King County Physical and Behavioral Health Integration Design Committee

Meeting Summary

April 29, 2016; 9:00 – 12:00 PM

Mercer Island Community Event Center, 8236 SE 24th Street, Mercer Island, WA 98040

Members Present: *Susan Mclaughlin – King County Department of Community & Human Services, Betsy Jones – King County Executive's Office, Maria Yang – King County Behavioral Health Organization, Jennifer De Young – Public Health – Seattle & King Count, Roger Dowdy – Neighborcare, Ken Taylor – Kent Valley Services, David Johnson – Navos , Patricia Quinn – Therapeutic Health Services, Emily Transue – Coordinated Care, Vicki Isett – Community Homes, Angie Riske – Multicare Behavioral Health, Julie Lindberg – Molina of Washington, Victoria Evans – Molina Healthcare, Marc Avery – Community Health Plan of Washington, Katherine Switz – Many Minds Collaborative, Suzanne Peterson-Tanneberg – Seattle Children's Hospital, Melet Whinston – United Healthcare, Stacy Fennell – Sea Mar, Maureen Linehan – City of Seattle Human Services, Aileen DeLeon – WAPI , Daniel Malone – DESC*

Members Not Present: *Tom Trompeter – HealthPoint, Darcy Jaffe – Harborview, Anne Shields – UW AIMS Center*

Staff: *Liz Arjun – King County, Jen Martin – Community Change, Martha Gonzalez – King County*

Guests: *Mark Fadool, Debra Gumbardo, Elizabeth McCauley, Robert Hilt and Annette Quayle – Seattle Children's Hospital and Regional Medical Center*

Welcome

Liz Arjun welcomed the group, new members, and the guest facilitator Jen Martin of Community Change and reviewed the agenda. New members included Katherine Switz representing the Many Minds Collaborative, Melet Whinston representing United Healthcare and Vicki Evans, representing Molina Health Care of Washington.

Pediatric Settings Providing Behavioral Health

Suzanne Peterson-Tanneberg with Seattle Children's Hospital introduced guest speakers from Seattle Children's Hospital, the University of Washington and Odessa Brown Children's Clinic. Bios for the speakers and presentations are available at the end of the summary.

Presenters included Mark Fadool representing Odessa Brown Children's Clinic, Debra Gumbardo, the Chief of Psycho-Social Services at Seattle Children's Hospital, Elizabeth McCauley, Associate Director of Child Psychiatry, Bob Hilt, Associate Director of Child Psychiatry, Seattle Children's Hospital and Annette Quayle, Manager of the Protection, Advocacy and Outreach Program at Seattle Children's Hospital.

Suzanne Tanneberg-Petersen provided a brief overview of the comprehensive Children's Hospital approach related to behavioral health which ranges from what happens in an outpatient primary care clinic, to a hospital

emergency department and inpatient setting, to a school-based clinic to community-based population approaches such as the PAL line to the non-medical patient advocacy work they do. Their overarching goal is to have meaningful physical and behavioral health outcomes for children, which requires this comprehensive approach.

Mark Fadool, Clinical Director of Mental Health, Odessa Brown Children's Clinic, began by describing the history of Odessa Brown Children's Clinic, which was conceived through consultation with and direction of the community in the 1960s. This approach has driven program development since then. As a result, behavioral health has long been available as part of the primary care services they offer, with child psychologists as a regular part of their consultation services. They do this by identifying children with the highest needs immediately and work with the family to find the best treatment for them in one location and convenient for the family. They are able to do this by working with families closely and using a pyramid of care which ranges from low intensity therapy to brief therapy and promoting first relationships. Mark pointed out that integration is more than having services available in one place (this is colocation). Rather, it is also about integrating the philosophy of all providers in the setting. All staff ranging from front end staff to security to behavioral health providers are trained to be part of this integrated approach and to identify and use "teachable moments" with families', even in the waiting room. Their behavioral health work goes beyond the clinic doors into the community. Mark gave the example of collaborating with the Boys & Girls Club soccer programs to help build a foundation for kids to teach social regulation and foundation for therapeutic programs. They would like to expand into more schools and collaborate with bigger institutions in these types of non-clinical based approaches such as home visits, gym classes and after school programs. They are very proactive and mindful about incorporating mentors that reflect the community they serve, regardless of race, color, country of origin, or language spoken. Mark closed by mentioning that in seeking to best serve the community, they are discussing some of the geographic shifts in their patient population - many of the children and families they serve are moving further away in the southern part of the city and county due to financial pressures- and what that means for the clinic.

Debra Gumbardo, Chief of Psycho-Social Services at Seattle Children's Hospital provided an overview of the inpatient and emergency behavioral health services they provide. She described the new 41 bed inpatient unit for psychology and behavioral medicine unit and she pointed out some of the data about length of stays and readmissions which indicate that there are potentially some key lessons from the King County Region. For example, while the average length of stay for all children in the unit is 8 days, for children who are residents of King County it is 6 days. Another example she noted was that while the readmission rate for the unit overall is 8%, it is only 1% for children who are residents of King County. She also shared data that show children tend to have long lengths of stays in the emergency room- on average 8 hours. They also have a pretty high admission rate- approximately 35%. A key reason the length of stays in the ED is so long is because they are working to coordinate with necessary services outside of the hospital. She also described an **arduous authorization process** for children to be admitted to the hospital. In addition to the inpatient and emergency services, Children's offers a number of outpatient specialty services including the autism center, mood/ anxiety clinic, PEARL, deaf/hard of hearing, early childhood, eating disorders, neuro-psych assessment and tele-psych services. Children's also has a team responsible for coaching front end staff on an integrated approach that incorporates behavioral health and teachable moments. Deb concluded by outlining areas for improvement including transitions between levels of care, improving and strengthening partnerships, co-location for emergency/crisis care, joint consultation, training and research to improve capacity.

Elizabeth McCauley, Associate Director of Child Psychiatry, Seattle Children's Hospital, provided an overview of Seattle Children's Partnerships with Schools, which include Seattle Public Schools, Issaquah Public Schools and some schools in South King County. They work with families and help to facilitate services they need for enhancement and partner with nurse practitioners who are located in the school-based clinics to bring their child psychologist into schools. Elizabeth pointed out that about 70% of the mental health services children receive take place in school-based settings and that the school-based mental health staff do not have enough support to meet the needs. To address this challenge, they developed a step-based model that involves a brief intervention and brief assessment of the child. Following this, most youth attend 4 or fewer sessions. In addition to this, they have developed a problem-solving skills curriculum and strategies for children in the school setting. A recent focus of their work is to reduce racial/ethnic disproportionality in disciplinary actions in schools and working with community partners in a developing a collaborative care model for the school environment.

Bob Hilt, Associate Director of Child Psychiatry, Seattle Children's Hospital is the Program Director for the Partnership Access Line- PAL, a telephone based consultation service for children's behavioral health issues for primary care providers. Bob described the PAL, which is available Monday – Friday from 8-5. The PAL receives calls, reviews cases and provides treatment summaries to providers. They employ a "teachable moments" strategy for primary care providers using problem-based learning. They can also refer to other providers. They are insurance blind, but are able to make appointments for children enrolled in Apple Health (Medicaid). In addition, they provide free psychiatric education conferences, free expert review care guide for primary care clinics and families. By doing this, they are expanding the capacity of the primary pediatric care workforce to meet the behavioral health needs of children. Bob noted that about 70% of calls are for seriously emotional disturbed children; very often for these calls, they recommend stopping medication. About 30% of the calls are about the same child. Bob also mentioned that in general there are very few studies related to providing integrated care for children and there is a need for measuring outcomes. They are working on a 1-year pilot in Tri-Cities to add on to their PAL structure and provide brief short term coordinated care.

Annette Quayle, is the Manager of the Protection, Advocacy and Outreach Program at Seattle Children's. Their purpose is to provide better health through legal advocacy. They train medical providers, social workers and other medical staff to understand the legal issues pertaining to health care and partner with Columbia Legal Services to provide direct legal services and advocate on systemic issues when appropriate. They have served over 300 families impacting 1059 people, 60% are non-white and 23% do not speak English as primary language. MLP has begun tracking the financial benefits of their services and have identified $172,044 in savings by reducing hospitalization and lengths of stays attributable to the services they have provided. Annette noted that about 1 in 6 people need legal support in order to have their health care needs adequately met and it is important that we track health care savings that result from these services. They are interested in working more with schools since so much health care children receives happens in schools. They want to offer more coaching and positive parenting for ages 0-3.

Discussion

After the presentations, Jen Martin asked members of the IDC to identify common elements and common challenges they heard across the presentations.

Common elements:

- Opportunistic care, teachable moments
- Taylor care modeling for the setting
- Practical needs addressed, program growth out of needs
- Looking at outcomes and research
- Needing more data, research, outcomes
- Leveraging resources
- Integrated common culture
- Team based: offering
- Immediate access
- Non-medical intervention can have great medical impacts
- Still divided MH/SUD
- People appreciate coaching

Common challenges:

- How do we pay for integration and value of outcomes
- Still divided MH/SUD
- Time to integrate and collaborate
- Need to have services available at the moment necessary
- Failing forward
- Building program, outcome focused
- How to send out information
- Staffing not enough certified psychologists
- More flexibility
- Cost saving structures
- Cultural access

Jen then asked the IDC, "How do we allow for flexibility and Implement community standards?"

- Not limited in how services are provided, co-location of services
- Services that will address Medicaid
- Incentivize collaboration

Themes for IDC Interviews

Jen Martin provided an overview of the interviews she conducted with IDC members about the role of the IDC, challenges to moving forward and other issues. (A report summarizing these interviews is included at the end of the meeting summary and there are slides in the slide deck that capture the key points). The general themes that were identified by the IDC included:

- Need clarity for decision making, scope of model
- Role of current legislation
- Restrictions and impact of healthier Washington and Medicaid Terminology.
- Time to Get Traction identify a timeline
- Ensure we understand the complexity

In general, there were many questions that members of the IDC had related to decision-making, role clarity (both of the IDC itself and members) and timelines.

Clarifying purpose and role of the IDC

Susan McLaughlin from King County followed Jen's presentation about the interviews with a presentation the staff prepared to help address these questions and move the IDC forward in its work. (The full slide deck is available at the end of this summary).

Susan pointed out that she will no longer be facilitating the PBHI meetings, but will now be a member of the IDC representing the King County Department of Community and Human Services. Susan described the various tables that have been established and are involved in the work that will determine the future of physical and behavioral health integration in the King County Region and the role each will play in the process. Essentially there are four tables involved: 1) the King County Accountable Community of Health, of which the 2) Physical and Behavioral Health Integration Design Committee is a formal Subcommittee; 3) the King County Internal Physical and Behavioral Health Integration Workgroup, which is responsible for researching and informing the pros and cons of the various options for King County government in a fully integrated system; and 4)the newly formed Washington State/King County leadership table which includes senior leadership from King County and Washington State which is responsible for aligning the King County Regional goals with the state goals as development of a King County model is evolves. The work of the IDC, the King County Internal Team and the Washington State/King County leadership meetings will inform the decision making that will be made by the King County Executive and the King County Council about the details of full integration in the King County Region, including models, financial infrastructure options and timing.

This presentation outlined the key recommendations the IDC will make including:

- What will the financial infrastructure for FIMC be and what is the optimal role of the County?
- What clinical model(s) of care do we want to see in our region?
- What is the timeline for implementation of full integration?
- What will the payment structure look like (for providers), a value- based payment?

Following this, Susan outlined the timeline for King County Government Decision-Making:

- Financial decision- Fall 2016
- Desired Clinical Model- Fall 2016
- Timeline for implementation of full integration end of 2016
- Payment structure- depends on implementation timeline

Priority Setting Exercise by the IDC

Jen Martin asked committee members identify the top 3 priorities that need to be addressed to complete the tasks they are charged with including: making a recommendation about the clinical model (s) of integrated care

for region, the optimal financial infrastructure that would support the/these model(s) and the optimal timeline to implement for full integration in the region. Staff will use this information to help develop a proposed workplan for consideration and refinement at the May 11th meeting. Priorities identified by the IDC included:

- Get research of other models to review financial structures and clinical
- Come to a consensus regarding what is the best for KCBHO and agencies.
- Develop a plan to present info to KC Government
- Pros and cons of early adopter experience in southwest Washington MCO vs BHO
- What is working well elsewhere?
- Sample "end users" against our ideas
- Develop pilot
- Who will be responsible for what? Infrastructure including crisis.
- What services need to be standard/community based/ payer blind
- What is working where in the country
- Decide what integration means
- Identify and understand models
- Decide 2018 or 2020
- We need to move up a couple levels in our model discussion to "continuum of care" discussions
- With higher level care model, then ask where are the gaps and what financing structure would best solve them
- Consider addressing directly the elephant in the room, which is there would be real "losers" in an FIMC BHO staff
- Prepare & respond to varying structures/models KC might adopt for "full integration"
- Get feedback/lessons from SW early adopter region
- Understand impact of waiver for our efforts
- Design the ideal clinical model
- Design the financial model that incentivizes the clinical model
- Examples of various models of FIMC
- Define parameters- what is in and out of scope
- What tools are we going to use to encourage collaboration
- Look at financial models and implications
- Systems mapping BHO vs MCO and how things would look regarding financial model and implications
- Develop mock up ideal structure for continuum of care that this committee adopts
- Draft outcomes
- Top five models of care
- Top three payment models
- Models of VBC in BH (Look at other states or systems)
- Financial Integration (drives everything else)
- Mapping of current state (financial/clinical/legal)
- Evidence based models of care
- Example from other states/countries of streamlined financing models (multiple sources of funds used together toward a common goal or program)
- Create workgroups!!!
- Finance structure including incentives
- How current models fit into future vision
- Develop a core definition of health and wellness to advise our work
- Develop a list of system transformation goals to advise models of care
- Develop a map of current BH care so we are aware of what needs to be preserved

- We need to develop a template for collaborative (i.e. - principals that every kind of service should address: info sharing requirements among specialties, one common treatment plan, outcome measures etc..)
- Bringing both physical health and behavioral health care services to community, non-healthcare settings (not just PH to BH and BH to PH settings)
- Discuss needs of SPMI population
- Value payments for comm. Services
- Southwest Washington system
- Other counties models
- Possible outcomes

Meeting Adjourned at Noon