**EXECUTIVE CHAMBERS**
HONOLULU

**DAVID Y. IGE**
GOVERNOR

# Hawai'i Health Care Innovation Models Project
# Population Health Committee Meeting
# October 16, 2015

Committee Members Present:
Beth Giesting, Co-Chair
Ginny Pressler, Co-Chair
Brigitte McKale
Andrew Nichols
Vija Sehgal
Kealoha Fox
Ryan Okahara (by phone)
Kerrie Urosevich
Sharlene Chun Lum
Katy Akimoto
Jamie Boyd

Staff Present:
Joy Soares
Trish La Chica
Abby Smith

Guests:
Lola Irvin
Brian Matson
Judy Mohr Peterson

Navigant:
Andrea Pederson
Laura Brogan
Sally Adams

Committee Members Excused:
Robert Hirokawa
Jessica Yamauchi
Andrew Garrett
Linda Rosen
Tom Matsuda
Debbie Shimizu
Tony Pfaltzgraff
Paige Heckathorn

## Welcome and Introductions

Co-Chair Beth Giesting welcomed Population Health committee members, guests, and the Navigant consultants who were joining us in person for the meeting. The members briefly introduced themselves, including those who were joining via teleconference.

## Review of Minutes from July 14 Meeting

Co-Chair Beth Giesting asked for corrections of minutes from the previous meeting. Minutes were approved unanimously as no feedback was received.

## SIM Overview

Andrea Pederson and Laura provided an overview of the SIM Deliverables and Roadmap, which includes a timeline of each task. The State Health Innovation or SHIP, is a federal requirement as part of the SIM grant and includes a Return on Investment analysis.

Chair Giesting talked about the transformation agenda which is to support healthy communities and families. Health care transformation looks at a system that is person- and family-focused and oriented to health. SIM is particularly looking at BH integration to improve population health.

The population health approach includes three components: clinical interventions, patient-centered linkages to resources in the community, and alignment of statewide resources for better health.

**Homelessness update (see slides below)**

Brian Matson provided an update on the administration's efforts to address homelessness. Governor Ige convened the leadership council 2 months ago. The Hawaii Interagency Council on Homelessness was statutorily created in 2012. So far, the program has assessed over 140 individuals with a common tool, which is administered by Partners in Care (composed of organizations and public health nurses). They also check on shelter bed availability daily. Currently, there are 150 beds available but various reasons that they aren't filled. The Interagency Council agrees that housing *is* healthcare and must be a priority.

In early August, there were 239 individuals and from those, 158 have now been placed into shelter and housing. Governor Ige announced on October 16th an Emergency Proclamation to increase funding to address homelessness statewide. It includes $1.3 million to extend the program through June/July. Matson also provided an overview on the work that has been ongoing over the past 6 weeks. The next steps include expanding services throughout O'ahu.

**Question:**

- What's driving the 150 excess beds? Some shelters are not open 24/7, some are driven by shelter policy such as dress codes, or services that don't offer laundry or showers; Homelessness initiative has been working to standardize shelter services.
- A comment from HUD said that they are working on legislation on accessory dwelling units, which is not a panacea but is expected to relieve some of the housing shortage.

**Early Childhood update**

Kerrie Urosevich provided an update on early learning efforts. The program started a collaborative systems design plan three years ago that looked at health systems and came up with 6 key areas for measuring young children's development birth to 8 (healthy births, safe and nurturing families, on-track health and development, equitable access to programs and services, high quality early childhood programs, and successful transitions between early childhood programs). On BH health, they are developing a comprehensive referral system for screening those ages 5 and under. The challenge is that we don't have the data, and we can't look at improvements over the time, and can't answer "How many of our children are on track?" EPSDT data could be helpful but it is not analyzed and reported in a meaningful way. We need the data to target services and interventions for early childhood.

**Questions:**

- Why are we having challenges in analyzing this data? Hard copies of data is scanned and sent to Phoenix in Arizona and analysis is done at the 50,000 foot level with

limited detail; we also don't have the state and backend infrastructure to analyze the data but Judy Mohr Peterson is very supportive of trying to find a solution for this.

**CHNA Update**

Andrew Garrett was not available but Giesting reported that the hospitals agreed that behavioral health as well as diabetes and access to care were the highest priorities Information on planned interventions should be forthcoming from HAH.

**Population Health Plan Requirements**

Abby Smith provided an overview of the components required by CMMI that need to go into the plan to address population health (see Slide 11). Giesting talked about what is being done on population health in Hawai'i which includes the administration's collaborative approach to addressing social determinants and health. The approach to the PH plan will be to:

- Identify: Hawai'i's many successful PH initiatives and positive outcomes. A special emphasis will be on tobacco, obesity, diabetes, disparities since those are CMMI requirements.
- Describe: New direction in collaboration across departments, focus on families and communities, system-building approach.
- Add SIM's Contributions: Behavioral health strategies, including resources and tools: CHWs, Motivational Interviewing, integration with primary care.

Trish La Chica noted that next steps will entail SIM staff and Navigant developing the PH plan, which will include statewide and community wide initiatives that are already underway. This will be distributed to the Committee in November for comment and input. The final draft of the PH plan will be included in the SHIP.

**Question:**

- Can the full SHIP also be shared? Yes this will be circulated to all the committees.
- Will this be sustained through Medicaid? - Yes but to draw down Medicaid/Federal dollars we need general fund dollars and need to think creatively on how we can fund these efforts.

**Opportunities for continued involvement in population health activities**

Lola Irvin, Administrator for the Chronic Disease Prevention and Health Promotion Division shared potential engagement opportunities with the PH Committee. Irvin's division at the Department of Health is looking at inequities across systems and priorities (such as tobacco cessation and built environments). The following short term opportunities were shared. Irvin will get the email list from SIM staff and forward these opportunities to the Committee.

- There will be a DOH/DHS symposium on Nov 5th.
- There is a Prevention Task Force
- There is a Food System Task Force
- There is a School Garden Hui - KCC

**Adjournment**

The committee was adjourned at 2:22pm.

# State Innovation Model Design

POPULATION HEALTH COMMITTEE

OCTOBER 16, 2015

# Welcome, Introductions, Minutes

1. Beth Giesting, Office of the Governor, Co-Chair
2. Ginny Pressler, Dept of Health, Co-chair
3. Katy Akimoto, HMSA
4. Jamie Boyd, Windward Community College
5. Sharlene Chun-Lum, Papa Ola Lokahi
6. Kealoha Fox, OHA
7. Andrew Garrett, HAH
8. Robert Hirokawa, Hawaii Primary Care Association
9. Brigitte McKale, Pali Momi, HPH

SIM Staff: Joy Soares
Abby Smith
Trish LaChica

Consultants:
Navigant

10. Tom Matsuda, Hawaii Community Foundation
11. Andrew Nichols, University Health Services
12. Ryan Okahara, HUD
13. Tony Pfaltzgraff, Kalihi YMCA/Community Rep.
14. Linda Rosen, HHSC
15. Vija Sehgal, Waianae Coast Comprehensive Health Ctr
16. Debbie Shimizu, No Wrong Door Grant
17. Kelly Stern, DOE
18. Kerrie Urosevich, Executive Office on Early Learning
19. Jessica Yamauchi, Hawaii Public Health Institute

# SIM Deliverables & Roadmap

**Navigant Healthcare Team**

**Lead: CCNC**

**BH Blueprint**

Outline of BHI Blueprint – *complete*

Interim drafts of BHI Blueprint – *complete/ October 2015*

Stakeholder discussions – *on-going*

Final BHI Blueprint – *November 2015*

**On-going activities include:**

- Weekly meetings with Governor's Office staff
- Monthly meetings with Judy Mohr Peterson
- Monthly meetings with SIM Committees

**Lead: Optumas LLC, JEN Associates**

**Cost Analysis & Return on Investment**

Data request – *complete*

Analysis plan – *adjusts based on BHI Blueprint* – *November 2015*

Initial review of claims data; data quality report – *November 2015*

Finalized database for analysis – *December 2015*

Preliminary impact model, ROI model, key assumptions and actuarial report – *January 2016*

**Lead: Navigant Healthcare**

**Evaluation & Management Plan**

Research and stakeholder discussion about quality and outcome measures - *on-going*

Draft matrix of viable quality and outcome measure options – *complete*

Data collection and reporting strategy - *November 2015*

Data submission plan - *December 2015*

Dashboard format for presenting quality/outcome measure results – *January 2016*

**SHIP Report**

SHIP Report Plan – *complete*

Draft outline of SHIP – *complete*

Expanded outline/interim draft of SHIP – *November 2015*

Interim draft of SHIP for review with committees – *December 2015*

Final SHIP report – *January 31, 2016*

# THE TRANSFORMATION AGENDA:

# HEALTHY FAMILIES AND COMMUNITIES IN HAWAI‘I

# State's goals for health and care

**Triple Aim**

1. Better health
2. Better care
3. Better value/lower costs

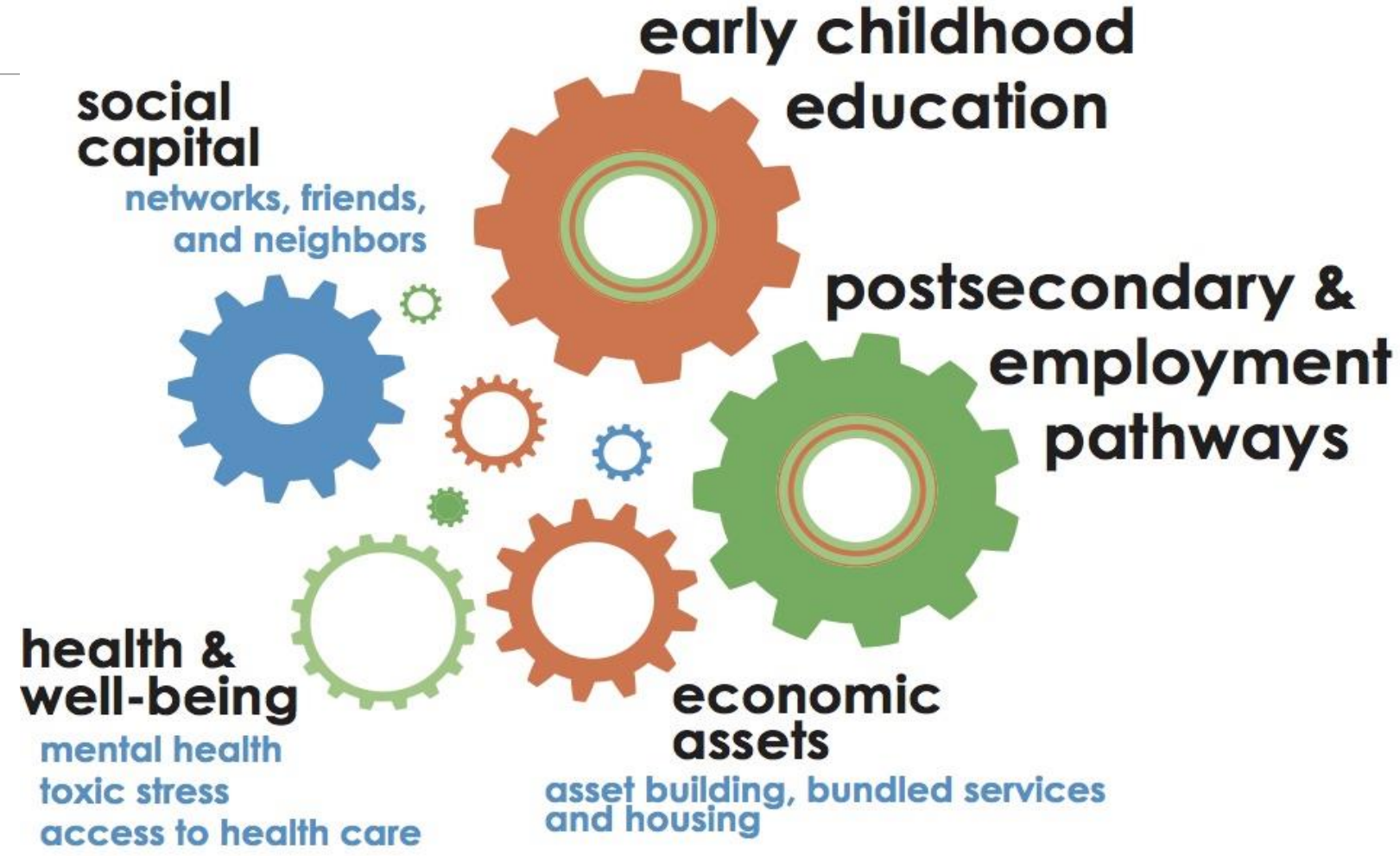
**Beyond Clinical Care**

1. Our house, our work, our education
2. Our families and community support
3. Our zip codes and our cultural codes

**Matching Needs to Resources**

1. Racial/ethnic identification
2. Geography
3. Economic resources

# Transforming components into systems




SIM Focus

# Health care transformation

1. System person/family-focused.  Oriented to health.

2. BH Integration
   - Improvement advances broader agenda for primary care change
     - Population health and care coordination
     - New service models and sites
     - New members of the work force, such as CHWs, and practicing in teams
     - Use of health information exchange, patient portals, IT, telehealth
     - Development of learning health care system, practice support
     - System alignment – metrics, payment strategies
     - Payment reform

3. Oral health improvement

# Population Health Approach

**All necessary for good health:**

| #1 Clinical Interventions | #2 Patient-Centered Linkage to Resources | #3 Align Environment/Policy/ Resources for Better Health |
|---|---|---|
| Screening<br>Prevention, early intervention<br>Curative<br>Palliative | Food<br>Housing<br>Health education/counseling<br>Support for therapeutic needs<br>Language/cultural support<br>HIT, Exchange, Portals, Telehealth | Social determinants of health<br>Poverty<br>Built environment<br>Education<br>Jobs and economic opportunity<br>Safety<br>Family and social supports |

# Another Way to Describe PH & SDOH…

**SERVICES THAT IMPACT HEALTH**

# Updates

- Reducing homelessness
- Early Learning
- CHNA
- Other?

# Pop Health Plan Requirements

- Improve the health and well-being of Hawai‘i population
- Emphasize high risk groups and disparities
- Address social determinants of health
- Address tobacco, obesity, and diabetes
- Show linkages to SIM behavioral health strategies and metrics

# Population Health in Hawai‘i

**Administration’s approach**

- Multi-generational
- Collaborative
- Transforming components into systems

**Some examples**

- Early learning
- Addressing homelessness
- No Wrong Door
- School health services
- MQD and SIM BH plan
- Sharing, using data

# Population Health in Hawai‘i

Many private and public initiatives

- CHNA (access, diabetes, mental health)
- DOH health promotion (diabetes, obesity)
- Tobacco cessation & progressive policy (Quitline, age 21)
- County initiatives (walk, bike, complete streets)
- Native Hawaiian Master Plan (system change to support health)

# Proposed Approach to PH Plan

Identify:  Hawai‘i’s many successful PH initiatives and positive outcomes.  Emphasis on tobacco, obesity, diabetes, disparities.

Describe:  New direction in collaboration across departments, focus on families and communities, system-building approach.

Add SIM’s Contributions:  Behavioral health strategies, including resources and tools:  CHWs, Motivational Interviewing, integration with primary care.

# Proposed Approach to PH Plan

Contents:

- Update needs assessment, health of Hawai‘i baseline
- Report on initiatives underway.  Highlight tobacco, obesity, diabetes, addressing disparities.
- SIM behavioral health integration
- Show connections and contribution to population health improvement
- Identify metrics, monitoring, reporting plans

| | | |
|---|---|---|
| **DOH-DHS-DOE collaboration**<br>**Early Learning**<br>**No Wrong Door**<br>**Homelessness**<br>**CHNA**<br>**Healthy Hawai‘i Initiatives**<br>**SAMHSA grants/supported programs (DOH, FQHCs, JABSOM)** | **USDOE School Transformation grant**<br>**Reducing homelessness**<br>**Papa Ola Lokahi & Master Plan**<br>**CHNA**<br>**Blue Zones and HMSA**<br>**County walk/bike projects** | **SIM:**<br>• **Emphasis on BH (MH, SA)**<br>• **Integration with primary care**<br>• **Motivational interviewing**<br>• **Advancing CHWs**<br>• **Oral health** |

# Proposed Approach to PH Plan

1. SIM Staff/Navigant to develop PH Plan
2. Distribute to committee for comment, input
3. Final draft included in SHIP and SIM deliverables

# Next Steps

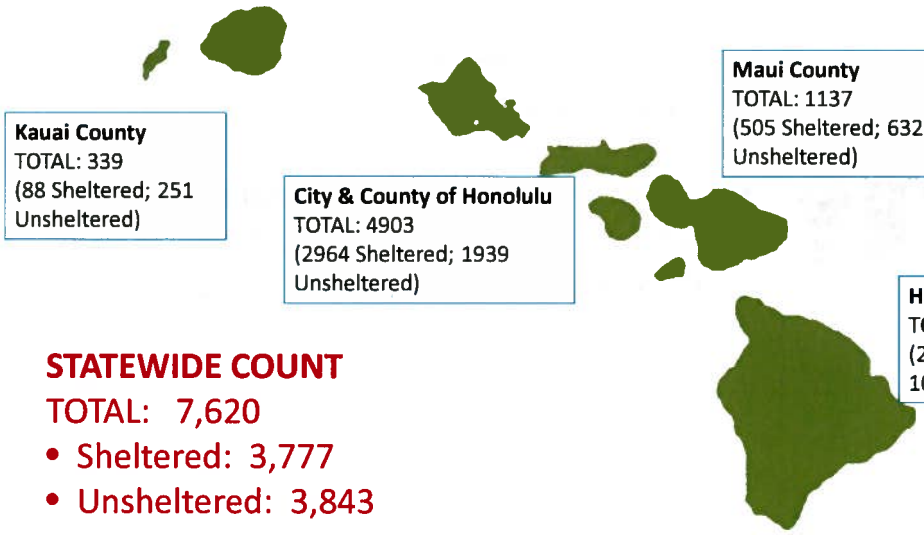
Opportunities/interest in continued convening on population health issues?

**Celebrate Hawai‘i’s success in working together to improve health and well-being**

Governor's Coordinator on Homelessness

October 16, 2015
Phone: (808) 586-0193

# Overview: 2015 Statewide Point in Time Count



**Kauai County**
TOTAL: 339
(88 Sheltered; 251 Unsheltered)

**City & County of Honolulu**
TOTAL: 4903
(2964 Sheltered; 1939 Unsheltered)

**Maui County**
TOTAL: 1137
(505 Sheltered; 632 Unsheltered)

**Hawaii County**
TOTAL: 1241
(220 Sheltered; 1021 Unsheltered)

**STATEWIDE COUNT**
TOTAL: 7,620
- Sheltered: 3,777
- Unsheltered: 3,843

## Overview of Existing Data

- Excess Shelter Capacity for Single Individuals
  - *Estimated 150 beds on any given night*
- Tend to have lower rates of exit to permanent housing
- Tend to have higher percentage who are assessed at the Permanent Supportive Housing (PSH) level of need

## Overview of Existing Data

- Limited Shelter Capacity for families with children
- 65% increase in unsheltered homeless families since 2013
- Higher rates of exit to permanent housing
- Tend to have higher percentage who are assessed at the Rapid Re-Housing or Mainstream levels of need

# A Coordinated Approach to Addressing Homelessness

Governor's Leadership Team on Homelessness

Hawaii Interagency Council on Homelessness

Partners in Care (Continuum of Care – Honolulu)

Bridging the Gap (Continuum of Care – Balance of State)

Community Stakeholders (Healthcare, Private Business, Faith-based, V.A., etc.)

# Our Framework Moving Forward

**Short-Term**

Build State capacity
Develop a model in Kakaako

Maximize existing shelter space

Identify and map resources

**Intermediate**

Gather data regarding homeless populations statewide

Replicate the 'Kakaako model'

Develop programs (Shelter, Rapid Re-Housing, or Permanent Supportive Housing) based on data

**Long-Term**

Sustainable funding

Development of permanent housing

Private-Public Partnerships

## The Kakaako Model

- ❑ Assertive outreach to homeless population
- ❑ Gather data to better understand population needs
- ❑ Inventory shelter space in surrounding areas (i.e. Next Step, I.H.S.)
- ❑ Coordinate enforcement, security and service provider efforts
- ❑ Identify and connect homeless families / individuals to shelter or other appropriate programs

## Successes demonstrated through Kakaako Approach

- **158 persons** placed into shelter or other housing
  - **25 families** with minor children
  - Placements represent **54% of the total population**, and **80% of families**
  - Exceeded our goal to place **50% of families** in shelter by the end of October
- Factors that contributed to successful placement:
  - Assertive Outreach
  - Flexibility in documentation requirements needed for shelter entry
  - On-site transportation
  - Coordination between City, State, Federal leaders and homeless service providers

## Emergency Proclamation

Earlier today, Governor Ige announced that he will be signing an emergency proclamation to address homelessness statewide. The proclamation has three main focuses:

- Increase funding for programs that accelerate entry into permanent housing by **$1.3 million statewide**
- Extend existing homeless service contracts until June 2016 and July 2016
- Facilitate rapid construction of a transitional housing site targeted at homeless families

## Overview of Approach

- ❑ Coordination between multiple stakeholders
- ❑ Partnership with homeless service providers
- ❑ Utilization of data to inform programming and lower barriers
- ❑ Maximize existing shelter and other resources
- ❑ Strengthen pathways to permanent housing