CALIFORNIA ASSOCIATION of PUBLIC HOSPITALS AND HEALTH SYSTEMS

CALIFORNIA HEALTH CARE SAFETY NET INSTITUTE

CHEAC COUNTY HEALTH EXECUTIVES ASSOCIATION OF CALIFORNIA

Whole Person Care Local Evaluation

August 13, 2019

Webinar recording available here

Welcome

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Today's Presenters

- Sacramento
- Alameda
- Small County Collaborative
- Los Angeles
- Marin
- San Diego
- Solano
- Contra Costa
- Napa
- San Francisco
- Orange

Logistics

Please mute yourself!
(We'll have to mute lines if there is background noise)

Presenters: we will advance slides for you -- please unmute yourself when it is your turn

Chime in when presenters share their questions for the group;

Feel free to use the chat box and we will read your questions & comments aloud

We will send a post-webinar survey to identify additional TA opportunities & needs. Your input is valued!

City of Sacramento WPC Pilot: Pathways to Health + Home Evaluation Overview

Research Questions

1. What is the impact of care coordination and "co-management" between Pathways partner organizations on enrollee health and housing outcomes? What factors contribute to enrollee engagement and success (e.g., staffing composition, caseload size, frequency of contact, communication between partners, service connections, etc.)
2. What is the role of temporary shelter placement on health and permanent housing outcomes? What are the most effective housing intervention strategies? What are the barriers and facilitators to connecting enrollees to health and housing resources?
3. What is the impact of the Pathways model on costs and cost-offsets for health plans and hospitals (e.g., inpatient days and ED utilization)?

Pathways Evaluation Overview

Pathways Enrollees Outcomes	• Health and Behavioral Health stability and self-management • ED and In-Patient Hospital Utilization • Housing type
Factors Influencing Outcomes	• Demographics (age, gender, etc.) • Level of program engagement • Housing/shelter type • Access to and utilization of health and behavioral health services
Costs and Financial Impact	• Offsets, savings • Value of Care Coordination
Impact on Cross-Sector Collaboration and Coordination	• Strength of partnerships, communication and collaboration across organizations • Shared vision and understanding of the problem/solutions • Better aligned and less duplication of services
Lessons Learned	• Challenges • Successes • Sustainability, scalability, spread

Evaluation Design & Methods

- **Evaluation Design**: Pre-post (with comparison groups, as feasible), participatory evaluation approach that includes input from City and Pathways partners in developing and prioritizing research questions and assessing the results.
- **Mixed Method Approach:** Qualitative (interviews, focus groups, document review, case note review) and quantitative (service utilization, claims, and cost)

Qualitative and Quantitative Data Sources

- Program documents (e.g., contracts, program polices)
- ED/Hospital utilization data
- Service utilization from Shared Care Plan portal
- Acuity assessment and Shared Care Plan (e.g., enrollee goals, interventions)
- Key informant interviews
- Cost/charges data

Discussion Topics for other Local Evaluators

- Timeline for obtaining service utilization/cost information from managed care plans
- Strategies for obtaining feedback from WPC program enrollees
- Impact of Health Home Program implementation on WPC program

alameda county care connect

A Whole Person Care Pilot

Alameda County Care Connect

Alameda County Health Care Services Agency, with John Snow, Inc. (JSI)

alameda county care connect

A Whole Person Care Pilot

Key Research Questions

- What impact has Care Connect had on health, health care, and wellbeing of individuals and the system of care in Alameda County?
  - What activities / services / infrastructure are most impactful?
  - What resources are needed to continue these pieces after 2020?
  - What resources are available for these activities? Where are there gaps in funding?
- How are consumers experiencing Care Connect?
- How has Care Connect fostered new collaboration in Alameda County?

alameda county care connect

A Whole Person Care Pilot

Evaluation Approach

- Quantitative Analysis of Program Activities
  - Program progress and impact data (2020 Goals)
  - Prospective data from program leads
  - Budget data
  - Feedback from Subject matter experts
- Key Informant Interviews
  - Care Connect staff
  - Leaders in relevant partner agencies and organizations
  - Front-line staff and providers
  - Consumers and family members

alameda county care connect

A Whole Person Care Pilot

Questions

- How are you showing outcomes/impacts (rather than process measures) over a short time period?
- How are you measuring or capturing cost savings (especially when working across sectors)?
- How are your evaluations connected to sustainability planning, if at all?

California Small County Collaborative Evaluation Design

Whole Person Care
California Small County Collaborative

Key Research Questions

- Did we cultivate multi-directional communication across agencies and partners?
- Did we increase access to healthcare services?
- Did we improve quality of care?
- Did we improve quality of life?
- Did we reduce costs (addressed through ROI study)?
- Note: These questions will be assessed for each county as well as the Collaborative as a whole

Data Collected

- Pre and post enrollment assigned PCP
- Updates to medications lists
- Access and use of eWPC system
- Hospitalizations
- ED visits
- 30-day readmissions
- Connection to housing services
- Housing status
- Referrals
- PHQ-9 depression assessment
- Care plan creation and use
- Care team members
- Client goals met

Evaluation Design Continued

Whole Person Care
California Small County Collaborative

Methods

- Quantitative analysis from eClient management system
  - Clients served and demographics
  - Descriptive statistics for key outcomes
  - Tracking data across program years
- Qualitative analysis
  - Client stories
  - Staff experiences
  - Client interviews
- Collaborative data collection design to determine what data to collect to generate measures for research question areas

Questions for Other Evaluators

- What system(s) are you using to collect and analyze data?
  - Do they meet your needs?
  - Are they cost effective?
- How do you balance the need for data collection with high demands on staff time?

Whole person Care
Los Angeles – Evaluation

Evaluation Leaders: Clemens Hong (LAC DHS), Amy Wohl (LAC DHS), Arleen Brown (UCLA)

Evaluation Contact: Francesca Cameron, FCameron@mednet.ucla.edu

Whole Person Care Los Angeles (WPC-lA)

- 16 programs serving 6 high-risk populations

  Those experiencing:

  - Homelessness
  - Justice involvement
  - Barriers to healthy pregnancy
  - Serious mental illness
  - Substance use disorder
  - Complex health conditions

- Over 50,000 unique clients

Los Angeles County

A complex Environment for Health Service Delivery

POPULATION RANKINGS

Population of LA County, SPAs, and Individual US States by Rank

1.	**California** (39,144,818)	31.	Iowa
2.	Texas	32.	Utah
3.	Florida	33.	Mississippi
4.	New York	34.	Arkansas
5.	Illinois	35.	Kansas
6.	Pennsylvania	36.	Nevada
7.	Ohio	37.	SPA 2-San Fernando (2,228,821)
8.	Georgia	38.	New Mexico
9.	LA County (10,192,376)	39.	Nebraska
10.	North Carolina	40.	West Virginia
11.	Michigan	41.	SPA 3-San Gabriel (1,799,204)
12.	New Jersey	42.	Idaho
13.	Virginia	43.	SPA 8-South Bay (1,568,950)
14.	Washington	44.	Hawaii
15.	Arizona	45.	New Hampshire
16.	Massachusetts	46.	Maine
17.	Indiana	47.	SPA 7-East (1,322,943)
18.	Tennessee	48.	SPA 4-Metro (1,167,286)
19.	Missouri	49.	Rhode Island
20.	Maryland	50.	SPA 6-South (1,048,734)
21.	Wisconsin	51.	Montana
22.	Minnesota	52.	Delaware
23.	Colorado	53.	South Dakota
24.	South Carolina	54.	North Dakota
25.	Alabama	55.	Alaska
26.	Louisiana	56.	District of Columbia
27.	Kentucky	57.	SPA 5-West (660,081)
28.	Oregon	58.	Vermont
29.	Oklahoma	59.	Wyoming
30.	Connecticut	60.	SPA 1-Antelope Valley (396,357)

EVALUATION OVERVIEW

Evaluation Component	Challenges & Solutions
Health Services Use and Administrative Data Analysis • Compare pre- and post- (and control group) on service use, quality, costs • Develop Risk Stratification Model • >50,000 clients	*Challenges:* • Harmonizing data from many sources & databases • Incomplete data– many missing variables • Lack of reference population *Solution:* Developing an integrated database
Social Service Organization Stakeholder Evaluations • Interviews with social service organizations delivering wrap-around services • Community partnered approach (around 120 contracted agencies with WPC-LA) • >50 interviews to-date	*Challenges:* • Obtaining contacts for various organizations • Defining a full list of partners (i.e., contracted vs. informal partnerships) *Solution:* Continuous feedback from WPC leadership
Community Health Worker (CHW) Interviews & Focus Groups • Interviews and focus groups with CHWs on successes, obstacles, the CHW role, client engagement, & SDOH • 25-30 in-depth interviews, 3-5 focus groups	*Challenge:* • Difference in CHW role per program (high-risk groups served) *Solution:* Phasing interviews with different groups of CHWs
Client Surveys • Surveys on Patient Reported Outcomes & experience of care • Develop Recovery Measure • Currently piloting	*Challenges:* • Hard to reach clients • Low response rates

QUESTIONS FOR OTHER PILOTS

- How do you track referral and receipt of social services by clients?
- Is there any way you are tracking and quantifying interactions/dose effect from CHWs, social workers, and patient navigators?
- For those not doing a randomized control trial, what control group are you using for utilization and administrative data?

Marin County Whole Person Care

Local Evaluation Questions

Are the following different before and after enrollment in case management?

-Rate and length of incarceration
-Emergency department utilization
-Inpatient utilization
-Psychological emergency services utilization

Have exits to permanent housing out of adult shelter changed from the first half of 2018 to the first half of 2019?

What are the key learnings from the WPC program that can be applied to other systems change efforts? (Qualitative)

MARIN HEALTH & HUMAN SERVICES
Health, Well-being & Safety

Marin County Whole Person Care

Local Evaluation Methods and Data

Quantitative Evaluation

-Evaluation conducted by WPC team including: data collection, data analysis, communication of findings

-Data sources: Partnership HealthPlan, HMIS, Tiburon (Marin County Jail)

Qualitative Evaluation

-Evaluation conducted by external consulting firm including: data collection, data analysis, communication of findings

-Data sources: Evaluators will review WPC resources, and interview WPC team, Partner Entities, clients, other stakeholders (hospitals)

MARIN HEALTH & HUMAN SERVICES

Health, Well-being & Safety

Marin County Whole Person Care

Local Evaluation Questions for Other Evaluators

How do you translate findings into cost?

How are you timing the evaluation? Are you evaluating earlier to have findings earlier or later to allow for more measurement time?

Have any pilots conducted a cost effectiveness analysis of WPC (or a component of WPC)?

MARIN HEALTH & HUMAN SERVICES
Health, Well-being & Safety

WHOLE PERSON WELLNESS

County of San Diego

Evaluation Questions

LIVE WELL SAN DIEGO

RESEARCH QUESTIONS

1) OUTCOMES FOR WPW PARTICIPANTS

- How does healthcare utilization compare pre- and post- enrollment into WPW?
  - ED visits, hospital days/LOS, psych inpatient days/psych LOS
    - E.g., Is there a significant difference between the # of ED visits in the 12 mos prior to enrollment into WPW vs. the 12 mos following enrollment into WPW
- What are outcomes for WPW clients who become permanently housed? How do outcomes compare between our housed and non-housed clients?

2) LEARNING LESSONS IN CARE COORDINATION

- What are some of the barriers in care coordination?
- What are some positive learnings/success stories from the pilot (e.g., housing and HDAP, partnership with Legal Aid, etc.)
- What were our experiences in working with multiple managed care plans?

3) FEEDBACK FROM PARTICIPANTS

- How do participants feel about their experiences with WPW?

DATA & METHODOLOGY

1) OUTCOMES FOR WPW PARTICIPANTS

- Health claims data from MCPs
- County data from Behavioral Health Services, Sheriff's Dept, etc.
- Paired t-test for pre-/post- pilot comparisons
- Logistic regression and/or two sample t-test to examine differences in outcomes for those housed vs not housed

2) LEARNING LESSONS IN CARE COORDINATION

- Process mapping with case managers, other providers
- Focus groups?
- Gap analysis

3) FEEDBACK FROM PARTICIPANTS

- Questionnaires
- Focus groups?

QUESTIONS FOR THE GROUP

- Are any evaluators looking at cost savings (or projected cost savings)? What methodologies are you using?
- How are evaluators handling missing data, especially if health claims data is missing (e.g., for FFS MCal clients)?
- How are evaluators capturing qualitative data (e.g., surveys? focus groups?)

Solano WPC Evaluation

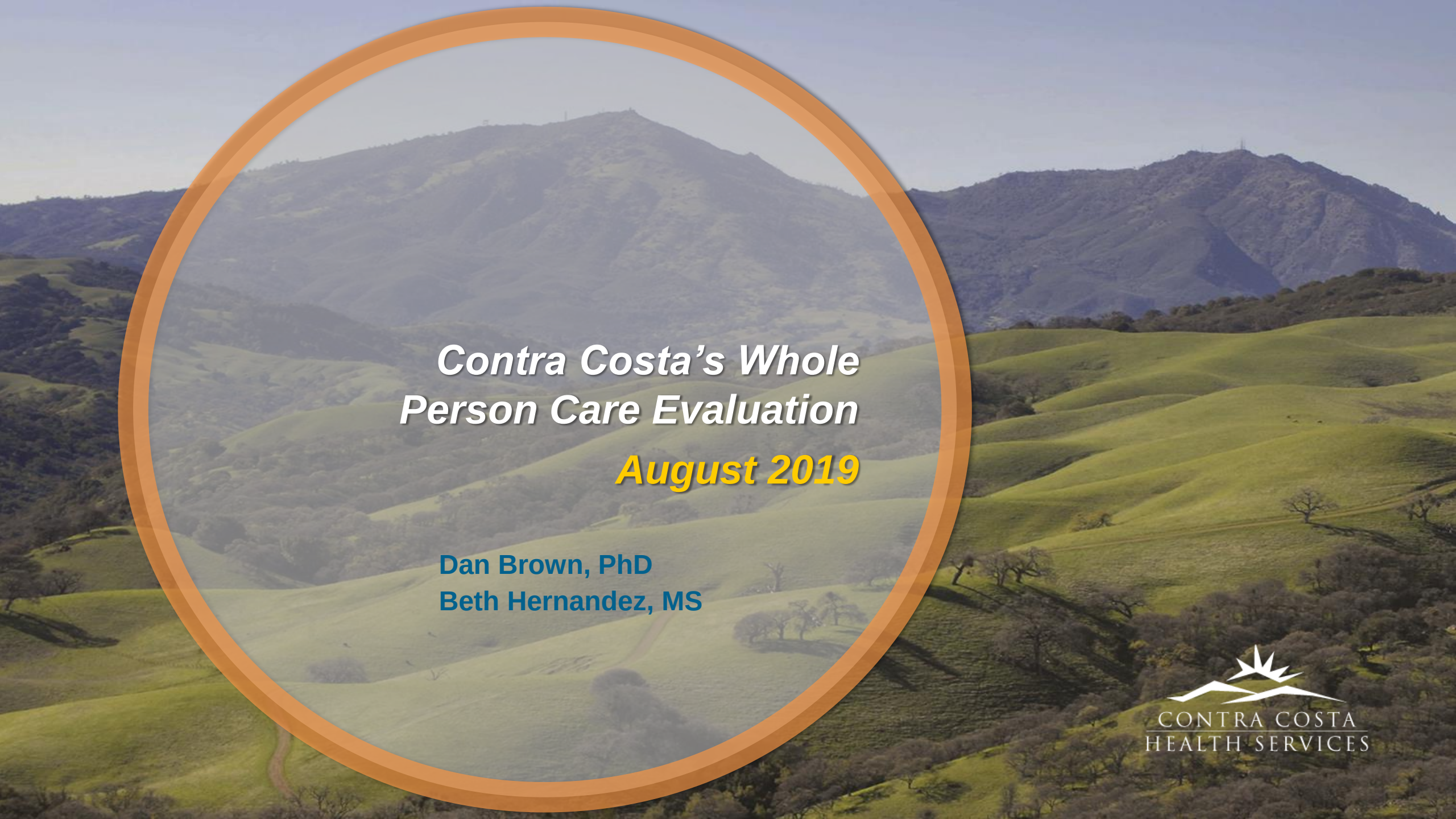
- Key research questions:
  - Are clients achieving better health outcomes?
  - What is the return on investment?
  - What elements of the program are primary drivers of positive outcomes, and how can we implement these pieces long-term?
  - Is there a more cost effective way to implement those interventions?

Data Collection

- Using MediCal claims data that is already being collected
- Possibly using medical records for clients who utilize the county's primary care clinic
- Client self-report data and staff evaluations of client progress (both already being collected)

Other Questions

- What are other LE's using as comparison group(s)?
- How do you determine the effects of WPC services that are also offered elsewhere in the community (redundant services)?



Contra Costa's Whole Person Care Evaluation

August 2019

Dan Brown, PhD
Beth Hernandez, MS

CONTRA COSTA
HEALTH SERVICES

Evaluation Questions

- How is the program impacting avoidable ED and inpatient utilization?
- How are broader care and utilization patterns changing?
- Have services that address social needs impacted utilization, public benefits enrollment, and health status?

Methods & Data

Methods

- Quantitative:
  - Randomized controlled trial
  - Identify risk-matched controls for each enrollee
  - Follow up for one year after randomization
  - Contrast outcomes to estimate program effect
- Qualitative:
  - Observations of case management visits
  - Patient Interviews
  - Document review of EHR and care plan

Program Outcomes

- ED
- Inpatient
- Outpatient care (primary, specialty)
- Behavioral Health Utilization
- Medi-Cal churn
- Public Benefits enrollment
- No Show rates

Questions for others

- How are you addressing missing outcomes?
  - Looking only at specific insurance statuses? Specific service delivery locations?
  - Engaging new data sources to broaden reach?

- What approaches are you using to demonstrate ROI?

Napa WPC Program Local Evaluation

- Napa County WPC pilot focuses on individuals **experiencing homelessness** or those at risk of homelessness, including high systems users.
- Estimated Number of Persons Served During Pilot Period: **800**

Mobile Engagement

- Coordination between emergency response services and a WPC engagement team to provide individuals with on-the-spot assessment and referral to health, social, and housing programs.

Coordinated Entry

- WPC personnel work with each participant individually to assess and connect participants to necessary services, such as food assistance programs or housing shelter resources.
- Housing navigators assist in developing a housing plan for
- Housing navigators assist in developing a housing plan for every homeless individual.

Tenancy Care

- Participants are assigned a care coordinator after being assessed and prioritized for housing services.
- Care coordinators work with homeless individuals to establish benefits, clear up credit issues, connect them to health and social services, and other necessary supports.

Strengths, Opportunities, Aspirations, and Results (SOAR) Program

- Dedicated case manager provides benefits advocacy and supports the process of client enrollment in SSI/SSDI.

RDA™ Resource Development Associates

Key Evaluation Questions

	Process Evaluation Questions	Outcome Evaluation Questions
 **System-level**	• What infrastructure is Napa County implementing for its WPC pilot program? • How are Napa's WPC pilot partners collaborating to implement the WPC pilot program?	• What are system-level impacts of Napa's WPC pilot program?
 **Program-level**	• What progress is Napa County making in implementing WPC services as planned?	• What are the financial outcomes of Napa's WPC pilot implementation?
 **Individual-level**	• Who participates in Napa's WPC pilot program and what services do they receive?	• What are the outcomes for people who participate in Napa's WPC pilot program?

Image credits: NeMaria, Phonlaphat Thongsriphong, and Becris from Noun Project

Evaluation Data Sources

Key Informant Interviews	• Interviews with program staff and partners to assess implementation successes and challenges.
Focus Groups	• Focus groups with clients to assess experience of care, perceptions, and facilitators or barriers.
Document Review	• Review of policies, procedures, publications, and shared agreements.
Client Assessments	• Validated client assessment surveys to assess client needs and outcomes
Data Analysis	• Administrative and service records related to client demographics, service utilization, finances, and homeless system entries, exits, and overall counts.

SAN FRANCISCO WHOLE PERSON CARE

UCSF Evaluation

Evaluators:
Dr. Hemal Kanzaria, Associate Professor, Department of Emergency Medicine (Co-PI)
Dr. Maria Raven, Associate Professor and Vice Chair, Department of Emergency Medicine (Co-PI)
Caroline Cawley, Research Associate, Department of Emergency Medicine

UCSF
University of California
San Francisco

Core Questions

How should San Francisco target the most vulnerable, highest risk shared populations?

Is San Francisco improving interagency, longitudinal care coordination?

How should San Francisco evaluate change and measure success?

What methodologies are you using?

- Development of score used to identify High Users of Multiple Systems (HUMS)
- Interdisciplinary process to create care recommendations for high utilizers
- Review of homeless deaths in San Francisco
- Interviews with key stakeholders across the county
- Longitudinal data analysis of predictors of high service utilization, mortality
- Study of the intersection of health utilization with criminal justice involvement
- Creation of long-term metrics/evaluation criteria for WPC-supported services (high intensity mobile case management team, psych respite, health resource center)

What data are you collecting?

- Coordinated Care Management System: integrated data platform that includes medical, mental health, substance use, and housing service encounters, demographics, diagnoses
- Death records from the SF Office of the Chief Medical Examiner
- Emergency Department Information Exchange
- Criminal justice data from the California Policy Lab/SF District Attorney

Questions for other local WPC evaluators

To what degree have other WPC evaluators been involved in any implementation aspects of their county pilots? Are there any non-evaluation projects that you've supported?

How will you handle WPC funding ending in 2020? Will all evaluation projects wrap up on December 31st, or are evaluators securing alternate sources of funding to continue their work in 2021?

Orange County
Whole Person Care Project

August 2019

WPC Key Research Questions

- Is WPC reduce inappropriate or unnecessary Emergency Room visits/inpatient utilization?
- Is the WPC collaborative meeting client's needs in real-time: social, medical and behavioral?
- Does WPC increase readiness for Coordinated Entry process?
- Do WPC clients improve/increase success in finding and sustaining housing placement?
- Is there a return on investment savings from reduced Emergency Room visits?

Whole Person Care Pilot Program Logic Model

Target Audience: Medi-Cal eligible homeless in Orange County that are high utilizers of emergency room health care services

Inputs	Activities	Outcomes	
		Short-Term Outcomes	Long-Term Outcomes -Problem Solution

• Budget $31 M (over the course of the program 2020); applicable for: services, partnerships, and administrative costs
• Staff: 6 +
  • Interns: 2
• Partners: 28~
  • Hospitals, Clinics, Shelter providers, etc.
• Monthly meetings: 6 types with different sets of partners and one that includes all partners
• Experience: 2019 is PY 4 – 2.5 years
• Equipment
• * Transportation to/from meetings
	• Beneficiary is connected to wrap-around upon cue into the program from Hospital, Community Clinic, Shelter Bed; applicable programs and services that include:
	  • Recuperative Care
	  • One-on-one CalOptima personal care coordinator
	  • Coordinated Entry into permanent supportive housing
	  • Linkage to mental health and/or substance use disorder treatment
	  • Community Referral Network
	  • Referrals management
	  • Electronic system is notified and the beneficiary's Care Plan is created following initial enrollment
		• Increase follow-up after hospitalization for mental illness
		• Increase in Primary Care Physician visits
		• Improved management of referrals to services through electronic system
			• Reduction in Emergency Room visits utilization
			• Better managed care (mental and physical health)

External Influences: Continuous funding approval Orange County Board of Supervisors/ Health Care Agency, contracts terminated or fulfilled

WPC Key Research Methodology

- Blend of process and case level outcome measures

- Process Measures including:
  - Focus groups
  - Participant, provider and WPC staff surveys
  - Observations
  - Semi-structured interviews
  - Document review

- Outcome measures including:
  - Aggregate universal metrics
  - Case level participant health and behavioral health data from all PMPM clients, including recuperative care

WPC Data Sources

- WPC Connect Coordinated Care Management System
- Emergency Room Notification System
- Community-Based Organization Referral System
- Recuperative/Medical Respite Care
- Hospital and Clinic-Based Care Navigation/Coordination
- Managed Care Personal Services Coordinator (CalOptima)
- Supportive and Linkage Services by Shelter Bed Providers
- Housing sustainability services, including peer support
- Additional Outreach & Engagement which work with WPC hospitals and clinics
- CalOptima claims and cost data
- Behavioral Health data

Questions for the larger group

- Are sites including the elderly, those with early signs of dementia, those needing assistance with daily living (ADLs), and those re-entering the community after being released from jail?
  - If so, how has your evaluation been modified to capture these participants and their service needs?

- How are you measuring sustainability efforts and successes?

Feedback & Next Steps

Please complete the post-webinar survey!
https://www.surveymonkey.com/r/HKRXY6L

Thank you!