King County Physical and Behavioral Health Integration Design Committee

Meeting Summary

January 13, 2016, 1:30 p.m. – 4:00 p.m

Navos-Revelle Hall, 1210 SW 136th St, Burien, WA 98166

Members Present: *Betsy Jones- King County, Maria Yang- King County, Roger Dowdy-Neighborcare Health, Tom Trompeter- Healthpoint, Ken Taylor- Valley Cities, David Johnson- Navos, Steve Daschle-Southwest Youth and Family Services, Patricia Quinn- Therapeutic Health Service, Darcy Jaffe- Harborview, Emily Transue- Coordinated Care, Torri Canda- Amerigroup, Vicki Isett- Community Homes, Anne Shields- UW Aims, Angie Riske- Multicare Behavioral Health*

Members Not Present: *Maureen Linehan- City of Seattle, Suzanne Petersen-Tannenberg- Children's Hospital and Regional Medical Center, Daniel Malone- DESC, Molly Donovan- Refugee Women's Alliance, Aileen DeLeon-WAPI, Erin Hafer- CHPW, Julie Lindberg- Molina, Doug Bowes – United Healthcare*

Staff: *Susan Mclaughlin- King County, Liz Arjun- King County, Lee Thornhill- King County, Debra Srebnik- King County*

Welcome

Susan McLaughlin welcomed the group and a new member was introduced, Angie Riske, representing Multicare Behavioral Health.

Retreat: From Reflection to Required Outcomes

Susan McLaughlin facilitated a discussion focused on taking the good work done at the December retreat and incorporating that work into guiding documents for the Committee's work over the next 10 months.

Working Definition of Integrated Care

The group reviewed and provided feedback to the "Proposed Working Definition of Integrated Care":

"An integrated health care system is one that is able to meet the physical and behavioral health care needs of an individual where their needs are addressed in a holistic fashion. In an integrated system, those providing care work as part of a team that is accountable to achieving improved patient outcomes that the patient has helped to identify. The patient experience is one that is ***simple and flexible*** *to what the patient needs when they need it because those involved in providing care to meet these outcomes are supported by a shared care plan, case management that does not belong to one system and financing to support overall patient outcomes, not individual services."*

The group made the following suggested revisions:

- Care management instead of case management
- Responsibility of the individual – willingness to attend to one's own health
- Accountability for everyone toward the outcomes
- Develop common understanding of terms and roles across systems
- Include mention of cultural relevance across physical and behavioral health systems

A revised working definition of integrated care that incorporates these suggestions will be presented at the February meeting.

Working Vision for 2020

The group reviewed and provided feedback to a "Proposed Working Vision for 2020":

"By 2020, Medicaid enrollees in King County will experience improved health and social outcomes because:

- *Beneficiaries are at the center of care planning;*
- *Beneficiaries are able to access the health and social service supports they need when they need them;*
- *Payers in the Region (including King County and the Washington State Health Care Authority) are aligned in how services are contracted and paid for;*
- *Payments are based on achieving improved health and social outcomes for clients allowing for the flexibility at the clinical level to address individual needs;*
- *Systems are sharing information with one another in order to support improving client outcomes"*

The group made a number of suggested revisions including:

- Clarity about what we mean by saying payments are based on achieving improved health and social outcomes
- Acknowledge individual accountability and responsibility because they are engaged in care and activated, driving services
- Incorporating a vision of seamlessness since it will improve the client experience
- A system that has the minimum amount of administrative complexity so that the system can prioritize money for care
- Confirm we are talking about all Medicaid eligible, including those we don't know that much about

A revised working definition of the vision will be presented at the February meeting.

Results

Susan McLaughlin began the conversation about results that was started at the December retreat by providing some clarity about results for the work of the PBHI committee vs. the results of the Accountable Community of Health. Susan explained that the results expected from the PBHIDC would feed into the population level results expected and measured by the Accountable Community of Health. In other words, we can expect changes at the population level in the community because of the focused work on integration.

She then presented the group with a framework (see below) that contrasted different populations (e.g. young adults) with the varying level of behavioral health needs an individual might have over the lifespan (e.g. milds tos moderate behavioral health needs) to help frame the conversation. This concept is in keeping with the continuum approach that the committee has discussed in the past. The goal is that over time, the matrix will be will be populated with the different models we think will give us the results we would like to see for the specific sub-populations.

Subpopulation	Outcomes: Standards of Care	Outcomes:	Outcomes:	Outcomes:	Outcomes:
Older Adults		MHIP SBIRT			
Adults		MHIP SBIRT			
Young Adults		SBIRT			Wraparound/ WISe
School Age Children	Routine screening for development and social/emotional needs			Children with Special Needs Program	Wraparound/ WISe
Birth – 5	Routine screening for developmental and social/emotional needs				
Level of BH Need	No identified BH Needs	Mild-Moderate BH Needs	Specialty BH Needs	Specialty Medical Needs – no BH	Complex Care Needs – BH and chronic medical

Some feedback was given about this approach- in general the group felt that this would help to keep the group focused on results, rather than finances and help to avoid potential duplication of services. People also appreciated this concept because it allows for a focus on prevention and early intervention as part of the continuum and to look at the total cost of care for an individual and the expected results which can be easily translated to the idea of value-based purchasing rather than volume-based purchasing. The group wanted to be sure that there was the opportunity to add more subpopulations- Susan affirmed that "yes" this is an iterative process and a "living document" similar to the "working vision" and "working definition of integrated care". Vicki Isett representing individuals with developmental disabilities, noted that for individuals with developmental disabilities, services are used for the majority of the their lifetime. Many other committee members commented about the importance of her perspective in this work because of that experience and that perhaps a good exercise for our group would be to look at current system failures for individuals with developmental disabilities and focus on improving system protocols.

Debra Srebnik continued the conversation about results by revisiting the work the group had done in December. She listed the top three results that the committee had identified for children and adults for physical health and behavioral health.

Physical for children:

1. Doing things that make them happy, not using substances
2. Being able to participate in activities
3. Being Housed and have a home

Behavioral for children:

1. Not being distracted by negative things
2. Conflict management skills
3. Connected to community and families.

Physical for adults:

1. Doing things to be maintaining health, screenings.
2. Physically and financially able to participate in activities that are meaningful.
3. Longevity

Behavioral for adults:

1. Hopeful
2. Connected to communities

The committee discussed these four results categories to begin narrowing them down to a results statement that could apply to the work of the PBHI committee. Some expressed concerns about narrowing things down, but the committee decided to proceed and see what emerged.

As a result of the discussion, the committee proposed that across both children and adults, there seemed to be four general results buckets: home, meaningful activity, connection with a community and a healthy lifespan. It was noted that all of these need to be viewed/framed to be culturally responsive- otherwise it's unlikely we will achieve the results we hope for.

There was a brief discussion about considering a fifth bucket that could relate to being trauma-free and having emotional intelligence. It was then discussed that this element could be incorporated into one of the other buckets because these concepts are so much a part of recovery frameworks that builds on resilience.

Debra used this information to develop a proposed results statement for the IDC work:

Desired Result: *All people in King County are on a path for a healthy lifespan, and have a home, ability to contribute to meaningful activities, and connection to a culturally-relevant community.*

*** Notes:

- "On path for healthy lifespan" means having the health-promotion skills and resilience – with the ultimate goal that lifespan disparities are eliminated
- Initial focus is on Medicaid population, expanding to whole population over time
- And – all indicators need to be measured in a way that is culturally-relevant

She then took this statement and the four buckets and identified potential "indicators" that could be used to measure progress into the four areas:

Indicators – All people in King County…	Age	Data source
…have health and resiliency		
Not distracted by trauma, poverty, violence -ACES in adults (not available for children)	Child	BRFSS 2009-2011, expect asked again in 2017
-% below poverty level	Child	US Census
-child abuse/neglect- reports? Substantiated?	Child	CPS involvement
Not using alcohol/drugs In past 30 days… -binge alcohol use; any alcohol use -marijuana use; illicit drug use -tobacco use	Child Adult?	Healthy Youth Survey (HYS) – grades 6, 8, 10, 12
Conflict management/problem-solving skills -I know how to disagree w/o starting fight -When I have problems in school, I am good at finding ways to solve them	Child	HYS
Doing things to maintain health (screenings) -How long since you've been to routine checkup -Have a primary care provider Know what they need to be healthy (how to maintain)	Adult	BRFSS Data gap
Past 30 days – how often felt hopeless How satisfied with life; -How happy	Adult	BRFSS (satisfied/happy not every year)
Life expectancy	Adult	Death certificates (hard to split by BH issue/no issue)
…are able to contribute to meaningful activities		
How often has child's 'condition' affected ability to do things that other children do	Child	National Survey of Children – KC - adopt/modify for 2016
Meeting minutes of physical activity per guidelines…	Child	HYS
During the past 30 days, for about how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation?	Adult	BRFSS
…are connected to community & family		
-I have an adult to talk to -I feel I am getting along with parents/ guardians -When I'm not home, one of my parents knows where I am and who with -If I had a personal problem, I could ask my mom or dad for help. -My parents give me lots of chances to do fun things with them. -My parents ask me what I think before most family decisions affecting me are made.	Child	HYS
-How many people could you count on to come help you if you called for practical help, like someone to pick up groceries, talk to about a problem, or provide you or a household member with care? -How often do you and people in your community do favors for each other? -You can count on adults in your community to watch out that children are safe and don't get in trouble.	Adult	BRFSS – not asked every year
…have a home		
-# of homeless children/youth	Child Adult	OSPI and HMIS – may not be complete

Workplan

Following the discussion about results, the committee reviewed a proposed workplan. In general, it was agreed that it was a good approach to spend different meetings focused on different aspects of integration (e.g behavioral health in a primary care setting). A number of suggestions were made in the light of the discussions that preceded this agenda item including: having a separate session focused on chronic illness and behavioral health, adding the four buckets discussed during the results discussion, using the continuum framework, but understanding that this model may not apply to all, incorporating the use of standards to allow for flexibility (e.g. standard assessment with standard service array that allows flexible services within the array). The workplan will be revised and shared with the committee.

Updates

A few updates were provided to the group including legislation that would create the opportunity for regions to receive support from the state for being "mid-adopters". This would mean that instead of full integration happening in 2020, that full integration would happen sometime before then, likely 2017. King County has been involved in these discussions and will keep the committee updated about implications for the work of the IDC.

The committee also spent a few minutes discussing what was being submitted to the Health Care Authority for waiver toolkit ideas. King County was planning to submit one related to Familiar Faces and Physical and Behavioral Health Integration among others. The AIMS Center was involved in reviewing a number of proposals. The committee was interested in learning more at the next meeting.

The committee spent a few minutes discussing the topic and speakers for the February IDC meeting. The topic will be providing behavioral health in primary care settings and identified Tom Trompeter (HealthPoint), Stacy Fennell (Sea Mar), Roger Dowdy (Neighborcare), Suzanne Petersen (Children's Hospital), Darcy Jaffe (Harborview) and Anne Shields (UW AIMS Center) to prepare content for the meeting. Liz Arjun will schedule a speaker call to work on the details.

Logistics

The committee offered a couple of suggestions to help make future meetings more productive and accomplish the goal of the committee. They suggested have more Q&A time to allow for more conversation among the group and to change the meeting start time to 1:30 and dissolve the networking time so that there is an additional 30 minutes for content.

Proposed Working Definition of Integrated Care:

An integrated health care system is one that is able to meet the physical and behavioral health care needs of an individual ~~where their needs are addressed~~ in a holistic, culturally responsive fashion and where the individual is engaged in their care. In an integrated system, those providing care work as ~~part of~~ a team that is accountable to achieving ~~achieving improved~~ patient outcomes that the patient has helped to identify. The patient experience is one that is **simple and flexible** in meeting ~~to what the~~ a patient's needs when they need it because those involved in providing care ~~to meet these outcomes~~ are supported by a shared care plan, ~~case management that does not belong to one system~~, have an understanding of their roles in the system, care management does not belong to one system and financing ~~to support~~supports overall patient outcomes, not individual services.

Vision

When asked to articulate what would be different in 2020 if our region was providing integrated care, the Integration Design Committee identified the following common themes:

- Systems are sharing information
- Prevention is a higher priority
- Improved client outcomes are a shared community priority, not an agency or organization priority
- Access across systems is easier
- Population Outcomes are improving
- Payers are aligned in paying for outcomes

Proposed Working Vision:

By 2020, Medicaid enrollees in King County will experience improved health and social outcomes because:

- Beneficiaries are at the center of care planning;
- Beneficiaries are able to access the health and social service supports they need when they need them;
- Payers in the Region (including King County and the Washington State Health Care Authority) are aligned in how services are contracted and paid for;
- Payments are based on achieving improved health and social outcomes for clients allowing for the flexibility at the clinical level to address individual needs;
- Systems are sharing information with one another in order to support improving client outcomes.

King County Physical and Behavioral Health Integration Design Committee
Monday, December 21st 2015

RBA Results discussion facilitated by Nadine Chan and Debra Srebnik

What does this mean for people's lives?

- Get better quicker
- Reduced health disparities
- Happier with what they get because they are getting what they need

1. CHILDREN

A. PHYSICAL HEALTH

We want children who are…

Physically active (15)
- able to participate in meaningful activities (e.g. sports, engage socially with peers)

Not using alcohol or other drugs/substance (12)
Housed/have homes (10)

Not getting pregnant (7)
Feeling healthy (7)
Making good nutrition choices (5)
Doing things that will keep them healthy (e.g. screenings, dental, vision checks) (4)
Enjoying school and learning (1)
Not obese (0)
Fully immunized (0)

B. BEHAVIORAL HEALTH

We want children who are…

Not distracted by trauma, poverty, violence (14)
Have conflict management/resolution/problem solving skills (12)
Connected to community & families (11)
- Hopeful

Not being bullied (8)
Not under control of criminal justice/juvenile justice system (6)
Have resources to participate in activities (e.g. clothes for sports, $ to participate in activities) (4)
Connected to positive mentors (3)
Believe recovery is possible (3)

Not embarrassed by stigma from behavioral health issues (1)

Enjoying school & learning (0)
Not automatically diagnosed/referred to treatment

2. ADULTS

A. PHYSICAL HEALTH

We want adults & elders who are…

Doing things to maintain health (e.g. screenings, dental, vision, link to BH): (15)
Know what they need to be healthy (e.g. how to maintain): (14)
Living longer (driven by health disparities between those with BH issues & others) (10)

Believe recovery is possible (4)
Have planned pregnancies (4)
Not limited by chronic pain (3)
Feel healthy (2)
Not obese
Making good nutrition choices

B. BEHAVIORAL HEALTH

We want adults and elders who are:

Hopeful (14)
Connected to communities (10)
Physically and financially able to participate in activities that are meaningful (e.g. sports, social): (9)

Housed/have homes (8)
Good cognitive health (e.g. no Alzheimer's): (5)
Getting treatment instead of incarceration (4)
Feeling healthy (3)
Employed (3)
Not embarrassed by stigma & behavioral health issues (1)

3. POTENTIAL CROSS CUTTING ISSUES

- Housing
- Connections to family & community
- Hopefulness?

4. STORY BEHIND THE CURVE

- People with BH issues and/or ethnic minorities are more often incarcerated and often only getting treatment when incarcerated
- We also provide some services to people without Medicaid
- People have gaps in coverage
- Some people don't know what they need to be/become healthy
- Some people only seek out services when problems become acute (men more often?)

- People lack confidence that the system will provide what is needed

5. STRATEGY IDEAS

- Mental health screenings (e.g. depression) will be seen as vital signs – like blood pressure
- Need for single care plan approaches

6. PERFORMANCE MEASURES

- Reduced ER use
- Increase providers who are informed
- Increase navigation of system
- Increase high quality of care/standards
- Increase seamless care domains of health
- Increase person-centered approaches
- Increase feelings that systems are/will be responsive
- Increased happiness with what they get/getting what they need
- Timely approval
- Access to appointments
- Have stable coverage
- High quality services for both insured and uninsured
- Access to treatment for co-occurring disorders
- Accessing benefits
- Confidence in system
- Easy to enter & feels easy to access (perceptions)

7. Reflections & Reactions

- Living longer feels too distant (under adult priorities)
  - Proposed edit “healthy aging at all ages”
- Discussion that the majority of what was put on flipcharts reflect social determinants (80%)
  - Suggestion to look deeper into the referenced Harvard Study. Clinical access issues are still significant for Medicaid pop with BHI
- Surprised that having a home didn’t rise to the top for adults
  - Note that it did come in as # 4 but group should use this list over time to see how needs/ideas change over time.
- We need a better understanding of how these categories connect to health outcomes and are interrelated (e.g. children’s health interdependent with adults)
- This exercise forced us to choice between aspects of system.
  - Doesn’t this go against the goal of integrating? Uncomfortable to participate.
  - It reflects our starting point/current state is siloed
- Important to reflect on parallel processes and what other groups are having similar conversations/doing similar integration/transformation work (e.g. Accountable Communities of Health)

King County Physical and Behavioral Health Integration Design Committee
Discussion materials for meeting January 13, 2016

Summary of December 21, 2015 RBA Results discussion and Potential Indicators for consideration

Results for Children/Youth (# of votes in)	Possible Indicators	Data source
Physically active – defined as being able to participate in meaningful activities (e.g. sports, with peers) (15)	-How often has child's 'condition' affected ability to do things that other children do	Question is from National Survey of Children – KC could select this (or create item that doesn't specify 'condition') for its own child survey starting 2016
	-meeting min. of physical activity per guidelines…	Healthy Youth Survey grades 6, 8, 10, 12
Not distracted by trauma, poverty, violence (14)	-ACES in adults (not available for children)	BRFSS 2009-2011, expect asked again in 2017 but not asked regularly
	-% below poverty level	US Census
	-child abuse/neglect- reports? Substantiated?	CPS involvement
Not using alcohol or other drugs/substances (12)	In past 30 days… -binge alcohol use -any alcohol use -marijuana use -other illicit drug use -tobacco use	Healthy Youth Survey – grades 6, 8, 10, 12
Have conflict management/ resolution/problem solving skills (12)	-I know how to disagree w/o starting fight -When I have problems in school, I am good at finding ways to solve them	Healthy Youth Survey -grades 6, 8, 10, 12
Connected to community & families (11)	-I have an adult to talk to -I feel I am getting along with parents/ guardians -My parents ask if I've gotten homework done -When I am not at home, one of my parents knows where I am and who I am with. -If I had a personal problem, I could ask my mom or dad for help. -My parents give me lots of chances to do fun things with them. -My parents ask me what I think before most family decisions affecting me are made.	Healthy Youth Survey – grades 6, 8, 10, 12
Housed/have homes (10)	-# of homeless children/youth	OSPI and HMIS – may not be complete

Results for Adults/Older Adults (# of votes)	Possible Indicators	Data source
Doing things to maintain health (e.g. screenings, dental, vision) (15)	-How long since you've been to routine checkup -Have a primary care provider	BRFSS
Hopeful (14)	-Past 30 days – how often felt hopeless	BRFSS
	-How satisfied with life -How happy	BRFSS – not asked since 2010
Know what they need to be healthy (e.g. how to maintain) (14)	?	Data gap
Living longer (life expectancy disparity between those with and w/o BH issues are gone) (10)	Life expectancy	Death certificates (but difficult to split between those with/without behavioral health issues
Connected to communities (10)	-How many people could you count on to come help you if you called for practical help, like someone to pick up groceries, talk to about a problem, or provide you or a household member with care? -How often do you and people in your community do favors for each other? -You can count on adults in your community to watch out that children are safe and don't get in trouble.	BRFSS – not asked every year
Physically and financially able to participate in activities that are meaningful (e.g. sports, social) (9)	During the past 30 days, for about how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation?	BRFSS

Proposed Work Plan for Physical and Behavioral Health Integration Design Committee

DRAFT – For Discussion Purposes Only

Meeting Schedule	Topics/Discussion	Outcomes
January	Wrap-Up Retreat, Revise Charter per discussion. Develop and agree to workplan for 2016 Environmental scan of what is happening in the community and elsewhere in the country; TAC report with specific models	Clarity about vision Committee is pursuing and expected outcomes. 2016 Workplan
February	Integration in primary care settings: MHIP; SBIRT; other models? Invite speakers: UW AIMS; CHPW; CHCs (and ideally CHCs working with a CMHC too)	Committee gains better understanding of the models and how they operate; Strengths, challenges
April	Integration in primary care settings: Taking to scale What will it take?	Committee identifies what it would take to bring integrated BH into all primary care settings; what are the barriers; who are the key players; what else is needed
May	Specialty Behavioral Health What is the role? How does it connect with primary care setting – transitions and hand-offs	Committee defines the role of specialty behavioral health and how it connects to primary care settings; how do individuals flow back and forth; what types of coordination and communication are needed
June	Specialty Behavioral Health Bi-directional integration of primary care into community behavioral health Navos; ACRS; DESC; Kitsap; other models?	Committee gains better understanding of the models and how they operate; strengths, challenges
July	Integration in behavioral health care settings:	Committee identifies what it would take to

	Taking to scale What will it take?	bring primary care into behavioral health settings; what are the barriers; who are the key players; what else is needed
August	Multi-disciplinary Community Teams Other community services What other services and supports are needed to deliver integrated care that either sit outside of clinic walls or are payor blind?	Design of community health teams and other necessary services and supports; role of CHW/Peer Support Specialists
September	Initial Draft Report of Integrated Care Models Discuss Financing and explore role of the County- TAC report here?	
October	Finalize Draft Models and financing Final Meeting; Wrap Up	