MASSACHUSETTS
HEALTH POLICY COMMISSION

Quality Improvement and Patient Protection Meeting

June 22, 2016

MASSACHUSETTS
HEALTH POLICY COMMISSION

AGENDA

- Approval of Minutes from May 18, 2016
- Presentation on HPC's Report Opioid on Opioid Abuse in Massachusetts, issued pursuant to Chapter 258 of the Acts of 2014
- Presentation from Hallmark Health on COACHH CHART Phase 2 Project
- Update on Neonatal Abstinence Syndrome (NAS) Investment Opportunity
- Schedule of Next Meeting

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HEALTH POLICY COMMISSION

Vote: Approving Minutes

Motion: That the Quality Improvement and Patient Protection Committee hereby approves the minutes of the Committee meeting held on May18, 2016, as presented.

Information Sessions for Providers on RBPO Appeals

In collaboration with the Massachusetts Hospital Association (MHA), the HPC will hold two information sessions on establishing an appeals process for patients of Risk-Bearing Provider Organizations (RBPOs).

Open to RBPOs and provider organizations seeking HPC certification as Accountable Care Organizations (ACOs), HPC staff will provide an overview of the appeals process requirements outlined in the recent Interim Guidance and respond to provider organizations' questions regarding implementation and reporting.

Thursday, July 14, 2016,10:00am-11:30am
Massachusetts Hospital Association, 500 District Avenue, Burlington, MA 01803

Wednesday, July 20, 2016, 11:00am-12:30pm
Health Policy Commission, 50 Milk Street, 8th Floor, Boston, MA 02109

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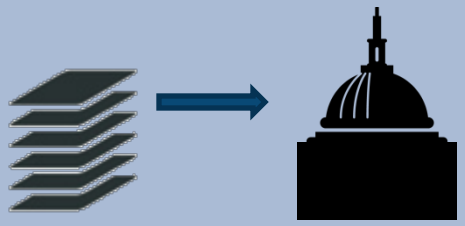
Primary aims of HPC's report on the opioid epidemic in Massachusetts, as required by chapter 258 of the acts of 2014

1

Providing new research, data, or evidence to support and inform policy



2

Draw on our experience with investment, certification & technical assistance programs

3

Identifying strategic policy opportunities for care delivery and payment reforms for substance use disorder treatment that are likely to result in reduced spending and improved quality/access

HPC

New and revised analyses since March 2016 QIPP meeting

Updated analyses

- Massachusetts hot spots
- Payer analysis
- Distance to MAT provider
- Opioid-related hospital visits by patient zip code

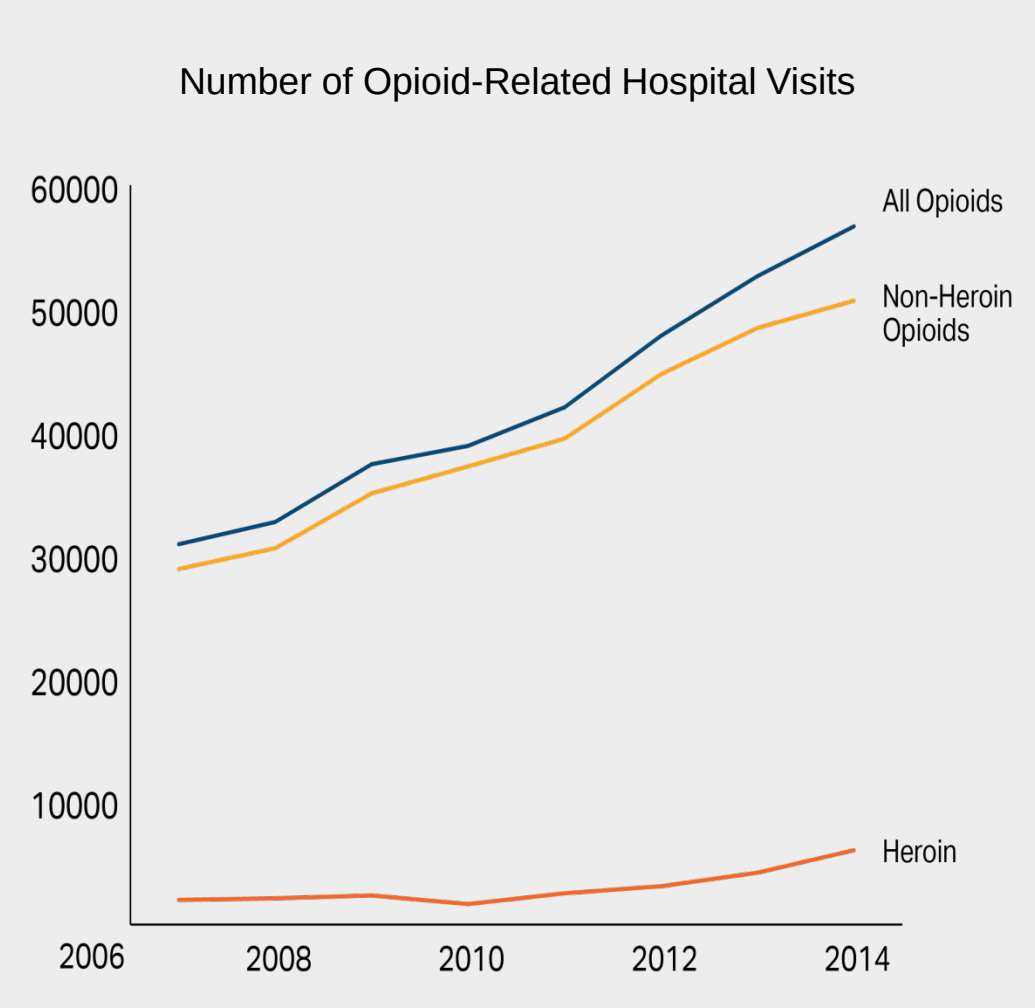
New analyses

- Opioid-related hospital visits by hospital
- Analysis of the opioid epidemic on gateway cities*
- Creation of opioid hospital utilization by city/down (as analog to DPH death rates by city/town)

See appendix for methodology notes

*Under M.G.L. c. 23A section 3A, a Gateway City is defined as a municipality with: population greater than 35,000 and less than 250,000; median household income below the state average; and rate of educational attainment of a bachelor's degree or above that is below the state average. For more information on gateway cities, please visit http://www.mass.gov/hed/community/planning/gateway-cities-and-program-information.html

The number of opioid-related hospital visits have increased substantially since 2007



Rate of Change of Opioid-Related Hospital Visits

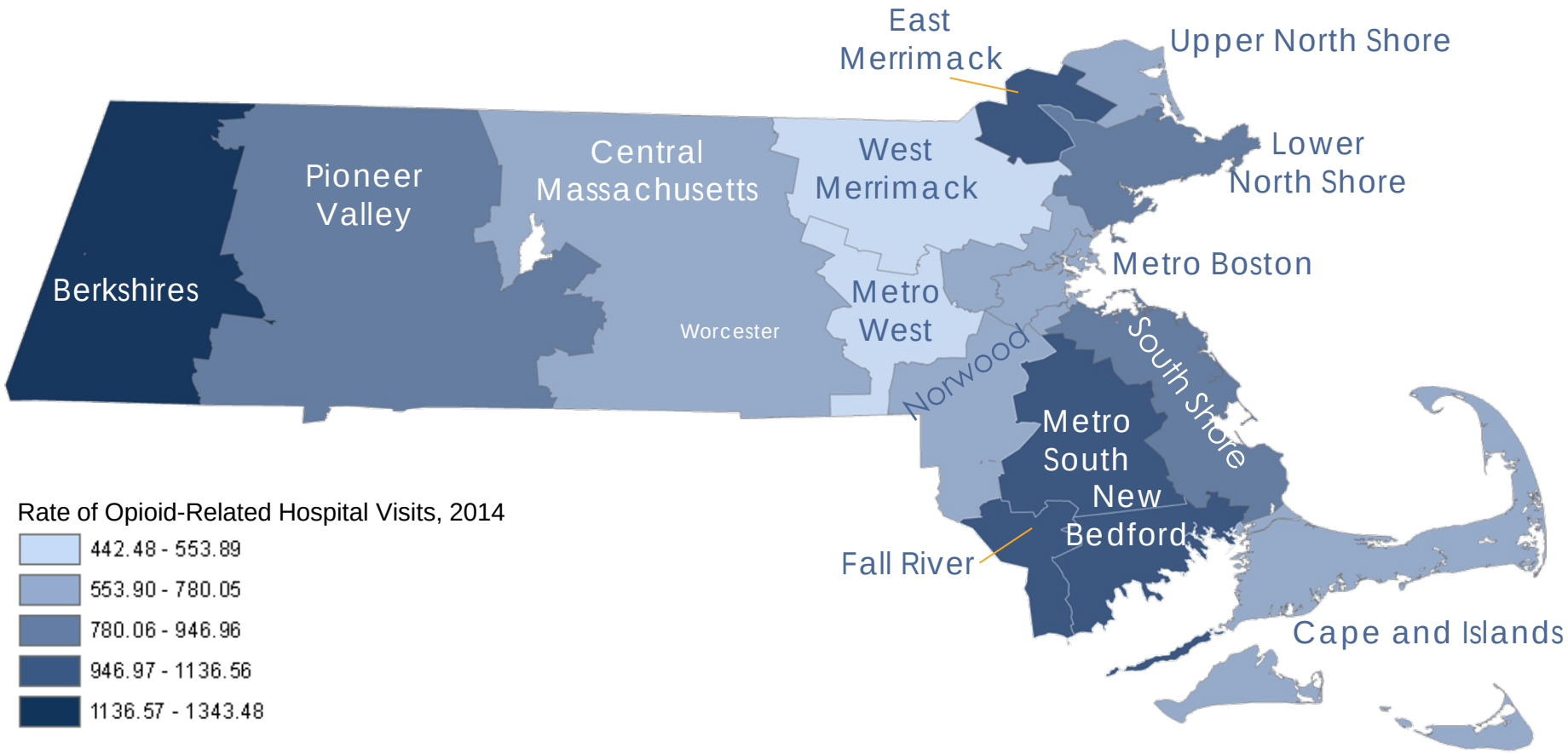
Years	Non-Heroin Opioids	Heroin
2007-2008	6%	6%
2008-2009	15%	11%
2009-2010	6%	-29%
2010-2011	6%	52%
2011-2012	13%	23%
2012-2013	8%	35%
2013-2014	5%	43%

201%

increase in heroin-related hospital visits between 2007 and 2014

Source: HPC Analysis—CHIA, Hospital Inpatient Discharge Database, Outpatient Observation Database, and Emergency Department Database, 2007-2014
See appendix for notes on methodology

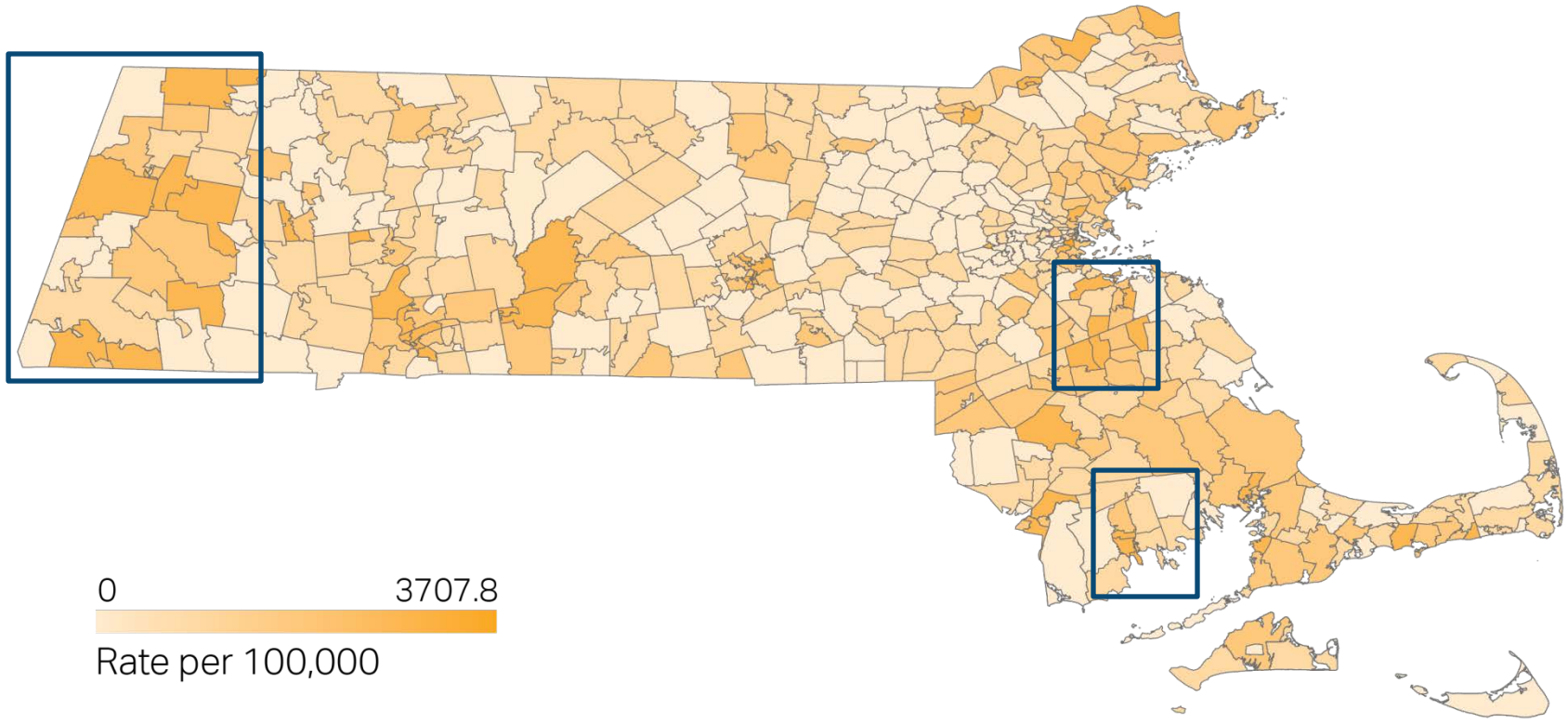
The rate of opioid-related hospital visits varies significantly across the Commonwealth (mapped by patient's zip code, not site of care)



Source: HPC Analysis—CHIA, Hospital Inpatient Discharge Database and Emergency Department Database, 2014; American Community Survey, 2009-2013.

Residents living in the Berkshires, Fall River, and Metro South regions are utilizing the hospitals for opioid related treatment at disproportionately higher rates

All opioid-related hospital visits by patient zip code, 2014

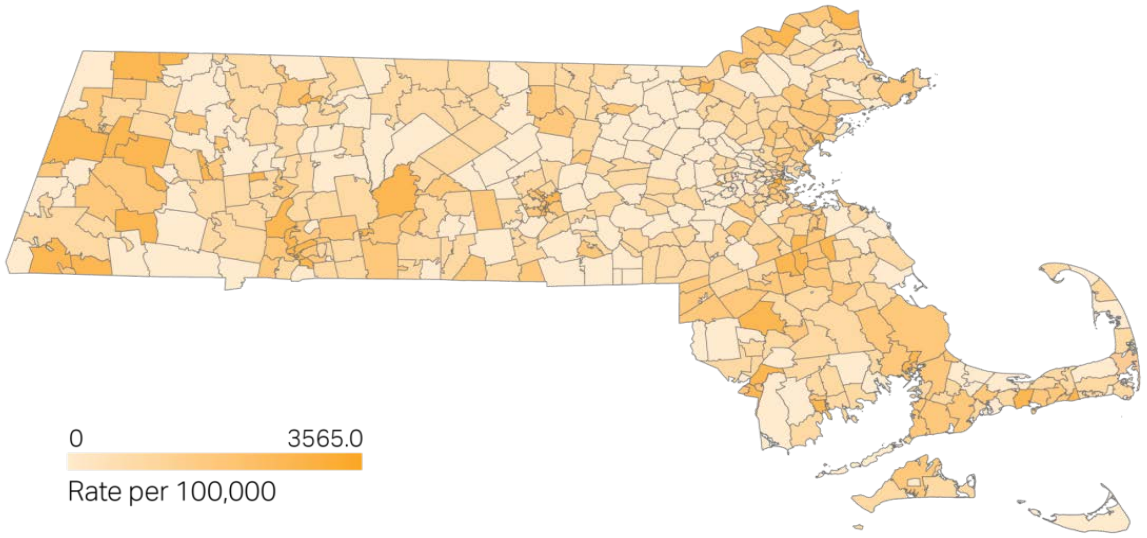


Darker shading indicates higher rates of admissions

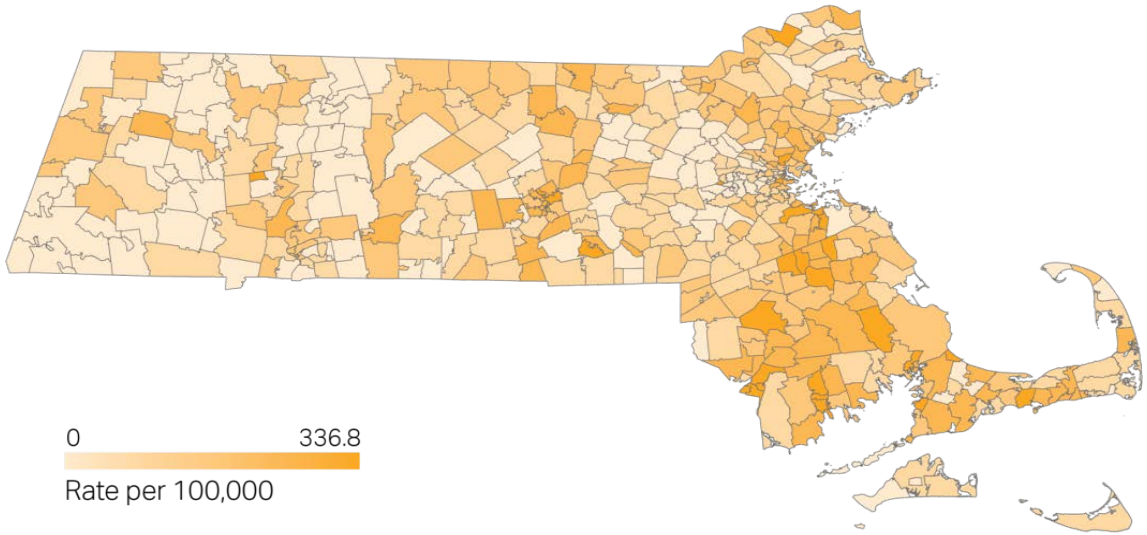
Note: Note: Hospital visits includes both ED visits and inpatient admissions. To control for extreme values in small communities, the rates were truncated at the 98th percentile

Source: HPC Analysis—CHIA, Hospital Inpatient Discharge Database and Emergency Department Database, 2014; American Community Survey, 2010-2014.

In general, the communities that have high rates of non-heroin opioid related hospital visits also have high rates of heroin related hospital visits



Hospital visits related to non-heroin opioids by patient zip code, 2014

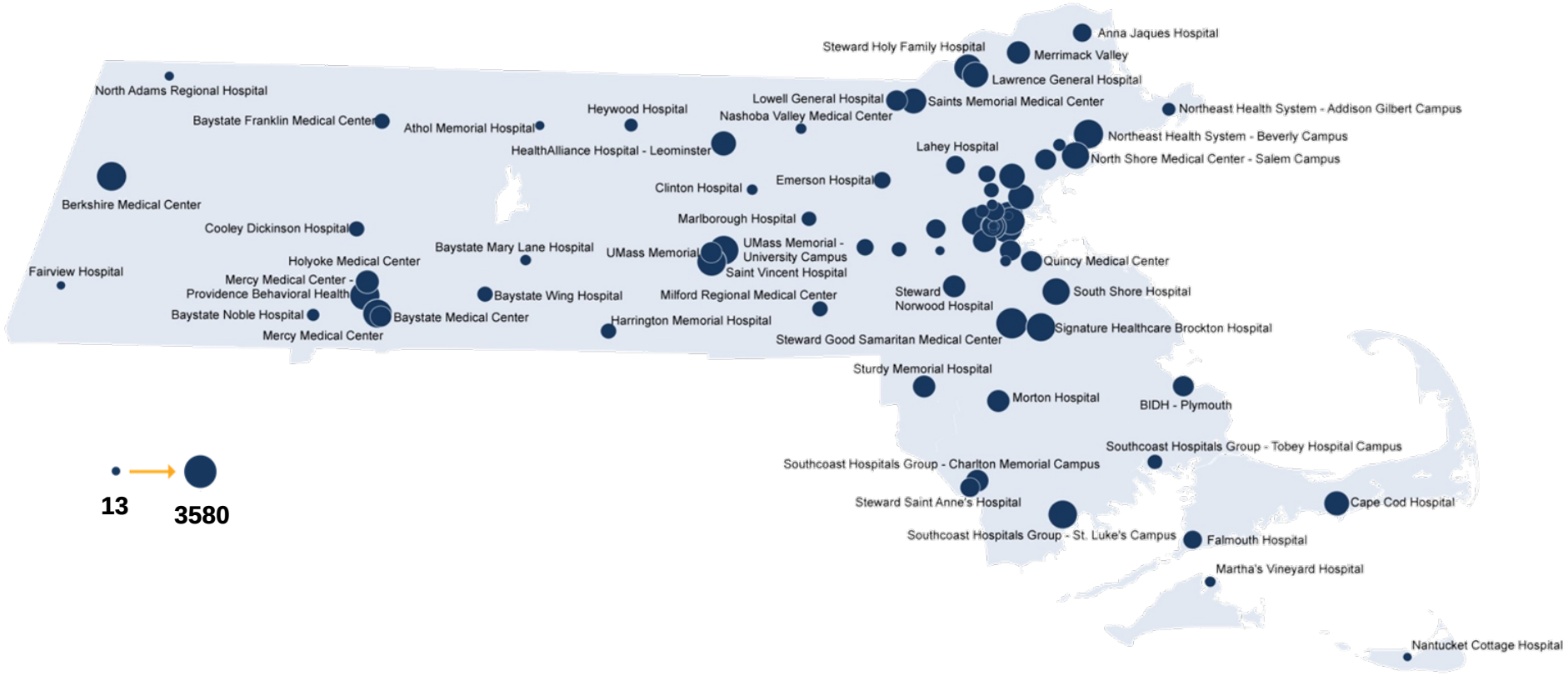


Hospital visits related to heroin by patient zip code, 2014

Note: Note: Hospital visits includes both ED visits and inpatient admissions. To control for extreme values in small communities, the rates were truncated at the 98th percentile

Source: HPC Analysis—CHIA, Hospital Inpatient Discharge Database and Emergency Department Database, 2014; American Community Survey, 2010-2014.

Hospitals treat large numbers of patients for opioid related illness (mapped by volume per hospital, not patient residence)



Note: Hospital visits includes both ED visits and inpatient admissions.
Source: HPC Analysis—CHIA, Hospital Inpatient Discharge Database and Emergency Department Database, 2014

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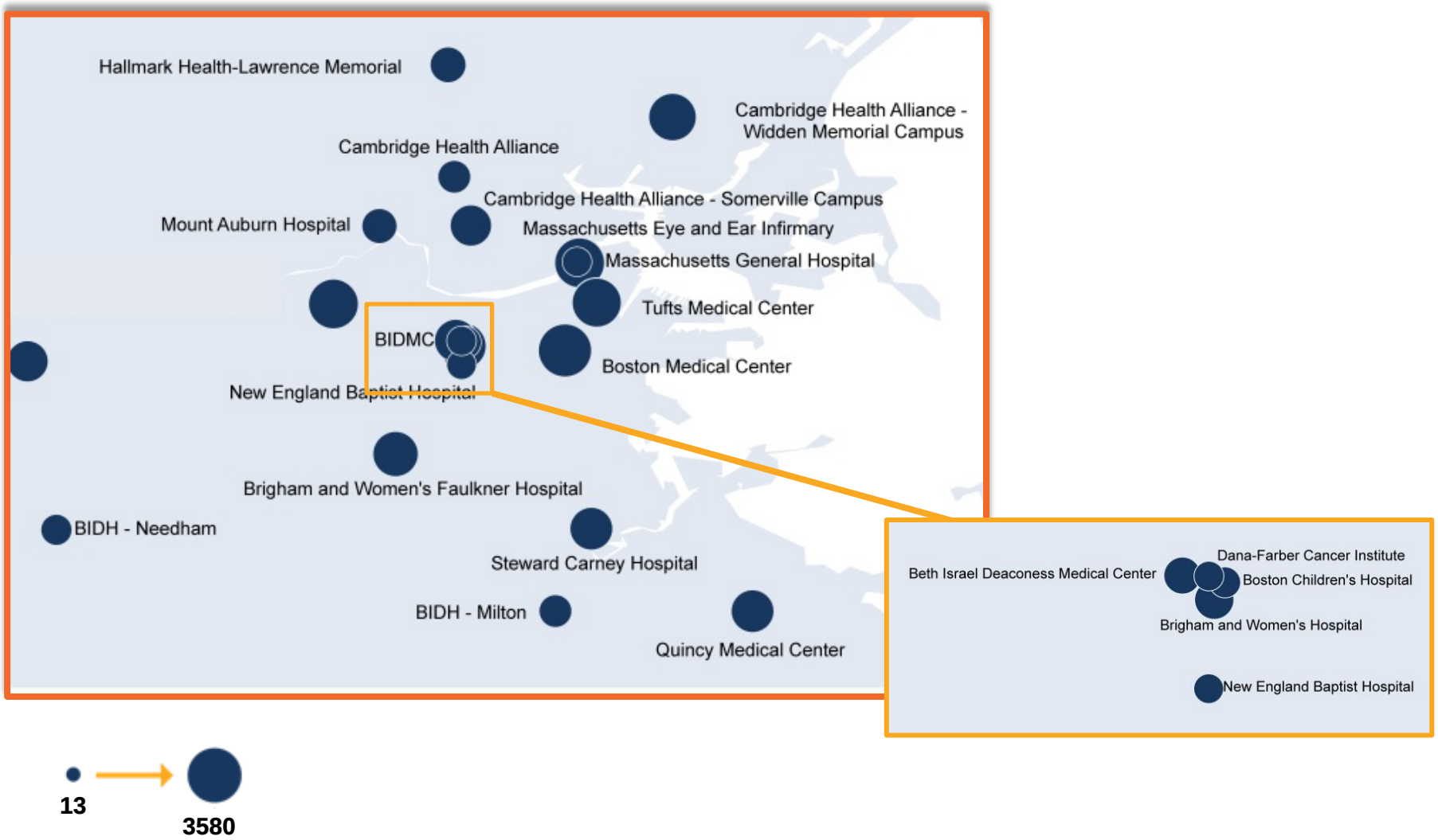
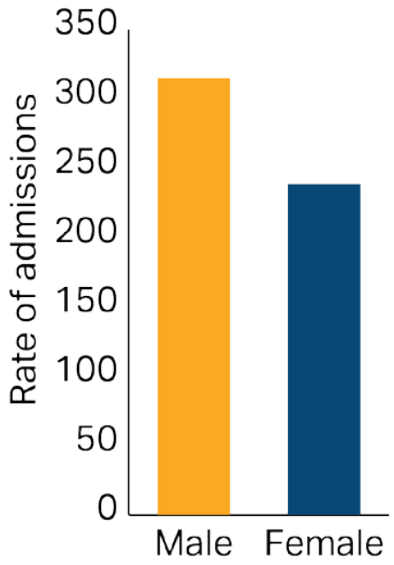


Note: Hospital visits includes both ED visits and inpatient admissions.
Source: HPC Analysis—CHIA, Hospital Inpatient Discharge Database and Emergency Department Database, 2014

More males, young adults and individuals from low-income communities had an opioid-related inpatient admission

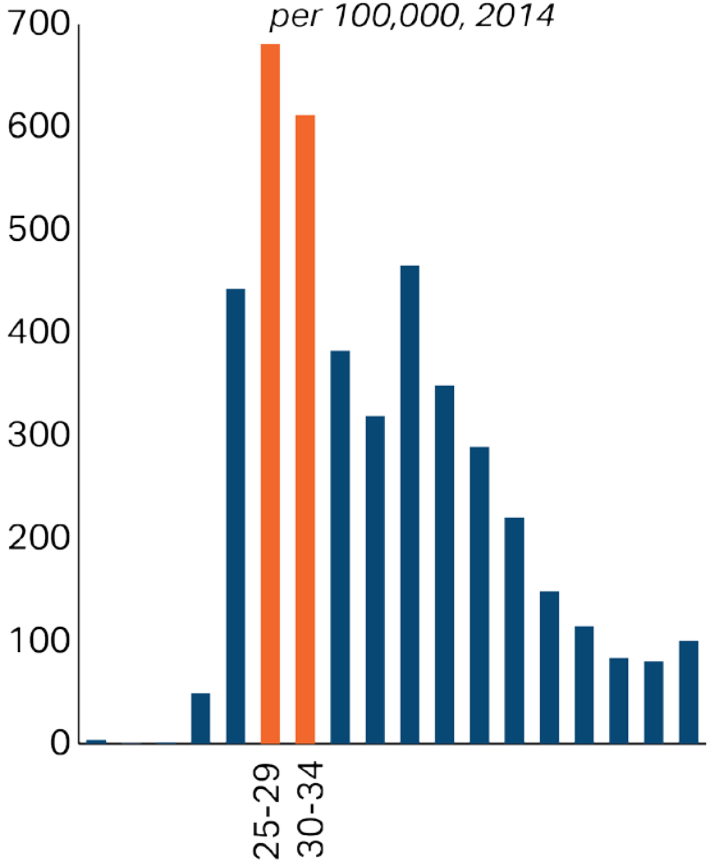
Inpatient Admissions by Gender

Opioid–related inpatient admissions per 100,000, 2014



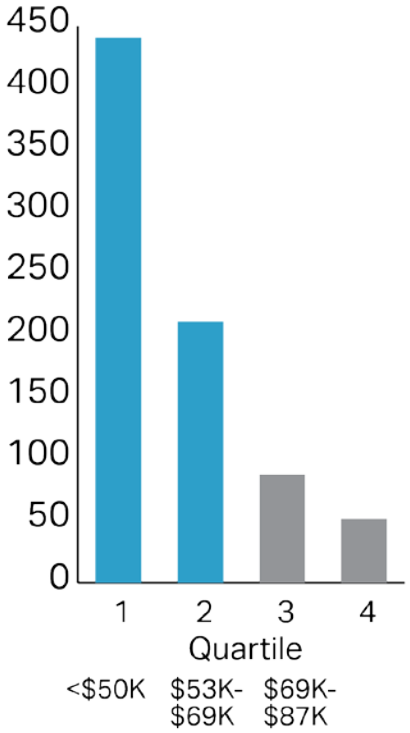
Inpatient Admissions by Age

Opioid–related inpatient admissions per 100,000, 2014



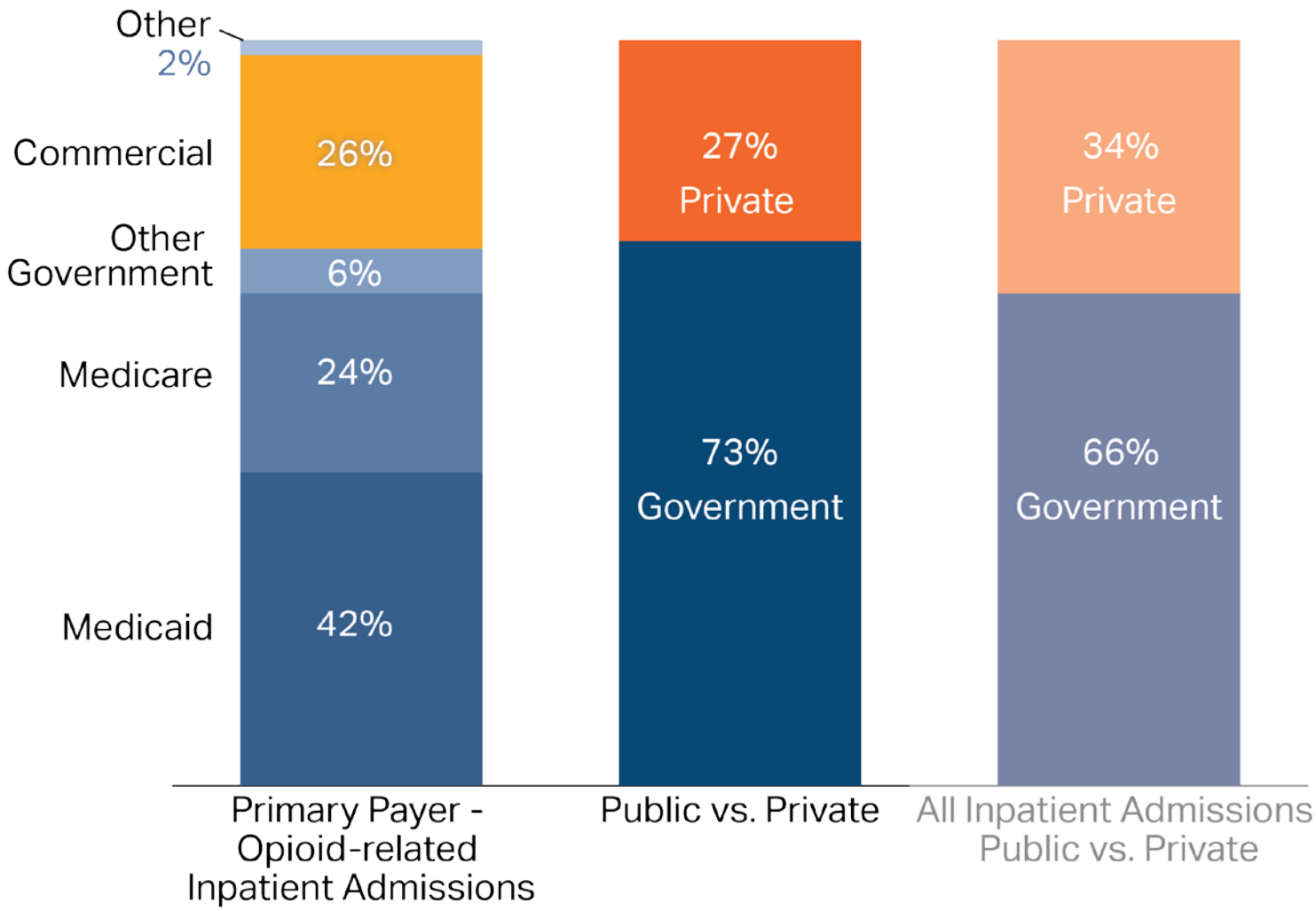
Inpatient Admissions by Income Quartile*

Adjusted for age and sex



Source: HPC Analysis—CHIA, Hospital Inpatient Discharge Database, 2014, American Community Survey, 2010-2014

The opioid epidemic disproportionately impacts specific payers within the Commonwealth



Source: HPC Analysis—CHIA, Hospital Inpatient Discharge Database, 2014
Note: Principal Payer for Opioid-Related Inpatient Admissions, 2014, n=17,756

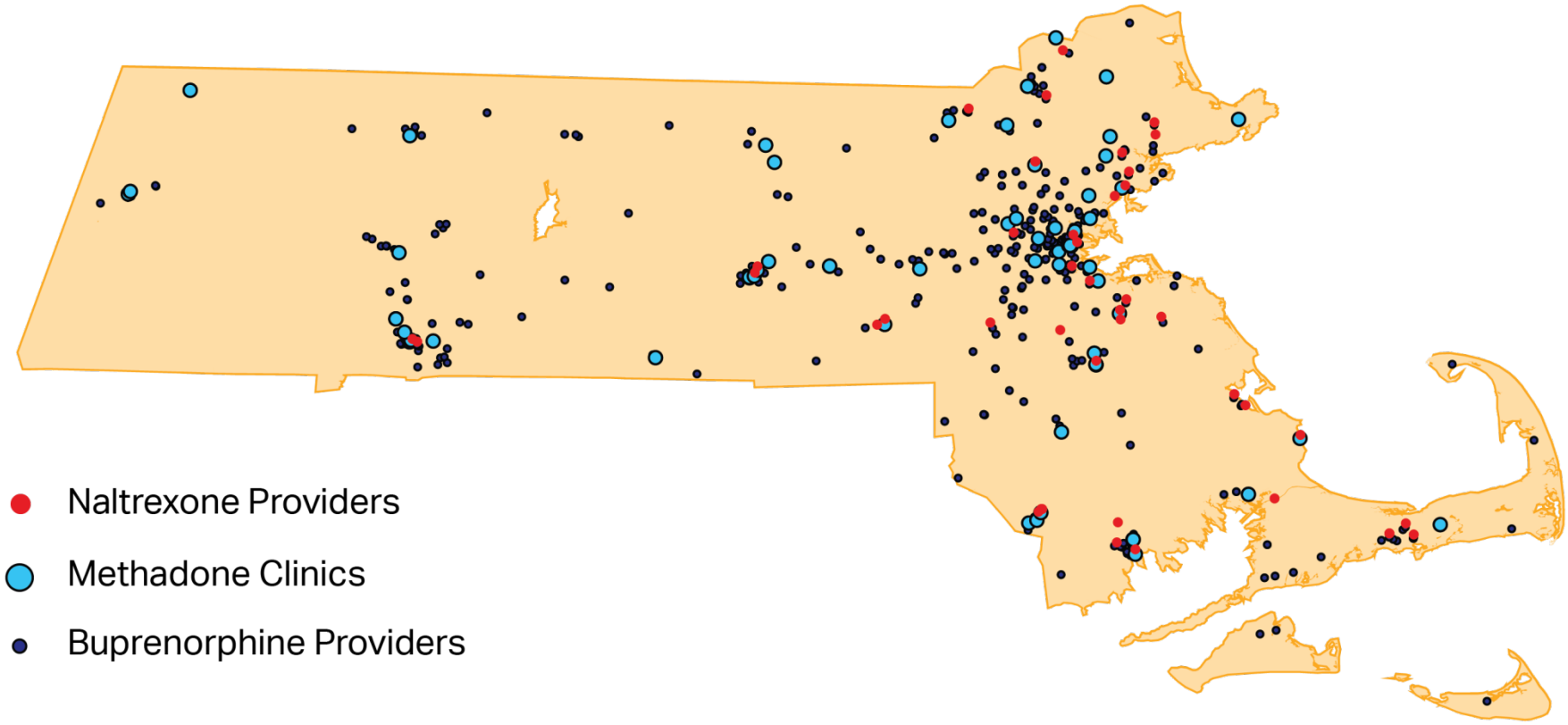
Opioid addiction is most effectively treated with MAT, a treatment protocol that combines prescription medication with behavioral therapy and counseling.

MAT reduces rates of addiction, infectious disease transmission, and opioid-related hospital utilization. Yet MAT is not widely utilized – in 2012, fewer than 50% of adults and adolescents suffering from opioid addiction received MAT (nationally).

Three Types of MAT
Methadone – Reduces addiction cravings and blocks opiate receptors. Must be administered daily in **federally licensed** Opioid Treatment Program, which can limit access due to travel and cost constraints; many patients are not able or willing to attend and/or pay for daily visits.
Buprenorphine – Reduces addiction cravings and blocks opiate receptors. Patients can receive a prescription from any buprenorphine-licensed **physician**, rather than having to regularly visit a specialized clinic.
Extended-release injectable naltrexone – Blocks opiate receptors . Can be prescribed by any health care **provider** licensed to prescribe medications.

Sources:
Substance Abuse and Mental Health Services Administration, Results from the 2012 National Survey on Drug Use and Health: Summary of National Findings, NSDUH Series H-46, HHS Publication No. (SMA) 13-4795. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2013.
National Institute on Drug Abuse. Medication-Assisted Treatment for Opioid Addiction – April 2012. Topics in Brief. https://www.drugabuse.gov/sites/default/files/tib_mat_opioid.pdf. April 2012. Accessed December 3, 2015.

MAT availability varies widely by region, with no clear relationship to the burden of the epidemic



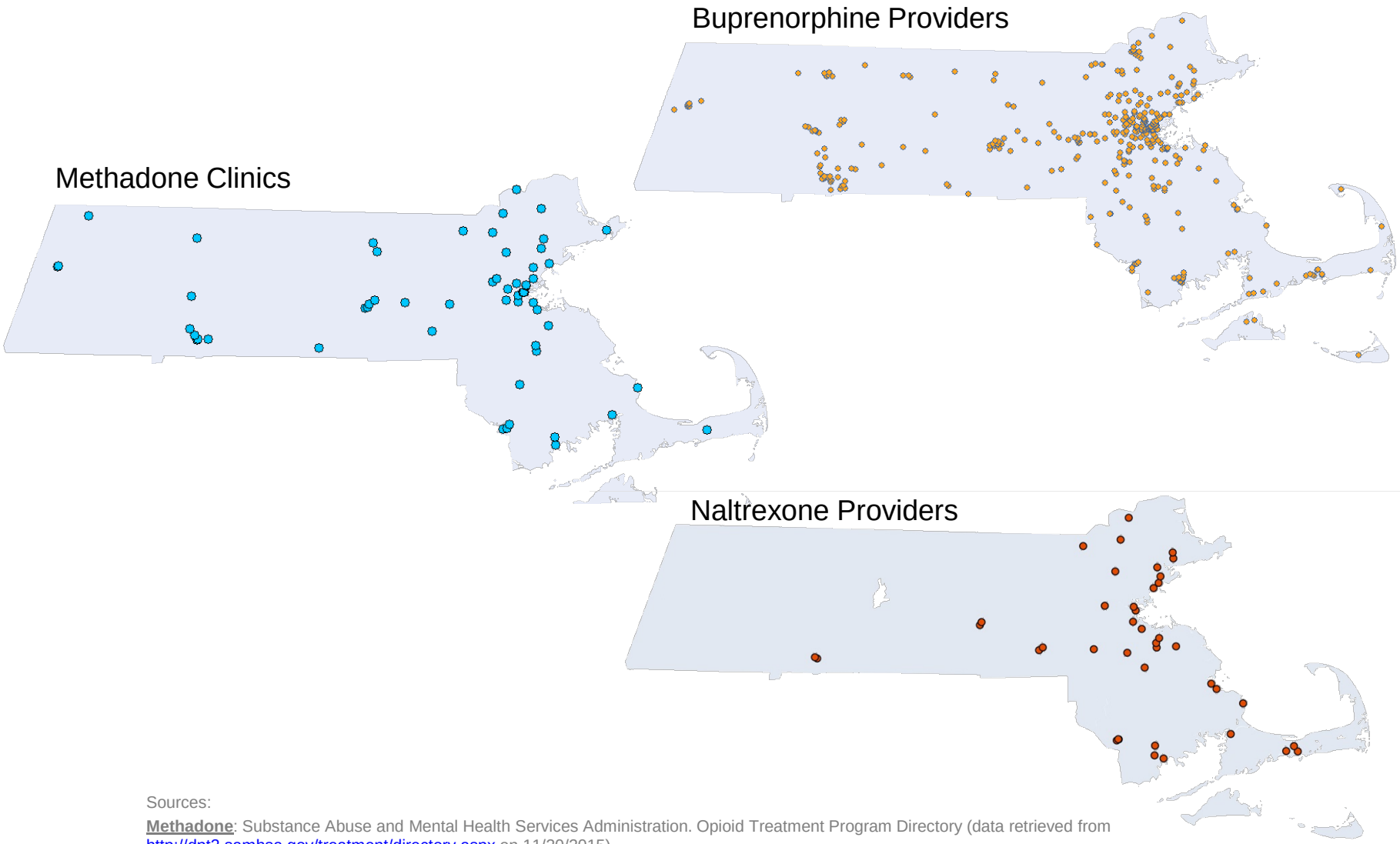
Sources:

Methadone: Substance Abuse and Mental Health Services Administration. Opioid Treatment Program Directory (data retrieved from http://dpt2.samhsa.gov/treatment/directory.aspx on 11/20/2015)

Buprenorphine: Substance Abuse and Mental Health Services Administration. Buprenorphine Treatment Physician Locator (data retrieved from http://www.samhsa.gov/medication-assisted-treatment/physician-program-data/treatment-physician-locator on 11/5/2015)

Naltrexone: Prescriber lists provided by Alkermes Pharmaceuticals (data received on 8/20/2015)

MA has a larger number of buprenorphine providers and a smaller number of naltrexone providers and methadone clinics. There is a heavy concentration of providers in Metro Boston and Springfield.



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HPC

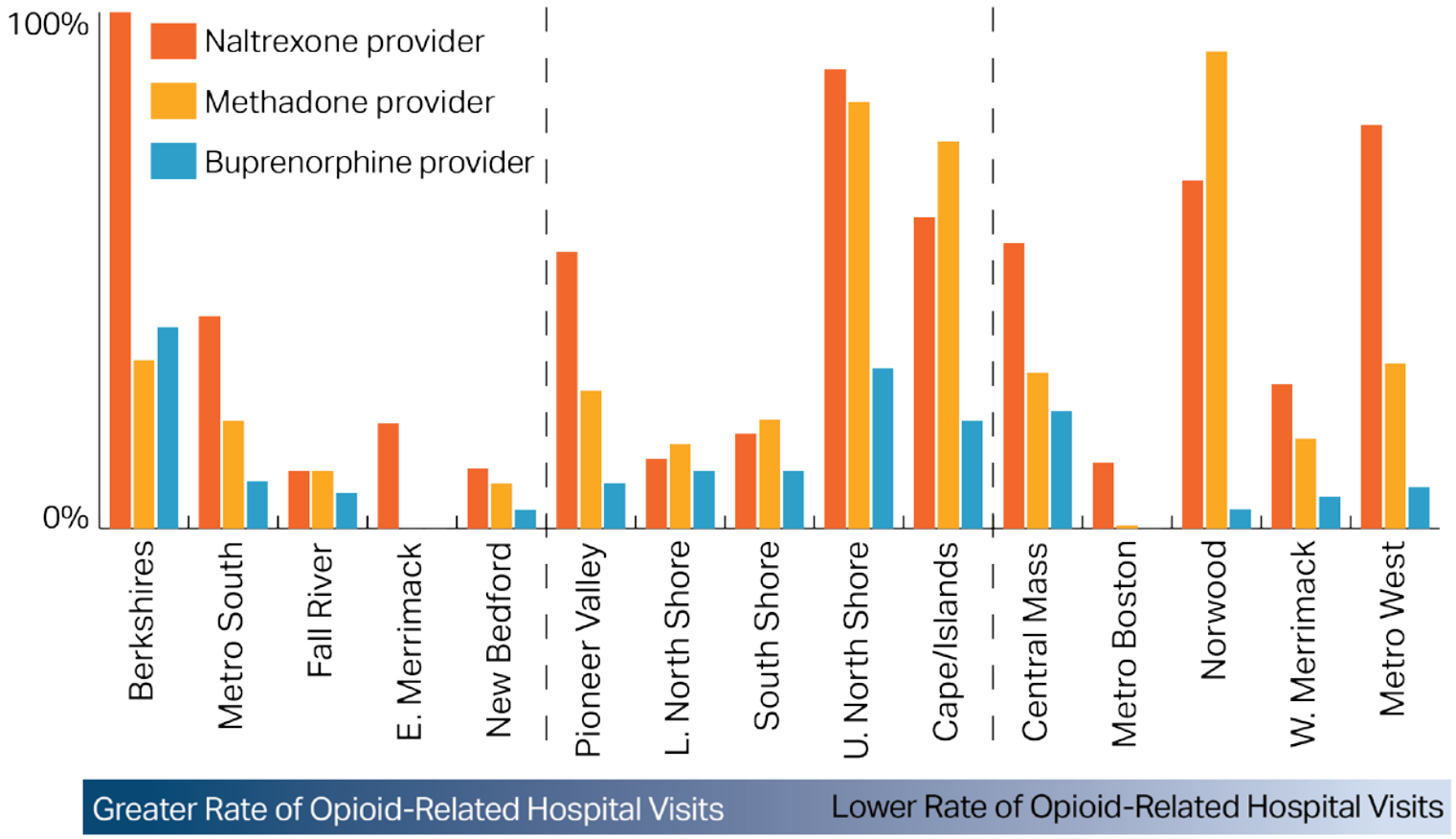
Survey of Massachusetts buprenorphine providers

The HPC worked with an expert firm to conduct a survey of buprenorphine prescribers to better understand the current capacity to deliver MAT and the resources needed to improve service delivery.

Survey domain	Key findings
Current vs. Potential Capacity	• **79% of physicians** were certified to treat up to 100 patients with **54% actively treating 80 or more patients** (65% of whom are addiction specialists). • 30% of physicians with a 30-patient limit are **serving 24 or more patients**.
Access to Treatment	• Physicians reported that patients are waiting between **one to three weeks** to obtain buprenorphine treatment.
Counseling	• 64% of physicians* indicated that **76% or more of their patients are receiving counseling along with MAT**. • 18% indicated **51% - 75%** are receiving counseling. • 18% indicated that **50% or less** are receiving counseling. **45 physicians responded to this question*
Needed Resources and Supports	• Additional staffing • Awareness of SUD counselors • Outreach to identify opioid use disorder patients • Payer supports *(Payer support was identified as the most pressing issue with **specific problems related to low reimbursement rates, frequent prior authorizations/ referrals, credentialing paperwork and service limits**)*.

SAMHSA's Buprenorphine Physician Locator was utilized to identify 717 physicians waivered to prescribe buprenorphine in MA (not all physicians elect to be included in the locator). A random sample of 150 physicians (authorized to treat either 30 or 100 patients) were contacted and 48 (response rate of 32%)

There is regional variation in the percentage of patients with opioid-related hospital visits who must travel more than 5 miles to access MAT



Note: Travel distances are defined as the distance between the patient's zip code of residence and the zip code of the nearest in-state provider.

Sources: HPC analysis-CHIA Hospital Inpatient Discharge Database and Emergency Department Database, 2014

Methadone: Substance Abuse and Mental Health Services Administration. Opioid Treatment Program Directory (data retrieved from http://dpt2.samhsa.gov/treatment/directory.aspx on 11/20/2015)

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HPC

NAS is a clinical syndrome marked by low birth weight, respiratory distress, feeding difficulty, tremors, increased irritability and crying, diarrhea, and occasionally seizures.

- Use of MAT (e.g., buprenorphine, methadone) during pregnancy is critical, despite causing NAS, to minimize risk of addiction relapse, which causes far greater harm to fetal development
- Nationally, the number of infants born with NAS has increased sevenfold in the past decade
- In 2009, the rate of NAS in Massachusetts was approximately three times higher than the national average

Sources:

Kocherlakota, P. Neonatal abstinence syndrome. 2014. *Pediatrics*. 134(2): 547 – 561

Patrick SW, Schumacher RE, Benneyworth BD, Krans EE, McAllister JM, Davis MM. Neonatal abstinence syndrome and associated health care expenditures: United States, 2000-2 *JAMA*. 2012. 307(18):1934-40.

Lee KG. Neonatal abstinence syndrome. National Institute of Health, U.S. National Library of Medicine, MedlinePlus. https://www.nlm.nih.gov/medlineplus/ency/article/007313.htm. January 31, 2014. Accessed December 8, 2015.

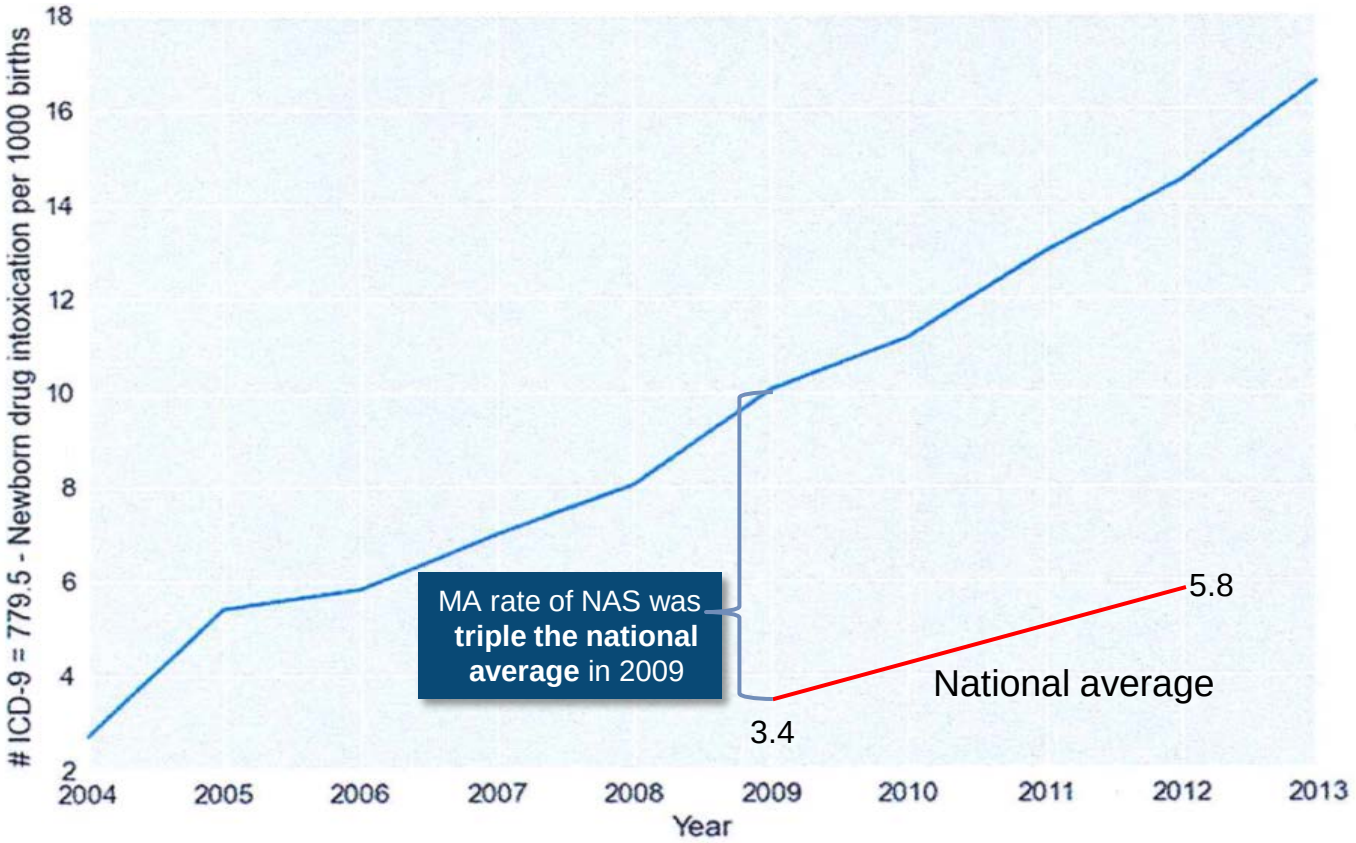
Peltz & Anand. Long-Acting Opioids for Treating Neonatal Abstinence Syndrome: A High Price for a Short Stay?. 2015.

Gupta M and Picarillo A. Neonatal abstinence syndrome (NAS): improvement efforts in Massachusetts. NeoQIC Meeting. January 2015.

HPC

The rate of NAS is increasing significantly in Massachusetts

From 2004 to 2013 the Incidence of NAS increased from <3/1000 hospital births to **>16/1000 hospital births** per year

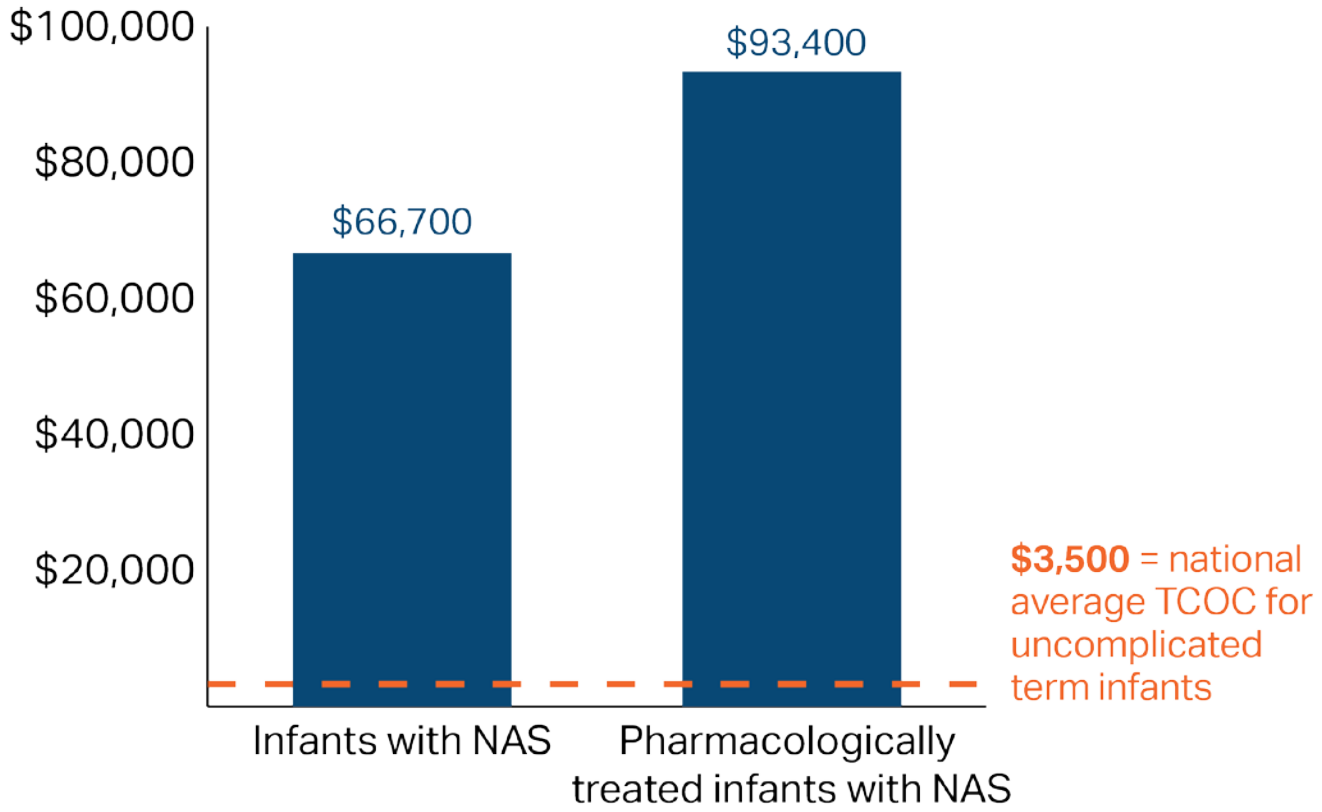


Sources:

1. Gupta M and Picarillo A. Neonatal abstinence syndrome (NAS): improvement efforts in Massachusetts. neoQIC. January 2015. PowerPoint presentation.
2. Patrick S, Davis M, Lehman C, Cooper W. Increasing incidence and geographic distribution of neonatal abstinence syndrome: Unites States 2009 to 2012. Journal of Perinatology 2015; doi: 10.1038/jp.2015.36. [Epub ahead of print]

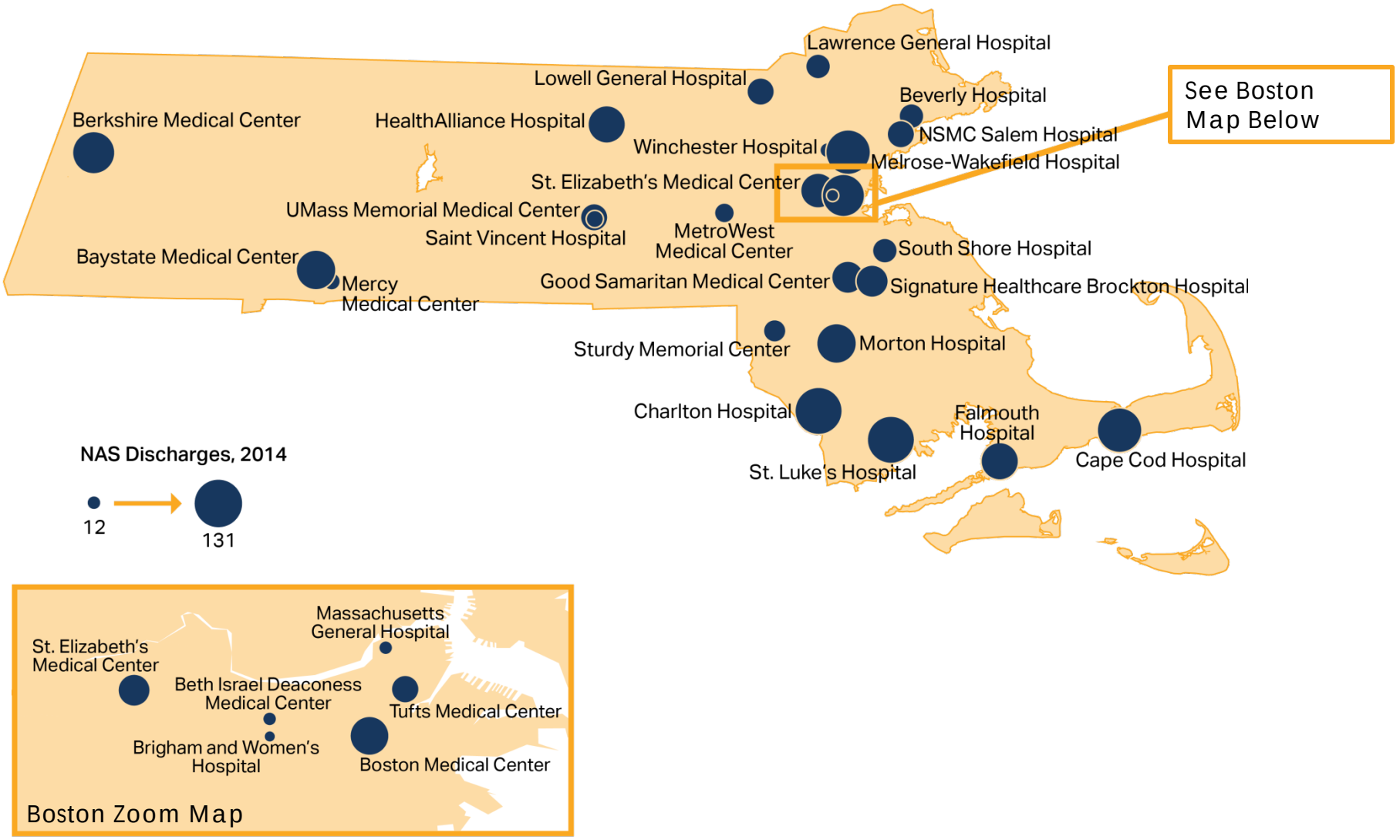
Treatment of newborns with NAS is markedly more expensive than uncomplicated deliveries

Average cost of infants with NAS, United States (2009-2012)



Graph Source: Patrick SW, Davis MM, Lehman CU, Cooper WO. Increasing incidence and geographic distribution of neonatal abstinence syndrome: Unites States 2009 to 2012. Journal of Perinatology. 2015; doi: 10.1038/jp.2015.36. [Epub ahead of print]

The prevalence of NAS discharges varies across the Commonwealth, with high rates of discharges in discrete pockets of the state



Source: HPC analysis of Center for Health Information and Analysis, Inpatient Discharge Database, 2014; Only includes hospitals with 12 or more NAS discharges using ICD-9-CM diagnosis code 779.5 (drug withdrawal syndrome in a newborn)

Informing Community Dialogues: Middlesex DA Ryan's Opioid Task Force

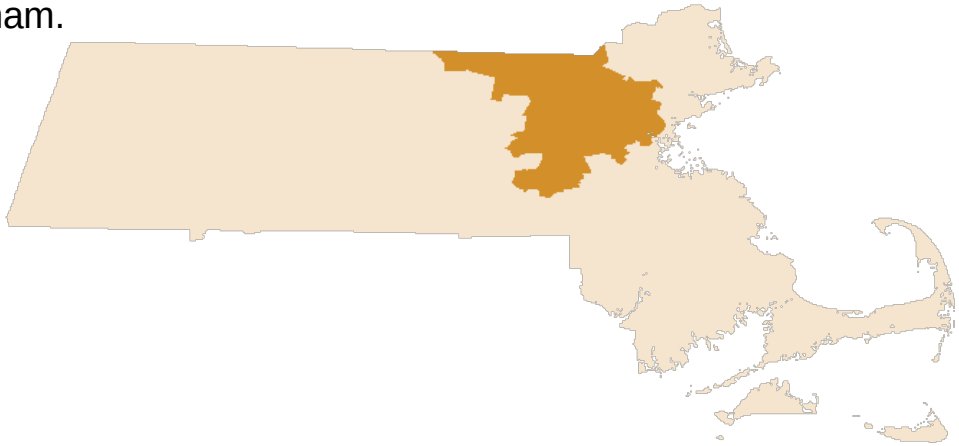
2015-2016 Has Seen a Dangerous Spike in Overdose Deaths

From January 1 to May 1, Middlesex County alone experienced

58 fatal heroin overdoses

District Attorney Marian Ryan launched a new opioid task force in early summer 2015 to help fight against the epidemic with a coordinated, collaborative regional approach

The Middlesex County Opioid Task Force focuses on combating the increase in drug overdoses the area. Communities include Lowell, Cambridge, Newton, Somerville, Framingham, Malden, and Waltham.



The Task Force includes first responders, police and fire officials, municipal health workers, doctors, nurses, social workers, substance abuse counselors, community-based advocates, and probation officers.

Numerous state and local elected officials, public administrators, and health care executives have joined onto the Task Force.

HPC

Informing Community Dialogues: Middlesex DA Ryan's Opioid Task Force

Role of the HPC

District Attorney Ryan included the HPC in recent Task Force meetings to present the HPC's new opioid research and data to help frame the conversation. This aligns with the HPC's goal of presenting data and information to inform community based action to address the epidemic.

- Staff presented on the HPC's geo-mapped data that could inform policy and provide valuable information about how to help those suffering from opioid dependence and their families.
- Staff also presented on the growing prevalence of substance exposed newborns in Middlesex County and highlighted the opportunity for coordinated action by state and local entities

HPC staff presented at three community meetings in 2016:

1. April 8 at Lowell General Hospital
2. May 11 in Framingham
3. June 16 at Lawrence Memorial Hospital in Medford

Policy discussion to inform potential recommendations

1 How best can the Commonwealth systematically track the impact of the opioid epidemic on the health care system?

- How best can the Commonwealth collect and make public information on the availability of evidence-based treatments, including MAT, behavioral therapies, and dual-diagnosis providers?
- How should the Commonwealth continue to track the impact on hospitals and EDs?

2 How best can the Commonwealth increase access to evidence-based opioid use disorder treatments?

- How should the Commonwealth encourage ACOs coordinate with behavioral health providers?
- How should payers support integration of evidence -based opioid use disorder treatment into primary care?
- What barriers exist to access to comprehensive mental health and substance use disorder treatment for a range of subpopulations (adults, seniors, children and adolescents) and what steps could be taken to reduce barriers to treatment for patients with dual diagnoses?

3 How best can the Commonwealth best support the efforts of multi-stakeholder community coalitions (e.g., hospitals, first responders, the judicial system, schools, social services) to address the impact of the opioid epidemic at the local level, in those areas where the epidemic has taken the greatest toll?

4 How best can the Commonwealth test, evaluate and scale innovative care models for treating opioid use disorder and related conditions, given the increasing number of promising care delivery strategies? Areas of particular interest might include:

(a) ED-based initiation of medication assisted treatment (and coordination of follow-up care)
(b) Innovative NAS treatment models
(c) Use of telemedicine to increase access to treatment

HPC

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COACHH

Collaborative Outreach and Adaptable Care at Hallmark Health

QIPP

June 22, 2016

Hallmark Health System

Outline

1. Hallmark Health and CHART
2. Service Delivery Paradigm
3. Case Vignettes
4. Preliminary Findings
5. Challenges and Innovations
6. Questions and Discussion

COACHH

HALLMARK HEALTH AND CHART

CHART 1

- Award for the development of a pilot program to reduce opioid prescriptions in the Emergency Department for patients with back pain
- Focused on prescriber protocols and training
- Reduced opioid prescriptions for back pain patients by 11%-13% in 3 month pilot in 2014

CHART 2 HPC Award

Funding to provide services that are *currently* beyond the reimbursement realities of the healthcare system

CHART 2

- Align healthcare resources, reduce ED overutilization, and coordinate services for defined cohorts of complex patients
- Reduce ED utilization by 20% for high utilizing patients over the 24 month period of performance
- Track data and performance with enabling technology

COACHH: It Takes a Village..

- Senior HHS Leadership: Steven Sbardella, MD, Chief Medical Officer, Ryan Fuller, VP of Strategic Planning, William Doherty, MD, Chief Operating Officer

- Internal Partners: Emergency Department, Quality, Finance, Community Services, Information Technology, Nursing, Behavioral Health, Maternal Child Health

- Community Partners: HPC, CCTP, Mystic Valley Elder Services, Eliot Community Human Services, Local Police Departments, Middlesex District Attorney's Office

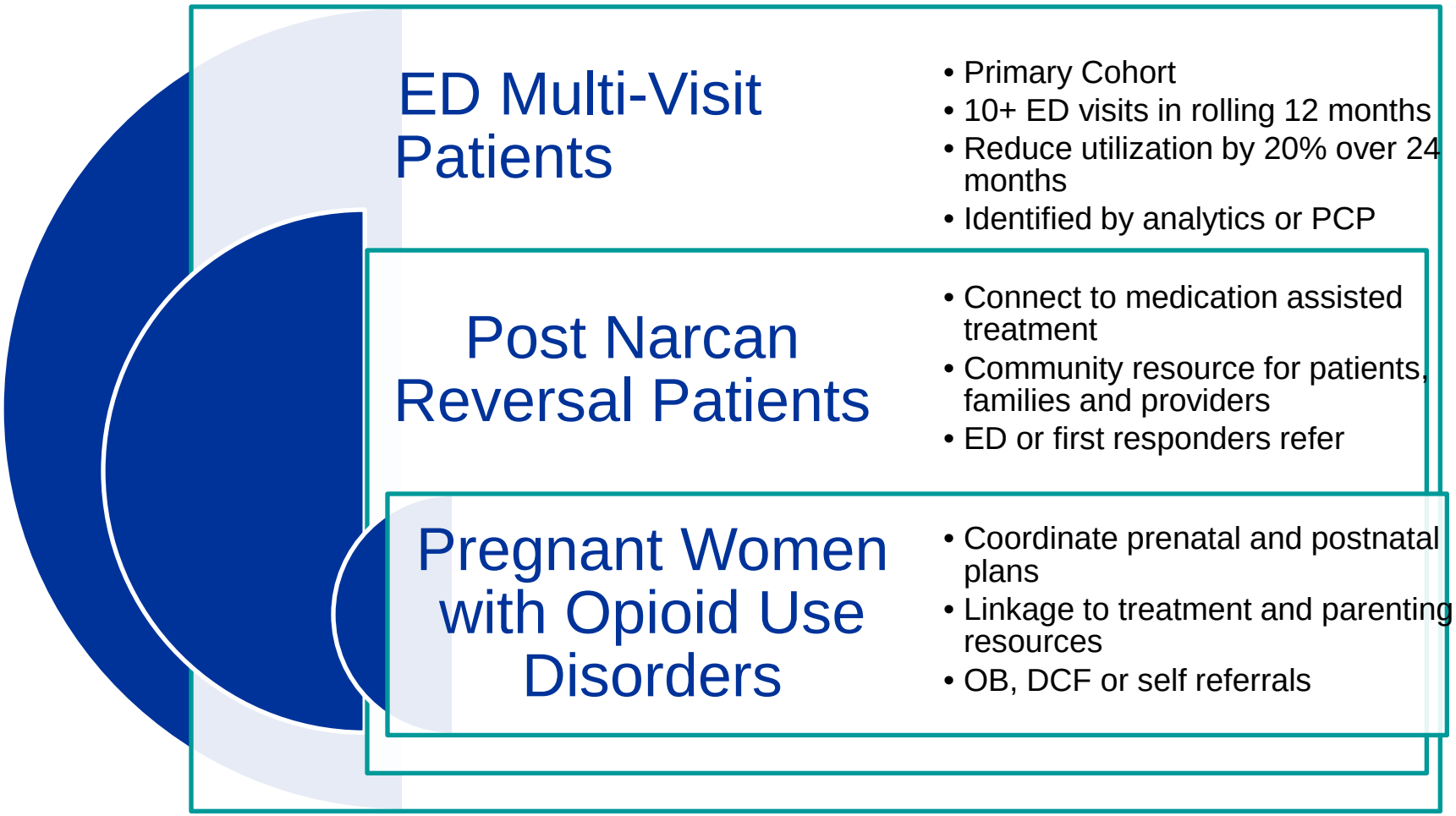
COACHH

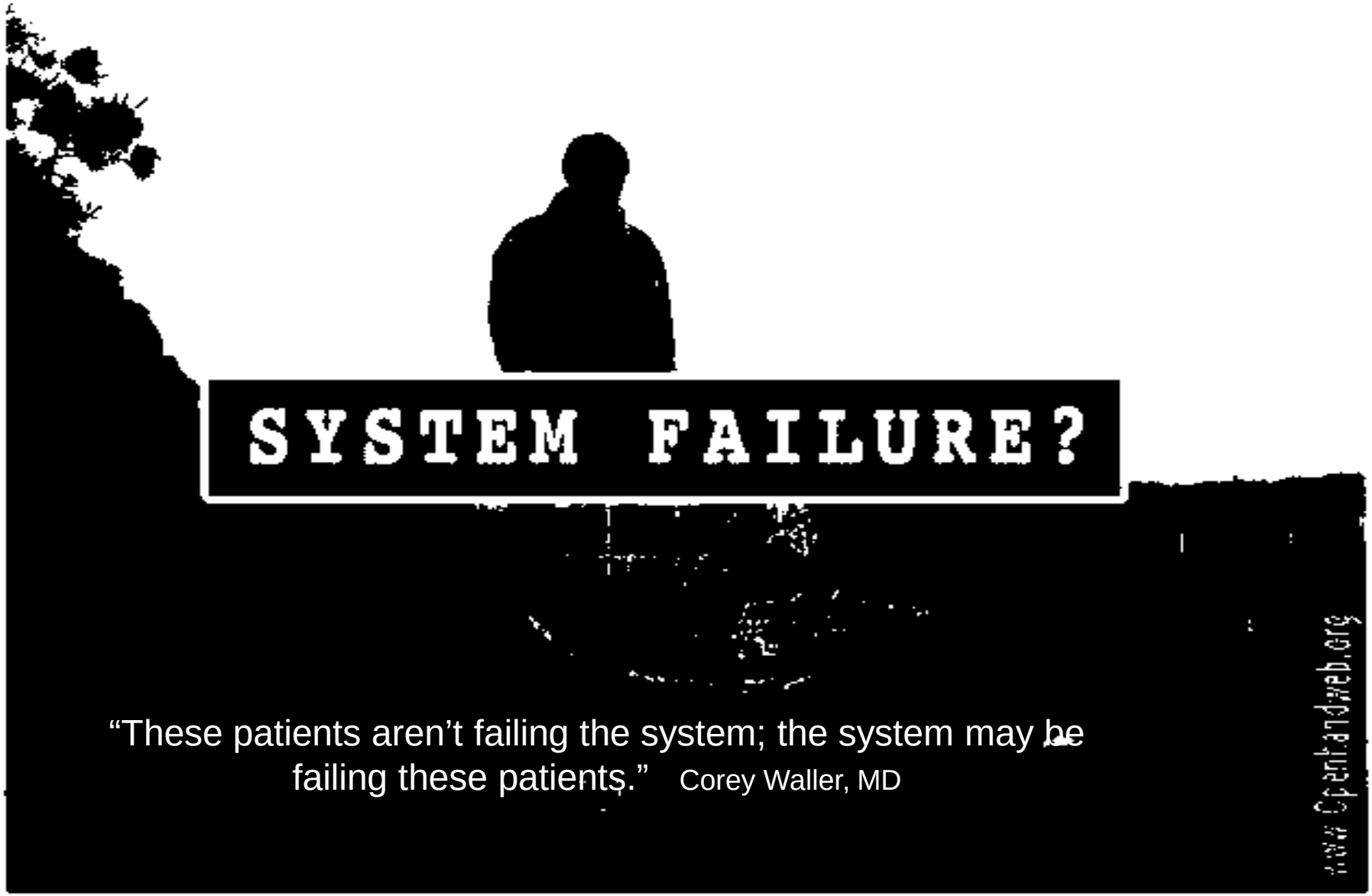
SERVICE DELIVERY PARADIGM

COACHH

Enhance Not Replace

COACHH: Three Cohorts



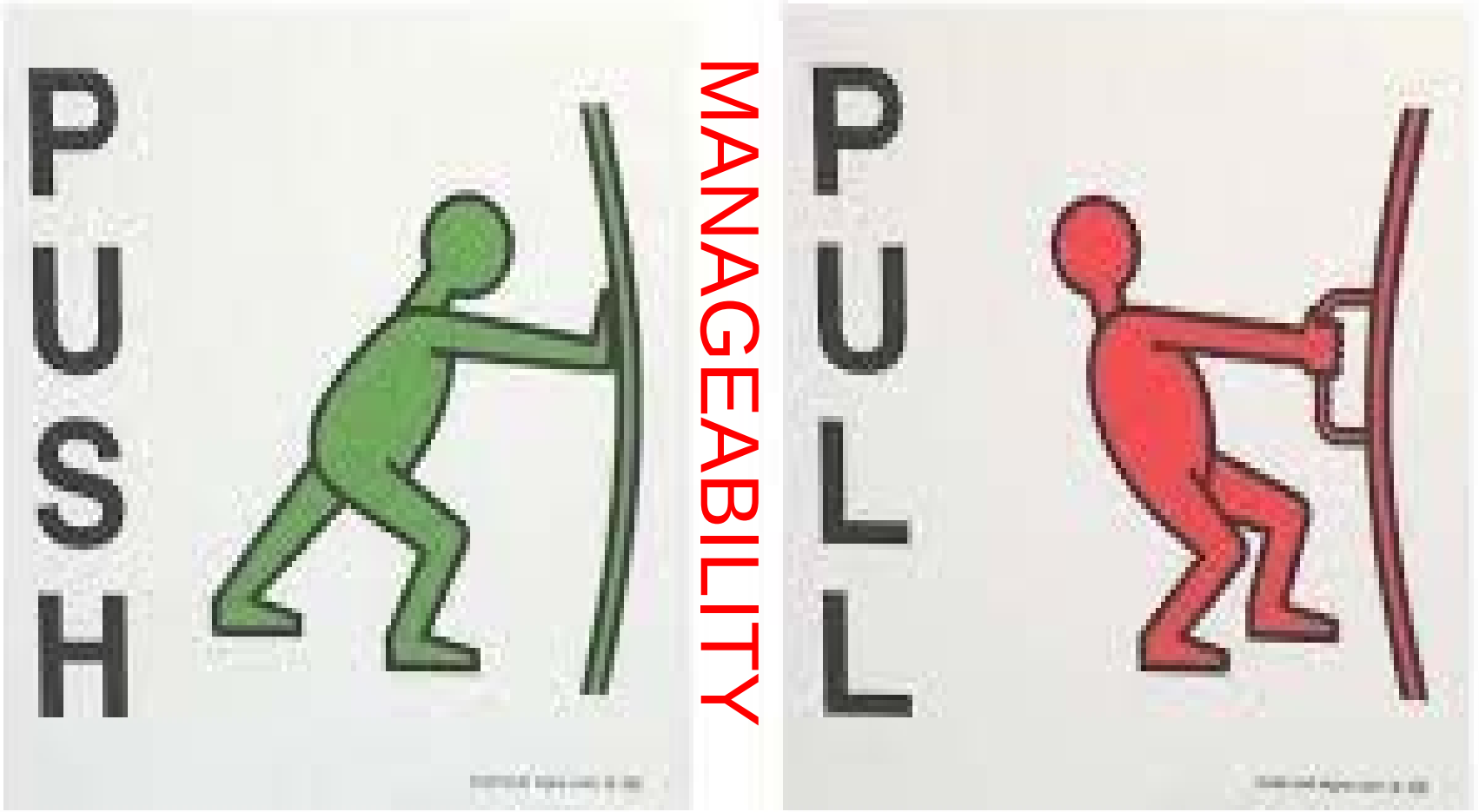


"These patients aren't failing the system; the system may be failing these patients." Corey Waller, MD

COACHH: Guiding Principles

- Focus on collaboration, empowerment, prioritization of needs, and harm reduction
- De-medicalization of the target populations
- Patient Driven/Provider Informed
- Innovative longitudinal vs. episodic interventions
- Elimination of the ED as the default crisis plan for community providers

COACHH: Access to Care



Hallmark Health

The COACHH Team

- Beth Lucey, LICSW: Social Work Supervisor
- Ann Marie Zeimetz, Collaborative Care Coach
- Amy Lemieux, PharmD: Pharmacist
- Gerdine Marsan, Collaborative Care Coach
- Jacqueline Walthall, Collaborative Care Coach
- Lina Feldman, MD, Physician Consultant
- Xiaohui Wang, PhD, MD, Physician Consultant
- Maggie Pierre, RN, NP, Nurse Practitioner
- Carol Plotkin, LICSW, Executive Director
- Suzanne Mitchell, MD Jacob Howe, MD, Training Consultants

COACHH: Launch Activities

- Daily Team Huddles: Focus on safety, communication, education, and collaboration
- Patient Identification via Data Analysis
- Patient Engagement and Enrollment
- Provider and Community Buy In

COACHH: Service Model

48 Hour Follow Up

- All patients contacted within 48 hours of discharge

Consistent Contact

- Weekly phone calls, home visits
- 24 hour on call coverage
- To date: 10 contacts per patient served

Array of Services

- NP, Social Work, Pharmacy, Care Coordination, Health Coaching, Care Plans

COACHH: Visit Locations

Patient Homes

Community: e.g. Coffee Shop/Library/T stations

Emergency Departments

Inpatient Psychiatric and Medical Units

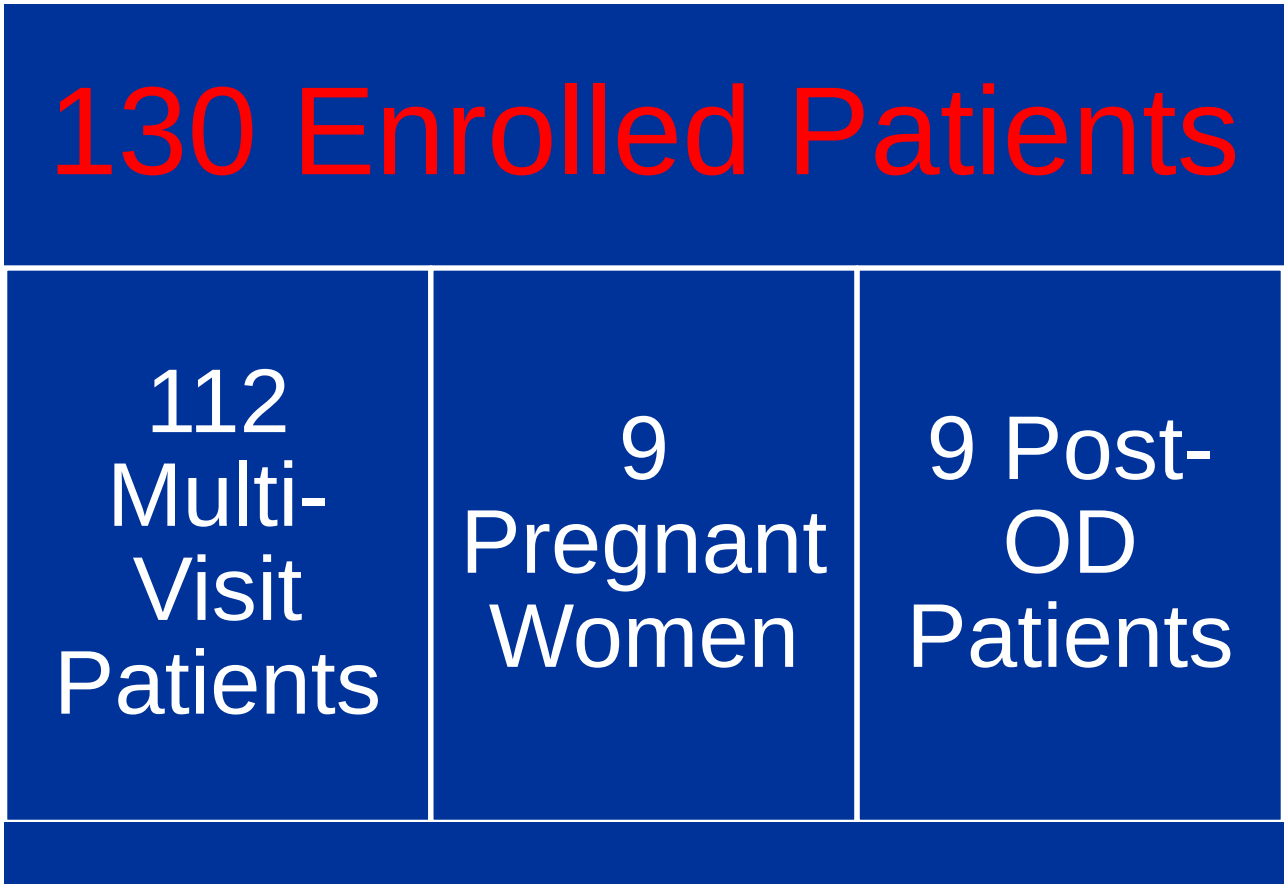
Medication Assisted Treatment Programs

Nursing Homes/Group Homes/Rehab

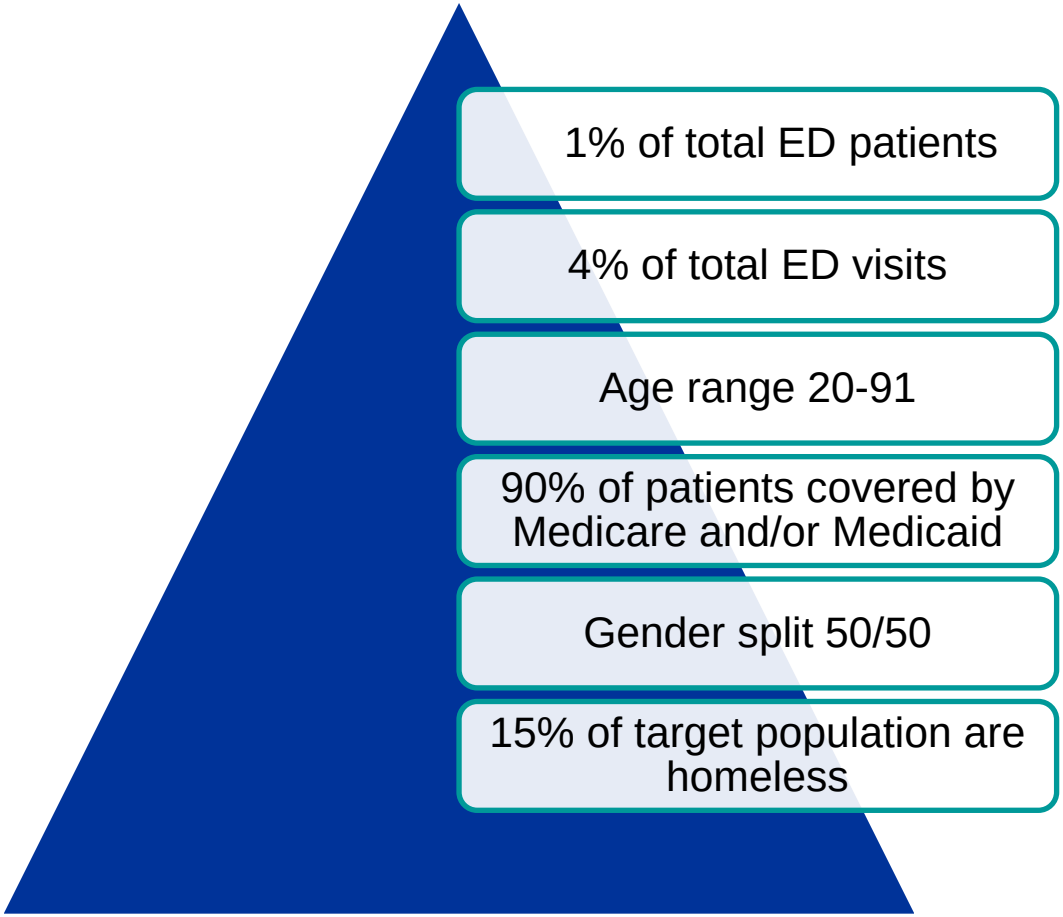
PCP/Specialist Offices

COACHH Office

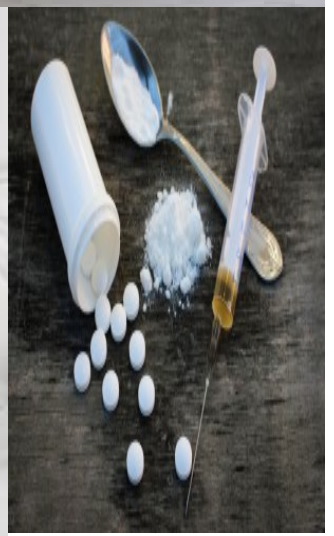
COACHH: Six Month Enrollments



MVP Target Population Factoids



Patient Vignettes



COACHH: MVP

- Senior Citizen with > 150 ED visits in one year for migraines and abdominal pain
- Lives alone; limited financial and social resources; history of anxiety
- Well known to many local care providers and agencies

Basic, Very Basic, Interventions

Hallmark Health

Saving Money and Aligning Resources

Two ED visits at HHS since enrollment in COACHH. Weekly home visits and daily calls made by the COACHH team and crisis plan developed with ED team.

At the run rate of 3 ED visits per week, an estimated **70** ED visits *may* have been averted in the past six months.

The Opioid Epidemic

A young member of the community was referred to COACHH by the Chief of Police following one of multiple heroin overdoses with Narcan reversals in one year. The COACHH social worker met with the patient in the ED; the patient initially declined participation. The social worker persisted with outreach efforts and subsequently enrolled the patient in COACHH. Referrals to detox and methadone maintenance were facilitated. The patient is making significant progress with recovery and return to work. One of the Collaborative Care Coaches meets with the patient weekly.

COACHH

PRELIMINARY FINDINGS

COACHH: Initial Results

COACHH	# of Patients	% Change
ED Visits 30 Days PrePost Enrollment	**106**	**-19%**
ED Visits 90 Days PrePost Enrollment	**72**	**-12%**
ED Visits 180 Days PrePost Enrollment	**10**	**-50%**

Clinical Drivers of Utilization

- Substance Use Disorders
- Serious and Persistent Mental Illness
- Chronic Pain

Socioeconomic Drivers of Utilization

Social Isolation

- Elders at home/Elders at risk
- Young adults aging out of “the system”

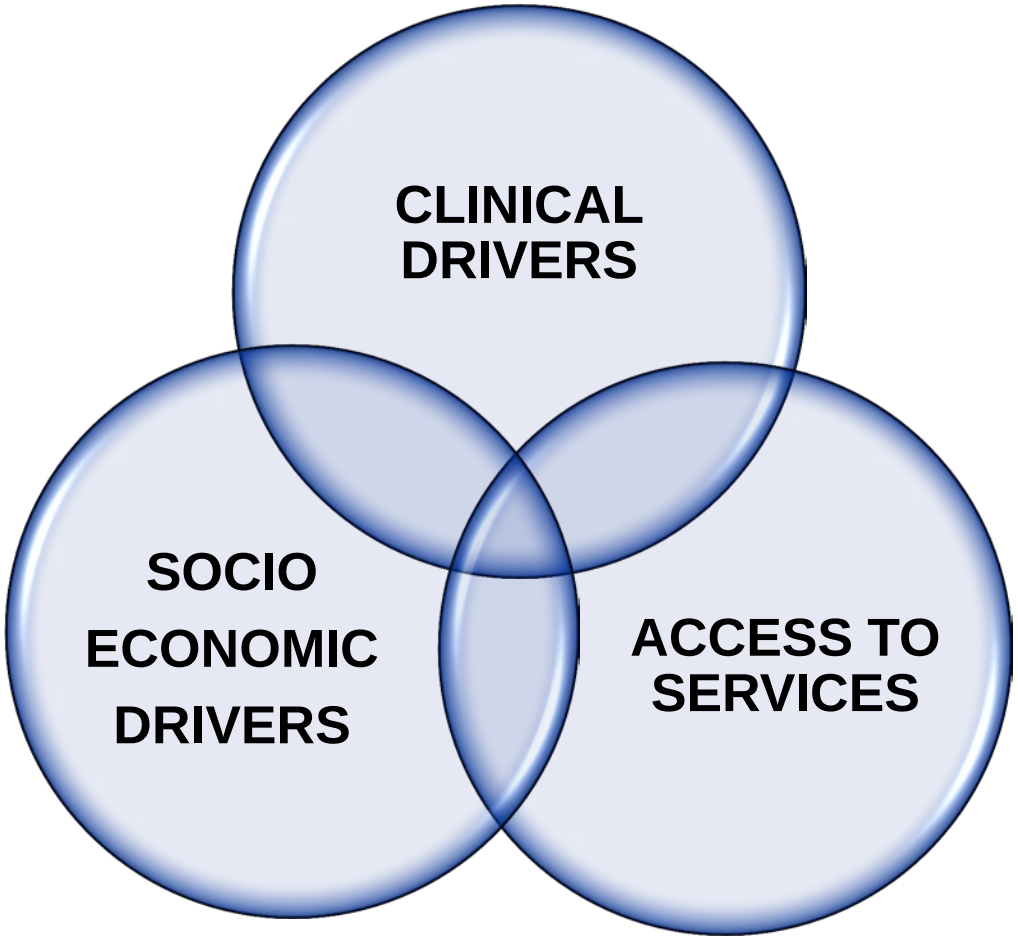
Poverty

- Homelessness
- Food Insecurity

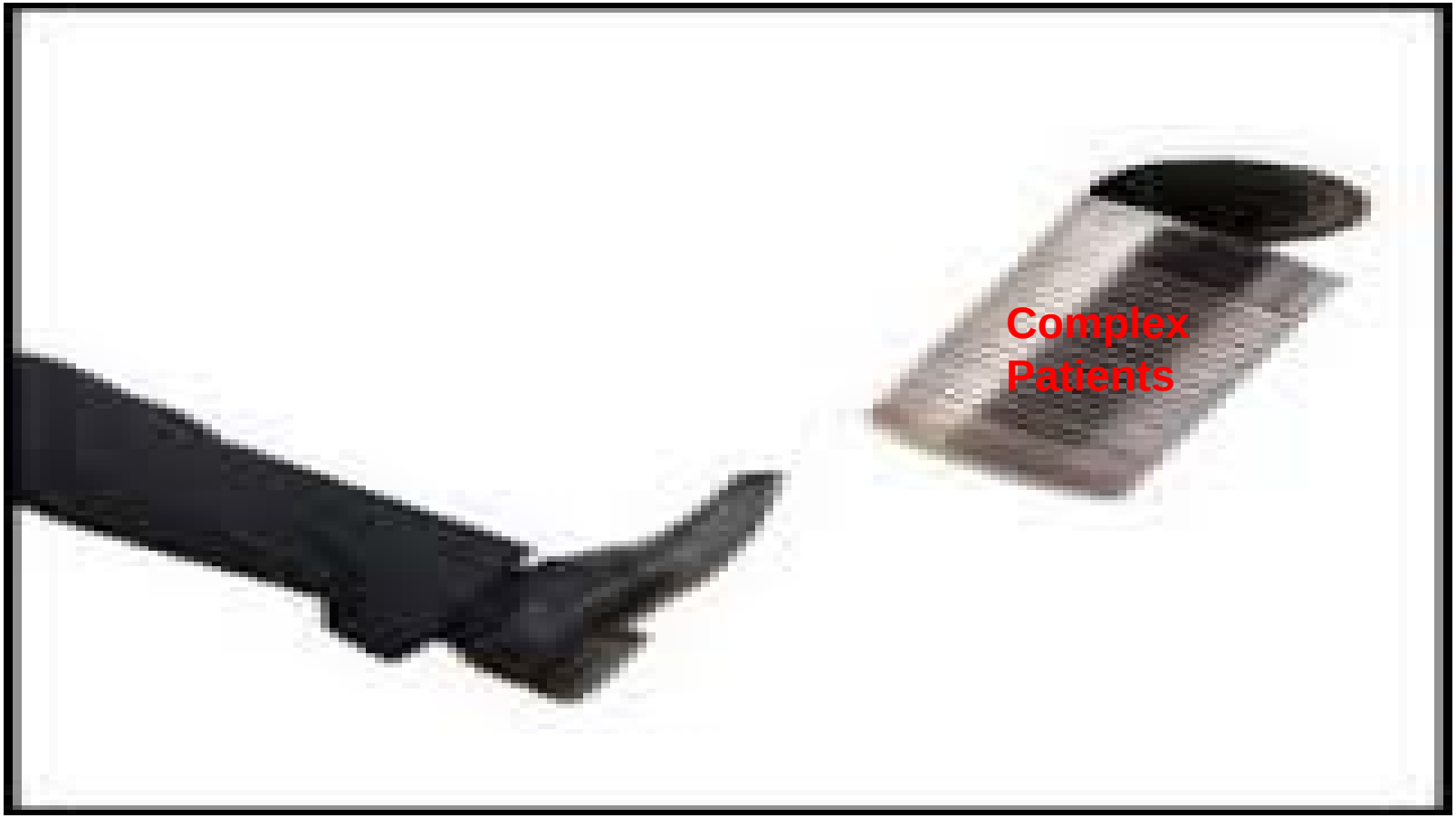
Dis-Integrated Care

- Matching individual needs to available care
- Resource fatigue

COMPLEX PATIENTS



Treatment Ownership



COACHH: Observations

- The majority of high utilizing patients do not visit the ED solely for medical treatment
- Thawing treatment freeze sparks creativity
- A highly engaged team may influence patterns of utilization
- A synergistic relationship exists between provider/patient behavior

COACHH

CHALLENGES AND INNOVATIONS

COACHH: Challenges

- Resources for patients with chronic pain, substance use disorders, homelessness, elders at home
- Stigma that freezes care: “Frequent Fliers”, “Addicts”, “Non-Compliant”
- Episodic vs Longitudinal Care
- SUSTAINABILITY

Selected Community Activities and Innovations

- Middlesex District Attorney's Pilot on Identifying Patients at High Risk for Fatal Overdose
- Group for Pregnant Women at Middlesex Recovery
- Collaboration with Local Police and Fire Departments
- Collaboration with DMH, DDS, DCF, Crisis Teams, Group Homes
- Community Presentations on Opioid use, Mental Health and COACHH

COACHH: Next Steps

COACHH

On behalf of Hallmark Health and the COACHH team, thank you for your interest and support.

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HEALTH POLICY COMMISSION

AGENDA

- Approval of Minutes from May 18, 2016
- Presentation on HPC's Report Opioid on Opioid Abuse in Massachusetts, issued pursuant to Chapter 258 of the Acts of 2014
- Presentation from Hallmark Health on COACHH CHART Phase 2 Project
- **Update on Neonatal Abstinence Syndrome (NAS) Investment Opportunity**
- Schedule of Next Meeting

HPC is investing in care delivery models that efficiently treat NAS

$3,500,000 → Eligible birthing hospitals

Summary

The NAS Investment Opportunity provides funding for inpatient and outpatient initiatives to eligible birthing hospitals in MA to develop and/or enhance evidence-based programs designed to improve care for infants with NAS and for women in treatment for opioid use disorder during and after pregnancy.

This model will provide additional funding for engagement and retention in treatment efforts, to be directly administered by DPH through an Interagency Service Agreement (ISA). This expands a SAMSSA-funded, DPH-led program that coordinates addiction services during pregnancy and for the first six months post-hospital discharge.

Objectives

1. Coordinate and improve SUD treatment for mothers
2. Extend the reach of the federal grant awarded to DPH
3. Increase adoption of best practices (e.g., breastfeeding, rooming-in protocols) and reduce and lengths of stay, costs, and readmission rates

Key Dates

Information Session:
March 25, 2016 (Webinar)

Proposal Deadline:
May 13, 2016

Anticipated Awardee Announcements:
July 2016

Anticipated Period of Performance:
Category A: October 2016 to December 2017
Category B: October 2016 to December 2018

HPC

Joint HPC-DPH initiative allows for investment in several points of intervention across the continuum of care

During pregnancy (Pre-Natal) Care

Post delivery and during in-patient care

After hospital discharge

HPC Pilot Program: Category A
FY16 State Budget Funding
$500,000

DPH "Moms Do Care" Program
Federal Grant
$3,000,000

HPC-DPH Expansion: Category B
Funded through CHART Investment Program to expand DPH's work up to $3,000,000

HPC-DPH Interagency Investment Partnership to Support Statewide NAS Investments

$6,500,000 Million: Total Statewide Investment to Address NAS and its Effects

- The goal of the DPH's federally funded **Moms Do Care** (MDC) program is to expand access and adherence to medication-assisted treatment (MAT) for women with opioid use disorder during pregnancy and after delivery.
- In **NAS Category A**, HPC is providing funding to hospitals to develop and test a fully integrated model of inpatient post-natal supports from delivery to discharge for families with substance exposed newborns.
- In **NAS Category B**, HPC is expanding DPH's MDC initiative by funding two additional CHART-eligible hospitals to replicate the MDC initiative while also incorporating the delivery to discharge component to test a full array of supports along the broader care continuum.

Implementation of HPC Expansion of DPH's "Moms Do Care" (MDC) Program (NAS Category B)

- HPC investment of up to $3,500,000 **more than doubles** the federally funded DPH "Moms Do Care" initiative.
  - Large portion is funded through the Distressed Hospital Trust Fund ($3,000,000)
  - HPC anticipates making two Category B awards to CHART-eligible hospitals
- For implementation of Moms Do Care, DPH procured important external vendors, including:
  - **Evaluation** services from Advocates for Human Potential (AHP)
  - **Training** and **technical assistance** services from Boston Medical Center (BMC)
  - **Training, technical assistance, capacity building, and project coordination** services from the Institute for Health and Recovery (IHR).
- These DPH vendors will provide support, and scale the "Moms Do Care" replication project for the HPC:
  - Pursuant to an interagency service agreement (ISA) with HPC, DPH will amend its existing vendor contracts to allow for the provision of evaluation, training, and technical assistance services at the HPC's MDC replication sites.
  - HPC Funding To DPH via ISA: **$1,196,124** [Project Period is August 2016 – June 2019].

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- **Schedule of Next Meeting**

Contact Information

For more information about the Health Policy Commission:

Visit us: http://www.mass.gov/hpc

Follow us: @Mass_HPC

E-mail us: HPC-Info@state.ma.us

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Appendix A: Research Methods

Key definitions and methods

Methods

To assess the impact of the opioid epidemic on the Massachusetts health care system, HPC examined the number of **opioid-related hospital visits**.

To assess the availability of medication-assisted treatment (MAT), an evidence-based protocol that combines medication with behavioral therapies to treat individuals with opioid use disorder, the HPC examined the **location**, **geographic region**, and **patient travel times** for all three forms of MAT. For the purposes of this analysis, MAT includes outpatient methadone clinics, buprenorphine prescribers, and naltrexone providers.*

Definitions

Hospital visits

Includes **inpatient admissions** and **emergency department visits**

- Due to data limitations, only inpatient admissions and ED visits are included in certain analyses. See "Sources" on slides for details.

Opioid-related

Hospital visits with a primary or secondary diagnosis related to abuse and/or misuse of prescription opioids and/or heroin**

- This set of diagnoses is broader than the set used to calculate DPH's previously published estimates of deaths averted

Geographic regions

The HPC's standard regions, described in previous versions of the Cost Trends Report.***

*Methadone data as of 11/20/2015; Buprenorphine data as of 11/5/2015; Naltrexone data received on 8/20/2015

**Analysis based on AHRQ H-CUP methodology See appendix for comparison of codes

***For more information on the HPC's regions, please see http://www.mass.gov/anf/docs/hpc/07012014-cost-trends-report.pdf

ICD-9-diagnosis codes used in HPC and DPH opioid-related hospital visit analyses

ICD-9-CM diagnosis code	Description	HPC	DPH
304	OPIOID DEPENDENCE-UNSPECIFIED	X	
304.01	OPIOID DEPENDENCE-CONTINUOUS	X	
304.02	OPIOID DEPENDENCE-EPISODIC	X	
304.03	OPIOID DEPENDENCE, IN REMISSION	X	
304.7	OPIOID OTHER DEP-UNSPECIFIED	X	
304.71	OPIOID OTHER DEP-CONTINUOUS	X	
304.72	OPIOID OTHER DEP-EPISODIC	X	
304.73	OPIOID OTHER DEP-IN REMISSION	X	
305.5	OPIOID ABUSE-UNSPECIFIED	X	
305.51	OPIOID ABUSE-CONTINUOUS	X	
305.52	OPIOID ABUSE-EPISODIC	X	
305.53	OPIOID ABUSE-IN REMISSION	X	
965	OPIUM POISONING	X	X
965.01	HEROIN POISONING	X	X
965.09	POISONING BY OTHER OPIATES AND RELATED NARCOTICS	X	X
E850.0	ACCIDENTAL POISONING BY HEROIN	X	X
E850.2	ACCIDENTAL POISONING BY OTHER OPIATES AND RELATED NARCOTICS	X	X
E935.0	ADVERSE EFFECTS OF HEROIN	X	
E935.2	OTHER OPIATES AND RELATED NARCOTICS CAUSING ADVERSE EFFECTS IN THERAPEUTIC USE	X	

Note: HPC's methodology is adapted from a method developed by AHRQ (http://www.ncbi.nlm.nih.gov/books/NBK246983/), but adds diagnoses related to heroin

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Summary of An Act relative to Substance Use, Treatment, Education and Prevention

An Act relative to Substance Use, Treatment, Education and Prevention (1/2)

Bill. No. 4056

Passed unanimously and signed on March 14, 2016 by Governor Baker

Includes a number of recommendations from the Governor's Opioid Working Group

Key provisions relating to health care system

Mandatory evaluation of patients presenting with opioid overdose symptoms (effective July 1, 2016)

- Must be conducted w/in 24 hrs of arrival at ED
- If treatment is indicated, must be offered (inpatient or outpatient)
- If patient refuses treatment, must be provided with information on outpatient resources
- Evaluation must be covered by all payers

7-Day supply limit on opiate prescriptions (effective immediately)

- First time prescriptions to adults cannot exceed 7 day supply
- No prescription to minor can exceed 7 day supply
- Exceptions for emergencies, chronic pain, palliative care, oncology

Partially filling prescriptions (effective immediately)

- Pharmacist may partially fill schedule 2 drug at patient's request, but may elect not to
- Unfilled portion of prescription is void

HPC

An Act relative to Substance Use, Treatment, Education and Prevention

Sections of particular relevance to the HPC

1. Requires the HPC, in consultation with DPH and DMH, to study and report on the availability of health care providers that serve patients with dual diagnoses of substance use disorder and mental illness, in inpatient and outpatient settings. The commission shall report to the joint committee on mental health and substance abuse and the house and senate committees on ways and means no later than 12 months following completion of the study.

2. Establishes a special commission to examine the feasibility of establishing a pain management access program, with the goal of increasing access to pain management for patients in need of comprehensive pain management resources. The executive director of the HPC shall serve on the commission. The commission shall begin meeting in June, 2016, and submit its recommendations along with drafts of any legislation by December 1, 2016.

3. Requires carriers to report to the Office of Patient Protection (OPP) on the total number of medical or surgical claims and mental health or substance use disorder claims submitted to and denied by the carrier.

4. Amends statute governing consumer appeal process for risk-bearing provider organizations (RBPOs) & accountable care organizations (ACOs) to require provider denials to inform patients of the right to appeal the decision to the OPP.

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HPC investments addressing the Opioid Crisis

Integrating behavioral health into primary care: PCMH PRIME

#	Criteria (practice must meet ≥ 7 out of 13)
1	The practice has **MOUs with BHPs** and/or **co-located BHPs** (e.g., same building)
2	The practice **integrates BHPs** within the practice
3	The practice collects and regularly updates a comprehensive health assessment that includes **behaviors affecting health and mental health/substance use history of patient and family**
4	The practice collects and regularly updates a comprehensive health assessment that includes **developmental screening** using a standardized tool
5	The practice collects and regularly updates a comprehensive health assessment that includes **depression screening** using a standardized tool
6	The practice collects and regularly updates a comprehensive health assessment that includes **anxiety screening** using a standardized tool
7	The practice collects and regularly updates a comprehensive health assessment that includes **SUD screening** using a standardized tool (N/A for practices with no adolescent or adult patients)
8	For patients who have recently given birth, the practice screens for **post-partum depression** using a standardized tool (e.g., at 6 weeks and 4 months)
9	The practice **tracks referrals** until the consultant or specialist's report is available, **flagging and following up on overdue reports**
10	The practice implements clinical decision support following **evidence based guidelines** for a mental health an[illegible]er
11	The practice establishes a systematic process and criteria for identifying patients who may benefit from **car[illegible]** process includes consideration of behavioral health conditions
12	The practice has one or more PCPs on staff licensed to prescribe **buprenorphine**
13	If practice includes a **care manager**, s/he must be qualified to identify/coordinate behavioral health nee[illegible]

Proof of proficiency for criteria #2 automatically satisfies criteria #1

HEALTH POLICY COMMISSION PCMH PRIME CERTIFIED 2016

HPC

BHI TA for Pathway to PRIME practices

HPC will hire a vendor to create, monitor, manage the technical assistance program that includes each of the 13 PRIME criteria. HPC and the vendor work in close collaboration to understand progress of the practices on behavioral health integration criteria..

Requirement for TA	Description
Includes mix of broad and practice-specific TA modes	• Includes some one-on-one practice coaching opportunities • Includes broad-based learning opportunities for all practices (e.g. learning collaboratives) • Does not rely on webinars or online modules • Matches practices with appropriate content and mode
Focuses on most challenging PCMH PRIME criteria	• Prioritizes delivering TA on the criteria practices need most help with • Able to offer TA on any of the 13 PCMH PRIME criteria as needed
Accommodates practices on different timelines	• Allows multiple opportunities for practices to receive similar content/assistance • Ensures whenever a practice enters the TA program, it has opportunities to learn from other practices
Delivers maximum value to practices and HPC	• Hiring one vendor instead of multiple minimizes administrative costs and maximizes the share of contract dollars spent on direct practice TA • Utilizes current TA available / partners with MA organizations already providing support to practices • Reports regularly to HPC on practice progress

Supporting broad based community health coalitions: HPC CHART investments

Hallmark Health

- Interdisciplinary **Collaborative Outreach and Adaptable Care at Hallmark Health (COACHH) team** works to improve care for three patient populations: patients with frequent recurrent use of the emergency department, obstetric patients with active substance use disorder, and patients with near-lethal opioid overdose requiring a naloxone reversal
- **Patients are provided support** in enrolling in detoxification programs as needed, in MAT (including methadone, buprenorphine, and/or naltrexone), and in behavioral health treatment programs

BID - Plymouth

- Working to reduce ED utilization for patients with a primary behavioral health diagnosis through its **Integrated Care Initiative (ICI)**
- The ICI provides patients with an addiction assessment in the ED, coupled with follow-up services and linkage to detox, outpatient MAT and primary care
- Partnership with **Clean Slate Centers and Harbor Health Services** to provide outpatient **MAT** upon discharge from ED
- Collaboration with the **Plymouth Police Overdose OUTREACH** (Opioid User Taskforce to Reduce Epidemic And Care Humanely) Program to provide outreach and services to patients that have overdosed
- Partnership with the **Plymouth Drug and Mental Health Court** to provide jail pre-release

[1]This slide provides a sample of CHART initiatives focusing interventions for patients with opioid dependence and is not exhaustive.

Fully integrated care delivery systems: ACO certification

Vision of Accountable Care

A health care system that efficiently delivers well-coordinated, patient-centered, high-quality health care, integrates behavioral and physical health, and produces optimal health outcomes and health status.

Behavioral Health Integration and Accountable Care

The purpose of the HPC's ACO certification program is to complement existing local and national care transformation and payment reform efforts, validate value-based care, and promote investments by all payers in efficient, high-quality and cost-effective care across the continuum.

ACO certification criteria incents providers to better meet the needs of patients with behavioral health disorders. For example:

- An ACO must routinely stratify entire patient population and use the results to **implement programs targeted at improving health outcomes for highest need patients**. At least one program must address **behavioral health** and at least one program must address **social determinants of health** to reduce health disparities within the ACO population.
- To **coordinate care and services across the care continuum**, the ACO must **collaborate with providers outside the ACO** as necessary, including behavioral health providers, specialists, post-acute care and hospitals.

Innovative models

Neonatal Abstinence Syndrome

The HPC is investing **up to $3.5 million** in hospital quality improvement initiatives that drive towards **reducing the total cost of care between the delivery and discharge of opioid exposed newborns**. The HPC is coordinating its efforts with DPH by expanding on a federal grant that seeks to **increase collaboration between outpatient providers to improve retention in addiction treatment** during pregnancy and post-partum.

Tele-Behavioral Health

The HPC is investing up to $1 million in telemedicine innovations that enhance community-based access to behavioral health services for residents of Massachusetts with unmet behavioral health needs (target populations could include **individuals with SUD**, older adults aging in place, and/or children).

Buprenorphine Initiation in ED

There is currently an item under review by the MA Legislature for the FY17 budget to reallocate up to $3 Million from the Distressed Hospital Trust Fund for the HPC, in consultation with DPH, to implement a 2-year pilot program to **test a model of ED-initiated MAT** for individuals with opioid addiction.

Telemedicine pilot

An 18-month regional pilot program to further the development and utilization of telemedicine in the commonwealth

$1,000,000 → **Community-based providers and telehealth suppliers**

Summary of Pilot

- The HPC is to develop and implement a **regional telemedicine pilot** program to advance use of telemedicine in Massachusetts
  - The pilot shall incentivize the use of **community-based providers** and the delivery of patient care in a **community setting**
- To foster partnership, the pilot should **facilitate collaboration** between participating community providers and teaching hospitals
- Pilot is to be evaluated on cost savings, access, patient satisfaction, patient flow and quality of care by HPC

Pilot Aims

1. Demonstrate **potential** of telemedicine to address critical behavioral health access challenges in three high-need target populations (individuals with SUD; older adults aging in place; and/or children & adolescents)
2. Demonstrate effectiveness of multi-stakeholder collaboration
3. Inform policy development to support care delivery and payment reform

HPC

Source: HPC Telehealth Pilot Language – Section 161

Massachusetts legislature FY17 budget language for HPC, in partnership with DPH, to launch a pilot program to test a model of ED-initiated MAT

SECTION 26. The health policy commission, in consultation with the department of public health, shall implement a 2-year pilot program to further test a model of emergency department initiated medication-assisted treatment, including but not limited to buprenorphine and naltrexone, for individuals suffering from substance use disorder. The program shall include referral to and connection with outpatient medication assisted treatment with the goals of increasing rates of engagement and retention in evidence-based treatment. The commission shall implement the program at no more than 3 sites in the commonwealth, to be selected by the commission through a competitive process. Applicants shall demonstrate community need and the capacity to implement the integrated model aimed at providing care for individuals with substance use disorder who present in the emergency setting with symptoms of an overdose or after being administered naloxone. The commission shall consider evidence-based practices from successful programs implemented nationally in the development of the program. The commission may direct not more than $3,000,000 from the Distressed Hospital Trust Fund established in section 2GGGG of chapter 29 of the General Laws to fund the implementation of the program. The commission shall report to the joint committee on mental health and substance abuse and the house and senate committees on ways and means not later than 12 months following completion of the program on the results of the program, including effectiveness, efficiency and sustainability.

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Gateway cities in the Commonwealth with the high rates of opioid-related hospital utilization (ED visits & inpatient admissions)

Massachusetts gateway cities: high rates of prescription opioid and heroin-related ED visits and inpatient admissions

- Under M.G.L. c. 23A section 3A, a Gateway City is defined as a municipality with:
  - Population greater than 35,000 and less than 250,000
  - Median household income below the state average
  - Rate of educational attainment of a bachelor's degree or above that is below the state average

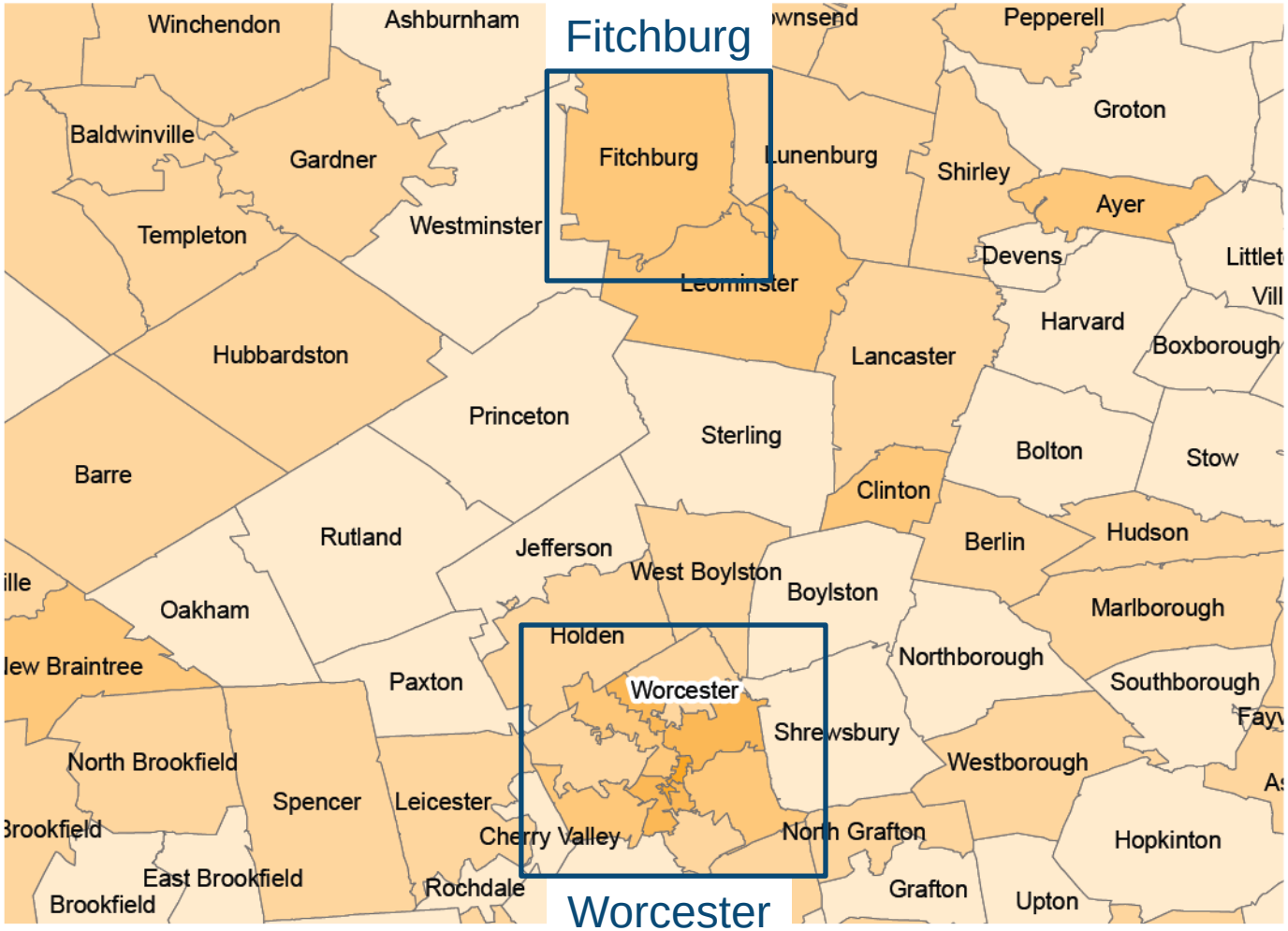
- 12 of the Commonwealth's 26 gateway cities, with high rates of ED visits and inpatient admissions, are concentrated in four general areas of the Commonwealth: Central Massachusetts, Southeastern Massachusetts, in the Merrimack Valley along the New Hampshire border, and in select cities in the Metro Boston, Metro South, and South Shore areas.

- These regions of the Commonwealth present a policy opportunity for allocating additional resources to help alleviate the burden of the opioid epidemic in these communities.

HPC

Source: http://www.mass.gov/hed/community/planning/gateway-cities-and-program-information.html

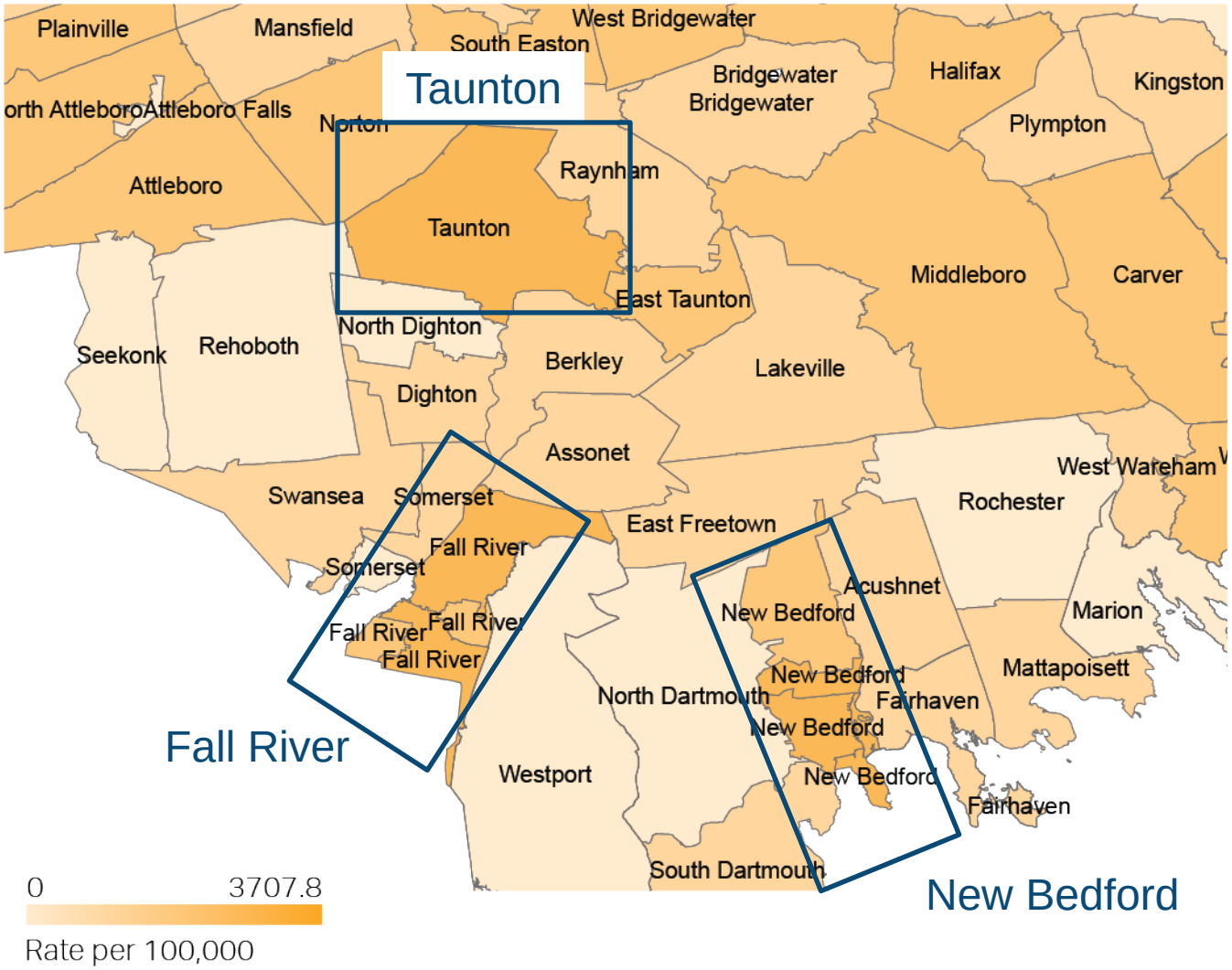
Central Massachusetts Gateway Cities



Note: Note: Hospital visits includes both ED visits and inpatient admissions.

Source: HPC Analysis—CHIA, Hospital Inpatient Discharge Database and Emergency Department Database, 2014; American Community Survey, 2010-2014.

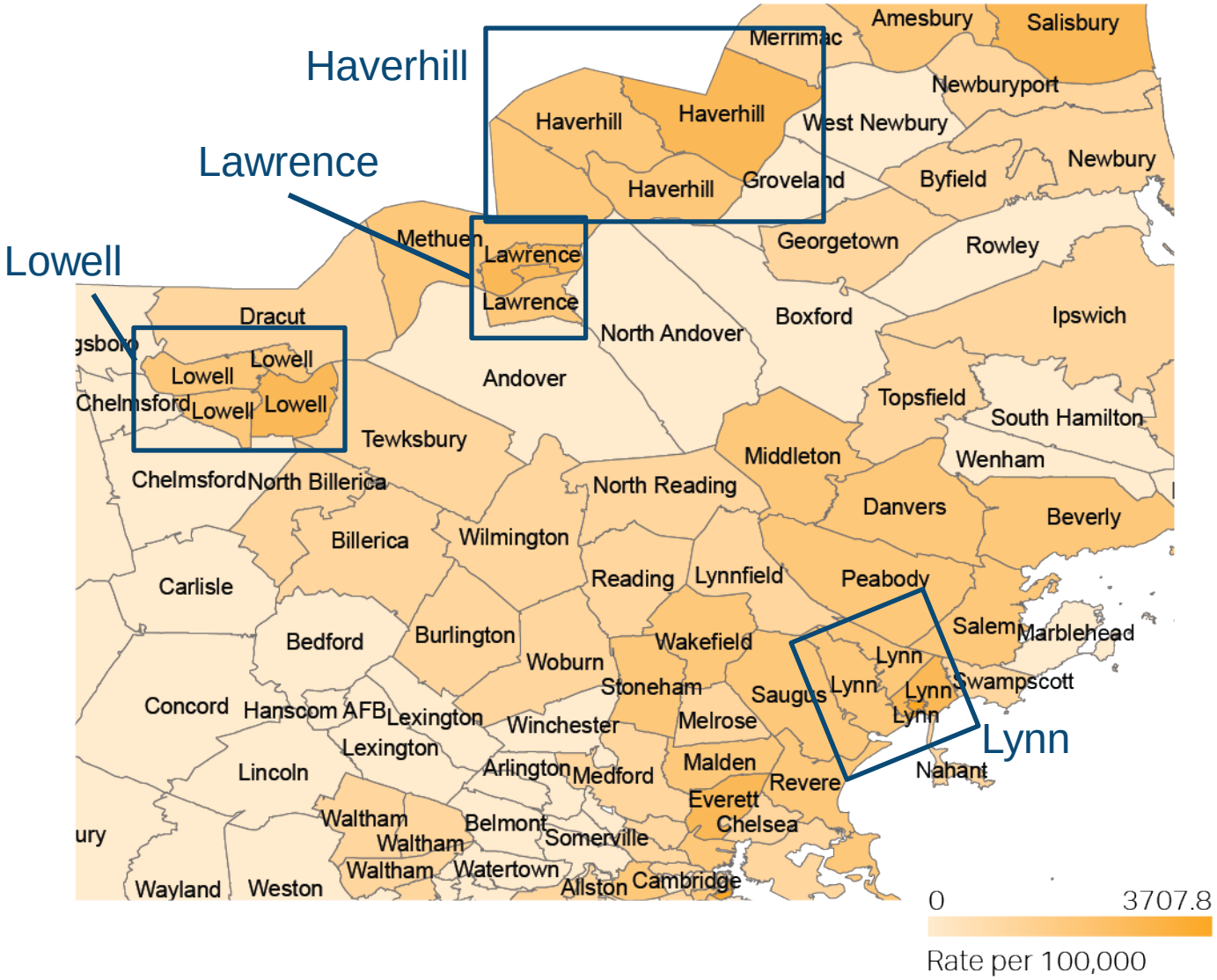
Southeastern Massachusetts Gateway Cities



Note: Note: Hospital visits includes both ED visits and inpatient admissions.

Source: HPC Analysis—CHIA, Hospital Inpatient Discharge Database and Emergency Department Database, 2014; American Community Survey, 2010-2014.

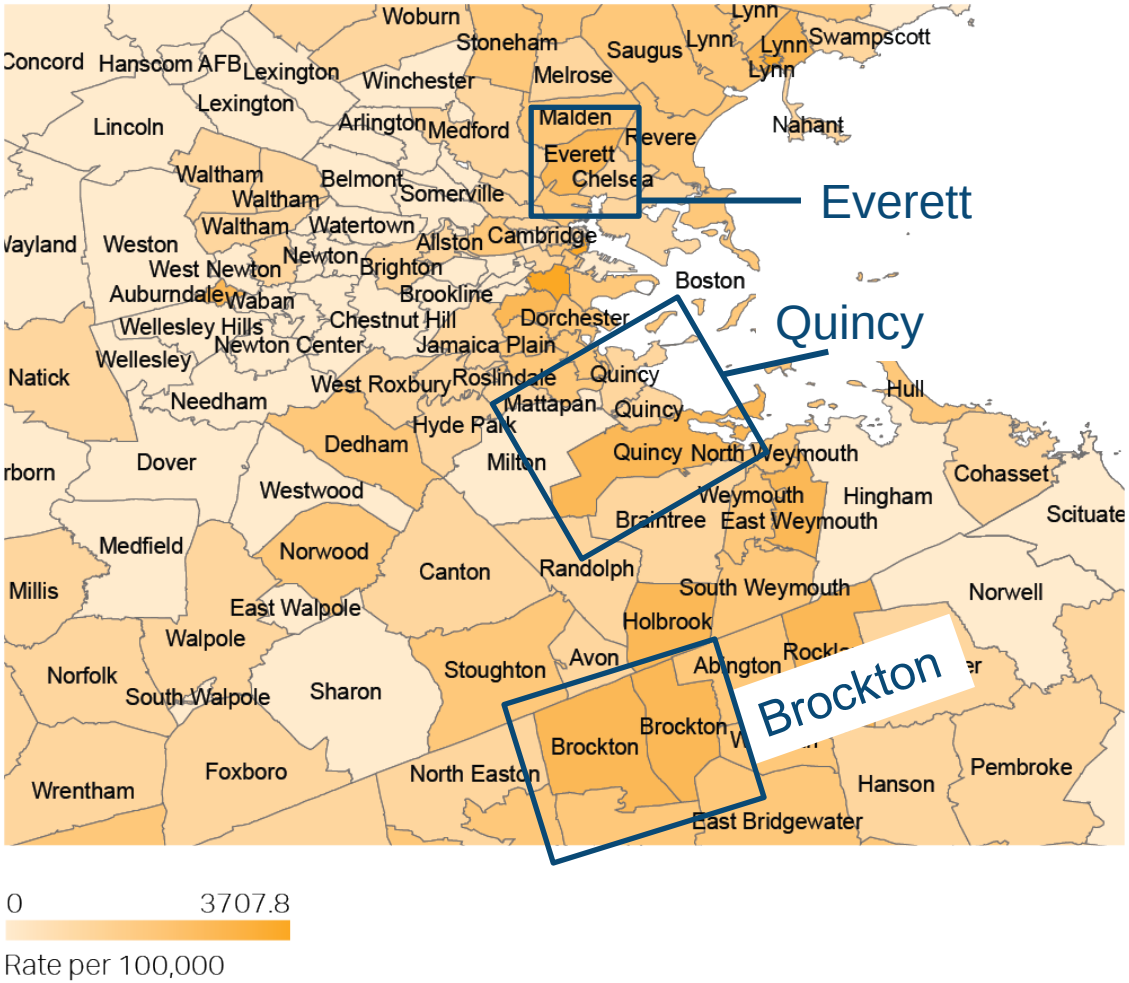
Merrimack Valley Gateway Cities



Note: Note: Hospital visits includes both ED visits and inpatient admissions.

Source: HPC Analysis—CHIA, Hospital Inpatient Discharge Database and Emergency Department Database, 2014; American Community Survey, 2010-2014.

Metro Boston, Metro South, and the South Shore Gateway Cities



Note: Note: Hospital visits includes both ED visits and inpatient admissions.

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