Physical and Behavioral Health Integration
Design Committee June Work Session

June 8, 2016; 8:30 a.m. - 5:00 p.m. (Happy Hour from 5-6 p.m.)

Meeting Goals:

- **Review and confirm our shared vision and definition of integration; clarify key outcomes, principles and scope for an integrated care model**
- **Review the overall timeline and workplan leading to recommendations by October 2016**
- **Complete educational presentations (including primary care in a behavioral health setting, current crisis system, mapping of the current physical health system)**
- **Explore core elements and aspirations for an integrated clinical model**
- **Review potential infrastructure model options**

Agenda

Welcome + Introductions 8:30-8:50 a.m. (20)
Liz Arjun, King County

Grounding the Work 8:50-10 a.m. (70)
Jen Martin, Facilitator & Liz Arjun, King County *Includes break*

- Agenda review, shared agreements and logistics
- Review and confirm our shared vision and definition of integration
- Clarify key outcomes for an integrated care model
- Review King County Principles
- Clarify scope for integrated care model (continuum from crisis to stability)
- Review overall timeline and workplan – review the workplan handout

Education Presentations (Clinical Models) 10 a.m.–Noon (120)
Includes 15-min break

- Physical Health in Behavioral Health Setting (cont.)
  - *Graydon Andrus, DESC & Nancy Sugg, Harborview (15 min)*
  - *Sonia Handforth-Kome, Valley Cities (15 min)*
- Discussion/Identify Key Themes – *Jen Martin (15 min)*
- Overview of Current Crisis System – *Maria Yang, MD, King County (45 min., including questions/discussion)*

LUNCH + Review and Discuss Integrated Care Model Core Elements 12-12:45 p.m. (45)

BREAK 12:45-1 p.m. (15)

Workgroup Sharing: Aspirational Ideas (Clinical Models) 1-1:45 p.m. (45)

- Each clinical workgroup reports out on 2-3 aspirational ideas for an integrated healthcare model and the key barriers or gaps that need to be addressed to make these ideas work.
- Given what we learned today about the crisis system, what are the implications for our recommendations?
- Overlap, patterns and questions – *Jen Martin, Facilitator*

Reviewing Current Infrastructure Model & Impacts on Clinical Delivery 1:45-3:45 p.m. (120)
Includes 15-min break

- Overview of current payment and contract requirements for MCOs and BHOs
  - *Karen Spoelman, King County Behavioral Health Organization*
  - *Torri Canda, Amerigroup & Erin Hafer, CHPW*
- How does the current infrastructure model impact the ability to provide integrated care at the service delivery level?
  - *Darcy Jaffe, Harborview*
  - *Ken Taylor, Valley Cities*
  - *Tom Trompeter, HealthPoint*

Introducing Potential Infrastructure Models 3:45-4:30 p.m. (45)

- Overview of potential infrastructure models – *Susan Mclaughlin*

Wrap Up/Next Steps 4:30-5 p.m. (30)

- Identify deliverables needed from clinical and infrastructure workgroups for July and August meetings
- What additional information is needed as we design recommendations?

Happy Hour: Endolyne Joe's Restaurant 5-6 p.m. (60)

KING COUNTY PHYSICAL AND BEHAVIORAL HEALTH INTEGRATION DESIGN COMMITTEE

June Work Session

June 8, 2016

Bethaday Community Learning Space

GROUNDING THE WORK

Jen Martin, Facilitator & Liz Arjun, King County

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, are engaged and activated;
- Beneficiaries are able to access the health and social service supports they need when they need them;
- Payments are based on achieving improved health and social outcomes for beneficiaries because we are paying for value rather than volume that allows for the flexibility at the clinical level to address individual needs;
- Payers in the Region (including King County and the Washington State Health Care Authority) are aligned in how services are contracted and paid for;
- Systems share information seamlessly with one another in order to minimize complexity for the beneficiary

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 in a holistic, culturally responsive fashion where the individual is engaged in their care. In this system, care management does not belong to one system and financing supports overall patient outcomes, not individual services. In an integrated system, those providing care work as a team that is accountable to achieving patient outcomes that the patient has helped to identify. The patient experience is one that is **simple and flexible** in meeting a patient's needs when they need it. Those involved in providing care are supported by a shared care plan, shared data and have an understanding of their respective roles in the system.

Results/Outcomes

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.

More Specifically:

- Are healthy and resilient
- Are able to contribute to meaningful activities
- Are connected to community & family
- Have a home

Scope

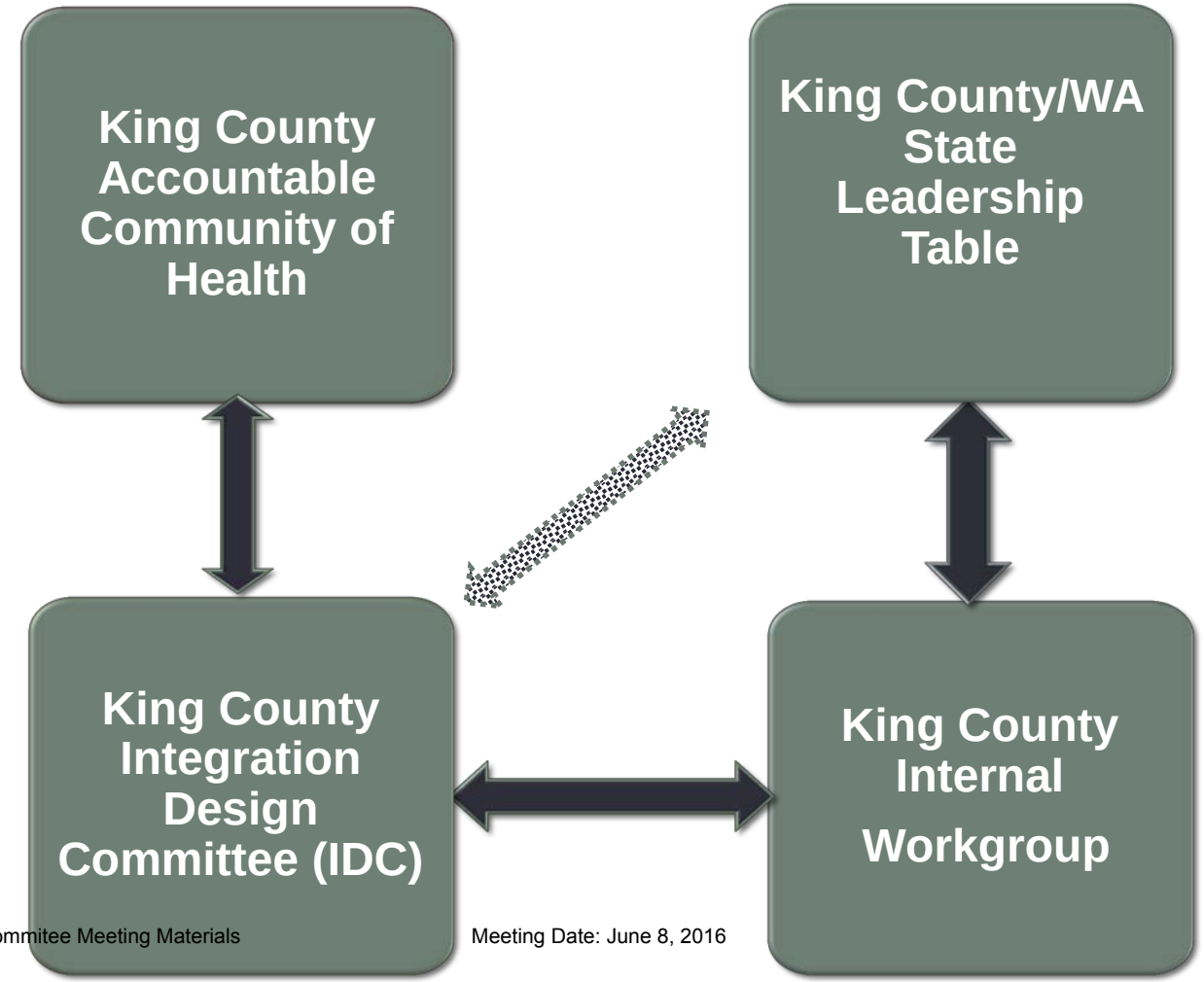
The Physical and Behavioral Health Integration Design Committee (IDC) will be responsible for developing a vision for a regional model of fully integrated physical and behavioral health for both children and adults. While **the initial focus** of the ESSB 6312 legislation is the population that receives care **via Medicaid funding**, the design work of this subcommittee **will inform the delivery of integrated care for populations beyond those eligible for Medicaid.**

Scope (cont.)

Includes:

- Identifying core components of integrated care,
- Distinguishing whether those components should be community-based, accessible to all and payer-blind,
- Ensuring the whole health needs of an individual are met regardless of where they seek services and what the level of those needs are,
- Ensuring that the model can be modified to address meeting the needs of individuals who identify from varying cultures and backgrounds,
- Analyzing and making recommendations for integrating financial processes,
- Providing a timeline and key milestones for implementation in the King County region

King County Principles



DESC/HMC Collaboration

Primary care clinics co-located in downtown Seattle mental health clinic
Second integration site in emergency shelter coming soon

- DESC
- Harborview Medical Center (HMC)
- Initial co-location project SAMHSA funded

DESC serves high need urban population including high percentage of individuals

- Experiencing homelessness, including chronic homelessness and housing instability
- Severe mental illness prevalent
- With co-occurring substance use issues – majority of individuals served
- High incidence of involvement with criminal justice

DESC

- Mission & History
- Beliefs & Values
- Scope of Services
- High level of integration across programs

desc
opening doors to end homelessness

Harborview Medical Center

- Established in 1877
- Owned by King County, managed by UW
- Mission
- Regional Trauma Center
- Specialty and subspecialty care
- Academic teaching center

UW Medicine

HARBORVIEW MEDICAL CENTER

Integration Team

- Advanced Registered Nurse Practitioner (ARNP): Provide primary and preventive care

- Medical Assistant: Register patients and check in patients, blood draws, immunizations

- Pre-existing staff:
Behavioral Health Case Managers, Psychiatric Nurses, Psychiatric Providers, Chemical Dependency Counselors, Peers, Drop-in center staff, Supported Employment, Shelter & Housing staff

Integration Goals

- Engage patients in medical care
  - Prompt response to acute health issues
  - Assist patients in engaging with already established outside primary care provider
  - Act as bridge to primary care for clients new to area
  - Primary care provider for patients who will only accept care at Mental Health Center
  - Fully blend primary health concerns within behavioral health services and treatment plans

Integration Goals

- Team approach to health care
  - Shared problem list with clear collaboration on all health issues
  - Primary and behavioral medication reconciliation
  - Consistent messaging and education on disease management
  - Educate behavioral health staff on key diagnoses, symptoms & treatment approaches
- Patient satisfaction
  - Build on trust already established at mental health center
  - Support provided to help manage chronic disease
  - Team aware and supportive of patient's self-management goals

Integration Goals

- Reduce Emergency Department visits
- Improve transitions of care from inpatient hospitalization

Challenges of Integration

Client level

□ Chaos of homelessness and trauma

□ Prevention difficult when “putting out fires”

□ Avoid disrupting already established primary care

□ Determining right amount of outreach based care vs site based care

□ Reluctance, distrust, ambivalence of participants

Challenges of Integration

Team level

- Change is hard for everyone
- Case managers often so over burdened that adding medical care to their plate is challenging
- Team members having to expand their role (ie psychiatric nurses taking on diabetes)
- Finding the right fit for team members: ie; a psychiatric nurse with medical experience or vice versa

Challenges of Integration

Agency Level

- Electronic health records, data sharing is difficult and documentation redundant.
- Expense of small clinics: well equipped clinics expensive, minimally equipped clinics can not fully integrate care
- Shifting job description/priorities of behavioral health staff

Challenges of Integration

- MCO preferred provider list
- Poor re-imbursement for primary care
- Challenges of remaining HIPPA compliant
- Lack of shared EHR – high priority for change

Gaps in Integration

- Lack of access to dental and vision
- Transitions of Care: Ability of hospitals and EDs to know who the patient's health care team is
- Integration of primary care to isolated housed individuals and homeless not accessing drop-in center
- Remaining patient centered: Patient's agenda may not include getting their A1C down

Gaps in Integration

- Care for patients not eligible for ACA or other funding
- Affordable housing

Valley Cities
Behavioral Health Care

Primary Care Integration at Valley Cities

Sonia Handforth-Kome
Chief of Operations - Outpatient

June 8, 2016

Model Description

- **Primary Care provider and MA provides services in Valley Cities sites:**
  - With HealthPoint in Auburn and Kent (Renton and Enumclaw coming soon)
  - With Public Health in Enumclaw

Valley|Cities Behavioral Health Care

Model Description, Cont.

- **Primary Care providers and BH providers co-located in same building**
  - With HealthPoint at Midway
  - With NeighborCare and Public Health at Northgate

Model Description, Cont.

- **BH providers contracted to provide services in Primary Care settings:**

  - Consultation through the MHIP program at:

    Healthpoint in Federal Way, Seatac, Bothell, Redmond, Mobile Medical Van; for Public Health in Eastgate, Downtown Seattle; for the Seattle Indian Health Board.

  - Direct in-person consultation at:

    Healthpoint in Federal Way, Renton, Seatac, Tukwila, Bothell, Redmond; Neighborcare in Rainier Beach, Columbia City, and soon Pike Place Market

Valley|Cities Behavioral Health Care

Model Description
PCP in BH Setting

- PCP & MA in Kent 2 days/wk, Auburn 3 days/wk
- VC front desk schedules appointments and checks in clients
- HealthPoint call center also schedules appts
- BH clinical teams support clients going to appointments
- PCP attends BH case consults
- Charting and billing is separate

Model Description
BH Co-Located with PCP

- Medical/dental providers consult ad hoc with BH clinicians re: client issues.
  - BH provides crisis response. Patients are not necessarily BH clients.
  - BH providers consult ad hoc with PCP re: client medical issues. Clients are not necessarily PCP patients.
- Medical/dental providers ask BH clinicians to attend clients during Med/dent appointments
- Medical/dental providers provided face-to-face “warm introductions”
- Medical and BH clinicians attend each others’ team meetings monthly, staff cases together
- Charting and billing is separate

Valley|Cities Behavioral Health Care

Model Description
BH Contracted

- In Eastgate, BH clinician provides care coordination and individual counseling to clients; charts in EPIC, paid by contract
- In all contacts, psych providers (ARNP and Psychiatrists) provide consultation to medical clinicians, and some individual medication management and psych evaluations services to clients. Charting is done in PCP EHR, provider is paid by contract; PCP bills for client services

Expected Results

- More clients connected with and active with preventive and primary care medical and dental services
- Healthier clients
- Better information sharing
- Better understanding of systems and how to link them
- Lower cost to system

Valley|Cities Behavioral Health Care

Barriers

- Partner Agencies operate in more than one county
- Partner Agencies bill fee-for-service
- Partner Agencies do not carry the same insurance contracts that Valley Cities carries, and vice versa
- Valley Cities model of care does not translate to fee-for-service or non-Medicaid service expectations
- Disparate information systems – hard to data share
- 42 CFR

Valley|Cities Behavioral Health Care

Barriers, Cont.

- Critical shortage of data from external systems makes tracking outcomes problematic
  - Emergency Room visits for any reason
  - Hospitalizations for any reason
  - Incarcerations
  - Medical/Dental Office Visits, plans, goals
- Difficulty identifying mutual clients
- Difficulty in obtaining benchmark data (how are we doing compared to other organizations in system?)

Barriers, Cont.

- Difficulty sharing client information “real-time” – ie, co-charting, sharing treatment plans
- Scheduling expectations differ between systems
- Language and approach of issues with clients (organization culture differences)
- Our staff are not well versed on medical issues

Valley|Cities Behavioral Health Care

Actual Results (Gaps)

According to AmeriGroup's Utilization Data on Valley Cities Clients:

HEDIS - Physical Health	HEDIS 2015 Goal	VC *Baseline	NC ** Baseline	HP ǂBaseline
Adults Access to Preventive/Ambulatory Health Services; AAP 20-44y	85%	88% (226/258)	100% (4/4)	90% (37/41)
Adults Access to Preventive/Ambulatory Health Services; AAP 44-64y	90%	93% (142/153)	100% (3/3)	93% (28/30)
Adult BMI Assessment; ABA	90%	46% (82/180)	50% (1/2)	78% (21/27)
Adolescent Well-Care Visit; AWC	60%	45% (15/33)	0% (0/0)	67% (2/3)
Breast Cancer Screening; BCS	66%	61% (11/18)	0% (0/0)	67% (2/3)
Cervical Cancer Screening; CCS	68%	38% (95/252)	67% (2/3)	56% (22/39)
High Blood Pressure Control; CBP	65%	0% (0/43)	0% (0/2)	0% (0/4)
Diabetes A1c Control , CDC A1c >9, Lower is better	35%	6% (3/47)	0% (0/1)	50% (3/6)
Comprehensive Diabetes Care, CDC-Eye Test	63%	49% (23/47)	100% (1/1)	667% (4/6)
Comprehensive Diabetes Care, CDC-Neph	85%	98% (43/47)	0% (0/1)	100% (6/6)
Chlamydia Screening in Women; CHL	62%	54% (14/26)	0% (0/1)	0% (3/3)
Frequency of Ongoing Prenatal Care; 81%+	70%	0% (0/5)	0% (0/0)	0% (0/0)
Imaging Studies for Low Back Pain; LBP	78%	20% (3/15)	0% (0/0)	0% (0/2)
Pharmacotherapy Management of COPD Exacerbation; PCE, Systemic Corticosteroid	75%	100% (4/4)	0% (0/0)	100% (1/1)
Pharmacotherapy Management of COPD Exacerbation; PCE, Bronchodilator	87%	100% (4/4)	0% (0/0)	100% (1/1)

Actual Results (Gaps)

According to AmeriGroup's Utilization Data on Valley Cities Clients:

	Valley Cities (n=74) *
Proposed Utilization Measures	Baseline
Mental Health Outpatient Professional Utilization	
Mental Health Inpatient Hospitalization	
Physical Health IP Hospitalization	5 (6.76%)
Physical Health IP Readmissions	1 (1.35%)
Emergency Department Utilization	2 (2.70%)

Actual Results (Gaps)

- Difficult to keep PCP schedule attended to expected level
- PCP occasionally frightened of our clients
- PCP financial goals not being met due to contract conflicts
- Clients report they like the services
- Clients report that the services they receive help

Valley|Cities Behavioral Health Care

Thank You

Question / Comments?

Sonia Handforth-Kome, COO
shandforth-kome@valleycities.org

Valley|Cities
Behavioral Health Care

Overview of the Behavioral Health Crisis System

Maria Yang, MD

King County PBHI Retreat

8 June 2016

Agenda

1. Brief definitions
2. Crisis services for unenrolled clients
3. Crisis services for enrolled clients
4. Opportunities for improvement
5. Populations that are left out

King County Integration Design Committee

Medicaid Managed Care

Partners in Community Health

June 8, 2016

Presented jointly by Amerigroup, Community Health Plan of Washington, Coordinated Care, Molina Healthcare of Washington and UnitedHealthcare

What is Medicaid Managed Care?

- Managed Care is a health care delivery system organized to manage cost, utilization, and clinical and service quality.
- Medicaid managed care provides for the delivery of Medicaid health benefits and additional services through contracted arrangements between state Medicaid agencies and managed care organizations (MCOs), such as health plans and behavioral health organizations (BHOs), that accept a set per member per month (capitation) payment for these services.
- By contracting with MCOs, states can reduce Medicaid costs and better manage utilization of health services.
- MCO contracts with the State Medicaid Agency are profit-limited contracts.
- MCOs strive to reinvest cost savings through shared savings programs and provider partnerships.
- Improvement in health plan performance, health care quality, and outcomes are key objectives of Medicaid managed care.

Medicaid Managed Care in Washington

- Health Care Authority is the single state Medicaid agency in Washington, which means it holds the authority and receives payment from the federal government for Medicaid.
- HCA and DSHS have agreements in place that places management and oversight of most behavioral health programs within DSHS
- Since 1987, Washington has utilized managed care for physical health coverage (through 1932a) – originally “Healthy Options” and now “Apple Health”
- Since 1993, the state has operated its mental health Medicaid benefit via a 1915b waiver - through the RSNs (now BHOs)
- Both authorities require enrollment in managed care

Medicaid Managed Care in Washington Today

- 1.8 million Washingtonians enrolled in Apple Health (Medicaid) and approximately 92% are enrolled in managed care and growing
- The five health plans are Amerigroup, Community Health Plan of Washington, Coordinated Care, Molina Healthcare of Washington and UnitedHealthcare
- In 2016, Washington is transitioning from a county by county basis for managed care contracts to a regional managed care approach to better align across the care continuum (shared regions for Physical Health and Behavioral Health (BHOs))
- 5 Medicaid Managed Care Plans are contracted with the state to deliver physical health and mild to moderate mental health services
- In SW Washington, Fully Integrated Managed Care (FIMC) went live on 4-1-2016, with the full continuum of physical and behavioral health services within one contract. CHPW and Molina are the 2 FIMC plans in SW.

Role of MCOs in Washington

- MCOs provide coordinated care through a defined network of health care systems and providers.
- MCO role goes far beyond paying claims and approving or denying authorization for services...MCOs invest significant time and resources to:
  - Facilitate Care Management, Health Promotion, & Wellness
  - Assure Clinical and Service Quality
  - Build Provider Networks
  - Engage & Partner with Communities
  - Leverage Data and Technology
  - Monitor & Maintain Compliance
  - Maintain Program Integrity

Care Management

- **Health Homes:** comprehensive community based care management program
- **Complex Case Management:** members actively involved in health goals and increased self management for improved health outcomes
- **Care Coordination:** assisting members in navigating the health care system including referrals, community resources, coordination, and education
- **Transitional Case Management:** care coordination so members in acute care facilities and at risk for readmission
- **Disease Management:** targets major disease classifications such as obesity, asthma, diabetes, COPD
- **Utilization Management:** authorizations, inpatient and admission reviews, transitional care

Pursuit of Quality

- All plans are NCQA certified and responsible for reporting on HEDIS and CAHPS measures
- Among other things NCQA demands attention to
  - "Quality of Care" and the "Quality of Service"
  - Safety
  - Cultural and Linguistic appropriateness and addressing health disparities
- Quality and Health Promotion Activities:

  Provider: pay for performance, trainings, collaboration

  Member: phone, mail, email, txt, newsletters, brochures

  Community: outreach and education activities
- Performance Improvement Projects:
  - Contract language requiring the MCOs to pilot one clinical Performance Improvement Project (PIP), which involves piloting a mental health intervention that is evidence-based, research-based or a promising practice and is recognized by the Washington State Institute for Public.

Finance Capacity

- MCOs are risk-bearing entities contracted by HCA for the full continuum of physical health (ie IP, OP, ED, Medical Specialty, DME. Carve outs include long term care, SMI for MH, SUD, and dental)
- MCOs have risk-adjusted rates
- MCOs are profit-limited. The State Medicaid agency sets a maximum profit of 3%. Profits greater than 3% must be returned to the Medicaid Agency (50% of profits between 3% and 5%; 100% of profit greater than 5%).
- MCOs maintain sufficient reserves as required by the OIC
- MCOs have payment model expertise
- MCOs have actuarial resources in order to validate that rates are actuarially sound

Value Based Purchasing

- Washington aims to drive 80 percent of state-financed health care and 50 percent of the commercial market to value-based payment by 2019
- As of April 1, 2016, the following measures are included in Apple Health Medicaid managed care contracts statewide:

  - Adult's Access to Preventative/ Ambulatory Care
  - Well Child Visits
  - Comprehensive Diabetes Care
  - Medical Assistance with Smoking and Tobacco Use Cessation
  - Body Mass Assessment
  - Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia
  - Ambulatory Care Sensitive Conditions – Hospital Admissions
  - Emergency Department (ED) Visits
  - Plan All-Cause Readmission Rate
  - Inpatient Utilization
  - Drug & Alcohol Treatment Penetration *
  - Initiation of Alcohol & Other Drug Dependence Treatment
  - Engagement of Alcohol & Other Drug Dependence Treatment
  - Mental Health Service Penetration*
  - Psychiatric Hospital Readmission Rate*

Leveraging Data and Technology

- Advanced healthcare analytics and data
- Information Exchange and Interoperability
- Examples:
  - Claims-based data
  - Real-time ED/admission based data (Pre-Manage/EDIE)
  - Patient registry
  - Shared cost savings analysis

Building Provider Networks

- Contract with providers to ensure the availability of a sufficient number and type of providers within a required distance to meet the diverse needs of the members
- To engage providers, most MCOs offer a continuum of payment approaches including value based models for provider partners to provide opportunities to share savings and be rewarded for high quality care
- Networks are routinely monitored to ensure Access & Availability standards are maintained

Apple Health Mental Health Benefit

For mild to moderate mental health enrollees that do not meet Access to Care Standards (ACS)

- **Covered Services:**
  - Outpatient Mental Health (including psychiatric and psychological testing, evaluation and diagnosis, treatment, counseling and medication management)
  - Applied Behavioral Analysis (ABA) treatment services
  - Psychotropic medication
  - Medication Assisted Treatment (MAT)
  - Screening Brief Intervention Referral to Treatment (SBIRT)
  - SUD treatment is carved out
- **Contracting:**
  - FFS Payment Structure based on Medicaid rates but varies by plan
  - Prior authorization and utilization management varies by plan
  - Network includes FQHCs, CMHCs, & behavioral health professionals

Additional Models: MHIP

Mental Health Integration Program (MHIP)

Description

A **stepped-care** treatment program that emphasizes **integrated** and **evidence-based** services provided mostly **in the primary care clinic**, that **includes specialty MH services when indicated**

Principles of Effective Integrated Collaborative Care

Patient Centered Team Care

- Team members collaborate effectively.

Population-Based Care

- Patients are tracked in a registry: no one ‘falls through the cracks’.

Measurement-Based Treatment to Target

- Treatments are actively changed until the clinical goals are achieved.

Evidence-Based Care

- Treatments used are ‘evidence-based’.

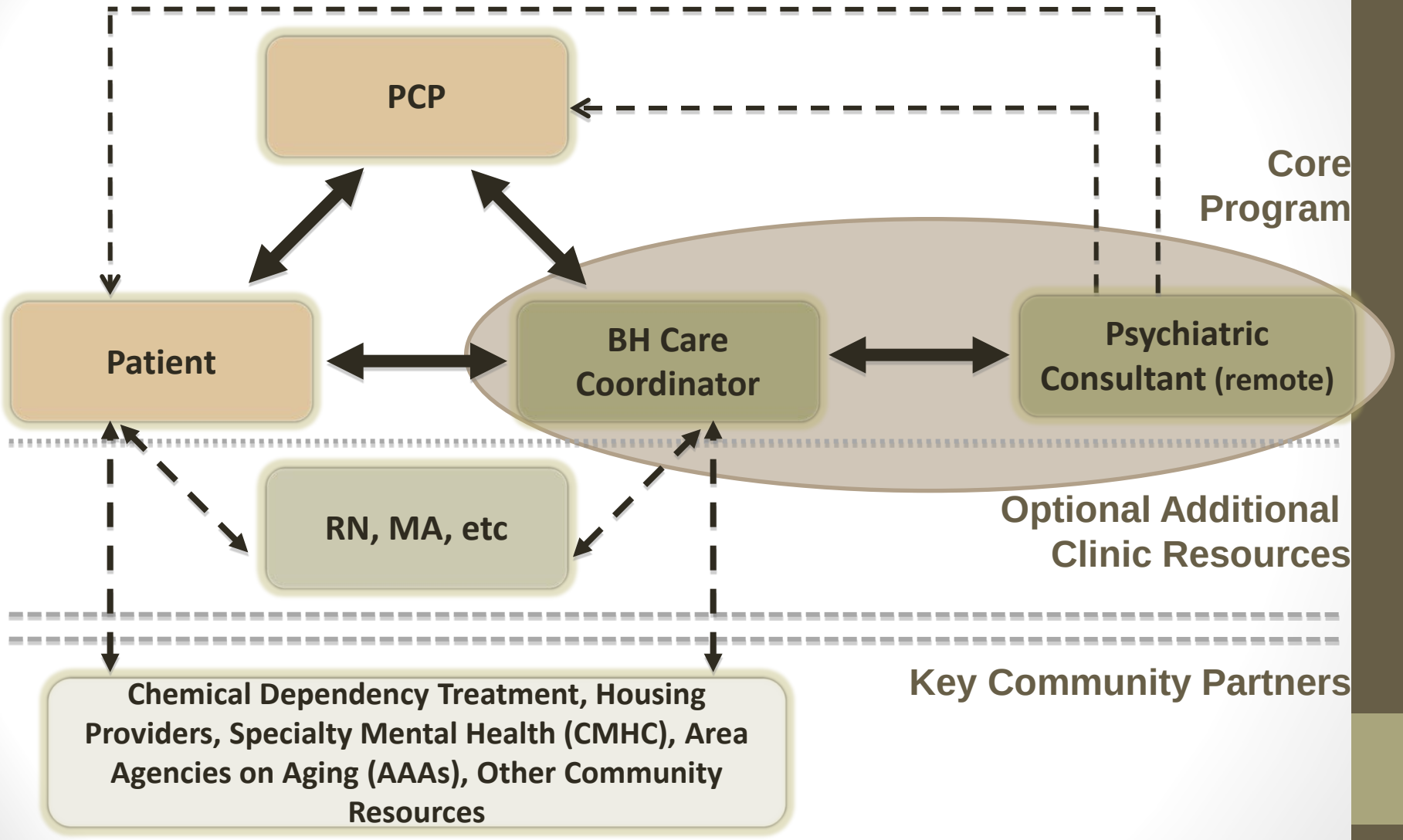
Accountable Care

- Providers are accountable and reimbursed for quality care and outcomes.

MHIP Services & Payment Model

- Level 1 (services provided in primary care)
  - Integrated/embedded MH care coordinator
  - Caseload management (using MHITS)
  - Psychiatric consultation (remote)
  - Emphasis on evidence-based practices
  - Use of screening and tracking tools
  - 50% of funding is value-based (tied to achievement of performance measures
- Level 2 (services provided in specialty mental health)
  - Payment modeled after the King County case rate
  - Additional incentive payment if process measures were achieved

MHIP Model


PCP
Patient
BH Care Coordinator
Psychiatric Consultant (remote)
RN, MA, etc
Chemical Dependency Treatment, Housing Providers, Specialty Mental Health (CMHC), Area Agencies on Aging (AAAs), Other Community Resources
Core Program
Optional Additional Clinic Resources
Key Community Partners

MHIP Outcomes

- Reduced inpatient admissions
- Smaller increases in inpatient psychiatric costs
- Lower increases in homelessness in clients receiving services through MHIP
- Reduced arrest rates in clients receiving MHIP services

http://chammp.org/Program-Evaluation/Reports/General-Assistance-Disability-Lifeline-(DL).aspx

- Demonstrated clinical outcomes -- Pay-for-performance-based quality improvement cuts median time to depression treatment response in half
- Hospital savings of over $11.2 million in initial 14 months of statewide MHIP implementation – net savings of $66 pmpm

Critical Infrastructure Components

Components Critical to MHIP:

- Financial and Administrative Integration
- Alignment with local funding
- Lifted Access to Care Standards
- Data Sharing via Shared Care Plan
- Training Program

Barriers:

- FFS Architecture
- Not a standard benefit

Additional Models, Cont.

- SW Washington FIMC Examples
  - Covering full scope of Physical and Behavioral Health Services (with exception of Crisis Services and State Hospitals)
  - MCOs have worked to align administrative and reporting requirements
- National Examples
  - PACT – anywhere from FFS to monthly case rates with potential incentives based on achievement quality measures
  - Behavioral Health Quality Incentive Programs – Designed for CMHCs and drive by behavioral health performance measures

Questions?

KING COUNTY BEHAVIORAL HEALTH ORGANIZATION—A SPECIALTY MANAGED CARE PLAN

PRESENTED BY:
KAREN SPOELMAN, M.M.

MEDICAID MANAGED CARE IN KING COUNTY TODAY

Approximately 405,0000 King County Residents are enrolled in Apple Health (Medicaid recipients)

All 405,0000 Medicaid recipients in King County are members of the King County Behavioral Health Organization Medicaid Plan

The BHO is responsible for integrated mental health and substance use disorder treatment services for all of its members that meet Medical Necessity.

ROLES AND RESPONSIBILITIES OF BHOS IN WASHINGTON

BHOs provide coordinated care through a defined network of behavioral health care providers.

BHO roles and responsibilities also go far beyond paying for services and authorization for services..

- Assuring Clinical and Service Quality
- Building Comprehensive and Diverse Provider Networks
- Engage & Partner with Allied Systems and Communities
- Leveraging Data and Technology
- Monitor & Maintain Compliance
- Maintain Program Integrity

FINANCIAL CAPACITIES

BHOs are risk-bearing entities contracted by DBHR for the full continuum of behavioral health services

BHOs have risk-adjusted rates

BHOs maintain sufficient risk reserves as required by the DBHR

BHOs manage multiple funding sources

BHOs have a broad variety of managed care payment models to address the diverse array of services provided within the service continuum.

DATA AND TECHNOLOGY

Comprehensive Data Management System

Information Exchange and Interoperability with Network Providers

Examples:

- Complete Authorization, Service, Utilization, and Outcome Data Management
- Real-time psychiatric hospital admission data and Real-time jail admission data that are pushed out to Network Providers daily.
- Registry of Provider Network Clinicians
- Utilization of Pre-Manage/EDIE for care management
- Case Rate and other Managed Care Payment Management

GUIDING PRINCIPLES THAT ARE THE FOCUS OF SERVICE DELIVERY IN THE BHO

Recovery and Resiliency

Person-centered and Tailored care

Culturally Responsive care

Collaborative and Coordinated Care

LEVELS OF CARE IN THE BHO

Crisis Services

- For all King County Residents

MH and SUD Outpatient

- For Medicaid and low income Residents

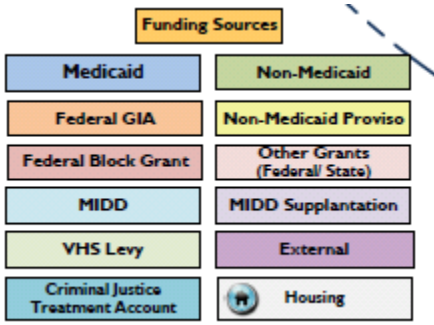
MH and SUD Residential Treatment

- For Medicaid and low income Residents

Psychiatric Inpatient

- Voluntary-for Medicaid and state funded Residents
- Involuntary-for all residents

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 (shelter & Stabilization)
- Sobering
- Community Hospital Emergency Dept
- Crisis Solutions Center

- Opiate Treatment Services
- Outpatient BH Services
- Western State Hospital
- Permanent Supportive Housing
- Medical respite

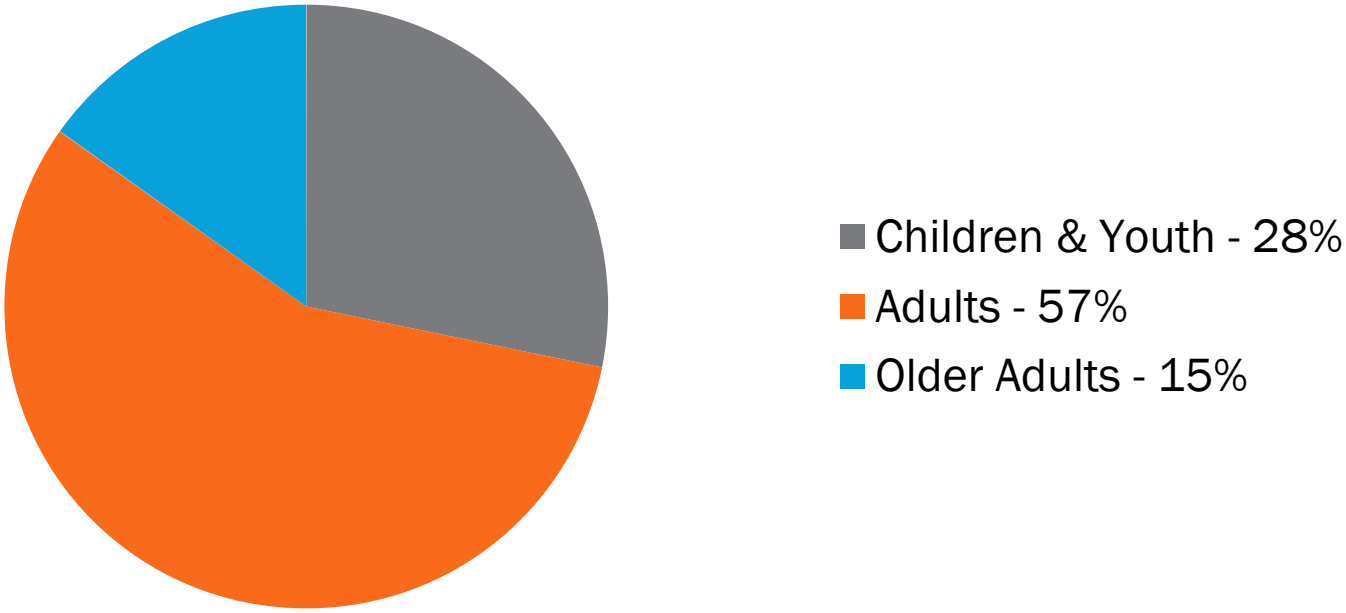
- SUD Residential Services
- Supervised Living (IMD)
- Long Term Residential (IMD)
- Expanded Community Service
- Program of Assertive Community Treatment (PACT)

- Supported Employment
- Clubhouse
- Standard Supportive Housing
- Recovery Cafe
- Support Groups

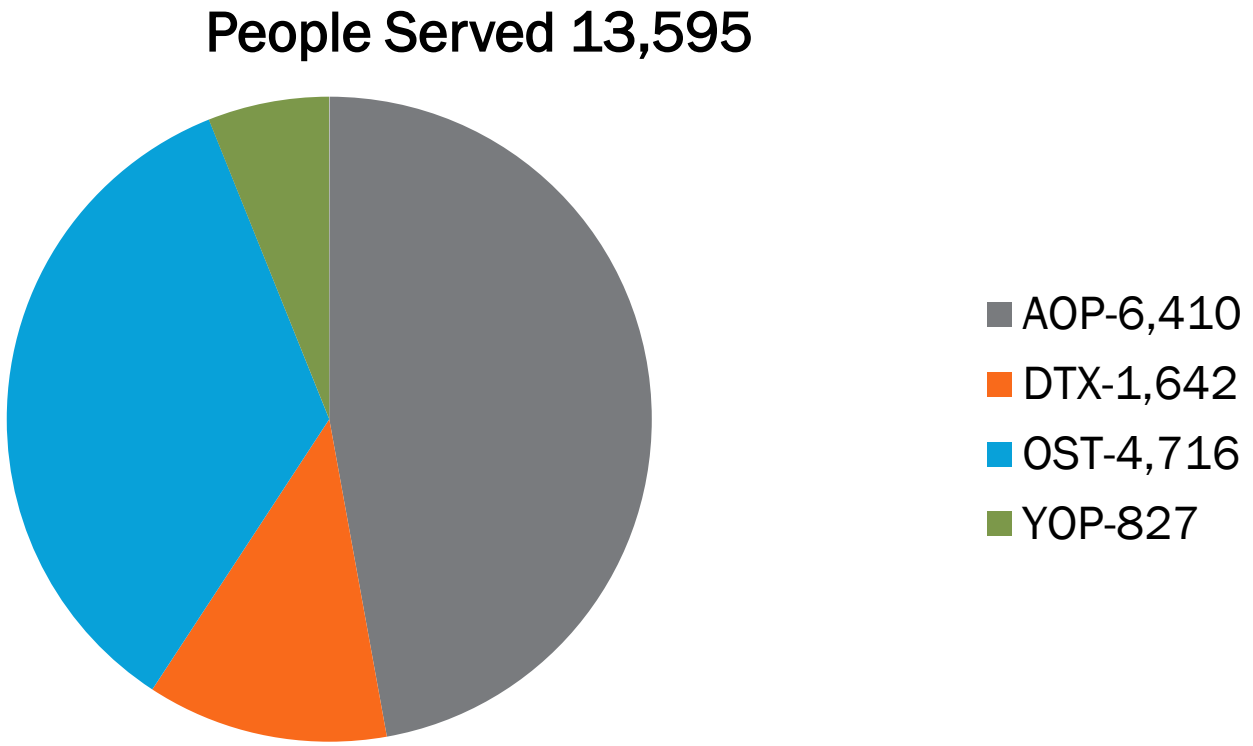
Continuum of services from crisis to stability

KING COUNTY BHO MENTAL HEALTH SERVICES

49,100 people served in 2015



SUD POPULATION SERVED IN 2015



MH AND SUD OUTPATIENT SERVICES

Medical Necessity state defined “Access to Care Criteria”

12 month benefit length

- Risk Adjusted based on functional need

Paid via case rates which is a shared risk arrangement between the BHO and network providers

COVERED SERVICE FOR MH OUTPATIENT

- Intake Assessment
- Individual Treatment
- Family Treatment
- Group Treatment
- Medication Management
- Medication Monitoring
- Day Support
- High Intensity Treatment
- Residential Services
- Peer Support
- Stabilization Services
- Therapeutic Psycho-education
- Psychological Assessment

COVERED SERVICES FOR SUD OUTPATIENT

IOP/OP

- Intake Assessment
- Individual Treatment
- Family Treatment
- Group Treatment
- Case Management

Medication Assisted Treatment

- Dosing for Methadone
- All of the above outpatient services

INPATIENT SERVICES

Psychiatric

- Voluntary inpatient care must be pre-authorized
- Involuntary inpatient care is authorized by Designated Mental Health Professionals

SUD

- Involuntary care is authorized by Designated Chemical Dependency Professionals

BHO CRISIS SERVICES

For King County Residents for whom a mental substance use disorder cannot be ruled out

- Children's Crisis Outreach Response Services
- Crisis and Commitment Services
- Crisis Solution Center and Mobile Crisis Team
- Detoxification Services
- Sobering Services
- Crisis Stabilization Services
- Next Day Appointments (adults)
- Hospital Diversion Beds
- Non-emergent outreaches (children/youth)

BHO RESIDENTIAL SERVICES

For People Who Need MH Services

Congregate Care—24/7 staffed facilities

- Supervised Living (SL)
- Long Term Rehabilitation (LTR)

Standard and Intensive Support Housing Services

(Behavioral health and housing supports provided to individuals in their own apartments/homes)

RESIDENTIAL SERVICES CONTINUED

For People Needing SUD Services

24/7 staffed facilities

- Intensive Inpatient Residential Treatment Services
- Long-Term Care Residential Treatment Services
- Pregnant and Parenting Women Residential Treatment

Recovery House

OTHER BEHAVIORAL HEALTH SERVICES

- Clubhouses
- Supported Employment
- Program for Assertive Community Treatment (PACT)
- Homeless Outreach Stabilization and Transition (HOST)
- Hospital Transition including Peer Bridger Services
- Wraparound Teams for children and families
- Jail Transition Services
- Mental Health and Drug Courts
- Diversion, Re-entry and Treatment for people involved with the Criminal Justice Systems
- Pregnant and Parenting Women specialty SUD services

King County Principles for Full Integration

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, and are **engaged and activated**;
3. Individuals are able to access the health and social service supports **when and where they need** them in a culturally responsive fashion
4. Individuals **achieve improved health and social outcomes** as a result of full integration
5. **Recovery** principles are prominent across the system of care and recovery practices are expected and rewarded
6. Services address a person's health and wellbeing **across the lifespan**
7. 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
8. 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
9. **Information is shared seamlessly** across providers in order to minimize complexity for the individuals served
10. 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
11. **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
12. 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
13. Ongoing **investments in health promotion, prevention, and early intervention** are made to prevent the occurrence of health and behavioral health conditions and achieve improved population health
14. Ongoing **investments** are made to build and maintain necessary system and provider capacity **to provide a full continuum** of health (including behavioral health) services
15. The system is active in **addressing the social determinants of health** including integration of housing, employment, criminal justice diversion and other recovery support services
16. Services are **community-based** and delivered in the least restrictive setting possible

17. Transformation includes **getting waste out** of the system, reducing duplications, minimizing administrative burden and overhead and achieving efficiencies by investing in things necessary to achieve outcomes

	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; identify workgroups, leaders and assign responsibilities	Review IDC vision, outcomes, integrated care definition, principles, and scope.			Staff drafts report with key recommendations between September 14th and early October.	Final vote on recommendations and timeline. *Submit final recommendations report to ACH.*
Education/ Current System Mapping	Begin mapping Behavioral Health and learning about primary care models in behavioral health setting	Complete mapping the Behavioral Health System; learn about crisis system; review contractual requirements for MCOs and BHOs in current systems	Anything identified from the June meeting the IDC needs more information about; review lessons learned from SW WA and 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** present aspirational ideas and barriers to address at June 8th meeting.	**Workgroups** submit additional thinking about an integrated clinical model **by July 7th** for **IDC** to review at July 13th meeting.	**Workgroups** present recommendations about clinical models to best serve the populations to full **IDC** at August 10th meeting (bring stakeholder feedback)	**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** potential infrastructure models.	**Workgroup** meets re: pros and cons of each potential infrastructure model; prepares for **IDC** discussion at July 13th meeting.	**Workgroups** discuss which infrastructure models might best support the clinical models and design principles; bring thoughts for full **IDC** discussion on August 10th	**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	
Timing					**IDC** determines best timeline for implementation	

Proposed options for Fully Integrated Managed Care (FMIC) in the King County Region

MCO Lead Model	Public-Private Partnership Model	County Lead Model
General Concept: Designated MCOs have full risk and responsibility for continuum of physical and behavioral health	**General Concept:** Collaborative partnership with governance structure and contractual arrangements that allow for risk and gain sharing	**General Concept:** King County has full risk and responsibility for continuum of physical and behavioral health care
TAC Option 1: MCO subcontracts to County BHO for behavioral health for specialty population (SMI)	**TAC Option 5: New entity is created in collaborative partnership between King County and MCO who co-lead and share risk/gain**	**TAC Option 3: State contracts with King County for full physical and behavioral health for a specialty populations as one of multiple plans available in region**
TAC Option 2: MCO subcontracts to County BHO for behavioral health for all Medicaid	**New Option: Virtual Partnership where money flows to one entity with shared governance and contractual mechanisms to support risk and gain sharing**	**TAC Option 4:** King County subcontracts to MCO for physical health care
TAC Option 7: County BHO goes away – King County government role is monitoring and assurance/oversight only		**TAC Option 6:** King County subcontracts back to MCO for physical and behavioral health • King County braids funds through contract • King County providers monitoring and assurance/oversight

King County Physical and Behavioral Health Integration Design Committee
June 8, 2016

Speaker Bios

Graydon Andrus, MSW
Director of Clinical Programs
DESC

Graydon Andrus, MSW, is the Director of Clinical Programs at DESC, a large multi-service agency in Seattle with integrated programs for mental health, chemical dependency, shelter, supportive housing; which uses recovery, housing first and harm reduction approaches. His professional life has been focused on delivery of clinical case management, program development and program management for the past 28 years. In his current capacity, he manages DESC's mental health, chemical dependency treatment, supported employment, and crisis diversion programs, all having a focus on serving vulnerable homeless and recently homeless adults.

Nancy Sugg, MD
Medical Director
Harborview Medical Center Pioneer Square and Homeless Programs

Dr. Sugg is the Medical Director of Harborview Medical Center's Pioneer Square Clinic and Homeless Programs. She has worked closely with Seattle-King County Public creating integrated medical services for homeless patients in a variety of settings. She is an Associate Professor of Medicine at the University of Washington where her research interests are in interpersonal violence and health care disparities. She has been a primary care internist for homeless and low income patients for 25 years and enjoys teaching the next generation of physicians in care of vulnerable populations. She also serves on the Governing Council of the Pacific Hospital PDA, which provides over 1.5 million dollars yearly in grants to decrease disparities in the Puget Sound region

Sonia Handforth-Kome, MA
Chief Operating Officer
Valley Cities

Sonia Handforth-Kome, M.A., Chief Operating Officer, has been working in medical and behavioral health care systems since 1987. Her first job in the medical field was as an office manager for a physical and occupational therapy management company in North Carolina. Sonia's experience in health system management has run the gamut from providing technical support on practice management systems and electronic health record systems, to coding, medical transcription, billing and collections, organizational change management, EHR/EPM selection and implementation, grant writing, strategic planning, advocacy and policy development; and from for-profit urban office-based specialty care to non-profit rural/frontier facility-based integrated care, including primary care, emergency care, dental services, physical therapy, substance abuse services, mental health services, and alternative medicine. Sonia has worked in health systems in North Carolina, California, Alaska and Washington, and in payment systems including fee-for-service, capitated, grant-funded, and case rate. In July of 2001 she moved from a multi-site OB/Gyn physician practice in California to a position as Executive Director for the Iliuliuk Family and

Health Services, Inc. community health center/frontier extended stay clinic in Unalaska, Alaska. During her time as ED of IFHS, Sonia also served on the board of the Alaska Primary Care Association (as President for five years), and on the board of the Northwest Regional Primary Care Association (as a member of the Executive Committee of that board for four years). Sonia also volunteered with many community organizations, including the Ballyhoo Lions Club and the Aleutian Arts Council, as well as being elected and serving for eleven years on the Unalaska City School District Board, and for ten years as a Yoga instructor for the local community center. In October 2011 she retired as ED of IFHS and started consulting with local non-profits and CHCs in the state of Alaska. In June 2013 she began working for Valley Cities Counseling and Consultation, a community behavioral health center in Washington as Chief Operating Officer. Sonia received her Bachelor's degree in Physics with Honors from the University of North Carolina at Chapel Hill, and her Masters' degree in Organization Management from the University of Phoenix in Oakland.

Karen Spoelman
Behavioral Health and Recovery Division
King County

Karen Spoelman, M.M. is the Cross Systems and Contract Services Coordinator of the King County Behavioral Health and Recovery Division. In that role she also serves as the Section Chief for network provider recruitment and contracting for both the mental health and substance use disorder treatment services. Ms. Spoelman is also responsible for the fostering and formalizing of relationships with allied systems (e.g. education, child welfare, criminal justice). Karen has been a planner/manager in public sector managed care mental health and substance abuse service system at the regional/county level for 21 years and previous to that worked in quality and facilities management for a large non-profit community-based behavioral health treatment agency for 9 years.