Contact Information	**Liz Arjun, King County; 206.263.9107; Elizabeth.arjun@kingcounty.gov** **Which organizations were involved in developing this project suggestion?** Over the past year, a multi-sector design team in King County has engaged in planning sessions that informed the development of the "Familiar Faces" initiative. Their work has informed this project suggestion, and its implementation would come under the auspices of the Familiar Faces Steering Committee
Project Title	**Intensive Community-Based Care Teams for Adults With Complex Health and Social Needs Including Justice System Involvement (King County Familiar Faces)**

Problem Statement

It is well established that a small subset of the population accounts for the majority of health care costs. While innovative models of care management for the Medicaid population with complex needs continue to evolve, relatively few focus on individuals transitioning into and out of the criminal justice system, a group that includes many low-income adults with significant physical and behavioral health needs who face various economic, social, legal, and housing challenges. When the ACA expanded coverage, many previously uninsured adults with justice system involvement became eligible for Medicaid. Partners in King County were especially successful in enrolling eligible individuals into Medicaid, including many justice-involved adults.

While Medicaid rules preclude the use of Medicaid resources for people while they are incarcerated, the need to better coordinate care for these beneficiaries as they enter, leave, or are diverted from local jails is critical for improving their health and social outcomes – and for controlling costs in Medicaid. Studies have found that justice system involvement has been associated with higher hospital and ED utilization, for example. Local data analysis of this population confirms the extent of complex health issues: a King County data analysis found that during calendar years 2013 and 2014, more than 1,273 and 1,252 individuals, respectively were booked into the King County Jail system four or more times. Of these two cohorts; 94 percent had a behavioral health condition (including mental health and or substance use disorder), 93 percent had at least acute medical condition, 51 percent had at least one chronic medical condition, and more than 50 percent were homeless.

The Familiar Faces Initiative, a current initiative of focus for the King County region's Accountable Community of Health during its design year, is a broad-scale systems improvement effort focused on individuals booked into the King County Jail four or more times in a 12-month period who also have a mental health and/or substance use disorder. In 2015, this Initiative pulled together a cross sector Design Team which includes representatives from housing providers, substance use providers, mental health providers, community health centers, Medicaid Managed Care Organizations, Public Health-Seattle & King County, the King County Department of Community and Human Services, the City of Seattle, criminal justice organizations including courts, police, and the King County Department of Adult and Juvenile Detention to design a system for the population focused on achieving the following outcomes: improved housing stability, improved health, improved housing stability, reduced emergency department usage, reduced criminal justice involvement, improved client satisfaction and lowered costs.

A recent report from the Center for Health Care Strategies, "Opportunities to Improve Models of Care for People with Complex Needs: Literature Review" [i] identifies a set of evidence-based strategies for improving outcomes and lowering costs for high-need, high-cost populations. The review cites care model aspects that have been associated with improved outcomes, such as the use of intensive, multi-disciplinary care teams, effective targeting, physical/BH integration, the incorporation of trauma-informed approaches, patient activation strategies, and addressing housing stability, among others. These key elements are found in the proposed project design for Familiar Faces. The CHCS literature review contains the key findings and outcomes (including cost reductions) for the most recent studies of care management models for high-risk, high cost populations. Examples include models such as Hennepin Health, whose preliminary results have shown a shift in care from ED and hospital to outpatient settings, and the percentage of patients receiving optimal diabetes, vascular, and asthma care has increased, as has patient satisfaction.

This project would have a significant impact on Medicaid beneficiaries in moving this complex population from a

reliance on episodic use of high cost, intensive services such as the Emergency Department, inpatient hospitalizations and the King County Jail, to a community-based model of harm reduction interventions and primary care that includes access to support in navigating the criminal justice system and access to needed social supports.

Project Description

Which Medicaid Transformation Goals[ii] *are supported by this project/intervention? Check box(es)*

X Reduce avoidable use of intensive services
X Improve population health, focused on prevention
Accelerate transition to value-based payment
X Ensure Medicaid per-capita growth is below national trends

Which Transformation Project Domain(s) are involved? Check box(es)

X Health Systems Capacity Building
X Care Delivery Redesign
Population Health Improvement – prevention activities

Target Population

Three groups would be target for this intervention in the King County Region Including:

- Adults who are frequent users (defined as having been booked four or more times into the King County Jail) who also have a mental health or substance use disorder.
- Individuals who are diverted from a jail booking by law enforcement through the Law Enforcement Assisted Diversion Program (LEAD) program who have a mental health and/or substance use disorder.
- Youth involved in the juvenile justice system who have a mental health and/or substance use disorder. Data indicate that more than 50 percent of the Familiar Faces population between the ages of 19-24 had at least one encounter with the juvenile justice system. This does not include Familiar Faces over the age of 24 and is therefore likely an underrepresentation of the proportion of the population that has touched the juvenile justice system before ever becoming a "Familiar Face".

Relationship to Washington's Medicaid Transformation goals.

This project will reduce avoidable use of intensive services, such as hospital emergency rooms and inpatient hospitalizations, jails stays; and impact the Medicaid cost per capita growth to remain below the national average.

Project goals, interventions and outcomes expected during the waiver period, including relationship to improving health equity /reducing health disparities.

The overarching goal of the Familiar Faces Design Team is to improve health and social outcomes by implementing the comprehensive "Future State Vision" in the King County region. This Medicaid project would accelerate the refinement and testing of a core element of the Future State Vision: Community-Based Intensive Flexible Care Management Teams with connections to criminal justice system supports. As detailed further in the project metrics section, expected outcomes include: improved housing stability, improved health, improved housing stability, reduced emergency department usage, reduced criminal justice involvement, improved client satisfaction and lowered costs.

These Care Teams are designed to be community-based and not belong to one system, one agency or one program and will be centrally managed in the Region to ensure standardization and minimize duplication across the system. Care Teams would be equipped with tools to be electronically connected and use of single care plan either through the Emergency Department Information Exchange (EDIE) or by becoming a testing site for Link4Health. Most importantly, these community-based teams would allow for the flexibility necessary to provide continuity of care serve a population whose needs change, who may flow in and out of coverage, whose managed care plan may change, and whose access to care management should be able to flex and move with the person without disrupting

trusting relationships.

Links to complementary transformation initiatives

- **King County Mental Illness and Drug Dependency (MIDD) Action Plan**- Local levy in the King County Region that provides more than $50 million annually to support programs for people suffering from mental illness and chemical dependency, diverting them from jails and emergency rooms by getting them proper treatment.
- **Law Enforcement Assisted Diversion (LEAD)-** A current model in the King County Region, has seen great success as a promising practice to divert low-level offenders from the criminal justice system by ensuring the health and social support needs for the individual are addressed. LEAD contracts with an outreach organization equipped to provide these services while prosecutors and law enforcement manage criminal justice involvement to keep the individual in the community.
- **Physical and Behavioral Health Integration Subcommittee/King County Accountable Community of Health**- The King County Accountable Community of Health has established a Design Committee tasked with developing a model of fully integrated health care for the region. This work is happening in close collaboration with the Familiar Faces Initiative and is expected to propose similar design elements, e.g. Community-Based Care Teams.
- **Coordinated Entry for Housing and Housing Supports**- One of the foundational supports necessary for improving outcomes for the Familiar Faces population is access to housing and associated supports; data indicate that over half of the population was identified as homeless. The supportive housing supports that would be developed under Initiative 3 could potentially be accessed as a resource for some of the Familiar Faces. However, this will not address the overall lack of available housing for the population in the region. While it is understood that Medicaid cannot make capital investments to increase the housing resources in the region, it will be important to continue to advocate for these resources in the region.
- **SAMHSA Trauma-Informed Care "Train the Trainer":** King County, along with the Washington State Department of Corrections, the City of Seattle and other key partners from the Familiar Faces Initiative were recently awarded a SAMHSA grant to help develop a Trauma-Informed System, one of the foundational elements of the Familiar Faces Future State Vision. This funding and technical assistance supports development of comprehensive trauma-informed approach across the health and human service and criminal justice systems in the region.

Potential partners, systems, and organizations (e.g., health and social service providers, ACH participants) needed to be engaged to achieve the results of the proposed project.

This project builds upon multi-sector work done to date in King County through the Familiar Faces Initiative that includes representatives from the criminal justice system, community-based mental health and substance abuse providers, hospitals, housing providers, managed care plans and local government. This project has been one fostered by the King County ACH and would continue to involve a multi-sector implementation team.

Core Investment Components

Proposed activities and cost estimates ("order of magnitude") for the project.

Project Manager to Support the Familiar Faces Steering Committee:

As strategies are implemented, refined, and expanded, the Familiar Faces Steering Committee will be the entity responsible for the development of procedures/protocols/MOU development among the many partners involved. This entity will also be responsible for monitoring data to determine if course corrections are necessary in order to achieve overall outcomes, where cost shifting or cost savings are occurring and potentially serve as a place where shared savings are negotiated. This committee is also responsible for monitoring and oversight of other related strategies that will support the Intensive Community-Based Care Teams, including selection and testing of care tools such as EDIE or Link4Health to support care planning and the recently awarded SAMHSA Trauma-Informed Care grant. Estimated Cost for Project Manager: $125,000/year

Intensive Community Based Care Teams:

Each care team will serve approximately 25 individuals. Care teams would include the following components: ARNP, mental health professionals with substance use expertise, care manager with substance use disorder expertise, mental health or co-occurring disorder expertise, OT/vocational support, peer or community health worker and

housing support specialist. Some of these positions would be funded by traditional Medicaid sources, others would be funded by this project. Given ongoing negotiations, it is unclear how much would be paid for via these funds and how much would need to be paid for via the project. At a minimum we anticipate that care manager and peers/community health workers would be paid for via the project. Estimated costs are below:

Care Team Costs

Care manager with substance use disorder expertise, mental health and co-occurring disorders expertise-(depending on need of client)	$100,000/year
Peer or Community Health Worker	$50,000/year
Total per Care Team	**$150,000/year**

Total Estimated Costs, Number of Individuals Served & PMPY

	Individuals Served	Number of Teams	Team & Project Manager	PMPY
Year 1	250	10	$1,625,000.00	$6,500.00
Year 2	500	20	$3,125,000.00	$6,250.00
Year 3	1,000	40	$6,125,000.00	$6,125.00
Total			**$10,875,000.00**	

How long it will take to fully implement the project within a region where you expect it will have to be *phased in.*
Two years

The financial return on investment (ROI) opportunity, including estimated amounts and associated ROI timeline.
Work is ongoing in the King County Office of Performance of Strategy and Budget to better understand the costs associated with serving the Familiar Faces population in the current system. This includes costs associated with jails stays, court proceedings, behavioral health care costs. We are just beginning to receive claims information about physical health care costs. This information will help us to better understand the ROI opportunities. Based on previous work in the region, we can estimate at a minimum a 15% reduction in emergency department costs and a 10% reduction in hospitalization costs for the population. Because we are just beginning to obtain claims data for the population, we do not have the full picture yet of what this translates into on a per person basis. We anticipate having more information to better understand the ROI opportunities by June 2016.

Project Metrics

The Familiar Faces Steering Committee is working to identify specific measures that can be tied to the overall outcomes that the Future State Vision was developed to address. These measures will pull from the statewide common metrics set and Medicaid starter set. *Potential Examples* are given below.

Improved health status
- Access to Preventive/Ambulatory care

Improved housing stability
- Attainment of housing/reduced homelessness
- Retention in housing for 12+ months (HUD)

Reduced criminal justice involvement
- Reduced jail admissions and days

Reduced avoidable hospital and ED use
- Reduced 30-day all-cause readmission

Improved client satisfaction with quality of life (QOL)
- Improved WHOQOL physical, emotional, social QOL

[i] http://www.chcs.org/media/HNHC_CHCS_LitReview_Final.pdf