MeHI
MASSACHUSETTS eHEALTH INSTITUTE
at the MassTech Collaborative

2017 MeHI Forum

for Connected Communities Grantees and Collaborators

Wednesday, December 13th, 2017

Welcome Grantees and Community Collaborators

- **Behavioral Health Network**
  - Holyoke Health Center
  - Pioneer Valley Information Exchange (PVIX)
  - Trinity Health of New England (Mercy Medical Center/Providence Behavioral Health Hospital)
  - SMC Partners, LLC
- **Berkshire Health Systems**
  - Berkshire Medical Center
  - Berkshire Healthcare Systems
  - Family Practice Associates
- **Cape Cod Healthcare**
  - Duffy Health Center
  - ECG Management Consultants
- **Lowell General PHO**
  - Genesis HealthCare
- **Brockton Neighborhood Health Center**
  - Brockton Area Multi-Services, Inc. (BAMSI)
  - High Point Treatment Center
  - Signature Healthcare Brockton Hospital
- **Reliant Medical Group**
  - AdCare Hospital
  - Jewish Healthcare Center
  - Milford Regional Medical Center
- **Upham's Corner Health Center**
- **Whittier IPA, Inc.**
  - Great Lakes Caring
  - Amesbury Psychological Center, Inc.
  - Country Center for Health and Rehab.

MeHI Staff Supporting the Connected Communities Program

- **Keely Benson, Connected Communities Program Manager**
  - Working with Lowell General PHO, Upham's Corner Health Center, and Whittier IPA
- **Stephanie Briody, Community Manager**
  - Working with Brockton Neighborhood Health Center and Cape Cod Healthcare
- **Andrea Callanan, Community Manager**
  - Working with Behavioral Health Network, Berkshire Health Systems, and Reliant Medical Group
- **Olivia Japlon, eHealth Programs Associate**
- **Joe Kynoch, Technical Project Manager**

Today's Agenda

- Welcome and State of Technology and Innovation in Massachusetts
- Overview of MassHealth ACOs and Community Partners Program
- Engaging Community Collaborators, Presented by Brockton Neighborhood Health Center
- *Break*
- Connected Communities Workflow Best Practices Panel
- *Lunch and Networking*
- MeHI's 2016 Learning Collaborative: Overview and Work Products
- MeHI's 2017 Learning Collaborative: Overview of Use Cases and Work Products
- Reminder: Mass HIway Connection Requirement
- Closing Remarks

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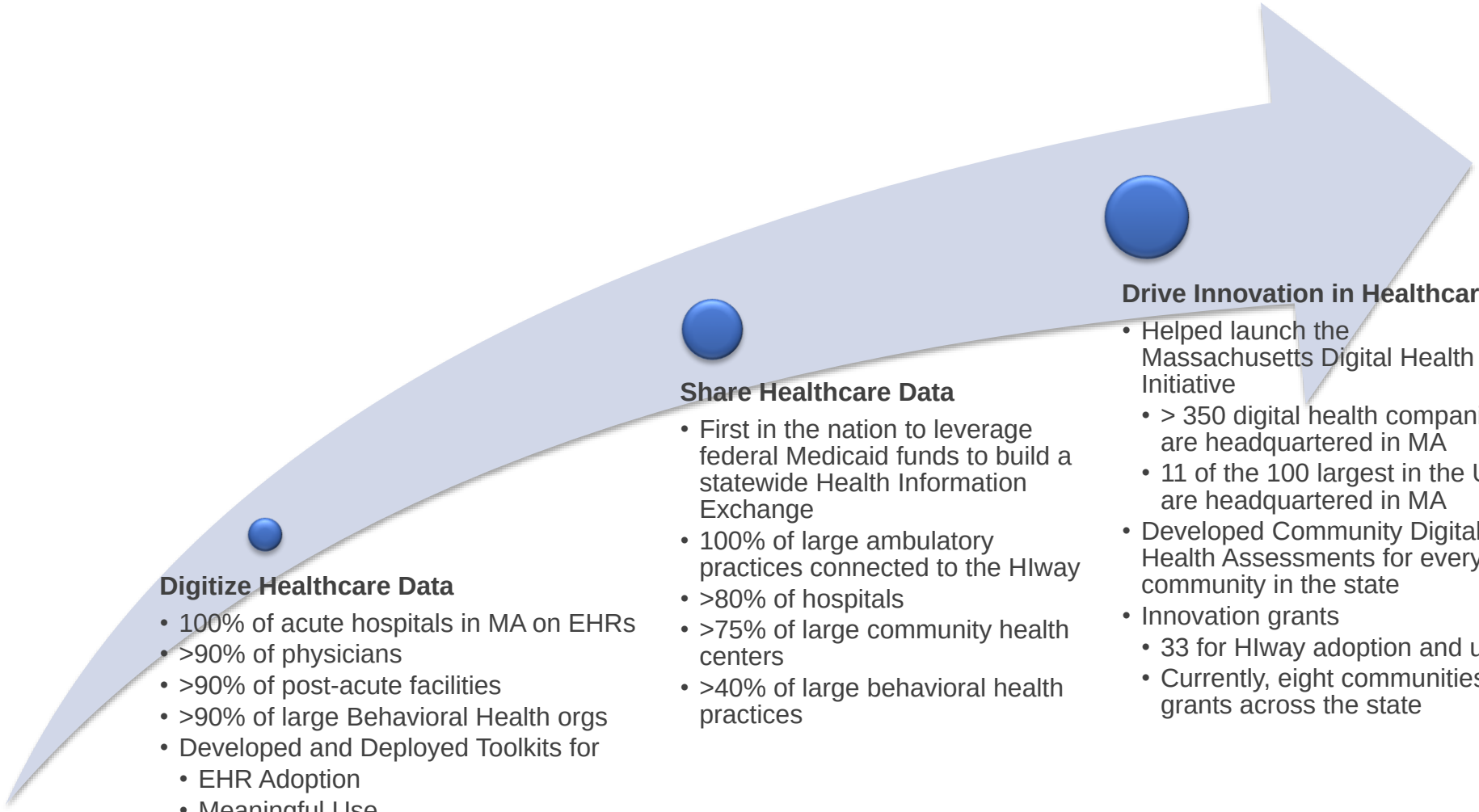
State of Healthcare Technology and Innovation in Massachusetts

Laurance Stuntz, Director, MeHI

MeHI: Healthcare Technology & Innovation 2008 – 2017+



Digitize Healthcare Data

- 100% of acute hospitals in MA on EHRs
- >90% of physicians
- >90% of post-acute facilities
- >90% of large Behavioral Health orgs
- Developed and Deployed Toolkits for
  - EHR Adoption
  - Meaningful Use
  - Health Information Exchange
- Direct support for >70 hospitals, >8,000 physicians, and hundreds of post-acute and behavioral health orgs

Share Healthcare Data

- First in the nation to leverage federal Medicaid funds to build a statewide Health Information Exchange
- 100% of large ambulatory practices connected to the HIway
- >80% of hospitals
- >75% of large community health centers
- >40% of large behavioral health practices

Drive Innovation in Healthcare

- Helped launch the Massachusetts Digital Health Initiative
  - > 350 digital health companies are headquartered in MA
  - 11 of the 100 largest in the US are headquartered in MA
- Developed Community Digital Health Assessments for every community in the state
- Innovation grants
  - 33 for HIway adoption and use
  - Currently, eight communities grants across the state

MASS DIGITALHEALTH

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MassHealth Payment and Care Delivery Innovation

ACO and Community Partner Implementation

Executive Office of Health & Human Services

December 2017

Agenda

1. Overview of MassHealth Payment and Care Delivery Innovation (PCDI)
2. ACO / MCO and CP Integration- ACO/MCO CP Agreement Structure
3. Opportunities for Health Information Exchange
4. DSRIP Statewide Investments
5. Quality Measurement

What is MassHealth Payment and Care Delivery Innovation (PCDI)?

- The Executive Office of Health and Human Services (EOHHS) is committed to a sustainable, robust MassHealth program for its 1.8 million members
- EOHHS is making changes to MassHealth for managed care-eligible members – introducing ACOs and Community Partners (CPs) to emphasize care coordination and member-centric care
- ACOs have groups of primary care providers (PCPs) and other providers who work together to improve member care coordination and better meet overall health care needs
- Community Partners (CPs) are community-based experts who will provide care coordination services to and connect members with available behavioral health and LTSS services. CPs will be available to certain members with high needs as determined by MassHealth or the ACO/MCO. Providers make referals for consideration.

Fundamentals of Coordinated Care and Population Health Management

- Improve population health and care coordination through sustainable, value-based payment models
- Improving patient outcomes and member experience. Providers rewarded for delivering value and not the volume of services provided
- Provide incentives to improve care coordination and achieve performance standards across multiple measures of quality, including prevention and wellness, chronic disease management, and member experience
- Invest in Community Partners to collaborate with ACOs to provide care coordination and care management supports to individuals with significant behavioral health issues and/or complex long term services and supports (LTSS) need
- Improve integration of physical and behavioral health care

Overview of ACO Models

Accountable Care Partnership Plans:

- A network of PCPs who have exclusively partnered with an MCO to use their provider network to provide integrated and coordinated care for members.
- Paid a prospective capitation rate for all attributed members. Responsible for all contractually covered services and take on full insurance risk.
- May earn savings if they meet certain quality thresholds.

Primary Care ACOs

- A network of PCPs who contract directly with MassHealth, using MassHealth's provider network including the Massachusetts Behavioral Health Partnership (MBHP), to provide integrated and coordinated care for members.
- MassHealth pays providers on a fee for service basis directly.
- May earn savings if they meet certain quality thresholds.

MCO-Administered ACOs

- A network of PCPs who may contract with one or multiple MCOs and use the MCO provider networks to provide integrated and coordinated care for members.
- MCO-Administered ACOs are not presented as a enrollment option.
- MassHealth pays providers on a fee for service basis directly.
- May earn savings if they meet certain quality thresholds.

MassHealth ACOs, MCOs and PCC Plan

Accountable Care Partnership Plan
• Be Healthy Partnership
• Berkshire Fallon Health Collaborative
• BMC HealthNet Plan Signature Alliance
• BMC HealthNet Plan Community Alliance
• BMC HealthNet Plan Mercy Alliance
• BMC HealthNet Plan Southcoast Alliance
• Fallon 365 Care
• My Care Family
• Tufts Health Together with Atrius Health
• Tufts Health Together with BIDCO
• Tufts Health Together with Boston Children's ACO
• Tufts Health Together with CHA
• Wellforce Care Plan
Primary Care ACO
• Community Care Cooperative (C3)
• Partners HealthCare Choice
• Steward Health Choice

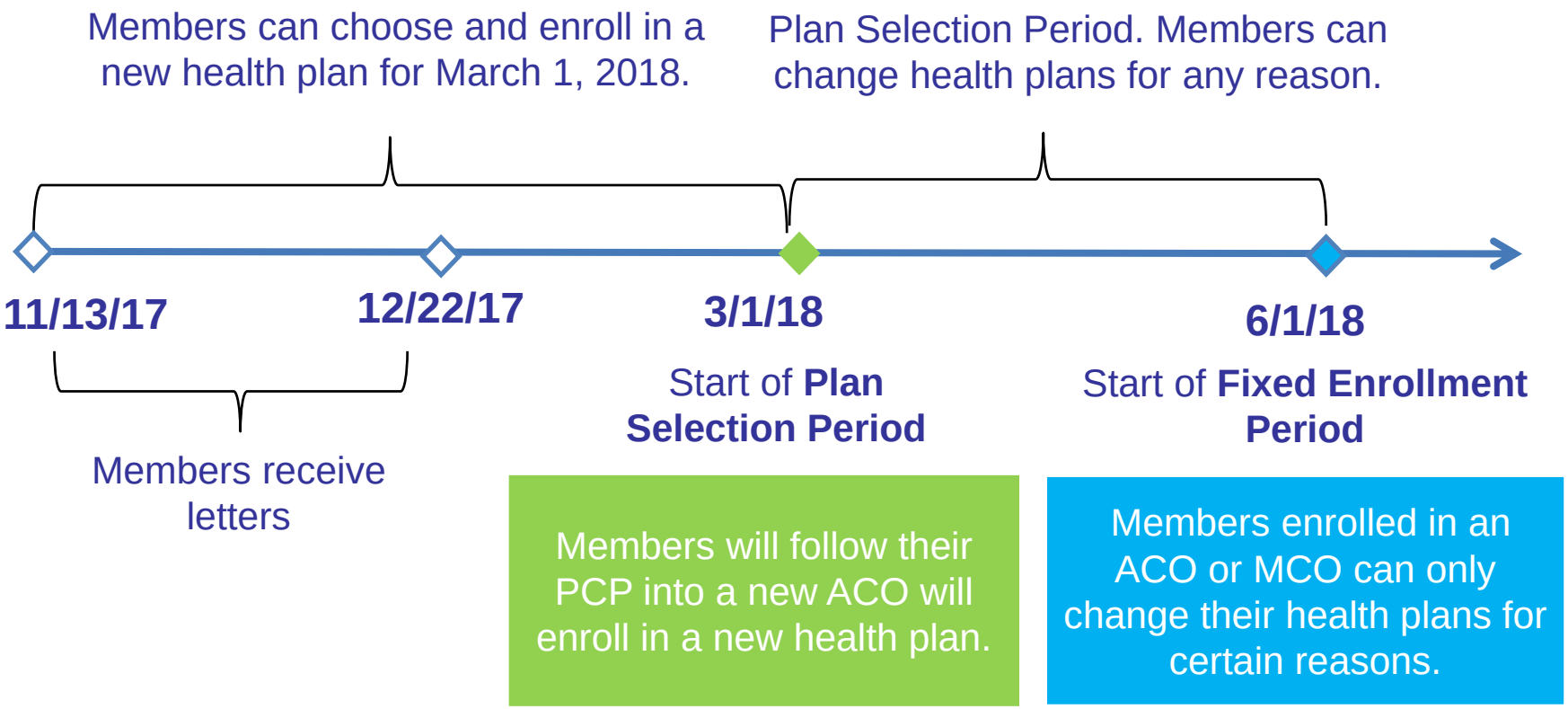
MCO-Administered ACO
• Lahey Clinical Performance Network

MCO
• Boston Medical Center Health Plan (BMCHP)
• Tufts Public Plans (Tufts)

PCC Plan
• Primary care Providers in the PCC Plan network

Important Member-Choice Dates

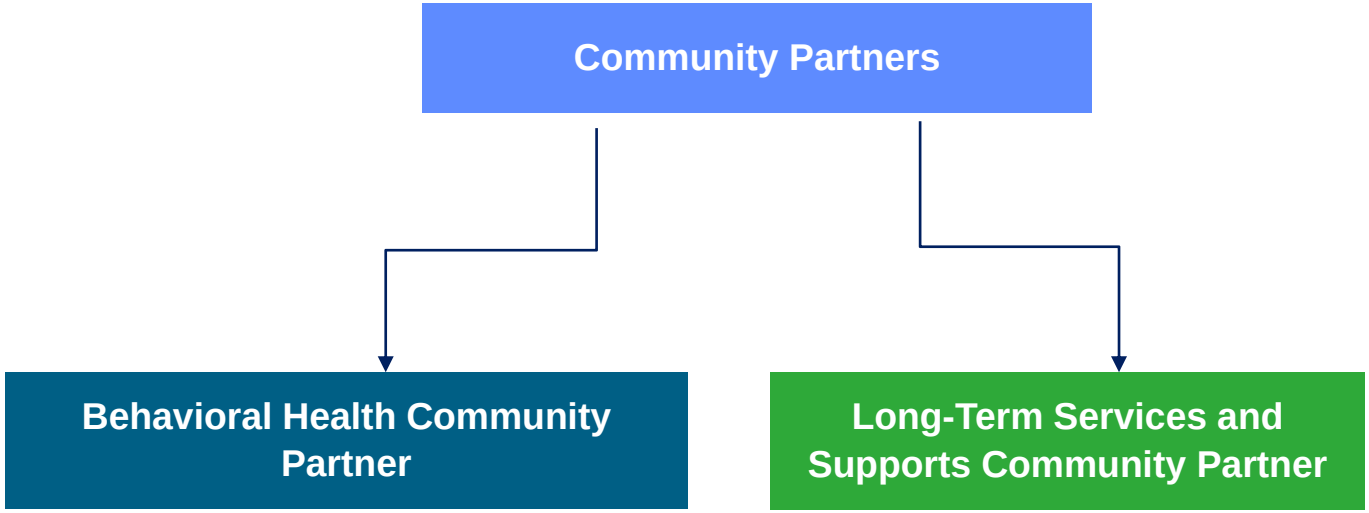
Important dates for current managed care eligible members (below) For new members, after March 1, plan selection is the first 90 days after enrollment in an ACO/MCO and fixed enrollment is for the remaining 275 days of the year. All members have a new plan selection period every year.



Community Partners *(anticipated to launch in June 2018)*

CPs are organizations experienced with either Behavioral Health or Long- Term Services and Supports that partner with ACOs and MCOs in coordinating and managing care for certain CP-eligible members

MassHealth will procure CPs to support ACOs and MCOs in coordinating and managing care for certain members. CPs address the social determinants of health. ACOs will be required to partner with CPs so that care can be coordinated.



BH Community Partners (BH CPs) will provide comprehensive care management including coordination of physical and behavioral health, bringing in BH clinical management expertise to overall care coordination

Long-Term Services and Supports Community Partners (LTSS CPs) will coordinate between physical health and LTSS systems

Who will Community Partners serve?

BH CPs will serve a population with high BH needs and include:

- ACO and MCO-enrolled members age 21 and older with SMI and/or SUD and high service utilization
- For members < 21 years of age with SED, existing CSAs under CBHI[1] will continue to provide ICC services for such members
  - Members 18-20 with SUD diagnosis and high utilization will be eligible for BH CP supports if requested
- Members with co-occurring BH and LTSS needs will be offered BH CP supports. Only assignment to a single CP is permitted.

LTSS CPs will serve a population with complex LTSS needs and include:

- ACO and MCO-enrolled members age 3 and older
- Members with complex LTSS and behavioral health needs; members with brain injury or cognitive impairments; members with physical disabilities; members with intellectual or developmental disabilities, including Autism; older adults eligible for managed care (up to age 64); and children and youth with LTSS needs

1 CSA = Community Service Agency; CBHI = Children's Behavioral Health Initiative; ICC = Intensive Care Coordination

What will Community Partners do for members?

BH CP Functions	LTSS CP Functions
Comprehensive Care Management	**LTSS Component of Care Coordination**

1. Outreach and engagement;
2. Comprehensive assessment and person-centered treatment planning;
3. Care Coordination & Care Management, including across
  1. Medical
  2. Behavioral Health
  3. Long Term Services and Supports;
4. Care Transitions;
5. Medication Reconciliation;
6. Health and Wellness Coaching; and
7. Connection to Social Services and Community Resources, including Flexible Services
	1. Outreach and engagement;
	2. LTSS Care Planning including Choice Counseling;
	3. Care Team Participation;
	4. LTSS Care Coordination;
	5. Support for Transitions of Care;
	6. Health and Wellness Coaching; and
	7. Connection to Social Services and Community Resources, including Flexible Services

Selected Community Partners (1/2)

- On August 24, 2017 EOHHS announced the selection of eighteen (18) BH Community Partners and eight (8) LTSS Community Partners for contract negotiations.
- Entities listed below are those with which ACOs and MCOs would contract. Many are comprised of multiple components.
- CP organizational configurations include:
  - Single legal entities
  - Single legal entities comprised of Consortium Entities, which operate as part of the legal structure
  - Single legal entities with Affiliated Partners, which operate jointly under a management agreement

- The **BH CPs selected** for contract negotiations are as follows:

Selected BH Community Partners	
1. Behavioral Health Network, Inc.	10. Eliot Community Human Services, Inc.
2. Behavioral Health Partners of Metrowest, LLC	11. High Point Treatment Center, Inc.
3. Boston Health Care for the Homeless Program	12. Innovative Care Partners, LLC
4. The Bridge of Central Massachusetts, Inc.	13. Lowell Community Health Center, Inc.
5. The Brien Center for Mental Health and Substance Abuse Services, Inc.	14. Northeast Behavioral Health Corporation d.b.a Lahey Behavioral Health Services
6. Clinical Support Options, Inc.	15. Riverside Community Care, Inc.
7. Community Care Partners, LLC.	16. Southeast Community Partnership
8. Community Counseling of Bristol County	17. South Shore Mental Health Center, Inc.
9. Community Healthlink, Inc.	18. Stanley Street Treatment Partnership

Selected Community Partners (2/2)

The **LTSS CPs** selected for contract negotiations are as follows:

Selected LTSS Community Partners
1. Alternatives Unlimited, d.b.a Central Community Health Partnership
2. Boston Medical Center d.b.a Boston Allied Partners
3. Elder Services of Merrimack Valley, d.b.a Merrimack Valley Community Partnership
4. Family Service Association
5. Innovative Care Partners
6. LTSS Care Partners, LLC
7. Seven Hills Family Services, Inc.
8. WestMass Elder Care, d.b.a Care Alliance of Western Massachusetts
9. Greater Lynn Senior Services, Inc. d.b.a. North Region LTSS Partnership

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ACO / MCO and CP Integration

- MCOs and Accountable Care Partnership Plans are expected to partner with all BH CPs and at least two LTSS CPs in their Service Area.
- EOHHS will provide further guidance regarding with which BH/LTSS CPs Primary Care ACOs and MCO-Administered ACOs must partner, based upon the geographic distribution of the ACOs' members.
- Prior to the CP Operational Start Date on June 1st, 2018, ACOs and MCOs are expected to execute contracts with CPs by March 30th, 2018

ACO/MCO – CP Agreement Structure

- **Purpose of the ACO/MCO – CP Agreement:** To delineate the respective roles and responsibilities of the contracting entities (ie. the CP and the MCO in the Accountable Care Partnership Plan, the Primary Care ACO, or the MCO-Administered ACO) and to promote coordination and integration in care management and care coordination.

- **Agreements require each party to:**
  - Agree to the terms of collaboration between parties
  - Jointly develop, implement, and maintain Documented Processes reflecting these agreed upon processes prior to the CP Operational Start Date.

- **Documented Processes:**
  - Enrollee Assignment and Engagement
  - Outreach
  - Administration of Care Management and Care Coordination
  - Recommendation for Services
  - Data Sharing and IT Systems
  - Performance Management and Conflict Resolution
  - Termination

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Summary of Documented Processes & Opportunities for Health Information Exchange

Documented Process	Topic
1. Exchange of Assigned Enrollee data	Enrollee Assignment & Engagement
2. Voluntary or automatic changes to Enrollee Assignment or Engagement with the CP	Enrollee Assignment & Engagement
3. The CP's notification of the ACO or MCO regarding progress on outreach to Assigned Enrollees	Outreach
4. Enrollee care coordination and care management	Administration of Care Management & Care Coordination
5. Enrollee transitions of care	Administration of Care Management & Care Coordination
6. ACO or MCO communication with the CP regarding authorization decisions of CP-recommended covered services	Recommendations for Services
7. Communication between Parties upon notification of prior authorization decisions regarding non-ACO or MCO covered State Plan LTSS	Recommendations for Services
8. Management of the ACO/MCO – CP Agreement	Performance Management & Conflict Resolution
9. Conflict resolution	Performance Management & Conflict Resolution
10. Development of performance improvement plan	Performance Management & Conflict Resolution
11. Reporting gross misconduct or critical incident	Other Requirements

Form, Format and Frequency of Health Information Exchange

Documented Process	Data to be Exchanged
1. Exchange of Assigned Enrollee data	Enrollee's name; date of birth; MassHealth ID number; Enrollee address and phone number; Primary Language (if available); and PCP name, address and phone number
4. Enrollee care coordination and care management	Comprehensive Assessment and Care Plan with specified domains.

- Data elements and domains have been specified in ACO/MCO and CP Contracts with EOHHS
- Form, format, and frequency for exchange are not standardized and must be agreed upon by ACO/MCO and CP in Documented Processes

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DSRIP Statewide Investments

1. DSRIP Statewide Investments Overview

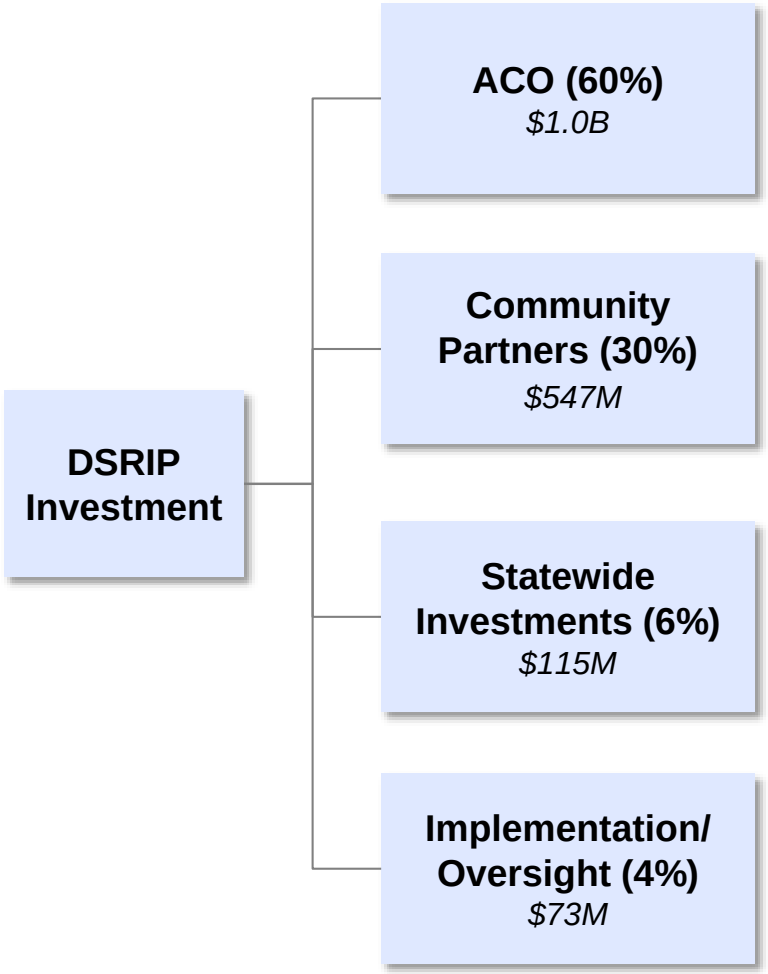
2. Workforce Development Programs
   - Student Loan Repayment Program
   - Primary Care/Behavioral Health Special Projects Program
   - Investment in Community-based Training and Recruitment
   - Workforce Development Grant Program

3. Technical Assistance Program
   - Overview
   - ACO and CP TA Components
   - TA Projects

4. Alternative Payment Methods Preparation Fund

DSRIP Funding Overview

- Delivery System Reform Incentive Payment (DSRIP) Program totals $1.8B over five years and supports four main funding streams
- **Eligibility for receiving DSRIP funding** will be linked explicitly to **participation in MassHealth payment reform efforts**



- Supports Accountable Care Organization (ACO) investments in primary care providers, infrastructure and capacity building, flexible services, and expansion of ACO model to **safety net providers**
- Funding contingent on **ACO adoption** and **partnerships with Community Partners**

- Supports Behavioral Health (BH) and Long Term Services and Supports (LTSS) Community Partner (CP) **care coordination**, CP and Community Service Agency (CSA) **infrastructure and capacity building**, and **new funding** into community-based organizations
- Funding contingent on **CP adoption** and **partnerships with ACOs**

- Allows state to more efficiently **scale up statewide infrastructure and workforce capacity**
- Examples include **workforce development and training** and **technical assistance to ACOs and CPs**

- Small amount of funding will be used for **DSRIP operations and implementation**, including **robust oversight**

Statewide Investments Overview

Statewide Investments (SWIs) will help to **efficiently scale up statewide infrastructure and workforce capacity**, and **provide assistance to ACOs and CPs** in succeeding under alternative payment models. Currently **$115M** is preliminarily allocated across five years for the SWIs.

1. **Student Loan Repayment Program:** program aims to address shortage of providers at community-based settings by repaying a portion of providers' student loans in exchange for four year commitments at CHCs, CMHCs, ESPs, and organizations participating in a Community Partner
2. **Primary Care/Behavioral Health Special Projects Program:** program that provides support for CHCs, CMHCs, ESPs, and organizations participating in a Community Partner to allow providers to engage in one-year projects related to accountable care implementation
3. **Investment in Community-based Training and Recruitment:** program aimed at increasing the number of family medicine and nurse practitioner residents trained in CHCs and BH providers recruited to CMHCs
4. **Workforce Development Grant Program:** program to support development and training to enable members of the extended healthcare workforce to more effectively operate in a new health care system
5. **Technical Assistance (TA):** program to provide TA to ACOs, CPs, and CSAs as they participate in payment and care delivery reform
6. **Alternative Payment Methods (APM) Preparation Fund:** program to support providers that are not yet ready to participate in an ACO, but want to take steps towards APM adoption
7. **Enhanced Diversionary Behavioral Health Activities:** program to support investment in new or enhanced diversionary levels of care that meets the needs of members with behavioral health needs at risk for ED boarding within the least restrictive, most clinically appropriate settings
8. **Improved Accessibility for People with Disabilities or for whom English is not a Primary Language:** programs to assist providers in delivering necessary equipment and expertise to meet needs of people with disabilities or for whom English is not a primary language

1 Student Loan Repayment Program

Purpose	Reduce the shortage of **primary care and behavioral health providers** in community settings
Approach	MassHealth will repay a portion of the student loan obligations for providers selected for the program in exchange for their four-year commitment to serve in a **community health center (CHC)**, **community mental health center (CMHC)**, **emergency service provider (ESP)**, or **organization participating in a Community Partner (CP)**. Quarterly **learning days** will be offered as a component of this investment to improve retention of providers in community-based settings.

Eligible Applicants	**Max Loan Repayment** (over two years)	**Slots** (per year)
Family physicians, general internists, pediatricians, psychiatrists, psychologists	$50,000	~30
Advanced Practice Registered Nurses (APRNs), Nurse Practitioners (NPs), Physician Assistants (PAs)	$30,000	~20
Licensed Independent Clinical Social Workers (LICSWs), Licensed Certified Social Workers (LCSWs), Licensed Mental Health Counselors (LMHCs), Licensed Marriage and Family Therapists (LMFTs), Licensed Alcohol and Drug Counselors I (LADC1s)	$30,000	~20
Total Number of Slots (over five years)		**~280**

Expected Launch: February 2018

Expected Year One Funding: ~$1.8 million

Expected Total Funding: ~ $14.7 million

2 Primary Care/Behavioral Health Special Projects Program

Approach	MassHealth will award one-year grants to **CHCs, CMHCs, ESPs, or organizations participating in a CP** related to accountable care to engage and retain PC + BH providers in the community setting.

Eligible Applicants	**Eligible Providers**	**Funding Amount**	**Number of Projects** (over 5 years)
CHCs, CMHCs, and ESPs participating in MassHealth payment reform and **organizations participating in a CP**	Family physicians, general internists, pediatricians, psychiatrists, psychologists	**$40,000** per project	**~120** projects
	APRNs, NPs, PAs		
	LICSWs, LCSWs, LMHCs, LMFTs, LADC1s		
Project Examples	• A NP within a CHC uses special project funding to implement group visits for prenatal care; • A family physician in a CHC leads a pilot project focused on using text messaging to activate diabetes patients; • A LICSW implements SBIRT protocols in her CHC unit; • A psychiatrist in a CMHC pilots a project aimed at better connecting patients to primary care • Potential for HIE/HIT-specific projects		

Expected Launch: February 2018

Expected Year One Funding: ~$1.15 million

Expected Total Funding: ~ $5.4 million

3a Family Medicine and Nurse Practitioner Residency Training

Purpose	Increase the number of **primary care physicians** and **nurse practitioners (NPs)** trained in CHCs and prepared to care for patients in community settings
Approach	Provide funding to increase the number of available family medicine and NP residency training slots in programs with existing infrastructure that train residents in CHCs.

Eligible Applicants	**Funding Amount**	**Slots*** (over 5 years)
Family Medicine Residency Programs *with existing infrastructure for training residents in community health centers*	Up to **$150,000 per family medicine resident per year** to cover resident compensation and the CHC costs associated with training residents Up to **$20,000 per family medicine resident per year** to cover hospital-based costs of training residents	~10
Nurse Practitioner Residency Programs *with existing infrastructure for training residents in community health centers*	Up to **$85,000 per nurse practitioner resident per year** to cover resident compensation and the CHC costs associated with training residents	~6

*Exact numbers will depend on the mix of applications received.

Expected Launch: *Family Medicine:* July 2019 (new residency slots filled in 2019 due to family medicine match process); *Nurse Practitioner:* July 2018 (new residency slots filled)

Expected Year One Funding: $150,000 (program management only)

Expected Total Funding: ~ $6.7 million

3b Community Mental Health Center BH Recruitment Fund

Purpose	Increase the number of **psychiatrists and nurse practitioners (NPs)** with prescribing privileges at CMHCs by diminishing known obstacles to recruitment in these settings
Approach	MassHealth will make available "recruitment packages" consisting of student loan repayment and provider-led special project grants that **CMHCs** can offer as enticements to prospective new hires.

Eligible Applicants	**Eligible Providers**	**Funding Amount for Recruitment Packages**	**Slots*** (over 5 years)
CMHCs *established and participating in payment reform*	Psychiatrists	Up to **$50,000 per recruited psychiatrist** to support student loan repayment Up to $**50,000 per recruited psychiatrist** per year over two years to lead projects related to accountable care	~15
	Nurse Practitioners	Up to **$30,000 per recruited NP** to support student loan repayment Up to **$40,000 per recruited NP** per year over two years to lead projects related to accountable care	~7

*Exact numbers will depend on the mix of applications received.

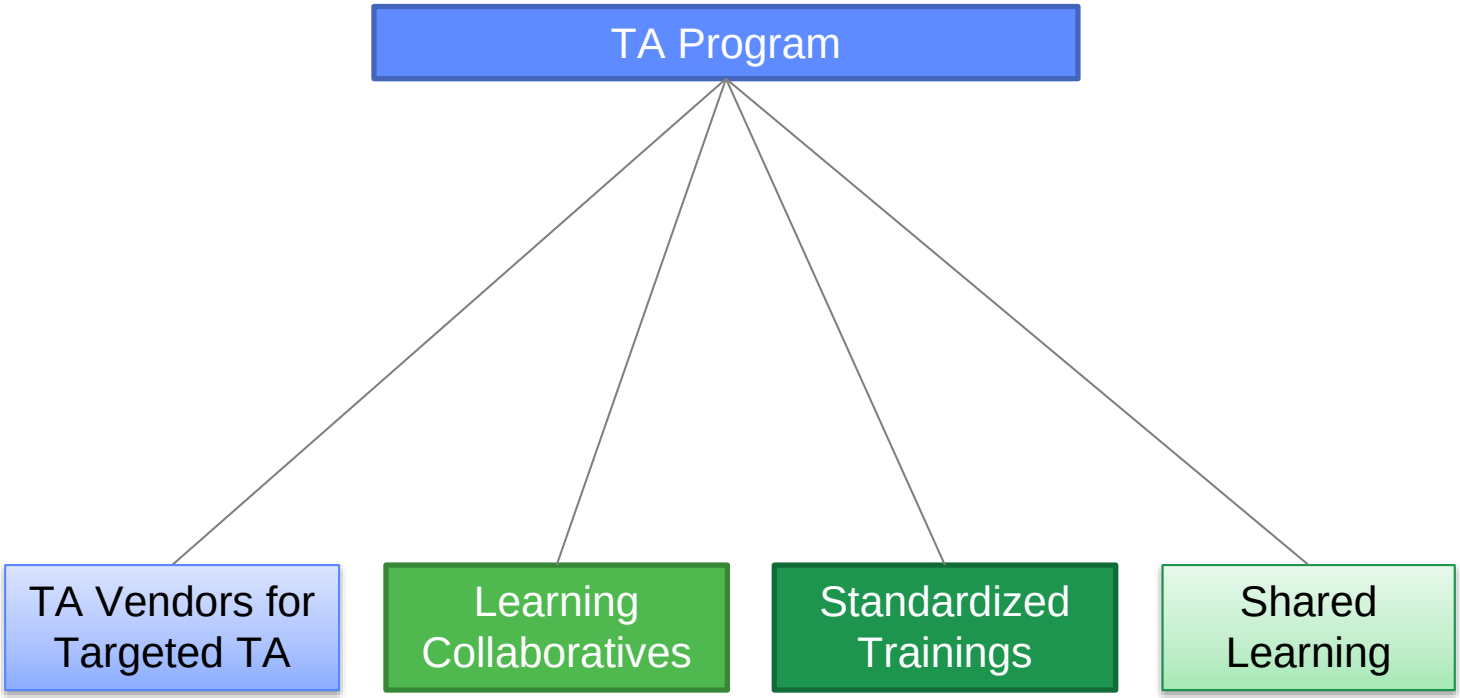
Expected Launch: February 2018
Expected Year One Funding: ~$1 million
Expected Total Funding: ~ $3.3 million

4 Workforce Development Grant Program

- Guiding principle: Focus on areas with high anticipated need by ACOs and CPs. Programs will focus on improving the availability of a well-trained healthcare workforce beyond general internists, nurse practitioners, psychiatrists, licensed behavioral health providers, etc.

- Program model still in development, potential focus on:
  - Community health workers
  - Peer specialists
  - Recovery coaches
  - Other frontline workers

5 Technical Assistance (TA) Program



Year One Funding: $10.7 million
Total Funding Over 5 Years: $45.1 million

Proposed TA Vendor Categories

TA Vendor Categories

- Areas to procure TA vendors have been developed and are currently under review
- Proposed TA vendor categories were developed via surveys and interviews with ACOs, CPs, and affiliated entities

Examples of HIE/HIT TA projects might include:

- Improve data connectivity between ACOs and CPs
- Facilitating data connectivity between an ACO and its provider entities (e.g. CHCs)
- Support increasing connection to Mass Hiway

MassHealth is actively collaborating with the HIway Adoption and Utilization Services (HAUS) Program to find areas of alignment to maximize resources and ensure efforts are complimentary.

Alternative Payment Methods (APM) Preparation Fund

Proposed Approach	• Award project grants to provider entities not in an ACO that will **support those providers joining an ACO in the next year**

Criteria	**Project Categories**	**Funding Amount** (Year One)
• Project's impact on ability to join an ACO • Need for funding in order to implement project • Number of MassHealth members represented at entity • Demonstrated commitment from a contracted ACO	• **Enhanced data integration, clinical informatics, and population-based analytics** • Shared governance and enhanced organizational integration • Enhanced clinical integration • Catalyst grants for integration	Large Project: **$500,000** Medium Project: **$250,000** Small Project: **$50,000**

- In Year 1, the APM Preparation Fund will be focused on provider entities not yet in an ACO. In subsequent years, the APM Preparation Fund may consider entities that are not yet participating in a CP.

Expected Launch: April 2018

Expected Year One Funding: ~$2.2 million

Expected Total Funding: ~ $12.4 million

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ACO Quality Measures Goals and Objectives

- ACOs will be accountable for providing high-value, cross-continuum care, across a range of measures that improves member experience, quality, and outcomes.

- Quality metrics will ensure savings are not at the expense of quality care.

- ACOs cannot earn savings unless they meet minimum quality thresholds.

- Higher quality scores may:
  - Raise an ACO's shared savings payment
  - Reduce the amount the ACO needs to pay back in shared losses.

- MassHealth will regularly evaluate measures and determine whether measures should be added, modified, removed, or transitioned from pay-for-reporting to pay-for-performance, and will engage stakeholders as appropriate.

CP Quality Measures Considerations

Goals for measures:

- Integration of CPs with ACOs and MCOs.
- Align with ACO quality measure slate.
- CP, along with ACO, should be accountable for traditionally medical measures in order to promote integration of care.
- CP supports should impact avoidable utilization.
- Priority on engagement of members

DSRIP ACO Quality Measures: An Update

MassHealth is undertaking modifications to the preliminary ACO quality measure slate issued July 2017

The proposed changes are *preliminary* and have not yet been approved by CMS or finalized by MassHealth

All proposed changes to the measures will take effect for ACO Year 1: 2018

ACO quality measures will remain ”reporting-only” in 2018

Preliminary Modifications to 2018 ACO Quality Measure Slate

Objective	Impact
Fewer measures	Reduction in the total number of quality measures
Lower administrative burden	Reduction in the number of quality measures requiring collection of clinical data (e.g., hybrid measures)
Established measures	More priority for measures which meet national standards for measure validity and reliability
Promote care integration	Focus on a select number of measures in the areas of SDOH, BH, and LTSS care integration
Alignment	Make efforts (when appropriate) to align with commercial payers

ACO quality measure slate will remain ”reporting-only” in 2018

Preliminary Modifications to 2018 ACO Quality Measure Slate

Remain in 2018 ACO Quality Slate

Clinical Quality Measures

1. Immunization of Adolescents
2. Oral/Dental Evaluation
3. Timeliness of Prenatal Care
4. Tobacco Use: Screening and Cessation
5. Asthma Medication Ratio
6. Diabetes Care: A1c >9
7. Controlling High Blood Pressure
8. Initiation and Engagement: Alcohol or Other Drug Dependence Treatment*
9. Depression Screening & Follow-up
10. Depression: Utilization of PHQ-9 for Monitoring Symptoms*
11. Depression: Response at Twelve Months*
12. Follow-up for Children Prescribed ADHD Medication: Continuation Phase
13. ED Visits for Individuals Experiencing SMI**
14. Readmissions: Adult
15. Follow-Up after ED Visit for Mental Illness (7-days)
16. Follow-Up after Hospitalization for Mental Illness (7-days)
17. Social Services Screening
18. Community Tenure
19. LTSS CP Engagement and Care Plan (90 days)
20. BH CP Engagement and Care Plan (90 days)

New Measures Added to 2018 ACO Quality Slate

21. Readmissions: Pediatric (NQF#2393)
22. Childhood Immunization Status (HEDIS, NQF#38, Combo 10)
23. Metabolic monitoring for Children and Adolescents Receiving Antipsychotics (HEDIS, NQF# 2800)
24. Continuity of Pharmacotherapy for Opioid Use Disorder*** (NQF# 3175)

Removed from 2018 ACO Quality Slate

Novel EOHHS Measures:

- Utilization of Behavioral Health CP
- Utilization of LTSS CP
- Utilization of Outpatient BH Services
- Utilization of Flexible Service
- Developmental Screenings: Under 21
- Hospital Admissions for SMI/SUD/SED
- ED Utilization for SMI/SUD/SED*
- Readmissions for persons with LTSS needs
- LTSS Assessment *(folded into care plan*)
- Opioid Addiction Counselling (*replaced)*

Potentially Avoidable Utilization

- Potentially Preventable Admissions (3M)
- Potentially Preventable ED Visits (3M)
- Diabetes Short-Term Admissions
- COPD/Asthma Admissions

HEDIS Measures

- Well Child Care Visits: 0-15 months
- Well Child Care Visits: 3-6 years
- Adolescent Well Care Visits
- Weight Assessment & Nutrition Counselling
- Adult BMI Assessment
- Postpartum Care *(lost NQF endorsement)*
- Follow-up for Children Prescribed ADHD Medication: Initiation Phase

* Measures will be combined to form 1 measure score
** Measure is replacement for “ED Utilization for SMI/SED/SUD
*** Measure is replacement for Opioid Addiction Counselling

Proposed MassHealth ACO Quality Measures

*Year 1: 2018 (*All Measures are Pay-for-Reporting; grouped by clinical area*)*

Prevention and Primary Care
- Childhood Immunizations
- Immunizations for Adolescents
- Oral/Dental Evaluation
- Timeliness of Prenatal Care
- Tobacco Use Screening

Chronic Disease Management
- Asthma Medication Ratio
- Diabetes Care: A1c >9%
- Controlling High Blood Pressure
- Follow-up Care For Children Prescribed ADHD Medication

Substance Use Disorder:
- Initiation and Engagement of Alcohol or Other Drug Dependence Treatment*
- Continuity of Pharmacotherapy for Opioid Use Disorder

Member Experience Surveys:
- CG-CAHPS, BH, LTSS

Mental and Behavioral Health
- Depression Screening & Follow-up
- Depression: Monitoring & Response*
- ED Visits for Individuals Experiencing SMI
- Metabolic Monitoring for Children and Adolescents receiving Antipsychotics

Care Transitions
- Follow-up after ED visit for Mental Illness
- Follow-up after Hospitalization for Mental Illness
- Hospital Readmissions (adult & pediatric)

SDOH Care Integration:
- Social Services Screening

BH and LTSS Care Integration
- Community Tenure
- BH CP Engagement and Care Plan
- LTSS CP Engagement and Care Plan

* Measures will be combined to form 1 measure score

ENGAGING COMMUNITY COLLABORATORS

MeHI Forum – December 13, 2017

Allyson Pinkhover, MPH
Connected Communities Project Manager

Brockton Neighborhood Health Center

Brief Overview

- **Purpose:** Work collaboratively with community partners to improve care coordination for patients with behavioral health conditions, particularly substance use disorders
- **Grant Partners**
  - BAMSI
  - Signature Healthcare Brockton Hospital
  - Brockton Neighborhood Health Center
  - Good Samaritan Medical Center (Steward)
  - High Point Treatment Center

Brockton Neighborhood Health Center

Project Vision

- Right information at the right time
  - Coordinate care at admission, prior to discharge, and before referral appointment
  - Hear back on the outcome of a referral
- Communicate more effectively between organizations
  - Know who the point people are
  - Send information in a timelier manner
  - Build relationships outside of our organizations
- Use improvements to help keep BH patients engaged in care

Brockton Neighborhood Health Center

Collaborator Engagement

- What keeps motivation high?
  - Project is very technically focused
    - Important to come back to the spirit of the grant
  - Emphasis on how this is making processes easier
  - Setting deadlines & establishing accountability

Brockton Neighborhood Health Center

Collaborator Engagement

- Quarterly Meetings
- One-on-one Meetings with project manager (monthly/bimonthly)
- Engaging Direct Care Staff

Brockton Neighborhood Health Center

Quarterly Meetings

- **Early phase:** project planning, patient consent
- **Middle phase:** patient consent, coordination of testing
- **Late phase:** troubleshooting, expansion planning
- **Throughout:** communicate deliverables and deadlines, establish next steps for following months
- Always at least one representative from each trade partner organization, usually more than one

Brockton Neighborhood Health Center

One-on-One Trade Partner Meetings

- Usually occur monthly/bimonthly depending on needs
- Review progress on deliverables/tasks
- Address any project issues

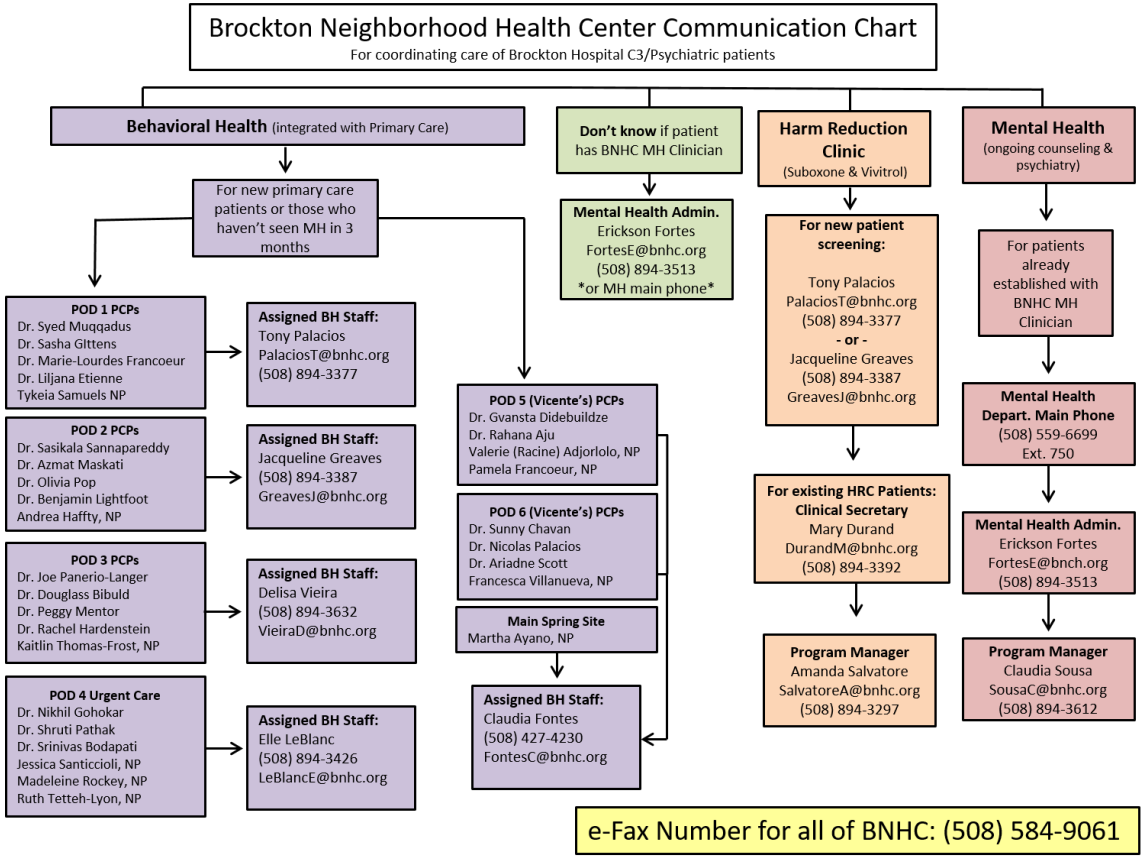
Brockton Neighborhood Health Center

Engaging Direct Care Staff

- Identified opportunities to address issues between departments
- Example: BNHC MH/BH & Brockton Hospital Psychiatric Unit
  - Discussed communication & care coordination issues between departments
  - Created a Communication Chart

Brockton Neighborhood Health Center

Engaging Direct Care Staff



Brockton Neighborhood Health Center

Engaging Direct Care Staff - Connected Communities Breakfast

- Looking for an opportunity to bring direct care staff together
- Ensure that good “point people” are able to meet
- Reviewed CCDs, Consent, & Case Studies

Brockton Neighborhood Health Center

Summary

- Remember the reason you're working together & why you're working toward it
- Set deadlines & regularly scheduled meetings
- Keep it interactive & enjoyable

Brockton Neighborhood Health Center

Questions?

Brockton Neighborhood Health Center

MeHI
MASSACHUSETTS eHEALTH INSTITUTE

at the MassTech Collaborative

Break

MeHI
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at the MassTech Collaborative

Panel Discussion: Workflow Best Practices

Jenni Bendfeldt *– ECG Management Consultants*
Larry Garber,MD *– Reliant Medical Group*
David LaPlatney *– Behavioral Health Network*
Jennifer Pelletier *– Country Center for Health and Rehabilitation*
Allyson Pinkhover *– Brockton Neighborhood Health Center*
Stacey Smith *– Great Lakes Caring*

Workflow Best Practices: Cape Cod Healthcare

Cape Cod Healthcare

Trading Partners & Collaborators	
Cape Cod Hospital	Kindred at Home
Falmouth Hospital	Bourne Manor
JML Care Center	Gosnold
Community Health Center of Cape Cod	Pavilion
Duffy Health Center	Seashore Point
Harbor Health	Mayflower Place
Outer Cape Health Center	Windsor
BAYADA	

Workflow Best Practices: Cape Cod Healthcare

- **Use Case: Sending transition of care documents electronically from Cape Cod Healthcare (CCHC) to collaborating organizations**

Workflow Challenges	Best Practices Used
Needed to develop reporting and monitoring tool to track end-user/unit secretary compliance in following the process of sending 4 discharge documents upon discharge.	Worked with Cerner to develop a report that tracks and records when a C-CDA is sent along with a patient's discharge.
Identified a bug/software defect in Soarian Clinicals affecting Falmouth Hospital unit secretaries not consistently receiving the order to send 4 documents to collaborating organizations.	Met with Cerner to reconfigure system's logic to avoid canceling outstanding orders at the time of discharge.

Workflow Best Practices: Cape Cod Healthcare

Workflow Challenges (continued)	Best Practices Used (continued)
Identified inconsistencies/superfluous information in the C-CDA documents, and therefore and opportunity to streamline documentation to offer more meaningful information.	Revised formatting of C-CDA and conducted testing.
Transcription turnaround time was too long; needed to give secretaries real-time access to documents.	Implemented system workflow for converting discharge summaries from transcription to front-end clinical templates.

Workflow Best Practices: Cape Cod Healthcare

Greatest Success of Grant Project So Far:

Standardizing clinical care documents in an electronic format that can be automatically sent to collaborating organizations has not only allowed the multiple organizations involved with patient's care timely access to patient's clinical information, but also left a record of the information being sent, so that care teams know exactly where the information is at any given time.

Reliant Medical Group

Trading Partners	
Reliant Medical Group	Vital EMS
AdCare Hospital	St. Vincent Hospital
Beaumont Rehab & Skilled Nursing Center (Westborough)	Worcester Rehabilitation & Health Care Center
Family Health Center of Worcester	Notre Dame Long Term Care Center
Holy Trinity Nursing and Rehabilitation Center	VNA Care Network and Hospice
Jewish Healthcare Center	UMass Memorial Medical Center
Life Care Center of Auburn	Milford Regional Medical Center
MetroWest Medical Center	

Workflow Best Practices: Central & MetroWest IMPACT 2.0

- **Use Cases:**
  - **Provide Baseline Patient Summary Document to ER when patient presents to ER**
  - **Provide Baseline Patient Summary Document to Skilled Nursing Facility when patient is admitted there**
  - **Notify Home Health Agency when patient presents to ER and whether or not they are admitted to hospital**
  - **Send encounter-level CCD with visit note to Home Health Agency when their patient is seen by PCP or specialist**

Workflow Best Practices: Central & MetroWest IMPACT 2.0

Workflow Challenges	Best Practices Used
Getting ER and SNF providers to see patient's medical history	Use event-notification ADTs to trigger PCP's EHR to send CCD through MA HIway back to facility, including facility's MRN
Letting Home Health Agencies know when their patient has been seen in the ER (see sooner) or admitted to the hospital (do not see patient)	Use Home Health registration data to subscribe to event notifications
Letting the Home Health Agencies know when there is a change to the treatment plan	Use Home Health registration data to subscribe to PCP and specialist notes

Workflow Best Practices: Central & MetroWest IMPACT 2.0

Greatest Success of Grant Project So Far:

Automatically sending CCD summary documents via MA HIway to St. Vincent Hospital ER, MetroWest Medical Center ER, Milford Regional Medical Center ER, UMass University Hospital ER, UMass Memorial ER, UMass Marlborough Hospital ER, and UMass HealthAlliance ER when Reliant Medical Group patients arrive there. Average = 3,700 CCD's sent each month

Workflow Best Practices: Behavioral Health Network

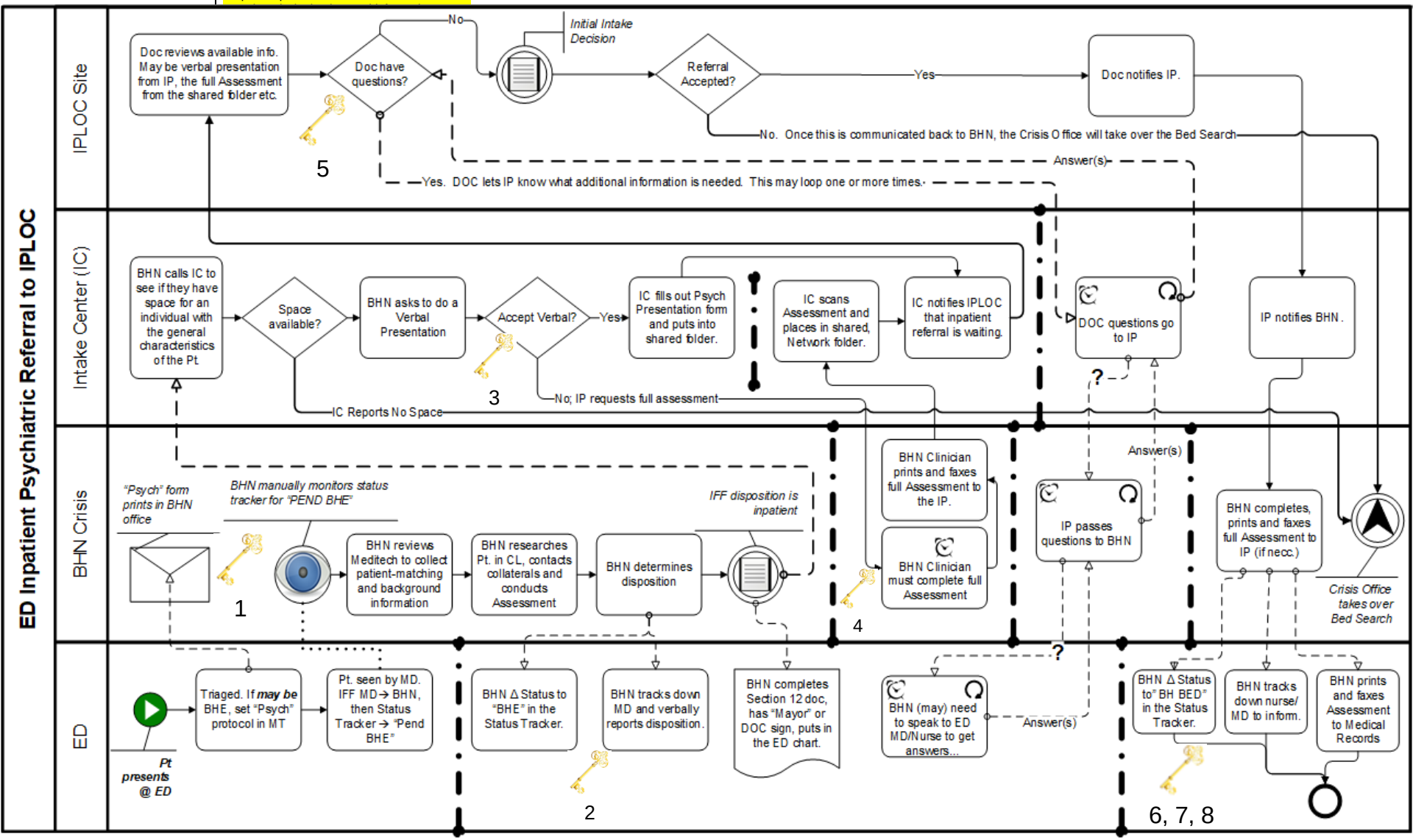
Behavioral Health Network

Trading Partners	
Behavioral Health Network	Baystate Brightwood Health Center
Baystate Wing Memorial Hospital	Baystate Noble Hospital
Pediatric Associates of Hampden County	Baystate High Street Health Center – Adult & Pediatric
Mason Square Neighborhood Health Center	Providence Behavioral Health Hospital
Holyoke Health Center	Holyoke Medical Center
Pioneer Valley Information Exchange	

What is CCI about?

- CCI is about Process Improvement.
  - Or Change Management.
  - Or Quality Improvement, or…
- Some permutation of "What's happening now?" and "What would we rather have happen?" and "How do we get there from here?"
- There are lots of approaches out there, lots of tools… PDSA, TQM, Six Sigma, Lean, Lean Six Sigma…
- One use case involving 18 interacting "entities" across 4 organizations, the other involving 13 "entities" across 4 organizations.
- But, at the core, CCI is about managing boundaries-
  - Tech boundaries, communication boundaries…
  - Care boundaries

- How is background information about the patient passed from EMS/Police?



How do we make it work?

- Engage everyone involved to understand what they want to have happen- ***their*** "Ideal".
- ***Really*** understand the *existing* workflows.
- Document the workflows in a way that ***everyone*** can understand.
- ***Cooperatively*** analyze them to identify leverage points. "What's the *purpose* of this task?"
- ***Collaboratively*** build new workflows that leverage available technology to move ever closer to that shared "Ideal".

Workflow Best Practices: Whittier IPA / Wellport HIE

Presented by Community Collaborators: Great Lakes Caring & Country Center for Health and Rehabilitation

Additional Community Collaborators for this Grant
Anna Jaques Hospital
Amesbury Psychological Center
Home Health VNA
Essex Inpatient Physicians
Maplewood Center

Workflow Best Practices: Great Lakes Caring

- **Use Case: Home Care Agency utilizing Wellport HIE's clinical data repository to gather clinical information for patient care including medication reconciliation**

Workflow Challenges prior to implementing Wellport	Workflow after implementing Wellport
Prior to the Wellport HIE implementation, referrals were sent to Great Lakes with little clinical information or patient background.	Intake department logs into Wellport to access clinical information from a patient's most recent hospitalization or physician visit.
Medication Reconciliation: When patients were referred, little, if any medication information was shared with Great Lakes.	Homecare clinicians leverage Wellport for the most up-to-date and reliable medication list for a patient. EMR is integrated with SureScripts which gives a 14 month look back on all dispensed medications for a patient. While a patient is on services with Great Lakes Caring, they may have a medication change (through physician or ER visit). Wellport allows clinicians to easily access most up-to-date medication list.

Workflow Best Practices: Great Lakes Caring

Greatest success of utilizing Wellport so far:

Instant access to a variety of clinical information to improve patient care.

Workflow Best Practices: Country Center for Health and Rehab.

- **Use Case: Skilled Nursing Facility (SNF) utilizing Wellport HIE's clinical data repository to gather clinical information for patient care**

Workflow Process Integrating Wellport HIE

- Upon admission to Country Center, each resident was searched in Wellport to see if they had been opted in
- If a resident had not been opted in, staff would ask them to sign a consent upon admission
- The nurse admitting the patient referred to Wellport to look at discharge summary and medication reconciliation
- On occasion, nurse's were able to obtain additional relevant information such as flu shot, pneumovax, or current lab work
- Medication reconciliation was helpful at times, but not what Country Manor found to be most useful aspect of Wellport
- Look at results from a hospitalization: x-rays, labs, medications
- Receiving an admission from home, medication lists, primary care visits
- Current residents who are in the hospital
- Following up on discharged residents whether they made it to PCP appointments

Workflow Best Practices: Country Center for Health and Rehab.

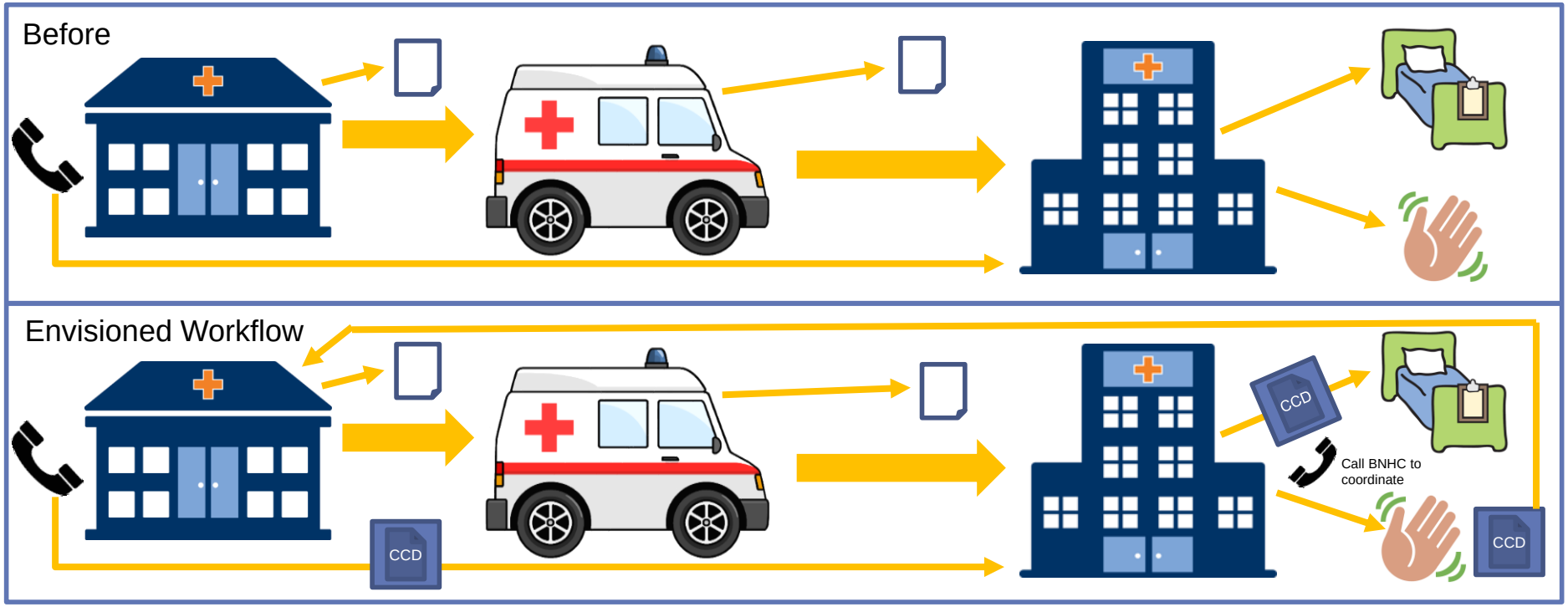
Greatest successes of utilizing Wellport so far:

- *Wellport has been helpful at the SNF level for all scenarios*
- *Continuing communication across the continuum is really the key to success for all industries*
- *Wellport allows Country Center to gather information that may take hours or days to find in other circumstances*
- *The best way for all interested parties to have success with Wellport is to ensure everything is uploaded in real time to patient care being received*

Brockton Neighborhood Health Center

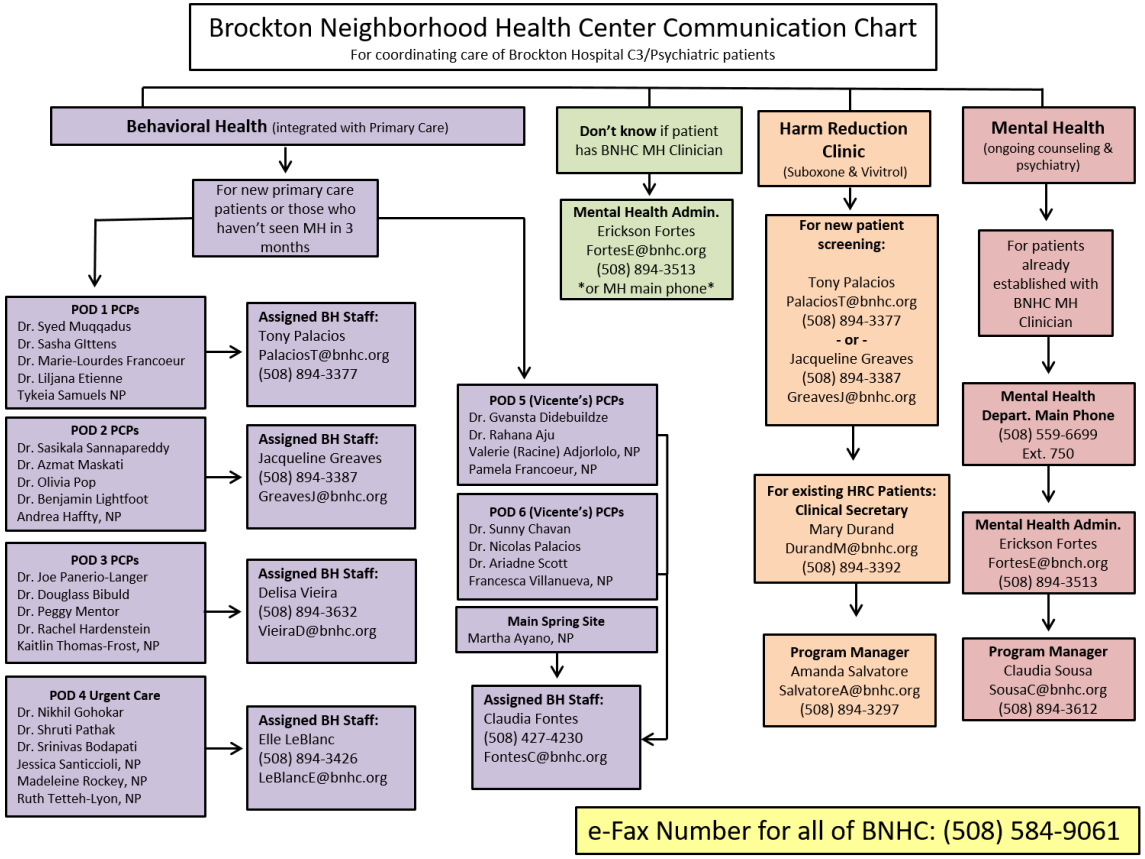
Trading Partners
Brockton Neighborhood health Center
Signature Healthcare Brockton Hospital
Good Samaritan Medical Center
Brockton Area Multi-Services, Inc. (BAMSI)
High Point Treatment Center

Comparing Workflows – Sectioning a Patient



Brockton Neighborhood Health Center

Who do I coordinate care with?



Brockton Neighborhood Health Center

Workflow Best Practices: Brockton Neighborhood Health Center

- **Use Case: Exchange of a CCD when sectioning a patient (between Brockton Neighborhood Health Center and Brockton Hospital – could be expanded in future)**

Workflow Challenges	Best Practices Used
Determining who sends and receives a CCD	Engagement of direct care staff, and allowing them to self-identify issues in the existing workflow
Knowing the right person to receive information or coordinate care with	Development of communication chart; use of “free text” field when transmitting a CCD
Anticipated challenge: some staff will be less likely to adapt the new workflow and therefore send CCDs	Find a “project champion” in each department to encourage peers to use new workflow

Workflow Best Practices: Brockton Neighborhood Health Center

Greatest Success of Grant Project So Far:

Collaboration among trade partners. We've really developed the ability to work together well, even as five different organizations with different needs and priorities.

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Lunch & Networking

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MeHI 2016 Behavioral Health Learning Collaborative Update

Lis Renczkowski, Content Specialist, MeHI
Samantha Halloran, Compliance Manager and HIPAA Privacy & Security Officer, BNHC
Allyson Pinkhover, MPH, Connected Communities Program Manager, BNHC

Impetus for Learning Collaborative

- Behavioral Health information-sharing is often limited by misconceptions about laws and regulations
  - Specific (often stricter) laws and regulations for behavioral health and substance use disorder information
  - Confusion and reluctance among care providers
    - Tendency to err on the side of caution
    - Sharing is reduced to “lowest common denominator”
  - May lead to inconsistencies, fragmented care, and poor patient outcomes
- MeHI decided to address these issues through a Learning Collaborative
  - Give participants a forum to define problems and what might help
  - Develop tools to:
    - Facilitate communication among providers and encourage participation in BH information exchange
    - Educate patients and caregivers about the benefits and potential risks of health information-sharing

Participants

- Amesbury Psychological Center
- Baystate Community Services
- Beacon Health Options
- Behavioral Health Network
- Berkshire Health Systems
- Brockton Neighborhood Health Center
- Child and Family Services
- Experience Wellness Centers
- HighPoint Treatment Center
- L.U.K. Crisis Center, Inc.
- Lowell House
- MA Attorney General's Office
- Mass League of Community Health Centers
- MassHealth
- Multicultural Wellness Center, Inc.
- South Shore Mental Health
- SSTAR
- UMass Medical School

Process & Timeline

Phase	Activities
Workshop 1 October 7, 2016	• Approved scope of project and work products • Reviewed first drafts of Patient Handout and Patient Talking Points
Workshop 2 November 4, 2016	• Reviewed revised Patient Handout and Patient Talking Points • Reviewed first draft of Provider Discussion Document
Workshop 3 December 16, 2016	• Reviewed revised Provider Discussion Document • Reviewed first draft of Administrator FAQs and Consent Form Template

Legal Review	• Outside legal counsel reviewed and provided recommendations on
	  • Provider Discussion Document
	  • Administrator FAQs
	  • Consent Form Template
	• Documents updated accordingly

Pilot, Education and Promotion July-December 2017	• Published tools on MeHI website mid-July • Currently piloting documents at participating organizations and collecting feedback • Plan to deliver educational webinars

Learning Collaborative Work Products

- Patient Handout
  - Designed to be given to patients; explains what behavioral health information is and the benefits and risks of sharing it
- Patient Talking Points
  - Designed to educate staff and prepare them to answer patient questions
- Provider Discussion Document
  - Intended to foster mutual, accurate understanding of requirements for sharing behavioral health information
- Administrator FAQs
  - Designed to help management understand requirements for sharing behavioral health and other sensitive information
- Consent Template
  - Intended to help providers standardize their patient consent rules and procedures

Pilot: Brockton Neighborhood Health Center (BNHC)

July 2017

- Distributed four of the work products to program managers and administrative staff in Behavioral Health, Mental Health, and Harm Reduction Clinic
  - Administrator FAQs, Consent Form, Patient Talking Points, Provider Discussion Document
  - Waiting to share Patient Handout – needs to be translated into other languages
- Qualitative feedback: Program Managers were grateful for reference documents that had undergone legal review

August 2017

- Continued to use tools with new patients in Harm Reduction Clinic
- Rolled out documents to 10 additional providers in Mental Health Department
- Qualitative feedback: providers in the Mental Health Department had questions about BNHC policies governing appropriate use of the consent form
  - i.e. if Consent Form should only be used for clinical purposes, or when disclosing information to a lawyer or family member
  - Use of the tools is prompting discussion and decision-making about internal policies

Pilot: Brockton Neighborhood Health Center (BNHC)

September 2017

- Continued to use tools in both the Harm Reduction Clinic and the Mental Health Department
- Qualitative feedback: staff reported that use of the tools was going well and that patients had few questions and were willing to sign the Consent Form.
- Next steps: BNHC is contracting to create an electronic version of the Consent Form to make filling out the form easier, including auto-populating demographic information, and to better track whether or not a consent form is on file.

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MeHI 2017 Learning Collaborative: Interoperability and Workflow

Keely Benson, MPA, Connected Communities Program Manager, MeHI

MeHI 2017 Learning Collaborative: Interoperability & Workflow

- In partnership with representatives from 20 healthcare organizations, MeHI developed and refined a set of planning tools for organizations participating in Health Information Exchange (HIE)
  - These resources outline the decisions and steps involved in establishing interoperability and engaging in successful information exchange
  - The tools are designed to work in a variety of diverse care settings, offering universal best practices while also allowing for customization

MeHI 2017 Learning Collaborative: Interoperability & Workflow

- The Learning Collaborative focused on 2 use cases (or “care coordination stories”) and the interoperability and workflow requirements necessary to support their success
  1. Hospital (inpatient unit) to post-acute care providers- skilled nursing facility, inpatient rehabilitation facility or home care agency
  2. Hospital emergency department to community health center/behavioral health organization
- MeHI hosted 3 Learning Collaborative Workshops. Through group review and feedback the Learning Collaborative produced two detailed document tools
  - Comprehensive HIE Use Case Planning Form
  - HIE Technology and Workflow Project Plan
- 35 individuals participated in the 2017 Learning Collaborative. These individuals represented 20 distinct organizations.

List of Participating Organizations

- Berkshire Healthcare System
- Brockton Neighborhood Health Center
- Child and Family Services
- D'Youville Life & Wellness Community
- EOHHS/Mass Hlway
- Experience Wellness
- Gosnold, Inc.
- Kindred Eagle Pond
- Lowell General Hospital
- Lowell General PHO
- Lynn Community Health Center
- Marian Manor / The Carmelite System
- Mass League
- Reliant Medical Group
- Signature Healthcare - Brockton Hospital
- South Shore Mental Health
- SSTAR and SSTAR of Rhode Island
- Steward Healthcare - Good Samaritan Hospital
- Tufts Medical Center
- Upham's Corner Health Center

Major Takeaways from Workshops 1 and 2

- Healthcare organizations who plan to exchange clinical information electronically need to breakdown much of the planning information between the sending organization and receiving organization so that staff understand their roles and responsibilities in the data exchange and care coordination process
- Need to understand early on the specific clinical information that is needed by the receiving organization and the documents that contain that clinical information
- Need to determine what types of documents sending organizations are capable of sending, and what receiving organizations are capable of consuming
- All stakeholders that will be involved in the implementation of the use case should be identified early on
  - All vendors (EHR, HISP vendors including the Mass HIway)
  - Staff that will be impacted by workflow changes and a workflow champion should be identified
  - Organizational leadership buy-in

Use Case Planning Form for Health Information Exchange

- Planning Form
  - Designed for use within organizations to provide sponsors, IT, clinical and non-clinical staff with an understanding of the purpose of the planned interoperability project and its value to the organization, patients, staff and the community
  - Addresses various impacts of implementing the use case and includes details about what the use case requires and how it operates at a high level
- Goes beyond the Use Case Development Form used in the Connected Communities Grant

Use Case Planning Form for Health Information Exchange

- Captures requirements for both the organization sending clinical information and the organization receiving it

Organization Information	Sending Organization	Receiving Organization
Name		
Organization Type		
Executive Sponsor (include contact info.)		
Primary Contact (include contact info.)		
EHR System		
HISP		
Can data be exchanged between networks/EHRs now?		
Investment required What additional modules and/or development are required? What level of staff training will be required? Consider initial cost and ongoing support.		
Project Start Date Kick off meeting		
Proposed Key dates and Milestones For example: Sending Organization: 1. HIE module in place 12/31 Receiving Organization: 1. Test transaction 3/1 2. Test transaction validated 3/31 3. Test transaction loaded into system 5/1		
Direct address to be used		

Use Case Planning Form for Health Information Exchange

- Identifies the stakeholders and project team members that should be included early on and captures relevant contact information

Project Team	Sending Organization	Receiving Organization
Sponsor (from sending OR Receiving Organization)		
Project Lead/Manager Responsible for the entire project (from sending OR receiving organization)		
Trading Partner Project Lead/Primary Contact Reports to the project manager. Responsible for tasks at own organization.		
Clinical/Direct Care Staff Representative A representative from each department involved. Ideally, a technology super-user, or other champion of HIE, but someone who understands the workflow in that dept. (See list of Clinical/Direct Care Staff Representatives below)		
IT Main contact		
IT Support Contact		
EHR Vendor Support Contact		
Other if not listed above (Staff trainer, workflow champion)		

Use Case Planning Form for Health Information Exchange

- Includes specific considerations for patient consent to increase clinical information exchange once technology is in place

Patient Consent	Sending	Receiving
Data sharing Is there a process in place to ensure that patient's will have signed a consent to share their clinical information for treatment purposes through a Consent to Treat or Notice of Privacy Practices form?		
42 CFR Part 2 If behavioral health (BH) or substance use disorder (SUD) information is going to be exchanged, is there a process in place to ensure that the patient has signed a general designation to share their BH/SUD information (part of updated 42 CFR Part 2 Rule)?		

Use Case Planning Form for Health Information Exchange

- Includes detailed section for data requirements to support specific care-coordination story

Data Requirements (see Recommended Clinical Documents for receiving organizations below for additional information)	Sending	Receiving
C-CDA document templates supported **C-CDA document template types: Available in C-CDA R1.0/R1.1:** Continuity of Care Document (CCD) Discharge Summary History and Physical (H&P) Consultation Note Diagnostic Imaging Report (DIR) Operative Note Procedure Note Progress Note Unstructured Document **Additional Document Types available in C-CDA R2.0:** Care Plan Referral Note Transfer Summary		
C-CDA document template required for use case		
Attachment type supported For example: .pdf, .xls, .csv		
Attachment type required		
Other data/documents not included in C-CDA supported or needed for use case **For example:** 1. Discharge Instructions if summary is not available 2. BH Comprehensive assessments 3. MOLST		
When will document be sent (after patient encounter, in hourly or daily batch)?		

Technical and Workflow Project Plan for HIE

- Purpose:
  - Develop a pre-filled project plan that includes the specific areas of effort and the tasks associated with them that must be addressed when implementing one of the discussed use cases.
- Areas of Effort/Focus
  - Stakeholder Engagement
  - Technology Requirements
  - Workflow
  - Measuring Outcomes/Quality Reporting

2017 Learning Collaborative Tools on MeHI website

- 2017 Learning Collaborative Tools can be found on the MeHI website
  - Use Case Planning Form
  - Technical and Workflow Project Plan (will be added soon)

http://mehi.masstech.org/support/learning-collaboratives

- Please send comments to Lis Renczkowski (renczkowski@masstech.org) or Keely Benson (benson@masstech.org)

Spring 2018 Learning Collaborative

- Preview: Spring 2018 Learning Collaborative
  - How to Optimize Impact of HIE on the Receiving Side?
  - Critical Activities in Process Improvement
  - Process Mapping: a Key Tool in Process and Change Management
  - Example Processes: Designing Patient-Centered Care Coordination
    - How to Use Process Mapping to Optimize the New Process?
  - Example Process Questions: Upon Receipt of CCDA, What Do We Do With It? How Will We Close the Loop?
  - Seeking Participants

Questions?

Commonwealth of Massachusetts
Executive Office of Health and Human Services

The Mass HIway Connection Requirement

December 2018

What Is the Mass HIway?

The Mass HIway is the statewide Health Information Exchange (HIE) providing secure, electronic transport of health-related information between health care organizations and providers regardless of affiliation or technology. The Mass HIway offers:

- **HIway Direct Messaging** offers a secure point-to-point transport of electronic patient health information among healthcare organizations and authorized government agencies for purposes of patient treatment, payment, or operations. The Mass HIway does not use, analyze or share information in the transmissions.
- **HIway Provider Directory** offers a searchable directory of healthcare providers operating statewide to support provider to provider communications. The directory contains information for 21,000+ providers.
- **HIE Adoption and Utilization Services (HAUS)** offers project management services to Medicaid providers to assist with the challenges of implementing provider to provider communications over the Mass HIway. Mass HIway is working with MassHealth to tailor these services to serve the Medicaid ACO pilot project.
- **Connection to Massachusetts Registries** to facilitate submission to 9 Massachusetts Department of Public Health and MassHealth applications. These include the immunization registry, syndromic surveillance, and childhood lead poisoning reporting and account for over 7.7 million transactions per month.

HIway connection requirements for 2018

Reminder for Connected Communities Grantees: As per 101 CMR 20.00 (also known as the Mass HIway Regulations), a next phase of HIway connection requirements will become effective in January 2018, with an attestation form due to EOHHS on July 1, 2018.

Below are the HIway connection requirements for 2018:

- **Acute Care Hospitals:**
  - **January 1, 2018:** Their Year 2 requirement is to send or receive HIway Direct Messages for at least one use case that is within the **Provider-to-Provider Communications** category of use cases
  - **July 1, 2018**: due date for the Year 2 Attestation Form

- **Large & Medium Medical Ambulatory Practices and Large Community Health Centers:**
  - **January 1, 2018:** Their Year 1 requirement is to send or receive HIway Direct Messages for at least one use case (and that use case can be within any category of use cases)
  - **July 1, 2018:** due date for the Year 1 Attestation Form
  - As per section 20.06 of the regulations, Large & Medium Medical Ambulatory Practices, and Large Community Health Centers have 10 or more licensed providers participating in providing health care.

    In the regulations, a licensed provider is defined to be a medical doctor, doctor of osteopathy, nurse practitioner, or physician assistant.

Source: Adapted from the November HIT Council Meeting Presentation

Next steps

- **The updated *Year 1 Attestation Form* and the new *Year 2 Attestation Form* are expected to be available in early 2018:**
  - *January 1, 2018:* a paper version of the Attestation Form is expected
  - *March 2018:* an on-line version of the Attestation Form is expected
    (Note: EOHHS prefers Provider Organizations to use the on-line version)
  - *July 1, 2018:* due date for Provider Organizations to submit the Attestation Form

- **The Mass HIway will host a webinar about the HIway connection requirement and the attestation process:**
  - The webinar will be on Thursday Jan 18, 2018. Noon – 1pm.
  - More information is available on the Mass HIway website: http://www.masshiway.net

- **Stakeholders can contact the Mass HIway about the attestations form:**
  - To ask a general questions about the attestation: MassHIway@state.ma.us
  - To submit a completed attestation form: MassHIwayAttestation@state.ma.us

Source: Adapted from the November HIT Council Meeting Presentation

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Closing Remarks

Closing Remarks: 2018 and Beyond

- Sustainability of Connected Communities Grant Projects to improve care coordination within your communities
  - Milestone 4: Sustainability Plan
  - Maintaining relationships beyond the grant
- Thank you for your commitment to improving interoperability and patient care within you communities!
- Thanks to:
  - Panelists and Speakers
  - MassHealth
  - Mass HIway
  - Health Policy Commission
  - MeHI Staff

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Thank you!