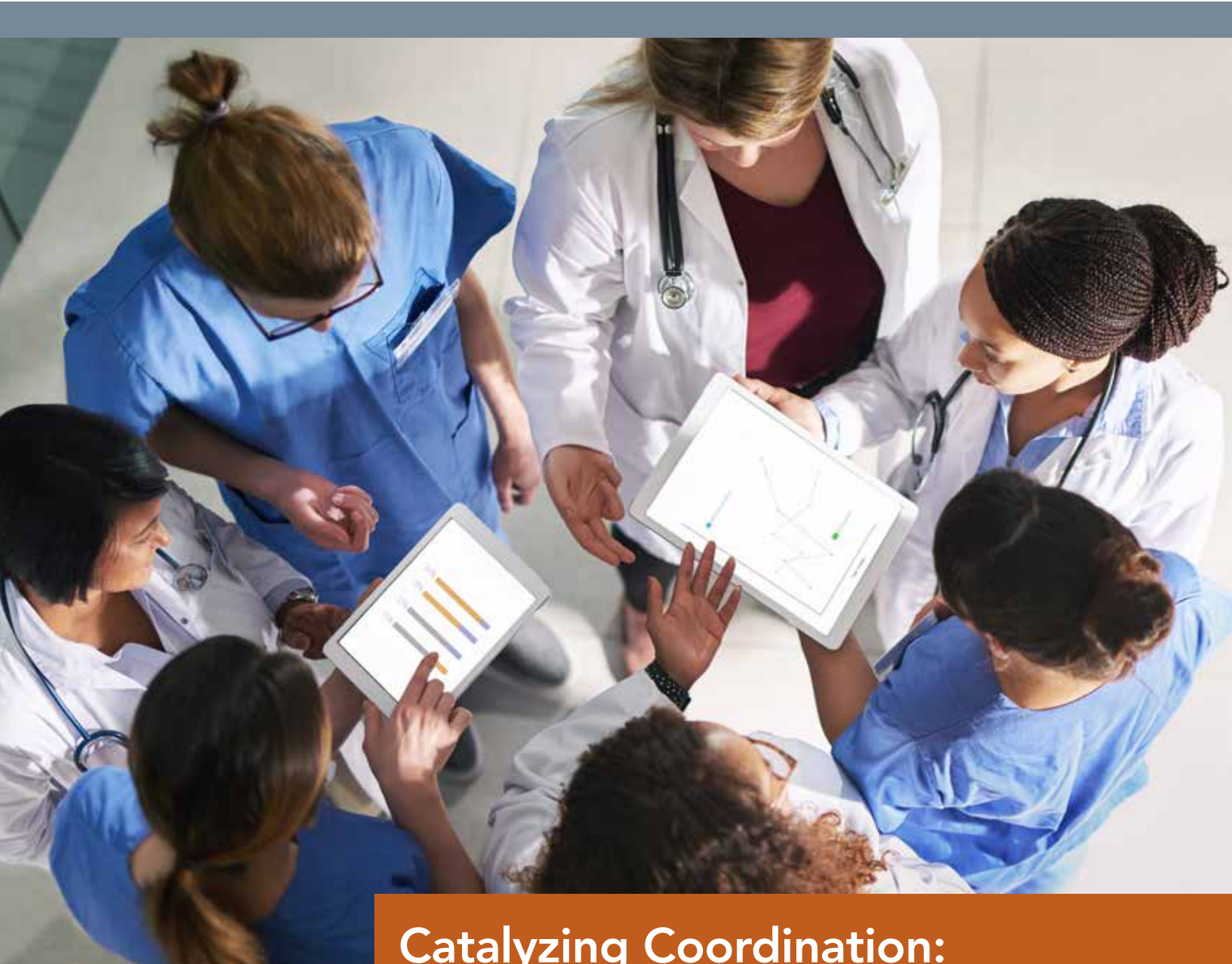




California Health Care Foundation



## Catalyzing Coordination: Technology's Role in California's Whole Person Care Pilots

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## About Intrepid Ascent

Intrepid Ascent guides health care organizations through the adoption and use of information technology to reach their clinical and business goals. Intrepid Ascent's services identify strategic pathways to integrated care, promoting the exchange and use of information to enhance value in a learning health system.

For more information, visit [www.intrepidascent.com](http://www.intrepidascent.com).

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## About the Foundation

The California Health Care Foundation is dedicated to advancing meaningful, measurable improvements in the way the health care delivery system provides care to the people of California, particularly those with low incomes and those whose needs are not well served by the status quo. We work to ensure that people have access to the care they need, when they need it, at a price they can afford.

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# Executive Summary

Imagine if our health care system could seamlessly coordinate care to meet all of a patient's physical, behavioral, and social needs. The impact would be enormous. Downstream health outcomes would improve, and costs to the health care system, as well as to individual patients, would decrease. Value-based payment systems would truly be feasible. With this vision in mind, many large payers and providers have recently announced significant investments in care integration.<sup>1</sup>

Integrating care across sectors is no easy task. The breadth and depth of new partnerships and systemic changes required to truly integrate services across the continuum of care can be dauntingly complex. This report offers an unvarnished look at one California initiative undertaking this challenge. California's Whole Person Care (WPC) pilot is a five-year, \$3 billion waiver program that includes 25 counties and one city pursuing pilot projects<sup>2</sup> to integrate care for a subset of Medi-Cal patients. Specifically, the WPC pilot targets individuals who have multiple chronic conditions, as well as those who are experiencing homelessness or other social and behavioral health crises.

This report discusses the technological challenges and successes encountered by pilot participants as they have begun to implement new systems and solutions to accomplish the goals of WPC. (See Appendix A for a glossary of abbreviations used in this report.) While integrated care requires an array of capabilities, one of the most fundamental is an organization's ability to share data. If entities cannot effectively exchange information about the patients they share, then they cannot effectively coordinate care for those patients.

## Technology Opportunities and Challenges in WPC

The WPC pilot involves a diverse array of stakeholders, services, and data found within the participating entities, and the needs of the program's target populations are great. All but one WPC pilot, which is led by a city, are led by a county entity, and all involve numerous county partners — including non-health care agencies, such as criminal justice and housing — as well as a host of local health care and social service providers.

The WPC opportunity has galvanized pilot counties to develop meaningful solutions for care coordination across sectors, providing both funding and guidelines for change. In attempting to establish common means of sharing data and coordinating care among myriad entities, WPC pilots must navigate a range of issues, both technological and organizational. While they are equally important, the technological issues offer tangible, actionable opportunities for innovation and are the focus of this paper.<sup>3</sup> The findings reported are based on 25 survey responses and 20 in-depth interviews conducted with pilot participants. Case studies of two counties illuminate the innovative thinking and sustained effort that has led to technology-facilitated breakthroughs with care coordination.

## Opportunities for Technology Vendors

Several specific technological capabilities have emerged as especially critical to fulfilling the core competencies required of WPC pilots. None of these capabilities are unique to WPC, however; and all have value to offer to other care integration initiatives. Some of these capabilities are already offered by health information exchange organizations (HIEs or HIOs) and electronic health records (EHRs) as part of broader solutions, so vendors developing these capabilities as stand-alone solutions must be able to demonstrate their unique value.

These capabilities include the following:

- ▶ **Care coordination and case management.** WPC and other integrated care initiatives are creating a new demand for shared platforms for team-based, proactive care planning and coordination. These tools must be accessible and functional for a wide range of users, in both clinical and social service settings, and often must operate alongside existing systems for care and service documentation, such as EHRs and Homeless Management Information Systems (HMISs).
- ▶ **Data quality monitoring and improvement.** Being able to assess and enhance the quality of data from diverse sources is critical to the success of any complex interdisciplinary, interagency care coordination effort.
- ▶ **Flexible data analytics and reporting.** At a minimum, WPC pilots and other care integration efforts need to meet government or payer reporting requirements. User-friendly, customizable

reporting tools that automate data integration can save huge amounts of time. WPC pilots are also required to implement multiple data-driven Plan-Do-Study-Act (PDSA) improvement cycles over the course of the program, which benefit from analytic systems that enable insights. Many entities are also seeking more advanced analytics tools to help them continually assess and refine the deployment of finite resources, such as street team outreach workers.

- ▶ **Identity management.** Patient record matching can prove especially difficult for multi-organizational networks, like WPC pilots, serving transient populations that have frequent gaps or changes in key identity attributes, such as phone number or address. WPC pilots with small enrollee populations have primarily relied on manual identity management methods, but only more automated solutions are truly sustainable and scalable.
- ▶ **Data sharing across sectors.** Even pilots that have a robust EHR or regional HIO meeting their basic clinical data exchange needs may still find additional features, such as real-time emergency department (ED) alerts, useful. They may also need custom integrations with systems from different service sectors. For example, some pilots have struggled to efficiently share data with HMIS, the homelessness reporting system used to interface with the US Department of Housing and Urban Development.
- ▶ **Social service referrals.** A growing number of vendors are attempting to provide social service directories that allow for easy referrals from clinical care settings into social service settings. However, providers continue to find them lacking when it comes to providing real-time capacity updates, closing referral loops, and enabling bidirectional data sharing and communications with the service providers. Providers are also seeking tools that can proactively suggest tailored referrals based on patient data and algorithms.
- ▶ **Real-time communication for team-based care.** In the past, providers have relied largely on secure email, faxing, and phone calls to collaborate securely. But these methods do not lend themselves well to high-touch coordination of care among dispersed team members for many

patients at once. These modes of communication can also be impractical for frontline workers, who may only have mobile devices or may need more immediate responses. Providers are seeking secure solutions that enable real-time and continuously available engagement, such as texting or instant messaging, or care coordination tools that include secure mobile apps for communication.

## Common Technology Implementation Challenges

As the WPC pilots have sought to implement new technology-enabled solutions, and add features to existing ones, they have encountered a range of challenges. Here are some of the most common ones:

- ▶ **Building consensus around a technology approach.** With so many different data systems used by so many partnering organizations, pilots must agree on a shared technology approach to facilitate the coordination of services. Generally, pilots have chosen one of two paths. They have either added features and users to an existing EHR system — generally the county's EHR — or implemented a new care coordination platform for all entities to learn and use. Some pilots have also procured additional niche technology tools to fill in feature gaps, such as real-time care alerts.
- ▶ **Aggregating data from many systems.** There is an overwhelming volume and diversity of data potentially available from participating entities. Pilots are struggling to access, aggregate, and analyze these data efficiently. When data are integrated poorly, the consequences compound downstream, for example, inhibiting patient matching or slowing down results reporting. Rather than risk these issues, many pilots are still relying heavily on duplicative and manual data entry.
- ▶ **Ensuring technology complies with nuanced policies and agreements.** In order to streamline the sharing of patient data, many pilots have taken steps to develop new, more comprehensive data-sharing agreements and patient authorization forms. The work does not end there, however — pilots must find technology solutions that can honor and implement these nuanced agreements. Similarly, pilots must ensure that data-sharing solutions meet 42 CFR Part 2, or "Part 2," regulations,



which govern the disclosure of most substance use disorder (SUD) treatment data — when required. Some pilots have sought out care coordination tools with robust consent management features to help with disclosure compliance and transparency.

- **Navigating partners' skepticism of new technology tools.** While many pilots have successfully deployed technology to facilitate collaboration within county entities, such progress has been slower when it comes to external community partners. Some health care entities have balked at sharing clinical data with non-health care partners who have no experience handling protected health information. Other entities, such as some small, community-based organizations, are reluctant to change from paper-based data collection and referrals to the digital methods embraced by the pilots.

These are certainly not the only challenges that the WPC pilots have encountered as they have sought to implement data-sharing and care coordination solutions. Other challenges include developing and executing a clear and inclusive vision, piloting new staffing models, navigating complex legal issues, establishing new relationships, and identifying pathways to long-term sustainability. While technology can certainly play a role in overcoming some of these challenges, it is not sufficient to solve any of them alone. Those looking to dive deeper into these more organizationally and legally oriented challenges, as well as additional data-sharing challenges, should refer to the California Department of Health Care Services (DHCS)'s midpoint assessment paper.<sup>4</sup>

An in-depth look at two counties — Marin and Contra Costa — and how technology opportunities and challenges have manifested in these different settings is provided in the case study section of this report. The two counties profiled differ in fundamental ways that have in turn affected the role technology has played in their WPC approaches. Contra Costa County has an extensive, integrated, county-run health system and a population about five times the size of Marin's. In contrast, Marin County's WPC services are provided through a broader network of community partners, and their budget is approximately one-tenth the size of Contra Costa's.

## Conclusions

The progress of the WPC pilots thus far reflects and supports a broader shift toward more coordinated care, with an innovative focus on shared care planning across sectors. These pilots have done much of the hard and underappreciated work of building the critical infrastructure without which a more integrated health care system cannot exist. That infrastructure is legal and organizational — consensus around patient consent forms, data-sharing agreements, and interpretations of complex regulations — as well as technological — shared systems for exchanging data and coordinating care.

There is great variation in the amount of progress achieved by the 25 pilot programs thus far. Many of these differences are due to the strong local dynamics that exist both within health care ecosystems and in the broader communities they serve. The systems and capabilities already in place in each community before their WPC pilots began have profoundly shaped how pilots have unfolded since, from the technology infrastructure they have built to the priorities and partnerships they have pursued.

Another important driver of WPC progress has been the counties themselves, whose leadership, infrastructure, and resources have had an impact on attempts at integrating care. Counties offer centralized access to the many nonclinical partners — including housing, behavioral health, and criminal justice agencies — that are vital to coordinating comprehensive services for vulnerable patients. Counties are also strongly motivated to improve outcomes for the people most likely to use their most strained and resource-intensive services, such as jails and EDs.

The remaining duration of the WPC pilot will allow counties to solidify technology implementations and document the impact of better, more proactive care coordination. The program's emphasis on continual quality improvement has equipped counties well to continue refining their approaches to service delivery and collaboration. Though funding for the WPC pilot will sunset at the end of 2020, this innovative investment made by the state's Medi-Cal program, with federal funding support, has generated significant momentum that promises meaningful returns. If communities continue to strengthen the infrastructure and relationships they built during this pilot, their pathways to achieving truly integrated care should remain bright beyond 2020.

# Project Background and Approach

## Background

Whole Person Care (WPC) is a five-year program (2016–2020) authorized by the Centers for Medicare & Medicaid Services (CMS) under California’s Medi-Cal 2020 waiver and administered by the California Department of Health Care Services (DHCS), for Medi-Cal beneficiaries who have the greatest needs and use the most services. Up to \$1.5 billion in federal funds is matched by \$1.5 billion in local public funds to support “the coordination of health, behavioral health, and social services, as applicable, in a patient-centered manner with the goals of improved beneficiary health and wellbeing through more efficient and effective use of resources.”<sup>5</sup> Pilots are asked to demonstrate increased care coordination, increased access to social services, improved housing stability (if applicable), improved health outcomes, and reductions in avoidable use of emergency and inpatient services, among other measures.<sup>6</sup> Eighteen pilots were funded in a first round in November 2016. A second round of pilots were approved in June 2017, adding seven more.<sup>7</sup> Harbage Consulting summarizes the 25 approved WPC pilots — their target populations, proposed strategies, and budgets — in a paper originally written in 2017 and updated in 2018.<sup>8</sup>

Each WPC pilot was encouraged to identify its own target populations under the umbrella of vulnerable Medi-Cal adults. Target populations include individuals who meet any or all of the following criteria:

- ▶ With repeated incidents of avoidable emergency department (ED) use, hospital admissions, or nursing facility placement
- ▶ With two or more chronic conditions
- ▶ With mental health and/or substance use disorders (SUDs)
- ▶ Who are high-risk pregnant mothers
- ▶ Who are currently experiencing homelessness
- ▶ Who are at risk of homelessness, including individuals who will experience homelessness upon release from institutions (e.g., hospital, skilled nursing facility, rehabilitation facility, jail/prison, etc.)<sup>9</sup>

WPC has provided opportunities for counties to develop service strategies that are not currently reimbursed by Medi-Cal to address the broad needs of these clients who have complex care needs. It has encouraged new collaboration with partners working on the social determinants of health (SDOH) to connect clients with primary care and support services and reduce use of crisis systems such as hospital EDs or criminal justice. The need for intensive cross-discipline collaboration has pushed pilots to build broader data governance and technology infrastructure to enable data sharing across sectors.

## Research Approach

The California Health Care Foundation partnered with Intrepid Ascent (Intrepid), a health information technology (IT) consulting company, to understand the technology and policy solutions that pilots are developing to meet the requirements of WPC. In particular, the research focused on understanding the opportunities and challenges pilots are encountering related to data sharing, a fundamental prerequisite for any kind of care integration or coordination work. In the spring of 2017, Intrepid surveyed all 25 WPC pilots to learn more about technology tools required to do WPC work in general and data sharing in particular. In addition, Intrepid interviewed 10 WPC pilots to learn more about their approaches. These surveys and interviews revealed a range of common lessons learned about the tools, policies, and relationships required to deliver WPC and implement effective data sharing.

To better understand the types of innovation happening within WPC pilots, the research team identified two counties that have taken very different approaches yet encountered successes and challenges shared by many other pilots. One is a large, densely populated county with a highly integrated, county-run health system (Contra Costa), and the other is a midsize county with no county-run health system (Marin). The case study process included additional document review and 10 key informant interviews with stakeholders in each county. The counties identified both internal staff and county or community partners that could speak to specific data-sharing successes and challenges thus far.

# Common Data-Sharing Needs and Approaches

The four core functionalities required by WPC and described in Table 1 all require pilot participants to engage in some form of data management and exchange. Pilots vary widely in the technology tools they use for these tasks and in how they are using WPC funding to make progress toward a more automated and integrated vision.

**Eligibility and enrollment.** To identify the Medi-Cal patients who meet their defined eligibility criteria, pilots must aggregate a diversity of data sets, including utilization data from the Medi-Cal health plan, Medi-Cal status from statewide databases that track enrollment (MEDS or C-IV), homelessness information from a Homeless Management Information System (HMIS), and additional usage information from other billing systems. In most counties, data aggregation and eligibility determination are mostly manual processes. The ability to automate eligibility through computer modeling requires having sufficient internal IT resources to manage a data warehouse that can regularly receive data from key sources. While manual eligibility determination works for smaller programs, the ability to take programs to scale could depend on automation of these processes.

**Care coordination and planning.** Pilots must bring together health care and service providers from different county departments, community-based organizations, and health systems to proactively coordinate care. The county health and human services department is often the lead entity for WPC pilot projects (with some exceptions). Other important partners include the following:

- ▶ County departments (behavioral health, public health, probation, sheriff, county jail)
- ▶ Health system partners (county and/or private hospitals, community medical centers, community mental health providers, SUD treatment providers, health information exchange organizations [HIEs or HIOs])
- ▶ Payers (Medi-Cal managed care plans)
- ▶ Community-based service organizations (shelter and housing providers, homelessness service providers, food security organizations, reentry organizations)
- ▶ Other public entities (e.g., housing authorities)

An optimally comprehensive care coordination strategy would provide partners with appropriate access to historical health information and real-time utilization alerts, as well as a shared place to proactively plan and coordinate care.

**Table 1. WPC Technology and Data Exchange Needs**

FUNCTIONALITY	PROGRAM TASKS
<b>Eligibility and enrollment</b>	<ul style="list-style-type: none"> <li>▶ Identification of target population clients and ongoing eligibility determination</li> <li>▶ Consent management</li> <li>▶ Coordination of handoff to care teams and service providers</li> </ul>
<b>Care coordination and planning</b>	<ul style="list-style-type: none"> <li>▶ Shared comprehensive care plans for proactive planning</li> <li>▶ Secure care team communication and collaboration</li> <li>▶ Electronic referrals, including referrals to non-health care organizations such as housing services</li> </ul>
<b>Health information exchange (HIE)</b>	<ul style="list-style-type: none"> <li>▶ Event notifications (e.g., on ED or hospital admit and discharge)</li> <li>▶ Selected information from a client's health record</li> <li>▶ Query-based HIE</li> </ul>
<b>Analytics and reporting</b>	<ul style="list-style-type: none"> <li>▶ Aggregating baseline data</li> <li>▶ Data normalization and data quality monitoring and improvement</li> <li>▶ Patient identity matching across diverse sources</li> <li>▶ Performance and outcomes monitoring (inform Plan-Do-Study-Act [PDSA] cycles; reporting)</li> </ul>

**Health information exchange (HIE).** Health information exchange is the process by which entities share health information across systems. By requiring care coordination across a large number of providers, WPC has reignited the need to develop and expand HIE capabilities among all levels of clinical providers. WPC is providing new use cases for HIE in communities that do not have access to cross-organizational information through a common electronic health record (EHR) network (like Epic's Care Everywhere). Some smaller pilots are implementing lighter, more targeted solutions such as alerting tools (offered by vendors such as Collective Medical) to locate priority patients at points of care, alert care team members to crisis events, and better track use of crisis systems such as EDs. Others are leveraging existing community HIE infrastructure, such as nonprofit regional HIOs, to streamline data sharing in and out of WPC data systems.

**Analytics and reporting.** WPC emphasizes continual assessment, a focus on program improvement through Plan-Do-Study-Act (PDSA) interventions, and reliable tracking of patient and program outcomes. Without reliably and regularly reported data, counties struggle to get a clear picture of their progress — let alone to file the basic reports required of them.

## Common Challenges in Building Data-Sharing Infrastructure

As pilots have attempted to build the systems, both organizational and technological, required to enable these four core capabilities, they have encountered a range of challenges. The survey and key informant interviews identified a few broad trends across the pilots. While some relate very tangibly to the mechanisms of data exchange, others intersect with broader organizational issues.

### Developing Agreements

Most counties had existing agreements for sharing medical information between some key partners at the outset of their respective pilots. However, as pilots have realized that their WPC work could benefit from sharing behavioral health information with more partners, or sharing

housing status information with clinical partners, they have decided to pursue more comprehensive data-sharing agreements. Most counties have also developed a universal client authorization or consent form, or release of information (ROI), that clients sign as part of their enrollment in WPC. Establishing patient consent and data-sharing procedures is critical to program success, but it takes time to develop such procedures with a large set of participating organizations. (See Appendix D for sample consent forms from participating counties.)

## Sharing Behavioral Health Information

Pilots understand the promise of more robust behavioral health data-sharing capabilities: better facilitation of WPC participants' movement through levels of behavioral health care, more effective triaging of mental health services, and a way to ensure that services are not duplicated. But the pathway to implementing those capabilities can be less clear. While many counties are further integrating mental health service information, and substance use information that is not governed by 42 CFR Part 2 regulations, most have struggled to share information from county substance use treatment programs. Two recent publications from the California Health Care Foundation offer pilots constructive guidance for navigating the challenges — some perceived and others real — surrounding the oft-misunderstood Part 2 regulations.<sup>10</sup>

## Technological Transformation Driving Systemic Changes and Challenges

Pilots' pursuit of new solutions for care coordination and data sharing has inevitably necessitated broader systemic changes, including changing contracting mechanisms, building new service structures or teams, and developing both technological infrastructure and internal staff capacity. Teams are finding it challenging to build new technological infrastructure while simultaneously trying to provide new services. As change happens in phases, it is often difficult to avoid duplicate data entry or workflow processes while systems are being established or are building to their full functionality.

The process of implementing shared technology systems and policies also inevitably necessitates participation by many partners. Constructive new relationships and



collaborations have blossomed both within counties and across sectors as a result. The case studies presented later in this paper provide additional examples and benefits of these new opportunities for collaboration.

## Making Data Useful

Counties are making new connections, gathering new data sources, and using data for program improvement through PDSA cycles required by WPC. These processes encourage counties to continually monitor their program structure and make adjustments to improve program quality throughout the life of the project. Additionally, counties are asked to report on client outcomes for defined measures, which requires linking WPC services with health care utilization. This process is providing new visibility into unduplicated numbers of vulnerable clients in a county and how those clients interact with various systems and services within a county. However, while relationships, agreements, and technology systems are being established, it is often a very manual labor-intensive and time-consuming process to consolidate and aggregate data from multiple sources for reporting.

## Choosing a Core Technology Model

In order to provide a central platform on which the core sharing and coordination functionalities required by WPC can take place, pilots must choose to either expand existing technology infrastructure or develop new infrastructure. At this point in the pilot program, most counties are still building and optimizing their technology systems, and very few have fully established their long-term approach. Through a review of all 25 pilots, two common broad technology architecture models were identified.

**1** The first commonly used model is an **electronic health record (EHR) approach** that builds on and expands existing EHR tools within the county. This approach works well in counties that have an integrated health system and a well-established and modern EHR that is widely shared. In a region with broad access to the same EHR, using that EHR for data sharing can be efficient. It requires that county divisions all be on the same EHR and that the pilot have comprehensive arrangements or partnerships between required service providers within a WPC region to provide the appropriate levels of access and integration. In some pilots this may be difficult given that many different EHRs may be

in use across WPC partners. However, in areas where it is a feasible option, this approach enables participants to begin data-sharing projects with greater ease, speed, and foundational preparedness. Customization and/or integration of additional data sources may be required to make the EHR usable for care coordination.

**2** The second approach focuses on **building a new, shared care coordination system** that can be accessed by a wide variety of partners and integrated with other data systems. This approach provides a centralized solution that bridges the gap in areas where WPC partners do not share a common EHR. This approach also offers nuanced levels of protection for sharing sensitive data. It may also provide the ability to reduce duplicate data entry by establishing methods for data to flow back and forth between the systems people usually use to do their work. If there are a large number of partners, it may be necessary to create connections between the care coordination system and many partner systems, which can be labor intensive. However, existing regional HIOs often gather information from many clinical sources and act as a single source of connection to the care coordination system for all of those clinical sources, greatly simplifying the effort required to connect. Gathering different types of data into a care coordination tool may reduce the need for data warehouses or data-aggregating tools (see Appendix B for a glossary of technology terms).

Table 2 (page 10) details how pilot resources and service structures can influence both implementation strategy and long-term development. Regardless of the model they choose, all pilots are building on existing infrastructure and are making decisions about how to expand or replace technology tools to meet new demands for identifying frequent users, coordinating care, and conducting evaluation and reporting activities. Finding the right tools to support both short- and long-term goals is challenging.

While Table 2 outlines how aspects of a pilot's existing infrastructure can affect its choice of technology model, those are not the only factors. Pilots must also consider broader organizational dynamics.

**Budget and IT capacity constraints can be limiting factors.** For many pilots, budget constraints limit the technology tools and approaches realistically available to

them. Similarly, the capabilities and capacities of internal IT staff and assets can constrain what is possible, especially when it comes to automation and integration. Where money is available and internal IT capacity is not, external contractors can certainly help fill in gaps. However, building up internal IT capacity is the best pathway to ensuring sustainability when WPC pilot funding ends.

**Ongoing assessment and user engagement are critical to build buy-in.** Putting in place ongoing processes for engaging with end users to refine and develop tools is critical to increasing the likelihood of long-term adoption. Just as important is the use of ongoing monitoring tools to objectively assess the performance of new systems and correct course as needed.

**Consensus around minimum data requirements can be difficult to build.** Counties are engaging in important conversations between divisions and partners about the minimum information required to provide care for complex clients. Partners are working to assess the value of data from various sources and be specific and comprehensive about what is needed.

**Leadership matters.** Finally, while the solutions and approaches WPC pilots choose depend on many factors, their success ultimately relies on county leadership having a strong understanding of the value of effective data sharing and the resources and support required to implement it. This includes a commitment to navigating regulatory and political issues, which can be especially complex surrounding sensitive data and organizational

**Table 2. How Existing Pilot Infrastructure Shapes Technology Model Choices**

	EHR MODEL	CARE COORDINATION MODEL
<b>Level of county integration</b>	<ul style="list-style-type: none"> <li>▶ Highly integrated county health system</li> </ul>	<ul style="list-style-type: none"> <li>▶ Less-integrated county health system</li> </ul>
<b>Using and adapting existing county technology</b>	<ul style="list-style-type: none"> <li>▶ Best for pilots with widely shared EHRs that can expand to include new tools for care coordination, analytics, and eligibility management</li> <li>▶ Usually leverages an existing system and therefore does not require a new system procurement</li> <li>▶ One system for all users</li> </ul>	<ul style="list-style-type: none"> <li>▶ Best for pilots with no single EHR solution; community HIO may or may not be present</li> <li>▶ Common for counties with different EHRs for physical health and behavioral health divisions, and for key community partners like hospital systems</li> <li>▶ Generally requires a new IT system procurement</li> </ul>
<b>Case management service approach</b>	<ul style="list-style-type: none"> <li>▶ WPC case management services provided by internal county staff</li> <li>▶ All county staff use the same technology tool</li> </ul>	<ul style="list-style-type: none"> <li>▶ WPC case management contracted to external service providers, who must often operate alongside internal county staff</li> <li>▶ Staff at contracted organizations use different technology tools</li> </ul>
<b>Connecting data sources</b>	<ul style="list-style-type: none"> <li>▶ Members of the multidisciplinary clinical teams share the same EHR</li> <li>▶ Single data source for reporting and analytics</li> </ul>	<ul style="list-style-type: none"> <li>▶ The care coordination tool must gather curated clinical information via:               <ul style="list-style-type: none"> <li>▶ Regional HIO,</li> <li>▶ Connecting directly to individual EHRs, and/or</li> <li>▶ Using third-party alerting tools</li> </ul> </li> <li>▶ Automated connections to external data sources required to bring programs to scale</li> </ul>
<b>Cost of developing care coordination capabilities</b>	<ul style="list-style-type: none"> <li>▶ Few EHRs include out-of-the-box solutions for case management; need resources to build modules and/or templates</li> </ul>	<ul style="list-style-type: none"> <li>▶ Multiple efficient and lightweight solutions exist that can be implemented relatively quickly and adapted to many use cases</li> <li>▶ Still requires some customization to support WPC workflows but generally already built to optimize care coordination and team communication capabilities</li> </ul>

politics. All counties that have had success with increasing safe and secure data sharing among departments and with community partners have also had active and collaborative relationships with administrative leadership, including compliance officers and legal counsel, as well as support from political leadership.

## Opportunities for Collaboration

WPC pilots are not occurring in a vacuum and involve many incentives, stakeholders, and policies that overlap with other initiatives happening around the state. In the best of cases, these areas of overlap have produced fruitful new partnerships and collaborations, a few of which are outlined below.

**Partnering with Coordinated Entry for housing placements.** Concurrent with the start of WPC pilots, the US Department of Housing and Urban Development (HUD) began requiring Coordinated Entry (CE), defined by HUD as a “process that standardizes the way individuals and families at risk of homelessness or experiencing homelessness access [and] are assessed for and referred to the housing and services that they need for housing stability.”<sup>11</sup> Since many WPC pilots target clients who are experiencing homelessness or are at risk for homelessness, many counties have fostered close collaboration between WPC and CE teams.

These teams often work together to triage clients into appropriate housing placements and levels of case management services. Their newfound ties can also foster the exchange of valuable data, providing housing providers with more information about their clients’ physical and mental health issues, and giving clinical providers more insight into their patients’ social situations. However, the logistics of that exchange can be challenging. For example, most CE programs integrate and track their data within an HMIS, the reporting system required by HUD. WPC teams use other systems for reporting, so the two teams must collaborate to develop means of sharing information across both technology systems and data types.

**Helping counties prepare for Health Homes implementation.** While CE focuses on pairing clients with case management services related to housing, other state programs are also supporting clients with complex

medical needs to combat the high costs and poor health outcomes that result from beneficiaries using crisis services such as emergency rooms for nonemergent needs. The Health Homes Program (HHP) is a Medi-Cal program that supports Medi-Cal managed care plans to provide comprehensive case management for clients with two or more chronic conditions who are frequent users of the health system. The goal is for those managed care plans to partner with WPC pilots to establish care teams and coordination systems in preparation for Health Homes implementation. Three California counties have already implemented Health Homes, and an additional 11 counties are scheduled to do so in July of 2019.<sup>12</sup>

**Partnering with criminal justice to reduce recidivism.** California has taken steps to reduce overcrowded prison populations, reform sentencing, increase treatment options for those on post-release supervision, and reduce recidivism. Some WPC pilots are working with county criminal justice partners to facilitate transitions out of county jails and into appropriate clinical treatment, housing solutions, and/or supportive community services. WPC pilots can also help counties keep people out of the criminal justice system by connecting them to other intervention and treatment options, including behavioral health and SUD treatment services.

## Opportunities for Technology Vendors

Our surveys, interviews, and case studies uncovered myriad opportunities for technology vendors to enhance WPC pilots’ capabilities related to data sharing and care coordination. These capabilities are vital to the implementation of many forms of integrated care, and as such, they have scalability and value well beyond the scope and horizon of the WPC demonstration.

Technology vendors interested in pursuing partnerships with counties, as well as other public sector partners, should be aware of some unique challenges. For example, the contract and response to the request for proposal (RFP) are considered legal documents. Any functionality proposed by the vendor but not actually available in the product can create a material breach of contract. Also, procurement timelines can be lengthy due to complicated contracting, board of supervisor approval processes, and other government guidelines for procurement.

## High-Priority Technology Needs

**Data quality monitoring and improvement.** Being able to assess and enhance the quality of data from diverse sources is critical to the success of any complex interdisciplinary, interagency care coordination effort. Interoperability across clinical and other service providers requires a robust means of mapping and standardizing data within the case management solution. This may be offered via background capabilities within the case management solution itself or may be provided by a third-party software that provides an integration engine, which could include the services of a local or regional HIO. Los Angeles county uses a third-party integration engine that is not operated by an HIO, where the data extracted or transferred from other systems for use within the case management solution are validated, mapped, and prepared for input within the care coordination application. In contrast, the vast majority of the interoperability services in both Marin and San Joaquin counties is being handled by the local HIE, with the case management solution providing only the “last mile” of interoperability support. EHR-based counties tend to rely heavily on national networks such as Epic’s Care Everywhere to manage interoperability, with the EHR itself or its related interoperability modules providing these functions.

**Data sharing across sectors.** Even pilots that have a robust EHR or regional HIO that meets their basic clinical data exchange needs may still desire additional features, such as real-time ED alerts. They may also need custom integrations with systems from different service sectors. For example, some pilots have struggled to efficiently share data with HMIS, the homelessness reporting system used to interface with HUD.

**Flexible data analytics and reporting.** At a minimum, WPC pilots and other care integration efforts need to meet government or payer reporting requirements. User-friendly, customizable reporting tools that automate data integration can save huge amounts of time. WPC pilots are also required to implement multiple data-driven PDSA cycles over the course of the program, which benefit from analytic systems that enable insights. Many entities are also seeking more advanced analytics tools to help them continually assess and refine the deployment of finite resources, such as street team outreach workers.

**Care coordination and case management.** WPC and other integrated care initiatives are creating new demand

for shared platforms for team-based, proactive care planning and coordination. These tools must be accessible to a wide range of users, in both clinical and social service settings, and often must operate alongside existing systems for care and service documentation, such as EHRs and HMIS. Common uses of these tools include tracking consent, identifying and connecting a multidisciplinary care team, making referrals to a variety of services and providers, providing secure communication, tracking client goals, and facilitating task management.

**Public data systems integration.** A growing focus on SDOH through WPC as well as other programs will only increase the need for connections between social service systems and clinical systems, and drive demand for the ability to analyze and report on data derived from both systems. One example is connecting software tools that support housing services with clinical providers who are serving the same clients. HMIS systems are specifically designed to meet HUD reporting requirements. While counties are able to design custom modules themselves, HMIS vendors do not support these modules. Many counties have also had challenges in creating connections between their HMIS system and other county data systems. Some vendors are starting to establish relationships to bridge this divide between housing services providers and health services providers.

**Identity matching.** Patient record matching — the process of accurately matching a patient with all of his or her existing medical records — can prove especially difficult for multi-organizational networks, like WPC pilots, serving transient populations. Such populations often have gaps or frequent changes in key identity attributes, like their phone number or address, making matching more difficult. WPC pilots with small enrollee populations have primarily relied on manual identity management methods, but automating this process will make it sustainable and scalable. Technology tools like master person indexes (MPIs) exist to match patient records from different sources, even when their information is slightly different, thereby preventing the creation of duplicate records and maintaining the usability of the data within connected systems. Some MPI tools can also assist in processing duplicate record backlogs and merging and cleaning data, easing the burden of manually reconciling duplicate records. Some pilots have access to MPI solutions via their EHR or local or regional HIOs, but others do not — furthermore, the quality and accuracy of existing patient-matching solutions can vary.

**Social service referrals.** Although a growing number of vendors (2-1-1, Aunt Bertha, and Health Leads) provide social service directories that allow for referrals from clinical care settings into social service settings, providers find them lacking when it comes to:

- ▶ Providing real-time capacity updates,
- ▶ Maintaining resources and information in multiple languages,
- ▶ Closing referral loops, and
- ▶ Enabling bidirectional data sharing and communications with the service providers.

Ideally, these platforms would offer up-to-date provider directories with sophisticated search ability. Providers are also seeking tools that can proactively suggest tailored referrals based on patient data and algorithms.

**Real-time communication for team-based care.**

Historically, providers have relied largely on secure communication methods with lengthy response times, such as secure email, faxing, and voicemails. But these methods do not lend themselves well to high-touch care coordination among dispersed team members caring for many clients at once. They can also be impractical for frontline workers, who may only have mobile devices or may need more immediate responses. Thus, providers are seeking secure solutions that enable more real-time and continuously available engagement, such as texting or instant messaging, or care coordination tools that include secure mobile apps for communication.

## Conclusions

With two years remaining in the WPC demonstration, pilots have made significant strides in building the technological and organizational infrastructure required to deliver truly coordinated care for clients with complex needs. Pilots' technological progress has included, albeit to varying degrees, the integration and aggregation of data from myriad systems, the implementation of new or augmented solutions for care coordination and data sharing, and the adoption of actionable analytics and reporting tools. Most pilots, however, continue to use work-arounds and suboptimal solutions to execute many of the functions required to deliver integrated care. Ample opportunities exist for vendors to offer scalable, nimble solutions to a host of challenges, including meeting patients' social needs, integrating data across diverse systems, and solving key data-sharing barriers, such as patient identity and consent management issues.

Organizationally, the process of implementing new technologies has both catalyzed positive changes and highlighted persistent challenges. On the positive side, requiring partners to implement and collaborate using new, shared tools has helped break down silos and forge new relationships. It has also motivated entities to reckon with vital questions about data, such as what should be shared, with whom, and how. Organizational challenges that remain barriers both to the implementation of technology specifically and to WPC more broadly include building consensus among many distinct entities, adapting to rapid transformational changes, and navigating complex questions related to regulations, risk, and sustainability.<sup>13</sup>

WPC's emphasis on continual program improvement has created momentum for pilot counties to continue building on the innovations, improvements, and insights they have gained, even after the program ends in 2020. This important investment, and the numerous entities that have come together to leverage it, will leave many communities significantly closer to the ultimate goal of providing holistic, highly coordinated care to some of their most vulnerable members.



## Case Studies

The research team identified Contra Costa County and Marin County as examples of the two different data-sharing and technology approaches described above. These case studies explore how these two counties are expanding their care coordination practice to integrate nonclinical partners and how data-sharing and technology tools are supporting this work. Table 3 summarizes some key characteristics of the two case study counties.

Appendix C lists the county staff and partners interviewed for the case studies. To learn more about the challenges and solutions reported by a host of other counties participating in WPC, please see the DHCS's midpoint assessment of progress and challenges on all aspects of the WPC pilots.<sup>14</sup>

**Table 3. Case Study County Comparison**

	CONTRA COSTA COUNTY	MARIN COUNTY
<b>Technology model</b>	EHR model	Care coordination system model
<b>Level of county health services integration</b>	Contra Costa Health Services (CCHS) is a large, integrated county health system, comprising a hospital, clinics, public health, detention health, housing, EMS, hazardous materials, and behavioral health; one (of two) managed care plans in the county is integrated in CCHS.	County does not run hospitals, public health clinics, or primary care clinics except for behavioral health clinics and detention health services; there is one independent managed care plan.
<b>Case management service approach</b>	<ul style="list-style-type: none"> <li>▶ All WPC case managers are hired by the county.</li> <li>▶ Clients are triaged based on a risk algorithm to different levels of case management across multidisciplinary specialty teams.</li> </ul>	<ul style="list-style-type: none"> <li>▶ WPC case management is contracted to external service providers, including Federally Qualified Health Centers (FQHCs) and housing providers.</li> <li>▶ Focus on intensive low-ratio case management for highest-need, most vulnerable population.</li> </ul>
<b>County technology at the beginning of the WPC project</b>	Established EHR (Epic) used by all CCHS partners (originally established in 2012) and a county-managed centralized data warehouse.	No data system shared across county departments, but HIE beginning to link clinical partners throughout the county.
<b>County population (2017)*</b>	1.1 million	261,000
<b>Estimated Medi-Cal eligible population (2018)<sup>†</sup></b>	269,000	46,000
<b>Estimated beneficiaries over the life of the pilot</b>	42,000 (5 years)	3,516 (4 years)
<b>Beneficiary description from application</b>	Frequent users of multiple systems	Homeless or those at risk for homelessness, and/or those with complex medical conditions
<b>WPC five-year budget</b>	\$204 million	\$20 million

\*US Census Bureau, *Community Facts* [search results], American FactFinder, accessed March 31, 2019, [factfinder.census.gov](https://factfinder.census.gov).

<sup>†</sup> California Department of Health Care Services, *Medi-Cal Certified Eligibles – Recent Trends*, last modified March 11, 2019, [www.dhcs.ca.gov](https://www.dhcs.ca.gov).

## CommunityConnect

### Background

The Contra Costa Whole Person Care pilot, called CommunityConnect, has a budget of \$204 million to serve up to 42,000 patients at various levels of case management over the five years of the pilot. The program seeks to coordinate services through a two-pronged approach: (1) integrated and coordinated data systems and (2) enhanced and coordinated case management. The pilot originally also included opening a sobering center, but implementation difficulties have redirected funds to focus on targeted case management for patients leaving alcohol and other drugs (AOD) treatment facilities.

Contra Costa County has a well-established and integrated health system. Contra Costa Health Services (CCHS) runs a hospital (Contra Costa Regional Medical Center), 13 community clinics, a behavioral health division, county detention health, a managed care health plan (Contra Costa Health Plan, or CCHP), school-based health center programs, health care for the homeless, public health home visiting nurses, mobile health units, and communicable disease programs. CCHS also has a robust IT department, which began a technology transition to a county-wide EHR (Epic) and an internally managed data warehouse in 2012. In addition to the EHR, the data warehouse gathers data from multiple county systems. The county data warehouse has three core purposes: (1) to facilitate sharing data between those systems and the Epic EHR, allowing relevant information to be viewable at the point of care, (2) to aggregate data from many systems for reporting and strategic planning, and (3) for patient risk stratification, population health management, and identifying gaps in care.

Contra Costa County saw the WPC pilot as an opportunity to make better use of these robust data made available by the existing IT and EHR infrastructure and to close data-sharing gaps that existed in the system. Areas of focus in the pilot have included using data to automate time-intensive processes, sharing data with a more diverse range of partners, and equipping frontline workers with data to target and improve the services they provide.

### Successes

#### Incorporating New Data Sources into the Data Warehouse

The CommunityConnect team successfully brought new and relevant data streams into the county data warehouse. The warehouse receives data from sources outside of the EHR system, but also feeds the EHR system with specific data elements from outside systems. Data exchange occurs between the EHR and the HMIS for housing and homelessness information, Sharecare for behavioral health utilization and claims, Persimmony for public health nursing programs, the emergency medical services (EMS) system, CCHP claims, and prescription fills from outside pharmacies. Some data from these systems are shared directly in the EHR through the patient chart, allowing all care team members access. Other information is used in the background by program managers for patient stratification by risk scores, predictive analytics for strategic planning, and reporting. New data sources have allowed the county to refine their ability to appropriately assign and serve patients. Two examples of expanded data integration are highlighted below: (1) transitioning the behavioral health services division to Epic and (2) integrating housing information with clinical information.

#### Data-Driven Program Enrollment

One of the biggest successes of the program is the establishment of an automated, scalable system for identifying clients who are frequent users of multiple systems and assigning them to personalized services. The system depends entirely on the availability of robust and accessible data. First, predictive analytics are used to identify clients likely to have an avoidable ED visit or an avoidable inpatient visit in the next year. Clients identified as high risk are automatically enrolled and assigned to an appropriate case manager — a matching process optimized with the help of relevant data, such as clinical history and geographic area, stored in the county's data warehouse. Reducing the amount of manual work related to enrollment has not only made the program more scalable, but also freed up resources to reallocate to direct client services and case management. In fact, CommunityConnect estimates that automating the work required to determine a client's eligibility and enroll them in the pilot has saved 347 administrative hours per month.

## Commitment to Case Management

CommunityConnect hired and trained over 100 direct service case managers throughout the county. They are supported by multidisciplinary teams for cross-specialty support and consult. These case managers support over 14,400 patients every month, who are enrolled and assigned according to a risk algorithm predicting future service needs. Some case managers provide telephonic case management, while others engage in field-based case management. All case managers connect to service providers throughout the health system and document their activities within tools built in the Epic EHR for CommunityConnect (see Appendix E for screenshots of care coordination functionality developed by Contra

Costa County IT in Epic). These tools make the case management work visible to the larger health system:

- ▶ Comprehensive social needs assessments to document and track SDOH
- ▶ Care plan documentation through patient-defined goals
- ▶ A visible and dynamic care team list
- ▶ Providing real-time notifications to care team members for life events (discharged from ED, inpatient stays or detention) and tracking follow-up to these events in the patient's health record

### SPOTLIGHT

#### Behavioral Health Integration

The mental health clinics within the Behavioral Health division of CCHS were some of the last CCHS entities to transition to the Epic EHR, in September 2017, with the support of WPC funding. Before that time, outpatient psychiatry record keeping and clinical notes resided in paper charts. As part of the commitment to WPC, the county decided to share mental health information widely with care providers using the EHR. In order to facilitate information sharing, the county rolled out the EHR to the ambulatory mental health departments, and implemented Sharecare for behavioral health billing for community-based service providers outside of the county health system. The transition was implemented in phases: Behavioral health prescriptions, medications, and appointment scheduling were completed first and made accessible to care teams across all divisions. After the completion of the Sharecare billing system, a summary of this information was interfaced back into the EHR, allowing care teams to understand services provided in the community. As a result, providers can now access a complete picture of mental health services by all providers in a central location.

**Within just one week of behavioral health providers starting to document in the EHR, providers reported benefits of having access to that new information in the shared EHR.** For example, the psychiatric emergency department and the inpatient psychiatric unit were now able, for the first time, to easily view information on care coordination and referrals from their

partners on the ambulatory side of the mental health department. Having a clearer, fuller picture of mental health services available in the shared EHR allows the county to focus on process improvement. For example, they can now monitor how patients are referred to services through the Behavioral Health Access Line, the county's first gateway to seeing a behavioral health provider, and how long it takes to go from screening to referral. That information can now be shared across the system to aid in more real-time assessments and process improvements.

The shared EHR also allows contracted community providers access to client records in the EHR via a web-based portal and the ability to collaborate in care planning with county colleagues. Additionally, all CCHS patients have access to a patient portal to view and schedule appointments, medications, and diagnoses, and to communicate with their providers.

One challenge that persists is partners' inability to share or view data related to SUD treatment services (covered by the 42 CFR Part 2 regulations). These data are not currently documented in Epic. Challenges unique to these data are discussed below.

## Expanded Patient Consent

While the existing CCHS patient consent form covered data sharing within the Contra Costa health system, CommunityConnect quickly developed an additional “Interagency” Release of Information form that all clients sign upon enrollment in WPC. This form enables case managers to quickly share data with identified community partners providing services for SDOH, including housing, legal aid, food security, and financial stability, and allows case managers to more rapidly coordinate care outside of the CCHS system (see Appendix D for both Contra Costa consent forms).

## Developing a Comprehensive Social Service Database

CommunityConnect staff worked to expand and update resources available in Health Leads Reach, a social resource directory that helps case managers identify local resources for their clients. The directory now includes over 1,200 local community resources. In addition, CommunityConnect developed a patient-facing application called CoCoHealth, available in mobile application stores (i.e., Google Play and Apple’s App Store), that allows county residents to access Health Leads Reach. Divisions across CCHS have expanded their use of Health Leads Reach to connect clients to community services,

### SPOTLIGHT

#### Housing and Homelessness Data Sharing

Contra Costa Health Services created a new division called Health, Housing and Homeless Services, reflecting the county’s commitment to approach homelessness holistically. Contra Costa County has about 3,000 persons experiencing homelessness on any given day. About 250 programs at organizations throughout the county serve about 9,000 people a year and enter service and program information into an HMIS. There was previously no way to share that information with providers of other disciplines, or to receive information about who else might be working with those homeless clients. One of Contra Costa’s goals through WPC was to transition to an HMIS system that could better share information with their data warehouse and the EHR. Using WPC funds, the county implemented a new HMIS in 2017 that is now fully integrated with the data warehouse. Since the CommunityConnect program uses a universal consent form across all county services, these newly integrated data are accessible to the health services department, including case managers and social workers in both clinical settings and community-based organizations.

The data warehouse now includes data on whether an individual has accessed any homeless program in the past 15 years and a measure that indicates whether that person is currently homeless. In the future, HMIS data available in the EHR will include housing programs the patient is actively engaged with and contact information. Data from the EHR that flow into the HMIS include the name and contact information of case managers for three different case management programs (CommunityConnect case management, public health nursing,

and CCHP case management). In addition, data from the HMIS shared via the county’s data warehouse serve as valuable inputs to the predictive risk algorithms used for program enrollment and case manager assignment. Kimberly Thai, the HMIS system administrator, described the benefit of having reports on housing status available in the EHR:

*Having all of the information in one place [the EHR] has allowed us to be more efficient. In the past, we would have had to look up a person in three different systems to see what services they were getting. Now we can run a report in the EHR to see where they’re active in the system and where they’ve been. It saves time for case management.*

While homelessness programs are required to track information in HMIS for HUD reporting, the reporting and analysis functions in that system are not sophisticated. However, integrating homelessness information from HMIS into the data warehouse allows CCHS to automatically create, update, and manage the county’s Housing Priority (“By Name”) List for its Coordinated Entry (CE) program. A query to the HMIS data in the data warehouse identifies new homeless individuals and pulls their information into a report that housing providers can access through a web-based portal. Rather than tracking housing priority manually for over 700 new clients a month, they are now able to identify the most vulnerable clients, match them to appropriate levels of supportive housing, and more accurately and efficiently assign housing resources across the entire county.

both through the patient-facing CoCoHealth app and the staff version of Health Leads Reach, which offers additional functionalities.

#### CONTRA COSTA

##### Partnering with the EHR Vendor

Contra Costa Health Services has an active IT department that worked closely with the WPC program to develop customized tools in the Epic EHR to meet the needs of the program. They built out sections for the social needs screening and care coordination, including client-defined goals (see Appendix E for screenshots). CCHS reported that Epic has been interested in the types of changes they made to support complex care coordination and have conducted a number of learning visits. Epic is working very closely with CCHS to understand the needs and functions required to integrate social care considerations into the platform and is developing new social care modules to offer other customers.

## Other Promising Connections and Tools

Contra Costa continues to use WPC funds to experiment with closing data gaps and connecting providers within its system to serve vulnerable clients. Other initiatives include the following:

- ▶ **Integrating public health nursing home visiting notes into the EHR.** Documentation from public health nursing home visiting programs is now available within the EHR for all Epic users to see.
- ▶ **Detention health.** Both physical and mental health services provided within the county detention facilities are documented in Epic, which supports information sharing and collaboration post-release. Case managers receive real-time notifications when a patient on their caseload is released from detention, so they can quickly intervene with services. Additionally, detention history is included in the CommunityConnect predictive risk algorithm and is available in the data warehouse for other analytical needs. The county is still working on improving transitions of care and discharge planning for clients in the criminal justice system.

- ▶ **Support for foster youth.** Finally, as a result of increased data integration with the Employment and Human Services Department, Children & Family Services Bureau, the IT team can flag youths in the foster care system for primary care providers. This allows providers to know the youth's status and support any additional needs required. It also highlights all of the services the foster youth is receiving in the system.

## Challenges

While CommunityConnect has achieved rapid success in connecting care teams across the county, a few gaps remain, primarily due to regulatory restrictions on data sharing and the challenges of connecting to providers outside of the county system.

### Alcohol and Substance Use Disorder Treatment Services

While the majority of mental health services and information were incorporated into the Epic EHR in 2017, due to regulatory concerns, SUD treatment information from programs covered by 42 CFR Part 2 is not yet included.<sup>15</sup> The county convened a work group to address issues and develop solutions. However, many county legal teams, including Contra Costa's, have been cautious in interpreting 42 CFR Part 2 requirements for sharing SUD treatment information. Therefore, despite programmatic willingness to share the data for CommunityConnect, issues in Contra Costa County include the following:

- ▶ Developing a universal consent form that protects information as required but allows data sharing across the integrated county health system
- ▶ Determining how to collaborate and share data with SUD treatment providers in community-based organizations
- ▶ Implementing these solutions in the integrated EHR

To test the ability to share this information and to develop workflows to restrict access when it is required, one Contra Costa County SUD treatment program is piloting data sharing in the EHR. This program has developed a new patient consent form with data-sharing options that include the ability to not share patient data in the county EHR. The downside is that clients who choose that option are currently excluded from county treatment options and instead are referred to community SUD treatment



providers. This is due to the county health system's belief in the necessity of data sharing for providing holistic and fully coordinated care.

### Human Services Eligibility Data

Like many other counties, Contra Costa's Employment and Human Services Department (EHSD) is separate from its health services department (CCHS). While the universal consent form that all 14,400 active WPC clients sign<sup>16</sup> includes all CCHS divisions and many housing community partners, it does not cover automatic data sharing with the EHSD. WPC enrollment depends on Medi-Cal eligibility, which is tracked in EHSD databases. Although both departments are extremely interested in collaborating on their shared clients, they are currently limited in sharing data beyond Medi-Cal eligibility between systems. It is believed that the sharing of these data would require gathering additional explicit consent from all active clients, which is an onerous programmatic burden. The WPC and EHSD teams continue to work toward a data-sharing agreement, partnering with legal counsel and other WPC counties to investigate permitted data-sharing workflows and determine the best path forward to provide coordinated care across departments.

To solve this problem in the meantime, three EHSD eligibility workers, called Social Service Program Assistants, are colocated in the WPC offices. These workers help identify clients who have problems with their eligibility, research the reason for their eligibility lapse, and work with clients and their case managers to resolve the issue. For example, if a client's Medi-Cal coverage lapses, they would reach out to the client to reapply for benefits. If the data-sharing agreement were in place, allowing this information to be integrated in the data warehouse, case managers could instead receive alerts before benefits expire and work with clients to maintain their Medi-Cal and program enrollment status.

Additionally, CommunityConnect has 12 EHSD social workers that are integrated into the multidisciplinary teams. These staff are employees of EHSD but sit within the Public Health division of CCHS, so they are able to access both systems. Having as part of the CommunityConnect team social workers who know how to navigate not just the health arena but also broader human services has expanded the collective knowledge of the multidisciplinary teams and given patients a broader level of service.

While EHSD staff look forward to more streamlined data sharing, they are inspired by the relationships they are forming while working across departments. Accessing two data systems (the EHR and their social service databases, MEDS and CalWIN) also gives them a more sophisticated understanding of the barriers to coordination and ideas for how to make systems more efficient and collaborative.

### Expanding to External Service Providers

While the county employs all case management roles internally, many important services are provided outside of the county system. Currently, data sharing with external partners is relatively limited. External clinical providers (community clinics or FQHCs) are able to view client records via an Epic web-based portal, while Kaiser Permanente providers can access information through Epic's Care Everywhere. The county is exploring expanding portal access to contracted behavioral health providers, with at least view-only functionality and possibly the ability to edit care plan notes. Collaboration with many other community partners — such as food banks, transportation services, and other safety-net organizations — continues to require more fragmented means of communication through email, fax, and phone; however, CommunityConnect is actively exploring technological capabilities to connect to these organizations.

### Sustainability

Contra Costa County hired all of the WPC case managers as permanent positions, demonstrating CCHS's commitment to the collaborative care model. The scale of the program in Contra Costa County has the potential to standardize and legitimize social case management. The number of program participants and a robust IT and evaluation team allow the WPC pilot to test many approaches and tools with a large enough sample of clients to refine algorithms and measure impact.

County leaders view their investment in internal systems and capacity building as a long-term investment in sustainability. System improvements funded by WPC increase the capacity of the whole system and support many programs and services. The Behavioral Health division is looking to follow the model of the county hospitals in developing a more robust leadership structure around informatics in order to operationalize their changes and be able to maintain and refine their use of Epic without

contractors moving forward. They have already developed a system of discipline-specific champions, but recognize they'll need more leadership involved to triage requests and make thoughtful changes.

Looking to the future beyond WPC, CCHS convened a Waiver Integration Team to examine the dozens of county waiver-funded programs for opportunities either to consolidate and collaborate in some areas, or to standardize and scale other services across the system. This cross-discipline group is working together to identify funding cycles and opportunities for future support.

Contra Costa County CommunityConnect rapidly developed their existing EHR and data warehouse to better support comprehensive care coordination within their integrated system. Risk analytics and designated case management staffing allow them to serve over 14,000 patients per month with tailored levels of services. Investments in both technology and staffing will persist beyond the WPC funding period.

## MARIN COUNTY

# Whole Person Care

## Background

Marin County Whole Person Care, which was funded in the second round of applications in June 2017, has a budget of \$20 million over 4 years.<sup>17</sup> Marin County plans to provide case management services to 400 or more clients at a given time: up to 220 clients in intensive housing case management, 170 clients in medical case management, and 60 clients in mild to moderate case management. The county tracks a larger number of clients that are ready to receive services as they become available. Through contracted partners, the Marin County WPC program has 26 housing case managers, five medical case managers, and four mild to moderate behavioral health case managers.

Marin County's program includes efforts to engage with clients and bring them into systems of care, with a focus on ending chronic homelessness.<sup>18</sup> According to the 2017 point-in-time count,<sup>19</sup> Marin County has about 1,100 homeless residents, about 350 of whom are considered chronically homeless. Because the county anticipated that HHP, a Medi-Cal State Plan benefit in certain counties, would begin to provide case management for many Marin Medi-Cal clients starting in 2019, they revised their WPC target population and services to focus on a more intensive case management model for the most complex clients. In contrast, Contra Costa was never an HHP county, so they provided all tiers of services to their clients based on level of risk from the beginning of their pilot.

Marin County has an integrated Department of Health and Human Services (HHS) that includes Planning and Administration (the division that provides homelessness services), Social Services, Public Health, and Behavioral Health and Recovery Services (BHRS). The county closed the last of its public health clinics in 2017, so it does not provide any physical health services. Instead, three hospitals provide health services in Marin County — Marin General Hospital, an independent health care district hospital; Novato Community Hospital, part of the Sutter Health network; and the Kaiser Permanente San Rafael Medical Center — as well as four community health centers and various other provider practices. The WPC

program in Marin launched with three types of intensive case management services:

- ▶ Intensive housing case management (case manager-to-client ratio of 1:17), partnering with the Coordinated Entry process<sup>20</sup> with the goal of ending chronic homelessness
- ▶ Medical case management for patients with complex care needs (ratio of 1:30)
- ▶ Mild to moderate behavioral health case management (ratio of 1:30) to provide support to clients who do not meet diagnostic criteria for severe and persistent mental illness and do not qualify for county mental health services but do require health home support

Since Marin County does not have an internally integrated health system, they have contracted out case management services to well-established partners, including community health centers and housing and homeless service provider organizations. The county's lack of a health system also means they did not have an existing shared EHR system on which to do the bulk of their WPC work. Scoping, building, and implementing an alternative platform to host the types of collaboration, data sharing, and communication required by WPC is an important part of Marin's pilot.

## Successes

### Building Tools for Data Sharing and Care Coordination

Like Contra Costa County, Marin County sought to build upon and expand existing care collaboration and data-sharing infrastructure with WPC funding. Since Marin County does not have a clinical system with a shared EHR, the county has been working to develop ways to make data visible to appropriate care providers. Even before WPC funding, the county was working to establish an HIE resource called the Marin Health Gateway (Gateway), which was scheduled to go live during the third year of the WPC project. Through phased implementation stages, starting with the largest hospital and largest community clinic organization, the Gateway will integrate information from the four community health centers, Marin General Hospital, EMS, county behavioral health and crisis services, detention health services, and the Medi-Cal managed care health plan.

While the Gateway will share retrospective information on clients and how they use health and social systems, the county had no existing tool for proactive care coordination or case management, especially for use by external partners. Very early in the WPC project, they identified the need to find and implement a care coordination system that could be accessed by both county staff and diverse external partners. They conducted a community technology assessment in the fall of 2017 to see if an existing tool could be expanded. They then convened a series of stakeholder meetings in January of 2018 to identify the requirements of a care coordination tool. The county released a request for proposals in February 2018 and selected a vendor, ACT.md, by April 2018. Contracting was completed and design and implementation began in June 2018, and the first version of the system went live in early October. The county is calling their ACT.md tool "WIZARD," which stands for WPC Information Zone: Access to Real-time Data. Currently, case managers, social service workers, and the epidemiology and administrative team that manages WPC eligibility manually enter information in WIZARD. As the county moves into phase 2 of implementation, they will establish a data exchange with HMIS to eliminate duplicate data entry and verification workflows for the CE program, and with the Gateway for clinical alerts and a curated set of health information.

### Universal Release of Information and Data-Sharing Agreements

Like Contra Costa County, Marin County is committed to sharing as much relevant and actionable information as possible with carefully established care teams, while preserving the privacy and security of clients' data. The initial process of developing their universal authorization — release of information (ROI) — in collaboration with their very proactive compliance team helped to raise awareness among stakeholders that data could be shared in new ways. This awareness included educating stakeholders on the WPC authorizing legislation (WIC §14184.60), which gives broad authority to WPC pilots to share relevant health information, records, and other data among participating entities to carry out program activities such as target population identification, coordinating care in real time, sharing data between systems, and evaluating individual and population progress. While WPC pilots recognize that the state has encouraged data sharing with and among WPC-participating entities, having a universal authorization that explicitly states how information will be

used helps reduce complexity and closes gaps to ensure compliance with regulations. The current ROI includes all relevant county departments (including employment and social services) and key community partners (see Appendix D for the current ROI). If a client signs a full ROI, then all assigned care team members from participating entities can exchange information about all aspects of care, except SUD treatment information from providers covered by 42 CFR Part 2. Collaborative development of the ROI and shared understanding of expanded data sharing under the WPC statute helped address partners' concerns and establish trust. The county continues to educate partners as it brings new agencies or organizations onto the ROI. It also continues to educate providers about organizations operating in the county and builds a shared understanding of Marin's service universe.

In addition to the ROI, Marin County is developing a layered trust framework to ensure privacy and security of protected health information. First, the Gateway established a participation agreement and data-sharing policies and procedures that exceed Health Insurance Portability and Accountability Act (HIPAA) requirements for all clinical partners. In addition, the county developed a data-sharing agreement for WPC-participating organizations using WIZARD. Its purpose is to establish clear expectations for confidentiality and data stewardship among those diverse partners, particularly partners that are not governed by HIPAA (e.g., housing and social service agencies). The Marin WPC director, Ken Shapiro, expressed his gratitude for WPC's working relationship with its compliance team. "They are proactive," he said, "as they want to help share data in a way that is both ethical and legal, and they help us navigate and create policies, while also helping us resolve all of the challenging scenarios and questions that come up every day."

One of the important functions of the shared case management system is to track client ROIs, so that all providers have a shared understanding of who they can communicate with for care coordination. Even without access to a client's care plan, system users can see if a client has a signed ROI, whether they have a completed housing vulnerability assessment administered by the CE team (called the VI-SPDAT), and whether they are enrolled in one of the WPC service bundles. Having access to this information minimizes complex recruitment efforts and helps close referral loops.

#### MARIN COUNTY

##### Partnering with a Care Coordination Vendor

The ACT.md WIZARD team supports a variety of comprehensive case management programs and applies experience and learning between program models. While care team members in Epic have to be part of an organization that is an Epic customer, anyone — from any organization — can be invited to ACT.md's care teams and collaborate within the tool. This works well for Marin WPC's cross-organizational care team model. While ACT.md is specifically designed for collaborative teams to track client-identified goals on a variety of topics, Marin County worked with ACT.md to develop customized workflows and projects for outreach, eligibility determination, consent management, and collaborative triage to services to better work with the CE team. WPC reporting requirements are pushing ACT.md to develop more flexible reporting options for customers like Marin County. ACT.md has been a collaborative partner with the county in developing functionality to support the WPC program. (See Appendix F for screenshots of the WIZARD tool.)

#### Establishing Cross-Disciplinary Teams

Establishing WPC as a new business unit within Marin County HHS allowed the county to build a multidisciplinary team and bring analysts together under the WPC umbrella to develop innovative approaches to serving the county's most vulnerable and complex clients. The WPC business unit hired a data analyst, forged connections with social services, and colocated the homelessness analysts with the WPC team. The data analyst built data systems to demonstrate the value of increased data sharing, as well as to gather baseline data to demonstrate results. In addition, the WPC director held monthly meetings of managers from different divisions within HHS, many of whom had never interacted before WPC.

## SPOTLIGHT

### WPC Housing Collaborative

To capitalize on energy around both CE and WPC, the WPC project in Marin County immediately focused on collaborating with the CE team and providing housing case management. Marin County supervisors set aside 50 Section 8 housing vouchers for CE to dedicate to chronically homeless individuals, paired with supportive case management from WPC. As Howard Schwartz, a member of CE and WPC teams in Marin put it, “WPC is tied at the hip to the voucher system.” This provided an immediate way to house clients, allowing the pilot to show results quickly. As mentioned above, the county reorganized its internal infrastructure to combine WPC and homelessness services into one division, incorporating the county homelessness policy analysts into the WPC team and moving all housing-related service contracts under the WPC umbrella. The county also recognized that data sharing would be essential to managing the CE Housing Priority (“By Name”) List and referring appropriate clients into WPC services (see Appendix F for a description of the CE and WPC collaboration).

Following an RFP process, the county awarded a contract to provide housing case management to a collaborative of four organizations with deep roots and expertise in different aspects of services for people experiencing homelessness:

- ▶ **St. Vincent de Paul Society of Marin County** focuses on information and referral, conducting street outreach to potential clients and working with them to sign Marin’s ROI and to enroll them when eligible. The society also provides a bridge for those who are on the journey to housing as well as housing case management for some of the most vulnerable clients, through its Homeless Outreach Team.
- ▶ **The Ritter Center FQHC** provides housing-based case management using an assertive community treatment model, with complete, intensive wrap-around services.
- ▶ **The Marin Housing Authority** provides housing location services and subsidies for many people enrolled in the program and coordinates the CE process.

- ▶ **Homeward Bound of Marin** provides “housing-focused shelter”<sup>21</sup> as interim housing placements for many WPC clients as well as permanent supportive housing units, including case management for individuals, families, and veterans who qualify.

Marin adopted a housing-first approach with no pre-conditions to be in housing other than to engage with a case manager on a regular basis. Since CE requires the county to prioritize housing for the most vulnerable, those clients need the intensive, high-touch, low-ratio case management provided by WPC in order to succeed in maintaining their housing.

All of the housing case managers are connected to multidisciplinary teams through WIZARD. Primary case managers can invite other care team members to collaborate on care plans, communicate about client needs, react quickly to acute medical or social events, and facilitate transitions of care between systems. This web-based system allows housing case managers to collaborate with primary care providers to connect their clients to medical services, get updates about the status of social benefits, and know when their clients are interacting with the county jail system.

The WPC Housing Collaborative organizations appreciate the work the county has done to build trust and relationships that make information sharing in the county possible. As part of the outreach team that gathers client consent, they notice that most clients are willing to share information for a program that has already demonstrated real results. The key message in the community is that WPC is getting people housed, which encourages others to participate.



## SPOTLIGHT

### Closer Collaboration with Behavioral Health

Marin County HHS's BHRS division sees itself as a primary partner to the WPC program, as they share the commitment to moving the needle on wellness for the target population. WPC has supported constructive conversations about how to establish more fluid information sharing between county behavioral health services and primary care services as WPC partners, to facilitate communication about referrals, avoid duplicative services, and transition clients out of intensive psychiatric case management and into more appropriate levels of community care. As one unit supervisor said of the collaboration, "In the end, we're able to provide clients with exceptional services in a collaborative way."

The BHRS Access Team runs a 24/7 phone line (Access line) and offers in-person visits during business hours. They assess client needs and help triage clients into the most appropriate level of care. Before WPC, there were fewer options for clients if they did not meet the diagnostic criteria for Specialty Mental Health Services at the county level even though many providers in the county had identified the need for a mild to moderate behavioral health case management service. The Access line staff can refer clients to WPC mild to moderate case management if they meet WPC criteria. They can also communicate with WPC case managers about the status of client referrals if the client has signed a WPC ROI.

Behavioral health staff are noticing that having close partnerships with housing providers expands the ability to connect reluctant clients with treatment. For example, individuals can choose housing as their initial treatment, even if they are not ready to consent to intensive mental health services. Through the WIZARD system, the BHRS division knows that the client is housed and receiving intensive case management support from a trained housing case manager as a first step toward wellness.

From the behavioral health perspective, the WPC ROI makes collaboration with other providers not only more efficient but more compassionate. Having a universal ROI and access to a shared case management system allows them to share program status information with frontline providers more quickly and minimizes confusion for vulnerable clients who are not easily engaged in systems. Rather than having them sign 10 different consent forms in order to navigate the system of care, they only have to sign one.

The BHRS division will connect to both the HIE and to WIZARD in specific ways. Some BHRS staff joined WIZARD in 2018 to track whether clients were receiving WPC case management. In 2019, they will start receiving alerts from health care partners when one of their clients is in the ED or admitted to the hospital. They plan to implement alerting back to medical care team members when one of their clients has a psychiatric emergency, although these types of alerts are less common and harder to define. WPC also plans to bring additional behavioral health users into the WIZARD platform to collaborate on shared clients or to help clients transition between programs. For example, staff from the county's Mobile Crisis Team will begin using WIZARD in early 2019. Additional users might include staff who work on county homeless mental health programs, such as the Full Service Partnership Odyssey Program, the services of which include outreach to homeless clients with severe mental illness.

## SPOTLIGHT

### Collaboration Between Criminal Justice and Social Services

Marin WPC has forged new relationships and the ability to share carefully defined information with existing county and city staff working in criminal justice. The WPC ROI includes the district attorney, probation, the public defender, Central Marin Police Authority, City of Novato, City of San Rafael, and the Marin County Sheriff's Office. In addition, the county developed a new data-sharing agreement that specifies what types of information can be shared with criminal justice partners. In general, the ROI allows criminal justice partners to share information with case managers that would improve a client's care or help them receive services. Criminal justice partners are able to access the name and contact information of a case manager in order to collaborate with them but do not have access to personal health information or the client's care plan.

Because of its early focus on people experiencing homelessness and mental health issues, the Marin WPC project connected with progressive community partners like the San Rafael Police Department (SRPD). The SRPD invested in outreach and relationship building by hiring a trained therapist to engage people experiencing homelessness in downtown San Rafael. She has established trust and connections to people experiencing chronic homelessness and has been instrumental in bringing people into services, including the WPC program, and keeping them out of the criminal justice system. Because Marin tied housing vouchers to the WPC program, awareness of the program's effectiveness is spreading, and people are willing to participate.

As in Contra Costa, the WPC program in Marin has social workers who collaborate closely with WPC case managers. These social workers use WIZARD to share information. In the county jail, social workers identify and collaborate with case managers to plan for discharge and to try to reduce recidivism. One social worker said of her experience: "I have a lot of people who are constantly coming in and out of custody because of behaviors related to their homelessness. I try to talk to people while they're in, get them to sign a WPC ROI, and connect them to the treatment team,

so the team knows when they'll be released. Then I do what I can before they're released to get them connected to social supports like Medi-Cal, General Assistance, help with clothes." Social workers in the jail now have access to all data systems (HMIS, WIZARD, C-IV, MEDS) and can pull relevant information from any of them to share with case managers using WIZARD. Before WPC, once a client entered the jail, communication with any other service providers, including behavioral health and housing services, was difficult. As Dawn Kaiser, the Behavioral Health Quality Improvement Director, described it, "Jail, from our perspective, should be an episode of care, with connection to services before and after. But it has been a black box." WPC is not able to provide services while a client is in jail, but shared data now allow jail and social service staff to coordinate a client's care plan upon release.

In addition to improved social services coordination in the jail, WPC team members use WIZARD to improve coordination on social benefits for all enrolled clients. Case managers in the county had reported that gathering information on benefits eligibility and status had to be done manually and was extremely time-consuming in the past. Because social services are part of Marin's Department of HHS and are included in the ROI, social service workers conduct a monthly review of the entire WPC client list in WIZARD and update the benefits status for Medi-Cal, CalFresh, CalWORKs, SSI/SSDI, and Medicare. Any member of the care team can access that information and know that it is current. Case managers also receive alerts when benefits like Medi-Cal are expiring, so that they can work with clients to maintain their eligibility.

## Challenges

### Phased Change and Duplication

While the system changes catalyzed by WPC have already led to some efficiencies, the transition period required some duplicate data entry. This duplicate work will persist until automated data exchange can be implemented between key systems — a process that requires a phased approach. Because Marin does not have an integrated, county-run health system with a shared EHR, the WPC team is working to identify how to minimize the need to regularly conduct work in multiple systems. They are also working to identify connection strategies that minimize the need to access multiple systems; however, until those connections are made, some duplicate workflows will continue.

Another challenge of not having an integrated, county-run health system with a shared EHR is the need to forge relationships and create connections, one division and organization at a time. The Gateway helps with this process for clinical sources as they are already engaged with data-sharing agreements and are planning and developing connections. This will allow the HIE to serve as a consolidated point of connection to WIZARD, rather than requiring WIZARD to create individual connections with behavioral health, detention health, EMS, and each hospital and clinic. This allows WPC staff to focus on additional data sources that are not included in the HIE effort, such as HMIS.

The county has set ambitious internal timelines to implement data exchange tools and is working with stakeholders to be deliberate about phasing in change. Mark Shotwell, the executive director of the Ritter Center, said, “The county has been thoughtful about its impact on providers, shaping what they’re asking for, so it is achievable in a step-by-step manner. We see them working as hard as we are working on this change effort. And they are willing to listen and reprioritize if something is just too difficult.”

### Substance Use Disorder Treatment Information Sharing

As in most other counties, sharing information from SUD treatment providers covered by 42 CFR Part 2 is challenging. Currently, no SUD treatment information from these providers is included in either the HIE or WIZARD. Marin County hopes to develop policies and procedures for managing this type of data in the future, including an updated consent form for WPC participation.

### Partnering with the Local Managed Care Health Plan

Marin County is served by one Medi-Cal managed care plan, Partnership HealthPlan of California, which also has members in 13 other counties in Northern California. Marin has relatively few members compared with some other counties. Some health plans are developing internal medical case management services to support implementation of the HHP described above. While the county expected Partnership would implement HHP in mid-2019, the health plan subsequently decided not to implement the program.

During WPC planning, the county envisioned that a telephonic case management model could work well for many of the county’s Medi-Cal clients. They hoped to develop deeper collaboration to care for the small percentage of clients who are very complicated and are intensively using many types of county services. For these clients, a more intensive case management model is required, and having bidirectional data flow between the county and Partnership would be constructive for adequately serving them. While the current ROI would allow for that level of connection, operationalizing the exchange is difficult.

Nonetheless, county leadership is testing more-intensive case management with the WPC pilot and envisions an ongoing role for this type of intensive case management to complement any case management services provided by Partnership. As Marin County’s deputy health officer described it, “These patients cross systems that are firmly outside the touch of most health plans but firmly within the county WPC collaboration, like criminal justice, county behavioral health and crisis services, and homeless outreach services. However, there should be a carve-out for the county to provide the low-ratio, intensive case management for the most high-utilizing, most complex,

and most vulnerable patients.” The county also hopes that, through participation in the Marin Health Gateway, Partnership will provide use data for program eligibility determination, care coordination, outcomes reporting, and population health management. For example, the BHRS division identified that they would be better able to plan and prioritize services for clients they’re working with if they could receive information from the health plan on the top 200 service users in the county.

### Batch Information from Social Services

While Marin County, unlike Contra Costa County, can share information about benefits status in WIZARD for care coordination, these data have to be entered and updated manually for all clients. This process is burdensome, and the workload will increase as the county expands enrollment. Most counties have found that it is nearly impossible to integrate with or receive batch data exports from state data systems. Medi-Cal enrollment is the key eligibility criteria for WPC, but the only way to access that information is by manual lookup in the social services data system and data entry into WIZARD. Counties are working with the state to try to establish agreements for more efficient sharing of this information.

### Sustainability

Marin County believes that they have the vision and leadership support to create new relationships and connect departments in a way that could support lasting change. For example, their entire Board of Supervisors is supportive of the WPC program, making obtaining approvals much easier. There is a great deal of interest in solving homelessness in the community, and the results coming from the collaboration between CE and WPC are gaining attention and support. Getting a data analyst on board quickly allowed the program to begin tracking outcomes and communicating early wins. A robust evaluation effort is helping WPC show savings to local systems such as hospitals, the health plan, and criminal justice, thus strengthening its case for deeper collaboration and sustainability.

Another part of systems transformation in Marin County that will persist beyond the life of the pilot is redesigned contracts and standardized case management practices. One early effort of setting up housing case management included reviewing all external contracts for housing and homeless services and making sure that they were not paying two providers for the same service. The county rewrote contracts to move toward a value-based payment system, tied to client outcomes. Finally, they required use of the WIZARD system in their contracts and built billing reports into WIZARD to support invoicing for services.

Like Contra Costa County, Marin County is leveraging WPC funding to invest in integrated technology tools to facilitate information with the ultimate goals of minimizing duplication and improving client outcomes. They are actively working with additional internal and community partners to build support and use cases for both the HIE and the WIZARD case management tool.

Finally, the county is working to develop community standards for collaborative case management, supported by a technology tool that is relatively inexpensive to maintain. Marin County hopes that the county, hospital partners, and health plans will recognize the benefit of their intensive, housing-first, community-based case management model and grow it to scale. BHRS also sees WIZARD as an important tool that provides unique value not offered by the HIE, EHR, or billing systems and is interested in exploring how it can be expanded to serve additional programs. The county’s long-term goal with WIZARD is to have a shared system that includes all clients of interest in the county, not just WPC clients, where everyone can check in and coordinate to support the triple aim.

## Appendix A. Glossary of Abbreviations

<b>AOD</b>	Alcohol and other drugs	<b>IT</b>	Information technology
<b>BHRS</b>	Behavioral Health and Recovery Services (Marin)	<b>MEDS</b>	Medi-Cal Eligibility Data Set
<b>CalWORKs</b>	California Work Opportunity and Responsibility to Kids	<b>MPI</b>	Master person index
<b>CCHP</b>	Contra Costa Health Plan	<b>Partnership</b>	Partnership HealthPlan of California
<b>CCHS</b>	Contra Costa Health Services	<b>PDSA</b>	Plan-Do-Study-Act
<b>CE</b>	Coordinated Entry, a program to prioritize homeless clients for housing programs	<b>QI</b>	Quality improvement
<b>C-IV</b>	Social services database for tracking social benefits	<b>RFP</b>	Request for proposal
<b>CMS</b>	Centers for Medicare & Medicaid Services	<b>ROI</b>	Release of information
<b>DHCS</b>	(California) Department of Health Care Services	<b>SAMHSA</b>	Substance Abuse and Mental Health Services Administration
<b>ED</b>	Emergency department	<b>SDOH</b>	Social determinants of health
<b>EHR</b>	Electronic health record	<b>SRPD</b>	San Rafael Police Department
<b>EHSD</b>	Employment and Human Services Department (Contra Costa)	<b>SSI/SSDI</b>	Supplemental Security Income / Social Security Disability Insurance
<b>EMS</b>	Emergency medical services	<b>SUD</b>	Substance use disorder
<b>FQHC</b>	Federally Qualified Health Center	<b>VI-SPDAT</b>	Vulnerability Index – Service Prioritization Decision Assistance Tool
<b>Gateway</b>	Marin Health Gateway, an HIE resource	<b>WIC</b>	Welfare and Institutions Code
<b>HHP</b>	Health Homes Program	<b>WIZARD</b>	WPC Information Zone: Access to Real-Time Data (Marin County's care coordination tool)
<b>HHS</b>	(Department of) Health and Human Services (Marin)	<b>WPC</b>	Whole Person Care
<b>HIE</b>	Health information exchange		
<b>HIO</b>	Health information organization		
<b>HIPAA</b>	Health Insurance Portability and Accountability Act		
<b>HMIS</b>	Homeless Management Information System		
<b>HUD</b>	(US Department of) Housing and Urban Development		



## Appendix B. Glossary of Technology Terms

**Bidirectional integration or data sharing** is two-way communication between electronic systems such as EHRs, HIEs, or other data systems. For example, source system 1 can share data with system 2 for specific purposes, while system 2 can also act as a source of information that may share data with system 1. Sharing data back and forth between both systems results in completeness of data in each system.

**Data warehouse** is a large store of data accumulated from many sources, which, when combined, can be used to conduct data analytics and reporting based on the needs of the given program or project.

**Electronic health record (EHR)** is a digital version of a patient's paper chart. EHRs are real-time, patient-centered records that make information available instantly and securely to authorized users. While an EHR does contain the medical and treatment histories of patients, an EHR system is built to go beyond standard clinical data collected in a provider's office and can be inclusive of a broader view of a patient's care.

**Health information exchange (HIE)** is the electronic transmission of health care data among facilities. It may also refer to an organization that facilitates data exchange.

**Homeless Management Information System (HMIS)** is a local information technology system used to collect client-level data and data on the provision of housing and services to homeless individuals and families and persons at risk of homelessness. The chosen HMIS software solution must comply with HUD's data collection, management, and reporting standards.

## Appendix C. Interviewee List, by County

### CONTRA COSTA

ORGANIZATION/TITLE	NAME
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#### Health Services

Chief Medical Officer	Jennifer Tong
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#### Contra Costa CommunityConnect

Program Manager	Emily Parmenter
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Lead Program Evaluator	Elizabeth Hernandez
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Chief Analytics Officer	Bhumil Shah
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#### HMIS

Administrator	Kimberley Thai
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#### Behavioral Health EHR Implementation

Project Manager	Megan Rice
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Integration Services Manager	Amanda Dold
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#### Employment and Human Services

Department Manager	Neely McElroy
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### MARIN

ORGANIZATION/TITLE	NAME
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#### Health Services

Deputy Medical Officer	Lisa Santora
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#### WPC Pilot

Director	Ken Shapiro
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Senior Program Analyst	Charis Baz
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#### WPC Housing Collaborative Partners

Ritter Center Executive Director	Mark Shotwell
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WPC Housing Case Manager	Mark Sorensen
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Marin County Senior Homelessness Program Coordinator	Carrie Sager
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St. Vincent de Paul Director of Systems Change (Coordinated Entry partner)	Howard Schwartz
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#### Behavioral Health and Recovery Services

Director of QI	Dawn Kaiser
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Unit Supervisor	Angela Tognotti
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#### Criminal Justice Partners

WPC Jail Social Worker	Rebekah Reali
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San Rafael Police Department Mental Health Outreach Liaison	Lynn Murphy
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## Appendix D. Whole Person Care Consent Forms

Figure D1. Contra Costa County Health Service HIPAA Notice of Privacy Practice, page 1  
(for health services)

**CONTRA  
COSTA  
COUNTY**



EFFECTIVE DATE: 11/10/2016

### **NOTICE OF PRIVACY PRACTICES**

THIS NOTICE DESCRIBES HOW MEDICAL  
INFORMATION ABOUT YOU MAY BE USED  
AND DISCLOSED AND HOW YOU CAN GET  
ACCESS TO THIS INFORMATION

PLEASE REVIEW IT CAREFULLY

#### **Who will follow this notice**

This Notice describes Contra Costa County's privacy practices for:

- Contra Costa Regional Medical Center
- The Ambulatory Care Health Centers and affiliated satellite clinics located in Antioch, Bay Point, Brentwood, Concord, Martinez, Pittsburg, Richmond, and San Pablo
- The Mental Health Centers of Contra Costa County, and the Contra Costa Mental Health Plan
- The Public Health Centers and programs of Contra Costa County
- The Alcohol and Other Drug Services programs of Contra Costa County
- Emergency Medical Services
- The Contra Costa Health Plan
- All employees, physicians, health care professional staff, and others authorized to enter information into your medical or health record.
- Volunteers or persons working with us to help you.
- Selected county employees responsible for payment and operational support.
- Self-insured group dental plans and flexible spending health accounts for County employees.
- All providers that the above named entities contract with to provide medical services.

All of the above named entities will follow the terms of this Notice. In addition, all of the above may share medical information with each other for treatment, payment, or health care operations purposes as described in this Notice.

#### **Our promise regarding your medical information**

Contra Costa County documents the care and services you receive in written and electronic records. In this Notice, we will refer to those records as "medical information". We need this information to provide

you with quality health care and customer services, evaluate benefits and claims, administer health care coverage, measure performance, and to fulfill legal and regulatory requirements. We understand that medical information about you and your health is personal. We are committed to protecting your medical information and following all state and federal laws related to the protection of your medical information.

This Notice tells you about the ways in which we may use and disclose medical information about you. It also describes your rights and certain obligations we have regarding the use and disclosure of medical information.

We are required by law to:

- make sure that medical information that identifies you is kept private (with certain exceptions);
- give you this Notice describing our legal duties and privacy practices with respect to medical information about you; and
- follow the terms of the Notice that is currently in effect.

#### **How we may use and disclose medical information about you**

Sometimes we are allowed by law to use and disclose your medical information without your permission. We briefly describe these uses and disclosures and give you some examples. Some medical information, such as certain mental health, drug or alcohol abuse patient information, and information related to HIV or genetic tests, have stricter requirements for use and disclosure, and your permission will be obtained prior to some uses and disclosures. However, there are still circumstances in which these types of information may be used or disclosed without your permission.

How much medical information is used or disclosed without your permission will vary depending on the intended purpose of the use or disclosure. When we send you an appointment reminder, for example, a very limited amount of medical information will be used or disclosed. At other times, we may need to use or disclose more medical information such as when we are providing medical treatment.

**Figure D1. Contra Costa County Health Service HIPAA Notice of Privacy Practice, page 2**  
(for health services)

**FOR TREATMENT** We may use medical information about you to provide you with treatment or services. We may disclose medical information about you to doctors, nurses, therapists, technicians, interns, medical students, residents or other health care personnel who are involved in taking care of you, including offering you medical advice, or to interpreters needed in order to make your treatment accessible to you. For example, a doctor may use the information in your medical record to determine what type of medications, therapy, or procedures are appropriate for you. The treatment plan selected by your doctor will be documented in your record so that other health care professionals can coordinate the different things you need, such as prescriptions, lab tests, referrals, etc. We also may disclose medical information about you to people outside our facilities who may be involved in your continuing medical care, such as skilled nursing facilities, other health care providers, case managers, transport companies, community agencies, family members, and contracted/affiliated pharmacies.

**FOR PAYMENT** We may use and disclose medical information about you so that the treatment and services you receive may be billed to and payment may be collected from you, an insurance company, or a third party. For example, we may need to give your health plan information about a surgery you received so your health plan will pay us. We may also tell your health plan about a proposed treatment to determine whether your plan will cover the treatment or medication. We may also share your information, when appropriate, with other government programs such as Medicare or Medi-Cal in order to coordinate your benefits and payments, or with practitioners outside the hospital or health centers who are involved in your care, to assist them in obtaining payment for services they provide to you.

The County Health Plans (including the Contra Costa Health Plan and the self-insured group dental plans and flexible spending health accounts for County employees) may use or disclose medical information about you to determine eligibility for plan benefits, obtain premiums, facilitate payment for the treatment and services you receive from health care providers, determine plan responsibility for benefits, and to coordinate benefits.

**FOR HEALTH CARE OPERATIONS** We may use and disclose medical information about you for certain health care operations. For example, we

may use your medical information to review the quality of the treatment and services we provided, to educate our health care professionals, and to evaluate the performance of our staff in caring for you. We may also combine medical information about many patients to decide what additional services we should offer, or whether certain new treatments are effective. Your medical information may also be used or disclosed for licensing or accreditation purposes.

The County Health Plans may use and disclose health information about you to carry out necessary insurance-related activities. Examples include underwriting, premium rating, conducting or arranging medical review, legal and audit services, fraud and abuse detection, business planning, management, and general administration. However, the County Health Plans are prohibited from using or disclosing genetic information about you for underwriting purposes.

**BUSINESS ASSOCIATES** We sometimes obtain services through contracts with business associates. We require a business associate to sign a contract with a written agreement stating they will safeguard your protected health information. We may disclose your medical information to our business associates so that they can perform the job we have asked them to do.

#### **ELECTRONIC HEALTH INFORMATION EXCHANGE**

We participate in an electronic health information exchange (HIE) which allows health care providers to share your medical information that is necessary for your treatment. The information shared is maintained in a secure system and is not released outside of the healthcare setting without your written authorization. You may opt out of sharing your information by contacting the Health Information Management Department at 925-370-5220.

**FOR REMINDERS** We may contact you to remind you that you have an appointment, or that you should make an appointment at one of our facilities.

**FOR HEALTH-RELATED BENEFITS & SERVICES** We may contact you about benefits or services that we provide.

**FOR TREATMENT ALTERNATIVES** We may tell you about or recommend possible treatment options or alternatives that may be of interest to you.

**Figure D1. Contra Costa County Health Service HIPAA Notice of Privacy Practice, page 3**  
(for health services)

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**FOR FUND-RAISING** We may contact you to provide information about raising money for the hospital and its operations through a foundation related to the hospital. We would only use contact information, such as your name, address, phone number, and the dates you received treatment or services at Contra Costa Regional Medical Center. If you do not want the hospital to contact you for fund-raising efforts, write the Privacy Office of Contra Costa County at 50 Douglas Drive #310-E, Martinez, CA 94553.

**FOR THE HOSPITAL DIRECTORY** When you are a patient in Contra Costa Regional Medical Center, we create a hospital directory that only contains your name and location in the hospital. Unless you object in writing at the time of admission, this directory information will be released to people who ask for you by name. (Note: If you are admitted to a psychiatric care unit, no information about you will be listed in the hospital directory.)

**TO FAMILY AND OTHERS WHEN YOU ARE PRESENT** Sometimes a family member or other person involved in your care will be present when we are discussing your medical information. If you object, please tell us and we won't discuss your medical information, or we will ask the person to leave.

**TO FAMILY AND OTHERS WHEN YOU ARE NOT PRESENT** There may be times when it is necessary to disclose your medical information to a family member or other person involved in your care because there is an emergency, you are not present, or you lack the decision-making capacity to agree or object. In those instances, we will use our professional judgment to determine if it is in your best interest to disclose your medical information. If so, we will limit the disclosure to the medical information that is directly relevant to the person's involvement with your health care. For example, we may allow someone to pick up a prescription for you.

**FOR RESEARCH** Research of all kinds may involve the use or disclosure of your medical information. Your medical information can generally be used or disclosed for research without your permission if an Institutional Review Board (IRB) approves such use or disclosure. An IRB is a committee that is responsible, under federal law, for reviewing and approving human subjects research to protect the safety and welfare of the participants and the confidentiality of medical information. Your medical information may be important to further research efforts and the development of new knowledge. For

example, a research study may involve a chart review to compare the outcomes of patients who received different types of treatment.

We may disclose medical information about you to researchers preparing to conduct a research project. On occasion, researchers contact patients regarding their interest in participating in certain research studies. Enrollment in those studies can only occur after you have been informed about the study, had an opportunity to ask questions, and indicated your willingness to participate by signing a consent form.

**AS REQUIRED BY LAW** We will disclose medical information about you when required to do so by federal, state, or local law.

**TO AVERT A SERIOUS THREAT TO HEALTH OR SAFETY** We may use and disclose your medical information when necessary to prevent or lessen a serious and imminent threat to your health or safety or someone else's. Any disclosure would be to someone able to help stop or reduce the threat.

**FOR DISASTER RELIEF** We may disclose your name, city where you live, age, sex, and general condition to a public or private disaster relief organization to assist disaster relief efforts, and to notify your family about your location and status, unless you object at the time.

**FOR ORGAN AND TISSUE DONATION** If you are an organ or tissue donor, we may release your medical information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ-donor bank, as necessary to facilitate organ or tissue donation and transplantation.

**FOR MILITARY ACTIVITY AND NATIONAL SECURITY** We may sometimes use or disclose the medical information of armed forces personnel to the applicable military authorities when they believe it is necessary to properly carry out military missions. We may also disclose your medical information to authorized federal officials as necessary for national security and intelligence activities or for protection of the president and other government officials and dignitaries.

**FOR WORKER'S COMPENSATION** We may release medical information about you to workers' compensation or similar programs, as required by law. For example, we may communicate your medical information regarding a work-related injury or illness to claims administrators, insurance carriers, and others responsible for evaluating your claim for workers' compensation benefits.



Figure D1. Contra Costa County Health Service HIPAA Notice of Privacy Practice, page 4  
(for health services)

**FOR PUBLIC HEALTH DISCLOSURES** We may use or disclose medical information about you for public health purposes. These purposes generally include the following:

- to prevent or control disease (such as cancer or tuberculosis), injury, or disability;
- to report births and deaths;
- to report suspected child abuse or neglect, or to identify suspected victims of abuse, neglect, or domestic violence;
- to report reactions to medications or problems with products or medical devices;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to comply with federal and state laws that govern workplace safety; and
- to notify emergency response employees regarding possible exposure to HIV/AIDS, to the extent necessary to comply with state and federal laws.

**FOR HEALTH OVERSIGHT ACTIVITIES** As health care providers and health plans, we are subject to oversight by accrediting, licensing, federal, and state agencies. These agencies may conduct audits on our operations and activities, and in that process they may review your medical information.

**FOR LAWSUITS AND OTHER LEGAL ACTIONS** In connection with lawsuits, or other legal proceedings, we may disclose medical information about you in response to a court or administrative order, or in response to a subpoena, discovery request, warrant, summons, or other lawful process. We may disclose your medical information to courts, attorneys, and court employees in the course of conservatorship and certain other judicial or administrative proceedings. We may also use and disclose your medical information, to the extent permitted by law, without your consent to defend a lawsuit.

**FOR LAW ENFORCEMENT** If asked to do so by law enforcement, and as authorized or required by law, we may release medical information:

- to identify or locate a suspect, fugitive, material witness, or missing person;
- about a suspected victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- about a death suspected to be the result of criminal conduct;
- about criminal conduct at one of our facilities; and

- in case of a medical emergency, to report a crime; the location of the crime or victims; or the identity, description, or location of the person who committed the crime.

**TO CORONERS AND FUNERAL DIRECTORS** We may release medical information to a coroner or medical examiner to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors as necessary to carry out their duties.

**INMATES** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution for certain purposes, for example, to protect your health or safety or someone else's. Note: Under the federal law that requires us to give you this Notice, inmates do not have the same rights to control their medical information as other individuals.

**MULTI-DISCIPLINARY PERSONNEL TEAMS** We may disclose medical information to a multi-disciplinary personnel team relevant to the prevention, identification, management or treatment of an abused child and the child's parents, or elder abuse and neglect.

**SPECIAL CATEGORIES OF INFORMATION** In some instances, your medical information may be subject to restrictions that limit or preclude some uses or disclosures described in this Notice. For example, there are special restrictions on the use or disclosure of certain categories of information, such as tests for HIV or treatment for mental health conditions or alcohol and drug abuse. Government health benefit programs, such as Medi-Cal, may also limit the disclosure of beneficiary information for purposes unrelated to the program.

### **All other uses and disclosures of your medical information require your prior written authorization**

Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. Please note that the revocation will not apply to any authorized use or disclosure of your medical information that took place before we received your revocation. Also, if you gave your authorization to secure a policy of insurance, including health care coverage from us, you may not be permitted to revoke it until the insurer can no longer contest the policy issued to you or a claim under the policy.

**Figure D1. Contra Costa County Health Service HIPAA Notice of Privacy Practice, page 5**  
(for health services)

**MARKETING AND SALES** We will not sell or give your information to an outside agency for the purposes of marketing their products to you without your written authorization.

**PSYCHOTHERAPY NOTES** Most uses and disclosures of psychotherapy notes require written authorization.

### **Your rights regarding your medical information**

Your medical information is the property of Contra Costa County. You have the following rights, however, regarding your medical information, such as your medical and billing records. This section describes how you can exercise these rights.

**RIGHT TO INSPECT AND COPY** With certain exceptions, you have the right to see and receive copies of your medical information that was used to make decisions about your care, or decisions about your health plan benefits. If your medical information is maintained in an electronic health record, you may obtain a copy of that information, with certain exceptions, in electronic format, and if you choose, you may direct us to transmit an electronic copy directly to another entity or person. Any such designation must be clear, conspicuous, and specific.

If you would like to see or receive a copy of your record on paper or electronically, please write us at the address where you received care. If you don't know where the record that you want is located, please write us at the Privacy Office of Contra Costa County, 50 Douglas Drive #310-E, Martinez, CA 94553. We may charge a fee for the costs of copying, mailing, or other supplies associated with your request. If the copy is in an electronic form, the fee shall not be greater than the labor costs incurred in responding to your request. If we don't have the record you asked for but we know who does, we will tell you who to contact to request it.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, in most cases, you may have the denial reviewed. Another licensed health care professional chosen by Contra Costa County will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

**RIGHT TO CORRECT OR UPDATE YOUR MEDICAL INFORMATION** If you feel that your medical information is incorrect or important

information is missing, you may request that we correct or add to (amend) your record. Please write to us and tell us what you are asking for and why we should make the correction or addition. Submit your request to the Privacy Office of Contra Costa County, 50 Douglas Drive #310-E, Martinez, CA 94553.

We may deny your request if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- was not created by us;
- is not a part of the medical information kept by or for us;
- is not part of the information which you would be permitted to inspect and copy; or
- is accurate and complete in the record.

We will let you know our decision within 60 days of your request. If we agree with you, we will make the correction or addition to your record.

If we deny your request, you have the right to submit an addendum, or piece of paper written by you, not to exceed 250 words, with respect to any item or statement you believe is incomplete or incorrect in your record. If you clearly indicate in writing that you want the addendum to be made part of your medical record, we will attach it to your records and include it whenever we make a disclosure of the item or statement you believe to be incomplete or incorrect.

### **RIGHT TO AN ACCOUNTING OF DISCLOSURES**

You have the right to receive a list of the disclosures we have made of your medical information. An accounting or list does not include certain disclosures, for example, disclosures to carry out treatment, payment, and health care operations; disclosures that occurred prior to April 14, 2003; disclosures which you authorized us in writing to make; disclosures of your medical information made to you; disclosures to persons acting on your behalf.

To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Office of Contra Costa County, 50 Douglas Drive #310-E, Martinez, CA 94553. Your request must state the time period to be covered, which may not be longer than six years and may not include dates before April 14, 2003. You are entitled to one disclosure accounting in any 12-month period at no charge. If you request any additional accountings less than 12 months later, we may charge a fee.

**Figure D1. Contra Costa County Health Service HIPAA Notice of Privacy Practice, page 6**  
(for health services)

**NOTIFICATIONS** We will notify you as required by law if your medical information is unlawfully accessed or disclosed.

**RIGHT TO REQUEST LIMITS ON USES AND DISCLOSURES OF YOUR MEDICAL INFORMATION**

You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. However, by law, we do not have to agree to your request. Because we strongly believe that this information is needed to appropriately manage the care of our members/patients, we rarely grant such a request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

We will honor a request to restrict disclosures to a health plan for services that have been paid out-of-pocket, in full, unless the disclosure is required by law or is determined to be necessary for treatment purposes.

To request restrictions, you must make your request in writing to the Privacy Office of Contra Costa County, 50 Douglas Drive #310-E, Martinez, CA 94553. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

**RIGHT TO CHOOSE HOW WE SEND MEDICAL INFORMATION TO YOU**

You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only phone you at work or use a P.O. Box when we send mail to you.

To request confidential communications, you must make your request in writing, specify how or where you wish to be contacted, and submit it to the Privacy Office of Contra Costa County at 50 Douglas Drive #310-E, Martinez, CA 94553. When we can reasonably and lawfully agree to your request, we will.

**RIGHT TO A PAPER COPY OF THIS NOTICE**

You have the right to a paper copy of this Notice upon request. One way to obtain a paper copy of this Notice is to ask at the registration area of any Contra Costa Health Services' facility. Or, call the Contra Costa Health Plan Member Services at 1-877-661-6230, option 2, or the Privacy Office of Contra Costa County at 925-957-5430.

You may also obtain a copy of this Notice of Privacy Practices on our website at:  
<http://cchealth.org/policies/medical-privacy.php>

**Changes to this Notice**

We may change this Notice and our privacy practices at any time, as long as the change is consistent with state and federal law. Any revised Notice will apply both to the medical information we already have about you at the time of the change, and any medical information created or received after the change takes effect. We will post a copy of our current Notice in all of the Contra Costa Health Services' facilities and on our website at:

<http://cchealth.org/policies/medical-privacy.php>

The effective date of the Notice will be on the first page, in the top right-hand corner.

**Questions**

If you have any questions about this Notice, please contact the Privacy Office of Contra Costa County at 925-957-5430.

If you have questions related to health information privacy, access the Office for Civil Rights' database under "HIPAA" at: [www.hhs.gov/ocr/privacy](http://www.hhs.gov/ocr/privacy)

**Complaints**

If you believe your privacy rights have been violated, you may file a complaint with any of the following: Contra Costa Health Plan members, please call Member Services at 1-877-661-6230, option 2.

Clients of the Contra Costa Mental Health Plan may call the Office of Quality Assurance at 925-957-5160. You can write the Privacy Office of Contra Costa County, 50 Douglas Drive, #310-E, Martinez, CA 94553, or call our 24-hour Privacy Hotline at 1-800-659-4611.

Medi-Cal beneficiaries may file a privacy complaint with the California Department of Health Care Services: Privacy Officer, c/o Office of Legal Services; P.O. Box 997413, MS0011, Sacramento, CA 95899-7413. (916) 440-7750 email: [privacyofficer dhcs.ca.gov](mailto:privacyofficer dhcs.ca.gov)

You may file a written complaint with the secretary of the Department of Health & Human Services. Instructions on how to file a complaint are found by clicking on "How to File a Complaint" under the section on "HIPAA" at: [www.hhs.gov/ocr/privacy](http://www.hhs.gov/ocr/privacy)

Or, you can call the San Francisco Office for Civil Rights at (415) 437-8310 to request the Health Information Privacy Complaint Form package.

**We will not take retaliatory action against you if you file a complaint about our privacy practices.**

**Figure D2. Contra Costa County Whole Person Care Interagency Authorization, page 1**  
(for information sharing with community partners)

Contra Costa Health Services

- Contra Costa Regional Medical Center
- Contra Costa Health Centers
- Behavioral Health and Substance Use
- Public Health
- Community Connect Partnership

Name:

MRN:

**AUTHORIZATION TO DISCLOSE HEALTH INFORMATION / INTERAGENCY RELEASE**

Name:	Date of Birth:
AKA (Other name(s) you have used):	
Street Address:	Phone #:

I am the ☐ Patient ☐ Parent/Guardian ☐ Conservator ☐ Representative

By signing and initialing below, I hereby authorize Community Connect Partnership to release and share limited health information in order to coordinate my care and services with selected agencies listed on side 2 of this form. The use of my health information will only be used in the delivery of services related to my participation in Community Connect Partnership.

_____ Client Initial	I understand that the type of information that may be shared includes: <ul style="list-style-type: none"> <li>• Name and contact information</li> <li>• Completed needs assessment, and/or care plan form(s)</li> <li>• Information related to service utilization</li> <li>• Any other personal information including but not limited to demographics and the minimum necessary health information needed to access services</li> </ul>
_____ Client Initial	I understand that signing this form authorizes the release of my personal information only to agency staff members whose work is specifically and directly related to services provided for my benefit of ANY of the agencies listed on side 2 of this form.
_____ Client Initial	I understand that all communication between agencies is confidential and may not be re-disclosed and that I have a right to receive a copy of this authorization.
_____ Client Initial	I understand that this authorization may be revoked in writing by me at any time and delivered to the address where I received care or services. If I do not revoke this authorization it will expire one (1) year from the date of my signature.
_____ Client Initial	I understand I have a right to inspect or obtain a copy of the information disclosed and I may refuse to sign this authorization. Payment, enrolment or eligibility for benefits will not be conditioned on my providing or refusing to sign this authorization.

Date:	Patient/Representative Signature:
If signed by someone other than the patient, please print name:	
Staff/Provider Signature:	
If applicable, Witness of Verbal Release:	

MR340 (5.2018)

**Figure D2. Contra Costa County Whole Person Care Interagency Authorization, page 2**  
(for information sharing with community partners)

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Name: \_\_\_\_\_

MRN: \_\_\_\_\_

**Community Connect Partnership Agency Listing:**

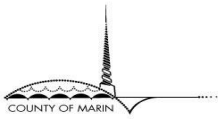
AIDS Project of the East Bay	Monument Crisis Center
A Chance for Freedom	Money Management
ANKA Behavioral Health, Inc.	Pathways Hospice and Home Health
BAART	Planned Parenthood
Bay Area (Richmond) Rescue Mission	Pueblos del Sol
Bay Area Legal Aid (BayLegal)	Rainbow Community Center
Cabulance Comfort	Reach
Cole House	Regional Center of the East Bay (RCEB)
Community Violence Solutions	Reentry Success Center
Contra Costa Interfaith Housing (CCIH)	Rotocare Clinics
Contra Costa Housing Authority	Rubicon Program
Diablo Valley Ranch	Shelter, Inc.
East County Wollam House	Social Security Administration
Familias Unidas	STAND! For Families Free of Violence
Frederic Ozanam Center	Trinity Center
Food Bank of Contra Costa/Solano Counties	UJIMA
Greater Richmond Interfaith Program (GRIP)	Veterans Administration
Hospice of Contra Costa County	Winter Night's Shelter
Love A Child	YWCA
Other: _____	Other: _____
Other: _____	Other: _____

Individuals not affiliated with an agency:

Name: \_\_\_\_\_

Name: \_\_\_\_\_





**Marin County - Whole Person Care Program**  
**Consent to Release and/or Exchange *Non-SUD* Patient Records**

Participant Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Month/day/year  
Medi-Cal CIN (Please include if known) \_\_\_\_\_

Completion of this document authorizes the use and disclosure of protected health and/or eligibility information about you. This excludes the release of any Substance Use Disorder (SUD) records subject to 42 C.F.R part 2. Failure to provide all information requested may invalidate this consent.

**Who May Use, Disclose or Share My Information:**

In order for Whole Person Care (WPC) to identify and coordinate services available to you, it is essential that we have your permission to share and exchange relevant information with your care providers and other providers of services available to you. The following is a comprehensive list of those agencies who participate in the WPC Program. Sharing any of your information with any of these agencies will only be on a need to know basis and only for the coordination of your care or services.

I hereby authorize the release of the below-identified information by, and the exchange of the below-identified information between, all Marin County Whole Person Care project agencies, entities, and facilities, which may include the following: Marin County HHS (**Excludes Substance Use Disorder Records subject to 42 CFR Part 2**), Marin County District Attorney, County of Marin Probation Department, County of Marin Public Defender, Bright Heart Health, Buckelew Programs, Center Point (**Excludes Substance Use Disorder Records subject to 42 CFR Part 2**), Central Marin Police Authority, City of Novato, City of San Rafael, Coastal Health Alliance, Community Action Marin, Downtown Streets Team, Healthy Marin Partnership, Homeward Bound, Kaiser Permanente San Rafael, LifeLong Medical, Marin City Health and Wellness Center, Marin Community Clinics, Marin County Sheriff's Office, Marin General Hospital, Marin Housing Authority, Opportunity Village, Partnership Health Plan of CA, Ritter Center, Senior Access, St. Vincent de Paul Society, Sunny Hills Services, The Spahr Center, US Department of Veterans Affairs, Whistlestop.

A complete and current list of participants, individuals and entities has been provided to me and is available from the Whole Person Care Webpage: <https://www.marinhhs.org/whole-person-care>

Participant Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Month/day/year

**The Purpose(s) of Disclosure(s)/Sharing:**

The purpose of this consent is to enable staff and members of the authorized entities listed above to coordinate, collaborate, and assess appropriate medical, housing and/or supportive services related to obtaining housing and improving care coordination (including but not limited to outreach, case management, emergency shelter, employment services, benefits assistance, medical and/or behavioral health services, life skills classes, and housing search assistance). I understand that Information will not be shared for any other purpose unless required by law or specifically authorized by me.

**My Rights**

- ▶ I may refuse to sign this consent. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits otherwise available to me.
- ▶ I have a right to receive a copy of this consent.
- ▶ I may revoke (take back) this consent at any time. To do so I must submit my revocation request in writing to the following address:

**Compliance Program - Department of Health and Human Services,  
20 N. San Pedro Rd, San Rafael, CA 94903  
Or e-mail: [HHSCompliance@marincounty.org](mailto:HHSCompliance@marincounty.org)**

- ▶ My revocation will take effect upon receipt, except to the extent that others have already acted in reliance upon this authorization.

**Re-Disclosure:**

I understand that health and personal information disclosed pursuant to this Authorization could be re-disclosed by the recipient. Such re-disclosure is, in some cases, not protected by California law and may no longer be protected by federal confidentiality law such as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Parts 160 and 164. I understand mental health records are subject to Welfare & Institutions Code 5328 and the CA Confidentiality of Medical Information Act, and cannot be re-disclosed without my written consent unless otherwise provided for or required by law.

**What Will be Disclosed or Exchanged:** This is a full-disclosure authorization of my health and/or eligibility information, unless I specify any limitations below. Information which may include medical, surgical, communicable diseases, labs, medications, eligibility for state benefits, and any other personal information which may assist the above agencies in carrying out the purpose(s) indicated below. Mental health and HIV

Participant Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Month/day/year

test results are specifically protected by Federal or State law and require my explicit consent to release these records, if any, as indicated below:

**Client Cell Phone** (optional):

*I agree to receiving calls or texts at this number:* (    ) \_\_\_\_ - \_\_\_\_\_

**Mental health treatment records** \_\_\_\_\_ (Sign to Permit)

**Results of HIV Tests** \_\_\_\_\_ (Sign to Permit)

**Limitations:** The following information may **not** be used, disclosed or shared:

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**Additional Parties:** I provide permission to share and exchange relevant information with the following individuals or organizations:

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**Expiration:**

This authorization expires on (date): \_\_\_\_\_,  
or (event): example: I am no longer enrolled in the Whole Person Care Project.

If I do not write in a date or event, this authorization will remain in effect for three (3) years from the date of my signature.

Signature \_\_\_\_\_ **Today's date** \_\_\_\_\_  
Participant/Legal Representative

If not signed by individual (enrollee), name and relationship of Legal Representative:

---

Witness Signature (optional) \_\_\_\_\_

Witness Printed Name \_\_\_\_\_ Today's Date \_\_\_\_\_

Participant Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Month/day/year

-----  
**For Office Use Only:**

Revoked by (name) \_\_\_\_\_ Date \_\_\_\_\_

Revocation received by: (name) \_\_\_\_\_


Date informed WPC project: \_\_\_\_\_

## Appendix E. Contra Costa County Resources

### Epic Functionality to Support Care Coordination

CCHS and Epic approved screenshots of many of the care coordination functions developed in CCHS's Epic EHR.

Figure E1. Social Needs Assessment

 Social Needs

Medical

Do you need assistance with connecting to a Doctor?

YesNo

Do you have any dental concerns or needs?

YesNo

Do you have any vision or eye care needs?

YesNo

Do you have any outstanding medical bills that you are concerned with?

YesNo

Are there any medical supplies, medications, or specialty care appointments that you need that you haven't been able to access?

YesNo

Additional information:

Behavioral Health

Do you have any mental health concerns?

YesNo

Do you have any substance use concerns?

YesNo

Would you like to be connected to resources to receive support/counseling/treatment for mental health or substance use?

YesNo

Additional information:

Safety

Do you feel physically and emotionally safe where you currently live?

YesNo

Are you currently in a situation where you are being hurt or harmed in any way?

YesNo

Additional information:

Housing

What is your current living situation?

StreetShelterDoubled upSober Living Environment (SLE)Residential treatmentTransitional housingSingle room occupancy (SRO)Board and careOwn or rentOther

Do you believe you are at risk of losing your housing within the next 6 months?

YesNo

Do you live alone or with other people?

AloneLives with people

Additional comments:

Do you have any pets?

YesNo

Additional comments:

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Figure E1. Social Needs Assessment, *continued*

Additional comments:

Would you like information about utility discount programs? (i.e., PG&E, water, phone)

Would you like information about home repair programs? (i.e., Weatherization Program)

Would you like information about rental assistance resources?

Would you like information about shelters in your area?

Additional information:

**Finances**

Do you currently have a source of income?

Have you received or are you currently applying to any income/public assistance programs, such as SSI, SSDI, GA, Cal-Works, or others?

Would you like assistance applying for Income/Public Assistance Programs?

Additional information:

**Food Security**

Do you or your family struggle with having enough food to eat every day?

Would you be interested in information about food programs and food stamps?

Additional information:

**Transportation**

Do you need help with transportation to/from medical or other important appointments?

How do you currently get to/from your medical or other important appointments?

Additional information:

**Support System**

When you feel stressed/overwhelmed, do you need additional support in your life?

What is something you like to do or something in your life you are proud of?

Do you have any children and/or adults who are dependent on your care that you would like additional resource information for?

What support/resources do you feel that you need?

Additional information:

**Education/Employment**

Would you like information about educational opportunities?

Would you like information about job training programs?

Would you like information about job placement programs?

Additional information:

**Legal**

Do you need legal assistance information? (ex: immigration, child custody/support, tenant issues, restraining orders, etc.)

Additional information:

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Figure E2. Identifying and Tracking Client-Identified Goals

Active Goals		
	Last Edited	Most Recent
<b>Behavioral Health</b>		
Adequate substance abuse related support	2018 11:38 AM by Roshawn R Adams, SAC	Precontemplation ( /2018)
<b>Social Need</b>		
Adult Education	2018 11:38 AM by Roshawn R Adams, SAC	Preparation ( /2018)
Completed Goals		
	Last Edited	Most Recent
<b>Behavioral Health</b>		
COMPLETED: Adequate Mental Health	2018 11:40 AM by Roshawn R Adams, SAC	Precontemplation ( /2018)
COMPLETED: optometrist	2018 11:15 AM by Roshawn R Adams, SAC	No change ( /2017)
<b>Health &amp; Care Coordination</b>		
COMPLETED: Adherence to Medication Regime	2018 3:50 PM by Roshawn R Adams, SAC	
COMPLETED: Coordinate Vision Care	2018 10:24 AM by Roshawn R Adams, SAC	
<b>Social Need</b>		
COMPLETED: Legal	2018 12:13 PM by Roshawn R Adams, SAC	Maintenance ( /2018)
COMPLETED: Transportation	2018 3:51 PM by Roshawn R Adams, SAC	No change ( /2017)

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Figure E2. Identifying and Tracking Client-Identified Goals, *continued*

<div> <div>Active Goals</div> </div>	
Behavioral Health	
Substance Abuse Related Support	
2018	
<b>Category:</b> Substance Use	
<b>Describe the client's current concerns or needs:</b> Clt is currently in the precontemplation stage of change as he minimizes his SUD.	
<b>Resources/education/support provided:</b> NA	
<b>Updates/Next steps:</b>	
<ul style="list-style-type: none"> <li>2018: Counselor will continue to strengthen rapport and build trust prior to confronting clt's SUD.</li> </ul>	
<b>Outcome:</b> Motivational interviewing to foster readiness for linkage: Use MI to increase readiness for treatment	
Health & Care Coordination	
Dental Care	
2018	
<b>Describe the client's current concerns or needs:</b> Lost top partials approx 1 year ago	
<b>Resources/education/support provided:</b> NA	
<b>Updates/Next steps:</b>	
<ul style="list-style-type: none"> <li>18: Aid clt in scheduling a dentist appt.</li> </ul>	
<b>Outcome:</b>	
Denti-Cal Education: Pending	
Med Adherence / Pharmacy Coordination	
10/24/2018	
<b>Describe the client's current concerns or needs:</b> Clt struggles staying compliant with medication due to limited mobility and difficulty accessing public transportation.	
<b>Resources/education/support provided:</b> NA	
<b>Updates/Next steps:</b>	
<ul style="list-style-type: none"> <li>18: Counselor managed to pick of clt's remaining medication and deliver it to him at his uncle's house.</li> <li>18: Counselor picked up 3 out of 4 of clt's medications and delivered them to him. Counselor was informed one medication won't be available until the next day.</li> </ul>	
<b>Outcome:</b>	
Med Compliance: Provided or sent resource(s)/information	
Social Need	
Housing	
2018	
<b>Describe the client's current concerns or needs:</b> Clt is currently homeless, spends a lot of time at [redacted]. Clt recently discharged from [redacted] for	
<b>Resources/education/support provided:</b> C.O.R.E.	
<b>Updates/Next steps:</b>	
<ul style="list-style-type: none"> <li>18: Clt stated he is currently residing at the [redacted] Shelter located at [redacted] (555) 555-5555</li> <li>18: Call 211 to check for shelter service availability.</li> </ul>	
<b>Outcome:</b>	
Emergency Shelter: Accessed/Utilized resource	
Transportation	
2018	
<b>Describe the client's current concerns or needs:</b> Clt recently had his leg amputated, struggles with public transit.	
<b>Resources/education/support provided:</b> CCHP Transportation Service (Contra Costa Health Plan (CCHP))	
595 Center Ave	
Martinez, California 94553	
(555) 555-5555	
<b>Updates/Next steps:</b>	
<ul style="list-style-type: none"> <li>18: Counselor to aid clt in signing up for all transportation services which eligibility criteria he meets.</li> </ul>	
<b>Outcome:</b>	
Medi-Cal Transportation Benefit (CCHP or Kaiser): Provided or sent resource(s)/information	
Utilities	
12/4/2018	
<b>Describe the client's current concerns or needs:</b> Clt recently lost his cell phone and due to limited finances can't afford a replacement. Clt receptive to case management wh	
<b>Resources/education/support provided:</b> CMCT Cell phone	
<b>Updates/Next steps:</b>	
<ul style="list-style-type: none"> <li>18: Counselor managed to contact clt while in the emergency dept of Kaiser Fremont. Counselor informed clt of cell phone resource to which he was receptive</li> </ul>	
<b>Outcome:</b>	
Telephone: Referral placed	

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Figure E3. Active Care Team Contacts List

**Care Teams**

**Patient Care Coordination Note** Edited: Caryl Blount, CHW 11/1/2018

This patient is enrolled in the CommunityConnect program with a primary care manager of Caryl Blount who can be reached at 555-555-5555. More information can be found within the Care Team and Communications section in the patient snapshot.

**Patient Care Team**

Team Member	Relationship	Specialty	Start	End	Updated
<b>PCPs</b>					
Caryl Blount, CHW Phone: 555-555-5555	PCP - CommunityConnect		11/1/2017		11/1/17
Gearline Duplessis	PCP - Care Coordinator		11/1/2017		11/1/17
Kathryn Elizabeth Hamlin, MD Phone: 555-555-5555 Pager: 555-555-5555	PCP - General		11/1/2017		11/1/17
<b>Pittsburg</b> Phone: 555-555-5555	PCP - Patient Location		11/1/2017		11/1/17
<b>Patient Eligibility</b>	PCP - Patient Eligibility		11/1/2016		11/1/16
<b>Other Patient Care Team Members</b>					
Tabitha Goldenberg, RN PHN	Public Health Nurse	Public Health	11/1/2015	End	11/1/15

Figure E4. Event Notifications and Tools to Follow Up After Crisis Events

**In Basket**

Cheryl M Jordan, SAC's In Basket > Outside Events 0 unread, 3 total

Status Date Patient Event

**Read** 11/1/2018 **Patient Discharged** Expires 11/1/2019

Organization: Sutter Health Affiliates and Community Connect Pra...

**Outside Event Notification**

Patient: [Redacted]  
Seen at: Sutter Health Affiliates and Community Connect Practices  
Date: 11/1/2018  
Details: Patient Discharged

Encounter Summary generated on 11/1/2018

**Patient Demographics** - y.o. Female, born 11/1/1978

Patient Address	Communication	Language	Race / Ethnicity
3901 LONE TREE WAY ANTIOCH, CA 94509	(555) 555-5555 (Mobile) (555) 555-5555 (Home) (555) 555-5555 (Work)	English (Preferred)	Asian / Not Hispanic or Latino

**Reason for Visit**

Reason	Comments
Abdominal pain	abdominal pain x 7 days nausea and vomiting, denies fever.

**Encounter Details**

Date	Type	Department	Care Team	Description
11/1/2018	Emergency	Delta Medical Center Emergency Services 3901 Lone Tree Way Antioch, CA 94509 (555) 555-5555	<b>Banas, Marek Krzysztof, DO</b> 3901 LONE TREE WAY ANTIOCH, CA 94509-6200 (555) 555-5555	

**Social History** - as of this encounter

Tobacco Use	Types	Packs/Day	Years Used	Date
Never Smoker				
Smokeless Tobacco: Never Used				
Alcohol Use	Drinks/Week	oz/Week	Comments	
No				
Sex Assigned at Birth	Date Recorded			
Not on file				
Job Start Date	Occupation	Industry		
Not on file	Not on file	Not on file		
Travel History	Travel Start	Travel End		

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Figure E4. Event Notifications and Tools to Follow Up After Crisis Events, *continued*

Outreach

High Risk Event

CommunityConnect Post High Risk Hospital Event Initial Assessment

Event Information:

Patient was contacted this encounter regarding a recent high-risk event:

ED Visit IP Visit PES Visit 5150 Order

Primary Diagnosis:

Primary Discharge Diagnosis:

Can you tell me a little bit about what brought you to the hospital/PES/ER?

Yes No

Additional information:

Symptoms:

Since you've been discharged, have you been feeling better than when you went in?

Yes No

Do you know how to contact the advice nurse?

Yes No

Additional information:

Medications:

Were you sent home with any new medications or prescriptions?

Yes No

Additional information:

Follow-Up Appointments:

Do you have any future medical appointments scheduled?

Yes No

Were you referred to any of the following services when you were discharged: home health, case management, mental health care, financial counseling or durable medical equipment?

Yes No

Do you know how to leave a message for your primary care provider by calling the care coordinator at your clinic, or by accessing myccLink?

Yes No

Is anyone helping you in the home?

Yes No

Plan:

Reviewed discharge plan and other instructions with client:

Yes No

Reviewed how to address any issues identified above with client:

Yes No

Provided assistance to schedule follow-up appointments/tests:

Yes No

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## Appendix F. Marin County Resources

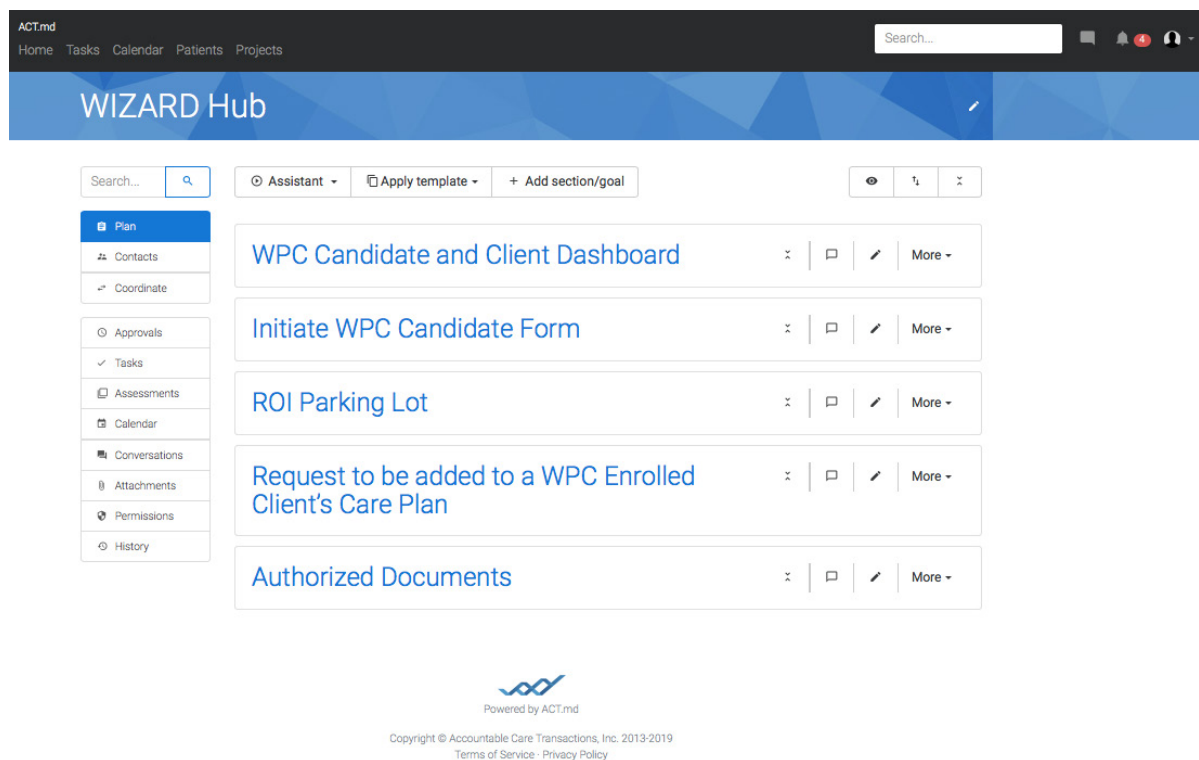
### WPC and CE Collaboration

Marin County has developed several online resources to describe its housing-first approach to ending chronic homelessness and the collaboration between the WPC and CE programs:

- ▶ For more on Coordinated Entry and WPC collaboration, see [www.marinhhs.org](http://www.marinhhs.org).
- ▶ For more on Marin County's housing-first approach, see [housingfirst.marinhhs.org](http://housingfirst.marinhhs.org).
- ▶ For a video on ending chronic homelessness and WPC goals, see [youtube.com](http://youtube.com).

### ACT.md WIZARD Care Coordination System Screenshots

**Figure F1. WIZARD Hub.** This section allows community members to access information about which clients are enrolled in WPC, initiate referrals to the program, upload consent forms, and request to be added to a care team.



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**Figure F2. Contacts.** Care team members as well as important client contacts are tracked in the plan. Care team members can be invited from any organization to access the web-based care plan. Their organization does not need to be a separate ACT.md customer.

The screenshot displays the ACT.md web-based care plan interface. At the top, a navigation bar includes 'Home', 'Tasks', 'Calendar', 'Patients', and 'Projects'. A search bar is located in the top right corner. Below the navigation bar, a header section for the patient 'Keira Test' (Female, Born 1 Jan 1970) is shown, with a status 'Not yet invited'. A green banner at the bottom of this header indicates 'Contact saved.'.

The main content area is divided into two sections: 'Family & caregiver contacts' and 'Clinical & community contacts'. Both sections have an 'Add...' button in the top right corner.

**Family & caregiver contacts:** This section lists family members, friends, and caregivers involved in Keira Test's care. It contains two entries:

Name	Relationship	Contact Information	Access
Brother Test	Brother	(555) 555-5555 WORK	No access to plan
Keira Test	Patient		No access to plan

**Clinical & community contacts:** This section lists clinicians and community resources involved in Keira Test's care. It contains two entries:

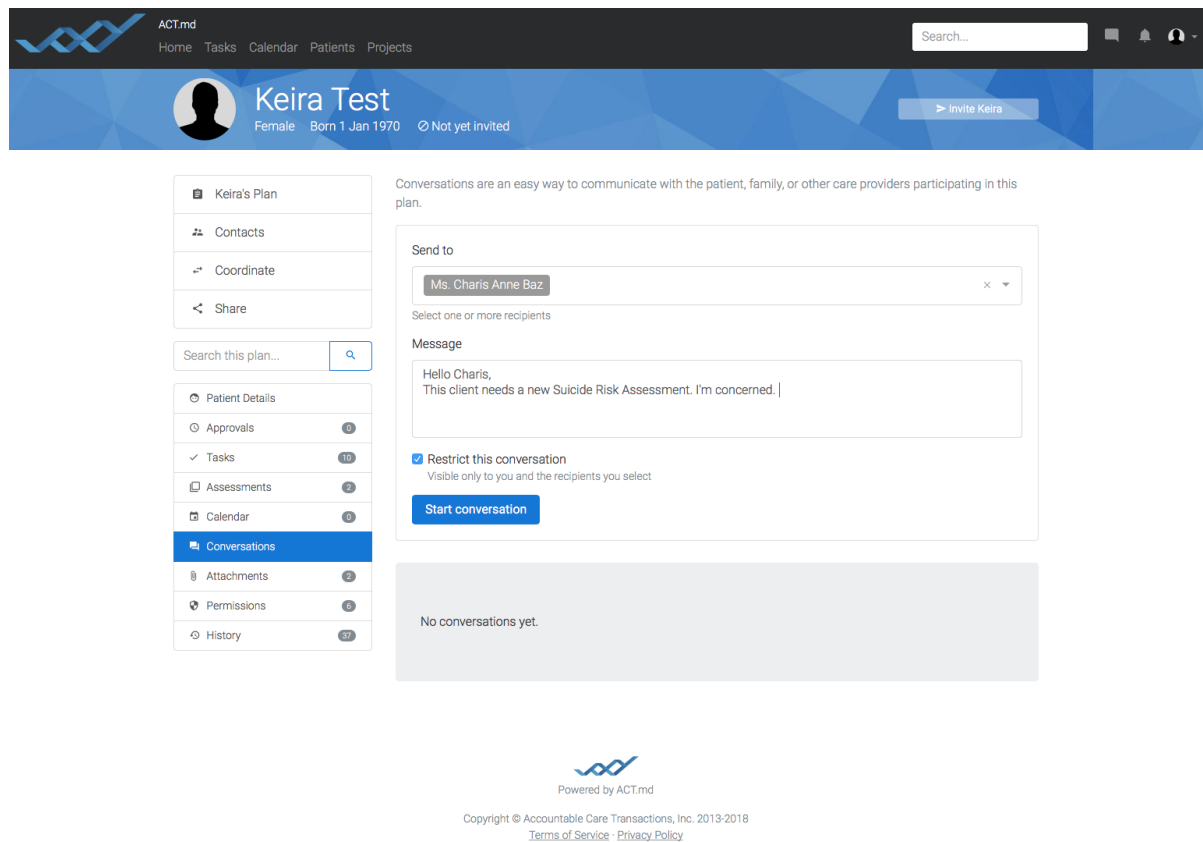
Name	Role	Contact Information	Location
Ms. Charis Anne Baz Whole Person Care Business Unit Administrator	Benefits Navigator	(415) 473-2188 WORK	
Mark Sorensen Ritter Center Administrator	Housing Case Manager	(415) 720-3514 PRIMARY	

A note at the bottom of the clinical contacts section states: 'Note: To give someone permission to access this plan, visit the [permissions page](#).'

The interface is powered by ACT.md, as indicated by the logo and text at the bottom.

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**Figure F3. Conversations.** WIZARD users can communicate with each other securely and can select preferred contact methods, including mobile app notifications, email, or text. Care team members can assign referrals and collaboration tasks to other WIZARD users.



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**Figure F4. Coordinate.** Case managers can log outreach to and visits with clients for tracking both ongoing goals and interventions, as well as for billing the county for contracted services.

ACT.md  
Home Tasks Calendar Patients Projects

Search...

**Keira Test**  
Female Born 1 Jan 1970 Not yet invited

Invite Keira

Keira's Plan

Contacts

Coordinate

Share

Search this plan...

Patient Details

Approvals 0

Tasks 10

Assessments 2

Calendar 0

Conversations

Attachments 2

Permissions 0

History 37

**New outreach**

Note

Related activities

☐ Phone call ☐ Visit

☐ E-mail ☐ Letter

☐ Meeting

Minutes spent... minutes

☐ Unable To Reach

Date of outreach Now Time of outreach

Save

No outreach reported yet.

Powered by ACT.md

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**Figure F5. The Client's Plan.** All enrolled clients have a comprehensive care plan where care team members can track relevant information, document client-identified goals, and coordinate through tasks, events, messages, or alerts.

**Keira's Plan**  
Female Born 1 Jan 1970 Not yet invited [Invite Keira](#)

**Keira's Plan**  
[Assistant](#) [Apply template](#) [Add section/goal](#)

[Contacts](#)  
[Coordinate](#)  
[Share](#)

Search this plan... [Search](#)

[Patient Details](#)  
[Approvals](#) (0)  
[Tasks](#) (10)  
[Assessments](#) (2)  
[Calendar](#) (0)  
[Conversations](#)  
[Attachments](#) (2)  
[Permissions](#) (6)  
[History](#) (37)

**Enrollment and Intake** [Zoom](#) [Expand](#) [Edit](#) [More](#)

**Alerts and Updates** [Zoom](#) [Expand](#) [Edit](#) [More](#)

**Referrals** [Zoom](#) [Expand](#) [Edit](#) [More](#)

**Basic Client Info** [Zoom](#) [Expand](#) [Edit](#) [More](#)

**Social Determinants and Public Benefits** [Zoom](#) [Expand](#) [Edit](#) [More](#)

**Medical: Client Identified Goal** [Zoom](#) [Expand](#) [Edit](#) [More](#)

Access to this section is restricted to 1 person. [Permissions](#)

**Medical: Client Summary** [Zoom](#) [Expand](#) [Edit](#) [More](#)

**Housing: Client Identified Goal** [Zoom](#) [Expand](#) [Edit](#) [More](#)

Goal is [Not started](#) to be achieved by [Date not set](#)

**Housing: Summary and Current Status** [Zoom](#) [Expand](#) [Edit](#) [More](#)

**Housing: Detailed History** [Zoom](#) [Expand](#) [Edit](#) [More](#)

**Behavioral Health: Client Identified Goal** [Zoom](#) [Expand](#) [Edit](#) [More](#)

Goal is [Not started](#) to be achieved by [Date not set](#)

**Behavioral Health: Client Summary** [Zoom](#) [Expand](#) [Edit](#) [More](#)

**Behavioral Health: Risk Assessment** [Zoom](#) [Expand](#) [Edit](#) [More](#)


**Behavioral Health: Substance Use** [Zoom](#) [Expand](#) [Edit](#) [More](#)

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**Figure F6. Social Determinants and Public Benefits.** This section provides a space for case managers to track patient concerns and issues. Social service benefits navigators update the public benefits assessment each month with the client's current benefits status. They create tasks for case managers if a client is in danger of losing his or her public benefits.

ACT.md

[Home](#)
[Tasks](#)
[Calendar](#)
[Patients](#)
[Projects](#)



Keira Test

Female
Born 1 Jan 1970
Not yet invited

## Social Determinants and Public Benefits



More ▾

**Severity level** (In Crisis, Vulnerable, Safe, Building Capacity, Empowered/Thriving): **Vulnerable**

Document the following as needed for the client:

- **Income concerns:** Client is on SSI so this isn't a pressing concern
- **Environmental concerns:** Lives with grandmother who chain smokes indoors
- **Food concerns:** Has Cal-Fresh but lacks a place to store or prepare food. Grandmother's housing is a single room occupancy which they share without kitchen access. Use of community dining rooms inconsistent due to transportation issues
- Education level achieved and/or concerns: n/a
- Social concerns: n/a
- **Health Care concerns:** Has difficulty getting to appointments due to transportation issues
- **Housing concerns:** Currently living with very frail elderly grandmother. Unclear what will happen when grandmother passes (See Housing: Detailed History).
- **Transportation Concerns:** This is a consistent problem due to grandmother's house being in west marin and lack of a vehicle and need to use a walker. Bus service inconsistent
- Work concerns: n/a
- Other Unmet Needs: (clothing, employment, other, etc): n/a



☆ Please give me the steps to get this client evaluated for SSI

Antoine B. Sept

01 Mar



☆ Complete the Public Benefits Assessment

[Click here to open the assessment »](#)

Social Service ...

Unscheduled



New task



Add an assessment



New event



New attachment



Apply template



Powered by ACT.md



## Endnotes

1. Jessica Kent, *Kaiser Permanente Launches SDOH Initiatives Targeting Housing Security*, Health IT Analytics, January 22, 2019, [healthitanalytics.com](https://www.healthitanalytics.com); and CVS Health, "CVS Health Announces \$100 Million Community Commitment Following Acquisition of Aetna," press release, January 14, 2019, [cvshealth.com](https://www.cvshealth.com).
2. Two small counties, San Benito and Mariposa, are organized into one pilot program called the Small County Collaborative. Sacramento WPC is led by the City of Sacramento and not a Sacramento County entity.
3. Please see DHCS's midpoint assessment of progress and challenges on all aspects of the WPC pilots: Lucy Pagel, Carol Backstrom, and Hilary Haycock, *Whole Person Care: A Mid-Point Check-In*, California Department of Health Care Services, March 2019, [www.dhcs.ca.gov](https://www.dhcs.ca.gov) (PDF).
4. Pagel, Backstrom, and Haycock, *Whole Person Care: A Mid-Point Check-In*.
5. California Department of Health Care Services, "Whole Person Care Pilots," last modified March 22, 2019, [www.dhcs.ca.gov](https://www.dhcs.ca.gov).
6. California Department of Health Care Services, *Attachment GG: WPC Reporting and Evaluation*, amended May 12, 2016, [www.dhcs.ca.gov](https://www.dhcs.ca.gov) (PDF).
7. First-round pilots include Alameda County Health Services Agency; Contra Costa Health Services; County of Orange, Health Care Agency; County of San Diego, Health and Human Services Agency; Kern Medical Center; Los Angeles County Department of Health Services; Monterey County Health Department; Napa County; Placer County Health and Human Services Department; Riverside University Health System, Behavioral Health; San Bernardino County – Arrowhead Regional Medical Center; San Francisco Department of Public Health; San Joaquin County Health Care Services Agency; San Mateo County Health System; Santa Clara Valley Health and Hospital System; Shasta County Health and Human Services Agency; Solano County Health & Social Services; and Ventura County Health Care Agency. Second-round pilots include City of Sacramento; County of Marin, Department of Health and Human Services; County of Santa Cruz, Health Services Agency; County of Sonoma, Department of Health Services Behavioral Health Division; Kings County Human Services Agency; Mendocino County Health and Human Services Division; and Small County Collaborative (Mariposa and San Benito Counties).
8. Lucy Pagel, Tanya Schwartz, and Jennifer Ryan, *The California Whole Person Care Pilot Program: County Partnerships to Improve the Health of Medi-Cal Beneficiaries*, Harbage Consulting, updated February 2018, [harbageconsulting.com](https://www.harbageconsulting.com) (PDF).
9. California Department of Health Care Services, *Whole Person Care Program: Medi-Cal 2020 Waiver Initiative*, November 2016, [www.dhcs.ca.gov](https://www.dhcs.ca.gov) (PDF).
10. Deven McGraw, Robert Belfort, and Alex Dworkowitz, *Fine Print: Rules for Exchanging Behavioral Health Information in California*, California Health Care Foundation, July 24, 2015, [www.chcf.org](https://www.chcf.org); and Robert Belfort and Alex Dworkowitz, *Overcoming Data-Sharing Challenges in the Opioid Epidemic: Integrating Substance Use Disorder Treatment in Primary Care*, California Health Care Foundation, July 2018, [www.chcf.org](https://www.chcf.org). In addition, the Legal Action Center analyzed SAMHSA guidance documents on the regulation; see Legal Action Center, "SAMHSA and ONC Publish Two New Guidance Documents Clarifying 42 CFR Part 2," news release, May 24, 2018, [lac.org](https://www.lac.org).
11. US Department of Housing and Urban Development, *CoC Program Toolkit - CoC Responsibilities and Duties*, HUD Exchange, accessed March 30, 2019, [www.hudexchange.info](https://www.hudexchange.info).
12. For more information about Health Homes, see California Department of Health Care Services, "Health Homes Program," last modified March 27, 2019, [www.dhcs.ca.gov](https://www.dhcs.ca.gov).
13. For more on these organizational challenges, refer to Pagel, Backstrom, and Haycock, *Whole Person Care: A Mid-Point Check-In*.
14. Pagel, Backstrom, and Haycock, *Whole Person Care: A Mid-Point Check-In*.
15. McGraw, Belfort, and Dworkowitz, *Fine Print: Rules for Exchanging Behavioral Health Information in California*; Belfort and Dworkowitz, *Overcoming Data-Sharing Challenges in the Opioid Epidemic: Integrating Substance Use Disorder Treatment in Primary Care*; and Legal Action Center, "SAMHSA and ONC Publish Two New Guidance Documents Clarifying 42 CFR Part 2."
16. All CommunityConnect enrollees sign a WPC consent form at their first visit with their case manager, either in person or on the phone. See Appendix D for examples of CommunityConnect's consent forms.
17. Pagel, Schwartz, and Ryan, *The California Whole Person Care Pilot Program: County Partnerships to Improve the Health of Medi-Cal Beneficiaries*.
18. Marin Health and Human Services recently posted a video about these goals; see [youtube.com](https://www.youtube.com).
19. All counties conduct a point-in-time count to estimate homelessness every other winter. See Applied Survey Research, *Marin County 2017 Homeless Census & Survey: Comprehensive Report*, accessed March 31, 2019, [www.marinhhs.org](https://www.marinhhs.org).
20. Coordinated Entry is described in more detail on page 11 of this report. Also see Appendix F for a description of the overlap between WPC and CE.
21. Shelter services that are focused on getting people into housing, not just providing shelter for one night.