COMMONWEALTH OF MASSACHUSETTS

HEALTH POLICY COMMISSION

June 10, 2015

Board Meeting

Agenda

- Overview on the State Conflict of Interest Law
- Approval of Minutes from the April 29, 2015 Meeting
- Executive Director Report
- Quality Improvement and Patient Protection Update
- Cost Trends and Market Performance Update
- Community Health Care Investment and Consumer Involvement Update
- Care Delivery and Payment System Transformation Update
- Administration and Finance Update
- Schedule of Next Commission Meeting (July 22, 2015)

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Vote: Approving Minutes

Motion: That the Commission hereby approves the minutes of the Commission meeting held on April 29, 2015, as presented.

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June 10 Board Meeting: Votes

1. Minutes from April 29, 2015
2. Proposed Regulations for the Office of Patient Protection
3. Final Recommended Regulation Governing Nurse Staffing in Hospitals ICUs
4. Fiscal Year 2016 HPC Operating Budget

Agenda

- Overview on the State Conflict of Interest Law
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- Executive Director Report
- **Quality Improvement and Patient Protection Update**
  - Final Regulation Governing Nurse Staffing in Hospital ICUs
  - Proposed Regulations for the Office of Patient Protection
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Nurse Staffing Law – Chapter 155 of the Acts of 2014

An act relative to patient limits in all hospital intensive care units.

Section 231. For the purposes of this section, the term "intensive care units" shall have the same meaning as defined in 105 CMR 130.020 and shall include intensive care units within a hospital operated by the commonwealth.

Notwithstanding any general or special law to the contrary, in all intensive care units the patient assignment for the registered nurse shall be 1:1 or 1:2 depending on the stability of the patient as assessed by the acuity tool and by the staff nurses in the unit, including the nurse manager or the nurse manager's designee when needed to resolve a disagreement.

The acuity tool shall be developed or chosen by each hospital in consultation with the staff nurses and other appropriate medical staff and shall be certified by the department. The health policy commission shall promulgate regulations governing the implementation and operation of this section including: the formulation of an acuity tool; the method of reporting to the public on staffing compliance in hospital intensive care units; and the identification of 3 to 5 related patient safety quality indicators, which shall be measured and reported by hospitals to the public.

Codified at MGL c. 111, § 231

Regulatory Development: Stakeholder Engagement/Feedback

Public Listening Sessions

- CHIA Daley Room October 29, 2014
- State House Gardner Auditorium November 19, 2014

HPC Staff ICU Visits

- Boston Children's Hospital
- Brigham and Women's Hospital
- Steward Morton Hospital & eICU campus

Feedback on Quality Measures

- HPC solicited feedback on quality measures on December 10, 2014
- Received 3 submissions

QIPP Committee Meetings

- August 13, 2014
- October 29, 2014
- December 10, 2014
- January 6, 2015
- March 4, 2015 (release of 4 proposed quality measures)
- May 20, 2015

HPC Staff Meetings with Stakeholders

- Massachusetts Hospital Association
- Massachusetts Nurses Association
- American Nurses Association-MA Chapter
- Department of Public Health (DPH)
- Organization of Nurse Leaders
- Quadramed (acuity tool vendor)
- Massachusetts Council of Community Hospitals
- Steward Health Care System
- Navigant Consulting Inc.
- Accenture
- DPH Shattuck Hospital

Release of Proposed Regulation 958 CMR 8.00

- Voted on by QIPP Committee January 6, 2015
- Voted on by HPC Board January 20, 2015

Public Hearings on Proposed Regulation

- Boston March 25, 2015
- Worcester April 2, 2015

Official Public Comment Period

- January 20, 2015 – April 13, 2015

Key Considerations in Development of Regulation 958 CMR 8.00

Recognition of Hospital/ICU Differences

- Recommended final regulation strikes the appropriate balance consistent with the statutory goals of promoting patient-centered staffing while recognizing unique circumstances of each hospital ICU
- Emphasis on the process for development or selection of acuity tool

Role of ICU Staff Nurses

- Meaningful opportunity for participation and input by ICU Staff Nurses in the selection, development and implementation of Acuity Tool

Consideration of Administrative Burden

- Recommended final regulation's reporting requirements balance need to ensure staffing compliance with reasonable administrative requirements.

Role of DPH

- The Department of Public Health (DPH) will develop and implement certification and compliance procedures

Recommended Final Regulation 958 CMR 8.00

958 CMR: HEALTH POLICY COMMISSION

958 CMR 8.00: PATIENT ASSIGNMENT LIMITS FOR REGISTERED NURSES IN INTENSIVE CARE UNITS IN ACUTE HOSPITALS

Section

Recommended amendments in response to public comment

Patient Assignment Limits (Title and 8.01)	▪ Title changed from "Registered Nurse-to-Patient Ratio in Intensive Care Units in Acute Hospitals" to "Patient Assignment Limits for Registered Nurses in Intensive Care Units in Acute Hospitals" to more accurately describe the law's requirements ▪ Corresponding change in Scope and Purpose (8.01) for consistency
Application of Limits "at all times" (8.04)	▪ Based on public comments, including the fact that the statute does not require it, removed language stating that Patient Assignment limits must apply "at all times during a Shift" and "at any time during a Shift" from 958 CMR 8.04(1) and (2) ▪ Language was intended to make clear that assignment limits are not elective; language was not intended to impose unreasonable requirements that impede ICU daily work flow ▪ DPH may consider guidance on this issue
Composition of Advisory Committee (8.06)	▪ Consensus in public comments that the registered nurses involved in the advisory committee should be ICU staff nurses ▪ Amended to increase staff nurses' role to require *at least* 50% direct care ICU staff nurses in the ICU in which the Acuity Tool will be deployed ▪ Changing the advisory nature of the committee is contrary to the statute ▪ Added language (in a new 8.06(4)) to address potential administrative efficiency in Acuity Tool development process in Acute Hospitals with multiple ICUs

Certification Timeline (8.12, as renumbered)	▪ Incorporating feedback, extended certification timeline in 8.12, as renumbered, as follows:
	  ▪ Academic medical centers must comply with DPH's requirements for certification of Acuity Tools by March 31, 2016, or as otherwise specified in DPH's requirements for certification
	  ▪ All other Acute Hospitals must comply with DPH's requirements for certification of Acuity Tools by September 30, 2016, or as otherwise specified in DPH's requirements for certification

Recommended amendments in response to public comment, continued

Additional Bargaining Obligations (8.06(3))	▪ Based on public comment, and the fact that the language is not required by the statute and is a statement on applicable obligations, removed language in proposed regulation 8.06(3) in its entirety

Identification of Quality Measures (8.11)	▪ At the March 4 QIPP committee meeting, the HPC released the following four proposed quality measures for public comment: (1) Central Line-Associated Blood Stream Infection (CLABSI); (2) Cather-Associated Urinary Tract Infection (CAUTI); (3) Pressure Ulcers (hospital acquired); and (4) Patient Fall Rate (all falls, with or without injury)
	▪ Comments received on all of the proposed quality measures, as well as recommendations for other measures for inclusion
	▪ Consensus to change Patient Fall Rate to Patient Falls with Injury
	▪ The HPC recommends the following quality measures:
	  ▪ (1) CLABSI – NQF #0139
	  ▪ (2) CAUTI – NQF #0138
	  ▪ (3) Pressure Ulcers – NQF #0201; and
	  ▪ (4) Patient Falls with Injury – NQF #0202
	▪ Following promulgation of the regulation, the HPC will issue a bulletin specifying the measures, which will be distributed widely and posted on the HPC's website

ICU Staffing Plan (formerly 8.12)	▪ Section 8.12 in the proposed regulation required Acute Hospitals to develop a Registered Nurse staffing plan based on the implementation of and compliance with 958 CMR 8.00 ▪ Based on analysis of comments received, removed the section altogether ▪ Section is unnecessary given the compliance obligations elsewhere in the regulation and is not expressly required by the statute

Amendments not recommended in response to public comment

"Default" Ratio of 1:1	▪ Statute specifies that "the patient assignment for the registered nurse shall be 1:1 or 1:2 depending on the stability of the patient…" ▪ Despite some comments asserting that the statute requires a default ratio of one nurse to one patient, no change to language regarding Patient Assignment limits ▪ Reflecting the statutory language, regulation does not require Acute Hospitals to implement a "default" Patient Assignment of 1 nurse to 1 patient in ICUs
Application of Limits to Unit (Definition of "ICU Patient" in 958 CMR 8.02)	▪ Statute requires compliance with nurse staffing requirements in all intensive care units ▪ No change to language specifying that the staffing requirements apply to intensive care units in Acute Hospitals and hospitals operated by the Commonwealth ▪ HPC recognizes that some Acute Hospitals, particularly community hospitals, may have patients with lower acuity in an ICU for a variety of reasons (e.g., lower acuity patients for whom transfer or discharge is not recommended, boarders, location of specialized technology or equipment, patients with unique care needs) ▪ However, the statute requires unit-wide applicability of the staffing limit requirements and the HPC does not have flexibility on this issue
Patient Assessment (8.05)	▪ No change on the issue of collective Staff Nurse assessment, based on the law and supporting testimony and comments ▪ Per the statute, in the event of a disagreement between the judgment of the Staff Nurse assessing the patient and the Acuity Tool, the regulation allows the Nurse Manager to consult with Staff Nurses on the unit, in addition to other factors, to determine the appropriate Patient Assignment ▪ However, in response to comments from nurses, included language to clarify that nothing in 8.05 limits the application of relevant state or federal law to registered nurses, including the state licensure requirements for nurses ▪ Did not adopt suggested alternative (generally, more frequent) assessments of ICU Patient stability using the Acuity Tool, as 8.05(3) establishes the appropriate minimum assessment using the Acuity Tool

Additional recommendations

Required Elements of the Acuity Tool (8.07)	▪ Based on analysis of public comments, created defined terms for both “Clinical Indicators of Patient Stability” and “Indicators of Staff Nurse Workload,” incorporating language from proposed regulation 8.07(4), and removed the exemplary specificity from the body of the text ▪ Specific indicators will be determined during the Acuity Tool development or selection processes for each ICU

Records of Compliance (8.08)	▪ 8.08(1) – Records of Compliance for Certification Purposes
	  ▪ Specifies the types of records required to be retained, which is now a defined set of records
	▪ 8.08(2) – Records of Staffing Compliance
	  ▪ Allows Acute Hospitals to determine the appropriate mechanism for documentation and retention, consistent with state and federal law applicable to records that include individually-identifiable health information, used by hospitals to make decisions about the care and treatment of patients
	▪ In consultation with DPH, no change recommended to the 10 year retention requirement

Acuity Tool Certification and Compliance (8.09)	▪ In order to provide flexibility to DPH in its development of certification and compliance procedures, removed 8.09(1) and (2) in their entirety
Public Reporting on Staffing Compliance (8.10)	▪ Simplified the method for reporting in 8.10(2) to require that Acute Hospitals post the reports provided to DPH on the hospital’s website; further, recommend clarifying DPH’s role in determining the appropriate form and manner for reporting on staffing compliance to DPH ▪ Based on public comments, removed 8.10(1)(b) in its entirety ▪ No change regarding posting or requiring notice of the law
Collection and Reporting of Quality Measures (8.11)	▪ Simplified the method for reporting in 8.11(3) to require that Acute Hospitals post the reports provided to DPH on their website ▪ Further, clarified DPH’s role in determining the appropriate form and manner for reporting quality measures

Discussion: Definition of Intensive Care Unit (958 CMR 8.02)

Overview of Issue	▪ Statute applies to "all intensive care units," including those "within a hospital operated by the Commonwealth"; "the term 'intensive care units' shall have the same meaning as defined in 105 CMR 130.020…" ▪ DPH licensure regulation defines "intensive care unit' as well as Coronary Care Unit (CCU), Burn Unit, Pediatric Intensive Care Unit (PICU), and Neonatal Intensive Care Unit (NICU) ▪ Proposed regulation applied to all such units licensed by DPH
Summary of Comments	▪ Hospital commenters objected to the application of the Patient Assignment limits to ICUs other than adult ICUs on legal and policy grounds. They stated that NICUs, PICUs, CCUs and burn units are separately defined in 130.020 and raised a number of policy and operational concerns with a broad definition, especially for NICUs which have unpredictable admissions and require flexibility to care for infants with a range of acuity. ▪ Other commenters disputed a narrow interpretation of applicability of the statute, supporting the application to all ICU types because the statute contains no explicit exceptions or indications that the law was intended to apply to adult ICUs only.
Recommendation	▪ The definition of ICU in the proposed regulation was based on a reasonable interpretation of the statute and the DPH licensure regulation ▪ However, given extensive commentary asserting alternative legal interpretations and policy considerations, staff recommended that the QIPP Committee advance the proposed regulation's definition of ICU in 958 CMR 8.00 for further discussion at the full Commission meeting on June 10 ▪ QIPP Committee approved the advancement of the final recommended regulation to the full Commission for consideration, provided that the Commission further discusses the definition of ICU

Proposed new section 958 CMR 8.12

8.12: Certification Timeline

Each Acute Hospital shall comply with the requirements of the Department for certification of an Acuity Tool for each ICU by the dates below, or as may be otherwise specified in the Department's requirements for certification:

(1) Each Acute Hospital that is an academic medical center, as the term is used by the Center for Health Information and Analysis, shall comply with the requirements of the Department for certification of an Acuity Tool for each neonatal intensive care unit no later than January 31, 2017, and for all other ICUs no later than March 31, 2016.

(2) All other Acute Hospitals shall comply with the requirements of the Department for certification of an Acuity Tool for each ICU no later than January 31, 2017.

Next Steps

May 20: QIPP Meeting

Voted to advance recommended final regulation to HPC Board

June 10: HPC Board Meeting

Discussion of and vote to approve and promulgate 958 CMR 8.00

Post-Promulgation of 958 CMR 8.00:

- HPC issues guidance identifying the four patient safety quality measures for public reporting
- DPH develops certification and compliance requirements
- Considerations for evaluation of the law

Vote: Approving final regulation

Motion: *That, pursuant to section 231 of chapter 111 of the Massachusetts General Laws, the Commission hereby approves and issues the attached FINAL regulation on patient assignment limits for registered nurses in intensive care units in acute hospitals, as amended.*

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Office of Patient Protection Regulation Updates

Medical Necessity Criteria

958 CMR 3.101

- Changes to state law providing access to medical necessity criteria took effect on July 1, 2014, pursuant to FY 2015 budget*
- Updates are required to conform regulation to applicable Massachusetts law
- Updates will clarify expanded access to proprietary and non-proprietary medical necessity criteria

Open Enrollment Waivers

958 CMR 4.000

- Updates are required to conform regulation to Affordable Care Act and related Massachusetts law
- Definition of “eligible individual” changed
- Updates would not significantly change waiver process

* Ch. 165 of the Acts of 2014, sections 18, 172 & 173 amending M.G.L. c. 6D, §16(a); c. 176O, §§12(a) & 16(b)

Medical Necessity Criteria Regulation, 958 CMR 3.101

OPP Regulation	Proposed Update
958 CMR 3.101(3)(b)	Replace current language. Criteria will be disclosed to OPP, proprietary criteria not subject to Mass. public records laws, M.G.L. c. 4, §7, clause Twenty-sixth and M.G.L. c. 66, §10.
958 CMR 3.101(3)(c)	Non-proprietary criteria: access to the general public.
958 CMR 3.101(3)(d)	Proprietary criteria: access to insureds, prospective insureds and health care providers. Requester must identify particular treatments or services for which applicable criteria or protocols are requested.
958 CMR 3.101(4)	Non-proprietary criteria: publication on publicly available website, must be up to date.
958 CMR 3.101(5)	Insurance carrier must provide requested criteria as soon as possible and within 30 days.

Open Enrollment Waiver Regulations, 958 CMR 4.000

OPP Regulation	Proposed Update
958 CMR 4.020	Change definition of “creditable coverage” to add ACA-compliant plans, remove YAP plans which are no longer offered
958 CMR 4.020	Change definition of “eligible individual” to comply with changes to statute; resident of Massachusetts
958 CMR 4.020	Minor clarifications to definitions of “health plan,” “intentionally forgo enrollment” and “nongroup health plan”
958 CMR 4.030	Add reference to ACA, remove outdated waiver eligibility requirements
958 CMR 4.050	Updates to include reference to ACA; include reference to Health Connector as additional source of guidance
958 CMR 4.060	Minor clarification to wording
958 CMR 4.070	Change reporting date from July 1 to April 1 to consolidate and simplify report to OPP

Proposed Timeframe To Update OPP Regulations

- May 20, 2015 – QIPP Committee review of proposed regulations
- June 10, 2015 – HPC review of proposed regulations
- July 8, 2015 – Public hearing on proposed regulations at QIPP committee meeting
- August 2015 – Deadline to submit public comments on proposed regulations (date TBD)
- Fall 2015 – QIPP Committee review of final regulations
- Fall 2015 – HPC review of final regulations
- Fall/Winter 2015 – Publication of final regulations in Mass. Register

Vote: Approving Proposed OPP Regulations

Motion: That the Commission hereby approves the issuance of the PROPOSED updates to Office of Patient Protection regulations, 958 CMR 3.00, Health Insurance Consumer Protection, and 958 CMR 4.00, Health Insurance Open Enrollment Waivers, as advanced by the Quality Improvement and Patient Protection Committee and hereto attached, for public comment.

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- Quality Improvement and Patient Protection Update
- **Cost Trends and Market Performance Update**
  - Recent Material Changes
- Community Health Care Investment and Consumer Involvement Update
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Types of transactions noticed

April 2013 to Present

Type of Transaction	Number of Transactions	Frequency
Physician group merger, acquisition or network affiliation	12	29%
Acute hospital merger, acquisition or network affiliation	8	20%
Formation of a contracting entity	7	17%
Clinical affiliation	6	15%
Merger, acquisition or network affiliation of other provider type (e.g. post-acute)	4	10%
Change in ownership or merger of corporately affiliated entities	3	7%
Affiliation between a provider and a carrier	1	2%

Update on notices of material change

Notices Received Since Last Commission Meeting

- Affiliation between UMass Memorial Health Care and Quest Diagnostics Massachusetts
- Acquisition of South Shore Medical Center by South Shore Physician Ambulatory Enterprise, an affiliate of South Shore Hospital
- Joint venture between Shields Health Care Group (Shields) and Signature Healthcare Brockton Hospital to operate a PET/CT diagnostic imaging clinic
- Joint venture between Shields and Sturdy Memorial Hospital to operate a PET/CT diagnostic imaging clinic

Update on notices of material change

Elected Not to Proceed

- **Joint venture between UMass Memorial Health Care and Shields Health Care Group to open and negotiate contracts for a new ambulatory surgery center in Shrewsbury**
  - The proposed ASC would likely draw some volume from hospital outpatient departments, which, based on our analysis of the All Payer Claims Database, has the potential to result in substantial cost savings.
  - We do not anticipate a negative impact on access, quality or the competitive market.

- **Acquisition of Noble Hospital and its affiliates by Baystate Health**
  - Our analysis indicates that Noble is in financial distress; we anticipate that the cost and market impact from acquisition is less than that of closure.
  - Baystate has committed to operating Noble as a general acute care hospital for five years and has stated that it does not intend to decrease access to the behavioral health or emergency department services currently available at Noble. We did not find evidence that the transaction is likely to negatively impact clinical quality.

Update on notices of material change

Elected Not to Proceed

- **Clinical affiliation between Partners HealthCare and Steward Health Care System for pediatric and newborn medicine services at certain Steward hospitals**
  - We found that pediatric and neonatal services currently provided by Children's Hospital (Children's) will instead be provided by ***lower-priced*** Partners physicians and hospitals.
  - Children's also provides a significantly greater proportion of pediatric and neonatal services than either Partners or Steward; to the extent that this transaction results in services being shifted from Children's physicians to these other providers, we also would not anticipate a negative market impact.
  - We did not find evidence than the transaction is likely to negatively impact clinical quality or patient access to services.

Agenda

- Approval of Minutes from the April 29, 2015 Meeting
- Executive Director Report
- Quality Improvement and Patient Protection Update
- Cost Trends and Market Performance Update
- **Community Health Care Investment and Consumer Involvement Update**
  - CHART Phase 1 Final Report
  - CHART Phase 1 Presentation from Dr. Steven Sbardella, Hallmark Health System
  - CHART Phase 2 Update and Technical Assistance Plan
- Care Delivery and Payment System Transformation Update
- Administration and Finance Update
- Schedule of Next Commission Meeting (July 22, 2015)

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- Approval of Minutes from the April 29, 2015 Meeting
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  - **CHART Phase 1 Final Report**
  - CHART Phase 1 Presentation from Dr. Steven Sbardella, Hallmark Health System
  - CHART Phase 2 Update and Technical Assistance Plan
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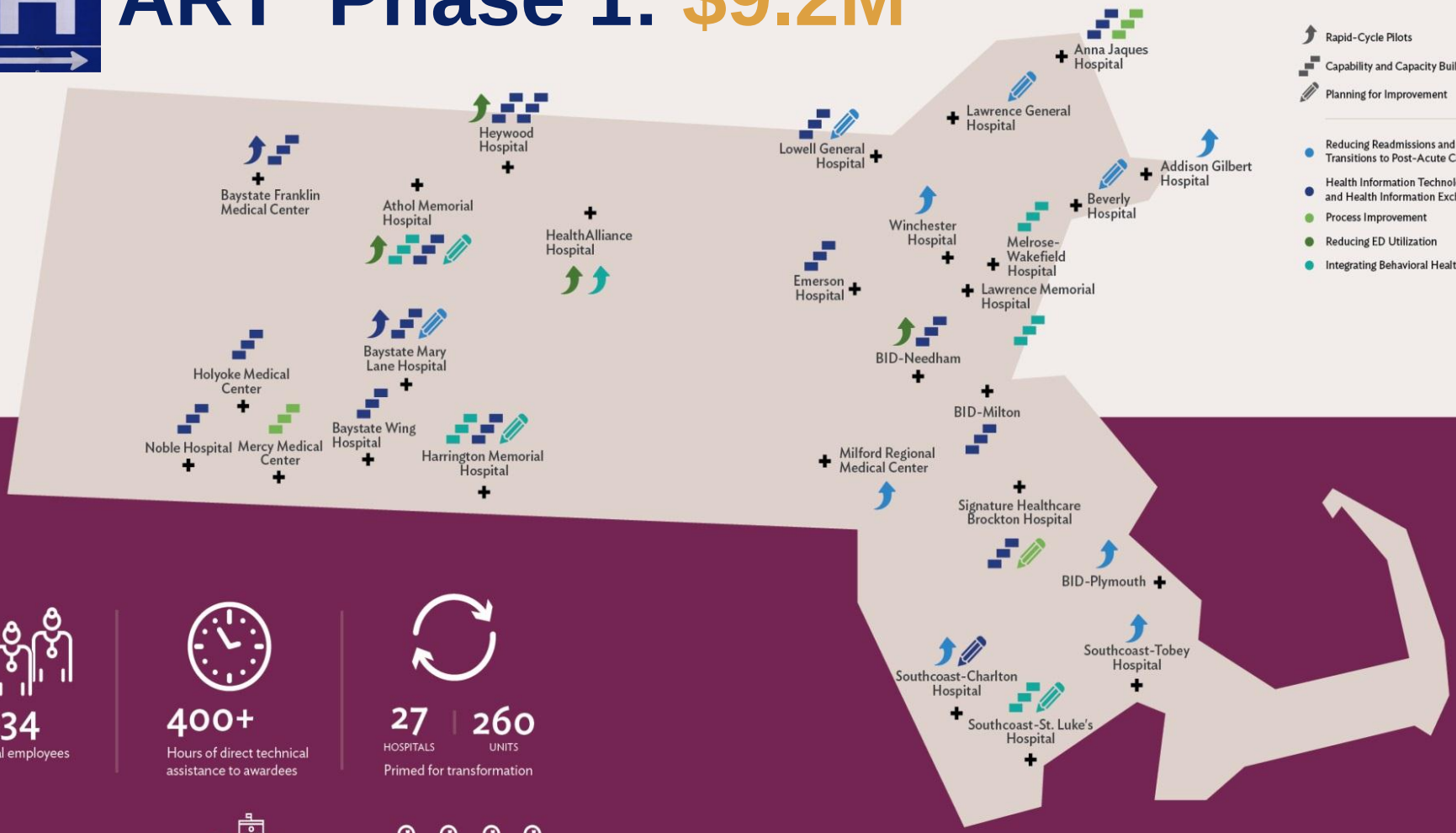
CHART Phase 1 Report

1. Introduction to the CHART Investment Program
   - CHART Overview
   - Topline Impacts
2. CHART Program Goals and Theory of Change
3. HPC Investment Approach: Building a Foundation for Transformation
4. The CHART Hospital Engagement Model
   - High intensity partnership
5. Overview of Investment Priorities
   - Reducing Readmissions
   - Reducing Unnecessary Emergency Department Use
   - Enhancing Behavioral Health Care
   - Building Technology Foundations
6. Key Lessons Learned from Phase 1 Initiatives
7. Moving Into Phase 2: Applying Lessons to Enhance CHART

CHART Phase 1: $9.2M



2,334
Hospital employees trained

400+
Hours of direct technical assistance to awardees

27 HOSPITALS | **260** UNITS
Primed for transformation

90%
of respondents believed that CHART Phase 1 moved their organization along the path to system transformation

316
Community partnerships formed or enhanced by awardees

167,000+
Patients impacted by Phase 1 initiatives

PHASE ONE

Leading national health care policy organizations recognize CHART as innovative state-based model to promote high value care

CHART featured at key national meetings; staff and advisors routinely consulted locally and nationally on innovative delivery models

	Center for Health Care Strategies Complex Care Innovation Lab[1]	Academy Health Annual Research Meeting	Brookings/Dartmouth ACO Summit Annual Meeting
Title	*What's State Government Got to Do With It?*	*Use of Locally-Derived Data to Target All-Payer Care Delivery Interventions: Lessons from Large-Scale Improvement Initiatives in CHART*	*State Innovations in Accountable Care*
Participants	Billy Millwee (Texas Medicaid Director) Bill Rago (Texas HHS Commission) Steve Somers, CHCS (Moderator)	HPC staff (Poster Session)	Bob Atlas (NC DHHS) Marni Bussell (Iowa Medicaid) Matt Salo (NAMD) Steve Cha, CMS (Moderator
Synopsis	Role of state and local governments in supporting super-utilizer programs and leveraging resources and policy to scale interventions	CHART Phase 1 lessons on use of locally-derived data (EHR, administrative data, patient interviews, etc.) fostered nimble improvement Initiatives and directly informed Phase 2	CHART as innovative public-private partnership with data driven approaches to ACO-oriented improvement in less resourced settings

Competitively Selected

1 The Complex Care Innovation Lab is a Robert Wood Johnson funded program to support 12 leading superutilizer programs around the nation, including organizations such as Hennepin Health, the Camden Coalition, HealthShare of Oregon, Commonwealth Care Alliance, Spectrum Health and many others

June 2015

HALLMARK HEALTH SYSTEM HEALTH POLICY COMMISSION

CHART

- **C**ommunity **H**ospital **A**cceleration, **R**evitalization, & **T**ransformation

- Investment Program supported by the Health Policy Commission

- *"CHARTING A COURSE FOR THE RIGHT CARE AT THE RIGHT TIME IN THE RIGHT PLACE "*

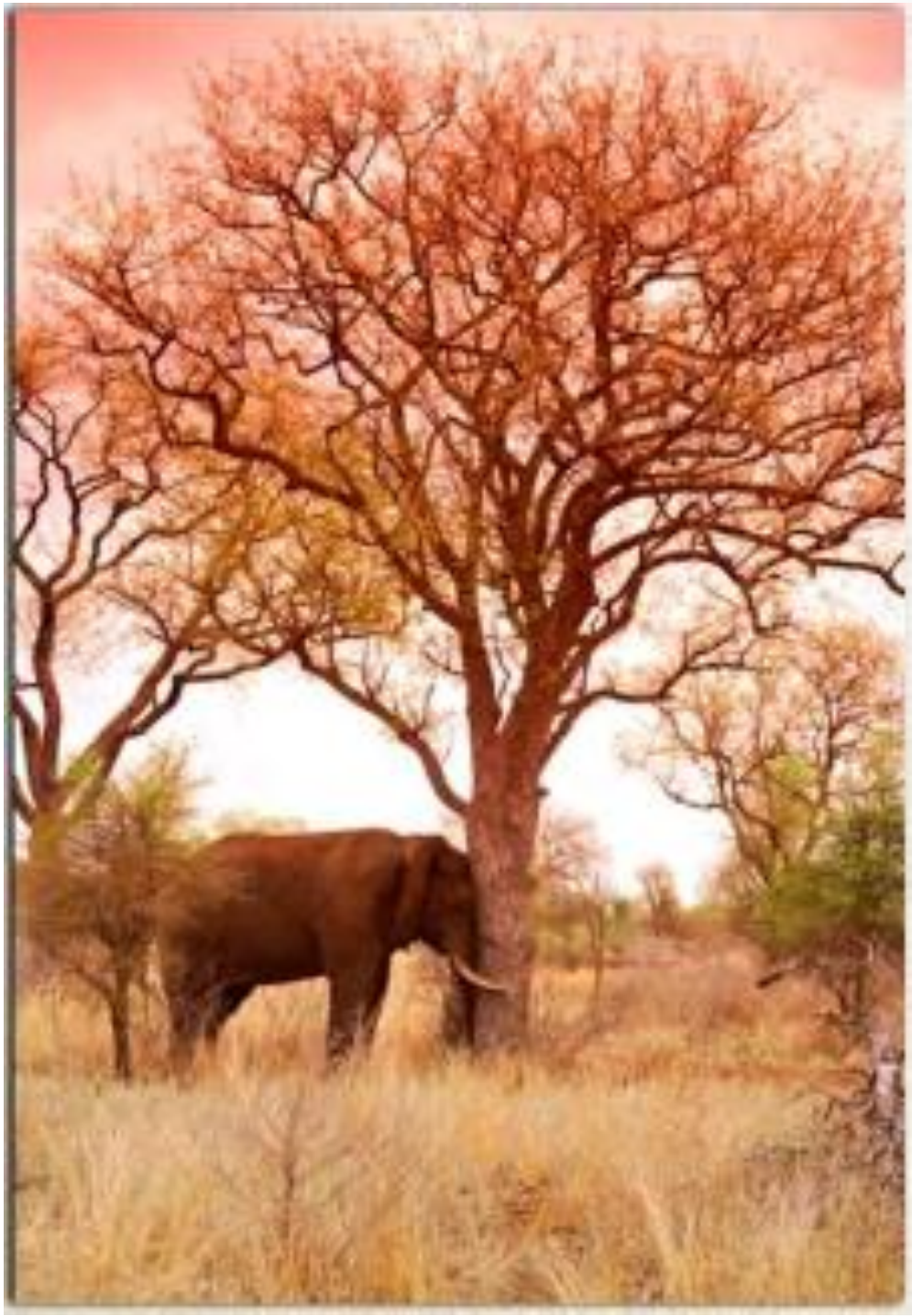
CHART: Goals

- Established through the Commonwealth's landmark cost containment law, Chapter 224 of the Acts of 2012

- The goal of the program is to:
  - promote care coordination, integration, and delivery transformations
  - advance electronic health records adoption and information exchange among providers
  - increase alternative payment methods and accountable care organizations
  - enhance patient safety, access to behavioral health services, and coordination between hospitals and community-based providers and organizations

CHART Phase 1: Goals

- Implementation of pilot models that improve quality of care and/or reduce cost
- Building capability or capacity that align with the goals of better health, better health care, and lower costs
- Meaningful operational and business planning activities that will yield a strategic vision towards system transformation



Guiding Principles From the HPC team

- Don’t boil the ocean
- Keep it simple
- Follow the data

CHART Phase 1: Hallmark Health

- 2014: Governor Patrick declared the growing use of opiates as a public health emergency
  - According to the DPH: The number of fatal opiate overdoses increased by 90% in Massachusetts between 2000 and 2012

Table 2: Hallmark Health System Community Health Needs Assessment Indicators regarding Opioid Use

CHNA Indicators (per 100,000)	Hallmark Health System Core Region	Massachusetts	Variance
Alcohol/substance-related ED visits*	826	759	67
Opioid-related ED visits*	364	214	150
Opioid-related mortality**	11.5	9.3	2.2

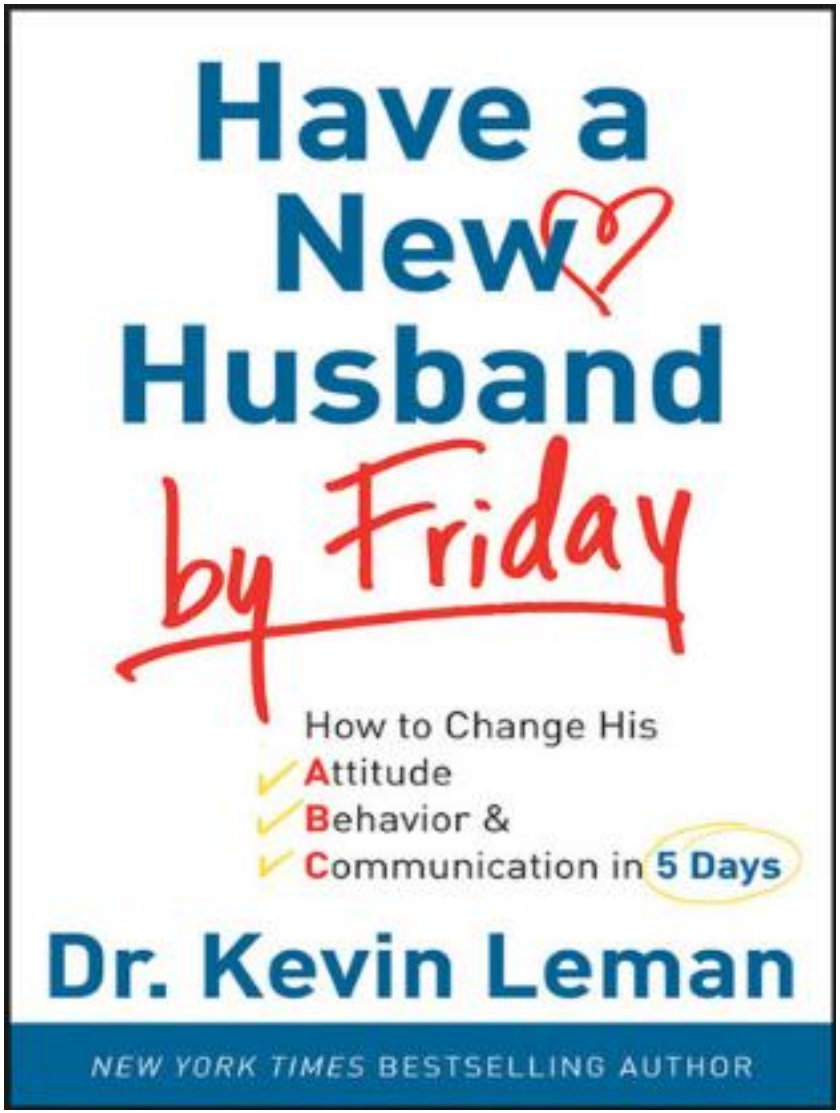
*Massachusetts. Division of Health Care Finance and Policy's Uniform Hospital Discharge Dataset System, data from 2007-2009
** Massachusetts. Department of Public Health's Registry of Vital Records for 2007-2009

- Health Policy Commission Chart 1 Summary

CHART Phase 1: Hallmark Health: Our Focus

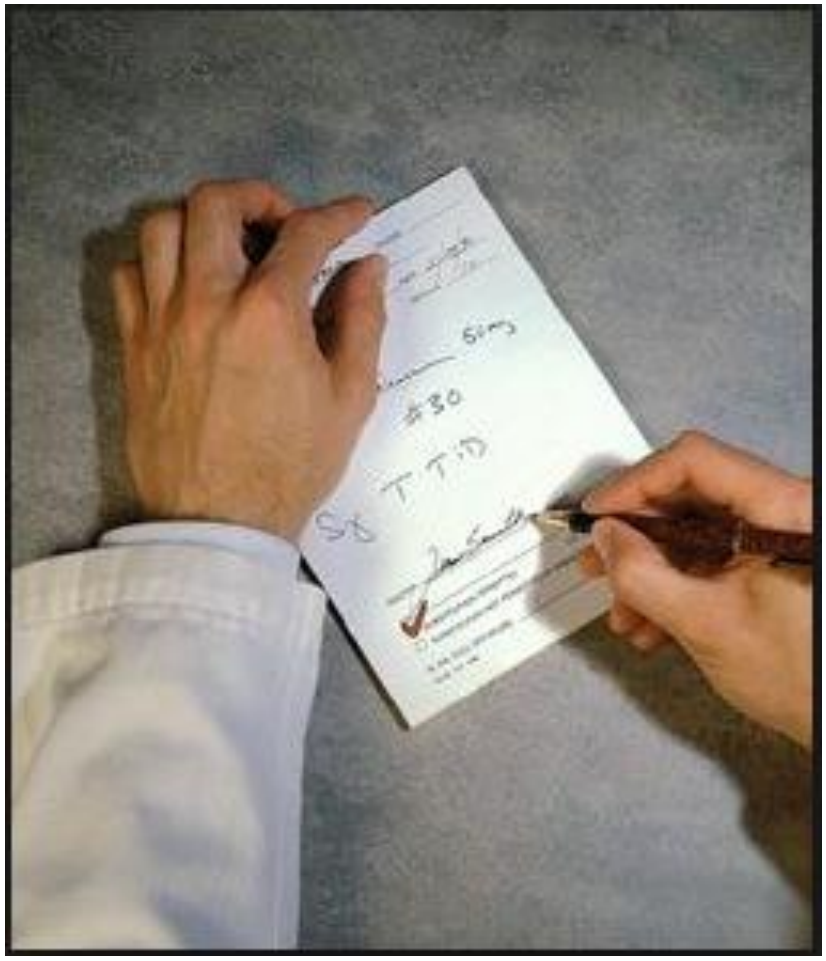
- "Mitigation of Harm: An Integrated Care Strategy to Recognize, Prevent, and/or Reduce Substance Use Disorder in Adults Presenting in the ED/Urgent Care with Back Pain"
- 6 month program
- ***Sustainability was crucial***

"Slam Dunk"


Have a New Husband by Friday
How to Change His
Attitude
Behavior &
Communication in 5 Days
Dr. Kevin Leman
NEW YORK TIMES BESTSELLING AUTHOR

" Reality Check"

Where We Focused Our Efforts



Sustainability: Our Model

- Know your audience
  - Understand the Urban Legends and the ***Reasons*** they developed
  - How do people learn
- All-or-Nothing: Forcing the Issue
  - Fails with a cohort of independent personalities (Physicians)
- Process:
  - Standardization
  - Keep the issue in the forefront

The Issue

- “Are you prescribing a potentially addictive medication?” (yes / no)
  - Justify why or why not

CHART Phase 1: Hallmark Health

Table 3: Hallmark Health System CHART Phase 1 Project Indicators

	Lawrence Memorial Hospital	Melrose-Wakefield Hospital
Total patients who presented with lower back pain to the Hallmark Health System EDs and urgent care center from April to June of 2014	267	401
Patients who received opioids:	50	95
Complete adherence to bundle compliance	60%	31%
Narcotic justification documentation	90%	84%
Imaging justification for patients who did not receive imaging studies	88%	86%
Documented use of the PDMP for patients receiving opioids	60%	36%
Documented review of past medical history	76%	43%
Documentation of type of medication, dosage and pill count	88%	81%
Narcotic prescription rate (2013 = baseline, 2014 = April to June)	2013: 40% 2014: 23%	2013: 42% 2014: 31%

- Health Policy Commission Chart 1 Summary

CHART Phase 2: Hallmark Health

- ***Enhance behavioral health care***
- Improve hospital-wide (or system-wide) processes to reduce waste and improve quality and safety
- Increase the rate of utilization of appropriate level of service

CHART Phase 2: Hallmark Health

- Target populations: High Utilizers, et.al.
  - ≥ 10 ED visits within 12 months
    - 147 people = 2359 ED visits (~ 5% of ED visits)
  - Patients requiring Narcan Reversal
    - 339 in 2014
  - Obstetric Patients with a Substance Use Disorder
    - 46 in 2014 (~5% of births)

CHART Phase 2: Hallmark Health

- *“CHARTING A COURSE FOR THE RIGHT CARE AT THE RIGHT TIME IN THE RIGHT PLACE “*

Key lessons learned from Phase 1 initiatives

Key Lessons

1. The composition of transformation teams is important
2. Process improvement is key to improving overall efficiency
3. Leadership and management must engage throughout the lifecycle of initiatives
4. Technology can lay the foundation for transformation
5. Data analysis is essential to measure performance and drive improvement
6. Community partnerships are challenging to build, but are essential to success in value-based health care
7. Sustaining low-cost options for acute care is critical for maintaining a value-based system

Directly informed Phase 2

Implications for Phase 2

Focus funding and attention on key priorities

Continue to provide enhanced technical assistance

Require and facilitate data collection, measurement, and overall hospital reporting

Engage deeply in program design

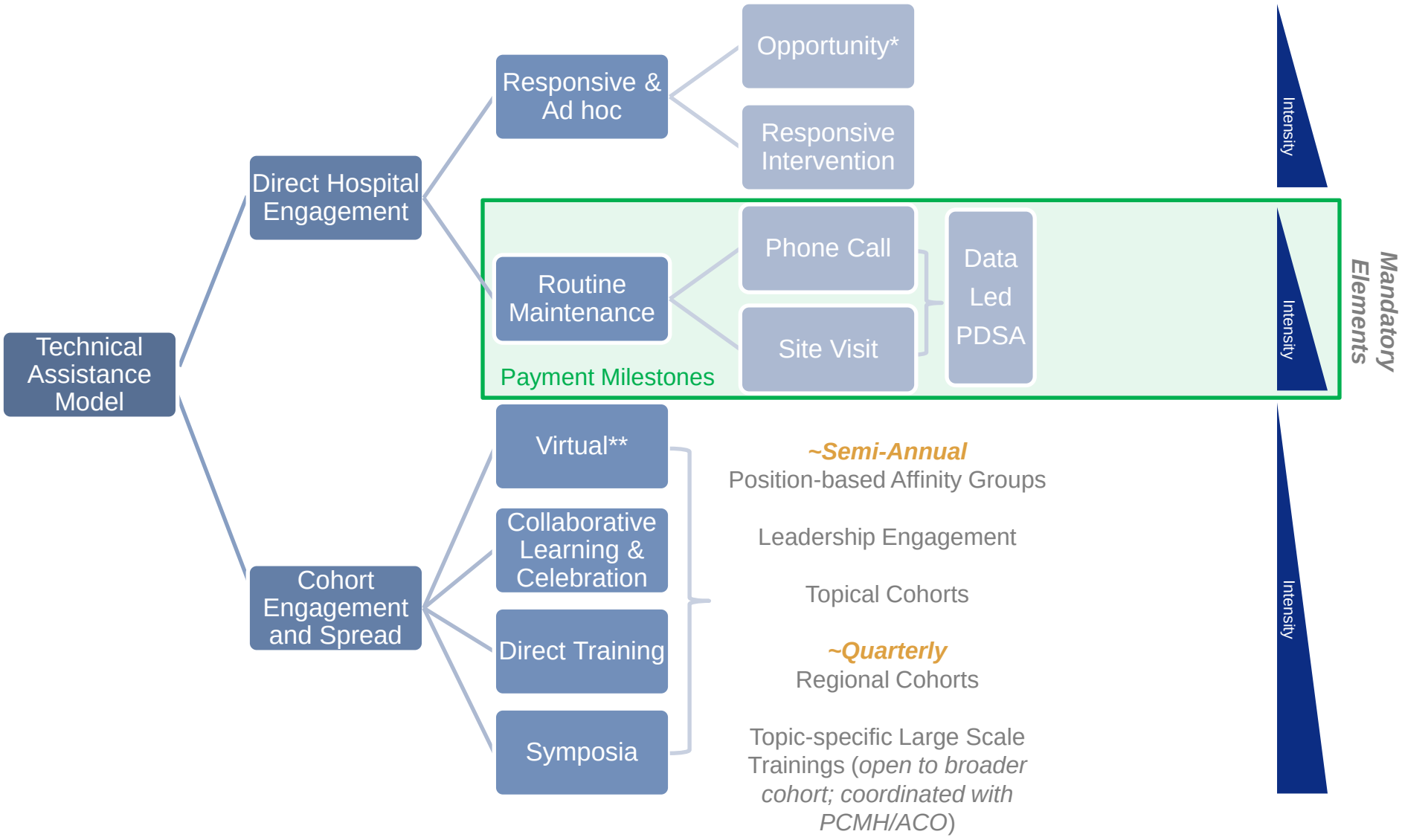
Support cross-functional composition of transformation teams

Implementation Planning

Agenda

- Approval of Minutes from the April 29, 2015 Meeting
- Executive Director Report
- Quality Improvement and Patient Protection Update
- Cost Trends and Market Performance Update
- Community Health Care Investment and Consumer Involvement Update
  - CHART Phase 1 Final Report
  - CHART Phase 1 Presentation from Dr. Steven Sbardella, Hallmark Health System
  - **CHART Phase 2 Update and Technical Assistance Plan**
- Care Delivery and Payment System Transformation Update
- Administration and Finance Update
- Schedule of Next Commission Meeting (July 22, 2015)

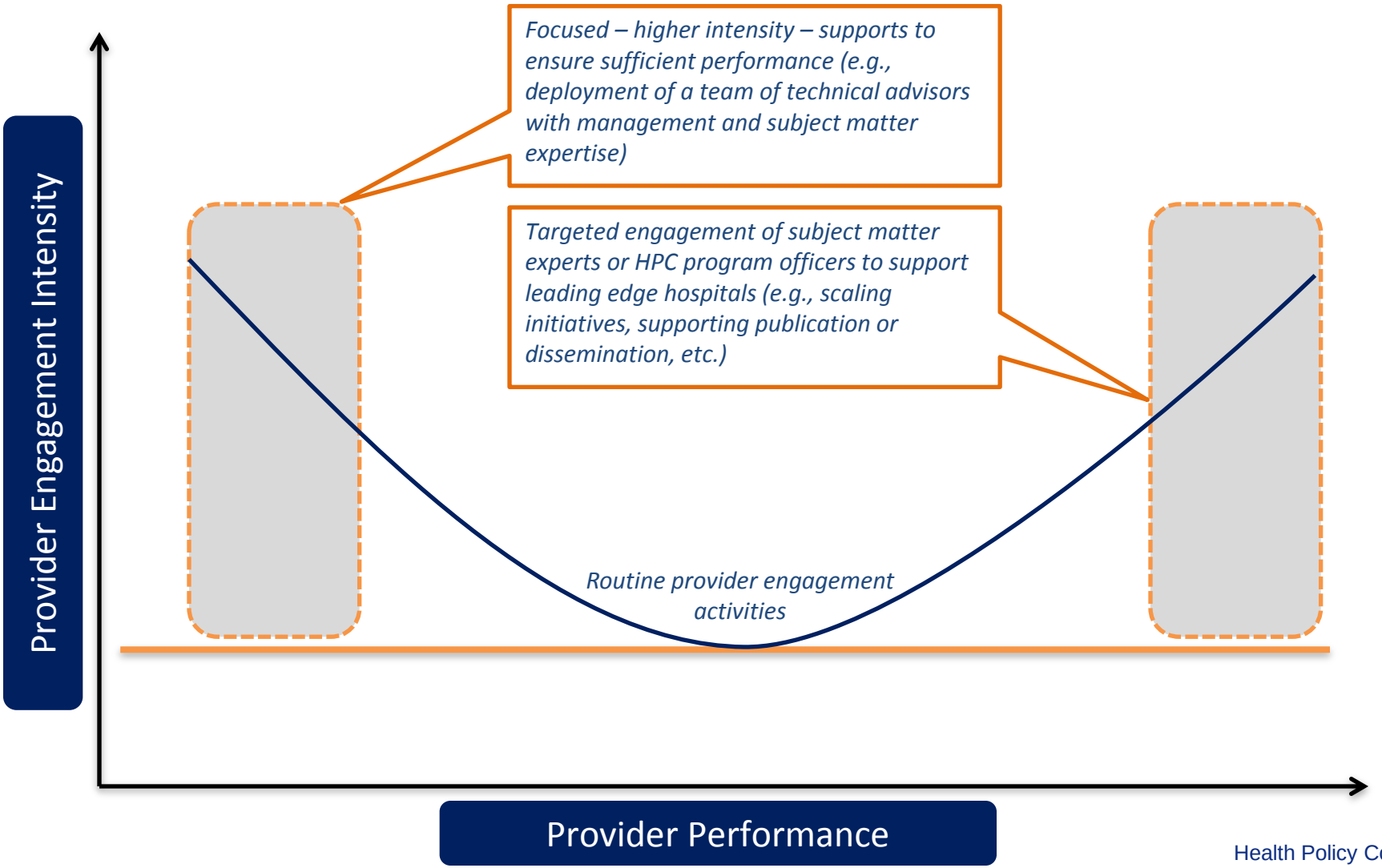
Modes for technical assistance and provider engagement



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

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

Provider engagement intensity will be stratified across the cohort based upon opportunity for maximal benefit from engagement



Technical assistance approaches

State-wide meetings	Regional convenings	Site visits	Training opportunities	Calls with staff and TA experts	Leadership engagement

HPC will hold two statewide meetings in CHART 2

- *Fall 2015 Launch Meeting:* Initial meeting focusing on content and peer sharing will kick-off the performance phase of the program
- *Spring 2016 Interim Meeting* (open to public): Interim statewide meeting will be held focused on highlighting success, challenges, and best practices on individual, hospital-specific, and regional levels.

State-wide meetings	Regional convenings	Site visits	Training opportunities	Calls with staff and TA experts	Leadership engagement

Regional convenings will be a cornerstone of peer learning

- Peer-peer learning; discussion of local success and operational factors associated with effective implementation
- Discussion of local partnerships and community-based organization engagement
- Linkage with models and programs tied to CHART initiatives that are effective elsewhere
- Some regional meetings will be segmented into affinity groups (e.g., clinical leadership, operational leadership, frontline staff, community partners, etc.)

Technical assistance approaches

State-wide meetings | Regional convenings | **Site visits** | Training opportunities | Calls with staff and TA experts | Leadership engagement

Site visits will be a key opportunity for executive engagement

- At a minimum, staff will conduct site visits at each Phase 2 CHART hospital biannually. Visits will generally include:
  - A meeting with the executive team to review progress and overall project implementation (data dashboard review).
  - Discussions with implementation teams on tests of change, implementation barriers, appropriate adaptation and overall project progress.

CHART hospitals with insufficient progress will likely require additional site visits and other touch points. Higher performing hospitals may also have increased touch points to harvest successful practices, stimulate activity at other hospitals and to build momentum in the entire group.

State-wide meetings | Regional convenings | Site visits | **Training opportunities** | Calls with staff and TA experts | Leadership engagement

Trainings will bolster skills of front-line staff, managers, and leadership

- HPC anticipates hosting 2-3 trainings annually. All trainings will be in-person but will be recorded and made available on the CHART program website. Trainings available to CHART hospitals and PCMH or ACO certified entities / those pursuing certification.
- HPC will seek to partner with other organizations in the market

Technical assistance approaches

State-wide meetings	Regional convenings	Site visits	Training opportunities	**Calls with staff and TA experts**	Leadership engagement

HPC will continue frequent virtual contact with multiple purposes

- *Performance Management Calls:* Approximately monthly performance management calls led by Program Officer(s) to review activities and progress and discuss methods to overcome barriers. Semi-structured to review operational data, payment and other reporting issues
- *Coaching Calls*: Approximately monthly expert coaching calls with Program Officer(s) and Senior Advisors (content experts) to review activities and progress and discuss methods to overcome barriers.

State-wide meetings	Regional convenings	Site visits	Training opportunities	Calls with staff and TA experts	**Leadership engagement**

HPC will seek opportunities to engage current and emerging leaders

- *Current leadership* engagement activities would focus on the C-Suite and assumes more interaction and dialogue among the leaders (with networking for the CEOs, CMOs, CNOs, CFOs, and COOs). These activities would create an environment where current senior leaders engage more deeply on healthcare transformation as it applies to CHART
- *Emerging leader* activities to take mid-level, business line and other thought leaders and provides a structured curriculum that heavily links to the CHART project activities at each organization. Focused on building leadership capability and to sustain momentum after the current investments expire.

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- **Care Delivery and Payment System Transformation Update**
  - Final Data Submission Manual for the Registration of Provider Organizations Program
- Administration and Finance Update
- Schedule of Next Commission Meeting (July 22, 2015)

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Registration of Provider Organizations

The HPC is charged with implementing a registration program for Provider Organizations.

M.G.L. c. 6D, § 11

The commission shall require that all provider organizations report the following information for registration and renewal: (i) organizational charts showing the ① **ownership**, ② **governance** and ③ **operational structure** of the provider organization, including any ④ **clinical affiliations**, ⑤ **parent entities**, ⑥ **corporate affiliates**, and ⑦ **community advisory boards**; (ii) the number of affiliated ⑧ **health care professional** full-time equivalents and the number of professionals affiliated with or employed by the organization; (iii) the name and address of ⑨ **licensed facilities**; and (iv) such other information as the commission considers appropriate.

M.G.L. c. 12C, § 9

Notwithstanding the annual reporting requirements of this section, the commission may require in writing, at any time, additional information reasonable and necessary to determine the **financial condition**, **organizational structure**, **business practices** or **market share** of a registered provider organization.

Registration of Provider Organizations

The files in the DSM track to the categories of data identified in the statute.

DSM File	Statutory Charge
Background Information	Ownership ① Governance ② Parent entities ⑤ Community advisory boards ⑦
Corporate Affiliations	Operational structure ③ Corporate affiliates ⑥
Contracting Affiliations	Operational structure ③
Contracting Entity	Governance ② Operational structure ③
Facility File	Licensed facilities ⑨
Physician Roster	Health care professionals ⑧
Clinical Affiliations	Clinical affiliations ④

Registration of Provider Organizations

The HPC has devoted significant time to crafting a balanced, value-adding program.

2013

- Initial RPO listening sessions with stakeholders
- Draft regulation presented to CDPST and Board
- Public comment period for draft regulation begins

2014

- Stakeholder engagement meetings on proposed data elements
- Draft Data Submission Manual released for public comment
- Public hearing on draft regulation and draft DSM
- HPC promulgates final regulation and releases Part 1 DSM
- Provider Organizations complete Initial Registration: Part 1

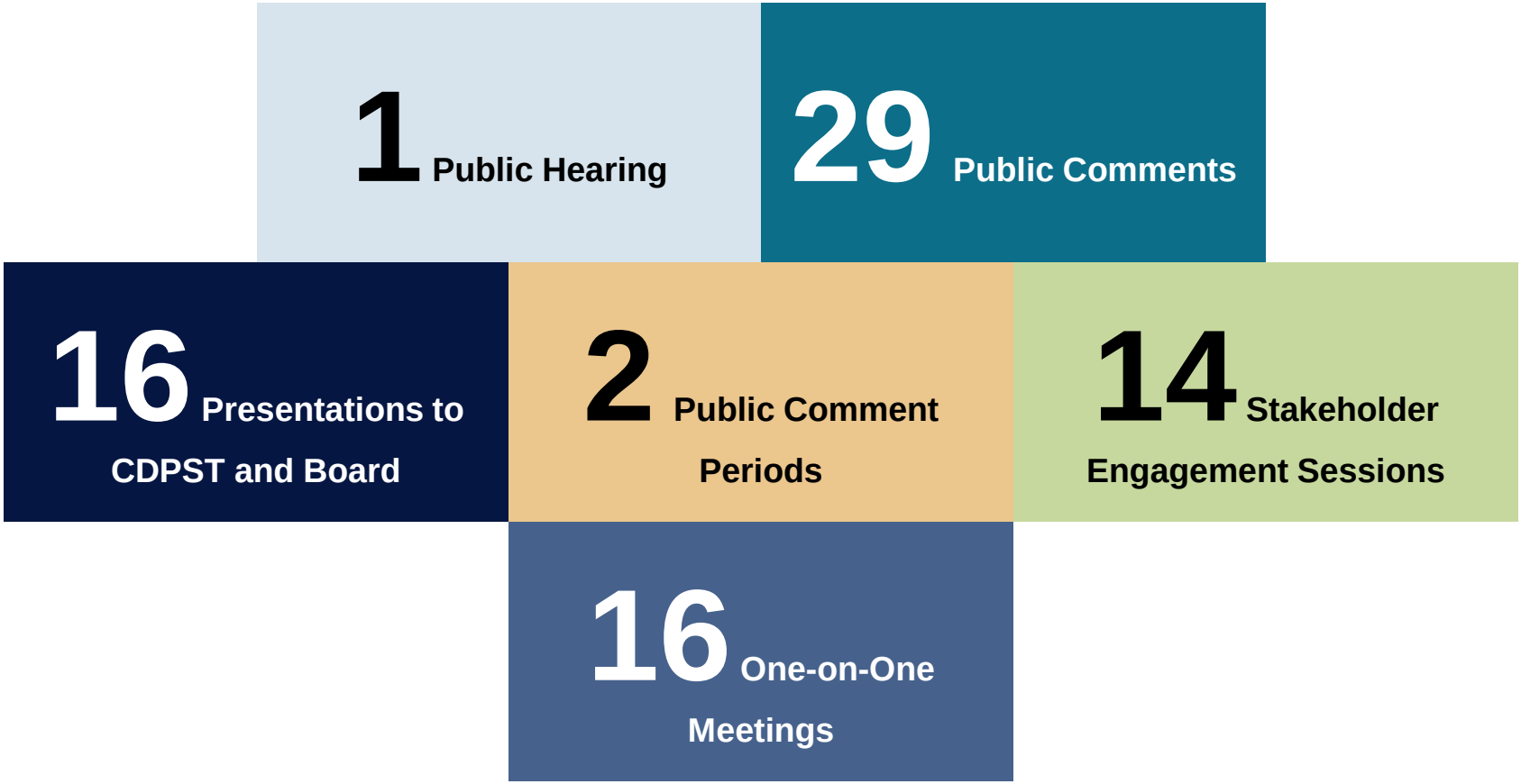
2015

- 11 Small-group stakeholder sessions to discuss Part 2 DSM
- Draft DSM for Part 2 released for public comment
- *HPC releases final DSM for Initial Registration: Part 2*
- *Provider Organizations complete Initial Registration: Part 2*

Ongoing informal engagement

Registration of Provider Organizations

The HPC extends its sincere thanks to the individuals and organizations that have provided feedback and insight over the last 2 years.



Registration of Provider Organizations

Many data elements have been removed from the proposed DSM or redesigned to reduce administrative burden.

Removed
Operational Organizational Chart
Corporate Affiliate Address
Participation Agreement Start Date
Participation Agreement End Date
Administrative Fees, Retention, Dues
Direction of Fees, Retention, Dues
Licensing Entity
Reporting of Unlicensed Sites
Reporting of Unowned Facilities
Compensation Part of Clinical Affiliation
Description of Compensation
Agreement End Date

Redesigned
Description of Governance Structure
Funds Flow
Contracting Affiliations File Structure
Books of Business by Payer/Product
Provider FTE Information
Reportable Clinical Affiliations
Agreement Start Date

- Background Information File
- Corporate Affiliations File
- Contracting Affiliations File
- Facility File
- Clinical Affiliations File

Registration of Provider Organizations

The HPC received public comment on the Part 2 DSM from 10 organizations during the April 2015 comment period.

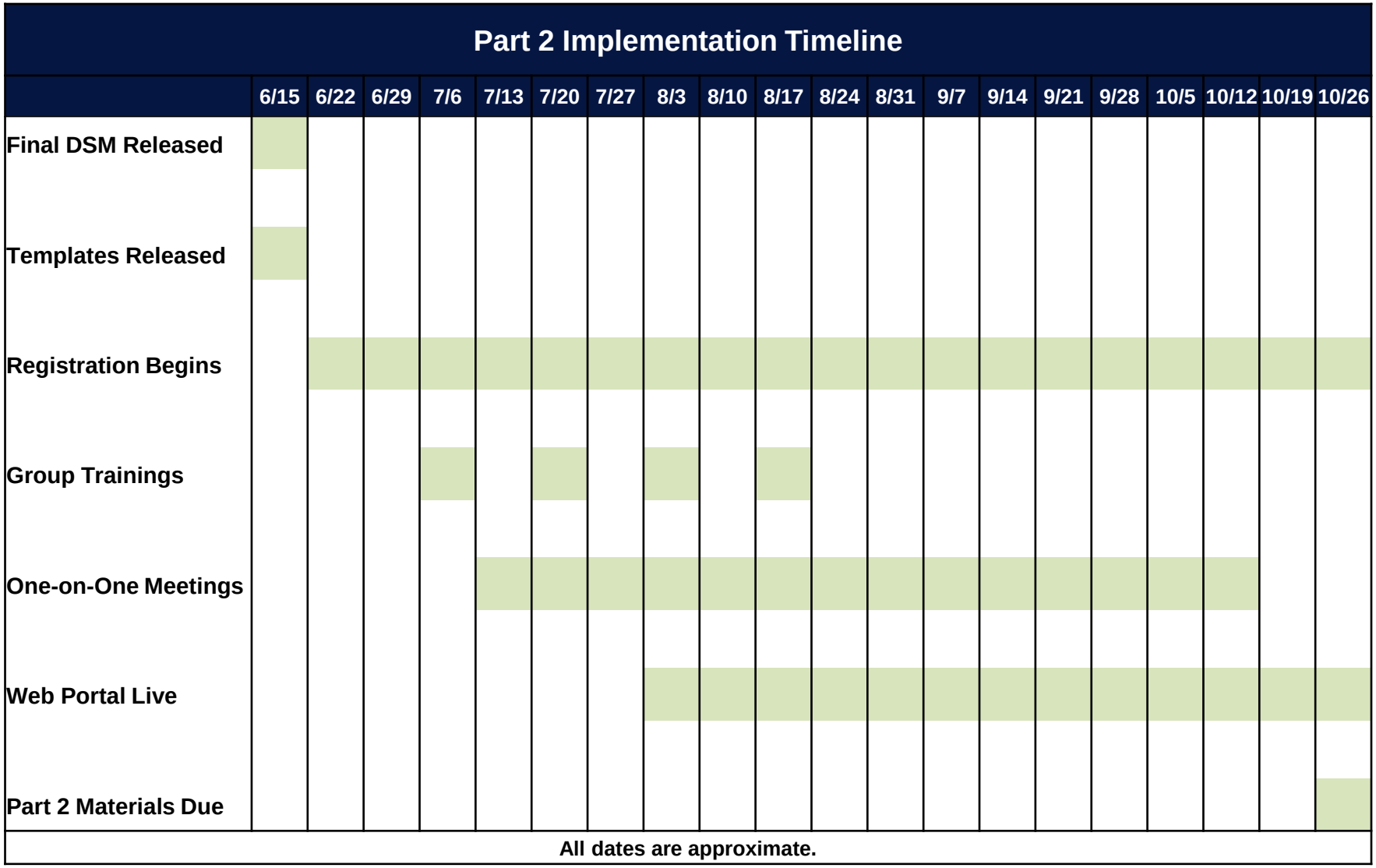
- Atrius Health
- Baystate Health
- Beth Israel Deaconess Care Organization
- Conference of Boston Teaching Hospitals
- Hallmark Health PHO
- Locke Lord Edwards (Provider Representative)
- Massachusetts Hospital Association
- Massachusetts Medical Society
- Partners HealthCare System
- UMass Memorial Health Care

Registration of Provider Organizations

The HPC identified 5 key themes in the public comments.

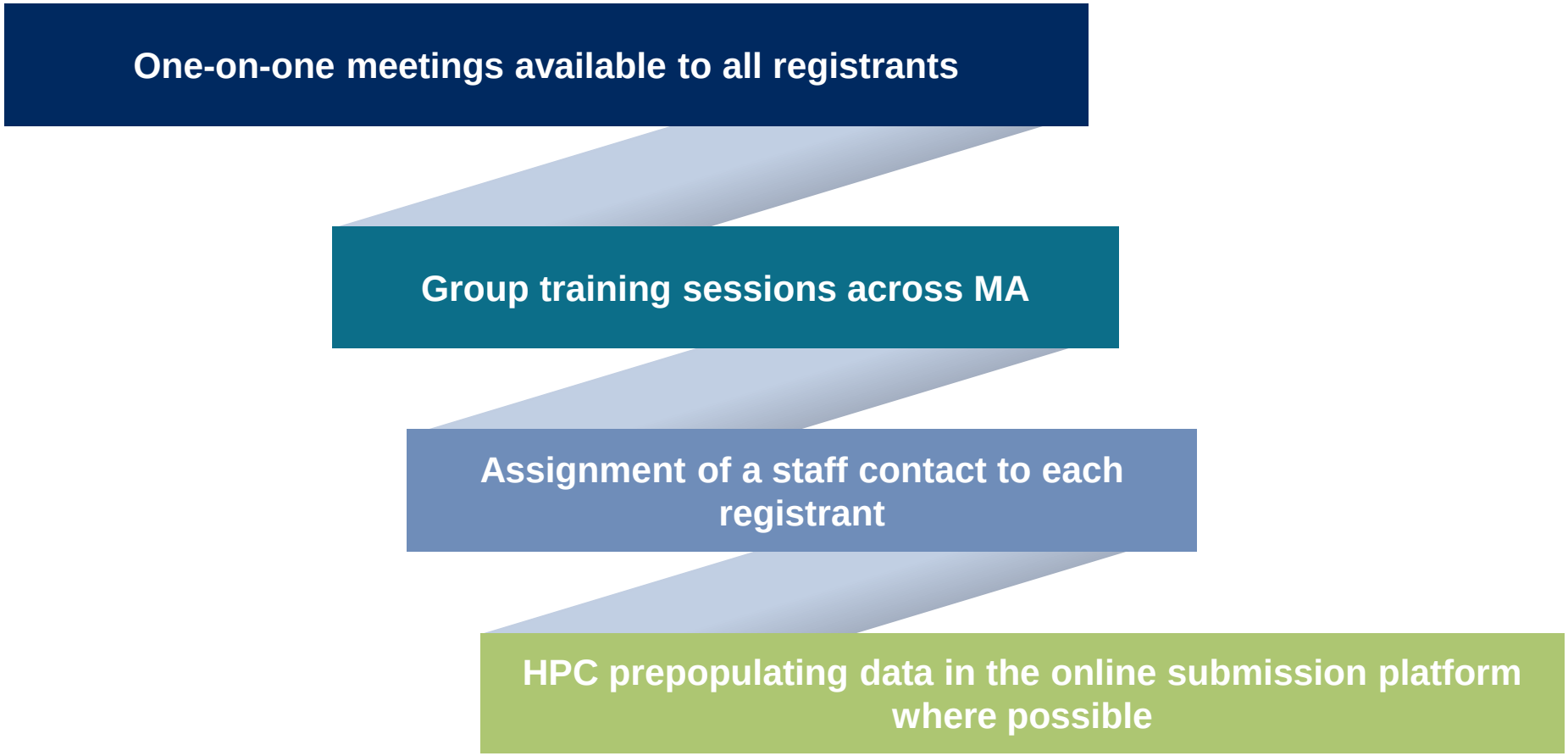
Comment	Response
Timing	The HPC has extended the deadline for submission of Part 2 information to October 30, 2015.
Suggestions to Improve Data Elements	The HPC has updated several data elements with suggested wording changes and new answer options.
Potentially Duplicative Data Elements	Data elements about contracting practices appear in multiple files, but they are not duplicative. The HPC has added clarifying text to address confusion.
Administrative Burden	Registrants can attest that information is available through other agencies for select questions. The HPC did not find additional opportunities for streamlining the DSM.
Proprietary Information	The DSM includes four carefully targeted questions about global payment arrangements that retain a sufficient level of generality to protect any confidentiality.

Registration of Provider Organizations



Registration of Provider Organizations

RPO Program staff are dedicated to providing extensive technical assistance to registrants.



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  - **Fiscal Year 2016 Budget**
- Schedule of Next Commission Meeting (July 22, 2015)

Vote: Authorizing Continue Spending for Fiscal Year 2016

Motion: That the Commission hereby authorizes the Executive Director to continue spending funds to support the ongoing operations of the agency at the level of funding approved by the Commission for fiscal year 2015, until the Commission approves the operating budget for fiscal year 2016 at its next meeting.

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Contact Information

For more information about the Health Policy Commission:

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