King County Framework for an Accountable, Integrated System of Care for Low-Income Residents

June 25, 2012

Background

In King County, the benefits of good health are not equally shared by all residents. Today, one out of every five King County residents – over 420,000 adults and children – lives below 200 percent of the federal poverty level. Relative to those with higher incomes, this group faces significant inequities in health, with high and rising levels of chronic illness such as heart disease, diabetes, and mental health and substance abuse disorders. Of particular concern is that this burden of poor health disproportionately affects racial and ethnic minority residents.

Adding to these health challenges, approximately 30 percent of those living below 200 percent of the federal poverty level are uninsured. Those who do have coverage often access it through public programs with limited benefits such as Medicaid, Medicare, and the Basic Health Plan. Community and public health centers, hospital systems, the long-term care system, mental health and substance abuse agencies, correctional health services, health plans, and housing and human service programs constitute the "safety net" health system that provides much of their care.

Spurred by deepening health inequities, the rising cost of health care, and the opportunities presented under health care reform, King County convened a group of safety net providers, payors, consumers, and other community leaders in 2011. Known as the King County Health Reform Planning Team, this group of stakeholders has been working toward an accountable, integrated system of care that drives better health and well-being for King County's low-income and underserved residents.

As health reform unfolds in Washington State and across the nation, King County has a unique opportunity to leverage new funding and reform designs to address the shortcomings in the current system. Over the next 18 months, the King County Health Reform Planning Team's leadership is critical to organizing the safety net delivery system to improve the system of care for the most vulnerable residents in the community.

Purpose of the Framework

This Framework lays out a vision for an accountable system of care that is effective in reducing health inequities experienced by low-income residents of King County, and describes the core elements that stakeholders agree are needed to achieve it. The Framework communicates the form of the "finished structure," but is not intended to serve as the roadmap to get there—those strategies will appear in companion documents and actions, and will evolve depending on opportunities available under the Affordable Care Act (ACA) and elsewhere. This Framework is intended for a broad community audience of consumers, care providers, policymakers, and

funders. It is meant as a tool to drive specific collaborations and partnerships that will move a transformed system of care to implementation.

Numerous agencies and partnerships in the King County community have already taken or are taking concrete steps to put in place the elements laid out in this framework. Going forward, the King County Health Reform Planning Team will leverage current efforts and work to strengthen existing collaborations to fill in what's missing and to accelerate progress.

While this framework represents a vision for all low-income residents in King County, current financial and policy realities suggest that not all individuals will have access to the necessary services and supports to achieve optimum health. Even with expanded health care coverage under the ACA, some individuals will remain uninsured or underinsured and continue to have limited access to health care relative to others. Furthermore, limited resources and funding mandates, including stringent eligibility criteria, prohibits access to some services for some people. Despite this reality, the King County Planning Team is committed to promoting equitable access to health and social services and will develop policies that promote a system of care that strives to provide needed services to residents whenever possible.

Vision: An Accountable System of Care for King County's Low-Income Residents

For low-income residents of King County, the transformed system of care will place the individual at the center. Care will be coordinated through a person-centered medical home—sometimes also called a health home—that provides for or assures a broad range of culturally appropriate, integrated preventive, medical, dental, behavioral health, and social services – with a single point of accountability. This medical/health home will be embedded in a broader integrated system of care that includes access to an array of social services including housing assistance, employment, basic needs, family support services, legal assistance, income assistance, and crisis services. Healthy community environments will encourage recovery and promote individual and community wellness for all residents.

The entire system of care will be responsible for the achievement of health and wellness goals for residents, and for managing costs. Proactive work with the payment, regulatory, and information technology systems at the local, state, and federal level will help assure that they support and enable this vision.

FOUR CORE CAPABILITIES OF A TRANSFORMED SYSTEM OF CARE

The following section describes the core elements identified as necessary to transform the system of care in King County and achieve the overall vision of the King County Health Reform Planning Team.

1. Care will be organized around the individual in a way that best supports their health.

Across the U.S., the health care crisis is driving new models of person-centered care that are showing they can deliver greater satisfaction for individuals and families, better health for the residents, and lower costs. Central to the transformation is the person-centered medical home or health home, a comprehensive approach to organizing primary care. Individuals have an ongoing relationship with a primary care provider and care team, which collectively take responsibility for providing and coordinating all of the person's health care needs including primary and specialty care, behavioral health services, health promotion, and chronic care management. This approach counters the historic fragmentation, waste, and inefficiencies of our health care system, and holds promise for improving health of all county residents, regardless of income level.

Because low-income residents face greater inequities in health, access to a person-centered medical home is particularly important. In the King County system of care, individuals will get the right care at the right time in the right place, in a culturally and linguistically appropriate manner. Care will be coordinated across providers, and smooth handoffs will occur when individuals transition from one setting to another. A single plan of care, single problem list, and a single medication list shared among all members of an individual's care team will help assure high quality, efficient, and well-coordinated services. The team will work to assure integration of primary care, oral health, behavioral health, prevention and health promotion services, and social services. Integration of mental health and substance abuse services is especially critical to design, both by integrating behavioral health into primary care, and by integrating primary care into behavioral health settings where needed in order to meet individual needs. Finally, access will be improved through health coverage, convenient hours, transportation help, electronic health records, and the use of mobile services and telemedicine where appropriate. Formal recognition of medical/health homes will be encouraged to help assure consistency and quality of these services and practices.

The King County system of care will intentionally create environments where individuals are actively involved in self-management and shared decision-making and where their preferences are honored. Education, technology, and training for individuals, family members, and staff will support this empowerment and engagement.

2. Robust system of care management for those with chronic health conditions

Chronic health conditions are those that persist for a long time, examples of which include asthma, diabetes, cancer, epilepsy, mental health and substance abuse disorders, HIV/AIDS,

and hepatitis, among others. In most cases, care for individuals with chronic health conditions is paid for by multiple funding streams in multiple service systems (i.e., medical, mental health, substance abuse and/or long-term care). As a result, care is often fragmented and difficult to navigate. Many individuals with chronic health conditions have multiple needs that may overlap and impact one another, and a lack of coordination too often results in poor health outcomes and costs that could have been avoided To address these challenges, intensive care coordination that works across service domains and disciplines is an essential ingredient in a transformed system of care.

The King County system of care will assure that care management, including self-management support, is organized in a systematic, rational way that prevents duplication and assures integration with the medical home. For high-need individuals with complex chronic medical, behavioral health, and social needs, the King County system of care will ensure a targeted and intensive care management model that identifies and engages individuals, and manages both health and social service needs, including housing stability. Care managers will help support safe and high quality handoffs when people transition from one care setting to another. Where needed, care management services will be capable of providing "high touch" (in person), community-based support through low caseloads and use of interdisciplinary teams that involve medical, mental health, substance abuse, long-term care, and peer support services. For those with chronic health conditions who fall into a lower tier of need and risk, chronic disease self-management support, wellness coaching, and related services will be available, both in the clinic and in the community.

3. The delivery system will increasingly offer services through culturally appropriate community hubs organized around the needs of individuals.

For many individuals within the safety net, unaddressed social needs and health concerns often go hand in hand. Typically referred to as the social determinants of health (SDOH), factors such as affordable and safe housing, family wage jobs and job training, healthy built and natural environments, and quality education have significant impacts on the overall health and well being of individuals and communities. A coordinated system of care combines not only medical and behavioral health services but includes integration of social services and supports to address the whole person in a culturally and linguistically appropriate manner. More coordination linking residents to needed social services can improve their lives and lead to lower health care costs, a win-win for the individual and the community.

In a transformed system of care, a series of community hubs will be in place throughout the county that include integration and rapid access to a wide range of services and supports. For example, individuals will experience easier pathways into health services, insurance coverage, housing assistance, employment, family support services, legal assistance, income assistance, basic needs, crisis services, and more. Going beyond co-location of services, hubs will strive to serve as focal points for community wellness, incorporating opportunities for physical exercise,

access to healthy foods, classes on living well with chronic conditions, or other elements tailored to the given community. In our community today we have many successful partnerships among community health centers, behavioral health agencies, public health, housing and human service agencies, and community development programs upon which to build. They provide a critical basis from which can evolve into an even more comprehensive approach to improving individual and community wellness.

4. A prevention, wellness, and recovery orientation will infuse the system of care as well as the community environment.

Ultimately, successful transformation of the King County system of care means shifting from a system focused primarily on treating illness to one focused on *preventing* illness and promoting recovery and resiliency. Therefore, services to prevent disease, detect health problems early, and support wellness and recovery will be integrated into the system of care and be clearly visible within the community hubs. Prevention, wellness and recovery services will also be provided in community settings, such as schools, work sites, social service programs, and housing. Preventive services will reach individuals across the lifespan. To lower the risk of future health problems, King County will promote optimal early childhood development and provide early intervention services.

In addition to individual-level preventive services, the system of care will focus on improving the conditions of our communities – the places where people live, learn, work and play – through policy and system change tools. The King County system of care will work across such sectors as health, housing, transportation, land use, and community and economic development to create healthy, safe community environments that will in turn support greater equity in health for all residents of King County. Improving communities means improved health, increased productivity, and greater environmental sustainability.

CORE INFRASTRUCTURE NEEDED TO SUPPORT AN INTEGRATED SYSTEM OF CARE

The four core elements above lay out the new way the King County system of care will partner with individuals and communities to improve health—a new way of doing business in health and human services that will create better health while controlling costs. To carry this out, several critical infrastructure components are necessary to ensure effective service delivery changes. This section describes five core infrastructure components that must be put in place to achieve the overall vision.

1. A transformed workforce to carry out this work.

New types of workers with new skills are needed to carry out the culturally appropriate, consumer-driven approach to services described above, and to reduce the health inequities that are especially marked in King County compared to other large U.S. counties. To help

achieve this aim, King County and its partners will work to advance the field of community health workers and peer support workers, trained staff who share or have close ties to the cultural, community, and life experiences of the individuals they work with. This new workforce will be in widespread use, linked to medical homes, care management services, and prevention initiatives to support individuals with access to insurance coverage, system navigation, advocacy, health education, disease self-management, and linkage to social services. In addition, the King County system of care will ensure an adequate and well-supported primary care and behavioral health workforce to serve individuals in the safety net population including support for training in care coordination and interdisciplinary team functions.

2. Health information technology infrastructure to support this work.

To carry out the expectations of the medical home, including good care coordination, electronic tools are needed to help support the rapid movement and sharing of client information. Electronic health records will be in use across health safety net providers in King County, including behavioral health providers. Providers will be able to view and exchange clinical data electronically, and individuals will be able to access personal health records to support them in better managing their own care. Technology will also be used in innovative ways throughout the county to support health promotion and disease self-management, and to help overcome linguistic and transportation barriers. Providers, payors, and public health will use aggregate data to drive improved quality and efficiencies, and to reduce inequities.

3. A supportive financial, policy, and regulatory environment.

In a transformed system of care, funders will transition from paying for volume to paying for value. Base payments will fund prevention, treatment and care management costs. Financial policies and practices will align with the Triple Aim of better health, better quality and reduced costs, to assure that individuals have easy access to the care that they need; promote better health by paying incentives to health care providers who achieve positive health outcomes for and with the individuals they serve; and promote reduced health care costs by fostering efficiencies that create savings that can be shared among providers and reinvested in building community capacity.

Looking beyond the health care delivery system, the King County system of care will strive for a policy environment that better supports the development of healthy communities: equity criteria will systematically become part of our community decision making processes so that gaps in health outcomes by income groups, geographic areas and race/ethnicity can be closed over time.

4. Performance measures and accountabilities to support achieving the triple aim.

Providers will commit to measurement-based treatment to target and the use of evidence-based and evidence-informed care. This includes each individual having a treatment plan with clearly established and measurable goals. Each individual's progress on personal goals and

clinical outcomes will be routinely tracked and monitored. Similarly, there will be a commitment to measuring improvements at the population level that include the overall health of community environments. Since population health measures may take years to change, it will be important to measure intermediate steps along the way and evaluate how well community improvement initiatives are working as they are implemented and spread.

5. Leadership and commitment to work together in new ways.

Finally, we must all be willing to lead the way to health improvement. Individuals, families, and communities will have to play stronger roles in promoting their own health and wellness. Health and social service organizations will need to partner in different ways and shift their workflows, focusing on quality, outcomes, and coordination. And funders will need to coordinate with each other to better support and encourage these innovations and improvements over time.

On June 25, 2012, this framework was endorsed by the King County Health Reform Planning Team. Endorsement means support for the concepts and a willingness to work in ways that support its realization. It does not imply financial commitments. If your organization would like to be involved in moving this vision forward, please join our efforts. Contact Jennifer DeYoung or Susan McLaughlin for more information about how to get involved.

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