

COMMONWEALTH OF MASSACHUSETTS  
HEALTH POLICY COMMISSION

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CHART Phase 2:  
Implementation Plan  
Athol Hospital/Heywood Hospital  
Joint Award

HPC approval date: September 23, 2015

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Version: 3



# Introduction

This Implementation Plan details the scope and budget for Athol and Heywood Hospitals' (the "Participating Hospitals") 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 the Participating Hospitals 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 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
- Joint Award Governance



# Key personnel

Name	Title	CHART Phase 2 Role
Winfield Brown, MSB, MHA, FACHE	President and Chief Executive Officer, Heywood Hospital and Athol Hospital	Executive Sponsor
Rebecca Bialecki	Vice President of Community Initiatives, Heywood Hospital and Athol Hospital	Clinical Investment Director
Dawn Casavant	Vice President of External Affairs and Chief Philanthropy Officer, Heywood Hospital and Athol Hospital	Operational Investment Director
Jen Cormier	Sr. Accountant, Heywood Hospital and Athol Hospital	Financial Designee
Selena Johnson	Project Manager, Heywood Hospital	Project Manager, Heywood Hospital
Jennifer Desjardins	Project Manager, Athol Hospital	Project Manager, Athol Hospital

# Target population

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## Definition

- Patients\* as identified by one or more of the following:
  - ED Behavioral Health (BH)\*\* ,\*\*\*:
    - Any BH diagnosis
    - The subset of high utilizers ( $\geq 10$  ED visits in a year) will be provided enhanced services, but is not measured separately and not additional inclusion criteria for the target population
  - Youth and families of the Gardner & Athol/Royalston school systems with Behavioral Health needs

## Quantification

- 5,500 ED visits per year
- 933 children and families

\* Target population definition includes all payers and ages 18+; excluding OB, deaths, transfers to acute inpatient, and discharge to acute rehab

\*\*ICD-9 290-319 which currently includes tobacco

\*\*\*Required target population for cohort-wide standard measures

# Aim Statement

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## Primary Aim Statement

Reduce 30-day ED revisits by 10% for patients with any BH diagnosis by the end of the 24 month Measurement Period.

## Secondary Aim Statement\*

Increase referrals by 20% to BH services by school-based services by the end of the 24 month Measurement Period.

# Baseline performance – ED utilization

		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	1,669	1,459	1,751	1,735	1,765	1,869	1,901	1,906	1,844	1,840	1,678	1,783	1,767
	All ED Revisits	356	282	341	365	343	373	400	373	399	397	381	375	365
	Revisit Rate	21.33%	19.33%	19.47%	21.04%	19.43%	19.96%	21.04%	19.57%	21.64%	21.58%	22.71%	21.03%	20.68%
	LOS (min)	207.6	222	229.8	207	202.8	207.6	219.6	216.6	231	217.8	199.8	192	213
Target Pop	Target Pop ED Visits	425	389	438	456	431	473	475	529	481	495	460	489	462
	Target Pop ED Revisits	134	99	128	143	126	137	141	144	163	157	169	161	142
	Revisit Rate	31.53%	25.45%	29.22%	31.36%	29.23%	28.96%	29.68%	27.22%	33.89%	31.72%	36.74%	32.92%	30.72%
	LOS (min)	300.6	313.8	309.3	292.5	277.8	288.6	297.6	285.6	312.6	288.6	283.8	261.6	293

# Baseline performance – School-based children & families

		Jan 14	Feb 14	Mar 14	*Apr 14	May 14	Jun 14	**Jul 14	**Aug 14	Sep 14	Oct 14	*Nov 14	*Dec 14	Total	Avg.
Baseline Data CHART 1	All Referrals for BH & CR				65	91	40	1	13	59	39	18	33	359	40/mo
	Screened for CR supports				25	44	30	7	12	16	18	20	19	191	21/mo
	Screened for BH Services				38	49	17	1	8	45	28	14	18	218 *53 are waitlisted	24/mo
	On-site BH services				17	40	11	1	5	37	16	11	16	154	17/mo
	BH outsourced				2	6	2	0	1	14	19	10	10	64	7/mo
No ED Services in CHART 1***	ED visits (0-17) Target: Diagnosis 290 - 319 (Any)	49	37	68	40	88	48	45	36	60	48	44	50	152AH 461 HH Total: 613	51/mo
Heywood Hospital Only	Target Pop ED Revisits	2	3	9	5	12	8	4	4	2	6	2	10	67	6
Heywood Hospital Only	Revisit Rate	5.41%	10.00%	16.98%	16.13%	17.91%	20.51%	14.29%	19.05%	4.76%	17.14%	5.71%	23.26%	14.53%	14.53%
Heywood Hospital Only	Median LOS (min)	229.8	258.6	249	259.8	277.8	279	262.5	297.6	209.7	303.6	250.8	265.8		262

Athol Hospital/Heywood Hospital Joint Award – Version 3

BH = Behavioral Health

CR = Community Resources

\* April: school based clinical program started at the end of April

\*\* July & August: summer months / limited school access

\*\*\* Natural collection of adolescents who came to the ED during CHART Phase 1.

Abridged Implementation Plan – Not for budgeting or contracting purposes

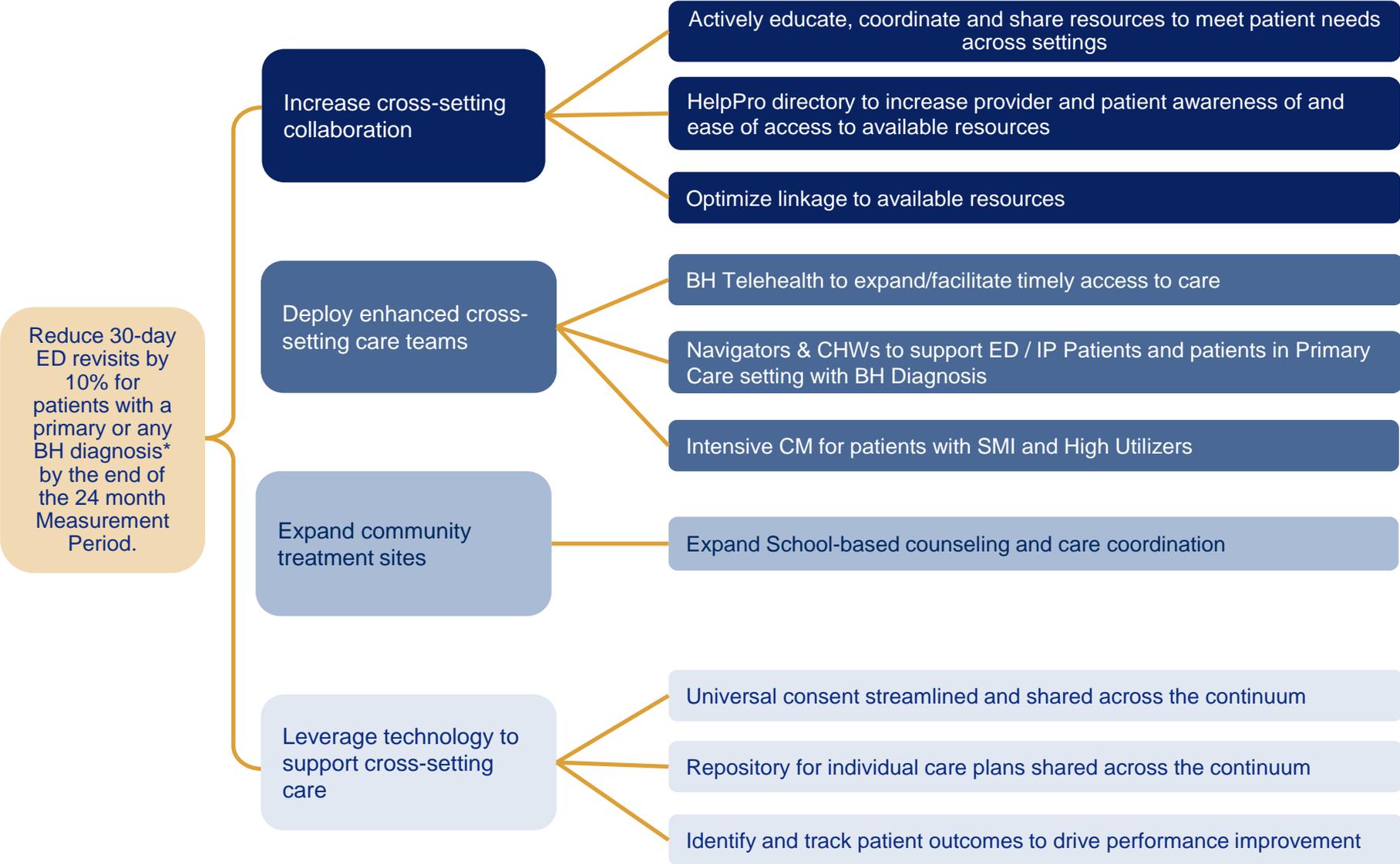
# Estimated impact

Abridged Implementation Plan – Not for budgeting or contracting purposes

	Current Expected Served	Current Expected	New Expected Avoided Events	New Expected Events
Reduced ED high utilizers	ED high utilizers seen per year by high risk care team = 182 visits	182 ED visits per year are due to these patients (average of 15/month)	Goal is to reduce usage of these patients by 20% = 36 visits overall	Reduction of ED high utilizers visits to = 146 visit/year
ED all BH pts	142 BH revisits ED per month	142 BH ED revisits per month	Goal is to reduce ED revisits by 10% = 14 revisits monthly	New goal is to be at 128 ED BH revisits monthly
Behavioral Health Integration/ Provider Community Education	<ol style="list-style-type: none"> <li>1) Education: all practitioners SBIRT Training (81) *</li> <li>2) Physician/NP Scope of Pain Training: zero serviced *</li> <li>3) In Patient: 3375 of which 2531 have a diagnosis</li> </ol> <p><i>* Deck 4: it was suggested by HPC &amp; agreed upon by all to open the trainings to all levels of PCPs/clinicians, FQHC's and others in the community.</i></p>	<ol style="list-style-type: none"> <li>1) 5 practices with 81 staff. 10 SBIRT trainings.</li> <li>2) Phy/NP to train 21 in Scope of Pain</li> <li>3) zero SBIRT screens within IP</li> </ol> <p><i>* Engage trainings through Grand Rounds to hit larger audience</i></p>	<ol style="list-style-type: none"> <li>1) 100% increase in knowledge of tools at PCP: SBIRT</li> <li>2) 100% Scope of Pain trained</li> <li>3) 20% increase in SBIRT screens within IP = 506/yr</li> </ol>	<ol style="list-style-type: none"> <li>1) 80-100% to be trained (64-81)</li> <li>2) 21 Phy/NP/PA Scope of Pain trained.</li> <li>3) 42 SBIRT screens within IP per month</li> </ol>
Youth and School Based Care Coordination	<ol style="list-style-type: none"> <li>1) 154 students receive on-site BH therapy at school (at capacity)</li> <li>2) 191 youth &amp; family receive care coordination support.</li> <li>3) 25 Youth &amp; Family identified as needing ICM.</li> <li>4) 613 youth went through our ED (51/mo)</li> </ol>	<ol style="list-style-type: none"> <li>1) 53 students are waitlisted for BH sessions</li> <li>2) 191 receiving service/care coordination</li> <li>3) 25 current ICM needs</li> <li>4) Zero of these 613 youth being serviced by our program while in the ED</li> </ol>	<ol style="list-style-type: none"> <li>1) 95 anticipated BH referrals + 53 waitlisted = 148 total increase</li> <li>2) 76 anticipated referrals + 191 current = 267 – 35 ICM needs = 232 care coordination</li> <li>3) 10 anticipated ICM family needs</li> <li>4) 10% reduction of youth ED visits = 552 visits/yr (46/mo)</li> </ol>	<ol style="list-style-type: none"> <li>1) 302 New Total receiving on-site BH therapy.</li> <li>2) 232 New Total for Care Coordination</li> <li>3) 35 Total for ICM (Gardner schools)</li> <li>4) Reduce Youth ED visits to 552 visits/yr (46/mo)</li> </ol>
Resources Identification / Sharing	HelpPro: zero serviced	200 potential community partners	200 community partners engaged	Technical build-up of the online system to include presentation and participation of program partner listings. 16 new listings per month, 200 total. <i>* Tool for ED Navigators and PCPs as well as community providers and general residents.</i>
Infrastructure Development	Workforce Development: <ul style="list-style-type: none"> <li>• Lack of Providers</li> </ul>	Develop tele-health service capacity	Tele-health to support psychiatry access to care.	Comprehensive tele-health model for community

Athol Hospital/Heywood Hospital Joint Award – Version 3

# Driver Diagram



Abridged Implementation Plan – Not for budgeting or contracting purposes

Athol Hospital/Heywood Hospital Joint Award – Version 3

\*Target population definition includes all payers and ages 18+; excluding OB, deaths, transfers to acute inpatient, and discharge to acute rehab. Includes 290-319 which currently includes tobacco

# Service model (1 of 4)

## Narrative description

We intend CHART 2 activities to result in a reduction of ED BH revisits by 10%; a reduction of ED HU revisits by 20%; a 20% increase in use of SBIRT screening within/across primary care, IP and ED settings; and an increase in access to behavioral health services in the North Central Region.

We seek to significantly reduce both the incidence and prevalence of persons accessing emergency services for mental health and /or substance use disorders, and a reduction of readmissions of high utilizers with behavioral health diagnosis, by implementing multiple strategies focused on enhancing both the behavioral health infrastructure as well as implementing best practice models of behavioral health care coordination and delivery.

### Strategies within the ED include the use/implementation of:

#### Intensive Case Manager

The Intensive Case Manager (ICM) performs case management activities for a sub-set of behavioral health clients who frequent the ED. They will work with a smaller caseload reserved for higher-utilizers (clients who use the ED > 10 times per year) and multi-problem patients. Intensive coordination and monitoring of client's treatment/rehab services. Goal is to maximize daily functioning of patient, not necessarily symptom elimination. ICM will provide navigation support to patients and families to prepare and assist them to ensure they are connected to a medical home, and to remove barriers to improve post-discharge compliance and help them to access the right care at the right time and place, leading to a reduction in ED usage.

Service is provided over varied time lengths, dependent upon severity of client needs. Minimum of 5 meetings per client & approximately 5-8 hours/client minimum.

Athol Hospital subcontracting position.

#### Behavioral Health Navigator

The ED Navigator blends brief therapy and discharge planning. Will provide assessment, intervention, and support to patients in the ED. Assists with navigating the complex health care service system, including but not limited to assisting with health insurance enrollment, identifying and accessing community resources, referrals and education. Work focus will include behavioral health discharge planning, home care planning, and supporting the IP setting with SBIRT screening needs and disposition. Some light case management over varied time lengths, dependent upon client needs post-ED visit. Identifies and refers patients to the CHW. Service is provided mainly within the ED. Some light case management over varied time lengths, dependent upon client needs post-ED visit. Minimum of 2 meetings per client approximately 2-4 hours/client.

Heywood & Athol Hospitals staffing positions.

#### Community Health Worker

The Community Health Worker (CHW) will support the ED BH Care Team (comprised of the Behavioral Health Therapist, Intensive Case Manager, and the Navigator) by reaching patients via regular follow up phone calls and home visits to provide on-going support and follow-up assistance with accessing community-based resources. The CHW will be the patient advocate and assist clients with health insurance enrollment, community resources, referrals, education, social, residential, financial and other services appropriate for the client. Providing case management to families of the ED through navigating the complex health care system, building individual and community capacity (supporting health behavior change).

Service is provided over varied time lengths, dependent upon severity of client needs. Minimum of 3-4 meetings/contacts per client & approximately 3 hours/client minimum.

Heywood & Athol Hospitals staffing positions.

# Service model (2 of 4)

## Narrative description

### Peer Mentor (weekends)

The Peer Mentor is part of the CARES project, an innovative project to support the recovery of individuals receiving medical services for addiction related problems. CARES primarily targets individuals who come to the attention of hospitals and medical providers, usually due to their substance abuse, and who are not already engaged in behavioral health services and supports. CARES uses an approach of expanding established resources found to be helpful to individuals in early recovery. Peer Mentors provides a mobile, peer-supported, early intervention that is non-judgmental, caring, knowledgeable, persistent and strength based. Peer Mentor does not replace any current service but allows individuals to have additional support while facing the challenges of transitioning to and engaging in available programs.

Service is provided only on the weekend, on-site, while within the ED, and may extend over varied time lengths, dependent upon severity of client needs. Minimum of 3-4 meetings/contacts per client & approximately 3 hours/client minimum.

Athol Hospital subcontracting position

### Strategies within the School Systems include the use/implementation of:

#### School-based Care Coordinator

School-based Care Coordinator will assist students and families to access on-site behavioral health services as well as off-site community based clinical and non-clinical resources. The Care Coordinator will also track and submit data on a regular basis.

Service is provided onsite at the school. Some light case management over varied time lengths, dependent upon family/student needs. Minimum of 2-3 meetings per family/student (client) approximately 2-4 hours/client.

Heywood & Athol Hospitals staffing positions

#### School-based Intensive Case Manager

The School-based Intensive Case Manager (ICM) performs case management activities for a sub-set of behavioral health students and their families. They will work with a smaller caseload reserved for higher-need and multi-issue students/families. Intensive coordination and monitoring of student/family treatment/community services. ICM will provide navigation support to student/families to prepare and assist them to ensure they are connected to a medical home, and to remove barriers and help them to access the right care at the right time and place, and to serve as student/family advocate as needed, leading to a reduction in ED usage.

Service is provided over varied time lengths, dependent upon severity of student/family (client) needs. Minimum of 5 meetings per client & approximately 5-8 hours/client minimum.

Heywood Hospital staffing position

#### School-based Clinician/Therapist

The School-based Clinician/Therapist is responsible for providing services related to the delivery of mental health care to assigned student/clients at the designated school location and will provide consultation services to the school staff to support the overall mental health goals of the each student/client and to help support the overall mental health goals of the school.

Service is provided over varied time lengths, dependent upon severity of student/client needs. Approximately 1 hour sessions. Full caseload is 25 sessions/week.

Heywood & Athol Hospitals subcontracting positions.

# Service model (3 of 4)

## Narrative description

Strategies to increase access to Behavioral Health Services in the North Central Region include the use/implementation of:

### Regional Behavioral Health Collaborative

Regional Behavioral Health Collaborative provides a forum for dialogue across the North Central and North Quabbin communities to discuss and develop best practices to improve early identification of mental illness and to increase access to behavioral health care. Three key sub-collaborative focus groups have evolved and will look to address topics that impact our region as a whole. These groups are: Resource Sharing & Awareness; Care Coordination; & Advocacy.

Our first large-scale and impactful project will address resource sharing and awareness through the development/enhancement of the HelpPro directory. Technical build-up of the online system to include presentation and participation of program partner listings. 16 new listings per month, 200 total.

Tool for ED Navigators and PCPs as well as community providers and general residents.

Year 1: build up the technical aspects of the directory and partner with/enroll 200 community and clinical providers. Year 2: full usage of technology. Care Plan Coordination and Universal Consent form communication loopback to support patient care is a continuing project and driver of our overall work within the healthcare system and also within our educational/community systems.

Drawing on the strength and interest of the RBHC membership beyond CHART specific activity our BH focused group (the RBHC) has opportunity to address other shared areas of need/concern for the region.

2-hour Collaborative meetings occur monthly. Sub-committee work occurs outside of meeting times and within allotted meeting sessions.

Approximately 2-3 hours per week additional work per hospital to manage engagement and activity within the Collaborative.

Heywood and Athol Hospitals subcontracting HelpPro technology and support. Hospitals staff the management and coordination of Collaborative overall and other sub-committee work (info sharing, consent, etc.).

### Behavioral Health Tele-health Services

The expansion of Behavioral Health Tele-health to provide access to mental health, psychiatry and consultation services for patients and providers. Connecting PCPs and other medical personnel with Behavioral Health Specialists for consultation and treatment through video consultation and or client treatment through video conferencing. This technology introduction will bridge the gap to care which exists in our service area.

Service: to increase/develop Telehealth service capacity to support psychiatry access to care. Tele-health HUB will be developed. 5-7 Tele spoke sites will be initiated. (Purchase and training initially then implementation following planning period.) Service is provided on-site, while within the PCP or other spoke site, short-term/immediate dependent upon severity of client needs.

Heywood & Athol Hospitals subcontracting positions dependent on need/location.

### Behavioral Health Integration/ Provider Community Education

Services: Education to all practitioners on SBIRT Training & Physician/NP Scope of Pain Training to increase in knowledge of tools with PCP and increase in SBIRT screens with IP population.

5 practices with 81 staff offering approximately 10 SBIRT trainings. Phy/NP to train 21 in Scope of Pain offering approximately 3 trainings. Service are then provided by provider as needed to clients.

Social Worker to support comprehensive integration of behavioral health care in the primary setting. Assisting patients to receive care for inter-related conditions fostering community and clinical linkages for patients with behavioral health and/or substance abuse disorder needs.

Heywood & Athol Hospital subcontractor/trainer to offer training sessions. Social Worker role approximately 40 hrs/week.

# Service model (4 of 4)

## Narrative description

### Project Analyst

Responsible for all data collection modalities and reporting needs.  
Heywood & Athol Hospitals staffing position (approximately 40 hrs/week shared)

### Primary Care Physicians Certified in Addiction Services

Primary care practices to become certified – One physician will be in the Main street location, is Suboxone certified and will become an Addiction specialist.  
Another potential PCP is located in the hospital, close to the ED and will share support and resources with the ED. They represent 2 physicians into separate practices.

### CHART Project Manager

Responsible for the execution and oversight of all North Worcester County and North Quabbin/Franklin County CHART 2 initiatives.  
Services at the North Quabbin do not currently exist so there is a need for a governance structure to develop these services. The PM will lead the assessment and communication pieces.  
Heywood & Athol Hospitals hiring each 0.5FTE positions

# Service worksheet

## Service Delivered

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

## Personnel Type

- Hospital-based nurse
- Hospital-based social worker
- Hospital-based pharmacist
- Hospital-based NP/ APRN
- **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
- Community-based peer
- Community agency
- **Physician/ APRN X**
- Palliative care
- EMS
- Skilled nursing facility
- Home health agency
- **Other: Community Health Worker X**
- **Other: School-based Coordinator X**
- **Other: Peer Mentor X**
- **Other: Case Manager X**
- **Other: School-based Clinician X**

## Service Availability

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

# Service mix (1 of 2)

Service	By Whom	How Often	For How Long
For intensive coordination and monitoring of high utilizer client's treatment/rehab services.	Intensive Case Manager (0.25 FTE Subcontract at Athol) *CSO subcontract bundle	182 visits/yr among 10 pts. Averages 15 visits/month by this group. Minimum of 5 meetings per client & approximately 5-8 hours/client minimum.	30 day service outlook
Primary resource coordinator of behavioral health services for patients in the ED and IP settings, for general evaluation, navigating the health care system, assisting with health insurance enrollment, community resources, referrals and education.	Behavioral Health Navigator (2.40 FTE at Heywood & 1 FTE at Athol)	As needed for any ED BH pt (462 av/mo or 15/day) including HU within the ED (142 av/mo or 5/day) and the families. Potential min of 5-8/day or 150-240/mo. Minimum of 2 meetings per client approximately 2-4 hours/client.	30 day service outlook (position is full grant cycle)
Reaching patients via regular follow up phone calls and home visits to provide on-going support and follow-up assistance with accessing community-based resources. Case manages over varied time lengths	Community Health Worker (1 FTE Heywood & 1 FTE at Athol)	Potential min of 4-5/day or 120-150/mo. Minimum of 3-4 meetings/contacts per client needs & approximately 3 hours per/client minimum. *data is in form of VISITS from Deck2 ED Utilization	30 day service outlook
Mobile, peer-supported, early case management intervention immediately within the ED to pts who are not already engaged in behavioral health services and supports.	ED Peer Mentor (0.50 FTE Subcontract weekends only at Athol) *CSO subcontract bundle	Provided only on the weekend in Athol to BH pts, on-site, as needed, while within the ED, and may extend over varied time lengths. Potential of 4-5/day or 32-40/mo. Working 2 days a week = 8 days a month. Minimum of 3-4 meetings/contacts per client & approximately 3 hours/client minimum.	30 day service outlook
Assist students and families to access on-site behavioral health services as well as off-site community based clinical and non-clinical resources. The liaison between school, clinical, and community resources.	School Based Care Coordinator (2.75 FTE in Gardner & 2 FTE in Athol)	Servicing 359 community services and BH referrals over approximately 36 weeks/ 10 per week. Minimum of 2-3 meetings per family/student approximately 2-4 hours/client time-on-task. Planned growth (this school year) by additional: 302 new BH referrals and 232 new referrals to community services.	30 day service outlook
Provide navigation support to student/families to prepare and assist them to ensure they are connected to a medical home.	School-based Intensive Case Manager (1 FTE at Heywood)	Minimum of 5 meetings per client & approximately 5-8 hours/client minimum. Currently have 25 families/students worthy of ICM. Anticipate another 10 by end of school yr for a caseload of 35.	30 day service outlook
Provide in-school therapy and support to students, and consultation services to the school staff to support the overall mental health goals of the each student/client	School-based Clinician/Therapist (2 FTE Gardner -Community HealthLink) & 3 FTE Athol - subcontracted CSO	Service is provided over varied time lengths, dependent upon severity of student/client needs. Approximately 1 hour sessions. Full caseload is 25 sessions/week. Current total receiving services is 154. Outsourced total is 64. Anticipate 95 BH referrals. Have 53 on waitlist. 148 expected new services needed this school year.	30 day service outlook

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Athol Hospital/Heywood Hospital Joint Award – Version 3

## Service mix (2 of 2)

Service	By Whom	How Often	For How Long
Coordinate the Regional Behavioral Health Collaborative to implement the HelpPro directory, process for coordinating Care Plans and Universal Consent forms, and other shared BH concerns/needs of the region	Equiv of 0.62 FTE (Heywood budget) across the hospitals to staff the management and coordination of Collaborative overall and other sub-committee work	HelpPro: Year 1: build up the technical aspects of the directory and partner with/enroll 200 community and clinical providers. Year 2: full usage of technology. RBHC: 2-hour Collaborative meetings occur monthly. Sub-committee work occurs outside of meeting times and within allotted meeting sessions in additional work per hospital to manage engagement and activity within the Collaborative.	30 day service outlook
Education to all practitioners on SBIRT Training & Physician/NP Scope of Pain Training to increase in knowledge of tools with PCP and increase in SBIRT screens with IP population. Service are then provided by provider as needed to clients.	Behavioral Health Integration/ Provider Community Education – subcontracted. (1 FTE SW subcontracted training between Heywood and Athol) *CSO subcontract bundle	5 practices & 2 EDs, with 81 staff offering approximately 10 SBIRT trainings. Phy/NP to train 21 in Scope of Pain offering approximately 3 trainings. Service are then provided by provider as needed to clients. Opening training to all PCP/Clinicians, FQHC, and other community members through Grand Rounds.	Grant Cycle View
Data collection modalities and reporting needs	Project Analyst (1 FTE between Heywood & Athol) – Heywood budget	All data reporting and needs between projects	Grant Cycle View
Project Management for the execution and oversight of all North Worcester County and North Quabbin/Franklin County CHART 2 initiatives.	CHART Project Manager 1.0 FTE at Heywood & 1.0 FTE at Athol)	Project oversight	Grant Cycle View
For general evaluation, navigating the health care system, assisting with care plan, support to access community resources, referrals and education within PCP office.	Intensive Care Manager RN – PCP location (.50 FTE) – Heywood budget	As needed for any BH patients within the PCP office	Grant Cycle

# FTE/units of service hired at my organization

5 FTEs at Athol Hospital  
10.27 FTEs at Heywood Hospital

# FTE/units of service contracted

6.75 FTEs

# List of service providers/community agencies

Type of Service Provider	Community Agency Name	New or Existing Relationship
Behavioral Health Service Provider, Tele-health, SBIRT trainings	Clinical Support Options (CSO)	Existing with Athol Hospital and new with Heywood Hospital
Behavioral Health Service Provider	Community Health Link (CHL)	Existing with Heywood Hospital
Target Population Location	Gardner Public Schools	Existing with Heywood Hospital
Target Population Location	Athol Royalston Regional School District	Existing with Athol Hospital
Behavioral Health & Substance Abuse Partnership Engagement	North Quabbin Community Coalition (NQCC)	Existing with Athol Hospital and new with Heywood Hospital
Behavioral Health & Substance Abuse Partnership Engagement	Joint Coalition on Health (JCOH)	Existing with Heywood Hospital and new with Athol Hospital
Behavioral Health & Substance Abuse Partnership Engagement	Suicide Prevention Task Force	Existing with Athol Hospital and Heywood Hospital
Behavioral Health & Substance Abuse Partnerships	Opiate Education and Awareness Task Force of Franklin County	Existing with Athol Hospital and new with Heywood Hospital
Culturally and linguistically appropriate care modalities. CHW workers.	North Central Mass Minority Coalition	Existing with Heywood Hospital and new with Athol Hospital
Enabling technology, on-line resource inventory	HelpPro	New for Athol Hospital and Heywood Hospital
Scope of Pain trainings	Dr. Ruth Potee	New to Athol Hospital and Heywood Hospital
FQHC “look-a-like” development strategy	The Resource Group	New to Athol Hospital and Heywood Hospital
Behavioral Health Partnerships Engagement	The SHINE Initiative	Existing to Athol Hospital and Heywood Hospital

# Summary of services

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For a summary of services,  
see previous slides on service model.

# Cohort-wide standard measures – Hospital utilization

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.

Report the measures marked with an X for each individual hospital as well as for the aggregate of the two hospitals.

# Cohort-wide standard measures – ED utilization

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)		
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

Athol Hospital/Heywood Hospital Joint Award – 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.

Report the measures marked with an X for each individual hospital as well as for the aggregate of the two hospitals.

# Cohort-wide standard measures – Service delivery

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.

Report the measures marked with an X for each individual hospital as well as for the aggregate of the two hospitals.

# 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.  
 Report the measures marked with an X for each individual hospital as well as for the aggregate of the two hospitals.

## Program-specific measures (1 of 2)

Measure Definition	Numerator	Denominator
% of all pts received SBIRT Screenings in PCP	Total Screens Provided in PCP	Number of total pt visits PCP over age 13
% of PCP pt SBIRT screens that are Positive	Positive Screen Total	Total Screens Provided
% of PCP positive SBIRT screens that are referred to Navigator	Support referrals to Navigator	Positive Screen Total
% of all pts received SBIRT Screenings in IP	Total Screens Provided in IP	Number of total pts in IP
% of IP pt SBIRT screens that are Positive	Positive Screen Total	Total Screens Provided
% of IP positive SBIRT screens that are referred to Navigator	Support referrals to Navigator	Positive Screen Total
% of all pts received SBIRT Screenings in ED	Total Screens Provided in ED	Number of total pts in ED
% of ED pt SBIRT screens that are Positive	Positive Screen Total	Total Screens Provided
% of ED positive SBIRT screens that are referred to ED Navigator	Support referrals to ED Navigator	Positive Screen Total
% of all non-Medicaid ED pts received Crisis Assessment by ED Navigator	Total Crisis Assessments Provided	Number of BH pts in ED
% of Medicaid ED pts received Crisis Assessment by ED Navigator	Total Crisis Assessments Provided	Number of BH pts in ED with Medicaid

## Program-specific measures (2 of 2)

Measure Definition	Numerator	Denominator
% of pts admitted after Crisis Assessment	Total pts admitted or transferred to IP post ED Crisis Assessment	Number of Crisis Assessments Provided
% of ED Therapeutic Sessions by ED Navigator to reduce idle non-therapeutic / awaiting transfer time	Total Therapy Sessions Provided per 24 hours in ED	Number of BH visits in ED
% of ED Therapeutic Sessions by ED Navigator to reduce idle non-therapeutic / awaiting transfer time (supporting pt care access to lower level of OP)	Total Therapy Sessions Provided per 24 hours in ED	Number of BH pts in ED
Count of SB pts that are referred to ICM	Support referrals to ICM	Total pts served in SBCC program
Crisis Assessment Timeliness: average of minutes between request and evaluation	Total Crisis Assessments Requested	Average # minutes between request for eval. and eval start
% of PCP based referrals utilizing Tele-psych tool	Total PCP tele-psych Referrals provided	Number of PCP BH pts
% of SB referrals utilizing Tele-psych tool	Total SB tele-psych Referrals provided	Total target SB population
% of SB referrals to BH	Total SB Referrals to BH Needs	Total target SB population
% of SB referrals to Community Care	Total SB Referrals to Community Care Needs	Total target SB population
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

# Continuous improvement plan (1 of 2)

<p><b>1. How will the team share data?</b></p>	<p>Data will be shared through a myriad of interactions:</p> <ul style="list-style-type: none"> <li>* Formal Monthly reporting outlines (written)</li> <li>* E-mail of report(s) to team members</li> <li>* Meeting discussion/review among team members</li> <li>* Presentation/updates to larger sets of Hospital and Community partner mtgs</li> <li>* Continual communication between team members (phone, email, verbal)</li> </ul>
<p><b>2. How frequently will you (PM, Investment Director) look at the data (e.g., weekly)?</b></p>	<p>PM, PD, ID &amp; ED Leadership to include the ED Director, Chief of Emergency Medicine, and Nurse Manager of Emergency Services, will review the Monthly reporting outline and will be engaged in the meetings or communications bi-weekly or weekly regarding program and data to keep them abreast of programmatic strides. Both the PM, PD, and the ID use this information as they communicate with all other hospital-wide/community-wide partnerships.</p>
<p><b>3. How often will your executive team (VPs, C-suite) review CHART project reporting (e.g., monthly)?</b></p>	<p>Our executive/leadership team meets weekly. We intend to have at least one monthly update scheduled. We may provide bi-monthly brief updates to better fit the timeframe and enhanced interest of the team. However, several of the VPs are directly tied to the project and may share updates more casually and/or frequently.</p>
<p><b>4. How often will your front line CHART staff (SW, care team) review reporting (e.g., weekly)?</b></p>	<p>Front line CHART staff will review reporting in several ways:</p> <ul style="list-style-type: none"> <li>• Formal Monthly report (with all programmatic aspects)</li> <li>• Weekly or bi-weekly reviews of real-time project specific efforts in team mtgs or supervision.</li> </ul>
<p><b>5. How often will your community partners review data (e.g., weekly, monthly)?</b></p>	<p>Community partners are at the table and considered on our teams. They will be included as front line CHART members. For those that are not as directly involved they may partner along side our executive team for reporting and programmatic sharing purposes. Others more removed will be used in an advisory capacity at monthly Collaborative meetings.</p>
<p><b>6. Which community partners will look at CHART data (specific providers and agencies)?</b></p>	<p><u>Executive/leadership level</u> - ED Leadership team, VPs within these partnering groups include: Clinical Support Options; Community Health Link; Gardner Public Schools; Athol Royalston Regional School District; North Central Mass Minority Coalition.</p> <p><u>Front line level</u> –ED Leadership team, Clinical and programmatic staff working within or alongside the project within these partnering groups include: ED Leadership (ED Director), Clinical Support Options; Community Health Link; Gardner Public Schools; Athol Royalston Regional School District; North Central Mass Minority Coalition; HelpPro.</p> <p><u>Advisory level</u> – community partners engaged in information sharing and project activities across the region helping to address like-issues meeting monthly yet not directly front line project engagement (at the moment at least) include: North Quabbin Community Coalition; Joint Coalition on Health; Suicide Prevention Task Force; Opiate Education and Awareness Task Force of Franklin County; The SHINE Initiative; Center for Human Development; Valuing Our Children.</p>
<p><b>7. Will the quality committee of your board review CHART reporting (e.g., quarterly)?</b></p>	<p>A Quality committee representative has been an active partner in developing our reporting outline from the beginning. We will maintain a connection with them as a team member in the broad scope of reporting needs and also as a formal review of the CHART reports within the VP level of our organizations.</p>

# Continuous improvement plan (2 of 2)

<p><b>8. Who will collect measures and produce reporting for Cohort-wide and program specific measure (e.g., Data Analyst, PM, ID)? Describe.</b></p>	<p><b>Cohort-Wide</b></p>	<p><b>Program specific</b></p>
<p><b>9. What is your approximate level of effort to collect these metrics? Describe.</b></p>	<p><b>Cohort-Wide</b></p>	<p><b>Program specific</b></p>
<p><b>10. How will you ensure that you are able to collect both your program specific and the cohort-wide measures? Describe.</b></p>	<p><u>Cohort-wide metrics:</u> we are writing a report to pull the identified data points. We'd like to have reports for: (1) for Athol Hospital, (1) for Heywood Hospital, and (1) with combined hospital totals (attempting to build the combined report). Reports will be run monthly by the Analyst reviewed/assisted by PM prior to sharing with all teams.</p> <p><u>Program specific metrics:</u> could be tracked on paper/spreadsheet until we are able to build tool within database. Edits to EMR are feasible. Reports will be tallied weekly/bi-weekly by team members and reviewed by the Analyst reviewed/assisted by PM for bi-monthly/monthly reporting needs. Teams will review in weekly/bi-weekly supervision mtgs.</p>	
<p><b>11. How will you know when to make a change in your service model or operational tactics? Describe.</b></p>	<p>Our teams are developing workflow plans to address programmatic goals. We intend to build into the system bi-monthly/monthly reviews of data as well as workflow structure within our team meetings to address potential changes in service or operational tactics.</p>	
<p><b>12. Other details:</b></p>	<p>RBHC/Tele-psych/Quabbin Retreat activities will be tracked by PMs and other identified staff/partners to ensure timely completion of steps/activities to fulfill project outline. Data/results will be reviewed by team bi-weekly/monthly to ensure fulfillment of tasks. Full collaborative will review data and progress monthly.</p>	

# Enabling Technologies plan

Functionality	User	Vendor	Cost
Tele-psych efforts are to enhance capacity and ease of access to mental health treatments, psychiatry and BH consultation services for patients and providers through video consultation and or client treatment through video conferencing. This technology introduction will bridge the gap of access to care which exists in our service area.	Athol Hospital is the initial focus with specific emphasis on OP/ED/School Based patients. Heywood Hospital is secondary option for the Partial Program initially with potential spokes into ED/SB.	CSO	<b>\$43,500</b> Equipment & service contract * Service contract includes training and access to established pool of providers for tele-consultation.
Online Resource Inventory is intended to substantially increase awareness of and access to services for residents of North Central MA. In addition it will enhance care coordination in all service venues that use it. Founded to improve the public's access to the services of mental health clinicians and organizations this tool is an extremely effective therapist finder, on a national basis. Today it is one of the oldest, most comprehensive therapist and mental health services finders on the Web and a valuable tool to match people with mental health needs to local mental health services. We will expand the behavioral health listings available across our region to include other community based support programs (food, shelter, programs supports, etc.).	CHART staff, hospital staff, schools partners, patients & families, as well as community providers and general residents.	HelpPro	<b>\$221,900</b> \$120k build-out of tool \$60k service contract: use support, reports, trainings, management of org. listings, etc. \$70k Service Dues (covered for 200 org. listings for 2 years)
Tool used to support service delivery capture and program analytics across the project.	CHART Staff (all ED based and school-based team members), Heywood Hospital and Athol Hospital	Athena Communicator Enterprise	<b>\$54,167</b> Buildout & support

# Enabling Technologies plan – Q&A

1. How are you going to identify target population patients in real-time?  
HU are pre-identified and we are able to see BH patients real-time. There is an initial screening and the information is captured in the ED EMR. We are looking at ways to build to the EMR to click directly on a CHART patient. BH diagnosis is available in the medical record – if there are multiple reviews of the case, information will be flagged with a BH component and an update will be made in the system.
2. How will you measure what services were delivered by what staff?  
Care navigator and CHW are engaged to support patients and information can be tracked in the enabling tech platform. Currently looking through data deck for the measures that will need to be reported and doing cross-walk with options to identify reporting. We will be using a service capture platform to articulate measurement as well as care coordination/case management support.
3. How will you measure outcome measures monthly?  
Part of the current built-out process. Data input will be done daily and data analysts will pull data weekly. Team meetings will be in place to review patient admissions/case load. There are also ED leadership meetings occurring bi-weekly that will look at the workflow. Also, there are VP leadership monthly meetings. In addition PM and direct staff manager will be meeting concurrently to review the data. The platform we choose will facilitate monthly outcome measurements.
4. What tool/platform will you use to facilitate cross-setting and multi-disciplinary coordination of care?  
Team-meeting focused approach as is the model today. Community partners have a seat at the table. The Care Navigator is the recipient of the information and will help support tracking patients across the continuum. There are also shared documents (e.g. universal care plans) between Athol Memorial & Heywood Hospitals via a shared secured database. For the School-based program, secure email communication (via mass Hlway) and work with Care navigator via platform. We will be using a service capture platform to track/engage cross-setting 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?  
Current care plans, live in a binder in the ED (designated area for CHART care plan binder). Through the platform we will be able to create/edit care plans to be downloaded and scanned into the EMR. The care plans are developed during team meetings and beyond the ED, there is input from providers, program manager and outside in the community: this is more of care management plan or d/c plan for Care Navigator – resides in the same locations.
6. Do you have a method for identifying what clinical services your target population accesses? (e.g. ADT notification when ED visits, admissions, discharges from the hospital occur, and/or admissions/discharges from SNF, home health care, visits in the ambulatory setting, attendance at intensive outpatient treatment, etc.)  
At the moment, Navigator take the lead and CHWs support next steps and manages the follow-up. Beyond that, existing relationship with the community – awareness of who the patients are is key. And developing networking and notification flow including monthly meetings. Engaging in the Athena Communicator Enterprise platform to track service delivery.

## Other essential investments

Other Investments	Cost
Clinical and Support Options – staffing for intensive case manager, school-based clinicians, and peer supports	\$254,815
Lease space- North Quabbin Community Coalition for project manager office	\$4,800
SBIRT Training provided by Clinical and Support Options	\$5,000
Addiction Certification - American Board of Addiction Medicine Certification	\$5,000
The Resource Group – development planning for FQHC for BH patients	\$27,000
Laptops, phones, and computers for community health workers and school-based care coordinators	\$4,000
Minority Coalition Guidance/Training – community health worker consult support	\$8,320
Travel - community health workers traveling to patient homes and community based settings	\$5,500

# Key dates

Key milestone	Date
Launch date (beginning of your 24 month Measurement Period)	10/1/15
Post jobs	3/13/15
New hires made	8/28/15
Execute contracts with enabling technology vendor (vendor name: Athena Communicator Enterprise)	9/15
Enabling technology – testing initiated	11/15
Enabling technology – go-live	12/15
First test report of services, measures	11/15
Readmissions reduction initiatives support 50% of planned patient capacity	9/28/15
Readmissions reduction initiatives support 100% of planned patient capacity	10/15/15
Trainings completed:	
SBIRT Training (10 trainings over 5 practices/81 staff) 1or2xMonth over 5or10 months starting Jan. 2016	Rotating 2016
Scope of Pain (3 trainings for 21 Phy/NPs) 1xMonth over 6 months starting Jan 2016	Rotating 2016
First patient seen	10/1/15

# Community partners/subcontractors

Name	Business Address	Website	Contact Name	Contact Title	Contact Phone	Contact Email Address
Clinical Support Options (CSO)	8 Atwood Drive, Suite 301 Northampton, MA 01060	<a href="http://www.csoinc.org/">http://www.csoinc.org/</a>	Karin Jeffers	President & CEO	413-582-0471	<a href="mailto:kjeffers@csoinc.org">kjeffers@csoinc.org</a>
Community Health Link (CHL)	72 Jaques Avenue, Worcester, MA 01610  100 Erdman Way, Leominster, MA 01453	<a href="http://www.communityhealthlink.org/chl/">http://www.communityhealthlink.org/chl/</a>	Carolyn Droser	Executive VP	508-421-4336	<a href="mailto:CDroser@communityhealthlink.org">CDroser@communityhealthlink.org</a>
North Central Mass Minority Coalition	The Minority Coalition c/o Three Pyramids, Inc. 66 Day St. Fitchburg, MA 01420	<a href="http://www.theminoritycoalition.org/">http://www.theminoritycoalition.org/</a>	Adrian Ford	Administrator	978-424-4305	<a href="mailto:aford121@comcast.net">aford121@comcast.net</a>
The Resource Group	86 Avon Hill St., Cambridge, MA 02140	<a href="http://lisablout.com/index.html">http://lisablout.com/index.html</a>	Lisa Blout	Executive Director	617-547-1958	<a href="mailto:lisa@lisablout.com">lisa@lisablout.com</a>
HelpPRO	Three Wallis Court, Suite 7 Lexington, MA 0242	<a href="http://173.76.34.212/HP/CommunityResourcesSearch.aspx">http://173.76.34.212/HP/CommunityResourcesSearch.aspx</a>	Jeanna Blauner  Bill Blout	Community Relations  Project Director	978-202-5606  781-862-5215	<a href="mailto:jablauner@comcast.net">jablauner@comcast.net</a>  <a href="mailto:bblout@helppro.com">bblout@helppro.com</a>
Athena	athenahealth, Inc. 311 Arsenal St. Watertown, MA 02472	<a href="http://www.athenahealth.com/">http://www.athenahealth.com/</a>	Brian S. Shelly	Director Enterprise Sales Emerging Services	781-707-8505	<a href="mailto:bshelly@athenahealth.com">bshelly@athenahealth.com</a>