A Journey to Improve the Health of LA County Residents

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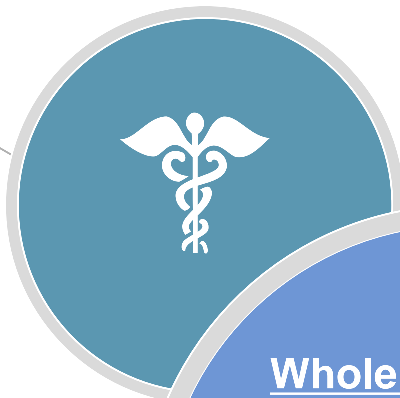
Whole Person Care (WPC) - LA Overview

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



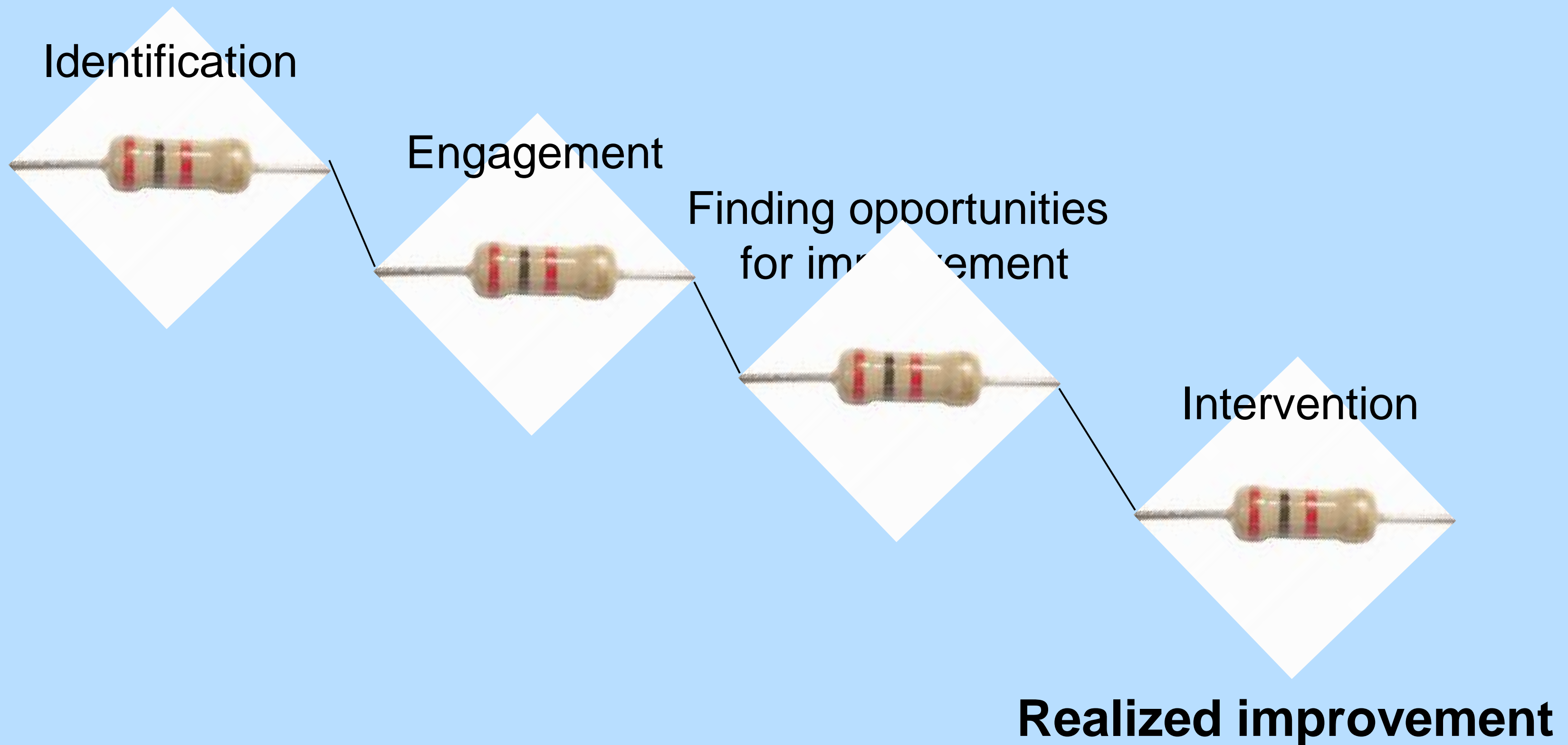
Goal: Collaboration
Increase integration and collaboration among county agencies, health plans, providers, and other entities

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

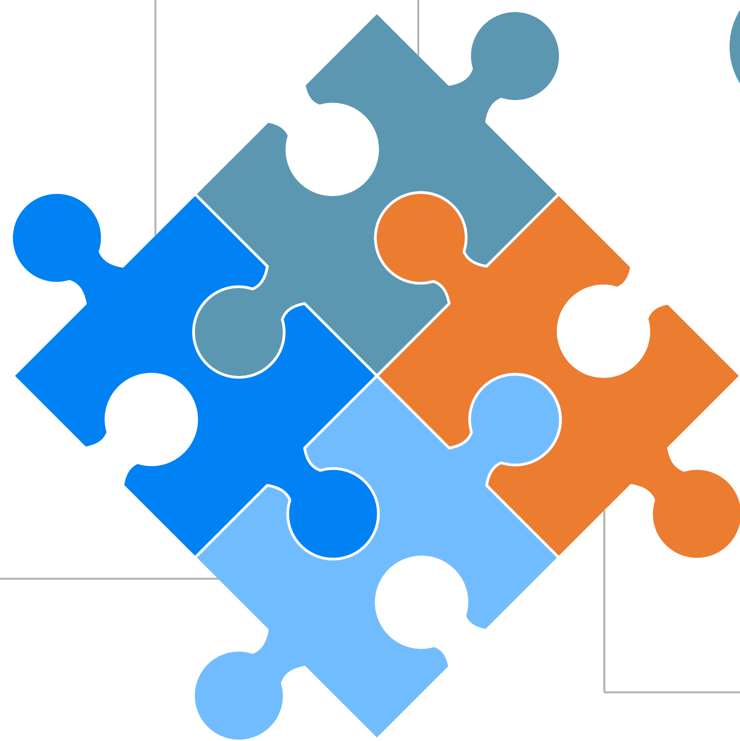
Goal: Coordination
Increase coordination and appropriate access to care

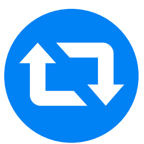
Goal: Data Integration
Improve data collection and sharing to support case management, monitoring, and program improvement

WPC-LA – Addressing Key Drops in Potential for Complex Care Management Programs



WPC-LA Highlights





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

Regional Care Management Teams
Regional care teams apply a "no wrong door" approach and provide "care without walls"

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

WPC-LA

- **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*

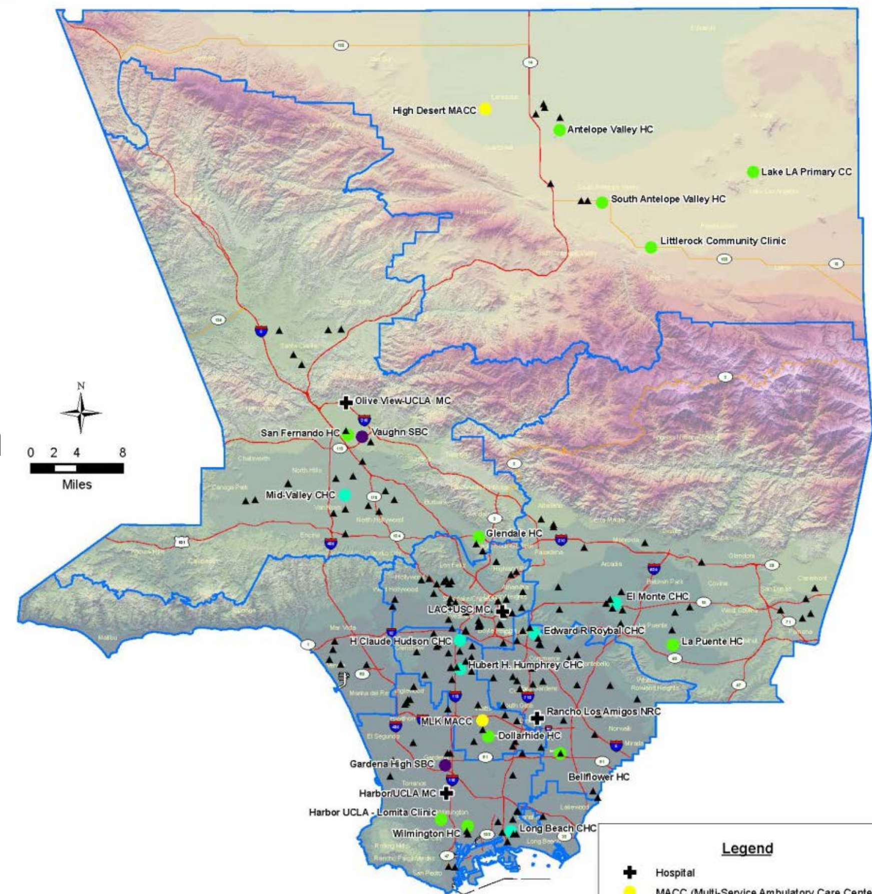
Transitional Care Management

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

* All programs provide accompaniment & navigation to health & social services & comprehensive assessment and care planning

Health Services
LOS ANGELES COUNTY

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

ELM Care Management

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

Health Services
LOS ANGELES COUNTY

PowerChart Organizer for MANAGERS, CARE

Task Edit View Patient Chart Links Notifications Navigation Help

Home | Care Manager Dashboard | Patient List | Message Center | Multipatient Task List | Ambulatory Organizer | Dynamic Worklist | Dynamic Worklist Import | Quality Measures | AMION | CDC VIS | Remin: 0 Msg: 0

Suspend | Charges | Exit | Calculator | AdHoc | PM Conversation | Communicate | Patient Education | Medical Record Request | Add | Patient Pharmacy | Scheduling Appointment Book | Documents | Explorer Menu

Recent | Name

Care Manager Dashboard — Full screen | Print | 0 minutes ago

100%

Case List | Care Manager Overview

Cases By Status

Status	Cases
New	1
Pending Enrollment	0
Enrolled	1
Active	1
Pending Closure	0
Total Cases	3

Potential Cases List (23)

Organizer Observation Notifications

All Visits

No results found

Notes/Reminders (2)

Result Range: All

Reminders (2)

Patient	Subject / SubType	Due
Doe, Jason Jon DOB: -- MRN: --	Reminder Message zzCare Coordination Referral	08/02/17 16:00
Harrell, Donna DOB: -- MRN: --	Reminder Message Patient Follow-up	07/22/17 11:04

Care Management Referral

Active Tab – iView Assessment

iView and I&O

CM Comprehensive Evaluation Adult
- Communication Method
- Environment, Resources and Services Eval
- Medication Adherence Assessment
- Durable Medical Equipment:
- Skilled Services Evaluation
- CM Systems Evaluation
- Psychosocial Behavioral Eval
- Summary of Recent Visit
- Barriers to Care Evaluation

CM Comprehensive Evaluation Peds
CM Condition Evaluation Adult
CM Condition Evaluation Peds
CM Condition Evaluation Maternity
CM Transitional Care Evaluation
CM Clinical Values Measurement
CM Transitional Care Evaluation

Last 24 Hours

Immediate Needs or | Critical | High | Low | Abnormal | Unauth | Flag | And | Or

Result	Comments	Flag	Date	Performed By
Environment, Resources and Service...				

08/03/2017
17:26 PDT

Environment, Resources and Services Eval
- Lives In
- Immediate Needs or Current Concerns
- Support System
- Special Services and Resources

Medication Adherence Assessment
- Adherence Other
- Primary Administrator of Home Medication
- Medication Knowledge Needs
- Home Medication Behavior Problems
- Prescriptions Filled Pharmacy Prior DC
- Perceived Medication Barriers
- Medication Adherence Method
- Assessed Medication Regime Barriers

Durable Medical Equipment:
- Current DME at Home
- CM Durable Medication Equipment:
- Home Equipment, Anticipated

Skilled Services Evaluation
- Currently Receiving Skilled Services
- Skilled Services

CM Systems Evaluation
- Rate Your Physical Health
- Hearing Evaluation
- Vision Evaluation
- Speech/Communication Evaluation
- Musculoskeletal, Fine, Gross Motor Skill
- Cognitive
- General Symptoms
- Respiratory Symptoms
- Cardiovascular Symptoms
- GI Symptoms
- Bowel Ostomy Type
- Genitourinary Symptoms
- Urinary Elimination
- Feeding Tube Type
- Skin Symptoms
- Wound Type

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

Community Care Management

Full screen | Print | 1 hours 15 minutes

100%

Patient Summary X | Enrollment X | Active Case X | Close Case X | +

Patient Information
Manage Case
Histories
Allergies (1)
Visits (1)
Home Medications (2)
Observation Notifications
Screenings and Assessments (2)
ELM
Recommendations
Immunizations (0)
Care Plan
Care Team
Reminders (2)
Communication Events (3)
Documents (4)

Create Note
Case Summary Note
Care Plan Note
Select Other Note

Care Plan +

All Visits

All (1) | Unmet (1) | Future (0) | Met (0)

1

Care Team +

Role/Relationship

This Visit

--

Cross-Visits

Care Manager | MANAGER, CARE | -- | -- | --

Edit Goals and Interventions

Goal *

Search and select, or key in unique goals | 0/100

Start * | Target * | Department | Confidence Level | Barriers | Status

-- | -- | -- | --

Interventions *

+ Intervention

Add another goal | Save | Cancel

Reminders (2) +

All Visits | All | Today | More

Show Only My Reminders | Filter by Subtype: All Subtypes

!	Subject	Subtype	📎	Due	From
	Reminder Message	Lab X-ray Follow-up		--	MANAGER, CARE
	Follow up for initial assessment	Initial Assessment		06/18/17 14:14	MANAGER, CARE

Active Tab – Care Plan Note

Community Care Management

100%

Patient Summary | Enrollment

Patient Information
Histories
Allergies (0)
Home Medications (0)
Visits (1)
Observation Notifications
Screenings and Assessments (0)
ELM ...
Recommendations ...
Immunizations ...
Care Plan ...
Care Team ...
Reminders ...
Communication Events ...
Manage Case ...
Documents (0)

Create Note
Case Summary Note
Care Plan Note
Select Other Note

Documentation

Add

Care Plan Note | List

Tahoma 9

Medication Compliance

Goals and Interventions
Care Plan

Symptom Management

Upcoming Scheduled Appointment

Next Care Plan Revision Date

Contact Information and Office Hours

Problems
Ongoing
No qualifying data
Historical
No qualifying data

Procedure/Surgical History

Medication List
No active medications

Allergies
No active allergies

Note Details: Care Manager Outpt Note, MANAGER, CARE, 09/13/2017 13:08 PDT, Care Plan Note

Sign/Submit

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

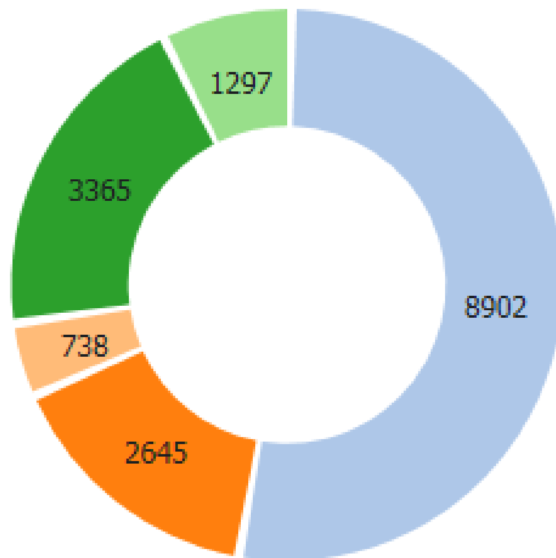
- Improve patient outcomes;
- Enhance access to quality care;
- Decrease hospital readmissions;
- Ensure continuity and seamless transitions; and
- Improve the individual patient and staff experience.

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

Cases By Status

Cases By Status



Status	Cases
New	8902
Pending Enrollment	2645
Enrolled	738
Active	3365
Pending Closure	1297
Total Cases	16947

Total Active Care Plans: 5,921

Care Management Dashboard

TOC Intervention

% Met

100%
80%
60%
40%
20%
0%

0% 13% 23% 23% 23% 24% 39% 30% 34% 38% 39%

October 2017 December 2017 February 2018 April 2018 June 2018 August 2018

Month of Measure Date

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.

Questions?