

COMMONWEALTH OF MASSACHUSETTS  
HEALTH POLICY COMMISSION

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CHART Phase 2:  
Implementation Plan:  
Charlton Memorial, St. Luke's and  
Tobey Hospitals Joint Award

HPC approval date: December 10, 2015

Last modified date: July 20, 2016

Version: 3



# Introduction

This Implementation Plan details the scope and budget for Charlton Memorial, St. Luke's and Tobey Hospitals (the “Participating Hospitals”) Award in Phase 2 of the Health Policy Commission’s (HPC) Community Hospital Acceleration, Revitalization, and Transformation (CHART) Investment Program. Southcoast Hospitals Group (“Contractor”) is contracting with the HPC on behalf of the Participating Hospitals. The Implementation Plan is incorporated by reference into and is subject to the requirements of the Phase 2 Joint Award Contract, including the Phase 2 Joint Award Terms & Conditions.

Many capitalized terms appearing in the Implementation Plan are defined in the Phase 2 Joint Award Terms & Conditions or the Phase 2 Request for Proposals (RFP). In addition to capitalized terms, the Implementation Plan may include other acronyms and/or abbreviations whose meaning is understood by Contractor and the HPC in the context of the Implementation Plan. If there is disagreement concerning the meaning of a term, acronym, or abbreviation, the HPC’s interpretation shall govern.



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# Key personnel

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Name	Title	CHART Phase 2 Role
Keith Hovan	President and Chief Executive Officer	Executive Sponsor
Paul Iannini, MD	Physician-in-Chief	Clinical Investment Director
Patrick Gannon	Executive Director and Chief Quality Officer	Operational Investment Director
Cathryn Newell	Senior Project Manager	Project Manager
Darlene Frates	Senior Accountant	Financial Designee

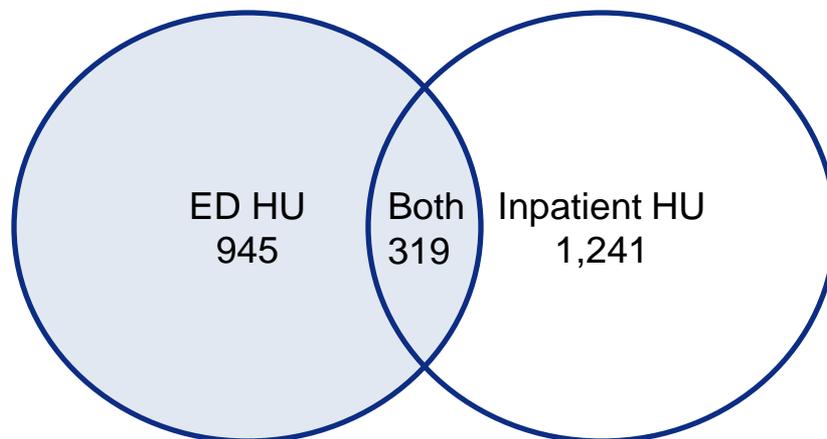
# Target population

## Definition

- Patients\* with a personal history of high utilization, as identified by one or more of the following:
  - $\geq 10$  ED visits in the last 12 months (ED HU)
  - $\geq 4$  inpatient discharges in the last 12 months (Inpatient HU)

## Quantification

- ED: 945 patients used 14,228 ED visits
- Inpatient HU: 1,241 patients used 6,537 inpatient hospitalizations



\*Target population definition includes all payers and aged 18+; excludes OB except for any pregnant woman identified in ED as having an SUD – regardless of utilization

# Aim Statement

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## Primary Aim Statement

- Reduce 30-day readmissions by 20% for patients with  $\geq 4$  inpatient discharges in the past 12 months, by the end of the 24 month Measurement Period.
- Reduce 30-day ED revisits by 20% for patients with  $\geq 10$  ED visits in the past 12 months, by the end of the 24 month Measurement Period.

## Secondary Aim Statement\*

Reduce ED LOS by 20% for patients with  $\geq 10$  ED visits in the past 12 months, 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 revisits – Charlton Memorial Hospital

Abridged Implementation Plan – Not for budgeting or contracting purposes

		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.	Total
Hospital-Wide	All ED Visits	5200	4807	5308	5350	5478	5483	5772	5587	5372	5228	4980	5399	5330	63964
	All ED Revisits	608	909	1012	1082	1078	1108	1243	1160	1157	1063	966	1066	1038	12452
	Revisit Rate	12%	19%	19%	20%	20%	20%	22%	21%	22%	20%	19%	20%	19%	19%
Target Pop: ≥10 ED	Target Pop ED Visits	244	253	286	308	298	341	372	380	349	307	274	314	311	3726
	Target Pop ED Revisits	116	177	202	224	215	254	287	294	264	231	206	231	225	2701
	Revisit Rate	48%	70%	71%	73%	72%	74%	77%	77%	76%	75%	75%	74%	72%	72%

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# Baseline performance – ED revisits – St. Luke’s Hospital

Abridged Implementation Plan – Not for budgeting or contracting purposes

		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.	Total
Hospital-Wide	All ED Visits	7000	6648	7326	7212	7543	7354	8040	8020	7545	7666	7180	7490	7418.67	89024
	All ED Revisits	1050	1510	1733	1793	1822	1805	2034	2055	1874	1977	1784	1832	1772.42	21269
	Revisit Rate	15%	23%	24%	25%	24%	25%	25%	26%	25%	26%	25%	24%	24%	24%
Target Pop: ≥ 10 ED	Target Pop ED Visits	560	551	656	709	716	669	760	750	683	655	614	651	665	7974
	Target Pop ED Revisits	266	407	477	538	538	503	591	600	515	522	470	503	494	5930
	Revisit Rate	48%	74%	73%	76%	75%	75%	78%	80%	75%	80%	77%	77%	74%	74%

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# Baseline performance – ED revisits – Tobey Hospital

Abridged Implementation Plan – Not for budgeting or contracting purposes

		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.	Total
Hospital-Wide	All ED Visits	2183	1941	2287	2317	2464	2601	2787	2668	3238	3290	2964	3292	2669	32032
	All ED Revisits	283	453	525	517	570	533	597	571	711	815	723	783	590	7081
	Revisit Rate	13%	23%	23%	22%	23%	20%	21%	21%	22%	25%	24%	24%	22%	22%
Target Pop: ≥10 ED	Target Pop ED Visits	193	165	191	218	231	217	233	198	228	236	213	205	211	2528
	Target Pop ED Revisits	86	127	136	167	183	167	174	149	173	184	163	152	155	1861
	Revisit Rate	45%	77%	71%	77%	79%	77%	75%	75%	76%	78%	77%	74%	74%	74%

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# Baseline performance – ED revisits – Total

Abridged Implementation Plan – Not for budgeting or contracting purposes

		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.	Total
Hospital-Wide	All ED Visits	14383	13396	14921	14879	15485	15438	16599	16275	16155	16184	15124	16181	15418	185020
	All ED Revisits	1941	2872	3270	3392	3470	3446	3874	3786	3742	3855	3473	3681	3400	40802
	Revisit Rate	13%	21%	22%	23%	22%	22%	23%	23%	23%	24%	23%	23%	22%	22%
Target Pop: ≥10 ED	Target Pop ED Visits	997	969	1133	1235	1245	1227	1365	1328	1260	1198	1101	1170	1187	14228
	Target Pop ED Revisits	468	711	815	929	936	924	1052	1043	952	937	839	886	874	10492
	Revisit Rate	47%	73%	72%	75%	75%	75%	77%	79%	76%	78%	76%	76%	74%	74%

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# Baseline performance – Readmission – Charlton Memorial Hospital

Abridged Implementation Plan – Not for budgeting or contracting purposes

		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.	Total
Hospital-Wide	Readmits	70	154	142	166	145	137	154	143	139	161	173	213	150	1797
	Discharges	1175	1062	1174	1154	1077	1133	1129	1139	1167	1293	1253	1327	1174	14083
	Rate (%)	6%	15%	12%	14%	13%	12%	14%	13%	12%	12%	14%	16%	13%	13%
Target Pop ≥4 Discharges	Readmits	25	62	51	75	79	66	75	82	87	80	87	94	72	863
	Discharges	132	136	138	182	157	155	180	180	188	176	188	189	167	2001
	Rate (%)	19%	46%	37%	41%	50%	43%	42%	46%	46%	45%	46%	50%	43%	43%

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# Baseline performance – Readmission – St. Luke’s Hospital

Abridged Implementation Plan – Not for budgeting or contracting purposes

		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.	Total
Hospital-Wide	Readmits	100	199	271	275	249	228	200	240	244	256	236	238	228.00	2736
	Discharges	1581	1495	1642	1615	1571	1476	1561	1573	1510	1571	1422	1551	1547	18568
	Rate (%)	6%	13%	17%	17%	16%	15%	13%	15%	16%	16%	17%	15%	15%	15%
Target Pop ≥4 Discharges	Readmits	43	96	141	159	140	127	108	126	162	147	128	147	127	1524
	Discharges	243	250	301	324	303	273	284	310	330	303	276	305	292	3502
	Rate (%)	18%	38%	47%	49%	46%	47%	38%	41%	49%	49%	46%	48%	44%	44%

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# Baseline performance – Readmission – Tobey Hospital

Abridged Implementation Plan – Not for budgeting or contracting purposes

		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.	Total
Hospital-Wide	Readmits	30	68	68	63	66	84	76	80	82	80	84	67	70.67	848
	Discharges	453	445	457	432	481	505	503	475	498	495	474	480	474.83	5698
	Rate (%)	7%	15%	15%	15%	14%	17%	15%	17%	16%	16%	18%	14%	15%	15
Target Pop ≥4 Discharges	Readmits	16	34	36	37	40	55	50	46	55	48	40	28	40.417	485
	Discharges	75	76	75	88	100	108	97	93	97	91	71	63	86.167	1034
	Rate (%)	21%	45%	48%	42%	40%	51%	52%	49%	57%	53%	56%	44%	47%	47%

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# Baseline performance – Readmission – Total

Abridged Implementation Plan – Not for budgeting or contracting purposes

		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.	Total
Hospital-Wide	Readmits	200	421	481	504	460	449	430	463	465	497	493	518	449	5381
	Discharges	3209	3002	3273	3201	3129	3114	3193	3187	3175	3359	3149	3358	3196	38349
	Rate (%)	6%	14%	15%	16%	15%	14%	13%	15%	15%	15%	16%	15%	14%	14%
Target Pop ≥4 Discharges	Readmits	84	192	228	271	259	248	233	254	304	275	255	269	239	2872
	Discharges	450	462	514	594	560	536	561	583	615	570	535	557	545	6537
	Rate (%)	19%	42%	44%	46%	46%	46%	42%	44%	49%	48%	48%	48%	44%	44%

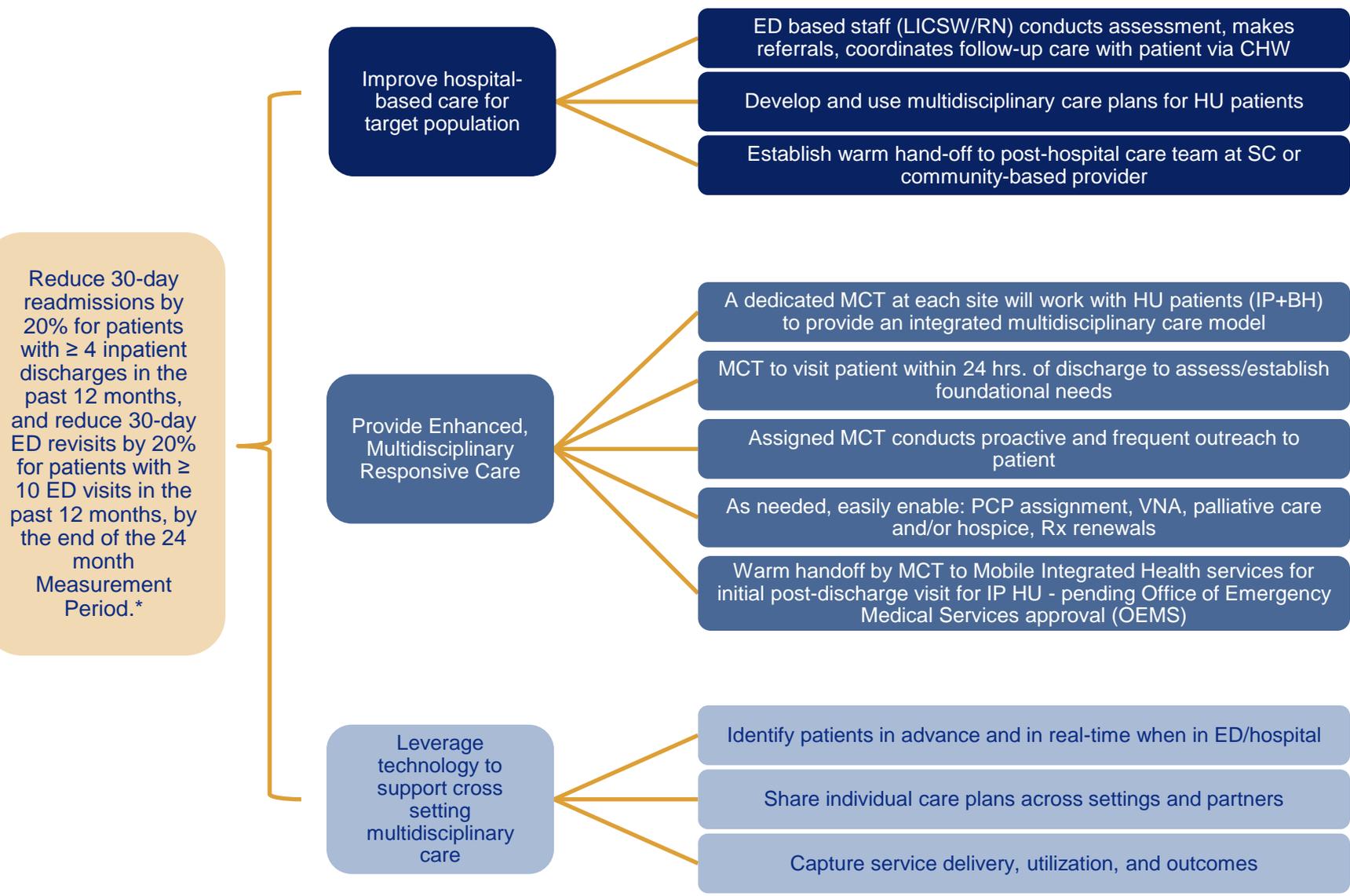
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# Estimated monthly impact

		Current Expected Served	Current Expected Events	New Expected Avoided Events	New Expected Events
Charlton	Emergency Dept. Visits	311 ED visits/month	Given an average 30-day revisit rate of 72%, we expect $0.72 * 311 = 224$ ED 30-day revisits/month.	Given a goal of 20% reduction of 30-day revisits, we expect $0.2 * 224 = 45$ avoided ED 30-day revisits/month	Then, we expect $224 - 45 = 179$ 30-day revisits/month
	Inpatient Discharges	167 discharges/month	Given an average 30-day readmission rate of 43%, we expect $0.43 * 167 = 72$ 30-day readmissions/month	Given a goal of 20% reduction of 30-day readmissions, we expect $0.2 * 72 = 14$ avoided 30-day readmissions/month	Then, we expect $72 - 14 = 58$ 30-day readmissions/month
St. Luke's	Emergency Dept. Visits	494 ED visits/month	Given an average 30-day revisit rate of 74%, we expect $0.74 * 494 = 366$ ED 30-day revisits/month.	Given a goal of 20% reduction of 30-day revisits, we expect $0.2 * 366 = 73$ avoided ED 30-day revisits	Then, we expect $366 - 73 = 293$ 30-day revisits/month
	Inpatient Discharges	292 discharges/month	Given an average 30-day readmission rate of 44%, we expect $0.44 * 292 = 128$ 30-day readmissions/month	Given a goal of 20% reduction of 30-day readmissions, we expect $0.2 * 128 = 26$ avoided 30-day readmissions/month	Then, we expect $128 - 26 = 102$ 30-day readmissions/month
Tobey	Emergency Dept. Visits	211 ED visits/month	Given an average 30-day revisit rate of 74%, we expect $0.74 * 211 = 156$ ED 30-day revisits/month.	Given a goal of 20% reduction of 30-day revisits, we expect $0.2 * 156 = 31$ avoided 30-day ED revisits	Then, we expect $156 - 31 = 125$ 30-day revisits/month
	Inpatient Discharges	86 discharges/month	Given an average 30-day readmission rate of 47%, we expect $0.47 * 86 = 40$ 30-day readmissions/month	Given a goal of 20% reduction of 30-day readmissions, we expect $0.2 * 40 = 8$ avoided 30-day readmissions/month	Then, we expect $40 - 8 = 32$ 30-day readmissions/month
Total	Emergency Dept. Visits	1,016 ED visits/month	756 ED 30-day revisits/month	151 avoided ED 30-day revisits/month	605 ED 30-day revisits/month
Total	Inpatient Discharges	545 discharges/month	240 30-day readmissions/month	48 avoided 30-day readmissions/month	192 30-day readmissions/month

# Driver Diagram

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\*Target population definition includes all payers and aged 18+; excludes OB except for any pregnant woman identified in ED as having an SUD – regardless of utilization

# Service model

## Narrative description

The Southcoast CHART program proposes to enhance care for patients frequently seeking care in the ED ( $\geq 10$  visits/12 months) as well as for patients with a personal history of repeated hospitalizations ( $\geq 4$  IP admissions/12 months). Collectively, these patients are referred to as high utilizers (HUs). The proposed service model is founded on the Spectrum Health Complex Care Team model, which is comprised of the following staff and herein referred to at Southcoast as MyCareTeam (MCT): MD (oversight and patient care role; FTE varies by team type and anticipated site volume), but generally follows the model: NP/PA (prescriber), LICSW (behavioralist), RN CM, CHW and staff nurse for medical teams. Clinical pharmacist services will be available as needed. The overall goal of the service model is to keep patients out of crisis situations thereby reducing the need for ED visits and possible inpatient admission.

Proactively or upon presentation at a Southcoast hospital, a HU patient shall be assigned to a MCT via timely, electronic notification. A community health worker (CHW) will attempt to engage the patient to offer assistance in helping the individual access foundational needs, care, and care coordination. Once accepted by the patient, the patient will receive enhanced, responsive multidisciplinary care from the MCT that will serve as a time-limited adjunct to traditional primary care and will be highly focused on outpatient needs regardless of diagnosis.

Services will include integrated behavioral health care, medical care, social work, pharmacy, health literacy education and care navigation. Services will be patient-centered, culturally appropriate, responsive, 24/7 phone access, i.e. contact line provided by MCT during business hours and off-hours phone and home-visit coverage by Mobile Integrated Health provider (contingent on Mobile Integrated Health Provider), patient, persistent, and longitudinal with the ultimate goal of establishing patient stability (medical, social, and behavioral) over time. Mobile integrated health services will augment services (TBD if feasible and approved by waiver from OEMS). For all patients, care plans will be prospectively created based on history, reassessed following each hospital encounter and updated as often as may be required.

In the case of BH patients in the ED setting, the assigned MCT clinicians will be notified of the patient's admission in real time through auto-notification. MCT staff will deploy to the patient's bedside, working collaboratively with the ED care team to identify patient care needs. As required, Massachusetts Behavioral Health Partnership/ESP staff may be needed to screen sub-populations of BH patients and/or to arrange for placement.

Upon determination of patient disposition from the ED, through medical clearance by the ED provider in collaboration with MCT members, the MCT staff will assume responsibility to work with the patient to establish a plan for post-discharge services, including, but not limited to: warm hand-off with a designated MCT member; follow-up contact with the patient in the home (or equivalent); escort services to the next provider of care appointment, which may include a community partner organization, co-management of logistics to a community partner agency and any other needed services.

For SUD patients, the same model will be used but incorporating highly coordinated co-management with community-based SUD providers, South Shore Mental Health (SSMH) and SSTAR Addiction Treatment and/or Southcoast's own SUD provider. The assigned MCT will work with the patient to establish a coordinated care plan prior to the patient's discharge from the ED.

For pregnant women with SUD identified in the ED, ED staff will contact MCT for evaluation and referral to services. Community partner agency staff may be included as MCT members for purposes of coordinating, documenting and reporting patient services under this service model, whether medical, BH or SUD. Southcoast's existing care management services (IP and OP) will work collaboratively with MCTs.

Based on our calculations of the number of patients who meet the utilization criteria of the target population, Southcoast will staff:

- Two MCTs at Charlton Memorial (246 HU and 228 ED HU);
  - Two teams at St. Luke's (424 HU and 427 ED HU), with a 3<sup>rd</sup> team starting in month 7; and
  - One team at Tobey (100 HU and 138 ED HU).
- Each of these teams will include the capacity to assist OB patients with active SUD who are otherwise not optimally serviced by any other services through their insurance plan or community providers.

# Service worksheet

Abridged Implementation Plan – Not for budgeting or contracting purposes

## Service Delivered

- Care transition coaching X
- Care planning X
- Case finding X
- Behavioral health counseling X
- Engagement X
- Follow up X
- Transportation X
- Meals
- Housing
- In home supports X
- Home safety evaluation X
- 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 X
- 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 X
- Community-based health worker X
- Community-based psychiatrist X
- Community-based advocate X
- Community-based coach
- Community-based peer X
- Community agency X
- Physician X
- Palliative care
- EMS X
- Skilled nursing facility X
- Home health agency X
- Other: \_\_\_\_\_
- Other: \_\_\_\_\_
- Other: \_\_\_\_\_
- Other: \_\_\_\_\_

## Service Availability

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

## Service mix (1 of 6)

MyCareTeam #1

Site: St. Luke's Hospital

Type: Medical

Service	By Whom	How Often	FTE
Oversight/care provider	Physician	As needed	0.2 (contracted)
Care provider	NP/PA	Per individual patient needs	1.0 (contracted)
Behavioralist	LICSW/Behavioralist Therapist	Per individual patient needs	1.0
Nursing care/OP clinic	RN	Per individual patient needs	0.5
Case management	Nurse Case Manager	Per individual patient needs	0.5
Patient contact	CHW	Every one to several days	3.0
Home arrival assessment	Paramedic	At DC from hospital	TBD
Urgent home visit	Paramedic	As needed	TBD
Clinical pharmacist	Pharm.D.	Per individual patient needs	0.4 across St. Luke MCTs

<b># FTE/units of service hired at my organization</b>	5.2
<b># FTE/units of service contracted</b>	1.2

## Service mix (2 of 6)

MyCareTeam #2

Site: St. Luke's Hospital

Type: BH

Service	By Whom	How Often	FTE
Oversight/care provider	Psychiatrist from South Shore Mental Health - contracted	As needed	0.4 (contracted)
Care provider	Staff RN	Per individual patient needs	0.5 (this person also 0.5 at Charlton)
Behavioralist	LICSW/Behavioralist Therapist	Per individual patient needs	1.0
Case management	Nurse case manager	Per individual patient needs	0.5
Patient contact	CHW	Every one to several days	3.0
Home arrival assessment	Paramedic	At DC from hospital	TBD
Urgent home visit	Paramedic	As needed	TBD
Clinical pharmacist	Pharm.D.	Per individual patient needs	0.4 across St. Luke's MCTs
<b># FTE/units of service hired at my organization</b>		5.4	
<b># FTE/units of service contracted</b>		0.4	

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## Service mix (3 of 6)

MyCareTeam #3

Site: St. Luke's Hospital

Type: TBD

Service	By Whom	How Often	FTE
Oversight/care provider	Physician	As needed	0.2 (contracted)
Care provider	NP/PA	Per individual patient needs	1.0 (contracted)
Behavioralist	LICSW/Behavioralist Therapist	Per individual patient needs	1.0
Nursing care/OP clinic	RN	Per individual patient needs	0.5
Case management	Nurse Case manager	Per individual patient needs	0.5
Patient contact	CHW	Every one to several days	3.0
Home arrival assessment	Paramedic	At DC from hospital	TBD
Urgent home visit	Paramedic	As needed	TBD
Clinical pharmacist	Pharm.D.	Per individual patient needs	TBD

<b># FTE/units of service hired at my organization</b>	5.0
<b># FTE/units of service contracted</b>	1.2

## Service mix (4 of 6)

MyCareTeam #1

Site: Charlton Memorial Hospital

Type: Medical

Service	By Whom	How Often	FTE
Oversight/care provider	Physician	As needed	0.2 (contracted)
Care provider	NP/PA	Per individual patient needs	1.0 (contracted)
Behavioralist	SW/Behavioralist Therapist	Per individual patient needs	1.0
Nursing care/OP clinic	RN	Per individual patient needs	0.5
Case management	Nurse Case Manager	Per individual patient needs	0.5
Patient contact	CHW	Every one to several days	3.0
Home arrival assessment	Paramedic	At DC from hospital	TBD
Urgent home visit	Paramedic	As needed	TBD
Clinical pharmacist	Pharm.D.	Per individual patient needs	0.4 across Charlton MCTs

<b># FTE/units of service hired at my organization</b>	5.2
<b># FTE/units of service contracted</b>	1.2

## Service mix (5 of 6)

MyCareTeam #2

Site: Charlton Memorial Hospital

Type: BH

Service	By Whom	How Often	FTE
Oversight/care provider	Psychiatrist from SSTAR Addiction Treatment – contracted	As needed	0.5 (contracted)
Open access hours	SW from SSTAR Addiction Treatment – contracted	As needed	0.5 (contracted)
Care provider	NP	Per individual patient needs	.75* (contracted)
Behavioralist	LICSW/Behavioralist Therapist	Per individual patient needs	1.0
Case management	Nurse case manager	Per individual patient needs	0.5
Patient contact	CHW	Every one to several days	3.0
Home arrival assessment	Paramedic	At DC from hospital	TBD
Urgent home visit	Paramedic	As needed	TBD
Clinical pharmacist	Pharm.D.	Per individual patient needs	0.4 across Charlton MCTs
Care provider	Staff RN	Per individual patient needs	0.5 (also 0.5 at St. Luke's)

<b># FTE/units of service hired at my organization</b>	5.20
<b># FTE/units of service contracted</b>	1.75

\*NP is shared across Charlton & Tobey hospitals

## Service mix (6 of 6)

MyCareTeam #1

Site: Tobey Hospital

Type: Medical + BH

Service	By Whom	How Often	FTE
Oversight/care provider	Physician	As needed	0.1 (contracted)
Oversight/care provider	Psychiatrist from South Shore Mental Health - contracted	As needed	0.1 (contracted)
Care Provider (BH)	NP (for BH)	Per individual patient needs	0.25*,** (contracted)
Care Provider (Medical)	NP from GNBCHC – contracted	Per individual patient needs	0.5** (contracted)
Behavioralist	LICSW/Behavioralist Therapist	Per individual patient needs	1.0
Case management	SW or nurse case manager	Per individual patient needs	0.5
Patient contact	CHW	Every one to several days	3.0
Home arrival assessment	Paramedic	At DC from hospital	TBD
Urgent home visit	Paramedic	As needed	TBD
Clinical pharmacist	Pharm.D.	Per individual patient needs	0.2

<b># FTE/units of service hired at my organization</b>	4.7
<b># FTE/units of service contracted</b>	0.95

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Abridged Implementation Plan – Not for budgeting or contracting purposes

\*NP is shared across Charlton & Tobey hospitals

\*\*Lower FTE allocation is due to significantly lower anticipate patient volume at Tobey hospital

# List of service providers/community agencies

Type of Service Provider	Community Agency Name	New or Existing Relationship
Health center (medical)	Greater New Bedford Community Health Center/New Bedford	Existing
Health center (medical with proposed BH)	Greater New Bedford Community Health Center/Wareham	New for this location
Health center (medical)	Health First/Fall River	New
Behavioral health center (BH, SUD, medical)	SSTAR/Fall River (2 locations)	New
Behavioral health services	Seven Hills/New Bedford, Child and Family Services	Current referral source
Behavioral health services	Bayview Counseling/Wareham	Current referral source
Behavioral health services	High Point/New Bedford	Current referral source
Behavioral health services	South Shore Mental Health Associates	Current referral source
Substance abuse care	AdCare/Dartmouth, PAACA, Gosnold Counseling	Current referral source
Medication management for SUD, methadone (M), suboxone (S), vivitrol (V)	<p><b>New Bedford:</b>            CSAC: M, S            Seven Hills: M, S, V            Southcoast provider office practice: S, V            Clean Slate: S, V            Highpoint: S, V            Child and Family Services: S, V</p> <p><b>Fall River:</b>            SSTAR: M, S, V            Habit Opco: M, S, V</p> <p><b>Wareham - Habit Opco:</b> M, S, V</p>	Current referral source
Community health workers	YWCA/New Bedford	Existing
Patient transportation services	PAACA/New Bedford	Existing

# Summary of services (1 of 2)

## Clinical service and staffing mix

### Prior to Presentation:

- Create individual patient registries in Epic for the two target populations
- Enable ability for MyCareTeam members to document patient interventions and encounters in a standardized fashion in Epic
- Enable ability to stratify patients by payer (ACO, MCO, SNP, etc.) to establish contacts for collaboration
- Identify which patients have social services / HCBS / ASAP services in place and document such in Epic
- Develop first draft individual care plans; care plans are available to MyCareTeams via Epic
- Identify which patients are candidates for SUD treatment, CHW outreach, MOLST or palliative/hospice care consultations, etc.

### When patients are registered as a Southcoast ED or inpatient:

- Epic provides a notification to the assigned MyCareTeam members
- ED staff will contact the ED/BH MyCareTeam to evaluate and refer a pregnant patient with SUD for co-managed care and services with a community-based provider
- Care plans, if available, are accessible to MyCareTeam via Epic; care instructions may be communicated via PatientPing for patients in a SNF setting
- The assigned MyCareTeam responds to the ED to help avert inpatient admission, if clinically appropriate, and establishes post-ED services and support for medical, BH and/or SUD diagnoses
- The assigned MyCareTeam follows admitted patients to collaborate with the inpatient care coordination team and clinicians to create a combined care plan and establishes a working, collaborative relationship with the patient/family
- Telepsych services will be arranged for off-hours consultation, (vendor TBD)

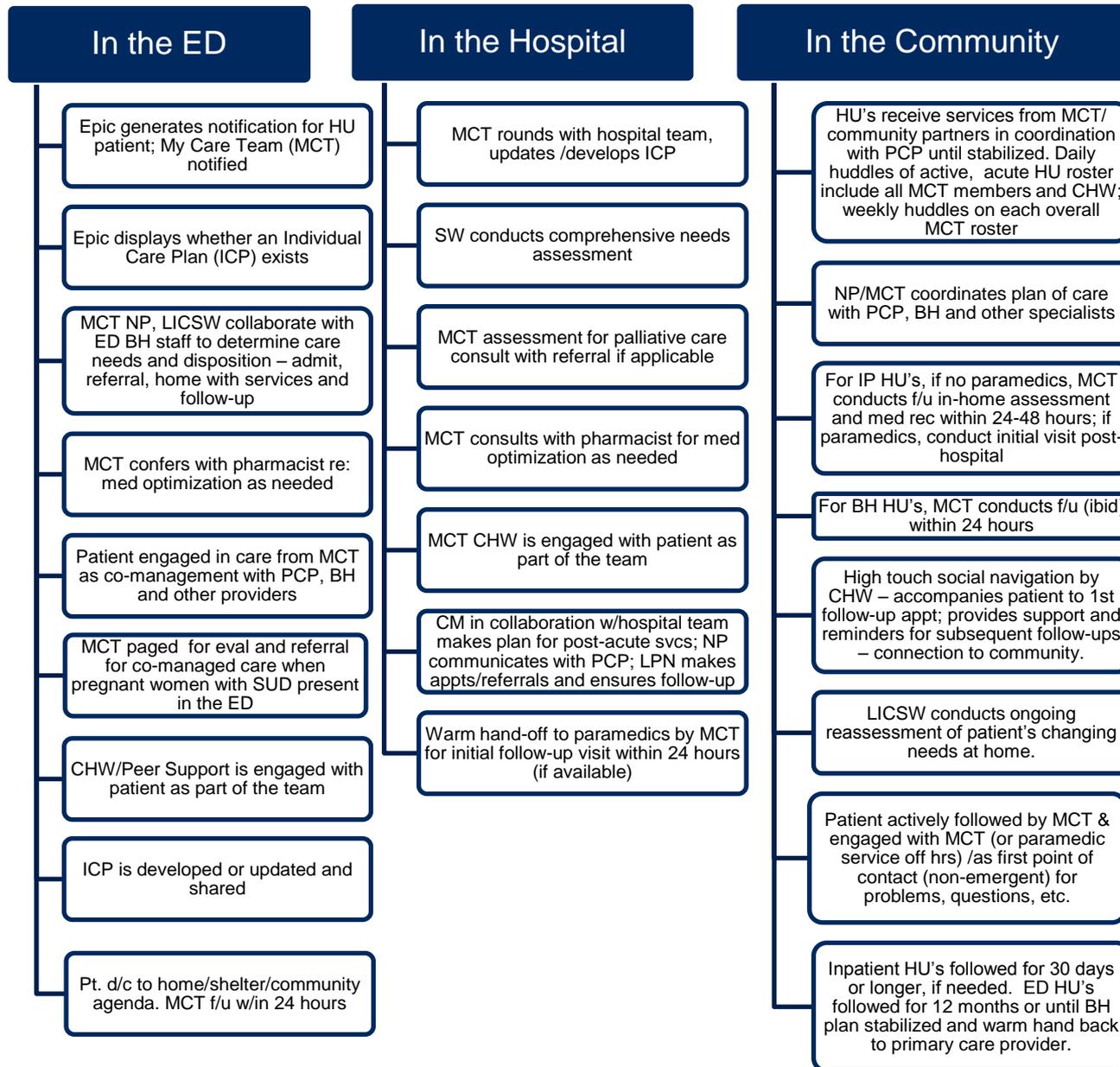
### Non-Southcoast Hospitals settings of care:

- MyCareTeam members (as assigned) round on patient in any care setting (SNF, home with services, home, etc.)
- Immediate follow-up provided by MyCareTeam within 24 hours of discharge
- Outpatient clinic-setting visits, supplemental to PCP-directed care, available through Southcoast or community partners, i.e., SSTAR, SSMH, or Greater New Bedford and Wareham Community Health Center, and supported by similar care team models and coordinated with Southcoast's MyCareTeams including BH and SUD services.
  - Services provided by MCTs and community partners may include: Medication-assisted therapy, CBT/DBT, individual, group, and family therapy, psychiatric medication evaluation, and stabilization consistent with best evidenced-based treatment practices
- Home visits, in home (or in SNF) pharmacist-conducted medication reconciliation and medication optimization as needed
- Frequent contact extended by CHW to patient; frequent contact also provided by clinicians as appropriate to the patient's needs
- Daily or more frequent phone calls to patients with greatest, most frequent needs
- Incrementally develop the integration and presence of BH services within the larger primary care practices and/or clinics as resources permit
- MIH providers off-hours coverage, including phone triage, home visits for assessment, and medical clearance, and/or referral for transport to ED.

### Service Duration for HU Patients:

- ED BH HU's: one year per patient with quarterly reassessments
- Inpatient HU's: 30 days

# Summary of services (2 of 2)



## Cohort-wide standard measures – Hospital utilization measures

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

# Cohort-wide standard measures – ED utilization measures

Data Elements	All	ED HU Target Population	IN HU Target Population	Duplicates removed TP
12. Total number of ED visits	x	x	x	x
13. Total number of unique ED patients	x	x	x	x
14. Total number of ED visits, primary BH diagnosis				
15. Total number of unique patients with primary BH diagnosis				
16. Total number of ED visits, any BH diagnosis				
17. Total number of unique patients with any BH diagnosis				
18. Total number of 30-day ED revisits (ED to ED)	x	x	x	x
19. Total number of 30-day revisits (ED to ED), primary BH diagnosis				
20. Total number of 30-day revisits (ED to ED), any BH diagnosis				
21. ED revisit rate	x	x	x	x
22. ED BH revisit rate (primary BH diagnosis only)				
23. ED BH revisit rate (any BH diagnosis)				
24a. Median ED LOS (time from arrival to departure, in minutes)	x	x	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)				

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Abridged Implementation Plan – Not for budgeting or contracting purposes

Standard exclusions: <18, OB (DRG 765-782), discharged deceased or transfer to acute hospital  
 Report the measures marked with an X for each individual hospital as well as for the aggregate of the three hospitals.

# Cohort-wide standard measures – Service delivery measures

Data elements	Target Population	ED HU Target Population	IN HU Target Population	Duplicates removed TP
27. Total number of unique patients in the target population	X	X	X	X
28. Number of acute encounters for target population patients	X	X	X	X
29. For acute encounters in measure #28, number of these with any CHART service provided after discharge and within 48 hours	X	X	X	X
30. Total number of contacts for the target population	X	X	X	X
31. Average number of contacts per patient served	X	X	X	X
32a. Min number of contacts for patients served	X	X	X	X
32b. Max number of contacts for patients served	X	X	X	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	X	X	X
34. Number of units of service provided, by service types (e.g., care coordination, medication optimization, clinical care, counseling, needs assessment, etc.)	X	X	X	X
35. Number of units of service provided, by role type (NP, LICSW, Pharmacist, Community Health Worker, Peer)	X	X	X	X
36. Average time (days, months) enrolled in CHART program per patient	X	X	X	X
37. Range time (days, months) enrolled in CHART program per patient	X	X	X	X
38. Proportion of target population patients with care plan	X	X	X	X

Abridged Implementation Plan – Not for budgeting or contracting purposes

Southcoast Hospitals Group – Version 3

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

## Cohort-wide standard measures – Payer mix

Data elements	Medicare	Medicaid	Commercial
39. Count of patients in the Target Population- ED HU Target Population	x	x	x
39. Count of patients in the Target Population-IN HU Target Population	x	x	x
39. Count of patients in the Target Population-Duplicates removed TP	x	x	x

## Program-specific measures – High utilizer

Measure ID	Measure Description	ED HU Target Population	IN HU Target Population
H001	Number of TP patients identified for whom there is a full six months of time passed following CHART eligibility	x	x
H002	Total discharges for 6 months before CHART eligibility	x	x
H003	Total 30-day readmissions for 6 months before CHART eligibility	x	x
H004	Total ED visits for 6 months before CHART eligibility	x	x
H005	Total 30-day ED revisits for 6 months before CHART eligibility	x	x
H006	Total discharges for 6 months starting on and inclusive of the date of CHART eligibility	x	x
H007	Total 30-day readmissions for 6 months starting on and inclusive of the date of CHART eligibility	x	x
H008	Total ED visits for 6 months starting on and inclusive of the date of CHART eligibility	x	x
H009	Total 30-day ED revisits for 6 months starting on and inclusive of the date of CHART eligibility	x	x
H010	Total months following CHART eligibility without exit event	x	x

# Program-specific measures

Measure	Numerator	Denominator	How will you collect this?
<b>Service Delivery Measurement</b>			
1. % Target population patients assessed in ED	# of patients assessed for assignment	Patients who meet the HU definitions	Epic
2. % Target population patients assessed in inpatient setting	# of patients assessed for assignment	Patients who meet the HU definitions	Epic
3. % target population patients engaged in program	# of patients assigned to MCT	# assessed for assignment	Epic registries
4. % target population patients (HU) with ED care plans	# of patients on a MCT with an ED care plan	Patients assigned to a MCT	Manual or via Epic
5. % target population patients (HU) with longitudinal care plans	# of patients on a MCT with a longitudinal care plan	Patients assigned to a MCT	Manual or via Epic
6. % target population patients with contact <24h after visit or discharge	# of patients on a MCT with a contact within 20 hours	Patients assigned to a MCT	Epic and/or Endeca

# Continuous improvement plan (1 of 2)

<p><b>1. How will the team share data? Describe.</b></p>	<p>The SC-CHART2 team leaders will identify data monitoring needs and formats to be developed by the SC Informatics Team members supporting CHART2. Weekly/monthly and other reports will be shared through the in-house analytics tool and/or emailed to CHART2 leadership.</p>
<p><b>2. How frequently will you (PM, Investment Director) look at the data (e.g., weekly)? Describe.</b></p>	<p>Data will be shared weekly, monthly and longitudinally as applicable to the dataset. Run charts will be used where applicable to identify progress towards the overall goal of visit reduction for each of the two target populations and shared with MyCareTeam members and others within and external to SC as appropriate.</p>
<p><b>3. How often will your executive team (VPs, C-suite) review CHART project reporting (e.g., monthly)? Describe.</b></p>	<p>High-level performance data will be presented to the SC Quality Steering Committee (highest ranking quality committee within the hospitals) monthly; these data are forwarded to the Quality Committee of the Board of Trustees and the full Board; the same data are reviewed at monthly meetings of the entire Southcoast Leadership team (all corporations).</p>
<p><b>4. How often will your front line CHART staff (SW, care team) review reporting (e.g., weekly)? Describe.</b></p>	<p>Front line staff will review pertinent data (measures that matter) at weekly huddles with the MyCareTeam leaders.</p>
<p><b>5. How often will your community partners review data (e.g., weekly, monthly)? Describe.</b></p>	<p>Similar to #4 above, applicable community partner agencies will receive weekly, monthly and/or quarterly data that is pertinent to their involvement with Southcoast and CHART2 performance and its goals.</p>
<p><b>6. Which community partners will look at CHART data (specific providers and agencies)? Describe.</b></p>	<p>Still to be confirmed, but likely community partners will include the New Bedford Community Health Center locations (NB and Wareham), HealthFirst (Fall River) and SSTAR (Fall River).</p>
<p><b>7. Will the quality committee of your board review CHART reporting (e.g., quarterly)? Describe.</b></p>	<p>See #3 above.</p>

## Continuous improvement plan (2 of 2)

<b>8. Who will collect measures and produce reporting for Cohort-wide and program specific measure (e.g., Data Analyst, PM, ID)? Describe.</b>	<b>Cohort-Wide</b>	<b>Program specific</b>
	The assigned team members from the SC Informatics Department	The assigned team members from the SC Informatics Department
<b>9. What is your approximate level of effort to collect these metrics? Describe.</b>	<b>Cohort-Wide</b>	<b>Program specific</b>
	The largest amount of time will be spent producing the initial reports and ensuring their accuracy. This will take approximately one month to ensure everything is correct. Most of these data will come from sources that are within our EMR. Some work is needed to identify and secure data feeds from outside sources (e.g. Patient Ping or similar). Once these initial reports are complete the monthly effort to produce them will be less than a day to run and ensure accuracy of the reports. However if for some reason the reports do not run correctly there will be some effort needed to troubleshoot and fix the issues.	
<b>10. How will you ensure that you are able to collect both your program specific and the cohort-wide measures? Describe.</b>	Data for both cohort-wide and program- specific measures will be coming from the same sources. When setting up the reports we will confirm that we are pulling the proper variables to distinguish between the two measures.	
<b>11. How will you know when to make a change in your service model or operational tactics? Describe.</b>	If the desired goals are not substantially progressing or are regressing, the CHART2 leadership shall identify the reasons using available data, leadership, front line staff and provider knowledge from Southcoast and community partners, and/or will use a structured FMEA analysis to identify barriers, solutions, and will recommendation changes in the service model to achieve the targeted goals. Substantive changes to the service model will be discussed with HPC.	

# Enabling Technologies plan

Functionality	User	Vendor	Cost
Measurement of outcomes and services delivered by CHART 2 systems, processes and services for monthly required reporting to HPC; daily, weekly, monthly analysis by Southcoast teams with longitudinal trending of CHART 2 service line performance data to drive performance and further improvements to reach desired goals for patients and hospital utilization.	Informatics Dept; CHART 2 leadership group	Oracle Business Intelligence and Endeca Server products with support from Edgewater Ranzal Services: database and reporting system set-up, training, operations manual development	Database for analytics with server, software, training: \$800,000 <ul style="list-style-type: none"> <li>• Oracle Business Intelligence Enterprise Edition Suite incl. 2 years tech support and maintenance = 318,518</li> <li>• Oracle Endeca Discover Studio &amp; Server, Oracle Endeca Data Integrator = 324,350</li> <li>• Edgewater Ranzal Services = 157,132</li> </ul>
Measurement of encounters across settings and across providers	MyCareTeam members, selected community partners	Epic with external data upload from providers manually or electronically into Endeca	IS resource to build data capture and care plan functions in Epic: \$90,000
Measurement of encounters across provider networks - exploring expansion for BH patients cared for at GNBCHC, SSTAR, SSMH.	As above plus SNFs	Patient Ping	\$1,200

# Enabling Technology plan Q&A

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1. How are you going to identify target population patients in real-time?  
Internally: Epic registry functionality. Externally: Patient Ping or manual documentation via Southcoast-template spreadsheets
2. How will you measure what services were delivered by what staff?  
Internally: Epic and Endeca. Externally: Data entered into Endeca
3. How will you measure outcome measures monthly?  
Epic data plus Endeca for analysis and reporting to include data from SC-template spreadsheets or manual data entry process
4. What tool/platform will you use to facilitate cross-setting and multi-disciplinary coordination of care?  
Internally: Epic. Externally: Epic or manual documentation on spreadsheets (per #1 above)
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?  
Internally: Epic. Externally: Patient Ping will notify SNF-provider that a patient is enrolled with a MCT and provides contact information for MCT designee. Provider can reach out to obtain an ICP.
6. Do you have a method for identifying what clinical services your target population accesses?  
Yes, Epic will be able to provide this documentation for services provided by Southcoast in any of our care settings across the continuum except for pregnant women with SUD who present in the ED and who have less than 10 ED visits recorded for the prior 12 months; the latter will require manual notification. Spreadsheets per #1 above will be required by community partner agencies who do not have Epic access for documentation.

## Other essential investments

Other Investment	Budget Required
Telepsych services for off-hours consultations (vendor TBD)	\$172,500
Mobile integrated health (vendor TBD)	\$150,000
Patient transportation/livery service	\$288,478 (\$108,478 CHART-funded)
Travel budget for CHW home visits	\$30,600
CHW certification from Boston Public Health Commission	\$9,750 (\$650/person)
Travel budget for CHW training	\$8,262
Patient Care Cards	\$2,400
<b>Program-wide leadership and clinicians:</b>	
Clinical Investment Director (P Iannini)	\$145,200 (\$108,900 CHART-funded)
Operations Investment Director (P Gannon)	\$145,200 (\$108,900 CHART-funded)
Clinical Executive Director (L Dakin)	\$170,000
Project Manager (C Newell)	\$76,500
Clinical Pharmacist (TBD)	\$204,000

## Key dates

Key milestone	Date
Launch date (beginning of your 24 month Measurement Period)	1/1/16
Post jobs	12/1/15
New hires made	1/15/16
Execute contracts with service delivery partners: South Shore Mental Health, SSTAR Addiction Treatment, GNBCHC	12/15/15
Execute contracts with EPIC, Oracle, Endeca, Patient Ping	Completed
Execute contract with Psych consult service or other telepsych provider	12/15/15
ED revisit & Inpatient readmission reduction initiatives support 50% of planned patient capacity (estimated)	2/1/16
ED revisit & Inpatient readmission reduction initiatives support 100% of planned patient capacity (estimated)	4/1/16
First test report of services measures	2/1/16
Enabling technology deployed – Epic, Patient Ping, Oracle/Endeca	12/1/15
Enabling technology tested – Epic, Patient Ping, Oracle/Endeca	12/1/15
Trainings completed: Epic, Patient Ping, Oracle/Endeca	1/4/16
Registry of High Utilizers created	12/1/2015
First patient seen	1/15/16

# Community partners/subcontractors (1 of 2)

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Name	Business Address	Website	Contact Name	Contact Title	Contact Phone Number	Contact Email Address
South Shore Mental Health	215 Sandwich Road, Wareham, MA	<a href="http://www.ssmh.org">www.ssmh.org</a>	Arthur Bence	Program Director	508.295.3600	<a href="mailto:abence@ssmh.org">abence@ssmh.org</a>
SSTAR Addiction Treatment	400 Stanley Street Fall River, MA	<a href="http://www.sstar.org">www.sstar.org</a>	Nancy Paull	CEO	508.324.3500	<a href="mailto:Npaull@sstar.org">Npaull@sstar.org</a>
Greater New Bedford CHC	874 Purchase St, New Bedford, MA 02740	<a href="http://www.gnbchc.org">www.gnbchc.org</a>	Peter Georgeopoulos	CEO	508.984.8405	<a href="mailto:peterg@gnbchc.org">peterg@gnbchc.org</a>
Edgewater Ranzal Services	108 Corporate Park Drive, Suite 105 White Plains, NY 10604	<a href="http://www.ranzal.com">www.ranzal.com</a>	Bob Rozelle	Principal Architect	914.253.6600	<a href="mailto:brozelle@ranzal.com">brozelle@ranzal.com</a>
Epic	1979 Milky Way, Verona, WI 53593	<a href="http://www.epic.com">www.epic.com</a>	Adam Nielsen Jill Koenen	Account Managers	608.271.9000	<a href="mailto:adnielse@epic.com">adnielse@epic.com</a> <a href="mailto:jkoenen@epic.com">jkoenen@epic.com</a>
Oracle	8 Van de Graaff Dr, Burlington, MA 01803	<a href="http://www.oracle.com">www.oracle.com</a>	Ari Seelinger	Healthcare Technology Acct. Mgr	781.565.1532	<a href="mailto:Ari.seelinger@oracle.com">Ari.seelinger@oracle.com</a>
Patient Ping	330 Congress St, Boston, MA 02210	<a href="http://www.patientping.com">www.patientping.com</a>	Jay Desai	Lead Executive	617.701.7816	<a href="mailto:jay@patientping.com">jay@patientping.com</a>
Boston Public Health Commission	1010 Massachusetts Ave #2, Boston, MA 02118	<a href="http://www.bphc.org">www.bphc.org</a>			617.534.5395	
Clean Slate	244 Main St, Roundhouse Annex, Northampton, MA 01060	<a href="http://www.cleanslatecenters.com">www.cleanslatecenters.com</a>	Peter Monaghan	Regional Practice Manager	508.930.5230	<a href="mailto:pmonaghan@cleanslatecenters.com">pmonaghan@cleanslatecenters.com</a>
Telepsych consult vendor (TBD)						
Mobile Integrated Health Services provider (TBD)						

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## Community partners/subcontractors (2 of 2)

Name	Business Address	Website	Contact Name	Contact Title	Contact Phone Number	Contact Email Address
Southcoast Physicians Group	200 Mill Road, Suite 180 Fairhaven, MA 02719				508.973.2174	
Giga Med I, LLC	606 Tarkiln Hill Road New Bedford, MA 02745				508.985.1955	

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