Physical and Behavioral Health Integration
Design Committee September Work Session

September 14, 2016; 8:30 a.m. – 4:30 p.m.

TAF Bethaday Community Learning Space
605 SW 108th St, Seattle, WA 98146

Meeting Goals:

- Review "System Transformation **Results and Outcomes**"
- Review and approve core **service and system elements** for integrated care
- Discuss **infrastructure recommendations** and next steps
- Discuss and decide on **implementation timeline**
- Review draft **outline of recommendation report**
- Review **next steps**

Agenda

Welcome + Introductions *Liz Arjun, King County*	8:30-9 a.m. (30)
Update from Other Advisory Tables and State of Washington *Betsy Jones, King County*	9-9:15 a.m. (15)
Review *System Transformation Results and Outcomes* *Liz Arjun, King County*	9:15-9:35 a.m. (20)
Review and Approve Core System and Service Elements *Liz Arjun, King County & Marc Avery, University of Washington*	9:35-10:20 a.m. (45)
BREAK	10:20-10:40 a.m. (20)
Infrastructure Subcommittee Recommendations – Governance *Betsy Jones, King County & Darcy Jaffe, Harborview*	10:40-Noon (80)
LUNCH	Noon-12:45 p.m. (45)
Exploring King County's Role *Susan Mclaughlin, King County*	12:45-2 p.m. (75)
BREAK	2-2:15 p.m. (15)
Implementation Timeline Review and Discussion *Jennifer Martin, Facilitator*	2:15-3 p.m. (45)

BREAK	3-3:10 p.m. (10)
Review Recommendations Report Outline *Liz Arjun, King County*	3:10-4:10 p.m. (60)
Wrap Up/Next Steps *Jennifer Martin, Facilitator*	4:10-4:30 p.m. (20)

Service and System Components for an Integrated System of Care

Core System Categories	Core Service Components
Access and Equity: Service components ensure the needs of the population are met	Patients have access to timely routine and urgent-care outpatient services for primary care, behavioral health, and other care providers to provide necessary services to maximize prevention, remission and recovery.
	Strategies are developed that prioritize outreach, engagement, and maintenance in care of difficult-to-reach consumers including the opportunity for same day care when appropriate.
	Patients have access to mobile medical services, triage services, diversion, and respite care to provide safe, effective, and evidence-based alternatives to emergency rooms, inpatient care, incarceration or no care at all.
	Primary care and other providers have timely access to specialty consultation for the purpose of care planning.
	Care and services address the needs of the child's family/caregivers/support system as well as the individual.
	Care and services that address the needs of individuals experiencing stigma associated with Serious Mental Illness and Substance Use Disorders are available.
	Screenings and services are culturally and linguistically competent.
	Peer services and supports are offered.
Whole Person Needs Across the Continuum from Prevention to Recovery: Service components promote delivering integrated care at the individual level	Consumer education is available to maximize health literacy and engagement.
	First Responders are trained in behavioral health interventions to reduce stigma, and promote referral and engagement into health and social services rather than into emergency rooms and jails.
	Consent for sharing information is obtained including across the crisis system.
	Standardized, evidence-based screening and outcomes measurement tools are used and information is accepted and used across systems and providers.
	Care planning is individualized, uses shared-decision making where individuals are involved in goal setting to develop a single care plan that is used across systems and providers.
	Information is easily shared between providers including crisis providers and other non-traditional providers (social services and housing).
	Care Coordination is available, financially supported and incentivized.
	Team-Based Care is available, financially supported and incentivized.
	Consumers have access to resource centers, educational groups, crisis lines, and chat rooms
	Work, education, and meaningful activities are promoted and supported as part of a consumer's overall wellness.

Value-Based Purchasing and Maximizing Resources: Components ensure the most effective use of dollars	Care is delivered in the "right place, right time, right care" to effectively and efficiently achieve outcomes; Adjustments are made when outcomes are not achieved as expected.
	Problem-focused, brief interventions are included in the continuum of services and are utilized when appropriate in response to initial assessments, and triaging of issues.
	Collaboration and coordination across systems and providers is incentivized to encourage communication, promote effective delivery of services and reduce duplication.
	Referral mechanisms are standardized between separate service providers to improve the efficiency and coordination of care.
	Providers are incentivized for achieving patient outcomes.
Infrastructure: Foundational elements support an integrated health care system	Providers have access to a clinical registry to track outcomes, to facilitate care adjustments, to perform quality improvement, and to facilitate value-based reimbursement.
	Movement toward uniform use of electronic health records and/or health information exchange mechanisms are used.
	Care and service providers are educated and trained in how to share information and have reliable processes to regularly share information for the purposes of integrating and coordinating care.
	Development and use of a single shared care plan among providers.
	System-wide trainings are deployed across providers to standardize and improve patient care outcomes and experience across the continuum of care.

Measuring Progress and Achieving Outcomes

Early in its work together, the Integration Design Committee used Results-Based Accountability to articulate the outcomes they would like to realize from providing integrated care for the residents of King County:

All people in King County are on a path for a:

- *Healthy lifespan**
- *Have a home*
- *The ability to contribute to meaningful activities*
- *Connection to a culturally relevant community.*

*"Healthy lifespan" is defined by having the health promotion skills and resilience needed to reduce or eliminate lifespan disparities.

The services and system components articulated by the IDC outline the pieces they believe are the necessary building blocks to achieve these outcomes. However, it is important to recognize that achieving these outcomes will require a multi-year effort that will involve numerous players working together. A key next step will be to identify common indicators and measures that can be used to track progress and make course corrections along the way. Selected indicators and measures must reflect what happens at the population, individual and systems level and must be culturally relevant.

Full Integration in King County: A Recommendation about the Path Forward

1. Background and Context
    a. National/State Context with the ACA and Movement towards full integration and state law directing this
    b. Additional reasons- better achieve the triple aim- evidence in our community about what integration can mean
2. King County Approach
    a. Long history in KC of raising and allocating local dollars to help create a continuum of care for behavioral health, which has included the behavioral health portion of the Medicaid PMPM (carve out)
    b. Long history of innovation and partnership (include examples – MIDD investments, SBIRT, MHIP, etc.)
    c. Note: this history is part of the reason we want to stay part of the conversation, much knowledge and history that could be lost
    d. In order to move forward in the region, working in a different way, convening a table to develop a recommendation of what fully integrated managed care should look like in the region, including the clinical components of an integrated approach.
    e. Describe the IDC: Goal to ensure that we don't just focus on the financing, but also what happens at the clinical level. The process overall, getting grounded together, (vision, definition, results/outcomes, principles), education, establishment of workgroups to identify key clinical elements, infrastructure workgroup.
3. Grounding Documents
    a. Vision
    b. Definition of Integrated Care
    c. Principles
    d. Results and Outcomes
4. Essential Elements of Integrated Clinical System
    a. Service Element
    b. System Elements
    c. What this will mean for clients- (reference outcomes, triple aim, results, maybe an anecdote?
5. Recommended Infrastructure to Support Clinical Integration
    a. Describe current funding structures and how it works-
    b. What works well, what doesn't
    c. Acknowledge state funding not sufficient enough to deliver the clinical model(s) we are recommending and we must maximize all resources available
    d. How? Describe recommended infrastructure model, including principles of governance, incorporation of outcomes into contracts, etc.
6. Timing and Next Steps
    a. What timing does the committee feel is realistic to implement fully integration in the Region?
    b. Is there room for a phased approach- what might that look like- added benefit of this approach and using benchmarks to continue to indicate movement is happening and is done in a way that doesn't dismantle current structure completely, but instead is a back and forth of setting up the new structure and then testing readiness to move ahead slowly. Maintain stability for clients, but also the system.?
    c. Next Steps