COMMONWEALTH OF MASSACHUSETTS

HEALTH POLICY COMMISSION

Quality Improvement and Patient Protection Committee

December 10, 2014

Agenda

- Approval of Minutes from October 29, 2014
- Discussion of Behavioral Health Task Force Report and the HPC's Behavioral Health Agenda
- Update on ICU Nurse Staffing Regulation
- Schedule of Next Committee Meeting (TBD)

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- **Approval of Minutes from October 29, 2014**
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Vote: Approving Minutes

Motion: That the Quality Improvement and Patient Protection Committee hereby approves the minutes of the Committee meeting held on October 29, 2014, as presented.

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Behavioral Health Task Force Report: Background

Behavioral Health Integration Task Force

Chapter 224 established a “special task force to examine behavioral, substance use disorder, and mental health treatment, service delivery, integration of behavioral health with primary care, and behavioral , substance use disorder and mental health reimbursements systems”. This 19-member Behavioral Health Integration Task Force issued its report of findings and recommendations in July 2013 to the Legislature and the Health Policy Commission. The 29 recommendations were organized by the following broad topics:

Clinical models of integration
Reimbursement
Privacy
Education and Training
Workforce Development
Other

Task Force Report and the HPC

The Task Force Report continues to inform the work of the Health Policy Commission in promoting behavioral health integration throughout our varied responsibilities. As we look forward to 2015, the QIPP Committee will continue to play a leadership role in developing and implementing a policy agenda consistent with key recommendations of the Behavioral Health Integration Task Force.

HPC will focus on select recommendations from BH Taskforce report (1/2)

	BHTF Recommendations	HPC Next steps
Clinical Models of Integration	▪ **(1)** Move toward new and emerging models of integration, utilizing evidence-based effectiveness while recognizing diversity in model-type and the needs of individuals with lived experience	▪ Incorporate new & emerging models of integration into PCMH and ACO certification criteria ▪ Support widespread adoption of new & emerging models of integration across the care continuum through BH & CHART investments ▪ Evaluate new and emerging models of integration upon inclusion in certification and investment programs
Reimbursement	▪ **(4)** BH services should be included in APMs	▪ BH services to be included in model payment designs for PCMHs and ACOs ▪ HPC to work with other agencies and SQAC to identify a uniform set of outcome measures ▪ HPC to test outcome measures in investment programs ▪ HPC to work with key stakeholders to assess feasibility of risk / health status adjustment for behavioral health conditions
	▪ **(6)** APMs must include quality and financial measures of BHI. DMH, DPH and HPC should develop recommendations on a uniform set of measures	
	▪ **(12)** Organizations that are responsible for integrated BH services should be held accountable for quality and outcome measures that are caseload sensitive.	

HPC will focus on select recommendations from BH Taskforce report (2/2)

	BHTF Recommendations	HPC Next steps
Parity	▪ **(5)** Insurance carriers must comply with MA parity laws, including payment for neuropsychological assessment as a medical benefit ▪ **(8)** Medical necessity criteria should be transparent and expanded	▪ Ongoing role of QIPP in convening and monitoring of parity implementation ▪ Promote enhanced transparency of medical necessity criteria through OPP; ▪ Research and make recommendations on other legislative and regulatory changes regarding availability of data to support parity enforcement

Other	▪ **(27)** HPC to monitor implementation of BHTF recommendations
	▪ **(28)** There should be further study of whether a BH Carve-Out model continues to be appropriate and is able to deliver integrated care
		▪ Ongoing role for QIPP Committee and HPC to monitor BH trends and develop relevant policy recommendations, with focus on:
		  ▪ Integration (clinical and payment)
		  ▪ Outcomes measurement
		  ▪ Data/transparency
		  ▪ Parity

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Nurse Staffing Regulations – Key Requirements and Considerations

MGL c. 111, 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.

Listening Sessions and Stakeholder Meetings

Public Listening Sessions

- HPC Daley Room 10/29/14
- State House Gardner Auditorium 11/19/14

HPC Staff ICU Visits

- Boston Children's Hospital
- Brigham and Women's Hospital
- Planned: Morton Hospital (12/16/14)

HPC Staff Meetings with Stakeholders

- Massachusetts Hospital Association (8/4/14)
- Massachusetts Nurses Association (8/12/14 & 12/8/14)
- American Nurses Association-MA Chapter (9/5/14)
- Department of Public Health (9/17/14)
- Organization of Nurse Leaders (9/29/14 & 11/21/14)
- Quadramed (acuity tool vendor) (9/23/14)
- Massachusetts Council of Community Hospitals (10/9/14)
- Steward Health Care System (11/13/14)
- Navigant Consulting Inc. (11/14/14)
- Accenture (11/18/14)
- Planned: DPH Shattuck Hospital (12/12/14)

Key Considerations Identified

Application of the Nurse Staffing Law

- Applies to ICUs in MA acute care hospitals and DPH's Shattuck Hospital
- 105 CMR 130.020 includes general and specialty ICUs:
  - Critical Care
  - Coronary Care
  - Intensive Burn Care
  - PICU
  - NICU
- Stakeholders raised questions about application to NICUs

Registered Nurse-Patient Ratio

- Law requires 1:1 or 1:2 patient assignment for each Registered Nurse
- Depends on stability of the patient as assessed by the acuity tool and staff nurses in the unit
  - Stakeholders raised questions about whether hospitals must implement "default" ratio of 1:1

Key Considerations Identified: Formulation of Acuity Tool

What is the current landscape?

- Less than 20% of MA hospitals currently use an acuity tool
- More commonly used in AMCs than in community hospitals
- Tool models vary from paper checklist to comprehensive software

What do existing tools measure and how are they used?

- Patient acuity/mortality risk and nursing workload
- Used retrospectively for budgeting and resource planning purposes
- Hospitals are not currently using existing acuity tools to make staff assignments in a prospective manner
- Typically used as one of several variables to consider for staffing

What should the acuity tool measure?

- Clinical/ physiological indicators of patient stability
- Non-clinical patient characteristics (e.g., communication skills, cultural barriers, family support etc.)

Key Considerations Identified: Formulation of Acuity Tool

Other hospital/unit-specific considerations for patient assignments

- Nurse competency/experience
- Availability of ancillary/support staff
- Layout of the unit
- Patient mix/rate of admissions in the unit
- Other environmental factors

Criteria for use

- Assessment made by staff nurse
- Frequency of assessment
- Ease of use
  - Stakeholders differ on whether patient assessment made using tool should become part of patient record

Development or selection of tool by hospital

- Time and resources necessary for implementation
- Process to incorporate input of nursing and other staff
  - Stakeholders differ on regulatory approach regarding formulation of tool: flexible vs. prescriptive

Key Considerations Identified: Quality Measures

Criteria for selection

- Evidence-based, standardized, validated and nationally-accepted
- Capable of benchmarking over time
- Currently collected and reported in MA
- Nursing-sensitive
- Applicable across ICU-types, if feasible

Suggested Quality Measures:

- Post-operative wound dehiscence (MNA)
- Poor glycemic control (MNA)
- Adult inpatients reporting pain control (MNA)
- Death among surgical inpatients with serious treatable complications (MNA)
- Patient Falls with Injury (MNA, ANA)
- Restraint prevalence (ANA)
- Patient Falls without Injury (ANA)
- Registered Nurses Hours per Patient Day (ANA)
- Hospital Acquired Infections: CLABSI (ANA, ONL)
- HAI: CAUTI (ANA, ONL)
- Hospital-acquired pressure ulcers (ANA-ONL)

HPC seeks additional comment on quality measures.

Key Considerations Identified: Public Reporting of Staffing

Where is patient assignment information reported?

- Hospital website
- MHA PatientCare Link?
- HPC? DPH? CHIA?
- Patient medical record

What information is reported?

- Staffing compliance – level of detail?
- Quality measures
- When is the information to be reported?
- Align with other reports vs. “real time”?
- Post requirements of law in the ICU

Key Considerations Identified: Other Issues

1. DPH Certification of Acuity Tool
2. Enforcement
3. Evaluation

Next Steps

1. Hold next QIPP Meeting on January 6, 2014 – development of proposed regulation
2. Seek further comment on ICU quality measures

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Contact Information

For more information about the Health Policy Commission:

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