MINUTES OF THE COMMUNITY HEALTH CARE INVESTMENT AND CONSUMER INVOLVEMENT COMMITTEE

Meeting of December 2, 2015

MASSACHUSETTS HEALTH POLICY COMMISSION

THE COMMUNITY HEALTH CARE INVESTMENT AND CONSUMER INVOLVEMENT COMMITTEE OF THE MASSACHUSETTS HEALTH POLICY COMMISSION
HEALTH POLICY COMMISSION
50 MILK STREET, 8TH FLOOR
BOSTON, MA 02114

Docket: Wednesday, December 2, 2015 11:00 AM-12:30 PM

PROCEEDINGS

The Massachusetts Health Policy Commission's Community Health Care Investment and Consumer Involvement (CHICI) Committee held a meeting on Wednesday, December 2, 2015 at the Health Policy Commission, 50 Milk Street, 8th Floor, Boston, MA 02109.

Committee members present included Dr. Paul Hattis (Chair); Mr. Ron Mastrogiovanni; and Ms. Lauren Peters, designee for Ms. Kristen Lepore, Secretary of Administration and Finance.

Mr. Rick Lord and Ms. Veronica Turner were absent.

Dr. Hattis called the meeting to order at 11:06 AM.

Item 1: Approval of Minutes

Dr. Hattis asked for any changes to the meeting minutes from October 14, 2015. Seeing none, **Mr. Mastrogiovanni** made a motion to approve the minutes. **Ms. Peters** seconded the motion. The motion passed with three votes in the affirmative.

Item 2: Update on CHART Phase 2 Operations

Mr. Iyah Romm, Policy Director for Care Delivery Innovation and Investment, noted that 22 of the 25 CHART projects are operational as of December 1, 2015. He said that the last three projects, joint awards to multiple CHART hospitals, will launch in early 2016. Mr. Romm reviewed the work completed by various hospitals to date.

Mr. Romm stated that the CHART team will provide routine updates to the committee on project progress. He added that the CHART hospitals have been invited to provide updates on their work to the committee.

Dr. Hattis asked if any of the hospitals will be launching after January 1, 2016. Mr. Romm responded that the HPC does not anticipate any hospitals launching after that date.

Item 3: Approval of CHART Technical Assistance Contract Extension

Mr. Romm noted that the CHART team provides extensive technical support to hospitals with the help of Collaborative Healthcare Strategies (CHS). He noted that the committee will be asked to endorse additional funding for the HPC's contract with CHS. Mr. Romm noted that CHS has provided extensive technical assistance to hospitals throughout the implementation planning process.

Mr. Romm stated that the HPC utilizes three types of professional services for the CHART Investment Program: hospital technical assistance, strategic consultation, and monitoring and evaluation. He said that CHS provides a majority of the support for hospital technical assistance and some support for strategic consultation alongside HPC staff.

Mr. Mastrogiovanni asked for clarification on the amount of time staff spends providing direct technical assistance versus outside vendors. Mr. Romm responded that the staff spends a significant amount of time providing direct technical assistance, including phone calls, site visits, and convenings. Mr. Mastrogiovanni asked Mr. Romm to estimate the amount of work hours dedicated to providing support at each hospital. Mr. Romm responded that, while he does not have the number of hours, providing hospital support is the principle area of work for the CHART team. He added that hospitals have different levels of need for support.

Mr. Seltz asked Mr. Romm to discuss the workload of each CHART program officer. Mr. Romm responded that each program officer manages about seven awards, while also supporting the program as a whole.

Dr. Hattis asked why the contract extension is necessary. Mr. Seltz responded that the implementation planning process took longer than expected, and CHS has expertise that can only come from outside contracting.

Mr. Mastrogiovanni asked about the terms of the contract. Mr. Seltz said the contract is based on an hourly rate.

Dr. Hattis noted CHS principal Dr. Boutwell's impressive clinical and quality improvement background and the value she brings to the CHART program.

Dr. Hattis asked for a motion to endorse the contract extension with CHS move it to the full board for approval. Ms. Peters motioned. Dr. Hattis seconded. The motion passed unanimously.

Item 4: Discussion of Program Design for the Health Care Innovation Investment Program

Mr. Griffin Jones, Senior Manager for Care Delivery Innovation and Investment, summarized responses from a survey of market participants on the Health Care Innovation Investment Program (HCII). He noted that most of the responses were from behavioral health organizations and community health centers.

Mr. Jones said the HPC sent the survey to over 125 market participants, including the HPC Advisory Council. The survey was open for three weeks and had just under 100 responses, mostly from the executive and financial leadership.

Mr. Jones said the goals of the survey were to gauge progress in challenge areas and investigate market interest in scaling innovation models. Mr. Jones said the challenge areas ranged from behavioral health integration to variable episodes. The survey showed that all areas are ripe for innovation.

Dr. Hattis asked if progress was based on the individual organization or the entire field. Mr. Jones responded that progress was measured at the individual organization level, asking participants if the areas were fully integrated into the day-to day operations.

Mr. Jones said no group reported sufficient progress in any of the challenge areas. He said there was variation in challenge areas when broken up into respondent type, but noted that the health plan/payer group only received three responses. He noted that the variation can be attributed to the wide range of participants eligible for this program.

Mr. Jones noted that the survey allowed respondents to list additional challenge areas. He said most individuals provided nuances on the draft areas.

Mr. Jones said the HPC was looking to focus the investments to drive impactful innovation. He said that while there are eight general areas of focus, the end goal is to drive cost reduction.

Mr. Seltz said that the survey showed broad interest in all of the eight challenge areas. He said that he hopes the HPC can engage with different entities to further understand priorities. Mr. Seltz said the HPC will be rigorous about what they expect from participants. He added that there could be partnerships between the different respondent types.

Dr. Hattis said the eight recommended categories are consistent with what he has heard from the Advisory Council, which is the reason he supports the draft challenge categories.

Mr. Mastrogiovanni noted his concern over the total investment amount. He noted that $6 million is not enough to drive change in all of the areas. He stated that the HPC should not "over-select" participants and fail to achieve results. Dr. Hattis said that he understands Mr. Mastrogiovanni's perspective.

Mr. Romm said the unifying theme in all of the challenge categories is cost. He added that the HPC must focus on the most cost-actionable elements.

Ms. Peters echoed the need for cost reduction. She added that the funding should be made available to all players in the market, not just provider groups.

Mr. Jones said that the HPC will continue to finalize framework for selection criteria. He said the HPC hopes to get approval for the RFP in January before opening the funding opportunity through a competitive process.

Item 5: Discussion of Program Design for the HPC's Telemedicine Pilot

Mr. Romm stated that the HPC received a $500,000 appropriation in the FY16 state budget to develop a regional telemedicine pilot. He stated that staff hoped to bring the full program design to the board in January for approval.

Ms. Cecilia Gerard, Deputy Policy Director for Care Delivery Innovation and Investment, reviewed the proposed goals for the program, noting that some came from legislative language while others stemmed from interviews with key stakeholders. She noted that all stakeholders are interested in cost, access, and quality.

Ms. Gerard reviewed key challenges to cost and access in Massachusetts. She noted that the HPC's telemedicine pilot will focus on reducing spending on avoidable hospital readmissions and improving access to behavioral health care for high need populations.

For the focus on reducing spending on avoidable hospital admissions, Ms. Gerard noted that post-acute care use in Massachusetts is higher than the US overall for both institutional and in-home care. She stated that nearly 1 in 5 patient discharges to these settings bounce back to the hospital within 30 days.

For the focus on improving access to behavioral health care, Ms. Gerard stated that the number of behavioral health visits to the emergency department has grown faster than any other type of visit since 2010. She said that behavioral health patients who find it difficult to access care will forego getting said care or use urgent care for non-emergency reasons.

Dr. Hattis asked whether there is evidence that telemedicine can help yield a solution to these problems. Mr. Romm responded that, given budgetary constraints, it is unlikely that the HPC's telemedicine pilot will provide the full solution to these problems. Ms. Gerard added that she will lay out examples of interventions that fit the HPC's appropriated budget. She said that applicants will have to tailor interventions to their populations.

Ms. Gerard said the first model was designed by Harvard Medical School and implemented by a for-profit nursing home chain in Massachusetts. She said that the nursing home noticed that hospital transportation increased when medical staff was not onsite on weekends. To address the issue, six facilities received video support from on-call emergency medical doctors while five facilities continued with a telephone service. She said researchers found that the nursing homes who utilized the additional telemedicine support averaged a reduction of 15 hospitalizations per year at a savings of $151,000 per facility. She said the nursing homes that most integrated this support found the most savings.

Dr. Hattis asked whether the savings are to Medicare and not the nursing home. Ms. Gerard responded in the affirmative.

Ms. Gerard said the other example is a program from the Washington State Mental Health Integration Program (MHIP). She said behavioral health coordinators embedded in over 100 community health centers to identify patients with behavioral health needs and connect them with resources in the community. She said a psychiatrist would review the cases weekly to advise on treatment plans. She said that MHIP found that they can decrease referrals to behavioral health specialists by treating these patients in the primary care setting. She said they saw savings of over $11 million in avoided hospital costs in the first 14 months of the program. Dr. Hattis said that this figure will require more discussion to fully understand where the costs are going.

Ms. Gerard briefly reviewed other examples of effective telemedicine programs.

Mr. Mastrogiovanni asked whether ambulatory providers were engaging in telemedicine programs. Mr. Romm said there are some examples where EMS are starting to use telemedicine as a home-based monitoring program. He added that there is a lot of opportunity for innovation in that area.

Ms. Gerard stated that the HPC hopes to make one award for regional collaboration to focus on either post-acute care or behavioral health access expansion. She said all providers are eligible and one entity can apply on behalf of a consortium.

Dr. Hattis said that, in order to meet the expectation of the legislature, the pilot has to support a model that can be replicated by others. In addition, he stated a preference for funding organizations that are not well-resourced to adopt innovations like telemedicine on their own. Ms. Gerard responded that providers have informed the HPC that designing one of these programs from scratch can take up to a year. She said ease of integration of telemedicine in clinical practice is an important factor when designing the program. Mr. Romm said with $500,000, the purpose is to "break the ice" and see how telemedicine can fit into the delivery system. Dr. Hattis reiterated that the HPC's pilot program should be something that can be easily reproduced by other entities with limited resources.

Mr. Mastrogiovanni asked if it made sense to define metrics for the goals to assess the effectiveness of the program. Ms. Gerard said that the plan is to create such metrics. She added that the goals for the program will transition to evaluation criteria for the pilot.

Mr. Seltz noted that the legislature gave the HPC the responsibility for developing this pilot because of the agency's experience in investments through the CHART program. He added that the pilot needs to have a high likelihood of success and strong results, so that it can be reproduced in other regions. He said the potential goal of expanding access can have incredible downstream impacts on spending.

Mr. Seltz said that while proposals could be very strong with regard to providing access to services, it may be difficult to measure those cost impacts in the pilot time period.

Dr. Hattis asked if the behavioral health focus includes substance abuse. Ms. Gerard responded in the affirmative. Dr. Hattis discussed examining the societal needs that can be impacted by telemedicine, noting the current opioid crisis.

Mr. Seltz said the HPC is not only exploring patient-to-provider telemedicine, but also provider-to-provider telemedicine. He noted that behavioral health services, like addiction management, could be administered in a primary care setting with tele-support from addiction specialists.

Mr. Romm concluded that staff hopes to come back to the board in January with an updated conversation, adding that he welcomes continued thoughts about priorities on which the HPC should be focusing.

Item 6: Update on the HPC's Community Hospital Study

Mr. Romm said the HPC is finalizing the Community Hospital Study. He said the HPC anticipates releasing the report in early 2016 during a policy roundtable event, which will include representatives from various aspects of the health care industry and the broader Massachusetts community. Mr. Romm said that the study will engage the community in a dialogue about the path forward for community hospitals.

Item 7: Presentation on CHART Phase 2 Project by Dr. Peter Smulowitz, Beth Israel Deaconess - Plymouth Hospital

Dr. Peter Smulowitz, Dr. Pedro Bonilla, and Ms. Sarah Cloud gave a presentation on BID-Plymouth's CHART Phase 2 project.

Item 8: Schedule of Next Meeting

Dr. Hattis said that the next meeting is scheduled for Wednesday, January 6, 2015 at 9:30 AM. He adjourned the meeting at 12:29 PM.