

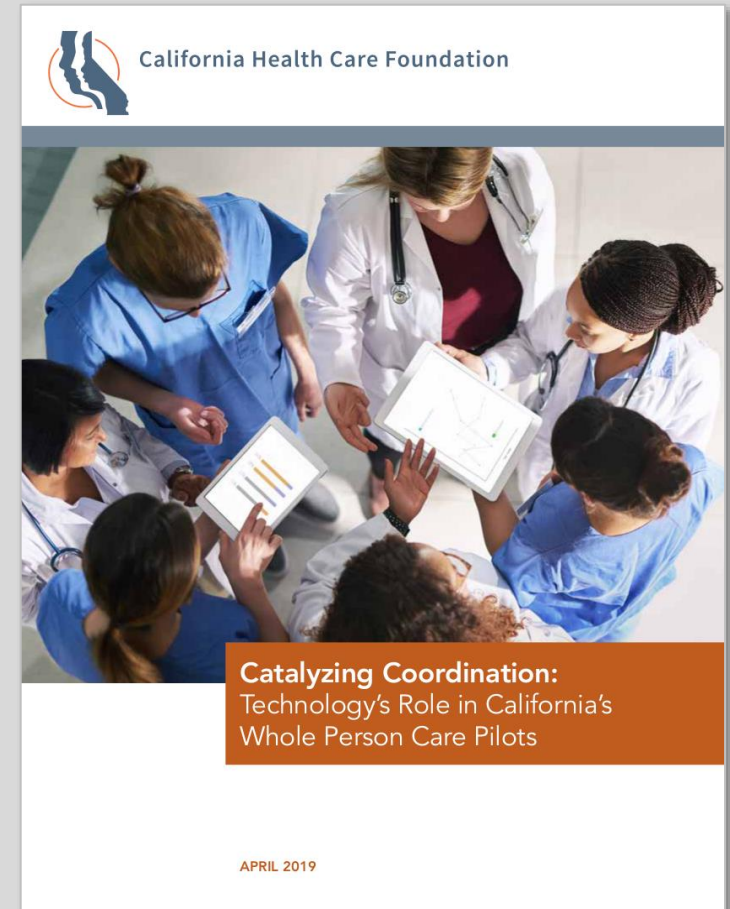


Technology Successes and Challenges in the Whole Person Care Pilots

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

Whole Person Care:

A Mid-Point Check-In

March 2019



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

Health Information Exchange

- Data-sharing across organizations and IT systems
- Event notifications
- Clinical data repository with comprehensive client record

Eligibility and Enrollment

- Identity management
- Target population eligibility determination
- Handoff to service providers
- Developing cohorts
- Consent management

Care coordination

- Care team collaboration across sectors
- Secure communication
- Comprehensive care plan
- Screenings/assessments
- Referrals

Reporting and Analytics

- Data visualization
- Program monitoring and improvement (PDSAs)
- Reporting on performance and outcomes
- Proactive population management

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	<ul style="list-style-type: none"> ➤ 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 	<ul style="list-style-type: none"> ➤ 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	<ul style="list-style-type: none"> ➤ WPC case management services provided by internal county staff ➤ All county staff use the same tool 	<ul style="list-style-type: none"> ➤ 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	<ul style="list-style-type: none"> ➤ 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

Community Resource Referral Platforms: A Guide for Health Care Organizations

Yuri Cartier, MPH
Caroline Fichtenberg, PhD
Laura Gottlieb, MD, MPH

April 16, 2019



Commissioned by the Episcopal Health Foundation, Methodist Healthcare Ministries of South Texas, Inc., and St. David's Foundation.

siren

Includes:

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

Emerging Vendor Space Overlap



Care Coordination/ Case Management Platforms

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

Community Resource Referral Platforms

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

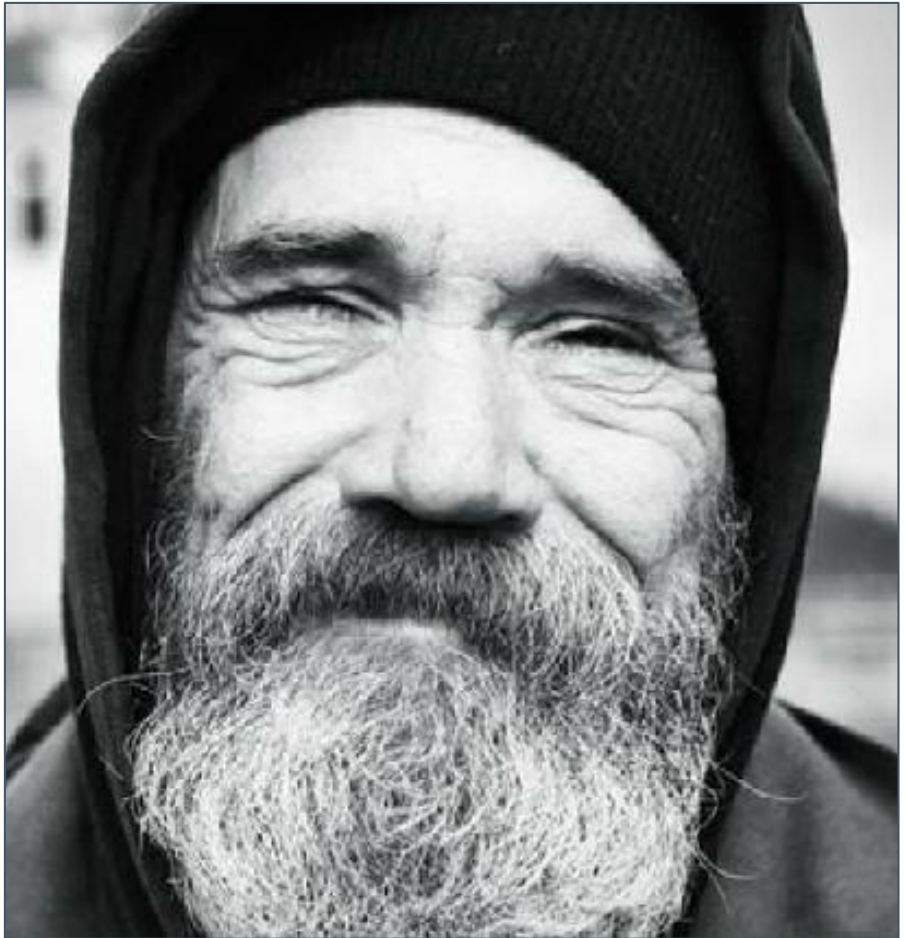
County of Marin, Department of Health and
Human Services

June 4, 2019



Agenda

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



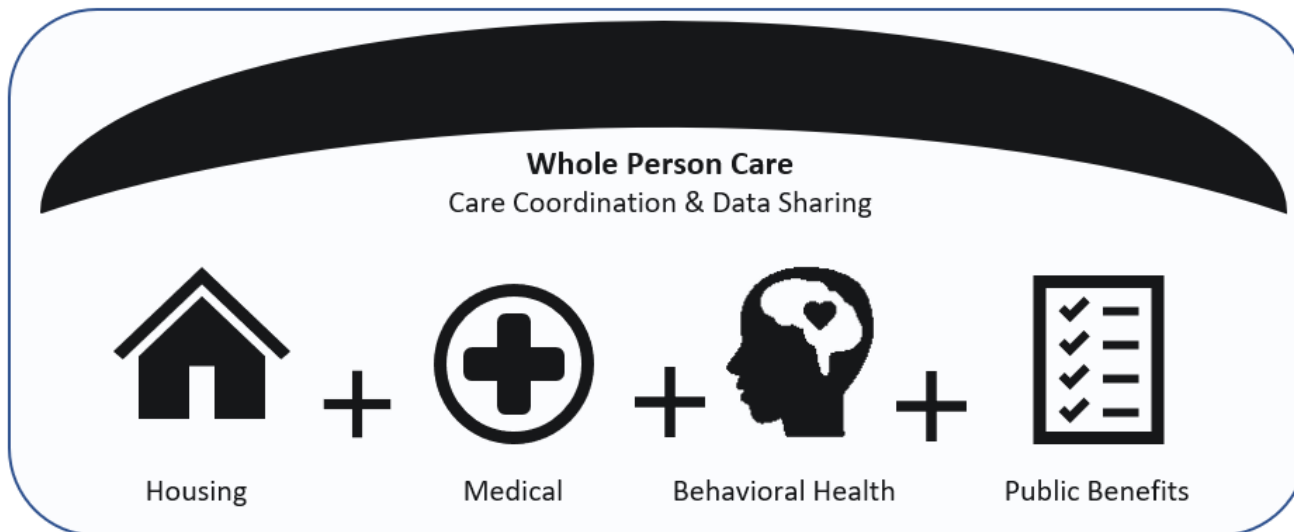
Program Overview

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

- **Case Manager assessments:** PHQ-9, social determinants, etc.
- **Benefits assessments:** Medi-Cal, CalFresh, SSI
- **Care plan creation**

Sam's Challenges

- Unable to get mail from Social Services (no address), routinely dropped from benefits.
- Generally given piece of paper for benefits interview, often lost.
- Couldn't find Sam.

WPC Solutions

- Create task for case manager with paperwork needed and due date well in advance. Benefits renewed on time.
- Create a task for case manager with due date and upload a scan.
- 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

The screenshot displays the user interface of the Coordination Platform for a client named Keira Test. The header bar includes the client's name, a profile icon, and details such as Sex (Female), DOB (1 Jan 1970), and Account status (Not yet invited). A left-hand navigation menu lists various functions: Plan, Contacts, Coordinate, Approvals, Tasks, Assessments, Calendar, Conversations, Attachments, Permissions, and History. The main content area is organized into several sections, each with a title bar and expand/collapse controls. The sections are: 'Enrollment and Intake' (orange header), 'Housing: Client Goal - shared housing in Novato' (blue header) which includes a status bar showing 'Goal is Not started' and 'to be achieved by Date not set', 'Alerts and Updates' (orange header), 'Social Determinants and Public Benefits' (orange header), 'Medical: Client Summary' (green header), 'Behavioral Health: Client Summary' (orange header), and 'Housing: Summary and Current Status' (blue header).

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

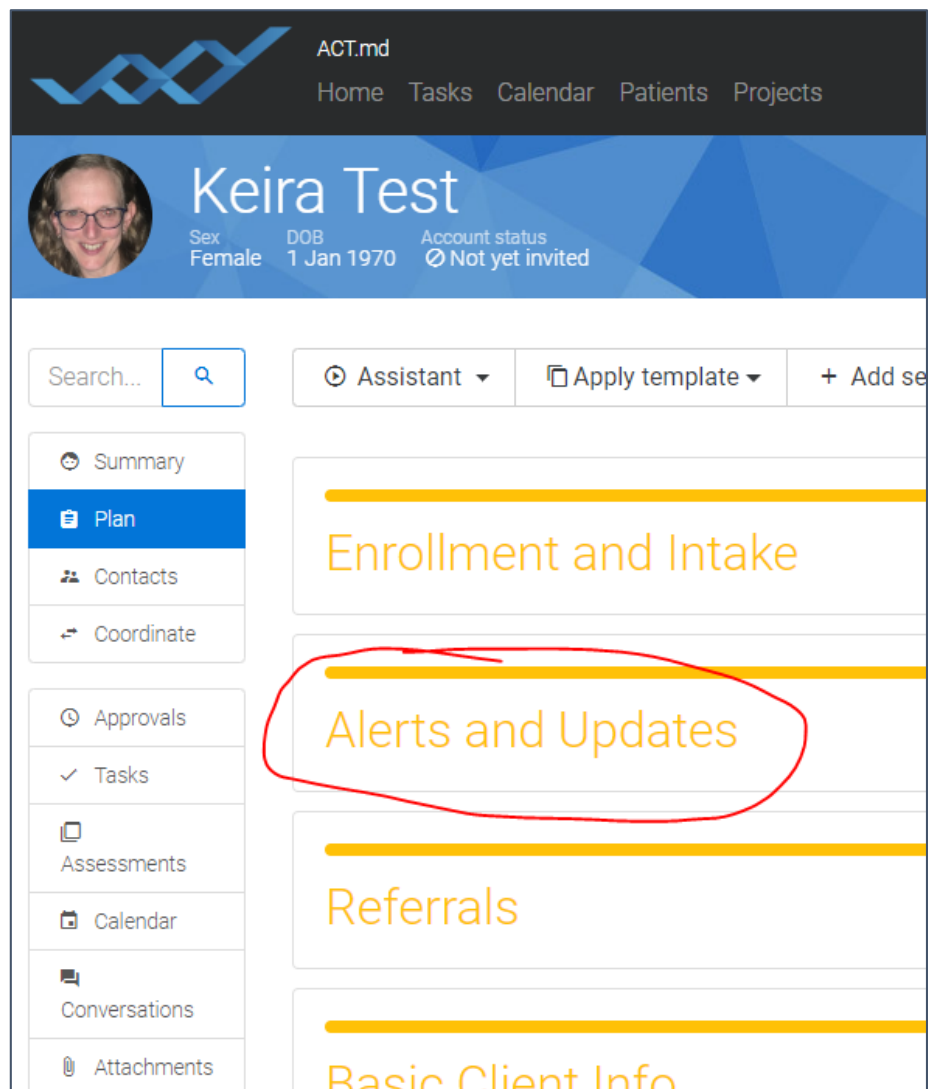
- Requires new levels of data sharing for by-name shared care planning
- Coordinated Entry has housed **130 out of the 329 chronically homeless** in Marin; expect to house all by end of 2022
- “A Systemic Approach: Whole Person Care and Coordinated Entry” (video): <https://youtu.be/6GCHmxklFgg>

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!

Charis Baz, MPH

cbaz@marincounty.org





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?	<ul style="list-style-type: none">• 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?	<ul style="list-style-type: none">• Broader than just WPC staff• WPC case manager, CCHS provider network, community provider organizations
How is information shared?	<ul style="list-style-type: none">• 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?	<ul style="list-style-type: none">• 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

Social Needs

Medical

Do you need assistance with connecting to a Doctor?

Do you have any dental concerns or needs?

Do you have any vision or eye care needs?

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

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

Additional information:

Behavioral Health

Do you have any mental health concerns?

Do you have any substance use concerns?

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

Additional information:

Safety

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

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

Additional information:

Housing

What is your current living situation?

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

Do you live alone or with other people?

Additional comments:

Do you have any pets?

Additional comments:

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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?

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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Best Practice Advisories to Add Patient Goals

▼ BestPractice Advisories

Expand/Collapse All ↺

ⓘ Please add Adequate Housing goal

✓ Accept (1) ⬆

Enact

Ignore

Select enact to add the adequate housing goal to patient's care plan

✓ Accept (1)

ⓘ Please add Adequate Mental Health goal

✓ Accept (1) ⬆

Enact

Ignore

Select enact to add the adequate mental health goal to the patient's care plan

✓ Accept (1)

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 [REDACTED] Shelter located at [REDACTED] (555) 555-5555. Clt recently discharged from [REDACTED] for drinking alcohol which he denied.

Resources/education/support provided: C.O.R.E.

Updates/Next steps:

- [REDACTED]/18: Clt stated he is currently residing at the [REDACTED] Shelter located at [REDACTED] (555) 555-5555
- [REDACTED]/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:

- [REDACTED]/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:

- [REDACTED]/18: Counselor managed to contact clt while in the emergency dept of Kaiser Fremont. Counselor informed

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 ([REDACTED] 2018)
Social Need		
Adult Education	2018 11:38 AM by Roshawn R Adams, SAC	Preparation ([REDACTED] 2018)

Completed Goals

	Last Edited	Most Recent
Behavioral Health		
COMPLETED: Adequate Mental Health	2018 11:40 AM by Roshawn R Adams, SAC	Precontemplation ([REDACTED] 2018)
COMPLETED: optometrist	2018 11:15 AM by Roshawn R Adams, SAC	No change ([REDACTED] /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 ([REDACTED] /2018)
COMPLETED: Transportation	2018 3:51 PM by Roshawn R Adams, SAC	No change ([REDACTED] /2017)

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CMCT Header and Care Team

Need Interp: **No**

Spoken Lang: **English**

Written Lang: **English**

PCP: Malaika Scott, MD

WEST COUNTY HEALTH CEN...

CommunityConnect

My Pat List Reminders: **None +**

Care Teams					
Patient Care Coordination Note Edited: Caryl Blount, CHW /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
PCPs					
Caryl Blount, CHW Phone: 555-555-5555	PCP - CommunityConnect		/2017		17
Gearline Duplessis	PCP - Care Coordinator		/2017		17
Kathryn Elizabeth Hamlin, MD Phone: 555-555-5555 Pager: 555-555-5555	PCP - General		/2017		17
Pittsburg Phone: 555-555-5555	PCP - Patient Location		/2017		17
Patient Eligibility	PCP - Patient Eligibility		/2016		16
Other Patient Care Team Members					
Tabitha Goldenberg, RN PHN Phone: 555-555-5555	Public Health Nurse	Public Health	/2015	End	15



Data-Related Successes and Challenges

Successes	Challenges
<ul style="list-style-type: none">• Highly integrated existing infrastructure• Adding new data sources to the CCHS data warehouse• Data-driven enrollment and assignment• Expanded patient consent	<ul style="list-style-type: none">• 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

Emily.Parmenter@cchealth.org





Thanks for attending!

For the full report, visit:

www.chcf.org/catalyzingcoordination

