MINUTES OF THE QUALITY IMPROVEMENT AND PATIENT PROTECTION COMMITTEE

Meeting of December 9, 2015

MASSACHUSETTS HEALTH POLICY COMMISSION

THE QUALITY IMPROVEMENT AND PATIENT PROTECTION COMMITTEE OF THE MASSACHUSETTS HEALTH POLICY COMMISSION
HEALTH POLICY COMMISSION
50 MILK STREET, 8TH FLOOR
BOSTON, MA 02109

Docket: Wednesday, December 9, 2015 11:00 AM-12:30 PM

PROCEEDINGS

The Massachusetts Health Policy Commission's Quality Improvement and Patient Protection (QIPP) Committee held a meeting on Wednesday, December 9, 2015 at the Health Policy Commission's offices, 50 Milk Street, 8th Floor, Boston, MA 02109.

Board members present included Mr. Martin Cohen (Chair); Dr. Wendy Everett; Dr. Carole Allen; Dr. Paul Hattis; and Ms. Alice Moore, designee for Ms. Marylou Sudders, Secretary of Health and Human Services.

Ms. Veronica Turner was not present at the meeting.

Mr. Cohen called the meeting to order at 11:06 AM and reviewed the day's agenda.

Item 1: Approval of Minutes

Mr. Cohen asked for any changes to the meeting minutes from November 12, 2015. **Dr. Everett** made a motion to approve the minutes. **Dr. Allen** seconded the motion. The motion passed with five votes in the affirmative.

Item 2: Discussion of Program Design for HPC's Pilot on Neonatal Abstinence Syndrome

Ms. Katherine Record, Deputy Director of Accountable Care and Behavioral Health Integration, reviewed the HPC's Neonatal Abstinence Syndrome (NAS) Pilot Program. Ms. Record stated that, if endorsed by the QIPP Committee, the full Board would discuss the program on December 16, 2015.

Ms. Record stated that staff has continued to refine details on the project and investment design. She reviewed the two proposed categories of funding.

Category A provides assistance through the HPC's NAS reserve, a $500,000 appropriation in the fiscal year 2016 state budget to pilot postnatal interventions for NAS. Ms. Record stated that hospitals receiving Category A funding would pilot in-patient quality improvement initiatives. Ms. Record stated that Category A will fund up to two hospitals that are

ineligible for the CHART investment program. She added the HPC will consider in-kind match proposals as a competitive factor.

Category B, NAS investments through the CHART program, will work in tandem with the Department of Public Health's (DPH) ongoing *Moms Do Care* program. The HPC will allocate $3,000,000 from the CHART investment program to fund NAS interventions from pregnancy to six months post birth. Ms. Record noted that up to three CHART eligible hospitals could receive funding through Category B.

Ms. Record reviewed examples of best practices for evidence-based interventions. She highlighted the importance of disseminating learnings from the NAS pilot programs to non-grantees.

Dr. Hattis asked whether hospitals are making an effort to create coordination protocols with community partners. Ms. Record responded that the HPC's NAS pilots could help to increase community coordination.

Ms. Record reviewed the eligibility criteria for the HPC's NAS pilots and provided a list of eligible hospitals. She stated that hospitals must have at least five times the national rate of NAS by discharge (national rate is 3.4 per 1000 births) or over 60 NAS discharges in the last year. Ms. Record stated that the HPC will verify eligibility through an examination of discharge data for the six months prior to the application period.

Noting their high delivery rate, Dr. Everett asked why Brigham and Women's Hospital was not eligible for the NAS pilots. Mr. Iyah Romm, Policy Director for Care Delivery Innovation and Investment, responded that data is limited by the underdiagnoses of NAS. He noted patient population also likely impacts eligibility since the Medicaid population is often most impacted by NAS. Dr. Everett asked the HPC to provide the NAS data for the Massachusetts General Hospital and Brigham and Women's Hospital.

Mr. Cohen asked whether staff expected hospital NAS discharge data to substantially change in 2015. Ms. Record responded in the affirmative, but noted that the directionality of the change is unknown. She reviewed various changes in NAS discharges between 2013 and 2014.

Dr. Hattis asked how the data represents transfers. Mr. Romm responded that the data reflects the last site of discharge.

Ms. Record provided a detailed overview of the proposed pilots under **Category A**. She stated that the HPC will undertake a competitive process to fund up to two non-CHART eligible birthing hospitals to develop and implement a "delivery to discharge" quality improvement initiative. She noted that these pilots will focus on integrating care.

Ms. Record reviewed a list of best practices to address NAS and reduce the cost of care. She stated that these range from increasing the use of breastfeeding to improving the relationship between hospitals and the Department of Children and Families.

Ms. Record provided a detailed overview of the proposed pilots under **Category B**. She reiterated that the HPC's pilots would build upon DPH's *Moms Do Care* program. She noted that this program, funded through a SAMHSA grant, is currently financing three programs to address NAS across Massachusetts. Ms. Record emphasized the importance of the scope of the *Moms Do Care* program, highlighting that it addresses NAS from pregnancy to six months post birth, a time when the risk of relapse is extremely high.

Ms. Record stated that 2-3 pilots will be funded through **Category B**, which will incorporate HPC's "delivery to discharge" inpatient quality improvement initiative (Category A) with DPH's *Moms Do Care* program. This will allow the HPC to address broader points of intervention and assess the effect of pre-natal intervention by comparing results from pilots in Category A to those in Category B.

Dr. Everett asked how the HPC would measure outcomes. Mr. Romm responded that the HPC is considering the number of infants born with NAS and/or the severity of NAS as potential outcome measures. Dr. Everett stated that the HPC could also examine subsequent pregnancies.

Mr. Cohen asked whether other states received NAS funding through the SAMHSA grant. If so, he suggested that the HPC compare data with those states. Ms. Record responded that there were different variations of NAS programs. She stated that the HPC and DPH would work with SAMHSA to see if programmatic data will be made available.

Ms. Record reviewed the HPC's technical assistance and evaluation metrics. She noted that the HPC is still working to refine these areas.

Ms. Record said that a goal of the pilot programs is to disseminate best practices statewide by creating an environment in which participating hospitals share best practices with their peers. Mr. Cohen noted his appreciation for the inclusion of peer-to-peer training.

Ms. Record said the HPC is currently developing the Request for Proposals for release in early 2016, with Board approval.

Dr. Hattis asked whether CHART hospitals will have to submit detailed budget proposals. Mr. Romm responded in the affirmative.

Mr. Cohen asked for a motion to advance the proposal to the full Board. Dr. Allen made the motion. Undersecretary Moore seconded. The motion passed unanimously.

Item 3: Discussion of Program Design for the HPC's Pilot on Paramedicine

Mr. Romm stated that the fiscal year 2016 state budget included a $500,000 appropriation for the HPC to conduct a pilot program in Greater Quincy to study the impact of using community paramedicine to enhance care for patients with behavioral health conditions.

Mr. Romm said the objectives of the program are to test a currently non-reimbursed payment model for innovative field triage, reduce emergency department boarding, enhance the quality and outcomes from behavioral health services, and ensure that the model has safeguards so that patients with medical emergencies are not bypassing emergency departments.

Dr. Hattis asked whether the HPC was focusing on reducing hospital boarding in the Quincy satellite emergency department or all emergency departments in the greater Quincy area. Mr. Romm responded that the scope of the project is still under development. He noted that in 2014 about 3,000 behavioral health patients in Quincy were transported to a hospital by EMS. Of those, 390 were considered not medically complex.

Dr. Allen asked whether this program will include pediatric patients. Mr. Romm responded that the scope was still under consideration but that no decision to exclude pediatric patients had been made.

Dr. Allen asked whether the behavioral health objective includes substance abuse issues. Mr. Romm responded in the affirmative. Ms. Record added that the vast majority of patients who experience emergency department boarding have a behavioral health condition.

Mr. Romm reviewed the various state agencies that are collaborating to frame and implement the paramedicine pilot. He stated that the HPC has the overarching role of providing guidance on program framework and goals. He noted that the HPC will be thoughtful to layout the framework without making clinical decisions.

Dr. Allen emphasized the role of local health boards, noting that they can better assess the needs of their community and publicize the program. Mr. Cohen added that the program should include coordination with social workers.

Mr. Romm provided an overview of the current role of emergency medical services (EMS) and emergency service providers (ESP). He noted that the Commonwealth has a broad vision for these roles to work together more effectively to ensure that patients arrive at the proper site of care. To demonstrate this, Mr. Romm reviewed two examples of behavioral health crisis management.

Dr. Everett noted that there are interesting innovations around the country that use EMS to provide primary care to individuals with low-acuity needs.

Mr. Romm reviewed the four main approaches to paramedicine. He noted that these were informed by an environmental scan. Mr. Romm said the use of EMS is highly varied by community.

First, Mr. Romm said there are mobile health care paramedics who provide both physical and behavioral care in the home. He said this approach is usually successful when there is a

clear role differentiation between mobile health paramedics and EMS. He said this approach is usually employed with patients known to the system.

Second, Mr. Romm said alternative destination transport can divert patients to the appropriate site of care, such as an urgent care center, clinic, detox center, mental health hospital, or emergency room.

Third, Mr. Romm noted the use of field intercept, in which primary 911 teams activate community paramedics to facilitate assessment, field treatment, or triage.

Finally, Mr. Romm reviewed the nurse-triage EMS response, through which nurses in a 911 call center triage low-acuity calls to offer clinical guidance or appropriate resources.

Mr. Romm stated that many of these approaches are currently used primarily for physical health. He added that the Commonwealth must determine how to leverage best practices for behavioral health.

Mr. Romm briefly reviewed paramedicine interventions throughout the country. He highlighted two initiatives in Boston through which field paramedics have access to electronic health records and basic medical capabilities and work in close coordination with on-call doctors and nurse practitioners.

In framing next steps for the HPC's paramedicine pilot, Mr. Romm emphasized the need for the Quincy community, including social services and clinical providers, to drive care coordination. He stated that the HPC is still developing the scope of the program, in part by looking to the community for input on areas of need.

Mr. Cohen asked what deliverables the HPC has to deliver with respect to this pilot. Mr. Romm responded that the HPC would publish an evaluation report on the pilots to disseminate best practices.

Dr. Everett noted that this process runs the risk of being very top-down. She suggested close collaboration with Quincy throughout the development process. Undersecretary Moore stated that Quincy's legislators were very supportive in drafting the pilot's FY16 appropriation.

Undersecretary Moore emphasized the need to incentivize long-term service and support the full integration of behavioral health. She noted that the Executive Office of Health and Human Services is working to create long-term sustainability in these areas.

Item 4: Schedule of Next Meeting

Mr. Cohen said that the next meeting is scheduled for Wednesday, January 6, 2015 at 10:30 AM.

Item 5: Adjournment

Mr. Cohen adjourned the meeting at 12:09 PM.