Partnering for Whole Person Care

Alameda County's Experience

Innovations Summit on Integrated Care
October 7, 2016

Agenda

- 1. Basics of the new complex pops programs:
 - Whole Person Care Pilots
 - PRIME
 - Health Homes Program
 - Global Payment and Alternative Payment Methodologies
- 2. Critical organizational players
- 3. How we are organizing ourselves
- 4. Four critical challenge areas

Target Populations: Simple Concept

WPC = High Utilizers of Multiple Systems

- ED Utilizers
- Virulent addiction
- Homelessness
- Untreated mental illness
- Socially Isolated
- May **not** be high medical cost.....

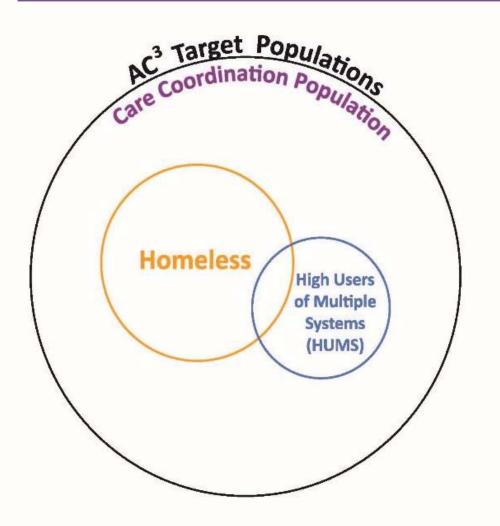
- Hospital Utilizers
- Multiple chronic medical issues
- Also behavioral
- High medical costs

Health Homes = Multiple Complex Conditions

Initiatives at a Glance

	Whole Person Care	PRIME	Health Homes
Populations	HUMS	Both	Multiple Complex Conditions
Intent	 Address high utilizers . Housing for health. Integrated Health! 	 Transform public hospitals Emphasis on care transitions and ambulatory. 	 Support high cost members Care management partnerships with community
Managed By	County	Public Hospital	Managed Care Plans
Time Period	2016-2020	2016-2020	Variable
Program	1115 Waiver	1115 Waiver	ACA 2703

Alameda County WPC plan



Big \$ investments in:

- Supportive Housing infrastructure
- Creation of a "community health record"
- Linking clients to PH, BH, SUD treatment and housing resources in real time

Our Partners









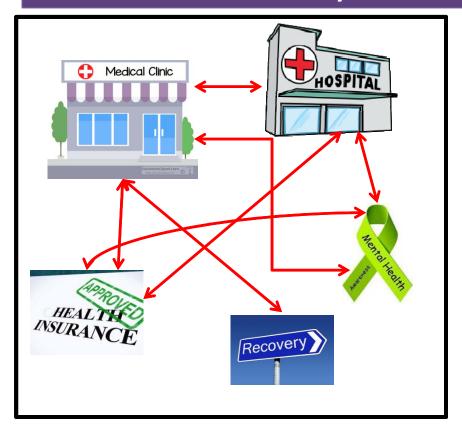


Health care you can count on. Service you can trust.

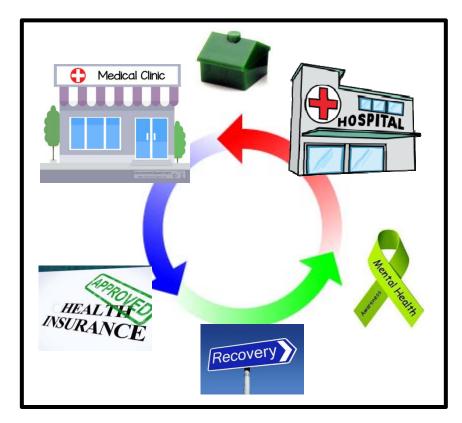


Getting People to the Table

From Many Conversations to One*

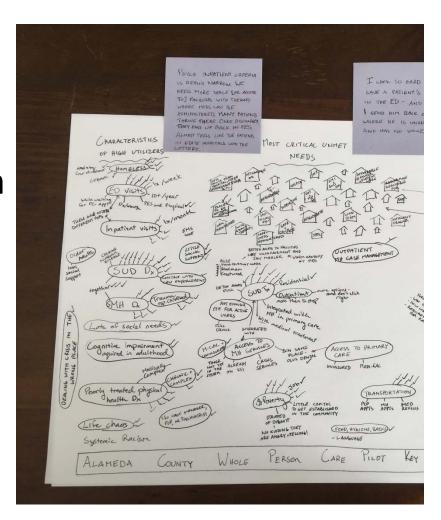


* And adding housing.....



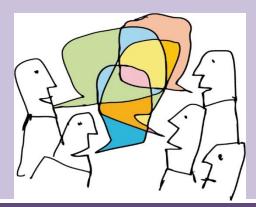
How We Organized: New Initiatives on Old Alliances

- Building on history of smaller bilateral projects
- Investing time in the infrastructure of collaboration
 - Front-line interviews
 - The Engine Team
 - Rapid response to ACH opportunity as an example
 - Special outreach to Housing
- Patience is important!



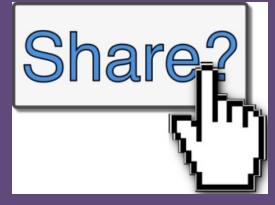
Four Challenges We Addressed

Bridging Cultural Differences



Dueling Metrics





Data Sharing



Sustainability

Deep Culture

Investing in Relationships

- BH clinicians hired by FQHCs
- Psych consultants to Primary Care
- UC Davis Primary Care Psychiatry Fellowship
- Primary Care services within specialty BH
- Drug Medi-Cal Waiver

Alameda County Behavioral Health

PCPCP

Primary Care / Psychiatry Consultation Program

Adult trained psychiatrists providing education, training, and on/off-site consultation.



Doctors Lucas Jones, Cheryl Baggeroer, Fuensanta Botello, Margo Pumar

WEEKLY ON-SITE VISITS FOR CONSULTATION VIA CHART REVIEW, CURBSIDE, OR PATIENT ASSESSMENTS AND CO-VISITS CAN BE OBTAINED BY COMPLETING A PSYCHIATRY CONSULTATION REQUEST FORM.

Dr	will be at your site on	
from	and can be reached at	
For addi	tional questions outside these hours On-Call Telephone	

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Sharing Data

- No one has all the data relevant to any one client
- BHCS is the receiver in two-way exchanges to do initial matching
- Large investment of resources in the minutiae of matching fields
- Homeless Management Information System is the next frontier......
- SUD treatment still an unknown

Metrics Overload

- HHP, WPC and PRIME have own metrics
- Key aspect of work: collaboration at both operational &
 leadership levels
 - Cross-walking metrics, reconciling denominators, numerators
 - Understanding how partners are prioritizing different metrics
- Examples at Leadership level:
 - Clear alignment
 - Pushing integration
- Example at Operational level -- when NOT to prioritize a metric:
 - Lots of operational improvement within an organization

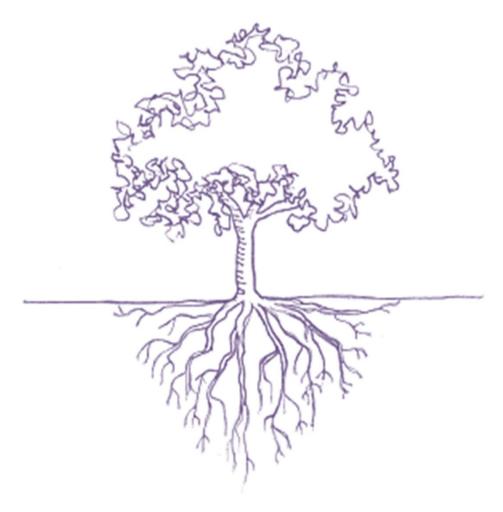
Final Challenge: Sustainability

Important to partner with the MCOs:

- Local initiative (Alliance)
- Anthem Blue Cross
- Behavioral Health
- Medi-Cal Drug Waiver
 Organized Delivery System
 (coming)

- MCOs will administer the care management bundle for WPC
- Aspiring CB-CME's will be WPC sites
- Health Homes are...





The best time to plant a tree is 20 years ago... the second best time is today