EXECUTIVE CHAMBERS
HONOLULU

DAVID Y. IGE
GOVERNOR

Hawai'i Health Care Innovation Models Project
Delivery and Payment Committee Meeting
September 30, 2015

Committee Members Present:
Judy Mohr Peterson (Co-chair)
Joy Soares (Co-chair)
David Herndon
Mark Fridovich (by phone)
Marya Grambs
Deb Goebert (by phone)
Paul Young
Jennifer Diesman
Alan Johnson
Karen Krahn
Danny Cup Choy
Kristine McCoy (by phone)
Karen Pellegrin (by phone)
Gary Okamoto

Staff Present:
Trish La Chica
Beth Giesting
Abby Smith

Committee Members Excused:
Dave Heywood
Chad Koyanagi
Bill Watts
John Pang
Kelley Withy
Kenneth Luke
Sondra Leiggi
Sid Hermosura
Anna Loengard
Wendy Moriarty
Rudy Marilla

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

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 last meeting. Any changes should be emailed to abigail.r.smith@hawaii.gov.

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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. Future meeting will focus on children. (Please see slides) SIM will also present any relevant findings from community meetings and focus groups in future meetings. Full report of focus groups will be shared and presented once complete.

Discussion on Anxiety (Slides)

- There tends to be an overuse of medication that isn't always the best first course of action
- Question from committee member about whether PHQ-9 can detect anxiety. Dr. Lancaster answered that risks can be identified in screen, and there will be a separate screen for those with suicidality.
- A committee member expressed concern about overuse of benzodiazepines and long term consequences. Dr. Lancaster reiterated that other options will be part of this toolkit.
- A committee member asked what the definition of overutilization is so that can review members on their plan. Dr. Lancaster said there are ranges that are acceptable, and also the amount of time the person has been on as this can lead to addiction.
- A committee member said they see a lot of addicted patients who have been on benzodiazepines for a long time. Providers need information/education. A lot of doctors are also prescribing the same medication for anxiety and depression.
- A committee member noted that opioids, benzodiazepines, and muscle relaxers are a common triad. Needs to be awareness about other medications prescribed at the same time as well. SIM will try to address this in the Blueprint.
- SIM will include anxiety in depression toolkit, have conversations about return on investment with JEN Associates, and get back to health plans with overutilization ranges/operational definitions.

Integration of Primary and Behavioral Health Care and the Role of Care Management / Coordination (Slides 19 to 32)

- A committee member suggested moving away from fee for service and giving providers a lump sum to address behavioral health issues.
- Dr. Mohr Peterson responded that anything is possible in discussion, and we can see what will work in Hawaii Medicaid. How do we incent so that providers are spending enough time with people who need it, and how do we ensure that primary care providers have enough support to feel comfortable?
- A committee member noted the barrier that those who are severe need to see psychiatrists/specialist and many don't take Med-QUEST. Many patients also don't go to these visits once they are scheduled.
- Dr. Mohr Peterson brought up the importance of a warm hand-off and integrated care settings. We will need multiple models since we are trying to create a system that meets the needs of the people and community providers.
- A committee member brought up that the primary care setting is also a good way to address patients with chronic substance use issues who are not currently using. The patient could be referred if they relapse.

- Screenings and brief interventions do not necessarily have to be done just by doctors. This will also be discussed in more detail. It is important that SBIRT be done by a member of the team so that it doesn't seem as though the patient is being pushed off because it's a behavioral health issue. Emergency departments are also a good setting for SBIRT.
- Dr. Lancaster stated that usually less than 5% of those screened actually need a referral to specialty services.
- A committee member noted the value in using clinical pharmacists.
- In answer to a question about the success of using SBIRT in primary care Dr. Mohr Peterson said that the evidence shows effectiveness, even in the onesie/twosie practices, especially when payment is reformed. When SBIRT is implemented across a broad range of providers at the same time (not just physicians) it is also more successful.
- A committee member reiterated the importance of transitioning stable patients back to primary care and of specialty services, and the importance of addressing the physical health needs of those with SMI/SPMI.
- A committee member asked if the plan is to look at interventions that affect all PCP's. Response is that it can be up to the practices which models to choose, but plans may also want to provide incentives. Measures will likely be process oriented to start out with. Dr. Mohr Peterson suggested staying away from pilot programs and working more broadly. Med-QUEST's goal is to meet with all plans to align efforts. Conversations will also occur with the hospitals and other community partners, especially in how to address upstream and downstream factors.
- A committee member asked about health information exchange. SIM is also working on this and will discuss at a future meeting.
- Discussion about SBIRT and who will provide it:
    - Oregon started with just PCP's and other physicians
    - In New Mexico and Washington focused on a broader group of health care providers (training curriculums from others states will be obtained by SIM)
    - Who do we think is appropriate/how would we like to set up the training for SBIRT?
    - Responses:
        - Definitely more than just physicians, applied more proactively, PA's, MA's, physical therapists, community health workers
        - Alan will talk with UCLA about providing SBIRT training/costs
- Co-Chair Soares gave a review of what Delivery and Payment committee has agreed to in this meeting: Anxiety will be included in the depression toolkit. Information will be provided on prescribing medications and strategies to avoid unintentionally over-medicating patients on the common triad of opioids, benzodiazepines, and muscle relaxers. (A review of all agreements thus far will be discussed at next meeting).

<u>Next Meeting</u>
The next Delivery and Payment Committee meeting will be on **October 14th from 12-2:00pm in the State Capitol, Room 329.**

*Health Plans were asked to think about different models of payment for these activities for upcoming meetings.

Adjournment

The meeting was adjourned at 1:41 pm

State Innovation Model Design 2

DELIVERY AND PAYMENT COMMITTEE

SEPTEMBER 30, 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. Sid Hermosura, Waimanalo Health Center
7. David Herndon, HMSA
8. Dave Heywood, UnitedHealth Care
9. Robert Hirokawa, Hawaii Primary Care Association
10. Alan Johnson, Hina Mauka
11. Chad Koyanagi, Institute for Human Services
12. Karen Krahn, Dept of Health
13. Sondra Leiggi, Castle Medical Center
14. Anna Loengard, Queen's CIPN
15. Rudy Marilla, Kaiser Permanente
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
Discussion on Anxiety	Dr. Michael Lancaster
Behavioral Integration Models	Dr. Michael Lancaster

- Review proposed models and goals
- Why behavioral health integration is important
- Key components of proposed models
- Delivery and payment models for care coordination in other states
- Providing and financing training models
- Financing

Agenda Continued

- Behavioral Integration Models Continued — Dr. Michael Lancaster
  - Key questions and decisions points
    - Who will provide the service?
    - How will it be financed?
    - How will it be measured?
    - How will it impact the return on investment?

Operational and Other Issues — Joy Soares

- Privacy and Security Issues
- Workforce/Care Coordination
- Payment Models and Quality Incentives

- 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

STARTING WITH 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

Anxiety Discussion

Presentation to the Delivery & Payment Committee – 9/30/2015

State of Hawaii Health Care Innovation Office

Dr. Mike Lancaster

Depression Tool Kit – Screenings as EBP

- PHQ- 2/9 Screenings will often identify other potential issues to address:
  - Suicidal Ideation
  - Bi-Polar Disorders
  - Anxiety Disorders

Diagnosis and Treatment of Anxiety

- Anxiety is often a normal part of life
- Anxiety can become pathological if it:
  - Interferes with daily life functions
  - Lasts more than 6 months
  - Evolves to obsessive/compulsive behaviors
- Anxiety is often seen as a co-morbid condition in the PCP practice and the medical or BH condition must be identified and treated along with the anxiety
  - Physical illness- Thyroid disease, cardiac valve disease, neurological disease
  - BH conditions, substance abuse issues, depression

Treatment of Anxiety:

- Non-Medication:
  - Relaxation exercises, Yoga, exercise (increase natural endorphins)
  - Cognitive Behavioral Therapy (CBT)
    - ✓Evidenced based intervention to focus on changed thinking patterns that support fears
    - ✓Change the reaction pattern to anxiety-provoking situations

Treatment of Anxiety, cont'd:

- Medications:
  - Anti-depressants- generally preferred class of medications for long term control of anxiety
    - ✓ SSRI/SNRI- may take 3-6 weeks to be fully effective; must take regularly; aware of SE and must monitor for adherence
  - Anti-Anxiety- used for short periods of time for relatively immediate relief; problematic in long term use (tolerance, sedation, problematic in at-risk populations- children /adolescents, elderly, pregnant women)
    - ✓ Benzodiazepines- generally rapid onset of action for relief of anxiety; includes alprazolam, clonazepam, lorazepam, diazepam
    - ✓ Non-benzodiazepines- slower in onset of action but fewer side effects; includes buspirone, hydroxyzine, propranolol (performance anxiety)

Questions?

Community Care
OF NORTH CAROLINA

Integration of Primary and Behavioral Health Care and the Role of Care Management / Coordination

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 in more detail during our next meeting.

Evidence-Based Practices to Address Mild/Moderate BH Conditions in Primary Care:

- Focus is on Substance Use, Depression, Anxiety and Motivational Interviewing
- Goals:
  - Increase comfort level for PCPs in treating Substance Abuse (SA), Depression and Anxiety in their practice
  - Provide support for PCPs through Evidence-Based Practices (EBP) models of care, education and training, and provider consults
  - Establish referral pathways for more complex patients- timely access to BH care
  - Support mild to moderate BH patients to receive care in PCP setting

Why Do This?:

- Integrated Care provides better outcomes
- In a patient centered system-meet the patients where they are
- These patients are in the PCP practices already
- Keep the mild to moderate BH patients in the PCP system, and not in more expensive specialty care
- Cost of care for co-morbid cases is high- early identification and treatment works

Key Components of Delivery of EBP to Provide Payment:

- Training and Sustaining Knowledge
- Care Management/Care Coordination
- Consults/Triage
- PCP Referrals
  - Timely access
  - Emergent access

Delivery and Payment:

- Each of the EBPs have key elements that will be required to be successful:
  - Delivery
    - ✓Training- initial, sustainable Technical Assistance (TA), learning collaborative
    - ✓Care Coordination- patient support, practice support
  - Payment
    - ✓Med-QUEST and Managed Care Organizations (MCO)
    - ✓MCOs and Practices

Care Coordination:

- Systems approach to population management linking patients and families with the right service at the right time in the right amount
- Distribute available resources to address needs:

What	Who
Support timely referrals to appropriate resources when necessary	MCOs
Outreach to most vulnerable patients	MCOs PC Practices
Support registry for chronic conditions in practice settings with patient monitoring	PC Practices
Knowledge and understanding to link patients / families to available community resources and supports	MCOs PC Practices

Models of Care Coordination

Provided in a capitated system by the MCO

Covered as a billed service by providers in the community

Provided in a capitated system through MCO contract with community agency

Provided centrally through state control (North Carolina) Medicaid pays CCNC a PM/PM for care coordination through local networks)

Payment – Care Coordination

Role of MCO Contractually Defined	• Contracts require MCOs to assess, create service plan and coordinate care for individuals with "behavioral health conditions, including substance abuse, who are not receiving services through CCS…"
Role of State	• Policy should facilitate EBP- provider to provider consult, assist with triage for PCP, team based care, tele-psychiatry, support screening/brief interventions
Role of Practice	• Provide support for registry, patient screenings, monitoring progress, outreach

Training / Sustaining Knowledge

- Training on EBP models of care
  - Rationale
  - Screening/Identification
  - Intervention
  - Consult/Triage
  - Referral as necessary

How to Train / Sustain

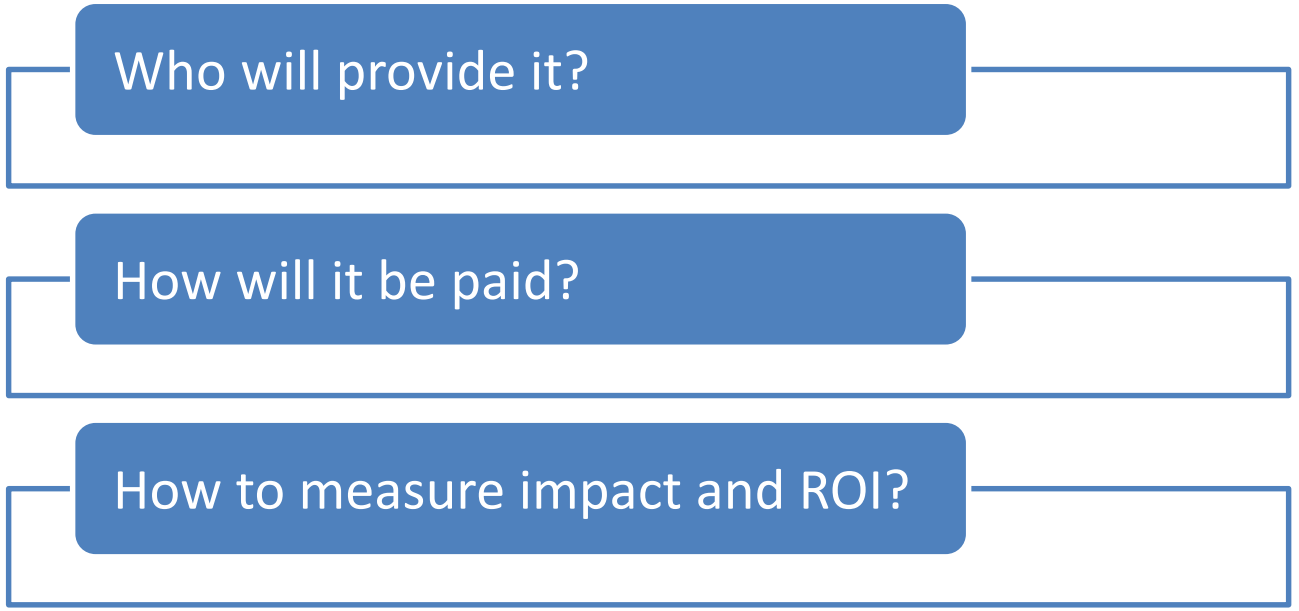
- Models of Training
  - Online/Face-to-Face/CME
  - Academic support: JABSOM? UH Hilo? Others?
  - AHEC, Project ECHO, Addiction Technology Transfer Center Network (ATTCN) Others?
- Sustain and Grow Knowledge Base
  - Technical Assistance: academic centers, MCOs
  - Learning Collaboratives: state, MCOs, academic
  - Tele-psych Consultation: JABSOM or private contracts

Payment – Train / Sustain

- Identify State Resources
  - JABSOM- contracted by state or MCO or provider groups
  - AHEC- contract to provide EBP training statewide
  - State Departments- ADAD, AMHD, CAMHD
  - MINT trainers in-state (5) for Motivational Interviewing
- Identify Outside Resources
  - Contract/hire trainers- consider training of trainers
- Identify Free/Inexpensive (relatively) Resources
  - Online, webinar, etc.- CME many states have excellent programs for EBP (Washington, Oregon, NC, etc.)

Key Points for Discussion

- Assume that Hawai'i wants to offer the EBP discussed to PCP and their patients- SBIRT, Depression/Anxiety Tool Kit, Motivational Interviewing
- Care Coordination & Training/Sustaining of the EBP are key components:



Questions?

Operational and Other Issues

Privacy and Security Issues

Real and/or perceived issues related to not being able to exchange 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 strategies 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

- Additional Delivery and Payment Committee meetings have been scheduled; the 10/29 meeting will need to be rescheduled
- Navigant site visit in October
- Need volunteers for meeting to discuss ROI analysis

Next Meeting

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

Capitol, room 329