A Journey to Improve the Health of LA County Residents

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Whole Person Care (WPC) - LA Overview

**Mission**
Build an integrated health system that delivers seamless, coordinated services

**Goal: Collaboration**
Increase integration and collaboration among county agencies, health plans, providers, and other entities

**Goal: Coordination**
Increase coordination and appropriate access to care

**Whole Person Care**
A 5-year pilot program that builds countywide infrastructure & community capacity to improve care to sickest, most marginalized Medi-Cal beneficiaries

**Goal: Data Integration**
Improve data collection and sharing to support case management, monitoring, and program improvement
WPC-LA – Addressing Key Drops in Potential for Complex Care Management Programs

Potential opportunity

Identification

Engagement

Finding opportunities for improvement

Intervention

Realized improvement

Adapted from J Eisenberg JAMA. 2000
Regional Care Management Teams
Regional care teams apply a “no wrong door” approach and provide “care without walls”

Integrated Health Delivery
Participant engagement & care coordination enabled by health delivery teams & IT/data integration

Community Health Workers (CHWs)
Social service teams driven by CHWs with shared lived experience

Transitional Care Coordination
Accompaniment & linkage to and integration with long-term providers during high-risk times
WPC-LA Programs

**Homeless High-Risk**
- Homeless Care Support Service
- Tenancy Support Services
- Recuperative Care
- Sobering Center

**Justice-Involved High-Risk**
- Re-entry Enhanced Care Coordination
- Community-based Re-entry
- Juvenile Aftercare

**Mental Health High-Risk**
- Intensive Service Recipients
- Residential and Bridging Care
- *Kin Through Peer

**Perinatal High-Risk**
- Mama’s Neighborhood

**SUD High-Risk**
- Engagement, Navigation & Support

**Medical High-Risk**
- Transitions of Care

**Other Services**
- Benefits Advocacy
- *Medical Legal Partnership

*Add-on program – requires enrollment in at least one other WPC-LA program*
## Transitional Care Management

<table>
<thead>
<tr>
<th>Program</th>
<th>Identification &amp; Engagement</th>
<th>Key Interventions*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Justice Involved High-risk</td>
<td>Universal Jail Screening; Community Referral</td>
<td>Jail-to-Home – pre-release planning, benefits re-enrollment, release meds; Focus on re-integration, triggers to re-incarceration</td>
</tr>
<tr>
<td>SUD High-risk</td>
<td>Community Referral (EDs/Hospitals, Child &amp; Family Services, Courts)</td>
<td>Focus on recovery coaching, linkage to treatment &amp; between treatment sites</td>
</tr>
<tr>
<td>Mental Health High-risk</td>
<td>Mental Health Facility Referral; Pre-/ post-discharge follow-up</td>
<td>Focus on getting individuals with Serious Mental Illness (SMI) to right level of care</td>
</tr>
<tr>
<td>Transitions of Care</td>
<td>Hospital Referral – Pre-/ post-discharge follow-up</td>
<td>Focus on post-discharge stabilization, linkage back to PCP</td>
</tr>
<tr>
<td>Recuperative Care</td>
<td>Hospital Referral – Post-discharge follow-up</td>
<td>Focus on post-discharge stabilization for individuals who are homeless; linkage to Permanent Supportive Housing (PSH)</td>
</tr>
</tbody>
</table>

* All programs provide accompaniment & navigation to health & social services & comprehensive assessment and care planning
Overview of LA County Department of Health Services (DHS)

- **2nd** Largest public health system in the nation
- **360,000** empaneled lives
- **218** Patient-Centered Medical Home teams (**1200** Providers)
- **27** facilities (hospitals and ambulatory care clinics)
- **94** Care Managers
Care Management is a person-centric approach of proactive surveillance, coordination, and facilitation of health services across the care continuum to achieve optimal health status, quality, and costs.

- ELM Care Management solution enables
  - Coordination of care across the entire care team;
  - Visibility for case information and activities; and
  - Identification of High-Risk patient populations.

- Intended users
  - Care Managers, Care Manager Supervisors.

- Leverages
  - Data from the EHR, health plan claims, and population registry (ELM); and
  - Identification and Alignment algorithms that identify patients for care management services.
PCMH Multidisciplinary Team Members

- Provider- Assume care for all empaneled patients
- RNI Caregiver- Manage patient throughput, address patient calls, portal messages, verification of medications
- RNII Nurse Directed Clinic staff- Conduct Nurse Visits, Address health promotion, prevention and chronic disease management under the auspices of IDPC approved Standardized Procedures
- RNII Service Coordinator- Addresses members with Out of Network access, coordinates linkage from Out of Network access, back to PCMH team
- RNIII Care Manager- Complex Care Management of High-Risk patients
- CMA- Day of Visit, In Between Visits, Closing care gaps, administer certain meds/vaccines
- LVN- Day of Visit, In Between Visits, Closing care gaps, administer certain meds/vaccines, verification of medications
- Clerk- Check in, reminder calls, Closing care gaps
- CHW- Home visits per referral, accompany patient to appointments, linkage to services
- Social Work- Address psycho-social and social determinants of health
- Health Education staff- group and/or one on one patient education
- Clinical Pharmacist- Medication management
ELM Care Management Risk Stratification

- **High Risk Algorithms**
  - Identifies patients who qualify for care management services based on certain parameters.

- **The 5 Program Identification Algorithms**
  - High Risk Adult and Senior;
  - Transition Care Management;
  - High Risk Maternity;
  - Utilization Coordination;
  - High Risk Pediatrics.
Care Manager Dashboard

Cases By Status

<table>
<thead>
<tr>
<th>Status</th>
<th>Cases</th>
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</thead>
<tbody>
<tr>
<td>New</td>
<td>1</td>
</tr>
<tr>
<td>Pending Enrollment</td>
<td>0</td>
</tr>
<tr>
<td>Enrolled</td>
<td>1</td>
</tr>
<tr>
<td>Active</td>
<td>1</td>
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<tr>
<td>Pending Closure</td>
<td>0</td>
</tr>
<tr>
<td>Total Cases</td>
<td>3</td>
</tr>
</tbody>
</table>

Potential Cases List (23)

Organizer Observation Notifications

All Visits

No results found

Notes/Reminders (2)

Result Range: All

<table>
<thead>
<tr>
<th>Patient</th>
<th>Subject / SubType</th>
<th>Due</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doe, Jason Jon</td>
<td>Reminder Message</td>
<td>08/02/17 16:00</td>
</tr>
<tr>
<td>DOB: -- MRN: --</td>
<td>zz Care Coordination Referral</td>
<td></td>
</tr>
<tr>
<td>Harrell, Donna</td>
<td>Reminder Message</td>
<td>07/22/17 11:04</td>
</tr>
<tr>
<td>DOB: -- MRN: --</td>
<td>Patient Follow-up</td>
<td></td>
</tr>
</tbody>
</table>
To document - double-click in the appropriate cell to the right of the name of the result or measure. This will allow you to tab through sections.
Active Tab - Care Plan
DHS Care Management Program Framework

- Provides a basic structure
- Incorporates biopsychosocial factors, social determinants of health, and Wagner’s chronic disease model to achieve the quadruple aim.
- Requires that the ambulatory RN work at the top of his/her license
- Includes policies and procedures such as
  - Manual referral process; and
  - Procedure for tasking care team members using the EHR clinical messaging function.
DHS Care Management Program Goals

Goals are aligned with the quadruple aim and seek to

- Improve patient outcomes;
- Enhance access to quality care;
- Decrease hospital readmissions;
- Ensure continuity and seamless transitions; and
- Improve the individual patient and staff experience.
DHS Care Management Program Strategies

- Define roles and responsibilities
- Develop Care Management policies, procedures, clinical protocols
- Training and development
- Inter-professional collaboration
- Leverage technology
- PCMH case conferences
- Multidisciplinary collaboration
Total Active Care Plans: 5,921
Care Management Dashboard

Month of Measure Date

- October 2017: 0%
- December 2017: 13%
- February 2018: 23%
- March 2018: 23%
- April 2018: 24%
- May 2018: 39%
- June 2018: 30%
- July 2018: 34%
- August 2018: 38%
- September 2018: 39%
Care Management Adoption—Next Steps

- Adoption and Institutionalization of ELM Care Management in Primary Care for management of high risk, complex patients
  - Monitor adoption through surveys and reports
  - Continue to build CM skills via
    - sustainable ongoing care manager training;
    - care management touch point calls;
    - skills sharpeners; and
    - train the trainers.