MIDD Briefing Paper

BP 33 Coordinated Care for High Risk Older Adults and Adults with Disabilities

Existing MIDD Program/Strategy Review ☐ MIDD I Strategy Number _____ (Attach MIDD I pages)
New Concept X (Attach New Concept Form)
Type of category: New Concept

SUMMARY: This concept proposing a team based model, composed of registered nurses (RNs) and social workers (MSWs), to coordinate care across systems for older adults (age 60+) and people with disabilities who reside in King County. Building on the success demonstrated by the King County Care Partners (KCCP) pilot program, this model would provide a community-based, multidisciplinary team to facilitate communication and coordination between systems and utilize evidenced based approaches to support older and disabled adults with behavioral health issues in making positive and sustainable choices for their health and well-being[1].

Collaborators:

Name	**Department**
Maureen Linehan	Seattle Human Services Dept., Aging and Disability Services Division

Subject Matter Experts and/or Stakeholders consulted for Briefing Paper preparation. List below.

Name	Role	Organization
Maria Langlais	Strategic Advisor	Seattle Human Services Dept., Aging and Disability Services Division
Andrea Yip	Strategic Planning Manager	Seattle Human Services Dept., Aging and Disability Services Division

The following questions are intended to develop and build on information provided in the New Concept Form or gather information about existing MIDD strategies/programs.

A. Description

1. **Please describe the New Concept or Existing MIDD Strategy/Program: Please be concise, clear, and specific. What is being provided to whom, under what circumstances? What are the New Concept Existing MIDD Strategy/Program goals? For New Concepts, does it relate to an existing MIDD strategy? If so, how?**

This concept proposing a team based model, composed of registered nurses (RNs) and social workers (MSWs), to coordinate care across systems for older adults (age 60+) and people with disabilities who reside in King County. Building on the success demonstrated by the King County Care Partners (KCCP) pilot program, this model would provide a community-based, multidisciplinary team to facilitate communication and coordination between systems and utilize evidenced based approaches to support

[1] http://www.agingkingcounty.org/KCCP_WhatWeDo.htm.

older and disabled adults with behavioral health issues in making positive and sustainable choices for their health and well-being[2].

Individuals will be identified for care coordination by the County Area Agency on Aging (AAA) through a predictive model tool (PRISM) based on Medicaid claims data. In addition, individuals may be identified by community organizations partnered with the AAA such as senior centers, Evergreen Health Geriatric Regional Assessment Team, community health clinics, and housing social workers. Services will be provided based on an individualized, comprehensive assessment of medical and behavioral health history and on behavioral and social barrier screens, and will focus on the following areas: development of self-care goals; coaching in health self-management; connecting with community resources; coordinating care across medical and behavioral health systems, which includes accompanying the individual to clinic appointments. The care coordinator will provide frequent monitoring of the individual for up to 12 months or until the individual has demonstrated sustainable progress on self-care goals and development of self-management skills. Once this is achieved the care coordinator will transition the individual to either a primary care coordinator or behavioral health care manager, whoever is the most appropriate to provide ongoing outreach and general support.

The program goals include improved health outcomes for a vulnerable and growing population, crisis prevention, and reduced system cost.

2. **Please identify which of the MIDD II Framework's four Strategy Areas best fits this New Concept/Existing MIDD Strategy/Program area** (Select all that apply):

   ☒ **Crisis Diversion** ☒ **Prevention and Early Intervention**

   ☐ **Recovery and Re-entry** ☒ **System Improvements**

   Please describe the basis for the determination(s).

The foremost strategy area of this concept is system improvement. This care management model provides a coordinator of services for an older or disabled adult identified as a high-cost Medicaid beneficiary due to complex social and health issues. The coordinator's main roll will be to organize and manage all of the varied systems the individual is involved with in order to optimize the overall health of the individual. The secondary strategy areas are prevention and early intervention and crisis diversion as this model is designed to prevent the need for urgent care and divert individuals away from crisis services by creating a base of care the individual can rely on when in need.

B. Need; Emerging, Promising, Best, or Evidence Based Practices; Outcomes

1. **Please describe the Community Need, Problem, or Opportunity that the New Concept/Existing MIDD Strategy/Program addresses: What unmet mental health/substance use related need for what group or what system/service enhancement will be addressed by this New Concept/Existing MIDD Strategy/Program? What service gap/unmet need will be created for whom if this New Concept Existing MIDD Strategy/Program is *not* implemented? Provide specific examples and supporting data if available.**

Older adults and people with disabilities with multiple complex medical and behavioral health issues are failing in a number of systems. This failure stems from the inability of these individuals to successfully

[2] http://www.agingkingcounty.org/KCCP_WhatWeDo.htm.

navigate needed support systems, including housing, behavioral and physical health and long term care, because these systems are not equipped to address the needs of this population in an integrated and effective way. This failure has significant costs to social and health systems – five percent of Medicaid individuals use 50 percent of resources[3].

The number of older adults in the United States is expected to increase dramatically from 40.3 million in 2010 to 72.1 million in 2030.[4] According to the King County Regional Support Network 2015 Second Quarter Mental Health Plan Report Card, the number of older adults and people with intellectual, neurological, and physical disabilities who have accessed behavioral health treatment has steadily increased since 2012[5]. Between 14 to 20 percent of older adults have one or more mental health and substance use conditions. Depressive disorders are one of the most prevalent diagnoses and substance use is also a significant problem.[6] A recent article in the U.S. News stated that there was a 78 percent increase of older adults in emergency departments due to misuse of prescription and illicit drugs and a fivefold increase in hospital admissions due to opioid overdose[7]. Opioids are often prescribed for legitimate reasons such as chronic pain and post-medical procedures, but because seniors are often prescribed many medications and many suffer from cognitive deficits, it can be challenging to avoid harmful interactions and accidental overdosing.

Healthy People 2020 states that substance use among people with disabilities is an emerging trend and they are most likely to experience difficulties or delays in getting the health care they need[8]. The King County Community Health Indicators show that nearly one quarter of the population are disabled with numbers being slightly higher in South Seattle[9].

Adult disability (%)
King County 24% (23%-25%)
East 20% (19%-22%)
North 21% (18-24%)
Seattle 24% (22%-26%)
South 26% (24%-28%)

[3] Report to Congressional Requesters. (May 2015). United States Government Accountability Office. http://www.gao.gov/assets/680/670112.pdf
[4] Institute of Medicine. (2012). *The Mental Health and Substance Use Workforce for Older Adults: In Whose Hands?* 2012. Washington, DC: The National Academies Press.
[5] King County Regional Support Network 2015 Second Quarter Mental Health Plan Report Card. Pages 1 and 3. November 2015. http://www.kingcounty.gov/~/media/health/mentalHealth/reportsAndPlans/151202_2015_Q2_Mental_Health_Report_Card.ashx?la=en.
[6] Institute of Medicine. (2012). *The Mental Health and Substance Use Workforce for Older Adults: In Whose Hands?* 2012. Washington, DC: The National Academies Press.
[7] Lisa Esposito. U.S. News & World Report, Health. Silent Epidemic: Seniors and Addiction. December 2015. http://health.usnews.com/health-news/individual-advice/articles/2015/12/02/silent-epidemic-seniors-and-addiction
[8] Healthy People 2020. December 2015. https://www.healthypeople.gov/2020/topics-objectives/topic/disability-and-health
[9] King County Community Health Indicators. http://www.kingcounty.gov/healthservices/health/data/indicators.aspx.

The current system is not designed to help those with special needs. Barriers include lack of understanding by both individuals and providers about available resources and eligibility requirements, the need to follow-up with phone calls and paperwork, limited transportation to get to appointments, and long waitlists. A person dealing with anxiety and depression may not have the capacity to initiate and follow through on all the steps required for an initial appointment, let alone on-going care. These barriers are particularly challenging for a person with an intellectual, developmental, or physical disability, or an older adult. These groups require hands on, intensive support to navigate their way through the system and reach their full potential.

If this concept is not implemented, those with more severe and complex needs may not access the mental health and chemical dependency services they need to recover. As a result, these conditions will remain undiagnosed and untreated, resulting in increased morbidity and poorer health outcomes in these populations and increased cost to the health care system. As the percentage of older adults in the US population continues to grow over the next 15 years, this gap will only widen.

2. Please describe how the New Concept/Existing MIDD Strategy/Program Addresses the Need outlined above.

Care Coordination presents a tremendous opportunity to improve access across systems – both access to care for individuals, and access to needed information for their care providers. This model for care coordination was developed in 2009 and was one of a series of pilot projects sponsored by the Center for Health Care Strategies (CHCS) to seek out innovative and cost-effective strategies while improving health care access and quality. CHCS identified the complex and disjointed system many of the high need population face as the primary issue to address in the pilot. Per their 2012 spotlight report on KCCP, "The typical KCCP individual had a primary care physician, one or more physician specialists, a mental health provider, entitlement program caseworkers, and perhaps a nutritionist, a diabetic educator, and a social worker. That complexity can be very confusing, especially for individuals with limited education, cognitive or psychosocial impairments, and language barriers[10]". This model has demonstrated that a care coordination team can maximize "windows of opportunity" – getting individuals the right services/care at the right time – in three ways:

1) Facilitating access to systems and services when individuals are ready to receive them. By facilitating intake and providing key linkages across systems (connecting individuals to services and care), the care coordination team, comprised of RNs and MSWs, enhances the capacity of currently over-taxed systems (e.g., high caseloads, crisis intervention services; emergency rooms, and hospital discharge);
2) Communicating with providers across systems to implement an integrated care plan. Care coordinators provide important linkages for care providers, ensuring they have the right information at the right time to develop a care plan that is appropriate for the individual's needs.
3) Working directly with individuals to develop goals and action plans and effect sustainable change using evidenced based approaches (e.g., motivational interviewing (MI), care transitions, and trauma-informed practice). Care Coordinators meet with individuals in their home or in other community settings, including hospitals prior to discharge, to identify immediate needs and connect to resources to improve their health and well-being. They engage individuals by building trusted relationships and support individual self-efficacy by

[10] Center for Health Care Strategies, Inc. Improving Medicaid High-Risk Care Management Overview: King County Care Partners. November 2012.

providing tools, coaching, information and linkages to empower individuals to meet their own health and wellness goals.

3. **What EVIDENCE exists that the approach of this New Concept/Existing MIDD Strategy/Program will successfully address the identified need? Please cite published research, reports, population feedback, etc. Why would this New Concept/Existing MIDD Strategy/Program be expected to work? If this is an existing MIDD I strategy, please provide evidence of the results from existing MIDD evaluation reports, including who has/has not benefited from this strategy.**

A study funded by CHCS on the KCCP pilot program found that multidisciplinary care management of high-cost Medicaid beneficiaries resulted in reduced individual psychiatric costs, reduced criminal justice involvement, and improved access to drug and alcohol treatment[11]. This model also "shows promise of reducing costs and improving quality and outcomes for high-cost Medicaid individuals, particularly those with alcohol and chemical dependency problems"[12]. Another study of older adults still living in the community found that integrated care management was a cost-effective approach to reduce admissions to hospitals and individual functional decline[13].

4. **Please specify whether this New Concept/Existing MIDD Strategy/Program is a/an: Promising Practice Please detail the basis for this determination. Please include a citation or reference supporting the selection of practice type.**

Care coordination has been identified as a key quality improvement strategy for health systems. Its effectiveness, however, depends on proper matching between the health issue and the care coordination intervention used[14]. As stated previously in a CHCS study on the KCCP pilot program implemented by Aging and Disability Services (ADS), a division of the City of Seattle's Human Services Department, this model shows promise of reducing health care costs and improving outcomes for complex individuals.

Because this model showed promising practice, the State of Washington in 2013 implemented a similar program called Health Home as a strategy to address high cost, high risk Medicaid and Medicare eligible clients. (http://www.hca.wa.gov/medicaid/health_homes/Pages/index.aspx) The model is not available in King or Snohomish counties.

5. **What OUTCOMES would the County see as a result of investment in this New Concept/Existing MIDD Strategy/Program? Please be as specific as possible. What indicators and data sources could the County use to measure outcomes?**

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[11] Janice F. Bell PhD MPH, David Mancuso PhD , Toni Krupski PhD, Jutta M. Joesch PhD, David C. Atkins PhD, Beverly Court, MHA PhD, Imara I. West MPH, Peter P. Roy-Byrne MD. Care Management for Medicaid Clients with High Health Care Costs: Evaluation of One-Year Health and Social Outcomes. http://www.agingkingcounty.org/docs/KCCP_Abstract_Bell3-15-11.pdf.

[12] Harris Meyer. Improving Medicaid High-Risk Care Management Overview: King County Care Partners. Center for Healthcare Strategies, Inc. November, 2012.

[13] Roberto Bernabei, Francesco Landi, Giovanni Gambassi, Antonio Sgadari, Giuseppe Zuccala, Vincent Mor, Laurence Z Rubenstein, PierUgo Carbonin. Randomised trial of impact of model of integrated care and case management for older people living in the community. BMJ 1998;316:1348

[14] Agency for Healthcare Research and Quality. Care Coordination, Quality Improvement. http://www.ahrq.gov/research/findings/evidence-based-reports/caregaptp.html.

The KCCP program had both a qualitative and quantitative evaluation. Both evaluations showed that people are connected to services that meet their needs and keep them out of crisis. Measurable outcomes include[15]:

- Lower psychiatric inpatient costs.
- Fewer total arrests and charges.
- Higher odds of receiving individual alcohol/drug treatment.
- Reduction in homelessness.
- Good, trusting relationships with an RN or MSW.
- Reduced 30-day hospital readmission rates.
- Personal empowerment and goal achievement.

For the evaluations, data was used from the Department of Social and Health Services Research and Data Analysis Client Outcomes Database. Qualitative data was collected through individual surveys.

If funded, individual demographic and clinical data would be collected from the following: pre/post evidence-based assessment tools such as the Quality of Life screen, Patient Health Questionnaire-9 for depression, Overall Anxiety Severity and Impairment Scale for anxiety, Alcohol Use Disorders Identification Test-C for alcohol and substance abuse, and individual care plan outcomes. During the KCCP pilot the KCCP Integrated Tracking System (KITS) was used. KITS was built upon the Medical & Mental Health Integrated Tracking System (MHITS) using the CARE Management Tracking System developed by the University of Washington AIMS Center[16]. If implemented, KITS will be again be used to track and evaluate data.

C. Populations, Geography, and Collaborations & Partnerships

1. **What Populations might directly benefit from this New Concept/Existing MIDD Strategy/Program:** (Select all that apply):

☐ **All children/youth 18 or under**	☐ **Racial-Ethnic minority (any)**
☐ **Children 0-5**	☐ **Black/African-American**
☐ **Children 6-12**	☐ **Hispanic/Latino**
☐ **Teens 13-18**	☐ **Asian/Pacific Islander**
☐ **Transition age youth 18-25**	☐ **First Nations/American Indian/Native American**
☐ **Adults**	☐ **Immigrant/Refugee**
☒ **Older Adults**	☐ **Veteran/US Military**
☐ **Families**	☐ **Homeless**
☐ **Anyone**	☐ **GLBT**
☐ **Offenders/Ex-offenders/Justice-involved**	☐ **Women**
☒ **Other – Please Specify: adults with disabilities**	

Please include details about this population such as: individuals transitioning from psychiatric hospital to community; individuals judged incompetent by the court; children of drug users who are in foster care, etc.

[15] http://www.kccarepartners.org/files/2012/03/RTC_Evaluation_TECHNICAL_REPORT_FINAL-3_15_12a.pdf
[16] http://aims.uw.edu/resource-library/care-management-tracking-system-cmts

Vulnerable adults – older adults and adults with disabilities who have a mental health or SUD diagnosis or at risk of a diagnosis, and are failing or at risk of failing in multiple systems (housing, behavioral health, healthcare, long term care).

2. **Location is an important factor in the availability and delivery of services. Please identify whether this New Concept/Existing MIDD Strategy/Program addresses a specific geographic need in the following area. Please provide additional that discusses the basis for the selection**: County-wide

Care coordination services would be available to all King County residents' ages 60+ or adults 18+ living with a disability and a mental health or SUD diagnosis or are at risk for MH or SUD.

3. **What types of COLLABORATIONS and/or PARTNERSHIPS may be necessary to implement this New Concept/Existing MIDD Strategy/Program, and with whom (other jurisdictions & cities, law enforcement, first responders, treatment providers, departments within King County, housing, employers, etc.)? Please be specific.**

Cross system collaboration includes, but is not limited to: aging network providers; mental health and substance abuse organizations; and health care providers, including hospitals and clinics. ADS has actively built relationships with many of these potential partners already through other program work such as Care Transitions, PEARLS, and King County Care Partners. More recently, ADS has also been collaborating with both first responders and the criminal justice system to identify vulnerable adults who are at risk of abuse or neglect and affect a coordinated response.

D. Drivers, Barriers, Unintended Consequences, and Alternative Approaches

1. **What FACTORS/DRIVERS, such as health care reform, changes in legislation, etc. might impact the need for or feasibility of this New Concept/Existing MIDD Strategy/Program? How?**

Almost 18 percent of the King County population is 60 years of age or older and two of ten people have a disability. The fastest growing segment of the population is the 85 and older age group. There was a 42 percent increase in the older adult population in King County between the years 2000 - 2013 and increased life expectancies will only strengthen this demonstrated wave of aging boomers[17]. Between 14 to 20 percent of older adults have one or more mental health and substance use conditions and according to the King County Regional Support Network 2015 Second Quarter Mental Health Plan Report Card, the number of older adults and people with intellectual, neurological, and physical disabilities who have accessed behavioral health treatment has steadily increased since 2012[18,19].

[17] Aging in King County. Profile of the Older Population.
[18] King County Regional Support Network 2015 Second Quarter Mental Health Plan Report Card. Pages 1 and 3. November 2015. http://www.kingcounty.gov/~/media/health/mentalHealth/reportsAndPlans/151202_2015_Q2_Mental_Health_Report_Card.ashx?la=en.
[19] Institute of Medicine. (2012). *The Mental Health and Substance Use Workforce for Older Adults: In Whose Hands?* 2012. Washington, DC: The National Academies Press.

Health and Human services transformation in King County charts a course for achieving the triple aim of better health, better care, and lower costs. KCCP is a strategy that aligns well with the individual/family level of the transformation and the need to improve access to person-centered, integrated, culturally competent services.

2. **What potential BARRIERS, if any, might there be to implementation? How might these be overcome? Who would need to be involved in overcoming them?**

The biggest barrier to implementation is expected to be individual engagement. The KCCP pilot program was successful in engaging 45 percent of the total target group. The coordination team underwent motivational interviewing (MI) training, which improved individual activation and engagement. Requiring the coordination caregivers to receive training in MI would be essential in overcoming this barrier[20]. A recognized barrier for engagement is transportation to and from appointments. Though team members would provide services to individuals in their own community, in order to create a sustainable and effective health plan, the individual will need access to reliable transportation which is not available to many of them. It may require additional funding for special needs transportation to overcome this barrier and/or more health programs that offer services in individuals' homes.

3. **What potential UNINTENDED CONSEQUENCES might exist if this New Concept/Existing MIDD Strategy/Program is implemented? Please be specific---for whom might there be consequences?**

In the KCCP pilot, ADS experienced some pushback from providers in primary care clinics, housing, and behavioral health systems. There was some confusion on roles and perception that KCCP was duplicative. KCCP was able to show providers how their patients' care was not being coordinated in an effective way, and once the care coordinators were able to show results, for example, individuals getting long awaited chemical dependency treatment or reducing their emergency room visits, the pushback dissolved into collaboration. Now that integration and collaborative individual care is much more accepted, this degree of pushback is not expected.

4. **What potential UNINTENDED CONSEQUENCES might there be if this New Concept/Existing MIDD Strategy/Program is *not* implemented? Please be specific---for whom might there be consequences?**

If this concept is not implemented, the system will remain status quo for these individuals. Individual behavioral health needs will continue to be unmet or inadequately addressed, while overall system costs increase. In addition, the project may miss the opportunity to inform and influence health and human services system transformation efforts, locally and statewide. The institutional knowledge and infrastructure needed to implement this program are in place now; there is a limited window to leverage these resources.

5. **What ALTERNATIVE APPROACHES currently exist to address this need apart from this New Concept/Existing MIDD Strategy/Program? At a high level, how does this New Concept/Existing MIDD Strategy/Program compare to those other approaches in terms of**

[20] Harris Meyer. Improving Medicaid High-Risk Care Management Overview: King County Care Partners. Center for Healthcare Strategies, Inc. November, 2012.

cost, feasibility, etc. Could this New Concept/Existing MIDD Strategy/Program be merged with one or more of the alternatives? What are the pros/cons of merging?

Other parts of the state have implemented a Health Home model for dually eligibly (Medicare and Medicaid) individuals who have been identified as high utilizers. The Health Home model is similar to the care coordination approach outlined here, but with some key differences; primarily, Health Homes focus on long term care needs rather than behavioral health. Also, data shows engagement rates are much lower than the proposed KCCP model[21]. Managed care organizations have also attempted to provide this type of comprehensive approach, however, their models have limitations as well: they generally employ a phone-based model, which limits both their ability to identify and respond to complex individual needs and the scope of intervention. For example, workers do not accompany individuals to appointments and they have limited access to external systems.

Existing MIDD strategies for older adults such as the Geriatric Regional Assessment Team (GRAT) and Asian Counseling and Referral Service's (ACRS) Wellness and Wisdom program are important intervention models and should be linked to this new strategy, not merged. GRAT provides brief intervention and ACRS provides behavioral health services while KCCP would provide the linkage to ongoing holistic services and care coordination between these and any other systems the individual is involved in.

E. Countywide Policies and Priorities

1. **How does this New Concept/Existing MIDD Strategy/Program FIT within the CONTINUUM of care, and within other county initiatives such as Behavioral Health Integration, Health and Human Services Transformation, Best Starts for Kids, All Home, the Youth Action Plan, and/or the Vets and Human Services Levy or any other County policy work?**

The basic premise of care coordination is following the person as they navigate through their continuum of care. Care managers work with the individual, their family and social systems, and their health providers to develop plans that optimize the individual's overall health status and quality of life. This integrated network works together to identify the individual's needs and coordinate care, including mental health and chemical dependency treatment, making it a fit with Behavioral Health Integration. This model also fits perfectly with the Health and Human Services Transformation initiative in that it diverts the use of crisis-oriented services to focus on prevention and eliminates disparities by providing the unique care that is necessary for these two populations to thrive in their communities. King County could utilize the KCCP model not only for the high risk older adult population, but also the identified need of a community care management team for the Familiar Faces Initiative.

2. **How is this New Concept/Existing MIDD Strategy/Program rooted in principles of recovery, resiliency, and/or trauma-informed care?**

The fundamental component of recovery and resiliency is collaboration, which is the bedrock of this proposal. Care coordination helps people thrive by providing high quality services that focus on holistic care that improves the individual's overall quality of life, which makes it rooted in the principles of

[21]Health Home Program Dashboard Report. November 2015. http://www.hca.wa.gov/medicaid/health_homes/documents_reports/HH%20Dashboard%20November%202015.pdf

recovery and resiliency. MI, a key component of care coordination and trauma-informed practice, is built on the principles of engaging and empowering individuals in their own recovery.

3. **How does this New Concept/Existing MIDD Strategy/Program enact and further the County's EQUITY and SOCIAL JUSTICE work?**

This concept furthers the County's Equity and Social Justice work in that it provides intensive, hands on, necessary care management to two unique, growing populations in King County. A quarter of the County population has a disability and a fifth of the population is 55 years of age or older, and this number is expected to grow significantly over the coming years. Between 14 to 20 percent of older adults have one or more mental health and substance use conditions[22] and Healthy People 2020 states that substance use among people with disabilities is an emerging trend[23]. Almost 23 percent of older adults in King County are minorities and the majority of older adults in King County living in poverty are minorities[24]. People with disabilities are overwhelmingly over the age of 65, undereducated, unemployed/unable to work, identify as gay, lesbian, bisexual, or transgender, and are living on less than $15,000 a year[25]. Over 3,000 older adults and over 5,000 adults with disabilities used emergency shelters in 2014[26].

Older adults and people with disabilities have special needs that are unlike other populations that the system is set up for. These unmet special needs result in higher co-morbidity and mortality rates and unique challenges that limit their opportunity to reach their full potential and achieve personal growth and fulfillment.

F. Implementation Factors

1. **What types of RESOURCES will be needed to implement this New Concept/Existing MIDD Strategy/Program** (staff, physical space, training, UA kits, etc.)**?**

Staffing requirements are scalable. Full implementation is a team of 5.75 full-time employees (FTE), composed of two RNs, three Care Coordinators (MSWs), and one supervisor (.75 FTE), to provide care coordination for 1,000 individuals per year. A minimum of 1.5 FTEs would be required to launch a pilot program to serve 300 individuals a year, and partial implementation with three FTEs could serve 600 individuals per year.

Staff will be located in one of the two AAA offices in either Renton or Seattle, and ADS will provide cubicle space and administrative support in-kind. Other operations needs such as equipment, cell phone, and travel will be captured through an administrative rate of 15 percent.

[22] Institute of Medicine. (2012). *The Mental Health and Substance Use Workforce for Older Adults: In Whose Hands?* 2012. Washington, DC: The National Academies Press.
[23] Healthy People 2020. December 2015. https://www.healthypeople.gov/2020/topics-objectives/topic/disability-and-health
[24] Aging in King County. Profile of the Older Population.
[25] Communities Count. Social and Health Indicators Across King County. Disability/Activity Limitations: Summary and Data Highlights. 2012. http://www.communitiescount.org/index.php?page=daily-disability-limitations.
[26] Aging in King County. Profile of the Older Population.

As the program expands, ADS will hire new staff. In past pilots, ADS has been able to successfully recruit from internal candidates who have already received training in MI. For new hires, this training can be provided through online resources at nominal cost.

2. Estimated ANNUAL COST. $501,000-$1.5 million Provide unit or other specific costs if known.

A loaded staffing cost for full implementation with 5.75 FTEs is $888,894. The project can launch on a pilot scale for a cost of $267,055 for the first year.

	Year 1 Pilot	Year 2 Partial Implementation	Year 3 Full Implementation
# of Individuals per year	300	450	600
Care Coordinator	$130,000	$260,000	$305,144
RN	$76,286	$152,572	$390,000
Clinical Supervisor	$25,936	$51,872	$77,808
Total Staffing	$232,222	$464,444	$772,952
Admin (15%)	$34,833	$69,666	$115,942
Total Cost	$267,055	$534,110	$888,894

3. Are there revenue sources other than MIDD that could or currently fund this work? Clarify response, citing revenue sources.

ADS has explored other revenue sources for this work, including public and private funding and contracts with managed care organizations, but has not been able to identify a sustainable revenue source. Grant funding is a great resource for piloting innovative models, but it is difficult to secure ongoing support for programs. Seattle-King County Public Health applied for funding from the Centers for Medicare and Medicaid Services Health Care Innovation Challenge (CMMI) in 2012 to expand and enhance the KCCP program; the application was not successful because the program was not considered "new".

ADS recently concluded a two year contract with a local managed care organization to deliver care coordination services for their high-risk Medicaid participants. Unfortunately, the reimbursement rate was not sufficient to support required staffing given the limited volume of individuals who opted into the program. While other managed care providers have expressed interest, most have opted to develop in-house approaches. Over time, funding from managed care and other health care providers could be leveraged with other resources to more fully support and sustain the program model.

In the future, State healthcare reform efforts may present opportunities for funding coordinated care models. AAA's in other parts of the state have implemented Health Homes for dually eligibly individuals. The state will be looking at results from these Health Homes to determine whether the model should be supported and expanded, but it is not anticipated they will take any action, including expansion, before July 2017.

4. TIME to implementation: Less than 6 months from award

a. What are the factors in the time to implementation assessment?

Institutional knowledge and infrastructure to implement the concept are in place. ADS has trained and experienced staff who can launch the pilot phase, preferably with a three month lead time to reassign current workload and conduct a hiring process to backfill positions. This lead time is also sufficient to reestablish partner relationships from the KCCP pilot.

b. What are the steps needed for implementation?

Implementation will be an iterative process, starting with a small pilot with experienced staff and partner agencies. The steps include:

1) Hire new staff or backfill case manager/RN positions.
2) Reestablish relationships with health system partners. Identify and develop relationships with new partners. Market program with aging network providers.
3) Update process, protocols and related materials.
4) Reestablish Data systems through a contract with the University of Washington AIMS center.
5) Create steering committee for continuous quality improvement.

c. Does this need an RFP?

No. As the designated AAA and local administrator for Medicaid Case Management, ADS staff would deliver the care coordination services and work with other partners to develop Memorandums of Agreement regarding coordination.

G. Any OTHER INFORMATION that would assist reviewers with making recommendations about this New Concept/Existing MIDD Strategy/Program? (Optional). Do you have suggestions regarding this New Concept/Existing MIDD Strategy/Program?

New Concept Submission Form

Please review the preceding pages before completing this form.

Please be specific. Be sure to describe how the concept addresses mental health or substance abuse needs <u>in King County</u>. All programs funded by MIDD II must be implemented in King County.

#33.

Working Title of Concept: Coordinated Care for High Risk Older Adults and Adults with Disabilities

Name of Person Submitting Concept: Maureen Linehan
Organization(s), if any: Seattle Human Services Department, Aging & Disability Services Division
Phone: 206-684-0104
Email: Maureen.linehan@seattle.gov
Mailing Address: PO Box 34215, Seattle WA 98124-4215

Please note that county staff may contact the person shown on this form if additional information or clarification is needed.

Please share whatever you know, to the best of your ability.
*Concepts must be submitted via email to MIDDconcept@kingcounty.gov by **October 31, 2015**.*

1. Describe the concept.
Please be specific, and describe new or expanded mental health or substance abuse-related services specifically.

Older adults and people with disabilities with multiple complex medical and behavioral health issues are failing in a number systems. This failure stems from the inability of these individuals to successfully navigate needed support systems, including housing, healthcare, behavioral health and long term care, and because these systems are not equipped to address the needs of this population in an integrated and effective way.

This failure has significant costs to social and health systems -- 5% of Medicaid individuals use 50% of resources.

The Aging and Disability Services division at the City of Seattle, which serves as the County Area Agency on Aging (AAA), is proposing a team based model to coordinate care across systems for this high need vulnerable population. Building on the success demonstrated by King County Care Partners, this model will provide a community-based, multidisciplinary team to facilitate communication and coordination between systems, and utilize evidenced based approaches to support individuals in making positive and sustainable choices for their health and well being.

2. What community need, problem, or opportunity does your concept address?
Please be specific, and describe how the need relates to mental health or substance abuse.

Problems:
1) Behavioral health systems can be difficult to access for people in non-crisis situations.
2) As a result, vulnerable adults over-utilize higher cost systems, such as hospital and emergency response systems, to address short term needs, while their root cause behavior issues remain unaddressed.
3) For those with access to behavior health systems, lack of communication across systems limits the effectiveness of services/care, resulting in higher utilization and higher costs across all systems.

Gaining entrance to behavioral health systems is difficult for people who are not in a crisis situation. Barriers include lack of understanding about available resources and eligibility requirements, the need to follow-up with phone calls and paperwork, limited transportation to get to appointments, and long waitlists. A person dealing with anxiety and depression may not have the capacity to initiate and follow through on all the steps required for an initial appointment, let alone ongoing care.

Because of high caseloads and limited capacity, professionals in long term care, emergency response, and health care systems do not have time to assist individuals in navigating other systems and services. It is not uncommon for a individual who has indicated a desire to seek substance abuse or other behavioral health treatment to be given a list of resources which they must navigate on their own. This approach, while well meaning, is not helpful for individuals with functional limitations and behavioral health challenges; they become overwhelmed to the point of inaction, potentially closing the window of opportunity on their willingness to seek help.

Individuals who have successfully navigated access to multiple systems may not be making significant progress as each system is equipped to respond to their own assessment criteria (e.g., long term care case

workers focus is on meeting the individual's personal care needs). Providers who employ a multi-disciplinary framework still lack access to information necessary to inform a comprehensive assessment of individual needs and develop an effective service plan. Managed care organizations have attempted to provide a comprehensive approach, however, their model, which is primarily phone-based, has a limited ability to identify and respond to complex individual needs.

Opportunities:
There is a tremendous opportunity to improve access across systems, positively impacting quality of care and behavioral health outcomes, and reducing overall systems costs, while meeting the individual where they are.

3. How would your concept address the need?
Please be specific.

The care coordination team can help maximize "windows of opportunity" – the right services at the right time – by:
1) facilitating access to systems and services when individuals are ready to receive them.
2) communicating with providers across systems to implement an integrated care plan.
3) working directly with individuals to develop goals and action plans and effect sustainable change using evidenced based approaches (e.g., motivational interviewing, care transitions, and trauma-informed practice)

By facilitating intake and providing key linkages across systems, the care coordination team, comprised of RNs and counselors/social workers, will enhance the capacity of currently over-taxed systems (e.g., high caseloads, crisis intervention services; ER, and hospital discharge).

Care Coordination can improve access across systems, positively impacting quality of care and behavioral health outcomes, and reducing overall systems costs. Trusted providers work directly with individuals to help them access and use services, and to ensure their care needs are coordinated across systems. Care Coordinators meet with individuals in their home or in other community settings, including hospitals prior to discharge, to identify immediate needs and connect to resources to improve their health and well-being.

4. Who would benefit? Please describe potential program participants.

Vulnerable adults – older adults and adults with disabilities -- who are who are failing or at risk of failing in multiple systems (housing, behavioral health, healthcare, long term care).

Potential program participants are:
1) Current long term care case management individuals with behavioral health needs that are not being effectively served.
2) Older adults and adults with disabilities with multiple complex issues, including behavioral health, and personal care needs, who may be eligible for long term care services.

5. What would be the results of successful implementation of program?
Include outcomes that could be measured and evaluated. Please indicate whether this data is currently collected in some fashion, and in what form.

People are connected to services that meet their needs and keep them out of crisis. Measurable outcomes include:
Lower psychiatric inindividual costs.
Fewer total arrests and charges.
Higher odds of receiving inindividual alcohol/drug treatment.
Good, trusting relationships with an RN or MSW.
Reduced 30 day hospital readmission rates.
Personal empowerment and goal achievement.

Data is available from Medicaid claims data, and through other data sources in health, human services, and criminal justice systems. Qualitative data is collected through annual individual/consumer surveys.

6. Which of the MIDD II Framework's four strategy areas best fits your concept? (you may identify more than one)

☒ **Prevention and Early Intervention:** Keep people healthy by stopping problems before they start and preventing problems from escalating.
☒ **Crisis Diversion:** Assist people who are in crisis or at risk of crisis to get the help they need.
☐ **Recovery and Reentry:** Empower people to become healthy and safely reintegrate into community after crisis.
☒ **System Improvements:** Strengthen the behavioral health system to become more accessible and deliver on outcomes.

7. How does your concept fit within the MIDD II Objective – to improve health, social, and justice outcomes for people living with, or at risk of, mental illness and substance use disorders?

Modeled after King County Care Partners, Care Coordination is based on a person-centered approach to help individuals improve their health and quality of life, and to experience wellness and recovey. Getting people the right services at the right time can prevent problems from escalating, stabilize crises, and empower people to positively impact their own health. Care Coordination employs a individual-centered approach to meet the objective of improved health outcomes for people living with or at risk for behavioral health issues.

8. What types of organizations and/or partnerships are necessary for this concept to be successful? Examples: first responders, mental health or substance abuse providers, courts, jails, schools, employers, etc.

Cross system collaboration includes: aging network providers; mental health and substance abuse professionals; health care providers, including hospitals and clinics. ADS has actively built relationships with many of these potential partners through our work in Care Transitions, PEARLS, and King County Care Partners. More recently, ADS has been collaborating with both first responders and the criminal justice system to identify vulnerable adults who are at risk of abuse or neglect and effect a coordinated response.

9. If you are able to provide estimate(s), <u>how much funding per year</u> do you think would be necessary to implement this concept, and <u>how many people would be served</u>?

Pilot/Small-Scale Implementation:	**$ 206,000 per year, serving 300 people per year**
Partial Implementation:	**$ 412,000 per year, serving 600 people per year**
Full Implementation:	**$ 695,000 per year, serving 1000 people per year**

Once you have completed whatever information you are able to provide about your concept, please send this form to *MIDDConcept@kingcounty.gov*, no later than 5:00 PM on October 31, 2015.

If at any time you have questions about the MIDD new concept process, please contact MIDD staff at *MIDDConcept@kingcounty.gov*.