**HAWAII HEALTH AUTHORITY**

Department of Budget and Finance

STATE OF HAWAII

**Minutes of Meeting**

**Date:** Wednesday, April 17, 2013

**Places:** Hawaii Community Development Authority

461 Cooke Street

Makai Room

Honolulu, HI 96813

Maui Memorial Medical Center

221 Mahalani Street

Kahului Tower, 3rd Floor

Room VTC 1

Wailuku, HI 96793

1. **Call Meeting to Order**

The Hawaii Health Authority meeting was called to order at 4:08 PM by Jory Watland.

**HHA Members present:**

Les Chun (MMMC)

Stephen Kemble (JABSOM)

S. Peter Kim (JABSOM)

Marion Poirier (JABSOM)

Jory Watland (JABSOM)

**HHA Members absent:**

Rey Graulty

Ginny Pressler

Nathan Chang

Ritabelle Fernandes

**Guests present:**

Beth Giesting

1. **Review of Meeting Minutes from January 7, 2013 –** deferred
2. **Report from Legislative Committee and Definition Committee**

Jory Watland and Stephen Kemble reported on meetings with legislators, including Donna Kim, David Ige, Roz Baker, Joe Souki, Sylvia Luke, and informal e-mail correspondence between Dr. Kemble to Josh Green. Jory Watland was dismayed in particular by Sen. Baker’s comments that she felt the legislature never intended Hawaii to implement the Hawaii Health Authority or its mandate to develop a universal health care system. Marion Poirier added that she and Jory Watland had visited with Michelle Kidani, who investigated what happened to the $100,000 appropriated by the legislature for the HHA. She reported that Budget and Finance told her the Governor’s office has no intention of releasing the $100,000 to the HHA, and that the HHA should be referred to Beth Giesting, who would be responsible for determining allocation of the money.

1. **Reports from Definitions Committee and Personnel Committees:**

Neither committee has met recently, so there are no reports.

1. **Report from Hawaii Health Care Project**

Beth Giesting reported that Hawaii had been awarded a $937,691 federal State Innovation grant to plan for health reform and improvement over 6 months from April through September. The plan will include figuring out how to expand use of Patient Centered Medical Homes and how to develop an infrastructure to provide additional wraparound care coordination services, to enable private physicians to provide more effective care for patients with complex health needs, specialized mental health needs, etc. We also want to improve system integration in various ways, such as a “Medical Neighborhood” to improve coordination of specialty care services, diagnostic services, and pharmacy services with primary care. We also want to improve coordination between hospital services and outpatient services, along the lines of Hawaii Pacific Health’s effort to develop an Accountable Care Organization. The idea is to align the health care system for better value, developing quality metrics, saving money for the system, and making sure people get the right level of care when they need it. We are also working on changing the health care payment system to follow what the delivery system is trying to accomplish, moving away from fee-for-service, especially for primary care and hospital services. The health information system also needs to be further developed so we can incentivize physicians and other providers to use electronic health records. This includes long-term care and ancillary services. We need to ensure that there is a good system for exchanging health information electronically and building a database. We also need to develop a common set of meaningful measures for quality of care. We also need to improve the health care work force, especially for primary care, behavioral health, and oral health. We are also trying to look at how to improve public health and population health, and expanding community health centers to expand access.

Marion Poirier asked if these efforts would include the State funded health services such as State Mental Health Centers, dental, and public health services, in addition to the Federally Qualified Health Centers. Beth Giesting indicated that the State funded services would be included.

Steve Kemble stated that he supports care coordination, community care networks and patient centered medical homes. However, he expressed major concerns, including the dysfunction in our Medicaid system, declining participation by private sector doctors adding to access problems for patients, and new trainees in primary care specialties and psychiatry avoiding Medicaid when they go into practice due to their negative experiences with Medicaid managed care during their training. If doctors don’t participate in Medicaid, then care coordination programs can’t work. We may end up developing a two-tier system in which Medicaid recipients can obtain care only at the community health centers, and the private sector handles everything else. A recent survey of all the psychiatrists in Hawaii found that only 1/3 are still accepting Medicaid, and most of those are not taking the QExA plans. Without a new system of mental health clinics, we don’t have the manpower to provide psychiatric services to the Medicaid population. Even if we train more psychiatrists, if they won’t see Medicaid patients when they go into practice then we can’t solve our behavioral health access problems.

Dr. Kemble also expressed the concern that by committing to a multi-payer model, we are committing to the most expensive possible way to administer health care reform and Medicaid, and that will lose the potential savings we could have achieved with a simplified administrative structure. We will therefore find it very difficult to “bend the cost curve” at all.

Beth Giesting pointed out that “multi-payer” is a requirement of the grant. Dr. Kemble pointed out that other states (Vermont, Oregon, Connecticut, North Carolina) are implementing similar “multi-payer” grants, but using them to develop delivery systems that manage care directly, without a layer of managed care plans between the funding source and the providers that mostly obstruct care, as opposed to supporting providers in delivery of cost-effective care. Our Medicaid “multi-payer” managed care system is actually causing most of the care coordination problems that we see in practice. Unless the managed care plans really change their business model, we will have a major problem engaging doctors. Peter Kim confirmed that in his experience, Medicaid patients are having progressively worsening problems obtaining necessary care.

Jory Watland commented that there is a current lack of attention to public health matters such as oral health and the declining availability of public health nurses. We need strategies to address the social determinants of health in addition to just medical care. In addition, he has observed deterioration of service delivery at the federally funded health centers. Dr. Kemble pointed out that the Community Care Network component of the Hawaii’s health reform initiative is intended to reach out into the community and address the social determinants of health, along the lines of what public health nurses do and have done in the past.  
  
Electronic record keeping was discussed, and Jory Watland said we should look at the system developed by the VA, which is well established and in the public domain. Steve Kemble pointed out that the electronic medical records used by Kaiser and the V.A. were designed to support patient care and quality improvement, but those electronic records were developed for capitated systems that do not deal with billing, so they can’t be easily adapted to the private care sector.

Dr. Kemble suggested that the main focus for the HHA should be to work on designing a new comprehensive plan from the ground up that would provide truly cost-effective and sustainable health care and health promotion. The Hawaii Health Project is trying to implement the Affordable Care Act by taking what exists and trying to make incremental adjustments, hoping they will improve the cost-effectiveness of care, but without a “ground-up” redesign of the health care system. If, after 2-3 years it becomes apparent that this effort is failing to achieve its goals, the HHA should have a comprehensive, cost-effective, efficient health system proposal developed and ready to offer instead. Since the HHA is not being allowed to set policy now and our role is limited to planning, then we can still work on developing a bill for such a system without a large budget, or even with no budget.

Jory Watland offered the HHA’s support to Beth Giesting in implementing the Affordable Care Act in any way we can, recognizing that Hawaii’s health reform initiative is on a tight time line.

1. **Draft Letters to Governor and Budget and Finance Director**  
   Marion Poirier motioned and it was seconded by Peter Kim that the circulated letters be transmitted to the Governor and the Director of Budget and Finance. Discussion ensued around Les Chun statement that he hadn't received the letters. Marion Poirier noted that she had sent e-mails to his two addresses and had not received notice of any technical difficulties. Les Chun abstained from voting because of his position that the e-mailed letters had not been received. All other members voted "yes." The motion passed.
2. **Future Staffing and Meetings for the HHA**

Beth Giesting reported that continued HHA staffing would not be possible. Chelsea's replacement would not be available to the HHA, since she would be needed for other Governor's Office duties. Beth did offer to handle meeting notice posting requirements.   
  
The status of a future meeting location was unresolved, but members will work on this matter during the interim. While no date was set for the next meeting, there was consensus that late afternoon on Monday was the preferred meeting day and time of meetings.  
  
The meeting was adjourned at 5:15 P.M.