

Together We Care

MHAB

April 16, 2020

WHOLE PERSON CARE

Cruz to Health

Lynn Lauridsen, MPH

Whole Person Care Program Coordinator
Santa Cruz County Health Services Agency

WPC – C2H: Program Overview

- Whole Person Care pilot projects test county-based initiatives across the state to improve care management and health outcomes of Medi-Cal beneficiaries with co-occurring chronic conditions, complex needs, and history of high utilization of multiple systems
- WPC – C2H’s primary services are services that are not billable to Medi-Cal
- Funding:
 - California Department of Health Care Services - Medi-Cal 2020 waiver
 - Mental Health Services Act Innovations grant (INN – IHHS)
 - Other County non-leveraged funding sources (i.e. General Funds)
- Project timeline: July 2017 – December 2020



WPC-C2H: Target Population

Adult Medi-Cal beneficiaries of Health Services Agency clinics with the following risk factors:

A behavioral health*
and/or substance use
diagnosis

&

At least two of the following:

- ≥ 2 chronic health conditions (i.e. diabetes, COPD)
- Prescribed ≥ 5 medications for chronic health conditions
- Homeless or at-risk for homelessness
- ≥ 4 psychiatric hospitalizations within last 12-months
- ≥ 2 medical hospitalizations within last 6-months
- Institutional living or custody within last 12-months

*Includes mild to moderate diagnoses

Referrals not meeting the above criteria may still qualify dependent on the demonstrated need and program capacity.

Whole Person Care – Cruz to Health (WPC-C2H)

Systems Change

Direct Services

Process Improvements
Lean Six Sigma/PDSAs

Data Sharing Infrastructure

Care Coordination

Evidence-Based Interventions

Non Medi-Cal Billable services

Improved data sharing / communication

Care coordination & co-management platform: Together We Care (SCHIO)

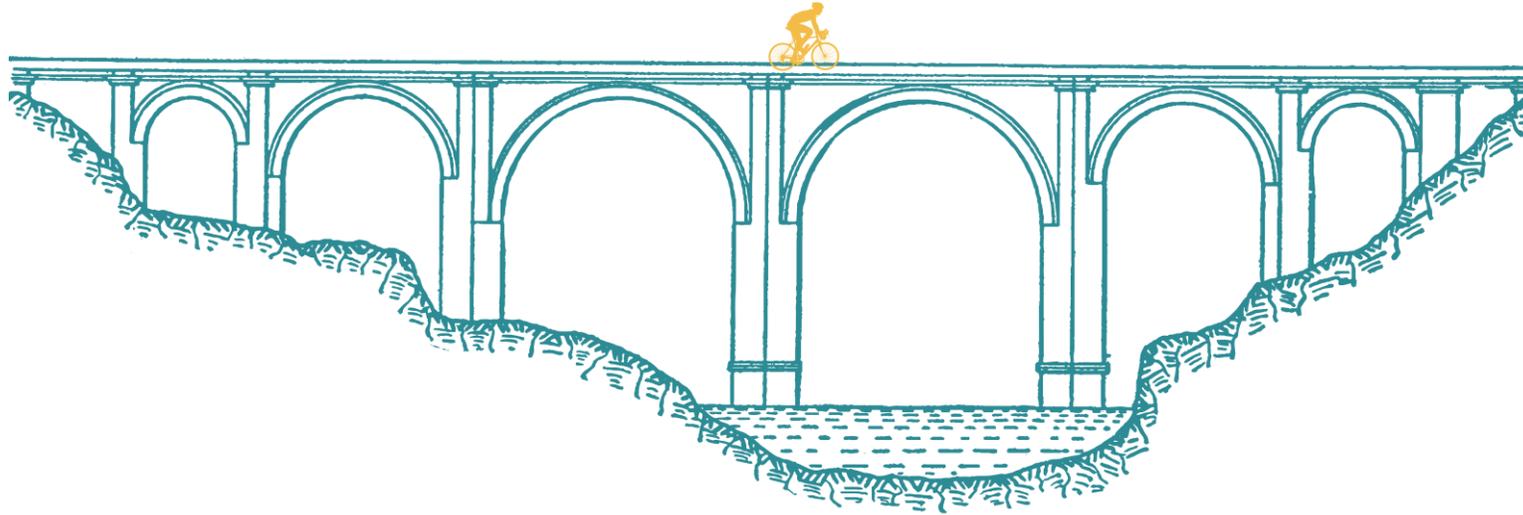
Improved collaborations / Common definitions

Workforce development / Professional networking

Integrated-Illness Management and Recovery (I-IMR); TeleFriend remote monitoring devices

Housing/Tenancy Supports; Housing Navigation; Enhanced behavioral health teams; Peer support

Bridging the Care Coordination Gap



- WPC – C2H as a *community* asset
 - Providing dedicated resources and efforts towards common goals of improved care coordination and data sharing
- DHCS vision of laying groundwork for what comes next in Medi-Cal (CalAIM)



Together We Care Vision Statement

We share a vision of sustaining and building upon existing standardized and secure exchange of health and social service information across organizations to facilitate person-centered, comprehensive care.

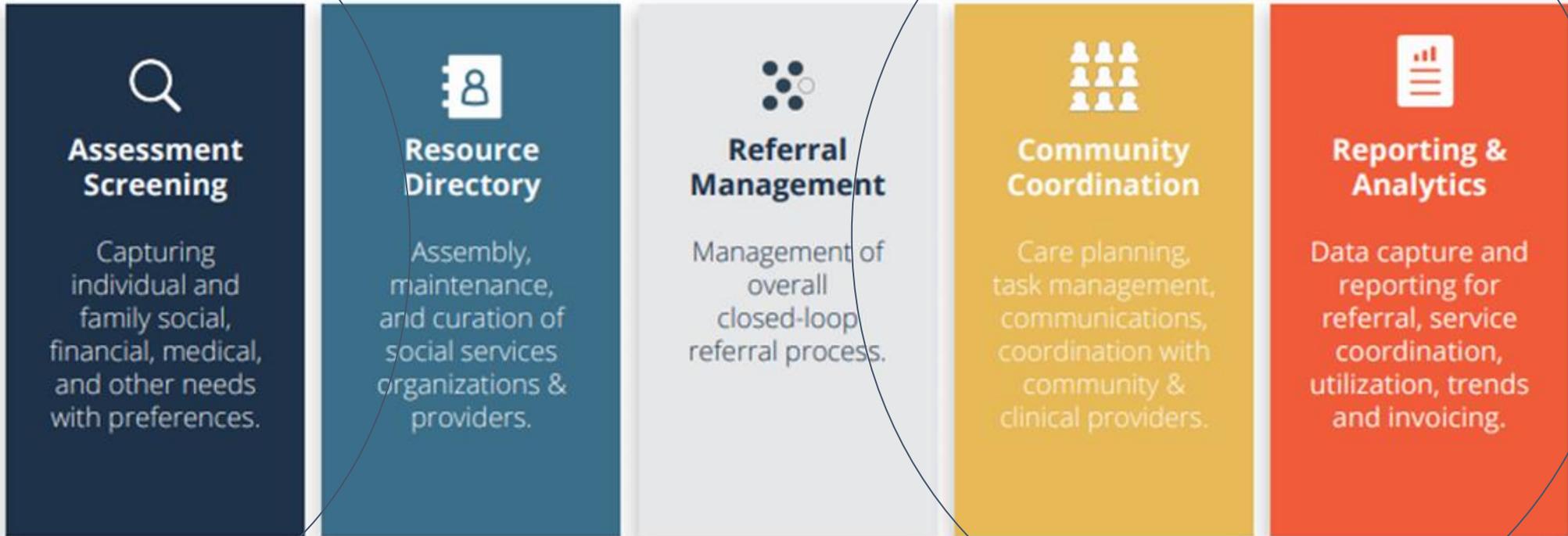
“Together We Care” Platform

- Care Management and Community Resource Referral System
- Seamless communication
- Share patient information
- Coordination of tasks across the care continuum
- Multidisciplinary partners



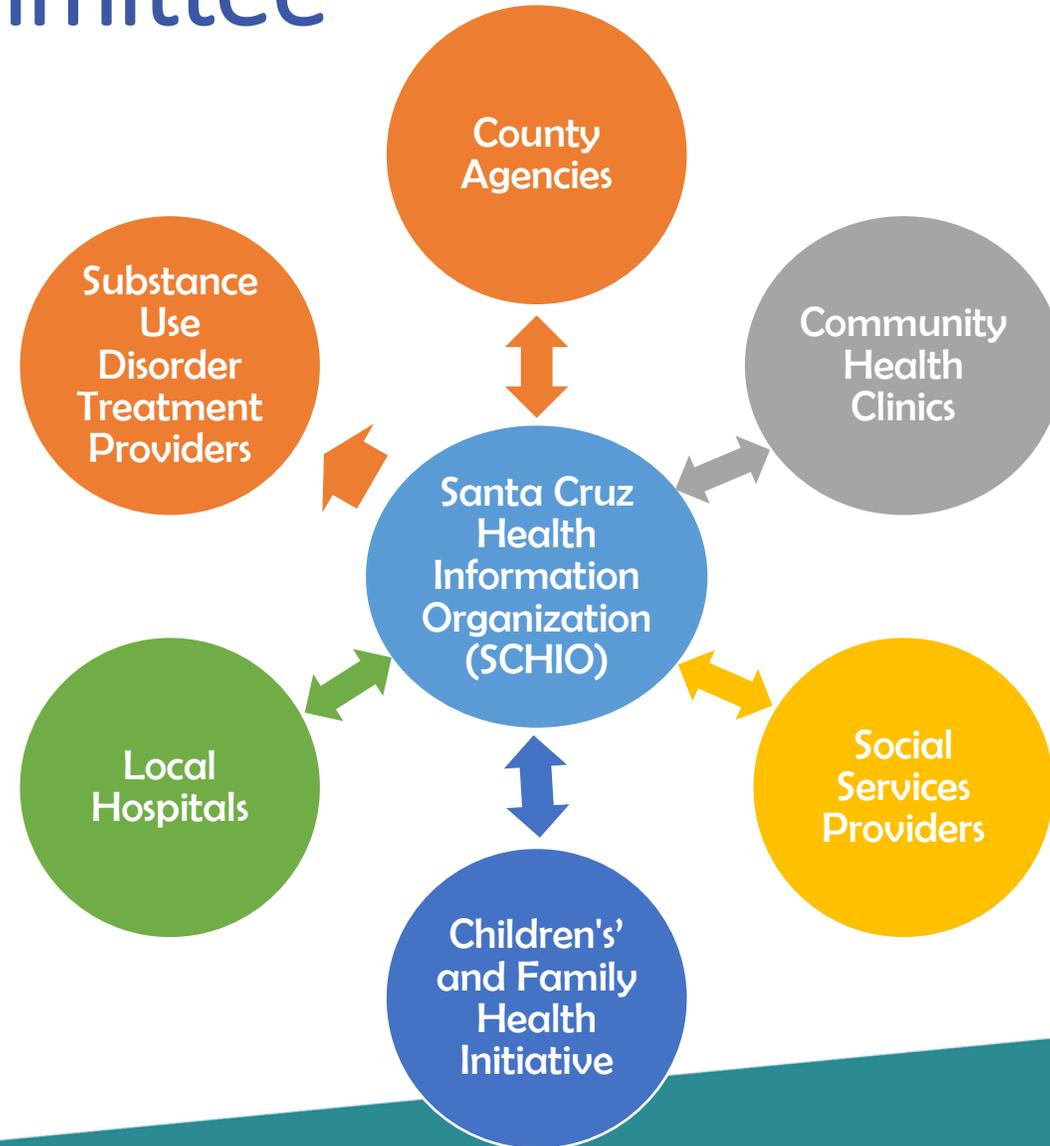
The Era of SDOH Care

Community collaboration is a social determinant of health.
Here's how the top performing communities are adapting.



Confidential and Proprietary. All Rights Reserved

“Together We Care” - Vendor Selection via Review Committee



Early Users

Whole Person Care – Cruz to Health (HSA & community partners)

Moving Health Care Upstream (Salud, WLC, PVPSA, Community Ventures)

SCCHC Complex Care Management (SCCHC and community partners)

Sample of WPC use with Front St, Inc.

Together We Care Santa Cruz HIO

Home Tasks Calendar Patients Projects Consents

 **Front St Test**

Sex: Female | DOB & Age: 26 Mar 1975 (45y) | Cruz to Health Pr... Enrolled

Share Assistant

Summary Plans Contacts Outreach Conversations Consents

- Approvals
- Tasks
- Assessments
- Calendar
- Attachments
- Permissions
- History

+ Add section/goal

Plan Cruz to Health

- Enrollment and Intake** ✓ 16
- Alert and Events** 1
- Referrals**
- Shared Patient Information**
- Medical Goal: Keep all medical appointments**
Goal is **In progress** to be achieved by **15 May 2020**
- Behavioral Health Goal: Get more sleep**
Goal is **In progress** to be achieved by **22 May 2020**
- Housing Goal: [Enter details here]**
Goal is **Not started** to be achieved by **Date not set**
- Social Connectedness Goal: Attend IIMR group**
Goal is **In progress** to be achieved by **22 Apr 2020**

Multiple care providers can document and communicate within the platform.

Front St Test
Sex: Female | DOB & Age: 26 Mar 1975 (45y) | Cruz to Health Pr...: Enrolled

Summary | Plans | Contacts | Outreach | Conversations | Consents

New outreach

Note

Minutes spent...

Activity

- Care Planning
- Referral
- Education
- Goals
- Medications
- Care Coordination

Mode

- Face To Face
- Phone Call
- Text
- Meeting
- Email
- Visit
- Letter

Date of outreach: [] Now | Time of outreach: []

[Save outreach](#)

Outcome

Summary | Plans | Contacts | Outreach | Conversations

Conversations are an easy way to communicate with the patient, family, or other care provi

[Start a new conversat](#)

Lynn Lauridsen · 10 April 2020, 11:25AM PDT
test

[No replies](#) [Reply](#)

Lynn Lauridsen · 10 April 2020, 10:42AM PDT
Sending another private message. 🎉

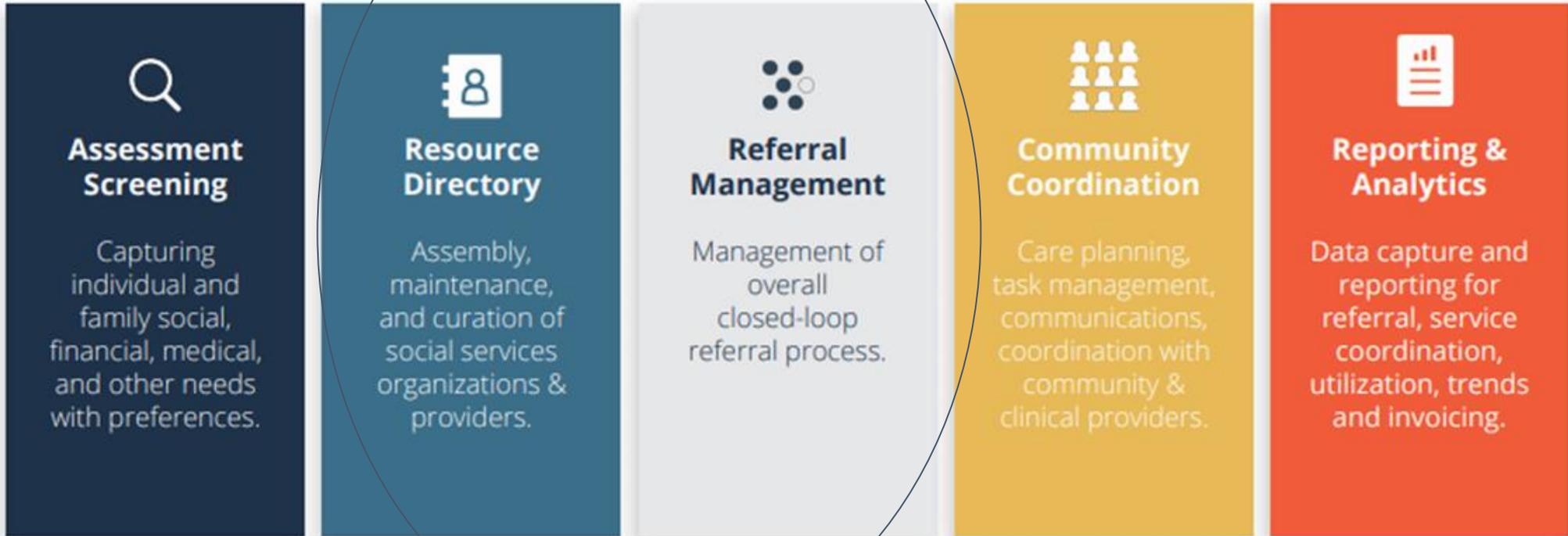
[1 reply](#) [Reply](#)

Lynn Lauridsen · 31 March 2020, 3:50PM PDT
Hi Patrice, This WPC test client needs a Peer Coach. Rowena did an intake assess support organizing his schedule.

[1 reply](#) [Reply](#)

The Era of SDOH Care

Community collaboration is a social determinant of health.
Here's how the top performing communities are adapting.



Confidential and Proprietary. All Rights Reserved