King County

Task Force on Regional Human Services (TFRHS)

Regional Services to be Provided Through a Countywide Partnership

Basic Service Level Qualitative Analysis
8-6-04

#4 Health Care To be as Physically and Mentally Fit as Possible		
REGIONAL SERVICES Recommended for a Countywide Partnership	**OTHER REGIONAL SERVICES (primarily funded by state and federal governments)**	**LOCAL SERVICES (funded by local or municipal governments)**
• **Basic Health Care to Provide a Network of Community Health Services** (dental care, medical care, home health services, school-based health and health education services, community outreach) • **Diversion and Transition Services for Persons in the Criminal Justice System with Mental Health and Substance Abuse Problems**	• Adult day health services • Case Management for frail seniors and people with disabilities to allow them to stay home • Mental health and chemical dependency inpatient / residential services for youth & adults • Mental health and chemical dependency outpatient services, e.g. assessment/evaluation, day treatment, individual/group counseling, emergency intervention, etc. • Mental health specialized treatment, e.g. dual diagnosis • Senior wellness and transportation, e.g. volunteer transportation, escorts to medical appointments • Therapy for children ages 0-3 with developmental disabilities	• Health promotion and chronic disease management, e.g. HIV/AIDS, diabetes, cancer, epilepsy, CPR training, etc. • Counseling and rehabilitation training, e.g. persons with vision impairments, multiple sclerosis • Family counseling and support groups

The Regional Policy Committee (RPC) Task 2 Report has been the structural basis for the work of the Task Force—the focus has been on the *Regional Services to be Provided through a Countywide Partnership* defined in the report. Throughout Task Force materials, reference to Regional or a Regional System is a reference to a countywide effort, not necessarily to King County government. Reference to a region (sometimes called sub-region) within King County (North, East, South, Seattle) is a reference to the geographic area and the people who live there, not necessarily to the jurisdiction(s) located there.

Basic Health Care

Summary of research, best practices, promising practices

- People who lack health insurance are more likely to forego needed care, resulting in negative health status and adverse financial consequences. As a result of foregoing care, the uninsured receive fewer preventive services, are less likely to receive regular care for chronic diseases, are less likely to fill a prescription, and are more likely to be hospitalized for a condition that could have been avoided with timely access to ambulatory care. However, insurance is not always sufficient to obtain health care, as there may be shortages of providers or providers who will not see new Medicaid or Medicare patients. Studies have concluded that having a regular doctor improves access to primary care and health outcomes more effectively than having insurance coverage or even the ability to pay fully for one's health care. Primary care is essential for people with chronic diseases such as diabetes or hypertension.[i]

- Cultural competence can have a real impact on clinical outcomes. Ignoring culture can lead to negative health consequences in many ways. For example, patients may choose not to seek needed services for fear of being misunderstood or disrespected, and patients may not adhere to medical advice because they do not understand or do not trust the provider. Providers may not order appropriate tests or medical interventions due to cross-cultural misunderstandings. Best practice requires culturally competent, linguistically appropriate services across all segments of the healthcare system, including mental health and substance abuse services.[ii]

- Community Health Centers (CHCs) [non-profit, community based providers of primary care] are participating in a multi-year national initiative to implement models of patient care and change management in order to transform the system of care for underserved populations. The Institute for Healthcare Improvement (IHI), a not-for-profit organization with support from the Bureau of Primary Health Care (BPHC), has organized the Health Disparities Collaboratives—the Collaboratives are focused on reducing disparities in health outcomes for poor, minority, and other underserved people.[iii]

- The Health Disparities Collaboratives have implemented models for screening, diagnosing and managing chronic conditions such as diabetes, cardiovascular disease, asthma, depression, cancer and HIV. These efforts have led to improved health outcomes for patients as well as lowered costs in treating patients with chronic illness.[iv]

- Medical cost offsets occur when clients use less medical care if they are able to get mental health services. When this happens, the decrease in cost of medical care may be greater than the cost associated with use of mental health services. The net savings generated are referred to as cost offsets. This means that savings generated in medical care offset the costs of mental health care. A review of medical cost offsets concluded that cost offsets are most pronounced for individuals with chronic medical conditions, such as heart disease, who are treated for depression. Also, providing a general Medicaid population mental health treatment through a managed care arrangement has been shown to reduce subsequent medical service use and costs.[v]

Prevalence or utilization data

- For the three year average 1999-2001, 9.2% of King County adults under age 65 did not have any health insurance coverage; for North Region this was 14.6%, the highest of the Regions.[vi]

- The highest uninsured rates are among the King County Hispanic/Latino population (24.1%), those age 18-24 (21.4%), and those with incomes below $25,000 per year (61%).[vii]

- For the two year average 1998-2000, 7.7% of King County children under the age of 18 did not have health insurance; for children below the Federal Poverty Level, 21.9% were uninsured during this time period.[viii]

- In October 2002, Medicaid coverage for non-citizen immigrants was eliminated. As of January 2004, eligibility requirements were tightened and Medicaid families above 100% of poverty level are required to pay $15-25 monthly premiums. Dental coverage for adults was reduced in August 2003, eliminating payments for crowns and root canals.[ix]

- The Basic Health Plan capped its enrollment at 100,000 for the 2003-2005 biennium. This is a 20% reduction in available slots.[x]

- People who have insurance may also face an access barrier. A 2001 national study found that only 55% of doctors in the Seattle area accepted new Medicare patients, compared to 71% in 1997.[xi]

- In Bellevue's 2003 household telephone survey, 19% identified as a problem not being able to pay for or get medical insurance, and 15% mentioned not being able to pay for the doctor, prescriptions or dental bills.[xii]

- A mobile dental van is provided by Evergreen Healthcare Dental Services and Northwest Medical Teams International for low-income residents in East Region. As of September 2003, there were 85 on the waiting list, with wait times of up to 10 months.[xiii]

- In King County, 72% of 19- to 35-month-old children are up to date on immunizations. The goal is 90%. Low-income areas are 6 to 10 percentage points below the county rate.[xiv]

- South Region has been designated as an under-served area for dental services.[xv] North Region residents have the greatest travel distances to existing clinics.[xvi] 15% of North Region residents are uninsured.[xvii]

- Public Health and Community Health Centers serve the Medicaid and uninsured populations at 23 medical clinic sites and 19 dental clinic sites. In 2002 they served 128,014 medical patients and 67,245 dental patients.[xviii] There has been a rise in the number of uninsured users, from 27-40% in CHC and Public Health clinics. Nearly half of CHC revenues come from Medicaid, which is changing eligibility rules and coverage of services.[xix]

- In Washington, Community Health Centers serve more than one in three low-income uninsured residents.[xx] In South Region, four health centers documented one week in March 2004 during which there was an unmet need for 241 visits, equivalent to an annual number of 12,500 visits.[xxi]

- School-based and school-linked health centers are comprehensive primary care clinics providing medical and mental health screening and treatment for young people on or near school grounds. The centers target adolescents who are uninsured and underinsured—those who have nowhere else to go to get medical care and counseling. They also serve young people who have insurance, but who want confidential care and advice. Public Health partners with seven community health agencies to administer 14 school-based health centers in Seattle and two school-linked health centers in Burien and Renton. In 2002 they served 2,198 users in the school-linked centers and 4,000 in the Seattle school-based centers. A review of the Seattle school-based centers found that 1 in 3 students in schools with health centers used the services; 36.7% of visits were related to mental health services, 38% were illness related, and 48% of visits included preventive services.[xxii]

- Birth rates to King County girls age 15-17 declined from a high of 23.9 per 1,000 in 1992 to 10.9 per 1000 in 2001. The decline has been especially sharp in Seattle. Teen birth rates, averaged over 1998-2000 were highest in the Highline, Auburn, Enumclaw, Tukwila, and Seattle school districts.[xxiii] The decline in Seattle coincides with the establishment of school-based health clinics that provide reproductive health education and services.[xxiv]

- One in four sexually active teens will get a sexually transmitted disease (STD) this year; only 35% of sexually active teens have ever been tested.[xxv]

- In 2000, 22% of King County public high school 10th grade students reported binge drinking in the past 2 weeks; 48% of 12th graders reported alcohol use in the past 30 days.[xxvi]

Relationship to other goal areas, regional services, local services, other systems

In regard to substance abuse and mental health services:

- A report for the California Health Foundation cites the Surgeon General's Report regarding the national prevalence of addictive disorders at 9%. Additional research reported that about 2% of the population meets the criteria for the most severe degree of abuse.[xxvii] The Surgeon General's Report states that 19 percent of the adult U.S. population has a mental disorder alone (in 1 year); 3 percent has both mental and addictive disorders; and 6 percent has addictive disorders alone. Therefore, about 28 to 30 percent of the population has either a mental *or* addictive disorder. A subpopulation of 5.4% of adults is considered to have a "serious" mental illness. About 20% of children are estimated to have mental disorders with at least mild functional impairment. Federal regulations also define a sub-population of children and adolescents with more severe functional limitations, known as "serious emotional disturbance" (SED). Children and adolescents with SED number approximately 5 to 9% of children ages 9 to 17.[xxviii]

- Planning documents prepared by South Region and the City of Bellevue identify the lack of access to mental health services as an issue. The number of people served by King County's Prepaid Health Plan for public mental health services rose 7.7% between 2001 and the first quarter of 2003, from 19,932 to 21,471 individuals[xxix] However, Federal and State changes have restricted services to the non-Medicaid population, and state law mandates services to the most seriously ill. As is demonstrated in the DSHS study data below, the public mental health system is serving the most seriously ill population. It is not currently financed to serve the non-Medicaid population or less seriously ill populations.

- The statewide treatment gap for substance abuse also creates an access barrier. Of those who met eligibility requirements for publicly funded treatment in 2001, 26.3% received treatment; for adolescents this number was 25.9%.[xxx]

- DSHS recently reported on the success of a project that shifted Medicaid funding to purchase earlier and faster substance abuse treatment for clients identified with serious medical disabilities. The two-year-old program "showed that early, effective treatment of drug and alcohol problems not only paid dividends in medical spending but in public safety…hat we found was that funding was one of the major barriers for treatment—in effect, the Division of Alcohol and Substance Abuse's funding has allowed it to serve only a quarter of those in need of—and eligible for—DASA services."[xxxi]

- Another DSHS study found that approximately 47% of the Adult Aged, Blind and Disabled Medicaid population had a mental health/substance abuse diagnosis, and of this group, slightly over half were

served by the public mental health system and just under half were not. Among those served, 28% had a substance abuse diagnosis, compared to 12% of those not served. The study concluded that publicly funded mental health treatment is associated with lower medical costs. For Medicaid-only clients, medical cost savings increased from just over $100 per member per month (PMPM) in the first year of follow-up, to $126 PMPM in the second follow-up year. The savings offset 41 to 50% of the cost for providing the outpatient mental health care.

Those who were served by the mental health system had a pattern of diagnoses that were more severe and complex, a pattern also reflected in their psychotropic medications. Those not served by the public mental health system had predominantly depression, substance abuse and adjustment and stress disorders. Among the clients receiving community mental health services it was noted that at least 1 in 2 of those who received high levels of outpatient treatment had psychotic disorders. The medical cost savings were greatest for those receiving moderate amounts of outpatient care; those who received the most hours had considerably lower savings amounts.[xxxii]

Local planning initiatives

- The King County Health Action Plan (KCHAP) was formed in 1996. Program oversight for the Action Plan comes from a volunteer Steering Committee which meets on a quarterly basis. Through its policy and pilot project development the Action Plan has established public/private partnerships of over 40 organizations representative of all levels of the health care field: local managed care organizations, community clinics, hospitals, business, labor, consumer and community groups, and county and state governmental agencies. Through this system of collaboration, the Action Plan emphasizes the mobilization of resources to improve health through system integration, partnerships, mutual responsibility and effective strategies.

  Kids Get Care ensures that children, regardless of health insurance status, receive early integrated preventive physical, developmental, mental health and oral health services through attachment to a health care home. It is supported by a U.S. Health Resources and Services Administration (HRSA) Community Access Program grant to design, develop, implement and evaluate program. Kids Get Care increases the delivery of comprehensive well child visits. Participating clinics increased the rate of children up-to-date with well child visits by 41%. Research shows that Medicaid children who are up-to-date with well child checks have a 48% lower chance of having an avoidable hospitalization.

  A Washington Dental Service Foundation (WDSF) analysis shows potential savings of roughly $1.5 million statewide if fluoride varnishes were applied during well child visits for children ages zero to five instead of waiting to pay to fill the cavities that occur without this preventive treatment. WDSF, the University of Washington and Medical Assistance are promoting early fluoride varnishes and oral health care through the Access to Baby and Child Dentistry program. Kids Get Care refers young children to ABCD providers at two of its seven current sites in King County.

  In summary, it would cost the same amount to continue to pay for avoidable hospitalizations and caries treatment as it would to implement a Kids Get Care site at 44 additional locations and pay for fluoride varnishes throughout the state. Re-engineering the delivery of children's primary care services to provide greater support for preventive services can improve well child visits while reducing unnecessary hospitalizations and cavity treatment.[xxxiii]

- The Seattle Family and Education Levy is governed by the Levy Oversight Committee, which includes the Mayor, City Council President, Seattle Schools Superintendent, School Board representation and two citizen representatives. The task of the group is to establish the policy framework, propose allocations and oversee implementation. The Levy Citizens Advisory

Committee (CAC) is made up of 43 citizens who represent a broad cross-section of the community and had expertise in the proposed strategic areas of investment. The CAC gathered input from experts, recommended service areas for investment and prioritized service areas for highest impact. The Strategic Areas in the 2004 proposed levy include: Support Early Learning; Focus on Family Involvement and Support; Invest in Out-of-School Time; Help High-Risk Youth; and, Support Student Health.[xxxiv]

- The South Region will focus on decreasing tobacco use and increasing physical activity among adults and children.[xxxv]

Issues identified by presenters to TFRHS

- Healthcare needs are greatest in areas with high numbers of low-income and uninsured/Medicaid residents
- The safety net is fraying, clinics are seeing increased number of uninsured patients and Medicaid reimbursement fails to cover the cost of care
- Access to specialty care is extremely difficult to arrange
- There are long waits for dental care for low-income adults
- Lack of free or low-cost medical and dental services for immigrants not covered by state or federal programs
- Need for translators and culturally competent services
- Prescription drugs and some services not covered by Medicare
- Reduction in publicly funded mental health services is impacting the community health system
- Only 1 in 5 people who need substance abuse treatment can access it, due to lack of funding

Examples of current outcome measurements and performance

- A survey of users of Seattle school-based health centers found that 91% were more able to get health and mental health services by using the centers, 90% received services sooner than they would have otherwise, and 75% received services they would not have otherwise received.[xxxvi]
- Community Health Centers of King County report a 43% success rate for children receiving immunizations by their 2nd birthday, an increase of 2-3% over the prior year.[xxxvii]
- Three Kids Get Care clinic sites increased their overall rate of two-year-olds up-to-date with well child visits by 41%, from 53% to 75%.
- CHCs are monitoring chronic conditions, for example:
  - 65% of clients will have blood pressure of less than 140/90
  - Increase the retinal eye exam rate for diabetic patients from 26% to 53%

Recommendations regarding future indicators

Process indicators

- For clinic services, adopt the indicators used by the IHI/HRSA Health Disparities Collaboratives for each disease area (e.g., Asthma, Diabetes, Cardiovascular, Depression). For example: Percentage of patients with diabetes with two HbA1c tests in the last year.

- For school health centers, consider the Young Adult Health Care (YAHC) survey. The topics included in the survey assess care that is nationally recommended in the Maternal and Child Health Bureau's Bright Futures, the American Medical Association's Guidelines for Adolescent Preventive Services, and the American Academy of Pediatrics Health Supervision Guidelines. The YAHC has been developed by the Child and Adolescent Health Measurement Initiative (CAHMI), a national collaboration committed to measuring and improving the quality of health care for children and adolescents.

Quality Measure	YAHC Survey Questions
1: Counseling and screening to prevent risky behaviors	Questions:11a-d, 12a-c,13c, 17, 20, 24, 33)
2: Counseling and screening to related to sexual activity and STD's	Questions: 13b, 28, 30
3: Counseling and screening related to diet, weight and exercise	Questions: 9a-9c
4: Counseling and screening related to emotional health and relationships	Questions: 10a-d, 13a, 15
5: Care provided in a confidential and private setting.	Questions: 6, 7
6. Preventive health information	Questions: 34-37
7: Helpfulness of counseling provided	Questions: 18, 21, 25, 29, 31
8: Communication and experience of care (draft adolescent CAHPS® items)	Questions: 38-43, 46
6. Help in completing the survey	Questions: 55-56
7: Socio-demographic items (age, gender, race)	

Outcome indicators

- For clinic services, adopt the indicators used by the IHI/HRSA Health Disparities Collaboratives for each disease area (e.g., Asthma, Diabetes, Cardiovascular, Depression). For example: Average HbA1c level for all patients with diabetes.

- For school health centers, adopt the Young Adult Health Care (YAHC) survey.

Topical Focus	YAHC Survey Questions
1: Health care utilization (time since last visit, time since last visit for regular or routine care, places where teen receives care, whether the teen filled out a checklist or survey about his/her health prior to office visit, problems in getting needed care)	Questions: 1-5, 45
2: Knowledge about where to get confidential care	Question: 8
3: Participation in risky behavior (smoking, drinking, sexual activity, condom use, seat belt use)	Questions: 16, 19, 22, 23, 26, 27, 32
4: Emotional health	Question: 14
5: Health status	Questions: 45, 47, 48a-c, 49, 50-51

Diversion and Transition Services for Persons in the Criminal Justice System with Mental Health and Substance Abuse Problems

Summary of research best practices, promising practices

- Recommendations from the American Bar Association's Criminal Justice Mental Health Standards and national evaluations support the efficacy of jail diversion initiatives (both pre-booking and post-booking). Model pre-booking programs include: Police-Based Crisis Intervention Teams (made up of police officers with specialized training in mental health issues), Mental Health Deputy Program (deputies dedicated full time to screening and transporting individuals with suspected mental illness), Police-Based Specialized Mental Health Response (mental health professionals employed by the police department provide on-site and telephone consultations to officers in the field), Psychiatric Emergency Response Teams [PERT], System wide Mental Assessment Response Teams [SMART] (uniformed patrol officer and civilian mental health clinician teams), and Mobile Crisis Teams (clinicians from different disciplines). Key to all of these efforts is community partnership with the mental health system and the existence of a "drop off center" to minimize officer down time.[xxxviii]

- Successful diversion efforts require diverting an individual *away from jail*, and *into* adequate treatment services. Effective post-booking diversion services have six central features: integrated services (multiple services coordinated under a single entity), regular meetings of key agencies, "boundary spanners" (formal liaison staff between systems), strong leadership, early identification (within the first 24-48 hours after arrest), and distinctive case management services.[xxxix]

- A review of plans put forward by California counties in response to new funding targeted to the mentally ill offender noted a number of common gaps and strategies to address them: alternate sanctions; focused discharge planning; training of law enforcement; case management; housing in the community; education and training; co-occurring disorder services; crisis response; transportation; and clinical staff in the jails. Among the top three gaps mentioned was housing—Sacramento County noted that more than half of its mentally ill offender population is homeless. Housing is the second most cited resource needed, after a continuum of alternative sanctions, and followed by crisis services.[xl]

- Maryland's Community Criminal Justice Program builds on the research regarding the key elements that must be part of any multidisciplinary response to the jailed mentally ill: interagency agreements, consensus on defined goals, delineation of responsibilities, interagency communication, cross training, and ongoing program review. Additionally, researchers have called for integrated service, regular meetings of key agency representatives, "boundary spanners", strong leadership, early identification of the mentally ill in correctional settings, and distinctive case management services.[xli]

- The King County Mental Health Court (MHC) was one of the first in the nation, and has received a large number of awards, with many national and international visitors who are considering replication in their jurisdictions as a post-booking strategy. The goal of the MHC is to increase public safety and humanely deal with individuals with mental disorders who enter the criminal justice system. It offers misdemeanant defendants a single point of contact with a dedicated team consisting of the judge, prosecutor, public defenders, treatment court liaison and probation officers. The court liaison is present at all hearings and is responsible for linking the defendant with appropriate services and for developing an initial treatment plan with the treating agency. Defendants are placed on probation and assigned specialized probation officers who provide an intensive level of supervision.[xlii]

Prevalence or utilization data

- Studies of police departments across the country estimate that 7% of all police contacts involve mentally ill people in crisis. Studies of U.S. jails show that between 6 and 15% of all jail inmates have severe mental illness, and three out of four mentally ill inmates have a co-occurring alcohol or drug abuse problem. Research shows that mentally ill individuals who use alcohol or drugs and don't take their medications are three times more likely to be arrested than others with mental disorders.[xliii]

- In 2002, 60-75% of the 25,000 people booked into jail tested positive for illegal drugs.[xliv]

- In 2001, 15% of jail bookings were assessed for mental illness; roughly 1/3 were found to have a serious mental health issue and of those, about half also had a substance abuse problem.[xlv]

- African Americans are consistently reported at a higher percentage in jail than their representation in the general population.[xlvi]

Relationship to other goal areas, regional services, local services, other systems

- The Surgeon General's Report states that 19 percent of the adult U.S. population has a mental disorder alone (in 1 year); 3 percent have both mental and addictive disorders; and 6 percent have addictive disorders alone. Therefore, about 28 to 30 percent of the population has either a mental *or* addictive disorder. A subpopulation of 5.4% of adults is considered to have a "serious" mental illness.[xlvii]

- The HUD definition of chronic homelessness is single adults with disabling conditions who have been continually homeless for a year or more, or have had 4 or more episodes of homelessness in the past 3 years. The 2002 transitional housing and emergency shelter survey reported 45% of all individuals having at least 1 disability; among single adults, that percent rose to 76%.[xlviii]

Local planning initiatives

- King County has developed and financed an array of services related to the diversion of persons with mental health and substance abuse problems from the justice system. This includes the following components:[xlix]
  - Crisis Triage Unit/Harborview
  - Mentally Ill Offender Community Treatment Program (MIOCTP)
  - Drug Court/Mental Health Court
  - Veterans Incarcerated Project
  - Criminal Justice Initiatives Continuum of Services
    - Improved screening and assessment
    - Co-occurring disorder treatment
    - Criminal justice liaisons
    - Mental health treatment vouchers
    - Methadone vouchers
    - Housing vouchers
    - Assistance with benefit eligibility paperwork
    - Intensive outpatient treatment
    - Cross system training
    - Project evaluations

Issues identified by presenters to TFRHS

- Issues relating the chronic street population, the homeless mentally ill and the impact on the community and criminal justice system have recurred in questions and comments from Task Force members, presenters and the audience.

Examples of current outcome measurements and performance

- Mental Health Court significantly reduced recidivism (75.9% decrease in number of offenses) and occurrence of violent criminal activity (87.9% decrease in percentage of violent offenses) one year after graduation. There was also a 90.8% reduction in jail time.[l]

- The San Diego PERT system intervened in 3,803 incidents during one year. Only 3.4% of those incidents required a jail-based disposition.[li]

Recommendations regarding future indicators

Process indicators

- Number of persons served
- Amount and duration of services provided
- Percent of persons completing program
- Number of persons in stable housing

Outcome indicators

- Percent of decrease in the percent of violent offenses committee by program graduates
- Recidivism rate for program compared to other mentally ill offenders not in the program

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[ii] http://erc.msh.org/mainpage.

iii www.ihi.org/collaboratives; www.healthdisparities.net.

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[xiv] Presentation to TFRHS, South King Council of Human Services.

[xv] Presentation to TFRHS, South King Council of Human Services.

[xvi] Presentation to TFRHS, Public Health-Seattle & King County.

[xvii] Presentation to TFRHS, North King County.

[xviii] Presentation to TFRHS, Public Health—Seattle & King County.

[xix] Presentation to TFRHS, King County Alliance for Human Services.

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