

COMMONWEALTH OF MASSACHUSETTS
HEALTH POLICY COMMISSION

CHART Phase 2:
Implementation Plan
Baystate Franklin Medical Center

HPC approval date: September 18, 2015

Last modified: April 19, 2016

Version: 2



Introduction

This Implementation Plan details the scope and budget for Baystate Franklin Medical Center’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
Thomas Higgins, MD	Interim President and Chief Medical Officer	
Leesa-Lee Keith, RN	Chief Nursing Officer and Director of Patient Care	Clinical Investment Director
Andrea Nathanson	Director of Finance	Operational Investment Director and Financial Designee
Annette Szpila	Project Manager	Project Manager

Target population

Definition

- Patients with a personal history of high utilization,^{*} as identified by one or more of the following:
 - 4 or more hospital discharges in the prior 12 months
 - 5 or more BH ED visits (primary or secondary diagnoses) in the prior 12 months

Quantification

- 466 discharges per year (97 patients)
- 1,213 ED visits per year (95 patients)

Primary Aim Statements

Reduce 30-day ED revisits by 25% for patients with ≥ 5 BH ED visits (primary or secondary) or ≥ 4 inpatient stays in the last year by the end of the 24 month Measurement Period.

Reduce 30-day readmissions by 25% for patients with ≥ 5 BH ED visits (primary or secondary) or ≥ 4 inpatient stays in the last year by the end of the 24 month Measurement Period.

Baseline performance – Readmission reduction

		Nov 13	Dec 13	Jan 14	Feb 14	Mar 14	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14	Oct 14	Avg.
Hospital-Wide	Readmits	27	26	28	28	37	40	45	37	43	34	39	32	35
	Discharges	213	241	275	239	276	308	309	308	297	288	275	319	279
	Rate (%)	12.7%	10.8%	10.2%	11.7%	13.4%	13.0%	14.6%	12.0%	14.5%	11.8%	14.2%	10.0%	12.4%
Target Pop	Readmits	4	9	13	11	19	23	21	14	15	17	20	18	15
	Discharges	22	29	35	30	44	56	42	40	40	39	48	41	39
	Rate (%)	18.2%	31.0%	37.1%	36.7%	43.2%	41.1%	50.0%	35.0%	37.5%	43.6%	41.7%	43.9%	39.5%

Baseline Performance – ED utilization reduction

		Nov 13	Dec 13	Jan 14	Feb 14	Mar 14	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14	Oct 14	Avg.
All	All ED Visits	1,769	1,785	1,865	1,604	1,805	1,865	2,146	1,990	2,153	2,092	1,958	2,033	1,922
	All ED Revisits	443	441	434	375	459	498	529	479	551	533	465	518	477
	Revisit Rate	25.0%	24.7%	23.3%	23.4%	25.4%	26.7%	24.7%	24.1%	25.6%	25.5%	23.7%	25.5%	24.8%
	LOS (min)	156	160	177	185	181	177	175	178	176	165	166	177	174
Target Pop	Target Pop ED Visits	96	86	75	78	90	130	119	125	114	105	114	81	101
	Target Pop ED Revisits	69	66	49	56	63	99	91	91	80	83	85	51	74
	Revisit Rate	71.9%	76.7%	65.3%	71.8%	70.0%	76.2%	76.5%	72.8%	70.2%	79.0%	74.6%	63.0%	72.8%
	LOS (min)	145	186	226	210	223	172	220	264	238	241	185	263	224

Estimated monthly impact

	Current Expected Served	Current Expected Readmissions	New Expected Avoided Readmissions	New Expected Readmissions
Reduce ED 30-day revisits	101 ED visits per month (1,213 per year) served by the initiative	Given an average revisit rate of 73% for this population, we expect $.73 \times 101 = 74$ revisits per month (888 per year)	Given a goal of 25% reduction in revisits, we expect a $.25 \times 74 =$ an average of 19 avoided revisits per month (228 per year)	Then, we expect $74 - 19 = 55$ revisits per month (660 per year)
Reduce inpatient 30-day readmission	39 discharges per month (466 per year) served by Care Transitions team	Given an average readmission rate of 39.5% for this population, we expect $.395 \times 39 = 15$ readmissions per month (180 per year)	Given a goal of 25% reduction in readmissions, we expect $.25 \times 15 =$ an average of 4 avoided readmissions per month (48 per year)	Then, we expect $15 - 4 = 11$ readmissions per month (132 per year)

Driver Diagram

Reduce 30-day ED revisits and 30-day readmissions by 25% respectively for patients with ≥ 5 BH ED visits (primary or secondary) or ≥ 4 inpatient stays in the last year by the end of the 24 month Measurement Period.

Enhance care in ED

Screen for SUD and/or BH using assessment tools

Perform Brief Intervention, Refer to Treatment ([S]BIRT) for +SUD screens

CCT notified when Pt in ED – work with ED staff to determine appropriate services versus admission.

For CCT – LICSW with Psych NP and/or NP (as indicated) lead Development of multidisciplinary individualized care plan (ICP)

LICSW coordinates referral to outpatient/ community services – warm hand-off to OP , PHP, other peer support, Community Health Worker

Enhance Inpatient Care

LICSW or NP rounds with inpatient Hospital team, develops/ updates multidisciplinary ICP

LICSW assesses transitions & ensures services, supports, etc.

Pharmacist reviews meds for appropriateness, affordability, adherence.

CHW establishes relationship and provides navigation/high touch support in community

Increase Access to Behavioral Health care

Increase access to, and participation in, Partial Hospital Programs through additional intake capacity

LICSW follow-up to ensure connection to outpatient BH services; connects to BH peer support in community

Leverage technology to support cross-setting complex care

Create flag in ED to identify Target Population

Repository for sharing individual care plans

Real time notification when patient presents for care across settings

Narrative description

Baystate Franklin Medical Center will reduce avoidable utilization [measured as readmissions and revisits] for the target population of individuals with a BH diagnosis and 5 or more ED visits by 25% and for the target population of inpatient high utilizers patients with 4 or more inpatient stays by 25% by intensifying assessment and services in the ED and inpatient settings, by deploying a dedicated clinical team across care settings, and by increasing access to behavioral health services. We will deliver a new service model, supported by enabling technologies.

Prior to presentation in the ED:

- We will identify all target population patients based on our defined criteria, and create a registry
- The registry will be updated as individuals “screen in” to the target population, based on their utilization history and Dx
- We will create a flag in the EDIS to identify 30-day return patients, as well as target population patients (HU)
- Where appropriate, we will develop an ED-based acute hospital (or individual care plan) – intended to support ED clinician decision making regarding decision to admit.
- We will develop a working template of a cross-setting comprehensive care plan that will be shared and updated among all service providers, including PCP specialists and behavioral health clinicians. This care plan will be developed, updated and disseminated by the CHART complex care team.

In the ED:

- ED triage nurses will screen all patients for SUD and BH using CAGE and other tools identified with HPC’s support.
- Patients who screen +, a Brief Intervention and Referral to Treatment will be performed by ED Mental Health Worker (MHW) or ED staff RN’s ([S]BIRT)
- LICSW coordinates referrals to outpatient /community services as well as BH peer support for follow-up as indicated.
- For Inpt HU: Complex Care Team notified when HU in ED, NP and SW accesses/updates individual care plan, and works with ED staff to determine appropriate services versus admission.

In the Hospital:

- Complex Care Team rounds on HU Inpatients and develops multidisciplinary, cross setting individual care plan
- Complex Care Team in collaboration with hospital staff assess clinical and social needs and coordinates PAC services including CHW’s for high touch support/navigation
- For BHHU, CCT led by LICSW in collaboration with Psych NP and BH providers access or develop a comprehensive care plan
- Pharmacist optimizes medications including poly pharmacy, affordability and adherence.
- Community health worker establishes relationship prior to discharge

Following Discharge, for 30 days or as needed:

- CCT follows patient as needed, including telephonic and/or in-home visits by LICSW, NP, and/or CHW
- Rapid access to partial hospitalization - as appropriate
- CCT ensure follow-up of BH treatment plan and links to rapid access to PCP when needed

Service worksheet

• Service Delivered

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

• Personnel Type

- X **Hospital-based nurse (CNL)**
- X **Hospital-based social worker**
 - Hospital-based pharmacist (as needed- in kind)
 - Hospital based community resource specialist
- X **Community-based nurse**
- X **Community-based social worker**
- X **Community-based behavioral health worker**
 - Community-based psychiatrist/ mental health clinician (as needed)
 - Community-based transition coach (subcontracted through ESMV)
 - Home health agency (as needed)
 - Skilled nursing facility (as needed)
- X **Community-based peer**
 - Community-based pharmacist
- X **Community agency**
 - Community-based advocate
 - Physician
 - Palliative care
 - EMS
- X **Hospital-based NP/APRN**
- X **Hospital-based behavioral health worker**
 - Hospital based psychiatrist

• Service Availability

- X Mon. – Fri.
- X **Weekends (on call)**
- X **Holidays (on call)**

- X Days
- X **Evenings – until 8-9P**
 - Nights
 - Off-Shift Hours
 - 7days

Service mix

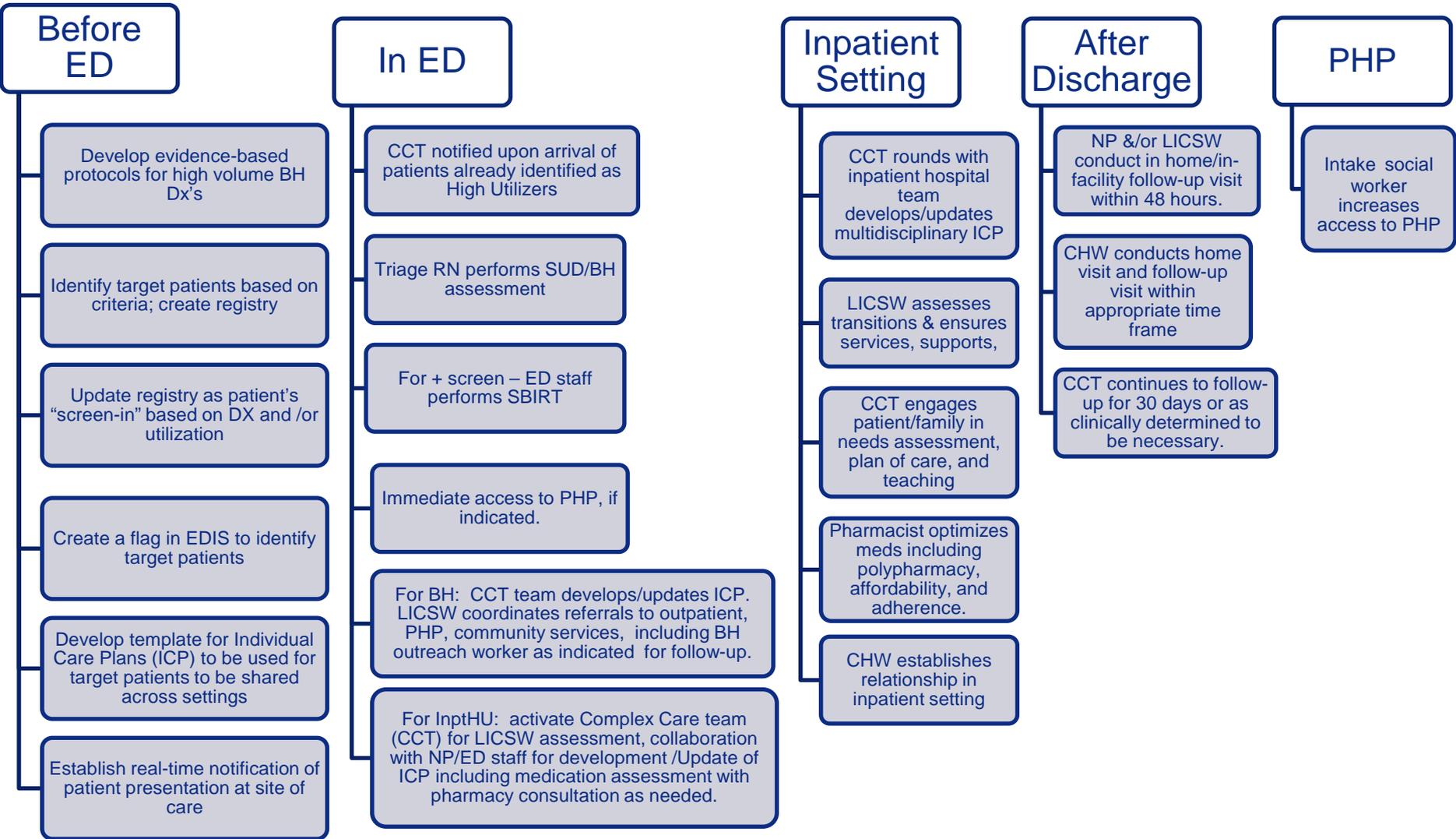
Service	By Whom	How Often	For How Long
SBIRT	Mental Health Worker (MHW) based in BFMC ED (bachelors/masters) – existing; <i>not CHART-funded</i>	Available 24/7 Used as needed	Each encounter is brief Available for length of award
Medication optimization including poly pharmacy, affordability and adherence	BFMC Pharmacist – existing; <i>not CHART-funded</i>	Available Mon – Fri, 8am-4pm Used as needed	Each encounter is brief Available for length of award
Member of Complex Care Team (CCT) - Collaborate in development/update of multidisciplinary, individual care plan (ICP), link to PCP, med management	2 FTEs – Clinical Nurse Practitioners (Medical and Behavioral Health) – BFMC	In hospital ED engagement/inpatient rounds. Post –hospital/post-ED a member(s) of CCT will follow-up with patient within 24 hours. Home visit for inpatient HU's within 48 hours. Ongoing support/follow as indicated by CCT.	Follow for 30 days or longer if needed
Leader/Coordinator of CCT – collaborate with NP(s) to develop ICP, initial post-discharge visit and assessment of needs	1 FTE - Licensed Independent Clinical Social Worker (LICSW)– Lead/Coordinator of CCT	In hospital ED engagement/inpatient rounds. Post –hospital/post-ED a member(s) of CCT will follow-up with patient within 24 hours. Home visit for inpatient HU's within 48 hours. Ongoing support/follow as indicated by CCT.	Follow for 30 days or longer if needed
Member of CCT – Community-based support for patients on panel	3.5 FTEs Community Health Workers (CHW) – Contracted – possibly 2 different skill levels	As needed to ensure patient stabilizes in community and receives follow-up care.	Follow for 30 days or longer if needed
SUD Recovery &/or BH Peer Support (Peer Specialist)	0.5 FTE Peer Recovery & Support Specialist - contracted	As needed to ensure patient stabilizes in community and to provide support for follow-though on plan.	Follow for 30 days or longer if needed
Medical oversight and NP supervision	Physician/Psychiatrist (stipend)	Based on patient needs	Needed for duration of CHART
Partial Hospitalization Expansion	1.0 FTE Intake Professional LICSW: <i>0.5 FTE CHART funded and 0.5 FTE BFMC In-kind</i>	Daily	Duration of CHART

# FTE/units of service hired at my organization	3.5 FTEs
# FTE/units of service contracted	4 FTEs

List of service providers/community agencies

Type of Service Provider	Community Agency Name	New or Existing Relationship
Home Care/Community Resources	Franklin County Home Care Corporation	Existing
Behavioral Health Services	Clinical Support Options (CSO)	Existing
Behavioral Health Services	Servicenet	Existing
Behavioral Health Services	Center for Human Development (CHD)	Existing
Primary Care Practices	Valley Medical Group	Existing
Primary Care Practices	Community Health Center	Existing
Primary Care Practices	Greenfield Family Medicine	Existing
Primary Care Practices	Connecticut River Internists	Existing
Primary Care Practices	Deerfield Adult Medicine	Existing

Summary of services



Cohort-wide standard measures – Hospital utilization

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

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	x	x
15. Total number of unique patients with primary BH diagnosis	x	x
16. Total number of ED visits, any BH diagnosis	x	x
17. Total number of unique patients with any BH diagnosis	x	x
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	x	x
20. Total number of 30-day revisits (ED to ED), any BH diagnosis	x	x
21. ED revisit rate	x	x
22. ED BH revisit rate (primary BH diagnosis only)	x	x
23. ED BH revisit rate (any BH diagnosis)	x	x
24a. Median ED LOS (time from arrival to departure, in minutes)	x	x
24b. Min ED LOS (time from arrival to departure, in minutes)	x	x
24c. Max ED LOS (time from arrival to departure, in minutes)	x	x

Standard exclusions: <18, OB (DRG 765-782), discharged deceased or transfer to acute hospital

Note: Data elements that do not have a population selected are not required for measurement. Not all measures are required for all hospitals.

Cohort-wide standard measures – Service delivery

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

Updated Measure Definition	Numerator	Denominator
# CCT hours per month per patient case	Total service time of chart clinicians in minutes for prior month	Total number of patients receiving services in prior month
% of BH HU Target population with ED care plans	Count of ED BH HU's with ED care plan	Total number of ED BH HUs from prior month
Average Partial Hospitalization (PHP) time (in days) from referral to intake for ED BH target pop patients and range	Count of patients referred to PHP in prior month	Sum of time – in days – from referral to intake for patients referred to PHP in prior month
Average PHP time (in days) from intake to program start for ED BH target pop patients and range	Count of patients referred to PHP in prior month	Sum of time – in days – from intake to program start for patients referred to PHP in prior month
% of ED Hu patients who received an SBIRT screening	Count of ED HUs who received an SBIRT screen	Total number of ED HUs from prior month
Total Discharges to SNF	Number of inpatient discharges that were discharged to a skilled nursing facility	N/A
Total Discharges to Home Health	Number of inpatient discharges that were discharged to home health	N/A
Total Discharges to Home	Number of inpatient discharges that were discharged to home	N/A
Total number of primary BH ED visits discharged home	Number of ED visits with a primary diagnosis of BH, that were discharged to home	N/A
Total number of primary BH ED visits admit to med/surg	Number of ED visits with a primary diagnosis of BH, that were admitted to med/surg	N/A
Total number of primary BH ED visits admit/transfer to psych unit	Number of ED visits with a primary diagnosis of BH, that were admitted/transferred to psych unit	N/A
Total number of any BH ED visit discharged to home	Number of ED visits with any diagnosis of BH, that were discharged to home	N/A
Total number of any BH ED visit admit to med/surg	Number of ED visits with any diagnosis of BH, that were discharged admitted to med/surg	N/A
Total number of any BH ED visit admit/transfer to psych unit	Number of ED visits with any diagnosis of BH, that were admitted/transferred to psych unit	N/A

Continuous improvement plan (1 of 2)

<p>1. How will the team share data?</p>	<p>Plan is to maintain up-to-date reporting on CCT activity. We'll need a plan to determine which types of information are shared with whom and by what method. Will use a combination of shared access to system data and email distribution of reports, etc.</p>
<p>2. How frequently will you (PM, Investment Director) look at the data (e.g., weekly)?</p>	<p>PM (or team lead if no PM) will look at data daily. Clinical investment director will review activity weekly. Operational investment director will review monthly.</p>
<p>3. How often will your executive team (VPs, C-suite) review CHART project reporting (e.g., monthly)?</p>	<p>Both CHART investment directors are on the BFMC executive team and will share high-level information on CHART project activity with the team on a monthly basis as part of standing team meetings.</p>
<p>4. How often will your front line CHART staff (SW, care team) review reporting (e.g., weekly)?</p>	<p>CCT will review data on current patient panel daily and will review higher-level data weekly or monthly as appropriate.</p>
<p>5. How often will your community partners review data (e.g., weekly, monthly)?</p>	<p>Community partners as members of CCT will review data along with care team. Community partner leadership will receive/review data consistent with BFMC senior team.</p>
<p>6. Which community partners will look at CHART data (specific providers and agencies)?</p>	<p>Franklin County Home Care Corporation Clinical & Support Options</p>
<p>7. Will the quality committee of your board review CHART reporting (e.g., quarterly)?</p>	<p>Baystate Health CHART Steering Committee will be responsible for reporting program performance to system quality board on a regular basis.</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
9. What is your approximate level of effort to collect these metrics?	Cohort-Wide	Program specific
10. How will you ensure that you are able to collect both your program specific and the cohort-wide measures?	Assure understanding of which data reside in what systems and assign responsibility for accurate collection and reliable reporting.	
11. How will you know when to make a change in your service model or operational tactics?	The CHART team will regularly review CHART data to identify issues and opportunities for improvement. We will use a lean management approach to continuous improvement.	

Enabling Technologies plan

Functionality	User	Vendor	Cost
Reporting, care management, individualized care plans	Program manager and members the care team	Medecision	\$210,000 funded by HPC (total \$360,00)

Enabling Technologies plan – Q&A

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

- BFMC will use MIDAS to identify patients that meet the high utilizer criteria and use an existing function in CIS to trigger an alert when an HU patient is in the ED.

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

- BFMC will use Medecision software to schedule and track all staff activities.

How will you measure outcome measures monthly?

- BFMC will extract hospital data using MIDAS.

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

- BFMC will use Medecision and PVIX to facilitate cross-setting and multidisciplinary coordination of care.

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?

- Individual care plans will be created and updated in Medecision and will be shared using PVIX and CIS.

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

- We will be able to identify clinical services accessed by our target population if provided by the subset of providers with whom we intentionally partner/connect. We do plan to connect with the larger primary care practices and bh providers in the area. We may not be able to identify services provided by other providers.

Other essential investments

Other Investments	Cost
Physician supervision (stipend)	\$50,000
Baystate VNA Purchased Services	\$14,400
Staff travel to patients homes	\$6,000

Key dates

Key milestone	Date
Launch date (beginning of your 24 month Measurement Period)	11/1/2015
Post jobs	9/7/15
New hires made	10/15
Readmissions reduction initiatives support 50% of planned patient capacity	11/15
Readmissions reduction initiatives support 100% of planned patient capacity	2/16 (credentialing takes 90 days)
First test report of services, measures - Medecision	11/20/15
Enabling technology – testing initiated	11/2/15
Enabling technology – go-live	12/1/15
Trainings completed, if any [describe these – include multiple lines as necessary]	12/15
First patient seen	11/15/15

Community partners/subcontractors

Name	Business Address	Website	Contact Name	Contact Title	Contact Phone Number	Contact Email Address
Franklin County Home Care Corporation	330 Montague City Road, Suite 1 Turners Falls, MA 01376-2530	www.fchcc.org	Roseann Martoccia, MPA	Executive Director	413-773-5555 x2270	rmartoccia@fchcc.org
Clinical & Support Options	8 Atwood Dr. Northampton, MA 01060	www.csoinc.org	Nick Fleisher, LICSW	Vice President of Community-Based Services	413-773-1314 x1019	NFleisher@csoinc.org
Medecision, Inc.	8121 Preston Rd. Ste. 900 Dallas, TX 75225	www.medecision.com	William Gillespie, MD	Chief Medical Officer	860-916-7337	wgillespie@gillespiehealthstrategies.com
Baystate Visiting Nurse Association and Hospice	50 Maple Street Springfield, MA 01101		Sally Kaufmann, MS OTR	Director, Post Acute Integration and Business Development	413-794-6529	sally.kaufmann@baystatehealth.org
Baystate Medical Practices (MD supervision of NPs)	Multiple – within Baystate system		Tom Higgins, MD	Chief Medical Officer, BMP Northern Region	413-773-2394	Thomas.Higgins@baystatehealth.org