COMMONWEALTH OF MASSACHUSETTS

HEALTH POLICY COMMISSION

Community Health Care Investment and Consumer Involvement

December 2, 2015

Agenda

- Approval of Minutes from October 14, 2015 Meeting (**VOTE**)
- Update on CHART Phase 2 Operations
- Approval of CHART Technical Assistance Contract Extension (**VOTE**)
- Discussion of Program Design for the Health Care Innovation Investment Program
- Discussion of Program Design for the HPC's Telemedicine Pilot Program
- Update on the Community Hospital Study
- Presentation on CHART Phase 2 Project by Peter Smulowitz, Beth Israel Deaconess – Plymouth Hospital
- Schedule of Next Committee Meeting (January 13, 2016)

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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 October 14, 2015, as presented.

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Discussion Preview: Update on CHART Phase 2 Operations

Agenda Topic

Update on CHART Phase 2 Operations

Description

Staff will present an update on CHART Phase 2 planning and implementation progress to date. As of December 1, 2015, 22 of 25 CHART awards have launched. Holyoke Medical Center and Hallmark Health (Joint Award) launched on December 1. Staff will provide a brief overview of each award and commissioners will have an opportunity to ask about early successes and challenges.

Key Questions for Discussion and Consideration

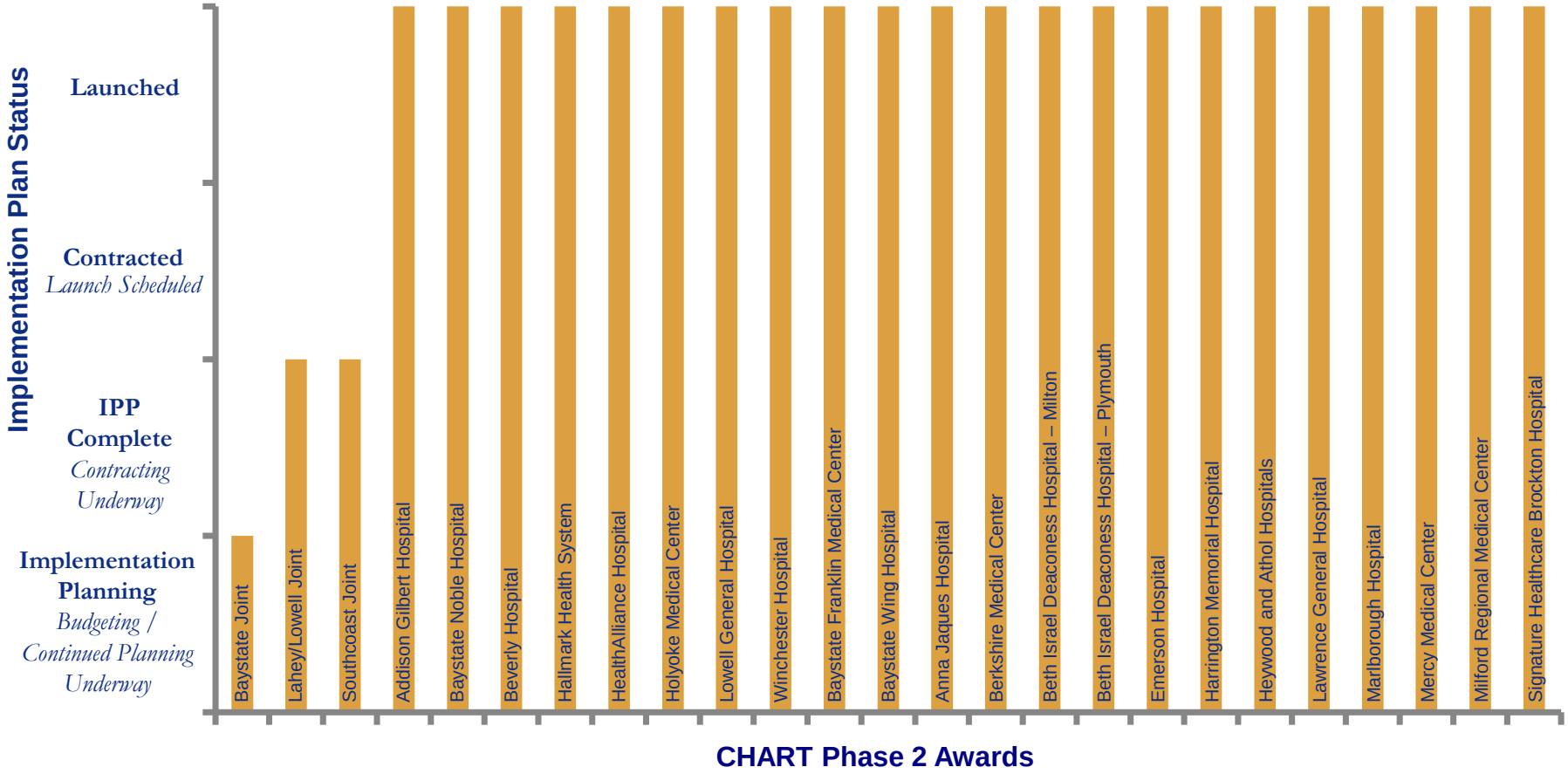
What updates on CHART Phase 2 hospital performance would be beneficial for the Committee to receive on a regular basis as hospitals move into operations?

Decision Points

No votes proposed. A full briefing on the first full quarter of performance will be provided in February 2016.

Implementation Plan status update

12 Awards launched in September and October; **8** Awards launched in November; **2** Awards launched in December; **3** Awards anticipated to launch in January



Updated October 13, 2015 – changing rapidly

Two awards launched on December 1, both focused on enhancing behavioral health care and reducing ED utilization

Hallmark Health *$2,500,000*	Cross-setting, multi-disciplinary care team serving patients with a history of recurrent ED utilization or SUD, including specialized care for obstetric patients with active SUD to reduce ED utilization. Intensive outpatient BH treatment, care planning, and linkage to community resources.
Holyoke Medical Center *$3,900,000*	Cross-setting care teams serving patients with a history of recurrent ED utilization and BH diagnoses to reduce ED utilization. BH-trained ED RNs de-escalate, screen, and triage BH patients; multi-disciplinary outpatient clinic for intensive BH treatment, care planning, and linkage to community resources. Specialty ED capital project to improve care for BH patients

Holyoke Medical Center ER nurse manager calls expansion 'awesome'

"I felt bad for patients there because space is very tight, privacy is very difficult to achieve and we need to provide more dignity for people in the ED…In an area that is very busy, oftentimes what happens is the anxiety escalates and conditions get worse.

[The ED behavioral health wing] will address safety concerns [for patients with behavioral health conditions], but more importantly it will have an environment that de-escalates the anxiety, the issues [these patients] have.

Spiros Hatiras
President & CEO
Holyoke Medical Center

CHART-funded portion of the budget; in-kind and system contributions are additional

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Discussion Preview: CHART TA Contract

Agenda Topic

Approval of CHART Technical Assistance Contract Extension

Description

Staff will seek the Committee's endorsement of a proposed amendment to the Commission's contract with Collaborative Healthcare Strategies for an additional amount of up to $250,000 through June 30, 2016, for clinical expertise in ongoing support of the CHART Investment Program. Staff will present on the overall categories of professional services to support CHART and describe the role that Collaborative Healthcare Strategies fulfills in support of both CHART hospitals and the HPC.

Key Questions for Discussion and Consideration

What services does this contract provide for CHART hospitals?
Do CHART hospitals report value from these services?

Decision Points

Vote proposed. Commissioners will be asked to endorse the proposed contact amendment and recommend that the Board vote to approve it at the December 16, 2015 meeting

Overview of total professional services to support CHART investments

Relative Magnitude of HPC Professional Services Expenditures to Support CHART In FY16

Type of Professional Support	Description of Services	Aprox. Proportion of HPC Spending
Hospital Technical Assistance	Direct hospital support including one-on-one advising, regional meetings, training, subject matter expertise, and development of tools and content to support CHART hospitals	>50% Includes **Collaborative Health Strategies** and other contracts
More than half of total professional service budget projected to be spent on direct hospital support.		
HPC Strategic Consultation	Consultation supporting CHART program development and operations, including implementation planning, review and feedback on data and hospital reports, and development of tools to support hospital oversight	<25% Includes **Collaborative Health Strategies** and other contracts
Monitoring and Evaluation	Development and implementation of awardee monitoring tools (fiscal oversight) and an evaluation approach to garner learnings and assess impact of CHART investments	<25% Full funding to other contracts

Vote: Approving staff recommendation for contract award

Motion: That, the Community Health Care Investment and Consumer Involvement Committee endorses the recommendation of the Executive Director to amend the Commission's contract with Collaborative Healthcare Strategies for an additional amount of up to $250,000 through June 30, 2016, for clinical expertise in ongoing support of the Commission's Community Hospital Acceleration, Revitalization and Transformation (CHART) Investment Program, subject to further agreement on terms deemed advisable by the Executive Director, and recommends that the Board approve this recommendation at its meeting on December 16, 2015.

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Discussion Preview: Health Care Innovation Investment Program

Agenda Topic

Discussion of Program Design for Health Care Innovation Investment Initiative

Description

Staff will present summary findings from the stakeholder survey on HCII conducted in November 2015. The survey measured importance and progress of different challenge areas and innovations, and gathered suggestions for additional Challenges and Innovations for consideration, and award amounts necessary to impact them.

Key Questions for Discussion and Consideration

Do Commissioners agree that responses are validating to all of HPC's draft Challenges, particularly behavioral health?
Do Commissioners agree with a program design approach that allows a broad range of Challenges which Applicants may propose to target with innovations meeting strict impact criteria?

Decision Points

No votes proposed. Commissioners will be asked to provide feedback on overall program development. A final program design for HCII's competitive application process will be presented to the CHICI committee in January.

HCII Survey Results – executive summary

The HPC engaged stakeholders through an online survey addressing key decisions for the HCII Program. The following slides highlight the learnings and key decisions resulting from market feedback.

A synthesis of responses confirms that the HPC identified Challenges that are important to many market participants

- **Robust response** from the market.
  - High representation from **BH organizations** and **CHCs**
  - Lower representation from **Payers**, **Consumer Groups**
- Responses are validating to **all** of HPC's draft Challenges
  - Particularly **behavioral health**
- **Broad variation between types of respondents** in rating Challenges and Innovations
  - This variation reflects the **broad eligibility pool** for this program
- Some consensus around **more, smaller, awards**

HCII Stakeholder Survey – by-the-numbers

125+

Number of Stakeholders to whom the survey was distributed

Included stakeholders from across the health care field, including

- Providers
- Payers
- Consumers
- Patient advocates
- Business
- Labor
- Education
- Innovation

3 Weeks

Duration the Survey was live and publically available on HPC's website during November 2015

98

Total number of market respondents

Executive and Senior Operational or Financial Leadership

Medical Leadership and Staff

The 15-20 minute survey gauged:

	5pt Likert scales	
Importance of Challenge Areas	"Not at all important"	"Extremely important"
Progress in Challenge Areas	"Little to no progress or understanding"	"Fully integrated into our day-to-day operation"
Interest in testing and/or scaling Innovation models	"Not at all interested"	"Extremely interested"

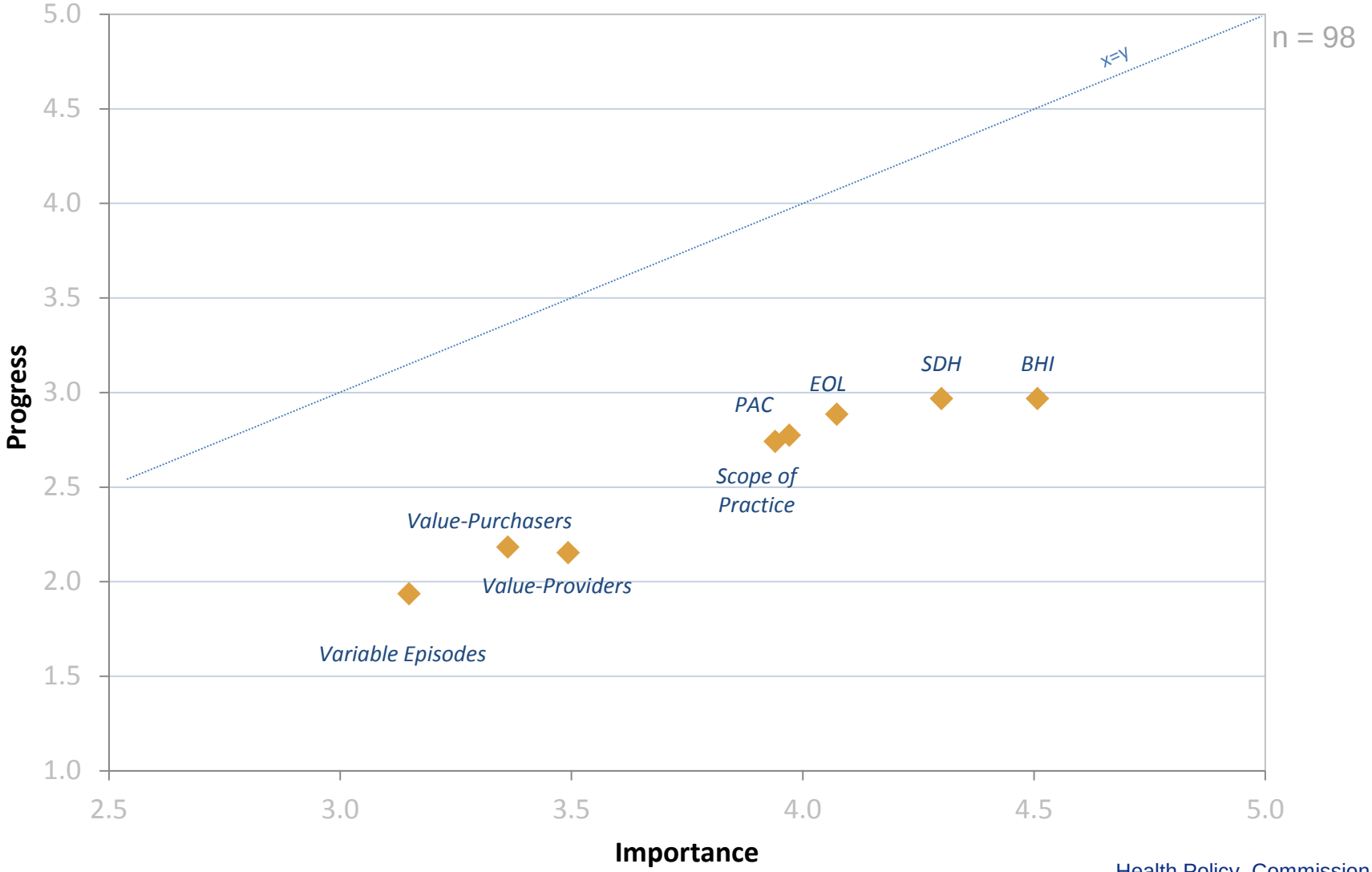
Respondent Affiliation:

	Proportion of Respondents
Health Care Facilities (Hospitals, and Multi-Hospital Systems, Post-Acute Care)	39%
Integrated Service Delivery Systems (ACOs/Integrated Delivery Systems, Physician Groups, CHCs)	30%
Behavioral Health Providers	23%
Health Plan/Payers	3%
Other*	5%
Total:	100%

* "Other" responses included "Consumer", "Professional Association", "Academic/Research", "Pharma", and "Government."

HCII Stakeholder Survey – challenge areas, importance vs progress

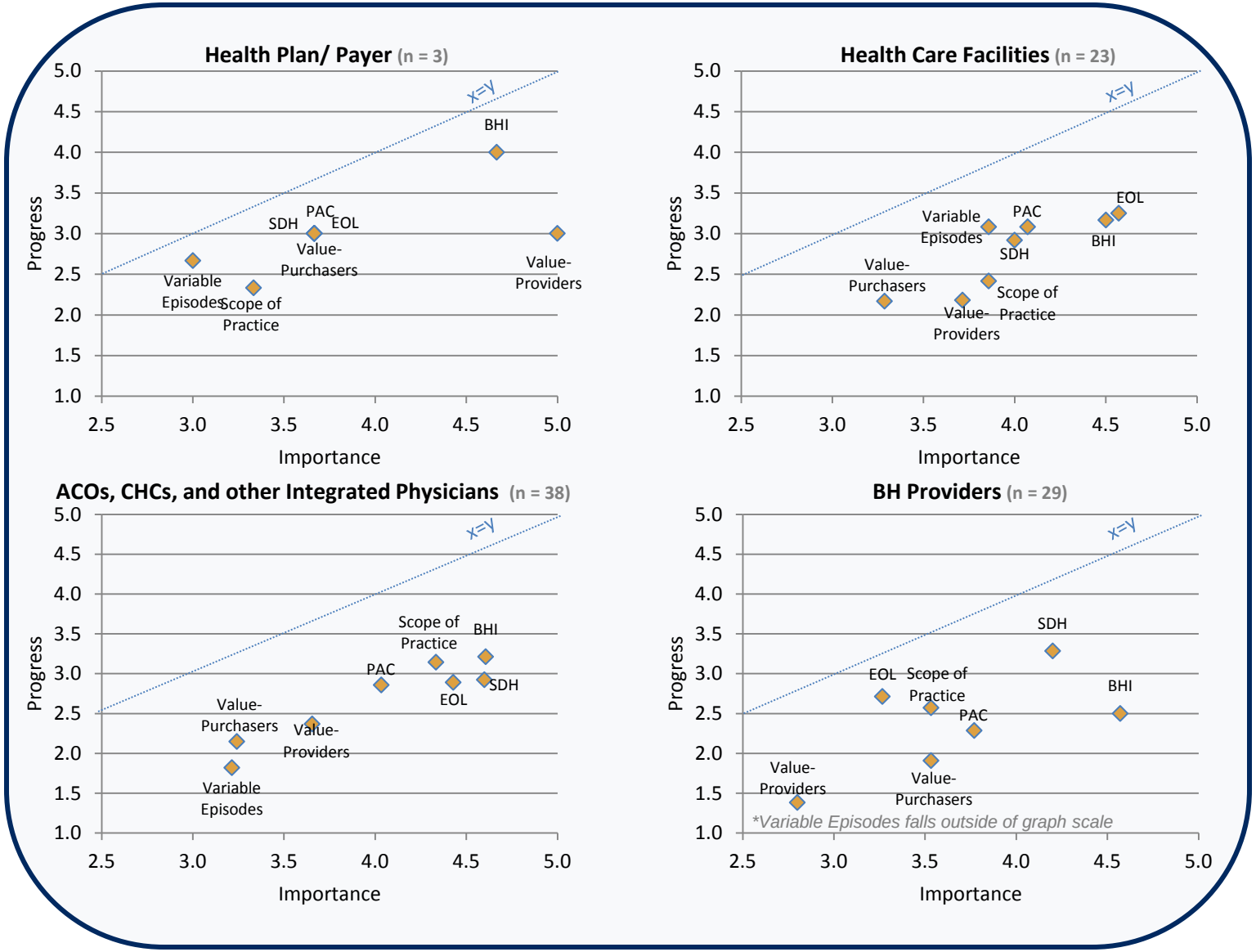
Although most Challenges' importance exceeded respondents' ability to make progress against them, average progress in an area appeared to be proportionate to the relative level of its importance.



HCII Stakeholder Survey – importance vs progress by respondent type

No respondent type indicated sufficient Progress in any Challenge.

BHI emerges as the only Challenge indicated as a top priority (≥4) across all respondent types, but great variability exists in all other domains.



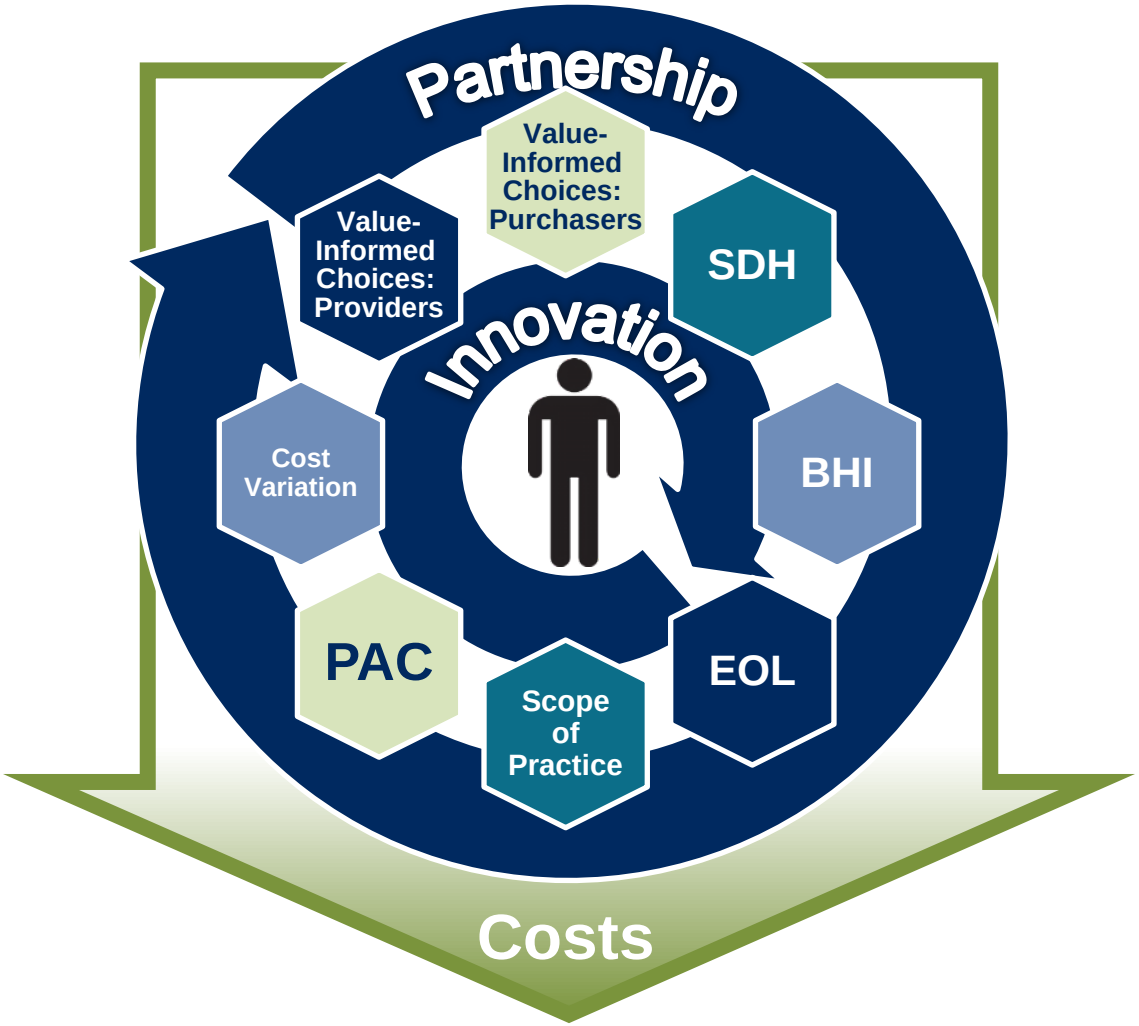
HCII Stakeholder Survey Summary – free text responses

Respondents noted additional cost drivers and innovations for consideration by the HPC. Many either highlighted nuances of existing Challenges or provided the HPC with concepts to consider including in future design choices. Some suggestions were out of scope for HCII's goals.

Additional Challenges	Additional Innovations	HPC Resolution
Readmission reduction	Telemedicine	Encompassed in current HCII design
BH reimbursement parity	Enhance community BH	
Care coordination	Address SDH	
"Payment reform"	"Payment reform"	Addressed in HPC's policy activity and investments
IT infrastructure sufficiency	Practice transformation	
Administrative complexity	Administrative simplification	Out of scope for HCII; addressed by HPC and other agencies
Drug pricing		
Health Information Exchange		

HCII program design framework

Health Care Innovation Investment Program: *Focusing patient-centered innovation on Massachusetts' most complex health care cost challenges.*



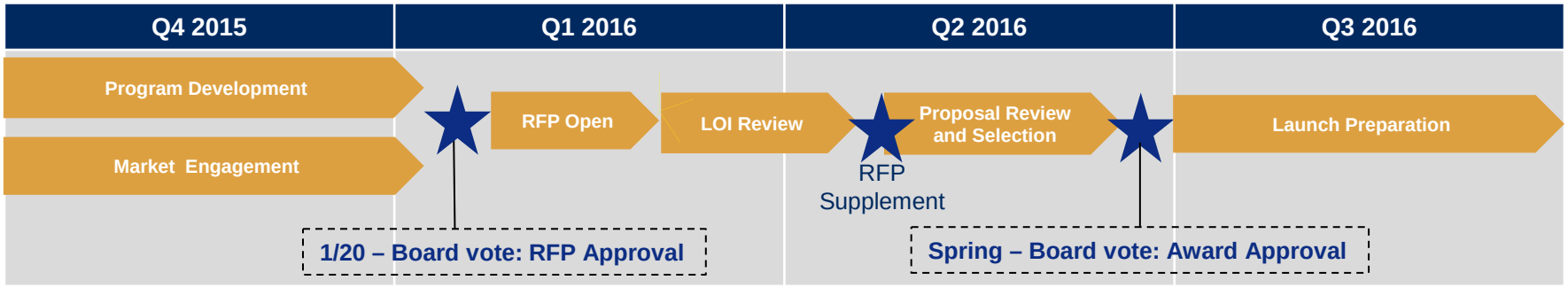
Broad array of eligible Challenges	Capture innovations from a diverse swath of applicants

+

Narrow selection criteria	Define rigorous requirements for high-quality innovation and partnership in order to achieve sustainable cost-reduction

HCII Round 1 anticipated timeline and remaining key decisions

The HPC anticipates refining key decisions and developing the RFP into January 2016, 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 ☐ **Finalize proposal framework and selection criteria** Current Focus ☐ Review LOIs, provide comment. ☐ Draft RFP release awardees	☐ Receive full proposals and select ☐ Provide feedback on program design in contracting process ☐ Distribute initial funding ☐ Finalize performance monitoring and data collection approaches to measure impact
Output	• Program goals • Program priority areas	• Funding criteria • Mechanism for procurement • Awardee selection	• Contracted awardees • Performance monitoring • Impact

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Discussion Preview: Telemedicine Pilot Program

Agenda Topic

Discussion of Program Design for Telemedicine Pilot Program

Description

In July, the legislature awarded the HPC $500,000 to conduct a regional pilot to study the impact of using telemedicine for consultation, diagnosis, and treatment. Staff will present a program design for consideration by the Committee. The proposed design considers key cost and access challenges in Massachusetts and focuses on successful applications of telemedicine for reducing readmissions of patients from post-acute settings and enhancing access to behavioral health care for high-need populations and geographies.

Key Questions for Discussion and Consideration

How should the HPC prioritize between post-acute care and behavioral health?
Should we consider specific opportunities to support telemedicine via other HPC investment programs?
Should the HPC encourage payer-provider collaboration in this pilot? If so, how strongly and through what mechanisms?
Should the HPC favor organizations that have experience with telemedicine and therefore existing expertise and infrastructure, or those with interest in developing new capability?

Decision Points

No votes proposed. Commissioners will be asked to provide feedback on overall program development. A final program design for the Telemedicine Pilot will be presented to the CHICI committee in January.

Goals of telemedicine pilot program

Payers, providers, and policymakers are interested in understanding the impact of using telemedicine for consultation, diagnosis, and treatment. Goals of piloted models may include:

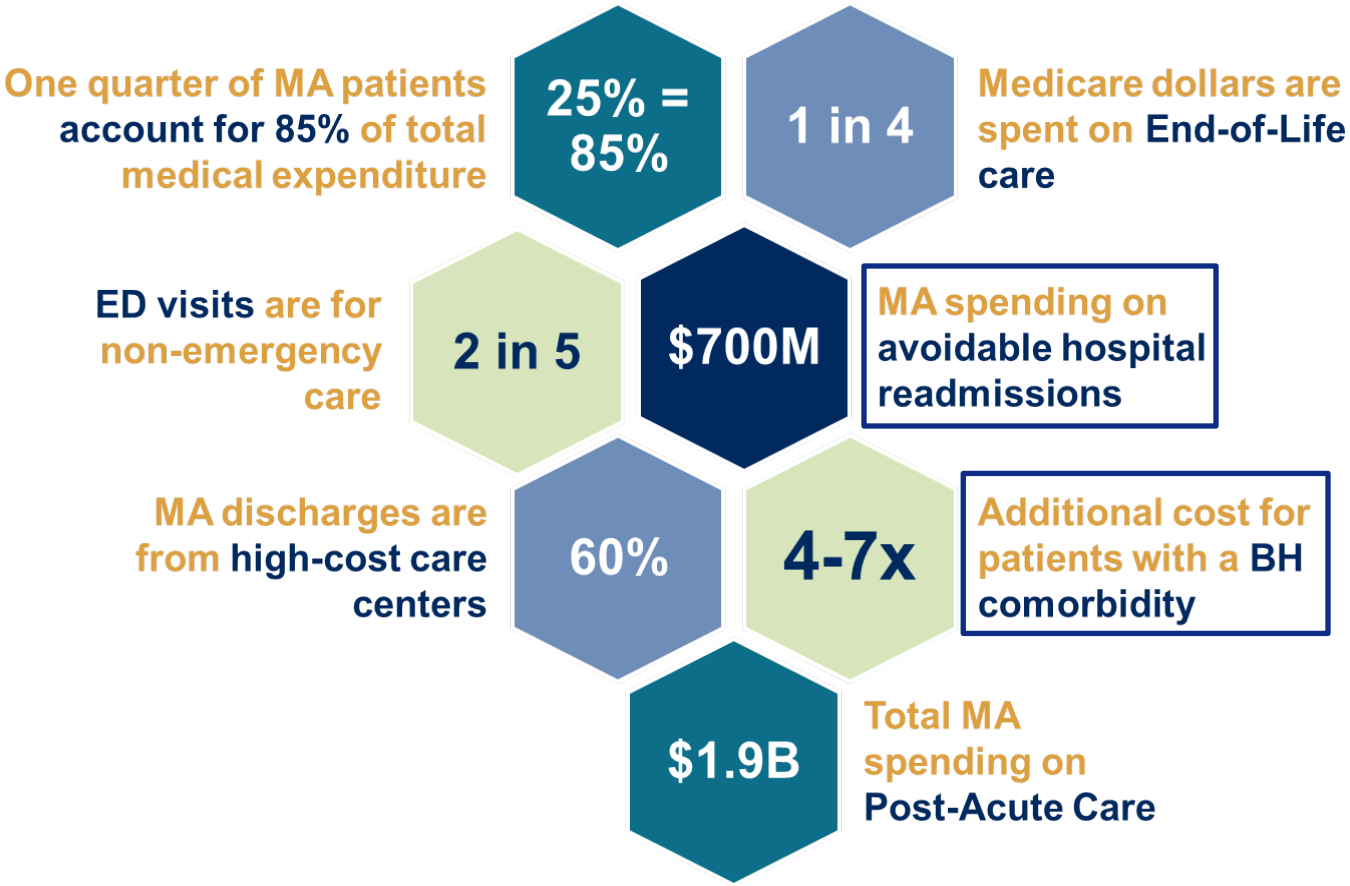
1. Telemedicine should demonstrate **cost savings** and/or **enhance access to care**
2. Telemedicine should maintain or **improve patient experience** and **quality** of care
3. Telemedicine should **improve patient flow**
4. Telemedicine should **improve providers' operating efficiency** through optimal allocation of clinical staff among partnering sites and use of staff time
5. Telemedicine should enhance community-based care and **reduce the number of patients transferred for specialty evaluations** when appropriate care could be delivered at the originating setting
6. Telemedicine should **improve provider satisfaction**
7. Telemedicine care models should be closely linked back to primary providers to ensure **continuity of care**
8. Telemedicine should **not result in duplicative utilization** patterns and, where appropriate, should reduce overall utilization over an episode of care

Source: HPC Telehealth Pilot Language – Section 161; HPC Stakeholder Engagement

Selection of priority areas

Key Cost and Access Challenges in Massachusetts

Substantial and persistent challenges in access to behavioral health care have been reported by the HPC and other agencies with clear links to ED high use, readmissions, and other health and spending impacts



Selection of priority areas

Through our Cost Trends research, the HPC has identified two areas of urgent need for enhanced care delivery models that we propose focusing this pilot program to address

1 Reducing rehospitalizations of patients in post-acute settings

PAC use in MA is higher than the US overall for both institutional and in-home care

Institutional settings like **SNFs and IRFs** tend to see higher-acuity patients with conditions at higher risk for readmission, such as stroke, any post-surgical, and kidney and respiratory infections

Nearly **1 in 5 patients** discharged to these settings bounce back to the hospital within 30 days; a study has found many of these to be for primary care-treatable reasons

2 Improving access to behavioral health care for high need populations or geographies

Behavioral health visits to the ED, up 24% since 2010, have grown the most rapidly of any type of visit

Patients who find it **difficult to access** care for behavioral health will forego care or use urgent care for non-emergent needs. Comorbid BH patients **cost 4-7x more** than others

There are many different sub-populations within behavioral health (e.g. patients with substance-use disorders, non- and complex mental health) on which providers can focus

Sources: Health Policy Commission Cost Trends Reports 2014 and 2015 (in development); CHIA Readmissions Report 2015; Carter 2003

Other considerations for pilot priority areas and geographies

Other telemedicine applications have already begun to demonstrate value in Massachusetts, as indicated by provider and consumer uptake	
Inpatient Acute Models	Support for **provider-to-provider inpatient acute care**, such as telestroke, have demonstrated value and are used more extensively than any other type of service in MA. Others, like teleICU that have not reached scale, have **start-up costs that are out of budget** for this HPC investment opportunity.
Direct to Consumer	**Direct-to-consumer video consults through national platforms** (e.g. American Well, Doctor on Demand, Teladoc) for low-acuity primary or specialty care have shown increased uptake nationally. In spite of limited payer coverage for these services in Massachusetts, they have existing commercial presence and recently have seen rapidly increasing consumer use. This market activity is already testing the case for coverage.
Store and Forward	**Store and forward technology** to support radiology, dermatology, and other diagnostic specialties is promising but the economics of these approaches make them **currently advantageous** to providers and therefore less relevant for this pilot program.

Sources: MGH telemedicine program; Rock Health; NEHI Tele-ICU

1 Model example: Post-Acute Care Readmission Reduction

In Massachusetts, a for-profit nursing home chain switched from off-site/on-call service to telemedicine physician coverage during off hours to increase access to medical care

Intervention

A study team from Harvard worked with the MA-based chain to randomize the intervention to a cohort of 11 facilities that staffed both SNF and residential beds

Six facilities received telemedicine support from a call center staffed by emergency medicine doctors. Five continued with telephonic on-call service during off hours.

Outcomes

A nursing home averaging 180 hospitalizations per year could expect to see a reduction of about 15 hospitalizations per year through the use of provider-provider consults

→

This resulted in an average projected savings to Medicare of **$151,000 per nursing home per year***

Researchers estimate the magnitude of these cost and utilization outcomes would be greater if the intervention focused on SNF beds only

Sources: Grabowski (2014); HPC interview with Grabowski Nov. 2015;

*The average projected savings to Medicare for a nursing home utilizing telemedicine services would be $151,000 per nursing home per year, relative to the less-engaged facilities. The annual cost of the telemedicine service in this study was $30,000 per nursing home, implying net savings of roughly $120,000 per nursing home per year. Given the variable costs of telemedicine technology, we do not report a net figure.

2 Model example: Enhancing Behavioral Health Access

The ***Washington State Mental Health Integration Program (MHIP)*** is funded by the Community Health Plan of Washington, a Medicaid MCO, to increase access to behavioral health care in primary care settings

Intervention

The **Collaborative Care Model** provides collaborative depression care side-by-side with chronic medical care treatment directly to patients in community health centers via telemedicine with a care coordinator at the hub coordinating access between a primary care provider and a remote psychiatrist

Outcomes

Behavioral health coordinators embedded in over 100 CHC work closely with primary care teams and meet weekly with a remote consulting psychiatrist at UWMC

→

MHIP decreased referrals by increasing BH care in a primary care setting

In the first 14 months, it saved more than **$11 million in avoided hospital costs**

Sources: NASHP; Community Health Plan of Washington (CHPW) Presentation

2 Other existing models: enhancing behavioral access

		Outcomes	Intervention
Substance use disorder			
WISCONSIN UNIVERSITY OF WISCONSIN–MADISON	ADDICTION CHESS	A-CHESS patients reported a lower average number of risky drinking days and higher likelihood of consistent abstinence than patients who received only treatment as usual	Patients received a smart phone with static and interactive features connected to a counselor to assist in alcohol abstinence
Serious mental illness			
vinfen	HEALTH BUDDIES	Vinfen estimates that 183 interventions averted 71 ED visits for a complex population that does not have adequate access to care management	Patients report health status daily and are coached by an app-based device. NPs review status and outreach to patients
Non-complex mental illness			
VA	CARE COORDINATION HOME TELEHEALTH	Improved quality of life; 50% fewer hospitalizations; 11% fewer ED visits; LOS reductions by up to 3 days	Home monitoring along with nurse-based or social worker-based care coordination

Sources: Vinfen; chess.wisc.edu; Veterans Administration

Note: Many models cross-over to treat populations of patients with various degrees of behavioral health complexity

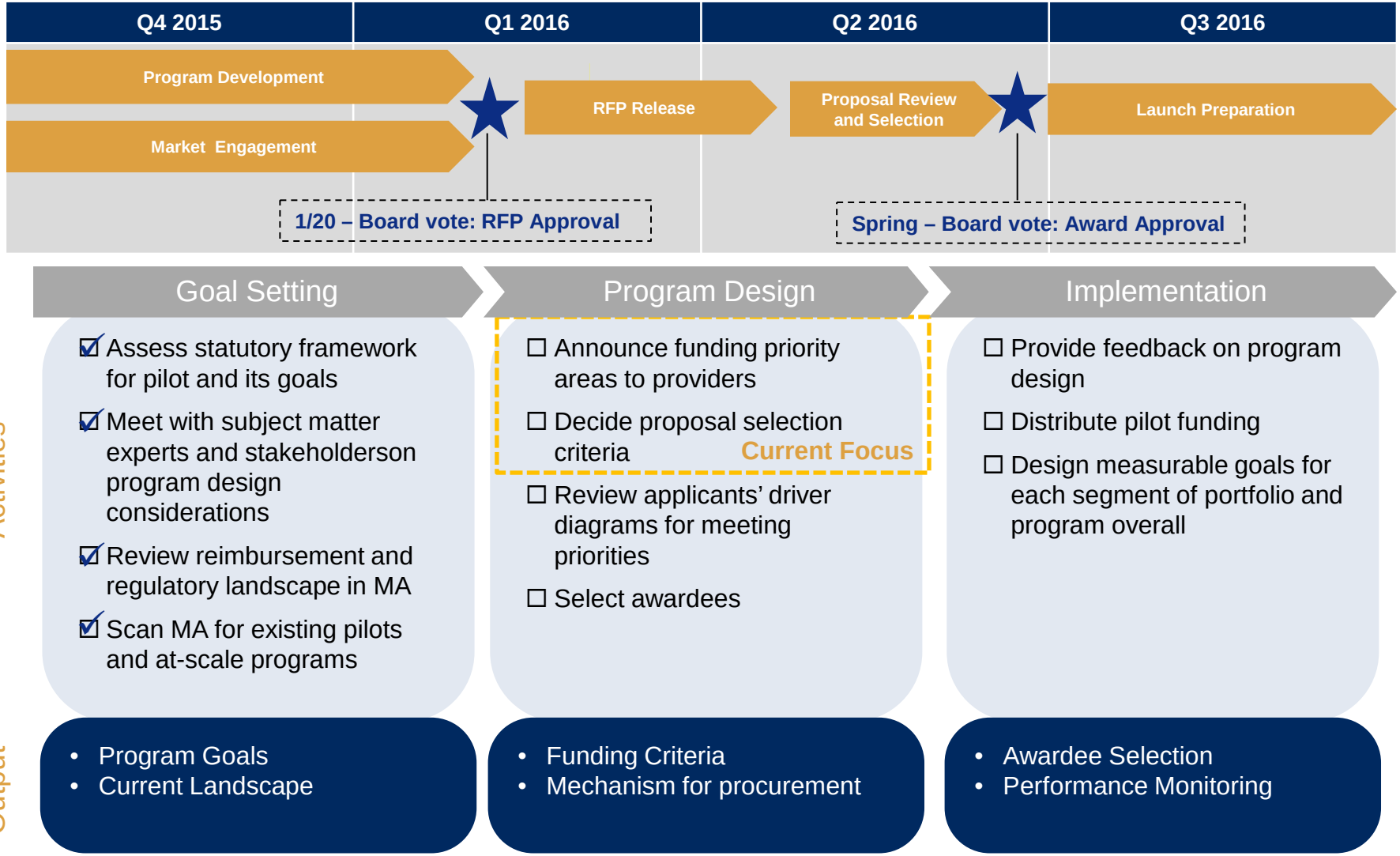
Summary of telemedicine pilot program key design choices

Investment Focus	• Include *one/two* areas of priority in a request for proposals. Solicit proposals that compete on the merits of cost efficiency and overall impact (on access and cost): Reducing readmissions from post-acute care *and/or* enhancing access to behavioral health services
Application Process	• Applicants (including partners) will select one of two focus areas (PAC or BH), identify a target population, develop a driver diagram indicating how their intervention will achieve a quantifiable aim, and make a compelling argument that use of telemedicine is preferable to traditional care approaches
Award Size and Duration	• 12 month pilot; one $500,000 award
***Proposed* Proposal Goals**	• Demonstrate access expansion OR cost savings (or both) • Demonstrates how pilot will improve patient experience and quality of care • Demonstrates how pilot will improve operating efficiency through optimal allocation of clinical staff among partnering sites and use of staff time • Demonstrates how pilot will improve provider satisfaction • Prior experience implementing telehealth • Likelihood of sustainability • Evidence base for proposed telehealth model
Eligibility	• All providers in Massachusetts are eligible to apply • A single entity may apply on behalf of a consortium of providers • Require some level of collaboration with a teaching hospital; no funding requirement
Collaboration	• Partnerships between multiple provider organizations will be required
Evaluation	• Applicants must indicate key outcomes of interest, measures to assess those outcomes, and include a plan for rapid-cycle evaluation to improve the efficacy of the model during implementation • The HPC will conduct an evaluation of the impacts of the project

Key design choices for discussion

Three outstanding design choices for development of a request for proposals	
Prioritizing PAC vs BH	▪ How should we prioritize between **post-acute care** and **behavioral health**? ▪ Should we consider specific opportunities to support telemedicine via other HPC investment programs?
Role of health plans	▪ Should we encourage **payer-provider collaboration** in this pilot? If so, how strongly and through what mechanisms?
Prioritizing experience	▪ Should we favor organizations that have **experience** with telemedicine and therefore existing expertise and infrastructure, or those with interest in developing **new capability**?

Timeline


Q4 2015
Q1 2016
Q2 2016
Q3 2016
Program Development
Market Engagement
RFP Release
Proposal Review and Selection
Launch Preparation
1/20 – 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
☐ Announce funding priority areas to providers
☐ Decide proposal selection criteria
Current Focus
☐ 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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Discussion Preview: Community Hospital Study

Agenda Topic

Update on the Community Hospital Study

Description

Staff will present an update on the Community Hospital Study undertaken by the HPC. The presentation will include an outline of the anticipated report and a proposed release plan. The release plan includes a Policy Breakfast with roundtable discussion of the findings and their implications with market participants in February 2016 followed by development of an Action Plan in Spring 2016.

Key Questions for Discussion and Consideration

Does the outline align with Commissioners' priorities and interests for this study?
What is the Committee's view on the proposed release plan?

Decision Points

No votes proposed. Commissioners will be asked to provide feedback on the report outline and release plan. Select findings from the report will be presented at the January CHICI meeting and the full report will be released in February 2016.

Community hospital study background

The need for better understanding the state of community hospitals

- Hospitals and health systems in Massachusetts are facing an unprecedented impetus to transform care delivery structures and approaches
- Community hospitals, which may be contending with persistent market dysfunction can be particularly sensitive to such change
- Massachusetts is at the cusp of delivery system transformation, and effective, action-oriented planning is necessary to ensure that hospital resources are distributed to meet current and future community need

Objectives of the community hospital study

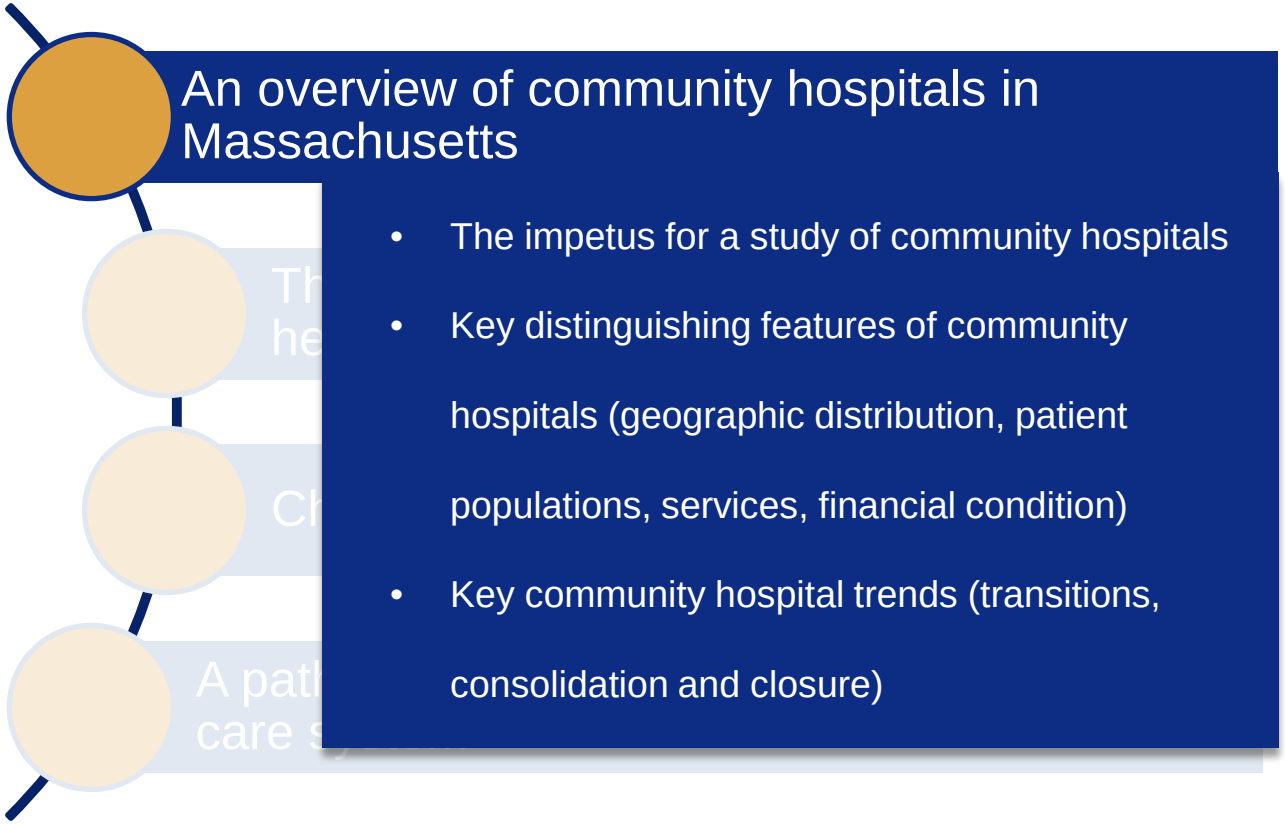
- To understand and describe the current state of and challenges facing community hospitals
- To examine the implications of market dynamics that can lead to elimination or reduction of community hospital services
- To encourage proactive planning to ensure sustainable access to high-quality and efficient care, especially for services that are historically under-reimbursed
- To identify challenges to and opportunities for transformation in community hospitals

A transformed, well-supported community health system

Community hospital study outline

- An overview of community hospitals in Massachusetts
- The value of community hospitals to the health care system
- Challenges facing community hospitals
- A path to a thriving community-based health care system

Report outline



Report outline

An overview of community hospitals in Massachusetts

The value of community hospitals to the health care system

Community-based care and access

- Care close to home / drive time analyses
- Patient populations / payer mix

Quality and Efficiency

- Examination of quality performance by community hospitals and patient perception of quality and value
- Variation in spending and costs for community-appropriate care at community vs other hospitals

A pa
care

Report outline

An overview of community hospitals in Massachusetts

The value of community hospitals to the health care system

Challenges facing community hospitals

- Referral patterns and consumer perceptions
- Consolidation of hospitals and primary care providers with large systems
- Decreasing inpatient volume and misalignment of supply and demand for hospital services (current and future)
- Payer mix, service mix, and variation in prices
- Non-traditional market entrants
- Implications if current trends continue

A pa
care

Report outline

An overview of community hospitals in Massachusetts

The value of community hospitals to the health care system

Challenges facing community hospitals

A path to a thriving community-based health care system

- Most patients should get most care in an efficient and high-quality setting close to home
- Providers must adapt to make this possible, and incentives and regulation should align to support them
- Call to develop an **Action Plan** in concert with market participants

Report release plan: Fostering dialogue and developing an Action Plan

Developing a successful path to a thriving community-based health care system requires multi-stakeholder engagement and incorporation of many diverse viewpoints

Report findings spur market-wide dialogue and support identification of priority actions to be taken by providers, payers, purchasers and government

HPC finalizes and releases report in early February 2016; early findings shared at CHICI in January

HPC convenes a Policy Roundtable in late February 2016 (Date TBD) to share findings from the report and foster dialogue among industry leaders about its implications

The Policy Roundtable will feature keynote speakers to reflect on findings and necessary market changes as well as a panel of providers, payers, purchasers, labor, and communities to reflect on necessary strategy and policy changes

In collaboration with stakeholders, HPC develops an Action Plan to be released in Spring 2016 to address findings of the report. Recommendations will be oriented towards providers, payers, purchasers and policymakers

Through the CHART Investment Program, research and policymaking activities, and stakeholder partnership, the HPC will seek to advance the Action Plan to address priorities for communities across the Commonwealth

Agenda

- Approval of Minutes from October 14, 2015 Meeting (VOTE)
- Update on CHART Phase 2 Operations
- Approval of CHART Technical Assistance Contract Extension (VOTE)
- Discussion of Program Design for the Health Care Innovation Investment Program
- Discussion of Program Design for the HPC's Telemedicine Pilot Program
- Update on the Community Hospital Study
- **Presentation on CHART Phase 2 Project by Peter Smulowitz, Beth Israel Deaconess – Plymouth Hospital**
- Schedule of Next Committee Meeting (January 13, 2016)

Discussion Preview: CHART Phase 2 Presentation

Agenda Topic

Presentation on CHART Phase 2 Initiative by Beth Israel Deaconess Hospital – Plymouth

Description

Dr. Peter Smulowitz, Dr. Pedro Bonilla, and Sarah Cloud will present to the Committee on their early experiences in CHART Phase 2. BIDH-Plymouth has a $3.7M award from the HPC to reduce total hospital admissions for patients dually eligible for Medicare and Medicaid by 10%, and to reduce total ED visits for patients with a behavioral health diagnosis by 10%. BIDH-Plymouth's Integrated Care Initiative has a strong focus on enhancing behavioral health services in both emergency and primary care settings.

Key Questions for Discussion and Consideration

What have been the early successes and challenges of BIDH-Plymouth's CHART Phase 2 initiatives? What lessons have the BIDH-Plymouth team learned that can inform other CHART hospitals or the HPC's policy development activities?

Decision Points

No votes proposed. Discussion only.

Beth Israel Deaconess Hospital – Plymouth

Beth Israel Deaconess Hospital
Plymouth

$5.17M BIDH-P Project Cost = **$3,700,000** HPC CHART Investment + **$1,221,058** *BIDH-P Contribution* + **$250,476** *System Contribution*

Target Population

Dual eligible patients

850

discharges per year

Aims

Primary Aim

Reduce admissions by **10%**

ED patients with a primary BH diagnosis

3,000

visits per year

Primary Aim

Reduce ED visits by 10%

Secondary Aim

Reduce ED LOS by 10%

Beth Israel Deaconess Hospital – Plymouth

Beth Israel Deaconess Hospital
Plymouth

$5.17M	=	$3,700,000	+	$1,221,058	+	$250,476
BIDH-P Project Cost		HPC CHART Investment		*BIDH-P Contribution*		*System Contribution*

CHART Project

Once referred, dual eligible patients will be screened and assessed by the nurse care manager in the **Complex Patient Program**. A member of the multidisciplinary care team will provide a home visit, as needed, as the patient is managed across the continuum of care. Care plans are developed, implemented, and reassessed on an ongoing basis.

The **Integrated Care Initiative** will establish a community-wide approach to treating behavioral health patients. Behavioral health services will be co-located in primary care practices, with LICSWs providing brief interventions during PCP visits. In the Emergency Department, the Behavioral Health Team will work in collaboration with ED staff and collateral community providers to help patients: access necessary supports; ensure continuity of primary and behavioral health care; and to stabilize patients.

McLean Hospital is providing LICSW and psychiatric care for pediatric patients. **The Herren Project** will provide school-based early intervention, education, and outreach programs to Plymouth high schools.

Enabling Technology

The investment in Enabling Technology will support many modalities of secure clinical information exchange among care team members and community partners, including:

- Individualized care plans and ADT notifications on patients being treated by CHART
- Secure exchange of clinical information with five LTC facilities and five community-based behavioral health providers
- Secure video conferencing among clinical teams and partners supporting patient care

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Contact information

For more information about the Health Policy Commission:

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Appendix: Additional materials to support presentations

- Additional Materials for Program Design for the Health Care Innovation Investment Program
- Additional Materials for Program Design for the HPC's Telemedicine Pilot Program
- Summary of CHART Phase 2 Award to Beth Israel Deaconess – Plymouth Hospital

HCII Round 1 draft challenge areas

The HPC outlined inclusion criteria through which 8 Challenges were identified as potential domains applicants may elect to target in their Proposals.

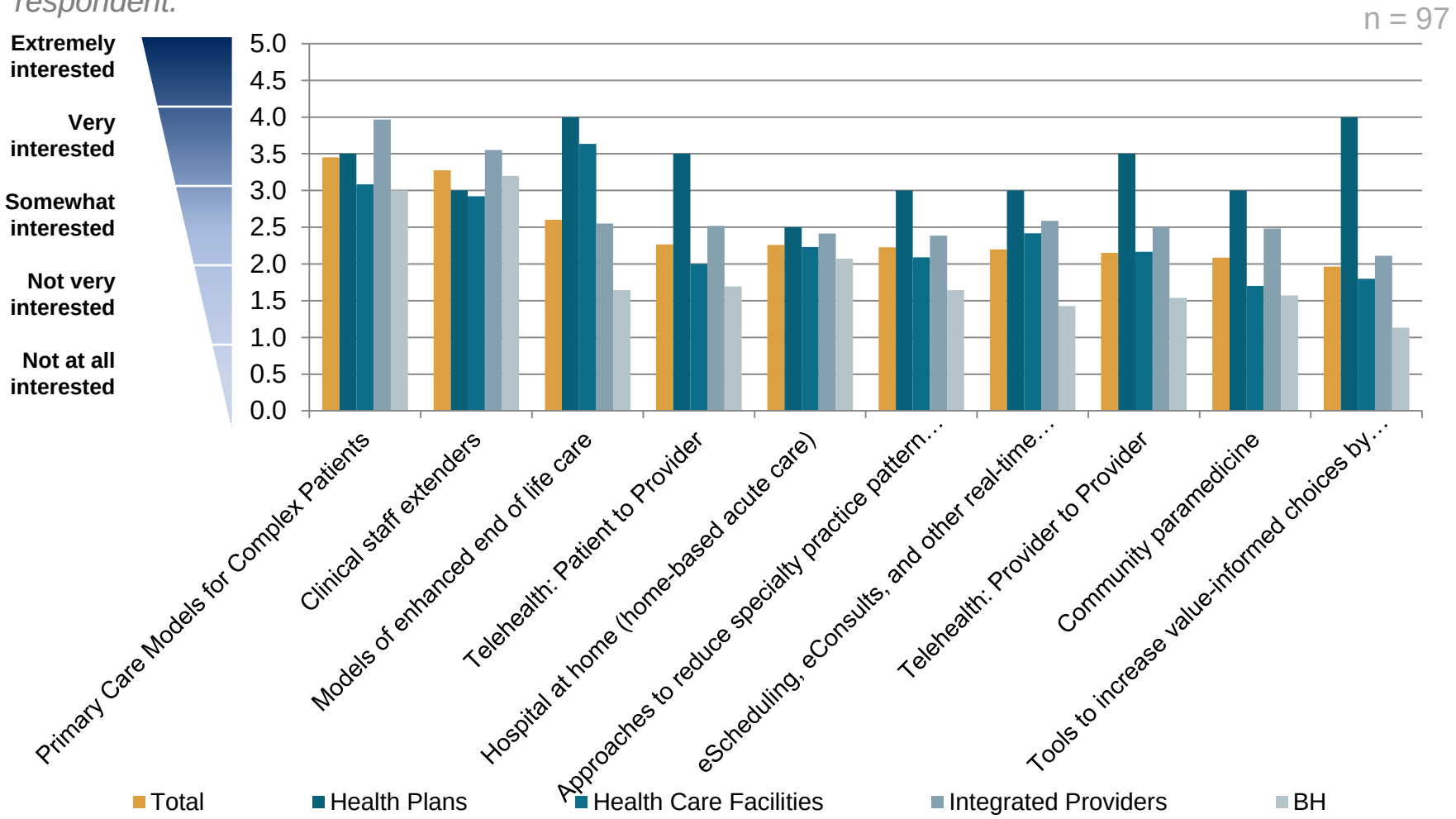
Need	Innovation Opportunity
Persistent health challenge and a significant cost driver	Limited existing market progress, despite strategic importance and promising emerging solutions

	Challenge
SDH	Meet the health-related social needs of high cost patients
BHI	Integrate behavioral health care (including substance use disorders) with physical health services for high risk / high cost patients
Value-Informed Choices: Purchasers	Increase value-informed choices by purchasers that optimize patient preferences
Value-Informed Choices: Providers	Increase value-informed choices by providers that address high-cost tests, drugs, devices, and referrals

	Challenge
Cost Variation	Reduce cost variability in hip/knee replacements, deliveries, and other high-variability episodes of care
PAC	Improve hospital discharge planning to reduce over-utilization of high-intensity post-acute settings
EOL	Ensure that patients receive care that is consistent with their goals and values at the end of life
Scope of Practice	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 tech)

HCII Stakeholder Survey – interest in innovations

Respondents indicated their relative interest in a number of innovations, rating workforce and process-driven innovations higher than tool- and technology-driven solutions. Ratings varied widely by type of respondent.

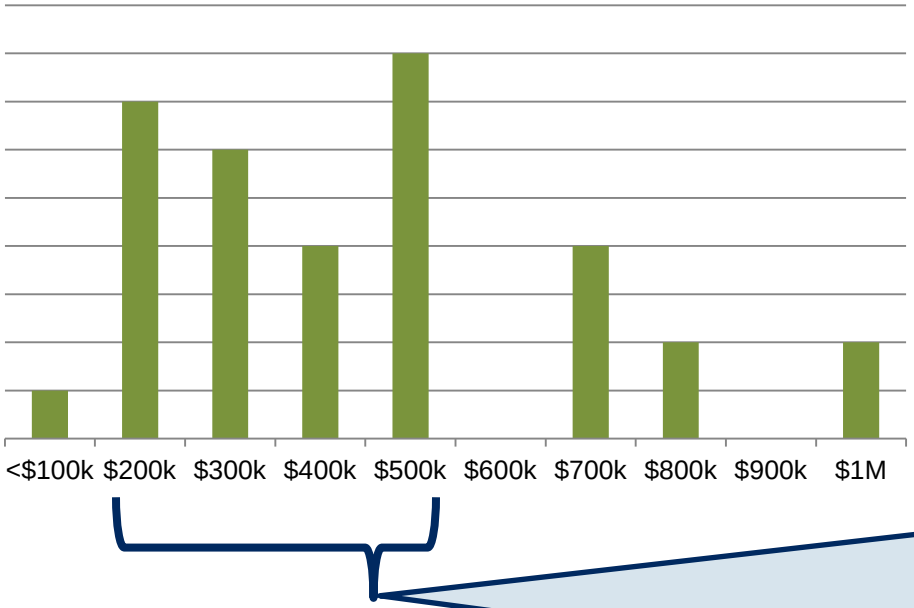


HCII Stakeholder Survey Summary – funding caps

Respondents were asked to indicate how much money would be required to deploy and test innovations. Responses varied widely, but clearly supported more, smaller award caps.

Frequency of per-year funding amounts indicated by respondents

n = 34



Smaller (i.e., $200-500k per year) awards…

- Provide sufficient short-term initial start-up costs
- Incentivize initiatives of strategic importance to applicants
- Emphasize thrift and entrepreneurial creativity
- Allow the HPC to make more awards with HCII funds

Telemedicine Pilot

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

$500,000 → **Community-based providers and telehealth 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

Statutory Objectives

1. Demonstrate **cost savings potential** of telemedicine
2. Implement a model that preserves or improves **quality & 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

Source: HPC Telehealth Pilot Language – Section 161

Local and regional examples of value of telemedicine

Two-Way Video Conferencing

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

CHART funded

Utilize telehealth behavioral health visits to expand access to psychiatric services

Utilize telehealth visits to expand access to primary care

Provider-Provider Support

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

Telephonic consultations between child/adolescent psychiatrist and the pediatric PCP

Passive Remote Monitoring

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

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]

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.

1 Other existing models: Post-Acute Care Readmission Reduction

In Massachusetts, Partners Healthcare is piloting SNF-based telemedicine

Intervention

- ***In pilot:*** **SNFists**, hired by the hospital system but based at a SNF, collaborate with SNF staff to provide primary care to recently discharge patients with a goal of reducing hospital readmissions
- **Specialty provider-to-provider consultations** via telemedicine provide specialty care not otherwise staffed at a SNF
- **Continuity visits** by nurses follow patients in whatever setting they are

In California, Sonoma West Health Medical Center is reducing hospital readmissions through telemedicine partnerships with skilled nursing facilities

Intervention

Sonoma West is delivering advanced technology and access to specialists to SNFs that agree to partner with them in care transitions. SNFs newly acquired access includes **pulmonology, neurology, psychiatry, dermatology and intensivist care**, made available through telemedicine applications

Sources: Brandeis Health Care Forum; Fierce HealthCare