King County Physical and Behavioral Health Integration Design Committee

Meeting Summary
August 10, 2016; 1:30– 4:30 PM
Navos-Revelle Hall
Burien, WA

***Members Present:**, Betsy Jones- King County Executive's Office, Jennifer DeYoung- Public Health- Seattle & King County, Maria Yang- King County Behavioral Health and Recovery Division, Angie Riske- Multicare, David Johnson- NAVOS, Julie Lindberg- Molina Healthcare, Vicki Evans- Molina Healthcare, Steve Daschle-Southwest Youth and Family Services, Katherine Switz- Many Minds, Amina Suchoski,- United Healthcare, Torri Canda- Amerigroup, Daniel Malone- DESC, Darcy Jaffe- Harborview, Anne Shields- UW AIMS Center, Erin Hafer-Community Health Plan of Washington, Roger Dowdy- Neighborcare, Tory Gildred- Coordinated Care Health, Stacy Fennel- Sea Mar Community Health Services (phone), Suzanne Peterson-Tanneberg- Seattle Children's Hospital, Tom Trompeter- HealthPoint, Ken Taylor- Valley Cities, Marc Avery- Community Health Plan of Washington, , Andrea Yip- Seattle Aging and Disability Services, Colette Rush- Healthcare Authority, Isabelle Jones- Healthcare Authority*

***Members Not Present:** Susan McLaughlin- King County Department of Community & Human Services, Maureen Linehan- City of Seattle Aging and Disability, Aileen DeLeon- WAPI, Patricia Quinn- Therapeutic Health Services, Molly Donovan- REWA*

***Staff:** Liz Arjun- King County, Jen Martin- Community Change, Travis Erickson- King County, Martha Gonzalez- King County*

Welcome & Introductions

Liz Arjun welcomed the committee members and gave an overview of the agenda. Jen Martin reviewed the overall timeline and scope of work plan for the September retreat. The goal is to finalize recommendations that day. The draft recommendations summary will be sent for review by the IDC in advance of the October meeting where there will be a final review and approval.

Southwest Washington – Summary of Lessons Learned and Q&A

Given that many IDC members were unable to attend the July meeting, Liz recapped the Southwest Washington presentation. In addition, the committee had a chance to ask questions from members of the panel who represented Southwest Washington - Isabel Jones from the Health Care Authority, Julie Lindberg from Molina and Erin Hafer from Community Health Plan of Washington.

Q: Could you elaborate on the health advisory board?
A: The Behavioral Health Advisory Board (required by every BHO) is still being established and includes several consumer groups. Another group that is not yet formalized is the strategic planning counsel group which includes the MCOs, Beacon Health Options, the County, a housing provider, the mental health ombudsman and a few others- is focused on addressing gaps and problems with the

implementation of full integration in the region. They would like for this group to eventually live with the ACH, however at this time the ACH is being restructured.

Q: Have you received consumer feedback about the changes?
A: Consumers like the single point of access and resources. The integrated approach has been helpful, especially for care management services for mental health. Right now the voice of the consumer is represented by the Mental Health Ombudsman and Executive Director of a peer organization (Consumer Voices Are Born). Once the Behavioral Health Advisory Board is stablished they will also serve as a consumer voice.

Q: Why are there 3 organizations operating in the region (2 MCOs and Beacon)?
A: Federal Medicaid rules requires that there be at least 2 managed care plans in each region to allow for community choice- in this region, Molina and Community Health Plan of Washington have contracts with the Health Care Authority for the physical and behavioral health care services for the Medicaid population. In addition, the Health Care Authority has a contract with Beacon Health Options to serve as the Behavioral Health Administrative Services Organization (BHASO) in the region which manages the crisis system that all individuals in the region are eligible for including Medicaid, non-Medicaid (private) and uninsured.

Q What will value-based models look like in the future?
A: Potentially full risk with physical partners, aid sharing and sharing of cost savings. They anticipate providing technical assistance and support to providers to help them move in the same direction. Using local money to support these pieces is a goal of integrated purchasing; however at this time, there isn't much money available for this. They are looking at ways to pull together funding from various sources, leveraging levy dollars in the future.

Q: What does the ideal ACH look like?
A: The big advantage is broader participation from multiple agencies; criminal justice, education, housing, legal, medical responders etc. The overall cost implications can be explored on many layers, it presents an opportunity to look at savings. They would like to have a contractual relationship with one another. They would like to utilize their time and reduce duplication.

Q: Why did Southwest Washington contract the BHASO role out to Beacon rather than have the counties apply to serve in this role?
A: All counties had the right of first refusal to serve in this role. Southwest made this decision for many reasons including the knowledge that Beacon has expertise and experience providing these functions around the country and is cost effective.

Q: Did the state elect to RFP separately for crisis services and managed care?
A: Yes, since it's technically a different scope of work than the Medicaid managed care scope.

Clinical Model **Recommendations – Review and Discuss Service and System Elements**

The committee had a chance to review the King County Integration Design Committee Core Clinical Elements (see attached document). The first column is the "value/principle" and the definitions. The "evidenced by" column are the components that meet that principle, the final column "Additional Comments" were specific examples and comments from workgroup members that need to be kept in

mind as work is done to identify measures. The committee had an opportunity to ask questions and make comments. Comments highlighted in purple referred to the "Hard to Reach/Hard to Serve" Population and those in red highlighted referred to those specific to Children's and Families.

- The term "Care Coordination" needs more clarity. The adult work group struggled with distinguishing what is working now and what needs to be changed. Another suggestion was to clarify duplication of "Care Coordination." In general, people felt that "Care Coordination" section needs to be more specific.
- "On-demand" care language should give specifics or be removed.
- There seems to be duplication on several items and could be cleaned up.
- Value based-section "firm handshakes" is a confusing term- clarified that it is about ensuring that contracts exists between organization that pay for and support coordination.
- The screen and training piece should call out suicide prevention, not just refer to crisis.

A smaller group that includes the leads from the clinical workgroups will work with Liz to finalize the document. She, Marc Avery and Maria Yang will also meet with Jurgen Unitzer, Director of the AIMS Center to get his feedback. The group also discussed the need to include outcomes. Some committee members suggested linking this work to the outcomes work the IDC did in December and January and that we shouldn't have a corresponding outcome for each line. IDC members wanted to be sure that the work they have done on identifying strategies and possible measures was not lost. Liz reassured the group that this background information will be included in the recommendation summary.

Infrastructure Discussion

Darcy Jaffe led a discussion with the group about potential infrastructure models to support integrated care for the region by sharing key takeaways from the infrastructure workgroup conversation. The workgroup found that the "County- Lead" and the "MCO-Lead" models kept the conversation focused on who ultimately holds the contract with HCA rather than on what will best support the clinically integrated system that the IDC has designed. Many expressed concerns about what happens to County funding and other pieces that the county has historically contributed if we move to an MCO-lead model. The workgroup felt that the Public-Private Partnership Model (or some iteration of it) allowed the best opportunity to build on everyone's strengths. Workgroup members shared/explored whether there was a way to achieve the goals of the Public-Private partnership virtually rather than through establishing a new entity. The goal would be to establish some sort of shared partnership with shared governance for those organizations funding care in the region driven by agreed upon common outcomes. The workgroup had many questions about risks, legality and how this could work and what "governance" would involve and how best to prevent carve outs. The IDC was supportive of the direction the workgroup was going, echoed many of the questions they raised and would like more details on what this could look like. They wanted to know more about how reinvestments might work, more about the role of the County, how this helps to drive toward value-based purchasing (outlined by the Health Care Authority) and how RFP language could be developed to support this model. There was one suggestion about using the work on the Mental Health Integration Project as a place to look because of the partnerships it spurred.

Next Steps

The committee unanimously agreed for the Workgroup to continue exploring the Public-Private Partnership Model and the MCO-Lead model for clarity at the September meeting. A revised version of the core elements will be sent out in advance of the September meeting. The infrastructure workgroup will meet again prior to the September retreat.

King County Integration Design Committee Core Clinical Elements – August 8, 2016

***Notations in given in purple are specific for the hard-to-reach/hard-to-serve population, red are specific to children, youth and families*

Principles	Core Components in an Integrated System of Care	Additional Comments
The System is Client Centered and Promotes Equity 1. Individuals experience significant gains in health and well-being because the system shifts from a costly, crisis-oriented response to health and social problems, to one that focuses on prevention, embraces recovery, and eliminates disparities 2. Individuals receiving services are at the center of care planning, are engaged and activated, and self-management is promoted 3. Individuals are able to access the health and social service supports when and where they need them in a culturally responsive fashion; services are community-based and delivered in the least restrictive setting possible 4. Individuals achieve improved health and social outcomes as a result of full integration 5. The system extends beyond Medicaid and supports individuals who are low income, or uninsured, including non-Medicaid, immigrants/refugees and undocumented as well as those covered by private insurance and ensures equity of experience regardless of payer	Patients have access to timely routine and urgent-care outpatient services for primary care, behavioral health*, and other care providers to provide necessary services to maximize the potential to reduce suffering/disability/complications, and to maximize engagement into services and remission/recovery from illness.	*Behavioral Health (definition) includes mental health, substance use, co-occurring, and health behavior counseling and services *Urgent Care * Transportation to access services *Hard to Reach: timely = same day access (otherwise people are lost) or care that is brought to them
	Primary care and other providers have quick access to specialty provider-to-provider consultation for the purpose of care planning.*	*Examples of peer to peer consultation services include PAL's Plus line for children, MAT recommendations for SUD patients, and pain management consultation.
	Care and services address the needs of the child's family/caregivers/support system as well as the individual	
	Challenges adding stigma related to individuals with SMI and SUD (and other vulnerable populations) are addressed in order to ensure equitable access.	*Examples of services that reduce barriers include easily accessed- transportation, childcare, and interpretation services.
	Patients have access to mobile medical services, triage services, diversion, and respite care to provide safe, effective, and evidence based alternatives to inpatient care and incarceration or no care at all.	*Examples include Safe Places, King County Mobile Medical Van, where, when and how people need it, including house calls for the "hard-to-reach"
	Services are strategically co-located (or increased in proximity) to maximize service convenience and engagement. Care is integrated and accessible such that there is "no wrong door" and warm-handoffs are ensured	*Examples include primary care behavioral health care centers, jail health services, school based health centers. (with practitioners who are skilled in MH and SUD screening, assessment, intervention, behavioral health management), CCORS & embedded in local ED's such as at Seattle Children's
	Strategies are developed to prioritize outreach, engagement, and maintenance in care of difficult-to-reach consumers.	
	First Responders are trained in BH to improve interventions, reduce stigma, and promote referral and engagement into services.	Examples include Mental Health First Aid., crisis intervention training
	Screenings and services are culturally and linguistically competent	
	Peer services are offered	

The System Addresses Whole Person Needs Across the Continuum from Prevention to Recovery 6. Full integration at the clinical and financial levels ensure mechanisms to treat the whole person and align incentives as the best way to improve health and social outcomes 7. Services address the individual's health and well-being across the lifespan; specifically, services for children, adolescents, elderly and individuals with disabilities are systematically designed and utilized to meet their unique needs. 8. Ongoing investments in health promotion, health literacy, prevention, and early intervention are made to prevent the occurrence of health conditions and achieve improved population health 9. The system is active in addressing the social determinants of health including integration of housing, employment, criminal justice diversion and other recovery support services 10. Recovery principles are prominent across the system of care and recovery practices are expected and rewarded	Consent for sharing information is obtained including within the crisis system	Recognize need for confidential care of youth 13+; working with family structure as identified by client. Development of communication loop for information sharing
	Consumer education is available to maximize health literacy and engagement	Education to services outside of the health care world- daycares, schools, media, other non-health care settings
	Standardized evidence-based screening and outcomes measurement tools are used and information is used and accepted across provider; care planning is individualized and uses shared-decision making and individual goal setting	Examples include PHQ9, AUDIT, DAST, and Risk screenings for infant mental health occur in pre/postpartum and family planning/prenatal settings Broadband generalized screening/risk assessments in primary care
	Information is easily shared between providers including crisis providers and other non-traditional providers (social services and housing)	
	Care Coordination is Offered	Consumers have a point person to help them navigate a complex system Consumers are connected to appropriate services and barriers are addressed transportation, language, literacy, scheduling). Not necessarily clinic-based- telephonic and clinic-based unlikely to work for hard-to-reach population, Mobile benefit that moves with the client, regardless of location or payer. Family-focused care approach and availability that recognizes confidentiality Collaboration/communication back with primary care Potential Measures: Increased access to specialty care, primary care and health education. Early intervention of health issues, preventive care.
	Team-Based Care is available	Clinicians are ready and able to treat the unique needs of the hard-to-reach population including the use of engagement skills, motivational interviewing, trauma-informed care
	Work, education, and meaningful activities are promoted and supported as part of a consumer's overall wellness.	Activities are incorporated into a plan which is tailored to each individual (recognizing that traditional activities may not be appropriate)
	Access to resource centers, educational groups, crisis lines, and chat rooms	Existence of a "one stop" after hours call numbers (i.e. for BH as well as medical RN call line).* could be the role of the care coordinator

The System Promotes Value-Based Purchasing and Maximizing Resources 11. Payments are based on achieving improved health and social outcomes for individuals because we are paying for value rather than volume, allow for the flexibility and capacity at the clinical level to address individual needs and payment models are adjusted to meet the needs of various populations 12. Providers are supported in their efforts to improve health and social outcomes because the system uses standardized measures that are used frequently to provide feedback and make course corrections when necessary 13. Services provided are chosen from among those practices that have demonstrated evidence of effectiveness, whenever possible and brief treatments are emphasized when appropriate 14. All funding sources are maximized and fully leveraged: Medicaid, block grant, philanthropy, local taxes and levies, grants, etc. to ensure a full continuum of health services 15. Payers in the Region (including King County and the Washington State Health Care Authority) are aligned in how services are contracted and paid for, including aligning incentives across payers	Care is delivered in the "right place, right time, right care" at the lowest level of care to effectively achieve outcomes; Care is quickly adjusted when outcomes are not achieved as expected	Outcome measures and timing must reflect individual client needs
	Problem-focused brief interventions are included in the continuum of services and are utilized when appropriate in response to initial assessments, better triage of issues	Assessments must not be deterrents to getting care- must be streamlined and transferable
	Collaboration and coordination is incentivized to encourage "firm handshakes" and communication, promote effective delivery of services and reduce duplication	"Firm handshakes" determined by relationships
	Referral mechanisms are standardized between separate service providers to improve the efficiency and coordination of care.	Example includes EPSDT benefit is standardized for children and used to screen and refer children for to care with tight handshake (vs. warm handoff Referrals need to take into account information about relationships and establishing trust with consumer Coordination of care across agencies is standard practice and includes in-person meetings
The System Invests in the Infrastructure Necessary to Support the System 16. **Information is shared seamlessly** across providers in order to minimize complexity and errors and maximize efficiency and effectiveness for the individuals served 17. Ongoing **investments** are made to build and maintain necessary system and provider capacity **to provide a full continuum** of health services	Provider access to clinical registry for tracking outcomes, adjust care, perform quality improvement, and to facilitate value-based reimbursement.	Ensure provider use of registry to track hard-to-reach clients
	Movement toward uniform use of electronic health records and/or health information exchange mechanisms are used Care and service providers are educated and trained in how to share information and have reliable processes to regularly share information for the purposes of integrating and coordinating care	Need for communication loops- standard protocols for sharing information (what is able to be shared by who, when) obtaining/sharing ROI; how and what is documented when done with the purpose of inclusion of client and other systems.
	Mechanisms of care support and ability to share care plans.	MHITS, EDIE Pre-manage
	System-wide trainings are deployed across providers to standardize and improve patient care outcomes and experience across the continuum of care.	Examples include Mental Health First Aid, Trauma-Informed Care, Motivational Interviewing

Updated 7/1/2016

KING COUNTY PHYSICAL AND BEHAVIORAL HEALTH INTEGRATION DESIGN COMMITTEE

GUIDING DOCUMENTS

SEPTEMBER 2016

WORKING VISION

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. A key factor in achieving this vision is moving from an environment where health and human services are delivered in programmatic siloes determined by funding source, to an integrated health care system that is able to address whole person health (physical and behavioral) needs, is person-centered and determined by an individual's unique needs.

WHAT DOES THIS LOOK LIKE: WORKING DEFINITION OF INTEGRATED CARE

An integrated health care system is one where providers and payers work collectively to meet the physical and behavioral health needs of an individual in a timely, holistic and culturally responsive fashion where the person receiving services is engaged in their care. In this system, there is "no wrong door"- individuals receiving services are able to access the services when and where they need them. Care coordination happens across providers, payers and other organizations serving the person to minimize duplication and complexity. There is accountability to the individual, to those involved in providing services and to payers for achieving outcomes that the individual has helped identify. Those involved in providing services are supported by a shared care plan, shared data and have an understanding of their respective roles. Financing supports the integrated system by paying for overall outcomes and value for the person receiving services, not individual services.

KING COUNTY PRINCIPLES FOR FULL INTEGRATION

The System is Client-Centered and Promotes Equity

1. Individuals experience significant gains in health and well-being because the system shifts from a costly, crisis-oriented response to health and social problems, to one that **focuses on prevention, embraces recovery, and eliminates disparities**
2. Individuals receiving services are at the center of care planning, are **engaged and activated,** and self-management is promoted

3. Individuals are able to access the health and social service supports **when and where they need** them in a culturally responsive fashion; services are **community-based** and delivered in the least restrictive setting possible
4. Individuals **achieve improved health and social outcomes** as a result of full integration
5. The system **extends beyond Medicaid** and supports individuals who are low income, or uninsured, including non-Medicaid, immigrants/refugees and undocumented as well as those covered by private insurance and **ensures equity of experience** regardless of payer

The System Addresses Whole Person Needs Across the Continuum from Prevention to Recovery

6. Full integration at the clinical and financial levels ensure mechanisms to **treat the whole person and align incentives** as the best way to improve health and social outcomes
7. Services **address the individual's health and well-being across the lifespan;** specifically, **s**ervices for children, adolescents, elderly and individuals with disabilities are **systematically designed and utilized to meet their unique needs.**
8. Ongoing **investments in health promotion, health literacy, prevention, and early intervention** are made to prevent the occurrence of health conditions and achieve improved population health
9. The system is active in **addressing the social determinants of health** including integration of housing, employment, criminal justice diversion and other recovery support services
10. **Recovery** principles are prominent across the system of care and recovery practices are expected and rewarded

The System Promotes Value-Based Purchasing and Maximizes Resources

11. Payments are based on achieving improved health and social outcomes for individuals because we are **paying for value** rather than volume, allow for the flexibility and capacity at the clinical level to address individual needs and payment models are adjusted to meet the needs of various populations
12. Providers are supported in their efforts to improve health and social outcomes because the system uses standardized measures that are used frequently to provide feedback and make course corrections when necessary
13. Services provided are chosen from among those practices that have demonstrated evidence of effectiveness, whenever possible and brief treatments are emphasized when appropriate
14. **All funding sources are maximized** and fully leveraged: Medicaid, block grant, philanthropy, local taxes and levies, grants, etc. to ensure a full continuum of health services
15. Payers in the Region (including King County and the Washington State Health Care Authority) are **aligned in how services are contracted and paid for,** including aligning incentives across payers

The System Invests in the Infrastructure Necessary to Support the System

16. **Information is shared seamlessly** across providers in order to minimize complexity and errors and maximize efficiency and effectiveness for the individuals served
17. Ongoing **investments** are made to build and maintain necessary system and provider capacity **to provide a full continuum** of health services

EXPECTED RESULTS

Early in its work together, the Integration Design Committee used Results-Based Accountability to articulate the outcomes they would like to see from providing integrated care for the residents of King County:

"All people in King County are on a path for a:

- *Healthy lifespan**
- *Have a home*
- *The ability to contribute to meaningful activities*
- *Connection to a culturally relevant community."*

*"Healthy lifespan" is defined by having the health promotion skills and resilience needed to reduce or eliminate lifespan disparities.

The services and system components articulated by the IDC identify the necessary building blocks to achieving these outcomes.