

COMMONWEALTH OF MASSACHUSETTS
HEALTH POLICY COMMISSION

CHART Phase 2:
Implementation Plan
Holyoke Medical Center

HPC approval date: October 1, 2015

Last modified: June 20, 2016

Version: 2



Introduction

This Implementation Plan details the scope and budget for Holyoke 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
Spiros Hatiras	President and Chief Executive Officer	Executive Sponsor
John Kovalchik	Manager of Behavioral Health	Clinical and Operational Investment Director
Melissa Perry	Director of Behavioral Health Nursing	Project Manager
Paul Silva	Senior Vice President of Finance	Financial Designee

Target population

Description

- All ED BH* patients**
 - High utilizer subset: Patients with ≥ 10 ED visits in the last 12 months

Quantification of Target Population

- 7,800 ED BH visits/year
 - High utilizer subset: 3,000 ED visits across 185 patients

* All behavioral primary or secondary health diagnoses (ICD-9 290-319)

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

Aim Statement

Primary Aim Statement

Reduce 30-day ED revisits by 25% for 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 patients with a primary or secondary BH diagnosis by the end of the 24 month Measurement Period.

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	3,291	2,824	3,018	2,955	3,156	3,100	3,356	3,217	3,235	3,131	2,792	3,072	3,096
	All ED Revisits	740	663	706	662	747	691	858	790	818	733	658	695	730
	Revisit Rate (%)	23	24	23	22	24	22	26	25	25	23	24	23	24
	LOS (min)	215	204	190	177	179	176	174	186	203	189	181	195	189
Target Pop	Target Pop ED Visits	676	575	649	577	661	652	664	632	663	650	605	689	641
	Target Pop ED Revisits	155	138	150	107	136	129	188	137	148	122	137	162	142
	Revisit Rate (%)	23	24	23	19	21	20	28	22	22	19	23	24	22
	LOS (min)	530	578	519	574	553	512	493	599	673	721	594	549	574

Please note: Target population for LOS is a subset of visits with a primary BH diagnosis

Estimated monthly impact

	Current Expected Served	Current Expected Revisits	New Expected Avoided Revisits	New Expected Revisits
Reduce 30-day BH ED Revisits by 25%	641 ED BH (primary & secondary) visits per month	Given an average revisit rate of 22%, we expect $0.22 * 641 = 141$ revisits per month.	Given a goal of 25% reduction of revisits, we expect a $0.25 * 141 = 35$ avoided per month	Then, we expect $141 - 35 = 106$ revisits per month

Abridged Implementation Plan – Not for budgeting or contracting purposes

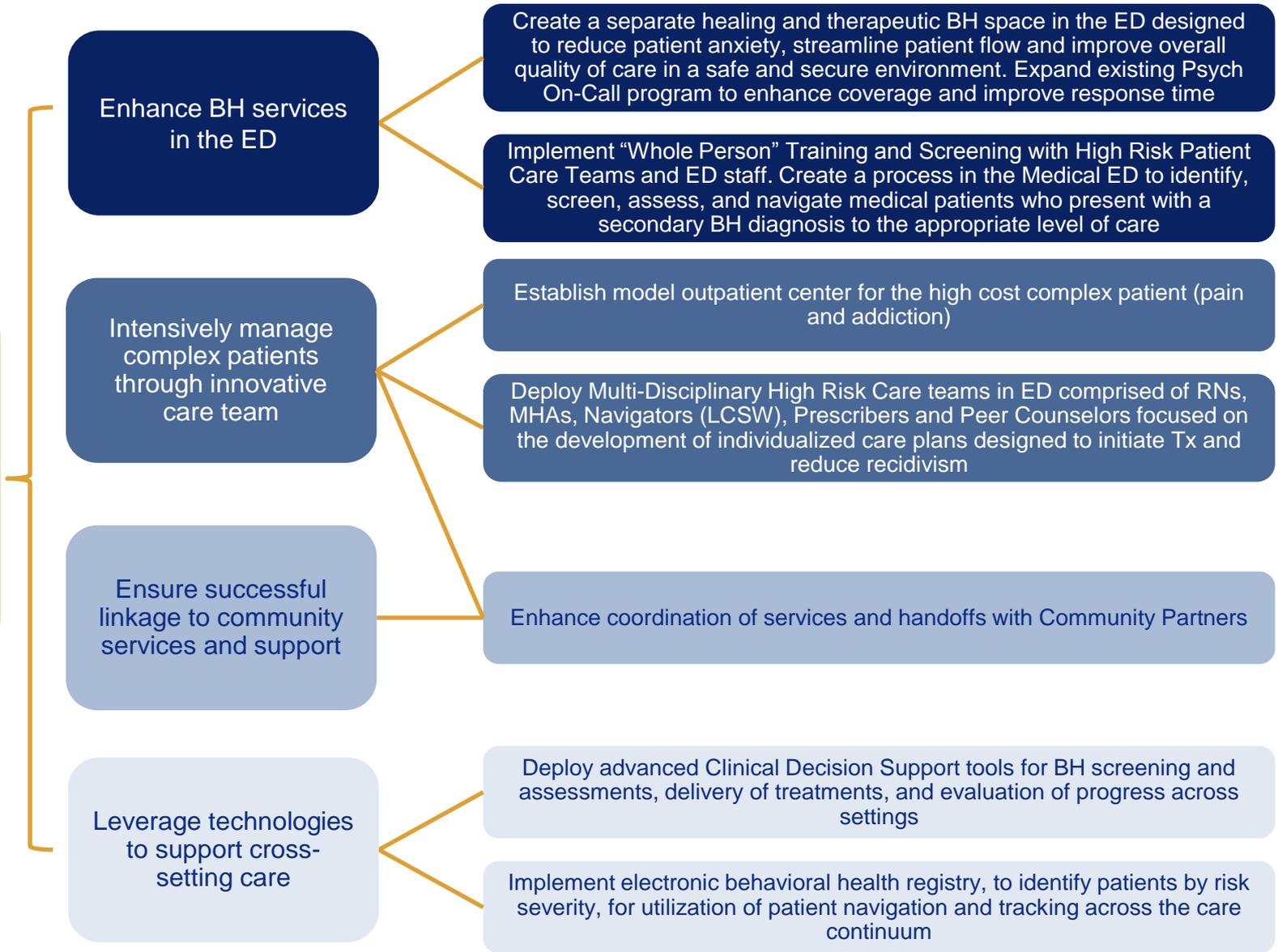
Holyoke Medical Center – Version 2

*Estimated impact does not account for additional impact of HU population

Driver Diagram

Abridged Implementation Plan – Not for budgeting or contracting purposes

Reduce 30-day ED revisits for patients with a primary or secondary BH diagnosis by 25% by the end of the 24 month Measurement Period.



Holyoke Medical Center – Version 2

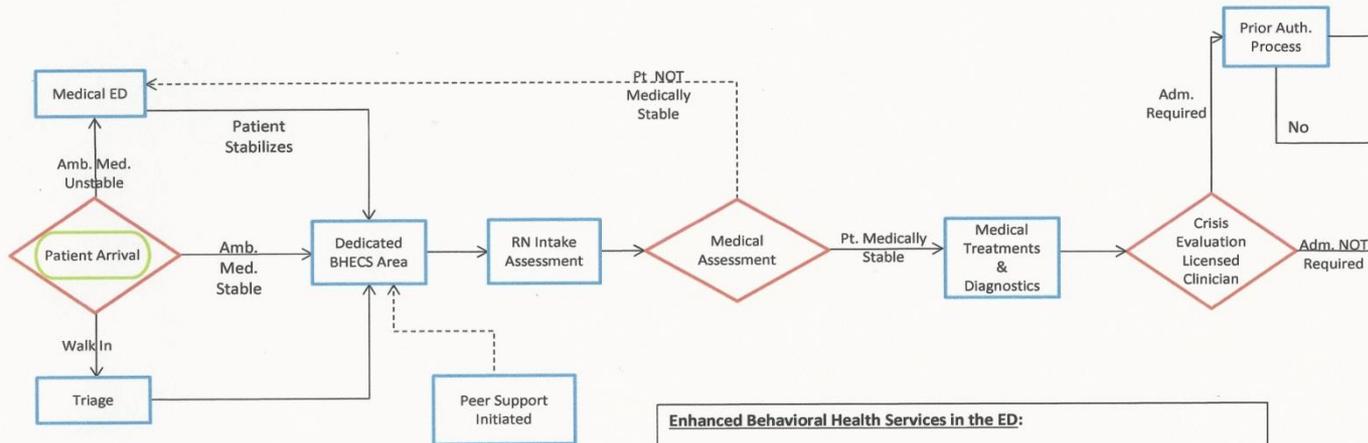
Service model (1 of 4)

Narrative description

Holyoke Medical Center (HMC) proposes to leverage existing hospital strengths/resources and community partnerships to create an innovative exemplary Behavioral Health Emergency Care Service (BHECS), with the principal goal of reducing by 25% all BH 30-day Emergency Department (ED) revisits by patients with a primary or secondary Behavioral Health (BH) diagnosis. The BHECS will deliver higher quality, safer, more effective and intensive care to the wide range of patients who present at the ED with a primary BH diagnosis, and will deploy an innovative multidisciplinary, outreach based care model to better serve the highest utilizers of ED services. In addition, the program will effectively identify, screen and assess those medical patients with a secondary BH diagnosis to ensure that they are afforded access to the appropriate level of care as necessary. At the same time, this highly coordinated initiative will introduce robust care navigation in partnership with community-based organizations to ensure that patients receive targeted interventions, including those necessary to address the high incidence of complex, challenging social issues, and are referred to the right services for successful follow through on their care plans. To improve efficiencies and support targeted care across the continuum, the program will seek to maximize and leverage both existing and new cutting edge technology to further enhance the exchange of information and patient tracking with both internal and external providers. The initiative will also provide a complementary link with the hospital's Delivery System Transformation Initiative (DSTI), with particular emphasis on the integration of behavioral health and primary care within individual primary care provider offices.

Service model (2 of 4)

HOLYOKE MEDICAL CENTER CHART PHASE 2 - ED SERVICE MODEL: PATIENTS WITH PRIMARY BH DIAGNOSIS



Enhanced Behavioral Health Services in the ED:

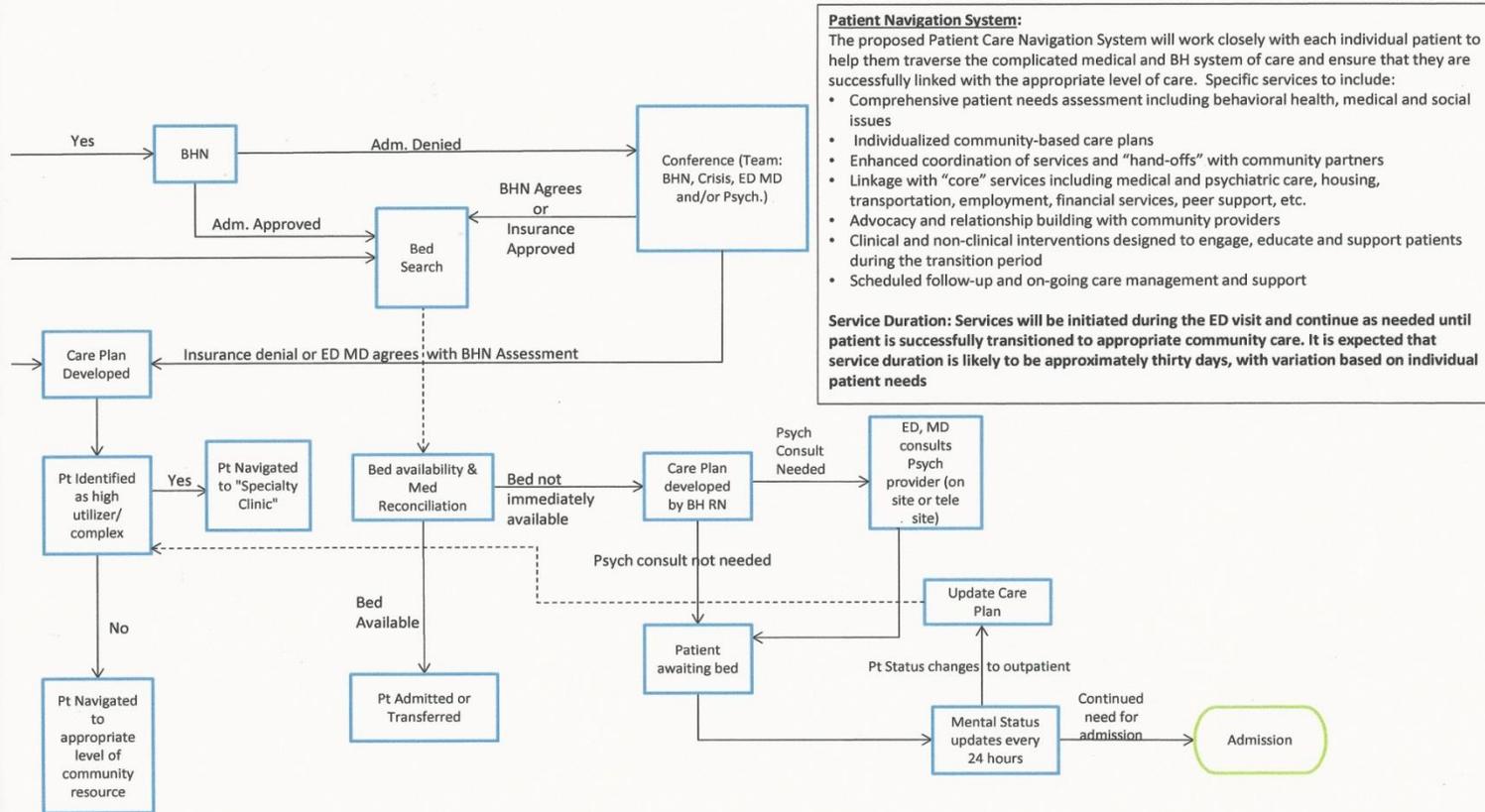
HMC will create a separate healing and therapeutic Behavioral Health Emergency Care Service (BHECS) space in the ED designed to reduce patient anxiety, streamline patient flow and improve overall quality of care in a safe and secure environment. Specific services to include:

- Engagement/enrollment
- Medical assessment, clearance and identified treatment
- Crisis stabilization
- Patient monitoring and de-escalation
- Psychiatric evaluation and assessment
- Psychopharmacological services
- Medication treatment and monitoring
- Peer support
- Motivational interviewing

Service Duration: Above services will be provided as needed throughout the length of the individual patient's ED stay.

Service model (3 of 4)

HOLYOKE MEDICAL CENTER CHART PHASE 2 - ED SERVICE MODEL: PATIENTS WITH PRIMARY BH DIAGNOSIS



Patient Navigation System:
 The proposed Patient Care Navigation System will work closely with each individual patient to help them traverse the complicated medical and BH system of care and ensure that they are successfully linked with the appropriate level of care. Specific services to include:

- Comprehensive patient needs assessment including behavioral health, medical and social issues
- Individualized community-based care plans
- Enhanced coordination of services and "hand-offs" with community partners
- Linkage with "core" services including medical and psychiatric care, housing, transportation, employment, financial services, peer support, etc.
- Advocacy and relationship building with community providers
- Clinical and non-clinical interventions designed to engage, educate and support patients during the transition period
- Scheduled follow-up and on-going care management and support

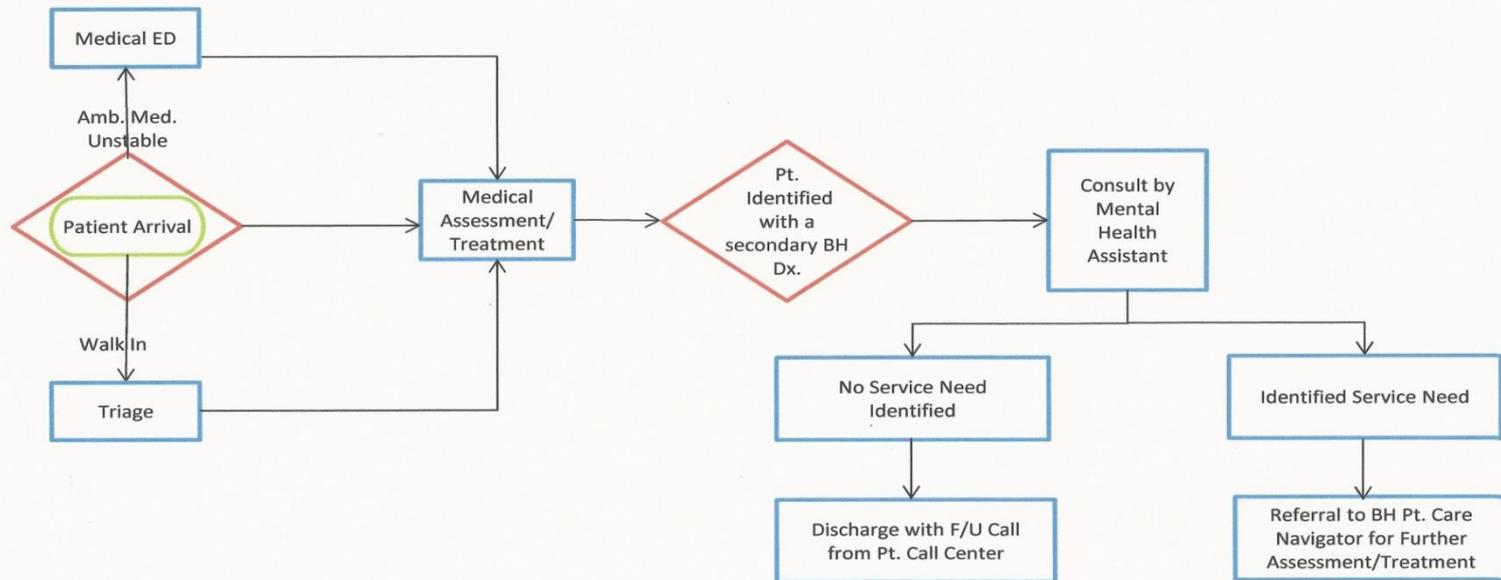
Service Duration: Services will be initiated during the ED visit and continue as needed until patient is successfully transitioned to appropriate community care. It is expected that service duration is likely to be approximately thirty days, with variation based on individual patient needs

Abridged Implementation Plan – Not for budgeting or contracting purposes

Holyoke Medical Center – Version 2

Service model (4 of 4)

HOLYOKE MEDICAL CENTER CHART PHASE 2 - ED SERVICE MODEL: PATIENTS WITH SECONDARY BH DIAGNOSIS



Service worksheet

Abridged Implementation Plan – Not for budgeting or contracting purposes

Service Delivered

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

Personnel Type

- Hospital-based nurse X
- Hospital-based social worker X
- Hospital-based pharmacist X
- Hospital-based NP/APRN X
- Hospital-based behavioral health worker X
- Hospital based psychiatrist X
- Hospital-based RN X
- Community-based nurse X
- Community-based social worker X
- Community-based pharmacist
- Community-based behavioral health worker X
- Community-based psychiatrist
- Community-based advocate X
- Community-based coach
- Community-based peer X
- Community agency (CBFS X)
- Physician
- Palliative care
- EMS (already do some of this) X
- Skilled nursing facility
- Home health agency
- Other: Medical Assistant
- Other: _____
- Other: _____
- Other: _____
- Other: _____

Service Availability

- Mon. – Fri. X (clinic)
- Weekends
- 7days X (ED)
- Holidays
- Days
- Evenings (peers availability) X
- Nights (peer availability) X
- Off-Shift Hours _____

Holyoke Medical Center – Version 2

Service mix

Service	By Whom	How Often	For How Long
Program Oversight	Admin Director - .25 FTE (ED)	Weekly	Ongoing
Medical and Behavioral Patient Care	Behavioral Health RN – 4.80 FTE (ED)	24/7	Duration of Pt.'s Stay in the BHECS
Patient Monitoring, Support and Counseling	Mental Health Assistant (MHA) – 4.80 FTE (ED)	24/7	Duration of Pt.'s Stay in the BHECS
Assessment, Treatment, Care Planning, Navigation and Linkage	Patient Navigator (Licensed Social Worker) 5.95 FTE 1.15 FTE (CL), 4.80 FTE (ED)	Peak Hours of Operation/Clinic Hours Monday-Friday	30 Days Post D/C from BHECS/Duration of Pt.'s Treatment
Psycho-Pharmacological Services	Psychiatric Mental Health Clinical Nurse Specialist (APRN) 1.15 FTE (CL)	Clinic Hours Monday - Friday	Duration of Pt.'s Treatment
Case Management	RN Case Manager 1.0 FTE (CL)	Clinic Hours Monday-Friday	Duration of Pt.'s Treatment
Psychiatric Consultation and Evaluation	MD Staff	24/7 – 365 days/year in ED	On-Call
Internal Medicine/SUD Treatment/Clinical oversight	MD .50 FTE (CL)	Peak Clinic Hours	Duration of Pt.'s Treatment
Case Management, Navigation and Linkage	Community Health Worker 3.0 FTE (CL)	Clinic Hours Monday-Friday	Duration of Pt.'s Treatment
Peer Support and Advocacy	Peer Counselor 1.60 FTE (ED)	Peak Hours of Operation and On-Call	Duration of Pt.'s Stay in the BHECS and post D/C
Administrative Support	Administrative Assistant .50 FTE (CL)	Peak Clinic Hours	Ongoing
Patient Vitals and related MD Assistance	Medical Assistant 1.0 FTE (CL)	Clinic Hours Monday-Friday	Ongoing

# FTE/units of service hired at my organization	24.55
# FTE/units of service contracted	

Abridged Implementation Plan – Not for budgeting or contracting purposes

Holyoke Medical Center – Version 2

CL = Clinic; all clinic-based staff will provide services in existing facilities

ED = Emergency Department; some ED staff will provide services in existing facilities, some phased-in using existing swing space, some phased-in as new construction completion permits. See the Budget for more details.

List of service providers/community agencies

Type of Service Provider	Community Agency Name	New or Existing Relationship
Behavioral Health	River Valley Counseling Center (RVCC)	Existing
Behavioral Health and Substance Abuse	Behavioral Health Network (BHN)	Existing
Behavioral Health	Center for Human Development (CHD)	Existing
Behavioral Health, Substance Abuse, Residential	Gandara Center	Existing
Peer Support and Advocacy (Behavioral Health)	Western Mass Recovery Learning Center	Existing
Peer Support and Advocacy (Substance Abuse)	Western Mass Peer Recovery Learning Center	New
Medical and Healthcare Prevention	Holyoke Heath Center	Existing
Medical	Western Mass Physician Associates (WMPA)	Existing
Substance Abuse	Adcare	Existing
Advocacy	NAMI	Existing
Elder Services	Western Mass Elder Care	New

Summary of services

Clinical service and staffing mix

Prior to Launch

- Create a registry of HU
- Review whether care plans already exist
- Establish flag in ED for BH and for HU
- Coordinate meetings with EMS/Police and HCBS providers re: frequently shared patients, specifically patients on the HU list

In ED

- Provide patient with primary BH issue presents to the BH side of the ED
- BH-specialized care in the ED
- Create individualized care plans
- Provide timely evaluations in the ED through new relationships with consultants
- Patients with secondary BH issue seen in medical side of ED
- Identify, assess, refer to Navigator as needed

Post ED for non-HU

- Peer and navigator will follow up in-person or telephonically (“BRIDGE Model”)
- Support groups, recovery learning community
- High touch encouragement and support

Post ED for HU

- HU referral to complex care clinic
- Multidisciplinary, outreach-based, high-touch therapy and social support focused care
- Continuous attempts to engage and re-engage patient in care
- Expect to serve 250 people per year

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”)		
9. Total number of 30-day Returns to ED from “ANY BED”		
10. Readmission rate (“IN readmissions” divided by “IN”)	x	x
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.

Cohort-wide standard measures – ED utilization measures

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
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)		

Abridged Implementation Plan – Not for budgeting or contracting purposes

Holyoke Medical Center – Version 2

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

Abridged Implementation Plan – Not for budgeting or contracting purposes

Holyoke Medical Center – Version 2

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 – 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

Program-specific measures

Measure	Numerator	Denominator	How will you collect this?
<u>Clinic</u>			
1. Total # patients served per month	N/A	N/A	eCW/Meditech
2. % of patients who drop out of the program	# of patients who dropped out of the program	Total # of patients discharged from the program	eCW/Meditech
3. Average (range) LOS in the program (in weeks)	N/A	N/A	eCW/Meditech
4. % of patients referred and linked to community program after d/c from the program	# of patients d/c and linked to community program	Total # of patients discharged from the program	eCW/Meditech
<u>ED</u>			
5. # of encounters	N/A	N/A	eCW/Meditech
6. # HU target population patients encountered in ED	N/A	N/A	eCW/Meditech
7. % of patients with secondary BH diagnosis who are screened	# of patients with secondary BH diagnosis who are screened	Total # of patients with secondary BH diagnosis	eCW/Meditech
8. % of patients referred and linked to appropriate level of care	# of patients referred and linked to appropriate level of care	Total # of patients referred to appropriate level of care	eCW/Meditech
9. # staff injuries	Total # of staff injuries		Manual collection
10. # of patients restraints used	Total # of patients on whom restraints are used	Total # of patients with secondary BH diagnosis	Manual collection

Continuous improvement plan (1 of 2)

<p>1. How will the team share data? Describe.</p>	<p>It is anticipated that the Team will continue to meet on a regularly scheduled basis to review and analyze data and specific program measures, ensuring the successful implementation and on-going operation of the project.</p>
<p>2. How frequently will you (PM, Investment Director) look at the data (e.g., weekly)? Describe.</p>	<p>Core members of the Team (i.e. PM, Investment Director, Clinical Director) will have on-line access to program-specific data, and will meet at least bi-weekly to provide the opportunity to quickly identify positive/negative trends and implement appropriate interventions as required.</p>
<p>3. How often will your executive team (VPs, C-suite) review CHART project reporting (e.g., monthly)? Describe.</p>	<p>The PM will provide monthly strategic briefings for Senior Leadership regarding the status of the CHART project. Briefings will include a review of key data pertaining to program-specific measures, along with any relevant operational and personnel issues.</p>
<p>4. How often will your front line CHART staff (SW, care team) review reporting (e.g., weekly)? Describe.</p>	<p>Weekly staff meetings will provide a forum among front line CHART staff for the exchange of all program-specific information. Additionally, these meetings will provide staff an opportunity for dialogue with program leadership, during which they will be encouraged to provide feedback and ideas to improve efficiencies and overall program performance.</p>
<p>5. How often will your community partners review data (e.g., weekly, monthly)? Describe.</p>	<p>HMC currently hosts a regularly scheduled meeting with key community partners and state DMH representatives every other month. These meetings will be expanded to include additional providers as identified, and will serve as a forum for the exchange of core program data and operational issues.</p>
<p>6. Which community partners will look at CHART data (specific providers and agencies)? Describe.</p>	<p>Those community partners to be given access to program data, as well as the specific program information to be shared, will ultimately be based upon HMC successfully obtaining the necessary Affiliation Agreements, MOU's and/or other related patient and agency releases to ensure compliance with confidentiality requirements.</p>
<p>7. Will the quality committee of your board review CHART reporting (e.g., quarterly)? Describe.</p>	<p>Internal reporting of specific CHART quality indicators will be incorporated into HMC's existing Quality Improvement Plan protocols, including regularly scheduled reports to the quality committee of the board.</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
	PM in conjunction with designated IT and program personnel.	PM in conjunction with designated IT and program personnel.
9. What is your approximate level of effort to collect these metrics? Describe.	Cohort-Wide	Program specific
	The majority of data will be collected through creation of customized and automated reporting programs, which will require an estimated one full time additional Data Analyst. However, it is anticipated that the demand for this position will gradually decline following initial program start-up.	The majority of data will be collected through creation of customized and automated reporting programs, which will require an estimated one full time additional Data Analyst. However, it is anticipated that the demand for this position will gradually decline following initial program start-up.
10. How will you ensure that you are able to collect both your program specific and the cohort-wide measures? Describe.	As indicated above, HMC plans on developing a system of automated reporting programs which it anticipates will both minimize effort and ensure data collection accuracy. The PM will ultimately be responsible for the timeliness and accuracy of the data being reported.	
11. How will you know when to make a change in your service model or operational tactics? Describe.	HMC routinely utilizes the PDSA approach to quality improvement with new and/or restructured program initiatives. This approach allows for timely identification and remediation of negative program and related operational trends and shortfalls.	
12. Other details:		

Enabling Technologies plan

Functionality	User	Vendor	Cost
Advanced Clinical Decision Support Tool Utilizing Natural Language Processing	Hospital Staff High Risk Care Team	Qpid Health	\$150,000 - Includes install, training, interfaces, core engine, connectivity, defined use case and yearly ASP fees. \$40,000 - Data/Application analyst: Interface Integration, Query Design, IT Project Management

Abridged Implementation Plan – Not for budgeting or contracting purposes

Holyoke Medical Center – Version 2

Enabling technology: Q&A

- 1. How are you going to identify target population patients in real-time?** HMC will implement a programming query based on defined diagnosis criteria to identify target population (Primary, Secondary, and High Utilizer Behavioral Health) patients in real-time utilizing MEDITECH during the triage assessment process. This program query will automatically send an alert to the patient tracker board allowing the care team to visually identify patients who have presented to the Emergency Department for behavioral health services. The following indicators will be utilized on the patient tracker: C = Chart Project Criteria for Primary or Secondary diagnosis; HU1 for High Utilizers 3 – 10 visits per year; HU2 for High Utilizers > 10 visits per year. HMC will advance the Behavioral Health Screening process within 6 months by deploying an advanced Clinical Decision Support tool (e.g. Qpid) utilizing natural language processing (NLP) to automatically extract and assemble actionable information from both structured and unstructured data in MEDITECH and eClinicalWorks.
- 2. How will you measure what services were delivered by what staff?** Qpid
- 3. How will you measure outcome measures monthly?** HMC will measure the outcome measures defined on the Program-Specific slide monthly by developing a system of automated reports. The reports will automatically be printed and/or emailed to project team members on a weekly basis. The Project Team will review outcome measures monthly and develop corrective action plans as necessary.
- 4. What tool/platform will you use to facilitate cross-setting and multi-disciplinary coordination of care?** Initially, HMC will utilize MEDITECH as the primary tool/platform to facilitate cross-setting and multi-disciplinary coordination of care. HMC will provide access to the MEDITECH application for partners who have completed the necessary Affiliation Agreements and/or other related patient agency releases to ensure compliance with confidentiality requirements. HMC expects to utilize other software applications such as eClinicalWorks Clinical Care Management Record to develop a registry of behavioral health patients for cross continuum navigation and a clinical call system to extend care outside of the hospital walls so patients can stay connected with care givers to ease and improve transitions throughout the continuum of care.
- 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?** The care plans will reside in the hospital MEDITECH system. All existing confidentiality laws, regulations and requirements related to this patient population will be adhered to as the program is developed. As mentioned above, access will be provided to partners who have completed the necessary Affiliation Agreements or releases.
- 6. Do you have a method for identifying what clinical services your target population accesses?** HMC will develop a comprehensive behavioral assessment form with mandatory key fields for tracking of referrals and services for the target population. Qpid may provide the analytical capability to query these fields.

Other essential investments

Other Investment – Describe	Approximate Budget Required
Enhanced On-call psychiatric consultation service contract	\$156,000

Key dates

Key milestone	Date
Launch date (beginning of your 24 month Measurement Period)	12/1/15
Post jobs	10/1/15
New hires made	11/16/15
Execute contract with Qpid	8/3/15
Execute agreement with HMC's physicians for enhanced on-call services	10/15/15
ED revisit reduction initiatives support 50% of planned patient capacity	12/1/15
ED revisit reduction initiatives support 100% of planned patient capacity	2/1/17
First test report of services measures	11/15/15
Enabling technology – Qpid testing initiated	10/5/15
Enabling technology – Qpid go-live	12/31/15
Trainings completed: Qpid, BH for RNs	12/1/15
First patient seen	12/1/15
Registry of High Utilizers created	11/15/15

Community partners/subcontractors

Name	Business Address	Website	Contact Name	Contact Title	Contact Phone Number	Contact Email Address
Data application analyst	TBD	TBD	TBD	TBD	TBD	TBD
Qpid Health Inc.	175 Federal Street, Suite 1300 Boston, MA 02110	www.qpidhealth.com	Diane Hamm-Vida, MSN, RN, IST	Project Manager	859-496-7156	diane.hamm-vida@qpidhealth.com

Abridged Implementation Plan – Not for budgeting or contracting purposes

Holyoke Medical Center – Version 2