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A Whole Person Care Pilot

Alameda County Care Connect Steering Committee

November 20, 2020

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Welcome

John Jones, Director of Engagement, East Oakland Black Cultural Zone and Just Cities

Nancy Halloran, Deputy Director, AC Care Connect

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Agenda

1. Welcome
2. Consumer Story
3. Director's Report
4. Care Connect Program Year 6 Planning
5. CalAIM Overview
6. Care Connect CalAIM Planning
7. Steering Committee in 2021
8. Adjourn

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Consumer Story

Josh Levine, Safer Ground Program Coordinator, Berkeley Food & Housing Project

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Director's Report

Kathleen Clanon, MD; Director, AC Care Connect

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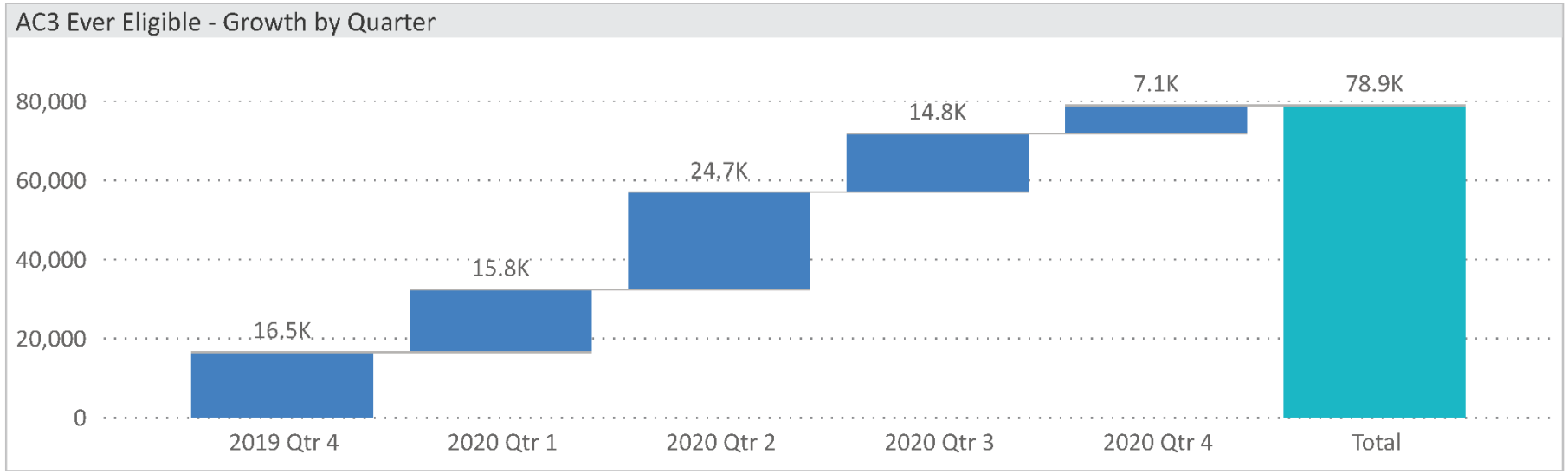
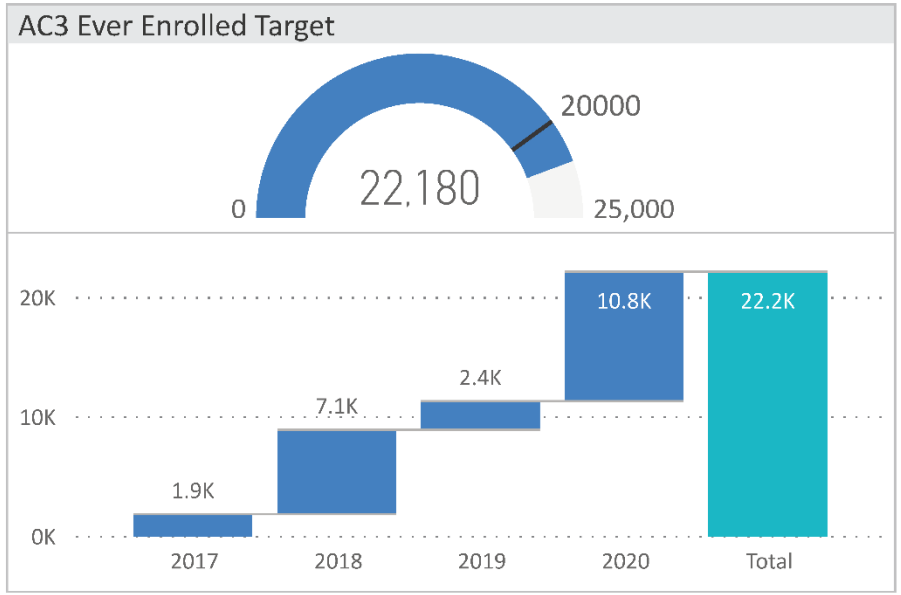
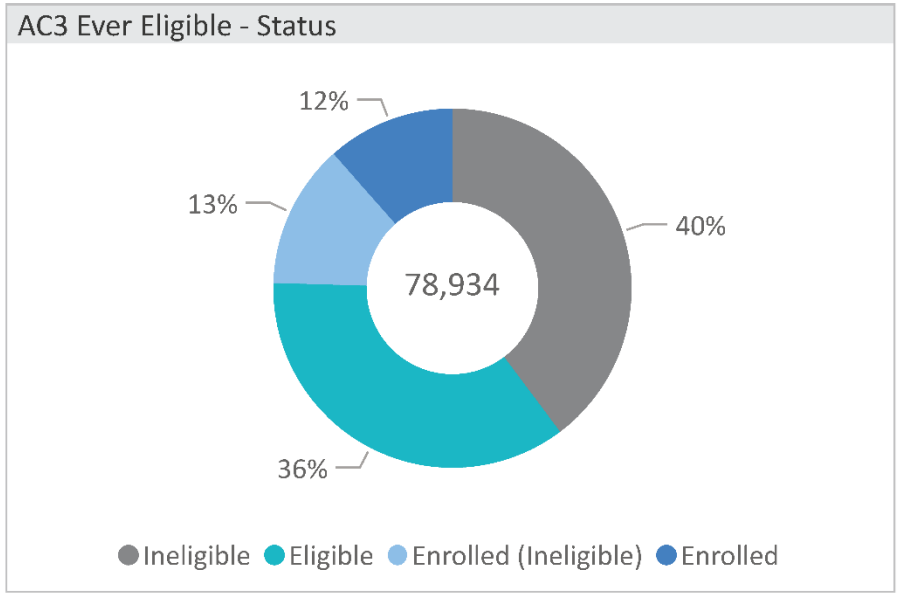
Alameda County Updates

- Measure W is still uncertain.
- COVID-19 Surge
- Whole Person Care Renewal

Care Connect (13 November 2020)

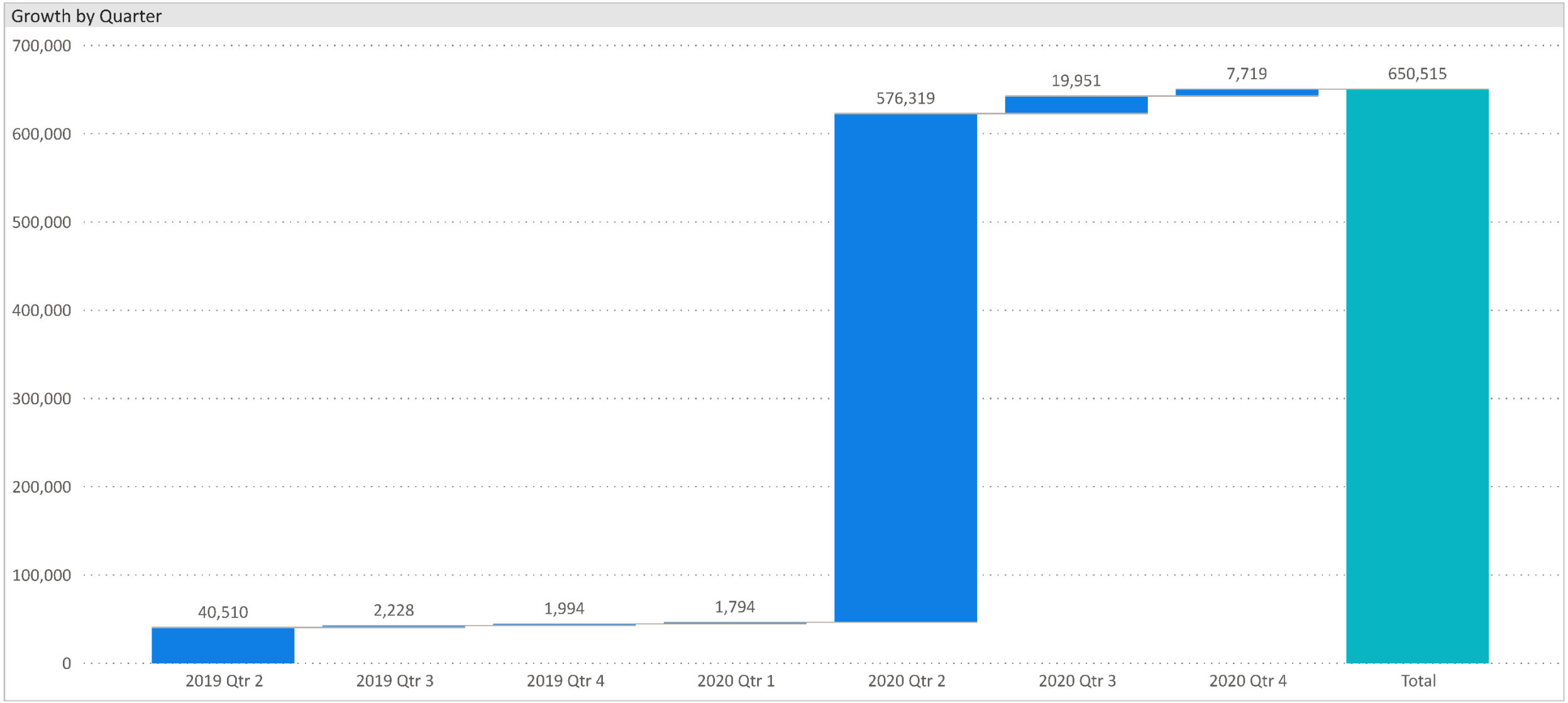






Data source: Social Health Information Exchange and Enrollment & Eligibility database for Ever Enrollees.

Expanded Population (13 November 2020)



Data source: Social Health Information Exchange.

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Program Year 6 (2021) Planning

Nancy Halloran, Deputy Director, AC Care Connect

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Program Year 6 Updates and Timeline

- DHCS is still waiting (but feeling very confident!) about approval from CMS on the 1115 waiver extension.
- In preparation, DHCS asked us to submit a budget proposal for Program Year 6 (2021) by mid-December.
- Budget will likely be a little less than our current budget, but we can rollover unused funds from this year.
- We'll be reaching out to partners to discuss 2021 plans/budget in the next few weeks.

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Original Focus on Critical Changes….

- Care Coordination
- Care Integration
- Housing and Homelessness
- Data Sharing
- Behavioral Health Crisis Response
- Consumer and Family Experience

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…to Care Connect Community Impacts

- Engage partners to create a system of care for people without a home
- Ensure Alameda County's sick and disabled people stay in their homes or return home in a timely manner
- Reduce health outcome disparities among people living with severe mental illness
- Implement early interventions to reduce occurrences of emergency behavioral health crises
- Provide coordinated care through information sharing that is stable, secure, supported, and well-utilized
- Collaboratively create a new culture and infrastructure to ensure cross sector, culturally affirmative integrated care can happen in Alameda County.

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Program Year 6 Planning Principles

- **Invest in**
  - What is successful/making a difference
  - Solidifying, hardwiring change
  - Finding adoptive parents
  - Nothing new (unless it contributes to sustaining existing work)
- **Considerations**
  - Critical Changes→ Care Connect Community Impacts
  - Bandwidth
  - Other funding sources, drivers (of the work), champions
  - Focus on focusing
  - Streamlining and simplifying
- **Draw down all of the money!**

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Program Year 6 Planning Activities

- Review existing deliverables with partners
- Coordinate with CalAIM Planning
- Possible new deliverables/incentives
  - Sustainability incentives for CalAIM planning, preparation, capacity development, etc.
  - Medi-Cal enrollment potential and jail population: CalAIM requires Medi-Cal for reentry population
  - Consumer peer to peer program
  - Increase in respite to help with Project RoomKey / HomeKey

California Advancing and Innovating Medi-Cal (CalAIM) overview

Beau Hennemann, Director, Special Projects, Anthem, Inc.

California Advancing and Innovating Medi-Cal (CalAIM)

- CA is moving away from the existing 1115 Waiver, known as ***Medi-Cal 2020***, to a new 1915(b) Waiver

- New 1915(b) Waiver will include:
  - Medi-Cal Managed Care
  - **Whole Person Care Pilots**
  - Health Home Programs
  - Drug Medi-Cal Delivery System
  - Community-Based Adult Services

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CalAIM Timeline Updates

- CalAIM is definitely happening.
- In Lieu of Services and Enhanced Care Management to begin Jan 2022
- State will send us very soon a template to comment on that they will ask Managed Care Plans to return by June 2021

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CalAIM and Whole Person Care Overlap

- **Population Health Management**: Medi-Cal managed care plans are asked to develop and maintain a patient-centered population health strategy, which is a cohesive plan of action for addressing member needs across the continuum of care based on data driven risk stratification, predictive analytics, and standardized assessment processes.
- **Enhanced Care Management**: A collaborative and interdisciplinary approach to providing intensive and comprehensive care management services to individuals.
- **In Lieu of Services:** Services that can be offered in lieu of other more traditional services under Medi-Cal managed care

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Population Health Management

- Plans must establish a population health management program. Key components include:
  - Incorporation of Population Health Management Assessment
  - More robust and standardized risk assessment tools
  - Modified risk stratification and reassessment processes
  - Solidified provider referral processes
  - Wellness and prevention services
  - Use of robust predictive analysis to manage emerging risks
  - More focus on identifying and assisting with SDOH/LTSS-based needs, including with CHW support
  - Multi-tiered care management approach, including basic, complex and ECM
  - Coordination and use of ILOS
  - Integration of health information technology

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Enhanced Care Management

- Focus on face-to-face intensive care management
- Target populations include:
  - High utilizers with frequent hospital or emergency room visits/admissions;
  - Individuals at risk for institutionalization with SMI, children with Serious Emotional Disturbance or SUD with co-occurring chronic health conditions;
  - Individuals at risk for institutionalization, eligible for long-term care;
  - Nursing facility residents who want to transition to the community;
  - Children or youth with complex physical, behavioral, developmental and oral health needs (i.e. California Children Services, foster care, youth with Clinical High Risk syndrome or first episode of psychosis);
  - Individuals experiencing chronic homelessness or at risk of becoming homeless; and
  - Individuals transitioning from incarceration.

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In-Lieu-Of Services

- Optional benefits Implemented in HHP/WPC counties Jan 2022 and Statewide by July 2022
- HHP/WPC enrollees grandfathered in
- Flexible wrap-around supports that are traditionally not funded by plans
- Builds off of/expands on Whole Person Care Services and SDOH efforts
- Requires the build out of a new type of network and operational procedures
- Goal is to build capacity to fully integrate into LTSS in 2026

ILOS

- SNF Transition Services
  - RCFE, ARF, Board and Care
  - Transition CM services
- Housing Navigation
- Housing Deposits
- Housing Tenancy and Sustaining Services
- Short Term Post Hospitalization Housing
- Recuperative Care
- Day Habilitation Programs
- Non-IHSS Personal Care/Homemaker Services
- Home Modifications
- Meals/Medically Tailored Meals
- Sobering Centers
- Respite (for caregivers)

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Care Connect CalAIM Planning

Jennifer Martinez, Program Development Director, AC Care Connect

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Sustainability Readiness Deliverable: Overview

- Four independent sub-deliverables total $1M in incentives
  - System Readiness
  - Information System Readiness
  - Operational Readiness
  - Provider and Consumer Readiness
- Will need partnership to accomplish many of these triggers

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What we're working on in 2020: System Readiness

	STATUS	TRIGGER	STAKEHOLDERS
	☑	Convene Safety Net planning meetings (monthly)	Executive leadership from all 4 public healthcare systems
PROCESS	☐	Convene cross-sector/multi-level Planning Forums (2)	•Executives •Program managers •Front-line workers
PROCESS	☐	Convene re-entry care transition planning group	•ACCC •SSA •ACBH •Sheriff •CHCN •Probation •MCPs
PRODUCTS	☑	Conduct financial, risk, & org capacity analysis	•ACCC •MCPs

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What we're working on in 2020 -> 2021: Information System Readiness

	STATUS	TRIGGER	STAKEHOLDERS
PROCESS	☑	Develop data governance	• ACCC • DEU • MCPs • Others
	☐	Adapt data systems to report encounters & other key elements	• ACCC • MCPs • DEU • Providers
	☐	Create implementation plan for high-priority providers	• ACCC • MCPs • Providers
	☑	Develop capacity for population health & SDOH	• ACCC • DEU • MCPs
PRODUCTS	☐	Adapt data sharing agreements	• ACCC • ACBH • MCPs • CHCN • AHS
	☐	Create housing service claims app that pulls from HMIS	• ACCC • DEU • MCPs
	☑	Train providers on IT systems to support new services	• ACCC • DEU • Providers

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Work to come in 2021: Operational Readiness

	STATUS	TRIGGER	STAKEHOLDERS
PROCESS	☑	Convene beneficiary transition planning teams	• ACCC • MCPs
PROCESS	☐	Create plan for transitioning MH & Housing services	• ACCC • ACBH • MCPs • Possible input from CHCN and AHS
PROCESS	☐	Collaborate on design for financing, billing, & staffing	
PROCESS	☐	Develop options for coordinated care model	
PROCESS	☐	Create plan to leverage existing provider networks	
PRODUCTS	☐	Agree on transition and service SOW & contract terms	• ACCC • ACBH • MCPs

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Work to come in 2021: Provider and Consumer Readiness

	STATUS	TRIGGER	STAKEHOLDERS
PROCESS	☐	Hold input & training sessions for current & new providers	• FSP & MH • SUD • CBCMEs • Housing Navigation
PROCESS	☐	Hold consumer input focus groups (2)	• Consumers and/or advocates
PRODUCTS	☐	Develop training materials for consumers & providers	• ACCC • ACBH • MCPs
PRODUCTS	☐	Develop shared reporting metrics	• ACCC • ACBH • MCPs • Providers
PRODUCTS	☐	Develop & implement beneficiary outreach	• ACCC • ACBH • MCPs

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Steering Committee in 2021

Scott Coffin, CEO, Alameda Alliance for Health

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Breakout Group Discussion: What is your vision for the Steering Committee in 2021?

- Given the presentation on CalAIM, what can a Steering Committee contribute to progress in 2021?
- What has been most valuable about the Steering Committee and your experience with this group?
- Where has the Steering Committee been most effective? *(Ex. Keeping members abreast of developments to support system transformation, considering opportunities for collaboration and system change, identifying strategies and participants for strategic and implementation planning, etc.)*
- Should the composition change in this next phase of implementation?
  - Is the group the right size?
  - Should the configuration remain the same?
  - Are there others who should be at the table?

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Breakout Group Logistics

- Groups will be given 15 minutes to discuss.
- Groups should self facilitate.
- Groups should assign someone to take notes.
- Steering Committee groups will be asked to share summary thoughts afterward in the chat.

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Breakout Group Debrief

- Was your group in agreement? Or did you have very different viewpoints?
- What are your recommendations/feedback? (one person in each group report in the chat)
  - Given the presentation on CalAIM, what can a Steering Committee contribute to progress in 2021?
  - What has been most valuable about the Steering Committee and your experience with this group?
  - Where has the Steering Committee been most effective?
  - Should the composition change in this next phase of implementation?

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Next Steps

- Care Connect will report back in December on what our plan is for 2021 Steering Committee
- December Steering Committee will be focused on
  - Celebration of our progress
  - Reflection
  - Looking forward to 2021

Adjourn

Next Meeting: December 18, 2020

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For more information visit www.accareconnect.org