MASSACHUSETTS
HEALTH POLICY COMMISSION

Meeting of the Care Delivery Transformation Committee

June 5, 2019

MASSACHUSETTS
HEALTH POLICY COMMISSION

AGENDA

- **Call to Order**
- Approval of Minutes
- Learning and Dissemination Outputs: ACO Program Policy Brief #3 and Tele-Behavioral Health Guidance from HPC Awardees
- Program Design: MassUP Interagency Project to Align Population Health and Community Health Initiatives
- Partnership Update: MassChallenge HealthTech
- Evaluation Update: CHART and Health Care Innovation Investment (HCII) Programs
- SHIFT-Care Awardee Spotlight: Holyoke Medical Center
- Schedule of Next Meeting (October 2, 2019)

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VOTE: Approving Minutes

MOTION: That the Committee hereby approves the minutes of the CDT Committee meeting held on February 27, 2019, November 28, 2018, and October 10, 2018, as presented.

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New Publication: ACO Certification Policy Brief #3

Transforming Care: Risk Contracts and Performance Management Approaches of Massachusetts ACOs

- HPC-certified ACOs **collectively hold 85 risk contracts** with public and commercial payers, of which **26 are "upside only" contracts**
- The **number of quality measures** included in individual payer contracts **ranges from zero to 51**
- The majority of ACOs **share performance reports** among their clinician leadership on a **monthly or quarterly basis**
- When distributing shared savings among their participating providers, most ACOs consider performance on **quality, efficiency, and cost**; some also consider **patient satisfaction and adoption of health information technology**

MASSACHUSETTS HEALTH POLICY COMMISSION

MAY 2019

ACO POLICY BRIEF

Transforming Care: Risk Contracts and Performance Management Approaches of Massachusetts ACOs

As health care providers organize as accountable care organizations (ACOs) and assume responsibility for the total cost of care and health outcomes for their patients, successful providers and payers alike are implementing strategies to improve the underlying health of the population served. This emerging focus on addressing the needs of a defined population, as opposed to those of an individual patient, is reflected in the development of population health management (PHM) programs. These programs are commonly delivered by an ACO and its community partners, informed by an assessment of the risk and health needs of the populations, and supported by reformed payment and claims data from health plans.

As ACOs more effectively assess the health and needs of their patients, there is an increasing focus on addressing non-medical needs of the population through the integration of physical, behavioral, and social determinants of health (SDH).[1,2,3] The SDH are "the structural determinants and conditions in which people are born, grow, live, work and age,"[4] and mounting evidence suggests that addressing patients' social needs impacts health outcomes and total health care spending.[5,6,7,8,9] This is particularly true for the most complex patients—those with additive risk of comorbid medical, behavioral, and social needs, such as a patient with cardiovascular disease, substance use disorder, and unstable housing. One study found that environmental surroundings, socio-economic factors, and individual activity account for nearly two-thirds of morbidity and premature mortality.[10]

The Health Policy Commission (HPC) recognized the importance of improving population health in issuing statewide standards for certifying Massachusetts ACOs, under which the HPC certified 17 ACOs in 2017.[i] These standards require ACOs to demonstrate all-payer capabilities in population health, including risk stratification of the patient population and program implementation to address identified needs regarding behavioral health and the SDH.

This policy brief, the second in a series,[11] defines the HPC's PHM requirements for ACO Certification, summarizes the certified ACOs' responses to those requirements, and concludes with a discussion of the policy implications of the findings.[12]

HPC standards require ACOs to demonstrate that their governing body assesses performance and sets strategic performance improvement goals at least annually; and reviews a performance dashboard that includes at least one quality measure in the domains of process, efficiency, outcomes, and patient experience of care

i The 2017 certified ACOs are: Atrius Health, Inc.; Baycare Health Partners, Inc.; Beth Israel Deaconess Care Organization; Boston Accountable Care Organization, Inc.; Cambridge Health Alliance; Children's Medical Center Corporation; Community Care Cooperative, Inc.; Health Collaborative of the Berkshires, LLC; Lahey Health System, Inc.; The Mercy Hospital, Inc.; Merrimack Valley Accountable Care Organization, LLC; Partners HealthCare System, Inc.; Reliant Medical Group, Inc.; Signature Healthcare; Southcoast Health System, Inc.; Steward Health Care Network, Inc.; Wellforce, Inc. For more information on the certified ACOs and the ACO Certification program, visit: https://www.mass.gov/service-details/the-hpc-accountable-care-organization-aco-certification-program

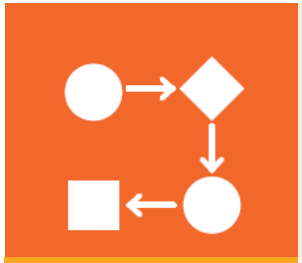
ACO Policy Brief | 1

HPC

New Publication: HPC Guide to Implementing Telemedicine for Behavioral Health

Tele-Behavioral Health Implementation Guide

Highlighting insights from the HPC's 2018 knowledge sharing session and awardee roundtable on telemedicine for behavioral health (teleBH), this guide covers four key areas of program development: **workflow**, **data and measurement**, **workforce**, and **technology**.



Develop a risk management plan for troubleshooting technological difficulties

"Make sure you have a signal [and] that your wifi works. There is nothing worse than having psychiatrically compromised clients on tele and all of a sudden you lose signal—that can be actually quite dangerous, let alone frustrating."

—UMASS MEMORIAL MEDICAL CENTER

Expose behavioral health providers to teleBH technology to normalize it and increase their comfort with the modality

"I'm working on developing—with the dean of a school of social work—a certificate class in tele-behavioral counseling so students will actually be trained and have the opportunity to be comfortable with the modality."

– HEYWOOD HOSPITAL

Prepare for the ways that teleBH will enhance you interactions beyond just accessibility

"We are reaching people who would otherwise not be receiving care. They face barriers related to transportation in very rural counties or anything associated with stigma, shame or fear... [teleBH] removes those barriers and that is huge."

—BERKSHIRE MEDICAL CENTER

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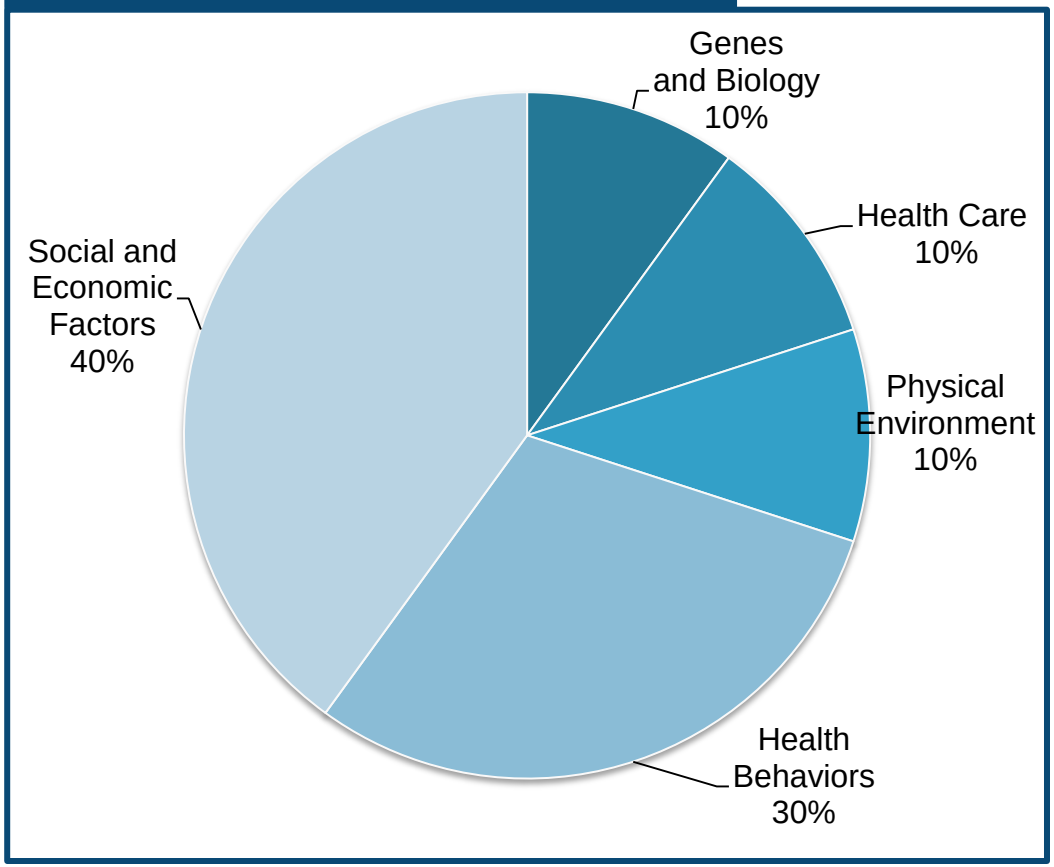
There is an emerging consensus that addressing social determinants of health is essential to improving population health, reducing health inequities, and controlling health care costs

Factors that Impact Health



MASSACHUSETTS HEALTH POLICY COMMISSION

2018 Annual Health Care

COST TRENDS REPORT

PROMOTING AN EFFICIENT, HIGH-QUALITY HEALTH CARE DELIVERY SYSTEM

#8. SOCIAL DETERMINANTS OF HEALTH. The Commonwealth should continue to address the impact of social determinants of health (SDH) on health care access, outcomes, and costs.

HPC

SOURCE: Tarlov, A. Public Policy Frameworks for improving population health. Annals of the New York Academy of Sciences. 1999. 896. 281-93

Health Inequity Pathway — Upstream, Midstream and Downstream

Policies and Environments

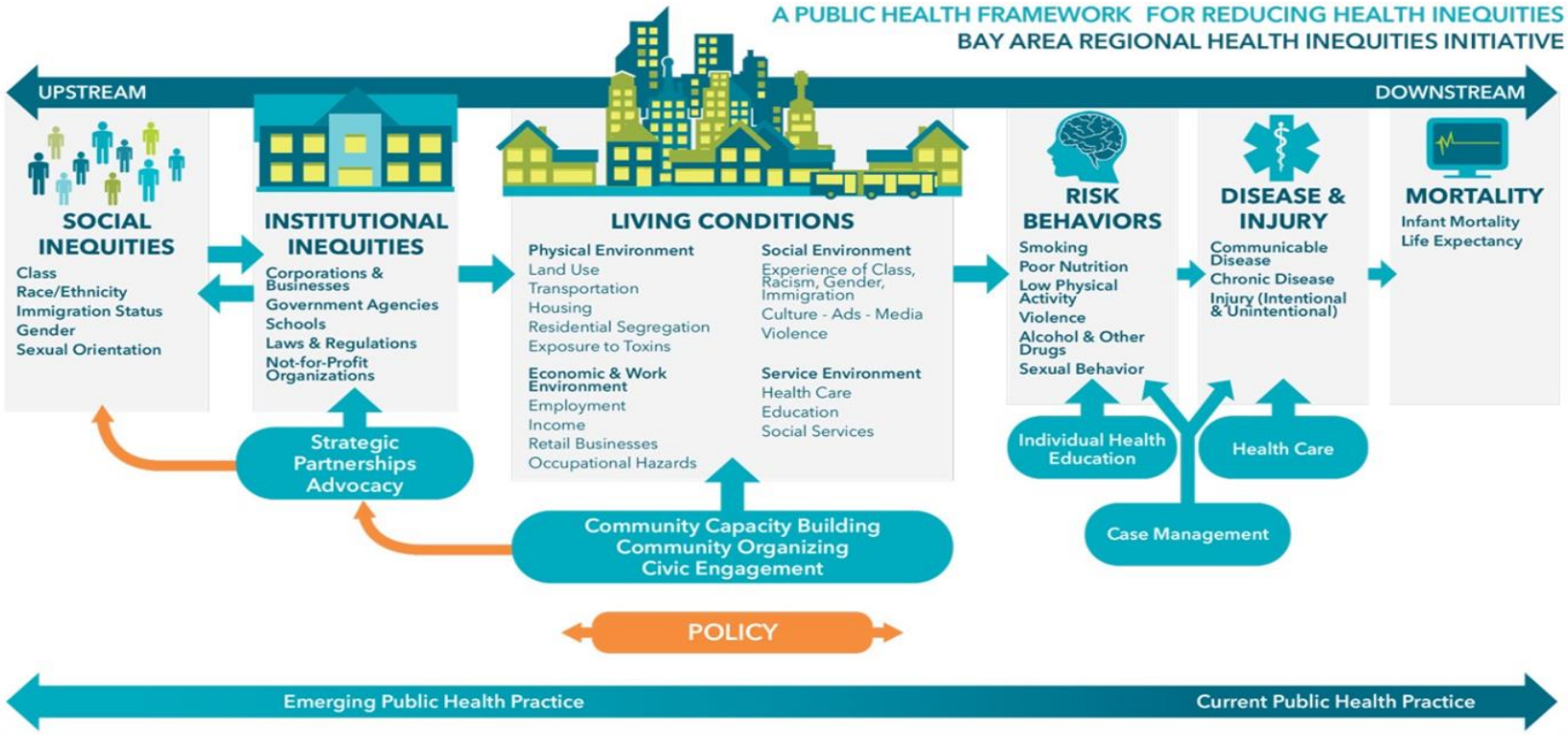
Address **policies and environments** to change these unjust systems ex: *housing policies, land trusts, etc.*

Increased Risk

Mitigate the **impact of the increased risk** caused by these unjust systems ex: *supportive housing, new development, stabilization initiatives*

Health-related Social Needs

Address the **immediate health-related social needs** caused by these unjust systems ex: *air conditioner vouchers*



Source: Adapted from the Bay Area Regional Health Inequities Initiative

The HPC seeks to advance health equity through many workstreams

The **HPC's care delivery transformation mission** is to promote an efficient, high-quality system with aligned incentives that reduces spending and improves health by delivering coordinated, **patient-centered care that accounts for patients' behavioral, social, and medical needs**

Investments

Investment programs offer opportunity to **identify issues related to health inequity**

SHIFT-Care Challenge includes a track specifically designed to address an identified social need

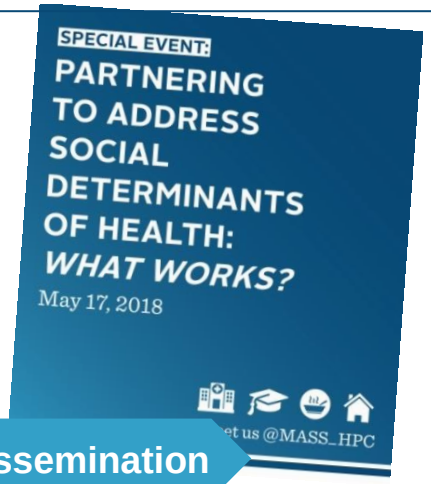
Many **CHART programs** focused on addressing health-related social needs (HRSN) to reduce avoidable acute care use

Certification standards

ACO Certification program standards encourage providers to prioritize population health management programs that address behavioral health needs and social determinants of health

Research

HPC's research often focuses on identifying gaps in care and areas of inequity (e.g. co-occurring disorders care)



Learning and Dissemination

Creates opportunities to share learnings and **provide forums for collaboration** across state agencies, local municipalities, and with advocacy groups

In May 2018, the HPC hosted an event entitled, "**Partnering to Address the Social Determinants of Health: What Works?**" which convened policymakers, experts, and market participants to highlight the need for cross-system partnerships to address HRSNs

The Case for a Coordinated Strategy to Align Health Care System and Community Health Initiatives

Context

- Health systems and accountable care organizations (ACOs) **have clinical and financial interest in improving population health and reducing health inequities**
- **Strong partnerships are necessary** for success; communities and health systems/ACOs need **technical assistance and capacity-building investment** to partner effectively

Challenges

- Difficulties working within individual health systems/ACOs, as well as in collaboration with external health systems, municipal governments, and community organizations to address HRSN
- Data can inform and promote collaborations between health systems/ACOs and communities to address the SDoH, but challenges and barriers exist that limit ability to share and collaborate effectively

Opportunity

- Support the development of **community collaborations that better align resources and policy levers**, including community health needs planning, community benefits programs, ACO population health approaches, municipal public health efforts, and determination of need programs, particularly in areas with demonstrated health needs/inequities

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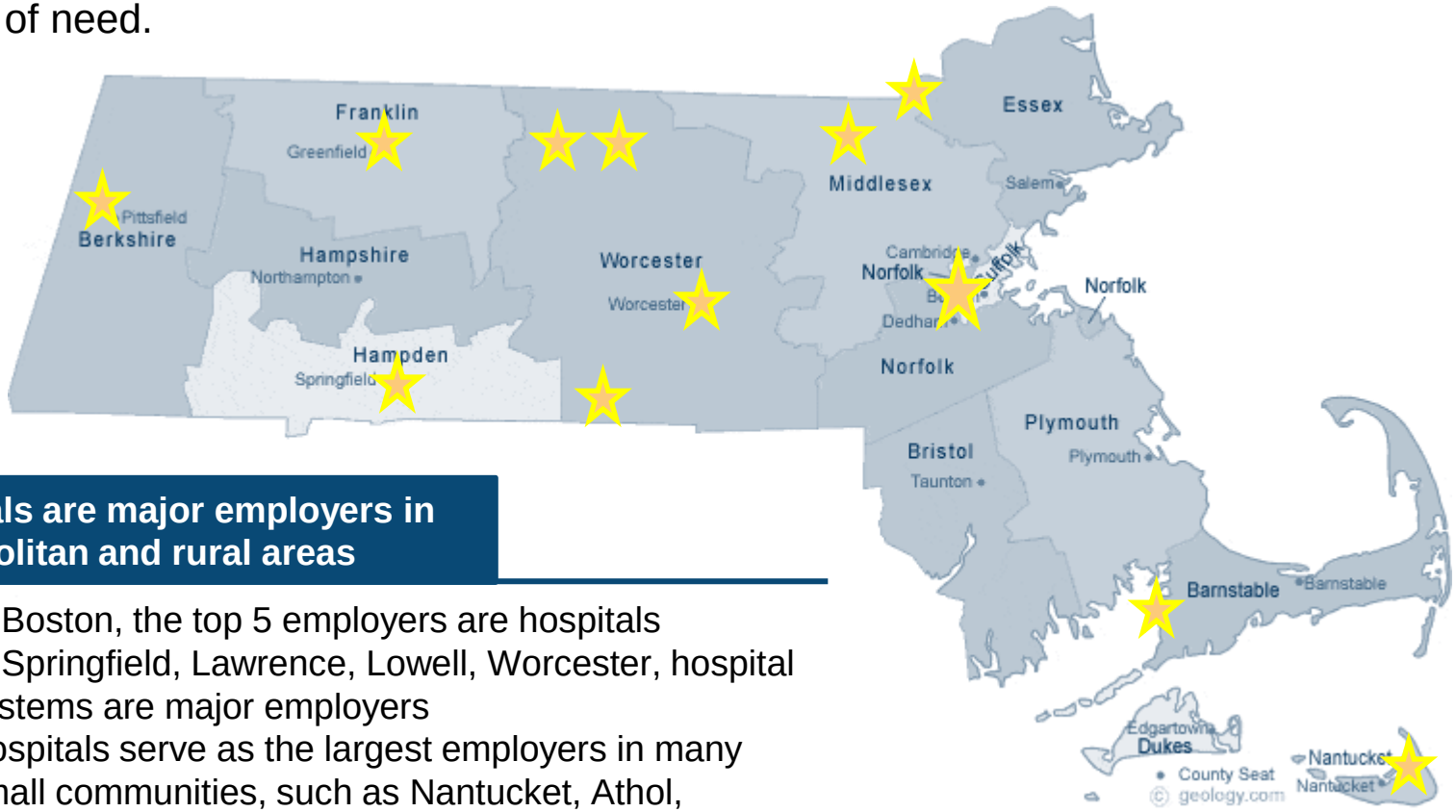
Health systems play an important role in their communities and are well-positioned to collaborate on "upstream" initiatives to improve health

Hospitals and health care systems play an important role in communities as anchor institutions, care providers, employers, and community development collaborators. This provides a unique opportunity **to address health upstream**, collaborating with community-based and social service organizations and local municipalities to address areas of need.



Hospitals are major employers in metropolitan and rural areas

- In Boston, the top 5 employers are hospitals
- In Springfield, Lawrence, Lowell, Worcester, hospital systems are major employers
- Hospitals serve as the largest employers in many small communities, such as Nantucket, Athol, Gardner, and Southbridge

Source: Executive Office of Labor and Workforce Development, Largest Employers by Area; Massachusetts Health & Hospital Association, Hospital Directory:

There is an opportunity to leverage HPC's ACO technical assistance resources to drive "upstream" health system - community collaborations

~$2.5 million in funding over 3 years

- Overall HPC ACO Certification program goal is to **enable acceleration of care delivery transformation** towards value-based, integrated care, that addresses the behavioral, social, and physical needs of patients and communities
- TA program should **complement other HPC and state-wide efforts** that support ACOs to address HRSN (e.g. DSRIP)
- Opportunity to **support success and sustainability** of ACO Certification competencies including **population health management**

Introducing Moving Massachusetts Upstream (MassUP)

MassUP Vision:
Better health, lower costs and reduced health inequities — across communities and populations in Massachusetts — through effective partnerships between government, health care systems, and communities to address the social determinants of health.

- **A partnership across state agencies — DPH, MassHealth, AGO, and HPC**
- Goal: to engage in **policy alignment activities** and make **investments to support health care system–community collaborations** to more effectively address the "upstream" causes of poor health outcomes and health inequity

The MassUP action plan is envisioned to include four key strategies

Investment Program

- The HPC will fund a **competitive grant opportunity** for 2 community collaboratives to align SDoH investments across all 3 streams of the health inequity pathway: policies and environment, increased risk, and health-related social needs (see next slide)

Technical Assistance

- DPH will **provide dedicated TA either through staff or contracted resources** to the community collaboratives (e.g. programmatic content expertise, data expertise, convening/facilitation expertise)

Evaluation

- DPH **will analyze, document and disseminate the design elements necessary to address the SDoH** in clinical and community collaboratives

Aligning Policy

- MassUP will **identify policy opportunities and work to alleviate state-level policy barriers** across MassUP agencies and other SDoH influencing agencies

Investment Strategy Overview: Key Anticipated Awardee/Community Activities Over the Three Years of Investment

Planning and coalition-building

Health system/ACO(s) will **convene a partnership with municipal public health departments and CBOs with shared governance/decision making**. Engage trusted organization to facilitate.

Based on an **identified structural barrier to health** (e.g. transportation, housing), work with facilitator organization to **refine multi-level plan** (i.e., short, medium, and long-term strategies at each level of health inequity pathway) for addressing it

Strategy and program development

Develop necessary strategies/ approaches to community engagement, communication, IT/data collection and analysis, and staffing, including identifying at least 1 FTE dedicated to managing the effort cross functionally

Establish mechanisms to provide funding to CBO partners as appropriate, leveraging other funding as available (e.g. CBO, local foundation, alignment with existing or proposed DoN-CHI, alignment with or new Community Benefits expenditures, DSRIP, etc.)

Implementation and evaluation

Execute on multi-level plan

Implement **evaluation plan in partnership with DPH**

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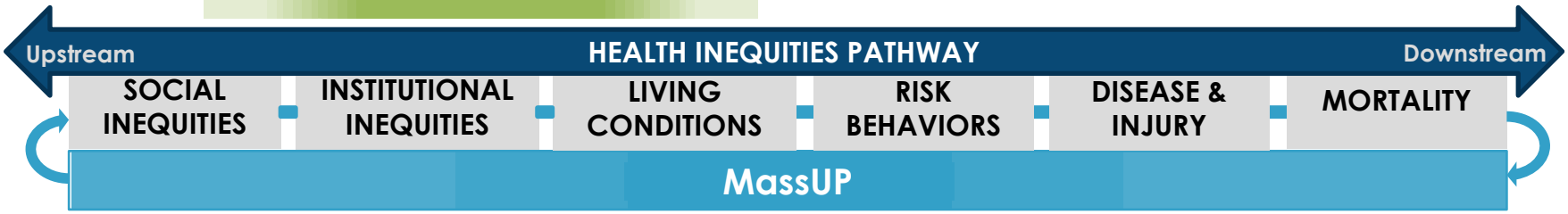
MassUP investments will complement the Commonwealth's efforts to address the SDoH across the health inequities pathway

MA DoN Community-based Health Initiative

Organizations seeking a DoN from DPH are required to **fund CHIs which support evidence-informed SDoH strategies addressing** EHS Health Priorities

MassHealth Flexible Services

Provides a payment stream for **MassHealth ACOs to provide services to address key HRSN:** housing and nutrition



AGO Community Benefits

Guidelines for non-profit hospitals and HMOs for implementing community benefit programs and performing Community Health Needs Assessments. Encourages **community engagement and consideration of: EHS focus areas (e.g. homelessness, SUD), DPH Health Priorities, and the role of racism in health care access**

HPC /AGO Grants

28 grants to providers and partnerships for **innovative programs that address the SDH and BH needs of complex patients.** Partnerships include health care organizations, non profits, CBOs, and government agencies

DSRIP

Supports successful implementation of launch the MH ACO program, including infrastructure development, Community Partner care management and relationship building, and statewide investments in workforce development and other areas

Aligning State Policy Strategy Overview: Identifying Opportunities and Catalyzing Policy Action

- **Explore potential mitigation strategies to address health-related regulatory or other legal barriers** identified by the community collaboratives in the course of their work (e.g. opportunities to use funds more flexibly)

- **Align guidance, investment,** and other requirements or opportunities where possible

- **Discuss additional state-level policy development opportunities** and recommendations to support MassUP's goals
  - Engage other state agencies as appropriate and through existing initiatives such as the Community Compact and associated implementation of Compact Best Practices

  - Engage stakeholders through current stakeholder bodies (e.g. MassHealth advisory groups, HPC Advisory Council, etc.) and/or a new dedicated group

MassUP Interagency Working Group on State-level Policy Change

Governance via a state agency steering committee, co-chaired by DPH and HPC

Advisory council of community stakeholders

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- Initial **investment in communities**
- **Policy leadership** and **subject matter expertise**

- **Subject matter expertise and policy leadership**
- **Alignment** with other resources/grant programs including use of DoN funds (state and local)

- Support for **Community Benefits learning collaborative**

MASSACHUSETTS EXECUTIVE OFFICE OF HEALTH & HUMAN SERVICES

- **Subject matter expertise**
- **Support alignment of agency resources and policies**

MassUP Program Tentative Timeline

	Investment program	Policy Work Group
2019	**May – June** • HPC-DPH draft and execute ISA **July – August** • Stakeholder engagement **September – October** • Finalize investment program design • Prepare RFR **November** • Issue investment program RFR	**May** • Work group kick off meeting **Summer** • Stakeholder engagement to identify key policy barriers to effective community collaborations **Fall** • Regular meetings to plan and prepare for Community Benefits Learning Collaborative
2020	**March** • Receive proposals • Select investment awardees **April** • Announce awards • Contract with awardees; program launch	**Winter** • Community Benefits Learning Collaborative

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Overview of the HPC's Partnership with MCHT

In September 2018, the HPC entered a partnership with digital health accelerator, MassChallenge HealthTech (MCHT), with the goals of promoting community-based providers' access to digital health solutions and identifying digital health tools that may address high-priority policy areas

Funding	▪ **1 Year: ~$170k commitment to support MCHT's operating costs and provide pilot funds to start-ups to test innovations in community-based provider systems**

Collaboration areas	**Source startups to address high-priority policy areas**	**Promote partnerships with community-based providers**	**Develop marketplace resources**
	Serve as a Champion in MCHT's Core Program, and issue challenge areas to source startups that are working to address them.	Promote partnerships between digital health startups and community-based providers through a scholarship program and through community-building events.	Co-author resource guides to the piloting and adoption of digital health solutions in a variety of provider settings in MA.

MCHT and the HPC co-hosted an event on digital health innovation and ACOs

Catherine Harrison
Deputy Policy Director, Care Delivery Transformation and Strategy
Massachusetts Health Policy Commission

Adam Landman
Chief Information Officer
Brigham and Women's Hospital

Laurance Stuntz
Director
Massachusetts eHealth Institute

Sree Chaguturu
Vice President of Population Health Management
Partners HealthCare

Matt Mullaney
Chief Financial Officer
Community Care Cooperative

Liz Asai
Chief Executive Officer
3Derm

"[T]he best discussions with startups are collaborative."
- Dr. Sree Chaguturu, Partners HealthCare

"*[G]reater provider engagement leads to better outcomes.*"
- Matt Mullaney, C3

"[I]f you told someone you were going to cut their dermatology referrals in half [in a FFS environment], they'd turn you away….we need to deliver a completely different pitch to each ACO."
- Liz Asai, 3Derm

HPC issued 5 challenge areas for startups aligned with policy priorities

1. Enabling health care providers and patients to prevent avoidable emergency department visits
2. Enabling employers and employees to prevent avoidable emergency department visits

3. Enabling health care providers and patients to prevent avoidable hospital readmissions

4. Enabling health care providers and patients to address health-related social needs
5. Enabling providers and patients to enhance timely access to behavioral health care

HPC

MCHT 2019 Cohort: HPC Matches and Activities

HPC worked with three startups as a Dedicated Advisor, and awarded two $25,000 scholarships to promote collaborations with community-based providers.

buoy

A chat bot clinically trained to converse with people to help make decisions about where to seek care (e.g. urgent care, ED, PCP)

DynamiCare HEALTH

Digital platform that addresses substance use by helping people monitor and change their use of drugs, alcohol, and tobacco, and rewards healthy behavior

Marigold HEALTH

Mobile app for anonymous text-based group psychotherapy for patients in substance use disorder care, moderated by a peer/clinician

Activities and Accomplishments with HPC Support

Met with Massachusetts Employer Health Coalition members and partners, including the Group Insurance Commission and South Shore Health

Discussed early usage data with HPC to identify consumer preferences and decision making trends

Presented solutions to HPC investment awardees and other providers via HPC-hosted webinar

Secured commitment from Lahey Health to pilot the platform, leveraging HPC scholarship funds

Developed a Spanish version of the app and will pilot it with Behavioral Health Network, leveraging HPC scholarship funds

HPC

The HPC is also collaborating with MCHT on a research project to support collaboration between community providers and digital health innovators

In addition to the scholarship program, Champion matchmaking program, and board of advisors participation, the Massachusetts Health Policy Commission is engaging in a research collaboration with MassChallenge HealthTech to develop a community health system focused innovation guide.

Stakeholder interviews	Focus Groups	Survey	Innovation Guide
Interview provider organizations with a history of digital health innovation	Host three groups – startups, and providers with and without dedicated innovation teams – to discuss innovation culture, operations, and ingredients for success	Seek input from a broader sample of startups and providers on similar topics	Develop a tactical resource for health systems and startups to collaborate more effectively

Focus Group Findings: Cultural and Operational Insights

*"**Breaking through [the silos] is key**…if you can commit to a process by which people from [all the relevant departments] can sit together and review [the solutions]…creating that process is important."* - Provider participant

Engagement from leadership is critical to establishing a culture of innovation

Alignment of digital health solutions with mission of expanding access, improving care, and lowering costs

Existing IT capabilities within the health system

Purposeful evaluation and business case planning

Representation from different departments in initial conversations

Parallel processing of pilot launch and contracting

Including the patient perspective

Strong provider champions who have credibility among their peers, enthusiasm, and a willingness to learn and explore

HPC

Focus Group Findings: Barriers and Possible Solutions

> *"**Fee-for-service is killing us right now**…dis-incentivizing providers from using a product like ours that provides better care at a lower cost"*
>
> - Startup participant

IT challenges within the health system

- **Significant time spent on contracting**
- **Lack of baseline data from the health systems for evaluation**
- **Lack of funding and staff resources**

Digital health solutions may lack interoperability with EHRs

- **Improved data sharing capabilities**
- **Cultural shift to seeing technology as a part of delivering health care**
- **Move towards value-based care**

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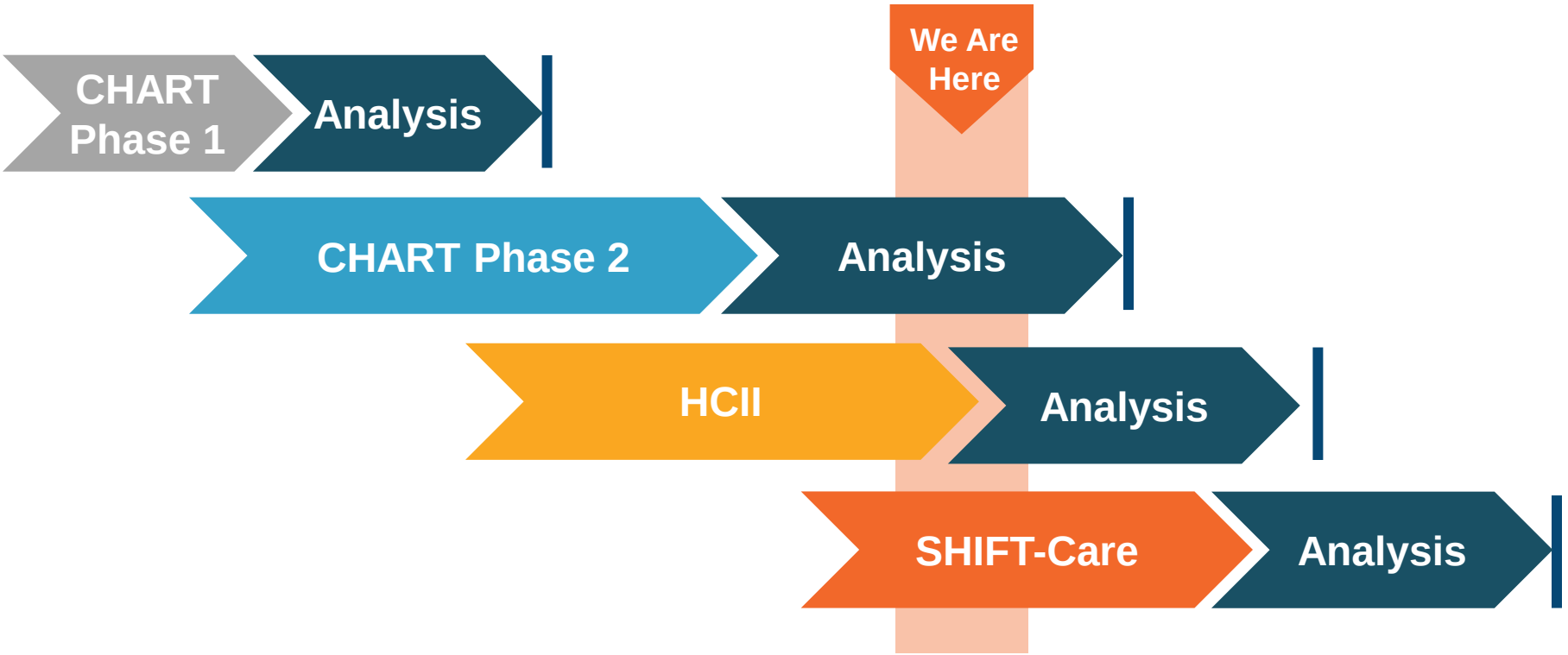
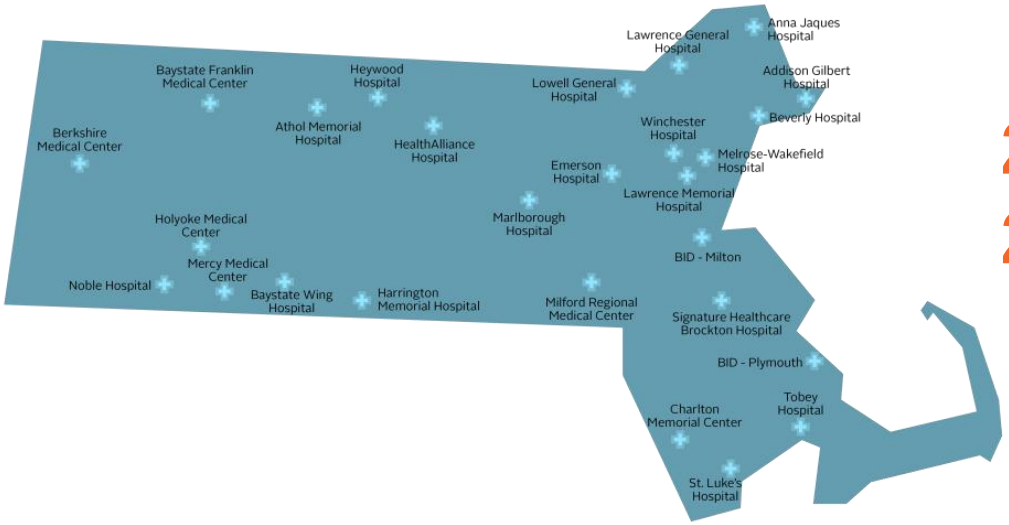
Impact analysis and evaluation are integral to each HPC Strategic Investment program



The following slides highlight emerging findings from the in-progress evaluations of the **CHART Phase 2** and **HCII** investment programs.

Overview of the HPC's CHART Phase 2 Investment Program



2 YEARS*
25 AWARDEES

CHART Phase 2 Program Goals

Orient organizations toward value based care

Integrate care across medical, social, and behavioral needs

Utilize data and analytics to better serve patients

Provide care in the most appropriate setting

*CHART Phase 2 programs launched on a rolling basis beginning September 2015 and were implemented over the period of 24 months, with the final Period of Performance ending January 31, 2018.

CHART Phase 2 Evaluation Report Outline

1 **Part One: Program Design, Implementation, and Strategic Planning**

A narrative that documents CHART Phase 2 from procurement through preparation, implementation, and the strategic planning process.

2 **Part Two: Impact**

Addresses the question "Were the goals of CHART accomplished? To what extent, and in what ways?"

- Acute care utilization
- Patient experience
- Provider impact
- Addressing the needs of complex patients
- Community partnership
- Operational use of data
- Sustainable organizational change

Report Development Timeline

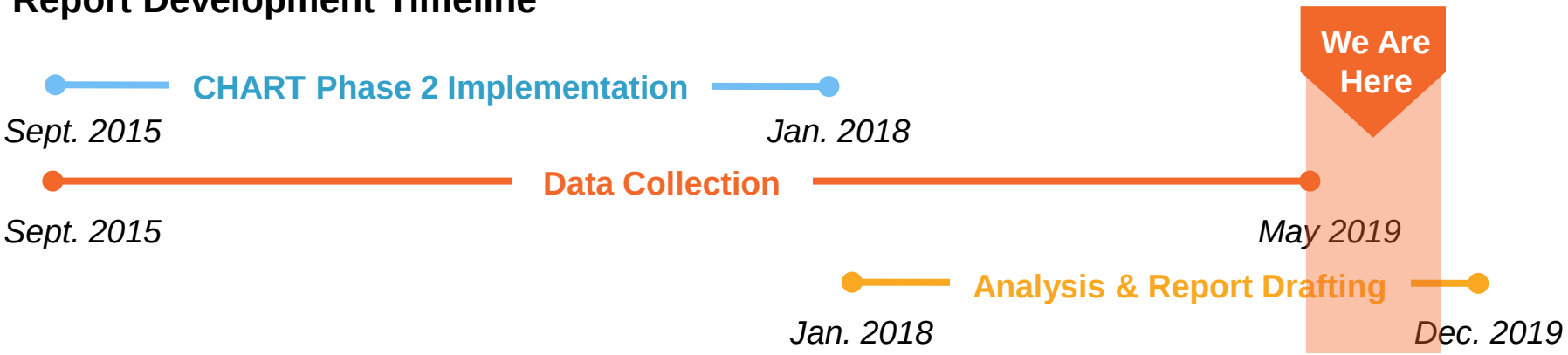


CHART Phase 2 Evaluation: Implementation Highlight

Most hospitals defined their target population based on a **history of high utilization or behavioral health diagnosis**.

Many hospitals also included **social complexity or medical complexity** as criteria eligibility.

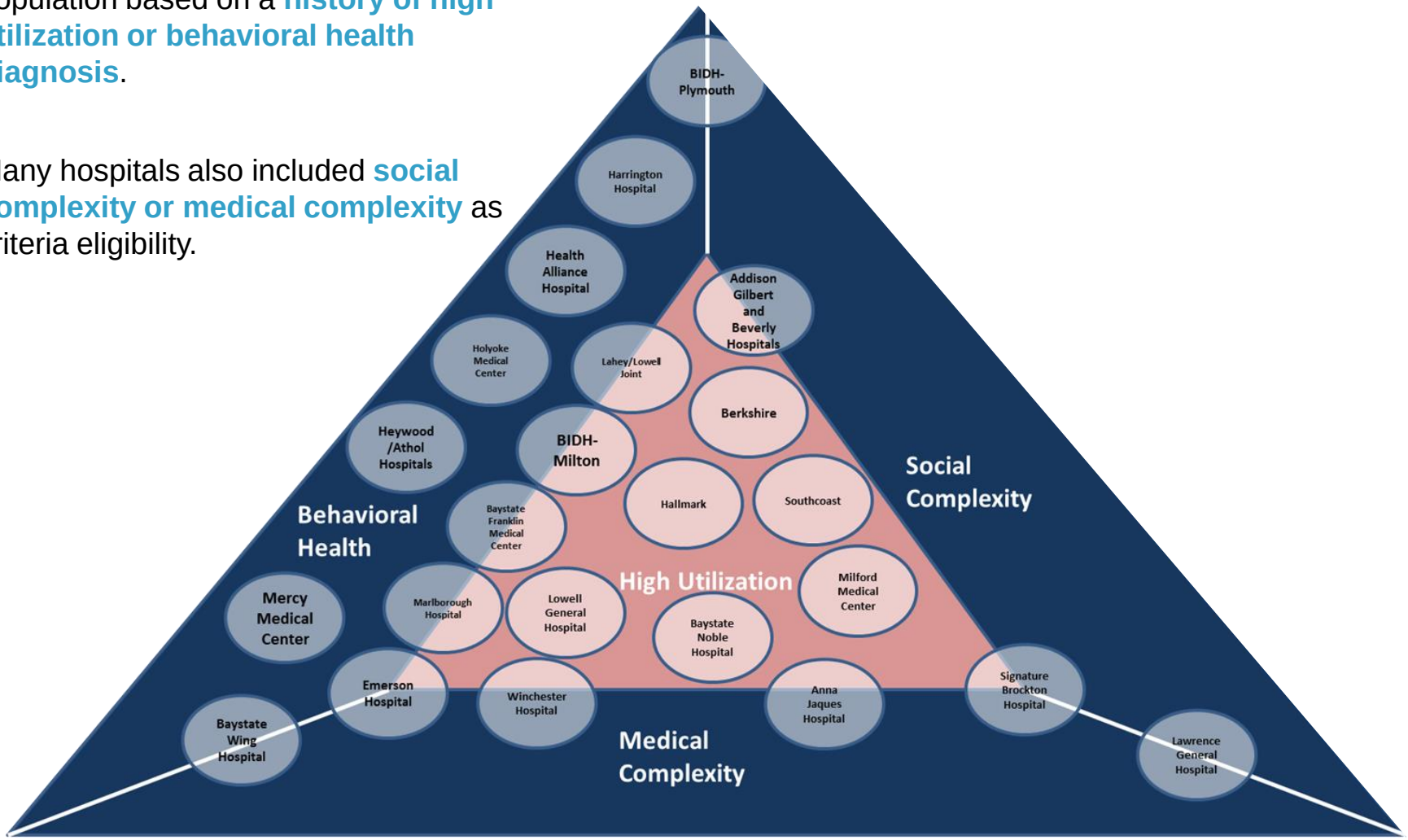


CHART Phase 2 Evaluation: Impact Highlight

Key themes from Boston University School of Public Health interviews with CHART patients:*

Complex patients' lives and experiences

- Stigma
- Multiple care providers not on the same page
- Confusion
- Gaps in care
- Disempowerment

What patients valued about CHART

- Individual attention
- Someone who cares and builds a relationship
- A person they can contact anytime, about anything

How CHART changed patients' interactions with the health care system

- Patients felt more confident, knowledgeable and able to advocate for their own priorities
- Less reliant on the ED to access care
- Noticed communication and coordination among their multiple providers

"You have somebody on your side…they made themselves available.

"… They helped me find a primary care physician.

"…they pay more attention to what I'm saying. And they ask more questions to dig deeper.

"…due to the CHART program they kept me out of the hospital.

*To conduct the Patient Perspective Study (PPS), the BUSPH evaluation team interviewed 51 patients from 8 CHART hospitals.

Overview of the HPC's Health Care Innovation Investment Program

The Health Care Innovation Investment Program (HCII): $11.3M invested in innovative projects that further the HPC's goal of **better health and better care at a lower cost.**

Health Care Innovation Investment Program: Three Pathways

	Targeted Cost Challenge Investments (TCCI)	Telemedicine Pilot Initiatives	Mother and Infant-Focused Neonatal Abstinence Syndrome (NAS) Interventions
Primary Goal:	Reduce health care **cost** growth while improving quality and access	Increase **access** to behavioral health care using telemedicine	Improve **care** for substance-exposed newborns
Target Populations:	8 diverse cost challenge areas: 	Patients from the following categories with Behavioral Health needs: 1. Children and Adolescents 2. Older Adults Aging in Place 3. Individuals with Substance Use Disorders (SUDs)	Pregnant women with Opioid Use Disorder (OUD) and substance-exposed newborns 

HCII Evaluation: Telemedicine Pilots Highlights

Promising signals of success deploying telemedicine models in clinical and non-clinical settings to underserved populations to increase behavioral health access, while achieving high levels of patient satisfaction

Emerging Findings

Heywood Hospital (Member of the Heywood Healthcare Family)

Over 3,300 contacts with students and families by School-based Care Coordinators

PPOC Pediatric Physicians' Organization at Children's

Patients receiving telepsychiatric assessment within 15 days of referral increased from 16% to 50%

Riverside Community Care THE HELP YOU NEED CLOSE TO HOME

81% of older adult patients who initially reported technology challenges reported an increased comfort using telemedicine

UMassMemorial Medical Center

Decreasing trend in 30 day readmissions

HPC

HCII Evaluation: TCCI Highlights

Diverse models are showing promising performance on cost reduction and a variety of outcome measures.

Behavioral Health Network: Families who were permanently housed more than **tripled**

Care Dimensions: Reduced readmissions by 21% among the enrolled population

Boston Health Care for the Homeless Program: Rate of preventive screening for colorectal cancer was nearly twice as high for patients enrolled in the TCCI program

Brookline Community Mental Health Center: ED visits fell from an average of 3.8 per patient per year to 2.6 per patient per year

Hebrew SeniorLife: Residents transported to the ED by ambulance decreased by 18%

Berkshire Medical Center: 95% of patients were satisfied with program services and would recommend them to a friend or family member

+ An innovative care coordination study performed by Brandeis including data from patient interviews and staff focus groups

HPC

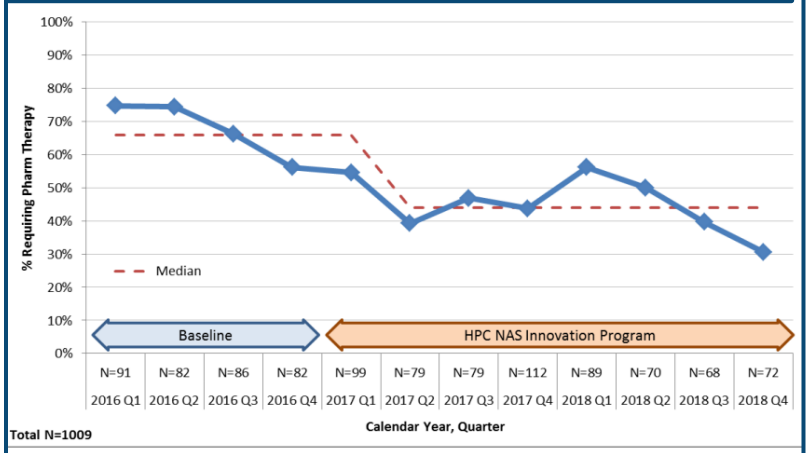
HCII Evaluation: NAS Highlights

Emerging Findings

- 1,244 mother-infant dyads served through 2018
- Substantial reductions were seen in length of stay, need for neonatal ICU care, and need for pharmacologic therapy
  - Suggests potential for significant cost-savings

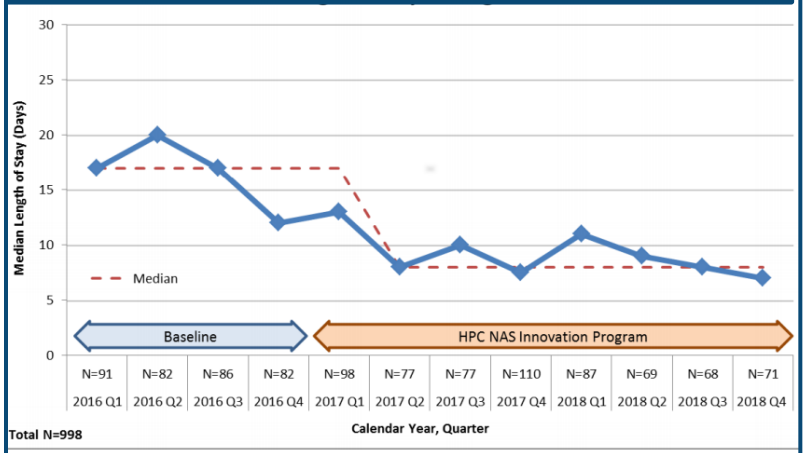
Note: data collection, cleaning, and visualization was completed in collaboration with NeoQIC

% of Term OENs Requiring Pharmacologic Therapy for NAS



The need for pharmacologic therapy decreased by 33% from 66% to 44%.

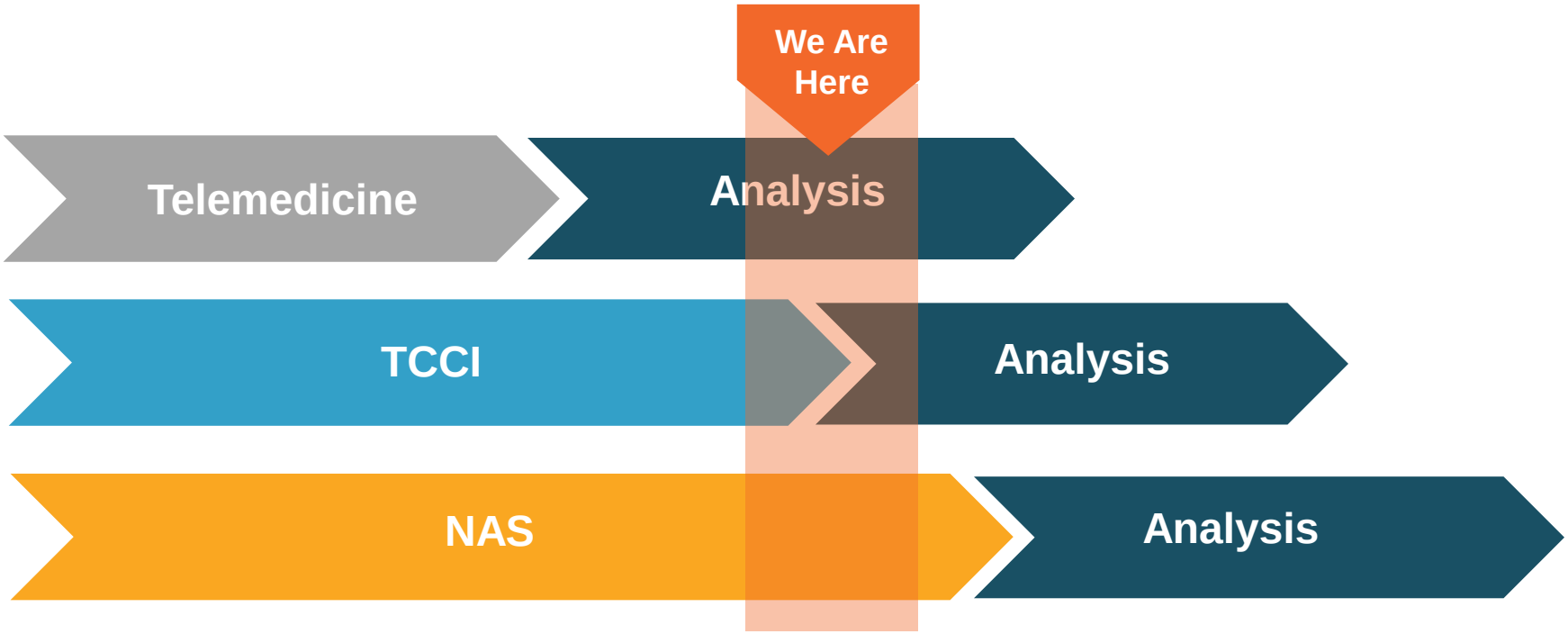
Median Length of Stay Among Term of OENs



Overall hospital length of stay decreased by 53% from 17 days to 8 days.

Note: Data shown reflect 1 year of NAS data; year 2 data is expected to be available by end of summer 2019.

HCII Internal Evaluation Timeline



	Program period end*		Evaluation report
Telemedicine	Fall 2018	- - - - →	Fall 2019
TCCI	Spring 2019	- - - - →	Spring 2020
NAS	Summer 2019	- - - - →	Summer 2020

*Telemedicine awards were contracted for 12 months of implementation, TCCI awards for 18 months, and half of NAS awards for 18 months, half for 2 years. Several awards entered into no cost extensions, extending the implementation periods.

MASSACHUSETTS
HEALTH POLICY COMMISSION

AGENDA

- Call **to Order**
- Approval of Minutes
- Learning and Dissemination Outputs: ACO Program Policy Brief #3 and Tele-Behavioral Health Guidance from HPC Awardees
- Program Design: MassUP Interagency Project to Align Population Health and Community Health Initiatives
- Partnership Update: MassChallenge HealthTech
- Evaluation Update: CHART and Health Care Innovation Investment (HCII) Programs
- **SHIFT-Care Awardee Spotlight: Holyoke Medical Center**
- Schedule of Next Meeting (October 2, 2019)

Overview of the HPC's SHIFT-Care Challenge Investment Program

The SHIFT-Care Challenge: ~$10M invested in **innovative, community-based, collaborative projects** that support and scale promising ideas to **reduce avoidable acute care use.**

SHIFT-Care Tracks

Health-related Social Needs

6 awards:
$4.2M

Addressing health-related social needs

Innovative models that **address health-related social needs** of patients with complex needs in order to prevent unnecessary acute care utilization

Awardees

Community Care Cooperative (C3)
Baystate Health Care Alliance
Boston Medical Center
Hebrew SeniorLife
Holyoke Health Center*
Steward Health Care Network

Medication for Addiction Treatment in the ED

9 awards:
$5.7M

Enhancing OUD treatment

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

Awardees

Addison Gilbert and Beverly Hospitals
BID-Plymouth
Harrington Hospital
Holyoke Medical Center
Lowell General Hospital
Massachusetts General Hospital
Mercy Medical Center
North Shore Medical Center
UMass Memorial Medical Center

HPC

*Holyoke Health Center's award is focused on managing care for patients with mild to moderate behavioral health needs in the primary care setting.

Care Model for Initiating Medication for Addiction 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 medication for addiction treatment (MAT) for patients with opioid use disorder (OUD).

In addition to initiating MAT, 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.

The care model builds upon Yale New Haven Hospital's efforts to offer ED-based buprenorphine initiation*:

What:

Identify patients	Enroll in program	Initiate MAT	Engage in recovery services
• Patient presents with symptoms of OUD or after an overdose	• SW/CHW/RC** recommends patient to program • Enrolls patient in program, with patient consent	• ED physician or other qualified prescriber initiates medication 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

* Some awardees also offer program services to eligible patients who are identified in the ED but are admitted to their inpatient units.
**Social worker, community health worker, recovery coach

SHIFT-Care MAT in the ED Awardees

Awardee	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 MA	$208,190	$742,407
Holyoke Medical Center	Western MA	$437,353	$750,000
Lowell General Hospital	Merrimack Valley	$202,203	$750,000
Mercy Medical Center	Western MA	$172,015	$486,580
MGH	Metro Boston	$549,414	$516,048
North Shore Medical Center	North Shore	$250,000	$750,000
UMass Memorial Medical Center	Central MA	$383,673	$550,000
	Total Costs:	**$8,727,108.94**	**$5,717,066**

HPC

SHIFT-Care Program Status Update

- All SHIFT-Care Awardees have launched
- The HPC has contracted with Brandeis University to facilitate collaborative learning and perform a cohort-wide evaluation of the nine hospitals focused on ED-based MAT initiation.

SHIFT-Care Challenge Awardee Spotlight: Holyoke Medical Center (HMC)

Holyoke Medical Center

Service Model

HMC's program engages with patients with OUD who present in the **ED, inpatient, or outpatient settings**, or are **identified in local courts and jails**.

Social workers assess patients' eligibility for the program. A **psychiatric advanced care practice nurse** who has a **waiver** to prescribe buprenorphine evaluates eligible patients then prescribes MAT or refers patients to next-day follow-up at HMC's Comprehensive Care Center (CCC), which offers walk-in access without a referral. Patients can also access mental health services at the co-located River Valley Counseling Center.

Patients who engage in the SHIFT-Care program are assigned a **nurse navigator** who coordinates appointments with primary care providers and refers to other services and providers as appropriate.

The Gandara Center trains and staffs peer recovery coaches in the ED during evening hours, to support patients in navigating available services.

Target Population

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

Primary Aim

Reduce ED visits by 20% for the target population compared to baseline in 18 months

Partners

- Gandara Center
- River Valley Counseling Center, Inc.
- Providence Behavioral Health Hospital
- Hampden County Sheriff's Department

HPC Funding	Total Initiative Cost
$750,000	**$1,187,353**

HPC

Bridging to Recovery

Introduction to

Massachusetts Health Policy Commission SHIFT-Care Grant

John Kovalchik, LICSW

Director of ACO Operations
SHIFT-Care Investment Director

Holyoke Medical Center

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Affiliations

Members of Valley Health Systems in Holyoke:

- Holyoke Medical Center
- Holyoke Visiting Nurse Association
- Holyoke Medical Group
- River Valley Counseling Center

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Communities We Serve

- The service area for Holyoke Medical Center includes **8 communities**: 3 in Hampden County, 5 in Hampshire County.
- The total population of the service area is over **180,000** people.
- Three of the largest communities (Holyoke, Chicopee and West Springfield) are located in Hampden County and contain **two-thirds** of the population served.
- Approximately **89%** of the population lives in urban areas.

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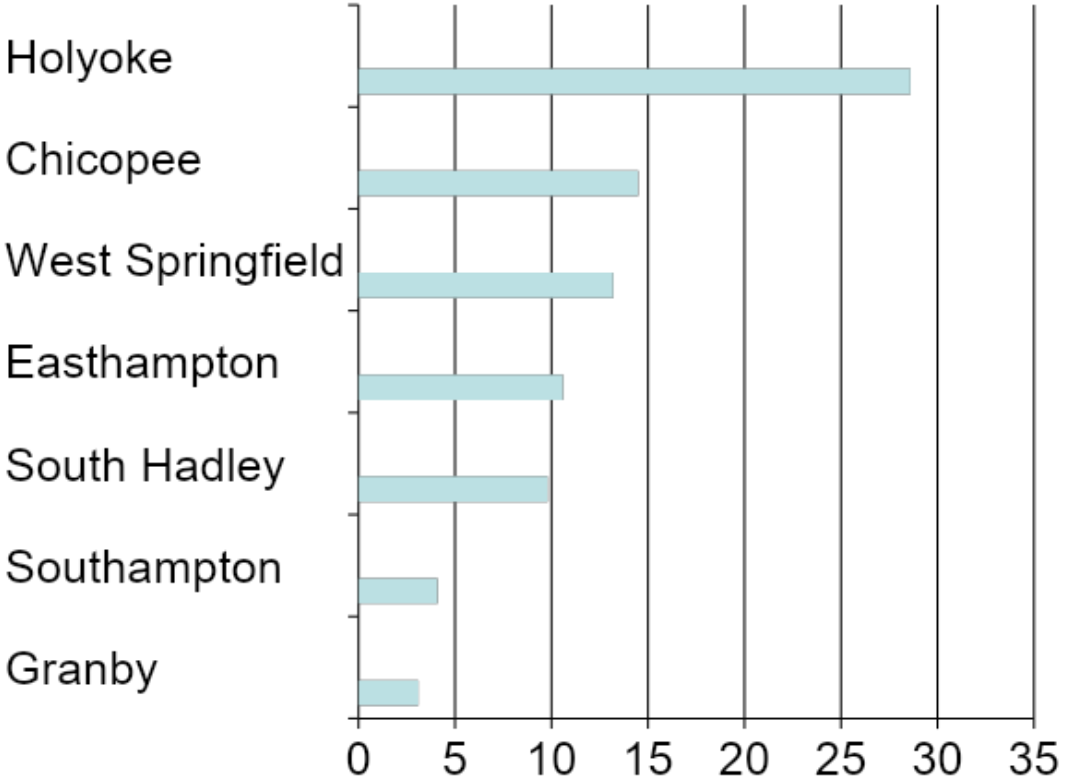
Demographics / Population in Poverty (%)

Holyoke, MA: Race (US Census)	
Hispanic/Latino	52.7%
White alone	42.3%
Black alone	3.5%
Asian alone	1.8%
Two or more Races	1.0%
American Indian alone	0.4%
Other Race alone	0.05%



2017 American Community Survey

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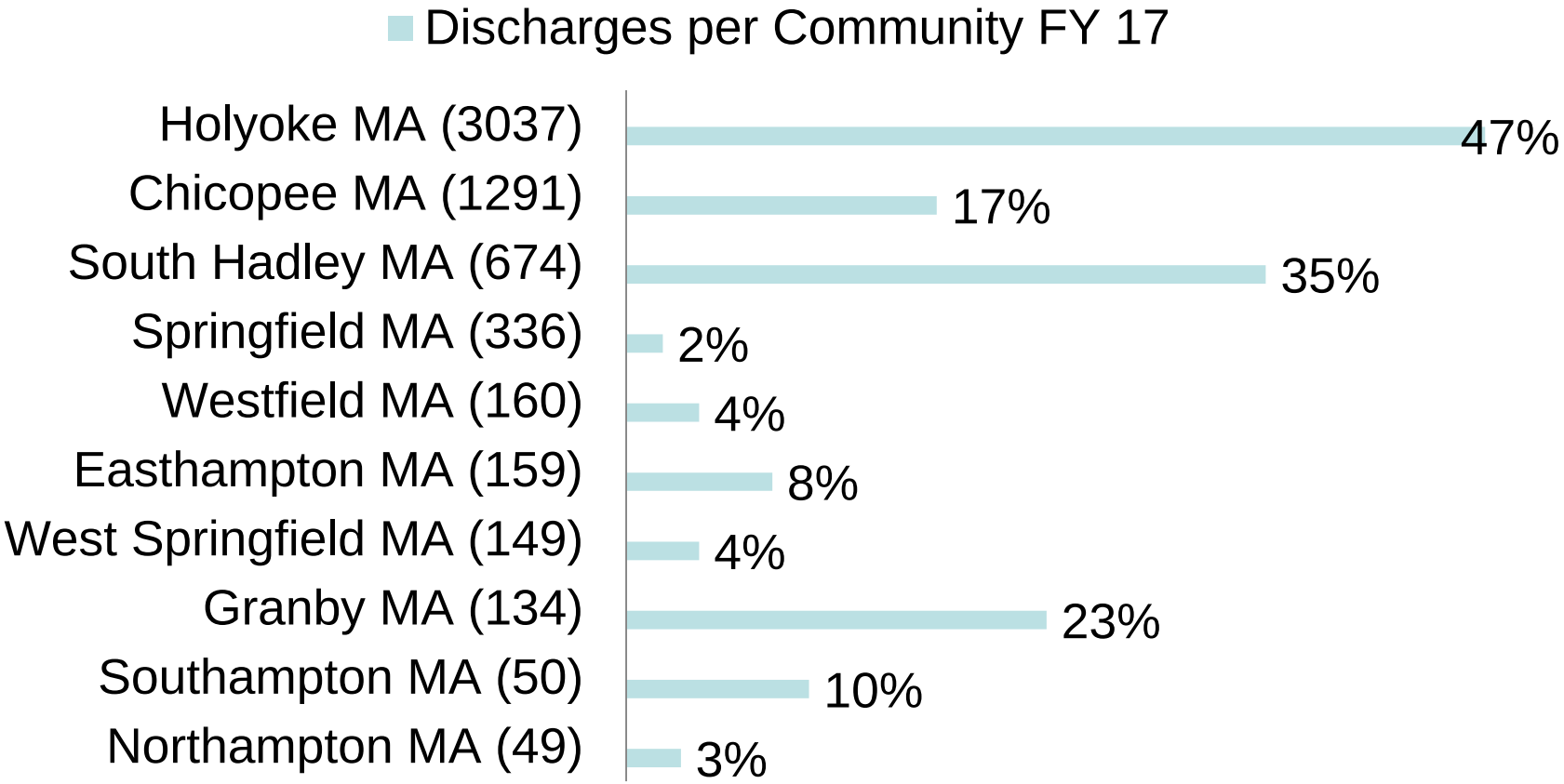
CHIA MA Hospital Profiles FY 17



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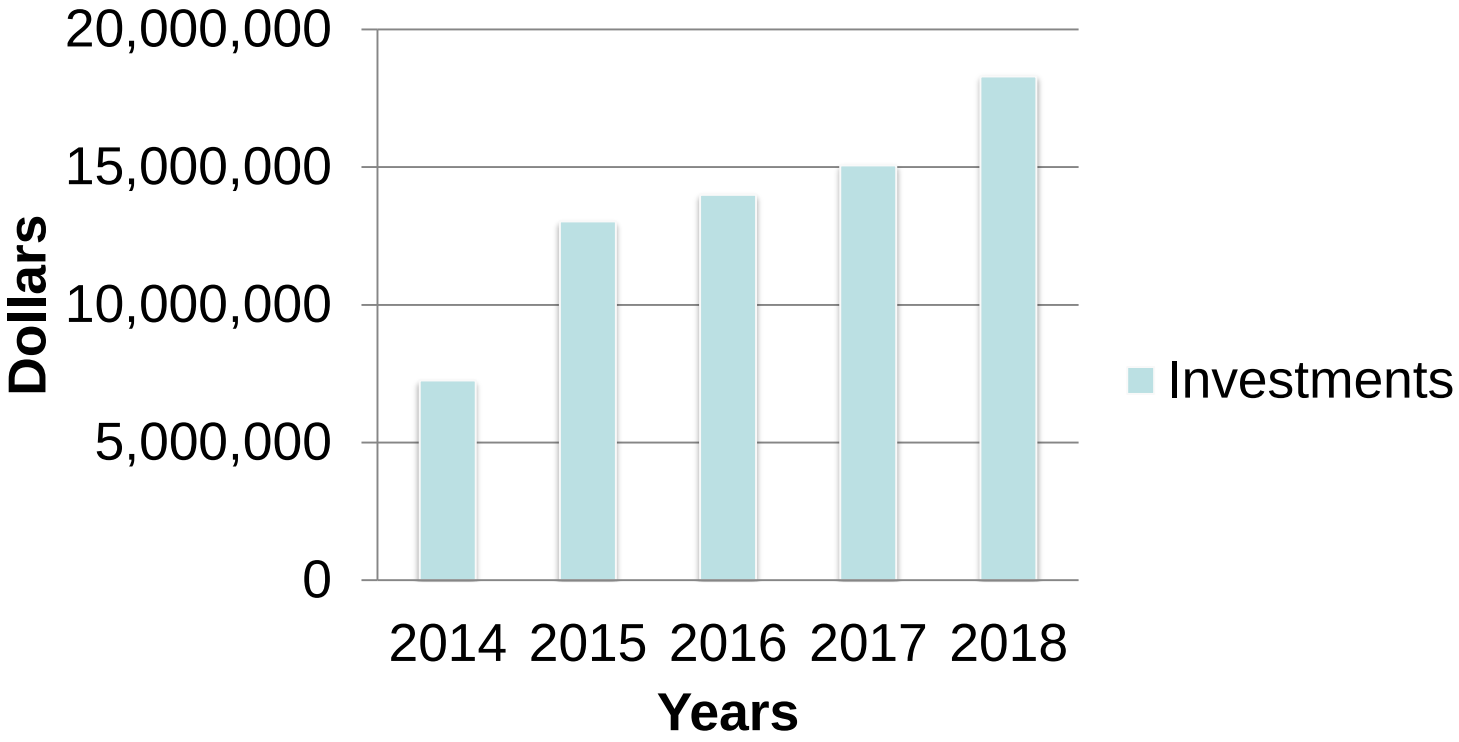
Community Benefit Investments



TOTAL INVESTMENT $67,640,038

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How We Invest In Our Community

- **Shuttle & Valet Service (Approx. 3,000 rides a month)**
- **Transportation to hospital**
  - *Dedicated Van service of PHP (Behavioral Health)*
- **Community meals (2x a month)**
- **Support groups**
- **Educational classes** *(nutrition, weight management, diabetes management, parenting, etc.)*
- **Community Health Worker outreach**
- **Workforce Development**
- **Coalition Building/Advocacy/Health Fairs**
- **Financial Consultation: access to coverage**

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Holyoke Medical Center

Our Mission

To improve the health of all people in our community.

Our Vision

To be the best place for care and the best place to work.

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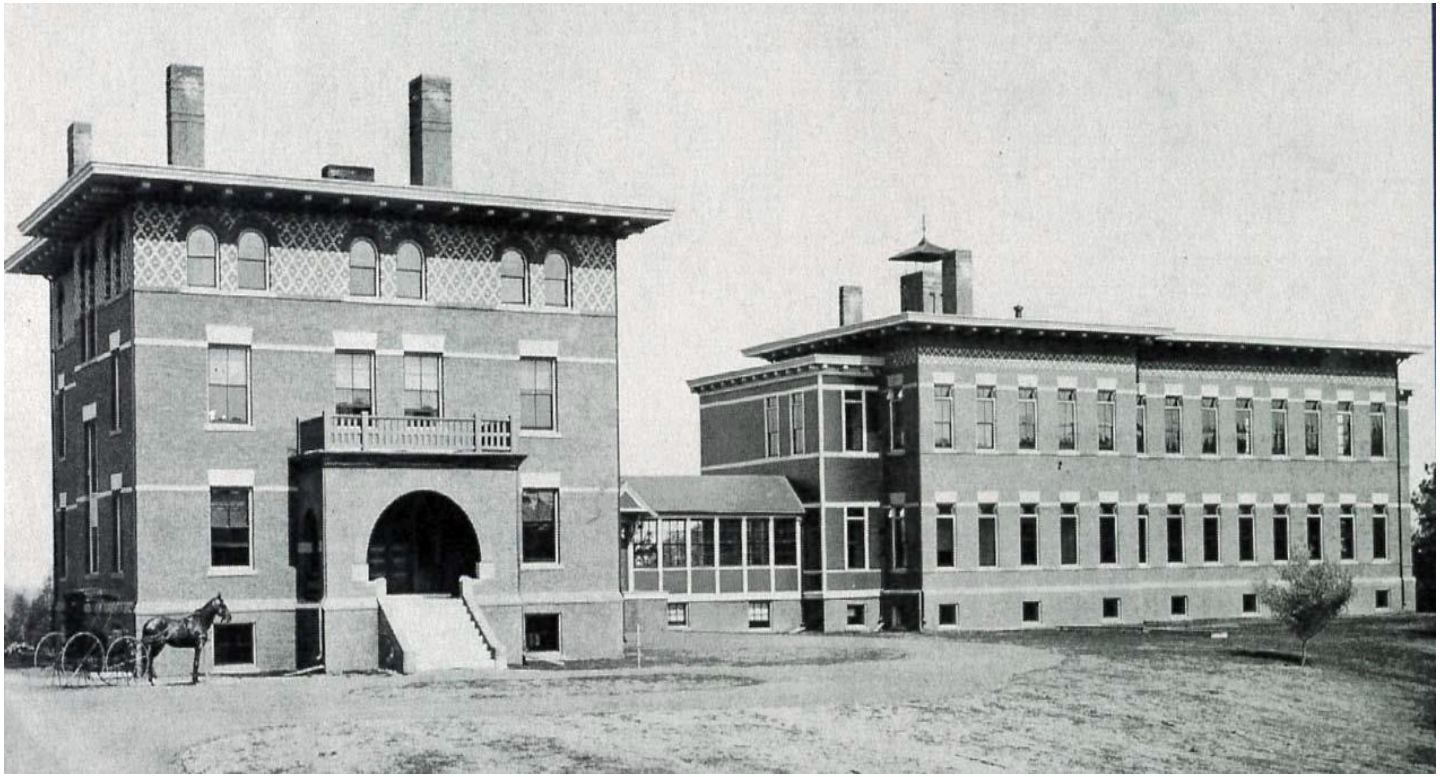
About Us

What started as a 40-bed hospital in 1893….



Holyoke Medical Center

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…has grown to be a **198-bed facility** with over **1,300 employees.** Each year Holyoke Medical Center admits more than **7,500 patients**, while the Emergency Department currently experiences an annual volume of more than **45,000 visits**.

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Center for Health Information and Analysis FY17

- Mid size Community High Public Payer (HPP)
  ~DSH/Safety Net Hospital
- Public Payer Mix: 76 %
- Outpatient visits: 123,788
- Readmission Rate: 14.5% (state average 15.4%)

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ISO 9001: 2015 Certified

- In 2018 Holyoke Medical Center achieved **certification** to the ISO 9001:2015 Quality Management System, reflecting our commitment to quality, transparency, and customer satisfaction

- We are the **first and only** hospital in Western Massachusetts to obtain this prestigious accomplishment
- **Valid for three years** and is provided by DNV GL – Business Assurance

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LEAPFROG

HOSPITAL SAFETY GRADE

Holyoke Medical Center

575 Beech Street
Holyoke, MA 01040-2223

View the full Score

This Hospital's Grade

https:/www.hospitalsafetygrade.org/

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Reasons We Responded to RFP

- Unique opportunity to stem what is considered by many to be a nation-wide epidemic
- High on the priority list for HPC as well as the Governor's office
- Dovetails with previous efforts supported by HPC (*i.e. CHART),* which bolstered BH resources and reduced recidivism to the ED for that population.
- Offered funding to support a behavioral health wing in our new Emergency Department

Emergency Department

HMC has the newest Emergency Department in the region

Opened July 6, 2017

21,460 square foot facility

40 treatment areas

Designated Behavioral Health area

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Reasons continued….

The grant aligns with many of our existing efforts:

MAT Clinic

Robust Case-Management/Care Navigation/Coordination of Care

Innovative technology to align patient care

Population-based care

Consideration of social determinants of health

Control of cost through the stewardship of resources

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At the heart 

Tragedy we at HMC deal with on a daily basis devastates families, the people we love and adversely impacts the communities we serve.

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- Between 2012 and 2013, Holyoke had a substance use emergency room visit rate that was **60% higher** than the state. (**2016 CHNA*)
- In the year 2015, **71%** of individuals entering treatment listed opioids as their primary substance. *(*MDPH www.mass.gov/chapter55/)*
- HMC substance abuse hospitalization rate was more than **3 times** that of the state. *(*2016 CHNA)*
- In 2016, between Holyoke and Chicopee, MDPH reports that there were **543 EMS incidents** related to opioids. *(MDPH Aug. 2017 EMS incidents www.mass.gov)*

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Bridging to Recovery

Introduction to Massachusetts Health Policy Commission SHIFT-Care Grant

Maria Quinn, MSN, PMHNP-BC
Psychiatric Nurse Practitioner
SHIFT-Care Program Manager

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Preparing Our Team

- Multidisciplinary weekly meetings
- Meeting with Emergency Department leadership and providers
- Meeting with community partners, Gandara Center and River Valley Counseling Center, leadership
- Engaging consultant
- Kickoff meeting with key team members, community partners and leadership

Identifying Our Intended Demographic

- One year look back at HMC clients with history of documented diagnosis as provided by HPC
- “Flag” created for these individuals so when they presented to HMC ED moving forward, flag will appear
- Brief chart review by team member prior to screening

HMC ED visits individuals with OUD Diagnosis

January and February 2019

- Approx. 100 ED visits each month*
- Almost ALL with BH diagnosis
- More than 45% Hispanic
- Approx. 15% Homeless
- Majority males
- Ages 26-40

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Of these visits…

- Approx. 30% were due to OVERDOSE
- Approx. 25% returned to the ED within 30 days

BRIDGING TO RECOVERY

Did You Know...

Holyoke Medical Center has received a $750,000 grant from the Massachusetts Health Policy Commission to help stem the opioid epidemic within our community. Through this grant, referred to as the SHIFT-Care Grant, we aim to:

1. Support individuals with opiate use disorder by connecting them with community resources and treatment options, including Medication Assisted Treatment (MAT).
2. Provide more stable community-based alternatives for patients who frequently utilize the ED.
3. Establish a network of community providers who can support these individuals on their road to recovery.

Addiction is a chronic disease, that over time results in brain changes that affects an individual's ability to control drug use and drug seeking behaviors, regardless of negative consequences. As with other chronic illnesses, addiction is treatable, and while there are medications available to assist with treatment, it's important to understand that there is no one pathway to recovery for everyone. Opioid addiction is an issue that is affecting our neighbors and families; as a community hospital we have the opportunity to make a difference.

To learn more, call John Kovalchik (ext. 2840) Maria Quinn (ext. 4835).

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www.HolyokeHealth.com

The road to recovery starts in the ED

- Social Work and Assessment Team (SWAT) will have an increased presence in the ED
- support individuals with behavioral health and addiction treatment needs
- identify and engage patients struggling with substances
- offer help connecting with resources
- offer treatment and support including MAT, peer recovery coaches, and individual and group therapy

Narcan

- provided to at-risk patients, or family members
- given upon discharge from the ED and other hospital units
- expected to reduce the risk of mortality by overdose in our community

Peer Recovery Coaches

- affiliated with The Gandara Center
- present in the ED in the evenings
- shown competency in their own personal recovery and use of coping skills
- have strong community relationships
- will serve as a guide or mentor to those currently in or seeking treatment

Community Navigation Team

- consists of nurses, community mental health workers, disease specific community health workers and other disciplines
- act as a point of contact to all potential patients
- address the social determinants of health
- link patients to community resources and services
- address medical, mental and social needs

HMC Comprehensive Care Center (CCC)

- outpatient office located in Suite 404 of Holyoke Medical Center
- offers MAT to our community
- collaborates with River Valley Counseling Center to ensure clients are connected to therapy services quickly
- walk-in hours available: 10am-12pm, Monday thru Friday

Model of Care

- Increasing Social Work presence in Emergency Department
- Peer Recovery Coach presence in ED during the evening hours
- Narcan to identified patients and family members
- Initiating Suboxone® in ED when appropriate, AND referring to treatment
- Addiction consults on medical floors
- Call center follow up to all patients who came through ED (opportunity to capture missed clients)
- RN Navigator to fill gap between ED and treatment by addressing barriers to recovery
- CMHW in each primary care office to support providers and patients with appropriate referrals and follow up

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Beyond the ED

- Collaborations with community partners
- Team members will be tracking how the patients who initiated treatment engage with treatment outside of the ED
- Once a patient is identified as eligible and added to the program, our team will be notified if they return to the hospital.

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Comprehensive Care Center

Providing medication assisted treatment and counseling for opioid dependency.

The Comprehensive Care Center at Holyoke Medical Center manages the use of prescription medication to treat opioid dependency, while licensed mental health counselors from River Valley Counseling Center provide psychological treatment and substance abuse counseling.

Help is available! Call for more information: (413) 535-4889

Holyoke Medical Center

575 Beech St, Suite 404 • Holyoke, MA 01040
Phone: (413) 535-4889
HolyokeHealth.com

6.2018

Comprehensive Care Center

- Located in Holyoke Medical Center
- Infectious Disease treatment
- Outpatient Medication Assisted Treatment
  - Suboxone®
  - Sublocade®
  - Vivitrol®

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Comprehensive Care Center

Open access hours Monday–Friday, 10am to 12pm

- RN driven program
- Bilingual clinical staff
- Partnership with River Valley Counseling Center
- Weekly clinical team meetings
- Onsite therapy to accommodate clients

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Gandara Center

- Peer Recovery Coaches in ED
- Hope for Holyoke

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Goals for SHIFT-Care funding

- Culture change
- Reduce number of ED visits
- Reduce number of AMA hospital discharges related to substance use/withdrawal
- Increasing access to recovery oriented services
- Providing Narcan and educating patients and family members around its use

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HEALTH POLICY COMMISSION

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- Partnership Update: MassChallenge HealthTech
- Evaluation Update: CHART and Health Care Innovation Investment (HCII) Programs
- SHIFT-Care Awardee Spotlight: Holyoke Medical Center
- **Schedule of Next Meeting (October 2, 2019)**

Upcoming 2019 Meetings and Contact Information

Board Meetings

Wednesday, July 24
Wednesday, September 11
Monday, December 16

Committee Meetings

Wednesday, October 2
Wednesday, November 20

Contact Us

Mass.Gov/HPC
@Mass_HPC
HPC-Info@mass.gov

Special Events

2019 Cost Trends Hearing
Day 1 – Tuesday, October 22
Day 2 – Wednesday, October 23

HPC