# Whole Person Care: Learning and Scaling to Create System Change

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# Whole Person Care in a Nutshell

- A component of California's Department of Health Care Services (DHCS) Section 1115 Medicaid Waiver: Medi-Cal 2020
- $3 billion pilot program
- Funded through December 2020
- Leverages local funds to draw down federal financial share

# What is Whole Person Care?

- 25 county-based Whole Person Care (WPC) pilot programs to:
  - improve care coordination
  - enhance data sharing
  - improve integrated patient-centered care across sectors
  - meet patients' holistic needs, such as housing and social services
  - reduce high utilization of multiple systems
  - lead through collaborative leadership
  - improve patient health outcomes
- WPC services are those not billable to Medi-Cal

# Target Population

- Medi-Cal beneficiaries
- High users of multiple systems
- Patients with persistent poor health outcomes
- Examples:
  - Homeless or at risk of homelessness
  - Persons with serious mental illness
  - Post-incarcerated individuals
  - Frequent users of emergency rooms or emergency psychiatric facilities
  - Transitional Aged Youth (TAY)
  - Persons with co-occurring chronic medical conditions

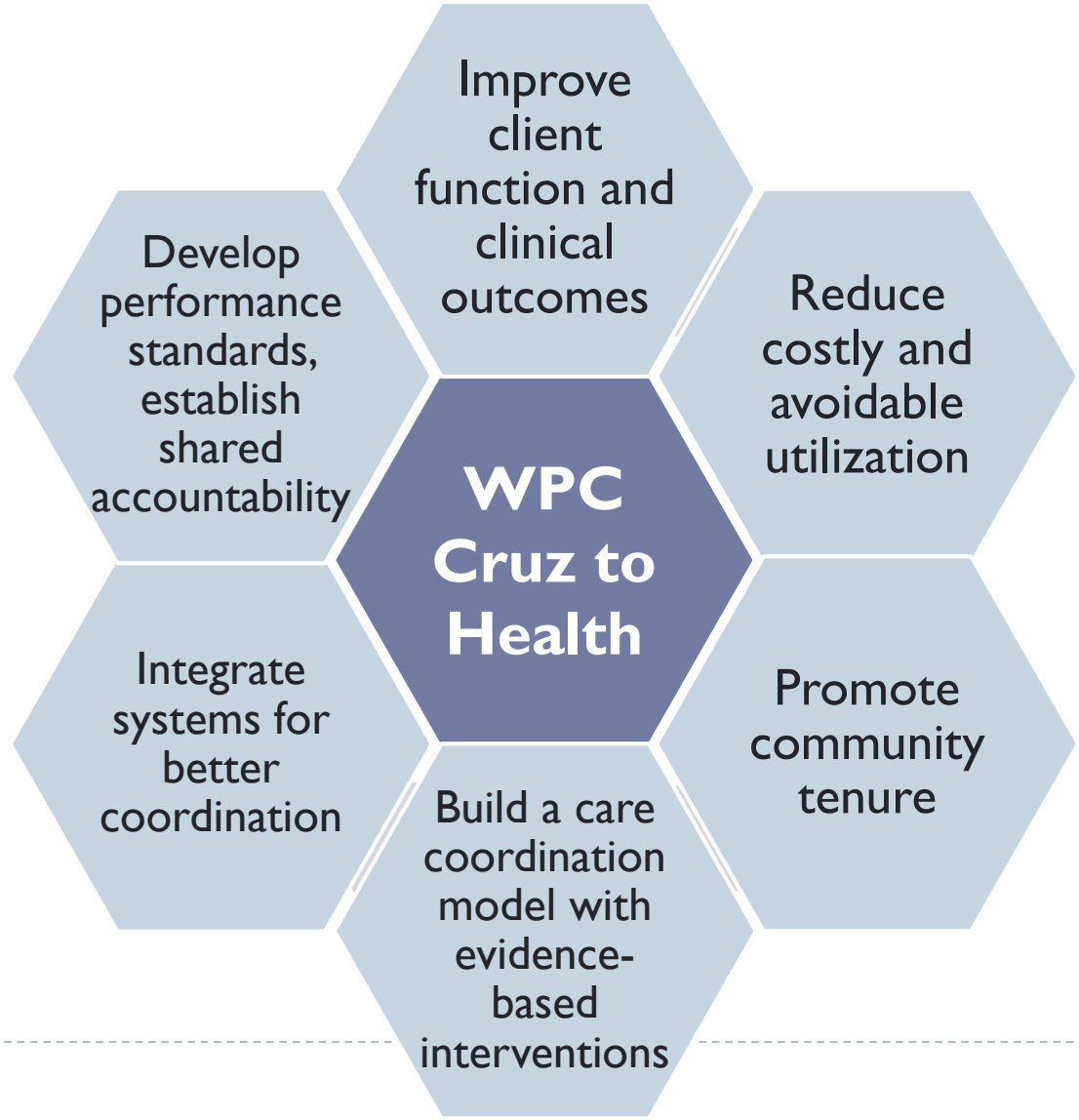
# Key Components

- Breaking down silos through data sharing
- Pilot testing innovations with flexible financing
- Outcomes and Metrics based
  - Universal Metrics
  - Variant Metrics
- Quality Improvement through Rapid Plan Do Study Act (PDSA) cycles
- Statewide formal evaluation

# Santa Cruz County – Who We Serve

- Adult Medi-Cal beneficiaries of Santa Cruz County Health Services Agency Clinics
- Risk factors:
  - Mental health and/or substance use disorder diagnosis
  - At least two of the following:
    - Two (2) or more chronic physical conditions
    - Five (5)  or more medications for chronic conditions
    - Four (4) or more psychiatric hospitalizations in prior 12 months
    - Two (2) or more medical hospitalizations/ED visits in prior 6 months
    - Homeless or at risk for homelessness
    - Institutional living in prior 12 months or currently living in IMD or jail

# Santa Cruz County – Program Goals



# Santa Cruz County – Services

| | |
|---|---|
| Behavioral Health Bundle | • Intensive support team assists participants with their goal to live successfully in the community, to manage their own medications, and be engaged with meaningful daily activities |
| Clinical Bundle | • Case management/care coordination in primary care clinics<br>• Medical oversight for telehealth program<br>• Program management and IT infrastructure |
| Intensive Housing Support Bundle | • Housing Navigation<br>• Peer Support<br>• High level of contact |

# Santa Cruz County – Services

| | |
|---|---|
| **Intermediate Housing Support Bundle** | • Housing Navigation<br>• Peer Support<br>• Stepped-down level of contact |
| **Housing Transitions** | • One-time housing transition costs for homeless individuals<br>• Up to $4,500 per individual |
| **Evidence-based Interventions** | • Integrated Illness Management Recovery (I-IMR) program for individuals with co-occurring psychiatric and medical conditions<br>• In-home telehealth monitoring program |

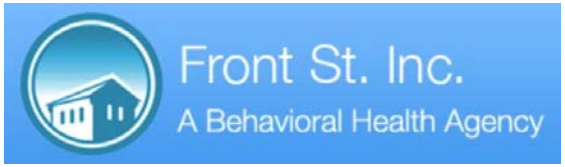
# Santa Cruz County – Partners





















# Santa Cruz County – Care Coordination

## Care Coordination Strategies

| Health Improvement Partnership (HIP) | | Santa Cruz Health Information Exchange (HIE) | | IT integration |
|---|---|---|---|---|
| Organize Care Coordination Workgroup, facilitate case management discussions | Training on strengths-based case management model for WPC and community partners | Identify community's data sharing needs and develop care coordination application | Care plans accessible in new application and integrated with EHR systems | County's EHR systems (Epic, Avatar), HIE application, and telehealth devices |

# Santa Cruz County – Data and Metrics

## Universal Metrics

- ED utilization
- General hospital utilization
- Timely follow-up after psychiatric hospitalization
- Initiation and engagement in SUD treatment
- Comprehensive care planning

## Variant Metrics

- Timely case management following discharge or release
- Coordinated case management
- All-cause readmissions
- Psychiatric rehospitalizations
- Hospital coordination: medication lists at discharge, timely documentation
- Depression remission (PHQ-9)
- Suicide risk assessments
- Control of diabetes, hypertension
- Substance abuse counseling (SBIRT)
- Housing referral outcomes
- Permanent supported housing project

# Santa Cruz County – Data and Metrics

## Additional Metrics

- EMS utilization
- Health care costs
- Telehealth program and I-IMR program:
  - Psychiatric symptoms, blood glucose, $SpO_2$, BMI
  - Health self-efficacy (Self-Rated Abilities for Health Practices)
  - Health self-management of symptoms (Integrated Illness Management Recovery scale)
- Client satisfaction

# Santa Cruz County – Contact Information

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# Solano County Health and Social Services

- Presenters:
  - Ciara Gonsalves, Senior Compliance and Quality Assurance Analyst
    - Responsible for QI and PDSA Reporting to the DHCS
  - Emery Cowan, Mental Health Administrator
    - Responsible for BH Integration and Services Data Tracking
- Organizational Structure
  - Grantee: Solano County
  - Subcontractor: Solano Coalition for Better Health


Solano Coalition for Better Health

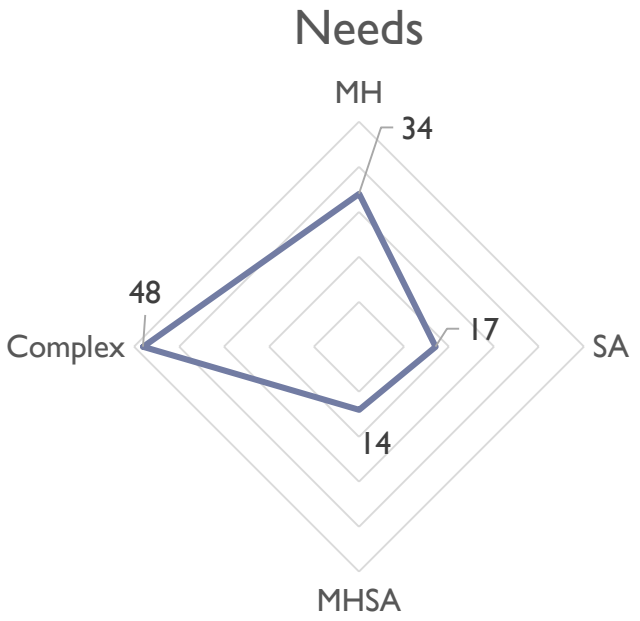
# Solano County: Who We Serve

## Target Population

- Solano County residents with the highest medical utilization
- Repeated incidents of avoidable emergency department use
  - Priority outreach to client list from the local Medi-Cal managed Care Plan, Partnership Health Plan
- 2+ chronic health conditions, at least one of which are mental health and/or substance use disorders.
  - High number of homeless or at high risk of homelessness.

## Persons Served

- Goal - 250 over 5 years
- Started enrollment: March 2017
- Year 1 enrollment: 95 (38% of goal)



# Program Structure: Staffing

- Solano County Oversight
  - HSS Administration
  - 5 Staff in Project Implementation Team- Public Health and Behavioral Health Divisions

- Subcontractor Staff
  - 1 Consultant- liaison between county and provider
  - 1 Project Manager
  - 1 Care Coordinator (Licensed Psychologist)
  - 4 Community Health Outreach Workers (CHOWs)

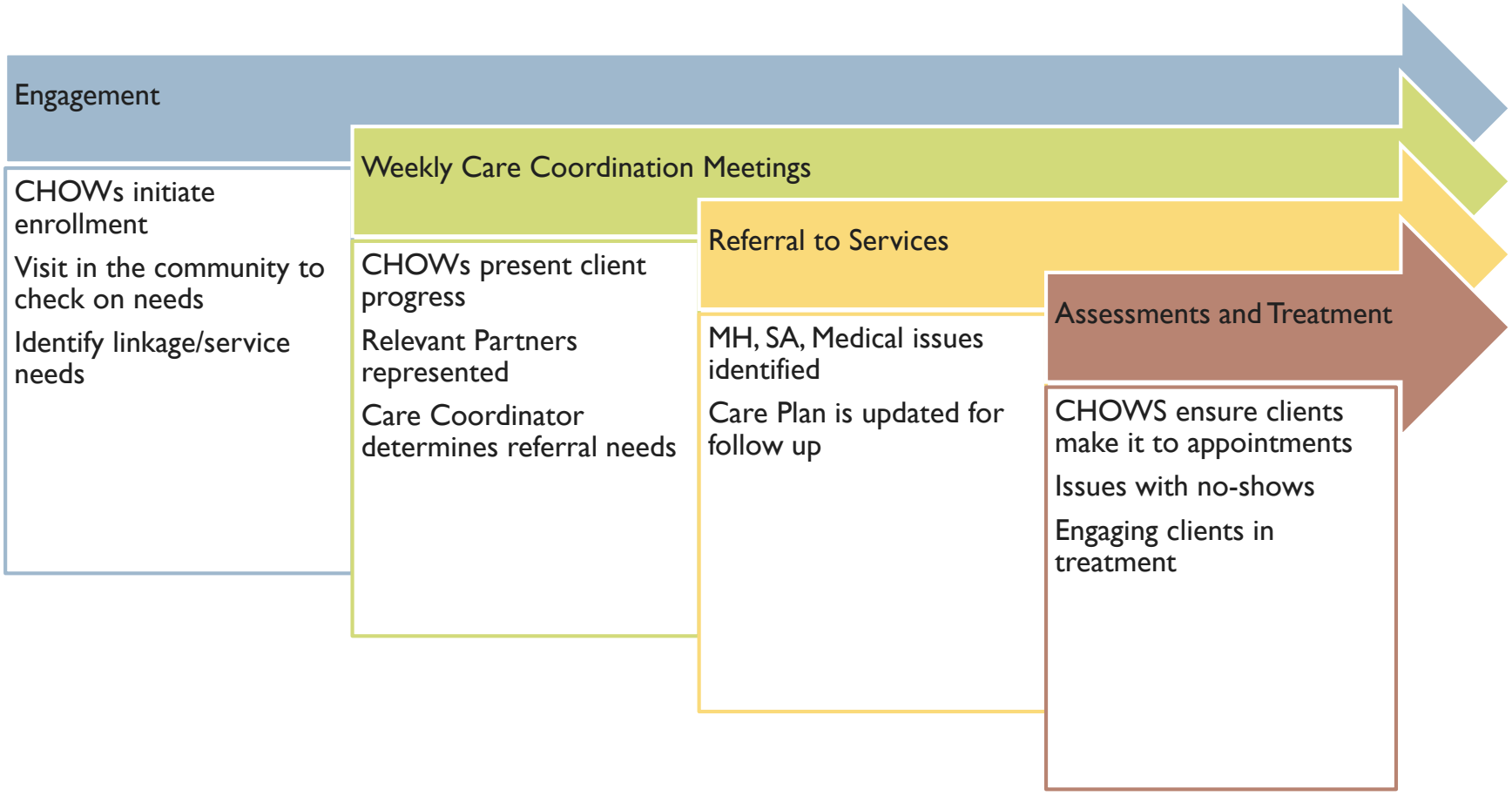
# Program Structure: Committees

- Steering Committee
  - High-level structure with participants from all pilot partners to provide reports and address barriers
- Planning and Operations
  - Operational/programmatic level committee that functions more as a work-group and reports to the Steering Committee
- Information Technology (IT)
  - Formed to assess IT needs and used ongoing to assess pilot IT issues
- Data, Metrics, Quality Improvement
  - Combination meeting to review data and use it to inform and make decisions, including QI initiatives and PDSAs

# Program Structure: Services

| | |
|---|---|
| **Participant Engagement** | Community health outreach workers (CHOWs) work to identify and enroll potential participants, refer individuals to services and resources, and coordinate care. |
| **Program Orientation & Assertive Engagement** | Engagement specialists monitor WPC pilot participation and work collaboratively with the care team to ensure that lapses in self-care, relapse, and other significant disengagement are addressed immediately. |
| **Comprehensive, Person-Centered Multi-Modal Screening Tool** | Participants are provided a multi-modal screening tool arranged and facilitated by CHOW personnel. The screening tool screens for medical, behavioral health, and other issues within an FQHC environment, and participants are offered services to quickly secure their health and well-being. |
| **Complex Care Coordination (CCC)** | CCC provides comprehensive case management for medical and behavioral health services for WPC pilot participants in home and community settings. Activities address participant progress and needs across all major dimensions of care, including consideration of self-care, disease management, treatment adherence, follow-through, obstacles that need to be address by the provider team, overall utilization, and overall progress. |
| **Field Outreach & Linkage** | community-based resources through assertive outreach, appointment facilitation and completion assistance, miscellaneous care support, and participant engagement services. |
| **Primary Care Services** | Linkage to primary care services for chronic disease management. |
| **Mental Health and Substance Use Treatment** | Services provide a harm-reduction approach and individually-tailored engagement, treatment, relapse prevention, and relapse recovery services to participants. |
| **Housing and Social Service Assistance** | Housing advocacy and support services are provided to participants through housing resource specialists. Social service assistance, including food services, transportation resources, and community-based organization referrals, are also provided to participants. |

# Care Coordination

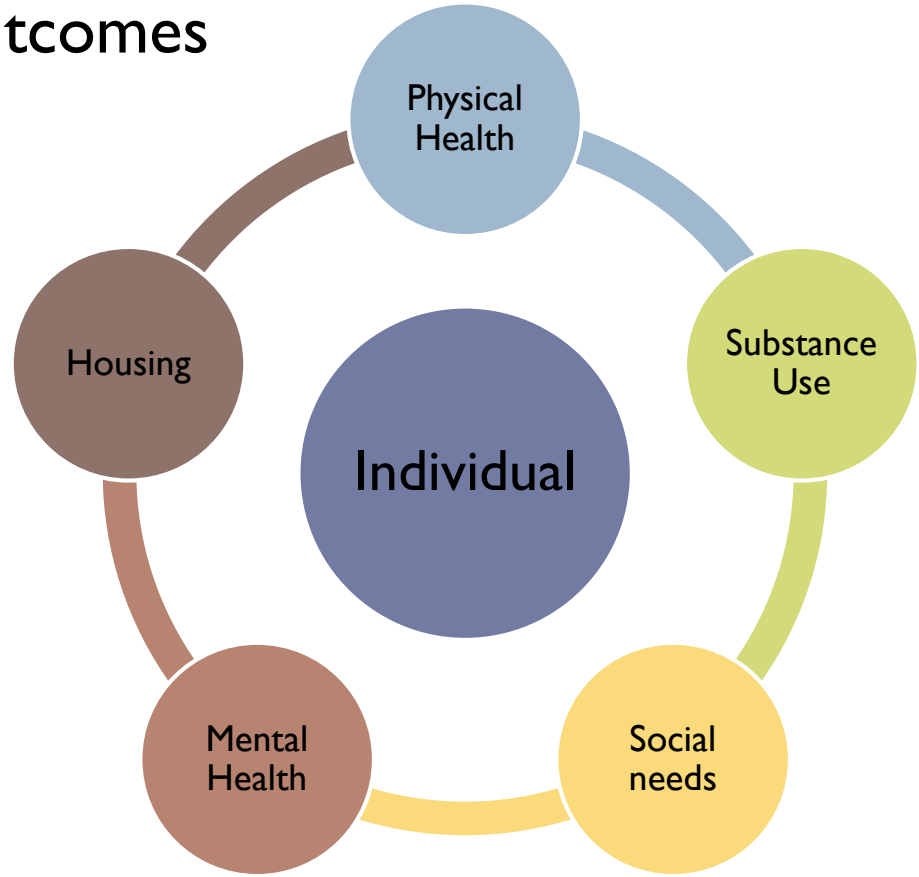


# Partners are Key!

- Developed working agreements (MOUs) among many of the partners and are in the process of developing written Policies and Procedures among partner agencies:
  - (Contractor) Solano County contracts with the Solano Coalition for Better Health to provide WPC services;
  - Solano County Employment & Eligibility
  - Solano County Public Health
  - Solano County Behavioral Health- includes mental health and substance use
  - Solano County Medical Services/Family Health Services
  - Partnership Health Plan
  - NorthBay Medical Center/NorthBay VacaValley Hospital
  - Kaiser Permanente Vallejo Medical Center/Kaiser Permanente Vacaville Medical Center
  - Bay Area Community Services
  - Fairfield Housing Authority
  - La Clinica
  - Community Medical Centers

# Program Goals

- Improve physical health
- Improved Mental Health outcomes
- Sobriety and Recovery
- Lower Recidivism
- Increase stable housing
- Decrease Costs



# Data, Data, Data! Enrollment

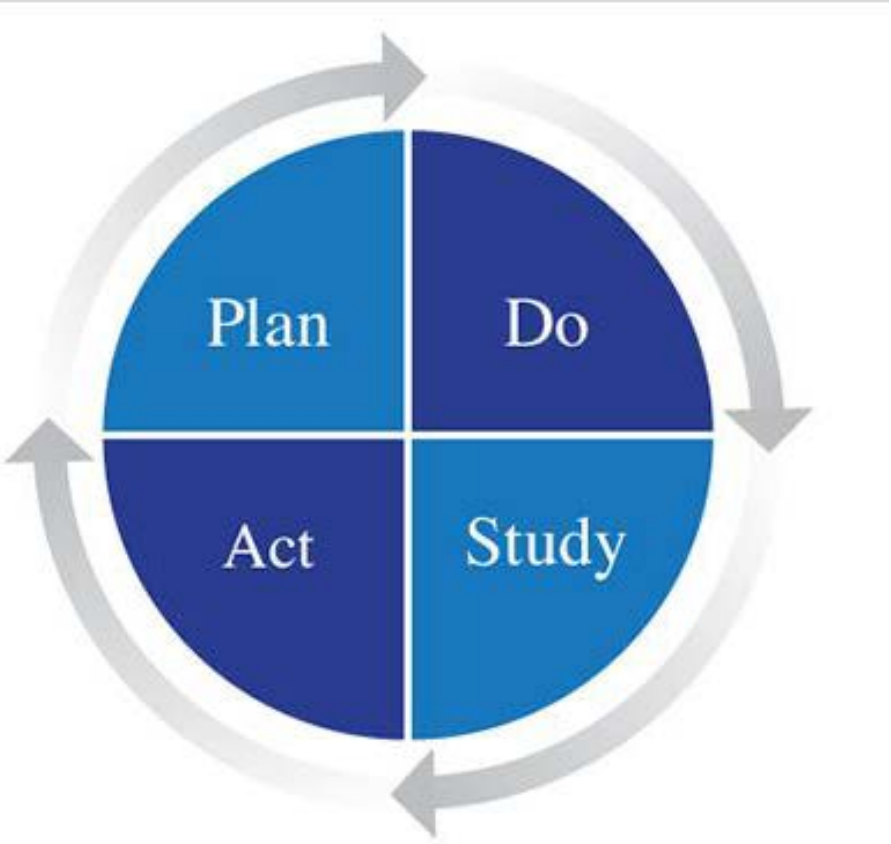
- Between March 2017 and February 2018
  - Enrollment: 95 clients
  - Disenrollment: 5 clients during same time frame
    - Four deceased
    - One withdrew due to challenges in meeting goals

# Data, Data, Data! Metrics

- Universal Metrics
  - Ambulatory Care/ED Visits
  - Inpatient Utilization
  - Initiation and Engagement AOD Treatment
  - Follow-up After Hospitalization for Mental Illness
  - Comprehensive Care Plan Established within 30 days
  - Care Coordination/Case Management/Referral Infrastructure
  - Data and Information Sharing Infrastructure
- Variant Metrics
  - All-Cause Readmission Rate
  - Depression Remission at 12 months (PHQ-9)
  - Adult Depression Disorder/Suicide Risk Assessment (NFQ-0104)
  - Supportive Housing Measure: refers to housing that is linked with flexible, voluntary support services
  - Administrative #4: Care Coordination Team Meetings for Care Plan Development

# PDSA's as a CQI Tool

- State Required PDSAs
  - Ambulatory Care
  - Inpatient Utilization
  - Comprehensive Care Plan
  - Care Coordination
  - Data/IT
- The occasional 'other'
  - Ex: Planning & Operations



# Napa County WPC

Target group: homeless, Medi-Cal beneficiaries who have high levels of vulnerability and/or frequent service use.

The WPC program in Napa is both:

- ***Changing the service system*** to benefit all homeless people through enhanced comprehensive outreach services and coordination of housing resources; and

- ***Providing intensive care coordination*** to the most vulnerable homeless people, and those who use the most services.

# Napa County – Services

## Outreach/Mobile Engagement – 70 clients (monthly caseload)

- Find new people and enroll them in the program to get them on the fast track to housing
- Try to prevent ED visits and hospitalizations with mobile care
- Discharge planning support

## Coordinated Entry – 60 clients (monthly caseload)

- Centralized intake into housing for homeless population
- Prioritization based on vulnerability
- Connections to services and housing

## Tenancy Care – 85 clients (monthly caseload)

- Keep people housed
- Address care needs and outcomes

## SOAR – 15 clients (monthly caseload)

- Assistance with gaining SSI/SSDI benefits

# Napa County – Partners

ABODE SERVICES

NAPA COUNTY CALIFORNIA

A Tradition of Stewardship
A Commitment to Service

St. Joseph Health
Queen of the Valley

McAlister Institute

CITY OF NAPA CALIFORNIA

PARTNERSHIP HEALTHPLAN of CALIFORNIA

RDA

Catholic Charities of the Diocese of Santa Rosa

Department of Health Care Services Medi-Cal

# Napa County – Care Coordination

## Care Coordination Strategies

### System level

- Care Coordination Workgroup
- System-wide data sharing practices (infancy stage!)

### Client level

- Contract with Queen of the Valley to provide care planning and coordination services
- Care plans accessible in Act MD platform
- IT integration: Behavioral Health, Physical Health, Housing data → Data warehouse solution

# Napa County – Data and Metrics

## Universal Metrics

- ED utilization
- General hospital utilization
- Timely follow-up after psychiatric hospitalization
- Initiation and engagement in SUD treatment
- Comprehensive care planning

## Variant Metrics

- All-cause readmissions
- Psychiatric rehospitalizations
- Suicide risk assessments
- Housing referral outcomes

# Napa County – Data and Metrics

## Additional Metrics

- Cross system service utilization
- Health care costs
- Criminal justice involvement
- Quality of life
  - Living skills
  - Employment and income
  - Community involvement
  - Participation in structured activities
- Experience of care

# Napa County – Contact Information

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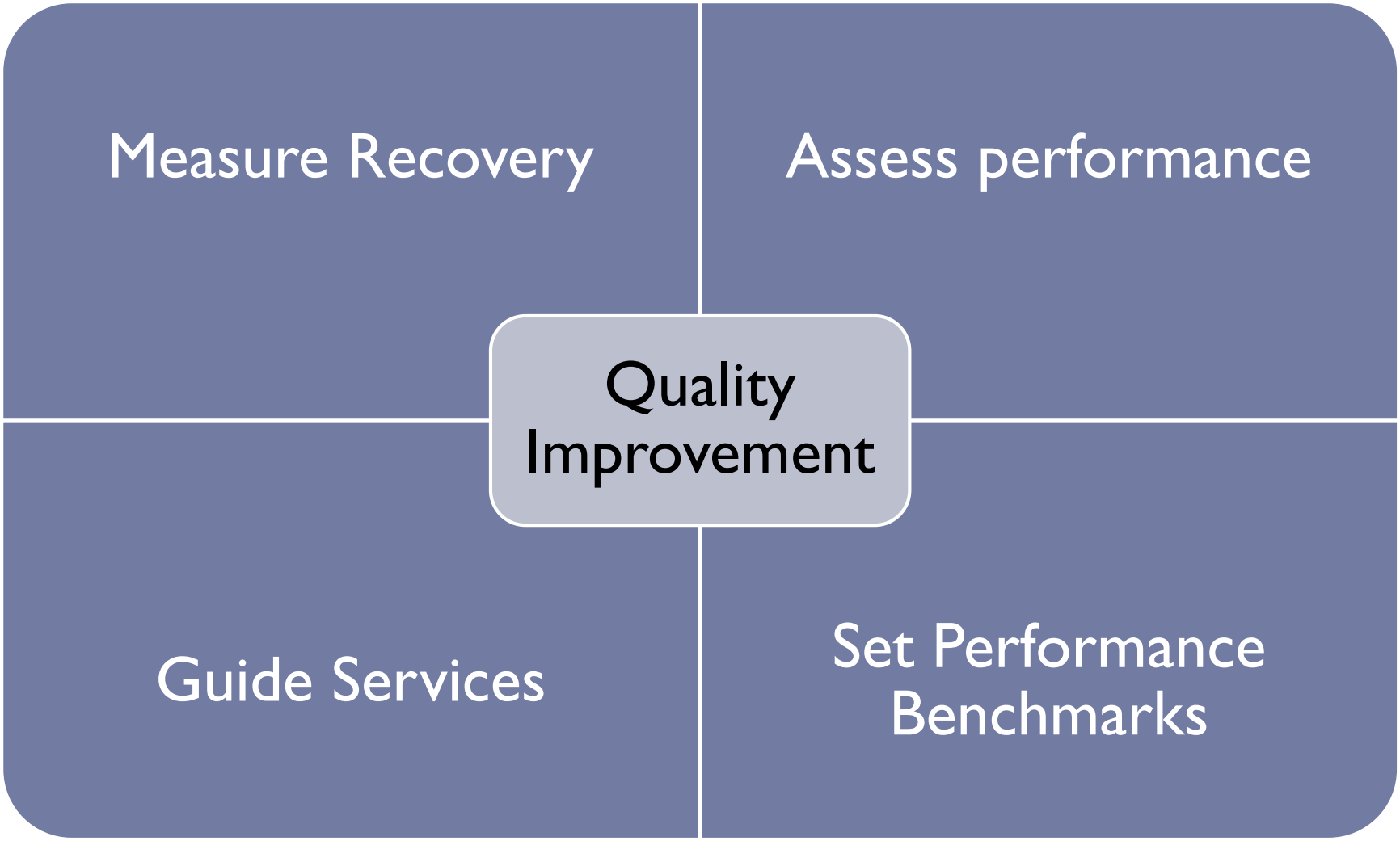
# Using Data


Measure Recovery
Assess performance
Quality Improvement
Guide Services
Set Performance Benchmarks

# Key Performance Metrics

- Client level
  - Housing status
  - Institutional care utilization
  - Social connectedness
  - Meaningful and productive use of time
  - Health status
- Provider/System Level
  - Are the most in-need clients being served?
  - Are clients staying in treatment recovering and ultimately transitioning to community supports?
  - Are services being delivered in the manner intended (fidelity)?

# Housing Status

*For Children (birth to 18):*

% homeless on the streets or in emergency shelter

% living with family

% in out of home placement

*For Adults (18 and above):*

% homeless on the street or in emergency shelter

% living with family

% living independently

% living in a supervised setting (board and care, sober living, assisted living)

# Social Connectedness
# Meaningful and Productive Use of Time

- Social connectedness:
  - With friends
  - With family
  - With community

- Meaningful and Productive Use of Time:
  - Employment
  - Volunteering
  - Education
  - Community Engagement

# Client Level Performance Expectations

| Level of Care | Metric | Benchmark | |
|---|---|---|---|
| | *Housing* | *After 1 year* | *After 2 years* |
| | % Homeless | | |
| | % living independently | | |
| | *Institutional Care* | | |
| | % hospitalized (psych) | | |
| | % incarcerated | | |
| | *Employment* | | |
| | *% employed, volunteering or in school* | | |

# System level Performance Expectations

| Metric | Benchmark | Time in Care |
| --- | --- | --- |
| Cost/Client | | |
| Drop Out Rate | | |
| Graduation Rate | | |
| Utilization of First Responders | | |
| Inpatient – emergency care utilization | | |

# For Discussion

- How has your Whole Person Care program used data to inform:
  - Treatment decisions with clients?
  - Programmatic issues?
- Does your program use PDSA cycles?
  - If so, how have they informed your work?
- How do you envision learning from Whole Person Care informing service delivery in the future?