CHART LEADERSHIP SUMMIT: PROCEEDINGS REPORT

A Report on the Proceedings of the Community Hospital Acceleration, Revitalization, & Transformation (CHART) 2014 Leadership Summit

Massachusetts Health Policy Commission
Worcester, MA | September 2, 2014

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In order to facilitate collaborative learning across community hospitals in Massachusetts and develop a shared vision of community hospital transformation, the Health Policy Commission (HPC) organized a one-day executive leadership summit on September 2, 2014. The event brought together senior leaders from hospitals participating in the Community Hospital Acceleration, Revitalization, and Transformation (CHART) Investment Program to focus on principles of quality improvement, strategic and operational planning for system transformation, and change management.

CHART Program

Established through the Commonwealth's 2012 health care cost containment law, CHART is a $120 million competitive investment program. Through CHART, the HPC invests in eligible community hospitals to enhance their delivery of efficient, effective care. In October 2013, the HPC awarded $10 million to 28 community hospitals through CHART Phase 1 to support short term, high-need expenditures. The HPC awarded an additional $60 million in funding in October 2014, which focused on maximizing appropriate hospital use and enhancing behavioral health care.

CHART Leadership Summit

Over 175 senior executives - including hospital board members, chief executive officers, and other chief officers and directors responsible for key clinical and administrative functions - gathered in Worcester, MA to participate in the Leadership Summit. The agenda for the CHART Leadership Summit featured presentations from Massachusetts officials and expert faculty in the fields of delivery system transformation, patient safety and reliability, performance measurement and improvement, organizational learning, leadership, and teamwork. In addition to interactive content-delivery sessions, CHART awardees led smaller breakout session through which participants had the opportunity to engage with each other and share lessons from ongoing transformation efforts.

Summit Themes: From Volume to Value

Massachusetts spends more per person on health care than any other state—nearly $9,300 per person each year.[1] This amount is 36% higher than the national average, or a difference of nearly $2,500. Given growing public concern for health care costs as well as a rapidly changing market for hospital services, the CHART Leadership Summit emphasized helping community hospital leaders develop strategies to move their organizations from volume-based to value-based financial and clinical models. The following key themes emerged from the summit:

- **Common Characteristics of any Transforming Hospital:** While community hospitals are highly heterogeneous, all transforming organizations require focus on approaches to managing the health of populations, ensuring safety and reliability, adopting new business models and payment approaches, and building effective partnerships with community organizations.

- **Moving from Community Hospitals to Community Health Systems:** Community hospitals can and should serve as hubs of local innovation. As such, they must align to meet communities' needs—moving away from an inpatient-anchored model and toward an outpatient-centric, whole-person model of care across settings and time. In doing so, community hospitals will have to find effective ways to build partnerships across the care continuum with other hospitals, health care providers, local public health departments, and social service providers (e.g. housing, nutrition).

- **Accelerate Payment Reform**: While uneven payment strategies from the payer community could frustrate the progress of community hospital transformation, the move toward value-based payment in Massachusetts is underway and decisive. Hospital success in a value-driven environment demands clinical and financial alignment with physicians and other providers. Many of the activities idealized in community health systems are not incentivized in a fee-for-service environment; accelerated movement towards al-

ternative payment approaches – including those that ensure participation by community hospitals without affiliated primary care physicians – is necessary to sustain meaningful change.

- **Support Integrated Models of Behavioral Health and Primary Care**: Caring for behavioral health patients is a challenge for all community hospitals. This is particularly emblemized by emergency department boarding of mental health and substance use disorder patients for days, if not weeks. Investment in the development of community-based care models that integrate primary, behavioral health, and acute services is necessary to ensure appropriate cross-continuum care. Models should further connect patients to community providers to prevent unnecessary hospitalizations and emergency department visits.

- **Culture is Central to any Transformation Effort:** Culture is highly varied across CHART hospitals, and even more so across units within hospitals. Culture change and organizational improvement needs to be a top priority of the CEO and senior leadership team in any transforming organizaiton and must be communicated to all staff in regular and visible ways.

- **Invest in Quality and Safety through Workforce Development**: Hospitals should create and sustain macro- and micro- level system changes in quality and safety by investing in workforce development, particularly middle managers. Leaders – and the HPC – should provide training on how to advance organizational change, monitor and measure improvement, communicate in ways that are psychologically safe, and set clear expectations. Executive leadership must be visible, and front-line staff must understand what they need to do to support a hospital's vision for transformation.

- **Investment is Necessary to Drive Transformation**: While hospitals are striving to transform to meet community needs in a changing health care environment, investment is necessary to drive meaningful change. Investment is particularly necessary to build structures for cutting edge data analytics, reconfiguration of service offerings, and workforce enhancement.

- **The HPC and the CHART Investment Program Play a Valuable Role in Convening and Providing Technical Assistance**: In addition to direct investments, CHART provides valuable resources through provider engagement. Future activities could include:
  - *Convening*: Workshops, meetings, and collaboratives for awardees to share learning, challenges, and best practices in a facilitated setting
  - *Direct Technical Assistance:* Guidance supporting specific needs of awardees
  - *Leadership Engagement:* Development of hospital leadership engagement opportunities, including skill development related to strategy and tactics of transformation
  - *Supportive Data and Analytics:* Development of data and analytic tools to support providers in driving transformation (e.g., rapid-cycle evaluation, high-risk patient identification, or performance benchmarking)
  - *Training*: Large scale training opportunities in topics such as Lean, principles of quality improvement, and applied analytics
  - *Dissemination*: Centralized library of tools such as videos, interactive media, and written resources to promote and share best practices and guidelines, fed by both awardees and the HPC's evaluation activities.

Summit Agenda

The schedule for the CHART Leadership Summit featured presentations from Massachusetts officials as well as expert faculty in the fields of delivery system transformation, patient safety and reliability, performance measurement and improvement, organizational learning, leadership, and teamwork. In addition to general sessions, participants had the opportunity to engage with each other in smaller breakout sessions led by fellow CHART awardees who shared lessons from ongoing transformation efforts in Massachusetts. Each session was facilitated by an HPC expert and included CHART hospital panelists. Consistent with the themes of the leadership summit, and based on the goals of the CHART program, the targeted topics included:

A. Enriching Community Partnerships
B. Skills and Principles of Safety, Reliability and Culture
C. Community Care and Population Health
D. Innovative Business Practices

Introduction: CHART Leadership Summit

In order to facilitate collaborative learning and information sharing across community hospitals in Massachusetts, the Health Policy Commission (HPC) organized a one-day in-person executive leadership summit on September 2, 2014. This session brought together senior leaders from hospitals participating in the Community Hospital Acceleration, Revitalization, and Transformation (CHART) program to develop a shared vision of community hospital transformation through a focus on principles and skills of quality improvement, strategic and operational planning for system transformation, and change management. Over 175 senior executives gathered in Worcester, Massachusetts to participate in the leadership summit, including hospital board members, chief executive officers, chief medical officers, chief nursing officers, chief financial officers, chief operating officers, chief strategy officers, and other directors responsible for key clinical and administrative functions such as finance, nursing, information technology, medicine, quality improvement, patient safety, behavioral health, and emergency services.

The following report summarizes the proceedings of the Leadership Summit, including faculty presentations, themes, and output from facilitated discussions among participants. Topics of the day included hospitals' strategies for change, best practices in existing change efforts, barriers to transformation, opportunities for cross-hospital collaboration, and strategies for leveraging CHART investments and related activities to drive transformation.

The Summit identified key themes and suggestions for driving change among community hospitals through the CHART program. A complete list of faculty and participants in the Leadership Summit is available in Appendix I.

Health Policy Commission

The Health Policy Commission was established in 2012 through the Commonwealth's landmark health care cost containment law, Chapter 224 of the Acts of 2012: "An Act Improving the Quality of Health Care and Reducing Costs through Increased Transparency, Efficiency and Innovation." The HPC is an independent state agency responsible for monitoring and moderating health care cost growth, improving access to quality accountable care, and reforming the way health care is delivered and paid for in Massachusetts.

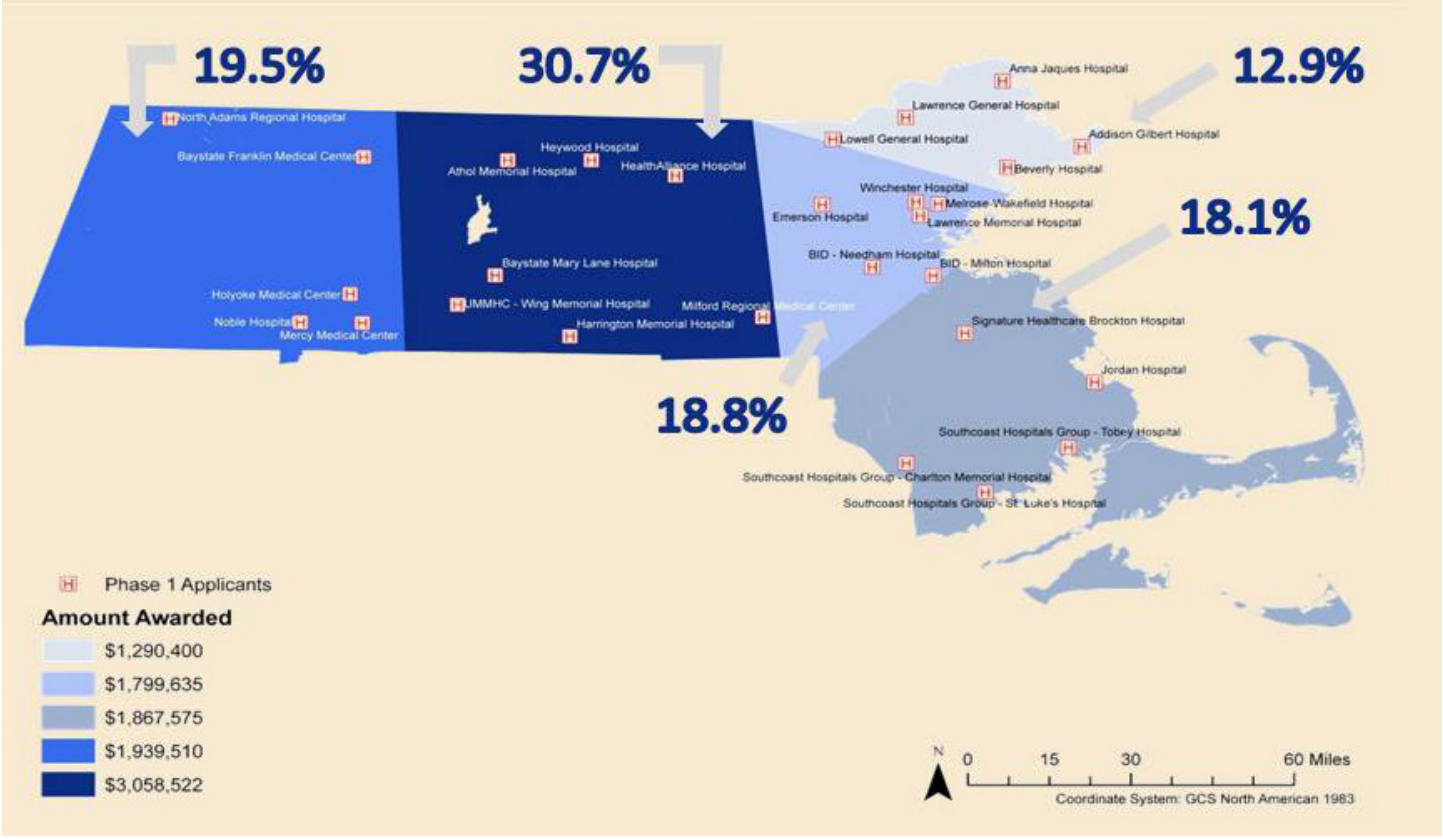
Community Hospital Acceleration, Revitalization, & Transformation Program

Established through Chapter 224, CHART is a $120 million reinvestment program funded by an assessment on large health systems and commercial insurers. CHART will make phased awards to certain Massachusetts community hospitals to enhance their delivery of efficient, effective care. The goal of the program is to promote care coordination, integration, and delivery transformations; to advance the adpotion of electronic health records and information exchange among providers; to increase alternative payment methods and accountable care organizations; and to enhance patient safety, access to behavioral health services, and coordination between hospitals and community-based providers and organizations. CHART eligibility criteria is specified through regulation and Chapter 224. CHART hospitals share the common characteristics of being non-profit, non-teaching hospitals with a relatively lower prices than many other hospitals.

> "We view community hospitals as hubs of local innovation."
>
> *Iyah Romm, Director of Policy for System Performance and Strategic Investment, Health Policy Commission*

Appreciating that community hospitals have varied resource needs and are diverse in size, geographic location, population need, financial health, affiliation with systems, and previous experience with investment funds, the HPC established a phased approach to CHART investments. In October 2013, the HPC solicited responses from eligible community hospitals

Figure 1: Awards in Phase 1 of the CHART Investment Program



to participate in the first phase of CHART funding. CHART Phase 1 distributed $10 million to 28 community hospitals to support short term, high-need expenditures (Figure 1). Through these projects, the HPC is assessing the capability and capacity of participating institutions, developing engagement and fostering learning among CHART-eligible hospitals, and building a foundation for system transformation.

In October 2014, the HPC awarded a total of $60 million in CHART Phase 2 funding. Phase 2 of the CHART Program invests in high-impact initiatives focused on driving health care system transformation and incentivizing community hospitals to prepare for participation in alternative payment models and accountable care. Recognizing the diversity of community hospitals across the Commonwealth, CHART Phase 2 is intended to accelerate the transformation of eligible hospitals through a focus on maximizing appropriate hospital use, enhancing behavioral health care, and improving hospital-wide processes. These actions are intended to drive better alignment of community hospital services and capabilities with the health and health care needs of the communities the hospitals serve.

Summit Objectives

As a requirement of Phase 1 of the CHART Investment Program, senior executives from participating CHART hospitals were invited to participate in the one-day leadership summit (Phase 2 eligible hospitals were additionally invited to attend). The objectives for the Summit included:

- Developing a shared vision of community hospital transformation
- Identifing high-yield tactics to improve safety and reliability
- Identifing high-yield tactics to optimize community-based care and population health
- Understanding considerations of community hospital business models – transform in a volume based environment
- Understanding hospitals' strategies for change, best practices in existing change efforts, and barriers to transformation
- Exploring opportunities for cross-hospital collaboration
- Discussing strategies for leveraging CHART Investments and related activities to drive transformation
- Understanding additional opportunities for the HPC to support and accelerate transformation

SESSION I:
Community Hospitals in a Dynamic Healthcare Environment

Speaker: John Polanowicz
Secretary, Massachusetts Executive Office of Health and Human Services

Key Points

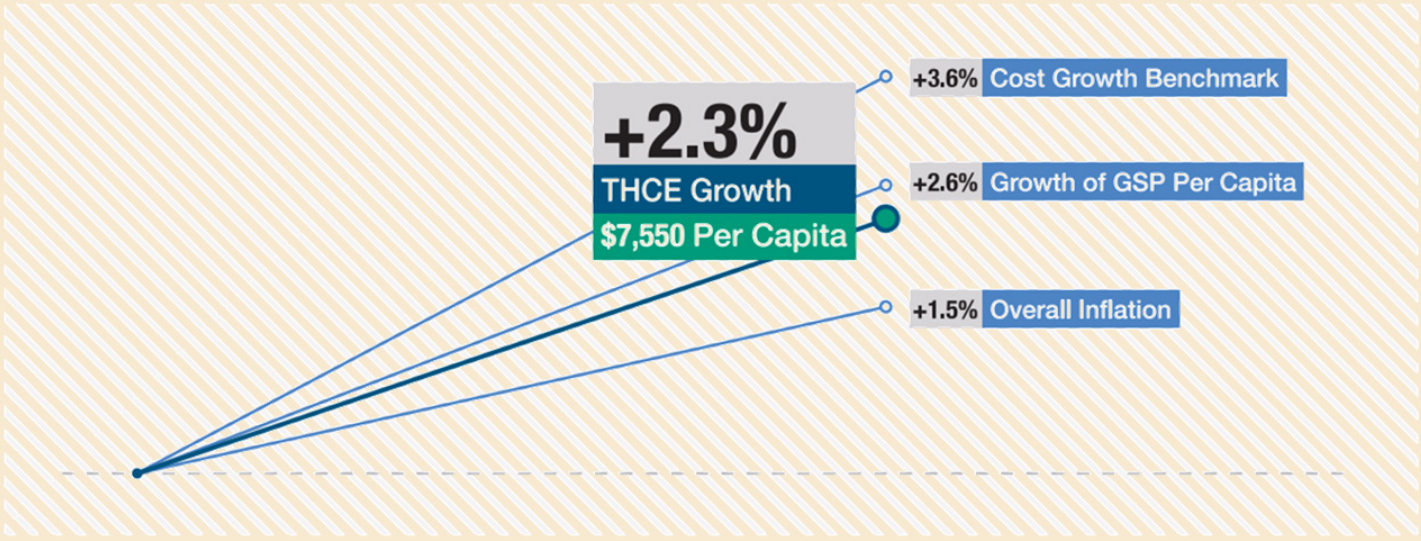
- Despite a recent slowdown in growth, health care spending continues to rise faster than inflation and is unsustainable.
- The Commonwealth is actively supporting the adoption of alternative payment methodologies to incentivize transformation of the health care system by rewarding value instead of volume.
- CHART, SIM, and other Chapter 224 investments represent opportunities to drive transformation.

While Massachusetts can be proud of a health care system that has the lowest rate of uninsurance in the nation, it also spends more on health care per person than any other state. Recognizing the unsustainable trajectory of the Commonwealth, with the broad support of consumers, payers, providers, and purchasers, the Legislature passed and Governor Patrick signed Chapter 224, the Commonwealth's health care cost containment law. Chapter 224 sets a first-in-the-nation target for controlling the growth of total health care expenditures in Massachusetts through the creation of the state's health care cost growth benchmark. The benchmark is tied to the growth in the state's economy. For calendar years 2013-2017, the cost growth benchmark is equal to Massachusetts' economic growth rate. The economic growth rate for 2013 and 2014 is equal to 3.6 percent.

Containing Health Care Costs

While providing opening remarks for the CHART Leadership Summit, Secretary Polanowicz was pleased to announce the Center for Health Information and Analysis (CHIA) found that total health care expenditures grew by 2.3 percent from 2012 to 2013, well below the 3.6 percent health care cost growth benchmark (Figure 2). Although per capita growth in total health care expenditures was lower than the cost growth benchmark, health care spending still rose faster than inflation. Given these findings, Secretary Polanowicz stated that much work needs to be done to continue to address the high cost of health care in Massachusetts.

Figure 2: Massachusetts Total Health Care Expenditures (THCE), 2012-2013



Source: CHIA and other public sources. Inflation data from Bureau of Labor Statistics. Consumer Price Index 12-month Percent Change. Gross State Product data from U.S. Bureau of Economic Analysis: Widespread But Slower Growth in 2013: Advanced 2013 and Revised 1997-2012. Statistics by GDP by State.

Alternative Payment Methodologies

One important strategy for addressing health care costs is the implementation of alternative payment methodologies (APMs). Chapter 224 sets a mandate for Massachusetts to move forward with APMs as a way to further incentivize providing the right care, in the right place, at the right time. APMs reward providing value over volume, and offer a contrast to the current fee for service payment model that contributes to unnecessary health care spending. A report by CHIA found that adoption of APMs by payers and providers stalled in 2013. He noted that the Commonwealth needs to look at more aggressive ways to support and accelerate the adoption of APMs among public and private payers. Secretary Polanowicz called on participants to accelerate their push towards APMs.

State Innovation Model Initiative

Massachusetts is also moving forward with the implementation of its State Innovation Model (SIM) initiative, a $44 million dollar effort funded by a competitive grant that Massachusetts was awarded by the Center for Medicare & Medicaid Innovation (CMMI). The SIM initiative will support public and private payers in transitioning to integrated care systems, enhancing data infrastructure for care coordination and accountability, advancing a statewide quality strategy, integrating primary care with public health and other services, and creating measures and processes for evaluating and disseminating best practices.

The Path Forward

Through the CHART Investment Program, the HPC is working to support community hospitals in transitioning to a new value-based, patient-centered health care environment. Secretary Polanowicz described the unique opportunity that community hospitals have to help the Commonwealth better tailor services to meet the unique needs of their communities while containing health care costs. To do so will require that the Commonwealth's health care system, including community hospitals, become more efficient, coordinated, accessible, and of a higher quality. This requires engaged and committed leadership, focused on transforming systems, cultures, and workforce to meet the evolving needs of communities.

In 2006, the Commonwealth passed a bold and ambitious law, known as Chapter 58, which has enabled Massachusetts to achieve the lowest rate of uninsurance in the nation. One criticism of the law was that it did not sufficiently address health care costs, an issue which took on a new level of urgency during the recession when funding for health care squeezed out other priorities. In 2012, the Commonwealth pushed forward with a package of new legislative initiatives, which sought to keep Massachusetts health care cost growth within sustainable levels. The health care cost containment law, Chapter 224, builds upon Chapter 58 and other Massachusetts health care laws, including Chapter 205 (2008) and Chapter 288 (2010), which expanded data transparency and reporting on cost trends. Secretary Polanowicz closed by reiterating his view that community hospitals, and their leaders, have an opportunity and imperative to drive Massachusetts' transformation of payment and care delivery.

SESSION II:
Controlling Healthcare Costs and Investing in Community Hospitals

Speaker: David Seltz
Executive Director, Health Policy Commission

Key Points

- The CHART program fosters community hospital transformation and supports development of a value-based health care environment.

Health Policy Commission

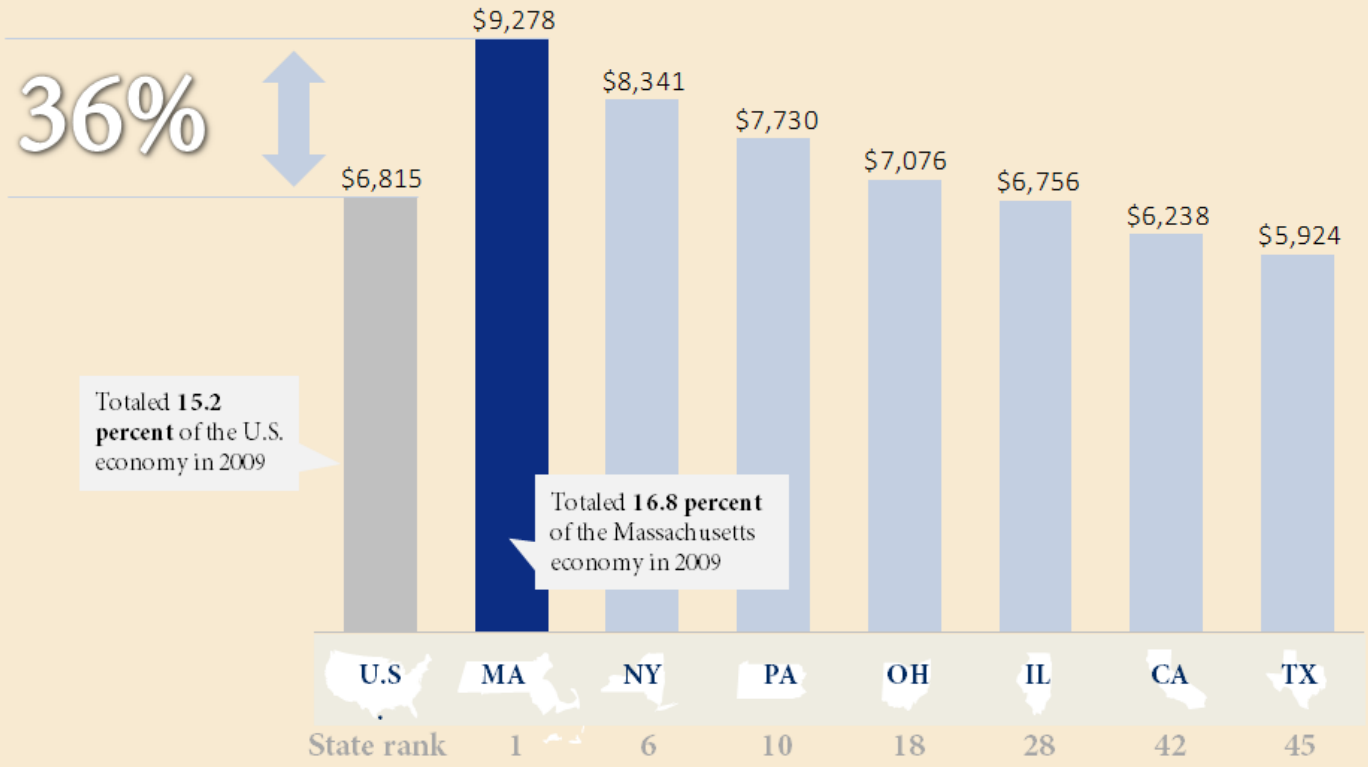
Under Chapter 224, the Legislature created the Health Policy Commission (HPC) as an independent state agency to oversee cost containment efforts and promote system transformation. The Governor, Attorney General, and State Auditor have appointed an 11-member board made up of public and private sector leaders with diverse areas of expertise to govern the HPC.

The mission of the HPC is to promote informed dialogue, evidence-based policy, and innovative models to foster transformation through ongoing evaluation of the Massachusetts health care system. In pursuing this mission, the HPC's activities can be grouped into four broad areas:

1. Promoting the adoption of new delivery system models through a certification program for patient-centered medical homes and accountable care organizations;
2. Investing in the Commonwealth's community hospitals to establish the foundation necessary for sustainable system transformation;

Figure 3: Comparative Health Care Costs

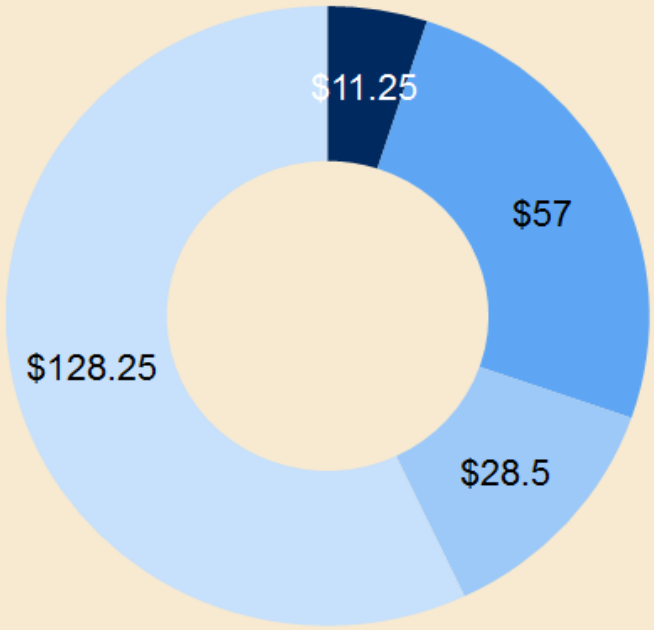
Per capita healthcare spending in Massachusetts is highest of any state by per capita health care expenditures (2009 dollars)*



*Personal health care expenditures (PHC) are a subset of national health expenditures. PHC excludes administration and the net cost of private insurance, public health activity, and investment in research, structures and equipment.
Source: Centers for Medicare and Medicaid Services; Bureau of Economic Analysis; HPC analysis

Figure 4: Chapter 224 Foundational Investment into System Transformation

Chapter 224 created nearly one-quarter of a billion dollars in provider investments from 2013-2017



Distressed Hospital Fund: Supports investments in community hospitals

e-Health Institute Fund: Supports providers in adopting interoperable health information technology

Prevention and Wellness Trust Fund: Supports community-based public health and health promotion activities

Health Care Payment Reform Fund: Supports the operations of the Health Policy Commission

Source: Section 241 of Chapter 224

3. Monitoring system transformation in the Commonwealth and cost drivers therein; and,
4. Examining significant changes in the health care marketplace and their potential impact on cost, quality, access, and market competitiveness.

Investments in Community Hospitals

Chapter 224 also created nearly $250 million dollars worth of investments for providers between 2013 and 2017, of which $120 million supports investments in community hospitals (Figure 4). The HPC is authorized to distribute funds for community hospitals through a competitive proposal process. To do so, the HPC created the Community Hospital Acceleration, Revitalization, and Transformation (CHART) Program, which seeks to achieve sustainable, scalable interventions that benefit communities by advancing the following goals:

1. Promote efficient, effective, integrated care delivery;
2. Improve quality and patient safety while reducing costs;
3. Develop capacity to become an Accountable Care Organization;
4. Advance adoption of health information technology and the electronic exchange of information between providers; and,
5. Increase capacity to bear risk and adopt alternative payment methodologies.

Phase 1 CHART funding provided a total of $10 million to 28 eligible hospitals. Phase 2 CHART funding, which was recently awarded, will provide $60 million in tiered, multi-year opportunities focusing on three outcome-oriented domains: maximizing appropriate hospital use, enhancing behavioral health, and reducing waste/improving safety. The imperative for such transformation is clear – costs are soaring, quality is high – but not proportionately so – and access challenges for vulnerable populations remain.

SESSION III:
The Innovation Imperative: CHART and the Path to the Second Curve

Speaker: Iyah Romm
Director of Policy for System Performance and Strategic Investment, Health Policy Commission

Key Points

- The outlook for a volume-driven hospital business model no longer appears sustainable.
- Hospitals are optimistic about the opportunity for transformation through APMs – and call for acceleration of their adoption.
- Community hospitals must serve as hubs of local innovation and align to meet communities' needs.
- Community hospitals must engage in all four core elements of transformation to be successful.

According to an HPC analysis of Centers for Medicare and Medicaid Services (CMS) data, Massachusetts spent 36 percent more per person in personal health care expenditures in 2009 than the U.S. average—the highest in the nation (Figure 3). Of the total difference in personal health care expenditures, over 40 percent was associated with hospital care, which amounts to an average of $1,000 in additional spending per person per year. In total, Massachusetts wastes up to $27 billion each year in unnecessary spending on health care. The money wasted on health care cannot be used on other priorities and represents an unsustainable trend that must be addressed.

Hospital Utilization and Price Disparity

The differences between Massachusetts and national rates of spending on health care, specifically on hospital services, can be seen in measures of hospital utilization (Table 1). Massachusetts' hospital utilization is higher than the national average in a number of categories.

While hospital utilization in Massachusetts is higher than the national average, it is the not the only driver of expenditure growth in the state. Data from Massachusetts' All-Payer Claims Database shows that, from 2009-2011, price increases have driven recent commercial expenditure growth, whereas utilization has been the relative driver to Medicare expenditure growth.

Part of the reason Massachusetts' spending on hospital services is so high is related to where care is delivered. According to 2012 data collected by CHIA, total payments for inpatient and outpatient services in Massachusetts tend to concentrate among higher priced acute hospitals. Specifically, higher priced acute hospitals (above statewide median relative price) received 84 percent of total payments for inpatient services and 75 percent of total payments for outpatient services. Moreover, these higher priced acute hospitals also accounted for 70 percent of total commercial inpatient discharges.[3] Notably, by definition CHART hospitals have relative prices below the statewide median relative price.

Negative Hospital Sector Outlook

Table 1: Measures of Hospital Utilization[2]
Per 1,000 population; 2011 unless noted

Measure	MA	US	%
Inpatient Admissions	1.10	1.00	10%
Emergency Department Visists	468	415	13%
Outpatient Visits (Non-ED)	2,907	1,691	72%
Outpatient Surgery (CY2010)	71	56	27%

While utilization of hospital services has been a dominant driver of health care spending in Massachusetts and the U.S., forecasts point to weaker growth in the future due to decreases in volume, renewed competition through mergers and acquisitions, and higher capital pressures due to increasing age of physical plant. Further, low relative price community hospitals have been a leading segment of the market to show financial stress, including reduced occupancy and decreased revenue. The future could hold continued compression of margins and lower cash reserves. According to an August 2014 report by Standard & Poor's, the non-profit health care sector is likely to continue to have a negative operating environment into 2014-2015.

"I don't see any future for community hospitals…I think there's a fantastic future for community health systems. If small standalone hospitals are only doing what hospitals have done historically, I don't see much of a future for that. But I see a phenomenal future for health systems with a strong community hospital that breaks the mold [of patient care]."
Community Hospital CEO

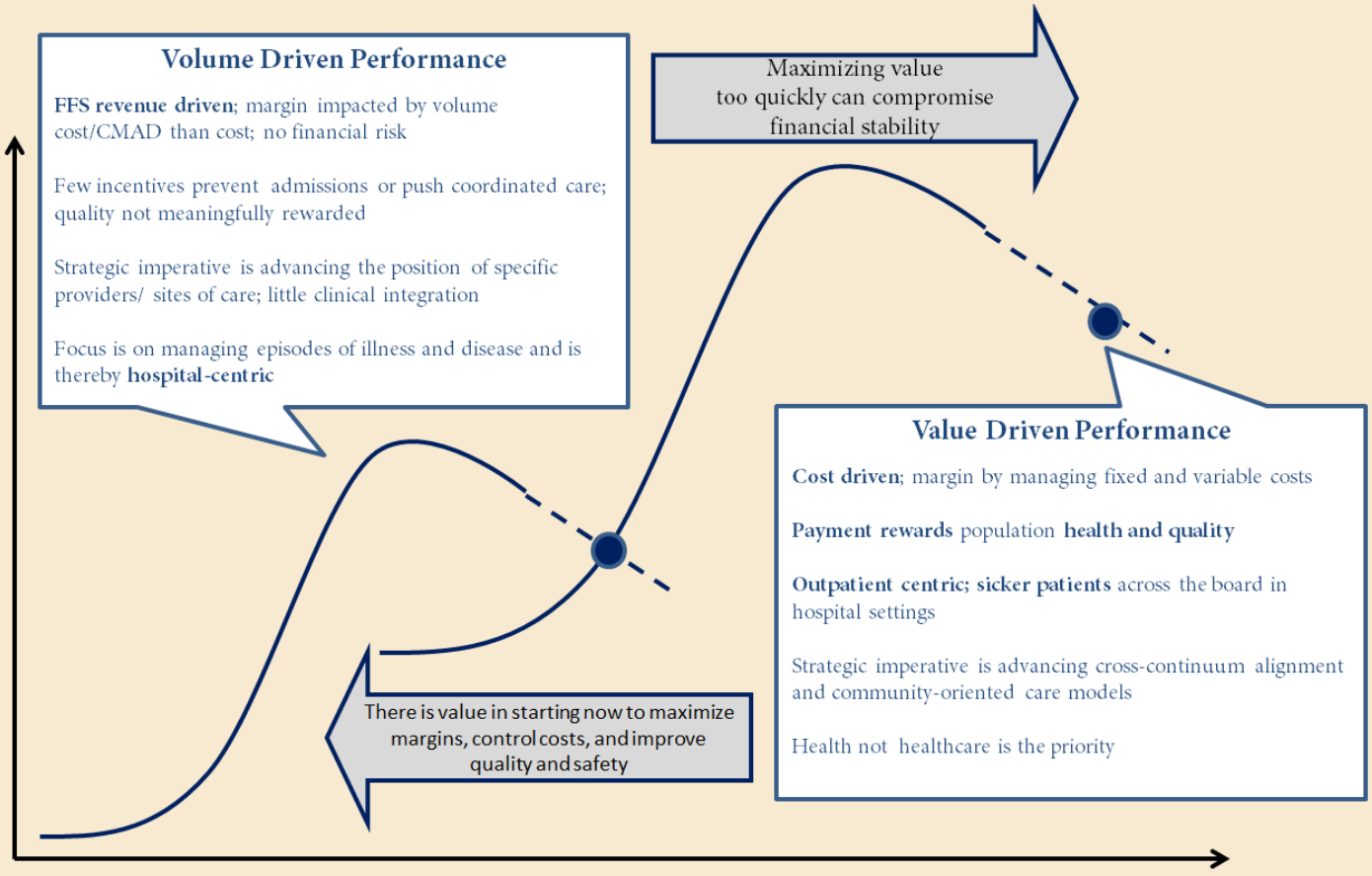
Innovation Imperative: The Second Curve

With these data points as a backdrop, there are two alternative scenarios for community hospitals in the future. One scenario is based on the existing community hospital business model, which emphasizes volume of services. The outlook for this business model no longer appears sustainable. A second alternative is characterized by meeting the demands of the new business environment, which instead emphasizes value. Using the theories of futurist Ian Morrison, these two environments can be distinguished "First Curve" and "Second Curve" business models (Figure 5).[4]

Leaders of community hospitals need to develop strategies to move their organizations away from a volume-based environment to more value-based systems and business models. In this vision for the future, community hospitals will serve as hubs of local innovation and align to meet communities' needs—moving away from an inpatient anchored model and toward an outpatient-centric, whole-person model of care across settings and time. In doing so, community hospitals will have to find effective ways to build partnerships with other hospitals, health care providers, and non-health care providers.

Figure 5: The Path to the Second Curve

Per capita healthcare spending in Massachusetts is highest of any state by per capita health care expenditures (2009 dollars). We waste up to $27 billion each year in unnecessary spending.



Source: Adapted from Your Hospital's Path to the Second Curve, American Hospital Association, 2014

Mr. Romm invited Amy Boutwell, MD, MPP an advisor to the CHART program, to briefly kick-off the discussion by helping to distinguish between the role of a community hospital and the role of a "community health system." Participants offered many perspectives in response to Mr. Romm's question.

- **Integrate with Primary Care and Behavioral Health**. One hospital CEO indicated this his hospital was already generating 80 percent of its revenue from outpatient services and that his hospital was trying to align and integrate primary and behavioral health care.
- **Move from Physician-Centered Model to Patient-Centered Model**. Another participant, who identified as a physician, responded by highlighting the challenge associated with getting physicians to think about medical care from a population health perspective. The participant stated that this population health/ whole-person model of care, "threatens our fundamental identify that we are the center of the health care universe." Another participant agreed by stating that the challenge was to move away from a physician-centered model to a patient-centered model.
- **Pre-Fund Investments**: One participant suggested that purchasers of health care will need to pre-fund investments in order for the health care system to move forward. Another participant agreed, stating that funding is necessary to work with community providers and work effectively across the continuum of care.

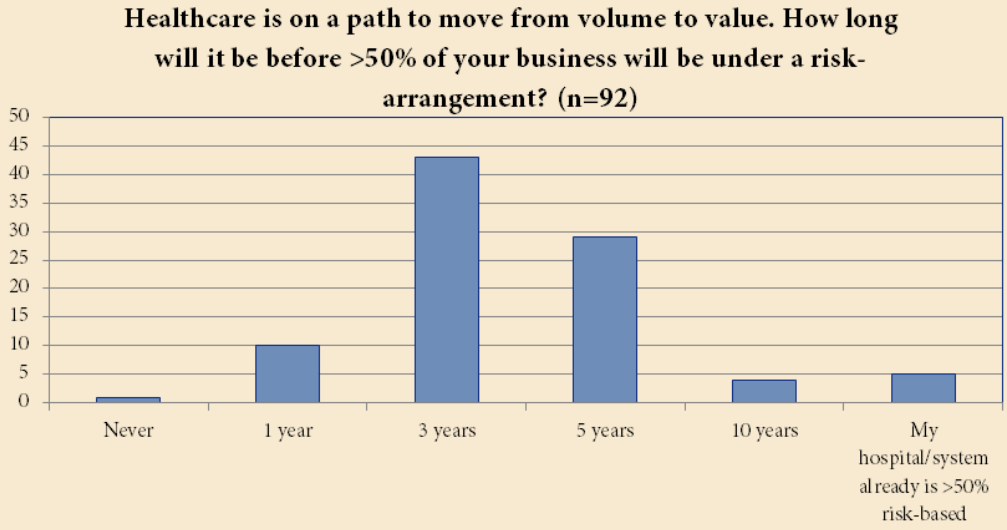
Discussion

Mr. Romm asked CHART Leadership Summit participants to think about what environmental conditions need to be present to encourage community hospital leaders to begin the process of moving from volume driven to value-driven models of care. Put another way, he asked "When do you flip the switch?" Mr. Romm then introduced the HPC's four core elements of transformation:

1. **Safety and Reliability**: As CHART hospitals strive for the second curve, organizational focus on safety and reliability – including efficiency – will be imperative;
2. **Population Health**: The community orientation of CHART hospitals requires a primary focus on whole-person care across settings and time;
3. **Business Transformation**: In parallel with operational transformation, CHART hospitals will need to prepare themselves for success in an alternative payment environment; and
4. **Community Partnership**: Meaningful community engagement will be requisite for successful transformation of CHART hospitals. Early engagement will foster long-term success.

Figure 6: Leaders answered questions about their readiness for transformation

Most hospital leaders predict >50% APMs in 3-5 years



SESSION IV:
Massachusetts Community Hospital Utilization, Quality, and Cost

Speaker: Amy Boutwell, MD
President, Collaborative Healthcare Strategies

Key Points

- Value-driven business models will require greater alignment between hospitals and community providers.
- Leadership Summit participants believe outmigration is tied to patient preferences for receiving care at institutions with a recognized brand and reputation for high-quality care.
- Substantial variation exists across CHART hospitals on most measures; understanding the root causes of variation will support improvement efforts.
- The HPC and other government agencies can support transformation efforts by making available more, better data, faster.

Context

The HPC introduced the CHART Book, a hospital-specific packet with customized information on each hospital as well as de-identified data on others in the CHART cohort. The CHART Book is intended to encourage dialogue by acknowledging variation in performance. The HPC framed the CHART Book as a way to use data as a tool to engender discussion about the underlying causes of variation in performance and spur action to address those causes.

Discussion

Dr. Amy Boutwell facilitated a detailed discussion on distinct sections of the CHART Book, then opened the session for discussion and audience survey questions.

Financial Performance: The first section of the CHART Book concerned financial status of the CHART cohort, expressed by total margin, average age of plant, and change in occupancy over time. The total margin data showed that all but two CHART hospitals had a negative total margin. Prompted by a question from the facilitator, a number of audience members raised questions or concerns about the financial data as presented, including:

- Hospitals rarely monitor hospital margin in isolation, because their concern is typically the performance of their health system as a whole, including physician groups and other affiliates.
- Hospitals focus on operating margins rather than total margins.
- Total margins could be arrayed by price to assess the impact of relative cost on margins statewide.

Outmigration: The second section of the CHART Book addressed statewide data concerning patient flow in and out of 15 distinct regions of the Commonwealth. All regions experience outmigration, or a flow of patients from the region to the metro Boston region. Using real-time interactive technology, Leadership Summit participants were surveyed about their perceptions of why patients leave local communities. The survey showed:

- Most participants felt that the reason for outmigration was due to patient preference to receive care at institutions with a recognized brand and reputation for high-quality care.
- Participants noted that in some cases outmigration may be to affiliate hospitals, which could be the desired outcome for a particular hospital system. Participants also indicated that a main concern of CHART hospitals is not necessarily overall flow patterns, but rather, when patients leave the community for services that the hospital does well.
- Notably, hospital executives currently monitor outmigration and patient flow very closely and have mechanisms to track it.

Quality, Patient Safety, and Efficiency Measures: The third and fourth areas of focus from the CHART Book concerned quality and safety measures as well as a set of efficiency and utilization-related measures. Taken as a whole, the available data demonstrated significant variability across all hospitals, including CHART hospitals. In addition, higher- and lower- quality hospitals are not the same across measures. Different hospitals excel in different areas, which suggest there are opportunities for sharing best practices.

Table 2: CHART Participant Survey:

What is the main reason that patients leave your region for care?

Participation Responses	N	%
Patient Preference: brand or reputation (including quality) of referral site	70	63%
Patient Preference: formal organizational affiliations	15	12%
Provider Preference: personal relationships with other providers	10	9%
Patient Preference: brand or reputation (including quality) of referral site	6	5%
Patient Preference: personal relationships with other providers	6	5%
Other/Unknown	3	2%
Health insurance Networks	1	1%
Total	111	100%

What is the primary barrier to reducing preventable hospitalizations that your community faces?

Participation Responses	N	%
Lack of alignment of the hospital and community providers	34	31%
Insufficient access to primary care	24	22%
Fee for service payment (misaligned incentives)	19	18%
Provider-patient communication challenges	14	13%
Lack of control over community physicians by the hospital (e.g. lack of physician engagement)	8	7%
Total	108	100%

Does your hospital have corporate, contractual, or clinical affiliation with post-acute care facilities, including home health agencies?

Participation Responses	N	%
Combination of corporate, contractual, and clinical affiliations	45	47%
Corporate affiliation	23	24%
Clinical affiliation	18	19%
Provider-patient communication challenges	7	7%
Contractual affiliation	3	3%
Total	96	100%

Participants were surveyed about perceived barriers to reducing preventable hospitalizations, which spurred discussion by audience members, who said:

- Poor alignment between hospitals and community providers is a main reason for hospitalizations that could have been prevented.

- Patient behavior and insufficient access to primary care also present barriers to reducing hospitalizations. An Emergency Department physician suggested that in one community, the most important problem is insufficient access to primary care, driven by the fact that local ambulatory settings are not open beyond regular business hours. Hospitals are left as "the only place to go."

The session ended with an audience survey question about corporate structure in CHART hospitals (Table 2). Based on participant responses, a majority indicated that their hospitals already had in place some form of corporate, contractual, or clinical affiliation with post-acute facilities. These affiliations are viewed as key drivers of addressing avoidable re-hospitalizations and emergency department visits.

SESSION V:
Hospital Safety, Reliability, and Culture

Facilitators:
Allan Frankel, MD, Safe and Reliable Healthcare
Michael Leonard, MD, Safe and Reliable Healthcare
Bryan Sexton, PhD, Duke University Health System

Key Points

- Early results from CHART hospital assessments show that there is significant opportunity to "genetically wire" safety and high reliability within hospitals' organizational cultures.
- Hospital leaders can create and sustain macro- and micro- level system changes in quality and safety by investing in workforce development, particularly middle managers.

Context

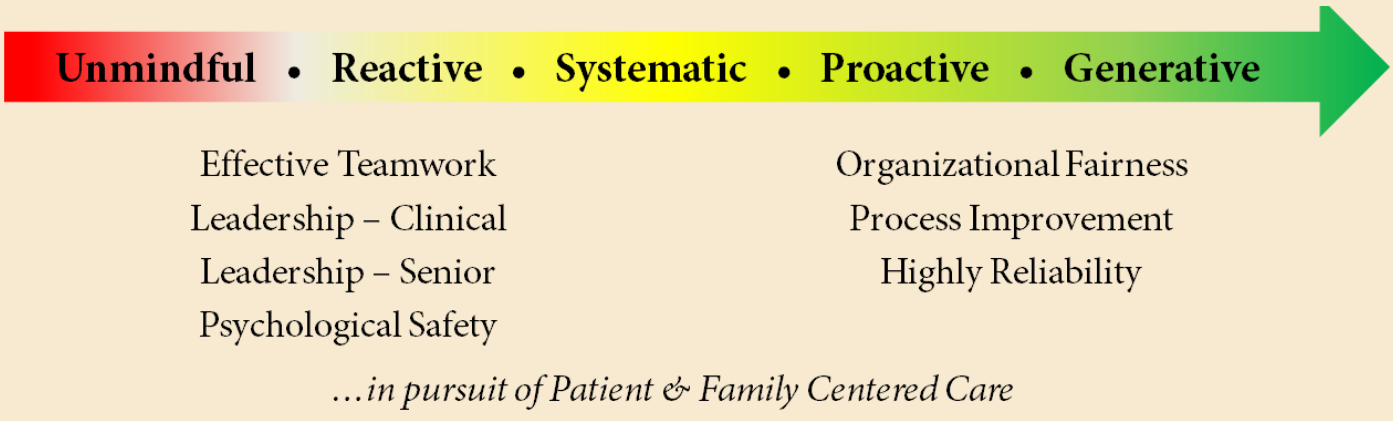
Medical errors and avoidable patient harm and death in the United States remain unacceptably high. Recent evidence shows that roughly one in three hospitalized patients experiences an adverse event, and in six percent of cases, the adverse event is severe enough to prolong the patient's hospitalization and send him or her home with a permanent or temporary disability.[5] Nationally, costs associated with medical errors run into the billions. The National Quality Forum's National Voluntary Consensus Standards for the Reporting of Healthcare-Associated Infection Data reported that "an estimated 2 million HAIs alone occur each year in the United States, accounting for an estimated 90,000 deaths and adding $4.5 billion to $5.7 billion in healthcare costs."[6]

The Institute of Medicine report *Preventing Medication Errors* identified error rates across a variety of settings and types, estimating that about 400,000 preventable adverse drug events (ADEs) occur each year in U.S. hospitals with an estimated annual cost of $3.5 billion.[7] Technology alone cannot fix the harm in health care. The evidence on safety culture indicates that perceptions about teamwork, safety, and leadership correlate with the quality and safety of care.[8]

CHART participants heard a summary of research findings concerning the development of high-reliability hospital environments that deal with risk and hazard on a daily basis. Improving safety and culture can best protect against the risks associated with working in complex environments through a "sociotechnical" learning system comprised of seven core elements described below (Figure 7):

1. **Effective Teamwork**: Patient care is an extremely complex process, and effective communication and teamwork is a fundamental requirement. It is important to structure communication through briefings (huddles, checklists, etc.), debriefings, SBAR and other standardized tools, and the use of critical language to maintain situational awareness and preclude problems from showing up at the bedside.

Figure 7: SocioTechnical Framework



2. **Clinical Leadership**: Engaged clinical leaders hear patients and front-line caregivers' concerns regarding defects that interfere with the delivery of safe care. Clinical leadership should promote improvement to increase safety and reduce waste.
3. **Senior Leadership**: Similar to clinical leadership, senior leaders are the keepers and guardians of these attitudinal norms as well as the learning system. They are engaged with patients and front-line caregivers.
4. **Psychological Safety**: Speaking up is not associated with being perceived as ignorant, incompetent, critical or disruptive (leaders must create an environment where no one is hesitant to voice a concern and caregivers know that they will be treated with respect when they do).

> "Culture lives at the unit level."
> *Bryan Sexton, PhD, Duke University Health System, senting culture survey results for CHART hospitals*

5. **Organizational Fairness:** Caregivers know that they are accountable for being capable, conscientious and not engaging in unsafe behavior, but are not held accountable for system failures.
6. **Process Improvement**: Hospitals employ different approaches and models of quality improvement, such as Lean, Six Sigma and the Plan-Do-Study-Act model. Generally quality improvement efforts involve identifying target areas for improvement; determining what processes can be modified to improve outcomes; developing and implementing effective strategies to improve quality; tracking performance and outcomes; and disseminating results to spur broad quality improvement.
7. **High Reliability**: The hallmark of excellence is the ability to consistently do the basics in a measurable, sustainable manner. Visible, reliable processes help reduce clinical variation; they also allow the individuals providing care to see the work in a way that drives measurable improvement through testing and rapid cycle improvement.

The 27 CHART Phase 1 hospitals were examined through a qualitative sociotechnical assessment of organizational culture. The aggregate scores for the hospitals' performance in the seven key sociotechnical domains were provided to each individual hospital and grouped as follows:

- *Reactive*: "Safety is important. We do a lot every time we have an accident"
- *Systemic*: Systems are being put into place to manage most hazards
- *Proactive*: "We methodically anticipate" to prevent problems before they occur
- *Generative*: Organizational culture is "genetically-wired" to produce safety

The results showed relatively consistent findings across the seven domains. The largest share of CHART hospitals fell in the "Reactive" category across virtually every domain except "Effective Teamwork," where results were more evenly split between Reactive and Systematic. Data was presented across hospitals, individual roles, and hospital units. A recurring theme was that managers should not look at aggregated hospital level data, but at the unit level.

Discussion

In response to this presentation, facilitators asked Leadership Summit participants to offer perspectives on opportunities and challenges suggested by the data. Participants noted the need to:

Invest in Middle Managers. Discussion among participants centered on some of the challenges associated with reaching middle managers, who are critical to bridging the gap between macro- and micro-systems level change. Participants shared that middle managers, who have not historically been focused on as a group, face the most pressures with the fewest resources. Middle managers can have a wide variation in talent, needs, and desires. For example, middle managers need training on creating "aim statements," driving change, communicating in ways that are psychologically safe, and being able to set clear expectations.

Instill "Lean" Principles. One participant shared that all managers in her hospital were Lean Six Sigma Yellow Belt trained following a recognized need for management education and training. Another participant indicated that training managers in the language and techniques of Lean principles helped change the model of care in his hospital leading to sustained and demonstrable changes in patient engagement and quality.

Breakout Session A: Enriching Community Partnerships

Facilitator:
Amy Boutwell, MD, MPP, President, Collaborative Healthcare Strategies

Case Examples:
Addison Gilbert Hospital
Lawrence General Hospital

Context

Breakout Session A focused on building community partnerships in order to develop and strengthen more integrated approaches to delivering care, particularly outside the hospital setting. Coordinating and partnering with community-based providers and organizations is a key strategy identified by the American Hospital Association to move hospitals from the first curve, or volume-based environment, to the second curve, in which hospitals will be building value-based systems and business models that help deliver care in the most appropriate setting.[9] Breakout Session A included two short presentations from hospitals that have developed notable community partnerships.

Addison Gilbert Hospital

Addison Gilbert Hospital (AGH) is a 58-bed hospital in Gloucester, Massachusetts, and is a part of Lahey Health System. During the breakout session, representatives from AGH described the creation of the Healthy Gloucester Collaborative through the Gloucester Health Department. The Healthy Gloucester Collaborative was formed in reaction to a series of related issues that were affecting the hospital and community, including frequent and inappropriate use of the emergency department (ED) due to opiate abuse in the community, significant churn between a local shelter and the ED, and public safety officials' frustration with the number of transports to the ED from a local shelter.

The Healthy Gloucester Collaborative has brought together physicians, hospital officials, addiction treatment providers, shelter representatives, law enforcement officials, and emergency medical services (EMS) providers. The group addresses medical and behavioral health issues alongside social and educational challenges to address the problem of opiate abuse.

Key Points

- Community hospitals can serve as the epicenter of community partnerships including implementation of new, evidence-based treatment protocols.
- Most CHART hospitals already have a foundation of community partnerships from which they can leverage change and promote value-based systems and business models.
- HPC can support community partnerships through highlighting best practices as well as tools and approaches to developing and codifying relationships between parties

Lawrence General Hospital

Serving Merrimack Valley and Southern New Hampshire, Lawrence General Hospital (LGH) has 189 beds and approximately 12,000 inpatients, 70,000 emergency visits, 1,800 births, and 200,000 outpatient visits annually. LGH is clinically affiliated with both Beth Israel Deaconess Medical Center and Floating Hospital for Children at Tufts Medical Center.

During the breakout session, a representative from LGH discussed the hospital's partnership with the local community health center. LGH and the health center have a long-standing relationship, including a joint residency program and a variety of other financial and academic collaborations. The institutions were both negatively impacted by the inappropriate use of LGH's ED by patients who could have otherwise been seen in less intensive settings.

> "I always thought I wanted to run the hospital with the best quadruple bypass surgery – now I want my kids not to need them."
> *Community Hospital CEO*

Working through the financial and legal issues, the organizations created a health center site within the ED, where a physician can triage patients and send them directly to the health center. The federal law requiring hospitals to treat individuals with emergency medical

conditions until their condition is stable created some barriers and regulatory issues; however, LGH worked hard to convince regulators to support the partnership's efforts to provide appropriate care. The initiative successfully reduced the number of lower acuity patients receiving care in the LGH ED. One key to the successful effort was LGH's willingness to share resources to address a common problem and give up some control over the space.

> "Groups should be set up to … drive to a shared outcome. Don't just set up community groups for fun."
> *Community Hospital Executive*

Discussion

When partnerships involve different actors and explore ways to use services well together, community hospitals can serve as the epicenter of both the organizing effort and the implementation of new treatment protocols. Participants were invited to share perspectives and experience on their efforts to work with community partners. Several important points emerged from the discussion:

- **Most CHART hospitals have some form of existing community partnerships.** Almost all attendees indicated that their hospitals have existing community partnerships. Addressing the importance of community partnerships, one hospital CEO conveyed that one-third of his time is spend outside of the institution, and said "I always thought I wanted to run the hospital with the best quadruple bypass surgery – now I want my kids not to need them."

- **Find common goals to engage with community partners.** Participants explained that community engagement can be "messy work" since varied perspectives and unaligned incentives can create challenges. A common theme among participants was the importance of engaging with partners around "common pain points" to ensure alignment and commitment. One audience member said "Groups should be set up to … drive to a shared outcome – don't just set up community groups for fun." Common goals or shared outcomes should also define which partners come to the table. In the absence of such a shared vision, community collaboration can become a "clearinghouse for initiatives." One audience member said their collaborative had "a ton of ideas but had to find out what was most important," and once they had done so, they were able to begin to develop concrete advancements.

- **Manage expectations with community partners.** A number of participant comments addressed the importance of managing expectations and meeting time for larger diverse groups of community partners. One participant suggested that each time a group comes together, time should be focused and intended to demonstrate that the group is continually moving forward. An important factor is to establish core values and guidelines for the group.

- **Provide financial assistance to support partnerships.** The importance of resources, both financial and informational, was a common theme in discussions. It was acknowledged by a number of audience members that hospitals have to be willing to help with resources to get a working partnership off the ground by providing "seed money" or help with fundraising efforts. Experienced participants mentioned the importance of identifying ways to make sure that a partnership-based effort is sustainable.

> "We could no longer ask people to do more with less."
> *SPHS/Mercy Medical Center representative, describing the rationale for implementing a hospital-wide care coordination and management system*

- Share data with community partners. Working together also requires sharing of data and the creation of ways to feed data back to the community to show results and to justify ongoing efforts.

Breakout Session B: Skills and Principles of Safety, Reliability, and Culture

Facilitators:
Allan Frankel, MD, Safe and Reliable Healthcare
Michael Leonard, MD, Safe and Reliable Healthcare

Case Examples:
Signature Healthcare Brockton Hospital
Sisters of Providence Health System (SPHS) - Mercy Medical Center

Context

Breakout Session B built on the earlier sessions surrounding safety and culture by focusing on practical interventions to improve safety, reduce waste and inefficiency, and improve patient-centered care. Two case examples were shared:

Signature Healthcare Brockton Hospital

Representatives from Signature Healthcare Brockton Hospital (SHBH) described the hospital's implementation of Lean management principles over the last four years. All SHBH employees have a significant role in improving the environment of care through solving problems, generating improvement suggestions, setting goals, and and measuring results. This program trains staff on Lean fundamentals, develops balanced scorecards, suggests systems and problem-solving methodologies to reduce waste, improves efficiency, and identifies and improves patient-centered care and safety issues. Improvement specialists deliver Lean training and coaching, policy deployment and implementation, and focused improvement facilitation and support; develop strategy and policy to support Lean deployment; deliver focused improvement results; and lead an annual planning cycle for policy deployment and focused improvements that lead to world class performance.

SPHS/Mercy Medical Center

Representatives from SPHS—Mercy Medical Center described cultural changes and implementation of a new care coordination and management system used throughout Mercy Medical Center, with cross departmental hubs tracking all inpatients and ED patients in real-time. To accomplish this goal, the hospital contracted with Care Logistic™ to devise a care coordination and management system, operating 24/7, that integrates departmental and hospital system workflows and provides actionable data to both clinical staff and patients on key performance indicators, such as length of stay (LOS), patient flow times (e.g., the time it takes to get a patient's bed ready or the time it takes to obtain an MRI), discharge process times, re-admission rates, the number of ED patient holds (ED patients awaiting hospital beds), and patient satisfaction levels upon discharge.

With a transformational care coordination and management model, hospital staff in all departments are able to "follow" each patient throughout his or her day on a visual board, which displays the patient's name, DRG (diagnostic related group), risk status, and real-time tracking of all scheduled tests and procedures. The Care Logistics™ Model helps hospitals reduce their average LOS, increase operational capacities, lower case costs, boost quality metrics, and improve patient satisfaction scores.

Since implementing the program, Mercy Medical Center has seen its average length of stay drop from 4.8 to 3.5 days, as well as reduced readmissions, a signficant reduction in the number of patients boarding in the emergency department, and an increase in staff satisfaction. Representatives from Mercy Medical Center stressed that implementation was not just about instilling the new technology, but that it also includes integrating the technology into a wider effort to change the culture at the hospital. Senior leaders now participate in multi-discplinary rounds and are as visible as possible.

Key Points

- Engaging employees in improving the environment of care through problem solving, generating improvement suggestions, goal setting and measuring results can improve safety, reduce waste and inefficiency, and improve patient-centered care.
- Culture change and organizational improvement needs to be a top priority of the CEO and senior leadership team and must be communicated to all staff in regular and visible ways.

Discussion

Following the presentations by hospital leaders from SHBH and Mercy Medical Center, participants engaged in a short question and answer period to probe deeper into the successes and challenges faced by each of the presenting hospitals. Several key themes emerged:

- **Process improvement and culture change takes time and phased planning.** SHBH indicated that learning began with a weekly book review meeting on Lean principles—initially among leadership, but subsequently extended to the entire staff as an open invitation. Meetings involved chapter reviews on Lean concepts and ideas, which resulted in introducing the new Lean language into the organization. Following that, Lean techniques and tools were implemented simultaneously, including daily huddles, employee suggestion submission tools, and problem solving boards. SHBH leadership indicated that they may have done implementation in zones rather than all at once if they had to do it again.

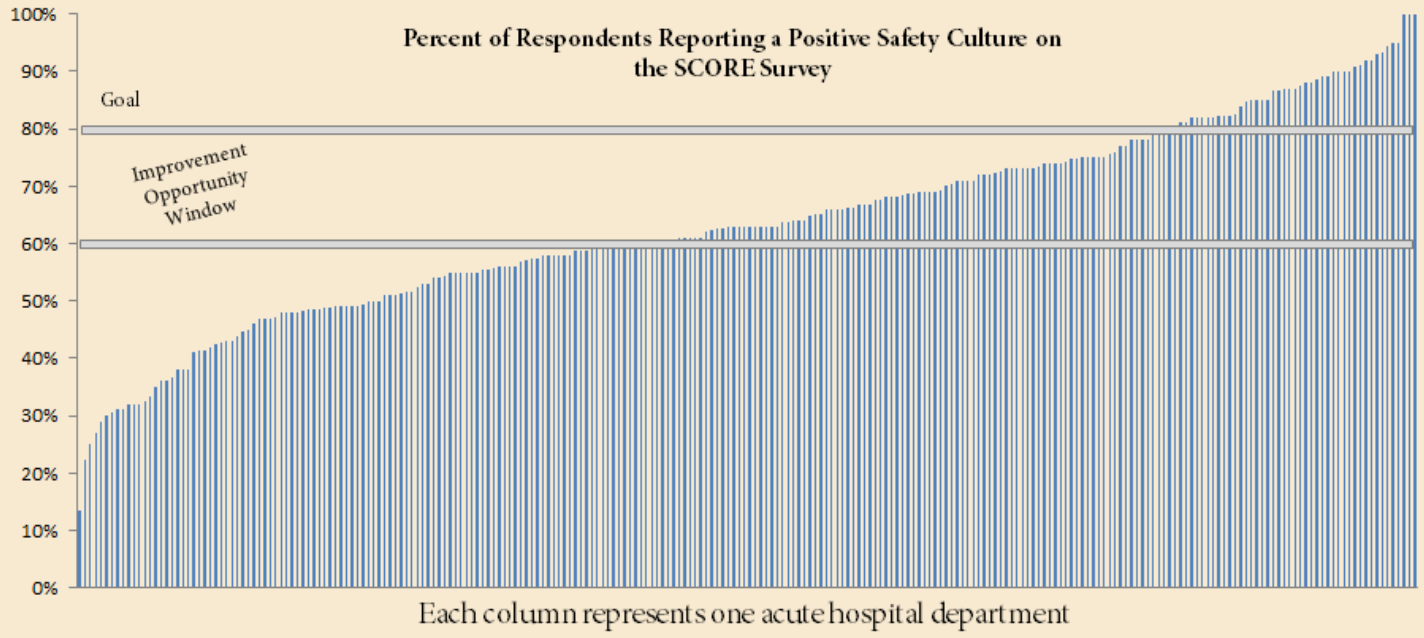
- **Start culture change by building trust.** Both organizations explained how important it was to engage clinical and administrative leadership early in the change management process. Communication through town hall meetings and other communciation channels was critical. One hospital indicated that it gave physicians the opportunity to sponsor clinical improvement project/teams, which empowered them to become invested in the program. Physicians chose to be involved, which changed the conversation.

- **Senior leaders need to be visible.** This is not the kind of change senior leaders can delegate. Culture change and organizational improvement needs to be a top priority of the CEO and senior leadership team. Leaders must be willing to "walk the talk" and stay with it when implementation becomes challenging. Senior leaders should participate in multidiscipinary rounds and focus on how to react in a postive manner when issues and challenges arise.

- **Set goals and measure progress continously.** SHBH stressed the importance of daily or weekly methods for measuring and tracking targets related to top organizational priorities. Quality objectives and performance should be rolled up to the hospital's goal attainment tracking system and reported to leadership and the hospital's board on a regular basis.

Figure 8: Hospital Culture Survey Results by Unit

The SCORE survey reports respondents by hospital department. There is wide variation reported in the percentage of respondents who reported a positive safety culture across departments. This variation demonstrates substantial opportunity for driving improvement in the environment in which clinical services are delivered.



Source: Safe and Reliable Healthcare, LLC

SESSION VI:
Resilience as a Leadership Imperative

Speaker: Bryan Sexton, PhD, MS
Duke University Health System

Key Points

- Active Constructive Responding (ACR), which concerns how to respond to the sharing of good news, has been shown to effectively alleviate stress and help avoid employee frustration, anger, suspicion, mistrust, and burnout.
- Asking questions that encourage a colleague to talk about their good news and savor their positive emotions can have compounding effects in the workplace.

Context

During lunch, Leadership Summit participants listened to a presentation entitled "The Intersection of Hospital Performance, Stress and Fatigue: Resilience as a Leadership Imperative." The lunch address focused on the challenges presented by working in the high-stress environment of a hospital and engaged the participants interactively to demonstrate strategies that managers and staff can use to address those challenges and, thereby, increase resilience.

An example of a management strategy shared with participants was "active constructive responding" (ACR), which details how to respond to the sharing of good news. ACR builds on research into intimate relationships, which suggests that supporting partners when good things happen is as important in building a relationship as supporting when bad things happen. The technique is characterized in conversation by maintaining eye contact and positive facial responses (e.g. smiling and laughing) when appropriate, as well as asking questions that encourage the other person to talk about their good news and savor their positive emotions. The use of ACR can alleviate stress, which can help prevent prolonged periods of stress that lead to frustration, anger, suspicion, mistrust, and, ultimately, burnout.

Discussion

Dr. Sexton facilitated a learning exercise whereby participants engaged in brief form of ACR with a partner. Participants shared a success story with their partner and practiced ACR techniques.

Breakout Session C: Community Care and Population Health

Facilitator:
Bruce Spurlock, MD, President and CEO, Cynosure Health Solutions

Case Examples:
Baystate Franklin Medical Center
HealthAlliance Hospital

Key Points

- Invest in the development of community-based care that integrates primary care and behavioral health as an effective, value-driven population health management strategy.
- Connect patients to community providers to prevent unnecessary hospitalizations and emergency department visits.

Context

Significant improvements in health outcomes and successful control of the rise in health care spending will not occur unless the underlying drivers of poor health are addressed, including both the social and physical determinants of health, many of which are outside the boundaries of the health care system. Therefore, Breakout Session C explored examples of community-level interventions. The breakout session featured representatives from Baystate Franklin Medical Center and HealthAlliance Hospital, who shared their experiences addressing behavioral health issues confronting their communities.

Baystate Franklin Medical Center

Baystate Franklin Medical Center is a 90-bed community hospital located in Greenfield, MA. Recently, the hospital and its community partners (police, courts, and primary care practices) created the regional Opioid Education and Awareness Task Force to address issues of opioid addiction in Franklin County and the North Quabbin Region. Like many other communities, Franklin County has been experiencing an increase in the number of people misusing and becoming addicted to prescription opioids and heroin. This has led to overdose-related deaths and ongoing health and social problems since not enough people are achieving long-term recovery from opioid addiction. An 18-month analysis of Baystate Franklin's patients indicated that opioid dependent patients visited the hospital an average of 5.1 times in 18 months compared to 1.9 times for patients without a substance abuse disorder.

"This is not something that is going to be solved inside the hospital walls."
Baystate Franklin Medical Center representative describing the problem of opiate addiction in Franklin County and North Quabbin Region

The Opioid Education and Awareness Task Force set about to reduce the rates of opioid misuse and addiction and the incidence of opioid overdose. It also sought to increase the rates of long-term recovery from opiate addiction.

To do so, the Task Force has sought to hold physicians accountable for the medications they prescribe and for making sure patients use the medications properly. One strategy to achieve these goals is through the education and implementation of the "Safe Prescriber Pledge." Over 60 doctors in the area have signed onto the pledge and agreed to take steps to combat opiate addiction.

Doctors pledge to learn to recognize symptoms of addiction and substance abuse in patients and direct them to appropriate treatment for their addiction; make proactive use of the Massachusetts Prescription Monitoring Program, which helps prescribers notice doctor-shoppers and drug-seekers and to help law enforcement and medical agencies prosecute problem prescribers; apply risk stratification to improve care of the patient and reduce risk of harm; recognize that not all pain requires opioid medicine; and, regularly assess patients with opioid prescriptions for well-being and improvement in function. Doctors also commit to seeing patients more often, giving urine drug tests, and conducting pill counts.

HealthAlliance Hospital

A representative from HealthAlliance Hospital described implementing a program to enhance how a patient navigates behavioral health services in the hospital's emergency department (ED). HealthAlliance Hospital serves the communities in North Central Massachusetts and Southern New Hampshire; it is a member of UMass Memorial Health Care. With the support of CHART funding, HealthAlliance Hospital is leveraging the use of social workers as behavioral health patient navigators in the ED to coordinate care, enhance communication between caregivers (both in the hospital and in the community), provide education, and serve as a patient advocate.

The patient navigator ties in community partners (e.g. community health centers) and other care supports, such as intensive case management services. Responses from patients have been overwhelmingly positive and ED visits have decreased since the program began.

Discussion

Following presentations from both hospitals, participants were asked to reflect on their own experiences addressing population health concerns. The discussion focused on issues relating to the emergency department because that is where a lot of problems in providing access to quality community care options become apparent. Participants noted:

- **Emergency department boarding is a symptom of lack of community-based care options or linkages**. One theme that emerged from both projects discussed during the breakout was the ongoing problem with emergency department boarding, particularly for behavioral health patients, and how it relates to ensuring that the ED has linkages with community-based partners to solve the problem of "frequent fliers." One participant described how his hospital opened a behavioral health diversion clinic adjacent to the ED. This intervention significantly impacted ED boarding, although it resulted in patients waiting at the hospital until an inpatient bed was available.

- **Connect inpatients to community-based behavioral health providers to prevent unnecessary emergency department visits.** Another participant described the importance of connecting patients leaving the behavioral health inpatient setting and connecting them quickly with community-based care—in order to avoid ED visits following discharge.

- **Partner with community mental health agencies to find grants and other sources of funding to ensure access to services.** ED boarding for behavioral health patients is part a symptom of a breakdown in access to community-based providers, particularly for adolescents and children as well as providers who treat violent, sexual offenders. In those cases, several participants described efforts to partner with community mental health agencies and find grants to fill budget holes to support these services.

Breakout Session D: Innovative Business Approaches

Facilitator:
John Freedman, MD, MBA, Principal, Freedman HealthCare

Case Examples:
Beth Israel Deaconess Hospital – Plymouth
Southcoast Hospitals Group

Context

Breakout Session D focused on practical and innovative approaches to business transformation, including implementation of alternative payment methodologies (APM). The breakout session included brief introductory remarks by representatives from Beth Israel Deaconess Hospital—Plymouth and Southcoast Hospitals Group.

Beth Israel Deaconess Hospital—Plymouth

Beth Israel Deaconess-Plymouth is a 150-bed, acute care community hospital and serves residents from 12 towns in Plymouth and Barnstable counties. It is an affiliate of Beth Israel Deaconess Medical Center in Boston. Representatives from BID-Plymouth emphasized the importance of changing the paradigm of care in hospitals, stating, "In Massachusetts, we're good at doing things to people instead of for people. We have to flip the switch to get there."

Southcoast Hospitals Group

Southcoast Hospitals Group is comprised of three community hospitals including Charlton Memorial Hospital in Fall River, St. Luke's Hospital in New Bedford and Tobey Hospital in Wareham. A senior leader from Southcoast Hospital Group stressed that in his community, despite advances statewide, there are still a significant number of uninsured and a depressed economy, so his job is to focus on making the health care dollar go farther and be more effective. He stated that the change should come in how hospitals think about things like community benefits. He relayed an example of how the hospital provided funding to build a basketball court and worked with law enforcement and city officials to support maintenance in a collaboration to address obesity.

> "In Massachusetts, we're good at doing things to people instead of for people. We have to flip the switch to get there."
> *Community Hospital CEO*

Key Points

- Hospitals should identify hallmark community-based services where it can retain or increase market share.
- People who are in the hospital that do not need to be are being harmed due to potential complications and overutilization of care.
- Physician compensation models should be flexible (e.g., depending on the area of specialty) and should include significant linkage to quality benchmarks.

Discussion

The balance of the breakout session consisted of Dr. John Freedman and participants asking questions followed by discussion. Several questions and themes emerged from the discussion:

- Moving from fee-for-service to alternative payment methodologies requires focusing on drivers other than inpatient volume. One hospital saw admissions drop 10-15 percent after implementing the Medicare Shared Savings Program; however, the hospital was committed to the program and more importantly knew that reducing admissions was the best thing for patients. The hospital representative stated that investments in infrastructure are crucial, but manageable. The real financial issue is a decrease in inpatient volume. The speaker noted that part of the answer is retaining patients in the community. He stated that it is important to pick the "hallmark services" where a hospital thinks it can retain or increase market share. The speaker said that having fewer patients is also an opportunity to reduce costs. Another hospital representative stated that

his hospital is committed to living within the benchmark of Medicare fee-for-service rates and used that as a guidepost in evaluating the changing the cost structure. Another hospital executive stated that his facility has reduced use of hospitalists given reductions in volume.

- Hospitals must move on from just exploring payment alternatives with some payers to a full commitment to move away from traditional reimbursement and care delivery models. One hospital executive said that hospitals cannot make the switch from volume to value fast enough. He stated that if leadership is capable of showing results and sharing data internally, the dynamic with doctors will change significantly and create new energy around the transformation. Another participant encouraged attendees to make the move away from volume-based care—stating that people who are in the hospital that do not need to be are being harmed due to potential complications and overutilization of care.

- Change management requires active physician engagement and alignment. Participants noted that change management is difficult and is largely about getting physician practices aligned. One hospital created both a physician leader and a business leader, who were asked to work together on quality and outcomes as well as business development and budget. Physician champions who understand the mission and new direction of the organization are very important. One participant noted that it is critical to have physician acknowledgement that doctors may not need to (or may not be able to) see every patient. Participants mentioned examples of using Advance Practice Registered Nurses (APRNs) for primary care and relying on nurses or physical therapy specialists to determine whether a patient needs to see a neurologist.

- Physician compensation models must support the change from volume toward value. "Many doctors grew up doing volume and churning patients and they don't want to give that up," one participant said. "But if we can lower unit cost by having (patients) see midlevel practitioners, it's good for the system and doesn't necessarily affect quality." Another participant indicated that his hospital does not have one physician compensation model, but stated that it has to be based on panel size and other clinical measures. The discussion also turned to the importance of having different approaches for primary care physicians and specialists. Specifically, for primary care, it's important to have a significant piece of compensation tied to quality bonuses. For all doctors, a transition period is important and the model should incentivize covered lives and quality. One participant shared how his hospital started to introduce patient experience and "citizenship" measures into reimbursement incentives. Examples include time from check-in to an exam room, and speed of contacting a referral. The speaker felt it was important that doctors be involved in developing these "behavioral expectations." A number of commenters emphasized that having data available to clinicians is very important. One respondent said "the way you get physicians to accept risk is to show them the data and show them what they can do to succeed."

> "The way you get physicians to accept risk is to show them the data and show them what they can do to succeed."
> *Community Hospital CEO*

- Recruitment approaches and administrative structures can help hospitals make the transition from volume to value. Participants noted that financial cross-subsidization across the system is a reality. One hospital indicated that it is making investments that it knows will mean negative margins, but "once we get to the future state, the math will balance out." Another hospital, which is involved in an ACO, has a full-time recruitment infrastructure that is working to identify physicians. This is much easier if there is a physician leader to support recruitment. Referral practices were also discussed. A participant stated that it is important to have doctors involved in the recruitment process, because they will only refer care to when they are comfortable with the provider. Lastly, the point was made that an ACO involves hardware, software and people—all of which is expensive. The goal is to make sure that the investment in competency results in consistent care and the financial benefit will come in the future.

SESSION VII:
LEADERSHIP AND THE PATH FORWARD: OPPORTUNITIES FOR CHART & HPC

Speaker: Bruce Spurlock, MD
President and CEO, Cynosure Health Solutions

KEY POINTS

- CHART hospitals are typically fully engaged in efforts respond to "the innovation imperative." A central threat to transformation in community hospitals is a failure to act decisively to take on risk.
- Changes in care delivery will require teamwork and engagement of staff throughout an institution.
- Middle managers play a crucial role in leading transformation and developing culture norms at the unit level.

CONTEXT

After attendees had finished the last of the breakout discussions, Dr. Bruce Spurlock facilitated a discussion designed to support reflection about the day's learnings. Dr. Spurlock structured the discussion around two questions discussed for short periods at individual tables, followed by large group discussion:

- Assume your hospital fails at needed transformation – why did it fail?
- What do CHART Hospitals need to do not to fail?

DISCUSSION

Several themes and observations were made regarding the path forward for community hospitals.

- While uneven payment strategies from the payer community could frustrate the progress of community hospital transformation, in Massachusetts, the move toward value-based payment is underway and decisive. A recurring theme across leadership summit sessions was the importance of the timing of hospital transformation efforts. A variety of metaphors were used to illustrate the conundrum: when should hospitals "flip the switch" and embrace a care delivery system based on quality instead of volume?; How can providers manage "with one foot in two canoes?" Hospitals recognize that misaligned payer expectations – in the form of residual volume-based payment methods or value-based contracts with competing clinical priorities -- can exert a powerful influence on hospital and physician behavior. Notwithstanding that recognition, CHART hospitals are typically fully engaged in efforts respond to "the innovation imperative," and indeed a central threat to transformation in community hospitals is a failure to act decisively to take on risk.

- Community hospitals need a combination of sophisticated leadership and resources to address and adapt to the changes underway in the health care system. Other threats to successful systemic care delivery reform in community hospitals involve resources and capacity. Community hospital leadership teams and managers need new skills and tools that enable care that is responsive to all factors affecting a patient and a community. Hospital leaders also need to understand how to effectively manage through change within their institutions, particularly when there are competing priorities derived from day-to-day challenges of operating a hospital. Communication with staff and patients in the community about the hospital's strategic plan will be an essential element of success.

- Middle management and line staff must be informed and engaged participants in transformation. Across the Leadership Summit domains of patient safety, hospital culture, leadership for transformation, and patient and community engagement, the role of middle managers – service line chiefs and nurse managers – in supporting transformation is critical. Changes in care delivery will require teamwork and engagement of staff throughout an institution. Middle managers play a crucial role in leading transformation and developing culture norms at the unit level. For those managers it is important to set specific goals in order to define what "transformation" means in concrete terms. Front-line staff must understand what they need to do to support a hospital's vision for transformation.

SESSION VIII:
Enabling Transformation through Engaged Leadership

Speakers: Sara Singer, PhD, MBA
Harvard School of Public Health
Iyah Romm
Director of Policy for System Performance and Strategic Investment, Health Policy Commission

Key Points

- Unit level managers need support, skills and consistent strategic direction.
- Hospitals should strive for a culture that is psychologically safe for all employees to raise concerns and share mistakes.
- Hospital leaders should recognize that front-line staff understand problems the best, and should connect with and listen to those workers.

Preliminary Results of World Management Survey of CHART Hospitals

Iyah Romm presented preliminary results of the World Management Survey of CHART hospitals. Results included eight CHART hospitals who participated in the survey, which was voluntary but encouraged by the HPC. CHART hospital management scores show room for improvement across the CHART cohort and within individual hospitals. The results showed there is more variation in management scores within hospitals than across hospitals. Within hospitals, CEOs tend to be more optimistic about management performance than service line chiefs or nurse managers. Both findings suggest the primacy and importance of management skills at the unit or service level and validate the concerns of CHART hospitals that unit level managers need support, skills and consistent strategic direction. Preliminary findings also show that CHART hospitals score lower than a comparator state and the overall World Management Survey sample.

Principles for Leading Organizational Transformation

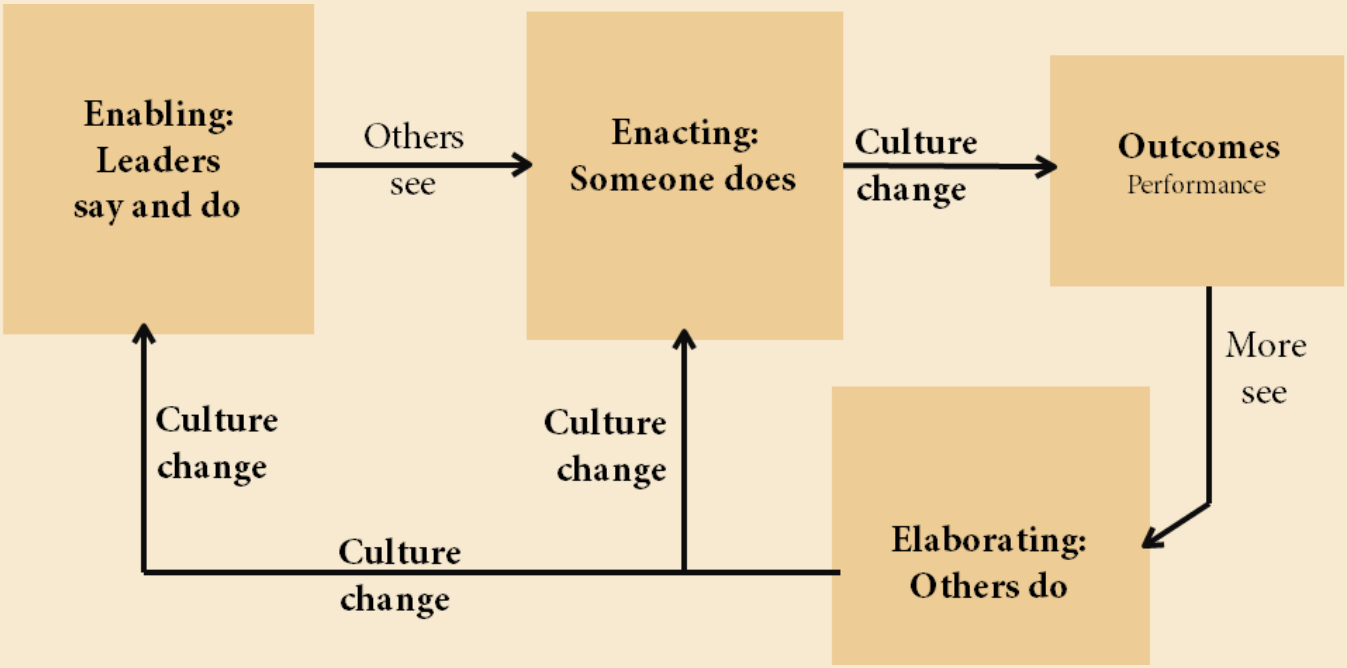
Based on the World Management Survey preliminary results and persistent evidence of preventable harm in

Table 3: Key Findings from CHART Respondents : Variation in CHART Cohort

	Comparator State (13 hospitals, 66 interviews)			CHART Hospitals (8 hospitals, 58 interviews)		
	Average Management Score *hospital level*	Within hospital standard deviation	Across hospital standard deviation	Average Management Score *hospital level*	Within hospital standard deviation	Across hospital standard deviation
Mean	3.29	0.43	N/A	3.06	0.37	N/A
C-suite	3.42	N/A	0.39	3.26	N/A	0.33
Chiefs	3.24	N/A	0.59	2.83	N/A	0.44
Nurse Managers	3.27	N/A	0.54	3.01	N/A	0.23
Administration	3.42	N/A	0.39	3.26	N/A	0.33
Cardiology	3.04	N/A	0.54	2.81	N/A	0.80
OB/GYN	3.37	N/A	0.40	2.79	N/A	0.29
Orthopedics	3.19	N/A	0.70	2.90	N/A	0.39
Surgery	3.20	N/A	0.57	2.97	N/A	0.28

Source: Measuring Managerial Alignment in Healthcare: Preliminary Results – the World Management Survey in select CHART Hospitals, Olivia Jung and Raffaella Sadun, Harvard Business School, 2014

Figure 8: How Cultures Change



Source: Adapted from Singer, S. J., & Vogus, T. J. (2013). A Review of Reducing Hospital Errors: Interventions that Build Safety Culture. Annual Review of Public Health, 34(21) 1-24.

hospitals nationally, the CHART program provides an opportunity to accelerate the pace of improvement in community hospitals. Dr. Sara Singer explained that the slow pace of improvement in hospital performance can be attributed to one of two factors:

- A deficiency of will or ambition on the part of hospital leaders; or,
- A lack of understanding about how to lead improvement.

Hospitals leaders can support an environment that enables systemic change through a three-fold framework:

1. Understand the culture of the institution and the characteristics of a culture that can support change. Hospitals should strive for a culture that is psychologically safe for all employees to raise concerns and share mistakes. Culture should be learning-oriented with distinct mechanisms for learning and training, and system-oriented with a focus on perfecting systems and minimizing risk. Leaders must model behaviors that support a safety-oriented culture, including respect of all ideas and concerns.
2. Provide leadership which is action-oriented and undertaken with humility and in partnership with teams. The actions of hospital leaders have an outsized impact of organizational culture. Skillful leadership requires partnering, building consensus, and empowering others to act. Hospital leaders should recognize that front-line staff understand problems the best, and should connect with and listen to those workers.
3. Enable and reinforce actions through systems, by aligning organization strategy, capabilities, systems and processes toward a performance goal. Taking action through systems means that problems must be addressed over time, across a continuum of care, and in a multi-disciplinary way. Approaching improvement through systems rather than through patients or conditions helps address the greatest barrier to health system improvement, the fragmentation of systems of care

The CHART Opportunity

The CHART program is a unique opportunity informed by the vision of the HPC to support improvement community hospital through financial resources, expert coaching, and data sharing to provide tools for improvement. The program will also benefit from peer-to-peer sharing and a dynamic market in which payment reforms are a high policy and payer priority. With all those factors taken together, the CHART program presents an opportunity for hospital leaders to accelerate change.

Endnotes

1. Source: CMS Bureau of Economic Analysis; HPC analysis
2. Kaiser Family Foundation; American Hospital Association; Medical Expenditure Panel Survey; HPC analysis
3. Source: Center for Health Information and Analysis – 2012 Relative Price Data Supplement
4. American Hospital Association, Committee on Research. (2014, January). Your hospital's path to the second curve: Integration and transformation. Chicago, IL: Health Research & Educational Trust.
5. Classen DC, Resar R, Griffin F, et al. 'Global trigger tool' shows that adverse events in hospitals may be ten times greater than previously measured. Health Aff (Millwood). 2011;30:581-589.
6. NQF, National Voluntary Consensus Standards for the Reporting of Healthcare-Associated Infection Data: A Consensus Report, Washington, DC: NQF; 2008.
7. Institute of Medicine, Preventing Medication Errors, Washington, DC: National Academies Press; 2006. Frankel. A, Leonard M. Update on Safety Culture. Web M&M: AHRQ; July/August 2013.
8. American Hospital Association, Committee on Research. (2014, January). Your hospital's path to the second curve: Integration and transformation. Chicago, IL: Health Research & Educational Trust.
9. American Hospital Association, Committee on Research. (2014, January). Your hospital's path to the second curve: Integration and transformation. Chicago, IL: Health Research & Educational Trust.

Appendix I: Faculty and Attendees

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