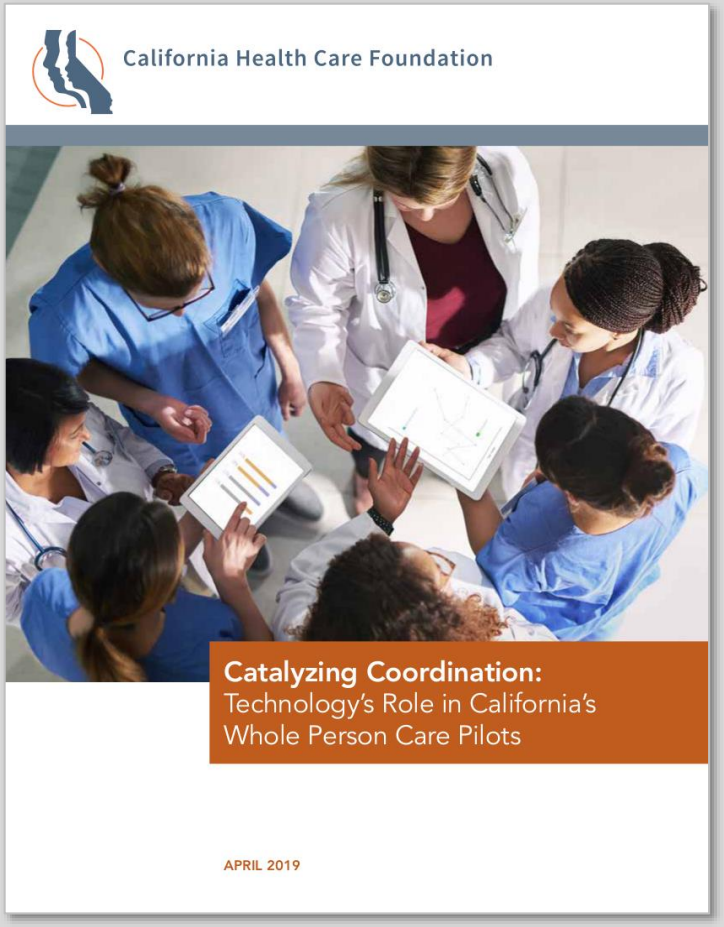
Technology Successes and Challenges in the Whole Person Care Pilots

Mark Elson, PhD, and Keira Armstrong, MPH

Intrepid Ascent

June 4, 2019



Housekeeping

- **All lines are muted**
- **To ask a question:**
  - You can submit a question at anytime through the Q&A platform located at the bottom center of your screen (NOT the chat function).
- **This session will be recorded**
  - The recording and slides will be available on the CHCF website.
  - You will receive an email with a link once they are available.

Agenda

- **Intrepid Ascent**
  - Whole Person Care Pilot Overview
  - *Catalyzing Coordination* Findings Overview
  - Other New Resources and Research
- **Marin County**
  - Pilot Overview
  - Patient Story
  - Tech-Enabled Approach to Care Coordination and Health Information Exchange
- **Contra Costa County**
  - Pilot Overview
  - Tech-Enabled Approach to Case Management
  - Data-Sharing Successes and Challenges

Whole Person Care (WPC)

- Five-Year Department of Health Care Services (DHCS) pilot program (2016–2020) to improve access and quality of care for the most marginalized Medi-Cal beneficiaries.
- $3B in federal and local match to 25 counties and one city participating in 25 pilots.
- Promotes deeper coordination between service providers across sectors such as health and housing, requiring pilots to form new partnerships and share data.
- Pilots identify target populations, assess health and housing needs, coordinate care in real time, and evaluate outcomes.

Image from JSI: *Project Spotlight: Whole Person Care in California's Safety Net*

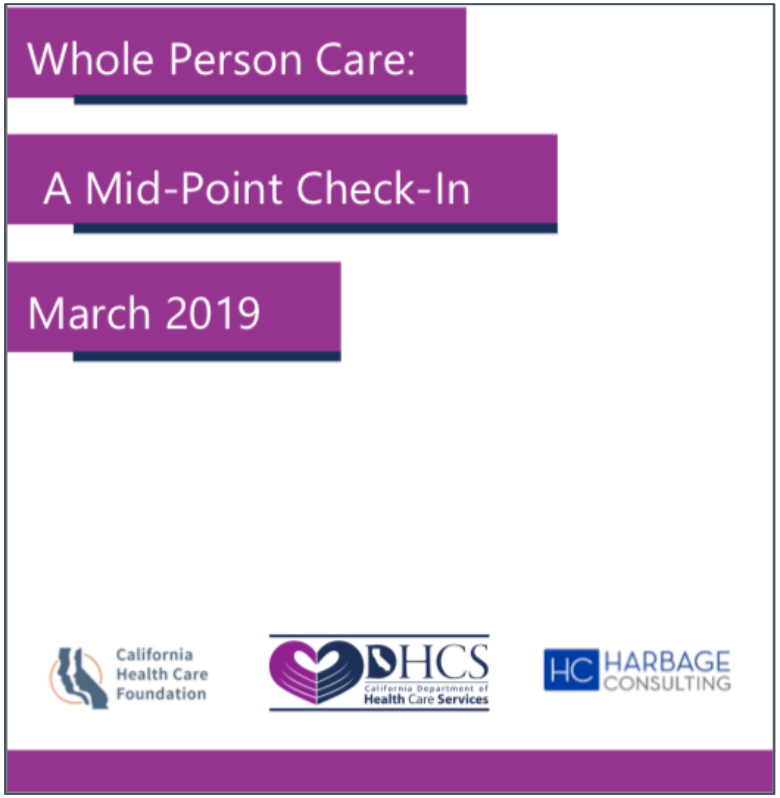
Target Population

Vulnerable Medi-Cal Adults

- Homeless or precariously housed
- Medically complex
- Mental health or substance use issues
- Involved in criminal justice system
- Frequent users of emergency services and crisis health systems

WPC Mid-Point Check-In Report

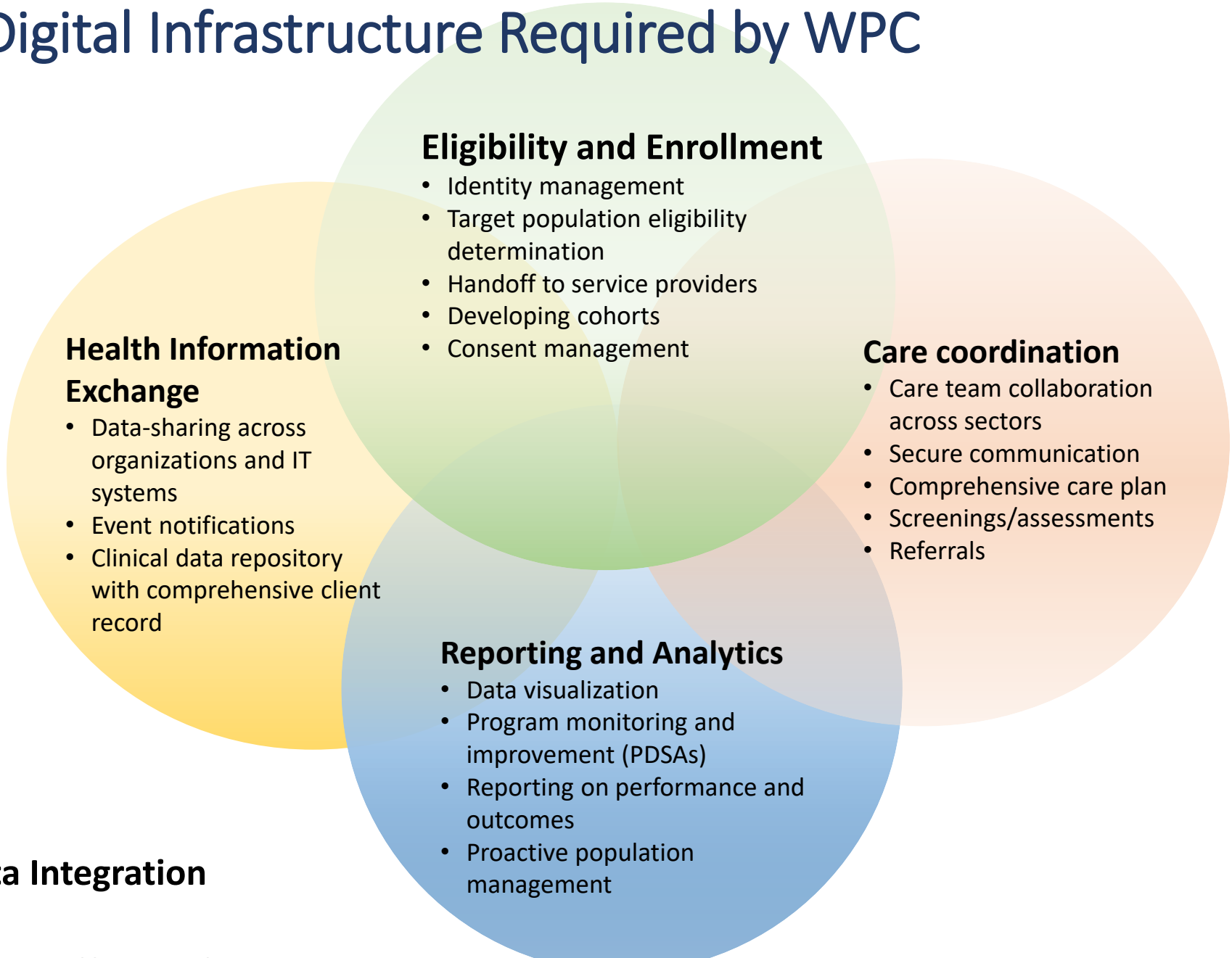
- Successes and challenges of implementations
- Examples of innovative program approaches to support target populations:
  - Sobering centers
  - Medical respite/recuperative care
  - Community health workers
  - Service navigation centers/support
  - Re-entry transitions
  - Housing services



Data-Sharing Successes and Challenges

Successes	Challenges
Data Governance	
Policy frameworks that accommodate data-sharing across sectors	Takes time to establish trust and confidence for broader data sharing
Developing new data-sharing agreements and client authorizations	Difficult to share 42 CFR Part 2-covered substance use information
Rapid Systems Transformation	
Building new technical and services infrastructure simultaneously	Creating consensus for a shared technology approach
Adoption of coordination tools by distributed care teams	Minimizing duplicate data entry during transitions
Making Data Useful	
Using data for program improvement (Plan, Do, Study, Act cycles)	Challenging to gather and aggregate data from multiple sources

Digital Infrastructure Required by WPC



Data Integration

Characteristics of Technology Models

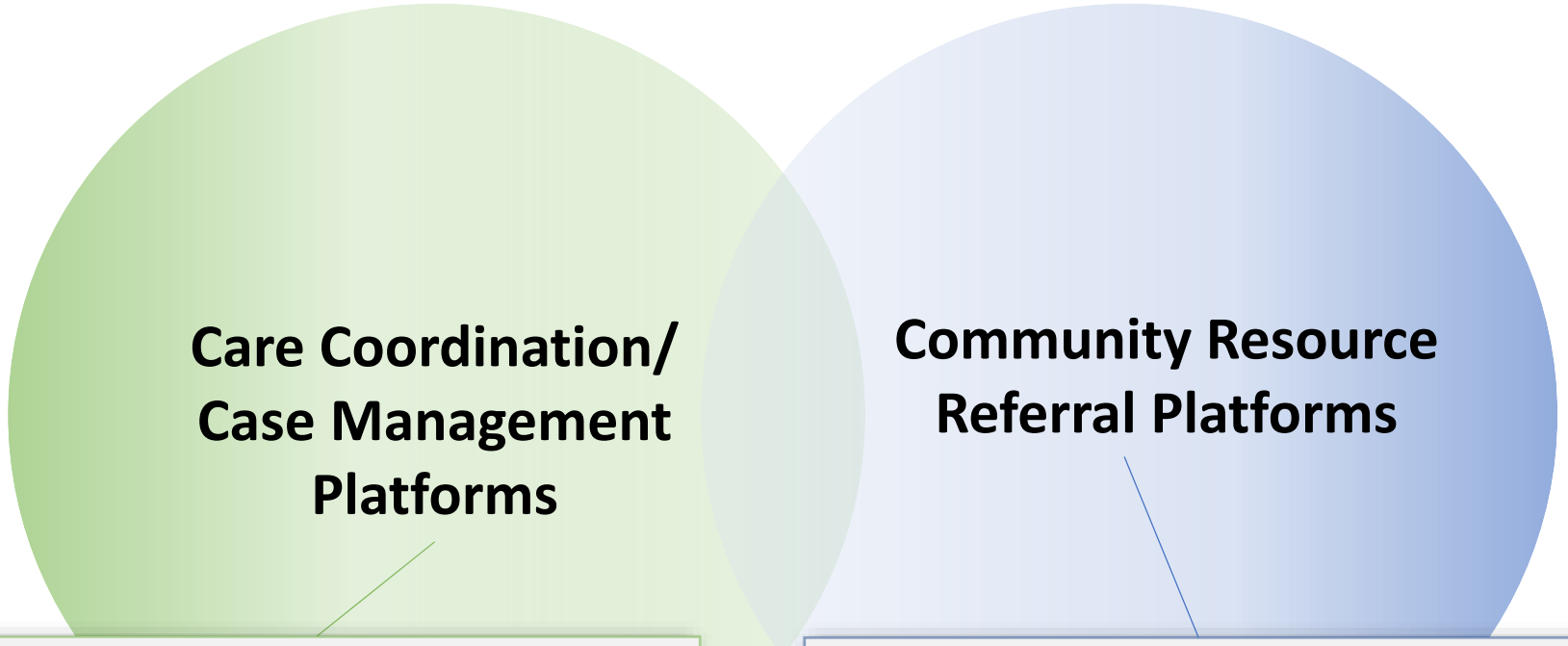
	EHR MODEL (Contra Costa)	CARE COORDINATION MODEL (Marin)
Level of county integration	➢ Highly integrated county health system	➢ Less integrated county health system
Utilizing and adapting existing county technology	➢ Best for pilots with widely shared electronic health records (EHRs) that can include new tools ➢ One system for all users; one data source for reporting and analytics	➢ Best for pilots with no single EHR solution; may have community health information organization (HIO) ➢ Generally requires a new IT system
Case management service approach	➢ WPC case management services provided by internal county staff ➢ All county staff use the same tool	➢ WPC case management contracted to external service providers and county ➢ Distributed staff have different native IT systems
Connecting data sources	➢ Members of multidisciplinary clinical teams share the same EHR	➢ Incorporates curated clinical information via regional HIO, direct EHR connections, or third-party tools ➢ Automated connections to external data sources required to scale
Cost of implementation or development	➢ Few EHRs include out-of-the-box solutions for case management; need resources to build modules/templates	➢ Solutions can be implemented and adapted to many use cases, with some customization to support WPC

Includes:

- Side-by-side comparison table of platform features and functionalities (pp. 16–18)
- Platform profiles (pp. 52–96)

UCSF

Emerging Vendor Space Overlap



Focus on:

- Care team collaboration across sectors
- Comprehensive care plans including goals and interventions
- Screenings and assessments
- Integration of clinical data
- Dynamic task lists
- Referrals
- Reporting

Focus on:

- Directory of community-based organizations and social services
- Referrals, referral tracking across sectors
- Social screenings and assessments
- Goals and interventions
- Auto-suggested resources
- Geomapping features
- Client resources and materials
- Reporting

Marin County Whole Person Care

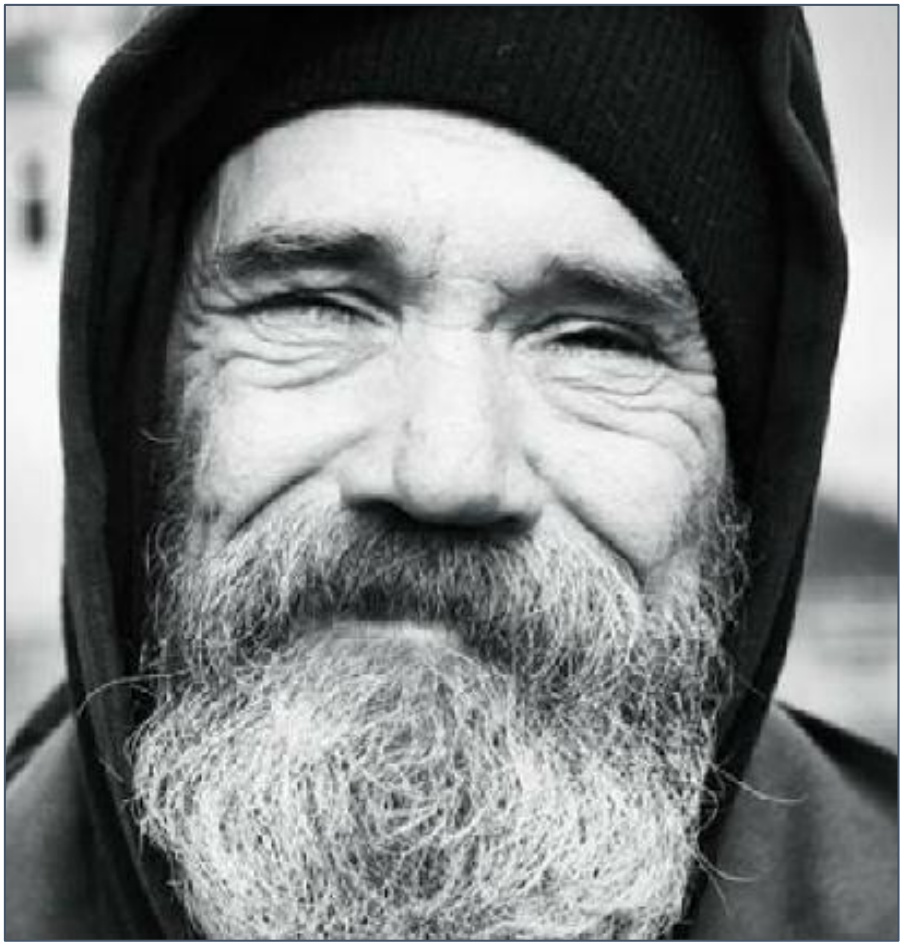
Charis Baz, MPH

County of Marin, Department of Health and Human Services

June 4, 2019

Agenda

- Program Overview
- Case Management & Care Coordination
- Health Information Exchange



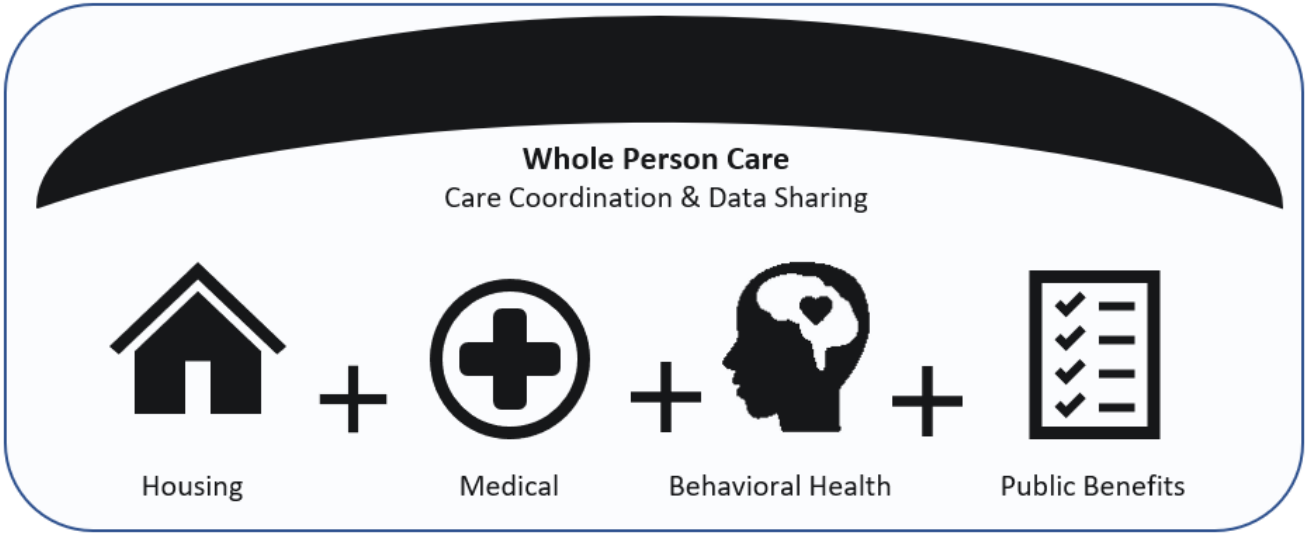
Program Overview

Goal

Coordinate care and share data across housing, medical, mental health, and social services.

Target Population

- Medi-Cal adults with a focus on people experiencing homelessness
- Medically complex individuals who may not be homeless



Client Counts

Case Management

225+ clients in intensive case management, with 400 expected by the end of 2019

Care Coordination

Care coordination platform has **1,100+ consented individuals**, with 2,000 expected by end of 2019.

Case Management

- Client-centered
- Community-centered: Looking at social determinants of health in the client's life in the community
- Coordinated with interdisciplinary teams

Types of case management provided by contracted community partners:

- **Housing** case management
- **Medical** case management
- **Mild to Moderate Behavioral Health** case management

Partnerships

Other Partnerships Supported by Whole Person Care (WPC):

- Housing Authority: Housing subsidies, housing locator, landlord partnership
- Jail social worker
- Social services eligibility worker
- General relief navigator
- Institutions for Mental Disease (IMD) Step-Down incentives
- Police department homeless outreach
- Street outreach and clinical services for mentally ill homeless

Sam's Story: Tech-Supported Case Management

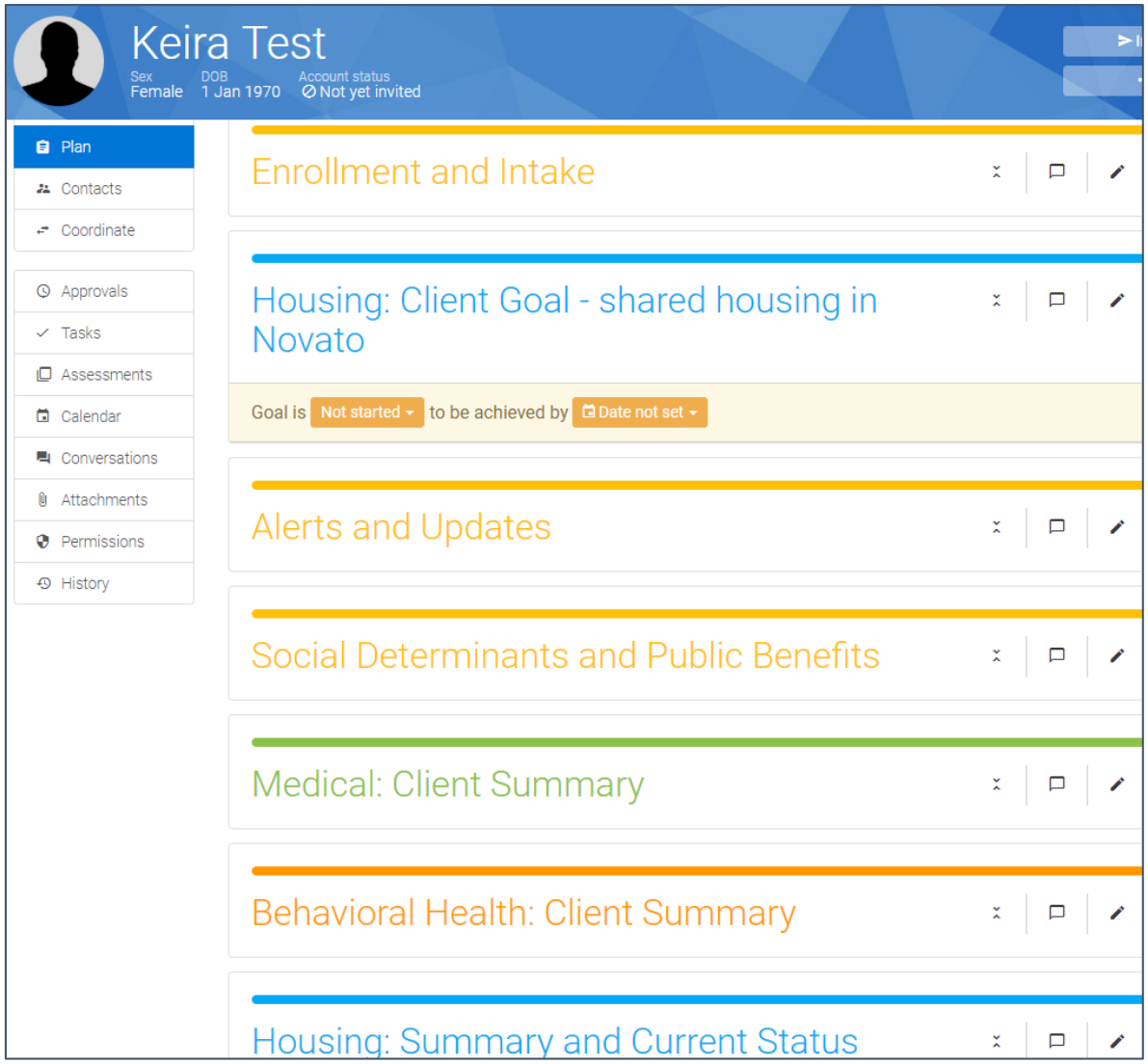
Enrolled in housing case management with Downtown Streets Team since last fall.

Enrollment Process	Sam's Challenges	WPC Solutions
• **Case Manager assessments:** PHQ-9, social determinants, etc.	• Unable to get mail from Social Services (no address), routinely dropped from benefits.	• Create task for case manager with paperwork needed and due date well in advance. Benefits renewed on time.
• **Benefits assessments:** Medi-Cal, CalFresh, SSI	• Generally given piece of paper for benefits interview, often lost.	• Create a task for case manager with due date and upload a scan.
• **Care plan creation**	• Couldn't find Sam.	• Looked in jail booking log, contacted WPC jail social worker to get on visitor list to do paperwork.

Coordination Platform

Used by:

- Hospitals
- Clinics
- Public guardian
- County and contracted behavioral health
- …as well as contracted case managers



Housing: Coordinated Entry

Why?

- People who are homeless have a life expectancy 25 years less than their housed peers
- Permanently housing a person experiencing chronic homelessness is cost-effective

Seeing Results

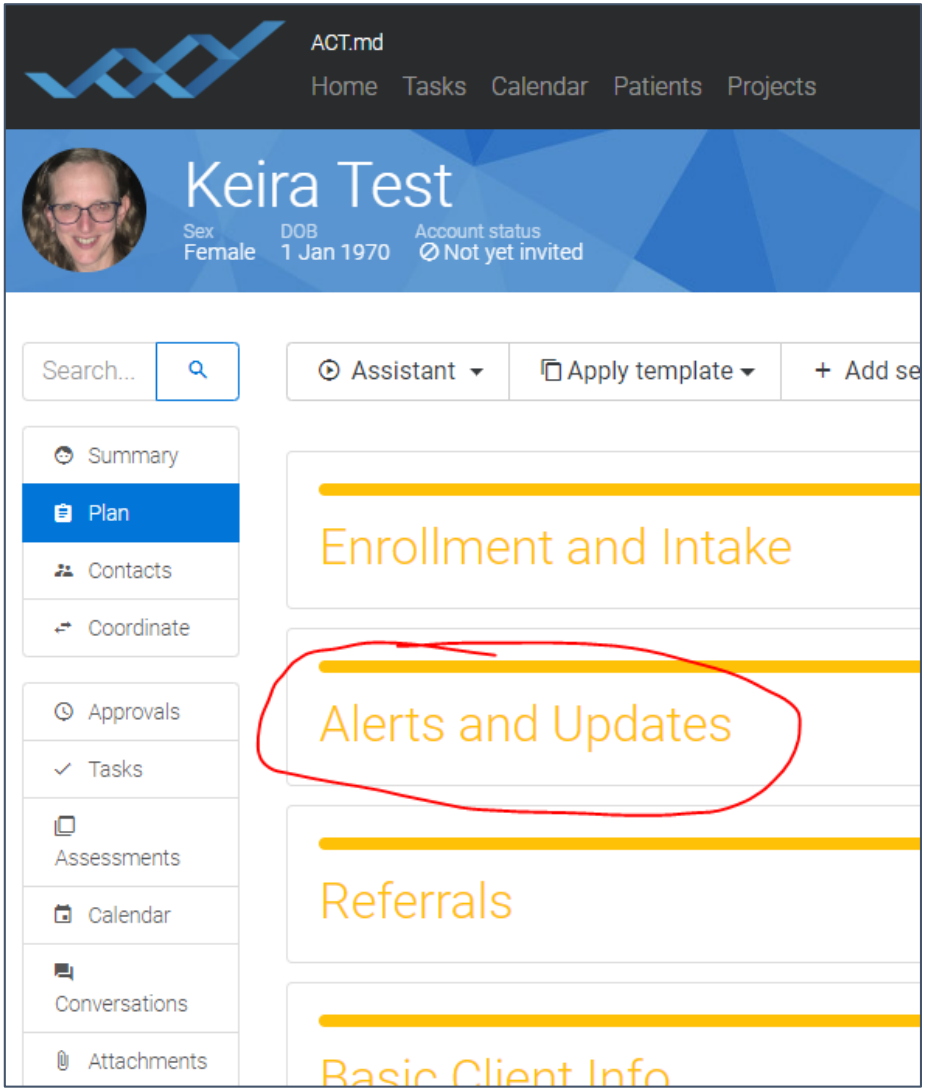
- Requires new levels of data sharing for by-name shared care planning
- Coordinated Entry has housed **130 out of the 329 chronically homeless** in Marin; expect to house **all** by end of 2022
- "A Systemic Approach: Whole Person Care and Coordinated Entry" (video): https://youtu.be/6GCHmxklFqg

Health Information Exchange

Coming Soon

Integration with the Marin Health Gateway Information Health Exchange:

- Initially, real-time admission and discharge information from Marin General Hospital will appear in client plans
- Later, information from other hospitals and local Federally Qualified Health Center clinics
- Eagerly anticipated by case managers to close “black holes” in care



Thank you!

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Contra Costa County: CommunityConnect Program

Emily Parmenter, MHA

Program Manager, CommunityConnect

June 4, 2019

WPC at Contra Costa: CommunityConnect

Target Population

- High utilizers of multiple systems

Two Case Management Models

- Telephonic
- Field-based
- Data-driven, automated assignment

Program Overview

- 12,700 patient capacity
- Predictive analytics risk model to identify patients
- Voluntary enrollment period of one year

Centering Social Needs

- Social needs screening drives patient-centered care plan

CommunityConnect Care Plan

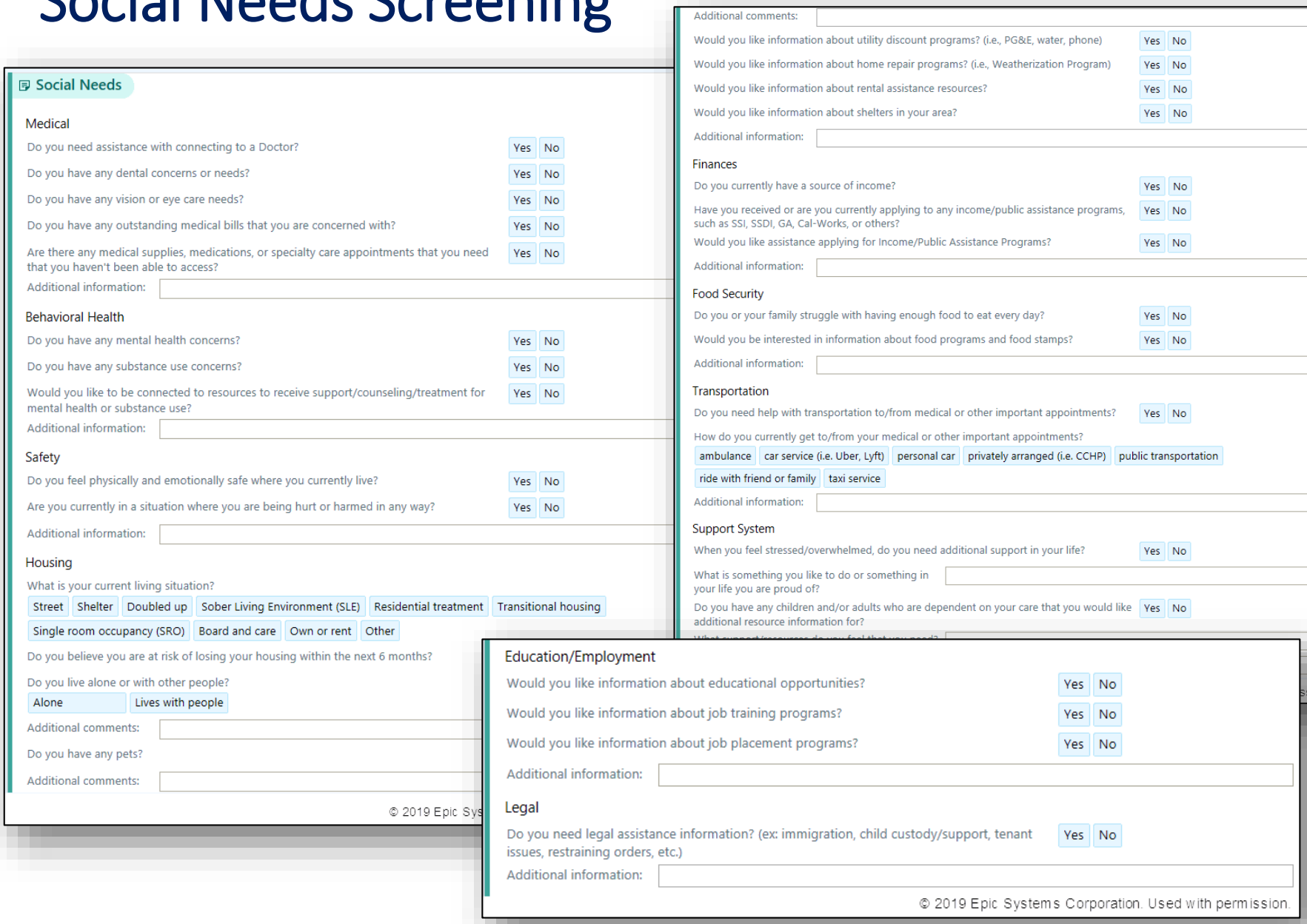
Where is the care plan located?	• Built into Epic electronic health record (EHR) • Highly integrated system accessible to all at Contra Costa Health Services (CCHS) • Shared platform among local hospital networks allows for health information exchange (HIE) through Care Everywhere
Who has access to the care plan?	• Broader than just WPC staff • WPC case manager, CCHS provider network, community provider organizations
How is information shared?	• Epic EHR access: Internal CCHS, Care Everywhere, HIE portal access • New interfaces for non-EPIC users: Homeless Management Information System (HMIS), Public Health Persimmony
What information is included?	• Existing EHR tools: Demographics, medications, utilization history, care team members • New WPC tools: Social needs screening, patient goals, real-time high-risk event notifications, behavioral health treatment information

Tools to Support Social Case Management

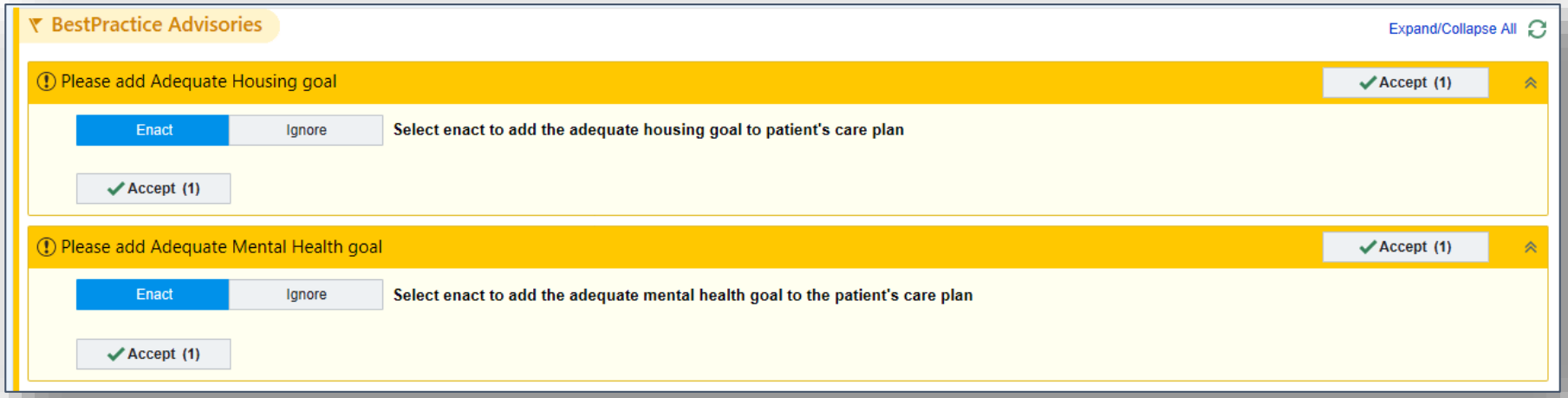
Patient Story

- Amy
- 31-year-old mother of two
- Identified as a high utilizer in WPC risk model
  - 10 emergency department (ED) visits
  - 3 psychiatric ED visits
  - Previous substance use history
  - Bipolar diagnosis

Social Needs Screening



Best Practice Advisories to Add Patient Goals



Patient Goals Form Care Plan

Social Need

Housing

2018
Describe the client's current concerns or needs: Clt is currently homeless, spends a lot of time at . Clt recently discharged from for drinking alcohol which he denied.
Resources/education/support provided: C.O.R.E.
Updates/Next steps:
- **/18:** Clt stated he is currently residing at the Shelter located at (555) 555-5555
- **/18:** Call 211 to check for shelter service availability.

Outcome:
Emergency Shelter: Accessed/Utilized resource

Transportation

2018
Describe the client's current concerns or needs: Clt recently had his leg amputated, struggles with public transit.
Resources/education/support provided: CCHP Transportation Service (Contra Costa Health Plan (CCHP))
595 Center Ave
Martinez, California 94553
(555) 555-5555
Updates/Next steps:
- **/18:** Counselor to aid clt in signing up for all transportation services which eligibility criteria he meets.

Outcome:
Medi-Cal Transportation Benefit (CCHP or Kaiser): Provided or sent resource(s)/information

Utilities

12/4/2018
Describe the client's current concerns or needs: Clt recently lost his cell phone and due to limited finances can't afford a
Resources/education/support provided: CMCT Cell phone
Updates/Next steps:
- **18:** Counselor managed to contact clt while in the emergency dept of Kaiser Fremont. Counselor informe

Outcome:
Telephone: Referral placed

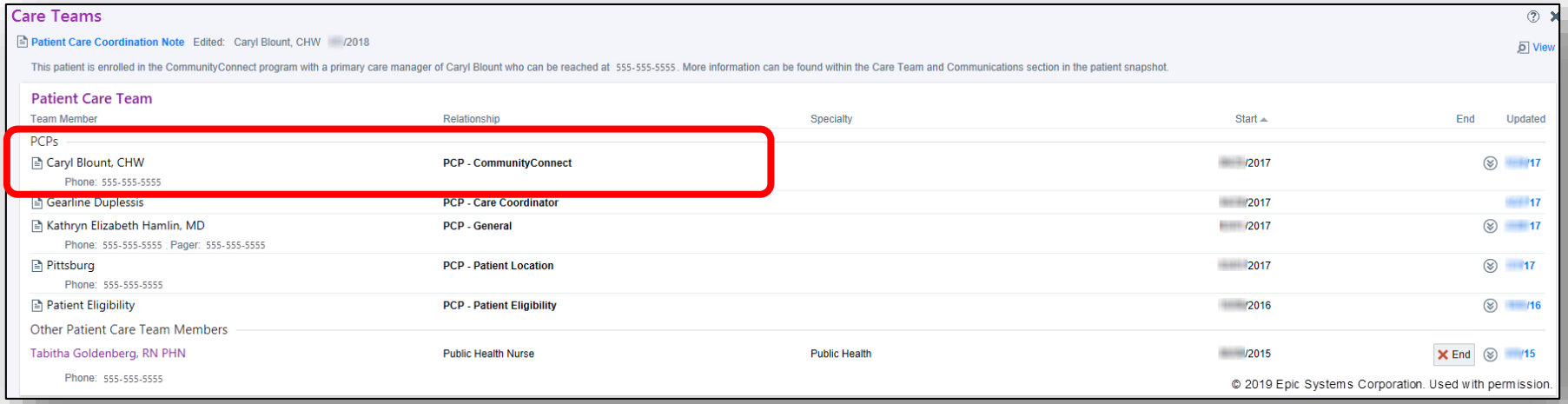
Active Goals

	Last Edited	Most Recent
Behavioral Health		
Adequate substance abuse related support	2018 11:38 AM by Roshawn R Adams, SAC	Precontemplation (2018)
Social Need		
Adult Education	2018 11:38 AM by Roshawn R Adams, SAC	Preparation (2018)

Completed Goals

	Last Edited	Most Recent
Behavioral Health		
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)
Health & Care Coordination		
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	
Social Need		
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)

CMCT Header and Care Team



Data-Related Successes and Challenges

Successes	Challenges
• Highly integrated existing infrastructure • Adding new data sources to the CCHS data warehouse • Data-driven enrollment and assignment • Expanded patient consent	• Inability to share or view substance use disorder treatment information • Delayed integration with our Human Services Division • Expanding to external service providers

Thank you!

Emily Parmenter, MHA

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Thanks for attending!

For the full report, visit:
www.chcf.org/catalyzingcoordination