

COMMONWEALTH OF MASSACHUSETTS
HEALTH POLICY COMMISSION

CHART Phase 2:
Implementation Plan
Anna Jaques Hospital

HPC approval date: September 15, 2015

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Version: 3



Introduction

This Implementation Plan details the scope and budget for Anna Jaques Hospital’s (“Contractor”) Award in Phase 2 of the Health Policy Commission’s (HPC) Community Hospital Acceleration, Revitalization, and Transformation (CHART) Investment Program. The Implementation Plan is incorporated by reference into and is subject to the requirements of the Phase 2 Award Contract, including the Phase 2 Terms & Conditions.

Many capitalized terms appearing in the Implementation Plan are defined in the Phase 2 Terms & Conditions or the Phase 2 Request for Proposals (RFP). In addition to capitalized terms, the Implementation Plan may include other acronyms and/or abbreviations whose meaning is understood by Contractor and the HPC in the context of the Implementation Plan. If there is disagreement concerning the meaning of a term, acronym, or abbreviation, the HPC’s interpretation shall govern.



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Key personnel

Name	Title	CHART Phase 2 Role
Mark Goldstein	President and Chief Executive Officer	Operational Investment Director
Gail Fayre, MD	Chief Medical Officer	Clinical Investment Director
Terry Rooney	Grant Project Manager	Project Manager
Kirsten Arnold	Director of Finance	Financial Designee

Definition

- 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
- Population 2: Patients at risk of high utilization as determined by BIDCO predictive modeling or clinical assessment to be at high risk

Quantification

- 876 discharges per year
 - 134 high utilizers with 666 discharges per year
- >2,340 ED visits per year
 - ~297 patients

^{*}Required target population for cohort-wide standard measures

^{**}Definition includes all payers and aged 18+; excluding OB, deaths, transfers to acute inpatient, and discharge to acute rehab

^{***}Exclude encounters with primary diagnosis of behavioral health, for the purposes of defining high utilization only

Aim Statement

Primary Aim Statement

Reduce 30-day readmissions by 20% for high utilizers of the hospital and ED by the end of the 24 month Measurement Period.

Secondary Aim Statement*

Reduce 30-day ED revisits by 25% for high utilizers of the hospital and ED by the end of the 24 month Measurement Period.

*Your secondary aim statement is a performance measure only and is not tied to Achievement Payment.

Baseline performance – Readmission reduction

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		Jan 14	Feb 14	Mar 14	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Avg.
Hospital-Wide	Readmits	70	83	77	58	60	47	61	65	46	63	55	TBD	62
	Discharges	464	418	462	435	447	407	438	424	394	425	381	TBD	427
	Rate (%)	15.1%	19.9%	16.7%	13.3%	13.4%	11.5%	13.9%	15.3%	11.7%	14.8%	14.4%	TBD	14.6%
Target Pop	Readmits	26	46	42	23	34	23	27	30	22	33	22	TBD	30
	Discharges	81	84	95	67	79	66	73	66	65	70	55	TBD	73
	Rate (%)	32.1%	54.8%	44.2%	34.3%	43.0%	34.8%	37.0%	45.5%	33.8%	47.1%	40.0%	TBD	40.9%

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Baseline performance – ED utilization reduction

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		Jan 14	Feb 14	Mar 14	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Avg.
All	All ED Visits	2160	1880	2209	2168	2271	2320	2665	2594	2194	2201	2033	TBD	2245
	All ED Revisits	164	155	144	157	144	113	150	149	146	154	122	TBD	145
	Revisit Rate	7.6%	8.2%	6.5%	7.2%	6.3%	4.9%	5.6%	5.7%	6.7%	7.0%	6.0%	TBD	6.5%
	LOS (min)	242	235	243	218	202	213	223	225	231	217	212	TBD	224
Target Pop	Target Pop ED Visits	163	164	223	200	211	195	211	215	189	193	177	TBD	195
	Target Pop ED Revisits	45	51	49	53	58	40	43	50	43	55	31	TBD	47
	Revisit Rate	27.6%	31.1%	22.0%	26.5%	27.5%	20.5%	20.4%	23.3%	22.8%	28.5%	17.5%	TBD	24.2%
	LOS (min)	253	248	267	260	208	230	244	237	200	234	210	TBD	236

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Estimated monthly impact

	Current Expected Served	Current Expected [Events]	New Expected Avoided Events	New Expected Events
HU 30-day readmissions	73*	(41% readmission) 30	(20% reduction of readmissions) 6	24
ED 30-day revisits	195	(24.2% rate) 47	(25% reduction) 12	35

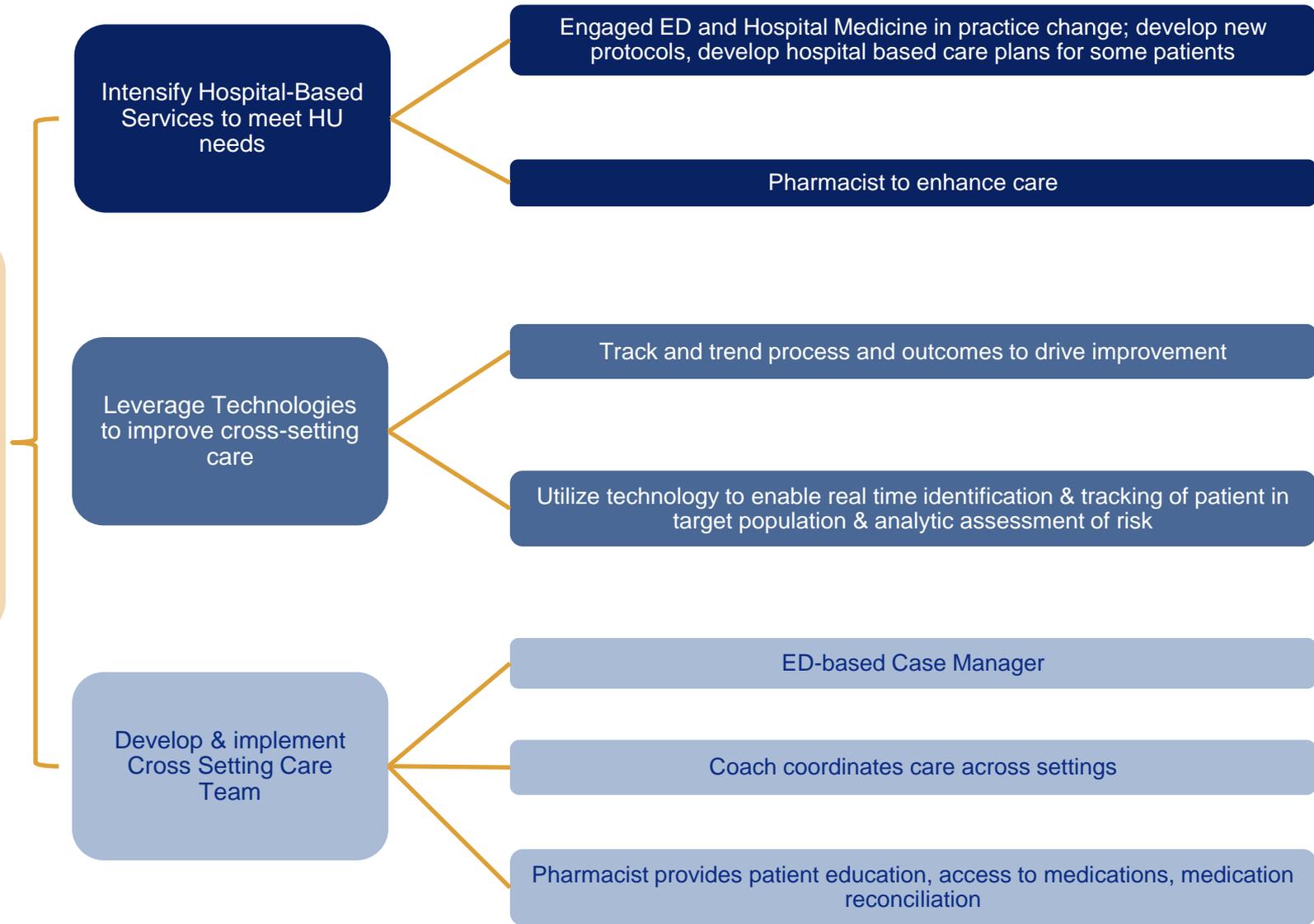
Avoided inpatient readmissions: 72 per year
 Avoided ED visits: 144 visits per year

*Using patients with a personal history of high utilization (Population 1); not including predicted HU (Population 2)

Driver Diagram

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Reduce 30-day readmissions by 20% for patients with a history of 4 or more hospitalizations or 6 or more ED visits per year



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*High utilizers are defined as 4 or more hospitalizations OR 6 or more ED visits in prior 12 months. Target population definition includes all payers and aged 18+; excluding OB, deaths, transfers to acute inpatient, and discharge to acute rehab

Service model

Narrative description

Anna Jaques Hospital's initiative for CHART Phase 2 grant funding is focused on decreasing readmissions and providing interventions that have demonstrated evidence of being effective. These efforts identify the highest risk patients and provide additional support to decrease the likelihood of readmission. The efforts are in collaboration with Elder Services of the Merrimack Valley (ESMV) that has demonstrated success in decreasing readmissions for a subset of Medicare patients in the 3026 grant program.

CHART 2 would expand on this program by utilizing the ESMV care transition intervention at the time of discharge and follow the patient in the community for 180 days. An ED case manager will focus on identifying patients that could be cared for without requiring hospital services and better served in alternative care settings such as home services or a skilled nursing facility. The inpatient focused intervention team will include a clinical pharmacist. The pharmacist will focus on enhancing the patients understanding of their medications, becoming a key component of the discharge process. The inpatient team will be working with the nurses, inpatient case managers and physicians with multidisciplinary rounding to assure the appropriate plans are in place prior to discharge.

Service worksheet

Abridged Implementation Plan – Not for budgeting or contracting purposes

Service Delivered

- Care transition coaching X
- Case finding X
- Behavioral health counseling
- Engagement X
- Follow up X
- Transportation
- Meals
- Housing
- In home supports
- Home safety evaluation
- Logistical needs
- Whole person needs assessment
- Medication review, reconciliation, & delivery X
- Education X
- Advocacy X
- Navigating X
- Peer support
- Crisis intervention
- Detox
- Motivational interviewing X
- Linkage to community services X
- Physician follow up
- Adult Day Health
- Other: _____

Personnel Type

- Hospital-based nurse X
 - Hospital-based social worker X
 - Hospital-based pharmacist X
 - Hospital-based NP/APRN
 - Hospital-based behavioral health worker
 - Hospital based psychiatrist
 - Community-based nurse X
 - Community-based social worker
 - Community-based pharmacist
 - Community-based behavioral health worker
 - Community-based psychiatrist
 - Community-based advocate
 - Community-based coach X
 - Community-based peer
 - Community agency X
 - Physician *** mention b/c have agreement with them to see their patients urgently
 - Palliative care X
 - EMS
 - Skilled nursing facility X
 - Home health agency X
 - Other: ___ ESMV Staff _____
 - Other: _____
 - Other: _____
 - Other: _____
 - Other: _____
- **community NP through BIDCO

Service Availability

- Mon. – Fri. X
- Weekends X
- 7days
- Holidays
- Days
- Evenings
- Nights
- Off-Shift Hours __

**We will learn best hours*

PAC partnership
Share information about HU
Warm handoffs to SNFs

PALL CARE SCREEN IN MEDITECH
Care dimensions consult

ED CM during day because to align with hours of referral agencies and PCP offices; also aligned with busiest hours in the ED

Service mix

Abridged Implementation Plan – Not for budgeting or contracting purposes

Service	By Whom	How Often	For How Long
Case Manager (Emergency Room)	RN	Full time FTE 1.0	7 days per week
Case Manager (Emergency Room)	RN	Part time FTE 0.25	7 days per week
Pharmacist	RPh or Pharm.D	Part time FTE 0.44	5 days per week
Administrative Professional	Clerical	Part time FTE 0.4	3 days per week
Elder Services of Merrimac Valley Coach + ESMV Support Staff	SW	Full time Monday-Friday \$375 per case Project 22 new cases per month = \$99,000 per year	180 days post discharge
Registration Representative	Clerical	Part time FTE 0.09	For each HU patient
Project Manager	Coordinating Clinical efforts and feedback on processes	Part time 0.5 - Contracted	5 days per week

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# FTE/units of service hired at my organization	2.18 FTE
# FTE/units of service contracted	264 care transition episodes per year

List of service providers/community agencies

Type of Service Provider	Community Agency Name	New or Existing Relationship
Elder services	Elder Services of Merrimack Valley	Existing
VNA	Angels Homecare	Existing
VNA	Home Health VNA & Hospice	Existing
SNF	Country Center for Rehab	Existing
SNF	Maplewood Rehab	Existing
SNF	Merrimack Valley Health Center	Existing
SNF	Port Rehab	Existing
Physician group	Whittier IPA	Existing
Hospice agency	Care Dimensions	Existing
ACOs	BIDCO	New

Summary of services

Narrative description

At Implementation Launch:

- Identify all patients discharged from AJH who had 4 or more hospitalizations in the past 12 months (source: discharge data)
- Cohort all known High Utilizers – run a list, identify known clinical/nonclinical issues (interview ED, hospital medicine)
- Feed from BIDCO re: patients at risk of becoming HU; quantify how many individuals this is per month
- Create flag in ED Information System to identify HU in real-time when registered in ED
- Create automated notification to CHART high risk care team (ED CM) when HU presents to the ED in real-time (from alert)
- AJH leadership to engage ED clinicians to raise awareness of CHART program, HU, admission avoidance, role of ED CM

In ED:

- HU or at-risk patient is identified in real-time; visual cue to ED clinician that this is “high utilizing” patient
- ED CM gets notified when HU/target pop patient registers in ED and engages in care
- ED CM leads AJH-based inpatient and ED team to develop comprehensive Acute Hospitalization Care Plans for HU and patients at risk of becoming HU as appropriate
- ED CM will ID patients who need a care plan and coordinate development
- ED CM works with ED clinicians to identify options to avoid admission, using the acute hospitalization care plan and leveraging the high risk care team resources to ensure follow up and linkage to care
- ED CM consults CHART Pharmacist to provide med review in ED as needed
- ED CM is hired at 1.23 FTE (49 hours weekly) (7 hours/day, 7 days per week) – can be leader of High Risk Care Team/Effort
- ED CM will get list of patients that were seen when off-hours

In the Hospital:

- Pharmacist-based medication optimization for all HU patients (134 patients with 666 discharges per year)
- Pharmacist / ED CM is champion of hospital based care team to ensure 100% MOLST discussion, reliable referral to pall care, BH, etc.
- Administrative assistant will ensure 100% timely follow up appointments with PCP and specialists are made

Post-Hospital:

- Patients not otherwise covered by CCTP are referred to ESMV for post hospital transitional care
- ESMV will deliver in-person follow up and status evaluations at any location (e.g. SNF or home)
- Most intensive contact (at least 4 visits) will occur in first 30 days, followed by less intensive contact over 180 days.
- Pall care through Care Dimensions
- NP contract with BIDCO for Home visits of their covered patients

Cohort-wide standard measures – Hospital utilization measures

Data elements	All	Target Population
1. Total Discharges from Inpatient Status (“IN”)	x	x
2. Total Discharges from Observation Status (“OBS”)	x	x
3. SUM: Total Discharges from IN or OBS (“ANY BED”)	x	x
4. Total Number of Unique Patients Discharged from “IN”	x	x
5. Total Number of Unique Patients Discharged from “OBS”	x	x
6. Total Number of Unique Patients Discharged from “ANY BED”	x	x
7. Total number of 30-day Readmissions (“IN” to “IN”)	x	x
8. Total number of 30-day Returns (“ANY BED” to “ANY BED”)	x	x
9. Total number of 30-day Returns to ED from “ANY BED”	x	x
10. Readmission rate (“IN readmissions” divided by “IN”)	x	x
11. Return rate (ANY 30-day Returns divided by “ANY BED”)	x	x

Cohort-wide standard measures – ED utilization measures

Data Elements	All	Target Population
12. Total number of ED visits	x	x
13. Total number of unique ED patients	x	x
14. Total number of ED visits, primary BH diagnosis		
15. Total number of unique patients with primary BH diagnosis		
16. Total number of ED visits, any BH diagnosis		
17. Total number of unique patients with any BH diagnosis		
18. Total number of 30-day ED revisits (ED to ED)	x	x
19. Total number of 30-day revisits (ED to ED), primary BH diagnosis		
20. Total number of 30-day revisits (ED to ED), any BH diagnosis		
21. ED revisit rate	x	x
22. ED BH revisit rate (primary BH diagnosis only)		
23. ED BH revisit rate (any BH diagnosis)		
24a. Median ED LOS (time from arrival to departure, in minutes)		
24b. Min ED LOS (time from arrival to departure, in minutes)		
24c. Max ED LOS (time from arrival to departure, in minutes)		
25a. Median ED LOS (time from arrival to departure, in minutes), primary BH diagnosis		
25b. Min ED LOS (time from arrival to departure, in minutes), primary BH diagnosis		
25c. Max ED LOS (time from arrival to departure, in minutes), primary BH diagnosis		
26a. Median ED LOS for ED boarders per DPH boarder definition (patients with a primary behavioral health diagnosis who remain in the ED for 12 or more hours from ED arrival to ED departure)		
26b. Min ED LOS for ED boarders per DPH boarder definition (patients with a primary behavioral health diagnosis who remain in the ED for 12 or more hours from ED arrival to ED departure)		
26c. Max ED LOS for ED boarders per DPH boarder definition (patients with a primary behavioral health diagnosis who remain in the ED for 12 or more hours from ED arrival to ED departure)		

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Cohort-wide standard measures – Service delivery measures

Data elements	Target Population
27. Total number of unique patients in the target population	x
28. Number of acute encounters for target population patients	x
29. For acute encounters in measure #28, number of these with any CHART service provided after discharge and within 48 hours	x
30. Total number of contacts for the target population	x
31. Average number of contacts per patient served	x
32a. Min number of contacts for patients served	x
32b. Max number of contacts for patients served	x
33. Number of units of service provided by service modality (including, e.g., phone call, virtual interaction, face to face in office, face to face in home, etc.)	x
34. Number of units of service provided, by service types (e.g., care coordination, medication optimization, clinical care, counseling, needs assessment, etc.)	x
35. Number of units of service provided, by role type (NP, LICSW, Pharmacist, Community Health Worker, Peer)	x
36. Average time (days, months) enrolled in CHART program per patient	x
37. Range time (days, months) enrolled in CHART program per patient	x
38. Proportion of target population patients with care plan	x

Cohort-wide standard measures – Payer mix

Data elements	Medicare	Medicaid	Commercial
39. Count of patients in the Target Population	x	x	x

Program-specific measures – High utilizer

Measure ID	Measure Description
H001	Number of TP patients identified for whom there is a full six months of time passed following CHART eligibility
H002	Total discharges for 6 months before CHART eligibility
H003	Total 30-day readmissions for 6 months before CHART eligibility
H004	Total ED visits for 6 months before CHART eligibility
H005	Total 30-day ED revisits for 6 months before CHART eligibility
H006	Total discharges for 6 months starting on and inclusive of the date of CHART eligibility
H007	Total 30-day readmissions for 6 months starting on and inclusive of the date of CHART eligibility
H008	Total ED visits for 6 months starting on and inclusive of the date of CHART eligibility
H009	Total 30-day ED revisits for 6 months starting on and inclusive of the date of CHART eligibility
H010	Total months following CHART eligibility without exit event

Program-specific measures

Measure	Numerator	Denominator
% of target population seen by CM in ED	TOUCH POINT WITH PT	HR PT PRESENTS TO ED
Medication Reconciliation on discharge	MED REC ON DISCHARGE	HR PT DISCHARGED
Medication Reconciliation on 1 f/u call	MED REC ON ONE PHONE CALL F/U	HR PT DISCHARGED
ESMV intervention completed/target pop accepting referral	INTERVENTIONS POST ACUTE CARE	HR PT ACCEPTING REFERRAL
% of target population patients with warm handoff	TEAM MEMBER DISCUSSED CASE WITH NEXT CARE PROVIDER	HR PT ADMITTED
% of target population seen <7 days of ED visits	HR PATIENTS SEEN WITHIN 7 DAYS POST ED VISIT	HR PT PRESENTS TO ED
% of target population seen <7 days of discharge	HR PATIENTS SEEN WITHIN 7 DAYS POST ADMISSION	HR PT ADMITTED
30-day return for target pop (exclude BH)	ED VISITS WITHIN 30 DAYS IN PATIENT WITHOUT PRIMARY PSYCH DIAGNOSIS	ALL ED VISITS
30-day return for target pop (exclude BH)	30 DAY READMISSION IN PATIENT WITHOUT PRIMARY PSYCH DIAGNOSIS	ALL INPATIENT ADMISSIONS
Target population satisfaction with ESMV	PATIENT SATISFACTION SCORES	NUMBER OF PATIENTS WHO TOOK THE SURVEY

Continuous improvement plan (1 of 2)

<p>1. How will the team share data?</p>	<p>Monthly team meetings to review data; if process measures not meeting goal will meet weekly with data</p>
<p>2. How frequently will you (PM, Investment Director) look at the data (e.g., weekly)?</p>	<p>Monthly for outcomes measures Process measures reviewed weekly</p>
<p>3. How often will your executive team (VPs, C-suite) review CHART project reporting (e.g., monthly)?</p>	<p>Quarterly</p>
<p>4. How often will your front line CHART staff (SW, care team) review reporting (e.g., weekly)?</p>	<p>Monthly for outcomes measures Weekly update for process measures</p>
<p>5. How often will your community partners review data (e.g., weekly, monthly)?</p>	<p>As above</p>
<p>6. Which community partners will look at CHART data (specific providers and agencies)?</p>	<p>IPA leadership, ESMV</p>
<p>7. Will the quality committee of your board review CHART reporting (e.g., quarterly)?</p>	<p>Quarterly review by quality committee of board, will also share with staff through patient safety committee quarterly</p>

Continuous improvement plan (2 of 2)

8. Who will collect measures and produce reporting for Cohort-wide and program specific measure (e.g., Data Analyst, PM, ID)?	Cohort-Wide	Program specific
	Report writing is outsourced for grant and Admin Personnel and Program Manager will generate reports	Same
9. What is your approximate level of effort to collect these metrics?	Cohort-Wide	Program specific
	Moderate/high	Moderate/high
10. How will you ensure that you are able to collect both your program specific and the cohort-wide measures?	Structure outsource reports with it and program management	
11. How will you know when to make a change in your service model or operational tactics?	If not meeting process measure outcomes, and if not seeing change in cohort utilization after 6 months.	

Enabling Technologies plan

Functionality	User	Vendor	Cost
Monthly reporting	CHART clinical team	Information Technology Analyst	\$74,184.36, including fringe
Report building	CHART clinical team	Programmer	\$20,000

Enabling Technologies plan – Q&A

How are you going to identify target population patients in real-time?

- They will be identified in Meditech for appropriate staff and physicians

How will you measure what services were delivered by what staff?

- Reports will inform interventions by presence of documentation in Meditech by care team members

How will you measure outcome measures monthly?

- Reports run through Meditech and Care at Hand. Reporting on total readmission rates

What tool/platform will you use to facilitate cross-setting and multi-disciplinary coordination of care?

- No direct interface, but will have physical paper access

Where will individual care plans reside, and what is the plan for making them available on a need-to-know basis 24/7 in the ED, hospital, and ambulatory settings?

- In the EMR, Meditech

Do you have a method for identifying what clinical services your target population accesses?

- We can identify admissions/discharges for our facility, ED visits for our facility. We will not have information for all patients on other services they utilize outside of our partners information such as ESMV, home health etc.

Other essential investments

Slide intentionally left blank.

Key dates

Key milestone	Date
Launch date (beginning of your 24 month Measurement Period)	10/1/15
Post jobs (YP's CM position has been posted. Meeting Pharmacy next week to discuss job description & posting date)	9/11/15
New hires made	10/16/15
Execute contracts with service delivery partners (ESMV can be done in next 2-3 weeks but according to RB Iatrics will need additional time to get report design done.)	10/15/15
Initiatives support 50% of planned patient capacity	11/1/15
Initiatives support 100% of planned patient capacity	12/1/15
First test report of required measures <ul style="list-style-type: none"> • Pilot report on outcome measures for CHART patients seen Oct 1-31 –but dependent on HPC delivery of final metrics by 8/26 so Iatrics has enough time to get the reports designed. • Reporting on process measures can begin on 10/1/15. 	11/6/15
Trainings completed, if any [describe these – include multiple lines as necessary] <ul style="list-style-type: none"> • Case Manager, Pharmacist & Admin Assistant on Meditech. • Project Manager trainings on Meditech & Care at Hand complete. 	10/23/15
First patient seen	10/1/15
Other important milestones you have identified (e.g., staff/user acceptance/patient satisfaction survey) <ul style="list-style-type: none"> • Patient satisfaction survey issued to all CHART patients receiving ESVM services within 14 days of completion of 180 days of service? 	14 days post receipt of 180 days of services from ESVM

Community partners/subcontractors

Name	Business Address	Website	Contact Name	Contact Title	Contact Phone Number	Contact Email Address
Elder Services of the Merrimack Valley (ESMV)	280 Merrimack St Suite 400, Lawrence, MA 01843	www.esmv.org	Nicole Ingachuck	Staff Development Manager	(978) 946-1316	ningachuck@esmv.org
Terry Rooney	183 High St. Newburyport, MA 01950	n/a	Terry Rooney	Project Manager	(978) 463-1403	trooney@ajh.org