

COMMONWEALTH OF MASSACHUSETTS
HEALTH POLICY COMMISSION

CHART Phase 2:
Implementation Plan
Baystate Wing Hospital

HPC Approval Date: September 21, 2015

Last Modified: July 21, 2016

Version: 3



Introduction

This Implementation Plan details the scope and budget for Baystate Wing 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
Michael Moran	Baystate Health Eastern Region President and Chief Administrative Officer	Executive Sponsor
David L. Maguire, MD	Baystate Health Eastern Region Chief Medical Officer	Clinical Investment Director
Lisa Ann Beaudry, MPH, BSN, CNM	Regional Vice President and Chief Nursing Officer	Operational Investment Director
Leah Bradley	Director, Behavioral Health	Project Manager
Pamela Desautels	Controller	Financial Designee

Target population

Definition:*

Patients with a life limiting condition and/or a behavioral health diagnosis, as identified by the diagnosis codes below:

- 50+ years
- All payers
- ICD-9 codes: 291-316 (behavioral health ICD-9s that excludes Dementias); 401-449; 466-466.19 (diseases of the circulatory system that excludes rheumatic fever, rheumatic heart disease and diseases of veins and lymphatics); 480-487.1; 490-519 (diseases of the respiratory system that excludes acute respiratory infections, other diseases of the respiratory tract and influenza without pneumonia or other respiratory manifestations); 8.45 C.Diff; 427.31 Afib

Quantification

- ~1,047 admissions per year – 596 patients/year

Aim Statement

Primary Aim Statement

Reduce 30-day readmissions by 20% for patients with life limiting conditions and/or behavioral health diagnosis by the end of the 24 month Measurement Period.

Secondary Aim Statement*

Reduce 30-day ED returns by 10% for patients with life limiting conditions and/or behavioral health diagnosis 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	15	33	37	35	33	30	43	27	28	26	24	15	31
	Discharges	270	253	277	280	275	267	268	265	256	248	229	266	268
	Rate (%)	6	13	13	13	12	11	16	10	11	10	10	6	12
Target Pop*	Readmits	8	15	21	21	16	16	18	16	12	10	12	11	15
	Discharges	97	77	85	96	87	91	78	69	96	91	84	96	87
	Rate (%)	8.25	19.48	24.71	21.88	18.39	17.58	23.08	23.19	12.5	10.99	14.29	11.46	16.81

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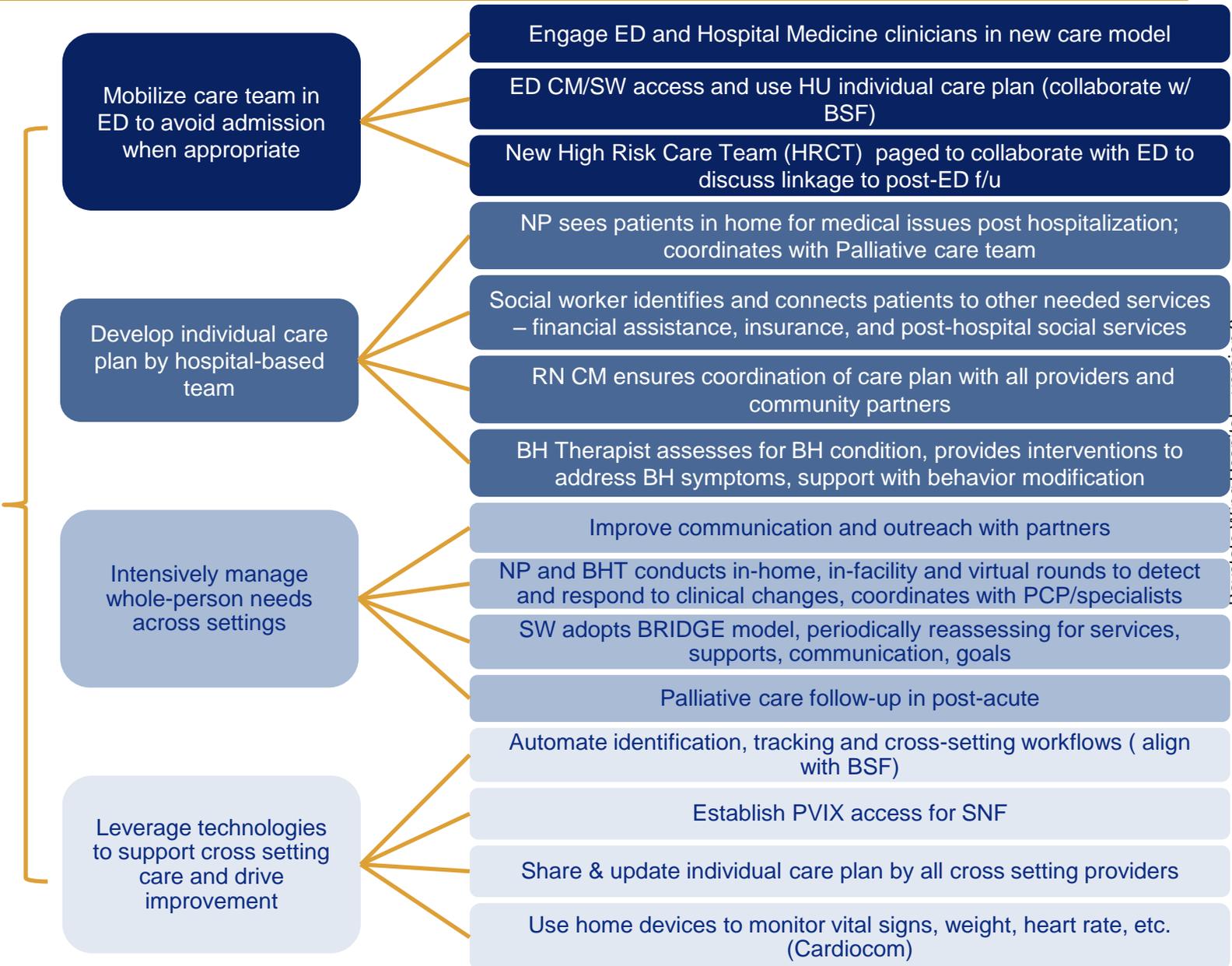
Estimated monthly impact

	Current Expected Served	Current Expected Readmissions	New Expected Avoided Readmissions	New Expected Readmissions
30-day readmissions target population admissions	87/month	15 / month (16.81%)	3 / month (20% reduction)	13

Driver Diagram

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Reduce 30-day readmissions by 20% for patients with life limiting conditions and/or behavioral health diagnosis by the end of the 24 month Measurement Period*



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* Enrollment for the first 6 months will target those who are readmitted and over the age of 50

Service model

Narrative description

Hospital-based team includes:

- Physician – contracted; either a geriatrician or palliative care expertise sought
- NP – 0.4 FTE – palliative care or geriatrician (different specialty depending on physician)
- RN – Case Manager – team lead – 1.0 FTE
- BH Therapist – 0.4 FTE
- Social Worker – 0.9 FTE
- Palliative Care Nurse – 0.8

Team follows the patient from the hospital to home, providing visits within 3 days:

- NP – sees patient in home for medical issues post hospitalization
- RN – monitors medical conditions; coordinates care with other providers; ensures care plan is distributed to all providers and care givers
- BH Therapist – assess patient for BH condition, provide interventions to address BH symptoms, provide support on behavior modification
- Social Worker – identifies and connects patient to other needed services – financial assistance, insurance issues, etc.
- Palliative care – services provided for those TP patients who would benefit from this service. NP or MD internal capacity to ensure continuity of care through end of life

Motivational interviewing training supports team

Service worksheet

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Service Delivered

- Care transition coaching
- Case finding
- xBehavioral health counseling
- xEngagement
- xFollow up
- xTransportation
- Meals
- Housing
- xIn home supports
- xHome safety evaluation
- Logistical needs
- xWhole person needs assessment
- xMedication review, reconciliation, & delivery
- xEducation
- xAdvocacy
- xNavigating
- Peer support
- Crisis intervention
- Detox
- xMotivational interviewing
- xLinkage to community services
- xPhysician follow up
- Adult Day Health
- Other: _____

Personnel Type

- X Hospital-based nurse (follows patient to home)
- X Hospital-based social worker (follows patient to home)
- X Hospital-based pharmacist/tech?
- X Hospital-based NP/APRN – can provide home visits
- X Hospital-based behavioral health worker (follows patient to home)
- Hospital based psychiatrist
- Community-based nurse
- Community-based social worker
- Community-based pharmacist
- Community-based behavioral health worker
- Community-based psychiatrist
- Community-based advocate
- Community-based coach
- Community-based peer
- Community agency
- Physician
- xPalliative care
- EMS
- Skilled nursing facility
- Home health agency
- Other: _____

Service Availability

- X Mon. – Fri.
- Weekends
- 7days
- Holidays
- Days
- Evenings
- Nights
- Off-Shift Hours _____
- X Wing's VNA as on-call; evenings and weekends

Service mix

Service	By Whom	How Often	For How Long
NP – 0.4 FTE – palliative care training	BWH	Up to weekly depending on need	Variable
RN – Case manager – team lead – 1.0 FTE	BWH	Weekly on average – more or less as needed	Variable
BH Therapist – 0.4 FTE	BWH	Weekly on average – more or less as needed	Variable
Social Worker – 0.9 FTE	BWH	Weekly on average – more or less as needed	Variable
Palliative Care Nurse – 0.8 FTE	BWH – VNA/Hospice	Weekly on average – more or less as needed	Variable
Physician consultation (contracted .05 FTE)	Baystate Palliative Care Program	Weekly – up to 4 hours	Variable

FTE/units of service hired at my organization

3.5

FTE/units of service contracted

0.05

List of service providers / community agencies

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Type of Service Provider	Community Agency Name	New or Existing Relationship
Post-acute care	SNFs and Acute Rehab: Quaboag, Wingate, Health South,	Existing & with new processes for coordination and collaboration
Home Infusion	Baystate Home Infusion	Existing & with new processes for coordination and collaboration
Primary Care	Baystate Health (Wing, Mary Lane, Springfield)	Existing
Care managers/navigators	BHN, Carson Center, Fallon Total Care Plan, CCA	Existing & with new processes for coordination and collaboration

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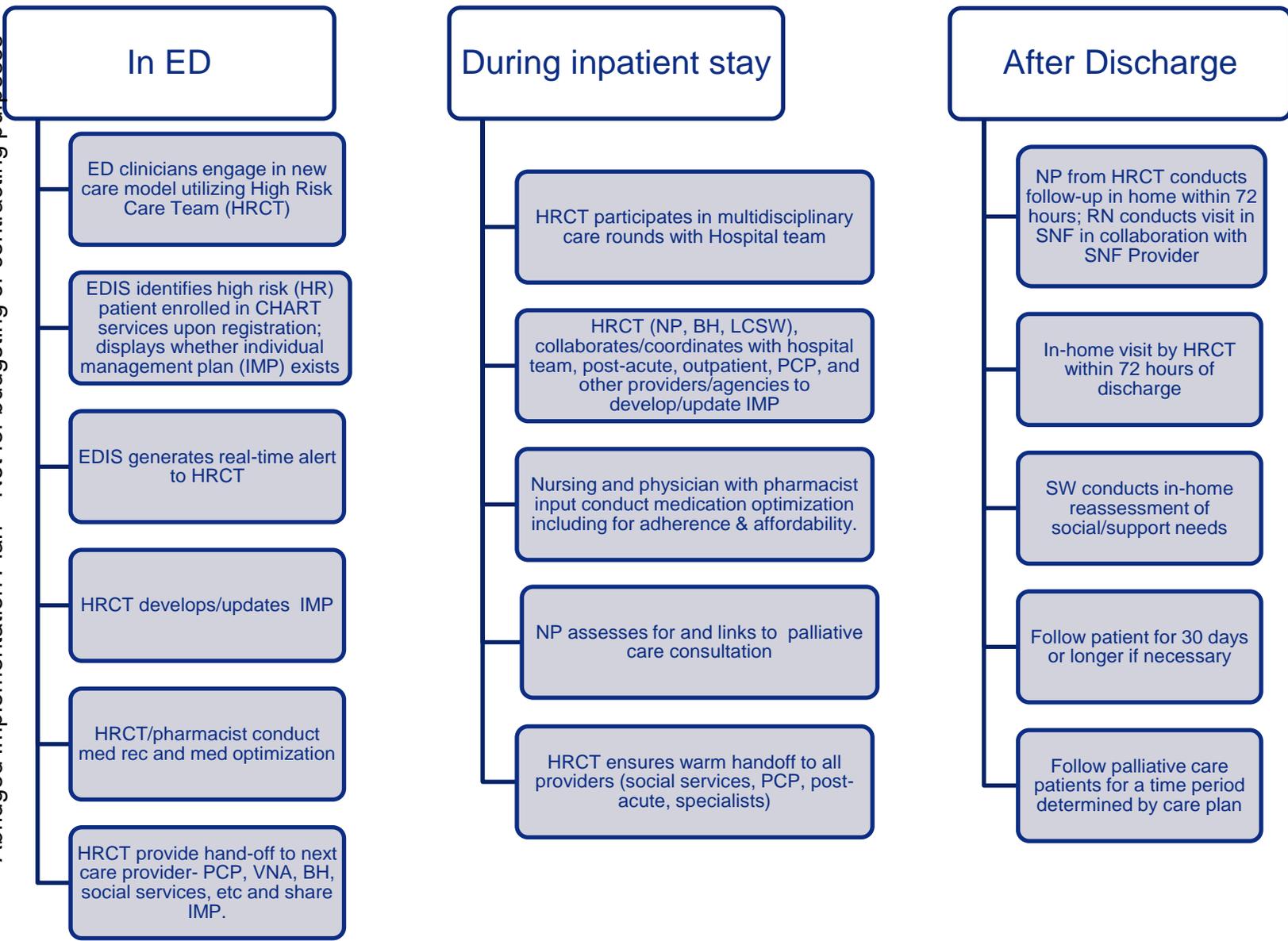
Summary of services (1 of 2)

Program components

- Support and education to family/caregiver
- Single multi-disciplinary care plan follows the patient; aligned with Baystate Franklin Medical Center
- ED care plan provides guidance to the ED staff when the patient presents; aligned with Baystate Franklin Medical Center
- Trigger or flag in Meditech or Touchmedix identifies CHART patient
- PVIX access for other care givers (e.g., nursing homes – app developed through CHART Phase 1 at Baystate Franklin Medical Center)
- Ensure PCP and specialty providers have the most up to date information (PVIX where available – otherwise care coordinator will manage)
- Transition patient to PCP after stabilized (CHART NP provides this service until the patient is stabilized)
- Regular team meetings – 1 hour check in every morning and a 2 hour tx team weekly
- Steering Committee includes CHART leadership, physician leaders, PFAC member

Summary of services (2 of 2)

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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

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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	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)		
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		
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

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Updated Measure Definitions	Numerator	Denominator
Percent of patients who decline participation in the CHART services	# declining CHART participation	#in the target population
% of patients who “complete” the service	# discharged from active services	#in the target population
Percent of patients seen within 72 hours of hospital discharge	# seen within 72 hours	# of CHART patients discharged
Percent of TP patients who are discharged and return to the ED within 30 days and are not admitted	# of TP patients who are discharged and return to the ED within 30 days and are not admitted	# of TP patients who are discharged and return to the ED within 30 days
% of CHART patients with ED care plan	# of patients with ED care plans	# of patients in TP
% of CHART patients with longitudinal care plan	# of patients with longitudinal care plans	# of patients in TP
% of target population that had a palliative care consult and a MOLST form completed	# of patients with MOLST forms completed	# of patients with palliative care consult
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 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

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Continuous improvement plan (1 of2)

<p>1. How will the team share data? Describe.</p>	<p>We expect the team to start with daily one-hour meetings as the program is underway. There will also be a weekly tx plan meeting for 3 hours. A member of the core team will be involved in these meetings daily for the first quarter. The frequency will be reviewed at the end of each week to establish its necessity.</p>
<p>2. How frequently will you (PM, Investment Director) look at the data (e.g., weekly)? Describe.</p>	<p>The CHART core team will review the data monthly in its formal report. There will be weekly meetings of the core team as the project is getting underway. The frequency will be reviewed at the end of each week to establish its necessity.</p>
<p>3. How often will your executive team (VPs, C-suite) review CHART project reporting (e.g., monthly)? Describe.</p>	<p>This will be reviewed monthly at the PI Committee that consists of senior managers and board members. This committee reports up to the Wing Board of Directors. The frequency will be reviewed at the end of each week to establish its necessity.</p>
<p>4. How often will your front line CHART staff (SW, care team) review reporting (e.g., weekly)? Describe.</p>	<p>If the reporting is automated, the team will look at it weekly in the tx plan meeting. The frequency will be reviewed at the end of each week to establish its necessity.</p>
<p>5. How often will your community partners review data (e.g., weekly, monthly)? Describe.</p>	<p>The CHART partners will review the data monthly at the monthly meeting. The frequency will be reviewed at the end of each week to establish its necessity.</p>
<p>6. Which community partners will look at CHART data (specific providers and agencies)? Describe.</p>	<p>HealthSouth, Quaboag Valley, Wingate, LifeCare, Baystate VNAH and Hospice, Baystate Wing VNA and Hospice</p>
<p>7. Will the quality committee of your board review CHART reporting (e.g., quarterly)? Describe.</p>	<p>Yes, it will be incorporated into the PI report.</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
	Project Director; ET	Project Director; ET
9. What is your approximate level of effort to collect these metrics? Describe.	Cohort-Wide	Program specific
	Project Director; ET	Project Director; ET
10. How will you ensure that you are able to collect both your program specific and the cohort-wide measures? Describe.	Project Director; ET	
11. How will you know when to make a change in your service model or operational tactics? Describe.	Analysis on whether change in service model or operational tactics will be triggered by deviations from the project plan or the presence of any unexpected outcomes. For example, the number of the target population identified, the ratio of acceptance/declination of participation, readmission rates of participants, staffing variances, etc.	
12. Other details:		

Enabling Technologies plan

Functionality	User	Vendor	CHART Cost
Reporting capability Reliable, monthly (or more frequent) measurement of outcomes (principally utilization metrics) for total hospital and for defined target population	CHART team	Medecision	\$95,000
Admission-Discharge-Transfer Notifications Notification-based system to track target population utilization/ services across the continuum	CHART HRCT	Baystate Health IT will use PVIX (local health information exchange) to notify CHART HRCT members for ADT notifications	\$20,043
Cross-Setting, Multi-disciplinary Care Management To capture the services delivered by role and type (process measures) and to create day-to-day care management tool to assign role-based activities/patient hand-offs	We expect an image of the care plan to be available in PVIX for partners to view the care plan.	Medecision for the care management system.	Included in Med Decision cost above
Individualized Care Plans Care plans that are accessible 24/7 to providers on a need-to know basis to facilitate quality care and optimize services	The care plan will be in Medecision and will be in PVIX for partners to view 24/7.	Medecision	Included in Med Decision cost above
PVIX Development - .4 FTE	IT specialist	PVIX	\$16,800

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Other essential investments

Other Investment – Describe	Budget Required
On-call 24/7 coverage by CHART team on rotating basis	\$20,000
Motivational interview training for all FTEs on CHART project – UMass web-based training	\$1,550
Supplies/educational material for CHART patients	\$4,375
Travel time for CHART staff to travel to patients homes	\$26,000

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	11/20/15 – Med Decision
Enabling technology (Med Decision) – testing initiated	11/2/15
Enabling technology (Med Decision) – 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

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Name	Business Address	Website	Contact Name	Contact Title	Contact Phone Number	Contact Email Address
Baystate Geriatric/Palliative Care Program	759 Chestnut Street, Springfield, MA	Baystatehealth.org	Thomas Lombardo	Director, General Medicine Geriatrics	413-794-2860	Thomsa.lombardo@baystatehealth.org
Medecision, Inc.	8121 Preston Rd. Ste. 900 Dallas, TX 75225	Medecision.com	William Gillespie, MD	Chief Medical Officer	860-916-7337	wgillespie@gillespiehealthstrategies.com

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