Medicaid Innovation Accelerator Program (IAP)
Physical and Mental Health Integration
Medicaid Strategies for Promoting Provider Capacity for
Physical and Mental Health Integration
February 6th, 2018

[Intro]

Laurie Hutcheson, facilitator and policy fellow at the National Academy for State Health Policy (NASHP): Our agenda for today's webinar:

- Brief overview of the Medicaid Innovation Accelerator Program (IAP) Initiative
- Key principles to expand provider practice capacity for physical and mental health (PMH) integration
- Brief overview of state strategies for promoting provider capacity for PMH integration
- New Hampshire and Hawaii examples

Presenters:

- Melissa Cuerdon, Disabled and Elderly Health Programs Group, Center for Medicaid and CHIP Services
- Dr. Benjamin Miller, Chief Strategy Officer, Well Being Trust
- Kelly Capuchino, Senior Policy Analyst, New Hampshire Department of Health and Human Services, Division for Behavioral Health
- Dr. Judy Mohr-Peterson, MED-QUEST Administrator, Hawaii Medicaid director

Kitty Purington: I'm with NASHP, and I will take over for Melissa for a while. We are having a technical problem there. Medicaid IAP has provided technical support through the Center for Medicare & Medicaid Innovation and it lives in the Center for Medicaid and CHIP Services. It has supported states' Medicaid delivery system reform efforts in a number of ways. This particular webinar is the focus of the physical and mental health integration track. IAP has also supported states in their efforts to work on reform around substance use disorders (SUD), long-term services and supports (LTSS), and other areas such as value-based purchasing (VBP).

Through this IAP track, physical and mental health integration, IAP worked with nine states over 12 months to enhance their physical and mental health integration approaches through technical support on issues such as administrative alignment, payment and delivery system reform, and quality measurement. As Laurie mentioned, this webinar is the third in a series of four national dissemination (NDS) webinars in the IAP integration program area.

To give you an idea of the participating teams, it was a diverse group of states from across the country engaged in very different areas of integrated care. Now to Laurie for an overview.

Laurie Hutcheson: We'll now hear Dr. Ben Miller's views on key principles regarding expanding provider capacity for PMH integration and what challenges practices must take on to be successful.

Dr. Ben Miller: Good afternoon, everyone. Today we're going to be discussing one of the most important topics I think any state policymaker should consider when it comes to redesigning our healthcare in-service to better integration: Workforce, what we expect from our providers, and the various roles they play on an integrated team. Simply put, how do we enhance our systems and providers to have more

capacity? I'll quickly go over why this matters, go into some problems and solutions we're solving through integration, and then dive deep in the provider capacity for integrated teams with an acknowledgement of the importance of practice competency. I'll summarize key principles, provide additional resources, and then onto questions and answers.

Let's start where we should always start, why this matters. You all know the data but it's still important to remind ourselves that there's a substantial amount of meat out there when it comes to mental health and substance use in this country. In a report we recently released with Trust for America's Health, "Pain in the Nation," we called out the number of lives lost to alcohol, drugs and suicide. We showed based on that data how we could see a 60% to 100% increase in those deaths in the coming decade if we do nothing about this. This is our challenge, our call. We must do something here. We know that integrating care is one major solution to actually accomplish our goal of solving these problems we have. You can see more of the report at paininthenation.org.

What's the problem and why are things seemingly getting worse? It comes down to this slide. People interact with the system in mainly predictable ways due to the reaction and the nature of healthcare. First, there's some type of trigger event that brings them into healthcare. That's the entry point. It may be the emergency department, a school, primary care. As most of these settings are siloed, people often fall through the cracks and do not get their needs met. Treatment is often too far removed, but most common is their referral. It is the most common way we respond to people's needs.

When the mental health system cannot manage the demand, people are bounced back into the system. That's the cycle and why integrating into places like primary care solves one piece of this problem. So some solutions here, and you all know the evidence and that integration provides an opportunity for us to give timely access to mental health services in places like primary care. But there are clear guidelines and parameters we need to consider. As you see from this slide, we can't just screen without a plan for treatment. We can't just place any mental health provider into the primary care context and expect that it's just going to work. We must think about mental health and medical conditions as a part of a singular treatment plan and really consider the evidence base that's going to set us up for success.

Central to the problem of fragmentation is this promise of integration. It is integration done strategically, thoughtfully, and with intent, purpose and direction. We know more now than ever about what works and what doesn't work. There's many websites you can go to to find the latest, greatest evidence in this space. There are three major issues I want to talk about briefly when we talk about capacity.

I want to start with practice level capacity. These are issues we'll have to contend with both at a practice and policy level:

1. Depending on how your state has contracted for mental health services there are definitely going to be barriers to how patients access care. This translates down to a clinical level where workflows may be impacted based upon certain rules, regulations or policies that exist at a system or state level.
2. Fundamentally, we're talking about a different paradigm here, a different culture that requires us to think about the systems and structures we have in place within our states and how this may inhibit or support integration efforts. Does your state have a culture that really allows for integration to be as robust as it could be?
3. All is lost without data that allows us to track our patients to assess how well they're doing and ultimately move to a place where we're able to track outcomes and assign values to services rendered. Assessing these very basic but fundamental issues within your state may allow for easier adoption and ultimate capacity for integrated clinical systems.

At the heart of our states' attempts to integrate care is this agreement of what we expect of our mental health system as well as our mental health workforce. As seen on this slide, there are ways to conceptualize mental health and the work done in primary care that goes far beyond just tackling basic mental health issues. Working from left to right on the slide, you can see we're going from more general (assessing psychosocial issues) all the way to individuals that have more severe mental health needs.

From a policy perspective we might limit what our mental health clinicians do by how we contract for mental health and Medicaid. We may have negotiated this with a managed care organization (MCO) or behavioral health organization (BHO) contract. Whatever may have been done, it's important to recognize that one of the first steps in enhancing the capacity of our workforce is allowing our workforce to do much more than what we may have agreed for them to do. Mental health is one of the best examples of this as we often require certain diagnoses. We limit the session numbers, the service locations. It's important to highlight that we're never going to have enough of the workforce we actually need, but we really need to consider how do we take who we have and allow them to operate at capacity to allow them to do the things that will ultimately benefit the community that they're serving.

In Colorado, through our State Innovation Model, we recognized that one of the most significant ways to enhance capacity was to create consistent standards around what we expect from our mental health clinicians when they're working in primary care, what value do they add and what would you expect from them. We need to approve a method creating a consensus process to agree to core competencies that should be expected from mental health and primary care. We did this as practices, policymakers and payers were all beginning to support integration, but there was no standard from what to expect of the mental health workforce. No one knew what they were going to get. This was a problem.

So we took the evidence, organized the leaders, surveyed them on the evidence, brought them together for a meeting, agreed on a starter draft of competency, surveyed them again and then published them for use. This is important because our method as seen here could easily be adopted by other states and we actually said that going into this process. We wanted to create a living document that would ultimately need to be modified by those using it, that Colorado creating a set of competencies for its workforce to work in primary care was inevitably going to change as our workforce strengthened, and as we created new training programs that allowed our providers to understand what they needed to do in primary care to be most successful. We had a great number of stakeholders and leaders that attended to this, and we really created a product that ultimately became a baseline, a standard for what to expect from our workforce.

As you can see on this slide, we really went back and forth on the evidence and we synthesized the best thinking out there, and ultimately came to a place that everybody understood what they wanted to have happen within the practices. We created a document. So when Colorado decided to target and integrate mental health into 400 primary care practices, so many different partners came to the table, including foundations as well as training and education programs. We collectively knew that there needed to be some type of line drawn in the sand, one that didn't incite a fight between disciplines but was more focused on our outcome as a state.

This is a really important point here. In your states it's inevitable that when we start talking about who's going to do what in what setting, guild issues will come up. People will talk about scope of practice. We didn't want to have to address that immediately. We wanted this to be about behavioral health clinicians across the board, licensures, and we wanted to be able to build off of that for our conversation. So at a global level we ultimately ended up creating eight competencies that we expect for mental health and primary care. But we didn't want to stop there. We actually wanted to take the competencies and create ways that people can use them beyond the document, so we created a series of video vignettes.

What does this mean for any of us? First, there are quite a few principles for state policymakers that should be considered today.

- We must begin to see mental health for what it is, not just a specialty service but one that is truly part of the broader enterprise of healthcare, a broader part of primary care. It's a generalist function in many settings. This forces our states to consider how some of their policies and practices may inadvertently silo and limit the full capacity of a mental health provider to deliver care. Why do we see this as different from care management and other core practice transformation supports? In fact, one could argue that this is much more value add for the outcomes and costs when we integrate mental health.
- Without standards we run the risk of everyone saying that they are competent to work in primary care. We know this factually to be untrue. Without a standard for mental health clinicians, no one will know what to expect, how to act and operate, or even the best way to maximize members of a team. This will almost instantly be a rate-limiting factor for your state in trying to steal your integration work.
- We really must consider how our payment methods sometimes force our mental health clinicians to operate in certain and limited ways. We will only pay for this service in this setting are examples of that. While not the purpose of today's webinar, there are promising new models of payment that can reinforce integration in the full range of mental health services that I briefly described.
- When primary care owns your mental health resources, it takes on a different feel for the practice and the clinicians. This is not temporary. We can actually do more and experiment more because the primary care practice owns this. Contractual relationships, while not a bad place to start, make some of the maturation and nuance of integration a lot more challenging down the road. It doesn't become a true integrated culture.
- Last but not least technology. What presentation is complete without a call to technology that it can help enhance what we do everywhere, but especially in ways that help us reach our rural areas? This is also going to be critical in scaling and ultimately sustaining some of our integrated work.

In closing, I want to draw your attention to a few other states outside of Colorado who are also addressing some of these same issues. You can see on the slide here that Oregon recently released an entire report on integrated care which includes plans for standards for clinicians. Again, it gets to the heart of how do we increase the capacity of our workforce and primary care to do more and see more and be most efficient in what they do. Check out that link. Also, our friends in Virginia have created a really nice approach to substance use and primary care that includes other pieces including mental health integration, so it's not just about how are we going to address substance use and some of the problems we're facing in primary care around addiction, but how do we wrap around a team to that individual so that the addiction is addressed but we also provide some type of supportive counseling or ongoing health behavior intervention.

Last but not least, I want to draw your attention to the link at the top around the competencies I mentioned. I went over this relatively quickly but in our state, Colorado, we realized that creating another document that was just going to be used as a source document for the state that foundations bought into (as you can see from the previous slide) as well as our state was going to be insufficient. We needed to create products and tools that practices could immediately see and implement in order to really get to that true range of mental health needs in primary care. So we created a series of video vignettes, none longer than 90 seconds, that walk through each of the competencies. In our estimation, one of the best ways we could get practices to instantly see how this is going to enhance capacity is to show them. These are animated vignettes. There's no famous actors, these are more cartoonish, but they get to the heart of

the issue. They ultimately drive us back to the place where we can begin to demand more from our providers, ask more from our providers, yet support them in the ultimate goal we're all trying to achieve, which is integrating care. Thank you.

Laurie Hutcheson: A few questions for Ben. *You talk about competencies for behavioral health providers within primary care. Could you talk about the training or competencies or how you help the primary care practices make their cultural shift to work with the behavioral health practitioners? Different kinds of providers have different lengths of time, for example, they're used to seeing their clients. What about those competencies?*

Dr. Benjamin Miller: We started with behavioral health clinicians because we knew that immediately the primary care practices, including the providers, were going to start asking where can I get one of those? What type of provider do I want? Where do you go to find somebody that knows how to work with me in this unique workflow? We started and in the process of doing that we were asked a lot along the way. It's not just behavioral health clinicians you need to enhance the competency around; it's all the clinicians working on the team.

So we looked at the other evidence around primary care. There's a tremendous amount of evidence around team-based competencies and off the top of my head I can't tell you where to look for those. But we started with behavioral health because we knew that to be the most problematic. What was interesting when we started to field test some of the competencies and work through a little bit more with the frontline practices is that the primary care clinicians, they understood a little bit more around what to expect from their behavioral health clinicians, which then changed a little bit of their own competency for behavioral health. As an example, without the competencies what was very common in practice is that a primary care clinician would see a patient with some type of mental health need and immediately just say that's depression, that's going to go to my mental health clinician. They would make a referral in-house or out-of-house.

With these competencies, we talked about the behavioral health clinician could actually augment or even complement the primary care clinician's assessment of mental health. So you get a little more refinement in is this mild depression or are we now differentiating between depression and bipolar, or is there is a little sprinkle of anxiety on top? So we enhanced the primary care clinician's capacity to oversee and ultimately find out what was really going on with the patient in front of him. A friend of ours who participated in this process described it as a rising tide raises all boats. That is, the behavioral health clinician coming in properly trained to the competencies would ultimately bring the rest of the team up with them as they increased the understanding of what they were actually intending to do through their integration.

Laurie Hutcheson: *Can you say more about what the State of Colorado has done about providing the training and more importantly getting participation among providers in the training?*

Dr. Benjamin Miller: I chose the State of Colorado's workforce work group for our State Innovation Model. Once we were able to ultimately create those competencies, which did take a bit of time, about a year from beginning to end and then another year for the videos, we allowed the practice transformation teams that were out there working directly with the practices—again through our SIM grant—to use the competencies as examples of what practices should be doing when they integrate. It was an example where mental health clinicians might have some ideas on what they thought needed to be done, but these competencies actually gave them a source document as well as examples of what it looks like in practice.

Now what we're doing in partnership with the state is actually taking it to the next level, which is we're seeing which training and education programs within the State of Colorado are actually utilizing the

competencies to train their clinicians coming out of school. We're looking at this a couple different ways. One, how do you look at the pipeline? How do you begin to prepare the workforce that's currently being trained to have these competencies as a core part of who they are when they enter into the workforce and ultimately graduate? That's one part.

The second part is how do you take the clinicians out there already in practice and somewhat give them an opportunity to be trained to these competencies. We're having a meeting in a couple of weeks talking about just that. So we haven't figured it out entirely yet, but for your states interested in looking at setting a standard for clinicians within practice and really being considerate of the competencies to ultimately achieve integration, I would say it has to be done in tandem. You really need to create competencies while you simultaneously work with your training and education programs to ultimately give you this workforce that will be useful for you.

Lastly, and this is essential for our success, is that we have a stake at the table from the beginning. The state through the governor's office as well as through our Medicaid agency and behavioral health agencies, they all participated and provided guidance and feedback throughout. Even now they are some of our best advocates in utilizing the competencies within practice. So it's a tool that is not only useful for frontline clinicians but has also been useful for our staff at the state level.

Laurie Hutcheson: *Regarding your comments about pushing providers to own their own behavioral health resources and to be fully accountable for measured outcomes, can you say more about that?*

Dr. Benjamin Miller: As you know, Medicaid through how it pays measured contacts can begin to really extend the playing field around mental health, for lack of a better term. With our data platforms we are moving towards new and novel ways to track how well people are doing. Why don't we just use this to embrace how we're addressing mental health and Medicaid? So when I talk about ownership fees, we actually have seen this happen in real time in some of our practices here where we've watched and observed when practices simply enter into a contractual relationship, which is fine, to initially onboard a mental health clinician. If there's inherently some tension that is felt, whether through the financing, the different cultures, the lack of training or alignment, it makes it really hard for primary care to really almost truly, seamlessly integrate that clinician into their practice.

Don't get me wrong, they're doing good stuff and it's helping a lot, it's truly helping people's lives. But at the end of the day if we had a magic wand and could do everything we wanted to do, it seemed like it makes more sense, considering the heightened capacity of our practices to use data to inform what they do, to allow them to also have that member of the team that they can integrate just as much as they integrate other functions that they're using technology for, like care management. When it's not a part of the team it still feels like a little bit of a one-off. It's a wonderful idea and it becomes somewhat of a platitude for some folks, but it really makes it more difficult to totally see that this is us now. This is the way we're going to do business. This is the standard of care when that person is on your team versus it's simply another contractual relationship. That's what I mean by own. Own might be the wrong word, but it's truly that mental health clinicians aren't a line item on a budget, they simply become part of the primary care team.

Laurie Hutcheson: I'm going to provide a very brief overview of strategies available to states, including some Dr. Miller touched on, to promote provider capacity for PMH integration. State Medicaid programs have a variety of policy levers including promoting ways to move away from fee for service to alternative payment models (APMs) that may provide financial incentives, for example: a) enhanced fees to assist providers in adopting key elements of PMH integration; and b) using Medicaid state plan and waiver options to make system changes and implement models that support integration and care coordination;

for example, implementing a health home state plan amendment that enables the providers to embed behavioral health clinicians in their practices, as we've been hearing about, and work towards patient-centered medical home recognition.

States may use waiver authority to implement innovative models that provide external care coordination and support to practices regionally, for example. States can use state plan authority to fund nontraditional services such as SBIRT screening and peer workers, or to enable use of video conferencing for counseling sessions and to provider consultations. States also can collaborate, as we've just been hearing about, across state agencies to develop and implement learning collaboratives and training hubs, and provide other assistance such as practice transformation consultation. Last but not least, states can use managed care contracting in a number of ways to promote PMH integration among the MCO organizations' contracted providers. For example, states can encourage or require MCOs to begin to shift to alternative payment mechanisms. They can provide incentives for practices to conduct care coordination, build relationships with community partners, and the MCOs can support providers to collect and report data on standardized quality measures and facilitate data exchange.

Now we're going to shift to in-depth state examples. We're going to hear what New Hampshire and Hawaii are implementing and what strategies we just touched on are being employed. First, Kelly Capuchino of New Hampshire.

Kelley Capuchino: As Dr. Miller and Laurie Hutcheson already identified, here in New Hampshire we have already begun to apply many of the activities and strategies they were talking about. I intend to speak beyond my slides and give you specific examples of what that looks like here in New Hampshire. I'll provide our background and goals, then share highlights of our DSRIP demonstration and the lessons learned.

The demand for services here in New Hampshire, like for all of you, was increasing. Our psychiatric inpatient wait list was growing with people who had been in emergency rooms awaiting admissions for days and sometimes weeks. Our staffing vacancies were high across provider types and we were dealing with the opioid epidemic. We knew we needed to do a better job of providing comprehensive and integrated care to effectively address the needs of the individuals we were serving.

At a high level, the DSRIP initiative began to focus on some of these things through integration, expanding provider capacity, and reducing gaps in transitions. The New Hampshire waiver really aimed to implement the SAMHSA integration framework through the application of specific projects that required primary and BHPs, and they needed to implement a core standardized assessment process, certain health information technology (HIT), and development of a workforce strategic plan, all with the goal of driving towards new payment methodologies for Medicaid.

New Hampshire wanted to build upon the strong foundational principles that were core to our service delivery system for a long time including the whole person approach. It was important to us to align the work with other existing initiatives. We didn't want to just pop up something new, another initiative, and not have it fully woven in with all of the work that people had been doing for a long time. We knew it was important to approach it that way to ensure sustainability of the successful outcomes of the demo.

Building upon the existing initiative, we required all our participants to engage in two statewide projects and mandatory projects, in addition to some community-driven projects. So we had three projects that everybody was going to participate in, and those were specific to workforce, HIT, and integration. But the new features of this initiative here in New Hampshire were really the integrated delivery networks (IDNs) and our waiver payment methodology, which was 100% incentive-based. The state contracted with administrative lead organizations in the community who were responsible for organizing a network of community providers within each region of the state. Those groups of providers, those integrated delivery

networks, had to be comprised of primary care physicians, SUD, public health network, community mental health centers, FQHCs, social service agencies addressing social determinants of health, transportation, housing, employment, community supports. The list goes on, but it had to be a broad and rich set of providers. They had to demonstrate that to us in their application.

The administrative leads who convened those providers then had to develop governing structures for those regional networks on clinical, financial and data technology. The leads had to assist the partners in establishing protocols for standardized reporting of finance and specific data metrics. The lead took the responsible for contracting with providers and issuing RFPs and developing local workforce strategic plans that would help them with those community-driven projects that I referenced, and address workforce gaps identified in their community and needs assessments within their regions.

Our focus of course was on the integration of the SAMHSA framework. There were some common goals across the IAP and the demo waiver, such as the emergency room waiting list, the implementation of the core standardized assessment process, and moving 50% of our Medicaid provider payments into an APM. These projects are examples of where New Hampshire intentionally focused and built upon existing initiatives. For example, we were the recipient of a balancing incentive award because we were a state that had to rebalance. The core standardized assessment is predicated based upon the Administration for Community Living (ACL) and CMS indicating in the balancing incentive program what domains had to be incorporated. So we had already rolled that out with our community mental health and BHPs, our area agencies, and our aging and disability resource centers.

In the IAP, we had been focusing and working on the emergency department wait list. In the DSRIP waiver we introduced the APM initiative. We required that all the IDN partners begin implementing the core standardized assessment process, the domains that I just referenced that ACL and CMS had required through the balancing incentive program. They began to initiate it but they have until December 2018 to complete it. The intersections of the core standardized assessment and the integration work and the ED wait list are illustrated in an example I want to share with you.

In New Hampshire, we work to improve timely and quality information sharing between the hospital emergency room and the community providers in both primary and behavioral health settings. We wanted them to identify needs, and make appropriate referrals and warm handoffs. We were going to rely heavily on some of the technology that I'll talk about later. So we began to share the emergency department wait list dated daily. Now statistics were really the information that we shared more broadly, but with payers we were reviewing, detailing and talking about on a daily basis member information. This information provided numbers of people within each hospital who referred them, who their primary BHP was, what their insurance was, providing people an at-a-glance awareness of the number of people in each ED by each of those payer and referral sources, by age and how long they'd been there. We sent the information to providers, payers, hospitals, and program directors.

We kicked the initiative off with a 30-day mandatory call-in with hospitals and CMHCs, commercial and Medicaid payers. The commissioner's office was on the call, the division director. To qualify, information was shared using the secure FTP, and protected health information was only provided to the payers and it was their job through their care coordinators to go back and reach out to the hospitals and the providers in the community that were working with these individuals.

We believe that implementing some of those strategies and working together with our previous and the integrated delivery network that we could have a meaningful impact on people's lives—reducing the number of people in the ED, supporting them in their home and communities, and reducing the pressures of staff working in the EDs under these situations and improve their work experience. Ultimately, if the

integrated delivery networks could lead their regional provider partners and successfully coordinate and here's the key, the gathering of the data and the outcomes reporting, that they would be well-positioned to demonstrate the value of their role in APMs.

My observation was that the providers began to build relationships, first in the 30 days. Then we had meetings face to face, and they were building trust which positioned them to engage in an open and constructive dialogue about the challenges of the process. For a long time you had heard them finger pointing and grunting and blaming. The process really evolved to a place where they were collaborating and coordinating on care and treatment for the individuals they were serving.

But we did build upon the SAMHSA framework here, and within the DSRIP waiver we required that all participating primary BHPs continue to make progress along the SAMHSA framework. They report to us every six months twice a year. So providers were initially paid for process payments, such as an assessment of the integration framework practice within every primary and BHP office. They had to come back and show us that they knew exactly what all their participating partners were doing in the areas of integration and what things they weren't doing.

In the first year of the program they got those process payments. In subsequent years they are paid for reporting and that is the current payment cycle we're in now. Yet, later towards the end of 2018, 2019 and 2020, they will be paid specifically for outcome. One thing we did differently in New Hampshire was we did add to the SAMHSA framework specifically requiring that there be multidisciplinary core teams across all areas of integration and that the integrated delivery networks and the primary behavioral health partners share information utilizing care plans, treatment plans, and case conferences that they develop standardized workflows and protocols and full implementation of a comprehensive core standardized assessment process.

There's always a lot of discussion about what the comprehensive core standardized assessment means and did we make them use one tool, and of course we didn't. What we did was we adopted those 13 domain areas that came to us through the balancing incentive program core standardized assessment requirements. The domains within the comprehensive assessment were carried over from CMS and a community LTSS focus was really embedded within that. Our target population here within our delivery system reform incentive program was our person with serious mental illness and substance use disorders and complex medical comorbidities, individuals who are at risk. The assessment included domains in areas of demographics, medical, substance use disorder, housing, family and social supports, education, employment, entitlement, legal, risk assessment including suicide risk, and functional status (ADLs and IADLs). You can probably imagine the reaction for some of these things on the BH side was why do we really need to ask that? And the initial reaction on the primary care side was that's stuff that the BH people are going to ask; we don't really need to ask that, do we? More about that in a minute.

In addition to those requirements, New Hampshire also added the requirement for depression screening and brief intervention and referral to treatment, so the whole SBIRT model. In addition to our comprehensive core standardized assessment, the IDNs participated in a number of technology investments. They conducted a facilitated current state assessment with a focus on HIT for all their primary and behavioral health providers. They came to consensus on a set of minimally required, desired and optional HIT and exchange tools. They agreed upon infrastructure projects for the IDNs to pursue using those agreed-upon technologies. All of that was really focused and predicated upon them enabling clinical outcomes and financial performance measurement and reporting functions within the IDN, across the IDN, and between IDNs and the state.

So ultimately as you can see on this slide, they agreed to deploy an event notification system, direct secure messaging, a shared care plan, and a data aggregator. While I have a slide at the end that talks about some of the lessons learned, I do want to say that here on this slide that regularly convening clinical and HIT-focused individuals across the partner organization at least twice a month to discuss all the processes and outcome measures and inform the process for gathering and reporting data has really been key to the buy-in and execution of the work that they're doing.

In addition to the integration and HIT, we did have a workforce capacity initiative. The statewide workforce task force is comprised of IDNs and they continue to prioritize and address policy, recruitment, retention, training, and privacy barriers. For example, two of the IDNs have pilot programs with higher education institutions right now that include a career ladder. The state licensing agency is now participating on the workforce task force policy committee, identifying and addressing opportunities for efficiencies in the licensing process as well as barriers to recruitment.

New Hampshire is a state that doesn't have reciprocity. Just an example of one of the things people deal with when coming here from another state is in order to get licensed here you need to provide notes or something from your supervisor indicating that they oversaw you during your orientation period and pre-licensing phase. But if you're 50 years old, that's information that's very, very difficult to get. So having the licensing board at the table and working through some of these issues is really helpful to us.

Finally, the legislative Interoperability Committee is studying mental health and social service business process alignment, and information system interoperability. Their focus is to improve access to services, reduce duplicative effort, and reduce overall cost of medical and social services. But they give us an ear and provide us an opportunity to inform the legislative group on what some of the barriers are, specifically related to integration, technology, privacy, and workforce.

Finally, with all that work being done and as I said on one of my first slides, New Hampshire is moving towards APMs. We're focused on moving our APMs along the LAN framework into value-based purchasing. We're in the process currently of drafting our re-procurement RFP to incorporate those payment arrangements into our managed care contracts. Lots of decisions still need to be made with regard to the details of that procurement language. Suffice it to say I'm not at liberty to talk about those publicly but generally there is agreement that the value-based purchasing should be tied to the successes of the New Hampshire DSRIP waiver that focus on transformation and integration of the service delivery system and incorporate the social determinants of health.

What are our lessons learned?

- Providers don't have a strong capacity to use their own data for integration. They've gathered lots of data, it's in their system in informational data fields, but they're not fields that they can query. They're fields that they can read.
- Training providers to leverage appropriate referral partners when they do a positive screen has been a big concern. When they apply that core standardized assessment process, and training them on what those resources are, takes time and a willingness on the provider side to change the way they think about the needs of the people they're serving.
- The landscape is constantly shifting, with leadership changes and acquisitions, policy changes, funding levels. The lesson for us is we need to be responsive to partners in how the changing landscape impacts their ability at any given time to participate in any of our activities, not just our waiver activities. We need to be flexible if we want our partners to stay at the table. Our IDN leaders are bringing partners on board in waves and they're doing rapid cycle evaluation

> throughout the demo period, which affords some flexibility for partner agencies who have had interruptions in their ability to participate.
> - The IDNs also have the ability to achieve payment for a missed milestone in the reporting period immediately following the reporting period that they missed that mark. So if they were looking for January to June and had a mark they were supposed to meet and they missed it, then they could try to achieve that in the next reporting period.
> - Finally and not least, federal, state and organization privacy laws, rules, policy continue to prevent real barriers to data and information sharing. Some of it is real, some of it is perceived, some of it is at the organization level. But it's extremely, extremely time-consuming for organizations who have a multitude of different policies to come together and try to address their privacy barriers.

That's what we're doing here in New Hampshire.

Laurie Hutcheson: We have questions. *Can you talk more about how structurally the IDNs are related to the managed care organizations?*

Kelley Capuchino: Remember we have an administrative lead, an organization that raised their hand and said pick me, I want to organize providers in this regional geographical area. Then they brought all those players together. Any direct care providers they brought on board already are Medicaid providers. So they have standing relationships with the MCOs. That being said, they would tell you that at times they do feel like competitors. The MCOs are concerned about what the IDNs are going to do and will they replace them, and the IDNs are concerned that the MCOs might be duplicating efforts around care coordination that they think they are better positioned to do using these kinds of technologies in meeting people in the community and on the ground where they work and live and get their services and their needs met.

The MCOs do meet with the IDNs twice a month. Both times they meet there are two meetings back to back. One is a learning collaborative. The other is a data meeting. Then there is general IDN operations, administration inefficiencies and are data health information exchange discussions. The IDNs would love for the MCOs to provide them data about their attributed members, the individuals who live within their region, but the MCOs are still at a place where they're willing to provide that information, and they make it available through a really great web-based platform but to their providers. The IDNs have discussions with the MCOs around who they're providing care coordination to, but the net that the IDNs are trying to cast is to a much broader population than the MCOs cast when we're talking about case management activity.

Laurie Hutcheson: *Can you speak more generally about the SAMHSA framework and how New Hampshire has used it as a guide? Also how are the IDNs working with the practices in their areas to make progress on the framework?*

Kelley Capuchino: SAMHSA has a framework that you have this link to (in chat box). We think of it more as a bidirectional process. If you open the link you would see there's a lot of activities that begin from making referrals to being fully physically collocated. That's an example of what the SAMHSA framework addresses in terms of integration. There are many, many kinds of things that can happen around integration, from having consultation to sharing information using direct secure messaging to agreeing to protocols for referral and warm handoffs. So we use that SAMHSA framework to identify the kinds of integration activities we want them to make progress on but we don't dictate you have to make progress on every single one of these elements, because some of them are coming to us with some significant progress already. In our state you have to make continued progress on every single incentive payment period.

So we want to make sure they look at that and make progress in any one of those things. Sometimes it could be on the far right of that framework and sometimes on the far left. We don't particularly identify those as being more integrated or less integrated, they're just varying degrees of integration. The IDNs assist primary care offices with this integration, first by doing some of the things that Dr. Miller talked about and you talked about by identifying a competency framework, coming up with a training curriculum that they will be deploying across those offices over the 5-year demo period. Defining what the schedule for that looks like. Making sure they make the technology for the primary care offices available because you can't expect to get up and leave their office and go to all-day presentations. These are direct care providers that have many competing priorities, the most important of which is really treating the individuals coming in their front doors.

So the IDN leads hired integration behavioral health coordinators to go into the primary care offices and to assist them in the understanding of the framework and to apply some of the protocols that they begin to roll out in the first wave, second wave, third wave using their rapid cycle evaluation. The IDN lead is really charged with making all that resource available to not just primary care but primary care and behavioral health, and coordinating them to other providers in the community that are outside primary care and behavioral health that we believe will improve the outcomes for individuals through a broader integration model.

Laurie Hutcheson: Now to Judy Mohr-Peterson to hear about Hawaii's efforts to build provider capacity for PMH integration.

Dr. Judy Mohr-Peterson: I am Hawaii's Medicaid director. My approach is going to be a little bit different than the prior speakers although I'll be building on much of what they covered. Because of that I also am not going to be repeating much of what they said. Other than on lessons learned, I could just say ditto to everything New Hampshire covered. It's pretty much the same aspects going on in Hawaii.

I'm going to cover a brief description of our overall health inform efforts. I'm going to focus on integration of physical and behavioral health. I'm actually using behavioral health because in our state we are approaching both substance use and mental health simultaneously. Even though the delivery systems and the treatment modalities are very different, from a primary care perspective and the perspective of the individuals we are serving those two things go hand in hand. I'm going to walk through several initiatives we focused on for the integration of physical and behavioral health and talk about what we are still planning on doing but not yet launched, then cover lessons learned.

Because I know the majority of people on the line are coming from a Medicaid background, it's usually helpful to explain the Medicaid program here in Hawaii. We have been ranked as the healthiest state for a number of years. We are considered to have a very efficient and effective healthcare delivery system. Our overarching vision is embracing health and wellness. We serve about one-quarter of the state's population, which is similar in size to New Hampshire's, about 1.4 million. We've had an 1115 demo waiver since 1994, which is also up for renewal this year. That's one of the things we're working on and one reason the behavioral health integration is such a strong focus for us is because it's a major part of our renewal effort.

We did have a SIM planning grant but did not have a testing or a design one, and we don't have any of the DSRIP incentive measures either. We're using our 1115 waiver as our point for innovation. We are 100% managed care including LTSS. We have a mental health managed care carve-out for seriously mentally ill adults who have a functional need. A little on our delivery system as well: We have geographic isolation. We are a long way away from the mainland and are a separate island. For that reason, we have geographic separation as well and a concentration of our providers on one main island, which means we have very

small practices that are very geographically isolated. It's extremely difficult to have co-located practices, for example, to access specialty care including behavioral health care. Those are some things we're trying to address in what we're doing.

We're up for our waiver renewal. It's pretty basic—we're focusing on the Triple Aim. But somewhat uniquely we're focusing on a multigenerational approach that's also culturally appropriate, that focuses on both individual and population health outcomes.

This is our overarching framework for innovation. I'm not going to go through each one. I talked about using a multigenerational approach, what we call 'Ohana Nui. I did want to also note that we are focusing on leveraging and supporting community initiatives. Similar to New Hampshire, we're trying to build on those community efforts and practice innovations that are happening already on the ground with the practices, within the communities, in which they're pulling folks together to address their community's needs. Interestingly enough, or perhaps not interesting at all for these purposes, most of these initiatives include some aspect of behavioral health integration and physical health integration. It is a very common theme and a great need.

We've already talked about the social determinants of health. One of the aspects we haven't called out explicitly is that when we're talking about physical healthcare and behavioral health integration, we are still continuing to focus on that 10% medical care. So until we start to focus and broaden, which is why we're trying to work with the various communities and various social service agencies, it's still going to be stuck there. That's why we do need to start going beyond that in order to truly address behavioral health and physical health needs and the overall health outcomes of our population.

It's also helpful to again remind ourselves that our entire healthcare delivery system is built on the concept of body parts and diseases as opposed to taking a holistic and whole person approach. We very much separate the head from the rest of the body and treat it and have treated it as if they were separate. That's a legacy we're dealing with today, so when we're talking about physical health and behavioral health integration, it's from this basis. Of course those are not separate. They do influence each other, which all of you know, but it is surprising to me whenever I use this particular slide in my other presentations the number of people who come up and tell me they have not actually thought about it this way before. It's one of the tools we use in our communication efforts with the larger community.

As I mentioned, we're using this 'Ohana Nui approach. That means we're focusing on a multigenerational approach to support young children and their families early and concurrently and throughout the life cycle. That means that we don't focus on just the children, we also focus on the adult. In doing that we take a look at each of these different aspects. So today's delivery system within the human services area and the healthcare area, all of these things are separate. Financial assistance, food and nutrition, housing. What we're doing is trying to look for a way to bring those together in an integrated approach by putting that family and that person in the middle.

For the healthcare delivery system this is what we're picturing, a model that looks like this. A model that yes, we have our clinical services, but there's also recognition of needing to focus on the public health and community-based interventions, focusing on health and wellness within our communities, within our built environment, and then going even beyond that to the community problem-solving.

This is our project summary. We're investing in primary care, in outcomes for high-need, high-cost individuals, payment reform and alignment, and supporting community-driven initiatives. There are also foundational building blocks using HIT, workforce capacity, performance measurement, and evaluation. In other words, exactly everything that the people who came before me have spoken about—how important it is for their initiatives to survive.

One of the initiatives we have is focusing on homelessness. One reason I'm talking about homelessness is one of the things we recognize in the behavioral health integration effort is that we could not limit it to just talking about the primary care practice level. We discovered immediately that in those conversations there was a great deal of resistance to basic screening assessments and motivational interviewing because of the fear of the acute level, the most acute level individuals who have the most severe behavioral health needs. Consequently, we immediately had to shift our focus to have a continuum that wasn't focused just at the primary care level but also was thoughtful and intentional about the gaps that we had at the most acute level. One of those primary areas is homelessness, particularly for chronically homeless as well as the family.

We have a number of homeless families, the highest per capita in the country, and the majority of them, particularly the chronically homeless, had some form of mental illness or substance use or both. We see the same thing with our family assessment and families. There are high behavioral health needs as well as education, food and nutrition, and then housing. So we put a lot of supports in to help address that.

We also are working on the screening for brief intervention and referral for treatment, which is an evidence-based practice to identify abuse and prevent substance use at the primary care level. It is very important for us to focus on that because of the number of pregnant women and other individuals who have substance use issues.

In the past year to year and a half we've been focused on trying to get primary care providers as well as OB-GYNs and safety net clinics to use the SBIRT 100% of the time so that it builds up their capacity. As I've mentioned before, most of the practices are largely small and independent, so it's very important for us to be able to support them no matter where they are. We did a lot of partnering with the Department of Health and their alcohol and drug abuse programs as well as their maternal and child health programs to train OB-GYNs in the use of SBIRT.

We used it as part of a larger effort, something we called a One Key question, which is actually an Oregon-based model in which you ask women if they would like to get pregnant in the upcoming year and depending on what the answer is you go down different pathways. If the answer is yes, they would like a family in the upcoming year, you want to make sure that the women are as healthy as possible. So we've done a lot of training on the use of SBIRT in these contexts to try to do prevention of harm and help women not use substances while they're pregnant for a healthy pregnancy and healthy baby.

We also expanded that to use a quality metric for SBIRT training for hospitals as another screening location within the emergency room or inpatient. At this point we've had nearly 100% of the hospitals have started to do their training and we'll be making this performance grant.

Another priority initiative has been our telehealth. As is obvious, we are an island state with distribution resources and I focused on just one particular island. But it leads to a vast underserving in our rural areas and our neighbor islands, particularly in the areas of psychiatrists and behavioral health. There have been some very successful efforts in this area. We had a pilot as well, so this has been one method we are using and expanding to be able to expand access to scarce resources such as psychiatrists. We found that if our primary care providers don't have some way to access either psychiatrists or the BHPs, then they will not adopt and will not take on these lead integration efforts. Again that's why we're taking on these consultation services like telehealth, etc. That's why it's so important for us.

We had some legislation that removed essentially almost all the barriers we had in place for use of telehealth. We required the managed care plans to pay for any telehealth services. They are to pay the same as if they would for a regular visit if it's medically appropriate to do so. We removed any kind of geographic limitations on the use of telehealth. We included an additional tele-modality such as live

consultation and mobile health, and then we allowed telehealth services to originate in a person's home and other nonmedical environments if that was appropriate to do so. The mission we already piloted it with are Department of Health Partners. They were using it for their telepsychiatry and with the families in a really, really highly successful way. Now we're continuing to move in this direction and we're trying to pay for these services differently to help encourage it as well.

We also are focusing several other provider capacity opportunities within the state, so we're still in the developmental stages of trying to develop community care teams to support these really isolated locations. We're faced with the challenges in that we have our various managed care plans and that we also have a small population. So we don't want each of the managed care plans to have their community care team, which would just lead to a competition for some very, very scarce resources.

We're also leading on to that value-based purchasing, also using the LAN network. We already have it as part of our current managed care contracts. We're expanding and evolving that to focus on the LAN network. We've also incorporated some additional performance metrics within the contracts for some pay for performance as well. Finally, as part of our waiver we're looking at different ways we might be able to support curbside consults, care coordination, those kinds of efforts not traditionally covered or paid for using Medicaid dollars.

Lessons learned:

- This is going to sound pretty obvious but what we have found is that partnerships and relationships are fundamental and key, and if we don't have those trust levels at the community level all the way up to the leadership level, then no efforts in this particular area are going to work. We found that within various community initiatives, they either make or break the various different locations. In a state like Hawaii where there are two degrees of separation for everyone, relationships are truly fundamental.
- Everything takes much longer than what you think. Data sharing is a perfect example. You think gosh, we have models. Other states have models of how this can work. Surely we can make this happen. Then a year and a half later you've just signed your first agreement.
- Focusing on the population health needs of the individual communities: This gets to those community initiatives that it's really, really important for the communities to be able to come together, for the state to be able to support those, and support what they're developing for their particular needs. For example, we have one community that's developing an integrated model and focusing on the complex needs of the population. They brought together the hospitals, social service providers, hospice, palliative care, and community health centers. One of the things they recognized is when they were coming together—and it might sound like a small thing—is they had no way in which to convene a group together to talk about particular cases or individuals like a quality assurance team that most hospitals and provider networks have, because they weren't all covered entities. So they are now working actually at the legislative level to be able to support that.
- You have to have an excellent understanding of delivery systems because every system in every community is different. That's why I mentioned so many different times that we're a small well community with small providers and what it takes to support them is very different than what it takes to support well-integrated IPAs or evolved health systems.
- Again, very, very key, payment systems have to evolve with the delivery system. You can't really do one without the other. That change is extremely hard and challenging because we've had a fee for service system for so long and we've had providers in very siloed systems for a long time. Changing that means changing business models, not just changing workforce flows, workforce

capacity, etc. It's changing fundamentally business models as well. When you're doing all that together that's really, really hard work and one of the lessons we learned here as well.

Laurie Hutcheson: A couple questions. *You ended with some of your lessons learned and challenges. What are you going to focus on first with the 1115 and to fund first among the HOPE Project initiatives you mentioned, in specific focusing on the culture shift in the practices.*

Dr. Judy Mohr-Peterson: One of the things we recognize is that details matter, and that also being able to look at it as puzzle pieces, that you have to move various pieces forward together at the same time. So we've started to lay the foundation with the SBIRT model, for example. We intend on rolling out some additional training models like the SBIRT model for communities, for example, motivational interviewing in general and screening for depression. We are changing the managed care plans and some of the incentive payments and incentive payment models. That's another change occurring now that will continue to evolve.

The areas we are focusing on that are the least developed are two particular areas. One is promoting something called curbside consults and the Project Echo. Those are two areas that provide those supports for the primary care that we have gaps in, so we're doing a lot of work and focus on that and trying to help fund it. Medicaid won't be the only funder in that particular area but we hope to be one of the funders. Again that comes to what Medicaid is allowed to fund and not allowed to fund. As I mentioned, we're not a DSRIP state and don't have DSRIP funds so we have to use a more traditional method of looking at Medicaid funds and how to use them in different ways. We're looking to do that via managed care plans if people are interested. We have a 25-page vision document we're happy to share with people for an idea about where we're going in greater detail. We will have a link by the end of the week.

Laurie Hutcheson: A few key takeaways from today's presentations:

- The importance of physical and mental health integration among provider practices and the challenges providers face in making the shift to integration, including the need to change the culture of the practice, finding ways to ensure the workforces are competent and able to effectively provide care coordination/manage data collection, use and sharing.
- Fortunately, there are many tools states have to help providers expand their capacity for physical and mental health integration and our state presenters gave us a lot of good examples of those including using the Medicaid state plan waiver authorities.
- As a payer, determining ways to pay providers differently. How to serve as a convener or partner effectively with other state agencies to support practices with external teams, training collaborations.
- How states can help providers with data challenges, with employing technology including telehealth to extend their reach.
- How important relationships are to really help providers make the cultural shift and for everyone to learn how to be more integrated.
- The opportunities available to use payment differently to support integration.

This was a lot of information in a short amount of time. Upcoming IAP activities: A fourth webinar on administrative and reimbursement strategies on March 26th.

I thank our presenters profusely.

Please share your feedback in the window that pops up on your screen.

Thank you.

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