

**MINUTES OF THE QUALITY IMPROVEMENT AND PATIENT  
PROTECTION COMMITTEE**

**Meeting of December 10, 2014**

**MASSACHUSETTS HEALTH POLICY COMMISSION**

**THE QUALITY IMPROVEMENT AND PATIENT PROTECTION COMMITTEE OF THE  
MASSACHUSETTS HEALTH POLICY COMMISSION**  
Center for Health Information and Analysis  
Daley Room, Two Boylston Street, 5<sup>th</sup> Floor  
Boston, MA 02116

---

**Docket: Wednesday, December 10, 2014, 10:00 AM – 11:00 AM**

---

**PROCEEDINGS**

The Massachusetts Health Policy Commission's Quality Improvement and Patient Protection (QIPP) Committee held a meeting on Wednesday, December 10, 2014 in the Daley Room at the Center for Health Information and Analysis located at Two Boylston Street, 5<sup>th</sup> Floor, Boston, MA 02116.

Committee members present were Ms. Marylou Sudders (Chair), Dr. Carole Allen, Dr. Wendy Everett, and Dr. Ann Hwang, designee for Mr. John Polanowicz, Secretary of Health & Human Services.

Ms. Veronica Turner participated via phone.

Ms. Sudders called the meeting to order at 10:08 AM.

Ms. Sudders stated that she was recently selected by Governor-Elect Charlie Baker to serve as the incoming Secretary of Health and Human Services. She noted that her role at the day's meeting would not be in that capacity, but rather as a private citizen and professor at the Boston University School of Social Work. She added that, at the day's meeting, Dr. Hwang would serve as the designee for the Secretary of Health and Human Services.

**ITEM 1: Approval of minutes**

Ms. Sudders asked for any changes to the minutes from the October 29, 2014 meeting. Seeing none, Ms. Sudders called for a motion to approve the minutes as presented. Dr. Everett made the motion. Dr. Allen seconded. Members voted unanimously to approve the minutes. Voting in the affirmative were the four committee members present.

**ITEM 2: Discussion of Behavioral Health Task Force Report and the HPC's Behavioral Health Agenda**

Ms. Sudders reviewed the day's agenda. She stated that the Committee would discuss the HPC's 2015 behavioral health agenda as well as the Behavioral Health Task Force's report. She added that the Committee would also hear an update on the development of regulations governing nurse staffing in intensive care units.

Mr. David Seltz, Executive Director, introduced Ms. Katherine Record, HPC's Senior Manager for Behavioral Health Integration. Mr. Seltz stated that Ms. Record would focus on behavioral health integration issues for the accountable care and patient-centered medical home (PCMH) certification programs as well as other payment reform initiatives. He added that Ms. Record's work, in conjunction with Ms. Jenifer Bosco, Director of the Office of Patient Protection, would be imperative to furthering the HPC's behavioral health initiatives.

Mr. Seltz stated that Chapter 224 created the Behavioral Health Task Force. He noted that the Task Force provided the HPC and Legislature with recommendations for further improving access to behavioral health services in the Commonwealth. Mr. Seltz stated that the HPC is using the report to identify areas where the HPC could incorporate behavioral health integration into existing initiatives.

Mr. Seltz stated that staff identified three key areas of alignment between the HPC's goals and the Behavioral Health Task Force report.

First, the HPC will examine clinical models of behavioral health integration. This will be done through (1) certification programs for PCMH and Accountable Care Organizations (ACO) and (2) investments in CHART Phase 2 for the adoption of widespread and emerging models of integration.

Mr. Seltz reviewed the second area of focus: reimbursements. He stated that the HPC will work with other agencies and the Statewide Quality Advisory Committee (SQAC) to identify outcome measures for behavioral health services. He also noted that, as the HPC continues to discuss Alternative Payment Methodologies (APMs), integrating behavioral health into APMs can be further explored.

Mr. Seltz reviewed the third area of alignment between the HPC and the Behavioral Health Task Force: mental health parity. He stated that the HPC's role in ensuring parity would expand through the Office of Patient Protection (OPP), which offers consumers an external review process to appeal denied behavioral health claims. Mr. Seltz also stated that the HPC can play a convening role for mental health parity by facilitating meetings with key stakeholders to discuss solutions.

Mr. Seltz reviewed final recommendations from the Behavioral Health Task Force, including the HPC's role to monitor behavioral health trends and develop relevant policy recommendations.

Mr. Seltz stated that the Task Force's initial recommendations are broad and that the Committee's feedback will be incorporated into a full behavioral health agenda for 2015.

Dr. Everett stated that the recommendations and proposed goals of the Behavioral Health Task Force are extremely thoughtful. She asked how the HPC would work to implement these goals and whether other stakeholders, such as the Department of Public Health (DPH) and the Department of Mental Health (DMH), would be directly consulted. Mr. Seltz responded that the purpose of the day's agenda is to garner feedback from the Committee

on how best to develop and implement strategies geared towards achieving these goals. He stated that he would seek an endorsement from the board on a set of specific goals once this preliminary feedback had been processed. He noted that the HPC would continue to collaborate with DPH and DMH throughout this process.

Dr. Allen stated that there should continue to be significant discussion about outcome measures, specifically with regard to ACOs. She added that there is a strong commitment to behavioral health integration in the ACO and PCMH models, which encourages system-wide transformation.

Ms. Sudders stated that the highlighted recommendations reflect what is most appropriate for the HPC's mission.

Dr. Allen stated her strong support for the HPC to further examine whether a "carve-out" model of behavioral health insurance continues to be appropriate and delivers integrated care.

Dr. Hwang stated her support for these select focus areas of work for the HPC.

Ms. Sudders stated that the HPC will work to make these recommendations more specific and integrate them with the work of the HPC as a whole.

### **ITEM 3: Update on ICU Nurse Staffing Regulation**

Ms. Sudders reviewed the HPC's role in developing a regulation governing nurse staffing in hospital intensive care units (ICUs). She noted this is a complex issue that involves the consideration of patient safety and care as well as safe labor standards.

Mr. Seltz stated that the HPC visited several ICUs, held two public listening sessions, and held over a dozen meetings with public and private stakeholders since beginning work on this regulation in August 2014.

Mr. Seltz introduced Ms. Lois Johnson, General Counsel, to review the HPC's role and continuing work on ICU nurse staffing.

Ms. Johnson reviewed preliminary considerations identified by the statute. She stated that the statute applies to all ICUs in Massachusetts acute care hospitals and the Department of Public Health's (DPH) Shattuck Hospital. She reviewed the definition of ICUs, noting that it includes general and specialty ICUs, including critical care, coronary care, intensive burn care, pediatric intensive care units (PICUs), and neonatal intensive care units (NICUs). She added that there had been significant stakeholder conversation about the application of the regulation to NICUs.

Ms. Johnson reviewed the statute's requirement for 1:1 or 1:2 patient-to-nurse staffing ratios. She stated that the staffing ratio depends on the stability of the patient as assessed

by an acuity tool and staff nurses in the unit. She stated that stakeholders questioned whether hospitals must default to a 1:1 ratio.

Dr. Everett asked for clarification on what a “default” ratio would mean for hospitals. Ms. Johnson noted that the statute does not create a default nurse staffing ratio. She stated that, if there were a default 1:1 ratio, a nurse would be assigned one patient and the acuity tool would identify those circumstances when a nurse could take two patients.

Ms. Johnson reviewed the current landscape of ICU nurse staffing in Massachusetts. She stated that less than 20% of Massachusetts hospitals currently use an acuity tool. She added that acuity tools are more commonly used in AMCs than in community hospitals. She added that tool models vary from paper checklists to comprehensive software.

Ms. Johnson reviewed existing acuity tools and how they are being used. She stated that tools generally assess patient acuity, mortality risk, and nursing workload. She stated that the tools are generally used retrospectively for budgeting and resource planning rather than for real-time staff assignments.

Ms. Johnson reviewed stakeholder feedback on different elements under consideration for measurement by the acuity tool, including clinical and physiological indicators of patient stability and non-clinical patient characteristics, such as communication skills, culture barriers, and family support.

Ms. Johnson reviewed stakeholder feedback on other hospital and unit-specific considerations for patient assignments, such as nurse experience, availability of ancillary support staff, unit layout, patient mix, and other environmental factors.

Ms. Johnson reviewed feedback on the criteria for use of an acuity tool. Stakeholders emphasized the need to consider patient assessments made by staff nurses, the frequency of said assessments, and the ease of using an acuity tool. She added that stakeholders differed on whether patient assessments should be part of patient’s record.

Ms. Johnson reviewed stakeholder feedback on the development or selection of an acuity tool. She stated that there was significant discussion on how to maximize time and resources. She added that the HPC has continued to meet with stakeholders and incorporate feedback from nurses and hospital staff into the regulatory process.

Mr. Seltz asked for comments from Committee members.

Dr. Allen noted that it is important to keep patient safety and quality of care in mind as the ultimate goal of the regulation.

Ms. Johnson reviewed stakeholder feedback on the identification and selection of key quality measures. She stated that the HPC had identified preliminary criteria that are evidence-based and standardized, able to be benchmarked, currently collected and reported in Massachusetts, nursing-sensitive, and feasibly applicable across ICU-types. She

added that the HPC had identified a preliminary set of ten suggested quality measures and would continue to seek feedback in this area to encourage applicability and validity.

Dr. Hwang stated that these quality measures should be meaningful and clinically significant from a health outcomes perspective. Dr. Allen added that proposed criteria for selection should include a measure of patient experience. Ms. Johnson responded that the list of quality measures was still in development and final recommendations would include commissioner feedback.

Ms. Sudders asked whether the HPC would be soliciting public comment on these measures. Ms. Johnson responded that the HPC would post a request for comment on its website on these quality measures in order to assess their validity.

Ms. Johnson reviewed other key considerations required by the law, including the certification of acuity tools and enforcement of the law by DPH.

Mr. Seltz stated that evaluation would be done in coordination with other state agencies and academic advisors in order to build a vigorous review process.

Dr. Everett stated that the HPC should identify how best to make sound recommendations within a rapidly changing and transforming delivery system. She added that her research demonstrated significant success of acuity tools within the community hospital system when compared to academic medical centers (AMC). She stated that the law requires a very broad recommendation and that the HPC should consider these special circumstances throughout the regulatory process.

Mr. Seltz reviewed next steps for the Committee. He stated that a QIPP meeting had been scheduled to discuss draft regulations. He added that the regulatory process requires a full public comment period and hearing to further inform the development of regulations.

Ms. Sudders commended the HPC for its work to this point and noted this concluded the discussion for this agenda item.

#### **ITEM 4: Schedule of Next Committee Meeting (January 6, 2015)**

Ms. Sudders announced the next meeting of the Quality Improvement and Patient Protection Committee (January 6, 2015) and adjourned the meeting at 11:05 AM.