COMMONWEALTH OF MASSACHUSETTS

HEALTH POLICY COMMISSION

Community Health Care Investment and Consumer Involvement Committee

February 25, 2015

Agenda

- **Approval of Minutes from the October 22, 2014 Meeting (VOTE)**
- Approval of Minutes from the December 3, 2014 Meeting (VOTE)
- Discussion of CHART Investment Program
- Discussion of Healthcare Innovation Investment Program
- Presentation by Massachusetts Health Quality Partners on the Choosing Wisely Campaign
- Schedule of Next Committee Meeting

Vote: Approving Minutes

Motion: That the Community Health Care Investment and Consumer Involvement Committee hereby approves the minutes of the Committee meeting held on October 22, 2014, as presented.

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Vote: Approving Minutes

Motion: That the Community Health Care Investment and Consumer Involvement Committee hereby approves the minutes of the Committee meeting held on December 3, 2014, as presented.

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- Approval of Minutes from the October 22, 2014 Meeting (VOTE)
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- **Discussion of CHART Investment Program**
  - CHART Phase 1 Case Studies
  - CHART Phase 2 Update
  - CHART Phase 2 Technical Assistance Plan
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CHART Phase 1 evaluation products

A series of Phase 1 evaluation outputs are currently in development or complete

1. ***Complete* - Programmatic learnings to inform Phase 2:** HPC staff have continuously collated and captured key lessons to inform ongoing program development and hospital improvement efforts. These tools and approaches are actively being implemented in Phase 2, including directly informing the creation of the implementation planning period.

2. ***Complete* - CHART Leadership Summit Proceedings Paper:** Staff developed and released a proceedings paper on the Leadership Summit. Staff are working to finalize an aggregate report developed based on the assessments conducted by Safe & Reliable Healthcare for release.

3. **Case Studies on Key Themes:** HPC has commissioned up to six case studies of key themes in CHART Phase 1. Each will include multiple hospitals. Cases will be released on a rolling basis and will include topics such as: using data to understand a population and design an intervention, the importance of engaged leadership, and how to address social and behavioral drivers of hospital utilization.

4. ***In progress* - Summative Evaluation Report:** Subsequent to receipt of all final reports and completion of the Phase 1 close out survey, the HPC will release a summative evaluation report on Phase 1. This is anticipated in Q1 2015.

Through case studies, CHART hospitals can share learnings in improvement program design and operations with other organizations

- The HPC has engaged Health Management Associates (HMA) to highlight key themes from CHART Phase 1 projects through a series of case studies
- The HPC intends for the experiences and lessons exhibited in this series to assist other providers, the public, and policy makers in designing and promoting similar short-term, high-impact improvement initiatives in their communities and organizations
- Each case study will include multiple hospitals and will be released on a rolling basis

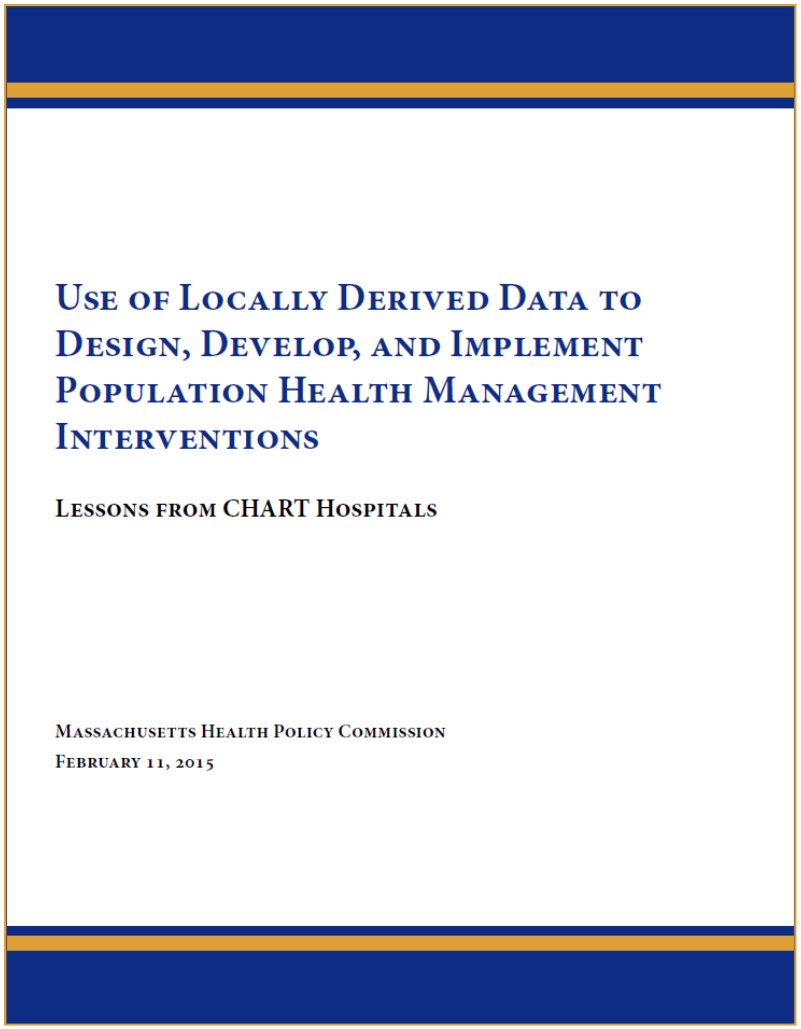
The first three case studies in the series are:

1. Use of Locally-Derived Data to Design, Develop and Implement Population Health Management Interventions
2. Deploying Effective Management Strategies to Drive Change
3. Strategies to Align Clinical and Non-clinical Care to Address Community's Behavioral and Social Needs

1 Use of Locally-Derived Data to Design, Develop and Implement Population Health Management Interventions

1st

of many opportunities for findings and lessons drawn from CHART investments to be shared broadly with the community of providers, payers, and the public



USE OF LOCALLY DERIVED DATA TO DESIGN, DEVELOP, AND IMPLEMENT POPULATION HEALTH MANAGEMENT INTERVENTIONS

LESSONS FROM CHART HOSPITALS

MASSACHUSETTS HEALTH POLICY COMMISSION
FEBRUARY 11, 2015

Use of locally-derived data enabled targeted program design and performance monitoring at select CHART Phase 1 hospitals

Background

- Population health management interventions are difficult to design due to the diversity of health needs and conditions present in any community
- Data that are collected by a hospital, referred to as locally-derived data, effectively depict the hospital's patient population and can be used in focusing interventions
- With technical assistance delivered through the CHART program, CHART Phase 1 hospitals applied analytical frameworks to their own local-derived data in novel ways

CHART hospitals highlighted in Case Study 1

Addison Gilbert Hospital
A member of Lahey Health

- Community Health Needs Assessment
- Administrative Data
- Project Dashboards

Beverly Hospital
A member of Lahey Health

- Administrative Data
- Patient and Family Caregiver Interviews
- Provider Interviews

Hallmark Health

- Medical Record Review
- Community Health Data
- Project Dashboards

Addison Gilbert Hospital sought to reduce 30-day all cause readmissions by piloting a high-risk intervention team and monitoring its performance

Identifying patients at high risk for readmission	Addison Gilbert Hospital designed the pilot to serve any patient with a chronic illness who was admitted to the hospital for inpatient service or observation
Analyzing root causes of readmission	The project team interviewed patients and their caregivers to assess clarity of discharge instructions and ease of scheduling follow-up appointments
Designing the HRIT	Members of the team had expertise in chronic disease management, behavioral health counseling and access to community based services
Monitoring performance	A weekly patient dashboard tracked medication count, discharge disposition, 30-day readmission rate, length of stay and patient outreach activities

Learning Enabled by Using Locally-derived Data

Among the 26% of patients in the high-risk population who were readmitted within 30 days, 79% had medication inaccuracies and 22% were referred back to the hospital by another provider

Beverly Hospital used administrative data analysis to challenge long-held assumptions on the characteristics of its high risk population

Beverly Hospital initially envisioned a focus on cardiovascular readmissions for CHART Phase 1, given attention paid to congestive heart failure in research and public reporting

Rather than relying on national indicators to identify a program focus, the CHART team challenged Beverly to uncover needs specific to its community through analysis of 2013 discharge and readmissions data and interviews with patient and providers

Learning Enabled by Using Locally-derived Data

Beverly expanded its definition of "high-risk" to include:

- Behavioral health comorbidity
- Respiratory illnesses
- Skilled nursing and home care discharges
- Medicare and Medicaid high utilizers

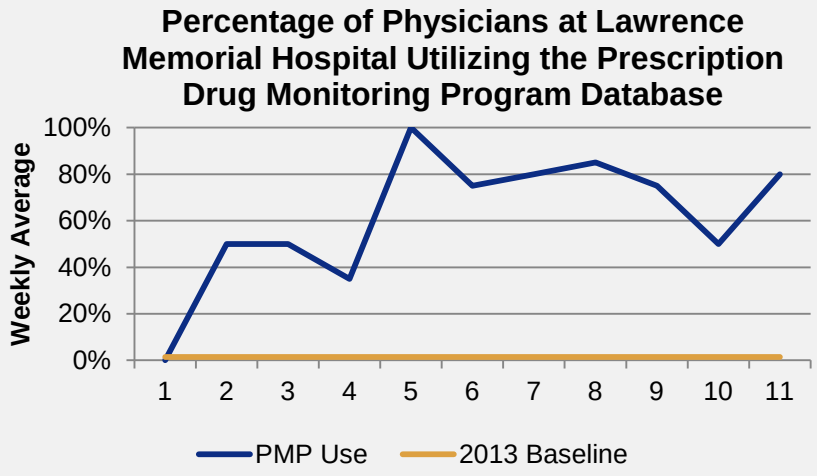
Appendix B: Readmissions Data Analysis Template[i]

Use the most recent 12 months of data available, calendar or fiscal year. Identify readmissions as any return to the inpatient setting for any reason within 30 days of discharge from the inpatient setting. This analysis is for non-obstetric, non-pediatric, adult medical/surgical/behavioral health patients. Exclude discharges that are coded as deaths or transfers to another acute care hospital.

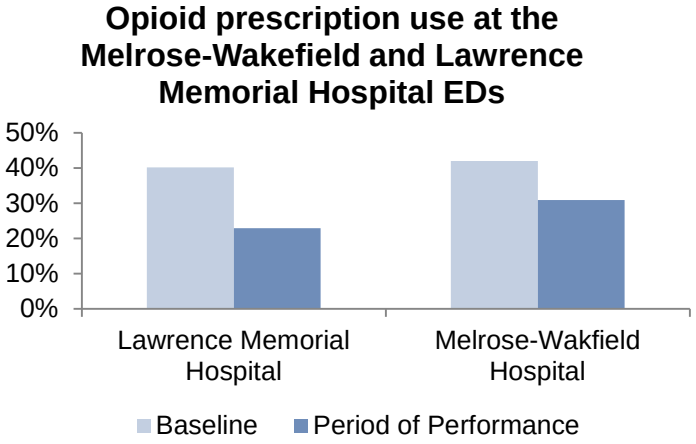
Data Element	Medicare	Medicaid	Self-Pay	Total
1. Total number of discharges alive (exclude transfers, deceased, <18yrs, obstetric)				
2. Total number of individual patients				
3. Total number of 30-day readmissions				
4. Overall readmission rate (#3/#1)				
5. Discharge disposition (from #1): a. Home (no home health) (#, %) b. Home with home health (#, %) c. Skilled nursing facility (#, %)				
6. Average number of days between discharge and readmission for all readmissions, days 0-30 (or #, % of readmissions within 0-6, 7-14, 15-30 days, respectively)				
7. Top 10 discharge diagnoses resulting in readmission (based on index DRG) a. List top 10 diagnoses b. Report number of readmissions per diagnosis c. Report readmission rate per diagnosis (readmissions for diagnosis/ discharges for diagnosis)				
8. Top 10 readmission discharge diagnoses (based on readmission discharge DRG) a. List top 10 diagnoses b. Report number of readmissions per diagnosis c. Report % of all readmissions accounted for by each top 10 readmission diagnosis				
9. Proportion of top 10 readmission diagnoses as a percentage of all readmissions (sum of readmissions in top 10/total readmissions)				
10. High-utilizing population (H.U.) a. Number of people hospitalized three or more times in past 12 months (H.U.) b. Number of hospitalizations among H.U. c. Discharge disposition of H.U. (home, home health, skilled nursing facility) d. Top 10 discharge diagnoses among H.U. 30-day readmission rate among H.U.				

Hallmark Health System used medical record review and dashboards to implement clinical practice guidelines for prescribing opioids in the ED

Seeking to understand the drivers of opioid prescribing in its emergency departments, HHS reviewed close to 1,000 patient medical records and found substantial variation in prescribing patterns, which led to the development and implementation of rigorous clinical practice guidelines to reduce practice pattern variation



Adherence to guideline protocols were tracked by physician and trended week-over-week to monitor compliance



Opioid prescription use decreased by 26% from baseline at Melrose-Wakefield Hospital and by 43% at Lawrence Memorial Hospital

Key lessons learned

1. Locally-derived data can support targeted and rapid interventions that yield demonstrable improvements at relatively low cost
2. Programmatic design and care interventions should evolve based on rigorous and continuous analysis
3. Multiple sources of quantitative and qualitative data should be used identify and validate community and individual patient needs

Looking toward Phase 2

The HPC CHART team is working with each Phase 2 award team in the Implementation Planning Period to use locally-derived data to refine their target populations for their CHART Phase 2 projects and enhance design of interventions. Ongoing measurement during Phase 2 will place continued emphasis on use of local data

Informed an optimized model of transformation for CHART Phase 2

The HPC is actively using learning and feedback from Phase 1 to inform Phase 2

1. **Hospitals' capacity for calculating new metrics** for CHART initiatives was limited. IPP is focusing heavily on metric identification, feasibility, and data flow to the HPC

2. Dedicated **project management resources** and leadership engagement were contributors to successful implementation. IPP is ensuring attention to project management resources

3. **Data driven approaches to defining** patient needs and target populations resulted in key learnings for awardees that shifted clinical models and approaches. IPP is using analytics to specify target populations to improve alignment with community need

4. **Hiring new staff** quickly is a challenge, especially in under-resourced communities. CHART Phase 2 is encouraging partnership with existing resources, where available, prior to hiring new staff or building new hospital capacities.

5. **Adaptation of clinical models** based on early outcomes and lessons learned is critical to high impact interventions. IPP is encouraging adaptive, data driven approaches supported by rapid-cycle evaluation to optimize initiatives.

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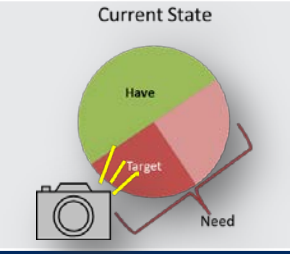
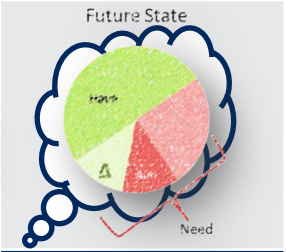
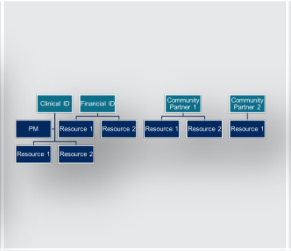
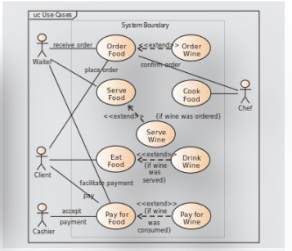
Overview of the Implementation Planning Period (IPP)

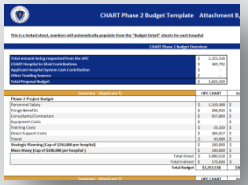








	1. Describe Current State	2. Verify Aim	3. Refine Service Model	4. Finalize Staffing Model	5. Develop Technology Req's	6. Develop Mass HIway cases
Activity Description	Utilize your data and patient interviews to be able to define your target population and describe the state of the measures you intend to affect	Using your baseline, quantify the specific impact your Initiatives will seek to have on the target population by the end of the Period of Performance	Design Initiatives that address the needs (i.e., Drivers) of the target population in order to achieve the Aim Statement	Specify the exact staffing model to support Phase 2 investments (service delivery, administrative, and leadership needs)	Specify lightweight technologies to be used to support achievement of Aim(s)	Specify intended uses of Mass HIway (to be further developed post-IPP)



	7. Define Scope of Strategic Plan	8. Describe Non-Service Investments	9. Develop Measurement Plan	10. Submit Final Budget	11. Extrapolate Project Milestones	12. Finalize Payment Schedule
Activity Description	Define broad goals for strategic planning, to be refined and subject to HPC approval after release of Community Hospital Study	Specify needs and requirements for service-delivery investments (e.g., training, capital, consultants, TA, etc.)	Finalize measurement plan (including validation of data sources and ability to collect measures) for standard and award-specific metrics	Specify final budget based on prior amendments and up to Board -approved award cap	Specify all project milestones (including goals and metrics where appropriate) to assess successful completion	Align disbursement schedule with project milestones including both process and achievement based payments

Staff and hospitals have found IPP to be valuable but also resource-intensive

Intensive, collaborative planning requires resources but will yield:

1. Strong interventions with quantified, measureable aims
2. Clinical models employing best known practices
3. Strong opportunities for successful transformation
4. Sufficient time for marshalling effective resources both within and external to awardee hospitals
5. Appropriate, measured oversight with rapid-cycle improvement throughout period of performance

Investment in planning is investment in transformation

Staff are actively working in partnership with hospitals to resolve key implementation challenges

With competing priorities and limited resources, hospitals find it challenging to devote time and attention to clinical program design	→ Hospitals are actively being encouraged to use Implementation Planning payment to fund dedicated Project Managers
Data and analytics infrastructure is under-resourced at many hospitals	→ CHART contemplating ADT-enabled, technology solution
Hospitals seek technical assistance in core functional areas and key program domains	→ Technical assistance plan will provide responsive supports, many of have been fielded during IPP (e.g., regional convening)

During IPP the HPC reaches agreement with the awardee on services to be provided as well as clinical and non-clinical workflows

Measure	Total	Proportion of Total (%)
A. Total Discharges	7883	100%
B. Total Discharges to Post-Acute Care	3038	38.5%
C. Discharges to SNF/IRF/LTAC*	1542	50.8%
D. Discharges to Home Health	1496	49.2%
E. Discharges to Home	4395	55.8%
F. Discharges with Primary or Secondary BH Diagnosis	4269	54.2%
G. Total (adult non-OB) 30-day Readmissions	1094	13.9%
H. Readmissions Occurring <4 days of d/c	188	17.2%
I. Readmissions Occurring <10 days of d/c	477	43.6%
J. Readmissions with a Primary or Secondary BH Diagnosis	573	52.4%
K. Number of Patients with ≥4 Hospitalizations Past Year	234	---
L. Total Number of Discharges Among [K]	1182	15.0%
M. Total 30-day Readmissions Among [K]	526	48.1%
N. % of Discharges that Result in Readmissions Among [K]	---	44.5%

Example Only: Target Population Development

54%

behavioral health comorbidity among hospital discharges

48 | 234

% Patients

234 superutilizers drive readmission rate

A key output of IPP, CHART Phase 2 Aim Statements, are impactful and measurable

Reduce 30-day readmissions by 20% for patients with a history of recurrent acute care utilization, social complexity, and/or in need of palliative care, within two years

Reduce 30-day ED revisits by 10% for all ED patients with a primary or secondary BH diagnosis, and reduce 30-day readmissions by 20% for all high utilizers within two years

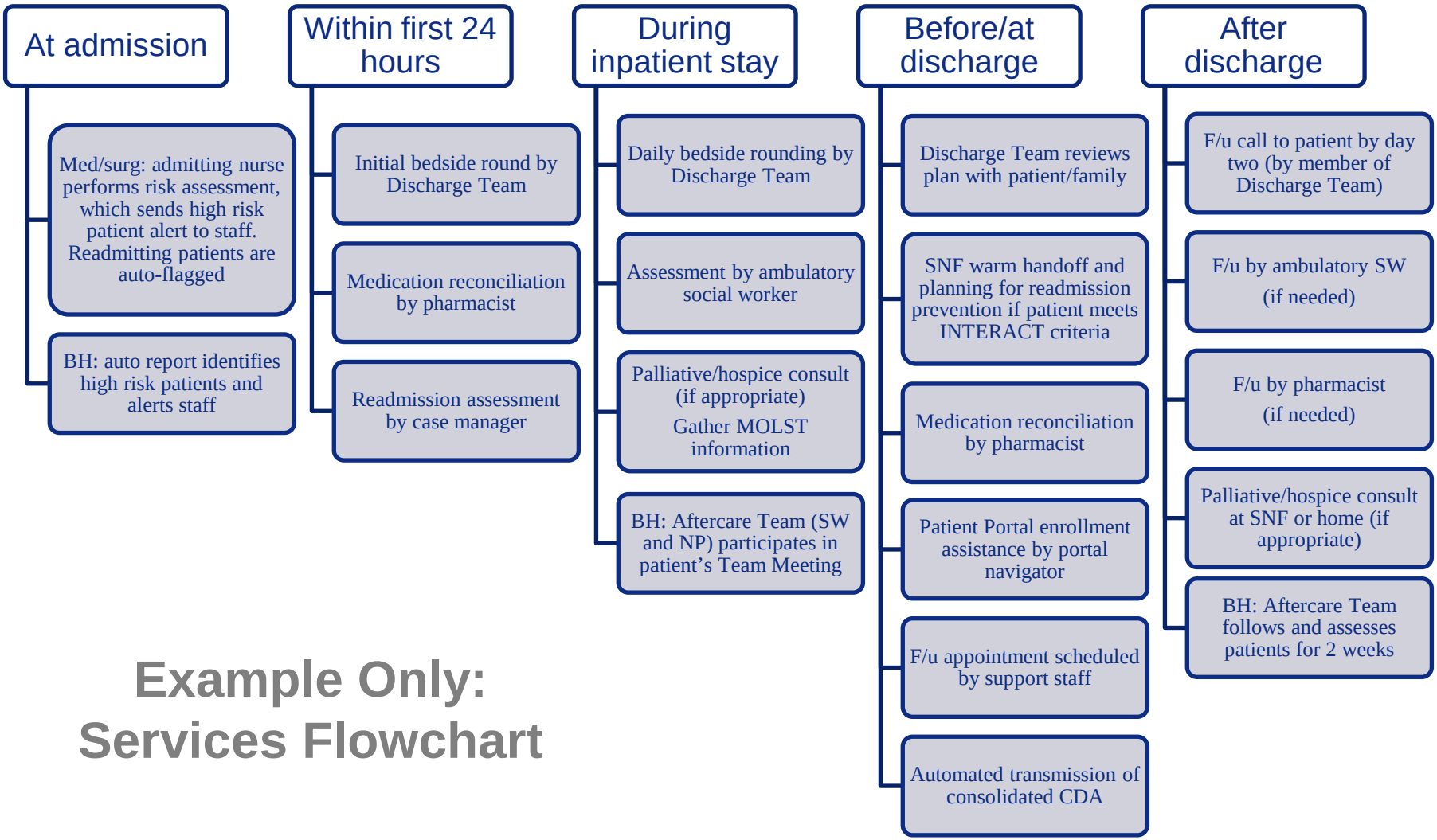
Aim Statements focus interventions and are the backbone of service models

Reduce 30-day readmissions by 20% for all med/surg patients discharged to SNF, home care, or palliative care; BH patients readmitted within 30 days; and all patients with two or more readmissions in the past six months, within two years

Reduce 30-day ED revisits and 30-day readmissions to inpatient psych by 25% for patients with BH conditions within two years

Example Only: Aim Statement Development

During IPP the HPC reaches agreement with the awardee on services to be provided as well as clinical and non-clinical workflows



Example Only: Services Flowchart

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Provider engagement and support plan

Models for '*monitoring and accountability*' and '*technical assistance*' are integrated and aligned to maximize impact and efficiency

In CHART Phase 2, we look forward to continuing our partnership with CHART hospitals. HPC support in Phase 2 will include enhanced technical assistance activities, within a '**Will, Ideas, Execution**' improvement framework. In this closed loop process, execution informs ongoing will building, leadership activities and testing of new ideas

Will

- **Leadership engagement**, oversight and accountability
- Supportive **data and analytics** addressing micro and macro system issues
- Cross-organizational communication to accelerate change through **social influencers**

Ideas

- **Convening** to spread effective practices, implementation approaches and strategies to overcome barriers
- **Dissemination tools** such as information repositories, regional progress reports, change packages, etc.
- Subject matter and evidence-based **expertise** both from participants and other successful programs elsewhere

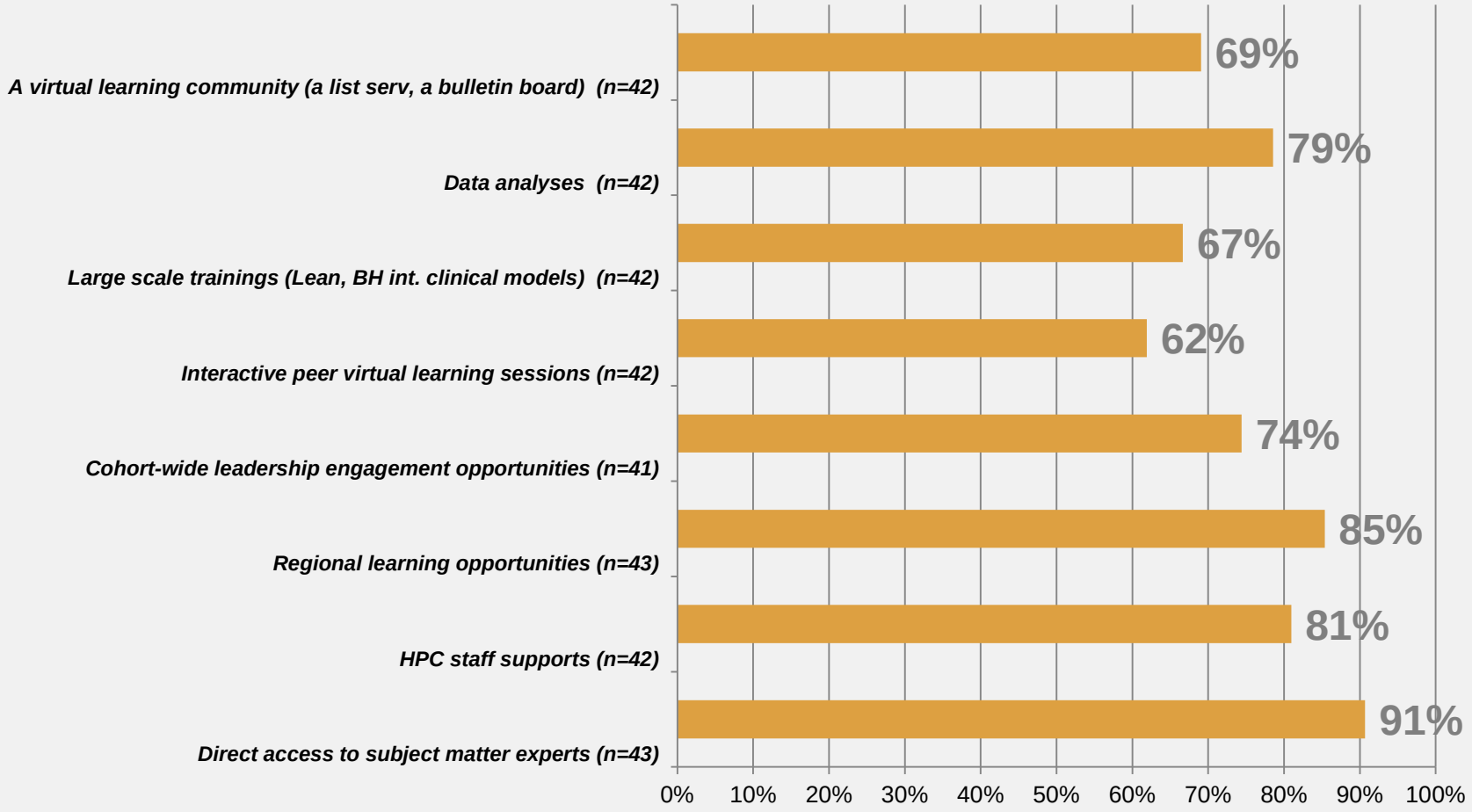
Execution

- **Direct technical assistance** customized to organizational needs and capabilities
- **Capacity building** for sustainability and the ability to address emergent system transformation
- **Network building** to strengthen collaborative relationships and promote independent problem solving
- Story telling of situations, **prototypical** (yet de-identified) patients that were dramatic and led to change/adoption

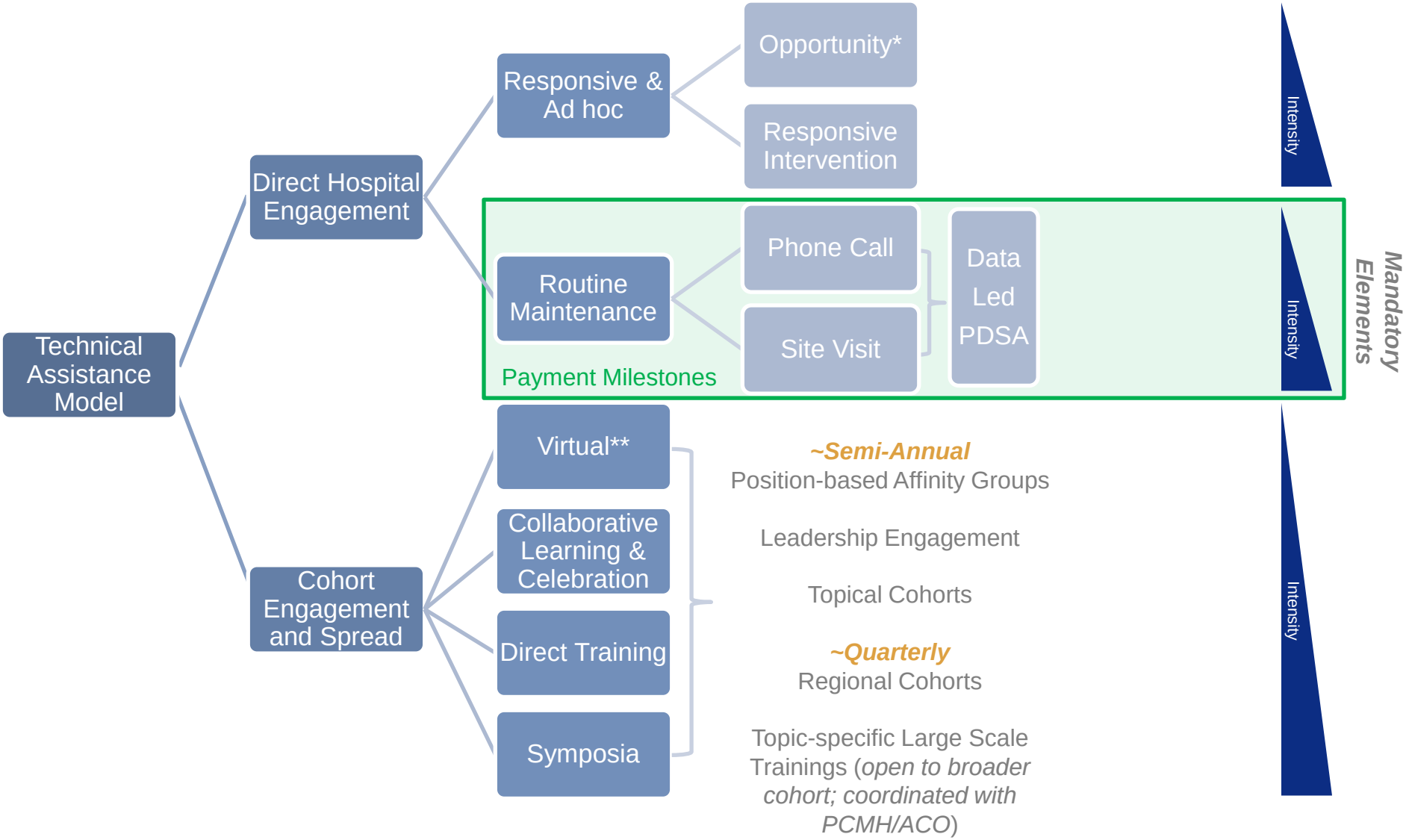
Nolan TW. *Execution of Strategic Improvement Initiatives to Produce System-Level Results*. IHI Innovation Series white paper. Cambridge, MA: Institute for Healthcare Improvement; 2007.

Provider engagement and support

Percent of respondents who agreed or strongly agreed that it would be helpful for the HPC to facilitate:



Modes for technical assistance and provider engagement



* Opportunities e.g., publication opportunities, pivot points for significant adaptation or enhancement, evolution of the scope and scale of interventions

** Virtual: **Passive** (content delivered to hospitals) or **Active** (facilitated)

Technical assistance topics and necessary expertise

Technical assistance will focus on themes of CHART investment and common topics necessary for hospital transformation

Potential Topics for Technical Assistance Activities

- *Performance improvement, e.g.,*
  - Applying improvement systems (Lean, Baldridge, Model for Improvement, etc.)
  - Data analytics and reporting
  - Team building with effective communication; physician and staff engagement
- *Achieving aims, e.g.,*
  - Reducing readmissions, ED visits, avoidable admissions
  - Identifying high-risk populations, including clinical, social and other factors
  - Behavioral health integration models
  - Chronic complex patients
- *Specific interventions, e.g.,*
  - BRIDGE and INTERACT models
  - Tele-behavioral health
  - Use of care navigators and community health workers
  - Developing community coalitions/partnerships

Necessary Content Expertise

- *Care delivery models*
  - Acute and chronic behavioral health management (including primary care integration)
  - ED care coordination with ambulatory providers
  - Community care models (e.g., accountable care communities, community health workers, regional “hot spotting”)
  - Care-coordination across the continuum
  - Hospital readmission reduction programs
  - Patient Centered Medical Home (Neighborhood)
  - Intensive Outpatient Care Programs (e.g., primary care based, case management based, partnership based)
- *Transformation prerequsisites*
  - Cross cutting HIT topics (similar issues, not software specific discussions)
  - Hospital flow
  - Data analytics, data reporting to accelerate adoption, data mining for improvement
  - Project management
  - Improvement capacity building (target middle managers, improvement team leaders)

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Vote: Providing Additional Support to CHART Hospitals for Effective Implementation Planning

Motion: That the Community Health Care Investment and Consumer Involvement Committee endorses an approach to Implementation Planning that ensures effective oversight and optimizes the success of anticipated CHART Phase 2 initiatives. The Committee directs staff to examine mechanisms for providing additional, focused financial support to CHART hospitals to ensure effective Implementation Planning, in addition to ongoing technical assistance, and to present a proposal for such support to the Board for consideration on March 11, 2015.

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Health Care Innovation Investment Program (HCII)

Establishment of the Health Care Innovation Investment Program

- M.G.L. c. 6D § 7
- Funded by revenue from **gaming licensing fees** through the Health Care Payment Reform Trust Fund
- Total amount of **$6 million**
  - *May increase if 3rd gaming license is awarded*
- Unexpended funds may to be rolled-over to the following year and do not revert to the General Fund
- **Competitive** proposal process to receive funds
- Broad eligibility criteria (*any **payer or provider***)

Purpose of the Health Care Innovation Investment Program

- To **foster innovation** in health care **payment** and service **delivery**
- To **align** with and **enhance** existing funding streams in Mass. (e.g., DSTI, CHART, MeHI, CMMI, etc.)
- To support and further efforts to meet the **health care cost growth benchmark**
- To improve **quality** of the delivery system
- **Diverse uses** include incentives, investments, technical assistance, evaluation assistance or partnerships

Chapter 224 provides guidance on program development process and framework but does not provide detailed specifications for use of funds

Program development considerations

1. HPC shall solicit ideas for payment and care delivery reforms directly from providers, payers, research / educational institutions, community-based organizations and others
2. HPC must coordinate with other state grant makers
3. Investments must be evaluated for cost and quality implications
4. Chapter 224 encourages broad dissemination of learnings and incorporation of successes into ACO certification and state-administered payment reforms
5. Suggests potential funding priorities such as in safety-net and DSH providers, support for PIPs, employee wellness programs, evaluation of mobile health technologies and chronic disease management programs for rural health and underserved areas

Investments that catalyze care delivery and payment innovations

In 2015, HPC will release a first round of innovation funding (HCII.1)

Principles for HCII program development

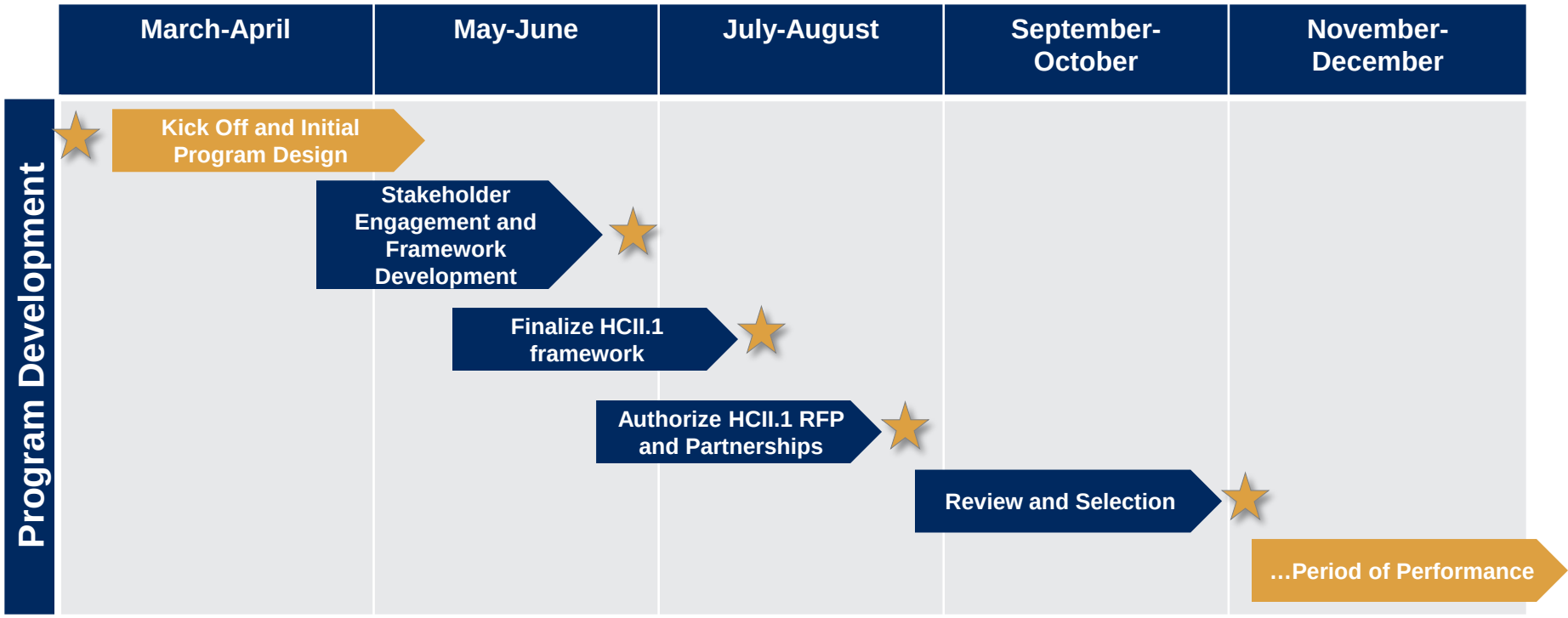
- Design a program infrastructure that will support the testing of payment and care delivery models and provide opportunities to scale successful initiatives through further investments and policy
- Prioritize evidence-based approaches for evaluating and funding investments
- Engage in extensive dialogue with market participants to identify the highest-need areas for payment and care delivery reform that are not adequately addressed by policy, the market, or current investment programs
- Build a nimble approach to investment that maximizes impact of relatively small investments

$3M

Anticipated 2015-2016 Investment

High-level HCII.1 timeline

The HPC will conduct extensive stakeholder engagement, program development, and strategic planning in Q1 to Q2 2015 to develop a framework for the first round of Health Care Innovation Investment funding.



Stars indicate estimated Committee/Board presentations

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Contact information

For more information about the Health Policy Commission:

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E-mail us: HPC-Info@state.ma.us

Appendix

CHART Phase 1 by the numbers*

CHART Phase 1: $10M

162,000+

Patients impacted by Phase 1 initiatives

2,200+

Hospital employees trained

27 | 260

Hospitals Units

Primed for system transformation

92%

Phase 1 Feedback survey respondents believed that CHART Phase 1 moved their organization along the path to system transformation

308

Community partnerships formed or enhanced by awardees

400+

Hours of direct technical assistance to awardees

*Updated February 25, 2015

2 Deploying Effective Management Strategies to Drive Change

Background

- The health care industry as a whole has been slow in utilizing dedicated individuals with strong management experience and skills to lead projects, instead relying on clinical or technical staff with substantial other responsibilities
- In addition to strong project managers and processes, the success of individual initiatives depends on senior-level support
- Need and opportunity to develop middle-management was echoed throughout CHART Phase 1 activities and the Leadership Summit

CHART hospitals highlighted in Case Study 1

Addison Gilbert Hospital
A member of Lahey Health

Deep leadership engagement directly supporting project staff as well as championing the project throughout the organization substantially removed roadblocks

HealthAlliance Hospital
A Member of UMass Memorial Health Care

HealthAlliance Hospital's project manager had substantial autonomy and sole responsibility to CHART implementation; flexed work schedule meet 24 hour nature of the ED

SIGNATURE HEALTHCARE

Signature Healthcare Brockton Hospital had multidisciplinary executive team champions to support institution-wide change

Key lessons learned

1. There is tremendous variation within and across hospitals in project management capacities; often success relies on skilled and dedicated individuals and not development of effective systems.

2. Many organizations are challenged to provide effective models for development of middle management, which has impacts on culture and performance

3. Project managers must have experience, credibility, and the technical expertise required for change management in a clinical setting

4. Sustained, organization-wide change requires leadership with both long term strategic vision and a hands-on approach, including executive sponsors who enable, support, and empower middle-management

Looking toward Phase 2

- CHART staff is strongly encouraging hospitals to assign a dedicated project manager with project management training and experience, to their Phase 2 projects; initiation payment funds are being focused towards early deployment of key project leaders
- The HPC has required a 10% time commitment from a senior operational and clinical leader for Phase 2 to ensure ongoing leadership engagement and buy-in