MASSACHUSETTS
HEALTH POLICY COMMISSION

Meeting of the Care Delivery Transformation Committee

June 13, 2018

MASSACHUSETTS
HEALTH POLICY COMMISSION

AGENDA

- **Call to Order**
- Approval of Minutes
- CDT Updates
- PCMH PRIME Strategy Recommendations
- Quality Measure Alignment Taskforce Update
- Transforming Care: The CHART Playbook Preview
- Schedule of Next Meeting (October 3, 2018)

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VOTE: Approving Minutes

MOTION: That the Committee hereby approves the minutes of the CDT Committee meeting held on February 14, 2018, as presented.

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  - HPC Care Delivery Spring Event Recap
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HPC Spring Care Delivery Special Event Overview

SPECIAL EVENT:

PARTNERING TO ADDRESS SOCIAL DETERMINANTS OF HEALTH: *WHAT WORKS?*

May 17, 2018

BREAKFAST AND PANELIST POSTER PRESENTATION 8:00AM

WELCOME 8:25AM
Mr. David Seltz, Executive Director, Massachusetts Health Policy Commission

KEYNOTE 8:30AM
Dr. Alice Chen, Chief Medical Officer, San Francisco Health Network

REMARKS 8:55AM
Dr. Monica Bharel, Commissioner, Massachusetts Department of Public Health

PANEL DISCUSSION 1: 9:10AM
Practical Approaches for Partnering to Address the Social Determinants of Health

MODERATOR: **Dr. Donald Berwick**, Senior Fellow, Institute for Healthcare Improvement; Commissioner, Massachusetts Health Policy Commission

CHART Investment Program Awardee and Partner Dyad:
- **Ms. Selena K. Johnson**, Project Manager, Heywood Healthcare
- **Mr. Mark J. Pellegrino**, Superintendent, Gardner Public Schools

Health Care Innovation Investment (HCII) Program Awardee and Partner Dyad:
- **Dr. Katherine Moss**, PhD, Vice President of Integration, Behavioral Health Network
- **Mr. Israel Ortiz**, Director of Residential Programs, WayFinders, Inc.

Accountable Care Organization (ACO) Certification Program and Partner Dyad:
- **Ms. Robin Hynds**, Vice President of Care Continuum, Lawrence General Hospital
- **Ms. Vilma Martinez-Dominguez**, Community Development Director, Mayor's Health Task Force, City of Lawrence

PANEL DISCUSSION 2: 10:10AM
Policy Approaches to Support Partnerships that Address the Social Determinants of Health

MODERATOR: **Ms. Audrey Shelto**, President, Blue Cross Blue Shield of Massachusetts Foundation

- **The Honorable Representative Jeffrey Sánchez**, Chairman, House Committee on Ways and Means
- **Dr. Myechia Minter-Jordan**, President and CEO, The Dimock Center
- **Ms. Ellen Lawton**, JD, Co-Director, National Center for Medical-Legal Partnerships, The George Washington University
- **Ms. Lauren A. Taylor**, co-author of The American Health Care Paradox, Harvard Business School, Health Policy and Management

CLOSING REMARKS 10:55AM

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Highlights from the HPC Spring Care Delivery Special Event

On May 17, over 150 representatives from health care provider organizations, community-based organizations, payers, government, academia, and the interested public attended the HPC's special event, "Partnering to Address Social Determinants of Health: *What Works*?"

"Where we live matters for our health and access to health, and race matters,"
- Dr. Monica Bharel

10 panelists

150+ attendees

3 posters

"The poverty threshold has been a way for us to exclude people from benefits."

- Alice Chen, MD

272 twitter engagements

50+ HPC awardee and Certified ACO representatives

27 tweets

"There are also things that may not have a business case at all, but are worth doing because it is the morally right and just thing to do"
- Lauren Taylor

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- Appendix

PULSE@MassChallenge Background

Founded in 2016, PULSE@MassChallenge ("PULSE") is the Commonwealth's official digital health hub. PULSE was designed on the pillars of the Massachusetts Digital Health Initiative, a private-public partnership with the goal of making Massachusetts a leading digital health hub nationally and globally. PULSE aligns its program with recommendations from the Massachusetts Digital Health Council.

Founding Pillars
MA Digital Health Initiative

Build a **Marketplace**

Build a **Community**

Improve **Data** Access & Transparency

63 startups have participated in PULSE

$4.5M+ revenue

$18.8M+ funding generated during the program

40+ partners engaged with PULSE.

HPC

HPC - PULSE@MassChallenge Collaboration

Digital health can help solve significant challenges in healthcare in support of the HPC's vision for care delivery transformation

The HPC will leverage digital health startups that have been carefully vetted around a challenge area of high priority (e.g. social determinants, avoidable ED use)

The HPC and PULSE will promote the development of digital health innovations in community-based health care settings with which the HPC invests through SHIFT-Care

Through this collaboration, the HPC will align with the Governor's Digital Health Initiative and support recommendations made by the Digital Health Council.

The HPC will inform the strategy and direction of health care innovation and entrepreneurship in the Commonwealth by partnering with PULSE

HPC

Proposed Collaboration with PULSE

At the June 5 PULSE Finale event , the HPC announced a commitment to partner with PULSE, which doubled the Commonwealth's investment in the digital health incubator.

Funding

- **1 Year: ~$170k commitment to support PULSE's operating costs in promoting the development of digital health innovations in community-based health care settings**

Collaboration areas

Be a "Champion" in PULSE's Core Program

As a Champion, the HPC supports Pulse's process to engage with one or more startups in the HPC's identified policy priority areas.

Support for a bridging community-based providers and the digital health ecosystem

The HPC and PULSE mentor and support startups who want to work with community-based providers to accelerate health innovation in those care settings. Specifically, PULSE may create a "how-to guide" for startups navigating community-based provider organizations.

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Overview of RBPO/ACO Appeals

- **Chapter 224 requires the HPC to develop requirements for internal appeals and an external review process for RBPOs and ACOs**
  - Office of Patient Protection (OPP) is directed to establish requirements for DOI-certified Risk Bearing Provider Organizations (RBPO) and HPC-certified Accountable Care Organizations (ACO) to implement appeals processes for reviewing patient appeals as well as an external review process to obtain third party review of such appeals

- **The statutory requirements are similar to existing OPP consumer protection rules regarding review of health plan medical necessity determinations but apply to provider decisions about referrals, treatments and access to care**

Proposed Regulation 958 CMR 11.00

- **Interim Guidance released April, 2016**
  - **Collected quarterly reports since October 2016**
  - **Held multiple information and listening sessions with provider organizations**
- **Presented draft regulation at CDT Committee on February 14, 2018**
- **Proposed regulation Released by the Board on April 25, 2018 for public comment, the proposed regulation 958 CMR 11.00 closely tracks the Interim Guidance regarding internal appeals for RBPOs and ACOs and proposes an external review process similar to that used for carriers.**

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Public Hearing held on May 25, 2018

Comments and Testimony Submitted By:
Atrius Health
Beth Israel Deaconess Care Organization
Children's Medical Center Corporation
Health Law Advocates Health Care For All Mental Health Legal Advisors Committee
Massachusetts Health and Hospital Association
Massachusetts Association of Health Plans
Massachusetts Medical Society
Southcoast Health

Key Considerations for Final Regulation Based on Comments

- Effective date of regulation
- Timeframes for internal appeals processing and resolution
- Standard for external review and factors considered
- External review fees and cost implications
- Notice requirements
- Clinical reviewers credentials and expertise
- Medical records and authorization to release
- Form and manner of review request
- Opportunities for clarification

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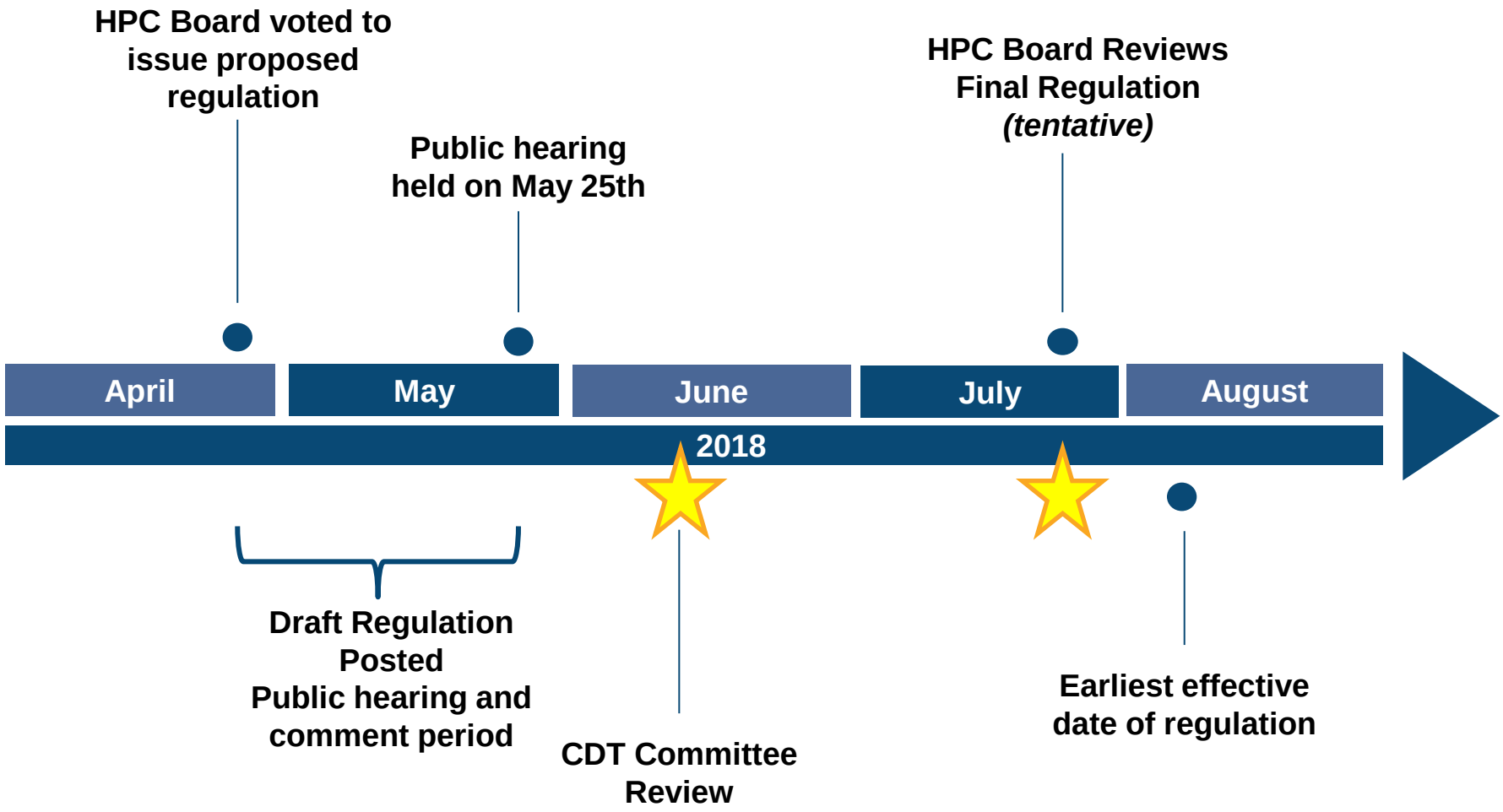
Timeline


HPC Board voted to issue proposed regulation
Public hearing held on May 25th
HPC Board Reviews Final Regulation (tentative)
April
May
June
July
August
2018
Draft Regulation Posted Public hearing and comment period
CDT Committee Review
Earliest effective date of regulation

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Practices Participating in PCMH PRIME

Since January 1, 2016 program launch:

79 practices
are PCMH PRIME Certified

17 practices
are on the **Pathway to PCMH PRIME**

1 practice
applying for NCQA PCMH Recognition and PCMH PRIME concurrently

97 Total Practices Participating

~11% of MA physicians practice in a site participating in PCMH PRIME

~9% of MA physicians practice in a PCMH PRIME Certified site[1]

~29% of MA physicians in NCQA PCMHs practice in a PCMH PRIME Certified site[2]

~2% of MA physicians practice in a site on the Pathway to PCMH PRIME[1]

~5% of MA physicians in NCQA PCMHs practice in a site on the Pathway to PCMH PRIME[2]

1 Data from 51/2018 NCQA PCMH Recognition list, HPC PCMH PRIME program status data, and Association for American Medical Colleges' 2017 State Physician Workforce Data Book
2 Data from 5/1/2018 NCQA PCMH Recognition list and HPC PCMH PRIME program status data
Notes: Included clinicians listed as MDs and DOs in NCQA data

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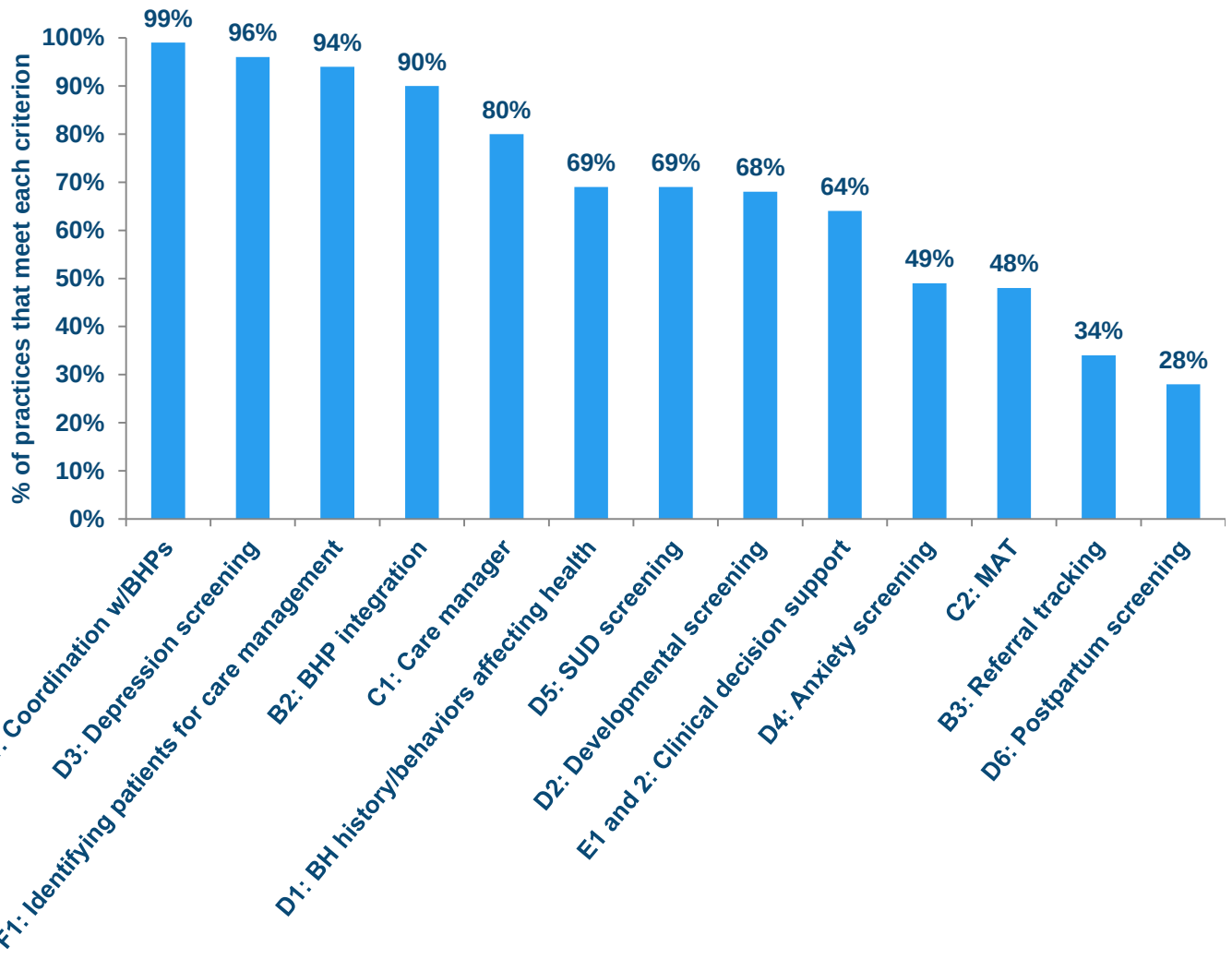
Percent of Practices that Submitted a PCMH PRIME Survey to NCQA that Meet Each Criterion



- **On average, practices that submitted a PCMH PRIME survey satisfy 9 criteria**
- The highest scoring practice met 13 criteria
- The most commonly met PCMH PRIME criteria is coordination with behavioral health providers through formal agreements, or colocation of behavioral health providers in primary care practice sites*
- The least commonly met criteria is postpartum screening

Source: Monthly NCQA reports on PCMH PRIME survey results
Notes: Practices submitting a PCMH PRIME survey to NCQA include the 79 PCMH PRIME certified practices and 1 practices that submitted a survey but failed to achieve certification. For the practices that initially failed the survey review but later achieved certification, only the second PCMH PRIME surveys are included.
For D2, practices that marked this criterion as N/A have been removed from denominator.
*Practices that satisfy B2 automatically receive credit for B1.

NCQA Training Participation

In conjunction with NCQA, the HPC has held a variety of trainings on criteria, documentation requirements, and application processes.

9
PCMH PRIME webinars

~192 attendees

93% of survey respondents found trainings effective

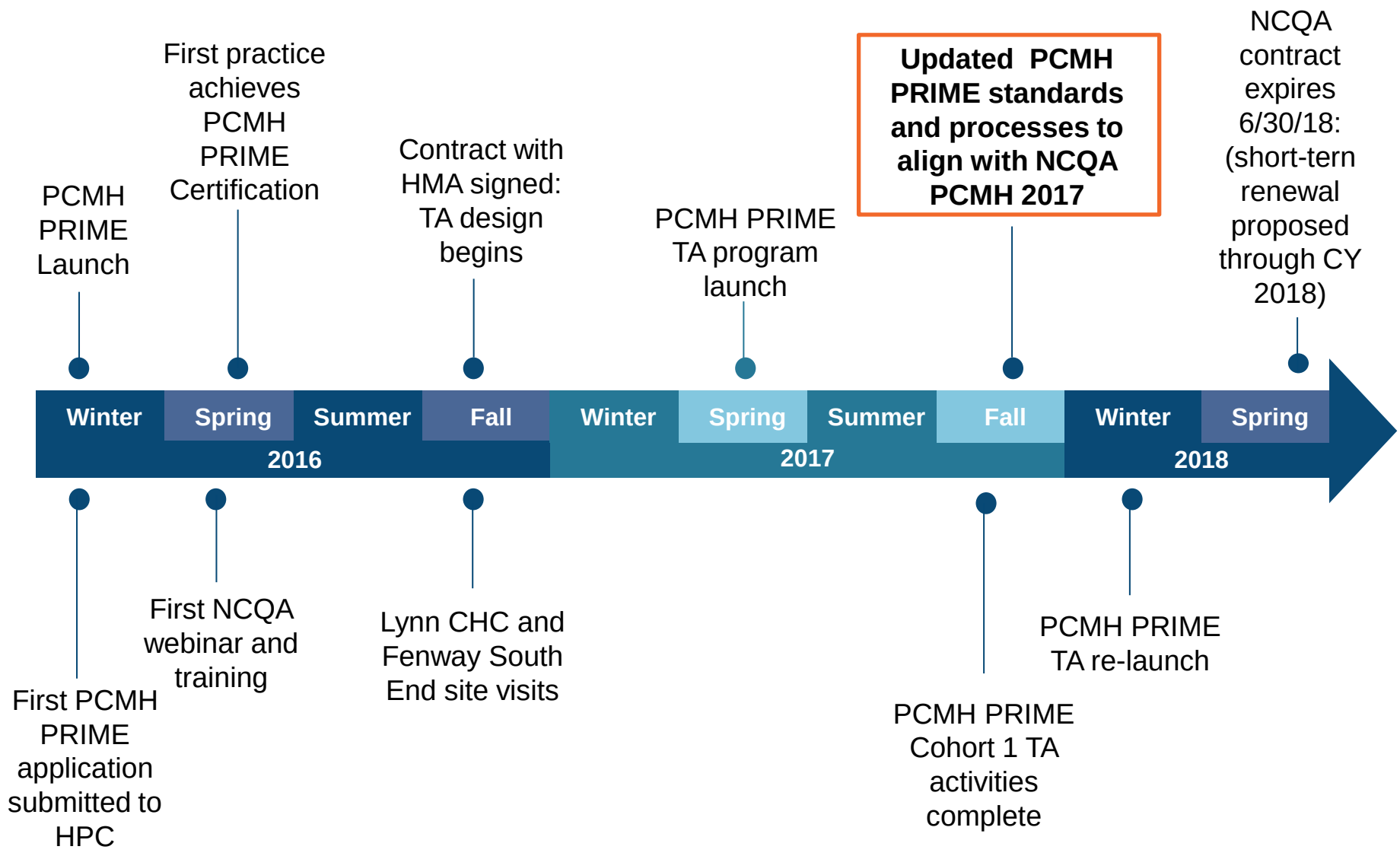
5
in-person PCMH trainings

171 attendees

96% of survey respondents found trainings effective

Source: HPC PCMH PRIME program status data, including evaluation surveys for NCQA trainings

PCMH PRIME Milestones



PCMH PRIME Strategy Development

Several factors, both operational and strategic, are driving the need to consider the future of PCMH PRIME.

HPC's contract with NCQA expires on **June 30, 2018.**

The first practice's PCMH PRIME Certification will expire on **May 17, 2019.** Any new standards or program requirements should be implemented at least six months prior.

In 2017, NCQA introduced the updated PCMH Recognition program, including a **Distinction in BHI** module to recognize PCMH practices that achieve BHI capabilities.

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PCMH PRIME in Context: HPC's Vision for Care Delivery Transformation

PCMH certification is just one of various levers in HPC's toolbox to promote our care delivery transformation vision.

CARE DELIVERY TRANSFORMATION

Primary Policy Aim: Promote an efficient, high-quality system with aligned incentives that reduces spending and improves health by delivering coordinated, patient-centered and efficient health care that accounts for patients' behavioral, social, and medical needs through the support of aligned incentives between providers, employers and consumers.

HPC Programmatic, Policy and Research Areas

- Certification programs (ACO, PCMH)
- PCMH and ACO technical assistance programs
- Investment programs (CHART, HCII, new investments)
- Learning and dissemination activities
- Program evaluation
- Policy convening and development work including:
  - Alternative payment methods expansion
  - Quality measurement alignment and improvement
  - Strategic collaborations with other state agencies (e.g. MassHealth, GIC, Connector, DPH, DMH)
- Office of Patient Protection (OPP)
- Research (e.g., avoidable acute care utilization, behavioral health integration, opioid epidemic)

PCMH PRIME in Context: Key BHI Policies and Programs

EOHHS BH Investment and Reforms

- **Over $600 million in new funding** over five years to address treatment gaps and increase service rates[1]
- **Improving BH care coordination** for MassHealth members through the Behavioral Health Community Partners program beginning July 2018[2]
- **Restructuring and strengthening** the Department of Mental Health's Adult Community Clinical Services program beginning July 2018[1]

Medicare reimbursement for BHI

- In 2017, CMS introduced **new Medicare billing codes for BHI services**
- Three codes are used to bill for monthly Collaborative Care model services
- One code is used to bill for monthly non-CoCM BHI services[3]

NCQA Distinction in BHI Program

- In 2017, NCQA introduced the Distinction in BHI program to **recognize PCMH practices that achieve BHI capabilities**[4]
- The Distinction in BHI includes 9 PCMH PRIME criteria

1 "Reforms to strengthen and improve behavioral health care for adults". Executive Office of Health & Human Services. January 17, 2018. https://www.mass.gov/files/documents/2018/01/24/bh-system-restructuring-document_1.pdf

2 "Payment and Care Delivery Innovation; FACT SHEET: Specialists (including medical specialists, home health, and DME)." Executive Office of Health & Human Services. April 23, 2018. https://www.mass.gov/files/documents/2018/04/23/PCDI-FS-SPC%20%28Rev.%2004-18%29.pdf

3 "MLN Fact Sheet: Behavioral Health Integration Services". Medicare Learning Network, Center for Medicare and Medicaid Services, U.S. Department of Health & Human Services. ICN 909432, January 2018. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BehavioralHealthIntegration.pdf

4 "NCQA PCMH Standards and Guidelines (2017 Edition)". National Committee for Quality Assurance, http://store.ncqa.org/index.php/catalog/product/view/id/2776/s/2017-pcmh-standards-and-guidelines-epub/

NCQA's Distinction in Behavioral Health Integration Program Released Fall 2017

NCQA PCMH Recognized practices are eligible to seek NCQA's Distinction in Behavioral Health Integration; practices may apply for NCQA PCMH Recognition and Distinction in BHI concurrently

- NCQA's Distinction in BHI has **18 criteria – 11 core and 7 elective.**
- Practices seeking this distinction must meet ***all core criteria*** and ***two elective credits.***
- 7 BHI distinction criteria are also included in the PCMH Recognition standards
- 8 BHI Distinction criteria are the same as or similar to PCMH PRIME criteria
- There is no additional application fee for practices that apply for BHI Distinction concurrently with PCMH Recognition

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PCMH PRIME Standards vs. NCQA's Distinction in BHI

	PCMH PRIME	NCQA Distinction in BHI
Eligibility	NCQA PCMH Recognized practices (MA only)	NCQA PCMH Recognized practices (all states)
Certification/ recognition period	3 years	1 year- after initial application, practices submit abbreviated documentation to maintain distinction
Total number of criteria	13 criteria	18 criteria
# of criteria needed to pass	Any 7 criteria	13 criteria, including all 11 "core" criteria and any 2 of 7 "elective" criteria
Overview of standards	• Information sharing with BH providers • Integration of BH providers into primary care • Referral tracking and follow up • Comprehensive health assessment including BH screenings (6 criteria) • Identifying high-risk patients for care management • Care manager to support patients with BH needs • Evidence-based decision support • Medication-assisted treatment	• Includes 9 PCMH PRIME criteria • Additional components of the collaborative care model such as brief interventions, consultative relationship with a BH provider, and monitoring BH symptoms and adjusting care • BH resources and training for care team • Integrated health record and care plans for behavioral and physical health • Monitoring of BH clinical quality measures and taking action to improve performance • Controlled substance database review

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Recommendation for the Future of PCMH PRIME

We recommend that the **HPC adopt NCQA's Distinction in BHI by spring 2019, and contract with NCQA to cover practice application fees and provide trainings.**

- Adopting BHI Distinction would allow HPC to **maintain focus and momentum on BHI**, while pushing for **increased care delivery transformation** via more challenging standards and continued work with the ~100 practices in the program
- Aligning with both NCQA standards and program operations allows for **administrative simplification for practices and the HPC**
- Covering NCQA's Distinction in BHI application fees and sponsoring trainings would offer **incentives to practices,** and **enable HPC to receive data from NCQA** on practice Distinction in BHI results
- Adopting the BHI distinction module by spring 2019 **will allow the new standards to go into effect** prior to the first PCMH PRIME Certification expiration date when practices will begin to renew certification

Operational Details for Recommended Approach

Content of standards

NCQA Distinction in BHI standards will replace current PCMH PRIME criteria. Distinction in BHI would represent a **higher bar, with more standards and more advanced capabilities** required than PCMH PRIME.

Long-term contract renewal w/NCQA	✓	**HPC sponsors PCMH seminars**	✗
HPC covers practice application fees	✓	**HPC sponsors Distinction in BHI webinars**	✓
HPC receives data on practice performance	✓		
HPC pays NCQA for program marketing	✗	**HPC pays NCQA to develop standards**	✗

Advantages

- Increased alignment with NCQA standards and maintains NCQA relationship
- Opportunity to advance market through more advanced standards
- Provides support to practices for BHI Distinction
- HPC continues to receive data on practice performance (though not screening rates)
- Moderate reduction of HPC staff resources required over time

Disadvantages

- Some practices may not be able to meet higher standards for BHI
- HPC loses control over standards and no longer makes final certification decisions

Recommended Approach for Trainings

We recommend that the **HPC offer webinars on NCQA's Distinction in BHI but *not* continue to offer in-person PCMH seminars.** Paying for BHI Distinction webinars will allow the HPC to publicize and support practices in applying for the Distinction in BHI. Given in-person seminars mostly focus on basic PCMH Recognition content, we can better deploy those resources elsewhere.

NCQA trainings are distinct from the PCMH PRIME technical assistance program. **We recommend revisiting the future of PCMH PRIME TA once a decision about program criteria/structure has been reached.**

Distinction in BHI Webinars

- **90-minute webinars** providing an overview of Distinction in BHI standards and application process
- NCQA is not currently providing Distinction in BHI webinars

PCMH seminars

- **1.5 day in-person seminars** providing an overview of NCQA's PCMH standards and application processes
- Historically these trainings have included a unit on PCMH PRIME

PCMH PRIME TA

- **Practice coaching, webinars, and knowledge sharing sessions** provided by Health Management Associates to support practices in building BHI capabilities
- Modest uptake to date

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Stakeholder Feedback on Distinction in BHI

The HPC solicited feedback from a few PCMH PRIME Certified practices on the Distinction in BHI standards, including a range of practices types (e.g. community health centers, practices within a large health system, and smaller practices).

Value of standards

- Practices generally agreed that the standards appropriately describe high-quality, evidence-based care
- Some practices are already implementing most or all capabilities described in the BHI Distinction

Feasibility

- Some practices stated that certain “Core” criteria (BH03, BH06, BH07) would be a barrier to BHI Distinction due to cost or administrative burden
- Documenting some capabilities may be difficult
- Standards may be particularly challenging to small to moderately sized practices that are not integrated into a larger system

Additional content suggestions

- Some practices suggested additional content areas for HPC to explore:
  - Access to BH care
  - Supporting BH needs of patients with other chronic conditions
  - Supporting the needs of vulnerable populations
  - BH process improvement
  - Trauma-informed Care

Key Upcoming Dates

May 24 - June 1, 2018 – Stakeholder engagement with select PCMH PRIME Certified practices

June 13, 2018 – Discuss recommendations with CDT

By June 30, 2018 – Extension contract with NCQA

September 12, 2018 – HPC Board vote on program revisions

November 15, 2018 – Target date to announce new program standards

May 17, 2018 – First practice's PCMH PRIME Certification expires

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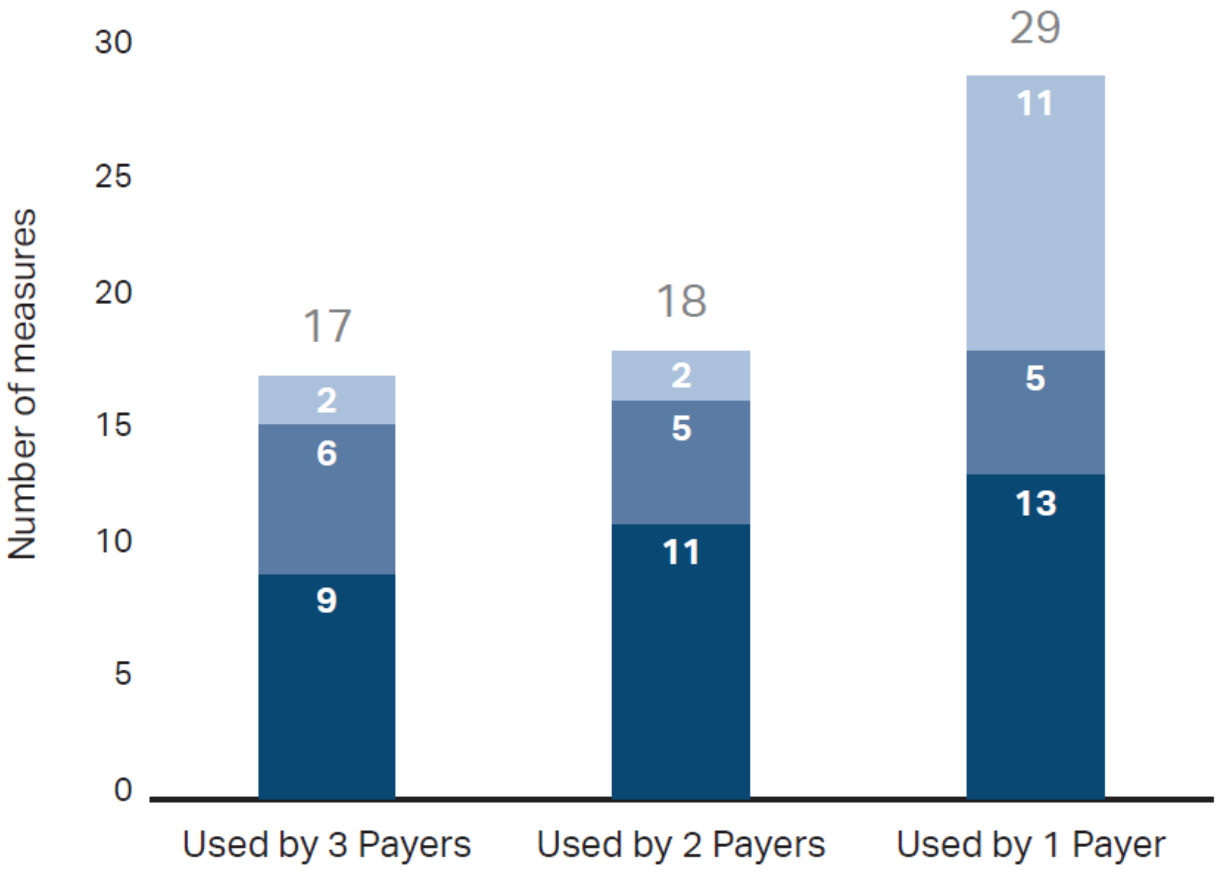
Quality Measure Misalignment Across Commercial Payers in MA, 2017



SOURCE: HPC analysis of payer-reported data on quality measure use in 2017

Quality Measure Alignment Taskforce and DSRIP Subcommittee Overview

In the spring of 2017, EOHHS convened the Quality Measure Alignment Taskforce and DSRIP Subcommittee with representatives from the provider, payer, consumer, advocate and academic communities with expertise in health care quality measurement. EOHHS also engaged Michael Bailit (Bailit Health Purchasing LLC) as the taskforce facilitator.

Quality Measurement Taskforce Goals

1. Develop a multi-payer aligned measure set for use in ACO contracts beginning in 2019
2. Identify where current measure gaps exist and develop a strategy to address them

DSRIP Subcommittee Goals

3. Advise MassHealth on quality measures and methodology for ACOs, Community Partners, and other DSRIP programs
4. Advise MassHealth on developmental measures, included those that CMS is requiring under the terms of the 1115 waiver and DSRIP

Taskforce Participants

Stakeholder type	Participant
Medical Provider	Boston Children's Hospital South End Community Health Center Dimock Health Center Atrius Health Partners HealthCare
BH Provider	Lynn Community Health Center Behavioral Health Network
Academic / Measurement Expert	Arlene Ash, UMass Medical School* Barbra Rabson, MA Health Quality Partners* Aswita Tan-McGrory, Disparities Solution Center
Consumer/ Advocate	Dennis Heaphy, Disability Policy Consortium* Lisa Iezzoni, Mongan Health Policy Institute*
Payer (BH)	Massachusetts Behavioral Health Partnership*
Payer (Commercial)	Tufts Health Plan Harvard Pilgrim Health Care Blue Cross Blue Shield of MA
Payer (Public)	Tufts Public Plans Commonwealth Care Alliance* Health New England

State agency	Participant
EHS Co-Chair	Lauren Peters
MassHealth Co-Chair	Ipek Demirsoy
CHIA	Ray Campbell
DMH	David Tringali*
GIC	Roberta Herman
DPH	Kate Fillo*
HPC	Katie Shea Barrett
MassHealth	Linda Shaughnessy* Alon Peltz*
DOI	Kevin Beagan

***Subcommittee Member also**

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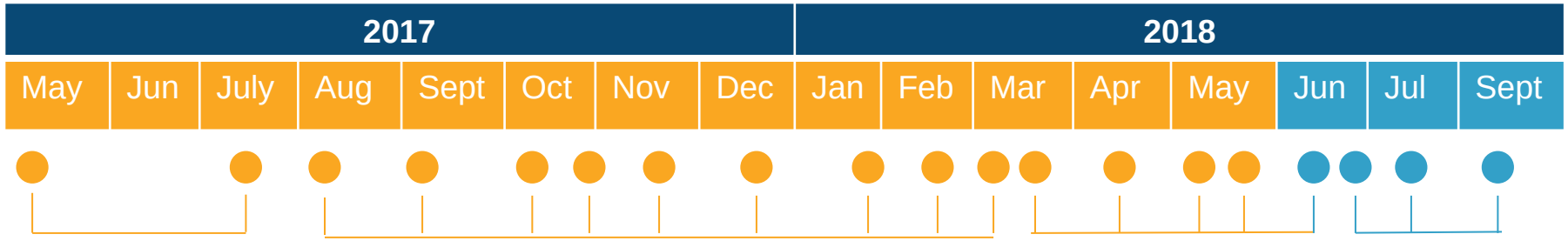
Taskforce Process



Meetings 1-2

- Describe current landscape
- Agree on guiding principles
- Lay groundwork for Taskforce process

Meetings 3-12

- Review candidate measures
- Identify measure gaps warranting measure development

Meetings 13-18

- Second pass review of measures
- Resolve question of Core/Menu
- Identify final set of Core and Menu measures

Meetings 19-20

- Plan for implementation
- Discuss the process for maintenance of the measure set
- Plan for gap-filling/and developmental measure testing

Guiding Principles

Purpose: The overarching aim of the measure set is to promote multi-payer alignment in global budget alternative payment model (APM) contracts in Massachusetts. Measures do not need to satisfy all of the guiding principles in order to be selected.

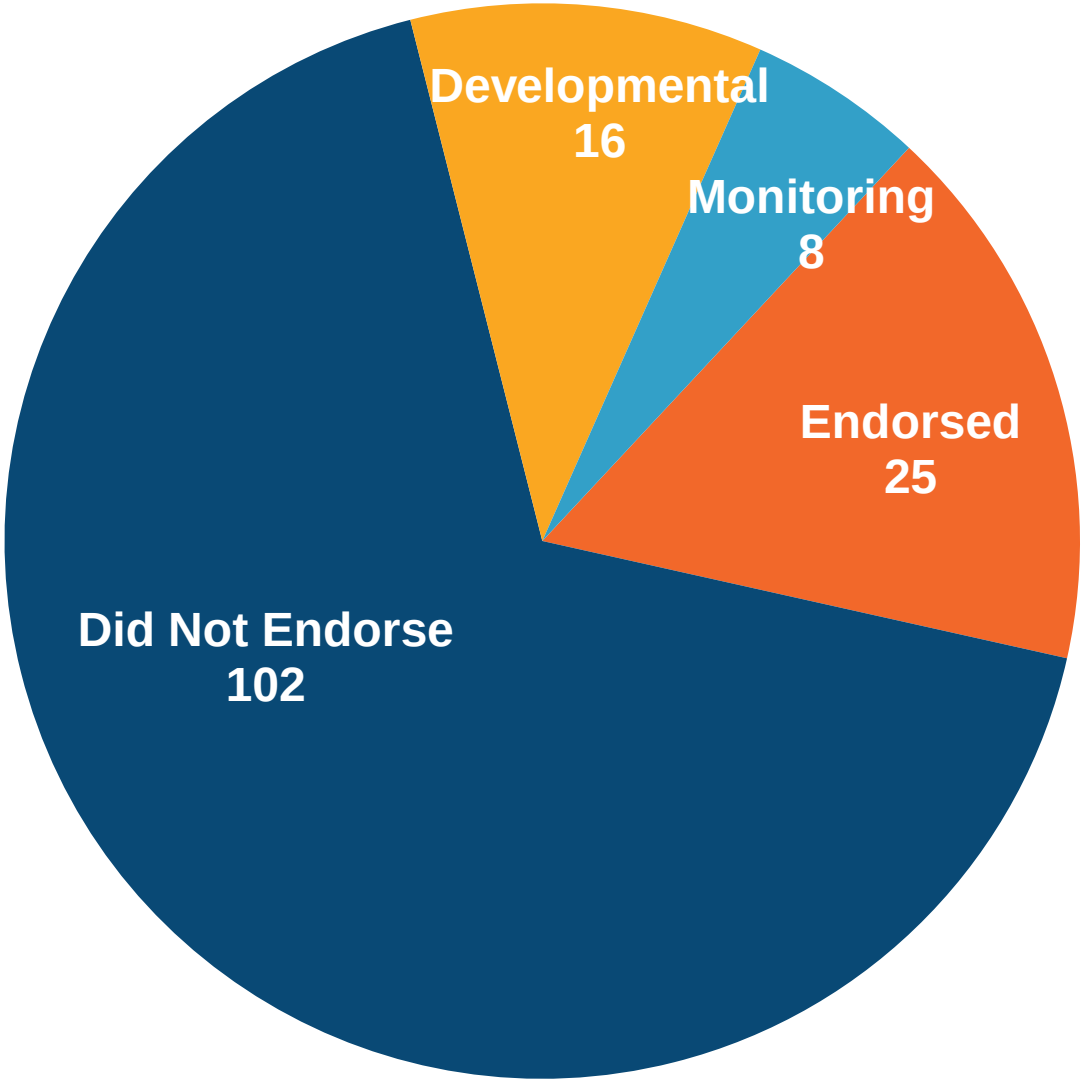
Principles to be Applied to Individual Measures

1. Evidence-based, scientifically acceptable, nationally-endorsed and valid at the level at which it is being used (ACO-level in particular).
2. Required data should be either readily available, not overly burdensome to collect, or, if burdensome, of demonstrable value for improving patient care.
3. Represents an opportunity for improvement
4. Is important to consumers and supports the triple aim of better care, better health and lower cost.

Principles to be Applied to the Measure Set

1. Prioritize health outcomes, including measures sourced from clinical and patient-reported data.
2. Provide a largely complete and holistic view of the entity being evaluated (e.g., ACO, primary care practice, hospital).
3. The measure set should strive for parsimony.
4. Taken as a whole, high performance on the proposed measure set should significantly advance the delivery system toward the goals of safe, timely, effective, efficient, equitable, patient-centered (STEEEP) care.
5. Promotes value for consumers, purchasers, and providers.

The Taskforce reviewed over 150 measures and endorsed 25 measures



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Endorsed Measures by Domain

Domain	Sub-Domain	Number of Endorsed Core/Menu Measures	Number of Endorsed Monitoring Measures	Number of Tentatively Endorsed Developmental Measures
Prevention and Early Detection	Physical Health Conditions	8	3	1
	Mental Health Conditions	1	0	1
	SUD Conditions	0	0	1
	Oral Health Conditions	0	0	1
Chronic Illness Care	Physical Health Conditions	5	2	4
	Mental Health Conditions	6	0	0
	SUD Conditions	3	0	0
Acute Care		1	0	2
Maternity Care		0	3	0
Equity		0	0	2
Social Determinants of Health		0	0	1
Patient Experience		1	0	2
Integration		0	0	1
Total		**25**	**8**	**16**

Taskforce Decision Points and Process Milestones

April 26, 2018: Taskforce vote on Core/Menu set approach (Yes-20; No-4; Absent-4)

March 8, 2018: Taskforce tentative decision to allow for a limited number of additional supplemental and developmental measures per contract

March-June 2018: Select measures for the Core and Menu sets

July 2018: Bailit Health Purchasing completes preliminary report

Aug 2018: Opportunity for public comment and finalize report

Sept-Dec 2018: Begin discussions around gap filling and developmental measures

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MASSACHUSETTS
HEALTH POLICY COMMISSION

AGENDA

- Call to Order
- Approval of Minutes
- CDT Updates
- PCMH PRIME Strategy Recommendations
- Quality Measure Alignment Taskforce Update
- **Transforming Care: The CHART Playbook Preview**
- Schedule of Next Meeting (October 3, 2018)

CHART Phase 2: Concluding Activities

CHART Phase 2 Contract Close Out

- Determining Achievement Payment – Spring 2018
- Finalizing No Cost Extension work – Summer 2018
- Conducting financial reconciliation – Summer/Fall 2018

Learning and Dissemination Output

- Cultivating lessons learned - Ongoing
- Creating CHART Playbook – Late summer 2018

BUSPH Evaluation Deliverables

- Patient Perspective report – Summer 2018
- ACO Readiness report – Summer 2018
- Final Summative report – Summer 2019

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Purpose of the Playbook

The Playbook is a **practical guide** to implementing population health management for patients with complex social, behavioral, and medical needs.

It draws from the experience of the CHART Phase 2 cohort which deployed **multi-disciplinary teams** to enhance **community-based care**.

What lessons from CHART are providers looking for?

Question		Response	Playbook Approach
What do providers want to learn?	1	Practical ways to address social and behavioral determinants	Concrete programmatic guidance to address BH and SDH
How do providers want to learn?	2	With practical and succinct resources	Straightforward explanatory narrative with relevant tools and templates
What *best practices* should HPC adopt?	3	Responsive, layered, and actionable strategies	Comprehensive operational insights that managers can adapt to suit their needs

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What is the right tone for a practical guide?

Style:
Practical, explanatory, accessible, actionable

Audience:
Multi-disciplinary care team managers at provider organizations

CHART Playbook Outline

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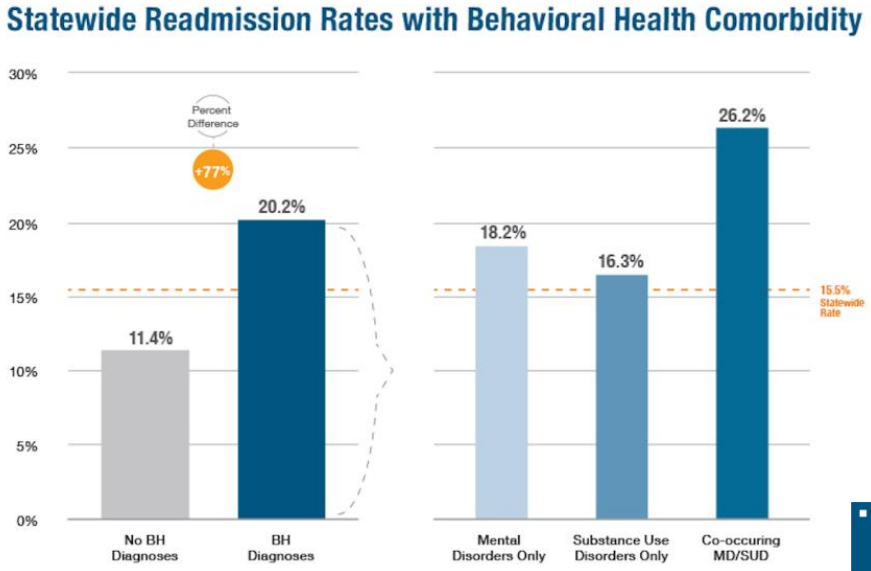
Excerpt from Lesson 1 - Identifying Patients

Outline: Lesson 1

- Defining and identifying vulnerable populations
  - **Clinical criteria-based case finding**
  - Audit administrative behavioral health patient identification with clinical data
  - Utilization-based case finding
  - Screening for social determinants of health
- Case finding efficacy and iteration



CHIA.

Method A - Clinical screen-based case finding

Summary: While this is the most resource intensive method, it is also the most accurate. Using this method will result in a low number of false positives, false negatives, and missed patients. A face-to-face screen or comprehensive medical chart review can provide a more nuanced understanding of the patient and their situation.

Strengths	Limitations
• Identifies patients at the point-of-care using clinical criteria, providing a high level of confidence that patients are flagged appropriately • Allows for initial level of face-to-face contact with the patient	• Time and labor intensive method • No ability to construct historical baseline data, as you cannot retroactively screen patients

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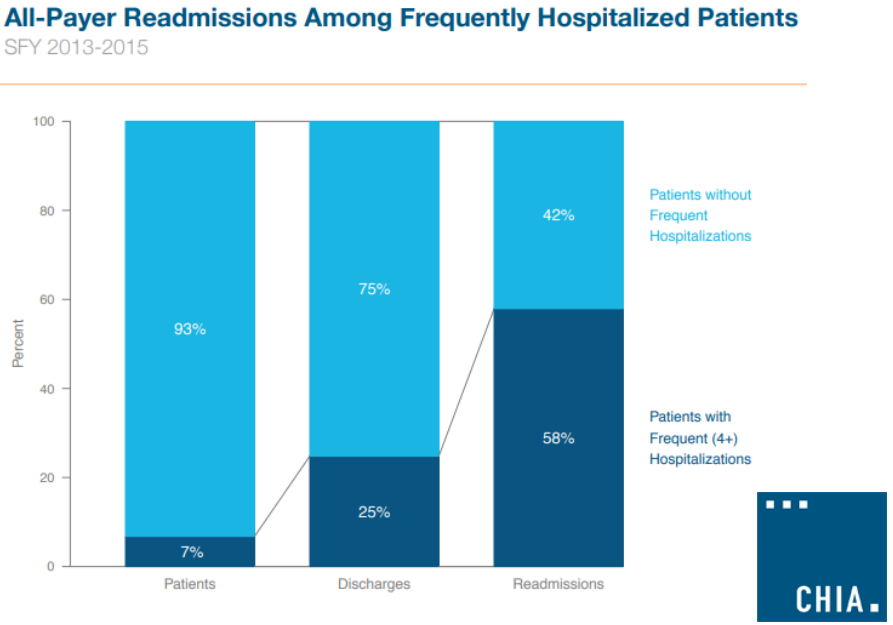
Excerpt from Lesson 1 - Identifying Patients

Outline: Lesson 1

- Defining and identifying vulnerable populations
  - Clinical criteria-based case finding
  - Audit administrative behavioral health patient identification with clinical data
  - **Utilization-based case finding**
  - Screening for social determinants of health
- Case finding efficacy and iteration



Method C - Utilization-based case finding

Summary: This method is diagnosis agnostic and, as a result, can identify patients with wide-ranging diagnoses or SDH. Patients identified through this method should be contextualized to understand their drivers of acute care utilization.

Strengths	Limitations
• Relatively low administrative and analytical burden overall compared to clinical-factor patient identification approaches (Methods A and B) • Enables forecasting of target population size • Enables flexible target population sizing and triage by utilization/time ratio	• False positives are more likely since episodic "multi-visit patients" will appear in this query (i.e., OB patients, cancer patients, post-surgical patients who require follow-up) • Evaluating program efficacy is challenging due to the natural fluctuations in utilization by this population. (See Lesson 5 for more on creating historical controls)

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Excerpt from Lesson 1 - Identifying Patients

Outline: Lesson 1

- Defining and identifying vulnerable populations
  - Clinical criteria-based case finding
  - Audit administrative behavioral health patient identification with clinical data
  - Utilization-based case finding
  - **Screening for social determinants of health**
- Case finding efficacy and iteration

Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context	Healthcare System
— Employment income — Expenses — Debt — Medical bills — Support	— Housing — Transportation — Safety — Parks — Playgrounds — Walkability	— Literacy — Language — Early childhood education — Vocational training — Higher education	— Hunger — Access to healthy options	— Social integration — Support systems — Community engagement — Discrimination	— Health coverage — Provider availability — Provider linguistic and cultural competency — Quality of care

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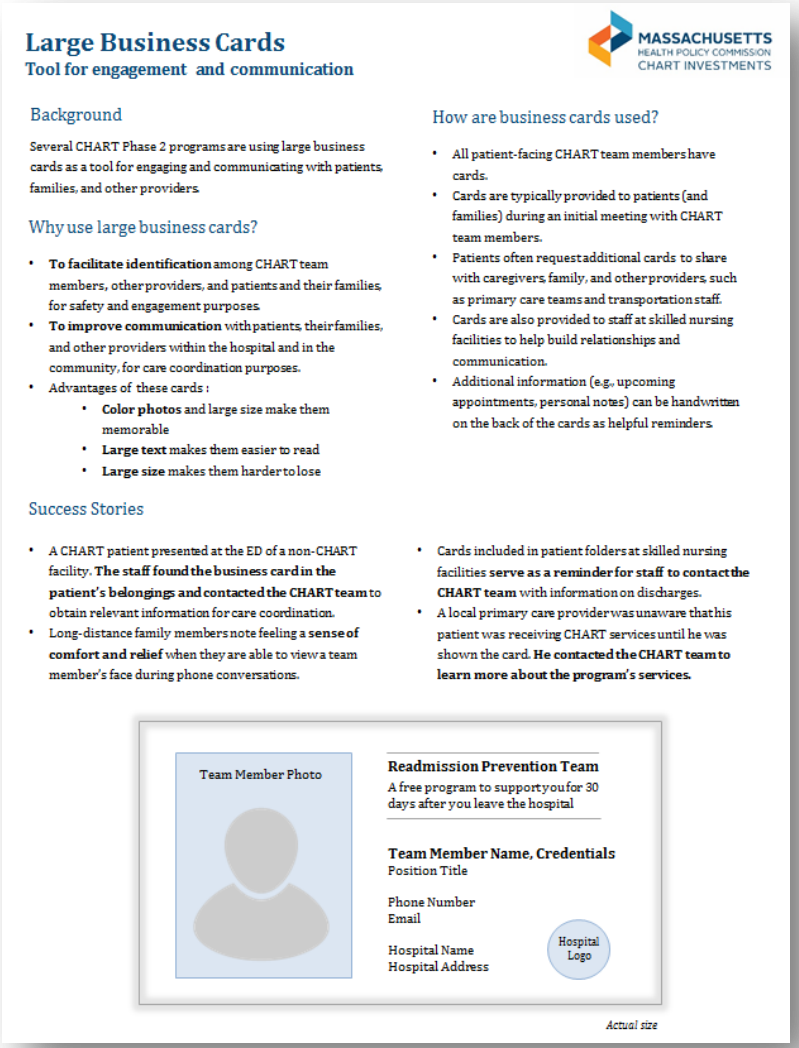
Example Tool in Playbook

Outline: Tools

- Social determinants of health screening questionnaire
- Patient tracking registry
- Comprehensive needs assessment
- **Large Business Cards**
- Example program brochure
- Readmission Review Tool
- Discharge Checklist
- Longitudinal care plan template
- 48 hour follow-up script
- Example program newsletter
- Team Daily Huddle tool
- Home visit safety protocol
- Primary Care Provider outreach letter
- SNF capabilities checklist
- Community resource inventory template
- Enabling technology vendor key qualities



Large Business Cards
Tool for engagement and communication

MASSACHUSETTS HEALTH POLICY COMMISSION CHART INVESTMENTS

Background

Several CHART Phase 2 programs are using large business cards as a tool for engaging and communicating with patients, families, and other providers.

Why use large business cards?

- **To facilitate identification** among CHART team members, other providers, and patients and their families, for safety and engagement purposes.
- **To improve communication** with patients, their families, and other providers within the hospital and in the community, for care coordination purposes.
- Advantages of these cards :
  - **Color photos** and large size make them memorable
  - **Large text** makes them easier to read
  - **Large size** makes them harder to lose

How are business cards used?

- All patient-facing CHART team members have cards.
- Cards are typically provided to patients (and families) during an initial meeting with CHART team members.
- Patients often request additional cards to share with caregivers, family, and other providers, such as primary care teams and transportation staff.
- Cards are also provided to staff at skilled nursing facilities to help build relationships and communication.
- Additional information (e.g., upcoming appointments, personal notes) can be handwritten on the back of the cards as helpful reminders.

Success Stories

- A CHART patient presented at the ED of a non-CHART facility. **The staff found the business card in the patient's belongings and contacted the CHART team** to obtain relevant information for care coordination.
- Long-distance family members note feeling a **sense of comfort and relief** when they are able to view a team member's face during phone conversations.
- Cards included in patient folders at skilled nursing facilities **serve as a reminder for staff to contact the CHART team** with information on discharges.
- A local primary care provider was unaware that his patient was receiving CHART services until he was shown the card. **He contacted the CHART team to learn more about the program's services.**

Team Member Photo

Readmission Prevention Team
A free program to support you for 30 days after you leave the hospital

Team Member Name, Credentials
Position Title

Phone Number
Email

Hospital Name
Hospital Address

Hospital Logo

Actual size

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2018 Meetings and Contact Information

Board Meetings

Wednesday, July 18, 2018
Wednesday, September 12, 2018
Thursday, December 13, 2018

Committee Meetings

Wednesday, June 13, 2018
Wednesday, October 3, 2018
Wednesday, November 28, 2018

Contact Us

Mass.Gov/HPC
@Mass_HPC
HPC-Info@state.ma.us

Special Events

Monday and Tuesday, October 15 and 16, 2018: Cost Trends Hearing

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Appendix

2017 PCMH PRIME Criteria

#	Criteria (practice must meet ≥ 7 out of 13)
1	The practice has at least one **care manager** qualified to identify and coordinate behavioral health needs.
2	The practice has at least one clinician located in the practice who provides **medication-assisted treatment**, and **provides behavioral therapy** directly or via referral, for substance use disorders.
3	The practice works with behavioral healthcare providers to whom the practice frequently refers, to **set expectations for information sharing and patient care.**
4	The practices **integrates behavioral healthcare providers** into the care delivery system of the practice site.
5	The practice **tracks referrals** to behavioral health specialists and has a process to monitor the timeliness and quality of the referral response.
6	The practice conducts a comprehensive health assessment that includes **behaviors affecting health, and the mental health/substance use history of patient and family.**
7	The practice conducts **developmental screening** using a standardized tool for patients under 30 months of age.
8	The practice conducts **depression screenings** for adults and adolescents using a standardized tool.
9	The practice conducts **anxiety screenings** for adults and adolescents using a standardized tool.
10	The practice conducts **alcohol use disorder or other substance use disorder screenings** for adults and adolescents using a standardized tool.
11	The practice conducts **postpartum depression screenings** using a standardized tool.
12	The practice implements **clinical decision support** following evidence-based guidelines for care of mental health conditions and substance use disorders.
13	The practice establishes a systemic process for **identifying patients who may benefit from care management**, and criteria that include consideration of behavioral health conditions.

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NCQA Behavioral Health Distinction Criteria

BH 01 (Core)	**Has at least one care manager qualified to identify and coordinate behavioral health needs**
BH 02	Provides resources and training for the care team to enhance its capacity to address the behavioral health needs of patients (Practices must meet 5/6 sub-criteria)
BH 03 (Core)	**Has at least one clinician located in the practice who can directly provide brief interventions on an urgent basis for patients identified with a behavioral health condition**
BH 04	Has at least one clinician located in the practice who can support medication-assisted treatment (MAT), and provide behavioral therapy directly or via referral, for substance use disorders
BH 05 (Core)	**Works with behavioral healthcare providers to whom the practice frequently refers, to set expectations for information sharing and patient care**
BH 06 (Core)	**Has a formal agreement/consultative relationship with a licensed behavioral health provider or practice group that acts as a resource for patient treatment, referral guidance and medication management**
BH 07 (Core)	**Tracks referrals to behavioral health specialists and has a process to monitor the timeliness and quality of the referral response**
BH 08	The practice has a single integrated health record for a patient's physical and behavioral health information or has a protocol for exchanging information
BH 09	Care plan is integrated and accessible by both primary care and specialty behavioral health providers

NCQA Behavioral Health Distinction Criteria, continued

BH 10	Reviews controlled substance database when prescribing relevant medications
BH 11 (Core)	**Conducts depression screenings for adults and adolescents using a standardized tool**
BH 12 (Core)	**Conducts behavioral health screenings and/or assessments using a standardized tool. (Implement two or more of the following screenings : anxiety, AUD, SUD, pediatric BH screening, PTSD, ADHD, postpartum depression)**
BH 13 (Core)	**Implements clinical decision support following evidence-based guidelines for care of mental health conditions**
BH 14 (Core)	**Implements clinical decision support following evidence-based guidelines for care of substance use disorders**
BH 15 (Core)	**Monitors and assesses symptoms over time for patients identified with a mental health or substance use condition and adjusts the treatment plan for patients who do not demonstrate improvement**
BH 16	Monitors and assesses symptoms over time for patients identified with a mental health or substance use condition and adjusts the treatment plan for patients who do not demonstrate improvement. The practice monitors and assesses for both a mental health condition and substance use disorder
BH 17 (Core)	**Monitors performance using at least two behavioral health clinical quality measures**
BH 18	Sets goals and acts to improve upon at least two behavioral health clinical quality measures

Distinction in BHI vs. PCMH PRIME Costs

For both Distinction in BHI and PCMH PRIME, no additional fees are charged to practices that apply concurrently with initial PCMH recognition. The below fees would be charged to practices applying during PCMH annual reporting or separately from any PCMH-related submissions.

Overall, **the Distinction in BHI is more expensive** than PCMH PRIME. The HPC may be able to negotiate fees with NCQA to minimize this additional expense.

Distinction in BHI pricing

	Single-site	Multi-site
Clinicians 1-12	$250 per clinician	$125 per clinician
Clinicians 13+	$25 per clinician	$12.50 per clinician

PCMH PRIME pricing

First clinician	$275 per clinician
Clinicians 2-12	$137.50 per clinician
Practices with 13-50 clinicians	$1787.50 total
Practices w/51+ clinicians	$1787.50 + $10 for each clinician after #50