EXECUTIVE CHAMBERS
HONOLULU

DAVID Y. IGE
GOVERNOR

Hawai'i Health Care Innovation Models Project
Delivery and Payment Committee Meeting
September 10, 2015

Committee Members Present:
Judy Mohr Peterson (Co-chair)
Joy Soares (Co-chair)
Wendy Moriarty
John Pang
Karen Pellegrin (by phone)
Kelley Withy
Paul Young
Chris Hause (by phone)
Jennifer Diesman
Kenneth Luke
Sondra Leiggi (by phone)
Alan Johnson
Karen Krahn
Danny Cup Choy
Kristine McCoy (by phone)
Sid Hermosura (by phone)
Anna Loengard

Committee Members Excused:
David Herndon
Mark Fridovich
Marya Grambs
Deb Goebert
Dave Heywood
Chad Koyanagi
Bill Watts
Gary Okamoto

Consultants: (by phone)
Mike Lancaster
Denise Levis
Laura Brogan
Andrea Pederson
Alicia Oehmke

Staff Present:
Trish La Chica
Beth Giesting

Welcome and Introductions:
Co-chairs Mohr Peterson and Soares welcomed committee members and opened the meeting with introductions.

Minutes
Soares asked the committee for any changes needed in the minutes from August 13th. No changes were suggested and the committee approved the minutes from the previous meeting.

Hawaii Health Care Innovation Models Project
Delivery and Payment Committee Meeting
September 10, 2015

SIM 2 Goals and Focus Areas (Slides 4 to 11).

Beth Giesting reviewed the SIM goals, priorities, and rationale. This meeting will focus on the behavioral health integration for adults. The next meeting will focus on children. (Please see slides)

Adult Behavioral Health Integration Models (Slides 12 to 39)

Dr. Michael Lancaster continued the discussion of evidence based practice (EBP) models for behavioral health integration. Some key points:

- The BHI models give everyone the opportunity to decide which model to implement. It is also important to understand the cultural needs and social determinants of health that are prominent among the Medicaid population.
- We recognize that any change in the system is difficult. But the priority is to identify and treat people who are already in primary care. We need available and sustainable training models that we can provide to primary care physicians.
- We want to build upon expertise and leverage relationships with different agencies.
- A matrix of the options for EBP by Target Population (mild to moderate) is on slide 18.
- The proposed EBPs for adults are: SBIRT, Screening and treatment for Depression and Anxiety, and Motivational Interviewing.
- **SBIRT Discussion**
    - Stakeholder feedback from focus group discussions:
        - Recommendations: provide consultation services, develop a list of resources, provide referral service or a number for primary care to call, have psychiatrists available to provide consultation
        - We are challenged by having no step down units, no beds. SMI are taking up all beds and there are none available mild to moderate
        - Other issues: no post-discharge follow up
        - MI received positive responses from providers , PHQ9 is also being practiced
    - Multi-disciplinary team could really help with mild to moderate.
    - Motivational interviewing is really helpful in working with BH and chronic conditions
    - ACT teams were mentioned in the past – for SMI/SPMI
    - Community health centers are ready to do screening
    - The MI model was developed around tobacco and substance abuse and is also helpful for those with chronic conditions, and for adolescents
    - State funding has forced us to look at most critical, high risk, but this model really focuses on the front end of this
    - SIM is also looking at: privacy and security issues, care coordination issues, access issues
    - QCIPN (Queen's Clinically Integrated Physician Network): We are working on behavioral health integration as well. We are beginning to implement screening and have put together programs that support physicians in helping them manage their patients. In the next year we will put together a mental health model.
        - Now only a physician network, but needs to be inter-disciplinary
        - Queen's contracts with UH Psychiatry department, which has a lot of experience in telepsychiatry

        - How do we get our PCPs accustomed to using technology or using curbside consult model services?
        - 3 good programs: KP on Maui, Queen's, PCA telepsych in Hawai'i Island
        - David Roth can be a resource on telepsychiatry
        - Building a referral platform on top of HHIE
    - Targeting pregnant women will work
    - Using SBIRT on those with chronic conditions will work
    - Physicians may not want to screen all patients
    - PCPs in focus groups have lamented that programs like service coordination offered through health plans can't be offered to all their patients and would like to see something they can use with their entire patient population.
    - Could the PC clinics do the screening and, if warranted, have a regional or centralized service provide the brief intervention?
    - PCPs have said that health plans should pay for this service if they are requiring them to include it in their metrics.
    - SBIRT can also be administered by other paraprofessionals that patients interact with during the visit.
    - Could be similar to flu vaccine program where an external office does the screening and communicates with PCP
    - There's a lot of wrap around services for those going to CHCs, but not for private PCPs
    - Pharmacists are among the most trusted; there's a lot of data showing how we can leverage pharmacists to strengthen the current workforce without adding burden to PCPs
    - SBIRT target population can focus on:
        - Pregnant women
        - Adults with chronic conditions
        - Everybody – population determined by PCP

Screening for Depression and Anxiety Discussion:

- Project ECHO – no payment structure available
    - 1.5 hour every week on case-based consultation
- QCIPN - providers earn points, which translate to incentives for getting training
- SA – when you leave the facility for treatment, sometimes the patient's mild to moderate SA may go away but depression or other conditions do not
- Under PCMH recognition to get to level 1 depression screening is required
- We should focus on small provider offices since larger organizations are more likely to be doing it already
- How can we incentivize 1-2 person PCP offices?
- What's the clinical imperative? What will get them to achieve better outcomes?
- Depression target population can focus on:
    - Pregnant women
    - Adults with chronic conditions
    - Anybody as determined by PCP

Motivational Interviewing (MI) – Discussion:

- Training is needed for broad implementation
- MI can be part of same roll out as SBIRT or depression screening; it can be a component of each of these approaches.
- MI uses messaging that frames BH models as a means to better manage chronic disease
- There's value in focusing on building community supports and services to empower patients and families to manage their own health
- MI target population can focus on:
  - Everybody – population determined by PCP
  - As part of MI or Depression screening

Operational and Other Issues (Slides 40-44)

Soares provided brief updates on SIM:

- Privacy and Security Issues – SIM continues to work with key stakeholders and providers on how to capture best practices and develop use case examples in sharing behavioral health information.
- Workforce/Care Coordination – the Workforce committee is focused on opportunities with CHWs and clinical pharmacists as staff who can support the BH care team.
- Payment Models and Quality Incentives – SIM continues to work with Judy Mohr Peterson and Navigant in developing measures that would evaluate the BH delivery and payment model.

Next Meeting

The next Delivery and Payment Committee meeting will be on **September 30th from 12-1:30pm in the State Capitol, Room 309.**

Adjournment

The meeting was adjourned at 1:40pm.

State Innovation Model Design 2

DELIVERY AND PAYMENT COMMITTEE

SEPTEMBER 10, 2015

Welcome and Introductions

1. Judy Mohr Peterson, 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, Institute for Human Services
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

SIM Staff: Trish LaChica and Abby Smith

Agenda

Welcome and Introductions	Judy Mohr Peterson
Review of Minutes	Joy Soares
SIM 2 Goals and Focus Areas	Beth Giesting
Adult Behavioral Health Integration Models	Dr. Michael Lancaster
Operational and Other Issues ▪ Privacy and Security Issues ▪ Workforce/Care Coordination ▪ Payment Models and Quality Incentives	Joy Soares
Other Business	Joy Soares
Adjourn	

SIM Goals

Triple Aim + 1

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

SIM Goals

Nurturing healthy families – whole-family approach

- Investing early in keiki and their young parents for future generations.
- Coordinating systems, programs, and services.

SIM2 Focus Areas

Two health care delivery areas that can focus us on ‘Ohana:

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

- Adults and children in the primary care settings with mild to moderate 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 BH focus

Feedback from stakeholders, providers, community

- BH conditions disproportionately affect the most vulnerable populations.
- Access to behavioral health services is challenging, particularly for the Medicaid population.
- While transformation is progressing, BH has largely been left out of innovations.
- Stakeholder feedback from the SIM first round identified behavioral health services need to be strengthened, and that the lack of BH training and resources was an obstacle to offering those services at the primary care level.
- Synergy with other initiatives: Community Health Needs Assessment (CHNA) identified behavioral health as a priority.

Data on BH

- Community Health Needs Assessment 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.
- In 2013, >1 in every 4 adults (27.5%) in Hawai'i reported having poor mental health.[i]
- Asian Americans, Native Hawaiians, and Pacific Islanders (AA/NHPIs) represent 82.5% of the population in Hawai'i, yet have the lowest utilization rates for mental services among all populations, regardless of gender, age, and geographical location.[ii]
- The number of suicides for youth ages 15 to 24 more than doubled from 2007 to 2011.[iii]

Rationale for Focusing on Mild-Moderate BH Conditions

Data and stakeholder feedback revealed there is an opportunity…

Behavioral health integration with primary care – effective awareness, diagnosis and treatment of mild to moderate behavioral health conditions – could improve outcomes and lower costs.

Rationale for Focusing on Mild-Moderate BH Conditions

- PCPs provide 60-70% of BH care for mild to moderate conditions.
- Feedback from Hawaii stakeholders suggest that many PCPs are not screening because of the lack of BH training and resources needed to provide those services at the primary care level.
- Potential return on investment: co-morbidity costs in Hawaii
  - SIM HHIC analysis revealed there was a co-existing mental health condition in 34% of hospitalizations (CY2012 - $483 million).
- National behavioral health integration initiatives have demonstrated improved outcomes and a strong return on investment for patients with mild to moderate behavioral health conditions.
- Data on behavioral health integration pilots in Hawaii are not available yet, but anecdotally providers report they think their patients are receiving better care.

Focus Today is on Adults

WE'LL FOCUS ON CHILDREN DURING OUR NEXT MEETING

Community Care
OF NORTH CAROLINA

Whole Person Care

Integration of Primary and Behavioral Health Care

Presentation to the Delivery & Payment Committee – 9/10/2015

State of Hawaii Health Care Innovation Office

Dr. Mike Lancaster

BHI models will take into consideration:

- The need to develop a blueprint that can be supported by health plans, providers and patients and their families.
- The desire to build these models with engaged providers.
- The need to be flexible and to meet providers / practices where they are in the process of BHI and with the model that makes the sense for their patient population.

Cont. BHI models will take into consideration:

- The desire to offer two to three different BHI models with applicability to different populations.
- The models must be sensitive and understand the social determinants of health and issues of cultural diversity that are prevalent in the Medicaid population.
- Build models on existing infrastructure to leverage resources.
- Other considerations from the D & P Committee?

Focus on two to three EBP models:

- Provides a choice for providers – meeting them where they are
- Keeps it simple
- Sustainable in a PCP model of care
- Recognizes that any change at the practice will present challenges
- Focuses on early adopters

Build on Existing Infrastructure:

- Build on / develop relationships
  - CAMHD
  - CCS
  - JABSOM
  - MCOs
  - IPAs
  - Provider Groups
  - Schools, DHS, DOH
  - Etc.

Need Available and Sustainable Training Models:

- Academic Medical Centers
- Area Health Education Centers
- Managed Care Organizations
- CME online/webinar – proven models available
- Telepych / telemedicine
- Others?

Choices for EBP by Target Population (mild – moderate):

	Depression and Anxiety	Substance Abuse	Motivational Interviewing
12 – 18 years	☑	☑	☑
> 18 years	☑	☑	☑
Pregnant Women	☑	☑	☑
Women of Child Bearing Age	☑	☑	☑

Proposed EBP for PHP/BH Integration

1) **SBIRT**- Screening, Brief Intervention, Referral for Treatment; to help address the hidden issues with substance misuse in a PCP population
2) **Screening and Treatment of Depression and Anxiety** - based on IMPACT model to identify and treat depression in a PCP population
3) **Motivational Interviewing**- educate, engage, empower consumers we serve to be part of their health workforce

Note: We will discuss anxiety during our next meeting.

Priority Populations for SBIRT

Pregnant women

- Substance use during pregnancy will have a negative impact on birth outcomes and is detrimental to the mother and the baby
  - Studies indicate that prenatal care greatly reduces the negative effects of SA during pregnancy, including decreased risks of low birth weight and prematurity
  - ACOG has an official opinion on the value and importance to screen for SA during pregnancy
- ***Current Activities in Hawaii:***
  - Dr. Ira Chasnoff has worked with 16 clinics on Oahu and the Big Island for about 10 years
  - Alignment with other initiatives: The Hawaii Maternal and Infant Health Collaborative is working to make SBIRT the standard of care for all prenatal providers

Cont. Priority Populations for SBIRT

Adults with chronic conditions

- Individuals with comorbid physical and behavioral conditions are at greater risk for poor health outcomes and unless the behavioral health issues are addressed, they will have a difficult time managing their chronic illness(es)
  - SAMHSA supports SBIRT for adults with chronic conditions
  - 2006 eight state report by Colton et al documented that individuals with comorbid behavioral health conditions will have a much shorter life expectancy

Cont. Priority Populations for SBIRT

Adults with chronic conditions

Hawaii-specific data: 2012 HHIC SIM Report

- A mental health condition was a co-existing diagnosis in 34% of hospitalizations
- Diabetes was a co-existing condition for 28% of potentially preventable hospitalizations and 10% of hospital readmissions
- Health disparities:
  - High blood pressure and diabetes are more prevalent among native Hawaiians, Filipinos and Japanese[1]
  - The prevalence of asthma is highest among the Native Hawaiian population[1]
  - One in five Native Hawaiian/Pacific Islander had a diagnoses depressive disorder – the highest percentage of all racial groups in the US[2]

Cont. Priority Populations for SBIRT

Additional Groups to Consider

- Women of Child Bearing Age

Discussion: What populations should we prioritize?

Which Clinical Settings Should be Prioritized for SBIRT models?

- OB/GYNs
- Primary Care Integration to occur:
  - Private Practices
  - Community Health Centers
  - Others?

Major Supports Providers Will Need for SBIRT:

- Training program – train the trainer
- Champions in the practice
- Learning collaboratives for champions to share best practices
- Tools, workflows and toolkits
- Clearly defined system transformation expectations and guidelines
- Incentives – payment reform
- Effective workforce to support the initiative

Priority Populations for Screening for Depression

Pregnant women

- Perinatal and postpartum depression are some of the most common medical complications during pregnancy and the postpartum period. And, if untreated can have very negative effects on women, infants and families.
  - ACOG recommends screening for depression with validated screening tools, such as the Edinburgh, PHQ-9 and Beck.

Priority Populations for Screening for Depression

Pregnant women – Hawaii-specific data[1]

- About 1 out of 7 women (14.5%) with a recent live birth reported Self Reported Postpartum Depressive Symptoms (SRPPD)
- Other Pacific Islander, Other Asian, Samoan, Hawaiian, Filipino, and Korean had the highest SRPPD estimates
- Women more likely to report SRPPD were younger, less educated, not married, **were Medicaid/QUEST insured**, had an unintended pregnancy, smoked and used illicit drugs in pregnancy, and reported intimate partner violence
- Women that report SRPPD were more likely to use drugs during pregnancy, smoke in the last 3 months of pregnancy, experience intimate partner violence, have a premature delivery

Alignment with other initiatives: Hawaii Maternal and Infant Health Collaborative also interested in addressing perinatal and postpartum depression

Cont. Priority Populations for Screening for Depression

Adults with chronic conditions

- Prevalence of co-morbid physical and behavioral conditions is high in the Medicaid population and both need to be treated and addressed for optimal health outcomes – whole person care.
  - The U.S. Preventive Services Task Force recommends screening for depression as it is among the leading causes of disability in person 15 years and older and individuals with chronic conditions are considered “at risk”.

Cont. Priority Populations for Depression

Adults with chronic conditions

Hawaii-specific data: 2012 HHIC SIM Report

- A mental health condition was a co-existing diagnosis in 34% of hospitalizations
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Cont. Priority Populations for Screening for Depression

Members with complex needs (aka high utilizers)

- Prevalence of co-morbid physical and behavioral conditions is high in the Medicaid population and both need to be treated and addressed for optimal health outcomes – whole person care.
    - The U.S. Preventive Services Task Force recommends screening for depression as it is among the leading causes of disability in person 15 years and older and individuals with chronic conditions are considered “at risk”.

Hawaii-specific data: 2012 HHIC SIM Report

- Approximately one in every 10 hospitalizations and ER visits are potentially preventable.
- Total annual costs associated with potentially avoidable stays/visits:
    - To ER: $93 Million (charges)
    - To hospital: $159 million (estimated cost)
    - For hospital readmissions: $103 million (estimated cost)
- Differences in potentially preventable ER utilization and hospital readmission exist by race/ethnicity and by County of patient residence.
    - Disparities: Highest among Other Pacific Islander and Hawaiians, and highest on Kauai

Discussion: What populations should we prioritize?

Which Clinical Settings Should be Prioritized for Screening for Depression?

- Private Practices
- Community Health Centers
- Others?

Major Supports Providers Will Need to Support Screening for Depression:

- Training program – train the trainer
- Champions in the practice
- Learning collaboratives for champions to share best practices
- Tools, workflows and toolkits
- Clearly defined system transformation expectations and guidelines
- Incentives – payment reform
- Effective workforce to support the initiative

Motivational Interviewing

- An EBP that will be a component of practice change, and will be incorporated into most of the previous described elements.
- MI as a practice change model in itself will focus on entire practices to integrate this EBP model of care for care of all patients
- MI is culturally appropriate for most clients

Priority Populations for Motivational Interviewing

Pregnant women

- Motivational Interviewing is an evidence based practice (person-centered form of talking) that will enable trained providers to better engage with their patients. MI educates, engages and empowers consumers to elicit and strengthen their motivation for change
    - Proven model to increase patient engagement

Adults with chronic conditions

- Same rational as above

Members with complex needs (aka high utilizers)

- Same rational as above

Discussion: What populations should we prioritize?

Which Clinical Settings for Motivational Interviewing:

- High Volume Practices
- Small Private Practices
- Community Health Centers
- Health Departments
- Others?

Major Supports Providers Will Need to Support Motivational Interviewing:

- Training program – train the trainer
- Champions in the practice
- Learning collaboratives for champions to share best practices
- Tools, workflows and toolkits
- Clearly defined system transformation expectations and guidelines
- Incentives – payment reform
- Effective workforce to support the initiative

What Will We Need to Succeed?

- Engaged providers and engaged consumers
- Support and endorsement from stakeholders
- Potential alignment of payment / reimbursement
- Potential policy revisions
- Other thoughts from Delivery and Payment Committee members on what will be needed to make this work in Hawaii?

Discussion and Recommendations:

- Based on elements noted above discuss recommended EBP and target group to address
- Factors to consider:
  - Clinical need/ importance
  - Keep it simple to implement (no change is easy)
  - Fits into PCP model of practice with minimal disruption
  - ROI – clinical and fiscal
  - Will resonate with PCPs

Drum roll……Committee recommends …….

Operational and Other Issues

Privacy and Security Issues

Real or perceived issues related to not being able to share behavioral health data

- Related SIM Strategy:
  - Request technical assistance from federal agencies to provide information on when information can be shared for specific use cases (e.g. OB/GYN to pediatrician)
  - Circulate draft document providing information on when information can be shared for feedback
  - Post and share final document in many settings

Operational and Other Issues

Privacy and Security Issues Continued

- Information sharing is inefficient
  - Related SIM Strategy:
    - Collect specific use case information and determine if there are ways to make the process easier for providers.
    - Determine if the ways should be included in plan
    - Develop template PCPs and BH providers can use to share information
    - Other issues related to privacy and security?

Workforce and Care Coordination

Primary care practices need support and team to help screen and treat

- Explore how Community Health Workers (CHW) can support practices
- Explore how clinical pharmacist can support practices
- Decrease practice barriers for psychologists
- Provider to provider consults
- Other strategies?

Workforce and Care Coordination

Primary care practices need care coordination support

- Explore how Community Health Workers (CHW) can support practices
- Explore how health plans can support practices
- Provider to provider consults
- Other strategies?

Other Business

- SIM will schedule additional Delivery and Payment Committee meetings

- Navigant site visit in October

Next Meeting

Tuesday, October 14th, 12:00-2:00 pm

State Office Tower, Leiopapa a Kamehameha, Room 1403