COMMONWEALTH OF MASSACHUSETTS

HEALTH POLICY COMMISSION

Community Health Care Investment and Consumer Involvement

October 14, 2015

Agenda

- Approval of Minutes from June 3, 2015 **(VOTE)**
- Discussion of the 2015 Health Care Cost Trends Hearing
- Update on CHART Phase 2 Operations
- Discussion of CHART Phase 2 Evaluation
- Discussion of Health Care Innovation Investment Program
- Presentation on Telemedicine Pilot Program Development
- Schedule of Next Meeting (December 2, 2015)

Fall/Winter 2015 HPC Meetings

October 21 full commissioner meeting has been rescheduled to November 18.

Wednesday, October 14

9:30AM CTMP

11:00AM CHICI

Thursday, November 12

9:30AM CDPST

11:00AM QIPP

Wednesday, November 18

11:00AM Advisory Council

12:00PM Full Commission

Wednesday, December 2

9:30AM CTMP

11:00AM CHICI

Wednesday, December 9

9:30AM CDPST

11:00AM QIPP

Wednesday, December 16

12:00PM Full Commission

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Vote: Approving Minutes

Motion: That the Committee hereby approves the minutes of the Community Health Care Investment and Consumer Involvement Committee meeting held on June 3, 2015, as presented.

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2015 Health Care Cost Trends Hearing: Selected Takeaways

Key themes from 2015 Cost Trends Hearing significant to CHICI's responsibilities and areas of focus

Achieving an accountable, patient-centered, integrated delivery system	Implications for CHICI
▪ Behavioral health integration remains critical; underpayment and access remain widely-cited issues. Low-acuity units (e.g., crisis stabilization) are needed	▪ HPC should continue to invest in behavioral health integration through HCII and future rounds of CHART. HPC's pilot programs (EMS, NAS) will inform new models of care
▪ Opportunity through team-based care models (with community-clinical linkages) enabled by CHWs, NPs, LICSWs, etc., to address high-cost, high-risk patients	▪ CHART Phase 2 will inform models of care for high-risk, high-cost patients across MA, in particular use of multi-disciplinary teams. Similar models should be considered in HCII.
▪ ED overuse can be aided through expanded access (retail clinics, urgent care, after hours)	▪ Integration between traditional health systems and retail clinics / urgent care is ripe for testing
▪ Hospital systems need statewide benchmarks for high-risk populations to evaluate their care delivery	▪ The Commonwealth should promote data alignment and benchmarking for high-risk populations to support PHM
▪ Payment policies should support innovation in care delivery, including tele-health.	▪ Tele-health pilot program (and potentially HCII) will help enhance the case for reimbursement parity and use of models under APMs

Strengthening CHICI's high-value, high impact investment programs

Key themes from 2015 Cost Trends Hearing significant to CHICI's responsibilities and areas of focus

Engaging consumers in making, value-based decisions with information and incentives	Implications for CHICI
▪ Payers' price transparency tools now offer information on cost and quality, but take-up is low and there is room for improvement. PROMs would aid value-informed decisions	▪ CHICI should continue to monitor and promote effective transparency tools. PROMs should be explored in HCII projects to enhance ability of consumers to make choices around value
▪ High-deductible health plans are increasingly prevalent, but cause consumers to scale back care indiscriminately, especially low-income consumers. Tiering providers or services on value may be preferable and payment differentials among tiers increase	▪ In conducting research on consumer preferences funded by the Robert Wood Johnson foundation, the HPC should examine choice-patterns for different services, including whether larger payment differentials between tiers or cash-back programs may be effective
▪ Value-based insurance should also focus on upstream decision points. Ultimately, doctors strongly influence patients' use of care and choice of specialists and hospitals	▪ CHICI should continue to monitor the efficacy and uptake of value-based insurance products. In collaboration with CTPM, CHICI should explore referral effects in MA where appropriate
▪ Overarching need for greater transparency for consumers and policy-makers	▪ HPC should support Administration-wide price and quality transparency efforts

Strengthening CHICI's consumer engagement activities

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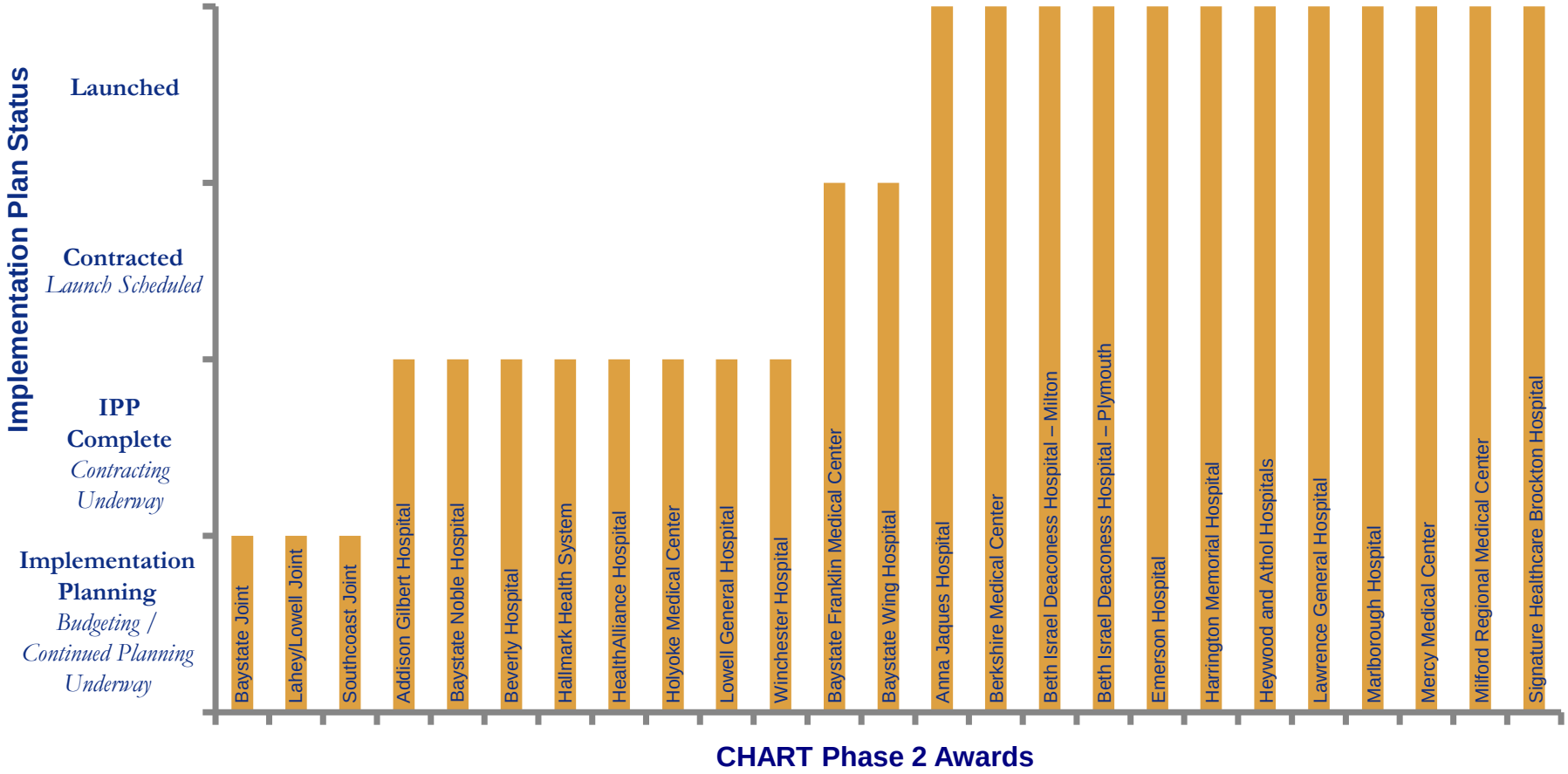
Implementation Plan status update

12 Awards launched in September and October; **9** Awards anticipated to launch in November; **4** Awards anticipated to launch in December



Updated October 13, 2015 – changing rapidly

Northern Berkshire Neighborhood of Health

Berkshire Health Systems

$4.04M
Berkshire Project Cost

=

$3,000,000
HPC CHART Investment

+

$1,039,522
Berkshire Health Systems Contribution

Target Population

All patients from Northern Berkshire County that are hospitalized

2,298
discharges per year

Aims

Primary Aim

Reduce 30-day readmissions by **20%**

Secondary Aim

Reduce 30-day returns to ED from any bed by 10%

Northern Berkshire Neighborhood of Health

Berkshire Health Systems

$4.04M	=	$3,000,000	+	$1,039,522
Berkshire Project Cost		HPC CHART Investment		*Berkshire Health Systems Contribution*

CHART Project

Berkshire Health Systems will develop **individual care plans** for patients at high risk for unnecessary hospitalization, address social issues that lead to recurrent acute care utilization, provide enhanced care for chronical ill patients, increase access to behavioral health services (including both addiction medicine and psychiatry), and use enabling technology to support cross setting care and drive improvement. Enhanced services will be provided both at Berkshire Medical Center in Pittsfield (for patients from Northern Berkshire County), and in particular will **restore and expand healthcare services in North Adams** and surrounding communities.

The **Brien Center** (enhanced addiction treatment services) and **EcuHealth** (insurance enrollment and community supports) will partner with Berkshire Health Systems.

Enabling Technology

The investment in enabling technology will help the Complex Care Team manage patients that are high risk by **coordinating care** within a new platform, Allscripts Care Director. This platform gives the full care team the ability to more effectively manage care across the care continuum, including:

- Share **clinical information and risk assessments** across clinical settings and community partners
- Develop and share **care plan elements**, including education, transportation, counseling and goals
- Share care plans with the **patient and family**
- Share appropriate information with **community health workers**

Additional investments will support access to **telepsychiatry** throughout the region

Early challenges from Berkshire Medical Center's Neighborhood for Health

Twice as many SUD patients than expected	▪ Shifted 0.5FTE SW to medicine side of ED to meet increased demand ▪ Coordinating acute psych and Neighborhood For Health
Primary Care ▪ Engagement ▪ Access (estimate 30% of patients lack a PCP, all panels closed in region) ▪ Linkage (NP role not filled; will substantially enhance care model)	▪ Convening PCP meetings and sharing patient vignettes with PCPs to demonstrate value of 'virtual PCMH' supports that can be provided by Neighborhood for Health ▪ Leveraging telepsych platform for collaboration and coordination
Patients often lack transportation and access to social supports is a key challenge	▪ Deploying Patient Assistance Fund routinely ▪ CHW spends 30% of time focus on transportation issues; linkages to nutrition and fuel supports are common

"The Neighborhood Health has let us engage with patients in a completely novel way: meeting them where they are at and identifying their concerns and their priorities, but still addressing the very real medical and psychiatric concerns that keep sending these patients back to the ER."
Tori Upsen, Psych NP, Neighborhood for Health

Beth Israel Deaconess Hospital – Milton

$2.28M BIDH-M Project Cost = **$2,000,000** HPC CHART Investment + **$204,978** *BIDH-M Contribution* + **$73,000** *System Contribution*

Target Population

Emergency department patients with a primary behavioral health diagnosis

1,400

patients per year

Aims

Primary Aim

Reduce excess ED boarding by **40%** for long stay patients

Secondary Aim

Reduce ED revisits by 20%

Beth Israel Deaconess Hospital – Milton

$2.28M	=	$2,000,000	+	$204,978	+	$73,000
BIDH-M Project Cost		HPC CHART Investment		*BIDH-M Contribution*		*System Contribution*

CHART Project

With **extensive community collaboration**, BIDH-M will implement an integrated behavioral health initiative. CHART will fund 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 BH navigation. A multidisciplinary team will provide comprehensive clinical and supportive services. Individualized care plans

Key collaborator and partner **South Shore Mental Health** will provide behavioral health clinical and navigation services in the BIDH-M ED and in the community. Multiple acute, community provider, municipal, and social service stakeholders will participate in an integrated learning consortium.

Enabling Technology

The investment in Enabling Technology will provide supportive **dashboard functionality** to the multisite, multidisciplinary team to inform continuous improvement. Additionally, BIDH-M will develop and share **ED care plans** to address clinical, physical, social, and dietary needs. **Secure text messaging** will provide HIPAA-compliant real-time communication between care team members and with patients.

BID – Milton: Integrated Care Learning Consortium

First of its kind meeting for the region; CHART-funded learning network to bring providers together who were being seeing similar problems in the community around behavioral health (BH)

56 attendees

Agenda

- Presentation on the current state of BH in the Commonwealth
- An interactive session where the group brainstormed the current and future state of behavioral health

What next?

- This Consortium will be used to strengthen community partnerships
- Generate cohesion around common problems that all providers face

27 orgs

Integrated Care Learning Consortium

Member Organizations

Current October 8, 2015 (welcoming new participants)

Arbour Health System	Curry College	Milton High School
Atria Senior Living	Fallon Ambulance	Milton Public Schools
Atrius Health	Harvard Vanguard-Braintree	NAMI Mass
Bay State CS	Health Policy Commission	PACE Program / Harbor Health
BID-Milton	Interfaith Social Services	Quincy WIC Program
BID-Milton Patient and Family Advisory Council	Learn to Cope	Randolph Board Of Health
BID-Plymouth	Manet Community Health Center	Randolph Public Schools
Blue Hills Regional Tech School	Massachusetts Association of Behavioral Health Systems	Square Medical
BU School of Public Health	Milton Board of Health	Quincy Police Department
CHNA 20	Milton CARES	

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- Update on CHART Phase 2 Operations
- **Discussion of CHART Phase 2 Evaluation**
  - Purpose of the evaluation
  - Approach and key components
  - Key outcomes of interest
- Discussion of Health Care Innovation Investment Program
- Presentation on Telemedicine Pilot Program Development
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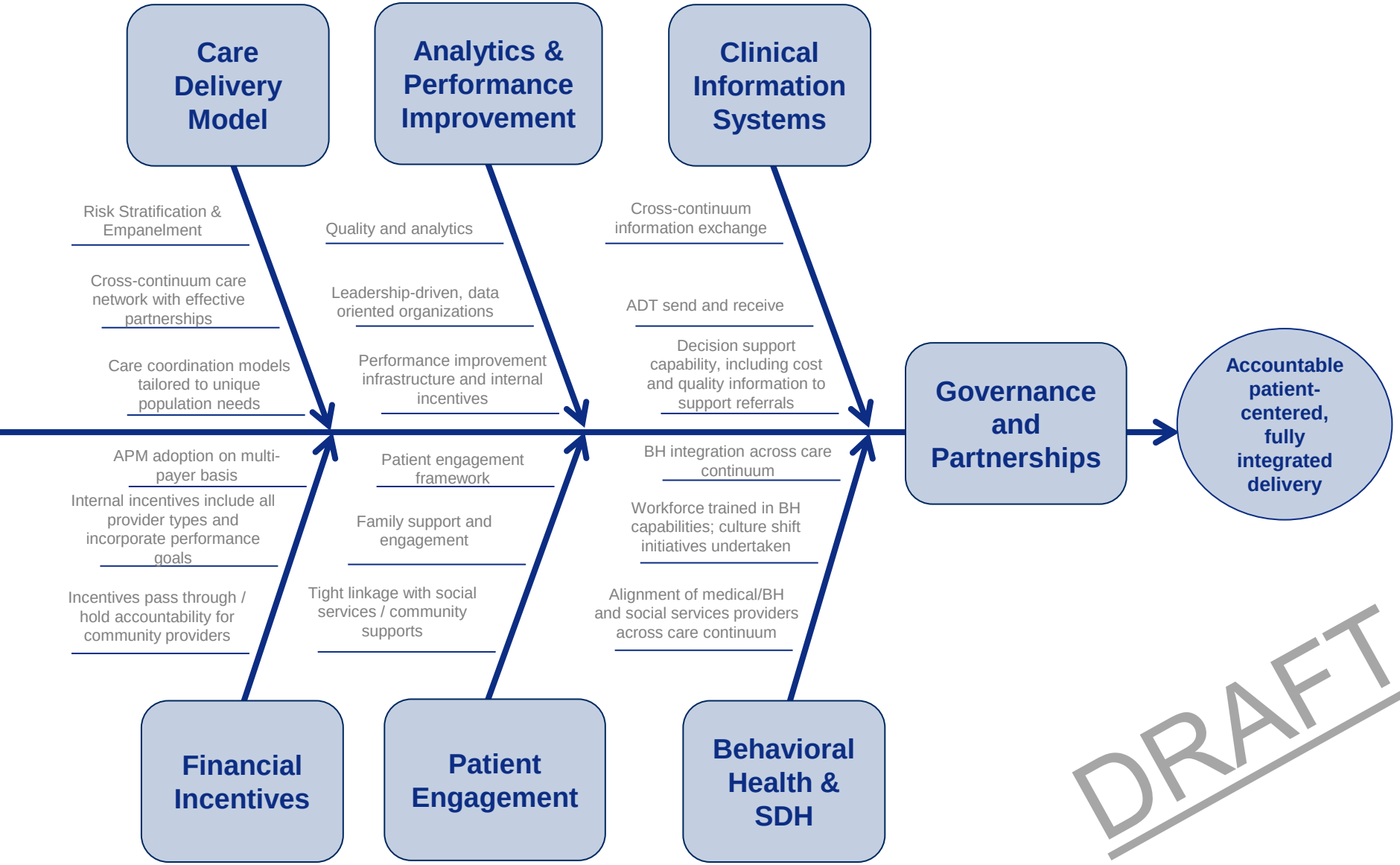
A framework for assessing readiness to deliver accountable care



DRAFT

Goals of CHART Phase 2 evaluation

1. To assess CHART awardees' performance in meeting their Phase 2 program aims to decrease waste and improve patient care, individually and collectively
   - Reduce preventable hospital utilization (readmissions, ED utilization, etc.) and associated cost savings
   - Enhance access to high quality, integrated behavioral and physical health services as well as social supports
2. To identify processes that contributed to program success as well as those that did not
3. To assess the efficacy of investments in supporting development of capabilities for accountable, patient-centered integrated care at CHART hospitals as a foundation for sustainability, such as:
   - Team-based, multidisciplinary care models with behavioral health and social supports
   - Analytics, performance improvement, and provider strategy
   - Hospital-community partnerships

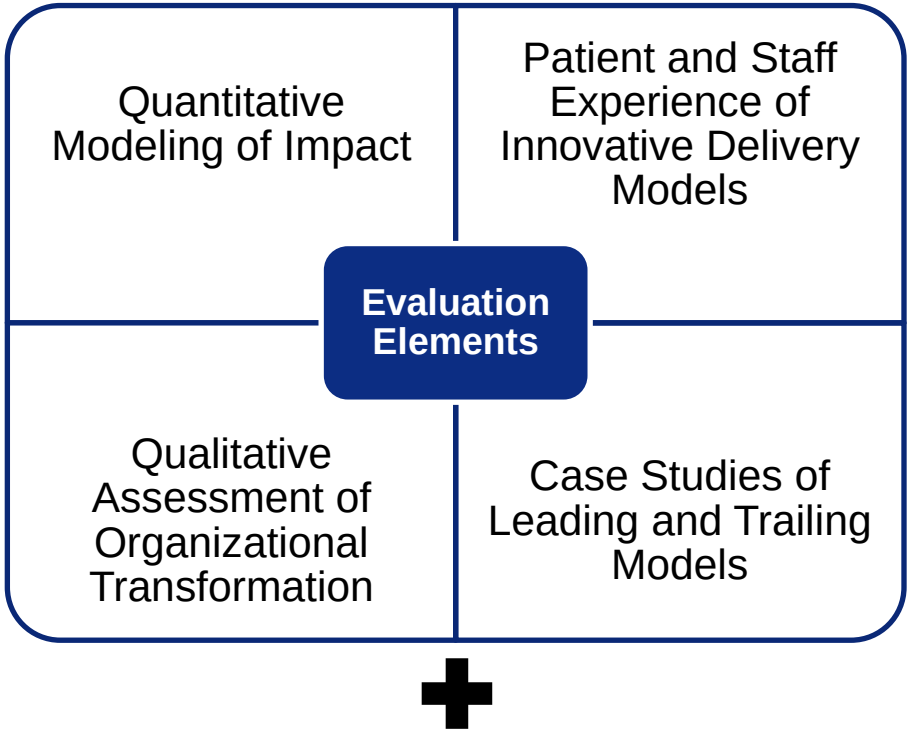
Abt Associates and HPC have begun a 10-week engagement to design an evaluation plan to meet these goals

Discussion – methodological approach

How should we weigh the strengths and weaknesses of each evaluation approach?

	Descriptive		Experimental
Design	A pre-post comparison to measure change in performance over time	Quasi-experimental, e.g. a difference-in-differences comparison	Randomized control trial
	All include case studies, staff surveys on key questions, and descriptive patient stories		
Strengths	Results are delivered within the program timeframe Least expensive option	Can draw causal inference Costs scale to choice of comparison group and level of analysis	Can treat environmental and complex questions Produces the most precise estimate of program impact
Weaknesses	Cannot attribute CHART's impact to measurable change Supports only narrowly defined research questions Prone to measurement error	A good comparison group is difficult to find and may contribute to a longer data lag pending choice of group	Most expensive option Long lead time to results due to data lags and analysis No will to randomize interventions

Evaluation components



HPC Ongoing Performance Monitoring and Awardee Engagement

Evaluation and Learning Outputs

Interim Evaluation Report
Delivered midway through the CHART Phase 2 period of performance, the interim evaluation report will document baseline findings and progress to goals

Final Evaluation Report
Delivered after the end of CHART Phase 2, the final evaluation report will include secondary source data and a complete analysis of findings

Case Studies
Case studies will allow the evaluation team to assess the impact of community partnerships, enabling technology and other program elements on Phase 2

Routine Performance Analyses
Performance analyses will deliver timely and actionable evidence on whether the CHART program and individual investments are meeting their targets

Tools and Materials from High Performing Awardees
Dissemination of best practices is ongoing and is intended to encourage adaptation and performance improvement among peers in the CHART cohort

Next steps

HPC and Abt will finalize evaluation design in the coming weeks and launch evaluation to support Phase 2 operations

- Abt Associates delivers report & analytic plan detailing a proposed approach for evaluating CHART Phase 2
- HPC solicits Phase 2 awardee feedback on the evaluation design
- HPC staff present the evaluation design to CHICI and the full Commission
- HPC onboards evaluation firm
- Evaluator baselines awardee and program performance

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- Update on CHART Phase 2 Operations
- Discussion of CHART Phase 2 Evaluation
- **Discussion of Health Care Innovation Investment Program**
  - Review of statutory charge
  - Program development considerations and priority areas
  - Next steps
- Presentation on Telemedicine Pilot Program Development
- Schedule of Next Meeting (December 2, 2015)

HCII background

Establishment of the Health Care Innovation Investment Program

- M.G.L. c. 6D § 7
- Funded by revenue from **gaming licensing fees** through the Health Care Payment Reform Trust Fund
- Total amount of **$6 million**
  - *May increase if 3rd gaming license is awarded*
- Unexpended funds may to be rolled-over to the following year and do not revert to the General Fund
- **Competitive** proposal process to receive funds
- Broad eligibility criteria (*any **payer or provider***)

Purpose of the Health Care Innovation Investment Program

- To **foster innovation** in health care **payment** and service **delivery**
- To **align** with and **enhance** existing funding streams in Mass. (e.g., DSTI, CHART, MeHI, CMMI, etc.)
- To support and further efforts to meet the **health care cost growth benchmark**
- To improve **quality** of the delivery system
- **Diverse uses** include incentives, investments, technical assistance, evaluation assistance or partnerships

HCII program development considerations

Chapter 224 provides guidance on program development process and framework but does not provide detailed specifications for use of funds

1. HPC shall **solicit ideas for payment and care delivery reforms** directly from providers, payers, research / educational institutions, community-based organizations and others
2. HPC must coordinate with other state grant makers
3. Investments must be **evaluated for cost and quality implications**
4. Chapter 224 encourages broad dissemination of learnings and incorporation of successes into ACO certification and state-administered payment reforms

Investments that catalyze care delivery and payment innovations

HCII investing in 'validated innovation'

Research on innovation emphasizes the opportunity for the HPC to focus investments in 'innovation' on 'adaptation' of emerging models rather than the 'invention' of new ones.

Innovation isn't "just about generating new ideas or finding new uses for the iPad. ...Lately, the innovation field has shifted its focus from the generation of ideas to rapid methods of running experiments to test them."

Innovation as Discipline, Not Fad
-David A. Asch, and Roy Rosin
The New England Journal of Medicine, August 19, 2015

"Providers need to actively seek out good ideas that have been tried and refined, bring those ideas home, and adapt them for local use."

Health Care Needs Less Innovation and More Imitation
-Anna M. Roth, and Thomas H. Lee
Harvard Business Review; November 19, 2014

"Good ideas themselves are not innovations; instead, they become innovations when the have economic impact, when they add [business and social] value."

Permanent Innovation
-Langdon Morris
Innovation Academy Publishing; November 19, 2014

Drive sustainable market value by investing in adaptation of promising innovations from the field

HPC is engaging key health care innovation experts to support program design

Molly J Coye MD, MPH, MA

Strategic Advisor to the HPC

Dr Coye brings many years of experience in public health, government, large hospital systems, insurance companies, academia and nonprofits. Dr. Coye is **Social Entrepreneur in Residence** at NEHI. Previously she was **Chief Innovation Officer** for UCLA Health. Dr. Coye was also the **founder and CEO of the Health Technology Center** (HealthTech), a non-profit education and research organization established in 2000 that became the premier forecasting organization for emerging technologies in health care. Dr. Coye has also served as **Commissioner of Health** for the State of New Jersey, Director of the California State Department of Health Services, and Head of the Division of Public Health Practice at the Johns Hopkins School of Hygiene and Public Health.

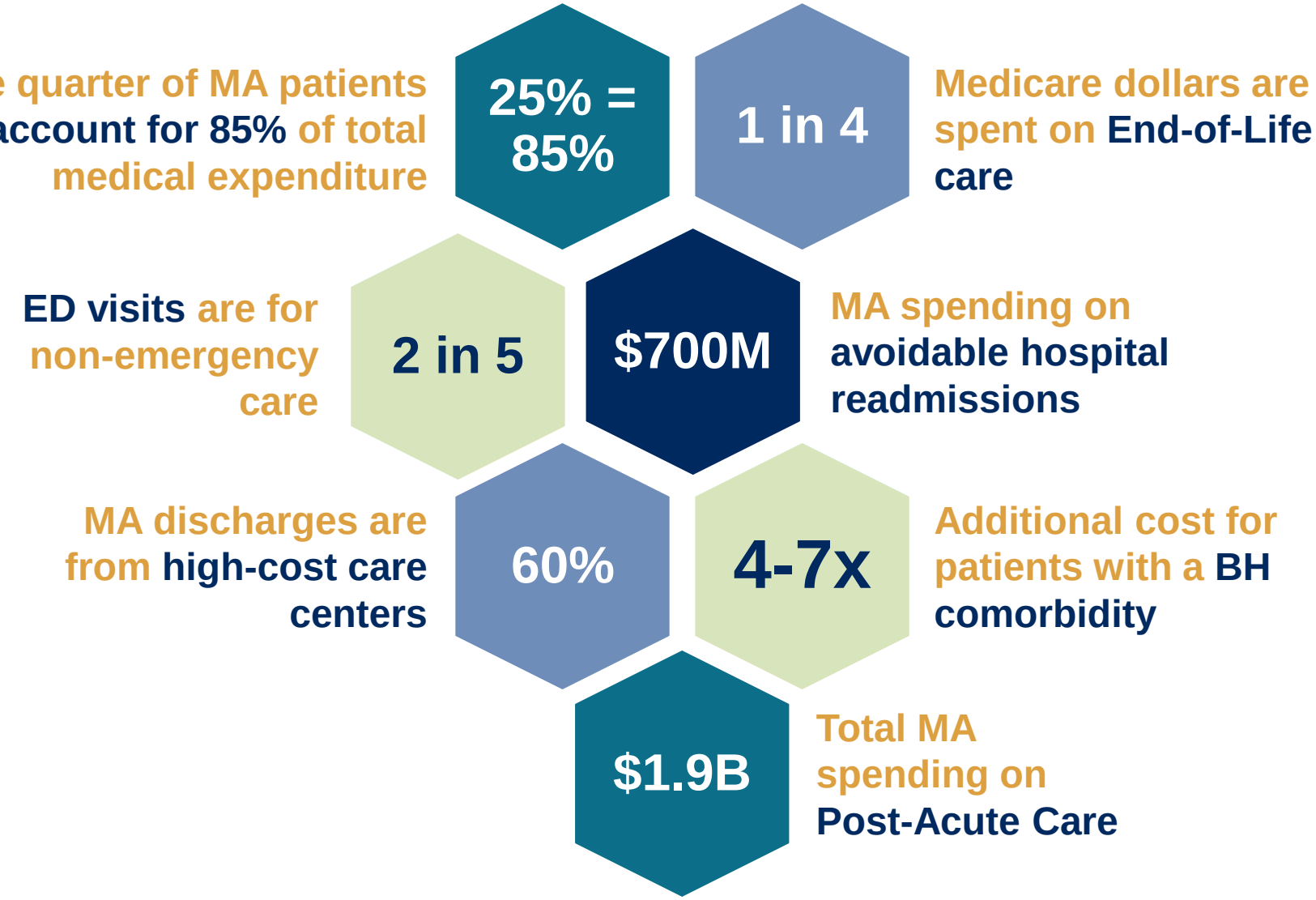
Dr. Coye holds MD and MPH degrees from Johns Hopkins University and an MA in Chinese History from Stanford University, and is the author of two books on China.

Technical Advisory Group

The HPC also anticipates convening a technical advisory group (TAG) to support final design and implementation of the Health Care Innovation Investment Program. The TAG will consist of credible, established experts from relevant fields, but unassociated with any likely applicants for the program. The TAG will include individuals with expertise in:

- Care Delivery
- Innovation and Technology
- Policy and Research
- Investment and Entrepreneurship

Primary cost drivers in Massachusetts identified by HPC

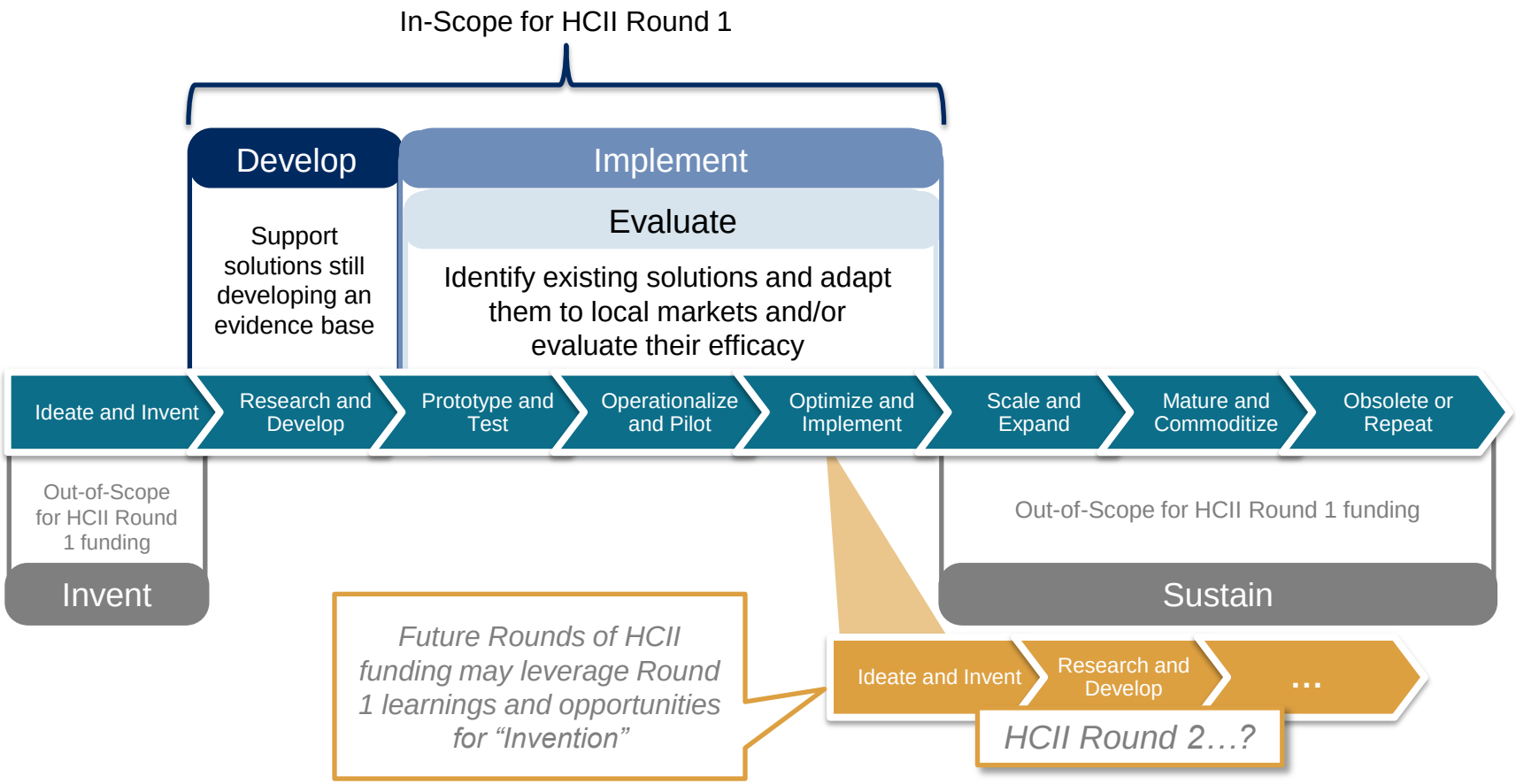


HPC 2014 Cost Trends Report
HPC July 2014 Cost Trends Supplement
HPC 2015 Annual Cost Trends Hearing – AGO Report

Where in the innovation life cycle can HCII be most effective?

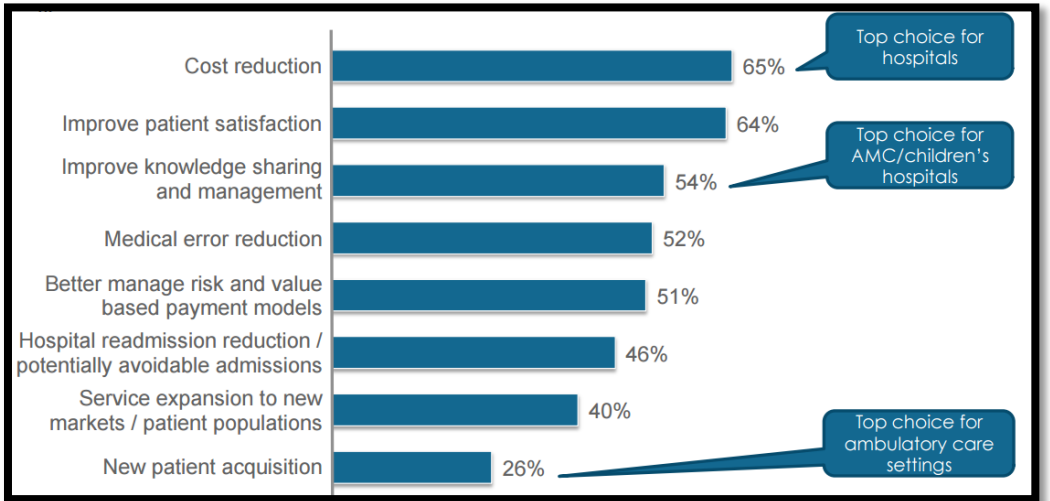
HCII may use its funds to develop, implement, or evaluate promising models in payment and service delivery. Within this model framework, HCII Round 1 funding would focus on investment in rapid adoption of existing models with a preliminary evidence base.

1½ – 5-year "Innovation Lifecycle"

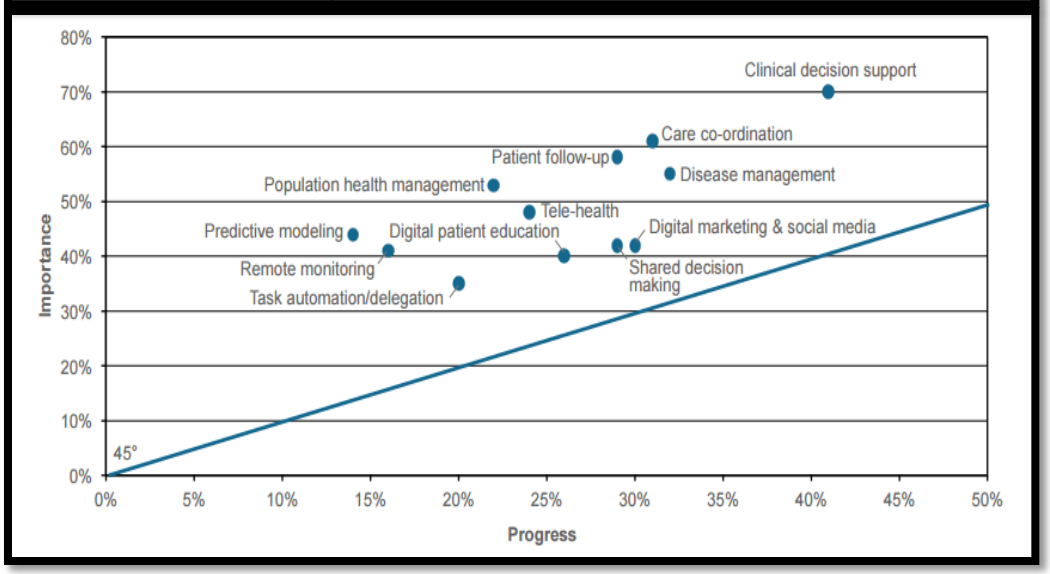


Existing models for health care innovation

Health care innovation exists as an emerging discipline around the globe. Recent survey work of providers, payers, entrepreneurs and other innovators informed design choices for HCII.



What do Provider Innovation Initiatives Focus On?



Innovative Technologies Provider Progress vs. Importance

http://hitconsultant.net/2014/02/05/himss-state-healthcare-innovation-2014-infographic/
http://www.commonwealthfund.org/publications/chartbooks/2015/apr/survey-of-health-care-delivery-innovation-centers

Health care innovation market scan

Surveys of existing innovations in the market focusing on substantial (>20%) cost savings emerged meaningful features and barriers common even to diverse interventions and have helped guide HCII key design considerations.

45%

Average cost-savings generated

Key Mechanisms

Expanding aide roles
Lower-cost, less-complex care settings
Telehealth and telemedicine
Cost-effective decisions by clinicians and providers
Management of diagnostics and pharmaceuticals

50%

Number of innovations paid for via provider and payer involvement

Barriers

Lack of reimbursement
Regulations
Clinical resistance
IT requirements

1-3 years

Range of time from implementation to savings yield

Drivers

Cost savings
Patient preference
Competitiveness

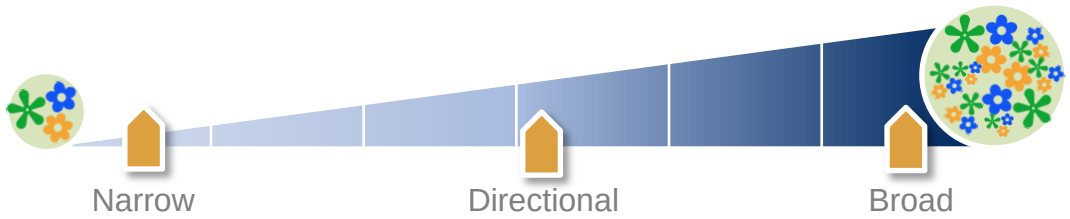
HCII Round 1 primary design choice: how should investments be focused?

Stakeholder recommendations were divided between prescribing a narrow focus for investment based on HPC priority areas and allowing a diverse swath of ideas to emerge.

Which framework will generate investments that achieve HCII's Primary Aim?

Primary Aim

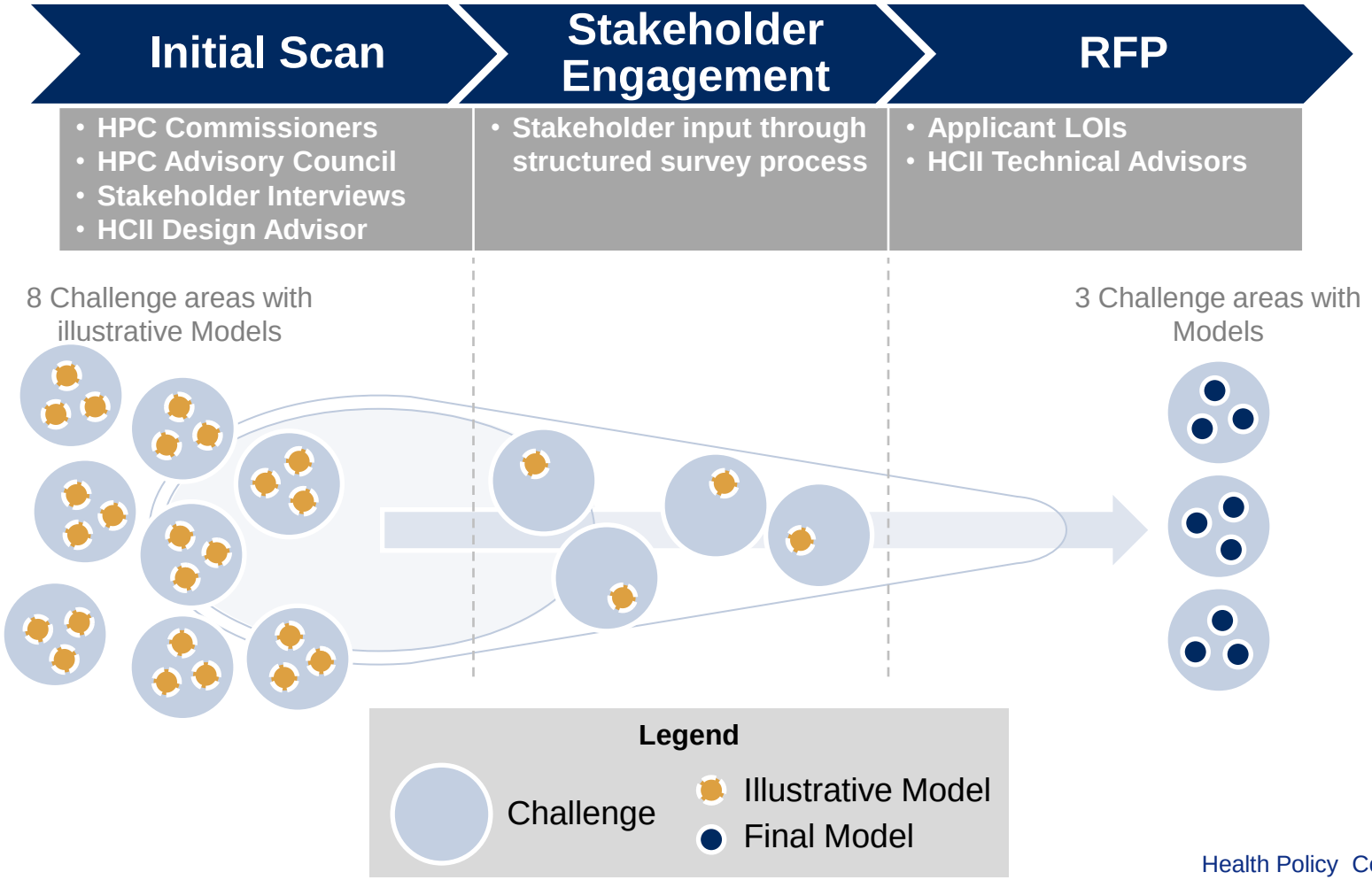
Demonstrably Reduce Growth of THCE



	Directive	Hybrid	"Let 100 Flowers Bloom"
	Allow only 2-3 models for Applicants to scale	*Allow Applicants to inform selection of challenges & models, but ultimately compete by adapting from a focused list*	*Allow Applicants to propose any innovations*
Pros	• Promotes concentrated impact on a specific issue • Builds shared learning community, evidence base, and scale opportunities	• Applicant viewpoints substantially inform models • Focuses effort on select challenges to maximize impact	• Allows broad Applicant choice • Facilitates creativity
Cons	• Drastically limits Applicant choice • Eliminates any potential for creative new models	• (More) complex process may not yield consensus • Emphasizes 'imitation' over 'invention'	• Substantial risk of diluted impact • Difficult to contrast Proposals for selection

HCII Round 1 application process maximizes applicant input and engagement

The HPC will demonstrate the principles of innovation by focusing on clear, measureable, Challenges, but still meet the market where it is by flexing its options through a refinement process that adapts to applicant feedback.



HCII Round 1 challenge inclusion criteria

Initial draft challenges were determined by taking cost reduction as its defining goal, and synthesizing best practice approaches to innovation with stakeholder feedback. Those factors guiding challenge inclusion are below.

Need	Innovation Opportunity	Feasibility & Sustainability
• **Persistent health challenge** for people, especially the underserved, of Massachusetts • The challenge is a significant **cost driver** that threatens the benchmark and can be improved with equal or better quality	• Existing solutions have made **limited progress** • **Preliminary evidence** of innovation potential already exists • **Synergy** with other Commonwealth investments and certification programs • Demonstrable **market interest** in disruption, primarily through substantially and rapidly changing:	• Challenge is **actionable** by potential applicants • Potential for **sustainability**, translation, and scale • Responsive to interventions enough to demonstrate measurable impacts within approximately **18 months**

Settings	Providers	Costs	Decisions	Tools or Tech

HCII Round 1 draft challenge areas

Specifically, the HPC would issue an RFP with an initial list of approximately 8 challenges meeting inclusion criteria, from which applicants may choose to submit a model in their LOI.

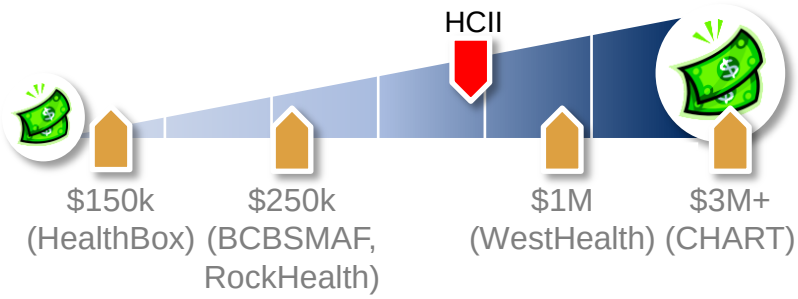
	Challenge	EXAMPLE Models
1	**Meet the health-related social needs of high cost patients**	*The California Endowment funds case management services via the "Healthy Homes, Healthy Families" initiative to engage doctors in improving housing conditions for children with disparate health outcomes.*
2	**Integrate behavioral health care (including substance use disorders) with physical health services for high risk / high cost patients**	*Seton Healthcare Family Psychiatrists contracted with a third party telepsychiatry company to ensure that patients could receive needed mental health care within one hour, regardless of time of day.*
3	**Increase value-informed choices by purchasers that optimize patient preferences**	*Clear Cost Health is a web-based price transparency tool that assists employers and patients alike in selecting cost-effective sites of care within a specific geographic area.*
4	**Increase value-informed choices by providers that address high-cost tests, drugs, devices, and referrals**	*HomeMeds, administered by Partners in Care Foundation, assists populations in medication management via home aides and support services to reduce variability and unnecessary prescriptions.*
5	**Reduce cost variability in hip/knee replacements, deliveries, and other high-variability episodes of care**	*In 2013, Walmart initiated its Centers of Excellence (COE) program, which designated six providers for their employees to seek care at. Each represented a high-quality, low-cost center of care in order to keep costs down.*
6	**Improve hospital discharge planning to reduce over-utilization of high-intensity post-acute settings**	*RightCare is a software that identifies high-risk patients at the point of admission and streamlines process to identify appropriate and cost-effective PAC.*
7	**Ensure that patients receive care that is consistent with their goals and values at the end of life**	*Hospice of Frederick County, based in Maryland, has created a rural-based hospice service that targets primarily underserved populations (i.e. minority communities, disabled peoples) in ensuring continuity of care and appropriate utilization.*
8	**Expand scope of care of paramedical and medical providers who can most efficiently care for cost patients in community settings (e.g., through care models, partnerships, or technology)**	*GVK and EMRI have partnered to create 108 EMS, which coordinates with local first responders to assist in delivering care to patients in need and prevent unneeded ED admissions.*

Leverage new partnerships, tools, technologies, as well as data and analytics to adapt and optimize innovative models for maximal impact

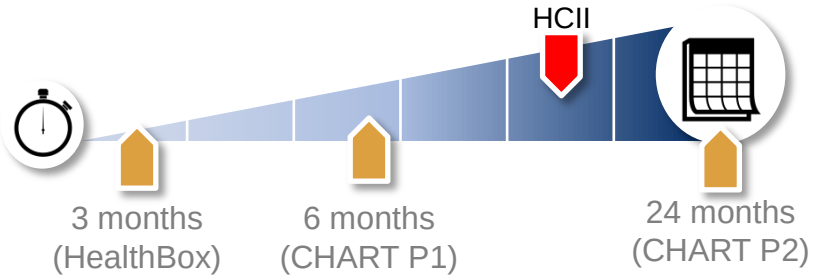
HCII Round 1 award size and duration

Other key design considerations have been made based on comparable grant and investment programs in the marketplace.

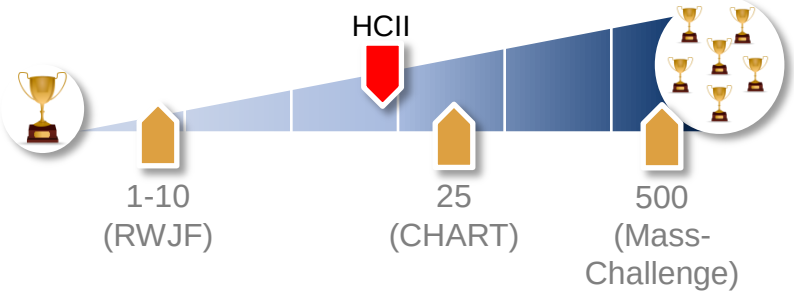
Max HCII Award **Cap**: $750k per award



HCII Award **Max Duration**: 18 Months

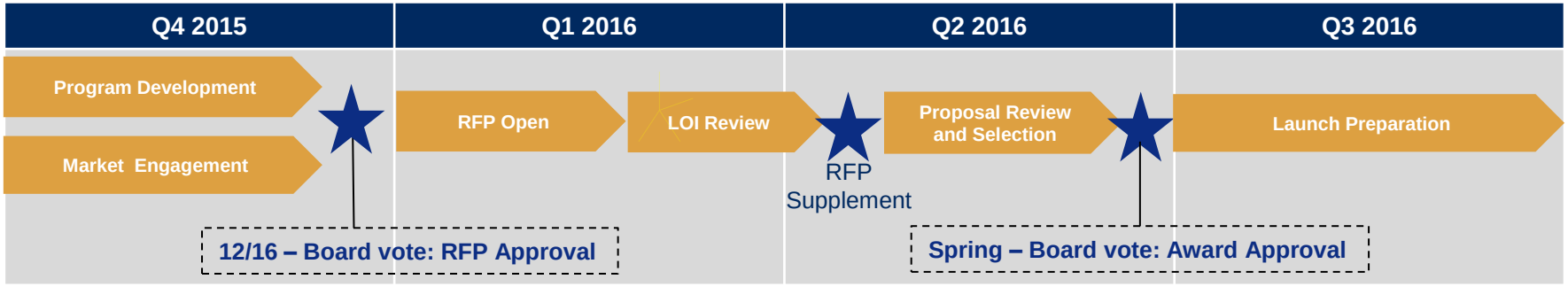


HCII Number of Awards: 8-15 Awards



HCII Round 1 anticipated timeline and remaining key decisions

The HPC anticipates refining key decisions and developing the RFP through 2015 Q4, leading to an RFP launch in 2016 Q1, and subsequent program launch in Spring 2016.



	Goal Setting	Program Design	Implementation
Activities	☑ Evaluate Ch. 224 and HPC governance structure to understand bounds / flexibility of the program ☑ Scan literature for public and private investment models ☑ Meet with key partners, funds, and industry leadership to identify gaps in funding ecosystem	☐ Discuss funding priority areas and program framework with stakeholders **Current Focus** ☐ Finalize proposal framework and selection criteria ☐ Review LOIs, provide comment. ☐ Receive full proposals and select awardees	☐ Provide feedback on program design in contracting ☐ Distribute pilot funding ☐ Ensure select measurable goals are tracked for each segment of portfolio and program overall
Output	• ***Program goals*** • ***Program priority areas***	• ***Funding criteria*** • ***Mechanism for procurement*** • ***Awardee selection***	• ***Contracted awardees*** • ***Performance monitoring*** • ***Impact***

Agenda

- Approval of Minutes from June 3, 2015 (VOTE)
- Discussion of the 2015 Health Care Cost Trends Hearing
- Update on CHART Phase 2 Operations
- Discussion of CHART Phase 2 Evaluation
- Discussion of Health Care Innovation Investment Program
- **Presentation on Telemedicine Pilot Program Development**
  - Review of statutory charge
  - Exploring the value of telemedicine
  - Design considerations
  - Next steps
- Schedule of Next Meeting (December 2, 2015)

Telemedicine Pilot Program

A 1-year regional pilot program to further the development and utilization of telemedicine in the Commonwealth

FY 2016 Budget Initiative

$500,000 → **Community-based providers and telemedicine suppliers**

Summary of Statute

- The HPC is to develop and implement a one-year **regional telemedicine pilot** program to advance use of telemedicine in Massachusetts.
  - The pilot shall **incentivize** the use of **community-based providers** and the delivery of patient care in a **community setting**
- To foster partnership, the pilot should facilitate **collaboration** between participating **community providers and teaching hospitals**
- Pilot is to be evaluated on cost savings, patient satisfaction, patient flow and quality of care by HPC

Objectives

1. Demonstrate **cost savings potential** of telemedicine
2. Implement telemedicine model that preserves or improves **quality and patient satisfaction**
3. Develop **multi-provider (regional) partnerships** related to telemedicine

Key Dates

Q3-Q4'15	Q1-Q2'16	Q3-Q4'16	Q1-Q2' 17
Pilot Planning & Community Engagement	Pilot Implementation and Rapid-Cycle Testing		Evaluation

→ Sustainability

Types of service models commonly considered as components of telemedicine

Real-Time Interactive Services

Description

Real time interactive communication between the patient and a practitioner at the distant site using interactive telecommunications equipment that includes, at a minimum, audio and video.

Benefit (vs. usual medical care)

Increased Access and Patient Satisfaction

Interactive services can provide immediate advice to patients who require medical attention.

Common Applications

- Neuropsychology
- Rehabilitation
- Nursing Home Care
- Pharmacy
- Emergency Medicine

Store-and-Forward

The transmission of a patient's medical information from an originating site to the health care provider at a distant site without the presence of the patient.

Improved Patient Flow

Substitution costs in that remote services can replace a full-time FTE on staff.

- Dermatology
- Radiology
- Pathology

Remote Monitoring

Also known as self-monitoring or self-testing, remote monitoring uses a range of technological devices to enable clinicians to monitor biometric and disease markers remotely and to enable patients to better comply with their care plans.

Reduced Cost and Improved Quality

Coupled with a robust clinical care model, RM has been shown to improve quality of life and reduce hospitalizations, ED visits and unscheduled primary care visits.

- Diabetes
- Cardiovascular Disease
- Asthma
- Aging in place

Many programs involve aspects of one or more of these service models. The pilot's target population, region, and outcome of interest will determine the combination of service models used.

Sources: Telemedicine and e-Health Journal, Centers for Medicaid and Medicare Services, AHRQ

Local and regional examples of value of telemedicine

Two-Way Video Conferencing

MASSACHUSETTS GENERAL HOSPITAL

MGH TelePsych *program allows patients to* receive personalized, convenient psychiatric care from their home, workplace or any private location

Berkshire Medical Center
BERKSHIRE HEALTH SYSTEMS

CHART funded

Utilize telehealth behavioral health visits, expand access to psychiatric services

MASSACHUSETTS circlehealth Emerson Hospital

Utilize telehealth visits, expand access primary care

Provider-Provider Support

Beth Israel Deaconess Medical Center

ECHO Age links BIDMC geriatric specialists, neurologists and psychiatrists with providers in the community through a weekly teleconference to discuss cases and to co-develop treatment plans

MCPAP
Massachusetts Child Psychiatry Access Project

Telephonic consultations between child/adolescent psychiatrist and the pediatric PCP

Passive Remote Monitoring

SIGNATURE HEALTHCARE

CHART funded

Homeward Bound, a CHART Phase 2 funded initiative, uses a combination of telemedicine and nurse-led home visits to support high-risk patients with COPD and CHF at home

HealthAffairs

In the nursing home, a switch from on-call to telemedicine physician coverage during off hours resulted in fewer hospital admissions[2]

Active Remote Monitoring

NEHI New England Healthcare Institute

Intensivists promoting remote ICU care decreased mortality by more than 20 percent, decreased ICU lengths-of-stay by up to 30 percent, and reduced the costs of care[1,3]

UMassMemorial Health Care

Steward
Steward Health Care System

With tele-ICU, a clinician in one "command center" is able to remotely monitor, consult and care for ICU patients in multiple locations[3]

1. Kvedar J, Coye MJ, Everett W. *Connected Health: A Review Of Technologies And Strategies To Improve Patient Care With Telemedicine And Telehealth. Health Aff* February 2014 vol. 33 no. 2 194-199.
2. Grabowski DC, O'Malley AJ. Use of Telemedicine Can Reduce Hospitalizations of Nursing Home Residents and Generate Savings For Medicare. doi: 10.1377/hlthaff.2013.0922 Health Aff February 2014 vol. 33 no. 2 244-250.
3. Fifer S, Everett W, Adams M, Vincequere J. Critial Care, Critical Choices: The Case for Tele-ICUs in the Intensive Care. New England Healthcare Institute and Massachusetts Technology Collaborative. December 2010.

National examples of the value of telemedicine

There are many examples of applications of telemedicine that illustrate its potential for improving access, quality, and efficiency in health care. Some programs have the potential to decrease medical costs as well through reduced utilization of high-cost settings and the prevention of complications.

After initiation of telepsychiatric services, patients' hospitalization utilization decreased by an average of approximately 25%.[1]

With approximately 100,000 telehealth visits per year and 800,000 visits since it's inception, the **UMMC Center for Telehealth** is reaching patients across rural Mississippi.[2] Within the Mississippi Diabetes Telehealth Network, preliminary results on the first 100 patients showed no hospitalizations or ER visits for diabetes. Implementation resulted in a 25% reduction in overall staffing costs.

Project Echo is a hub-and-spoke knowledge-sharing networks, led by expert teams who use multi-point videoconferencing to conduct virtual clinics with community providers.

1. Godleski L, Darkins A, Peters J. *Outcomes of 98,609 U.S. Department of Veterans Affairs Patients Enrolled in Telemental Health Services, 2006–2010. Psychiatric Services* 2012 63:4, 383-385 2.
2. Henderson, K Healthcare Transformation Using Technology: Improving Access, Improving Health & Lowering Cost. October, 2015.

Timeline

Q4 2015	Q1 2016	Q2 2016	Q3 2016
Program Development Market Engagement	RFP Release LOI Review	Proposal Review and Selection	Launch Preparation

12/16 – Board vote: RFP Approval

Spring – Board vote: Award Approval

	Goal Setting	Program Design	Implementation
Activities	☑ Assess statutory framework for pilot and its goals ☐ Meet with subject matter experts and stakeholderson program design considerations ☐ Review reimbursement and regulatory landscape in MA ☐ Scan MA for existing pilots and at-scale programs Current Focus	☐ Announce funding priority areas to providers ☐ Decide proposal selection criteria ☐ Review applicants' driver diagrams for meeting priorities ☐ Select awardees	☐ Provide feedback on program design ☐ Distribute pilot funding ☐ Design measurable goals for each segment of portfolio and program overall
Output	• *Program Goals* • *Current Landscape*	• *Funding Criteria* • *Mechanism for procurement*	• *Awardee Selection* • *Performance Monitoring*

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Contact information

For more information about the Health Policy Commission:

Visit us: http://www.mass.gov/hpc

Follow us: @Mass_HPC

E-mail us: HPC-Info@state.ma.us