WHOLE PERSON CARE

SHARING DATA ACROSS SECTORS TO IMPROVE CARE COORDINATION

CIBHS Behavioral Health Informatics Conference
May 2, 2018
Agenda

- Whole Person Care (WPC) Program Overview
- Alameda County Care Connect
- Santa Clara County WPC
- Q&A
Whole Person Care
Program Overview
CA 1115 Waiver: Medi-Cal 2020

- Public Hospital Redesign and Incentives in Medi-Cal (PRIME)
  - Pay-for-performance successor to DSRIP

- Global Payment Program (GPP)
  - Improved access to services for uninsured patients

- Whole Person Care Pilot (WPC)
  - Brings together health, behavioral health, social services, and community partners to care for high-risk, high-utilizing patients
  - Addresses the needs of the whole person: medical, behavioral, emotional, and economic
WPC Goals and Strategies

- Integration and coordination among county agencies, health plans, and community partners
- Better health outcomes for highest risk clients
- Infrastructure that will ensure local collaboration over the long term

- Inappropriate emergency department and inpatient utilization
WPC By the Numbers

- 5 year program
- $1.5B total federal funds
- $300M annual available
- 2 application rounds
- 18 applicants in round 1
- 7 applicants in round 2
WPC Participating Entities

Required partners...

- Medi-Cal managed care health plan
- Health services agency
- Specialty mental health agency
- Additional Public agency
- Community partners

...Work together to:

- Identify target population (common high-utilizers)
- Share data
- Coordinate care in real time
# WPC Performance Measures

## Health Outcomes Universal Metrics
- Ambulatory Care - Emergency Department Visits
- Inpatient Utilization - General Hospital/Acute Care
- Follow-up After Hospitalization for Mental Illness
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

## Health Outcomes Variant Metrics, as applicable
- 30 day All Cause Readmissions
- Decrease Jail Recidivism
- Overall Beneficiary Health
- Controlling Blood Pressure
- HbA1c Poor Control <8%
- Depression Remission at Twelve Months
- Adult Major Depression Disorder (MDD): Suicide Risk Assessment

## Housing Variant Metrics, as applicable
- % homeless permanently housed > 6 months
- % homeless receiving housing services that were referred for housing services
- % homeless referred for supportive housing who receive supportive housing

## Pilot-identified Pay for Outcome metrics, other than required universal and variant metrics
### WPC Estimated 5-Year Beneficiary Count

<table>
<thead>
<tr>
<th>Larger: Over 100,000</th>
<th>Large: Between 10,000 and 100,000</th>
<th>Medium: Between 1,000 and 5,000</th>
<th>Small: Between 250 and 800</th>
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<tbody>
<tr>
<td>Los Angeles</td>
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<td>Kings</td>
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<td>Alameda</td>
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<td>Santa Clara</td>
<td>Sacramento*</td>
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<td>San Francisco</td>
<td>San Bernardino</td>
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<td>San Diego</td>
<td>Small County Collab.</td>
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<td>San Mateo</td>
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<td>Ventura</td>
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<td>*City of Sacramento</td>
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## WPC Target Populations

<table>
<thead>
<tr>
<th>Target Population Criteria</th>
<th>Pilots</th>
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</thead>
<tbody>
<tr>
<td>Individuals who are <strong>homeless/at-risk for homelessness</strong></td>
<td>19</td>
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<tr>
<td><strong>High utilizers</strong> with repeated incidents of avoidable ED use, hospital admissions or nursing facility placement</td>
<td>18</td>
</tr>
<tr>
<td>Individuals with <strong>mental health and/or substance use disorder conditions</strong></td>
<td>14</td>
</tr>
<tr>
<td>Individuals <strong>recently released from institutions</strong> (e.g., county jail, IMD, skilled nursing facility, etc.)</td>
<td>9</td>
</tr>
<tr>
<td>High utilizers with 2+ <strong>chronic conditions</strong></td>
<td>7</td>
</tr>
<tr>
<td>Service</td>
<td>Number of Pilots</td>
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<tr>
<td>---------------------------------------------</td>
<td>------------------</td>
</tr>
<tr>
<td>Peer Educators/CHWs</td>
<td>20</td>
</tr>
<tr>
<td>Wellness and Education</td>
<td>14</td>
</tr>
<tr>
<td>Housing Services</td>
<td>16</td>
</tr>
<tr>
<td>Flexible Housing Pool</td>
<td>18</td>
</tr>
<tr>
<td>Post-Incarceration Services</td>
<td>8</td>
</tr>
<tr>
<td>Homeless Outreach</td>
<td>11</td>
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<tr>
<td>Mobile Services</td>
<td>6</td>
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<tr>
<td>Respite Services</td>
<td>6</td>
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<tr>
<td>Sobering Centers</td>
<td>6</td>
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</tbody>
</table>
WPC Progress

- Convened steering committees
- Hired/formed care teams
- Developed care coordination workflows
- Selected/implemented IT platforms
- Established data sharing MOUs/processes

Early Focus on Infrastructure Development
WPC Progress

- Enrolled clients and delivered services
- Convened steering committees
- Hired/formed care teams
- Developed care coordination workflows
- Selected/implemented IT platforms
- Established data sharing MOUs/processes

Early Focus on Infrastructure Development
# WPC Early Lessons

<table>
<thead>
<tr>
<th>Challenges</th>
<th>Solutions</th>
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<tbody>
<tr>
<td>System Culture Change</td>
<td>• Cross-sector steering committees</td>
</tr>
<tr>
<td></td>
<td>• Inventory and streamline duplicative care management programs</td>
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<tr>
<td>Communications/Staff Buy-In</td>
<td>• WPC “Roadshow”</td>
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<tr>
<td></td>
<td>• Communications strategy (bulletins, website)</td>
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<td></td>
<td>• Monthly all-partner “learning community”</td>
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<tr>
<td>Hiring</td>
<td>• Staffing registries and contractors</td>
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<tr>
<td></td>
<td>• Hiring exam to ID correct skillset</td>
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</tbody>
</table>
# WPC Early Lessons

<table>
<thead>
<tr>
<th>Challenges</th>
<th>Solutions</th>
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</thead>
<tbody>
<tr>
<td>Data Privacy/Sharing</td>
<td>• Universal consent form/policy</td>
</tr>
<tr>
<td></td>
<td>• Software turns on/off sensitive data in real-time</td>
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<td></td>
<td>• Behavioral Health manages data warehouse</td>
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<tr>
<td>Medi-Cal Churn</td>
<td>• Eligibility office cross checks WPC client list for redetermination</td>
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<tr>
<td></td>
<td>• Outreach staff comb MEDS files</td>
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<td></td>
<td>• Field enrollment by social service workers</td>
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<tr>
<td>Client Engagement/Enrollment</td>
<td>• Enroll upon release from jail</td>
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<tr>
<td></td>
<td>• CHWs/peer educators</td>
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<td></td>
<td>• Mobile outreach</td>
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</tbody>
</table>
THANK YOU
Learn more at safetynetinstitute.org/wpc

Amanda Clarke
aclarke@caph.org
Focus

High Utilizers of Multiple Crisis Systems
-or-
Homeless in the past 2 years
-or-
Enrolled in a complex care management program
Six Critical Changes

Care Coordination

Care Integration: especially among primary care, mental health, substance use, and housing,

Data Sharing: establish a Community Health Record

Housing & Homelessness

BH Crisis Response System: decrease revolving door acute psych care

Improve Consumer & Family Experience
Overall Timeline

- Start-up: Jan-Jun 2017
- Phase 1 Pilot: Jul 2017-Sep 2018
- Phase 2 Pilot: Sep 2018-2019
- Scale-up, Sustainability Planning 2019-2020
- Wrap-up & sustainability 2021
Items in grey are available through the pCHR in the near term.

ADT alerts
- Sutter
- SF General
- Washington,
- Contra Costa
- John George

FSP and Service Team available Q1 ’18

- John George IP and PES
- Pathways to Wellness
AC Care Connect Data Warehouse

Core Data:
BHCS
- Specialty mental health service utilization (ongoing – billing)
- Substance abuse disorder treatment service utilization (ongoing – billing)
DHCS
- Medi-Cal enrollment status, health plan assignment (Monthly)

Housing and Community Development
- Homeless/housing services (moving towards regular sharing)

CHCN
- Primary care medical home and physical health utilization – claims
- Prioritization for permanent supportive housing (coordinated entry)
- Jail discharges

Alameda Alliance for Health
- Primary care medical home and physical health utilization – claims (monthly)

Anthem Blue Cross
- Primary care medical home and physical health utilization – claims (moving towards automated, monthly sharing)

Emergency Medical Services
- Emergency transports including 5150s
- LifeLong Medical Care
- Detailed service utilization, clinical measures, care team members
AC Care Connect Community Health Record is a curated set of information for all AC Care Connect clients which includes a shared care plan.

**Phase I: pCHR Overview and Timeline**

**AC Care Connect Community Health Record**

- **Phase I: pCHR (Oct 2017-Oct 2018)**
  - Wave A: Oct 2017
  - Wave B: March 2018
  - Wave C: Q2 2018
  - Help Desk Support: Technical and Workflow
  - Feedback Loop: Leverage existing AC Care Connect activities

- **Phase II: SHIE/CHR (Jun 2018-Dec 2020)**
  - RFP Process: Oct 2017 to September 2018
  - CHR Design: Fall 2018
  - CHR Implementation: Winter 2019
Goals of the prototype Community Health Record

- Test process workflows and technical requirements in prep for the Phase 2 SHIE/CHR solution
- Save end users time digging for information
- Proactively provide client info to avoid repeatedly asking the same questions
- Spur connection with other providers
- Alert providers when their client is in crisis
Successes of the pCHR and Data Exchange Process

• Launched pCHR with 4 organizations and 11K clients
• Developed a Health Data Repository Data Sharing Agreement – 6 organizations have executed
• Expanded the BHCS Data Warehouse as interim Central Repository – leveraging their expertise with sensitive datasets
• Engaged housing providers as covered entities
Challenges to implementation of pCHR and early Data Exchange

• Users need to be reminded of the usefulness
• Housing case managers express some fear as they shift to HIPAA
• 42CFR Part 2 proves to be challenging for sharing SUD in the pCHR stage – the technical infrastructure just isn’t there
• BHCS control over managing risk in data sharing
Moving forward with the Social Health Information Exchange

SHIE will provide the infrastructure for managing

- Will include social determinants (housing, social services) as initial datasets
- Exchange of sensitive datasets (SUD, Criminal Justice)
- Consent management
- Enterprise Bus architecture for mutually interacting software applications like the CHR
- Enterprise Master Person Index (EMPI)
SANTA CLARA COUNTY
WHOLE PERSON CARE
VISION Whole Person Care is better health through CARE, care for participants and the systems supporting them.

Connection
Participants feel connected to someone who cares and to services valuable to them. The system is coordinated and communicates.

Access
Participants are able to get necessary services easily and quickly. The system offers seamless transitions between levels of care.

Resilience
Participants are better able to handle life stressors. The system is flexible to adapt to changes and emerging needs of these individuals.

Efficiency
Participants do not over utilize or under utilize services. The system employs technology to maximize resources.
Criteria for Enrollment (Santa Clara County)
- Participants meet criteria of HUMS (9+ points) or are in a care coordination program serving HUMS or at-risk of HUMS population.
- Medi-Cal Beneficiary
- Age 18-64
- No Diagnosis of Dementia
- Ambulatory visit within 90 Days

Our Population (Santa Clara County)
- There are currently about 3700 clients enrolled in WPC throughout all of Santa Clara Health and Hospital System.
- Our goal is to have 10,000 beneficiaries enrolled by the end of 2020.
To address gaps in current service system and to provide alternatives to and reduce avoidable use of emergency services, we have created several pilot programs which will become part of our permanent infrastructure.

1. Sobering Center
2. Peer Respite
3. Care Coordination
4. Patient Navigation
5. Others (e.g. Medical Respite, Nursing Home Diversion, etc.)
A Sobering Station, as part of the existing plans for a future Restoration Center, will provide an alternative to reduce the avoidable use of Emergency Medical Services (EMS), Emergency Department (ED), Emergency Psychiatric Services (EPS), and incarceration of acutely intoxicated adults; provide safe, short-term (4-12 hours) sobering services for consumers, and; provide critical linkages to care and connect care coordination (aka “hot handoff”) to support consumers’ engagement with the appropriate medical and behavioral healthcare resources as well as address barriers to health and wellness.
Intended to provide a home-like, peer-staffed environment for those experiencing mental health crises, where participants can learn healthier boundaries and develop safety planning. This investment provides an alternative to inpatient psychiatric treatment when the individual is not a danger to self/others but requires a supportive environment, and is designed to reduce avoidable use of EDs, EPS, and inpatient services.
Care Coordination: Responsibility for coordinating and supporting behavioral health care within the clinic and for coordinating referrals to clinically indicated services outside the clinic.

This includes:
- A designated person assigned as the Care Coordinator.
- Assessing for Care Coordination needs.
- Including Care Coordination in action steps with clients.
- Communicating and collaborating with other healthcare providers.
- Supporting clients in engaging into medical and behavioral health care services.
- Addressing barriers to health and wellness through linkage (including homelessness, criminal justice, social services).
Similar to the No Wrong Door Approach, the Patient Navigation Center will provide patients/clients with a universal gateway to VMC, BHSD, and community services that are available to them in Santa Clara County.
Data Infrastructure – New Developments

- Identifying clients as Whole Person Care in electronic health records (EHRs).
- Up to date care team rosters and contact information in EHRs.
- Shared decision making for service coordinators and health care providers in real-time.
- Secure data exchange.
- Data to inform program improvement.
42 CFR Memo - County Counsel/Compliance

1. Federal law (42 C.F.R Part 2) prohibits the disclosure of any information that could identify a patient as an alcohol or drug patient (SUTS records), with limited exceptions. Unlike mental health or physical health records, SUTS records cannot be shared for treatment purposes without the patient’s consent.

2. SUTS records can be shared for certain other reasons under a Qualified Service Organization Agreement (“QSOA”) to provide services to the program, such as data processing, bill collecting, dosage preparation, laboratory analyses, or legal, accounting, population health management, medical staffing, or other professional services.

3. There is currently a QSOA that allows sharing of SUTS data with certain departments within the Health & Hospital System for these purposes.

4. If SUTS data will be integrated into HealthLink (EMR) to be shared with treatment providers and others who do not fall under the QSOA, we recommend that SUTS clients sign appropriate consent forms before their information is shared.
<table>
<thead>
<tr>
<th>SUTS Confidentiality Requirement</th>
<th>Decisions Made to Address Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>SUTS clinical documentation cannot be shared with other HealthLink end-users until the patient grants authorization for their substance use treatment information to those end-users.</td>
<td>SUTS providers will give patients the option to sign a Universal Consent during their first face-to-face clinic encounter, authorizing all SUTS information to be shared with other HealthLink end-users, including all HHS and Epic Care Link end-users.</td>
</tr>
<tr>
<td>SUTS Confidentiality Requirement</td>
<td>Decisions Made to Address Requirements</td>
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</tr>
<tr>
<td>SUTS patients cannot be refused services if they do not wish to share substance use treatment information with other HealthLink end-users.</td>
<td>SUTS providers will give patients the option to sign a Medications and Orders Consent which will allow a patients’ medications and orders to be shared with other HealthLink users in order for the SUTS providers to ensure patient safety checks can be made against medications and orders can be communicated with other departments on HealthLink such as the pharmacy and lab. Should a patient decline to sign a Medications and Orders Consent, SUTS providers will work with the patient to find treatment services at a contracted Community Based Organization. Additionally, SUTS providers will document all SUTS information in a SUTS Confidential note type and all encounters must be marked as sensitive.</td>
</tr>
<tr>
<td>SUTS Confidentiality Requirement</td>
<td>Decisions Made to Address Requirements</td>
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<tr>
<td>Once a Medications and Orders Consent is signed, all non-medications and non-order clinical documentation cannot be shared with non-SUTS end-users.</td>
<td>SUTS providers will mark encounters as sensitive if a patient signs a Medications and Orders Consent and will complete all non-medication and non-order clinical documentation in a SUTS Confidential note type that will only be viewable to SUTS HealthLink providers.</td>
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<tr>
<td>SUTS Confidentiality Requirement</td>
<td>Decisions Made to Address Requirements</td>
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<tr>
<td>SUTS providers need a way to communicate a patient has not signed a Universal Consent and their SUTS information must be protected from non-SUTS HealthLink end-users.</td>
<td>SUTS providers will add a patient flag only viewable to SUTS providers that will trigger an alert for SUTS providers that all clinical documentation (other than medications and orders) should be documentation in a SUTS Confidential note type and all encounters should be marked as sensitive.</td>
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</tbody>
</table>
Sample – Authorization for Use or Disclosure of PHI

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>Date of Birth</th>
<th>ID or Medical Record #</th>
<th>Address</th>
<th>Phone</th>
</tr>
</thead>
</table>

**Authorization for Use or Disclosure of Protected Health Information**

I give permission to Santa Clara Valley Health and Hospital System (SCVHHS) (comprised of Valley Health Plan, Santa Clara Valley Medical Center, Public Health Department, Valley Health Center, and the Behavioral Health Services Department) to use and release to:

**Recipient Name:** [blank]  
**See Attachment B**

**Purpose:** The health information disclosed may only be used for the following purposes:

- Evaluate eligibility for participation in the Whole Person Care (WPC) program
- Provide and coordinate services to me under the WPC program
- Manage my services and conduct quality improvement related activities

**Information to be Released**

- Medical Record
  - All health information (e.g., diagnosis, test results, treatment)
  - Imaging and/or Films
  - Reports
  - Billing
  - Dental
- HIV/AIDS Test Results
  - Initial: [NA]
- Drug & Alcohol Treatment
  - Initial: [NA]
- Mental Health
  - Initial: [NA]
- Other: [blank]

**Delivery Preference:**

- Mail
- Pick up
- Other

**Delivery Format:**

- CD
- Film
- Paper
- Other

**Duration:** The authorization is valid immediately and will be valid until 12/31/2020 (give date).

**Cancellation:** I understand that I have a right to cancel this authorization any time. A cancellation (1) must be in writing (2) sent or given to the Health Information Management Department, 751 S. Bascom Ave., San Jose, CA 95128. A cancellation when it is received by the department. A cancellation will not apply to actions already taken by SCVHHS under this authorization or if the authorization was required for getting insurance coverage and the insurer has a legal right to contest a claim. Verbal cancellation will be accepted for behavioral health medical record pursuant to WIC Section 5326. Call 408-885-5770.

**Conditions:** I understand that treatment, payment, enrollment, or eligibility for benefits will not be based on my giving or refusing to give this authorization except if my treatment is related to research, or if health care services are given to me only for creating protected health information for release to a third party. I also understand that I may refuse to sign this authorization. A copy of this authorization is as valid as an original. I have the right to receive a copy of this authorization.

**Redisclosure:** Information disclosed pursuant to this authorization could be redisclosed by the recipient. Such redisclosure is in some cases not prohibited by California law and may no longer be protected by federal confidentiality law (HIPAA), although information protected by 42 CFR Part 2 continues to be subject to that protection. In addition, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.

<table>
<thead>
<tr>
<th>Patient/Patient's Representative Name</th>
<th>Patient/Patient's Representative Signature</th>
<th>Relationship</th>
<th>Date</th>
</tr>
</thead>
</table>
You qualify for a new, free program – Whole Person Care.

You will maintain Medi-Cal benefits.

The program can help with housing applications, moving costs, food, and transportation.

With enhanced Care Coordination – you have a main point of contact.

There is an opportunity to opt out should you wish to do so.

We have a central phone number to contact for more information about WPC.
Data comes from HealthLink (EMR). Work is underway on synthesizing the data from UniCare (Legacy EMR)

- At least 40% are Homeless.
- At least 55% report Behavioral Health (MH and SU) challenges.
- The majority are not in programs with Care Coordination services.
- Many are criminally justice involved.
- Majority are English speakers.
- More are male than female.

- Very few responded to the initial enrollment letters.
- Pilot showed good response from direct outreach.
Outreach Calls by WPC QIC:

1. Check MH UniCare for history. Call only those who do not have a current MH opening.
2. Start with the highest HUMS Score.
3. Call client and use the WPC script.
4. Check HealthLink, UniCare, HMIS as appropriate.
5. Care Coordinate resources with client.
6. Set another time to talk if needs follow up.

• After Call:
  1. Email Team Member to open in UniCare (up to 5 clients at a time).
  2. Enter service in UniCare and progress note.
  3. If making referrals, call client back the following week to check status.
  4. If client wants MH services, transfer the call using Call Center’s back door number 408-494-2899. Inform Call Center staff it is a WPC client. Give clinician the contact info., name, and insurance so they can run it before they make the conference call. Following, view HL to see where the referral is made.

• Data collection:
  1. Utilize Excel Spreadsheet to keep track of the type of referrals made for each call which also has UniCare #, PCP’s name, and comments.
Whole Person Care – Outreach Script, Letter, Appointment Card

**Appointments**

I am calling to let you about a new program we've been enrolled in called Whole Person Care which offers several services to help you achieve better health outcomes. We're interested in hearing more about the challenges you face. I'd like to spend some time talking to you to see how we can help with your needs. Is now a good time to complete an assessment?

1. From our records, I see that your current VMC Primary care provider is __________. Are you connected with them? If you are not connected with a VMC PCP, I can assist you. Do you want me to help you with this?

2. What challenges do you have accessing your VMC PCP services or making those appointments? What services would you need to address those problems?

3. I can assist in helping you get referred to Mental Health and / or Substance Use Treatment services. Do you want me to help you with this?

4. Are you experiencing any housing related stress? (I can help answer questions about housing resources in our county. Do you have any questions about this?)

5. Are you experiencing any financial stressors? (What is your source of income? Would you like information on any public benefits?)

6. Are you experiencing any stress related to the legal system?

7. Is there anything else I can help you get your needs met?

**Referral Services provided:**

- [ ] PCP Name
- [ ] Other Medical
- [ ] SUTS Gateway
- [ ] Mental Health
- [ ] VI-SPDAT
- [ ] Shelter
- [ ] Other Housing
- [ ] Financial/Benefits
- [ ] Legal
- [ ] Other Community Services: ____________________________

Thank you for your time and information. Here is my phone contact information if you need to reach me:

I look forward to hearing from you and working with you to access your health care needs.
Concluding: Use a 3-Pronged Approach

- New Programs
- Data Infrastructure
- Care Coordination
Questions

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Todd.Landreneau@hhs.sccgov.org
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