EXECUTIVE CHAMBERS
HONOLULU

DAVID Y. IGE
GOVERNOR

Hawai'i Health Care Innovation Models Project
Steering Committee Meeting
Capitol 329
November 13, 2015 | 12:30 pm – 2:00 pm

Committee Members Present:
Beth Giesting, Chair
Judy Mohr Peterson
Sue Radcliffe
Jill Oliveira Gray
Jennifer Diesman
Malia Espinda
Chris Hause
Ginny Pressler
Alan Johnson
Christine Sakuda
Debbie Shimizu

Staff Present:
Joy Soares

Guest:
Kelley Withy

Consultants (by phone):
Laura Brogan, Navigant
Andrea Pederson, Navigant
Sally Adams, Navigant
Alicia Oehmke, Navigant
Mike Lancaster, CCNC
Denise Levis, CCNC

Committee Members Excused:
Mary Boland
Gordon Ito
Robert Hirokawa
Marya Grambs
Rachael Wong
Roy Magnusson
Scott Fuji
George Greene

Welcome and introductions
Chair Beth Giesting called the meeting to order with introductions at 12:35 pm.

Review/approval of Minutes from October 14, 2015
Giesting asked for the committee's comments or edits to the minutes from the last meeting. No feedback was received and the minutes were accepted.

Review agreements and focus on children
Joy Soares reviewed the issues on which the committee has already reached agreement, including the focus of SIM work on behavioral health integration and the evidence-based practices to be included in Hawaii's plan (see slides 4-7). Giesting outlined the rationale and approach to address BHI for children,

starting routinely at age 12 but noting that the same practices can be used for younger children, when needed (see slides 8-11).

Focus group report

Guest Dr. Kelley Withy provided an overview of the process and findings from focus groups on behavioral health integration and care coordination she conducted across the state for the SIM planning process (see handout). Ten focus groups met on all islands (Lana'i's group was by telephone) between July and September. 86 health care professionals participated, including PCPs, psychiatrists, psychologists, and others. Highlights included that neighbor islanders feel the shortage of providers and other resources more acutely and also report greater geographic and transportation barriers. Training (on-island) is needed. PCPs would appreciate a directory of the behavioral health providers available for referral. Telehealth was identified as a possible resource but none of the providers have time or incentives to use it themselves. Providers were frustrated by lack of information exchanged when referrals were made. Complaints about insurers included ensuring network adequacy, effectively managing referrals, and administrative, credentialing, and billing hassles. There was a general recognition that the BH system does not work well, is not coordinated, and should be organized more effectively. Committee comment included an emphasis on the need to invest in and ensure use of a system for health information exchange in order to support coordination of care.

Community meetings

Soares reported on the feedback from 7 statewide community meetings during which the SIM priorities were presented (see handout). The meetings, carried out between Sept. – Oct. 2015, were combined with public hearings for the ACA Waiver Proposal and the No Wrong Door Plan. After brief overviews were presented, most of the meetings broke into smaller groups to discuss the proposals. For SIM, the meetings confirmed community agreement with the need for a better behavioral health system; fielded some common complaints about provider shortages, lack of coordination, and frustration with certain insurance processes; and provided information about the gaps and resources available on each island.

Draft blueprint & feedback

Dr. Lancaster briefly outlined the blueprint followed by questions on the blueprint's intended audience and purpose and comments that it is generally, to help PCPs understand BHI but also intended to be a roadmap for MQD and the health care system for creating an effective BHI system. Feedback by email was requested by November 20, 2015.

Proposed system supports

Soares and Denise Levis outlined a proposed approach to BHI system support that includes training, and on-going support, provider consultations, and triage and referral (see slides 16-22). Discussion included support for certain shared resources such as training and consults. There was some disagreement that triage and referral fit as well as a shared service. Some pilots that provide some or all of these services include 2 in Hawaii with DOH CAMHD or JABSOM Dept. of Psychiatry providing support to several FQHCs. NC, MN, MA, and other states have also had successes with shared BHI resources.

Adjournment and next meeting

At 2:00 the meeting was adjourned and the rest of the agenda was deferred. The next meeting is at noon on 12/8/15 from 12-1:30 in State Office Tower, Room 1403.

State Innovation Model Design 2

DELIVERY AND PAYMENT COMMITTEE

NOVEMBER 13, 2015

Agenda

Welcome and Introductions	Beth Giesting
Review Minutes	Beth Giesting
Review Agreements	Joy Soares
Focus on Children	Beth Giesting
Focus Group Report	Dr. Kelley Withy
Community Meeting Summary	Joy Soares
Draft Blueprint & Feedback	Dr. Mike Lancaster
Proposed System Supports	Dr. Mike Lancaster

Agenda

- Measures — Laura Brogan
- Process Updates — Beth Giesting
  - Population Health Plan
  - Oral Health Draft Plan
  - Update on actuarial analysis
  - SHIP
- Adjourn

Agreements on BHI

SIM Goals :

- Identify **behavioral health integration** delivery and payment models. Agree to strategies that improve 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 and/or integrate behavioral health specialty services and community support services in primary care and prenatal practices.
- **Improve care coordination** that links people with behavioral health conditions to treatment and community support services.

- SIM efforts start with **Medicaid** and 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

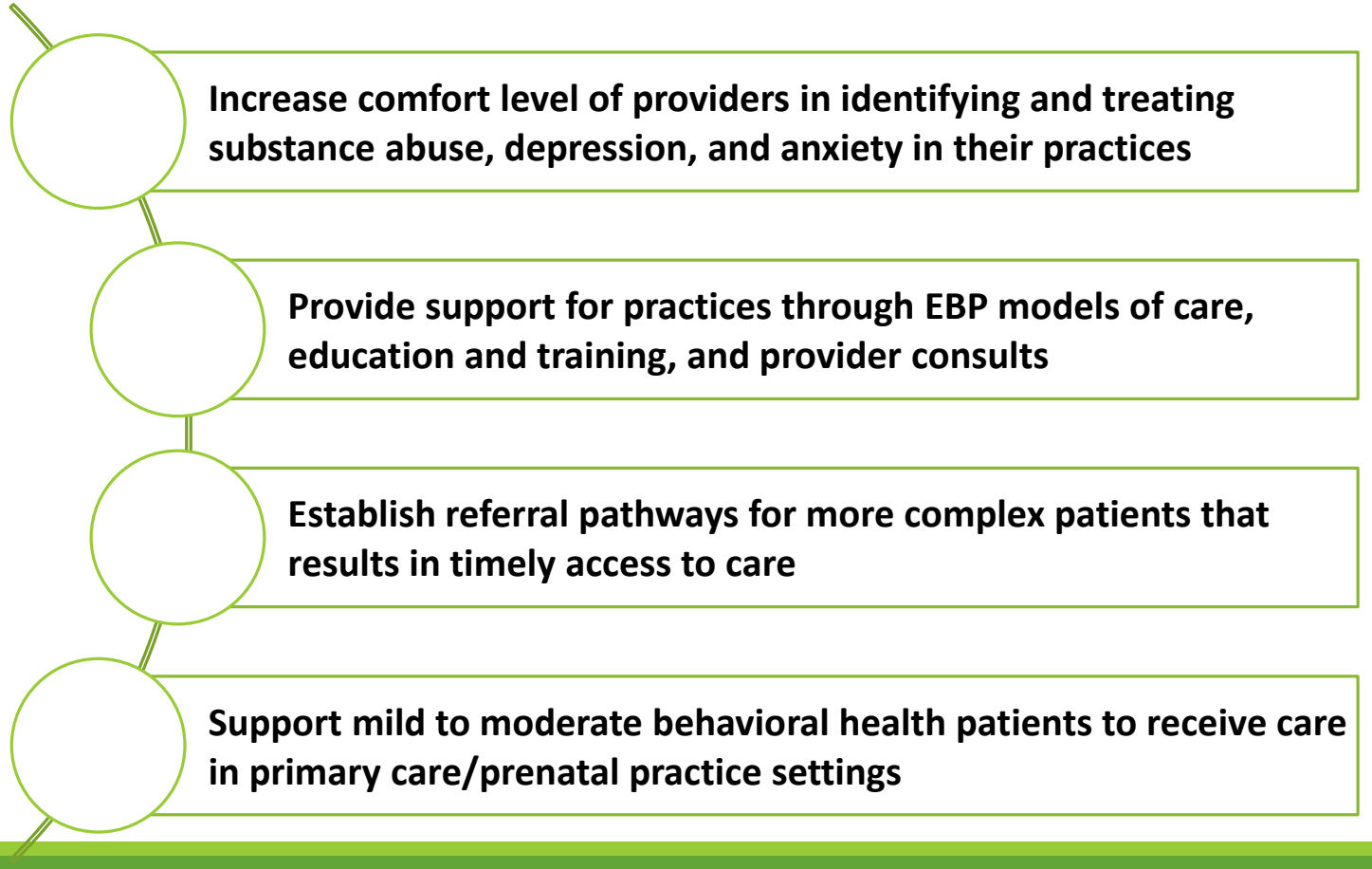
Agreements on Evidence-Based Practices

- SIM will focus on three evidence-based practice (EBP) models for **children** (starting at age 12) and **adults**.

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%) 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”

Focus Group Report

DR. KELLEY WITHY

Community Meetings

JOY SOARES

Purpose of the Blueprint

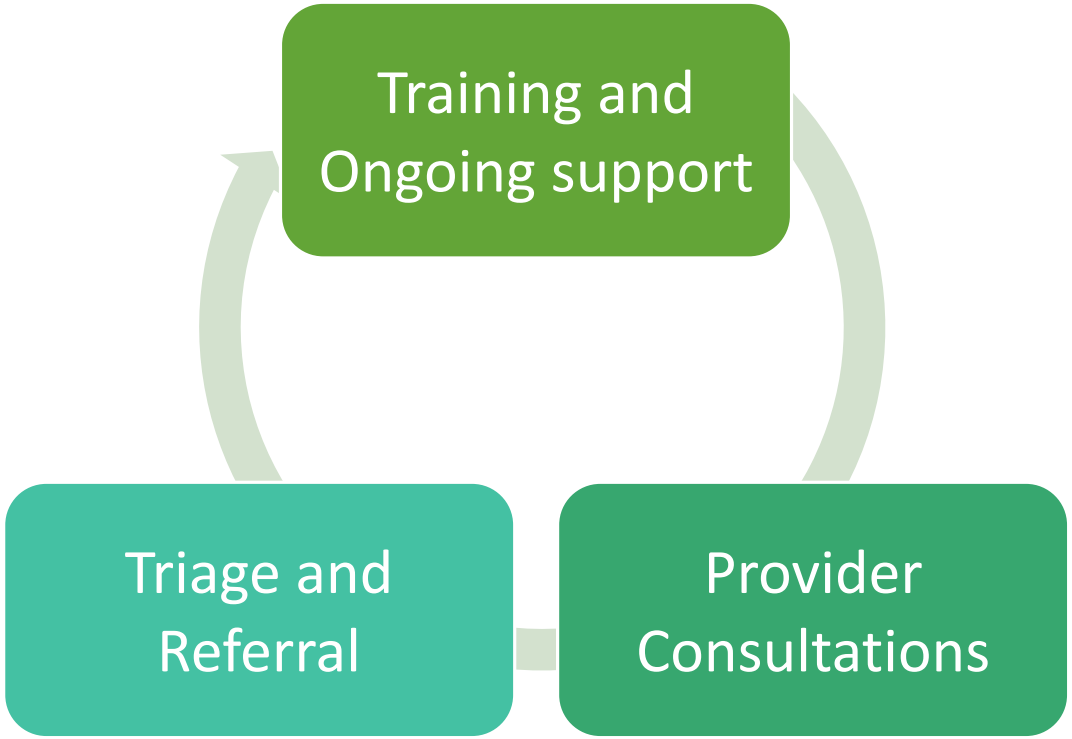
- Intended audience: PCPs
- Provides recommended clinical practices to implement the three models of behavioral health integration
- Discusses the need for focused training and clinical support for adopters (technical assistance, learning collaboratives)
- Discusses the need for practice champions who 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?

Questions?

SIM Evaluation Plan

NAVIGANT CONSULTING

Evaluation Components

Evaluation Design

Option 1: Data Tracked Separately for Participating and Non-Participating PCPs

- Two study cohorts: participating PCPs and non-participating PCPs (control group)
- Requires providers to "sign up" for behavioral health integration program
- May involve patient assignment and/or patient consent
- May involve "Matched Comparisons" (e.g., by island, by target group)
- Allows for more direct analysis of the impact of behavioral health integration on patients' outcomes, costs, etc.

Option 2: Data tracked universally for all PCPs

- No stratification by participating/non-participating providers
- Less rigorous evaluation that only allows for observations of longitudinal system-wide changes

Data Collection and Reporting

- Track participating providers through participation agreements and registry (Option 1 only)
- Establish baseline for selected measures
- Collect data on selected HEDIS measures
- Collect data on measures that require new surveys or other efforts (e.g., tracking PCP attendance at trainings)
- Compile measures and produce statewide dashboards

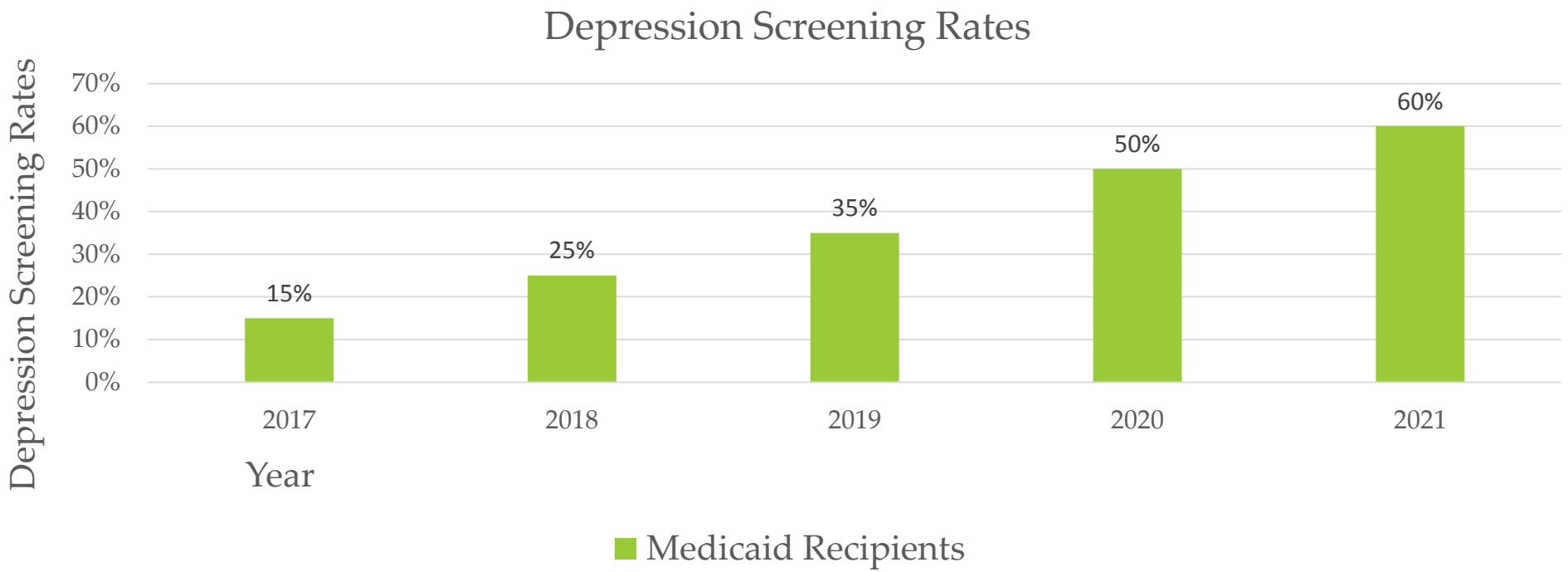
Measure Criteria

Criteria to consider when selecting measures:

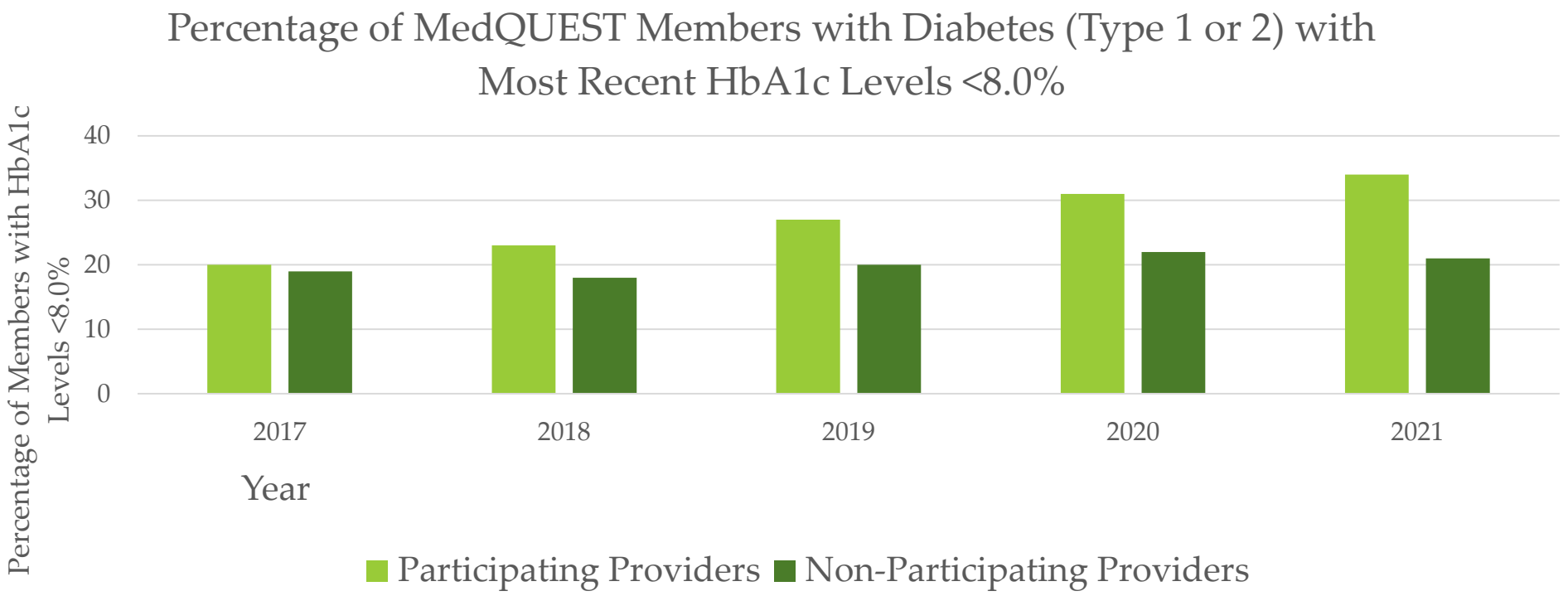
Universe	Source	Collector	Domain	Duration
• All PCPs and patients • Only participating PCPs and their patients (consider cell size) • Intended effect of P4P measures	• Claims data • Clinical charts / EHR records • Patient and provider surveys • Existing state or national data sources	• MCOs • MedQUEST • Other entity (e.g., UH Office of Public Health Studies)	• Preventative Care • Quality of Care & Process • Utilization • Population Health	• Short-term (e.g., uptake) • Long-term (e.g., outcomes)

Goal: Alignment Across all QUEST Integration MCOs

Sample Dashboard - 1



Sample Dashboard - 2



Process Updates

Oral Health Plan

- Input for the plan from OH Committee and DOH 2015 Key Findings report
  - Emphasis on preventive services and access
  - Draft report to be sent to SC after OHC completes review

Population Health Plan

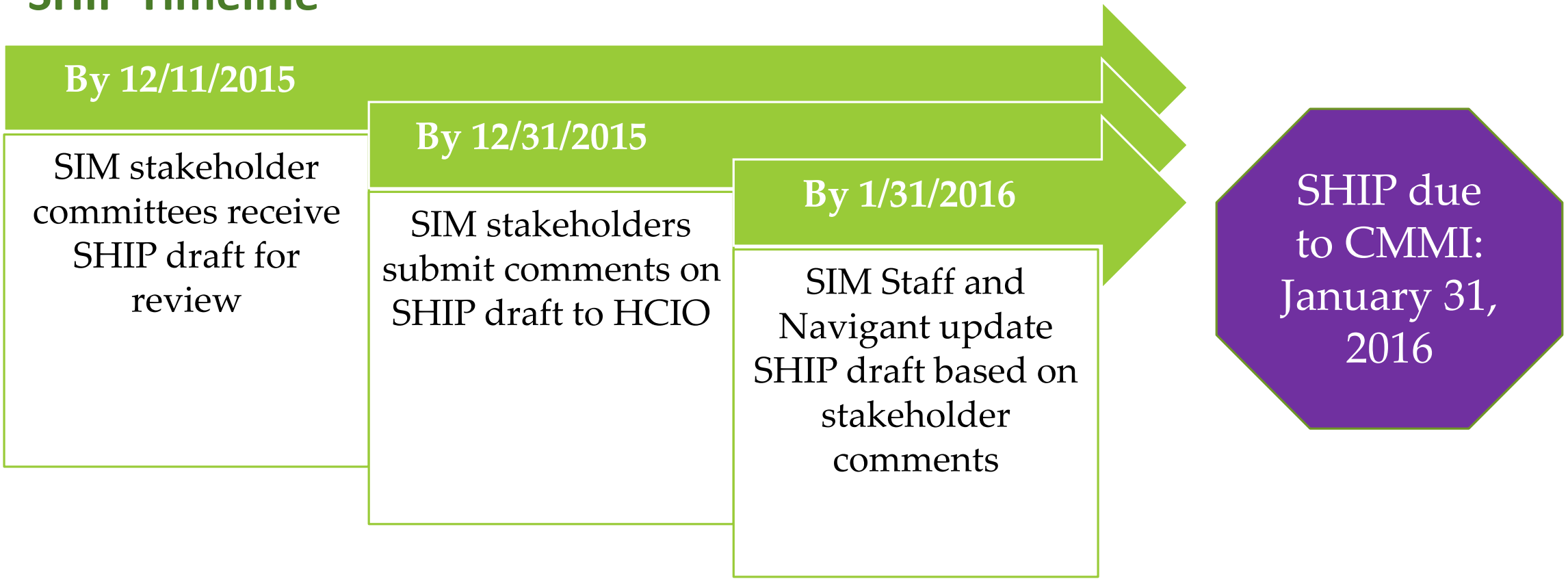
- Will pull together narrative of efforts already underway: healthy families, disparities, social determinants, tobacco, obesity, diabetes, SIM emphasis on behavioral health

Actuarial Analysis

- Data still being compiled for JEN and Optamus

Process Updates

SHIP Timeline



Next Meeting

December 1st in State Office Tower Room 1403