Complex Care Team aims to reduce readmissions for high-needs patients

BAYSTATE NOBLE HOSPITAL

Baystate Noble Hospital is a 97-bed acute care community hospital in Westfield that sees approximately 32,000 visits each year in its emergency department (ED). Baystate Noble is part of Baystate Health, a large, non-profit integrated health care delivery system serving Western Massachusetts.

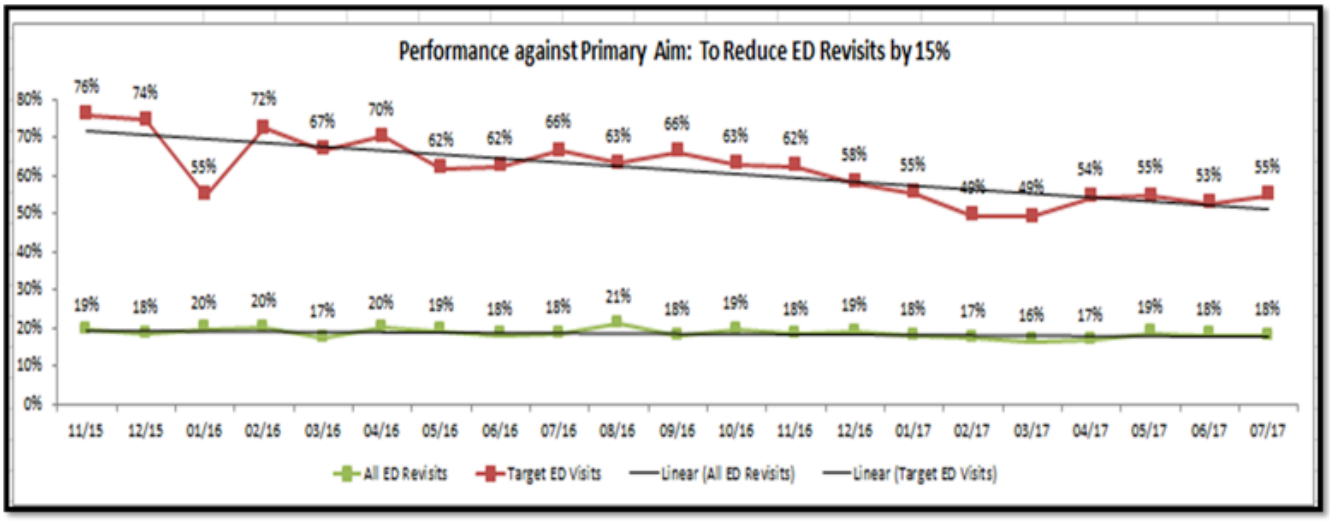
Challenge

Patients with high utilization of the emergency department tend to have more complex medical, social and behavioral health needs than the general population. This combination of characteristics can lead ED teams to spend significant time and resources managing these patients only to see them return. Baystate Noble Hospital set a goal to reduce 30-day readmissions by 25 percent among patients with high ED utilization and was awarded $1.2 million in support from the CHART Program to implement a program. Baystate Noble defined their intervention population as patients who had had four or more inpatient admissions or 10 or more ED visits in the past year.

Action

Baystate Noble began by assembling a Complex Care Team (CCT) that would identify and provide ongoing services and support to patients in the intervention population while they were in the ED, during an admission, and following discharge. The CCT was comprised of two nurses, two social workers and a full-time mental health clinician. Many of Noble's intervention patients had both chronic medical and behavioral health diagnoses, so having a mental health professional on the team was essential. The team assessed eligible patients, developed individualized care plans (ICP), coordinated medication optimization, and made 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.

Exhibit A: Performance against Primary Aim: To reduce ED revisits by 15%



The CCT built close relationships with nearby service providers, including the Behavioral Health Network, the respite care provider, the local pharmacy, Adult Community Clinical Supports workers, and other clinicians that were involved in the care of their patients. These close relationships allowed for monthly care plan meetings where the team would review the patients' progress and identify needs. These relationships also helped facilitate easier placement of patients when they needed an inpatient bed or appointment or when they needed to be connected to additional services. CCT was able to coordinate with the local pharmacist to deliver medications to patients. This home delivery service helped patients maintain their medication compliance by lowering barriers to obtaining medications.

The full-time mental health clinician on the CCT served as a liaison to the crisis mental health clinician who was on contract through the Behavioral Health Network. The CCT clinician also provided mental health support to patients when they were on-site for an ED visit, if they were boarding while waiting for a placement, or if they were admitted to the hospital.

In addition to providing care to patients while they were in the hospital, the CCT regularly reached out to their patients, either by phone or through home visits. Frequent phone calls to the patients helped identify barriers to care before they became urgent and made patients feel that they had supports in place should they need them. Home visits helped to bridge patients with counseling or medication checks to make sure they were getting the treatment they needed between appointments. Members of the CCT also accompanied patients to doctor's appointments, which helped improve communication between the patients and their primary care physicians.

Outcomes

Ultimately, Baystate Noble was successful in achieving their target reduction in ED revisits among this very vulnerable population. After the CHART grant funds terminated, the hospital invested in hiring a full-time mental health clinician on the medical floors as well as a transitional care coordinator in the ED to help manage this population of patients in the ED. The transitional care coordinator is an integral member of the ED team who is able to meet with patients right away and to help connect patients to services, review teaching with patients and ensures that these patients get what they need.

What is CHART?

The project described in this case study was supported by a Community Hospital Acceleration, Revitalization and Transformation (CHART) Investment from the Commonwealth of Massachusetts Health Policy Commission (HPC). The CHART program made innovative investments in the Commonwealth's community hospitals with the goal of establishing a foundation for sustainable care delivery. CHART funds enabled the hospitals to develop new care models designed to help patients avoid costly acute care settings like the emergency department by assessing local needs, modifying services, and expanding relationships with medical, social, and behavioral health community organizations.

501 Boylston Street, 5th Floor, Boston, MA 02116
BetsyLehmanCenterMA.gov
617-701-8271 • info@BetsyLehmanCenterMA.gov

BETSY LEHMAN CENTER for Patient Safety