Community Health Care Investment and Consumer Involvement

Health Policy Commission

Committee Meeting
February 24, 2014

Agenda

- Approval of the minutes from October 9, 2013 meeting
- Update on CHART Phase 1 Investment Program
- Overview of CHART evaluation approach
- Update on CHART Phase 2 framework
- Discussion of CHICI Committee priorities for 2014
- Schedule of next committee meeting (April 2, 2014)

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Vote: Approving minutes

Motion: That the Community Health Care Investment and Consumer Involvement Committee hereby approves the minutes of the Committee meeting held on October 9, 2013, as presented.

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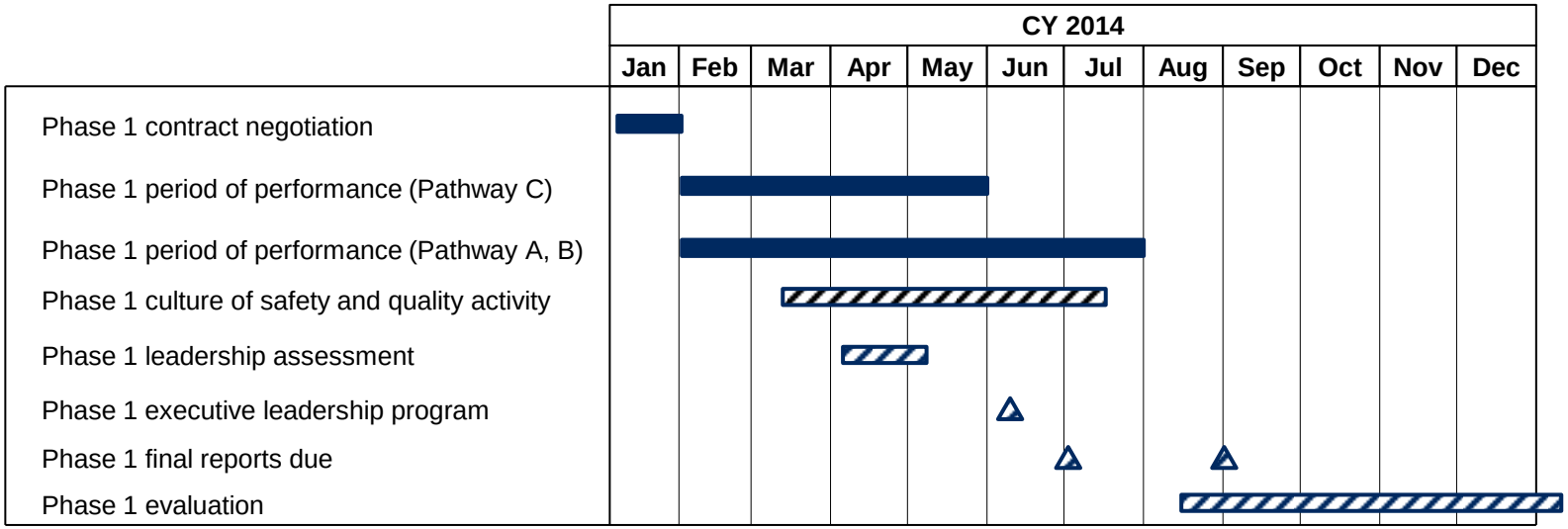
CHART Phase 1 operational timeline



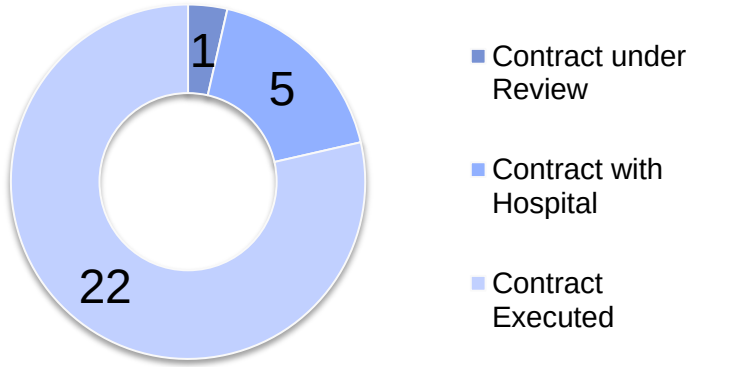
Indicates tentative date

Indicates firm date

Phase 1 contracting is progressing

- After the January 8 Board vote to accept and approve awards, Award Letters were sent to 28 hospitals with required revisions and justifications to work plan, budget, and metrics. Responses were due January 24.
- Once responses are reviewed and approved by Staff, contract packages are prepared and sent electronically to each hospital, to be signed and returned to the HPC for execution.
- Staff anticipate full contract execution by March 1.

Contracting



Amended Funding Total

$9,947,060

Implementing technical assistance

Project-specific technical assistance

- HPC providing project-specific assistance to select project types (e.g., care coordination pilots, planning grants, etc.)
- HPC increased project support of higher risk Phase 1 projects (e.g., community telepsychiatry) either through funding external expertise or requiring engagement of clinical/operational committees in awardee institutions
- MeHI providing technical support and oversight to five HIT/HIE heavy awards
- HPC available to awardees throughout Phase 1 on an 'as-needed' basis, but technical assistance structured as a 'light touch'

Cohort-wide requirements

- HPC engaging experts to support hospitals relative to culture of safety and quality improvement activities
- Kick-off phone calls immediately following contract execution
- Monthly check-ins
- *Learning, Improvement, and Diffusion* capability & capacity assessment (as required by the RFP)
  - Consultation with HPC-designated expert on culture of safety assessment and improvement
  - Executive leadership program
- Final report deliverable to the HPC

Looking to Phase 2

Lessons Learned from Phase 1 *Process*

- Release **RFP and application materials earlier** to allow for increased dialogue during formalized Information Sessions and Q&A during Phase 2 application process
- **Adapt Phase 1 administrative protocols** for review and evaluation of Phase 2 applications
- Increase **length of application window** and **narrow focus of application** (e.g., reduced need for hospital demographic information, increased need for ROI estimates, etc.)
- Hold one-on-one meetings with awardees / grantees throughout Phase 1 to build **strong relationships**
- Conduct survey / focus group to **assess Phase 1 application process from CHART hospital perspective** to inform optimized Phase 2 process
- **Continue ongoing coordination of CHART activities with key partners** (e.g. Prevention and Wellness Trust Fund, Infrastructure and Capacity Building Grants, Workforce Transformation Trust, DSTI, MeHI e-Health investments, SIM, etc.)

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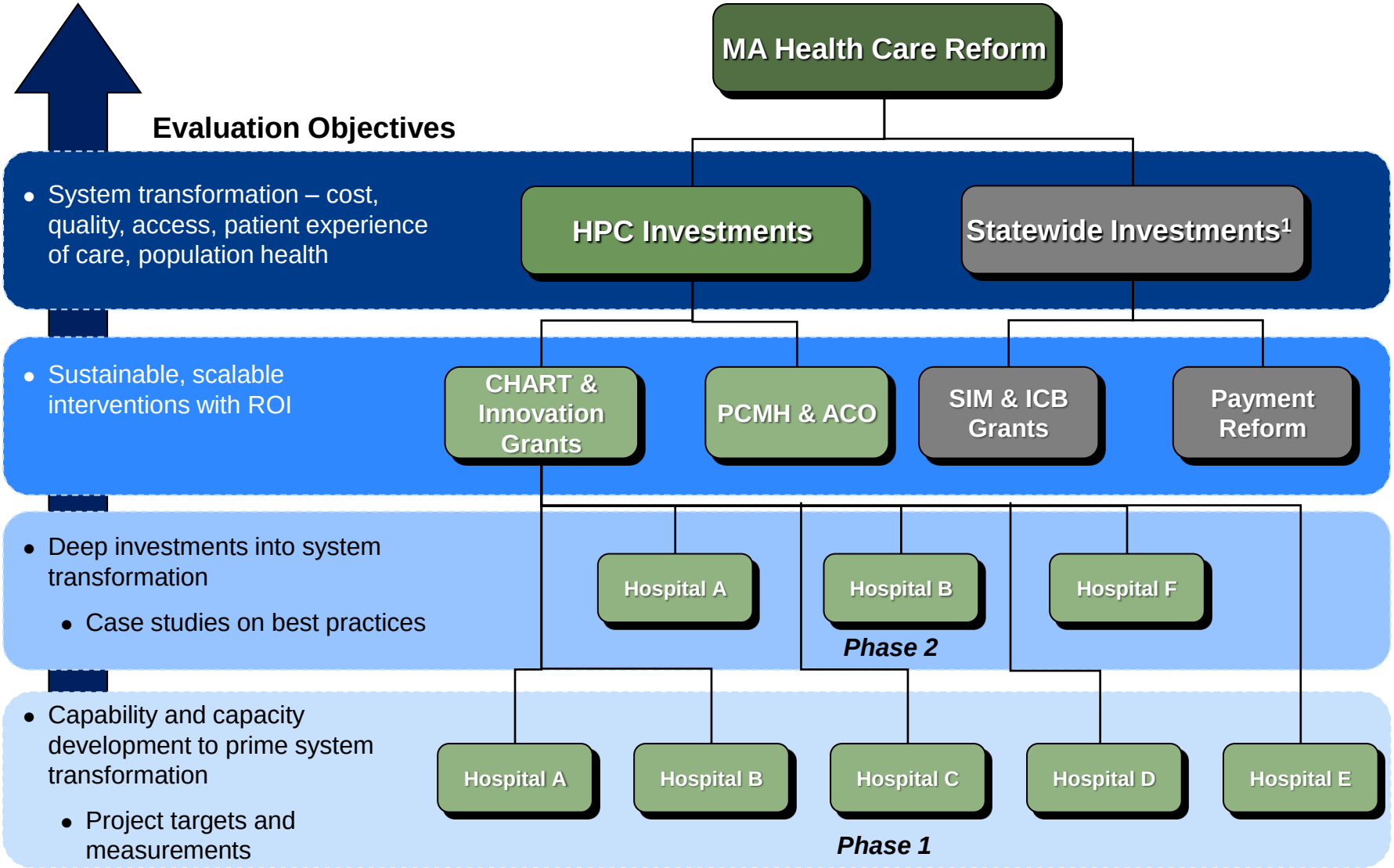
General evaluation framework

Develop CHART evaluation within a wider context



[1] Examples only – HPC anticipates developing evaluation framework in the context of many activities across the Commonwealth, including all Chapter 224 investments

Approach to Phase 1 evaluation

Evaluation goals

- The evaluation will draw upon CHART program documents, existing hospital reports, and limited additional data collection from participating institutions.

- The overall HPC Care Delivery Evaluation Framework has three broad purposes:
  - To assess the efficacy of the investment program in achieving specific **quantitative and qualitative goals**, including the **ROI, sustainability and scalability** of specific projects
  - To advance **knowledge** regarding opportunities, challenges, and best practices for **healthcare organizations that seek to transform** care delivery
  - To support a **culture of measurement, accountability, and continuous improvement** within participating hospitals and the HPC

- The Phase 1 evaluation has five more narrow aims:
  - To **assess the progress and output of each specific CHART Phase 1 investment**
  - To establish a **baseline understanding** on the capability and capacity of participating hospitals
  - To identify **best practices and foster shared learning** among participating hospitals
  - To strengthen HPC's **grant stewardship** practices, through documentation and reflection.
  - To **inform the development of future HPC investments and care delivery policy**

Phase 1 evaluation: Data sources and evaluation outputs

A HPC Driven Metrics

1. HPC will assign metrics for evaluation of proposed investment priorities
   a) Publically available data sources
   b) Focus groups and cohort surveys
2. Awardee feedback on Phase 1 administration will be solicited and incorporated

B Menu of Metrics (SQMS, CMMI)

1. HPC will assign metrics for evaluation of proposed investment priorities
   a) Baseline scenarios
   b) Industry and/or organization benchmarks
2. Applicants will choose from a menu of metrics to be evaluated for success

Phase 2

C Applicant Driven Metrics

1. HPC received milestones, metrics, and targets for evaluation for each proposal
2. Awardees proposed metrics as related to program objectives
   a) Baseline scenarios
   b) Industry and/or organization benchmarks

1 Baseline findings: hospital performance and program structure (Summer 2014)

2 Phase 1 evaluation report (Winter 2015)

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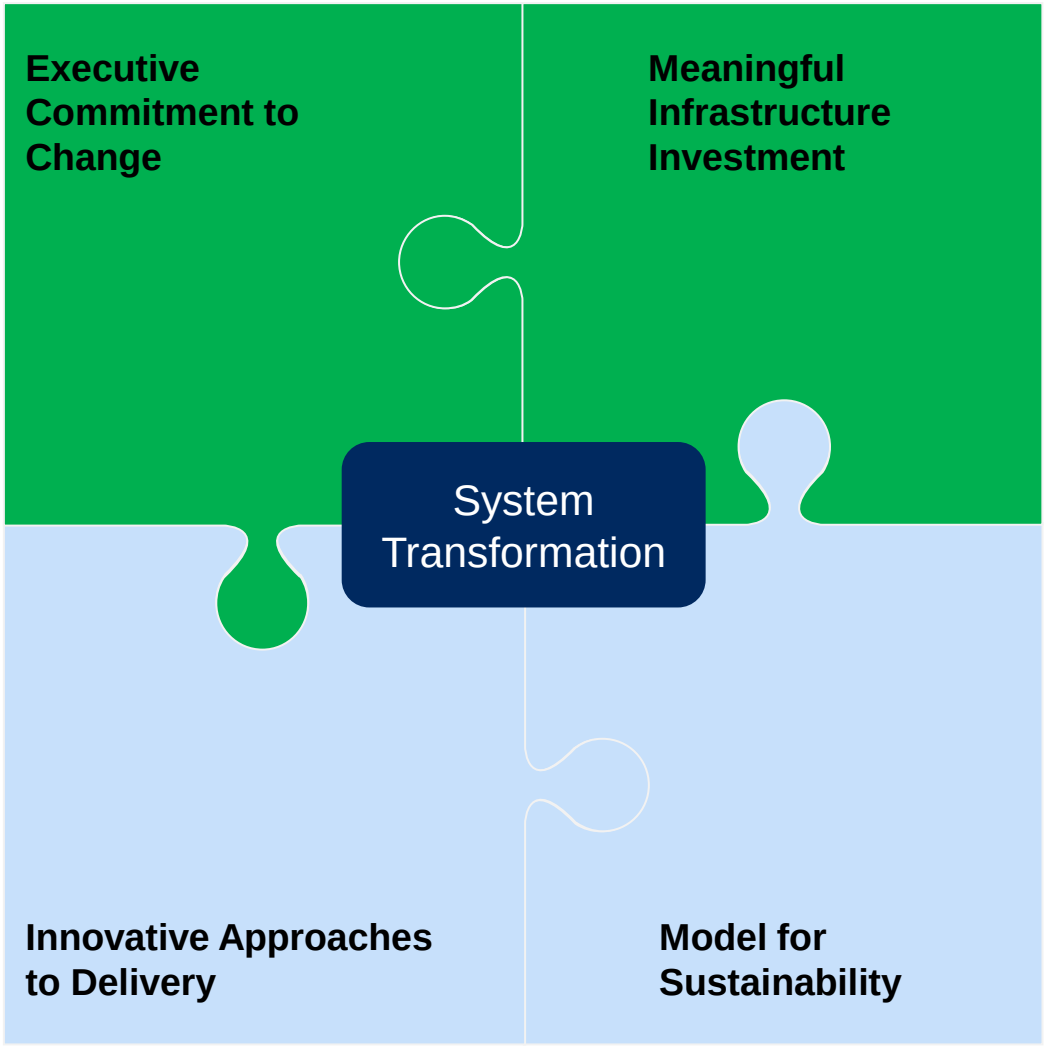
Necessary factors of change



Factors for Phase 1 investment

Factors for Phase 2 Investment

Looking from Phase 1 to Phase 2

Phase 1: Fall 2013 – Foundational Activities to Prime System Transformation

- Modest investment with many eligible hospitals receiving funds
- Short term, high-need expenditures
- Participation not requisite for receipt of Phase 2 funds nor a guarantee of Phase 2 award
- Identified need to assess capability and capacity of participating institutions
- Opportunity to promote engagement and foster learning

Phase 2: Spring 2014 – Driving System Transformation

- Deeper investment in limited set of hospitals – competitive application process
  - **Multi-year, system or service line** transformations in **Commission-identified areas of focus**
  - **Testing models** of system transformation
- **Opportunities for 'all-play' engagements** – Pay for Success, or similar – non-competitive
- Close engagement between awardees and HPC

Ongoing program development

QI, Collaboration, and Leadership Engagement
Measurement & Evaluation
HPC Partnership with Awardees

CHART framework – driving to deep investment in Phase 2

Phase 1: Approach

- **Pathway A: Simple pilots in higher performing systems**
  - <6 month model testing programs in areas aligned with CHART goals
- **Pathway B: Capability and capacity development**
  - Clinical information flow between hospital and community-based providers
  - Tools and training to promote cost reduction and quality improvement (e.g., Lean)
  - Clinical triggers and flags
  - Building to collaboration
- **Pathway C: Planning**

Phase 1: HPC Operations

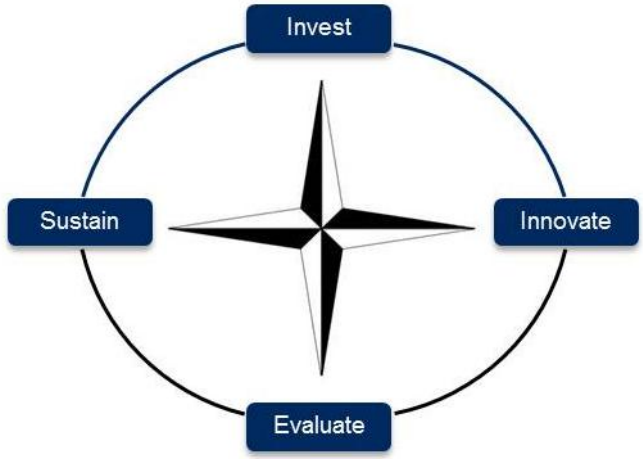
- **HPC partnership with awardees**
  - QI, efficiency, collaboration, and leadership engagement
  - Capability, capacity, and culture assessment and development
  - Data capacity development
  - Building learning environments
- **Early evaluation**

Phase 2: Spring 2014 – Driving System Transformation

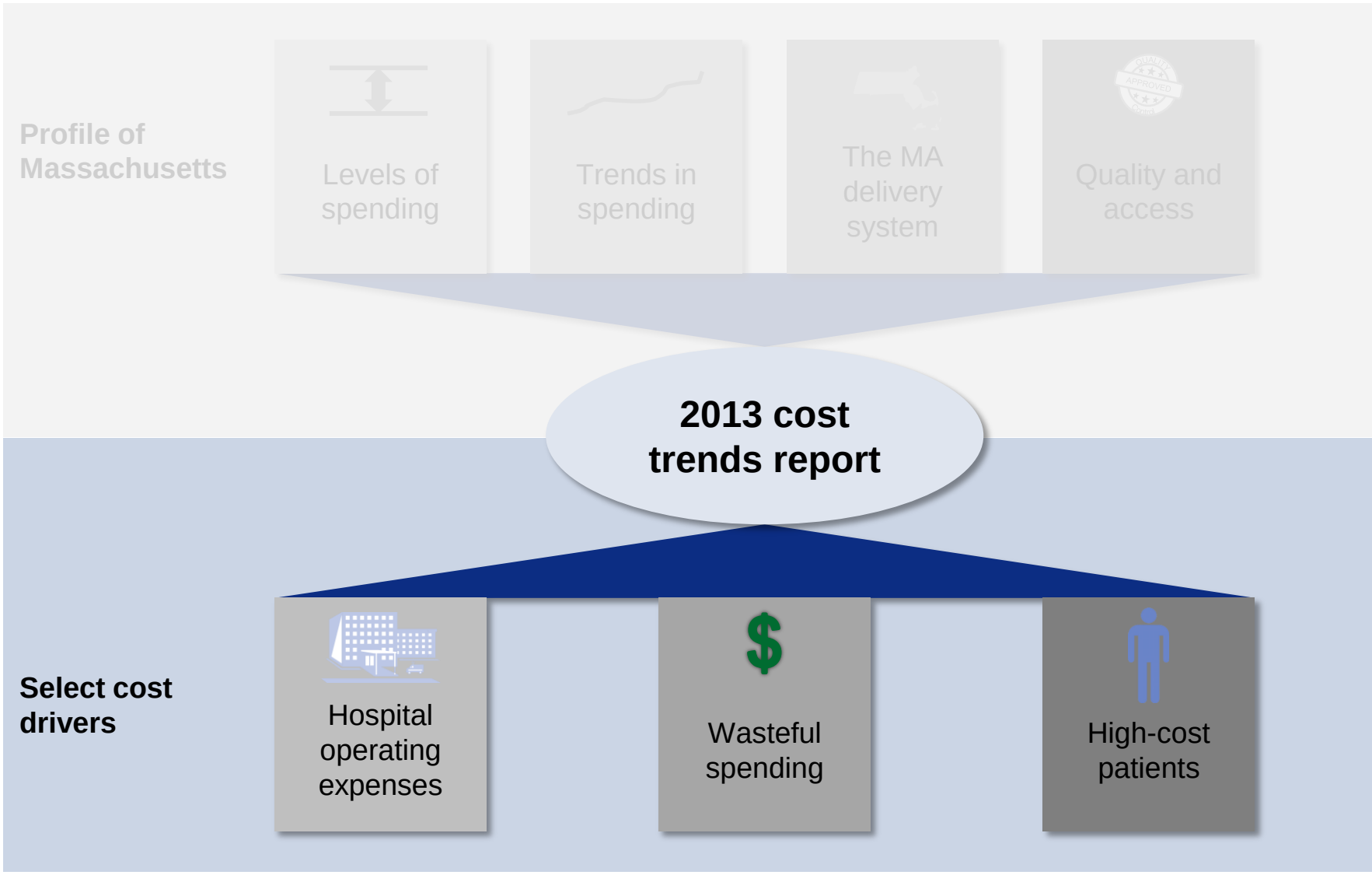
- **Behavioral Health, e.g.:**
  - ED boarding
  - Inpatient treatment of SA
  - BH integration
- **Care Coordination and Care Transitions, e.g.:**
  - Readmission/preventable hospitalization reduction
  - Hot-spotting/PHM
- **Service Line Efficiency, e.g.:**
  - OB/GYN
  - ICU/Med-Surg
  - Resource stewardship

Key decision points for Phase 2

- Size of total opportunity
- Structure of tier(s) & caps
- Specificity of project focus
- Funding model(s)
- Ensuring accountability
- Leveraging partnerships
- Connection with future phases



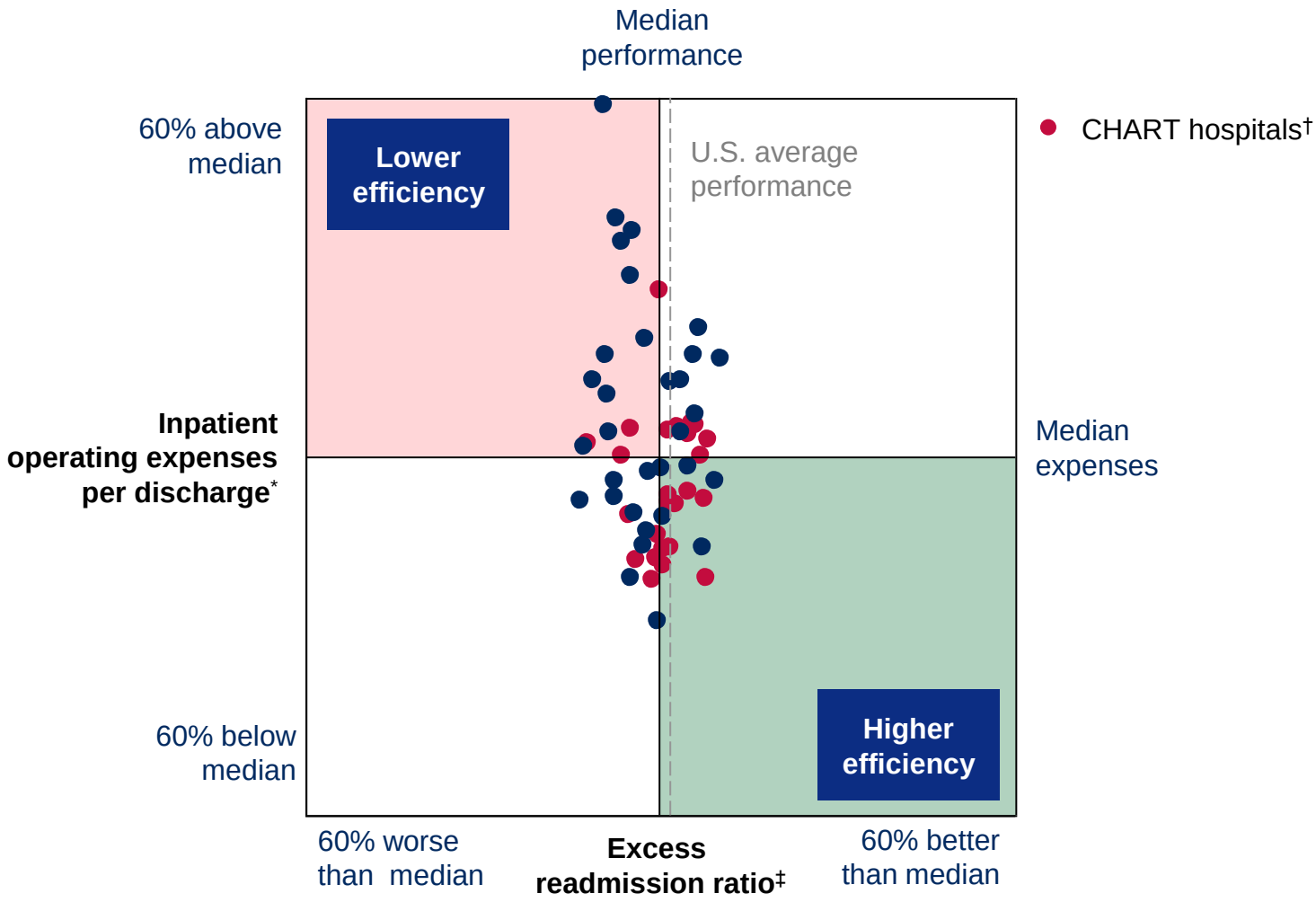
The 2013 Cost Trends Report outlined a series of barriers to reform consistent with those identified in CHART development



Source: 2013 Cost Trends Report

Quality performance relative to inpatient operating expenses per admission

Excess readmission ratio versus dollars per case mix adjusted discharge*



* 2012 inpatient patient service expenses divided by inpatient discharges. Adjusted for hospital case mix index (CHIA 2011) and area wage index (CMS 2012).

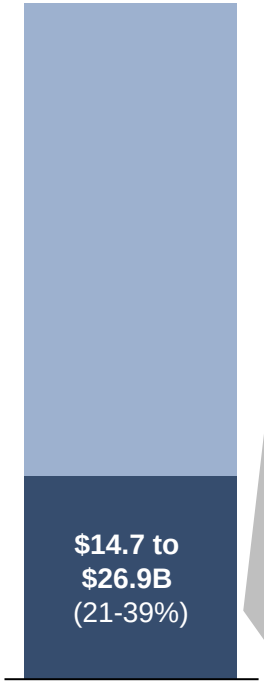
† Athol Memorial Hospital and Shriners Hospital are not displayed, as data were not available for measures shown.

‡ Composite of risk-standardized 30-day Medicare excess readmission ratios for acute myocardial infarction, heart failure, and pneumonia (2009-2011). The composite rate is a weighted average of the three condition-specific rates.

Source: Center for Health Information and Analysis; Center for Medicare & Medicaid Services; HPC analysis

Statewide estimate: in Massachusetts, there was $14.7 to $26.9B of wasteful spending in 2012

Wasteful spending in the Massachusetts health care system
Percent of personal health care expenditures, 2012



	Category	Description	MA examples
CLINICAL	Overtreatment	▪ The delivery of unnecessary services or treatment in a care setting that is more intensive than needed	▪ Intensity of care **~3.5% higher** than U.S. average
CLINICAL	Failures of care delivery	▪ Avoidable spending due to care not delivered or due to care delivered poorly (e.g. HAIs, ineffective preventive care)	▪ **$300-$450M potential savings** from community prevention programs
CLINICAL	Failures of care coordination	▪ Avoidable spending due to communication failures and lack of care integration across settings (e.g. preventable readmissions)	▪ Readmissions represent **> $700M in avoidable spending**
STRUCTURAL	Pricing failures	▪ Excessive levels of payment for health-care services	▪ **Significant variation** in relative price **not tied to quality**
STRUCTURAL	Administrative complexity	▪ Spending not directly associated with care delivery that could be eliminated without affecting the quality of care	▪ Some physician organizations estimate **>10% of NPSR** spent on administrative costs

Replicated Berwick and Hackbarth national approach (JAMA 2012) for Massachusetts based on distinct, mutually-exclusive areas of waste

Source: 2013 Cost Trends Report

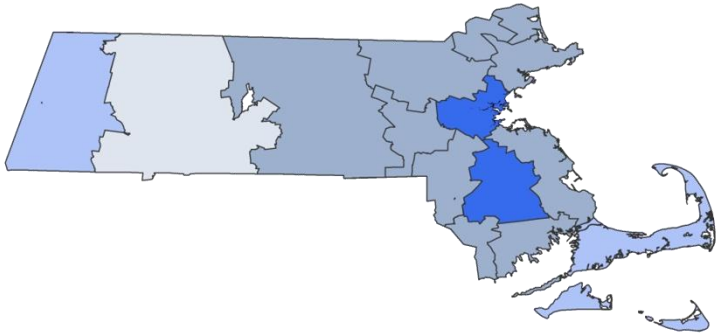
Region of residence: modest regional variation in concentration of high-cost patients

Concentration of high-cost patients by region

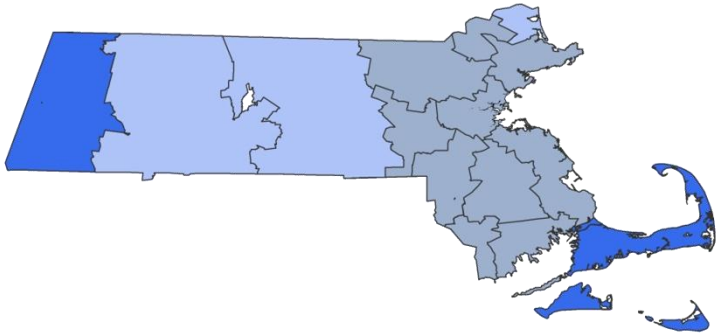
Percent difference from statewide average, adjusting for age and sex

- Greater than +20%
- +10% to +20%
- ±10%
- -10% to -20%
- Less than -20%

MEDICARE



COMMERCIAL



- Dynamics differ between commercial and Medicare populations
- The Pioneer Valley / Franklin region had a low concentration of high-cost patients for Medicare and commercial populations
- Differences may be due to patient characteristics (e.g., condition prevalence), social characteristics (e.g., education) or health system characteristics (e.g., high-priced providers, practice variation)

Source: 2013 Cost Trends Report
Note: Medicaid data will be included in future analyses

The 2013 Cost Trends Report also describes a series of applicable remedies

HOSPITAL OPERATING EXPENSES

WASTEFUL SPENDING

HIGH-COST PATIENTS

What solutions could be applied by CHART hospitals to drive improvement across these domains?

(examples only)

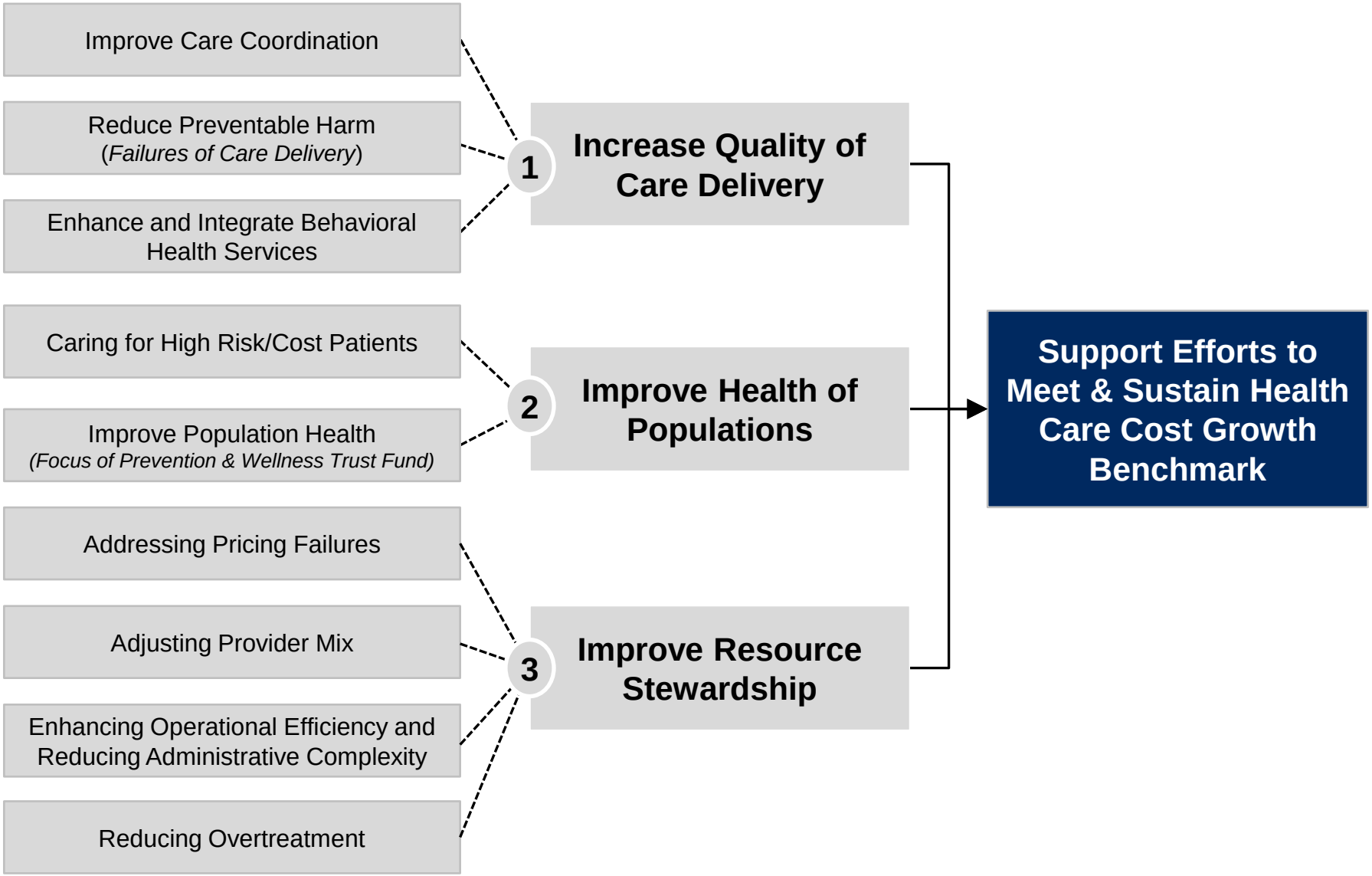
- Lean / Six Sigma *(general process improvement)*
- Time driven activity-based costing
- Implementing management best practices and coordinated leadership approaches
- Reducing administrative complexity

- Top-of-license work
- Reducing excessive Labor and Delivery spending (early elective deliveries; C-sections)
- Reducing Inappropriate imaging
- Reducing preventable harm
- Investing in Choosing Wisely initiatives

- Reducing inappropriate hospital use through care management / hot-spotting
- Ensuring access to and integration of behavioral health services
- Investment in analytics for identification of prevalence and modeling persistence

Source: 2013 Cost Trends Report

Preliminary discussion of goal setting for Phase 2



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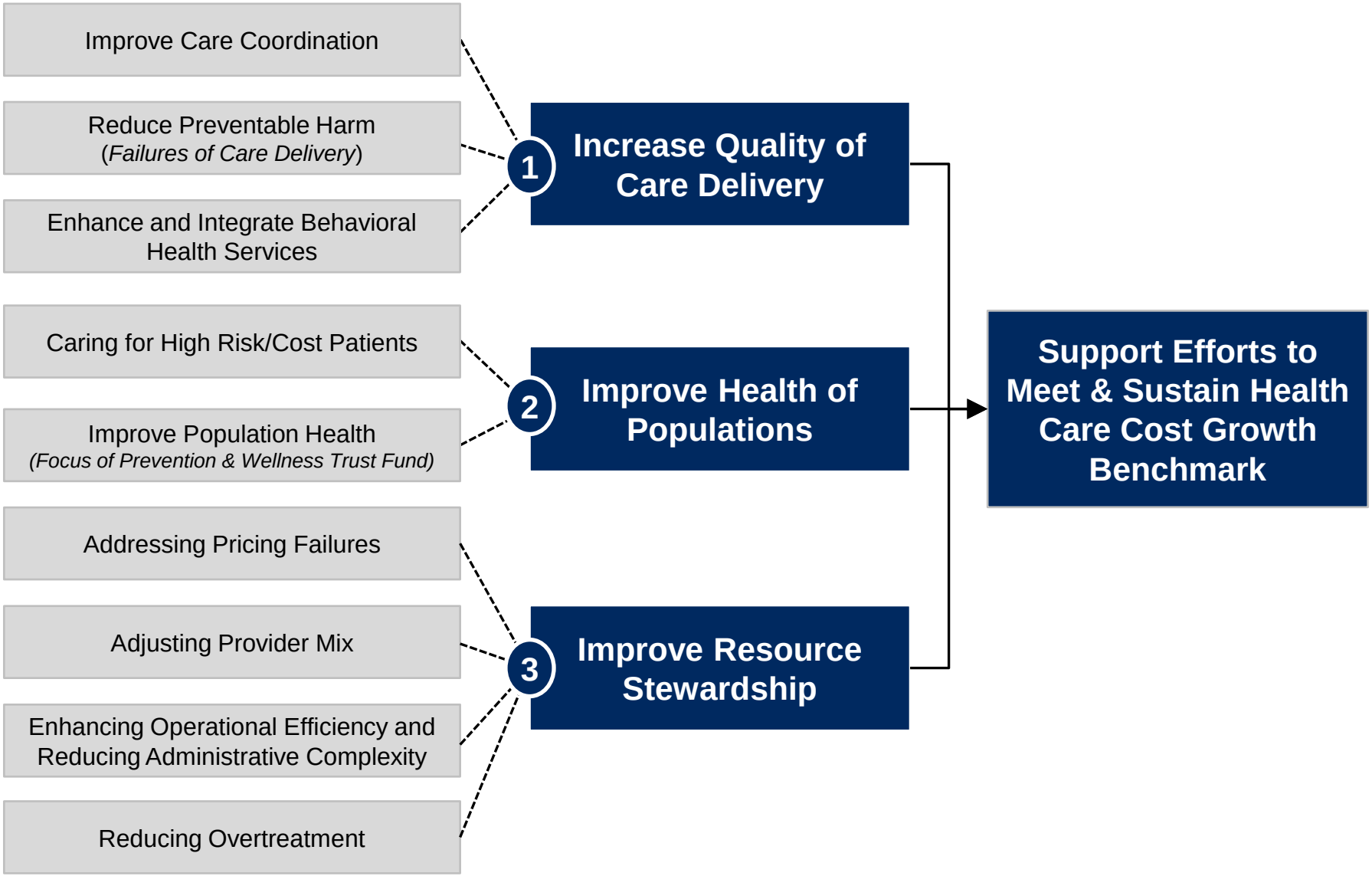

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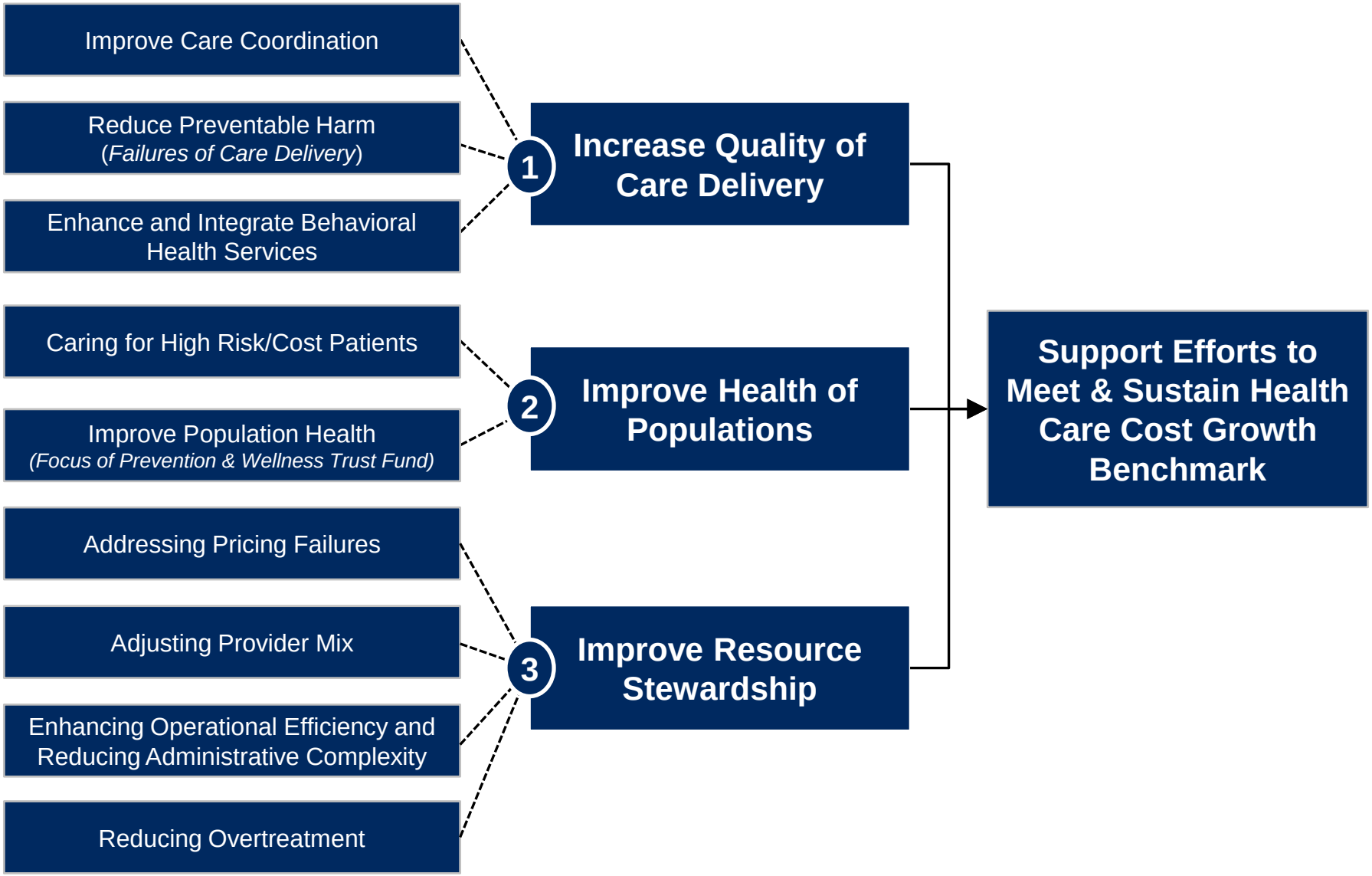

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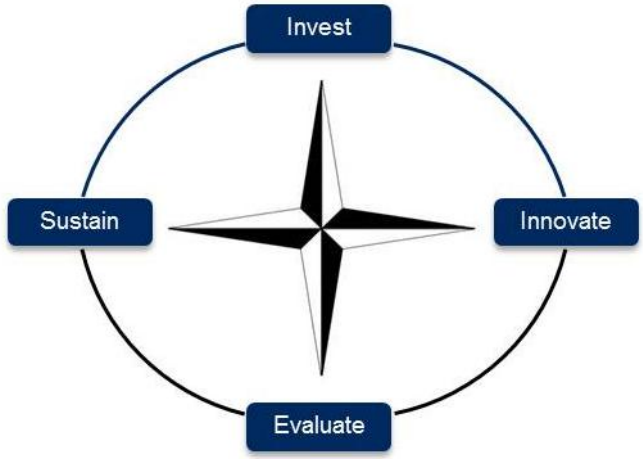


Preliminary discussion of scope of Phase 2

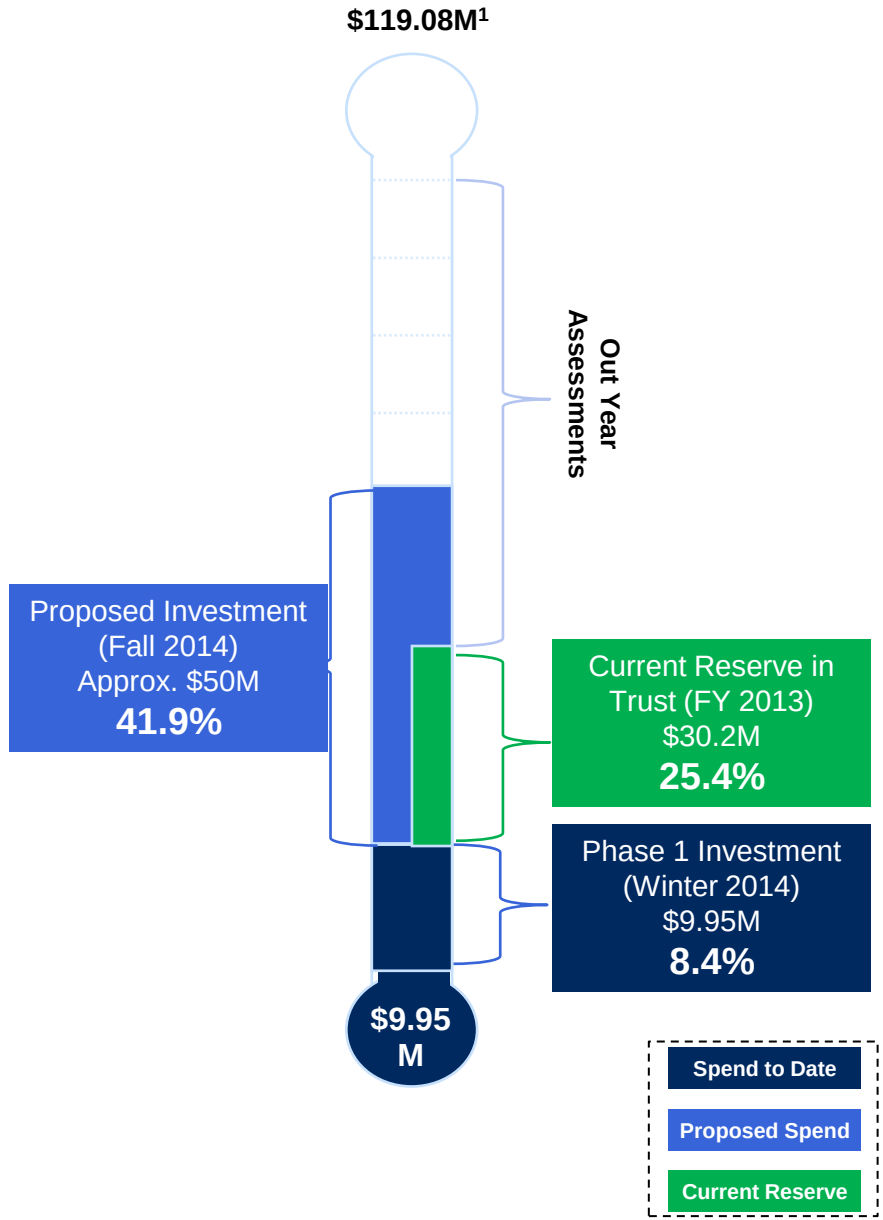
Fund allocation and preliminary program structure

- Staff propose a **total funding of approximately $50M** with two tiers:
  - Large scale transformation awards: **multi-year awards** (highly selective):
    - *Innovative approaches to care delivery and hospital operations*
    - *Required parallel engagement in care delivery enhancement and operating efficiency improvement*
  - Focused intervention awards: **multi-year** awards (numerous):
    - *Evidence based models, clinical or operational*
    - *Potential opportunity for pooled investments across awardees (e.g. regional investments_*
- **Funds flow should promote accountability** through one or more payment models, including, e.g., P4P (milestone based process or outcome payments), shared savings, etc.
- A central theme should be **community-focused, collaborative approaches** to care delivery transformation

Next steps

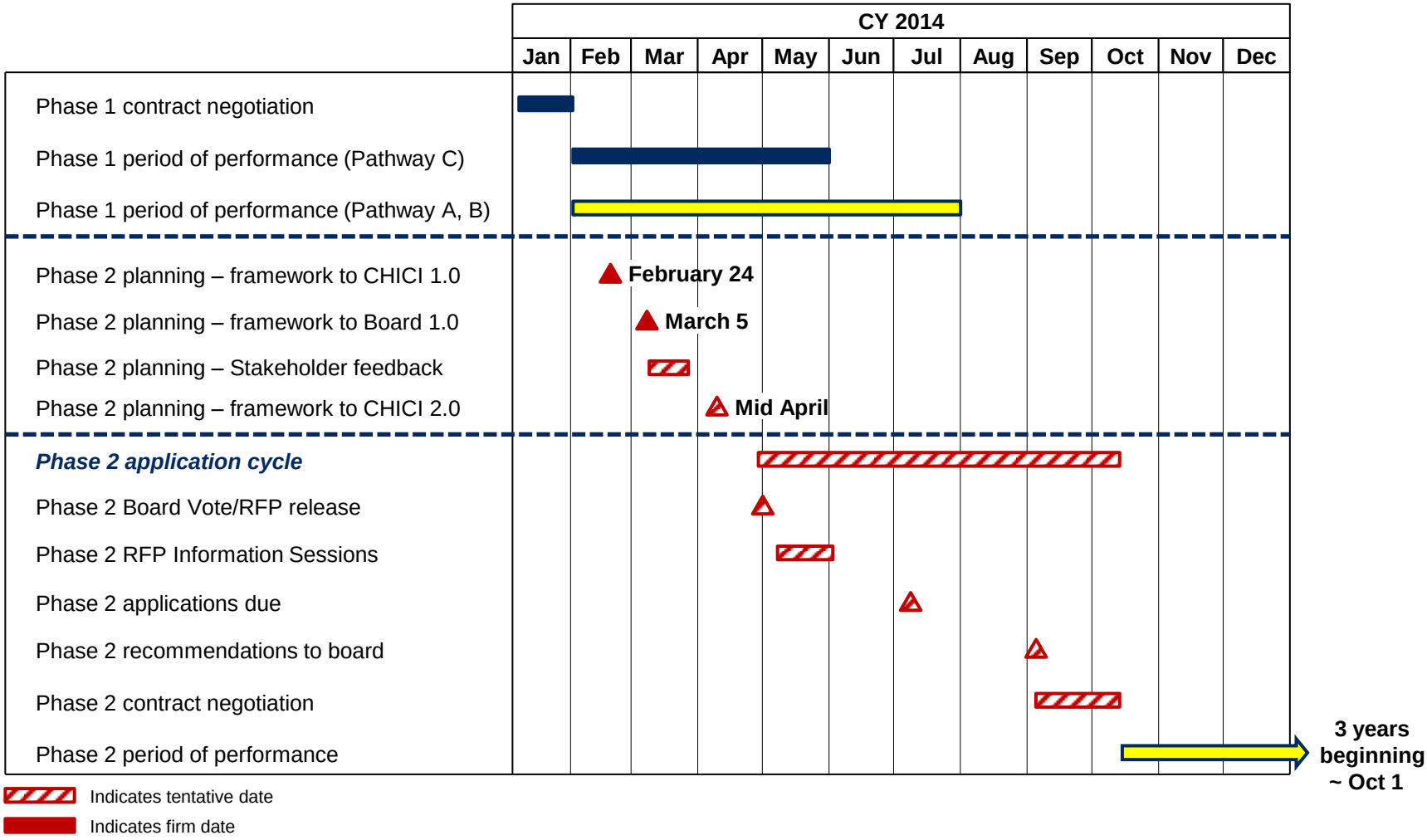
Staff activities and Committee engagement

- Staff to continue developing Phase 2 framework, including:
  - Increased specificity of tiers
  - Comprehensive analysis of CHART communities and hospitals
  - Adapting administrative framework to early lessons learned from Phase 1
  - Evaluating evidence base regarding potential payment models
- Staff to present updated framework to Board for consideration in March, followed by stakeholder engagement process
- Staff to evaluate approaches to achieving economies of scale relative to CHART projects (e.g., centralized data analytics resources)
- Staff to conduct site visits with awardees early in Phase 1, to build strong relationships and engagement
- Staff to continue goal-setting activities, including framework of quantitative targets for Committee consideration



[1]Distressed Hospital Trust funding pool after mitigation for select health systems

CHART Phase 1 and Phase 2 timeline



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Contact information

For more information about the Health Policy Commission:

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