Fully Integrated Managed Care in King County

A Recommended Path Forward

Proposed by the King County Integration Design Committee

January 2017

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EXECUTIVE SUMMARY

Implementation of the Affordable Care Act has spurred a number of efforts in Washington to reform the health care system in order to achieve the Triple Aim of improved health, better health care quality and lowered costs. A key piece of these reform efforts is to deliver whole-person care that addresses all the needs an individual may have that contribute to poor health outcomes. To help facilitate this, Washington state leaders passed legislation, Senate Bill 6312 in 2014, which requires full integration of physical and behavioral health care services for Medicaid beneficiaries by 2020, an essential tool for achieving integration. King County has long played a significant role in meeting the health care needs of the region's residents as an assurer, an advocate, a convener and a funder, when necessary. Additionally, King County has served as the regional entity to administer the first Medicaid funded mental health services as the Regional Support Network (RSN) and then administering both mental health and substance use disorder treatment services through an integrated managed care contract as the Behavioral Health Organization (BHO) for the King County region. Due to historical state shortfalls in funding the behavioral health continuum, King County has increasingly contributed local funding to support behavioral health services for residents, including Medicaid beneficiaries and others in need of services in the region. In order to ensure that the state's goal of whole-person care takes into account the local assets in the region as the state moves forward in this important effort, King County convened an Integration Design Committee (IDC) to make recommendations about the path to full integration for King County. To effectively facilitate and ground the work, the IDC developed a vision of integrated care, a definition of integrated care, and adopted principles to guide decision-making. Subsequently, the IDC heard from experts in the region about best practices for delivering integrated care. After these foundational activities, the IDC proposes the following recommendations:

1) Implement core components of a clinically integrated system of care that addresses whole-person needs.
2) Establish a local shared governance structure that aligns and leverages the array of financing and policy levers, including Medicaid, King County resources and other resources necessary to support a clinically integrated system of care.

Immediate next steps for achieving full integration in King County include presenting these recommendations to a number of key parties including the Interim Leadership Council of the King County Accountable Community of Health, the King County Executive, the King County Council and state leaders.

ACKNOWLEDGEMENTS

This report summarizes the work and recommendations put forward by the King County Physical and Behavioral Health Integration Design Committee (IDC). The IDC was established as a subcommittee of the King County Accountable Community of Health by the Interim Leadership Council to make recommendations about the path forward for delivering fully integrated health care in the King County region and met from November 2015 through December 2016. The IDC was comprised of individuals representing behavioral health providers, physical health providers, county staff, Medicaid managed care organizations and others. Committee members are listed on Page 5 of this document. Thank you to each of the design committee members for their time and dedication to this critical work. Throughout its work together, the IDC heard from experts in the community about best practices for delivering integrated care in various settings. A list of these experts and their biographies is available in Appendix A.

The work of convening the IDC and development of the recommendation summary was done by staff at King County and the IDC Steering Committee. The IDC Steering Committee included Anne Shields, Daniel Malone, Darcy Jaffe, David Johnson, Jennifer DeYoung, Erin Hafer, Betsy Jones, Julie Lindberg, Marc Avery, Susan Mclaughlin, Suzanne Petersen Tanneberg, and Tom Trompeter.

The process of the IDC was supported through a contact with Community Change who provided facilitation and strategic guidance, with many thanks to Jennifer Martin.

King County Integration Design Committee

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BACKGROUND

A visual timeline broken out by Federal, State and King County with pivotal events leading to current recommendations follows this report as Appendix B.

National Landscape

Passage of the Affordable Care Act (ACA) in 2010 sparked the beginning of an evolution of the health and human services systems across the country, Washington State and here in King County. During the initial phases of implementation, significant attention was given to the expanded opportunities to obtain health care coverage. As a result of these coverage expansions, more than 115,000 people in King County gained health care coverage, and the physical, emotional and financial security that accompanies those gains.[1] As the coverage expansions were implemented, conversations began to focus on reforming the health care delivery system in order to achieve the "Triple Aim" - better health, better care and lower costs.[2] Making progress toward the Triple Aim is critical to ensuring the health care system is sustainable and most importantly, improving health outcomes for the individuals receiving care and for the overall population.

State Landscape

Here in Washington State, delivery system reform to make progress toward the Triple Aim was launched under an initiative called "Healthier Washington", which has three main goals:

1. Improving how services are paid for by rewarding quality over quantity.
2. Building healthier communities through a collaborative regional approach.
3. Ensuring health care focuses on the whole person.[3]

GOAL ONE: Improving How Services Are Paid For

Currently, health care providers are generally paid for the *quantity* of health care they deliver to an individual, rather than for the *quality* of care they deliver. In order to make progress toward the Triple Aim, the first goal of *Healthier Washington* outlines a plan for increased use of value-based purchasing in Medicaid contracts to ensure dollars are being used to reward providers for improving outcomes.

GOAL TWO: A Regional Approach

Recognizing health care delivery happens locally, the second goal of *Healthier Washington* is the creation of Accountable Communities of Health (ACH) - a regional collaborative of partners working together to improve the health outcomes for the people in those communities.

GOAL THREE: Whole Person Care

The third goal of the *Healthier Washington* Initiative is ensuring the ability to deliver whole person care with a focus on methods of integrating care and connecting with community services to achieve the best possible outcomes for individuals. The current system creates barriers to comprehensively address physical health, mental health, substance use disorders and other basic needs such as housing, which play a significant role in determining one's overall health. This results in unnecessary and duplicative costs, lowered quality and most importantly, poorer outcomes for individuals in these systems. A significant body of research has documented the value of providing clinically integrated care for individuals to improve health outcomes and lower costs.

The Washington State Legislature passed Senate Bill 6312 on March 12, 2014 to help facilitate the transition to whole person care through financial integration of Medicaid purchasing.[4] The legislation included three components to fundamentally change how Medicaid-funded health and behavioral health services will be purchased and delivered in the state. First, the creation of new Regional Service Areas (RSA) for Medicaid purchasing by the state to align purchasing areas for physical health and behavioral health (mental health and substance use disorder) services, which established King County as a single county RSA. Second, the integrated purchasing of behavioral health (mental health and substance use disorder) services through a single managed care contract by April 1, 2016; in King County, integrated behavioral health services began being administered on April 1, 2016 through the King County Behavioral Health Organization (BHO) (previously the King County Regional Support Network). The third and final component of the legislation calls for the full integration of physical health and behavioral health by January 1, 2020.

The Washington State Health Care Authority also pursued an 1115 Medicaid waiver to help facilitate the delivery system reforms envisioned by the *Healthier Washington* initiative. The 1115 Medicaid waiver is an important tool that will give the state more flexibility to contract for Medicaid services, make up-front outcomes-focused investments to drive systems change, and provide opportunities for delivery system innovation and learning which are key to making reform efforts possible. The state received

approval for its waiver proposal on January 6, 2017 from the Centers for Medicare and Medicaid Services.[5]

King County Landscape

King County began exploring regional health care reform opportunities in 2013. The County's blueprint, known as the *King County Health and Human Services Transformation Plan*, was developed in partnership with community stakeholders and calls for an accountable, integrated system of health, human services, and community-based prevention. The Plan's stated goal is that 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."[6]

The Transformation Plan charted a five-year course to a better performing health and human service system for the residents and communities of King County, Washington. The Transformation Plan directed King County to work in new ways to address issues of health and social equity by breaking down internal siloes to better deliver services to the individuals and communities it serves and to partner with individuals and communities to identify and implement solutions to the problems they face.

The Transformation Plan called for an initial focus at two levels: the individual and the community level.

- **At the individual/family level**, the Plan called for strategies designed to improve access to person-centered, integrated, culturally competent services when, where, and how people need them. The current execution of this strategy is through the Familiar Faces Initiative, which was launched in 2014, is focused on improving outcomes for individuals who are high utilizers of the King County Jail who also have a behavioral health disorder.
- **At the community level**, the Plan called for improvement of community conditions and features because health and well-being are deeply influenced by where people live, work, learn, and play. The current execution of this strategy is through Communities of Opportunity, which is a public-private partnership to create greater health, social, economic and racial equity in King County so all people thrive and prosper, regardless of race or place.

Local Support for Behavioral Health

King County has a long history of raising and allocating local funds to help create a continuum of behavioral health care services. These funds serve as a foundational component to provide services for individuals enrolled in Medicaid, those individuals who are ineligible for Medicaid-funded services and for individuals who need crisis services. Three key sources of local funds include the Veteran's and Human Services Levy, the Mental Illness and Drug Dependency (MIDD) Sales Tax Levy and the Best Starts for Kids Levy.

Veterans and Human Services Levy

In November 2005, King County voters passed the first Veterans and Human Services Levy which generated funding for a wide range of programs to assist 1) veterans, military personnel and their families and 2) individuals and families in need. Funding was evenly split between the two populations and focused on achieving three overarching goals:

- Reducing homelessness and emergency medical costs
- Reducing criminal justice system involvement
- Increasing self-sufficiency by means of employment.[7]

In August 2011, the voters of King County voted overwhelmingly to renew the Veterans and Human Services Levy for another six years. The Veterans and Human Services Levy has provided approximately $18 million annually to achieve these goals since it was originally passed in 2005.[8]

Mental Illness and Drug Dependency Sales Tax Levy

King County experienced several consecutive years of state budget cuts to its mental health programs, resulting in loss of services or extremely limited eligibility for many low-income people in need. Additionally, inadequate state funding for substance use disorder treatment services over many years limited access to treatment for many county residents. As a result, a high number of these individuals were arrested, jailed or hospitalized instead of receiving care in their community.

In recognition of the detrimental effects these budget cuts were having on the ability of local communities to address behavioral health issues, in 2005, the Washington State Legislature created an option for counties to raise the local sales tax by 0.1 percent to augment state funding for mental health and chemical dependency services and therapeutic courts.[9] In November 2007, the Metropolitan King County Council voted to enact a one-tenth of one cent sales tax to fund the strategies and programs

outlined in King County's Mental Illness and Drug Dependency (MIDD) Action Plan, which had been developed earlier that year.[10] The programs were designed to stabilize people suffering from mental illness and chemical dependency, diverting them from jails and emergency rooms by getting them proper treatment. The MIDD funding yielded approximately $30 million in its first year and over $50 million annually through 2016 (when the sales tax levy was initially scheduled to end). The MIDD sales tax levy was successfully renewed in August 2016 and is in place through 2025 and will continue to bring significant local funding to support the behavioral health continuum and other components that support individuals with behavioral health disorders to get the health and social supports they need in the community rather than in institutional settings such as emergency rooms and jails.[11]

Best Starts for Kids Levy

In 2015, King County residents approved the Best Starts for Kids levy, an initiative focused on investing in early intervention and prevention strategies to improve the health and well-being of King County residents. This levy will produce $65 million annually to support a variety of strategies and is a key part of how King County will transition to less expensive, more effective upstream solutions to costly challenges, as envisioned in the King County Health and Human Services Transformation Plan. Prevention and early intervention are the most effective and least expensive ways to address our most serious problems. Science tells us that lifelong problems can often be prevented by investing heavily in children before age five and making strategic investments at critical points in young people's development before age 24. Prior to *Best Starts for Kids*, much of the County's funding had been in response to negative outcomes—severe mental illness, homelessness, substance abuse, chronic illness and youth who have dropped out of school or been involved in the juvenile justice system. Almost three quarters of the King County General Fund is allocated to expenditures related to the law and justice system.[12] The Best Starts for Kids Levy will play a critical role in supporting a transformed health system in the region in future years.[13]

These major local funding sources have helped create a foundation that supports the behavioral health continuum in the King County Region. Innovative programs such as the Mental Health Integration Project (MHIP), the integration of best practices such as Screening, Brief Intervention, and Referral to Treatment (SBIRT) into primary care settings and schools, the Crisis Solutions Center and jail diversion and reentry programs were made possible because of the local support to address the unmet behavioral health needs in the community. It is largely due to this historical role and the County's commitment to advocacy and assurance for all its residents that in contemplating the statewide move toward fully

integrated managed care, King County leadership committed to establish a community process to provide guidance on the path toward integrated physical and behavioral health care in the region.

The King County Physical and Behavioral Health Integration Design Committee

The King County Accountable Community of Health (ACH) was launched with support from the state in the summer of 2015 as the regional collaborative responsible for improving the health of King County residents. Comprised of individuals representing organizations ranging from Medicaid Managed Care Organizations (MCOs) to organizations representing various consumer groups in the region, this collaborative, a key component of the state's *Healthier Washington* Initiative, is working together to improve the health outcomes for the people in King County communities. Recognizing the strong relationship between the goals of King County's ACH to improve the health of King County residents and the benefits of providing whole-person integrated care, the Physical and Behavioral Health Integration Design Committee (IDC) was launched as a formal subcommittee of the ACH in November 2015. The IDC is responsible for making recommendations to the ACH about the best path forward to providing fully integrated physical and behavioral health for both children and adults in the King County Region.

The King County IDC was charged with developing a vision for a regional model of fully integrated physical and behavioral health for both children and adults enrolled in Medicaid. While the focus of the state legislation is Medicaid funding, it was anticipated that the design work of the subcommittee would help inform the delivery of integrated care for populations beyond those eligible for Medicaid. Specifically, the IDC was responsible for:

- Identifying core components of integrated care
- Distinguishing which components should be community-based and accessible to all
- Ensuring the whole health needs of an individual are met regardless of where they seek services and what the level of need is
- Analyzing and making recommendations regarding the infrastructure and financing to support the components of the integrated system of care
- Providing input on potential roles for King County in supporting the integrated system of care.

The IDC was established to serve as a forum for open communication, shared expertise, and collective decision-making for the development of a clinical model of integrated health care delivery.

The work of the IDC can be described in three phases: getting grounded together, learning together and designing together. The first phase was focused on establishing a shared vision for an integrated system of care, and a shared definition of integrated care.

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. A key factor in achieving this vision is moving from an environment where health and human services are delivered in programmatic siloes determined by funding source, to an integrated health care system that is able to address whole person health (physical and behavioral) needs, is person-centered and determined by an individual’s unique needs.

WHAT DOES THIS LOOK LIKE? DEFINING INTEGRATED CARE

An integrated health care system is one where providers and payers work collectively to meet the physical and behavioral health needs of an individual in a timely, holistic and culturally responsive fashion where the person receiving services is engaged in their care. In this system, there is “no wrong door”- individuals receiving services are able to access the services when and where they need them. Care coordination happens across providers, payers and other organizations serving the person to minimize duplication and complexity. There is accountability to the individual, to those involved in providing services and to payers for achieving outcomes that the individual has helped identify. Those involved in providing services are supported by a shared care plan, shared data and have an understanding of their respective roles. Financing supports the integrated system by paying for overall outcomes and value for the person receiving services, not individual services.

Following the work to define a collective vision and definition of integrated care, the IDC established a set of principles to guide the design work and inform the development of core recommendations.

KING COUNTY PRINCIPLES FOR FULL INTEGRATION

The System is Client-Centered and Promotes Equity

1. Individuals experience significant gains in health and well-being because the system shifts from a costly, crisis-oriented response to health and social problems, to one that focuses on prevention, embraces recovery, and eliminates disparities.
2. Individuals receiving services are at the center of care planning, are engaged and activated, and self-management is promoted.
3. Individuals are able to access the health and social service supports when and where they need them in a culturally responsive fashion; services are community-based and delivered in the least restrictive setting possible.
4. Individuals achieve improved health and social outcomes as a result of full integration.
5. The system extends beyond Medicaid and supports individuals who are low income, or uninsured, including non-Medicaid, immigrants/refugees and undocumented as well as those covered by private insurance and ensures equity of experience regardless of payer.

The System Addresses Whole Person Needs Across the Continuum from Prevention to Recovery

6. Full integration at the clinical and financial levels ensure mechanisms to treat the whole person and align incentives as the best way to improve health and social outcomes
7. Services address the individual's health and well-being across the lifespan; specifically, services for children, adolescents, elderly and individuals with disabilities are systematically designed and utilized to meet their unique needs.
8. Ongoing investments in health promotion, health literacy, prevention, and early intervention are made to prevent the occurrence of health conditions and achieve improved population health.
9. The system is active in addressing the social determinants of health including integration of housing, employment, criminal justice diversion and other recovery support services.
10. Recovery principles are prominent across the system of care and recovery practices are expected and rewarded.

The System Promotes Value-Based Purchasing and Maximizes Resources

11. Payments are based on achieving improved health and social outcomes for individuals because we are paying for value rather than volume, allow for the flexibility and capacity at the clinical

level to address individual needs and payment models are adjusted to meet the needs of various populations.

12. Providers are supported in their efforts to improve health and social outcomes because the system uses standardized measures that are used frequently to provide feedback and make course corrections when necessary.
13. Services provided are chosen from among those practices that have demonstrated evidence of effectiveness, whenever possible and brief treatments are emphasized when appropriate.
14. All funding sources are maximized and fully leveraged: Medicaid, block grant, philanthropy, local taxes and levies, grants, etc. to ensure a full continuum of health services.
15. Payers in the Region (including King County and the Washington State Health Care Authority) are aligned in how services are contracted and paid for, including aligning incentives across payers.

The System Invests in the Infrastructure Necessary to Support the System

16. Information is shared seamlessly across providers in order to minimize complexity and errors and maximize efficiency and effectiveness for the individuals served.
17. Ongoing investments are made to build and maintain necessary system and provider capacity to provide a full continuum of health services.

The intent of this phase of the work was to provide a common understanding for the IDC to help provide some parameters and guidelines for the design work the committee was tasked with. Following the grounding work, the IDC heard from a number of experts in the region about best practices for providing integrated care. For a list of individuals who shared their expertise about integrated clinical care with the IDC, please see Appendix A. These two initial phases of work provided a strong foundation for the IDC to work together to design a clinically integrated system of care and make its recommendations.

Recommendations

The core service components articulated by the IDC outline the building blocks to achieve the Triple Aim and the outcomes for the population (see Appendix C for a detailed results statement). The IDC recognizes achieving these outcomes will require a multi-year effort that will involve active collaboration across sectors.

- **Recommendation 1:** Implement core components of a clinically integrated system of care that addresses whole person needs.
- **Recommendation 2:** Establish a local shared governance structure that aligns and leverages the array of financing and policy levers, including Medicaid, King County resources and other resources necessary to support a clinically integrated system of care.

Recommendation 1: Implement core components of a Clinically Integrated System of Care that Addresses Whole-Person Needs

To ensure the integrated health system addresses the needs of the various subpopulations across the continuum, core elements were grouped into four broad categories that parallel the IDC's guiding principles:

1. **Access and Equity:** Service components including health services and social determinants (such as housing, transportation, etc.) ensure the needs of the population are met.
2. **Whole Person Needs Across the Continuum from Prevention to Recovery:** Service components, including health services and social determinants (such as housing, transportation, etc.), promote delivering integrated care at the individual level.
3. **Efficient Use of Resources to Achieve Optimal Outcomes:** Components ensure the most effective use of dollars.
4. **Infrastructure:** Foundational elements support an integrated health care system.

The IDC recommends the following core service elements be present in a clinically integrated system:

CORE COMPONENTS OF AN INTEGRATED SYSTEM OF CARE THAT ADDRESSES WHOLE PERSON NEEDS	
Core System Categories	**Core Service Components**
Access and Equity: Service components including health services and social determinants (such as housing,	Individuals have access to timely routine and urgent-care outpatient services for primary care, behavioral health, specialty care and other care providers to provide necessary services to maximize prevention, remission and recovery.

transportation, etc.) ensure the needs of the population are met	Strategies are developed that prioritize outreach, engagement, and maintenance in care of difficult-to-reach individuals including the opportunity for same day care when appropriate.
	Individuals 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 individual'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 including health services and social determinants (such as housing, transportation, etc.) 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 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 an individual's overall wellness.
Efficient Use of Resources to Achieve Optimal Outcomes: Components ensure the most effective use of dollars	Care is delivered in the "right place, right time, right intensity" 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 optimal outcomes and recovery for individuals.
	Value-based purchasing is used as a mechanism to improve outcomes and quality.
System 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 is supported 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.
Next Steps: Common indicators and measures will be identified to track progress and make course corrections along the way to achieving these results. Selected indicators and measures must reflect what happens at the individual, system and population level and must be culturally relevant.	

Recommendation 2: Establish a local shared governance structure that aligns and leverages the array of financing and policy levers, including Medicaid, King County resources and other resources necessary to support a clinically integrated system of care.

Current State Funding

Currently, Medicaid funding for physical health care services and behavioral health for individuals who do not meet access to care standards is contracted through five Medicaid managed care plans in King County: Amerigroup, Community Health Plan of Washington, Coordinated Care, Molina and United Healthcare. Medicaid behavioral health services (including mental health and substance use disorder treatment services) for individuals who do meet access to care standards are contracted through an integrated managed care contract to the King County Behavioral Health Organization (BHO). The King

County BHO is managed and operated by King County through its Department of Community and Human Services, Behavioral Health and Recovery Division. The King County BHO also holds contracts with the state to operate the crisis system, and receives federal block grants and other state funds to support the behavioral health continuum of care. Senate Bill 6312 directs that by January 1, 2020,

"*The community behavioral health program must be fully integrated in a managed care health system that provides mental health services, chemical dependency services, and medical care services to Medicaid clients".*[14]

Current Local Funding

King County invests more than $100 million annually in the behavioral health continuum. This includes funding through the Mental Illness Drug Dependency (MIDD) plan (.1% sales tax), the Veterans and Human Services Levy (VHSL) and Best Starts for Kids (BSK), among other sources. This local funding expands the behavioral health continuum beyond what Medicaid pays for, including prevention and early identification of behavioral health conditions, crisis diversion, jail diversion, housing, capital investments, workforce development, implementation of evidenced-based practices, and physical and behavioral health integration. It also provides services and supports for individuals who are not Medicaid eligible including immigrants/refugees, undocumented people, and low-income uninsured. This funding is currently 100% aligned with the behavioral health continuum.

Future Funding

The IDC recognizes financial integration, as specified in SB 6312, as an essential lever to achieving the Triple Aim, and does not recommend any changes to this legislation at this time. However, the IDC also acknowledges the importance of the King County local funding and supports maintaining those resources in the health (physical and behavioral) care system and working to better align those resources to support overall delivery system transformation. Through the shared governance table proposed below, King County and its community partners would work together to assure shared outcomes are defined and achieved by aligning contracts and incentives across the physical and behavioral health care system. The work of the shared governance table would also include establishing benchmarks and milestones for system transformation and working collectively to make recommendations to payers and funders about critical contract elements that would support integrated care delivery and whole person care.

The IDC proposes establishment of a local shared governance structure, made up of the State, County, MCOs, and other key partners including the King County Accountable Community of Health, to align resources to achieve the Triple Aim for both those enrolled in Medicaid and low-income individuals in the region. The roles and responsibilities of this shared governance structure are: (1) **identifying shared outcomes, accountabilities, and standards** for what is to be achieved collectively; (2) **making recommendations to HCA about contract elements** that would best support the integrated clinical system; and (3) **monitoring progress** towards those outcomes once implementation begins. To do this, the IDC proposes this shared governance table:

1. **Adopt the Principles of Full Integration:** The IDC recommends the shared governance table formally adopt the "Principles for Full Integration" developed by the IDC (see page 13).These principles will serve as the foundation for how the group works together and evaluates system transformation.
2. **Clarify Roles and Responsibilities:** While many of the details about how this table will be established and who will participate are not within the scope of the IDC's work, the IDC does recommend some parameters for what the roles and responsibilities of the shared governance table should be. These include:
    - Provide collective ownership of the integration model (clinical and financial) places individuals at the center of focus and ensures implementation of best practices across the health care system.
    - Develop a set of agreed-upon outcomes and associated metrics, milestones, and performance indicators on the path to full integration will be used to inform changes to the current funding model including the move towards value-based contracting.
    - Align and standardize processes, where appropriate, across providers (primary care and behavioral health) to minimize administrative burden at the provider level and to support successful integration at the clinical level.[*]
    - Develop and/or implement shared data systems and evaluation across MCOs and the County in coordination with statewide efforts to foster health care system transparency

[*] The IDC does not envision that the Shared Governance Structure dictate or oversee contractual relationships between payers and providers. However, it does envision that the shared governance structure will make collective recommendations about how best to standardize and align processes when possible to minimize administrative burden at the provider level and support the overall system of care for the region.

and oversight, to minimize duplication, and to support providers to ensure outcomes are achieved.

- Develop investment priorities that support the health care system and make mutual investments toward shared priorities including shared savings arrangements where appropriate.

3. **Explore optimal role(s) for King County in the Delivery System:** As the shared governance table works collectively to transform to a more integrated system of care, members will examine the optimal role of the County within the delivery system and discuss what contractual relationships should look like in the future. These discussions will inform discussions between the County and HCA, the development of the fully integrated managed care contract, and the scope and roles of King County vis-à-vis its managed care plan partners in a transformed environment.

Key Decisions

Looking forward, there are a number of important next steps to achieving full integration in King County including:

- Securing support from state leadership for this approach
- Obtaining an endorsement from the Interim Leadership Council of the King County Accountable Community of Health
- Securing support from the King County Executive and the King County Council
- Beginning work with key representatives from the community to begin outlining what a shared governance structure might look like.

Conclusion: Aligning Many Levers for a System of Care for All

There are a number of important funding and policy levers available at the federal, state and local level to support the King County Integration Design Committee's Vision of Integrated Care. Financial integration of Medicaid purchasing through contracting at the state level required by Senate Bill 6312 is only one of these. Others include the 1115 Medicaid waiver, the state-only funds that support behavioral health and the crisis system, federal block grants that support mental health and substance use disorder treatment, and others. A unique additional lever in the King County Region are the significant local resources and successful innovations that have already advanced the availability of clinically integrated care across the region that can also be leveraged to support this vision. By focusing on outcomes and articulating the core clinical elements that need to be in place to achieve them, the IDC has begun the work that should serve as a guide for how these various levers can be pulled in the future to achieve the desired outcomes. Future work to align these levers must build on the successes, innovation and lessons learned from here in the region and most importantly must take into account how best to support the providers who will be responsible for making the changes at the delivery system level necessary to achieve the outcomes.

In this integrated system, no matter where a person seeks care, they are screened for physical health, mental health and substance use disorder needs as well as other needs that impact their overall health such as housing, employment, access to healthy food, child care and transportation. The care a person receives in this system is measurement-based and is adjusted to ensure outcomes are achieved. In this system, multi-disciplinary care teams are available to care for a person's whole health needs using a

single problem list, single medication list and a shared single care plan. Peer Support Specialists and Community Health Workers are readily available when needed as part of a person's care team. Information flows quickly and seamlessly among all care providers on the team and registries are used to track and follow up with clients to ensure follow through and outcomes are achieved. In this system, providers are rewarded for improving the health and well-being of the clients they serve.

By working together to leverage and align these resources, the vision of a clinically integrated system of care works for all people in King County the IDC has proposed can be achieved. As a result, the people of King County will have equitable opportunities to be healthy, happy, self-reliant and connected to community.

Appendix A

Guest Presenter Bios

Mark Fadool, MS
Clinical Director of Mental Health
Odessa Brown Children's Clinic

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
Chief of Psycho-Social Services
Seattle Children's Hospital

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
Associate Director of Child Psychiatry
Seattle Children's Hospital

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
Program Director for the Partnership Access Line
Seattle Children's Hospital

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
Manager of Protection, Advocacy & Outreach Program
Seattle Children's Hospital

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. The MLP received the WA State Access to Justice Partnership Award in 2015.

Paul Tegenfeldt, MSW
VP of Healthcare Integration
Navos

Paul Tegenfeldt is a social worker by training and has worked in community-based health care organizations for all of his professional life. For over 20 years Paul worked at Neighborcare Health where he had a number of different roles including managing medical and dental clinics, Manager of School-Based Health Center Program and Director of Operations. For the past 5 years, Paul has led the healthcare integration efforts at Navos to implement a fully integrated model of providing primary care in a behavioral health setting to a population that has arguably the some of the greatest health disparities of any group.

Jane Simpson, RN
Area Manager
Public Health—Seattle & King County

Jane Simpson has a Bachelor's of Science degree in Nursing and has worked for Public Health since 1989 as a public health nurse, supervisor and manager. Her two main areas of focus have been maternal/child health and delivery of primary care services to an underserved/high needs population.

Graydon Andrus, MSW
Director of Clinical Programs
DESC

Graydon Andrus, MSW, is the Director of Clinical Programs at DESC, a large multi-service agency in Seattle with integrated programs for mental health, chemical dependency, shelter, supportive housing; which uses recovery, housing first and harm reduction approaches. His professional life has been focused on delivery of clinical case management, program development and program management for the past 28 years. In his current capacity, he manages DESC's mental health, chemical dependency

treatment, supported employment, and crisis diversion programs, all having a focus on serving vulnerable homeless and recently homeless adults.

Nancy Sugg, MD
Medical Director
Harborview Medical Center Pioneer Square and Homeless Programs

Dr. Sugg is the Medical Director of Harborview Medical Center's Pioneer Square Clinic and Homeless Programs. She has worked closely with Seattle-King County Public creating integrated medical services for homeless patients in a variety of settings. She is an Associate Professor of Medicine at the University of Washington where her research interests are in interpersonal violence and health care disparities. She has been a primary care internist for homeless and low income patients for 25 years and enjoys teaching the next generation of physicians in care of vulnerable populations. She also serves on the Governing Council of the Pacific Hospital PDA, which provides over 1.5 million dollars yearly in grants to decrease disparities in the Puget Sound region

Sonia Handforth-Kome, MA
Chief Operating Officer
Valley Cities

Sonia Handforth-Kome, M.A., Chief Operating Officer, has been working in medical and behavioral health care systems since 1987. Her first job in the medical field was as an office manager for a physical and occupational therapy management company in North Carolina. Sonia's experience in health system management has run the gamut from providing technical support on practice management systems and electronic health record systems, to coding, medical transcription, billing and collections, organizational change management, EHR/EPM selection and implementation, grant writing, strategic planning, advocacy and policy development; and from for-profit urban office-based specialty care to non-profit rural/frontier facility-based integrated care, including primary care, emergency care, dental services, physical therapy, substance abuse services, mental health services, and alternative medicine. Sonia has worked in health systems in North Carolina, California, Alaska and Washington, and in payment systems including fee-for-service, capitated, grant-funded, and case rate. In July of 2001 she moved from a multi-site OB/Gyn physician practice in California to a position as Executive Director for the Iliuliuk Family and Health Services, Inc. community health center/frontier extended stay clinic in Unalaska, Alaska. During her time as ED of IFHS, Sonia also served on the board of the Alaska Primary Care Association (as President for five years), and on the board of the Northwest Regional Primary Care Association (as a member of the Executive Committee of that board for four years).Sonia also volunteered with many community organizations, including the Ballyhoo Lions Club and the Aleutian Arts Council, as well as being elected and serving for eleven years on the Unalaska City School District Board, and for ten years as a Yoga instructor for the local community center. In October 2011 she retired as ED of IFHS and started consulting with local non-profits and CHCs in the state of Alaska. In June 2013 she began working for Valley Cities Counseling and Consultation, a community behavioral health center in Washington as Chief Operating Officer. Sonia received her Bachelor's degree in Physics with Honors from the University of North Carolina at Chapel Hill, and her Masters' degree in Organization Management from the University of Phoenix in Oakland.

Karen Spoelman
Behavioral Health and Recovery Division
King County

Karen Spoelman, M.M. is the Cross Systems and Contract Services Coordinator of the King County Behavioral Health and Recovery Division. In that role she also serves as the Section Chief for network provider recruitment and contracting for both the mental health and substance use disorder treatment services. Ms. Spoelman is also responsible for the fostering and formalizing of relationships with allied systems (e.g. education, child welfare, criminal justice).Karen has been a planner/manager in public sector managed care mental health and substance abuse service system at the regional/county level for 21 years and previous to that worked in quality and facilities management for a large non-profit community-based behavioral health treatment agency for 9 years.

Sarah Arnquist
State Director
Beacon Health Options

Sarah Arnquist is a State Director with Beacon Health Options. Sarah's work focuses on designing and implementing innovative programs to deliver mental health and substance use services to people with public health insurance in California and Washington. Sarah's experience includes working directly with top officials in California's Medi-Cal program, engaging stakeholders on divisive public policy issues, and collaborating with international health care leaders to study successful models of health care delivery. She began her career as a newspaper reporter, covering health care and social welfare issues in California. Sarah has an MPH from Johns Hopkins Bloomberg School of Public Health and a Bachelor's degree in journalism from the University of St. Thomas.

Vanessa R. Gaston
Director
Clark County Community Services

Vanessa Gaston is the Director for Clark County Community Services. She is responsible to oversee a department with 58 employees and an annual budget of over $28 million. Community Services administers grants, contracts and programs for alcohol and drug treatment, local mental health services, crisis service system, veteran services, developmental disability, youth services, low-income home rehab, housing and homeless programs for Clark County. Ms. Gaston also served as the Administrator for SWBH Regional Support Network covering Clark and Skamania Counties. She worked with the Governing Board and staff to successfully transition over the responsibilities for mental health services to managed care organizations effective April 1, 2016.She currently serves on the Board of Directors for Washington Community Action Partnership. She is the designated lead representative from Clark County working with other regional County representatives and Health Care Authority on Early Adopter implementation for full Medicaid integration between mental health, chemical dependency and physical health programs. She was instrumental in creating the SWWA Regional Health Alliance and serves as the Board Secretary. She served as a Washington State Human Rights Commissioner and board member for WIN211. She was also appointed and served on the Oregon State Board of Education. She brings to her jobs strong administrative and communication skills, with a strong background in leadership positions. Ms. Gaston has a Master's degree in Public Administration with a focus on Education and Social Policy Administration from the University of Washington and a bachelor's degree from Evergreen State College. Her past experience includes 12 years in Washington State Government working for the Department of Social and Health Services and the Washington State Department of Veteran Affairs. She

also served honorably in the U.S. Army. Ms. Gaston has an extensive background with over 26 years working with various human service, health, employment and educational programs and issues.

Erin Hafer
Director of New Programs Integration & Network Development
Community Health Plan of Washington

Erin Hafer, MPH, is Director of New Programs Integration & Network Development at Community Health Plan of Washington. Ms. Hafer has extensive experience working with managed care and delivery systems to integrate health care reform opportunities through strategic planning, product development, care delivery and payment model innovation, and legislative advocacy. Ms. Hafer partners closely with Washington State agencies and community partners on health care transformation activities, including Fully Integrated Managed Care, Value-Based Purchasing and Accountable Communities of Health. She is experienced in developing models to improve access to care for individuals with complex conditions, including individuals with mental health conditions and substance use disorder. Ms. Hafer has provided program oversight of the innovative, Mental Health Integration Program (MHIP) since its inception in 2007. In addition, she has participated in the successful design and implementation of integrated community health programs such as CHPW's Health Homes Care Coordination Program, the SAMSA sponsored Washington State Screening, Brief Intervention and Referral to Treatment–Primary Care Integration (WASBIRT-PCI) Project, and the Centers for Medicare and Medicaid Services (CMS) Health Care Innovation Challenge -- COMPASS (Care of Mental, Physical and Substance Use Syndromes).

Isabel Jones
Medicaid Integration Project Manager
Washington State Health Care Authority

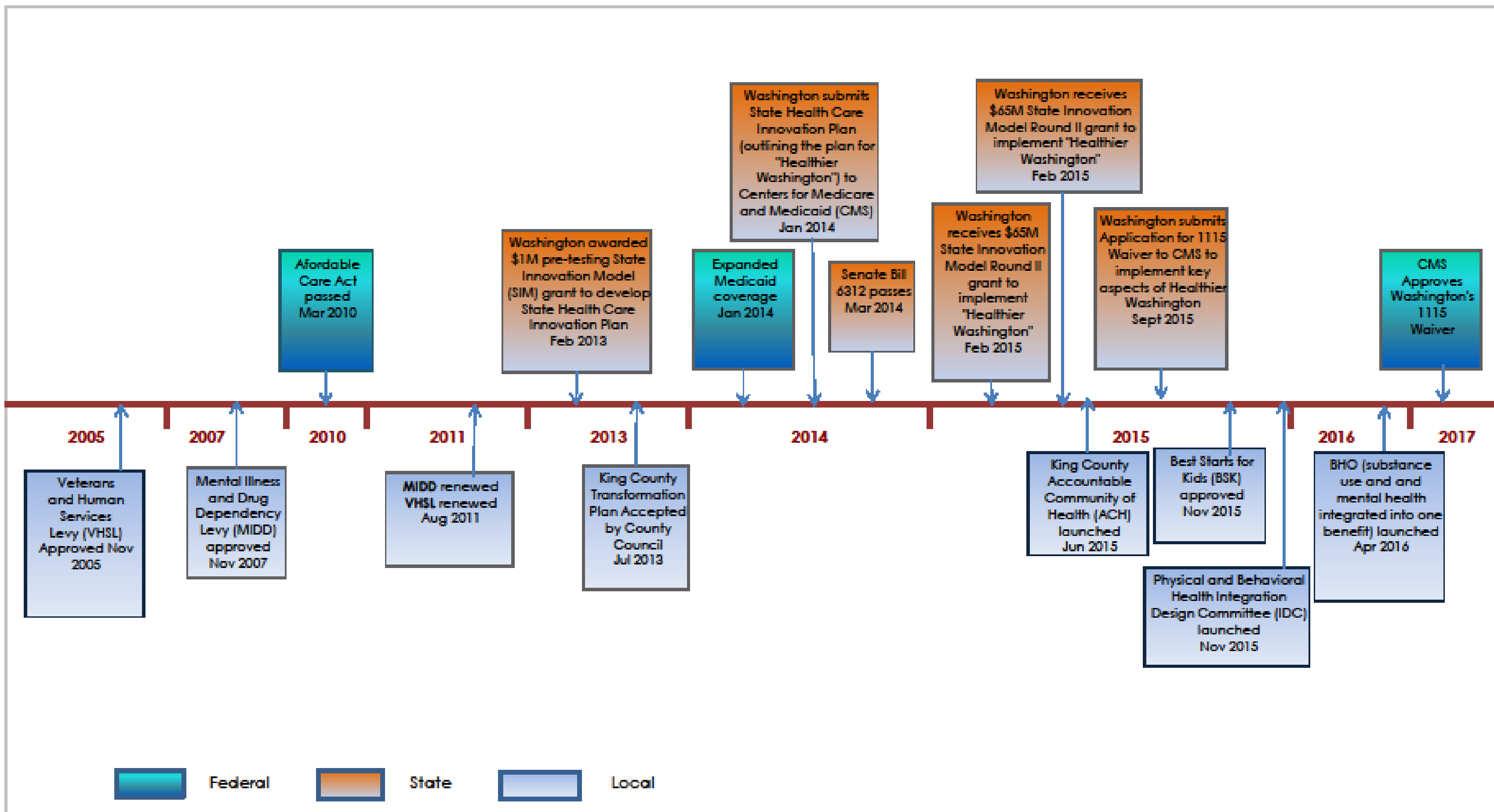
Isabel Jones is the Medicaid Integration Project Manager at the Health Care Authority, within the division of Policy, Planning and Performance. Isabel is responsible for the implementation of Payment Model I under the State Innovation Model (SIM) Grant, and her work is focused on redesigning Medicaid purchasing in Southwest Washington, to integrate the purchasing of physical and behavioral health services. Prior to joining the HCA, Isabel worked in the White House Domestic Policy Council Health Office as a Policy Assistant, focused on implementation of the Affordable Care Act. Isabel also worked or Senator Tom Carper as a health policy fellow where she focused on policy analysis, and served as a legislative correspondent for health and education issues for Senator Maria Cantwell. Before moving to D.C., Isabel worked in her home state of Washington as a field organizer for both President Obama's campaign in 2008 and Senator Cantwell's re-election campaign in 2006, positions in which she managed several offices and hundreds of volunteers. Isabel holds a Master's degree in Public Policy from American University (2013) and a B.A. in International Studies from the University of Washington (2008).

Julie Lindberg
Vice President of Healthcare Services
Molina Healthcare of Washington

Julie Lindberg is a licensed clinical social worker with over 20 years of experience serving low-income, ethnically diverse populations in care delivery and health plan settings. Julie has overseen comprehensive children and adult outpatient mental health programs serving Medicaid and indigent populations in Los Angeles County and Seattle, WA.As the Behavioral Health Director of Clinical Operations at Group Health Cooperative, Julie led efforts to improve the integration of physical and behavioral health care through the promotion and adoption of routine depression and substance use

screening tools in primary care, and integrated case management models such as TeamCare. As the Vice President of Health Care Services with Molina Healthcare of WA, Julie oversees all clinical programs including case management and utilization management. Julie is actively involved in the development of high-touch community-based case management models including a community health worker program, care transitions, and Health Homes. Julie is trained in Motivational Interviewing, the IMPACT model, and the Screening, Brief Intervention, Referral and Treatment (SBIRT) model.

Detailed Timeline of Health Reform Activities at Federal, State and Local Level



Appendix C

Full Results Statement

The Integration Design Committee used Results-Based Accountability to articulate the expected outcomes 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 of the clinically integrated system as articulated by the IDC identify the necessary building blocks to achieve these outcomes.

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