



MASSACHUSETTS
HEALTH POLICY COMMISSION

Mental Health America Regional Policy Meeting:
*Proceeding in the Evolving Public and Private
Landscape*

August 8, 2017



AGENDA

- About the HPC
- Investment Programs
- Provider Certification Programs
- Behavioral Health Integration Research

Chapter 224 of the Acts of 2012 established the HPC and a target for reducing health care spending growth in Massachusetts.

Chapter 224 of the Acts of 2012

An Act **Improving the Quality** of Health Care and **Reducing Costs** through Increased **Transparency, Efficiency, and Innovation**.



GOAL

Reduce total health care spending growth to meet the **Health Care Cost Growth Benchmark**, which is set by the HPC and tied to the state's overall economic growth.



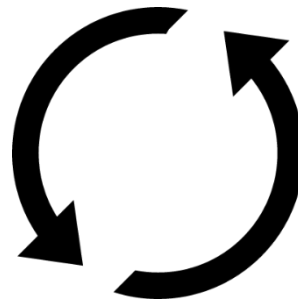
VISION

A **transparent** and **innovative** healthcare system that is **accountable** for producing **better health** and **better care** at a **lower cost** for the people of the Commonwealth.

The HPC, in collaboration with others, promotes and monitors priority policy outcomes that contribute to the goal and vision of Chapter 224.

Strengthen market functioning and system transparency

in which payers and providers openly compete, providers are supported and equitably rewarded for providing high-quality and affordable services, and health system performance is transparent in order to implement reforms and evaluate performance over time.



The two policy priorities reinforce each other toward the ultimate goal of reducing spending growth

Promoting an efficient, high-quality system with aligned incentives

that reduces spending and improves health by delivering coordinated, patient-centered and efficient health care that accounts for patients' behavioral, social, and medical needs through the support of aligned incentives between providers, employers and consumers.

The HPC employs four core strategies to advance its policy priorities.

RESEARCH AND REPORT

INVESTIGATE, ANALYZE, AND REPORT
TRENDS AND INSIGHTS



CONVENE

BRING TOGETHER STAKEHOLDER
COMMUNITY TO INFLUENCE THEIR
ACTIONS ON A TOPIC OR PROBLEM



PARTNER

ENGAGE WITH INDIVIDUALS, GROUPS,
AND ORGANIZATIONS TO ACHIEVE
MUTUAL GOALS



WATCHDOG

MONITOR AND INTERVENE WHEN
NECESSARY TO ASSURE MARKET
PERFORMANCE



Research, convening, and partnering are critical to HPC's efforts to promote behavioral health integration.

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HPC promotes
integration through
**investments, certification
programs**, and a
research agenda to
track trends.



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HPC Investment Programs

HPC's care delivery transformation investments advance our vision of accountable care:

A health care system that efficiently delivers on the triple aim of better care for individuals, better health for populations, and lower cost through continual improvement through the support of alternative payments.

CHART Phase 2

Community Hospital Acceleration, Revitalization, and Transformation

\$60 million invested • **25** competitively selected projects • **24** months

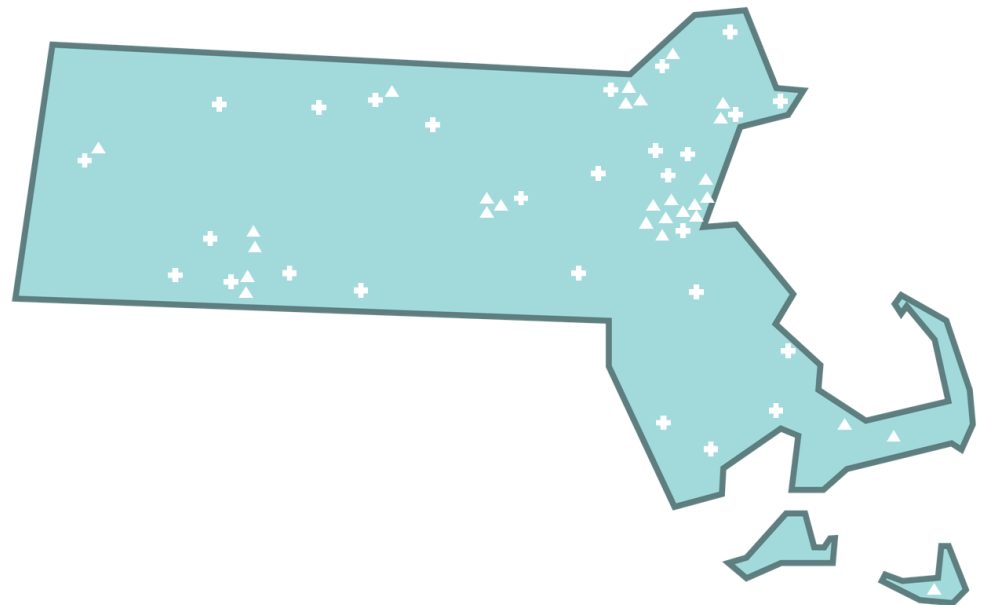
→ Investments in certain community hospitals¹ to enhance the delivery of efficient, effective care

HCII

Health Care Innovation Investments Program

\$11+ million invested • **20** competitively selected projects • **3** pathways

→ Targeted Cost Challenge Investments (TCCI)
→ Telemedicine Pilot Initiative
→ Mother and Infant-Focused Neonatal Abstinence Syndrome (NAS) Interventions



¹ CHART hospital eligibility, as determined by Chapter 224 of the Acts of 2012, excludes acute care hospitals or health systems with for-profit status, excludes major acute care teaching hospitals, and excludes hospitals whose relative prices are determined to be above the statewide median relative price.

✦ CHART Phase 2 awardees

▲ HCII awardees (inclusive of Telemedicine Pilot partners)



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CHART award: Beth Israel Deaconess Hospital – Plymouth



Beth Israel Deaconess Hospital
Plymouth

\$5.2M

Total project cost

\$3.7M

HPC CHART
investment

\$1.5M

In-kind
investment



7,567

patients served
to date*

TARGET POPULATIONS

All patients
with dual
eligibility

ED patients with
a primary
behavioral
health diagnosis

PRIMARY AIMS



Reduce 30-day returns
by

10%

for patients with dual
eligibility

Reduce 30-day ED revisits
by

20%

for patients with primary
behavioral health diagnosis

PROGRAM SUMMARY

In BIDH–Plymouth’s Complex Patient Program, patients with dual eligibility are screened and assessed by a nurse care manager for healthcare services and social support needs. A member of the multidisciplinary care team provides home visits and patient needs are managed across the continuum of care, including collaboration with skilled nursing facilities, primary care, hospice, and palliative care service providers. Care plans are developed, implemented, and reassessed on an ongoing basis. The Integrated Care Initiative (ICI) uses a community-wide approach to care for behavioral health patients: behavioral health services are co-located in primary care practices, with social workers providing care during PCP visits. In the ED, the behavioral health team works with ED staff and community providers to help stabilize patients, assess needs and access necessary supports, and ensure continuity of care in the community.

KEY INNOVATIONS TO IMPROVE QUALITY AND ACCESS TO BEHAVIORAL HEALTH TREATMENT

→ **Collaboration with the Plymouth Police Department to send clinicians to patients’ homes following a drug overdose with the goal of enrolling patients in addiction services and/or transporting patients directly to detox if desired.**

→ **ICI clinicians provide referrals to the Plymouth Drug and Mental Health Court for patients with open charges that appear to be related to addiction.**

CHART award: Beth Israel Deaconess Hospital – Milton



Beth Israel Deaconess Hospital
Milton

\$2.2M

Total project cost

\$2M

HPC CHART
investment

\$224K

In-kind
investment



994

patients served
to date*

TARGET POPULATION

Patients in the ED with
LOS>8hrs who are referred
to SSMH for a behavioral
health crisis evaluation

PRIMARY AIM



Reduce excess ED boarding
by

40%

for long stay behavioral
health patients

PROGRAM SUMMARY

With extensive community collaboration with key partner South Shore Mental Health (SSMH), BIDH – Milton implemented an integrated behavioral health initiative with the goal of reducing excess Emergency Department (ED) boarding by 40%. The initiative includes rapid triage and timely crisis evaluation and supportive care, intensive stabilization and care management, expedient linkages to community partners and providers, community care management, peer support, and behavioral health navigation. A multidisciplinary team provides comprehensive clinical and supportive services. SSMH provides behavioral health clinical and navigation services in the BIDH – Milton ED and in the community. Multiple acute, community provider, municipal, and social service stakeholders participate in an integrated learning consortium.

KEY INNOVATIONS TO IMPROVE QUALITY AND ACCESS TO BEHAVIORAL HEALTH TREATMENT

- **Creation of a dedicated pod in the ED designed to calm and facilitate engagement with behavioral health patients in crisis.**
- **Community partner (South Shore Mental Health) clinicians are located in the ED, which supports positive relationship development with patients and expedites the referral process to services in the community.**

CHART award: Harrington Memorial Hospital

\$2.3M

Total project cost

\$2.1M

*HPC CHART
investment*

\$200K

*In-kind
investment*



7,777

*patients served
to date**

TARGET POPULATION

Patients with a primary or
secondary behavioral
diagnosis in the ED

PRIMARY AIM



Reduce 30-day ED revisits
by

15%

PROGRAM SUMMARY

Harrington Memorial Hospital aims to reduce recurrent Emergency Department (ED) utilization by increasing access to cross continuum care for patients with a behavioral health diagnosis. Behavioral health screening and assessment occurs throughout the hospital and ED and patients are engaged by a multi-disciplinary community outreach team of nurse navigators, social workers, and community health workers. Services include inpatient treatment for patients with co-occurring mental health and substance use disorders, a substance use intensive outpatient program, a partial hospitalization program, and intensive follow-up within the community, and transportation to improve access. Additionally, Harrington Memorial Hospital enhanced its partnership with Dudley District Court to provide clinical support and case management for patients with opioid-related court involvement.

KEY INNOVATIONS TO IMPROVE QUALITY AND ACCESS TO BEHAVIORAL HEALTH TREATMENT

- Behavioral health case finding throughout the hospital and primary care setting
- Patients are assessed and engaged in real-time
- Close collaboration with group homes
- ED utilization by patients with BH has decreased significantly over the course of the CHART program

Telemedicine award: Heywood Hospital

\$514,301

Total project cost

\$425,570

HPC investment

\$88,731

In-kind investment



900

*patients targeted
for services*

TARGET POPULATION

Students of Narragansett
Regional Middle & High
Schools, and students of Ralph
C. Mahar Regional School

PRIMARY AIM



Increase access to
behavioral health services by

10%

PROGRAM SUMMARY

Heywood Hospital has developed a collaborative school-based tele-behavioral health model focused on bridging gaps in care for children and adolescents with unmet behavioral health needs.

This initiative utilizes telehealth technology to increase much needed access to behavioral health care services by providing school-based counseling services through remote video consultations between students and CSO providers, with the additional support of a guidance counselor at the school acting as a care coordinator and tele-presenter.

This initiative leverages national evidence for utilization of telehealth to build on the foundation that was established by Heywood through their successive CHART Phase 1 and Phase 2 projects. This current work expands the types of services provided to students, and widens the net to include students at additional schools.

HEYWOOD HOSPITAL IS PARTNERING WITH THE FOLLOWING ORGANIZATIONS:

- Athol Hospital
- Clinical and Support Options (CSO)
- Narragansett Regional Middle School
- Narragansett Regional High School
- Ralph C. Mahar Regional School
- Northeast Telehealth Resource Center
- Mclean Hospital

TCCI award: Boston Health Care for the Homeless Program



\$919,085

Total project cost

\$750,000

HPC investment

\$169,085

In-kind investment



115

*patients targeted
for services*

TARGET POPULATION

High-cost MassHealth patients with high ED utilization (> 6 visits) and/or hospital utilization (> 2 admissions) in the most recent 6 months

PRIMARY AIM



Reduce total number of emergency department visits and hospitalizations by

20%

PROGRAM SUMMARY

Utilizing the Veteran's Health Administration's Homeless Patient Aligned Care Team Program as a template, Boston Health Care for the Homeless Program and its partners are leveraging the legal structure they developed as part of an EOHHS ICB grant to create a social-determinants Accountable Care Organization for high risk homeless patients engaging with providers across a spectrum of services.

Boston Health Care for the Homeless Program will serve as a hub for a team of PCMHs, shelters, and advocacy organizations to identify patients, track utilization, and provide intensive case coordination for patients whose needs span many types of services and providers.

BOSTON HEALTH CARE FOR THE HOMELESS PROGRAM IS PARTNERING WITH THE FOLLOWING ORGANIZATIONS:

- Bay Cove Human Services
- Boston Public Health Commission
- Boston Rescue Mission
- Casa Esperanza
- Massachusetts Housing and Shelter Alliance
- The New England Center and Home for Veterans
- Pine Street Inn
- St. Francis House
- Victory Programs

TCCI award: Lynn Community Health Center

\$881,843

Total project cost

\$690,000

HPC investment

\$191,843

In-kind investment



675

*patients targeted
for services*

TARGET POPULATION

Primary care patients of LCHC
with a serious mental illness

PRIMARY AIM



Reduce unnecessary health
care utilization by

15%

PROGRAM SUMMARY

Lynn Community Health Center is implementing an intensive care coordination program deploying community health workers to monitor medication adherence with the assistance of clinical pharmacy services for adult patients (20 years or older) with a serious mental illness.

Lynn Community Health Center is building on their Here-For-You demonstration with Neighborhood Health Plan and Beacon Health Options to create a care management model utilizing community health workers and incorporating clinical pharmacy supports to remotely monitor medicine adherence and compliance of patients with serious mental illness. Lynn Community Health Center will utilize data they receive regularly from MassHealth to track what services this population is over-utilizing and under-utilizing, allowing the CHWs to direct these patients to appropriate care.

LYNN COMMUNITY HEALTH CENTER IS PARTNERING WITH THE FOLLOWING ORGANIZATIONS:

- Eaton Apothecary
- Partners Connected Health
- Massachusetts Behavioral Health Partnership

NAS award: Boston Medical Center



\$357,053

Total project cost

\$248,976

HPC investment

\$108,077

In-kind investment



~115

*patients targeted
for services*

TARGET POPULATION

All infants monitored or scored
for symptoms of Neonatal
Abstinence Syndrome

PRIMARY AIM



Reduce length of inpatient
stay by

40%

PROGRAM SUMMARY

Boston Medical Center (BMC) is implementing an inpatient quality improvement program aimed at improving the care provided to substance exposed newborns.

Hospital staff monitor infants for NAS using an innovative scoring model, and provide non-pharmacologic care whenever possible (minimizing stimuli, allowing breast feeding when possible, facilitating rooming-in with birth mother). BMC also runs an outpatient fully integrated obstetric and addiction medicine clinic, which supports pregnant and post-partum treatment.

SECONDARY AIMS:

- Reduce the use of pharmacologic treatment for infants with NAS by 30%
- Increase breastfeeding initiation rate by 15%
- Increase parental bedside presence by 20%

NAS award: Lowell General Hospital



\$1.4M

Total project cost

\$999,032

HPC investment

\$452,332

In-kind investment



~50

*patients targeted
for services*

TARGET POPULATION

Inpatient Initiative:

All infants monitored or scored for symptoms of Neonatal Abstinence Syndrome

Outpatient Initiative:

At least 50 pregnant women with Opioid Use Disorder over two years

PRIMARY AIM

Inpatient Initiative:

Reduce length of inpatient stay by

15%

Outpatient Initiative:

Increase utilization of pharmacologic treatment by

20%

PROGRAM SUMMARY

Lowell General Hospital is implementing an inpatient quality improvement initiative aimed at improving the care provided to substance exposed newborns, while also providing wraparound supportive services to pregnant women with Opioid Use Disorder.

Pregnant women are enrolled in comprehensive and integrated obstetric and addiction treatment, including pharmacologic treatment (methadone or subutex), and matched with a peer support, who continues to support the woman 6 months post partum. After delivery, hospital staff monitor infants for NAS, and provide non-pharmacologic care whenever possible (minimizing stimuli, allowing breast feeding when possible, facilitating rooming-in with birth mother).

LOWELL GENERAL HOSPITAL IS PARTNERING WITH THE FOLLOWING ORGANIZATIONS:

- WomanHealth
- Lowell Community Health Center
- OB/GYN Associates of Merrimack Valley
- Clean Slate
- Habit OPCO
- South Bay Lowell Mental Health Clinic
- South Bay Lowell Early Childhood Services
- Thom Anne Sullivan Center
- MA WIC Nutrition Program



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HPC is charged with developing PCMH and ACO certification programs to promote high-quality, coordinated, patient-centered accountable care

Vision of Accountable Care

A health care system that efficiently delivers well coordinated, patient-centered, high-quality health care, integrates behavioral and physical health, and produces optimal health outcomes and health status through the support of reformed (non-FFS) payment.

- 1 Create a **roadmap** for providers to work toward **care delivery transformation** – **balancing** the establishment of **standards** with room and assistance for **innovation**
- 2 Establish a **common framework** for data collection, information gathering, evaluation and dissemination of best practices to promote transparency for future learning
- 3 Develop standards that **align with payers'** own **principles for accountable care** to further link accountability and enhance administrative simplification
- 4 Assure **patient engagement and protection** in their care, especially for vulnerable populations

PCMH PRIME: Integrating behavioral health, improving patient care



Under-diagnosis and under-treatment of behavioral health conditions (mental illness and substance use disorders) is a serious public health problem. Almost 50 percent of adults will develop at least one mental illness during their lifetime.



When behavioral health care is available in primary care practices, patients may be more likely to receive appropriate, high-quality care.

The Massachusetts Health Policy Commission's PCMH PRIME Certification program recognizes primary care practices that demonstrate behavioral health capabilities.



The PCMH PRIME program promotes the delivery of comprehensive and patient-centered care that addresses the emotional, psychological, and medical needs of patients in a coordinated way.

To view a list of PCMH PRIME Certified practices, please visit the HPC website (<http://bit.ly/PCMHPRIMEHome>).

ACO Certification Program Principles

- 1 **Care should be seamless** and guided by patients and families
- 2 Systems should **use evidence-based guidelines and be mindful of waste** so resources can be distributed to those who need it most
- 3 Support a **pluralism of ACO models** (e.g. community health center-led; primary care physician-led, hospital-led, medical and behavioral health provider partnerships)
- 4 Encourage medical provider-led ACO **to work with other non-medical providers** in the community
- 5 Systems should do no harm, **support safe and effective care**
- 6 Commit to regularly **assess the program** to ensure continuous improvement and market value

Overview of ACO Certification Criteria

Pre-requisites

4 pre-reqs.
Attestation only

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

1 Assessment Criteria

6 criteria
Sample documents, narrative descriptions

- ✓ Patient-centered, accountable governance structure
- ✓ Participation in quality-based risk contracts
- ✓ **Population health management programs**
- ✓ **Cross-continuum care: coordination with BH,** hospital, specialist, and long-term care services

2 Required Supplemental Information

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

- ✓ Supports patient-centered primary care
- ✓ Assesses needs and preferences of ACO patient population
- ✓ **Develops community-based health programs**
- ✓ Supports patient-centered advanced illness care
- ✓ Performs quality, financial analytics and shares with providers
- ✓ Evaluates and seeks to improve patient experiences of care
- ✓ Distributes shared savings or deficit in a transparent manner
- ✓ Commits to advanced health information technology (HIT) integration and adoption
- ✓ Commits to consumer price transparency



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Behavioral Health Integration Research: Informing Care Delivery Reform

Reporting in 2013 **Cost Trends Report** on cost of care for comorbid BH condition and at least one other chronic health condition.

Monitoring the number of opioid related **ED visits, hospital admissions**, and births presenting with Neonatal Abstinence Syndrome (**NAS**) to inform resource allocation decisions.

Reporting on supply of providers offering pharmacologic assisted opioid use disorder treatment

Monitoring opioid related hospital utilization (admissions and ED visits) to inform investments in and reforms to the current care delivery system and payment systems could improve the efficiency with which OUD is treated in the Commonwealth.

Monitoring BH related ED visits and related ED boarding (spending 12 or more hours in the ED)

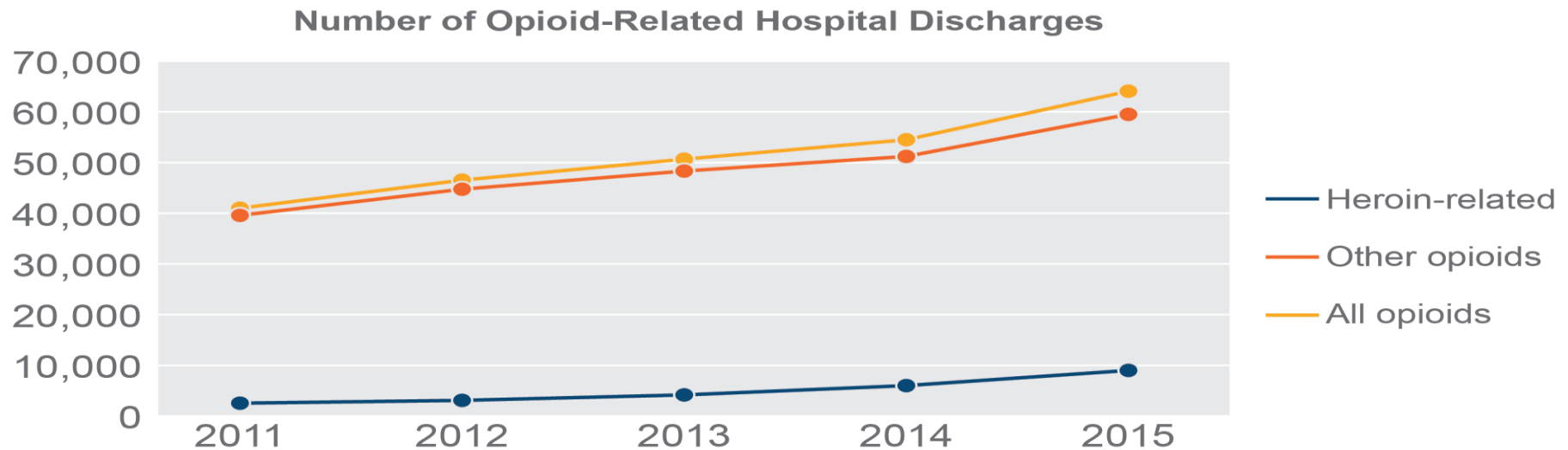
COMMONWEALTH OF MASSACHUSETTS
HEALTH POLICY COMMISSION

OPIOID USE DISORDER IN MASSACHUSETTS

An Analysis of its Impact on the Health Care System, Availability
of Pharmacologic Treatment, and Recommendations
for Payment and Care Delivery Reform



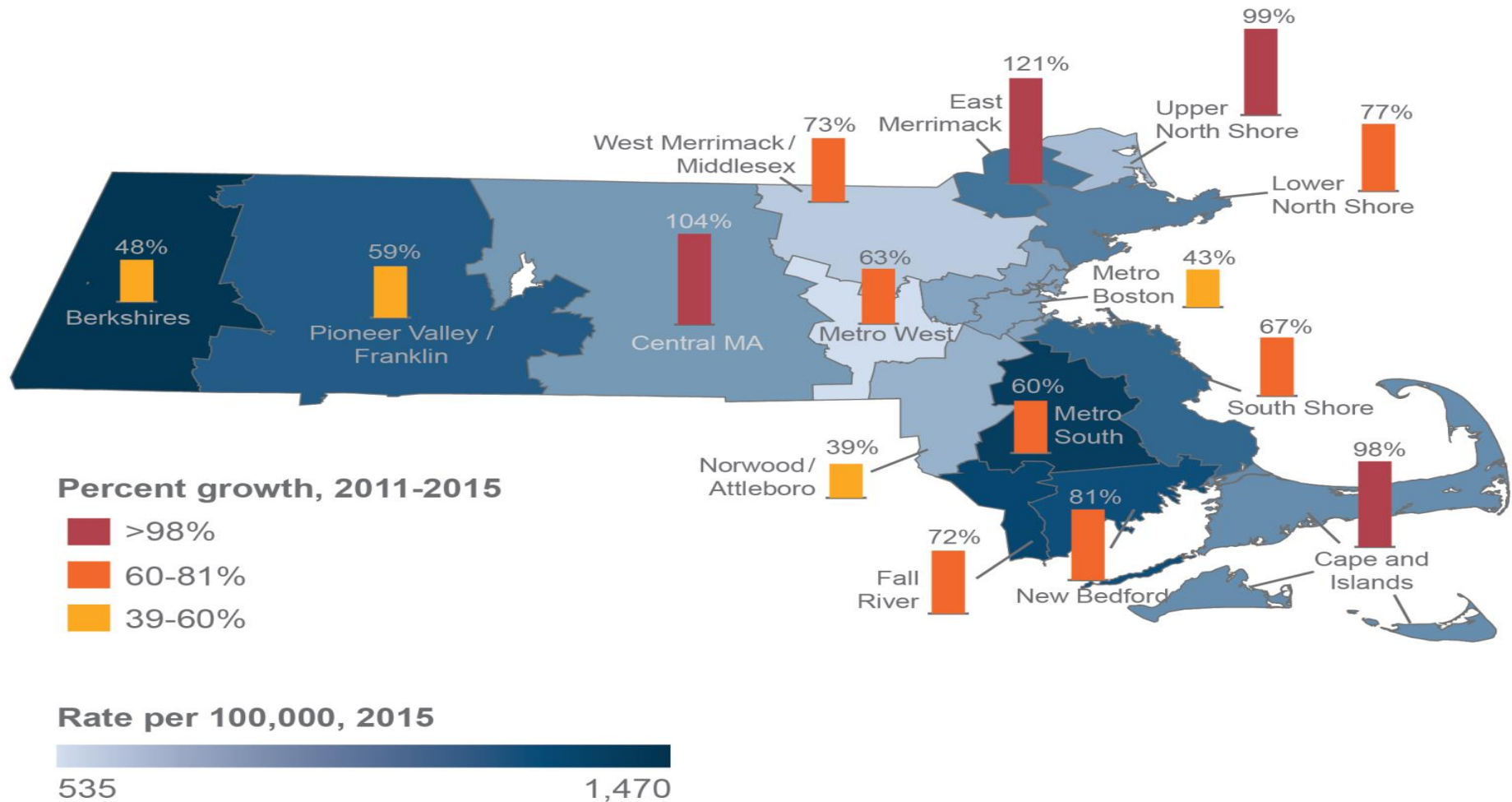
Focus on impact of opioid epidemic on hospitals across the Commonwealth



Rate of Change in Opioid-Related Hospital Discharges

	Years	Heroin-related	Other opioids	All opioid-related
Growth	2011-2012	22%	13%	14%
	2012-2013	35%	8%	9%
	2013-2014	44%	6%	8%
	2014-2015	50%	16%	18%
	2011-2015	256%	50%	56%

Opioid related hospital utilization is increasing almost uniformly across the state



Data can be found at

Source: HPC analysis of the Center for Health Information and Analysis (CHIA), Hospital Inpatient Discharge and Emergency Department Databases, 2011 and 2015

Contact Information

For more information about the Health Policy Commission

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