



EXECUTIVE CHAMBERS  
HONOLULU

DAVID Y. IGE  
GOVERNOR

**Hawai'i Health Care Innovation Models Project  
Steering Committee Meeting  
Capitol 329  
October 14, 2015 | 10:30am – 12:00pm**

Committee Members Present:

Beth Giesting, Chair  
Judy Mohr Peterson  
Sue Radcliffe  
Gordon Ito  
Robert Hirokawa  
Jill Oliveira Gray  
Jennifer Diesman  
Marya Grambs  
Christine Sakuda

Staff Present:

Joy Soares  
Trish La Chica  
Abby Smith

Consultants:

Laura Brogan, Navigant  
Andrea Pederson, Navigant  
Sally Adams, Navigant  
Alicia Oehmke, Navigant (by phone)  
Mike Lancaster, CCNC  
Denise Levis, CCNC (by phone)  
Steve Schramm, Optumas  
Stephanie Taylor, Optumas

Committee Members Excused:

Debbie Shimizu  
Mary Boland  
Rachael Wong  
Roy Magnusson  
Ginny Pressler  
Alan Johnson  
Scott Fuji  
George Greene (by phone)

**Welcome and introductions**

Chair Beth Giesting welcomed the group to the Steering Committee meeting. Everyone provided introductions, including SIM consultants Navigant, Optumas, and Community Care of North Carolina (CCNC), who were here for the site visit.

**Review/approval of Minutes from September 1, 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.

**Committee work/updates**

**Hawai'i Health Care Innovation Models Project  
Steering Committee Meeting  
October 14, 2015**

Giesting shared that the Population Health committee is leading the Population Health Plan section of the SHIP which focuses on state-wide initiatives that aim to improve population health outcomes in behavioral health, as well as in diabetes, obesity, and tobacco cessation. The Oral Health Committee is working on both administration and legislative strategies to restore adult oral health benefits in Medicaid.

**Overview of the Week Ahead**

Andrea Pederson and Laura Brogan of Navigant provided an overview of the site visit week, which includes meeting with 25 different stakeholder groups. They also discussed the SIM Timeline & Roadmap that breaks up the SIM deliverables into 4 key tasks: 1) Behavioral Health Blueprint; 2) Cost Analysis and Return on Investment; 3) Evaluation & Management Plan; and 4) the SHIP Report.

**The Transformation Agenda (See Slides 6-9)**

Giesting reviewed the State's goals for health and care which are aligned with the Triple Aim goals, must go beyond clinical care, and must meet other unique Hawai'i needs. Several components affect health, such as social capital, early childhood and education, employment, the economy, etc. SIM focuses on health and well-being transformation efforts. The changes that will be proposed to support behavioral health integration will not be in isolation, rather they will be part of the overall agenda to transform the health care system.

**BHI – Status and Agreements Presentation and Discussion: Review of BH Blueprint (See Slides 10 to 25)**

Dr. Mike Lancaster shared overall SIM agreements for Hawai'i Integrated Care. SIM will start with Medicaid and focus on children and adults, including pregnant women and women of child-bearing age. Agreement on 3 models is needed and participation is voluntary. Dr. Lancaster reviewed the 3 BHI models: SBIRT, Screening for Depression and Anxiety, and Motivational Interviewing.

One of the key decisions is to define what care coordination and training can look like. Dr. Lancaster shared the potential roles of the expanded BH care team which can include Community Health Workers, Pharmacists, Psychologists, and the use of tele-psychiatry.

HIT Issues: Giesting shared some of the issues that have come up as part of HIT in Behavioral Health Integration. SIM has been working with HHIE to determine ways to better exchange information. The key piece of HIT is to make information available at the point of service. Part of HHIE's role is determining what can be exchanged and shared without violating 42 CFR Part 2.

Models of Care Coordination: Dr. Lancaster shared 4 potential care coordination models and the accompanying pros and cons for each. Please see slides 21 to 25.

**Question:**

A committee member asked about the inclusion of brief intervention (in SBIRT) as part of 42 CFR Part 2.

- 42 CFR Part 2 pertains to SA, and does not apply to practitioners.

**Presentation and Discussion: Introduction to Return on Investment (See slides 26 to 34)**

Steve Schramm led the presentation on behalf of Optumas and noted another team member, Zach Aters, who is not with us today. Schramm shared the process of projecting future expenditures and the determinants of risk for SIM BH Integration:

**Hawai'i Health Care Innovation Models Project**  
**Steering Committee Meeting**  
**October 14, 2015**

1. Program Design is the how - the operational structure – as in how can this be operationalized?
2. Target population: Mild to moderate BH conditions as well as adults with oral health needs. Who is the program targeting?
3. Benefits: What benefits are we affecting? Benefits can be explicit. An example is the Brief Intervention component of SBIRT, and how this can be an expense to the practice. Expenditures can go up in the administrative and clinical areas.
4. Service Delivery Network: Who are the different players in the system? Where will new programs be added? BH Integration impacts both the BH providers and the PCPs.

Cost/Trend Analysis: Schramm shared that the following different components that impact the cost/trend analysis and data model. Trend in this context applies to change, mix, and price of services. Data: Adjusting for IBNR (incurred but not reported); program changes; population changes  
Potential Trend Ranges

**Questions:**

- Does the model look at the QUEST population only? This model can be structured to accommodate and include other populations but for this initial analysis we are looking at QUEST. The available data is limited to QUEST right now.
- Does acute care include primary care? Acute care includes all care except long term services and supports.
- What are the projected savings of early intervention on pregnant mothers? To estimate the impact successfully, we need enough data to quantify the effect of the intervention and potential savings. The report will note the potential for high-end savings in this area but the incidence is low so can't be included in the body of the ROI analysis.
- How is low, moderate, and aggressive impact defined? This is based on what we determine as achievable based on Hawaii's care model. Higher impact can be seen in between low risk and high risk populations, because services for this population have not been historically provided by the state.

ROI Analysis: Data is projected under different scenarios. Please see slides 31-34.

**Navigant Update: Measures and SHIP Laura Brogan (See slides 35 to 43).**

A handout of the draft measures was provided to the Committee. Laura Brogan clarified which measures are included and how direct and indirect are defined. She noted the sources of measures.

Measures are divided into 4 categories: Preventive Care Measures, Quality of Care Measures, Utilization Measures, and Population Health Measures. Please see slides 40 to 43. Italicized measures mean that they are currently collected by QUEST.

**Questions:**

- Are QUEST measures included? These are highlighted in the handout.
- Will these measures be included across the board or just with different settings such as FQHCs? Will tracking be mandatory? Tracking these measures is not mandatory but can be used to look at improvement over time. Measures can be voluntary with potential incentives. It is better to look at the entire population versus seeing this data with just the early adopters.

**Hawai'i Health Care Innovation Models Project  
Steering Committee Meeting  
October 14, 2015**

- Do we know if the proposed models will have an impact on these measures or are we just making assumptions? Direct measures will have an impact, and some research does show an impact on indirect measures. Note that this is a list of *potential* and not *required* measures. SIM is asking the SC to review these measures and provide feedback on the selection of these measures. Part of the SIM plan includes identifying which measures will be implemented over the 5-year period.
- How do we screen children on SBIRT? We are encouraging screening in adolescents for SA, tools such as CRAFT can be used.

**Next Meeting:** The next meeting is on November 13, from 12:30pm-2:00pm at Capitol 329.

**Adjournment:** The meeting was adjourned at 12:00pm.

DRAFT

# State Innovation Model Design 2

---

STEERING COMMITTEE MEETING

OCTOBER 14, 2015

# Committee Updates

---

- Population Health Committee
- Oral Health Committee

# Overview of the Week Ahead

---

## Objectives

- Recap project progress
- Refine BHI Blueprint
- Introduce ROI analysis concepts
- Discuss quality and outcome measures
- Review SHIP outline

## Common Themes

- Evidence-based Models
- Care Coordination
- Training
- Workforce Opportunities
- Funding
- Payment for Services

## Stakeholders

- Physicians & Physician Associations
- Substance Abuse Providers & Advocates
- Mental Health Professionals, Providers & Advocates
- Managed Care Organizations
- State Agency Staff
- Committee Members

*More than 25 meetings to discuss, brainstorm, listen and engage*

# SIM Deliverables & Roadmap

**Navigant Healthcare Team**

<b>Lead: CCNC</b>	<b>Lead: Optumas LLC, JEN Associates</b>	<b>Lead: Navigant Healthcare</b>
-------------------	--	----------------------------------



## 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



## 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*



## 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*



# Meeting Objectives

---

**To outline a transformation agenda to improve health of families and communities:**

- Primary care and Behavioral Health (children and adults)
- Value-based payment reform
- Workforce changes
- Other system supports

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



# Health care transformation

---

Person/family focused and oriented to health

BH improvement advances broader agenda for primary care change

- New service models and sites
- Population health and care coordination
- New members of the work force, such as CHWs, and practicing in teams
- Use of health information exchange, patient portals, IT, telehealth
- Support for learning health care system, practice support
- System alignment – metrics, payment strategies
- Payment reform

Oral health improvement

# Community Care

OF NORTH CAROLINA

## *Whole Person Care*

Hawai'i SIM Payment and Delivery Committee

October 14<sup>th</sup>, 2015

Dr. Mike Lancaster

## Goals for this Discussion:

---

- Overview of SIM agreements thus far
- Overview of the three proposed BHI models
- Identify any alignment and/or synergy with current efforts around BHI
- Recognize the applicability of the models to populations
- Consensus on realistic expectations and buy-in for training and financing the models
- Identify pros and cons with care coordination models

# SIM Agreements for Hawai'i Integrated Care:

---

- 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 the 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 the care coordination of people with behavioral health conditions and linkage with treatment and community support services.

# SIM Agreements for Hawai'i Integrated Care:

---

- SIM efforts will start with Medicaid and focus on children and adults (including pregnant women)
- Focus on three Evidence-Based Models:
  - SBIRT
  - Screening and Treatment of Depression (also focuses on anxiety)
  - Motivational Interviewing
- Participation is voluntary. PCP/OB will select a model that fits their population/interest

# SIM Agreements for Hawai'i Integrated Care:

---

- The goals of these evidence-based practices include:
  - Increase comfort level of providers in identifying and treating substance abuse, depression, and anxiety in their practices
  - Provide support for practices through evidence-based practice models of care, education and training, and provider consults
  - Establish referral pathways for more complex patients that results in timely access to care
  - Support mild to moderate behavioral health patients to receive care in primary care/prenatal practice settings

# Proposed Evidence Based Practices for 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** - 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

## Key Components of Delivery of EBP to Provide Payment:

---

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

# How to Train and Sustain all EBP Models

---

- 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

## Workforce Issues and Opportunities:

---

- Community Health Workers (CHWs)
  - Path to certification
  - Community College – education / job builds
  - Define role of CHWs in the system
- Pharmacists
  - Inclusion in team based care
  - Pharm2Pharm
  - Medication reconciliation
- Psychologists
  - Inclusion in behavioral health planning
  - Consider prescribing privileges
- Tele-psychiatry
  - doc to doc consultation
- Role of SA Department

## Health Information Technology Issues:

---

- Use of information technology has great potential for designing and facilitating integration efforts.
- Computerized exchange of BH information is complicated by the need to comply with specific confidentiality requirements (CFR 42 part 2).
- Privacy laws, regulations and policies hinder integration efforts as providers often apply the strictest interpretation of privacy laws to “protect” patients.
- Providers have stated the utmost importance of confidentiality in engaging adolescents in treatment.

## Health Information Technology Issues, cont.:

---

- Conversations between physical and behavioral health providers must occur to ensure the necessary communication and information is available to optimize care and outcomes
  - Working on processing consent directives
  - Developing a referral and communication process and method to share meaningful information
  - Supporting the use of electronic prescribing
  - Agreeing on elements to include in a continuity-of-care (CCD) document

# Models of Care Coordination – Define Expectations

---

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)

# Models of Care Coordination – Pros and Cons

---

Provided in a capitated system by the MCO

## ***Pros***

- PCPs have a know resource
- Standardized processes for care coordination (CC) – if defined by the State
- Remove access and support barriers to CC
- MCOs can align with other efforts

## ***Cons***

- Each MCO may have their own process and expectations for PCPs
- Potential limitation of funds to support BHI
- Availability of workforce

# Models of Care Coordination – Pros and Cons

---

Covered as a billed service  
by providers in the  
community

## **Pros**

- Practices can pay for CC and bill for their services
- Practices / PCPs can determine who needs CC
- Provide an incentive for PCP to integrate care

## **Cons**

- No service definition
- Medicaid will need to build /define services and payments
- Potential for lack of standardization in the implementation of the CC models

# Models of Care Coordination – Pros and Cons

---

Provided in a capitated system through MCO contract with community agency

## **Pros**

- More local approach
- CC more knowledgeable on and linked with community resources
- Use local available workforce
- Build referrals and relationships locally

## **Cons**

- Lack of available resources and workforce in remote and rural communities
- MCOs have to fund the service so funding may be an issue
- Potential for different approaches to CC across agencies – standardization issues

# Models of Care Coordination – Pros and Cons

---

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

## **Pros**

- Standardized approaches and definitions
- State determines focus of CC intervention (in concert with providers)
- Provides support for patient in practices

## **Cons**

- Training
- Medicaid will need to build service and payment definitions and processes



# Hawaii SIM

Cost/Trend Analysis and  
Return on Investment Analysis

---

**OCTOBER 14, 2015**

# Process of Projecting Future Expenditures

- Determinants of Risk
  1. Program Design (How?)
  2. Target Population (Who?)
  3. Benefits (What?)
  4. Service Delivery Network (Where?)

# Cost/Trend Analysis

---

- Focus on Projecting Future Risk of Program(s)
- Normalize Data
  1. IBNR
  2. Program Changes
  3. Population Changes
- Separate Utilization and Unit Cost by Major Category of Service
- Identify Cost Drivers

# Cost/Trend Analysis

---

- Isolate Historical and Concurrent Trends
- Project Prospective Trend Adjusting for Changes in:
  1. Mix
  2. Reimbursements
  3. Program Design

# Dynamic Cost/Trend Model

---

- Potential Trend Ranges
  1. Low, Moderate, or Aggressive
  2. Externalities
- Target Areas
  1. Geography
  2. Population
  3. Setting

# Return on Investment (ROI) Analysis

- Compare Projected Future Program Expenditures against Future Intervention Costs
- Base Data Projected Forward
- Two Projection Scenarios
  1. Absence of Interventions
  2. Presence of Interventions

# ROI: Projection 1 – No Interventions

- Base Data Validation
- Normalization
- Program Changes
- Trend
- Non-Medical Loading

## ROI:Projection 2 – Interventions Present

- Understand the SIM Interventions
- Project Impact on Total Costs and Utilization
- Focus on Change in Risk of Population
- Analyze by Major Category of Service

# Dynamic ROI Model

---

- Care Management Impacts
  1. Low, Moderate, or Aggressive
  2. Downward Pressure on Acute Care
- Target Areas
  1. Geography
  2. Population
  3. Setting

# Behavioral Health Integration Measures

---

LAURA BROGAN, NAVIGANT CONSULTING

# Objectives

---

The objectives for this conversation are to determine:

- Are we are on the right track?
- Are there other measures we should we consider?
- What are the next steps?

# Approach to Measure Selection

---

The scope of proposed measures includes those that are:

- **Directly related** to mild/moderate behavioral health conditions
  - Therefore, proposed measures do not relate to schizophrenia, antipsychotic medications or psychiatric hospitalizations
- **Indirectly related** to behavioral health - focused on chronic diseases/conditions that may be influenced by improved management of behavioral health
  - For example, outcomes related to diabetes, hypertension and COPD and social outcomes

# Sources of Measures

---

- Healthcare Effectiveness Data and Information Set (HEDIS)
- Consumer Assessment of Healthcare Providers and Systems (CAHPS)
- Centers for Medicare and Medicaid Services (CMS) Core Medicaid Measures
- The Agency for Healthcare Research and Quality (AHRQ) Integration Academy Measure Atlas\*
- The National Quality Forum (NQF) Quality Positioning System
- Home-grown

*\* Proposed measures from the AHRQ Integration Academy were modified to more closely align with Hawaii's integration initiative*

# Measure Categories

---

Proposed measures fall into four categories:



# Measure Categories

---

- **Preventative Care Measures - 4**
  - Focus on screenings and assessments to measure steps taken to prevent disease and improve health outcomes
    1. Screening for Clinical Depression and Follow-Up Plan
    2. SBIRT Utilization
    3. Maternity Care – Behavioral Health Risk Assessment
    4. Preventative Care & Screening: Tobacco Use: Screening & Cessation Intervention

# Measure Categories

---

- **Quality of Care and Process Measures - 9**
  - Focus on the quality of care patients are receiving, processes employed by providers, and behavioral health integration performance
    1. Depression Remission at Twelve Months
    2. Experience of Care and Health Outcomes
    3. *Follow-Up Care for Children Prescribed Attention Deficit/Hyperactivity Disorder (ADHD) Medication\**
    4. *Antidepressant Medication Management\**
    5. Percentage of Members with Behavioral Health Conditions Who Visited a PCP and had Service Coordination Services Recorded
    6. Psychiatric Consultations
    7. Behavioral Health Integration (BHI) Training for PCPs
    8. PCP Confidence to Provide Behavioral Health Treatment
    9. Use of Electronic Patient Tracking System

*\*Indicates that QUEST requires MCOs to report this measure*

# Measure Categories

---

- **Utilization Measures - 3**
  - Focus on the usage of (non-preventive) medical services
    1. *Mental Health Service Utilization\**
    2. *Plan All-Cause Readmissions\**
    3. Behavioral Health-Related Emergency Department (ED) Utilization

*\*Indicates that QUEST requires MCOs to report this measure*

# Measure Categories

---

- **Population Health Measures - 10**
  - Focus on the long-term health outcomes and overall population health of patients receiving integrated services
    1. Mental/Emotional Health Rating
    2. Pediatric Symptom Checklist (PSC)
    3. Behavioral Health Comorbidity Rates
    4. Comorbidity Total Cost of Care
    5. *Comprehensive Diabetes Care: HbA1c Control\*†*
    6. *Controlling High Blood Pressure\*†*
    7. Obesity Rates
    8. High School Graduation Rates
    9. Employment Rates
    10. Rates of Homelessness

*\*Indicates that QUEST requires MCOs to report this measure*

*†Indicates an existing QUEST P4P measure*

# Next Steps

---

- Develop an Evaluation Plan
  1. Identify potential behavioral health integration (BHI) quality and outcomes measures
  2. Identify opportunities and gaps and vis a vis the potential measures
  3. Determine the most feasible subset of quality and outcomes measures based on available data and resources
  4. Develop a data collection/reporting strategy
- Develop Dashboard Prototypes

# Next Meeting

---

The meeting on November 3 will be rescheduled.