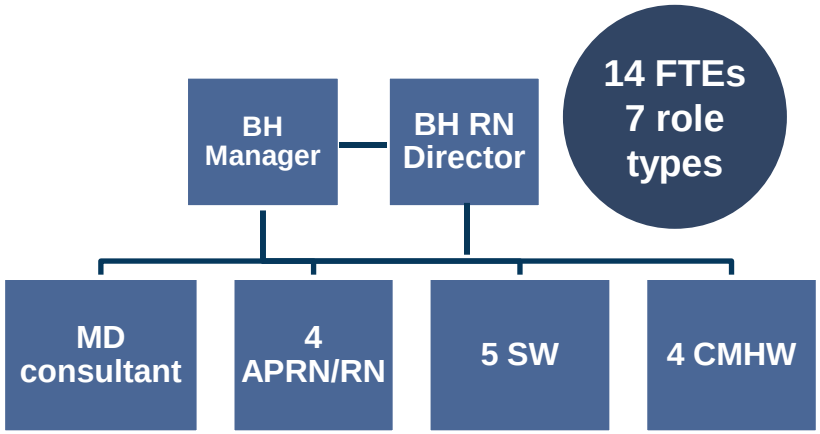
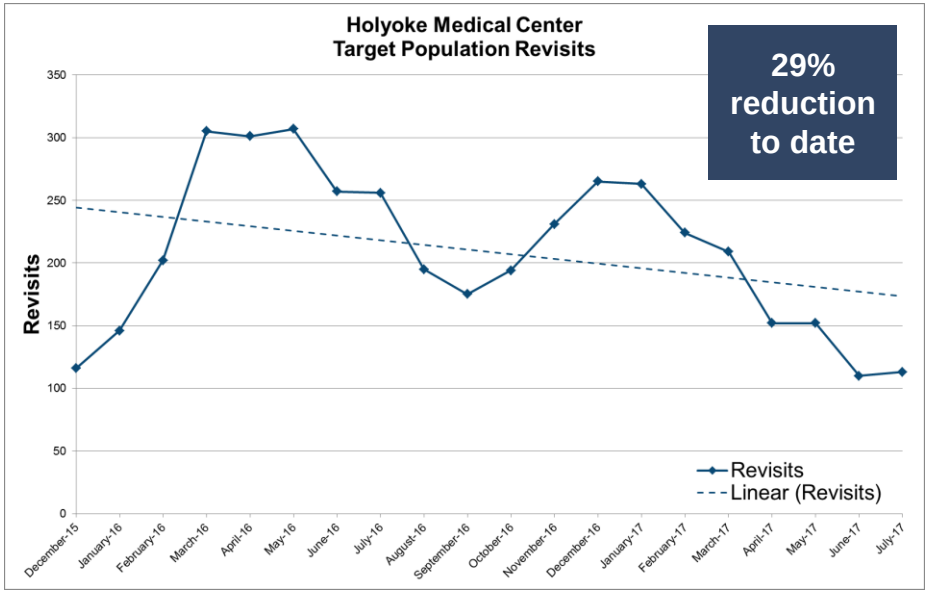
Holyoke Medical Center
Improving care for behavioral health ED patients

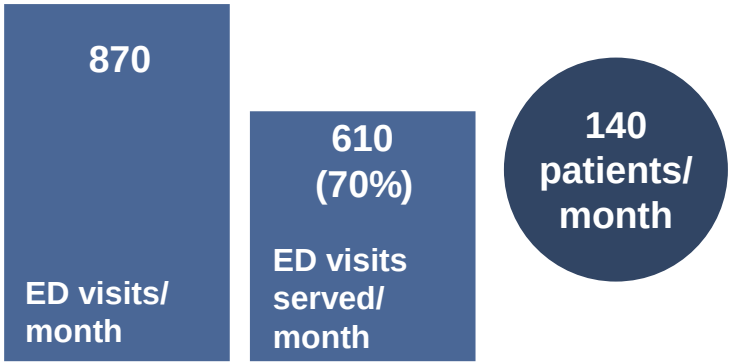
Holyoke Medical Center

Team





Average volume



Success factors

- ✓ **Flexible model to address patient needs**
- ✓ **Active presence in ED**
- ✓ **Persistence and commitment to engagement**
- ✓ **Director-to-Director level advocacy and problem-solving**

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