INFORMATIONAL BRIEFING

State Option to Provide Health Homes in Medicaid, Patient-Centered Health Home State Plan Amendment (SPA)

HOUSE COMMITTEES on HEALTH, HUMAN SERVICES
SENATE COMMITTEES on HEALTH, HUMAN SERVICES

January 21, 2014

ROBERT HIROKAWA, CEO
NANI MEDEIROS, POLICY & PUBLIC AFFAIRS DIRECTOR
HAWAI'I PRIMARY CARE ASSOCIATION

HPCA

HAWAI'I PRIMARY CARE ASSOCIATION

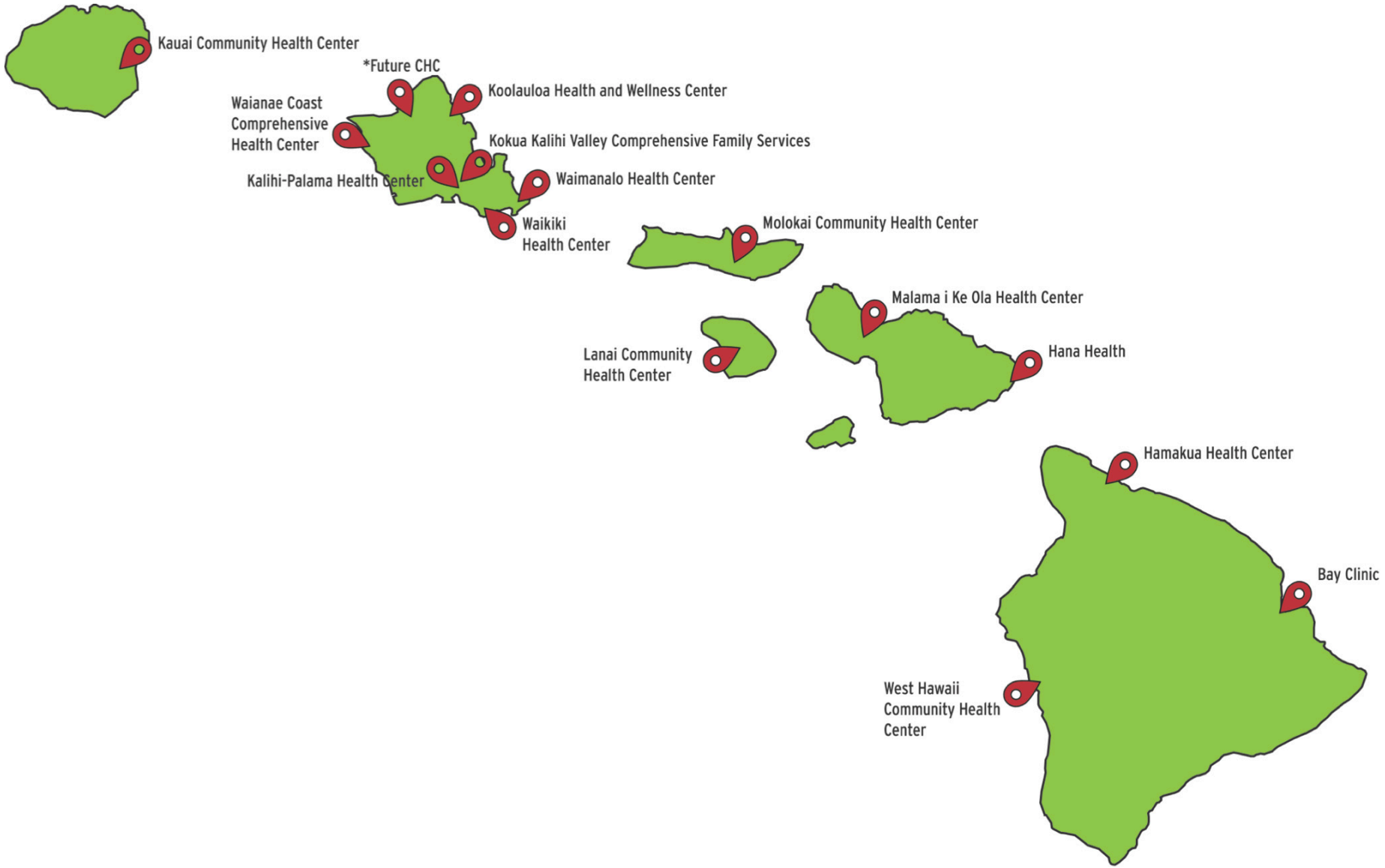
MEMBERSHIP ORGANIZATION MADE UP OF HAWAI'I'S COMMUNITY HEALTH CENTERS (SINCE 1989)

MISSION

The HPCA improves the health of communities in need by advocating for, expanding access to, and sustaining high quality health care through our statewide network of Community Health Centers.

COMMUNITY HEALTH CENTERS
(CHCs)

- CHCs RECEIVE FEDERAL GRANTS UNDER SECTION 330 OF THE PUBLIC HEALTH SERVICE ACT.
- CHCs MUST PROVIDE CARE IN AN UNDERSERVED AREA OR POPULATION
- HAVE A GOVERNING BOARD OF DIRECTORS WHICH INCLUDE CHC PATIENTS AND COMMUNITY MEMBERS


Kauai Community Health Center
*Future CHC
Koolauloa Health and Wellness Center
Waianae Coast
Comprehensive
Health Center
Kokua Kalihi Valley Comprehensive Family Services
Kalihi-Palama Health Center
Waimanalo Health Center
Waikiki
Health Center
Molokai Community Health Center
Malama i Ke Ola Health Center
Lanai Community
Health Center
Hana Health
Hamakua Health Center
Bay Clinic
West Hawaii
Community Health
Center

COMMUNITY HEALTH CENTERS

What they do

- FOCUS ON **SOCIAL DETERMINANTS OF HEALTH**
- ENABLING SERVICES
- PATIENT-CENTERED MEDICAL HOME
- MEDICAL, BEHAVIORAL, ORAL HEALTH SERVICES
- SUBSTANCE ABUSE TREATMENT
- VISION

CHCs: WHO THEY SERVE

(2012)

COMMUNITY HEALTH CENTERS
CARED FOR

144,427

PATIENTS STATEWIDE

THAT'S AN INCREASE OF

23%

SINCE 2008

CHCs: WHO THEY SERVE

(2012)

24% UNINSURED

50% COVERED BY MEDICAID

73% AT OR BELOW THE FEDERAL POVERTY LEVEL

$27,090 annual household income (family of 4)

COMMUNITY HEALTH CENTERS
CHRONIC ILLNESS

DIABETES
12,207

KAUAI	491
OAHU	6,691
MAUI	898
HAWAII	4,127

COMMUNITY HEALTH CENTERS

CHRONIC ILLNESS

MENTAL HEALTH

11,432

KAUAI	398
OAHU	7,287
MAUI	1,131
HAWAII	2,616

COMMUNITY HEALTH CENTERS
CHRONIC CONDITION

HOMELESS
12,459

KAUAI	61
OAHU	10,862
MAUI	951
HAWAII	585

PATIENT-CENTERED HEALTH CARE HOMES

PATIENT-CENTERED HEALTH CARE HOMES

TRANSFORM HEALTH CARE FROM SICKNESS TO WELLNESS

ENCOURAGE INTEGRATION & COORDINATION TO REDUCE CHRONIC ILLNESS

HEALTH CARE HOMES
TRIPLE AIM

- **IMPROVE** HEALTH OUTCOMES
- **CONTROL** LONG TERM COSTS
- **ENHANCE** PATIENT EXPERIENCE

HPCA'S COMMITMENT TO PATIENT-CENTERED HEALTH CARE HOMES

- TRAINING AND TECHNICAL ASSISTANCE TO ALL CHCs
- PCHCH PILOTS
- PCMH-INSTITUTE
- CMS APCP DEMONSTRATION
- HEALTH HOME STATE PLAN AMENDMENT
- HAWAII HEALTHCARE PROJECT/SIM

COMMUNITY HEALTH CENTERS
PCHCH IMPLEMENTATION

2008

Visioning and Strategic Planning

2009

Medical Home Conference with CareOregon

2010

Pilot Learning Collaborative and Site Visits

2011

Pilot Full Implementation, NCQA Initiative

2012

Pilot Completed, Data Collection & Analysis, Quarterly Learning Meetings

2013

NCQA Recognition, Qualis Training

PATIENT-CENTERED HEALTH CARE HOMES
SUCCESSFUL TRANSFORMATION

- ORGANIZATION-WIDE CULTURE CHANGE
- PATIENT-CENTERED CARE AND ENGAGEMENT
- TEAM-BASED CARE AND INNOVATION
- REDESIGN OF WORKFLOWS AND PHYSICAL SPACE
- EMR AND REGISTRY IMPLEMENTATION

PATIENT-CENTERED HEALTH CARE HOMES
SUCCESSFUL TRANSFORMATION

- NEW POSITIONS AND ROLES; **TEAM REDESIGN**
- IMPROVED COMMUNICATION, COLLABORATION AND INTEGRATION: **WARM HANDOFFS**
- CARE COORDINATION AND MANAGEMENT: **CARE PLANS**
- MOTIVATIONAL INTERVIEWING AND **SELF MANAGEMENT SUPPORT**

COMMUNITY HEALTH CENTERS
NCQA RECOGNITION

LEVEL 3

Waimanalo Health Center

West Hawaii Community Health Center

LEVEL 2

Bay Clinic

Kalihi-Palama Health Center

Malama I Ke Ola Health Center

PATIENT-CENTERED HEALTH CARE HOME

COMMUNITY HEALTH CENTER PILOTS

COMMUNITY HEALTH CENTER PILOTS

PCHCH INCORPORATED A SET OF CORE VALUES

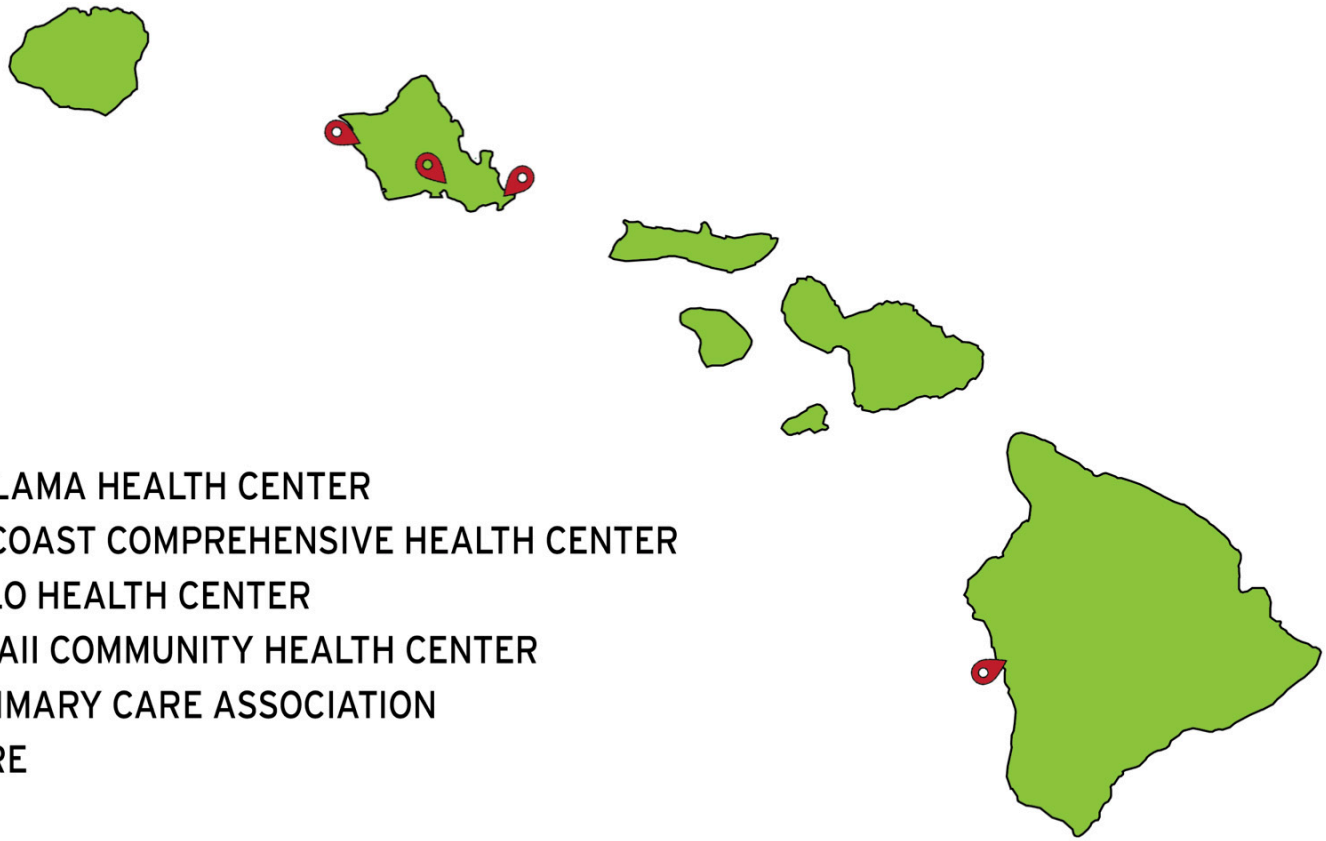
- PATIENT DRIVEN AND FAMILY CENTERED
- INTEGRATED AND HOLISTIC CARE
- BARRIER -FREE ACCESS
- TEAM BASED CARE DELIVERY

PCHCH MODEL ASSUMED COMMUNITIES WOULD HAVE DIFFERENT CHALLENGES AND NEEDS

DESIGN FLEXIBILITY WAS A FUNDAMENTAL COMPONENT TO TAILOR THE MODEL TO PARTICIPATING CHC

UTILIZED A COMMUNITY OF PRACTICE TO ENHANCE PCHCH TRANSFORMATION SUCCESS

CHC PILOT PARTICIPANTS



- KALIHI-PALAMA HEALTH CENTER
- WAIANAE COAST COMPREHENSIVE HEALTH CENTER
- WAIMANALO HEALTH CENTER
- WEST HAWAII COMMUNITY HEALTH CENTER
- HAWAII PRIMARY CARE ASSOCIATION
- ALOHACARE

TARGET POPULATION

TARGETED DEFINED POPULATIONS TO CREATE MANAGEABLE SYSTEMATIC CHANGE

- DIABETES
- DEPRESSION

PATIENTS WERE **ACTIVATED** INTO PILOT PROJECT

PATIENTS OPTED INTO PILOT FOR ENHANCED CARE

METRICS

DIABETES

- DIAGNOSIS OF 250.XX
- HEALTH CARE HOME ELIGIBILITY:
  HgbA1C GREATER THAN OR EQUAL TO 8

DEPRESSION

- DIAGNOSIS OF 296.2X, 296.3X, 300.4
- HEALTH CARE HOME ELIGIBILITY:
  PHQ-9 GREATER THAN 9

ACTIVATION INTO HEALTH CARE HOME PILOT WAS DONE BY PATIENT AGREEMENT

METRICS

PROCESS

- ACTIVATION RATE
- DIABETES: **HgbA1C TEST, EYE EXAM, FOOT EXAM, SELF MANAGEMENT GOAL**
- DEPRESSION: **PHQ-9 USAGE, PHQ-9 FOLLOW-UP RATE**

OUTCOMES

- IMPROVEMENT IN DIABETES OUTCOMES (**A1C, BP, LDL**)
- DEPRESSION RESPONSE & REMISSION (**PHQ-9**)

FUTURE

- PATIENT EXPERIENCE: DETERMINE COMMON MEASURES
- RETURN ON INVESTMENT

IMPROVED
PATIENT EXPERIENCE

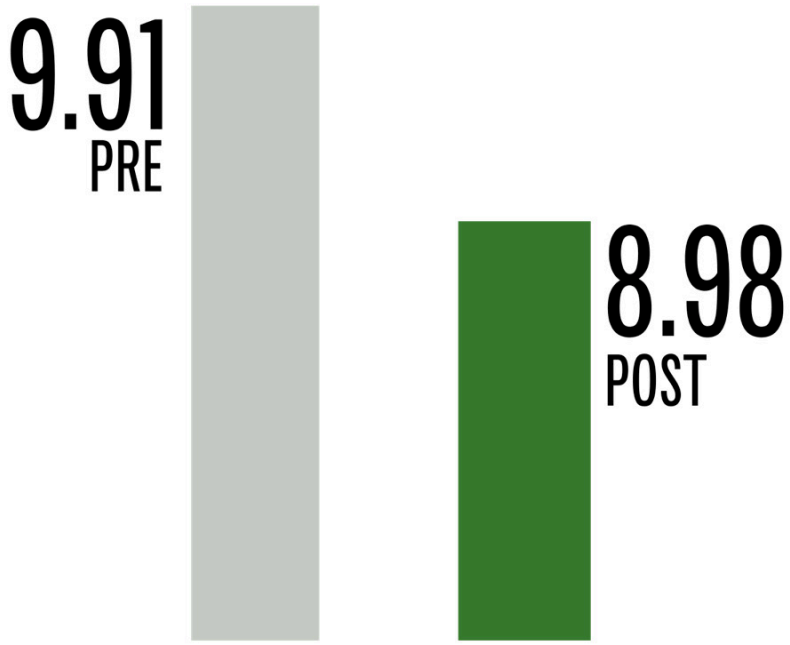
ACCESS
ABLE TO MAKE A SAME DAY APPT WHEN SICK OR HURT — 81%

COMMUNICATION
PROVIDERS LISTENED TO YOU — 90%

COORDINATION
PROVIDER TALKED WITH YOU ABOUT HEALTH GOALS — 94%

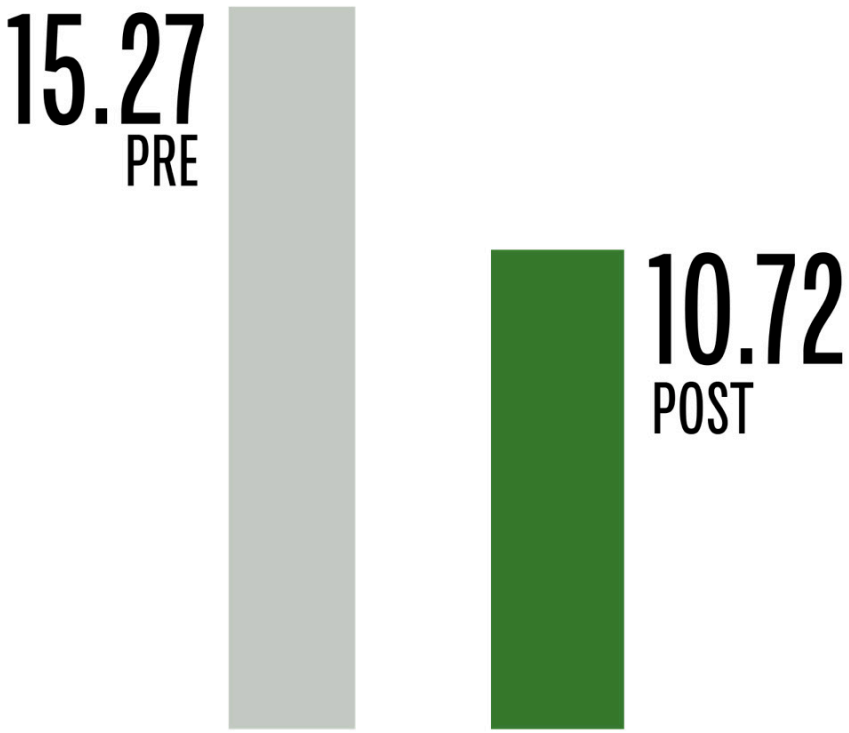
WHOLE PERSON CARE
HELPED TO FIND OTHER SERVICES YOU NEED — 95%

IMPROVED HEALTH OUTCOMES
DIABETES



HbA1c Scores

IMPROVED HEALTH OUTCOMES
DEPRESSION



PHQ-9 Scores

IMPROVED
COST OF CARE

EMERGENCY DEPARTMENT

-55%

HOSPITAL INPATIENT

-10%

TOTAL COST OF CARE

-6%

based on per member per month (PMPM) data

FUTURE EXPANSION OF MODEL

- INTEGRATION OF BEHAVIORAL HEALTH (MENTAL HEALTH / SUBSTANCE ABUSE), AS WELL AS ORAL HEALTH
- TRANSITION OF CARE (HOSPITAL, PRIMARY, SPECIALTY)
- SOCIAL DETERMINANTS OF HEALTH -> STRENGTHEN PCHCH
  STANDARDIZATION OF ENABLING SERVICES, QUALITATIVE DATA
- LEARNING HEALTH SYSTEM
  MERGE POPULATION AND CLINICAL DATA, COMMUNITY DASHBOARDS
- PERSON- AND COMMUNITY-CENTERED

OPPORTUNITIES OF INFLUENCE

- DELIVERY AND PAYMENT REFORM
- MEDICAID HEALTH HOME
- HAWAII HEALTHCARE PROJECT / CMS STATE INNOVATIONS PLANNING MODEL

PATIENT-CENTERED HEALTH CARE HOME

STATE PLAN AMENDMENT

POPULATION CRITERIA

STANDALONE (DEFINED BY STATE ELIGIBILITY OF SVCS)

- SERIOUS AND PERSISTENT MENTAL ILLNESS (SPMI)
- SERIOUS MENTAL ILLNESS (SMI)
- SUPPORT FOR EMOTIONAL AND BEHAVIORAL DEVELOPMENT (SEBD)

TWO OR MORE

- CVD DEFINED BY CARDIOMYOPATHY & HEART FAILURE
- CHRONIC OBSTRUCTIVE PULMONARY DISEASE
- DIABETES
- OBESITY
- MENTAL HEALTH CONDITION
- SUBSTANCE ABUSE

PROVIDER REQUIREMENTS

A HEALTH HOME PRACTICE

- MUST BE REGISTERED WITH THE STATE OF HAWAII DHS AND PROVIDED A STATE-ASSIGNED HEALTH HOME PROVIDER ID
- MUST ADHERE TO HEALTH HOME PROVIDER STANDARDS
- MAY INCLUDE BUT IS NOT LIMITED TO PRIMARY CARE PRACTICES, FEDERALLY QUALIFIED HEALTH CENTERS, AND RURAL HEALTH CLINICS

MULTIDISCIPLINARY TEAM (INCLUDING, AT MINIMUM)

- DESIGNATED PRACTITIONER AND CLINIC SUPPORT STAFF
- DEDICATED RN CARE MANAGER
- BEHAVIORAL HEALTH CONSULTANT
- NAVIGATOR, CARE COORDINATOR, OR PEER SPECIALIST

PROVIDER STANDARDS

HEALTH HOME PRACTICES MUST ATTEST TO

- RECOGNITION/CERTIFICATION
- PERSONAL PROVIDER FOR EACH PATIENT
- CONTINUITY OF CARE DOCUMENT (CCD)/CARE PLAN
- WHOLE PERSON ORIENTATION
- COORDINATED/INTEGRATED CARE
- EMPHASIS ON QUALITY AND SAFETY
- ENHANCED ACCESS

HEALTH HOME SERVICES

SECTION 1945(H)(4) OF THE ACT DEFINES HEALTH HOME SERVICES AS "**COMPREHENSIVE AND TIMELY HIGH QUALITY SERVICES**."

- COMPREHENSIVE CARE MANAGEMENT
- CARE COORDINATION AND HEALTH PROMOTION
- COMPREHENSIVE TRANSITIONAL CARE FROM INPATIENT TO OTHER SETTINGS, INCLUDING APPROPRIATE FOLLOW-UP
- INDIVIDUAL AND FAMILY SUPPORT
- REFERRAL TO COMMUNITY AND SOCIAL SUPPORT SERVICES
- USE OF HEALTH INFORMATION TECHNOLOGY TO LINK SERVICES

NEXT STEPS

DATA ANALYSIS

ESTIMATE ELIGIBLE POPULATION, REVIEW OF CHRONIC DISEASE BURDEN DATA TO ENSURE POF IS APPROPRIATE

MONITORING AND EVALUATION

DETERMINE MEASURES, DEVELOP LOGIC MODEL, IDENTIFY DATA SOURCES

ALIGNMENT

CROSSWALK PROVIDER STANDARDS/HEALTH HOME SERVICES TO MEDICAID MCO REQUIREMENTS AND HAWAII PCMH "FLOOR"; DETERMINE HEALTH HOMES PLACE IN SPECTRUM OF CARE DELIVERY

HEALTH HOME SERVICES

REVIEW (THROUGH EACH DISEASE AREA "LENS" TO ENSURE COMPREHENSIVENESS, ENSURE HEALTH HOME TEAM MAKEUP IN ADEQUATE, DETERMINE WAYS HIT WILL LINK, ENSURE INTEGRATION IS PROMOTED)

HEALTH EQUITY

DETERMINE HOW TO ADVANCE HEALTH EQUITY FOR VULNERABLE POPULATIONS; CREATE A PROCESS MAP OF HEALTH HOME PATIENT THROUGH SYSTEM

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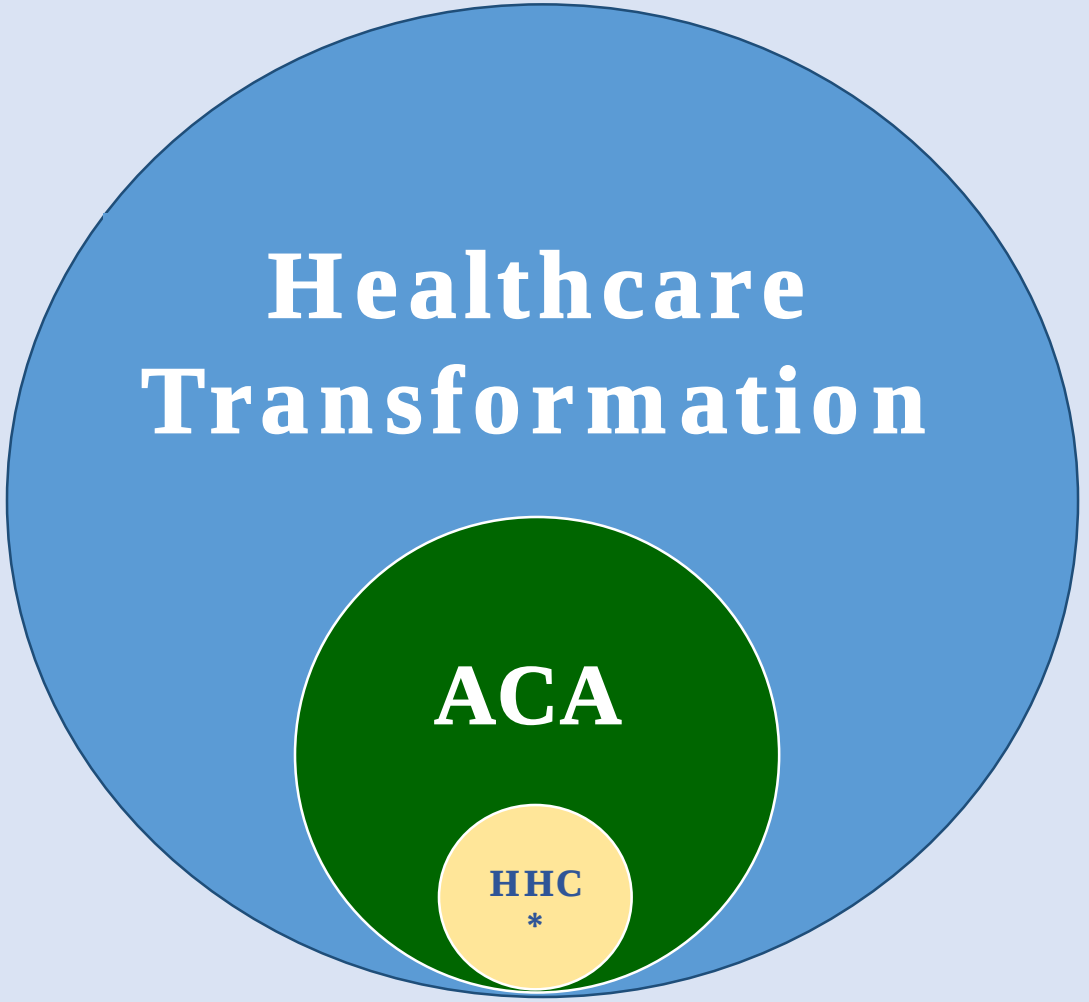
Health Care Transformation and the Health Home

Beth Giesting
Healthcare Transformation Coordinator
Office of the Governor

What do we mean by “Transformation?”

The ACA provides federal support for aspects of transformation, including the insurance exchange and the health home.

However, health care transformation is a much larger agenda that includes all of health care delivery, health care financing, data and health IT, workforce, and support for healthier individuals and communities.



** Hawaii Health Connector*

What's Wrong with our Health Care System?

1. Hawai'i Health Realities

- Obesity increased from 10.7% in 1992 to 23.1% in 2012
- Diabetes increased from 3.2% in 1992 to 8.3% in 2012
- Life circumstances affect health and need for care

2. Delivery System

- Timely access for all is limited
- System is specialty-oriented and fragmented
- Chronic disease registries and info exchange not universally used
- Behavioral health services in short supply

3. Equity

- Worse outcomes for NH/Pac Islanders
- Socio-economic status influences obesity, hypertension, asthma, diabetes
- Access poorer on Neighbor Islands

4. Cost

- 2000-09, cost of insurance premiums almost doubled
- Hawai'i spends nearly $7000/person/yr
- Payment systems need to pay for quality, health improvement

Better Care & Savings Go Together

Timely access & care management can curb health care cost growth

Potential Savings for Hawai‘i

- 1 in 10 ER visits & hospitalizations could be avoided. Costs $353 M
- ER & hospital charges for diabetes complications: $1.3 B
- ER & hospital charges for mental health: $99 M

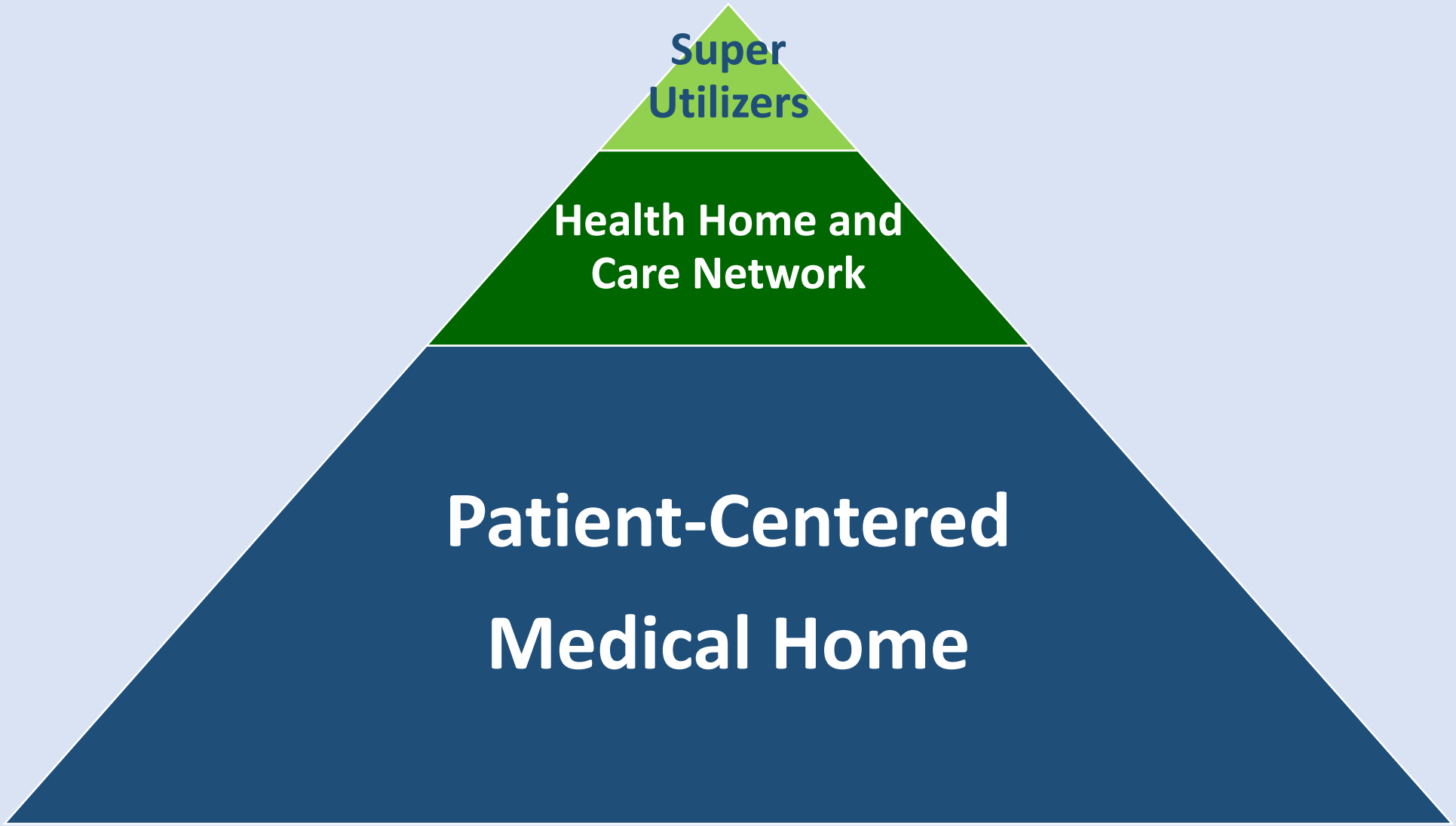
Potential savings for QUEST

Avoidable ER/Re-Hospitalization: $52 M

ER & hospital charges related to diabetes: $212 M

ER & hospital charges related to mental health: $43 M

Change in Health Care Delivery



Health Homes & Cost-Effectiveness

Care Coordination

- Link to regular source of primary care
- Link to BH and specialty services
- Coordinate care among providers
- Support care in appropriate settings
- Reconcile medications
- Assist with behavior modification if needed
- Case management tailored to specific needs

Results

- Reduction in avoidable ER and hospital admissions
- Better control of chronic diseases (regular check-ups, keep specialty appointments, take medication, improved lifestyle)
- Increased access to behavioral health services
- More stable living conditions (public benefits, jobs, housing)

Additional Health Care Transformation Needs

- **Delivery system redesign**
  - PCMH, core quality measures, shared responsibility for outcomes
- **Health information technology**
  - EHRs, Information Exchange, All Payer Claims Database (APCD)
- **Payment changes**
  - Reward outcomes, focus on quality, reduce administrative burden, adjust risks
- **Workforce and access issues**
  - Train for new team delivery models, review scope of practice, use telehealth
- **Alignment in policy and programs**
  - Be sure MQD, DOH, EUTF, etc. align programs, policy, funds to meet transformation and population health goals

Beth Giesting

Healthcare Transformation Coordinator

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