



## King County

### Department of Community and Human Services

Jackie MacLean, Director

401 Fifth Avenue, Suite 500  
Seattle, WA 98104

(206) 263-9100 Fax (206) 296-5260  
TTY Relay 711

## IMPLEMENTATION PLAN

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

#### Activity 3.1 A: Behavioral Health Integration

---

#### 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 3.1 A, Behavioral Health Integration (non-veteran specific) 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*

The target populations for this levy investment have many complex and extensive needs in common, including periodic or long term homelessness, extreme poverty, mental illness, and abuse or addiction to drugs and alcohol. Both populations tend to be frequent users of King County safety net services, including both primary care and hospital emergency departments.

The Service Improvement Plan also sets aside funding for services to vulnerable individuals and families who are not generally eligible for publicly funded mental health services, but are experiencing difficult life circumstances. These circumstances include mental illnesses and/or other chronic health conditions, problems with drug use or addiction, periodic or long-term homelessness, poverty, domestic violence or other circumstances that create instability and health risk.

King County's community health centers, public health centers, and other core safety net clinics<sup>1</sup> served 138,108 low-income persons in 2011, including many homeless and high risk

---

<sup>1</sup> Demographics reported here include clients of Harborview Medical Center's Pioneer Square Clinic, but do not include clients served at Harborview's other primary care sites.

individuals and families. Of this total, 39 percent (n = 54,091) were uninsured. The majority of uninsured were between 35-59 years (47 percent of uninsured) or 19-34 years (38 percent). Of uninsured adults, 30 percent were Latino and 15 percent were Black / African American or East African.

- A 2006 report described the demographics of persons enrolled in the state-funded General Assistance-Unemployable (GA-U) program (now Apple Health):
  - GA-U eligibility is restricted to low income people who are physically and/or mentally incapacitated and unemployable for more than 90 days.
  - Many GA-U clients are part of the target populations: challenged by poverty, physical illness, mental health and substance abuse issues, and lack of housing.
  - King County is home to approximately 2,500 individuals who may be eligible for time-limited GA-U benefits.<sup>2</sup>
  - State data show that around 45 percent of this population has an identified mental health issue.<sup>3</sup>
- The health department's Health Care for the Homeless Network (HCHN) contracts with community agencies to improve access and provide services for homeless and formerly homeless people. Services are provided in shelters, day centers, supportive housing facilities, and health centers. In 2006, a total of 21,438 persons were served by HCHN contractors and public health centers.
  - Of this total, 57 percent of those served were people of color and 43 percent had no insurance coverage. Homeless people served were African American (23 percent), Hispanic or Latino (16 percent), Asian/Pacific Islander (7 percent), American Indian/Alaska Native (5 percent) or multiracial (5 percent).
  - Of all those served outside of primary care settings, 31 percent had at least one mental health diagnosis and/or chemical dependency diagnosis.

### **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>4</sup> Patients identified in a primary care setting as needing behavioral health services include those with emotional distress, mood disturbance, as well as

---

<sup>2</sup> Verbal communication with Betsy Jones, Community Health Plan consultant to GA-U Pilot, August 2007.

<sup>3</sup> Bennett, Amandalei. "GA-U Managed Care Pilot: Report to the Legislature." Health and Recovery Services Administration, Division of Program Support Office of Care Coordination. Washington State DSHS, January 2006.

<sup>4</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

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 mental health and chemical dependency services.<sup>5</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>6</sup>

*b) Populations to be Served*

Activity 3.1A focuses on high risk individuals and families experiencing difficult life circumstances including homelessness and other unstable housing situations, who are at risk of mental illness, substance abuse, and associated health problems.

*c) Promotion of Equity and Social Justice*

Activity 3.1A 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 low income, high-risk individuals and families; people of color and people with limited English proficiency are more likely to be classified as low income. 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>7</sup> Activity funds are also used to support

---

<sup>5</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>6</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>7</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

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 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 Community Health Plan of Washington (CHP), Harborview Medical Center, and Valley Cities Counseling and Consultation to implement Activity 3.1A. CHP subcontracts with safety net clinics and the University of Washington, Department of Psychiatry to provide services for Activity 3.1A.

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.

**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>Human Services Levy</b>	\$625,000	\$625,000	\$625,000	\$625,000	\$625,000	\$625,000
<b>Total</b>	\$625,000	\$625,000	\$625,000	\$625,000	\$625,000	\$625,000

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

Activity 3.1A 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>8,9,10</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 3.1A has demonstrated very positive outcomes, including depression and/or anxiety improvement for 55% of clients in treatment.

**8. Service Partnerships**

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

---

<sup>8</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>9</sup> Simon G. Collaborative care for depression. BMJ. 2006;332:249-250

<sup>10</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.

## 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>	<ul style="list-style-type: none"> <li>Number of persons screened</li> </ul>	4,198	5,000	Report Card – Services
<b>Treatment/ Intervention</b>	<ul style="list-style-type: none"> <li>Total Number of all clients receiving treatment</li> </ul>	3,248	4,000	Report Card – Services
	<ul style="list-style-type: none"> <li>Number of clients who are have reduced depression or anxiety scale</li> </ul>	55%	45%	Report Card - Outcomes

Participating agencies must also achieve five 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 25% of contracted funds contingent on achieving the five 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 2014, contractors were 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.
5. Providers will achieve a care plan goal for 10% of active L1 caseload.