Achieving Alignment: Integrating Complex Care Programs Under a Population Management Strategy

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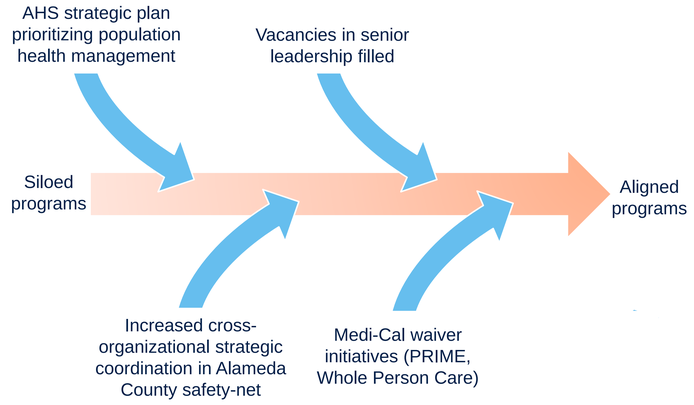
Problem Statement

While several programs at AHS provide complex care management services, there is minimal strategic or operational alignment of these efforts. This leads to missed opportunities to provide care to medically & social complex patients.

Discovery

- Interviews with leaders at other systems with best-practice care models revealed established high-level support for a focus on attributed populations
- Interviews with leaders within AHS revealed varying comfort and familiarity with focus on attributed populations

Contextual factors affecting the alignment of programs serving medically & socially complex patients at AHS



Goals and Objectives

Goal: To improve the quality of care for medically & socially complex patients receiving primary care through Alameda Health System by deploying a standardized model of complex care management as part of a cogent population management strategy.

Outcome-oriented Objective: Align activities of siloed programs providing services to medically & socially complex patients in order to position organization to participate in contracts as a Community Based Care Management Entity.

Results

Accountability

- New dedicated venues for accountability: management/ operations, oversight/executive sponsorship
- Consolidation to single cost center

Care Model

- Standardization of team structure, care model, target population, workflows
- Team embedded in additional primary care clinic, agreement to expand to third

Integration / Sustainability

- Contract executed with Alameda Alliance for Health for Health Homes Program pilot
- Complex care management identified as “Critical Initiative” for FY 18 by executive team

Lessons Learned

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- Understanding the landscape or context surrounding an initiative is critical
- Changed or vacant high level positions can cause initiatives to stall
- Having support throughout the leadership chain makes change management more effective
- Pilot programs that have erected silos for survival can develop inertia that resists operational mainstreaming

Next Steps

- Leverage contracts with county and Med-Cal plan to improve care coordination efforts across broader attributed population
- Further develop organizational competencies around population management through complex care management efforts
- Clarify operational relationships between Ambulatory Care, Care Management, and Complex Care under new Chief of Population Health

Mission Model Canvas

Key Partners	Key Activities	Value Propositions	Buy-in & Support	Beneficiaries
Alameda County Health Care Services Agency Alameda Alliance for Health	Develop, iterate, share A3 document Develop and iterate organizational structures Execute project plan for PRIME 2.3	Clear business owner for complex care management Standardization of care model Integration into broad population health strategy to manage attributed lives	Updates on external initiatives Sharing successes	Vice President of Care Management Clinic Medical Directors Interim Chief of Population Health
	Key Resources Project manager IT/IS Business development Executive attention/bandwidth		**Deployment** Population Health Working Group Direct communication, one-on-ones	

Mission Budget/Cost	Mission Achievement/Impact Factors
Direct service FTE: Community Health Worker, RN, LCSW FTE support from: IT Application, Business Intelligence, Project Management	Health Homes Program pilot PMPM revenue Whole Person Care Pilot PMPM revenue PRIME Project 2.3 pay for performance incentives