Physical and Behavioral Health Integration
Design Committee

May 11, 2016; 1:30 PM – 4:00 PM

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

Meeting Goals:

- **Agree on a workplan and structure that addresses the priorities identified by the IDC in April;**
- **Begin mapping the behavioral health system;**
- **Begin learning about key elements to provide physical health care services in behavioral health setting**

Agenda

1. **Welcome & Introductions** 1:30 – 1:40 pm
   Liz Arjun , King County
2. **A Workplan that Meets our Priorities** 1:40 – 2:45 pm
   Jennifer Martin, Facilitator
3. **Understanding the Behavioral Health Ecosystem** 2:45 – 3:15 pm
   Susan McLaughlin, King County
4. **Clarifying Q&As** 3:15 – 3:30 pm
   Jennifer Martin, Facilitator
5. **Behavioral Health Settings Providing Primary Care** 3:30 – 3:50 pm
   Paul Tegenfeldt, Navos
6. **Final Thoughts/Next Steps** 3:50 – 4:00 pm
   Liz Arjun, King County

****NAVOS has generously offered to tour IDC members around their integrated clinic immediately following the meeting*

Next Meeting: June 8; 8:30 AM – 5:00 PM
Mercer Island Community Center
8236 SE 24th Street, Mercer Island, WA 98040

Physical and Behavioral Health Integration Design Committee

Proposed Approach and Work Plan

May 11, 2016

As discussed at our April 29 IDC meeting, we have a very short timeframe to make recommendations to King County leadership regarding a meaningful path forward to full integration for the region. Among the recommendations that the IDC will be making are:

- Recommendations about the optimal clinical model(s) of integrated care for the King County region;
- Recommendations about the optimal financial infrastructure to support this/these clinical delivery model(s), including the optimal role of King County government; and
- Recommendations about the optimal timeline for implementation of full integration in the region based on community readiness
- Recommendations regarding new payment structures and value based purchasing strategies for providers

What is needed to get to a recommendation in each area?

Following interviews with individual members of the IDC and a prioritizing exercise at the April IDC meeting, members have identified the following items as key information or decisions needed to complete their recommendations:

Clinical model(s):

- We need to move up a couple levels in our model discussion to "continuum of care" discussions
- Develop mock up ideal structure for continuum of care that this committee adopts
- Identify higher level care model, then ask where are the gaps
- Evidence based models of care
- Design the ideal clinical model
- Further define outcomes: develop a core definition of health and wellness

Financial infrastructure and optimal role of King County:

- Research on various financial infrastructure models
- Greater understanding of SW Washington Model – what is the model; lessons learned
- Look at financial models and implications –risks/benefits
- Mapping of current systems and responsibilities – MCOs and BHOs
- Who would be responsible for what parts of the system in "full integration" including crisis services

Timeline for implementing:

- Decide 2018 or 2020 or some other timeline based on community readiness

Finance and Payment:

- Examples of value based purchasing models from other places
- How to set up a financial payment structure and incentives to support goals/outcomes
- Understand impact of waiver

Approach to the Work

In order to accelerate the work of the IDC and meet the timeline of having recommendations ready by early fall, members of the IDC Steering Committee propose that the IDC work through a combination of monthly meetings of the IDC, two all-day work sessions of the IDC and establishing workgroups to work in between IDC meetings.

The IDC established four workgroups in the following areas at the May 11th meeting:

1. Clinical design – children/adolescents
2. Clinical design – adults
3. Clinical design – hard to serve/non-traditional populations such as homeless
4. Financial infrastructure

Meeting Structures and Schedule

Currently, the IDC has monthly meetings scheduled from May through October 2016. The Steering Committee is proposing that those meetings get used according to the work plan below. The meeting structure includes two all-day work sessions – one in June and one in September. It is also expected that the identified work groups would meet regularly in between IDC meetings to complete tasks.

	May	June	July	August	September	October
IDC Meetings	**May 11 (regular meeting)**	**June 8 (all day work session)**	**July 13 (regular meeting)**	**August 10 (regular meeting)**	**September 14 (all day work session)**	**October 12 (regular meeting)**
Overall Project Management/ Administrative	Agree and Finalize Workplan	Review IDC vision, outcomes, integrated care definition, and continuum of clients (and our focus within that).			Review outcomes, vision, and definition of "integrated care"	
	Identify workgroups, leaders and assign responsibilities				Review information from workgroups about pros/cons on infrastructure models	
					Review lessons learned so far	
					Review outside/political factors	
					Staff drafts report with key recommendations (September-October)	
						IDC reviews and finalizes report
Education/ Current System Mapping	Begin mapping Behavioral Health	Complete mapping the Behavioral Health System	Anything identified from the June meeting the IDC needs more information about			
	Begin learning about primary care models in behavioral health setting	Complete learning about the Behavioral Health System	Lessons learned from SW Washington			
		Learn about the crisis system				
		Review contractual requirements for MCOs and BHOs in current systems – mapping what is where today	Lessons learned from BHO implementation			

Clinical Model	**Workgroups** focused on Children, Adults and non-traditional settings meet to clarify the common elements, common challenges and common standards important to best serve the population	**Workgroups** meet to determine the best clinical model(s) necessary to achieve outcomes for their specific population and the pros and cons of potential finance infrastructure models to support the clinical models (between June retreat and July meeting).		**Workgroups** present recommendations about clinical models to best serve the populations to full IDC.	**IDC Determines** which clinical model(s) are most likely to achieve goals of integration including outcomes, do these models meet the full continuum of needs including crisis services	
Infrastructure Model		**IDC reviews** Technical Assistance Collaborative Report models and associated examples; explore pros and cons	**Workgroups** continue to meet, focus on making sure that the full continuum of services is addressed, make recommendation about what infrastructure models best support it.	**Workgroups** make recommendation to full committee about infrastructure most likely to support the clinical models identified and that support the continuum of services	**IDC** determines which infrastructure model is most likely to support the clinical models and allow for clients to move up and down the continuum of services easily	
		Compare what we've learned about our current system, what we want the future system to look like and narrow to those infrastructure models we think are most likely to support the vision of integrated care that will result in the agreed upon outcomes. Identify what else we need to do, know about these models				
Timing					**IDC** determines best timeline for implementation	

King County Behavioral Health System Overview

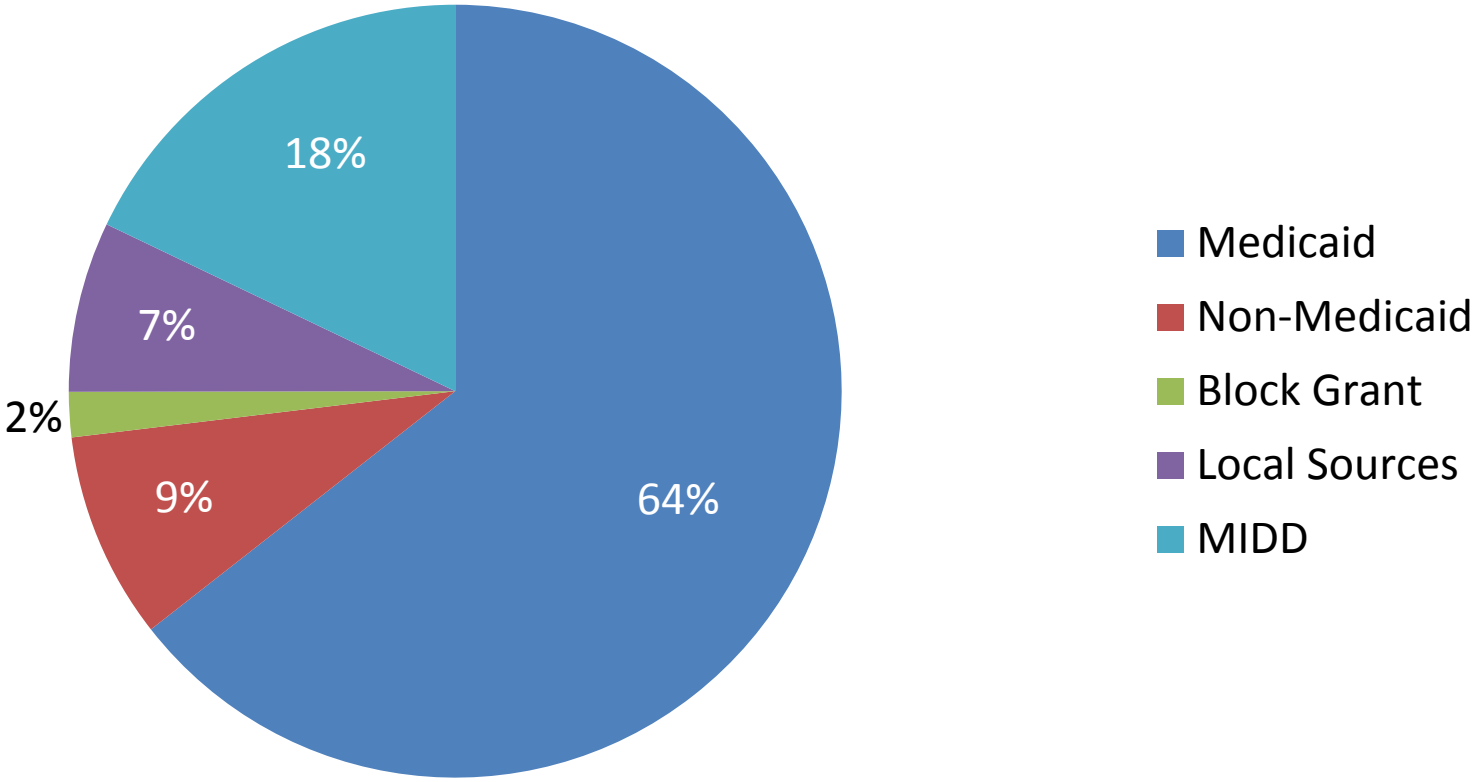
Physical and Behavioral Health Integration Design Committee

May 11, 2016

What do we do?

- Crisis response for ALL persons in King County regardless of payer
- Inpatient and outpatient MH and SUD services for all Medicaid eligible individuals who are residents of King County and who meet state determined access to care
- Many other behavioral health and recovery services depending on funding
- Invest in behavioral health infrastructure through planning and capital

Total BH Revenue Sources



BHO Revenue

- **Medicaid:** largest funder; Medicaid regulations drive the system; can only be expended for persons covered by Medicaid and for Medicaid approved services

- **State (non-Medicaid):** most flexible funding; has been decreased every year due to state budget; pays for required services not covered by Medicaid

- **Federal Block Grant:** different rules for MH and SUD block grants; can only be expended for certain approved services

- **Local Funding Sources:** (sales tax; VHSL; millage; grants) most flexible funding; controlled locally; used to fill gaps in continuum, cover services not allowed under Medicaid, and cover persons not covered by Medicaid

Guiding PRINCIPLES

- Recovery and Resiliency
- Person-centered and Tailored care
- Culturally Responsive
- Collaborative and Coordinated

The Medicaid Behavioral Health Plan

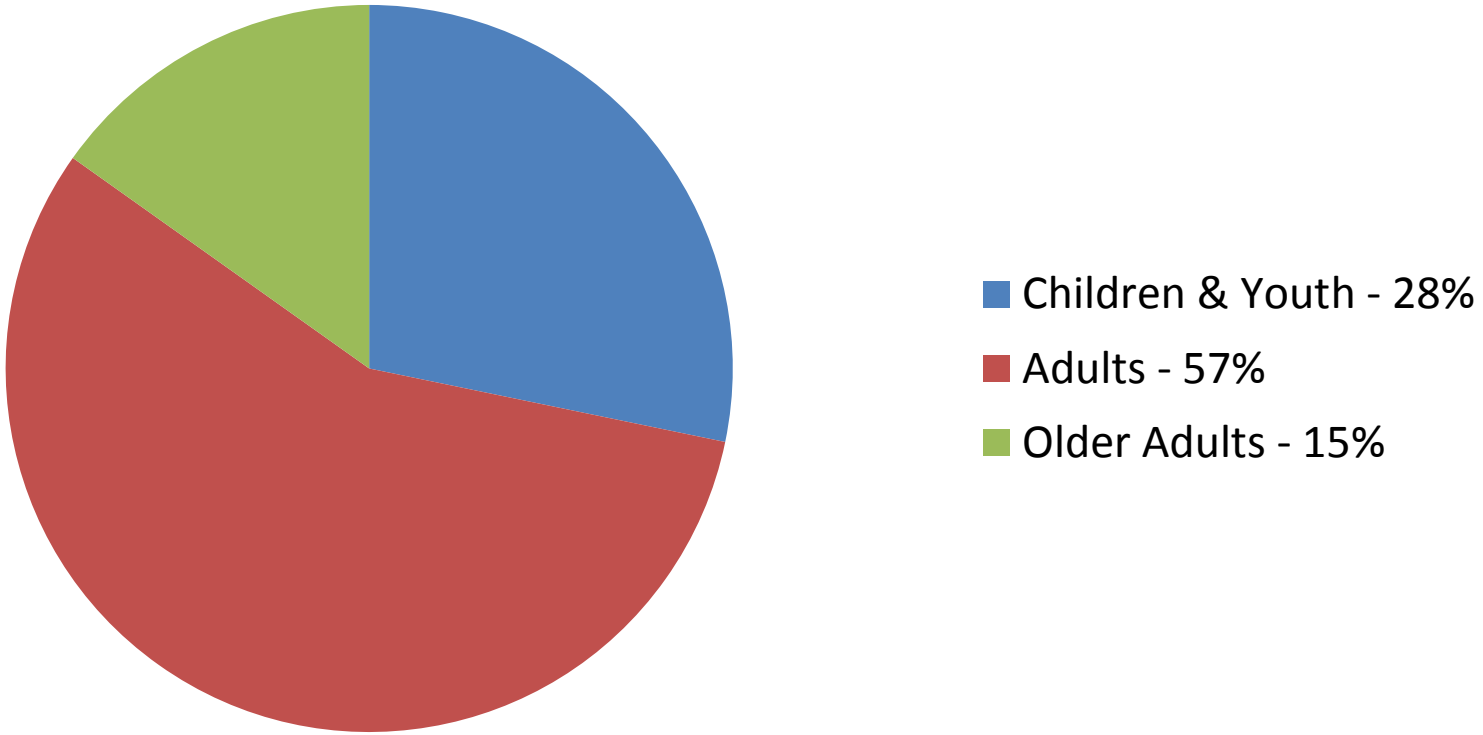
- BHRD operates the BHO for the King County region
- Receive an integrated (MH and SUD) capitated payment for all Medicaid eligible individuals (approximately 420,000)
- Provide range of required Medicaid services – based on state plan

The Medicaid Behavioral Health Plan

- State determined access to care (medical necessity)
  - MH: based on the presence of a qualifying diagnosis and impairment in functioning as a result of a mental illness
  - SUD: based on the presence of a qualifying diagnosis and level of need from ASAM dimension criteria

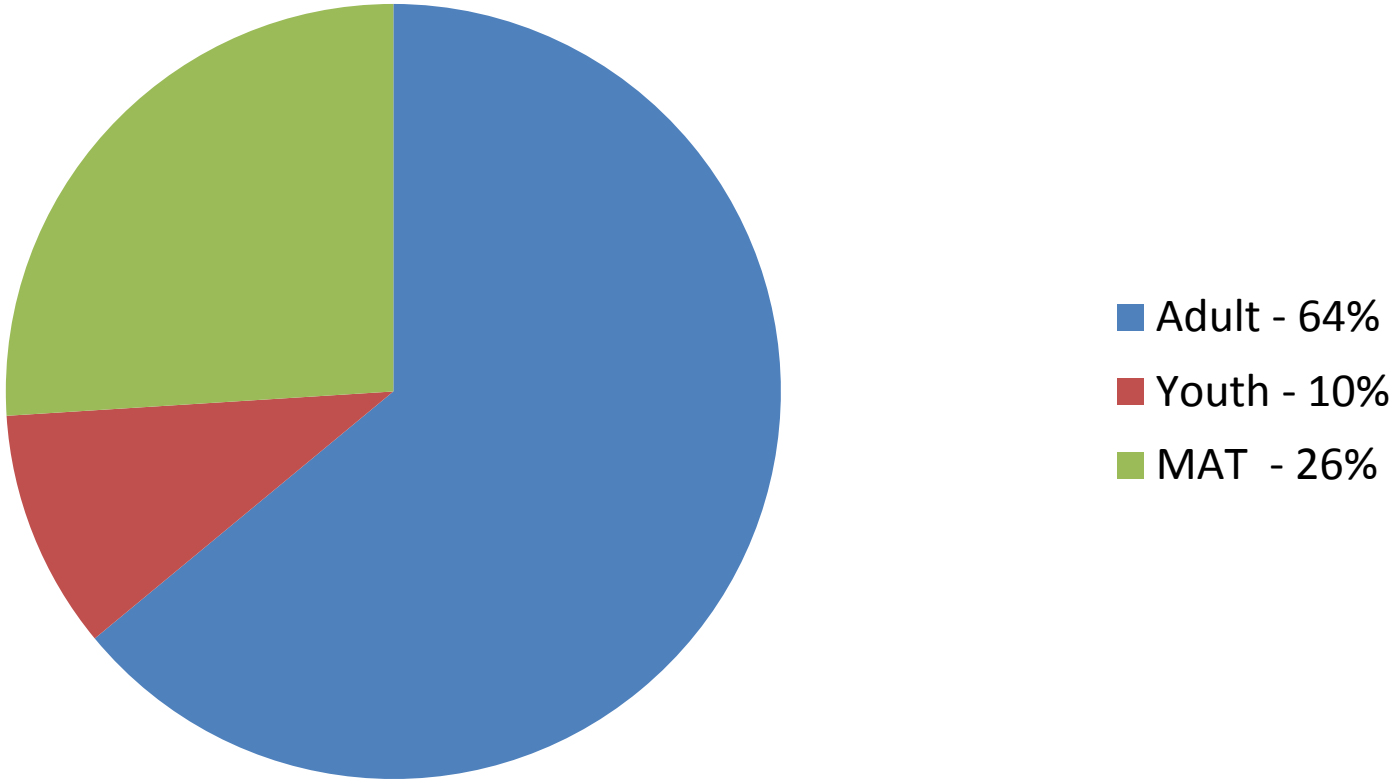
King County Mental Health Provider Network

20 Provider Agencies, 24 subcontracted Agencies – 49,100 people served in 2015

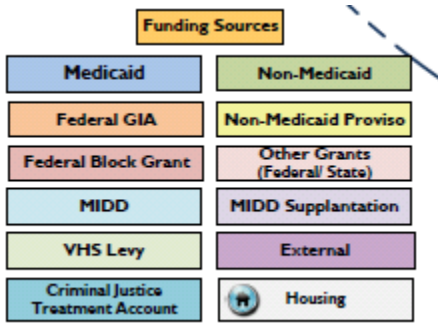


King County Substance Use Provider Network

31 Contracted Provider Agencies
11, 646 clients served in 2015



Behavioral Health Continuum



- Crisis Clinic Screening
- Crisis & commitment services DMHP
- Mobile Crisis Team
- Next Day Appointment & Stabilization
- Detox
- Emergency Services Patrol
- Substance Abuse Involuntary Treatment
- Crisis Respite Program (shelter & stabilization)
- Crisis Diversion Bed (shelter & Stabilization)
- Sobering
- Community Hospital Emergency Dept
- Crisis Solutions Center
- Opiate Treatment Services
- Outpatient BH Services
- Western State Hospital
- Permanent Supportive Housing
- Medical respite
- SUD Residential Services
- Supervised Living (IMD)
- Long Term Residential (IMD)
- Expanded Community Service
- Program of Assertive Community Treatment (PACT)
- Supported Employment
- Clubhouse
- Standard Supportive Housing
- Recovery Cafe
- Support Groups

Continuum of services from crisis to stability