The Role of Public Health in a Countywide Integrated Services Delivery Program

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County Health Executives Association of California Annual Meeting
October 4th, 2023
Long Beach, California

RivCoONE
Coordinating Services. Connecting People.

Roadmap

- Context and Overview – Michelle DeArmond
- Holistic Health Assessment – Geoffrey Leung
- Service Navigation, Family Resource Centers, and Community Health Workers – Danielle Huntsman
- Administrative Structure, Data Sharing, and Lean Process – Jennifer Claar
- Key Takeaways
- Questions

Context and Overview

Riverside County

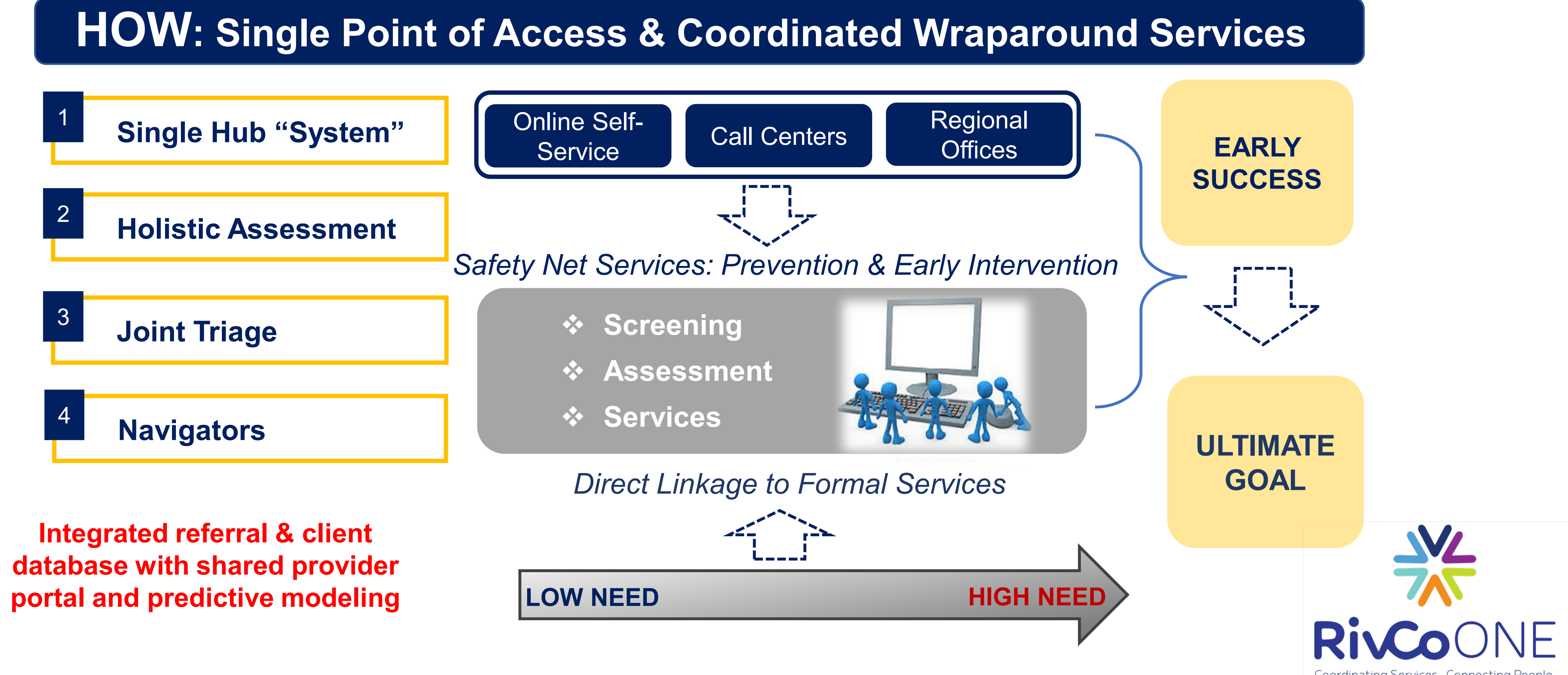
- 2.5 million residents
- 7,200 square miles
- 4th largest county in California by area and population
- 10th most populous county in U.S.
- 2nd fastest growing County in U.S. (of 3k counties)
- HPI 39.3

Current State: Fragmented County Services

- > 40 county departments
- > 40 approaches
- County resident may be sent to multiple different departments at different locations for different services
- *→ can we alter our paradigm from program-centered service to person-centered service?*

WHY? Reasons for Action

- Many residents are not getting needed services and supports at the optimal time and place for achieving positive outcomes
- When residents receive services, we address the presenting need, but often misses the chance to assess other needs and opportunities.
- Residents with complex challenges receive services and supports in a fragmented manner.



Board of Supervisors Resolution 2021-189

Develop an Integrated and Comprehensive County Health and Human Services System and a Coordinated Care Model County *(December 12, 2021)*

Goals of Integrated Services Delivery

- ❑ Strengthen prevention and early intervention services
- ❑ Improve service experience for Riverside County residents who have complex needs

Selecting an Initial Pilot Site

- Local Community Health Center
- Trusted Location
- High Volume of Potential Clients

Recruiting Initial Partners:

Integrated Services Delivery

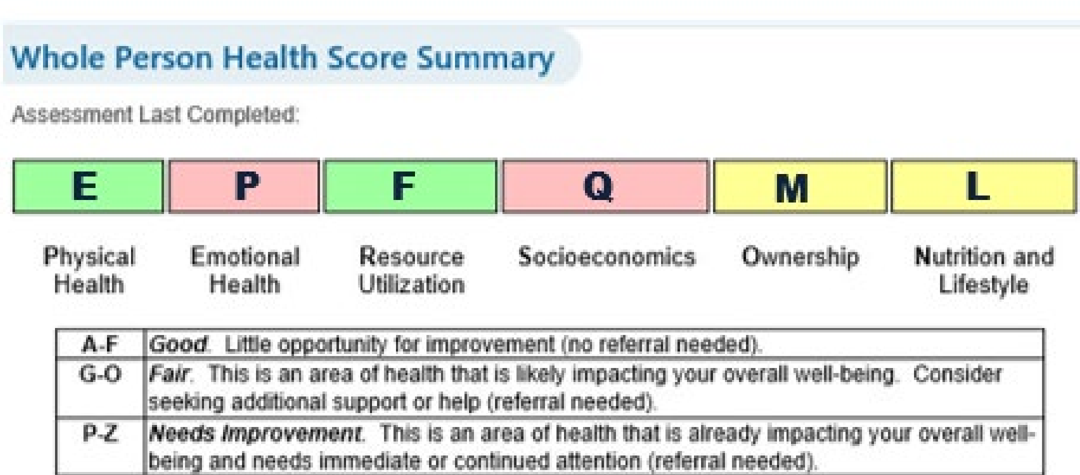
Office of County Counsel

Future State: Integrated Service Delivery

Holistic Health Assessment

Whole Person Health Score Overview

- **6-letter score** that provides a **snapshot of health** (each letter representing a different dimension):
  - **P**hysical Health
  - **E**motional Health
  - **R**esource Utilization
  - **S**ocioeconomics
  - **O**wnership & Activation
  - **N**utrition & Lifestyle
- **Letters range from A to Z** for each dimension ("A" being the best and "Z" being the worst)
- Based on a **28-question assessment**
- **Client preference for letters** over numbers



Whole Person Health Score Summary

Assessment Last Completed:

E	P	F	Q	M	L
Physical Health	Emotional Health	Resource Utilization	Socioeconomics	Ownership	Nutrition and Lifestyle

A-F	*Good.* Little opportunity for improvement (no referral needed).
G-O	*Fair.* This is an area of health that is likely impacting your overall well-being. Consider seeking additional support or help (referral needed).
P-Z	*Needs Improvement.* This is an area of health that is already impacting your overall well-being and needs immediate or continued attention (referral needed).

52 year old gentleman with uncontrolled diabetes

Whole Person Health Score Elements

- Blue font – more fluid
- Purple font – somewhat fluid
- Black font – more static

Whole Person Health Score: Elements

Physical
- Blood Pressure
- Body Mass Index
- Chronic Condition Load
- Functional Activity

Emotional
- Depression
- Anxiety
- Social Support
- Prayer / Meditation / Relaxation
- Meaning / Purpose

Resource Utilization
- Emergency Room / Hospital Visits
- Outpatient Visits
- Prescription Medications
- (Zip Code)

Blue font – more fluid
Purple font – somewhat fluid
Black font – more static

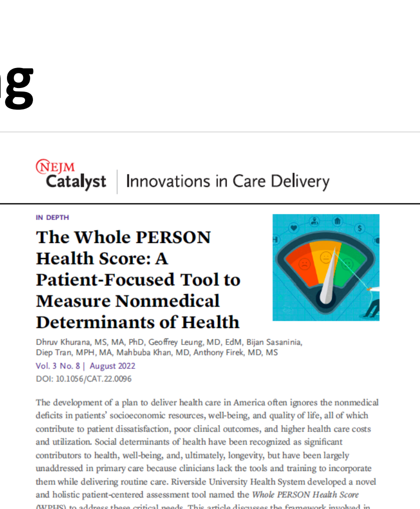
Socioeconomics
- Finances
- Housing
- Education, Employment
- Food Access, Transportation

Ownership and Activation
- Self-Rating
- Knowledge
- Self-Efficacy
- Self-Management

Nutrition and Lifestyle
- Diet, Physical Activity
- Sleep
- Smoking
- Alcohol, Substance Use

Whole Person Health Score Construct

- Based on a **28-question assessment**
- Each question represents an element that is associated with **longevity**
- Answers to each question have a different **weighting** and are converted into a final **6-letter score**
- **Client-centered design**
- **Iterative design process**
- Designed for **self-administration**
- Available in **English and Spanish**
- **Validated** instrument
- Allows for more **strategic intervention**
- Unlike other SDOH tools, designed to **track change over time** and **measure impact of interventions**
- Can serve as a **universal metric**
- Can be used at an **individual** or **population** level



NEJM Catalyst | Innovations in Care Delivery

IN DEPTH

The Whole PERSON Health Score: A Patient-Focused Tool to Measure Nonmedical Determinants of Health

Dhruv Khurana, MS, MA, PhD, Geoffrey Leung, MD, EdM, Bijan Sasaninia, Diep Tran, MPH, MA, Mahbuba Khan, MD, Anthony Firek, MD, MS

Vol. 3 No. 8 | August 2022

DOI: 10.1056/CAT.22.0096

The development of a plan to deliver health care in America often ignores the nonmedical deficits in patients' socioeconomic resources, well-being, and quality of life, all of which contribute to patient dissatisfaction, poor clinical outcomes, and higher health care costs and utilization. Social determinants of health have been recognized as significant contributors to health, well-being, and, ultimately, longevity, but have been largely unaddressed in primary care because clinicians lack the tools and training to incorporate them while delivering routine care. Riverside University Health System developed a novel and holistic patient-centered assessment tool named the *Whole PERSON Health Score* (WPHS) to address these critical needs. This article discusses the framework involved in developing, implementing, and evaluating the WPHS in a multidisciplinary, primary care, safety-net setting. The assessment tool consists of 28 questions (or elements) across six domains of health (one for each letter in the PERSON score [Physical Health, Emotional Health, Resource Utilization, Socioeconomics, Ownership, and Nutrition and Lifestyle]) that were chosen on the basis of a literature review of factors that affect lifespan, mortality, and longevity. The patient receives a letter grade ranging from A (the best) to Z (the worst) in each domain. The A–Z letter assignment is not based on a normalized calculation. Rather, letter assignment is based on anticipated impact on life expectancy. The grades are classified into three colors — red, yellow, and green — on the basis of the severity of the

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NEJM Catalyst, August 2022

SCIENCE-IN-BRIEF
November 2022

TURNING SCIENCE INTO ACTION

The Whole PERSON Health Score: A Patient-Focused Tool to Measure Nonmedical Determinants of Health

The following is a synopsis of "The Whole PERSON Health Score: A Patient-Focused Tool to Measure Nonmedical Determinants of Health" published in August 2022 in the *New England Journal of Medicine (NEJM) Catalyst*.

What is already known on this topic?

Social Determinants of Health (SDOH), which include health behaviors, socioeconomic factors, and the physical environment, contribute to about 80% of clinical outcomes in a community.[1,2] Yet, primary clinical care often overlooks SDOHs, thereby ignoring underlying nonmedical needs of patients and upstream factors that may impact a patient's overall well-being and quality of life. In acknowledging the importance of addressing SDOHs, the Centers for Medicare & Medicaid Services (CMS) issued guidance in 2021 to encourage state health officials to include strategies that address SDOH in Medicaid and the Children's Health Insurance Program to improve health outcomes cost-effectively.[3] Addressing SDOHs within a primary and clinical care environment may uncover nonmedical needs and improve patient engagement, patient satisfaction, adherence to treatment schedules and medication, and reduce health care costs and overuse.[4-8] Nonetheless, programs that address SDOHs are lacking, with reimbursement and identification and measurement of SDOHs cited as the primary causes for the limited number of programs.[9]

What is added by this article?

While existing survey tools to identify and address SDOH factors may identify nonmedical needs, they assume that SDOHs remain static.[10-14] Health care personnel cannot use many of these tools to track changes in SDOHs, limiting patient understanding of their own SDOH status and missing an opportunity to adopt holistic health care models. The Whole PERSON Health Score (WPHS) displays survey results through a color-coded visualization to nudge health care teams and personnel to engage patients in their own care. The simple visualization allows health care personnel to identify gaps in their holistic care, highlight which SDOH domains require attention, and prompts referrals to nonmedical resources to address the respective gaps. Additionally, the WPHS simplifies tracking of SDOHs over time, assesses the impact of staff- or patient-initiated interventions, and supports care-coordination.

The WPHS is a novel approach to measure SDOHs using a 28-question assessment to quantify a person's health in six domains: Physical Health, Emotional Health, Resource Utilization, Socioeconomics, Ownership, and Nutrition and Lifestyle (PERSON). The assessment measures patient needs based on the 6 domains of SDOH and results are color-coded into Green, Yellow, or Red to provide a visual signal of the level of need associated with the domains and is intended to prompt physicians to initiate discussions with patients and make appropriate referrals. This color system was paired with a 26-letter rating system where A–F is green and indicates low need; G–O is yellow and indicates moderate need; and P–Z is red and indicates high need, a trigger that the domain is impacting the patient's health and requires immediate attention.

CDC Science-in-Brief, November 2022

Integrated Services Delivery Pilot

Examples of Referrals and Resources Provided to 1300+ Pilot Clients

- **Medi-Cal application**
- Behavioral Health referral
- Breastfeeding Program referral
- **Cal Fresh application**
- Dental referral
- **Food Bank resources**
- **Housing Support**
- Job Fair resources
- Legal Aid referral
- Nutrition referral
- **Office on Aging referral**
- Transitional Housing referral
- **Transportation resources**
- **Utility Assistance**

Pilot Site: 2023 Client Experience

Patient Satisfaction Scores at Jurupa Valley Community Health Center (2023 - post ISD implementation)

Whole Person Health Score Completed? N Y

Max: 4
Average: 3.3

Patient Satisfaction Domain	N	Y
Respect for what patient said	3.2	3.8
Provider listened	3.2	3.7
Trust provider	3.2	3.9
Seen in timely manner	3.1	3.5
Got enough info re: treatment	3.1	3.6
Staff courtesy/resp...	3.1	3.9
Knew medical history	2.9	3.2
Knew what to do if questions	2.8	3.5
Discussed illness prevention	2.5	3.2

Patient Satisfaction Score (y-axis: 0, 1, 2, 3, 4)
Patient Satisfaction Domain (x-axis)

NRC WPHS. Power BI.
2023 Calendar Year.
Accessed September 19th, 2023.

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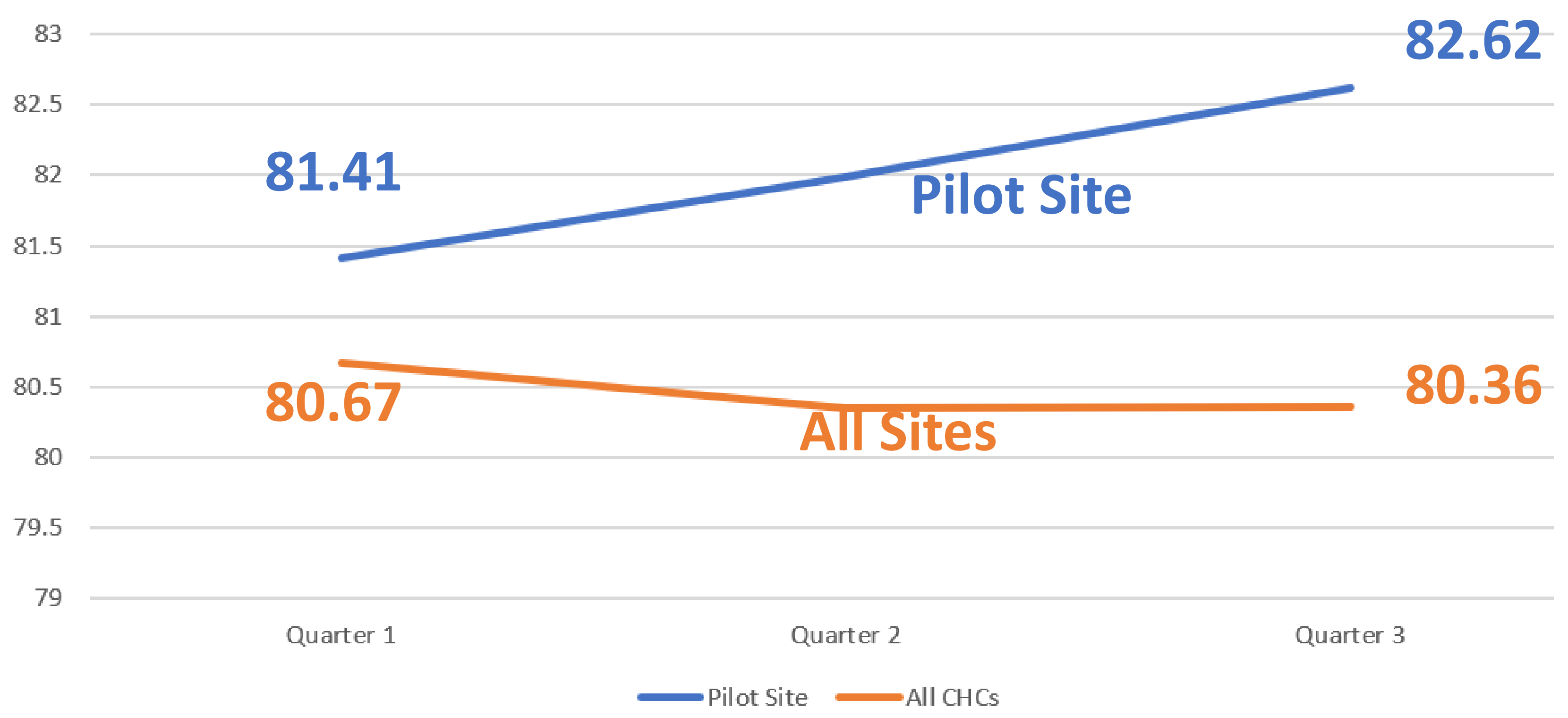
Whole Person Health Score Composite Upward Trending at Pilot Site



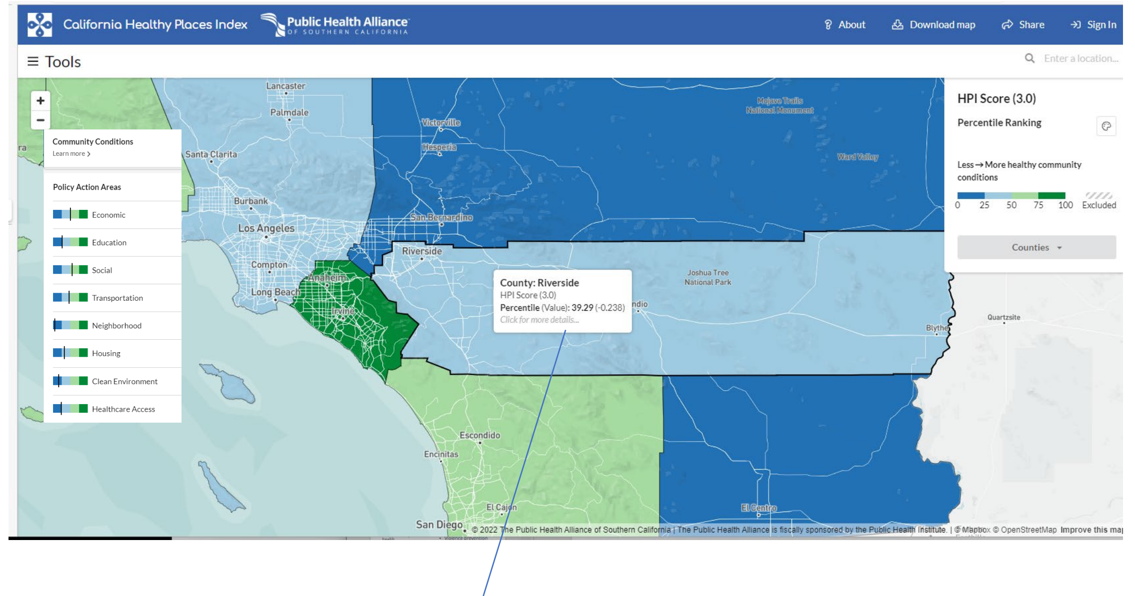
Pilot Site Clinic: # WPHS = 4,136
(# of unique patients = 3,860)

All Clinics: # WPHS = 25,163
(# of unique patients = 23,912)

"Whole Person Health Score Composite." Based on September 16th, 2023 RUHS Whole Person Health Score Data Set. September 16th, 2023.

Whole Person Health Score and Healthy Places Index Track Similarly by City

City	HPI	WPHS Composite
Hemet	5.9	76.2
Desert Hot Springs	7.9	75.9
Perris, **Mead Valley**	10.7	81.8
Moreno Valley - High School and Mall	11.2	80.6
Coachella	11.3	80.6
Banning	11.7	81.6
San Jacinto	13.2	78.2
Blythe	14.3	72.9
Indio	18.1	77.5
Jurupa Valley	18.4	81.1
Cathedral City	20.2	79.3
Lake Elsinore	22.9	78.8
Riverside - Arlington / Arlanza	29.4	80.8
Palm Springs	30.6	76.4
Corona, Temescal Valley	34.8	82.9
Wildomar	38.8	79.4
Palm Desert	44.3	79.4
Beaumont	46.4	82.7
Canyon Lake	49.9	83.6
La Quinta	50.5	82.1
Menifee	53.8	82.2
French Valley, Keller Crossing	53.9	84.5
Murrieta - Murrieta Hot Springs	56.4	84.1
Eastvale, Norco, **Corona**	57.1	85.6
Murrieta	58.5	79.3
Chino, Norco, **Corona**	63	85.1
Temecula	63.1	82.2
Redlands	64.7	88.3



Riverside County HPI = 39.3 (out of 100)

Based on May 27, 2022 RUHS Whole Person Health Score Data Set and May 2022 Healthy Places Index

Service Navigation, Family Resource Centers, and Community Health Workers

Integrated Services Delivery Pilot Site Staffing: Current State

- **3 Social Services Practit**ioners (in-kind contribution by Department of Public Social Services)
- **1 Social Services Practitioner** (in-kind contribution by First Five) – Family Resource Center
- **1 Social Services Supervisor** (in-kind contribution by Department of Public Social Services)
- **0.5 FTE Health Services Assistant** (in-kind contribution by Department of Public Health)

→ Is there a more sustainable model of staffing?

Community Health Worker

- Creation of **new job classification** (Riverside County)
- New **Medi-Cal benefit** covering Community Health Worker (CHW) services as of July 2022
  - **Health Education** (education, coaching, goal-setting)
  - **Health Navigation** (connect to community resources, provide referrals, perform outreach, assist with enrollment, address health care barriers, address health-related social needs, serve as a cultural liaison)
  - **Screening and Assessment**
  - **Individual Support or Advocacy**

CHW Services May Address Issues that Include but are not Limited to:

- Control and prevention of chronic conditions or infectious diseases
- Mental health conditions
- Substance use disorders
- Need for preventive services
- Perinatal health conditions
- Sexual and reproductive health
- Environmental and climate-sensitive health issues
- Child health and development
- Oral health
- Aging
- Injury
- Domestic violence
- Violence prevention

Medi-Cal Provider Manual for the Community Health Worker. California Department of Health Care Services. Updated July 2022. https://files.medi-cal.ca.gov/pubsdoco/Publications/masters-MTP/Part2/chwprev.pdf (accessed July 24th, 2022).

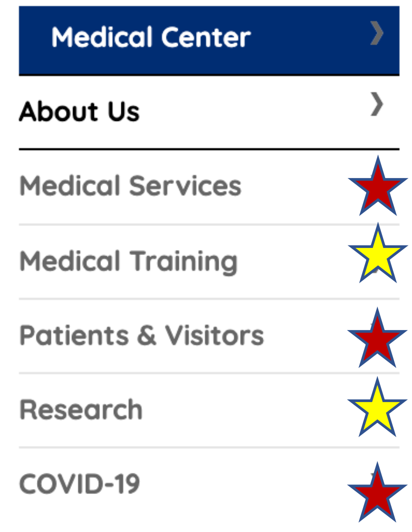
Community Health Worker Billing and Reimbursement

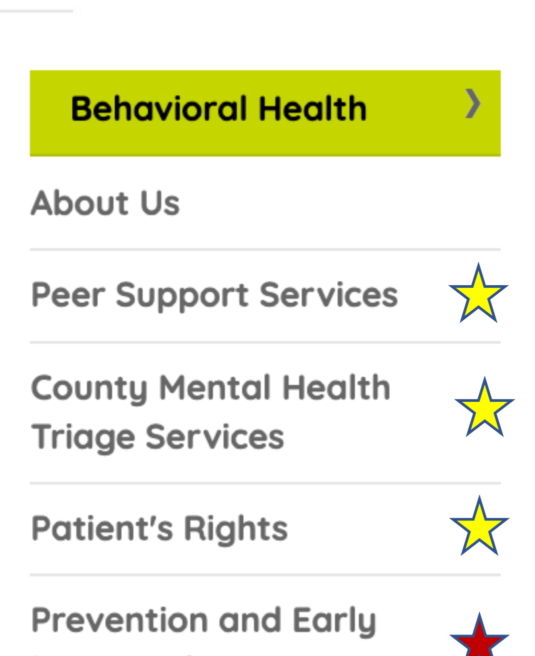
- “Education and training for **patient self-management** by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver / family) each **30 minutes**”
  - **98960**: individual patient **($26.66)**
  - **98961**: 2-4 patients **($12.66)**
  - **98962**: 5-8 patients **($9.46)**
- **Maximum** frequency is **four units** (two hours) **daily** per beneficiary; additional units per day may be provided with an approved Treatment Authorization Request
- Providers should use **modifier U2** to denote services rendered by CHW’s
- **No place of service restric**tions for CHW services
- DHCS clarified that **telehealth** CHW encounters eligible

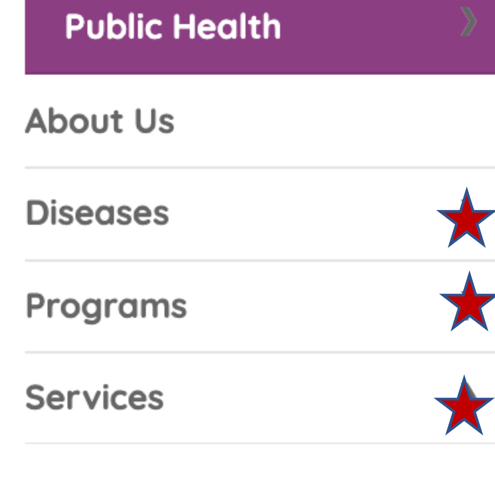
Medi-Cal Provider Manual for the Community Health Worker. California Department of Health Care Services. Updated July 2022. https://files.medi-cal.ca.gov/pubsdoco/Publications/masters-MTP/Part2/chwprev.pdf (accessed July 24th, 2022).
Medi-Cal Coverage of Community Health Worker (CHW) Services is Effective July 1, 2022. California Department of Health Care Services. Originally published June 29th, 2022. Updated on August 19th, 2022. https://files.medi0cal.ca.gov/pubsdoco/newsroom/newsroom_31781_01.aspx (accessed October 30th, 2022).

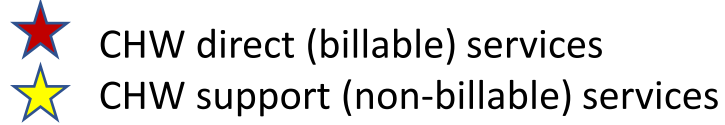
High Level Diagram: Possible CHW Integration

Critical Care → Acute Care → Care Management → Prevention









RUHS-Community Health Worker HUB

RUHS-Public Health programs

RUHS-Medical Center

RUHS-Beahavioral Health

RUHS-Community Health Centers

RUHS- Public Health

Referral, Intake, and, Centralized Claims Management

Community Health Worker Hub Development

Need Qualtrics access, see WPHS results, how stored, how can access results. How to know if previously completed by a client

Could Qualtrics universal authorization WPHS link into Epic eligibility criteria assessment?

Not currently linked to Epic. Would need to be scanned in Epic with H.I.M. QC support

CHW services billable to Medi-Cal

Consent to enter and participate in CHW program

Access to Medical records in Epic needed, after consent

Separate program consent to enroll into CHW program. Independent of Form-250

Different Form IDs for universal authorization form and program consent form

Intake center & email, fax, phone

Outreach (IEHP list)

CBO Referral

Are we able to collect verbal consent first (continuum of care clause) and fill in universal authorization later?

Obtain verbal consent. Register into Epic (CHW I)

Determine eligibility, incl WPHS

Split eligibility into 2. Medi-Cal eligible and CHW service eligible

Eligible?

No

Patient ECM Enrolled?

No

For verbal, need clear documentation. Who, what, when, details.

Could flow sheet of APL be used for eligibility instead of WPHS until connecting with client?

Check process flow against APL for compliance

Can bill initial WPHS if it is determined pt is not eligible for CHW services? Need switch to prevent double billing grant funded and for non-qualifying

Electronic Health Record System

- Template Build and Role-Based Access
- Documentation
- Coding and billing
- Referrals
- Compliance

Administrative Structure, Data Sharing, and Lean Process

Office of Service Integration

- Initial Funding: $3 million
- Staffing
  - Managing Director, Deputy Director, Regional Manager
  - Social Services Planner, Executive Secretary, Research Specialist
- Contracts
  - Legal Consultant
  - Lean Consultant
  - ESRI

Data Sharing: Overview of What is Permitted

- CalAIM
- Health Care Operations (including population-based activities)
- Medicaid and SNAP Enrollment (Medi-Cal and CalFresh)
- Implementation of Social Services
- Multi-Disciplinary Teams

HIPAA Covered Entity Designation

- Current State: County Health System, Office on Aging, Human Resources, County Information Technology, Emergency Management Department, Fire Department, County Counsel, Sheriff’s Department

- Future State: Department of Public Social Services, Office of Service Integration, First 5, Child Support Services, Veterans’ Services, Housing and Workforce Solutions, Public Authority, Probation, Executive Office

HIPAA Covered Entity Obligations

- Training
- Data Validation
- Data Retention & Release
- Physical & Technical safeguards to data
- Role-based access & access management (business need to access data)
- Accountability / Responsibilities at department, staff, and contractor levels
- **Designated Compliance Liaison / Officer

Universal Release of Information (1 of 3)

WHAT INFORMATION CAN BE DISCLOSED AND USED

My initials below authorize Riverside County agencies to disclose and use the following information:

	Initial
Demographic Information (name, address, phone number, date of birth, social security number)	
Financial Information (earnings, assets, health insurance)	
Basic documentation (photo ID, IRS Form W-2, VA Form DD214)	
My enrollment in county programs (including substance-use programs, self-sufficiency programs such as CalWORKs, CalFresh, TANF, and other social service programs)	

Universal Release of Information (2 of 3)

My initials below authorize Riverside County agencies to disclose and use the following information:

	Initial	From (Date)	To(Date)
Medical Information (diagnoses, disabilities, types of care—except for types of health information listed below)			
Mental Health Treatment Information			
Genetic testing information			
HIV/AIDS Diagnosis & Treatment Information			
Alcohol/Drug Treatment Information			

Universal Release of Information (3 of 3)

WHO MAY USE AND DISCLOSE YOUR INFORMATION TO PROVIDE ASSISTANCE ACCESSING PUBLIC PROGRAMS?

All Agencies Listed Below (Initial Here) ☐

Or initial below to authorize only specific agencies:

Agency	Initial
Riverside University Health System (Medical Center, Community Health Centers, Behavioral Health, Public Health)	☐
Riverside County Department of Public Social Services (assistance programs for food, cash, housing, health coverage such as Medi-Cal, CalFresh, CalWORKs)	☐
Riverside County Office on Aging (support services for seniors, people with disabilities, and their caregivers)	☐
First 5 Riverside County (access to quality childcare, home visiting, pediatric services, developmental screenings, parent support services)	☐
Riverside County Probation (assistance with understanding court procedures, Victim Restitution Services, outreach kiosk reporting)	☐
Housing and Workforce Solutions (HWS): (Workforce Development, Housing Authority of Riverside County, Continuum of Care, Community Solutions Division)	☐
Child Support Services (helping parents/guardians to access legal rights and payments)	☐
Veterans Services (access to benefits, medical/other treatment services, compensation)	☐

Technology Projects and “Sprints”

- **System of Insight**
  - Geomapping areas of need with existing community resources
  - Development of a County Needs Index
- **System of Engagement**
  - Creation of a virtual front door (via kiosks, mobile devices, etc.)
- **System of Record**
  - Consolidated database
- **Agile methodology** of product development and project management

Lean Process

RAPID IMPROVEMENT EVENTS (RIE)

Service navigation

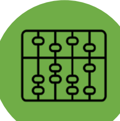
Whole Person Health Score integration

Referral processes/FRC

Pre-visit/ACC registration

Whole Person Health Score reassessment

Kiosks


Referral criteria- Universal intake, needs/gaps algorithm

Child Assessment & Healthy Steps Integration

PROJECTS

- Marketing, scripting, branding
- Provider WPHS utilization training
- Closed loop referrals
- Longitudinal Plan of Care operationalization
- Needs/gaps algorithm

Key Takeaways

JAMA Health Forum.

JAMA Forum

Health Systems and Social Services—A Bridge Too Far?

Sherry Glied, PhD; Thomas D'Aunno, PhD

Author affiliations and article information are listed at the end of this article.

Robust evidence shows that social conditions (including housing, food security, education, and transportation) are critical factors in promoting individual and population health. There is also evidence that addressing the social determinants of health can improve health status.[1] It is thus not surprising that, in the past several years, health care systems, policymakers, and researchers have renewed their interest in the role that health care systems and particularly hospitals can play in identifying and responding to the social needs of patients.[2] Indeed, Horwitz and colleagues identified 57 health systems, including 917 hospitals, that recently have launched programs to address social determinants of health.[3]

The health systems dedicated $2.5 billion of funding to these programs, of which about two-thirds was specifically committed to housing-focused interventions (other focus areas included employment, education, food security, and transportation). In short, health systems are making sizable investments in the social determinants of health. Proponents argue that these investments are needed not only because of the evidence on the health effects cited above, but also because community-based social service agencies and state social welfare systems are typically inadequately funded to address social needs.

We disagree. Health systems and hospitals should tread warily into the provision of social services and policymakers should not encourage this approach. It has real risks, such as diverting scarce resources to socially less-desirable uses, and few prospects of success. Social determinants of health should be addressed by the social service organizations and governments that specialize in this work. There are fundamental mismatches between the priorities and capabilities of hospitals and health systems and the task of addressing social determinants of health.

One mismatch arises from heterogeneity among hospitals. Investing in social needs is costly and requires managerial attention, but while the health system as a whole spends a great deal of money, the finances of hospitals typically mirror the finances of the communities they serve. Accordingly, the systems where patient needs for social services are greatest are those that are already struggling to meet their core missions around patient safety and quality care. Their patients rely on them to devote their budgets and attention on improving patient care, for example, by maintaining adequate nurse staffing levels. For these institutions where the social needs are greatest, a pivot from the central mission to addressing social needs can be a dangerous distraction.

In better-resourced hospitals, providing social services will always be no more than a grace note to hospitals' institutional priorities. Social workers, who know the most about how to address these needs, make up only a fraction of the health care labor force at hospitals and within health systems, and typically hold little power in the organizations. The incentives operating within most health system organizations, and particularly those that do not primarily serve safety net populations, mean that funding intended for social services is unlikely to be spent in the ways that are optimal for population health.

Some see collaborative relationships with social service organizations that specialize in this work as a way to address the lack of expertise within hospitals.[4] But hospitals and health systems do not typically play well with others. They are bigger, stronger, and more politically well-connected than local community social service providers and differ from their erstwhile colleagues in their cultures, leadership styles, and managerial practices. Numerous studies show that lack of alignment on these dimensions bodes poorly for the effectiveness of cross-sector collaboration.[5]

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Questions?

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