Technology Models to Enable Community Based Whole Person Care

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Consultant, Intrepid Ascent

Proposed Agenda

Topic	Facilitator/Presenter	Duration
Introduction to Whole Person Care (WPC)	Keira Armstrong	15 Minutes
Examples from Three WPC Pilot Communities	Mark Shotwell (Marin) Alfonso Apu (San Joaquin) Beth Hernandez (Contra Costa)	45 Minutes
Panel Discussion and Audience Questions	All	30 Minutes

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WHOLE PERSON CARE BACKGROUND

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Whole Person Care Goals

- Five-Year Pilot program (2016-2020) authorized by CMS and administered by DHCS for high-risk and high-utilizing Medi-Cal patients. Currently in Year 3.
- Flexible federal funding to improve health and housing outcomes, and more efficiently and effectively use health care resources
- Pilots identify target populations, assess health and housing needs, coordinate care in real-time, and evaluate outcomes
- Promotes deeper collaboration and coordination between service providers by requiring pilots to form new partnerships and share data

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Target Populations

- Vulnerable Medi-Cal Adults
  - Homeless or precariously housed
  - Medically Complex
  - Mental Health or Substance Use
  - Involved in Criminal Justice Systems
  - Frequent users of emergency services and crisis health systems

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Community-wide, multi-sector collaboration

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Opportunities for WPC Counties

- Build governance and technology infrastructure
- Non-reimbursed service models
- New collaboration with partners working on SDOH
- Build care coordination across various healthcare provider organizations, including behavioral health
- Create processes that may scale to other care coordination programs over time
- Illustrate value in reducing ED utilization

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California Health Care Foundation WPC Research

- Identify and share best practices for:
  - Technology models that support complex care coordination
  - Data sharing with new community partners
  - Sustainability of infrastructure and relationships

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WPC Key Functionality

Eligibility / Enrollment	Identification of target population clients and eligibility determination Consent management Coordinate hand-off to care teams and service providers
Care management tools for proactive care planning	Shared comprehensive care plans Electronic referrals including to non-clinical organizations such as housing services
Clinical data sharing / HIE	Event notifications (e.g. on hospital admit, discharge) Selected information from a client's health record Query-based health information exchange
Analytics	Baseline data Data normalization and data quality monitoring Performance and outcomes monitoring (inform PDSA cycles; reporting)

Community Approaches to Collaboration

- **EHR Based (Contra Costa)**
  - Counties with widely shared EHRs that can expand to include new tools for care coordination, analytics, eligibility
  - Must be able to integrate with non-clinical partners, or partners outside their network
- **Case Management System Based (Marin and San Joaquin)**
  - Counties with no single EHR solution
  - Implementing a shared Care Coordination system for WPC partners
  - Connecting with clinical data sources
    - HIE when available
    - EHRs
    - Alerting tools
  - Assessing tools for data aggregation and analytics

Data Sharing Successes and Challenges

Successes	Challenges
Developing Data Sharing Agreements	
Developing new agreements to allow sharing with new partners	Takes time to build consensus
	Difficult to share Substance Use Disorder Treatment information
Making Data Useful	
Using data for program improvement (plan, do, study, act cycles)	Challenging to gather and consolidate data from multiple sources for reporting
Rapid Systems Transformation	
Building new technical infrastructure and capacity	Automating data exchange and prioritizing data sources and recipients
New contracting mechanisms and service structures	Minimizing duplicate data entry during transitions

Opportunities for expanded use of WPC Innovation

- Health Homes for Patients with Complex Needs Program
- Public Hospital Redesign and Incentives in Medi-Cal Program (PRIME)
- Accountable Communities for Health
- HIE Services Expansion

Marin – Housing based case management for integrated health and housing services
San Joaquin – Expanding clinical care teams for complex care management
Contra Costa – County based case management to better address Social Determinants of Health

PILOT EXPERIENCE

Mark Shotwell, Executive Director

MARIN COUNTY – RITTER CENTER FQHC

Marin County Whole Person Care Housing Based Case Management

A Collaborative with Ritter Center, St. Vincent de Paul, The Housing Authority of the County of Marin, Homeward Bound of Marin, and Marin County Whole Person Care Department

Ritter Center Housing Based Case Management Collaborative

Population served: Homeless and precariously housed, high risk, high cost Medi-Cal Beneficiaries.

Marin WPC Target Population: 3,516 Medi-Cal beneficiaries

Goal: Demonstrate cost savings to State and County to ensure sustainability

Approach:
- Housing First / Assertive Community Treatment
- Address all of a person's social determinants of health—Whatever it Takes!
- Reimbursed on a per member, per month basis (3 interactions per month minimum)
- **$1,447,500 per year for up to 3 years**

Collaborative Partners

St. Vincent de Paul
- Outreach for Information and Referral
  - 2 outreach workers
  - Building upon success of the Homeless Outreach Team (HOT) model

Homeward Bound of Marin
- Housing Focused Shelter

Housing Authority of the County of Marin
- Housing Subsidies and Housing Locator

Ritter Center
- Housing Based Case Management
  - 7 new FTE over next year to serve 130 individuals

Transformative Practices

Assertive Community Treatment and Housing First
- Shared Caseload
- Leveraging a Transdisciplinary Team through partnership with the Ritter Center FQHC (330H) and other County FQHCs
- Daily Triage Meeting
- 24/7 access for urgent and crisis intervention
- Housing is the first intervention (no housing readiness)
- Participation in care is voluntary except for agreeing to minimum weekly home visits—Staff makes themselves irresistible!

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Success so far

- 68 People enrolled
- 35 Housed
- Collaborative is breaking down silos of Outreach, Case Management, Shelter, Medical Care, Behavioral Care and Acute Care
- WPC Universal Consent (Release Of Information) includes information sharing with 32 County and Community Partners

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Success so far

Technology transformations:
- Current Google Drive:
  - allows team to review all Case Manager/client interactions in daily triage
  - able to see services provided by Medical Case Managers from multiple provider agencies and social services.
- New web-based **Case Management System** that will vastly improve the exchange of social needs and health information in real time. (launch is today, October 4, 2018)
- Integration between Case Management system and **Marin County HIE** will allow for physical and behavioral health alerts and curated health information (Q4 2018):
  - Hospital, ER, Behavioral Health system, and Jail admits and discharges.

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Alfonso Apu, Behavioral Health Director

SAN JOAQUIN COUNTY– COMMUNITY MEDICAL CENTERS BEHAVIORAL HEALTH

Community Medical Centers (CMC) San Joaquin

Population served

- Complex Patients, homeless and at risk of homelessness, high utilizer of ED services, and moderate to severe behavioral health difficulties (Target: 2,255 clients)

Goal

- The overall goal of the program is to provide comprehensive services to eligible Medi-Cal beneficiaries enrolled in the County's Whole Person Care (WPC) Pilot, to improve health care outcomes, reduce emergency department utilizations, and provide support services to help mitigate and respond to homelessness or risk of homelessness.

Approach:

- Providing Whole Person Services as part of overall Complex Care Management Program.
- Continuity of integrated Primary Care Services 'Care Team' approach and Care Coordination.
- Utilizing success of Frequent User of ED Program.
- Tier System approach to interacting with patients, same-day appointments, warm-handoff, outreach care team (PA, BH, RN, CM).
- Stratification Process to assess patient needs.

Collaborative Partners

San Joaquin Behavioral Health Services

- Severe Mental Illness services, crisis services, housing and outreach case mangers

San Joaquin General Hospital

Central Valley Housing

Gospel Center Rescue Mission

- Recuperative care
- Recovery services

San Joaquin County Population Health

San Joaquin County Corrections Department

- Referrals from county corrections facility

Health Plan of San Joaquin

CMC: Role in Whole Person Care

- Largest FQHC in area, 17 centers, Recovery Treatment Program offering sobering, assessment, withdrawal and respite services.
- Partner in developing, structuring, and providing services for the program.
- Leveraging an existing integrated “Team Care” approach to Complex Care Participants.
- Participants receive services at 3 levels of care which are coordinated by the new WPC Health Navigator and Case Managers.

CMC: Services Provided

Services provided:

- Mental health assessments, interventions and treatment evaluations
- Crisis management
- Connect to stabilization services such as transportation, meals, housing, non-urgent medical care
- Link to other appropriate community supports to address social needs:
  - Establish a medical home, obtain primary medical care
  - Substance use treatment
  - Apply for SSI and public assistance
  - Link to enrollment counselors for insurance
  - Link to emergency, transitional and permanent housing
- Link to health education services, medical respite and hospice for chronic conditions
- Link to nursing services

Initial Challenges

- Limited options for Lead
- Identifying Lead was disorganized/fragmented, lack of response
- Lack of resources
- Bottle neck of referrals
- Limited data fields on referral form

Successes So Far

Patients Served:
- 316 receiving services
- 38% female, 62% male

New internal tools:
- NextGen Electronic Health Record (Before WPC)
- Care coordination template for Health Navigators and Case Managers
- Shared treatment plans and documentation between all Care Team members

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Successes so Far

New external data sharing capability and collaboration:
- Use of secure centralized platform to **share documents** with community partners and reduce duplication (Box.com)
- **Comprehensive consents** to share information
- HIE is in contracting for a **Case Management platform** to increase community collaboration on a shared care plan
- More partners participating in the **Health Information Exchange**

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Impact on Services

- Shared information including treatment plans, care coordination, documents
- Decreased duplication of services
- Similar shared language
- Effective use of resources and referral with collaborating care partners
- Effective care coordination
- Culture shift towards addressing holistic patient needs

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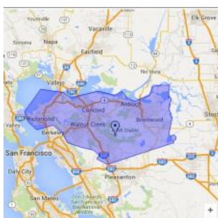
Beth Hernandez, WPC Lead Evaluator

CONTRA COSTA COUNTY– COMMUNITYCONNECT CASE MANAGEMENT

About Contra Costa County

- **Large County Health System**
  - Hospital and County Care Clinics (FQHC – Healthcare for the Homeless)
  - Behavioral Health Division
  - County Jail
  - Public Health School Clinics
  - Dental Vans
  - CCHP (Medi-Cal managed care plan)
- **FQHC Community Providers**
  - LifeLong Medical Care
  - La Clinica de la Raza
- **WPC Target Population:** 15,600

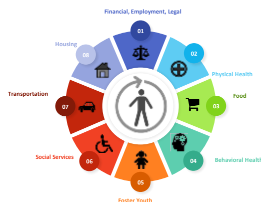


CommunityConnect at a Glance

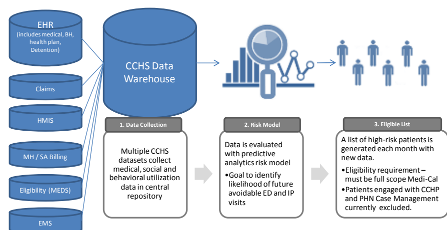
14,400
Patients

150
Direct Service Staff

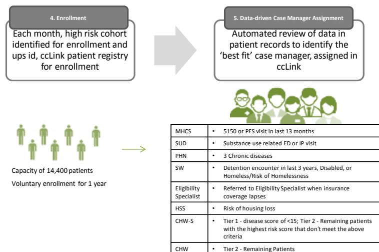
$40 million
pilot project



Patient Identification



Enrollment and Assignment



MHCS	• 5150 or PES visit in last 13 months
SUD	• Substance use related ED or IP visit
PHN	• 3 Chronic diseases
SW	• Detention encounter in last 3 years, Disabled, or Homeless/Risk of Homelessness
Eligibility Specialist	• Referred to Eligibility Specialist when insurance coverage lapses
HSS	• Risk of housing loss
CHW-S	• Tier 1 - disease score of <15; Tier 2 - Remaining patients with the highest risk score that don't meet the above criteria
CHW	• Tier 2 - Remaining Patients

Considerations for a Comprehensive Care Plan

- **Who**
  - is a care team member?
  - has access to the plan?
- **Where**
  - is the care plan located?
- **When and How**
  - is information shared?
- **What**
  - information is included in the plan?

Who

- is a care team member?
- has access to the plan?

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- Care team broader than just WPC staff
- WPC Case Managers
  - Each patient paired with a case manager providing either telephonic or field-based services
  - Case managers sit on multidisciplinary teams and provide internal program consults

PHN PHN PHN MHCS Social Worker
PHN TEAM A Homeless Specialist
PHN PHN CHW-S SAC
CHW CHW CHW PHN MHCS
CHW TEAM E Social Worker
CHW CHW SAC Social Worker

- Disciplines:
  - *CHW – Community Health Worker
  - CHW-S - Community Health Worker Specialist
  - HSS - Homeless Services Specialist
  - MHCS – Mental Health Clinical Specialist
  - PHN – Public Health Nurse
  - SAC – Substance Abuse Counselor
  - SSPA – Social Services Program Assistant (Eligibility Specialist)
  - SW – Social Worker

***** Telephonic Case Management services only**

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Who

- is a care team member?
- has access to the plan?

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WPC Case manager
Community Organization
CCHS Provider Network

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Where

- is the care plan located?

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ccLink
Linking best people, best care
Epic

- Considerations
  - Size of pilot and target population
  - Diverse patient population –
  case managers must collaborate across dozens of agencies
  - IT systems used by different care team networks
  - Currently available technology
- Decision: build care plan into EHR (Epic)
  - Highly integrated system accessible to all CCHS
  - Local hospital network also primarily on same platform, allowing HIE access through Epic's CareEverywhere module
- External Interfaces

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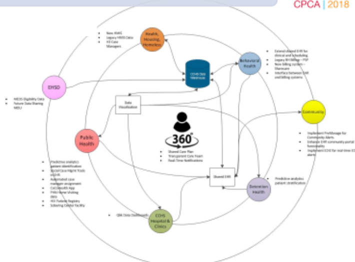
When and How

- is information shared?

- Epic EHR Access
  - Internal CCHS Clinics & Hospital
  - Behavioral Health
  - CCHP Health Plan
  - Detention
  - HIE Portal access to FQHC (La Clinica, LifeLong)
  - CareEverywhere (Epic) to other Epic hospitals (Kaiser, John Muir)
- Care team members outside EHR
  - New bidirectional interfaces with select systems:
    - HMIS
    - Public Health Persimmony
    - EDIE
  - Verbal communication only with signed patient release



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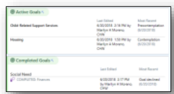
What

- information is included in the plan?

- Existing shared EHR tools
  - Demographics
  - Allergies
  - Medications
  - Utilization History
  - Health Maintenance
  - Health Plan
  - Billing
  - Care team members: PCPs, Care Coordinators, and Behavioral Health Staff
- New WPC tools
  - Social Needs Screening
  - Patient Care Plan - Goals
  - Real-time high risk events notifications
  - Behavioral Health treatment



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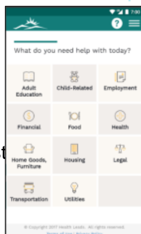
Other Technology Enhancements

- CoCo Health: Patient Facing App
- myChart: Patient messaging
- TigerText/Secure Chat: Patient texting
- HealthLeads: Social needs resources
- EDIE/PreManage: ER Alerts outside of syst
- QLIK analytic dashboards



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QLIK – Staff Level Dashboard

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Successes & Challenges

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+ Successes	- Challenges & Possibilities

• Solid Foundation with existing infrastructure
  • HMIS
  • Community Provider Portal
  • Parsimony/Public Health Nursing
• Use data to drive system integration
  • Data warehouse
  • Internal evaluation team
• Policy Support
  • Comprehensive ROI
• Waiver Integration Team
• Social Needs Screening & Resource Database
• Community Focus
• Investment in Infrastructure
	• Developing case management system within EHR
	  • Integrating social determinants and case management into medical chart
	  • No built in analytics
	
	• Integration with our Human Services division
	  • Conflicting federal and state mandates
	  • Policy limitations re: information sharing
	
	• Massive amount of information to sift through
	  • Infancy stages at tapping into analytic potential and program evaluation
	
	• Impact on administrative departments to support initiatives

CONTRA COSTA HEALTH SERVICES

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DISCUSSION