EXECUTIVE CHAMBERS

HONOLULU

David Y. Ige
GOVERNOR

Delivery and Payment Committee
State Office Tower, Room 1403
11:00am – 12:30pm
June 16, 2015

Proposed Agenda

1.	Welcome and Introductions	Rachael Wong
2.	State Innovation Model (SIM) Grant • Triple Aim + 1 • SIM 2 Opportunity • Health Care Improvement Targets • Target Population and Rationale	Beth Giesting
3.	SIM Process and Timelines	Joy Soares
4.	Committee Outline, Timeline, and Membership	Joy Soares
5.	Behavioral Health Integration Models	Dr. Bruce Goldberg Tina Edlund
6.	Discussion: Status of Behavioral Health Integration in Hawaii	Joy Soares
7.	Next Steps	
8.	Adjournment	

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Hawai'i Health Care Innovation Models Project
Delivery and Payment Committee Meeting
June 16, 2015

Committee Members Present:
Rachael Wong (Co-chair)
Joy Soares (Co-chair)
Mark Fridovich
Deb Goebert
Marya Grambs
Chris Hause (by phone)
Sid Hermosura (by phone)
Dave Heywood (by phone)
Alan Johnson
Karen Krahn
Sondra Leiggi
Kristine McCoy (by phone)
Wendy Moriarty
Gary Okamoto
John Pang
Paul Young

Guests:
Dr. Bruce Goldberg
Tina Edlund
Patricia MacTaggart
Danny Cup Choy, Ohana Health Plan
Jenifer Jessep, UHG (by phone)

Committee Members Excused:
David Herndon
Robert Hirokawa
Chad Koyanagi
Anna Loengard
Karen Pellegrin
Bill Watts
Kelley Withy

Staff Present:
Joy Soares
Trish La Chica
Abby Smith
Nora Wiseman

Welcome and Introductions:
Co-Chair Wong opened with introductions and announced the start of the new Medicaid director, Judy Moore Peterson, in July who will likely take over as co-chair of this committee.

Review of SIM Process:
Giesting and Co-chair Soares gave an overview of SIM process: (please see slideshow for more details).

- Health care innovation/transformation started with stakeholder convening in 2012

- SIM round 1 was carried out in 2013 with more stakeholder engagement
- First plan was broad and high level
- SIM round 2 provides opportunity to create a more finely tuned implementation plan, more narrowly focused
- All Payer Claims Database (APCD) and No Wrong Door (through Executive Office on Aging) also working in parallel to SIM
- SIM 2 focus is on behavioral health integration, particularly adults with mild to moderate BH conditions with co-occurring chronic conditions within the Medicaid population
- SIM 2 grant ends January 31, 2016 (Innovation Plan due)

A committee member asked if the possible return on investment was more for severe and persistently mentally ill.
Soares: The actuarial analysis showed a return for mild to moderate as well, especially those with co-occurring chronic conditions such as diabetes.

Co-chair Soares gave an overview of the current SIM Process:

SHIP Deliverables (Please see slides for more detail)

- Operational plan being developed is for over a 5 year period
- To develop a plan of action, 6 committees are working on different areas: steering, delivery and payment, health IT, workforce, population health, and oral health
- At each committee meeting, members will be informed about what other committees are working on. Opportunity to provide feedback and suggestions

Stakeholder Engagement:

- Focus Groups:
  - Nine focus groups will be led by Dr. Withy with behavioral health and primary care providers in July on all islands
- Community conversations:
  - Community meetings will be on all islands in August or September to provide preliminary thoughts on the way forward and receive feedback
- Website is now active through the Governor's webpage
  - Also opportunity to provide feedback on draft plan through the website

Decision making structure discussed (please see slides for more details)

Contractors:

- Dr. Bruce Goldberg is giving guidance on BH integration models and maximizing federal dollars
- Patricia MacTaggart from ONC is giving guidance on HIT vision and goals
- Navigant will consult on the following for the remainder of the SIM planning period (Jul –Jan)
  - Behavioral health integration blueprint
  - Costa analysis and return on investment
  - Proposed process of outcome evaluation and reporting
  - Write SHIP

Next meeting is Tuesday, July 21st, 11-12:30 in the State Office Tower, Room 1403

Committee was asked if there are any other organizations or individuals who should be added to the committee and to email staff with any ideas.

A committee member asked about money for implementation grant

- Soares: CMMI has said that grants will likely be more focused and not an implementation grant as we have known it. Working with Bruce on other opportunities to draw down federal dollars. We don't want to develop a plan that sits on a shelf, so sustainability will be part of the plan.
- Co-chair Wong shared that we are building on the foundation, and although we don't know what CMMI will do as far as funding, Medicaid is now an active participant and leader. Departments are now working really well together, and we have the opportunity to change how we look at what health care delivery is and health outcomes. We have done the groundwork to identify the target populations, and now we need to take the next steps.
- Soares: Previously we did a high level plan, and this round we are building on what we did last time and coming up with a far more detailed implementation plan to help us achieve our goals.
- Giesting: the first time around we identified what needs to be part of an innovation plan across the health care landscape.

<u>Dr. Bruce Goldberg presented about approaches to behavioral health integration</u>

- Family doctor by training
- Worked with Oregon on changing health care system

Hawaii is not alone in this. For the first time, there is a concrete realization that the mind and the body are integrated. As a health care system we have behaved as though they are separate and behavioral health has been stigmatized. A lot of efforts nationwide are focused on integrating physical and behavioral health. No one yet has figured out the perfect way to integrate. Opportunity to make things unique to Hawaii's circumstances.

Framework of BH Integration

- Coordinated Care
  - Referral network, enhanced communication, care management
- Co-located Care
  - Shared facilities but separate treatment plans, cultures, records
  - Shared facilities and records
- Integrated Care
  - Close collaboration in treatment planning, functions "within" primary care

Approaches (please see slides for more details)

- Screening, navigators, team based care, shared information systems, evidence-based guidelines, outcome measurement/tracking/registries, co-location, health homes, full integration
- Examples from Alaska and Portland
- Components shown to help success
- Use of data, analytics, reporting
  - What are the expectations? What are the outcomes being measured? Also needs to be support so that providers and plans can make the needed changes
- Examples of BH Integration (see slideshow)
- Community health/peer wellness model is gaining a lot of popularity around the country

Key environmental considerations:

- Diverse cultures
- Small group practices
- Geography
- Workforce

Process and developmental considerations

- Stakeholder engagement and support (clients, clinicians, payers)
- One model vs. diversity of approaches
- Outcomes, metrics and measurement
- Incentives
    - Not just monetary. Can also be helping to get better care for patients, technical assistance, creating better workflow, etc.
- Disincentives and barriers

Barriers

- Reimbursement and payment
- Culture
    - Service delivery and financing
    - Stigma
- Information sharing
- Workforce
    - Capacity and availability
    - Scope of practice issues
- System
    - Limited community resources
    - Confusing array of care pathways –mild, moderate, SPMI, criminal justice

Potential next steps

- Meet with and engage stakeholders
    - Listen to providers, plans, families
    - Understand needs, possibilities and their current environments
- Catalogue available resources, current programs
- Review data
- Develop models/interventions
- Pay attention to how you will measure progress
    - How is progress and success going to be measured?

Discussion:

Co-chair Wong: What has prevented us from moving forward in the past? Primary care providers don't know where to send patients who need more care.

Goldberg: it's amazing how things happen when you pay for them. Comment around payment reform, because of SIM states are allowed to pay for things that they previously couldn't. For example, Medicaid couldn't pay for community health workers. The SIM planning process can help figure out what should be paid for and HOW.

Co-chair Wong: What would ideal Hawaii systems look like?

A committee member: need to be some risk sharing so that everyone has skin in the game, otherwise this will just be a 5 year incentive program after grant money dries up. We need to prioritize where we want to make the change. It may be working class families who qualify for Medicaid, and then work on a model that we can apply to other populations. Risk sharing on provider and insurer level.

Soares: next meeting we will talk about target populations. We can narrow it down even more. We want to identify "impactable" populations. Committee should think about this and brainstorm. At this point, SMI and SPMI already have some services available that are not available for mild to moderate.

A committee member: Concerned about the status quo and fragmentation in care that exists and how we think about that and work to break it down over time or at least careful not to support and intensify the fragmentation. A lot of costs and suffering are attached to this. We have to focus and start somewhere, but attention needs to be paid to this at the design level.

Soares: Timing and starting with a particular population, year 2 we can add another population.

Co-chair Wong: Everybody has to be in. We all have to be aligned. Hospitals are choosing 1 indicator to work on in Community Health Needs Assessment process. HPCA is trying to go for a health home. SIM can try to enhance these efforts.

Soares: Health home is one of the models we can use.

A committee member: lack of providers and people to refer to.

Soares: This is a big problem. Providers don't want to screen if there is no one to refer to. Hopefully this committee can elucidate what types of services exist and what needs to be built.

A committee member: A lot of providers don't really understand substance abuse. Part of the reason why SBIRT fails is that there is no one to refer to. There is going to have to be an investment in some form of change. Education of doctors, systems. Providers and insurers need to work together. Because of fragmentation and payer/provider issues, a lot of patients just end up in the ER which has to be a huge cost to the system.

Soares: By the next time we meet, Navigant should be with us. We will be meeting again July 21st. Committee will be provided Dr. Goldberg's final analysis. Target population will be discussed as well as screening, who should do it, who should be screened. Five more meetings. General strategy will be to provide committee things to react to. Thank you all for being here, for your time and your expertise.

La Chica: Resources and minutes will be shared online.

Giesting: In the future we will be going paperless, so please print out your own copies or have them on your devices.

Health Care Innovation Website:
The Hawai'i Health Care Project site (hawaiihealthcareproject.org) is no longer being maintained. A new website will be hosted on the Governor's Office site, http://governor.hawaii.gov. Policy Analyst Trish La Chica will be managing content for the website, which will include program updates, agendas, minutes,

and meeting materials, opportunities to provide feedback, and health care innovation reports and resources.

Next Meeting

The next Delivery and Payment Committee meeting will be on July 21st at 11 am in the State Office Tower.

Adjournment

The meeting was adjourned at 12:38pm.

State Innovation Model Design 2

DELIVERY AND PAYMENT COMMITTEE

JUNE 16, 2015

Welcome and Introductions

1. Rachael Wong, Dept of Human Services, Co-Chair
2. Joy Soares, Office of the Governor, Co-Chair
3. Mark Fridovich, Dept of Health
4. Deborah Goebert, National Center on Indigenous Hawaiian Behavioral Health
5. Marya Grambs, Mental Health America
6. Chris Hause, Kaiser Permanente
7. Sid Hermosura, Waimanalo Health Center
8. David Herndon, HMSA
9. Dave Heywood, UnitedHealth Care
10. Robert Hirokawa, Hawaii Primary Care Association
11. Alan Johnson, Hina Mauka
12. Chad Koyanagi, IHS

SIM Staff: Joy Soares, Trish LaChica, Abby Smith, Nora Wiseman

13. Karen Krahn, Dept of Health
14. Sondra Leiggi, Castle Medical Center
15. Anna Loengard, Queen's CIPN
16. Kristine McCoy, Hilo Family Practice Residency
17. Wendy Moriarty, `Ohana Health Plan
18. Gary Okamoto, AlohaCare
19. John Pang, Pharmacist
20. Karen Pellegrin, UH Hilo College of Pharmacy
21. Bill Watts, Queen's Medical Center
22. Kelley Withy, AHEC
23. Paul Young, HAH

Review: 2012 - 2014

SIM Goals

Triple Aim + 1

- Better health
- Reliably good quality care
- Cost-effective care
- + Reducing disparities in health status and access to care

SIM Initiative

SIM is based on the premise that **state-led innovation**, supported by **broad stakeholder input** and engagement, will **accelerate health care delivery system transformation** to provide better health and better care at a lower cost.

SIM encourages public and private sector collaboration to design and test multi-payer models to transform the health care systems in the state.

SIM2 Targets

Behavioral health integration with primary care – effective awareness, diagnosis and treatment

- Patients in primary care settings with mild to moderate behavioral health conditions
- Patients with chronic conditions in combination with behavioral health conditions

Oral health improvement via increased access to timely and preventive services

- Access for children and increase dental sealants and fluoride varnishes
- Strategies to increase coverage for low-income adults

FOCUS IS ON MEDICAID

Rationale for Target Populations

- Feedback from stakeholders, providers, community.
- BH conditions disproportionately affect the most vulnerable populations.
- While transformation in Hawaii is progressing, BH has largely been left out of innovations.
- CHNA identified mental illness as number one preventable cause of hospitalization in 2012.
- SIM Round 1 actuarial analysis showed the average total cost for individuals with a BH diagnosis was three times the average total cost for individuals without a BH diagnosis.

Rationale for Target Populations

- Mental illness is a co-existing condition for 34% of potentially preventable hospitalizations and almost 10% of hospital readmissions (*SIM HHIC analysis*)

- Total annual costs associated with potentially avoidable stays/visits (*SIM HHIC analysis*):
  - ER: $93 million (charges)
  - Preventable hospitalizations: $159 million (estimated cost)
  - Readmissions: $103 million (estimated cost)

SHIP Deliverables

- Description of health care environment
- Health system design and performance objectives
- Delivery and payment innovations
- Population health plan
- Workforce plan
- Financial analysis
- Monitoring and evaluation plan
- Operational plan

SIM 2: Developing a Plan of Action

Committees

- Steering
- Delivery & Payment
- Health IT
- Work Force
- Population Health
- Oral Health

Committee Schedule

Oral Health Committee – June 12th (2nd Fridays)

Delivery and Payment – June 16th (3rd Tuesdays)

Population Health Committee – June 22nd (3rd Monday but may change)

Workforce – June 25th (4th Thursday)

HIT – committee membership and meeting times will be determined after Dr. Goldberg's visit

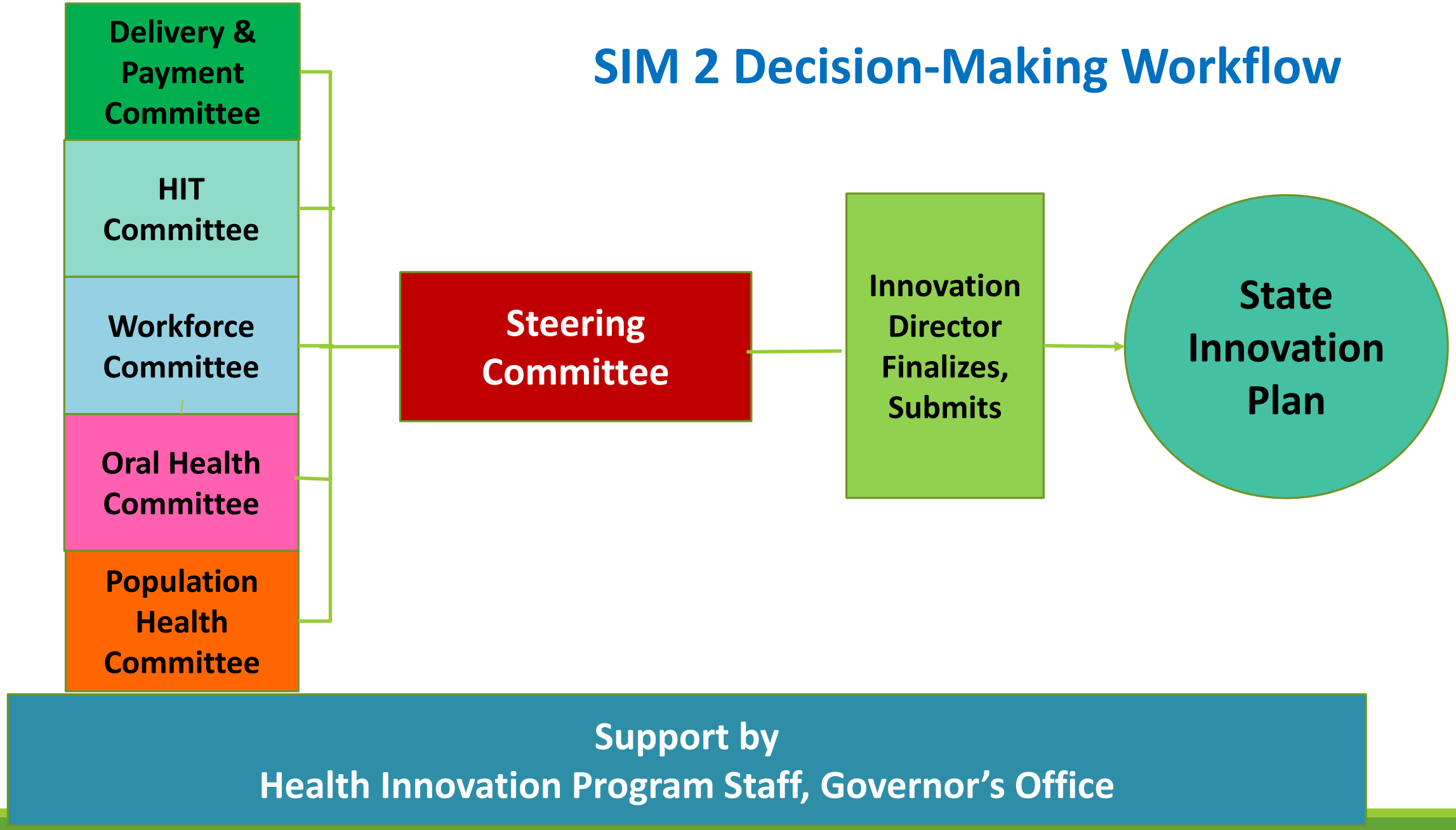
SIM 2: Stakeholder Engagement

- Provider focus groups – facilitated by Dr. Kelley Withy
  - Focus groups on all islands
  - Final report submitted by September 30th

- Community conversations
  - Meetings on all islands
  - Report completed by October 31st

- Webpage
  - All meeting materials posted
  - Opportunity to provide feedback on draft plan
  - http://governor.hawaii.gov/healthcareinnovation/

SIM 2 Decision-Making Workflow



SIM 2: Developing a Plan of Action

All-Committee Meetings

- SIM Kick-Off with Bruce Goldberg - May
- Initial SHIP Draft and Committee Check-In - September
- Structure & Sustainability Plans - November
- Final SHIP Celebration and Next Steps - January

SIM Contractor – Dr. Bruce Goldberg

Focus of the visit will be on:

- Strategic planning focusing HIT vision and goals
- Governance and sustainability of APCD
- Patricia Mactaggart from ONC will provide onsite technical assistance on how to leverage the SMHP and IAPD (waiting for approval from CMMI on Patricia's visit)
- HCI sustainability and structure

Final summary report and recommendations submitted by 07/31/15

- BH integration models
- HIT strategic planning
- HCI sustainability and structure
- Maximizing federal funding
- Plan for remainder of SIM grant – transition to new contractor

SIM Contractor – Navigant

- HCI awarded Navigant a $675,900 contract on June 1st
- Contract begins about July 1st
- Contract includes 4 tasks:
  - Behavioral health integration blueprint
  - Cost analysis and return on investment
  - Proposed process of outcome evaluation and reporting
  - Write SHIP
- Next steps:
  - Write and sign contract by July 1st
  - Debrief with offerors by June 5th and 8th
  - Negotiate specifics of workplan by July 15th

HCI Website

- The Hawaii Health Care Project (hawaiihealthcareproject.org) is no longer being updated
- Governor's Office to host HCI content (http://governor.hawaii.gov/)
  - Program updates
  - Agendas, minutes, meeting materials
  - Opportunity to provide feedback
  - Resources and reports

Next Meeting

Tuesday, July 21st, 11:00– 12:30 pm

State Office Tower, Leiopapa a Kamehameha, Room 1403