

COMMONWEALTH OF MASSACHUSETTS
HEALTH POLICY COMMISSION

CHART Phase 2:
Implementation Plan

Lawrence Memorial and Melrose-Wakefield
Hospitals' Joint Award

HPC approval date: 10/23/15

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Version: 4



Introduction

This Implementation Plan details the scope and budget for Lawrence Memorial and Melrose-Wakefield Hospitals' (the "Participating Hospitals") Award in Phase 2 of the Health Policy Commission's (HPC) Community Hospital Acceleration, Revitalization, and Transformation (CHART) Investment Program. Hallmark Health System, Inc. ("Contractor") is contracting with the HPC on behalf of the Participating Hospitals. The Implementation Plan is incorporated by reference into and is subject to the requirements of the Phase 2 Joint Award Contract, including the Phase 2 Joint Award Terms & Conditions.

Many capitalized terms appearing in the Implementation Plan are defined in the Phase 2 Joint Award 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
Alan Macdonald	President and Chief Executive Officer	Executive Sponsor
Carol Plotkin, MSW, LICSW,	System Director for Behavioral Health	Co-Clinical Investment Director
Steven Sbardella, MD	Vice President of Medical Affairs and Chief Medical Officer	Co-Clinical Investment Director
William Doherty, MD	Executive Vice President and Chief Operating Officer	Operational Investment Director
Susan Riley	Controller	Financial Designee

ED Patients with Personal History of Frequent ED Utilization

Definition*

- Patients with ≥ 10 ED visits in the last 12 months

Quantification

- 147 people used 2,359 ED visits

ED Opiate Overdose Patients and OB Patients with SUD

Definition

- ED patients requiring Narcan reversal*
- OB patients with SUD, as referred to the COACHH program**

Quantification

- 339 patients requiring Narcan reversal
- 46 OB patients with SUD

*Target population definition includes all payers and aged 18+; excluding OB, deaths, and discharge to acute rehab

**Target population definition includes all payers, and excludes deaths and discharge to acute rehab

Aim Statement

Primary Aim Statement

Reduce ED utilization by 20% for all ED HU patients by the end of the 24 month Measurement Period.

Secondary Aim Statements*

Increase post-ED contact with patients or families of patients who were seen in the Hallmark Health ED following an opiate overdose with Narcan reversal within 1 week of the index event by 25%, by the end of the 24 month Measurement Period.

Provide at least 1 COACHH team contact per week for the duration of their pregnancy, for 80% of Hallmark Health OB patients with SUD as referred to the COACHH program, by the end of the 24 month Measurement Period.

*Your secondary aim statements are performance measures only and are not tied to Achievement Payment.

Baseline performance – ED visits

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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	Annual
Hospital-Wide	ED Visits	4051	3532	3985	4042	4075	4025	4207	4207	3949	3936	3597	3574	47180
Target Pop	ED Visits	214	265	206	182	215	184	186	215	208	204	189	191	2359

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Annual ED High Utilizers				
# of visits	# Patients	Total Visits	% of total ED patients	# of total ED visits
10+	147	2,359	0.5%	5%

Select all ED patients 18+ years (except OB, Deaths, Acute Transfers)
Includes ED Admits

Estimated monthly impact

	Current Expected Served	Current Expected Events	New Expected Avoided Events	New Expected Events
Reduce ED HU utilization	$2359 / 12 = 197$ ED visits per month	$0.20 * 197 = 39$	39 visits reduced/month	$197 - 39 = 158$ visits/month

Driver Diagram

ing or contracting purposes
Abridged Implementation

Reduce ED utilization by 20% for all ED HU patients by the end of the 24 month Measurement Period*

Drive enhanced alignment of patients needs and appropriate healthcare and community based services

Engage/Enroll Multi-Visit Patients through historic registry and real time ED visits utilizing enabling technology and systematic outreach in ED, Hospital and Community

Generate communication with care providers to thaw treatment freeze, reduce stigma, and innovate creative approaches to addressing patient goals

Define and support patient driven goals for improving health and develop patient specific interventions targeted towards those goals

Provide Adaptable, Multidisciplinary, Collaborative Care

Replace the pattern of high reliance on ED services with responsive culturally sensitive, community care via community outreach and goal oriented interventions

Collaborate with healthcare providers, community agencies, families, and patients to address patient specific goals

Utilize data to identify patterns of ED use and collaborate with patients and providers to minimize barriers to care & drivers of ED utilization

Deliver comprehensive, innovative, integrated care from a highly engaged and creative interdisciplinary team that includes social workers, nurse practitioner, physicians, pharmacist, training consultants, and Collaborative Care Coaches

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Target population definition includes all payers, excluding OB, deaths, transfers to acute inpatient, and discharge to acute rehab. *Secondary aims improve care for OB patients w/ SUD and individuals with opiate overdose utilizing above strategies.

Service model

Narrative description

The CHART program will provide **C**ollaborative **O**utreach and **A**daptable **C**are at **H**allmark **H**ealth; the program will be referred to as COACHH. The COACHH program proposes to improve care for 3 cohorts of patients: patients with a history of repeated ED utilization, patients with a history of opiate overdose requiring Narcan reversal. and obstetric patients with active Substance Use Disorder (SUD).

The model is founded on the Spectrum Health Complex Care Team model, and modified to comprise the following staff:

- 1 Executive Director
- 1 part time (2 days per week) Physician
- 1 Nurse Practitioner (prescriber, medical)
- 1 Social Worker
- 1 part time Pharmacist
- 3 Community Health Workers / Peers (Collaborative Care Coaches)

The criteria for participation in the COACHH program is utilization of the ED (10+ in prior 12 months) or near-lethal opiate overdose. Upon identification, (which can either be in advance of a utilization event, or at the time of the utilization event), a community health worker will attempt to engage the patient in the ED, inpatient setting, or community setting offering assistance in helping the individual to access care and care coordination. When engaged, the patient would received enhanced, responsive, multidisciplinary care from a multidisciplinary team that would serve as a time-limited adjunct to traditional primary care. The services would focus on integrated behavioral health, medical, social work, pharmacy, patient education and care navigation. The hallmark features of the services are responsiveness, urgent availability, 24/7 phone access, patient-centered, consistency, adaptability, and longitudinal in nature with a focus on the person-in-context and establishing stability (medical, social and behavioral) over time.

Based on our calculations of the number of patients who meet the utilization criteria of the target population, we propose to staff 1 team which can ultimately serve 250 patients per year. Currently there are 147 prior-year patients. This allows incorporation of the 2 “secondary” target populations, 339 patients with Narcan reversals and 46 OB + SUD patients. We anticipate we can actively engage 50% of the target populations.

This care delivery model essentially represents a new service line at Hallmark Health. As such, it will be essential to create the clinical and managerial oversight to effectively deploy this new service line, and to empower those leaders and staff with the tools required to deliver cross-setting multidisciplinary care in a way that is measurable and analyzed on a monthly basis to drive to safe and effective target utilization, quality and cost objectives. Also, clinicians, staff, and leadership need to have necessary skills and values to be aligned with the objectives of the program.

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
- In home supports X
- Home safety evaluation
- Logistical needs X
- Whole person needs assessment X
- Medication review, reconciliation, & delivery
- Education X
- Advocacy X
- Navigating X
- Peer support
- Crisis intervention X
- Detox
- Motivational interviewing X
- Linkage to community services X
- Physician follow up X
- Adult Day Health
- Other: ___Medication Review and Education___
- Other: _MD/NP Assessment__
- Other: _____
- Other: _____
- Other: _____

Personnel Type

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

Service Availability

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

Please note: Call coverage 24/7

Service mix

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Service	By Whom	How Often	For How Long
Executive Director	Executive Director of COACHH	.82 FTE	Ongoing
Medical Management of the COACHH team	Physician	0.4 FTE: 2 days per week	Ongoing
Medical Management of the COACHH team and prescriber	NP	1 FTE	Ongoing
Comprehensive needs assessment, care plan development, counseling	SW	1 FTE	Ongoing
Medication management, optimization, education	Pharmacist	0.2 FTE	Ongoing
Outreach, peer support, patient engagement	Collaborative Care Coaches	3 FTEs	Ongoing
# FTE/units of service hired at my organization		6.42 FTE	

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List of service providers/community agencies

Type of Service Provider	Community Agency Name	New or Existing Relationship
VNA	Hallmark Health VNA	Existing
Medication Assisted Treatment	Middlesex Recovery	New
Behavioral Health	Community Counseling	Existing
Behavioral Health	Eliot Community Human Services	New in this capacity
Maternal Child Health	Mother Woman	New
Elder Services	Mystic Valley Services	Existing

Summary of services

Clinical service and staffing mix

Prior to Presentation: (establish registry and start to proactively manage)

- Create registry for ED High Utilizers (ED HU) and OB-SUD patients (OB and/or hospital data)
- Conduct cohort-wide medical record review for the purposes of identifying & filling gaps in care (as manifest by HU events)
- Identify patients by payer, whether part of ACO, MCO, SNP, etc.; contact for collaboration
- Identify which patients have existing social services / HCBS / ASAP services in place
- Develop first draft individual care plans
- Identify which patients are candidates for SUD treatment, CHW outreach, etc.

When patient presents to ED / inpatient:

- EDIS real-time identification of target population patients (ED or HU)
- EDIS notification automatically (pages/emails/notifies/populates) complex care team
- EDIS notification connects ED clinician to Individual care plan, if one exists
- Complex care team engages patient in the ED to establish relationship and begin to craft care plan
- Complex care team collaborates with ED clinicians as needed

Following ED:

- Complex care team engages with patient in any setting (SNF, home with home care, home, etc.)
- Immediate post-acute follow up <24h
- Clinic visits at “COACHH Office”
- Home visits, in home (or in SNF) pharmacist-conducted medication reconciliation & optimization
- Frequent CHW contact
- Daily phone calls / outreach to “super-utilizers” as needed

Service Duration

- Model anticipates following high needs patients for 1 year with quarterly reassessment

Cohort-wide standard measures – Hospital utilization measures

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

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.

Utilization measures are required to be reported for both campuses separately as well as aggregated totals. Service utilization measures and high-utilizer measures for payment are required only as aggregate totals.

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		
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)		

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.

Utilization measures are required to be reported for both campuses separately as well as aggregated totals. Service utilization measures and high-utilizer measures for payment are required only as aggregate totals.

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

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.

Utilization measures are required to be reported for both campuses separately as well as aggregated totals. Service utilization measures and high-utilizer measures for payment are required only as aggregate totals.

Cohort-wide standard measures – Payer mix

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

Utilization measures are required to be reported for both campuses separately as well as aggregated totals. Service utilization measures and high-utilizer measures for payment are required only as aggregate totals.

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

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

Utilization measures are required to be reported for both campuses separately as well as aggregated totals. Service utilization measures and high-utilizer measures for payment are required only as aggregate totals.

Program-specific measures

Measure Definition	Numerator	Denominator
Percent of Patients enrolled in COACHH > 6 months following Narcan reversal with 2+ visits for medication assisted treatment of SUD	Number of patients enrolled in COACHH > 6 months with 2+ visits for medication assisted tx of SUD	Total number of patients enrolled in COACHH > 6 months post index encounter
Percent decrease in ED visits for each enrolled COACHH patient for 12 month period post index encounter from baseline	# of ED visits for 12 month period post COACHH index encounter for each COACHH HUD enrollee	# of ED visits for 12 months prior to enrollment in COACHH for each COACHH enrollee
Total number of pregnant women with SUD in COACHH cohort with integrated treatment plan developed within 8 weeks of enrollment for management of SUD pre and post delivery.	Total number of pregnant women with SUD in COACHH cohort with integrated treatment plan developed within 8 weeks of enrollment for management of SUD pre and post delivery.	Total number of pregnant women with SUD in COACHH cohort
Follow up post-Narcan reversal	Number of patients (or families) with completed contact within 1 week of discharge following an ED encounter for opiate overdose with Narcan reversal.	All patients seen in ED for opiate overdose with Narcan reversal
Engagement with OB patients with SUD	Number of denominator patient who have weekly contact with the COACHH program	Total number of Hallmark Health OB patients with SUD, as identified by (1) referrals to the Maternal Child Social Worker from Hallmark obstetricians and family practitioners at physician offices or (2) otherwise referred directly to the COACHH program.
An additional measure of quality, access, or patient experience, to be identified by Hallmark and approved by the HPC	TBD	TBD

Continuous improvement plan (1 of 2)

<p>1. How will the team share data? Describe.</p>	<p>Our enabling technology or the Exec Director will email the weekly stats to the team.</p>
<p>2. How frequently will you (PM, Investment Director) look at the data (e.g., weekly)? Describe.</p>	<p>Exec Director and staff will look at stats daily. Investment director will review at weekly CHART meetings.</p>
<p>3. How often will your executive team (VPs, C-suite) review CHART project reporting (e.g., monthly)? Describe.</p>	<p>Project updates and key metrics will be reported out to multiple committees, which meet on a monthly or quarterly basis. This includes our quality, program development, and Executive leadership team</p>
<p>4. How often will your front line CHART staff (SW, care team) review reporting (e.g., weekly)? Describe.</p>	<p>They will review daily as the enabling technology will be integrated into their workflow. Metric review and trends will be reviewed by Program Manager with Staff at weekly department meetings. Top problems as identified by trends and staff will be reviewed at daily huddles.</p>
<p>5. How often will your community partners review data (e.g., weekly, monthly)? Describe.</p>	<p>The frequency of communication will be included in the service agreements with the community partners. Data will be shared weekly, and discussed monthly if not more frequently.</p>
<p>6. Which community partners will look at CHART data (specific providers and agencies)? Describe.</p>	<p>CHART data will be shared with community partners once a service agreement is executed. It is anticipated that community partners may include Eliot Community Human Services, Middlesex Recovery, and HH medical associates.</p>
<p>7. Will the quality committee of your board review CHART reporting (e.g., quarterly)? Describe.</p>	<p>Yes. Our Board Quality reviewed CHART Phase 1 metrics, have been updated on Phase 2 progress, and are eager to review Phase 2 metrics/progress.</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
	Exec Director, with support of business development & IT	Exec Director, with support of business development & IT
9. What is your approximate level of effort to collect these metrics? Describe.	Cohort-Wide	Program specific
	Moderate overall. Significant upfront investment	Moderate overall. Significant upfront investment
10. How will you ensure that you are able to collect both your program specific and the cohort-wide measures? Describe.	This will be one of the key deciding factors in selection of Enabling Technology. We will use standardized collection and reporting methodologies. Significant thought will also be given to how data is inputted/documentated as well as data extracted.	
11. How will you know when to make a change in your service model or operational tactics? Describe.	Like CHART phase 1, the Core CHART team, made up of COACHH Exec Dir, Grant Clinical Director, and Dir of Business Development, will meet each week to discuss progress and review metrics. The Executive Director will have daily huddles with her team, which will prove useful in identifying top problems and getting real time feedback from COACHH staff. Issues discussed at huddle can be circulated to the Core CHART team.	
12. Other details:		

Enabling Technologies plan

Functionality	User	Vendor	Cost
Real time identification & notification to care team when HU visit ED. Sharing of care plan with ED MD, if available. Workflow platform for CHW & COACHH team – track outreach, acceptance into program, follow up, etc. Reporting of metrics, outcome measures, & drill down capability. Connectivity with community partners.	COACHH Staff ED staff, Investment Directors, Business Development, IS, and community partners	Loopback Navigator	\$180,000
Loopback implementation cost, creating connection with hospital based system. Connection will be outsourced. Proposals from vendors are pending. Cost is approximate.	IT implementation for system	TBD	\$20,000
Reporting set-up in Loopback for HPC metrics	COACHH Staff ED staff, Investment Directors, Business Development, and IS	TBD	\$7,000
Connectivity and licenses for MD & NP to document and communicate with PCP/ED staff	MD/NP	GE Centricity	\$60,000

Enabling Technologies Plan – Q&A

1. How are you going to identify target population patients in real-time? *Loopback.*
2. How will you measure what services were delivered by what staff? *Loopback*
3. How will you measure outcome measures monthly? *Loopback*
4. What tool/platform will you use to facilitate cross-setting and multi-disciplinary coordination of care? *Loopback*
5. 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? *Loopback*
6. Do you have a method for identifying what clinical services your target population accesses? *Loopback*

Other essential investments (1 of 2)

Other Investment	Budget Required
Director of Strategy & Business Development to support CHART project	\$35,620
VP of IT for oversight of staff and implementation of enabling technologies for CHART project	\$3,630
Administrative and scheduling support to COACHH	\$60,000
Nursing Leadership to supervise COACHH NP and program nursing practices	\$10,890
Clinical Quality Leader to provide oversight of measurement tracking	\$10,890
Controller to oversee accounting of CHART funds	\$7,260
Emergency Department Director to develop protocols for identification of COACHH staff and training of staff	\$11,420
Medical Director of ED for team meetings for COACHH patients and oversight of MD protocols/communications	\$1,210
Training – COACHH staff training in Motivational Interviewing, Pain, SUD, and conference attendance	\$17,200
Training – Physician (ED and PCP) Care of Complex Patients, including SU	\$117,300
Laptops/Tablets, hardware, software – for 8 members of COACHH team	\$16,000
Working and clinical space for COACHH Team – office furniture and supplies. Patients will be seen in this location	\$12,000
Cell phones and monthly usage charges for 5 FTEs	\$7,560

Other essential investments (2 of 2)

Other Investment	Budget Required
Clinical equipment for 2 COACHH exam rooms (exam table, stools, side chair, diagnostic system, sharps container)	\$16,000
New space for COACHH Team @ Reading Medical Center, 30 New Crossing Road, Reading, MA	\$5,226 – CHART-funded \$47,037 – In-kind contribution
After hours call coverage 7days/week	\$51,070
Fund to facilitate access to care (bus/taxi voucher, child care, interpreter services, etc.)	\$13,000
Marketing material – handouts for ED patients, Narcan information, COACHH business cards	\$2,000
Credentialing, licensing for Medical staff and NPs	\$4,931
CHART Staff Travel – 5 FTEs for travel to meet with patients and travel between Hallmark EDs	\$14,560
Director of Software Applications to implement enabling technology	\$13,200
System Analyst for reporting and data quality assurance for enabling technology	\$10,000

Key dates

Key milestone	Date
Launch date (beginning of your 24 month Measurement Period)	12-1-15
Post jobs	8-4-15
New hires made	11-30-15
Execute contract with Loopback	8-25-15
Initiatives support 50% of planned patient capacity	12-1-15
Initiatives support 100% of planned patient capacity	2-1-16
First test report of services, measures	10-15-15
Enabling technology – Loopback testing initiated	11-15-15
Enabling technology – Loopback go-live	12-15-15
Trainings completed: Staff orientation will be completed prior to program launch. Trainings on substance use disorders, motivational interviewing, and pain management strategies are to be determined.	12-1-15; ongoing
First patient seen	12-1-15

Community partners/subcontractors

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Name	Business Address	Website	Contact Name	Contact Title	Contact Phone Number	Contact Email Address
Loopback Analytics	14900 Landmark Blvd. Suite 240 Dallas, Texas	Loopbackanalytics.com	Bobby Barajas	VP, Sales and Marketing	972-480-3304	bbarajas@loopbackanalytics.com
HL7/CCD Interface – Vendor TBD			TBD			
COACCH Staff Training – Vendor TBD			TBD			
Physician (ED and PCP) Training – Vendor TBD			TBD			
Report and extract of data – Vendor TBD			TBD			

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