Integrating County Delivery Services to Obtain Transparent and Accountable Outcomes

County Ideas that Work

NACO | VIRTUAL LEARNING COMMUNITY

May 22, 2014

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Today's Speakers

Uma Ahluwalia

Director, Department of Health & Human Services

Montgomery County, Maryland

Jerry Friedman

Director of Strategic Initiatives

Accenture Human Services

How many people are attending this webinar from your computer?

a. 1

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e. 5 or more

Does your county currently have an integrated delivery system?

a. Yes

b. No

c. Not sure

Is you county in the process of developing and/or implementing an integrated delivery system?

a. Yes

b. No

c. Not sure

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About Accenture

Accenture is a global management consulting, technology services and outsourcing company. Combining unparalleled experience, comprehensive capabilities across all industries and business functions, and extensive research on the world's most successful companies, Accenture collaborates with clients to help them become high-performance businesses and governments.

Today's Presenter

Jerry Friedman

Director of Strategic Initiatives for Accenture's Global Human Services Practice

Prior Experience:

- Executive Director of APHSA—2001 to 2010.
- Former state director in Pennsylvania, Washington State, and Texas.
- Former Human Services Director in Northampton and Dauphin County PA.

Outcome Evaluation

How many people served by human service agencies are indeed helped or have improved vs. how many people served had not improved or whose problems have worsened?

This was the question that four PA counties involved in a pilot comprehensive human services planning process sought to answer in the 1980's under a federal demonstration grant to establish a client outcome evaluation process.

Outcome Evaluation

Analysis Findings:

- 1,962 total target problems were identified for the 424 cases/families, which is an average of approximately 5 target problems per family
- The total end project results indicated that 59% of all clients experiencing a total of 1,928 target problems improved and 41% did not improve or worsened
- Lessons learned: a comprehensive intake diagnostic tool could be applied even within a categorical framework and progress could be measured across programs.

Contact

Jerry Friedman

Director of Strategic Initiatives for Accenture's Global Human Services Practice

jerry.friedman@accenture.com

+1 301.346.9875

Integrating County Delivery Services to Obtain Transparent and Accountable Outcomes

Health and Human Services

A Presentation by Uma S. Ahluwalia

Thursday | May 22, 2014

DEMOGRAPHICS

WHO ARE WE AND WHY THE NEED FOR TRANSFORMATION……

Information About our County.

Almost 1 Million Residents

32% Foreign Born

(2010 Census)

50.6% Racial/Ethnic Minority

(2010 Census)

17% Growth in our senior population over the next 2-years

49,344 out of 148,779 children in the public school system receives FARMS

6 Zip Codes of Extreme Need — Poverty on the Rise

Served 120,000 Households in Fiscal Year 2012. One-third used more than two services from Department

A Staff of 1,600 with over 80 Programs

Caseloads Growing

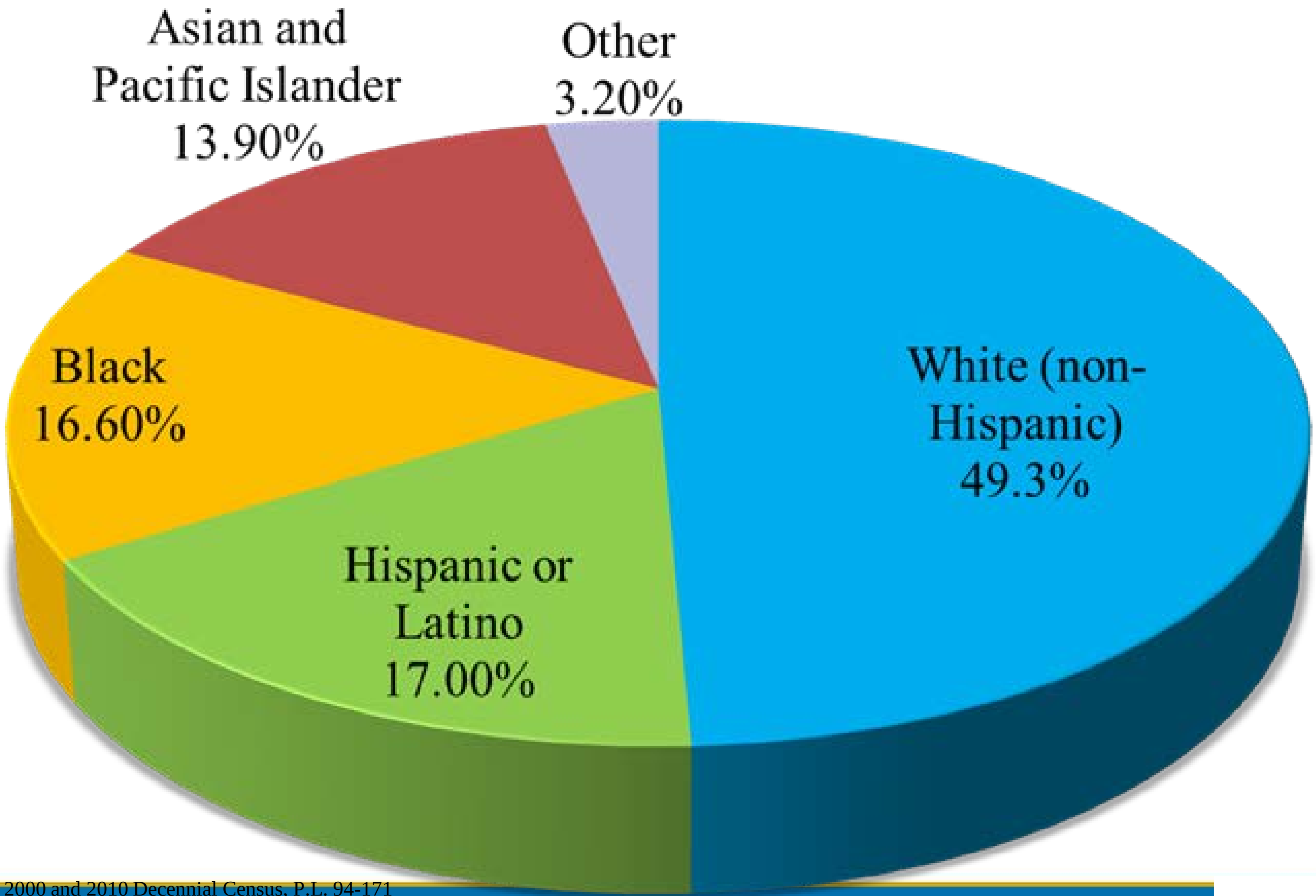
TCA: 43.4%

SNAP: 166%

MA: 68.7%

Serving almost 34,000 uninsured adults, children and pregnant women

Population by Race and Hispanic Origin
Montgomery County, Maryland



SOURCE: U.S. Census: 2000 and 2010 Decennial Census, P.L. 94-171 Redistricting Data/Center for Research and Information Systems, Montgomery County Planning Department, M-NCPPC.

Barriers to Access to Services

- Limited English Proficiency
- Education
- Transportation
- Lack of Health Insurance
- Geographic Barriers
- Lack of Culturally and Linguistically Competent Services
- Lack of Diverse Workforce
- Immigration Status
- Other

How is the Department of Health and Human Services Organized?

In 1994, four Departments Became One Entity …

Objective:
Integrated, Coordinated and Comprehensive Service Delivery.

How is the Department Organized?

One Director

Centralized Administrative Functions

- Moving towards single client record support by an interoperable database
- Uniform intake form to identify all service needs
- Designated entire HHS entity as HIPAA covered – including social service and income support programs

TRANSFORMATION

NUTS AND BOLTS AND COMPONENT PARTS……

Building an Integrated Service Delivery System.

Front Door

- No Wrong Door
- 100% Intake

Defining the Middle

- What Does Integration Mean for the 80% of Clients who uses 20% of Resources?

Intensive Case Teaming

- 20% of Clients Using 80% of Resources

Building an Integrated Service Delivery System.

Practice	Policy	People	Infrastructure
• Integrated Intake • Assessment • Case Planning • Service Delivery • Analytics	• Confidentiality • Ethics • Dispute Resolution • Equity • Others	• Training • Tools • Accountability • System Evaluation	• Technology • Quality Service Review (QSR) • Caseload Sizes • Contract Monitoring

INTEGRATED SERVICES PRACTICE MODEL

The Department's Integrated Services Practice Model:

- provides staff with mechanisms for routinely coordinating services across multiple programs and systems;
- supports a "No Wrong Door" approach that enables clients to access any and all available services based on need, regardless of which program door they enter the department through; and
- provides staff with quick and easy access to the full range of client services and supports, both within the department and through community partners.

Defining our Integrated Services Practice Model:

- A holistic way of thinking about and addressing the service needs of the whole person/family.
- A team approach that works to fully utilize available resources to address problems collaboratively.
- Maximize the impact of individual service components through integration of efforts, which results in improved services for clients and support for staff.

Systems Barriers: what we have learned

- Program requirements and program priorities sometime conflict and we need to create a process for staff to address these conflicts.
- Identifying lead case owner, when the client is receiving services in multiple programs within the Department is necessary to facilitate ongoing teaming.
- Continual education of Department staff about programs and services is essential to ensure that lack of knowledge is not a barrier to services.
- Limited resources with the County's service delivery system requires staff to work collaboratively in meeting client needs.
- Lack of a resource that meets the specific need of the client requires staff to be innovative in developing client resources.

Triple AIM in Health Care

Improved Experience of Care

Improved Population Health

Reduction in Per Capita Cost of Care

To Achieve Triple AIM two Tracks of Reform are Underway

(1) Delivery System Reform; and (2) Payment System Reform

Department of Health and Human Services

Healthy Montgomery

www.healthymontgomery.org

Community Benefit and the Local Health Improvement Council (LHIC)

- Healthy Montgomery is our LHIC

- Focus on access to care, healthy behaviors and inequitable outcomes

- 6 areas of focus:
  - *Obesity*
  - *Behavioral health*
  - *Cancer*
  - *Diabetes*
  - *Cardiovascular*
  - *Maternal and child health*

These priorities will drive hospital community benefit and public and private sector investments

NEIGHBORHOOD OPPORTUNITY NETWORK.

Residents and Service Professionals are Co-Investors in Neighborhood Opportunity Networks

Real and Sustainable Access to Services

- More residents of different backgrounds are accessing services.
- Significant increase in residents who report feeling honored, enriched and empowered.
- There is an active web of resident connectors knowledgeable about services who have a sense of trust with an active web of service providers.

Thriving Neighborhood Centers

- Increase in responsive formal services due to relationships and teams formed at center.
- Centers "owned" as vital anchor institutions in their communities

Thriving Neighborhood Networks of Mutual Support

- Residents of diverse backgrounds frequently gather and build supportive relationships.
- Increase in number of specific informal supports traded among and between residents.

MARYLAND

Leadership Institute of Equity and Elimination of Disparities (LIEED)

Expand the role and reach of the Minority Health Initiatives|Programs to collectively:

- Enhance collaborations and provide support to HHS service areas to enhance service delivery to racial|ethnic minority groups and emerging populations
- Actively participate in department-wide projects, programs, and special initiatives
- Inform state policies and decision-making related to addressing health disparities and well-being
- Provide formal TA and guidance to entities interested in developing and implementing culturally and linguistically competent programs
- Lead advocacy efforts directed at policies and practices needed to effectively reach and serve racial|ethnic minorities

TECHNOLOGY, ANALYTICS AND THE PRACTICE OF SHARING INFORMATION

THE PATH FORWARD TO A COST EFFECTIVE AND EFFICIENT CARE DELIVERY SYSTEM

The Process and Technology Modernization (PTM) Program lays the foundation for changing DHHS service delivery over the next few years.

Drivers	Goals
▪ Changes in service delivery best practice ▪ Changes required by the Affordable Care Act (ACA) implementation ▪ Difficulty/cost in maintaining many one-off applications supporting programs ▪ Inefficiencies from using multiple state systems	▪ Improve client outcomes ▪ Reduce overall costs of treatment ▪ Establish single platform for most service delivery ▪ Prepare for ACA-mandated changes ▪ Simplify on-going application maintenance ▪ Realize vision of integrated DHHS

Service Delivery Tomorrow.

… to a more integrated service delivery model that treats clients holistically and cost-effectively.

Treatment

Assessment

Eligibility

Intake

Aging and Disabilit y	Behavioral Health	Children Youth and Families	Public Health	Special Needs Housing

Client

- **No Wrong Door** for residents needing services
- Consolidated view of client engagement across most programs
- Integrated service delivery where appropriate

Shared Areas of Focus

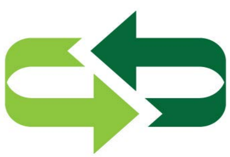
- Data collection, analysis and reporting
- Cultural and linguistic competency
- Access to health and social determinants-related services and care
- Health promotion and disease prevention
- Community engagement in planning and response

Why Integrate Data?

Over 30% of our clients use multiple services

Clients often have to tell their story multiple times and data has to be entered multiple times. Increases the risk of errors in the re-telling and re-entering

Without a master client index, it is hard to tell what services a client is getting across our enterprise and often services are duplicated and there is waste and inefficiency



Makes re-use of data impossible and it makes it more difficult for clients to access multiple services across the enterprise

What is our Approach?

- We have a HIPAA Policy and Risk Manager leading an office of 2.5 positions
- Continuously updating and staying on top of the federal and state policy environment
- Continuously training and working to align policy
- Our Process and Technology Modernization efforts which include the following – ECMS, eICMS, EHR, MCI, Legacy Systems and MCDHHS Portal will have policy, business process and practice alignment for HIPAA, 42CFR and other privacy statutes and regulations

COST BENEFIT ANALYSIS

A PUBLIC SECTOR EXPERIMENT…..

SROI versus ROTI

- ROTI goal was to address whether the government was making a wise investment; the SROI was whether the client and society benefit
- The ROTI analysis looked at 5 years of clients; SROI, at just one, with impact up to 4 years later. (If you divide 850% ROI by 5, you get 170%, which is line with the SROI results.)
- The ROTI analysis assumed the ITP program was designed and delivered in the way it was planned. It also assumed that services would be 30% successful at achieving outcomes. The SROI model used persona-specific success rates, based on the literature
- The SROI analysis was not as broad as it could be (e.g., did not look at the long-term effect on children), so the ROI is not as big as it should be

Return on Taxpayer Investment.

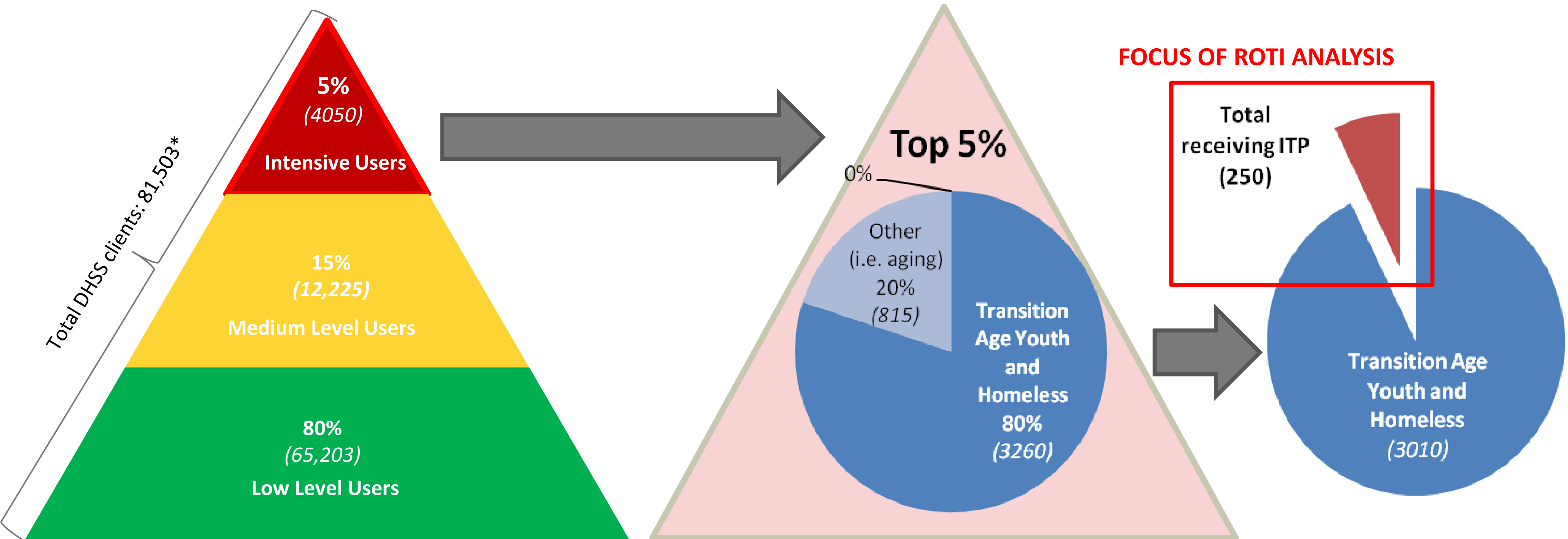
Executive Summary

The Return on Taxpayer Investment (ROTI) project will provide a business case that demonstrates the return on taxpayer investment on the implementation of an interoperable technology and an intensive teaming protocol for a targeted subset of homeless and transition age youth groups.

The Situation	Montgomery County DHHS provides a broad range of public health and human services to support the needs of the community's most vulnerable children, adults and seniors through five key service areas: Aging & Disability Services, Behavioral Health & Crisis Services, Children, Youth & Family Services, Public Health Services and Special Needs Housing. Currently, these services operate in silos, making it challenging to meet client needs from a holistic perspective. To overcome this challenge, the department desires to invest in an interoperable technology and integrated case management process that enable collaboration across multiple functions, increase operational efficiency across agencies, and ultimately lead to better client service and outcomes.
Key Question	**What is the financial return on investment to taxpayers for a strategic investment in an interoperability system and intensive teaming protocol?**
Key Considerations	• Out of all the clients served by the department, the most expensive clients are the intensive support users, who represent a small percentage of Montgomery County DHHS service population (approximately 5%). • These intensive support users access multiple services across DHHS using an agency-specific service delivery model (i.e. uncoordinated service among the programs providing support to the client) • The ROTI model focuses on the costs and benefits of the application of an interoperability system and an integrated case management protocol to the intensive support users in two target populations: Transition Age Youth and Homeless. • Each target population contains specific sub-categories that include specific criteria for an "intensive support user" within that group. • Average costs of service are calculated based on the most common "bundle of services" used by the intensive support user. • Cost and benefits are analyzed across four levels of government – County, State, Federal, and Other

Intervention Cohort.

Focus of the ROTI Analysis



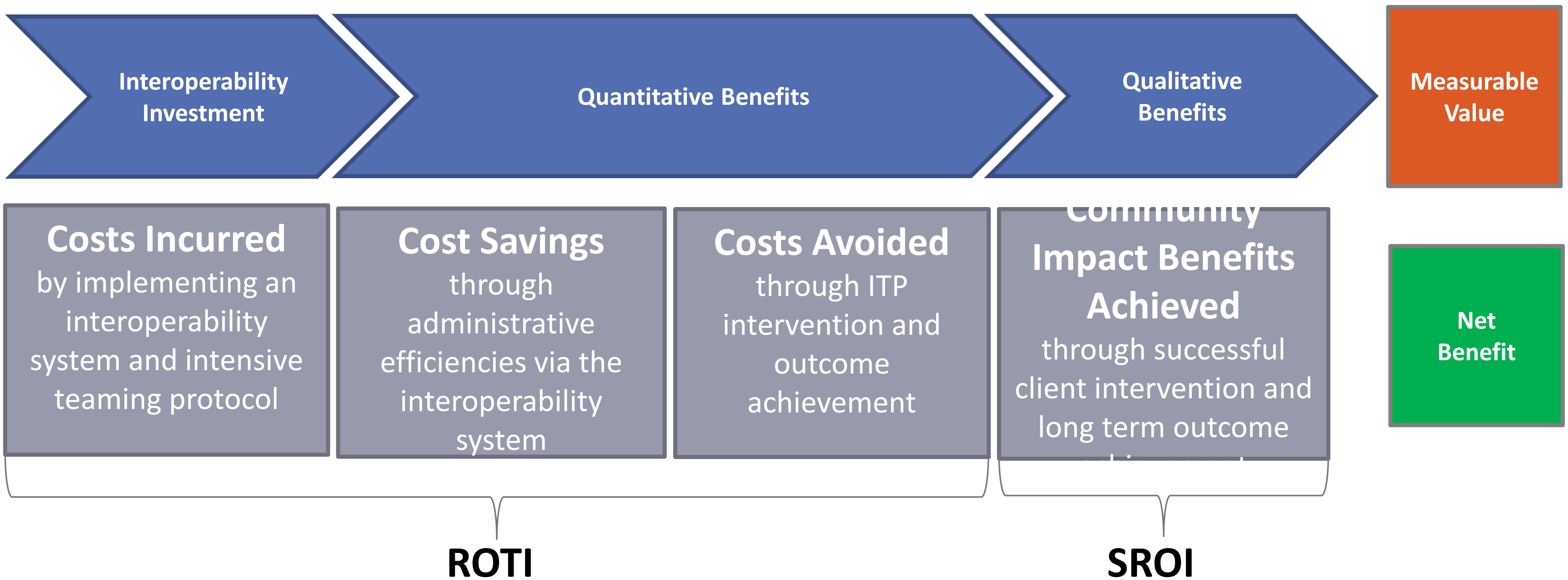
This pyramid shows the estimated breakdown of all the clients served by Montgomery County DHHS. The bottom of the pyramid shows the majority of the clients who are low level users and only utilize one service ("one and done"). The middle of the pyramid shows a relatively smaller group of medium level users who use two+ services, but also contain potential intensive support users. At the top of the pyramid are the intensive support users who use multiple services from the department and represent a significant cost to serve.

- *Within the Top 5%, 80% (3240)of the clients are part of the Transition Age Youth or Homeless categories.*
- *Of those 3240 clients, ~250 will receive the ITP.*
- ***The 250 receiving ITP are the focus of the ROTI analysis***

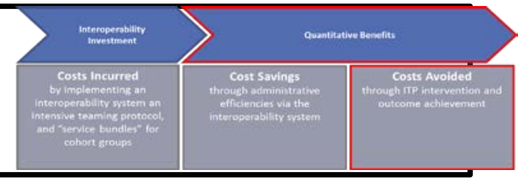
*Total number of DHHS clients based on FY12 DHHS Performance Plan

ROTI Approach.

The ROTI model analyzes the value of investing in an interoperability system and an intensive teaming protocol. The benefits are categorized as quantitative (which is the focus of the Accenture ROTI model) and qualitative (which is the focus of the Johns Hopkins Social Return on Investment SROI model). The net benefit of implementing an interoperability system and the ITP protocol can be expressed in terms of the value chain below.



Cost Avoidance Calculation.



The Cost Avoidance metric is connected to the expected outcomes from the Integrated Teaming Protocol. The calculation incorporates the five key domains (outcomes) to be achieved in the application of the ITP to each of the personas as well as the service bundle costs associated with a specific "future persona." The link between the current and future persona is based on the assumption that without an ITP intervention, the future state represents a likely end state for the current persona.

Key Inputs

Current to Future Personas Service Bundle Costs:

Current Persona		Future Persona
Children Aging out of Foster Care	→	Homeless Youth
Pregnant Teen	→	Homeless Family
Children Aging out of Disabilities	→	Homeless Youth
Homeless Youth	→	Homeless Individual
Homeless Family	→	Homeless Individual + Foster Care
Homeless Individual	→	Homeless Individual

Domain Related Outcomes:

- Housing
- Education
- Employment
- Access to Healthcare
- Permanent Connection

Cost Avoidance Calculation

Future Persona Service Bundle

+

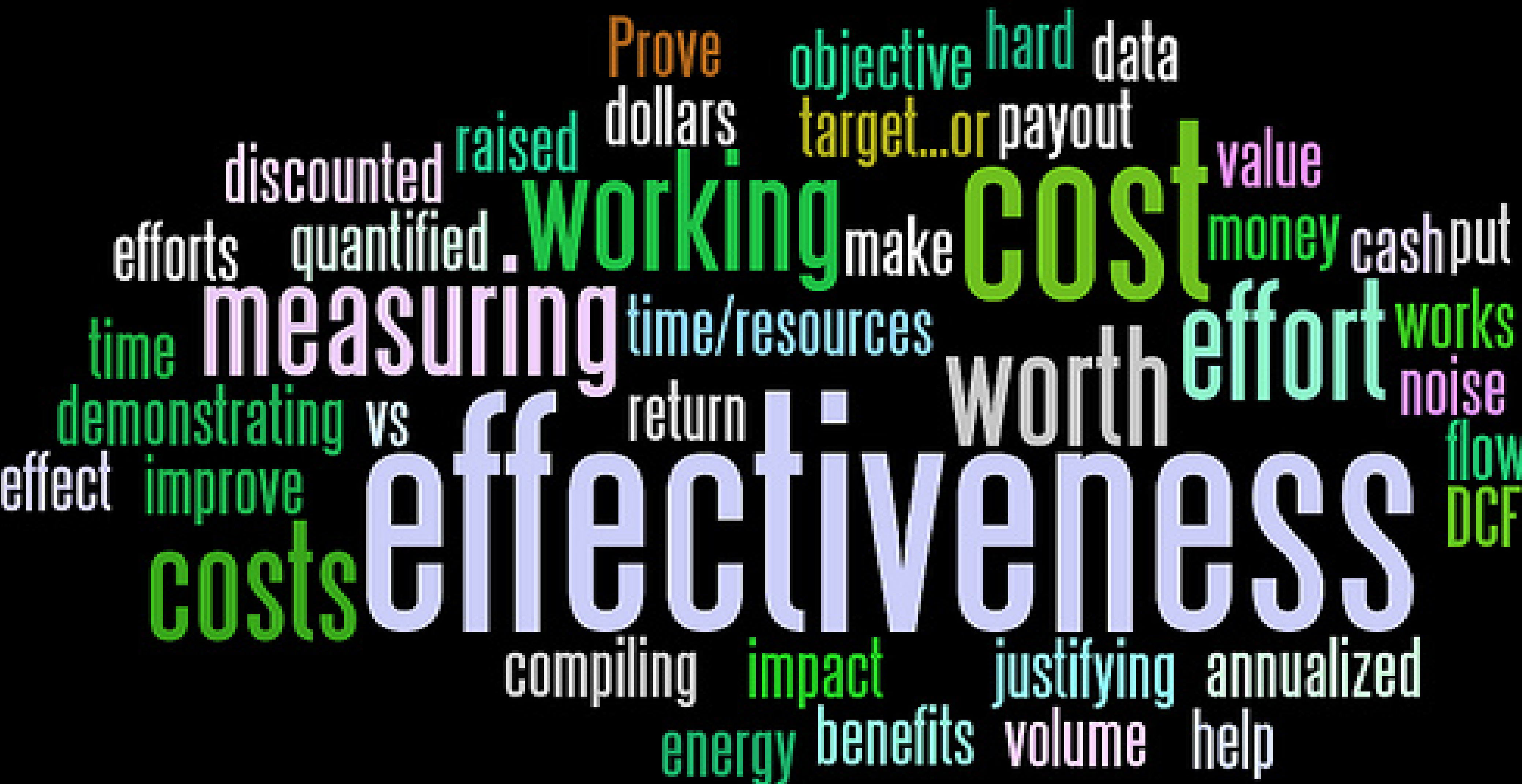
Domain Related Outcome

=

Costs Avoided for Current Persona x 30% Likelihood of Success of ITP

*Future personas represent the "worst case scenario" set of outcomes for the current persona

Social Return on Investment



Project Goal.

The High Level Question for Analysis:

In what way might

Integration and Interoperability

have value to society,

where "society" is taken to mean the client,
his or her family,

and others affected

by the client's life course?

Project Purpose: *Key Question.*

The task of the model is to answer:

*What **impact** does eICM/ITP*

make on the lives of the department's

***most difficult cases**?*

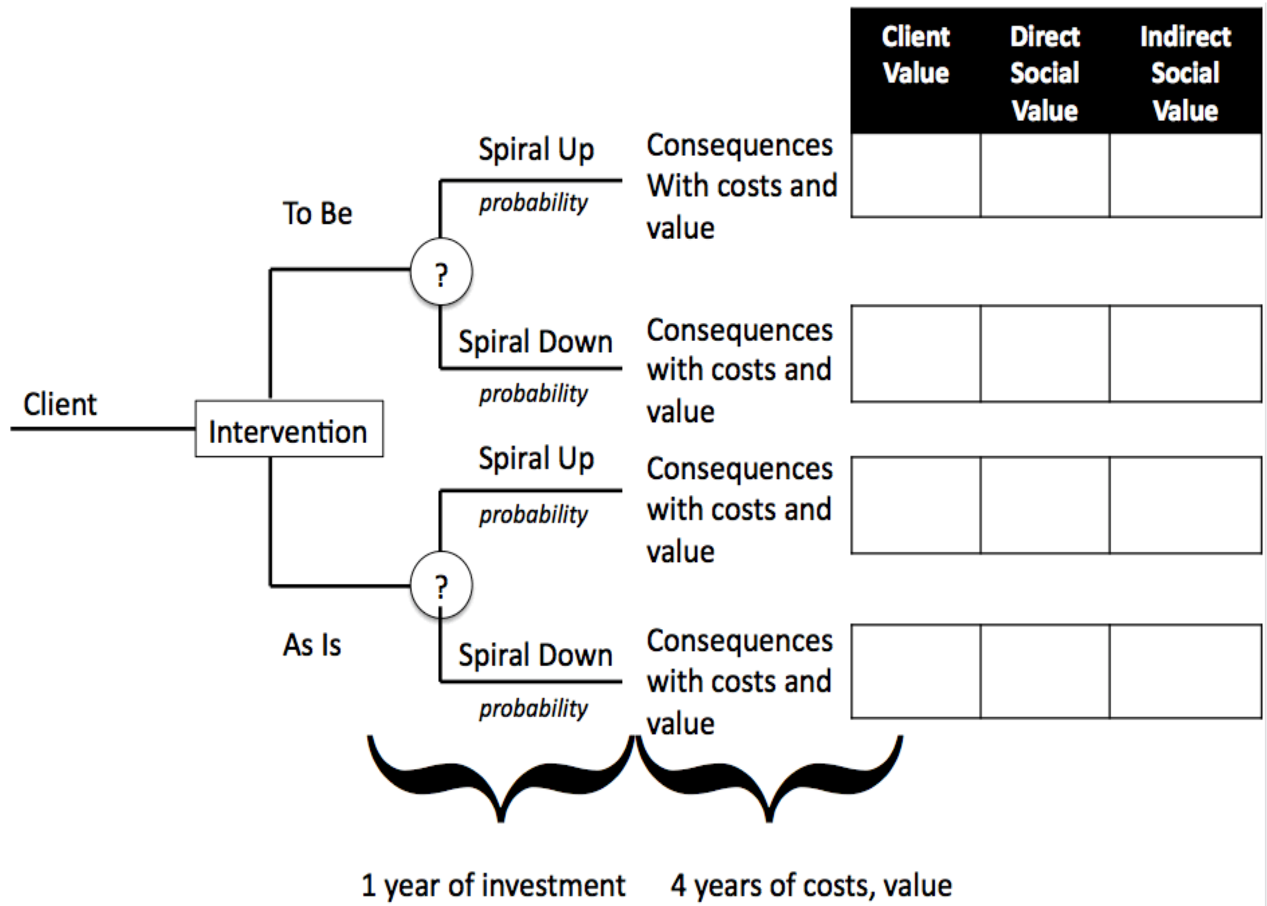
*Can we use that impact to **prioritize** investments or target populations?*

Core Question.

In particular, what impact (value) does the

To-Be service bundle, as experienced in 1 year, have on the subsequent 4 years of a client's life, ***compared to*** the current,

As-Is service bundle?



Project Personas: Same as ROTI.

Persona	Stakeholder Description	Spiral Up	Spiral Down
Aging out of foster care	17 years old, mental health, physical disabilities, developmental disabilities, reside in group home	• Supported housing • Working minimum wage • In maintenance health care	• Homeless or in a residential institution • Unemployed
Pregnant teen	16 years old, in high school, failing in school, 1st child, single parent, previous trauma (sexual abuse), highly dysfunctional family, housing is tenuous	• Supported housing • Completes high school (or GED) • Works, with child care support • Mental health continued support • Low likelihood of second infant	• Homeless • Unemployed • Liable to lose children to foster care
Aging out of disabilities	19 years old, developmental disabilities, physical disabilities, mental health, in a residential program	• Supported housing • Working minimum wage • Has health insurance • In maintenance healthcare	• Homeless or in a residential institution • Unemployed
Homeless youth	21 years old, co-occurring diagnosis (mental illness + substance abuse), behavioral issues	• Permanent housing • Employed • In maintenance health care for substance abuse	• Homeless
Homeless family	21-year-old single mother with multiple children, no access to housing, no income, severe mental health diagnosis	• Housed • No foster care	• Homeless • High likelihood of foster care for children
Homeless adult	45 year old mental health illness, physical disability, substance abuse	• Housed • Employed	• Homeless

Case Scenario.

- Client – K.R.
- 15-year old undocumented Latino female
- Expelled from school last spring for carrying a weapon. She was supposed to attend alternate school but she refused home based school. MCPS thought she had moved – and, consequently, she fell through the cracks and was not attending any school. She shows up at the County's maternal and child health clinic as 6-months pregnant. Father of baby is also high school drop out and not working. Lives with mom who has an abusive boyfriend. Child has history of physical abuse in home country. Child's mom is depressed and talks about harming herself. Child is not in school, very isolated, worried about her mom, pregnant, no good prospects of a job – if not attended this transition age youth will be the homeless family in a couple of years –
- Apply ROTI/SROI calculator

INTEGRATED PRACTICE - MANAGING PERFORMANCE

TRANSPARENCY – NOT JUST A PIPE DREAM

Quality Service Review

Purpose

- Determine how well is the client doing (status indicators)
- How well is the system doing in serving the client (practice indicators)
- About learning, not compliance
- Used for practice and system improvement

- **Process**
- Formal protocol for cross system qualitative evaluation
- 2 day review includes case record review, interviews
- with client, service providers, other informants
- Feedback sessions with primary caseworker, supervisor, program manager and Service Chief
- Scoring on each indicator. Narrative about findings for each case
- Identification of themes/issues found in each round by advisory committee
- Decision on follow up by Senior Leadership Team
- Follow up action(s)

QSR Indicators

Client Status

- Safety
- Behavioral Risk
- Health Status
- Emotional Status
- Living Situation
- Resources and Basic Necessities
- Quality of Life
- Permanency Prospects (Child Welfare Cases only)

Practice Indicators

- Engagement
- Teamwork
- Role and Voice
- Assessment and Understanding
- Long-Term Goals and Objectives
- Planning of Interventions
- Intervention Adequacy
- Tracking and Adjustment

Performance Data FY13

Team Formation

General Practice Cases	67%
Integrated Case Practice Cases	92%**

Team Functioning

General Practice Cases	50%*
Integrated Case Practice Cases	67%

Beneficial Impact (Weighted Sample of Cases Department Wide)

Overall	92%
Improved Health & Wellness	55.2%
Greater Independence	87.7%
Risk Mitigation	84.7%

* AND ** Based on small, limited sample

What are the Markers of Success?

- A seamless integrated Health and Human Services environment
- Integration at the point of intake and assessment
- Integration at the point of service delivery
- Collaborative case practice when case acuity is severe
- Improved client and patient outcomes
- A more equitable service delivery system
- Strong population health and program level data and analytics capabilities in addition to accessible case specific data

Thank You!

Uma S. Ahluwalia, Director
Department of Health and Human Services
401 Hungerford Drive
Rockville, Maryland 20850

240.777.1266

Uma.ahluwalia@montgomerycountymd.gov

Type your question into the questions box and the moderator will read the question on your behalf during the Q&A session.

If we are unable to answer all of the questions during the Q&A session, we will send you the questions and answers in an email.

Upcoming Webinar

<u>Collaborating with County Partners to Create an Employee Wellness Program</u>

Are there opportunities for collaboration within your county for creating employee wellness programs that can improve the well-being of your employees while potentially reducing health care costs?

When: Thursday, June 12, 2014, 2:00 PM - 3:15PM ET

Who: Hon. Paul Decker, County Board Chair, Waukesha County, WI and Healthstat Inc.

Register: www.naco.org/webinars

NACo 79th Annual Conference

When: Friday, July 11, 2014 to July 14, 2014

What: There will be several health meetings and workshops. A great opportunity to share and learn best practices.

Where: Orleans Parish/New Orleans, Louisiana

Register: www.naco.org/meetings