Quality and Productivity Commission

34th Annual Productivity and Quality Awards Program

"Leading with Excellence"

2021 APPLICATION

Title of Project (Limited to 50 characters, including spaces, using Arial 12-point font):

NAME OF PROJECT: LAC HEALTH HOMES PROGRAM: A TEAM-BASED INITIATIVE

DATE OF IMPLEMENTATION/ADOPTION: MAY 1, 2020

(Must have been **fully** implemented **for a minimum of** at least one year - on or before July 1, 2020)

☐ **CHECK HERE IF THIS PROJECT IS BEING SUBMITTED FOR THE *COVID-19 IMPACT AWARD* ONLY**. (Projects must be implemented on or before December 31, 2020. **Note**: Projects implemented less than one year ago will not be eligible for any other PQA awards. In addition, once a project is submitted, you cannot submit the same project for awards consideration in subsequent years).

PROJECT STATUS: X Ongoing _____ One-time only

HAS YOUR DEPARTMENT PREVIOUSLY SUBMITTED THIS PROJECT? _____ Yes X No

EXECUTIVE SUMMARY: Describe the project in 15 lines or less using Arial 12 point font. State clearly and concisely what difference the project has made.

The literature has shown that lack of access to care, inadequate care coordination, and underutilization of preventative services has led to poor outcomes. To address this, CMS launched Health Homes Program (HHP) in 2019 to offer eligible Medi-CAL members additional services that included comprehensive care management, care coordination, health promotion, transitional care, individual and family support, and referral to the community. This program not only positively impacts patient outcomes, it also benefits DHS as the system earns about $1,000 per patient enrollment. LAC+USC Medical Center was tasked to operationalize this program by enrolling eligible patients and managing their care. After several months of initial launch in 2019, on May 2020, the facility only managed to enroll 75 patients. Through thorough review of the challenges, successive PDSA iterations, and engaging the team to problem solve, LAC reached a milestone of enrolling over 500 patients on May 2021 (a year later), leading the system in total enrollments. The LAC Care Management and BHI team has not only impacted patients lives, they have also designed a strong, team-based framework that can continue to support whole person care.

BENEFITS TO THE COUNTY

(1) ACTUAL/ESTIMATED **ANNUAL** COST AVOIDANCE	(2) ACTUAL/ESTIMATED **ANNUAL** COST SAVINGS	(3) ACTUAL/ESTIMATED **ANNUAL** REVENUE	(1) + (2) + (3) = TOTAL **ANNUAL** ACTUAL/ESTIMATED BENEFIT	SERVICE ENHANCEMENT PROJECT
$ 0	**$0**	**$ 500,000**	**$ 500,00**	☐

ANNUAL = 12 MONTHS ONLY

SUBMITTING DEPARTMENT NAME AND COMPLETE ADDRESS LAC+USC Medical Center (Department of Health Services) Hospital Administration; Inpatient Tower, Room C2K113; Los Angeles Ca 90033	**TELEPHONE NUMBER** 3234096861
PROGRAM MANAGER'S NAME Faye Christen, DNP,MSN,CCRN-K; Teresa E. Ejanda-Sano, MSW,LCSW; Manuel Campa, MD **EMAIL:FCHRISTEN@DHS.LACOUNTY.GOV**	**TELEPHONE NUMBER** 3234096861
PRODUCTIVITY MANAGER'S NAME AND SIGNATURE **DATE** (PLEASE CALL (213)893-0322 YOU DO NOT KNOW YOUR PRODUCTIVITY MANAGER'S NAME) Laura Sarff *Signature on file*	**TELEPHONE NUMBER** **EMAIL**
DEPARTMENT HEAD'S NAME AND SIGNATURE **DATE** Christina R. Ghaly, M.D. *Signature on File*	**TELEPHONE NUMBER**

****ELECTRONIC, WET, OR SCANNED SIGNATURES ARE ACCEPTABLE****

We Support Plain Language

Title of Project (Limited to 50 characters, including spaces, using Arial 12-point font):
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1st FACT SHEET – LIMITED UP TO 3 PAGES ONLY: Describe the **challenge(s), solution(s), and benefit(s)** of the project **to the County**. What quality and/or productivity-related outcome(s) has the project achieved? Provide measures of success **and specify assessment time frame**. Use Arial 12 point font.

Process Improvement Award: Recognizes significant business process improvement or workflow enhancement.

Challenges

- Operationalizing/optimizing a new program: Putting a new program into practice requires process development, role definition, and leadership support.
- Mission Alignment: For a system made up of multiple enterprises, there is an objective to stay united with processes and goals.
- Access to Care: The most vulnerable patients with chronic conditions and challenges with social determinants of health are also the hardest to reach, and thus lack access to care. Therefore, engagement is essential.
- Multi-Disciplinary Communication/ Coordination: Meeting patients needs and providing service require adequate communication and coordination.
- Patient Experience/Support: with many contributing factors like social determinants of health and access, it is important to provide partnership and support for a patient and their unique needs.
- Technology: optimizing the use of the software and hardware requires the provision of patent equipment and support for technological challenges.
- Pandemic: It is important to adapt to the restrictions of the pandemic and continue to engage patients who can benefit from this service.

Solutions

- Using guidance from DHS, LAC created team-based workflows that detailed the pathway to engaging patients. The leadership team continuously improved the workflow via data evaluation and feedback from teams.
- Weekly leadership meetings were critical to quality improvement and for data sharing. This enhanced communication between team which includes the RN Care Managers, the Behavioral Health Team, and providers. This was also a vital platform for positive reinforcement as well as to address concerns.
- The team-based model was at the core of the success of this program. RN Care Managers and the BHI team worked closely together to engage, enroll, and manage patients as a part of daily operations. Moreover, case-conferencing was established to discuss and intervene on situations that required a multi-disciplinary lens involving RNs, BHI Team, and providers on a periodic basis.
- Continuous process evaluation and advancement occurred using PDSA cycles that were informed by key stakeholders. Effort included the use of motivational interviewing, SMART goals, protected time for Care Managers, and utilizing shared-work space to promote idea sharing and problem solving.

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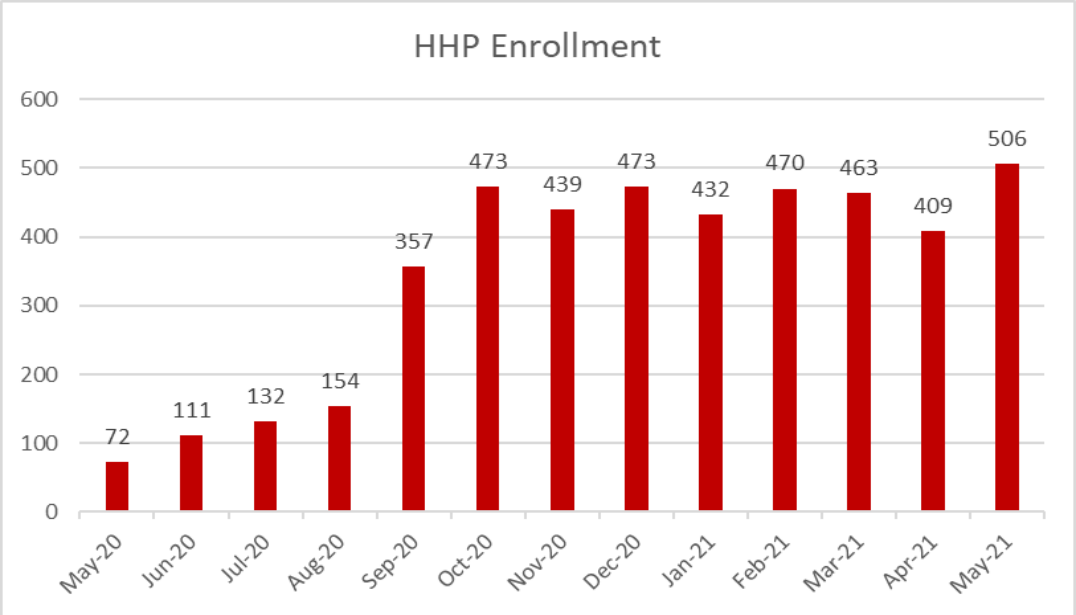
- The group designed innovative outreach strategies such as the "phone-a-ton" where a multi-disciplinary team worked together in the same space to share best practices.
- All connections with patients (via phone or face to face) created extra healthcare access where healthcare concerns were discussed, preventative services offered, and social determinants of health addressed.
- This experience enhanced both patient and staff satisfaction. Patients had a better experience navigating through the healthcare system while staff felt gratification to help.

Impact

- A year after LAC-relaunch on May 2021 and process improvement initiative, LAC has enrolled more than 500 patients, which is a DHS best. This is more than a 500% growth despite staffing redeployment during the pandemic.
- Innovative outreach strategies led more than 150 patients enrolled in one week.
- DHS has earned more than $500,000 with LAC enrollment alone.
- The qualitative gain of engaging patients, providing preventative services and addressing social determinants of health is immeasurable for each patient enrolled.
- Developed a strong data-driven, team-based, and patient-centered framework that is sustainable and replicable.



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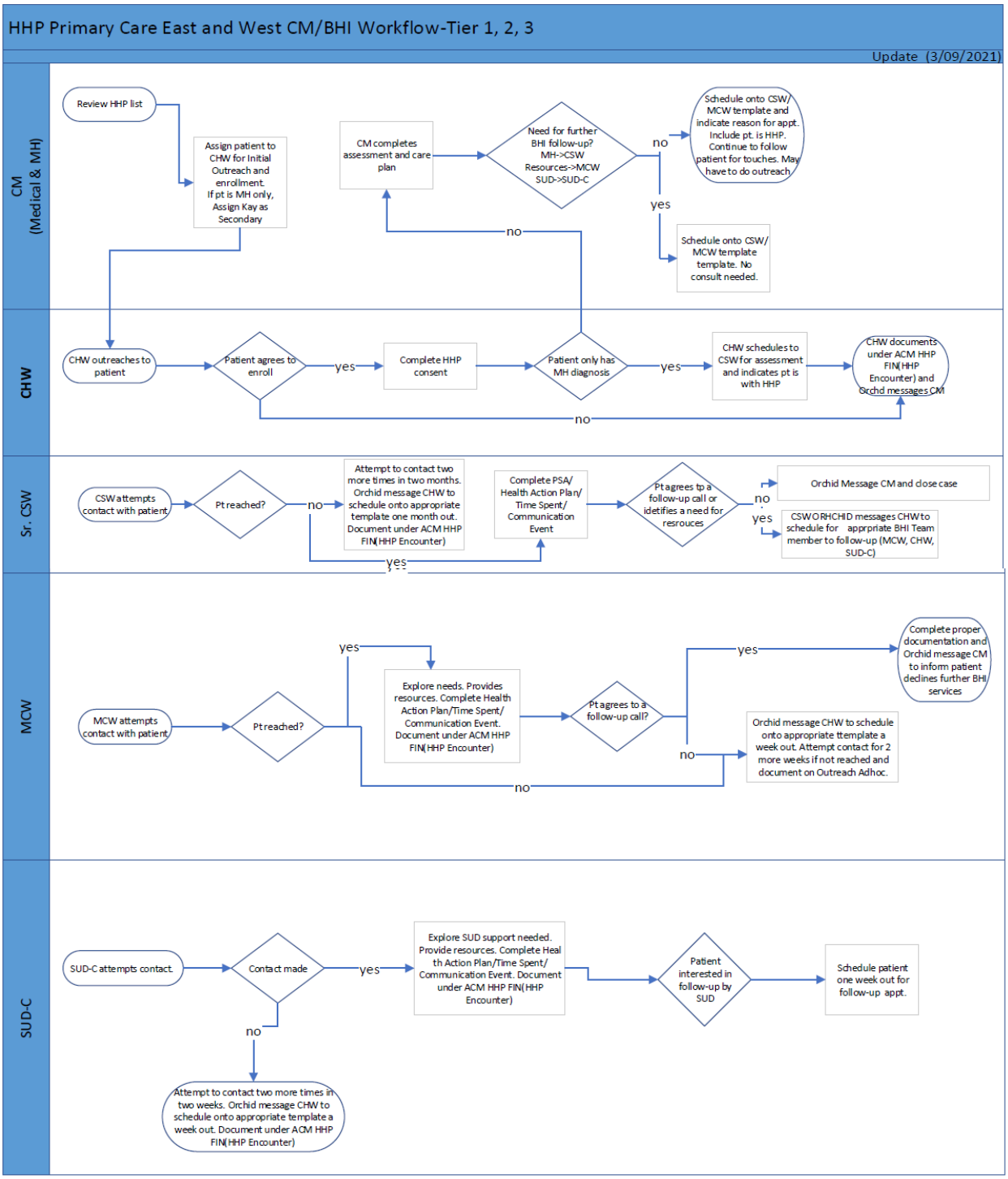

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Linkage to the County Strategic Plan – 1 page only. Which County Strategic Plan goal(s) does this project address? Explain how. Use Arial 12-point font.

I.2.1 Provide Subsidized Housing for Vulnerable Populations:
Primary Care has several resources that support those who are unhoused. 1) Health Homes Program (HHP)is a Medicaid benefit that provides team-based care and complex care coordination for high-risk patients with complex health needs. It is a collaboration between nurse Care Managers and the Behavioral Health Integration (BHI) staff to ensure the patients are linked to services and over all needs are met. 2)Housing for Health-LAC+USC Medical Case Workers and Community Health Workers refer patients who are housing insecure to LA County DHS Housing for Health division (HFH). They provide housing and services to people with complex medical and behavioral health conditions. 3)The Homeless Patient Intake assists medical staff in identifying patients who are homeless and housing insecure upon arrival to the hospital or emergency department. This ensures that patients with housing needs are provided an appropriate discharge plan that includes resources for social needs.

I.2.2 Streamline Access to Integrated Health Services:
Primary Care uses ELM Analytics to capture patients medical and mental health needs in order the provide integrated and collaborative care to patients. Once enrolled, patients are assigned to Care Managers who partner with the BHI Team to provide multidisciplinary support addressing both medical and psychosocial needs.

I.2.3 Integrate Substance Use Disorder (SUD) Treatment Services
The Adult outpatient clinics have a designated Substance Use Disorder Counselor (SUD-C) who provides support and linkage to resources that support harm reduction and abstinence. Addiction Treatment Starts Here (ATSH) opens access to medication for addiction treatment in primary care for patients with opioid use disorder. The SUD-C and the Licensed Clinical Social Worker assess patients needs, provides support, and links patients to services

III.2.2 Leverage Technology to Increase Visibility of and Access to Services
Using ELM and ELM analytics, the program uses an algorithm to identify and stratify patients to enable outreach efforts and engage patients. Patients were then offered services for their clinical conditions along with wellness and preventative services.

III.3.3 Measure Impact and Effectiveness of our Collective Efforts
The team-based, collaborative approach was central to the success of this program. Coordination of care was optimal form this approach.

III.3.6 Implement a Workplace of the Future
This effort epitomizes whole person care and patient's needs including social determinants of health through a team-based approach.

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COST AVOIDANCE, COST SAVINGS, AND REVENUE GENERATED (ESTIMATED BENEFITS TO THE COUNTY): If you are claiming cost benefits, include a calculation on this page. Please indicate whether these benefits apply in total or on a per unit basis, e.g., per capita, per transaction, per case, etc. You must include an explanation of the County cost savings, cost avoidance or new revenue that matches the numbers in the box. Remember to keep your supporting documentation. Use Arial 12-point font

Cost Avoidance: Costs that are eliminated or not incurred as a result of program outcomes. Please indicate whether these are costs to the County or to other entities.

Cost Savings: A reduction or lessening of expenditures as a result of program outcomes. Please indicate whether these were expenditures by the County or by other entities.

Revenue: Increases in existing revenue streams or new revenue sources to the County as a result of program outcomes.

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New Revenue:

The HHP program not only earns the system based on the standard capitated care management fees, each patient enrollment that meets HHP criteria, earns the system an additional $1,000 revenue. Based on the 506 enrollments in the month of May (506x$1000), the LAC team earned DHS approximately $506,000.