

COMMONWEALTH OF MASSACHUSETTS
HEALTH POLICY COMMISSION

CHART Phase 2:
Implementation Plan
Baystate Noble Hospital

HPC approval date: October 14, 2015

Last modified: October 4, 2016

Version: 5



Introduction

This Implementation Plan details the scope and budget for Baystate Noble 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
Ronald Bryant	President and Chief Executive Officer	Executive Sponsor
Rosa Benitez-Feldman	Director, Medical Surgical/Bronson Rehab Service	Clinical Investment Director
John Shaver	Chief Financial Officer	Operational Investment Director
Linda Puchalski	Project Manager	Project Manager
Jeffrey Cebula	Health Systems Accounting Manager	Financial Designee

Target population

Definition:

- All Discharges to SNF
- All High Utilizers* of ED/Hospital

Quantification:

- 432 d/c to SNF per year
- 1,380 ED visits + 264 inpatient discharges/year (47 patients)

Note: Target population definition includes all payers and ages 18+; excluding OB, deaths, transfers to acute inpatient, and discharge to acute rehab.

* Includes patients with ≥ 4 IP admissions in the past year, and patients with ≥ 10 ED visits in the past year.

Aim Statement

Primary Aim Statement

Reduce 30-day readmissions by 25% for patients discharged to SNF and HU of the ED and/or hospital by the end of the 24 month Measurement Period.

Secondary Aim Statements*

Reduce 30-day ED revisits by 15% for patients discharged to SNF and HU of the ED and/or hospital by the end of the 24 month Measurement Period.

Baseline performance – readmission reduction

Abridged Implementation Plan – Not for budgeting or contracting purposes

		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 within 30-day	24	12	22	28	21	11	11	17	24	20	27	21	20
	Discharges-All	253	200	237	253	194	204	185	181	192	196	212	201	209
	Rate (%)	9%	6%	9%	11%	11%	5%	6%	9%	13%	10%	13%	10%	9%
Hi Utilizers (=>4/yr)	Readmits within 30-day	9	6	14	13	12	6	4	8	13	6	11	12	10
	Discharges 4+ Admissions/Yr	23	15	25	24	23	22	15	24	24	18	27	24	22
	Rate (%)	39%	40%	56%	54%	52%	27%	27%	33%	54%	33%	41%	50%	43%
SNF Readmits	Readmits within 30-day	11	3	13	9	5	3	2	9	4	2	9	3	6
	Discharges-All SNF	51	31	55	49	32	27	24	32	28	30	35	32	36
	Rate (%)	22%	10%	24%	18%	16%	11%	8%	28%	14%	7%	26%	9%	17%

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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	2090	1785	1945	2120	2226	2055	2160	2181	2078	2136	1834	1877	2040
	All ED Revisits within 30-Day	289	318	363	393	446	410	427	450	436	433	375	346	391
	Revisit Rate	14%	18%	19%	19%	20%	20%	20%	21%	21%	20%	20%	18%	19%
	LOS (min)	150	138	147	150	144	144	138	144	144	144	144	144	144
Target Pop	Target Pop ED Visits Pts with 10+Visits/Yr	104	103	118	113	134	132	109	126	104	130	112	99	115
	Target Pop ED 30-Day Revisit (Pts w/10+ Visits/Yr)	48	71	86	77	99	91	72	94	73	97	81	80	81
	Revisit Rate	46%	69%	73%	68%	74%	69%	66%	75%	70%	75%	72%	81%	70%
	LOS (min)	186	210	156	138	210	195	186	183	207	177	201	162	184

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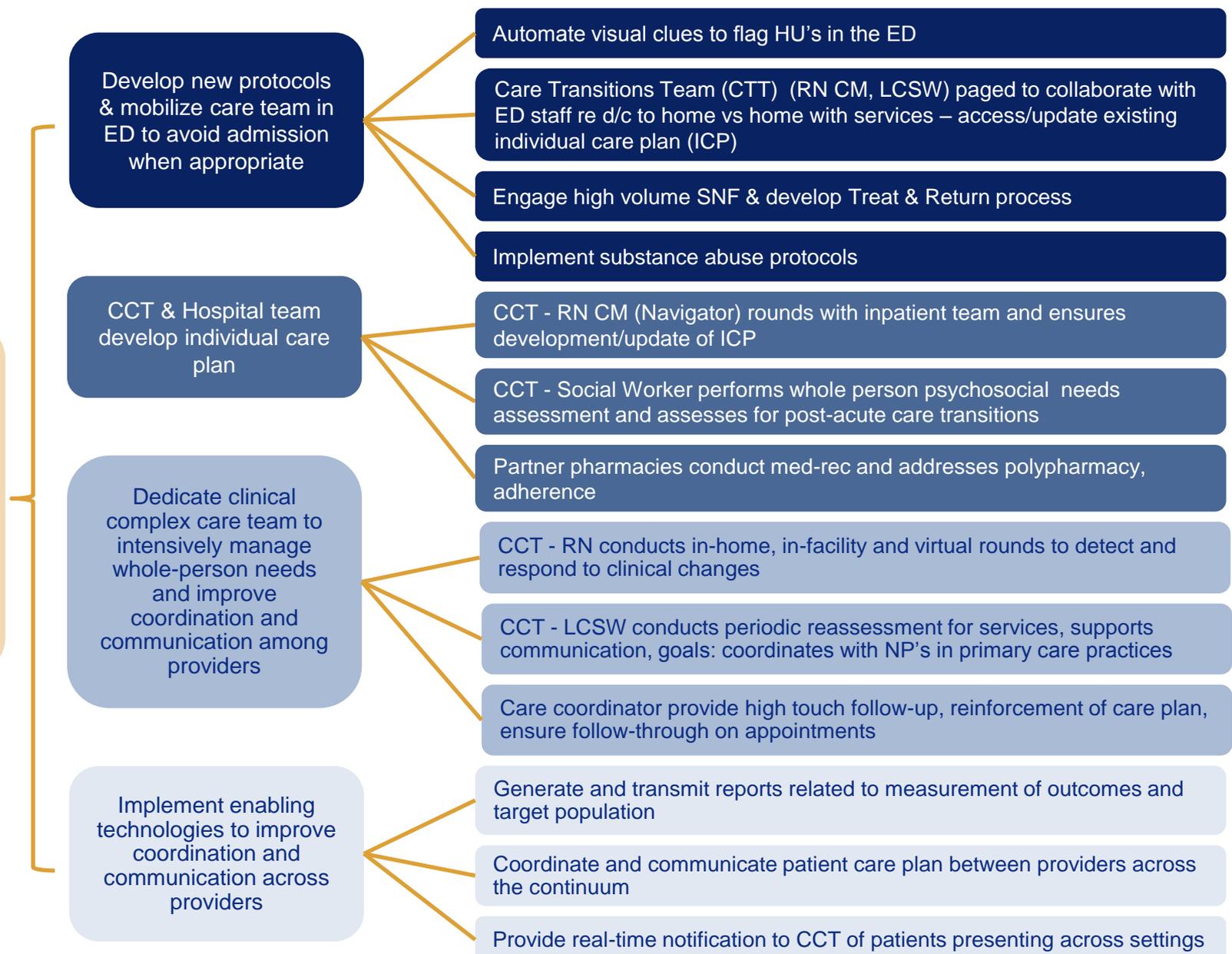
Estimated monthly impact

	Current Expected Served	Current Expected Revisit/Readmission	New Expected Avoided Events	New Expected Events
ED 30-day revisit reduction for ED High Utilizers	115 visits per month	Given an average revisit rate of 70%, we expect $0.70 * 115 = 81$ revisits per month.	12 avoided revisits.	$81 - 12 = 69$ revisits per month
30-day readmission reduction for IP High Utilizers	22 discharges per month	Given an average readmission rate of 43%, we expect $0.43 * 22 = 9$ readmissions per month.	2 avoided readmissions.	$9 - 2 = 7$ readmissions per month
30-day SNF readmission reduction	36 discharges per month	Given an average readmission rate of 17%, we expect $0.17 * 36 = 6$ readmissions per month.	2 avoided readmissions.	$6 - 2 = 4$ readmissions per month

Driver Diagram

Abridged Implementation or contracting purposes

Reduce 30-day readmissions by 25% for patients discharged to SNF and HU of the ED and/or hospital by the end of the 24 month Measurement Period.



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Note: Target population definition includes all payers and ages 18+; excluding OB, deaths, transfers to acute inpatient, and discharge to acute rehab.
 * Includes patients with ≥4 IP admissions in the past year, and patients with ≥10 ED visits in the past year.

Service model

Narrative description

Our service model will include 2.1 RN case management navigators, 1 care coordinators, 2.1 social workers, and 2 hospital physicians (not CHART-funded) in collaboration with our community partners whose primary focus will be on transitions in care for our established target population of high utilizers in ED and hospital re-admissions as well as re-admissions within 30 days from SNF.

Once identified, these patients will undergo a comprehensive interview by the navigator in the ER to identify gaps in care, educational and resource needs. A care plan will be created in collaboration with the ER physician, hospital Physician advisor, PCP, as well as all other home care agencies appropriate to coordinate a comprehensive plan of care. The navigators and coordinators will ensure appropriate access to medications through relationships with local pharmacies to deliver medications and bubble pack if necessary as well as provide discount cards to off set cost if that is identified to be an issue in medication compliance.

Referrals will be made to the appropriate community agency for behavioral health services through BHN and Carson Center. Referrals will be made to the appropriate elder care agency or VNA to meet home care needs such as nursing care, home making services, meal delivery. Education and scripting will be provided to PCP offices to ensure they are aware of community resources and what questions to ask to promote open dialog and needs assessment. PT1 forms will be filed for all MassHealth members to ensure safe, free transportation is available.

Detox resources will be provided and patients will receive high-touch medical and social navigation to find open beds for detox placement and ensure all needs driving acute utilization are met for 30 days post discharge. Social workers will be available to assist with financial needs, abuse issues and behavioral health/substance abuse issues/resources. Social workers will connect patient with peer supports in the community.

Case managers and social workers will work with homeless patients to find homeless shelters and start the application process for housing. Community meetings will be held monthly to keep community resources updated, collaborate care, provide cross continuum education and identify gaps in service.

Services will be delivered to target population on an ongoing basis until needs are met.

Service worksheet

Service Delivered

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

Personnel Type

- X **Hospital-based nurse**
- X **Hospital-based social worker**
- X **Hospital-based pharmacist**
 - Hospital-based NP/APRN
- X **Hospital-based behavioral health worker**
 - Hospital based psychiatrist
- X **Community-based NP**
- X **Community-based social worker**
- X **Community-based pharmacist**
- X **Community-based behavioral health worker**
 - Community-based psychiatrist
 - Community-based advocate
 - Community-based coach
 - Community-based peer
 - Community agency
 - Physician
- X **Palliative care**
 - EMS
- X **Skilled nursing facility**
- X **Home health agency**
 - Other: _____
 - Other: _____
 - Other: _____
 - Other: _____
 - Other: _____

Service Availability

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

Service mix

Abridged Implementation Plan – Not for budgeting or contracting purposes

Service	By Whom	How Often	For How Long
2.1 - RN Case Management Navigators	Baystate Noble Hospital	7 days a week 12 hour days	ongoing
1 - Care Coordinators	Baystate Noble Hospital	5 days a week 40 hour position	ongoing
2 - Physicians (Not CHART-funded)	Baystate Noble Hospital	As needed for care plan development	ongoing
2.1 - Social Workers	Baystate Noble Hospital	7 days a week 12 hour days	ongoing

# FTE/units of service hired at my organization	5.2
# FTE/units of service contracted	None

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List of service providers/community agencies (1/2)

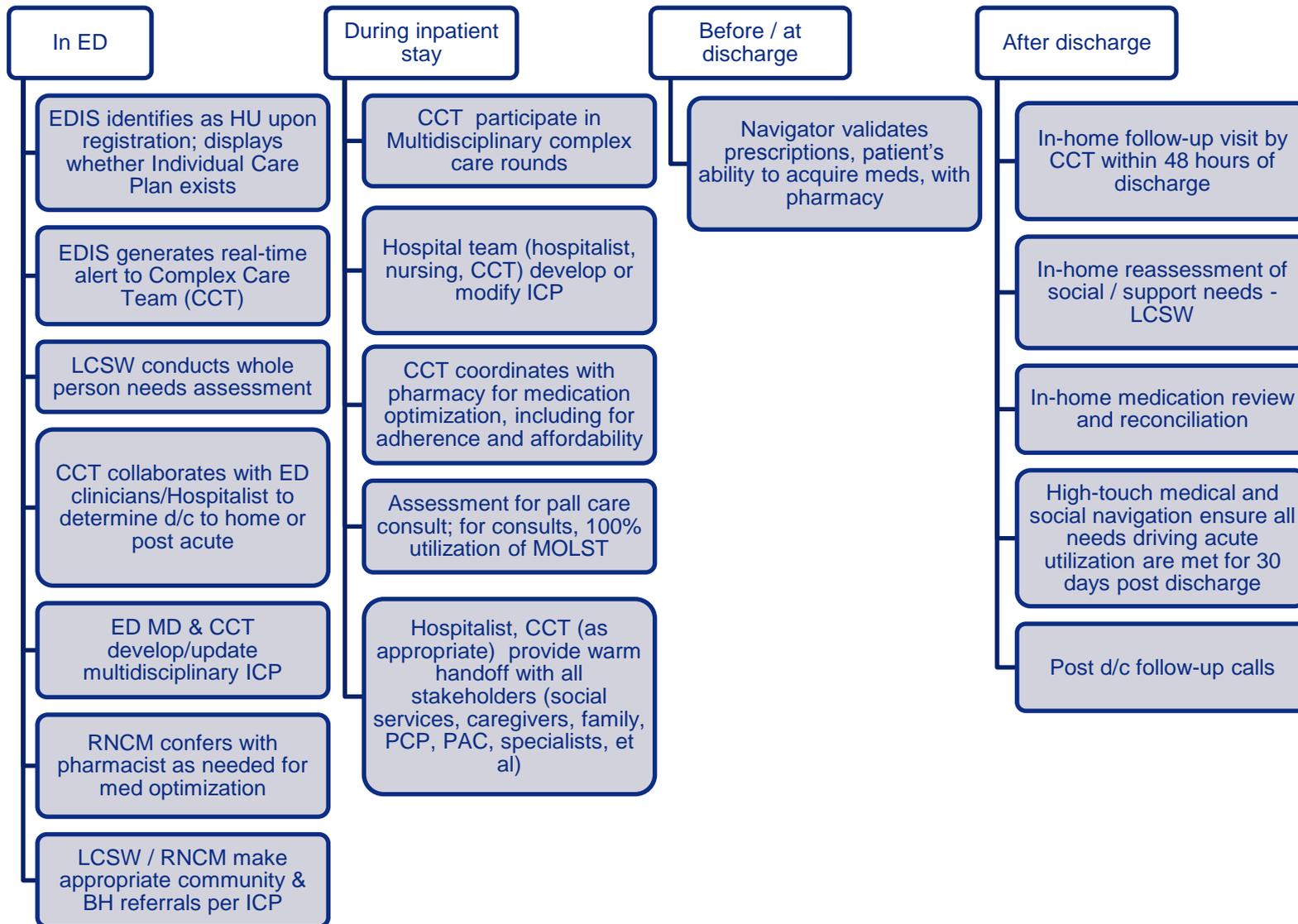
Type of Service Provider	Community Agency Name	New or Existing Relationship
Primary Care	Noble Medical Group	Existing
	Family Medicine	Existing
	Hilltown Community Health Center	Existing
Behavioral Health	Carson Center	Existing
	Behavioral Health Network	Existing
	Healthcare for the Homeless	Existing
	AdCare	New
	Department of Mental Health	Existing
Skilled Nursing Facility	Samaritan Inn	New
	Governors Center	Existing
	The Forum House	Existing

List of service providers/community agencies (2/2)

Type of Service Provider	Community Agency Name	New or Existing Relationship
Skilled Nursing Facilities	Genesis	Existing
	Renaissance Manor	Existing
Agencies	Department of Mental Health	Existing
	Westfield Police Department	Existing
Payers	Fallon	Existing
	Commonwealth Care Alliance	Existing
	Health New England	New
Visiting Nurses Association	Baystate Noble VNA	Existing
	Baystate VNA	Existing
	Council of Aging	Existing
Assisted Living	High Valley Elder Services (HVES)	Existing
	Armbrook	Existing
	American Inn	Existing
	Arbors of Westfield	New
Local Pharmacies	Walgreens, Rite Aid, CVS & Arrow	New

Summary of services

Abridged Implementation Plan – Not for budgeting or contracting purposes



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

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 - ED utilization

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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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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 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 specific measures

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

Program-specific measures

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
Treat and returned to SNF from ED	# of Pts presenting to ED who returned to SNF without admission	# of patients who present to ED from SNF
% of Target population with longitudinal care plans (visible across settings)	# of TP Patients with Longitudinal Care Plans	# of TP Patients
Mailed letters and reminders	Number of letters and reminders mailed to TP Patients	N/A
MD appts attended	# of appointments attended	# of appointments scheduled for TP Patients

Program-specific measures with HPC specifications

Measure Definition	Numerator	Denominator
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

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

Continuous improvement plan (1 of 2)

<p>1. How will the team share data? Describe.</p>	<p>Biweekly meetings, shared portal, automatic emails to community providers when seen at hospital</p>
<p>2. How frequently will you (PM, Investment Director) look at the data (e.g., weekly)? Describe.</p>	<p>Investment Director weekly PM daily</p>
<p>3. How often will your executive team (VPs, C-suite) review CHART project reporting (e.g., monthly)? Describe.</p>	<p>Initially will meet monthly with progress then taper to quarterly if appropriate</p>
<p>4. How often will your front line CHART staff (SW, care team) review reporting (e.g., weekly)? Describe.</p>	<p>Weekly meeting with PM, ID, and direct coordination team, monthly with community team and daily reviews of portal to track and monitor target population</p>
<p>5. How often will your community partners review data (e.g., weekly, monthly)? Describe.</p>	<p>Community partners will meet at monthly community meeting and as necessary if issue arises. Review portal stats of identified barriers or what's working well</p>
<p>6. Which community partners will look at CHART data (specific providers and agencies)? Describe.</p>	<p>SNF, VNA, PCP, BHN, elder services, pharmacies as appropriate</p>
<p>7. Will the quality committee of your board review CHART reporting (e.g., quarterly)? Describe.</p>	<p>Quarterly and as needed will seek advise from Director of Quality as well as update on progress and to ensure compliance with process.</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)? Describe.	Cohort-Wide	Program specific
	Data analyst, ID and PM	Data analyst, ID and PM
9. What is your approximate level of effort to collect these metrics? Describe.	Cohort-Wide	Program specific
	Moderate	Moderate to track and trend data need updated enabling technologies
10. How will you ensure that you are able to collect both your program specific and the cohort-wide measures? Describe.	Will work with insurance case manager to obtain update of resources used	
11. How will you know when to make a change in your service model or operational tactics? Describe.	When we are not meeting our goals of 15% reduction or when we see the utilization trends not changing or shifting the patients care to another facility or healthcare agency	
12. Other details:	N/A	

Enabling Technologies plan

Functionality	User	Vendor	Cost
Goal of enabling technology is to identify, track and report analytics as well as make appropriate referrals in a timely fashion that will meet our patients needs and be in-network with their insurance provider.	Investors, Clinical Staff and Project Manager	Medecision	\$84,000 (CHART funded portion)

Enabling technology: Q&A

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

- Target population patients will be identified in the hospital's Meditech system and email notification will go out to the CCT when the patient is registered in the system. The notification will go to the CCT & ED personnel that the patient is meets the criteria for the target population as well as the identification that the patient is a Chart Patient or has opted out of Chart.
- This functionality has been identified by Baystate Noble as a necessary enabler for their intervention.

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

- Through the use of the enabling technology - Medecision

How will you measure outcome measures monthly?

- Through the use of the enabling technology – Medecision? Still being investigated.
- This functionality has been identified by Baystate Noble as a necessary enabler for their intervention.

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

- Through the use of the enabling technology - Medecision

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?

- Through the use of the enabling technology - Medecision
- This functionality has been identified by Baystate Noble as a necessary enabler for their intervention.

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

- Through the use of the enabling technology - Medecision

Other essential investments

Slide intentionally left blank.

Key dates

Key milestone	Date
Launch date (beginning of your 24 month Measurement Period)	11/1/2015
Post jobs	09/15/2015
New hires made	10/15/2015
Execute contracts with enabling technology vendor (vendor name)	09/11/2015
Enabling technology – testing initiated	11/02/2015
Enabling technology – go-live	12/01/2015
First test report of services, measures	02/01/2016
Readmissions reduction initiatives support 50% of planned patient capacity	01/15/2016
Readmissions reduction initiatives support 100% of planned patient capacity	03/31/2016
Trainings completed, if any [describe these – include multiple lines as necessary]	12/01/2015
First patient seen	11/15/2015

Community partners/subcontractors

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Name	Business Address	Website	Contact Name	Contact Title	Contact Phone Number	Contact Email Address
Medecision	8111 Preston Rd Suite 900 Dallas, TX 75225	Medecision.com	William Gillespie, MD	Chief Medical Officer	860-916- 7337	wgillespie@gillespiehealthstrategies.com

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