

COMMONWEALTH OF MASSACHUSETTS
HEALTH POLICY COMMISSION

CHART Phase 2:
Implementation Plan
Harrington Memorial Hospital

HPC approval date: September 23, 2015

Last modified: September 27, 2016

Version: 3



Introduction

This Implementation Plan details the scope and budget for Harrington Memorial Hospital (“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
Edward Moore	President and Chief Executive Officer	Executive Sponsor
Greg Mirhej	Asst. Vice President, Outpatient Behavioral Health; Director - Recovery Services	Clinical and Operational Investment Director
Thomas Sullivan	Vice President and Chief Financial Officer	Financial Designee
Tracey Weeden	Director of Assessment Services	Project Manager

Target population

Definition

- Adult patients with a primary or secondary BH* diagnosis in the ED setting**

Quantification

- 1,800 ED BH visits

Aim Statement

Primary Aim Statement

Reduce 30-day ED revisits by 15% for adult patients with a primary or secondary BH diagnosis by the end of the 24 month Measurement Period.

Secondary Aim Statement*

Reduce ED LOS by 10% for adult patients with primary or secondary BH diagnoses 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 – ED utilization reduction

		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	2215	2048	2342	2239	2361	2451	2590	2540	2402	2419	2151	2313	2337
	All ED Revisits	50	60	56	54	51	50	61	45	49	51	48	60	53
	Revisit Rate	2%	3%	2%	2%	2%	2%	2%	2%	2%	2%	2%	3%	2%
Target Pop	Target Pop ED Visits	107	106	140	118	118	128	145	145	123	145	141	128	129
	Target Pop ED Revisits	6	21	9	8	5	11	15	9	12	11	11	10	11
	Revisit Rate	6%	20%	6%	7%	4%	9%	10%	6%	10%	8%	8%	8%	9%

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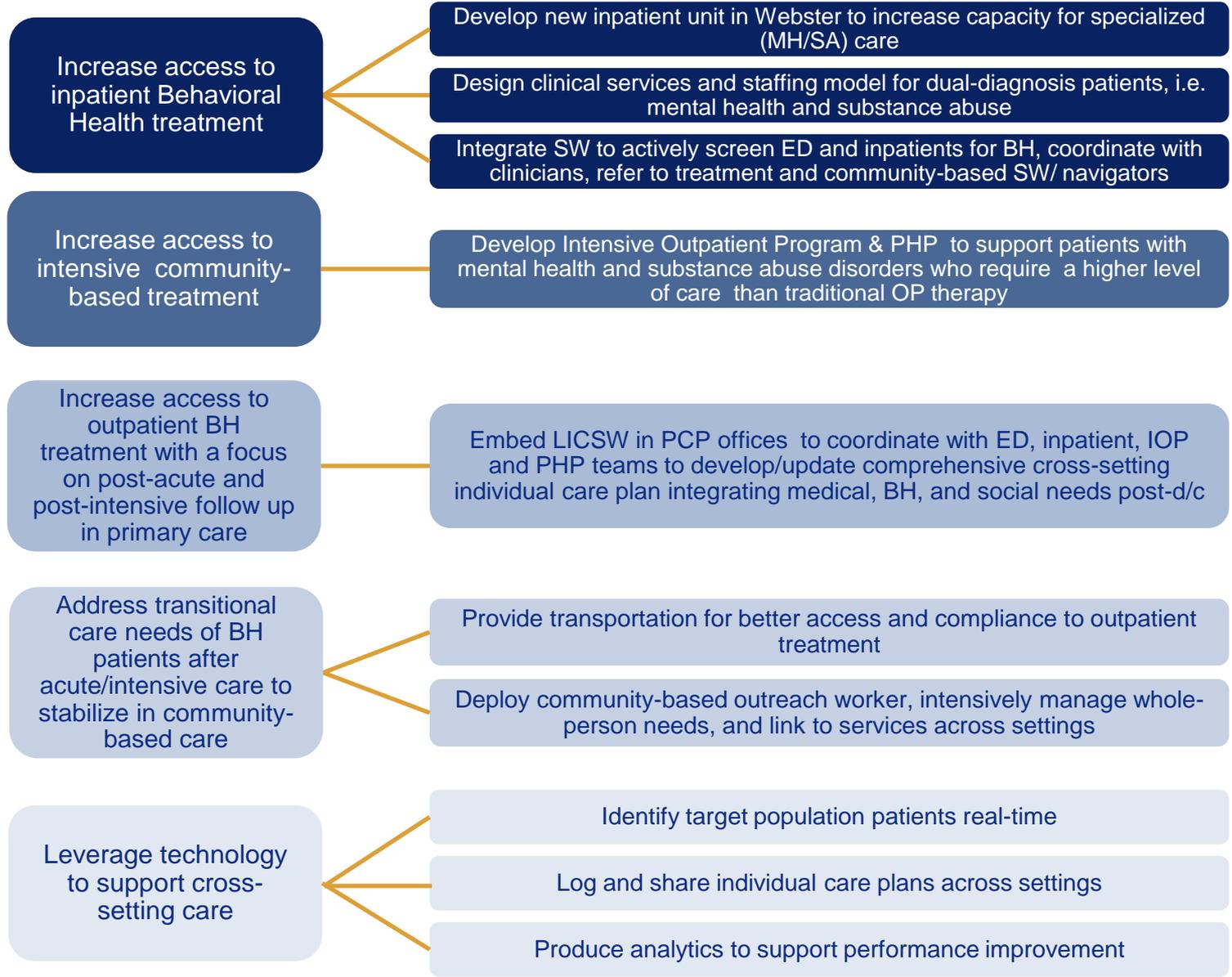
Estimated monthly impact

	Current Expected Served	Current Expected Events	New Expected Avoided Events	New Expected Events
30-day ED revisits	129 ED visits per month	Given an average ED revisit rate of 8%, we expect $0.08 * 129 = 11$ ED revisits per month	Given a goal of 15% reduction of ED revisits, we expect $0.15 * 11 = 2$ ED revisits avoided per month	Then, we expect $11 - 2 = 9$ ED revisits per month

Driver Diagram

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Reduce 30-day ED revisits by 15% for adult patients with a primary or secondary BH diagnosis by the end of the 24 month Measurement Period



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Service model (1 of 4)

Narrative description

The primary aim of the CHART 2 Grant is to reduce ED revisits by 15% for patients with behavioral health (BH) disorders within 24 months. The process to achieve this goal is to (1) increase access to appropriate inpatient treatment for patients with co-occurring mental health and substance abuse disorders; (2) develop intensive outpatient treatment programs to fill service gaps and to create a full continuum of BH care; (3) to provide BH screening and assessments on the Medical-Surgical Units at Harrington Hospital, ED, and in primary care offices to identify, assess, and refer patients to the appropriate level of outpatient services.

To achieve this goal, Harrington Hospital will develop a new inpatient psychiatric unit in Webster to increase capacity for specialized treatment of patients who have both mental health and substance abuse disorders. In addition, the development of intensive outpatient programs (Substance Abuse IOP in Southbridge, IOP and Partial Hospital Program in Webster) will provide a step-down for those discharged from inpatient hospital, as well as a higher level of care for those patients requiring more than traditional outpatient treatment as needs arise, therefore reducing need for hospital readmissions. Finally, clinicians will conduct assessments on the inpatient units and emergency room at Harrington Hospital in order to identify BH needs and connect patients to appropriate community services. Embedded clinical social workers in the offices will improve the ability of these practices to appropriately assess BH needs of their patients, engage these individuals, provide necessary on-site treatment, and link to appropriate community care.

Outline of each program and staffing:

Administrative Staff:

- 1 Clinical Director & Director of Assessment Services
- 0.2 Administrative/Project Manager

PROGRAMS & STAFFING:

Medical Home Model

LICSWs will be **embedded in or travel to PCP Offices** to work closely with the doctors, NP, and office staff to identify, provide clinical assessments, and refer patients to appropriate outpatient behavioral health services.

Staffing:

- 2.0 FTE Clinical Social Workers
- 2.0 FTE Patient Navigators

Service model (2 of 4)

Narrative description

Inpatient and Emergency Room Assessments

Harrington Hospital currently utilizes an LICSW through Psychiatric Emergency Services (PES) who performs psychiatric consultations on the medical-surgical units, and in the Emergency Department. The PES clinician will be joined by the following staff:

2.0 FTE LICSW who will be hired to work exclusively in the hospital to identify patients with BH needs and provide psychiatric clinical assessments.

1.0 FTE RN Nurse Navigator will work with medically-complex patients, i.e. those with co-occurring medical/BH conditions in order to link them to appropriate levels of care in the community in timely way.

1.0 FTE Patient Navigator to coordinate treatment and ensure patients are connected to appropriate levels of care/services and are able to follow-through. Navigators would help identified patients navigate the hospital system of services, schedule outpatient BH appointments, assist patients with insurance, and arrange/provide transportation. Navigators will also monitor patients post-discharge to ensure patients are engaged in services and address any obstacles to treatment.

Intensive Outpatient Program – Southbridge

Intensive Outpatient Programs in Southbridge will provide a higher level of mental health and substance abuse treatment than traditional outpatient services. Services are 3 hours/day, 5 days per week and include group therapy, individual therapy and family/couples therapy, and the program will be co-located with outpatient treatment program to create seamless and flexible integration of these services.

Staffing:

0.5 FTE LMHC Director/clinician

1.0 FTE MA-level therapist

1.0 FTE Patient Navigator

Partial Hospitalization Program and IOP in Webster

Harrington Hospital will have both an IOP and PHP located on the second floor of Harrington Hospital in Webster, next to the 16 Bed Inpatient Unit.

Partial Hospitalization Program (PHP) is a higher level of care than the IOP and is a step down from an inpatient psychiatric unit. The PHP in Webster will have two tracks for patients; a substance abuse and mental health (Dual Diagnosis) track, and a mental health (only) track. Clinical services are 6 hours/day, 5 days per week. Clinical treatment will include medication management, psychiatry appointments, group therapy, individual therapy, and family therapy. The patient Navigator will assist patients in accessing these services, as well as connecting them to other appropriate services (outpatient treatment, primary care, transportation, insurance, residential placements) and providing ongoing community support and case management.

Staffing:

1.0 Lead LICSW (onsite Director); 1.0 FTE LMHC; 2.0 MA/MSW Therapist (not licensed);

1.0 Patient Navigator; 0.5 Psychiatrist/Medical Director

Service model (3 of 4)

Narrative description

Webster Inpatient Unit

The Webster Inpatient Unit will be a 16 bed unit that has two specific clinical tracks: (1) patients with mental health/psychiatric disorders, (2) patients with both psychiatric and substance abuse disorders. Each track will have specific treatment programming.

Staffing (Not CHART-funded):

1.0 FTE Psychiatric Medical Director

1.0 FTE Psychiatrist and/or APRN

1.0 FTE Nurse Manager

27.0 FTE Clinical Staff (includes Nurses, MHAs, therapists) per DMH requirements for 6.6 clinical hours/day/patient

Service Mix/Intensity Required to Serve the Target Population

From the Data that Harrington Hospital has from patients who have been hospitalized out our 14 Bed Psychiatric Inpatient Unit, the breakdown is the following:

Mental Health/Psychiatric Diagnosis Only – 40%

Mental Health/Psychiatric Diagnosis with a Substance Abuse Diagnosis– 60%

As we move forward with building the new 16 Bed Inpatient Unit, the patient mix will minimally be the above 60/40 split.

Harrington Hospital Outpatient BH Services data is slightly different than that of the Inpatient Data:

Mental Health/Psychiatric Diagnosis Only – 30%

Mental Health/Psychiatric Diagnosis with a Substance Abuse Diagnosis– 70%

Transportation

Lack of transportation has historically been one of the most significant obstacles to accessing treatment in the region. Patients in need of services are often geographically removed from program sites and public transportation is practically non-existent. Although Harrington Hospital has tried to develop services across the region, lack of convenient transportation has still resulted in difficulty accessing treatment, sporadic compliance, and over-utilization of acute services in the absence of outpatient interventions.

Through the CHART 2 Grant, Harrington Hospital will contract with the Worcester County Sheriff's office to provide adequate transportation. There will be a specific focus on transporting patients to the intensive outpatient and partial hospital programs to reduce need for acute care re-admissions.

Service model (4 of 4)

Service	By Whom	How Often	For How Long
Medical Home Model – BH Assessments	2 LICSWs 2 Navigators	15-20 patients/ 8-hr day	Varied; two practices in Year 1, hope to add a 3 rd in Year 2.
Administration	1 Clinical Director & Director of Assessment Services 0.2 Administrative/Project Manager 0.1 Operational Investment Director		n/a
Inpatient and ER Clinical Assessments	1 – LICSW 1 – LICSW 1 – Navigator 1 – RN Nurse Navigator	12-15 patients/ 8-hr day	Varied; year 2 and beyond
Substance Abuse IOP Southbridge	0.5 LMHC - Director 1.0 MA-level therapist 1.0 Navigator	10-12 patients/ 8-hr day	Varied; year 2 and beyond
IOP Webster and PHP Webster (Year 2)	1.0 Lead LICSW – onsite Director 1.0 LMHC 2.0 MA/MSW 1.0 Navigator 0.5 Medical Director	20-24 patients/ 8-hr day across both sites	Varied; year 2 and beyond
Inpatient Unit Webster (Year 2)	16-bed unit 27 FTEs – <i>staffed to DMH requirements – this staffing is outside of CHART Phase 2 contract scope</i>	13-14 patients/ 8-hr day	Varied; year 2 and beyond

FTE/units of service hired at my organization

17.3

Service worksheet

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Service Delivered

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

Personnel Type

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

Service Availability

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

Psychiatric Emergency
Services: 24/7

Outpatient Services is open
M-Thurs, 8am – 8pm
Saturday 8am – 1pm

List of providers / community agencies

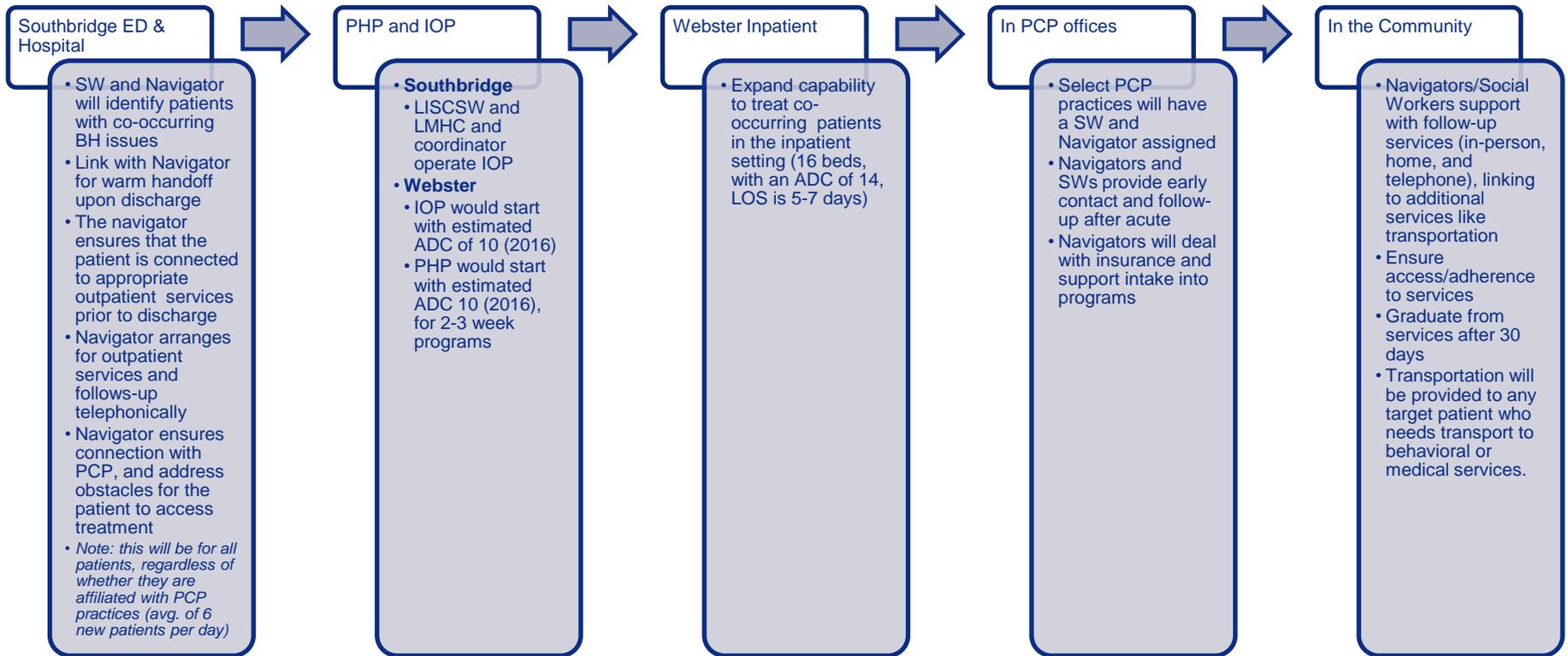
Type of Service Provider	Community Agency Name	New or Existing Relationship
Behavioral Health Provider	YOU, INC	Existing
Behavioral Health Provider	Bridge of Central Mass	Existing
Social Services	NAMI	Existing
Social Services	Center for Hope	Existing
Social Services	Tri-Valley Elder Services	Existing
Courts	Dudley District Court, E. Brookfield Court, Worcester District Court	Existing
Probation	Dudley, E. Brookfield, Uxbridge, Palmer, Westborough, Worcester, Framingham	Existing
Social Services	DMH, DPH, DCF	Existing
Behavioral Health – Substance Abuse	AdCare, Spectrum Health Systems	Existing
Social Services	Catholic Charities	Existing
Behavioral Health	South Bay Mental Health	Existing
Social Services	Central Mass Agency on Aging	Existing
Healthcare/Behavioral Health	Visiting Nurse Association	Existing
Behavioral Health	Community Health link	Existing

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Summary of services

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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

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

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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	
15. Total number of unique patients with primary BH diagnosis	x	
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	x	
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)	x	
23. ED BH revisit rate (any BH diagnosis)		
24a. Median ED LOS (time from arrival to departure, in minutes)	x	x
25a. Median ED LOS (time from arrival to departure, in minutes), primary BH diagnosis	x	

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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

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

Program-specific measures with HPC specifications

Measure	Numerator	Denominator
Total number of any BH diagnosis ED visits discharged home	Count of ED visits that were discharged to home	N/A
Total number of any BH diagnosis ED visits admit to med/surg	Count of ED visits that were admitted to med/surg	N/A
Total number of any BH diagnosis ED visits admit/transfer to psych unit	Count of ED visits that were admitted/transferred to psych unit	N/A

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Program-specific measures

Measure	Numerator	Denominator	How will you collect this?
1. % Target Pop (TP) assessed in ED	# Target pop assessed by ED SW/team	Total target pop admitted to ED	Athena Care Manager
2. % TP assessed in ED by ESP	# TP assessed by ESP	# TP admitted to ED	ESP Database
3. % TP assessed in Inpt	# TP assessed by Inpt SW/team	Total TP admitted to Inpt	Athena Care Manager
4. % TP seen post ED in PCP offices	# TP patients seen post-ED visit by SWs in PCP offices	Total TP referred to PCP for follow-up	Athena Care Manager
5. % BH patients assessed in PCP offices	# BH patients assessed by SWs in PCP offices	Total patients screened with BH diagnosis in PCP offices	Athena Care Manager
6. % TP admitted to IOP	# TP served by IOP	Total TP referred to IOP and Total TP	Athena Care Manager
7. % TP admitted to PHP	# TP served by PHP	Total TP referred to PHP and Total TP	Athena Care Manager
8. % TP treated in Inpt Dual Diag Unit	# TP served in DD Inpt Unit	Total TP found in 2 ED (Southbridge & Webster)	Athena Care Manager
9. % TP served by Navigators	# TP engaged by Navigators	Total TP referred for Navigation services	Athena Care Manager
10. Average # contacts by BH Team post-assessment	Total # visits, calls, contacts by SWs or Navigators following assessment	Total TP assessed	Athena Care Manager
11. % of TP linked to service	# TP successfully attended intake or initial appointment	Total TP referred for services	Athena Care Manager

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Continuous improvement plan (1 of 2)

<p>1. How will the team share data? Describe.</p>	<p>The Team will share data with the on-line managers, clinical staff, navigators, Chief of the ER, Director of Hospitalist Services, Vice President of Behavioral Health, COO of Harrington's Physician Services, CFO, CMO, and CEO.</p>
<p>2. How frequently will you (PM, Investment Director) look at the data (e.g., weekly)? Describe.</p>	<p>See Answer 3. Along with weekly CHART Reporting to the Senior Leadership Team, I meet with the hospital CEO on a weekly basis and the CHART Award is one of the ongoing topics that is discussed.</p>
<p>3. How often will your executive team (VPs, C-suite) review CHART project reporting (e.g., monthly)? Describe.</p>	<p>The VP of BH will present the available data at the Senior Leadership Team Meeting Weekly (CEO, CFO, CMO, COO of Harrington's Physician Services, Vice President of BH, VP of Quality, and CNO). The VP of Behavioral Health will discuss the program(s) weekly at supervision with the CEO, and there will be a monthly meeting with the above on a monthly basis.</p>
<p>4. How often will your front line CHART staff (SW, care team) review reporting (e.g., weekly)? Describe.</p>	<p>There will be a weekly meeting to go over reports, navigation, etc...</p>
<p>5. How often will your community partners review data (e.g., weekly, monthly)? Describe.</p>	<p>On a monthly basis, ER and inpatient reports will be shared with community partners.</p>
<p>6. Which community partners will look at CHART data (specific providers and agencies)? Describe.</p>	<p>The Bridge and the Department of Mental Health Regional Director and DMH area staff. On a quarterly basis, the materials will be presented to the HPS Doctors and Office Managers.</p>
<p>7. Will the quality committee of your board review CHART reporting (e.g., quarterly)? Describe.</p>	<p>CHART material will be presented to the Board of Directors on a quarterly basis.</p>

Continuous improvement plan (2 of 2)

8. Who will collect measures and produce reporting for Cohort-wide and program specific measure (e.g., Data Analyst, PM, ID)? Describe.	Cohort-Wide	Program specific
	Medical Records/IT Department	Medical Records/IT Department
9. What is your approximate level of effort to collect these metrics? Describe.	Cohort-Wide	Program specific
	Most of the information that has been requested has been available by writing specific reports from our existing EMRs.	Same
10. How will you ensure that you are able to collect both your program specific and the cohort-wide measures? Describe.	Once we know what specific measures the HPC is requiring, a specific report can be written that can be run as often as needed for reporting. Reports can be written that is specific to HPC, Intake Therapists, PCP Therapist, and for tracking navigators productivity.	
11. How will you know when to make a change in your service model or operational tactics? Describe.	As we gather data that is Cohort and Program Specific, we will be able to assess if our model is meeting the specific goals set forth by the HPC. If over time there are specific goals that are not met, the Hospital and HPC will work together to look at the data and decide if the goal is obtainable. If the goal is not obtainable, then the goal will need to be changed. If the goal is obtainable, the service model would need to be change to meet the goal(s).	
12. Other details:		

Enabling Technologies plan

Functionality	User	Vendor	Cost
Real time patient identification and alert, ICP sharing, measurement of standard measures and service delivery	Program management, hospital staff, primary care physicians	Athena Care Manager	\$30,000

Enabling Technology Q&A

1. How are you going to identify target population patients in real-time?
 - Athena Care Manager
2. How will you measure what services were delivered by what staff?
 - Athena Care Manager
3. How will you measure outcome measures monthly?
 - Athena Care Manager via MedHOST (EDIS) & Meditech (IP)
4. What tool/platform will you use to facilitate cross-setting and multi-disciplinary coordination of care?
 - Athena Care Manager
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?
 - Athena Care Manager will connect with Meditech and Allscripts to alert providers of care plans on file.
6. Do you have a method for identifying what clinical services your target population accesses?
 - Athena Care Manager

Other essential investments

Other Investment	Budget Required
Transportation service between Webster & Southbridge	\$93,000
Computers, cell phones, and service contracts for outreach staff	\$17,000
Education and training for new staff on Medical Home Model and psychiatry-informed primary care	\$4,000
Navigator training in use of assessments/screening tools	\$1,126
Outreach materials for SUD treatment	\$3,000
Travel budget for Navigators visiting patients in the home and taking patients to appointments	\$10,000
Per diem hospital data analyst to collect, analyze and submit monthly and quarterly CHART Phase 2 reporting, and monitoring ongoing care trends for populations served.	\$5,000
Contract IT consultant for data analyses and Meditech/Athena reconciliation	\$10,000

Key dates

Key milestone	Date
Launch date (beginning of your 24 month Measurement Period)	10/1/2015
Post jobs	7/15/2015
New hires made	8/31/2015
Execute contracts with service delivery partners: Athena, Sheriff's Office	9/15/2015
ED revisit reduction staff & initiatives at 50% of planned patient capacity	10/1/2015
ED revisit reduction initiatives at 100% of planned patient capacity	11/15/2015
First test report of services measures	9/28/2015
Enabling technology – Athena Care Manager testing initiated	10/31/2015
Enabling technology – Athena Care Manager go-live	12/31/2015
Trainings completed: Medical Home, Navigator Training	10/31/2015
First patient seen	10/1/2015

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Community partners/subcontractors

Name	Business Address	Website	Contact Name	Contact Title	Contact Phone Number	Contact Email Address
Athena Care Manager	311 Arsenal Street Watertown, MA 02472	www.athenahealth.com	Brian Shelly	Enterprise Sales Executive/Emerging Services	781-707-8505	bshelly@athenahealth.com
Worcester County Sheriff's Office	5 Paul X. Tivnan Dr. W. Boylston, MA 01583	http://www.worcestersheriff.com/	Mary Ann Reynolds	CFO	508-854-1831	reynolds.@sdw.state.ma.us
Huron Consulting Group (Formerly HSM Consulting)	125 Summer Street, Boston, MA 02110	www.huronconsultinggroup.com	Marc Del Sesto	Associate, Sr. Consultant	617-226-5500	mdelsesto@huronconsultinggroup.com

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