COMMONWEALTH OF MASSACHUSETTS

HEALTH POLICY COMMISSION

Joint Committee Meeting

Quality Improvement & Patient Protection

Care Delivery and Payment System Transformation

July 8, 2015

Agenda

- **Approval of QIPP Minutes from May 20, 2015**
- Approval of CDPST Minutes from June 10, 2015
- Public Hearing on Proposed Updates to Office of Patient Protection (OPP) Regulations
- Update on Nurse Staffing Quality Measures
- Presentation from the Office of the Attorney General on their Recent Behavioral Health Report, "Examination of Health Care Cost Trends and Cost Drivers"
- Discussion of Recommendations from the Governor's Opioid Task Force Report
- Discussion of the Health Policy Commission's Substance Use Disorder Report

Vote: Approving Minutes

Motion: That the Quality Improvement and Patient Protection Committee hereby approves the minutes of the Committee meeting held on May 20, 2015, as presented.

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- Approval of QIPP Minutes from May 20, 2015
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Vote: Approving Minutes

Motion: That the Care Delivery and Payment System Transformation Committee hereby approves the minutes of the Committee meeting held on June 10, 2015, as presented.

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Office of Patient Protection Regulation Updates

Medical Necessity Criteria

958 CMR 3.101

- Changes to state law providing access to medical necessity criteria took effect on July 1, 2014, pursuant to FY 2015 budget*
- Updates are required to conform regulation to applicable Massachusetts law
- Updates will clarify expanded access to proprietary and non-proprietary medical necessity criteria

Open Enrollment Waivers

958 CMR 4.000

- Updates are required to conform regulation to Affordable Care Act and related Massachusetts law
- Definition of “eligible individual” changed
- Updates would not significantly change waiver process

* Ch. 165 of the Acts of 2014, sections 18, 172 & 173 amending M.G.L. c. 6D, §16(a); c. 176O, §§12(a) & 16(b)

Proposed Timeframe To Update OPP Regulations

- May 20, 2015 – QIPP Committee review of proposed regulations
- June 10, 2015 – HPC review of proposed regulations
- July 8, 2015 – Public hearing on proposed regulations at QIPP committee meeting
- August 2015 – Deadline to submit public comments on proposed regulations (date TBD)
- Fall 2015 – QIPP Committee review of final regulations
- Fall 2015 – HPC review of final regulations
- Fall/Winter 2015 – Publication of final regulations in Mass. Register

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Examination of Health Care Cost Trends and Cost Drivers

Pursuant to G.L. c. 6D, § 8

OFFICE OF ATTORNEY GENERAL
MAURA HEALEY
ONE ASHBURTON PLACE
BOSTON, MA 02108

The Number of Lives Impacted by Behavioral Health Conditions Is Growing

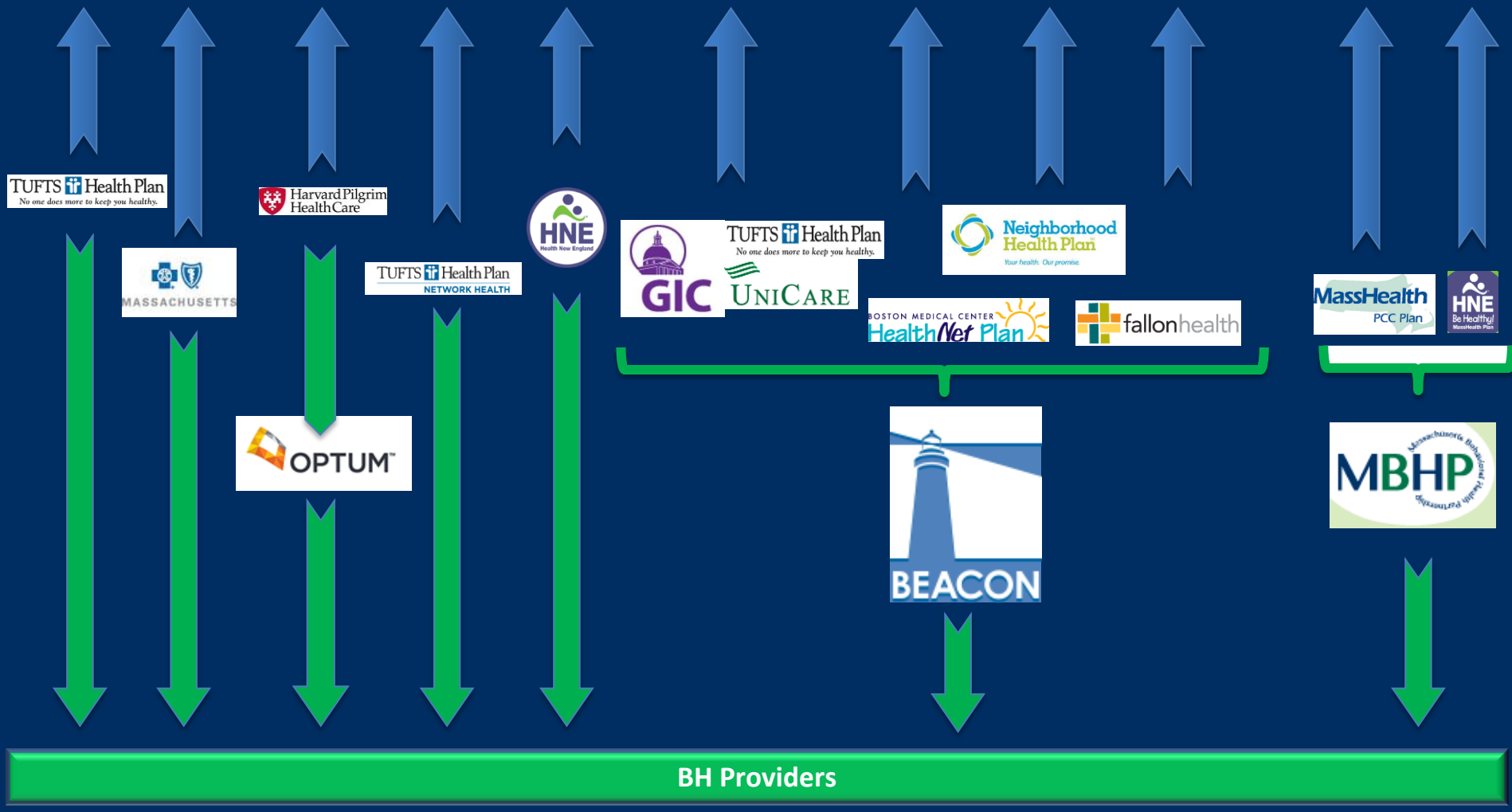
- While overall inpatient discharges at general acute care hospitals have decreased 5% from 2010 to 2013, total discharges for behavioral health conditions has increased 2%.
- In 2013, behavioral health diagnoses were the top primary diagnostic category for males aged 15-44 and females aged 5-44 (excluding discharges for child birth.
- HPC reports increase spending for patients with comorbid behavioral health and chronic medical conditions that exceeds the simple combination of each condition's independent effect.

The Importance of Care Coordination

- A key goal of health care reform is to better coordinate patients' care over time and across settings, which should raise quality and lower costs.
- Examples of major reform initiatives designed to improve care coordination:
  - Development of PCMHs and ACOs
  - Expansion of alternative payment methodologies
  - Improving patient communication and experience of care transitions

Current approaches separate "behavioral health" and "medical" care, resulting in a ripple effect that impacts the integration of behavioral health and medical care and impedes market analysis.

The Landscape for Managing and Reimbursing Behavioral Health Services Is More Complex than for Non-Behavioral Health Services



A Substantial Portion of Behavioral Health Benefits Are Managed by MBHOs

2013 Percent of Member Months by Behavioral Health Benefit Manager and Reimbursement Structure				
	Health Plan Risk and Admin (Fully-Insured)	**Health Plan Admin-Only (Self-Insured)**	**MBHO Risk and Admin**	**MBHO Admin-Only**
Commercial	30.8%	38.5%	15.3%	15.3%
Commonwealth-Subsidized Programs	21.0%	n/a	75.9%	3.1%

Notes:
Self-insured accounts retain the risk for their health care claims (including behavioral health). Thus, even if a self-insured account retains BCBS (who does not contract with an MBHO) as a third party administrator to administer its employees' health care benefits, BCBS would not be at risk for any claims, including behavioral health claims. That population would be reflected in the Health Plan Admin-Only column. All self-insured membership is reflected in how the third party administrator ("TPA") approaches behavioral health benefits, except GIC membership. Although THP manages behavioral health benefits in-house, GIC separately contracts with Beacon to manage the behavioral health benefits for GIC's THP and Unicare members, and thus GIC's THP members are reflected in MBHO Admin-Only. However, as discussed above, a small number of self-insured accounts separately carve out the administration of behavioral health benefits. If those accounts finance behavioral health in a way that differs from the approach taken by their TPA, those variances are not reflected in the chart above.
"Commonwealth-Subsidized Programs" do not include members in Medicaid FFS, Medicare, Dual Eligible, Senior Care Options, Program for All-Inclusive Care for the Elderly, Medical Security Program, or Veteran Affairs plans.

Where A Medical Patient's Experience of Care Delivery Can Already Be Complex . . .

55 year old overweight man with high blood pressure and chronic low back pain

Medicaid MCO Health Plan

Behavioral Health Manager

PCP

Pain Specialist

Cardiologist

Cardiologist

Pain Specialist

Cardiologist

Stable Condition

Chest Pain

Discharge

Chiropractor

Orthopedist

Hospital ED, admitted for chest pain and cardiac catheterization

Internist

PCP

. . . Adding a Behavioral Health Condition Further Complicates the Picture

55 year old overweight man with high blood pressure, chronic low back pain and opioid addiction

Medicaid MCO Health Plan

Behavioral Health Manager

PCP

Pain Specialist

Psychiatrist/ Addiction Specialist

Psychiatrist/ Addiction Specialist

Behavioral Health Case Manager

Health Plan case manager for prescription

Therapist

Cardiologist

Stable Condition

Addiction Relapses

Discharge

Therapist

Addiction counselor

Orthopedist

Hospital #1 ED transfer to Hospital #2 Inpatient SA Unit

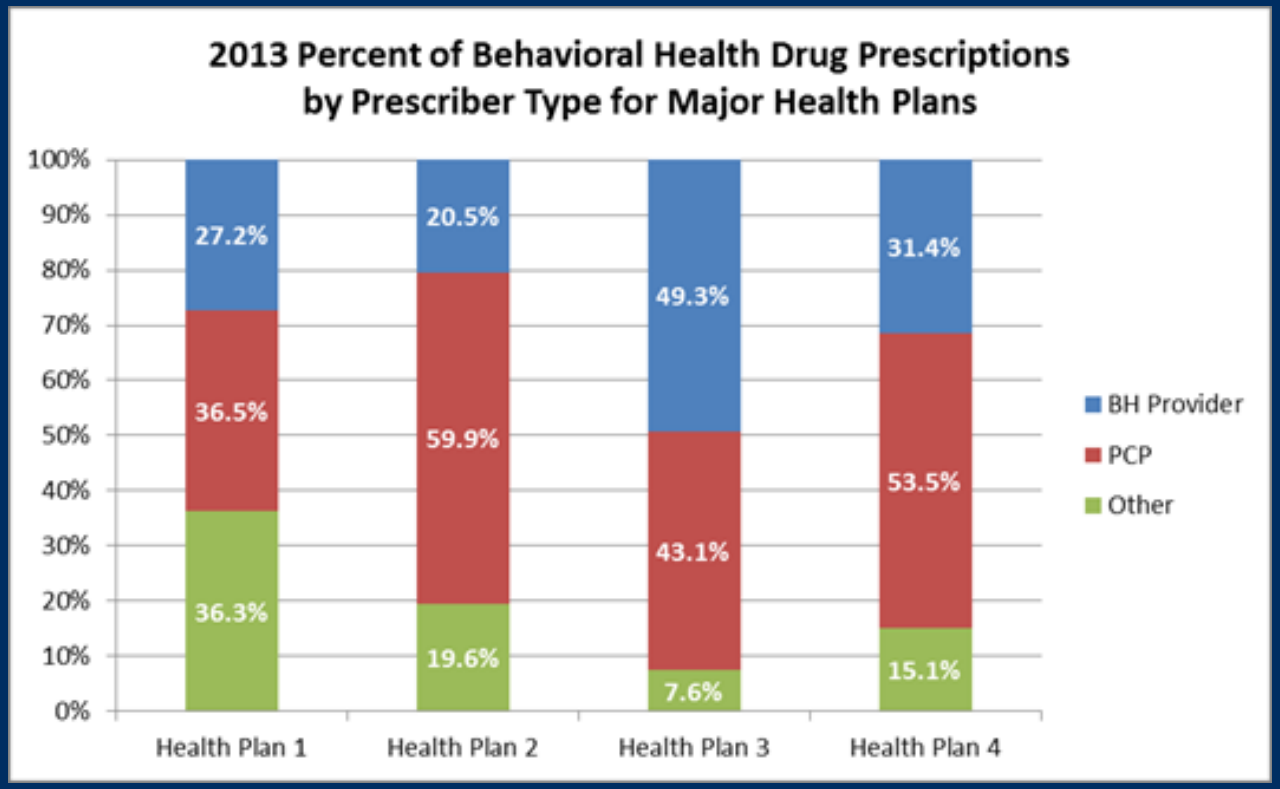
Internist

Pain Specialist

Intensive Outpatient Program

I. CURRENT APPROACHES TO MANAGING BENEFITS AND REIMBURSEMENT POSE CHALLENGES FOR CARE COORDINATION

Current Approaches to Managing Behavioral Health Benefits Challenge Data Communication



Note:

1. Behavioral health drugs are defined as all benzodiazepines, anti-depressants (e.g., tricyclics, selective serotonin reuptake inhibitors, selective serotonin norepinephrine reuptake inhibitors, serotonin modulators), anti-psychotics (e.g., phenothiazines, butyrophenones, atypical anti-psychotics), sleeping medications (e.g., ramelteon, zaleplon, zolpidem), antimanic agents (e.g., lithium), anorexigenic agents (e.g., amphetamine derivatives), alcohol use deterrents (e.g., disulfiram), and any others the health plans consider a behavioral health drug.

Current Financial Arrangements Offer Limited Incentives to Coordinate Care Across Behavioral Health and Medical Services

- MBHOs and payers contracts can include care coordination objectives, but lack any material financial incentives to do so.
- Global budgets often exclude risk for behavioral health services.

Complex Arrangements Challenge Efforts to Improve Low Reimbursement Rates

- For general acute hospitals that reported inpatient margins, from 2010-2013 cumulative margin for commercial and government business was a negative 39%, and for those that reported outpatient margins, the cumulative margin was a negative 82%
- Current MBHO and payer financing structures promote precise adherence to capitated budgets

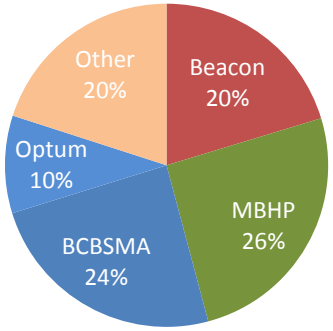
II. BEHAVIORAL HEALTH DATA LAGS COMPARED TO ADVANCES IN DATA FOR OTHER HEALTH SERVICES

Lack of Comparable Data on Utilization, Price, and Quality Constrains Analysis

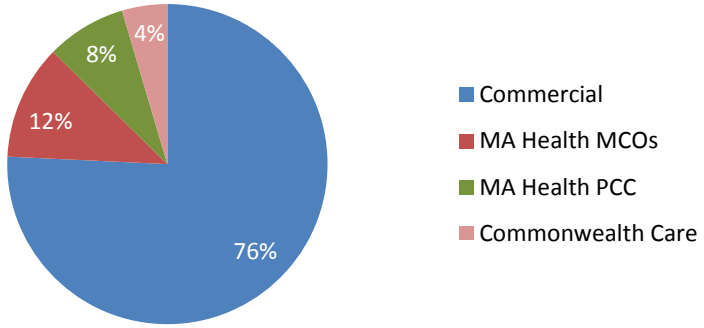
- Neither the HDD nor APCD include complete BH information
- Unable to adjust payment rates for case complexity
- Payers do not closely track differences in payment levels across providers
- Industry lacks standardized outcome measures for behavioral health services
- Quality improvement initiatives that do exist are not tied to meaningful financial incentives

Where Behavioral Health Spending Is Reported, Inconsistent Definitions and Methodologies Impede Analysis Of Behavioral Health Trends.

2013 Estimated Expenditures for Behavioral Health Services by Managing Entity



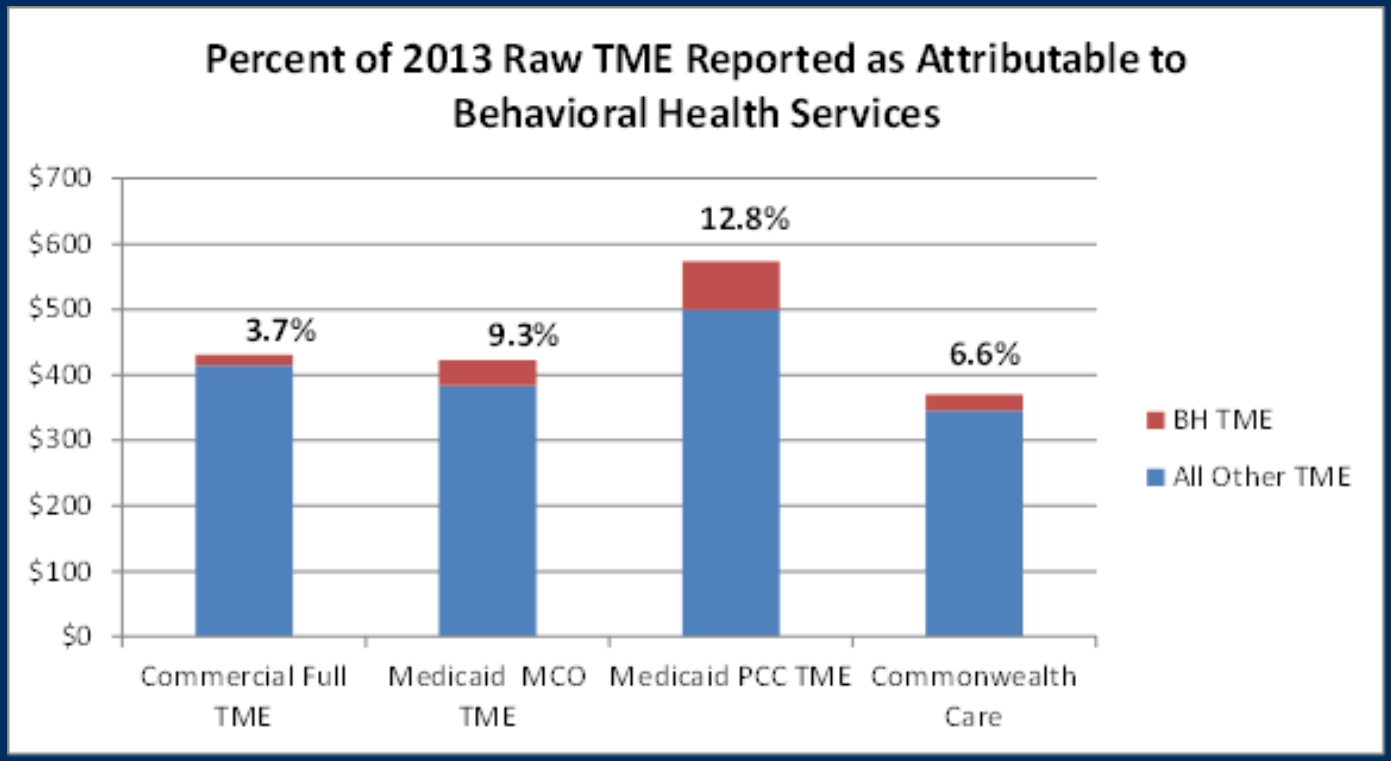
2013 Estimated Membership Distribution by Market



Notes:

1. Includes expenditures reported to the AGO as expenditures on behavioral health services.
2. Since risk share is minimal, risk share to MBHOs is excluded.
3. Health plans that subcontract with MBHOs reported MBHO spending on claims.
4. Excludes pharmacy spending.
5. Excludes Medicaid FFS, Medicare, Dual Eligible, Senior Care Options, Program for All-Inclusive Care for the Elderly, Medical Security Program, and Veteran Affairs populations.
6. Excludes Children's Behavioral Health Initiative ("CBHI") benefits that MassHealth provides to eligible children. Total 2013 spending on CBHI benefits for all eligible children was approximately $198 million.

Initial Review of Spending Data Raises More Questions than Provides Answers



Note:

1. Based on reported behavioral health expenditures. Reported data varies, but does not include prescription drugs, CBHI benefits, or behavioral health services provided by non-behavioral health providers (e.g., PCPs)..

Recommendations

- Take a close look at payment rates for behavioral health services and the effect those have on the availability of services statewide
- Reassess the financial arrangements that often lack meaningful incentives to integrate behavioral health and medical care
- Work to improve data reporting for behavioral health

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Commonwealth of Massachusetts

Executive Office of Health and Human Services

Health Policy Commission

Leslie Darcy

Director of Policy and Strategic Initiatives

July 8, 2015

Governor's Working Group: An 18 member expert panel, chaired by Marylou Sudders, Secretary of the Executive Office of Health and Human Services (EOHHS)

Goals: Reduce the magnitude and severity of harm related to opioid misuse and addiction and decrease opioid overdose deaths in the Commonwealth

Objective: Produce actionable recommendations to address the opioid epidemic in the Commonwealth

Activities:

- Hosted 4 listening sessions in Boston, Worcester, Greenfield, and Plymouth
- Held 11 in person meetings
- Examined documents and recommendations from more than 150 organizations
- Heard from more than 1,100 individuals from across the Commonwealth
- Reviewed academic research, government reports, and reports of previous task forces and commissions
- Submitted more than 65 actionable recommendations to Governor Baker on June 12, 2015

The Working Group's KEY STRATEGIES:

1. Create new pathways to treatment

Too many individuals seeking treatment utilize acute treatment services (ATS) as their entry point, even when a less acute level of treatment may be appropriate. By creating new entry points to treatment and directing individuals to the appropriate level of care, capacity will be managed more efficiently and the Commonwealth will be better able to meet the demand for treatment.

2. Increase access to medication-assisted treatment

Medication-assisted treatment for opioid use disorder (e.g. methadone, buprenorphine, naltrexone) has been shown to reduce illicit opioid use, criminal activity, and opioid overdose death. Increasing capacity for long-term outpatient treatment using medications as well as incorporating their use into the correctional health system, can be a life-saving intervention.

3. Utilize data to identify hot spots and deploy appropriate resources

By the time DPH receives overdose death data from the medical examiner, the data is stale. The Commonwealth should partner with law enforcement and emergency medical services to obtain up-to-date overdose data, which can be used to identify hot spots in a timely manner and allocate resources accordingly.

4. Acknowledge addiction as a chronic medical condition

Primary care practitioners must screen for and treat addiction in the same way they screen for and treat diabetes or high blood pressure. This will expedite the process for timely interventions and referrals to treatment.

5. Reduce the stigma of substance use disorders

The stigma associated with a substance use disorder (SUD) is a barrier to individuals seeking help and contributes to: the poor mental and physical health of individuals with a SUD; non-completion of substance use treatment; higher rates of recidivism; delayed recovery and reintegration processes; and increased involvement in risky behavior.

The Working Group's KEY STRATEGIES:

6. Support substance use prevention education in schools

Early use of drugs increases a youth's chances of developing addiction. Investing in the prevention of youth's first use is critical to reducing opioid overdose deaths and rates of addiction.

7. Require all practitioners to receive training about addiction and safe prescribing practices

Opioids are medications with significant risks; however, safer opioid prescribing practices can be accomplished through education.

8. Improve the prescription monitoring program

The Commonwealth's prescription monitoring program (PMP) is an essential tool to identify sources of prescription drug diversion. By improving the ease of use of the PMP and enhancing its capabilities, it will no longer be an underutilized resource.

9. Require manufacturers and pharmacies to dispose of unused prescription medication

Reducing access to opioids that are no longer needed for a medical purpose will reduce opportunities for misuse.

10. Acknowledge that punishment is not the appropriate response to a substance use disorder

Arrest and incarceration is not the solution to a substance use disorder. When substance use is an underlying factor for criminal behavior, the use of specialty drug courts are effective in reducing crime, saving money, and promoting retention in drug treatment. It is important that treatment occur in a clinical environment, not a correctional setting, especially for patients committed civilly under section 35 of chapter 123 of the General Laws.

11. Increase distribution of Naloxone to prevent overdose deaths

Naloxone saves lives. It should be widely distributed to individuals who use opioids as well as individuals who are likely to witness an overdose.

12. Eliminate insurance barriers to treatment

Removing fail first requirements and certain prior authorization practices will improve access to treatment. By enforcing parity laws, the Commonwealth can ensure individuals have access to behavioral health services.

Summary of Short-Term Action Items (6 months to 1 year)

Prevention

- Increase educational offerings for prescribers and patients to promote safe prescriber practices
- Develop targeted educational materials for schools
- Appoint members to the drug formulary commission
- Integrate information about the risks of opioid use and misuse into school athletic programs
- Conduct a public awareness campaign

Intervention

- Improve the PMP
- Outreach to prenatal and postpartum providers to increase screening for women with a substance use disorder
- Improve reporting of overdose death data
- Enhance data transparency, including EMS data
- Encourage naloxone to be co-prescribed with opioids
- Amend civil commitment process
- Identify hot spots for targeted intervention, using EMS, hospital, and police data
- Promote the Good Samaritan law
- Consider mandating testing for in utero exposure to alcohol and drugs at every birth
- Encourage and support alternatives to arrest
- Expand availability of Naloxone

Treatment

- Develop a central statewide database of available treatment services
- Transfer section 35 civil commitment responsibility from DOC to EOHHS
- Increase the number of office based opioid treatment programs
- Require DOI to issue bulletins on chapter 258 of the Acts of 2014 prior to Oct. 2015
- Pilot recovery coaches in emergency rooms and hot spots
- Bulk purchase opioid agonist and naltrexone therapies for correctional facilities
- Add 100 new ATS/CSS beds
- Open Recovery High School in Worcester
- Review capacity in the treatment system for women/families
- Analyze treatment spending in correctional facilities
- Increase the number of stepdown beds and services

Recovery

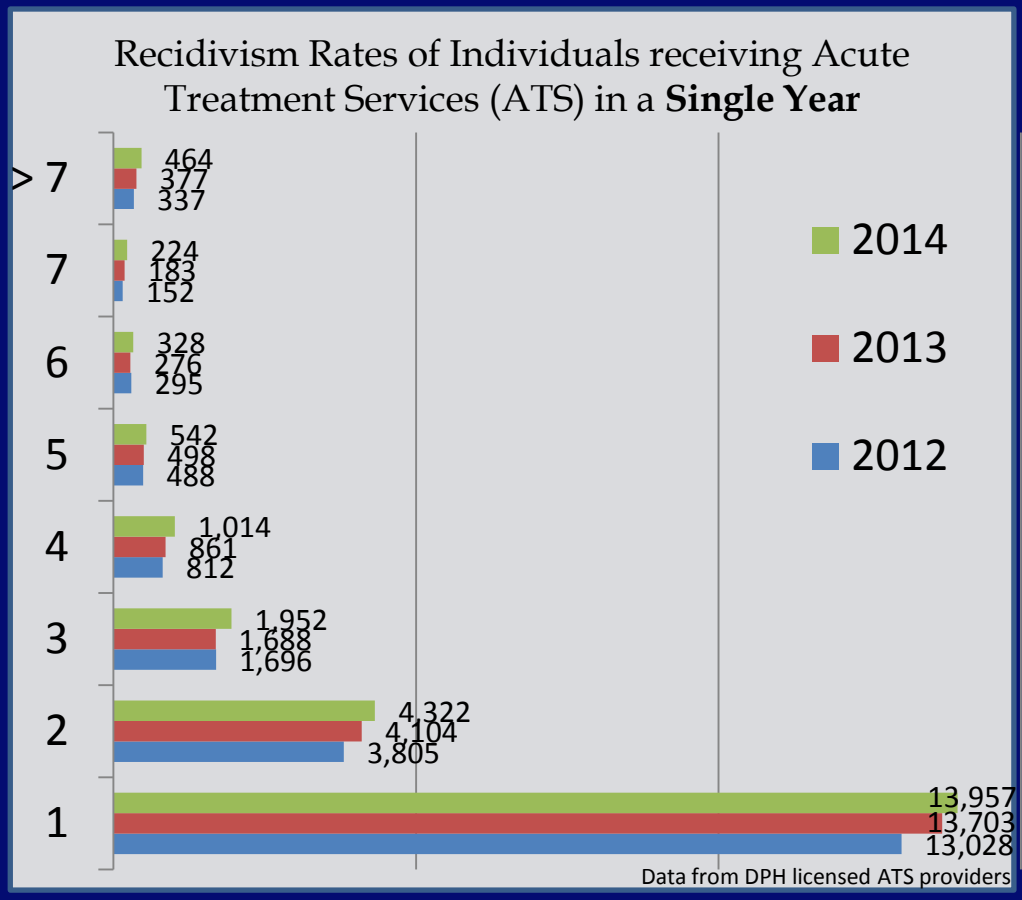
- Promulgate chapter 257 rates for recovery homes effective July 2015
- Establish a single point of accountability for addiction and recovery policy at EOHHS
- Suspend rather than terminate MassHealth coverage during incarceration
- Certify alcohol and drug free housing
- Enforce the requirement that BSAS treatment programs accept patients on an opioid agonist therapy
- Strengthen connections between law enforcement and community providers for individuals upon release
- Explore issuing certificates of recovery
- Review and revise discharge/court notification policies for section 35

Focusing on patient care can increase access without having to add beds

In 2014, **4,524 individuals** utilized ATS 3 or more times

Two individuals utilized ATS **23 times**

In 2014, if these individuals had received ongoing treatment, at least **16,000 additional** individuals could have received ATS



COMMONWEALTH OF MASSACHUSETTS

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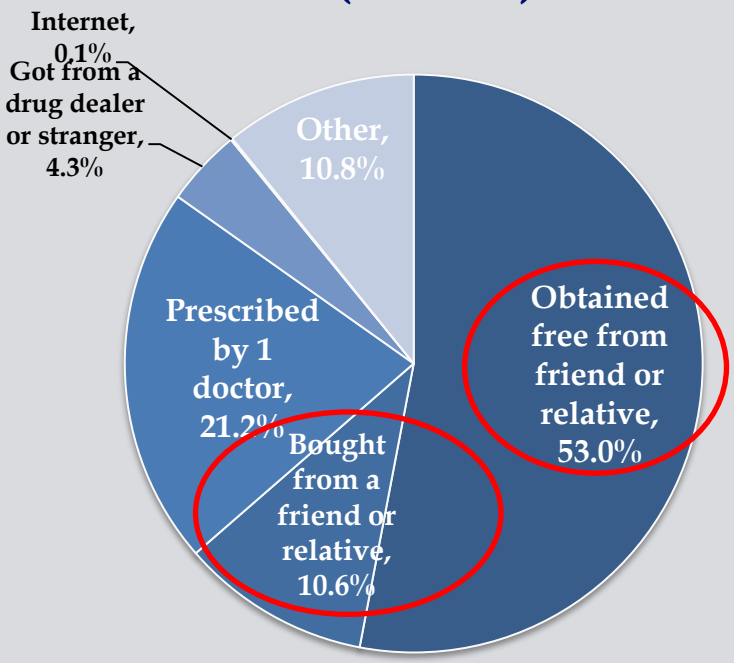
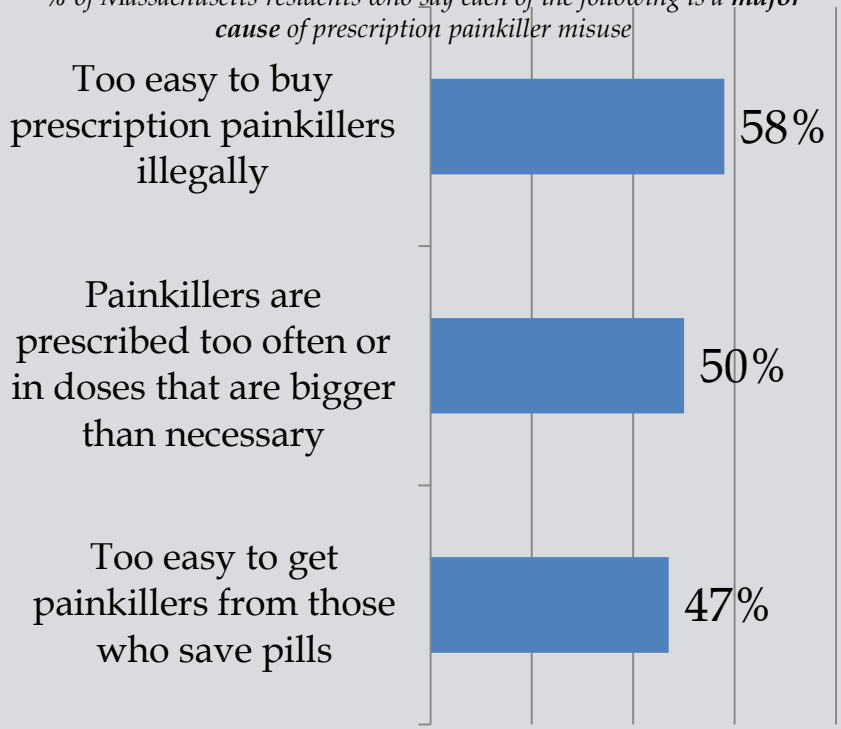
SOURCE, AMONG THOSE AGED 12 OR OLDER, WHO USED PAIN RELIEVERS NONMEDICALLY (2012-2013)



Source: Results from the 2013 National Survey on Drug Use and Health: Summary of National Findings, U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality

SURVEY: REASON FOR PRESCRIPTION PAINKILLER MISUSE

*% of Massachusetts residents who say each of the following is a **major cause** of prescription painkiller misuse*



Source: Boston Globe and Harvard T.H. Chan School of Public Health, Prescription Painkiller Abuse: Attitudes among Adults in Massachusetts and the United States

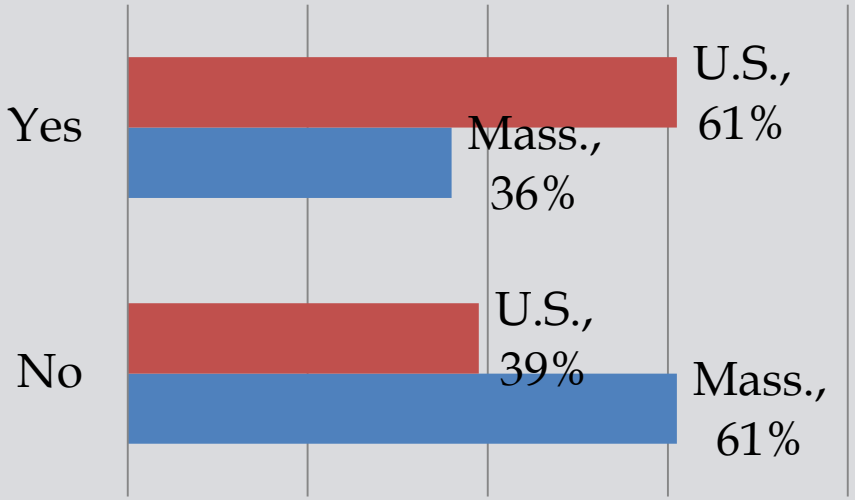
MASSACHUSETTS DOCTORS DISCUSS THE RISKS OF PRESCRIPTION PAINKILLERS WITH PATIENTS LESS THAN DOCTORS IN OTHER PARTS OF THE COUNTRY

In a 2015 survey, individuals who, in the past 2 years, **HAD** taken a strong prescription painkiller, such as Percocet, OxyContin, or Vicodin that was prescribed by a doctor for more than a few days, were asked the following question:

"Before or while you were taking these strong prescription painkillers, did you and your doctor talk about the risk of prescription painkiller addiction, or haven't you talked about that?"

Only 36% of Massachusetts residents said "yes", compared to 61% nationally

Did your doctor discuss the risks of addiction with you?



Source: Boston Globe and Harvard T.H. Chan School of Public Health, Prescription Painkiller Abuse: Attitudes among Adults in Massachusetts and the United States

Summary of Mid-Term Action Items (1 year to 3 years)

Prevention

- **Support substance use prevention curricula in schools**
- **Mandate pain management, safe prescribing and addiction training for all prescribers**
- **Partner with federal government regarding graduate medical education**
- Require manufacturers and pharmacies to dispose of unused prescription medication
- Require prescribers to discuss opioid side effects at point of prescription
- Allow partial refills across all payers
- Eliminate prescription refills by mail for schedule II medications
- Amend the curriculum for teachers as state universities to include training on screening and intervention techniques
- Have state universities develop substance use prevention curricula for schools

Intervention

- **Improve the PMP to ensure data compatibility with other states**
- **Develop training on neonatal abstinence syndrome and addiction for DCF staff**
- **Improve affordability of Naloxone**
- **Increase access to beds for section 35 patients**
- Implement electronic prescribing for opioids
- Increase screening for substance use at all points of contact in the medical system
- Increase the use of screenings in schools to identify at-risk youth for behavioral health issues

Treatment

- **Create a consistent public behavioral health policy through licensing reforms**
- **Pilot providing patients with access to an emergent/urgent addiction assessment by a trained clinician and direct referral to the appropriate level of care**
- **Increase points of entry to treatment**
- **Ensure section 35 patients receive a continuum of care**
- Enhance provider accountability by requiring treatment programs to report on outcomes
- Reform purchasing of substance use disorder treatment services
- Require DPH to advance standards of care by establishing industry benchmarks
- Add new non-ATS/CSS treatment beds

Recovery

- **Fund patient navigators and case managers**
- **Leverage community coalitions to address opioids**
- Ensure all infants with NAS are referred to early intervention by time of hospital discharge
- Increase drug and specialty court capacity
- Expand peer/family support
- Partner with businesses to remove employment barriers that recovering individuals experience

Summary of Long-Term Action Items (3+ years)

Prevention

- Support alternate pain therapies through commercial and public insurers & prepare a public report on what non-pharmacological treatments for pain are covered by all private and public insurers

Intervention

- Improve the PMP by interfacing the PMP with electronic health records

Treatment

- Establish and promote a longitudinally based system of addiction care
- Integrate primary care into substance use treatment programs

Recovery

- Reduce stigma among medical and treatment professionals

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HPC opioid abuse report statutory mandate

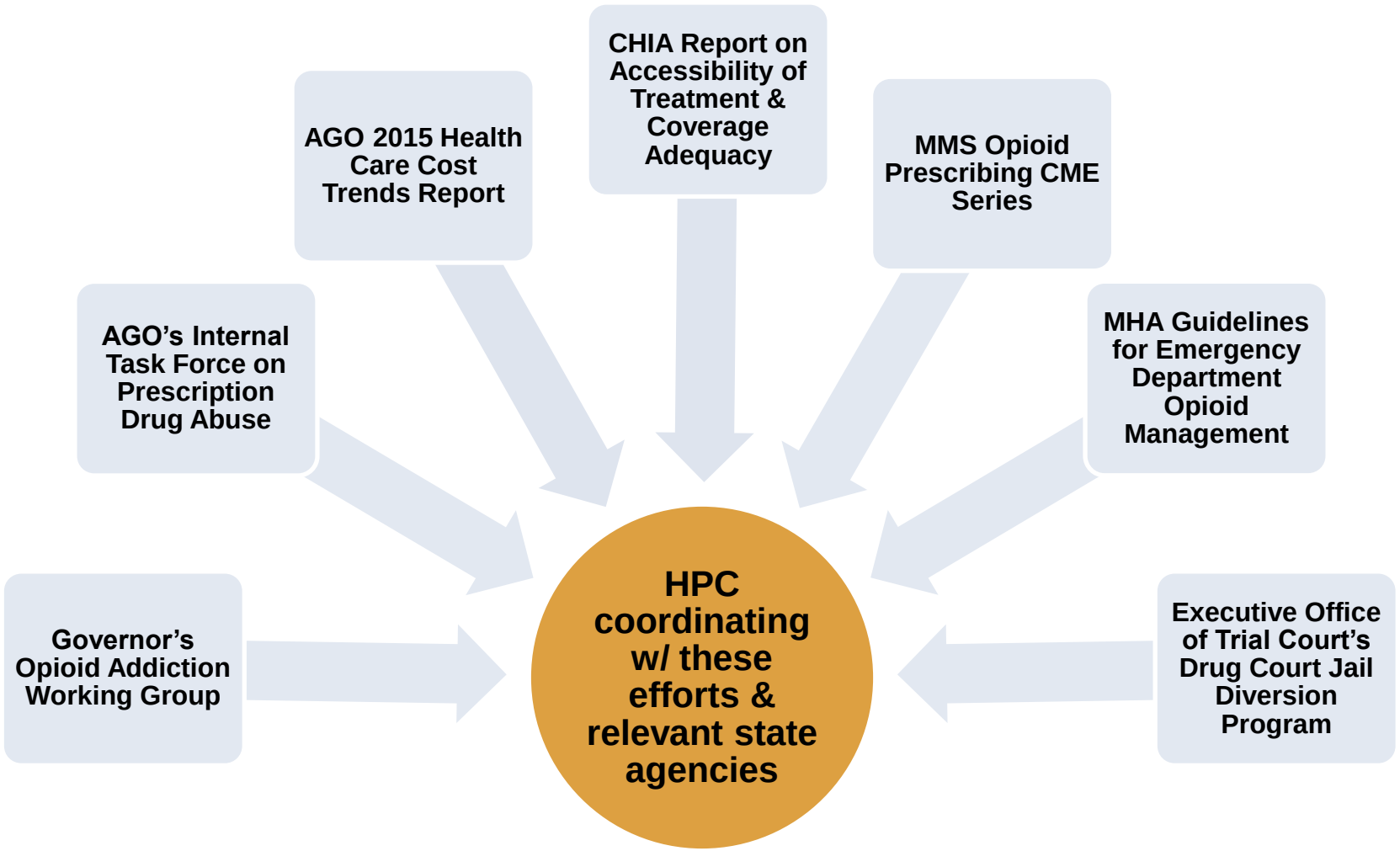
In 2014, the Legislature passed a comprehensive health care law, ch. 258 of the Acts of 2014, *An Act to Increase Opportunities for Long-Term Substance Abuse Recovery*.

Recognizing the HPC's unique mission and role in developing and promoting evidence-based health policy that improves the **transparency, accountability, efficacy, and efficiency** of our health care system, ch.258 charged the HPC to put forward recommendations on:

1. Improving the adequacy of coverage by public and private payers where necessary;
2. Improving the availability of opioid therapy where inadequate; and,
3. Identifying the need for further analyses by CHIA.

This is timely & actionable; state policy leaders (Governor Baker and the Legislature) are in the process of developing subsequent legislation to ch.258 to address the opioid crisis and have sought the HPC's guidance and recommendations.

Context: major activities in the Commonwealth relating to opioid abuse



Principles guiding HPC's opioid abuse report development

HPC's recommendations will be **objective, data-driven, and evidence-based**, drawing on leading state & national policies, emerging best practices, published literature, and input from a wide spectrum of experts and stakeholders. Recommendations will be focused and actionable, reflecting the statutory charge from the Legislature.

HPC seeks alignment and consistency with other Massachusetts activities, and aims to further contribute to policy around opioid abuse by:

1. Providing new research, data, or evidence to support and inform legislative action;
2. Supplementing previous reports with new or more *specific and actionable* recommendations, based on our research & analysis;
3. Identifying strategic opportunities for care delivery/payment reforms for substance use disorder treatment that are likely to result in reduced spending and improved quality/access (consistent with HPC's overall mission);
4. Drawing on our experience with investment & technical assistance programs (e.g., CHART hospital initiatives to reduce opioid prescribing);
5. Recommending specific data needs and further analyses to be addressed by CHIA, DPH, HPC, and other government actors.

For the past six months, the HPC has conducted research, interviewed stakeholders, surveyed providers, and attended public sessions related to the opioid epidemic.

Opioid abuse report stakeholder engagement to date

Gov't	Provider	Other
EOHHS and DPH	BIDMC	Alkermes (Vivitrol)
KY PMP	Atrius	Am. Academy of Pain Mgmt.
Senator Flanagan	BMC (Alex Walley, Medical Director, Opioid Treatment Program)	MA Medical Society
Senator Keenan	BMC (Dan Alford, Medical Director, Office-based Opioid Treatment Program)	BCBS (UR team)
AGO (HC division & internal opioid task force)	MGH Center for Community Health Improvement (Sarah Wakeman, Medical Director, SUD)	Am. Society for Addiction Medicine (ASAM)
Representative Malia	Lynn CHC (Mark Alexakos, CBHO)	MA Ass'c of Health Plans
Dept. of Corrections	MA Ass'c of Behavioral Health Systems	MA College of Emergency Physicians
Suffolk County Sherriff	Addison Gilbert	MA Hospital Association
Gloucester & Brockton Police Depts.	Boston Healthcare for the Homeless Program	BU School of Public Health (David Rosenblum, Professor)
First Justice Coffey (Dir. of Specialty Courts)	Spectrum Health	Am. Academy of Addiction Psychiatry (AAAP)
BSAS	Tufts (Daniel Carr, Program Director, Pain, Research Education & Policy)	MA Organization for Addiction Recovery

= Complete = Upcoming

Thesis

Incentives unaligned with evidence-based treatment protocols; practice patterns became “opioid centric”

CDC reports heroin use has increased by 50% among males & 100% among females in the 21st century; likelihood of heroin use is 40x higher among opioid dependent persons[1]

Addiction crisis arose

Reduce unnecessary supply by:

- Promoting responsible prescribing practices
- Improving accessibility and interoperability of PMP

Reduce incidence of addiction

Address addiction by increasing:

- diagnostic capacity in ED & ability to initiate where medically indicated
- dissemination of naloxone to slow morbidity
- availability of both medically assisted treatment and counseling / social supports

Reduce prevalence of addiction

1 Jones CM et al, Vital signs: demographic and substance use trends among heroin users – United States, 2002-2013, CDC MMWR (July 7, 2015)

Examples of new research informing HPC opioid abuse report

Consultant & Staff Deliverables

- Geo-map methadone clinics, buprenorphine, and naltrexone prescribers across the Commonwealth
- Convenience sample of buprenorphine prescribers to determine what proportion are nearing 100 pt. cap (stratified by specialty)
- Survey of inpatient facilities to determine which/how many do not provide access to MAT
- Assess what proportion of opioids are prescribed by each specialty (nat'l data)
- Survey PMP best practices in other states & tools to maximize PMP as clinical decision support tool
- Assess UR tactics to educate providers on prescription patterns
- Assess models of professional support available to buprenorphine and naltorexone prescribers (who are not addiction specialists)
- Assess non-medical providers ability to bill pursuant to ch. 258 mandate
- Research pain mgmt., safe prescribing, and addiction continuing medical education options and academic detailing processes
- Provider interviews; identification of best practice in acute & primary care settings
- Assess status-quo of needle exchange programs in MA (harm reduction as harder to access Rx causes spike in heroin demand)

Policy levers being considered to reduce incidence of opioid abuse

Policy levers to reduce incidence of opioid abuse

Expanded education and training in pain management and identifying addiction

Examples include CME options, academic detailing, technical assistance.

Technical assistance and training on safe prescribing

Examples include PMP training coupled with academic detailing, CME credit awarded for PMP training, dashboards reminding providers of best practices.

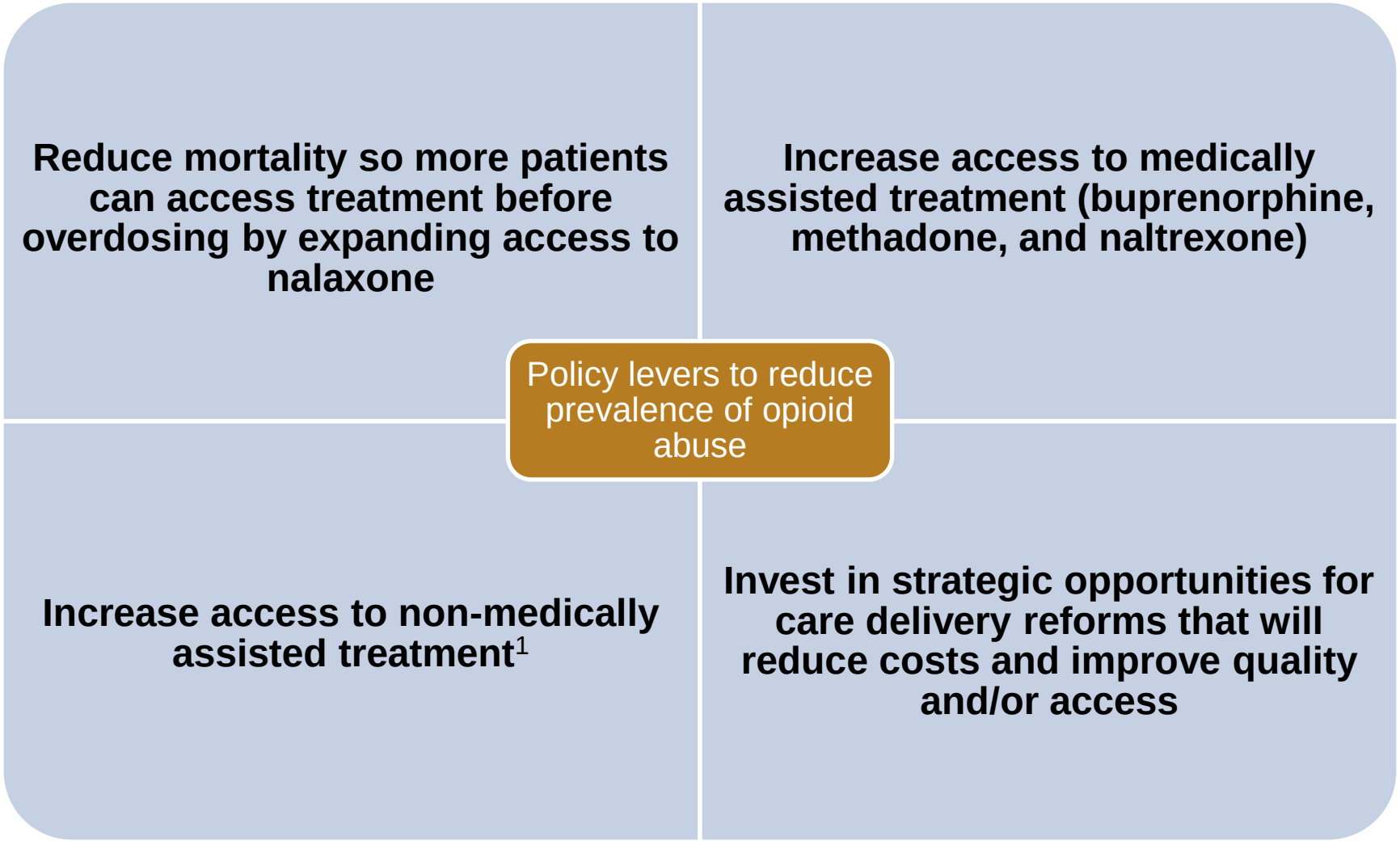
Reframing “pain contracts” to promote screening for early signs of addiction

Examples include contracts that prompt referral to treatment, instead of termination of provider-patient relationship.

Utilization review practices that identify “outlier” providers

Examples include identifying those providers who are prescribing at comparatively higher rates – frequency or dose – than peers with similar patients

Policy levers being considered to reduce prevalence of opioid abuse

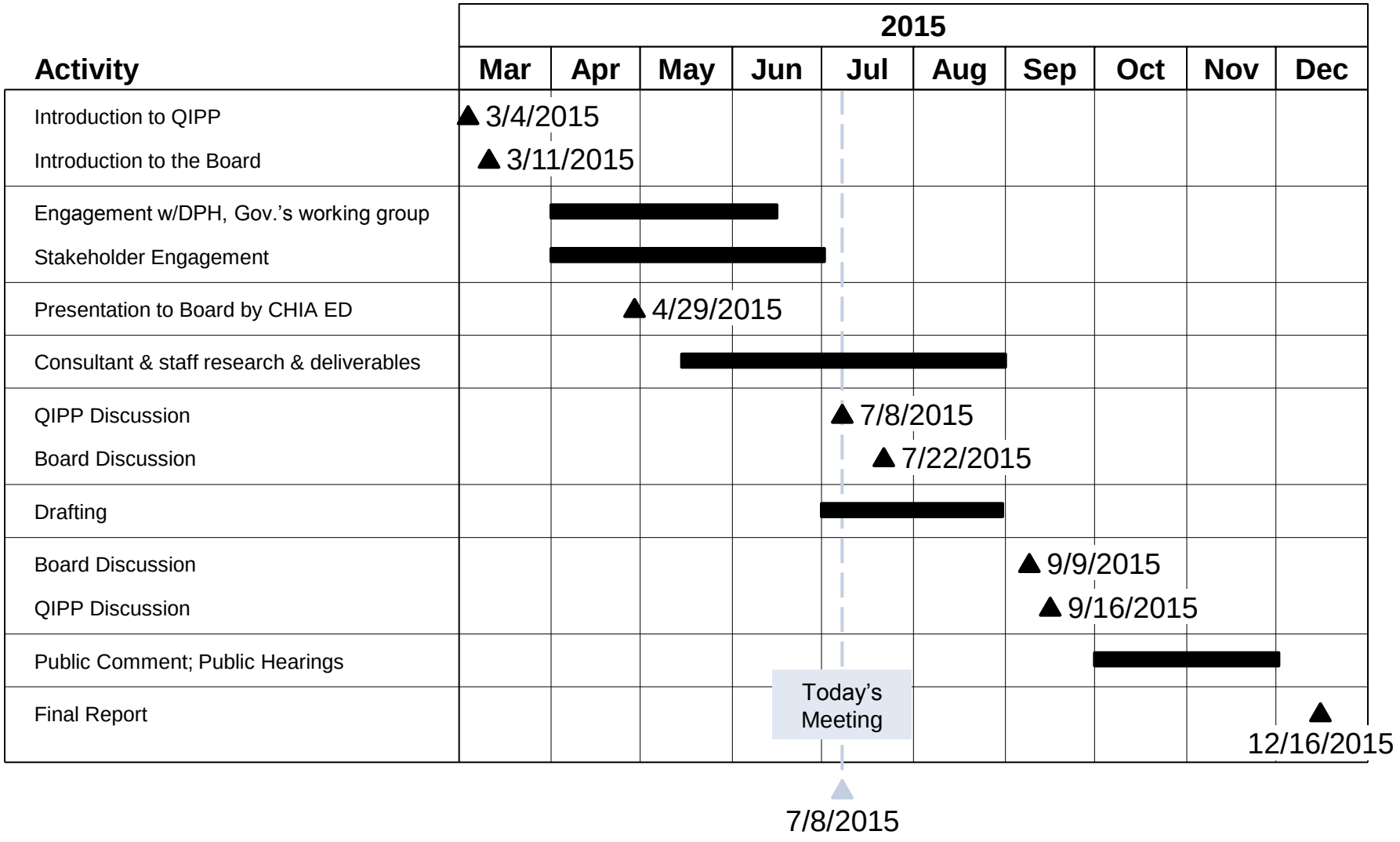


1. e.g. acute treatment services, clinical stabilization services, transitional support services, long-term residential treatment, day treatment, and outpatient counseling

Need for further data analyses (identified as research proceeds)

- Assess reimbursement structure (including co-pays) for medication-assisted treatment (methadone, buprenorphine, and naltrexone) (CHIA)
- Collect dispensary data to identify the rate at which medically inappropriate pill quantities are prescribed (e.g., the anecdotal 300 pills post-discharge) (CHIA and/or DPH)
- Systematically and regularly assess and report on EMR and inter-state interoperability progress and barriers (DPH)
- Assess the correlation between overdose deaths and listings in the PMP (or lack thereof) (DPH)
- Assess and report on the proportion of prescriptions filled for which the PMP was consulted (e.g., over a 6 month period) (DPH)

Timeline


2015
Activity
Mar
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Introduction to QIPP
3/4/2015
Introduction to the Board
3/11/2015
Engagement w/DPH, Gov.'s working group
Stakeholder Engagement
Presentation to Board by CHIA ED
4/29/2015
Consultant & staff research & deliverables
QIPP Discussion
7/8/2015
Board Discussion
7/22/2015
Drafting
Board Discussion
9/9/2015
QIPP Discussion
9/16/2015
Public Comment; Public Hearings
Final Report
12/16/2015
Today's Meeting
7/8/2015

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

Appendix: Points of intervention

Pre-conception

- Establish wrap-around social services and coordinate multidisciplinary care
- Provide access to contraception for women with substance use disorder (methadone clinics, primary care) to decrease incidence of NAS

Pre-natal

- Enhance substance use disorder screening to identify infants at risk for NAS
- Enhance access to methadone/buprenorphine maintenance (less harmful than opioid abuse)
- Continue to coordinate multidisciplinary care

Post-natal

- Drug testing in newborns to identify infants at risk for NAS
- Lower acuity of care (NICU → Special care nursery → pediatric floor) to decrease cost
- Rooming-in (soothing affect of being with mother, breastfeeding, skin to skin contact)
- Interventions designed to decrease length of (staff training, breastfeeding)
- Continue to coordinate multidisciplinary care

Childhood

- Continue to coordinate multidisciplinary care
- Peer support for at risk mothers