EXECUTIVE CHAMBERS
HONOLULU

DAVID Y. IGE
GOVERNOR

Hawai'i Health Care Innovation Models Project
Delivery and Payment Committee Meeting
November 6, 2015

Committee Members Present:
Judy Mohr Peterson (Co-chair)
Joy Soares (Co-chair)
Dave Heywood
Marya Grambs
Jennifer Diesman
Alan Johnson
David Herndon
Danny Cup Choy
Pat Spencer-Kelly (for Gary Okamoto)
Karen Krahn (by phone)
Anna Loengard (by phone)

Staff Present:
Beth Giesting
Abby Smith

Committee Members Excused:
Chad Koyanagi
Bill Watts
John Pang
Kelley Withy
Kenneth Luke
Sondra Leiggi
Sid Hermosura
Wendy Moriarty
Rudy Marilla
Mark Fridovich
Deb Goebert
Paul Young
Kristine McCoy
Karen Pellegrin

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

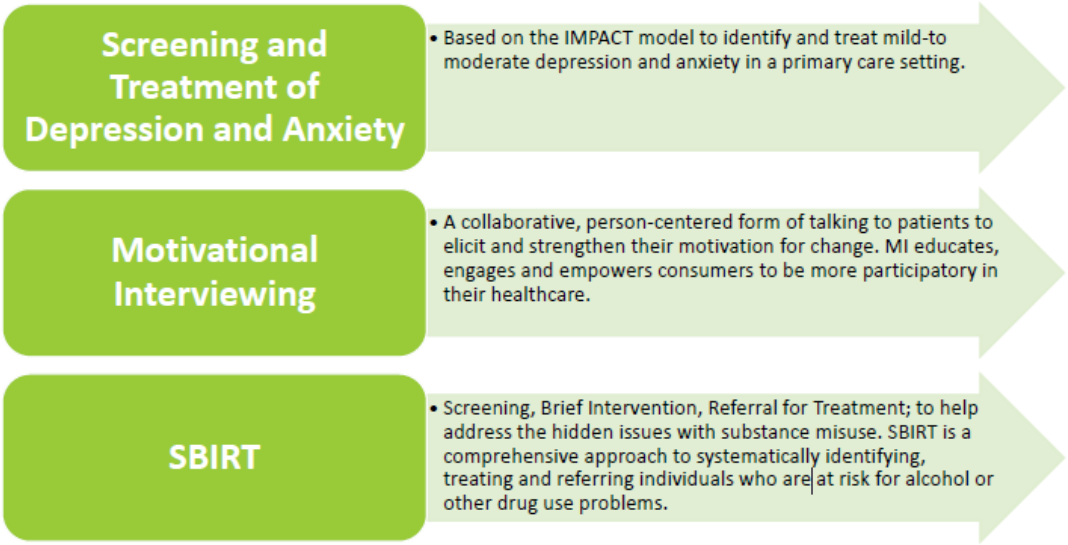
Welcome and Introductions:
Co-chair Mohr Peterson welcomed committee members and opened the meeting with introductions.

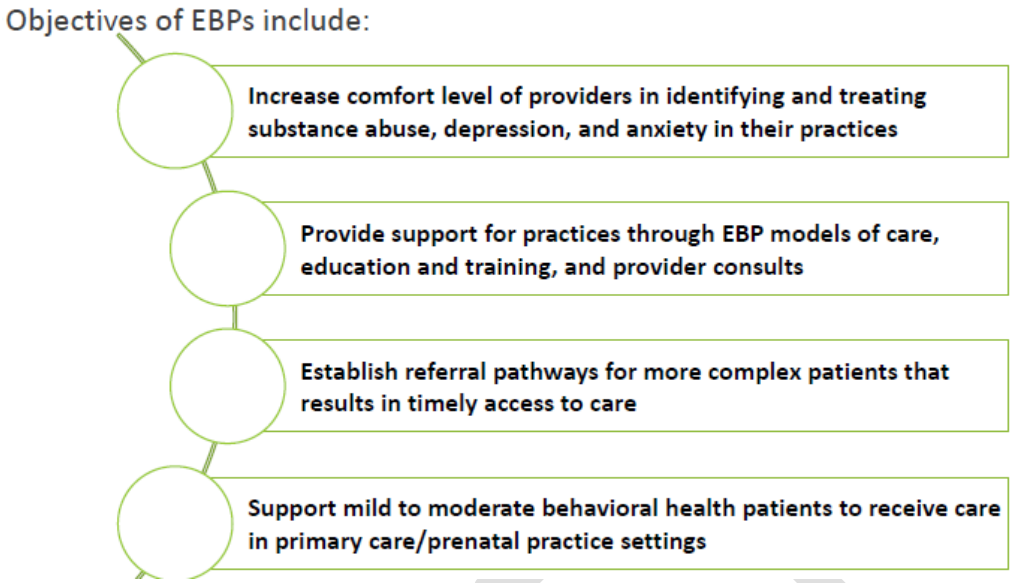
Agenda
Soares asked the committee for any changes needed in the minutes from last meeting. Any revisions should be emailed to abigail.r.smith@hawaii.gov. Overview of agenda and agreements was given.

Agreements thus far:

Agreements on BHI
SIM Goals:

- Identify **behavioral integration** delivery and payment models and agree to strategies and tactics to implement models that address improving early detection, diagnosis, and treatment of mild to moderate behavioral health conditions in primary care and prenatal settings.
- **Improve capacity** of primary care providers to address behavioral health issues on a primary care level and/or integrate behavioral health specialty services and community support services in primary care and prenatal practices.
- **Improve care coordination** of people with behavioral health conditions and linkage with treatment and community support services.
- SIM efforts are starting with **Medicaid** and will focus on children and adults, including pregnant women.
- System changes proposed in this initiative for BHI are expected to contribute to overall health care transformation in Hawaii
- SIM will focus on three evidence-based practice models:





Agreements on evidence-based practices:

- Provider (PCPs and prenatal care providers) participation is voluntary.
- Practices may choose to screen all patients or target populations.
- The depression tool kit also addresses anxiety, and will include strategies to avoid unintentionally over medicating patients on the common triad of opioids, benzodiazepines, and muscle relaxers.

Proposed Focus on Children (see slides)

- Question about what the Childhood Action Strategy covers. SIM will share their plan.
- Consensus was reached to focus on routine screening using the three proposed models for individuals ages 12 and over.
    - SBIRT will be new for some pediatricians. Providers concerned about the extra time needed to implement these models with patients.

Review BHI Blueprint: Dr. Lancaster (see slides and Blueprint word document)
Please provide feedback on the Blueprint by November 20th. You can email feedback to healthinnovation@hawaii.gov or any SIM team member.

BHI System Supports: (see slides)
Training and ongoing support, triage and referral, provider consultations

- Using physician organizations to manage provider consultations was suggested. A multi-pronged approach would be needed while capacity was built across IPO's and health plans.

BHI Payment Models
(Will be discussed next meeting instead)

Evaluation Measures
Please send feedback on measures to joy.soares@hawaii.gov

HIT Plan

Sharing information among PCPs and BH providers would be helpful. EHRs have not been much developed for BH use and BH providers have not been incentivized to adopt EHR use.

Next Meeting

The next Delivery and Payment Committee meeting will be on November 12th from 1:00-2:30 in the State Office Tower, room 1403.

Adjournment

The meeting was adjourned at 12:33pm

State Innovation Model Design 2

DELIVERY AND PAYMENT COMMITTEE

NOVEMBER 6, 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 La Chica, Beth Giesting, Abby Smith

Agenda

❖ Welcome and Introductions	Judy Mohr Peterson
❖ Review of Minutes	Joy Soares
❖ Proposed Focus for Children	Joy Soares
❖ Review Behavioral Health Integration Blueprint	Dr. Michael Lancaster
❖ BHI System Supports • Training and ongoing support • Provider Consultations • Triage and Referral	Dr. Mike Lancaster

Agenda Continued

Behavioral Health Integration Payment Models	Navigant Consulting
Evaluation Measures	Navigant Consulting
HIT Plan	Joy Soares
Adjourn	Judy Mohr Peterson

Review of Minutes

- September 30, 2015
- October 14, 2015

Agreements on BHI

SIM Goals :

- Identify **behavioral integration** delivery and payment models and agree to strategies and tactics to implement models that address improving early detection, diagnosis, and treatment of mild to moderate behavioral health conditions in primary care and prenatal settings.
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- SIM efforts are starting with **Medicaid** and focus will be on children and adults, including pregnant women.
- System changes proposed in this initiative for BHI are expected to contribute to overall health care transformation in Hawaii

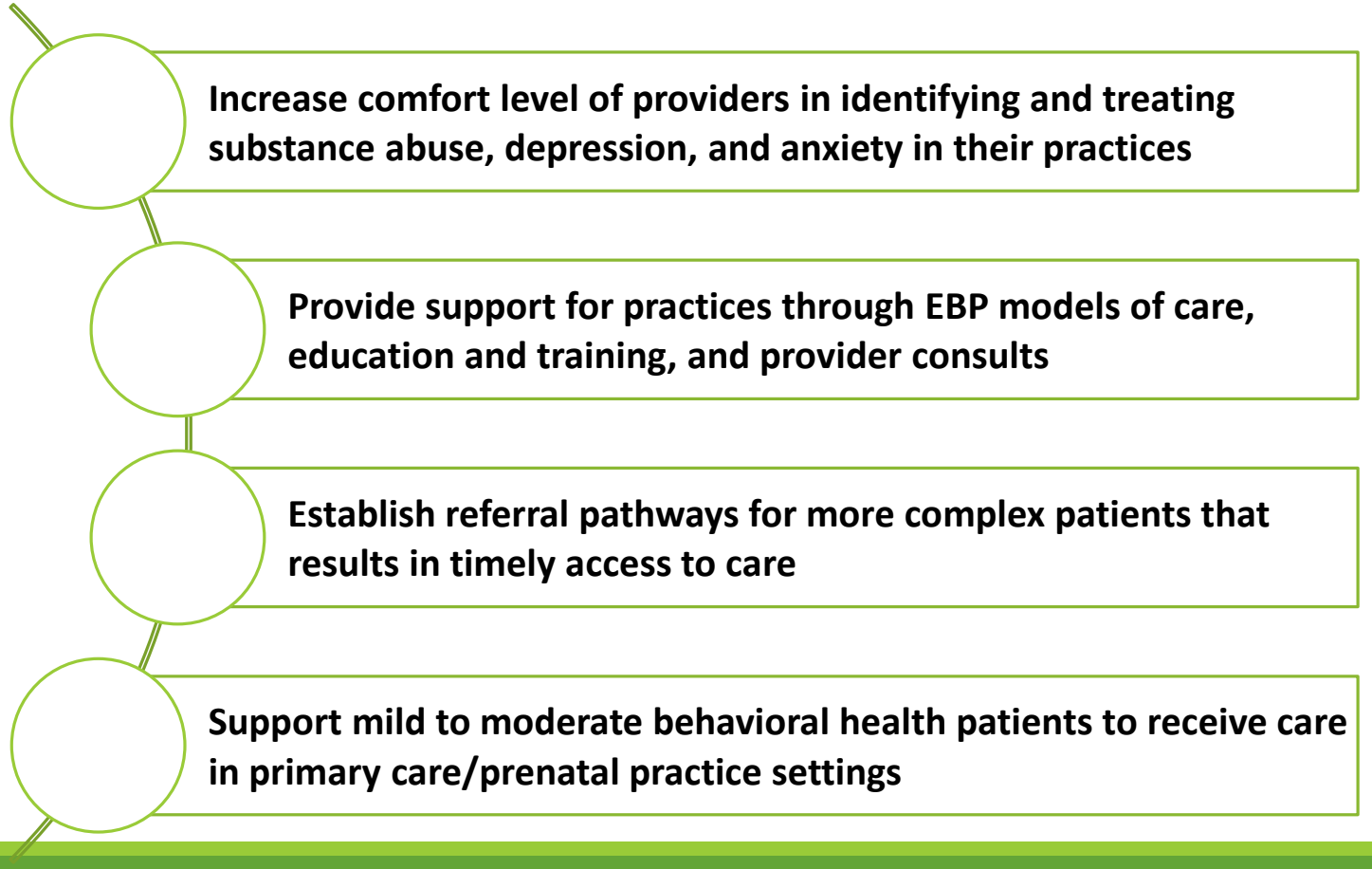
Agreements on Evidence-Based Practices

- SIM will focus on three evidence-based practice (EBP) models.

Screening and Treatment of Depression and Anxiety	• Based on the IMPACT model to identify and treat mild-to moderate depression and anxiety in a primary care setting.
Motivational Interviewing	• A collaborative, person-centered form of talking to patients to elicit and strengthen their motivation for change. MI educates, engages and empowers consumers to be more participatory in their healthcare.
SBIRT	• Screening, Brief Intervention, Referral for Treatment; to help address the hidden issues with substance misuse. SBIRT is a comprehensive approach to systematically identifying, treating and referring individuals who are at risk for alcohol or other drug use problems.

Agreements on Evidence-Based Practices

- Objectives of EBPs include:



Agreements on Evidence-Based Practices

- Provider (PCPs and prenatal care providers) participation is voluntary.
- Practices choose to screen all patients or target populations.
- The depression tool kit will address anxiety, and will include strategies to avoid unintentionally over medicating patients on the common triad of opioids, benzodiazepines, and muscle relaxers.

Proposed Focus On Children

- The three evidence-based practices can also be used with children. Suggested focus on youth ages 12-18

Rationale:

- Consistent with SIM goals:
  - Nurturing healthy families and communities
  - Investing early in children in a multi-generational approach
  - Addressing social determinants of health
  - Addressing the triple aim (better health, better care, better value)
  - Improving health equity and decreasing health disparities
  - Integration of behavioral health

Proposed Focus On Children - Rationale Continued

- Leveraging existing efforts - Builds on SIM behavioral health integration efforts focused on adults

- Not duplicating efforts - The Early Childhood Action Strategy and Hawaii Community Foundation are developing comprehensive strategies to improve outcomes for children up to 8 years of age.

- Stakeholder feedback revealed that behavioral health services for adolescents need to be strengthened, and a lack of BH training and resources was an obstacle to offering those services at the primary care level.

Hawai‘i Data on Adolescents

The number of **suicides** for youth ages 15 to 24 more than doubled from 2007 to 2011.

Disparities:

More than one in ten (11.9%) of Native Hawaii/Pacific Islander high school students attempted suicide one or more times in the past year, the highest proportion among all racial groups in the US. [1]

NHPIs ages 12 and older are abusing or dependent upon substances at rates much higher rates (11.3%) than blacks (7.4%), whites (8.4%), and Hispanics (8.6%). [2]

1. Asian & Pacific Islander American Health Forum. (2010). Health disparities. http://www.apiahf.org/sites/default/files/NHPI_Report08a_2010.pdf
2. US Department of Health and Human Services (2014). Results from the 2013 national survey on drug use and health: http://www.samhsa.gov/data/sites/default/files/NSDUHresultsPDFWHTML2013/Web/NSDUHresults2013.pdf

Data on Evidence-Based Practices for Adolescents

- **Overall –** fewer studies focus specifically on adolescents
- **SBIRT** – Growing body of evidence demonstrates the effectiveness of SBIRT for risky drug use in adolescents[1]
- **Depression/Anxiety** – Fewer studies done to demonstrate evidence in adolescents
- **MI** – Strong evidence to support MI as best practice to be used for all patients, including children and adolescents

1. Madras et al 2008; Saitz et al 2010; Bernstein et al 2005, SAMHSA 2011 “SBIRT in Behavioral Healthcare”

Community Care
OF NORTH CAROLINA

Behavioral Health Integration Blueprint

Presentation to the Delivery & Payment Committee – 11/6/2015

State of Hawaii Health Care Innovation Office

Dr. Mike Lancaster

Purpose of the BHI Blueprint

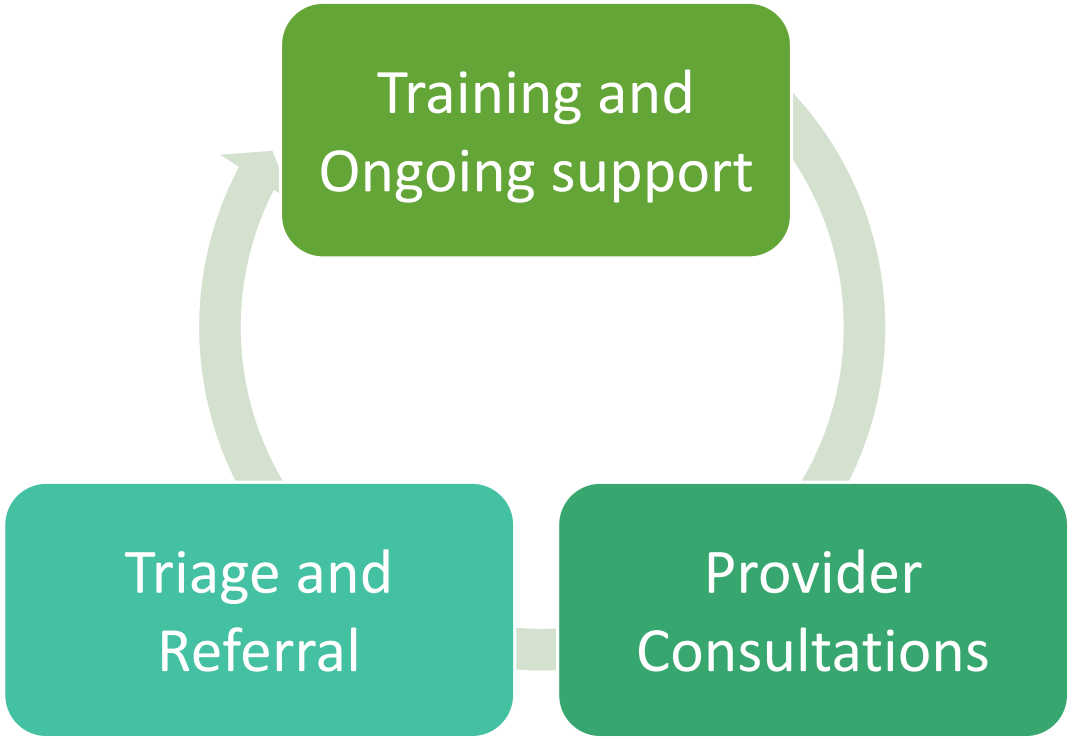
- Intended audience: PCPs
- Provides recommended clinical practices to implement the three models of behavioral health integration
- Discusses the need for focused training and clinical support for adopters (technical assistance, learning collaboratives)
- Discusses the need for practice champions who can organize the practice's staff and motivate change
- Discusses the importance of breaking down silos between primary care and behavioral health providers

Feedback on Blueprint

Email feedback to the Health Care Innovation Team (healthinnovation@hawaii.gov) by Friday, November 20th.

Approach to Discussion on BHI System Supports

Based on feedback from committees, focus groups and stakeholders, we put together a proposal on universal services needed to support BHI regardless of payer type (Medicaid, commercial, etc.).



Proposed Universal System Supports

Primary care practices told us they would like additional supports in place to assist them to increase screening and treatment of behavioral health conditions.

Proposal: The following services would be available to all PCPs in the state, for all BH conditions on the spectrum (mild, moderate, severe), and regardless of payer type (Medicaid, commercial, etc.).

1) PCP training and ongoing support
2) Provider to provider consultations
3) Triage and referral (FOR BEHAVIORAL HEALTH ONLY)
    - Linking consumers with behavioral health specialty care and community supports

Training and Ongoing Support

Primary care practices need initial training and ongoing learning opportunities to learn how to better screen and treat behavioral health conditions

Proposal: One entity accountable for coordinating and providing statewide training
Procurement is required

Pros	Cons
Ensure consistency in training across the state	Financing of efforts is complicated because multiple payers are involved
Potential benefit from cost savings/efficiencies	Sustainability and ongoing support is uncertain at this time
Training could be tailored to be culturally appropriate for the unique populations of Hawai‘i	Not certain how many PCPs are interested in training at this time
All payers benefit	Not all payers will be benefit equally

Provider to Provider Consultations

PCPs want to be able to consult with psychiatrists and BH specialists via phone or telehealth when needed

Proposal: One entity accountable for providing consultations for all PCPs in the state, for all BH conditions, for all payer types (Medicaid, commercial, etc.). Procurement is required.

Pros	Cons
Increases timely access to BH specialty providers across the state	Financing of efforts is complicated because multiple payers are involved
Potential to benefit from cost savings/efficiencies	Sustainability and ongoing support is uncertain at this time
Potential to efficiently utilize BH workforce	Not certain how many PCPs will utilize the service
All payers benefit	Not all payers will be benefit equally

Triage and Referral

PCPs need assistance in triaging care and making referrals to BH specialty providers.

Proposal: One entity accountable for providing triage and assistance with linking patients to BH specialty providers for all PCPs in the state, for all BH conditions, and for all payer types (Medicaid, commercial, etc.). Procurement is required.

Rationale: A more robust system to support PCPs is needed because:

- There is an acute BH workforce shortage
- BH referrals and linkages to services require providers to go outside the medical system and can be more challenging and/or time consuming

Universal Triage and Referral

Pros	Cons
Increases timely access to BH specialty providers across the state	Financing of efforts is complicated because multiple payers are involved
Assist PCPs in determining what type of service is needed, which can be challenging for some BH services	Sustainability and ongoing support is uncertain at this time
Potential to benefit from cost savings/efficiencies	Linking consumers to BH services and community supports is a function for which health plans are currently responsible
All payers benefit	Not all payers will be benefit equally

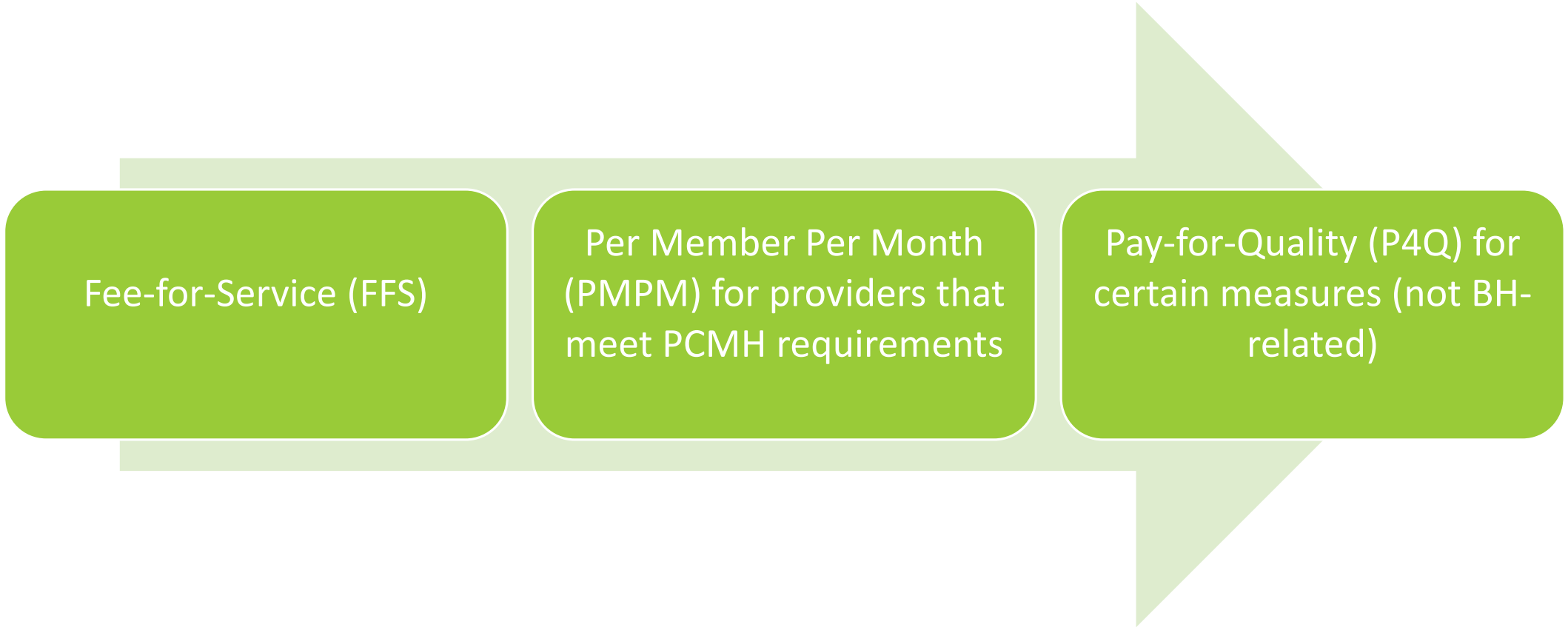
Combining Universal Services

Discussion Question: Is there benefit to combining any of the universal services so one entity is accountable?

Proposed Payment Models

Focus of discussion today is a proposal related to behavioral health integration in the primary care setting

Current Primary Care Payment Structure



Proposed Primary Care Payment Options

Current FFS Payment Structure remains in place, PLUS:

Option A

- Include behavioral health integration measures in PCP P4Q programs (e.g., depression screening rates)

Option B

- Provide a PMPM add-on for practices that adopt one or more of the three BHI models
  - PMPM could be tiered (practices that adopt all three models would receive a higher PMPM than practices that only adopt one)

PMPM add-on would cover the added time that it takes do BH screenings, brief interventions, and motivational interviewing, and time spent making referrals and consulting with BH specialists

Option C

- Option A + Option B
- Include behavioral health integration measures in P4Q programs AND provide an add-on PMPM for practices that adopt one or more of the BHI models

Questions?

Feedback on Evaluation Measures

Proposed measures fall into four categories:

Evaluation Measures

Discussion Questions:

1) Which measures should be prioritized? Excluded?

2) Which measures are good candidates for P4P?

3) What is the best way to measure care coordination for people with mild-moderate behavioral health conditions?

HIT Plan

- Identify privacy and security issues related to BH information exchange and develop strategies to address issues
  - Use case: Information exchange between prenatal/perinatal/pediatric settings
    - HHIE is developing paper that describes what can be exchanged legally; the paper will be distributed to interested stakeholders
  - Distribute sample universal consent forms
- Develop strategies and policies to increase utilization of telehealth
- Development of the All Payer Claims Database – increase transparency and analytic capability

HIT Plan Continued

- Increase information exchange during transitions of care - Admit Discharge Transfer (ADT) feeds
- Increase the number and percentage of providers using electronic health records, including BH providers
- Develop policies that incent or encourage connectivity to the Hawaii Health Information Exchange (HHIE) and exchange of information

Next Meeting

Thursday, November 12th, 12:00-1:30 pm

Capitol, room 329