AGENDA

- Joint Committee Meeting
  - Call to Order
  - Approval of Minutes from the November 2, 2016 Meeting
  - Community Resource Directories
  - Dual Diagnosis Study
  - Patient-Centered Medical Home Certification Program
  - Other Business
- Quality Improvement and Patient Protection: Public Hearing
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VOTE: Approving Minutes

MOTION: That the Committee hereby approves the minutes of the joint QIPP/CDPST meeting held on November 2, 2016, as presented.
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HPC’s Role in Supporting Community Resource Directories (CRD)

Statutory requirement within ch. 224 (Section 14 of MGL c.6D)

“The commission shall develop and distribute a directory of key existing referral systems and resources that can assist patients in obtaining housing, food, transportation, child care, elder services, long-term care services, peer services and other community-based services. This directory shall be made available to patient-centered medical homes in order to connect patients to services in their community.”

CRD alignment with HPC care delivery objectives

Providers in accountable care models should be able to address patients’ social needs, in addition to behavioral and medical care.

Cost Trends Hearings 2016: Social Determinants of Health Panel

“We need to learn who is around us, we are actually mapping the services now…it’s embarrassing how little I know about what’s going on 3 blocks outside of BMC.”
HPC Principles For a Community Resource Directory (CRD)

**Proposed guiding principles**

1. Align goals with statewide payment reform activities and priorities
2. Leverage and align with complementary state resource directory capabilities
3. Fill gaps where resource directory capabilities are minimal or do not exist
4. Lead with simple but high value directory functionality while incrementally enhancing capabilities over time

**Range of capabilities of existing provider-facing community resource directories**

- **If provider has no directory:**
  Then CRD becomes exclusive resource

- **If provider has poorly maintained directory:**
  Then CRD fills gaps or potentially replaces

- **If provider has directory with good geographic coverage but incomplete provider info:**
  Then CRD integrates and enhances by providing new provider information

- **If provider has directory with good community provider info but incomplete geographic coverage:**
  Then CRD integrates and enhances existing directory by adding geographic information

- **If provider has complete and well-maintained directory:**
  Then CRD integrates and adds local directory information to develop an accurate statewide resource
A number of platforms and directories of social services and resources exist nationally and across the Commonwealth.

1. Assessed current landscape

Existing resource directories range from simple to complex (e.g., from .pdf lists to sophisticated, interactive directories).
### Connecting the Dots: Alignment of CRD Efforts

**2. Identified alignment with other agency programs and objectives**

HPC staff learned there are many resource mapping and connecting efforts ongoing within state agencies, in addition to the private provider market.

<table>
<thead>
<tr>
<th>Agency</th>
<th>Efforts</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HPC</strong></td>
<td>Chapter 224 mandate; care delivery reform through certification and investment programs, research and analytics, and market monitoring</td>
</tr>
<tr>
<td><strong>Elder Affairs</strong></td>
<td>MassOptions and Mass 2-1-1 elder service listings</td>
</tr>
<tr>
<td><strong>Mass Health</strong></td>
<td>SIM investments focused on integrated community services</td>
</tr>
<tr>
<td><strong>DPH</strong></td>
<td>e-Referral pilot connecting providers to social service providers, with feedback loop</td>
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What do provider systems need in a CRD?

Conducted provider stakeholder interviews

Providers reported that a web-based resource directory with the ability to be personalized based on-site (e.g., integration with existing referral system or EHR) would help better address patient social needs. The capability to identify resources in the community is critical to the success of ACOs.

Provider reported current state

- Fragmented approach to resource identification (e.g., paper binders, institutional knowledge, some directory capability)
- Referral processes are not a closed loop; providers do not know if patient connected with a given resource

Provider reported desired business requirements

- Ease of use
- Rating system
- Core info
- Filters and free text
- Electronic info exchange
- Eligibility criteria
Good Availability and Variety of Directories in the Market

4 Conducted subject matter expert interviews

Directory technology tends to be either **consumer or provider-facing**. Experts consistently report that **quality** of resources (e.g., vetted, continuously maintained data) is more important than **quantity**, that **user-friendly features** result in increased adoption, and that **active and ongoing connections** between providers and resources is critical to the success of a directory.

Potential components for a successful resource directory implementation

- **Quality data**
- **Ease of use**
- **Provider training/support**
- **Meaningful measures and tracking**
- **Good Community Partnerships/Working Relationships**
- **Vetted resources**
- **Centralized curation/maintenance**
Questions for Discussion

5. Consider a path forward in creating a CRD-like service

Key Considerations

- How can the HPC best align with other public and private efforts?
- What is the optimal business and/or contractual relationship between potential vendor(s), providers, and the HPC?
- How can the HPC best support providers to meet the behavioral health and social service needs of patients in accountable care models?
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  - Statewide Community Resource Directories
  - **Dual Diagnosis Study**
    - Patient-Centered Medical Home Certification Program
    - Other Business
- Quality Improvement and Patient Protection: Public Hearing
The opioid legislation of 2016 charged the HPC with measuring the availability of providers treating co-occurring mental illness and substance use disorder (SUD).

1. **Create an inventory of health care providers capable of treating patients (child, adolescent, and/or adult) with dual diagnoses**, including the location and nature of services offered at each such provider.

2. **Assess sufficiency of and barriers to treatment**, given population density, geographic barriers to access, insurance coverage and network design, and prevalence of mental illness and SUD.

3. **Make recommendations to reduce barriers to care.**

See appendix for complete statutory language.

**Dual Diagnosis** is the term used to describe patients with both mental illness and SUD.
Both mental illness and substance use disorder are growing more common, but treatment availability is not increasing.

| ~20% and ~10% of Massachusetts residents have a mental illness or SUD, respectively.¹ | Mental illness and SUD rates are increasing among veterans.¹ | Only about half of adults with mental illness receive treatment; rates are even lower for SUD treatment.² |

Minorities access behavioral health treatment at lower rates than non-minority residents of the Commonwealth, and are less likely to be able to complete a course of treatment once started.³ Minorities are also experiencing higher rates of opioid-related mortality.⁴

1. 2015 Health Planning Council’s State Health Plan: Behavioral Health (SHP-BH)
Importance of Integrating Mental Illness and Substance Use Disorder Treatment

Mental illness and SUD each can confound the other’s presentation. Treatment of one while screening/treating the other produces optimal care.

Mental illness and SUD are strongly correlated and can be confused, even by trained providers

- Patients with a mental illness are at higher risk than the general population for SUD, and visa versa.¹
- Providers not trained to recognize both may mis/under-diagnose patients.²

Treatment of one affects treatment of the other

- “Self-medication” by individuals with un/under-treated mental illness can affect the presentation and severity of psychiatric symptoms.³
- Patients with un/under-treated SUD are more likely to violate psychiatric program/facility rules and/or drop out of treatment.⁴

Multiple state agencies are responsible for licensing providers who treat mental illness and SUD.

**Department of Mental Health (DMH)**
- Psychiatric inpatient facilities treating voluntarily or involuntarily committed patients; outpatient services amounting to more than 50% of a practitioner’s time

**Department of Public Health (DPH)**
- All outpatient and inpatient health care facilities

**Bureau of Substance Abuse Services (BSAS)**
- Inpatient SUD treatment facilities; outpatient facilities serving given volume of patients or providing given threshold of intensity of care

**Example challenges of multi-pronged licensure system:**
- Billing varies by payer with respect to current procedural terminology codes (CTP) (e.g., billing Behavioral Health carve out versus medical insurance company)
- Providers, such as social workers, need multiple licensures to treat both SUD and mental illness
Danger of Bifurcated Treatment: Example 1

21 year old woman with opioid use disorder (OUD) and anorexia nervosa (AN)

AN relapse

Hospitalization for AN

Discharge

Hospitalization for OUD

Discharge

OUD relapse (and higher risk of OD b/c of low body weight)
57 year old man with persistent alcohol use disorder (AUD), social anxiety disorder, diabetes, cardiovascular disease

Hospitalized for stabilization

AUD related fall; found days later with dangerously elevated heart rate and low blood pressure

Discharge

AUD relapse

Hospitalization in detoxification center

Discharge

AUD relapse; social anxiety exacerbated by lack of outpatient follow up
Consult with other state agencies (DPH/DMH)

Conduct scan of existing databases, literature review, and semi-structured interviews with academics (see appendix)

Create “map-able” inventory of providers

Map providers against:
- HPC region
- Population density
- Age group(s) served
- Accepted payment type(s)
- State-level prevalence data

Stakeholder engagement
- Providers, payers, advocates, patient representatives

Policy recommendations to reduce barriers to care

Committee input
Key questions for committee

- What is the value of mapping providers against these factors?

- Are there other approaches to quantifying availability of providers?

- Should HPC prioritize mapping treatment modalities (listed below) with strongest evidence base?
  
  - Cognitive Behavioral Therapy
  - Trauma Therapy
  - Couples / Family Therapy
  - Activity Therapy
  - Electroconvulsive Therapy
  - Group Therapy
  - Integrated Dual Disorders Treatment
  - Individual Psychotherapy
  - Psychotropic Medication
  - Telemedicine Therapy
  - Behavior Modification
  - Dialectical Behavior Therapy
  - Substance Abuse Counseling Approach
  - Rational Emotive Behavioral Therapy
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Practices Participating in PCMH PRIME

Since January 1, 2016 program launch

25 practices are PCMH PRIME Certified
Newly certified practices include:
Codman Square Health Center
Community Health Center of Cape Cod (3 sites)
Yogman Pediatrics
Cambridge Health Alliance (12 sites)

33 practices are on the Pathway to PCMH PRIME

3 practices are working toward NCQA PCMH Recognition and PCMH PRIME Certification concurrently
The NCQA PCMH Recognition program is releasing 2017 standards on March 31, 2017.

| PCMH 2017 standards streamline PCMH requirements to increase program focus on high-value capabilities |
| PCMH 2017 removes PCMH recognition levels to encourage practices to focus on depth of practice transformation rather than quantity of criteria met |
| Compared to PCMH 2014 standards, proposed PCMH 2017 standards further emphasize capabilities addressing behavioral health, social determinants of health, oral health, and coordination with community providers |
| Proposed PCMH 2017 standards include 4 PCMH PRIME criteria that were not already part of PCMH 2014 standards. 2017 program also offers “Behavioral Health Distinction” module that includes most of the PCMH PRIME criteria plus additional capabilities |
NCQA PCMH 2017 Redesign: New Evaluation Process

**Current Process**

- Practices complete application and submit documentation with little guidance from NCQA
- NCQA scores applications and follows up with practices as needed
- Practices renew recognition by undergoing a full review every three years

**Redesigned Process**

- Practices complete an online assessment and collaborate with NCQA to formulate evaluation plan
- Practices submit documentation at intervals according to evaluation plan and regularly check in with NCQA through a series of virtual reviews (three on average)
- NCQA scores practice applications once all documents are submitted
- Practices sustain recognition through annual check-ins with reduced reporting requirements
**NCQA Redesign Implications for PCMH PRIME**

HPC has begun discussions with NCQA on aligning PCMH PRIME with the PCMH Recognition redesign and 2017 standards.

### Key Program Design Considerations

- Duration of PCMH PRIME Certification under new NCQA annual review approach
- How to align PCMH PRIME review/renewal process with NCQA’s abbreviated renewal process
- Implications of PCMH 2017’s increased focus on behavioral health, including “Distinction” program

### Key Contract Considerations

- PCMH PRIME submission process and pricing under new NCQA platform and review process
- Incorporation of new NCQA standards and application process into HPC-sponsored NCQA trainings
- Communication strategy with practices about programmatic changes
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- Quality Improvement and Patient Protection
  - PUBLIC HEARING: Regulation Governing the Office of Patient Protection
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  - PUBLIC HEARING: Regulation Governing the Office of Patient Protection
Public Hearing on Proposed Regulation 958 CMR 3.000; Regulatory Timeline

May 18, 2016 – Previewed regulatory revision with the QIPP Committee

June 1, 2016 – Previewed regulatory revision to full Board

November 2, 2016 – QIPP Committee voted to advance proposed regulation

November 9, 2016 – Full Board voted to release proposed regulation

November 30, 2016 – Public hearing on proposed regulation
   Deadline to submit comments is today at 5:00PM
   Submit written comments to HPC-regulations@state.ma.us

January, 2017 (TBD) – QIPP Committee to review final regulation

January 11, 2017 – Full Board to review final regulation

*Dates may be subject to change.*
APPENDICES

- Statutory language
- Existing provider databases
- “Map-able” treatment modalities
The health policy commission, in consultation with the department of public health and the department of mental health, shall conduct a study on the availability of health care providers that serve patients with dual diagnoses of substance use disorder and mental illness, in inpatient and outpatient settings. The study shall include:

(i) an inventory of health care providers with the capability of caring for patients with dual diagnoses, including the location and nature of services offered at each such provider; and

(ii) an inventory of health care providers specializing in caring for child and adolescent patients with dual diagnoses, including the location and nature of services offered at each such provider; and

(iii) an assessment of the sufficiency of dual diagnosis resources in the commonwealth considering multiple factors, including but not limited to population density, geographic barriers to access, insurance coverage and network design, incidence of mental illness and substance use disorders and the needs of individuals with dual diagnoses.

The study shall also consider barriers to access to comprehensive mental health and substance use disorder treatment for adults, seniors, children and adolescents and shall include recommendations to reduce barriers to treatment for patients with dual diagnoses, including the appropriate supply and distribution of health care providers with such capability.

The commission shall report to the joint committee on mental health and substance abuse and the house and senate committees on ways and means not later than 12 months following the completion of the study.
National Survey of Substance Abuse Treatment (N-SSAT)

Annual census of public and private facilities providing SUD treatment (as of 2013)

Includes:

- Outpatient, inpatient, partial hospitalization, and residential treatment options
- Accepted forms of payment
- Age groups served
- Number providing mental health services
- Number offering various forms of pharmacotherapy

Limitations:

- Relies on voluntary self-reporting by facility (93.2% survey response rate in 2013)
- Number providing mental health services varies significantly from number reporting DMH licensure

National Mental Health Services Survey (NMHSS)

Annual census of public and private facilities providing mental health services as reported by DPH (as of 2015)

Includes:

- Outpatient, inpatient, partial hospitalization, and residential treatment options
- Accepted forms of payment
- Age groups served
- Number providing SUD services

Limitations:

- Does not identify pharmacotherapy availability