



King County

1200 King County
Courthouse
516 Third Avenue
Seattle, WA 98104

Meeting Agenda

Panel 4 – Equity and Justice for All (Discussion Related to Proposed 2019-2020 Biennial Budget)

*Councilmembers: Rod Dembowski, Chair, Larry Gossett,
Jeanne Kohl-Welles, Kathy Lambert, Dave Upthegrove*

*Staff: Andrew Kim (206-477-8495), Panel Lead, Clifton Curry (206-477-0877), Sahar Fathi (206-263-0960),
Jenny Giambattista (206-477-0879), Samantha Porter (206-263-9206), Wendy Soo Hoo (206-477-0890)*

Panel Assistant: Erica Newman (206-477-7543)

9:30 AM

Thursday, October 18, 2018

Room 1001

SPECIAL MEETING

Pursuant to K.C.C. 1.24.035 A. and F., this meeting is also noticed as a meeting of the Metropolitan King County Council, whose agenda is limited to the committee business. In this meeting only the rules and procedures applicable to committees apply and not those applicable to full council meetings.

1. Call to Order
2. Roll Call
3. Public Comment- Limited to 15 minutes

Briefing

4. Briefing No. 2018-B0176

Equity and Justice for All: Policy Discussion on the Proposed 2019-2020 Budget

Andrew Kim, Council Staff

Adjournment



Sign language and communication material in alternate formats can be arranged given sufficient notice (206-1000).

TDD Number 206-1024.

ASSISTIVE LISTENING DEVICES AVAILABLE IN THE COUNCIL CHAMBERS.



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**Metropolitan King County Council
Budget Panel Discussion 2019-2020**

EQUITY AND JUSTICE FOR ALL

On October 11, 2010, Ordinance 16948, also referred to as the "Equity and Social Justice Ordinance," was enacted establishing equity and social justice from an initiative to an integrated effort that intentionally applies the countywide strategic plan's principle of "fair and just" in all the county does in order to achieve equitable opportunities for all people and communities. The ordinance defines "fair and just" to mean that the county serves all residents by promoting fairness and opportunity and eliminating inequities through actions to which equity and social justice foundational practices are applied. The ordinance identified fourteen **determinants of equity** as the conditions that lead to the creation of a fair and just society in King County.

As part of the 2019-2020 biennium budget process, this panel will focus on how the county can best serve the needs of the most vulnerable residents while helping them reach their full potential. In particular this panel will evaluate budget decisions that relate to the following determinants of equity:

- A law and justice system that provides equitable access and fair treatment for all¹; and
- Health and human services that are high quality, affordable and culturally appropriate and support the optimal well-being of all people²;

This is the first of three budget panel discussions during which councilmembers will examine the following four focus areas and its related policy questions:

1. MENTAL ILLNESS DRUG DEPENDENCY (MIDD) LEVY and LAW ENFORCEMENT ASSISTED DIVERSION PROGRAMS

- What are the outcomes of the Law Enforcement Assisted Diversion (LEAD) program?
- What are the outcomes of the Navigator, RADAR, and related programs that also involve law enforcement personnel to assist individuals to divert from detention?
- Are current MIDD funded programs aligned with the original purpose of the MIDD Levy?

¹ K.C.C. 2.10.210.B.3.

² K.C.C. 2.10.210.B.8.

2. DELIVERY OF BENEFITS TO SUPPORT RESIDENTS IN POVERTY TO REACH THEIR FULL POTENTIAL

- What services and benefits are provided by the county to residents in poverty?
- How can the county integrate the delivery of services and benefits to residents in poverty to make it easier for them to receive all available resources?
- What is necessary to achieve integration on receiving services and benefits for residents in poverty?

3. PUBLIC HEALTH

- How can we lay the foundation of building a regional health plan in the county?
- How can we expand the county's efforts on HPV (Human Papillomavirus) to improve vaccination rates and increase screenings in an effort to reduce cervical cancer in the county?

4. BARRIERS TO SUCCESSFUL REENTRY AND THE CRIMINAL JUSTICE SYSTEM

- How do we alleviate the burden of bails? Can the county establish a "Public Bail Fund"?
- How can we eliminate barriers to re-entry, such as Legal Financial Obligations, civil penalties, and fines, for individuals in the criminal justice system?
- How can we implement incentives for the county's criminal justice agencies to eliminate barriers to re-entry?

October 18th (WEEK 1) Meeting Agenda:

1. Briefing and Discussion on Mental Illness Drug Dependency (MIDD) Levy and Law Enforcement Assisted Diversion Programs (60 minutes)
 - *Dan Satterberg, King County Prosecuting Attorney and PAO Staff*
 - *Leah Taguba, Senior Deputy Prosecuting Attorney*
 - *Natalie Walton-Anderson, Senior Deputy Prosecuting Attorney*
 - *Carol Cummings, Police Chief, City of Bothell*
 - *Shawn Ledford, Police Chief, City of Shoreline*
 - *King County Department of Community and Human Services Staff*
 - *Jim Vollendroff, Director, Behavioral Health and Recovery Division*
 - *Christopher Verschuyt, Program Manager, MIDD*
2. Briefing and Discussion on Delivery of Benefits to Support Residents in Poverty to Reach their Full Potential (60 minutes)
 - *Alex Doolittle, Executive Director from Seattle Community Law Center*
 - *King County Department of Community and Human Services Staff*
 - *Adrienne Quinn, Director (Outgoing)*
 - *Leo Flor, Director (Designate)*
 - *Public Health – Seattle & King County Staff*
 - *Patty Hayes, Director*
 - *TJ Cosgrove, Division Director, Community Health Services*
3. Briefing and Discussion on Public Health (60 minutes)
 - *City of Seattle Councilmember Teresa Mosqueda*
 - *Janet Varon, Executive Director, Northwest Health Law Advocates (NoHLA)*
 - *Public Health – Seattle & King County Staff*
 - *Patty Hayes, Director*
 - *Dennis Worsham, Division Director, Prevention*

October 25th (WEEK 2) Meeting Tentative Agenda:

1. Continue Briefing and Discussion on Mental Illness Drug Dependency (MIDD) Levy and Law Enforcement Assisted Diversion Programs *(30 minutes)*
 - *Dr. Susan Collins, Director, Harm Reduction Research and Treatment Center (HaRRT), Department of Psychiatry and Behavioral Sciences, University of Washington – Harborview Medical Center*
2. Briefing and Discussion on Barriers to Successful Reentry and the Criminal Justice System *(60 minutes)*
 - *Sean O'Donnell, Chief Criminal Judge, Superior Court*
 - *Theresa B. Doyle, Judge, Superior Court*
 - *Anita Khandelwal, Director, Department of Public Defense*
 - *Patty Noble-Desy, Recidivism Reduction and Reentry – Senior Project Manager, Office of Performance, Strategy & Budget*
3. Briefing and Discussion on Responses to Week 1 Follow-up Questions *(45 minutes)*
 - *Council Central staff*
 - *Department/Agency staff*
4. Preliminary Discussion on Possible Budget Options *(45 minutes)*
 - *Council Central staff*
 - *Department/Agency staff*

November 1st (WEEK 3) Meeting Tentative Agenda:

1. Briefing and Discussion on Responses to Week 2 Follow-up Questions *(45 minutes)*
 - *Council Central staff*
 - *Department/Agency staff*
2. Discussion on Final Budget Proposals and Consensus *(45 minutes)*
 - *Council Central staff*



**Metropolitan King County Council
Budget Panel Discussion 2019-2020**

EQUITY AND JUSTICE FOR ALL

Central Staff Name:	Wendy Soo Hoo Sam Porter	Date:	October 18, 2018 (Week 1)
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MENTAL ILLNESS DRUG DEPENDENCY (MIDD) LEVY and LAW ENFORCEMENT ASSISTED DIVERSION PROGRAMS

- What are the outcomes of the Law Enforcement Assisted Diversion (LEAD) program?
- What are the outcomes of the Navigator, RADAR, and related programs that also involve law enforcement personnel to assist individuals to divert from detention?
- Are current MIDD funded programs aligned with the original purpose of the MIDD Levy?

BACKGROUND

Law Enforcement Assisted Diversion (LEAD) is a collaborative pre-booking diversion program to provide community-based treatment alternatives to booking people in jail for low-level drug crime, prostitution, and other collateral crime due to drug involvement. LEAD receives ongoing funding through MIDD and was externally evaluated by researchers at the University of Washington. According to Executive staff, this evaluation established proof of concept for the LEAD model and was the basis for replication grants administered by the Bureau of Justice Assistance.

Response Awareness, De-escalation and Referral (RADAR) is a program intended to decrease use-of-force incidents between police and individuals with behavioral health and developmental disabilities and to reduce the repeated and inappropriate use of emergency services.¹ The program received one-time MIDD funds in 2016 that was awarded to the City of Shoreline to implement and evaluate the RADAR program over three years. The program went into effect January 1, 2017 and will be evaluated by researchers at George Mason University and the Police Foundation in 2018.² The RADAR analysis is scheduled to be completed in September 2019 and will include data from 2014 through June 2019. Due to its short-term, limited MIDD funding RADAR was not included in the MIDD evaluation and did not have established performance targets.

¹ RADAR, Shoreline Smart Policing Initiative, <http://www.shorelinewa.gov/government/departments/police-department/radar>

² Ibid

History of the Mental Illness and Drug Dependency Sales Tax (MIDD)

In 2005, the Washington State Legislature passed the Omnibus Mental Health and Substance Abuse Act in 2005. The law (RCW 82.14.460) authorized counties to levy a one-tenth of one percent sales and use tax to fund new or expanded mental health, chemical dependency or therapeutic court services. Subsequent revisions to the statute allowed housing and transportation³ to be funded with the sales tax revenues and enabled counties to supplant a percentage of existing funds on a predetermined schedule through 2016. Note that in 2011, the statute was revised to allow therapeutic court costs to be funded with the sales tax without being considered supplantation.

The King County Council authorized the Mental Illness and Drug Dependency (MIDD) sales tax in 2007⁴ with the policy goals of reducing the number of people using costly interventions (such as hospitals or the jail), the number of people repeatedly cycling through the jail, and the incidence and severity of chemical dependency and mental and emotional disorders in youth and adults; diversion of youth and adults from initial or further justice system involvement; and alignment with other Council directed efforts.

In 2016, the Council authorized the extension of the sales tax⁵ and adopted a Service Improvement Plan⁶ (SIP) to guide the investment of future MIDD revenues. The SIP organized the MIDD programs and services into four areas corresponding to the continuum of care: prevention/early intervention, crisis diversion, recovery/reentry and system improvements. In addition, the SIP called for supporting all therapeutic court costs. Table 1 below shows the MIDD expenditures for 2017-2018 and proposed budget for 2019-2020 by strategy area.

Table 1
MIDD 2017-2018 Expenditures vs. 2019-2020 Proposed Budget by Strategy Area

Strategy Area	2017-2018 Estimated Expenditures	2019-2020 Proposed Budget	Percent Change
Prevention/Early Intervention	\$34,520,000	\$38,837,000	13%
Crisis Diversion	\$31,028,000	\$46,798,000	51%
Recovery and Reentry	\$25,275,000	\$19,338,000	31%
System Improvements	\$8,508,000	\$14,484,000	70%
Therapeutic Courts	\$21,705,000	\$24,372,000	12%
Supplementals – Not Categorized	\$12,301,000	N/A	N/A
Administration	\$5,451,000	\$8,823,000	62%

As shown in the table above, the proposed budget would increase most significantly investments in Crisis Diversion, System Improvements and Administration.

³ In addition to treatment services and case management, housing and transportation have been added as examples of programs and services that may be funded as a "component of a coordinated chemical dependency or mental health treatment program or service."

⁴ Ordinance 15949

⁵ Ordinance 18333

⁶ Ordinance 18406

ATTACHMENTS

1. Executive Staff Responses to Policy Questions, dated October 12, 2018
2. City of Shoreline North Sound RADAR Navigator Program Presentation
3. RADAR Program Data Summary, dated April 18, 2018.

INVITED

1. Dan Satterberg, King County Prosecuting Attorney
2. Leah Taguba, Senior Deputy Prosecuting Attorney
3. Natalie Walton-Anderson, Senior Deputy Prosecuting Attorney
4. Carol Cummings, Police Chief, City of Bothell
5. Shawn Ledford, Police Chief, City of Shoreline
6. Jim Vollendroff, Division Director, King County Department of Community and Human Services, Behavioral Health and Recovery Division (BHRD)
7. Christopher Verschuyt, Policy and Strategy Coordinator, BHRD

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“Equity and Justice for All” Budget Panel Responses to Questions on MIDD | October 12, 2018

1. Are current MIDD funded programs aligned with the original purpose of the MIDD Levy?

Yes. As articulated in the Council-approved¹ MIDD 2 Service Improvement Plan, MIDD aims at this overarching result: people living with, or at risk of behavioral health conditions, are healthy, have satisfying social relationships, and avoid criminal justice involvement.² MIDD 2’s initiatives form a range of behavioral health services and programs in order to achieve these outcomes, as articulated through MIDD 2’s five Council-adopted policy goals.³ As in MIDD 1,⁴ each MIDD 2 initiative is directly aligned with one or more MIDD 2 policy goals.

The County updated the MIDD policy goals during the MIDD renewal process in 2016, via Ordinance 18407. The County updated the policy goal language to be recovery-oriented and reflect person-centered language, with the intent to focus on meeting the needs of people rather than on meeting system needs.⁵ One example of this was MIDD 2’s health and wellness goal,⁶ which replaced a prior narrower focus on symptom reduction.⁷ Although wording has changed, diversion from and reduction in the use of costly interventions, including jails, emergency rooms, and hospitals, remain a key focus of MIDD 2, as in MIDD 1.⁸

2. What are the outcomes of the Law Enforcement Assisted Diversion (LEAD) program?

LEAD was externally evaluated by researchers at the University of Washington utilizing quasi-randomized control trial study design beginning. All methodology was peer-reviewed in advance; the subsequent evaluation meets the Office of Justice Programs’ definition for evidence-based practices. Four reports detail outcomes in the areas of recidivism, connection to social services, quality of life, and legal system utilization and associated costs and can be found at <https://www.leadbureau.org/evaluations>.

This evaluation established proof of concept for the LEAD model and was the basis for replication grants administered by the Bureau of Justice Assistance, and opportunities exist to further develop the evidence base. There is a desire to conduct future evaluations that examine longitudinal outcomes as well as the application of the model to suburban cities and higher acuity mental health populations such as the *Trueblood* class member population. Seattle-King County LEAD’s Policy Coordinating Group, which includes representatives from the King County Prosecuting Attorney’s Office, the King County Executive’s Office, and King County Council, is in the process of planning for its next LEAD evaluation.

¹ Ordinance 18406.

² The MIDD 2 result and its policy goals are consistent with the enabling state legislation for MIDD, [RCW 82.14.460](#).

³ Ordinance 18407.

⁴ “MIDD 1” refers to 2008-2016, while “MIDD 2” refers to 2017-2025.

⁵ MIDD 2 Service Improvement Plan, page 33.

⁶ MIDD 2 policy goal 4.

⁷ MIDD 1 policy goal 3.

⁸ MIDD 2 policy goal 1 encompasses and updates the key components of MIDD 1 policy goals 1, 2, and 4.

3. What are the outcomes of the Navigator, RADAR, and related programs that also involve law enforcement personnel to assist individuals to divert from detention?

Since its inception, the MIDD evaluation has had a consistent approach to one-time investments of MIDD funds. The MIDD evaluation focuses on providing information about long-term outcomes related to MIDD's policy goals for *ongoing initiatives*, so programs funded on a one-time basis are not included.

In 2018 King County committed one-time MIDD Initiative RR-14 Shelter Navigation Services funding to support outreach workers from REACH that are part of the City of Seattle Navigation Team. Due to the one-time nature of this funding, the program is not included in the MIDD evaluation and did not have established MIDD performance targets.⁹

At this time, executive-proposed plans to continue initiative RR-14 funding on an ongoing basis in 2019-20 are projected to support navigation services as part of DCHS' enhanced shelter model, rather than continuing the one-time investment in the City of Seattle Navigation Team.

Response Awareness, De-escalation and Referral (RADAR) received one-time MIDD funds in 2016. This program was likewise not included in the MIDD evaluation and did not have established performance targets, due to its short-term, limited MIDD funding.¹⁰

Among ongoing MIDD services, MIDD initiative CD-06 Adult Crisis Diversion Center, Respite Beds, and Mobile Behavioral Health Crisis Team assists law enforcement and other first responders to divert individuals from jails and hospitals. In 2017 this initiative had significant long-term reductions in jail bookings (17% decrease)¹¹ and Harborview emergency department admissions (43% decrease).¹²

LEAD received one-time MIDD funds in 2016. The LEAD program was not included in the MIDD evaluation at that time, consistent with MIDD's evaluation approach for one-time funding. In 2017 LEAD was added as an ongoing MIDD 2 initiative (CD-01) and therefore is now included in the MIDD evaluation. At least one year must pass after starting MIDD services and data collection before outcomes can be measured for participants, so outcomes results from MIDD are not yet available. Initial short-term results are expected to be available sometime in 2019. See the previous question for additional information about external evaluations of the LEAD program model.

⁹ Information beyond the MIDD evaluation regarding the City of Seattle's own reporting and evaluation regarding navigation teams may be found through the Seattle City Auditor's office. See <https://www.seattle.gov/Documents/Departments/CityAuditor/auditreports/NavigationTeamReportingPlan110717.pdf> and http://www.seattle.gov/Documents/Departments/CityAuditor/auditreports/Review%20of%20Navigation%20Team%202018%20Quarter%201%20Report_10-2-18.pdf.

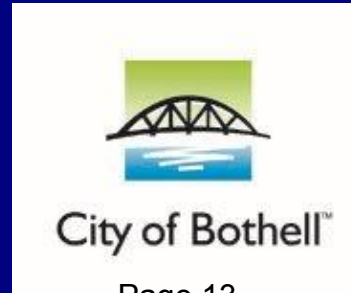
¹⁰ According to the City of Shoreline, researchers at George Mason University are expected to evaluate the RADAR program through a federal Department of Justice grant. See <http://www.shorelinewa.gov/government/departments/police-department/radar> and <https://www.shorelineareanews.com/2015/11/city-of-shoreline-awarded-grant-to.html>.

¹¹ MIDD 2017 Annual Report Technical Supplement.

¹² MIDD 2017 Annual Report.

North Sound RADAR Navigator Program

*Building a bridge between law enforcement, mental health
and the community*



RADAR – Broad Based

- Mental Illness
- Homelessness
- Alcohol/Drug Addiction



Navigator – Mental Health Professional

LEAD – narcotics personal use and low level dealing, prostitution. The person is Involved in criminal activity.

RADAR Navigator MHP – to reduce jail bookings, emergency room visits and connect those most in need to services, often suffering from mental illness and/or homelessness.



RADAR Navigator Outreach

- **Bothell** – 196 contacts
- **Shoreline** – 190 contacts
- **Kirkland** – 78 contacts
- **Kenmore** – 20 contacts
- **Lake Forest Park** – 16 contacts



Navigator Success

- Letter to Shoreline Police dated 09/26/18. “I feel that this department has shown extreme patience and concern and has a desire to rehabilitate residents rather than just punish them”
- Shoreline deputy – “RADAR has proven to be an invaluable tool for patrol by providing relevant information about subjects who suffer from behavioral health issues”.



North Sound RADAR Navigator Success Continued



City Contributions

- King County Risk Management \$50,000
- King County Prosecutor Dan Satterberg
- Department of Justice, Smart Policing Grant (2016) \$500,000
- Washington Sheriff's & Police Chief's (WASPC) \$102,000
- King County MIDD - \$200,000
- City of Shoreline – Part time Homeless Advocate
- Police overtime to focus on outreach w/ MHP Navigator



North Sound RADAR's Request

- **Connect people in need to services**
- 2019 – two Mental Health Professionals
\$319,629
- Part time MHP's \$64,976
- Supplies \$10,960
-
- 2020 – two mental health professionals
\$319,629
- Part time MHP's \$62,045
-
- Biennium \$777,239



RADAR: Key Takeaways

Charlotte Gill, April 18, 2018

- Mental health and suicide attempt calls for service make up about 3.5% of all calls in Shoreline, but this doesn't take into account other types of calls (like trespassing, assault, disturbances) that may also have a mental health component.
- Deputies spend about 25 percent more time dealing with mental health-related calls compared to other types of calls, representing an additional 125 more officer-hours per year.
- Shoreline deputies report that encountering people with a behavioral health issue is extremely common, happening every day or several times a week. 90% of deputies who responded to a department-wide survey said they had used force in such an encounter.
- RADAR deputies in Shoreline feel that the program gives them more access to information about citizens in need and how to connect them with services
- A total of 143 people have been contacted by the Mental Health Navigator in collaboration with the Shoreline Police Department between January 1, 2017 and March 12, 2018. 269 contacts have been made.
 - The highest utilizer has had 25 contacts with the Navigator and/or police department. Another service user has had 8 contacts so far, while three have had 7 contacts.
 - The most common type of situation (34% of individuals contacted) was behavioral health or medical issues, including paranoia, delusions, schizophrenia, dementia/Alzheimer's, traumatic brain injury etc.
 - 24% of individuals contacted were experiencing mental health issues, such as depression or suicidal behavior. Some of these cases were related to alcohol or drug use.
 - 11% of individuals contacted were intoxicated (alcohol or drugs)
 - 10% of individuals contacted had school-related issues, including 4 individuals who had made threats to bring a gun to school or shoot up the school
 - 8% of individuals were contacted for crime-related reasons, including domestic violence and assault. The majority of these individuals were victims rather than suspects.
 - 8 of 142 cases where this information was reported involved a referral or co-response with Shoreline Fire.
 - 83% of individuals contacted agreed to accept resources/assistance.
 - 14% of cases involved continued deputy/Navigator outreach.

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**Metropolitan King County Council
Budget Panel Discussion 2019-2020**

EQUITY AND JUSTICE FOR ALL

Central Staff Name:	Andrew Kim	Date:	October 18, 2018 (Week 1)
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PUBLIC HEALTH

- How can we lay the foundation of building a regional health plan in the county?
- How can we expand the county's efforts on HPV (Human Papillomavirus) to improve vaccination rates and increase screenings in an effort to reduce cervical cancer in the county?

BACKGROUND

Regional Health Plan In 2013, according to the U.S. Census, there were at least 5,800 uninsured immigrants in King County living at or below 138% of the federal poverty level, however this number discounts those that are undocumented.¹ According to healthcare.gov², Medicaid provides payment for treatment of an emergency medical condition for people who meet all income and state residency requirement but don't have an eligible immigration status. In addition to the provisions above, the State of Washington also offers the Alien Emergency Medical (AEM) Program, a limited Apple Health (Medicaid) coverage, for individuals who do not meet citizenship or immigration status requirements or for qualified individuals who have not met the five-year waiting period after receiving qualified immigration status. However, they must have a qualifying medical condition^{3, 4}

At its February 15, 2018 meeting, the King County Board of Health received a briefing on the "County-Based health Coverage for Adult Immigrants: A Proposal for Counties in

¹ "The Impact of the Affordable Care Act on Uninsured Adults in King County." Public Health – Seattle & King County. February 2013.

http://www.kingcounty.gov/depts/health/data/~/_media/depts/health/data/documents/impact-ACA-uninsured-adults-in-king-county-february-2013. Accessed October 16, 2018.

² Coverage for lawfully present immigrants. <https://www.healthcare.gov/immigrants/lawfully-present-immigrants/>. Accessed October 11, 2017.

³ A qualifying emergency medical condition must have or need at least one of the following: (1) a qualifying emergent medical condition such as emergency room care, inpatient hospital admission, or outpatient hospital surgery; (2) a cancer treatment plan; (3) dialysis treatment; (4) anti-rejection medication for an organ transplant; and (5) Long-term Care (LTC) services.

⁴ Washington State Health Care Authority: Free or low-cost health care for non-citizens. <https://www.hca.wa.gov/free-or-low-cost-health-care/apple-health-medicaid-coverage/non-citizens>. Accessed October 11, 2017.

Washington State”.^{5,6} The proposal was developed by the Northwest Health Law Advocates (NoHLA)⁷ and introduced by Board of Health member and City of Seattle councilmember Teresa Mosqueda. The proposal would expand health care services to low-income residents that are not eligible to access health care through existing public programs such as Medicaid, Medicare, and subsidized health insurance under the Affordable Care Act (ACA), due to their immigration status. The model was based on various models implemented across the country which include the City of San Francisco (Health San Francisco), City of Los Angeles (My Health LA), Contra Costa County in California (Contra Costa Cares), Montgomery County in Maryland (Montgomery Cares), and others.

The report provides a preliminary annual operating cost estimate to be approximately \$53 million in 2020, increasing to \$68 million in 2025 as enrollment grows from an estimated 35,430 to 39,043 individuals. Attachment 1 of this document includes an executive summary of NoHLA’s proposal.

In December 2017, Public Health – Seattle & King County (PHSKC) staff reviewed a draft of NoHLA’s proposal and provided feedback. Attachment 2 of this document includes PHSKC’s feedback to NoHLA. Executive staff notes that given that the NoHLA report focuses on health coverage for adult immigrants, PHSKC’s public health clinics have an open-door policy to provide services to any patient regardless of citizenship or residency status and without tracking this type of information in their systems.

Human papillomavirus (HPV) According to the U.S. Centers for Disease Control (CDC), the Human papillomavirus (HPV) is the most common sexually transmitted infection in the United States. CDC states that almost 79 million residents, most in their late teens and early 20s, are infected with HPV and approximately 14 million people become newly infected each year. There are over 40 different types of HPV where some types can cause health problems including genital warts, cervical cancer, and other cancers including cancer of the vulva, vagina, penis, or anus. It can also cause cancer in the back of the throat, including the base of the tongue and tonsils (called oropharyngeal cancer). CDC states that cancer often takes years, even decades, to develop after a person gets HPV. The types of HPV that can cause genital warts are not the same as the types of HPV that can cause cancers^{8,9}

The CDC reports that every year, approximately 19,400 women and 12,100 men in the United States are affected by cancers caused by HPV, and of those 12,000 women will be diagnosed with cervical cancer, and more than 4,000 women die from cervical cancer, even with screening and treatment.¹⁰

⁵ Northwest Health Law Advocates – County-Based Health Coverage for Adult Immigrants: A Proposal for Counties in Washington State, April 2018. URL: <http://nohla.org/wordpress/img/pdf/County-BasedReport2018.pdf>. Accessed October 16, 2018.

⁶ King County Board of Health Briefing 18-B04.

⁷ Northwest Health Law Advocates website: <https://nohla.org/>.

⁸ According to the U.S. Centers for Disease Control (CDC), HPV types 16 and 18 account for approximately 66% of cervical cancers in the United States. URL: <https://www.cdc.gov/std/stats17/other.htm#hpv>. Accessed October 16, 2018.

⁹ U.S. Centers for Disease Control (CDC)’s Genital HPV Infection - Fact Sheet. URL: <https://www.cdc.gov/std/hpv/stdfact-hpv.htm>. Page last updated: November 16, 2017. Accessed October 16, 2018.

¹⁰ *Ibid*.

The CDC states that the HPV vaccines (primarily *Cervarix* and *Gardasil*)¹¹ are safe and effective, and it can protect against diseases, including cancers, caused by HPV when given in the recommended age groups. The CDC recommends the following regarding vaccinations and screenings:

- All boys and girls ages 11 to 12 year olds get two doses of the HPV vaccine to protect against cancers caused by HPV;
- Catch-up vaccines for boys and men through age 21 and for girls and women through age 26, if they did not get vaccinated when they were younger;
- Routine screenings for women aged 21 to 65 years old can prevent cervical cancer;
- Gay and bisexual men (or any man who has sex with a man - MSM) through age 26; and
- Men and women with compromised immune systems (including those living with HIV/AIDS) through age 26, if they did not get fully vaccinated when they were younger.

The CDC reports that in 2017, 49 percent of adolescents nationwide were up to date on the HPV vaccine, and 66 percent of adolescents ages 13-17 years received the first dose to start the vaccine series. On average, the percentage of adolescents who started the HPV vaccine series increased by 5 percentage points each year from 2013 to 2017.¹² Public Health – Seattle & King County staff state that 55.9 percent of King County adolescents aged 11-17 have 1 or more doses of HPV vaccine (57.9 percent for female, 54.1 percent for male) as of December 31, 2017.

Today's panel discussion would explore the above policy question on how to expand the county's efforts on HPV to improve vaccination rates and increase screenings in an effort to reduce cervical cancer in the county. Attachments 3 and 4 of this document highlights the Public Health – Seattle & King County's (PHSKC) current efforts related to HPV, particularly in the Prevention Division, Public Health clinics, and the School-Based Partnership program. The attachment also speaks to PHSKC's proposals to expand the county's HPV work. The proposals would total approximately \$1.3 million of additional investments for the 2019-2020 biennium to expand HPV efforts. Lastly, Attachments 5 and 6 of this document provides data on the county's HPV vaccination rates.

ATTACHMENTS

1. Northwest Health Law Advocates (NohLA) – County-Based Health Coverage for Adult Immigrants Report – Executive Summary, April 2018
2. December 2017 Memo from PHSKC to NohLA Responding to Draft version of the County-Based Health Coverage for Adult Immigrants Report
3. PHSKC: Increasing HPV Vaccination Rates & Screenings, dated October 11, 2018
4. PHSKC: Additional information on HPV Vaccination Rates & Screenings, dated October 16, 2018

¹¹ According to the U.S. Centers for Disease Control (CDC), there are several HPV vaccines licensed in the U.S., notably the bivalent vaccine (*Cervarix*) and a quadrivalent vaccine (*Gardasil*). Both of these vaccines offer protection against HPV types 16 and 18, which account for 66% of all cervical cancers, and the quadrivalent vaccine protects against five additional HPV types accounting for 15% of cervical cancers. The quadrivalent vaccine also protects against types 6 and 11, which cause 90% of genital warts.

¹² U.S. Centers for Disease Control (CDC) HPV Vaccination Coverage Data. URL: <https://www.cdc.gov/hpv/hcp/vacc-coverage/index.html>. Page last updated: August 23, 2018. Accessed October 16, 2018.

5. Data: Immunization coverage among King County adolescents aged 11 - 17 years old as of December 31, 2017.
6. PHSKC: County Map of HPV Vaccination Rates as of December 31, 2017

INVITED

1. City of Seattle Councilmember Teresa Mosqueda
2. Janet Varon, Executive Director, Northwest Health Law Advocates (NoHLA)
3. Patty Hayes, Director, Public Health – Seattle & King County (PHSKC)
4. Dennis Worsham, Division Director, Prevention, PHSKC

County-Based Health Coverage for Adult Immigrants:

A Proposal for Counties in Washington State

April 2018



NoHLA
Northwest Health Law Advocates

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Executive Summary

Many low-income Washington residents are not eligible to access health care through public programs such as Medicaid, Medicare, and subsidized health insurance under the Affordable Care Act (ACA), due to their immigration status. While children generally have access to Washington Apple Health regardless of immigration status, adults do not. To address these gaps, many counties across the country have implemented health programs to increase access to health care services for adults. We have highlighted six such programs in this report. Based on our review, we provide recommendations for developing similar programs in Washington State counties.

Based on our research and an economic analysis prepared by HealthTrends, we offer these initial recommendations for program components for Washington counties to consider:

- Eligibility Criteria
 - To qualify for the program, an individual should:
 - Reside in the county in which the county-based program operates
 - Have household income at or below a threshold set at or above 400% of the Federal Poverty Level (FPL)
 - Be uninsured and ineligible for other coverage or be unable to cover the cost of a Qualified Health Plan (QHP) in the Washington Health Benefit Exchange (HBE)
 - Be 19 years of age or older
- Enrollment Process
 - Applications should be available at participating clinic sites, other community locations, and online.
 - Enrollment should be conducted by navigators and application assisters in a culturally appropriate and linguistically accessible manner.
 - Social security numbers and information about immigration status should not be collected as part of enrollment.
- Model for Providing Care and Participating Providers
 - The program should be based on a Patient Centered Medical Home model.
 - The application system (or software that is used for enrollment) should make available to all participating providers access to information on the individual's assigned medical home.
 - The program should leverage existing community resources.
- Benefits and Out-of-Pocket Costs
 - The benefits should be similar to the full scope Medicaid service package, wrapping around already-available services such as emergency Medicaid.
 - The program should include a care management/care coordination component.
 - There should be no premiums or out-of-pocket costs for individuals with incomes at 138% FPL and below. For individuals with incomes above that level, there should be only limited participation costs on a sliding fee scale.

- Program Cost – Two County Estimates¹
 - A preliminary estimate of the annual cost of operating this program in King County as it is phased in is approximately \$53 million in 2020, increasing to \$68 million in 2025 as enrollment grows from an estimated 35,430 to 39,043 individuals.
 - A preliminary estimate of the annual cost of operating this program in Yakima County is approximately \$18 million in 2020, increasing to \$21 million by 2025 as enrollment grows from an estimated 15,563 to 15,813 individuals.
 - Counties should explore all potential sources of funding to develop a plan for financing the county-based program.

¹ Program costs are estimated based on a capitated payment model. See discussion *infra* part V and Appendix C for more details.

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December 20th, 2017

To: Huma Zarif & Janet Varon, Northwest Health Law Advocates

FR: Ingrid McDonald, Policy Director PHSKC

CC: Patty Hayes, Director, PHSKC

Comments on: "County-Based health Coverage for Adult Immigrants: A Proposal for Counties in Washington State"

Thank you for this excellent report. We really appreciate your focus on the uninsured immigrant population; the helpful reviews of county programs to serve this population in California and other parts of the country; and the description and estimates of what it would take to cover this population in King County. Below are a few comments for your consideration.

Important Themes

- ***Focus on Least Accessible Services and Filling Gaps:*** Thank you for the discussion beginning on pg. 23. For further discussion on the types of services most in demand, we suggest you cite the reports from the Seattle /King County Clinic: <http://seattlecenter.org/skcclinic/>
- ***Fear of accessing services:*** Suggest more discussion on how to address the fear of accessing government services and strategies to make people feel safe. Are there emerging best practices? For more on what King County is doing on this front see: <http://www.kingcounty.gov/elected/executive/equity-social-justice/Immigrant-and-Refugee.aspx>
- ***Need for flexible services:*** Suggest additional discussion on how to make health care more accessible by meeting people where they are rather than expecting them to come to clinics, offices or other centralized locations. Strategies to explore could include mobile services, housing-based services and Community Health Workers.
- ***Creative and proactive outreach and enrollment:*** Thank you for discussion on centralized vs. distributed enrollment, our creativity and success with ACA enrollment in King is a platform to build on. See more information here: <http://www.kingcounty.gov/depts/health/locations/health-insurance/coverage.aspx>
- ***Concerns about loss of ACA coverage:*** For context, we recommend referencing federal action to unravel and undermine the Affordable Care Act and note that the gaps in

coverage that these county programs would seek to address are likely to grow in the future.

The Funding Challenge

- Thank you for providing the estimated cost of running this type of program in King County. The estimated \$53 million per year in 2020 and more in future years is a significant obstacle. More discussion of this challenge and analysis of potential funding sources would strengthen this report.
- The note on this in the introduction (page 4) cites the difficulty in capturing funding through the state budget for this purpose and states that funding for a local program may be easier to obtain. We recommend caution in discussing the potential to tap existing county resources or raise new revenues at the county level. Please reference the limitations that local governments in WA face, including the 1% property tax cap. This is in stark contrast to California, where counties receive a dedicated portion of vehicle licensing fees and sales tax revenue to finance county health and safety net programs.
- A related concern is whether the forecast underestimates the cost of the described program. For example, it assumes that nearly 100% of the cost of hospital care would be written off as charity care. From our experience, this may be unrealistic.
- Indirect administrative, operational and information technology expenses also look low. For example, the discussion on pg. 26 calls for information sharing among participating providers. As we know from our preliminary discussions as the Accountable Community of Health, this is a big, system-wide challenge that will be very expensive to fix and will require more research. We are happy to provide more information in this area if that is helpful.

Thank you for considering our comments. Visualizing what it would take to address the gaps in coverage for the immigrant population is a very important exercise and a critical first step in paving the way for change.

Thank you for your important work and let us know if we can be of further assistance.

Increasing HPV Vaccination Rates & Screenings

Information for Equity & Justice for All Council Budget Panel - October 10, 2018

Question

How can we expand the county's efforts on HPV (Human Papillomavirus) to improve vaccination rates and increase screenings in an effort to reduce cervical cancer in the county?

Public Health manages several programs to address the County's HPV vaccine and screening initiatives:

1. **Prevention:** As part of Best Starts for Kids (BSK), the Adolescent Immunization Quality Improvement Learning Collaborative partners with the University of Washington and the American Academy of Pediatrics to increase adolescent immunization, with a particular emphasis on HPV. This program leverages \$400k from BSK to support one FTE and an external contract.

Additionally, in 2017 the PHSKC School-Based Partnerships Program and the Immunizations Program received a grant from the Group Health Foundation (\$67k for period 11/2017-8/2019) to expand an existing project working to 1) increase awareness of the benefits of HPV vaccination and 2) improve access to vaccination services at school-based health centers (SBHCs). Based on a successful two-year project in thirteen Seattle Public Schools, Public Health is launching [student-led campaigns](#) at five additional high schools and strengthening immunization outreach to parents/guardians at six middle schools.

In 2018, the Public Health Immunization Program received a mini-grant from the American Cancer Society (\$10k) to create a targeted social media campaign promoting HPV vaccine to reach parents of middle and high school students in King County, add information to our PHSKC SBHC [webpage](#) about SBHCs and the services they provide (emphasis on HPV vaccination), and design and mail postcards to approximately 250 primary care practices in Seattle, Burien, Tukwila, Vashon and Bellevue to remind them about SBHCs and include link to the new webpage.

2. **Breast Cervical & Colon Health Program (BCCHP)**

The BCCHP Program provides roughly 1300 HPV tests per year but does not currently vaccinate for HPV. The program subcontracts with health care providers and organizations to provide direct services to individuals in their communities. BCCHP eligibility and screening policies reflect CDC guidelines given CDC funds the program through the Washington Department of Health. The entire BCCHP program budget is \$3.1M in 2019-2020. Additional testing is available through the STD clinic, which provides about 200 cervical cancer screening tests per year.

Outreach contractors include messaging around BCCHP including the importance of cervical cancer screening, and the Community Health Access Program (CHAP) helps refer clients to BCCHP eligible clinics.

3. **CHS Program Overview**

Sexual and reproductive health services are provided at three primary care clinics (Downtown, Eastgate, and Navos), four Family Planning clinics (Auburn, Federal Way, Kent and Eastgate), all school-based health centers (four of which are operated by Public Health and the rest by

Increasing HPV Vaccination Rates & Screenings

Information for Equity & Justice for All Council Budget Panel - October 10, 2018

community partners), and all of our Health Care for the Homeless Network clinics and their partners. These sexual health services include HPV vaccines, primarily for people under the age of 19. HPV vaccine is purchased and supplied by the Vaccine for Children (VFC) program. A limited amount of state-sponsored HPV vaccine is also available for those aged 19-26, however this supply is only sporadically available from Washington State Department of Health.

Between 2017 and September of 2018, the Public Health Family Planning and Primary Care clinics 1554 individuals initiated the HPV vaccination series. Because this vaccine is expensive, there is a gap in our uninsured clients. Should more HPV vaccine be made available, more public health clients would receive the HPV vaccination, particularly those who are uninsured aged 19-26. Currently, almost 50% of our family planning visits are uninsured.

In addition, our clinics provide cervical cancer screening to all eligible patients. Within the family planning program, we have a very high screening rate above 80%. We also serve a large Latina population and uninsured and underinsured patients.

The Family Planning Program has six community-based health educators who work in schools and community-based agencies serving youth and young adults. Educators provide direct health education on how to prevent HPV and link youth to care for HPV vaccines and cervical cancer screening clinical services. One of the health educators also worked with Public Health Immunization Program's HPV Vaccine Peer Champion program.

In addition, the Family Planning Program created a comprehensive, medically accurate, age-appropriate, and inclusive sexual health curriculum for elementary, middle school, high school and special education. This curriculum is used across the country. One of goals of the curriculum is to help young people access clinical services.

This work is provided within the broader scope of CHS clinical services and Family Planning health education. The costs are included in these larger program budgets.

Each of these programs could increase its scale to varying degrees with additional funding. Suboptimal HPV vaccination rates in King County are attributable to multiple barriers among health care providers, parents and adolescents, and include missed clinical opportunities, misinformation, lack of knowledge, and insufficient access and/or system gaps. The following strategies could be applied to expand efforts:

1. Purchase more HPV vaccine to increase coverage among the county's uninsured and other vulnerable populations.
2. Fund an FTE Care Coordinator to help clients receiving sexual health services improve completion rates of HPV vaccine series and timely cervical cancer screening and follow-up as indicated (such as diagnostic testing like colposcopy).
3. Increase funding for outreach and engagement programs such as the "HPV Vaccine Peer Champion" program.
4. Support policy changes to address the following issues:
 - a. Improve patient confidentiality for clients aged 19-26 under their parent's insurance by ensuring patients have the opportunity to limit disclosure of services to the policy holder.
 - b. Mandate sexual health education in school in Washington State so young people receive accurate information about how to prevent HPV and access services if they need them.

HPV Vaccine Council Follow-Up Questions**10/16/2018**

Question #1: What is the overall percentage of adolescents aged 11-17 with 1 or more doses of HPV vaccine in the county?

Response: 55.9% of King County adolescents aged 11-17 have 1 or more doses of HPV vaccine (57.9% Female, 54.1% Male) as of 12/31/17. Looking at HPV vaccine series completion rates for 11-17 year olds is complex because the recommended vaccine schedule changed in late 2016 for adolescents who started the series before age 15. So in the attached table, some of the teens need 3 doses to be complete and some are already considered complete with 2 doses.

See attached table for further breakdown of data.

Question #2. Is there similar data (map based) for HPV screenings conducted?

Response: At this time, countywide data is not available for HPV screenings. However, Public Health has convened the King County Family Planning Access and Quality Committee which includes safety net providers and key stakeholders representing all parts of King County. The goal of this Committee is to collectively improve family planning and sexual health services across the county by ensuring services are equitably available. Fundamental to the work of this committee is developing our capacity to systematically collect information needed to create a family planning dashboard representing the clients and services provided by King County's safety net. This dashboard would serve not only as a baseline, but also enable the Committee to strategically identify and launch improvement projects aimed at eliminating disparities in access and improve outcomes for underserved communities. The dashboard would allow us to track progress as well as specifically targeted activities such as HPV screenings among safety net providers across the County. The dashboard development is currently on hold until we secure the approximate \$75,000 - \$100,000 to fund it.

Question #3. Can you provide estimates of cost associated with the four strategies provided in the document?

The following strategies could be applied to expand efforts:

1. **Purchase more HPV vaccine to increase** coverage among the county's uninsured and other vulnerable populations.

Response: Community Health Services (CHS) was able to participate in the recent one-time offer of state-supplied HPV vaccines for adults with a subset of our family planning and primary care clinics receiving a minimal amount of vaccine. The amount of vaccine we previously received through this route supported less than 10% of our estimated need. Based on the recent best practice recommendation, we would aim to improve our vaccine series initiation and completion rate by 15% among our uninsured family planning and primary care clients' aged 19-26 years old. We will need to purchase 300 vaccines at a total cost of \$60,000 per year, totaling \$120,000 for the 2019-2020 budget.

2. **Fund an FTE Care Coordinator to help clients receiving sexual health services improve completion rates of HPV vaccine series and timely cervical cancer screening and follow-up as indicated (such as diagnostic testing like colposcopy).**

Response: A Registered Nurse will provide centralized care coordination support to Public Health's four family planning clinics, three primary care clinics and three school-based health centers. The primary responsibility of his role will be to support patient access to ongoing care through electronic health records tracking and patient contact to assure patients return for preventive care including HPV vaccine, screening and referral coordination for abnormal results for further diagnosis and treatment. The cost of a 1.0 FTE Registered Nurse for 2 year, including benefits and OH would be \$373,000. There is a possibility to scope this body of work for a different job class, which could reduce the costs.

3. Increase funding for outreach and engagement programs such as the "HPV Vaccine Peer Champion" program.

Response: CHS already has a team of family planning health educators who work with youth and young adults in schools and community-based agencies. Through their established relationships in these communities, they could expand the "HPV Vaccine Peer Champion." The team could support approximately up to 11 groups in 2019 and up to 14 in 2020.

In addition, Prevention could engage in efforts to increase knowledge and acceptance of HPV vaccines among parents/guardians and youth by:

- Leveraging resources and expertise with stakeholders to develop a comprehensive, coordinated communication campaign targeting parents (websites, PSAs, blogs, social media, and print), including messaging consistent with CDC's "HPV is cancer prevention" branding. For sub-populations, conduct formative research to develop culturally-competent messages and to identify accessible, acceptable and impactful modes of communication. Collaboration with multi-sector partners such as schools, faith-based and community-based organizations will expand the reach of the campaign.
- In an effort to engage with immigrant populations, host a series of community forums facilitated by trusted health care professionals. These forums will offer parents an opportunity to learn about HPV vaccine and ask questions.
- Sustaining and expand the school-based HPV vaccine promotion campaigns to reach additional school districts in King County and ensure sustainability of the peer-to-peer outreach and youth health advocacy model.

In order to conduct and coordinate the work outlined above, a Project Program Manager II (salary, benefits & OH) and HPV Vaccine Peer Champion supplies would be required at a biennial cost of \$335K.

4. Support policy changes to address the following issues:

- a. **Improve patient confidentiality for clients aged 19-26 under their parent's insurance by ensuring patients have the opportunity to limit disclosure of services to the policy holder.**
- b. **Mandate sexual health education in school in Washington State so young people receive accurate information about how to prevent HPV and access services if they need them.**

Response: Policy priorities are created and coordinated in conjunction with Executive's Office, with Foundational Public Health Services funding the current priority. The department would support other efforts at the state level to support policy changes and programs supporting HPV vaccination and screening.

The above strategies are the types of barriers identified by the King County Family Planning Access and Quality Committee that impact access to services and improve HPV rates. In addition, this Committee has identified the need to establish targeted community engagement to help the safety net system better identify and remove barriers such as those identified above as well as identify how and where to expand services to meet the needs of those residents most impacted by disparities. To support the Committee's work to coordinate across agencies, create and maintain community engagement, and identify ways to support policy change, a .50 to 1.0 FTE program manager would be needed with the cost ranging from \$200,000 to \$415,000 depending on job class and FTE level, including benefits and OH. Additional costs would include \$50,000 to \$75,000 to support community engagement participants and activities, such as stipends for participants, rental for events, etc. totaling a need of \$250,000 to \$490,000 for 2 years.

Question #4. Should the four strategies be implemented and successful, can you quantify the impact to vaccination and screening rates for the county?

Response: We continually strive to achieve the HealthyPeople 2020 Target of 80% HPV vaccine series completion. For the clinics that are participating in our Adolescent Immunization Quality Improvement Learning Collaborative (currently funded through Best Starts for Kids), we are expecting to see a 10-15% increase in HPV vaccine series initiation and completion rates above baseline by the end of the 9 month QI cycle.

For the strategies outlined above, quantifying the impacts would require significant additional scoping and detailed analysis. As with new program implementations, the Department would work to evaluate and quantify the program impacts, where possible.

Question #5. Other countries that have been successful with eliminating HPV have instituted dedicated vaccination programs in schools. Can you speak to this particular strategy?

Response: Differences in HPV vaccine coverage levels – particularly among high income countries (e.g. the US versus the UK and Australia) – reflect significant differences in delivery settings and existing infrastructures. In Australia, for example, voluntary school-based vaccination programs have evolved to become the primary method of delivering adolescent vaccines funded under Australia's National Immunization Program (NIP). These programs operate at a state and territory level and offer NIP vaccines to adolescents in specific school grades using local teams of trained vaccine providers. In the US, however, almost all childhood and adolescent vaccines are provided in a patient's medical home and Public Health routinely works with primary care providers to ensure quality immunization processes and adequate access to vaccines through the Vaccines for Children (VFC) program.

There are considerable political, organizational and logistical challenges to delivery of large scale immunization programs in schools in the US. Considerations include which organizational and funding models should be selected, questions about vaccine supply and distribution in light of the current national VFC program model, issues around staff capacity and workload, as well as how to inform parents, obtain consent, and minimize anxiety and distress to students.

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Immunization coverage among King County adolescents aged 11 - 17 years old (yo) as of 12/31/2017																	
11-17 yo	Total pop	1+ TDaP		1+ MCV		1+ HPV		2+ HPV		3+ HPV		Series 1:1:1*		Series 1:1:2**		Series 1:1:3***	
		N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
All	188809	137620	72.9	126523	67.0	105596	55.9	73838	39.1	45210	23.9	100774	53.4	71651	38.0	44239	23.4
Females	92624	67670	73.1	62312	67.3	53590	57.9	38425	41.5	24571	26.5	50865	54.9	37151	40.1	23973	25.9
Males	96185	69950	72.7	64211	66.8	52006	54.1	35413	36.8	20639	21.5	49909	51.9	34500	35.9	20266	21.1
11-12 yo	Total pop	1+ TDaP		1+ MCV		1+ HPV		2+ HPV		3+ HPV		Series 1:1:1		Series 1:1:2		Series 1:1:3	
		N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
All	55294	34735	62.8	30669	55.5	24485	44.3	8490	15.4	2399	4.3	23164	41.9	8145	14.7	2307	4.2
Females	27169	17146	63.1	15169	55.8	12386	45.6	4420	16.3	1310	4.8	11643	42.9	4237	15.6	1254	4.6
Males	28125	17589	62.5	15500	55.1	12099	43.0	4070	14.5	1089	3.9	11521	41.0	3908	13.9	1053	3.7
13-17 yo	Total pop	1+ TDaP		1+ MCV		1+ HPV		2+ HPV		3+ HPV		Series 1:1:1		Series 1:1:2		Series 1:1:3	
		N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
All	133515	102885	77.1	95854	71.8	81111	60.8	65348	48.9	42811	32.1	77610	58.1	63506	47.6	41932	31.4
Females	65455	50524	77.2	47143	72.0	41204	63.0	34005	52.0	23261	35.5	39222	59.9	32914	50.3	22719	34.7
Males	68060	52361	76.9	48711	71.6	39907	58.6	31343	46.1	19550	28.7	38388	56.4	30592	45.0	19213	28.2

Data source: Washington State Immunization Information System; all vaccines administered as of 12/31/2017

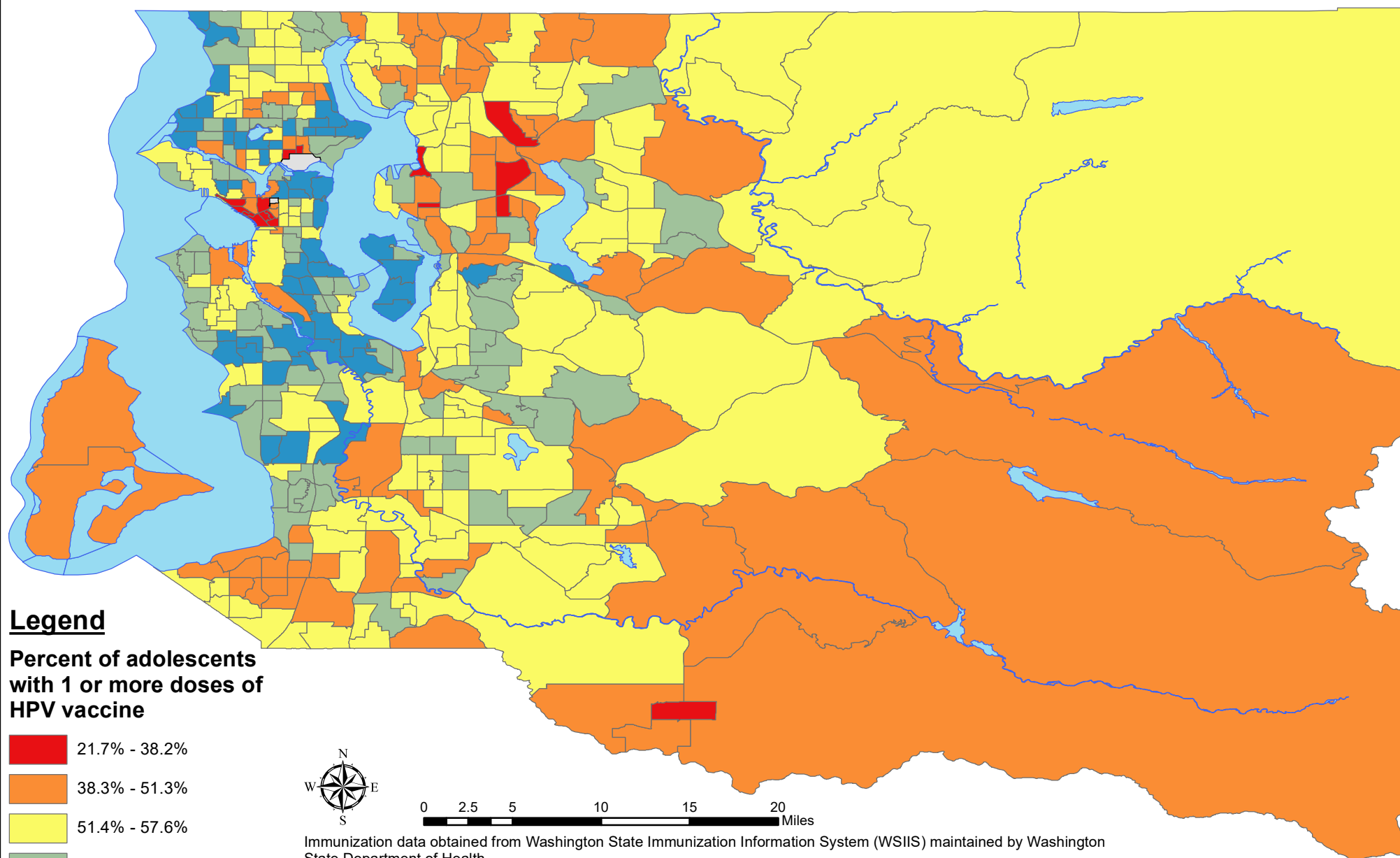
*Series 1:1:1 consists of ≥1 dose of TDaP (tetanus, diphtheria, and acellular pertussis), ≥1 dose of MCV (meningococcal conjugate), and ≥1 dose of HPV (human papillomavirus) vaccines

**Series 1:1:2 consists of ≥1 dose of TDaP (tetanus, diphtheria, and acellular pertussis), ≥1 dose of MCV (meningococcal conjugate), and ≥2 doses of HPV (human papillomavirus) vaccines

***Series 1:1:3 consists of ≥1 dose of TDaP (tetanus, diphtheria, and acellular pertussis), ≥1 dose of MCV (meningococcal conjugate), and ≥3 doses of HPV (human papillomavirus) vaccines

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Percent of all adolescents aged 11-17 with 1 or more doses of HPV vaccine as of December 31, 2017, by census tract of residence



Immunization data obtained from Washington State Immunization Information System (WSIIS) maintained by Washington State Department of Health.

All King County adolescents aged 11-17 years by December 31, 2017 with information on gender and a valid residential address in the WSIIS dataset were included. All vaccines were administered by December 31, 2017. Percentages were calculated using the number of specified adolescents residing in each census tract with the specified number of vaccine doses as the numerator and the total number of specified adolescents residing in each census tract as the denominator. Percentages for census tracts with less than 30 adolescents not shown due to unreliable estimates.



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**Metropolitan King County Council
Budget Panel Discussion 2019-2020**

EQUITY AND JUSTICE FOR ALL

Central Staff Name:	Sahar Fathi Andrew Kim	Date:	October 18, 2018 (Week 1)
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DELIVERY OF BENEFITS TO SUPPORT RESIDENTS IN POVERTY TO REACH THEIR FULL POTENTIAL

- What services and benefits are provided by the county to residents in poverty?
- How can the county integrate the delivery of services and benefits to residents in poverty to make it easier for them to receive all available resources?
- What is necessary to achieve integration on receiving services and benefits for residents in poverty?

SUMMARY

Today's policy discussion is intended to explore services and benefits provided by the county to residents in poverty and the opportunities possible to better integrate these services and make them more available to the constituents they are intended to serve. Attachment 1 is the Executive's response to the questions above. They have combined the questions and provided one general response for all three.

In Attachment 1 the Executive states that they are focusing on major service areas where integration of services is emphasized and "opportunity for improved integration exists." Those major service areas are Public Health – Seattle & King County's (PHSKC) Community Health Services, Department of Community and Human Services (DCHS) Programs and Data Integration Initiatives. These are managed by DCHS and PHSKC. The Executive has stated that where there are connections to other services (i.e. Transit), these have been included in the narrative to illustrate integration efforts and possibilities.

Attachment 1 provides an overview of the Community Health Services Division of Public Health and their range of services that are demonstrating integration– this includes public health centers and partnerships that provide some direct services. In addition, there are some challenges noted, including technology and fund sources. Some opportunities highlighted by the Executive include: (1) working with the Regional Accountable Community of Health (2) legislative analysis and (3) maintaining and increasing flexible funding.

Attachment 1 also provides an overview of the DCHS Framework for Integration and Systemic Challenges. The Executive has identified integration within their King County Veteran's Program, Regional Access Points, Integrated Managed Care, Human Services

Ticket Program, consolidated (integrated) reporting and by integrating providers into a community network.

Finally, Attachment 1 does an overview of data integration initiatives. The Executive has identified examples of integration through their Integrated Care Data Hub, Data Across Sections for Housing and Health (DASHH) Project, and the use of integrated health and human services data to support Medicaid transformation projects of HealthierHere¹. Some barriers the Executive have noted to data integration are (1) legal restrictions, (2) inconsistent regulations across data types and (3) organizational, cultural and bureaucratic barriers. Some opportunities they have noted include greater advocacy and messaging, standardization of individual consent and components of data collection, and improved connection of local integrated data systems with state coordinated systems.

Council central staff would note that there are more areas for future discussion, particularly in geographic disparity, possible models by other jurisdictions, and data (particularly performance metrics) on how health, economic, education, and other outcomes of those residents in poverty are correlated to the delivery of benefits. These topics may be further explored during Week 2 and Week 3 of this panel.

ATTACHMENTS

1. Executive's Responses to Policy Questions, dated October 16, 2018.
2. Presentation from Seattle Community Law Center (*to be distributed and presented at the meeting*)

INVITED

1. Alex Doolittle, Executive Director from Seattle Community Law Center
2. Adrienne Quinn, Director (Outgoing), King County Department of Community and Human Services (DCHS)
3. Leo Flor, Director (Designate), DCHS
4. Patty Hayes, Director, Public Health – Seattle & King County (PHSKC)
5. TJ Cosgrove, Division Director, Community Health Services, PHSKC

¹ HealthierHere, also known as the King County region's Accountable Communities of Health (ACH) is a regional collaborative that was established as a result of the 1115 Medicaid Waiver (app. \$1.2 billion), also known as the Medicaid Transformation Project (MTP). The MTP is a five-year investment agreement between the state of Washington and the Centers for Medicare and Medicaid Services (CMS) that aims to make large scale improvements to the state's Medicaid delivery system. The goal of HealthierHere is to improve health and health equity of the residents of King County.

Equity and Justice for All Council Budget Panel

Responses to Council Questions

ISSUE AREA 4: DELIVERY OF BENEFITS TO RESIDENTS IN POVERTY

Date Questions Received: 10/5/18, from Sahar Fathi

Date Responses Provided: 10/15/18

- 1. What direct services are provided by the county to those residents in poverty?**
- 2. How can the county improve delivering services and benefits to residents in poverty?**

Due to the extensive number of services provided by the County to residents in poverty, after conversations with Council staff, the initial set of responses by the Executive focuses on major service areas where integration of services is an emphasis of current and future efforts and opportunities for improved integration exists. The answers to these first two questions are folded into the summaries included in responses to question 3 below.

- 3. What is necessary to achieve integration of services more efficiently delivery services and benefits to residents in poverty?**

The major service areas selected to include in this response include the following:

- Public Health Community Health Services
 - Colocation and Integration of Public Health Services
 - Access and Outreach Team
 - Health Care for the Homeless Network
 - Medication Assisted Treatment Partnerships
 - Best Starts for Kids
- DCHS Programs
 - Integrating Systems of Programs (King County Veterans Programs, Regional Access Points, Integrated Managed Care)
 - Consolidated Reporting
 - Integrating Providers into a Community Network
- Data Integration Initiatives

This list primarily includes service areas managed by the Department of Community and Human Services (DCHS) and Department of Public Health – Seattle and King County (PH). Where possible, connections to other services, such as Transit, have been incorporated into the narratives to show that integration efforts and opportunities include more than just DCHS and PH. There are also efforts underway and opportunities to improve integration of services for justice-involved individuals. These topics are not covered in this set of answers because many of these issues will be addressed in the separate criminal justice and jail re-entry responses, slated for discussion on October 25.

Public Health Community Health Services

Overview of Public Health's Community Health Services Division

The Community Health Services Division (CHS) of Public Health assures basic health and human services are available to the most vulnerable people in King County, who are often outside mainstream healthcare systems due to barriers such as poverty, language, violence and race.

The Division **both provides** a wide range of services directly to clients (delivered primarily through a network of ten Public Health Centers), **and also assures** access to essential services through partnerships with community-based agencies. These services combine to promote public health and access to affordable, quality care.

The largest part of CHS is the **Public Health Center (PHC) system**, with ten Public Health Centers that each houses a mix of several distinct programs. The five largest PHC services (by visits and staffing) are: First Steps Maternity Support Services & Infant Case Management (MSS/ICM); WIC; Dental; Primary Medical Care; and Family Planning. In addition, about 20 satellite operations situated throughout the county increase accessibility to maternity support services and the WIC supplemental nutrition program. Satellites serve anywhere from 40 to 2,000 clients depending on the site.

PHC Programs	Description
Parent Child Health: Maternity Support Services/Infant Case Management (MSS)	Support for healthy pregnancies and babies through education and counseling
Parent Child Health: WIC	Supplemental nutrition services for women, infants and children
Primary Care	Basic medical care (Family medicine)
Dental Care	Preventive and restorative dental services, including a homeless focus downtown
Family Planning	Birth control and counseling, sexually transmitted infection services, breast and cervical cancer screening

The **four Partnership Programs** also offer some direct services to clients, while primarily managing significant contracts with other public and private agencies. The programs include:

- Access & Outreach (lead entity in King County for enrollment in health insurance and ORCA LIFT)
- Community Health Partnerships (manage City of Seattle and County funds to support health safety net organizations that address health disparities and improve health outcomes)
- Health Care for the Homeless Network (includes two Mobile Medical Vans and contracts with nine agencies that provide health care services to people experiencing homelessness.)
- School-Based Health Partnerships (oversee a network of more than 35 health clinics and services located at schools, funded primarily by City of Seattle and Best Starts for Kids levies).

Examples of Service Coordination and Integration

As a provider and a manager of partnerships within the health care safety net, CHS prioritizes coordination and integration of services for clients and patients. Consistent with health systems transformation, the integration of direct services, particularly primary care and behavioral health, is made manifest through a variety of approaches and investments. Additionally, programs and staff implement services and strategies that assist community members in accessing public and private benefits and programs that address a range of determinants of health. Examples of this work includes:

- **The colocation and integration of Public Health services** with other safety net partners to deliver “one-stop” access to health care services (primary care, dental, parent-child health, behavioral health). DCHS funded behavioral health providers such as Valley Cities counseling are often part of the service mix. These partnerships include: Meridian Center for Health, HealthPoint Midway, Federal Way Public Health Center, and Columbia City Center for Health.
- **The Access & Outreach Team** not only delivers efficient and convenient access to health insurances and ORCA LIFT, but also other publicly sponsored benefits such as Basic Food and utility assistance. Within the broad network of navigator partners overseen by Access & Outreach, enrollment opportunities are available at colleges and universities, DSHS Community Service Offices, private social service agencies, and Public Health Centers.

More details on ORCA LIFT: Metro’s ORCA LIFT offers a \$1.50 bus fare on Metro, Kitsap Transit, Sound Transit, and Seattle Streetcar at about half of the cost of a regular fare for people whose income is below 200% of the Federal poverty level. Since the inception of ORCA LIFT, Public Health and Metro Transit have worked together to conduct outreach and enroll eligible residents in the program. At Public Health facilities throughout King County, ORCA LIFT materials are displayed prominently and Public Health staff inform customers about the ORCA LIFT program, verify eligibility for the LIFT card quickly and easily using information collected to establish eligibility for other programs, and provide customers with activated ORCA LIFT cards and information on loading value. Public Health and Metro staff also work on outreach and program enrollment throughout King County including having remote enrollment events with Metro’s ORCA-To-Go—the mobile customer service unit.

- **The Health Care for the Homeless Network** delivers integrated care opportunities through a broad array of partnerships, creating access to both behavioral and physical health in locations that meet people experiencing homelessness where they are at. The Network both funds and develops behavioral health services in close coordination with DCHS. Additionally, the Network works closely with DCHS and Coordinated Entry for All (CEA), providing entry into the housing system for Network patients. For example, the Mobile Medical Vans include providers from community health centers and behavioral health agencies, and housing specialists.
- In the context of an opioid crisis, CHS is **expanding the delivery of medication assisted treatment** in partnership with DCHS. Recent federal awards are facilitating more community access to critical medications such as buprenorphine and naloxone. Our partnership with Navos Behavioral Health and Wellness to operate and integrated primary care clinic on their campus facilitates access to both MAT and behavioral health services. The proposed 2019-20 budget

includes expansion of the Buprenorphine Pathways program at the Downtown Public Health Center that offers low barrier access to MAT for clients of the co-located Needle Exchange. In addition, the expansion of the Buprenorphine Pathways program will serve as the linkage for discharged jail inmates receiving MAT services.

- **Investments in the Best Starts for Kids initiative** are made in long-standing CHS programs (WIC, NFP, First Steps) and in new community based programs. Both front-line providers and managers of CHS and community partners assure the coordination of and referrals into respective services.

Barriers to Coordination and Integration of Services

The challenges to better coordination and integration of services are largely driven by issues related to technology and the restrictions placed on fund sources – particularly federal dollars.

- **Technology:** In large part, health and human service records are now electronic. Unfortunately, there continues to be limitations in how these systems are able to “talk to one another”. This can lead to duplication of services and gaps in knowledge about the types and levels of care a community member may be receiving. The experience of a resident receiving services may be that they are tasked with redundant registration and assessment processes with multiple agencies and/or limited coordination between the providers participating in their support. These challenges are exacerbated by federal regulations that restrict information sharing between providers and agencies that are often uniquely defined by sector – e.g., physical health, behavioral health, housing, education.
- **Fund Sources:** Oftentimes, funding is categorical or inflexible as well as restricted to the types of expenses it can be applied. The services, staff and work that enables coordination and integration is often not reimbursable. For example, if funding is tied to direct clinical services, the limitations of extended care management that addresses the social conditions impacting a resident’s health may be more difficult to support and fund.

Opportunities to Improve Coordination and Integration of Services

- **Work with our Regional Accountable Community of Health:** HealthierHere’s implementation of Washington State’s 1115 Medicaid Demonstration Waiver presents opportunities to address technology and funding barriers. Investment in health information technology and health information exchange is a funded domain within the waiver. HealthierHere aspires to support the development of shared platforms across a variety of service providers in both health and human services can support better coordination and integration. Additionally, by definition the waiver fosters flexibility in that which Medicaid pays for through the move from volume-based to value-based payment. More flexible, outcome-based reimbursement models, and incentives to integrate physical and behavioral health are key opportunities which we will seek to leverage.
- **Legislative Analysis:** King County leadership has supported changes to federal policies that limit information sharing for care providers and is outdated in the context of advancing technology. An example of these advocacy efforts is to address the limitations of 42 CFR Part 2, a federal law governing confidentiality for people seeking treatment for substance use disorders from federally assisted programs.

- **Maintain/Increase Flexible Funding:** Categorical funding for services lack the adaptability to cover the expenses that promote and sustain integration and coordination. Whether these investments are in infrastructure (technology, co-location) or in programming and/or staff that bridge services and agencies, flexible funds are often the best resource to enhance seamless care for residents.

Department of Community and Human Services Framework and Approach to Integration

Overview of DCHS Framework for Integration and Systemic Challenges

System problems call for system solutions: We begin with the premise that homelessness, poverty, racism and inequitable access to opportunity are the results of systems that distribute benefits and burdens in ways that favor some people and make others more susceptible to health, housing, financial, and social instability. Individual programs are necessary to counteract these systems, but individual programs are insufficient. To make progress, King County must integrate its programs into systems that are up to the challenge of counteracting poverty, homelessness and inequitable access to opportunity.

Systems also yield better customer service: Integration is not just a way to build more effective systems. Integration of services can create more respectful customer experiences for residents seeking services from King County providers or contracted providers.

Examples of Where DCHS is Building Integrated Systems Along Multiple Axes

Integrating Systems of Programs: DCHS recognizes that individual programs cannot address the complex systems that address poverty. King County has the scale, scope and system role, however, to design the ways that individual programs combine and sequence to provide integrated services to residents.

- **Example: King County Veterans Program**

KCVP operates two walk-in service offices at which low-income veterans and their families may seek financial assistance provided by the County Veterans Assistance Fund. These are funded by Veterans Assistance Funds and the VSHSL, expenditures for which are both proposed in the Executive's 2019-20 budget. One of the central features of the VSHSL Implementation Plan is that it creates a system of integrated services for veterans and their families, and that system is centered around KCVP as a centralized access point. The purpose is to create a suite of veteran-centric services that are available for a veteran when they enter KCVP instead of merely offering referrals. This is already starting to happen: Both KCVP offices now have co-located staff from the Washington Department of Veterans Affairs, the Federal VA does its VASH Voucher orientation at KCVP Tukwila, and as of September 2018 both offices now have on-site access to contracted, VSHSL Transition Plan-funded VA benefits application service officers, legal aid attorneys for benefits appeals and eviction defense. Both locations also now have onsite employ services for veterans. The Implementation Plan's 2019 funding allows the further expansion of onsite services, including veterans outreach teams, veterans mental health care, and veterans community building activities.

The result: A veteran or their family member may be able to receive employment assistance, financial assistance, legal assistance, behavioral health services, housing stability services, and connections to Federal and State resources, all from visiting a King County Veterans Program Office.

- **Example: Regional Access Points**

County-funded contractors operate Regional Access Points (RAPs) at which persons experiencing homelessness may be assessed for enrollment in Homeless Management Information System (HMIS) and for possible housing referral through Coordinated Entry for All (CEA). Recognizing the opportunity to integrate services, County-funded homeless employment services are also provided on site at two Regional Access Points, and the entities selected to operate the RAPs are in several cases colocated with access to integrated behavioral health care.

The result: A person can arrive at a RAP, be screened for homelessness prevention services, be enrolled into HMIS, seek employment services, and have access to other services provided by contracted RAP provider, which may include Behavioral Health or Integrated Health Services.

- **Example: Integrated Managed Care**

The premise of King County's first-in-the-State and Nation effort to fully integrate managed care and then further combine each managed care organization into a larger system in which County resources such as those funded by MIDD is another example of integration. Under this approach, a Medicaid-eligible person (or a non-Medicaid-eligible person with low-income) enters the same system to seek care, and federally (via state) supported healthcare can be combined with locally funded initiatives so that movement between providers—as is often necessary when a person experiences housing instability—does not mean exiting and entering entirely new systems of care.

The result: a Medicaid-eligible person seeking care will not only have their integrated behavioral health care coordinated in one place, but persons shifting providers as their housing stability changes will be able to remain in a unified system that is further enhanced through connection to other County-connected services such as access to housing and other services that are being connected to housing.

- **Example: Human Services Ticket Program**

This program is an example where DCHS and Metro Transit coordinate on a ticket program serving individuals experiencing poverty. DCHS determines the eligibility of and directs Metro ticket allocations to human service agencies serving low income and homeless populations. In 2017, 157 agencies participated in this program. After receiving authorization from DCHS, human service agencies purchase their allocation of tickets from King County Metro Transit by paying 10 percent of the ticket fare value. King County Metro subsidizes the other 90% of the fare value of tickets as foregone revenue when they accept the Human Services tickets as fare payment. In 2017, 1.77 M tickets with a fare value of \$4.1 M were provided through this program. This represented a King County Metro Transit subsidy of \$3.68M, which was 83 percent of the total available in 2017, and resulted in a total costs to social service agencies of \$410 K.

Consolidated (Integrated) Reporting: In addition to integrating how services are provided, DCHS is implementing County guidance to integrate how we measure performance of programs and systems. The 2019-20 budget includes funding for a client-level data reporting system that will move King County towards consolidated reporting for human services and which will allow the County to gauge how recipients of services are in fact using programs in combination. DCHS is moving quickly towards consolidated reporting while also incorporating concerns in some program areas where tailored approaches may be necessary. These sensitive service areas include services for survivors of sexual assault and domestic violence and some services for immigrants and refugees.

Integrating Providers into a Community Network: Human services providers often provide feedback that competitive contracting processes split community based providers into competitive camps rather than sustaining the community-based networks that can better sustain persons experiencing poverty. King County is supporting processes that build community capacity through use of increased and sustained community engagement, a focus on supporting diverse community-based organizations, and then deployment of technical assistance and capacity building funds that can help smaller, culturally specialized, or geographically isolated organizations to join the network and community of providers rather than being kept separated from it. Specific inclusion of these approaches is proposed within the BSK and VSHSL Technical Assistance and Capacity Building funds.

Data Integration Initiatives and Considerations

Examples of Current Data Integration Initiatives

- **Integrated Care Data Hub:** DCHS and Public Health are coordinating on a data integration hub project being supported by KCIT as well as use of these data for point of care/service purposes. These projects have gone through the extensive KCIT project review process with PSB and the council. Additional information on these KCIT projects is available if needed. A policy brief is [available here](#).
- **Data Across Sectors for Housing and Health (DASHH) project:** Although housing is an essential component of the social determinants of health, the relationship between subsidized housing and health is only minimally understood. This limited understanding of how health and housing are linked has been fueled in part by data siloes that limit comprehensive insights into whole-person health. In an effort to overcome such limitations and to provide a stronger foundation for a growing regional (and national) focus on health and housing intersections, in 2016, the King County Housing Authority (KCHA), Seattle Housing Authority (SHA), and Public Health – Seattle and King County (PHSKC) joined to form the Data Across Sectors for Health and Housing partnership, focused on creating a unique and sustainable dataset containing linked health and housing administrative data. Key goals for DASHH were to use linked data to inform and measure future interventions, including policy, outreach, and programming to improve the health of King County residents, as well as to share this actionable data with key health and housing stakeholders. The final report is [available here](#).
- **Use of integrated health and human services data to support Medicaid transformation projects of HealthierHere (King County's Accountable Community of Health):** King County is currently using linked Medicaid and Behavioral Health Organization data to help guide HealthierHere to focus its

Medicaid transformation projects on those Medicaid members with the greatest room for improvement across a variety of clinical measures. Please feel free to review or reference a current example of population-level analytic work conducted on behalf of the ACH [available here](#). This publically available data product uses linked information from Medicaid and BHO data.

Current Barriers to Data Integration

- **Legal Restrictions:** Confidentiality requirements and other legal restrictions often prevent the sharing of client information between agencies. An example is the opt-in requirement of 42 CFR Part 2 which governs sharing of chemical dependency treatment data.
- **Inconsistent Regulations Across Data Types:** Governing legislation for different data sources is often different, complicating the ability for agencies to set up data sharing agreements.
- **Organizational, Cultural, and Bureaucratic Barriers.** These barriers often manifest as a data steward, such as a state agency from whom a data linkage is requested, not understanding why a county government would want to use their data. Or if understood, the use case being a very low priority to the data steward. In other words, agencies often do not see the value of data sharing and are reluctant to share data if they are not required to do so.

Opportunities to Improve Data Integration

- Greater advocacy and messaging for how data sharing and integration can be used to protect and promote community health, equity and social justice.
- Standardization of how individual consent for sharing client-level information is obtained across sectors (e.g. behavioral health, education, school, housing, etc.).
- Standardization in how social determinants of health data is collected by and shared across service providers.
- Improved connection of local integrated data systems with state-coordinated systems, including the state's Health Information Exchange (including the Clinical Data Repository).