MASSACHUSETTS
HEALTH POLICY COMMISSION

Meeting of the Care Delivery Transformation Committee

September 30, 2020

MASSACHUSETTS
HEALTH POLICY COMMISSION

AGENDA

- **Call to Order**
- Approval of Minutes (VOTE)
- ACO Certification Program Design
- Maternal and Child Health Investment Program: Stakeholder Feedback and Preliminary Investment Design
- Awardee Presentations: SHIFT-Care Investment Program and COVID-19 Impact
- New and Upcoming Publications: CHART Reports and ACO Datapoints

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VOTE: Approving Minutes

MOTION: That the Commission hereby approves the minutes of the Care Delivery Transformation Committee meeting held on **May 6, 2020,** as presented.

2020 HEALTH CARE COST TRENDS HEARING

COVID-19 AND THE MA HEALTH CARE SYSTEM: ASSESSING IMPACT, ADVANCING EQUITY

SAVE THE DATE
–
OCTOBER 20, 2020

TUESDAY, OCTOBER 20, 9:00 AM – 12:30 PM

KEYNOTE SPEAKER: DAVID R. WILLIAMS, MPH, PHD
Florence Sprague Norman and Laura Smart Norman
Professor of Public Health
Chair, Department of Social and Behavioral Sciences
Harvard T.H. Chan School of Public Health

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ACO Certification aims to promote ongoing transformation and improvement over time.

Initial Focus of HPC ACO Certification

- Create a set of **multi-payer standards** for ACOs to enable care delivery transformation and payment reform across multiple ACO programs in the market (Medicare, commercial, MassHealth)
- Build **knowledge and transparency** about ACO approaches
- Facilitate **learning** across the care delivery system
- Align with and complement **other standards and requirements** in the market, including MassHealth

Current Market

- **17 HPC-certified ACOs** in the Commonwealth serving nearly 3 million attributed patients
- **Variation** in ACO structure, operations, culture and other key attributes
- Evidence on the relationship between ACO capabilities and outcomes is still developing

Vision for Future Certification

- Develop the **evidence base** on how ACOs achieve improvements in quality, cost and patient experience
- Recognize ACO performance on **quality, cost, and health equity**
- Support **continued learning** through technical assistance, investment programs, and L+D opportunities

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Anticipated Timeline for Certification Standards Development, 2020-2021

August – September 2020 – Initial stakeholder engagement

September 2020 – Draft standards reviewed with HPC Care Delivery Transformation Committee

October – November 2020 – Public comment on proposed standards

Winter 2021 – Final standards presented to HPC Board for approval

Winter – Spring 2021 – Development of detailed Application Requirements document

Summer – Fall 2021 – ACOs prepare and submit applications; HPC reviews

January 2022 – Certifications take effect

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Overview of Current ACO Certification Criteria

Pre-requisites

5 pre-reqs.
Attestation only

- ✓ Risk-bearing provider organizations (RBPO) certificate, if applicable
- ✓ Any required Material Change Notices (MCNs) filed
- ✓ Anti-trust laws
- ✓ Patient protection
- ✓ Substantive, quality-based risk contract

1 Background Information

2 required criteria
Risk contracts template, quality reporting

- ✓ ACO Participants – primary care and hospital *(optional)*
- ✓ Risk contract information
- ✓ Risk contract performance

2 Assessment Criteria

5 criteria
Sample documents, narrative descriptions

- ✓ Patient-centered, accountable governance structure
- ✓ Population health management programs
- ✓ Cross-continuum care: coordination with BH, hospital, specialist, and long-term care services

3 Required Supplemental Information

3 criteria
Narrative or data
Not evaluated by HPC but must respond

- ✓ Distributes shared savings or deficit in a transparent manner
- ✓ Addresses low-value care delivery
- ✓ Supports patient-centered primary care and behavioral health integration

Principles for Revising the HPC's ACO Certification Framework

Recognize that knowledge on ACOs is still developing

ACOs and the policy community are still learning what works: ACO cost and quality performance tends to improve with experience

Provide flexibility to ACOs

Minimize reporting burden, provide substantial flexibility to ACOs, and allow for a multitude of approaches while requiring adherence to core principles for delivery system transformation

Focus on capacity for learning, improvement, and innovation

Emphasize capacity for continuous improvement and innovation to ensure ACOs are positioned to learn from success and failures*

Advance health equity in the Commonwealth

Incorporate health equity principles into the certification standards to encourage and support systemic improvements

*Consistent with the National Academy of Medicine's (formerly the Institute of Medicine) 'Learning Health System' concept

Proposed Updated ACO Certification Requirements

1 Pre-Requisites

3 required pre-reqs.
Attestations, org chart , risk contracts template

- ✓ Identifiable and unique Governing Body
- ✓ At least one risk contract with a public or private payer
- ✓ Legal compliance: RBPO certificate, if applicable; any required MCNs filed; anti-trust laws; patient protection; RPO filings

2 Assessment Criteria

5 criteria
Sample ACO documents, narrative descriptions, HPC templates

- ✓ Patient-centered care
- ✓ Leadership-driven culture of performance improvement
- ✓ Data-driven decision-making
- ✓ Population health management programs
- ✓ Whole-person approach

3 Required Supplemental Information

3-4 domains
Narrative or data
Not evaluated by HPC but must respond

- ✓ Use of innovative care models, including telehealth
- ✓ Activities to improve health equity, including governance representation and patient data collection
- ✓ Strategies to control TME growth

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Assessment Criterion 1: Patient-Centered Care

The ACO collects and uses information from patients to improve and deliver patient-centered care. Data or patient input collected as part of this process allows for stratification by race/ethnicity or socioeconomic factors.

ACOs must provide documentation of one item from each column:

Leadership Monitoring of Patient Experience

- Example(s) of **monitoring of patient experiences** on large scale (e.g., periodic surveys, online communities, patient focus groups, PES collection)
- Data collection on **cultural, linguistic, literacy,** etc. needs
- Demonstration of **robust consumer participation** in governance and bodies informing leadership (e.g., use of PFACs)

Patient Experience Data Used Strategically

- Written plans for **identifying areas for improvement** based on patient experience monitoring and **implementing strategies** to improve
- Description of **one ACO- or system-level initiative** to improve an aspect of patient experience in past two years
- **Outreach campaigns** or mobile alert programs to engage patients

Assessment Criterion 2: Culture of Performance Improvement

The ACO fosters a culture of continuous improvement, innovation, and learning to improve the patient experience and value of care delivery.

ACOs must provide documentation of two items:

Culture of Performance Improvement

- **ACO-sponsored improvement-oriented citizenship activities**, such as teaching or learning sessions
- **Leadership commitment to creating a culture of performance improvement**, e.g., tracking of system or ACO-level metrics against ACO goals by leadership
- **Defined systems or pathways for improvement and innovation,** such as implementation of systems learning and/or process improvement approaches
- **Internal financial incentives** encouraging improvement, e.g., funds flow or compensation
- **Metric-based selection or evaluation** of preferred clinical or non-clinical partners
- Support for an ACO-or-system-wide **primary care practice transformation strategy**

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Assessment Criterion 3: Data-Driven Decision-Making and Care Delivery

The ACO is committed to using the best available data and evidence to guide and support improved clinical decision-making.

ACOs must provide documentation of one item from each column:

Processes or tools deliver current clinical knowledge to the point of care

- Description of **data-driven initiative** to reduce waste or low-value care
- Support for use of **clinical decision support tool**, including description of prevalence of use and overrides
- Example of **evidence-based protocol or structured learning opportunity** developed or made available to clinicians

Providers receive actionable data (on quality, cost, etc.) to guide decisions

- Timely, **actionable data and/or feedback** on cost or quality performance at the provider or group level is provided periodically
- **Data analytics** offer providers understandable, actionable information on patient panels

Assessment Criterion 4: Population Health Management (PHM) Programs

The ACO develops, implements, and refines programs and care delivery innovations to coordinate care, manage health conditions, and improve the health of its patient population. Data or patient input collected as part of this process allows for stratification by race/ethnicity or socioeconomic factors.

ACOs must provide documentation of one item from each column:

Data and analytics to understand patient needs

- Use of clinical, claims, and/or socio-demographic data in patient **stratification algorithms or predictive analytics**
- Routine use of **standardized screening tools** in primary care settings to identify patients who would benefit from PHM programs

PHM programs, targets, and metrics for improvement

- Template identifying key features of **PHM programs** (e.g., priority areas, populations targeted, targets and metrics)

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Assessment Criterion 5: Whole-Person Care

The ACO recognizes the importance of non-medical factors to overall health outcomes and cost of care and seeks to integrate behavioral health and health-related social supports into its care delivery models.

ACOs must provide documentation of one item from each column:

Discrete goals for increasing behavioral health integration

- Behavioral health integration **progress and targets template** identifying priority areas, goals and metrics, current performance and future targets
- Example of implementation of at least one ACO-supported initiative featuring **close collaboration approaching an integrated practice***

Discrete goals for addressing health-related social needs

- Implementation of **health-related social needs screening processes**, including description of metrics tracked and performance targets

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* As defined in the "Standard Framework for Levels of Integrated Care" developed by the SAMHSA-HRSA Center for Integrated Health Solutions: https://www.thenationalcouncil.org/wp-content/uploads/2020/01/CIHS_Framework_Final_charts.pdf

Key Themes from Initial Stakeholder Input on the Proposed Assessment Criteria

- General support and appreciation for the HPC offering a **menu** of documentation requirement options
- Validation by ACOs that the proposed Assessment Criteria identify **important and relevant areas** for ACO focus, though consumer advocates urged more consideration of topics ACOs may be less focused on
- Interest in more **transparency** from the HPC, such as through outputs or learning opportunities, to demonstrate how information from certification is being used
- Continued requests to **minimize application burden** and ensure documentation requirements are meaningful
- Suggestion that the HPC be mindful of **COVID-19** related disruptions to operations in 2020 when evaluating ACO application materials in fall 2021

Supplemental Information Questions

Supplemental Information

As in previous certification cycles, we propose to request information on supplemental topics of interest to the HPC.

ACO responses may be used to support the transparency objectives of the certification program (i.e., advance understanding of ACOs in the Commonwealth), or to inform potential future components of the certification standards.

Data collection would be limited to a few topics, such as:

- Approaches to improving **health equity**
- Use of **innovative care models**, including telehealth
- Strategies to control **TME growth**

Health Equity Considerations in the ACO Certification Program

Health Equity in the Standards

In accordance with the HPC's action plan to ensure that health equity is a core component of our work today and going forward, ***health equity concepts will be embedded*** *into the ACO Certification program.*

- Propose to require **stratification by race/ethnicity or other socioeconomic factors** of data collected by ACOs to:
  - Monitor **patient experiences** in AC-1, and
  - Understand the needs of and stratify patients for **population health management programs** in AC-4
- Supplemental information questions will gather data on **ACO activities and priorities** to promote health equity, such as data collection, recruitment, and program development.

Opportunities for Certified ACOs

Information collected in the ACO Certification process may be used to focus new **technical assistance, investment, or other opportunities** specifically for Certified ACOs to accomplish improvements related to health equity

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Key Questions for Discussion

1. Does the **"learning health system" framework make sense** as the focus of the next cycle of ACO certification?

2. Are we capturing **the right topics**? Is there **anything obviously missing**?

3. Is the HPC's **commitment to applying a health equity lens appropriately represented** in the proposed criteria?

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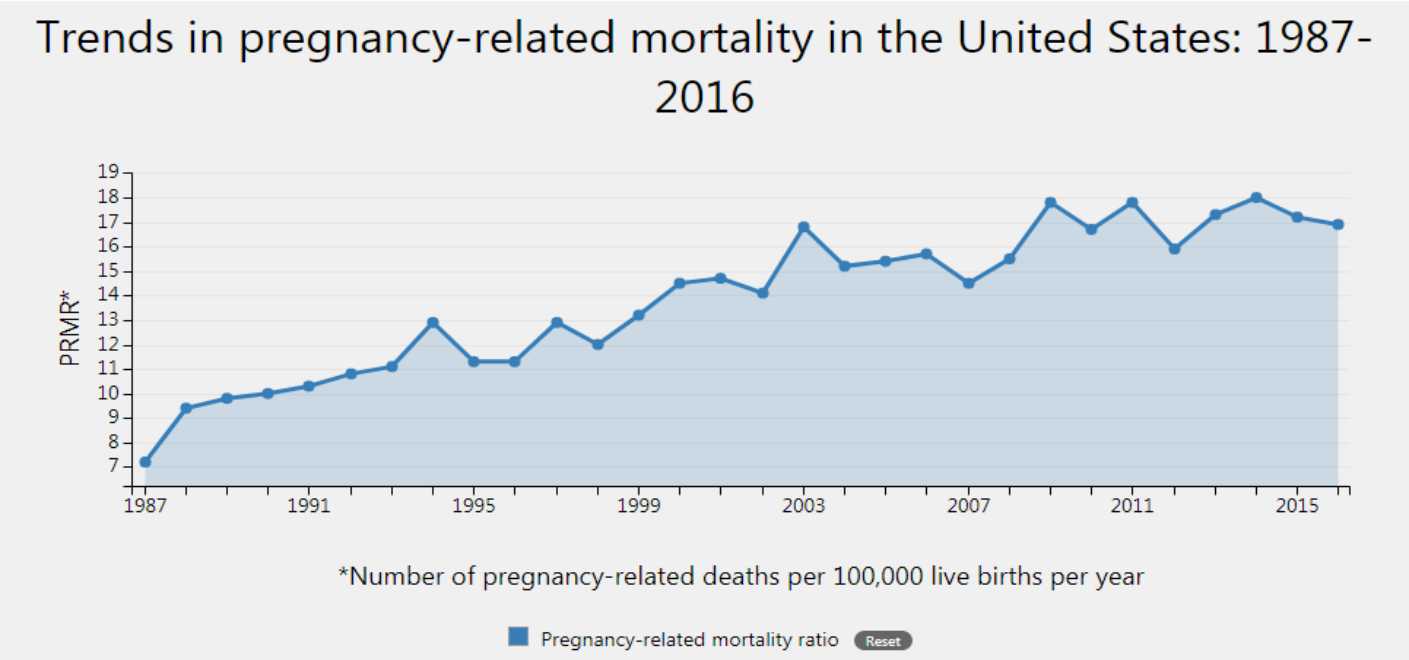
Legislative Language

SECTION 88. The health policy commission, in consultation with the department of public health and the Betsy Lehman center for patient safety and medical error reduction, shall implement a **2-year pilot program to reduce pregnancy-related deaths and improve pregnancy outcomes.** The commission shall consider evidence-based practices from successful programs implemented nationally and internationally in the development of the program. The department of public health shall provide relevant data to the commission in order to determine scope and scale of the program, including data on volume and prevalence of pregnancy-related deaths. **The commission shall select implementation sites through a competitive process in which applicants shall demonstrate: (i) community need; (ii) the capacity to address preventable causes of complications and death related to pregnancy and child birth; (iii) the ability to facilitate care coordination among health care providers; and (iv) a plan to formalize relationships between health care providers, including hospitals and community-based care providers**. The commission shall collect data to gauge the success of the program in decreasing pregnancy-related deaths and **track trends within the patient population, including, but not limited to, variance by age, race, and co-morbidities.** The commission shall issue a report annually, on or before June 30, to the joint committee on public health and the clerks of the house of representatives and the senate, which shall include program progress updates and outcomes data.

National Data and Trends

US Maternal Mortality Since 1987

- The pregnancy-related mortality ratio has increased from 7.2 deaths per 100,000 live births in 1987 to 16.9 deaths per 100,000 live births in 2016. The peak was 18 deaths per 100,000 live births in 2014.[1]
- 65.8% of pregnancy-related deaths between 2008-2017 were determined to be preventable.[2]



1. Center for Disease Control. (2020). Pregnancy Mortality Surveillance System. Retrieved from https://www.cdc.gov/reproductivehealth/maternal-mortality/pregnancy-mortality-surveillance-system.htm
2. Davis NL, Smoots AN, Goodman DA. Pregnancy-Related Deaths: Data from 14 U.S. Maternal Mortality Review Committees, 2008-2017. Atlanta, GA: Centers for Disease Control and Prevention, U.S. Department of Health and Human Services; 2019.

Racial and Ethnic Inequities in Massachusetts Maternal Mortality and Morbidity

- MA has the **2nd lowest maternal mortality** in the country,[1] but significant inequities by race and ethnicity exist.
- From 1998-2013, **Black non-Hispanic women** (175 per 10,000 hospitalizations) had **twice the rate of severe maternal morbidity (SMM)** including blood transfusion during delivery hospitalization as **White non-Hispanic women** (83 per 10,000 hospitalizations).[2]
- During 2000-2007, Black non-Hispanic women were **twice as likely to experience pregnancy-associated death** compared to White non-Hispanic women.[3]

1. America's Health Rankings analysis of CDC WONDER Online Database, Mortality files, United Health Foundation, AmericasHealthRankings.org, Accessed 2020.
2. Massachusetts Department of Public Health. Massachusetts State Health Assessment. Boston, MA; October 2017.
3. Maternal Mortality and Morbidity Review in Massachusetts: A Bulletin for Health Care Professionals, Pregnancy-Associated Mortality. 2000-2007. Boston, MA: Bureau of Family Health and Nutrition. Massachusetts Department of Public Health. February 2014.

Stakeholder Engagement

Accompany doula care

MARCH FOR MOMS

Steward Health Care Network

HEALTH CHOICE MASSACHUSETTS

PN QIN OF MASSACHUSETTS

PERINATAL-NEONATAL QUALITY IMPROVEMENT NETWORK

COMMONWEALTH OF MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH

COMMONWEALTH OF MASSACHUSETTS

BETSY LEHMAN CENTER for Patient Safety

MassHealth

THE 191ST GENERAL COURT OF THE COMMONWEALTH OF MASSACHUSETTS

Birth Sisters at BOSTON MEDICAL CENTER

EXCEPTIONAL CARE. WITHOUT EXCEPTION.

Themes from Discussions with Stakeholders

Opportunities and potential value

- Given the low incidence of pregnancy-related deaths in MA, it would be valuable to expand the scope to include **pregnancy-associated deaths and severe maternal morbidity.** While overall rates of these stats are low, **troubling inequities in outcomes by race and ethnicity persist**
- Doula-led care has been identified as a promising care model that improves health outcomes, lowers cost, and **reduces health inequities** especially for vulnerable populations
- Stakeholders emphasized the importance of affordable, accessible trainings and sufficient reimbursement rates to ensure a **diverse doula workforce**
- There is opportunity to **align work with other agencies and organizations in MA**

Clinical and operational considerations

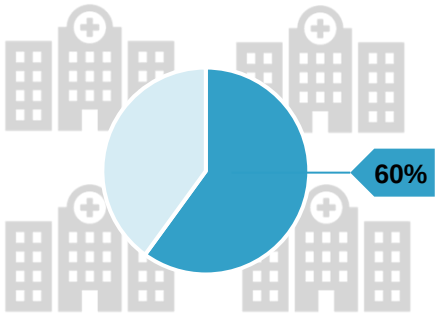
- Black, Indigenous, and People of Color (BIPOC), specifically Black birthing people, continue to have **negative experiences during hospital births**; it is important to understand and respect birthing people's decision on where and how to receive care
- A challenge for **sustainability** of a diverse doula workforce is training and support with adequate compensation
- It is important to clearly define a **target population** (e.g., Black birthing people, Hispanic birthing people, Native American birthing people)

Data on Black Birthing People in Massachusetts

1 in 10 births in Massachusetts are by Black Non-Hispanic birthing people[1]

11 of 30 of the biggest municipalities in Massachusetts have Black birthing percentages over 10.3%[1]

8 hospitals in Massachusetts have in house doula programs or partnerships with doula organizations



60% of births by Black birthing people in 2000 occurred at four hospitals [2]

1. Nergheen, V., Murray, L. (2019). *Massachusetts Births 2017.* Dorchester, MA. Massachusetts Department of Public Health
2. Massachusetts Department of Public Health. Births to Black Mothers in Massachusetts:1997-2000. December 2002.

Birth Justice

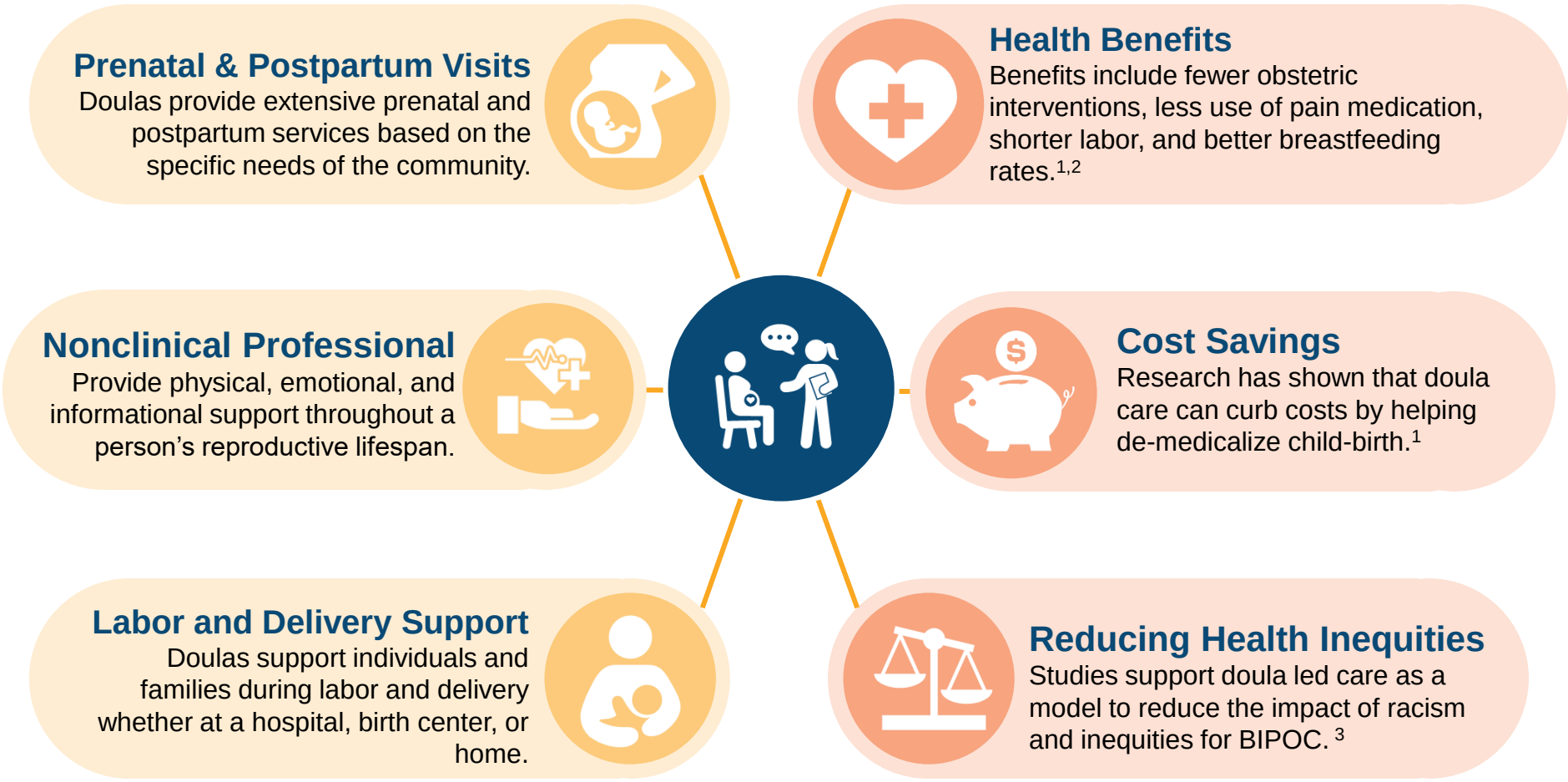
Birth justice is achieved when individuals are able to make informed decisions during pregnancy, childbirth, and postpartum, that is free from racism, discrimination of gender identity, and implicit bias. Birth justice requires that individuals fully enjoy their human rights regarding reproductive and childbirth-related health decisions, without fear of coercion, including coercion to submit to medical interventions, reprisal for refusal of care, and/or face the threat of inadequate medical care. Birth justice centers the intersectional and structural needs of individuals and communities.

Advancing Birth Justice: Community-Based Doula Models as a Standard of Care for Ending Racial Disparities

Ancient Song Doula Services, Village Birth International, and Every Mother Counts

Source: Ancient Song Doula Services, Village Birth International, and Every Mother Counts. Advancing Birth Justice: Community-Based Doula Models as Standard of Care for Ending Racial Disparities. March 2019. Retrieved from https://everymothercounts.org/wp-content/uploads/2019/03/Advancing-Birth-Justice-CBD-Models-as-Std-of-Care-3-25-19.pdf

What is a doula? What is the connection between doulas and racial equity?



1. Kozhimannil KB, Hardeman RR. Coverage for Doula Services: How State Medicaid Programs Can Address Concerns about Maternity Care Costs and Quality. Birth. 2016;43(2):97–9.

2. Kozhimannil, K. B., Attanasio, L. B., Hardeman, R. R., & O'Brien, M. (2013). Doula care supports near-universal breastfeeding initiation among diverse, low-income women. *Journal of midwifery & women's health*, *58*(4), 378–382. https://doi.org/10.1111/jmwh.12065

3. Bey A, Brill A, Porchia-Albert C, Gradilla M, Strauss N. Advancing Birth Justice: Community-Based Doula Models as a Standard of Care for Ending Racial Disparities. Ancient Song Doula Services, Village Birth Internationl, and Every Mother Counts. 2019 Mar 25;33.

Doula Landscape in Massachusetts

Training and Certification

- Doula trainings can range from one weekend to 80-hours
- There is currently no nationally regulated certification process to be a doula
- Many organizations offer certifications, but the process greatly varies; the leading certifying agency is DONA International

Reimbursement and Payment

- Doula care has not traditionally been covered by private insurance or Medicaid, which can create barriers to access
  - Medicaid coverage for doula services has been piloted in other states and there is currently legislation pending in Massachusetts
- Some health systems have found innovative ways to provide doula care to their patients
  - Examples include philanthropy dollars, ACO case management strategies, or volunteer doulas
- Doulas can be reimbursed using global payment, fee for service, or a combination of payment models

MA Doula Organizations/Programs

- Doula Organizations: Accompany Doula Care, Green River Doulas, Boston Doula Circle, Pettaway Pursuit Foundation, Springfield Community Doulas
- Doula Programs: Birth Sisters, Birthing Gently, Doula by My Side
- Doulas also operate independently

Design Elements and Principles for Investment Program

Support comprehensive doula care models

Support doula care models that provide extensive prenatal, labor and delivery, and postpartum services based on the specific needs of the community they serve by training and employing a diverse doula workforce.

Focus on people of color, specifically Black birthing people

Utilize data to better understand where BIPOC, specifically Black birthing people, are receiving perinatal services, and design a targeted program to serve these populations.

Promote collaboration between doula-based organizations and health care organizations (e.g. ACOs, hospitals, FQHCs)

Facilitate partnerships between health care organizations and existing doula agencies or programs to better integrate a doula workforce that supports birthing people in their communities.

Align with other efforts

Coordinate with policy makers, state agencies, and doula organizations at the state and national level to align efforts that focus on addressing racial inequities in maternal health outcomes.

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What could a doula-focused care model look like?

Doula organization & ACO partnership

Doula employed by the doula organization

A maternal child health case manager at the ACO identifies a pregnant patient eligible for doula services

The case manager reaches out to the patient and explains what a doula is and asks whether they are interested

Case manager works with the doula organization to match the doula with the patient's preferences

Doulas work with birthing parent through pregnancy, labor and delivery, and 6 weeks postpartum

Hospital-based doula care model

Doula employed by the hospital

Provider at Federally Qualified Health Center identifies an eligible patient who plans to deliver at the hospital

If the patient is interested in accessing doula services, the provider refers the patient to the hospital's doula program

The hospital connects the patient to a doula that is employed by the hospital

Doulas work with birthing parent through pregnancy, labor and delivery, and 6 weeks postpartum

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Proposed Investment Program Structure

The Investment Program will offer **$500,000 for two pilot programs over two years**. The aim of the Investment Program will be to **increase access to doula services** to **mitigate known racial and ethnic inequities**, enhance patient experience of care, and improve outcomes.

- **Target Population:** The program will support birthing people, particularly Black birthing people, throughout the prenatal, labor and delivery, and postpartum periods

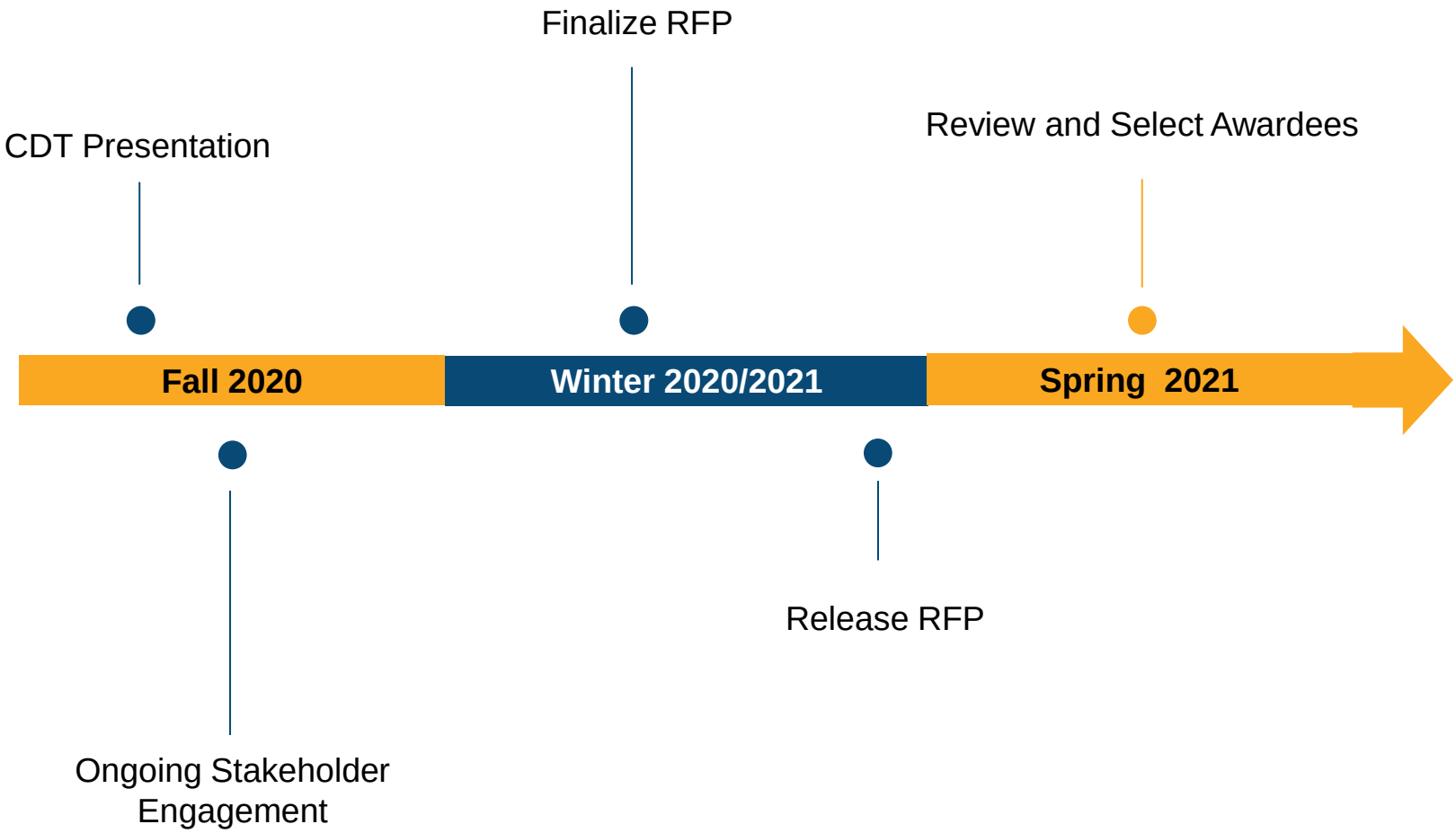
- **Key Elements:** Using HPC funding, Awardees will provide doula services to target population birthing people during the prenatal, labor and delivery, and postpartum period

  Doulas will provide perinatal support and provide connections to health care providers and social service providers.

  Other considerations include approaches to building and recruiting a diverse doula workforce (including potential to fund doula scholarships) and a commitment to providing culturally competent care that recognizes the impact of bias.

- **Additional HPC Report:** Training and resource development related to the role, support, and impact of doulas

Proposed Timeline



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SHIFT-Care Investment Program

A $10 million opportunity to address the whole-person needs of patients and reduce avoidable acute care use through innovative care models.

15 awards, with a focus on:

Health-related social needs ♦ **Timely access to BH** ♦ **Evidence-based OUD care**

Community Care Cooperative (C3)

- C3 developed ***Healthy Connections***, a community-based, integrated care management program for patients with complex needs.
- It includes intensive patient engagement with **community health workers** and **care managers** to identify and work towards **patients' health-related goals**, including addressing their medical, behavioral health, and social needs.

North Shore Medical Center (NSMC)

- NSMC's program **expands access to opioid use disorder (OUD) treatment** by offering medication for addiction treatment (MAT) initiation for patients who have experienced opioid overdose or who screen positively for OUD in the Emergency Department and on inpatient floors.
- NSMC is focused on building staff **capacity to prescribe buprenorphine**, and on implementing **anti-stigma efforts** throughout the hospital.

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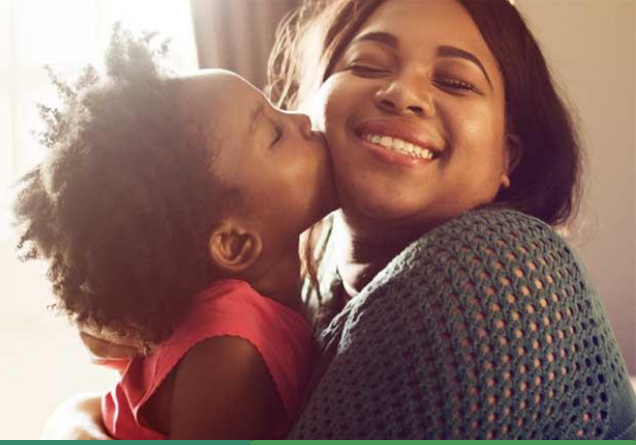
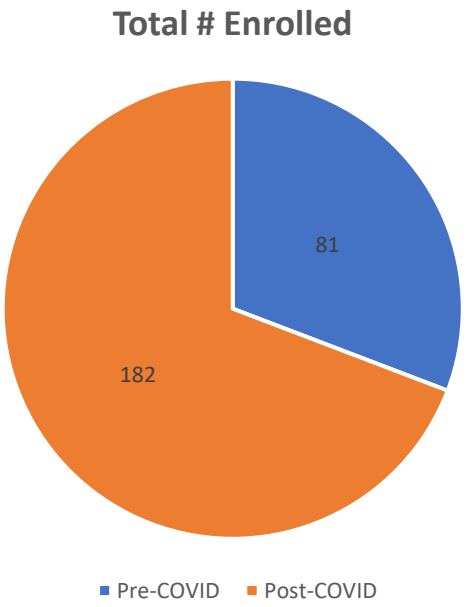
COMMUNITY CARE COOPERATIVE



Healthy Connections

September 30, 2020

Healthy Connections Data: Pre-COVID/Post-COVID



Closure Reasons by Time Period		
	Post-COVID	Pre-COVID
Closed - Goals Met	40%	20%
Closed - Lost Contact	45%	53%

COMMUNITY CARE COOPERATIVE

Biggest Lessons

- Cold calling works
- Housing, Housing, Housing
- Legal expertise integration
- Community Health Workers are awesome

The Value of Healthy Connections

1. ER Diversion

2. Little Big Things

3. Reducing missed appointments

Healthy Connections: DJ Dream Fund

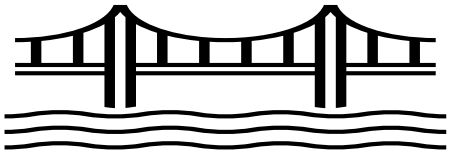
- From DJ Dream Fund Facebook Page regarding a C3 Patient/Family:

Little Big Things

Case Success Story:

Member is a 50-year-old Cape Verdean male who currently lives with his older daughter. His goals were housing, food, and financial stability. The member had already applied for housing before starting Healthy Connections and the CHW was able to call housing and was informed that the member is on the waiting list. When the member started Healthy Connections, he was worried about being financial unstable to take care of his daughter. The member got denied several times for SSI, and the CHW was able to get connected with the member's lawyer and fill in the language barrier between the member and his lawyer. After 3 months of communicating with the member and his lawyer, the member finally got approved for SSI and he is now receiving $850 monthly. The member was already receiving food stamps before we started working together but member was still struggling with getting more food. The CHW was able to educate the member on different resources for food such as food pantries around his neighborhood. The CHW was also able to help the member's youngest daughter with a college application and was also able to get the member a discounted price on his electricity bill. The member shared how he was struggling paying for fuel/gas and the CHW was able to get member fuel assistance. The member was very satisfied with the help that he received and the CHW made sure the patient had a good relationship with his PCP and health center before closing this case. The CHW also advised the member to call if any other needs come up and the CHW will call the member within 1 month to make sure no new needs are present.

Learning to Rebuild Bridges



Leigh Hardy, LICSW and MSW Intern, Dennis Falcione, worked with member dx with BPD, SUD, PTSD who had almost no provider or social supports. Most of this member's historical relationships ended in "burning bridges." While preparing for termination with this member, Dennis was concerned that member may feel the termination reinforces the member's thoughts that providers "never help," "always leave," or "don't like me." To his surprise, member responded to Dennis with "you are one of the good ones" and "I want to apologize, again, for when I was rude to you." Among other goals accomplished, member now has an additional provider support at a drop-in center, more positive friendships, and continues to be connected to HC PCP. Relationship with member has also helped divert potential IP admissions of member. The member will sometimes call Leigh while in ER. Leigh then helps advocate for a d/c or CSU admit, if appropriate.

***Member learning*:** extrapolate positive termination experience to future helping relationships

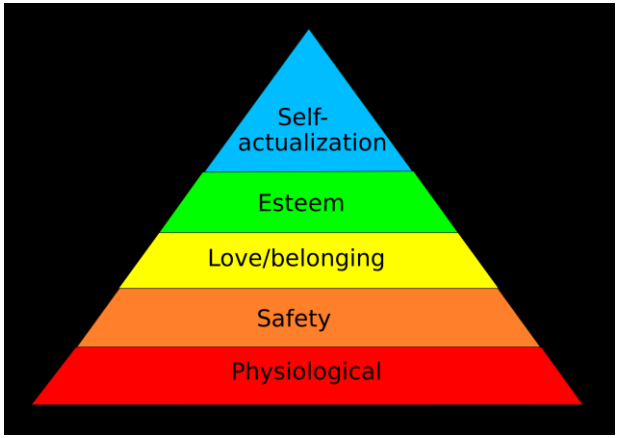
***Healthy Connections/C3 learning*:** an additional positive outcome to measure program's success

***Intern learning*:** therapeutic skills for complex/vulnerable people

Important Elements

- **Flexibility:**
  - Community-Based
  - Caseload 25-30

- **Emphasis on HRSN**



- **CHWs are awesome!**

Lived experience

+

Therapeutic rapport

=

More efficient interventions

Program Next Steps

HEALTHY CONNECTIONS TEAM WILL CONTINUE TO WORK WITH ELIGIBLE PATIENTS THROUGH 12/31/2020

HEALTHY CONNECTIONS WILL STOP TAKING REFERRALS ON 11/2/2020 (PROJECTED DATE; MAY CHANGE DEPENDING ON CASELOAD VOLUME OF CHHWS)

REPORTING ON HEALTHY CONNECTIONS TO HPC WILL ONLY INCLUDE PATIENTS DURING GRANT PERIOD AND WILL CUT OFF ON 10/31/2020

North Shore Medical Center: SHIFT-Care Update to the Health Policy Commission

September 30, 2020

Mark Schechter, M.D. and Tina McLoughlin

NORTH SHORE MEDICAL CENTER

PARTNERS HEALTHCARE | FOUNDED BY BRIGHAM AND WOMEN'S HOSPITAL AND MASSACHUSETTS GENERAL HOSPITAL

NSMC SHIFT-Care Status Prior to COVID-19

- NSMC's SHIFT-Care initiative is a key element of our strategic priority to "Improve Care and Reduce Stigma in SUD patients"
  - » Substance Use Disorder Steering Committee oversight
  - » Program implementation coincided with hospital-wide SUD anti-stigma training
- Recovery coaches have become a critical part of our care teams and have played a huge role championing our program
  - » 100-150 ED patient connections per month
  - » Deescalating situations in the Emergency Department
  - » Long term financial sustainability is a challenge
- Higher treatment engagement rates for inpatients than ED patients
  - » Shifted focus to inpatients
  - » All ED physicians and hospitalists obtained their DEA X waiver
- Development of ED and IP SUD data dashboards

NSMC SHIFT-Care COVID-19 Response

- NSMC experienced a significant reduction in non-COVID related ED visits from March to May
  - The volume and percentage of treatment eligible patients decreased
- NSMC immediately transitioned our recovery coach program to operate virtually
  - 100% of ED SUD patients were contacted by a recovery coach following discharge
  - Some patients preferred virtual engagement, emphasizing the importance of post-discharge follow-up
  - Inpatients were connected to recovery coaches via telephone and zoom
- NSMC has continued our SUD Steering Committee meetings despite the pandemic
- ED volume has picked up in recent months; the volume of treatment eligible patients (particularly inpatients) has also increased

NSMC SHIFT-Care Lessons Learned

- Importance of senior leadership buy-in and steering committee oversight
- The Emergency Department is a difficult environment to engage patients in suboxone treatment
- Recovery coaches can play a huge role connecting patients to MAT and other services after the initial ED encounter
  - » Even though our ED engagement rates are low, the impact of connecting ED patients to recovery coaches has resulted in treatment engagement down the road
- Stigma associated with BH and SUD patients is a barrier to treatment
- Data drives change

Opportunities looking forward….

- Support for SUD patients at other points of care
- Acute Psych Services team in the ED
- Geri Psych outpatients services
- Right sizing detox beds
- Increased access to outpatient care for teens suffering from substance use (eg bridge clinic with walk-in medical and behavioral health services available)
- Universal screening of social determinants of health in the ED

MASSACHUSETTS
HEALTH POLICY COMMISSION

AGENDA

- Call to Order
- Approval of Minutes
- ACO Certification Program Design
- Maternal and Child Health Investment Program: Stakeholder Feedback and Preliminary Investment Design
- Awardee Presentations: SHIFT-Care Investment Program and COVID-19 Impact
- **New and Upcoming Publications: CHART Reports and ACO Datapoints**

New and Upcoming HPC Publications in 2020

Updated Opioid Data Chartpack

Findings on opioid-related acute hospital utilization in Massachusetts through 2018 highlighting trends in ED and inpatient use, and health inequities by race, ethnicity, and income.

CHART Playbook

New!

Practical resource based on lessons learned from CHART program awardees for providers working to address the needs of medically and socially complex patients.

HPC-Certified ACO Profiles

High-level summary of each HPC-certified Accountable Care Organization recertified in December 2019.

HPC

CHART Phase 2 Evaluation Report

New!

Findings from the CHART Phase 2 Investment Program, including key outcomes related to the operational use of data, integration of whole-person care, partnerships, hospital utilization, and patient experience.

DataPoints: HPC-Certified Accountable Care Organizations in Massachusetts

Key facts about HPC-certified ACOs, focusing on risk contracts, approaches to provider compensation, and delivery system improvement efforts.

New!

Policy Brief: Serious Illness and End of Life Care in the Commonwealth

New data on end of life care for Medicare beneficiaries in Massachusetts by race and ethnicity including service intensity and hospice use, and early trends in the use of advance care planning.

Performance Improvement Plans in Massachusetts: Reflections on Five Years of Evaluating Payer and Provider Spending Performance

Overview of successes and challenges in the process for monitoring and enforcing payer and provider performance relative to the health care cost growth benchmark.

MASSACHUSETTS
HEALTH POLICY COMMISSION

Appendix:

Detail on ACO Certification Proposed Standards

Assessment Criterion 1: Patient-Centered Care
Proposed Standard

Patient-Centeredness	Culture of Improvement	Data-Driven Decisions	PHM Programs	Whole-Person Care

The ACO collects and uses information from patients to improve and deliver patient-centered care.

The ACO's leadership **systematically monitors and assesses** patient experience, perspectives, and/or preferences of the patient population served. Data or patient input collected as part of this process allows for **stratification by race/ethnicity or socioeconomic factors.**

This information—collected from sources like validated patient experience data or other patient surveys and feedback—**informs the ACO's strategy and/or organization-level initiatives** for improving care delivery.

Assessment Criterion 1: Patient-Centered Care
Potential Documentation Requirements

Patient-Centeredness	Culture of Improvement	Data-Driven Decisions	PHM Programs	Whole-Person Care

Option	Type	Description
A. Collecting information on patient experience, perspectives (ACOs must provide documentation of <u>one</u>)		
1	ACO doc. / brief narrative	Example(s) of **monitoring of patient experiences** on large scale (e.g., periodic surveys, online communities, patient focus groups, PES collection)
OR		
2	ACO doc. / brief narrative	Data collection on **cultural, linguistic, literacy, etc. needs**
OR		
3	Narrative / ACO doc.	Demonstration of **robust consumer participation in governance and bodies informing leadership** (e.g., consumer representation on Governing Body and use of PFACs)
B. Using information from AC-1.A to inform strategy (ACOs must provide documentation of <u>one</u>)		
1	ACO doc.	Written plans for identifying **areas for improvement via CAHPS or other PES surveys** and **implementing strategies** to improve
OR		
2	Narrative	Description of **one ACO- or system-level initiative** to improve an aspect of patient experience in past two years
OR		
3	ACO doc.	**Outreach campaigns** or mobile alert programs to engage patients (population or need identified via data in **A**)

Assessment Criterion 2: Culture of Performance Improvement
Proposed Standard

Patient-Centeredness	Culture of Improvement	Data-Driven Decisions	PHM Programs	Whole-Person Care

The ACO fosters a culture of continuous improvement, innovation, and learning to improve the patient experience and value of care delivery.

This culture is demonstrated by such things as: ACO-sponsored **citizenship activities** for ACO Participants; demonstrated **leadership commitment;** internal **financial incentives;** defined **systems or pathways for innovation and improvement; selection or evaluation of partners** based on alignment with ACO cultural priorities; or support for a **primary care transformation strategy**.

*The term “performance improvement’ is used broadly here to refer to activities or processes to improve on cost, quality, patient experience, efficiency, access, or outcomes metrics tracked under risk contracts **or** other internal goals for increasing the value of care delivery among ACO Participants. The term is not intended to refer to any particular methodology or formal training program.

Assessment Criterion 2: Culture of Performance Improvement
Potential Documentation Requirements

Patient-Centeredness | **Culture of Improvement** | Data-Driven Decisions | PHM Programs | Whole-Person Care

Option	Type	Description
Applicants must provide documentation of **two** of the following:		
1	ACO doc. or narrative	**ACO-sponsored improvement-oriented citizenship activities**, such as teaching or learning sessions, organizational management activities, or recruitment strategies aimed at advancing a culture of improvement
OR		
2	ACO dashboard or narrative	**Leadership commitment to creating a culture of performance improvement** demonstrated by tracking of system or ACO-level quality and financial metrics against ACO goals by leadership, or a narrative describing how the Governing Body(ies) sets strategic PI goals
OR		
3	ACO doc. or narrative	**Defined systems or pathways for improvement and innovation,** such as implementation of systems learning and/or process improvement approaches, or an example of an initiative where frontline staff identified waste/ inefficiency/quality improvement opportunities and were empowered by leadership to test and/or scale proposed solutions
OR		
4	ACO doc. or narrative	**Internal financial incentives**, e.g., funds flow, compensation structure, or other incentives, encouraging provider adherence to an organizational performance improvement strategy
OR		
5	ACO doc. or narrative	**Metric-based selection or evaluation** of preferred clinical or non-clinical partners to encourage alignment with ACO culture
OR		
6	ACO doc. or narrative	Support for an ACO-or-system-wide **primary care practice transformation strategy** based on advanced primary care principles, including continuous quality improvement

HPC

Assessment Criterion 3: Data-Driven Decision-Making and Care Delivery
Proposed Standard

Patient-Centeredness	Culture of Improvement	Data-Driven Decisions	PHM Programs	Whole-Person Care

The ACO is committed to using the best available data and evidence to guide and support improved clinical decision-making.

To facilitate learning among providers, decrease unwarranted variations in care delivery, and support provider adherence to evidence-based guidelines, the **ACO adopts processes or tools that make available reliable, current clinical knowledge at the point of care**.

The ACO also collects and offers providers **actionable data** (e.g., on quality, safety, cost, and/or health outcomes) to guide clinical decision-making, identify and eliminate waste, and enable high-value care delivery.

Assessment Criterion 3: Data-Driven Decision-Making
Potential Documentation Requirements

Option	Type	Description
A. Tools or processes to improve care delivery (ACOs must provide documentation of <u>one</u>)		
1	ACO narrative or ACO doc.	Description of data-driven **initiative to reduce waste/low-value care or decrease unwarranted variations in care delivery**, including outcome of intervention, in past two years
OR		
2	ACO doc. and/or short narrative	Example of **clinical decision support tool** in use, description of prevalence of use, and description of how often advice was overridden by clinicians and if/how the ACO is responding to overrides
OR		
3	ACO doc. and/or short narrative	Example of **evidence-based protocol or structured learning opportunity** developed or made available to providers and description of prevalence of use
B. Actionable data for improvement (ACOs must provide documentation of <u>one</u>)		
1	ACO dashboard or report	**Timely, actionable data and/or feedback** on cost/quality performance at the provider or group level is provided periodically, benchmarked to peers or external standard
OR		
2	ACO doc. or dashboard	**Data analytics** offer providers understandable, actionable information on patient panels (e.g., identify patients due for mammograms, or diabetic patients in need of HbA1c tests)

Assessment Criterion 4: Population Health Management Programs
Proposed Standard

Patient-Centeredness	Culture of Improvement	Data-Driven Decisions	PHM Programs	Whole-Person Care

The ACO develops, implements, and refines programs and care delivery innovations to coordinate care, manage health conditions, and improve the health of its patient population.

The ACO **utilizes data** to understand the health needs of its patient population. This may include use of stratification algorithms, predictive analytics, or patient screening tools in primary care settings. Data or patient input collected as part of this process allows for **stratification by race/ethnicity or socioeconomic factors.**

The ACO uses this data to design and implement **one or more patient-facing population health management programs** that address areas of need for a defined patient population. The ACO **sets targets for and measures the impact of these programs** to support continuous performance improvement over time.

Assessment Criterion 4: Population Health Management Programs
Potential Documentation Requirements

Option	Type	Description
A. Data and analytics to understand patient needs (ACOs must provide documentation of <u>one</u>)		
1	Narrative or HPC template	Use of clinical, claims, and/or socio-demographic data in **patient stratification algorithms** or **predictive analytics**
OR		
2	Narrative or ACO doc.	Routine use of **standardized screening tools** in primary care settings to identify patients who would benefit from PHM programs
B. Population health management programs, targets, and metrics for improvement		
1	HPC template	PHM **programs and targets template** (identifying priority area/program, populations targeted, goals and metrics, progress on metrics, and/or program change(s) made in past two years based on data gathered or targets missed over the course of implementation)

Assessment Criterion 5: Whole-Person Care
Proposed Standard

Patient-Centeredness	Culture of Improvement	Data-Driven Decisions	PHM Programs	Whole-Person Care

The ACO recognizes the importance of non-medical factors to overall health outcomes and cost of care and seeks to integrate behavioral health and health-related social supports into its care delivery models.

The ACO has taken steps – with respect to workforce, administration, clinical operations, and/or funding – to **integrate behavioral health care** into primary care settings. The ACO also **sets and measures progress on discrete goals** for further increasing integration over time.

The ACO also has taken steps to **understand and address its patients' health-related social needs** through screening and referral relationships with community-based and/or social service organizations. The ACO also **sets and measures progress on discrete goals** for improving the effectiveness of these processes.

Assessment Criterion 5: Whole-Person Care
Potential Documentation Requirements

Option	Type	Description
A. Behavioral Health Integration (ACOs must provide documentation of <u>one</u>)		
1	HPC template	*If an ACO- or system-wide strategy is in place:* BHI **progress and targets template** (including space for a brief narrative providing overview of status of ACO or system-level BHI strategy) identifying priority area, implementation goals and metrics, current performance and future targets.
OR		
2	Narrative or ACO doc.	*If no ACO- or system-wide strategy is in place:* Implementation of at least one ACO-supported initiative featuring **close collaboration approaching an integrated practice***
B. Support for Social Needs		
1	ACO doc. or narrative	Implementation of **HRSN screening processes** and use of **bi-directional methods or platforms** to refer patients to community services and facilitate communication between the ACO, PCP, and community-based service provider, including description of metrics tracked (including current performance and targets)

*As defined in the SAMHSA-HRSA Center for Integrated Health Solutions Levels of Integration Framework

Resources

Gordon and Betty Moore Foundation and American Institutes for Research. “A ROADMAP FOR Patient + Family Engagement in Healthcare Practice and Research.” (2014) https://www.air.org/sites/default/files/Roadmap-Patient-Family-Engagement.pdf

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Institute of Medicine. *Best Care at Lower Cost: The Path to Continuously Learning Health Care in America*. (2013) http://nap.edu/13444

Matthew DeCamp, Jeremy Sugarman, and Scott Adam Berkowitz. “Meaningfully Engaging Patients in ACO Decision Making.” *The American Journal of Accountable Care,* June 2015. https://www.ajmc.com/journals/ajac/2015/2015-vol3-n2/meaningfully-engaging-patients-in-aco-decision-making

Ann S. O’Malley, Eugene C. Rich, Rumin Sarwar, Eli Schultz, W. Cannon Warren, Tanya Shah, and Melinda K. Abrams. “How Accountable Care Organizations Use Population Segmentation to Care for High-Need, High-Cost Patients.” The Commonwealth Fund. January 2019. https://www.commonwealthfund.org/publications/issue-briefs/2019/jan/how-acos-use-segmentation-high-need-high-cost

Clare Pierce-Wrobel and Jeff Micklos. “How the Most Successful ACOs Act as Factories of Innovation.” https://www.healthaffairs.org/do/10.1377/hblog20180124.514403/full/

Anthony Shih, Karen Davis, Stephen C. Schoenbaum, Anne Gauthier, Rachel Nuzum, and Douglas McCarthy. “Organizing the U.S. Health Care Delivery System for High Performance.” The Commonwealth Fund. August 2008. https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_fund_report_2008_aug_organizing_the_u_s__health_care_delivery_system_for_high_performance_shih_organizingushltcaredeliverysys_1155_pdf.pdf