Health Reform Planning Team

April 22, 2013
2:00 to 4:00 p.m.
401 5th Ave, Seattle – Room 121/123

Attendees: Heidi Albritton, Carlos Andarsio, Rob Beem, Dave Budd, Molly Carney, Bolivar Choi, Lorri Cox, Bob Crittenden, Steve Daschle, Jerry DeGrieck, Jennifer DeYoung, Patricia Edmond-Quinn, Jesse Eller, Sharon Farmer, Anne Farrell-Sheffer, Charissa Fotinos, Gregory Francis, René Franzen, John Gilvar, Alicia Glenwell, Sherryl Grey, Karen Hambro, Yoon Joo Han, Patty Hayes, David Johnson, Pat Knox, Betsy Kruse, Cara Lauer, Natalie Lente, Maureen Linehan, Linda Madsen, Anna Markee, Vince Matulionis, Susan McLaughlin, Suzanne Pak, Colin Romero, Sarah Sausner, Kathleen Southwick, Ben Spanalonis, Karen Spoelman, Jerry Scott, Janet St. Clair, David Stone, Paul Tegenfeldt, Carrie Vanzant, Shawn West, Melet Whinston, Bill Wilson, Janna Wilson, Carol Wood, Kirsten Wysen

Joined Remotely: Frederick Chen, Jess Chow, Stacy Heinle, Verni Jogaratnam, Dani Schaeffner, Laura Treadway

----- Notes -----		
Welcome & Introductions	Jen DeYoung and Susan McLaughlin	2:00
Updates	All	2:05

Jennifer DeYoung noted that Medicaid Expansion is included in the proposed budgets of the WA State Senate and House, as well as the Governor's budget priorities, and although the amount of projected savings differs between them, this is a good indicator that Medicaid Expansion is going forward on schedule. David Johnson shared that there is some concern amongst behavioral health providers about what the Expansion will replace; Medicaid will not fund certain services, and if other funding streams are dismantled, there could be a negative impact to behavioral health infrastructure in King County.

Patty Hayes discussed King County's outreach and enrollment efforts. King County's application for the In-Person Assister grant will be submitted to the Exchange today (April 22), with results expected mid-May. Contracts are to be ready by July 1. Fifty-one agencies responded to King County's RFQ-Health Care Coverage Expansion through the Health Benefit Exchange; based on scoring, as many as possible were included, with the door left open for expansion if more funds became available.

Susan McLaughlin noted that the state-specific Medicaid Request for Application (RFA) for the Duals Financial Alignment Demonstration Project was released on April 10. This RFA is in conjunction with the CMS Medicare plan application that was released in January 2013. The State hosted a bidder's conference April 19, and proposals are due to the State May 15. Susan encouraged folks to take a look at the RFA, as it is indicative of how the State wants to run the project. The State will limit the number of plans operating in each county (min. of 2, max. 6). King County has not made a final decision about whether it will participate in the Duals Demonstration Project, but it has a strong interest in doing so, and is continuing conversations with WA State and the City of Seattle about possible participation. The Metropolitan King County Council will

need to approve the final 3-way contract between the state, CMS and the successful health plan(s) before King County can participate in the demonstration project. It is anticipated that this will happen sometime in Fall 2013.

***Integration of Services*:** 2:20

- **Primary Care/Behavior Health Integration Models**

Susan McLaughlin introduced the following two primary care/behavioral health integration projects that are underway in King County and noted that they can help us think about how to support these efforts and bring them to scale in our community.

- **Wellness for Asian Pacific American (WAPA) Project**
  Asian Counseling and Referral Service (ACRS) and
  International Community Health Services (ICHS)

Yoon Joo Han, Behavioral Health Director at ACRS and Sherryl Grey, project manager at ICHS, presented information about the Wellness for Asian Pacific American (WAPA) Project. WAPA goals are 1) To increase access to primary health care services by providing primary care service at ACRS outpatient mental health setting, and 2) To promote healthy living through an array of culturally competent wellness-education and support services. See slides attached.

Health disparities among the APA community call for culturally-relevant care and outreach/access to health screenings. Although many behavioral health clients present with medical risk factors, there are barriers to medical treatment, including lack of language proficiency, stress and lack of knowledge about navigating the system. This project recognizes the need to do something differently to facilitate primary care use. With the assistance of a Substance Abuse & Mental Health Services Administration (SAMHSA) grant, ACRS remodeled 2 counseling rooms to medical consult rooms. Many medical services (e.g. blood draws) are offered onsite, with linkages to specialty care available for services which are not offered on-site. The demand for dental services exceeds the current provision of dental services by the Dental Mobile Vans from Medical Teams International.

In addition to provision of medical services, the Wellness Program promotes culturally relevant wellness activities including exercise, cooking, nutrition, gardening, etc. These are well-attended and enjoyed by clients.

Behavioral health and medical staff coordinate care for clients and have a shared understanding of health problems. Case managers have to be knowledgeable about medical issues and serve the role as semi-health educators. Medical visits are scheduled every hour (vs. 15 minute industry standard intervals) to allow adequate time for consultation (sometimes with interpretation).

Suzanne Pak expressed surprise that health indicators for the APA population are worse than the white population (see slide #18) and asked how the public can be made more aware of these disparities. ACRS staff noted that it takes ongoing 2-way communication at the individual and community levels.

- **Behavioral and Primary Healthcare Integration**
  Navos Mental Health Solutions (Navos) and
  Public Health-Seattle & King County (Public Health)

Paul Tegenfeldt, Vice President of Integrated Care at Navos provided an overview of the behavioral and primary healthcare integration work funded by a recent SAMHSA grant. See slides attached.

Paul pointed out that the pace of behavioral health and primary care are very different, including

the staff work area in the design was key for increased collaboration. The shaded area of the map shown on slide #7 is primary care – it was noted that the visibility of primary care in this facility has raised awareness of these services among the behavioral health clients. It is expected that this facility will grow to have 500 users by end of year.

Colin Romero, MD, Assistant Medical Director, Public Health-Seattle & King County discussed integration lessons learned in the last year including: what is done in a primary care setting really accounts for only a small portion of a person's overall health – by focusing on collaboration, it feels like you can make a big difference in people's lives; finding the right staff is key – be deliberate about hiring flexible, non-judgmental people who can work well with clients; allow time to understand each other – traditionally mental health and primary care see things differently and have historically treated patients without awareness of treatment by the other; and leadership that supports the partnership is critical.

Carlos Andarsio, MD, Chief Medical Officer at Navos talked about the Collaborative Care Model Pilot which is supported by a visionary board, assembly of chiefs, and belief by all in how important patient voice is. It was noted that a Treat to Target (evidence-based interventions that drive positive outcomes) approach is being used with indicators that are tangible to medical providers and other indicators for mental health measurements (see slide #14). The 12 month pilot will launch in July 2013 and is aiming for a 10-20 person sample size.

Navos just launched their electronic health record (EHR), and Public Health is leading the work on Patient Registry. The Team Care approach is to look at Patient Registry and agree on a treatment plan for each client. Behavioral health and primary care providers have shared access to client information (but some electronic system barriers exist).

A question was raised as to how this work in linking with housing? Navos staff remarked that this is still being discussed, and that they are seeking a tool to delineate levels of housing.

Desired outcomes of this pilot include capturing a snapshot of integration work, and to show that we are affecting things in a positive sense; as well as developing systems for a single care team.

***Integration of Services*:** Janna Wilson and Susan McLaughlin

- **Health and Human Services Transformation work: Realizing Community Impact in King County**

Due to time restrictions, this update was deferred to next meeting.

Invited Guest Governor's Office: Bob Crittenden, MD, Senior Health Policy Advisor to Governor Inslee — 3:30

- **The Governor's Health Policy Priorities**

Dr. Crittenden noted the work of his office is about health in a broader sense (not just limited to health care). He offered an overview of the Governor's health policy priorities, which include:

- Facilitating the implementation of the Affordable Care Act (ACA), including: Medicaid expansion; getting the Health Benefits Exchange up (in 2 languages on web, written materials to be available in 8 languages, more language assistance to be available on phone); and working on a Federal Basic Health option which will give a better subsidized product for individuals 133-200% FPL (option to make this available won't be until next

year).

- Addressing delivery system issues, including: the State Innovations Model Grant planning process led by Karen Merrikin, which will be about integrating mental health into health (acknowledging that leverage is limited – purchasing power and participation by all is key), among other things; and the Dual Eligibles Demonstration Project consisting of 2 models (managed care and case management).
- Prevention (community-based) and wellness (associated with employers); looking at how to integrate into the health system and how do we get the public to be more aware of it?
- End of life care – work will focus on what patients want out of health care system (more to be developed on this item).
- The major health item before the legislature this year is Medicaid Expansion. The Governor's office is thinking creatively to place at least one public health issue to place on its legislative agenda; perhaps something around Community Transformation Grants (CTG) or rural issues.

Dr. Crittenden invited questions from meeting attendees.

David Johnson expressed concern that some "magical thinking" has happened around what Medicaid Expansion will cover, and that behavioral health coverage may suffer as a result. The State may have to use non-Medicaid dollars to pay for things the federal government won't reimburse for, such as: crisis and commitment services, etc.

Another concern was voiced about how coming changes to the chemical dependency inpatient treatment system (reduced beds in facilities, etc.) will affect federal match dollars.

Jesse Eller expressed interest in further conversations about integrating the AAA and others into this process.

It was pointed out that King and Pierce counties were part of a compelling study which showed that behavioral health care significantly reduced medical costs. Dr. Crittenden noted that while there are lots of services in King and Pierce county, the State needs to think about what can be done in other parts of the State. David Johnson pointed out that billing for tele-health (as is allowed for other parts of healthcare) could be part of the solution.

Janet St. Clair inquired about efforts around money following the patient and not the practice. Dr. Crittenden noted that progress is slow and limited by a fee for service environment. The managed care reimbursement pilot took a long time (1.5 yrs) to get agreement on in only 7 practices.

Wrap Up and Next Steps	Jen DeYoung and Susan McLaughlin	4:00
Jennifer DeYoung thanked attendees for their participation and noted that due to holiday schedule, next month's meeting will be held the 3rd Monday of the month, May 20.		
Meeting Adjourned		4:00

Next Meeting: May 20, 2013; 2:00-4:00pm; Rooms 121/123.

ASIAN COUNSELING and REFERRAL SERVICE

Hope and Opportunity in 30 Languages

3639 Martin Luther King Jr. Way S
Seattle, WA 98144

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ACRS Behavioral Health Program

A Partner
In a thousand of journeys
of Recovery, Healing and
Transformation of
people with a mental health challenge
to live a meaningful life
in a community
While striving to achieve
his or her full potential.

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ACRS Behavioral Health Clients

- 1,700 served annually
- 85% speaks a language other than English. 17 different languages and dialects (Mandarin, Cantonese, Taiwanese, Cambodian, Korean, Japanese, Tagalog, Ilocano, Lao, Mien, Hmong, Vietnamese, Samoan, Burmese, Chin, Bhutanese, Nepali)
- 91% were not born in the US.
- 95.2% "low-income" and "very low income."
- 25% have no health coverage

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ACRS Behavioral Health Clients

- Client Diagnosis:
  - Depression: 45%
  - PTSD and adjustment disorder: 17%
  - Schizophrenia or other psychotic disorder: 16%
  - Bipolar: 8%
  - Anxiety or phobia: 4%
  - Organic disorders including dementia: 3%

- Over 500 with a psychotic disorder, psychotic features in Depression, PTSD or other disorder, on psychotropic meditation and at higher risk for metabolic syndromes

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APA Health Disparity - Medical

- Lower use of most health care services
- Poorer patient-provider relationship with the PCP
- Hepatitis B: APAs account for over half of all chronic hepatitis B. One in ten infected with the hepatitis B virus (HBV)
- Diabetes: 20% Native Hawaiians; 47% America Samoans
- Cancer: 2X Cases, 2X Death rate due to cancer
- Vietnamese women: 5X more likely to be diagnosed with cervical cancer

APA Health Disparity - Medical

- Cardiovascular disease is the second leading cause of death
- Breast cancer is the second-leading cause of cancer death among APA women
- Lowest rates of mammography and clinical breast exam (CBE) screenings
- Higher prevalence of chronic liver disease and liver cancer
- Worst oral health indicators of any racial/ethnic group

ACRS Behavioral Health Clients
Health Condition

- 56% at risk for Blood Pressure
- 70% at risk for Diabetes
- 67% at risk for Cholesterol

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People *with* serious mental illness (SMI) die on average at the age of 53 years old

WAPA

WELLNESS FOR ASIAN PACIFIC AMERICAN PROJECT

A PROJECT BROUGHT TO YOU IN PARTNERSHIP BY

ASIAN COUNSELING and REFERRAL SERVICE

ICHS International Community HEALTH SERVICES

FUNDED BY

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
www.samhsa.gov

ICHS International Community HEALTH SERVICES

- VISION – Healthy people, stronger families, vibrant communities

- MISSION – ICHS provides culturally and linguistically appropriate health services to improve the health of Asian Pacific Islanders and the broader community.

- CORE VALUES : TEAM MEDIC

  Making a difference
  Excellence
  Diversity
  Integrity
  Customer Service

ACRS ASIAN COUNSELING and REFERRAL SERVICE

WAPA

A person-centered, collaborative, culturally competent, community-based care system of primary health services, wellness education and activities for underserved, at-risk, limited English proficient (LEP) Asian Pacific American immigrants and refugees with a Serious Mental Illness.

In partnership with International Community Health Services, a primary care provider and Federally Qualified Health Center (FQHC)

WAPA Goals

1: To increase access to primary health care services by providing primary care service at ACRS outpatient mental health setting.

2: To promote healthy living through an array of culturally competent wellness-education and support services.

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Paradigm Shift

- Transformation from Mental Health Service model to Wellness Service. Mind and body working together.
- Day activities program is Wellness Program
- Exercise, movement, dance are a part of all group activities
- Primary care needs are followed from intake to exit
- Integration and coordination among PC staff and psychiatric staff

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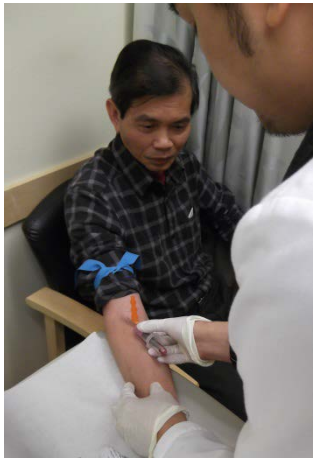
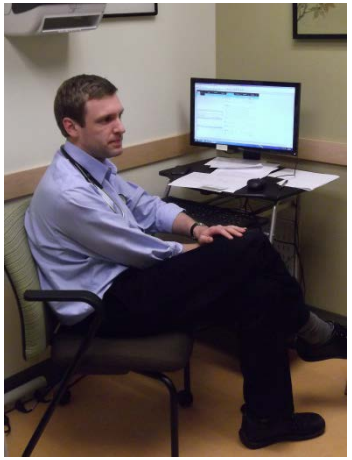
Primary Care Services

Onsite PCP services provided by external ICHS team include Preventive care, Health screening, treatment, EKG, blood draws, specialty care referrals





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Culturally Relevant Wellness Activities

- Health and wellness education and support activities including nutrition, diet, exercise program. Blending of Eastern approaches: Acupuncture, Tai Chi, Yoga, Meditation

- 15 different Wellness groups with more than 300 clients participating: Tai Chi, Yoga groups, Asian Zumba, Ethnic Wellness groups (Mien, Lao, Samoan, Cambodian, Vietnamese), Cambodian Elders group, two gardening groups, walking, Healthy Cooking, ping pong, traditional dance, and Karaoke group.

- Incentive system to encourage participation.
- Fun and culturally relevant activities.

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Other Components

- Dental Service through Dental Mobile Van from Medical Teams International
- Diabetes focused Wellness Groups
- Focus on smoking cessation and Tobacco free campus.
- Acupuncture

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Behavioral Health Care Managers

- Integrated care between bilingual Behavioral Health Care Manager, Psychiatric staff and PCP

- Care manager acts as interpreter, cultural broker, consultant, health educator, provides intensive follow-up, promotes coordination among involved parties, and leads the development of a integrated person-centered wellness plan.

Baseline Comparison of health risk

	ACRS clients At risk	Whites At risk
BMI	58%	78%
Cholesterol	62%	46%
Blood Pressure	56%	42%
Diabetes	70%	55%
Cholesterol	63%	46%

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Initial Health Outcomes

From Baseline to reassessment

	At risk at Baseline	At risk at Reassessment	Outcome Improved
Blood Pressure	56%	52%	23%
BMI	57%	54%	49%
Waist circumference	55%	57%	43%
Diabetes	70%	69%	42%
Cholesterol	63%	59%	31%

Based on 250 clients with health indicator information at intake and at 6-month follow up.

ACRS ASIAN COUNSELING and REFERRAL SERVICE

Ingredients for Success

- Transformation! It is now Wellness program, not just Mental Health program!!
- Partnership with ICHS with shared vision
- Care Manager and Health Home model
- Health Education to Mental Health Case Managers
- Cultural Competency
- Building Community

Behavioral and Primary Healthcare Integration

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Overview

- 4 year SAMHSA PBHCI demonstration grant
- Navos is 1of 94 grantees across the country and 1 of 3 here in Washington State
- Our goal is to develop a model that produces positive outcomes and is financially sustainable
- Partnership model with Public Health—Seattle & King County as our primary care partner
- Developing a health home for the SMI population served at Navos
  - One stop shopping
  - Integrated Team
  - Collaborative Care Model
- Resources
  - AIMS Center
  - Dale Jarvis

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Mental Health and Wellness Center

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Shared Reception

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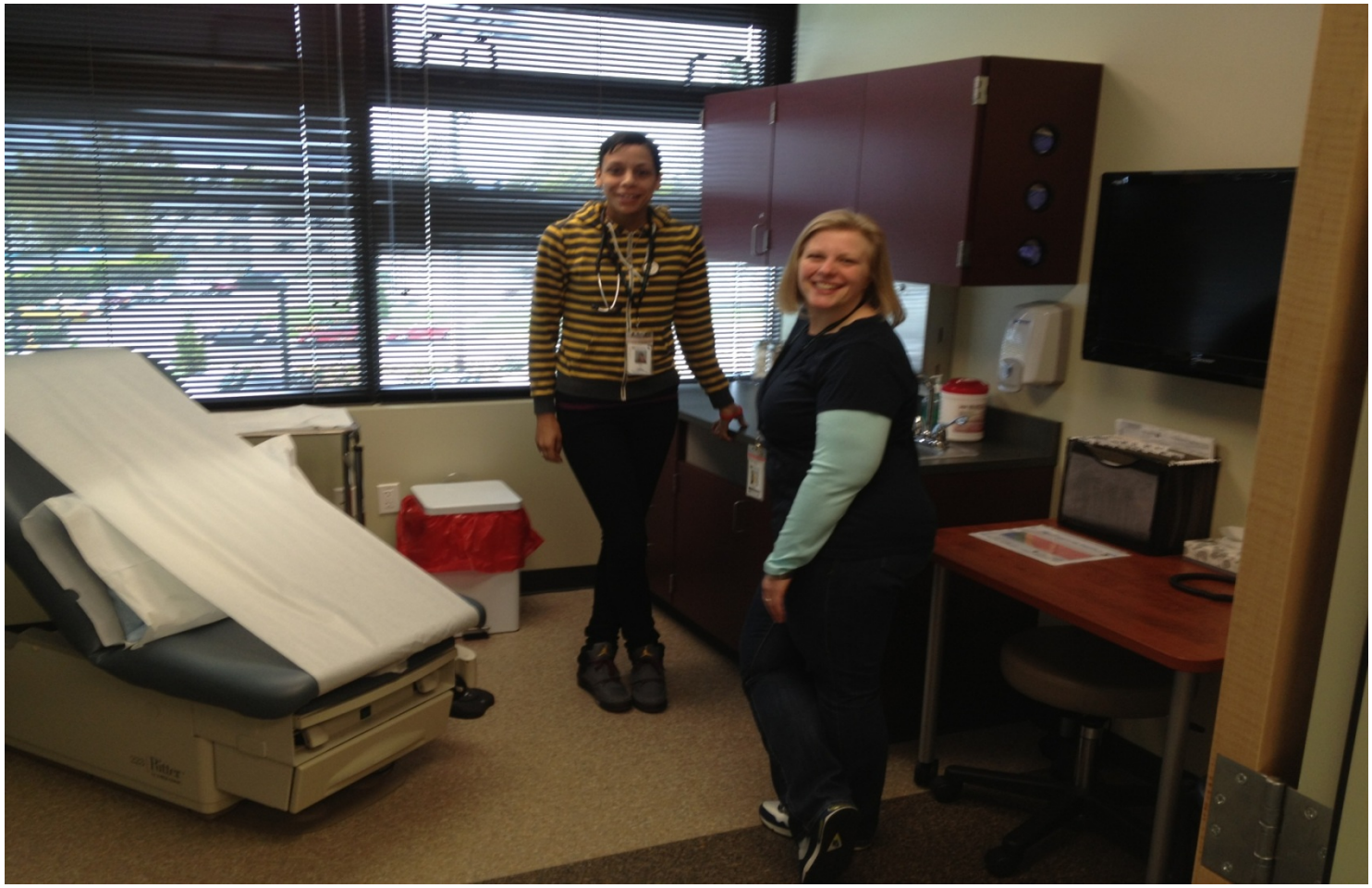
Exam Room



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Staff Work Area

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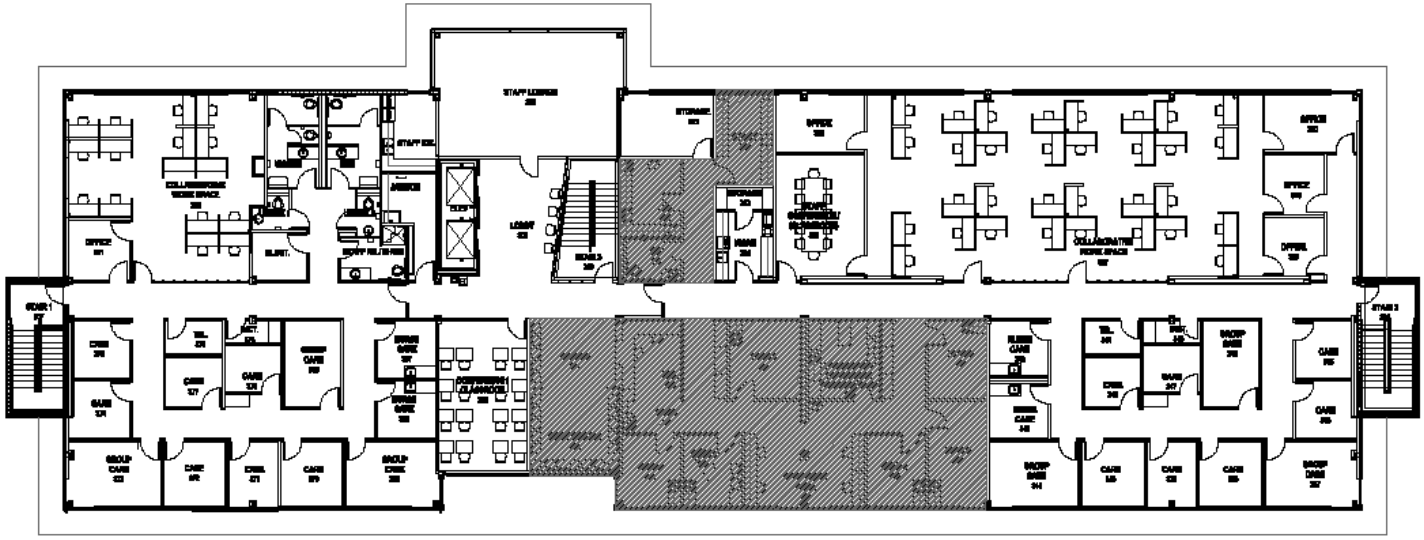
Floor Plan



THIRD FLOOR PLAN
5.1.2012

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1st Year

- Establish the partnership
- Launch clinic operations
- Develop relationships between primary care and behavioral health staff
- Develop opportunities for collaboration

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Clients

- Unduplicated users 359
- Referral source
  - HEART (Adult Outpatient) 65%
  - PACT 18%
  - ECS 10%
  - COD 3%
  - DV 2%
  - Other 2%

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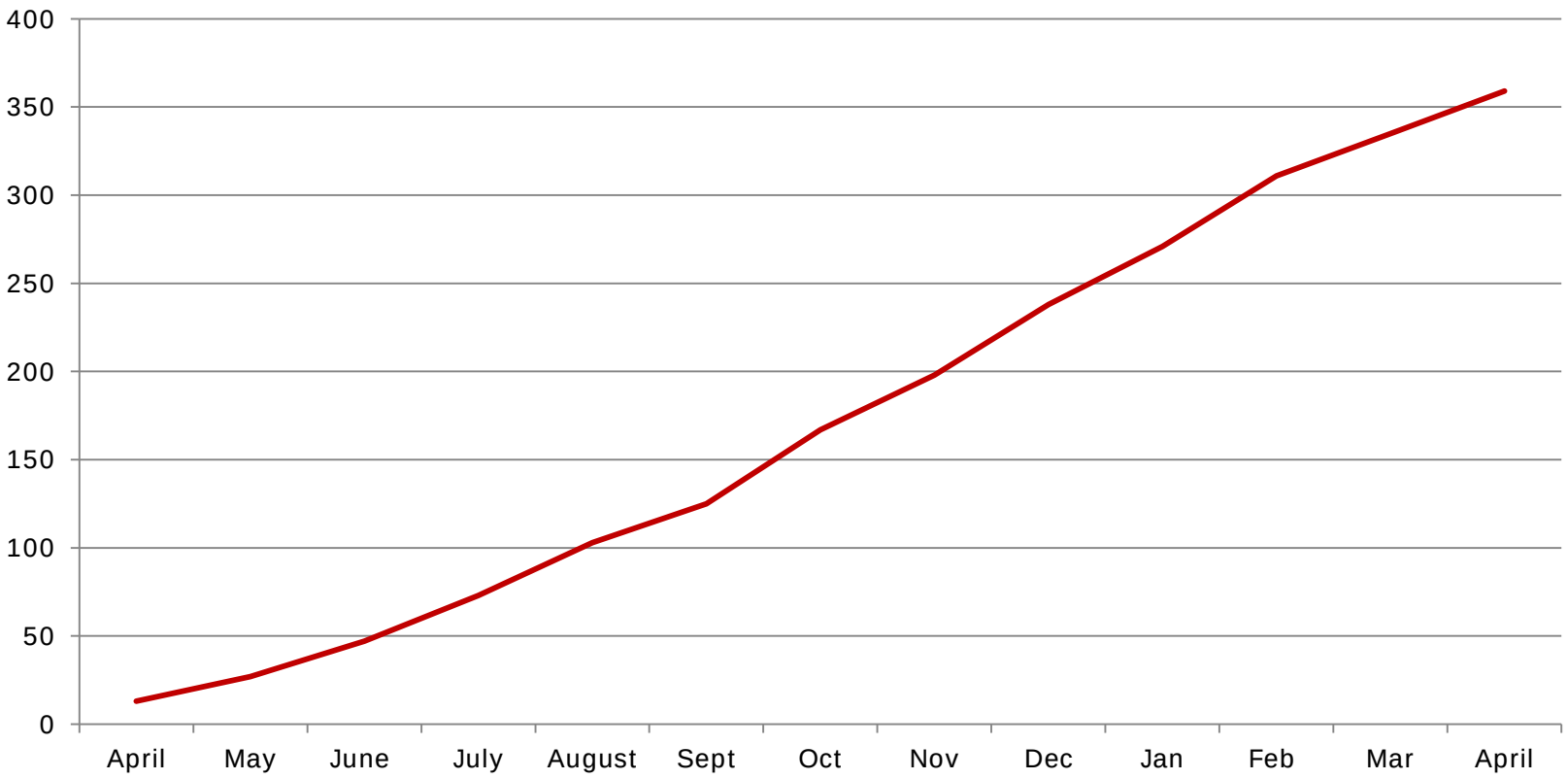
Unduplicated Users

April, 2012—April, 2013



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Baseline Outcomes

- Fasting Plasma Glucose
  - < 100 55%
  - > 100 45%
- Blood Pressure
  - Normal 28%
  - Pre-hypertensive 49%
  - Hypertensive 23%
- BMI
  - < 25 18%
  - 25-29.99 26%
  - ≥ 30 56%
- LDL
  - < 100 44%
  - 100-129 31%
  - > 130 25%
- Tobacco users 64%
- Stable housing 49%

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2nd Year

- Develop robust Wellness Program that is data driven and evaluated and supports clients in adopting healthy behaviors and managing their chronic illnesses (quit smoking, exercise and nutrition)
- Develop and implement a Collaborative Care Model and culture that produces positive outcomes

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Collaborative Care Pilot

- Team Care structure and process using Care Managers and involving both behavioral health and primary care
- Treat to Target using patient registry
- Trauma Informed Care

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Outcome Measures

- Hypertension (Systolic)
- Diabetes (HbA1c)
- Hyperlipidemia (LDL)
- Depression (PHQ9)
- Trauma (PC-PTSD)
- Tobacco use (CO level)
- Patient voice
- Housing

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Process

- Patient Registry
- Development of Team Care structure and approach
- Development of administrative and medical flow
- Staff engagement and 'buy in'
- 12 month pilot with a July, 2013 launch

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Goals

- Establish 'where we are' with the addition of the collaborative care model
- Establish a culture that embraces the 'Treat to Target' philosophy
- Sustain Trauma Informed Care in all the work we do
- Continue our efforts to strengthen, support, foster and sustain a strong relationship with our primary care partner
- Positive outcomes for those we serve…**'Clients get better!'**

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BE BETTER THAN OUR BEST!

Questions?

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