Health and Human Services Transformation: Draft Plan Elements

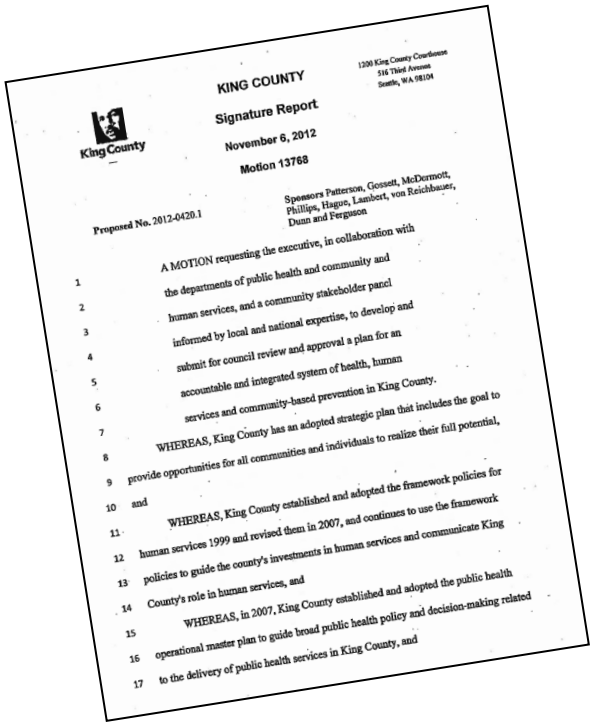
Response to King County Council Motion 13768

April 24, 2013 Panel Meeting

King County

King County Motion Requirements

- Calls for County Executive to develop a plan for an integrated, accountable system of health, human services, and community-based prevention



King County

KING COUNTY

Signature Report

November 6, 2012

Motion 13768

1200 King County Courthouse
516 Third Avenue
Seattle, WA 98104

Proposed No. 2012-0420.1

Sponsors Patterson, Gossett, McDermott, Phillips, Hague, Lambert, von Reichbauer, Dunn and Ferguson

A MOTION requesting the executive, in collaboration with the departments of public health and community and human services, and a community stakeholder panel informed by local and national expertise, to develop and submit for council review and approval a plan for an accountable and integrated system of health, human services and community-based prevention in King County.

WHEREAS, King County has an adopted strategic plan that includes the goal to provide opportunities for all communities and individuals to realize their full potential, and

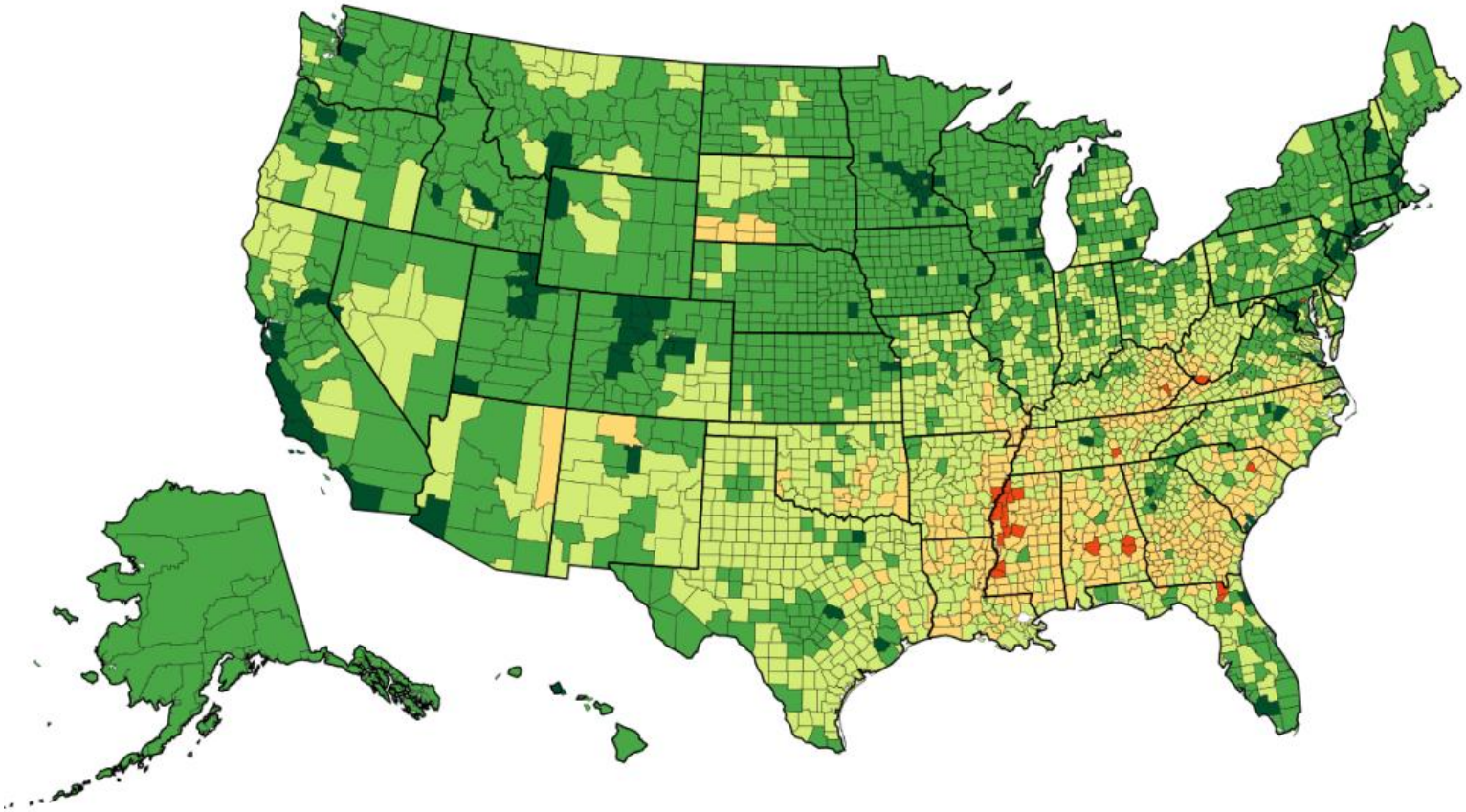
WHEREAS, King County established and adopted the framework policies for human services 1999 and revised them in 2007, and continues to use the framework policies to guide the county's investments in human services and communicate King County's role in human services, and

WHEREAS, in 2007, King County established and adopted the public health operational master plan to guide broad public health policy and decision-making related to the delivery of public health services in King County, and

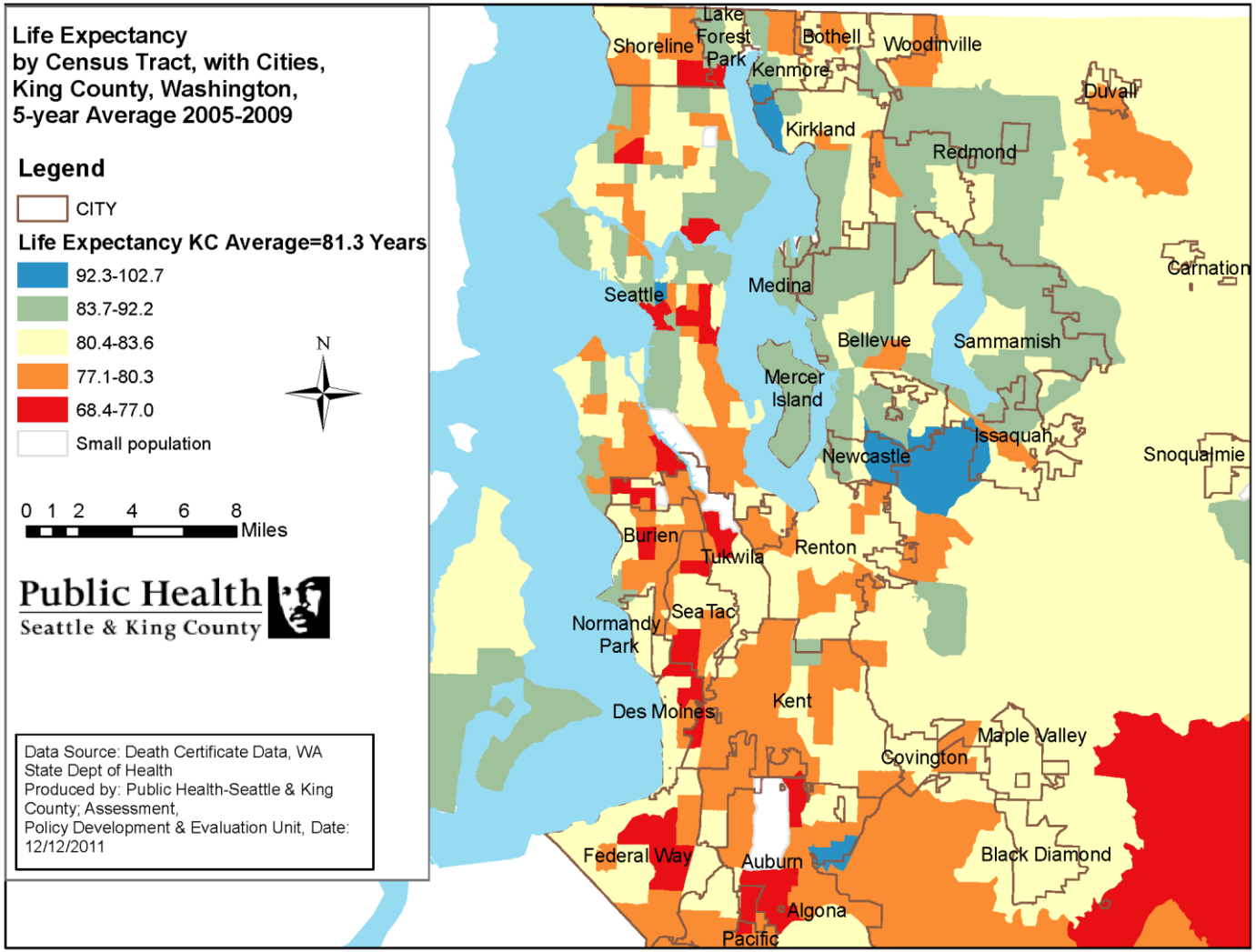
1. Vision and goals
2. Implementation strategies and plan
3. Coordination with existing policies
4. Performance measurement
5. Strategic investments and financing options

Good on Average

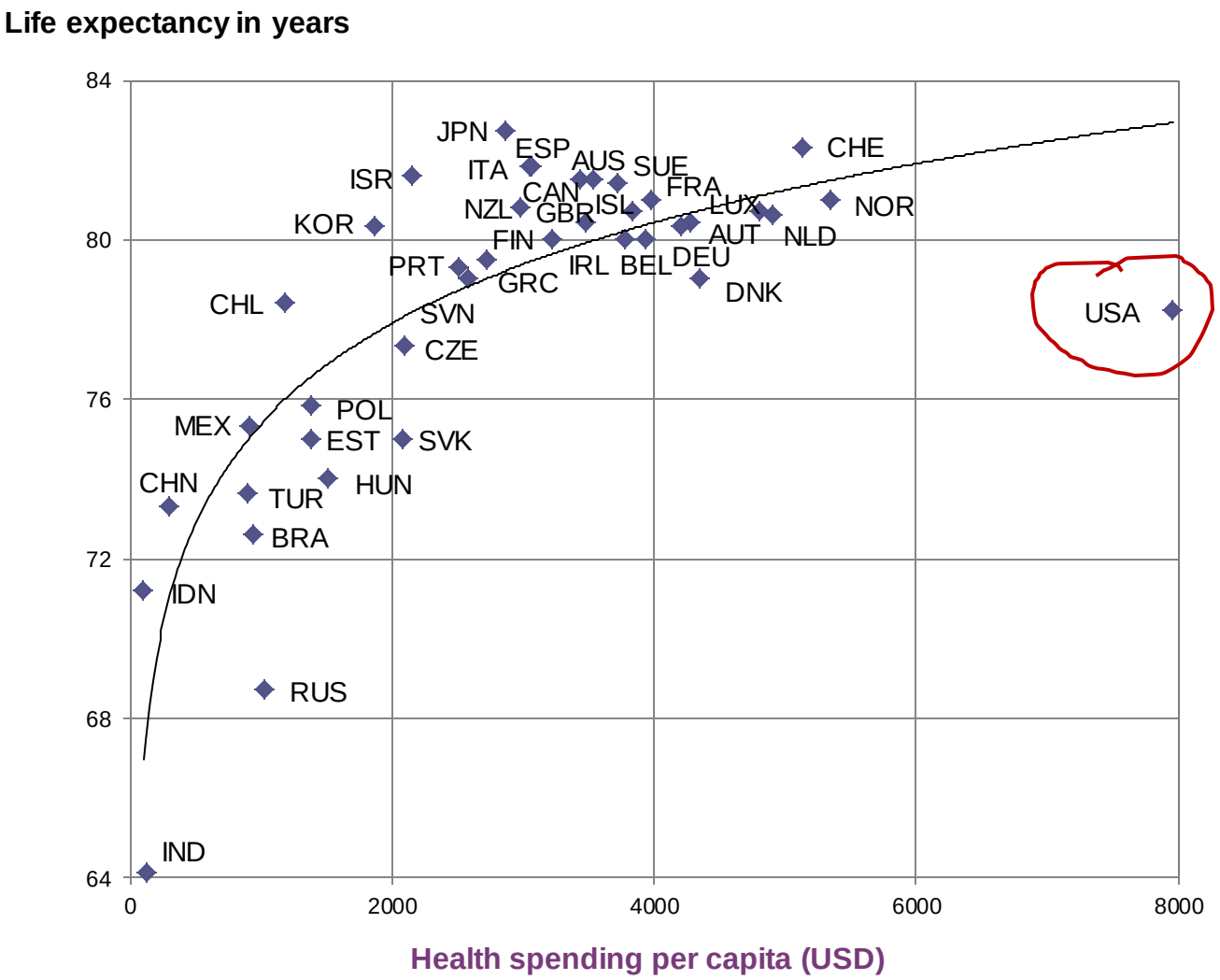
- King County ranks high



But low health and well-being for some

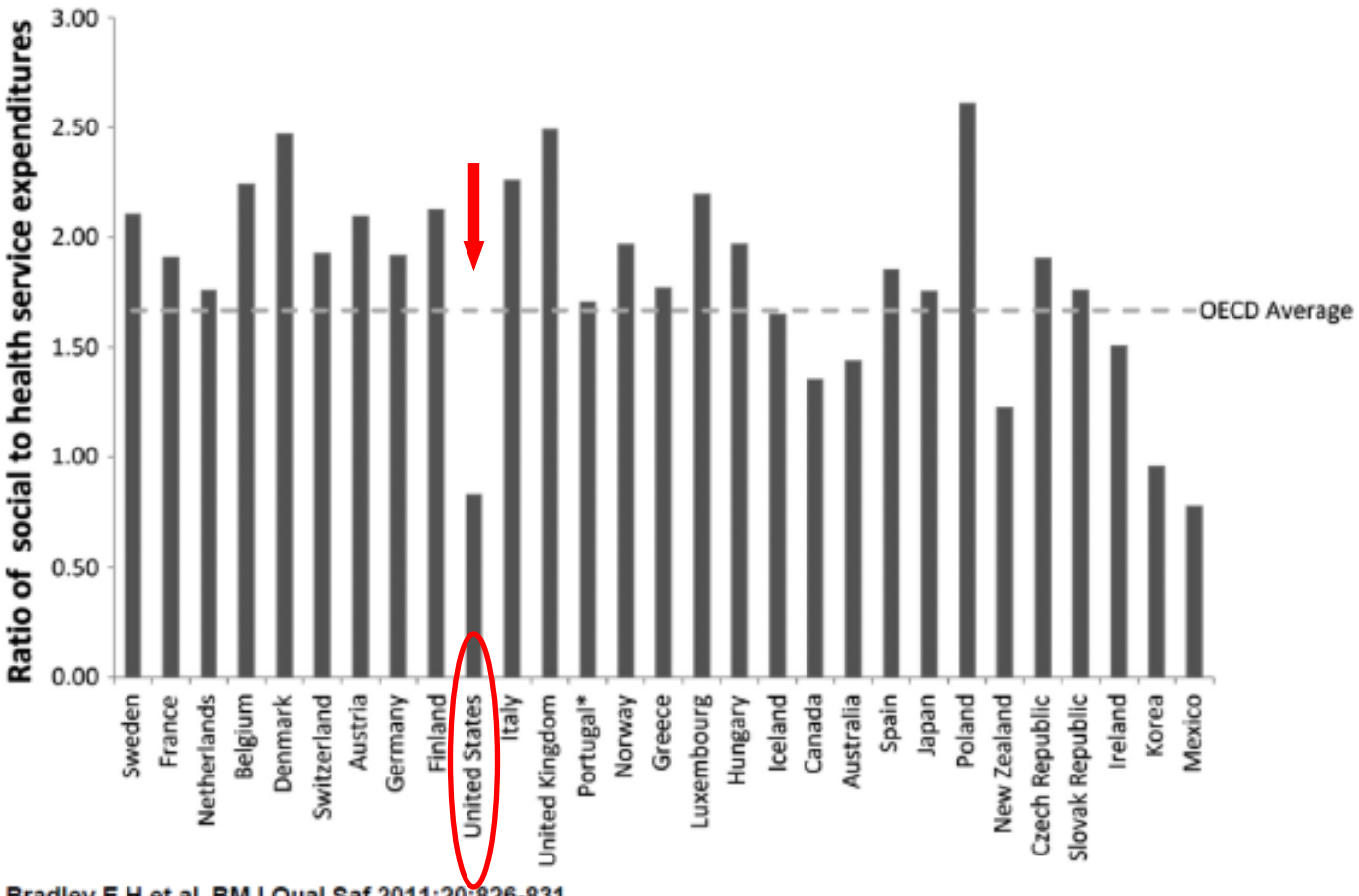


US spends the most



Low spending on social services relative to health services

Ratio of social to health service expenditures for OECD countries, 2005.



Bradley E H et al. BMJ Qual Saf 2011;20:826-831

So what
do we do?

Health & Human Services Evolution

Yesterday v. 1.0

- Sick care & crisis focus: little $ for prevention
- Uncoordinated services not well integrated
- Minimal reporting of quality and outcomes
- Pay for volume, not value

Today v. 2.0

- Beginning to shift $ upstream – more focus on prevention
- High impact strategies
- Still minimal integration
- Initial reporting of quality & outcomes

Tomorrow v. 3.0

- Healthy population centered; further shift of $ upstream
- Health & well-being of the individual tied to health of community
- Greater focus on social determinants of health
- Seamless integration of all services & supports
- Robust reporting of quality and outcomes
- Pay for value, not volume

Feedback from earlier work on vision, goals, & principles

- Goal should be more dynamic and “speak to people”
- Draw out focus on reducing disparities and need for cultural competence
- Look to language in King County Strategic Plan
- Too health care focused—broaden the language
- Needs to convey importance of strengths based approaches
- Add principle about being more adaptable

Vision & Goal

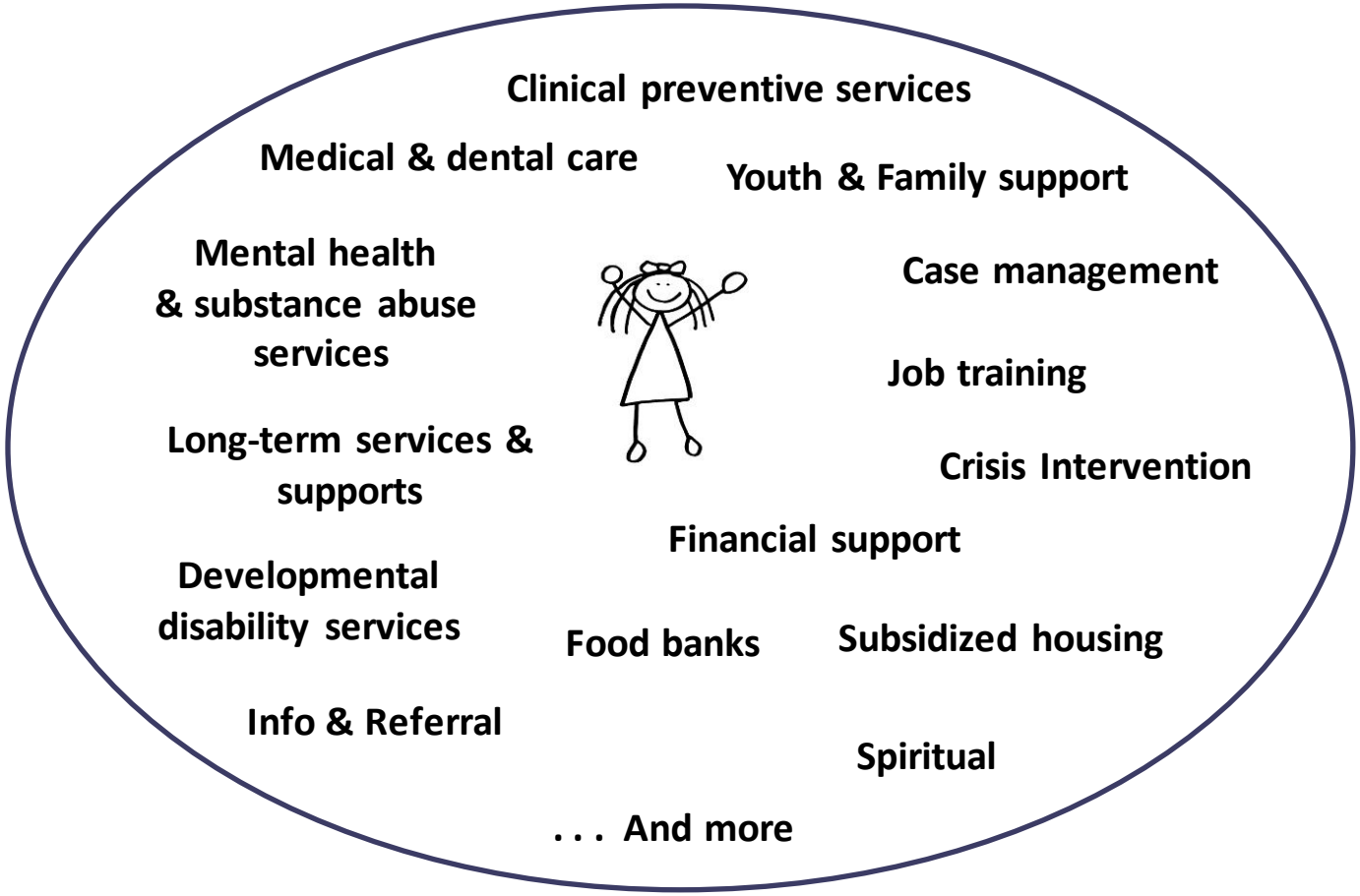
- **Vision:** All people in King County have the opportunity to thrive and reach their full potential

- **Goal:** By 2020, the people of King County will experience significant gains in health and well-being because our community worked collectively to make the shift from a costly, crisis-oriented response to health and social problems, to one that focuses on prevention, embraces recovery, and eliminates disparities

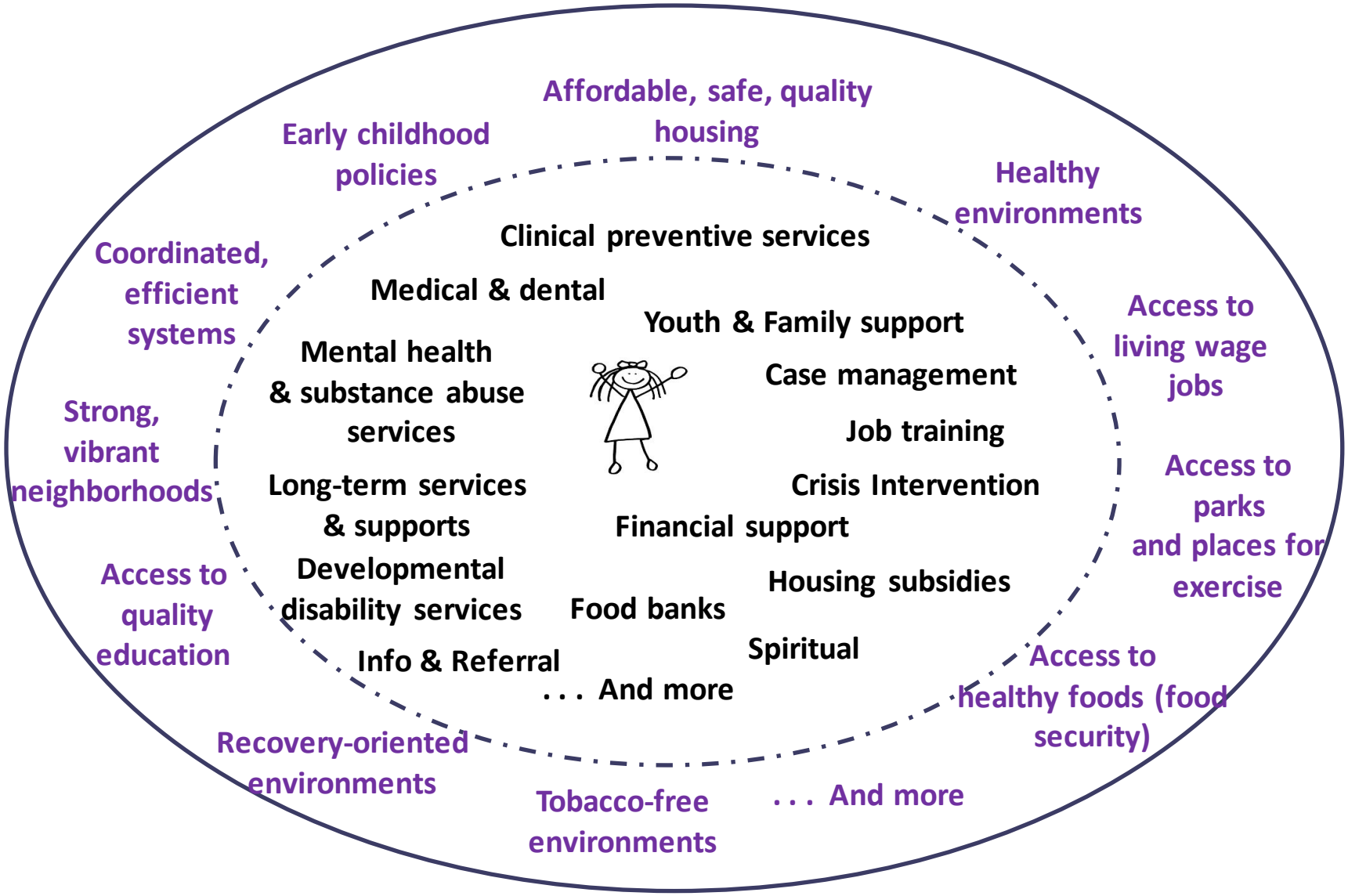
Principles (Nutshell version)

1. Be clear about outcomes
2. Individuals and families at the center
3. Be equitable; eliminate racial & ethnic disparities
4. Build on strengths to foster self-determination
5. Assure capacity, quality, & cultural competence
6. Be efficient
7. Prevent health and social challenges in the first place
8. Be adaptable
9. Achieve financial sustainability for the system
10. Build bridges across health and human services, public health, and community development

Broad Vision
Individuals & Families at the Center…



. . . in the context of their community



System Improvement Through Two Levels of Work

Individual-Level Interventions	• "Whole person" approach (person-centered/patient-centered) • Focus is on access to range of integrated health, human services, & preventive services • High-impact integration strategies such as: - Medical & behavioral health integration - Multidisciplinary case management/teams for those with complex needs • Cultivation of transformed workforce, IT infrastructure

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Community-Level Interventions	• "Community-centered" approach • Focus is on improving community features (where people live, work, and play) that influence health and well-being • High-impact strategies such as - Place-based initiatives - Policy & system change

Integration & Cross-Sector Work: A Local Strong Suit (Examples)

Individual-Level Interventions	• Behavioral health/primary care integration initiatives • Veteran's services integration • Domestic violence/sexual assault/behavioral health integration • Supportive housing units with on-site clinical, employment, & recovery supports • Youth-related – e.g., wraparound; homeless youth initiative; school-based health & human services

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Community-Level Interventions	• Making Connections White Center/Seattle • Yesler Terrace - Choice Neighborhoods • High Point • Global to Local • Community Transformation Grant/Communities Putting Prevention to Work

Accountability Mechanisms

	Accountability Through Contracts	Accountability Through Compacts (Collective Impact)
Individual/Client Level Interventions	Funder contracts with a housing program (such as # of clients who retain in housing for 12 months)	Group of funders agrees to coordinate RFPs to create 20 supportive housing units, to help end chronic homelessness
Community Level Interventions	Funder contracts with an entity for the successful implementation of a safe routes to schools program.	A group of partners form a coalition to reduce obesity in a neighborhood. Each partner takes different types of actions (funding, policy, etc).

Key Design Feature

Fewer silos among "individual" delivery level and "community" level work.

Instead: a single, supportive structure to integrate across domains for planning, measurement, financing strategies, accountability.

Reactions?

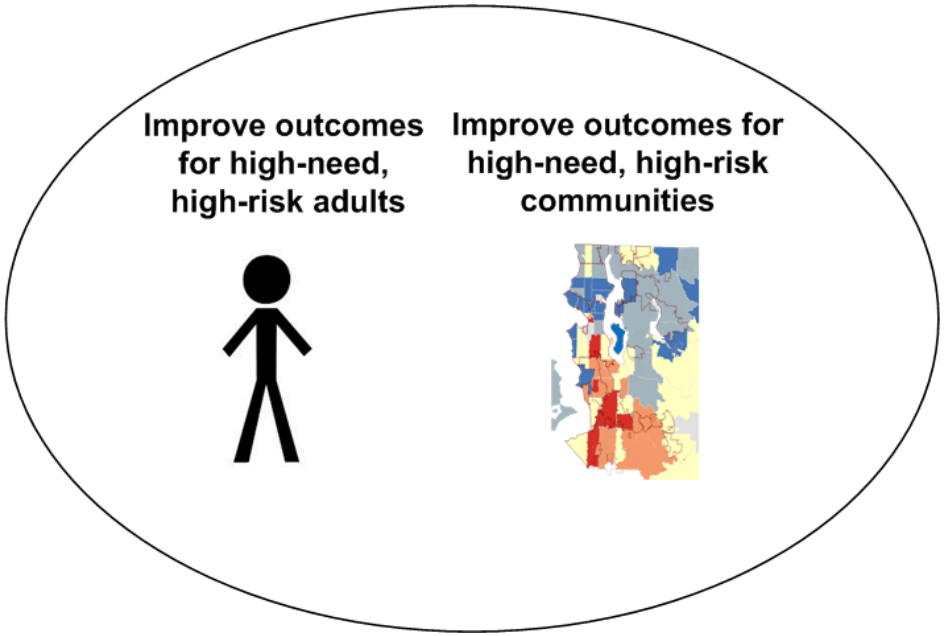
So where do we start?

Getting Outcomes in our Line of Sight

- Remind ourselves the Motion is about ***system*** transformation: improving the performance, integration, & accountability of the health, human service and community prevention systems for everyone
- Remind ourselves of key principles - outcome focused, reduced disparities
- Given the design elements, what's a way forward (not "pilots")?

A Way to Improve *Overall* HHS System Performance & Accountability

Improve system performance for *all* by focusing *first* on those people & places who most need that system to perform well.



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Leads to improved outcomes for those with the worst outcomes now – and a reduction in disparities

And tells us how well the system overall is doing (sentinel marker – a sort of watchperson)

Individual-level Initial Focus

1. Improve outcomes for high need, high risk adults

- Fast-moving system changes - opportunities to coordinate in new ways for even more value & better client service
- Some shared goals, investors, initiatives, & demonstrations already in play
- Near-term opportunities to coordinate with State Medicaid
- Risk of working at cross-purposes if we don't do anything
- Can't achieve outcomes unless multiple sectors get aligned

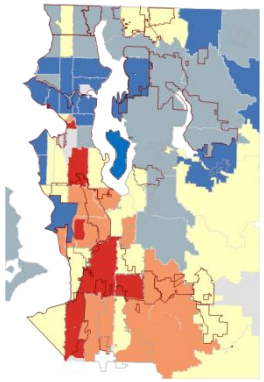
Individual-level Initial Focus

Why now?

- *State*: Medicaid Expansion, Dual Eligibles demo, Health Homes, managed care changes, HB 1519 (Accountability Measures), State transformation design work, mental health parity
- *Hospitals*: Working on ED high utilizers & reducing readmissions
- *Housing*: Permanent supportive housing interests
- *Homeless response*: chronic homeless initiatives, HEARTH Act changes (HUD McKinney assistance)
- *CJ System*: goals for reducing recidivism
- *County*: Public Health & DCHS policy goals & programs related to this group

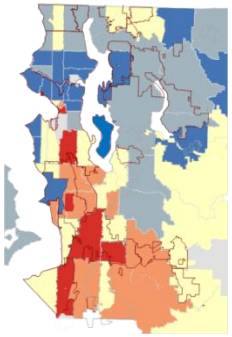
Community-level Initial Focus

2. Improve outcomes for high need, high risk communities



- We have place-based initiatives to build upon (how do we make less *ad hoc*?)
- Approach for tackling racial/ethnic and geographic inequities – and measuring change
- Strategies *must* come from the community, be locally owned
- Outcomes depend on multiple sectors getting aligned

Community-level Initial Focus



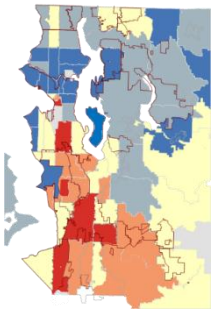
Why Now? Because . . .

- New recognition that among large metro areas, King County has some of the worst disparities
- Can build upon initial recent successes and current efforts
- Potential to leverage emerging opportunities (e.g., ACA hospital community benefit requirements; federal Medicaid/Medicare innovation grants?)
- This work improves the overall system performance for everyone – by figuring out strategies to prevent and tackle problems earlier

Sample Outcomes That Would Tell Us If the System is Working Better

For this group of high risk people, achieve:

- Improved housing stability
- Improved health status
- Reduced CJ involvement
- Reduced avoidable hospital ED use
- Improved client satisfaction with quality of life
- Reduced population-level health disparities



For these communities, achieve:

- Improved housing
- Increased employment
- Reduced ACES scores (adverse childhood experiences)
- Increased life expectancy

Reactions?

Funding and financing strategies

1. Make best use of existing resources by defining outcomes and aligning resources to support the identified outcomes
   - Broad view of existing resources
   - *Over time*, shift from spending mostly on crisis & sick care to mostly on human services & prevention
   - By aligning with others around shared outcomes, get more value and open new doors to resources

Funding and financing strategies

2. Leverage the opportunities provided under the Affordable Care Act

- Health coverage expansion, including Medicaid
- State Medicaid program - efforts to integrate care
- Centers for Medicare & Medicaid Services Innovation Center opportunities
- Occasional grant opportunities for behavioral health integration, community health center expansion, prevention, workforce, and more.

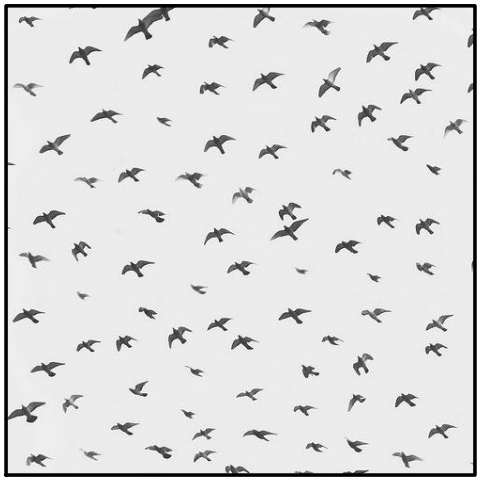
Funding and financing strategies

3. Set the Stage for New Resources
   - Assure adequate capacity in context of shifting to an outcome-driven system
   - Anticipated that new revenue sources and tools will be needed to achieve the goal of this Plan
   - Seeing and working on issues through a common lens can clarify gaps, solidify business case, and catalyze new investors

Reactions?

Next Steps

Today



Next Steps
Get organized

Leading to . . .
Purposeful motion

More information: http://www.kingcounty.gov/exec/HHStransformation.aspx

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