AMERICA'S ESSENTIAL HOSPITALS

Boston Medical Center's Experience with DSTI

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AGENDA

- Set the stage (MA – BMC network – DSTI)
- Over view of our DSTI projects
- More detailed review of selected projects to address questions
- Lessons learned

OUR SYSTEM (AND FUTURE ACO)

- Hospital - Boston Medical Center
- School - Boston University School of Medicine
- Primary Care - Boston Health Net at its CHCs
- Managed Care Plan - Boston Medical Center Health Plan (BMCHP)
- Providers – Faculty Practice Foundation (primary and specialty care) and Boston HealthNet employed by the CHCs
- Payers – Massachusetts Medicaid (and subsidized products), Medicare, BMCHP, other Medicaid MCO's, Medicare, Medicare MCO's, other commercial payers

BOSTON MEDICAL CENTER

Boston Medical emphasizes community-based care, with its mission to provide consistently accessible health services to all

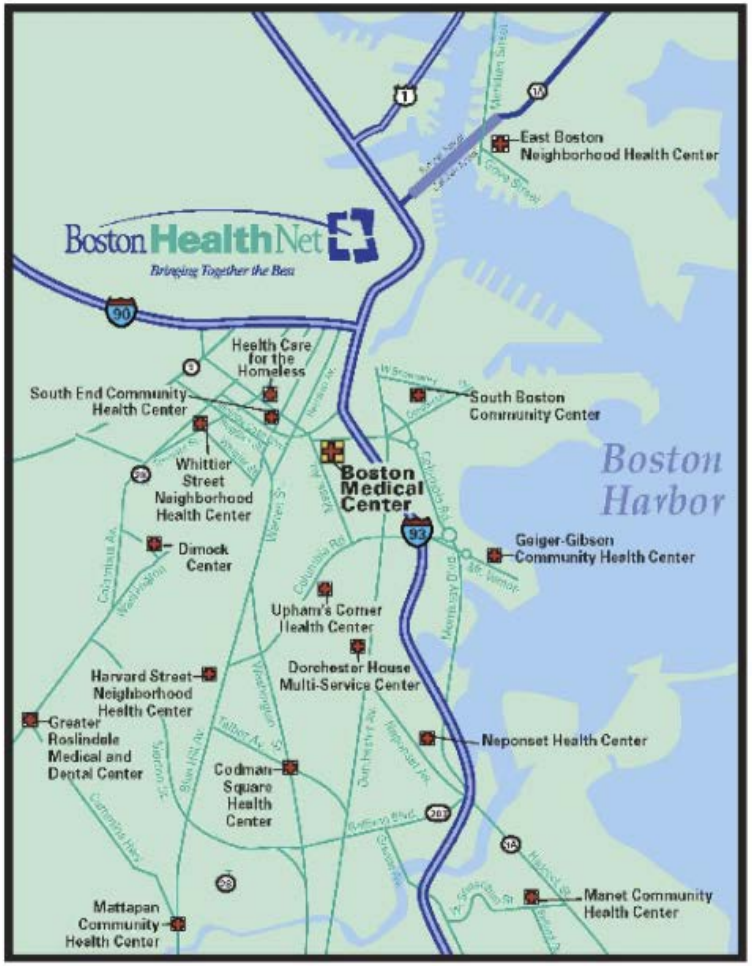
- 496-bed private, not-for-profit, hospital located in Boston's historic South End and is the primary teaching affiliate for Boston University School of Medicine.
- Largest safety net hospital in New England, with 26,035 admissions and 870,922 patient visits in the last year
- Busiest provider of trauma and emergency services in New England, with 129,783 visits last year.
- 70% of our patient visits come from underserved populations,
- 29% do not speak English as a primary language.

BOSTON UNIVERSITY SCHOOL OF MEDICINE

- BUSM was formed in 1873 when Boston University merged with the New England Female Medical College, becoming the first coeducational medical school. The New England Female Medical College, founded in 1848, was the first institution in the U.S. to train women in medicine and graduated the first black woman physician. Throughout our history, we have maintained a strong commitment to the study and practice of medicine in the context of a mission of service to society.

BOSTON HEALTHNET

- Established in 1995, Boston HealthNet is an integrated health care delivery system
- Comprised of the Boston Medical Center, Boston University School of Medicine and 15 community health centers.
- Population 250,000 – 300,000
- In FY 2013 Boston HealthNet health center patients accounted for 36.9% of all inpatient admissions to Boston Medical Center.



BOSTON MEDICAL CENTER HEALTH PLAN, INC. (BMCHP)

- Not-for-profit health maintenance organization founded in 1997 by Boston Medical Center.
- Serves over 295,000 members across the state through several product lines: MassHealth (Medicaid, including CarePlus), Qualified Health Plans, Commonwealth Care and Commonwealth Choice, a commercial plan.
- Largest MassHealth managed care plan in Massachusetts
- Newly approved insurance carrier in New Hampshire
- Consistently rated one of the top ten Medicaid health plans in the country according to the National Committee for Quality Assurance (NCQA) Medicaid Health Insurance Plan Rankings.

CARE PROVIDERS

BU FACULTY PRACTICE FOUNDATION VISION: We will transform healthcare as an integrated academic multi-specialty practice that defines and delivers equitable, high value, evidence-based care in partnership with our patients, institutions, and community.

MASSACHUSETTS PAYMENT REFORM

- Near universal health care in 2006
- Chapter 224 in 2012 – "An Act Improving the Quality of Health Care and Reducing Costs Through Increased Transparency , Efficiency and Innovation"

WHAT IS DSTI?

- Delivery System Transformation Initiative
- Goal: Link financial incentives to the Triple Aim
- Authorized as a component of the MassHealth Section 1115 Medicaid demonstration. DSTI is year 15 – 17 of the waiver.
- Program was restricted to 7 of 60 hospitals in the state who met both eligibility requirements:
  - » High Medicaid payer mix – 1 SD above the state average
  - » Low Commercial payer mix – 1 SD below the state average

BMC AND DSTI

- DSTI is key for financial success
- 3 year program July 2011 – June 2014 (not finalized until June 2012)
- We are currently working on DSTI 2.0 planned to be a 5 year renewal
- We look at DSTI as a 8 year project which we are now transitioning between from year 3 to year 4.

DSTI OBJECTIVES

- Category I – Further Development of an Integrated Delivery System.
- Category II – Improve Health Outcomes and Quality
- Category III – Enhance the ability to respond to state wide payment reform
- Category IV – Population Focused improvements

BMC DSTI PROJECTS

Category I – Further Development of an Integrated Delivery System.

- 1.1 – Patient Centered Medical Home
- 1.2 – Practice Support Center

Category II – Improve Health Outcomes and Quality

- 2.1 – BMC Simulation and Education Center
- 2.2 – Rapid Diabetes referral and follow up
- 2.3 – Project RED

Category III – Enhance the ability to respond to state wide payment reform

- 3.1 – ACO development
- 3.2 – Learning collaborative

Category IV – Population Focused improvements

QUESTIONS TO ADDRESS

1. How are you measuring outcomes? To what extent are you measuring results that go beyond the CMS measures?
2. Have you implemented DSRIP (DSTI) projects that have resulted in measurable net savings for the institution?
3. What implications has the waiver had on other areas of the hospital?
4. What practices have you put in place to ensure sustainability of your achievements?
5. What barriers did your team face over the course of the project? How did you overcome them?
6. Describe the experience from a clinical perspective and a leadership perspective. How did these experiences affect outcomes, if at all?
7. Can your results be replicated in other organizations?

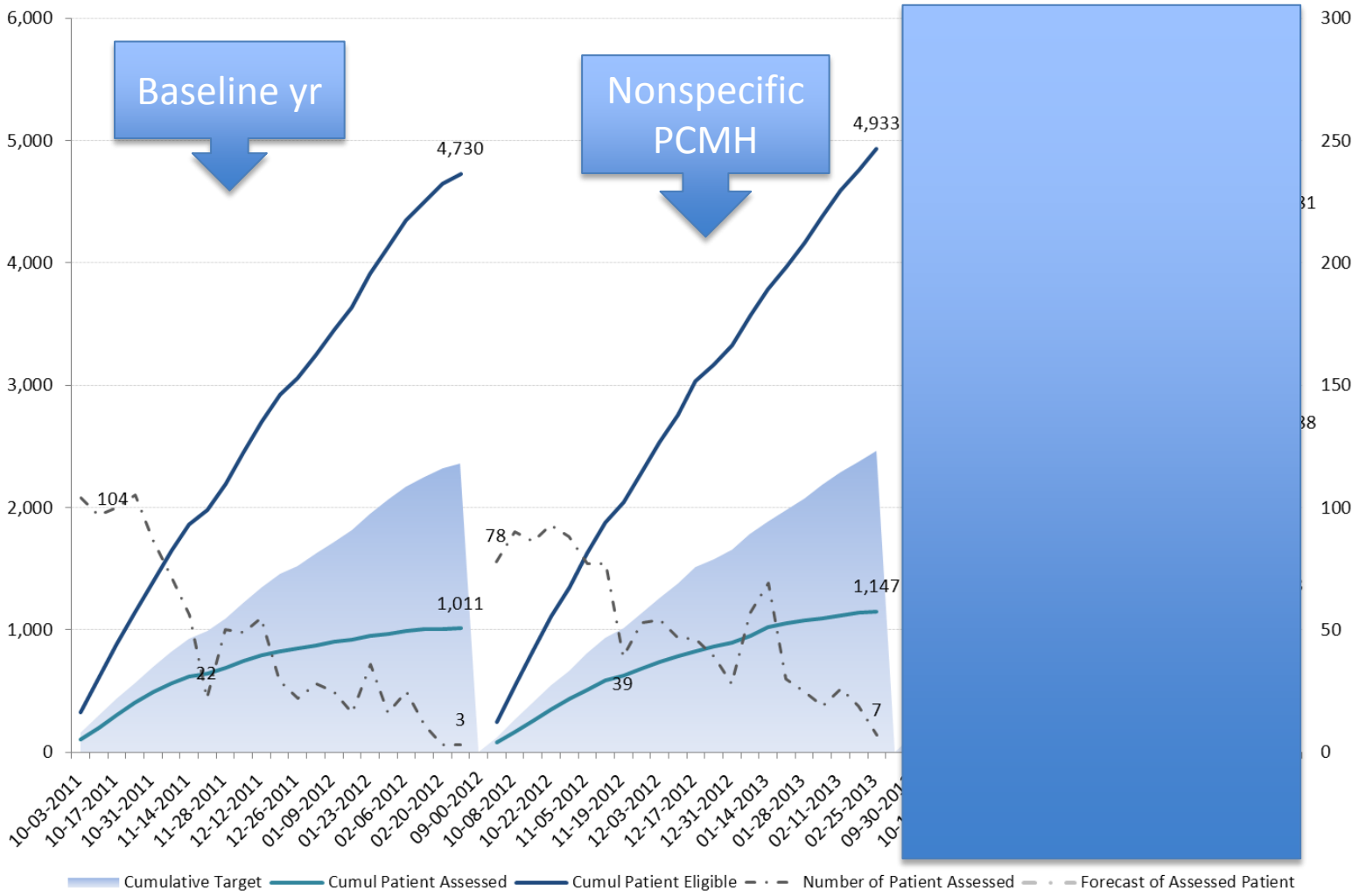
1.1 – PATIENT CENTERED MEDICAL HOME

- NCQA Medical Home
  - » Level 1 → 3
- Steering and Quality Committee
- Screening and prevention metrics improvement
- Collaborative culture

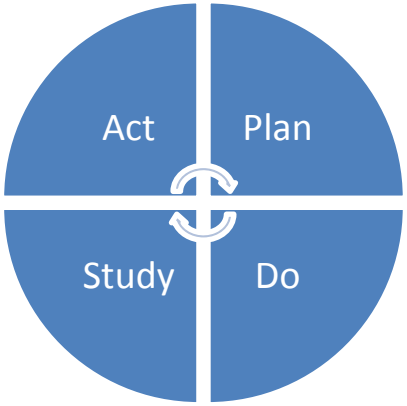
- IT issues
  - » Competing resources
  - » Clarity of requirements
- HR issues
- Cost issues
- Payments at odds with long range plans
- Perfection v. "just do it"

Family Medicine: Flu Vaccine Trend

*The target assumes 50% of eligible patients should get the vaccine




Pap
Team
Solutions
Provider issues
Systems Issues
Target
80%


Act
Plan
Study
Do

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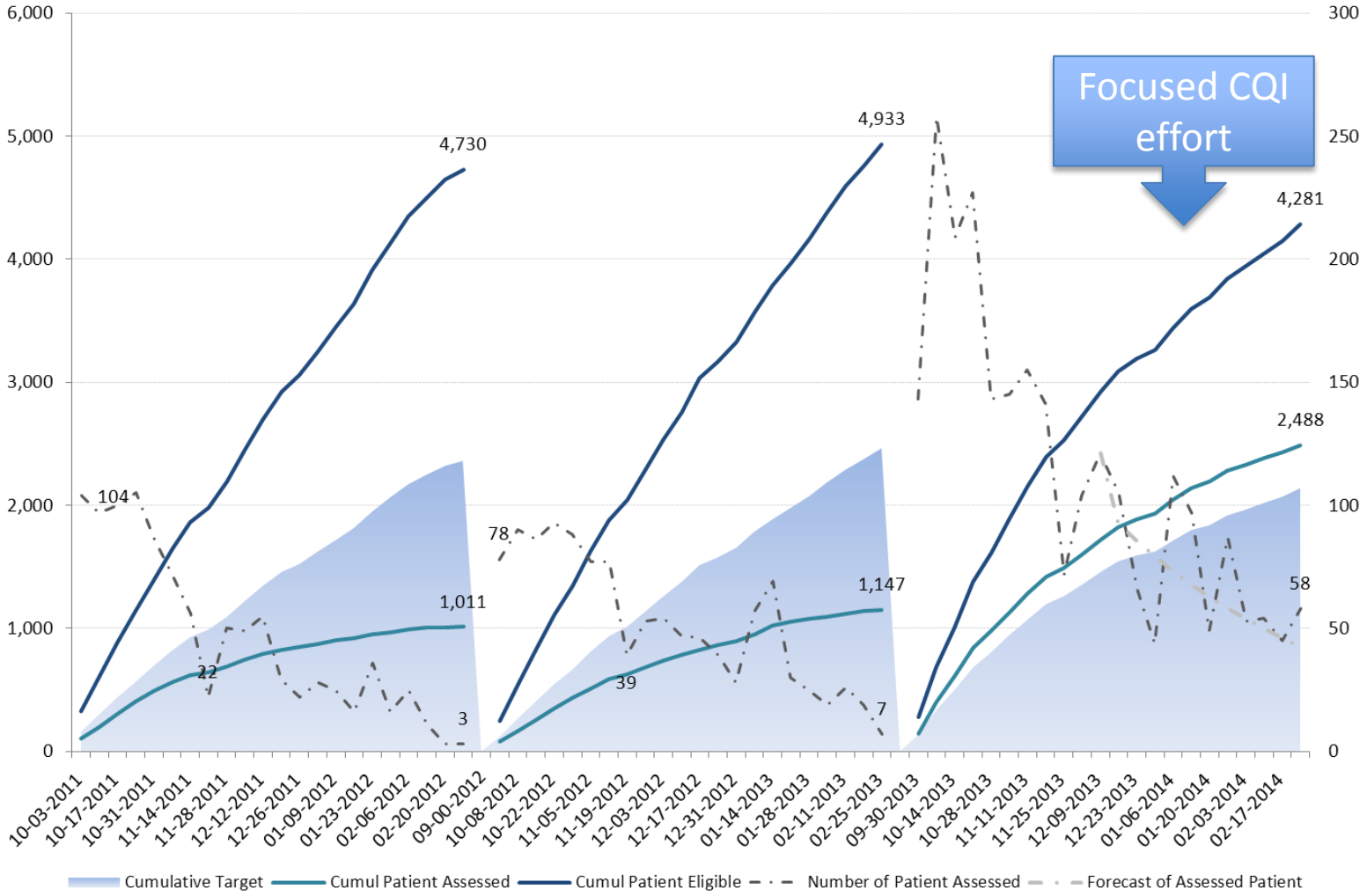
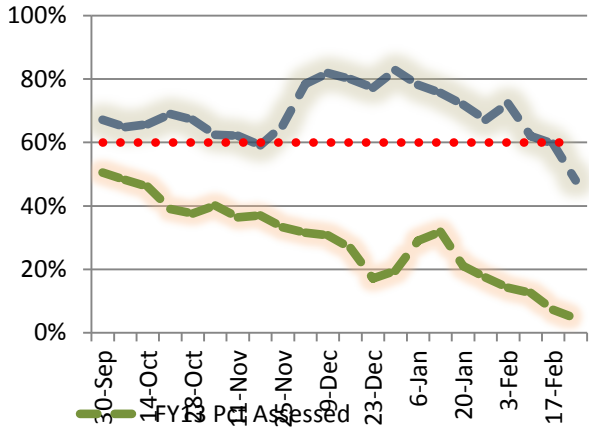
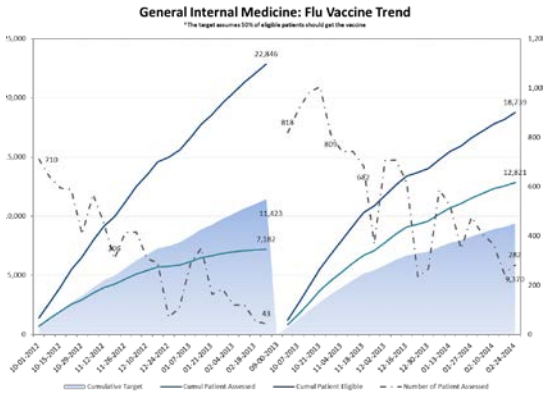
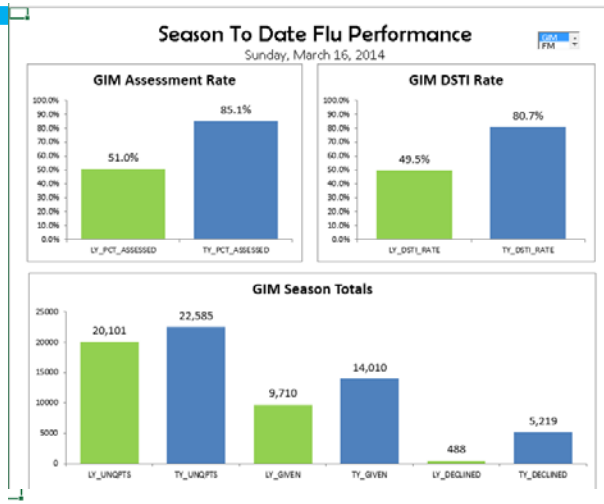
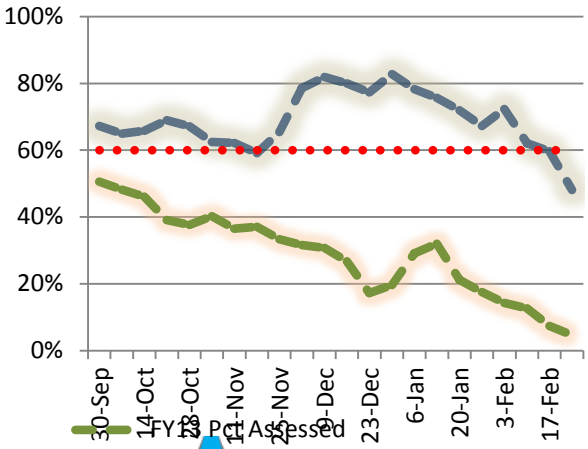


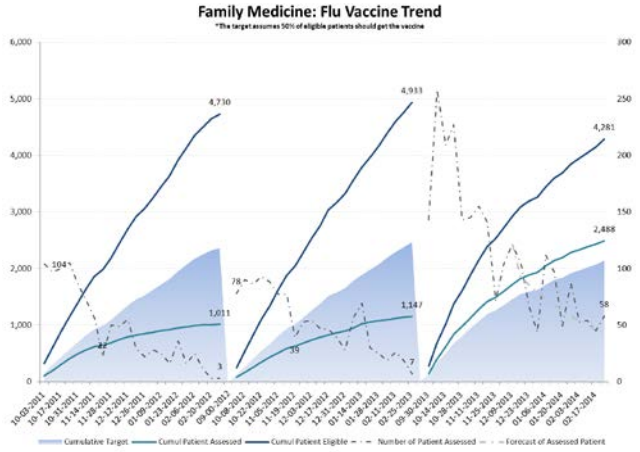
FLU VACCINATION METRICS

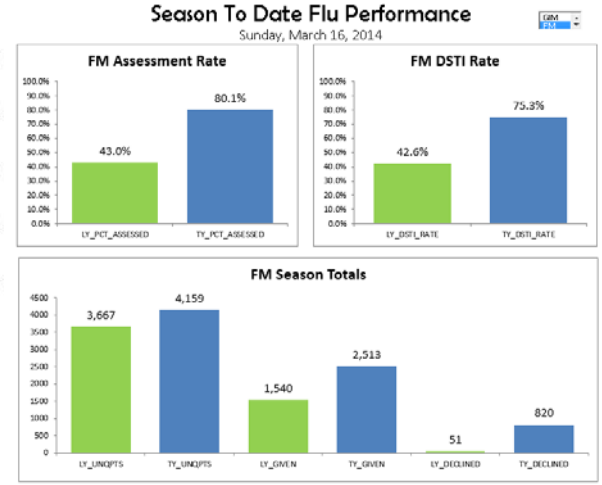












1.2 – PRACTICE SUPPORT CENTER

Measures:

- Call answering
- No show rates
- Outreach calls
- Hospital follow up appointments within 3 weeks
- Patient experience

Challenges:

- Bad data – contact info
- "No show" rates hard to move this way…Transportation is really the issue
- Live outgoing calls resource intensive

2.1 – BMC SIMULATION AND EDUCATION CENTER

- Multi-disciplinary approach to training.
- 13 new trainings designed and implemented to 1,800 clinical staff

- Anesthesia perioperative teams training
- Geriatrics family meeting
- Medicine "code blue"
- Nursing Critical care competency day
- Nursing ED competency day
- Labor and Delivery Teams training
- Phlebotomy Customer experience

3.1 – ACO DEVELOPMENT

- Consultant
- Scope of project
- Readiness report
  - » Process to develop by-laws and participation agreements
  - » High level funds flow
  - » Gap analysis
- Implementation timeline
- Leadership participation/education

Challenges:

- Developing high level financial models was difficult:
  - » access to Medicaid claims based data
  - » CHC financial system capabilities
- Independence of participating members each with a board
- IT infrastructure: Data sharing need for ACO not fully possible
- Slow roll out by state

3.2 – LEARNING COLLABORATIVE

- Structure – Led by America's Essential Hospitals
- Events
- Topics:
  - » Leading Change
  - » Lessons from CA DSRIP
  - » Future of PCMH
  - » Chronic Disease Management
  - » Integrating Physical & Behavioral Health (BH)
  - » Complex Care Management
  - » Improving Transitions of Care
  - » Preparing for alternative payments

Learning:

- Data driven decisions, analytics & IT resources
- Safety net patients offer inherent challenges.
- Integrate physical and BH.
- Team-based care, enhanced collaboration across disciplines & a focus on multiple dimensions of care
- Proper organizational & strategic alignment
- Continuous refinements and improvements
- Existing reimbursement policies are not structured to facilitate transformation.
- Restructuring is necessary for payment reform.

CATEGORY IV – POPULATION FOCUSED IMPROVEMENTS

- Core metrics
- Hospital specific metrics

LEADERSHIP PERSPECTIVES

- Projects aligned with key parts of BMC's strategic plan to:
  - » Provide the Right Care for every patient
  - » Operate as the lowest cost, highest performing health care provider
  - » Lead the transformation toward an integrated ACO
- Leadership Counsel established
- Each project has: VP sponsor, business owner, IT and clinical staff (~100 people total overall)

CLINICAL PERSPECTIVES

- Each team had multidisciplinary membership
- Many of the VP sponsors were clinicians
- Clinical Leadership understanding and buy-in was key.

WHAT CAN BE REPLICATED?

- All of it. Each project could be enacted at any hospital if it aligns with strategic goals and leaders are behind it.
- Key items to consider replicating:
  - » Leadership system
  - » Focus on a few goals, as IT independent as possible.
  - » Learning Collaborative

LESSONS LEARNED

- Alignment with overall strategic goals to get full leadership backing is a must
- Quality Metrics should be chosen carefully and well defined
- Financial rigor: Develop a system to track finances (cost/savings)
- IT system - important but be mindful of it change and analysis capacity
- Transformation takes time; time for training is crucial
- One cannot over communicate
- Using data to inform decisions prevents errors
- Cross disciplinary work from the start prevents waste
- Monitoring systems and be ready to adjust your approach
- Support your people leaders and staff – change is hard.

THANK YOU

- All the DSTI group members that did this work.
- Tom Traylor and Ellen Daley
- Maryam El Kherba and Roshan Hussain (IT analytics)
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- Brian Jack, MD
- DSRIP pioneers (CA)
- Staff of America's Essential Hospitals