MINUTES OF THE COMMUNITY HEALTH CARE INVESTMENT AND CONSUMER INVOLVEMENT COMMITTEE

Meeting of October 14, 2015

MASSACHUSETTS HEALTH POLICY COMMISSION

THE COMMUNITY HEALTH CARE INVESTMENT AND CONSUMER INVOLVEMENT COMMITTEE OF THE MASSACHUSETTS HEALTH POLICY COMMISSION
Health Policy Commission Conference Center
50 Milk Street, 8th Floor
Boston, MA 02109

Docket: Wednesday, October 14, 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 regular meeting on Wednesday, October 14, 2015 in the Conference Center at the Health Policy Commission located at 50 Milk Street, 8th Floor, Boston, MA 02109.

Members in attendance were Dr. Paul Hattis (Chair), Mr. Rick Lord, Mr. Renato Mastrogiovanni, and Ms. Lauren Peters, designee for Secretary Kristen Lepore, Executive Office of Administration and Finance.

Ms. Veronica Turner called into the meeting.

Dr. Hattis called the meeting to order at 11:10 AM.

ITEM 1: Approval of Minutes from the June 3, 2015 Meeting

Dr. Hattis asked for a motion to approve the minutes from June 3, 2015. Upon motion made by Mr. Mastrogiovanni and duly seconded by Mr. Lord, the minutes were unanimously approved by the members present.

ITEM 2: Discussion of the 2015 Health Care Cost Trends Hearing

Mr. Iyah Romm, Policy Director for Care Delivery Innovation and Investment, reviewed themes from the Cost Trends Hearing that are relevant to the HPC's investment programs. He noted that the Cost Trends Hearing will inform the HPC's work for the remainder of the year.

Dr. Hattis asked the commissioners if they had any comments or reflections on the 2015 Cost Trends Hearing.

Mr. Mastrogiovanni stressed the importance of transparency, stating that consumers need to understand what they are buying. He added that the industry and key stakeholders must also convene around the evaluation of quality.

Dr. Hattis agreed that consumers need transparency, but noted that the information must be provided in a useful way. He noted consumers do not have a lot of support when thinking through a healthcare decision.

Ms. Turner agreed that transparency is one aspect that the HPC must address, but that it alone is not enough. She said there needs to be more focus on educating consumers.

Dr. Hattis reiterated the Governor's praise of Lowell General Hospital and the notion of maintaining value based providers in the community. He said that the CHART program has been trying to do that.

ITEM 3: Update on CHART Phase 2 Operations

Ms. Margaret Senese, Senior Manager for Care Delivery Innovation and Investment, said that nearly half of the projects for Phase 2 of the CHART Investment Program have launched. She noted that the HPC anticipates that nine additional projects will launch in November and the final four projects will launch in December.

Ms. Senese reviewed the project by Berkshire Medical Center, the first hospital to launch its Phase 2 program. She said that the HPC will provide $3 million to the Berkshire Medical Center for services to high-risk patients in Northern Berkshire County. This project aims to decrease 30-day readmissions by 20% and reduce 30-day returns to the emergency department by 10%. Ms. Senese said that grant dispersal is linked to these measurable endpoints.

Ms. Senese stated that patients at Berkshire Medical Center become eligible for services upon admission. She noted that the project team will create individual care plans for patients based on key clinical areas. She said this program will address social and behavioral health needs.

Ms. Senese noted that the HPC's CHART investment will fund salaries for additional members of the care team. She added that the Brien Center and EcuHealth will be partnering with Berkshire Medical Center in this endeavor.

Mr. Lord asked who identifies patients as high risk. Ms. Senese replied that the project team does an intake assessment when offering services to the patient.

Mr. Mastrogiovanni asked for clarification on the cost savings from Berkshire Medical Center's CHART project, the redistribution of these savings, and the incentive for institutions to adopt these practices. Ms. Senese responded that these questions are part of a larger conversation the HPC is having with the CHART hospitals. She stated that these conversations will primarily focus on program sustainability.

Mr. Mastrogiovanni asked for clarification on whether cost savings projections were included in hospital's application for CHART Phase 2 investments. Mr. Romm responded that all organizations submitted an impact estimate that included the average cost of a readmission, the number of admission they hope to prevent, and the projected savings. He stated that this only informed a crude estimate of savings, since all patients require different care with varying prices.

Dr. Hattis asked whether the HPC funded projects in which the crude estimate of savings was less than the grant. Mr. Romm responded that the HPC moved forward with two capital projects in which the crude savings were less than the grant. He noted that these estimates are complicated and theoretical and that CHART programs are helping to demonstrate the cost of different services.

Mr. Seltz stated that the goal of the CHART Investment Program is to pilot valuable work and sample opportunities that create a more efficient health care system. He added that successful programs should expand to other hospitals.

Ms. Senese reviewed the access aspect of Berkshire Medical Center's CHART project. She noted that about 30% of patients lack a primary care provider. She added that the CHART project will engage physicians and leverage telehealth. Ms. Senese noted that transportation is an issue for patients in Berkshire County. She said the project's patient assistance fund will help address this problem.

Dr. Hattis asked for an update on BID-Milton. Ms. Senese stated that BID-Milton's integrated care learning consortium is dedicated to learning and community building. She said they are convening community providers to move behavioral health treatment forward.

Mr. Romm noted that BID-Milton is the only hospital in the CHART program focused solely on advancing behavioral health care and reducing unnecessary ED visits. He said this focused on community linkage and partners.

Dr. Hattis said community partners are a good place to invest resources. He asked if there were any more questions.

ITEM 4: Discussion of CHART Phase 2 Evaluation

Ms. Cecilia Gerard, Deputy Director of Care Delivery Innovation and Investment, reviewed the goals of CHART Phase 2 evaluation: (1) to reduce preventable hospital utilization and enhance access to integrated behavioral and physical health services; (2) to identify processes that contributed to program success as well as those that did not; (3) to measure the outcomes of decisions made independently by hospitals; and (4) to assess the efficacy of developing a sustainable model for accountable, patient-centered integrated care at CHART hospitals. Ms. Gerard stated that the HPC is contracting with Abt Associates to provide a recommended approach to answering these questions.

Ms. Gerard said that the HPC is considering three factors in determining the end point of the evaluation. She said approaches are (1) how precise will an estimate of impact of the program be; (2) how much time will it take to deliver results; and (3) how much will an evaluation cost.

Ms. Gerard stated that the HPC could take a variety of approaches to evaluation. At one end of the spectrum, the HPC could employ a descriptive approach, which would assess information at the beginning and the end of the evaluation period so the HPC can judge progress over time. She said the appeal of this approach is its convenience. The HPC would create a baseline using two years of CHART Phase 2 data and assess results from that. She noted that this method is unable to identify what action is responsible for any changes.

Ms. Gerard stated that, at the other end of the spectrum, the HPC could also employ an experimental approach, which is the gold standard for program evaluation. This approach would afford the HPC a very good impact estimate for the program. She noted that this type of approach is not feasible because hospital funding was not randomly assigned.

Ms. Gerard concluded that the HPC's evaluation approach will fall somewhere between descriptive and experimental. She noted that staff is still working through some of the details of the approaches as part of the evaluation design.

Dr. Hattis asked for clarification on the comparison group against which the HPC will assess the results of CHART hospitals. Ms. Gerard responded by noting that all of the eligible hospitals are participating in CHART Phase 2, making it difficult to find a comparison group. She noted that other states could have hospitals with similar investment programs. She stated that staff is currently identifying these groups. Dr. Hattis highlighted that Connecticut is beginning a similar journey.

Mr. Mastrogiovanni asked for clarification on the HPC's contract with Abt Associates. Ms. Gerard responded that the HPC has engaged Abt Associates in a fixed price contract to deliver a report and analytic plan to meet the goals of evaluation. She said the contract lasts 10 weeks.

Ms. Gerard noted that every evaluation will include two components, a quantitative modeling of the impact of each hospital intervention and a qualitative assessment of organizational transformation using tools like case studies and patient and staff studies. She said the CHART staff's ongoing performance modeling will also be a part of the evaluation.

Ms. Gerard reviewed the CHART evaluation deliverables. The HPC expects to release an interim report that discusses baseline performance and early findings, a final report that includes a complete analysis, and a series of case studies on key findings.

Ms. Gerard stated that the staff will return to the CHICI Committee with a recommended evaluation approach in early December.

Dr. Hattis clarified that the HPC, in collaboration with Abt Associates, will create an evaluation design that combines the various approaches. Mr. Romm responded in the affirmative.

Mr. Seltz stated that CHART Phase 2 evaluation work will not be an insignificant work. He noted that the HPC is contracting with a third party because the agency does not have the resources to do the work in-house.

Mr. Mastrogiovanni asked whether Abt Associates can bid on the evaluation project. Mr. Seltz said they can.

Mr. Lord asked about the timeline for evaluation. Ms. Gerard stated that evaluation will begin once a contract is awarded. She added that it will begin with a baseline of performance for all CHART hospitals.

Mr. Romm said the period of performance is anticipated to be 24 months.

ITEM 5: Discussion of Health Care Innovation Investment Program

Mr. Romm introduced the Health Care Innovation Investment Program (HCII). He stated that the board needs to make several key design decisions related to the program, including whether the investments have a narrow or broad focus.

Mr. Romm reviewed the background of HCII, which is a $6 million program envisioned by Chapter 224. He noted that the statutory eligibility criteria are very broad, but the key goal is fostering innovation in payment and delivery.

Mr. Romm reviewed the various definitions of innovation. Committee members discussed these definitions.

Dr. Hattis stated that HCII is not about scientific discovery, but rather it is about bringing ideas to scale. He added that the HPC should provide more of a push in places where there is already innovation occurring.

Mr. Mastrogiovanni noted that the impact of $6 million does not need to be huge. He said that the funds will most effectively be used by focusing on a narrow topic.

Mr. Seltz said that the goal of HCII is not to invest in early stage innovation. He added that the funds could be used to distribute lessons from the CHART Investment Program or focus on removing barriers that may stifle innovation throughout the state. He reviewed opportunities for innovation in telemedicine and end of life care.

Mr. Romm introduced Mr. Griffin Jones, Program Manager for Care Delivery Innovation and Investment.

Mr. Jones reviewed various focused opportunities for impactful innovation. He noted that there is a mandate to focus these funds on areas where the market is already innovating and emphasized the role of feedback from stakeholders and advisors in framing the program.

Mr. Jones reviewed a market scan conducted by the HPC, which provides a sense of where innovation is occurring. He noted that patient and population centered technology are especially nascent.

Mr. Jones said this gives us evidence-based ways of approaching innovation, including encouraging collaboration. He said vertical partnerships are ways of encouraging innovation.

Mr. Seltz asked Mr. Jones for clarification on the scope of the market scan. Mr. Jones responded that the scan includes 30 innovation centers that are investing broadly in health care.

Mr. Jones noted that after the scope of HCII is defined, the HPC must determine how to select awardees. He noted that stakeholders have indicated their desire for a directive with the competitive process, through which the HPC can assert a narrow list of what innovation models are acceptable.

Mr. Jones asked CHICI members for feedback on the HCII program. Mr. Romm clarified that staff is seeking feedback on the narrowness of the program's directive and the process through which the HPC should receive and review market feedback. He also asked the committee about their priorities.

Ms. Peters responded that one of Secretary Lepore's priorities is gaining a better understanding of those 25% patients who incur 85% of health care costs. She said this is an identifiable cost

challenge that requires a focused look at the health care of this population. She noted these populations are high utilizers of behavioral health services so that could tie those both together.

Mr. Lord noted that all of the proposed areas of focus are viable options. He agreed with Ms. Peters on the need to focus on high-cost patients.

Dr. Hattis encouraged the inclusion of end of life care. He also noted the need for the HPC to engage the health care community around a common approach to address some of the system's cost challenges.

Mr. Romm reviewed next steps, including gathering stakeholder feedback and defining key priorities.

Dr. Hattis said they will look forward further stakeholder discussion.

ITEM 6: Presentation on Telemedicine Pilot Program Development

Mr. Jeff Knott, Clinical Officer, reviewed the HPC's telemedicine pilot program, which was funded through the Commonwealth's fiscal year 2016 budget process. He noted that the one-year program will distribute $500,000 to community-based providers and telemedicine suppliers to promote patient care within the community setting.

Mr. Knott added that the program will be judged on cost savings, patient flow, patient satisfaction, and quality of care. He noted three program objectives: (1) to demonstrate the cost savings potential of telemedicine, (2) to implement telemedicine model that improves quality and patient satisfaction, and (3) to develop and strengthen multi-provider regional partnerships related to telemedicine.

Mr. Knott said that Massachusetts has many examples of telemedicine. He noted that Neighborhood for Health is a program at Berkshire Medical Center that utilizes telemedicine for behavioral health.

Mr. Knott reviewed SignatureHealth's homeward bound model, which employs a combination of telemedicine and nurse-led home visits to support patients with COPD and CHF.

Mr. Knott said a remote clinician in a command center in a teleICU setting is able to monitor, consult and care for ICU patients in multiple locations.

Mr. Knott also reviewed a remote ICU care model from New England Healthcare Institute which was able to decrease mortality by more 20%, decrease ICU lengths of stays by 30%, and reduce costs of total care.

Mr. Knott stated the VA has long been a promoter of telemedicine. He noted a study which found that patient-hospital utilization decreased by about 25% with the initiation of psychiatric telemedicine services.

Mr. Knott also noted the University of New Mexico's Project Echo, which connects specialists with community providers to review difficult patients and determine the best course of treatment. He said the need for Hep C treatment was greatly reduced.

Mr. Knott stated that the HPC's telemedicine pilot program is still in the planning stages. Mr. Romm said that the main goal, at this time, is determining whether to sync the innovation program with the telemedicine program. He noted that synching these programs could help spread telemedicine across the Commonwealth.

Dr. Hattis asked if the legislature could impact how the HPC spends the $500,000. Mr. Seltz responded in the affirmative.

ITEM 7: Schedule of Next Committee Meeting

Seeing no further business before the committee, Dr. Hattis adjourned the meeting at 12:35 PM.