King County Physical and Behavioral Health Integration Design Committee

Retreat

December 21, 2015; 9:00 am – 3:00 PM
Navos-Revelle Hall, 1210 SW 136th St., Burien, WA 98166

Members Present: *Susan McLaughlin- King County, Jennifer DeYoung- King County Public Health, Betsy Jones – King County, , Robin Arnold-Williams- Leavitt Partners, Suzanne Peterson Tannenberg- Seattle Children's, Aileen De Leon- WAPI, Vicki Isett- Community Homes, Torri Canda- Amerigroup, Steve Daschle- Southwest Youth and Family Services, David Johnson –Navos, Molly Donovan- Refugee Women's Alliance, Daniel Malone- DESC, Darcy Jaffe- Harborview Medical Center, Erin Hafer- Community Health Plan of Washington, Maureen Linehan- City of Seattle Aging and Disability Services, Patricia Edmond-Quinn – Therapeutic Health Service, Julie Lindberg- Molina Healthcare, Ken Taylor- Valley Cities, Stacey Fennell- Seamar, Thomas Trompeter- Healthpoint, Anne Shields-UW Aims, Debra Horowski- United Healthcare*

Members Not Present: *Emily Transue- Coordinated Care, Roger Dowdy - Neighborcare*

Staff: *Liz Arjun- King County, Nadine Chan– King County, Debra Srebnik- King County, Lee Thornhill- King County Public Health, Martha Gonzalez- King County*

Welcome

Susan McLaughlin from King County welcomed the group and introduced the day's facilitator, Robin Arnold-Williams, former DSHS Secretary and current Partner at Leavitt Partners.

Defining the Work

Robin Arnold-Williams led the group in an exercise to help define what "integrated care" means from a clinical perspective. To do this, the group was initially divided into 4 work groups and asked to define what constituted a system of "integrated care".

Team Yellow- defined a system that is flexible and able to deliver what is needed, when it is needed, with stepped intensity. With flexibility to provide healthcare services where people are, for those that won't come in to receive healthcare with multidisciplinary care teams.

Team Blue- discussed the elements of healthcare system including data flow and data sharing, incentivizing providers, populations based models. They articulated that it should include a benefit that that the client controls/directs and that incorporates team based approaches with an identified lead. They envisioned that this would need to function independent of any system and include a care coordinator responsible for patient needs. There should be no barriers to information/privacy protection and include financial accountability and services that are visible.

Team Red- discussed "whole health" driven by the client with navigation support from a care coordinator and based on evidence-based practices that meets all clients where they are at (figuratively & literally) with the end goal of improved health outcomes for the individual population in the most cost-effective way. Working toward the idea of, “feels simple to the client”.

Team Green-discussed finding out what, when and how much care a person needs. The individual determines what they need and where they need it. Integrated person-centered care plan with security in social determinants; home, job and sense of contacts to meaningful community, seamless plan.

The common elements identified by the 4 groups included:

- Simplicity
- Patient centered
- Shared care plan
- Stepped care/flexible care
- Care delivered where patient needs
- Complexity resides in system not for individuals
- Care coordinator to navigate through the system
- Collaboration, seeing each other as peer, team members among all providers

The 4 groups then worked on refining the key concepts. The teams reported the following:

Team Green- discussed “person-centered” and the idea of having a mission statement that reflects cultural context. Big picture goal in the patient’s own words, finding out what the individual wants out of their life and an approach that is based in trauma-informed care.

Team Blue- discussed “person-centered” and that the individual needs to be involved in the effort to develop accountable, agreed upon goals. The care coordinator is more of a servant leadership role participating with the team that serves the client. A person-centered approach has to be sensitive to service. “Shared care plan” means shared development, implementation and possibly having one plan with one team and one person co-leading the team.

Team Yellow- discussed how to deliver “whole health” and what it means for a provider to do this. They decided that data information is key, that includes who is serving the individuals and what they are doing for the individual. There needs to be a common set of goals and how client prioritizes those goals. Accountability is to the client and their goals. There needs to be flexibility to develop a strategy to address the different needs of each person that incorporates the concept of a continuum.

Team Red- discussed that “whole health” should encompass the full continuum of physical, social, environmental health of a person’s health with certain parameters. “Driven by the client” defined as working with clients where they are at and asking the client what is most important to them today. Care coordinator with flexibility not necessarily a single person could be a full team, developing a trusting relationship with team. Care coordinator not always tied to one system. Health outcomes looking at population based and individual outcomes for the client working towards collaboration between all systems.

Common Elements that were identified:

- Single plan that identifies who is involved and knowing who is the lead.
- Accountability for the client’s needs.
- Coordinating between different systems.
- Having a case manager that isn’t tied to one provider.

Differences:

- Team vs. single individual, depending on the needs of the client some may need an entire team.

Small groups were asked to identify what will look different for Medicaid enrollees by 2020 if this vision was implemented.

Group #2- Client wants and needs will dictate everything that happens; that systems will be respectfully sharing information, all informed of client's needs; that preventive care will become a high priority to invest in with the goal that people will get better sooner.

Group #1- Contract agreements would be aligned around care coordination, clients, would not belong to one agency. Implement depression screening as a vital sign. Recognizing that there are many providers and want larger pilots of systems.

Group #3- Clients are able to easily access services to meet their needs and less emergent care. The patients' happiness would be the main goal.

Group #4- Medicaid outcomes will improve because clients will feel that the system is responsive to their needs. That we will be using a stepped-up model with continuum of care with a maintenance plan that leans toward prevention. Shared accountability embedded in system that pays for meaning and outcomes. Not perverse incentives, county funding.

Results

Deb Srebnik from DCHS and Nadine Chan facilitated a session on results based accountability that began with a presentation- *the presentation and notes from this exercise are attached at the end of the summary.*

Moving Forward: Planning the Next 10 Months

The Committee then spent some time reviewing a proposed workplan and reflecting about what they needed to help with the work ahead. Robin flagged that it was important not to miss other related opportunities that could leverage the work.

A number of the committee members did not know the current system and made a number of specific suggestions about what else they needed to know including:

- A diagram of current systems
- A flow chart of Mental Health System from Jim Vollendroff (King County)
- More information on where money is being utilized for services with adults and children?
- More information in regards to EDIE system, learn more of about financial spending with children' health.
- A better understanding of specialty care, for people on Medicaid and behavioral health system.
- Outside of the RSN what other access is available from mental health and SUD system.
- Information of current utilization for the Medicaid eligible population of different health care services or outcomes of different subgroups.
- More information on delivery system financing from the state and clarity about their priorities.
- Best Starts for Kids information, evidenced-based research.

The IDC made some additional suggestions about who else they thought it would be beneficial to hear from:

- Peer Bridges Program
- AIMS/Qualis
- HCA
- Look at Vermont Care Coordinated Model (specific elements)
- Summary of lessons of community engagement from ad hoc groups.
- Learning from equity and inclusion summary.

The IDC articulated a few opportunities they wanted to be sure the work was aligned with including:

- 2016 Legislative Session
- MIDD levy funding renewal
- Other county funding
- Seattle Foundation & United Way of King County
- “Many Minds” Philanthropy- Katherine Switz on an ongoing basis
- State innovation model (SIM) funding for practice transformation
- SUD information integration
- ACH development

Members of the IDC gave some input into the “how” we might need to structure in order to accomplish the work ahead:

- Start with what we know models that exist, rather than global information search.
- Small work groups to then bring information to the larger group.
- Virtual meetings, different than the 9 scheduled meetings- include other options for times (besides typical work day 9-5)
- Possibly schedule 2 more 4 hour work sessions.
- Take the work group idea to the kitchen cabinet then send out to group via email.

RESULTS-BASED ACCOUNTABILITY

Adapted from Mark Friedman’s, “Trying Hard is Not Good Enough: How to produce measurable improvements for customers and communities

Why RBA?

RBA is a framework that offers a disciplined way of thinking and common language to guide action toward a measurable impact on:

- **Conditions of well being** for children, families, adults, and the whole community, and
- **Quality and effectiveness** of programs, policies, agencies and service systems.

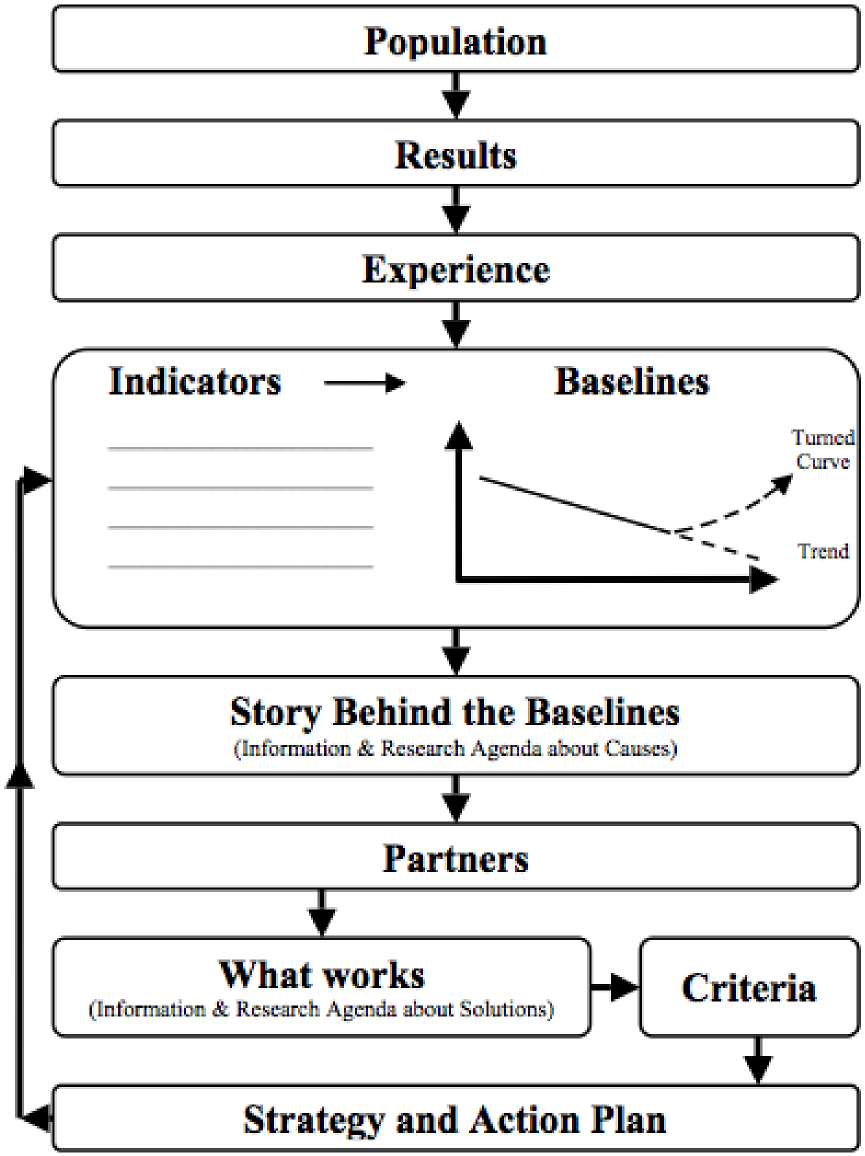
~~Not Compliance~~

Key Principles of RBA

- **Data-informed**, transparent decision-making
- **Starts at the end** to determine what you seek to achieve (results) and work backwards using data (indicators) to select and measure effectiveness of the means to those ends (strategies)
- Identifies appropriate level of **accountability**:
  - Population/community
  - Performance - Service System, Policy, Division, Agency, Program

Accountability

Getting from Talk to Action



Population

Results

Experience

Indicators → **Baselines**

Story Behind the Baselines
(Information & Research Agenda about Causes)

Partners

What works
(Information & Research Agenda about Solutions)

Criteria

Strategy and Action Plan

① 1. Who is this about?

② 2. What is the end?

③ 3. How are we doing?

④ 4. What's the story behind the baseline?

⑤ 5. Who are partners who have a role to play in turning the curve?

⑥ 6. What do we propose to do to turn the curve?

⑦ 7. How much did we do? How well did we do it? Is anyone better off?

Steps 1 and 2: Start with the End

Population Accountability

About the well-being of whole populations

Regions - States – Neighborhoods - Cities - Counties

RESULTS

A condition of well-being for children, adults, families or communities – that is aspirational and understandable to voters

- **People in King County are healthy**
- **People [with medical and behavioral health issues] achieve optimum health**

INDICATORS

A measure that helps quantify the achievement of a result

- ***Rate of population managing chronic health conditions (e.g., A1c and BP controlled psychiatric symptom management)***
- ***Rate of population reporting satisfaction with health status***

Criteria for Prioritizing Indicators & Performance Measures

Communication Power

Does the indicator/PM communicate to a broad range of audiences? Do people care about this indicator/PM?

Proxy Power

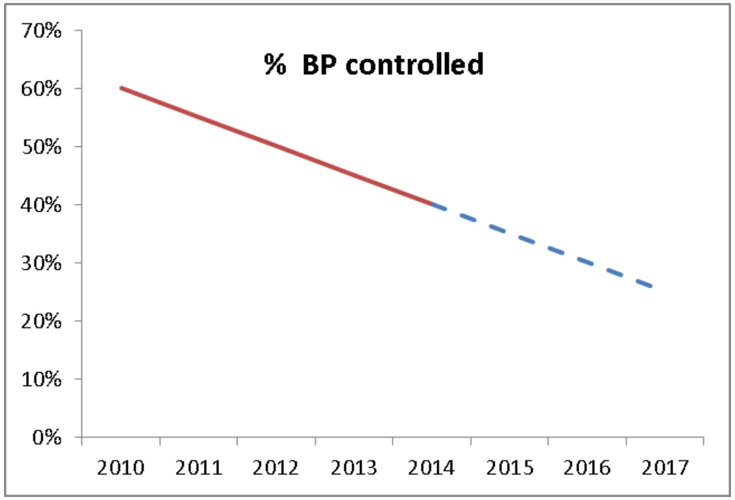
Does the indicator/PM say something of central importance about the result or strategy/program?

Data Power

Are quality data available on a timely basis.

Steps 3 and 4: What is the Baseline and the “Story Behind the Data”?

- Work backwards toward means/strategies
- What are root causes and forces that contribute to trend in indicator
- Ask “why, why why”? (3-5x)



Example:
Why is management of chronic conditions (e.g., BP control) going down (or not going up)?

People don’t know they have high blood pressure, why?

People don’t get routine medical care, why?

People don’t know where to get care they can afford

Step 5: Who are Partners who can Help to "Turn the Curve" of the Indicator?

- Identify likely and unlikely partners
- Outline contributions they can make
- Use a collective impact approach

Step 6: What Works to Turn the Curve of the Indicator?

STRATEGIES: A coherent collection of actions (policies, programs, services) that have a reasoned chance of influencing indicators (and results)

- Consider:
  - Evidence-based and promising practices
  - Community knowledge
  - Low and no-cost ideas
  - Off-the-wall ideas

Step 7: Performance Measurement

Performance Accountability

Well-being of the group directly impacted by the strategy

PERFORMANCE MEASURES

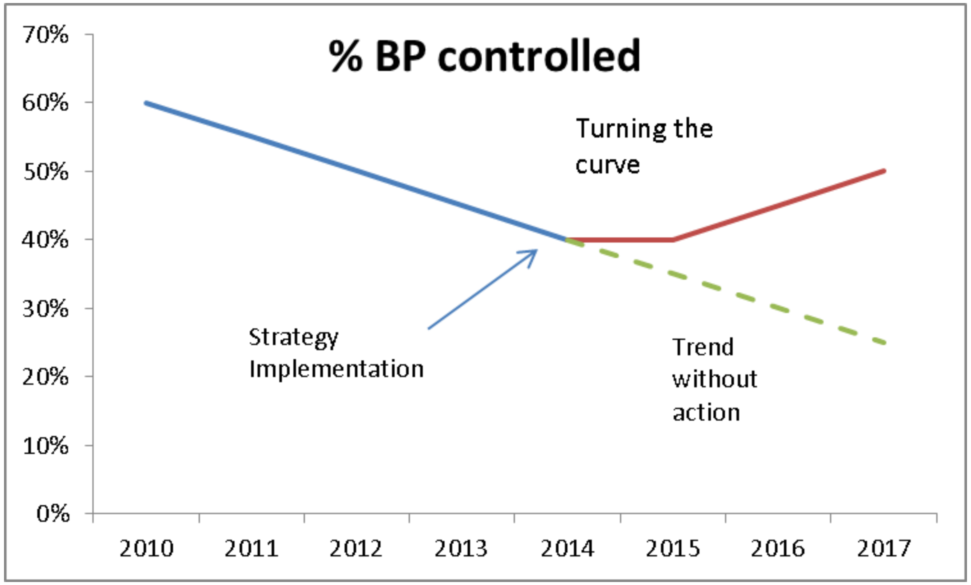
A measure of how well/how you know a strategy is working.

Three types:
1. Quantity How much did we do?
2. Quality How well did we do it?
3. Impact Is anyone better off?

1. **Example strategy:** Integrated care clinic does info/education campaign and outreach to improve primary care utilization among target population

2. **Example performance measures:**
   -% of targeted group seeing PCP within past year
   - % targeted group to taking prescribed medication

Repeat in PDSA cycle starting with Step 3 – Are strategies ‘turning the curve’ of the indicator?



0King County Physical and Behavioral Health Integration Design Committee
Monday, December 21st 2015

Flipchart Scribe – RBA section facilitated by Nadine Chan

What does this mean for people's lives?

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

1. CHILDREN

A. PHYSICAL HEALTH

We want children who are…

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

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

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

B. BEHAVIORAL HEALTH

We want children who are…

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

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

Not embarrassed by stigma from behavioral health issues (1)

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

2. ADULTS

A. PHYSICAL HEALTH

We want adults & elders who are…

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

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

B. BEHAVIORAL HEALTH

We want adults and elders who are:

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

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

3. POTENTIAL CROSS CUTTING ISSUES

- Housing
- Connections to family & community
- Hopefulness?

4. STORY BEHIND THE CURVE

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

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

5. STRATEGY IDEAS

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

6. PERFORMANCE MEASURES

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

7. Reflections & Reactions

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