KING COUNTY PHYSICAL AND BEHAVIORAL HEALTH INTEGRATION DESIGN COMMITTEE MEETING

April 29, 2016;

9:00 AM – Noon

Mercer Island Community Center

Today's Agenda

- **Welcome & Introductions**
- **Pediatric Settings Integrating Behavioral Health**
- **Discussion**
- **Break**
- **Themes from IDC Interviews**
- **Clarifying Purpose and Role of the IDC**
- **Building Our Next Steps Timeline**

Seattle Children's & Odessa Brown

Let's Get Results for Children and Teens

April 29, 2016

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Presenters

- **Mark Fadool, MS**: Clinical Director of Mental Health, Odessa Brown Children's Clinic
- **Deb Gumbardo, MS, RN, NE-BC**: Chief of Psycho-Social Services, Seattle Children's
- **Elizabeth McCauley, PhD, ABPP**: Associate Director of Child Psychiatry, Seattle Children's
- **Robert Hilt, MD**: Program Director for the Partnership Access Line, Seattle Children's
- **Annette Quayle, MS**: Manager of Protection, Advocacy & Outreach Program, Seattle Children's

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Desired Results

Physical for children:

- Doing things that make them happy, not using substances
- Being able to participate in activities
- Being housed and having a home

Behavioral for children:

- Not being distracted by negative things
- Conflict management skills
- Connected to community and families

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Mark Fadool, MS

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OBCC Behavioral Health

What We Provide

- Medical Clinic: services range from primary care to treatment of complex illnesses
  - 5 programs managed by OBCC to treat target populations: Sickle Cell Disease Program, Fit4You (obesity), Healthy Bodies Healthy Minds program (ADHD), Asthma, Complex Chronic Conditions
- Dental Clinic: Primary exams and treatment for children ages 12 months to 15 years
- Mental Health Clinic: psychological testing, individual and family therapy, parent training, evaluation of medicines, and home and school visits
- School-based Health: medical, mental health and nutrition services at Garfield High School, Madronna K-8 and Beacon Hill International School
- Foster Care: More than 10% of foster kids in King County receive care at OBCC
- WIC: nutrition support for low income mothers as well as other basic needs

Who We Serve – 23,437 Total Visits in FY15 (8.9% new)

- 70% Medicaid, 24% Commercial, 5% Other, 1% Other Govt./Charity/Self-Pay in FY14
- 80% are from Seattle and South King County
- 76% are non-chronic, "healthiest" patients
- 700 medically complex
- 1 in 5 speak Spanish at home
- 10% of the county's total foster kids
- Patient demographics: 52% Black, 19% Hispanic, 12% White and 4% Asian

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OBCC Behavioral Health

What is missing?

- Accessible location for families to access our services
- Proactive/nimble service coordination: increase of case management, outreach and collaboration with community partners
- Implementation of a culturally relevant universal screen used in primary care to assist in early detection of **needs** and **strengths**
- Co-location of MH providers in primary care focused on Before to 5 services

Concrete Suggestions for Integrated Care in King County

1. Strategically placed primary care clinics which offer integrated holistic services
2. Method of administering culturally relevant universal screens in primary care county-wide
3. Improved collaboration amongst community-led partners

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Behavioral Health Specialty Care at SCH

Deb Gumbardo, MS, RN, NE-BC

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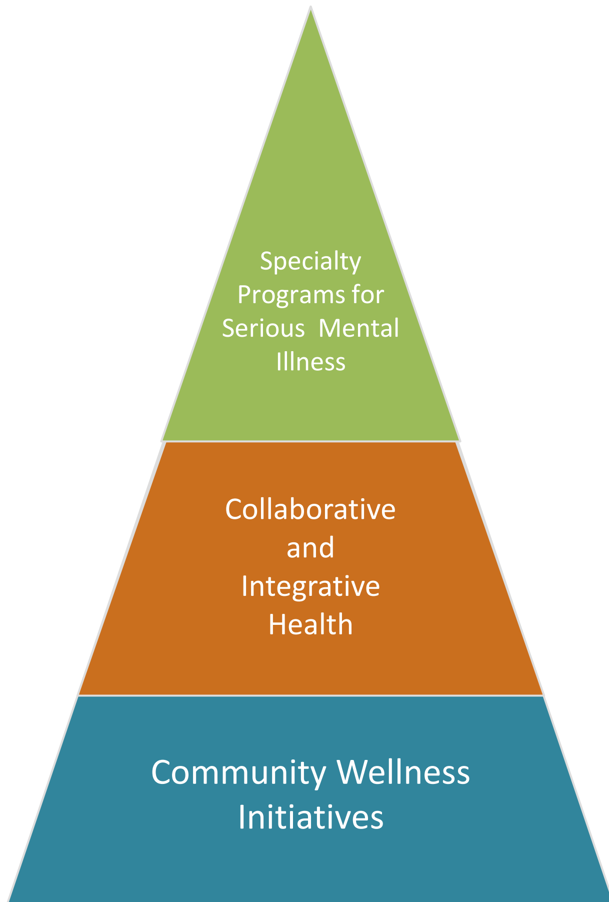

What We Provide:

- Specialty Outpatient and Inpatient Care, Pediatric Emergency Services
- Collaborative and Integrative Health
  - Partnership Access Line (PAL)
  - OBCC Integrative / school based services
  - Embedded MH services in pediatric tertiary care clinics
- Community Wellness
  - SMART- school based services
  - Prevention Wins Coalition
  - Parenting Education Medical Legal Partnership

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Psychiatry and Behavioral Medicine Services - Overview

- We are a multi-disciplinary service providing care, infants to young adults
- Our clinical services consist of an inpatient program with a *dedicated 41-bed unit*; consultation-liaison services ; emergency service; and outpatient clinics
- *$3.8 million* in extramural research funding in 2015
- *~ 45 faculty* members and SCH clinical staff (MDs, PhDs, NP, MHTs, RNs , Pediatric Mental Health Specialists)
- Training programs include child psychology interns, psychiatry fellows, general psychiatry residents, medical students and ARNPs from corresponding UW programs; over 20 trainees are involved annually
- We deliver our care at several locations including the hospital's *Main Campus*, the *Autism Center* in Seattle, *Bellevue* and *Odessa Brown Children's Clinic*
- To provide access to our region, we also provide tele-psychiatry services in locations across the state and Alaska

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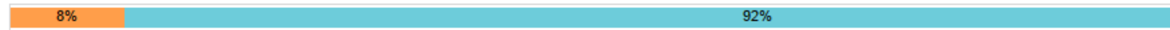
Specialty Programs for Serious Mental Illness

- Psychiatry and Behavioral Medicine Unit
  - 41 beds (40 % ↑ admissions FYTD '15- '16)
  - Seclusion / restraint free environment

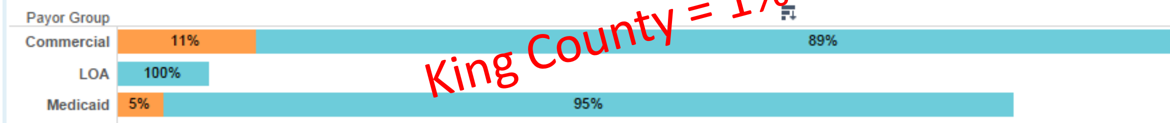
FYTD 2016 Recidivism by Payor

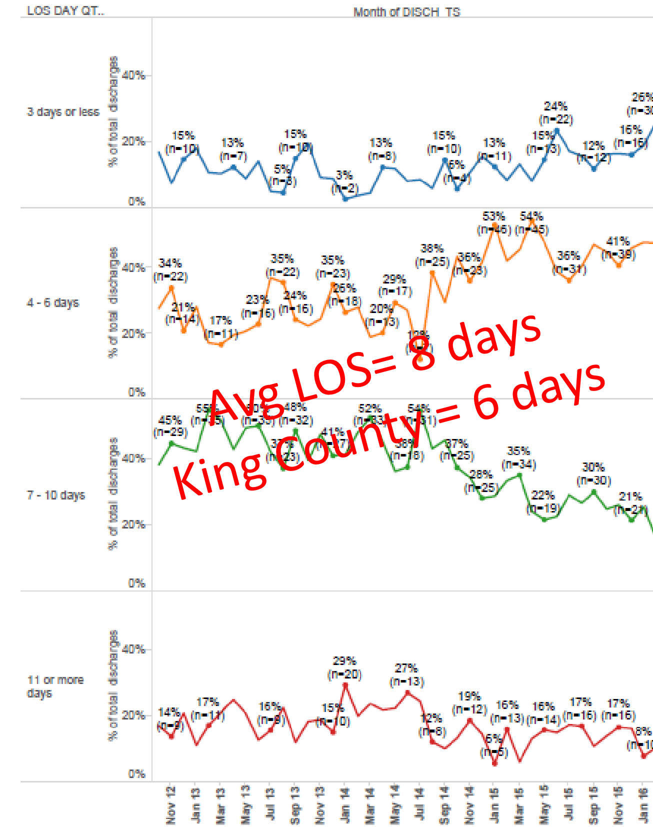
Non-recidivism
Readmission < 30 days

FYTD % Readmission < 30 days



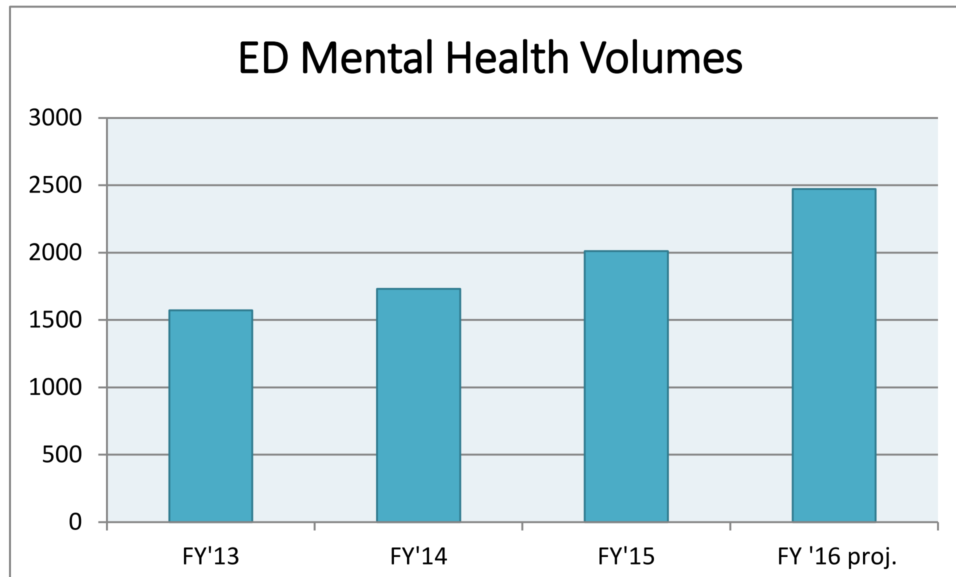
Readmits < 30 days and payor group





Specialty Programs for Serious Mental Illness

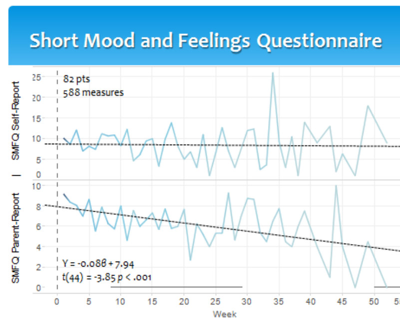
- Emergency Psychiatric Services- Crisis intervention and triage

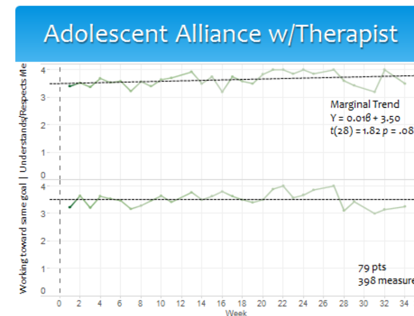


- Long Lengths of Stays (8 hrs)
- *Arduous* authorization process
- ~ 35 % admitted

- Research across our priority areas
  - Research embedded in specialty programs (Autism Center , Mood/ Anxiety Clinic, PEARL)
  - Deaf / Hard of hearing program, Early Childhood, Eating Disorders, Neuro-psych Assessment, tele- psych services

- Utilize and promote empirically based behavioral health assessment and treatment interventions.
  - Routine Outcomes Measurement





Specialty Programs for Serious Mental Illness

- Enhanced access addressing mental and psycho-social needs of families primarily served by medical specialties
  - Consultation and Liaison services
  - Behavioral Support Team
  - Peds psych partnerships (hem/onc, cardiology, GI, endocrine, pulmonary)

Opportunities for improvement

... Improved partnerships

- Ability to receive specialty services from another agency

i.e. DBT or other EBP or modalities, that may be indicated but not available at the primary tiering agency

- Transitions between levels of care or while child is receiving medical specialty services (" simple and flexible to meet the patient/ families needs")

- Co-location for emergency / crisis care

- Joint consultation , training and research to leverage expertise and expand capacity

Partnerships with Schools

Elizabeth McCauley, PhD, ABPP

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Community Wellness: Partnerships with Schools

- **2002 SCH/UW began active collaboration with Seattle Public Schools**
  - **Research collaboration: Developmental Pathways Project, High School Transition Study, Brief Intervention for School Based Counselors (BRISC)**
  - **Program Collaboration:**
    - **Middle School Support Project:**
    - Nesholm Family Fund: support school success/retention of high risk students with both academic and behavioral health needs
    - MSSP placed mental health professionals in 4 SPS hi needs middle schools to coordinate the multiple service needs of most at risk students

Partnerships with Schools

- **2006 Excellence Project**
  - Collaboration with S/KC Public Health to provide training and consultation to providers in school based clinics
  - Begin with 2 yr. Robert Wood Johnson grant, additional support from KCPH, levy monies, and the Loeb Family Foundation/SCHRI
  - Kicked off an ongoing partnership—Child psychiatry faculty and fellows provide training and consultation
  - Involves partnership with Group Health, Neighborcare, Swedish, International Community Health Services
  - 2013 extended to Issaquah, school King county districts/schools

Partnerships with Schools

- **2006 Excellence Project**
  - **Findings from initial work:**
    - Large caseloads, sole practitioner
    - Frequent disruptions
    - Engagement difficulties
    - Some students with subclinical presentations
    - Most youth attend 4 or fewer sessions

  Development of a brief intervention model (3-4 sessions) to maximize *intervention-setting fit* (Lyon, McCauley, Vander Stoep, 2011)
  - Institute of Educational Sciences, DOE—Brief Intervention for School Based Counselors program development award

Partnerships with Schools

- **2014 School Mental health Assessment, Research, and Training (SMART) Center**
  - Partnership between SCH Faculty and the UW School of Medicine and College of Education
  - Three areas of focus:
    - Training, technical assistance, advocacy
    - Assessment, screening and data utilization
    - Research and Evaluation
  - Example Projects:
    - Further testing of the BRISC approach
    - Partnership with SPS to assess strategies to address racial/ethnic disproportionality in disciplinary actions
    - Work with community partners to adapt and test a collaborative care model for the school environment

Partnership Access Line (PAL)

Bob Hilt, MD

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PAL Telephone Based Consultations

- Teachable moments
  - "problem based learning" with own patient
- Reach a large audience with limited resources
- No technological barriers or office changes
- In 2008, WA started the 2nd statewide child mental health consult service
  - Now > ½ of states have some version of this service…

Partnership Access Line (PAL) Process

PCC calls with a mental health question on any patient 8AM-5PM PST

PAL CAP provides a rapid access phone consult

Summarized advice is faxed to PCC (by next day)

Full in person or televideo consult *if* both desired by PCC & Medicaid child

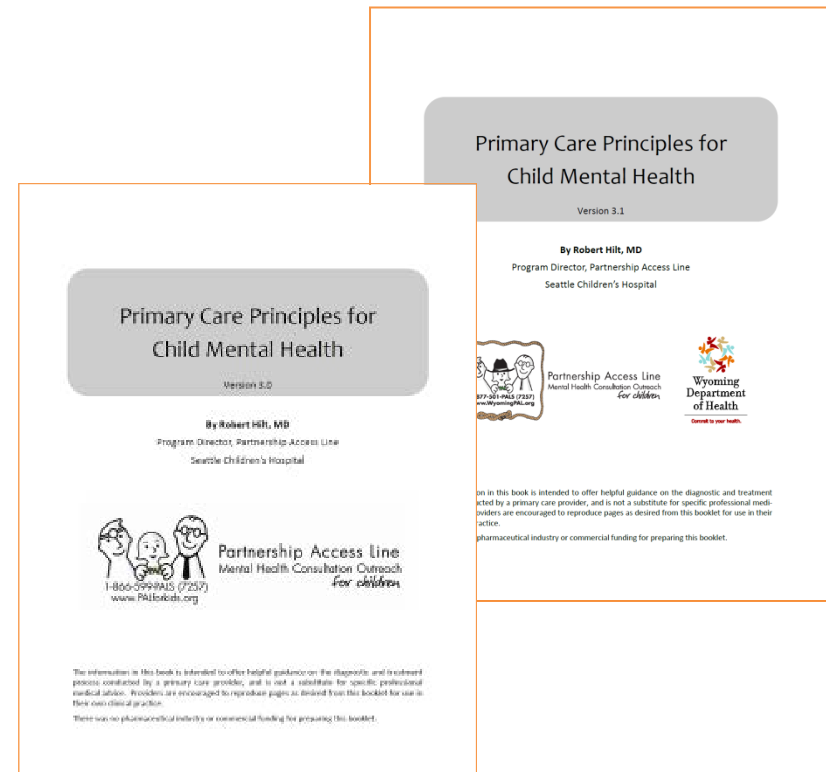
PAL worker provides resource assistance or a phone consult (by PCC or CAP request)

Same day PCC feedback

CAP=child & adolescent psychiatrist
PCC=primary care clinician

Other Unique Aspects of PAL

- Free psychiatric care education conferences
  - 4 times a year in WA
  - 3 times a year in WY
- Free, expert reviewed care guide for PCC and families
  - At palforkids.org and wyomingpal.org
- Quarterly fidelity audits and team consult approach to ensure consistent care



PAL Care Guide Examples

Anxiety Resources

Information for Families

Books parents may find helpful:

Freeing your Child from Anxiety (2004), by Tamar Cha

Helping Your Anxious Child (2008), by Rapee, PhD, Wi
Lyneham, PhD

Worried No More: Help and Hope for Anxious Childre

Talking Back to OCD (2006), by John March, MD

Freeing Your Child from Obsessive-Compulsive Disord

Books children may find helpful:

What to Do When You Worry Too Much (2005), by Da

What to Do When You Are Scared and Worried (2004

Websites parents may find helpful:

Anxiety Disorders Association of America
www.adaa.org

Children's Center for OCD and Anxiety
www.worrywisekids.org

Child Anxiety Network
www.childanxiety.net/Anxiety_Disorders.htm

American Academy of Child and Adolescent Psychiatr
www.aacap.org/cs/AnxietyDisorders.ResourceCenter

National Institute of Mental Health
www.nimh.nih.gov/health/topics/anxiety-disorders/i

Pediatric Symptom Checklist-17 (PSC-17)

Caregiver Completing this Form: ______________________ Date: ____________________

Name of Child: ____________________

		Please mark under the heading that best fits your child			For Office Use		
		NEVER	SOMETIMES	OFTEN	I	A	E
1.	Fidgety, unable to sit still						
2.	Feels sad, unhappy						
3.	Daydreams too much						
4.	Refuses to share						
5.	Does not understand other people's feelings						
6.	Feels hopeless						
7.	Has trouble concentrating						
8.	Fights with other children						
9.	Is down on him or herself						
10.	Blames others for his or her troubles						
11.	Seems to be having less fun						
12.	Does not listen to rules						
13.	Acts as if driven by a motor						
14.	Teases others						
15.	Worries a lot						
16.	Takes things that do not belong to him or her						
17.	Distracted easily						
	(scoring totals)						

Scoring:
- Fill in unshaded box on right with: "Never" = 0, "Sometimes" = 1, "Often" = 2
- Sum the columns.
  PSC17 Internalizing score is sum of column I
  PSC17 Attention score is sum of column A
  PSC17 Externalizing score is sum of column E
  PSC-17 Total Score is sum of I, A, and E columns

Suggested Screen Cutoff:
PSC-17 - I ≥ 5
PSC-17 - A ≥ 7
PSC-17 - E ≥7
Total Score ≥ 15

Higher Scores can indicate an increased likelihood of a behavioral health disorder being present.

PSC-17 may be freely reproduced.
Created by W Gardner and K Kelleher (1999), and based on PSC by M Jellinek et al. (1988)
Formatted by R Hilt, inspired by Columbus Children's Research Institute formatting of PSC-17

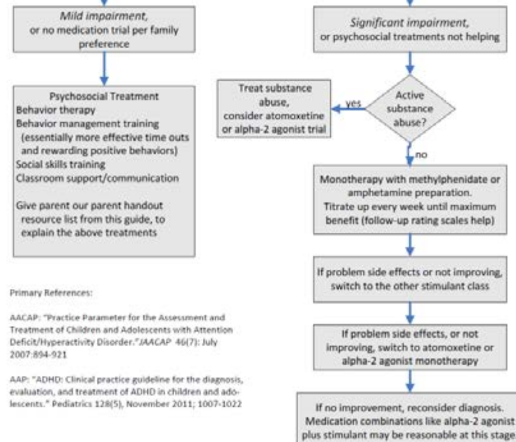
Considering ADHD diagnosis?
Problem from inattention/hyperactivity?

Consider comorbidity or other diagnosis:
Oppositional Defiant Disorder
Conduct Disorder
Substance Abuse
Language or Learning Disability
Anxiety Disorder
Mood Disorder
Autistic Spectrum Disorder
Low Cognitive Ability/Mental Retardation

Diagnosis:
Preschoolers have some normal hyperactivity/impulsivity: recommend skepticism if diagnosing ADHD in this group. (Note that Medicaid may require a medication review if prescribing and child age <5)
If rapid onset symptoms, note this is not typical of ADHD

Use DSM-5 criteria:
Must have symptoms present in more than one setting
Symptom rating scale strongly recommended from both home and school
Vanderbilt ADHD Scale (many others available, for a fee)
If unremarkable medical history, neuro image and lab tests are not indicated
If significant concern for cognitive impairment, get neuopsychological/learning disability testing

Treatment: If diagnose ADHD



Primary References:

AACAP: "Practice Parameter for the Assessment and Treatment of Children and Adolescents with Attention Deficit/Hyperactivity Disorder." JAACAP 46(7): July 2007:894-921

AAP: "ADHD: Clinical practice guideline for the diagnosis, evaluation, and treatment of ADHD in children and adolescents." Pediatrics 128(5), November 2011; 1007-1022

Written Consult Follow-Up Notes

Faxed on next business day

Partnership Access Line
Mental Health Consultation Outreach
for children

1-866-599-PALS (7257)
www.PALforkids.org

Exxxx Bxxxxxxx
Xxxx xxxxx xxxx
xxxxx, WA xxxxx
360-xxx-xxxx (Fax)

Dear Exxxx Bxxxxxxx,

On 1/4/2013 you had a telephone discussion with xxx xxxx of the Partnership Access Line regarding your patient xxxx xxxxxx. Based on the information you provided to our program, we offered some suggestions for how to better help xxxx. Below is a summary of those care suggestions as recorded by xxx xxxxx, which you might find helpful for future reference.

Particular non-medication interventions we recommended:
Psychiatric Evaluation - referrals already provided to family
Cognitive Behavior Therapy - for depression and anxiety; if self-harm is more chronic and prominent, consider Dialectical Behavioral Therapy

Psychosocial treatment advice discussed:
1. Pursue the excellent treatment plan that you have already laid out by obtaining a comprehensive psychiatric evaluation and follow up with the therapist to ensure evidence-based therapy is being conducted
2. Encourage the family to follow a crisis prevention plan: if one is not already in place, they should work with the therapist on one right away

Medication to consider stopping (in the next month), or to cancel plans to start:
Paxil - although the plan now is to stop it given more concerns about increased suicidality with Paxil and xxxx's perception that it is not helpful, Paxil can be reconsidered at a higher dose in the future if other antidepressants prove ineffective

Medication to consider starting (in the next month):
Prozac - can be helpful for depression and anxiety and potentially bulimia if there's significant binging and purging to qualify for the diagnosis

Ideas that were discussed for monitoring your patient:
1. Stop Paxil as planned and replace with Prozac as recommended: please refer to PAL Care Guide for details. If Prozac is not tolerated or ineffective, please call PAL for further recommendations if (___) does not already have a psychiatrist in place
2. Administer screening questionnaires from PAL Care Guide for depression, anxiety and eating disorder

Care Guide Components Recommended:
Depression, Anxiety, Eating Disorder

PAL Consult Characteristics

- 69% “Serious Emotional Disturbance” (CGAS < 50)
- Majority of calls on Medicaid clients

- 87% recommended to start a new psychosocial intervention
- 46% recommended to start a new medication
- 24% recommended to stop a medication

Other PAL Consult Data

- 30% case co-management (repeat discussions about the same child)
- 51% utilized PAL Social Work assistance
- Different kids than mandatory 2nd opinion reviews (only ~5% overlap)
  - Same consultants=fidelity of message
- Care recommended to remain with the PCP ($\pm$ a therapist) 2/3 of the time
- Provider feedback highly positive

Integrated Care Data for Kids

- Adolescent depression collaborative care
  - Up to 4 sessions brief CBT in PCC clinic
  - Care coordinator assistance for the PCC
  - 50% vs. 21% remission vs usual care
    - L Richardson et al 2014
- Behavior problems, ADHD, and anxiety
  - CBT based coaching sessions within PCC office (mean of 45 min total)
  - improvement in behavior problems, hyperactivity, and internalizing problems
  - reduced parental stress and greater consumer satisfaction
    - D Kolko et al. 2014

Elements of Integration

1. Early detection and screening in primary care
2. Person who works in the care coordination role
3. Ready access to child psychiatric consultation
    1. For provider “curbsides”
    2. For face to face evaluations with patients
4. Triage/referral plan for behavioral health treatment (traditional specialty mental health)
5. System for tracking and monitoring outcomes

AACAP, Best Principles for Integration of Child Psychiatry into the Pediatric Health Home, 2012

What “PAL Plus” Pilot Will Look Like

- PCC identifies children in need of services
  - Start with depression/anxiety
- Care coordinator identifies and follows cases
- Child therapist can see patient in the PCC office
  - Evaluation assistance and short term care support
- Child psychiatrist and psychologist consult with team weekly
  - Available for patient consult appointments
- Shared information system used by all providers

Parenting Education & Medical-Legal Partnership

Annette Quayle, MS

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MLP: Better Health Through Legal Advocacy

Washington Medical Legal Partnership

Medical Partners				Legal Partners	
Harborview Medical Center	Odessa Brown Children's Clinic	Seattle Children's Hospital	Valley Cities Counseling and Consultation	Northwest Justice Project	Private Bar (Pro Bono)

Tiered Response Through MLP

Advocacy

Direct Client Services

Provider Capacity Building, Education & Resources

Advocates on systemic issues to promote child health and well-being

Provides direct legal services and consultation to patient families

Trains medical providers and social workers to identify legal needs of patients and families and provide intervention, when appropriate

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Medical-Legal Partnership 2015 Stats

5 main areas of legal assistance:

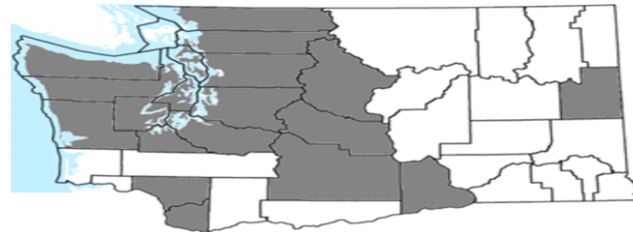
- **I** Income, public benefits
- **H** Housing, health insurance
- **E** Education benefits
- **L** Legal status, immigration
- **P** Personal safety, family law

315 families received direct legal services, impacting **1059** people

293 care providers trained in legal advocacy

3 systemic advocacy projects, including home nursing care

86% of patient-clients served below 200% of poverty level



Patient-clients in **21** counties served (**3** out of state)

60% of families served non-white

23% of patient- clients non-English speaking

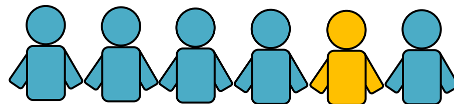
Over **215** pro bono hours provided by volunteer partners

MLP Financial Benefit to Healthcare

MLP Metrics	Data for 3 months (10/15-12/15)
Days of hospitalization avoided	41
Reduced length of stay days	79
Additional Revenue	$50,544
TOTAL FINANCIAL BENEFIT to Children's	$172,044

Medical-Legal Partnership

1 in 6 people need legal care to be healthy*



Recommendations

1. Resolve health-harming legal needs and remove barriers to health
2. Integrate MLP throughout the community
   - Health care
   - Schools
   - Social Services
   - Housing

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Positive Parenting

Resident and Staff Training in Positive Parenting Support

- Build provider capacity
  - Focus on importance of parents in long-term health and well-being of children
  - Provide relationship-centered care within a framework and strategies
    - Builds parent's confidence
    - Offers coaching to deal with challenging behaviors
    - Supports healthy parent-child relationships

- Training all first year residents beginning July, 2016.
- Goal: All staff trained in Positive Parenting Support

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Positive Parenting

All babies cry... sometimes a lot!

But it's normal.
Getting frustrated is normal too—
but no matter what,

NEVER SHAKE A BABY.

Shaking a baby can cause blindness, seizures, learning disabilities or death.

Introducing, the **Period of PURPLE Crying**® — a new way to understand normal infant crying and WHAT TO EXPECT AND DO when a baby cries.

Being a parent or caregiver is hard, and you are not alone!

Visit **www.dontshake.org** to learn about the Period of PURPLE Crying® and get the tips and strategies you need to keep babies safe.

The Period of PURPLE Crying

Statewide prevention of abusive head trauma

Understanding your baby's crying and knowing coping strategies

Dose One: In 80% of birthing hospitals in the state

Dose Two: primary care, day cares, public health, etc.

Dose Three: widespread media campaign

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Positive Parenting

Recommendations

1. Make Positive Parenting the community approach so consistent message is given:
   – Relationship is key, strategies are available, parents can meet the social and emotional needs of their children

2. Have PURPLE be the consistent message – in prenatal classes and visits, birthing hospitals and sites, primary care, other interactions.

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Questions & Discussion

Thank you!

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DISCUSSION

KEY INTERVIEW THEMES

IDC Interviews with Jennifer Martin

Interview Themes

Everyone believes in the vision and purpose of integrated care so that clients ultimately have better services and outcomes.

- **We should go when we’re ready (but keep moving)**
  - Our recommended model should be based on robust research, evidence-based practices, and piloted concepts
  - We should believe our recommendation will be more efficient, cost less, provide better care, be financially sustainable and result in better health outcomes
  - BUT we need the pressure of a deadline to keep us moving forward

Interview Themes (cont.)

- **We need some roles and scope clarification**
  - Decision-making: Where does this committee send recommendations and who ultimately makes the final decisions? What do they need to make those decisions?
  - Scope of Model: Are we focusing on integration of both financing and client services? What is the target population? Are we looking at evidence based practices or unproven approaches as well?
  - Current Legislation and Restrictions: What does the current legislation say about integrated health care? Are there parameters that we will be required to follow from the state and Health Care Authority (HCA)?
  - Impact of *Healthier Washington* and Medicaid Transformation: What could be the potential impact of the Medicaid waiver and state movement towards value-based purchasing mean for what the IDC should consider?

Interview Themes (cont.)

- **It's Time to Get Traction**
  - Appreciate education, but there is a short window even to 2020
  - Balance bringing everyone up to speed with moving forward (let's start looking at "straw" models
  - Identify a timeline so we can work backwards and create a workplan
  - Monthly meetings are not enough to do what we need to do

- **Ensure We Understand the Complexity**
  - Some still learning, others feel we're not digging deep enough (some need more information, others in "information overload")
  - Suggestion to map the current system so we know what it will mean to integrate what's currently under MCOs and BHO
  - Create a model that is not just behavioral and physical – there are specialty needs and social determinants of health

Other Themes

- **Stay focused on the ultimate goal**
- **Create space for all voices**
- **Uncertainty on the committee's level of influence** (but members will champion a model they believe in)
- **We have good representation on the committee** (just a few mentioned potential gaps)
- **What are everyone's interests or "non-negotiables"?** (put them on the table when we discuss models)
- **Not everyone can attend the meetings** (so don't switch meetings, find ways to keep people updated)

Other Things to Consider for the Model

- **Data Sharing**: this is key for integration success
- **Access**: "no wrong door" and meet people where they are
- **Roles**: Different opinions, but it must be effective, efficient and focused on increasing health for people in King County
- **Perspectives**: How we look at things will determine our success (i.e., preventative, holistic approach to *health* not illnesses)
- **Co-location vs. Collaboration**: different opinions but ultimately that people *experience* integrated services
- **Learn from Others**: SW WA and across the country; look at evidence based best practices
- **Creative and Intentional Financing**: what will support our goals and leverage cost-savings

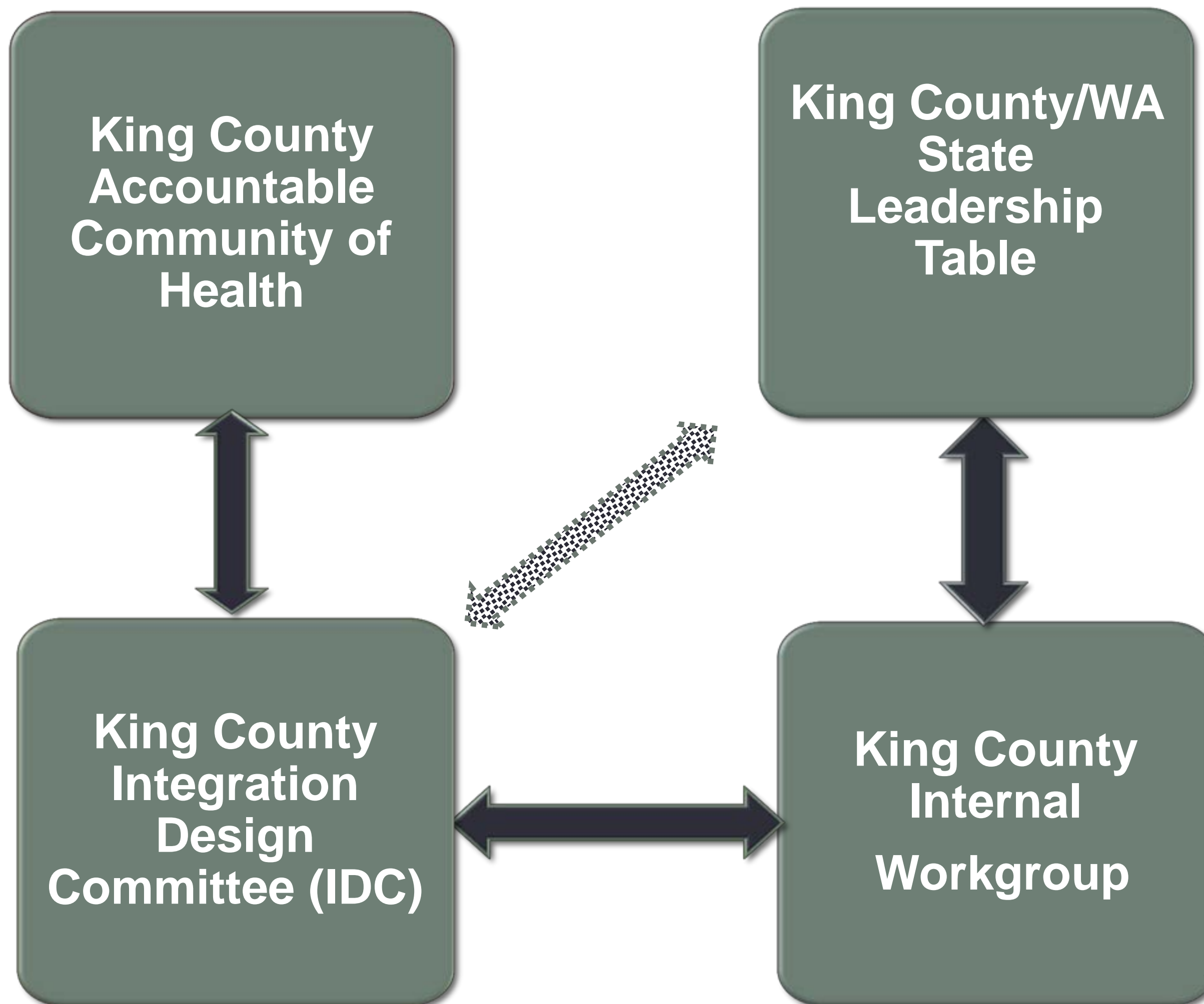
CLARIFYING PURPOSE AND ROLE OF THE IDC

Susan McLaughlin, King County Department of Community and Human Services

FULL INTEGRATION TABLES

Membership and Roles

Landscape of Full Integration Work in King County



King County Accountable Community of Health

- **Who is participating?**
  - Regional cross-sector partners: hospital systems, social service providers, health and behavioral health providers, housing providers, Medicaid Managed Care, local government (including King County).

- **What is the purpose?**
  - Identify regional health priorities
  - Support and further efforts to improve health care, lower costs and improve outcomes in the region.
  - Build on 4 priority areas where work is already happening, including physical and behavioral health integration.
  - Serve as a regional voice to the state about regional health priorities and how to further the work to achieve the triple aim.
  - Work across siloes to address the many factors that influence health (social determinants), not just access to health care.

Physical and Behavioral Health Integration Design Committee (You!)

- **Who is participating?**
  - Representatives from key sectors in the King County Region including MCOs, behavioral health, physical health, housing providers
- **What is the purpose?**
  - Recommend a model(s) of fully integrated care to serve **Medicaid clients and other vulnerable populations for the King County region**;
  - Advise King County on a path forward for Fully Integrated Managed Care, including a timeline that reflects the readiness of our community
  - Deliver recommendations to the King County Accountable Community of Health for their endorsement as a regional body
  - Deliver recommendations to the King County Executive and Council to inform decision making regarding FIMC

King County Full Integration Workgroup

- **Who is participating?**
  - Public Health, Behavioral Health and Recovery Division, Executive's Office, Office of Performance Strategy and Budget; Department of Community and Human Services

- **What is the purpose?**
  - Explore potential roles for King County in providing Fully Integrated Managed Care (FIMC)
  - Study and bring to the work aspects of other national integration efforts
  - Examine risks and benefits of various FIMC models
  - Synthesize and summarize activities of internal work, IDC, and state negotiations to develop a recommendation for a path forward

King County/Washington State Leaders

- **Who is participating?**
  - Department of Community and Human Services, Behavioral Health and Recovery Division, Executive's Office, Public Health- Seattle & King County, Governor's Office, Health Care Authority, Department of Social and Health Services

- **What is the purpose?**
  - Negotiate critical aspects of a Fully Integrated Managed Care model (for Medicaid population) for King County;
  - Maintain alignment between state goals and County goals
  - Establish a timeline and work plan for implementation on the decided regional timeline

IDC King County Staff

Susan McLaughlin, PhD: DCHS and the Behavioral Health and Recovery Division (Behavioral Health Organization); participates in State/County leadership meetings

Maria Yang, MD: Medical Director for BHRD/BHO and jail psychiatrist;

Betsy Jones: Health and Human Potential Policy Advisor to King County Executive; participates in State/County leadership meetings

Scarlett Aldebott-Green; King County Council central staff

Jennifer DeYoung: Public Health- Seattle & King County

Liz Arjun: Staffs and supports the work of the IDC

Full Integration: What the Legislation Says

- Calls for the integrated purchasing of mental health and substance abuse treatment (collectively, behavioral health) services through managed care by April 1, 2016
  - **DONE!** King County BHRD became the regional Behavioral Health Organization
  - Integrated mental health and substance use treatment
  - Move SUD system to managed care
  - Increased access to co-occurring disorder treatment
  - Numerous lessons learned to apply to continued integration efforts
- Calls for *full integration* of mental health, substance abuse and physical health care by January 1, 2020
  - A lot of debate about what full integration means

Key Decisions to be made

- What will the financial infrastructure for FIMC be and what is the optimal role of the County
  - MCOs administer all Medicaid physical & behavioral health
  - King County administers all Medicaid physical & behavioral health
  - King County operates a FIMC plan for a specialty population
  - Collaborative Care Partnership between King County and MCO(s)
  - Other options
- What clinical model(s) of care do we want to see in our region
- What is our timeline for implementation of full integration
- What will the payment structure look like (for providers)
  - How do we get to value based payments

HCA Full Integration Timelines*

Activity	2017 Adoption	2018 Adoption	2020 Adoption
HCA/Regional Engagement Begins	Now		
Non-Binding Letter of Intent	5/1/2016	5/1/2017	11/1/2018
County Engagement/Model Discussion/Finalize Model	7/1/2016	7/1/2017	1/1/2019
Binding Letter of Intent	8/1/2016	8/1/2017	2/1/2019
Release RFP	9/1/2016	9/1/2017	3/1/2019
RFP Response Due	11/1/2016	11/1/2017	5/1/2019
Announce Successful Bidders	1/1/2017	1/1/2018	7/1/2019
Sign Contracts	2/1/2017	2/1/2018	8/1/2019
Readiness Review	2 - 7/2017	2-7/2017	8/1/2019-1/1/2020
Contract Start	7/1/2017	7/1/2018	1/1/2020

*Subject to modification as needed

King County Decision Making Timeline*

Decision	Dates
What will the financial infrastructure for FIMC look like? - What is the optimal role of the County	Fall 2016
What is the desired clinical model(s) including crisis system	Fall 2016 (general) Detailed dependent on implementation timeline
Timeline for implementation of full integration (will we be a mid-adopter?)	By the end of the year (2016)
What will the payment structure look like - Value based payment models, etc.	Dependent on implementation timeline

*Subject to modification as needed

Other Factors and Context

State Convened Full Integration Work Group

- Convened by Bob Crittenden of Governor's Office
  - 3 subgroups: Crisis and non-Medicaid; Tribal relations; Finance and administration
  - Recommendations by October 2016

Healthier WA/Medicaid Transformation:

- State effort to reform Medicaid by seeking additional flexibilities through an 1115 waiver
  - Physical and behavioral health integration is key strategy of waiver and may create opportunities to accelerate implementation of integrated care models
  - 80% of Medicaid contracts are value based payment by 2020

Decision Making Structure

Work Happens Here

Decisions Happen Here

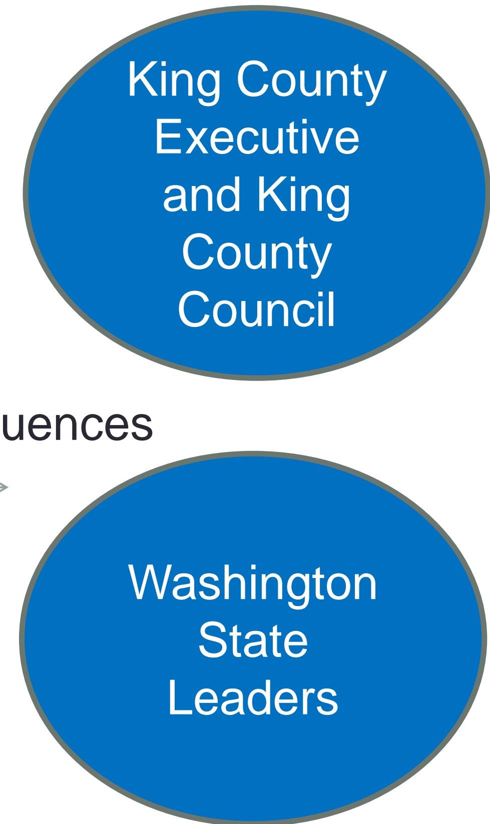
King County Accountable Community of Health

King County/WA State Leadership Table

King County Integration Design Committee (IDC)

King County Internal Workgroup

Informs/influences



Steps in Decision Making Process for Implementation

- Internal workgroup is compiling, studying, synthesizing and analyzing information from other national models
- Simultaneously, the IDC is studying and informing models of clinical and financial integration
- King County leadership is using this information in negotiations with state regarding financial infrastructure and role of King County
- Ongoing briefings with Executive Leadership and County Council
- Final proposal about financial infrastructure
- Depending on alignment with state:
  - Negotiate implementation timeline (including mid-adopter or not)
  - Legislative changes

Steps in Decision Making Process for Implementation

- If 2018 implementation timeline
  - January begin process for non-binding letter of intent
  - Step up full bodied negotiations with state around design (would include this group and others)
  - Legislative process for binding letter of intent

- If 2020 implementation timeline and/or legislative changes needed
  - Develop legislative strategy and goals
  - We have at least two sessions before 2020 implementation

How do final decisions get made?

- IDC is an <u>advisory group</u> that will make recommendations to King County about how to proceed and readiness of the community (clinical model(s); payment structure; timeline; and thoughts about optimal role of County)
- IDC will play a critical role in negotiations with the state and any legislative changes needed to achieve our goals (through current associations and channels as well as through the ACH)

How do final decisions get made?

- King County Executive makes final recommendation to council via legislation to submit binding letter of intent for implementation timeline
- County Council, through a Motion, approves binding letter of intent
- King County Executive makes final recommendation to council via legislation regarding any changes to the role of the County in FIMC
- County Council makes legislative changes to codify any changes to the role of the County in FIMC

WHAT IS THE BEST APPROACH TO GET THE JOB DONE

Jennifer Martin

IDC Current Schedule

Schedule Meetings	Planned Activities
May 11th IDC Meeting	Overview of Specialty Behavioral Health & Providing Primary Care in this Setting; Mapping of current system components
June 8th IDC Retreat	Consider Straw Proposals, Model Planning
July 13th IDC Meeting	Model Refinement
August 10th IDC Meeting	Role of County & Integrated Financing
September 14th IDC Meeting	Finalize Recommendations about the Integrated Model of Care (including financing), and role of the County in delivering the model

Note: This is NOT enough time to get the work done

Physical and Behavioral Health Integration
Design Committee

April 29, 2016; 9:00 AM – Noon

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

Meeting Goals:

- **Learn about the key elements to provide behavioral health care services to children and youth in pediatric settings;**
- **Identify components the committee thinks are important for children in designing the model**
- **Provide clarity about the role of the committee and environmental context**
- **Identify next steps timeline**

Agenda

1. **Welcome & Introductions** *Liz Arjun , King County*	9:00 – 9:15 am
2. **Pediatric Settings Integrating Behavioral Health** *Seattle Children's Hospital & Regional Medical Center Experts*	9:15 – 10:00 am
3. **Discussion** *Jennifer Martin, Facilitator* • What are the Common Elements? • What are the Common Challenges? • How do we allow for flexibility yet also implement community standards?	10:00 – 10:30 am
4. **Break**	10:30 – 10:40 am
5. **Themes from IDC Interviews** *Jennifer Martin, Facilitator*	10:40 – 10:50 am
6. **Clarifying purpose and role of the IDC** *Susan McLaughlin, King County*	10:50 – 11:15 am
7. **Building Our Next Steps Timeline** *Jennifer Martin, Facilitator*	11:15 – Noon

Next Meeting: May 11; 1:30 PM - 4 PM
Navos-Revelle Hall
1210 SW 136th St.
Burien, WA 98166

King County Physical and Behavioral Health Integration Design Committee
April 29, 2016

Speaker Bios

Mark Fadool, MS
mark.fadool@seattlechildrens.org
(206) 987-7261

I have worked for Seattle Children's Hospital for past 18 plus years and I'm honored to be the Clinical Director of Behavioral Health at the Odessa Brown Clinic (OBCC). I was raised in what was once called a ghetto outside of Pittsburgh in Aliquippa, PA. At the age of six due to multiple family crises I was adopted and nurtured by a wonderful feminist, civil rights advocate and social worker in a middle class suburb. This amazing life experience along with the opportunity to attend higher education led me to a career of working with families who were wrestling with poverty and racism. Much of my work prior to coming to Seattle Children's focused on helping troubled teens. Though this work is very important I often questioned why these families had not been offered mental health services sooner. The Odessa Brown Children's Clinic is one of those rare health homes that can provide incredible preventative/holistic health care by integrating mental health services into the primary care clinic. This type of innovative program design destigmatizes mental health which allows for better outcomes.
I am so grateful to be working in a clinic whose mission is, "Quality Care with Dignity".

Debra Gumbardo, MS, RN, NE-BC
debra.gumbardo@seattlechildrens.org
206-987-1855

Debra Gumbardo MS, RN , NE- BC , is the Chief of Psycho-social Services at Seattle Children's Hospital. She is committed to improving outcomes by building the capacity of all staff to meet the psycho-social needs of families. As a Lean fellow in the organization she also holds standard work, routine outcomes measurement , and the engagement of staff and families in process improvements as paramount to their success.

Elizabeth McCauley, PhD, ABPP
elizabeth.mccauley@seattlechildrens.org
206-987-2164

Dr. McCauley is a Professor of Psychiatry, University of Washington and Associate Director of Child Psychiatry, Seattle Children's Hospital (SCH). She is the Co-Director of the SCH Mood and Anxiety program and leads a research program designed to characterize the development, course, and management of clinical depression in youth. She is currently engaged in a series of federally funded investigations exploring the efficacy of school-based preventive and early intervention approaches for youth at risk of depression, and of behavioral activation as a therapy for depressed adolescents.

Robert Hilt, MD
Robert.Hilt@seattlechildrens.org
206-987-3073

Dr. Robert Hilt is an Associate Professor of Psychiatry at the University of Washington and Seattle Children's Hospital. He was trained as a general pediatrician at the University of Iowa, and as an adult and child psychiatrist at the University of Massachusetts. Dr. Hilt has worked as a primary care pediatrician and as a pediatric hospitalist before his current career as a child psychiatrist. Dr. Hilt is the Program Director for the Partnership Access Line, a child mental health consultation service for primary care providers in both Wyoming and Washington. He is the Program Director for the Medicaid psychiatric Medication Second Opinion Programs of Wyoming, Washington and Alaska, and MDT Consult Service in Wyoming. He is co-chair of the Committee on Collaboration with Medical Professions with the American Academy of Child and Adolescent Psychiatry, has served as the Mental Health Editor for the American Academy of Pediatrics' *PREP-Self Assessment*, and serves on the editorial boards for both *Pediatric Annals* and *Psychiatric Annals*.

Annette Quayle, MS
Annette.quayle@seattlechildrens.org
206.987.1005

Annette Quayle M.S. has more than 25 years' experience partnering with low-income and vulnerable families and communities. She is currently Seattle Children's Manager of the Protection, Advocacy and Outreach program which includes the Washington Medical-Legal Partnership (MLP), the Period of PURPLE Crying (prevention of abusive head trauma) and Positive Parenting. Previously, Annette served as the coordinator of MLP and developed the WA Coalition of Medical-Legal Partnerships. MLP received the WA State Access to Justice Partnership Award in 2015.