

COMMONWEALTH OF MASSACHUSETTS
HEALTH POLICY COMMISSION

CHART Phase 2:
Implementation Plan
Berkshire Medical Center

HPC approval date: August 26, 2015

Last modified: July 20, 2016

Version: 3



Introduction

This Implementation Plan details the scope and budget for Berkshire 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.



Contents of the Implementation Plan

- Key Personnel
- Target Population(s)
- Aim Statement(s)
- Baseline Performance
- Estimated Monthly Impact
- Driver Diagram
- Service Model
- Service Worksheet
- Service Mix
- List of Service Providers/Community Agencies
- Summary of Services
- Measurement Plan
 - Cohort-Wide Standard Measures
 - Program-Specific Measures
- Continuous Improvement Plan
- Enabling Technologies Plan
- Other Essential Investments
- Key Dates
- Community Partners/Subcontractors
- Deliverables and Reporting
- Payment Plan
- Budget



Key personnel

Name	Title	CHART Phase 2 Role
David Phelps	President and Chief Executive Officer	
Diane Kelly, RN	Chief Operating Officer	Clinical Investment Director
Darlene Rodowicz	Chief Financial Officer and Treasurer	Operational Investment Director
Ann MacDonald	Project Director	Project Manager
Paula Bush	Manager, General Accounting	Financial Designee

Target population

Definition

- All patients discharged* to Northern Berkshire County zip codes**

Quantification

- 2,298 discharges per year

*Inpatient and observation

**Target population definition includes all payers and ages 18+; excluding OB, deaths, transfers to acute inpatient; inclusive of North Adams, Adams, Cheshire, Williamstown, Savoy, Florida, Rowe, and Monroe (01220, 01225, 01267, 01256, 01247, 01367, 01350)

Aim Statement

Primary Aim Statement

Reduce 30-day returns by 20% for all inpatient and observation discharges of Northern Berkshire County residents by the end of the 24 month Measurement Period.

Secondary Aim Statement*

Reduce 30-day returns to ED from any bed by 10% for all inpatient and observation discharges of Northern Berkshire County residents by the end of the 24 month Measurement Period.

Baseline performance – Readmission reduction

		Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar14	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep14	Avg.
Hospital-Wide	Readmits	105	103	94	118	102	110	120	119	106	121	144	129	1272
	Discharges	794	788	757	863	743	811	872	844	873	879	887	842	8798
	Rate (%)	13.22%	13.07%	12.42%	13.67%	13.73%	13.56%	13.76%	14.10%	12.14%	13.77%	16.23%	15.32%	14.46%
Target Pop	Readmits	43	8	11	15	16	25	31	37	37	34	49	53	30
	Discharges	130	101	105	155	155	176	238	248	237	238	274	241	192
	Rate (%)	33.08	7.92	10.48	9.68	10.32	14.20	13.03	14.92	15.61	14.29	17.88	21.99	15.62

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Berkshire Medical Center – Version 3

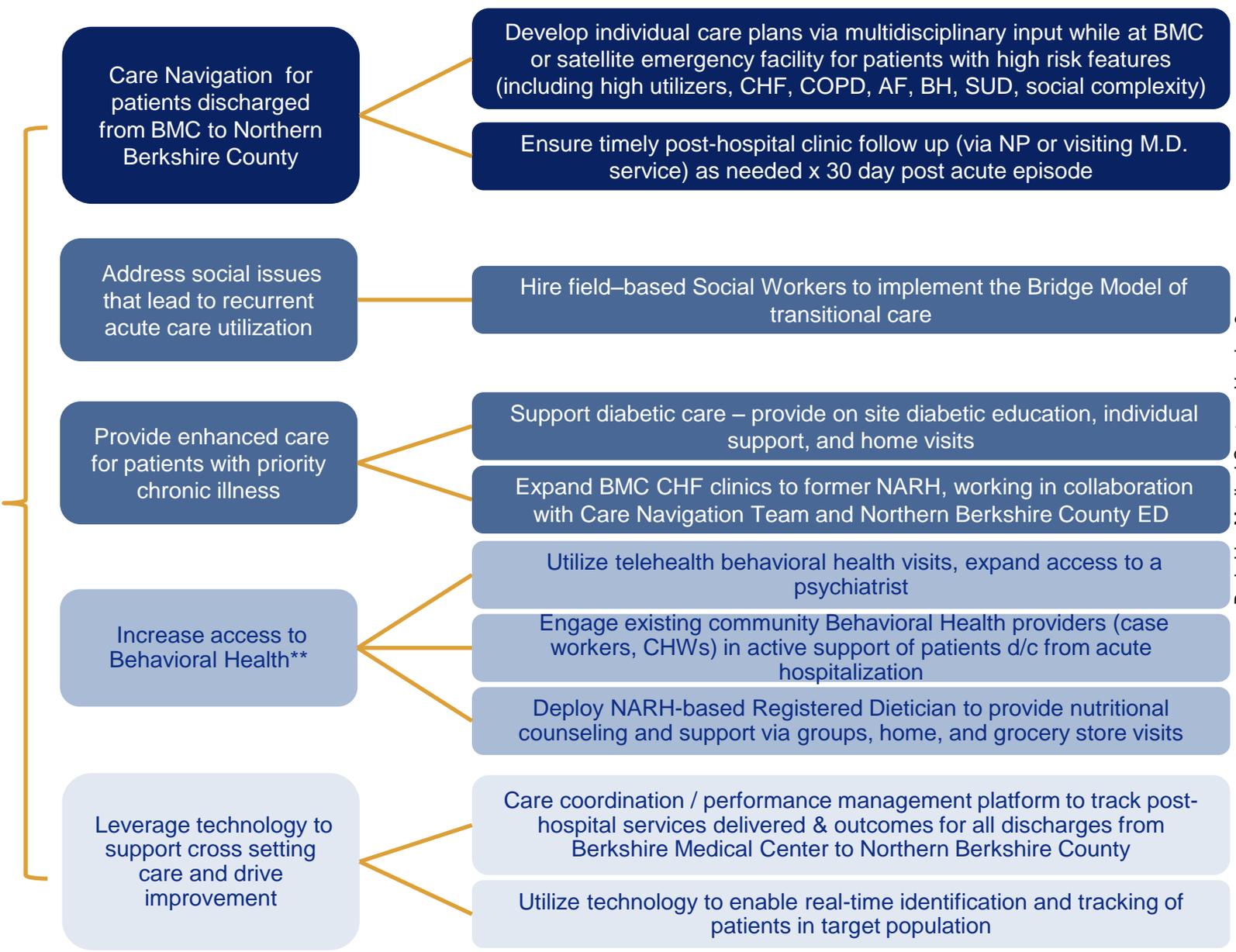
Estimated monthly impact

	Current Expected Served	Current Expected	New Expected Avoided Events	New Expected Events
30-day returns (readmissions to inpatient or observation) reduction	192 admissions	30 readmissions	6 readmissions	24 readmissions

Driver Diagram

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Reduce 30-day returns by 20% for all inpatient and observation discharges of Northern Berkshire County residents by the end of the 24 month Measurement Period*



Berkshire Medical Center – Version 3

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** Definition of behavioral health is mental health & substance abuse disorders

Service model

Narrative description

- 1.Reducing readmissions will be achieved by offering community-based coordinated care to the target population. This will require establishing effective partnerships with community-based social services.
2. Case identification and intervention will start as the individual enters the inpatient or emergency services at Berkshire Medical Center, including the Satellite Emergency Department located in North Adams. Initial contact will be made with both the individual and the care team to begin the assessment and evaluation for services. Communication with the community team begins during the individuals acute stay. A comprehensive care plan will be developed in collaboration with inpatient team, complex community care team (inclusive of RN,SW, CHW, Psych APRN, Psych SW), co-located at N.A. campus (Medical Neighborhood). The type and frequency of visits will be mutually agreed upon by the team and the individual.
3. The Care Coordinator is the care provider responsible for assessing and identifying whole person needs and health goals and providing the linkage to the appropriate resources in both the community and Medical Neighborhood. Given the needs of the individual, the care coordinator may be a RN care manager, Social Worker, or Community Health Worker. In addition to this three-person team, the Northern Berkshire County Medical Neighborhood will have a part-time APRN to support individuals who need immediate access to care, this can be facilitated by home visits (including SNF), or as on-site visit to the Northern Berkshire County Medical Neighborhood. The APRN will be the primary contact with individuals' PCPs to ensure ongoing communication. Regardless of the credential, the Care Coordinator will have expertise in self-management and patient advocacy. This will require formal education and certification to ensure expertise.
4. Behavioral Health Aftercare Team (BHAT) will decrease readmissions for high risk behavioral health patients as well as for patients with co-morbid medical and behavioral health issues by implementing the following: Screening patients for thought, mood, anxiety and substance use disorders, meeting the patients, collaborative development of a care plan that includes the patient's and other providers' input. The BHAT team will also maintain contact with the patient following discharge and actively intervene to support the patient in the community. The care plan will be shared with patient's permission to family and/or network supports, community support workers, emergency personnel (Brien ESP and BMC/BMC-SEF/Fairview Medical EDs) and all primary care and behavioral health providers in the community who work with the patient. The BHAT will consist of a part-time (.75 FTE) Psychiatrist experienced in the treatment of acutely ill patients with medical, substance use and psychiatric co-morbidities and a full-time (1 FTE) Licensed Independent Clinical Social Worker (LICSW). This team will meet with all readmitted patients who have a behavioral health and/or substance abuse diagnosis prior to discharge from the hospital and will actively participate in team meetings regarding patient treatment plans. The Aftercare Team will meet individuals within 3 days of discharge and follow their progress for thirty days, scheduling appointments for patients, serving as a liaison between other providers and community resources, providing bridging psychotherapeutic, supportive and psychopharmacological interventions when necessary and potentially making home visits. Telepsychiatry linkage for the psychiatrist to patients will be possible as needed for follow-up. This service will be available Monday through Friday. Additionally, in appropriate circumstances, the psychiatrist and social worker will provide outpatient detoxification if needed.
5. Chronic Condition Support:
 - CHF clinic – APRN provides treatment, education and group support, and home visits when needed, needed 2 days per week.
 - Endocrinology – CDE to facilitate group education support sessions at the Medical Neighborhood, and make home visits when needed. 2 days per week.
6. Community Support and Prevention: Smoking cessation, transportation, healthy food.
7. Nutrition Support: A nutritionist based out of the PCMN in North Adams will deploy to patients referred from the PCMN via onsite visits at NARH, house calls, or grocery store trips to help with healthy choices. Also anticipate referrals from Psychiatrist for nutrition challenges, though anyone on care coordination team, including patients self-referring may set up appointments with the nutritionist, appointments which would otherwise be difficult to get reimbursed.
8. All patients will be enrolled into a electronic navigation tool. This will allow for sharing an agreed-upon individualized care plan, with measureable goals and interventions to track.
9. Outpatient substance abuse detox will be offered with a coordinated day treatment program provided by the Brien Center, which will provide nutritional breakfast, snacks, and lunch.

Service worksheet

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Service Delivered

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

Personnel Type

- Hospital-based nurse
- Hospital-based social worker
- Hospital-based pharmacist
- Hospital-based NP/ APRN
- Hospital-based behavioral health worker
- **Hospital based psychiatrist x**
- **Community-based nurse x**
- **Community-based social worker x**
- **Community-based pharmacist x**
- **Community-based behavioral health worker x**
- **Community-based psychiatrist x**
- **Community-based advocate x**
- **Community-based coach x**
- Community-based peer
- Community agency
- **Physician/ APRN x**
- Palliative care
- EMS
- Skilled nursing facility
- **Home health agency x**
- **Other: Technology/ Data x**
- **Other: Quality/ PI Support x**
- **Other: Community Health Worker x**
- Other: _____
- Other: _____

Service Availability

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

Service mix

Service	By Whom	How Often	For How Long
Congestive Heart Failure Clinic Endocrinology Support	APRN – 0.4 FTE CDE – 0.4 FTE	2 days per week (see individuals 1x week) offer weekly group sessions	30 days
Care Navigation Team	RN Navigator – 1 FTE S.W. – 1.0 FTE CHW – 1.0 FTE APRN (BH) – 1.0 FTE APRN – (Adult) 0.5 FTE RN Care Coordinator – 1.0 FTE Customer Service Rep – 1.0 FTE	Minimum face-to-face once weekly, 192 individuals per month	30 days
Behavioral / Detox / Telepsychiatry	M.D. – 0.75 FTE S.W. – 2.0 FTE	As needed	30 days
Nutrition Counseling	Registered Dietician – 0.5	1x per week group sessions, house calls, grocery store visits.	Initial assessment to create plan (sometimes reimbursed), follow-up as necessary. Available late-morning to evening two days/week
# FTE/units of service hired at my organization		Clinical 10.55 FTE	
# FTE/units of service contracted		Substance Abuse Day Treatment/Brien Center – 89,000 (2.2 FTE)	

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Berkshire Medical Center – Version 3

List of service providers/community agencies

Type of Service Provider	Community Agency Name	New or Existing Relationship
Advocacy, education and linkage to community services	Northern Berkshire Community Coalition	Existing
Advocacy, meals, housing, transportation and linkage to community services	Berkshire Community Action Council (BCAC)	Existing
Behavioral Health	The Brien Center for Mental Health and Substance Abuse Services	Existing
Disability Services	Goodwill Industries of the Berkshires	New
Disability Services	Mass. Rehabilitation Services	New
Disability Services	Disabled American Veterans	New
Family support services & parent education	Berkshire Children and Families (BCF)	New
Family support services & parent education	Family Resource Center of Northern Berkshire County (CCB)	New
Financial Assistance	Department of Transitional Assistance	New
Financial Assistance	Social Security Administration	Existing
Food Assistance	Supplemental Nutrition Assistance Program (SNAP)	New

List of service providers/community agencies

Type of Service Provider	Community Agency Name	New or Existing Relationship
Health Care	Williamstown Medical Associates	New
Health Care	VNA and Hospice of Northern Berkshire	New
Health Care	Adams Internists	New
Heating and Energy Programs	MassSave	New
Housing	Berkshire County Regional Housing Authority	New
Housing	North Adams Housing Authority	New
Housing	Brayton Apartments	New
Housing	Mohawk Forest	New
Housing	Louison House	New
Housing	St. Joseph's Court Apartments	New
Linkage to elder/older adult community services and (meals)	Elder Services of Berkshire County, Inc. (including Meals on Wheels)	Existing
Meals	The Friendship Center Food Pantry	Existing
Meals	Berkshire Food Project	New
Meals	Northern Berkshire Interfaith Action	New
Patient advocacy and insurance enrollment	EcuHealth	Existing
Protective and Hotline Services	Elizabeth Freeman Center	New

Abridged Implementation Plan – Not for budgeting or contracting purposes

Berkshire Medical Center – Version 3

List of service providers/community agencies

Type of Service Provider	Community Agency Name	New or Existing Relationship
Recreation and social programs for all ages	Northern Berkshire YMCA	New
Support for elders/older adults	Adams Council on Aging/Visitor Center	New
Support for elders/older adults	North Adams Council on Aging/Mary Spitzer Senior Center	New
Support for elders/older adults	Williamstown Council on Aging/Harper Senior Center	New
Support for elders/older adults	Disabled American Veteran	New
Support for elders/older adults	Florida Council on Aging/Senior Center	New
Transportation	Berkshire Regional Transit Authority	Existing
Transportation	Tunnel City Transport	New
Transportation	Berkshire Rides	New

Summary of services

Narrative description

In advance of implementation:

- Identify all prior year “high utilizers” to cohort/flag
- Create “N. Berkshire County flag” in EDIS/EMR in Pittsfield
- Launch Allscripts “Care Director” to support individual care plans / HRCT management

In ED (Pittsfield)

- All patients from N. Berkshire County identified automatically in EHR via IT flag
- Notification automatically “pages” Care Team
- Care team will present to ED to work with ED staff and patients to implement individual plan of care, avert admit if appropriate

In Inpatient Setting (Pittsfield)

- On-site “care manager” (RN and BH SW) meets all patients admitted from N. Berkshire County (2300 per year, about 6 per day)
- On-site “care manager” shepherds the comprehensive whole-person care plan for all discharges, suggesting/coordinating referrals in inpatient and community as needed (BH, substance use, social services, pall care, MOLST, etc.)
- On-site “care manager” makes a warm handoff to the N. Berkshire County high risk care team

After discharge (N. Berkshire County)

- Unified HRCT (NP, RN CM, SW, CHW plus the BH supports) follow all patients whether d/c to SNF or home
- SW follows Bridge model of transitional care, assessing person in context, over time, linking to resources, providing brief motivational interviewing and psychosocial support
- Team will work together to manage all aspects of medical-BH-social needs and whole person needs
- Will document “individual care plan” in N. Adams ED
- Will be field based but offices at N. Adams site – on call for N. Adams presentations to avert transfer when appropriate
- Enhanced clinical services for BH, HF and DM will be available through home visits, group visits, “expanded cardiac rehab option” and telepsych services (all of which have limited access through current financial payment models)
- Any Care Team member may refer patients (who may also self-refer) to Nutritionist who provides group, home, and grocery-store based counseling

In ED (N. Adams)

- Automated notification of all patients who were d/c from BMC <30d of visit in EDIS
- Notification automatically “pages” HRCT
- HRCT members present to ED to work with ED staff and patients to implement individual plan of care, avert admit if appropriate

Cohort-wide standard measures – Hospital utilization measures

Data elements	All	Target Population	Northern Berkshire County Residents
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	

Abridged Implementation Plan – Not for budgeting or contracting purposes

Berkshire Medical Center – Version 3

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 measures

Data elements	ALL	Target Population	Northern Berkshire County Residents
12. Total number of ED visits			
13. Total number of unique ED patients			
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			
19. Total number of 30-day revisits, primary BH diagnosis			
20. Total number of 30-day revisits, 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

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Berkshire Medical Center – Version 3

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Cohort-wide standard measures – Payer mix-specific measures

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

Abridged Implementation Plan – Not for budgeting or contracting purposes

Berkshire Medical Center – Version 3

Program-specific measures (1 of 3)

Measure Definition	Numerator	Denominator	Based on your enabling technology decision, how will you collect this information?
Patient identification and contact	Number of patients with an inpatient status seen "In" patient to discuss program / services prior to discharge	All patients in cohort	Meditech / Electronic EHR
Patient participation rate	Patients agree to services	All patients in cohort	Care Director / Once Consent is signed
CHF measure (what percent require CHF resources)	# of patients with primary or secondary Dx of CHF referred to CHF resources in the Medical Neighborhood	All patients in cohort	Care Director Report
Timeliness of CHF patients receiving services	#of patients seen by CHF clinician within 48 hours of post discharge	# of patients with primary or secondary Dx of CHF referred to CHF resources in the Medical Neighborhood	Care Director Report
Care navigation linking CHF population to support services	# of services CHF patients access based on referral	# of referrals made to services with primary / secondary Dx of CHF	Care Director Report
Percentage of patients requiring diabetic resources	# of patients with a primary or secondary Dx of Diabetes referred to the CDE resources in the Medical Neighborhood	All Patients in cohort	Care Director Report
Timeliness of care provided to patients w/ diabetic Dx primary or secondary	#of patients seen by CDE clinician within 48 hours of post discharge	# of patients with primary or secondary diabetic Dx referred to CDE resources in the Medical Neighborhood	Care Director Report
Care navigation linking patients with primary or secondary Dx of diabetes to support services	# of services patients with diabetes access based on referral	# of referrals made to patients with primary / secondary Dx of Diabetes	Care Director Report

Program-specific measures (2 of 3)

Updated Measure Definition	Numerator	Denominator	Based on your enabling technology decision, how will you collect this information?
Behavioral health Dx (primary and secondary) with substance abuse	# of patients with a Behavioral Health (primary or secondary Dx) with substance abuse seen for initial visit while inpatient	# of patients d/c with a BH Dx (primary / secondary) with substance abuse	Care Director Report
Care navigation linkage to services	# of services patients with BH (primary / secondary) with substance abuse access based on referral	# of referrals made to services with primary / secondary Dx of BH with Substance Abuse	Care Director Report
Behavioral health Dx (primary and secondary) w/o substance abuse	# of patients with a Behavioral Health (primary or secondary Dx w/o substance) seen for initial visit while inpatient	# of patients d/c with a BH Dx (primary / secondary w/o substance abuse)	Care Director Report
Timeliness of services provided to patients w/ behavioral health (primary or Secondary) Dx with substance abuse	#of patients seen by BH clinician within 48 hours of post discharge	# of patients with primary or secondary BH with Substance Abuse Dx referred to BH resources in the Medical Neighborhood	Care Director Report
Care navigation linkage to services	# of services patients with BH (primary / secondary) access based on referral	# of referrals made to services with primary / secondary dx of BH	Care Director Report
Expand BH services via Telehealth	# of patients with BH Dx (primary and secondary) with substance abuse utilizing a Telehealth visit	# of patients with BH Dx (primary and secondary) with substance abuse	Care Director Report
Expand BH services via Telehealth	# of patients with BH Dx (primary and secondary) utilizing a Telehealth visit	# of patients with BH Dx (primary and secondary)	Care Director Report
BH Readmissions	# of patients with BH Dx (primary and secondary) readmitted to BMC	# of patients with BH Dx (primary and secondary) discharged from BMC in last 30 days	Meditech / MIDAS
BH ED Revisits	# of patients with BH Dx (primary and secondary) revisiting the ED either at NARH or at BMC	# of patients with BH Dx (primary and secondary) discharged from BMC in last 30 days	Meditech / MIDAS

Program-specific measures (3 of 3)

Measure Definition	Numerator	Denominator
Total number of 30-day returns after a Primary BH ANY BED discharge (ANY BED to ED) – Target Population	Count of index discharges with a primary BH diagnosis, followed by an ED visit for any diagnosis (BH or not) within 30 days	N/A

Continuous improvement plan (1 of 2)

<p>1. How will the team share data? Describe.</p>	<p>Create an internal “dashboard” via an existing report writing tool (Polaris)</p>
<p>2. How frequently will you (PM, Investment Director) look at the data (e.g., weekly)? Describe.</p>	<p>Weekly (possibly daily/ it will be available)</p>
<p>3. How often will your executive team (VPs, C-suite) review CHART project reporting (e.g., monthly)? Describe.</p>	<p>Weekly for the first quarter, will move to monthly if no issues identified</p>
<p>4. How often will your front line CHART staff (SW, care team) review reporting (e.g., weekly)? Describe.</p>	<p>Weekly care team meetings, monthly care team with community members</p>
<p>5. How often will your community partners review data (e.g., weekly, monthly)? Describe.</p>	<p>Monthly</p>
<p>6. Which community partners will look at CHART data (specific providers and agencies)? Describe.</p>	<p>All participating members will be included and have access to the data, final list still being developed</p>
<p>7. Will the quality committee of your board review CHART reporting (e.g., quarterly)? Describe.</p>	<p>Yes, Patient Care Quality – Board Quality Committee/Quarterly report will include services provided, utilization of services and outcome data – readmission rate</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 Integration Analyst 1 FTE Will collaborate with the Program Director to report, analyze, and communicate information	Program capability to build interfaces and extract data from data based
9. What is your approximate level of effort to collect these metrics? Describe.	Cohort-Wide	Program specific
	Upfront data reporting requirements	Consistent across the cohort
10. How will you ensure that you are able to collect both your program specific and the cohort-wide measures? Describe.	Building reports into centralized data base	
11. How will you know when to make a change in your service model or operational tactics? Describe.	Weekly reviewing of the availability of current data. This efforts will have weekly check in meetings with clinicians and support staff to ensure processes are working and communication is optimal	

Enabling Technologies plan

Functionality	User	Vendor	Cost
Ability to manage patients that are high risk, as defined by frequent hospital admissions and ED visits as well as those with chronic medical conditions by coordinating care within Care Director. This gives the care team the ability to see and add clinical information and risk assessments defined by the care team and further develop care plan elements such as education, transportation, counseling and goals. Care Plans are shared with the patient and visible to members of the care team. In addition, clinical data is available to credentialed providers of the care team who will be able to assist with goals and interventions and measure and document progress electronically. Discrete data is captured and reportable and shared with analytics tools to measure improvements and patient outcomes.	Care Coordination Team	Allscripts	\$156,800, licensing and start-up \$93,750, data integration analyst \$91,766, technology system analyst (including fringe)
Telemedicine (location based equipment in N. Adams, Breen, Williamstown LTC, medical neighborhood)	Clinicians	Presidio Network Solutions, LLC	\$10,861

Enabling Technologies plan – Q&A

Key Functionalities	How will your program do this? Include a description of specific tools, if any, and who will be able to access these tools. Please indicate if you need help thinking about helpful tools.
<p>Reporting capability Reliable, monthly (or more frequent) measurement of outcomes (principally utilization metrics) for total hospital and for defined target population</p>	<p>We already have strong data reporting capabilities using our Hospital System – Meditech which we will use to identify the patient population. This data will be analyzed and automatically fed into Care Director. We also have the capability to extract these same patients and cross reference the follow-up work being completed in Allscripts by the physicians. We have a very robust Data Warehouse (Polaris) that we will also use for data reporting. These systems can/will report on a regular basis – monthly – or more frequently. These reports and tools will be available to the entire CHART Team as well as Senior Leadership and other key stakeholders.</p>
<p>Admission-Discharge-Transfer Notifications Notification-based system to track target population utilization/ services across the continuum (<i>note: within your system and providers related to your CHART award only</i>)</p>	<p>We already have developed significant ADT notifications out of Meditech. These will be real-time patient population triggers. We will use these triggers to pull other data and again feed the target population into the Care Director for follow-up.</p>
<p>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</p>	<p>We plan to use Care Director to capture the patients being followed/managed and then use this tool to create electronic tasks to the providers in Allscripts as well as to feed tasks to the community providers (who will be using Care Director). We also plan to use dbMotion to correlate the clinical follow-up information as well as we will use our Polaris Data Warehouse to facilitate reporting.</p>
<p>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</p>	<p>Care plans will be individualized in Care Director and easily available to all care-givers, care-navigators and community partners.</p>

Abridged Implementation Plan – Not for budgeting or contracting purposes

Berkshire Medical Center – Version 3

Other essential investments

Other Investments	Cost
Equipment: PCs, Phones, Monitors, Docking Stations, Copier	\$37,595
Orientation to CHART program including Competency Based Education Modules for Care team on Community Based Care Navigation, working w/ Healthstream & membership to bridge transition collaborative	\$37,880
Patient Care Assistance Fund	\$25,000
Travel and Miscellaneous Cost	\$58,867

Key dates

Key milestone	Date
Launch date (beginning of your 24 month Measurement Period)	9/1/2015
Post jobs	7/2015
New hires made	8/2015
Execute contracts with service delivery partners – EcuHealth and Brien Center	7/2015
Execute contracts with Allscripts and Cisco (existing contracts); execute new contract with Care Director	6/2015
Staffing to handle 50% of planned patient capacity for readmission reduction initiatives	8/2015
Staffing to handle 100% of planned patient capacity for readmission reduction initiatives	8/2015
Test report of services measures	7/2015
Enabling technology suite testing initiated	7/2015
Enabling technology suite go-live	8/2015
Trainings completed: Interviewing techniques, health literacy, Care Navigation, IT	8/2015
First patient seen	8/2015

Community partners/subcontractors

Name	Business Address	Website	Contact Name	Contact Title	Contact Phone Number	Contact Email Address
Brien Center for Mental Health and Substance Abuse	251 Fenn Street P.O. Box 4219 Pittsfield , MA 01201	www.briencenter.org	Ms. Chris Macbeth	CEO	413-629-1288	Christine.Macbeth@briencenter.org
EcuHealth	99 Hospital Ave, Suite 208, North Adams MA 01247	www.ecuhealth.boxcarexpress.com	Karen Baumbach	Executive Director	413-663-8711	kbaumbach@bhs1.org
Allscripts	8529 Six Forks Rd. Raleigh, NC 27615	www.allscripts.com	Nicholas Pallang	Account Manager	781-414- 9569	Nicholas.Pallang@dbMotion.com
Data Integration Analyst	99 Middle Field Rd Hinsdale , MA 01235		Kevin K. Cahill	Owner / Data Analytics and Data Integration Specialist	413-629- 9088	kevinkcahill@gmail.com
Presidio Network Solutions, LLC		www.presidio.com				

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Berkshire Medical Center – Version 3