# Summary of SIM Public Hearing Process and Commentary

Transparency and community input are important aspects of planning health care system change. Although not required for the Hawaii's State Health Innovation Models (SIM) planning process, project leadership strongly endorsed the process of sharing the intent and status of plans and solicit community input.

In order to accommodate Hawai'i's diverse island geography, hearings were held in seven locations on six islands, as follows:

| | |
|---|---|
| **Kaua'i** | **September 14, 2015, 2:00 p.m. – 4:00 p.m.**<br>**Kaua'i Community College Cafeteria**<br>**3-1901 Kaumuali'i Highway**<br>**Lihu'e, HI** |
| **Maui** | **September 18, 2015, 10:00 a.m. – noon**<br>**J. Walter Cameron Center Auditorium**<br>**95 Mahalani Street**<br>**Wailuku, HI** |
| **Kona** | **September 21, 2015, 10:00 a.m. – noon**<br>**County Council Chambers at the West Hawai'i Civic Center, Building A**<br>**74-677 Kealakehe Pkwy**<br>**Kailua-Kona, HI** |
| **O'ahu** | **September 23, 2015, 2:00 – 4:00 p.m.**<br>**The Queen's Conference Center, Room 200**<br>**1301 Punchbowl Street**<br>**Honolulu, HI** |
| **Hilo** | **September 25, 2015, 10:00 a.m. – noon**<br>**University of Hawai'i at Hilo, College of Hawaiian Language, Hale'ōlelo, Lumi Pāhiahia (Performing Arts Hall)**<br>**200 West Kawili Street**<br>**Hilo, Hawai'i** |
| **Lana'i** | **September 29, 2015, 1:00 – 3:00 p.m.**<br>**Lana'i Senior Center**<br>**309 7th Street**<br>**Lana'i City, HI** |
| **Moloka'i** | **October 2, 2015, 10:00 a.m. – 12:00 noon**<br>**Kaunakakai Civic Center, Room 105** |

**Corner of Maka'ena and Ala Malama**
**Kaunakakai, HI**

To augment communication and enhance interest in the hearings, the Governor's Office organized them to include an overview and in-depth discussion of three important executive-level Affordable Care Act-related initiatives:

1. Hawai'i's proposed ACA State Innovation Waiver.
2. The strategies being developed as part of a State Innovation Models (SIM) Planning grant supported by the Centers for Medicare and Medicaid Innovation.
3. A "No Wrong Door" three-year plan supported by the federal Agency for Community Living intended to enhance access to services for the elderly, people with disabilities, and veterans (due to grant constraints this plan was not included in the public hearings on Lana'i and Moloka'i).

A copy of the SIM presentations shared at the public hearings is attached.

The Governor's Office hosted the public hearings with Deputy Chief of Staff, Laurel Johnston, serving as convener. ACA Waiver task force chair and Health Care Innovation Director, Beth Giesting, presented the ACA Waiver Proposal. SIM Project Director, Joy Soares, presented strategies and priorities for SIM. No Wrong Door Project Lead, Debbie Shimizu, presented the project's three-year plan. In the public hearings where break-out groups were indicated, each presenter facilitated discussion of her respective program.

Attendance for all seven public hearings totaled 163 with considerable variation by island, as follows:

| | | | |
|---|---|---|---|
| Kaua'i | 15 | Hilo | 10 |
| Maui | 40 | Lana'i | 25 |
| Kona | 9 | Moloka'i | 9 |
| Honolulu | 55 | **TOTAL** | **163** |

## SIM Proposal Questions, Comments, Suggestions

The following summarizes the community input on the SIM proposal at each meeting. Most frequently heard comments were:

- Agreement that improvements in access and sufficiency of behavioral health services need to be addressed.
- Agreement with the interventions outlined in the SIM plan.
- Provider shortages are made worse by lack of information about the network of care givers who are available.
- Frustration with the administrative challenges of being a provider to clients covered by MedQuest.

**Kaua'i, Sept. 14, 2015**

15 people attended.

SIM questions/comments:

- Where does funding come from? Who's going to pay?
- Provider-provider consults a good idea but not sure how it directly supports patients.
- What is ideal team?
- Many psychologists don't accept Medicaid or contract with certain plans because of administrative and reimbursement burdens. Many times administrative requirements are different for each plan, adding to the burden experienced by providers.
- Populations that are most in need are the ones least likely to get care.
- Having a consult line would be helpful. A triage solution would help doctors get patients the right kind of care. A consult line for providers should include a social worker, someone local. Placed in DOH?
- Patient navigators as used in oncology could provide a good model for BH.
- Mid-levels – APRNs and prescribing psychologists – in short supply on Kaua'i. Their services should be expanded. However, Kaua'i residents may not trust non-MD providers as much.
- Focus on mild/moderate is good. People with severe problems make up a small group.
- Concern that PCPs manage BH with medication only
- A pilot project on Kaua'i is combining BH with medical care for diabetic patients.
- Patients are not the obstacle for sharing information among providers. PCPs would like to get records from BH providers.
- Sustainability of the planned BH integration strategies is important
- Telehealth and CMEs are good strategies
- Plan would be better if more community providers were involved.
- Payment for care coordination/navigation needs to be included.
- Training PCPs is important.
- Independent practitioners need to be included in the plan.
- Reduce administrative burdens – prior authorizations and credentialing.
- Increasing availability of and streamlining the process to get BH services is very important.
- Provide concise training for PCPs to identify BH problems and get patient the right kind of help.
- Appreciates that the solicitation of community input and developing innovative strategies based on others' experiences.

Kaua'i issues:

- Island has no inpatient care for childhood substance abuse (no detox) or mental health
- Despite having limited resources for detox, detox treatment cannot be provided at an inpatient psychiatric ward or facility. Not sure if this is a state/federal regulation.
    - One attendee asked: Is there a rule that says you cannot do inpatient detox at a psychiatric facility? –Is it a State, Federal regulation or from the facility?
    - Only 1 psychiatrist on the island will come to the hospital.

**Maui, Sept. 18, 2015**

40 people attended.

SIM questions/comments:

- Proposed model appears to help primary care providers have resources to use with patients with BH needs.
- Can help address BH needs early on.
- Would plan make BH care more profitable for providers?
- Language is very inclusive and positive but would substitute the word "participant" for "consumer."
- Supports ideas on ROI and suggests collecting and showcasing success stories.
- Needs to address home-based care and BH across continuum of care and lifespan.
- HIT needs should be identified.
- Glad that there is a plan taking shape around this issue.
- Supports approach to improve early intervention for BH needs.
- Suggest incorporating ACE approach for primary care screening.
- Community-based wrap-around services are not addressed by the plan.
- Would be helpful to integrate care across hospital and agencies.
- Should promote prescriptive authority for psychologists.
- Need to address credentialing barriers. Can take months for psychiatrists to get credentialed.
- Local infrastructure (for the neighbor islands) needs to be improved in order to implement this plan.

**Kona, Sept. 21, 2015**

9 people attended.

SIM questions/comments:

Presentations were concise and informative.

BH integration is a positive approach.

Some QUEST MCOs deny services by not including substance abuse providers in their networks and punish providers when they complain.

Why are naturopaths not included as providers?

MCO credentialing and prior authorization processes drive away providers. Many provide services without getting paid.

**Honolulu, Sept. 23, 2015**

55 people attended.

SIM questions/comments:

- Caring for Medicaid patients has become more and more frustrating. 1994 Medicaid Managed Care resulted in lots of prior authorizations, only getting a few sessions at a time. Participation of psychiatrists in Medicaid dropped from 100% to about 67%. Private sector psychiatrists no longer want to see Medicaid patients. We need to look at why this is. If we are doing something that is having the opposite of the intended effect, we need to reevaluate.
    - High administrative burden
    - Standardizing the form is only 2% of the problem
    - Want a system that can follow the patient
    - Managed care plans, pharmacists, DHS policies are the major issues
        - If patients don't show up for visits with psych, they are bumped off the benefit
- Lack of places to refer patients. If a specialist is needed, it's unfair to expect the primary care doctor to treat.
    - Increasing access to psychiatrists and getting psychiatrist back into Medicaid would be beneficial
    - Access to provider to provider consultations
- Pilot and develop curriculum to train providers. Grant funding is helpful because there are fewer hoops to jump through than with managed care plans (too prohibitive).
- Curbside consultation does not mean malpractice liability to psychiatrist. A psychiatrist doesn't even need to know the patient's name to help another provider.
    - Hesitation when there isn't a relationship between providers and follow-up regarding the patient can't be ensured.
    - Projects that seem to work are the projects where there are established relationships.
    - Social gatherings between providers beforehand to build rapport
    - Psychiatrist can visit the practice once a month or so in the beginning
- Gap in care for young people because not many go to see a physician at all
    - Maybe go through schools. Meet them where they are
- Have a regional facility with psychiatrists/social workers/behavioral health providers are embedded in the staff. Share resources among practices.
- Concern about role of social workers/psychologists/behavioral health. Becoming hand maidens to primary care doctors. Role is becoming more supportive of health field. Roles are changing from therapy to consultation.
    - Psychologists will be forced into big groups or not even included because they are seen as too expensive. They are supposed to focus on medical issues rather than behavioral health issues for a period of 15 minutes rather than a full session.
    - Virtual medical home
    - Therapy has to be somewhere in the system
- The for-profit health plans will not act the same because they have national standards. Plan will be dead on arrival unless this is addressed.
    - QUEST doesn't do enforce network adequacy requirements
    - Solution is not to have for profit in the state

- The people driving up the costs are not the people going to primary care. They are usually the homeless. Services need to be where these people are.
- Medicaid would work better without competing health plans – single payer.
- Ensure that practicing providers have a central voice in planning to keep it grounded in reality.
- A positive for the plan is its acknowledgement that PCPs need more training.
- The priorities identified in the SIM are the right ones.
- It's important to measure the awareness of mental health issues. Increase awareness in schools, senior centers, etc.
- Great idea to integrate BH with primary care.
- Increase services for patients who need more intensive care.
- Good things about the plan are:
    - Integration of BH in PC
    - Plan to provide training for PCPs
- Curbside consults won't work for suicidal patients unless liability issues are addressed. Face-face help is needed for those patients.
- PCPs shouldn't be asked to screen until MH services are in place.

**Hilo, Sept. 25, 2015**

10 people attended. Did not break-out.

SIM questions/comments:

- BH won't improve until there are better economic opportunities for people on the Big Island.
- There are inadequate resources for SMI/SPMI. PCPs need to be assured that services can be provided if they screen.
- State is prioritizing the homeless who tend to have more serious MH needs. There's a disconnect with SIM's focus.
- BH services have been hard to get for people covered by some MCOs. QUEST Integrated cannot work with care for seriously mentally ill separated from medical care.
- Care coordination is poor.
- Will the use of evidence-based practices increase the cost to providers? For instance, there's a cost to providers who want to be certified as PCMH.

**Lana'i, Sept. 29, 2015**

25 people attended. Did not break-out.

SIM questions/comments:

- Is the plan to be used for a grant proposal? If so, how will funds be distributed across communities?
- Where does health literacy fit in? This is related to motivational interviewing.
- How will DOH and MQD coordinate provision of BH services?
- Who is participating in planning from neighbor islands and from state agencies?
- The mental health transformation grant during the Lingle Administration was a failure because the private sector wasn't engaged.
- There's good communication among providers on Lana'i that makes care coordination easier.

- How are nonprofit organizations going to be part of the plan?
- Medicaid and Medicare need to do more outreach because people don't understand eligibility and benefits.
- Treatment not available on Lana'i includes:
    - Substance abuse services for adolescents beyond what schools provide
    - SMI/SPMI supports like Club House
    - No mentoring programs
    - Geriatric dementia
- The needs of the neighbor islands don't get addressed. Plan needs to be tailored to needs and resources.
- What about providers – CHWs, PCPs, clinical pharmacists, telehealth?

**Moloka'i, Oct. 2, 2015**

9 people attended. Did not break-out.

SIM questions/comments:

- Psychologists are an important element in addressing BH needs.
- Moloka'i is small enough that everybody knows each other and can work together without being co-located.
- Tele-psych works well for kids.
- Telehealth doesn't work in all situations, though, e.g., domestic violence, suicidality.
- Moloka'i General Hospital (MGH) tried telehealth but didn't work well because of broadband inadequacies. A psychiatrist comes to the island once a month and is available by telehealth once a month.
- DOH can use tele-BH at their office. They also use this for family "visits" to kids being cared for off-island.
- AMHD uses telehealth to supplement care provided by a psychiatrist.
- Using the right screening tool is important. MGH wants to incorporate screening into work flow.
- Should consult with MGH on best way to train providers on Moloka'i.
- Staff need to be trained to deal with BH crises.
- Technology solutions don't work where people don't have ready access to computers and broadband.
- MQD MCOs have an array of services that most people don't know about.
- AHEC is trying to help with provider shortages. Work with kids to try to get them into health care careers. Would be good to get residents to train in rural areas.
- Reimbursement is a barrier. Prior authorizations (PA) for some plans can take months. Payment should be retroactive to when PA was submitted because providers render care and then aren't reimbursed.
- Took the Nā Pu'uwai psychologist more than a year to be credentialed with one plan.
- Every insurer has a different process. Creates problems for providers.

# STATE INNOVATION MODEL

Contributing to Healthy Families and Communities

**Sep-Oct 2015**

# STATE'S GOALS FOR HEALTH & CARE

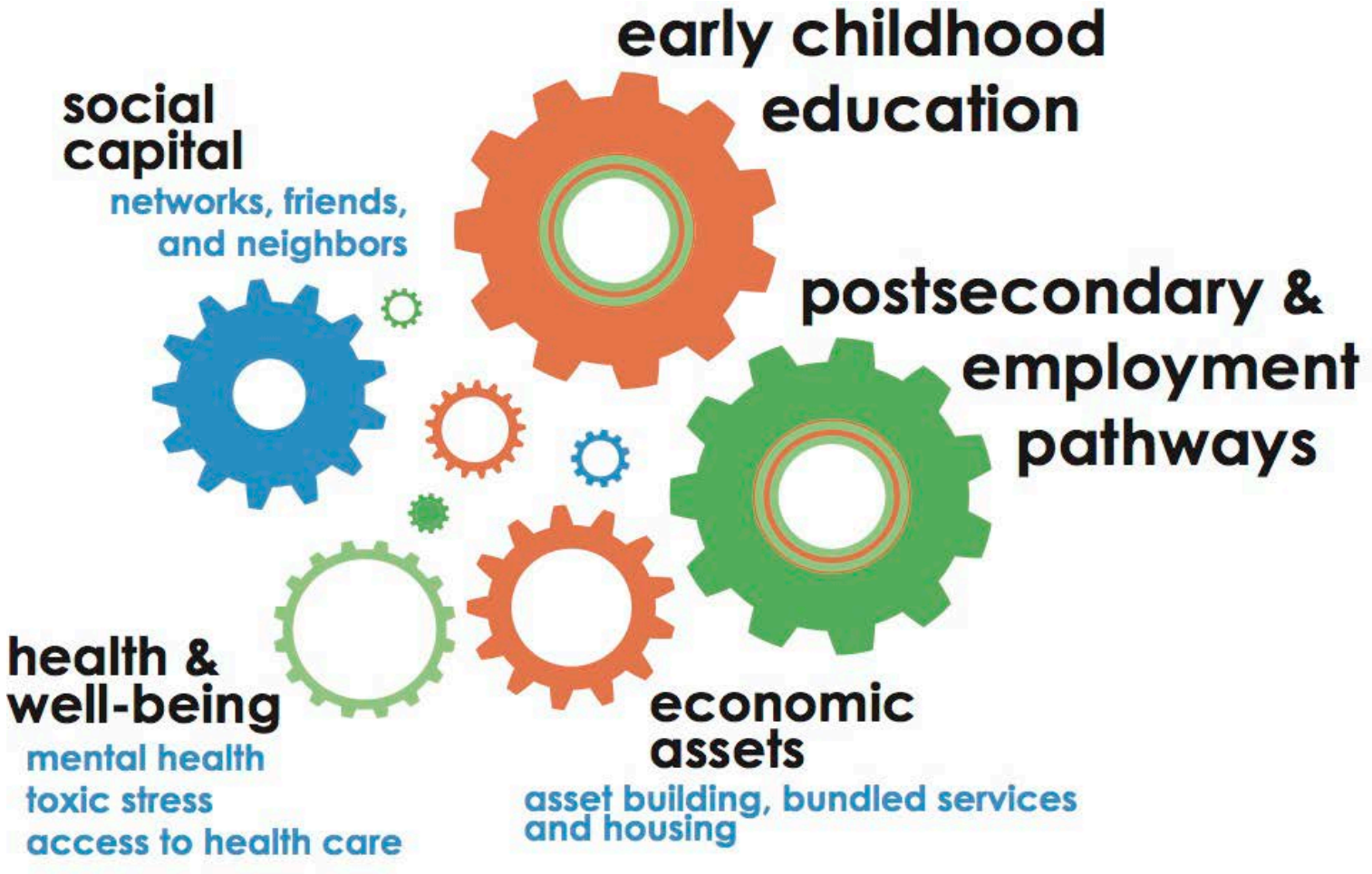
## Healthy Families/Healthy Communities

- Social determinants of health
- Racial/ethnic, geographic, economic health equity
- Triple Aim:  Quality, Health, Costs

# NURTURING HEALTHY FAMILIES & COMMUNITIES

- Coordinating systems, programs, and services
  - Support families and communities
  - Address Social Determinants
- Investing early in keiki and their young parents in multi-generation approach

# COMPONENTS TRANSFORMED INTO SYSTEMS




SIM Focus

# SIM FOCUS: HEALTH & WELL-BEING

## Health care areas that support ‘Ohana

Contributing to positive behavioral health through integration with primary care

- Adults and children
- In primary care and OB/GYN settings
- Mild to moderate behavioral health conditions (depression, anxiety, substance use)

STARTING WITH MEDICAID

# WHY BEHAVIORAL HEALTH?

- Behavioral health (BH) affects ability to **learn**, **work**, and be part of **healthy families** and **communities**.
- **YOU** chose BH during SIM round one as the top priority. So did hospital **Community Health Needs Assessment**.
- BH disproportionately affects the most **vulnerable populations**.
- **Access** to BH services is challenging, especially for the Medicaid population.

# DATA ON BEHAVIORAL HEALTH

- Hawaii data showed the average cost for individuals with a BH condition was **three times the average total cost** for individuals without a BH diagnosis.

- Mental illness was identified as the number one **preventable** hospitalization in 2012 (Community Health Needs Assessment).

- In 2013, more than one in every 4 adults (27%) in Hawai'i reported having **poor mental health**.[1]

1. Kaiser Family Foundation (2013). Perfect of adults reporting poor mental health by race/ethnicity: http://kff.org/other/state-indicator/poor-mental-health-by-re/

# DATA ON BEHAVIORAL HEALTH

- 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]

- Native Hawaii and Pacific Islanders 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%).


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

# WHY MILD TO MODERATE CONDITIONS?

- Potential **return on investment**: co-morbidity costs in Hawaii
  - A mental health condition was a co-existing diagnosis in 34% of hospitalizations

- National behavioral health integration initiatives have **demonstrated improved outcomes** and a strong return on investment for patients with mild to moderate behavioral health conditions.

# WHY FOCUS ON PRIMARY CARE?

- 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.
- Data on behavioral health integration pilots in Hawaii are not available yet, but anecdotally providers report they think their **patients are receiving better care.**

# AUDIENCE PARTICIPATION

# PROPOSED MODELS

- **SBIRT** - Screening, Brief Intervention, Referral for Treatment; to help address the hidden issues with substance misuse in primary care offices

- **Screening and Treatment of Depression and Anxiety** - based on IMPACT model to identify and treat depression in primary care settings

- **Motivational Interviewing** – is a client-centered method used to educate, engage, empower consumers to be part of their health

# PROPOSED MODELS

- **Voluntary!**
- Chose model(s) that meets the need of the community
- Develop training program
- Learning collaboratives
- Develop provider to provider consultation model
- Expand members of primary care team
  - Community Health Workers
  - Clinical pharmacists

# MAHALO!

More information and feedback:

http://governor.hawaii.gov/