



## King County

### Department of Community and Human Services

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## IMPLEMENTATION PLAN

### 2012 – 2017 Veterans and Human Services Levy:

#### Activity 3.1 B: Behavioral Health Integration For Veterans

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#### 1. Goal

The primary goal of this activity is to increase self-sufficiency of veterans and vulnerable populations.

#### 2. Strategy

The Veterans and Human Services Levy Service Improvement Plan (SIP) set a goal of Improving Health.

#### 3. Activity 3.1: Behavioral Health Integration

Activity 3.1B, Behavioral Health Integration for Veterans is one of two activities described in the Service Improvement Plan under this activity.

#### 4. Service Needs, Populations to be Served, and Promotion of Equity and Social Justice

##### *a) Service Needs*

##### **Veterans, Military Personnel, and Their Families**

King County is home to at least 127,000 veterans, military reservists and members of National Guard Units, including those who served in World War II, the Korean and Viet Nam Wars, the Gulf War, and recent and current conflicts in the Middle East.<sup>1</sup> Levy funds are intended to assist those in need who have served at any time in the U.S. military, so as to support veterans and their families to re-integrate into civilian life.

It is estimated that as many as 30 percent of homeless persons in King County are veterans.<sup>2</sup> The majority of disabled and low-income veterans in King County live in South King County and Seattle.<sup>3</sup> There is general agreement among organizations now working with veterans

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<sup>1</sup> Appendix A of the Service Improvement Plan provides a lengthy explanation of how veterans' discharge status is to be defined for the purpose of qualifying individuals for Levy support services.

<sup>2</sup> 2004 One Night County of Homeless People

<sup>3</sup> Veterans Administration benefits distribution and Puget Sound Health Care System, 2011

that those returning from more recent Middle East deployments tend to have lower incomes and less education than veterans of previous deployments.

Using government data sources, a recent working paper from Harvard University's John F. Kennedy School of Government analyzed the long-term needs and costs of veterans returning from the Iraq and Afghanistan conflicts, and found the largest unmet need to be mental health care.<sup>4</sup> The author notes: "The strain of extended deployment, the stop-loss policy, stressful ground warfare, and uncertainty regarding discharge and leave has taken an especially high toll on soldiers."

Needs of families shift dramatically depending on where the service member is in the cycle of deployment:

- In the pre-deployment stage, the service members' workload and stressors are tripled, and service members and families often experience discord, anger, and emotional detachment.<sup>5</sup>
- For families, deployment is exceedingly stressful, characterized by depression, anxiety, and sleep disturbance among other stress-related health problems.<sup>6</sup>
- Post-deployment presents the challenge of reintegration into family and civilian life, and service members' mental health symptoms often increase between the time of homecoming and three to four months post-deployment.<sup>7</sup> For families, dealing with the returning family member's severe mental and behavioral health conditions can be exceedingly stressful.
- Children's responses to deployment are varied and depend on age, as well as family and individual factors, but can include sadness, changes in eating habits, and decline in school performance.
- When mothers are the deployed parent, children also experienced problems in peer relationships, emotional expression, learning, and physical health. Families with returning service members who are experiencing PTSD and combat-related stress may also be at increased risk for child abuse.<sup>8</sup>

During deployment, a substantial proportion of service members experience significant traumatic events, the impact of which are magnified by the harsh living conditions of combat: Seventeen percent of soldiers serving in Iraq in 2006 suffered from acute stress, depression, or anxiety according to an Army survey, and rates were higher among soldiers who had at least one prior deployment (18 percent), a situation increasingly common in the current war.<sup>9</sup>

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<sup>4</sup> Bilmes, L. "Soldiers Returning from Iraq and Afghanistan: The Long-term Costs of Providing Veterans Medical Care and Disability Benefits." Faculty Research Working Papers, Harvard University JFK School of Government RWP07-001, January 2007.

<sup>5</sup> "The Psychological needs of the U.S. Military Service Members and Their Families: A Preliminary Report." American Psychological Association Task Force on Military Deployment Services for Youth, Families, and Service Members, February 2007. Available at <http://www.apa.org/releases/MilitaryDeploymentTaskForceReport.pdf>

<sup>6</sup> Ibid.

<sup>7</sup> Ibid.

<sup>8</sup> Ibid.

<sup>9</sup> Ibid.

The Harvard working paper estimates that 36 percent of veterans treated thus far - an unprecedented proportion –have sought help and been diagnosed with behavioral health conditions including PTSD, acute depression, substance abuse and other conditions.

Among the most prevalent injuries associated with the current military operation is traumatic brain injury (TBI) related to blast injuries. In 2005, 22 percent of all wounded had a TBI, which is frequently accompanied by cyclical depression, psychomotor coordination problems, hearing loss, affective instability, memory problems, and trouble concentrating.<sup>10</sup>

The trauma of war is frequently compounded for service members by the trauma of sexual violence. A 2003 Veteran’s Administration report indicated that, across National Guard and Reserve components, the estimated prevalence of any military sexual trauma (MST) during active duty is 60 percent among females and 27 percent among males. MST includes sexual harassment, sexual assault and rape. The estimated prevalence for rape among females is 11 percent and among males is 1.2 percent.<sup>11</sup> Exposure to military sexual violence increases the risk of domestic violence upon the service members’ return.<sup>12</sup>

### **Need for Integrated Behavioral Health Services**

The Levy Strategic Improvement Plan (SIP) recognized that a significant challenge for King County is the lack of access to behavioral health services, especially for individuals who are not eligible for Medicaid and long-term care in the public mental health system. Regional Support Network (RSN) community mental health agencies can offer limited to no access to outpatient mental health services for those who do not qualify for Medicaid. Only those persons with the most severely debilitating mental illnesses are able to qualify. There are no state and severely limited federal funding mechanisms to support the provision of behavioral health services in federally qualified health centers, including both community and public health centers.

Nationwide, mental health issues and substance abuse together constitute the leading reason for a visit to a health center.<sup>13</sup> Patients identified in a primary care setting as needing behavioral health services include those with emotional distress, mood disturbance, as well as chronic and complicated physical health diagnoses. These patients, including veterans and other high-risk individuals, frequently have significant co-morbidities, and are diagnosed with mental health disorders and serious chronic physical health conditions such as diabetes or hypertension. Providing care to these patients consumes significant King County health resources in primary care, inpatient settings, and emergency departments.

A recent evaluation of a sample of local health center 2006 claims data suggest that 18,000 to 38,000 diverse, low-income adults served by King County health centers are in need of

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<sup>10</sup> *ibid*

<sup>11</sup> “Military Sexual Trauma Among the Reserve Components of the Armed Forces.” The Veterans Millennium Health Care and Benefits Act. October 2003. Available at <http://veterans.house.gov/democratic/press/109th/pdf/mstreport.pdf>

<sup>12</sup> *Ibid*.

<sup>13</sup> 2003 Uniform Data System, cited in “Health Centers’ Role in Addressing The Behavioral Health Needs of Medically Underserved.” September 2004 Issue Brief from National Assoc. of Community Health Centers

mental health and chemical dependency services.<sup>14</sup> Of this number, around 40 percent (7,200 to 15,200) are not eligible for Medicaid or other publicly sponsored coverage. Between 12 and 17 percent of patients were diagnosed with a chemical dependency or mental health condition.

This is likely a significant underestimate of the prevalence of these conditions, as providers frequently tend to underutilize mental health and chemical dependency diagnostic codes unless there is reimbursement connected to these services. In a recent analysis of Colorado claims data for adult Medicaid managed care enrollees, where state reimbursements are available to qualified health centers, 39 percent had a psychiatric diagnosis.<sup>15</sup>

*b) Populations to be Served*

Activity 3.1B focuses on veterans, military personnel, and their family members who are at risk of mental illness, substance abuse, and associated health problems.

*c) Promotion of Equity and Social Justice*

Activity 3.1B promotes equity by improving access to health and human services, a key determinant of equity. This activity provides integrated mental health services that are high quality, free, and culturally appropriate. This activity specifically seeks to improve the mental health status and functioning of high-risk veterans, military personnel, and their family members. Veterans of color have significantly higher rates of mental health issues than white veterans and are more likely to be classified as low income.<sup>16</sup> Given this, it is expected that this activity will have a positive impact on communities of color and low-income communities.

To enhance positive impacts of this activity, community health center agencies providing services are held financially accountable for patient outcomes. Public Health – Seattle & King County uses a pay for performance contracting approach and provides extensive technical assistance and training to participating providers to ensure that services are provided with fidelity to evidence-based practices. A recent analysis of program data demonstrated that pay-for performance yields more timely follow-up care and a significant reduction in the time to depression improvement.<sup>17</sup> Activity funds are also used to support psychiatrist FTE to provide consultation to primary care physicians to ensure appropriate medication management. PHSKC also requires that agencies hire only licensed mental health providers for this activity. (WAC 246-809, 246-810, 246-924, 246-840)

A possible negative impact of screening and treating depression is breach of confidentiality and stigmatization. To prevent adverse impacts, PHSKC contracts with Federally Qualified Health Centers who are bound by federal HIPAA law to maintain the integrity of protected health information. Providing depression treatment in primary care also greatly reduces

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<sup>14</sup> 2006 claims data used in developing this estimate were made available from Community Health Centers of King County and Public Health Seattle & King County.

<sup>15</sup> Thomas et al. "Prevalence of Psychiatric Disorders and Costs of Care Among Adult Enrollees in a Medicaid HMO." 2005. *Psychiatric Services* 56:1394-1401.

<sup>16</sup> King County Department of Community and Human Services Evaluation Report: Status of Veterans and Veterans Services in King County, 2013.

<sup>17</sup> Unutzer et al 2011. Quality Improvement with Pay-for Performance Incentives in Integrated Behavioral Health Care. *American Journal of Public Health* June 2012, Vol 102, No. 6

stigma, as a patients' reasons for going to a primary care clinic are not immediately obvious to family or community members, as they would be at a mental health clinic.

## **5. Activity Description**

Public Health – Seattle & King County subcontracts with HealthPoint Community Health Centers, Neighborcare Health, Seattle Indian Health Board, Valley Cities Counseling and Consultation, and Community Health Plan of Washington to implement this activity.

Collaborative stepped care is coupled with a robust, web-based care management tool called the Mental Health Integrated Tracking System (MHITS). Similar to a chronic disease registry, MHITS tracks functional and symptomatic improvement, provides access to a variety of standardized assessment measures, supports systematic caseload management, and provides rich outcome data to drive quality improvement efforts.

Patients with severe or complex mental health needs are referred to licensed mental health community centers for more intensive services, and patients in need of treatment for chemical dependency are referred for treatment while receiving ongoing support in their primary care home. MHITS is then used to coordinate care between primary care and mental health providers. Improved communications ensure better clinical outcomes and conserve program resources.

The essential elements of the collaborative care model are described below:

- a. Staff collaboration on mental health treatment in the primary care setting occurs in two main ways: (1) the patient's primary care physician works with the mental health provider to develop and implement a mental health treatment plan; (2) the mental health provider and primary care providers consult with a designated psychiatrist to help change treatment plans if patients do not improve.
- b. Mental health providers communicate regularly with primary care providers and consulting psychiatrists to ensure that they are coordinating the client's mental health treatment; mental health providers facilitate care, provide brief therapeutic interventions, refer clients to appropriate resources, and monitor symptoms for treatment response.
- c. A designated psychiatrist consults systematically with the mental health provider and primary care physician on the care of patients who do not respond to treatments as expected. The psychiatrist may suggest referrals to community mental health and chemical dependency treatment agencies for complex patients who need more intensive service and who are eligible to receive more intensive services through these agencies.
- d. Mental health provider measure symptoms at the start of a patient's treatment and regularly thereafter using brief, structured screening and clinical rating scales that are appropriate for the specific disorders that are being treated. If patients are not improving, they change the course of treatment or add additional services in consultation with the primary care provider and/or consulting psychiatrist.

**Adapting the Model to Meet Veterans’ Needs:** As previously described, 36 percent of veterans treated nationwide thus far have sought help and been diagnosed with behavioral health conditions including PTSD, acute depression, substance abuse and other conditions. According to the program director for Veterans for America, a leading advocacy group, “The signature wounds from the wars will be (1) traumatic brain injury, (2) PTSD, (3) amputations and (4) spinal chord injuries, and PTSD will be the most controversial and most expensive.”<sup>18</sup>

Long-term manifestations of PTSD and other chronic health concerns suggest that a significant portion of returning veterans and their families, including Reservists and National Guard, will be at high risk for loss of housing, income and employment, and family and social support. The Public Health – Seattle & King County and its subcontractors will make identifying, assessing and obtaining housing for homeless veterans a priority.

Providers serving veterans and their families will receive and utilize training in military culture so that they can provide better service.

**6. Funds Available**

The 2012 Service Improvement Plan identified the following allocations for this activity.

	2012	2013	2014	2015	2016	2017
<b>Veterans Levy</b>	<b>\$600,000</b>	<b>\$600,000</b>	<b>\$600,000</b>	<b>\$600,000</b>	<b>\$600,000</b>	<b>\$600,000</b>
<b>Human Services Levy</b>	-	-	-	-	-	-
<b>Total</b>	<b>\$600,000</b>	<b>\$600,000</b>	<b>\$600,000</b>	<b>\$600,000</b>	<b>\$600,000</b>	<b>\$600,000</b>

**7. Evidence-based or Promising Practices**

Activity 3.1B uses the collaborative stepped care model, also known as the IMPACT Model. Collaborative stepped care has been shown to improve access, reduce overall costs, and improve mental health outcomes.<sup>19,20,21</sup> The IMPACT model is listed on the National Registry of Evidence-based Programs and Practices (NREPP) through the Substance Abuse and Mental Health Services Administration (SAMHSA). Activity 3.1B has demonstrated very positive outcomes, including depression and/or anxiety improvement for 57% of clients in treatment.

**8. Service Partnerships**

<sup>18</sup> Sullivan, P. Program Director of Veterans for America, 12/23/06 interview with L. Bilmes (reference 7).

<sup>19</sup> Gilbody S, Bower P, Fletcher J, et al. Collaborative Care for Depression: A Cumulative Meta-analysis and Review of Longer-term Outcomes. Arch Intern Med. 2006;166:2314-2321

<sup>20</sup> Simon G. Collaborative care for depression. BMJ. 2006;332:249-250

<sup>21</sup> Unützer J, Choi Y, Cook I, Oishi S. A web-based data management system to improve care for depression in a multi-center clinical trial. Psychiatric Services. 2002; 53:671-678.

PHSKC partners with the University of Washington Department of Psychiatry and Behavioral Sciences for training, technical assistance, and psychiatric consultation to Activity 3.1B providers and clinics.

### 9. Performance Measures

The following performance measures were identified by the Levy's Evaluation Team.

Objectives	Service Outputs/ Measures	Most Recent Performance	2013 Target(s)	Data Source
<b>Engagement/ Assessment</b>	• Number of clients contacted through outreach	159	175	Report Card – Services
	• Number of Veterans or their dependents screened for PTSD or other MH issues	576	600	Report Card – Services
<b>Treatment/ Intervention</b>	• Number of Veterans or their dependents enrolled	576	500	Report Card – Services
	• Number of clients who are have reduced depression scale	57%	45%	Report Card - Outcomes

Participating agencies must also achieve four Quality Aims, which are key measures of program quality and fidelity proven to equate to better outcomes for the families we serve. Public Health-Seattle & King County Community and School-Based Partnerships program, which manages these funds, uses performance-based contracting to hold agencies accountable to outcomes by making 20% of contracted funds contingent on achieving the four Quality Aims (5% for each Aim). Aims data is tracked in MHITS and real time progress is available to agencies so that they can monitor their progress and adjust their practice accordingly. In 2013, contractors are held to the following Quality Aims:

1. Maintain active caseload of 60 patients per 1.0 FTE
2. At least 50% of active caseload will be supported by at least two clinical contacts each month.
3. At least 40% of patients will achieve a 5 point or greater improvement on either the PHQ9 or the GAD7
4. Providers will receive psychiatric consultation on at least 80% of clients who are not improving.