MINUTES OF THE COMMUNITY HEALTH CARE INVESTMENT AND CONSUMER INVOLVEMENT COMMITTEE

Meeting of June 03, 2015

MASSACHUSETTS HEALTH POLICY COMMISSION

THE COMMUNITY HEALTH CARE INVESTMENT AND CONSUMER INVOLVEMENT COMMITTEE OF THE MASSACHUSETTS HEALTH POLICY COMMISSION
Health Policy Commission Conference Center
50 Milk Street, 8th Floor
Boston, MA 02109

Docket: Wednesday, June 3, 2015, 11:00 AM – 12:30 PM

PROCEEDINGS

The Massachusetts Health Policy Commission's Community Health Care Investment and Consumer Involvement (CHICI) Committee held a regular meeting on Wednesday, June 3, 2015 in the Conference Center at the Health Policy Commission located at 50 Milk Street, 8th Floor, Boston, MA 02109.

Members in attendance were Dr. Paul Hattis (Chair), Mr. Rick Lord, Ms. Veronica Turner, and Ms. Lauren Peters, designee for Secretary Kristen Lepore, Executive Office of Administration and Finance.

Dr. Hattis called the meeting to order at 11:00 AM.

ITEM 1: Approval of Minutes from the February 25, 2015 Meeting

Noting that there was a lack of quorum at the April 15 meeting, Dr. Hattis asked for a motion to approve the minutes from two meetings ago (February 25, 2015). Upon motion made by Ms. Turner and duly seconded by Mr. Lord, the minutes were unanimously approved by the members present.

ITEM 2: Approval of Minutes from the April 15, 2015 Meeting

Dr. Hattis reviewed the minutes from the last meeting (April 15, 2015). He clarified his comments in the minutes, noting that even though HPC is investing in community hospitals, community health transformation must involve all constituencies.

Dr. Hattis asked for a motion to approve the minutes from April 15, 2015. Upon motion made by Ms. Turner and duly seconded by Mr. Lord, the minutes were unanimously approved by the members present.

ITEM 3: Presentation on CHART Phase 1 Report

Mr. Iyah Romm, Policy Director for Care Delivery Innovation and Investment, noted that the HPC has spent the last few months closing out CHART Phase 1 initiatives.

Ms. Cecilia Gerard, Deputy Policy Director for Care Delivery Innovation and Investment, said that the HPC is reflecting on the experiences of Phase 1 as they begin Phase 2. She noted the wide variety of initiatives undertaken by the hospitals in Phase 1, reiterating that those projects had specific priorities primarily focused on reducing costs and creating a climate for innovation.

She said the success of these programs was due to technical employees at the hospitals and the HPC's CHART team.

Ms. Gerard reviewed CHART Phase 1. She noted that all of the hospitals that applied for Phase 1 funding received CHART awards. In Phase 1, the HPC committed $9.9 million. These awards ranged from $65,000 - $500,000 with an average award of $355,000. Ms. Gerard stated that these awards were given based on financial health, affiliations, project alignment with identified community need, and the amount of funding each hospital requested. She said the funding went to pilot programs, advancing technology, and strategic planning programs. At the end of Phase 1, some projects came in under budget, making the total spend $9.2 million.

Ms. Gerard said capacity-filling grants focused on two areas: training staff and investing in technology. She said over 2,300 hospital staffers across the Commonwealth were trained in new technology, new protocols, and process improvements during Phase 1.

Dr. Hattis asked for clarification on the staff trained. He noted the importance for low level staff to receive new training. Ms. Gerard responded that Mercy Hospital trained six individuals in leadership positions and identified champions in five departments for training in communication and inpatient delay reduction. Ms. Margaret Senese, Senior Manager for Strategic Investment, added that staff training was not limited to hospital leaders.

Mr. Lord asked how Mercy Medical Center was able to do 70 LEAN improvement projects in such a short period of time. Ms. Senese responded that 70 staffers were training in LEAN principles and each completed a project.

Mr. Romm pointed to the variety in training, noting that some hospitals implemented a new care protocol. He stated that Hallmark Hospital aimed to reduce opioid prescribing through physician training. He said that other hospitals, such as Mercy Medical Center, engaged the full care time, not just those providing clinical care.

Ms. Gerard said that the CHART hospitals worked with community partners on projects that focused on post-acute care and improved integration. She said the HPC counted 315 community partnerships during CHART Phase 1.

Ms. Gerard noted that the HPC supports CHART work through technical assistance. She said the CHART team has provided 450 hours of direct technical assistance to hospitals, including 140 coaching calls, 50 site visits, and a two-day leadership symposium.

Ms. Gerard reviewed a selection of CHART Phase 1 projects.

Ms. Gerard said a key policy position for the HPC is reducing readmissions. She said 55 Massachusetts hospitals will be fined for higher-than-expected readmission rates. She said that, through CHART funding, Addison Gilbert Hospital was able to tailor interventions to each patient using insurance claims, medical records, substance dependencies, and rates of medication prescribing. Ms. Gerard said that Addison Gilbert's readmission rate dropped from 19% in March 2014 to 8.8% in September 2014.

Mr. Lord asked why the readmission rate jumped back up to 16.5% in October 2014. Ms. Gerard responded that the jump in readmissions was due to an Addison Gilbert staff member leaving the program. Mr. Romm added that rates jumping up and down are very common in readmissions. He said that yearly readmission trends are more accurate. Mr. Romm said that there is modest improvement over time. He said that if an employee leaving is a factor is increased readmissions, then there needs to be increased protocols for continuing to enhance these models.

Dr. Hattis asked if it would be overly optimistic to think that the CHART program will help spur relationship building between hospitals and the justice system for individuals with substance use disorders. Mr. Romm responded that CHART has been enhancing community relationships.

Ms. Gerard said that reducing unnecessary emergency department visits was a focus of CHART Phase 1 and will continue into Phase 2. She added that patients with behavioral health conditions were the patients that needed the most support. She said that, through CHART funding, HealthAlliance Hospital linked 75 patients with PCPs in the community and increased communication to start transitioning patients that needed more community care.

Ms. Gerard said Hallmark Health System aimed to reduce opioid prescribing and enhance behavioral health supports. She stated that Hallmark developed a population management program for those visiting the emergency department with lower back pain, a common ailment treated with opioids. This program included enhanced existing prescription management programs and alternative pain management programs.

Ms. Gerard said that Baystate Mary Lane Hospital used CHART Phase 1 funding to enhance inpatient telemedicine services for speech therapy, cardiology, and behavioral health by moving them into outpatient services. She said their goal was reducing wait times and retaining patients at a lower cost and in a local setting.

Dr. Hattis asked which lessons in Phase 1 have relevance moving forward into Phase 2. Ms. Gerard responded that the HPC has a better understanding of the data collection and analysis capabilities of the hospitals. As such, CHART Phase 2 will work on standardizing and investing in data analytics. She also stressed the importance of transformation teams. She said that by training non-clinical staff, CHART hospitals can achieve better coordination with their patients. She said this type of coordination is something the HPC wants to encourage in Phase 2.

ITEM 4: Update on CHART Phase 2 Implementation Planning

Ms. Senese said the HPC has been preparing for CHART Phase 2 with five regional convenings, 27 site visits, 25+ expert advisor meetings, and 500+ hours of coaching calls. She added that the HPC team is working to find the highest value area of service and push CHART hospitals to see how much they can do with their CHART award.

Ms. Senese said that the CHART team is working with hospitals directly to define reporting requirements and complete the implementation planning process. Ms. Senese said CHART hospitals are actively modifying and editing plans based on HPC feedback.

Ms. Senese said that CHART Phase 2 is working to break down barriers between siloed community-based services and hospital-based services to address complex patient needs that are becoming more difficult to treat due to a fragmented system. She added that all of these issues make the case for more patient-centered accountable care.

Ms. Senese said that care teams in Phase 2 are developing specific initiatives to partner to with a variety of community-based organizations; many times CHART funds are going to these community organizations to help increase capacity. She said this is an example of an emerging model of CHART phase 2.

Mr. Lord asked if CHART hospitals have the flexibility to use funds to engage community partners. Ms. Senese responded that CHART budgets have sections for funds going directly to sub-contractors. She said the HPC has seen funds used to hire staff at the hospital as well as those used to engage a subcontractor or community partner.

Dr. Hattis asked whether HIPAA has been a barrier. Ms. Senese responded that she does not have a sense of how much is an actual barrier and how much is a perceived barrier, although she believes that it is more of a perceived barrier.

Mr. Romm said that the CHICI committee has had conversations about the challenges that providers have in information sharing and exchange. He added that the CHART team faces those same problems.

Dr. Hattis asked if it is something that hinders the CHART hospitals from completing their program. Mr. Romm responded that it is not.

ITEM 5: Discussion of CHART Engagement Plan

Mr. Romm stated that, when closing out Phase 1 of the CHART program, the HPC prioritized gleaning hospital feedback on improvements for Phase 2. He noted that the most hospitals asked for additional regional learning opportunities and direct access to subject matter experts. He said that the HPC considers technical assistance to have two separate parts: direct hospital engagement and cohort engagement and spread.

Dr. Hattis noted his appreciation that the HPC provides support to all hospitals, not just those that need it the most. Mr. Romm noted that there is value in focusing of those organizations on the leading edge.

Mr. Romm said there are six approaches to technical assistance: state-wide meetings, regional convenings, site visits, training opportunities, calls with HPC staff and technical assistance experts, and leadership engagement. He said that the HPC plans to hold two state-wide meetings during Phase 2. He noted that regional convenings are an opportunity for peer leading from within the group and will occur three times a year.

Mr. Romm said the training opportunities will be rolled into the regional convenings and possibly as standalone events. He said that there could also be topic specific training. Mr. Romm said that there could be collaboration with MassHealth because they are already doing technical assistance.

Dr. Hattis said that he sees the great value in the CHART program and thanked everyone who works on the team.

ITEM 6: Presentation on Impacts of Health Care Reform on Massachusetts Safety Net Hospitals

Dr. Hattis introduced Dr. Amy Lischko, a colleague of his at Tufts Medical School where she specializes in community medicine and public health. Dr. Lischko presented on the Impacts of Health Care Reform on Massachusetts Safety Net Hospitals.

ITEM 7: Schedule of Next Committee Meeting

Seeing no further business before the committee, Dr. Hattis adjourned the meeting at 1:25 PM.