COMMONWEALTH OF MASSACHUSETTS

HEALTH POLICY COMMISSION

January 20, 2015

Board Meeting

Agenda

- Approval of Minutes from the December 17, 2014 Meeting
- Executive Director Report
- Quality Improvement and Patient Protection Update
- Care Delivery and Payment System Transformation Update
- Cost Trends and Market Performance Update
- Community Health Care Investment and Consumer Involvement Update
- Schedule of Next Commission Meeting (March 11, 2015)

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Vote: Approving Minutes

Motion: That the Commission hereby approves the minutes of the Commission meeting held on December 17, 2014, as presented.

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  - ICU Nurse Staffing Proposed Regulation
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Nurse Staffing Regulation – 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 Engagement/Feedback

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

Nurse Staffing at Public Meetings

- July 3, 2014 – Commission
- **August 13, 2014 – QIPP Committee**
- September 3, 2014 – Commission
- **October 29, 2014 – QIPP Committee**
- **December 10, 2014 – QIPP Committee**
- December 17, 2014 – Commission
- **January 6, 2015 – QIPP Committee**

HPC Staff Meetings with Stakeholders

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

Feedback on Quality Measures

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

Key Considerations in Development of Proposed Regulation

Current Landscape

- Less than 20% of MA hospitals currently use an acuity tool; tool models vary
- Existing tools are used retrospectively for budgeting and resource planning purposes
- MA law is unique in requiring an “acuity tool” to determine patient stability and assignment

Focus on Process

- Provide appropriate balance between guidelines consistent with the statutory purpose of promoting patient-centered staffing while recognizing unique circumstances of each ICU
- Emphasis on process for development or selection of 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

Related Processes

- The Department of Public Health (DPH) will need to develop certification and enforcement procedures

Beginning of Regulatory Process

- QIPP Committee will hold an official public comment period, including a public hearing(s)
- HPC anticipates continued engagement with stakeholders and refinement of the regulation

Key Considerations in Development of Proposed Regulation

Application to Intensive Care Units

- The statute provides that "the term "intensive care units" shall have the same meaning as defined in 105 MCR 130.020 and shall include intensive care units within a hospital operated by the commonwealth."
- This DPH licensure regulation defines a general ICU as well as the following types of specialized "intensive care units": Coronary Care Unit, Burn Unit, Pediatric Intensive Care Unit and Neonatal Intensive Care Unit.
- Accordingly, the Proposed Regulation provides that the nurse ratio applies in all such units so licensed by DPH.

Unit vs. ICU Patient

- The statute requires the nurse to patient ratio apply "in all intensive care units" rather than to the "ICU patient."
- Accordingly, the Proposed Regulation reflects this legislative language and clarifies that the staffing requirements apply to all units licensed as ICUs by DPH and all the beds in such units.
- We recognize that hospitals may use their licensed ICU beds at times for patients with lower acuity for different reasons but the statute requires unit-wide applicability.

Nurse-to-Patient Assignment of 1:1 or 1:2

- The statute requires "the patient assignment for the registered nurse shall be 1:1 or 1:2 depending on the stability of the patient…"
- Accordingly, the regulations reflects this statutory language and do not require hospitals to implement "default" patient assignment of 1 nurse to 1 patient

Proposed Regulation 958 CMR 8.00

958 CMR: HEALTH POLICY COMMISSION

958 CMR 8.00: REGISTERED NURSE-TO-PATIENT RATIO IN INTENSIVE CARE UNITS IN ACUTE HOSPITALS

Section

Proposed Regulation 958 CMR 8.04: Staff Nurse Patient Assignment

- In all ICUs, the Patient Assignment for each Staff Nurse shall be one or two ICU Patients at all times during a Shift (i.e., no more than two patients)

- The proposed regulation does not prohibit a Patient Assignment of more than one Staff Nurse for an ICU Patient

"Patient Assignment" is defined as the assignment of a Staff Nurse to care for one or two specified ICU Patient(s) for a Shift, consistent with the education, experience and demonstrated competence of the Staff Nurse, the needs of the ICU Patient, and the requirements of the proposed regulation.

Overview of Acuity Tool

"Acuity Tool" is defined as a decision support tool using a method for assessing patient stability for the ICU Patient according to a defined set of indicators, and used in the determination of a Patient Assignment.

Requirements for the Acuity Tool:

1. Required process for development or selection of Acuity Tool by hospital
2. Tailored to the unique care needs and circumstances of the patient population in any ICU in which the Acuity Tool is deployed; and
3. Includes a method for scoring clinical indicators and other indicators of Staff Nurse workload (see 958 CMR 8.07)
4. Must be certified by DPH

Proposed Regulation 958 CMR 8.05: Assessment of Patient Stability & Determination of Patient Assignment

- The Staff Nurse assigned to care for the ICU Patient shall assess the stability of the ICU Patient utilizing the Acuity Tool developed or selected by the Hospital and certified by DPH, and the exercise of sound nursing assessment and judgment within the parameters of the Staff Nurse's continuing education and experience.

- If there is a disagreement between the Acuity Tool and Staff Nurse assessment of ICU Patient stability, the Nurse Manager or the Nurse Manager's designee shall resolve the disagreement in consultation as appropriate with the other Staff Nurses on the unit and, taking into account critical environmental factors such as nursing skill mix and patient census on the unit, and shall determine the appropriate Patient Assignment.

Frequency of use of Acuity Tool by Staff Nurse, at a minimum:

(a) Upon the ICU Patient's admission or transfer to the ICU;

(b) Once during a Shift; and

(c) At other intervals or circumstances as specified in the Acute Hospital's policies and procedures established pursuant to 958 CMR 8.07(6).

Proposed Regulation 958 CMR 8.06: Development or Selection and Implementation of the Acuity Tool

Required elements of Acute Hospital's process for development or selection of Acuity Tool for each ICU:

(a) Formation of an advisory committee:

- At least 50% Registered Nurses who are not Nurse Managers, a majority of whom are Staff Nurses working in the ICU; and
- Other members including representatives of nursing management and other appropriate ancillary and medical staff

(b) Advisory committee makes recommendations on the elements of the Acuity Tool, including:

1. Clinical indicators of ICU Patient stability (see 958 CMR 8.07)
2. Other indicators of Staff Nurse workload (see 958 CMR 8.07) and
3. Scores to be assigned to each indicator and how scores are tabulated and used in the determination of Patient Assignment.

Additional required elements of Acuity Tool development or selection process include, e.g., process for periodic review and evaluation of the implementation of the Acuity Tool.

Acuity Tool Certification and Enforcement by DPH

- Hospitals submit the Acuity Tool for each ICU for DPH certification prior to implementation and periodically as determined by DPH (958 CMR 8.09)
- DPH will determine whether the Acuity Tool was developed or selected by the Acute Hospital in accordance with the procedures and requirements of 958 CMR 8.00 (958 CMR 8.09)
- Hospitals must comply with the procedures for certification and enforcement as established by DPH (958 CMR 8.09)
- Hospitals must submit to DPH for Acuity Tool certification no later than October 1, 2015 (958 CMR 8.13)

Compliance: Records & Public Reporting

Public Reporting of Compliance (958 CMR 8.10)

- Hospitals must report at least quarterly to DPH, as specified by DPH:
  - (a) Staff Nurse-to-patient ratios by ICU; and
  - (b) Any instance and the reason in which the minimum Staff Nurse-to-patient ratio of one to two was not maintained
- Hospitals must issue quarterly reports to the public on Staff Nurse-to-patient ratios by ICU on the Acute Hospital's website, and as may be specified in HPC guidance

Records of Compliance (958 CMR 8.08)

- Each Acute Hospital shall document and retain for a minimum period of ten (10) years:
  - Records related to the process it followed for development or selection of the Acuity Tool; and
  - Records of staffing compliance indicating the results of the assessment of ICU Patient stability and determination of Patient Assignment for each ICU Patient

Collection and Reporting of Quality Measures

Collection of Quality Measures (958 CMR 8.11)

- The HPC is required to identify 3 to 5 patient safety quality indicators to be measured and reported by hospitals to the public
- In evaluating 11 quality measures suggested by stakeholders, the HPC will consider whether proposed measures are:
  - 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
- The HPC expects to finalize such measures either through sub-regulatory guidance or in the final regulation

Reporting of Quality Measures (958 CMR 8.11)

Hospitals shall:

1. Report ICU-related quality measures to DPH, as specified in HPC guidance;
2. Report the specified quality measures to DPH at least annually; and
3. Issue reports to the public on the specified quality measures for each ICU, at least annually, on the Hospital's website, and as may be specified in HPC guidance.

Development of Policies, Procedures & Plans

Policies and Procedures for Use of the Acuity Tool (958 CMR 8.07)

- Each Acute Hospital shall develop written policies and procedures specifying how the resulting Acuity Tool score will be used to support the determination that the ICU Patient requires care by one or more Staff Nurses, or by a Staff Nurse assigned to care for no more than two ICU Patients

Staffing Plan (958 CMR 8.12)

- Each Hospital shall develop and implement a Registered Nurse staffing plan for the ICU in which the Acuity Tool is deployed that incorporates data gathered from implementation of the Acuity Tool.

Next steps in the regulatory process

January 6 QIPP Committee meeting: voted to advance proposed regulation to HPC Board

January 20 HPC Board meeting: discussion of proposed regulation; vote to advance proposed regulation to public comment and hearing process

February Convene a working group to discuss evaluation of the law; release of recommended quality measures for public comment

March QIPP Committee meeting & public hearing(s) on proposed regulation; discussion of working group and release of quality measures; public comment period

April QIPP Committee meeting: discussion of recommended final regulation; vote to advance final regulation to HPC Board

April 29 HPC Board meeting: discussion of recommended final regulation; vote to approve and authorize regulation

Summer 2015 DPH develops and promulgates regulation governing certification and enforcement

**All dates subject to change*

Vote: Proposed Regulation on ICU Nurse Staffing

Motion: That the Commission hereby authorizes the issuance of the PROPOSED regulation on registered nurse-to-patient ratio in intensive care units in acute hospitals, pursuant to chapter 155 of the Acts of 2014, and directs the Quality Improvement and Patient Protection Committee to conduct a public hearing and comment period on the regulation pursuant to Chapter 30A of the General Laws.

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    - ACO Certification Program
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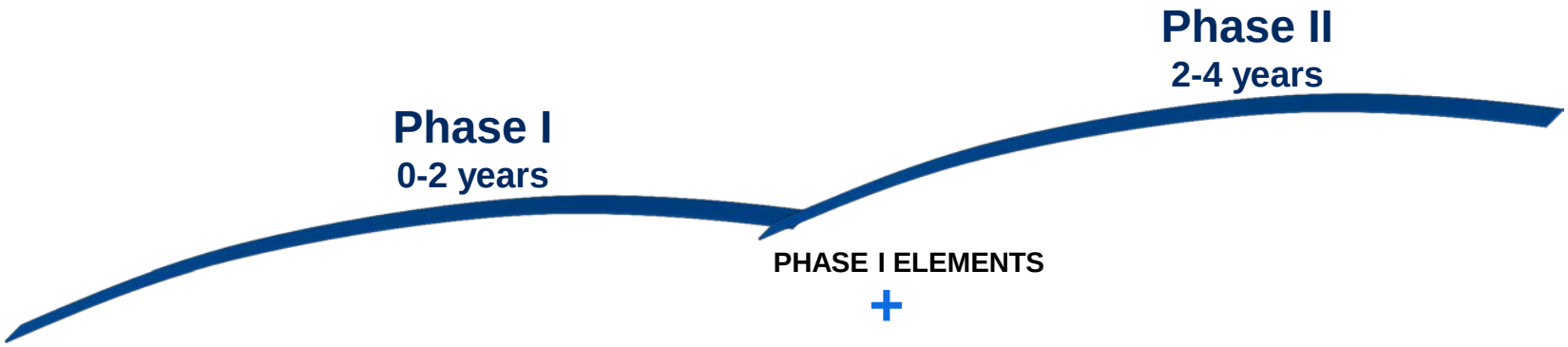
PCMH program – high level design



Certification Criteria

Phase I

- **NCQA Core Criteria**
  - Patient Centered Access
  - Team Based Care
  - Population Health Management
  - Care Management& Support
  - Care Coordination & Care Transitions
  - Performance Measurement & Quality Improvement
- **Modifications for Behavioral Health, Resource Stewardship, Population Health Management and Patient Engagement**

Phase II

PHASE I ELEMENTS

+

- **Advanced Population Health** (with focus on geographic level population health)
- **Advanced Behavioral Health**
- **Advanced Resource Stewardship** (broad set of efficiency measures practices need to meet)

Additional Program Elements

Phase I

- **Payment Incentives**
- **Technical Assistance (BH funds + priority status for other state agency funds)**
- **Consumer education / PR**
- **Simple provider reports**
- **PCMH capabilities foundational for ACO certification**

Phase II

- **Payment Incentives**
- **Consumer Incentives**
- **CHIA Provider Portal**

NCQA is uniquely qualified to partner with the HPC on the Patient-Centered Medical Home Certification Program

Chapter 224

- Chapter 224 directs the HPC to partner with an accrediting organization in developing PCMH standards and **specifically references the existing standards by the National Committee for Quality Assurance** (NCQA)

Qualifications

- NCQA is the most widespread PCMH recognition tool used in Massachusetts
  - More than 1,800 clinicians in 215 practice sites are **already NCQA PCMH recognized**
  - 135 practices in process of becoming NCQA PCMH recognized
  - EOHHS PCMH Initiative required NCQA recognition
- Approximately 15% of all PCPs nationwide deliver care in an NCQA-recognized PCMH
- NCQA has **expertise, IT platform, and training infrastructure** readily available

Alignment with HPC

- NCQA's standards and requirements are **closely aligned** with the goals of the HPC's PCMH certification program
  - Limited additional HPC-specific requirements
  - Only streamlined "upgrade" process will be required for practices already NCQA-recognized, reducing administrative burden and cost

Value

- NCQA will review HPC-specific elements with **no additional cost**
- **20% government discount**
- Customized technical assistance available

For discussion: NCQA – HPC contract

Costs to the HPC

Content Development

- Consulting support for **modifying** existing NCQA standards and **developing new requirements** specific to Massachusetts
- Consulting support to determine the best method by which modifications will be incorporated into the certification process and how **compliance** with new requirements will be assessed

Program Implementation

- Configuration of existing data systems (Interactive Survey System) to meet new HPC requirements
- Training of reviewers on the new HPC requirements
- Creation of a customized "upgrade" process for currently certified practices that will streamline the transition to the 2014 NCQA/HPC standards

Training &Technical Support

- **4 in-person training** sessions (1.5 days each, focused on currently non-certified practices)
- **6 webinars** (2-3 hours each), focused on practices currently certified
- **Phone/email support** for practices to receive guidance and support

- **~185K for 1st year**
- **~100K for subsequent years**

Costs to practices

- No additional fee to practices for HPC certification beyond NCQA's **standard fee structure**

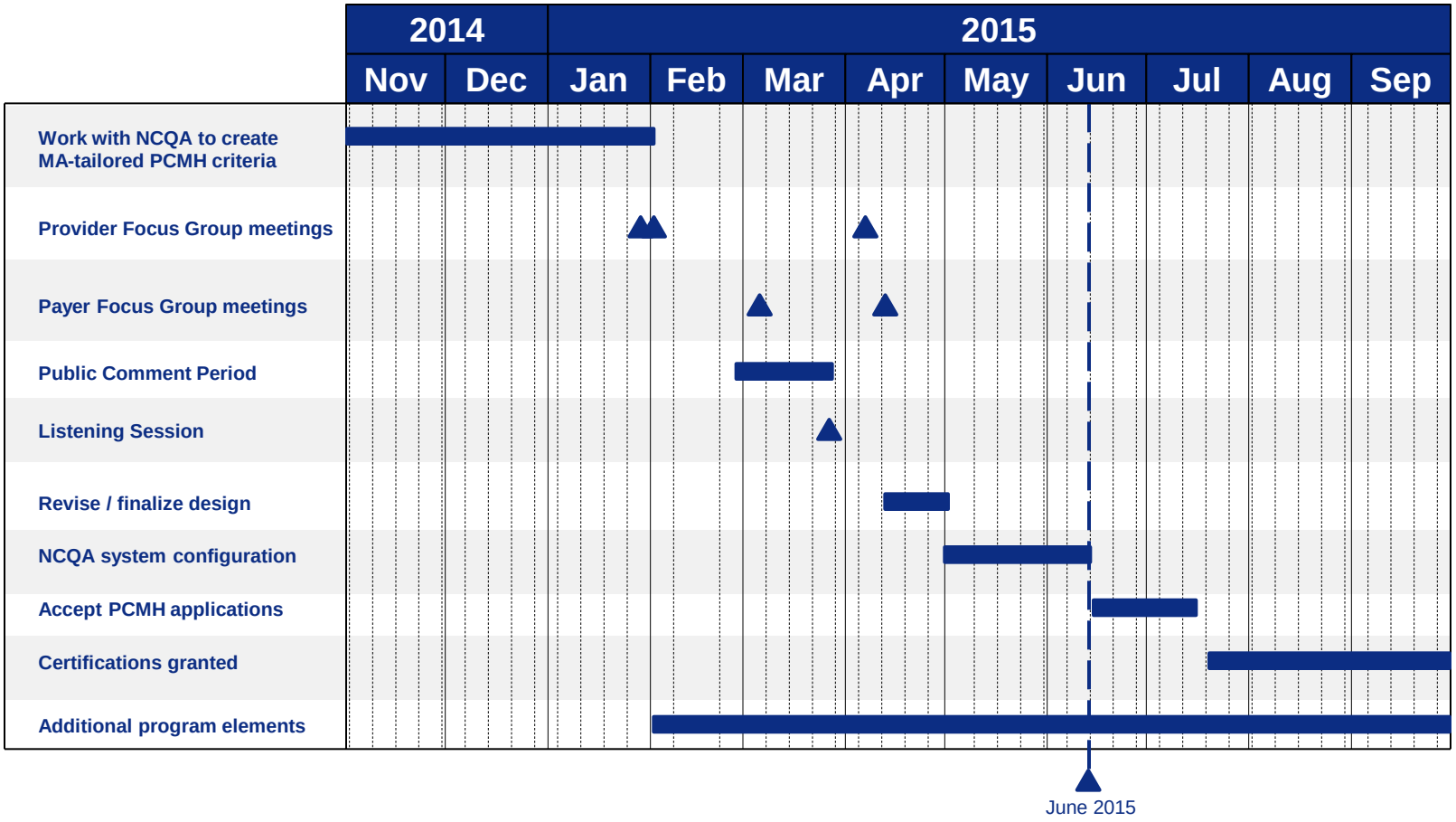
Costs will be based on volume of practices

Source: NCQA estimates

Comprehensive program design is critical for success; staff expects to seek Board approval for final program design at the April 29 meeting

Payment Incentives	- Engage with payers to encourage **payment incentives / other financial support** for practices certified under HPC PCMH Certification program - Develop '**PCMH model payment design(s)**', as mandated by Chapter 224 to align with objectives of the PCMH certification program, with input from stakeholders - Engage with payers and providers to encourage **adoption of 'model payment**' in future contracts
Technical Assistance	- **$1.5M** to improve BHI in the PCMH context, **HPC to earmark additional budget for other capabilities** - **Large-scale trainings** led by HPC and NCQA staff - Emphasis on **resource constrained practices** - **Likely low touch, scalable model**, given limited funding - Alignment with CHART and EHS TA programs
Consumer Marketing	- **Engage with consumer advocacy groups (e.g., HCFA) to** promote HPC certification program amongst consumers/patients - **Evaluate value proposition for engaging in large-scale marketing/branding campaign** to support adoption of PCMH model by consumers/patients
Provider Reports / CHIA Provider Portal	- NCQA to produce **practice-level overview reports** (once practices are certified), and monthly reports at the factor-level - **Data sharing with providers** to facilitate improvement based on data resources available to the HPC in the short term - **CHIA Provider Portal** to will ultimately replace intermediate provider reports
Consumer Incentives	- Engage with payers and employers to build in incentives for PCMH adoption into **insurance (demand side) design**

PCMH Certification Timeline



Vote: Statement of Intent with NCQA for PCMH

Motion: That the Commission hereby approves and authorizes the Executive Director to proceed with executing a contract with the National Committee for Quality Assurance, that will not exceed an annual amount of $200,000, upon completion of issuance of a notice of intent to contract, to meet the requirements of section 14 of chapter 6D of the Massachusetts General Laws for the patient-centered medical home certification program

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Goals for today's ACO discussion

- Discuss HPC's **goals** for the ACO certification program
- Review **design principles**
- Discuss certification **approach (outcome vs. capability based)**
- Discuss **framework of functional domains** for ACO certification
- Discuss **approaches from other state and commercial programs** for each functional domain
- Deliberate over **points of emphasis** for HPC's ACO certification program

Goals for the ACO certification program should be clearly linked to priority areas identified by Ch. 224 and the HPC

FOR DISCUSSION

	Proposed goals: HPC's ACO certification program should:
Fostering a value based market	• Establish **minimum standards** for high quality and efficient care, **to support and promote value based insurance design** • Promote models of provider integration that **support a competitive marketplace**
Promoting an efficient, high quality health care delivery system	• Promote excellence in **identifying population health needs** and implementing **integrated** care delivery models that support those needs, supported by **evidence-based practice guidelines**
Advancing aligned financial incentives and accountability	• Promote adoption of payment models and provider funds flows that provide **sufficient incentive to change provider behavior** to improve quality and efficiency • Establish a **pathway for increased accountability** for quality, cost and patient experience over time
Enhancing transparency	• Promote reliable, standardized, better integrated and progressively more sophisticated **performance measurement and public reporting at the aggregate and individual provider level**, as appropriate
Enhancing patient protection and engagement	• Ensure **patient access** to health care services across the care continuum • Improve access to and quality of health care services for **vulnerable populations**

Principles and process for developing ACO certification standards

Principles

ACO certification standards will:

- **Be compatible with existing Medicare ACO programs and MA commercial global budget contracts**
- **Be aligned with MassHealth ACO** program development timeline and requirements
- **Maintain flexibility** for market innovation while ensuring minimum standards for an efficient and high quality care delivery system
- Be **evidence-based**
- **Minimize unnecessary administrative burden** on providers

Process

Standards will be determined and refined based on input gathered from:

- MA providers, payers, and consumer advocacy groups
- National and regional subject matter experts
- CMS and other state ACO programs

Most state certification/Medicaid programs are based on capabilities and quality measures; initial experimentation with select outcome measures ongoing in New York and Texas

Eligibility / payment based on:	
No ACO activity	▪ Rhode Island ▪ Pennsylvania ▪ Michigan ▪ Ohio
Capabilities only	▪ Colorado ▪ Illinois
Capabilities Quality measures	▪ Minnesota ▪ Maine
• Capabilities • Quality measures • Reporting on utilization / outcome measures	▪ Oregon ▪ New Jersey
• Capabilities • Select outcome measures (PPEs)	▪ New York ▪ Texas

Certification would ideally be based on statewide agreed upon outcome measures and benchmarks; however, this is not feasible in the short term

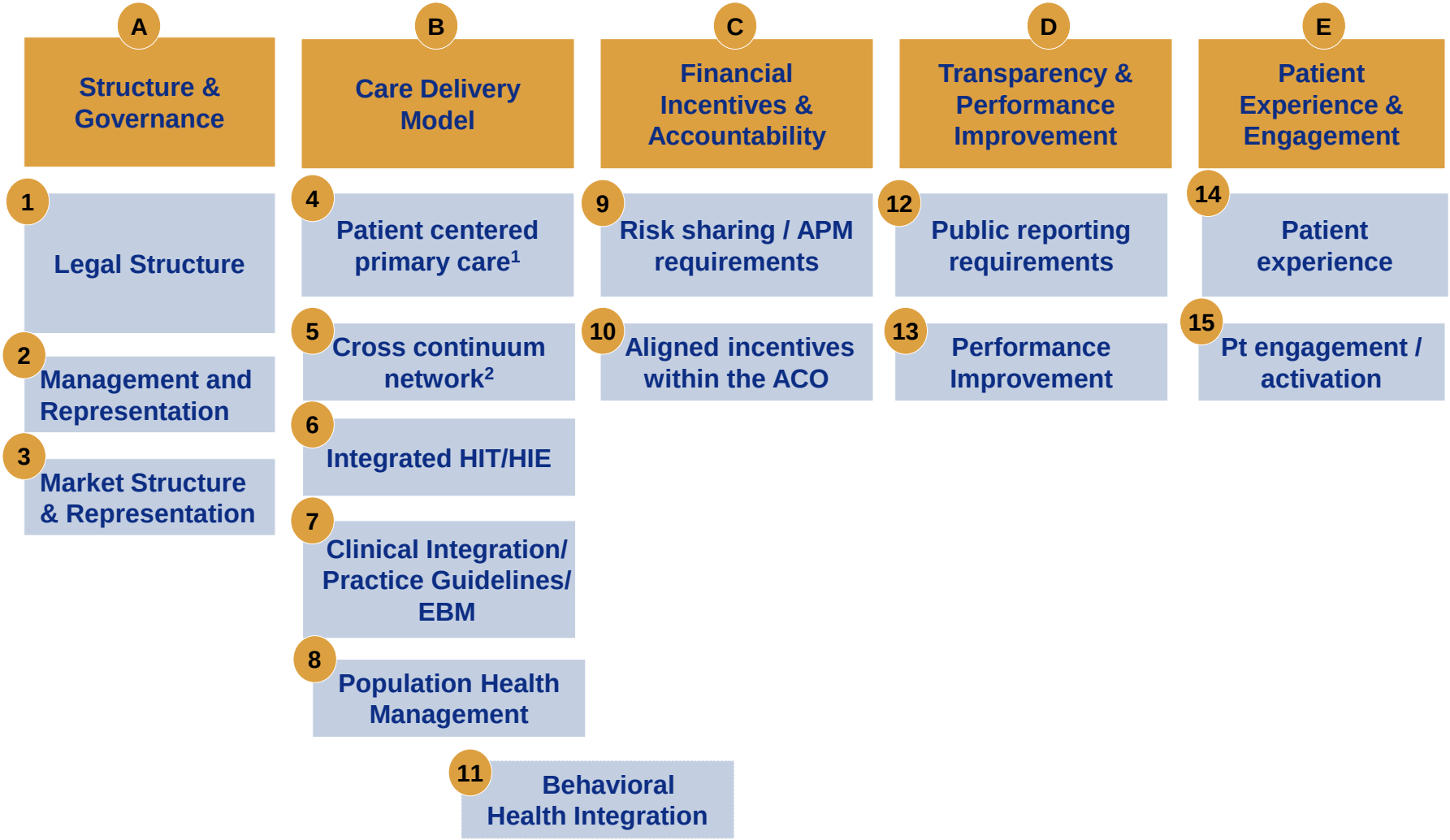
	Description	Feasibility
Certification based on holistic outcome measures	**Certification to include requirements for meeting an agreed upon threshold for:** • Growth in **Total Health Cost Expenditures** • **Quality** measures established by the SQAC • **Patient centeredness/activation**	**Currently not feasible:** • No market agreement on THCE calculation methodology using APCD, time lag associated with APCD • Statewide quality and patient centeredness measurement have significant limitations
Certification based on select outcome measures	**Certification based on meeting specific thresholds on select outcome measures (**e.g., ambulatory sensitive ED visits, potentially preventable readmissions)	**Currently not feasible:** • Proprietary methods exist for select measures (e.g., 3M PPE methodology)[1] • APCD, other data sources (e.g., MHDC, ED outpatient data set) have significant limitations
Certification based on capabilities	**Certification based on capabilities linked to 'intermediate goals' established by the HPC:** • Fostering a value based market • Promoting an efficient, high quality health care delivery system • Advancing APMs • Enhancing transparency • Ensuring patient protection	**Feasible**

Recommendation:

- **HPC's ACO certification program should be based on capabilities initially, supplemented with the use of select outcome measures for reporting purposes only**
- **Over time, in 2-4 years, HPC should aim to certify based on agreed upon outcome metrics**

[1] Currently being used in New York and Texas Medicaid programs

Required functions and capabilities can be categorized across 5 domains, each of which is tightly linked to identified goals



[1] Closely aligned with HPC PCMH requirements

[2] Includes community-based medical and non-medical services

HPC's ACO certification program is intended to build on Medicare ACO program and commercial global budget contracts

MA Commercial Contracts

Some requirements regarding quality and patient experience reporting

Flexible about other domains

Medicare Pioneer/MSSP programs

Stringent requirements regarding public reporting and governance

Some requirements regarding:

- Patient centeredness

- HIT

- Population Health Management

- APM progression

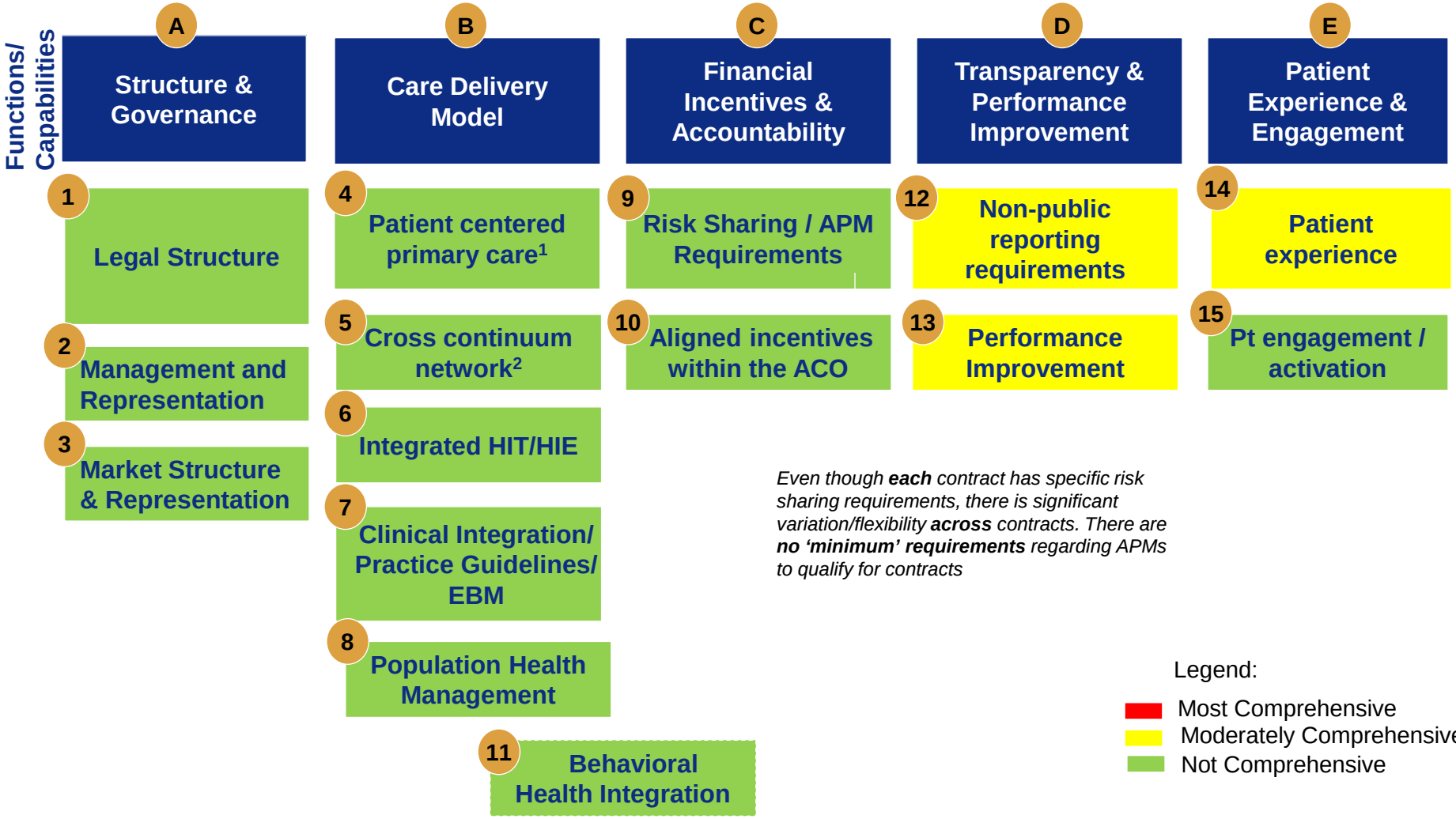
Flexible about other domains

HPC ACO certification domains

As described on the previous page

Source: Literature search, market knowledge, CMS, state ACO program RFAs, interviews

Commercial contracts in MA usually do not have specific requirements for most of the domains

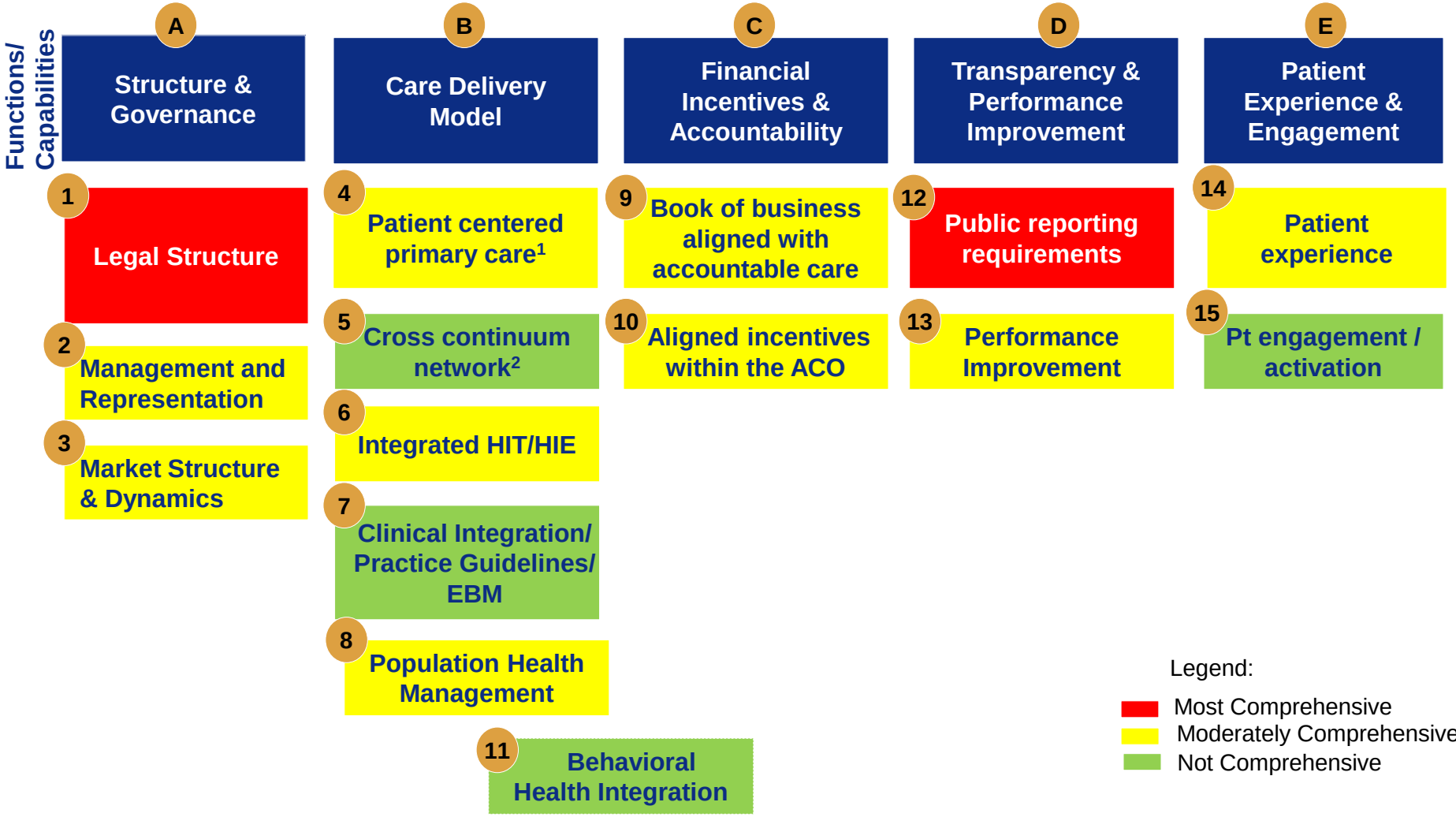


[1] Closely aligned with HPC PCMH requirements

[2] Includes community-based medical and non-medical services

Source: Literature search, market knowledge

Medicare ACO program requirements have varying degrees of comprehensiveness across the 15 domains



[1] Closely aligned with HPC PCMH requirements

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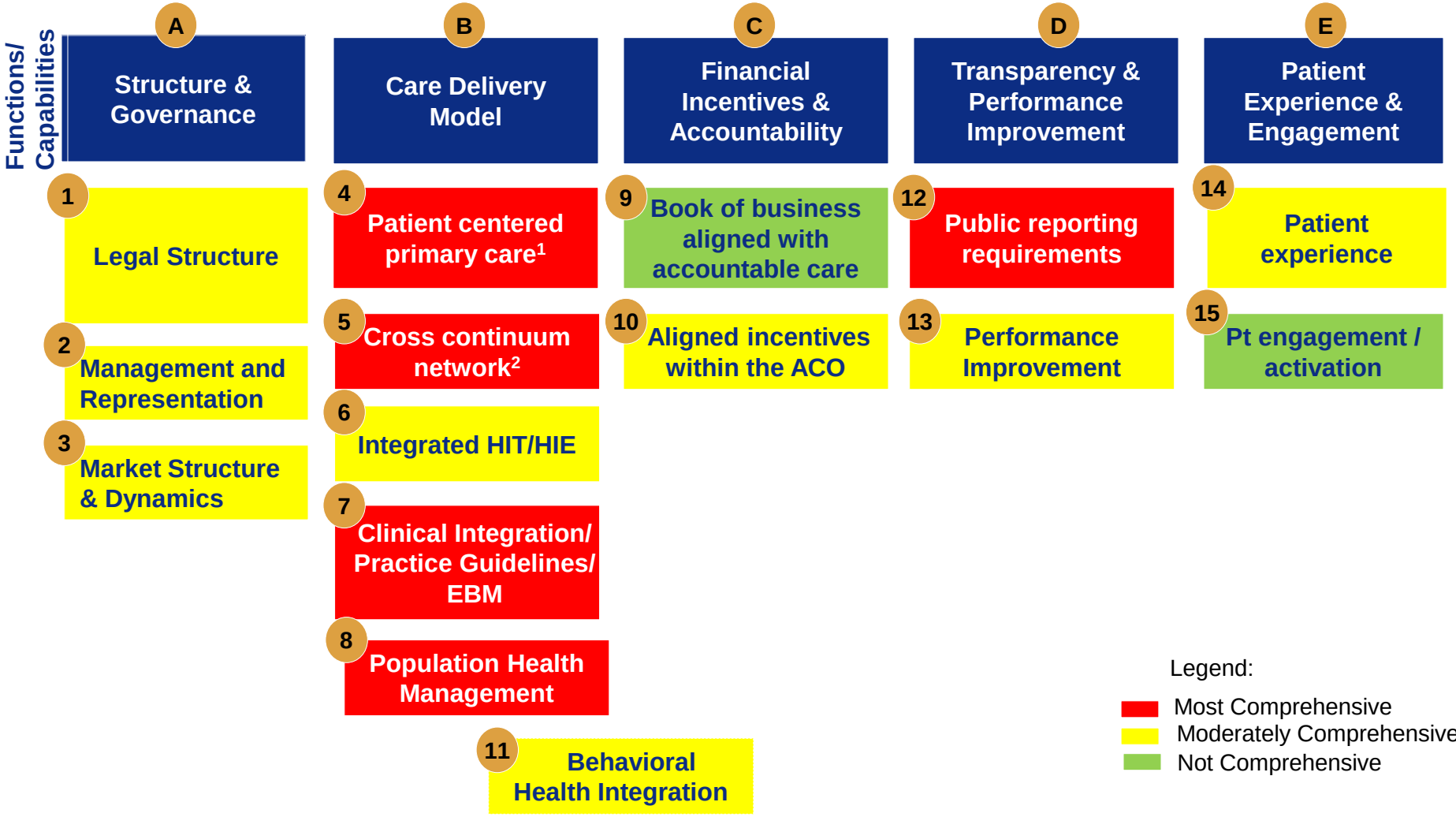
* Medicare Shared Savings Program (MSSP) & Pioneer Program

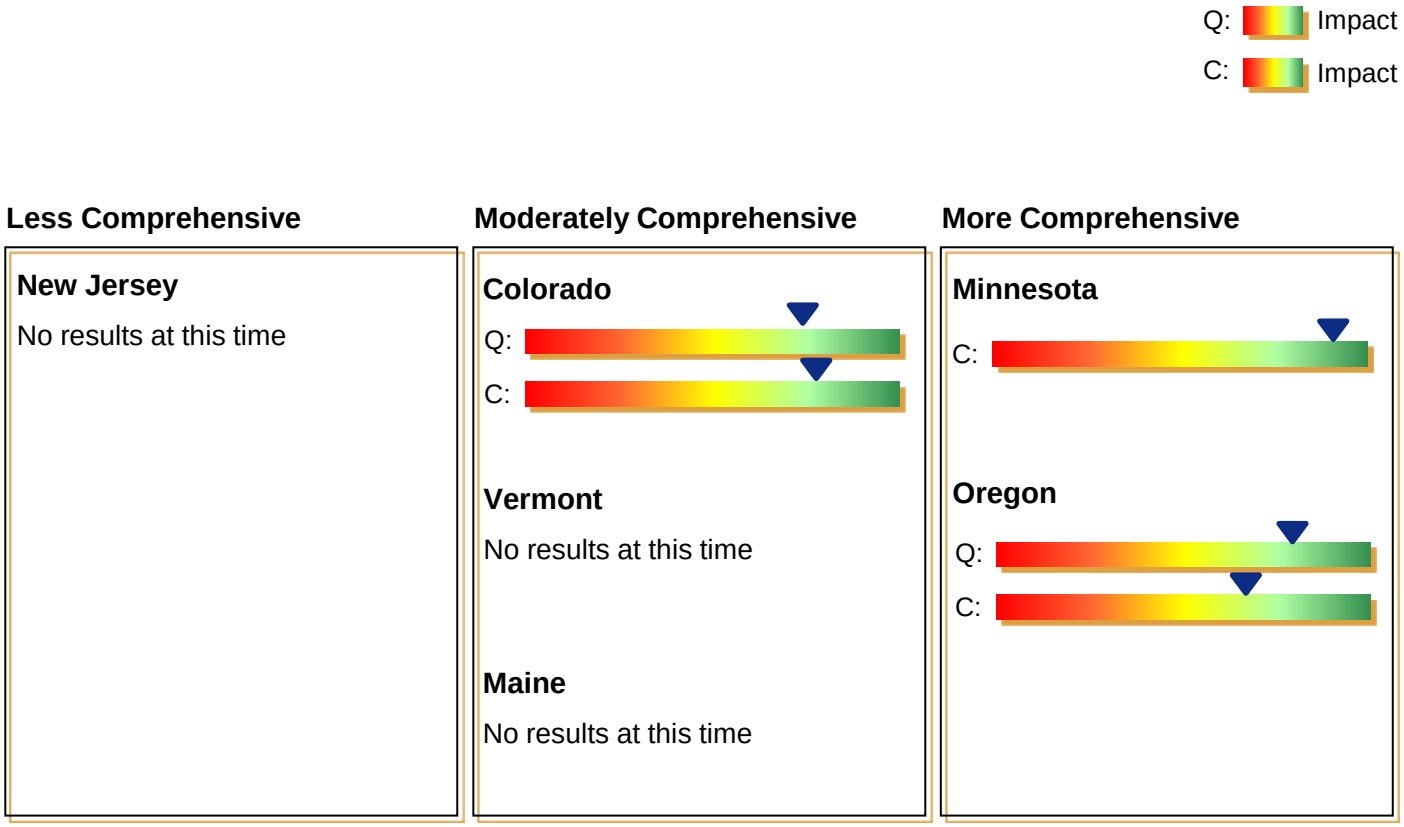
Other state ACO models tend to be most comprehensive with regard to care delivery and transparency requirements



[1] Closely aligned with HPC PCMH requirements

[2] Includes community-based medical and non-medical services

Quality and cost performance data on state ACO programs are limited; outcomes published by more comprehensive ACO programs appear promising*



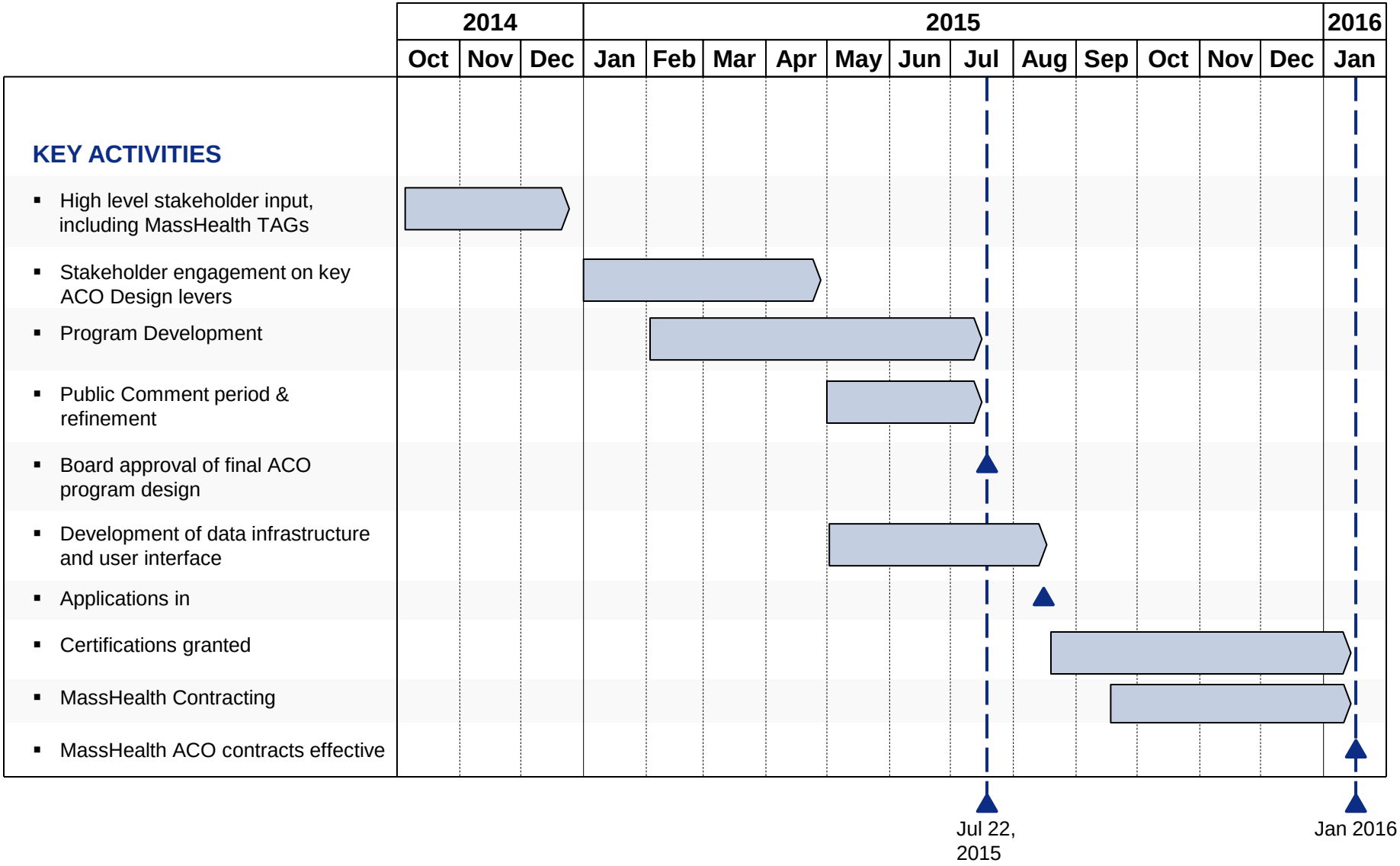
Source: Literature, State/CMS Reports

* Most states have yet to publish data on Quality or Cost Performance measures. Programs are either still in their 'reporting only' phase, or have yet to publish data

Discussion questions

- What specific points of emphasis should HPC have for the MA ACO certification program?
- How comprehensive should HPC's ACO certification standards be across each of the 15 domains?
- What additional programmatic elements would best enhance HPC's capability to deliver on intended outcomes?

ACO Certification Timeline is aligned with MassHealth ACO timeline; certification process is expected to begin in mid-August



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Registration of Provider Organizations

Provider Organizations were required to submit Part 1 materials to the HPC by 5:00pm on November 14, 2014.

Applications received on or before the 11/14 deadline:	62
Applications received after the 11/14 deadline:	14
Outstanding applications expected:	2

Conclusion: The HPC expects the total number of RPO applicants to remain in flux over the next few weeks. Contributing factors include:

- New applications received from organizations that missed the 11/14 deadline
- New applications from Risk Bearing Provider Organizations that did not complete the parallel RPO registration requirement
- Removal of duplicative applications submitted by organizations that have a corporate affiliation with another registering entity

Registration of Provider Organizations

Review Status of Applications Received as of 1/14	
Awaiting Review	21
Under Review	19
Awaiting Updates	9
Complete	27
Total Applications Received:	76

Registration of Provider Organizations

Review Criteria

- ❑ All of the required files were submitted
- ❑ The files were completed according to instructions in the DSM and HPC guidance
- ❑ The Provider Organization's materials are consistent with other sources, including:
  - ❑ AGO Public Charities filings
  - ❑ Secretary of State filings
  - ❑ Information shared with HPC during 1-on-1 meetings
  - ❑ Material Change Notices
  - ❑ RPO applications from affiliated organizations
- ❑ The Provider Organization has used the RPO terminology accurately

Review Process

HPC sends a confirmation receipt to the Provider Organization

↓

HPC reviews the materials for completeness and accuracy

↓

If HPC identifies errors/questions, the Provider Organization has 10 business days to respond

↓

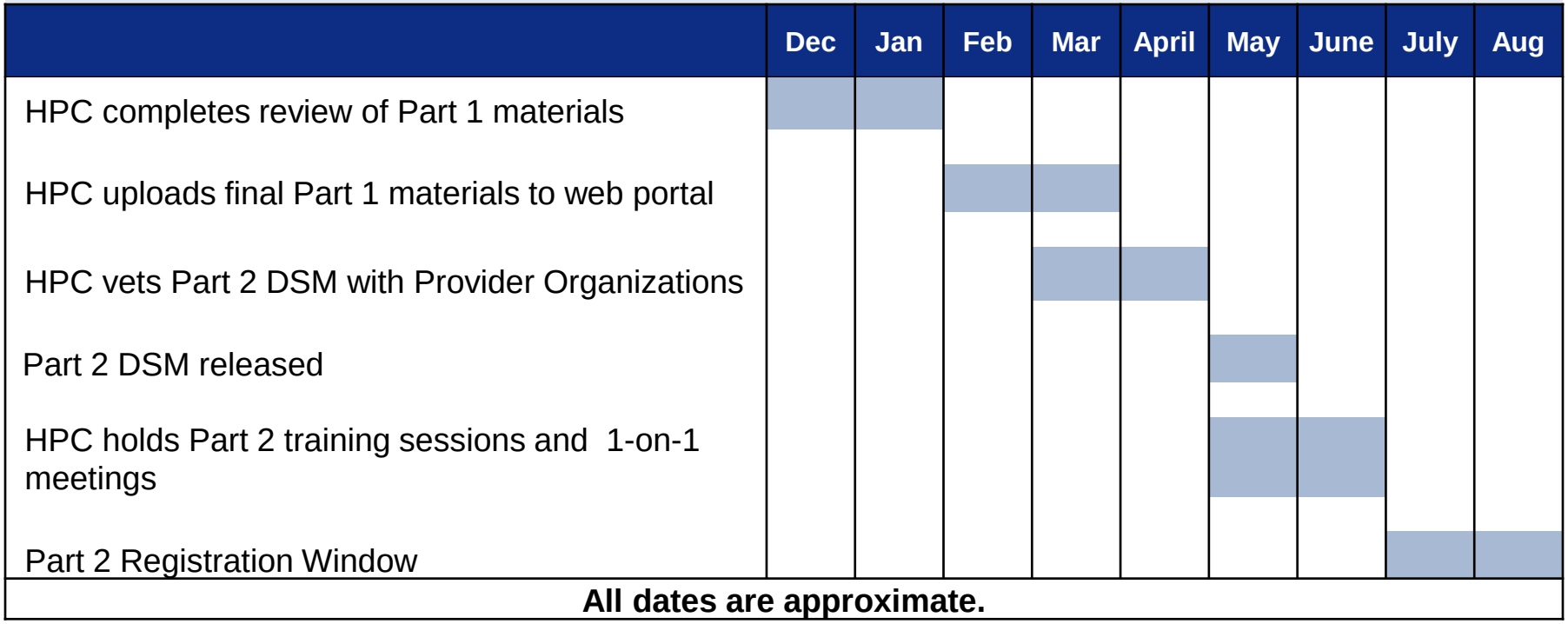
Updated materials are reviewed, as applicable

↓

The HPC sends a confirmation letter to the Provider Organization stating that no additional action is required until Part 2

Registration of Provider Organizations

Next Steps



Registration of Provider Organizations

Looking to Part 2

- The HPC is currently working to assemble the Data Submission Manual for Part 2.
- In drafting the Part 2 DSM, staff are working to incorporate, as appropriate:
  - Input received from Provider Organizations on the draft DSM released in April 2014
  - Answers to common questions received from Provider Organizations in Part 1
  - Updated definitions, clarifications and policies, based on staff's review of the Part 1 materials
- Staff anticipate providing ample opportunity for comment, questions and feedback from both Provider Organizations and HPC Commissioners. Detailed comments on definitions and data elements will help staff create a DSM that is clear and precise.

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Selected findings from 2014 Cost Trends Report

Spending trends	Per capita THCE grew by 2.3 percent. Below the benchmark.
Episodes	For selected episodes of care, spending varied among hospitals without significant differences in quality.
Post-acute care	In MA, 39 percent of patients received PAC following inpatient stay compared to national rate of 27 percent. Following total joint replacement, most hospitals discharge to institutional care more frequently than New England Baptist, a recognized specialty hospital.
Readmission rates	CMS will penalize 80 percent of Massachusetts hospitals for high readmissions rate.
ED visits	Almost half of the ED visits in 2012 were preventable.
Behavioral health	For a variety of medical conditions, spending for patients with behavioral health comorbidities is higher than spending for patients without such comorbidities.
APMs	Between 2012 and 2013, expansion of APM coverage stalled in the commercial sector.
Demand-side incentives	Thus far, we see potential value but limited adoption of narrow networks, reference pricing, and price transparency.
Transparency and data	The importance of transparency and data availability surface throughout our work.

Conclusions from the 2014 Cost Trends report

We find that there are significant opportunities in Massachusetts to enhance the value of health care, addressing cost and quality. We identify four primary areas of opportunity for improving the health care system in Massachusetts:

1. **Fostering a value-based market** in which payers and providers openly compete to provide services and in which consumers and employers have the appropriate information and incentives to make high-value choices for their care and coverage options,
2. **Promoting an efficient, high-quality health care delivery system** in which providers efficiently deliver coordinated, patient-centered, high-quality health care that integrates behavioral and physical health and produces better outcomes and improved health status,
3. **Advancing alternative payment methods** that support and appropriately reward providers for delivering high-quality care while holding them accountable for slowing future health care spending increases, and
4. **Enhancing transparency and data availability** necessary for providers, payers, purchasers, and policymakers to successfully implement reforms and evaluate performance over time.

The report includes specific commitments from the HPC and recommendations to market participants and other state agencies to advance these policy goals in 2015.

Proposed recommendations - overview

Fostering a value-based market

1. Massachusetts – lead nation in price transparency
2. Payers - develop and promote value-oriented products; enhance employer information
3. Employers - offer value-oriented products
4. Providers - demonstrate that proposed market changes offer benefits
5. HPC – examine past transactions to assess impacts

Promoting an efficient high-quality delivery system

1. Providers - adopt appropriate tools and share best practices in specific priority areas
2. HPC – reinforce priority areas via TA, investment, performance measurement and payment design
3. State agencies - develop a coordinated behavioral health strategy

Advancing alternative payment methods

1. Payers and providers – adopt APMs and increase their effectiveness
2. State agencies – prioritize efforts to define a standard set of provider quality measures
3. HPC - explore episode-based payment models
4. MassHealth - continue progress towards ACO

Enhancing transparency and data availability

1. HPC - develop measures to track system performance
2. CHIA - improve APCD capabilities, develop key spending measures
3. State agencies - coordinate on APM data collection, resource planning

Fostering a value-based market

Proposed Recommendations

Information and incentives to encourage high-value choices

1. Massachusetts should lead the nation in direct-to-consumer transparency, enabling access to detailed information on cost and quality.
2. Payers should continue to develop and promote value-oriented products and enhance provider information.
3. Employers should offer their employees plan choices that include value-oriented products, or embed value-based concepts into their chosen plan offering.

Market competition

1. Providers should present measurable indicators of how proposed material changes are likely to result in improved performance and demonstrate that benefits outweigh potential detriments.
2. The HPC will examine past transactions to assess their impacts.

Promoting an efficient, high-quality delivery system

HPC Priority Areas

- Addressing variation among providers in spending per episode and use of post-acute care
- Reducing readmission rates and ED utilization
- Care coordination and clinical integration across settings
- Identifying and managing high-cost patients
- Caring for patients in community settings
- Treatment of behavioral health conditions, especially via integrated models

Proposed Recommendations

1. Providers should adopt appropriate tools and share best practices in the priority areas.
   - Hospitals should focus on PAC and discharge planning.
   - PAC providers should collect and use patient assessment data.
2. The HPC will convene providers and offer TA in priority areas and emphasize these areas in investment programs and payment design.
3. The Commonwealth should develop a coordinated behavioral health strategy.
   - CHIA should begin collecting data in priority areas.

Advancing alternative payment methods

Proposed Recommendations

1. Payers and providers should focus on increasing adoption and effectiveness of APMs.
   - All payers should use APMs for 60 percent of HMO lives and 33 percent of PPO lives.
   - Payers and providers should evaluate how best to include behavioral health spending in APM budgets to support integrated, whole-person care and should work to adopt such arrangements starting in 2015.
2. The state should prioritize defining a standard set of provider quality measures for use in payer contracts, provider tiering, and improvement goals.
3. The HPC will convene stakeholders to explore episode-based payment models.
4. MassHealth should continue progress towards developing and launching an ACO.

Enhancing transparency and data availability

Proposed Recommendations

1. The HPC will develop a set of measures to track health system performance.
2. CHIA should improve APCD capabilities and transparency and develop key spending measures.
3. Government agencies should coordinate on APM data collection and continue health resource planning.

Vote: Issuing Annual Cost Trends Report

Motion: That, pursuant to section 8(g) of chapter 6D of the Massachusetts General Laws, the Commission hereby issues the attached annual report on cost trends.

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Next steps for 2015: summary of HPC commitments

In addition to our ongoing work streams and statutory responsibilities, the Cost Trends Report commits the HPC to a number of new and expanded policy and program initiatives for 2015. Staff will work with the HPC's four standing policy committees to develop detailed timelines and implementation work plans, and will update the full Board regularly on progress.

1. Develop MA's health system performance "dashboard"
2. Engage with payers, providers, and employers on advancing consumer-directed price transparency efforts
3. Engage with employers and payers – including the GIC- in efforts to enhance value-based product design
4. Develop approaches to examine past transactions and evaluate status of parties' commitments regarding cost, quality and access
5. Support provider efforts to adopt appropriate tools and share best practices to improve quality and efficiency in the specific priority areas (i.e. PAC, readmissions, HCP, ED utilization)
6. Develop coordinated technical assistance program through HPC's investment and certification programs in these priority areas

(continued)

Next steps for 2015: summary of HPC commitments

In addition to our ongoing work streams and statutory responsibilities, the Cost Trends Report commits the HPC to a number of new and expanded policy and program initiatives for 2015. Staff will work with the HPC's four standing policy committees to develop detailed timelines and implementation work plans, and will update the full Board regularly on progress.

7. Coordinate behavioral health integration strategy with other state agencies
8. Engage with payers and providers to advance the adoption of effective APMs, including through the exploration of episode-based payments
9. Coordinate with other state agencies to align APM reporting and expand types of APMs reported
10. Coordinate with other state agencies to align quality measurement
11. Support MassHealth's development of a Medicaid ACO program and ensure alignment with the HPC ACO certification program
12. Support and strengthen the work of CHIA's behavioral health data task force
13. Support and strengthen the work of the Health Resource Planning Council

In 2015, the Health Policy Commission will be issuing a number of important reports covering a diverse range of topics

Planned reports: January – June 2015

- 2014 Annual Cost Trends Report
- CHART Leadership Summit Paper
- CHART Phase-One Case Studies (5-6 total)
- CHART Phase-One Summary Evaluation Report
- Community Hospital Study
- Substance Use Disorder Report (as mandated by c.258 of the acts of 2014)

Throughout the year, the Health Policy Commission will complement these reports with a series of "white papers"

2015 Cost Trends Report

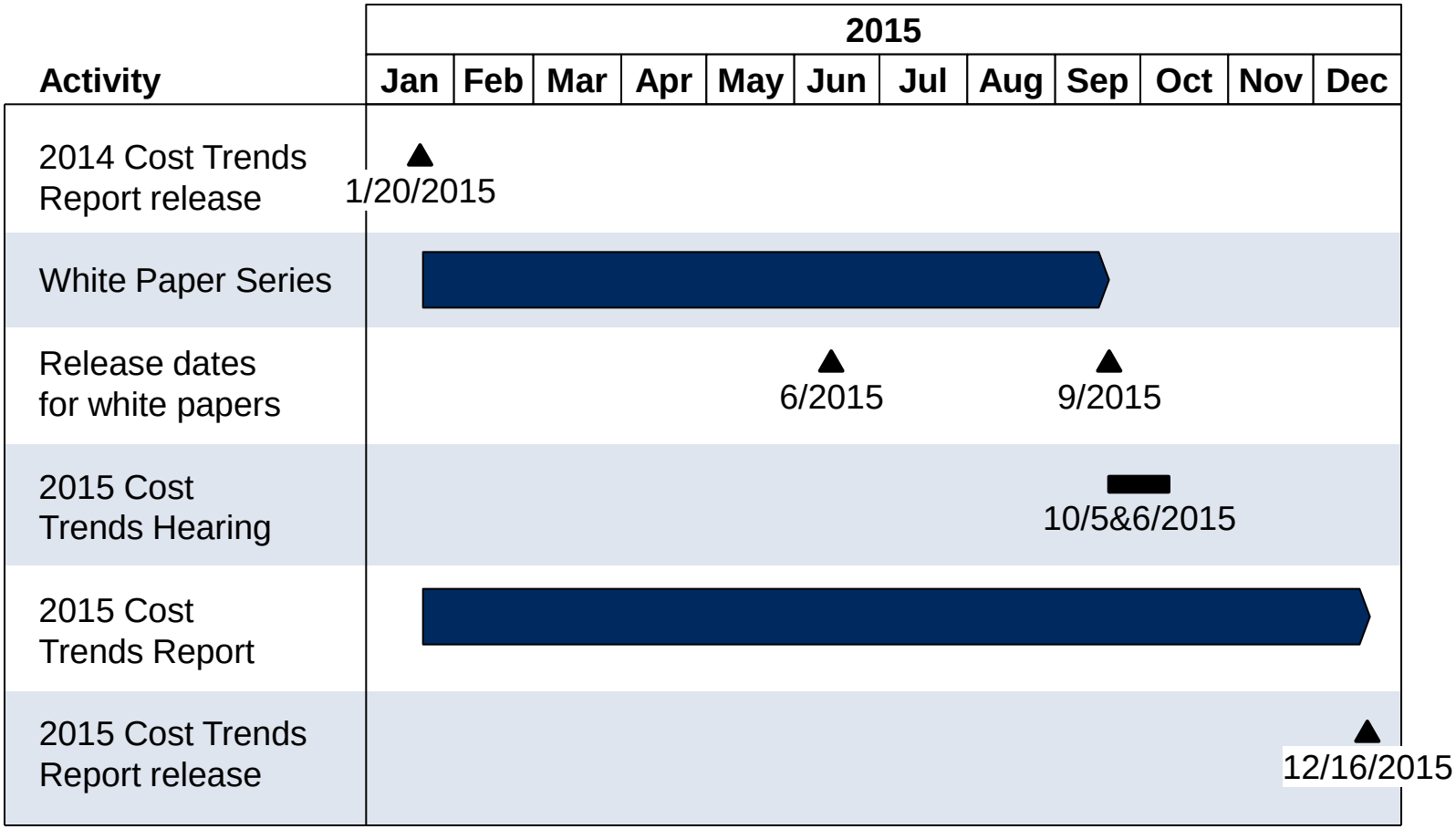
- Comprehensive report with market-wide view
  - Many descriptive analyses
  - Time trends and updates
  - National comparisons
  - Year-to-year continuity
  - May also include new or focused topics
- Publish one report at end of year

White Papers

- In-depth study of one issue
  - Deep examination of cause and effect
  - Often in partnership with outside researchers
  - Often uses advanced analytic methods or original data collection
- Publish 2-4 working papers in 2015 on an occasional basis

Examine trends, drivers, opportunities, progress
Include evidence-based recommendations to increase quality and efficiency
Choose actionable, relevant topics, where HPC is uniquely positioned to contribute
Employ rigorous methods & objective analysis

2015 research timeline



Potential topics for 2015 research – for discussion

- **Primary care access:** incl. urgent care, minute clinics and telehealth; changes in market, impact on ED use
- **New technology, including high-cost drugs/biologics:** impact on cost and quality
  Behavioral health integration: best practices, including best practices in working with MBHOs
- **APMs:** characterize the payment models used; impact of model type on spending
- **Employers and insurance markets:** potential value of strengthening demand-side incentives in MA; best practices and barriers; potential of private exchanges
- **Data for provider decision-making and health IT:** best practices and barriers
- **Episode payment:** technical studies to support potential use in MA
- **Social determinants of health and self-care**
- **Market concentration analysis of outpatient services (i.e. primary care)**

Topics may be covered in 2015 Cost Trends Report or HPC working papers

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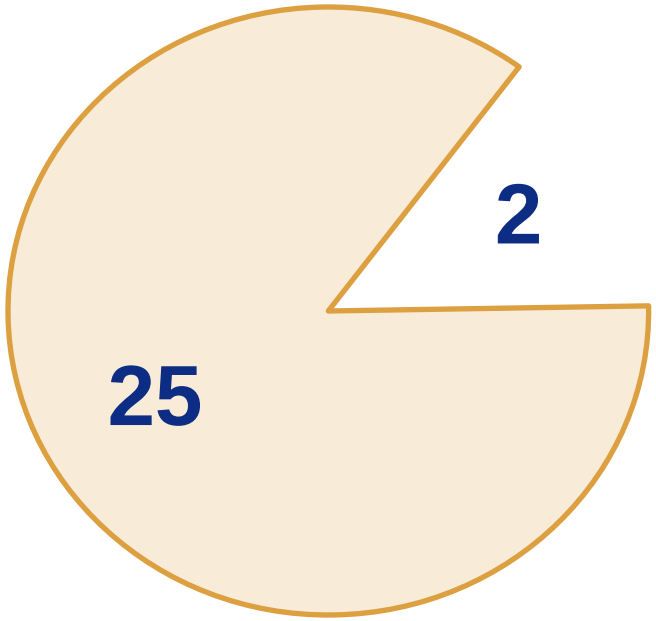
CHART Phase 1 status report – project completion



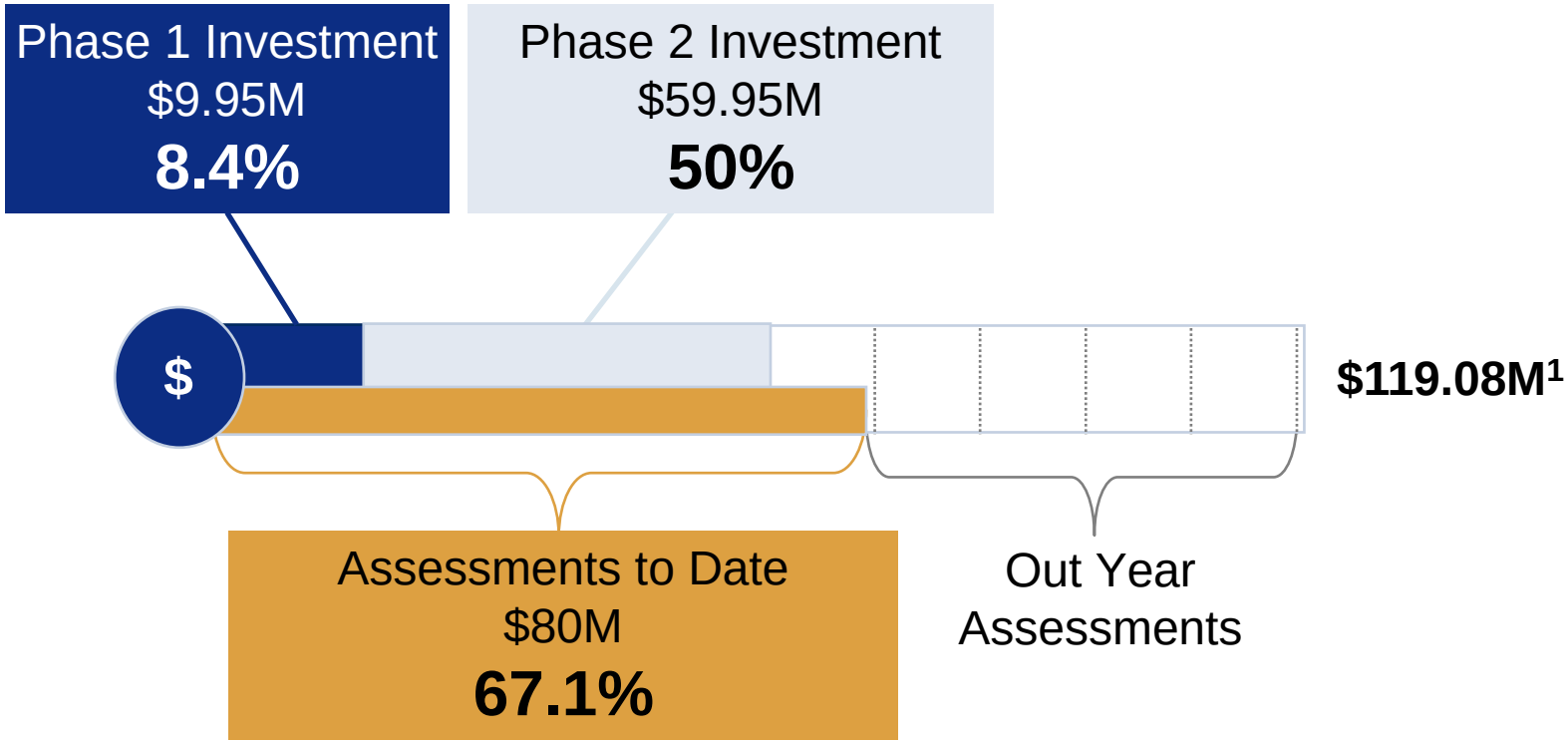
25 hospitals completed projects as expected by the end of 2014, many with no cost extensions.

Two hospitals encountered challenges in hiring staff for implementation, resulting in project delays

Deliverables	Final report Reconciled budgets End of period survey All work products
Budget Performance	There were no cost increases requested of the HPC. Award dollars not spent will be returned to the CHART fund. A final accounting will be included in the Phase 1 evaluation report

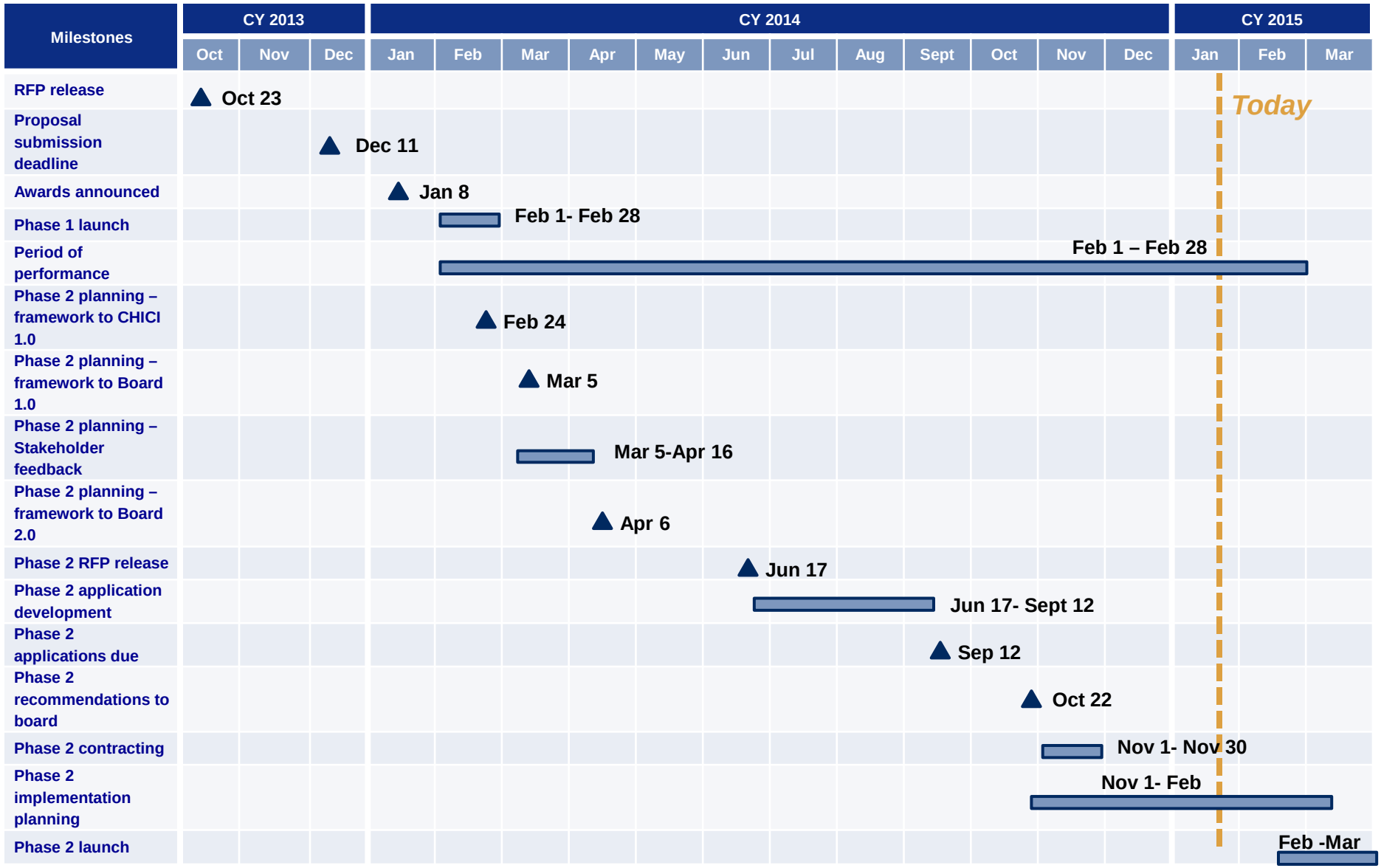
CHART Phase 1 status report – flow of funds

HPC has committed $69.9 million in funding to date



[1] Total Distressed Hospital Trust Fund pool (expected assessment after mitigation from select health systems)

CHART adhered to an accelerated timeline for soliciting and awarding investments and launching partnerships with awardees



Here is what select hospital leaders said about the CHART Program

"

CHART 1 initiatives impacted the effectiveness of patient care in our community in boundless ways…we never imagined the enormous need or the personal effects the care improvement would have on all members of our team. The team delivered the care and observing patients not coming back to the ED, staying at home and avoiding readmission…

-Dr. James Fanale, Senior Vice President, BID-Plymouth

CHART Phase 1 funds have been instrumental in helping Noble Hospital streamline care delivery and coordination of our limited resources…[our new] enabling technology has dramatically increased our staff's ability to communicate across departments and provide more timely care…

–Steve Cummings, CIO/COO, Noble Hospital

"

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Phase 1 program objectives to be evaluated

2014 marked the first phase of the CHART Investment Program, with the HPC focused on the following program objectives

- Partner with awardees to fund and plan high-need projects and pilots
- Engage hospitals around quality improvement, efficiency, collaboration, safety, and leadership
- Assess and develop capacity for continuous process improvement in care delivery and IT infrastructure at all CHART Hospitals
- Develop capabilities for data collection and measurement for reporting improvement outcomes

CHART Phase 1 anticipated evaluation products

A series of Phase 1 evaluation outputs are currently in development

1. **Programmatic learnings to inform Phase 2:** HPC staff have continuously collated and captured key lessons to inform ongoing program development and hospital improvement efforts. These tools and approaches are actively being implemented in Phase 2, including directly informing the creation of the implementation planning period.
2. **CHART Leadership Summit Proceedings Paper and Safe & Reliable Assessment:** Staff have developed and will release a proceedings paper on the Leadership Summit. Staff are working to finalize an aggregate report developed based on the assessments conducted by Safe & Reliable Healthcare for release.
3. **Case Studies on Key Themes:** HPC has commissioned up to six case studies of key themes in CHART Phase 1. Each will include multiple hospitals. Cases will be released on a rolling basis and will include topics such as: using data to understand a population and design an intervention, the importance of strong management, and how to address social and behavioral drivers of hospital utilization.
4. **Summative Evaluation Report:** Subsequent to receipt of all final reports and completion of the Phase 1 close out survey, the HPC will release a summative evaluation report on Phase 1. This is anticipated in Q1 2015.

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CHART Phase 1 by the numbers*

CHART Phase 1: $10M

162,000+

Patients impacted by Phase 1 initiatives

2,200+

Hospital employees trained

27 Hospitals | **260** Units

Primed for system transformation

92%

Phase 1 Feedback survey respondents believed that CHART Phase 1 moved their organization along the path to system transformation

308

Community partnerships formed or enhanced by awardees

400+

Hours of direct technical assistance to awardees

*Updated January 20, 2015

CHART Phase 1 investments primed 27 hospitals for system transformation

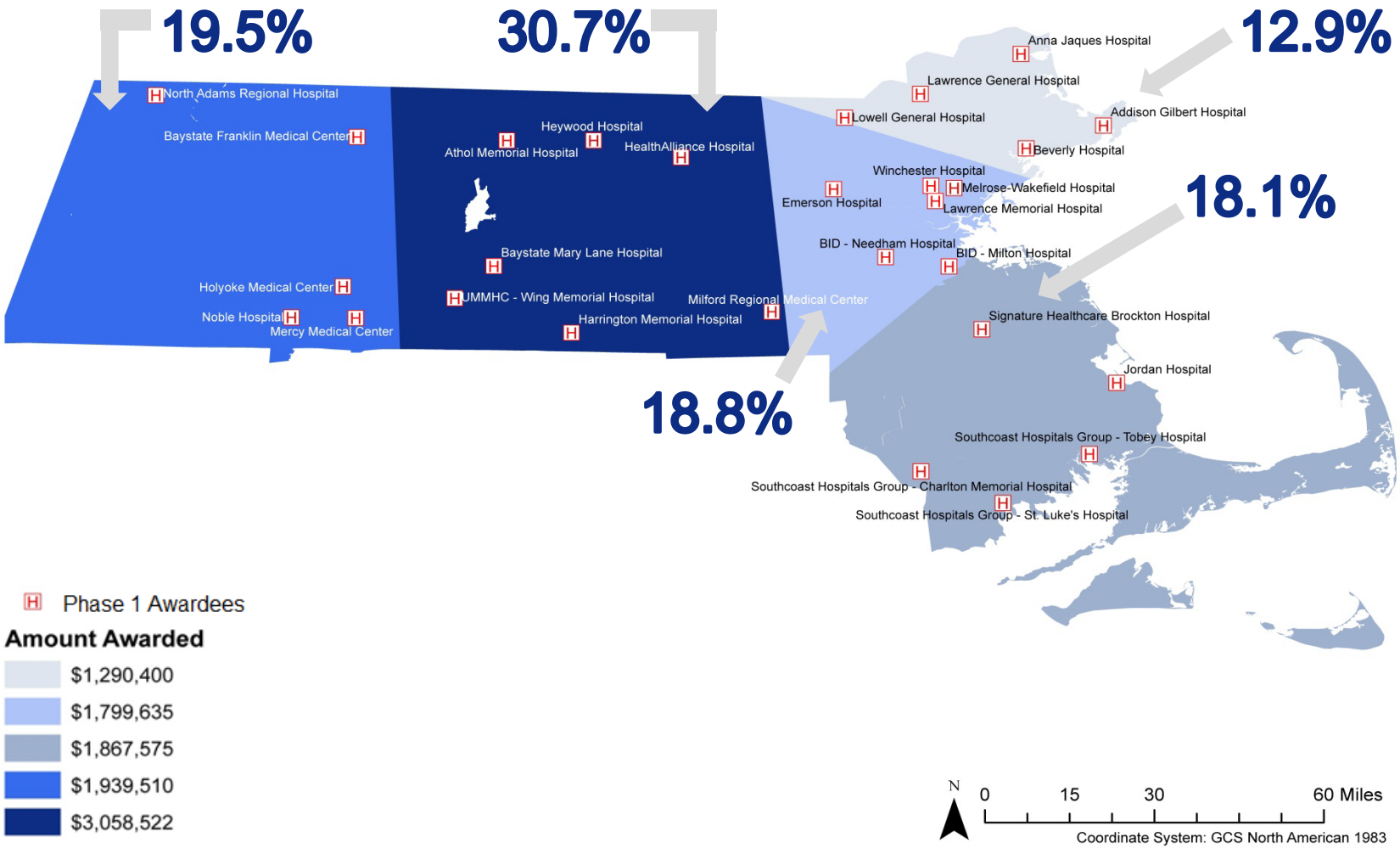


CHART Phase 1 investments impacted more than 162,000 patients*

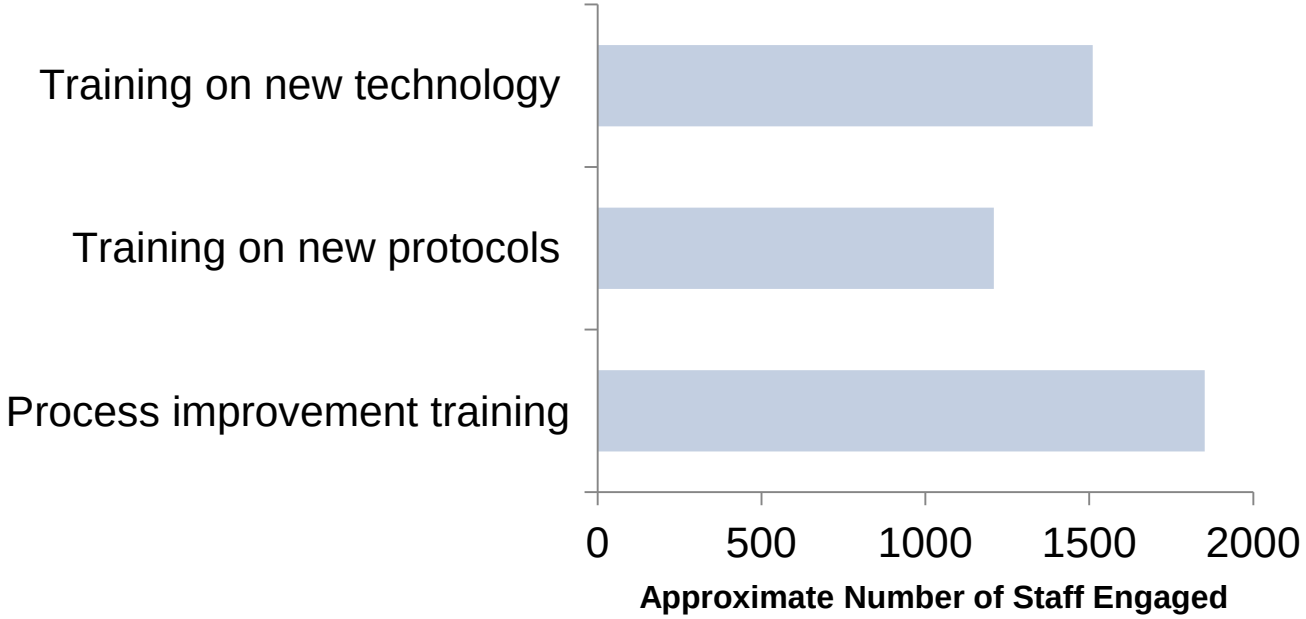
CHART projects have supported hospitals in delivering safer, more efficient medical and behavioral health care as well as extended their reach into social determinants of health

- A patient with diabetes was found to be without food at home by a community health worker funded by CHART, who drove her to a food bank and met her 'need' that would otherwise have resulted in an admission.
- A patient with learning disabilities and multiple chronic diseases visited the ED for minor issues like bug bites until a community case manager, funded by CHART, built a supportive relationship with him. This helped the patient access clothing and transition into adult foster care and decreased his frequent ED visits.
- A 70 year old with COPD, DM, and Bipolar disorder was a "frequent flyer" patient. The technology implemented with CHART funds allowed the ED case manager to identify this patient. The identification allowed the case manager to find out that the patient needed additional services which were then arranged for with another CHART funded technology and the patient was not readmitted for 60 days.

*This is an aggregate of self reported numbers by the hospitals and include both care delivery pilots and technology pilots that can touch many patients; total updated January 20, 2015

CHART Phase 1 investments trained over 2,200 hospital employees

CHART hospitals promoted staff development through trainings with a variety of areas of focus



153 ED staff across the Hallmark hospitals adopted a new care protocol for back pain management to reduce opioid prescribing by 26% at Melrose-Wakefield and 43% at Lawrence Memorial, and increase PMP use from 1.5% to 60%

Mercy Medical Center trained 70 staff and executed more than 70 Lean improvement projects in five departments including team communication for care transitions and inpatient delay reduction

*Individual staff training numbers were reported by each hospital to the HPC in Phase 1 Final Reports.

CHART hospitals formed or enhanced more than 300 partnerships with medical practices, behavioral health providers and community resources

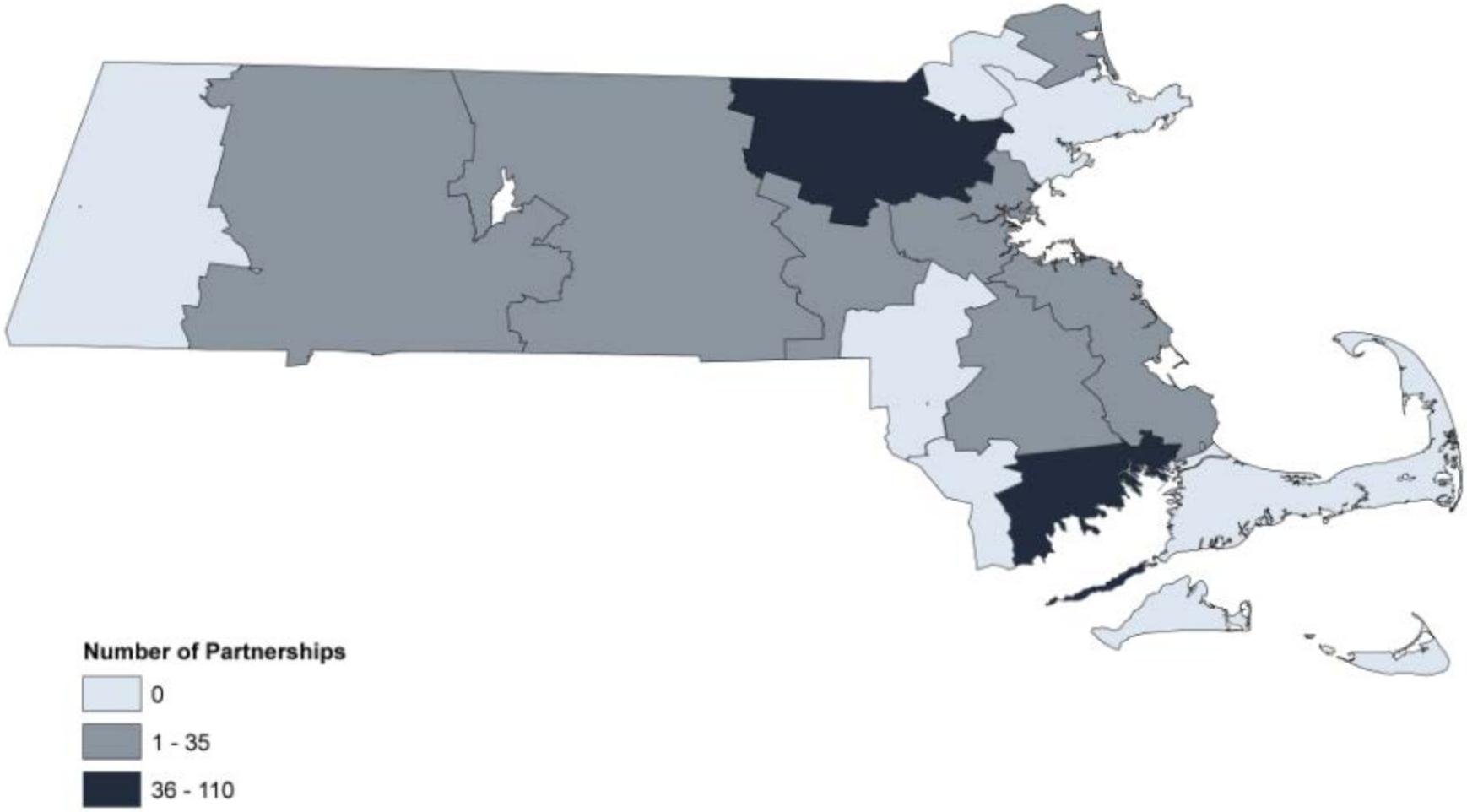


CHART Program engaged community hospital leadership

Hospitals were asked to give a specific example of how leadership helped their project, below are some of the responses:

"The commitment from leadership in all of the organizations that were working together on this project was excellent. I cannot think of any other projects where you have had Director, VP, and Executive level management from three different organizations working this closely together.

Hospital leadership was "at the table" for each meeting and committee component of our projects. In addition, leadership (Board of Directors and VPs) shared in our monthly check-in calls, engaged in conversation with our staff directly working on the projects, and helped to champion our work with other members of the community.

During the budget planning process for FY15, leadership was committed to sustaining our program into the next year despite anticipated budget constraints."

CHART Program delivered 400 hours of direct TA

Monthly Calls	HPC CHART program staff conducted calls with all hospitals for project updates, technical assistance, and setting expectations
Site Visits	HPC CHART program staff did site visits at all awardee hospitals
Safe and Reliable	Safe and Reliable visited each hospital to assess the culture of the hospital and helped hospitals increase response rates to culture surveys
Learning Session	All CHART hospitals were invited to a learning session about reducing avoidable hospital utilization
Leadership Summit	CHART hospital leadership gathered to view new HPC analyses on hospital performance and discuss the imperative for transformation
Mass HIway and MeHI	MeHI offered TA on the monthly calls for 6 hospitals doing large technical projects

Ninety-two percent of Phase 1 Feedback survey respondents believed that CHART Phase 1 moved their organization along the path to system transformation

Spotlight: Southcoast-St. Luke's asset mapping initiative

Southcoast Health

Southcoast Services | Find a Doctor | What's Happening | Your Health | Get Involved

Help: User Guide

Refine Search

Specialty

Community Resource

Service Setting

Select an Option

Age **Keyword**

Starting Location

1 Mile

City/Town or Zipcode Radius

Insurance

Select an Option

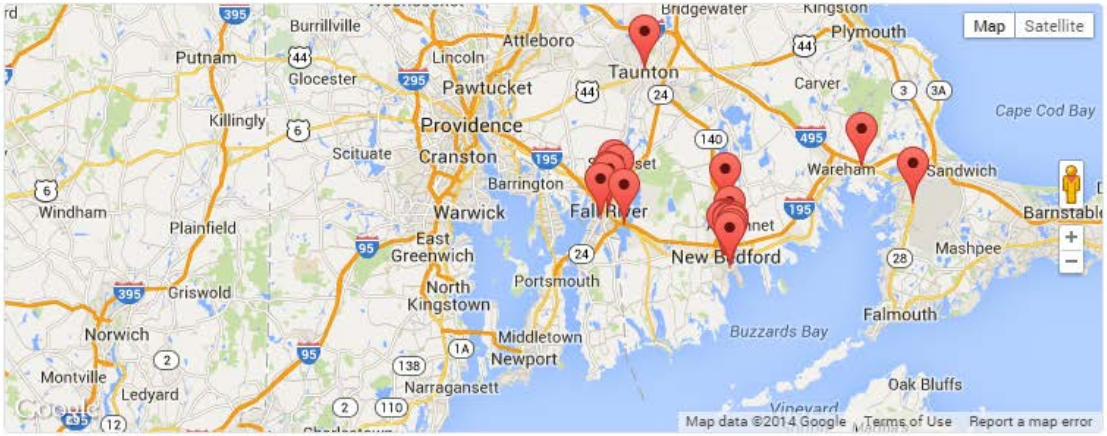
Language

Select an Option

Search Reset

- hide advanced search

Search Results



Your search yielded 25 results ...

Catholic Social Services

Sister Rose House
New Bedford, MA 02740

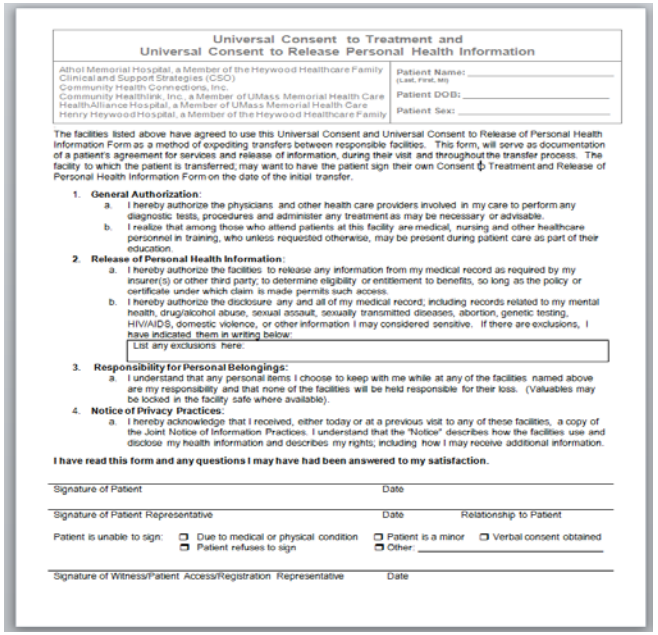
Sister Rose's House (formerly New Bedford Shelter Market Ministries) is a dry shelter for men only and is staffed 24 hours a day. The program offers a wide range of supportive services including assessment and planning, job and financial skills building, access to mental health services and referrals to other needed assistance programs.

Spotlight: North-Central Mass. regional behavioral health collaborative

These three awardees identified a need for sharing best practices and finding a common way to share information on frequent ED users with behavioral health comorbidities.

Athol, Heywood, and HealthAlliance created the Regional Behavioral Health Collaborative (RBHC) to develop best practices to improve early identification of mental illness and to increase access to behavioral health care among the North Central and North Quabbin communities.

- The hospitals invited community partners like Community Health Connections, Community HealthLink, Gardner Public Schools, and Athol Public Schools
- Created a universal patient consent form to enable efficient data sharing among institutions
- Created Regional Individualized ED Care Plan with the latest information on each patient who visits area organizations



Universal Consent to Treatment and
Universal Consent to Release Personal Health Information

Athol Memorial Hospital, a Member of the Heywood Healthcare Family
Clinical and Support Strategies (CSO)
Community Health Connections, Inc.
Community HealthLink, Inc., a Member of UMass Memorial Health Care
HealthAlliance Hospital, a Member of UMass Memorial Health Care
Henry Heywood Hospital, a Member of the Heywood Healthcare Family

Patient Name: (Last, First, MI)
Patient DOB:
Patient Sex:

The facilities listed above have agreed to use this Universal Consent and Universal Consent to Release of Personal Health Information Form as a method of expediting transfers between responsible facilities. This form, will serve as documentation of a patient's agreement for services and release of information, during their visit and throughout the transfer process. The facility to which the patient is transferred; may want to have the patient sign their own Consent to Treatment and Release of Personal Health Information Form on the date of the initial transfer.

1. **General Authorization**:
   a. I hereby authorize the physicians and other health care providers involved in my care to perform any diagnostic tests, procedures and administer any treatment as may be necessary or advisable.
   b. I realize that among those who attend patients at this facility are medical, nursing and other healthcare personnel in training, who unless requested otherwise, may be present during patient care as part of their education.
2. **Release of Personal Health Information**:
   a. I hereby authorize the facilities to release any information from my medical record as required by my insurer(s) or other third party; to determine eligibility or entitlement to benefits, so long as the policy or certificate under which claim is made permits such access.
   b. I hereby authorize the disclosure any and all of my medical record; including records related to my mental health, drug/alcohol abuse, sexual assault, sexually transmitted diseases, abortion, genetic testing, HIV/AIDS, domestic violence, or other information I may considered sensitive. If there are exclusions, I have indicated them in writing below:
   List any exclusions here:
3. **Responsibility for Personal Belongings:**
   a. I understand that any personal items I choose to keep with me while at any of the facilities named above are my responsibility and that none of the facilities will be held responsible for their loss. (Valuables may be locked in the facility safe where available).
4. **Notice of Privacy Practices:**
   a. I hereby acknowledge that I received, either today or at a previous visit to any of these facilities, a copy of the Joint Notice of Information Practices. I understand that the "Notice" describes how the facilities use and disclose my health information and describes my rights; including how I may receive additional information.

I have read this form and any questions I may have had been answered to my satisfaction.

Signature of Patient ____ Date ____

Signature of Patient Representative ____ Date ____ Relationship to Patient ____

Patient is unable to sign: ☐ Due to medical or physical condition ☐ Patient is a minor ☐ Verbal consent obtained ☐ Patient refuses to sign ☐ Other: ____

Signature of Witness/Patient Access/Registration Representative ____ Date ____

"[CHART] provided an opportunity to **collaborate on efforts to increase access**, strengthen **care coordination** and **improve the system of care** for both youth and individuals in crisis suffering from mental illness and addictions through the EDs…The relationships made or enhanced by our initial project's work hold promise for **great collaboration** in the years to come."

Spotlight: Telehealth to improve access and reduce cost in Western Mass.

Baystate Franklin Medical Center and Mary Lane's projects used telehealth to increase access to specialty medicine in the community setting.

Baystate Franklin Medical Center had 76 inpatient telehealth encounters between April 15 and September 15 in neurology, critical care, infectious disease, and geriatrics with the most encounters in neurology

86% of patients were satisfied with their telehealth encounter at BFMC. Evaluation of cost impacts is ongoing

Baystate Mary Lane Hospital had 40 telehealth encounters in outpatient neurology, inpatient speech, outpatient cardiology, and outpatient behavioral health

The wait time for the third next available appointment at BML went from 90 – 113 days for an in-person consult for neurology to 5 – 9 days for a telemedicine consult.

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Through case studies, CHART hospitals can share learnings in improvement program design and operations with other organizations

- The HPC has engaged Health Management Associates (HMA) to highlight key themes from CHART Phase 1 projects through a series of case studies
- The HPC intends for the experiences and lessons exhibited in this series to assist other providers, the public, and policy makers in designing and promoting similar short-term, high-impact improvement initiatives in their communities and organizations
- Each case study will include multiple hospitals and will be released on a rolling basis

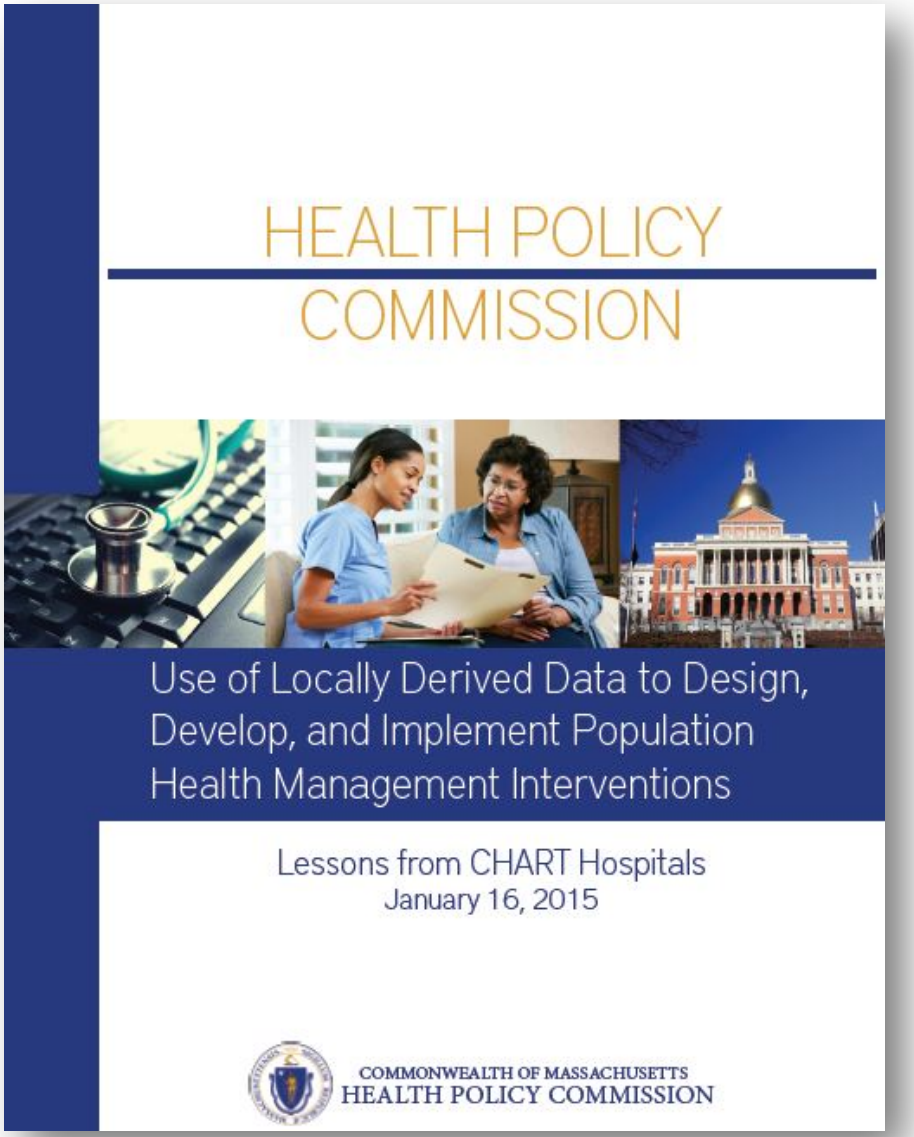
The first three case studies in the series are:

1. Use of Locally-Derived Data to Design, Develop and Implement Population Health Management Interventions
2. Deploying Effective Management Strategies to Drive Change
3. Strategies to Manage Social and Behavioral Drivers of Utilization

1 Use of Locally-Derived Data to Design, Develop and Implement Population Health Management Interventions

1st

of many opportunities for findings and lessons drawn from CHART investments to be shared broadly with the community of providers, payers, and the public



Use of locally-derived data was of tremendous value to select CHART Phase 1 hospitals and their experience has heavily informed Phase 2

Background

- Population health management interventions are difficult to design due to the diversity of health needs and conditions present in any community
- Data that are collected by a hospital, referred to as locally-derived data, effectively depict the hospital's patient population and can be used in focusing interventions
- With technical assistance delivered through the CHART program, CHART Phase 1 hospitals applied analytical frameworks to their own local-derived data in novel ways

CHART hospitals highlighted in Case Study 1

Addison Gilbert Hospital
A member of Lahey Health

- Community Health Needs Assessment
- Administrative Data
- Project Dashboards

Beverly Hospital
A member of Lahey Health

- Administrative Data
- Patient and Family Caregiver Interviews
- Provider Interviews

Hallmark Health

- Medical Record Review
- Community Health Data
- Project Dashboards

Addison Gilbert Hospital sought to reduce 30-day all cause readmissions by piloting a high-risk intervention team and monitoring its performance

Identifying patients at high risk for readmission	Addison Gilbert Hospital designed the pilot to serve any patient with a chronic illness who was admitted to the hospital for inpatient service or observation
Analyzing root causes of readmission	The project team interviewed patients and their caregivers to assess clarity of discharge instructions and ease of scheduling follow-up appointments
Designing the HRIT	Members of the team had expertise in chronic disease management, behavioral health counseling and access to community based services
Monitoring performance	A weekly patient dashboard tracked medication count, discharge disposition, 30-day readmission rate, length of stay and patient outreach activities

Learning Enabled by Using Locally-derived Data

Among the 26% of patients in the high-risk population who were readmitted within 30 days, 79% had medication inaccuracies and 22% were referred back to the hospital by another provider

Beverly Hospital used administrative data analysis to challenge long-held assumptions on the characteristics of its high risk population

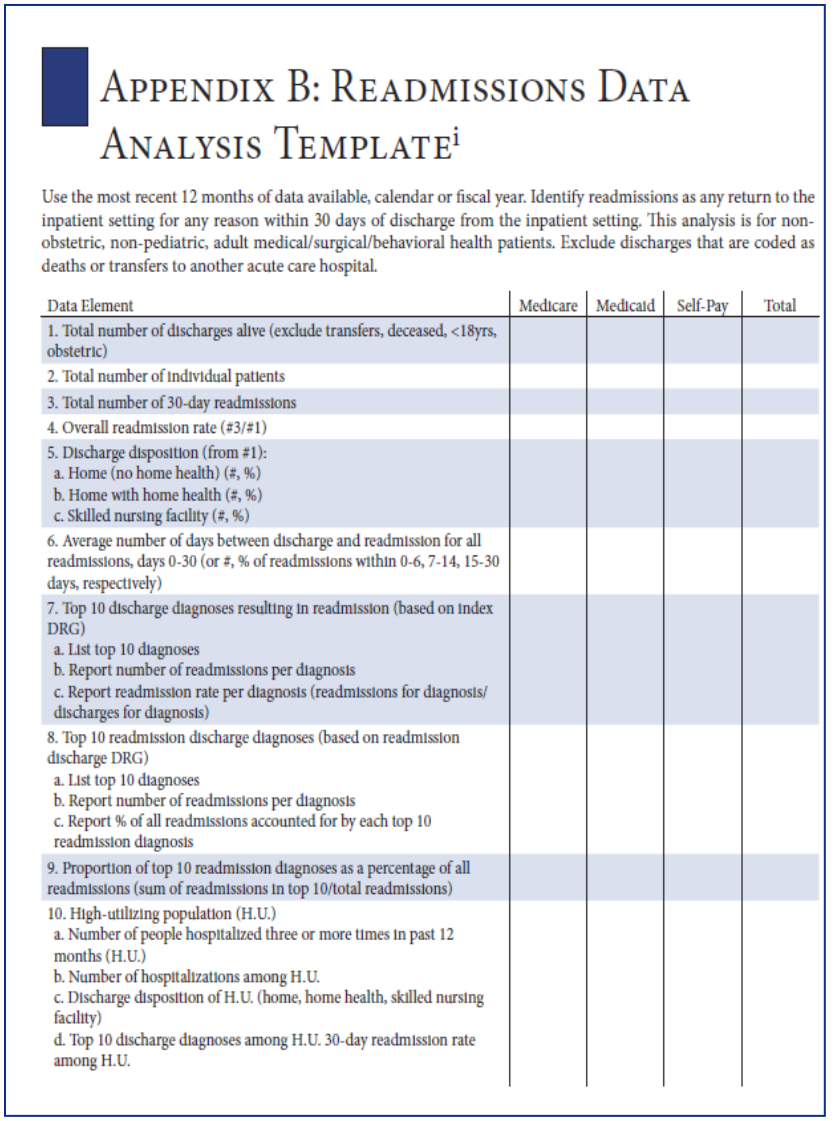
Beverly Hospital initially envisioned a focus on cardiovascular readmissions for CHART Phase 1, given attention paid to congestive heart failure in research and public reporting

Rather than relying on national indicators to identify a program focus, the CHART team challenged Beverly to uncover needs specific to its community through analysis of 2013 discharge and readmissions data and interviews with patient and providers

Learning Enabled by Using Locally-derived Data

Beverly expanded its definition of "high-risk" to include:

- Behavioral health comorbidity
- Respiratory illnesses
- Skilled nursing and home care discharges
- Medicare and Medicaid high utilizers



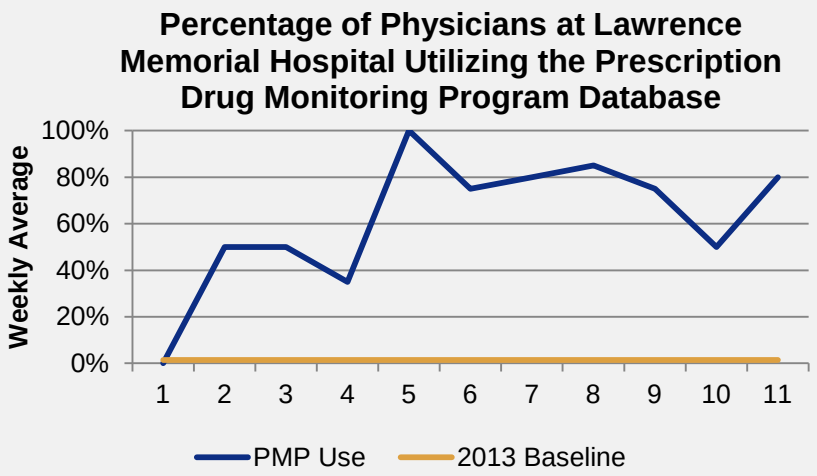
Appendix B: Readmissions Data Analysis Template[i]

Use the most recent 12 months of data available, calendar or fiscal year. Identify readmissions as any return to the inpatient setting for any reason within 30 days of discharge from the inpatient setting. This analysis is for non-obstetric, non-pediatric, adult medical/surgical/behavioral health patients. Exclude discharges that are coded as deaths or transfers to another acute care hospital.

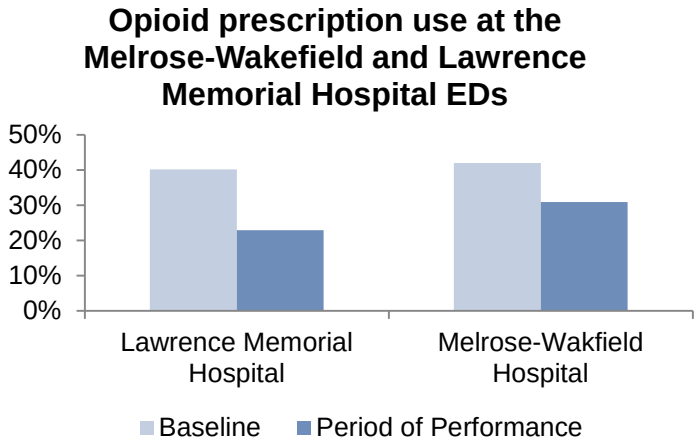
Data Element	Medicare	Medicaid	Self-Pay	Total
1. Total number of discharges alive (exclude transfers, deceased, <18yrs, obstetric)				
2. Total number of individual patients				
3. Total number of 30-day readmissions				
4. Overall readmission rate (#3/#1)				
5. Discharge disposition (from #1): a. Home (no home health) (#, %) b. Home with home health (#, %) c. Skilled nursing facility (#, %)				
6. Average number of days between discharge and readmission for all readmissions, days 0-30 (or #, % of readmissions within 0-6, 7-14, 15-30 days, respectively)				
7. Top 10 discharge diagnoses resulting in readmission (based on index DRG) a. List top 10 diagnoses b. Report number of readmissions per diagnosis c. Report readmission rate per diagnosis (readmissions for diagnosis/ discharges for diagnosis)				
8. Top 10 readmission discharge diagnoses (based on readmission discharge DRG) a. List top 10 diagnoses b. Report number of readmissions per diagnosis c. Report % of all readmissions accounted for by each top 10 readmission diagnosis				
9. Proportion of top 10 readmission diagnoses as a percentage of all readmissions (sum of readmissions in top 10/total readmissions)				
10. High-utilizing population (H.U.) a. Number of people hospitalized three or more times in past 12 months (H.U.) b. Number of hospitalizations among H.U. c. Discharge disposition of H.U. (home, home health, skilled nursing facility) d. Top 10 discharge diagnoses among H.U. 30-day readmission rate among H.U.				

Hallmark Health System used medical record review and dashboards to implement clinical practice guidelines for prescribing opioids in the ED

Seeking to understand the drivers of opioid prescribing in its emergency departments, HHS reviewed close to 1,000 patient medical records and found substantial variation in prescribing patterns, which led to the development and implementation of rigorous clinical practice guidelines to reduce practice pattern variation



Adherence to guideline protocols were tracked by physician and trended week-over-week to monitor compliance



Opioid prescription use decreased by 26% from baseline at Melrose-Wakefield Hospital and by 43% at Lawrence Memorial Hospital

Key Lessons Learned

1. Locally-derived data can support targeted and rapid interventions that yield demonstrable improvements at relatively low cost
2. Programmatic design and care interventions should evolve based on rigorous and continuous analysis
3. Multiple sources of quantitative and qualitative data should be used identify and validate community and individual patient needs

Looking toward Phase 2

The HPC CHART team is working with each Phase 2 award team in the Implementation Planning Period to use locally-derived data to refine their target populations for their CHART Phase 2 projects and enhance design of interventions. Ongoing measurement during Phase 2 will place continued emphasis on use of local data

2 Deploying Effective Management Strategies to Drive Change

Background

- The health care industry as a whole has been slow in utilizing dedicated individuals with strong management experience and skills to lead projects, instead relying on clinical or technical staff with substantial other responsibilities
- In addition to strong project managers and processes, the success of individual initiatives depends on senior-level support
- Need and opportunity to develop middle-management was echoed throughout CHART Phase 1 activities and the Leadership Summit

CHART hospitals highlighted in Case Study 2

Addison Gilbert Hospital
A member of Lahey Health

Deep leadership engagement directly supporting project staff as well as championing the project throughout the organization substantially removed roadblocks

HealthAlliance Hospital
A Member of UMass Memorial Health Care

HealthAlliance Hospital's project manager had substantial autonomy and sole responsibility to CHART implementation; flexed work schedule meet 24 hour nature of the ED

Signature Healthcare

Signature Healthcare Brockton Hospital had multidisciplinary executive team champions to support institution-wide change

Key lessons learned

1. There is tremendous variation within and across hospitals in project management capacities; often success relies on skilled and dedicated individuals and not development of effective systems.
2. Many organizations are challenged to provide effective models for development of middle management, which has impacts on culture and performance
3. Project managers must have experience, credibility, and the technical expertise required for change management in a clinical setting
4. Sustained, organization-wide change requires leadership with both long term strategic vision and a hands-on approach, including executive sponsors who enable, support, and empower middle-management

Looking toward Phase 2

- CHART staff is strongly encouraging hospitals to assign a dedicated project manager with project management training and experience, to their Phase 2 projects; initiation payment funds are being focused towards early deployment of key project leaders
- The HPC has required a 10% time commitment from a senior operational and clinical leader for Phase 2 to ensure ongoing leadership engagement and buy-in

Informed an optimized model of transformation for CHART Phase 2

HPC is actively using learning and feedback from Phase 1 to inform Phase 2

Lessons from hospital performance in Phase 1

1. **Hospitals' capacity for calculating new metrics** for CHART initiatives was limited. IPP is focusing heavily on metric identification, feasibility, and data flow to the HPC
2. Dedicated **project management resources** and leadership engagement were contributors to successful implementation. IPP is ensuring attention to project management resources
3. **Data driven approaches to defining** patient needs and target populations resulted in key learnings for awardees that shifted clinical models and approaches. IPP is using analytics to specify target populations to improve alignment with community need
4. **Hiring new staff** quickly is a challenge, especially in under-resourced communities. CHART Phase 2 is encouraging partnership with existing resources, where available, prior to hiring new staff or building new hospital capacities**.**
5. **Adaptation of clinical models** based on early outcomes and lessons learned is critical to high impact interventions. IPP is encouraging adaptive, data driven approaches supported by rapid-cycle evaluation to optimize initiatives.

CHART Phase 1 lessons learned: Informing technical assistance

HPC is actively using learning and feedback from Phase 1 to inform Phase 2

Areas where HPC may be able to provide additional support in Phase 2

1 Training

Key takeaway: Many projects relied on new positions like care managers and ED navigators that were new to the hospital or employee. The HPC may support trainings in key areas.

At one health system, acute care nurses, who transitioned to outpatient care managers, required training around population health management, accountable care organizations, risk sharing payment arrangements, and quality metrics to perform the new role.

2 Leadership engagement

Key takeaway: Leadership engagement was key to making needed changes. The HPC will continue to provide opportunities for leadership to engage in individual projects and across the cohort.

One hospital needed to improve discharge planning throughout the organization, which was out of scope for the project team. Leadership needed to be engaged to begin the discussion of system wide changes.

3 Involving community partners

Key takeaway: Community partners helped projects succeed. HPC can encourage convening community partners and highlight their importance to these projects.

One hospital found that their relationship with an affiliated practice improved their understanding of community needs and enhanced their ability to design an initiative that was culturally and linguistically appropriate.

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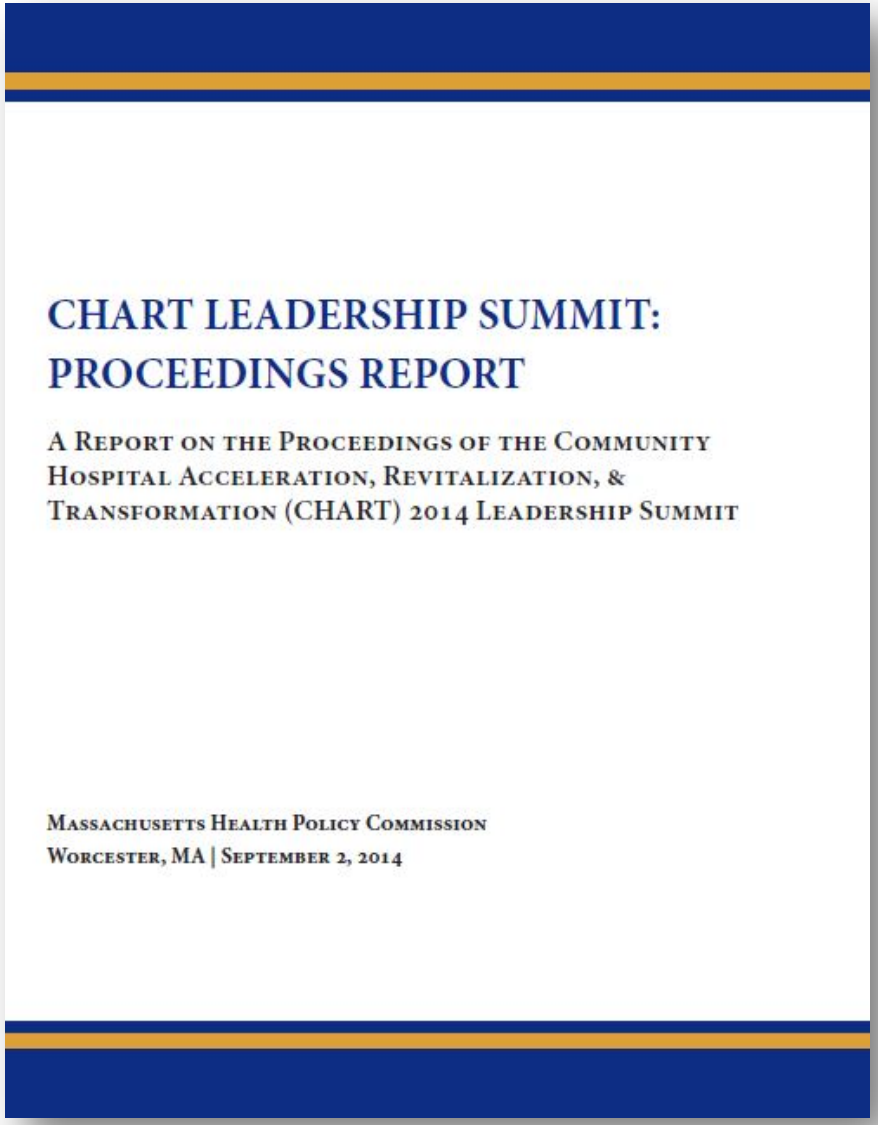
CHART Leadership Summit Proceedings Report

- Leadership Summit Proceedings report documents the presentations and dialogue at the CHART Phase 1 event held in September 2014
- The Proceedings Report includes detailed accounting of each staff and expert faculty presentation, including select findings
- The Report describes key themes discussed by attendees, including select surveys of hospital participants conducted during the event
- The Report provides a synthesis of findings and observations from the day's discussion and offers considerations for the HPC for continued provider engagement through the CHART program

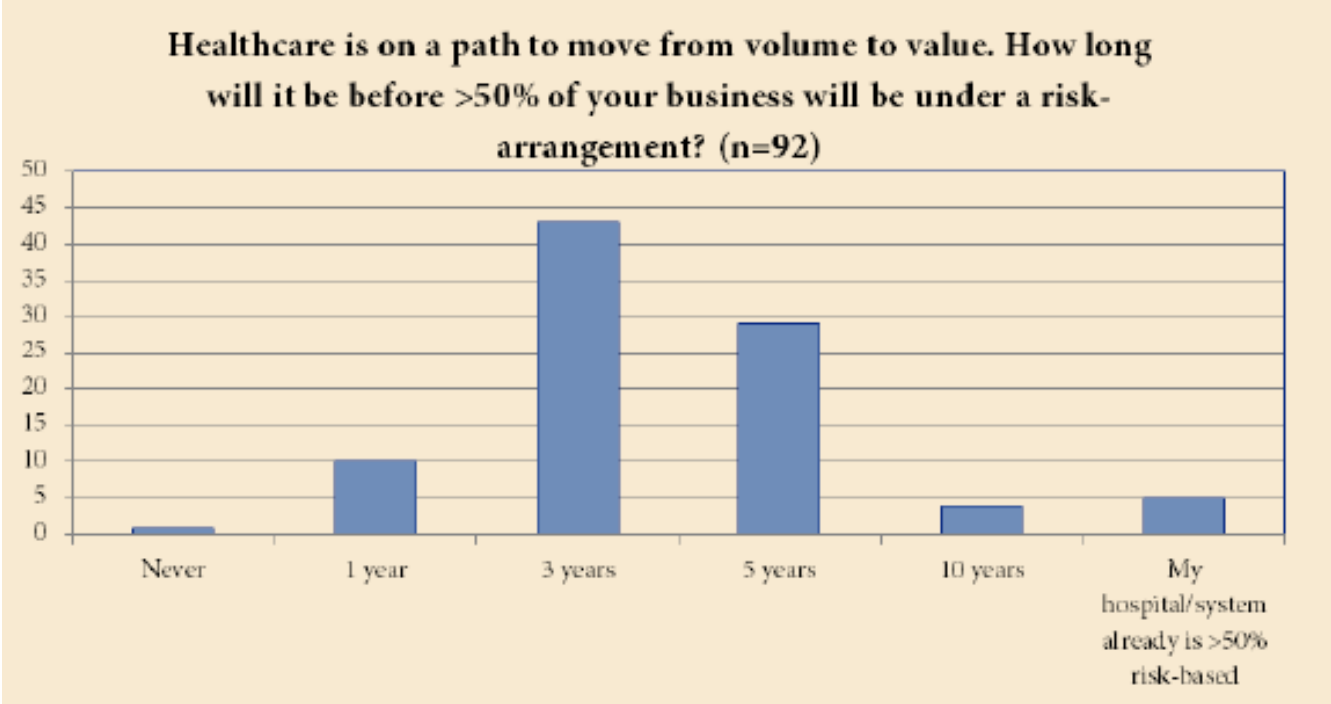


Participants shared many valuable insights about their perspectives on health system transformation

Most hospitals predict

>50%

APMs in 3-5 years



Leadership Summit discussion themes

Common Characteristics of Transforming Hospitals

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

From Community Hospitals to Community Health Systems

Community hospitals can and should serve as **hubs of local innovation and 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)

Acceleration of Payment Reform is Critical

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 APMs – including those that ensure participation by all variations of community hospitals – is necessary to sustain meaningful change

Leadership Summit discussion themes

Integrate Behavioral Health (Delivery Models and Payment)

All community hospitals are challenged by caring for behavioral health patients – particularly emblemized by challenges with **boarding of mental health and substance use disorder patients in emergency departments**. Investment in the development of **community-based care models** that **integrate primary and behavioral health**, as well as integrating **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.

All such models must be tied to inclusive **payment reform** that promotes integration

Culture and Workforce Development are Central to Transformation

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 in any transforming organization.

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 measuring improvement, communicate in ways that are psychologically safe, and set clear expectations.

Investment, Convening and TA are Necessary and the HPC is Central

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.

In addition to direct investments, CHART and the HPC provide valuable resources through **provider engagement**, including convening of peers and provision of direct technical assistance.

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CHART Phase 2 status report: rigorous approach to implementation planning

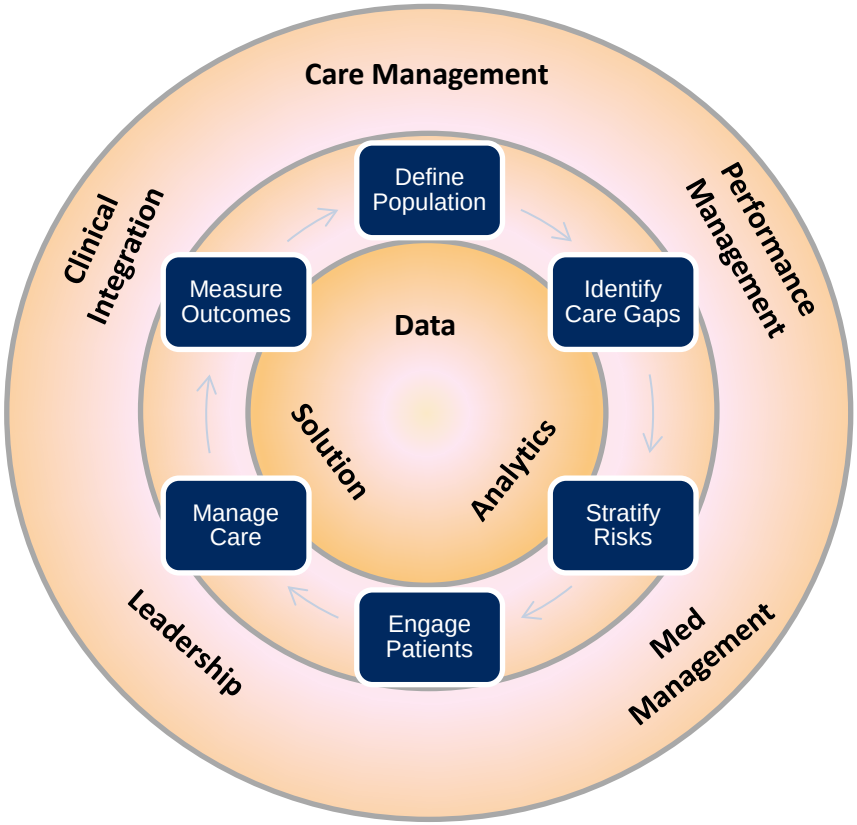
Implementation Planning Period is November 2014 through February 2015

- **Objectives of IPP**
  - Ensure all projects are positioned to successfully achieve their aim
  - Establish rigorous program oversight framework and management approach
  - Standardize vetting of program elements across all projects

- **Principles of IPP**
  - **Meet the needs of communities served by CHART hospitals:**
    - Patients are the foremost priority
  - **There are no easy answers:**
    - No “off the shelf” models of care to replicate across communities
  - **Adaptation is key**:
    - Approach to learning requires that clinical models are developed, refined, and continually improved as a cohort
  - **Collaboration is essential**:
    - Collaborative approach to improvement, opportunities for shared learning in the CHART cohort

- **Outputs of IPP**
  - Detailed implementation plan so that you can be successful over the next two years
  - Baseline metrics to build milestones and payment terms

Implementation planning provides foundation for clinical intervention



The center of the graphic represents priorities for Implementation Planning

The activities described in the middle ring are carried out in Implementation Planning to provide a critical foundation for successful initiative implementation

Adapted from Mosaic Lifecare Population Health Model

CHART Phase 2: primary elements of implementation planning

Key features of Implementation Planning

Measurement

- Build clear measurement plan across all investments
  - From measurements milestones and payment terms will be determined

Partnerships

- The implementation planning period will help the hospitals shift from the competitive procurement process to a **learning community cohort**
- Initiatives designed to meet local community needs, including pushing more impactful **community partnerships**

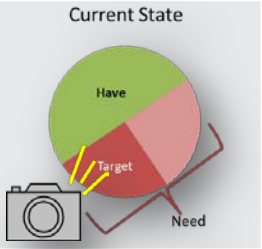
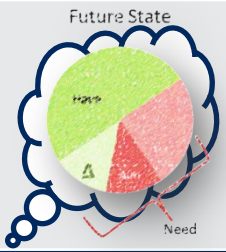
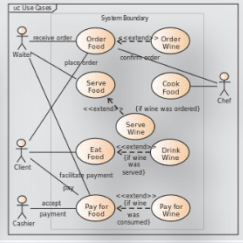
All payer

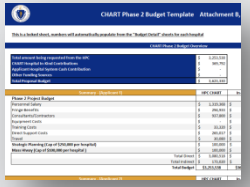
- Emphasis on the importance of **all-payer** target populations including **social and behavioral** determinants of health

Learning

- Tailoring interventions to specific **target populations**
- Adhering to known **best practices** where they exist and **intentional variation** encouraging innovation and variation where best practice is uncertain

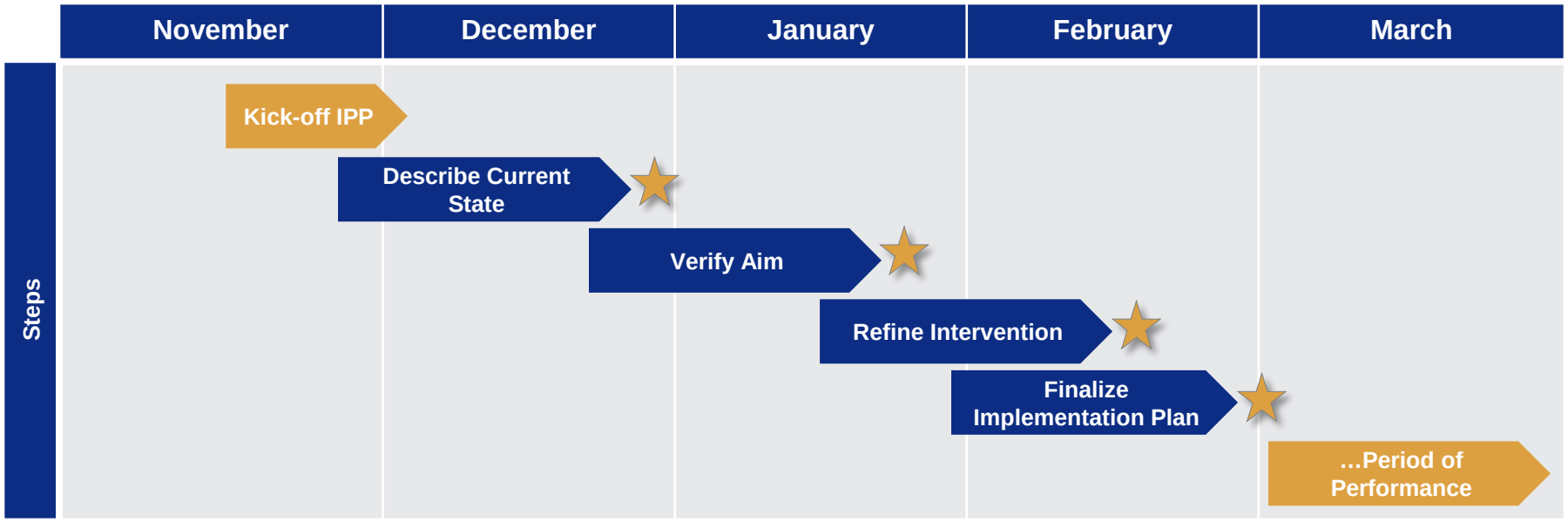
Sequence of the Implementation Planning Period: additional detail

	1. Describe Current State	2. Verify Aim	3. Refine Service Model	4. Finalize Staffing Model	5. Develop Technology Req's	6. Develop Mass Hlway cases
						
Activity Description	Utilize your data and patient interviews to be able to define your target population and describe the state of the measures you intend to affect	Using your baseline, quantify the specific impact your Initiatives will seek to have on the target population by the end of the Period of Performance	Design Initiatives that address the needs (i.e., Drivers) of the target population in order to achieve the Aim Statement	Specify the exact staffing model to support Phase 2 investments (service delivery, administrative, and leadership needs)	Specify lightweight technologies to be used to support achievement of Aim(s)	Specify intended uses of Mass Hiway (to be further developed post-IPP)

	7. Define Scope of Strategic Plan	8. Describe Non-Service Investments	9. Develop Measurement Plan	10. Submit Final Budget	11. Extrapolate Project Milestones	12. Finalize Payment Schedule
						
Activity Description	Define broad goals for strategic planning, to be refined and subject to HPC approval after release of Community Hospital Study	Specify needs and requirements for service-delivery investments (e.g., training, capital, consultants, TA, etc.)	Finalize measurement plan (including validation of data sources and ability to collect measures) for standard and award-specific metrics	Specify final budget based on prior amendments and up to Board -approved award cap	Specify all project milestones (including goals and metrics where appropriate) to assess successful completion	Align disbursement schedule with project milestones including both process and achievement based payments

High-level IPP timeline

IPP will utilize a phased approach to building thoughtful, realistic Implementation Plans that will ensure each Award enters into the Period of Performance with a clear, shared understanding of goals and responsibilities.



Stars indicate estimated HPC approval points

CHART Phase 2: anticipated approaches to provider engagement and support

Learning, Improvement, and Diffusion

- In CHART Phase 2, we look forward to continuing our partnership with CHART hospitals. HPC support in Phase 2 will include enhanced technical assistance activities, most of which will be optional, including:
  - **HPC Convening**: Routine regional meetings and ad-hoc affinity groups for awardees to share learning, challenges, and best practices in a facilitated setting
  - **Direct Technical Assistance**: Staff and experts available to support specific needs of awardees, particularly focused on high risk care, readmission reduction strategies, and BH
  - **Leadership Engagement**: Development of hospital leadership engagement opportunities, including skill development related to strategy and tactics of transformation through access to expert 'faculty' on a bimonthly basis
  - **Supportive Data and Analytics**: HPC will continue to develop data and analytic tools to support providers in driving transformation (e.g., rapid-cycle evaluation, high-risk patient identification, and performance benchmarking). As payment will be tied to milestones, reporting will be necessarily frequent and robust
  - **Training**: Staff are exploring opportunities for large scale training in topics relevant to Phase 2 awards
  - **Dissemination**: From Phase 1 initiatives – and continued into Phase 2 – staff are compiling a centralized library of tools and resources to promote and share best practices and guidelines, fed by both awardees and the HPC's evaluation activities. The first substantial input will be Phase 1 case studies

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Contact Information

For more information about the Health Policy Commission:

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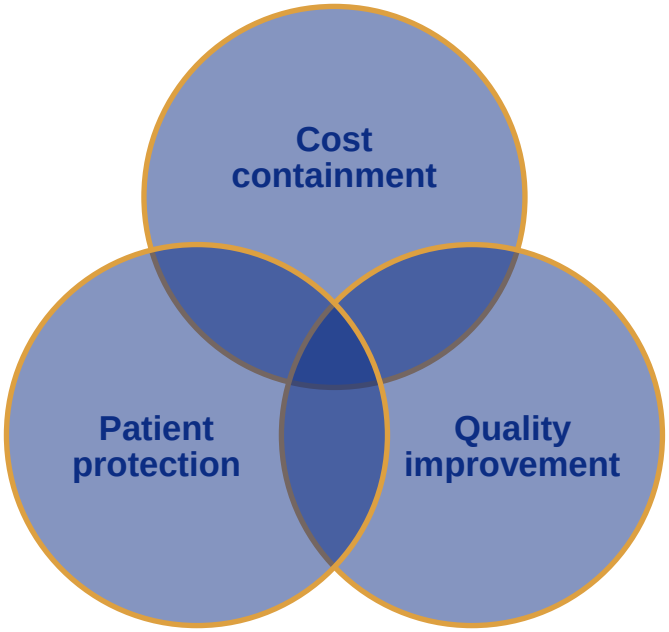
Appendix A:

Definition of ACO capabilities and evidence from other state and commercial ACO models

Ch. 224 links ACO certification to 3 overarching priorities, and specifies 15 related sub-goals that certification criteria should incentivize



- Reduce growth of health status adjusted **total expenses**
- Improve **quality** of health services using **standardized measures**
- Ensure **access** across care continuum
- Promote **APMs & incentives** to drive quality & care coordination
- Improve **primary care** services
- Improve access for **vulnerable populations**
- Promote **integration of BH services** into primary care
- Promote **patient-centeredness**
- Promote **HIT** uptake
- Promote demonstration of **care coordination & disease mgmt.**
- Promote **protocols for provider integration**
- Promote **community based wellness** programs
- Promote health of **children**
- Promote **worker training** programs
- Adopt **governance structure standards**, including those related to financial COI & transparency

There is considerable ACO/global risk contract activity in MA; however, comparison across contracts/care models is not feasible due to variability in contract elements

Not exhaustive, based on best available information

	Pioneer	MSSP	Commercial *
Physician only			
Accountable Care Clinical Services		X	
Acton Medical Associates			X
Atrius Health	X		X
Physicians Accountable Care Solutions		X	
Physicians of Cape Cod		X	
Hospital only			
Boston Medical Center		X	X
Children's Hospital Boston			X
Signature Healthcare Brockton Hospital			X
Sturdy Memorial Hospital			X
Integrated physician-hospital systems			
ACO of New England		X	
Baystate Health		X	X
BIDCO	X	X	X
Cape Cod Health Network		X	
Collaborative Health ACO		X	X
Lahey Health		X	X
MACIPA/Mount Auburn Hospital	X		X
Partners HS	X		X
Steward HS	X		X
Southcoast ACO		X	
South Shore PHO and South Shore Hospital***		X	X
UMass Memorial ACO, Inc.		X	
Wellforce HS**		X	X

* as of 2012

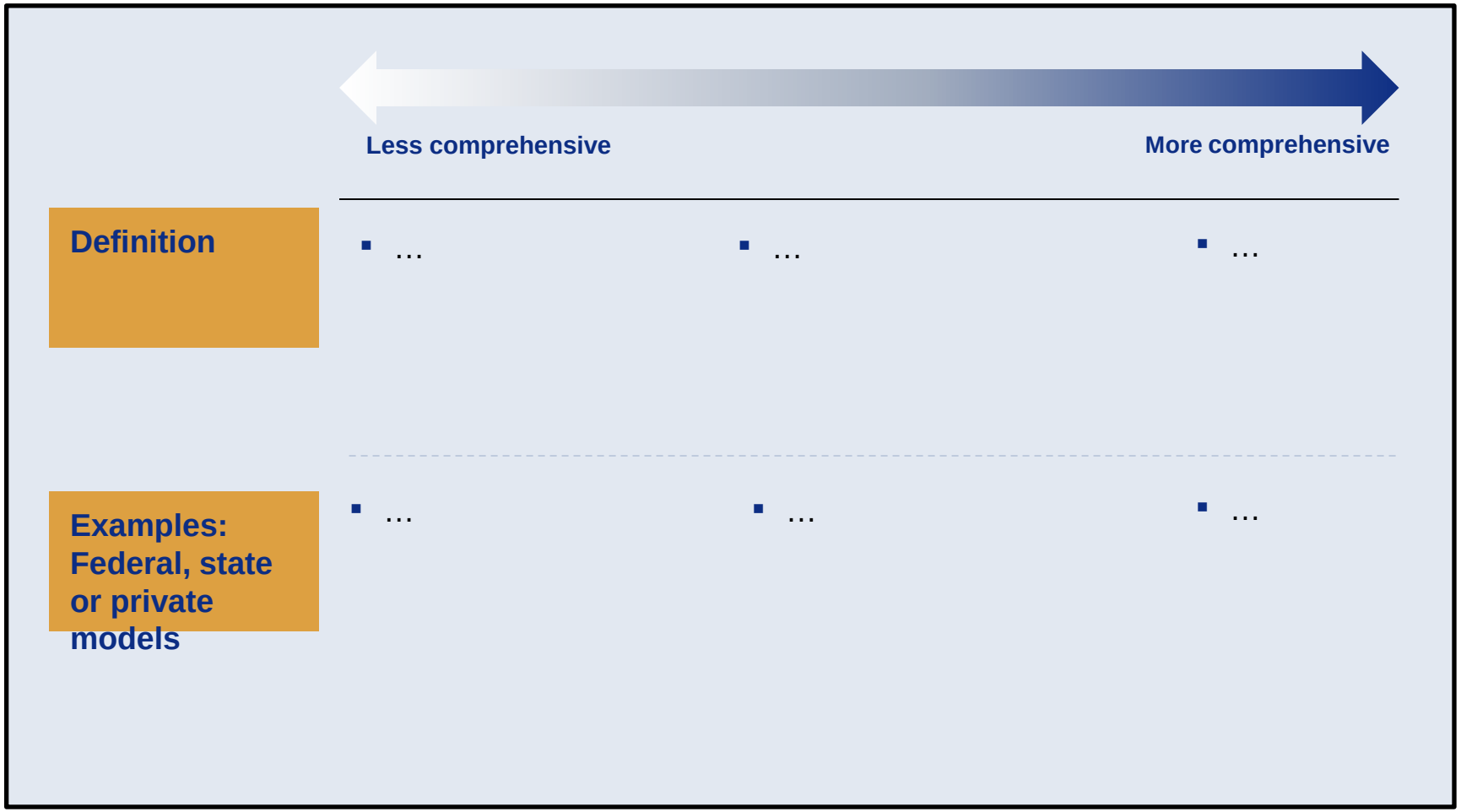
** Includes Circle Health and NEQCA/Tufts Medical Center

*** Includes Harbor Medical Associates

Source: CMS, MA select commercial payers

For each capability, requirements can be more or less comprehensive, based on available evidence from other states and commercial ACOs

Proposed template to help formulate certification standards



A 1 Legal Structure

Less comprehensive → More comprehensive

Definition
Legal entity
Lead entity

- No/Limited requirements
- Specific requirements regarding lead entity
- Must be a separate legal entity

Examples: Federal, state or private models

- **Maine**
  - Not required to form a new legal or financial entity
  - Must designate a legal Lead Entity to contract
- **Minnesota**
  - Not required to form a new legal or financial entity
  - Must be provider led
- **Illinois**
  - Must be provider led
  - Must have lead entity that has legal responsibility for the ACO
- **New Jersey**
  - Must be registered as a separate non-profit entity under NJ law
- **New York**
  - Must be a separate legal entity only if it is formed among multiple independent ACO participants
  - Must be comprised of clinically integrated independent health care providers
- **Medicare:**
  - Must be recognized as a single legal entity by state of incorporation

[1] Based on comparison between 2011 OR baseline and National Medicaid benchmarks.

A 2 Management and Representation

Less comprehensive → **More comprehensive**

Definition
Representation and management requirements

- No/Limited requirements

- Specific requirements regarding representation
- Some guidance regarding leadership/management structure

- Specific requirements regarding representation
- Specific guidelines regarding leadership/management structure

Examples: Federal, state or private models

- **Colorado:**
  - RCCOs must create a Performance Improvement Advisory Committee with provider and member representation
  - Must have permanently assigned contract manager, financial manager, and chief medical officer

- **Oregon:**
  - Governing body must include:
    - Major components of health care delivery system
    - 2+ providers in active practice, including a licensed physician and a MH or SU provider
    - 2+ members from the community
    - 1+ member of the community advisory council
  - Must establish community advisory council in each of the proposed service areas

- **Illinois**
  - If lead entity is single provider, governing body must include providers employed and not employed by lead entity
  - Must demonstrate meaningful involvement of the medical director and front-line providers

- **Medicare:**
  - Governing body must be reflective of member groups of providers and suppliers that form ACO (at least 75% participant control)
  - Incl. meaningful representation from consumer advocates and patients
  - Executives and staff for clinical, financial, management, HIT, and QI functions

- **New Jersey**
  - Board Membership must include:
    - providers, including a PCP and representation from other specialties
    - Social service agencies
    - 2+ consumer organization
  - Must obtain support from providers in the designated area – all of the general hospitals, at least 75% of qualified PCPs, and at least four qualified BH care providers
  - Management structure must include a Quality Committee, Medical Director, or governance structure responsible for overseeing the ACO's quality performance
  - Must designate leadership responsible for public engagement

B 4 Care Delivery: Patient Centered Primary Care

Less comprehensive → More comprehensive

Definition
Primary care working towards achieving the triple aim

- 'Basic' PCMH capabilities, flexibility in implementation:
  - Patient Centered Access
  - Team Based Care
  - Population Health Management
  - Care Management & Support
  - Care Coordination & Care Transitions
  - Performance Measurement and Quality Improvement
- Specific requirements/thresholds for implementing basic PCMH capabilities
- Enhanced PCMH capabilities, e.g.,
  - Behavioral Health integration
  - Resource Stewardship
  - Community based population health
  - End of life planning
- Specific requirements to contract with state- or nationally accredited PCMHs

Examples: Federal, state or private models

- **Minnesota**:
  - IHPs need to 'demonstrate' experience with innovative care delivery models, such as MN Health Home certification or other national certifications, community-based or collaborative partnerships
- **Medicare:**
  - ACO needs to describe how it will ensure care takes into account individual patient needs and preferences
  - ACO needs to demonstrate mechanisms for patient outreach and education, shared decision-making, care transitions, continuity of care, patient engagement, QI, etc.
- **Illinois**:
  - Access requirements for specific conditions (e.g., 80% of specialty referrals must be seen within 30 days)
  - Need to meet Health Homes requirements in Sec 2703 of the ACA
- **Oregon**
  - CCOs required to contract with a network of PCMHs recognized under Oregon's standards, including:
    - Concrete plans for increasing the number of enrollees served by certified PCMHs, incl targets
    - Concrete plans for advancing basic PCMHs to more advanced PCMHs

B 5 1 Care Delivery: Cross Continuum Network - Medical Services

Less comprehensive → More comprehensive

Definition
Identification of partners across the care continuum

Less comprehensive		More comprehensive
▪ Relationships with partners exist but not formalized or set up with incentives	▪ Formal relationships with partners exist, without aligned incentives	▪ Formal relationships with partners exist which include aligned incentives

Examples: Federal, state or private models

- **Medicare**
  - No specific requirements regarding network development
- **Illinois**
  - Accountable Care Entity (ACE) applications need to document:
    - ‘Network’ of primary care, specialty, BH and substance abuse providers and level of commitment (i.e., letter of intent, pending contract, ACE contract etc)
    - Percentage of services previously provided by the network to expected universe of enrollees
- **Minnesota:**
  - IHPs are not eligible for two sided risk arrangements unless they are an integrated delivery system that provides a spectrum of outpatient and inpatient care as a common financial and organizational entity
- **Oregon**
  - CCOs to have a formal contractual relationship with a dental services organization
  - CCOs shall demonstrate how hospitals and specialty service providers are accountable for achieving successful transitions of care

B 5 2 Care Delivery: Cross continuum network – Community based and public health services

Less comprehensive → **More comprehensive**

Definition
Connecting with patients with support available in the community, including non-clinical services

- ACO works with a select number of community-based organizations, but significant additional resources exist in the community

- ACO has processes and programs in place to connect patients with community-based resources (e.g. public agencies, housing authorities, transportation bodies)
- Process in place to evaluate usefulness of community-based resources and adjust partnership strategy on at least on an annual basis

Examples: Federal, state or private models

- **New York**
  - No specific requirements

- **Minnesota:**
  - Integrated Health Partnership (IHP) applications need to describe any *existing or planned partnerships* with community based / public health resources as well as the intended impact of the partnerships on key outcomes of interest
- **Illinois**
  - ACE applications need to describe *plan to coordinate* with state- and community-based social services and transportation to services

B 6 Care Delivery: Integrated HIT/HIE

For the purposes of the ACO certification program, integrated HIT is defined as:

- Majority of clinicians on EMRs, standardization in fields/use
- Ability to integrate inpatient and outpatient data from network and non-network providers including a variety of data sources (e.g. claims, labs, pharmacy, EMR)
- Real rime ADT information exchange amongst network and non-network providers
- Connecting to and transacting on HIE for a sizable portion of patient population (e.g., 20%+)

Definition
Ability to share clinical and non-clinical data across care settings

Less comprehensive → **More comprehensive**

▪ No/limited requirements for integrated IT	▪ Limited requirements for integrated IT, however, ACOs need to improve over time	▪ Extensive requirements for integrated HIT

Examples: Federal, state or private models

- **Minnesota:**
  - Physician groups are only eligible for upside only arrangements if they are not formally integrated with a hospital or integrated system via aligned financial arrangements and common clinical and information systems
- **Oregon**
  - CCOs are required to:
    - Identify network EHR adoption rates by provider type/geographic region; and develop and implement strategies to increase adoption rates of certified EHR;
    - identify current capacity and develop and implement a plan for improvement in HIE, including patient engagement through HIT
- **Medicare:**
  - Demonstrate ability for majority of ACO PCPs to meet Meaningful Use criteria
  - Enable beneficiary access to HER (e.g. patient portal)
  - Strong, credible, coordinated plan to support care coordination through HIT infrastructure
- **Illinois:**
  - All ACE providers must have the ability to utilize the Illinois Health Information Exchange (ILHIE)
  - Within 18 months of Contract Execution, the ACE must demonstrate real-time care connectivity between the EDs and PCPs.

B 7 Care Delivery: Clinical Integration / Practice Guidelines / Evidence Based Medicine

Less comprehensive → More comprehensive

Definition
Evidence based guidelines and best practices that are available at the point of care

- Little incorporation of evidence based guidelines into clinician practices

- Establish practice guidelines for select services/specialties
- Clinicians can access evidence based guidelines at the point of care, but must be initiated
- Monitor practice pattern variation

- Establish practice guidelines for all appropriate services/specialties
- Practice and evidence based guidelines are embedded in systems used at the point of care with alerts to support clinical decisions
- Monitor practice pattern variation
- Provide performance reports to participating providers that detail variation in care patterns
- Provide training and education on reducing variation

Examples: Federal, state or private models

- **Illinois**
  - [ACE] medical director is responsible for developing and implementing a care model, incorporating best practices
- **Minnesota**
  - No specific requirements

- **Oregon**
  - CCOs shall adopt practice guidelines, update them periodically as appropriate, disseminate to all affected Providers and use them for utilization management, Member education, and coverage of services
- **New York**
  - ACO needs to describe how it will use evidence based health care, and how the ACO will assure that ACO participants adhere to the quality improvement programs and clinical guidelines

- **N/A**

B 8 Care Delivery: Population Health Management[1]

	Less comprehensive		More comprehensive
Definition Coordination of care across settings with standardized protocols and interventions	▪ No/limited program to coordinate care across settings	▪ Patients are managed in the inpatient setting to ensure effective transition to lower acuity setting	▪ Comprehensive health assessment ▪ Process and programs in place to coordinate care across all settings (hospital, long term care, community). ▪ Protocols in place for intervention in each care setting based on patient profile
Examples: Federal, state or private models	▪ **N/A**	▪ **Illinois** – ACEs required to demonstrate transitional care coordination utilizing an evidence-based model among all providers including inpatient and ED follow-up ▪ **Medicare:** – Have population-based management tools and functions – Present a strong, credible, coordinated and feasible plan to use population-based care management, care coordination, clinical decision support, interventions, etc. – Demonstrate ability to coordinate and incorporate relevant social services in care plans and management	▪ **Oregon** – CCOs as required to conduct Community Health Assessment (CHA) and develop Community Health Improvement Plan (CHP) working with various specified stakeholders[2] – CCOs shall collaborate with OHA Office of Equity and Inclusion to develop meaningful baseline data on health disparities[3]. – CCOs shall conduct the CHA and CHP so that they are transparent and public in process and outcomes. ▪ **Minnesota** – IHPs need to define approaches and methods to coordinate care across the spectrum of services, supported by a payment model – IHPs will engage and coordinate with other providers, counties, and organizations, including county-based purchasing plans, that provide services to the IHP's patients on issues related to local population health goals.

1 Comprehensive health assessment, Care coordination, Care transition elements that go beyond the scope of PCMH activities outlined in B.3

2 Early Learning Council, Youth Development Council, Local Mental Health Authority, oral health care providers, the local public health authority , community based organizations, hospital systems , school health providers

3 Disparities to include those defined by race, ethnicity, language, disability, age, gender, sexual orientation, occupation, culture, class, religion, and other factors in its Service Areas

C 9 Financial Incentives and Accountability: Risk sharing/APM requirements

For the purposes of the ACO certification program, Book of Business from APMs is defined by:

- Speed of progression from shared savings to downside risk over time
- Share of total revenue that comes from contracts with accountability for Total Cost of Care
- Share of total revenue that comes from contracts with downside risk accountability for Total Cost of Care
- Share of specialist revenue that comes from APMs (e.g., episode based payments)
- Number of payer classes for which the ACO holds TCOC contracts

	Less comprehensive		More comprehensive
Definition	▪ No specific requirement	▪ Some requirements regarding progression towards higher levels of risk over time	▪ Specific requirements for ACOs to transition to higher levels of risk over time across a variety of APMs (e.g., global contracts, episode based contracts), differentiating between upside only and two-sided risk
Examples: Federal, state or private models	▪ **Illinois** – ACEs must demonstrate a reimbursement structure **aimed at creating value** and savings and that supports its model of care	▪ **Minnesota** – Shared savings for 'virtual IHPs', downside risk for integrated IHPs – Eligibility for shared savings start after **2% reduction** from baseline cost – Integrated IHPs need to transition to **symmetrical** downside risk in Year 2 ▪ **Oregon** – CCOs need to **implement a schedule of APMs**, with benchmarks and evaluation points identified that demonstrate direct support for transformation of care delivery across the care continuum. – CCOs shall assign a high priority to implementing **APMs for PCPs**; such payments and incentives shall provide a **sufficient level of financial support necessary to offset costs of PCMH transformation**, sustain adequate staffing and capital resources necessary to maintain the recognized tier level of PCMH care, ▪ **Medicare:** – APMs defined loosely to include "contracts that include **financial accountability** (shared savings and/or financial risk), evaluate patient experience, and include quality performance incentives" – ACOs need to assume **increased risk over the course of agreement** (Yr1: one-sided; Yr2/3: two-sided risk); proposed changes **eliminate this requirements** but lowers shared savings rate for ACOs who stay at same level of risk	▪ N/A

C 10 Financial Incentives and Accountability: Financial Incentives with the ACO

Less comprehensive **More comprehensive**

Definition ACO use of financial incentives	▪ Compensation for participating providers independent of ACO performance	▪ Bases some (<20%+) portion of the compensation provided to participating providers on the performance of the ACO as a whole, using clinical quality, cost and patient experience indicators	▪ Bases a significant (40%+) portion of the compensation provided to participating providers on the performance of the ACO as a whole, using clinical quality, cost and patient experience indicators
Examples: Federal, state or private models	▪ **Oregon:** – No specific requirements	▪ **Minnesota** – IHPs need to describe how they will distribute shared savings/losses among its component parts or entities. If applicable, the IHP should highlight the direct inclusion of community organizations in the payment model structure ▪ **Illinois** – ACEs must clearly delineate the flow of financial reimbursement among participating Providers down to the PCP including sharing in financial savings ▪ **New York** – ACOs must clearly delineate how shared savings will be distributed among ACO participants ▪ **Medicare:** – As part of the public reporting requirement, ACOs must report how shared savings are distributed amongst ACO participants	▪ **n/a**

B C 11 Behavioral Health Care Delivery and Payment Models: Definition

Less comprehensive → **More comprehensive**

	Less comprehensive		More comprehensive
Care Delivery:	**Coordinated care** ▪ PCP has phone consult ability with psychiatrist ▪ Record sharing capacity b/w PCP and BHPs[4]	**Co-located care** ▪ Psych MD or NP & PCP in same bldg; LCSW/RN available for immediate consult ▪ Tele-psychiatry capacity (tele-eval of patient, follow-up phone consult w/ PCP)[1] ▪ BH specialist keeps 50% of time unscheduled[5]	**Integrated care** (14% of ACO contracts, 2013)[2] ▪ BH trained LCSW/RN located in PCP office w/ psych MD available for phone consult & to see pts who do not respond to treatment[8] ▪ Ambulatory intensive care team for high-risk pts – MD, care mgr., LCSW, psychologist, pharmacist[12] ▪ Care coordinator case load inversely proportionate to pt risk level[12]
Payment:	**FFS**	**One-sided risk** ▪ BH consultation services (care mgmt., tele-consults) included in global payments or APMs[4] ▪ Some BH included in capitated risk (e.g., care mgmt. & phone consults for depression)[1] ▪ As of 2013, 84% of ACO contracts included MH and/or SUD services (nationally)[2]	**Two sided risk** ▪ Capitated payments include BH ▪ Savings shared with BH providers[8] ▪ Capitated payment to MCO; FFS to provider, all parties share savings & risk of loss (MCO can allocate PMPM funds in creative ways to incentivize care coordination)[9]

1 Kilbourne et al, Sustainable Lifelines: supporting integrated behavioral health services for children and adolescents in the accountable care era, AJAC, Dec. 2014.
2 Lewis et al, Few ACOs pursue innovative models that integrate care for mental illness and substance abuse with primary care, Health Affairs 33, 2014.
3 Fortney et al, Practice-based versus telemedicine-based collaborative care for depression in rural federally qualified health centers: a pragmatic randomized comparative effectiveness trial, Am J Psychiatry 170, 2013.
4 Straus JH & Sarvet B, Behavioral health care for children: the Massachusetts child psychiatry access project, Health Affairs 33:2153-2161 (2014).
5 Essentia Health, Results for depression, 2013, http://www.essentiahealth.org/main/Depression.aspx.
6 Integrated Behavioral Health Project, Phase I Summative Report, June 2009
7 North Country Health Systems Redesign Commission, Primary Health Behavioral Health Collaboration, Jan 21 2014
8 Chung H, Montefiore behavioral health integration & health reform: are we at the tipping point?; Chung H & Schwartz B, The Montefiore ACO & behavioral health: a work in progress; Chung H, The promise & progress of the ACO for behavioral health integration: current status at Montefiore medical center.
9 Sandberg et al, Hennepin Health, Health Affairs 33 (2014)

Behavioral Health Pilots – Coordinated Care

	Care delivery model	Payment model	Outcomes / Evidence base
MA Child Psychiatry Access Project[1]	▪ Psychiatrist, licensed therapist, & care coordinator housed at 6 hubs throughout state for virtual consultation ▪ PCP can receive immediate consult or order expedited face to face with patient (~18% of consults turn into face to face visits) ▪ Care coordinator assists w/ referrals into community BH services ▪ PCPs new to the program receive training on BH resources in their region, insurance coverage, and some education on BH conditions	▪ DMH funds 6 psychiatry "hubs" around state ($3.3 million, or $2.20 / child in 2014) ▪ $200,000 offset by billing for face-to-face visits (2014) ▪ MBHP administers payments to providers	▪ Tele-psychiatry consult w/in PCP office increases access to BH services and proven effective at improving outcomes in children[2] and adults[3] ▪ As of 2012, 50% of referrals not completed, even with care coordinator support ▪ 95% of PCPs in MA enrolled w/in 3 years; 455 practices (2,915 PCPs) as of June 2014 ▪ PCP understanding of BH conditions has increased – 67% reported being able to manage conditions they previously would have referred to a psychiatrist

1 Straus JH & Sarvet B, Behavioral health care for children: the Massachusetts child psychiatry access project, Health Affairs 33:2153-2161 (2014).
2 Kilbourne et al, Sustainable Lifelines: supporting integrated behavioral health services for children and adolescents in the accountable care era, AJAC, Dec. 2014.
3 Fortney et al, Practice-based versus telemedicine-based collaborative care for depression in rural federally qualified health centers: a pragmatic randomized comparative effectiveness trial, Am J Psychiatry 174(8) 2017.

Behavioral Health Pilots – Co-located Care

	Care delivery model	Payment model	Outcomes / Evidence base
Essentia Health (ND, ID, WI, MN)[1]	▪ BH providers (MA level) & psychiatric NP located in adjacent office to PCP ▪ BH providers assist w/ BH screenings & short term therapy; keep 50% of time unscheduled to facilitate immediate referral ▪ Psychiatric NP assists PCP w/ diagnosis & treatment plan ▪ Off-site consulting psychiatrist for complex cases	▪ Medicaid ACO – 2 sided risk ▪ Medicare ACO – 1 sided risk ▪ Private ACO contracts – risk varies ▪ Bundled payment includes offers outpatient SUD treatment, specialized detox facilities, psychiatric hospital treatment, & BH screenings ▪ Bundled payment does not include outpatient BH treatment	▪ 12% had improved depression scores w/in 6 months compared to 6% comparative group[2]
Crystal Run Healthcare (NY)[1]	▪ 2 FTE BH providers in PCP office ▪ PCP screens for depression, initiates and manages treatment, refers out when necessary ▪ Psychiatrist co-located in building of largest PCP practice to allow for warm hand offs w/ support from social workers ▪ Shared EMR, email, and scheduling systems	▪ 1 sided risk ▪ payment includes BH screening & outpatient treatment	▪ Warm handoff increases likelihood of follow through on BH referral by 60%[3]

1 Tierney KI, Saunders AL, & Lewis VA, Creating connections: an early look at the integration of behavioral health and primary care in accountable care organizations, Commonwealth Fund, Dec. 2014.
2 Essentia Health, Results for depression, 2013, http://www.essentiahealth.org/main/Depression.aspx.
3 North Country Health Systems Redesign Commission, Primary Health Behavioral Health Collaboration, Jan 21 2014.

Behavioral Health Pilots – Integrated Care

	Care delivery model	Payment model	Outcomes / Evidence base
Hennepin Health (MN)[1]	▪ Clinical social worker ▪ RN care coordinator ▪ Community health workers ▪ Social workers in DPH connect high-risk pts. w/ social services9 ▪ Link community providers to EMR (w/ pt consent)[2] ▪ Sober bed unit to divert SUD pts out of ED[2] ▪ Social worker in ED[2] ▪ Ambulatory intensive care unit (MD, RN, care coordinator, social worker, psychologist, pharmacist)	▪ Capitated payment to MCO; FFS to provider, all parties share savings & risk of loss (MCO can allocate PMPM funds in creative ways to incentivize care coordination)[3] ▪ Flexible PMPM allocation greater than expenditures as of 1st year analysis	**Health Outcomes** ▪ 9.1% decrease in ED over first year ▪ 3.2% decrease in admissions over 1st year[3] ▪ 2.5% increase in PCP visits over first year[3] ▪ 20% fewer crisis visits to ED[2] **Savings** ▪ Care coordinator led to ~10% reduction in cost per pt.[2] ▪ Rx mgmt. for high-risk pts resulted in > 50% savings on medications[2] ▪ Intensive care team for high utilizers reduced costs 40-95% per patient[2,4] ▪ Diverting pts into sober bed unit saved 50% on detox spending & 90% on ED expenditures[2] ▪ Social worker in ED estimated to reduce ED visits and admissions by 50%[2] ▪ Social workers connecting high risk pts to social services resulted in 70% reduction in cost[2]
Montefiore ACO (NY)[5]	▪ BH trained LCSW/RN located in PCP office ▪ Psychiatrist available for phone consult w/ PCP on Rx initiation & management ▪ Psychiatrist available to see pts not responding to treatment ▪ Extend BH EMR to PCP office ▪ RN care mgr. ▪ LCSW BH mgr.	▪ 2 sided risk ▪ Capitated payments include BH ▪ Bonuses to BH providers and PCPs	▪ PHQ-9 score among diabetic pts fell by average of 29% ▪ PHQ-9 score among pts w/ CV risk fell by average of 20% ▪ Mean PHQ-9 decreased 32% ▪ 30-44% in partial reemission (PHQ-9 < 10) ▪ 13% in full remission (PHQ-9 < 5) ▪ 35% had 5 point reduction in GAD-7 score ▪ 22% decrease in PCP utilization

1 Sandberg et al, Hennepin Health, Health Affairs 33 (2014)
2 Hennepin County, Hennepin Health, November 2013
3 Hennepin County, Hennepin Health, June 2014
4 Among the 5% of pts who accounted for 64% of expenditures
5 Chung H, Montefiore behavioral health integration & health reform: are we at the tipping point?; Chung H & Schwartz B, The Montefiore ACO & behavioral health: a work in progress; Chung H, Montefiore ACO for behavioral health integration: current status at Montefiore medical center.

State ACOs requiring some showing of integration, falling somewhere in the middle of the spectrum

	Care delivery model	Payment model	Outcomes / Evidence base
Oregon[1,2]	▪ Must demonstrate experience & capacity integrated BH & physical health services ▪ Must prioritize pts w/ mental illness/SUD ▪ Must screen for alcohol misuse ▪ Must screen for depression ▪ Must follow-up after hospitalization for mental illness (w/in 7 days)	▪ NA	▪ % pts receiving follow-up w/in 7 days after hospitalization for mental illness increased from 65% to 68% (2011-13) ▪ % pts screened for alcohol misuse and receiving intervention if appropriate increased from 0% to 2% (2011-13)
Louisiana[3]	▪ Must provide referral and coordination for specialized BH services (e.g., MH rehabilitation) & BH drugs)	▪ Must cover basic BH services	▪ NA
Colorado[4]	▪ Medicaid ACOs must screen for BH using PHQ-9, GAD-7, and AUDIT ▪ Must enter into participation agreement with state-wide network of BH providers ▪ Must demonstrate coordinated, co-located, or integrated BH	▪ Should be entering into 2 sided risk contracts by 2019	▪ NA
New Jersey[5]	▪ Must develop relationships with PCPs & BH providers to engage pts in treatment, promote mediation adherence, reduce SU, improve access to BH services, and ensure integrated primary & BH care	▪ Gainsharing plans to promote use of open access scheduling in BH care settings and funding interdisciplinary collaboration between PCPs and BH providers	▪ NA
New York[6]	▪ ACOs must obtain participation by BH providers (at least 4 w/in designated area) ▪ Must demonstrate how BH is integrated w/ physical health	▪ NA	▪ NA

1 Oregon Law c. 414 §§ 625 (1)(e), (2)(c), (2)(j), (2)(k)(B) (2013).
2 Oregon Health Authority, Quality and Accountability, 2013 data.
3 Louisiana Code, Title 50, c. 31, sections 3305(D)(11), (F)(7), & (F)(11) (2011).
4 Colorado's State Health Innovation Plan, Dec. 13, 2013
5 New Jersey c. 114, An Act Establishing a Medicaid Accountable Care Organization Demonstration Project and Supplementing Title 30 of the Revised Statutes
6 New York State Dept. of Health, Proposed Rule Making: Addition of Part 1003 and Amendment of Subpart 98-1 of Title 10 NYCRR (Accountable Care Organizations), 0

D 12 Transparency & Performance Improvement: Public Reporting Requirements (1/2)

Less comprehensive → **More comprehensive**

Definition
Tracking of standard and customized metrics, Identification of sources of variability & suggest solutions

- Nationally recognized Quality Measures are tracked and reported at aggregate level
- A formal tool is used to collect measurement data

- Quality Measures are tied to performance/payment as well as those just for reporting purposes only
- Utilization/Cost reporting is transparent and detailed

- Statewide Quality Reporting and Measurement System – or similar program – is used to collect statewide data for monitoring and comparison purposes
- Increasingly more comprehensive measures are collected and utilized (e.g. diabetes, vascular disease)

Louisiana

	mandatory measures	voluntary measures	Mandatory Reporting Only
Q	16/HEDIS/AHRQ		
U/C			Quarterly & Annually
PP			Quarterly reports to Dept. of Health and Hospitals
PE	CAHPS		
SP			Semiannually
SRE	29		

New Jersey

	mandatory measures	voluntary measures	Mandatory Reporting Only
Q	21 mandatory; 6 voluntary	6	6
U/C	Annual savings calculations	6	1 (mental health)
PP			Annually to Dept. Human Services
PE	7 – CAHPS, similar		
SP			
SRE	29		

Minnesota

	mandatory measures	voluntary measures	Mandatory Reporting Only
Q	36		
U/C			At least annually to Commissioner
PP			Yes
PE	14 – CAHPS		
SP	Yes		
SRE	29		

- Q = Quality Measures ; U/C = Utilization/Cost Measures; PP = Patient Protection; PE = Patient Experience ; SP = Strategic/Transformation Plan; SRE = Serious Reportable Events
- Mandatory Measures are most often tied to payment/performance.

D 12 Transparency & Performance Improvement: Public Reporting Requirements (2/2)

Less comprehensive → **More comprehensive**

Definition
Tracking of standard and customized metrics, Identification of sources of variability & suggest solutions

- Nationally recognized Quality Measures are tracked and reported at aggregate level
- A formal tool is used to collect measurement data

- Quality Measures are tied to performance/payment as well as those just for reporting purposes only
- Utilization/Cost reporting is transparent and detailed

- Statewide Quality Reporting and Measurement System – or similar program – is used to collect statewide data for monitoring and comparison purposes
- Increasingly more comprehensive measures are collected and utilized (e.g. diabetes, vascular disease)

Illinois

	mandatory measures	voluntary measures	Mandatory Reporting Only
Q	29		
U/C			Monthly & Annual
PP			Quarterly
PE			Yes
SP			
SRE	29		

Vermont

	mandatory measures	voluntary measures	Mandatory Reporting Only
Q	33		
U/C	15		1
PP			Yes
PE	7-9		
SP			
SRE	29		

Maine

	mandatory measures	voluntary measures	Mandatory Reporting Only
Q	16	2/5	5
U/C	32		
PP			Yes
PE	CAHPS		
SP			
SRE			Yes

- Q = Quality Measures ; U/C = Utilization/Cost Measures; PP = Patient Protection; PE = Patient Experience ; SP = Strategic/Transformation Plan; SRE = Serious Reportable Events
- Mandatory Measures are most often tied to payment/performance.

D 13 Transparency & Performance Improvement: Performance Improvement Requirements

Less comprehensive — More comprehensive

	Less comprehensive		More comprehensive
Definition work flow analysis, benchmarking, and guidance to implement best practice	▪ Operational effectiveness and efficiency benchmarked against the industry occasionally (e.g. biannually)	▪ Operational effectiveness and efficiency benchmarked against the industry annually, select initiatives launched as a result	▪ Regular assessment of how operations can improve (e.g. benchmarking, flow analysis). ACO knows the largest drivers of waste and act on plans to change operations
Examples: Federal, state or private models	▪ **New Jersey:** – ACO must explain policies, technical capabilities, and organizational structures it expects to develop to meet goals/objectives, and project benchmarks	▪ **Illinois:** – ACE will use data from Dept. of Health and Family Services to drive quality improvement and health outcomes – ACE must describe internal QI plan/processes ▪ **Medicare:** – 33 QMs to drive performance improvement in Years 2 & 3 – Based on Medicare data, Physician Quality Reporting System (PQRS), ACO data, surveys – Amount of savings ACO receives is based on point system, which is based on percentile achieved in performance areas	▪ **Minnesota**: – IHPs must develop infrastructure to internally report on quality and cost metrics, monitor performance, and use results to improve care over time – Quality Incentive Payment System (QIPS) – levels based on: ▫ absolute performance, and ▫ improvement over time – Dept. of Health sets benchmarks and improvement targets – Minimum threshold based on lowest rate attained by providers (using historical data); target for improvement is 3% higher than the minimum threshold

E 14 Patient Experience & Engagement: Patient Experience

Less comprehensive → **More comprehensive**

Definition
Patient Experience is measured, compared against a benchmark, and used as a way to improve patient care

- Provider/Practice implements a patient satisfaction survey utilizing a formal tool
- Patient Satisfaction is scored and tied to payment and/or performance measure

- Patient satisfaction/experience results are increasingly valued in the overall QM total
- Survey tool is extensive and comprehensive enough to fully evaluate multiple facets of patient experience

- Patient satisfaction is not only part of the core quality measures, but is given substantial weight of total QM

Examples: Federal, state or private models

- **Maine:**
  - 10% of scoring
  - Year 1 &2 → reporting only
  - Year 3 → performance
    - Thresholds will be compared against National CG-CAHPS data
      - ≈ 84% average
  - CAHPS

- **Oregon:**
  - 1 Incentive Measure/16 total Incentive Measures
  - Year 1 → reporting only
  - Minimum Thresholds:[1]
    - 2013: 84%
    - 2014: 89%
    - 2015: 89.6%
  - CAHPS

- **Minnesota:**
  - 25% of scoring
  - Sub-divided into 4 clinic & 10 hospital modules
  - Year 1 → reporting
  - Year 2 & 3 → performance
    - Minimum threshold: 30%
    - Upper threshold: 90%
      - Points awarded for attainment of different thresholds
  - CAHPS

- **Medicare:**
  - 25% of scoring
  - Year 1 → reporting
  - Year 2 & 3 → performance
  - CAHPS

[1] Based on comparison between 2011 OR baseline and National Medicaid benchmarks.

E 15 Patient Experience & Engagement: Patient Engagement/Activation

Less comprehensive → **More comprehensive**

Definition
Measures the extent to which a patient is knowledgeable, confident, and involved in her/his health care

- Patient engagement is part of discussions or goals among ACOs, but nothing greater or more tangible has been developed

- Recognizes importance of measuring patient engagement
- Has begun process of formalizing inclusion of patient engagement measures within ACO framework, but has yet to fully realize

- Develops and implements a detailed strategy on how to best engage patients and caregivers
- Develops training program, creates cultural/language/age appropriate materials to aid both providers and patients, partners with community-based organizations to strengthen resources available to patients/caregivers
- Utilizes a formal tool to measure level of patient activation within practice

Examples: Federal, state or private models

- **Minnesota:**
  - 2014 RFP:
    - IHPs must demonstrate how they will "meaningfully engage patients and families as partners in the care they receive."
    - Must demonstrate capacity to receive data from State and use to identify opportunities for patient engagement
- **Medicare:**
  - Demonstrate ability to engage and activate patients at home to improve self-management [no formal assessment tool required]

- **Vermont:**
  - Part of the Core Measures, but reporting not required Year 1:
    - "How's Your Health?"
    - Patient Activation Measure (PAM)

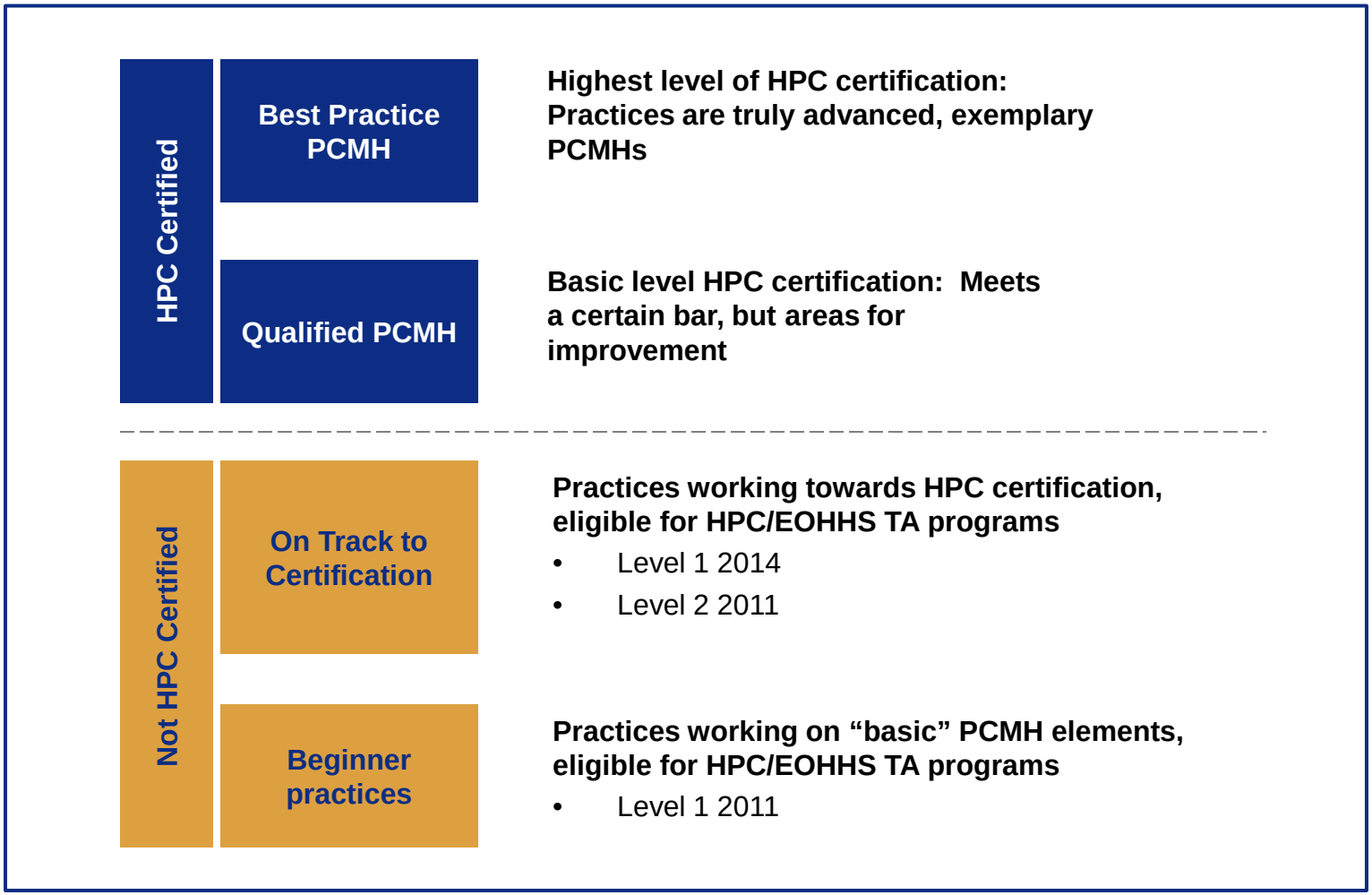
- **Oregon:**
  - OHA Published Full Report and Recommendations outlining 5 key strategies to improving "person- and family-centered care" (2013)
  - Encourages use of PAM® assessment tool
  - Other evidence-based tools:
    - Shared-decision making
    - Health literacy
    - Self-management
  - OHA sample CCO contract requires demonstrated measurement and coordination of patient engagement

Appendix B:

HPC modifications to NCQA PCMH standards for:

- Behavioral Health Integration
- Resource Stewardship,
- Population Health Management
- Patient Experience

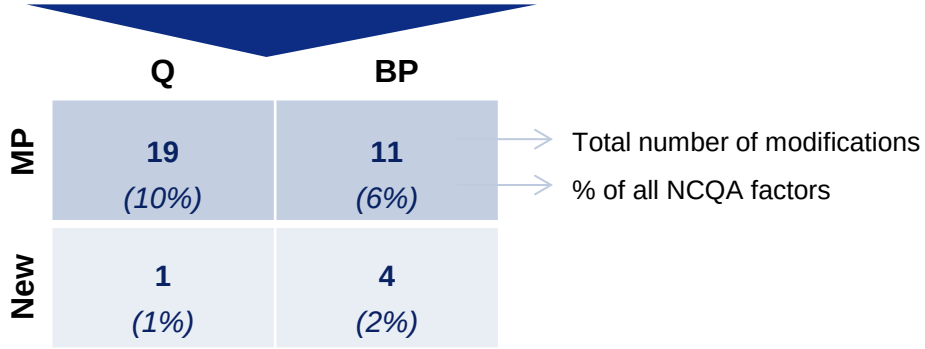
PCMH Certification: Proposed structure



Overall, HPC certification will require low degree of modifications to existing NCQA criteria

Total number of modifications

	Qualified PCMHs				Best Practice PCMHs only			
	BH	***RS***	***PE***	***PHM***	***BH***	***RS***	***PE***	***PHM***
Existing factors								
2011 factor → HPC MP factor	4	1	3	6***	0	0	1	3
2011 Critical Factor (or part of MP element) → HPC MP factor	3*	0	0	0	0	1	1	0
2014 only → HPC MP factor	0	0	0	0	0	0	0	1
2011 enhanced → HPC MP factor	0	0	0	0	0	0	0	0
2014 enhanced → HPC MP factor	0	2	0	1	0	3	0	1
New Factors								
Part of 2014 NCQA	2**	0	0	0	0	0	0	0
Not part of 2014 NCQA	0	0	0	0	4	0	0	0



* 1 factor would be must-pass as part of HPC modifications for the population health management domain

** 1 factor would be new as part of HPC modifications for the population health management and resource stewardship domains

*** Includes a "modified scoring" factor (Element 5C, factors 1-4 allot double points)

NCQA Modifications: Behavioral Health (1/5)

	2011 NCQA Requirements	2014 NCQA Requirements	HPC Requirements	Level*
Screening/ Health Assessment	**2C: Comprehensive Health Assessment** CHA includes: ▪ 6. Behaviors affecting health ▪ 7. Patient and family MH/SU ▪ 8. Developmental screening using a standardized tool (NA for practices with no pediatric patients) ▪ 9. Depression screening for adults and adolescents using a standardized tool	**3C: Comprehensive Health Assessment** CHA includes: ▪ *Very similar to 2011 standards*	▪ **Make the following 2014 standards critical factors:** – 3.C.6 – 3.C.7 – 3.C.8 – 3.C.9	All
			▪ ***New factor***: anxiety screening for adults using first 2 questions on GAD-7 or equivalent and full screen if patient tests positive[1]	All
			▪ ***New factor:*** SUD screening using AUDIT-C and DAST or equivalent[1] (CRAFFT or equivalent for adolescent patients)[2] and SBIRT or equivalent if patient tests positive[3]	All

[1] validated diagnostic aid, available in public domain; part of AIMS Center evidence-based integrated collaborative care model that is used in NY, MT, WY, WA, AK, ID, US Military; used in UMass affiliated PCMHs, recommended in CO PCMH planning documents.

[2] Recommended by 2013 Behavioral Health Task Force; AIMS Center recommends DAST as alternative for adolescent populations

[3] evidence-based intervention and/or referral to treatment that follows diagnostic screening; validated by several studies including those funded by SAMHSA

NCQA Modifications: Behavioral Health (2/5)

	2011 NCQA Requirements	2014 NCQA Requirements	HPC Requirements	Level*
Referral Tracking	**5B: Referral Tracking and Follow-Up (MUST PASS)** ▪ 4. Tracking the status of the referrals, including required timing for receiving a specialist's report ▪ 3. Following up to obtain specialist's report ▪ 4. Establishing and documenting agreements with specialists in the medical record if co-management is needed	**5B: Referral Tracking and Follow-Up (MUST PASS)** ▪ 1. Considers available performance information on consultants/specialists when making referral recommendations ▪ 3. Maintains agreements with behavioral healthcare providers ▪ 4. Integrates behavioral healthcare providers within the practice site ▪ 8. Tracks referrals until the consultant or specialist's report is available, flagging and following up on overdue reports (critical factor) ▪ 9. Documents co-management arrangements in the medical record	▪ **Make following 2014 standards critical factors:** – 5.B.3 – 5.B.8 – 5.B.9 ▪ ***Modified scoring:*** 5.B.1 – double points for meeting this factor ▪ ***Modified requirement:*** 5.B.8 – Practice tracks referrals until the consultant or specialist's report is available, flagging and following up on overdue reports and making at least second contact with patients who did not accept or follow through with BH referral. ▪ ***New Factor:*** Practice assesses effectiveness of agreements at least annually and adjusts practice patterns accordingly	All All All BP

NCQA Modifications: Behavioral Health (3/5)

	2011 NCQA Requirements	2014 NCQA Requirements	HPC Requirements	Level*
Care Management of High Risk Patients	**3B: Identify High- Risk Patients** To identify high-risk or complex patients the practice: ▪ 1. Establishes criteria and a systematic process to identify high-risk or complex patients ▪ 2. Determines the percentage of high-risk or complex patients in its population	**4A: Identify Patients for Care Management** The practice establishes a systematic process and criteria for identifying patients who may benefit from care management, which includes consideration of: ▪ 1. Behavioral health conditions ▪ 2. High cost/high utilization ▪ 3. Poorly controlled/ complex conditions ▪ 4.Social determinants of health ▪ 5. Referrals by outside organizations (e.g., insurers, health system, ACO), practice staff or patient/family/caregiver ▪ 6.The practice monitors the percentage of the total patient population identified through its process and criteria (critical factor)	▪ **Make following 2014 standard a critical factor:** – 4.A.1 ▪ ***New factor:*** if care manager in practice, s/he must be trained to identify and coordinate behavioral health needs	All BP

NCQA Modifications: Behavioral Health (4/5)

	2011 NCQA Requirements	2014 NCQA Requirements	HPC Requirements	Level*
Evidence Based Protocols	**3A: Implement Evidence-Based Guidelines** Practice implements evidence-based guidelines through POC reminders for patients with: ▪ 1. The first important condition+ ▪ 2. The second important condition+ ▪ 3. The third condition, related to unhealthy behaviors or mental health or substance abuse (critical factor)	**3E: Implement Evidence-Based Decision Support** Practice implements clinical decision support following evidence-based guidelines for: ▪ 1. A MH or SU disorder (critical factor) ▪ 2. A chronic medical condition ▪ 3. An acute condition ▪ 4. A condition related to unhealthy behaviors ▪ 5. Well child or adult care Requires providing the source of guidelines and examples that demonstrate how guidelines are implemented (e.g. charting tools, screen shots, workflow organizers, condition-specific templates for treatment plans/patient progress monitoring)	▪ ***Modified requirement*:** 3.E.1 – a MH and SU disorder	All

+ Stage 2 Core Meaningful Use Requirement

NCQA Modifications: Behavioral Health (5/5)

	2011 NCQA Requirements	2014 NCQA Requirements	HPC Requirements	Level*
Performance Improvement	**6A: Measure Performance** The practice measures or receives data on the following: ▪ 2. At least three chronic or acute care clinical measures	**6A: Measure Performance** At least annually, the practice measures or receives data on: ▪ 3. At least three chronic or acute care clinical measures	▪ ***Modified requirement:*** 6.A.3 - one of these measures must be related to BH	All

NCQA Modifications: Resource Stewardship (1/2)

	2011 NCQA Requirements	2014 NCQA Requirements	HPC Requirements	Level*
Measuring Utilization	**6A: Measure Performance** The practice measures or receives data on the following: ▪ 3. At least two utilization measures affecting health care costs	**6B: Measure Resource Use & Care Coordination** The practice measures or receives data on the following: ▪ 2. *Very similar to 2011 standard*	▪ **Make the following 2014 standards critical factors:** – 6.B.2 ▪ ***Enhanced requirement:*** – At least **four utilization measures** affecting health care costs – Including either: ▫ Overuse of imaging, or ▫ Appropriate use of antibiotics	All BP
Action to improve performance	**6C: Implement Continuous Quality Improvement (MUST PASS)** The practice uses an ongoing quality improvement process to: ▪ 1. Set goals and act to improve performance on at least three utilization measures	**6D: Implement Continuous Quality Improvement (MUST PASS)** The practice uses an ongoing quality improvement process to: ▪ 3. Set goals and analyze at least one utilization measure ▪ 4. Act to improve at least one utilization measure	▪ ***Enhanced must pass requirement:***[1] – 6.D.3 ▫ Set goals and analyze at least **two utilization measures** ▫ Set goals and analyze at least **four utilization measures** – 6.D.4 ▫ Act to improve performance on at least **two utilization measures** ▫ Act to improve performance on at least **four utilization measures**	All BP All BP

[1] **Similar measures are implemented in many other states across the country, sample examples are below:**

MD: Pediatrics – assess and report on 3-5 measures within Year 1-2; meet thresholds Year 3.
Adult – assess and report on 12-18 measures Year 1-2; meet thresholds Year 3

MN: Practice must measure, analyze, and track measures related to cost-effectiveness of services

NCQA Modifications: Resource Stewardship (2/2)

	2011 NCQA Requirements	2014 NCQA Requirements	HPC Requirements	Level*
Demonstrating improved performance	**6D: Demonstrate Continuous Quality Improvement** The practice demonstrates ongoing monitoring of the effectiveness of its improvement process by: ▪ 1. Tracking results over time ▪ 2. Assessing the effect of its actions ▪ 3. Achieving improved performance on one measure ▪ 4. Achieving improved performance on a second measure	**6E: Demonstrate Continuous Quality Improvement** The practice demonstrates continuous quality improvement by: ▪ 3. Achieving improved performance on one utilization or care coordination measure	▪ **Make the following 2014 standard a critical factor:** – 6.E.3	BP

NCQA Modifications: Population Health Management (1/4)

	2011 NCQA Requirements	2014 NCQA Requirements	HPC Requirements	Level*
Evidence-Based Decision Support	**3A: Implement Evidence-Based Guidelines** The practice implements evidence-based guidelines through point-of-care reminder for patients with: ▪ 1. The first important condition ▪ 2. The second important condition ▪ 3. The third condition, related to unhealthy behaviors or mental health or substance abuse (CRITICAL FACTOR)	**3E: Implement Evidence-Based Decision Support** The practice implements clinical decision support following evidence-based guidelines for: ▪ 1. A mental health or substance use disorder (CRITICAL FACTOR) ▪ 2. A chronic medical condition ▪ 3. An acute condition ▪ 4. A condition related to unhealthy behaviors ▪ 5. Well child or adult care ▪ 6. Overuse/appropriateness issues	▪ **Make the following 2014 element must pass:** – 3.E ▪ ***Enhanced requirement:*** – 3.E.6 – At least **two** overuse/appropriateness issues, one of which must be either: ▫ Overuse of imaging, or ▫ Appropriate use of antibiotics	All BP
Identify High-Cost/Utilization Patients	**3B: Identify High-Risk Patients** To identify high-risk or complex patients the practice: ▪ 1. Establishes criteria and a systematic process to identify high-risk or complex patients ▪ 2. Determines the percentage of high-risk or complex patients in its population	**4A: Identify High-Risk Patients** The practice establishes a systematic process and criteria for identifying patients who may benefit from care management, which includes consideration of: ▪ 1. Behavioral health conditions ▪ 2. High cost/high utilization ▪ 3. Poorly controlled or complex conditions ▪ 4. Social determinants of health ▪ 5. Referrals by outside organizations ▪ 6. The practice monitors the percentage of the total patient population identified through its process and criteria (CRITICAL FACTOR)	▪ **Make the following 2014 element must pass:** – 4.A*	All

* **4.A.1** is also a critical factor under Behavioral Health.

NCQA Modifications: Population Health Management (2/4)

	2011 NCQA Requirements	2014 NCQA Requirements	HPC Requirements	Level*
Coordination with Community Resources	**4B: Provide Referrals to Community Resources** The practice supports patients/families that need access to community resources: ▪ 1. Maintains a current resource list on five topics or key community service areas of importance to the patient population ▪ 4. Offers opportunities for health education programs (such as group classes and peer support)	**4E: Support Self-Care and Shared Decision Making** The practice has, and demonstrates use of, materials to support patients and families/caregivers in self-management and shared decision making. The practice: ▪ 6. Maintains a current resource list on five topics or key community service areas of importance to the patient population including services offers outside the practice and its affiliates ▪ 7. Assesses usefulness of identified community resources	▪ **Make the following 2014 standards critical factors:** – 4.E.6 – 4.E.7	 All BP
Document Advance Care Planning Preferences	**2C: Comprehensive Health Assessment** To understand the health risks and information needs of patients/families, the practice conducts and documents a comprehensive health assessment that includes: ▪ 5. Advance care planning (NA for pediatric practices)	**3C: Comprehensive Health Assessment** ▪ 5. *Same as 2011 standard*	▪ **Make the following 2014 standard a critical factor:** – 3.C.5	All

* **MN:** requires that practices "demonstrate ongoing partnership(s) with at least one community resource, including training staff on which resources are available and how to refer them to patient population

* **IL:** also emphasizes an ongoing partnership and coordinating care with community resources

NCQA Modifications: Population Health Management (3/4)

	2011 NCQA Requirements	2014 NCQA Requirements	HPC Requirements	Level*
Care Transitions	**5C: Coordinate with Facilities and Manage Care Transitions** On its own or in conjunction with an external organization, the practice systematically: ▪ 1. Demonstrates its process for identifying patients with a hospital admission and patients with an ED visit ▪ 2. Demonstrates its process for sharing clinical information with admitting hospitals or EDs ▪ 3. Demonstrates its process for consistently obtaining patient discharge summaries from the hospital and other facilities ▪ 4. Demonstrates its process for contacting patients/families for appropriate follow-up care within an appropriate period following a hospital admission or ED visit ▪ 5. Demonstrates its process for exchanging patient information with the hospital during a patient's hospitalization ▪ 6. Collaborates with patient/family to develop a written care plan for patients transitioning from pediatric to adult care (NA for adult-only & family practices) ▪ 7. Demonstrates the capability for electronic exchange of key clinical information with facilities ▪ 8. Provides an electronic summary-of-care record to another care facility for >50% of transitions of care++	**5C: Coordinate Care Transitions** ▪ 1,2,3,4,5,7 *Very similar to 2011 standards* **2A: Continuity** The practice provides continuity of care for patients/families by: ▪ 4. Collaborating with the patient/family to develop/implement a written care plan for transitioning from pediatric care to adult care	▪ ***Modified scoring:*** – 5.C.1-4 ▫ double points ▪ **Make the following 2014 element must pass:** – 5.C ▪ **Make the following 2014 standard a critical factor:** – 2.A.4*	All BP All

2.A.4. from the 2014 standards aligns with 5.C.6. from the 2011 standards.
++ Stage 2 Meaningful Use Requirement
+Stage 2 Core Meaningful Use Requirement

NCQA Modifications: Population Health Management (4/4)

	2011 NCQA Requirements	2014 NCQA Requirements	HPC Requirements	Level*
Performance Improvement	**6A: Measure Performance** The practice measures or receives data on the following: ▪ 1. At least three preventive care measures	**6A: Measure and Improve Performance** At least annually, the practice measures or receives data on: ▪ 1. At least two immunization measures	▪ ***Enhanced requirement:*** 6.A.1 - Practices must measure/receive immunization data for each population above the specified threshold:[1] ▫ 80% for < 2 year olds ▫ 85% flu vaccination for 6mths-4yrs ▫ 85% for adolescents/pre-college, including - 50% HPV vaccination for females; 30% for males ▫ 70% for pregnant women ▫ 60% for seniors	All
Addressing Disparities	**6C: Implement Continuous Quality Improvement (MUST PASS)** The practice uses an ongoing quality improvement process to: ▪ 3. Set goals and address at least one identified disparity in care/service for vulnerable populations.	**6D: Implement Continuous Quality Improvement (MUST PASS)** ▪ 7. *Same as 2011 standards*	▪ **Make the following 2014 standard a critical factor:** – 6.D.7	BP
Preventive & Follow-Up Care		**6G: Use Certified EHR Technology**[2] The practice uses a certified EHR system: ▪ 10. The practice generates lists of patients, & based on their preferred method of communication, proactively reminds >10% of patients/families/caregivers about needed preventive/follow-up care+	▪ **Make the following 2014 standard a critical factor:** – 6.G.10[3]	BP

[1] Rates are based on 2011-2013 data for MA-specific immunization rates, in accordance with MA immunization schedules and guidelines.

2 The *2011 standards included preventive/follow-up care standards, but 2014 specifically requires the use of EHR to enhance these standards.*

3 MN & IL: Both states require communication regarding preventive/follow-up care, AAFP strongly recommends communication regarding preventive/follow- up care.

+ Phase 2 Core Meaningful Use Requirement

NCQA Modifications: Patient Experience (1/2)

	2011 NCQA Requirements	2014 NCQA Requirements	HPC Requirements	Level*
CLAS Requirements	**1F: Culturally and Linguistically Appropriate Services (CLAS)** The practice engages in activities to understand & meet the cultural and linguistic needs of its patients/families: ▪ 1. Assessing the racial and ethnic diversity of its population ▪ 2. Assessing the language needs of its population ▪ 3. Providing interpretation or bilingual services to meet the language needs of its population ▪ 4. Providing printed materials in the languages of its population	**2C: Culturally and Linguistically Appropriate Services (CLAS)** The practice engages in activities to understand and meet the cultural & linguistic needs of its patients/families by: ▪ 1. Assessing the diversity of its population ▪ *2-4 same as 2011 standards*	▪ **Make the following 2014 standards critical factors:**[1] – 2.C.1,2 – 2.C.3,4	 All BP
Measure Patient/Family Experience	**6B: Measure Patient/Family Experience** Practice obtains feedback from patients/families on their experiences with the practice and their care: ▪ 1. The practice conducts a survey (using any instrument) to evaluate patient/family experiences on at least three of the following: – Access – Communication – Coordination – Whole-person care/self-mgmt. support ▪ 2. The practice uses the PCMH CAHPS Tool ▪ 3. The practice obtains feedback on the experiences of vulnerable patient grps. ▪ 4. The practice obtains feedback from patients/families through qualitative means	**6C: Measure Patient/Family Experience** *Same as 2011 standards*	▪ **Make the following 2014 standards must pass:**[1] – 6.C.1,2,4	All

[1] Almost every state requires CLAS standards for certification fulfillment. **MN** requires that a practice formulate an availability plan for accessing interpreters.

NCQA Modifications: Patient Experience (2/2)

	2011 NCQA Requirements	2014 NCQA Requirements	HPC Requirements	Level*
Continuously Improve Patient Experience	**6D: Demonstrate Continuous Quality Improvement** The practice demonstrates ongoing monitoring the effectiveness of its improvement process by: ▪ 3. Achieving improved performance on one measure	**6E: Demonstrate Continuous Quality Improvement** The practice demonstrates continuous quality improvement by: ▪ 4. Achieving improved performance on at least one patient experience measure	▪ **Make the following 2014 standards must pass:** – 6.E.4	All BP
Patient Involvement in Continuous Improvement	**6C: Implement Continuous Quality Improvement (MUST PASS)** The practice uses an ongoing quality improvement process to: ▪ 4. Involve patients/families in quality improvement teams or on the practice's advisory council	**2D: The Practice Team (MUST PASS)** The practice uses a team to provide a range of patient care services by: ▪ 10. Involving patients/families/caregivers in quality improvement activities or on the practice's advisory council	▪ **Make the following 2014 standard a critical factor:** – 2.D.10	BP