MASSACHUSETTS
HEALTH POLICY COMMISSION

Massachusetts Health Policy Commission:

Research and Programs to Expand the Availability of Evidence-Based Behavioral Health Care Treatment

May 21, 2019

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HEALTH POLICY COMMISSION

AGENDA

- **Background on the HPC**
- Co-Occurring Disorders Care in Massachusetts Report
- EXCLUSIVE PREVIEW: Opioid-Related Acute Hospital Utilization
- SHIFT-Care Investment Program: MAT in the ED

In 2012, Massachusetts became the first state to establish a target for sustainable health care spending growth

Chapter 224 of the Acts of 2012

An Act **Improving the Quality** of Health Care and **Reducing Costs** through Increased **Transparency**, **Efficiency**, and **Innovation.**

GOAL

Reduce total health care spending growth to meet the **Health Care Cost Growth Benchmark**, which is set by the HPC and tied to the state's overall economic growth.

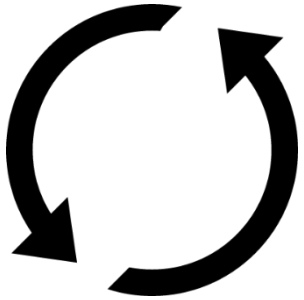
VISION

A **transparent** and **innovative** healthcare system that is **accountable** for producing **better health** and **better care** at a **lower cost** for the people of the Commonwealth.

HPC

The HPC promotes two priority policy outcomes that contribute to reducing health care spending, improving quality, and enhancing access to care.

Strengthen market functioning and system transparency



The two policy priorities reinforce each other toward the ultimate goal of reducing spending growth

Promoting an efficient, high-quality delivery system with aligned incentives

The HPC employs four core strategies to advance its mission.

RESEARCH AND REPORT

INVESTIGATE, ANALYZE, AND REPORT TRENDS AND INSIGHTS

CONVENE

BRING TOGETHER STAKEHOLDER COMMUNITY TO INFLUENCE THEIR ACTIONS ON A TOPIC OR PROBLEM

WATCHDOG

MONITOR AND INTERVENE WHEN NECESSARY TO ASSURE MARKET PERFORMANCE

PARTNER

ENGAGE WITH INDIVIDUALS, GROUPS, AND ORGANIZATIONS TO ACHIEVE MUTUAL GOALS

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Mandate for the HPC to study the statewide availability of providers treating co-occurring mental illness and substance use disorder

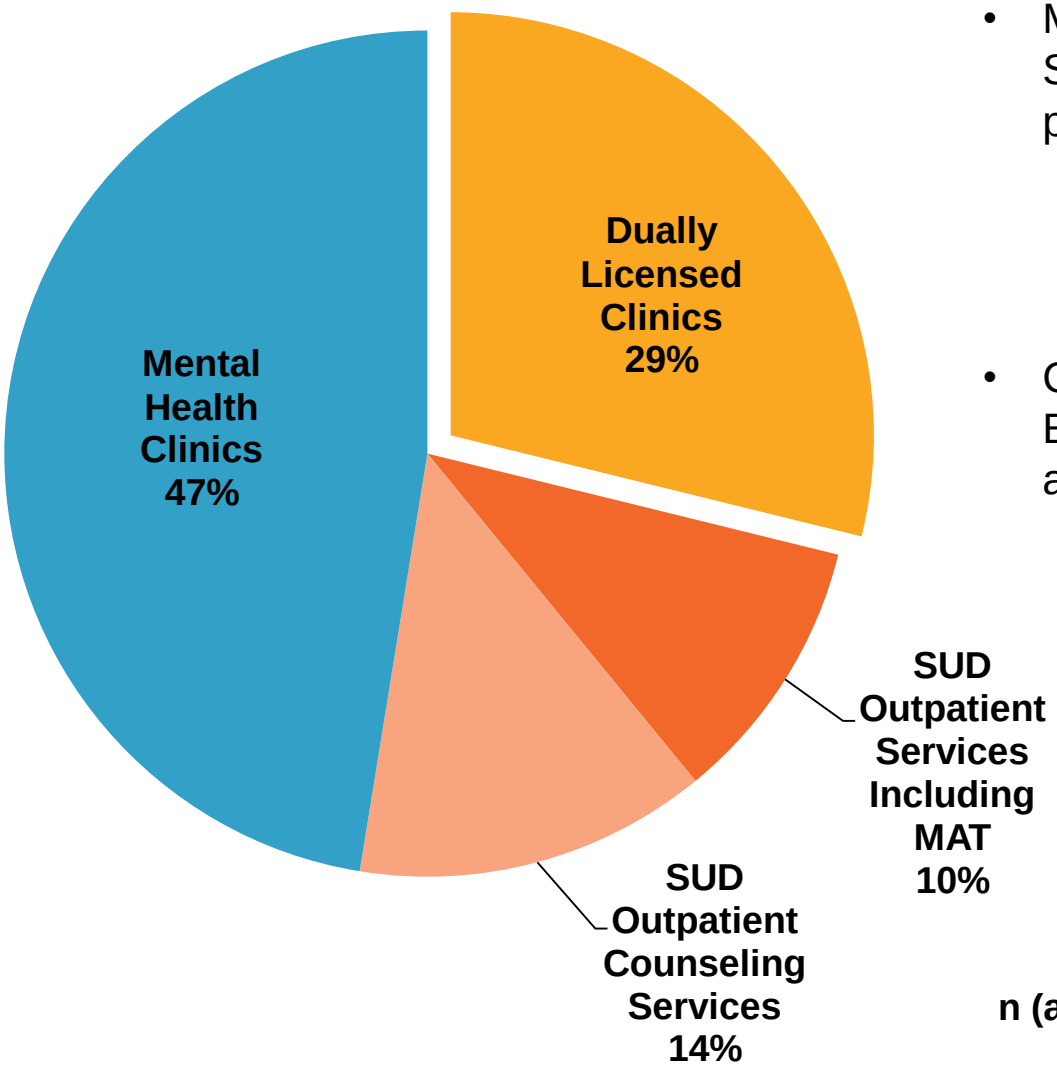
Chapter 52 of the 2016 Session Laws, ***An Act Relative to Substance Use, Treatment, Education and Prevention***, charges the HPC, in consultation with the Department of Public Health and the Department of Mental Health, with assessing the availability of providers treating "dual diagnosis," or co-occurring mental illness and substance use disorder (SUD).

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

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

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

Only a quarter of behavioral health clinics and counseling sites are licensed to treat both mental illness and SUD

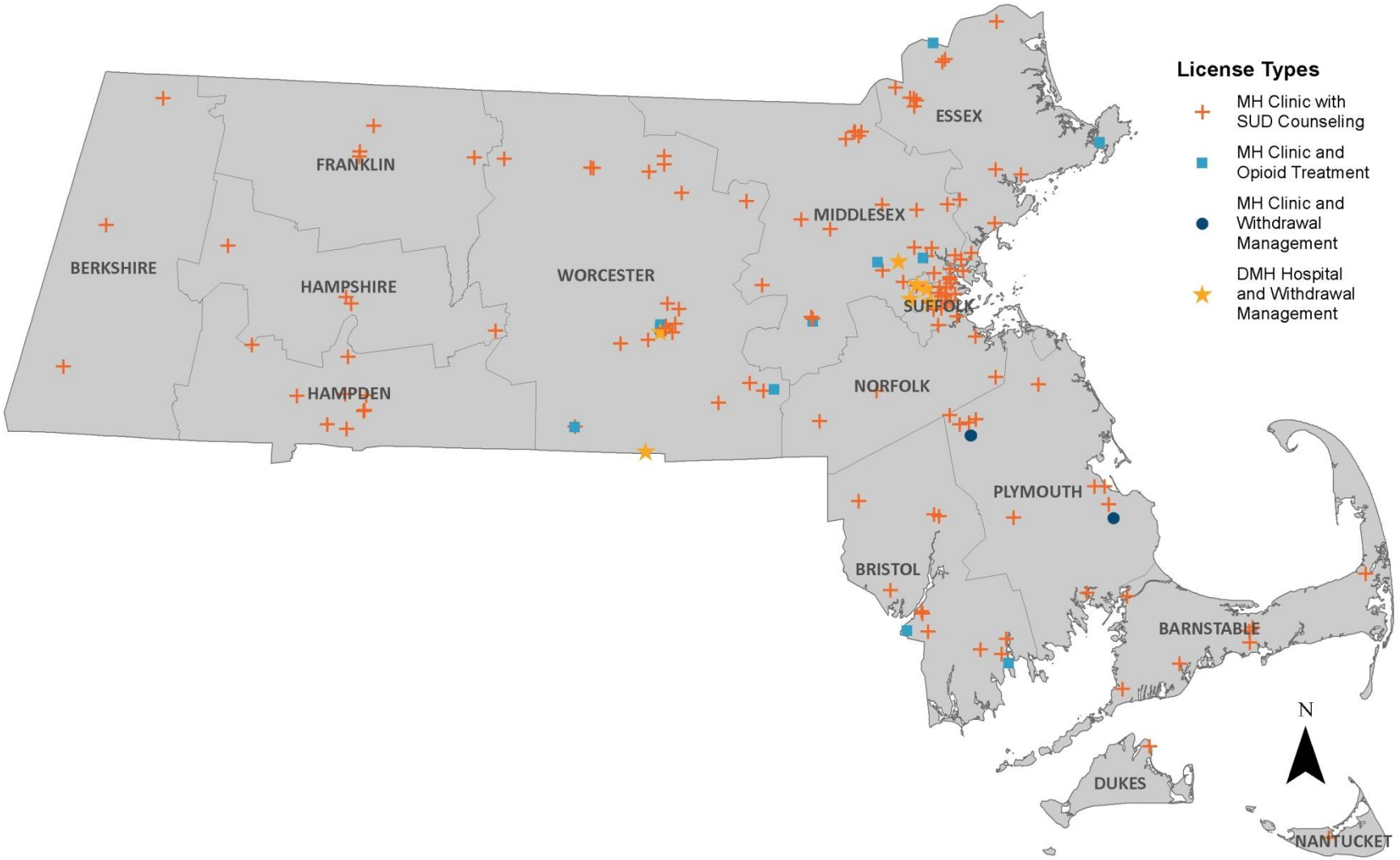


- Mental health clinics without an SUD license represent 50% of providers
  - These sites may still treat patients with SUD, per individual staff members' clinical licenses
- Clinics with dual licensure follow BSAS requirements for staffing and treatment protocols

n (all license types) = 586

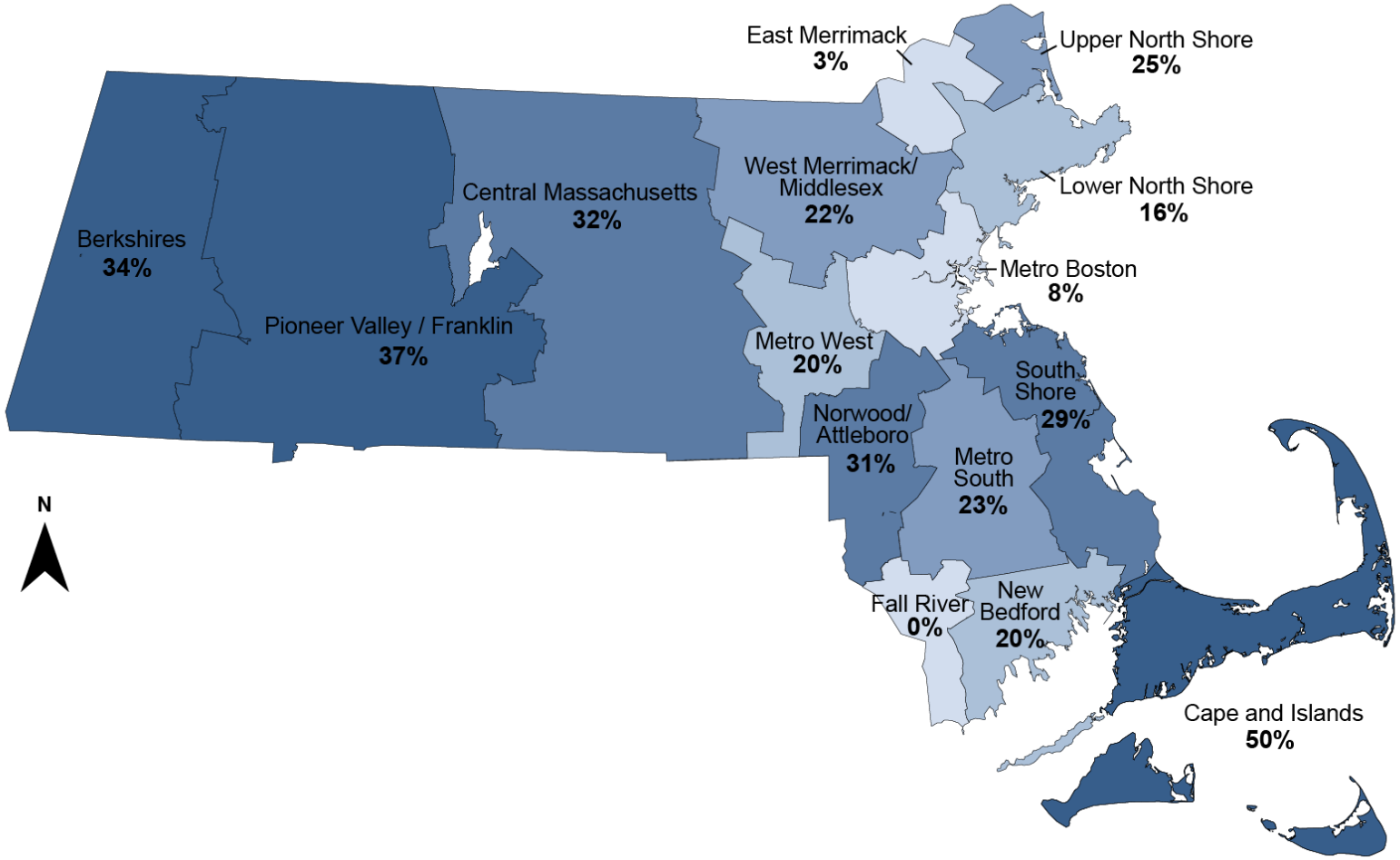
Source: HPC analysis of DPH (Division of Health Care Facility Licensure and Certification and Bureau of Substance Addiction Services) licensing data.
Note: while community health centers (CHC) that have mental health or SUD licenses are included, any CHC or primary care provider not licensed as a mental health or SUD clinic is not included, regardless of whether it provides prescribing for mental health or SUD.

Locations of all dually licensed provider sites in Massachusetts, 2018



Source: HPC analysis of DPH (Division of Health Care Facility Licensure and Certification and Bureau of Substance Addiction Services) and Department of Mental Health licensing data.

Percent of population over 18 who live more than a 15 minute drive from the nearest dually licensed clinic, 2018



Note: There are 15 HPC regions, which are based on patterns of patient travel for inpatient care. For more information on how HPC created these regions, please see: http://www.mass.gov/anf/docs/hpc/2013-cost-trends-report-technical-appendix-b3-regions-of-massachusetts.pdf. Driving distance is based on HPC analysis of population by zip code from American Community Survey, 5 year estimates, 2016, U.S. Census Bureau

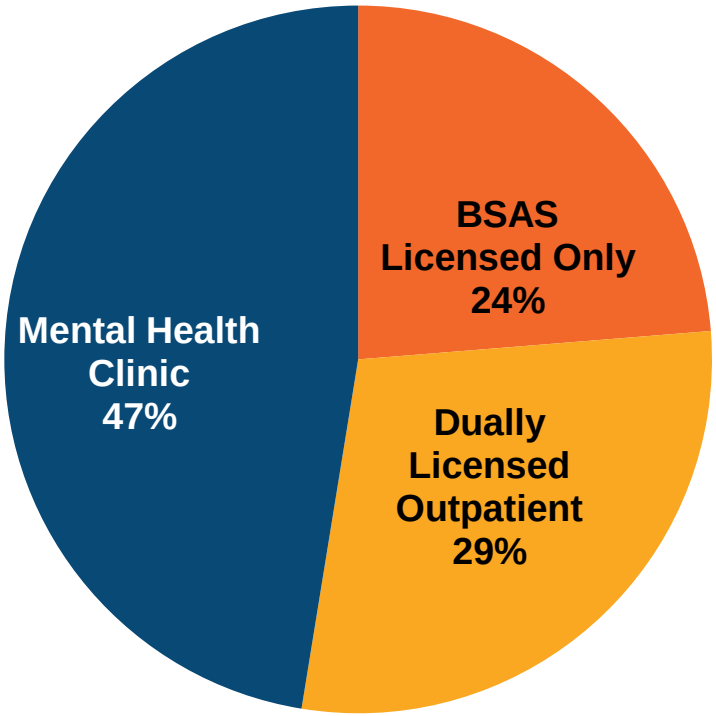
Survey Methodology

- HPC combined data from **commercial payers' provider directories** and data from the Substance Abuse and Mental Health Services Administration (SAMHSA) with **state licensing data** from DMH and multiple bureaus within DPH.
- HPC cross-referenced these files by address and provider name to identify the number of licensed provider sites by type(s) of license and HPC region.
- HPC contracted with a expert vendor to create a **survey for providers** that would determine:
  - services provided
  - populations served
  - the extent to which services specifically for co-occurring disorders are provided
  - barriers to providing integrated care for co-occurring disorders
- The survey received responses from 405 sites of service, representing **slightly more than 50% of licensed behavioral health treatment sites** in Massachusetts.
- In addition, the survey received responses from 170 independent clinicians in active practice who represent an important component of commercial payers' behavioral health provider networks.

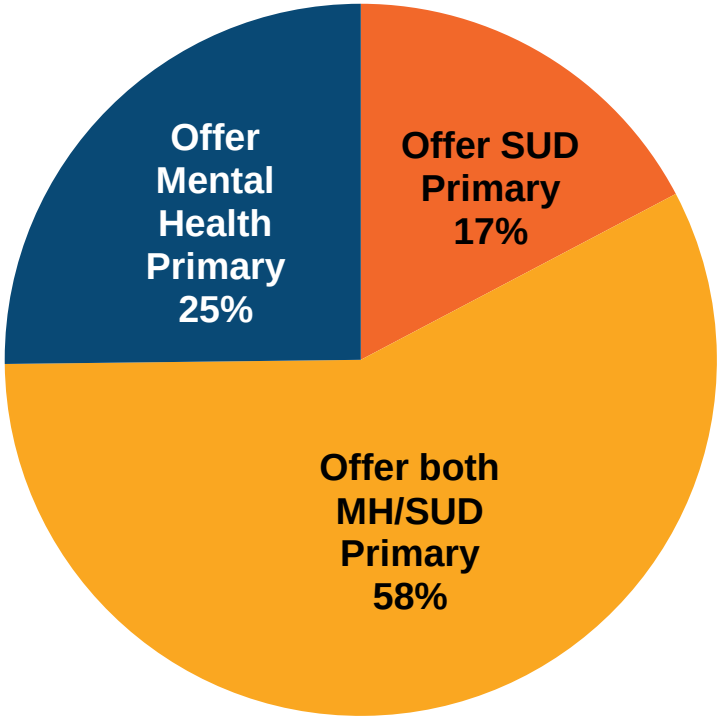
Providers reported offering both mental health and SUD services at a higher rate than the dual licensure rate would suggest

Clinics that are licensed only to provide mental health services are allowed to treat SUD, as their individual clinicians' professional licenses authorize them to treat *any* behavioral health diagnoses. While these sites may choose not to pursue parallel BSAS licensure, they still serve patients with co-occurring disorders.*

Licensed Clinic By Types, as of October 2018, N=586

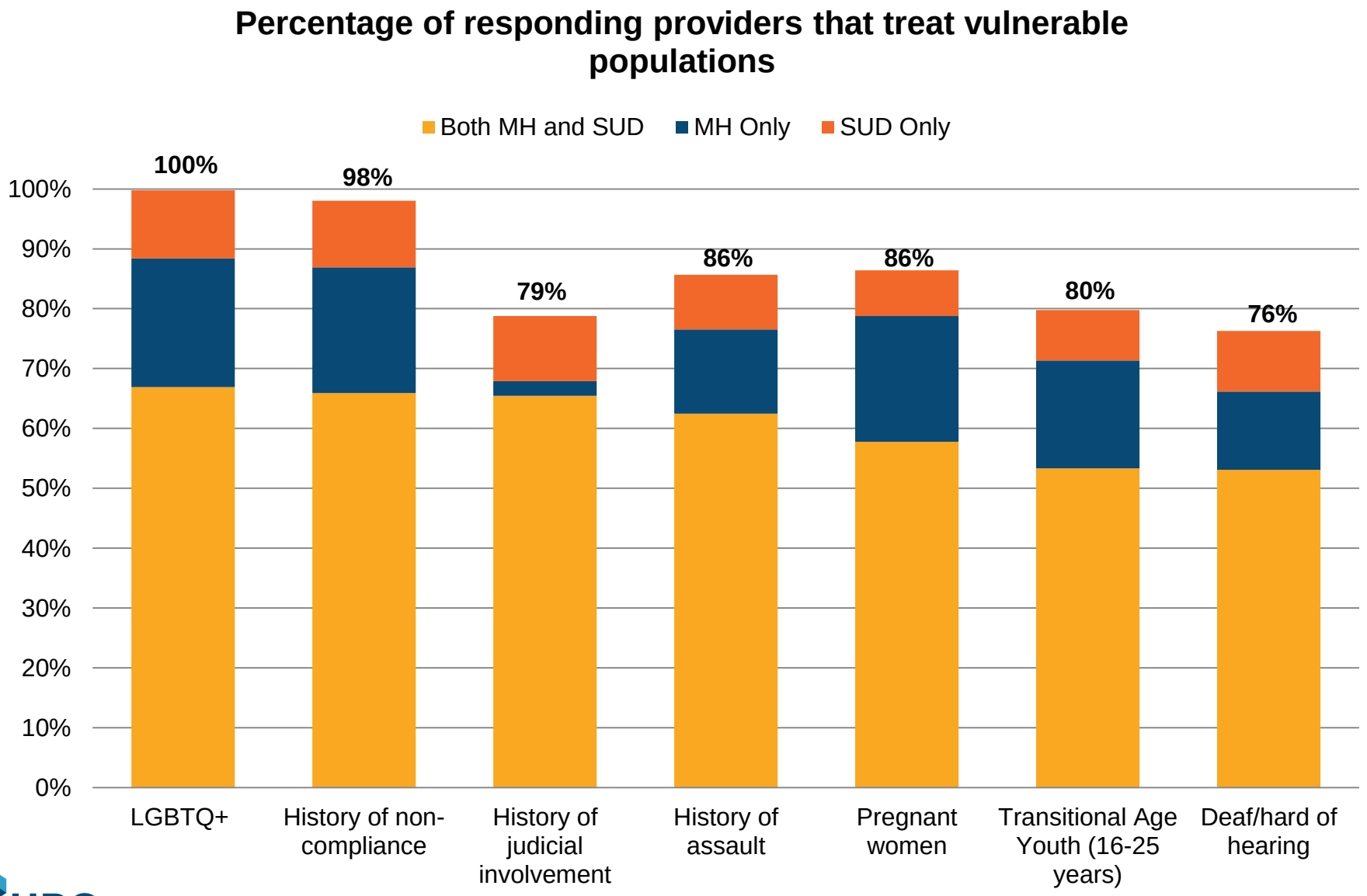


Survey respondents by Primary Service, N=405



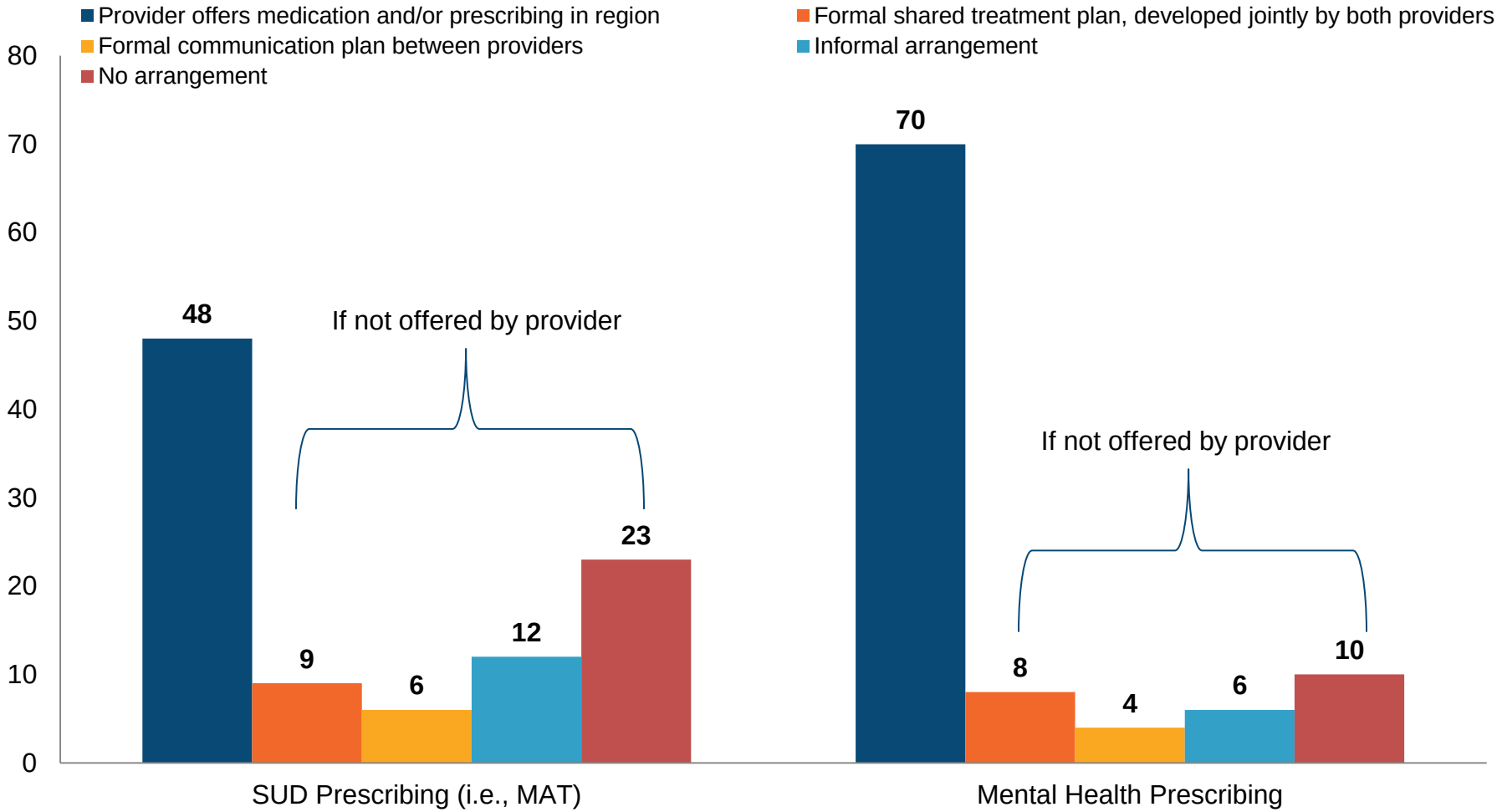
* This is also true for clinics that are licensed to provide SUD services and do not seek parallel mental health clinic licensure.

Providers reported different rates of treating particular vulnerable populations



Providers reported a range of prescribing arrangements; some have no arrangements for providing medication

Prescribing and medication arrangements of providers who report serving co-occurring disorder (n=98*)



*Of all survey respondents that reported offering outpatient services for mental health and SUD, 98 responded to both 1) a question about SUD prescribing and 2) about mental health prescribing.

Summary of Recommendations

Licensing and Regulation

- The Commonwealth should continue **to develop a systematic approach to identifying and monitoring** prevalence of co-occurring disorders and the corresponding service capacity and availability.
- EOHHS should continue its efforts to **streamline the licensure process** for providers seeking both SUD and mental health licenses.

Integrated Care Models

- The Commonwealth should continue to **promote and fund evidence-based integrated care models** for the treatment of co-occurring disorders, particularly those that integrate care with community based organizations, primary care providers, and social service organizations.

The Commonwealth should strengthen access to behavioral health medication treatment and recognize it as a standard of care.

Workforce

- The Commonwealth should continue to invest in developing a **diverse, well-trained, and supported** behavioral health workforce.

Payment Policy

- Payers should **improve reimbursement rates and payment policies** to encourage access to and integration of behavioral health care.

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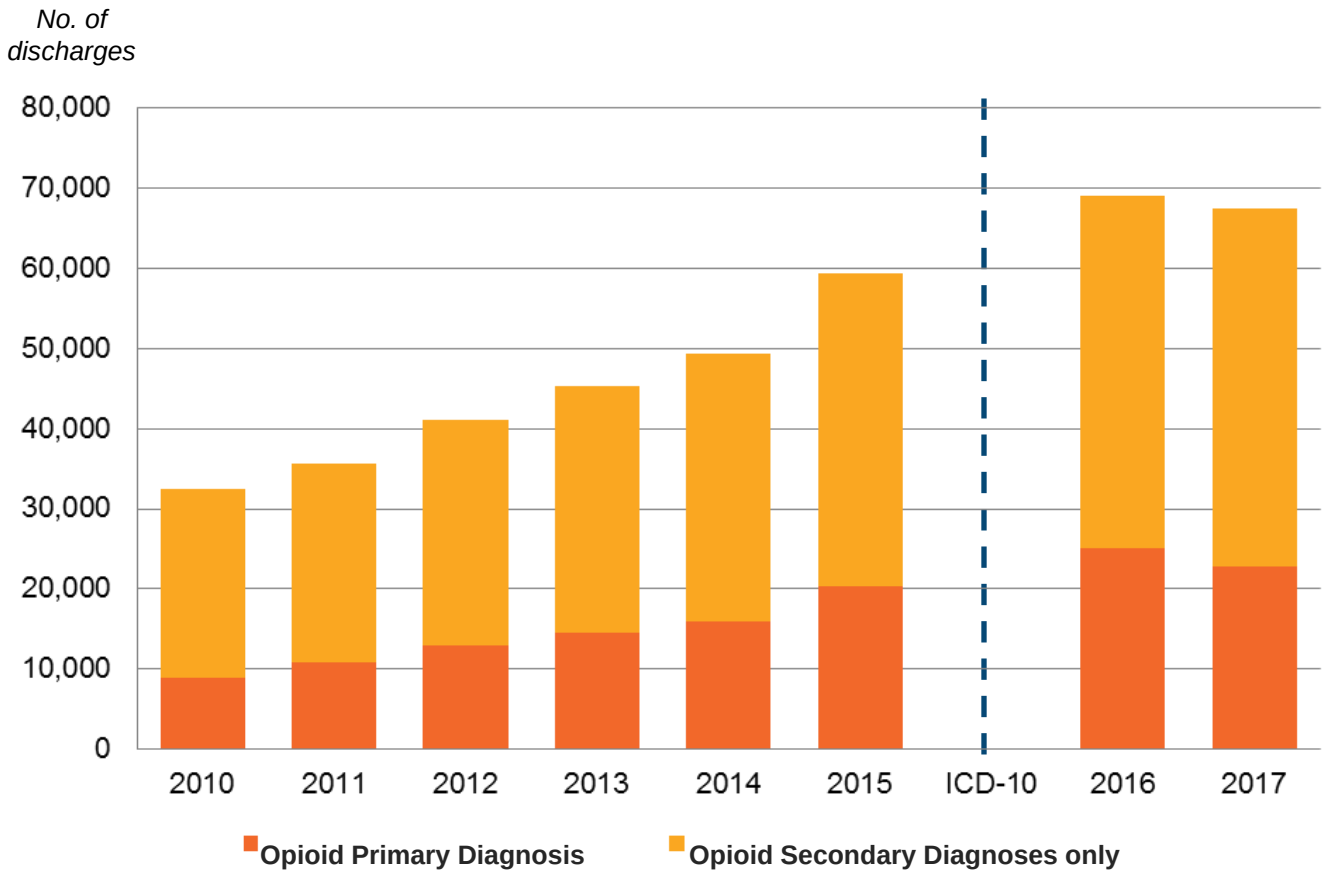
Opioid-related acute care hospital ED and inpatient utilization, 2010-2017

ED and Inpatient



Since 2010, opioid-related acute hospital discharges (both ED and inpatient) have grown substantially in Massachusetts, accelerating to **20% growth** between 2014 and 2015, followed by **16.6% growth** between 2015 and 2016.

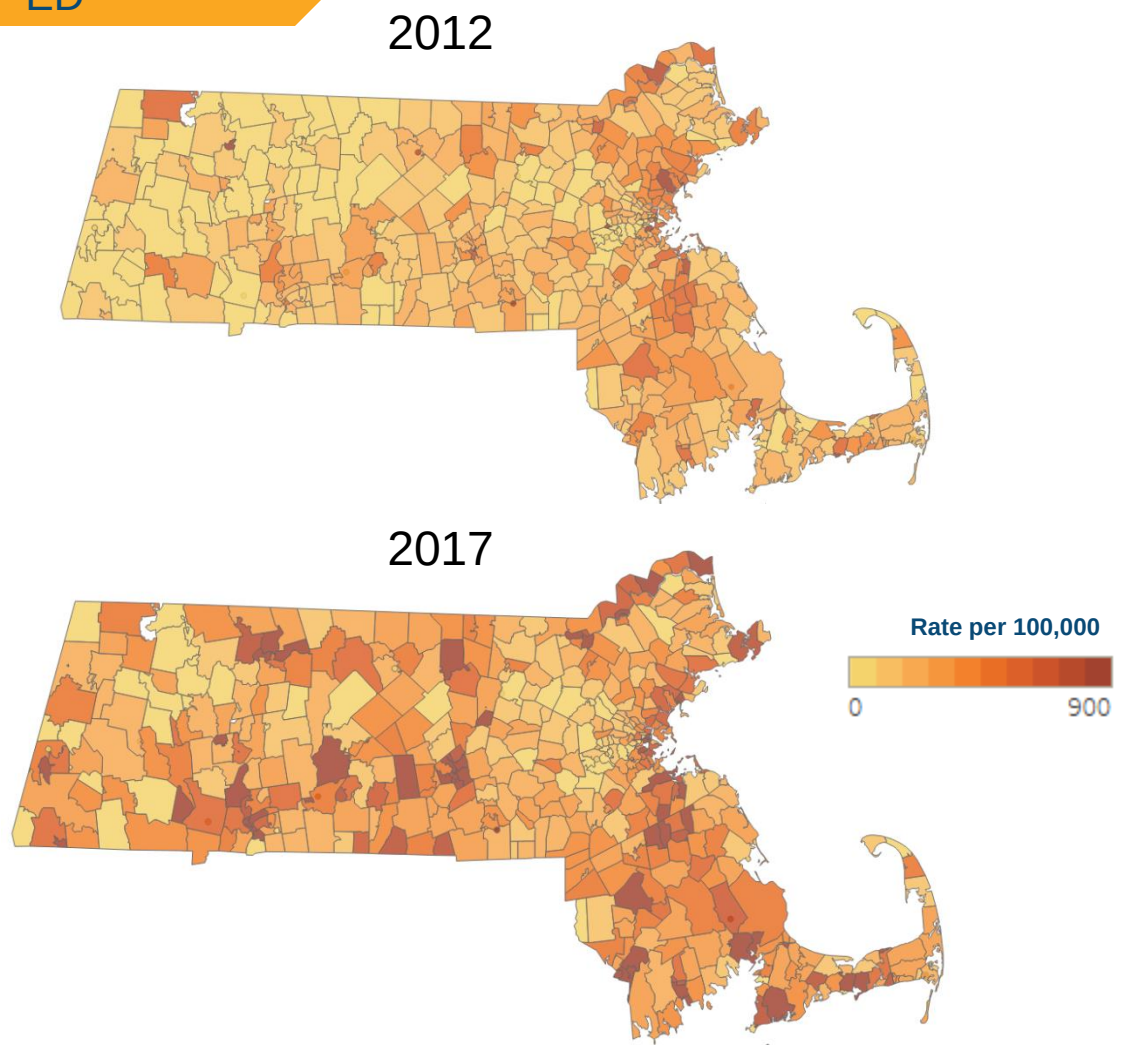
From 2016 to 2017, the rate **declined by 2.3%**.

Source: Data: HPC Analysis of the Center for Health Information and Analysis (CHIA), Hospital Inpatient Discharge and ED Databases, 2010-2017.

Note: Dates are based on the federal fiscal year, which runs from October 1 to September 30. Some discontinuity in trends may exist between 2015 and 2016 due to the transition from ICD-9 diagnosis codes to ICD-10 diagnosis codes on October 1, 2015. From 2011 to 2014, the CHIA databases included only the patient's first 15 diagnosis codes. However, as of 2015 all of a patient's diagnosis codes are included. Please see methodology section for more detail about the impact of this change.

Opioid-related ED discharges by zip code of patient residence, 2012 and 2017

ED



As in 2012, in 2017 there was considerable variation in opioid-related ED utilization across the Commonwealth, but in most zip codes, the rate **increased** over that five-year period.

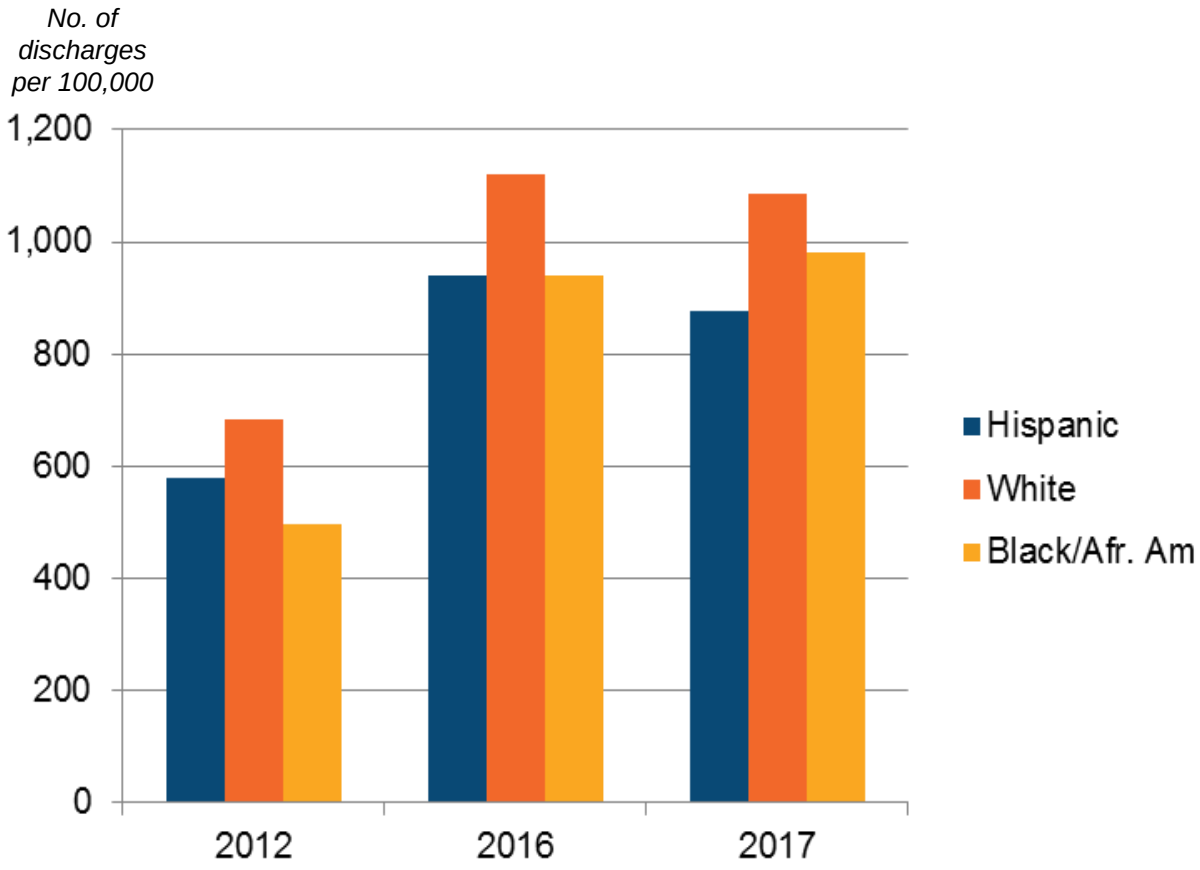
By 2017, the proportion of zip codes with more than 500 opioid-related ED discharges per 100,000 people had nearly **tripled** since 2012 (i.e., 28% of zip codes compared to 10% in 2012).

Source: HPC Analysis of the Center for Health Information and Analysis (CHIA), ED Databases, 2012 and 2017, and U.S. Census Bureau, and ACS 5 year population estimates by Zip Code Tabulation Areas, 2012 and 2017.

Note: Mapped by a patient's permanent zip code, not site of care. 2017 data includes opioid-related discharges identified using all of a patient's diagnoses and ICD-10 diagnosis codes.

Opioid-related hospital discharge rates per 100,000 by race and ethnicity, 2012, 2016, and 2017

Inpatient and ED



In 2017, patients identified as non-Hispanic White had the **highest rate** of opioid-related discharges (1,084 discharges per 100,000 people) but experienced a **3% decrease** from 2016.

Those identified as Hispanic also experienced a **nearly 7% reduction** in the rate of opioid-related discharges between 2016 and 2017.

The rate increased **more than 4%** from 2016 to 2017 among those identified as Black/African American, to 981 discharges per 100,000.

For all race identifiers available, the rate increased by **more than 50%** between 2012 and 2017; among Black/African Americans, the rate increased by 98% in that time period.

Source: HPC Analysis of the Center for Health Information and Analysis (CHIA), Hospital Inpatient Discharge and ED Databases, 2012, 2016, 2017; U.S. Census, ACS 5 Year demographic and housing estimates, 2012, 2016, 2017.

Notes: U.S. Census data used for the calculation of the rate included only people with single race. The census estimates of multi-racial populations are not included in the rate calculation. Racial data from the Hospital Inpatient Discharge Database may classify people with two or more races differently than the census data does, so rates per 100,000 should be interpreted with caution. Each year's rate is calculated in the same manner, so the rates can be compared over time. The analysis does not include racial classifications of Asian and Other, as each had low numbers and comprised 2% of the data. Racial data was missing from 1.6% of opioid-related discharges.

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SHIFT-Care sought proposals that addressed the whole-person needs of patients through two innovative care models.

Innovative Model 1: Addressing health-related social needs

- Support for innovative models that **address health-related social needs** of complex patients in order to prevent a future acute care hospital visit or stay
- 5 awards made totaling $3,288,234.49

Innovative Model 2: Addressing behavioral health needs

- Support for innovative models that **address the behavioral health care needs** of complex patients in order to prevent a future acute care hospital visit or stay
- 10 awards made totaling $6,467,066.02

OUD FOCUS: Enhancing opioid use disorder (OUD) treatment

- Support for innovative models that expand access to opioid use disorder treatment by **initiating pharmacologic treatment in the ED** and connecting patients to community-based BH services

Care Model for Initiating Pharmacologic Treatment in the ED

The legislature appropriated funding to the HPC to implement a pilot grant program to further test a model of ED-initiated pharmacological treatment of opioid use disorder (OUD) for patients who present in the emergency setting with symptoms of overdose or after being administered naloxone.

In addition to initiating pharmacological treatment, Awardees will provide patients with referrals to outpatient follow-up treatment with the goal of increasing rates of engagement and retention in evidence-based care for their OUD.

What:

Identify patients	→	Enroll in program	→	Initiate medication for addiction treatment	→	Engage in recovery services
• Patient presents with history or symptoms of OUD or overdose		• SW/CHW/RC recommends patient to program • Enrolls patient in program with patient consent		• ED physician or other qualified prescriber initiates pharmacological treatment for OUD		• Patient leaves ED with medication and a follow-up appointment ASAP, within 72 hours of discharge

Where:

ED, practice sites, or in the community	Emergency Department	Outpatient Setting

HPC

SHIFT-Care MAT in the ED Awardees

Applicant Entity	Location	Awardee Contribution	HPC Funding
Addison Gilbert/Beverly	North Shore	$375,146	$565,422
BID Plymouth	South Shore	$247,469	$606,609
Harrington Memorial Hospital	Central	$208,190	$742,407
Holyoke Medical Center	Western	$437,353	$750,000
Lowell General Hospital	Merrimack Valley	$202,204	$750,000
Mercy Medical Center	Western	$172,016	$486,580
MGH	Metro Boston	$549,414	$516,048
North Shore Medical Center	North Shore	$250,000	$750,000
UMass Memorial Medical Center	Central	$383,673	$550,000

Total costs: $8,727,109

SHIFT-Care Challenge Awardee Highlight: North Shore Medical Center (NSMC)

NORTH SHORE MEDICAL CENTER

Service Model

NSMC ED physicians identify patients who are candidates for medication for addiction treatment (MAT), and, depending on clinical appropriateness, initiate treatment in the ED or provide a take-home dose to "bridge" patients for up to three days until outpatient appointments are available. A recovery coach or community health worker meets with eligible patients to discuss available care options and support services. Patients who initiate MAT then receive a referral to their primary care provider (PCP) or one of NSMC's SHIFT-Care-supported outpatient partners:

- **Lynn Community Health Center** is expanding its urgent care clinic access to include Sundays
- **North Shore Physicians Group** is expanding its capacity to provide MAT by training and supporting PCPs pursuing waivers to prescribe buprenorphine

Target Population

Adult patients who present to the NSMC ED following opioid overdose, or who have a positive OUD screening result

Primary Aim

Reduce ED visits by 50% for the target population compared to baseline in 18 months

Partners

- Lynn Community Health Center
- North Shore Physicians Group
- North Shore Community Health
- Bridgewell

HPC Funding	Total Initiative Cost
$750,000	$1,000,000

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Contact Information

For more information about the Health Policy Commission

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