Physical and Behavioral Health Integration
Design Committee Retreat

December 21, 2015 9:00 AM– 3:00 PM
(Coffee and Networking 8:30 AM-9:00 AM)

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

AGENDA

1.	**Welcome and Introductions** *Susan McLaughlin, King County Department of Community and Human Services*	9:00 – 9:15 am
2.	**Defining Our Work** *Robin Arnold-Williams, Leavitt Partners*	9:15 – 12:00 pm
	BREAK	11:00 – 11:10 am

Goals:

- *A definition of what "Integrated Care" means and clarity about the population*
- *A Vision for the population*

	LUNCH BREAK	12:00 – 12:15 pm
3.	**What Are the Results We Want?** *Deb Srebnik, King County Department of Community & Human Services & Nadine Chan, Public Health-Seattle & King County*	12:15 – 2:00 pm

Goal: Defined Results Expected from the Vision

	BREAK	1:50 – 2:00 pm
4.	**Moving Forward: Planning for the Next Ten Months** *Robin Arnold-Williams, Leavitt Partners*	2:00 – 3:00 pm

Goal: Framework for how we will accomplish the work

Table 10. Average Monthly Caseloads by Calendar Year

Shaded cells represent populations for whom projection modeling is not complete.

Initiative 1: Medicaid program average monthly caseloads represent the population that could be served by investments in Initiative 1 transformation projects.																
Medicaid Population	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Children - Disabled	16,553	16,956	17,096	17,360	17,760	18,259	18,712	18,889	18,297	18,331	18,409	18,508	18,605	18,704	18,844	18,902
Children Non-Disabled	520,073	527,408	553,858	616,213	669,301	693,734	700,376	703,385	740,514	784,985	809,497	832,252	855,905	880,231	916,932	930,976
Adults - Disabled	112,162	114,199	117,560	122,569	129,875	136,066	138,538	140,565	133,123	132,651	133,363	134,075	134,785	135,498	136,512	136,936
Adults Non-ABD	128,286	121,009	120,499	130,427	141,211	143,833	142,720	142,319	166,940	173,145	177,817	181,498	185,626	189,848	196,361	198,582
Aged	62,251	62,171	62,566	63,945	65,450	66,972	68,540	70,064	71,578	73,494	75,259	76,991	78,773	80,595	83,267	84,367
Expansion Adults	29,958	30,842	33,197	36,382	37,909	32,344	29,875	33,349	405,337	551,352	569,149	576,317	580,894	583,816	586,267	587,177
Initiative 2: Medicaid program average monthly caseloads represent the population that could be served by investments in alternative LTSS benefits.																
MAC adults (currently accounted for in the Aged and Disabled Medicaid populations																
"At Risk" of Medicaid Demonstration Expansion Population																
Initiative 3: Medicaid program average monthly caseloads represent the population that could be served by investments in supportive housing and supported employment benefits.																
Supportive housing target population																
Supported employment target population																
Total Caseload to be Served through the Demonstration – current Medicaid eligibility groups and Demonstration expansion group																
DEMONSTRATION TOTAL																

Enrollees in Medical Programs By County Report, 201510
Report Number: CLNT-10422.0
Data Source: ODS Data Warehouse
Report Owner: Kevin Cornell, 360-725-

		KING		
SUMMARY GROUP NAME	**Statewide Total**	**ADULTS**	**CHILDREN**	**TOTAL**
AEM Expansion Adults	280	93	0	93
Apple Health For Kids	782,139	642	163,407	164,049
Elderly persons	72,608	24,637	0	24,637
Family (TANF) Medical	48	13	4	17
Family Planning	12,692	3,078	694	3,772
Former Foster Care Adults	2,101	365	53	418
Foster Care	27,680	64	4,365	4,429
Medicaid CN Caretaker	144,601	29,280	0	29,280
Medicaid CN Expansion	567,869	143,251	0	143,251
Other Federal Programs	15	4	0	4
Partial Duals	57,366	12,305	3	12,308
Persons with disabilities	30,880	7,417	337	7,754
Persons with disablities	118,513	21,729	3,184	24,913
Pregnant Womens Coverage	18,568	4,551	0	4,551
Total	**1,835,360**	**247,429**	**172,047**	**419,476**

Enrollment figures for the most recent 3 months are preliminary. The figures on this report may vary to some small degree from those found in the monthly 802 report due to the time frame of when the data is pulled.

* Adults are people age 19 and older

** Children are people under age 19.

*** Program Groups:

1. Children's Medical Program includes children financed by Medicaid (Title XIX), State Children's Health insurance Program (CHIP) and state-only financed coverage for children that do not qualify for Medicaid or CHIP

King County Physical and Behavioral Health Integration Design Committee
Vision/Mission Statements from Authorizing Documents

KING COUNTY

King County Health & Human Services Transformation[1] and
King County Accountable Community of Health
VISION: By 2020, the people of King County will experience significant gains in health and well-being because our community worked collectively to make the shift from a costly, crisis-oriented response to health and social problems, to one that focuses on prevention, embraces recovery, and eliminates disparities.

HEALTH CARE AUTHORITY[2]

VISION: A *healthier* Washington.
MISSION: Provide high quality health care through innovative health policies and purchasing strategies.

Healthier Washington 1115 Demonstration Waiver[3]
"Washington envisions a delivery system for all its Medicaid beneficiaries – children, families, adults and the elderly - that proactively assesses need, manages health services and drives population health improvement. This transformation requires a fundamental shift in the health care delivery system from reliance on clinical silos, institutional settings, and treating episodes of illness, to becoming fully integrated, community-driven, and focused on providing high quality, cost effective, and well-coordinated care and recovery supports."

Washington State Health Care Innovation Plan[4]
"By 2019, the people of Washington will be healthier because the state has collectively shifted from a costly and inefficient system for health care to aligned, person-centered primary care health systems approaches focused on achieving common targets for better health, better care, improved quality, lower costs, improved person and family experience, prevention, and reduction of disparities."

State Innovation Model (SIM) Application[5]
"The Healthier Washington project is predicated on the realization that better health, better care and lower costs can only be achieved if state resources and communities are significantly more aligned. This requires overdue changes in health care delivery and financing methods, deeper recognition of social determinants of health, and innovative policies and structures.**"**

DEPARTMENT OF SOCIAL AND HEALTH SERVICES (DSHS)[6]

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[1] See: http://www.kingcounty.gov/elected/executive/health-human-services-transformation.aspx
[2] HCA Mission, Vision and Values, see: http://www.hca.wa.gov/Documents/10-501_mission.pdf
[3] 1115 Demonstration Waiver request, available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/wa/wa-medicaid-transformation-pa.pdf
[4] Full plan available at: http://www.hca.wa.gov/hw/Pages/resources_and_documents.aspx
[5] Full application available at: http://www.hca.wa.gov/hw/Pages/resources_and_documents.aspx

MISSION: As a Department we are tied together by a single mission: to transform lives. Each administration within DSHS has a refined focus on this mission. Individually we have the following missions:

Aging and Long-term Support Administration – to transform lives by promoting choice, independence and safety through innovative services.

Behavioral Health and Service Integration Administration – to transform lives by supporting sustainable recovery, independence and wellness.

Children's Administration – to transform lives by protecting children and promoting healthier families through strong practice and strong partnerships with the community and tribes.

Developmental Disabilities Administration – to transform lives by creating partnerships that empower people.

Economic Services Administration – to transform lives by empowering individuals and families to thrive.

Rehabilitation Administration –to transform lives by creating pathways for self-sufficiency through meaningful partnerships, employment, new opportunities and effective rehabilitation.

Financial Services Administration – to transform lives by promoting sound management of Department resources.

Services and Enterprise Support Administration – to transform lives by helping those who serve succeed.

VISION:

- People are healthy,
- People are safe,
- People are supported,
- Taxpayer resources are guarded

[6] DSHS Strategic Plan Mission, Values, Vision; see: https://www.dshs.wa.gov/strategic-planning/mission-vision-and-values

King County Physical and Behavioral Health Integration Design Committee Retreat
Defining Our Work
Background Information to Guide "Integrated Care" Definition Discussion

King County Physical and Behavioral Health Integration Design Committee Charter

Key Terms related to "Integrated Care" used in document

- Fully integrated physical and behavioral health care
- Whole health needs
- Integrated whole person services
- Integrated person-centered care
- Improve health and social outcomes/indicators
- Value based purchasing

How are other states on the same path defining "integrated"?

OREGON

"Care is coordinated at every point – from where services are delivered to how the bills get paid."

"CCOs have the flexibility to support new models of care that are patient-centered and team-focused, and reduce health disparities. CCOs are able to better coordinate services and also focus on prevention, chronic illness management and person-centered care. They have flexibility within their budgets to provide services alongside today's OHP medical benefits with the goal of meeting the Triple Aim of better health, better care and lower costs for the population they serve."[1]

NEW YORK

"Care Management for All"

"New York's long term goal is to ensure that every Medicaid member has access to fully-integrated care management. This means that health plans and their network partners will need to manage the complete health, long term care, behavioral health and social needs of the populations they serve. It may take up to five years for plan partners to evolve and develop comprehensive, high-quality networks that are sufficient to meet the unique needs of all members."

"Fully-integrated means that a single care management organization would be responsible for managing the complete needs of a member (acute, long term and behavioral care)."

"Fully-integrated care management for all must mean expanded access to evidence-based behavioral health services."[2]

MINNESOTA/Hennepin County[3]

"By coordinating patient-centered and holistic health care, human services and education, the county is working to prevent and alleviate chronic illnesses and create an expectation of health and prosperity for all."

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[1] http://www.oregon.gov/oha/ohpb/pages/health-reform/ccos.aspx
[2] http://www.health.ny.gov/health_care/medicaid/redesign/docs/mrtfinalreport.pdf
[3] http://www.hennepin.us/healthcare

ARIZONA/Maricopa County

Arizona Health Care Cost Containment System (AHCCCS) statement of need and strategy[4]:

> "Navigating the complex health care system is one of the greatest barriers to obtaining medically necessary health care. For Arizonans with SMI, obtaining needed health care has been challenging and further complicated by concerns around poor medication management and stigma, sometimes causing many individuals to forgo physical health care. Because many persons with SMI also experience co-morbidities, management of chronic diseases like diabetes or hypertension has also been poor.
>
> To help address these issues, AHCCCS collaborated with behavioral health partners to create a more streamlined system that reduces barriers to care for members and also increases accountability of the RBHA for managing the "whole health" of persons with SMI. To carry out this new approach, RBHAs manage the delivery of physical health services, in addition to behavioral health services, to increase member engagement in obtaining medically necessary physical health services."

From CMS approval document:

> "CMS is approving the state's request to expand the integration of physical and behavioral health services for individuals with SMI …. The objective of this integration project is to reduce the fragmentation of care that this population currently experience as they navigate the multiple systems of care in order to receive their physical and behavioral health services. The demonstration will test the effect of integrating behavioral and physical health services for this population by measuring the improvements in health outcomes as compared to the state's current structure."[5]

From RFP Statement of Work[6]:

> "Integrating the delivery of behavioral and physical health care to SMI members is a significant step forward in improving the overall health of SMI members. Under this Contract, the Contractor is the single entity that is responsible for administrative and clinical integration of health care service delivery, which includes coordinating Medicare and Medicaid benefits for dual eligible members. From a member perspective, this approach will improve individual health outcomes, enhance care coordination and increase member satisfaction. From a system perspective, it will increase efficiency, reduce administrative burden and foster transparency and accountability."

CALIFORNIA

1115 Waiver extension request includes Regional Integrated **Whole-Person Care Pilots**[7]

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[4] http://www.azahcccs.gov/BehavioralHealthIntegration.aspx

[5] CMS waiver approval document Dec. 14, 2014; available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/az/az-hccc-ca.pdf

[6] Full copy of RFP and additional information available at: http://www.azahcccs.gov/BehavioralHealthIntegration.aspx

[7] Complete 1115 Waiver renewal information available at: http://www.dhcs.ca.gov/provgovpart/Pages/1115-Waiver-Renewal.aspx

"Participating entities will be responsible for identifying the cross cutting needs of the Medi-Cal members, provide coordination services and share data across all of the involved entities in order to achieve the whole-person care model. Members will have an individualized care plan and a single accountable, trusted care manager that ensures access to all needed services across the spectrum of care and support. Financial flexibility will permit providers across partnering sectors to do what is right for the client and will align incentives for providers to collaborate. Proposals must include a detailed plan for achieving care coordination and integration across all of the participating entities and must include behavioral health integration as a component."

Selection of how others are defining "integrated"?

AHRQ – Agency for Healthcare Research and Quality[8]

Definition of Integrated Behavioral Health Care:
The care a patient experiences as a result of a team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population. This care may address mental health and substance abuse conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress-related physical symptoms, and ineffective patterns of health care utilization.

- **The term "behavioral health" is used to emphasize the broad applicability of integrated health services in medical care.** Behavioral health encompasses behavioral factors in chronic illness care, care of physical symptoms associated with stress rather than diseases, and health behaviors, as well as mental health and substance abuse conditions and diagnoses.
- **The term "patient-centered care" reinforces that the patient is a key stakeholder in integrated care.** Patient-centered care is defined as health care that establishes a partnership among practitioners, patients, and their families (when appropriate) to ensure that decisions respect patients' wants, needs, and preferences and that patients have the education and support they need to make decisions and participate in their own care.
- **The use of the term "systematic" indicates that integration needs to be a routine part of care.**
- **Integrated behavioral health care teams and services do not have to be present or delivered in the same physical location to meet the definition of integrated care.**

National Approaches to Whole-Person Care in the Safety Net[9] (March 2014)
Prepared by John Snow, Inc. (JSI)
In collaboration with the California Association of Public Hospitals & Health Systems
and the California Health Care Safety Net Institute

"For the purposes of this paper, we propose a working definition of Whole-Person Care as the coordination of health, behavioral health, and social services in a patient-centered manner with the goals of improved health outcomes and more efficient and effective use of resources."

[8] http://integrationacademy.ahrq.gov/atlas/What%20Is%20Integrated%20Behavioral%20Health%20Care
[9] Available at: http://www.chcf.org/cin/notes-from-the-field/whole-person-care-safety-net

“At the most basic level, “patient-centered” means delivering the right care to a patient at the right time and in the right place. “Patient-centered” often means that the individual—and often, his or her family—is actively engaged in his or her care in an appropriate setting, whether that be a primary care clinic, behavioral health clinic, or homeless shelter. Patient-centered care is also often characterized by multiple providers working with an individual to develop a single, individualized care plan that takes into account the patient’s goals, motivations, and needs across multiple systems. Lastly, individuals may have a designated care manager or care coordinator to support the implementation of the care plan, connect the patient to a range of appropriate services, coordinate multiple services, monitor progress towards care plan goals, and adjust interventions as needed along the way.”

Results-based Accountability

Glossary and Summary Steps

POPULATION-LEVEL ACCOUNTABILITY – APPROPRIATE FOR COLLECTIVE IMPACT

RBA STEPS 1 AND 2 – DEFINE RESULTS FOR POPULATION

RESULTS - desired condition of well-being – the ends we want – for the population (or subpopulation) of children, families or communities of interest. State in plain English. Examples: All children are born healthy; All children are healthy and ready for school; All children succeeding in school; All youth becoming happy, productive contributing adults; Stable and self-sufficient families. (In other frameworks, results are often called outcomes or goals.) The RBA process starts with the ends and works backward to means. Results are about populations or subpopulations. RBA step 1 is defining the Population/subpopulation of interest. RBA step 2 is defining Results. Results frame the discussion about population-level accountability. They are the responsibility of partnerships – not one entity.

STEP 3A – DEFINE INDICATORS

INDICATOR - a population-level measure which helps quantify the achievement of RESULTS. An indicator is a proxy for well-being of the *whole* population. Think about how could you recognize the given result in measurable terms? What would we see, hear, feel, observe? (In other frameworks, indicators are often called benchmarks, milestones, or even outcomes.) Note that population-level accountability (i.e.,. population-level indicators) – are bigger than any one program or agency or level of government. They are the responsibility of partnerships rather than a single entity.

STEP 3B – GET BASELINE

BASELINE – for each population INDICATOR, obtain a data picture of where you've been and where you're headed (trend) if you stay on the current course. This involves obtaining more than one measurement point. If only have one measurement point – determine how you know whether it is good or bad – and where you think the trend will be headed.

STEP 4 – DESCRIBE THE STORY BEHIND THE BASELINE

STORY behind the baseline – the root cause of why the indicator picture looks like it does (ask 'why' 5 times…). To do this work – you'll need to gather the **relevant PARTNERS** with a Role to Play and knowledge about the indicator, past trends and what might work going forward.

STEP 5 AND 6 – IDENTIFY WHAT WORKS

WHAT WORKS – define strategies/interventions to improve the story ('turn' the data curve). This involves obtaining the collective knowledge from relevant Partners (RBA step 5) about the story and evidence from what's worked in the particular community from experience and research. No single action by any one agency can create the improved results want and need. Make sure to include low and no-cost ideas. Selecting strategies/interventions is RBA step 6. Consider the following criteria: specificity (specific action, not rhetoric), leverage (will it make big or little difference), values (consistent with personal and community values), and reach (feasible this year, next year or 3-10 years)

PROGRAM/SYSTEM PERFORMANCE -LEVEL ACCOUNTABILITY – APPROPRIATE FOR PROGRAM EVALUATION

STEP 7 – DEFINE PERFORMANCE MEASURES

PERFORMANCE MEASURE- **a measure of how well agency or program, or service delivery system is working.** Performance measure are typically are about client populations -- people who receive a given service – a known group. While population-level results and indicators are about the *ends* we want – strategies and performance measures are about the *means* to get there. There are 3 types of performance measures:

- What did we do? (e.g., # clients served; how much service delivered, unit cost, etc.)
- How well did we do it? (% timely actions, % complete actions, etc.)
- Is anyone better off? (these can also be called client/customer results - quantity and quality of change in skills/knowledge, attitude, behavior, circumstance)

Good measures have: communication power (readily understood as important by the general public), proxy power (say something of central importance about the program/service system), data power (quality, reliable, feasible data). (In other frameworks, performance measures are also often called program measures – but sometimes outcomes!) Note that the first two types of performance measures (what did we do? How well?) cover the logic model concepts of "activities" and "outputs".

When a program is small – it is not hard to distinguish the client population (for defining performance measures) from the total population (for defining indicators). However, as a program's population approaches the total population (of the state, county, city, community, etc.), program performance measures begin to play a double role – to be both performance indicators and population indicators. This most often happens in education (e.g., graduation rates – within given school/district of interest v. population rate) and public health (childhood immunizations – rate within given program of interest v. rate in population). Performance measures for service systems and prevention programs will often play this double role. Performance measures frame discussion of performance-level accountability. Unlike, population-level indicators, performance measures *are* intended to be specific to the program/system that would be accountable for their change.

Step 8 -**GET BASELINE - PM LEVEL**

BASELINE – for each PERFORMANCE MEASURE, obtain a data picture of where you've been and where you're headed (trend) if you stay on the current course. Akin to Step 3 but for performance measures rather than population indicators- this step involves obtaining more than one measurement point, if possible.

Mental Health Gap Analysis

Gap Analysis by Regional Service Area

Table 2 presents Table 1 data by Regional Service Area (RSA), which were recently established in a joint decision of the Healthcare Authority and the Department of Social and Health Services.

Table 2: 2014 Gap Analysis by Regional Service Area

	Peninsula RSA	North Sound RSA	King RSA	Pierce RSA	Thurston Mason RSA	Timberlands RSA	Greater Columbia RSA	North Central RSA	Southwest Washington RSA	Spokane RSA	Statewide Totals
Safety Net Population											
Medicaid	76,900	256,200	396,300	209,000	75,000	91,400	237,700	86,400	121,500	177,500	1,727,900
Uninsured <200%	12,000	36,900	74,200	27,900	14,400	11,900	46,600	16,800	31,200	26,700	298,600
Total	88,900	293,100	470,500	236,900	89,400	103,300	284,300	103,200	152,700	204,200	2,026,500
Mental Health Service Need											
Medicaid	26,100	80,600	129,500	67,000	24,600	30,500	67,900	24,600	37,200	56,900	544,900
Uninsured <200%	3,000	8,900	19,200	6,300	3,800	2,800	10,800	4,200	8,500	6,600	74,100
Total	29,100	89,500	148,700	73,300	28,400	33,300	78,700	28,800	45,700	63,500	619,000
Number of Persons Receiving Ambulatory Mental Health Services											
Medicaid	8,900	25,000	50,300	22,000	6,900	10,000	22,100	7,800	13,700	16,200	182,900
Uninsured <200%	2,300	4,300	6,300	3,700	900	1,800	5,700	2,000	2,000	2,600	31,600
Total	11,200	29,300	56,600	25,700	7,800	11,800	27,800	9,800	15,700	18,800	214,500
% of Need Served	38%	33%	38%	35%	27%	35%	35%	34%	34%	30%	35%
Ambulatory Mental Health Service Gap											
Medicaid	17,200	55,600	79,200	45,000	17,700	20,500	45,800	16,800	23,500	40,700	362,000
Uninsured <200%	700	4,600	12,900	2,600	2,900	1,000	5,100	2,200	6,500	4,000	42,500
Total	17,900	60,200	92,100	47,600	20,600	21,500	50,900	19,000	30,000	44,700	404,500
Gap %	62%	67%	62%	65%	73%	65%	65%	66%	66%	70%	65%

Although the gap levels vary by region, there is no region where more than 38% of the need was met.

Substance Use Disorder Gap Analysis

Gap Analysis by Regional Service Area

Table 2 presents Table 1 data by Regional Service Area (RSA), which were recently established in a joint decision of the Healthcare Authority and the Department of Social and Health Services.

Table 2: 2014 Gap Analysis by Regional Service Area

	Peninsula RSA	North Sound RSA	King RSA	Pierce RSA	Thurston Mason RSA	Timber-lands RSA	Greater Columbia RSA	North Central RSA	Southwest Washington RSA	Spokane RSA	Statewide Totals
Safety Net Population											
Medicaid	76,900	256,200	396,300	209,000	75,000	91,400	237,700	86,400	121,500	177,500	1,727,900
Uninsured <200%	12,000	36,900	74,200	27,900	14,400	11,900	46,600	16,800	31,200	26,700	298,600
Total	88,900	293,100	470,500	236,900	89,400	103,300	284,300	103,200	152,700	204,200	2,026,500
Substance Use Disorder Service Need											
Medicaid	10,900	32,800	53,300	27,200	10,200	12,400	26,300	9,500	15,000	23,100	220,700
Uninsured <200%	1,100	3,400	7,800	2,300	1,500	1,000	3,900	1,700	3,500	2,600	28,800
Total	12,000	36,200	61,100	29,500	11,700	13,400	30,200	11,200	18,500	25,700	249,500
Number of Persons Receiving Substance Use Disorder Services											
Outpatient	2,820	7,930	8,880	3,840	1,890	2,830	4,630	1,970	2,810	4,280	41,880
Residential/Inpatient	770	2,600	2,170	970	490	580	1,060	350	1,360	1,410	11,760
Opiate Substitution Tx	30	1,170	3,410	860	330	140	150	0	290	400	6,780
Total	3,620	11,700	14,460	5,670	2,710	3,550	5,840	2,320	4,460	6,090	60,420
% of Need Served	30%	32%	24%	19%	23%	26%	19%	21%	24%	24%	24%
Substance Use Disorder Service Gap											
Unserved Gap	8,380	24,500	46,640	23,830	8,990	9,850	24,360	8,880	14,040	19,610	189,080
Unserved Gap %	70%	68%	76%	81%	77%	74%	81%	79%	76%	76%	76%

Although the gap levels vary by region, there is no region where more than 32% of the need was met.